PROCEEDINGS OF THE 3RD INTERNATIONAL MUSLIM LEADERS' CONSULTATION ON HIV / AIDS Islamic Approach to HIV / AIDS Enhancing the Community Response

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Sheraton Addis,
Addis Ababa, Ethiopia
23rd - 27th July 2007

USAID

IMAU

EIASC

EMDA

Islamic Approach to HIV/AIDS
Enhancing the Community Response

Jihad on AIDS - Self discipline using Allah's guidance

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3RD INTERNATIONAL MUSLIM LEADERS' CONSULTATION

ON HIV/AIDS

SHERATON ADDIS, ADDIS ABABA, ETHIOPIA

23 – 27 JULY 2007

Theme: THE ISLAMIC APPROACH TO HIV/AIDS:

ENHANCING THE COMMUNITY RESPONSE

Motto: JIHAD ON AIDS – SELF DISCIPLINE USING ALLAH'S GUIDANCE

Organizers : Islamic Medical Association of Uganda
Ethiopian Islamic Affairs Supreme Council

Sponsors : USAID / Health Policy Initiative, Task Order 1 (HPI), Washington
PEPFAR Ethiopia

Partners : World Conference of Religions for Peace
UNAIDS
ACTIONAID
Family Health International (FHI)
Population Services International
Nigerian AIDS Council

Chairman, Organizing Committee: Dr. Magid Kagimu

Programme Officer : Dr. Karama Said

International Advisory Committee:

1. Dr. Magid Kagimu - Uganda
2. Dr. Karama Said - Uganda
3. Ms. Nakimwero Hadija - Uganda
4. Ms. Asiya Mohmood Mwanzi - Kenya
5. Mrs. Durosinmi Lateefa - Nigeria
6. Mr. Nik Fahmee - Malaysia
7. Al Haj Talib Abdul Rashid - New York-USA
8. Dr. Sayed El-Zenari - Egypt
9. Imam Cisse Djiguiba - Ivory Coast

Local Organizing Committee (Ethiopia):

1. Haj Teshale Kero
2. Mr. Nuredin Jamal
3. Ms. Fatuma Abdella
4. Haji Yusuf Yassin Ali
5. Mr. Abdulhafiz Kemal
6. Mr. Nuri Kedir
7. Mr. Elias Seid

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Editors: Dr. Magid Kagimu
Dr. Karama Said
Jan Hogle PhD.

IMAU EIASC EMDA

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ABBREVIATIONS

ART - Antiretroviral Therapy

CBO - Community Based Organizations

CDC - Centers for Disease Control and Prevention

C & S - Care and Support

EIASC - Ethiopian Islamic Affairs Supreme Council

EMDA - Ethiopian Muslim Development Agency

FBOs - Faith-based Organizations

HCT - HIV Counselling and Testing

HQ - Holy Qur'an

IAA - Islamic Approach to HIV/AIDS

ICPIAA - International Centre for Promotion of the Islamic Approach to HIV/AIDS

IGAs - Income Generating Activities

IMAU - Islamic Medical Association of Uganda

IMLC - International Muslim Leaders' Consultation on HIV/AIDS

MYL - Muslim Youth Leaders

MWL - Muslim Women Leaders

NGOs - Non-Government Organizations

PHAs - People Living with HIV/AIDS

PLWHAs - People Living with HIV/AIDS

PMTCT - Prevention of Mother to Child Transmission (of HIV)

RL - Religious Leader

STDs - Sexually Transmitted Diseases

STI - Sexually Transmitted Infections

USAID - United States Agency for International Development

VCT - Voluntary Counselling and Testing

FOREWORD

Bismillahi Rahman Rahim (In the name of Allah the Most Gracious, Most Merciful)

The Third International Muslim Leaders' Consultation (3rd IMLC) was held in Addis Ababa, Ethiopia from 23 – 27 July 2007 at the Sheraton Addis Hotel. Organized by the Islamic Medical Association of Uganda in conjunction with the Ethiopian Islamic Affairs Supreme Council, the consultation was sponsored by USAID / Health Policy Initiative, Task Order 1 (HPI), Washington and PEPFAR Ethiopia. Particpants were well-prepared for the consultation by receiving advance consultation packages on arrival, containing details on the entire programme, and additional information about activities in which they would participate, including group discussions, plenary presentations based on the outcome of the discussions, sharing of experiences on HIV/AIDS issues in different countries, and resolutions and commitments which would be made as part of the consultation. The week ended with a closing ceremony, followed by a field visit to the Grand Mosque of Addis Ababa where the Imam gave a sermon on HIV/AIDS to a large congregation. The details of these activities are presented in this document of the proceedings of the 3rd IMLC.

International Muslim Leaders' Consultations (IMLCs) are a Muslim community initiative intended to promote and coordinate the Islamic approach to HIV/AIDS (IAA). It is believed that as Muslim communities work together in accordance with guidance from Allah in the Holy Qur'an and the traditions of Prophet Muhammad (SAW), their impact on HIV/AIDS will be greater. The first beneficiary in following Allah's guidance is the individual soul. This is emphasized in the Holy Qur'an 39:41 – *"Verily we have revealed the book to them. In truth, for instructing mankind. He then, that receives guidance, benefits his own soul. But he that strays injures his own soul. Nor are you set a custodian over them."*

The value of communities working together is well illustrated by one author in the following quotation:

> "The work of groups can become both more efficient and more significant as our increasingly complex world requires a level of response and innovation beyond the capacity of any single member. A story that illustrates what happens when a system is viewed as a whole is told of the design and building of a new car. The work involved a number of engineers divided into teams each responsible for one aspect of the finished product. Because of the intense time pressure, teams initiated quick fixes on their own whenever anything wasn't working quite right. But many of the quick fixes produced unintended consequences and problems for other teams. For example, solving a vibration problem by adding structural reinforcements increased the weight of the car and created new problems for the chassis team. It wasn't until a working group made up of several teams got together and developed a systems understanding of the whole process that solutions that benefited the whole were discovered and the car was delivered early and under budget. One by-product of seeing the system as a whole was that the various teams began to speak together as one 'we'. Up to this point, there had been someone to blame for every problem: the other teams, their bosses, not enough time. When the 'theys' go away and the 'we' shows up, people's awareness and capabilities change. Much in society is like the dysfunctional car making system. It is not that we need more instruction from the top about what to do; we need more leadership from the bottom about how we can work together to transform the whole into which the parts fall." (Flowers B.S. 2007 The American Dream and the Economic Myth page 32-33. Fetzer Institute).

The IMLCs have a vision of eventually contributing to eradicating HIV/AIDS globally by translating the concept of the Islamic approach to AIDS into practice. The 3rd IMLC was a contribution towards the realization of this long-term vision. It was a working group of Muslim community leaders at many levels who met together to analyze and understand the Islamic approach to HIV/AIDS and how it can be effectively implemented for the benefit of all. These proceedings describe the outcome of the deliberations of this international team. These are the voices of Muslim communities and their friends from 29 different countries and five different continents. A consistent message in these voices underscores the value of using the Islamic Approach to HIV/AIDS (IAA) in addressing all issues concerning the HIV/AIDS pandemic. This message is repeated in line with Allah's method of teaching. Allah's message in the Holy Qur'an is consistent but repeated to ensure improved understanding.

"Allah has revealed from time to time the most beautiful message in the form of a book, consistent with itself, yet repeating its teaching in various aspects. The skins of those who fear their Lord tremble thereat; then their skins and their hearts do soften to the remembrance of Allah. Such is the guidance of Allah. He guides therewith whom He pleases, but such as Allah leaves to stray can have none to guide." HQ 39:23.

There are five other issues, which stand out in these voices. One is participatory training of Muslim leaders in how to implement the IAA. The second one is continuous education and reminding of individuals, families and communities about the practical application of IAA. The third addresses gender imbalances, especially the protection of women. The fourth encourages interfaith collaboration for the promotion of IAA. The fifth one is the importance of monitoring and evaluating the IAA..

These proceedings are intended for all involved in combating AIDS for their own benefit and that of their families and communities. We urge you to read the proceedings in order to increase your understanding of the Global Islamic response to HIV/AIDS. We pray to Almighty Allah to assist you in putting the IAA into practice.

Dr. Magid Kagimu,
Chairman, Organizing Committee for the 3rd IMLC.

THE PROGRAMME

The programme booklet was distributed in advance to the participants. The contents of the booklet included the background to the IMLCs, participants' expectations, and the Ethiopian Muslim history, as shown in the following pages.

Welcome Remarks

In the name of Allah the Most Gracious the Most Merciful

I would like to welcome you all to the 3rd International Muslim Leaders' Consultation on HIV/AIDS (3rd IMLC). AIDS is a global problem that concerns all of us. For some of us, AIDS has reached home and it is a daily problem we have to live with. For others, it is still far from home but we fear it may reach home and we are struggling to keep it away. We are concerned about AIDS as individuals. Anyone can get AIDS through temptations resulting in risky behaviour, or through getting contaminated blood as one undertakes various activities in life. We are concerned about AIDS as families. Our children may get AIDS at the time of birth or when they start engaging in risky behaviours. Our spouses may get AIDS as a result of temptations or through contaminated blood. Our brothers and sisters may get AIDS as a result of their social interactions. We are concerned as social human beings that our friends may get AIDS. We are concerned as nations and as communities that millions of people have got AIDS, millions have died of it and millions may get it in the future. Our major concerns are in the areas of HIV prevention, treatment, care and support. How can we prevent AIDS as individuals, as families, as communities and as nations? How can we treat the disease as individuals, as families and as nations? How can we care and support those who are infected and affected by AIDS, as individuals, as families, as communities and as nations?

The answers to these questions are complex. This is because Allah's world is complex. We need to look for Allah's guidance and use it to be able to live through this complex world successfully. This is the Islamic approach to addressing any concerns or problems, including AIDS. For example, Allah guides us that we must work together to protect each other from problems as indicated in these verses of the Holy Qur'an.

"The Believers, men and women, are protectors, one of another: they enjoin what is just, and forbid what is evil: they observe regular prayers, pay Zakat and obey Allah and His Messenger. On them will Allah pour His mercy: for Allah is exalted in power, wise." HQ 9:71

There is much wisdom in this guidance from Allah. If we work together, the impact on the enemy AIDS will be greater and we shall be better protected. If each one is on their own, the enemy AIDS will take us one by one. A good analogy is that of rice. Assume AIDS the enemy, is a snake in the rice field. If we throw a grain of rice at the snake, it will have no impact. If rice is combined and packed into a sack and we throw the sack of rice at the snake in a coordinated way, the snake is likely to be trapped and killed. We therefore need to work together in a coordinated way. If we are not coordinated, even if we are together, we may miss the target.

Let us all remember that Islam means submission to Allah's will and guidance in all aspects of life. According to the Holy Qur'an, Allah's guidance is the best and most trustworthy guidance in life.

HQ 6:71-73
"Say. Shall we call on others besides Allah, Things that can do us neither good nor harm, and turn on our heels after receiving guidance from Allah? Like one Whom the Satans Have made into a fool, Wandering bewildered through the earth, his friends calling 'come to us', (Vainly) guiding him to the Path. Say: Allah's guidance is the (only) guidance, and we have been directed to submit ourselves to the Lord of the worlds"; "To establish regular prayers and to fear Allah: For it is to Him that we shall be gathered together."
"It is He who created the heavens and the earth with truth: The day He saith, "Be", Behold! it is. His word is the truth. His will be the dominion the day the trumpet will be blown. He knows the unseen as well as that which is open. For He is the wise, well acquainted (with all things).

HQ 2:256-257
"Let there be no compulsion in religion: Truth stands out clear from Error: whoever rejects Tagut (Evil ones, false leaders) and believes in Allah has grasped the most trustworthy hand-hold, that never breaks. And Allah hears and knows all things. Allah is the protector of those who have faith: from the depths of darkness He leads them forth into light. Of those who reject faith the patrons are the Tagut (Evil ones, false leaders) from light they will lead them forth into the depths of darkness. They will be companions of the fire, to dwell therein (For ever)".

Muslim communities believe that if Allah's guidance is followed, all problems can either be prevented or managed properly. They believe that in the ideal situation where everyone is following Allah's guidance, problems such as AIDS would not occur or if they did occur, the impact would be minimal. The challenge for all Muslim communities is to find Allah's guidance and use it to move towards the ideal situation. The degree of success of the communities in meeting this challenge varies. Muslim communities are not homogenous. Some people in the communities are stronger, others are weaker and no one is perfect. However, according to Islamic guidance, believers need to share challenges and successes as they struggle towards the ideal. The stronger ones must support the weaker ones and weaker ones must learn from the stronger ones. The following teaching from Prophet Muhammad (Peace be upon him) illustrates this matter.

"It was related on the authority of Abu-Hurayrah (radiyallahu anhu) that the Prophet (sallalahu alayhi wasallam) said, "Whosoever dispels from a believer some grief pertaining to this world, Allah will dispel from him some grief pertaining to the Day of Rising. Whoever makes things easy for someone who is in difficulties, Allah will make things easy for him both in this life and the next. Whosoever conceals (the fault of) a Muslim, Allah will conceal (his faults) in this world and the next. Allah is ready to help a servant so long as the servant is ready to help his brother. Whosoever walks a path to seek knowledge therein, Allah will make easy for him thereby a path to the Garden. No community ever assembles in one of Allah's houses to recite Allah's Book and carefully study it among themselves but tranquility descends to them, and mercy covers them, and the angels surround them, and Allah makes mention of them among those who are with Him. He whose work detains him will not be hastened by his (noble) ancestry."

Muslim communities have been struggling to combat AIDS using the strength of their faith teachings since the beginning of the AIDS epidemic. Efforts have been made at individual, family, community, national, regional and international levels. The degree of success at these various levels has not yet been satisfactory. New cases of HIV/AIDS are still occurring and these include Muslims. People are still dying of AIDS, including Muslims.

During the International Conference on AIDS held in Durban, South Africa in 2000, some practitioners working in predominantly Muslim communities felt that it was necessary to coordinate the Islamic response to AIDS internationally and create opportunities for sharing experiences and best practices. These practitioners included representatives from the Islamic Medical Association of Uganda, the Islamic Medical Association of South Africa and the Malaysian AIDS Council. These individuals first conceived the idea of International Muslim Leaders Consultations, and attempted to secure funding from various sources for the first consultation. USAID agreed to fund the 1st International Muslim Leaders' Consultation on HIV/AIDS (1st IMLC), held in Kampala in November 2001. The motto was: **"Jihad on AIDS: Self discipline using Allah's guidance".** Participants at this consultation resolved to hold a second consultation in Malaysia, to set up a resource centre in Uganda to promote the Islamic approach to AIDS, and to attempt to institutionalize the Islamic response into an existing International Islamic organization.

Implementing these resolutions took place to a significant extent. The 2nd IMLC was held in Malaysia. At this consultation, participants recognized a need to clarify and articulate the Islamic approach to various issues related to AIDS, and to institutionalize IMLCs to improve planning and follow up of outcomes. The first phase of the Centre for the Promotion of the Islamic Approach to HIV/AIDS was constructed in Uganda, with the recognition of the need for guidance on management and operations to ensure that it fulfils the needs of the communities it is designed to serve.

We are gathered here to continue with the Jihad on AIDS and build on the experiences of the 1st and 2nd IMLCs. We would like to thank all of you who are our partners in the Jihad on AIDS, especially USAID which has consistently supported this initiative. We pray to Almighty Allah to reward you all abundantly. We also pray to Almighty Allah to make the 3rd IMLC a success for the benefit of our communities.

Dr. Magid Kagimu,
Chairman, Organizing Committee for the 3rd IMLC,
International Centre for Promotion of the Islamic Approach to HIV/AIDS, (ICPIAA)
c/o Islamic Medical Association of Uganda
P. O. Box 2773
Kampala, Uganda
Tel: 256-41-4570701/3/4
Mobile: 256-782-016868
Fax: 256-41-4251443
Email: imau@utlonline.co.ug
Website: www.imau-uganda.org

BACKGROUND TO THE INTERNATIONAL MUSLIM LEADERS' CONSULTATIONS ON HIV/AIDS (IMLCS)

From: International Centre for Promotion of the Islamic Approach to HIV/AIDS:
c/o Islamic Medical Association of Uganda
P. O. Box 2773 Kampala Uganda,
Tel: 256-414-570701/3/4
Email : imau@utlonline.co.ug
Website : www.imau-uganda.org

In the name of Allah the most Gracious, the most Merciful

"O ye who believe! Fear Allah as He should be feared, and die not except in a state of Islam. And hold fast, all together, by the rope which Allah (stretches out for you), and be not divided among yourselves; and remember with gratitude Allah's favour on you; for you were enemies and He joined your hearts in love, so that by His Grace, you became brethren; And you were on the brink of the pit of fire, and He saved you from it. Thus does Allah make His signs clear to you: That you may be guided. 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: They are the ones to attain felicity. Be not like those who are divided amongst themselves and fall into disputations after receiving clear signs. For them is a dreadful chastisement." HQ 3:102-105

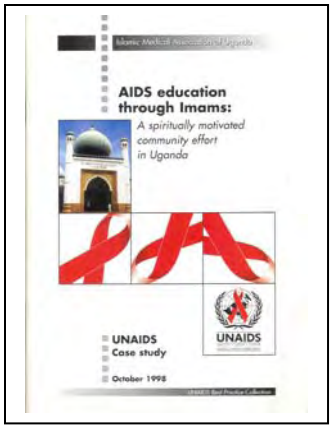
Allah gives us guidance in the above verses of the Holy Qur'an regarding the way believers should live in view of the complexity of problems that they may face in His world. They should submit to Allah's will and guidance up to the time of death. They should work together using Allah's guidance. It is Allah's guidance that turns people who would have been enemies, into friends working together. Believers must not be divided among themselves after the clear guidance of Allah. It is not wise to engage in disputes after the clear guidance of Allah. There must arise a band of people among the believers coordinating the community response, educating the people about what is right and forbidding what is wrong, to ensure success in life when faced with problems such as AIDS. Therefore, AIDS is a global problem that can be addressed using Allah's guidance to believers regarding coordination and working together.

What has the Muslim community done so far to coordinate their response to HIV/AIDS?

The AIDS epidemic was first identified in the early 1980's. Initially it was thought to be among homosexual men in the USA who were also intravenous drug users. Later on, it was noted in the heterosexual population in other parts of the world, especially in Africa. The major modes of HIV transmission were identified as: sex between men and women, sex between men and men, intravenous drug use when sharing contaminated needles, and transmission of the virus from mother to child. All these modes are related to the behaviours of communities. HIV/AIDS was noted to be occurring in people engaging in risky behaviours regardless of race or religion. It was recognized by the scientific community that prevention and control of HIV infection would require a change of behaviours from those that were risky to those that are safer.

Faith communities recognized that they could play a significant role in promoting behaviours that minimize HIV infection, and therefore began promoting behavior change among their followers. Many communities initially worked in isolation to tackle the epidemic. There were many challenges, including how to respond to those who deviate from faith teachings. Eventually, religious leaders recognized a need to organize opportunities for sharing experiences in dealing with the challenges of the new epidemic. People in the Christian faith were among the first to organize consultations on HIV/AIDS for their leaders and followers.

Muslim communities were slower in organizing a unified and coordinated response for their communities. Many individuals and organizations worked in isolation to address the challenges of HIV/AIDS in their communities. The Islamic Medical Association of Uganda (IMAU) was one of these organizations. In 1989, IMAU began mobilizing Muslim communities in Uganda to start using the strength of their faith to combat AIDS. The top Muslim leader in Uganda at that time, the Chief Kadhi, noted after a dialogue with IMAU that fighting AIDS was a struggle of the soul to control behaviour. This was the Jihad of the soul that Prophet Muhammad (Peace be upon him) had encouraged among all his followers. The Chief Kadhi therefore declared a Jihad on AIDS to re-awaken the Muslim community in Uganda to fight the epidemic using the strength and guidance of the Qur'an and the teachings of Prophet Muhammad (SAW).



IMAU then provided technical and logistic support to over 1,000 Imams to help them educate their communities in how to prevent and control HIV/AIDS. Muslim communities in Uganda welcomed this initiative. In 1998, UNAIDS identified this initiative in their 'Best Practices Collection' as one of the effective ways to mobilize communities to combat AIDS. With support from UNAIDS and other partners, this initiative was shared with Muslim communities in other countries in Asia and Africa including Malaysia, Tanzania, South Africa and Nigeria. In the process of sharing this experience, participants realized that Muslim communities in various parts of the world have similar values and aspirations, because they derive their guidance from common sources, namely the Holy Qur'an and teachings of Prophet Muhammad (SAW). These communities therefore face similar challenges. They generally agreed that guidance from Allah would help them to manage the HIV/AIDS epidemic. However, implementing these guidelines at the community and individual level remained a major challenge. Those who were trying to implement this Islamic approach needed opportunities to share their experiences with their colleagues.

In 2000, a group of Muslim practitioners interested in using the Islamic approach to combat HIV/AIDS met in Durban, South Africa during the International Conference on AIDS, including representatives from the Islamic Medical Association of Uganda, Islamic Medical Association of South Africa and the Malaysian AIDS Council. The group noted that the interests of Muslim communities were not being adequately addressed by current international AIDS conferences. They agreed to organize an international consultation to share experiences of Muslim communities and to begin to articulate the Islamic approach to combating AIDS. The 1st International Muslim Leaders' Consultation on HIV/AIDS was then held in Kampala, Uganda, sponsored by USAID, in November 2001 with proceedings published in 2002. Participants agreed on the following major resolutions:

1. Mobilize resources and conduct three-day workshops to disseminate experiences and results of the consultation to Muslim Leaders at various levels in our respective countries.
2. Hold the 2nd International Muslim Leaders Consultation in Malaysia after one year on a suitable date to be determined by the Malaysian AIDS Council.
3. Establish an international resource centre in Uganda for coordinating and promoting the Islamic approach to HIV/AIDS prevention and control at the international level.
4. Lobby the Organization of Islamic Conference (OIC) to establish or designate a department or a desk for promoting the Islamic approach to HIV/AIDS prevention and control. The representative from Jordan will lead the lobby along with other countries including Malaysia, Uganda and Sudan.

As noted above, it was resolved to establish a resource centre in Kampala, Uganda to coordinate the Muslim community response. IMAU was able to obtain funds to start the resource centre as part of Saidina Abubakar Islamic Hospital (SAIH). This centre is functional at the moment with volunteers from IMAU.

The 2nd IMLC was held in Malaysia in 2003. At this consultation, participants resolved to hold a 3rd IMLC in 2005 assuming God willing and funds become available. There were special challenges that arose during the 2nd IMLC. It was not clear whether the deliberations of the consultation were within Islamic guidance. It was therefore resolved that a committee of Muslim scholars review the proceedings prior to publication to ensure Islamic guidance was followed. Due to financial and logistic constraints, this committee was not able to meet. Another challenge noted was that the mission, vision, objectives and management of IMLCs were not clear. The role of the resource centre was also not clear since the centre is supposed to follow up the resolutions of IMLCs but it had not been facilitated to do so.

During the 1st IMLC, it was resolved that participants hold three-day workshops for leaders in their countries to disseminate experiences and results of the consultations. It was only in a few countries such as Nigeria and Malawi where these workshops took place. No system had been set up to document and track implementation of this resolution. The expected impact of IMLCs on Muslim communities was not clearly identified. We hope to build on these experiences and address the challenges during the 3rd IMLC.

What is the way forward with regards to coordination of the Muslim community response to AIDS?

The Muslim community is not homogeneous. However, there are some generally agreed Islamic principles that can be adapted and implemented by various communities in their fight against AIDS, depending on the local situation. These principles are not yet adequately articulated and utilized. One of the objectives of IMLCs should be to discuss and articulate these principles including the way they can be used to fight AIDS. There is also a need to implement, monitor and evaluate projects within Muslim communities based on the common principles of the Islamic approach to HIV/AIDS prevention, treatment, care and support. The implementation experience can then be shared at IMLCs and best practices scaled up. In other words, in order to increase the impact and effectiveness of their response to HIV/AIDS, Muslim communities should work to put UNAIDS' "Three Ones" concept into practice, namely: one coordinating mechanism, one strategic framework for action, and one monitoring and evaluation framework to track outcomes and impacts.

This concept is in line with Allah's guidance calling on believers to work together and avoid disputes that divide them. In conjunction with several international stakeholders, IMAU held a planning meeting in March 2005 in Kampala, Uganda to create a basic strategic framework for coordinating the global Islamic response to HIV/AIDS, in view of the experiences and challenges of the 1st and 2nd IMLCs. This strategic framework appears on the following pages.

STRATEGIC FRAMEWORK FOR ACTIVITIES OF THE INTERNATIONAL CENTRE FOR PROMOTION OF THE ISLAMIC APPROACH TO HIV/AIDS

Mission:
To provide practical and current resources on the Islamic Approach to HIV/AIDS for sharing locally and internationally.

Vision:
An International Centre of excellence implementing the Islamic Approach to HIV/AIDS.

Goal:
To enhance effective responses of communities to HIV/AIDS through access to resources based on Islamic principles and scientific knowledge.

Objectives:

Objective 1:
To establish a functional international centre for coordination, advocacy and promotion of the Islamic approach to HIV/AIDS prevention, treatment, care and support for the benefit of all communities.

Activities:
1. Construct and equip the training facilities for the Islamic approach to HIV/AIDS including a mosque, conference facilities, library and offices.
2. Hire personnel to manage the centre.
3. Deliver services for HIV/AIDS prevention, treatment, care and support using the Islamic approach, at the centre.

Objective 2:
To establish satellite project sites using the Islamic approach to HIV/AIDS.

Activities:
1. Initiate, establish and support demonstration project sites using the Islamic approach to HIV/AIDS prevention, treatment, care and support. Respective local stakeholders will run the services.
2. Hire local personnel to manage the sites.
3. Deliver services for HIV/AIDS prevention, treatment, care and support using the Islamic approach, at the sites.

Objective 3:
To establish a network of stakeholders promoting the Islamic approach to HIV/AIDS.

Activities:
1. Build capacity of coordinators for the Islamic approach to HIV/AIDS.
2. Participate in organizing International Muslim Leaders' Consultation (IMLCs).
3. Participate in organizing international technical committees. The committees will consist of Muslim scholars, religious leaders, health professionals and other stakeholders. They will draft practice guidelines for the Islamic approach to various HIV/AIDS related issues.
4. Provide Secretariat services for the IMLCs.

Objective 4:

To conduct research, publish and disseminate findings on various aspects of Islamic approach to HIV/AIDS.

Activities:

1. Initiate and write research proposals on various aspects of the Islamic approach to HIV/AIDS.
2. Organize and facilitate collaborative research on the Islamic approach to HIV/AIDS.
3. Mobilize resources for research.
4. Conduct research on various aspects of the Islamic approach to HIV/AIDS including the evaluation of the rationale and effectiveness of the Islamic approach to HIV/AIDS.
5. Generate data for the effective management of HIV/AIDS using the Islamic approach.

Objective 5:

To document and disseminate best practices on the Islamic approach to HIV/AIDS.

Activities:

1. Publish and disseminate monographs on various aspects of the Islamic approach to HIV/AIDS.
2. Attend conferences and meetings to share experiences of the Islamic approach to HIV/AIDS with other stakeholders.
3. Make a database of resource persons with expertise in the implementation of the Islamic approach to HIV/AIDS.
4. Organize technical assistance missions to assist in the implementation of the Islamic approach to HIV/AIDS.

Objective 6:

To enhance the quality of life of the communities using the centre.

Activities:

1. Provide holistic quality services to the communities using the centre.

Monitoring and Evaluation of the centre:

Activities:

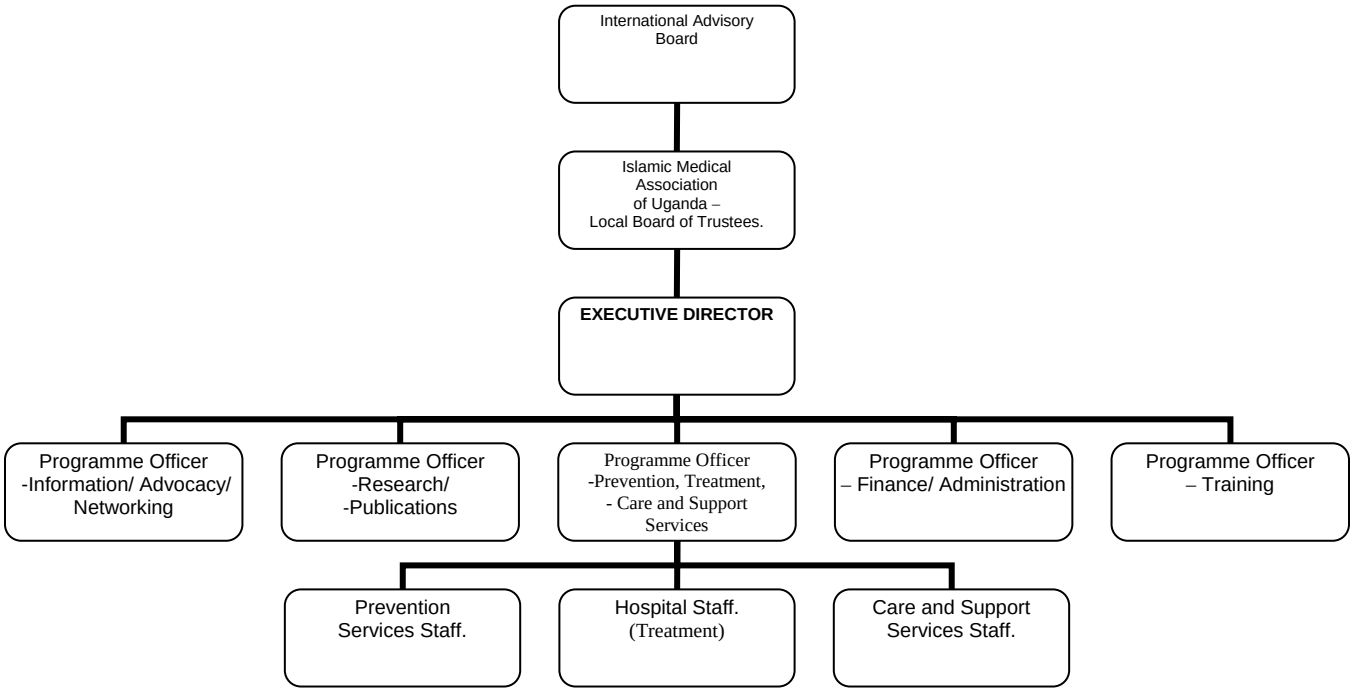
1. Consult a monitoring and evaluation expert.
2. Design monitoring and evaluation guidelines.
3. Disseminate guidelines to all concerned.
4. Review performance of the centre.
5. Receive feedback from country level activities.
6. Produce reports on centre activities.

Management of the Centre:

Activities:

1. Identify required personnel.
2. Create a budget for the centre including recurrent and development budgets.
3. Seek funding for the centre.

Organization Structure of the International Centre for the Promotion of The Islamic Approach to HIV/AIDS:



STRATEGIC FRAMEWORK FOR ACTIVITIES RELATED TO THE INTERNATIONAL MUSLIM LEADERS' CONSULTATIONS ON HIV/AIDS (IMLCs)

Mission:
To promote and coordinate the Islamic approach to HIV/AIDS by learning from and sharing experiences.

Vision:
To eradicate HIV/AIDS globally using the Islamic approach.

Goal:
To reach a consensus on the Islamic approach to HIV/AIDS.

Objectives:

Objective 1:
To conduct IMLCs every two years.

Activities:
1. Constitute an international planning committee.
2. Determine a theme.
3. Constitute sub-committees for implementation.

Objective 2:
To articulate the Islamic approach to HIV/AIDS.

Activities:
1. Identify contemporary issues related to HIV/AIDS.
2. Identify Islamic teachings related to these issues.
3. Reach a consensus, document and disseminate the outcome.

Objective 3:
To assess and share experiences on various aspects of the Islamic Approach to HIV/AIDS.

Activities:
1. Call for abstracts on studies and interventions conducted in various areas of the Islamic approach to HIV/AIDS.
2. Review abstracts and select best practices.
3. Call for and review full papers.
4. Select and share best practices.

Objective 4:
To conduct regional Muslim Leaders Consultations (RMLCs) annually.

Activities:
1. Constitute a regional planning committee.
2. Determine a theme.
3. Constitute sub-committees for implementation.
4. Organize regional consultations.
5. Review post-IMLC interventions at country level.
6. Make recommendations

Objective 5:
To develop a five year strategic plan for IMLCs.

Activities:
1. Constitute a strategic planning committee.
2. Consult experts.
3. Make a draft strategic plan after consultation.
4. Share the draft strategic plan with stakeholders.
5. Make a final strategic plan.
6. Publish and disseminate the plan.

Monitoring and Evaluating the IMLCs:

Activities:
1. Consult a Monitoring and Evaluation expert.
2. Design monitoring and evaluation guidelines.
3. Disseminate guidelines to all concerned.
4. Review performance of IMLCs.
5. Receive feedback from country level activities.

Management of IMLCs:

Expected impact of IMLCs at the community level:

1. Participants will mobilize their local Muslim leaders to learn from the experiences of the consultation and discuss the way forward.

2. Increase awareness of the Islamic approach to HIV/AIDS among all stakeholders locally in host countries and internationally.

3. Increase commitment of participants to implement strategies set during IMLCs.

4. Develop networks among participants to ensure effective responses follow the consultations.

5. Identify projects for implementation with international collaboration, using the Islamic approach to HIV/AIDS.

FIRST INTERNATIONAL MUSLIM LEADERS' CONSULTATION ON HIV/AIDS:

Kampala, Uganda: 1 – 4th November 2001

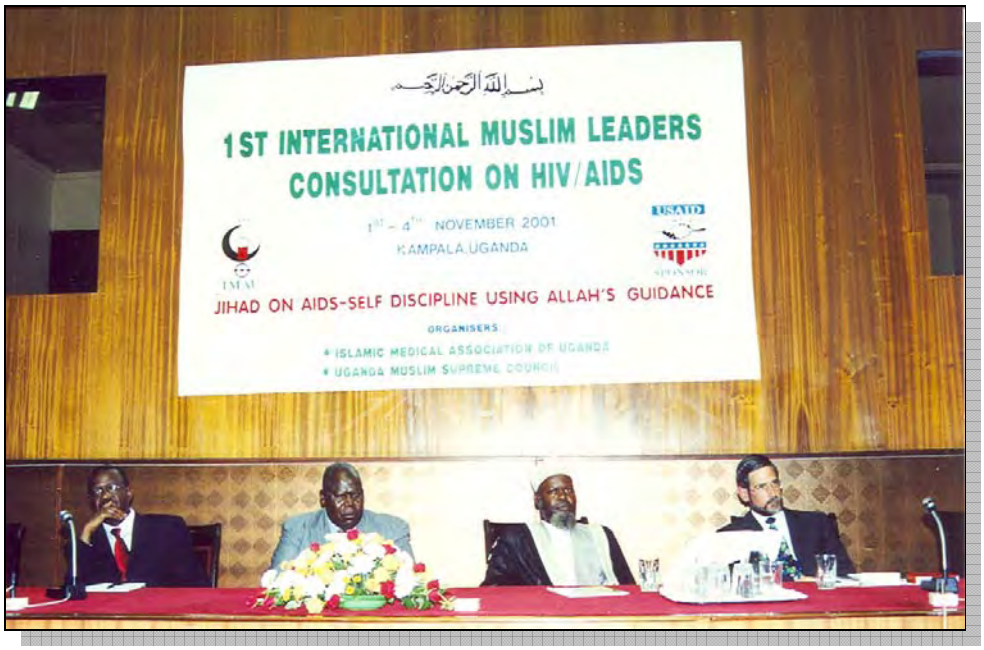
Theme:
Strategies for strengthening and expanding the international Muslim community response to AIDS.

Motto:
Jihad on AIDS: Self discipline using Allah's guidance.

Goal:
Achieve greater involvement and better co-ordination of Muslim communities in their HIV/AIDS prevention and control efforts, both nationally and internationally.

Specific objectives:

1. To share experiences so far gained regarding the national and international Muslim community response to HIV/AIDS.
2. To discuss and articulate the Islamic contribution to HIV/AIDS prevention.
3. To discuss and articulate the Islamic contribution to HIV/AIDS care and support.
4. To discuss and articulate the Islamic contribution to mitigating the impact of HIV/AIDS.
5. To discuss and articulate strategies for strengthening, expanding and evaluating the national and international Muslim community response to HIV/AIDS.



2ND INTERNATIONAL MUSLIM LEADERS CONSULTATION ON HIV/AIDS:

Kuala Lumpur, Malaysia: 19th – 23rd May, 2003

Theme:
The caring Ummah: Transforming the response.

Objectives:

1. To explore the feasibility of creating a Muslim leaders' HIV/AIDS network.
2. To discuss the role and use of faith in response to awareness and prevention of HIV/AIDS.
3. To explore the application of Islamic principles/teachings in response to prevention, care and support of HIV/AIDS.
4. To discuss the creation of a positive and enabling environment to mitigate stigma and discrimination.
5. To discuss and address the vulnerability and impact of HIV/AIDS on women, orphans and children.

Expectations:

1. Identify and document progress made since the 1st IMLC.
2. Strengthen mechanisms for sharing experiences.
3. Formalize the organizational structure for convening future International Muslim Leaders' Consultations.
4. Advocate for strengthening the use of the Islamic faith in HIV prevention, care and support.
5. Improve commitment at various levels of the community and government regarding the use of the Islamic approach to HIV/AIDS.
6. Coordinate Muslim communities in identifying initiatives and activities around the world using the Islamic approach to AIDS in order to make this information known for possible emulation and adaptation by other Muslim communities.

Proposed outcomes:

1. A "Declaration of Commitment" for individual Muslims to be able to make their own personal commitment to the issue of HIV/AIDS.
2. Production of IEC materials that help to mitigate and sustain understanding in dealing with the issue of HIV/AIDS in the context of Islam.
3. Share experiences of using the Islamic approach to prevent AIDS.
4. Train Muslim leaders as facilitators to promote the Islamic approach to HIV/AIDS in their communities.
5. Develop common strategic plans, guidelines and policies to combat HIV/AIDS.
6. Build and strengthen the organizational capacity of the Muslim community at the international level.
7. Initiate international task forces to advise Muslim communities on issues of HIV/AIDS.

3RD INTERNATIONAL MUSLIM LEADERS CONSULTATION ON HIV/AIDS:

Addis Ababa, Ethiopia: 23rd – 27th July 2007

Theme:
The Islamic Approach to HIV/AIDS: Enhancing the Community Response

Motto:
Jihad on AIDS: Self discipline using Allah's guidance.

Goal:
To reach a consensus on the strategies and modalities for implementing the Islamic approach to HIV/AIDS prevention, treatment, care and support.

Purpose:
To bring Muslim leaders together as a "Think Tank" to discuss contemporary issues on HIV/AIDS from the Islamic perspective.

Objectives of The 3rd IMLC:

1. To articulate and analyze the concept of the Islamic approach to HIV/AIDS and how it can be transformed from theory into practice.
2. To share experiences on the implementing various aspects of HIV/AIDS prevention, treatment, care and support using the concept of the Islamic approach to AIDS
3. To develop basic strategic plans to reach Muslim communities more effectively in implementing the Islamic approach to HIV/AIDS.
4. To plan for follow up activities after the 3rd IMLC in relation to implementing the Islamic approach to HIV/AIDS.

Expected Outcomes Of The 3rd IMLC, Inshallah (God Willing):

1. Participants will reach a consensus on the concept of the Islamic approach to HIV/AIDS and how it should be transformed from theory into practice.
2. Participants will share experiences and best practices on the implementation of the Islamic approach to HIV/AIDS.
3. Participants will develop basic strategic plans for implementing the Islamic approach to HIV/AIDS among Muslim communities.
4. Document and disseminate the proceedings of the 3rd IMLC.
5. Enhance the capacity and enthusiasm of participants to implement the Islamic approach to HIV/AIDS prevention, treatment, care and support.

3rd IMLC Participants' Expectations

1. Develop a concrete policy to reduce stigma and discrimination of PHAs, especially women.
2. Address Islamic practices that may strengthen the empowerment and support of PHAs and their legal rights. Set up a fund to assist unemployed Muslim PHAs to start IGAs.
3. Share experiences, professional ideas and expertise in the Islamic approach to HIV/AIDS prevention, treatment, care and support including data from Muslim populations and best practices from various countries.
4. Form a task force to articulate resolutions to advocate for priority funding from donor countries for projects in Muslim communities.
5. Produce one strategic plan to guide Muslim communities in implementing HIV/AIDS work in their countries. This must include a practical way of monitoring the Islamic approach to AIDS (IAA) activities and following up recommendations.
6. Plan dates and host countries for future IMLCs.
7. Develop a methodology for approaching issues of HIV/AIDS within the IAA, including but not limited to condom use, premarital VCT, polygamous unions, commercial sex work, sexual orientation, and injecting drug use, and attempt to reach consensus, using supporting verses from the Qur'an and Hadith.
8. Explore the role of doctors, other health workers, and communities in promoting Islamic principles and practices in dealing with the moral, psychosocial and ethical dilemmas facing Muslim PHAs.
9. Address the role of youth in the Islamic approach to HIV prevention, treatment, care and support in Islamic countries, and sharing experiences with youth participants.
10. Integration of HIV/AIDS issues in other development programmes such as health, education, poverty alleviation, sanitation.
11. Expect to write a report on the 3rd IMLC and share with colleagues in home countries.
12. Experience the process of organizing national and international conferences, especially IMLCs.
13. Create a strong partnership and network to standardize and enhance the scale up of the IAA at the country level; network should include religious leaders, professionals and institutions concerned.
14. Contribute freely on areas of common interest to develop implementation guidelines for the IAA.
15. Assess and promote HIV/AIDS knowledge among the participants.
16. Recognize the scientific aspects of IAA and that such an approach can be effective in coping with the HIV/AIDS epidemic.
17. Share various approaches to IAA implementation, challenges and how to deal with them.
18. Identify the role of Muslim Supreme organizations in countries.
19. Provide literature, CDs and manuals to the participants to enhance greater understanding of the IAA.
20. Explore the issue of gender vulnerability to HIV/AIDS, and risks to women and children.
21. Provide training and capacity building to design and implement projects, and to promote IAA, Islamic values and cultural norms in various Muslim communities.
22. Receive a certificate of attendance.
23. Document a commitment from participants to implement the IAA.
24. Clarify and reach consensus on the Islamic approach to HIV/AIDS, and identify which aspects of IAA are applicable in non-Islamic settings.
25. Compare IAA with other non-Islamic approaches.

Programme For The 3RD IMLC -- Addis Ababa, Ethiopia: 23rd – 27th July 2007

Theme: "The Islamic Approach to HIV/AIDS: Enhancing the Community Response"

TIME	Day 1:	Sunday 22/7/2007
8.00 a.m-8.00 p.m.		Arrival, registration and introduction to programme
7:00 pm. – 9:00 pm.		Dinner
		Day 2: Monday 23/7/2007
Session 1:		**Opening Ceremony -- Chairperson and Master of ceremonies**: **Mr. Nuredin Jamal**
8.00 a.m. -9:00 am.		Arrival and registration of participants and guests
9.00 a.m.-9:10 am.		Recitation of the Holy Qur'an 10: 1-5 and reflections by Sheikh Taha Harun from Ethiopia
9:10 a.m.-9:20 am.		Welcome remarks by the Head of Relief and Social development sector - Haji Teshale Kero, The Ethiopian Islamic Affairs Supreme Council
9:20 a.m.-9:25 am.		Welcome song
9:25 a.m.-9:35 am.		Welcome speech by General Secretary, Ethiopian Islamic Affairs Supreme Council - Haji Yusuf Ali Yassin
9:35 a.m.-9:45 am.		Speech by the Chairman, International Advisory Committee – Dr. Magid Kagimu
9:45 a.m.-10:05 am.		**Key note address by Prof. Malik Badri**: Enhancing the transformation of The Islamic Approach to HIV/AIDS prevention, treatment, care and support from theory to community practice: Why the Islamic approach should work to control HIV/AIDS, why it is not adequately working, and how it should be made to work better.
10:05 a.m.-10:10 am.		Ethiopian song
10:10 a.m.-10:50 am.		Speech by Guest of Honour – Dr. Tedros Adhanom Ghebreyesus, Minister of Health, Ethiopia
10:20 a.m.-10:20 am.		Speech by US Ambassador – Mr. Donald Yamamoto
10:50 a.m.-11:30 am.		Group photo and break tea
Session 2: Background Information: Chairperson: Dr. Munirat Ogunlayi		
11.30 a.m.-11:40 am.		Recitation of the Holy Qur'an 42:30-43, and reflections by Imam Talib Abdul Rashid
11:40 a.m.-12:10 pm.		Introductions and background to 3rd IMLC by Dr. Magid Kagimu
12.10 a.m.-12:40 pm.		Scientific update on the HIV/AIDS pandemic in the world and in the Muslim communities: Transmission, Prevention, Treatment, Care and Support. Speaker: Dr. Oussama Tawil from UNAIDS (Middle East and North Africa (MENA) Region)
12:40 pm.- 12:50 pm.		Islamic Approach to HIV/AIDS: Experience of the Islamic Republic of Iran: Ayatollah Gorban-ali Dorri Najaf-abadi: State Prosecutor General of the Islamic Republic of Iran.
12.50 p.m.- 2:30 pm.		Lunch and Dhuhur prayers
Session 3: Plenary session followed by Group discussions: Chairperson: Dr. Lateefah Durosinmi		
2.30 -2.50 p.m.		Introduction to Group discussion themes: Situation Analysis: Mr. Jim Cairns/Dr. Karama Said
2:50-3.00 p.m.		Reflections by Muslim living with HIV/AIDS
3.00 p.m.		Group discussions: Questions 1 – 4.
4.30 p.m.		Break tea and Asr prayers
5.00 p.m.		Group discussions continued: Questions 1 – 4.
7.00 p.m.		Magharib prayers
7.10 p.m.		Meetings of drafting committees for presentations, resolutions and evaluation
8.00 p.m.		Isha prayers
8.30 p.m.		Dinner.

Day 3: Tuesday 24/7/2007

Session 4: Plenary group presentations. Chairperson Dr. Sayed El Zenary

8.00 -8.10 a.m. Recitation of the Holy Qur'an 96: 1-19, and reflections by Sheikh Ali Lubowa
8.10-10.30 a.m. 15 minutes: power point presentations, 13 minutes: discussions.
Questions 1 - 4 Groups I - V
10.30 a.m. Break tea

Session 5: Sharing experiences of progress, best practices and challenges in the implementation of the Islamic approach to HIV/AIDS. Chairperson: Ms. Yousra Bagadi

Session 5(a) Partnership with Imams and other religious leaders:

11.00-11.10a.m. Topic: Exploring the Islamic potential as a solution for HIV/AIDS
Speaker: Mr. Nuredin Jamal Mukhtar – Ethiopia.
11.10-11.20a.m. Topic: Implementing the Islamic approach to HIV/AIDS at the mosque level:
Successes and challenges from Ugandan Imams.
Speaker: Sheikh Shaban Ramadhan Mubajje – Mufti of Uganda - Uganda
11.20-11.30a.m Topic: The Lambeth Southwark and Lewsiham African Muslim Communities
Campaign against HIV: Speaker: Ms. Sukainah Jauhar – United Kingdom
11.30-12.00 noon Discussions.

Session 5(b) : HIV/AIDS awareness among Muslims:

12.00-12.10p.m. Topic: Afghanistan Human Rights organization: HIV/AIDS and STI awareness program
Speaker: Dr. Baz Mohammad Shirzad – Afghanistan.
12.10-12.20p.m Topic: HIV/AIDS overview and Philosophy of control in Sudan.
Speaker: Dr. M.S. Al Khalifa – Sudan.
12.20-12.30p.m Topic: HIV/AIDS awareness in the Arab States.
Speaker: Dr. Sayed El-Zenari - Egypt
12.30-1.00p.m. Discussion.
1.00 p.m. Dhuhur prayers and lunch

Session 6: Plenary session followed by Group discussions: Chairperson: Hadijah Nakimwero

2.30-2.50 p.m. Introduction to Group discussion themes:
Goals, objectives, activities, implementation -- Mr. Jay Gribble
2:50-3.00 p.m. Reflections by Muslim living with HIV/AIDS
3.00 p.m. Group discussions – Questions 5 – 9.
4.30 p.m. Asr prayers and evening tea.
5. 00 p.m. Group discussions continue – Questions 5 – 9.
7.00 p.m. Magharib prayers
7.10 p.m. Meetings of drafting committees for presentations, resolutions and evaluation
8.00 p.m. Isha prayers
8.30 p.m. Dinner

Day 4: Wednesday 25/7/2007

Session 7: Plenary group presentations. Chairperson: Ms. Bibi Dhansay

8.00-8.10 a.m. Recitation of Holy Qur'an 17: 32-39 and reflections by Sheikh Muhammad Waiswa
8.10 -10.30 a.m. 15 minutes power point presentation, 13 minutes discussion.
Questions 5 – 9 Groups I – V
10.30 a.m. **Break tea.**

Session 8: Sharing experiences of progress, best practices and challenges in the implementation of the Islamic approach to HIV/AIDS. Chairpersons: Imam Talib Abdur Rashid and Mr. Abdulhafiz Kemal Issa.

Session 8(a): Addressing the needs of Muslim women and youth:

11.00-11.10a.m. Topic: Promoting sexual reproductive health rights issues of Muslim Women in Purdha Practice. Speaker: Hajarat Suleiman – Nigeria.

11.10-11.20a.m Topic: Essential life skills for effective implementation of the Islamic approach to HIV/AIDS prevention, treatment, care and support among women and youth. Speaker: Mrs. Hadija Nakimwero, Kibira, Uganda.

11.20-11.30a.m. Topic: Sexual health and HIV/AIDS primary prevention needs of African Muslim women in London Borough of Camden. Speaker: Ms. Yousra H. Bagadi – UK

11.30-12.00 noon Discussion.

Session 8(b): Addressing needs of women and youth continued:

12.00-12.10p.m Topic: Social economic impact of HIV/AIDS on youth: A Kenyan perspective of Muslim youth affected by the epidemic. Speaker: Ms. Rukia Bakari - Kenya

12.10-12.20p.m Topic: Experience with African religious leaders living with HIV/AIDS. Speaker: Sheikh Ali Banda.

12.20-12.30p.m Topic: Stigma, a hinderance to HIV/AIDS prevention interventions in Muslim communities in Nigeria: A case study of the Federal Capital Territory Abuja Nigeria. Speaker: Ismael Abdulqadir Danesi – Nigeria.

12.30-1.00p.m Discussion.

1.00 p.m. Dhuhur prayers and lunch.

Session 9: Plenary session followed by Group discussions. Chairperson: Mr. Nuri Kedir

2.30-2.50 p.m. Introduction to group discussion themes: Monitoring, evaluation, resource mobilization, resolutions and commitments: - Dr. Jan Hogle

2:50-3.00 p.m. Reflections by Muslim living with HIV/AIDS

3.00 p.m. Group discussions – Questions 10-13

4.30 p.m. Asr prayers and evening tea.

5.00 p.m. Group discussions continue – Questions 10-13.

7.00 p.m. Maghrib prayers

7.10 p.m. Meetings of draft committees for presentations, resolutions and evaluation.

8.00 p.m. Isha prayers

8.30 p.m. Dinner

Day 5: Thursday 26/7/2007

Session 10: Plenary Group presentations. **Chairperson: Mr. Nuredin Jamal**

8.00-8.10a.m Recitation of the Holy Qur'an 4: 59-64 and reflections by Sheikh Abdul Magid Mbago

8.10-10.30 a.m. 15 minutes power point presentation and 13 minutes discussion. Questions 10 – 13, Groups I - V

10.30 a.m. Break tea

Session 11: Sharing experiences of progress, best practices and challenges in the implementation of the Islamic approach to HIV/AIDS. **Chairpersons: Mr. Nuri Kedir/Prof Wasey Akhtarul**

Session 11(a): Interfaith collaboration:

11.00-11.10a.m Topic: FBOs and religious leaders involvement in HIV/AIDS in Zanzibar. Speaker: Ms. Nuru R. Mbarouk – Zanzibar.

11.10-11.20a.m Topic: Peace building and interfaith dialogue to combat HIV/AIDS in Indonesia. Speaker: Ms. Dhalia Madanih – Indonesia.

11.20-11.30a.m Topic: Working with other religious communities to promote the Islamic approach to HIV/AIDS: Speaker: Mr. Jim Cairns – World Conference of Religions for Peace/USA.

11.30-12.00noon. Discussion.

Session 11(b): Implementation of the Islamic approach to HIV/AIDS:

12.00-12.10p.m Topic: Training Nigerian Muslim Leaders on HIV/AIDS:

Speaker: Dr. Lateefah Durosinmi – Nigeria.

12.10-12.20p.m Topic: Islamic Approach to HIV/AIDS through male circumcision.

Speaker: Dr. Farag El Mobasher - Sudan

12.20-12.30p.m Topic: The Islamic faith based network model for improving HIV/AIDS services.
Speaker: Dr. Zainab Akol - Uganda

12.30-1.00p.m Discussion.

1.00 p.m. Dhuhur prayers and lunch

Session 12: Plenary discussion, resolutions, workplan and way forward related to the Islamic approach to HIV/AIDS prevention, treatment, care and support and how to enhance its implementation by individuals, families and communities.
Chairpersons: Dr. Magid Kagimu/Mr. Nuredin Jamal

4.30 p.m. Asr prayers and break tea.
5.00 p.m. Plenary discussions continue
7.00 p.m. Maghrib prayers
7.10 p.m. Meetings of drafting committees for resolutions and evaluation.
8.00 p.m. Isha prayers
8.30 p.m. Dinner

Day 6: Friday 27/7/2007

Session 13: Resolutions and closing ceremony:Chairpersons: Haji Teshale Kero/Dr. Magid Kagimu

8.00-8.10 a.m Recitation of the Holy Qur'an 7: 200-206, translation and reflections by Sheikh Lubowa Ali Ali - Uganda

8.10-9.10 a.m Presentation of final resolutions, commitments and workplans– Dr. Lateefah Durosinmi

9.10-10.30a.m. Closing ceremony. Master of ceremony – Mr. Nuredin Jamal

9:10 a.m.-9:20 am. Closing remarks by the Chairman Local Organizing Committee – Haji Teshale Kero

9:20 a.m.-9:20 am. Vote of thanks by the Chairman International Advisory Committee – Dr. Magid Kagimu

9.25 a.m – 9.30 a.m Vote of thanks by participants representative – Prof. Wasey Akhtarul

9:30 a.m.-9:35 am. Ethiopian song

9:35 a.m.-9:45 am. Speech by representative of US Government – Mr. Scott from USAID

9:55 a.m.-10:15 am. Speech by Chief Guest –Sheikh Elias Redman, Vice President Ethiopian Islamic Affairs Supreme Council

10:15 a.m.-10:20 am. Closing Dua

10:20 a.m.-10:50 am. BREAK TEA

Session 14: Field visits

10.50 a.m. Field visit to a mosque community implementing the Islamic approach to HIV/AIDS
Sheikh Taha Harun, Mr. Nuredin Jamal, Haj Teshale Kero

12.30 p.m. Juma prayers and lunch
2.30 p.m. Continuation of field visits
4.30 p.m. Asr prayers and evening tea
5.00 p.m. Continuation of field visits
7.00 p.m. Maghrib prayers
8.00 p.m. Isha prayers
8.30 p.m. Dinner

3RD IMLC ENDS.

MUSLIMS AND ISLAM IN ETHIOPIA

From: Ethiopian Islamic Affairs Supreme Council

It was Allah's wish that the 3rd IMLC be held in Ethiopia. IMLCs are learning opportunities. It is likely Allah wanted us to learn and reflect on Muslims and Islam in Ethiopia. There are many lessons to learn. One of them is that Ethiopia was the first nation outside of Arabia to protect Islamic values and freedoms. The Islamic approach to HIV/AIDS is a value that needs protection in the fight against AIDS. Ethiopia is therefore a good reminder about this issue and the fact that it was a Christian country that initially protected Islamic values. We are therefore, reminded of the importance of interfaith collaboration in promoting Islamic values. The story of Muslims and Islam in Ethiopia as outlined below is therefore instructive.

In Islamic history and tradition, Ethiopia (Abyssinia or Al-Habersham) is known as the "Haven of the First Migration or Hijra." For Muslims, Ethiopia is synonymous with freedom from persecution and emancipation from fear. Ethiopia was a land where its king, Negus or Al-Najashi, was a person renowned for justice and in whose land human rights were cherished. Inhuman oppression and torture of Muslims touched the tender heart of prophet Muhammad (SAW) who advised his followers to seek shelter in a foreign land.

The first migration [Hijra] of the Companions and relatives of the Prophet Muhammad (peace and blessings be upon him) to Ethiopia celebrates the birth of freedom of expression and beliefs, whereas, the Second Migration of the Prophet Muhammad to the Madinah celebrates the end of oppression.

When Prophet Muhammad (peace be upon him) instructed a small band of his early followers to flee Mecca and cross the Red Sea in the 7th month of the 5th year of Muhammad's mission, he knew that they would find a safe place of protection in the neighboring Ethiopian Christian kingdom. At first there were 10 men and 5 women. After staying two months in Abyssinia, the emigrants came back to Makkah. The Quraysh became jealous of the gradual success of Islam and they now began to redouble their persecution. Thereafter, for the second time 101 companions, of which 18 were women, crossed the Red Sea for the court of the friendly king known in Arab tradition as Ashama Ibn Abjar, or Al-Nagashi Ashama. The party of first emigrants included such notables as the third Caliph Othman Ibn Affan and his wife Ruqayya Bint Rasulillah, the prophet's daughter. Among those given asylum in Ethiopia were two future wives of Prophet Muhammad (peace be upon him) -- Ramla Bint Abi Sufyan, better known as Umm Habiba, and Sawda Bint Zama'a. The king of Abyssinia cordially received the immigrants. The chief of the quarysh sent a delegation to the king of Abyssinia with a request to force out the Muslims from his kingdom. Najashi the king of Abyssinia heard both sides and was highly impressed by the ideals of the Muslims. He allowed the Muslims to live there peacefully. Muslim chroniclers maintain that Prophet Muhammad (peace be upon him) corresponded with the Ethiopian monarch and that when the king died, the Prophet performed the Salat Al-Gha'eb, or prayer in absentia -- the first such prayer recorded in Islamic history. .

Prophet Muhammad (peace be upon him), as a token of his gratitude to the deceased king, urged his followers to especially revere the Ethiopians and treat them kindly. "Utruku Al-Habasha wa tarakukum," Prophet Muhammad (peace be upon him) is said to have admonished his followers -- "Leave the Abyssinians alone, so long as they do not take the offensive."

These two groups consisted of key, da'awah committed persons who were also very close to the Prophet. These factors contributed greatly to the success of their mission in sowing the seeds of spreading Islam in Ethiopia and beyond. With this political asylum at the Aksum court, and royal protection, the Muslim immigrants were able for the first time to practice their religion with full freedom and to actively involve themselves in da'awah. They were using their expertise in business and trade to enhance the Islamic image, as most of them were professional merchants who had trade links with Abyssinia years before the advent of Islam.

Seeing this rapid growth of Islam in his kingdom, the Negus dispatched a delegation of seventy priests to Makka to meet Prophet Muhammad and to find out more about Islam. This was the first foreign delegation to visit Prophet Muhammad. The Prophet recited to them " Yasin, By the Qur'ran, full of wisdom (HQ - 36:1-2) until he completed the whole chapter to the end. They listened attentively and wept. They then embraced Islam. The Quraish were disturbed with this development and tried to discourage them from accepting Islam, but their efforts were in vain as the Ethiopians just ignored them. These were the first Christians to accept Islam, and Almighty God revealed verses 52 to 55 of chapter 28 in praise of their stand and subsequent reward in the hereafter.

Holy Qur'an chapter 28: verse 52-55

"*Those to whom we sent the Book before this, they do believe in this (revelation); And when it is recited to them, they say: We believe therein, for it is the truth from our Lord: Indeed we have been Muslims (Bowing to Allah's Will) From before this. Twice will they be given their reward, for that they have persevered, that they avert evil with Good, and that they spend (in charity) out of what we have given them. And when they hear vain talk, they turn away therefrom and say: To us our deeds, and to you yours; Peace be to you, we seek not the ignorant."*

The conversion to Islam of the Abyssinian's Christian delegation, and few years later the conversion of the King (the Negus) himself to Islam, was an additional force in the spread of Islam in the region. Subsequently all the heterogeneous peoples of the Red sea towns from Massawa to Zeila on the coast in present-day Djibouti, and off-lying Dahlak archipelago and Buri peninsula embraced Islam. From these towns, Islam spread among the nomads of the lowlands neighbouring the coast, like Bega and Afar (or Afar-Dankil). Islamic expansion was connected with trade, and traders from the coast were active throughout the region. Within a short period, there were numerous Islamic communities throughout northeastern and southeastern regions of Aksum kingdom and a string of trade-based Muslim principalities along the trade routes leading inland from Zeila. The eastern plain and the Harar plateau region where the nomadic tribes of Afar (or afar-Dankil) Somali, Beja, Saho live, became a wholly Muslim region.

Ethiopia And The Mediaeval Arabian World

The ancient Christian kingdom of Abyssinia kept itself aloof from the Muslim world that engulfed it. The early eighth century, however, saw the mushrooming of Muslim communities that sprang up in different parts of present-day Ethiopia; these communities were not necessarily linked through politics or trade with Christian Abyssinia. Islam spread especially quickly among the nomadic peoples who inhabited the arid and far-flung corners of the country.

Arabian nomads lived similarly to the peoples of the Horn of Africa such as the Afar and the Somali peoples of the lowlands to the east and south of the Ethiopian highlands where the Christian kingdom flourished. Among the Oromo, another nomadic people whose language is related to those of the Afar and Somali people, Islam spread gradually. The Oromo shared the highlands with Christian Abyssinia, but the Oromo were predominant in the western, southern and eastern parts of the highlands, while the Christians were traditionally concentrated in the northeastern highlands. .

Muslim traders monopolised the spice trade between the Mediterranean and the Indian Ocean. Even though Ethiopia was located at the crossroads of the spice trade, it isolated itself and was largely excluded from the lucrative trade. Generally though, Christian Ethiopia in mediaeval times was a landlocked and largely self- sufficient kingdom. The Muslim sultanates of Ethiopia, however, were heavily involved in the spice trade. By the mid-16th century, there were 15 different Muslim sultanates in what is today Ethiopia. These Muslim states prospered tremendously because of their trading in coffee and spices. The most powerful and influential of these sultanates were Iffat (an Oromo sultanate in Shoa) and Adal (Afar). Other important kingdoms included Kefa, and Jimma in southwestern Ethiopia. These latter two sultanates are reputed to be the original homeland of coffee. .

The Arabic-speaking ports of Berbera, Massawa and Zeila on the Red Sea and the Gulf of Aden were springboards from which the new religion spread into remoter parts of the region. The spread of Islam among the peoples of the Horn of Africa took place over several centuries. Islam was quickly adopted by the Somalis, the Afar, the Sidamo and many Oromo ethnic groups that are to this day predominantly Muslim. Ifat and Zeila became important Muslim sultanates, as did the Jimma and the Sidemen peoples, who had important commercial ties to Arabia and the Muslim countries bordering the Mediterranean, the Red Sea and the Indian Ocean.

Ahmed The Left-Handed And The Rise Of Harar

The legacy of the 1528-1560 Muslim-Christian wars that ripped Ethiopia apart was mistrust between Christians and Muslims that never completely abated. Successive regimes have tried to gloss over the deep-rooted differences and have tried to foster a sense of national unity but the outcome of the wars continued to breed hostility. At the heart of the jihad, was the Muslim city of Harar, perched high in the Ahmar Mountains of eastern Ethiopia and long-regarded as the beacon of Islam.

Harar became a Muslim power under Sultan Abu Bakr Mohamed in 1520. Its rise to prominence, however, was bloody and battle-ridden. Abu Bakr Mohamed was quickly toppled and killed by the religious zealot and military strongman Ahmed ibn Ibrahim, better known as Ahmed Gragn or Ahmed the Left-Handed.

Ahmed Gragn's ultimate aim was to unite the Muslims of the Horn of Africa by establishing an Islamic state in the region. To accomplish this aim, he launched a holy war or jihad against Christian Ethiopia. Gragn at first appeared to be invincible. His armies overran Shoa in 1529, Amhara in 1531 and finally Tigray in 1535. The ancient Christian kingdom of Ethiopia appeared to be mortally wounded. According to Ethiopian Church records, nine out of every 10 Ethiopian Christians were forced to convert to Islam as a direct result of Ahmed Gragn's campaigns. His goal was the complete Islamisation of the country. Relations between the Christians of northeastern Ethiopia and the thriving Islamic sultanates of eastern, central and southwestern Ethiopia were traditionally characterized by a tense co-existence. With Ahmed Gragn's campaigns, open hostilities and conflict became the norm. At stake was the destiny of Ethiopia and the entire Horn of Africa, as well as the cultural orientation of an ancient multi-linguistic and multi-religious land.

Lebna Dengel, the reigning Christian emperor at the time, sent urgent dispatches to the Portuguese requesting their aid. In 1540, some 400 Portuguese troops arrived to train and arm the Christian Ethiopian army. For the first time in Ethiopian history, guns were used on the battlefield. The tables were turned and the Muslim forces fled.

The introduction of firearms determined the course of battle and the future of the country. The Muslim armies, however, were still able to exile Lebna Dengel to the impregnable Monastery of Debra Damo in Tigray where he later died in 1543. His son Galawdewos ascended the Solomonian throne and died in 1559 during the siege of Harar, after which his head was paraded around the city on a stake.

Muslim traders and scholars from Harar, however, continued to have a tremendous influence on the Islamization of other parts of Ethiopia and different ethnic groups of the country. In 1647 Emir Ali Ibn Dawoud ruled Harar with an iron fist, and in a determined effort to Islamise the non-Muslim Oromo tribes surrounding the city, he embarked on a series of jihads. Today the bulk of Ethiopia's Muslims are Oromo.

Islam: from Abyssinia (Ethiopia) to the East Coast of Africa

The already existing historical contacts and trade activity between Abyssinia and East Africa was further strengthened and became more active and flourishing with the establishment of Islam in Abyssinia. Hence, Islam in the East Coast of Africa made its first impressions through commercial exchange between the coastal people and the Muslim traders. It is strongly believed that the Muslim traders from Abyssinia introduced Islam in these shores during the lifetime of Prophet Muhammad (S.A.W), and probably before his emigration to Madina. There is evidence from archaeological findings, written records and oral traditions, which indicate that the East African coast was the scene of the earliest sub-Saharan Islamic community. The earliest and most detailed evidence so far discovered of an Islamic presence in East Africa has been at Shanga in the Lamu archipelago.

Numerous Arab and Muslim chroniclers have lavished praise on the only land beyond Arabia's border that Prophet Muhammad (peace be upon him) turned to in his hour of need -- the only country that responded positively to his call for assistance. Perhaps the most important Arab treatise celebrating the special role Ethiopia played in early Islam was Jalal Al-Din Al-Suyuti's seminal work Raf' Sha'n Al- Hubshan (The Raising of the Status of the Ethiopians), written in the late 15th century. It was an earnest plea to reaffirm the equality of the races in Islam.

Interestingly enough, because Ethiopia is widely seen as an isolated bastion of the monotheistic religions in Africa -- Judaism, Christianity and Islam -- the ancient religious, linguistic, cultural and commercial ties that bind the country to ancient Arabia, Egypt and Nubia have often been overlooked.

Geographical proximity and linguistic affinity ensured that Ethiopia's history and culture were intertwined with that of Arabia since ancient times. Ethiopia emerged as a country of special symbolic significance at the dawn of Islam. "For Muslims, Ethiopia is synonymous with freedom from persecution and emancipation from fear," wrote a former president of the Washington, DC-based Federation of Ethiopian Muslims in North America.

Furthermore, the rich heritage of Islam can be found among the Ethiopian people who speak the Semitic and Cushitic, Afro-Asiatic languages, which include Arabic. Among the Cushitic-speaking peoples of Ethiopia who embrace Islam are the Afar of the desolate Danakil depression, the Somali, the Oromo (the most populous ethnic group in Ethiopia today), and the Sidamo. The Semitic speaking people of Harar are also Muslim. The centuries-long legacy of Muslim arts is apparent all around the country, but especially in historical cities such as Harar. The people of Harar are culturally distinct from other Ethiopians, both Muslim and Christian. They speak Adari, a Semitic language closely related to Arabic and Amharic, and have been staunch

Muslims. Adari, derived from the Arabic word *hadar*, meaning urbanite or urbane, emerged as the language of scholarship and trade in a huge swathe of eastern Ethiopia. Today it is largely confined to Harar and the Ahmar (Red) mountain range surrounding the city.

Ethiopia has the third largest Muslim population in Africa after Nigeria and Egypt. The country has between 30-40 million Muslims, although estimates vary considerably. Still there is a sizable Muslim community in Ethiopia, more numerous than the entire population of countries like Iraq, Algeria or Morocco. It is also a community that has long cherished its special bond with the Muslims of Egypt, Yemen and Arabia.

Emergence And Profile Of Ethiopian Islamic Affairs Supreme Council

The Ethiopian Muslim community undertook intensive struggles against the Christian monarchy to affirm their civil rights. After the fall of the monarchy through the 1974 revolution, the Muslim community movements started mass demonstrations in different parts of the country. For instance, the mass demonstration by Muslim residents of Addis Ababa in April 1974 was one of the earliest, and certainly the largest manifestation of popular protest and demand for the redress of old injustices. The demonstrations effectively exploded the legend promoted by the Emperor that Ethiopia was a Christian country in which the Muslims were highly oppressed. Following the mass demonstrations, Muslim elders and representatives of the community presented a 13-point document to the government demanding the recognition of Islam as a religion and respecting Muslim rights as citizens.

The government was not happy with the Muslims' demands for rights. However, the mass demonstrations influenced the government to provide positive responses for a few issues raised by the Muslim community. For example, the three principal Islamic holidays, Id al-Fitr, Id Al-Adha and Mawlid were accepted as official holidays in the country from 1974. This success encouraged Muslims to struggle for further rights.

As a result of the intensive struggles of the Ethiopian Muslims, a pilgrim (Hajj) committee was established in 1974 with 16 members. Muslim scholars, ulama and other interested groups attempted to establish a national and official Islamic affairs council in 1976. But the attempts of Muslims to secure legal recognition for the Ethiopian Islamic Affairs Supreme Council failed throughout the Darg regime. Later on at the end of the Darg regime in September 1990 the council obtained recognition to establish itself officially.

Undoubtedly the fall of the military regime in 1991and the establishment of democratic systems in the country have brought remarkable benefits to Ethiopian Muslims. The Muslim community has the rights to travel to Mecca without any restriction, import Qur'ans and religious texts, celebrate Islamic holidays in the stadium, and establish different Islamic organizations and associations. These were major achievements. The reorganization of the Ethiopian Islamic Affairs Supreme Council on a countrywide basis was also a significant change in the history of Ethiopian Muslims.

The introduction of the democratic system to the country secured the rights of all religions to establish their own associations and freedom to preach their faiths. In referring to these rights, the Muslim community formed an election committee to establish the Islamic Council at all levels of administrative structure of the country. With this participation of the majority of Muslim communities, the current Ethiopian Islamic Affairs Supreme Council was established in October 1995 at the national level.

The Ethiopian Islamic Affairs Supreme Council has seven major organizational levels: Supreme Council, Regional Higher Council, Zone Council, City Council, Woreda (District) Council, Kebele council and Masjid representatives. The Supreme Council office is found in Addis Ababa. The internal organizational structure is as follows:

- General Assembly
- Audit and inspection service Committee.
- Executive Committee
- Five main divisions for:
  - Development, Social and Administration
  - Education and Da'iwa
  - Organization and Regions
  - Hajj and Umra
  - Mosques and endowment

Vision:

To see a society that possesses a high level of Islamic faith and material knowledge, and living in a peaceful and prosperous world. Insha Allah!

Mission:
Establish a strong foundation for the expansion of Islamic education in order to make Ethiopian Muslims direct their life on the basis of Islamic principles and organize and lead the Muslim community in engaging in socio-economic development, thereby enabling it to actively participate in the political activities of the country, so as to be direct beneficiaries from the outcomes.

Values:
Governed by Qur'an, Hadith, Ijma'I, Qiyas, and also by law and constitution of the nation within the Islamic context.

Objectives:
- To coordinate, lead and direct Islamic affairs of the country.

- To encourage and enhance the situation of how the Muslim community benefits from human and democratic rights they have attained and to work with the government of the country for the benefit of Muslims as well as the entire community.

Major achievements in the last eleven years:
- Developed modern organizational structure.
- Developed two terms of strategic plan for both spiritual and socio-economic affairs.
- Ensured constitutional rights by facilitating conditions for the construction of mosques, Qur'anic schools, Islamic schools, offices, holiday celebration places, cemetery places, etc.
- Established Development Agency and organized The Ulama Council, for Da'awa and Fetwa matters.

Major planned projects

	Types of project	Estimated Budget (Ethiopian Birr)
1	Supreme Council Office construction	30,030,000.00
2	Establishment of	
	• Qura'nic center	9,000,000.00
	• Islamic training center	51,820,00.00
	• Islamic square	1,010,144,974.00
	• CT center	3,500.000.00
	• Health centers	1,700,000.00
	• National Islamic Museum	5,870,992.50
	• Public library	957,700.00
3	Construction of	
	• medresa schools	30,020,000.00
	• mosques	21,041,025.00
	• Weqfi round Anwar Mosque	100,000,000.00
4	Conduct Islamic researches	200,000.00
	Total	1,208,964,691.50

1 US dollar is approximately equal to 8.65 Birr.

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THE OPENING CEREMONY, 3rd IMLC

Recitation of the Holy Qur'an and Reflections

The opening ceremony started with the recitation of the Holy Qur'an by Sheikh Taha Harun, the Imam of the Grand Mosque of Addis Ababa.

> *"A.L.R. These are the Ayats of the Book of Wisdom. Is it a matter of wonderment to men that we have sent our inspiration to a man from among themselves? That he should warn mankind (Of their danger), and give the good news to the Believers that they have before their Lord the good actions they have advanced. (But) say the Unbelievers, this is indeed an evident sorcerer! Verily your Lord is Allah, who created the heavens and the earth in six days, then He established Himself on the Throne, regulating and governing all things. No intercessor (can plead with Him) except after His leave (Has been obtained). This is Allah your Lord; Him therefore serve you; will you not receive admonition? To Him will be your return of all of you. The promise of Allah is true and sure. It is He who begins the process of creation, and repeats it, that He may reward with justice those who believe and work righteousness; but those who reject Him will have draughts of boiling fluids, and a Chastisement grievous Because they did reject Him. It is He who made the sun to be a shinning glory, and the moon to be a light (of beauty), and measured out stages for it, that you might know the number of years and the count (of time). Nowise did Allah create this but in truth and righteousness. (Thus) does He explain His signs in detail, for those who know."* Holy Qur'an 10:1-5

These verses highlight the first and most important component of the Islamic approach to AIDS. This is the belief in Allah who regulates and governs all things. All believers are therefore, instructed to serve Allah.

WELCOME REMARKS FROM THE LOCAL ORGANIZING COMMITTEE

Remarks made by Haj Teshale Kero, the Head of Relief and Social Development, Department in the Ethiopian Islamic Affairs Supreme Council (EIASC)

In the Name of Allah, the most Gracious, the Most Merciful. Your Excellency Dr.Tewodros Adhanom, Minister of the Federal Democratic Republic of Ethiopia, Ministry of Health, Your Excellency C.D.C. Director, Your Excellencies Ministers and Ambassadors, Distinguished participants of this Consultation and Dear invited guests, Asalamu'alaikum Warahmatulahi Wabarakatuhu

For the last 25 years, the world has been struggling to curb the multi-faceted problems inflicted on it by HIV/AIDS. As HIV/AIDS is a global problem, no nation and no community has been left untouched. According to 2006 UNAIDS report, about 39.5 million people are believed to live with the virus globally. Subsaharan countries are the worst stricken where 28 million people are living with the virus. According to the Ethiopian Ministry of Health report of 2006, ever since the first two cases of HIV/AIDS were diagnosed in 1984, the total number of people living with the virus is estimated to be 1.3 million and about 1 million people have died leaving about 1 million orphans. Many older people in society are also left without someone to care for them. Because of this, demographic structural changes have occurred. For example, there is an increasing number of child- and elderly-headed families, the old people at their pension time are forced to look after their grand children, and PLWHA are stigmatized and discriminated. However, Islam teaches us to protect ourselves from the virus and to give care and support for those infected and affected through obeying the orders of Allah.

Ladies and Gentlemen, no political ideology, no social order, no nation, no region, no ethnic group, no tribe, no educational level, no profession, no religion, no black and no white race is spared. All are equally stricken by HIV/AIDS with no discrimination. All nations and peoples are subjected to this pandemic. We all might not be personally infected, but directly or indirectly we are living with the problem. We, Muslims, are expected to provide an Islamic response to control and curtail this disease. We need to exchange best practices and information in this regard. Based on this, this consultation aims at enhancing the response of the community in curbing the damage inflicted globally and in preventing the pandemic and its problem among communities. The theme of this consultation is the Islamic Approach to HIV/AIDS: enhancing the community response. This refers to believing in Allah, understanding scientific facts about HIV/AIDS, prevention, treatment, care and support, using Islamic teachings, forming partnerships with religious leaders and making use of their administrative structures, and controlling oneself to bring about behavioral change.

The main objective of this consultation, which is held in our capital Addis Ababa, is therefore, to enhance the response to this common problem through the Islamic Approach. Ladies and Gentlemen, The EIASC after it was re-organized, has been doing its level best in its developmental activities through the Ethiopian Muslim Development Agency (EMDA). This is the development wing of the council and it is organized under the division of the relief and social development department. We recently held a public rally that was honored by H. E. Girma W/Georges, president of Federal Democratic Republic of Ethiopia and the vice president of the supreme council. In addition, youth centers were established in our project sites as well as boys' and girls' Anti-AIDS clubs. These are among the efforts being done to combat the pandemic.

Ladies and gentlemen, as you know HIV/AIDS is causing a multi-faceted problem in the world and especially in our country. Governments, FBOs, NGOs and communities are doing a lot to reduce the spread of HIV infection. The EIASC, through its development wing, EMDA, with resources solicited through partnership with different organizations, is also engaged in HIV/AIDS prevention, care and support efforts. It is registering remarkable results so far. In the past many Muslim communities especially the Ulammas (scholars) did not give adequate attention to HIV/AIDS. But eventually after seeing the multi-faceted impact of the pandemic, they have started responding to it. To prevent HIV/AIDS, Allah in His Holy Quran instructed every man and woman not to fornicate. By this, He not only requires us to refrain from extramarital sex but not to get close to the way of fornication. Hence, based on this teaching, our religious leaders especially Imams, Da'es, Islamic council executives, the community and individuals are persistently teaching and supporting the fight against the pandemic.

Ladies and Gentlemen, our religious leaders are listened to, trusted, and respected by their communities. They can play a significant role in curbing the spread of HIV/AIDS and breaking the silence. They can do this through enhancing community knowledge by combining scientific information with Islamic teachings. They can also give spiritual and material support to the

infected and affected, and encourage the public to go to VCT Centers. I believe that this consultation will enable our country to forge meaningful friendships with the outside world.

The EIASC, through its national consultation organizing committee and other subcommittees together with the domestic and overseas partners, has been working towards the realization of this consultation. This included writing and dispatching official invitation letters to domestic and international participants, facilitating hotel accommodation, and engaging in other administrative and logistic activities. To do this, IMAU and PEPFAR in the US Embassy have been communicating with us through telephone, email and personally. They have provided meaningful technical and financial support. For the success of this consultation, the national organizing committee has been working day and night, and now we are here by the help of Allah. For this, I would like to acknowledge and thank our government ministries for their full support, especially the Ministry of Foreign Affairs.

Distinguished guests, during your stay in our city, Addis Ababa, I assure you that the national organizing committee is at your disposal to serve you in any matter with traditional Ethiopian hospitability. Lastly, I would like to extend my gratitude to IMAU, EIASC, the US Embassy to Ethiopia, USAID, World Conference of Religions for Peace, PACT Ethiopia, and Pathfinder International Ethiopia, for their financial support. The EIASC relief and social development department and the Ethiopian Muslim development agency staff have done most of the coordinating and organizing work for the consultation. I am grateful to them. Last, but not least, I would like to acknowledge our government's support, especially our Foreign Ministry for helping us with entry visas for the international participants. I would like to extend my heartfelt thanks to all of those who have helped us materially and morally. Thank you.

Wabilahi Tawfik
Wasalamu alayikum Warahmatulahi Wabarakatuhu

WELCOME SPEECH FROM THE ETHIOPIAN ISLAMIC AFFAIRS SUPREME COUNCIL

(Speech given by Haji Yusuf Ali Yassin the Secretary General of the Ethiopian Islamic Affairs Supreme Council)

In the name of Allah the Most Gracious the Most Merciful. Thanks to Allah, the Lord of the universe, the Owner of the last day and let peace be upon the prophet Mohammed, his family and his followers. Your Excellency Dr Tewodros Adhanom, Minister of the Federal Democratic Republic of Ethiopia, Ministry of Health, Your Excellency the US Ambassador, Mr. Yamamato, The Director of CDC, Honourable Ministers and Ambassadors, Distinguished guests, Asalamu'alaikum Warahmatulahi Wabarakatuhu!

First of all, I would like to say thank you in the name of Allah to all of our guests and participants. The host of this consultation is a country found in the first chapter of Islamic history. It is a country that directly or indirectly supported Islam and Muslims and played a crucial role with passion and determination. So this consultation will create an opportunity for those of you who came here from different parts of the world to acquire enough knowledge about the Habasha land, Ethiopia, that has played a great role in the history of Islam. History tells us that Ethiopia had great ties with the Islamic world since the prophet Ibrahim (P.B.U.H). During his old age, Allah pleased him with Ismail from the Habasha (Ethiopia) woman, Hajjar. The prophet Ismail's descendants and responsibilities bestowed upon them by Allah have enabled us to reach this stage.

The Prophet Mohammed's (P.B.U.H) upbringing, identity and Islam have a direct tie with this country, Ethiopia. During his childhood the Habasha woman, Ummu Aimen, looked after him as he was left an orphan because of the death of his parents. In the history of Islam, a man who called up people for congregational prayer (the first man to say Athan) for the first time and among the leading pioneers to embrace Islam was Billal, an Ethiopian by decendency.

Distinguished participants, I believe that you all know the first migration of Muslims and the warm welcome accorded to them by the then Habasha King Ashamaitel Nagashi in Islamic History. During the persecution against the prophet Muhammad (P.B.U.H.) and his few followers, the only safe place to seek refuge was the Habesha land, Ethiopia. The prophet said, "Habesha (Ethiopia) is a country of truth, in it exists a leader who offends no one and before him no one will be offended. So if you go there it will be good for you." Accordingly, His daughter Rukiya, His cousin Jafer, the 3rd Caliphate Ousman and many others of the prophet's relatives and followers made the first Islamic migration to our country, Ethiopia. During that time, the governor of the host country, King Negashi, accorded the Muslim migrants full respect and made them live in the premises of his Palace and pledged full support to further preach Islam in the same. The migrants lived for 15 years in peace and harmony. In this country, you can find a graveyard of many of the prophet's companions. Therefore, you are in the country where the first Hijira was made, where the close relatives and followers of the prophet (P.B.U.H) sought refuge, where Islam was officially accepted, where many Quranic verses were revealed because of this Hijra and where the prophet himself witnessed the hospitality of this country. We are privileged to host this consultation and we wish to make you feel at home.

Distinguished participants, the EIASC, the only organization structured at the federal level to represent approximately 40 million Muslim Ethiopians in development and spiritual matters, has established the Ethiopian Muslims Development Agency as the development wing of the relief and development section of the Supreme Council. Among the myriad activities that the agency has been currently undertaking is the prevention and control of HIV/AIDS by using Islamic teachings. The agency has been working by opening branches and giving services in all parts of the country especially in Muslim dominated areas. Hence, I expect that you will benefit much from the experience of our development agency in the fight against HIV/AIDS using the Islamic approach.

Additionally, Ethiopia is a country of many religions, in addition to Islam and Christianity. Ethiopia has accepted all religions in peace and all the followers of these religions live together in peace and harmony. For this it is known as exemplary by the world. The favorable weather conditions, spiced with the hospitality of its people, are also exemplary. Your presence to witness this will make you among the lucky people.

Ladies and Gentlemen, as you all know, it has now been several decades since HIV/AIDS invaded our social life. This virus continues to inflict great damage to the world community regardless of race, religion, color, age, educational background and so on. No medication has been found so far to completely eliminate the virus from a human being, once he or she is infected.

Nevertheless, many efforts have been made to combat this pandemic across the globe in prevention, treatment, and and support. Remarkable results are being documented, and there have been many consultations and much research carried out to scale-up best practices. We are here for the coming five days as part of this global effort.

To the problem imposed on us by HIV/AIDS, the Almighty Allah 1400 years ago revealed in His Holy Qur'an, chapter 17 verse 32: *"Do not come near to adultery, For it is a shameful deed and an evil, opening the road to other evils."* This message relates to one of the main transmission mechanisms of HIV/AIDS, which is through sex outside marriage. Allah has commanded us to keep ourselves from STDs and HIV/AIDS through Islamic ways. Therefore, to eradicate the present problems faced by our communities and substitute them with much more profitable things, we have to use the Islamic approach and thereby enhance HIV prevention, treatment and care and support given to the infected and affected. We have to explore the Islamic teachings and values in reaching to develop a common strategy. I am highly confident that we will work for the implementation of these Islamic principles.

Distinguished Participants, for the first time in the history of Ethiopia's constitution, Muslims enjoy equal rights with followers of other religions. In the past, Muslims were deprived of their rights. The Ethiopian FDR constitution and the government have given us all the strength and courage to include spiritual aspects in development planning. The support given by the government can be seen as one of the achievements in planning activities. Had it not been for the full support of different sectors of our government, we would not be where we are today.

The EIASC together with IMAU, the US Embassy to Ethiopia, USAID and our government, and above all, Almighty Allah, have put their effort into this consultation. I would like to express my deep gratitude to IMAU, the US Embassy, USAID, and PACT Ethiopia for their financial and technical support and to all those who have worked day and night by sacrificing their time and energy. Staff from the relief and social development department and the 3rd IMLC organizing committee, both local and international, are highly appreciated. We thank you all, who have helped us to reach here.

I now call upon H. E. Minister Dr. Tewodros Adhanom, of the F. D. R of Ethiopia Health Ministry, to declare the official opening of the 3rd IMLC.

Thank you

WELCOME SPEECH AT OPENING CEREMONY OF THE 3RD IMLC

By Dr. Magid Kagimu,
Chairman Organizing Committee and International Advisory Committee for 3rd IMLC

Bismillahi Rahmani Rahiim: In the name of Allah the most Gracious, most Merciful. The Guest of Honour Dr. Tewodros, Your Excellency Ambassador Yamamoto, distinguished guests, ladies and gentlemen, Assalam Alaikum, Warahmatullahi wa barakatuhu. First of all, I wish to thank Allah for enabling us to gather here to-day for the 3rd International Muslim Leaders' Consultation on HIV/AIDS. I say Alhamudu Lillah Rabil Alamina. This means Praise be to Allah the Cherisher and Sustainer of the Worlds. Secondly, on behalf of the International Advisory Committee I would like to welcome you all to this ceremony. A special word of welcome goes to the Chief Guest and His Excellency Ambassador Yamamoto.

International Muslim Leaders' Consultations on HIV/AIDS are an international Muslim community initiative with the main objective of preventing and controlling HIV/AIDS from an Islamic perspective. We have gathered here a team of representatives from Muslim communities throughout the world. These are the champions of the Islamic approach to HIV/AIDS. They include representatives from the following countries: Afghanistan, Algeria, Bangladesh, Chad, Egypt, Ethiopia, Ghana, India, Indonesia, Iran, Kenya, Malawi, Myanmar, Namibia, Niger, Nigeria, Pakistan, Philippines, Rwanda, Somaliland, South Africa, Saudi Arabia, Sudan, Tanzania, Thailand, Uganda, United Kingdom, USA, and Zambia.

I wish to remind you all that the running motto of International Muslim Leaders' Consultations is the "**Jihad on AIDS: Self-discipline using Allah's guidance**". This is the Jihad Nafs, which is the biggest Jihad for each one of us according to the teaching of Prophet Muhammad (Peace be Upon Him). It is the struggle of the soul against temptations that may lead any one of us to contract HIV. It is a struggle against temptations of stigmatizing people living with HIV/AIDS. It is a struggle against the temptations of *not* treating and caring for our people infected and affected by AIDS. It is a struggle by our people living with AIDS against the temptation of *not* taking their anti-retroviral drugs regularly, if they happen to get them. This is a very big struggle and a very long, lifetime struggle. This is why it is called the biggest Jihad or (Jihad Akbar). Fortunately, Allah and Prophet Muhammad (Peace be upon Him) have given us guidance of how to conduct this Jihad. We have come here to share experiences in this Jihad and to chart the way forward.

We would like to thank our allies in this Jihad. They include the United States government which has provided the major funding for the consultation through USAID / Health Policy Initiative, Task Order 1 (HPI), Washington and PEPFAR Ethiopia. We are very proud of this friendship between the American people and the international Muslim community. This friendship is spearheaded by Mr. Jason Heffner, the PEPFAR Country Coordinator in Ethiopia, and his team. The support of the United States government for the Jihad on AIDS should be widely known and publicized. In fact some people may be surprised by it and yet it is real. It is Allah's creation. It is Allah who creates friendship among His peoples according to the teaching in the Holy Qur'an chapter 3 (Aal–Imran) verses 102-103:

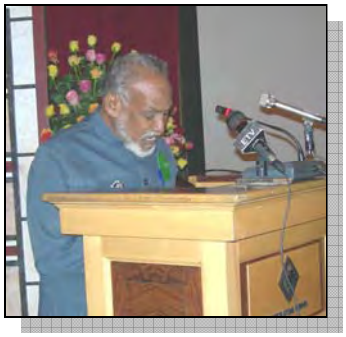
> *"O you who believe, fear Allah as He should be feared, and die not except in a state of Islam. (Submission to Allah's Will). And hold fast, all together, by the rope which Allah (stretches out for you), and be not divided among yourselves; and remember with gratitude Allah's favour on you; for you were enemies and He joined your hearts in love, so that by His Grace, you became brethren; and you were on the brink of the pit of Fire, and He saved you from it. Thus does Allah make His signs clear to you: That you may be guided."*

Therefore, this God-given friendship is one of the best examples we have that shows that the American people have a big heart towards the international Muslim community. Your Excellency, Mr. Yamamoto, this friendship has been going on for over 7 years. It started in the White House in 2000 when the American President Mr. Bill Clinton invited faith-based organizations including Muslims, for an HIV/AIDS conference. This is when I met Mr. Jason Heffner. As a follow up on this, we organized the 1st International Muslim Leaders' Consultation on HIV/AIDS in 2001 in Kampala, Uganda, with funding from the US government. Then we organized the 2nd IMLC in Kuala Lumpur, Malaysia, with funding from the Malaysian Government and the US government. Now we are here at the 3rd IMLC, again with support from the US Government, spearheaded by Mr. Jason Heffner. Therefore, the US Government has been consistent in supporting this initiative. We have appealed to many other donors for support without much success. However, the US government has always lent a listening ear to our cause because of our friendship. This kind of friendship needs to be encouraged and emulated in all international relationships.

I also wish to thank the Ethiopian government, all the Ethiopian people, and the staff in Sheraton Addis for the warm welcome they have given us. Special thanks go to the team at the Ethiopian Islamic Affairs Supreme Council who have worked tirelessly to make this consultation happen. I would like to thank the members of the International Advisory Committee and our technical advisors for their work in planning for the 3rd IMLC.

Finally, I would like to thank all of you for coming to participate in this ceremony. We pray to Almighty Allah to reward you all abundantly. Assalam Alaikum.

KEY NOTE ADDRESS: ANSWERS TO IMPORTANT QUESTIONS



(Presented by Prof. Malik Badri, Professor of Psychology, and one of the Muslim scholars who has worked on the Islamic Approach to HIV/AIDS for many years.)

What is the definition of the concept of the Islamic approach to AIDS prevention, and how can it be operationalized?

Islamic AIDS prevention is prevention based on Islam as a religion and a way of life. Islam is not only a limited set of religious commandments, it is a ground-breaking worldview and a revolutionary style of life that has a strong say on all aspects of human life. If, in preventing HIV infection, we aim at changing the attitudes and behavior of people, then we should research the field of modern psychology and the social sciences to know exactly what we mean by attitudes and behavior change. We will find that attitudes have three major components. These are the *cognitive, the affective and the behavioral*. In this definition, behavior becomes part of attitudes.

First, we have to gain knowledge about what we aim to develop an attitude about. When this knowledge is confirmed again and again, it becomes a belief; it becomes our faith. Second, we should know that for these beliefs to be effective they must be warmed up by the affective component of attitudes. The affective is the emotional aspect. Knowledge without being backed by love, fear, anxiety or happiness and pleasure is like uncooked frozen food. It will have to be heated up in the microwave of the affective side of man. This will then lead to the desired result, to the change in the behavior and to the practical side of prevention.

It is rather miraculous that the Prophet of Islam (PBUH) spoke exactly about these three components of the religion of Islam in his famous *Hadith* in which the Angel Gabriel asked him to define what *iman* is, what Islam is, and what *Ihsan* is. *Iman* or faith, the Prophet said is belief in Allah, in His angels, in His revealed books, in His prophets, in *qdar* and in the Day of Judgment. Therefore, *Iman* is mainly the cognitive dimension. When asked what Islam is, the Prophet spoke about prayers, fasting, Hajj and similar practical duties that the Muslim should do. Here again we see the similarity between the behavioral component of attitudes and that of practical Islam. As for *ihsan*, the prophet defined it as the worshipping of Allah as though you really see him because if you do not see him physically, He is seeing you all the time. Such intimacy and spirituality cannot be achieved without the positive dimension of the affect -- of love of Allah and His prophet. A number of other sayings of the Prophet speak clearly about the emotional aspect of Islam.

Islamic prevention should accordingly use these three components of attitude and behavioral change in addition to the fourth component of spirituality in a balanced way. Knowledge about how HIV infects and how to avoid being infected, even if given in an Islamic manner, is very important but by itself it may not bring about behavioral change. Instilling fear into hearts about the lethality of AIDS and about God's punishment here and in the Hereafter is quite essential, but it my not have its positive effect without proper knowledge about AIDS and without the spiritual dimension of obeying Allah out of love to Him and His Prophet. It is a combination of all these factors that can bring about results. Knowledge and faith warmed by emotions and transcended spiritually can make abstinence tolerable to the young unmarried and keep the married faithful to each other. However no strategy is able to purge society from promiscuity and fornication. An Islamic strategy should therefore find solutions to deal with such expected sexual adventures. It is in this situation that an Islamic approach should endorse the use of condoms as the lesser of the two evils. These evils are fornication or possible infection and death.

Why should the Islamic approach work to control HIV/AIDS among targeted communities?

Why is it that in almost all societies where Muslims and non-Muslims live together you find that the rate of HIV/AIDS among Muslims is less than the non-Muslim group? This is quite born out whether the Muslims are the minority or the majority in these multicultural countries. The reason for this phenomenon is obviously not the diet of Muslims or their biological constitution. It is the fact that they were brought up in a religion that gives them a comprehensive way of life that prevents a good number of them from unsanctioned sexual relations and prohibits them from drinking alcohol and abusing drugs. If this is an uncontested fact, then any strategy is bound to succeed if it helps people to become more "Islamic" regarding any un-Islamic risky behavior that can expose them to HIV infection. The issue is not whether an ABC strategy will bring about success in reducing HIV infection; it will. The issue is how best one can use this Islamic approach to achieve this goal. Thus, if AIDS prevention depends on changing

attitudes and behaviors, then it would be unpardonable and indefensible to exclude Islam as a way of life and as a crucial source of ethical values that strongly stand against behaviors that increase risk of HIV transmission.

Why is the ABC approach not adequately working to control HIV/AIDS in some communities and what can we do about that?

If the ABC approach is succeeding in many countries in which their populations have a strong faith base, why is the Islamic ABC approach failing to bring about the expected results in some countries? I believe that the reasons for this unexpected letdown are multifaceted. First, unwarranted great optimism about success may lead strategists to feel that the whole preventive strategy is not working if it does not produce a miraculous success. They forget what would have happened to such Muslim groups if only condoms were distributed to them without any moral Islamic guidance.

Also, experts should not forget that HIV is a very slow destroying retrovirus. Before applying the ABC approach, the graph for HIV infection might have been rising in that community. The Islamic ABC strategy might have slowed the inertia but this will not appear in blood testing. It would need a longer time to show its effect. If a car is slowly moving forward and you want to push it to go backwards, you must first use your force to bring it to a stop before reversing. Furthermore, as we said, the Islamic approach requires the utilization of the four components of the cognitive, affective, spiritual and behavioral aspects. If experts use only one dimension it may not bring about the desired result.

And finally, in some Muslim communities there are influential Muslim clerics and sheikhs who strongly stand against the use of condoms, even as a last option. If Islamic ABC workers fail to convince these Muslim leaders or to publicly put an Islamic justification for the use of condoms as the lesser of two evils, then many young men and women may become infected. If Islamic AIDS prevention workers cannot stand up to this immoderate stand against condom use, they must find a reasonable Muslim scholar in that community who can argue for the case.

In a rational and unbiased but religious manner, we find ourselves facing two extreme positions regarding condoms. One regards condoms as the major line of defense against HIV infection and sometimes behaves as if it is the *only* form of protection. To these the answer to better prevention is more and more condoms. The other considers any advocacy for its use an open invitation to promiscuity. The Islamically guided approach is in the middle! We must reject the first extreme of condoms… condoms …and more condoms since it is based on the philosophy and mores of the Western sexual revolution and it is not really succeeding even in the West.

However we should also reject the absolute "No" to condoms. Even if we do our best to advocate abstinence and being faithful to spouses, we would fail with many young people. No society can succeed in completely stopping its people from engaging in sex outside marriage. So, total rejection of condoms would only mean subjecting many young men and women to a deadly virus. Allah, as He said in the Holy Qur'an, forgives all sins and the fornicators of today may be the saints of tomorrow! So it is a choice between living and asking for forgiveness for one's sins or perishing in agony and despair.

Such choices would come under the well-known law of Islamic Jurisprudence of choosing the lesser of two evils. Indeed if we apply this rule to the use of a condom when a Muslim is unable to stop himself from unsanctioned sex, then wearing a condom should be viewed by Muslim clerics as *obligatory*. That is indeed so because though fornication is a great evil, exposing one's self or that of his sexual partner to a deadly disease is obviously a much greater evil.

In fact, Muslim Jurists have developed a hierarchy of evils that can afflict a Muslim. If one is forced in a situation, he should always select the one that is less sinful and less harmful. Losing one's faith and belief in God is the worst of all catastrophes. What next? The one that comes after it is losing one's life. So protecting life has this high position in Islamic jurisprudence. Third comes losing one's mind. This is followed by losing one's fortune and lastly comes the issue of committing major sins like fornication. I have detailed this issue because I think it is about time for Muslim jurists to come up with a collective strong verdict on this condom issue. This will not happen unless ABC Islamic prevention experts come together and put a strong plea to supreme Islamic authorities to issue a binding fatwa.

How can we enhance the "Islamicity" of our ABC strategy?

ABC AIDS prevention workers should first be motivated and should strongly believe that their way is the right approach for their Muslim communities. They must be aware of the conflict of the ABC approach with an "only condom" approach. This conflict is fueled by philosophical, social and economic drives. Philosophically, it is motivated by the ideology of the modern Western

sexual revolution; socially, the ABC approach was pioneered by African scholars from Uganda and is based on a religious moral venture; economically, it will reduce the income of companies that export condoms to the developing world. Western modernity dislikes moralization and it is not easy for a white Westerner to accept learning from black Africans. We must remember that racial prejudice in the AIDS crisis was seen very early in accusing Africans and their green monkeys of bringing the pandemic into existence. We do not wish to enforce our mode of prevention on Westerners if they prefer to limit their prevention to external manipulation and reject moralization. This is their philosophy and the way they see things. Similarly, we do not wish them to stand against an approach of prevention that has proven its success with our people simply because it goes against their way of life.

Islamic AIDS workers should know that with respect to prevention, any community is made up of three groups. Two of them are small in number and we have no problem with the Western approach regarding their prevention. The first is composed of a few religious persons whose Islamic style of life will definitely keep them away from HIV infection. They do not need our preventive efforts because they are already fully protected. We leave them alone unless they wish to help us in our prevention endeavor. The second is made up of the other extreme. They are the very few ones who do not care to take any advice. These are persons like prostitutes and the very promiscuous who have the highest rates of infection. For these, we also do not have a problem with promoting condoms as the main form of prevention. We also advocate condoms to them as the main line of defense against AIDS. Our difference with the Western style of prevention shows itself with the third group. This group is made up of the vast majority of citizens who are neither so religious as to need no prevention efforts, nor are they extremely promiscuous. It is here that the battle for the ABC program is witnessed.

In reinforcing the "Islamicity" of the ABC strategy with this third group, prevention workers should study well the four components of the Islamic approach that we have detailed earlier. They must be aware that there are clear differences between individuals and even between whole societies with respect to what aspect of the four components of Islam would be more useful in prevention. To some Muslim societies that bring up their children to mainly respect and submit to the commandment of *halal* and *haram*, the cognitive and practical behavioral aspects may be most important. The scholars in such societies do not talk much about spirituality or love. The term "Sufism" is a form of Islamic belief and practice. To them Islam should be mainly viewed as a set of commandments and if one is truly a slave of God, he should just listen and obey.

In some other Muslim societies, people's attitudes and behavior are influenced much more by speeches about spirituality and love of Allah and his Prophet. These are the groups that spend time listening to beautifully composed songs about the good character of the Prophet (PBUH) and his companions. The leading scholars in such societies are mainly Sufi in orientation. Though important, the cognitive aspect by itself cannot change attitudes and behavior. Changing behavior in such groups should strongly rely on the affective and spiritual aspects. So the ABC worker should know what aspects of Islam are adopted with greater espousal in the community he works in before he embarks on his duty. This also applies to individuals.

Islamically, what kind of help can we offer to those living with AIDS?

I do not wish in this last section to write much about the list of problems that an HIV-positive person would face nor how to meet each one of these problems. I only want to limit myself to the most devastating issue, which is stigma. This is the way the person views himself and the way others view him. It is mainly a psychological issue. In my limited experience, I have found those infected to suffer from much guilt and anger. Most of them were infected after unprotected sexual intercourse. They keep blaming themselves for it and feel that God has punished them and has driven them out of his Mercy. To these, a soothing talk reminding them about God's forgiveness for all sins and about the fact that the disease will purify them from all that they did in the past can be very comforting to them.

An authenticated saying of the Prophet states that if one happens to live in a town afflicted by a contagious epidemic, he should not leave his town and if he is outside of it, he should not enter it. The Prophet added that if one obeys this order and refuses to leave his infected town and was infected himself and died, he will be considered a martyr. Martyrdom or *shahadah* is the highest status that a Muslim can aspire for in Paradise. I tell Muslim people with AIDS that they are actually living the same conditions that the Prophet had specified. If they live with AIDS and prevent themselves from infecting others, and do that for the sake of Allah, they will die as martyrs. This can be spiritually very uplifting to them. Finally, a warm discussion about the nature of death in Islam as only a much higher level of extended existence in which our short life on earth would be seen as a few passing hours, would help greatly those who have already started to deteriorate. When the person with AIDS changes his picture about himself, he would better tolerate the social pressures that others put upon him.

SPEECH BY GUEST OF HONOUR

(Given by the Ethiopian Minister of Health, Dr. Tewodros Adhanom Ghebreyesus, who represented His Excellency Prime Minister Meles Zenawi)

His Excellency Prime Minister Meles Zenawi is unable to attend this very important meeting due to a very pressing commitment and I am making this speech on behalf of His Excellency. Dear Distinguished religious leaders, Your Excellencies, invited guests and Consultation participants: First of all, on behalf of our government and on my own behalf, please allow me to welcome you all to Ethiopia. It is such a great pleasure to me to be here with you at the opening ceremony of this august meeting of the 3rd International Muslim Leaders' Consultation on HIV/AIDS.

HIV/AIDS, as you know, is causing serious social and economic damage in our world. At the end of 2006, the number of people with HIV was estimated to reach 39.5 million, of which 24.7 million of those were from subsaharan Africa alone. Total deaths in the same year reached 2.9 million. By any standard, these figures are very tragic and unacceptable. A problem of such magnitude requires a concerted effort of the whole of humanity without exception because no race, no religion, no country is left unaffected.

As leaders of the Muslim community, you have taken the initiative to address the HIV/AIDS epidemic using Islamic principles and Islamic teachings, and by doing this you have taken the responsibility of saving humanity -- saving the world. On behalf of our government and on my own behalf, I would like to use this opportunity to express my appreciation to you all for the same. I would also like to give a special thanks to Chief Kadhi of Uganda and the Islamic Medical Association of Uganda for taking the initiative to establish such a very important international forum.

Now, I would also like to share with you the HIV situation in Ethiopia and what we are doing to address the problem. The national prevalence is 2.1% and in urban areas like Addis Ababa it reaches up to 7.7%. The current estimate of people living with the virus is 977,396. The estimated number of orphans is now expected to be 898,100. To address the epidemic, our Government designed a strategy to combat HIV/AIDS based on the three pillars of prevention, treatment, and care and support. When the revised strategic plan of the country was launched in January 2005, the number of people on free ART was only 900 compared to over 95,000 now. Community conversations are now common and resulting in the participation of people in addressing the problem. The number of people being tested is also increasing, and this years' figure is three fold compared to last year.

Although the progress so far is encouraging, the most difficult part of the challenge is still ahead of us and it needs a sustained effort as charted in our strategic plan. The encouraging results have been achieved due to the concerted efforts of all stakeholders in Ethiopia including the Ethiopian Islamic Affairs Supreme Council. In fact, in recognizing the significant contribution of all religious denominations in our country in the fight against HIV, the government supported the idea of making the Interfaith Forum the principal recipients of Global Funds, which was later endorsed by the Ethiopian CCM. The Interfaith Forum that includes the Muslim community submitted their first proposal to Round 7 of the Global Fund whose deadline for submission has just ended in July 2007. The support of the international community in the fight against HIV/AIDS has been unprecedented and I would like to also use this opportunity to recognize and thank all partners, notably PEPFAR, the Global Fund and the World Bank.

As you know, we will be celebrating our millennium – Ethiopian Millennium, in just 50 days. I am happy to share with you that the African Union member states have declared the Ethiopian Millennium as the African Millennium and the United Nations has also recognized it as our global event. Holding the 3rd International Muslim Leaders Consultation in Addis Ababa thus makes it a very special event and I thank you again for selecting Ethiopia as the host.

As you know, the first Hijiira was made to Al-Negasha, Tigray, in the northern region of Ethiopia. Ethiopia has played a very important and key role in the history of Islam by accepting the followers of Prophet Mohammed who fled persecution, and that is why Muslims consider Ethiopia as a symbol of Freedom. I want you to feel at home because Ethiopia is your home and the government is ready to extend its full support in any way possible.

I wish you successful deliberations and a pleasant time during your stay. I have now the pleasure to declare the consultation officially opened. I thank you.

SPEECH BY THE US AMBASSADOR TO ETHIOPIA

(Given by His Excellency, Ambassador Donald Yamamoto, the US Ambassador to Ethiopia.)

Dr. Tewodros; Dr. Magid Kagimu, Chair of the international advisory committee; Sheikh Taaha and Sheikh Redman of the Ethiopian Islamic Affairs Supreme Council; Professor Malik Badri, honored guests, including Foreign Minister Seyoum, Minister Drier, Minister Tedros and the Mayor of Addis Ababa, and my particular appreciation for the participation of our friends and colleagues from Algeria, Bangladesh, Philippines and other countries. A'salamu Aleikum. It is an auspicious occasion that we hold this consultation in Ethiopia, the crossroads where all religions meet, and in a country where things are going right in facing the challenge of HIV/AIDS.

This consultation is not about giving thanks to the U.S. and its people for our support. It is about you, each and every one of you, who have committed yourselves to work on this problem. The United States is grateful to you for giving us the opportunity to support this consultation through the President's Emergency Plan for AIDS Relief (PEPFAR), and for your continued commitment to this endeavour. PEPFAR's strategy works to support faith-based efforts, community-based implementation, and sound government leadership. Here in Ethiopia we give thanks to Prime Minister Meles for his sound leadership, to Minister Tewodros for his wise guidance, and to the efforts of Ethiopia's leadership, including Foreign Minister Seyoum and the Mayor of Addis Ababa for your effective approaches in facing these challenges.

We are also grateful to be able to work together with Muslim communities and leaders to advance our shared efforts in this endeavor. In 2003, Muslim, Protestant and Ethiopian Orthodox leaders joined together to mobilize their extensive influence, goodwill and networks among followers to reduce the stigma and discrimination associated with this epidemic. Last month, I had the honor to work with his Holiness, the Patriarch of the Ethiopian Orthodox Church at Entoto Mariam Church where he blessed the simultaneous complementary use of holy water and antiretroviral treatment, "the use of both together," enabling thousands of devout followers to guiltlessly receive both spiritual and bodily sustenance. We look to you, the religious leaders and community leaders, to return to your communities to spread the good word, to bring communities together to fight HIV/AIDS. You can shape social values, promote responsible behavior, increase public knowledge and influence opinion, as well as change attitudes, policies and laws.

I wish to underscore to you the fundamental approaches to be raised at this consultation in combating HIV/AIDs:

- A basic belief in God, the All Merciful Allah.
- Learning the scientific facts about HIV/AIDS prevention, treatment, care and support.
- Learning what is fact from fiction and implementing theory.
- Making use of relevant Islamic teachings.
- Articulating and analyzing the concept of the Islamic approach to HIV/AIDs and how it can be transformed from theory into practice.
- Forming partnerships with and making use of religious leaders and their administrative structure.
- Developing basic strategic plans to reach Muslim communities more effectively in the implementation of the Islamic approach to HIV/AIDS.

We must follow up on what we learn and share at this consultation so that we can shape communities and implement the Islamic approach to HIV/AIDs. We must always remember the compassion and justice of Allah. In this context, we must understand that each of us has a responsibility to constantly increase the intensity of the light of Allah within each of us and to help others discover the same light within themselves. We are all dependent on the Grace and Mercy of Allah. What we must all realize is the fundamental truth that we all have a common link, that we all live together on this small planet and that we must all understand and share with one another our common bonds to each other. We can learn and share with each other, bring all of us closer together through the Qu'ranic teachings, reaffirming and sharing these truths when we return to our communities.

I call on each of you to work together, to share together and to advocate together what this Consultation will advocate in meeting this common endeavor. Thank you

BACKGROUND INFORMATION

This session started with the recitation of the Holy Qur'an and reflections by Imam Talib Abdur Rashid from New York in the United States. He recited chapter 42:30-43 below.

> *"Whatever misfortune happens to you, is because of the things your hands have wrought, and for many (a sin) He grants forgiveness. Nor can you escape through the earth, nor have you, besides Allah any one to protect or to help. And among His signs are the ships, smooth-running through the ocean, as mountains. If it be His Will, He can still the wind, then would they become motionless on the back of the (ocean). Verily in this are signs for everyone who patiently perseveres and is grateful. Or He can cause them to perish because of the (evil) which (the men) have earned; but much does He forgive. But let those know, who dispute about our signs, that there is for them no way of escape. Whatever you are given (here) is (but) the enjoyment of this life; but that which is with Allah is better and more lasting: (It is) for those who believe and put their trust in their Lord. Those who avoid the greater sins and indecencies and, when they are angry even then forgive. Those who respond to their Lord, and establish regular prayers; who (CONDUCT) THEIR AFFAIRS BY MUTUAL CONSULTATION; who spend out of what we bestow on them for sustenance; And those who, when an oppressive wrong is inflicted on them, (are not cowed but) help and defend themselves. The recompense for an injury is an injury equal thereto (In degree); but if a person forgives and makes reconciliation, His reward is due from Allah: for (Allah) loves not those who do wrong. But indeed if any do help and defend himself after a wrong (done) to him, against such there is no cause of blame. The blame is only against those who oppress men with wrong-doing and insolently transgress beyond bounds through the land, defying right and justice: for such there will be a Chastisement grievous. But indeed if any show patience and forgive, that would truly be an affair of great resolution."*

These verses reflect the main background reason why IMLC are being held. The believers are advised to conduct their affairs by mutual consultation. The issue of HIV/AIDS requires mutual consultation in order to be effectively addressed.

INTRODUCTION AND BACKGROUND TO 3RD IMLC

(Given by Dr. Magid Kagimu)

Bismillahi Rahmani Rahim (In the name of Allah, most Gracious, most Merciful)

Main aim of the 3rd IMLC:
To serve Allah

Understanding Allah:
Who is Allah?
Are there any disputes about who Allah is?
Who are the servants of Allah?
All answers are in the Holy Qur'an.
I will read several verses of the Holy Qur'an. Please listen to them carefully with attention as advised in the Holy Qur'an: Al-A'araf, 7:204.

"When the Qur'an is read, listen to it with attention, and hold your peace that you may receive Mercy".

Serving Allah:

Serving Allah and using the Qur'an for answers and guidance is a command and it is for the good of our own souls. HQ. Surah An-Naml 27:91-92
"*For me, I have been commanded to serve the Lord of this city, Him who has sanctified it and to Whom (belong) all things, and I am commanded to be of those who bow in Islam to Allah's Will."*
"And to rehearse the Qur'an. And if any accept guidance, they do it for the good of their own souls, and if any stray, say: I am only a Warner".

Allah is one for all:

Allah is one for all creation and there should be no dispute about this with the people of the Book (Jews and Christians). One of our ground rules in the 3rd IMLC is to pray to Allah, which will restrain us from shameful and evil deeds
HQ: Surah Al-Ankabut 29: 45-46.
"*Recite what is sent of the Book by inspiration to you, and establish regular Prayer, for Prayer restrains from shameful and evil deeds; and remembrance of Allah is the greatest (thing in life) without doubt. And Allah knows the (deeds) that you do".*
"And dispute not with the people of the Book, except in the best way, unless it be with those of them who do wrong, but say, "We believe in the revelation which has come down to us and in that which came down to you; Our Allah and your Allah is One; and it is to Him we bow (in Islam)".

Allah is unseen, yet the most important part of our lives.

Allah is not seen but He is the most important controller of our lives. Allah is in charge of the visible and invisible or unseen world. The invisible or unseen is more important because it moves the visible. Our souls are invisible. If they are removed we do not move. We are dead.
HQ: Surah Al-Nahl: 16:77
"*To Allah belongs the unseen of the heavens and the Earth. And the Decision of the Hour (of Judgment) is as the twinkling of an eye, or even quicker, For Allah has power over all things".*

Allah gives us intelligence:

Allah gave us intelligence and we are here at the 3rd IMLC to use it to discuss issues of HIV/AIDS, as a "think tank". We should all use our intelligence on these issues as a way of thanks to Allah.
HQ: Surah Al Nahl. 16:78.
"It is He Who brought you forth from the wombs of your mothers when you knew nothing; and He gave you hearing and sight and intelligence and affections: that you may give thanks (to Allah)".

Allah advises us to discuss issues with wisdom and patience:
As we discuss HIV/AIDS issues let us use our wisdom and be patient.
HQ: Al Nahl 16: 125-128.

"Invite (all) to the Way of your Lord with wisdom and beautiful preaching and argue with them in ways that are best and most gracious, for your Lord knows best who have strayed from His Path, and who receive guidance".
"And if you punish, let your punishment be proportionate to the wrong that has been done to you: But if you show patience, that is indeed the best (course) for those who are patient".
"And do you be patient, for your patience is with the help from Allah; nor grieve over them and distress not yourself because of their plots".
"For Allah is with those who restrain themselves, and those who do good".

Allah advises us to say only the best and to be aware of shaitan (satan) who is divisive among people:
In our deliberations let's say only those things that are best. If we start saying bad things we must understand that shaitan has invaded us and wants to divide us. We must aggressively fight shaitan.
HQ: Surah Al Israa 17:53.
"Say to My servants that they should (only) say those things that are best, for Satan does sow dissensions among them; for Satan is to man an avowed enemy".

Allah advises us to refer contentious issues to the Holy Qur'an which has many comparable examples for guidance:
If there are any contentious issues in our discussions let us refer to the Holy Qur'an, which explains everything. Let us not just be contentious.
HQ: Surah Al Kahf 18:54.
"We have explained in detail in this Qur'an, for the benefit of mankind, every kind of similitude, but man is, in most things, contentious".

Servants of Allah are defined:
We have come to serve Allah and the servants of Allah are defined in the Qur'an.
HQ: Surat Al Furqan 25:63-76
"*And the servants of (Allah) Most Gracious are those who walk on the Earth in humility, and when the ignorant address them, they say, "Peace".*
"Those who spend the night in adoration of their Lord, prostrate and standing".
"Those who say, "Our Lord, avert from us the wrath of Hell, for its wrath is indeed an affliction grievous".
"Evil indeed is it as an abode, and as a place to rest in".
"Those who, when they spend, are not extravagant and not niggardly, but hold a just (balance) between those (extremes)".

"Those who invoke not, with Allah, any other god, nor slay such life as Allah has made sacred except for just cause, nor commit fornication/adultery; and any that does this (not only) meets punishment,
"*(But) the Chastisement on the Day of Judgment will be doubled to him, and he will dwell therein in ignominy.*
"Unless He repents, believes, and works righteous deeds, for Allah will change the evil of such persons into good, and Allah is Oft-Forgiving, Most Merciful".
"And whoever repents and does good has truly turned to Allah in repentance".

"Those who witness no falsehood, and, if they pass by futility, they pass by it with honourable (avoidance)".
"Those who, when they are admonished with the signs of their Lord, droop not down at them as if they were deaf or blind".
"And those who pray, "Our Lord, grants us wives and offspring who will be the comfort of our eyes, and give us (the grace) to lead the righteous".
"Those are the ones who will be rewarded with the highest place in Heaven, because of their patient constancy, therein shall they be met with salutations and peace".
"Dwelling therein:- how beautiful an abode and place of rest'.

Leaving home for Allah's sake recommended:
We have all left our homes for the sake of Allah like Lut did:
HQ: Surah Al Ankabut. 29:26.
"But Lut had Faith in Him. He said: "I will leave home for the sake of my Lord, for He is Exalted in Might, and Wise".

Allah advises travel and reflection:

We have travelled through Allah's earth to come here and think as well as reflect about our communities.
HQ: Surat Ar Rum. 30:8-9.
"Do they not reflect in their own minds? Not but for just ends and for a term appointed did Allah create the heavens and the Earth, and all between them. Yet there are truly many among men who deny the meeting with their Lord (at the resurrection).
"Do they not travel through the Earth, and see what was the end of those before them? They were superior to them in strength, they tilled the soil and populated it in greater numbers than these have done. Then there came to them their Apostles with Clear (Signs). (Which they rejected, to their own destruction). It was not Allah Who wronged them, but they wronged their own souls.

Allah advises patience on matters of collective action:

We have come to discuss a matter of HIV/AIDS, which requires collective action. We should all be patient and not move out of discussions anyhow. This is not an ordinary conference. It is a Consultation and we must all be serious. We were brought here by Allah. In effect we are summoned here to continue with the work of Prophet Muhammad (SAW). This is the Jihad on AIDS.
HQ: Surat Al Noor. 24:62-64.
"Only those are Believers who believe in Allah and His Apostle: when they are with him on a matter requiring collective action, they do not depart until they have asked for his leave, those who ask for your leave are those who believe in Allah and His Apostle; so when they ask for your leave, for some business of theirs, give leave to those of them whom you will, and ask Allah for their forgiveness, for Allah is Oft-Forgiving, Most Merciful."

"Deem not the summons of the Apostle among yourselves like the summons of one of you to another. Allah does know those of you who slip away under shelter of some excuse; then let those beware who defy the Apostle's order, lest some trial befall them, or a grievous Chastisement be inflicted on them.

"Be quite sure that to Allah belongs whatever is in the heavens and on Earth. Well does He know what you are intent upon, and the day they will be brought back to Him, and He will tell them the Truth of what they did, for Allah does know all things."

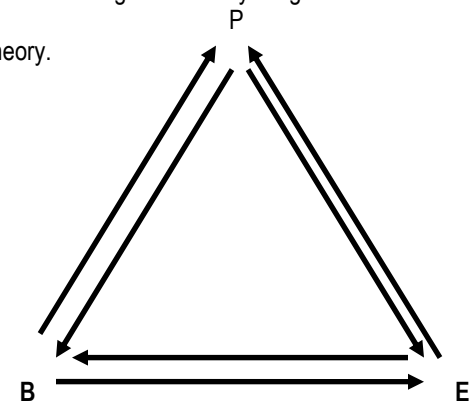
Theoretical basis of Islamic approach to AIDS:

Allah has given man intelligence. The Islamic approach to HIV/AIDS and the Jihad on AIDS have a theoretical basis. It is called the "social cognitive theory" proposed by Bandura. It states that human behaviour is an interaction of 3 factors.

1. Personal (P) – cognitive (knowledge), beliefs, affective (emotion), biological nature.
2. Environmental (E) – social influences e.g. religion
3. Behaviour (B) - e.g. prayer.

The interaction of these factors is shown diagrammatically in figure 1.

Figure 1: The social cognitive theory.



Source: Bandura A. (1994) Social cognitive theory and exercise of control over HIV infection. In R. Diclemente, J. Peterson (Ed). Preventing AIDS. Theories and methods of behavioural interventions . P 25 – 29. Plenum Press. New York.

The five components of the Islamic approach to AIDS can fit in this theory as follows:
P = Belief in Allah
= Scientific knowledge about AIDS
E = Using Imams and other religious leaders to educate communities
B = Using Islamic teachings and practices
Using concept of Jihad Nafs to control behaviour

3rd IMLC Programme booklet has the following:

- Background to IMLCs
- Goals and objectives of the IMLCs
- Goals and objectives of the International Centre for the Promotion of the Islamic Approach to AIDS
- Detailed programme
- Ethiopian Muslims History

Evaluation of 3rd IMLC will consist of:

- Daily evaluation – verbal appreciative inquiry: 4 questions to be answered.
  - What went on well during the day?
  - What recommendations do you suggest for improvement?
  - What one idea did you hear today that you might like to implement in your country?
  - What is the source of your motivation for participating in today's session?

Final evaluation
Participants' evaluation forms will be distributed on Thursday morning and returned Thursday evening after completion.

We pray to Almighty Allah to guide us in the deliberations of the 3rd IMLC

SCIENTIFIC UPDATE ON HIV/AIDS
(Given by Dr. Oussama Tawil from UNAIDS)

UPDATE ON THE GLOBAL AIDS PANDEMIC WITH SPECIFIC REFERENCE TO PREVENTION, TREATMENT, CARE AND SUPPORT IN MUSLIM COMMUNITIES

As Sy Elhadj*, Oussama Tawil**
*Department Director, Partnerships and External Relations; **Director, Regional Support Team, Middle East and North Africa

Twenty-five years into the epidemic is an important time for those of us working in the AIDS field to re-examine our work, to asses our progress and to redouble our efforts to prevent transmission of HIV infection and care for those living with the virus. One of the greatest barriers to HIV prevention, care, treatment and support is stigma and discrimination. I am especially honoured to be invited to this gathering of Muslims, including doctors and eminent religious leaders as you are people with much influence over community values and beliefs.

I hope that this consultation will include some ground breaking dialogue about stigma and discrimination leading to more action and that the strategy articulated by this meeting will boldly address some of the difficult issues that put our young people and women at risk of infection.

My presentation will cover four main areas.
1) The current state of the evidence on HIV prevalence in countries with significant Muslim communities
2) UNAIDS work with civil society in particular religious leaders and faith related NGOs
3) Examples of Muslim communities and organizations responding to AIDS

Figure 2:

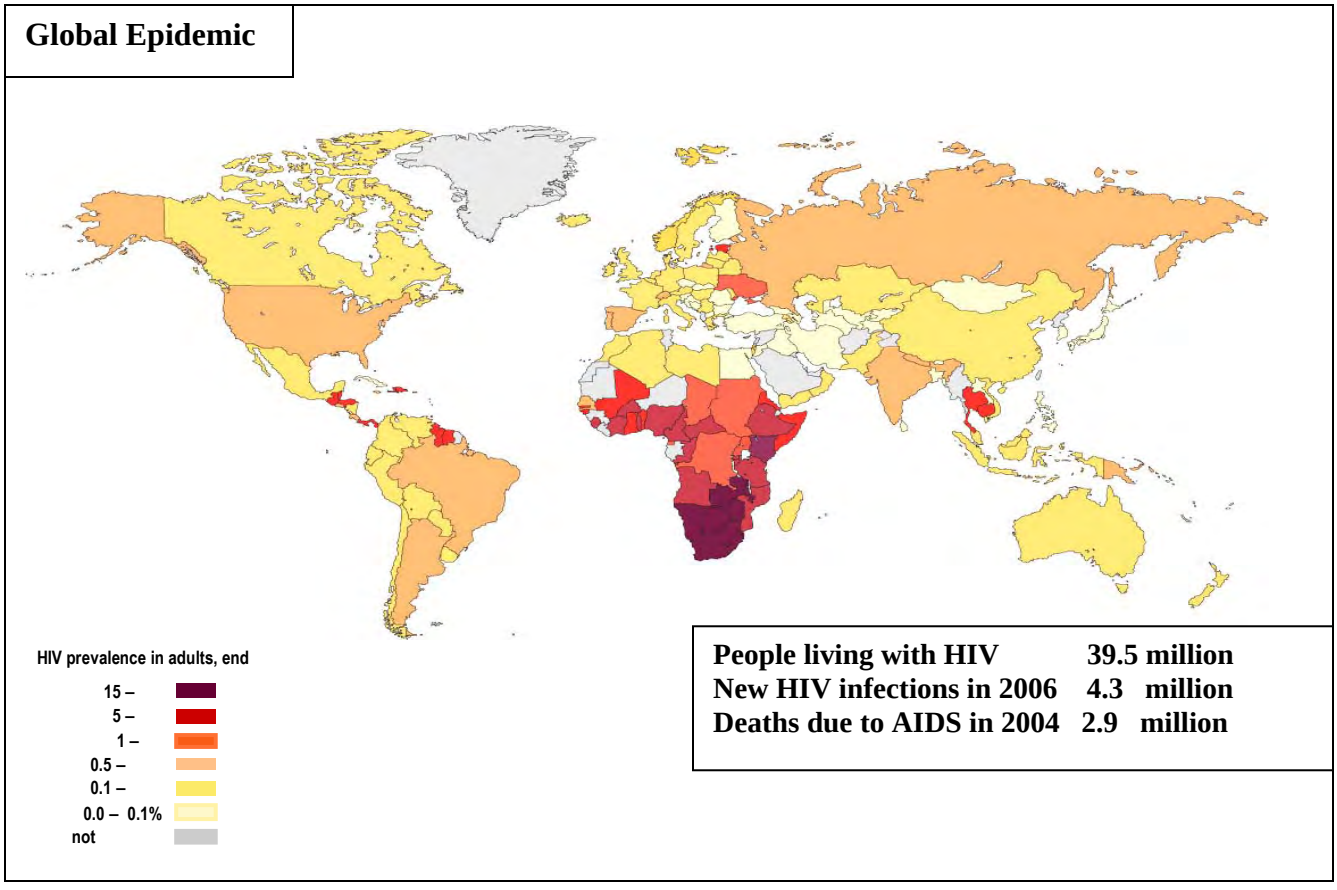


Figure 3: Global HIV: Change in Prevalence Rates

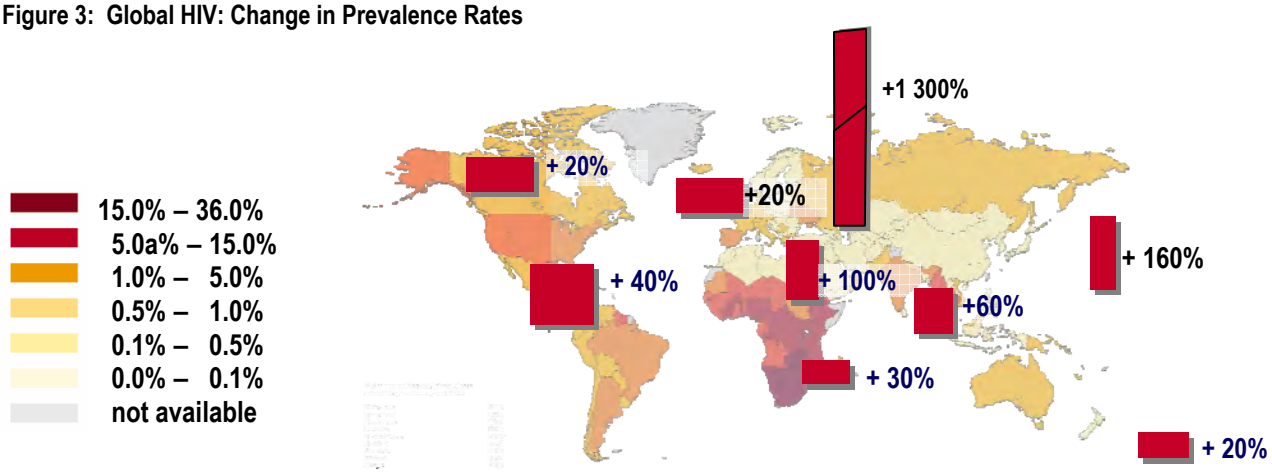


Figure 4: Estimated number of adults and children living with HIV by region, 1986–2006

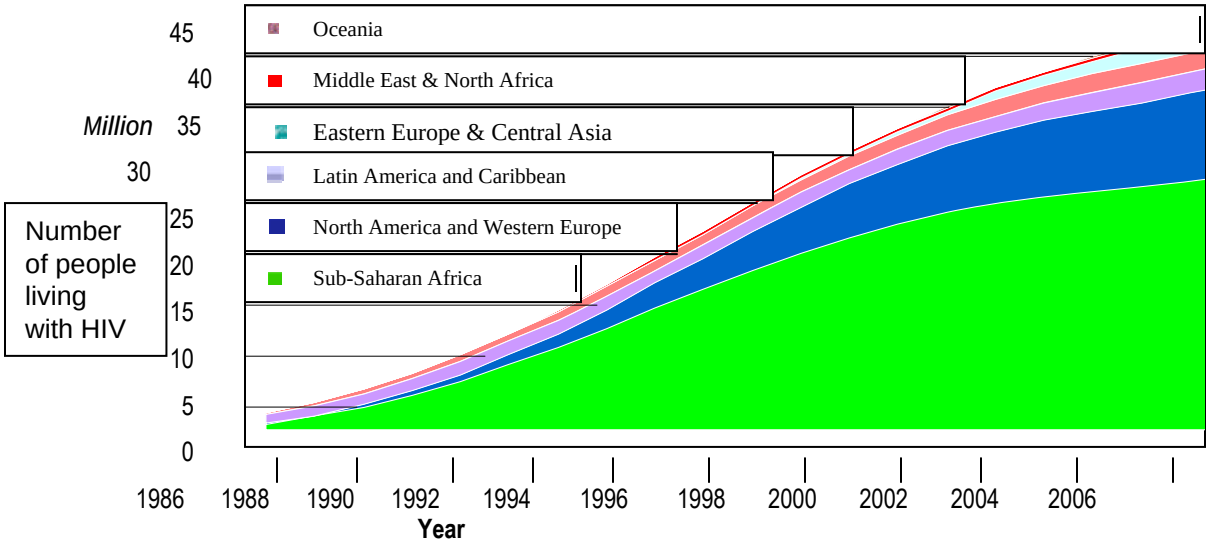


Figure 5: HIV prevalence (%) in adults in Africa, 2005

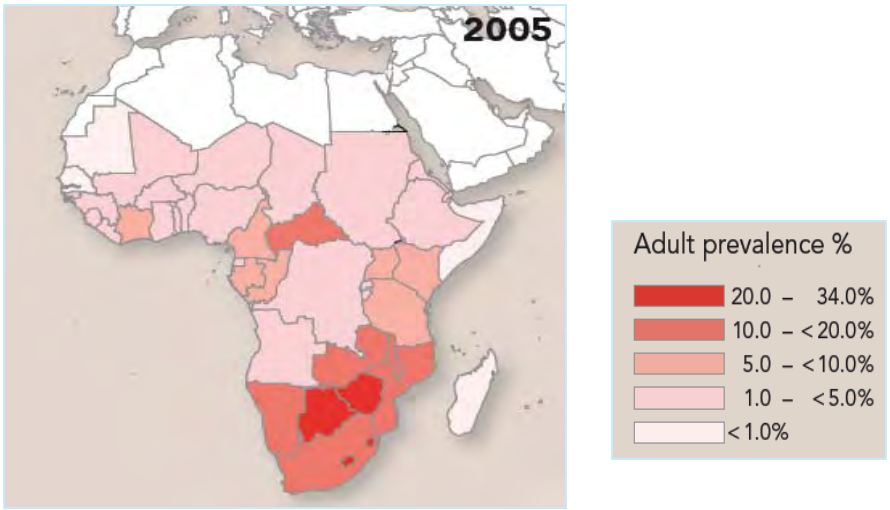


Figure 6: HIV prevalence in adults in Asia, 2005

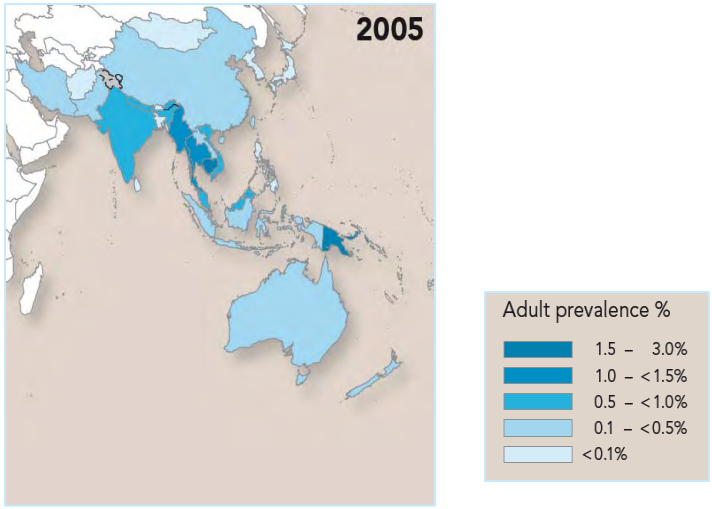
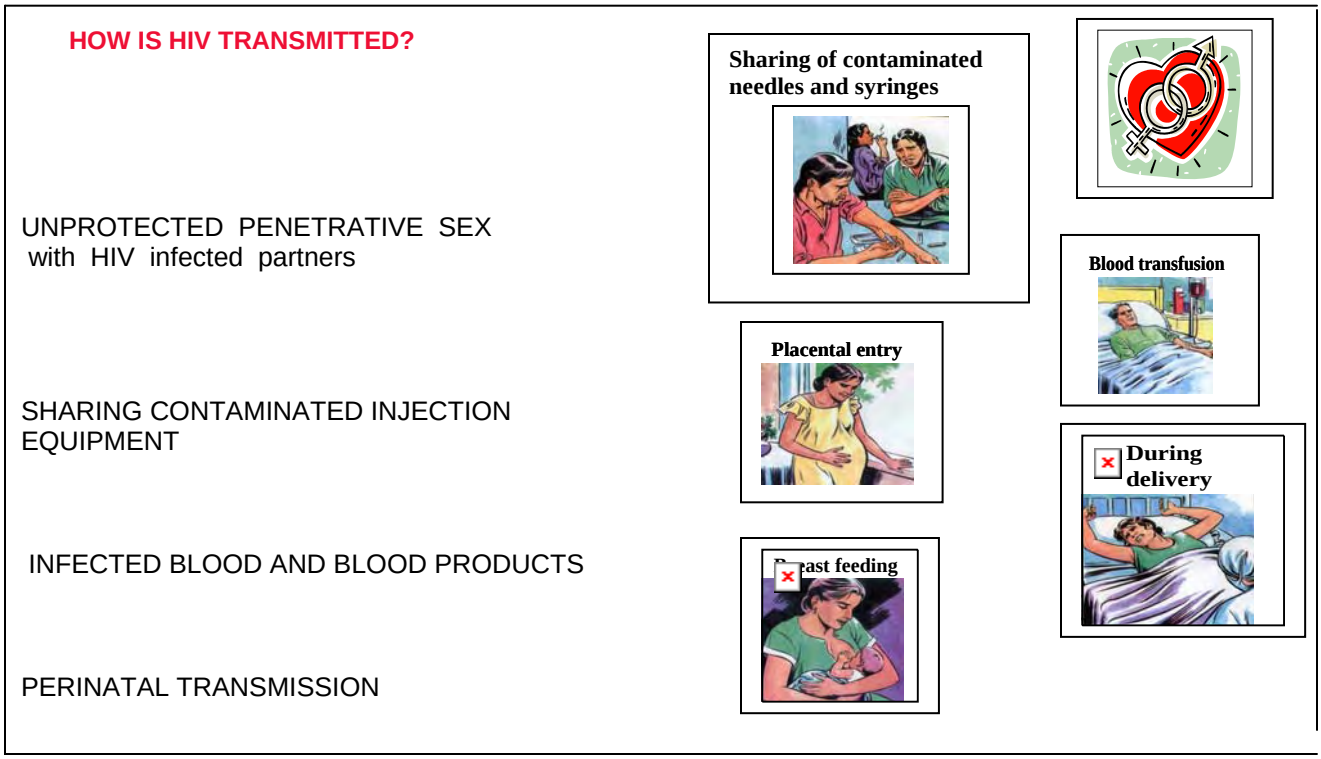


Figure 7.



MIDDLE EAST AND NORTH AFRICA

Although HIV surveillance remains weak in this region, more comprehensive information is available in some countries (including Algeria, Libya, Morocco, Somalia, and Sudan). Available evidence reveals trends of increasing HIV infections (especially in younger age groups) in such countries as Algeria, Libya, Morocco and Somalia.

The main mode of HIV transmission in this region is unprotected sexual contact, although injecting drug use is becoming an increasingly important factor (and is the predominant mode of infection in at least two countries, Iran and Libya).

Except for Sudan, national HIV prevalence levels are low in all countries of this region. However, most of the epidemics are concentrated geographically and among particular at-risk populations, including sex workers and their clients, drug injectors, and men who have sex with men.

Across the region, there is a clear need for more, better and in-depth information about the patterns of HIV transmission, especially the roles of sex work and of sex between men. On both fronts, scant information has been gathered; this suggests that there is a likelihood that HIV is transmitted through other risky behaviors or in other contexts. For example, in several countries of this region, a combination of inadequate surveillance data and strong socio-cultural taboos against sex between men could be hiding sex between men as a factor in HIV transmission

SUB-SAHARAN AFRICA

East Africa continues to provide the most hopeful indications that serious AIDS epidemics can be reversed. The countrywide drop in HIV prevalence among pregnant women seen in Uganda since the mid-1990s is now being mirrored in urban parts of Kenya, where infection levels are dropping, in some places quite steeply.

West and Central Africa (where estimated national HIV prevalence is considerably lower than in the south and east of the region) also show no signs of changing HIV infection levels, except for urban parts of Burkina Faso (where prevalence appears to be declining). Just as it is inaccurate to speak of a single 'African' AIDS epidemic, national-level HIV prevalence data can sometimes prompt incomplete pictures of the actual state of affairs.

Although the epidemics in West Africa vary in scale and intensity, this sub region historically has been less severely affected than other parts of sub-Saharan Africa. National adult HIV prevalence is yet to exceed 10% in any West African country, and there is no consistent evidence of significant changes in prevalence among pregnant women in recent years.

ASIA

An estimated 8.6 million people were living with HIV in Asia in 2006 and some 960,000 people became newly infected with the virus. Approximately 630,000 people died from AIDS-related illnesses in 2006.

EASTERN EUROPE AND CENTRAL ASIA

- The number of people living with HIV in Eastern Europe and Central Asia continued to rise in 2006. An estimated 270,000 people were newly infected with the virus, bringing to 1.7 million the number of people living with HIV in 2006—a twenty-fold increase in less than a decade.
- Although the rate of new HIV infections appears stable after the steep increases observed in 2001, an increase in the number of new HIV cases was again reported in 2005, compared to the two previous years.
- Almost one third of newly diagnosed HIV infections in this region are in people aged 15-24 years.
- Progress in expanding access to antiretroviral therapy has been slow. As of mid-2006, fewer than 24,000 people were receiving antiretroviral treatment—only 13% of the estimated 190,000 people in need of treatment.
- People who use non-sterile injecting drug equipment remain especially poorly served by efforts to rollout antiretroviral therapy. Although they represent more than two thirds of HIV cases in the region, they comprise only about one quarter of people receiving antiretroviral therapy.
- In Eastern Europe overall, using non-sterile injecting drug equipment remains the predominant mode of HIV transmission.
- In the context of such inadequate treatment and care coverage, the AIDS death toll in Eastern Europe and Central Asia grew from 48,000 in 2004 to 84,000 in 2006.

Summary of HIV Situation in the Middle East and North Africa (MENA)

- Diversity of HIV situation in the region: HIV prevalence ranges from much less than 0.0l to 2.9%
  - Low prevalence: most of the countries
- More countries may be in a concentrated epidemic profile if data become available
- Increasing HIV infection among women
- Sexual and drug injecting-related transmission occur
- Lack of data, political and social tension around HIV

Factors of Vulnerability

- Changing situation and practices among young people
  - A high percentage of the population
  - Youth unemployment
  - Low level of access to services, information and protection
- Socio-economic disparities and developmental challenges
- Marginality and stigmatization related to sexual behavior and drug use
- Gender inequities: socio-economic, employment, political and public participation, education, services
- Conflict and post-conflict situations
  - *Highest number of refugees in the world found in MENA*

Evolution of the Response to AIDS in MENA

- Increased ***political commitment and leadership*** in a number of countries
- More than 17 National Strategic Plans on HIV, including ***involvement of different partners*** : education, religious leaders, military, women, etc.
- Increased, mainly international ***resources***, to HIV response
- Increased focus on ***Prevention***
  - Young people
  - Increased understanding of vulnerabilities to HIV and access to services for marginalized populations
- Increase understanding of trends
  - Overcome perceptions of "low prevalence"
- Progress on access to ARVs, treatment and care for people living with HIV
- Reduced stigma and discrimination through efforts of partners: policy-makers, religious and community leaders, etc.
- Establishment of *Religious Leaders Network and Declaration in MENA* to reduce stigma and discrimination and support response to AIDS
- Evolving movement of people living with HIV
  - Declaration of Algiers of People Living with HIV from 15 countries in MENA

Main Challenges and Ways Forward

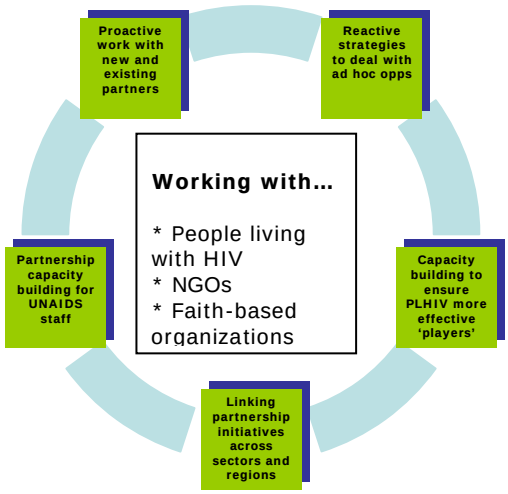
- *Political Commitment and Community Dialogue*
  - On prevention and sensitive issues
  - Access to treatment and provision of services
- *Increase access to Care, Treatment and Support*
  - Estimated that only 6% of those in need receiving ARVs in 2006
  - Coverage of prevention, information, means and services, condom use, and of VCT
- *Vulnerable Populations*
  - From innovative small programmes to sustained expanded programmes
  - Reduce stigma and discrimination of people infected or affected by HIV and marginalized groups
- *Reinforce collaboration with NGOs, FBOs, private sector*
- *Empower people living with HIV*
  - Increase access to services, training, sustainable support groups, associations, psychosocial support

UNAIDS Partnership Framework Objectives

- Reach out to optimally engage new sectors/actors in the AIDS response.
- Sustain and deepen the involvement of those already contributing - supporting them to respond to the shifting needs of the AIDS response.
- Broker linkages between partners and shift policy and rhetoric into action.

I will now move on to talk a little about how we work with civil society in UNAIDS, particularly with religious leaders and faith based organizations. This slide outlines the main areas of our work and the types of groups with whom we engage:

Figure 8:



Civil society organizations that UNAIDS engages:

- Organizations and networks of people living with HIV
- AIDS-focussed NGOs
- Human rights organizations
- Interest-based organizations
- Faith-based organizations
- Development and humanitarian organizations and agencies
- Memberships organizations
- Advocacy organizations
- Labour sector
- Business and private sector coalitions
- Private philanthropic organizations and foundations

Strategic Approaches in Working with FBOs

- Engage all religions
- Encourage interfaith dialogue and action
- Build partnerships- creating linkages across the sectors
- Support Religious Leaders and networks to speak out on AIDS
- Advocacy and Mobilizing resources for FBO responses

Our work with faith-based organizations is growing rapidly

- **We engage each religion separately –** to ensure that HIV and AIDS can be discussed within the context of each religious grouping and appropriate responses can be developed. *At the same time*:
- **We encourage interfaith dialogue and action -** working with people from other faith communities to provide the opportunity to exchange learning and build collaborative partnerships; this can be particularly effective at the country level.
- **Promote 'in reach**'- encouraging religious communities to be safe places for PLHIV.
- **Promote outreach-** leaders breaking the silence, communities providing care, support and treatment services.
- **Build partnerships -** creating linkages across the sectors; the response is only complete when all partners are fully engaged and work in collaboration with others.
- **Building the capacity of UNAIDS staff** to work with FBOs.

ISLAMIC APPROACH TO HIV/AIDS: THE EXPERIENCE OF THE ISLAMIC REPUBLIC OF IRAN

(Given by [46] llency Ayatollah Gorban-ali Dorri Najaf-abadi, State P[illegible]tor General of the Islamic Republic of Iran)

The prevalence of HIV is among the painful crises of the past century, threatening the world community with horrific effects on the health and life of society. Given its scale of impact and far-reaching repercussions, the global AIDS epidemic is both a grave challenge against individual lives and a serious public health, socio-economic and even political crisis. Let us instead concentrate on how to deal with the tragedy that was largely ignored by an epoch of high modernity at its peak of scientific and technological advancement.

Since contemporary rule was perceived as quietist and counter-progressive, sociologists claiming to uphold human freedom, conceived a new, untried civil order based on complete separation from – even contradiction of ethics. Hence, the greatest victim may have been morality, without which a culture void of modesty and compassion has developed under the guise of liberalism. The resulting challenges faced in spite of exceptional advances by the contemporary civilization - particularly in the area of public health – are now clearly visible; challenges of promiscuity and forgoing of religious teachings of sympathetic care which all stem from moral relativism and individualist liberalism.

The AIDS epidemic is largely a result of society's inattention and moral promiscuity and high-risk sexual behaviour as well as other similar factors. This whole introduction was intended as a reminder that a thinking person cannot help but to admit that the struggle to control and prevent the spread of this deadly disease requires a shift back to the warm and protective care characterized by the family, a shift back to the look of humane sympathetic concern. The world community needs spirituality and morality in all areas of personal and social interaction. Man's 'Fitra' -- our authentic and essential nature as humans -- is that of compassionate moral values based on justice on a global scale.

The world community has clearly stated its consensus on the necessity of ending the apathetic inaction against the destructive waves of the disease. What is needed now is a globally coordinated mobilization of this collective will in order to combat the transmission of the disease. Our concerted actions must succeed in integrating the efforts of physicians, jurists, psychologists and sociologists, as well as those of governments, NGOs, international agencies, and every member of the public active on any front against this tragic phenomenon.

Allow me, by way of sharing experiences, to simply outline some categories of effective and useful action taken by the Islamic Republic of Iran in response to the causes, and to the scale of this great human tragedy:

- **Infra-structure and Policy:**
  - Active involvement of Iran's Drug Control Headquarters, with some 60% of its substance abuse treatment resources dedicated to the expansion of HIV prevention programs (about 7 million USD in last year);
  - Allocation of additional funds to Iran's Ministry of Health under the category of emerging diseases (about 10 million USD this year);
  - Multisector: Active participation of more than 12 state institutions and ministries in the effort;
  - Conducting research on harm reduction strategies, social health improvement, reduction of discordant behaviour and response against offenders;
  - Expansion and universalization of the national public health network;
  - Measures to alleviate poverty and disparity as well as striving toward comprehensive justice as the underlying preventive strategy.
-

Prevention:

- Emphasis on strengthening the family institution and protecting the true values of the healthy family;
- Public awareness improvement regarding risk factors and the disease through mass information campaigns;
- Harm reduction interventions such as methadone maintenance therapy and needle and syringe programs for prevention of transmission through infected needles within the framework of a national committee for harm reduction and HIV/AIDS;
- Specific prisons' programmes including needle exchange and methadone;
- Extend teacher training at the school level;
- Encourage healthy, spiritual, moral and physical lifestyles choices among youth and the general public in order to reduce the risk of substance abuse, risky sexual behaviour and other destructive behaviour that could lead to the transmission of the disease.

- **Care and Treatment:**
  - Activation of more than 100 specialized HIV/AIDS clinics in each province and inside prisons which provide voluntary counseling and testing and care of patients (including provision of ARVs) free of charge;
  - Efforts to produce effective pharmacological medication, currently being tested in laboratory trials with some promising results (clearly, if successful, the mass production of such pharmaceuticals would benefit not only Iranians but others as well);
  - Focus on and planning for, the treatment of AIDS-related diseases such as TB, hepatitis, etc.

- **Support:**
  - Promotion of an attitude of protection, empathy and care toward PLWHAs as members of the great family of our society; refraining from measures that might lead to marginalization, stigmatization, invisibility or negative reactions;

Each one of these categories requires specific tactics and strategies in order to bring about a global reduction in the prevalence of the disease with the aim of eventual eradication.

The following approaches are worthy of consideration in this regard by all Muslim countries:

1. Development of policy and legislation commensurate to the scale of the problem;
2. Establishment or strengthening of "One" national HIV/AIDS coordinating body;
3. Extend support and help build capacity for the active participation of NGOs;
4. Education of youth and the general public (through schools etc.);
5. Protection and empowerment of People Living with HIV and vulnerable populations;
6. Promotion of means of prevention with integrated program monitoring and evaluation;
7. De-stigmatization of AIDS as a disease and its legislative categorization as a special disease;
8. Prevention and treatment of the psychological impact of the disease on the individual and society;
9. Promoting voluntary testing and counseling;
10. Information and educating the public as well as advocacy among religious leaders and reference social groups regarding the threat of HIV/AIDS; also raising awareness of the disease and the relevant medical issues among the elite, key players, the media, religious scholars etc.;
11. Dealing with the affairs of children who have been made orphans as a result of the epidemic;
12. Measures toward social justice, poverty alleviation and elimination of disparities have long been global priorities for the international community. Efforts to counter the HIV epidemic constitute an integral part of our collective global mandate of comprehensive development, improvement of public welfare and subsistence, combating illiteracy and disease and bridging the North/South divide.

I urge all those sympathetic souls and dutiful individuals representing international organizations, and charitable associations to join the battle to contain this tragic human catastrophe as they would with any contagious disease. I implore you to think about

the plight of innocent children and helpless mothers and to extend any kind of help and support that you can afford. By using known prevention and treatment methods we can help contain the level of risky behaviour, reduce the spread and the prevalence of the disease, and keep youth from shifting from lower-risk to higher-risk categories. If we are truly committed and plan out our response we will be able to organize and implement many different kinds of protection, treatment and technical interventions.

A certain portion of local, national and international financial resources need to be allocated for this purpose. Charitable associations and institutions must be encouraged to help finance the services and programs. The Islamic Republic of Iran is eager to share its experiences at any level and is prepared to cooperate with other nations in such areas as health and education as well as in legal and juridical matters, particularly concerning programs for incarceration and rehabilitation facilities.

The task before us is a sacred endeavour; a service to the suffering and to all humanity. To help save the lives of human beings is a universal imperative. We are all responsible before God, before history and before our great human and Islamic values. Any failure or shortfall in this regard would be unacceptable. May Allah endow us with the blessing of being able to serve.

To conclude, I wish to thank the organizers of this gathering and hope that with the new millennium our nations and governments begin to rationally and effectively utilize the lessons learned over previous ages and move toward the building of a world free from discrimination, poverty, crisis, injustice and evil by enacting moral and just virtues worthy of humanity; thus working together for our joint welfare, development and realization of justice, equality and righteousness.

Thank you.

GROUP DISCUSSION SESSIONS

There were three group discussion sessions, each starting at 2.30 p.m. and ending at 6.30 p.m. on Monday, Tuesday and Wednesday. Each session started with an introduction of the group discussion themes by at technical advisor. This was followed by reflections by a Muslim living with HIV/AIDS. Thereafter, the participants went into their group discussions. In the first session, background information was given describing some of the reasons for the group discussions. Each of the five groups was requested to make a strategic plan for one component necessary in addressing the HIV/AIDS problem. They were given guiding questions to answer in order to assist them in making the plans. The issues planned for were:

1. HIV prevention,
2. treatment,
3. care and support,
4. reduction of stigma and discrimination, and
5. life skills utilization.

The participants were requested to make basic strategic plans for addressing these issues using the Islamic approach to HIV/AIDS. The proceedings of these group discussions follow.

INTRODUCTION AND TECHNICAL REVIEW:

Each session started with a technical review of the main theme of the discussions. The three themes were: (1) situation analysis, (2) goals and objectives, and (3) monitoring and evaluation. Summaries of these technical reviews follow:

SESSION I. Situation Analysis

What is Situation Analysis?

A process to gather and analyze information that helps in:

- Guiding planning
- Building consensus
- Setting priorities
- Mobilizing action

How to do it:

- Gather data – HIV incidence, existence of policies, current activities taking place in the area, etc.
- Ask questions – identify factors that contribute to situation, identify consequences being caused by HIV/AIDS
- Share information/results – use the analysis to engage community and develop a plan.

Group Discussion – Session I

The questions each group will be looking at in Session I are designed to help you identify:

- Where we stand at the moment on the issues under discussion
- Where we need to go
- What our priorities are

Questions

- What are the target communities for an Islamic approach to HIV/AIDS?
- What are their needs; their strengths and weaknesses?
- What are the priority issues that must be addressed?

SESSION II - Goals and Objectives

50

Goal

- Broad general statement
- What the organization hopes to achieve
- Regarding a target population
- By end of planning period
- Focus on major outcomes or results
- Qualitative

Objectives

- Specific, quantifiable, and time-based statements for the achievement of goals
- *S*pecific—to avoid differing interpretations
- *M*easurable—to allow monitoring and evaluation
- *A*ppropriate—to goals and strategies
- *R*ealistic—achievable, challenging, and meaningful
- *T*ime bound—with a specific time period for achieving them

Strategic Interventions

- Interventions that are consistent with the overall strategy to achieve the goal e.g.
  - Establish a mosque-based care program
  - Train community leaders in Islamic approach to addressing HIV/AIDS

Activities

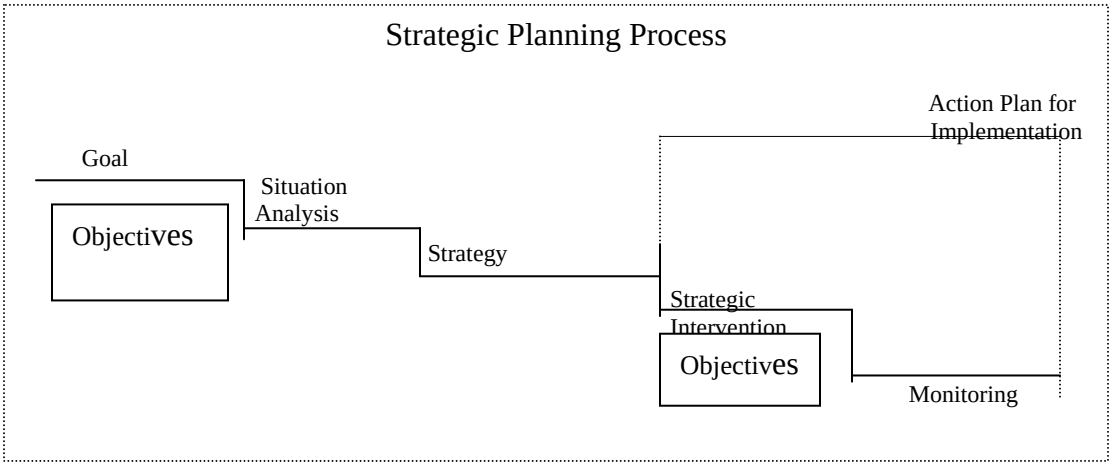
Specific actions that are necessary to achieve each objective (related to strategic intervention) e.g.

- Develop guidelines for care program
- Develop training curriculum for community members

Action Plan Defined

- What is the activity?
- Who is the person responsible for seeing that the activity is carried out?
- What resources are necessary?
- By what date should the activity be completed?
- Where will the activity take place?

Figure 9: Strategic Planning Process



SESSION III - Monitoring and Evaluation, Resource Mobilization, Resolutions and Commitments

What is Program Evaluation?

- A chance to find out what is working and what is not
- A chance to make changes to a program
- Useful, practical, and relevant
- Compare what happened to what was planned

What Evaluation is NOT:

- An opportunity to point fingers or lay blame;
- An activity that produces fear that a program will be reduced or eliminated
- A one time activity

Purpose of Evaluation:

- Inform action
- Enhance decision-making
- Apply knowledge to solve human and societal problems

Participatory Evaluation:

- Stakeholders substantively involved
- Project/program & evaluation *design*
- Identify evaluation issues
- Process of self-assessment
- Collection and analysis of data
- Action taken as a result of findings

Levels of Evaluation:

- Formative evaluation research (determines concept & design)
- Process evaluation (monitors inputs & outputs; assesses service quality)
- Effectiveness evaluation (measures and assesses outcome and impact)
- Cost-effectiveness analysis (includes sustainability issues)

What is Monitoring?

- Systematic, periodic tracking
- Continuous management function
- Provides regular feedback
- Accountability of achievement
- Results-oriented
- Compares actual with expected
- Process level evaluation

Hierarchical Objectives:

HIV/AIDS intervention evaluation:

- Longest term – impact – biologic
- Shorter term – outcome – behavioral
- Shortest term – output – activities (Process)

Questions to ask of an objective:

- How will we know this has happened?
- What kind of indicator will tell us?
- How will we measure it?
- Where will the data come from?
- How much will data collection cost?
- How will we interpret the data?
- Who will do all this? When? How?

Every objective needs indicators:

- Valid: measure what they intend to measure
- Reliable: produce the same results when used more than once to measure the same condition or event
- Specific: measure only what they're intended to measure
- Sensitive: should reflect changes in the state of the condition or event under observation
- Operational: possible to measure or quantify them with developed and tested definitions and reference standards
- Affordable: costs of measuring are reasonable
- Feasible: should be possible to carry out the pro **52** collection

In short, indicators need:

- Quantity
- Quality
- Time frame
- Means of verification (source of data)

Example of an impact indicator:

- 25% reduction in HIV prevalence among young women aged 15-24 attending antenatal clinics in [location] by [date];
- Monitors progress in preventing new infections; proxy for incidence; biologic; longest term change.

Examples of outcome indicators:

Knowledge:

- Statistically significant increase in the percentage of target population mentioning use of non-sterile razor blades during circumcision when asked how HIV can be transmitted (unprompted) by end of project

Project exposure:

- Statistically significant increase in the percentage of target population who reports hearing their Imam mention HIV/AIDS prevention at least once during religious gatherings by end of project
- Statistically significant increase in the percentage of target population who reports having been contacted by a Family AIDS Worker at least once during the previous 6 months, at the end of project

Attitude:

- Statistically significant increase in percentage of surveyed population reporting their perception that AIDS stigma and discrimination is "less now than it used to be in the past" at end of project [complementary qualitative data can explore *why* this might have happened]

Behavior:

- Statistically significant decrease in the percentage of target population sexually active in past 12 months, reporting sexual intercourse with at least one non-regular partner during the previous 12 months (at end of project)
- At least 75% of religious leaders who participate in AIDS care and support training make 4 home visits to AIDS patients in their mosque communities each month during the 6 months following training [self-reported]
- Statistically significant increase in the percentage of AIDS patients seen at clinic who report having been contacted at least once by their Imam at their home, in a comforting and compassionate manner, during the previous 12 months [prompted]
- At least 60% of participants attending most recent IMLC report participating in at least one strategic planning meeting sponsored by national AIDS control program in their home country, to report on their IMLC participation [data obtained from phone/email survey conducted 6 months post-IMLC]
- Percentage of district Imams trained in IAA
- Percentage of mosque communities sending representatives to IAA training
- Percentage of religious leaders committed to incorporating IAA into their religious ceremonies
- Percentage of AIDS patients in village who receive at least one visit from their Imam during the previous month

Examples of process indicators:

- Number of Imams trained each month
- Number of community members contacted by family AIDS workers each week
- Number of IAA manuals distributed each quarter
- Number of IMLC participants who schedule planning meetings with home country religious leaders each month

What is Resource Mobilization?

- *Not* just fundraising
- Obtaining needed resources (people, materials, funds, time) to do planned work
- Maximize range of resources from many providers through a variety of mechanisms
- Resources – different kinds of things that are needed
- Mechanisms – different ways of directly obtaining resources
- Resource providers – different people & organizations that contribute needed time, funds, materials, staff

What is a Resolution?

- A state or quality of firm determination
- A conviction to do something
- A course of action determined or decided upon
- A formal statement of a decision or expression of opinion put before or adopted by an assembly

What are Commitments?

- Pledges to action - to do something
- The state of being bound emotionally or intellectually to a course of action
- Best reached by consensus
- Formulated in a participatory fashion
- Written statements
- Can be monitored & evaluated

What are we evaluating?

Interventions:

- Prevention
- Treatment
- Care & support
- Stigma reduction
- Life skills utilization

Islamic approach:

- Belief in Allah
- Scientific knowledge
- Using Islamic teachings
- Forming partnerships
- Concept of Jihad Nafs

Implementing an "approach"

- "Approach" = method of doing something
- Technique
- Means to an end
- Unique way to intervene
- Faith-based strategy to reduce prevalence and incidence, and reduce risk behavior

A complicated question...

- How can an approach or method or concept be translated or incorporated into an intervention which can be monitored and evaluated?

How to "evaluate" the Islamic approach to AIDS?

- Believing in Allah
- Acquiring scientific knowledge about HIV/AIDS
- Making use of relevant Islamic teachings and practices
- Forming partnerships with religious leaders and their administrative structures
- Making use of the concept of Jihad Nafs

Many M&E tools already exist:
How can existing tools be used in M&E?

- Local resources
- National AIDS control programmes
- International resources via web
- PEPFAR
- UNAIDS
- "Three Ones"

Developing an M&E Plan

- Read what is written
- Ask questions
- Answer questions
- Repetition
- Remember past stories and experiences

Main evaluation questions?

- How will we know that we've made progress towards implementing an Islamic approach to HIV prevention, treatment, care & support, reduction in stigma & discrimination, and life skills utilization?
- What are our indicators of success?
- How will we measure them?

What is Evaluation? "Applied evaluative research is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policymakers and others who have a stake in efforts to improve the world." *Michael Quinn Patton*

Participatory Evaluation: "One of the negative connotations often associated with evaluation is that it is something done to people. One is evaluated. Participatory evaluation, in contrast, is a process controlled by the people in the program or community. It is something they undertake as a formal, reflective process for their own development and empowerment."
M. Patton, Qualitative Evaluation Methods, (2nd ed,), 1990, p. 129.

"Participatory evaluation aims to create a learning process for the program recipients that will help them in their effort to reach desired goals."
D. Greenwood and M. Levin, Introduction to Action Research, 1998, p. 239.

"The Three Ones" UNAIDS 2004

- ONE agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners
- ONE national AIDS coordinating authority with a broad based multi-sector mandate
- ONE agreed country level monitoring and evaluation system

BACKGROUND TO THE DISCUSSION TOPICS:

Background information: Each group started with a presentation to assist participants in understanding the background, reasons and methods for the group discussions. These presentations were as follows:

Expected outcome of the group discussions:

- Brief report of the proceedings of the group discussion
- A basic Strategic Framework for implementing the Islamic Approach to AIDS (IAA) for a mosque community
- A basic workplan of what the IMLC participant, Imam, individuals, families and community can do to implement the Islamic approach to AIDS for the mosque community.
- A basic monitoring and evaluation framework for activities related to the Islamic approach to HIV/AIDS at the mosque level.

Why are we gathered in groups for the 3rd IMLC?

- To serve Allah
- To enable each one of us as individuals to address HIV/AIDS
- To encourage our families and friends to address the problem of HIV/AIDS

- To empower our communities to combat HIV/AIDS
- To support our Imams in the work of assisting our communities to fight HIV/AIDS and care for people living with HIV/AIDS. IMLC Motto: Jihad on AIDS: Self discipline using Allah's guidance.

Teaching and learning methods used in the gr[55]ssions, derived from Allah's methods.

- Reading what is written
- Asking questions – Jibril's method
- Answering questions – Prophet Muhammad's (SAW) method
- Repetition
- Reminding of past stories and experiences

Purpose of the group discussions:

To assist the Imams to implement or put into practice the Islamic approach to HIV/AIDS prevention, treatment, care and support for their mosque communities.

Discussion questions will cover:

- Where are our mosque communities are as far as IAA is concerned e.g not yet perfect.
- Where they want to go as far as IAA is concerned, e.g nearer to Allah's guidance.
- How they will get there, e.g. through proper planning, implementation, monitoring and evaluation of IAA.

What the participants of group discussion sessions are expected to achieve:

- To understand how to plan for implementation of IAA for the mosque community
- To participate in making the basic strategic plans.
- To understand how to systematically implement the Islamic approach to AIDS for their communities around the mosque
- To understand how to assist Imams in planning for the implementation of IAA.
- To go back to their respective countries and start implementing IAA for their mosque communities and give regular feed back to the International Centre for Promotion of the Islamic approach to AIDS in Uganda.

Definition of a Mosque community for group discussion purposes

- Plan for a Mosque community, which has an Imam, a congregation for Juma prayers, surrounding households with individuals and families who look for mosque support whenever need arises.
- There are 100 households, each one with 5 people, and HIV prevalence rate of 5%. The mosque has a budget of 1,000 US $ per year for each of the five issues being discussed.
    - Prevention US$ 1,000
    - Treatment " 1,000
    - Care and support " 1,000
    - Stigma " 1,000
    - Life skills " 1,000
    - Total US$ 5,000

Components of HIV/AIDS Interventions Analyzed at the 3rd IMLC

There were five groups, with each group discussing a different type of HIV/AIDS intervention. A brief explanation of each intervention or topic appears in the table below. Many community-wide interventions include one or more of these components in a single program or project. The 3rd IMLC used small group sessions to analyze each of these components in detail in terms of how the implementation of each component can be supported by the Islamic Approach to AIDS.

Table 1: Intervention.

Component (Intervention)	**Definitions and explanations**
Prevention	Transmission occurs through: 1. Sex with an infected partner; 2. Contaminated blood via intravenous (IV) drug use with contaminated needles, contaminated blood transfusion, contaminated skin piercing instruments; and 3. From HIV positive mother to child; HIV infection is prevented through: 1. A-B-C plus: Abstinence, Being faithful and Condom use when appropriate, plus safe circumcision, HIV testing and counseling, antiretroviral treatment, HIV/AIDS care and support; 2. Avoiding HIV contaminated blood; 3. Preventing mother to child HIV transmission.
Treatment	HIV/AIDS is treated with medicines called antiretroviral drugs (ARVs). These medicines reduce the multiplication of HIV and improve the strength and well being of the person living with HIV/AIDS in the majority of cases.
Care and support of infected and affected	People infected and affected by HIV/AIDS include people living with HIV/AIDS, their families and the orphans of people who have died of AIDS. These people need physical, mental and spiritual care and support to assist them cope with the impact of HIV/AIDS in their families and communities.
Reducing stigma and discrimination of PLWHA	Stigma refers to significantly discrediting a person living with HIV/AIDS. Discrimination refers to exclusion or restriction of a person living with HIV/AIDS. The factors contributing to stigma and discrimination include the following: 1. HIV/AIDS is a life threatening disease and therefore is connected with death which elicits fear among people. 2. People are afraid of contracting HIV. 3. HIV/AIDS is associated with behaviours that are already stigmatized, e.g. adultery and premarital sex, sex between men, and intravenous drug use. 4. People living with HIV/AIDS are often thought of as being responsible for having contracted the disease. 5. Religious or moral beliefs lead some people to conclude that having HIV/AIDS is the result of a moral fault (e.g. adultery and premarital sex, multiple partner sexual networking) that deserves punishment. It has been said that the AIDS stigma formula is: AIDS = SEX = SIN = DEATH. 6. Stigma is a powerful means of social control applied by marginalizing, excluding and exercising power over individuals who display certain undesired differences. It is a common response to perceived threat when escape from or the destruction of this threat is impossible.
Life skills utilization	Life skills are tactics and tools used to save one's life and be able to survive. Components of life skills include (also see table 2): 1. Personal skills of knowing and living with oneself 2. Skills of living with others 3. Decision-making skills

The Islamic Approach to HIV/AIDS Life Skills for Prevention, Treatment, Care And Support

Life skills are tactics and tools used to save one's life and be able to survive. These skills are essential in AIDS prevention, treatment, care and support efforts of individuals, families and communities. The life skills are divided into 3 groups:

Table 2: Life skills.

1. Personal skills of knowing and living with oneself – explanations and definitions	
Self awareness	Knowledge of oneself: It refers to the "who and what" one is. It helps one to know and acknowledge his or her strengths and weaknesses. It is the ability of oneself to understand why they behave and make choices the way they do.
Self esteem	Belief in self as a worthy person: It is an experience of being competent to cope with the basic challenges of life and being worthy of happiness. The way we feel about ourselves affects virtually every aspect of our existence.
Assertiveness	The ability to stand up for oneself: It is knowing what you want and going out to get it in a positive, firm but reasonable manner.
Controlling emotions	The ability to overcome the strong illogical feelings of the human spirit: These can be fear, anger, love, guilt, hatred or grief. Emotions normally feel very real and overpowering at times but need to be kept under control so as to avoid regrets.
Coping with stress	Learning to identify symptoms of and managing the pressures that are caused by difficulties in life: Stress is an ever-present pressure. One should never allow stress to overcome him or her.
Patience and perseverance	The capacity to endure hardship, difficulty, unpleasantness or inconvenience with calmness, self-control and without complaint.
Saying no to Temptations	Being able to resist reacting to various urges, violent emotions and bad desires that may result in inappropriate or risky behavior. Self-control enables people to resist temptations.
Remembering and using Allah's guidance	Remembering to consult Allah and act on His guidance before making a decision to do anything.
2. Skills of living with others – explanations and definitions	
Interpersonal relationships	Developing and maintaining social relations between people. Quality of these relationships strongly influences family and community life.
Friendship formation	Establishing the conditions of sharing a friendly relationship or the process of acquiring persons with whom to share feelings, understanding and interests. Friends are helpers, supporters, advisers, and should be kind and understanding.
Empathy	Sharing another person's feelings. It is the power or state of imagining oneself to be another person and so sharing his or her ideas and feelings.
Negotiation	The act of discussing options, ideas, and information between conflicting persons so as to reach an acceptable agreement. It needs flexibility, assertiveness, creativity, listening skills, openness and honesty to be effective.

Table 2 cont…….

Effective communication	This is the act of making information, ideas, opinions, feelings, and news known and shared.
Peer resistance	The ability to withstand negative pressures and influences from peers.
Non-violent conflict resolution	Being able to resolve conflicts in a peaceful manner or never using force when resolving conflicts.
3. Decision-making skills – explanations and definitions	
Critical thinking	The intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action and as a result of careful judgment.
Creative thinking	Generally considered to be involved with the creation or generation of ideas, processes, and experiences -- exploring ideas, generating possibilities, looking for many right answers rather than just one.
Effective decision-making	The quality of being able to make correct choices or judgments and act on them with firmness.
Problem solving	The ability to deal with problems or to overcome difficulties after according attention and thought to them. It refers to getting an answer or developing a solution to a problem.

These life skills can be utilized to combat AIDS in line with Islamic principles. The positive aspect of each life skill has relevant Islamic teachings to support it. When the life skills are used in line with Islamic teachings for HIV/AIDS prevention, treatment, care and support, this is what is called the Islamic approach to HIV/AIDS life skills.

THE ISLAMIC APPROACH TO HIV/AIDS (IAA)

Each group discussed the operational definition of the Islamic approach to HIV/AIDS as follows:

The operational definition of the Islamic approach to HIV/AIDS includes the following:

1. *Believing in Allah and Prophet Muhammad (SAW)*

   This is the first pillar of Islam indicating that an individual recognizes that there is an invisible God who has power over all creation, who is the Most Gracious and Most Merciful and who has given guidance to mankind on how to live on this earth and in the Hereafter. This guidance includes Islamic teachings that promote HIV prevention, treatment, care and support, stigma reduction, and life skills utilization. One of the verses in the Holy Qur'an to support this is in chapter 10 verse 3:

   > *"Certainly your Lord is Allah, who created the heavens and the earth in six days and He established Himself on the throne of authority regulating and governing all things. No intercessor can plead with Him except after His leave has been obtained. This is Allah your Lord; therefore, serve Him. Will you not receive this reminder?"*

2. *Acquiring scientific knowledge about HIV/AIDS*

   Eliminating or reducing risk of infection requires learning about and understanding the scientific facts about HIV prevention and risk avoidance, and about treatment, care and support of people living with HIV/AIDS (PLWHA). Allah's guidance to believers is to read and learn in order to acquire knowledge and education. Holy Qur'an, chapter 96, verses 1-5:

   > *" Read! In the Name of your Lord who has created all that exists. He has created man from a clot. Read! And your Lord is the most generous who has taught by the pen. He has taught man that which he knew not."*

3. *Making use of relevant Islamic teachings and practices*

   For example, there is an Islamic teaching in the Holy Qur'an discouraging adultery, which can be a predisposing factor for HIV transmission.

   > *"Do not come near to adultery. For it is a shameful deed and an evil, opening the road to other evils" (Holy Qur'an 17.32)."*

   This means that people should not indulge in activities that stimulate their sexual desires, which could then lead them to commit adultery. Adultery is a shameful behaviour that may increase risk of HIV infection.

4. *Forming partnerships with and making use of religious leaders and their administrative structures*

   The Mosque Imams are the major pillars in this partnership. They can deliver AIDS education and counseling to grassroots communities. Islamic guidance in the Holy Qur'an encourages people to form partnerships for promoting good behaviours.

   "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. They are the ones to attain success."(Holy Qur'an 3.104)

5. *Making use of the concept of Jihad Nafs (struggle of the soul against temptation) by each individual to combat AIDS.*

   In this context, the Jihad on AIDS is about each person's individual struggle to control their own personal behaviour for the welfare of themselves and their families, as well as each community's struggle to address the broader context of preventing HIV transmission and to provide care and support to those coping with HIV infection. All Muslims were advised to participate in this Jihad Nafs by Prophet Muhammad (Peace be upon Him). He called it the biggest Jihad because it is not easy for anyone to control the tempting desires of his or her soul. Implementation of the first four components of the Islamic approach to HIV/AIDS above is likely to have a limited impact at the community level until a significant proportion of individuals participate in this Jihad. The Islamic approach to AIDS should be implemented at the individual level, at the family level, and at the community level. At the individual level, the person should believe in God, learn the scientific information about AIDS, learn the faith teachings that support AIDS prevention and control, listen to and use the advice of his or her Imams, and participate in the Jihad Nafs by controlling his or her behaviour. Family members should support each other in implementing these same things. Similarly, communities should support families and individuals in the implementation of all the components of the Islamic approach to AIDS.

The Questions:

Thirteen questions were answered in three sessions with each session covering a different theme in the process of basic strategic planning. The questions were similar for the five topics except that each group was concentrating on their own component (type of intervention). For example the questions for HIV prevention were as follows:

1. a. Are there any other components you feel should be included in the operational definition of IAA ?
   b. What is the role of each of these components in the Islamic approach to HIV/AIDS prevention? Identify examples of relevant Islamic teachings.
   c. What indicators identify successful implementation of the Islamic approach to HIV/AIDS prevention in the individual, family and community? Ensure the indicators are relevant to the 5 components of the Islamic approach to AIDS.
   d. Who gives the mandate to implement the Islamic approach to HIV/AIDS prevention at the individual, family and community levels?
2. What are the target communities for the Islamic approach to HIV/AIDS prevention?
3. a) What are the needs of the target communities as far as the Islamic approach to HIV/AIDS prevention is concerned? Ensure you identify the needs for the following groups: children, youth, men and women.
   b) What are the strengths and weaknesses of these target groups as far as implementing the Islamic approach to AIDS prevention is concerned?
   c) How should the weaknesses of those who are unable to consistently and correctly implement the Islamic approach to HIV/AIDS prevention, be handled?
4. What are the priority issues that need to be addressed in the Islamic approach to HIV/AIDS prevention for each of the target communities?
5. What are the major goals of the Islamic approach to HIV/AIDS prevention for the individual, family and the community?
6. What are the major objectives of the Islamic approach to HIV/AIDS prevention for the individual, family and the community? Make the objectives specific, measurable, achievable, realistic and time bound.
7. What major activities are needed to achieve the goal and objectives of the Islamic approach to HIV/AIDS prevention for the individual, family and community? Who should do the activities, when, with what motivation and at what cost in US$, for the Muslim community at a mosque. Plan for a mosque with 100 households, 5 people in each household, an HIV prevalence of 5% and a budget of US$.1,000 for HIV prevention. Make a matrix table of these items.
8. What channels of communication should be used to implement the Islamic approach to HIV/AIDS prevention by the individual, family and community?
9. a) What other partners and alliances are needed to network with in implementation of the Islamic approach to HIV/AIDS prevention in the target communities?
   b) What is the role of networking between communities and health facilities in the implementation of the Islamic approach to HIV/AIDS prevention?
   c) What types of interactions with other faiths can enhance the use of the Islamic approach to HIV/AIDS prevention by the individual, family and community?
10. What data needs to be collected to monitor the process of implementation of the Islamic approach to HIV/AIDS prevention by the individual, family and community?
11. What data needs to be collected to evaluate the impact of implementing the Islamic approach to HIV/AIDS prevention? Ensure the data is relevant to the 5 components of the Islamic approach to HIV/AIDS.
12. a) What are the possible resources for implementing the Islamic approach to HIV/AIDS prevention that can be mobilized locally and externally by the individual, family and community? Identify the required financial, human and technical resources.
   b) How can these resources be attracted and accessed?
13. What resolutions and committments should be made regarding enhancing of the Islamic approach to HIV/AIDS prevention by the individual, family and community?

PLENARY PRESENTATIONS OF GROUP DISCUSSIONS – SUMMARIES

A. **REFLECTIONS** -- Each plenary presentation started with recitation of the Holy Qur'an and reflections. These reflections in relation to the Islamic approach to HIV/AIDS were as follows:

Acquiring scientific knowledge:
Holy Qur'an: Al-Alaq, 96:1-5
Proclaim! (or Read!) In the name of your Lord and Cherisher, who created. Created man, out of a leech-like clot. Proclaim! And your Lord is Most Bountiful,. He who taught (The use of) the Pen, Taught man that which he knew not.

These verses support the component of the Islamic approach to AIDS that encourages acquiring scientific knowledge about HIV/AIDS. All believers are encouraged to read and learn in these verses.

Making use of relevant Islamic teachings:

Holy Qur'an: Al-Israh, 17:32-39.
Nor come nigh to adultery: For it is an indecent (deed) and an evil way. Nor take life-which Allah has made sacred-except for just cause. And if anyone is slain wrongfully, we have given his heir authority (to demand Qisas Or to forgive): but let him not exceed bounds in the matter of taking life; for he is helped (by the Law). Come not near to the orphan's property except to improve it, until he attains the age of full strength; and fulfill (Every) engagement, for (every) engagement will be enquired into (on the Day of reckoning). Give full measure when you measure, and weigh with a balance that is straight: that is better and fairer in the final determination. And pursue not that Of which you have no knowledge: for surely the hearing, the sight, the heart all of those shall be questioned of. Nor walk on the earth with insolence: for you cannot rend the earth asunder, nor reach the mountains in height. Of all such things the evil is hateful in the sight of your Lord. These are among the(precepts Of) wisdom, which your Lord has revealed to you. Take not, with Allah, another object of worship, lest you should be thrown Into Hell, blameworthy and rejected.

The above Islamic teaching warning believers not to come near to adultery and fornication and to have good behaviours is useful in prevention of HIV infection and care and support of the affected.

Forming partnerships with religious leaders:
Holy Qur'an: An Nisaa 4:59-64

O ye who believe! Obey Allah, and those charged with authority among you. If you differ in anything among yourselves, refer it to Allah and His Messenger, if you do believe in Allah And the Last Day: That is best, and most suitable for final determination.
Have you not turned your thought to those who declare that they believe in the revelations that have come to you and to those before you? Their (real) wish is to resort together for judgment (In their disputes) To the Evil (Tagut) Though they were ordered to reject him. But Satan's wish is to lead them astray far away (from the right). When it is said to them: "Come to what Allah has revealed. And to the Messenger". You see the Hypocrites avert their faces from you in disgust. How then, when they are seized by misfortune. Because of the deeds which their hands have sent forth? Then they come to you, swearing by Allah: "We meant no more than good-will and conciliation!". Those men, Allah knows what is in their heart; So keep clear of them But admonish them, And speak to them a word to reach their very souls. We sent not a Messenger, but to be obeyed, in accordance with the leave of Allah. If they had only, when they were unjust to themselves, come unto you and asked Allah's forgiveness. And the Messenger had asked forgiveness for them, they would have found Allah indeed oft-returning, Most Merciful.

The believers are advised to obey Allah, the Apostle and those charged with authority. These include religious leaders who teach their communities behaviors that promote HIV/AIDS prevention, treatment, care and support.

Making use of the concept of Jihad Nafs (Struggle of the soul against temptation):
Holy Qur'an. Al-A'araf – 7:200-206:

If a suggestion from Satan Assail you (mind), seek refuge with Allah: For He hears and knows (All things). Those who fear Allah, When a thought of evil from Satan assaults them, bring Allah to remembrance, when lo! They see (aright)! But their brethren (the evil ones) Plunge them deeper into error, and never relax (their efforts). If you bring them not a revelation, they say: "Why have you not got it together"? Say: "I but follow what is revealed to me from my Lord: This is (nothing but) Lights from your Lord, and guidance, and Mercy, for any who have faith." When the Qur'an is read, Listen to it with attention, and hold your peace: That you may receive Mercy. And do you (O reader!) Bring your Lord to remembrance in your (very) soul, with humility and remember without loudness in words, in the mornings and evenings; and be not you of those who are unheedful. Those who are near to your Lord disdain not to worship Him: They glorify Him and prostrate before Him.

Temptations to commit evil acts in relation to HIV/AIDS prevention, treatment, care and support are the work of Satan. The believers are advised to seek refuge with Allah if any temptations come to their minds.

B)

GOALS AND OBJECTIVES OF COMPREHENSIVE HIV/AIDS INTERVENTIONS USING THE ISLAMIC APPROACH TO AIDS (IAA) – 3RD IMLC 2007

The five groups each focused on one of the five types of HIV/AIDS interventions. The tables on the following pages summarize the efforts of *all five groups* for the questions on goals, objectives, indicators and activities. The first three levels of goals and objectives on this page are "higher-order" types of objectives that are very broad compared to the more specific types of objectives on the following pages. All three of these objectives will likely be the same for any HIV/AIDS intervention. They constitute **the longest-term aims** of most HIV/AIDS programming. At this level, the wording of the indicators is fairly non-specific because providing Quantity, Quality and Time parameters depends on the specific country, region, or project.

Table 3: Goals.

Hierarchical Goals and Objectives	*Indicators – how will we know that an objective/goal has been reached?*	*Means of verification – source of data?*
Super Goal: Quality of life improved in Muslim communities; (a very long term objective)	1. Improvements in country-specific (community-specific) quality of life indicators as defined and developed within local mosque communities; 2. Improvements in quality of community and home-based care and support services for people infected and affected by HIV/AIDS as coordinated within mosque communities; 3. Improvements in measures of economic support to orphans and vulnerable children within each mosque community;	National, regional or local surveys; Qualitative assessments;
Goal: Suffering and death due to HIV/AIDS reduced in Muslim communities; (a very long term objective)	1. Significant reduction in infant mortality rates, maternal mortality rates, & proportion of hospital admissions for AIDS-related complications within mosque communities; 2. Significantly improved life expectancy among PLWHA in mosque communities; 3. Improved measures of feelings of empowerment among people infected and affected by HIV/AIDS in mosque communities; 4. Evidence of increased levels of mercy and compassion in providing services to PLWHA in mosque communities;	Health facility data; Demographic and Health Surveys (national); Other KAP surveys; Qualitative assessments;
Biologic objective (impact): (longer term objective) Rate of HIV transmission in Muslim communities is reduced;	1. Statistically significant reduction in HIV prevalence among young women aged 15-24 attending antenatal clinics in mosque communities (proxy for incidence) by [date]; 2. Reduction in HIV prevalence among certain target groups, depending on the local situation;	National or regional seroprevalence and DHS surveys;

The behavioral objectives listed in the left column of this part of the table reflect the desired *outcomes* of the interventions as a result of producing the *outputs* listed on the following pages.

Table 4: Outcome objectives.

Objectives	**Indicators** – how will we know that an objective has been reached?	**Means of verification –** source of data?
Behavioral objectives (outcomes): 1. Effective prevention outreach efforts designed, implemented and evaluated within mosque communities; 2. Strength and well- being of PLWHA enhanced through effective treatment programs in mosque communities; 3. People infected and affected by HIV/AIDS provided with and empowered by appropriate physical, mental and spiritual care and support within their mosque communities; 4. Muslim communities provide services to PLWHA with mercy & compassion (reducing stigma and discrimination); 5. Life skills utilization programs empower mosque communities to more effectively cope with HIV/AIDS;	1.1 xx% of Imams, mosque administrators, youth association members, & Madrasa teachers *well-grounded* in the use of the IAA by [date]; 1.2 xx% of Imams *consistently promoting* HIV/AIDS prevention messages in their mosque communities by [date]; 1.3 xx% of community members within mosque communities *reached* with information about the IAA by [date]; 1.4 xx% decrease in multiple partner sexual networking among targeted populations in mosque communities by [date]; 1.5 xx% of adult Muslim individuals and couples *tested* for HIV by [date]; 2.1 xx% increase in proportion of PLWHA *receiving ART* within Muslim communities by [date]; 2.2 xx% increase in proportion of PLWHA in Muslim communities *receiving improved health and social services* by [date]; 3.1 xx% of residents of mosque communities infected and affected by HIV/AIDS contacted at least once within [time period] by mosque representative for care and support, as part of each mosque's needs assessment; 3.2 xx% of OVC receiving regular care and support within their mosque communities by [date]; 3.3 xx% of women living with HIV/AIDS receive economic and educational care and support within their mosque communities by [date]; 4.1 xx% increase in proportion of respondents reporting awareness of need for advocacy for changing approach to HIV/AIDS (among Muslim religious leaders and community members) by [date]; 5.1 xx% of Imams and assistants trained in knowledge of life skills utilization in [location] by [date]; 5.2 xx% of community members reached by their mosque representatives with information about life skills utilization in [location] by [date]; 5.3 IAA life skills programs integrated into national HIV/AIDS strategic framework by [date];	Training records; Mosque site visits/ individual interviews; Local/regional surveys; National or other behavioral surveillance surveys using standardized international indicators; VCT service data; Health facility data; Mosque outreach data; OVC needs assessment and follow up survey data; PLWHA needs assessment and follow up survey data; In-depth individual interviews; Patient satisfaction surveys; Mosque activity records; National AIDS Control Program Strategic Framework documents;

These output-level objectives summarize the areas addressed within the five working groups at the 3rd IMLC, for all types of interventions discussed:

Table 5: Output objectives.

Output 1: Provide *prevention information and education* for HIV/AIDS-related behavior change to all mosque community members using the IAA;	1.1 # Imams, mosque administrators, youth association members, female and male Madrasa teachers trained in effective HIV-related risk reduction strategies using IAA methods by [date]; 1.2 # community members reached/contacted with information and education provided using IAA by [date];	Training records; KAP surveys within mosque communities; Mosque activity/ service data;
Output 2: Provide increased access to *HIV treatment (ART)* within mosque communities using the IAA;	2.1 # ART service sites established or upgraded by [date]; 2.2 # ART service providers trained by [date]; 2.3 # doses of ART delivered to [location] by [date]; 2.4 # PLWHA provided with ART by [date];	Project reports; Encounter/user data from ART service site/ health facility;
Output 3: Provide confidential HIV *counseling and testing* to all adult Muslim individuals and couples using the IAA;	3.1 # VCT service sites established or upgraded in [location] by [date]; 3.2 # VCT counselors trained in [location] by [date] using IAA; 3.3 # adults (by gender, age, and religion) participating in VCT services in [location] by [date];	Project reports; Encounter/user data from VCT service site/ health facility;
Output 4: Provide compassionate *care and support services* for all those infected and affected by HIV/AIDS within mosque communities using the IAA;	4.1 # Imams, mosque administrators, youth association members, female and male Madrasa teachers trained specifically in how to provide compassionate care and support to people infected and affected by HIVAIDS using IAA by [date]; 4.2 Documented evidence of mainstreaming of HIV/AIDS care and support in sermons at mosques at end of project (EOP); 4.3 # visits made by Imams and assistants to community members infected and affected by HIV/AIDS by [date] using IAA; 4.4 # OVC receive care and support within their mosque communities by [date] using the IAA; 4.4 # women living with HIV/AIDS receive economic and educational support services within their mosque communities by [date] using the IAA;	Estimates of treatment, care and support outreach by local agencies; Site visits to mosque communities; OVC service data; Client service data; In-depth individual interviews;
Output 5: Provide training to *reduce stigma and discrimination* experienced by people infected and affected by HIV/AIDS using the IAA;	5.1 # Imams, mosque administrators, youth association members, female and male Madrasa teachers trained specifically in reducing stigma and discrimination against people infected and affected by HIVAIDS using the IAA by [date]; 5.2 # people reached by individuals trained above by [date];	Client service data; Project reports; In-depth individual interviews; Site visits to mosque communities;
Output 6: Provide training in *life skills utilization* techniques for coping with HIV/AIDS in mosque communities using the IAA;	6.1 # Imams, mosque administrators, youth association members, female and male Madrasa teachers trained in life skills utilization for services to people infected and affected by HIVAIDS using the IAA by [date]; 6.2 # people reached by individuals trained above by [date];	Client service data; Project reports; In-depth individual interviews; Site visits to mosque communities;
Output 7: Promote sharing experiences & ideas among all countries involved with *IMLC* meetings;	Evidence of regular reporting of local activities, lessons learned, accomplishments, to International Centre for Promotion of the Islamic Approach to HIV/AIDS (ICPIAA) in Uganda, with regular feedback from Uganda to all participants in IMLC by [date];	Documentation supplied to ICPIAA in Uganda;

Additional points to remember when using the tables above:

1. Behavior change indicators (at the *outcome* level) are usually worded in terms of a specific proportion of change desired or a statistically significant proportion (percentage) of change expected, based on formative evaluation research.
2. Indicators of outputs and activities are usually worded in terms of numbers of people, items or events, and are usually tracked on a monthly or quarterly basis.
3. When specifying indicators in a project proposal, be sure to include time boundaries (such as by a certain date, or by the end of the project [EOP], or within the next 12 months, for example) whenever possible.
4. Besides time boundaries, indicators should also specify "quality" [what kind of] and "quantity" [how much or many] whenever possible.
5. Use "if – then" questions to determine logical connections between levels of objectives; for example, "*if* AIDS-related suffering and death is reduced, *then* quality of life will improve" – moving from lower-level objectives to higher-level objectives. When going from top to bottom (higher level to lower level), say "in order to accomplish improved quality of life, we need to reduce suffering and death; in order to reduce suffering and death, we need to reduce HIV prevalence; in order to reduce HIV prevalence, we need to promote effective intervention programs" that produce behavior change, as summarized in the table with the behavioral objectives.
6. HIV/AIDS interventions are synergistic – meaning that interventions that incorporate multiple types of approaches are more likely to produce and maintain the kind of behavior change required to reduce risk permanently over the long term. While all interventions may not necessarily include all of the components above, a comprehensive approach to HIV/AIDS management in any geographic area will likely include elements of all the types of interventions described above.
7. The phrase "using the IAA" appears in almost every box in the tables above. Using the Islamic Approach to AIDS implies a specific set of techniques and methods of communication between people, based on the teachings of Islam. The interventions are designed to focus on mosque communities, although they do not exclude community members of other faiths, since inter-faith collaboration is strongly supported within the IAA.

Example of a work plan for activities at the mosque level:

Activities, indicators and means of verification for implementing the Islamic Approach to HIV/AIDS interventions at the mosque level summarize the very similar conclusions of all five groups.

Table 6: Example of workplan

Activities	*How will we know if we've made progress – indicators of achievement*	*Means of verification – where the data come from*
1. Report to mosque communities about 3rd IMLC in Addis (July 2007)	# of Imams, community leaders, participants attending; # and locations of meetings held;	Email containing information about the presentation/ meetings and report with dates, names, agenda, sent to ICPIAA in Uganda;
2. Establish a mosque IAA planning committee	# of Imams, community leaders, participants attending; # and locations of meetings held;	Dates, participants, agenda, next steps lists from reports of IAA planning committee meetings forwarded to ICPIAA in Uganda by email;
3. Develop & print curricula for training community members on IAA	implementation plan for production, pretesting & distribution of curricula; # of copies printed & distributed;	Samples of curricula, training plans, manuals, evidence of outreach forwarded by email to ICPIAA in Uganda;
4. Train Imams and trainers (ToT)	# of Imams and assistants trained; # of ToTs held; training plans developed;	Training reports forwarded to ICPIAA center in Uganda by email;
5.1 Educate and motivate communities and individuals; 5.2 Refer PLWHA	5.1 # and types of IEC materials produced and distributed; 5.2 # of families reached/educated by EOP or annually; 5.3 # of people reached/ educated by EOP or annually; 5.4 # of education sessions, home visits, support groups or other events held/formed; 5.5 # of Nasheed (songs and poems) developed; 5.6 # of people receiving care/support visits; 5.7 # of referrals made to health services during project period;	Activity report summaries prepared in a timely fashion, with copies submitted to ICPIAA in Uganda;
6. Develop a user-friendly system for monitoring, evaluation, and report-writing	6.1 M & E system developed, documented and shared with other IMLC participants via ICPIAA in Uganda; 6.2 # of field visits conducted;	Monthly/quarterly/annual monitoring and evaluation reports – copies submitted to ICPIAA in Uganda;

C)

IAA STRATEGIES:

At the 3rd IMLC, group discussions developed examples of various collaborative strategies useful when developing local interventions using the Islamic Approach to AIDS (IAA):

Table 7: IAA strategies.

Possible **channels of communication** used to implement the Islamic approach to HIV/AIDS prevention by the individual, family and community	1. Sermons (Khutbas) at mosques 2. Fliers/posters, pamphlets, bill boards and other IEC/BCC materials 3. Islamic social gatherings e.g. weddings, support groups, funerals 4. Lectures, conferences, consultations, meetings, seminars 5. Media (electronic and print) 6. Schools/Madrasas 7. Home visits, individual contacts 8. Influential and charismatic leaders 9. PLWHA 10. Counseling centers
Other **partners and alliances** needed to network with when implementing the Islamic approach to HIV/AIDS prevention in target communities	1. Government e.g. Ministry of Health, ACPs, civil societies, political parties/leaders 2. Health facilities; medical experts; medical associations 3. NGOs, CBOs, FBOs, UN agencies, other donors 4. Private companies 5. Media, e.g. TV and radio stations, people 6. Individual Muslims 7. Muslim Councils 8. Other faith communities 9. Islamiyyah schools; educational institutions 10. Muslim NGOs. 11. Other Mosques 12. Shariah courts; lawyers 13. Cultural and other religious groups/leaders 14. Traditional, women and youth leaders 15. PLWHA
Benefits of of **networking** between communities and health facilities in the implementation of the Islamic approach to HIV/AIDS prevention	1. Referral for treatment 2. Health education, esp for Imams about scientific facts about HIV/AIDS 3. Advocacy, esp for removing stigma and discrimination 4. Share resources (resource mobilization) 5. Technical assistance (TA) or professional assistance (medical treatment) 6. Joint planning and programming 7. Sharing information/dialogue/experiences 8. Referral of clients 9. Complementary counseling 10. Facilitate/encourage VCT/disclosure 11. Providing efficient care and support to patients 12. Avoiding duplication of effort

Table 7 cont…….

Benefits of **constructive interactions with other faiths** to enhance the use of the Islamic approach to HIV/AIDS by the individual, family and community	1. Share good experiences to obtain solutions to local, national and international problems 2. Coordination, esp of medical services 3. Share resources; joint mobilization efforts; joint social services; 4. Joint religious IEC/BCC materials 5. Interfaith dialogue, cooperation, mutual understanding, problem-solving 6. Can increase understanding of Islam 7. Peaceful co-existence 8. Developing consensus 9. Common campaign, training, funding HQ. 60:7-9 *"It may be that Allah will establish friendship between you and those whom you now hold as enemies. For Allah has power (Over all things) and Allah is oft-forgiving. Most Merciful. Allah forbids you not with regard to those who fight you not for your faith nor drive you out of your homes from dealing kindly and justly with them: For Allah loves those who are just. Allah only forbids you with regard to those who fight you for your faith, and drive you out of your homes, and support others in driving you out, from turning to them for friendship and protection. It is such as turn to them in these circumstances that do wrong."*

Financial, human and technical resources for implementing an Islamic Approach to AIDS (IAA) at the mosque level (from all working groups): –When developing plans for a project or program, consider all possible resources from this list, regardless of the type of intervention being planned. The list was compiled from all five groups' contributions.

Table 8: Resource mobilization:

Resources		Attracting resources
Financial	1. Zakat and Sadaqat 2. Personal donations 3. Local government funds 4. Charitable endowments 5. Community contributions 6. Membership contributions 7. Small scale investments 8. International donors 9. Mosque contributions	1. Community mobilization 2. Proposal writing 3. Sharing the success stories of the IAA 4. Fundraising e.g. community events, 5. Create income generating activities (IGAs) 6. Prayers/special Islamic occasions e.g. Eids, Ramadhan 7. Joint/participatory planning 8. Good/transparent management of IAA 9. Accountability for resources acquired 10. Advocacy
Human	1. Imams/Muslim clerics 2. Family members 3. IMLC participants 4. Health workers 5. Women groups 6. Youth organizations 7. PLWHAs 8. Men's groups 9. Madrasa/school teachers 10. Counselors 11. Social workers 12. Muslims living with HIV	
Technical	1. Medical professionals 2. Counselors 3. Islamic affairs village administrators 4. Social workers 5. Media experts 6. Training/IEC materials	

D) ADDITIONAL CONTRIBUTIONS FROM PRESENTATIONS OF GROUP DISCUSSIONS.

Additional contributions for all five working groups appear below, separated by individual group:

GROUP 1: HIV PREVENTION

Situation analysis:

Q1(a) Are there any other components you feel should be included in the operational definition of IAA?

Additional components to operational definition of IAA:

The following issues should be considered in putting the Islamic approach to AIDS into practice.

- Study the life of Prophet Muhmmad (Peace be upon Him).
- Family guidance
- Foster partnership with Family, community, sheiks, community leaders Sufi religious leaders, PLWHA, governments, traditional leaders, Islamic movements leaders.
- Strengthen the existing systems (especially financial empowerment)
- Peer support (e.g. young people)
- Capacity building and empowerment for Imams to do the required job
- Encourage parents to teach their children Islamic sex education
- Encourage timely marriage (not too early, not too late)
- Encourage HIV testing before marriage
- Provision of appropriate IEC/BCC materials

Q1(b) What is the role of each of these components in the Islamic approach to HIV prevention? Identify examples of relevant Islamic teachings.

Role of believing in Allah and Prophet Muhammad

- Guides behavior of Muslims
- It is the corner stone of the Islamic approach to HIV/AIDS
- Encourages obedience to Prophet Muhammad (SAW)
- Surat Al-Baqara, "2:2-5"
  This is the Book; in it is guidance sure, without doubt, to those who fear Allah, who believe in the unseen, are steadfast in prayer and who believe in the revelation sent to you, and sent before your time, and in their hearts have the assurance of the hereafter. They are on true guidance, from their Lord and it is these who will prosper..

Making use of Islamic teachings and practices

- Promotes avoiding fornication and narcotic drugs
- Encourages individual to put in his or her mind that Allah is always watching him/her

Forming partnerships with religious leaders

- Makes use of these groups to teach individuals and communities
- Information will reach a wide number of people
- Provides continuous reminders about good and bad behaviours; partners need to be well educated for this task
- Creates empowerment to enhance accomplishment of the planned interventions

Making use of the concept of Jihad nafs

- Helps in controlling temptations for people (both young and old)
- Warns young people about the dangers of risky behaviours
- Encourages behavior change

Q1(c) Who gives the mandate to implement the Islamic approach to HIV/AIDS prevention at the individual, family and community levels?

Mandate to implement IAA prevention

- Individual: Allah, Individual's conscience
- Family: Allah and Prophet Muhammad (SAW), and parents.
- Community: Allah, community leaders and governments

Q.2. What are the target communities for the Islamic approach to HIV prevention?

Target communities for IAA Prevention:

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Children, Youth, Women, Men, Disadvantaged, PLW[illegible] workers, intra venous drug users (IDU)

Q.3 (a) What are the needs of the target communities as far as the Islamic approach to HIV/AIDS prevention is concerned? Ensure you identify the needs for the following groups: children, youth, men and women.

Needs of the target communities:

- Children
  - Awareness raising according to their age
  - Protection from bad company
  - Financial support from parents
  - Education about Islam
  - Legislation by government
- Youth
  - Education
  - Empowerment for HIV prevention
  - Love & hope for a better future
  - Compassion, Care & Consideration
- Women
  - Economic empowerment
  - Education
  - Teaching them to protect themselves
  - Appropriate health services for women
  - Modesty
- Men : Modesty (how to lower gaze when meeting opposite sex in accordance to Islamic teachings; Islamic education
- PLWHA: Education, care & support
- Sex workers: Economic empowerment; Capacity building to resist temptations
- IDUs: HIV Counselling and testing

Q3(b). What are the strengths and weaknesses of these target groups as far as implementing the Islamic approach to AIDS prevention is concerned?

Strengths

- Children:
  - Follow their role models
  - Listen to their parents advice
  - Fast Learners
- Youth: Easily adapt
- Men: One of the pillars of the family; Have financial power (bread winners)
- Women: Other pillar of the family, Care givers, Transmitters of knowledge and culture

Weaknesses

- Children: Easily influenced
- Youth: Easily perverted
- Men:
- Assume they know every thing
- Rigidity in their behaviours
- Aggressive
- Arrogant
- Women: Vulnerable to men's negative influences; Emotional

Q3(c). How should the weaknesses of those who are unable to consistently and correctly implement the Islamic approach to AIDS prevention, be handled? **72**

Handling weaknesses

- Patience, care, counseling, education
- Islamic teachings
- Experience sharing
- Control (particularly for children)
- Family guidance
- Spiritual guidance

Q4. What are the priority issues that need to be addressed in the Islamic approach to HIV prevention for each of the target communities?

- Children: Love, care, protection and Islamic teachings
- Youth: Education (scientific & religious), Counseling
- Women: Dignity, care and support by society; Empowerment; Education
- Men: Education; Better understanding of the needs of women & children; Counseling

Q11. What data need to be collected to evaluate the outcome of implementing the Islamic approach to HIV/AIDS prevention? Ensure the data is relevant to the 5 components of the Islamic approach to AIDS.

IAA Component	Indicators
Believing in Allah and Prophet Muhammad (SAW)	■ Proportion of people who report using the belief in Allah in the prevention of HIV/AIDS ■ Proportion of people who use preventive methods (abstinence and faithfulness in marriage) using Allah's guidance ■ Proportion of people who are avoiding drug abuse using Allah's guidance.
Learning the scientific knowledge	■ Proportion of people with the correct scientific knowledge about modes of transmission and prevention of HIV/AIDS supported by IAA ■ Proportion of people who are going for treatment & rehabilitation for drug abuse in accordance with IAA
Making use of Islamic teachings and practices	■ Proportion of people who care for PLWHA (support positive prevention) ■ Proportion of people who are practicing the pillars of Islam (prayers, fasting, zakat, Haj) ■ Proportion of discordant married couples using HIV prevention methods in accordance to IAA. e.g. H.Q 2:195 "*And spend of your substance in the cause of Allah, and make not your own hands contribute to (your) destruction, but do good: For Allah loves those who do good* ".
Forming partnerships with and making use of religious leaders and their admin structures	■ Proportion of people who participate in community activities related to HIV/AIDS prevention in accordance with IAA ■ No. of support groups for positive prevention using IAA
Concept of Jihad Nafs	■ Proportion of people who report using the concept of Jihad Nafs in their HIV prevention methods (abstinence and faithfulness in marriage) ■ Proportion of people who are avoiding drug abuse by using the concept of Jihad nafs. ■ Proportion of people who care for PLWHA (support positive prevention) by using the concept ■ Proportion of people tested for HIV voluntarily by using the concept.

Table 8: Outcome Indicators for Assessing The Islamic Approach to HIV/AIDS Prevention.

Q 13 What resolutions and commitments should be made regarding enhancing of the Islamic approach to HIV prevention by the individual, family and community?

Resolutions

- To implement IAA prevention in our communities guided by our strategic frame work
- To continue exchanging the experiences of participants in the implementation of IAA prevention
- To share IAA prevention with other communities and people of other faiths
- To encourage Muslim leaders at all levels to integrate IAA prevention within their strategic frame work
- To encourage respective governments and international organizations to support and finance the IAA prevention strategy

Commitments

- To go back, popularize and implement IAA prevention in our different countries and communities

GROUP II - HIV/AIDS TREATMENT

Q1. Who gives the mandate to implement the Islamic approach to HIV/AIDS treatment at the individual, family and community levels?

Mandate

• Individual	• Family	• Community
o Allah o Self	o Allah o Head of family o Mother	o Allah o Community leaders o Ulama o Every person should be responsible for self and others

Q2. What are the target communities for the Islamic approach to HIV/AIDS treatment

Target audiences

- o Women
- o Children
- o Self
- o Men
- o High risk groups e.g. soldiers, prisoners
- o PHAs
- o Patients of sexually transmitted infections (STIs)

Q3(a) What are the needs of the target communities as far as the Islamic approach to HIV/AIDS treatment is concerned?

Needs as far as treatment is concerned

- Children
  - o Counseling and HIV testing
  - o Care and support
  - o Nutrition
  - o Medication
  - o Encouraging adherence
- Youth
  - o Counseling and encouragement not to give up treatment
  - o Empowerment
  - o Capacity building
  - o Information and Guidance
- Men
  - o Counseling
  - o Information sharing
  - o Adherence to treatment
  - o Nutrition support
  - o Disclosure counseling and support

- Women
    - Empathy
    - Economic Empowerment and to go for treatment
    - Information
    - Support and understanding from spouses
    - PMTCT services
- PHAs
    - Compassion
    - Spiritual empowerment
    - Family and community support
    - Counseling for adherence
    - Nutrition

Q3(b) What are the strengths and weaknesses of these target groups as far as implementing the Islamic approach to AIDS treatment is concerned?

Strengths

Children

- Obedient and Innocent, so will do as instructed e.g. take all medicine
- Have support of parents/guardians

Youth

- Strong, ambitious, hopeful and vibrant, therefore eager to take treatment

Men

- Have power and control over everything, so can access HCT, care and treatment anytime

Women

- Strong, persevering. tolerant, patient over treatment
- Near kitchen so they can eat well
- Have good health seeking behaviour

PHAs

- There is a known care model for them
- Have good information from counseling
- Know their HIV status

Weaknesses

Children

- Dependant on parents so may not get attention especially if parents too are sick
- Have less knowledge about HIV treatment
- They don't have resources
- Are vulnerable
- Many of them are orphans

Youth

Emotional, Weak iman, want independence, difficult to control while on HIV treatment

Men

- Secretive, shameful, don't disclose to their wives about their HIV status
- Can refuse treatment
- Have poor health seeking behaviour
- Don't go to support groups

Women

- Vulnerable, Poor, Dependant on husbands and Lack empowerment

PHAs

- Stigma
- Despair

Q3(c). How should the weaknesses of those who are unable to consistently and correctly implement the Islamic approach to AIDS treatment be handled?

Handling weaknesses

- Give information and education about HIV treatment
- Economic empowerment
- Access treatment improved
- Continuous counseling
- Family and Community to know about AIDS treatment and to be supportive

Q4. What are the priority issues that need to be addressed for each target group in the Islamic approach to HIV/AIDS treatment?

Priority issues to be addressed

Children

- Promote fear of Allah
- PMTCT & HIV testing for children

Youth

- Promote fear of Allah, PMTCT & HIV testing, Keep them at school
- Promote early and timely adulthood marriage (as soon as youth is ready)

Men

- Information about HIV
- Support for Disclosure

Women

- Information about HIV & Empowerment

PHAs

- Access to treatment, counseling & testing, Care and support, spiritual counselling
- Reduction of self and external stigma

Q13 What resolutions and commitments should be made regarding enhancing the use of the Islamic approach to HIV/AIDS treatment by the individual, family and community?

Resolutions

The 3rd IMLC participants resolve:-

- To implement the IAA treatment work plans
- That Imams should be committed to the implementation of IAA treatment
- To support PHAs to access and adhere to treatment
- That the Supreme Councils should provide leadership and guidance for the implementation of IAA treatment with Technical support from the 3rd IMLC participants
- That the International Center for the promotion of IAA should monitor implementation in countries

Commitments

To implement the resolutions and work plans and give feedback to International Center for the promotion of IAA in Kampala, Uganda

Group III - HIV/AIDS CARE AND SUPPORT

Expected outcomes

Q1(a) Are there any other component you feel should be included in the operational definition

IAA Components

Additional components to be kept in mind while putting the IAA into practice:

- Economic support to the orphans.
- Fearing Allah.
- Creating awareness (mass media).
- Influencing policy making
- Promoting Muslim NGO/Health societies
- Promoting human right issues

Q1(b) What is the role of each of these components in the Islamic approach to HIV/AIDS care and support of those infected and affected? Identify relevant supportive Islamic teachings

Role of components

Believing in Allah

- Gives hope to the affected and infected and the care givers.

Holy Qur'an: 2:255-257

Allah, there is no god But He, the living, the self-subsisting, supporter of all. No slumber can seize Him nor sleep. His are all things in the heavens and on earth. Who is there who can intercede in His presence except as He permits? He knows what appeared to his creatures as before or after or behind them. Nor shall they compass aught of His knowledge except as He will. His throne does extend over the heavens and the earth, and He feels no fatigue in guarding and preserving them. For He is the most high the supreme in glory. Let there be no compulsion in religion: Truth stands out clear from error. Whoever rejects Tagut and believes in Allah has grasped the most trustworthy hand hold that never breaks and Allah hears and knows all things. Allah is the protector of those who have faith: from the depths of darkness He leads them forth into light. Of those who reject faith the patrons are the Tagut from light they will lead them forth into the depths of darkness. They will be companions of the fire, to dwell therein for ever.

Learning scientific facts

- This creates awareness on care and support.
- Knowledge gives confidence.

Learning Islamic teachings

- Encourage care and support and reinforces hope.

Forming partnerships with religious leaders

- Imams can create awareness after juma'at prayers.
- Give hope through teaching and counseling.
- Create data base and disseminate information to members of community because they believe more in them.

Concept of Jihad Nafs

- Supports Muslim communities in care and support.

Q1(c). Who gives the mandate to implement the Islamic approach to HIV/AIDS care and support at the individual, family and community levels?

Mandate

Individual

- Allah gives mandate before any other
- Our free will to serve Allah.

Family

- Allah first then the head of family, parent or guardian.

Community

- Allah, Imams and other Religious leaders, plus the community leaders.

Q2. What are the target communities for the Islamic approach to HIV/AIDS care and support of the infected and affected?

Target audience

- Ourselves
- The Imams
- Children
- Families/ Relatives
- People living with HIV/AIDS
- Orphans

- The communities
- Herbalists
- Government

Q3 (a) What are the needs of the target communities as far as the Islamic approach to HIV/AIDS care and support of the infected and affected is concerned?

Needs

Children

- Education, knowledge about care and support.

Orphans

- Material support and counseling.

Youths

- Empowerment, guidance, counseling and rehabilitation.

Men

- Employment, counseling and support.

Women

- Empowerment, counseling and support.

PHAs

- Support ,encouragement to seek health care and support groups.

Q3 (b). What are the strengths and weaknesses of these target groups as far as implementing the Islamic approach to HIV/AIDS care and support is concerned?

Strengths:

Children

- Easily accept care and support.

Orphans

- Easily encouraged to live with other families

Youth

- Some can read and understand.issues

Men

- They are heads of families and have access to financial resources

Women

- Compassionate; caring for their health and others.

PHAs

- Can accept to live positively.

Weaknesses:

Children

- Can easily be manipulated

Orphans

- Are easily traumatized.

Youth

- Resist to suggestions, have peer influence and are stubborn.

Men

- Take time to open up, assume they know and are reluctant at seeking health advice.

Women

- Lack resources and easily taken up, always depend on husbands.

PHAs

- Feel neglected and get depressed.

Q3(c) How should the weaknesses of those who are unable to consistently and correctly implement the Islamic approach to HIV/AIDS care and support be handled?

Handling Weaknesses:

- Education and counseling
- Using Islamic teachings and counseling
- Economic empowerment for women ,men, youth children and orphans.
- Encouragement and support groups.

- Clarifying myths and misconceptions.
- Dialogue between men and women

Q4. What are the priority issues that need to be addressed for each of the target groups in the Islamic approach to HIV/AIDS care and support of the infected and affected?

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Priority issues to be addressed:

Children:

- Giving the right knowledge and information to prevent misleading them. (Both Islamic and scientific knowledge)

Orphans

- Economic empowerment and support.

Youth

- Scientific and Islamic education.

Men

- Encourage husbands to care and support their wives even when infected.

Women

- Islamic and scientific teachings

PHAs

- Give support , counseling and promote support groups.

Q13a What resolutions and commitments should be made regarding the Islamic approach to HIV/AIDS care and support of the infected and affected by the individual, family and community?

Resolutions

We resolve :

To use the Islamic approach to HIV care and support to improve the welfare of individuals , families and communities.

Commitment

We shall implement the action plan of this 3rd IMLC as regards to care and support to the best of our ability

GROUP IV: ISLAMIC APPROACH TO HIV/AIDS STIGMA AND DISCRIMINATION

Q1(b) What is the role of each of these components in the Islamic approach to HIV/AIDS stigma and discrimination? Identify relevant supportive Islamic teachings.

Role of components:

- **Believing in Allah**

This means you will do what Allah wants and therefore you will not stigmatize and discriminate

- **Learning scientific facts**
  - Reading facts about HIV/AIDS gives you the correct knowledge on HIV/AIDS & therefore you would not discriminate
  - The first verse of the Quran "Iqra" encourages reading: HQ: 96:1-5
    Proclaim or read in the name of the Lord and Cherisher, who created. Created man, out of a leech like clot. Proclaim and thy Lord is most Bountiful, He who taught the use of the pen. Taught man that which he knew not.

- **Making use of Islamic teaching and practices**
  Following Islamic teachings and practices means you will follow Allah's guidance and therefore you will not discriminate the sick.

- Forming partnership with religious leaders
  - Allah tells us to cooperate with good people

- Concept of "Jihad Nafs"
  A Mujahid is a person who controls himself and controls his temptations: Therefore the Mujahid will not stigmatize.

Q1(d). Who gives the mandate to implement the Islamic approach to HIV/AIDS stigma and discrimination at the individual, family and community levels?

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Mandate

Individual

- Allah and Prophet Muhammad (SAW)
- Parents

Family

- Parents.

Community

- Scholars, Imams, Political leaders.

Q2. What are the target communities for the Islamic approach to HIV/AIDS stigma and discrimination?

Target Audiences

- Imams
- Muslim women and men
- Madrasa Teachers
- Qadis
- Youth leaders ,
- Islamic civil society
- Scholars.
- Islamic medias ,
- Religious authority,
- PLWHA
- Parents,
- Singers,
- Children ,
- Non Muslims,

Q3(a). What are the needs of the target communities as far as the Islamic approach to HIV/AIDS stigma and discrimination is concerned?

Needs of Target Audience

- Children - Parental Guidance & Islamic Guidance
- Youth - Parental Guidance & Islamic Guidance
- Men - Knowledge on HIV/AIDS & Islam
- Women - Knowledge on HIV/AIDS & Islam

Handling weaknesses

- Constant education which should involve behaviour modelling
- Constant Islamic education & guidance on reduction of stigma & discrimination of PLWHAs.

Q3(b) What are the strengths and weaknesses of these target groups as far as implementing the Islamic approach to reducing HIV/AIDS stigma and discrimination is concerned?

Strengths:

Children

- Children's behavior easily modelled
- They can easily be taught
- Children have parent's guidance
- Children don't usually stigmatize

Youth

- Many youth are still under parents guidance
- Many youth have correct knowledge on HIV/AIDS

Men

- Most men are educated
- They have economic power

Women

- Are the pillars of the family
- Women have a soft and caring heart & do not stigmatize patients.

Weaknesses:

Children
- Children can't portray their feelings
- Children are easily influenced and therefore this could lead them to stigmatizing.

Youth
- They may not care about other people's problems
- They are not yet mature

Men
- They could misuse their power & discriminate the sick
- Usually have little time to seek knowledge on reduction of HIV/AIDS stigma

Women
- Rights of women are usually denied therefore, can easily be stigmatized when HIV positive.
- Usually suppressed

Q4. What are the priority issues that need to be addressed for each target group in the Islamic approach to HIV/AIDS stigma and discrimination for the target communities?

Priority issues to be addressed:

Children:
- Need knowledge on HIV/AIDS
- Need knowledge on Islam
- Need spiritual counseling & guidance

Youth:
- Need knowledge on HIV/AIDS
- Need knowledge on Islam
- Need spiritual counselling & guidance

Men:
- They need knowledge & constant reminder on HIV/AIDS
- They need education in Islam & Islamic guidance

Women:
- They need empowerment
- They need information on their rights
- They need knowledge on HIV/AIDS & Islam

Q13 What resolutions and commitments should be made regarding the Islamic approach to HIV/AIDS stigma and discrimination by the individual, family and community?

Resolutions

- We resolve from now on that we shall handle people with PLHAs with compassion and Mercy in all the Muslim communities that we serve.
- We resolve to persist and persevere till our goal is achieved in most areas populated by Muslims
- We resolve that stigma and discrimination against PLWHAs is unacceptable in the Islamic approach to HIV/AIDS"

Commitments

- Through advocacy and dialogue we commit ourselves to engage Muslim states and NGOs on how to address HIV/AIDS stigma and discrimination using IAA.
  - We commit ourselves to encourage Imams to incorporate the issue of HIV /AIDS stigma and discrimination in Friday Kutba,in order to reduce stigma and discrimination (S & D)
- We commit ourselves to helping PLWHAs to maintain a normal way of life in the mosque communities that we live in.
- We commit ourselves to encourage our communities to address issues pertaining to gender discrimination and suppression of women's rights in order to reduce HIV/AIDS stigma and discrimination.

GROUP V: ISLAMIC APPROACH TO HIV/AIDS LIFE SKILLS FOR PREVENTION, TREATMENT, CARE AND SUPPORT **81**

Q1(a) Are there any other components you feel should be included in the operational definition?

Additional components to be considered in putting the IAA into practice.

Belief in Allah and the Prophet Muhammad (SAW).

Q1(b) What is the role of each of these components in the Islamic approach to HIV/AIDS life skills for prevention, treatment, care and support? Identify relevant supportive Islamic teachings

Role of components:

Believing in Allah & the Prophet SAW;

Enhances utilization of life skills for HIV/AIDS prevention, treatment, care and support.

- Allah's guidance in the Qur'an and the Prophet's guidance in Hadith prevent us from engaging in adultery and fornication. Q17:32. *"Nor come near to adultery. For it is an indecent deed and an evil way".* This teaching supports good communication skills, assertiveness, decision making, self esteem etc.
- Belief in Allah enables us to engage in behaviours stipulated by Islamic injunctions .
- Belief in Allah will enable us to cope with whatever situation we find ourselves in while we continue to pray to Him to change the situation.
- Belief in Almighty Allah will enable us to build and develop positive relationships and prevent us from engaging in acts that are unlawful such as drug abuse and homosexuality.
  HQ: 5:90. "*O you who believe! Intoxicants and gambling, sacrificing to stones, and divination by arrows, are an abomination, of Satan's handiwork. Eschew such abomination, that you may prosper".*
  HQ: 29:28 - 29. *"And remember Lut; behold, He said to his people, You do commit lewdness such as no people in creation ever committed before you. Do you indeed approach men and cut off the highway and practice wickedness even in your councils? But his people gave no answer but this they said bring us the wrath of Allah if you tell the truth"..*
- Belief in Allah and the Prophet SAW enables Muslims to accept that whatever happens, be it good or bad, including HIV/AIDS is from Allah;Qur'an 64:11-13.

  "No kind of calamity can occur, except by the leave of Allah. And if any one believes in Allah, (Allah) guides his heart (a right): for Allah knows all things. So obey Allah, and obey His messengers, but if you turn back, the duty of our messenger is but to deliver the message clearly and openly. Allah! There is no god but He and on Allah, therefore, let the believers put their trust."

Learning scientific facts

Enhances utilization of life skills:

Islam enjoins us to seek knowledge HQ: 96:1-5). *"Proclaim! Or read! In the name of the Lord and Cherisher, who created. Created man, out of a leech like clot. Proclaim and the Lord is Most bountiful, He who taught the use of the pen, taught man that which he knew not."* We therefore need to be knowledgeable on HIV/AIDS & related issues. The knowledge will equip us to act as required.

Use of Islamic teachings

Enhances utilization of life skills.

Islamic teachings empower people to avoid what is bad and promote what is good. Knowledge of these teachings enhances worship of Allah and encourages effective communication, relationship building, self esteem, problem solving, rational decision making etc. (HQ:31:17-19).

"O my son! Establish regular prayer, enjoin what is just, and forbid what is wrong. And bear with patient constancy whatever befalls you; for this is firmness of purpose in the conduct of affairs. And swell not your cheek for pride at men. Nor walk in insolence through the earth: for Allah loves not any arrogant boaster. And be moderate in the pace, and lower the voice for the harshest of sounds without doubt is the braying of the ass.".

Forming partnerships with religious leaders

Enhances utilization of life skills

This is vital, as our leaders will always provide guidance for us using the Quran and traditions of the Prophet (SAW).

Concept of Jihad Nafs

Enhances utilization of life skills

The greatest Jihad is Jihad Nafs. Jihad Nafs enable us to control emotion, be patient and have good behavior. Control of the soul is supported in Qur'an 91:7-10

"*By the soul, and the proportion and order given to it, and its inspiration as to its wrong and its right. Truly he succeeds that purifies it, and he fails that corrupts it*".

Q1(d) Who gives the mandate to implement the Islamic approach to HIV/AIDS life skills for prevention, treatment and care and support at the individual, family and community levels?

Individual

- Spiritual inspiration from Allah and the teachings from the Prophet Muhammad (SAW)
- Self consciousness and self esteem;

Family

- Allah and the Prophet Muhammad (SAW);
- Family head/leadership;
- Family council;

Community

- Allah and Prophet Muhammad (SAW)
- Religious Leaders
- Community leaders

Q2. What are the target communities for the Islamic approach to life skills utilization for HIV/AIDS prevention, treatment, care and support?

Target audience

- Ourselves
- Our families, including the children
- Communities
- PHAs (People Living With HIV/AIDS)
- The Vulnerable groups

Q3 (a) What are the needs of the target communities as far as the Islamic approach to life skills utilization for HIV/AIDS prevention, treatment, care and support is concerned? Ensure you identify the needs for the following groups: children, youth, men and women

Needs of target communities

Children –Knowledge, love and security, health care and support
Youth – Education, empowerment, communication skills, quality care and holistic support;
Men – Education, including HCT and ART, empowerment, protection from superstitious practices.
Women – HCT services, HIV/AIDS education, Spiritual guidance, support, empowerment, protection from superstitious practices.

Q3(b) What are the strengths and weaknesses of these target groups as far as the Islamic approach to life skills utilization for HIV/AIDS prevention, treatment and care is concerned?

Strengths:

Children – Sociable,
Youth – family asset, easily differentiate bad & good.
Men –Assertive, decision makers, source of security, some of them have high Iman (faith).
Women –Cheerful, influential, caring and loving, educative, tolerant, good health seeking behaviour;

Weaknesses:

Children- easily scared, easily influenced and vulnerable.
Youth- Have very high desires & demands, easily influenced.
Men- aggressive, dictatorial, easily attracted to promiscuity ,have poor health seeking behaviour, higher tendency of using intoxicants, exploitative.
Women- Submissive, emotional, fearful and quiet, not decisive.

Q.3 c) How should the weaknesses of those who are unable to consistently and correctly implement the Islamic approach to life skills utilization for HIV/AIDS prevention, treatment and care be handled?

How to handle the weaknesses

- Education
- Spiritual counselling
- Empowerment
- Use of support groups
- Designing of special programs
- Rehabilitation
- Showing love & compassion

Q4. What are the priority issues that need to be addressed for each target group related to the Islamic approach to life skills utilization for HIV/AIDS prevention, treatment, care and support?

Priority issues to be addressed

Children - Issues of children abuse

Youth - Promotion of abstinence & Training in Islamic life skills

Men - Training in Islamic life skills, Empowerment of male Religious leaders and the followers

Women - Empowerment, Training in Islamic life skills, Empowerment of female Religious leaders and the followers.

Q13 What resolutions and commitments should be made regarding the Islamic approach to HIV/AIDS life skills for HIV/AIDS prevention, treatment, care and support by the individual, family and community?

RESOLUTIONS

We do hereby resolve to;

- ❑ Implement the Islamic approach to HIV/AIDS life skills for prevention, treatment, care and support.
- ❑ To promote the Islamic approach to HIV/AIDS life skills for prevention, treatment, care and support for individuals, families and communities.

COMMITMENTS

We do hereby commit ourselves to:

- ❑ To implement the work plan and resolutions.

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SHARING EXPERIENCES OF PROGRESS, BEST PRACTICES AND CHALLENGES IN THE IMPLEMENTATION OF THE ISLAMIC APPROACH TO AIDS

EXPLORING THE ISLAMIC POTENTIAL AS A SOLUTION FOR HIV/AIDS

The Experiences of the Ethiopian Islamic Affairs Supreme Council and
The Ethiopian Muslims Development Agency regarding HIV/AIDS Activities

Prepared and presented by:

Nuredin Jemal Muktar, Program Coordinator EIASC/EMDA

1. Introduction on HIV/AIDS

The fast spread of HIV/AIDS and its devastating results has engaged the attention of people all over the world. The problems created by the virus and its associated diseases have affected people all over the world, regardless of race, belief or standard of living. Each day more people are infected, more people are dying, and more children are becoming orphans, resulting in serious demographic problems, high social and economic dependency, low pace of development processes, and an ever-increasing care budget, among many other problems.

Management of the HIV crisis has risen to the top of the agenda for most governments, international institutions like the UN, religious leaders, and people everywhere, raising questions about preventing new infections, and caring for the many PLWHA who are in desperate need of many services.
How do we bring together all hands and stretch them jointly against the HIV enemy? How do we recognize the compatible and complementary roles of different approaches?

The Ethiopian Muslims Development Agency (EMDA) is the development wing of the Ethiopian Islamic Affairs Supreme Council (EIASC). It was established in 2001, legally registered as a Faith-Based Organization (FBO), and prepared 5 year strategic development plans in 2001 and 2006. EMDA started its very first project based work on HIV/AIDS prevention & care in collaboration with Pathfinder International, a US based NGO in 2001. Since then the Agency has continued to work on various Islamic HIV/AIDS prevention and control projects in partnership with government & non-government organizations. EMDA has served about 7 million people in the country in mainly prevention work, care & support, and stigma and discrimination reduction. This paper explores Islamic principles found in the original sources of Islamic Jurisprudence, and identifies activities undertaken by the implementing agency to respond to the problems of HIV/AIDS facing the Muslim community and the nation at large.

2. Profile of Muslims in Ethiopia

Ethiopia peacefully hosted Islam ahead of Mecca 1423 years ago. Since then people have been practicing Islam in this country. The size of the Muslim population is not exactly known, but different sources give varying estimates. The information released by the central statistics agency (C.S.A) describes the Muslim population to cover 33% of the total population. The information released by the government of U.S.A. states that about 40% of the total population are Muslims (Annual report on International Religious Freedom, 2001, page 33). The Ethiopian Islamic Affairs Supreme Council and many Muslim scholars estimate the size to be between 45 - 50% of the total population. Although there is no clear demarcation regarding the distribution of religions by followers, the eastern, southeast, southwest and parts of central and west Ethiopia are largely inhabited by Muslims. Muslims are dutiful to their religious rules and regulations provided they are given the right guidance by their Ulema, Imams and religious leaders. Although precise data are not available, active participation in religious services is high throughout the country.

3. An Overview of the HIV/AIDS Situation in Ethiopia

Located in the eastern part of Africa, Ethiopia is home to over 72 million people, comprising nearly 80 ethnic groups. HIV/AIDS was first detected in the country in 1984 in Assab (now Eritrea territory), the former port city of Ethiopia. In 2002, the adult prevalence rate was estimated to be 4.2%. The time series prevalence trend is rising from zero-in 1984 to 1% in 1989, 3.2% 1993, and 4.7% in 2005. The prevalence rate and distribution of the virus in the country is as follows:

HIV/AIDS prevalence

Urban 10.5 %
Rural 1.9 %
National 3.5 %

The highest prevalence is in Addis Ababa region (11.7 %) while the lowest is in SNNPR region at 2.3%.
It has been estimated that 137,000 people had died of AIDS. Available sources indicate that the incidence of HIV/AIDS is increasing and may continue in the short term. If the existing trend is unchecked, the country may encounter a reduction of more than one million people from the anticipated population by the year 2014 (AIDS in Ethiopia, MOH, 1998). The government of Ethiopia has adopted a National HIV/AIDS policy and guidelines, creating a collaborative working environment for all stakeholders. The key actors include:

- The government of Ethiopia with all of its constituencies; The National and Regional HIV/AIDS Prevention and Control Offices are the core coordinators of activities.
- Religious institutions: both the spiritual and development wings.
- NGOs - local, national and international, Trade unions, employers federation and civil society
- CBOs
- PLWHA Associations
- Youth, and women Associations

All stakeholders are exerting efforts to combat HIV/AIDS with a common goal and vision, and with varying strategies.

4. Rationale for Islamic HIV/AIDS Intervention

As an Islamic religious national organization, the Ethiopian Islamic Affairs Supreme Council (EIASC) shoulders the responsibility for supporting its constituents and all citizens of the country and humanity in all spheres of their life. The Qur'an encourages Muslims to take care of themselves and other people in their holistic life affairs. If a person is sick then he must be treated accordingly. The Qur'an repeatedly warns people and those who are in responsibility to lead their subjects fairly so that they may attain eternal bliss. Following is a short summary of the Islamic Approach as it can be used to combat AIDS through actions taken by the faithful and their leaders.

Prevention: As far as the prevention and control of the virus and its associated diseases is concerned, the stand of Islam is clear. Prevent any disease from occurring or take curative measures if it has occurred, both by spiritual supplications and use of permissible medications. Islam's rulings in the matter of HIV prevention are two fold: abstinence before marriage not only regarding sexual intercourse but all those ways that lead to adultery. Secondly, do not commit extra marital sex. Also for prevention purposes all the precautions necessary for preventing the virus other than sexual routes are to be observed strictly. As the Qur'an explicitly states: *"Nor come near to adultery for it is an indecent (deed). And an evil way."* (Qur'an 17:32)

..theQur'an states that the saving of a life is considered as the saving of humanity…

Besides, the Qur'an states that the saving of a life is considered as the saving of humanity, and the killing of a life is considered as a killing of humanity as a whole. So, preventing human beings from contracating HIV is implied by this teaching. Obtaining basic Islamic knowledge is an act of worship and mandatory. Islam laid down a heavy duty on the Ulema (scholars) to transmit the knowledge they gained. They are strongly advised and at the same time motivated by the Qur'an to transfer their knowledge to the believers as indicated in this saying: "*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: they are the ones to attain felicity*" (3:104**).** Another verse in the Qur'an advises as follows: "*You are the best of peoples, evolved for mankind enjoining what is right, forbidding what is wrong and believing in Allah***"** (3:110). Thus the Ulema (religious scholars) are advised to awaken society from its deep sleep and bring people together to fight against the common enemy of humanity -- HIV/AIDS -- so as to save lives of citizens.

One saying of the Prophet Muhammed (P.b.u.h) is as follows: *"All of you are Shepherds (ra-in) and all of you are accountable to your duties of watching."* Islamic teachings regarding prevention are simple and clear cut: do not commit adultery. The routes that lead to sex out of the wedlock should be avoided. In this regard, Islam institutes certain measures, for example, modest dressing including alhijab to cover the hair and the bosom of a lady, no unnecessary mixing of opposite sexes, keeping one's chastity, the performance of obligatory and optional prayers, fasting, avoiding alcohol, and avoiding gazing at the opposite sex. Also, Islam lays the ground for sex education in its own fashion. This includes educating the youngsters at puberty about their biological and sexual feelings and desires, perseverance in their sexual needs till marriage, etc. These are helpful measures to prevent adultery and and the risk of HIV/AIDS.

Curative measures: According to Islam, there is a medicine for each disease. Even though mankind may fail to find it out at times of immediate necessity, like the medicine for HIV, Allah has created its medicine. Islam encourages us to undertake unreserved research to look for proper and permissible medicine (by using the mind given by Allah, and all available technological support). Islam also encourages the believers to visit the sick and have an unreserved invocation and prayer to Allah to restore the health of the sick.

Care Measures: Islam has established an individual, family and communal share of responsibility in caring for the sick. The family and the nearer relatives and the neighbors are commanded to take care of their sick. Treating patients medically, nursing care, counseling, invoking prayers for Allah to cure the sick are all duties of family members. Prophet Muhammad (p.b.u.h) said: *"The right of a muslim over another muslim are seven. They include visiting a patient (Riyadu As Salihin)."*

Islam has also established a cornerstone for orphan care. The Qur'an and the Sunah sayings and deeds of the Prophet Muhammad (P.b.u.h) by and large emphasize care for orphans as being in the line of great acts of worship. Someone who even stretches his hand to an orphan's head in affection or in away of sharing his loneliness will be rewarded. The saying of the prophet indicates the great reward of orphan's guardians: "*Myself and the good guardian of an orphan are like this* (showing the index and middle fingers), "*Bukhari*."

Stigma and Discrimination: Patients should not be ostracized or alienated. Muslims are encouraged to show affection, love and compassion to the patient. If he has been infected through unlawful sexual relations, he is expected to repent. However, no one has the right to investigate the origin of the HIV infection.

Economic Support: The Qur'an is full of commands and guidance to the faithful to support the poor, the sick, the wayfarer, etc, economically and morally. Wealth is believed to be the gift of Allah and must be spent in the path of Allah "*... and spend out of what we have provided for them"* (Al Baqara 2:3). Every Muslim who has more than a day's food during the day of the festival of Ramadan day is obliged to feed at least one poor Muslim. Also the institution of Zakat (alms) is meant to support the poor. It is to be taken from the rich and to be distributed among the poor (both orphans and elders) as it has been spelt out by the prophet (p.b.u.h).

It is a spiritual, as well as a moral and national obligation on the part of EIASC/EMDA, to address the problems that arise mostly from adultery and to teach people about being modest, decent and caring. These are the prime concerns of any religious organization. EIASC/EMDA has committed itself and all of its branch organizations to the level of the mosque to march against the virus, willingly, voluntarily and courageously.

5. EIASC/EMDA HIV/AIDS Interventions

EIASC/EMDA's strategic approach to combating HIV/AIDS includes the goal of *"Halting the rapid expansion of HIV/AIDS and mitigating its effects among the Ethiopia population in general and the Muslim community in particular."* Objectives to achieve this goal include promoting behavior change among the sexually active segment of the population through abstinence before marriage and being faithful in marriage, and alleviating the economic and social impacts of the disease.

Strategies to achieve these objectives include:

1. Administering a participatory planning approach.
2. Sensitization, mobilization and consultative workshops at all levels of administration, from Wereda (district) to Regional and National level. The workshops involve the participation of the Ulema, Mosque Imams, members of the Islamic Council, local public leaders, government officials, CBO representatives, scholars, and others.
3. Fund raising for program implementation through project proposal writing.
4. Rendering care and support for PLWHAs, orphans and affected families in general.
5. Capacity building training for effective communication skills, counseling and home based care.
6. Effective utilization of mosque Imams for sermon delivery regarding HIV/AIDS issues.
7. Establishment of gender segregated youth Anti-AIDS clubs and applying peer communication as a strategy.
8. Utilization of mosques, Madrassa, religious festival days "EIDS", public meetings, home visits, schools, market centers as means of communication.
9. Preparation and distribution of IEC/BCC materials illustrating the scientific and spiritual facts, impacts, and preventive and curative measures in different languages.
10. Creating effective monitoring and evaluation systems.
11. Networking, partnership and synergy.
12. Gender sensitive project management approach.
13. Training elder orphans and youth PLWHAs in income generating schemes for self and family

The EIASC/EMDA has been undertaking HIV/AIDS prevention, care and control interventions and projects since 2000. There was a delay in the response in some Muslim communities due to lack of recognition, awareness, denial etc. Since then, the EMDA has been involved in various HIV/AIDS interventions using the Islamic approach in collaboration with the government, donor agencies and the Muslim community. The first intervention undertaken with funding from Pathfinder International involved organizing a national level **consultative workshop** on HIV/AIDS for Muslim leaders, scholars, and local government officials, with the intention of soliciting the support of the public and religious leaders.

The main strategy for delivering messages on HIV/AIDS prevention, care, socioeconomic support, and reducing stigma and discrimination, involves training the **mosque Imams** to include these issues in the **Friday khutba (sermon).** In this way, they can better reach the majority of the local people during Juma Congregational Salah (Prayer). They are also trained to address the issue of HIV/AIDS in public meetings held in their respective kebelles (Kebele is the smallest administrative unit in the Ethiopian government structure), during funeral and mourning ceremonies, wedding ceremonies and market places on market days. In addition, they transmit messages in Madrasas and schools. Messages for the Imams are arranged in such away that they should not be boring for the people to listen to. Message topics are to be varied from session to session and include obedience to Allah, HIV/AIDS modes of transmission and prevention, the importance of Hijab (Islamic costume for the girls and women), Islamic knowledge, prayers, good behavior, chastity, timely marriage, VCT, care for orphans and PLWHA, and the avoidance of alcohol and adultery. Some of the Imams train other Imams in their neighborhood mosques so that these newly trained Imams educate their communities during Juma and other suitable occasions in their respective Mosques. Our Imams hold home-to-home visits in order to deliver messages for those who do not attend mosques and to visit the patients. EIASC/EMDA recently organized a national level anti HIV/AIDS public rally program led by the President of the Federal Government of Ethiopia and the vice president of the EIASC. The intention of these rallies is to bring to the minds of all stakeholders the seriousness of the HIV/AIDS burden and mobilize them for care and support to the PLWHAs, orphans and to the affected segment of the society.

The other target group that needs special focus is the **youth**. For the purpose of reaching the youth, peer promoters were selected and trained in communication skills, group and public discussions, information dissemination, planning and reporting, and club formation skills. Manuals for operating youth Anti-AIDS Clubs were prepared and distributed by the agency. The trained youth peer promoters formed Muslim youth Anti-AIDS clubs for both sexes separately according to the Islamic Shariah. Clubs are formed both in school and in out of school settings. The University Muslim girls Anti-AIDS Club was formed by Addis Ababa University students. The major issues addressed by the clubs and promoters are youth- friendly "edutainment" transferring information and education through entertaining tools like drama, Muslim songs (Neshida) poems, video shows and audio messages. The girls clubs organize Coffee Drinking ceremonies for neighborhoods and invite people to attend these ceremonies (gatherings in neighborhoods for coffee drinking is customary among Ethiopian people). During these ceremonies, people listen to prearranged HIV/AIDS messages for prevention, treatment, curbing stigma and discrimination, and other related issues.

Experience-sharing visits among the Muslim youth anti-AIDS clubs were organized so that the youth of one town can travel to another town to share their experiences with their peers. Also, a long-exposure tour from the Eastern part of the country to a similar project-performing site in the Western part of the country was held. In collaboration with donors, the Agency recently opened eight Muslim youth centers in eight project sites. These centers have libraries, audio video materials and a café for the purpose of creating a youth friendly atmosphere for recreation and study. The centers are used separately for both sexes according to an agreed-upon program.

The third major focus group for message delivery is **women** who are trained to educate their peers in particular and their community in general. They are encouraged to form woman-to-woman information dissemination groups. Each group consists of the trained women, their friends and women found in the neighborhood. The purpose is to educate women and mobilize them during various social occasions where the women meet together, like weddings and mourning ceremonies, markets and Idir meetings. (The Ethiopian custom of Idir is a type of local association formed for collaboration and cooperation to assist members in case of death and sickness. Each member in case of emergency is assisted in funeral processes and the subsequent mourning ceremony after the burial services for three to 12 days. This is when the family of the deceased stays at home and is visited by friends and relatives for comforting and alleviating the distress related to death.)

In addition to the face-to-face information education and communication **(IEC),** EIASC/ EMDA has prepared a variety of behavior change communication **(BCC)** information in various local languages for printed and audio visual materials to transmit the Islamic and scientific ways of prevention, care and support, and reducing stigma, discrimination and denial. Messages prepared in Arabic languages target the Imams and Ulema, while the leaflets, brochures, booklets, posters, audiocassettes and radio messages target women, youth, and the Ulema. National and local radio stations were also contracted to broadcast special Islamic HIV/AIDS messages. Thus the Agency, through more than 3916 Imams, community educators, women, Idir leaders (both

for men & women separately), the youth peer promoters, Muslim youth Anti-Aids clubs, and the printed media have reached about seven million people using the Islamic approach.

Care and support services have been offered by the EIASC/ EMDA from its onset including home based care for bed-ridden patients, individual and group counseling for youth and interested clients such as married couples. Counselors and home-based caretakers (HBCT) were selected from Muslim and non-Muslim communities among young Imams, teachers, nurses and the youth. These groups of people were trained in basics of co[illegible]nd care taking. At the training sessions, both Islamic and secular approaches were applied. Quite a large number of p[illegible]ve benefited from these services. However due to lack of donor support for this intervention, the service was suspended until we locate additional funds.

Project Economic support has involved several different approaches. In the area of Technical Skills Training, EIASC/ EMDA has cooperated with donors, respective project sites and the community on an initiative to assist PLWHAs, orphans and vulnerable youth in sustaining themselves and their family members by operating Income Generating Schemes (I.G.S). In this instance, the Agency and the stakeholders identified and trained direct beneficiaries including PLWHAs, orphans and vulnerable girls. Training included trades like sewing and embroidery, bee keeping, silkscreen printing techniques, running hair salons, and basic computer skills for business-type writing. After the completion of the trainings they were given seed money to initiate income generating activities. Some of them struggled much and became successful by themselves. Others were not able to compete and were employed by private business enterprises. Others married or emigrated abroad.

Financial Support included business initiation budget donation for 284 orphan youth for sewing machines and computer purchase; support to 669 PLWHA and orphans; material and other fees for 100 orphans for stationery, school fees and uniforms.

The other methodology used, instead of formal training and cash donations, involved investing in **sheep and goat husbandry**. In this case, the Agency joined with local stakeholders and the beneficiaries to purchase and raise sheep and goats. This method worked especially well for rural and semi-urban areas where the beneficiaries have open space to rear animals. Most of the young orphans and vulnerable youth were successful in tending and breeding these small animals for further economic benefits and self-sufficiency.

HANAN'S SUCCESS STORY

One of the successful girls is Hanan Abajihad living in Seqa wereda of jimma zone, Oromiya Regional State. She received 1 sheep and 1 goat from the Agency in the first instance. Then after 3 years of intelligent rearing she currently owns 4 sheep and 8 goats. This was after selling the male offsprigs for daily living expenses for her self and her little brother. She is pursuing her high school education. She supports her three minors who have neither a father nor a mother to attend school from the income she is earning from the sales of sheep and goats. She is now becoming a real example for orphan support to demonstrate that if helped properly according to their setting they can be successful. They can also participate in preventing themselves and their sisters from zina (adultery) for financial reasons.

Community Initiated Support: The Imams, the youth and the community level educators mobilize people by using quotations from the Qur'an and Prophet Muhammad (Peace be up on him) to inspire local people to raise food, clothes and financial assistance for the PLWHAs and orphans during Juma sermons, Ramadan fasting season, the two Eid festivals, and other social occasions. Among several endeavors at project sites, one public initiative is the case of Bambasi town located 700 kms from Addis in the western part of the country. The Imams and the youth collaborated and started to mobilize the local people to extend their support for orphaned children. After a series of discussions, the local community decided to contribute monthly assistance for the orphaned children through Idirs (local associations for burial and mourning ceremonies where community members pay a membership fee per month and get service in case of emergency). Accordingly orphans are supported for school and daily sustenance by this initiative. This is in accordance with the Islamic teachings of cooperation with each other. "Help you one another in Albirr and Al taqwa (virtue righteousness and piety" Holy Qur'an chapter 5 verse 2)

6. VCT Endeavors and Successes

Institutional VCT activities: In the process of preventing and caring for HIV/AIDS, the Agency established a VCT center at its headquarters in Addis Ababa in 2005. Since then the service has assisted 1,000 people. The center has two counselor-nurses for both sexes, a laboratory technician, and support staff. The majority of the beneficiaries are young couples preparing for marriage.

Non-institutional VCT endeavor: In one its district offices at Kersa district, Jimma zone, located 300 kms southwest of Addis, the Agency launched a VCT campaign in collaboration with the local Jumea Mosque Imams and the district Islamic Affairs Council executive committee members. The district EIASC/EMDA project manager coordinates the initiative. After training, the

Imams vowed to promote the VCT concept and practice through their Juma sermons (khutbas). They create awareness and then mobilize the local people to get tested for HIV. They did not only *inform* their communities of the necessity and advantages of knowing one's serostatus, but they themselves set an example for their communities by getting an HIV test themselves, thus inspiring and encouraging others to be tested. This VCT concept and practice has gone further to remote rural sites where the young couples about to be married, and their parents, request for VCT results before approving the marriage. Even though getting tested might involve a journey of a day or two from villages to the Zonal capital, a total of 1,011 people were tested, of which 36 of them were found to be HIV positive. Four of those started ART. This endeavor undertaken by the Imams, and the successes achieved has made a great impact on the zonal Muslim community. We hope it will be replicated in other districts and regions.

Community Demand for VCT: After a long and extensive Dawah campaign by our Imams, the Muslim community elsewhere is requesting our Agency and the local government offices to establish VCT centers in their towns or localities. For example, in Bambasi town, the Imams struggled to raise awareness among the marginally served population. The community supported by the Imams and the youth requested the local government body to establish a VCT center under the government's health center. After this strong demand from the community, the VCT centre became a reality. The khadis there are strongly recommending VCT prior to marriage, although it is not mandatory.

Nefisa's story of HIV testing before marriage

Nefisa Haji Annur was an 18 year old girl living in Asossa town, the capital of Benishangul Gumuz Regional state about 778 km west of the metropolis with her 10 brothers and 8 sisters. She is the first to her mother and fourth to her father. She had good academic records in her elementary and junior secondary education. When she was in grade 11(10+1), she joined the Asossa Muslim Girls' anti-AIDS club established by the EMDA Asossa project office after taking a five day basic HIV/AIDS training conducted by the same in collaboration with Action Aid Ethiopia--SIPAA program. Based on her merits, she became chairwoman of the club and served for 1½ years. While she was working in the club, some one requested her for marriage. Her family had agreed and she also expressed her willingness to her family. She put HIV blood testing as a requirement before marriage. The family had taken her concern to the family of their daughter's proposed husband. He was requested by his family to go for VCT with Nefisa. He trembled and told his family to further extend the marriage to another term. The moment she heard the reaction, she convinced her family to cancel the marriage. Nefisa completed her secondary education with a very good grade that enabled her to join higher education. She made her way to Mekele University and joined the Department of Industrial Technology in 2005. She is now a 4th year student.

Through applying the above strategies the council has organized workshops and trainings, and delivered various services over the years, including selecting 36 intervention sites encompassing about 1,000 rural and urban kebeles in 9 regional states including Addis Ababa city. The national EIASC/EMDA project hopes to reach their target of 7 million people within three years.

Through these interventions, the following have been achieved:

1. 1093 Imams, Islamic Affairs, community and local government leaders were sensitized and mobilized through various workshops and seminars held at National, Regional and District levels to support and facilitate the program.
2. Held a national level Regional Experience sharing Consultative Workshop, held in collaboration with IMAU (Islamic Medical Association of Uganda) for 120 leaders.
3. Established National and District project site level Project Advisory Committees (PAC) for successful project management.
4. Produced various training manuals and project administration guides.
5. Developed a National HIV/AIDS mainstreaming guide.
6. Prepared an Islamic HIV/AIDS policy for institutional consumption.
7. Prepared Islamic HIV/AIDS Teaching textbooks and teacher guidebooks for high school and college level Muslim students to be taught in Muslim schools.
8. Established 50 Muslim youth Anti-AIDS clubs.
9. Prepared and distributed 6 types of IEC/BCC materials produced in the national languages of Amharic, Somali, Afar, Oromifa and Arabic (two types of posters, twelve types of leaflets, three types of booklets, brochures, flipcharts and audio cassettes) targeting youth, women, public communicators (educators), and the general public with HIV/AIDS awareness and

behavioral change messages. These materials are intended to create awareness on general and spiritual aspects of HIV/AIDS prevention, care, support and mitigation of stigma & discrimination.

10. Attained the commitments of the Regional Islamic Affairs leaders and mosque Imams to participate and lead HIV interventions in their respective regions.
11. Held various capacity building trainings for community communicators, teachers, and service providers: in prevention, trained 2,836 mosque Imams and public communicators, and 1,080 peer promoters; in care and support, trained 200 counselors, 162 home based caretakers, and 30 trainers of trainers; in establishing referral linkages and HIV/AIDS management, trained 20 medical and paramedical professionals; and in IGS project startup, trained 284 orphan youths.

In addition to these centrally executed projects by the head office, the respective Islamic Affairs Councils at all levels of Administration and individual Mosques are also holding the Dawah on prevention and care.

7. Lessons learned

The Ethiopian Islamic Affairs Council/EMDA has learned the following lessons through their many and varied activities:

1. Mosque Imams are effective resource persons in disseminating information about HIV/AIDS. They mobilize people for care and support of orphans, PLWHA and HIV testing before marriage. They teach by example regarding HIV voluntary testing.
2. The public supports faith-based HIV/AIDS prevention and care and support initiatives.
3. The public in general and the local opinion leaders in particular are the best partners in the fight against HIV/AIDS.
4. The public is appreciative and responds to HIV/AIDS teachings from its spiritual leaders.
5. The religious leaders in collaboration with local government leaders are effective in bringing about a difference in avoidance of risk behavior.
6. The youth have started to change their sexual behavior: some abstain from sex or take an HIV test before marriage.
7. Sustained behavioral change will be realized through faith-based teachings combined with scientific facts.
8. The attitudes of families and the communities change as they are given Islamic education, on individual & communal responsibility for prevention and control of HIV infection..

8. Problems encountered

1. In the initial stages some of the Imams, community leaders and the Muslims did not consider HIV/AIDS to be their issue. There was denial.
2. EIASC/EMDA has no reliable and diversified financial resources of their own. As a result, they face severe financial and logistic problems. This stopped them from scaling up different community HIV/AIDS prevention and control programs.
3 As a result of the country's large geographic size, the large number of the poor people, the relatively young organizational experience, and limited resources, the work for EIASC/EMDA on HIV/AIDS is a heavy burden.
4. Most of the main donors' funds are conditional on project objectives.
5 Some of the newly marrying couples become careless after premarital VCT.
6 Dropouts of service providers due to emigration and other reasons.

EIASC/EMDA is looking for organizational capacity building schemes and support from all interested bodies, e.g. NGOs, donors, UN systems and also from different countries.

9. Recommendations

EIASC/EMDA recommends the following to enable the Agency to continue its important work in HIV/AIDS prevention:

1. Expand the project activities to communities who have not yet been reached.
2. Develop advanced Islamic guidelines on HIV/AIDS related development issues.
3. Create local and international Islamic networking on community development issues.
4. Create strong Muslim PLWHA networks.
5. Extend the Dawah context to incorporate the use of ART.
6. Begin and expand ART services in existing networks.
7. Expand the VCT services to all project sites.
8. Undertake further research to improve the success of the Islamic Approach to HIV/AIDS.

9. Create a sustainable project management so that there will be no discontinuity after phasing out the projects.
10. Design an effective fund raising strategy.

IMPLEMENTING THE ISLAMIC APPROACH TO HIV/AIDS AT THE MOSQUE LEVEL: SUCCESSES AND CHALLENGES FROM UGANDAN IMAMS.

Presented by: Sheikh Shaban Ramadhan Mubajje, Mufti of Uganda

Background:

The HIV epidemic is announced: The Islamic Medical Association of Uganda (IMAU) has been implementing the Islamic Approach to HIV/AIDS since 1989. It all started in 1986 after the Ministry of Health of the Government of Uganda announced that there was a big problem of HIV/AIDS in the country. Everyone was called upon to participate in fighting this epidemic including religious organizations. The Christian religious denominations started mobilizing their communities first because historically, they have a better-organized health infrastructure. This is mainly because the Muslim community in Uganda entered the education and health sector services later than their counterparts.

IMAU is born: The Islamic Medical Association of Uganda began in 1988, following sharing of information between some Ugandan doctors who had lived abroad, International Muslim Non-Governmental Organizations that were interested in providing health services to communities, and local Muslim health professionals. In this initial exchange of experiences, it was noted that Islamic Medical Associations had been established in many countries including the USA, Jordan, Egypt, Sudan and South Africa. The main aim of these associations was to promote the use of Islamic principles in health service delivery.

Jihad on AIDS: Once IMAU was formed, they realized that one of the reasons why the Muslim communities were not participating adequately in combating AIDS was because they lacked technical guidance on these issues. IMAU therefore had a dialogue with top Muslim leaders in the Ugandan Muslim Supreme Council, headed at the time by the Chief Kadhi. After this dialogue, it was agreed that IMAU would organize a workshop of all the top district Muslim leaders called District Kadhis to discuss issues related to HIV/AIDS. At this workshop, IMAU facilitators presented the scientific facts about HIV/AIDS transmission and prevention, and began the discussion about the role of Islam in combating HIV/AIDS. Following this workshop, the leader of the Muslim community, His Eminence, the Chief Kadhi, noted that the major way in which the Muslim community would combat HIV/AIDS was to strengthen people's abilities to control their own behaviours as taught by Prophet Muhammad (Peace be upon Him). The Prophet told his followers after the battle of Hunain where they had suffered significant casualties that the biggest Jihad was yet to come. This is the Jihad Nafs, which means the fight against each one's own soul against temptations to engage in risky behaviours and practices such as those that lead to HIV infection. The Chief Kadhi thus called on all Muslims in Uganda to re-dedicate themselves to this Jihad Nafs. This was the beginning of Jihad on AIDS, which was a wake up call for all Muslims to fight this pandemic.

Defining the Islamic approach to HIV/AIDS: Following the discussions with Muslim leaders, the main issue that remained was how to implement or put into practice the Islamic guidance on combating HIV/AIDS. An operational definition of the Islamic approach to HIV/AIDS was drafted, and included the following:

1. Believing in Allah and therefore, obeying His commands.
2. Learning the scientific information about HIV/AIDS from health professionals.

3. Using Islamic teachings and practices such as those that promote HIV/AIDS prevention and control.
4. Training and using Imams to educate the communities.
5. Promoting the concept of Jihad Nafs for each individual to fight AIDS.

Mobilizing resources: IMAU contacted in-country donors to support the Islamic approach to HIV/AIDS, including Ministry of Health, WHO, USAID, and UNDP. The response was positive and IMAU started a programme of AIDS education and prevention through Imams.

Training Imams and their assistants: IMAU first developed a curriculum, which contained scientific information supplemented by relevant Islamic teachings. The mode of training was by guided discussion where IMAU trainers asked questions, and the Imams and their assistants gave appropriate answers. The Imams' assistants included an equal number of males and females. Over 1,000 Imams and 7,000 assistants, trained by IMAU, educated over 100,000 families.

Achievements: HIV infection rates in Uganda are lowest among Muslim communities according to the 2005 national sero-behavioural survey: prevalence is 7.1% among Protestants, 6.3% among Catholics and 5.0% among Muslims. It is possible that our efforts to implement the Islamic approach to HIV/AIDS yielded some positive results. We are not perfect since the HIV prevalence among Muslims of 5% is still very high. However, even with our imperfections we believe we are on the right track. If we can continue to re-energize our efforts of implementing the Islamic approach to HIV/AIDS, the rate of new infections will reduce further.

Challenges: The major challenge for implementing the Islamic approach to HIV/AIDS has been funding to scale up the initiative. Training and regularly supervising the 7,000 Imams in the country is expected to be costly. IMAU was only able to train 1,000 Imams. The follow up and refresher training of these Imams was only done for about 6 years. When funding stopped, the Imams continued to educate communities but at a lower level. These Imams had not been adequately empowered in strategic planning and resource mobilization to be able to continue implementing the Islamic approach to HIV/AIDS. Even if this had been done they would still need regular support and supervision to assist them in implementing their plans.

Recommendations: Proper strategic planning and resource mobilization is needed to scale up implementation of the Islamic approach to HIV/AIDS by Imams and their assistants at the mosque level. This requires collaboration between Imams and their leaders, health professionals, as well as donors.

THE LAMBETH SOUTHWARK AND LEWISHAM AFRICAN MUSLIM COMMUNITIES CAMPAIGN AGAINST HIV

Presented by: Sukainah Jauhar

If what is stated here is correct, it is from Allah, the errors are all mine and I therefore seek forgiveness for myself and all the believers. Allah knows best.

The Lambeth Southwark and Lewisham African Muslim Communities Campaign Against HIV is an innovative partnership between a number of African community based organisations and local mosques with African congregations who were concerned about the impact of HIV and Sexually Transmitted Infections (STIs) within their communities. Lambeth, Southwark and Lewisham Primary Care Trusts provide public health support and funding for the project.

The project aims to raise awareness of HIV/STIs and other sexual health issues, to prevent HIV/STI transmission, signpost people to appropriate services and to support members of our communities living with HIV who may face stigma and discrimination.

The partners believe sexual health issues should be constructively and co-operatively addressed within communities and are convinced that sexual health education campaigns for Muslim communities should combine public health messages with Islamic teachings or values.

Background

Lambeth, Southwark and Lewisham are Boroughs in South East London. The population of the three boroughs is in the region of 789,000 and includes many people who experience high levels of deprivation and the associated poor health outcomes. The population is diverse with many communities of different ethnic identities, languages and religions. Africans constitute a significant part of the population with well-established communities from East Africa, the Horn of Africa and West Africa.

South East London is more affected by the HIV epidemic than any other part of the United Kingdom (UK) and also has endemic levels of other sexually transmitted infections, which indicate high levels of unsafe sex. The potential for Chlamydia and Gonorrhoea, in particular, to act as co-factors in the transmission of HIV is cause for concern.

Since 1996 Africans have emerged as the group in which the greatest numbers of newly diagnosed cases of HIV infection occur in South East London and now exceed the number of new infections in the gay community. Whilst the majority of infections in Africans were acquired outside of the UK, there is evidence of primary transmission taking place locally. In 2005, 5,960 residents were known to be living with HIV, including 2,277 African people of whom 1,430 were women.

Prevention should be the mainstay of the response of the local National Health Service and other organisations to the challenge of HIV. It is important to know who is acquiring infection and how, so that preventative public health measures can be targeted at high-risk individuals. Both prevention and treatment services therefore need to be tailored to specific needs, with different population subgroups requiring different levels of attention.

How the project was set up.
Although there have been a range of HIV Prevention initiatives targeting African communities in place in the three boroughs for a number of years, there has been a gap in work with faith communities. Many health professionals felt it was difficult to engage with faith communities, particularly Muslims, on sexual health issues.

It was within this context that a number of workers from African community groups and a public health specialist from a local Primary Care Trust came together in 2003 to discuss the situation. We recognised that a number of Muslims were being diagnosed with HIV locally and that some were experiencing stigma and discrimination within their communities. It was agreed that information and education efforts in relation to HIV/STIs should reach all Africans irrespective of gender, ethnicity, country of origin and religious persuasion.

We considered that local mosques and Islamic Centres already provided a social network for people who are otherwise socially excluded or marginalised and also they could have considerable impact on behaviour. Many of the mosques have large active congregations, which could offer a good opportunity to reach people with HIV/STI prevention messages, as the respect and trust given to Imams and leaders made them influential in many aspects of personal, family and social life. We felt that Islamic Centres could play an important role in tackling stigma and discrimination against people living with HIV and in providing care and support to people living with HIV and could also encourage HIV testing and earlier uptake of services.

What did we do?
We believed that members of the Muslim communities should be encouraged to participate and eventually lead in this work, as without their involvement and ownership any project was unlikely to succeed. Islam has always encouraged discussion on matters that help protect our health and lives, provided this is within the context of Islamic moral values. The Prophet Mohammed (pbuh) said: *"Whoever, rises in the morning, without being concerned about the public and private affairs of fellow Muslims, cannot be considered him/herself as part of them"*

So initially we made contact with the imams, mosque committees, women's groups and opinion formers in local mosques with large African congregations and offered to support discussion of health issues affecting African Communities, including sexual health. It was felt important at this stage not to focus solely on sexual health as we recognized the sensitive nature of HIV/STI prevention in a religious context that respects silence on private areas of life. As a result, meetings were hosted at a number of Islamic Centres and we gave presentations on key health issues including diabetes, sickle cell disorder, hypertension and HIV and STIs.

These were well attended and many of the brothers and sisters were supportive of finding out more about HIV. In the discussions which followed it was pointed out that the Qu'ran places much emphasis on acquiring knowledge, and at the time of the prophet (pbuh), Muslims, both men and women were never too shy to ask the prophet about all affairs, including such private affairs as sexual life, so as to know the teachings and rulings of their religion concerning them. As Aisha, the wife of the prophet (pbuh) testified, *"Blessed are the women of the Ansar (the citizens of Madina). Shyness did not stand in their way seeking knowledge about their religion (Bukhari and Muslim)."*

It was felt that improving knowledge of these issues and the Qur'an teachings would enhance community awareness that sex is a natural part of life, and when questions arise, they can be discussed in a mature way without actually condoning certain behaviours. People felt that fear seems to do little in the way of preventing or curtailing certain behaviours, but in families where there is open discussion of these topics, there appears to be a stronger and more principled stand on correct moral values.
Many parents wanted support, as they felt uncomfortable in discussing sex education with their children in these difficult times where there is so much peer pressure and the influence of the media. A father has a duty to be able to answer his son's questions and a mother has the same duty to her daughter. It was also apparent that there were some superstitious beliefs associated with HIV infection, which needed to be addressed. Opportunities to remind people of how to correctly handle HIV positive people within the Muslim community should be taken.

Following these initial discussions, proposals for funding a targeted programme of HIV/STI prevention work with Muslim communities were submitted to the Primary Care Trusts. Despite some scepticism the African Muslim Campaign Against HIV was set up in 2004/5. A similar project working with African-led Churches was also set up at the same time.

The work of the Campaign
The current partners are:

- North Brixton Islamic Cultural Centre.
- Lewisham and Kent Islamic Cultural Centre.
- African Advocacy Foundation.

- African Refugee Community Health and Research Organisation
- WomanBeing Concern.
- Dayreel. (A Somali women's group)
- Lambeth, Southwark and Lewisham Primary Care Trusts.

The mission of the campaign is to raise awareness of HIV/STIs, to prevent HIV transmission amongst African Muslim communities, signpost people to appropriate services and to support community members living with HIV who may face stigma and discrimination.

It was agreed to focus on:

- Education on the causes and dangers of HIV, and on other sexual health issues.
- A clear message of abstinence and fidelity. However whilst we need to focus on the obligatory moral codes of conduct we also have a duty to provide advice and information so our brothers and sisters can protect themselves.
- An innovative 'Abstinence Campaign' among young people.
- Encouraging and facilitating early marriage among young adults.
- Pre marriage advice and referral for HIV testing and counseling.
- Sign posting people to local prevention and care and support services
- Active support and acceptance of HIV positive individuals in the community

Some of the Activities 2004-2007

Drawing on the different skills of the partners the following work has been undertaken:

- Outreach at mosques, cultural centres and other gathering and mixing sites.
- Engaging the Imams of the mosques to deliver khutbah on sexual health as it applies in Islam.
- Facilitating an Islamic Leaders Circle to discuss these issues.
- Funding a sessional worker at an Islamic cultural centre to support the work.
- HIV/STI information and education events for Muslim communities at a number of sites.
- Development of resources including a booklet on basic facts about HIV in English, Kiswahili, Somali and Arabic, a leaflet on FGM in English and Somali, and a training manual for community leaders.
- Workshops for mentors to develop knowledge and skills in spreading HIV prevention messages within the community.
- Youth activities, which have included discussion groups to provide information on HIV/STIs and teenage pregnancy; workshops on resisting unhelpful peer pressure and taming our Nafs; producing a DVD which gives information in a drama format; training a group of young men and a group of young women to perform rap, nasheed and drama with sexual health and relationship messages. They have given performances to other young people and parents at social events such as Eid Celebrations, etc; the aim being to support young people in these difficult times where there is so much peer pressure and media influence.
- Setting up a support group for HIV positive Muslim people, facilitated by a Muslim person living with HIV.

What have been the outcomes?

The work has resulted in increased participation and project ownership by the African Muslim community. In particular it has led to Muslim leaders' open participation in community sexual health campaigns including workshops and discussion groups. Parents have commited to supporting sexual health campaigns as well as supporting their teenage children in taking an active part in sexual health promotional activities. The project has also improved understanding of cultural issues and HIV leading to awareness of the impact of stigma and isolation of HIV positive people. This in turn has increased community support networks for providing ongoing informal support for individuals and families living with and affected by HIV. Access to local sexual health services has also been encouraged including referral for HIV testing. Referrals have also been made to other Islamic cultural centres and mainstream services such as housing benefit, immigration, social services etc.

What have been the challenges?

- There is often a high degree of autonomy in the way many mosques are run so that individual approaches to faith leaders are needed. This is often very time consuming but is essential to build the necessary trust and not be seen as a threat to their authority.
- Currently a serious barrier in building effective links is the extent to which health workers and the Muslim community feel insecure in relation to the current political climate and Islamophobic views of sections of the media.

- Leaders are often lacking in factual information around HIV and sexual health. This can create problems if people living with HIV are advised to stop medication, fast and disregard professional advice.
- Most Muslims see a role to support and care for the sick but HIV prevention may be more problematic especially if it entails promotion of condom use as protection against HIV/STIs, which may be seen as encouraging promiscuous behaviour.
- Whilst Islam (and many other religions) stresses [illegible], and mutual fidelity within marriage as the correct moral message for protection against HIV/STIs, we have [illegible] be pragmatic and acknowledge that not all Muslims practice their faith to the letter. In fact, people who may otherwise adhere to the precepts of Islam sometimes go through periods of weakness or pressure and thus commit adultery or fornication. These lapses are not only sinful, but also expose the person to the risk of being infected with the HIV virus and other STIs. In this case we argued that people need to be informed about where they can obtain advice on methods of protecting themselves. At the same time we can offer support and guidance.
- There are a diverse range of African traditional beliefs that also influence people's behaviour and sometimes it is difficult to separate what is a cultural and what is a religious issue.
- The full involvement of women has been integral to this project, however in some mosques women may not be encouraged to attend and so we needed to develop different strategies to engage them.

How to do it?

- When working with Muslim communities, health professionals need to be accurately informed and respectful about the religious beliefs held. Unfortunately there are still many stereotypes about Muslims.

- Be aware of what is a religious teaching and what may be more a cultural or traditional issue.

- Recognise mutual misunderstandings and mistrust. Avoid being seen as a challenge to the Imam and elders -- instead stress a supporting role!

- Remember often there are different agendas. The health professionals' priority may not be the same as the Imams and community leaders.

- Need to start at a level that the leader and community are at and accept that some will not wish to be involved in any HIV prevention activity. The bottom line would be that referral to appropriate agencies/sources of support can be offered.

- There are resource implications if this work is to be done effectively, both in terms of investment in time and in funding. Success is not just measured by the number of workshops, training events etc. Equally, if not more important, is the network of successful contacts and dialogue.

Conclusions

Although the project has not been formally evaluated, the partners believe it presents an innovative approach through which sensitive issues such as HIV and sexual health can be addressed with Muslim communities. Factual public health messages can be combined with Islamic teachings and values. Ownership and involvement of the community is key. With the correct and thoughtful approach most Muslim communities are not "hard to reach" and are concerned about health.

Our Holy Prophet Mohammed, (peace be upon him), has stressed the importance of health on many occasions. He once said to one of his companions, "*O' Abbas ask Allah for health in this world and in the next." (Al-Nasa`i). And, "No supplication is more pleasing to Allah than a request for good health." (Tirmidhi).*

The partners hope to continue to secure funding for the project and to involve more Islamic Centres in Lambeth Southwark and Lewisham as full partners. INSHALLAH.

A formal evaluation of the project is also planned for 2007/8. I acknowledge the contribution of all the partner agencies, without which the project would not have happened, and also the many brothers and sisters who supported us. We are very happy to share our experiences with others.

HIV/AIDS & STI AWARENESS PROGRAM
Afghanistan Human Rights Organization

Presented by: Dr Baz Mohammad Shirzad

Background

It is a mandatory requirement to do a research study and prepare a dissertation for the award of a postgraduate diploma in health management at the Indian Institute of Health Management Research (IIHMR), Jaipur. From February to April 2006, the timetable for my dissertation included assisting the National AIDS Control Programme manager in routine management activities, setting up VCT in Kabul, and conducting a special study.

Objectives of the study

To understand and document the source of knowledge about HIV/AIDS, knowledge levels of people regarding mode of transmission, misconception levels regarding HIV/AIDS, and knowledge about prevention of HIV/AIDS in Jalalabad city.

Methodology

The study was conducted in 4 areas in Jalalabad city (police department, outpatient department (OPD) of Jalalabad Public Hospital, Jalalabad High School and main city local residential area.), in April 2006. It was a quantitative study using a random sample of respondents from 4 areas of the city, thus focusing only on urban populations. The people working in the police department were aged 22 – 40 years. The female respondents were chosen from the Out Patient department of Jalalabad Public Health Hospital. Community and religious leaders were also chosen, because this group can easily contact communities and families.

Background characteristic of the sample

Total sample size was 500 people (male - 350 and female - 150). All people interviewed were aged 15-50 years. Ninety-two percent were Muslims and eight percent were Sikh. Eighty percent of respondents were literate; (1-9 year education, five percent, 10 years and above, 65 percent). All respondents were residents of Jalalabad city. Police and university students originally came from different parts of Afghanistan.

Analysis

Among the male respondents, 50.3 percent were aware of HIV/AIDS, compared to 33.3 percent among female respondents. The electronic media played a key role in increasing awareness about HIV/AIDS. Among both male and female respondents, 58 percent and 62 percent acquired knowledge from this medium of communication respectively. The print media also contributes significantly to the campaign for communicating awareness about the HIV/AIDS. About 41.5 percent of males and 44 percent of female acquired knowledge from this medium. Some 34 percent of males and 42 percent of females acquired knowledge from slogans, pamphlets, and posters. Friends and relatives also play a key role in spreading awareness with 33 percent of male and 30 percent female getting the knowledge from them. Some 32.4 percent of males and 34 percent of females reported doctors as the source of knowledge. Thirty percent of males and 28 percent of females mentioned receiving knowledge about HIV/AIDS from health workers. Those mentioning school teachers included 31.3 percent of males and 30 percent of females.

With regard to knowledge about the mode of transmission of the virus, 80 percent of males knew that sexual intercourse with an infected person can transmit the virus. Other modes like blood transfusion, mother to child transmission, and use of unsterilized instruments are relatively less known. This suggests that sexual intercourse was considered as the major mode of acquiring the virus. Nearly 87 percent of males and 88 percent of females correctly stated that the disease is not curable. Regarding knowledge of prevention measures; 29.5 percent of males and 38 percent of females reported safe sex as one of the preventive measures. For males, this included use of condoms during sexual intercourse (5.1 percent), sterilized needles and syringes for injection (31.3 percent), checking blood prior to transfusion (36.9 percent), and avoiding pregnancy when having HIV/AIDS (13.6 percent). For females, knowledge about prevention included sterilized needles and syringes for injection (30 percent), checking blood prior to transfusion (38 percent), and avoiding pregnancy when having HIV/AIDS.

Among the male respondents, 29.5 percent had complete knowledge about the modes of HIV/AIDS transmission. For female respondents this knowledge level was 32 percent. Male respondents who had no knowledge about modes of transmission were 9.1 percent and females 2 percent.

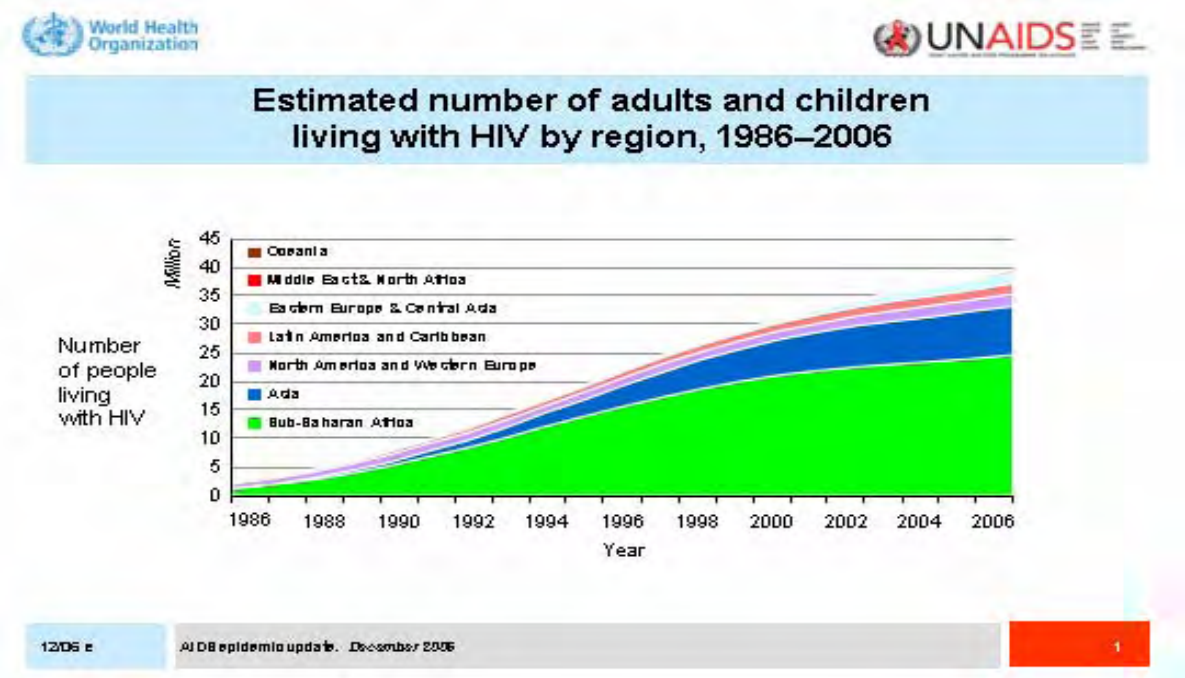
The survey data revealed misconceptions about modes of transmission by shaking hands, hugging, kissing, sharing clothes, sharing kitchen utensils, and mosquito bites; 58.5 percent of males and 60 percent of females had misconceptions about HIV/AIDS transmission.

Recommendation for AIDS Control Program

- Work at the provincial level should involve a multi-sectoral approach.
- HIV/AIDS education should be integrated in the school level for teachers.
- National HIV/AIDS Control department and curative medicine department should design programs for blood screening and training of medical staff.
- Screening of all donated blood for HIV and other blood borne pathogens, together with appropriate donor selection, should be done, because it has a major impact on reducing the risk of further spread of transfusion transmissible infections.
- Targeting of misconceptions through mass media should continue.

HIV/AIDS CONTROL PROGRAMS IN SUDAN – ISLAMIC PERSPECTIVE

Presented by: Dr M. S. Alkalifa and Dr Afaf H. Ahmed



Introduction: Situation of HIV/AIDS In Sudan

In Sudan, like other African countries, the data and information available about HIV/AIDS prevalence and the knowledge, attitudes and behavior of the population with regards to HIV/AIDS is not sufficient, and most of the data used for the assessment of the situation is extracted from the United Nations AIDS Programme (UNAIDS) Country Situation Report and Sudan National AIDS Control Program (SNAP). The Sudan response was prompt but comprehensive national policy was late. In 1987, Sudan established its National AIDS Control Program (SNAP). During 1987 to 1998, the SNAP formulated two short-term plans and two medium term plans. During 2003 to 2007, SNAP prepared a more comprehensive strategic plan (1,2,3). Sudan AIDS network (SAN) was established in 1995 by 30 NGOs but currently there are more than seventy members. The network is coordinating

voluntary efforts and represents the NGOs in SNAP and the AIDS NGOs Network for East Africa [ANNEA](4). The control program is characterized by collaboration, decentralization and flexibility (1).

Epidemiology

The epidemiology of HIV in Sudan is characterized by a variable situation with certain geographic areas clearly having a major problem. The Equatoria, the East and Khartoum states are the most affected. The first case was diagnosed in Sudan in 1986. Since then prevalence of the disease has increased. About 500,000-600,000 HIV positive cases are estimated to exist. The prevalence rate is 1.6% among the general population and 2.6% in adults. There is a higher prevalence in the high-risk groups (1.0% among women attending antenatal clinics, 4.0% among refugees, 4.4% among prostitutes, 1.6% among TB patients, and 2.5% among tea sellers) (1 & 5)

Control Programs

The logic framework is used in this paper to address the issue of HIV control programs. In its simplest model, it tackles the problem at three levels: the manifestations, the core and the roots of the problem. Applied to HIV strategic planning, the manifestations include the clinical, psychological, social and economical burden of the disease, which is of immediate relevance to the affected individual. The core of the problem, the HIV virus, has inspired much research towards an efficient curative drug therapy which will help to control the manifestations, while efforts at the root of the problem include avoiding exposure to the infection by behavioral changes, and preventing the spread of the infection by an efficient vaccination (6).

Objectives

The root of the problem of avoiding exposure to HIV is related directly to the social, religious and cultural values of the community. The need for designing special programs to suite these values for a given community may be a prerequisite for a successful control program. The objective of this paper is to illustrate the Islamic perspective as an example.

Historical Background And Basic Concepts

The roots of behavioral changes in Western culture can be traced to the 17th century when the conflict between the church and secularization began. The details of the conflict are beyond the scope of this paper, however, briefly, the conflict began with the fields of science, economics and politics to involve the family and human relations (which is the main domain of the church), as well as values and social traditions. At first, the results of the conflict threatened the sanctity of the family by seeming to accept sex with a partner other than the spouse, and to accept sexual relationships and family formation without formal marriage (boy- and girl-friends). From there, social mores appeared to accept the concept of the single parent family and then accept almost any form of sexual practice between consenting adults under the umbrella of respecting personal choice and privacy. These cultural changes were accompanied by a change in terminology with repulsive and impolite words like fornication, adultery, sodomy and prostitution, being replaced by milder and deceiving words like extramarital relations, multiple partners and alternatives to heterosexuality. All that led to ***free (sinful) sexual behavior***; both in multipartner relations and in forms of sexual practice, which in turn led to the spread of sexually transmitted infections (STIs). These social trends raised awareness of the concept of **safe sexual practice using condoms** and other means to avoid acquiring infections, especially HIV. Although it is obvious that the change in behavior to free sex is the root of the problem, almost all control efforts and budgets are geared towards enabling safer sexual practices (7). The Islamic perspective has been made clear 14 centuries ago by Hadith of the prophet Mohamed (PBUH): *"If fahishah or fornication and all kinds of sinful sexual intercourse become rampant and openly practiced without inhibition in any group or nation, Allah will punish them with new epidemics (ta'un) and new diseases which were not known to their forefathers and early generations." (8).* So, HIV and STIs are looked at as a ***punishment*** and a ***sequel of free (sinful) sexual behavior*** and if such behavior continues to prevail, the punishment will continue with emergence of new and more morbid diseases.

.HIV and STIs are looked at as a punishment...

Discussion

As mentioned earlier, the right approach to controling the HIV epidemic at its root is by avoiding exposure to the infection, but the debate arises when determining the root of the problem. The **Islamic perspective** defines the **root** of the problem as **free [sinful] sex** with unsafe sex as a sequel while the current *Western perspective* focuses on *unsafe sex* as the main challenge and any other efforts are regarded as complimentary (Fig 3). The Islamic perspective is more comprehensive and gives lasting solutions for the following reasons:

1. It respects human nature and organizes human needs in a more sincere, strong, durable and lovely relation through marriage.
2. By prohibiting free (sinful) sex, the problem of unsafe sex is automatically solved but by promoting safe sex the problem of free sex is encouraged.

3. The epidemiology of HIV prevalence is lowest in Muslim and conservative communities, where extra-marital sex is a sin. In Western and other communities, who practice safe free sex, HIV prevalence is high in high-risk groups [those who are exposed to free sex frequently].
4. The HIV prevalence is higher in poor communities exposed to free sex but not in poor conservative ones (e.g. in Sudan, prevalence is higher in Equatoria & the East but lower in the middle and northern states (1). So when promoting free sex by safe sex there will not be a guarantee for safe sex at all times as only one unprotected sexual contact may lead to disaster.
5. From points 2 and 3, it is apparent that it is difficult to maintain safe sex all the time for high-risk groups and for poor communities.
6. Syphilis, gonorrhea and other STIs were major clinical problems in the first half of the last century and when they were controlled with safe sexual behavior, HIV emerged as a more virulent clinical problem (in line with the Hadith of the prophet Mohamed [PBUH].
7. So, in essence the Western perspective on HIV interventions will lead to more free (safe) sex and promiscuity which is viewed from the Islamic perspective as a vicious circle; new critical problems which may be more morbid than HIV may emerge.

The Islamic perspective channels mainstream efforts towards combating free (sinful) sexual practice and facilitating marriage by lifting economical, social and ethnic constraints. It also acknowledges that some people may still fall into sinful practices but it again channels the efforts to pull them up to the right track and to protect them exceptionally while they are in the process of behavioral change.

Conclusion

Although policy makers and funding authorities like WHO and other UN agencies appreciate regional and cultural variations between communities, their efforts to promote behavior change remain directed towards promoting safe sex through condoms and other means (which encourage free sex). This is not the right approach for Muslim and other conservative communities. (However, these approaches may be needed as a temporary measure). The right approach is to pave the way for marriage and to abandon sinful sex. The most important point is to adopt the Islamic perspective as the main HIV control program by WHO and other authorities, hoping that it will become the main policy for all communities and to revise the concepts of modernity regarding the family and human relations. It may be high time for a new and wise look at the role of religion in human life, in order to end the devastating effects of this epidemic.

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PROMOTING SEXUAL REPRODUCTIVE HEALTH RIGHTS ISSUES OF MUSLIM WOMEN IN PURDAH PRACTICE

Presented by: Hajarat Suleiman,
Women Ummah Support Group, (WUSA) Abuja, Federal Republic of Nigeria

Introduction

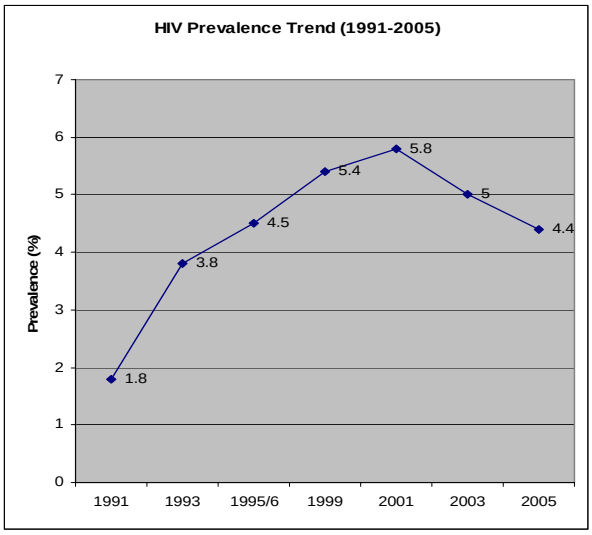
"The fact is that some women have been trapped. In some instances, reproduction is used, consciously or not, as a means to control women, to limit their options and make them subordinate to men. In many societies a serious approach to reproductive health has to have this perspective in mind. We must seek to address these issues from the Islamic perspective."

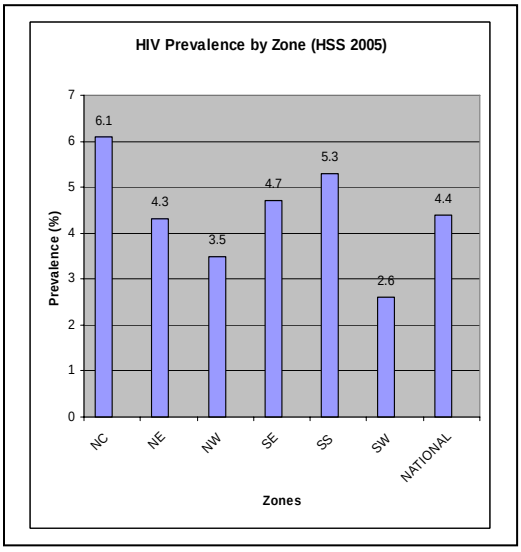
Women and children are the most affected by HIV/AIDS in Nigeria. The vulnerability is directly related to illiteracy, cultural beliefs, and educational status. Some Muslim women are under the purdah practice of confining women and excluding them from the mainstream of information. As a result of this, more women are infected daily and the rate of mother to child transmission of HIV increases in communities. It is deemed very important for WUSG to address these important and critical issues that men led organizations could not address adequately.

Current Situation

In Nigeria, the infant mortality rate is 90/1,000, and the maternal mortality rate is 10/1,000 (FMOH 2003).

HIV/AIDS Sentinel Survey in Nigeria





- In Nigeria, some Muslim women do not find it easy to relate with males especially concerning sexual and reproductive health issues. This limitation has, over the years, hindered sharing of reproductive health messages including HIV/AIDS related issues.
- The Nigerian Supreme Council for Islamic Affairs formed the Women Ummah Support Group (WUSG) in 2002 to address these challenges, as well as contribute to reducing the stigma and discrimination associated with people living with HIV/AIDS in rural communities.

Project objectives

- Create awareness about HIV/AIDS and contribute to reducing stigma and discrimination associated with HIV/AIDS.
- Bridge the gap created by Islamic Purdah practice and increase awareness to Muslim women.
- Improve active participation of Muslim women in Purdah in HIV/AIDS, and reproductive and health rights issues.

Interventions carried out

- Baseline survey (KABP) on Sexual and Reproductive Health Rights (SRHR) issues and HIV/AIDS in Muslim communities.

- Advocacy visits to Muslim leaders.
- Production of culturally acceptable IEC materials.
- Training for project beneficiaries.
- Formation of clubs in project communities.

Results and Achievements

- Survey showed that many Muslim women have no access to RH information or to health care services.
- Project activities well accepted and supported by Muslim communities.
- Women in purdah were able to participate in project activities.
- Culturally acceptable IEC materials e.g. Hijabs were produced and distributed.
- More people were reached through the multiplier effect of the IEC/BCC materials.
- Increased awareness about HIV/AIDS and sexual reproductive/health rights issues.
- Negotiation to improve the health center commenced.
- Increased response and commitment by the Muslim Ummah to SRHR issues and HIV/AIDS.
- Increased numbers of women participating in SRHR issues; voluntary counseling enhanced; referral services strengthened; (evidenced by 15% increase in new members in support group).
- Stigma and discrimination of PLWHAs reduced as a result of the intervention, observed by the way they eat with and care for PLWHAs after disclosure of status.
- Discordant couples re-united.
- 12 PLWHA and 4 orphans (vulnerable youth) were empowered to acquire skills, e.g. fashion designing and knitting, as a result of the training.
- Increased knowledge on the rights of PLWHAs, and care and support for PLWHAs.

Challenges

- Working with the women in purdah practice.
- Low level of literacy.
- Lack of office equipment for easy documentation of program activities.
- Resources for scaling up programmes implemented for better impact.
- Limited resources to reach more people as turnout was more than envisaged.

Lessons Learnt

- Proper education of women and religious leaders about reproductive health, HIV/AIDS, care and support for PLWHAs has proven effective in curtailing the spread of HIV/AIDS especially when provided in Islamic perspectives.
- Women were eager to learn as they could freely discuss sexuality issues without fear or shyness.
- PLWHA are powerful tools in the fight against HIV/AIDS, stigma and discrimination.

Major funds for implementing activities obtained from the *HIV Collaborative fund for Women and Families from TIDES Foundation:*

Potential partners:

- Action Aid International/Nigeria
- Network of PLWHAs (NEPWHAN)
- Africare International/Nigeria
- FCT Action Committee on AIDS
- CEDPA
- Winrock Nigeria

Priorities for the next 2 years:

- Intensify the massive awareness campaign.
- Target vulnerable groups – long distance truck drivers, sex workers and youth (in and out of school).
- Scale up community involvement.
- Scale up the treatment programmes.
- Capacity building – on-going process.

ESSENTIAL LIFE SKILLS FOR A PROGRESSIVE MUSLIM COMMUNITY TO USE IN THE ISLAMIC APPROACH TO HIV/AIDS.

Presented by: Nakimwero Hadijah Kibira, Chair Person, Uganda Muslim Women Vision

Introduction

Bismillah Rahman Rahim. All praise is due to Allah. I seek refuge in Allah from the evils of myself and my actions, and I ask for his forgiveness. I bear witness that none has the right to be worshiped except Allah alone and I bear witness that Muhammad (S.A.W) is his slave and messenger.

Verily in the creation of the heavens and the earth and in the alteration of day and night, are indeed signs for men of understanding. Those who remember Allah (always) standing, sitting, lying down on their sides, and think deeply about the creation of the heavens and the earth (saying) *"Our Lord! You have not created all this without purpose, glory to You. Give us salvation from the torment of the fire."* (Holy Qur'an, Imran 3:190-191).

Verily the most truthful speech is the word of Allah and the best guidance is that of Allah and His Messenger Muhammad (S.A.W). I ask Allah to guide us in this presentation to that which is proper and open all our understanding faculties; verily He is the one having power and authority to do so.

This paper focuses on the what, why, when, where and how various life skills can be utilized in the Islamic approach to HIV/AIDS.

Life Skills Defined

- Special abilities for people to function confidently and competently with the challenges and demands of every day life.
- The skills needed by an individual to operate effectively in society in an active and constructive way. *"And those who have been given knowledge, see that what is revealed from your Lord is the truth and that it guides to the path" (*Holy Qur'an - Ch. 34:6).
- Are the special tools that help one deal with the challenges of life.
- Can be employed in the various spheres of life.
- Are divided into 3 basic groups
    - Personal skills: Skills needed by an individual to function competently with the self.
    - Inter personal skills: The skills of knowing and living with others.
    - The skills of making effective decisions.
- Life skills are intertwined**.**

Rationale For Life Skills Utilisation In The Islamic Approach To HIV/AIDS

There is no doubt that HIV/ AIDS is one of the most serious disasters attacking every society. The Muslim community too is vulnerable. Lack of life skills among many Muslims, especially women and youth, is greatly responsible for the high level of vulnerability to HIV/AIDS. Many Muslims lack the necessary self/personal skills, interpersonal skills and effective decision-making skills to help them understand and reduce their risk of HIV infection.

Mankind is going through the information age where ideas are plentiful. The community is daily exposed to information from the media. While some information may be beneficial, much of it is misleading and a danger to the community, e.g. songs that emphasize love affairs, films that emphasize violence etc. However, what is lacking is the ability to evaluate ideas in a constructive manner. Many people, especially youth, are inquisitive and adventurous. Many youth are very sensitive to the behaviors and opinion of their peers and act on them even when their conscience tells them differently. Poverty is another challenge to the Muslim community. Many women are very poor and, along with the youth, have been ignored by other parts of the community in the process of earning a living. Because they are not educated, women end up in risky behaviors as they want to make ends meet. Because of all the above, some Muslims find themselves in danger of making uninformed and sometimes disastrous choices and life decisions. Life skills based programs are more effective in HIV/AIDS services, especially in changing

behaviors, than those that are focused on information alone. The Qur'an tells us *"Indeed We created man in the best of molds."* (Qur'an 95:4) There is no fault in Allah's creation; to man, Allah gave the purest and best nature. Our duty is to preserve, and nurture the distinctive character that Allah has created. The Qur'an also encourages us over and over again to think, reflect, ponder, understand, analyse and be patient.

Who Needs Life Skills?

- Children – particularly the girls, orphans, street children.
- Youth
- Parents
- Community leaders (Imams and Amirahs)
- Women and Men

What Are The Interventions To Acquire And Use Life Skills?

- Qur'an study
- Thankfulness to Allah
- Radio/ TV programs
- Role plays
- Listening
- Showing care and love
- Empowering women and children through participation.
- Training
- Sensitization about the life skills
- Guidance and counseling

Experiences With Life Skills Utilisation Among Muslim Women And Female Youth

Among its objectives, Uganda Muslim Women Vision (UMWV) aims at instilling and encouraging self-esteem and confidence among Muslim women and girls. Since its inception, we have embarked on training women and girls in life skills to realize that objective. In 2001, UMWV formed a strategic partnership with IMAU and committed itself to implementing the Islamic approach to HIV/AIDS. We emphasize building capacity among women and youth through focusing on awareness, life skills application, advocating for behavioural change and through guidance and counseling. Through its methods of training using poems, songs, public speeches and plays, life skills are provided and promoted. Our projects include:

1. The HIV/AIDS In-School Female Youth Project.

Created in 2001, this project focuses on HIV/AIDS awareness creation, behavioral change, life skills application, guidance and counseling among others. The project's direct beneficiaries are girls in primary and secondary schools, and in higher institutions of learning in Uganda. The project is implemented through conducting training workshops, seminars, school visits as well as exchange and exposure visits. Since then, various poems, plays and songs on various aspects of HIV/AIDS have been produced, acted, and competed in under the theme "Islam and HIV/AIDS."

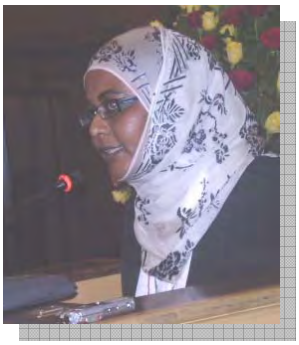
2. **The Media Program**

In partnership with the Network on Law, Ethics and HIV/AIDS (UGANET) since 2005, the UMWV embarked on media programs and training for community members on issues of HIV/AIDS and the law. The project aims not only to educate and inform the Muslim community about HIV/AIDS, human rights and the law, but also to encourage positive debates within the Muslim community on gaps identified between teachings and actual practice on the ground. The programs run once a week on Voice of Africa Radio, a Muslim community radio. They involve parliamentarians who are sensitized on the areas of concern and proposals that require legislative intervention from the Muslim community in order for them to take action.

Conclusion

While the Islamic Approach is one of the best practices in HIV/AIDS services among the Muslim community, Muslims need to acquire, develop and promote life skills in order to respond confidently to HIV/AIDS. Every progressive community must adopt life skills utilization, for they are tools provided by the Creator who asserts that He did not create Jinns and Mankind but only to worship him.

SEXUAL HEALTH AND HIV/AIDS PRIMARY PREVENTION NEEDS OF AFRICAN MUSLIM WOMEN IN LONDON (UK) BOROUGH OF CAMDEN



Presented by: Yousra H. Bagadi (BSc, MSc)

African Muslim women in London's Borough of Camden recently met in consultation around issues of HIV/AIDS. Focus groups generated information about sexual health and HIV/AIDS primary prevention needs for the target group. Muslim women from a rich variety of cultural backgrounds representing seven North African countries (Sudan, Somalia, Ethiopia, Eritrea, Morocco, Algeria and Tunisia) participated in the group discussions.

The consultation revealed: poor dissemination of information regarding HIV/AIDS services, a need for medical care promotion to empower informed choices, lack of collaboration between sexual health services and Muslim women, poor liaison between statutory, voluntary and Muslim women in assisting the development of faith-sensitive HIV information and services. This problem is compounded by the sensitivity of the issue and the associated taboos, denial and stigma. The seminar brought together delegates from the voluntary and statutory sectors, faith/community leaders, and African Muslim women. Some of the presentations included: HIV epidemiology in relation to African Muslim women, sexual health in Islam, and the difference between cultural practices and religious teachings, role of community/faith leaders in sexual health education. The seminar was successful and symbolized one of the first mixed public forums in London for Muslim women and men.

Introduction:

HIV continues to be one of the most serious communicable viruses in the UK. Undeniably, each year many thousands of individuals are being diagnosed with HIV for the first time. According to the Health Protection Agency (HPA) estimations in 2004 a total of 68,556 people were diagnosed with HIV in the UK, 57% of whom in London.

One of the key features of the HIV epidemic in London is its disproportionate impact on minority ethnic communities. The infection is still regarded as stigmatising within the ethnic minority communities in the UK. Like most traditional societies, Muslim communities (including those in the UK) are often characterised by a very loud silence when it comes to discussing about sex in public. Indeed, talking about sex remains a taboo or an embarrassing subject, which affects any discussion of HIV/AIDS and other STIs. Islam does encourage discussion on matters that will help to protect health and life. However, Muslim reactions are not always shaped by the best of their religious values.

In 2004 over half (64%) the people living with HIV/AIDS around the world were women. Women are more vulnerable to infection with HIV because: they are the receptive partners in vaginal sex, they are twice as likely as men to contract HIV from a single occasion of unprotected intercourse, they are less powerful and often unable to insist on safer sex or condom use and they are also frequently unable to prevent sex they do not want from their male partners (husbands).

African refugee Muslim women are thought to be less likely than women from other faith communities to access sexual health services in the UK. Based on personal conversations with a number of health professionals in differentGemto urinary medicine (GUM) clinics it was observed that African Muslim women tend not to use the existing services. A literature review via a number of databases including HIGH WIRE, MEDLINE, and other sources revealed no articles related to sexual health/HIV and African refugee Muslim women communities in the UK. A key element of the National strategy for Sexual Health and HIV is provision of appropriate, accessible sexual health to at-risk and hard to reach groups in the community in order to meet their needs. Recent publications highlighted the need for health authorities and primary care trusts to address health inequalities issues among ethnic minority patient groups and the Race Relations Act also emphasises the requirement for services including the NHS, to promote racial equality in access to services. Cultural, social, and economic variables have been revealed to be predictors of access to services, pattern of service use, and prevalence of sexual health problems.

Services must develop culturally appropriate models of service provision and health promotion, which are based on an understanding of the barriers to access the existing services by the particular societal group in order to facilitate equality of access (Beck *etal*. 2005). The PCT in partnership with the Holy Cross Centre have developed a consultation exercise seeking information on how to improve sexual health service delivery for African refugee Muslim women and ways in which sexual health promotion and HIV prevention methods could be made easily accessible in Camden.

Overall Aim of the Consultation Exercise:

To investigate the sexual health, HIV/AIDS knowledge, attitudes, beliefs, preferences, barriers and needs for African Muslim women refugees in Camden.

Objectives:

- To explore through consultation the level of knowledge on access to, use of, and satisfaction with sexual health and HIV/AIDS available information and services for African refugee Muslim women in Camden.
- To investigate awareness of sexual risk behaviour, and how to prevent transmission of STIs & HIV
- To explore Muslim women's attitudes and beliefs about Islamic Faith and the transmission of HIV
- To help formulate innovative interventions targeted at African refugee Muslim women for primary and secondary STIs and HIV prevention and the promotion of sexual health in Camden and Islington.

Study design:
Consultation exercise using focus groups to generate information about sexual health and HIV/AIDS primary prevention needs for African refugee Muslim women.

Methods:

Literature Review:
A literature review was first conducted to identify the relevant published information describing the magnitude and the impact of the HIV/AIDS epidemic in North African countries.

Recruitment:
North African Muslim women refugees were recruited via local community groups, voluntary organisations working with African Muslim women, and via ESOL groups as well as mosques and colleges.

Timeframe:
Focus groups took place between the 3rd December 2006 and the 22nd December 2006.

Focus groups data collection:

The groups took place in the Neighbourhood Centre, Camden PCT and St Pancras church, and lasted an average of two hours. The facilitator stimulated the discussion using a list of open-ended questions, developed from the literature review and observations from the outreach activities carried out with Muslim women. The topic guide was tested with the co-facilitators and a number of community workers (working with Muslim women). The facilitator encouraged interaction and exploration of additional issues and ensured that all the participants contributed. The facilitator and co-facilitator alternatively took notes and at the end, the facilitator summarised each discussion.

The Muslim Women's Seminar:

After six months, the African Communities team (part of the HIV prevention team at Camden PCT and the Holy Cross Centre Trust, Kings Cross) organised a seminar bringing together people from both voluntary and statutory sectors, faith and community leaders, and African Muslim women. Held at the St Pancras Hospital Conference Centre on the 2nd March 2007, the seminar's theme was the 'Sexual Health and HIV/AIDS Primary Prevention Needs for African Muslim Women.' The seminar's content included findings and recommendations of the consultation exercise, the epidemiology of HIV in the UK among African women, working with African Muslim women in GUM clinics, sexual health in Islam and the difference between cultural practices and religious teachings, the role of community leaders in sexual health education, and working with African Muslim women refugees (AMWR) in Lambeth Southwark & Lewisham (seminar report is available).

Participants:
A total of 50 North AMWR were interviewed for the exercise in 5 focus groups. Demographic characteristics of all the participants & composition of focus groups are detailed in table (1):

Table 1: Demographic characteristics of participants

	FG1 n=7	FG2 n=5	FG3 n=10	FG4 n=18	FG5 n=10
Median Age	47 (26-65)	47 (35-50)	30 (18-42)	38 (18-65)	43 (18-65)
Marital status	57% Divorced 29% Married 14% Single	100% Married	60% Single 30% Married 10% Divorced	50% Single 39% Married 6% Divorced 5% Widowed	70% Married 20% Divorced 10% Widowed
Education	University graduates	Secondary school education	10% degree 90% Secondary school education	Undisclosed	95% University graduates
Country of Origin	Sudan & Morocco, Algeria & Tunisia	Morocco & Tunisia	Somalia	Sudan, Eritrea, Ethiopia & Somalia	Sudan & Morocco & Algeria

Main Theme:

Five main themes were reported as impacting access to services:

1. Knowledge of HIV/AIDS, other STIs and antenatal testing
2. Barriers to discussing sexual health issues and accessing sexual health services
3. Muslim women's beliefs about HIV in relation to the Islamic faith
4. Experience using existing services
5. Preferred sources of information

Islamic faith values regarding pre-marital sex/sex outside marriage were an important underlying factor in most of the participants' responses to the majority of the questions. Sex outside marriage is considered as a scandal for the whole family and something that will bring shame and social isolation on the individual if it became known to the community.

Awareness of HIV/AIDS, other STIs and antenatal testing:
In terms of knowledge about HIV/AIDS and other STIs, the responses varied in each group and participants used both formal and informal terms to describe the infections.

Barriers to accessing sexual health services and discussing sex:
Participants consistently identified lack of awareness, cultural values, language and worries about confidentiality as the main barriers to access services.

"Mainly lack of information about AIDS in community centre; I have attended a number of health workshops in a local centre, but the topic of AIDS was not covered in any of them" (FG2)

"I think the main barrier is carelessness; if people are not directly affected by the problem then they will not take the effort to learn about how to avoid it and protect themselves". (FG1)

All the participants agreed that more sensitivity from clinic staff including GPs was needed. Difficulties in discussing issues connected to sex were highlighted by the majority of participants. Experience of sex education at a young age was reported as being very limited, with biology and religion classes as the main sources of information. Some participants had the information through friends and relatives of the same age. Other participants learned about sex and reproduction from television and books. None of the participants got the information through their parents when they were younger. It is significant that participants had some difficulty thinking of how to discuss sexual health matters with their children and young people in the community.

"We are often brought up in a state of ignorance with regards to sex issues, and as a result we may not be comfortable with discussing our own sexuality and how we can express it, let alone telling our children about it (approval from other participants)" (FG5)

Some participants reported concerns about the right way and age to start telling their children about sex. Not many reported that they are not aware of what their children learn about sex in schools.

"I think these courses should also cover what our children learn about sex in schools, and it will be helpful if it is explained in our own languages" (FG4)

There was a marked reluctance overall to discuss issues concerning sexual health with men except their husbands. Some participants reported concerns about the ways sons could be approached. From discussions in various groups, it was clear that because of cultural beliefs; men (brothers, fathers or husbands) expect their women to be 'innocent' and their definition of innocence is *not* to discuss sex. It was therefore suggested that there should be some awareness-raising workshops for Muslim men to correct those erroneous cultural norms and traditions.

The following extract shows a discussion among AMW from different focus groups about their experience of family planning (using condoms with their husbands), if they do and if not why?

Facilitator: have you ever discussed using condoms with your husbands? If not, why?

FG1 (HS): I can never convince my husband to use a condom for a long time and I will end up using contraceptive pills.

FG3 (IA): My husband only uses a condom when I get side effects from using pills.

FG2 (AR): On one occasion, my husband told me that it is just an uncomfortable piece of rubber and it always burst during intercourse, so it is useless (the facilitator explained about the benefits of condoms and their efficacy).

FG5 (MK): I think it prevents them from fulfilling their sexual desires.

FG4 (WH): Contraceptive pills for men should be produced and widely distributed as a solution (laughter).

Moreover, according to the responses from the different focus groups it was found that, the most stigmatised and discriminated-against groups in their communities were prostitutes, gay men, lesbians, drug/alcohol addicts, and promiscuous people. Women in all groups reported avoiding families and individuals with a reputation of immoral behaviours (as they named it).

Cultural and language barriers along with fear of discrimination and isolation were evident with regard to denial of HIV/AIDS problem.

Muslim women's beliefs about HIV infection:
Most of the participants agreed that Islam is a religion of mercy and that any infected individuals should receive mercy; the majority used Prophet Muhammad (Peace be Upon Him) Hadith (saying): *"Show Mercy to those who are less fortunate in this life then the One above will show you mercy"*

Some participants believe that obedience of Islam will protect Muslims from HIV:

"The Holy Qur'an states that everything good happening to us is a gift form Allah but, it is our responsibility, our action and our behavioural lifestyles, that would determine whether that gift (on top of which is our own well-being) would be maintained or denied."

{Whatever good, (O man!) happens to you, is from Allah; but whatever evil happens to you, is from your (own) soul. (Chapter 4, verse 79)"} (FG2)

Not many think that HIV infection is a punishment from Allah and that it is a sign that people are engaging in forbidden sexual practices:

"Homosexuals were the first to be affected, so this is a clear sign." (FG1)

"After the tsunami in 2004, it was found that the majority of tourists were homosexuals." (FG2)

"The people of Prophet Lut were punished for practising anal sex with same sex partners." (FG3)

Experience of using the existing services:
When the participants were asked about where they go for any sexual health problems, most of the participants said that they would go to see their GP for any sexual health problem. Some said that they ask to be referred by their GPs to see a lady gynaecologist, and that this process normally takes a very long time. Not many said that they go to pharmacies to avoid seeing a male doctor. None of the participants reported that they have visited a GUM (Genitourinary Medicine) clinic. All the above reflected a lack of awareness and collaboration between sexual health services and Muslim women and the urgent need for medical care promotion to empower informed choices.

Preferred sources of information:
The majority of the participants expressed the need for more workshops in their respective community centres, preferably facilitated by a trained faith or community leader who speaks their language. They also complained about the resources (i.e. booklets, leaflets, and posters) being offered. Sometimes they are not culturally/faith sensitive (because of visual demonstrations). So they recommended more culturally sensitive, simplified and pinpointed publications. Moreover, participants recommended that sexual health issues should be included more in Friday sermons to educate both adults and young Muslim people.

Discussion:
The consultation exercise undertaken has managed to gain preliminary understanding of the service user's perception of the services provided in Camden. It gave Muslim women an opportunity to discuss frankly and in privacy their knowledge about sexual health and HIV. In addition, it highlighted some of the barriers, beliefs and attitudes that avert Muslim women from accessing available services. It has also been realised that there is an urgent need for more awareness-raising about the infection and its roots of transmission as well as more information about available sexual services in the borough. Moreover, training of health providers about the African Muslim cultures is required; therefore it is now necessary to extend the consultation to service providers in an attempt to investigate their perceptions in dealing with African Muslim women. Additionally, faith and community leaders should be trained as peer educators in an attempt to raise awareness and prevent new infections. Finally, further research in this area is strongly recommended to facilitate the development of the basis for faith-sensitive educational materials, and to enhance Muslim women's access to sexual health services.

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SOCIO-ECONOMIC IMPACT OF HIV/AIDS ON YOUTH: A KENYAN PERSPECTIVE OF MUSLIM YOUTH AFFECTED BY THE EPIDEMIC

Presented by: Rukiya Bakari, Kenya

Introduction:
In less than two decades, more than 65 million people have contracted the HIV virus globally. Of these, 22 million have died from HIV-related illnesses and 17 million have been from Africa, which remains the the hardest hit of all the continents. According to UNAIDS, the total number of people living with the virus in Africa is nearly 30 million, with southern and eastern Africa being the most severely affected regions. Since the initial HIV infection in 1986, the epidemic has spread rapidly in Kenya. The impact of AIDS on a country level is great but the impact on individuals' suffering cannot be neglected. People living with HIV must often deal with a variety of medical problems alongside social discrimination, economic and emotional problems.

The epidemic places a tremendous burden on the public health system to provide adequate care for people living with HIV/AIDS and also to meet other needs of the population. Young people are a sexually active group that requires much information and education on reproductive health and sexually transmitted infections. Many young people are initiated into sex at an early age such as 17 years when they are married or outside marriage, exposing them to the risks of HIV infections. Furthermore, many young people are poorly informed about the basic facts of human sexuality and reproduction.

The lack of social skills, limited access to health care and counselling services, and the limited role of young people in HIV/AIDS prevention programmes aggravates their vulnerability to HIV infection. Sex is generally considered a taboo subject for discussion within Muslim society and especially within the family. This is a contributing factor to ignorance among many young people. Many Muslim youth who have completed high school join the unemployed list each year, are unable to attain a steady livelihood, and lack a clear direction in life. They seek excitement and pleasure through chewing khat, drinking alcohol, abusing drugs and other substances, and engaging in casual sex and other behaviours that put them at high risk of exposing themselves to the HIV.

Contributing factors to the spread of HIV/AIDS:
Poverty: Economic disempowerment causes men and women to fight for survival, which might expose them to the disease. Often in marriages, women without any stable economic base are at the mercy of husbands who are polygamous or in multiple relationships, thus exposing themselves to the possibility of contracting the disease. Women often feel that they cannot demand that their husbands use condoms because of their economic dependence, so their risk increases.

Discrimination: Discrimination is widespread against those infected with HIV/AIDS as well as their family members. The majority of HIV-positive individuals are from low-income groups, are less educated, depressed, and have lost their hope for the future. Most patients fear being abandoned by their family if they disclose their HIV status. Economic problems are the major issue because managing money for long-term treatment is difficult for those who cannot afford daily subsistence.

Moral decadence: Society as a whole has been affected by moral decadence, because of changing levels of social control, the influence of Western culture, the speed of social change, and the influence of global media.
Drugs: Substance abuse and alcoholism in Kenya has become a big problem even among Muslim youth, which may be attributed to peer pressure, and modern lifestyles that provide enormous challenges to parenting.

Wrong attitude: This involves some religious leaders and institutions who have a preconceived notion about any person suffering from HIV/AIDS as being" promiscuous and sinful." This "holier than thou" attitude contributes to condemnation and discrimination against those affected and infected.

Advances in technology: With the internet becoming a source of all kinds of information and easy access to over 100,000 pornography sites, young people have become more vulnerable than ever to sex and promiscuity.

Political aspects: Discriminatory government policies have also left many Muslim communities uneducated, unemployed and lacking in basic needs. The majority of Muslims are concentrated in slum dwellings, and in arid- and semi-arid areas, where crime rates are high. Youth are especially at risk since they engage in all manner of risky behavior to earn money to survive.

Targeted HIV/AIDS national programmes rarely reach the slums and Muslim populated areas. Any program addressing HIV/AIDS among Muslim communities has been an effort of Muslim NGOs and the Supreme Council of Kenya Muslims.

Gender inequality: In a majority of Muslim societies, there exists an imbalance in power between men and women, which is apparent in heterosexual relations as well as in the economic and social spheres of life – with men having greater power than women. For most women, the private life within the sanctuary of their houses is their whole life. Women remain uneducated and deprived of resources, making them unaware of their civil, legal and sexual rights, economically vulnerable and largely dependent on men. Due to these inequalities, women are more susceptible to contracting HIV/AIDS as they are less likely to be able to negotiate with their partners infected with HIV/AIDS. Women also are easy targets for abusive relationships and are less able to cope with illness once infected.

Ignorance/misinformation: Misconceptions about the disease and its causes are common. Some people in Muslim communities assume that all HIV infections are transmitted only through immoral sexual behaviours and are unaware that HIV can also be transmitted inadvertently through mother-to-child, accidental pricking of skin, and contact with contaminated blood (as in the case of health care professionals). There is also the possibility of an innocent spouse being infected by a husband who may have acquired HIV through sexual or drug-related contact with other infected persons. Therefore, due to lack of education, expression of compassion towards HIV/AIDS patients is wrongly perceived as tolerance towards the practices that lead to acquiring the infection.

Transmission mechanisms:
HIV can be transmitted from one person to another in a number of ways. In Kenya, the three most important transmission mechanisms are heterosexual contact, perinatal transmission and blood transfusion.

Sexual contact: The majority of infections are transmitted through heterosexual contact. Although the probability of transmitting HIV in a single act of intercourse may be low, a number of factors increase the risk. They include the viral load of the infected partner; the presence in either partner of sexually transmitted diseases (STDs) like syphilis, chancroid or herpes that cause genital ulcers; lack of male circumcision; or trauma during sexual contact. A significant number of Kenyan adults suffer from STDs and many have a large number of sexual partners, which increases their vulnerability and exposure to HIV. Consequently, most new HIV infections are due to heterosexual contact. Programmes designed to slow the spread of HIV need to focus on reducing transmission through sexual contact. Transmission risk is also high among men who have sex with men.

Perinatal transmission: Many children are infected perinatally; that is, they receive the infection from their mothers during pregnancy, at the time of birth or through breastfeeding. About 30 to 40% of babies born to infected mothers will themselves be infected. The rest will not be infected but are at risk of becoming orphans when their parents die from AIDS. About 100,000 children under the age of five are infected today.

Blood transmission: Transfusion with infected blood will almost always transmit HIV. However, in Kenya close to 100% of blood is screened for HIV before transfusion. Therefore, this mode of transmission is considered rare in Kenya. Contact with infected blood or body fluids is also a risk, which health workers, traditional birth attendants, traditional male or female circumcisers and others can minimize by practicing universal precautions, especially by wearing gloves and using sterile instruments. Injecting drugs or piercing with unclean instruments can also transmit the HIV.

Islamic Interventions:
Social stigma attached to HIV/AIDS exists in all societies including Muslim cultures. This stigma prevents those at risk from coming forward for appropriate counseling, testing, and treatment, as it involves disclosure of risky practices. The purpose of this paper is to define the extent of the HIV/AIDS problem in Muslim communities in Kenya, outline the major challenges to HIV/AIDS prevention and treatment, and discuss the concept of harm reduction, with a cultural approach, as a strategy to prevent further spread of the disease. Recommendations include integrating HIV prevention and treatment strategies within existing social, cultural and religious frameworks, working with religious leaders as key collaborators, and providing appropriate healthcare resources and infrastructure for successful HIV prevention and treatment programs in Muslim communities.

Reasons for the spread of HIV in Muslim communities are open to speculations. Islam places a high value on chaste behaviour and prohibits sexual intercourse outside of marriage. It specifically prohibits adultery, homosexuality, and the use of intoxicants.

Then how can the spread of HIV/AIDS in Muslim communities be explained? A logical explanation is that in spite of Islamic teachings, some Muslims do engage in activities that lead to acquiring HIV, including such high-risk practices as illicit drug use and/or premarital or extra marital sex. Men who engage in risky behaviours have the potential of transmitting the disease to their unsuspecting wives. With regard to curtailing the spread of disease, it is particularly troublesome that some governments in countries with large Muslim populations have been slow to respond to the rapidly spreading disease. Sexuality, considered a private matter, is taboo for discussion. More importantly, there is denial by some Muslims of an increasing HIV/AIDS threat.

Therefore, when education and counselling services are not readily and cheaply available, or when accessing such services means that the user has to disclose risk behaviours and is afraid to do so, he/she has no course but to make uninformed decisions. Effective counselling and education have been shown to change sexual behaviour and reduce the risk of HIV transmission even in high-risk groups.

In summary, the existing social, cultural and religious frameworks in some Muslim communities do not provide an environment for any safe disclosure for persons who are infected. Hence, the development of effective prevention and support services is often impeded. Meanwhile, growing gender imbalances in HIV rates (higher among women), and the tendency for the virus to be found disproportionately among marginalized and disadvantaged populations, mirror deeply entrenched systems of social inequality that help to fuel further spread of the epidemic. For those who are not educated, cultural expectations are very difficult to disregard. Containment of the HIV/AIDS epidemic among Muslim youth depends on a combination of individual and community level efforts to effect change in behaviour and lifestyle to break the chain of transmission.

The challenge of addressing the rising threat of HIV/AIDS in Muslim societies is significant. The most effective public health method of controlling the spread of AIDS is education and changing the way people behave. Political, financial, and social barriers have often kept the most effective prevention and treatment strategies from reaching persons at the highest risk. There is a need to ensure sustained access to preventive and treatment services for all high-risk groups. The goal of prevention is best achieved through an ongoing process, open to change and flexible to adaptation. Incorporating such change within religious and cultural frameworks is no easy task. This is the challenge we are facing and it is up to us, individually and collectively, as health care professionals and researchers to respond.

To ensure ongoing usefulness of public health policies related to HIV prevention, we must learn to synthesize old knowledge with new, and, at the same time, utilize opportunities to choose new directions. The framework proposed in this paper can serve as an initial model for appropriate HIV prevention and care programs in Muslim countries. Risk needs to be viewed within the context of the social subculture of Muslim countries to design strategies to reduce risk behaviours related to HIV transmission. The social dimension of health mandates that policy and program measures to stop AIDS combine social and biomedical scientific efforts. Our recommendations include education, involvement and mobilization of diverse stakeholders, particularly religious leaders; establishing sustainable financing for AIDS treatment and drug procurement; instituting regulatory mechanisms to ensure blood safety and appropriate delivery of HIV/AIDS counselling, screening and treatment services; improvement in health infrastructure; and training of health care workers. None of the above will be successful without reducing the stigma associated with HIV and AIDS, developing compassion for those afflicted and designing harm reduction strategies which would be conceptually integrated within the existing social, cultural, and religious frameworks in Muslim countries.

Conclusion:

Youth in Kenya are a group that is specifically hard hit by the pandemic. Given the situation, the government has realised that an effective response to HIV/AIDS in this country should be through educational resources since a large percentage of Kenyan children attend school. Further, the infrastructure and human resources in Kenyan schools can be used to promote preventive behaviour and create environments that enable and support this behaviour. To this end the government has put in place mechanisms to address HIV/AIDS on aspects of prevention and advocacy which include developing and teaching curricula that include education on family life, reproductive health, encouraging preventive behaviour through better parenting, counselling by religious leaders and community-centered youth activities through drama and music.

There is still a lack of adequate involvement by religious leaders in the mitigation of the socio-economic impacts of HIV/AIDS and also lack of proper monitoring and evaluation of their HIV/AIDS programmes.

It is time for us to stop being in denial and face the fact that a lot of our young people are exposing themselves to the possibility of contracting this virus that has no cure; we need to help them now before the future generation is wiped out.

STIGMA, A HINDRANCE TO HIV/AIDS PREVENTION INTERVENTIONS IN MUSLIM COMMUNITIES IN NIGERIA – A CASE STUDY OF THE FEDERAL CAPITAL TERRITORY ABUJA, NIGERIA.

Presented by: Ismaeel Abdulqadir Danesi, Interfaith HIV/AIDS Coalition of Nigeria

Introduction

HIV/AIDS remains one of the most challenging health, social and developmental issues facing Nigerians with extraordinary adverse effects on the Muslim community. All efforts directed at controlling the epidemic have been thwarted by widespread stigma and discrimination attached to HIVAIDS. This has further driven the pandemic underground, creating a fertile ground for continuous spread of the disease. As a result of this, prevention, care and support efforts have not achieved the desired results.

Description/findings

Stigma and discrimination are the major factors fueling the spread of HIV/AIDS in Nigeria. People suffering from HIV-related stigma often experience devastating consequences. Fear of discrimination sometimes causes them to refuse to be tested for HIV. Stigma can be in the form of isolation, rejection, exemption from important events, loss of identity and role, disappearance of existing relationships, restriction of participation in religious activities, and denial of religious rites even at point of death (funeral rites). Others who have tested positive find it difficult to make their status known to their families and religious members for fear of being subjected to stigma and discrimination, torture and deprivation.

Religious and cultural beliefs, myths and misconceptions regarding the origin and causes of HIV/AIDS are the major causes of the unprecedented degree to which stigma and discrimination against people living with HIV/AIDS have eaten into the fabric of our society. Some believe that it is only a sickness of prostitutes. Some believe it is a punishment from God for sinners. Others believe it is a creation of man directed at controlling the population of a segment of the human race.

There has been a high rate of human rights violations, on the grounds of serostatus, in families, community, workplace, schools, government institutions and faith communities. Ignorance and lack of adequate information about the disease is a major factor contributing to stigma. There has been an outright denial of the existence of HIV by some individuals, Muslim leaders and communities, posing serious adverse effects on individuals and communities. Some of these adverse effects include:

Poor health seeking behaviours, limited access to treatment and other services, increased psychological suffering, internalized shame, poor self-concept and pessimistic tendencies, lack of willpower and an urge to live, loneliness as a result of rejection by society, suicidal tendencies, negative emotions, hatred of the community, urge to hit back, poor quality of life, and miserable death. Some Muslim communities remain hard-to-reach due to the stigma attached to the pandemic. Some years back, discussing HIV/AIDS with Muslim leaders was taboo. People presenting the matter in the mosques or religious gatherings were not well received. Discussing condom use as one of the means by which transmission of the virus can be controlled was believed to promote promiscuity in society. The popular belief is that HIV can only be contracted through premarital, extramarital and homosexual relationships. There is a strong feeling that those who are infected are promiscuous, wayward and irresponsible. Hence HIV/AIDS is the price they pay as part of their punishment for the wrong they have done. Discussing sexual issues is strongly resisted as it is considered to be an act of immorality. It has been widely accepted that sexual behavior is a major route by which the virus is transmitted but other means of transmission also exist.

Abstinence remains the best means of HIV prevention

Abstinence remains the best means of HIV prevention. No doubt that people do reap from what they sow whether good or bad. No doubt that God does reward or punish people according to their deeds. Let us also realize that people do reap from what others have done whether good or bad. Calamities sometimes affect those whose own behavior has not necessarily been risky, but whose partners have put themselves and their spouses at risk. Let us acknowledge the fact that no human being is perfect. God sometimes imposes trials on His sincere servants in order to test their steadfastness in Him. We have seen innocent children born with HIV even when they had no opportunity to influence the decisions of their parents.

We have seen upright Muslim leaders living with the virus even when they have never engaged in the act of zina (promiscuity). Upon all these, the fact remains that our God 'Allah' is Compassionate, Merciful, Loving and Forgiving.

Reccommendations

Having examined the causes and effects relating to stigma in Muslim communities in Nigeria, the way forward includes following recommendations.

- Having the correct knowledge about HIV/AIDS and disregarding all sorts of misconceptions.
- Having a positive attitude towards PLWHA.
- Supporting PLWHA in all ways possible.
- Mainstreaming of anti-stigma messages into sermons and other religious programmes.
- Consistent preaching of love and compassion as entrenched in our religious beliefs.
- Including HIV/AIDS in the curricula of Qur'anic/Arabic schools and other institutions for the training of Imams.
- Advocating to government for the enactment of HIV/AIDS friendly policies.
- Advocating to the executive and legislative arms of government to enact anti stigma laws.
- Encouraging networking and collaboration among the various religious organizations and people of other faiths to fight HIV/AIDS related stigma and discrimination.
- Providing care and support for people infected and affected by HIV/AIDS in our communities.

Conclusion

If the correct knowledge and information about HIV/AIDS is acquired and shared, if religious and cultural misconceptions are avoided, and if love and compassion is shared among humanity, stigma and discrimination will be eradicated, we shall have an HIV/AIDS-free generation, and the world shall be a better place to live in.

INTERFAITH COLLABORATION IN ZANZIBAR

Presented by: Nuru Mbarouk Ramsa, Zanzibar AIDS Commission

Introduction:
Zanzibar is part of the United Republic of Tanzania under Union constitution. The revolutionary government of Zanzibar has a President and runs some of its own internal affairs. Zanzibar consists of two main islands -- Unguja and Pemba -- with an estimated population of 1,000,000 people. Over 90 % of the population is Muslim and the rest are Christians and Hindu. Religious beliefs form a part of the cultural traditions; the people are bound by a common language (Kiswahili), traditions, ethics and norms. Religion is perceived as a way of life and religious leaders and FBOs are an important link in reaching the population.

HIV/AIDS status:
Zanzibar has a relatively low HIV prevalence, documented at 0.6% (MOH, 2002 among general population). Women's infection rate is 4 to 6 times more than males. However, recent ANC female prevalence data shows 0.87 (ZACP 2006). The country may be said to have approximately 9,000 people living with HIV/AIDS. It is estimated that 600 Zanzibaris have died of AIDS since 1986 when the first three cases were detected.

FBOs' response to the epidemic
The Government first responded to the epidemic through the Ministry of Health. Recognizing that HIV/AIDS has broader effects beyond the health sector, the MOH established the Zanzibar AIDS Commission in 2003. The mandate of the commission among other things is to coordinate and provide strategic guidance to work with various stakeholders including FBOs. ZAC therefore, established an FBO coordinator's desk to assist and link FBOs' initiatives in the national response.

Among the first activities was mapping the existing FBOs to identify their roles. An interfaith committee was formed to bring together different faiths in the fight against the epidemic, and recently evolved into the Zanzibar Interfaith Association for Development and AIDS (ZIADA). It currently coordinates all interfaith associations on issues not only related to HIV and AIDS but also issues on community development as well. ZIADA has opened partnerships and networks, and accomplished a number of goals. There are however, challenges and gaps, which need more attention. "JIHAD ON AIDS" is the Muslim slogan used to fight the epidemic in Zanzibar; thus, messages with religious perception and teachings have been developed in posters, pamphlets and booklets to reach the Muslim population in mosques, religious gatherings and ceremonies. Some of the materials have been adopted from countries sharing the same environment like Uganda, Senegal and Malaysia. Religious leaders from Zanzibar were sent to these countries for study tours to share experiences.
ZIADA prioritized capacity building for religious leaders and FBOs. Outreach to stakeholders through trainings, seminars and workshops at the community level has resulted in more competent, active and important participants in the fight. Equally important were guides on HIV/AIDS and other related issues produced for Imams. More guides are underway to help the religious leaders and FBOs. HIV/AIDS curricula for Madrasa children have been also developed and are currently used for teaching children 10 to 24 years old.

Lessons learnt
- Zanzibar enjoys religious tolerance among its people through working on HIV and AIDS as one among the linkages.
- Religious approach is cost effective and sustainable because it is voluntary.
- Unacceptable sexual transmission relationships, immoral values, misbehaviors, drug abuse, rapping, stigma and discrimination are all against Islam. Religious leaders have been very cooperative and at a great advantage to advocate for good behaviours.
- Support and opportunities given to FBOs and religious leaders have motivated them by recognizing their strategic contributions to HIV/AIDS prevention, care and support.

Challenges
- Inadequate funding and material resources.
- Weak capacity in the technical issues, planning and programming.
- Stigma and discrimination.
- Behaviour change takes very long in spite of information and knowledge already acquired by the community.
- Gender imbalance in some social and economic settings.
- Sensitive issues in the religious perception especial condom, reproductive health and human rights.

Recommendations:
Religious leaders offer great potential for change in the communities. They should be recognized, equipped and motivated. They should also be respected to deal with areas that are in their comparative advantage. Islamic approach is voluntary based, cost-effective and sustainable. ◙ ◙ ◙ ◙ ◙

PEACE BUILDING AND INTERFAITH DIALOGUE TO COMBAT HIV/AIDS IN INDONESIA

Presented by: Dhea Dahlia Madanih, Asian Muslim Action Network (AMAN) Indonesia

Background

In Indonesia, like many other Asian countries, AIDS is a growing problem. The Indonesian Ministry of Health estimates that by 2010 there will be approximately 110,000 people who will either have full-blown AIDS or will have died of the disease, and another one million more will be HIV-positive. Furthermore, according to UNDP reports, there are groups at persistent risk for HIV infection related to sexual transmission and injecting drug use. The epidemic fuelled by drug injection is already spreading into remote parts of this archipelago. Experts warn that if risk behaviors among drug injectors, male, female and transgender sex workers, and among clients of sex workers do not change from the levels observed in surveillance performed in 2006, Indonesia will see a far worse epidemic. That is why the complexities of the HIV/AIDS epidemic need to be tackled through multiple strategies.

Interfaith Dialogue Frame Work

How should religious groups understand and respond to HIV and AIDS problems in Indonesia? Recently, by taking action using a religious approach to HIV prevention, Muslims and non-Muslim groups both government and non-governmental organizations in Indonesia, have made strategies through education campaigns to address the major challenges of HIV/AIDS. The social stigma attached to HIV/AIDS that exists in all societies is much more pronounced within some cultures. Lack of knowledge on HIV/AIDS prevention and treatment triggers potential conflicts among people as well as discrimination of PLWHAs. A few such incidents suggest that the concept of morality was the main factor causing stigma and discrimination. Community members consider HIV/AIDS as a consequence of moral transgression. As a result of this, stigma prevents those at risk from coming forward for appropriate counseling, testing, and treatment, as it involves disclosure of risky practices. Hence, the principles of harm reduction or harm minimization need to take into consideration the powerful impact of religious leaders who have great influence in many aspects of an individual's life in the community. Cooperation between religious communities ensures reaching a wide audience by tackling together the problems of HIV/AIDS through interfaith dialogue, and by building a community base at the grassroots level to disseminate HIV/AIDS prevention, care and support messages.

How to do it?

- Networking (inter and intra religious) in managing HIV/AIDS Prevention and Care programs.
- Education to give accurate knowledge of HIV transmission, methods of preventing HIV infection and the risk associated with ablution of the dead and unsterile circumcision to both religious leaders and communities.
- Building agreement as well as commitment in supporting peace to combat the HIV/AIDS problem
- Building awareness within religious communities through the same program, e.g. HIV/AIDS Prevention and Care programmes in Islamic Boarding Schools and Christian schools.

Important lesson

AMAN Indonesia used programs concerned with gender, HIV/AIDS and peace building which involve religious communities such as Islamic Boarding schools, madrasah teachers, and Majlis Taklis (Women Gathering) to enhance the capacity of religious communities to implement local level activities. In addition these communities mobilized the support needed for sustainable activities in HIV/AIDS and Peace Building. They involved both women and youth groups to build interfaith dialogue in tackling HIV/AIDS problems. The interfaith dialogue for HIV prevention makes a significant contribution by encouraging use of theological aspects in combating the spread of AIDS, increasing public awareness, and empowering directly and indirectly People Living with HIV/AIDS.

WORKING WITH OTHER RELIGIOUS COMMUNITIES TO PROMOTE THE ISLAMIC APPROACH TO HIV/AIDS

Presented by: James Cairns, World Conference of Religions for Peace

Greetings and peace. It is a pleasure to be with you here at the 3rd IMLC. I am the Director of Programs at the World Conference of Religions for Peace based in New York. Let me offer two sentences of introduction about my organization. The mission of *Religions for Peace* is to advance cooperation among the world's religious communities for peace. An important principle in our approach is that we utilize existing religious bodies as the basis for inter-religious cooperation. We also understand peace in a holistic way that includes transforming conflict, building peaceful and harmonious societies, alleviating poverty and disease, and caring for the earth. We seek to assist religious communities to take common action on issues of shared concern, and clearly HIV/AIDS is a critical challenge to the entire human family cutting across all religions and peoples. So, I have been leading our global efforts to support cooperation among religious communities to strengthen our collective response to HIV/AIDS. I have been asked today to speak about how this kind of inter-religious cooperation can support the Islamic approach to AIDS.

1) Cross cultural reality of HIV/AIDS:

Let me begin with two things that we know:

First, we know that HIV is not a respecter of boundaries; in fact, it is the opposite – an exploiter of boundaries that have been established between people, communities, and nations. It thrives in places of silence, exclusion, mistrust and ignorance.

Second, we know that human societies are diverse. You are well aware that Muslim communities do not live in isolation from others and that there are places where Muslims are in a majority and places where they are in a minority. This is the case both at a national level, but also at local community levels, and it can affect what kinds of resources Muslims have at their disposal to combat AIDS.

These two truths do not in any way diminish the value and importance of the "Islamic approach to HIV/AIDS" that is at the heart of this Consultation. This approach will help to ensure that Muslim communities are being both faithful and effective as they seek to respond to the challenge of HIV and AIDS. However, it does require that the Islamic approach be seen in the context of these two truths. How will Muslim communities interact with their neighbours of other faiths in responding to AIDS in ways that will not create the spaces and gaps where HIV spreads?

2) An open and collaborative approach:

In theory, it is possible to decide that Muslim communities only have responsibility for the well being of their members, trusting that other communities will in turn take care of their own. However, it is often the case that the local Muslim institutions are the only ones in an area and others are in need of services, or in reverse, that Muslim minorities in certain areas must get services from institutions run by other religious groups. In addition, the ethical obligations present in the teachings not just of Islam, but the other major faiths, are expressed in a universal language – our responsibility is for our neighbour regardless of what faith he or she follows.

This leads us to the value of an open and collaborative attitude in implementing the Islamic approach. HIV is not an "Islamic" or even a "religious" problem; so many of the things that are proven effective in combating the virus come from outside a religious approach. By collaborating with others, Muslim communities can benefit from shared learning and information about the most effective ways to respond to AIDS. As a result, programs can improve their quality and the impact they have on those affected by HIV and AIDS. Being open to collaboration also makes it more likely that Muslim communities can build partnerships with other actors that can bring more resources – skills, funding, material – to the fight against AIDS.

Collaboration with other religions is also important to more effectively influence governments and increase the participation of religious communities in national AIDS bodies and policy formation. The emphasis today at the global level is to work for national strategies that address universal access to the full range of HIV/AIDS services. If religious communities are not participating in the national plans then the efforts being made by Islamic and other religious groups are not counted in the national response and are thus less likely to gain support.

Let me offer some examples and highlights of how multi-religious collaboration is having an impact and helping to expand the capacity of Muslim communities to respond to AIDS. At *Religions for Peace*, our HIV/AIDS program works through inter-religious bodies at the country level and tries to help them develop capacity for running AIDS programs. Many participants here are members of these bodies, representing the Muslim community alongside colleagues from Christian, Hindu, Buddhist and other faiths, all of whom are committed to working on HIV/AIDS in their respective communities. What kind of impact can these groups have? They allow religious leaders to speak with one voice about HIV/AIDS. They can provide joint training and skills building opportunities for local groups and leaders. Donors are often more comfortable putting funds through an inter-religious body so that it does not appear that they are favouring or promoting one religion. The Inter-religious Council of Uganda plays a leading role in the National AIDS Council and CCM, representing the entire FBO sector and they are now receiving multi-million dollar grants that are distributed through their member communities to support local programs in mosques, churches, etc. We heard Dr. Sayed el-Zenari talk about CHAHAMA and the important role religious leaders – Christian and Muslim – are playing together to raise awareness and reduce stigma in the Arab states region.

3) Principles and Strategies for Collaboration

Even while it is clear that collaboration with other religions has many positive aspects, it is important that it happens in a principled way that does not violate or weaken any particular faith. So let me share briefly a few principles and strategies that we have learned over the years that can guide you as you seek to work with other religious groups.

Principles:

a) Mutual respect – this is the cardinal rule. If anyone enters into cooperation trying to undercut or attack another religious community, or to compel others to follow his or her particular way, then cooperation won't work. Representatives of each faith must acknowledge the legitimacy and dignity of the others.
b) Authentic representation – this principle is directly connected to respect. Each community has the right to decide who will represent it. Cooperation will not work well if it appears that one party has decided on who will participate from other groups.
c) Common interests – cooperation must be based on those issues/concerns that are shared among the different communities. The agenda cannot be imposed by one group on the others if working together is to be successful.
d) Existing structures – inter-religious cooperation needs to build on and make use of the structures that exist in each respective community.

Strategies:

a) Consultation – it is very important to take the time to engage in consultations among the religious communities to identify and develop the issues where cooperation is most likely and can be most successful. There will always be issues on which there is not full agreement, but these should not prevent cooperation on those concerns that are genuinely shared.
b) Multi-religious mechanisms – it is important that some kind of inter-religious structure is developed to serve as the platform for cooperation. It can be formal or informal, but it is necessary to ensure that there is not a perception the cooperation is being controlled or led by one particular community. These mechanisms also help demonstrate the genuine inter-religious cooperation to outside partners and other stakeholders
c) Limited partnership – drawing from the principle of "common interests" it is important that all parties take the approach that inter-religious collaboration will only take place in those areas of shared concern and that it will not interfere with internal concerns of each faith community.
d) Comparative advantage – inter-religious collaboration is most effective when it focuses on those areas where working together is a real advantage and it avoids duplicating those things that each religious community can do as well or better on its own. In the areas of HIV/AIDS some of the areas where cooperation adds real value include advocacy, resource mobilization, strategic and program planning, and representation in national AIDS forums/bodies.

I firmly believe that cooperation among religions does not violate any religion's own approach to addressing HIV/AIDS as long as it is done in this kind of principled way. Even more, I have seen evidence many times of how cooperation actually strengthens both the collective response of the religious sector and that of each respective religion as we all try to deal with the many challenges presented by HIV/AIDS. Thank you.

TRAINING OF NIGERIAN MUSLIM LEADERS ON HIV/AIDS

Presented by: Lateefah M. Durosinmi, PhD, Amirah, FOMWAN, Nigeria

Background

Eight Nigerian Muslim leaders attended the first International Muslim Leaders' Consultation on HIV/AIDS held in Kampala, Uganda, in November 2001. This consultation afforded the Nigerian Muslim leaders a first-hand opportunity to learn more about the Islamic Approach to HIV/AIDS prevention and control. Subsequently, the Federation of Muslim Women's Associations in Nigeria (FOMWAN), with sponsorship from DFID organized two training workshops on HIV/AIDS and Islam for Nigerian Muslim leaders based on their request to share the knowledge and skills gained from Uganda with other leaders in the country. The workshop was a perfect forum for the Nigerian Muslim leaders to discuss the experiences they gathered from Kampala and to train more leaders on using the Islamic approach to fight HIV/AIDS. The workshop facilitators were from the Islamic Medical Association of Uganda (IMAU). Participants were drawn from different states of the Federation and from many faith-based organizations.

The main theme of the workshop was the Islamic approach to the fight against HIV/AIDS. During the sessions, the participants identified and discussed the general factors responsible for the ignorance among Muslim Ummah in the fight against the HIV/AIDS scourge. They presented papers based on Islamic injunctions with copious quotations from the Qur'an and Hadith.

The workshops had the following general objectives:

- To get the participants to understand the Jihad against HIV/AIDS,
- To understand the Islamic approach to HIV/AIDS prevention,
- To understand strategies for evaluating the Nigerian Muslim community response to HIV/AIDS,
- To develop common advocacy and policy guidelines to address HIV/AIDS.

The workshop sessions were based on participatory approaches where participants were divided into different groups to tackle the issues raised. The discussions centered on the following issues:

- Contribution of Islam to ABCD of HIV/AIDS prevention;
- Faithfulness in marriage for HIV/AIDS prevention;
- Contribution of Islam to HIV/AIDS care and support;
- Contribution of Islam to mitigating the socio-economic impact of AIDS;
- Strategies for strengthening, expanding, coordinating and evaluating the national and International Muslim Community's response to HIV/AIDS.

The workshop was a milestone in the Jihad against HIV/AIDS in Nigeria. It produced a Training Manual document with the active involvement of Muslim Scholars committed to the active dissemination of the message for a sustainable response through workshops and seminars aimed at sensitizing people on the impact of HIV/AIDS, training them on prevention and control of the epidemic, taking up the responsibility of caring and supporting those infected and affected, as well as education on how *not* to stigmatize those infected and affected by the epidemic.

The Workshop Proceedings

The Workshop proceedings have been used as a basis to initiate a community dialogue on HIV/AIDS issues. The document has also been used to plan sermons as well as group talks at religious gatherings.

The manual contains:

1. Basic information on HIV/AIDS, such as:
   - HIV/AIDS in Nigeria
   - HIV/AIDS and poverty
   - HIVAIDS and development
   - HIV/AIDS and education
   - Islamic approach to HIV/AIDS

2. Group Discussion Sessions

A. Contribution of Islam (Allah's guidance) to ABCD of HIV/AIDS Prevention.
   Group 1. Abstinence from sex
   Group 2. Being faithful in marriage
   Group 3. Condom use
   Group 4. Avoidance of narcotic drug use, cultism and unsterilized instruments

B. Contribution of Islam to HIV/AIDS Care Support
   Group 1. Stigmatization of PLWHA
   Group 2. Care for people living with HIV/AIDS (PLWHA)
   Group 3. Counseling and spiritual care of PLWHA
   Group 4. Bereavement.

C. Contribution of Islam to mitigating the socio-economic impact of AIDS
   Group 1. Economic support for PLWHA
   Group 2. Orphan care
   Group 3. Income generation for AIDS related activities
   Group 4. Protection of legal rights of those affected by HIV/ AIDS

D. Strategies for strengthening, expanding, coordinating and evaluating the national and international Muslim community response to HIV/AIDS.
   Group 1. Initiating, strengthening and expanding the Muslim community response to HIV/AIDS
   Group 2. Coordination of the Muslim community response to HIV/AIDS
   Group 3. Evaluation of the Muslim community response to HIV/AIDS
   Group 4. Resource mobilization.

FOMWAN'S Activities On HIV/AIDS

The Federation of Muslim Women's Associations of Nigeria (FOMWAN) is a non-governmental, umbrella organization of Muslim women's associations. With a presence in 32 states and over 700 affiliated groups, FOMWAN has the capacity to reach up to twenty million women. FOMWAN works through a network of state level branches, local government chapters and affiliate-groups, including women's associations, Islamic schools and mosque organizations, prayer groups, professional Muslim sisters and Muslim women's trading groups. It is well known for its national and state level policy and programming on education, health and HIV/AIDS. FOMWAN members at all levels (National, States & Local Government Branches) have a track record of:

- remaining actively involved in the campaign against HIV/AIDS and holding various training workshops on HIV/AIDS;
- organizing various health programmes in states involving community and religious leaders;
- training clinical health workers in HIV prevention and management;
- training over a thousand Imams, Islammiya School teachers and female preachers on HIV/AIDS; (Part of the project was supported by NACA).
- organizing adolescent/youth sensitization workshops on prevention and control of HIV/AIDS in schools;
- collaborating with the States Action Committees on Aids, SACA;
- working harmoniously with other Muslim organizations and the Nigerian Supreme Council for Islamic Affairs (NSCIA) in order to reinforce strengths;
- holding activities and giving support to PLWHA.

Future Plans

The manual is for continuous use, but will be revised in the light of any new information in the prevention and treatment of HIV/AIDS.

THE ISLAMIC FAITH-BASED NETWORK MODEL FOR IMPROVING AIDS SERVICES

Presented by: Dr. Zainab Akol, Islamic Medical Association of Uganda

Background

Initial IMAU HIV/AIDS activities:
The goal of the Islamic Medical Association of Uganda in relation to HIV/AIDS is to contribute to the national and international response to HIV/AIDS guided by Islamic teachings and scientific knowledge. During the past 16 years, IMAU has worked towards this goal, observing many changes in HIV/AIDS prevention and control. For example, initially in the 80's and 90's there were either no antiretroviral drugs or they were too expensive. IMAU's efforts were then mainly targeted at increasing knowledge and awareness about HIV/AIDS transmission and prevention as well as compassionate care of the infected and affected. In 2003, antiretroviral drugs became more readily available at reduced costs. In addition, IMAU's experience and capacity to deal with HIV/AIDS strengthened.

Establishment of Saidina Abubakar Islamic Hospital and the International Centre for Promotion of the Islamic Approach to HIV/AIDS:
In 2001, the first International Muslim Leaders' Consultation on HIV/AIDS resolved that an International Centre for the Promotion of the Islamic Approach to HIV/AIDS be established in Uganda. IMAU mobilized resources and the centre was built as part of a new hospital called "Saidina Abubakar Islamic Hospital." The first phase of the hospital and centre was opened in January 2005. The hospital and centre are functioning well although they require more resources to improve the services. The Secretariat for the IMLCs is based at the centre.

Integration of AIDS Services:
It has been noted at both national and international levels that it is important to integrate HIV/AIDS services for the benefit of the clients and the community. This means that there should be linkages and referrals between the health facilities and the communities where the clients live. These integrated services are being promoted by USAID in Uganda as "the network model" for improving HIV/AIDS service delivery and by WHO as well.

Islamic faith-based network model for improving AIDS services:
IMAU decided to implement **"**the network model concept" in line with Islamic principles, known as "The Islamic faith-based network model for improving AIDS services." It includes the following components:

I. Health facility:

The health facility is Saidina Abubakar Islamic Hospital (SAIH). At this hospital, health service providers are encouraged to deliver HIV/AIDS services for prevention, treatment, care and support using their scientific knowledge supplemented by Islamic teachings. For example, the standard operating procedures for a Muslim service provider to incorporate Islamic faith into his or her work are as follows:

1. Believe in Allah. This means, give health services for Allah who taught you health sciences.
2. Pray as you start your work to seek Allah's help to make your work easy.
3. Pray as you start any procedure on patients.

When the service provider meets a client or patient he or she should do the following:

1. Greet patient: Assalam Alaikum.
2. Explain the condition you have found to the client. Inform the client that Allah is in charge of making him or her better.
3. Pray with the patient asking Allah to improve his or her condition.

Non-Muslim service providers are also encouraged to use similar principles that apply to their faith. The Muslim service providers are encouraged to use similar principles that are relevant when they provide services to non-Muslim patients and clients.

II. Community:

IMAU has trained Imams and their assistants on how to educate their communities on issues of HIV/AIDS prevention, treatment, care and support. The training is done using a curriculum that has both scientific information as well as Islamic teachings. IMAU has trained Imams around Saidina Abubakar Islamic Hospital. Each Imam has at least four assistants to help him -- 2 males and 2 females. The Imam and his team who are called **"**community educators**"** reach out to their communities through sermons during Juma prayers, home visits, group talks and mini-lectures. In addition, they refer patients and clients to Saidina Abubakar Islamic Hospital. A similar arrangement exists for Christian religious leaders and their assistants.

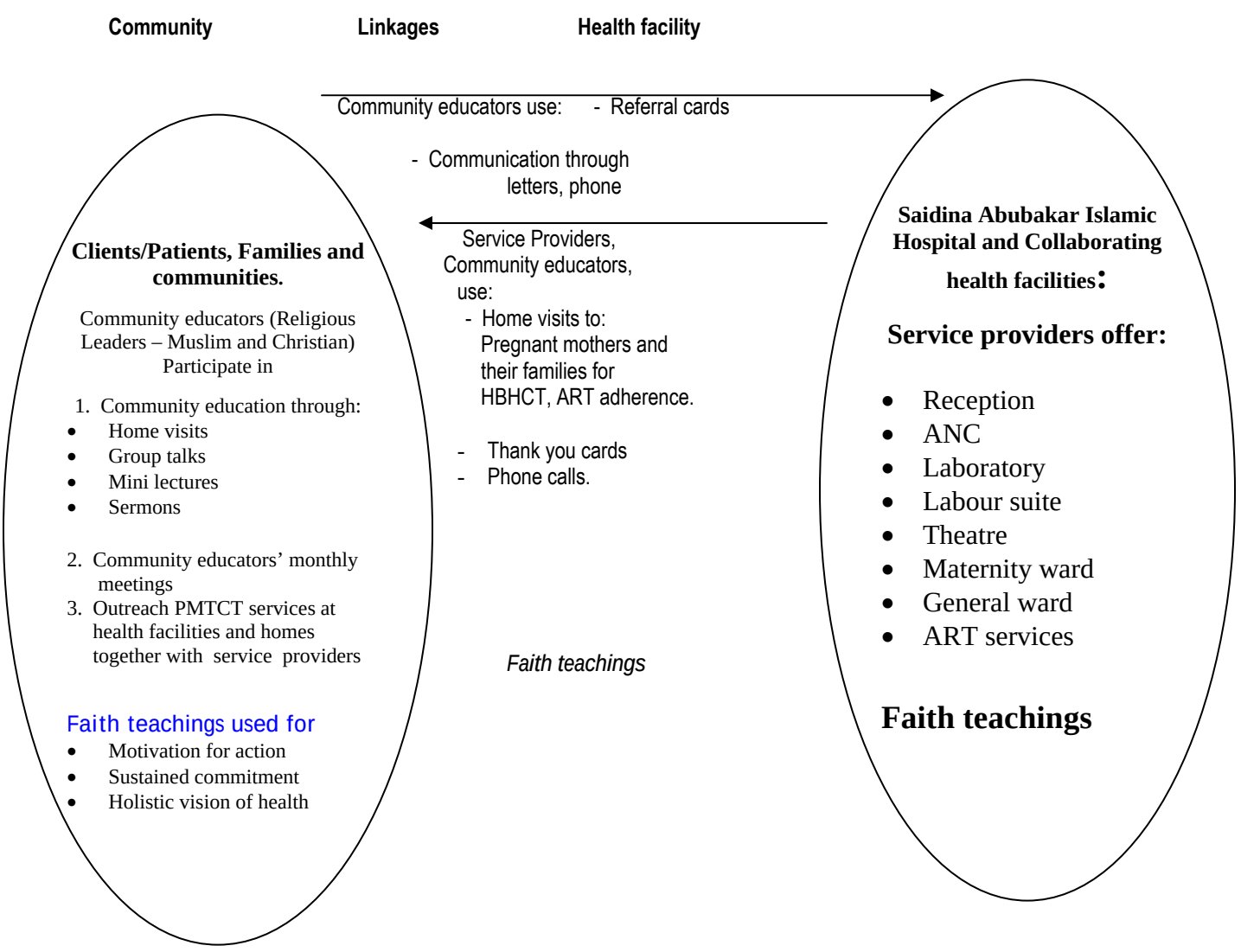
III. Linkages between community and health facility:

a) From community to health facility:
The Imam and his team refer clients to Saidina Abubakar Islamic Hospital using referral cards, letters or phone calls. Sometimes they escort the clients to the hospital. The clients themselves take the referral cards and letters to the hospital.

b) From health facility to communities**:**
Service providers refer clients back to the community educators through **"**thank you cards," letters and occasional phone calls. The service providers also provide home-based AIDS support such as HIV counseling and testing, and services for prevention of mother to child HIV transmission. In these circumstances, service providers visit homes guided by the Imams and their assistants who then provide ongoing care and support to clients and their families after the visits of the service providers.

A diagram depicting the Islamic faith based network model for improving AIDS services appears below:

Faith-based network model for improving AIDS services



ART = Anti-retroviral treatment

HBHCT = Home based HIV Counselling and Testing

ANC = Antenatal Clinic

Achievements:

This faith based network model has now been used for 2 years for improving PMTCT services in two districts namely Kampala and Wakiso. The outcome of work of the community educators for the year 2006/2007 is indicated in the table below.

Project activity	Planned Annual target	Achieved (April'06-March'07	% of annual target achieved
Education of new community members on PMTCT	150,000	279,486	181.7%
Provision of PMTCT ANC services to pregnant women at SAIH & Outreach centres	500	2,209	441.8%
Referral of pregnant women for PMTCT services	4,000	3,853	96.3%
Post training follow up for IMAU trainers	50	50	100%
Post training follow up for contact PMTCT service providers in collaborating health facilities.	50	50	100%
Training of service providers in counseling and infant feeding at SAIH.	5	5	100%
Post training follow up for IMAU community educators	1,500	1,500	1,500

PMTCT = Prevention of Mother to Child HIV Transmission
ANC = Antenatal Care
SAIH = Saidina Abubakar Islamic Hospital

The table indicates that this network model achieved the planned targets and even exceeded them in some instances.

Conclusion:

The Islamic faith based network model is a good delivery system for providing integrated HIV/AIDS services. It is supported by both communities and health facility service providers. It is flexible in that it can incorporate other religious leaders in the community to ensure comprehensive service provision to all members of the community.

Recommendation:

It is recommended that this model be scaled up to cover more communities. It should be used in the implementation of the Islamic approach to HIV/AIDS prevention, treatment, care and support.

PLENARY DISCUSSION OF RESOLUTIONS, WORKPLAN AND WAY FORWARD

During a plenary session near the end of the consultation, the participants did a general assessment of how far the objectives and expectations of the 3rd IMLC had been achieved and then made resolutions and recommendations for the way forward. The general assessment was a verbal YES or NO from participants. This is indicated after each objective or expectation. Where there was no clear answer, a short discussion followed and the summary is reported. The proceedings of these discussions were as follows:

Assessment of Achievement of Objectives:

1. To articulate and analyze the concept of the Islamic approach to HIV/AIDS and how it can be transformed from theory into practice. **YES**
2. To share experiences on the implementation of various aspects of HIV/AIDS prevention, treatment, care and support using the concept of the Islamic approach to AIDS. **YES**
3. To develop basic strategic plans to reach Muslim communities more effectively in the implementation of the Islamic approach to HIV/AIDS. **YES**
4. To plan for follow up activities after the 3rd IMLC in relation to the implementation of the Islamic approach to HIV/AIDS. **EXPECTED TO BE ACHIEVED AFTER DISCUSSING RESOLUTIONS AND WORKPLAN.**

Assessment of Achievement of Expectations:

1. To come out with a concrete policy to reduce stigma and discrimination of PHAs especially women.

   NO STIGMA AND DISCRIMINATION OF PHAs IS ACCEPTABLE IN THE ISLAMIC APPROACH TO HIV/AIDS.
2. To address Islamic practices that may strengthen the empowerment and support of PHAs and their legal rights. Set up a fund to assist unemployed Muslim PHAs to start IGAs. **DISCUSSED AND AGREED TO ADDRESS ISSUE THROUGH IAA**
3. Share experiences, professional ideas and expertise in the Islamic approach to HIV/AIDS prevention, treatment, care and support including data among Muslim populations and best practices from various countries. **YES**
4. To come out with resolutions to advocate for priority funding from donor countries for IAA projects in Muslim communities – form a task force for this. **INTERNATIONAL ADVISORY COMMITTEE (IAC) WILL LOOK INTO THIS**
5. To come out with one strategic plan that will guide Muslim communities in the implementation of HIV/AIDS work in their countries. This must include a practical way of monitoring of the Islamic approach to AIDS (IAA) activities and follow up of recommendations. **YES**
6. An agreed calendar for future IMLCs and host countries. **IMLCs TO BE HELD EVERY TWO YEARS; ENCOURAGE REGIONAL IMLCs EVERY YEAR INSHALLAH**.
7. Methodology of approaching the issues of HIV/AIDS within the Islamic approach to AIDS. Address problem issues like condoms, testing couples before marriage and polygamous unions, commercial sex workers, homosexuals and drugs addicts etc. and agree on a common agenda on them. Use of supporting verses from the Qur'an and Hadith. **DISCUSSED**. **COMMON AGENDA IS TO USE IAA IN ADDRESSING EACH OF THESE ISSUES AND CONTINUE SHARING PRACTICAL EXPERIENCES OF HOW TO HANDLE COMMUNITY WEAKNESSES. USE SUPPORTIVE VERSES FROM HOLY QUR'AN AND HADITH WHENEVER APPROPRIATE. EXAMPLE:**

   HOLY QUR'AN: 4:148:

   ALLAH DOES NOT LIKE THAT EVIL SHOULD BE UTTERED IN PUBLIC, EXCEPT BY HIM WHO HAS BEEN WRONGED AND ALLAH IS HE WHO HEARS AND KNOWS ALL THINGS

   HQ. 2:263

   " KIND WORDS AND COVERING OF FAULTS ARE BETTER THAN CHARITY FOLLOWED BY INJURY. ALLAH IS FREE OF ALL WANTS, AND HE IS MOST FORBEARING".

   THESE TEACHINGS ENCOURAGES PRIVATE HANDLING OF PROBLEM ISSUES WITH THE INDIVIDUALS CONCERNED.

8. Role of doctors, other health workers, communities in promoting Islamic principles and practices in dealing with moral, psychosocial and ethical dilemmas facing Muslim PHAs. **YES**
9. The role of the youth in the Islamic approach to HIV prevention, treatment, care and support in Islamic countries – sharing experiences with youth participants. **YES**
10. Integration of HIV/AIDS issues in other development programmes such as health, education, poverty alleviation, and sanitation. **YES**
11. Expect to write a report on the 3rd IMLC and share with those left behind at home. **YES**
12. Get experience in organizing national and international conferences especially IMLCs. **YES**
13. To create a strong partnership and network which correlate the quality and enhance the scale-up of the Islamic approach to HIV issues at country levels. This should include religious leaders, professionals and institutions concerned. **YES**
14. Participants should contribute freely on areas of common interest that can be used to document the implementation guidelines for the IAA. **YES**
15. To understand the knowledge levels about HIV/AIDS in the participants. **SOMEHOW**
16. To know that IAA is scientific and share experiences that it works. **NEED MORE INFORMATION**
17. To know various approaches to IAA implementation, challenges and how to deal with them. **YES**
18. To identify the role of Muslim Supreme organs in countries. **YES**
19. Literatures, CDs and manuals to be provided to the participants to enhance greater global understanding of the IAA. **SOME DISTRIBUTED**.
20. Gender vulnerability to HIV/AIDS especially among women and children. **YES**
21. Capacity building in designing and implementing projects, training to promote IAA, Islamic values and cultural norms in various Muslim communities. **YES**
22. Certificate of attendance. **TO BE MAILED**
23. To come out with commitment from participants to implement the IAA. **YES**
24. To get clarification and consensus on the Islamic approach to HIV/AIDS and how to prevent it. What parts of IAA are applicable in non-Islamic settings? **YES**
25. To compare IAA with other non-Islamic approaches. **YES**

RESOLUTIONS

The final resolutions were read and approved by the participants. These resolutions are as follows:

The 3rd International Muslim Leaders' Consultation on HIV/AIDS took place in Addis Ababa, Ethiopia from 23 – 27th July 2007, with more than 150 participants from 29 countries. The theme of the consultation was "*The Islamic Approach to HIV/AIDS: Enhancing the community response".*

We, the participants, resolve as follows:

1. To urge all Muslim communities and their leaders to be concerned with the HIV/AIDS epidemic and to continue the "Jihad on AIDS."

2. To implement the five components of the Islamic Approach to HIV/AIDS (IAA):
   - Believing in Allah and Prophet Muhammad (SAW).
   - Acquiring scientific knowledge on HIV/AIDS
   - Making use of relevant Islamic teachings and practices
   - Forming partnerships with religious leaders and their administrative structures
   - Making use of the concept of Jihad Nafs

   in providing services (prevention, treatment, care and support, stigma reduction, and life skills) to those infected and affected by HIV/AIDS in Muslim communities.

3. To encourage all Muslim leaders to integrate the IAA in their preaching, teaching and community programs.

4. To engage Muslim women and youth organizations in providing peer education and training on HIV/AIDS.

5. To endeavor to mobilize all Islamic educational institutions to address HIV/AIDS.

6. To conduct research to evaluate the impact of the IAA in Muslim communities.

7. That stigma, denial and discrimination against people living with HIV/AIDS (PLWHAs) is unacceptable.

8. To show compassion and mercy to PLWHAs, facilitate access to treatment, and enable them to feel fully accepted in local Muslim communities.

9. To encourage everyone to go for HIV counseling and testing, especially those preparing for marriage.

10. To work towards the establishment of an International Islamic Fund to support the implementation of the IAA.

11. To strengthen collaboration with other partners in a collective response to HIV/AIDS consistent with the IAA.

12. To promote inter-religious cooperation on HIV/AIDS consistent with IAA.

13. To advocate for international organizations and other key stakeholders to recognize the Islamic Approach to HIV/AIDS as an integral component in the global response to HIV/AIDS.

14. To urge our respective governments and international organizations to support and finance the IAA.

15. To form an international IAA network under the coordination of the International Center for the Promotion of the IAA in Uganda. The IMLC International Advisory Committee is to formulate the operational guidelines for this network.

16. To constitute ourselves into the General Assembly of Community Coordinators of IAA in the network.

17. To establish a Muslim women's forum within the IAA network to address women's issues on HIV/AIDS.

MONITORING AND EVALUATION:

It was agreed that participants monitor and evaluate their activities in the implementation of the Islamic approach to HIV/AIDS. It was agreed that the format below be used for a start:

Community Enhancement of the Islamic Approach to HIV/AIDS (CETIAA)

Community Coordinators' reporting form Form 5

Implementing partner:_____ Country of operation:_____

Name of reporting community coordinator:_____ Reporting period:_____

Prevention, Treatment, Care and Other Program Areas - Summary						
Program Area		Number of Service Outlets or Programs	Number of Clients/Individuals Served/Reached			Number of Service Providers Trained
			Female or Pregnant Women	Male	Total	
Prevention Programs using IAA:						
Prevention Programs: Total						
Abstinence/Be Faithful	Community Outreach					
Abstinence Only **(This is a subset of A/BF)**	Community Outreach					
Other Prevention Activities **(Not AB)**	Community Outreach					
Medical Transmission/Blood Safety						
Medical Transmission/Injection Safety						
PMTCT						
PMTCT Services	Received Counseling, Testing and test results					
	Complete ARV Prophylaxis in PMTCT setting					
Care Programs using IAA:						
Care and Support (including TB/HIV): Total						
Palliative Care/Basic Health Care and Support (HBHC) for HIV Infected Individuals (**including TB/HIV**)						
Palliative Care: TB/HIV(Prophylaxis and/or Treatment)						
Clients receiving TB + HIV care/treatment						
HIV+ clients receiving TB preventive therapy						
Orphans and Vulnerable Children						
Counseling **&**Testing And Receiving Results						
Other Program Areas using IAA :						
Laboratory Infrastructure						

Number of tests performed	HIV Tests					
	TB Tests					
	Syphilis Tests					
	HIV Disease Monitoring					
Strategic Information						
Other/Policy Analysis and System Strengthening						
Policy Development						
Institutional capacity building						
Stigma & discrimination reduction						
Community mobilization						
This form is filled by the country coordinator, every six months and submitted to the International Centre for Promotion of the Islamic approach to HIV/AIDS in Kampala, Uganda in the seventh month (i.e. July and January)						

HIV/AIDS Treatment/ARV Services using IAA - Summary (Direct Counts Only)

Program Areas	Number of Service Outlets	Number of Current Clients Served							Number of Service Providers Trained
		Children (0-14)			Adults (15+)				
		Female	Pregnant Female	Male	Female	Pregnant Female	Male	Total	
HIV/AIDS Treatment / ARV Services (including PMTCT+): Current (Active) Total									
New (Naive)Clients receiving ARVs:									
Clients EVER received ARVs.									
ART Sites including PMTCT+: Current (Active)									
New (Naive) clients receiving ART									
Clients EVER received ARVs.									
This form is filled by the country Community coordinator, every six months and submitted to the International Centre for Promotion of the Islamic approach to HIV/AIDS in Kampala, Uganda in the seventh month (i.e. July and January)									

There are four other forms that can help the Country Community Coordinator (CCC) for IAA to complete form 5. These are forms 1, 2, 3 and 4 as indicated below. These forms help the CCC collect relevant data from implementing religious leaders and their assistants. They can be adapted depending on the activities and the situation.

Community Enhancement of the Islamic Approach to HIV/AIDS (CETIAA): Form 1

COMMUNITY EDUCATOR'S ACTIVITY FORM: COMMUNITY EDUCATION FOR ALL

Month _____
Centre _____
Parish _____
Country _____

Name of Community Educator: _____

Date	Number of education activities		Number of people reached				Number of topics covered	
			Males		Females			
	Activity	Place	New	Re-attendance	New	Re-attendance	New	Revised
	Sermon							
	Mini-lecture							
	Group talks							
	Home visits							
	Sermon							
	Mini-lecture							
	Group talks							
	Home visits							
	Sermon							
	Mini-lecture							
	Group talks							
	Home visits							
	Sermon							
	Mini-lecture							
	Group talks							
	Home visits							
Total # of activities	Sermon							
	Mini-lecture							
	Group talks							
	Home visits							
Total # of people reached								
Total # of different topics covered								
Total # of referral cards distributed								

***This form should be given to the IAA coordinator at the end of every month*

Community Enhancement of the Islamic Approach to HIV/AIDS (CETIAA)

Form 2

COMMUNITY COORDINATORS' MONTHLY SUMMARY FORM: COMMUNITY EDUCATION FOR ALL

Name of Community Coordinator _____

Centre _____ **Date of meeting with community educators**_____

Training Venue _____

Parish/Ward _____ **District/State/Province** _____

Division/Sub-county _____ **Country** _____

Name of community educator	Activities				Number of people reached				Number of the topics covered	
					Males		Females			
	Sermons	Mini-lectures	Group talks	Home visits	New	Re-attendance	New	Re-attendance	New	Revised
TOTAL										

** *The Country Community Coordinators should summarize the activities of his/her community educators on this form every month. The Community leader should then return the form to the Coordinators responsible for the monthly meeting.*

Community Enhancement of the Islamic Approach to HIV/AIDS (CETIAA) **Form 3**

Community educator's activity form : Pregnant women

Date of activity	Pregnant mother's name	Number of topics covered in curriculum		Services provided to pregnant woman and family			Educated with husband (Y/N)	Community and Health facility Linkages		PREGNANCY STATUS
		NEW	REVISED	Given Spiritual education and support (Y/N)	Given education on PMTCT (Y/N)	Supported mother to follow medical advice (Y/N)		Referred to health facility for PMTCT services, (Y/N)	Client referred back to the community educator/volunteer with feed back from health facility (Y/N)	

CODES FOR PREGNANCY STATUS:

C = Continuing, **DHF**=Delivered from health facility (state **the name**),
DH= Delivered at home, **DPM**=Delivered from private midwife
DT= Delivered from the traditional birth attendant, **MC** =Miscarriage

Community educator's name: _____Centre/Division: _____District:/State/Province _____ Country_____

Signature: _____ Date: _____/_____

Month Year

To be submitted by the community educator to the coordinator, monthly

Community Enhancement of the Islamic Approach to HIV/AIDS (CETIAA)

Community educator's home based care activity form for people living with HIV/AIDS

Form 4

Client's name	Client No.	Number of the topic covered in the curriculum		Care services provided to client and family								Community and Health facility Linkages			Functional status
		NEW	REVISED	Given spiritual education and support (Y/N)	Given psychosocial support (Y/N)	Given education on HIV/AIDS (Y/N)	Supported client to follow medical advice (Y/N)	Supported client with a home based care KIT (Y/N)	Supported client with a basic Care package (Y/N)	Supported client with septrin prophylaxis(Y/N)	Supported client with insecticide treated net (ITN) (Y/N)	Referred to health facility with: R = Referral card P = Phone calls, N = Written note	Client escorted to health facility for HIV/AIDS services (Y/N	Health facility service provider made feedback through: F=Thank you card /feedback form, P=Phone call, N=Written note,	

CODES FOR FUNCTIONAL STATUS:

B = Bedridden (very sick)
A = Ambulatory (sickly but not bedridden)
W = Working (able to perform usual tasks)

Name of religious leader/Home care giver/Home treatment supporter: _____ Mosque: _____District:/state/Province _____

Signature: _____ Date: _____/_____

Month Year

To be submitted by the community educator, to the Country Community Coordinator monthly

CLOSING CEREMONY

The closing ceremony was attended by the US Ambassador Mr. Yamamoto, the Mayor of Addis Ababa, the representative of USAID, Mr. Scott, and the Vice Chairman of the Ethiopian Islamic Affairs Supreme council, Sheikh Elias Redman who gave his speech as follows:

In the name of Allah the most Gracious, the most Merciful, Distinguished EIASC executive committee members, Distinguished participants, Asalamu alayikum Warahmatulahi Wabarakatuhu. First of all, I would like to thank Allah who has enabled us to reach these concluding remarks. Alhamdulilahi Rabbil a'alamin

Dear brothers and sisters in Islam, during the past five days we have discussed the multi-faceted problems inflicted on our respective countries and across the globe by HIV/AIDS. We highlighted the role of Muslim communities in rolling back this pandemic, and the Islamic teachings that we should use in this regard which are in the Quran and Prophetic sunna. This is the strategy that will help us prevent and control this deadly disease. In addition to this, by coming together from different geographical areas, cultures and civilizations, we exchanged different experiences and best practices we have accomplished so far. These experiences show not only that HIV/AIDS directly and indirectly is the problem of the Muslims, but also show how much we are giving support for those who are in need in accordance to Allah's guidance.

Ladies and Gentlemen**,** I believe that you will understand what the consequences will be if we do not curb the current problem of HIV/AIDS that we are facing. The burden that it will put on development and the social problems it will create will be very complex. In this consultation we have learnt good lessons. We need to understand our responsibility in order to face the challenges ahead of us. With this spirit we are expected to move forward individually and as communities. We should follow the teaching of Allah, which says "Muslims should encourage each other to do good deeds and refrain from bad deeds." With the help of Allah we will reach our objectives, Inshaa Allah!

Ladies and Gentlemen, you all contributed to the smooth running of this consultation from the very beginning up to this day. I would like to say thank you in the name of Allah. For this I should mention some of the names because of their special support and assistance. I would like to say thank you in front of you to those who have financially and technically supported the consultation. These include; IMAU, EIASC, the US Embassy to Ethiopia, USAID / Health Policy Initiative, Task Order 1 (HPI), Washington, World Conference of Religion for Peace, PACT Ethiopia and Pathfinder International Ethiopia.

When we were selected to host this 3rd IMLC, we were challenged with the responsibility. We were not sure whether we would be able to give the time-honoured traditional hospitality of Habashas, which was started during King Asametel Najashi. However, all of our staff starting from the Executive Committee members to employees at all levels have worked day and night to make this consultation a success. For this, I would like to extend my heartfelt appreciation to them before all of you.

Dear brothers and sisters in Islam, today we have come to the conclusion of this consultation. This consultation has given us the opportunity to come together and forge new friendships. We can't help saying goodbye to each other. Let me pray for you that you go back home in peace.

Finally I can't say that all things were perfect during your stay here. If there were any imperfections, we humbly ask you to forgive us in the name of Allah because they were not intentional.

Thank you. Wasalamu alayikum Warahmatulahi Wabarakatuhu!

FIELD VISITS

The participants visited the Grand Mosque of Addis Ababa where the Islamic approach to AIDS is being implemented. They attended Juma prayers at this mosque and the Imam Sheikh Harun Taha gave a sermon on AIDS.

FRIDAY SERMON AT THE 3RD INTERNATIONAL MUSLIM LEADERS' CONSULTATION ON HIV/AIDS, ADDIS ABABA, ETHIOPIA, 23-27 JULY 2007, 13-RAJAB/1428 A.H.

Mosque - A/Jami-U Anwar
Topic - HIV/AIDS Epidemic
Preacher - Sheikh, Twaha Muhammad Haruna, Imam and Preacher Aljami-U Mosque
Date - 27/7/2007 (13-07-1428 A.H).

Part I of the sermon:

All praise is due to Allah whom we worship in His Majesty. He is alone in His earth and heavens. We praise Him. He is a true King, the Almighty, the All-wise. We praise Him the glorified and Him alone we ask for help, guidance, repentance and forgiveness. He is the oft-forgiving, the Most Merciful.

We are witnesses that none has a right of being worshipped except Allah alone, and nothing is associated with Him in worship. The one, the Self sufficient, Master whom all creatures need, the one who begets not nor was He begotten. There is none equal or comparable to Him. We also witness that Muhammad (P.B.U.H) is His messenger and slave, His chosen and loved one. He sent him (Muhammad) to all creatures. May Allah shower His mercy and blessings upon Prophet Muhammad, his family, all his companions and those who followed their footsteps until the day of recompense. Amma B'aad.

First of all I enjoin my soul together with yours to fear Allah, O you who believe. Fear Allah as He should be feared. Indeed our Lord has recommended that, in His book (The Qur'an) thus "O you who believe fear Allah as He should be feared, and die not except in a state of Islam" Imran (3:102).

Indeed fearing of Allah is light in one's heart and it is the best act one would ever meet Allah with, on the day whereon neither wealth nor sons will be of any use except him who comes to Allah with a clean heart. And do whatever you do with an intention of seeking Allah's pleasure. You should always remember that to Him you shall return, and you will be accountable and answerable for your deeds.

The best of you is he who commits himself and does what would benefit him in the hereafter, and the worst is he who transgresses Allah's bounds and prefers the desires of his soul. And be aware of the day when you shall be brought back to Allah. Then every person shall be paid whatever he earned, and they shall not be dealt with unjustly.

Today's topic on this splendid day shall rotate around the HIV/AIDS epidemic. Servants of Allah, let me share with you in this sermon about the dangerous and alarming topic that we hear about almost every single day. Different meetings and conferences have been conducted to discuss HIV/AIDS. Both hands are joined to fight against HIV/AIDS in almost every corner of the world. They have even reached to an extent of choosing a full day to commemorate the HIV/AIDS epidemic all over the world, and tried their level best to raise awareness of their societies from being infected by the virus.

Workshops and conferences are often organized to create awareness about the consequences of being infected by the virus. AIDS is a disease that can be transmitted from one person to another, and it has no cure yet. Allah has brought this disease (AIDS) partly as a warning to the transgressors who go beyond His bounds – men and women who commit adultery and fornication.

In this context let us ask ourselves, what this epidemic is? How is it transmitted from one person to another? What are its signs and symptoms? AIDS makes the infected person live an unhappy, stressful and sorrowful life. It is a lesson from the consequences that may occur if one transgresses Allah's bounds. Glad tidings are upon one who knows the consequences of anything before he or she gets involved in it.

Characteristics of HIV/AIDS:

AIDS is a condition that causes loss of weight, brought by a virus that is responsible for weakening the white blood cells in the body. Various theories and assumptions have been brought to trace the origin of the virus that causes AIDS, how it is transmitted and how it can be treated. A lot of arguments have been said, as regards to its origin, but because of time we cannot go into that.

This disastrous virus is found in the whole body once one is infected especially in the blood, body fluids, saliva and tears among others, as it is clearly stated by the specialists. Its prevalence rate is too high all over the world, which has led to an increase in the number of health workers working on this problem and the formation of AIDS organizations that try to give counsellling to the infected ones in order to prevent societies from being infected further.

Dear Muslims, it is upon us to briefly talk about the Islamic perspective regarding HIV/AIDS. We all know and believe that our religion (Islam) is not silent on the day-to-day circumstances. It is concerned about the prevailing situation.

Islam looks at humanity with a lot of care. That is why when Allah accomplished the creation of man, He did not give him freedom of behaving like animals. Man has regulations to follow. Man is Allah's creature whom He created from soil and blew in him the soul. And because of that, Angels prostrated for man and all the inhabitants of heaven and earth were surprised to see that Allah had created man from clay. Therefore, both the body and the soul have their respective responsibilities. As far as the soul is concerned, it should be obedient to Allah. If the soul goes astray, it creates problems to itself as well as the body.

Allah confirms that humanity is too weak, i.e. it can easily be tempted by Satan to change its way of life. This is evidently stated in the Qur'an "Allah wishes to accept your repentance, but those who follow their lusts, wish that you (believers) should deviate tremendously away (from the right path). Allah wishes to lighten (the burden) for you and man was created weak (e.g. cannot be patient to leave sexual intercourse outside marriage)".

Having known that humanity is weak and has little control over lusts, Islam laid strategies that would prevent man from disrupting Allah's orderly creation. We should not be like bad drivers who do not follow traffic lights. Whenever it shows red bad drivers do not stop and they may suffer themselves and cause suffering for others because of accidents.

Dear Muslims, these are some of the strategies that Islam laid down to keep humanity safe. Islam has already put preventive measures in place. It is upon us to follow them. These include: prohibition of fornication and adultery. To maintain this, Allah commanded the believing men and women to lower their gaze from looking at forbidden things and protect their private parts. He commended women not to show off their adornments and forbade them from displaying themselves (tabarruj). He encouraged separation of people of opposite sex whenever possible. He advised against unnecessary mixture of men and women in an endeavour to protect humanity against the likely consequences such as fornication and adultery. He reached to an extent of prohibiting a woman from traveling without a "Dhu-mahram" (any relative to her, e.g. her father, brother or husband) even if she is traveling for pilgrimage.

To support that, a man came complaining to the Prophet that he had registered his name among those who were going out for Jihad, and his wife was soon traveling for pilgrimage. So when he asked the Prophet what to do, the Prophet replied 'your family first'.

O servants of Allah, we should always remember that Allah prohibited fornication. However, He did not directly prohibit it. He first prohibited what could lead one to fornication. "And come not near to unlawful sex, verily it is a great sin, and an evil way that leads one to other evils". On top of that, Allah prohibited homosexuality. In a hadith narrated by Anas, May Allah be pleased with him, he said that Allah's messenger said "when my 'Umma' commits five destructive sins, Allah would destroy them. They include homosexuality and lesbianism.

Dear Muslims, AIDS was discovered in early '80s because of man's involvement in committing what Allah forbade such as homosexuality that led to the destruction of the people of Luut, and yet he (Luut) had warned them against it.

Allah bestowed the human body with enough protection. In so doing, He installed strong and resistant soldiers that defend the body against various diseases. These soldiers live in the blood and they work tirelessly day and night to protect the body against any infections. But when the HIV virus enters the body immune system it weakens the white cells, and after some time, it makes it easy for other opportunistic infections to attack the immune system, and consequently, different bacterias, germs and other viruses easily attack the body that is now weakened. Eventually, a person develops on and off fevers, skin rashes, loss of weight, until one dies.

Because of this dangerous virus, medical doctors all over the world hold different workshops and conduct research. However, they have not found the cure for this disease. In different workshops, medical doctors have confessed and declared that the only cure to this epidemic is following what the Qur'an advocates in matters concerning sexual affairs, i.e. the Qur'an advocates for marriage and faithfulness in marriage, and protection of the youth from amusements that tempt them to fornication.

O Allah, safeguard our chastity, and protect our families against HIV/AIDS, get us out from fawaahish (evil doings) both the seen and unseen for indeed you are able to do all things. I seek refuge with Allah from Satan the cursed one. "Allah is He who created you, then provided food for you, then will cause you to die, then (again) He will give you life (on the day of resurrection). Is there any of your (so-called) partners (of Allah) that do anything of that? Glorified is He! And exalted is He above all that (evil) they associated (with Him). Evil (sins and disobedience to Allah) has appeared on land and sea because (Allah) may make them taste a part of that which they have done, in order that they may return (by repenting to Allah and begging His pardon).

May Allah make you and me benefit from the recitation of the Qur'an and the Prophetic hadiths, and may He distance you and me from the torments of Hell fire. I have said what you have heard and I seek forgiveness for my soul, yours and the rest of the Muslims from the Almighty Allah. Seek for forgiveness from Him. Indeed He is the oft-forgiving most merciful.

Part 2 of the sermon:

All praise is due to Allah alone the irresistible. And I bear witness that there is none other than Allah alone who has the right of being worshipped and has no partners. He is the Creator of the heart and eyes. I indeed bear witness that our beloved Prophet Muhammad is His slave and His messenger, the chosen one. May He shower His perfect blessings to Him and to his family and to all his companions and those, who followed their footsteps so long as the day and night comes.

I enjoin my soul together with yours to fear Allah. Fear Allah, O Allah's servants and protect yourselves against that disastrous and dangerous disease. And be among those whom Allah referred to as follows "And those who guard their chastity except from their wives or the slaves that their right hands possess – for them, they are free from blame".

And be aware, dear Muslim youths, that you should engage yourselves in the amusements and sports that are not controversial to the Islamic teachings. Protect societies from men mixing up with women unnecessarily. All the above mentioned, are ways of preventing communities from being infected with the dangerous virus.

And finally, it is an obligation upon every individual, organization and governments to help one another in the fight against HIV/AIDS. With that pray for the warner –Muhammad S.A.W.

EVALUATION OF THE 3RD IMLC

Participants were requested to complete an evaluation form for the 3rd IMLC. The results of their evaluation are summarized in the table 1 below:

Table 1: Participants' evaluation of the 3rd IMLC

Issue	Response					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No. of participants (respondents)
1. Pre-consultation logistics (announcements, registration etc) were adequate.	64.4%(47)	32.9%(24)	2.7%(2)	0%(0)	0%(0)	73
2. Reception in Addis Ababa has been adequate	68.5%(50)	24.7%(18)	4.1%(3)	1.4%(1)	1.4%(1)	73
3. Accommodation and meals were adequate	73%(54)	23%(17)	0%(0)	2.7%(2)	1.4%(1)	74
4. Objectives of the consultation were achieved	45.9%(34)	45.9%(34)	6.8%(5)	1.4%(1)	0%(0)	74
5. Participants' expectations were realized	39.2%(29)	47.3%(35)	9.5%(7)	2.7%(2)	1.4%(1)	74
6. Programme handouts were appropriate, clear, and adequate	44%(33)	45.3%(34)	6.7%(5)	2.7%(2)	1.3%(1)	75
7. Participant feels more confident in implementing the Islamic approach to HIV/AIDS	67.6%(48)	31%(22)	0%(0)	1.4%(1)	0%(0)	71
8. Presentations were useful	58.7%(44)	33.3%(25)	4%(3)	2.7%(2)	1.3%(1)	75
9. Group work and plenary on various sessions were useful	55.8%(43)	40.3%(31)	1.3%(1)	1.3%(1)	1.3%(1)	77
10. The consultation was gender sensitive	64%(48)	28%(21)	5.3%(4)	2.7%(2)	0%(0)	75
11. There was adherence to Islamic principles	60.5%(46)	32.9%(25)	1.3%(1)	5.3%(4)	0%(0)	76
12. The whole consultation has been useful and reflective of IAA	59%(46)	35.9%(28)	3.8%(3)	1.3%(1)	0%(0)	78

**** Frequencies in brackets**

Remarks:

From this table, most participants who responded to the questions found the consultation useful.

Participants were asked for other comments, which are shown below:

I. What was the one most useful idea or suggestion you heard during the consultation that you might like to use in your own work?
   1. Implementation of the Islamic Approach to AIDS (IAA)
   2. Interfaith dialogue
   3. Involving women leaders in IAA

4. Reduction of stigma and discrimination using IAA
5. Monitoring and evaluation
6. Forming a Muslim women leaders forum
7. Divine values and virtues for marriage
8. Strategic plan for IAA
9. Life skills
10. Channels of communication
11. Collaboration with other religions
12. Local mosque workplan

II. What is the source of your motivation for implementing IAA?
1. Allah's reward
2. Learning about IAA and its implementation
3. Work for humanity
4. To contribute to the reduction of HIV prevalence in the country.

III. Recommendations for future IMLCs.

1. Increase the number of participating countries, especially the French speaking countries, and improve on regional balance.

2. Develop selection criteria for participants so that attending participants can understand and discuss HIV/AIDS issues on the floor more reasonably and at the same level.

3. Set up an active secretariat to coordinate IAA, follow up, monitor and evaluate IAA activities in different participating countries involved in IMLCs.

4. Invite potential donors like Islamic Development Bank to the consultations, and also set up a fund to help in the realization of IAA in different countries. Strengthen use of Islamic fund raising methods.

5. More scientific updates should be included in the consultations.

6. More women, youth, PLWHAs including men and health professionals, should be invited to attend the IMLCs. Participants from Muslim Supreme Councils of different countries should also be invited.

7. Advocacy for recognition of IAA by the United Nations.

8. More field visits to IAA projects should be included in IMLCs programmes.

List of participants of the 3rd International Muslim Leaders' Consultation on HIV/AIDS

AFGHANISTAN

Dr Baz Mohammad Shirzad
Afghanistan Human Rights Organization
Kabul, Afghanistan
Tel: 0093-700601088
Tel: 0093-799611136
baz.mohammad@gmail.com

ALGERIA

Dr. Youcef Belmahdi
UNAIDS
belmahdi63@yahoo.com
Ministry of Religious Affairs and Wakfs,
30/16 cite El Badr
Tel: +213 73 25 32 68
Algeria

BANGLADESH

Emdad Sheadhar
NHM AIDS Prevention Activities
sheadhar_bd@yahoo.com
Hafij Vila, 642/Kha-Barhatta Road,
Netrakona-244600, bangladesh
Tel: +881720134621
Bangladesh

EGYPT

Dr. Sayed El-Zenari
UNDP middle east
sayedzenari@yahoo.com
1191 Corniche El Nil, World Trade
Center, Boulac Cairo, P. O. Box 982,
Code 11599, Cairo
Tel : +202 10 1652918
Egypt

Dr. Oussama Tawil
UNAIDS
tawilo@unaids.org
Abdel El Razzak El Sanhoury Street,
Nasr City. Cairo 11371
Tel: 002 010 601 9091
Egypt

Radwan Salem
b.salem1@islamway.net
53 Abdel Aziz Fahmy Street,
El Nozha, Cairo
Tel: 01012277855
Egypt

ETHIOPIA

Abdela Zeinu
Dire Dewa
eiasc@ethionet.et
Ethiopia

Abubeker Ali
EIASC
eiasc@ethionet.et

Alfiya Ibrahim
EIASC
emdda@ethionet.et

Ali mohammed Siraje
Amhara
eiasc@ethionet.et

Awoel Sheikh Mehdi
Oromiya
eiasc@ethionet.et

Dr. Abdella Kedir
Ulema

Dr. Abdurazak Ahmed

Dr. Abdurhaman Shemsu
M.D

Dr. Miftah Mohammed
Scholar

Fethudin Ibrahim
EIASC
fetudin@yahoo.com

Fetiya Ibrahim
EIASC
eiasc@ethionet.et

Hadiya Mohammed
EIASC
eiasc@ethionet.et

Haji Abdo Ali
Addis Ababa
eiasc@ethionet.et

Haji Abdurahman
EIASC
eiasc@ethionet.et

Haji Ahmedel Hadi Seid
Southern
eiasc@ethionet.et

Haji Al-Hassen Al-Meumun
Benshangul Gumuz
eiasc@ethionet.et

Haji Arage Mohammed
Scholar
eiasc@ethionet.et

Haji Bedredin Hamid
Addis Ababa
eiasc@ethionet.et

Haji Hamid Omer
Gambella
eiasc@ethionet.et

Haji Ibrahim Sherif
Harar
eiasc@ethionet.et

Haji Kerara Al-Kherib
Benshangul Gumuz
eiasc@ethionet.et

Haji Mehbub Mohammed
EIASC
eiasc@ethionet.et

Haji Mohammed Abdela
Tegray
eiasc@ethionet.et

Haji Mustefa Hussein
Southern
eiasc@ethionet.et

Haji Seid Mohammed
Ulema
eiasc@ethionet.et

Haji Teshale Kero
EIASC
eiasc@ethionet.et

Haji Yusuf Ali Yassin
EIASC
eiasc@ethionet.et

Haji Yusuf Ibrahim
Gambella
eiasc@ethionet.et

Halima Akmel
EIASC
babahalim@yahoo.co.uk

Miss. Sara Muhammed
Youth
eiasc@ethionet.et

Mohammed Ali Idris
EIASC
eiasc@ethionet.et

Mr. Abdela Ismael
EIASC

Mr. Abdulhafiz Kemal Issa
Program Office
abdulkemalo@yahoo.com

Mr. Ahmed Wasse
Scholar

Mr. Awad Jibril
Scholar

Mr. Ayub Abdulkadir

Mr. Birara Modhammed
EIASC
birraraz@yahoo.com

Mr. Habib Seid
EIASC

Mr. Hashim Shitu
EIASC

Mr. Ilias Seid
EIASC
eiasc@ethionet.et

Mr. Mesfin Moges
EIASC
medfin_mog@yahoo.com

Mr. Musema Fereja
EIASC
mussema.fereja@yahoo.com

Mr. Nuredin Jemal Muktar
Project Manager
nuredin_jemal@yahoo.com

Mr. Nuri Kedir
Scholar
nurikam@ethionet.et

Mrs. Fatuma Abdella
EIASC

Ms. Bedriya Ausab
Addis Ababa
eiasc@ethionet.et

Ms. Bedriya Mohammed
Scholar
eiasc@ethionet.et

Ms. Feyda Khedir
Addis Ababa
eiasc@ethionet.et

Ms. Seid Negash
EIASC
eiasc@ethionet.et

Mufti Umer Idris
Muftti
eiasc@ethionet.et

Ousman Adem
EIASC
eiasc@ethionet.et

Rabiya Hussen
EIASC
rabihusen@yahoo.com

Sadiya Bedru
EIASC
sadia2flowers@yahoo.com

Sheih Mohammed Kahsaye
EIASC
eiasc@ethionet.et

Sheik Mohammed Abdulkadir
Muftti
eiasc@ethionet.et

Sheikh Ismael Abdela
Affar
eiasc@ethionet.et

Sheikh Abayezid Haji Kiyar
Jimma
eiasc@ethionet.et

Sheikh Adem Abdela
Nazeret
eiasc@ethionet.et

Sheikh Ahmedin Sheikh Abdelahi
Oromiya
eiasc@ethionet.et

Sheikh Ezedin Abdulaziz
Ulema
eiasc@ethionet.et

Sheikh Hamid Mussa
Ulema
eiasc@ethionet.et

Sheikh Kedir Mohammed
Tegray
eiasc@ethionet.et

Sheikh Kedir Mohammed Abagaro
Jimma
eiasc@ethionet.et

Sheikh Khalif Adem Osman
Somali
eiasc@ethionet.et

Sheikh Mohammed Deressa
Affar
eiasc@ethionet.et

Sheikh Mohammed Mubark
Tegraye
eiasc@ethionet.et

Sheikh Mohammed Sultan
Amhara
eiasc@ethionet.et

Sheikh Muktar Mohammed
Dire Dewa
eiasc@ethionet.et

Sheikh Muktar Mubarik
Harar
eiasc@ethionet.et

Sheikh Mussa Mohammed
Ulema
eiasc@ethionet.et

Sheikh Mustefa Mohammed Siye
Amara
eiasc@ethionet.et

Sheikh Omer Farah
Somali

GHANA

Zuleya Abdullah
Muarag
Kojo Thompson Road
Adabraka, 2nd Floor, Ampem House
C161/2
P. O. Box 8749, Accra North
Accra
Ghana
Tel: 021248068
Tel: 0244716527
murag@africonline.com.gh

Abdul-Karim Ibrahim Afa-zie
Dawah Academy
dawahacademy2005@yahoo.com
Premises of the Ministry of Fisheries
P. O. Box TL 155, Tamale
Agri Ridge, Tamale, Bogla Road,
Ghana

INDIA

Reshma Azmi
FXB-India
Devendra Nagar, Sector-1
LIG-E/105
P. O. Box 492009
Raipur / Chhattisgarh
India
Tel: +91-98934-38899 (m)
reshma.azmi@rediffmail.com
azmi.reshma@gmail.com

Shabab Alam
Misbah
Inside Court, Basti Hazrat Nizamuddin
107
New Delhi-110013
India
Tel: +91-9910126035
shababalam2000@yahoo.co.in

Prof. Akhtarul Wasey
Zakir Husain Institute of Islamic Studies,
Jamia Millia Islamia A-110
Jamia Nagar
New Delhi-110025, India
Tel: 9810541045
Tel: 00-91-11-26836077
akhtarulwasey@yahoo.co.uk

INDONESIA

Dhea Dahlia Madanih
Asian Muslim Action Network
(AMAN)Indonesia
Jl. Pancoran Timur II A No.06
South Jakarta
Indonesia
Tel: +62 7984164
Tel: +628170057371
dhee_dahlia@yahoo.com

Sonhaji Abdul Shomad
NU Chabang Pasuruan
nu_kabpasuruan@hotmail.com
Jl. Pesantren Ds. Glagah Sari
Kecamatan
Sukorejo RT. 04 RW. IV Kabupaten
Pesuruan,
Java Timur
Tel : +62343422900
Indonesia

Syafiq Abdul Mughni
Muhammadiyah
mughni54@yahoo.com;
Jl. Sudirnman III/1 Sidoarjo,
Taman Jenggala,
East Java
Tel: +62318961809
Indonesia

Ella Mutadjarridah Giri Komala
Majlis Ulema Indonesia - Mui West Java
muipropjabar@bdg.centrin.net.id
muipropjabar@plasa.com
Jl. L.L.R.E. Martadinata No. 105,
Bandung, 40114, West Java
Tel: +62227215349
Indonesia

Lahmuddin Nasution
Commission of Indonesian Ulama
Council of North Sumatera
tion@IAINSU.ac.id
IAIN North Sumatra Jl.
Willem Iskandar Pasar V Medan Estate,
Medan, Sumatera Utara 20372
Tel: +62616622925
Indonesia

Dr. H. Achmad Ramadan, MA
Center for HIV/AIDS Information and
Counseling of latHIVa IAIN Sumatera
Utara, Jl. Willem Iskandar Pasar V
Medan Estate, Medan – North
Sumatera, Gedung Fak. Tarbiyah
P. O. Box 20371
Medan, Indonesia
Tel: +62616622925
ramazait@hotmail.com

IRAN

Dr. Hamidreza Setayesh
UNAIDS
setayeshH@unaids.org
UNAIDS Iran, 39 Shahrzad blvd,
Tehran
Tel:+982122858950
Iran

Ayatollah Ghorban-Ali Dorri Najafabadi
UNAIDS
salems@undp.org
Iran

Dr. Hojattollaeslam Hessam-eddin Ashna
UNAIDS
salems@undp.org
Iran

Youscef Keheh
UNAIDS
salems@undp.org
Iran

KENYA

Prof. Mohamed S. Abdullah
Kenya Association of Muslim Medical
Practitioners
Doctor's Plaza, Room 210,
3rd. Parklands Avenue,
Aga Khan University Hospital,
P. O. Box 20707 - 00202
NAIORBI, KENYA
Tel: 374 0607
Abdullah@mediplan.or.ke

Lattif N. Shaban
Supreme Council Of Kenya Muslims
Njugu Lane Behind Biashara Street
Islamia House
P. O. Box 45163-00100
Nairobi, Kenya
Off: + 254-20-243109
Cep: +254-722-720142
lanshab@yahoo.com
ncep@supkem.or.ke

Rukiya Bakari
International Center for the protection
of Marginalised Children
rukiyahd@yahoo.com
No. 38 Pine Ridge Gardens
Rhapta rd. Westlands.
P. O. Box 4870 00100 Nairobi
Tel: +254 722 285482
Kenya

Dr. Hafsa Mohamed Zuber
Ministry of Health
hafsajin@yahoo.com
Flat no. 96 Memon Bamburi Estate,
Mombasa Malindi Highway,
P. O. Box 93217 Mombasa
Tel: +254 721 741550
Kenya

MALAWI

Chunga Ousmane
Quadria Muslim Association of Malawi
quadriamw@malwi.net
P. O. Box 1024, Lilongwe
08 741 464
Malawi

MYANMAR

Mr. Hoosein Abdul Kader
Cholia Muslim Religious Fund Trust
162, Bosunpet Street, Pabedan,
Yangon, Myanmar (BURMA)
Tel: +9598030873
kader@myanmar.com.mm

NAMIBIA

Sheikh Ssekamatte Ali
Windhoek Islamic Center
sekamateali@yahoo.com
Puccini Street, ERF no. 843,
P. O. Box 8560, Windhoek
Tel: 26461271927
Namibia

NIGER

Djataou Oussa
Society for Women and AIDS in Africa
swaaniger@yahoo.fr
B.P. 13 406 Niamey, Stade General ,
Niamey, Seyni Kontche
Tel: +227 722224, Niger

NIGERIA

Ismaeel Abdulqadir Danesi
Interfaith HIV/AIDS Coalition of Nigeria
4 Jaba Close, Dunukofia Street,
Area 11, Garki, Abuja, Nigeria
P O Box 3801, Garki, Abuja
FCT, Abuja, Nigeria
Tel : 08055608856
Maeel2001@yahoo.com

Dr. Durosinmi Lateefat Moyosore
Federation of Muslim Women
Association of Nigeria
lateefahdurosinmi@yahoo.com
Department of Chemistry, Obafemi
Awolowo
University, Ile-Ife, Orange free stste,
Tel: +234 0967214319
Nigeria

Sulaiman Hajarat
Women Ummah Support Group
wummahgroupng@yahoo.com
P. O. Box 7783, Wuse, FCT Abuja
Tel: +23495230796
Nigeria

Muhammad Ibrahim Adama
FOMWAN
adamamibrahim@yahoo.com
C/O kassim Ibrahim,
College of Education,
Maidugiri, Borno State,
Nigeria

Dr. Abdul Muhammad Adogie
Islamic Medical Association of Nigeria
maabdul90@yahoo.com
P. O. Box 1045 Zaria, RH Unit,
Dept. of Obstetrics and Gynaecology,
A. B. U. Teaching Hoapital, Zaria
Nigeria

Orire Abdulkadir
Jama'at Nasril Islam
jni@yahoo.com
41 Ali Akilu Road, Kaduna
Nigeria

Sani Rakiya
Women Ummah Support group
rakiyasaani@yahoo.com
National Mosque, Central Area, Abuja
Tel: 8032104440
Nigeria

Ahmad Abdur Rahman
ACTIONAID
Lagos
Nigeria

Hajo Mohamed Sani
Society of Family Health
hsani@sfhnkgeria.org
hajosani@yahoo.co.uk
P. O. Box 5116, Wuse-Abuja,
No. 9 Port Harcourt Crescent
Off Gimbiya Street, Area 11, Garki
Tel: 234-8033114244
Nigeria

PAKISTAN

Hameed ul Mehdi
Humanitarian organization providing
effective services, HOPES
Hussain Ali, Abdul Ali & company,
Sherah-e-IQBAL,
Qandahari Bazaar, 87300
Quetta, Pakistan
Tel : +92-3003814571
lionhu2m@gmail.com

Prof. Malik Babikir Badri
International Islamic University
malik1932@yahoo.com
Faculty of Social Sciences,
International University, Islamabad
+923 065331657
Pakistan

PHILLIPINES

Abdulbasit R. Benito
Bangsamoro Center for JustPeace in the Phil's. Inc. (BCJP)
Int. C 5, Don E. Sero Street, Rosary Heights IV
Cotabato City
Philippines
Tel : 063 064 390 2726
bob.bc.justpeace@gmail.com
centerforjustpeace@yahoo.com

RWANDA

Byukusenge Abdoul
Initiative Devt
onabdul@gmail.com
P. O. Box 4450, Kigali
Tel: +250501630; +2508512700
Rwanda

SAUDI ARABIA

Mohamed Hameduddin
Islamic Development Bank
P. O. Box 5925
Jeddah 21432
Saudi Arabia
Tel; +966503678218
mhamedud@isdb.org

SOMALILAND

Anwar Abdirahman Warsame
Shana HIV/AIDS Network
anwarwarsame@yahoo.co.uk
Hergeisa , Somaliland
Tel :+2522514432
Somaliland

SOUTH AFRICA

Dhansay Khursheed Bibi
48 Sandown Road
Rondebosch
7700
Cape Town
South Africa
Tel: 27 82 9737379
absa@iafrica.com

SUDAN

El Elmobasher Abu Bakar Abd Farag
Sudan National AIDS programme
mobash18@hotmail.com
Khatoum
Dr. +249912280709
Sudan

Dr. Mohammed Saeed Alkhalifa Hag
Sudanese Islamic Medical Association
afmo20@hotmail.com
sudanese_m_a@yahoo.com
P. O. Box 1937, Khartoum
Sudan

TANZANIA

Abdulla Talib Abdulla
Wakf And Trust Commission & Zanzbar
Supreme Council Of Ulamaa
Fuoni Kijito Upele 2776
P. O. Box 3027
Zanzibar
Tanzania
Tel: +255 777 474792
atalibu@yahoo.com

Dr. Amur Amur Abdallah
Tanzania Muslim Hajj Trust
amurmails@yahoo.co.uk
Mindu Street 563, Upanga ,
P. O. Box 65032, Dar Es Salaam
Tel : +255717936432
Tanzania

Ms. Nuru R.Mbarouk
Zanzibar Aids Commission
Shanghani Street
Kelele Square
P. O. Box 2820
Zanzibar, Tanzania
Tel: +255 0777 875 006
nururam@hotmail.com

Mzee Aisha Aboud
Zanzibar NGO Cluster
ashaaboud@msn.com
P. O. Box 4738 Zanzibar
Tel: +255 25 2230195
Tanzania

TCHAD

Adam Abakar Kayaye
Association Jeunesse Anti Clivage
Bp 11, Mao, Tchad
Tel: +235 623 57 32
kayaye76@yahoo.fr

THAILAND

Simone Charnley
Asian Muslim Action Network (AMAN)
74 Pradipat Road Soi 25
Mansion Sarasinee, Room 813
10400 Phayatahi, Bangkok
Thailand
Tel: +66 8467509 84
simone.charnley@arf-asia.org
Thailand

UGANDA

Dr. Akol Okure Zainab
Ministry of Health
akolzainabdr@yahoo.co.uk
P. O. box 7272, Kampala
Tel: +256 77 251008
Uganda

Dr. Karama Said Ali
Islamic Medical Association of Uganda
P. O. Box 2773, Kampala
Tel : +256 71 2251443
Uganda
skarama@imau-uganda.org
sakarama48@hotmail.com

Lubega Aligawesa Agiri
Mbarara Regional Referral Hospital
aglubega@yahoo.co.uk
P. O. Box 40, Mbarara
Tel : +256 77 2682923
Uganda

Sheikh Lubowa Ali Ali
Islamic Medical Association of Uganda
P. O. Box 2773, Kampala
Uganda
luub2006@yahoo.co.uk

Dr. Mayanja Magid Kagimu
Islamic Medical Association of Uganda
P. O. Box 2773, Kampala
Tel : +256 78 2016868
Uganda
mmkagimu@utlonline.co.ug
imau@utlonline.co.ug

Sheikh Mbago Abdul Maged Ramadhan
Islamic University in Uganda
P.O.Box 2773, Kampala
Tel : +256 77 2643672
Uganda
mbagomaged2@yahoo.co.uk

Sheikh Mubajje Shaban Ramadhan
Uganda Muslim Supreme Council
Kampala
Uganda
bwalula@hotmail.com

Nakebba Nulu
Uganda Muslim Women Vision
nnakeba@yahoo.com
P. O. Box 7531, Kampala
Tel: +256712880277
Uganda

Nakimwero Hadija
Uganda Muslim Women Vision
hadijakibira@yahoo.co.uk
P. O. Box 1211, Kampala
Tel: +256 77 2444198
Uganda

Sheikh Haruna Sengoba
Union of Muslim Councils for
East , Central and Southern Africa
P. O. Box 5137, Kampala
Tel: +256 772 413703
Uganda
cmu-cmu@yahoo.com

Nambajjwe Mastula
Uganda Muslim Women Vision
mnserugo@yahoo.com
P. O. Box 4216 Kampala
Tel: +256 41 347285
Uganda

Ojwang Juma
Islamic Medical Association of Uganda
12 KM off Bombo Road
P. O. Box 2773
Kampala
Uganda
Tel: 256-772-448117
ojwang71@hotmail.com

Sheikh Waiswa Muhammad Ali
Makerere University Business School Mosque
sheikhwaiswa@yahoo.com
P. O. Box 1337, Kampala
Tel: +25641258658
Uganda

Dr. Walakilra Misango Yusuf
Islamic Medical Association of Uganda
imau@utlonline.co.ug
P. O. Box 2773, Kampala
Tel: +256 77 2646776
Uganda

UNITED KINGDOM

Yousra Bagadi
Camden PCT & Holy Cross Centre Trust
6 Westbourne Crescent
London W2 3DB
United Kingdom
Tel: 02075303372
Tel: 07905431763
bagadiyousra@hotmail.com

Sukainah Jauhar
Directorate of Public Health
Lambeth Primary Care Trust
1 Lower Marsh
London SE1 7NT
United Kingdom
Tel: 020 7 716 7128
sukainah.jauhar@lambethpct.nhs.uk

Dr. Iyabode Munirat Ayoka Ogunlayi
Freelance consultant
26 Harrison Road Worthing. BN14 8LN
West Sussex United Kingdom
+447922218823 / +441903531691
iamogunlayi@hotmail.com

UNITED STATES OF AMERICA

Imam Abdur-Rashid Talib W.
The African - African American Muslim Commission
ImamTalib@aol.com
130 W. 113th Street, New York,
N.Y. 10026-3420
Tel: +212 662 4100
USA

Janice Alene Hogle
Senior Social Scientist
jh4cm@meadowrocks.com
5 Coyote Court , Madison,
Wisconsin, WI 53717
Tel: +6088313475
USA

Jim Cairns
World Conference of Religions and Peace
jcairns@wcrp.org
777 United nations Plaza, New York
USA

Jay Gribble
Constella Futures
USA

ZAMBIA

Sheikh Ali Banda
ZINGO/ZANERELA +
sheikhalibanda@yahoo.com
Plot 397A/45, Chipwenupwenu Street,
Makeni , P.O Box 34370, Lusaka
Tel: +260955844117 or 260977844117
Zambia

PARTICIPATING COUNTRIES:

1. Afghanistan
2. Algeria
3. Bangladesh
4. Egypt
5. Ethiopia
6. Ghana
7. India
8. Indonesia
9. Iran
10. Kenya
11. Malawi
12. Myanmar
13. Namibia
14. Niger
15. Nigeria
16. Pakistan
17. Philipines
18. Rwanda
19. Somaliland
20. South Africa
21. Saudi Arabia
22. Sudan
23. Tanzania
24. TChad
25. Thailand
26. Uganda
27. United Kindgom
28. United States of America
29. Zambia