



# FIMA Year Book 2007

FEDERATION OF ISLAMIC MEDICAL  
ASSOCIATIONS

الاتحاد العالمي للجمعيات الطبية الإسلامية

## **HIV/AIDS:**

Scientific, Ethical, and Islamic Dimensions.

## **Publisher:**

Jordan Society For Islamic Medical Sciences

In Collaboration With

Federation Of Islamic Medical Associations (FIMA)



# **FIMA**

## **Year Book 2007**

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متلازمة العوز المناعي المكتسب: الأبعاد العلمية والأخلاقية والإسلامية

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# Editorial

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Dear FIMA Members

Assalamu Alaykum

Bismillah al-Rahman al-Rahim

Praise be to Allah the most Merciful, the most Beneficent. May Allah shower His blessings and peace upon His Prophet Muhammad (PBUH).

I begin by thanking FIMA Executive Committee for honoring me with the responsibility to be the Editor-in-Chief again for the FIMA yearbook. I thank Allah (SWT) for giving me this opportunity and enabling me to accomplish this task. I pray to Allah (SWT) to accept this effort in His way and to reward all who participated in this endeavor.

I like to start this editorial by remembering with great sadness the loss past year of the late professor Muhammad Azhar Ali Khan (may Allah have mercy on him). Prof. Khan was the one who convinced me to accept the editorship of FIMA yearbook. He was a pioneer of the Islamic Medical Association of North America (IMANA)<sup>1</sup>. He was a devout Muslim who had worked hard to help improve healthcare of the Muslim community both in USA and abroad. Dr Khan was a close friend. I miss him, as many FIMA members who came to know him well. May Allah bless his soul, forgive his sins and admit him to His Paradise.

The Human Immunodeficiency Virus (HIV) infection that causes Acquired Immunodeficiency Syndrome (AIDS) is one of the worst pandemics affecting humans. It is estimated that 65 million individuals have succumbed to HIV infections, and 23 million have died. In 2006, there were 39.5 million “people living with HIV/AIDS” (PLWA). About 43 million individuals were newly infected that year and 2.9 million died from AIDS.<sup>2</sup>

Because the main methods of spreading HIV are homosexuality, promiscuous heterosexual sex, and intravenous drug use which are strictly forbidden in Islam, it has been assumed for a long time that HIV/AIDS does not exist in majority Muslim countries and this problem was ignored. However, it has become clear that in non majority Muslim countries e.g. South Africa, Malaysia, Uganda, HIV/AIDS is affecting Muslims as well as non Muslims and the disease has also appeared in majority Muslim countries. Thus all

Muslim countries have recognized the seriousness of the problem and have been trying to address it. This is why FIMA's Executive Committee decided that the theme of its annual conference in Istanbul (July, 2007) would be the various aspects of HIV/AIDS and hence this FIMA Year book.

In this yearbook, we are publishing papers presented at this conference by distinguished scholars with special expertise in HIV/AIDS from various parts of the Islamic world. Discussed is a wide range of aspects including epidemiology, prevention, treatment, spiritual aspects, Shariah guidelines, nature of responsibility, and effects on the family structure and the society, all stressing the Islamic perspective. Particularly stressed are the Islamic guidelines of prevention, the humane care of the patients, and the care of the orphans resulting from AIDS related death of their parents. We also include a description of actual programs initiated and managed by Islamic Medical Associations (IMAs) for the prevention and care of HIV/AIDS patients in four countries, Uganda, South Africa, Jordan and Malaysia.

Dr. Abdul Fadl Ebrahim describes how Islam deals with sex as a natural instinct that does not need to be suppressed but at the same time needs to be strictly controlled through the institution of marriage. He details practical guidelines for upholding sexual morality. Further, he discusses some Islamic rulings regarding intentional transmission of HIV, contracting HIV/AIDS within matrimony, and interaction with HIV/AIDS patients. He also discusses certain aspects of the law that pertains to the rights of HIV/AIDS patients in South Africa.

Dr. Ilkilic addresses a very interesting topic, the notion of individual responsibility. He presents a useful classification of illnesses based on the level of responsibility of the individual. There are illnesses (hereditary/genetic disease) for which an individual has no responsibility at all, some that the individual has a limited responsibility, for example, over exposure to the sun causing skin cancer, and those illnesses where the individual bears full responsibility as his/her behavior is primarily responsible for the illness such as liver cirrhosis caused by alcoholism, lung cancer caused by smoking, and HIV/AIDS caused by illicit sex or drug use. Dr. Ilkilic then discusses a controversial question that is whether AIDS is a Divine punishment or not. He argues that it is not. Others believe that it is. However from a practical viewpoint, both sides to this issue are in full agreement that this should not have any effect on how we care for AIDS patients. We should provide them with full medical care. We should support them on a social level. We should not discriminate against them. Dr. Ebrahim adds a point that we are responsible for offering counsel to these patients that includes instilling Islamic ethics in them such as the hope of the mercy of Allah and encouraging them to find inner peace through sincere repentance. Although the issue of the responsibility of the society

as a whole has not been addressed directly, it should be noted that when the moral and behavioral standards of the society deteriorate significantly so that promiscuous behavior becomes acceptable, encouraging more people to be involved in such behavior, epidemics will spread and new epidemics will appear. This has been reported in a Hadith "Wherever exorbitant fornication takes place in a people with shameless publicity Allah will bring down on them plagues and ailments that did not exist in their previous ancestors".

Drs. Askoy and Bedir discuss whether the unborn baby has rights as a person and trace the answer to this question by ancient Roman philosophers, by theologians from the Jewish and Christian tradition and finally by Islam. While the beginning of human life (personhood) is not described in the Old and New Testaments, fetal development and ensoulment has been referred to in several verses of the Glorious Qur'an. The timing of ensoulment has been referred to in Prophet Mohammad's (PBUH) ahadith. Different Muslim scholars have interpreted these ahadith as indicating ensoulment to occur either 40 or 120 days after conception. The authors argue that it occurs around day 50 and at that time the fetus is a full human person and thus acquires rights, such as the right to life, right to breast feeding, and right to be hugged among others. Because AIDS is a potentially lethal disease and the probability of the fetus of an HIV/AIDS woman getting infected then that fetus is deprived of the right to life. Therefore, they opine that intentional pregnancy of a HIV/AIDS wife/husband is a sin that requires "diyyah" (as in killing of an adult.) On the other hand, in the case of unintentional pregnancy of HIV/AIDS woman, the authors recommend termination of pregnancy (TOP) before day 50 and paying "al-ghurra" after the 50th day. Every attempt should be made to prevent the transmission to the fetus by proper medical treatment.

The infant will be also deprived of the right to breast feeding as this is a known route for HIV transmission and is advised against by all professional medical organizations. The infant/child will also be deprived of the right to be hugged as these behaviors (kissing etc) are potential threats of HIV infection transmission. The infant/ child will also be deprived of the right to proper parenting because of the mother's ill health and the probability of her or the father's premature death.

Dr. Mishal addresses a very significant topic i.e. Jurisprudence rulings as related to HIV/AIDS. He stressed the Islamic concept of care for and support of all individuals in the society including PLWAs despite disapproval of their life styles which caused them to acquire the infection. The Shariah rulings promote healthy life styles and laid down boundaries that safeguard humankind from destructive behaviors that led to the spread of STDs and more recently the AIDS pandemic.

Dr. Mishal outlines in his article the policies that were approved by the HIV/AIDS joint medical-jurisprudence workshop organized by the Islamic Organization of Medical Sciences (IOMS) in December 1993. These are all valid policies that need to be implemented. Dr. Mishal discusses isolation of PLWAs as a method to consider. I do not think that is necessary because the spread of infection is not airborne or by casual contact. Intimate (sexual) contact is needed. It will be important to screen all individuals that can transmit the infection for example prior to marriage and pregnant women then offer the proper counseling and treatment. While this is not foolproof because many of the offenders (e.g. drug addicts or homosexuals) may not be willing to identify themselves as such but the same applies to the concept of isolation. In any case, it is an interesting concept and needs further study.

Dr. Mishal discusses in detail the rulings related to family life including the right for separation and divorce, the rulings related to an infected pregnant woman, when an abortion is permissible, and the recommendation to not breast feed.

It is to be noted that while Drs. Askoy and Bekir strongly recommend TOP for infected pregnant women (before 50th day of conception), Dr. Mishal does not advocate TOP for that indication. This discussion has to be reconsidered in the light of the fact that the rate of vertical transmission to the fetus has been significantly reduced from the alarming 30% initially to the 2% now with current management.

Dr. Mishal also discusses the Shariah rulings in regards to transmission of HIV/AIDS to others and whether it is intentional, nonintentional, or just due to negligence, and the judgment in each case. A subject discussed also by Dr. Askoy and Bekir and Dr. Ebrahim.

Dr. Ozaras discusses the management of HIV infection with special emphasis on the newer antiretrovirals (ARVs) and the newer regimens as well as the diagnosis and treatment of opportunistic infections. He stresses the importance of early diagnosis and describes the follow up. Dr. Bakir discusses the prevention and treatment of pediatric HIV/AIDS. Identification of infected pregnant women is a necessary first step. Applying the new treatment protocols and elective delivery by cesarean section were shown to reduce vertical transmission to 2%. Breastfeeding is known to be a source of HIV transmission and is contraindicated in developing countries. However because most HIV infected women live in deprived conditions, they maybe unable to use safe breast milk substitutions and therefore breast feeding may be a safer option. Dr. Bakir also stresses the importance of preconception counseling to all women of child bearing age.

Drs. Dangor and Hoosen discuss the high prevalence of both sexually transmitted disease (STDs) and HIV/AIDS in South Africa and the high degree

of association between these two entities. They draw attention to the fact that treatment of STDs needs to be aggressively pursued as part of the attempts to curb the spread of AIDS as these infections (STDs) enhance both the susceptibility of an uninfected person to acquire HIV infection as well as the infectivity of an HIV infected individual. They conclude that the treatment of STDs, as HIV prevention strategy, is one of the most effective healthcare interventions available in Sub-Saharan Africa, and South Africa at this time.

Dr. Razali in his article points out the "feminization" of the AIDS pandemic as the infection rate of women are now double that of men. This trend increases the yearly number of infected children estimated to be 630,000 globally. About 2.1 million children will be living with infected and affected parents. Millions of children have already lost their parents. Currently it is estimated that there are 15 million AIDS orphans with an expected increase to 25 million by 2010. To reduce this tragedy efforts should be directed not only to primary prevention by living according to Islamic principles but also to secondary prevention by adequate treatment of affected parents and tertiary prevention by strategies to decrease vertical transmission from mother to fetuses/infants. Dr. Razali reminds us of the importance of taking care of the sick and needy PLWAs and avoiding stigmatization and discriminating against them as guiding Islamic principles.

The feminization of AIDS pandemic is not only evident in Malaysia as described by Dr. Razali but also in Sub-Saharan Africa and South Africa as stated by Dr. Hoosen and his co-authors. They ascribe this increase to the fact that women do not have control of their partners' sexual behavior. They cannot enforce condom use and are more prone to acquire STDs which remain asymptomatic. Further, women have less access to treatment and because of their lower social status, women have to have multiple sexual partners to provide economic and social security. Dr. Hoosen and his colleagues report on the use of vaginal microbicides as an important tool in decreasing the incidence of female infection because women will have control of their use. They discuss possible mechanisms of action of these medications. They report on five microbicides already in late stage clinical trials to assess their effectiveness.

Dr. Samasti discusses how Islam prescribes the means to fight the spread of communicable disease in general and more specifically the spread of HIV/AIDS.

Dr. Tasci espouses sexual education as an important tool in the fight against the spread of HIV/AIDS. He characterizes the different approaches of sex education based on the Islamic principles. He stresses the importance of the moral aspects of sexuality in any program of sexual education. He emphasizes the negative role of the media.

Different national Islamic Medical Associations (IMAs) have developed programs to minimize the spread of AIDS and to promote adequate care of patients and their families. In this issue we publish four articles describing these programs.

The program in South Africa as reported by Drs. Mohammed and Nawab has been established in 1998 as a collaborative effort between the IMA of SA (IMASA), Jamatul Ulama, and Islamic Careline and is called the Muslim AIDS Program (MAP). It promotes (A) Abstinence, (B) being faithful, and (C) commitment, compassion and circumcision. It conducts workshops, a life skills program, volunteer program, home based care, counseling and community awareness. In addition, it is running two orphans' and vulnerable childrens' programs. It also established a MAP care center in 2003 that provides various services to PLWA(s).

The Islamic Medical Association of Uganda (IMAU) has used an Islamic Approach to HIV/AIDS (IAA) for over 18 years. The operational definition of this approach was consolidated during the 3rd International Muslim Leaders Consultation on HIV/AIDS (IMLC) conference in Addis Ababa, Ethiopia in 2007.

It has five components: 1) Believing in Allah and Prophet Muhammad (PBUH). 2) Acquiring scientific knowledge about HIV/AIDS. 3) Making use of relevant Islamic teachings and practices. 4) Forming partnerships with and making use of religious leaders and their administrative structures. 5) Making use of the concept of Jihad al-nafs.

Dr. Kagimu, the Chairman of IMAU and the spearhead of the effort describes the implementation of the program, its strengths and weaknesses. He describes setting goals, the objectives, and activities of the program and how they are monitored in a detailed structured way.

Drs. Al-Qudah and Mishal from Jordan cite the report by the World Health Organization – Eastern Mediterranean Region (WHO-EMRO) of the number of PLWA(s) in this region to be 670,000. This gives a prevalence of 0.1% in adults which is much less than the global prevalence rate estimated to be 1/150. This is generally attributed to the adherence of the majority of Muslims living in this region to Islamic values. However, they reported that a significant proportion of our population (in Muslim countries) especially the youth are engaged in lifestyles and activities that ultimately will lead them to contract such infections. The authors designed a strategy of prevention that is based on moral, spiritual, and education models and was implemented in 2006. The main goal of this program is to raise the public awareness and to train local community workers/leaders. In addition to the workshops conducted in Jordan, they offered similar workshops in other Arab countries. The authors report the achievements of this program and the efforts to spread the program activities

in other Islamic countries.

The IMA of Malaysia established a half way house for women and children living with HIV/AIDS. It is called Rumah Solehah (RS).

Dr. Nordin describes in his article the establishment of this facility in July 1998 and its operation since then. More than 100 women and 50 children graduated from RS. Currently, it houses 22 children (3 months to 9 years old) and 8 women. It is supported by local donations and has received outside grants. It received a special mention Award in 2004 for excellence in care at the grass roots level.

These four examples show the great roles the IMA(s) are playing in the effort to control the spread of HIV/AIDS. I hope that our members and readers will appreciate the magnitude of the problem of HIV/AIDS pandemic especially as it relates to Muslim countries. They will appreciate the role Islam can play in the prevention of spread of this lethal infection and the role Islam can play in providing compassionate care and in reducing the human toll of the disease. Hopefully, the readers will appreciate the role the different IMAs are playing in this effort.

Readers may or may not agree with all the opinions expressed but hopefully they will be able to discuss these and make up their own minds.

Finally, I want to thank the authors who contributed to this issue, Drs. Mishal and Ebrahim of the editorial board for their help and guidance. My special thanks go to Dr. Hakan Ertin, the guest editorial board member for this issue of FIMA Year Book. Dr. Ertin was the convener of the last FIMA/HAYAT International Scientific Convention held in Istanbul-Turkey on July 13-15, 2007, with its Theme: HIV/AIDS- Scientific, Ethical and Islamic Dimensions. Dr. Ertin was instrumental in collecting the manuscripts by the authors from Turkey, and actively participated in their editing.

I sincerely appreciate the work of Dr. Mishal's staff for copy editing, and proofreading of the articles, especially Miss Elham Mohammad Swaid.

I pray that Allah (SWT) accept and bless our efforts in His service. May Allah (SWT) guide us to the right path and have mercy on us.

Wassalam

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# In Memoriam

## Professor Muhammad Azhar Ali Khan:

### Dedication to FIMA Is Key to Association's Accomplishments

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Professor Muhammad Azhar Ali Khan served FIMA ( Federation of Islamic Medical Associations ) with passion and dedication since its inception in 1981. He held the following positions while on the executive committee:

- 1983: secretary-treasurer
- 1985: reelected to secretary-treasurer
- 1987-1995: executive member
- 1997: president
- 1999: reelected president
- 2001-2007: executive director

Professor Khan either established or initiated the following projects, now central to the function of FIMA:

1. FIMA Accreditation Council for Certification of Continuing Medical Education (ACCCME), which was established to enrich, organize, and standardize continuing medical education programs of various Islamic medical associations and hospitals to ensure that the conventions and scientific meetings of these associations meet a minimum standard as forums for high-quality education.
2. FIMA Health Policy, which coordinates the principles and policies of health practices in countries where there are IMA memberships.
3. FIMA Special Consultation Status on the United Nations Committee of Non-Governmental Organizations (NGOs)/Department of Economic and Social Affairs.
4. FIMA Consortium of Islamic Medical Colleges (CIMCO), which has goals and objectives as follow:
  - Incorporating Islam into the existing medical education system in member institutions to prepare Muslim health professionals; and
  - Promoting health-related research to serve humanity in the light of Qur'an

and Sunnah; and

- Fostering collaboration in the field of Islamic medical education, training, and health service.

Professor Khan's work was exemplary and served as an inspiration to all. He demanded service and excellence and encouraged those he encountered to meet these objectives.

He continuously emphasized the value of effective communication, which is critical to the successful functioning of an organization, as is evident by him simply acknowledging receipt of an email. He recognized the value of cyber communication and especially the effective use of the FIMA website as a communication tool to facilitate discussion between the members and distribute critical information about the FIMA projects and other functions of the association.

He served as a mentor and role model to many of us in FIMA with his quiet, unassuming manner, yet large presence.

I leave you with his final words before his departure to Madinah and Makkah exemplifying the man's humility:

I will pray in Haram (the sanctuary in Makkah) and (give) thanks to Allah, the things we did together for the benefit of mankind. Our mission will continue and we will continue to seek His Rahma.

***Submitted by***

*Musa bin Mohammad Nordin, FRCP, FAMM  
President, FIMA*

*(Taken with permission from JIMA, volume 39, 2007).*

# Federation Of Islamic Medical Associations (FIMA) in Brief

---

- Established at the outset of the 15th Hijrah century, December 1981, in Orlando, Florida, USA, where senior leading medical figures representing ten Islamic medical organizations, from various parts of the world, convened and laid down the foundation of the Federation.
- Subsequently FIMA was incorporated in the State of Illinois as a non-profit organization, then acquired the special consultative status with the United Nations Economic and Social Council ( ECOSOC ).
- Since that time, FIMA membership progressively expanded to include 25 full members, 6 associate members, and more than 15 prospective and collaborating organizations from all over the world.
- Most FIMA activities and achievements are based on the endeavors of its member Islamic Medical Associations, in constructive mutual cooperation, and harmonious understanding.
- These activities include, but are not limited to:
  1. Cooperation in medical relief work, where and when needed in disaster stricken countries. The last endeavor was the “ Save Vision Campaign in Africa ”, where more than 14,000 cataract and intra-ocular lens surgeries were performed in Darfur-Sudan, Chad, Somalia, Senegal, Niger and Nigeria, by ophthalmology teams volunteering from IMAs from several countries.
  2. Scientific, professional and ethical jurisprudence related conferences, seminars and publications.
  3. Establishment of the Consortium of Islamic Medical Colleges (CIMCO), to foster cooperation in improvement of curriculum, training, research, administration, and up-bringing of model medical practitioners.
  4. Establishment of the Islamic Hospitals Consortium ( IHC ), to pursue cooperation and coordination among medical professionals and hospital administrators in areas of experience exchange, improvement of health care delivery, ethical, administrative and operational activities, to meet the most advanced international standards, in the context of Islamic principles.
  5. Publication of FIMA Year Books, which address biomedical ethical

issues that are needed for medical practitioners, educators as well as Jurists.

6. Medical students activities, including conferences, seminars, publications, camps, Umrah and Ziarah programs.
  7. Collaboration to extend a helping hand to Muslim medical practitioners in underprivileged countries, to work together and organize professional medical societies.
  8. CME programs, and establishment of a Council of highly qualified professionals for development, improvement and supervision of these activities.
  9. Recently, FIMA embarked on establishment of Resource Centers, such as the HIV/AIDS Resource Center, Islamic Biomedical Ethics Resource Center, and in the planning, is the Women's Affairs Resource Center.
- Islamic medical activities of FIMA have a holistic nature. Leadership, mutual cooperation and innovation are prerequisites for the welfare of our communities, our Ummah and humanity at large.
- .....

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# Islam and HIV/AIDS

*Abul Fadl Mohsin Ebrahim*

## Abstract

The HIV/AIDS pandemic threatens the very survival of the human race. What a tragedy that the vast majority of people who are actively involved in the mammoth fight against HIV/AIDS overlook the fact that HIV/AIDS is also an ethical and moral problem. It is an undoubted reality that the main avenue for the spread of HIV/AIDS is through secretions of the sexual organs and yet it is a pity that the focus of attention for combating the spread of HIV/AIDS is not on sexual activity and its regulation thereof. This article addresses some of the rights of HIV-positive patients in South Africa and how Islam proposes to curtail sexual promiscuity in society. It also touches upon the interaction of Muslims to HIV-positive patients.

**Key words:** *HIV/AIDS, rights, obligations, sexual morality, interaction.*

## Introduction

Humankind has made tremendous strides towards enhancing the quality of life, yet we are faced with some serious challenges which threaten our very existence on this planet. Some of these challenges are the resurgence of malaria and the deadly Ebola fever on the African continent and the greatest scourge of all is the escalation of human immunodeficiency virus (HIV) leading to acquired immunodeficiency syndrome (AIDS). It is alarming to note that since the first cases of AIDS were reported in 1981, infection with HIV has assumed pandemic proportions, resulting in 65 million people across the world succumbing to HIV infections, 25 million of whom have since died. In 2006, 39.5 million people were living with HIV, of whom 4.3 million persons became newly infected with HIV. By the end of 2006, 2.9 million people died from AIDS.<sup>1</sup> The status of HIV in South Africa is alarming:<sup>2</sup>

- The most current estimate is that 5.5 million people are living with HIV, which represents about 12 percent of the population.
- One in four people age 15 to 49 years is infected with HIV.
- Over 1,700 AIDS related deaths each day.
- Currently it is estimated that there are 600,000 orphaned children as a result of AIDS.

---

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Villages, towns and countries are fast being deprived of their most valuable asset - their human population. In order to make humanity aware of the gravity of the problem of HIV/AIDS, the United Nations (UN) declared December 1 of every year as World AIDS Day.

The rapid spread of HIV/AIDS and the accompanying fear of its impact on health care resources, man-power in industry and on the family have compelled the world to seriously consider ways and means by which this scourge could be combated. While one has to admit that millions of dollars have already been spent in every nook and corner of the globe with the aim of educating and encouraging people to implement preventative measures to safeguard themselves against contracting HIV/AIDS, it is unfortunate that the more intensified the efforts, the more HIV/AIDS seems to spread.

In various parts of the world, people who have been diagnosed HIV positive have suffered discrimination in one form or another, denied fair treatment and due to the high cost of antiretroviral drugs, many third world countries have not been able to supply their ailing population with these drugs. These realities have prompted many countries to come up with policies to safeguard the rights of HIV positive patients. Some of the rights of HIV-positive patients in South Africa are hereunder discussed.

#### **Right to Health Care and Medical Treatment**

According to the Universal Declaration of Human Rights, "Everyone has the right to a standard of living adequate

for the health and well-being of himself and of his family, including ... medical care and necessary social services.<sup>3</sup> It is important to note here that while the South African Constitution gives every person the right to access health care services, sufficient food and water and emergency medical treatment,<sup>4</sup> the South African National Department of Health's National Policy on Testing for HIV stipulates that a person must give informed consent before being tested for HIV. This implies "that the individual understands what the test is, why it is necessary and the benefits, risks, alternatives and possible social implications of the outcome."<sup>5</sup> In the event that someone has been tested and treated without his/her consent, he/she can:<sup>6</sup>

- (a) Complain to the Health Professions Council of South Africa (HPCSA).
- (b) Sue the health care worker for invasion of privacy
- (c) Lay a criminal charge of assault against the health care worker.

However, health care workers do not have to seek consent in the following circumstances:<sup>7</sup>

- (a) If the patient needs emergency medical treatment.
- (b) If blood has been donated.
- (c) If the patient is mentally ill (consent must be obtained from a next of kin).
- (d) If the (anonymous) blood sample is being used for health research (e.g. the antenatal studies).

## Right to Privacy

In South Africa, every person has a right to privacy and it is important to note that HIV/AIDS is not a notifiable disease.<sup>8</sup> Thus it follows that HIV-positive people cannot be forced to disclose their HIV status to anyone, except in rare instances. Health Professionals Council of South Africa (HPCSA) has recommended that health care workers should not disclose the HIV status of an individual to third parties (including family, sexual partners and employers) unless the patient has provided informed consent (i.e. know the consequences of their status being disclosed). However, the UN, World Health Organization (WHO) and Health Professionals Council of South Africa (HPCSA) have initiated certain guidelines which do make provision for “disclosure without consent” especially when patients refuse to tell their partners that they are HIV-infected and there is a real risk of infecting their sexual partners.<sup>9</sup>

It is to be noted that although there is no law at present in South Africa forcing people to disclose their HIV status to their partners, the Draft Sexual Offences Bill makes the intentional non-disclosure of HIV/AIDS by a person to their sexual partner a criminal offence.<sup>10</sup> Hence, a person who infects his/her sexual partner with HIV while knowing his/her HIV status could be charged with murder, attempted murder or assault under South African law. It is interesting to note that in Finland, despite the absence of specific legislation

on transmission of HIV infection to an unsuspecting partner, a Finnish court sentenced an HIV-positive man to 14 years’ imprisonment for having had sexual relations with over 100 women and failed to disclose his infected status to them.<sup>11</sup>

## Rights in the workplace<sup>12</sup>

In South Africa, various laws have been enacted in order to protect individuals, including HIV-positive individuals, from discrimination in the workplace. They are as follows:

### 10.4.1 The South African Constitution.

The Bill of Rights states that:

- Everyone has the right to fair labour practices.<sup>13</sup>
- Everyone is equal before the law and has the right to equal protection and benefit of the law.<sup>14</sup>

## The Labour Relations Amendment Act 12 of 2002

The Labour Relations Act safeguards employees from being discriminated against because of a disability (which includes HIV/ AIDS).<sup>15</sup>

## The Employment Equity Act 55 of 1998

The Employment Equity Act specifically prohibits unfair discrimination of people at work on the grounds of their HIV status.<sup>16</sup> Moreover, it also prohibits employers from testing their employees for HIV / AIDS, unless permission is granted by the Labour Court.<sup>17</sup>

The Occupational Health and Safety Act and Mine Health and Safety Amendment Act 85 of 1993.<sup>18</sup>

According to these Acts, employers are responsible to ensure that their employees are not at risk of HIV-infection at work. Moreover, employers are required to provide rubber gloves and train staff to use universal precautions when dealing with blood.

#### **Compensation for Occupational Injuries and Diseases Act 30 of 1993**

This Act is meant to ensure that employees have a right to compensation if they get infected with HIV in a workplace accident.

#### **10.4.6. Medical Schemes Amendment Act 131 of 1998 and Regulations**

The Medical Schemes Amendment Act of 1998 prohibits discrimination based on “state of health”. People with HIV/AIDS are entitled to reasonable care with “minimum level benefits” including the treatment of opportunistic infections. However, this Act does not require medical schemes to provide antiretroviral (ART) drugs to HIV-positive patients.

#### **Life Cover for HIV Patients**

In South Africa, until recently, life insurance companies excluded HIV-positive individuals from life policies. While acknowledging the fact that during the past few years (before 2006) insurance cover for HIV-positive people had been limited to R 100,000 and the premiums had been relatively high. In November 2006, AllLife launched a new product which offers cover up to R 3million and specific cover for certain AIDS-related disabling conditions. This

in effect means that HIV-infected clients would be regarded in a similar way to others who are living with other chronic medical conditions. This development may, in due course, lead to most banks in South Africa rescinding their policy of discriminating against people living with HIV/AIDS by excluding them from home loans.<sup>20</sup>

#### **Rights of HIV-Positive Prisoners**

Prisoners in general cannot be tested for HIV without their consent and those who are HIV positive have right to adequate health care, including access to antiretroviral treatment.<sup>21</sup>

#### **Rights of Victims of Sexual Assault**

During sexual assault the possibility exists of the transmission of HIV/AIDS to the victim. Thus in South Africa, a victim of rape can apply for the person who raped her not to be granted bail on the basis of having allegedly committed the crime while being aware of the fact that he had the acquired immune deficiency syndrome or the human immunodeficiency virus. This will be in accordance with Criminal Procedure Second Amendment Act 62 of 2001.<sup>22</sup>

In the United States of America, crime victim-related HIV laws require the testing of alleged and convicted sex offenders for HIV/AIDS, and the results of the offenders’ tests are disclosed to their victims. Moreover, some states even have laws that enforce both pre-conviction and post-conviction HIV/AIDS testing for sexual offenders.<sup>23</sup>



## Islamic Teachings vis-à-vis Sexual Morality

Globally, HIV/AIDS is perceived primarily as a health problem and nothing more than that. Consequently, the measures that are being propounded in order to curb the spread of HIV are inherently defective. The message that is being propounded worldwide is what came to be encapsulated in ABC. A stands for abstinence (from sex); B for be faithful (i.e. to stick to one sexual partner); and C for making use of condom when engaging in illicit sex. In other words, what is being advocated is that if one cannot abstain from sex and cannot stick to one sexual partner then one should engage in safe sex by making use of condoms for that would arrest the spread of HIV and protect people from contracting the virus. This message has only succeeded in licensing unrestricted sexual activity which has inadvertently promoted sexual promiscuity.

In the annals of history, there have been and still are two contending extreme views with regard to sex:

- (a) The restriction of sex to the satisfaction of the carnal desires.
- (b) Suppression of the sexual instinct and the advocacy of celibacy.

Islam's attitude towards sex may be understood and appreciated only if one makes a sincere effort to study the Glorious *Qur'an* and Ahadith (sing. Hadith) of Prophet Muhammad (PBUH). The Glorious *Qur'an* tells us that all that exists in this universe have been created in pairs as is evident from the following

verse:

*"And of everything We have created in pairs so that you may receive instruction."*<sup>24</sup>

Moreover, the Glorious *Qur'an* confirms that the primary objective for creating everything in pairs is to facilitate each species to procreate its own kind:

*"He has made for you pairs (mates) from among yourselves, and pairs among cattle: By this does He multiply you."*<sup>25</sup>

Islam, therefore, recognizes sex as a natural desire, but cautions that it is the institution of marriage which legitimizes the fulfilment of the sexual desire, which is otherwise forbidden. This is why both the Glorious *Qur'an* and Ahadith exhort Muslims to marry.

The Glorious *Qur'an's* imperative in this regard is:

*"Marry those among you who are single ...."*<sup>26</sup>

Prophet Muhammad's (PBUH) advice to the young Muslims was:

Young men, those among you who can support a wife should marry. For it keeps you from looking (at strange women) and protects you from immorality (i.e., safeguards your chastity).<sup>27</sup>

Interestingly, the Glorious *Qur'an* stipulates with whom marriage is unlawful, thereby safeguarding Muslims from indulging in incest and other sexual crimes. They are as follows:<sup>28</sup>

- (a) Fathers' wives; (b) mothers; (c) daughters; (d) sisters; (e) fathers' sisters; (f)

mothers' sisters; (g) brothers' daughters; (h) foster-mothers (i.e., "who gave you suck"); (i) foster sisters; (j) wives' mothers; (k) step-daughters under their guardianship (i.e. daughters of their wives under a previous marriage; (l) those who have been wives of their sons; (m) two sisters at one and the same time; (o) women who are already married (i.e., already in wedlock with other husbands).

Furthermore, the Glorious *Qur'an* also limits the number of wives that one may have at one and the same time to four.<sup>29</sup> This injunction is vital for it does in reality curb sexual excesses and perversions.

### 1.1.1 Goals of marriage

The goals of marriage based on the teachings of the Glorious *Qur'an* and the Hadith literature may be summarized as follows:

- (a) Procreation of the human species, who may in turn worship Allah.
- (b) Generation of love, comfort and peace between husband and wife.
- (c) Love for offspring. This love should eventually transcend and encompass all creatures so that each and every member of the human race develops a sense of belonging.
- (d) Protection of loneliness. Family helps one to feel a sense of security in that there are other concerned members around to assist one to overcome one's difficulties.
- (e) Entrenchment of responsibility. Family life generates in every person the spirit of working collectively for the betterment of one's family

members. This means that all major decisions are not to be taken in isolation, but in consultation.

### Sexual intimacy

The Qur'anic terminology pertaining to intimacy is characterized by pleasant subtlety that lends dignity to an activity which is forbidden except within the sphere of matrimony between husband and wife. The following verses illustrate this point:

*"Permitted to you, on the night of the fasts, is the approach to your wives. They are your garments and you are their garments."*<sup>30</sup>

*"Your wives are a tilth unto you; so approach your tilth when or how you will ....."*<sup>31</sup>

Instructing Muslims about modesty, Prophet Muhammad (PBUH) states:

Modesty is part of the faith.<sup>32</sup>

Moreover, it is interesting to note that the Glorious *Qur'an* includes chaste people in the category of *al-Mu'minin* (the Believers):

*"Successful indeed are the Believers – those who humble themselves in prayers; who avoid vain talk; who are active in giving zakah (compulsory charity); who guard their chastity except with those joined to them in the marriage bond"*<sup>33</sup>

### Practical guidelines for Upholding Sexual Morality

Some of the Islamic guidelines which could assist Muslims to uphold sexual morality are discussed hereunder:

### Early marriage

Prophet Muhammad (PBUH) while engaged in the process of advising young Muslims told them:

Young men, those of you who can support a wife should marry, for it keeps you from looking at strange women and preserves your chastity, but those of you who cannot marry should fast, for it is a means of cooling the sexual passion.<sup>34</sup>

### Lowering of the gaze

The Glorious Qur'an instructs the believing men and women to lower their gaze and to safeguard their chastity. Shaykh Yusuf al-Qaradawi explains this instruction in the following manner:

What Islam prohibits in the sphere of sex includes looking at a member of the opposite sex with desire; for the eye is the key to the feelings, and the look is the messenger of desire, carrying the message of fornication or adultery.<sup>35</sup>

It is primarily to protect his followers from being tempted to commit adultery or fornication the Prophet Muhammad (PBUH) to Sayyiduna Ali:

Ali, do not let the second look follow the first. The first is allowed, but not the second.<sup>36</sup>

Prophet Muhammad (PBUH) even looking at the member of the opposite sex with lust and desire as tantamount to zina (adultery) of the eyes.

The eyes also commit zina, and its zina is the (lustful) look.<sup>37</sup>

At this juncture, let us consider the Biblical and Qur'anic commandments which pertain to adultery. The injunction of the Old Testament as enumerated in the Ten Commandments is:

"Thou shalt not commit adultery".<sup>38</sup>

and that of the Glorious Qur'an is:

*"Do not come near to adultery. It is a shameful deed, an evil, opening the way to other evils".*<sup>39</sup>

It is evident that the Old Testament only uses the imperative to caution against the actual engagement in the act of adultery, while the Glorious Qur'an warns against coming near to adultery. It is for this reason that the Glorious Qur'an further commands the believing women to cover themselves with a loose outer-garment whenever they go out in public, for this, would protect them from being molested.<sup>40</sup> They are also cautioned not to talk invitingly as this may attract the attention of lustful men,<sup>41</sup> and not to walk in such a manner as to draw men's attention towards them.<sup>42</sup> It must be noted though that these Qur'anic injunctions do not suggest that women on the whole are not to be trusted. Nay, these injunctions are meant to protect them from being victims of rape and other sexual crimes.

In the western world, it is often boasted that women have been liberated for they can dress in any manner they so wish; take up any type of profession and intermingle freely with men. Is this in reality liberation? Those who design women's clothing design them

with the aim of giving the women who wear them maximum sex appeal. In other words, western women are being exploited to dress in such a manner to make themselves sexually appealing to the general public. Moreover, when women go out to earn a living, they become economically independent, causing them to think that there is no real need for them to get married. That is why we find that a substantial number of them are satisfied to be live-in-partners without exchanging any form of marriage vows and without the church's blessing. Their conscience does not bother them that they are living in sin although all religions condemn sex outside marriage. Furthermore, their intermingling freely with men in night clubs does result in many social ills like wife swapping, adultery, fornication, teenage pregnancies, single parents and an increase in divorce cases.

### **The 'awrah**

The [awrah] in legal terms implies the parts of the body that are to remain covered. Exposing such parts would be in contravention of the dictates of the Shari'ah and deemed haram (impermissible). The 'awrah of a Muslim woman is explained by Prophet Muhammad (PBUH) in a Hadith addressed directly to Sayyidatuna Asma', the daughter of Sayyiduna Abu Bakr:

After a girl attains the menstrual age (i.e., puberty) nothing should be seen of her except her face and hands.<sup>43</sup>

Even men are required by the Shari'ah to clad themselves properly. Prophet

Muhammad (PBUH) explained that the men should be covered at least from the navel to the knees.<sup>44</sup> Muslim men are, therefore, not permitted to wear conventional swimming trunks. If they are to participate in swimming activities, they have to ensure that they wear such shorts that would cover the area between the navel and the knees. In other words, there should be no indecent exposures of the bodies of both men and women in public, including the censure of using women as enticement in advertisements to sell goods or products of any sort.

Moreover, Prophet Muhammad (PBUH) cursed the women who try to resemble men and the men who try to resemble women, either in clothing or manners.<sup>45</sup> From this it can be inferred that unisex clothing has no place within the Islamic society. This injunction serves to prevent sexual perversions from creeping into the society.

### **Leisure time to be spent in ibadah (worship), sports and social upliftment work**

There is a saying which states that "idle minds are the devil's workshop." Muslims are therefore exhorted to spend their leisure time offering nawafil (supererogatory) salah (prayers) in order to attain closeness to their Creator. Muslim youth should be encouraged to productively spend their leisure time by participating in sports, social upliftment work, etc.

### **Punishments for sexual offences**

Illicit and same sex relations reflect irresponsibility and are categorized

by the Shari'ah as major crimes. The prescribed punishments, for example, for those who engage in illicit sexual intercourse are of a severe nature<sup>46</sup> and are meant to serve as deterrents. In contrast, in the western world, there is tendency to disguise sexual crimes by referring to them in such a manner to make them appear dignified. For example, adultery is termed as extra marital relationship and a young male and woman (not united in marriage) who are going out together are said to be courting or dating.

#### **Some Issues Pertaining to HIV/AIDS in light of Islamic Medical Jurisprudence**

##### **Premeditated attempt to spread HIV/AIDS**

Professor Malik Badri, a prominent Muslim psychologist, explains the condition of HIV-positive patients:

Most people with HIV may feel fit, going about their business without any health complaint while the virus is slowly but surely destroying their immune system... As is known, in all viral illnesses there is a time lag between the virus and the appearance of the disease. This time lag is called the incubation period... In case of the HIV, however, this incubation period may continue for an average of eight to ten years, though it may be as short as six months for some debilitated patients who may also suffer from other sexually transmitted diseases and viral infections.<sup>47</sup>

From the above, it is important to

note that HIV cannot be classified as a terminal illness until the symptoms of full blown AIDS manifest in the patient, making it difficult for that person to lead a normal life and deterioration of his/her life becomes evident.<sup>42</sup> It then follows that an HIV-positive person who deliberately attempts to infect someone else would not be exempted from facing the wrath of the law.

The Islamic Organization for Medical Sciences, Kuwait, in collaboration with the Kuwait Ministry of Health, the Jeddah Islamic Fiqh Council and the World Health Organization's East Mediterranean Regional Office, held its Seventh Islamic Medical Seminar on the theme AIDS-Related Social Problems - An Islamic Perspective in Kuwait from 6-8 December 2006. At the end of that seminar, Muslim jurists resolved that the intentional transmission of HIV contravenes Islamic norms. This is to be regarded as a sin as well as a legal offence and due punishment ought to be meted out to the aggressor in proportion to the effect of his/her action on the individuals and society as a whole. The following punishments would be applicable:<sup>48</sup>

- (a) If the intention is to spread the disease among a wider section of the community, the punishment would be in conformity with the following Qur'anic injunction: "The punishment of those who wage war against Allah and His Apostle, and strive with might and main for mischief through the land is: execution, or crucifixion, or the cutting off of hands and feet

from opposite sides or exile from the land: That is their disgrace in this world, and a heavy punishment in the Hereafter.”<sup>49</sup>

- (b) If an HIV-positive person sexually assaults another person with the intention of infecting that person and that person eventually dies of full-blown AIDS, then the death penalty would be effected upon the perpetrator of that particular crime.
- (c) In the event that the victim of the sexual assault contracts HIV, but does not die in the near future, then the qadi (Muslim judge) would exercise his discretion in imposing a deterrent punishment upon the aggressor. Eventually when the victim dies, his/her heirs would have the right to demand a ransom.
- (d) If the aggressor intended to target a specific person for the transmission of HIV, but somehow that person is not infected, then it would be left to the qadi to impose a deterrent penalty upon the aggressor.

10.10.2 HIV antibody testing before nikah (Islamic marriage contract) is effected.

It would be perfectly in order for a Muslim male and female to be tested for HIV antibody prior to entering into the Islamic marriage contract on the basis of the legal maxim, namely, *al-maslahah* (public good), bearing in mind that the main avenue for the transmission of HIV is through sexual intercourse.<sup>50</sup> But those requesting for this test ought to be made aware that

the HIV antibody test does not detect HIV directly but looks for antibodies to HIV. It is also equally important to note that there is a window period of about four to six weeks between the onset of HIV infection and the appearance of detectable antibodies to the virus. Antibodies are produced from about three weeks after infection and usually become detectable by four to six weeks after infection. It would therefore be preferable for Muslims who have disobeyed the commandment of Allah and indulged in illicit sexual relations (prior to marriage) to have the test done after three months for mostly everyone who is infected with HIV (99%) will have antibodies detected by three months after being infected.<sup>51</sup>

Moreover, in the event that if one of them is found to be HIV-positive, the other may either choose to go on with the marriage or abandon the idea altogether. However, if the uninfected person resolves to go on with the marriage with his/her infected husband/wife-to-be, then they must use a condom during sexual relations after marriage so as to reduce the risk of infecting the other partner and to frustrate pregnancy. Taking cognizance of the fact that condom use mishaps may result in pregnancy, it is the view of the writer of this paper that if either or both partners are HIV-positive then they could even resort to being sterilized to prevent pregnancy from occurring due to the fact that HIV can most certainly be transmitted from mother-to-baby, especially during

pregnancy and natural delivery. The legal maxim, namely, *ikhtiyar akhaffa dararayn* (i.e. choosing the lesser of two evils), would justify their being sterilized to protect them from having an offspring who would be at risk of contracting HIV, compounding their problem of having to care for another HIV-infected being.

### **Contracting HIV/AIDS within matrimony**

There are basically three avenues by which a married couple runs the risk of being infected with HIV: (a) infidelity on the part of one of them; (b) sharing of infected needles if one of them is a drug addict and (c) transfusion with contaminated blood. Illicit sexual intercourse and indulging in drugs are both censured by Islam. Therefore, if one of them is tested positive for HIV antibody which has been contracted either by having committed adultery and having shared contaminated needles with other drug users, the partner who had either been affected or not by the irresponsible lifestyle of his/her partner has the option to resort to divorce or have the marriage annulled.<sup>52</sup> It is necessary to point out that adultery is grounds for divorce, irrespective whether the unfaithful partner is infected with HIV or not.

However, if the partner contracted HIV through blood transfusion the uninfected partner has the option to stay within the marriage or to opt out of it. If they are both prepared to save their marriage then they ought to

take all precautionary measures when engaging in marital relations so as to safeguard the uninfected partner from contracting the virus.

### **Interaction with HIV/AIDS patients**

HIV-positive and AIDS patients should not be ostracized nor rejected. The Glorious Qur'an states:

*"Let not the hatred of others cause you to sway to injustice"*<sup>53</sup>.

In other words, Muslims must acknowledge the fact that irrespective of how HIV was contracted, these patients need the loving care of their family members and the people around them.

#### **10.10.5 Right to professional counseling**

It is equally important for HIV-positive and AIDS patients to have access to professional counseling. However, such counseling should not be restricted to making them cope with the disease, but should also include an element of Islamic ethos, instilling in them hope of the mercy of Allah. Prophet Muhammad (PBUH) encourages Muslims to sincerely advise each other as is evident from the following Hadith:

AI-din al-nasihah. AI-din al-nasihah. AI-din al-nasihah i.e, Religion is sincere advice. Religion is sincere advice. Religion is sincere advice....<sup>54</sup>

It is therefore imperative that every effort must be made to encourage them to strengthen their bond with their Creator by observing the *fara'id*



(obligatory acts of worship) and to find inner peace through *tawbah nasuhah* (sincere repentance).

### **Right to be treated**

HIV-positive patients cannot be refused access to medical care. They should therefore be given both moral and financial support to be in a position to gain access to antiretroviral treatment (ART). This can be inferred from the following Hadith:

The believers, in their love and sympathy for one another are like one body; when one part of it is affected with pain, the whole of it responds in terms of wakefulness and fever.<sup>55</sup>

A pertinent question that may be asked is whether zakat (compulsory charity) could be given to Muslim HIV-positive patients so that they may have access to ART. According to the Glorious Qur'an<sup>56</sup>, there are eight categories of people who may benefit from zakat and they are as follows: (a) the poor, (b) the needy; (c) those employed to administer (the funds); (d) those whose hearts have been recently reconciled, (e) those in bondage (including prisoners of war); (f) those in debt; (g) those who are in the way of Allah; and (h) the wayfarers.

ART can result in draining family resources, rendering the entire family destitute. In order to avert this, it would be perfectly in order to give zakat to Muslim HIV-positive patients so that they may be able to defray their medical expenses. After all, HIV-positive destitute Muslims qualify for

zakat since they fall in category (b) above, i.e. the needy. Assisting them to gain access to ART would considerably enhance their quality of life, enabling them to observe the *fara'id* (obligatory acts of worship).

### **Visiting and praying for HIV/AIDS patients**

Prophet Muhammad (PBUH) encouraged Muslims to visit the sick and to pray for them. This equally applies for HIV/AIDS patients. On visiting them, Muslims should address them with the same words as they would when visiting any other patient: "Do not worry, Allah willing, (your sickness) will be an expiation of your sins."<sup>57</sup> Even the *dua'* (supplication) that they would make for them would be the same as that which they would make for any other sick patient: "Take away the disease O Lord of the people! Cure him/her as You are the One Who cures. There is no cure but Yours, a cure that leaves no disease."<sup>58</sup>

### **Death certificate must reflect the real cause of death**

In South Africa, the real cause of death of people who die of AIDS is not reflected on the death certificate. Rather, AIDS-related illnesses like tuberculosis is declared as the cause of death thus making the mortality statistics linked to AIDS inconclusive. This status quo may in due course change as a result of Dr Leon Wagner's (a former state pathologist in the Free State) bold action in declaring on the death certificate that a particular woman had died of AIDS. That resulted in the



woman's family protesting against the pathologist's report which resulted in him being accused of unprofessional conduct. Dick Herman, a representative of the labour union, Solidarity, is of the view that if Dr Wagner were to be exonerated, doctors would be able to indicate AIDS as the real cause of death on the certificate and that would have tremendous consequences for the statistical documentation of the AIDS pandemic in South Africa.<sup>59</sup>

In light of Islamic Medical Jurisprudence, the real cause of death must be included on the certificate and it would be tantamount to khiyanah (treacherousness) on the part of a Muslim doctor not to disclose the real cause of death (of his / her patient). Allah categorically states in the Glorious Qur'an:

*"Verily Allah does not love the treacherous,"*<sup>60</sup>

Within the ambit of Islamic Medical Jurisprudence, therefore, HIV/AIDS cannot remain a non-notifiable disease in view of the fact that it can be passed on to others, thus placing the lives of others at risk. It is important to note that it is imperative for Muslims to know the real cause of death since family members are expected to participate in the ceremonious wash their dead ones before the funeral prayer is read over them and buried. Disclosing the real cause of death, namely that the person had died of AIDS, would enable the persons involved in ghusl al-mayyit (ceremonial bath of the deceased) to take extra precaution not to expose

themselves to the body fluids of the deceased, hence safeguarding their lives. Allah reminds us of the virtue of saving human life in the following Qur'anic verse:

*"Whoever saves a life it is as if he has saved the lives of entire humankind."*<sup>61</sup>

## Conclusion

There are basically four avenues by which HIV/AIDS may be transmitted from one person to another: (a) sexual contact, (b) mother-to-baby (MTB), (c) transfusion with contaminated blood, and (c) sharing of contaminated needles and syringes by drug addicts. The Islamic solution to the problem of HIV/AIDS is to go to the root of the problem and it advocates: (a) vigorous promotion of chastity before marriage, (b) upholding of sexual fidelity at all cost during marriage, (c) screening of blood donors (d) collaboration amongst social and cultural organizations to encourage people to uphold sexual morality and to create a drug free society.

Individuals ought to be made aware of the fact that in most cases it would be due to their irresponsible behaviour that could make them susceptible to contracting HIV/AIDS. The Glorious Qur'an warns:

*"And do not destroy yourselves, for indeed Allah has been to you Most Merciful"*<sup>62</sup>

Prophet Muhammad (PBUH), in an attempt to remind us not to voluntarily expose our body to any type of injury or harm, states:

*"...Your body has a right over you..."*<sup>63</sup>

What a tragedy that the vast majority of people who are actively involved in the mammoth fight against HIV/AIDS overlook the fact that HIV/AIDS is also an ethical and moral problem. Given the fact that the main avenue for the spread of HIV/AIDS is through secretions of the sexual organs, it is imperative, therefore, that the focus should be on sexual activity and its regulation thereof. While Islam recognizes that carnal passion is inherent in every human, it sanctions its fulfilment only within the confines of marriage. Adultery, fornication and same sex sexual relations are all regarded as crimes and the punitive laws of Islam are enforced upon the perpetrators of such crimes.

The Glorious Qur'an censures the intake of khamr <sup>64</sup> (intoxicants which incorporates both alcoholic drinks and drugs) thus closing the avenue for the transmission of HIV by sharing contaminated syringes.

While it may be true that an HIV-positive pregnant woman who is on ART lessens the risk of her transmitting

the disease to her baby, some Muslim jurists are of the view that it would be permissible for her to opt for an abortion during the very early stage of pregnancy, during the first forty days of falling pregnant.<sup>65</sup> Justification for this would be on two counts: (a) in consideration for the mother's health and (b) averting the potential risk of transmission of HIV to the fetus. However, it is the view of the writer of this book that it would be more plausible for the HIV-positive woman to make use of contraceptive devices or to opt for sterilization in order to safeguard her from falling pregnant altogether.

It would be unbecoming of Muslims to discriminate against their counterparts who are HIV positive. They are duty-bound to visit them and to pray for them, nay even to assist them financially for their antiretroviral treatment. Above all, they should remind them that Allah is Most Forgiving, encourage them to strengthen their bond with their Creator and to seek inner peace through sincere repentance.

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# Jurisprudence Rulings On HIV/AIDS Related Issues

*Aly A. Misha'l*

## Abstract

HIV/AIDS has raised more ethical and legal debates and has lead to dire social consequences in comparison to any illness that had befallen humanity. Muslim jurists have devoted significant attention to this scourge in their deliberations at seminars, in their writings and have issued rulings on a number of HIV/AIDS related issues over the past two decades.

The main concerns of Jurisprudence are protection of society from this major dilemma and its ramifications. By applying the holistic approach of the purposes and principles of Islamic Shari'ah, some of the most pertinent issues that this paper addresses are:

- Social, and medical care and rights of HIV/AIDS subjects in Shari'ah
- Policies to combat the pandemic and its ramifications
- HIV/AIDS individuals and family life: Marriage, separation, pregnancy, abortion, nursing
- Legal and criminal issues related to transmission of HIV/AIDS.

**Keywords:** *HIV/AIDS infection, HIV/AIDS prophylaxis, HIV/AIDS human rights, Purposes of Islamic Shari'ah.*

## Introduction

The epidemic of HIV/AIDS has affected all corners of the world, including all Muslim countries. Ethical and Jurisprudence aspects of the disease and its ramifications received attention over the past two decades.

Islamic jurisprudence is characterized by a holistic view that takes in consideration the following principles:

- 1- Islamic shariah Stipulates protection of human body, soul and mind.
- 2- The five purposes of shariah<sup>1</sup>:

Protection of Religion (Deen), Life (Nafs), Progeny (Nasl), Mind (Aql), and Wealth (Mal).

These purposes of Shari'ah provide a holistic relationship to preserve sanctity, dignity and safety of mankind.

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All have close relation with the concept of protection from and combating major dilemmas that face humankind, HIV/AIDS included.

The following main headings will be outlined, according to principles adopted by Shari'ah scholars.

### **Social and Medical care of HIV/AIDS patients in Shariah**

The principles of care and support of affected individuals, by society and state, are well established in Islamic Shari'ah <sup>2</sup>. This includes social, medical and financial care.

The human being is honored and glorified in Islam, *"And we honored the progeny of Adam"* <sup>3</sup>.

Glorification applies to all people, whether healthy or ill, alive or dead.

Islamic Shari'ah established built-in standards and regulations to promote sound and healthy lifestyles. Parallel to that, Shari'ah laid down sound limits and boundaries that safeguard humankind from destructive lifestyles and behaviors. The Glorious Qur'an tells us:

*".... He allows them what is good (and pure), and prohibits them from what is bad "and impure"* <sup>4</sup>.

*".... Allah commands justice, the doing of good and liberality to kith and kin"* <sup>5</sup>.

Islamic teachings caution from ways, means or lifestyles that may lead to

adverse outcomes.

*"... Nor come near to adultery, for it is a shameful "deed "and an evil"* <sup>6</sup>.

*"... Nor come near to shameful deeds, whether open or secret..."* <sup>7</sup>.

The Prophet (PBUH) said: " Wherever (exorbitant) fornication spreads widely among a people, with shameless publicity, Allah will bring down upon them plagues and ailments that never existed in their previous ancestors" <sup>8</sup>.

Prophylaxis in Islamic teachings is comprehensive, especially when measures are needed to combat a serious and spreading health dilemma like HIV/AIDS <sup>9,10</sup>.

This comprehensive approach includes:

- Moral and religious capacity-building of individuals and society.
- Lifestyle and behavior.
- Environment.
- Infection prophylaxis and control.

Infection prophylaxis is only one small aspect of the holistic prophylaxis of humankind from various dangers and evils, which aims at safeguarding of both individual and society.

Even in the early times of the Prophet (PBUH), the traditions were clear and comprehensive:

*"Run away from the leper as if you run away from a lion (beast)"* <sup>11</sup>

*" If any one hears of plague in a land,*

*nor should he go into it, or should he leave it if he was already there* “<sup>12</sup>.

Therapeutically, there is clear Islamic guidance to seek remedy and cure from all ailments:

*“ ... Seek cure, for Allah has not established a disease without establishing its cure ... ”*<sup>13</sup>.

Medical and psychosocial caring of HIV/AIDS patients is not different from that extended to all other patients.

In Islamic teachings, illness is a cause of facilitation of duties. Special considerations and exemptions are extended in performance of prayers, fasting, hajj, and other religious duties.<sup>2</sup>

Moreover, illness is considered a cause for facilitation of some types of punishments<sup>2</sup>.

### **Shari’ah Policies to combat AIDS and its sequelae**

Islamic Shari’ah addresses plans and undertakings that both government and society should adopt and implement to safeguard their people against the HIV/AIDS pandemic, or to minimize its deleterious effects.<sup>14</sup>

This disease, with its nature and various implications, deserves utmost care and attention for all possible effective measures.

The public at large should be prepared to give up some of its personal freedoms and conveniences to ensure effective protection.

It is very well established nowadays that worldwide adopted measures so far were deficient in combating the spread of this pandemic.

This recognized fact lays major responsibilities upon a Muslim state and society leaders to set an effective example of (Radical Prevention).

If this comprehensive prevention undertaking leaves some defects uncovered, they should be managed according to their merits and requirements.

### **Main outlines of Radical Prevention**

- 1- Nurturing of sound internal motives in the minds and hearts of people, especially the younger generation. Moral and spiritual values are instrumental to maintain healthy lifestyles for individuals and society.
- 2- Ensuring proper, healthy and constructive environment in Muslim societies.
- 3- Balancing of natural human instincts, desires and lusts, with Shari’ah approved social structure, including marriage.
- 4- Viable and sound measures, legislations and regulations should be adopted to ensure effective prophylaxis of the community, especially the youth.

### **Shari’ah Policies to combat the disease once it has invaded the Muslim society**

There is current epidemiological evidence that HIV/AIDS has relatively

limited infiltrations in most Muslim countries. The following policies were approved by the HIV/AIDS joint medical- Jurisprudence workshop in December 1993.<sup>15</sup>

- 1- Public education by all available means.
- 2- People should be prepared to accept some limitations on some aspects of their lifestyles and behaviors.
- 3- In this context, Shari'ah guidelines should be applied to adopt what is proper and useful to society, and to avoid or prevent what is harmful.
- 4- Accurate characterization of affected foci and individuals should be undertaken.
- 5- Mandatory laboratory testing for individuals who plan to undertake actions that may lead to infection spread, e.g. marriage, blood and organ donation. Testing in other situations should be assessed by qualified medical professionals.

Laboratory testing should be applied to individuals with lifestyles that usually lead to infection of others: Drug addicts, suspected homosexuals and deviators (sex workers .... etc).

- 6- Compulsory notification of health authorities about infected individuals.
- 7- Legislation and regulations to encourage affected, or suspected individuals, to seek proper diagnosis

and medical help.

- 8- At the same time, state and society should provide medical, social and economic care and support to infected individuals, with due protection of their dignity and confidentiality.
- 9- Special care facilities may be established and maintained for affected individuals.
- 10- Psychospiritual build up of patients should be undertaken to bolster their confidence in Allah's wisdom, mercy and forgiveness to all people who seek them.

#### **Isolation of HIV/AIDS patients.<sup>16</sup>**

There is a wealth of Islamic heritage and guidance in the area of infection control and prevention, from the times of the Prophet (PBUH).

Communicable diseases known at earlier Islamic eras included plague, leprosy, scabies and others. Islamic measures for isolation and prevention were established in earlier literature.

By analogy (Qiyas), it is incumbent on health authorities to adopt decisions to combat spread of infectious diseases with significant magnitude, including HIV/AIDS.

Any disease that has analogy to plague and other communicable diseases, should take a similar standard of care.

The state could opt for establishing special centers with certain isolation and management standards according



to approved scientific and ethical basis.

The Jurisprudence rule “Necessity is judged by its magnitude”<sup>17</sup> could be applied to establish the type and scope of these centers and the prevention policies in general.

In these centers, as well as in other forms of isolation, proper and flexible forms of care and productive life should be undertaken as much as practical.

### **HIV/AIDS Individual and family life**

The following standards were adopted by the Jurisprudence-Medical Seminar held in Kuwait in December 1993.<sup>2</sup>, and many aspects were approved by the Islamic International Covenant for Medical and Health Ethics adopted and published in 2005.<sup>18</sup>

- 1- It is incumbent on an infected husband/ wife to inform the other party.
- 2- The uninfected husband/wife has the right to take measures to safeguard his/ her health.
- 3- The uninfected party may opt for continuation of marriage. In this situation, it is the duty of both to pursue effective forms of protection, and to avoid pregnancy, including the use of condoms.
- 4- There are certain considerations in using condoms, that may modify decisions to continue the marital relationship:
  - A balance should be drawn between condom use within the framework of marriage, and the main established purpose of

marriage, namely: to increase progeny.

- Condoms do not guarantee prevention of transmission of the infection.

### **The right of separation ( Tafriq ) or Divorce<sup>(17-19)</sup>**

In the past, Shariah rulings of separation or divorce were made for leprosy, tuberculosis, and other infectious diseases. These were based on the following Shariah principles.

- The rule of avoidance of causing Harm.
- Harm should be “removed”. However if it cannot be removed completely then it should be removed by lesser Harm.
- Harm should not be removed by similar Harm.

Some jurists gave clear right of Tafriq (breaking of the marriage) bondage to both husband and wife. Others gave this right only to the wife, on the basis that the husband has the right to divorce.

Some jurists gave this right in disease situations that were present prior to the marriage contract, but not to those occurring after the contract.

Few jurists ruled against Tafriq on the basis of disease.

The current consensus among jurists established Tafriq as a right for the unaffected partner.

### **The Infected mother: Pregnancy and abortion**

It is incumbent on the infected woman to avoid pregnancy, in view of the significant probability of transmitting infection to her fetus, particularly in communities where there is lack of adequate medical therapy.

Termination of pregnancy ( TOP ) is another issue that was tackled by jurists <sup>2,18</sup>. The following points were agreed upon:

1. Prior to ensoulment: If the treating team is worried about transmission of HIV infection to the fetus: There is lack of consensus in allowing TOP. Some experts say the vertical transmission from the pregnant woman to her infant has been significantly decreased to less than 2% with the use of current antiretroviral therapy regimens, and elective cesarean section delivery.<sup>(20-22)</sup>

But if there is worry about serious complications that threaten life of the pregnant women from continuation of pregnancy, then TOP could be approved by the expert team, on the basis of avoiding the major of two harms by committing the lesser harm.

2. After ensoulment, there is consensus to prohibit TOP, because it is looked upon as killing of a human being. Expert medical opinion indicates high probability of infant safety with current antiretroviral management and cesarean section.<sup>(2,18-21)</sup>

Ensoulment is believed to occur

between 40 and 120 days after either conception/fertilization or implantation in the uterus, by different jurists.

### **HIV/AIDS Mothers and Infant nursing**

Past jurist consensus disallowed lactation and nursing if the mother had leprosy or other significant infectious diseases. The prominent jurist Al-Dasouky Al-Maliky stated: The nursing mother should fulfill the conditions of: sanity, competency and freedom from leprosy...etc. <sup>23</sup>

Contemporary jurists apply the same ruling for HIV/AIDS-infected mothers, as it is more infectious and potentially lethal.<sup>18,24</sup>

### **HIV/AIDS infected individuals and marriage**<sup>18,25</sup>

Marriage is meant to prevent promiscuous sexual relations and thus protects against all sexually transmitted diseases (STDs). For this and other considerations, Islam encourages early marriage.

All kinds of extramarital sexual relationships are prohibited in the strongest terms. Prohibitive punishments are prescribed as an established system.

There is a consensus among jurists that the marriage of HIV/AIDS infected subjects to unaffected ones is prohibited.

An HIV/AIDS subject, who knows of his/her status, should not seek marriage

to an unaffected subject.

He/she should be held liable to punishment if he/she intentionally does so.

An HIV/AIDS man, who is already married to an unaffected wife, and intends to use condoms, should inform her and ask her approval. The wife should understand that the use of condoms is not a guarantee of protection from infection. She has the right to divorce (see above).

Precautions to ensure prevention of marriage of HIV/AIDS subjects were addressed by Muslim jurists:

There is consensus for pre-marital testing and that punishment should be applied against non-compliant HIV/AIDS subjects.

Public education, as well as orientation of people planning to get married, is an effective measure for protection.

Marriage of two infected individuals received the attention of jurists. Some Shariah scholars allowed it, provided effective contraception, and provided that expert medical opinion determined that marriage will not exacerbate infection and or cause deterioration of health of the partners.

#### **Shariah rulings in regards to transmission of HIV/AIDS to others**<sup>18,26</sup>

Adopted legal and ethical rulings are based on the purposes and principles of Islamic Law.

Infected individuals, who intentionally spread their infection to others, are

held liable of intentional murder.

HIV/AIDS subjects who intentionally inflict physical injury upon others ( e.g. bites, cut wounds, injections ....etc ) are legally likened to those who introduce lethal poison to others. The majority of jurists apply rulings of intentional murder. Other jurists consider this act as unintentional murder.

Shariah rulings in regards to a married HIV/AIDS subject who transmits infection to his / her partner by sexual relations, depend on the subject's knowledge of his/her infective status. Most jurists consider this as an act of murder if he/she has this knowledge and did not inform the spouse.

Some jurists take in consideration the right of husband/wife for sexual relationship, which precludes capital punishment. They recommend imposing lighter types of punishment such as, *Diyyah*, *Kaffarah* ... etc.

On the other hand, if the affected spouse was not aware of his/her infection, it is considered a human mistake. Their real intentions are left to their Creator on the Day of Judgment. The Glorious Quran states:

“ ... Our Lord ! condemn us not if we forget or fall into error ... ”<sup>27</sup>

The Prophet (PBUH) said:

“ Allah (SWT) granted forgiveness to my Ummah for mistakes, or matters forced on them ”<sup>28</sup>

This, however, does not negate the right of others for *Diyyah* and *Kaffarah*.

Infection of others as a result of neglect, such as neglect of medical teams during surgeries, blood transfusion or organ transplantation...etc, was also considered by contemporary jurists.

Shariah stipulates that all medical actions should conform to recognized, current medical standards, as adopted by qualified medical experts and authorities. Any medical practice that falls short of these standards, should be liable. Traditional Jurisprudence has clear ruling "A medical practitioner who is ignorant or negligent... is to be held liable".

Any punishment should take into account issues of intention, negligence, or failure to pursue proper standards of medical care.

In Shari'ah, there is extensive literature in the area of medical responsibility and liability.

- Punitive measures in Shari'ah aim at protection of society and avoidance of avenues of contracting or spreading lethal diseases.
- Any form of punitive measures should be based on solid evidence, proper testimony or by admission.
- Taking in consideration the above principles, if infection was caused by drug injection, punishment should be similar to drinking alcohol. Some jurists, however, recommend the lesser punishment of reprimand( Taazir ).

In instances where infection was caused by *Zina* (fornication), the consensus is

to apply the punishment of *Zina*.

HIV/AIDS infection caused by homosexual acts, was looked upon as *Zina* by some jurists. Others, (Malikiyyah and Hanabilah) impose the capital punishment by stoning, whether the subjects were married or single. However, Hanfis considered the punishment to be only reprimand (*Taazir*). In their view this act is not considered as *Zina*, since there are no problems of lineage mixing. The current jurist consensus is capital punishment. Some jurists recommend burning of the body after the capital punishment.

These Shariah rulings are considered effective in bolstering protective efforts in the universal battle against the HIV/AIDS menace. By Western standards these rulings may be considered very strict or even cruel. In Western standards there is considerable lack of balance between their minimization of lifestyle and behavior modifications, rights of the community, and individual freedom and autonomy.

It is incumbent on medical professionals, workers in areas of ethics and human rights to study the required effective measures to protect from and combat HIV/AIDS pandemic in light of failure of the previous measures worldwide.

I am confident this humble effort is not without shortcomings. I pray to Allah (SWT), the source of all knowledge and wisdom, to forgive me for any such shortcomings which were beyond my intention.

"رَبَّنَا لَا تُؤَاخِذْنَا إِنْ كُنَّا مُسِيئِينَ أَوْ نَسِيئًا"

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# The Rights of an Unborn Baby with Special Reference to HIV/AIDS:

## An Alternative Approach from an Islamic Perspective

**Sahin AKSOY and Ahmet BEDİR**

### Abstract

In this presentation, unborn baby defines the embryological stages of zygote, embryo and fetus. Although unborn baby is considered, legally, morally and theologically, as a human being from the conception onwards, there is a 'turning point' in the embryological period which shall determine our moral and theological judgement.

'Rights' is a very popular subject, not only of ethical and legal discussions but also theological circles. In this presentation we will try to explore the concept of 'rights' as far as unborn and newborn babies are concerned. It will emerge from the discussion that rights of a newborn baby plays a significant role in determining the duties and responsibilities of parents and the state towards an unborn baby.

After defining these general, but fundamental concepts, we will try to relate them in case of HIV/AIDS. As it is known, HIV/AIDS is a social as well as a health care problem. The peculiar features of the disease require a broader look at the issue, in comparison to other health care problems, especially other sexually transmitted diseases. Although, Islam has some basic principles which automatically protect Muslim individuals and societies from this life threatening health care and social problem, it still needs to be re-addressed from different perspectives, that we intend to do in this paper.

**Keywords:** *Unborn baby, Rights of the newborn, HIV/AIDS*

There are two groups of views about the unborns' moral status:

According to the writers in first group, the basic criterion for being a person is being capable of valuing one's own existence. And the moral difference between a person and a non-person lies in the value that people give to their own lives. Through language a person can comment on and declare awareness or fully developed self-consciousness. So, the presence of language is definitive evidence that the beings who possess it are persons<sup>1</sup>. On these arguments pre-embryos, embryos, fetuses and even infants, are living beings even human beings, but definitely are not human persons. So, morally, we owe them nothing.

In his widely read article 'A defense for abortion and infanticide' Tooley observed that it is important to be very clear about what makes an entity a person, what gives that entity a right to life. He went on to define five necessary properties:

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1) The capacity to envisage a future for oneself, and to have desires about one's future state. 2) The capacity to have a concept of a self, 3) Being a self. 4) Self-consciousness. 5) The capacity for self-consciousness<sup>2</sup>. As unborn babies, very young infants and patients in persistent vegetative state (PVS), do not fulfill these requirements, they would not qualify as human persons. Singer, in a forceful line on personhood, made a point of comparing human 'animals' with 'non-human animals', arguing that there could be a person who is not a member of our species and, conversely, there could also be members of our species who are not persons<sup>3</sup>.

The writers in the second group argue that there is a spiritual side of a human individual. The history of this belief goes quite far back. There are many thinkers who believe human individuals consist of body and soul. Pythagoras (c. 580-497), being one of these, maintained "The earthly soul is said to be a temporarily fallen divinity, immortal in character, and the most essential and enduring part of each person's identity"<sup>4</sup>. Plato was also one of the ancient philosophers who accepted ensoulment as the beginning of human life. However unlike the Pythagoreans, Platonists and Neo-Platonists denied the ensoulment of the fetus in utero. They argued that the soul, being the special divine entity, had to enter the body from without (perhaps through the newborn's first breath)<sup>5</sup>. Aristotle (d. 322 B.C.), considered the first thinker who spoke explicitly of human

life as beginning, wrote: "The soul is the cause and the first principle of the living body"<sup>6</sup>. He suggested that, when first formed, the embryo replaced in due time, as a result of the causal influence of the specific semen's pneuma, by the sensitive soul. Finally, in the case of a human, the rational soul would appear to complete the generation of a human offspring.

Aristotle associated quickening and differentiation into distinct parts of 40 days for the male and 90 days for the female, and so has been traditionally interpreted as placing the beginning of the individual boy and girl at those times respectively. Aristotle's ideas on this subject influenced many philosophers and scientists from prior to Christian times right through to the Middle Ages, notably Thomas Aquinas (d.1274 A.C.), and for several centuries afterwards. His ideas also shaped the views of philosophers and scientists from the Islamic World and the East. For example, according to Musallam, Ibn-i Sina (Avicenna, d. 1037 A.C.), brought Aristotle's ideas up to date, and then re-started the original Aristotelian arguments on the basis of the new facts<sup>7</sup>.

Although there are many philosophical arguments about the spiritual side of human persons, from Pythagoras (c. 580-497 BC), and Aristotle (d. 322 BC) onwards, it is essential to refer to the authority of metaphysical and transcendental knowledge, as well as the religions.



## Judaism

Among major monotheistic religions, Judaism has a quite different approach to this issue. In Jewish mysticism, Kabala, there is a belief in the soul. There is complete agreement on a fundamental principle, regarding the moral status of a pre-nate, that is full human status is not acquired until birth. In Jewish law an unborn fetus is not considered a person (Hebrew '*nefesh*', literally 'soul') until it has been born<sup>8</sup>. However some of the Jewish authorities mention some special times in prenatal period. For example the great Jewish scholar of the twelfth century Moses Maimonides (1135-1204) wrote: "the time for complete formation of the fetus is thirty-five or forty-five days, and in twice that many days movement is created. In three times the (amount of) time from the onset of (fetal) movement, birth occurs<sup>9</sup>. Many rabbis rejected both Aristotle and Maimonides"<sup>10</sup>. Also some other authorities in the Talmud deem the embryo during the first forty days following conception 'as mere water', and as such an early zygote has no status at all, is not a person or '*nefesh*'. This kind of a distinction implies that the embryo after forty days has a different moral status. We thus can say that forty days in development of a fetus has some significance in Jewish understanding.

## Christianity

According to Christian theology the 'immediate animation' or 'ensoulment' is the point at which our humanity is

determined. But, the question of 'When does the ensoulment take place?' is not answered yet. Mahoney sums up the current Christian understanding regarding the beginning of life with the following suggestions: "In point of fact, current Roman Catholic teaching on the time of human ensoulment is one of uncertainty. Official Roman Catholic teaching, is that we cannot be absolutely certain when animation takes place, or when the conceptus or the fetus is a human person; but it may well be precisely at the moment of conception"<sup>11</sup>.

It is argued that, if one looks at the Christian tradition, one can see that the present very firm position held by some of the Christian churches is not the position they have always held. The idea of ensoulment, or the embryo becoming human in the full sense happening at a later stage in development, was very widely and respectably held, not just by theologians. Dyson examined this change in Christian understanding and wrote: "From early in Tradition, a distinction was drawn between an 'unformed' or 'formed' fetus. This distinction was based on whether or not the fetus could be recognized as 'human'. The fetus was regarded as 'formed' when it was physically developed enough to be the recipient of a human"<sup>12</sup>. He added that beginning in the seventeenth century the opinion that the soul was present from conception began to gain ground.

In the early ages of Christianity,

obviously also using Hebrew texts and the New Testament, formation of the fetus had been extensively discussed, without any special reference to Aristotle or other ancient philosophers. Dunstan examined this issue and came to the same conclusion and said: "The claim to absolute protection for the human embryo 'from the beginning' is a novelty in the Western, Christian and specifically Roman Catholic moral traditions. It is virtually a creation of the later nineteenth century, and that is a novelty indeed as traditions go"<sup>13</sup>. It appears therefore that in Christianity, the moral status of an unborn, is determined by the 'physical formation' is important.

Apparently, in monotheistic religions, in order to discuss some topics knowledgeably Divine guidance or Revelation is needed. Without such revelation, men, even prophets, would be unable to talk about these subjects. Without doubt, man's ensoulment and creation fit into this category. Ibn Al-Qayyim, a 14<sup>th</sup> century Muslim thinker from Damascus, identifies an area where only religions, and not sciences, have meaning. He says: "While ensoulment is a normal part of God's ways in the generation of human beings, its understanding is not open to the methods of science. Ensoulment belongs to a different realm of meaning, outside science but at the center of religion", he adds: "This time of ensoulment can only be known through revelation, for there is nothing in nature as such requires"<sup>14</sup>. However

this information is not disclosed in the Jewish and Christian Bible. For this reason there is uncertainty regarding this issue among Christian and Jewish authorities.

### Islam

In Islam, the situation is quite different. The creation of the human individual, and fetal development are referred to in several dozen verses of the Glorious Qur'an in various contexts<sup>15</sup>.

In particular two verses and two *ahadith* are worth mentioning here as they help understand the time of ensoulment and what the status of personhood entails.

The first verse is:

*"He Who created all things in the best way and He began the creation of man from clay. Then made his progeny from a quintessence of despised liquid. Then He created him in due proportion, and breathed into him of His spirit. And He gave you (the faculties of) hearing and sight and hearts. Little thanks do ye give!"*

This verse clearly reports that, first the human is 'shaped' (in due proportion), then he is 'ensouled', and finally the faculties of hearing and sight and hearts are formed. This verse informs us about the 'stage' of ensoulment in the intrauterine life.

The second is:

*"And indeed We created man from a quintessence of clay. Then We placed him as a small quantity of liquid (nutfa)*

*in a safe lodging firmly established. Then We have fashioned the nutfa into something which clings ('alaqa), then We made 'alaq into a chewed lump of flesh (mudgha) and We made out of that chewed lump of flesh into bones, and clothed the bones with flesh. And then We brought it forth as another creation. So blessed be God, the Best to create”.*

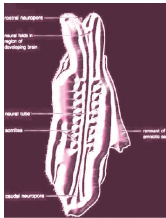
This verse is not as clear as the first one. It is possible to make different comments regarding the stages of physical developments mentioned in this verse. However, we think it is not that

important. The important thing here is the time of these physical developments that we are going to examine later. (Fig. 1, Fig. 2, Fig. 3)



DAY 6 BLASTOCYST

**Figure 1:** *nutfa* (small quantity of liquid)



Day 22

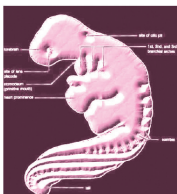


Leech



Day 23

**Figure 2:** *'alaqa* (something that clings)



Day 26



Day 28



Day 28

**Figure 3:** *mudgha* (a chewed lump of flesh)

The role of *Hadith* in Islamic teaching is to help us better understand and interpret the verses of the Glorious Qur'an, since Prophet Muhammad (PBUH) is the ultimate interpreter of the Qur'an. Prophet Muhammad (PBUH) was not only a religious or political leader for his nation but also a guide to teach Muslims how to understand Qur'anic verses. He was reported to have said two *ahadith* that we are going to quote, that help us tremendously better understand the above Qur'anic verses especially on physical development of the embryo and the time of ensoulment.

Prophet Muhammad (PBUH) said:

"Verily your creation is on this wise. The constituents of one of you are collected for forty days in his mother's womb; it becomes something that clings (*'alaqa*) in the same (period) (*mithla dhalik*), then it becomes a chewed lump of flesh (*mudgha*) in the same (period) (*mithla dhalik*). And the angel is sent to him with instructions concerning four things, so the angel writes down his provision (sustenance), his death, his deeds, and whether he will be wretched or fortunate. Then the soul is breathed into him"<sup>16</sup>.

And;

"Afterzygote(nutfa)hasbeenestablished in the womb for forty or forty-five nights, the angel comes and says: 'My Lord, will he be wretched or fortunate?' And both these things would be written. Then the angel says: 'My Lord, would he be male or female?' And both these things are written. And his deeds and actions, his death, his livelihood; these are also recorded. Then his document of destiny is rolled and there is no addition to or subtraction from it"<sup>17</sup>.

There are different versions (narrations) of both hadiths with very minor differences. The first hadith is reported only by Abdullah b. Mes'ud, but the second one is reported by Hudhayfa b. Asid and by some other 'companions' (*'sahabah'* close friends) of the Prophet Muhammad. Many Hadith scholars, by referring to the first hadith, and understanding the expression *mithla dhalik* as 'time equal to this period' rather than 'in the same period', have suggested that the angel comes to the prenatate and breathe in the soul 120 days after conception<sup>18</sup>. (Fig. 3)



Figure 3

Some earlier scholars<sup>19</sup>, and some contemporary researchers<sup>20</sup>, have not agreed on this interpretation, and concluded from both *hadiths* that, by understanding the expression *mithla dhalik* as 'in the same period', the completion of these developmental stages and ensoulment take place by 40th day of conception. As I discussed elsewhere to interpret the expression *mithla dhaliq* as 'in the same period' is more accurate in this context both from embryological and theological perspective<sup>21</sup>.

If it is accepted that ensoulment takes place at 120 days, the embryo should look like a *nutfa* (a drop of liquid; zygote) between days 0 and 40, it should be something like '*alaqa*' (something which clings; implantation stage) between days 40 and 80, and it should be similar to *mudgha* (a chewed lump of flesh; the occurrence of somites 'primitive streak') between days 80 and 120. As we know from the modern embryology these stages occur well before these times<sup>22</sup>. It can be understood from these verses and *hadith* that, in order to receive the soul, that means to be a full human individual person, a pre-nate must pass the stages of conception, zygote (*nutfa*), implantation ('*alaqa*'), formation of somites -primitive streak- (*mudgha*), and beginning of ossification and musculation. From the embryological information we have given above the ensoulment can not take place before 7 weeks after conception, since these embryological stages are not completed

before this time<sup>23</sup>.

When the second *hadith* we have quoted here is examined, it appears that they express very clearly that the angel comes -obviously to give soul- after *nutfa* (zygote) has been established in the womb for 40 or 45 days -or nights-. Since the implantation process is completed within nine to ten days of conception, ensoulment takes place sometime between 49-55 days after conception.

From the information derived from these verses and *ahadith*, as well as the current embryological knowledge, we can say that the soul meets with body in the beginning of 8 weeks around the day 50, and forms 'full human person'<sup>24</sup>. Therefore, according to many Muslim scholars, terminating the life of an embryo before the ensoulment is regarded as disliked (*makruh*), while it is considered as forbidden (*haram*) after this stage<sup>25</sup>.

Since the unborn baby is a 'full human' at this stage, it acquires rights.

### Rights in Islam

In Islam, being male or female, young or old, sane or insane is irrelevant, it is enough to be a human in order to be entitled to have rights. When the rights and responsibilities of children are compared, rights dominate the responsibilities. A child is entitled to use these rights after he reaches the age of having the "capacity to exercise"<sup>26</sup>. Until the age of having "capacity to exercise", the rights and responsibilities of the

child are followed by the 'guardian' or 'trustee' as his 'legal representative'.

The 'legal representative' is authorized to perform every action which is in favor of the child. Child begins to have rights from the very beginning.

### The Basic Rights of Children:

- 1) Right to know his parents.<sup>27</sup>
- 2) Right to life.
- 3) Right to have a good –decent-name.<sup>28</sup>
- 4) Right to breast feeding.<sup>29</sup>
- 5) Right to alimony (*nafaqa*).<sup>30</sup>
- 6) Right to accept *zakat*.<sup>31</sup>
- 7) Right to have proper parenting.
- 8) Right to be 'hugged' (*ḥaḍāne*).<sup>32</sup>

I will describe in detail a few of these

rights due to their relevance to HIV/AIDS parents.

### Right to Life

The Quran says:

*"...if anyone killed a person not in retaliation for murder, or/and because of spreading mischief in the land, it would be as if he killed all mankind, and if anyone saved a life, it would be as if he saved the life of all mankind. ...."*<sup>33</sup>

Prophet Muhammad's (PBUH) is reported to have said in the last Sermon:

*"...O people, just as you regard this month, this city as sacred, so regard the life and property of every Muslim as a sacred trust...."*<sup>34</sup>

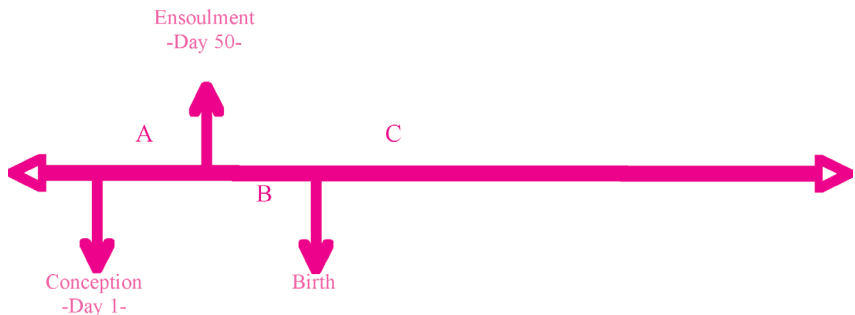


Figure 4

According to Islamic Laws in the period of A (Fig. 4), namely from conception to day 50, the punishment for "Killing the embryo (termination of pregnancy) or TOP" is *Ghurra* (10 camels) and *Al-aqila*. *Al-aqila* is a penalty, the amount

of which may vary, which is paid by the paternal relatives of the guilty. This system aims at social control over people by including the relatives in the punishment.

In the period B, the punishment is again

*Ghurra* (10 camels) and *al-aqila*. But in the period C, namely after birth, it is considered to be the same as a killing of an adult and the punishment is *Qisas* or *diyyah* (100 camels).

Some scholars suggest redemption (*al-kaffarah*) in case of child's death due to parents' negligence. But some others think that repentance and asking for forgiveness are enough.

It is obvious that HIV/AIDS severely threatens the right to life. Therefore, Intentional pregnancy of a HIV/AIDS wife and her husband are 'more' than a negligence. For this reason, it requires *diyyah*.

In case of unintentional pregnancy of HIV/AIDS woman, TOP before day 50 can be performed and *ghurra* is paid. However, after the 50th day, pregnancy is maintained by taking every necessary precaution to prevent transmission of infection to the unborn, as long as the continuation of pregnancy does not threaten the life of the mother.

### Right to Breast Feeding

Current research shows that an HIV-positive mother may pass the virus to her baby through breast milk. The World Health Organization, the American Academy of Pediatrics and the Centers for Disease Control advise against nursing if the mother is HIV-positive and a safe alternative is available. Therefore, having a child in case of HIV/AIDS deprives the child of his/her right to breast feeding.

### Right to have Proper Parenting

Besides the normal increase in responsibilities and demands on an HIV/AIDS woman as a parent, she will have to struggle with:

- Telling the child about HIV ( if she should and how to do it ).
- Discrimination from her child's school.
- Disciplining her children.
- Parenting her child inspite of feeling drained from HIV/AIDS.
- Complications of the disease or drug side effects.
- Giving the child a happy and secure life.
- Planning for the care of her child in the future when she dies prematurely.

### Right to be 'Hugged' (ḥadāne).

'Hugging' symbolizes a very close and intimate relation between mother and child. In this 'intimate' and close contact, kissing, biting and scratching are common behaviors of babies. Since all these behaviors are potential threats for the baby in case of HIV/AIDS parents, it is wrong for them to have children.

### Conclusions

Although "potentiality argument" does not count in Western bioethics, it must be a matter of concern for Muslim scholars. Zygote has the potential to be a human person from the first day

onwards. Therefore, the potential rights of an unborn baby should be taken into consideration.

Many potential –and some actual–

rights of the unborn in Islam, require individuals and the State to take necessary precautions for HIV/AIDS patients not to procreate.



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# Ethical Aspects of AIDS and the Notion of Responsibility: Some Theological and Philosophical Reflections

**Ilhan Ilkilic**

## Abstract

In the late 20<sup>th</sup> century, HIV and AIDS were considered to be exceptional infectious diseases.<sup>1</sup> In the beginning, the HIV epidemic was looked upon as a disease affecting a segment of society whose lifestyles were deemed iniquitous and debauched ("plague of homosexuals"). Thus for many people, the disease appeared to be a divine punishment for immoral behavior and a moral condemnation. Rapid developments in medical science helped to control HIV. Further, society's new tolerance towards HIV-patients have produced a shift from "exceptionalism to normalisation," especially in the Western world.<sup>2</sup> AIDS has attained, mainly in the European Union and the USA, the character of a chronic disease.<sup>3</sup>

AIDS has been discussed controversially in the Muslim world as well as the Western world.<sup>4</sup> In spite of extensive discussions, no clear and uniform ethical assessment of this disease has been reached, however. As yet, no answer to the question as to whether AIDS is a divine punishment or not has been offered, nor has the question as to who should take responsibility for making an ethical assessment of HIV/AIDS been clarified. This situation raises religious uncertainties as well as posing organizational and practical problems in the treatment and control of this disease in Muslim countries.<sup>5</sup>

**Keywords:** *HIV epidemic, divine punishment, AIDS and ethics, AIDS and individual responsibility.*

In my paper, I will discuss the question "Can AIDS be considered a divine punishment?" from an Islamic theological point of view. Then I will present the relationship between individual responsibility and the ethical assessment of the outbreak of AIDS from an Islamic philosophical point of view. Then, I will attempt to formulate some conclusions which follow from these theological and philosophical lines of arguments.

## Can AIDS be considered a divine punishment?

Is illness, according to the Islamic concept of faith, to be considered a punishment of God or an expression of God's anger - as it is in the Jewish faith? The Old Testament relates a story of certain Jews who broke the covenant with God. They had to suffer illnesses and plagues. This story is referred to in the following Qur'anic verse:

*Dost thou not know of those who went forth from their homes, and they were thousands, fearing death? And God said to them: 'Die'; then he brought them to life. Surely, God is Munificent to men, but most men are not grateful.<sup>7</sup>*

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In commentaries on the Glorious Qur'an there are various accounts and interpretations of this verse. According to one, the Israelites were commanded by God to wage a war, but they refused for fear of their lives and for fear of being defeated. They attempted to flee from the land, but were afflicted with an epidemic and resurrected by God after their deaths.<sup>8</sup>

It is to be noted that although the word illness does not occur here, many Qur'anic exegetes believe that the people fled from their homes in fear of death because of an epidemic.<sup>8</sup>

Another episode tells of a people in Iraq who left their city for fear of a plague in order to save themselves from death. Then God let them die and resurrected them again.<sup>9</sup> In another verse we read:

*And for every people there is a term, and when their term is come, they cannot remain behind a single moment, nor can they get ahead of it.*<sup>10</sup>

A lesson to be learned from both of these verses is the unchangeability of the time of death appointed by God. Any attempt on the part of humankind to change this time limit is declared by the Glorious Qur'an to be in vain. It is just as futile to believe that one could escape the doom laid on an individual or a people. The following verse illustrates this:

*And if God touch thee with affliction, there is none that can remove it but He; and if He touch thee with happiness, then He has power to do all that He wills.*<sup>11</sup>

In both stories about disobedient peoples, an epidemic is the cause of death, just as other peoples (according to the Glorious Qur'an) were destroyed by means of natural disasters.<sup>12</sup> Epidemics are not primarily to be understood as lasting states of punishment. Moreover, the mercy which God showed to the prophet Job in his illness and the alleviation of religious obligations provided for by Islamic law contradict the view that illness is always a divine punishment.

Although it is not possible to explain illness as punishment or an expression of the wrath of God from Islamic theological sources directly, it is conceivable that an individual Muslim could give preference to a personal interpretation along these lines irrespective of theological discussions.<sup>13</sup>

### **Responsibility and the ethical assessment of AIDS**

The question concerning agency or responsibility of human beings in regard to the outbreak of an illness leads us to the question as to what relationship there is between the freedom of human will and action and divine predestination (Qadar). In any case, there are a number of essential differences between the origins of a human action and the emergence of a disease. We will now list the basic characteristics which are decisive from a Muslim's perspective: In order to reach a desired goal, a human being

uses his or her own will to undertake specific measures. By means of an action which is appropriate within the divine laws of nature (Sunnat-Allah), he or she achieves a result. Both the result of an action and an illness arise in the knowledge and omnipotence of God, whose attributes enable him to know about them before they arise in the world of appearances. In Islamic belief, the emergence of a simple action and that of an illness are not to be equated, however. The first difference between the two is that according to Muslim understanding, the illness does not - under normal conditions- constitute the goal of an action. The second difference lies in the nature of responsibility. Freedom of will and action is the prerequisite for assuming responsibility for an action.<sup>14</sup> Since human beings have no influence on the causes of many illnesses, they bear no responsibility for them, unless of course lifestyle and habits have played a decisive role in their emergence. Such responsibility is premised on the obligation, anchored in Islamic sources, to care for one's health and to maintain it. In the next world, human beings will be called upon to account for the care they have taken for their health and the way they have treated their bodies in this world. This sense of responsibility can influence the willingness to undergo therapy.

The following is a classification of illnesses according to the degree of responsibility which the individual bears in regard to their emergence.

- a. Illnesses for which the patient bears no responsibility.

Illnesses for which human beings have no influence on its causes or emergence. Genetic or hereditary illnesses, for example, belong to this group.

- b. Illnesses for which the patient bears a limited responsibility.

In this group of illnesses, the human being plays a limited role in the emergence of the disease. Illnesses for whose etiology the lifestyle of the ill person has played a role, such as skin cancer, which is caused by overexposure to the sun, belong to this group.

- c. Illnesses for which the patient bears full responsibility.

This group is made up of illnesses whose causes can be traced back to human habits exclusively, such as liver failure caused by alcohol abuse or lung cancer caused by smoking.

It is not easy to make an argument for a direct correlation between the level of influence exerted by a patient on the emergence of his illness and decisions about therapy, for the obligation to allow oneself to be treated derives primarily from the conviction that the body is a gift of God given to human beings in order that they take care of it and that it should, as such, be protected. Thus, this classification of responsibility for the emergence of an illness can play a role in the ethico-religious interpretation of

illness or in the attitude to a medical intervention.

If a person is not responsible for his/her illness, the mercy of God rests on the individual and the individual does not need to feel guilty or assume divine punishment. If there is no chance of healing despite efforts to take the necessary measures, the person can rest in patient acceptance, assured that God forgives the sins of the ill.

In regards to the third group of illnesses, the question of responsibility is premised on a different theological foundation: here the person has made a contribution to his condition and to the emergence of his illness. In such circumstances it is possible that he would demonstrate more commitment to therapy on account of his sense of guilt.

In the second group of people, who bear only limited responsibility for the emergence of the illness, their attitude will depend more on their individual interpretation. Neither can we speak of strong feelings of guilt, as with the third group, nor of a situation for which they bear no responsibility, as with the first.

In all three groups, the role which the human plays in the emergence of an illness does not justify refusal of therapy on the basis of any principles relevant to Islam, however. Although it is assumed that a relationship between human responsibility for the emergence of an illness and the expected commitment to therapy exists, this cannot be

generalized.

If we transfer the aforementioned theological and philosophical arguments to the discourse on HIV and AIDS, the following inferences can be made:

It is a well-known fact that sexual intercourse is not the only form of HIV transmission. Therefore transmission through a blood transfusion or contact with infected blood can be assessed differently from infection through sexual intercourse in discussions about responsibility. But this fact does not allow us to make differences when it comes to providing medical treatment for HIV-positive persons who have been infected in different ways. The responsibility must remain on the individual level and it has no consequences for decisions made on the part of the physician. This becomes clear because the international guidelines on medical ethical issues, as well as Islamic medical ethics, reject inequality in medical treatment of people on the basis of previous behavior.

## Conclusions

1. Ethical discussions on HIV and AIDS in the Islamic world must accept that AIDS cannot be reduced to a "plague of homosexuals." Epidemiological studies show that AIDS is no longer the deadly "plague of homosexuals," but rather a disease of the (so-called) third world.
2. Because of the special features of

- HIV and AIDS, it does not seem possible to fight against HIV and AIDS with medical measures alone. In the Islamic world, we need social concepts and political measures which imply a holistic approach to HIV/AIDS. During the realization of such projects, the Islamic faith can play a positive role in the struggle against HIV/AIDS.
3. Based on the aforementioned Islamic theological and philosophical arguments, which argue that AIDS is not a divine punishment, a Muslim approach to HIV similar to that taken for all other diseases can be taken. This attitude can decrease the discrimination and isolation of HIV-positive persons.
  4. Prevention programs for HIV/AIDS must be aware of cultural and religious issues and differences. Therefore such programs should not be limited to the distribution of condoms as a preventive measure. Emphasizing adherence to Islamic sexual ethics can be useful for AIDS prevention in Muslim countries.
  5. The religious conviction that every "Muslim will be called to account for the care they have taken of their health and the way they have treated their bodies in the next world" can promote an approach which is beneficial for the prevention of HIV/AIDS. It is in fact counterproductive to make moral accusations against someone who is HIV-positive, for this would have a negative effect on the well-being of the patient.  
Based on the aforementioned arguments, it is not ethically acceptable to differentiate between HIV-positive persons and others when providing medical treatment.
  6. Taking action against the discrimination of HIV-positive persons in the world of employment and societal life can be based on similar Islamic theological and philosophical arguments.

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# Management Of HIV Infection

**Resat OZARAS**

## Abstract

The human immunodeficiency virus (HIV) was discovered in 1982, and treatment strategies were introduced 5 years later. Since the advent in 1995 of highly active antiretroviral therapy (HAART), which consists of at least three agents, a dramatic improvement has been seen in the survival. However, HAART may have side effects. Currently we have three different types of combination regimens, namely: NNRTI-based (1 NNRTI + 2 NRTI), PI-based (1-2 PI + 2 NRTI), and triple NRTI-based regimens.

A preferred regimen may include zidovudine+lamivudine+efavirenz, or tenofovir+emtricitabine+efavirenz or zidovudine+lamivudine+lopinavir/ritonavir.

Current guidelines suggest starting treatment according to CD4+ lymphocyte count, viral load and whether an AIDS-defining illness is present. An initial patient evaluation with HIV should include a detailed medical, patient education, a thorough physical examination, and laboratory tests. Opportunistic infections during the course of HIV infection may involve several organs, although their incidence decreased considerably after the use of HAART. The relative risk of the infections may be estimated by CD4+ lymphocyte counts and an effective prophylaxis should be initiated. Thus, the management of HIV-infected patients is a dynamic process and the physician should update his/her knowledge.

**Keywords:** *HIV, antiretroviral therapy, HIV therapy guidelines.*

The human immunodeficiency virus (HIV) was discovered in 1982, and treatment strategies were introduced 5 years later. Initially one or two drugs were given and often led to treatment failure. Since the advent in 1995 of highly active antiretroviral therapy (HAART), which consists of at least three agents, a dramatic improvement has been seen in the form of undetectable viral loads, improved CD4 counts, and improved survival. However, early HAART often consisted of drugs with complex dosing schedules, strict food requirements, and the need to take 16-20 pills/day<sup>1</sup>. Because of the need to treat long-term (continued over a lifetime) side effects of HAART, such as lipodystrophy, lactic acidosis, insulin resistance, and hyperlipidemia, were negative impacts for these patients<sup>2</sup>. These treatment challenges often led to patient nonadherence, with subsequent treatment failure and development of resistant strains in some patients. In fact, greater than 95% adherence to drug therapy is required for effective viral suppression and immunological improvement.

Over the past 10 years, the management of HIV infection has been improved by an increased number of effective antiretrovirals (ARVs), with more convenient dosing.

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Other improvements include increased potency of the newer agents, development of active agents against highly resistant viruses and improved adverse-effect profile (e.g., less gastrointestinal effects, improved lipid profiles). Optimal management of HIV infection includes at least three effective ARVs; from at least two different drug classes<sup>3</sup>. Current management strategies can control HIV infection and significantly reduce morbidity and mortality.

Monotherapy, two-drug combinations, sequential ARVs, drug "cycling", and treatment interruptions were shown to be ineffective management strategies and had led to earlier disease progression and emergence of drug resistance. Drug-drug interactions are common and caution is required when prescribing ARVs that inhibit or induce the cytochrome P450 pathway.

Zidovudine monotherapy demonstrated survival benefits in advanced HIV patients in the late 1980s and now we have several antiretroviral agents, belonging to four classes, and combination regimens contain at least three drugs. These four classes include the nucleoside/nucleotide reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI), protease inhibitors (PI), and fusion inhibitors (FI).<sup>4,5</sup>

NRTIs include zidovudine, lamivudine, stavudine, tenofovir, didanosine, abacavir, and emtricitabine; NNRTIs include efavirenz and nevirapine.

Lopinavir/ritonavir, atazanavir, fosamprenavir, fosamprenavir/ritonavir, indinavir/ritonavir, nelfinavir, and saquinavir are PIs; enfuvirtide is a fusion inhibitor.

The most clinical experience with use of combination therapy in treatment-naïve individuals has been based on three different types of combination regimens, namely: NNRTI-based (1 NNRTI + 2 NRTI), PI-based (1-2 PI + 2 NRTI), and triple NRTI-based regimens.

A preferred regimen may include zidovudine+lamivudine+efavirenz, or tenofovir+emtricitabine+ efavirenz or zidovudine+lamivudine+lopinavir/ritonavir.

During pregnancy, HIV infection may be treated with zidovudine+lamivudine+nevirapine or zidovudine+lamivudine+nelfinavir or zidovudine+lamivudine+saquinavir+ritonavir.

The CD4 count and viral load are the most important surrogate markers used to determine if treatment is indicated. Current guidelines suggest starting treatment in patients who are symptomatic with an acquired immunodeficiency syndrome (AIDS)-defining illness regardless of CD4 count or viral load, as well as in asymptomatic patients with a CD4 count of ( 200 cells/mm<sup>3</sup> ) or below. In patients with CD4 counts between ( 200 and 350 cells/mm<sup>3</sup> ) and viral loads above 20,000 copies/ml, some clinicians prefer to defer treatment, whereas others will

consider starting therapy; treatment is deferred in patients with CD4 counts above ( $350 \text{ cells/mm}^3$ ) and viral loads below 55,000 copies/ml.<sup>6</sup> If therapy is started, the selection of appropriate agents is based on comorbidities (liver disease, depression, cardiovascular disease), pregnancy status, adherence potential (dosage regimen, pill burden, dosing frequency), food restrictions (dosing with regard to meals), adverse drug effects, and potential drug-drug interactions.

The main aim of the management of human immunodeficiency virus (HIV) infection is the control of viral replication. This will result in the prevention or delay of the progressive immunodeficiency, providing prolonged survival and decreased selection of resistant virus. HIV management begins with the diagnosis. Early intervention improves quality of life, help avoidance of complications, and prevent transmission of both primary HIV infection which associates higher viral load and absence of antibodies and chronic infection. High risk behaviors should raise the suspicion and screening tests should be applied. An initial patient evaluation with HIV should include the followings: medical history (date of HIV serology, transmission category, AIDS-defining diagnoses, past medical history, especially TB and sexually-transmitted disease exposure, medications and alcohol...), patient education, a thorough physical examination, and laboratory tests (repeated HIV serology-confirmation,

CBC, CD4 count, quantitative plasma HIV-RNA, biochemistry, serology of toxoplasma, viral hepatitis, and syphilis, chest X-ray, tuberculin skin test, Pap smear...).

Opportunistic infections during the course of HIV infection may involve several organs, although their incidence decreased considerably after the use of effective antiretroviral treatment. The relative risk of the infections depend on the CD4+ lymphocyte counts: in patients with levels ( $<250/\text{mm}^3$ ), *Pneumocystis jiroveci* pneumonia, esophageal candidiasis, progressive multifocal leukoencephalopathy, and herpes simplex virus infections are seen. In levels below  $100/\text{mm}^3$ , cerebral toxoplasmosis, HIV encephalopathy, cryptococcosis, and miliary tuberculosis are the main disorders. In very low CD4 counts ( $<50/\text{mm}^3$ ), cytomegalovirus retinitis and atypical mycobacterial infections are prominent. Risk of Kaposi's sarcoma, reactivation of pulmonary tuberculosis, herpes zoster, and bacterial pneumonia increases and can be seen at any CD4+ level.

Pulmonary system is involved in nearly 70% of the cases and causes death in 1/3 of the cases; tuberculosis, *Pneumocystis jiroveci* pneumonia, and bacterial pneumonia being the main disorders. Central nervous system involvement with varying severity is seen in nearly half of the cases. The majority of lethal cases are associated with a neurological disorder. HIV dementia, toxoplasma encephalitis,

CNS lymphoma, progressive multifocal leukoencephalopathy, cryptococcal meningitis, neurosyphilis, CMV encephalitis are the relatively frequent disorders<sup>7</sup>. Gastrointestinal system is also involved frequently: Esophagitis may be due to candida, cytomegalovirus, and herpes. Diarrhea is a challenge and can be seen in nearly half of the cases: Salmonella, Cryptosporidium, Isospora, cytomegalovirus and HIV itself may cause diarrhea<sup>8</sup>.

Sequential tests include CBC, CD4 count, and quantitative plasma HIV-

RNA (every 3 months), tuberculin skin test (annually in high-risk patients with persistently negative results), syphilis serology (annually in sexually active patients), and Pap smear (6 month and annually if negative). Immunization against pneumococci, influenza, HBV, HAV, and tetanus should be provided.

Management of HIV-infected patients is a dynamic process and the attending physician should update his/her knowledge. Sharing the experience is also critical.

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# Pediatric HIV/AIDS: Prevention

**Mustafa Bakir**

## Abstract

The World Health Organization reports that 800,000 children under 15 years of age were newly infected during year 2001, and 90% of those children received HIV virus perinatally. HIV infection produces a wide range of clinical manifestations, from asymptomatic infection to marked immunodeficiency. The most acceptable routes of virus transmission in children are receipt of infected blood or blood products, parenteral exposure to contaminated equipments, vertical transmission from an infected mother to her offspring, and sexual contact with an HIV-infected individual in adolescens. Perinatal transmission is the most common source of HIV infection among infants and children. Children younger than 13 years of age account for 1.2% of the total number of AIDS cases reported in the United States. Children who are infected perinatally have a shorter clinical latent period and have a more rapid and progressive course. Strategies to prevent perinatal HIV infection must take into account the three potential points at which transmission to the fetus or infant can occur: in utero, intrapartum, and postpartum via breast milk. Progressive AIDS symptoms in mother, acute HIV infection during pregnancy, low maternal CD4 count, increased viral load in mother, and premature birth are all predisposing factors for infection in newborn infants. However, It was shown that the most important factor for perinatal HIV transmission is the maternal HIV-1 RNA level. The optimal approach is to maximally suppress the mother's virus load during pregnancy through the use of combination antiretroviral therapy, delivery by cesarean section and formula-feeding after birth. The main goal of antiretroviral therapy in children is to reduce the morbidity and mortality due to HIV infection, lower viral replication to a maximum range, preserve the child's immune system function, carry on a normal physical growth and neurocognitive development and improve the quality of life. Risk of perinatal transmission can be reduced down to less than 2% with effective antiretroviral therapy, elective cesarean section, formula feeding, and preconception counseling and care for HIV-infected women.

**Key words:** *Pediatric HIV, AIDS transmission, AIDS prevention.*

Joint United Nations Program on HIV/AIDS (UNAIDS) and World Health Organization (WHO) estimates that 39.5 million people all over the world live with HIV, 2.5 million newly infected with HIV, 2.1 million died from AIDS of whom 330,000 were children under 15 years of age in year 2007.<sup>1</sup> Because of growing concern on the increase in pediatric HIV, WHO<sup>2</sup>, Perinatal HIV Guidelines Working Group of United States Public Health Service Task Force<sup>3</sup>, and Working Group on Antiretroviral Therapy and Medical Management of HIV-Infected Children<sup>4</sup> published guidelines for prevention and treatment of pediatric HIV/AIDS in the years 2006 and 2007.

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Children can acquire HIV in utero (25%–40% of cases), intrapartum (60%–75% of cases), or postnatally through breastfeeding. Risk of HIV infection is 14% higher in women with established infection, and 29% higher in women with primary infection. Disease course in children is rapid compared with adults. Majority of children develop symptoms by 12 months of age, 50% die by 2 years of life, and 75% by 5 years of age. Therefore, identification of perinatal HIV exposure by universal out-out testing for pregnant women, with 3rd-trimester repeat testing for high-risk women, provides important opportunity to protect neonates from HIV infection. If the HIV status of parturient women is unknown, immediate postpartum maternal test or newborn HIV test should be performed.

In the United States, the rate of perinatal HIV transmission was 21% in 1994 before the standard zidovudine (ZDV) recommendation during pregnancy. In February 1994, the results of Pediatric AIDS Clinical Trials Group (PACTG) Protocol 076 documented that ZDV chemoprophylaxis could reduce perinatal HIV-1 transmission by nearly 70%<sup>5</sup>. The regimen includes oral ZDV initiated at 14–34 weeks' gestation and continued throughout pregnancy, followed by intravenous ZDV during labor and oral administration of ZDV to the infant for six weeks after delivery. Since the publication of the results of PACTG 076, epidemiologic studies in the United States and France have demonstrated dramatic

decreases in perinatal transmission with incorporation of the PACTG 076 ZDV regimen into general clinical practice<sup>(6–8)</sup>. Epidemiologic data have extended this efficacy to children of women with advanced disease, low CD4+T-lymphocyte counts, and prior ZDV therapy<sup>9</sup>.

In a meta-analysis of 15 prospective cohort studies the rate of perinatal HIV-1 transmission among women undergoing elective cesarean delivery was significantly lower than that among similar women having either nonelective cesarean or vaginal delivery, regardless of whether they received ZDV<sup>10</sup>. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, after reviewing these data, has issued a Committee Opinion, recommending consideration of scheduled cesarean delivery for HIV-1 infected pregnant women with HIV-1 RNA levels > 1,000 copies/mL near the time of delivery<sup>11</sup>.

Most HIV-infected women live in deprived conditions and lack access to clean water and sanitation. This limits their ability to employ safe breast-milk substitutes. Research on how to make breastfeeding safer is a high priority. Results from one study suggest that exclusively breastfed children are less likely to acquire HIV than those receiving mixed feeding (breast milk and other foods)<sup>(12, 13)</sup>.

The Center for Disease Control and Prevention (CDC) in USA, the American College of Obstetrics and

Gynecology (ACOG), and other national organizations recommend offering all women of childbearing age the opportunity to receive preconception counseling and care as a component of routine primary medical care<sup>14</sup>. The fundamental principles of preconception counseling and care have been outlined by the CDC Preconception Care Work Group's "Recommendations to Improve Preconception Health and Health Care"<sup>15</sup>. The following components of preconception counseling and care are recommended for HIV-infected women:

- Counsel on safe sexual practices that prevent HIV transmission to sexual partners, and protect women from acquiring sexually transmitted diseases, and the potential to acquire more virulent or resistant HIV strains.
- Counsel on eliminating alcohol, illicit drug use, and cigarette smoking.
- Educate and counsel women about risk factors for perinatal HIV transmission, strategies to reduce those risks, and potential effects of HIV and its treatment on pregnancy course and outcomes.
- When prescribing antiretroviral treatment to women of childbearing potential, considerations should include regimen effectiveness for treatment of HIV disease and the drugs' potential for teratogenicity should pregnancy occur. Women who are planning to get pregnant should strongly consider use of antiretroviral regimens that do not contain efavirenz or other drugs with teratogenic potential, as well as regimens that are effective in preventing mother-to-child transmission.
- Attain a stable, maximally suppressed maternal viral load prior to conception in women who are on antiretroviral therapy and want to get pregnant.
- Evaluate and control for therapy-associated side effects which may adversely impact maternal-fetal health outcomes (e.g., hyperglycemia, anemia, hepatic toxicity).
- Encourage sexual partners to receive HIV testing and counseling and appropriate HIV care if infected.
- Counsel regarding available reproductive options, such as intrauterine or intravaginal insemination, that prevent HIV exposure to an infected partner; expert consultation is recommended.
- Breastfeeding by HIV-infected women is not recommended in the U.S. due to risk of HIV transmission.

**In conclusion**, risk of perinatal transmission can be reduced down to less than 2% with effective antiretroviral therapy, elective cesarean section, formula feeding, and preconception counseling and care for HIV-infected women.



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# HIV Orphans

**Kamarul Azhar Mohd Razali**

## Abstract

The scale of the HIV/AIDS epidemic ever since its inception in the early 1980's is staggering. About 40 million people are living with HIV/AIDS (PLWHAs). More than half of them have died from AIDS.

About 3 million children under the age of 15 are living with HIV/AIDS, over 90% of them in sub-Saharan Africa. Another 14 million children have lost their parent/s to AIDS. Most of these children orphaned by AIDS live in developing countries, again more than 80% in sub Saharan Africa.

The impact of HIV/AIDS is most profoundly reflected in the lives of these children. Their survival, quality of life and holistic developmental potential are dependant on the abilities their care-givers, the community and policy makers to provide undivided and sustainable support.

Muslims role in addressing and championing this product of "human social disease" is paramount as HIV/AIDS has crept into the realms of the Ummah.

The noble Quran and Hadiths of The Prophet (PBUH) had sanctioned the primary preventive strategies against the treats of HIV/AIDS. However the guiding principles of compassion to the ones stricken (infected and affected) by HIV/AIDS makes it inevitable for Muslims to be in the forefront in confronting it (secondary - tertiary preventive and management strategies)

Realistically, we may not be able to achieve an HIV/AIDS free world, but we can by the Will of Allah SWT and with untiring efforts by all, make this temporary abode of us HIV/AIDS-less and orphan-less.

**Keywords:** *HIV orphans, HIV/AIDS prevention.*

Ever since description of the first published clinical case of AIDS in 1980, and now entering well into the third decade of its existence, the HIV/AIDS pandemic has infected nearly 40 million of mankind. That accounts to a ratio of 1 infected person for every 150 persons world-wide. There are 4.1 million newly infected adults with 2.4 million resultant adult AIDS death yearly. Fifty percent of new infections occur in young people. Everyday about 6000 young people contract HIV, mathematically giving rise to 250 and 4 infections per hour and per minute respectively.

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Women are especially prone to HIV infection by a ratio of 2:1, compared to men. Transmission of HIV to women is enhanced by biophysical, educational, economic, treatment inequalities and missed opportunities. Moreover women are inappropriately tasked with the greatest burden of AIDS care. The increasing 'feminization' of HIV/AIDS spread, especially in sub Saharan Africa, and the subsequent deliveries of infected newborns will eventually produce 2.3 million annual births to women with HIV.

Malaysia, being a country with a high HIV prevalence, is now observing an increasing trend of HIV infection amongst women. This worrying path is depicted in a thirteen-fold increase in transmission amongst the HIV infected adult population (from 1.16% in 1990 to 15.1% in 2006).

Globally, it is estimated that about 630,000 children will acquire HIV infections. About 2.1 million children will end up living with HIV (infected and affected) parents. Currently there are about 15 million AIDS's orphans; by 2010 this number will surpass the 25 million mark if the current trend is left unabated. The multitude of continuous problems faced by people living with HIV/AIDS (PLWHAs) will burden further the fragile dynamics faced by these families.

To overcome this highly complex problem of HIV/AIDS and its complications, a holistic approach

must be carefully planned and carried out to prevent further spread of this socio-clinical disease, minimize its effect, improve the quality of life of both the infected as well as the affected people and prolong survival .through the combined and sustained empathic effort by mankind. Indeed this list wish could be practised amongst the Ummah as depicted by the Glorious Qur'an:

﴿لَيْسَ الْبِرَّ أَنْ تُوَلُّوا وُجُوهَكُمْ قِبَلَ الْمَشْرِقِ وَالْمَغْرِبِ وَلَكِنَّ الْبِرَّ مَنْ ءَامَنَ بِاللّٰهِ وَالْيَوْمِ الْآخِرِ وَالْمَلَائِكَةِ وَالْكِتَابِ وَالنَّبِيِّنَ وَءَاتَى الْمَالَ عَلَى حُبِّهِ ذَوِي الْقُرْبَىٰ وَالْيَتَامَىٰ وَالْمَسْكِينِ وَابْنَ السَّبِيلِ وَالسَّائِلِينَ وَفِي الرِّقَابِ وَأَقَامَ الصَّلَاةَ وَءَاتَى الزَّكَاةَ وَالْمُوفُونَ بِعَهْدِهِمْ إِذَا عَاهَدُوا وَالصَّابِرِينَ فِي الْبَأْسَاءِ وَالضَّرَّاءِ وَحِينَ الْبَأْسِ أُولَٰئِكَ الَّذِينَ صَدَقُوا وَأُولَٰئِكَ هُمُ الْمُتَّقُونَ﴾

*"It is not righteousness that you turn your faces towards East or West but it is righteousness to believe in Allah and the Last Day and the Angels and the Book and the Messengers; to spend of your substance out of love for him for your kin, for orphans, for the needy, for the wayfarer, for those who ask and for the ransom of slaves, to be steadfast in prayer and give charity, to fulfil the contracts which you have made and to be firm and patient in pain or suffering and adversity and throughout all periods of panic Such are the people of truth, the God fearing"<sup>4</sup>.*

Al-Hakim narrated a Hadith by Prophet Muhammad (PBUH):

“...Wherever (exorbitant) fornication takes place in a people with shameless publicity, Allah will bring down on them plagues and ailments that never existed in their previous ancestors...”<sup>5</sup>

Islam had always emphasized on primary prevention as a practical means of keeping the well being of mankind at their best, as a healthy Ummah is always better than a sick one. Prevention of mother to child transmission (PPTCT) will surely benefit the Ummah and mankind generally as a HIV/AIDS-less community can ensure the transformation and growth of future generations to achieve their full potential.

Importantly secondary and tertiary preventive aspects encompass the prolonged survival with improved quality of life of HIV/AIDS infected parents of infected and affected children too. We must not forget to address the welfare and plight of the caregivers of PLWHAs as the sustenance of their livelihood must be taken into consideration as caring for our afflicted brothers and sisters demand a lot of attention and care.

Here, the compassion and empathy showered by the Ummah in caring and supporting PLWHAs will ensure their continued existence in this temporary abode, as Muslims: stigma

and discrimination against PLWHA's should not exist in our daily vocabulary and practices because ALLAH (SWT) only looks at the Taqwa level of each and everyone of us. It is how we sincerely care for our afflicted brothers and sisters that give bearing to ALLAH (SWT) on the Day of Judgement.

﴿قُلْ يٰعِبَادِيَ الَّذِينَ أَسْرَفُوا عَلَىٰ أَنفُسِهِمْ لَا تَقْنَطُوا مِن رَّحْمَةِ اللَّهِ إِنَّ اللَّهَ يَغْفِرُ الذُّنُوبَ جَمِيعًا إِنَّهُ هُوَ الْغَفُورُ الرَّحِيمُ﴾<sup>٥٧</sup> وَأَنِيبُوا إِلَىٰ رَبِّكُمْ وَأَسِئْمُوا لَهُ مِن قَبْلِ أَن يَأْتِيَكُمُ الْعَذَابُ ثُمَّ لَا تُنصَرُونَ<sup>٥٨</sup>

“Say: O my servants who have transgressed against their souls! Despair not of the Mercy of Allah for Allah forgives all sins for He is Oft Forgiving, Most Merciful.

“Turn you to your Lord in repentance and submit to Him before the chastisement comes on you, after that you shall not be helped”.<sup>6</sup>

The HIV/AIDS pandemic is the test of our times as time and again, we human beings have transgressed beyond the boundaries set up by ALLAH (SWT). Islam however has always showed practical solutions to problems faced by the Ummah. We probably could not make this world an HIV/AIDS free one but we certainly can make it less prevalent with less orphans.

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# Sexually Transmitted Infections (STIS) In Men And Women With HIV: A Southern African Perspective

**Yusuf Dangor and Anwar Hoosen**

## Abstract

**Objectives:** To report on the prevalence of sexually transmitted infections (STI<sup>s</sup>) in men and women with HIV in Southern Africa.

**Study Design:** This is a review of STI<sup>s</sup> in patients coinfectd with HIV in South Africa.

**Results:** The prevalence of urethral pathogens has not changed from the pre-HIV era with *Neisseria gonorrhoeae* being the commonest isolate, followed by *Chlamydia trachomatis*. For genital ulcers, genital herpes has now emerged as the commonest cause followed by syphilis with concurrent HIV rates of 60-80%. STI<sup>s</sup> are very common in symptomatic and asymptomatic women. Vaginal discharge of mixed aetiology occurred frequently with bacterial vaginosis being the commonest. Surprisingly high rates of STI<sup>s</sup> were detected in women presenting for termination of pregnancy.

**Conclusions:** The various studies have shown very high rates of STI<sup>s</sup> and HIV infections in men and women in South Africa. Besides conventional interventions to control STI<sup>s</sup> and HIV, broader, novel strategies (social and moral behavior) are required in order to make any significant and sustained impact on curbing these epidemics

**Keywords:** Sexually transmitted infections, human immunodeficiency virus, urethritis, vaginal discharge, genital ulcer disease.

## Introduction

Sexually transmitted infections (STI<sup>s</sup>) are a major global cause of acute illness, leading to infertility, long term disability and death, with severe medical and psychological consequences for millions of men, women and infants. The World Health Organization (WHO) estimated that 340 million new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis have occurred throughout the world in 1999 in men and women aged 5-49 years <sup>1</sup>.

The epidemic of STI<sup>s</sup> is one of the major challenges facing South Africa at the present time. Over six million episodes of STI<sup>s</sup> are estimated to occur in the country each year resulting in tubal infertility, ectopic pregnancy, spontaneous abortion, cervical cancer in women, tertiary syphilis in both men and women. In neonates STI<sup>s</sup> may result in congenital syphilis, blindness, pneumonia and AIDS <sup>2</sup>.

Gonorrhoea remains the most frequent diagnosis made at many primary health care clinics and among private practitioners in Southern Africa, particularly among men who work in remote areas from home<sup>3</sup>. Commercial sex is a prominent feature around many South African gold mines. It is widely regarded as one of the key factors in maintaining high STI<sup>s</sup> rates in the mining communities.

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Genital ulcer disease (GUD) due to chancroid, syphilis and genital herpes is common and non-ulcerative STIs, such as gonorrhoea, chlamydial infection and trichomoniasis are prevalent. Such high rates of curable STIs in South Africa mining communities create ideal conditions for HIV transmission.

The prevalence and incidence of STIs in most developing countries, including South Africa is very high, with women bearing the major burden of disease.

Sub-Saharan Africa, especially South Africa is currently experiencing one of the fastest growing and one of the most severe HIV/AIDS epidemics in the world with an estimated HIV prevalence of 11% in the general population; HIV prevalence is 16% among persons aged 15 to 49 years<sup>4</sup>. By the end of 2005 there were five and half million (5½) million people living with HIV in South Africa, and almost 1000 AIDS death occurring every day. National HIV prevalence among antenatal clinics attendees in South Africa is estimated to be 29.2% amongst pregnant women.<sup>5</sup> With the advent of the HIV epidemic and the interaction between HIV and STIs has made the control of STIs an urgent priority.

This paper is an overview of the various studies undertaken in South Africa on STIs in men and women with HIV. In addition it reports on the change in the patterns and trends of various STIs in persons coinfecting with HIV.

## Materials and Methods

Men with symptoms of urethritis, women with vaginal discharge and women with sexually acquired genital ulceration presenting at various primary health care clinics in South Africa were included in the various studies reported here. Endourethral swab specimens were obtained from men complaining of urethral discharge for the detection of *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, *Ureaplasma urealyticum*, *Trichomonas vaginalis*, *Mycoplasma genitalium* and herpes simplex virus (HSV). For men and women presenting with ulcers, specimens were collected for the detection of *Haemophilus ducreyi*, *C. trachomatis* (L1, L2, L3), *Treponema pallidum* and herpes simplex virus type II. Smears were collected from the base of lesions for the diagnosis of *Calytommatobacterium granulomatis*.

Vaginal swabs were obtained from symptomatic, asymptomatic women and from women presenting for termination of pregnancy for the diagnosis of *T. vaginalis*, bacterial vaginosis (BV), candida infections and endocervical swabs for the detection of *N. gonorrhoeae*, and *C. trachomatis*. Standard conventional methods as well as molecular techniques were used for the detection of the above sexually transmitted pathogens.

Serological tests used for the diagnosis of syphilis were the Rapid Plasma Reagin (RPR) test and the *Treponema Pallidum* Haemagglutination (TPHA) test. HIV infection was diagnosed by

the use of Determine HIV 1/2 (Abbott Laboratories, Chicago, IL). All positive results were confirmed by a second serological test (Capillus HIV 1/2: Trinity Biotech, USA) in accordance with WHO recommendations for testing in high prevalence areas.

## Results

The prevalence of established and potential pathogens of urethritis in men presenting to an STD clinic in Durban, Kwa Zulu Natal (KZN) in 2004 is shown in Table 1. Among the 335 cases, the prevalence of *N. gonorrhoeae* and *C. trachomatis* was 52% and 16% respectively. These two pathogens accounted for the majority of infections. *T. vaginalis* and HSV were each detected in 6% of cases. The potential causes of non-chlamydial and non-gonococcal urethritis identified in this group of men were *U. urealyticum* (36%) and *M. genitalium* (5%) whilst the seroprevalence of HIV was 45%.

The etiology of single and mixed infections in genital ulcer diseases in men and women attending an STD Clinic in Durban is shown in Table 2. Genital herpes was the commonest cause of sexually acquired ulceration followed by chancroid and syphilis. For genital herpes there was a tendency of delayed healing of ulcers as compared to healing of lesions due to other causative organisms.

The overall seroprevalence of HIV in genital ulcer disease was 75% with the women showing significantly higher

rates than men ( $P = 0.0004$ ). *T. pallidum* was significantly higher in men ( $P = 0.01$ ) and there was an association with HIV1- seronegative men on the basis of univariate and multivariate analyses ( $P < 0.001$ ;  $P = 0.01$ )

The prevalence of reproductive tract infections in asymptomatic and symptomatic women in Cape Town in 2004 showed significantly higher rates of STIs in the symptomatic group of women than the asymptomatic group with the exception of syphilis (Table 3). Significant differences were found in the rates of gonococcal as well as candidal infections ( $P < 0.05$ ) between the two groups. The rate of chlamydial infection was higher in the symptomatic group (13.7%) compared to the asymptomatic (9.2%) of women; but this difference was not significant. However, significantly more women in the asymptomatic group (8.3%) were found to be positive for syphilis compared to the symptomatic group (3.3%). High risk HPV types were present in both groups whilst HIV prevalence was higher in the symptomatic group (34.7%) compared to 21.4% in the asymptomatic women ( $P > 0.05$ )

A study to determine the vaginal and cervical pathogens in HIV infected women ( $N=387$ ) and HIV uninfected women ( $N= 305$ ) was conducted in Durban, KZN in 2003 (Table 4). Infection was detected in a total of five hundred and nineteen (75%) women. Significantly higher rates were diagnosed in HIV positive women and

these women also had higher rate of multiple infections.

Women presenting for termination of pregnancy (TOP) in Pretoria, South Africa in 2004 showed high rates of STIs (Table 5). The commonest infections were BV and yeasts. *C. trachomatis* (16%) was more frequently detected than *N. gonorrhoeae* (2%). The HIV prevalence in this group of women was 16%. *T. vaginalis* was present in 24 (11.5%) as a single infection and mixed in 7 (3.5%) ( $p=0.001$ ). *C. trachomatis* was detected in 20 (10%) as a single infection and mixed in 8 (4%) ( $p=0.015$ ). *N. gonorrhoeae* was detected in 6 (3%) as a single infection and mixed in 4 (2%) ( $p=0.5$ ). No pathogens were detected in 142 (71%) of cases.

## Discussion

Transmission of HIV-1 between adults in sub-Saharan Africa is mainly through heterosexual intercourse and is enhanced in the presence of sexually transmitted conditions <sup>11</sup>. STIs have reached epidemic proportions and the majority of infections go unrecognised and undetected and infected persons that are treated become rapidly reinfected. Such diseases are highly prevalent in many parts of Africa, including South Africa and could account for a substantial proportion of HIV-1 infections.

Untreated STIs, especially GUD enhance both the susceptibility of an uninfected person to acquire an HIV infection as well as the infectivity of

an HIV-infected individual <sup>12</sup>. Highest rates of HIV infections have been seen in men and women with GUD.

Cohen et al <sup>13</sup> showed that HIV-1 seropositive men with urethritis in Malawi had HIV-1 RNA concentrations in seminal plasma eight times higher than those men without urethritis. Gonorrhoea was associated with the greatest concentration of HIV-1 RNA. After the urethritis patients received treatment, the concentration of HIV-1 RNA in semen decreased significantly. These results showed that urethritis increases the infectiousness of men with HIV-1 infection.

HIV-1 control programmes directed against detection and treatment of STDs in patients already infected with HIV-1 may help to curb the epidemic. Treating of gonococcal urethritis may be a particularly effective strategy. The studies outlined in this paper show very high rates of STIs and HIV infections in symptomatic and asymptomatic men and women in the population.

The prevalence of urethral pathogens has not changed from the pre- HIV era with *N.gonorrhoeae* being the commonest isolate, followed by *C. trachomatis* <sup>6</sup>. Data from Africa on the prevalence of potential pathogens in male urethritis are scanty <sup>14, 15</sup>. The prevalence rates reported in the paper from Durban – KZN are in keeping with those from some other parts of Africa. The role of *U. urealyticum* and *M. genitalium* as potential causes of non-Chlamydial and non- gonococcal urethritis in men still



remains controversial<sup>6</sup>. Superficially, HIV infection appears to have little or no effect on acute gonococcal or chlamydial infection in southern Africa. There are no reports of changes in response to treatment and laboratory tests appear to be unaffected<sup>16</sup>.

Recent studies show a change in the prevalence patterns of the causative agents of GUD in relation to HIV-1 infection. Some observations also indicate a more severe and prolonged clinical presentation as well as decreased response to treatment in HIV-1 infected people<sup>17,18</sup>.

Prior to the HIV-1 epidemic in South Africa, the commonest cause of GUD was chancroid followed by syphilis. HSV was not a major cause of GUD<sup>19,20</sup>. The pattern of GUD has changed dramatically in people coinfected with HIV-1. Genital herpes has emerged as the commonest presentation in men and women co-infected with HIV-1, followed by chancroid and syphilis<sup>7,21</sup>. Ulcerative STIs such as chancroid, syphilis and genital herpes have a stronger effect on HIV than non-ulcerative STIs, presumably because of greater disruption of the genital mucosa<sup>22</sup>. Presently drugs for treatment of lesions due HSV are not included in the South African syndromic treatment protocols. The inclusion of antiviral therapy for HSV needs to be urgently considered for the syndromic management protocols.

A high burden of reproductive tract infections has been documented in

both symptomatic and asymptomatic women in South Africa. Increased rates of chlamydial infections have been detected (10-15%) compared to gonorrhoea (3-12%) in the various studies<sup>8,9</sup>. Recurrent bacterial vaginosis and persistent candidiasis appears to be common in HIV positive women.

The study by Moodley et al,<sup>9</sup> in KwaZulu Natal in 2003 showed that co-infection with HIV-1 did not affect response to treatment when the syndromic approach was used for management of non-ulcerative STIs in women. However, there was an association of HIV-1 infection with the lack of microbiological response for treatment of BV. This poor response to therapy has implications for HIV control. There may be a need to find alternative effective therapies for BV.

The study by Dangor et al<sup>10</sup> in 2004 on the prevalence of STIs amongst asymptomatic women presenting for termination of pregnancy (TOP) showed high prevalence of STIs. Vaginal discharge was diagnosed by the clinician in more than a third (35.5%) of the women, indicating a high presence of genital pathology in this population of young sexually active females. The two commonest pathogens detected were *T.vaginalis* (15%) and *C. trachomatis* (14%), whilst *N. gonorrhoeae* was detected in 4% of women. These high rates of infections are of concern in young sexually active women presenting for TOP. HIV infection was detected in

10 (16%) of the 60 women tested. This was on the unlinked sera performed anonymously in order to evaluate current policies and strategies for unwanted pregnancies in women of the reproductive age group. There is an urgent need to provide pre and post test counseling for HIV and screening for STIs for all women presenting for TOP at health care facilities in South Africa. In the absence of health facilities having the capacity for screening for STIs, administration of azithromycin and metronidazole should be considered for the treatment of common pathogens viz. *C. trachomatis* and *T. vaginalis*.

The local studies reviewed in this paper have shown the extent of the STI problem in this region as well as the intensity in terms of the relationship of STIs with HIV disease. It is not surprising that the HIV epidemic is at its greatest in this part of the world. A priority intervention should therefore, be to decrease the overall burden of STIs in the area, thus making positive impact on the HIV epidemic. The public health measures include

screening for STIs, comprehensive treatment of STIs (syndromic management), identification of high risk groups, promoting health care seeking behavior and the promotion of safe sex. Although the treatment of bacterial STIs as an HIV control strategy may be one of the most cost effective healthcare interventions available, much broader strategies are required for any significant and sustained impact on curbing the STIs and HIV epidemics.

More importantly, the common and significant trend that needs to be employed for controlling the STI and HIV epidemics is that of behavior change. Abstinence and chastity before marriage must be promoted as well as school programmes for education of youth. Furthermore, promotion of fidelity during marriage must be upheld at all costs. Merely treating the symptoms or periodic presumptive treatment will not lead to prevention of STIs. The ultimate solution is not only medical but moral and ethical as well.

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**Table 1. Etiology of Male Urethritis in a High HIV Population in Durban, KZN in 2004, (N=335)**

Disease/Pathogens	All cases	n (%)
<i>Neisseria gonorrhoeae</i>	174	(52)
<i>Chlamydia trachomatis</i>	55	(16)
<i>Ureaplasma urealyticum</i>	121	(36)
<i>Trichomonas vaginalis</i>	19	(6)
<i>Herpes simplex virus</i>	19	(6)
<i>Mycoplasma genitalium</i>	17	(5)
No pathogens detected	11	(3)
HIV antibody	152	(45)

Reference 6

**Table 2. The Prevalence of Etiological Agents of Genital Ulcer Disease (GUD) in Men and Women Attending an STD Clinic in Durban, KZN (2003)**

Disease	Total (n=587)	Male (n=438)	Female (n=149)	P Value
<b>Single Infections</b>				
Genital herpes	234 (40%)	175 (40%)	59 (40%)	0.9
Chancroid	45 (8%)	40 (9%)	5 (3%)	0.02
Treponema pallidum	42 (7%)	38 (9%)	4 (3%)	0.01
*LGV	43 (7%)	27 (6%)	16 (11%)	0.06
Donovanosis	4 (0.6%)	3 (0.6%)	1 (0.6%)	1.0
<b>Mixed Infections</b>	63 (11%)	44 (10%)	19 (13%)	-
Unsolved cases	156 (27%)	114 (26%)	42 (28%)	0.6
HIV antibody	441 (75%)	313 (71%)	128 (86%)	0.0004

Reference 7

\* LGV: *Lymphogranuloma venereum*

**Table 3. Prevalence of Reproductive Tract Infections in Asymptomatic and Symptomatic Women in Cape Town (2004)**

Disease/ Pathogen	Total (N=450) %	Asymptomatic (N=300) %	Symptomatic (N=150) %
<i>Neisseria gonorrhoeae</i>	7.3	5.5	11.0*
<i>Chlamydia trachomatis</i>	10.7	9.2	13.7
Bacterial vaginosis (BV)	62.1	60.5	65.3
<i>Trichomonas vaginalis</i>	10.7	11.0	10.1
<i>Candida species</i>	28.0	24.3	35.3*
Syphilis (RPR/TPHA)	6.7	8.3	3.3*
High Risk HPV types	36.3	33.8	41.3
HIV antibody	25.5	21.4	34.7

Reference 8

\* P &lt; 0.05

**Table 4. Prevalence of Etiological Agents of Vaginal Discharge in HIV Infected Women (N=387) and HIV Uninfected Women (N= 305) in Durban, KZN ( 2003)**

Disease/Pathogen	Total	HIV +v	HIV -v	P value
Bacterial vaginosis (BV)	479 (69)	302 (78)	177 (58)	<0.001
<i>T. vaginalis</i>	203 (29)	127 (33)	76 (25)	0.02
<i>N. gonorrhoeae</i>	86 (12)	62 (16)	24 (8)	0.001
<i>C. trachomatis</i>	73 (11)	58 (15)	15 (5)	<0.001

Ref 9

**Table 5. Single and Mixed STI<sup>s</sup> Among Women Presenting for TOP at the Dr George Mukhari Hospital, Pretoria, South Africa (N=200)**

<b>Pathogens</b>	<b>No. Positive (%)</b>
<b>Single Infections</b>	
<i>T. vaginalis</i>	24 (12)
<i>N. gonorrhoeae</i>	6 (3)
<i>C. trachomatis</i>	20 (10)
<b>Mixed Infections</b>	
<i>N. gonorrhoeae</i> + <i>C. trachomatis</i>	2 (1)
<i>N. gonorrhoeae</i> + <i>T. vaginalis</i>	1 (0.5)
<i>C. trachomatis</i> + <i>T. vaginalis</i>	5 (2.5)
<i>N. gonorrhoeae</i> + <i>C. trachomatis</i> + <i>T. vaginalis</i>	1 (0.5)
<b>No Pathogens detected</b>	141 (71)

Reference 10

# HIV/AIDS prevention using vaginal microbicides: An update

*Anwar Hoosen, Khatija Ahmed, and Nazira Cassim.*

## Abstract

With the HIV epidemic reaching devastating levels in Sub-Saharan Africa, there is an increasing need to research and develop new prevention strategies especially for women. Vaginal microbicide research has increased dramatically in the last 15 years with more than 16 potential candidates having reached phase 2 and 3 clinical trials. However, some products have been stopped in preclinical or early clinical stages for safety or lack of effectiveness of the product.

The results of studies carried out on these first generation products will be available in 2008. However, research needs to continue to develop better and more effective products. In addition, once products are developed it is important to ensure that the products are easily available and accessible to the vast majority of those susceptible to the infection especially the women of sub-Saharan Africa.

**Key words:** *Vaginal microbicide, HIV research, sexually transmitted infections,*

## Introduction

It is indeed interesting to note the following Hadith in the context of a condition such as HIV/AIDS: It is narrated Abu Hurairah (RA) that the Prophet (PBUH) said:

“There is no disease that Allah has sent down, except that He also has sent down its treatment”<sup>1</sup>

Furthermore, in considering such a disease as HIV infection with its progression to the acquired immunodeficiency syndrome (AIDS) the Islamic advice against stigmatization is also noteworthy.

A verse in the Glorious Qur'an translates:

«Woe to every (kind of) scandal-monger and backbiter»<sup>2</sup>

It is important for Muslims to keep this in mind when confronted with those infected and affected with HIV/AIDS.

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Stigma and discrimination related to HIV/AIDS are considered major barriers to proper preventive and health care measures for HIV infected people or those at risk of HIV infection.

Muslims are also advised not to be negative or judgmental towards others and this is highlighted in the following verse:

*“But if they repent and establish regular prayers and practice regular charity, then open the way for them: For Allah is Oft-Forgiving, Most Merciful.”<sup>2</sup>*

Furthermore, Muslims are guided to provide optimum care and sympathy to patients irrespective of the disease they suffer from and without exploring the reasons behind the said condition.

Due to the high prevalence of HIV there is a clear need for new technologies for the prevention (sexual and non-sexual transmission) and treatment of HIV. Despite years of effort, the production of an effective prophylactic HIV-1 vaccine remains elusive.<sup>4</sup> Correct and consistent male condom use has been shown to prevent HIV-1 transmission,<sup>5</sup> however, women are often unable to negotiate the use of condoms by their male partners<sup>6-8</sup>. The female condom has recently been marketed as an alternative barrier method,<sup>8</sup> However, the use of this device requires a certain level of skill, and at least the consent of the male partner. Furthermore, the efficacy of the female condom for the prevention of sexually transmitted diseases (STDs) is unknown. Cost and limited access to

the female condom is also a barrier in many countries especially those in the developing world.

### **HIV/AIDS – A women’s plight**

Over the past few years the HIV epidemic has accelerated into a devastating pandemic. Worldwide; women are increasingly bearing the brunt of this pandemic, especially women in sub-Saharan Africa. There is evidence that women are twice more likely to acquire HIV infection than their male counterparts and also acquire the infection 5-10 years earlier than men. Today, nearly 17.5 million women are living with HIV throughout the world. In Southern Africa 60% of adults living with HIV are women.<sup>9</sup>

The current HIV prevention strategies which include promotion of monogamy in relationships, condom use and comprehensive management of sexually transmitted infections (STI<sup>s</sup>) are not always feasible for women. Women do not have control of their partner’s sexual behavior, negotiating condom use is difficult if not impossible in some settings and (STI<sup>s</sup>) are often asymptomatic. Furthermore, due to an unequal social status and poverty many women have to have multiple sexual partners who provide economic and social security.

The relentlessness of the HIV/AIDS epidemic with its growing impact on women has prompted the urgency for the development of new prevention technologies.<sup>10</sup>



## Current and new HIV prevention technologies

The currently available and potential HIV prevention strategies are listed below:

### Current Prevention Strategies<sup>10</sup>:

- Ensuring safety of blood supplies.
- Behavioral risk-reduction interventions (including education and support).
- Access to male and female condoms.
- Risk reduction in drug use.
- Post-exposure prophylaxis (oral antiretroviral medication in occupational settings and prophylaxis for adults after exposure to HIV).
- Perinatal HIV treatment/prevention of mother-to-child transmission.
- Voluntary counseling, testing, diagnosis, and treatment of HIV infection.
- Male circumcision.

### Potential Prevention Strategies being researched<sup>10</sup>:

- Microbicides
- Pre-exposure prophylaxis (oral antiretroviral medication before potential exposure to HIV)
- Post-exposure prophylaxis (oral antiretroviral medication in non-occupational settings i.e. for adults

after exposure to HIV)

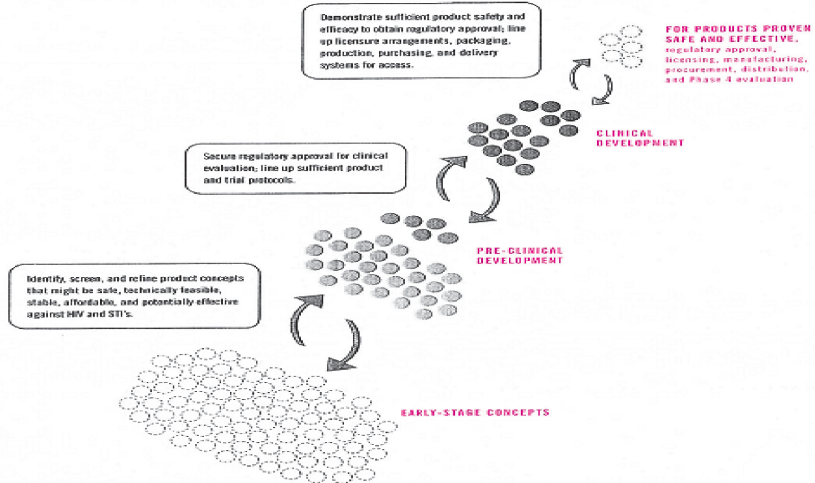
- Preventive and therapeutic HIV vaccines
- STDs treatment for reduction of HSV-2 (herpes) and other STDs.
- Use of diaphragms and other barrier methods.

If the above strategies are shown to be effective, these could be used in combination or separately in order to reduce HIV transmission and infection.

### Microbicides are now being recognized as one of the most promising prevention technologies on the horizon

By definition microbicides are compounds that, when applied topically, have the potential to prevent HIV infection and a number of other sexually transmitted infections. Significant advances have been made in microbicide research and development over the last 15 years. Numerous products have advanced in clinical trials. New strategies for product design and delivery are continually moving through the pre-clinical stages. Public-private partnerships and collaborations among research teams are making important contributions<sup>10</sup>. The various stages of microbicide research and development are shown in the figure below.

## STAGES OF MICROBICIDE RESEARCH AND DEVELOPMENT



**Figure 1: Stages of microbicide research development**

Despite the availability of new resources and attention being paid to the field, microbicide research still falls far short of the comprehensive, full-scale global effort that is needed to develop and deliver a product as quickly and efficiently as possible. In early 2008, results from at least one microbicide effectiveness trial will be known. The world needs to be ready for this news, with plans in place for licensing, production, and delivery: if the product is shown to be safe and effective. Furthermore, regardless of the results of the first trials, there is a need for a set of next-generation vaginal microbicide candidates to be developed to enter clinical studies.<sup>10</sup>

Topical microbicides are products that are designed to inhibit the sexual

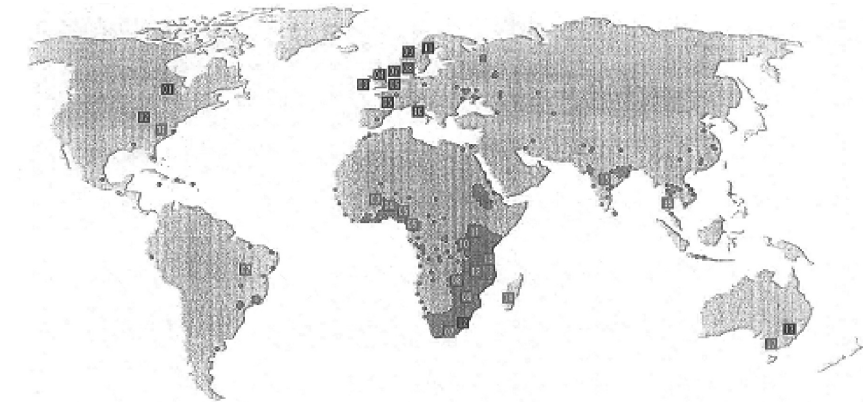
transmission of HIV and other disease pathogens.<sup>11,12</sup> Potentially, they can be applied vaginally to prevent both male-to-female and female-to-male transmission. They also offer a female-controlled prophylactic option in cases in which male condom use cannot be negotiated. Marketed chemical spermicides, which show some activity against STD pathogens *in vitro*, have been evaluated as topical microbicides. However, no clinical studies have yet demonstrated that these products can prevent HIV infection. It should be noted that the spermicide, N-9 has been shown to cause mucosal erosion and ulceration and this potentially increased a risk of HIV transmission.<sup>13</sup>

A vaginal microbicide effective against HIV and other STDs would be an

important addition to the current preventive methods. Many of the viral STDs, such as herpes simplex virus and HIV, have no cure for eradication and prevention is the only strategy for controlling the epidemics associated

with these STDs.

The figure below indicates the prevalence of HIV, ongoing microbicide clinical trials and sponsor companies for clinical trials.



**Figure 1: HIV infections current microbicide clinical trials and sponsor countries**

- People newly infected with HIV in 2005: each dot represents an estimated 10,000 people newly infected with HIV in 2005
- Countries with ongoing and planned clinical trials in 2005-2006
- Countries with public and/or private sponsors of microbicide development in 2000-2005

### **Microbicide products in clinical development**

More than sixteen candidate microbicides have reached the clinical stages of development. Of these, five have entered late-stage trials to assess their effectiveness. One has been successfully completed with results to be released in 2008. Two were discontinued for safety and lack of efficacy during interim analysis of data. It is possible that none of the current effectiveness trials will generate

a microbicide sufficiently effective for licensing. However, much is already being learned from these trials that will be critical for the next generations of new, refined, and combined candidates being prepared for effectiveness testing<sup>10</sup>.

The “present generation” of candidate microbicides in clinical development includes products utilizing four of the major mechanisms of action through which topical microbicides are intended to work viz.:

1. **Vaginal defense enhancement.**
2. **Cell surface disruption (surfactants).**
3. **Entry and fusion inhibition.**
4. **Replication inhibition.**

The main mechanisms of action, with examples of associated products that are now in clinical development are shown below:

**Vaginal defense enhancers** boost women's natural defenses against disease. The vagina is normally too acidic for spermatozoa to survive. However, semen, which is alkaline, neutralizes the acidity of the vagina, thereby enabling spermatozoa and HIV and other pathogens to survive more easily. Acid-buffering microbicides are designed to counteract the semen's neutralizing effects and keep the vagina acidic in order to inactivate sperms and some sexually transmitted pathogens, including HIV. Concepts in development include BufferGel™, Acidform™ gel, Mucocept™, and a product that mobilizes the acidifying action of lactobacilli.

**Surfactants** disable bacteria and viruses by damaging the organisms' membranes and outer coatings. In this activity, they are similar to currently available spermicides such as nonoxynol-9 (N-9). For safety reasons, researchers have focused on low concentrations of surface-acting microbicidal agents that are unlikely to harm human epithelium,

the protective layer of cells lining the vagina and rectum.

**Entry and fusion inhibitors** form a large and highly varied product category that includes three candidate products currently in effectiveness trials: Carraguard®, PRO 2000, and Cellulose sulfate (CS/Ushercell™). The clinical trials of the latter product (CS) were stopped in January 2007 as preliminary findings showed an increased HIV transmission in participants in the study product arm as compared to those in the placebo arm. Some of these products are non-specific blockers, which mean that they do not inhibit specific microbial pathogens, gene products, or transmission pathways but may act against multiple organisms. Some work by attaching themselves to pathogens thereby preventing attachment to host cells. Others bind to potential host target cells, forming a protective coating that prevents pathogens from attaching.

**Replication inhibitors** prevent viruses from multiplying in the cells they have entered. Currently, the repertoire of replication inhibitors is limited to those that target the HIV reverse transcriptase enzyme, critical for HIV replication. Many replication inhibitors were initially explored as potential HIV therapies but were found inadequate because they are not readily absorbed which in contrast enhance their possible use as microbicide candidates.

## MICROBICIDES IN CLINICAL TRIALS

MICROBICIDE CANDIDATES IN ONGOING CLINICAL TRIALS  
SUMMARY AS OF SEPTEMBER 2007

Phase	Candidate Name and Formulation	Mechanism of action	Sites by Country
3	Carraguard® gel†	Entry fusion Inhibitor	South Africa ( completed )
	0.5% and 25 PRO 2000/5 gels	Entry fusion Inhibitor	South Africa, Tanzania, Uganda, Zambia
2B	1% Tenofovir gel ("CAPRISA 004")	Replication Inhibitor	South Africa
2/2B	0.5% PRO2000/5 gel (P) and BufferGel® ("HPTN 035")	Entry/Fusion inhibitor and Vaginal defense enhancer	Malawi, South Africa, United States, Zambia and Zimbabwe
2	1% Tenofovir/PMPA gel	Replication Inhibitor	India, United States
½	Dapivirine (TMC120)vaginal ring	Replication Inhibitor	Belgium
	Dapivirine (TMC1200) gel	Replication Inhibitor	Rwanda, South Africa, Tanzania
	Invisible Condom™ gel	Entry fusion Inhibitor	Cameroon
1	Dapivirine (TMC120) vaginal ring	Replication Inhibitor	Belgium
	Dapivirine(TMC120) gel	Replication Inhibitor	South Africa
	1% Tenofovir/PMPA gel	Replication Inhibitor	Dominican Republic, United States
	0.1% UC-781 gel	Replication Inhibitor	United States
	0.1% and 0.25% UC-781 gel	Replication Inhibitor	United States
	0.1% and 0.25% UC-781 gel	Replication Inhibitor	Thailand
	3% Viva gel™ (spl7013 gel)	Entry fusion Inhibitor	Puerto Rico, United States
	3% Viva gel™(spl7013 gel)	Entry fusion Inhibitor	Kenya, United States,
N/A	Vaginal ring safety and acceptability study	Placebo ring	Kenya ,South Africa, Tanzania

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### **Screening concepts for future microbicide development**

There are now an estimated three dozen candidate microbicides in pre-clinical research and development. Approximately 30 of these are in an early stage of discovery and pre-clinical development. A remaining few are in more advanced pre-clinical development, poised to cross from laboratory and animal testing into clinical evaluation<sup>10</sup>. This number of potential products is not large enough. Attrition is an inevitable part of product development, and might be higher for a technology as new and innovative as microbicides. The majority of early candidates may not withstand scrutiny for reasons of technical feasibility or safety, and some may prove prohibitively expensive or unstable in the environmental conditions in the countries with the greatest burden of new HIV infections<sup>10</sup>.

To overcome these realities and advance a reasonable number of plausible candidates into safety studies in the clinic, a robust pre-clinical development effort is essential, with ongoing and sufficient funding support to continually identify, refine, and

advance products.

The first generation microbicides are likely to reduce risk of transmission by no more than 40-60 percent. But even a partially effective microbicide can provide substantial protection from HIV especially if used consistently. If a microbicide is 60% efficacious for HIV and/or STDs, then 2, 5 million HIV infections can be averted over 3 years, if the product is used in 73 low income nations<sup>14</sup>.

Despite the promotion of abstinence programs and monogamous relationships, the number of HIV infections continues to escalate. It is incumbent and obligatory on Muslim health care professionals to play a meaningful role in trying to control the HIV/AIDS epidemic. In addition to promoting good moral behavior, one needs to provide the best possible care for all patients and seek to identify novel prevention strategies. Muslims in collaboration with others should become involved in assisting with product development and conducting clinical research that will lead to reducing the number of new HIV infections.

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# Sexual Education

*Ali İhsan Taşçı*

## Abstract

For healthy sexuality, sexual education is necessary. However, the importance of sexual education may be understood only after problems occur at individual and societal levels.

Despite that moral sides of sexuality have differences related to cultures, some moral values are found generally acceptable. These are respectful behaviors to others, accepting sexual relationship as a norm after marriage, and behavior according to sexual identity.

The most harmful factor for moral values of sexuality is press. Media that encourage sexual freedom, and extra marital relations, harm the feelings of children, and degenerate family structure, and should be blocked. People have to respect societal values. They can live however they want but they should not inflict harm to values with blind excuses.

Is it possible to keep away youngs from abnormal sexual relationships in conditions that provoke sexuality? When religious beliefs and moral values come up against sexual desires, it is not easy for youngs. Parents should be aware of the seriousness of the condition. Marriage is the best protective measure suitable for human beings. To ease marriage, and to decrease marriage age can help to protect youngs from sexual risks.

**Keywords:** *Healthy sexuality, Islam and sexual education, Marriage in Islam.*

Sexuality deeply affects the person's happiness, success and relations. Healthy sexuality is one of the important factors that make person, family and society strong. For healthy sexuality, sexual education is necessary. However, the importance of the sexual education may be understood only after incidence of problems that occur at individual and societal levels.

The youth is able to perform duties such as working and advancing which are expected from them only if their desires, excitements and tensions of sexuality are satisfied in healthy ways. Otherwise, the young individuals may have psychological troubles or may blindly fulfill their desires and would face sexual dangers.

Relationships and family structure of the man and wife will be very precarious if the spouses do not have a satisfying sexual relationship both physically and mentally.

If the problems caused by sexual ignorance are understood, it would be helpful to understand the importance of sexual education:

- Increase of sexually transmitted diseases
- Increasing rate of unwanted pregnancy and abortion
- Increase of sexual problems
- Weakening of marriage relations, increase of misunderstandings and divorces
- Increasing number of women who are sexually abused
- Increased prostitution
- Increase of violence and crimes related to sexuality

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## Sexual Education Applications

Many parents can educate their children about sex through their conversations and by being fine examples. Nevertheless many parents do not understand their responsibilities about children's sexual education.

In Anatolian traditions, there were peoples named "Yenge" and "Sağdıç" who are responsible to educate the youth who are going to marry. If they are knowledgeable and conscious they might be useful in many ways. However, if they are uneducated they might do more harm than good.

Programmed sexual education is new. Especially, disrespectful behaviors of the young, demoralizing numbers of sexual transmitted diseases and illegitimate children, increasing prostitution, much of violence in family, sexual exploitation and rape cases make sexual education very important.

There are two ways for sexual education of the youth:

- Repression of the young's sexual instincts and sexual acts (Prohibitory sexual education).
- Protecting the young from sexually transmitted diseases and pregnancy. (Explanatory sexual education).

Sexual education programs that emphasize that sexual acts before marriage are forbidden, are the most useful for preventing out of wedlock pregnancy, and sexually transmitted diseases.

These programs are suitable for the moral values in various cultures. In this type of program, STDs, harms of pregnancy before marriage, virtue of sexual fasting from the religious and ethical points of view are emphasized. Alternatives are offered to the young for controlling their sexual feelings and behaviors.

Explanatory sexual education is premised on the idea that prohibitory sexual education could not be useful in practice. The aim is protecting the young from sexually transmitted diseases and unwanted pregnancy. For this aim, explanatory information and preventive measures are offered. Providing contraceptives including condoms is part of this program in some regions.

## Sexual Education Discussion

People react positively or negatively according to their understanding of the role of sexual education. Many parents tend not to understand the need of sexual education for their children.

**"It is not necessary to educate healthy sexual life. Sexuality is a special feature that started from the creation of human being. In marriage, wife and husband learn their sexuality and get the experience"**

People with this vision, what they understand from sexual education is nothing more than the type of sexual relationship. Besides sexual knowledge, many features like positive emotional development, respect to self and others,

having ethical values and virtual qualifications, and awareness of sexual risk is a subject of sexual education to be taught.

**“Sexual education of the youth only causes incitement and inappropriate behaviors!”**

Indeed, in the name of sexual education, given by irresponsible people can include pornographic material inciting sexuality, that may cause inappropriate sexual relationships of the youth. But in sexual education given with moral concerns, youngsters can be taught to control their feelings and to protect themselves from risks associated with sexuality.

**“Sexual education damages moral values of society”**

Sexual education programs given without moral concerns of the society are harmful. In Muslim society, programs including ideas like «it is normal to have sexual relationship during menstrual period», «before marriage for girls and boys to get to know each other better, it is beneficial to be closer in sexual way», «unimportance of hymen and virginity» will conflict with value judgement.

**“Suggesting contraceptives and condoms to youth means sexual relationship is allowed before marriage”**

Especially as it is seen in Western sexual education programs suggesting and providing contraceptives and condoms means that sexual relationships are

allowed. Therefore these programs are opposed. Supporters of this kind of programs think “it is not possible to stop relationships. Therefore we have to protect the youth from sexually transmitted diseases and unwanted pregnancies”. Ethical values are not taken into consideration. Also in our country, condom advertisements to avoid AIDS cause similar discussions.

**Moral Aspects of Sexuality**

There are universal moral values that are accepted by all. But there may be important differences in moral values between cultures. For example, killing someone is a universally evil action. Nevertheless in some cultures death penalty could be morally acceptable, but in some cultures it is not. There is also a dilemma about abortion.

While the values of sexuality may be different in different cultures, some moral values are found generally acceptable.

- Respectful behaviors to others.
- Accepting sexual relationship as a norm after marriage.
- Behave according to sexual identity.

Respectful behaviors to others can remove several problems related to the moral aspects of sexuality. If there is respect, there will not be abuses of the partners.

Even though considering sexual relationship after marriage as a norm

is generally accepted especially in Western societies, pre- and extra-marital relations may also be accepted or at least tolerated.

People should behave properly in ways that are appropriate to their sexual identity. When there is no negative factors, sexual identity develops according to sex of the person. But inappropriate behavior of other people or faults of parents when upbringing their children or sometimes certain improper incidents can cause development of sexual deviations.

Behaviors against the homosexuality could differ between societies as well as reactions taken against extra-marital sexual relationships.

### **Homosexuality**

In Nature, males and females are complimentary to each other. The reason of creation of humans in two sexes is to reunite them in holy, mystic and fertile way. There is no hope to build a strong future for societies unless the existence and health of marriage is protected.

Showing sympathy towards homosexuality, to propagate and show it publicly, is a radical challenge against the marriage system.

Today serious components of challenging health problems like AIDS that threaten the world, is closely related with homosexual acts. It should be considered that allowing homosexuality publicly will cause many sexual and physical health problems we

can not even imagine today.

If we think of homosexuality as one person's sexual free choice, or abnormal feelings that could not be suppressed, this can be approached in many different ways. If a person who has homosexual feelings and is challenged with this, it is our duty to help him and be tolerant of him. They should be congratulated if they do not put into practice their feelings. But if we think of homosexuality as a social phenomenon, it is a threat for society. All religions and ethical concepts are opposed to the concept of homosexual choice. Sexual freedom and homosexual choice should not be universal human rights on a social level.

Desensitisation with small stimuli is a way of social alteration. Allowence and application phases follow desensitisation phase. Eventhough this gradual alteration happens in years at individuals and at some examples; social alteration sometimes happens after several generations. Assestors of homosexuality exert this alteration phonemon. Today and future must be conserved from homosexual dangers.

These are suggestions to combat homosexuality:

- Persons who have feelings of homosexuality and who try not to act on these feelings should be supported.
- Stand up against people and foundations that try to legalize homosexuality.

- Give counseling to society to educate their children in a proper way.
- Encourage the youth to get married.
- Create a consensus that homosexuality is an abnormal feeling which should not be displayed.

### Prostitution

The widespread prevalence of prostitution indicates how much primitive is sexuality in this society. In the modern world people do not care about these women, who do not have their human rights. They do not have a warm home and they do not receive proper medical treatment.

Sexual education directs communal thoughts about prostitution. Thinking that prostitution helps the youngsters to learn sexuality and provides single individuals the opportunity to be sexually satisfied shows illiteracy of the people. It is impossible to block people who organise and condone prostitution. But if the youth has enough knowledge about the harms of prostitution for themselves and for society, probably there will not be customers for prostitution, and the problem will dwindle.

### Press and Sexuality

Moral values of sexuality are learnt by education. We should try to eliminate factors that are harmful for these values.

The most harmful factor for moral values of sexuality is the media. Broadcasts that

encourage sexual freedom and extra marital relations, harm the feelings of children, degenerate family structure, and should be blocked. People have to respect societal values, and should be careful to avoid harming these values with whatever excuses they may have.

### How do media affect sexuality?

- Aspects of sexual functions: Media present sexuality exaggeratedly and with myths. A person can start questioning himself and his or her partner. They compare themselves with others. As a result of this kind of thinking, fear of abnormality, and unsatisfied personality can occur.
- Aspects of moral and ethical values: The most important factor which protects society from degeneration is virtues and value judgement of this society. Values like heeding of family relations, and desire to live sexuality in marital bond, protects society. Otherwise degeneration, misuse of freedom, and fall of society may occur. In press, materials which affect moral values negatively, are often encountered.
- Aspect of women abuse: In the media, mostly women are presented with their sexuality. Sexual aspect of women should not be abused.
- Aspect of sexual deviation: One reason of a person's sexual deviation is to know that there are others who think and act like him. He will find no reason to change his behavior. Another reason is to perceive

abnormal behavior as normal.

### **Sexually Transmitted Diseases**

In 2007, 33.2 million [30.6-36.1 million] people were estimated to be living with HIV, 2.5 million [1.8-4.1 million] people became newly infected and 2.1 million [1.9-2.4 million] people died of AIDS.

There were an estimated 1.7 million [1.4-2.4 million] new HIV infections in sub-Saharan Africa in 2007- a significant reduction since 2001. However, the region remains most severely affected. An estimated 22.5 million [20.9-24.3 million] people living with HIV, or 68% of the global total, are in sub-Saharan Africa. Eight countries in this region now account for almost one-third of all new HIV infections and AIDS deaths globally.

Since 2001, when the United Nations Declaration of Commitment on HIV/ AIDS was signed, the number of people living with HIV in Eastern Europe and Central Asia has increased by more than 150% from 630,000 [490,000- 1.1 million] to 1.6 million [1.2- 2.1 million] in 2007. In Asia, the estimated number of people living with HIV in Viet Nam has more than doubled between 2000 and 2005, and Indonesia has the fastest growing epidemic.<sup>1</sup>

Sexually transmitted diseases (STDs) remain a major public health challenge in the United States. While substantial progress has been made in preventing, diagnosing, and treating certain STDs in recent years, CDC estimates

that approximately 19 million new infections occur each year, almost half of them among young people ages of 15 to 24<sup>2</sup>.

### **Prevention of STDs**

Knowing the seriousness of STDs, and decreasing their incidence is only possible with sexual education after childhood.

- Each person should have enough sexual education.
- Should know how to protect himself/ herself from STDs.
- Should support treatments for STDs.

### **Education about STDs**

Education is essential for prevention of STDs. Knowing the seriousness of STD's, and the methods of their spread, is only possible with enough education that is given from childhood. Otherwise all preventive efforts and factors may not be sufficient.

Youngsters should understand the importance of family. They should live sexuality in the marital relation. Youth provided with moral dimensions of sexuality would be more successful in protecting themselves.

Eventhough the youth are educated about STDs and understand the moral values, they may have difficulties to control themselves when their friends insist. Especially if they are under the effect of alcohol or drugs they will not be able to resist their sexual desires. Therefore youngsters, beginning

from childhood, should be taught the feeling of self confidence, the ability to control sexual desires, to resist friends insistence and ability to say no.

### **Marriage is protective**

Youngsters must be helped to avoid sexually transmitted diseases, undesirable pregnancy, sexual exploitation, psychological trauma and sexual violence.

Is it possible to keep away the youth from sexual relationships while living in circumstances that provoke sexuality? When religious beliefs and moral values come up against sexual desires,

it is not easy for the youth. Parents should be aware of the seriousness of the situation.

Marriage is the best protection: to ease marriage, and to decrease marriage age can help to protect youngsters from sexual risks.

The more delay in the marriage age the more sexual risks for youngs. Today people look first to complete their education, to start a good job, to save money and for males to complete military service, therefore marriage is delayed.

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# The Fight Against Communicable Diseases In Islam

**Mustafa Samasti**

## Abstract

The religion of Islam presented the most convenient system of life to humans and advised them of being respectful to balance of nature. Due to the fact that Islam is consistent with the creation, that means it is in harmony with the human nature, all aspects of the health issues have been covered by Islam. Even the principle of cleanliness, among those related with the health issue, is enough to prove the fact that Islam is also a religion of health. Islamic principles are highly effective for us to control the sources of germs, to prevent infections, to protect the resistance mechanism of the body and help it to work properly. Cleanliness is the most effective way for fighting against the germ sources. Until the 19<sup>th</sup> century when germs were discovered, the importance of Islamic principles for cleanliness was understood in the West. For centuries in Cristian World, dirtiness was equalized with nobility. Malady factors enter body via digestion, respiration, skin and genital ways. Islamic advices significantly supply prevention against the entrance of infections. It was mentioned in the Glorious Qur'an that foods and drinks should be clean and halal and should be moderate. The protection of babies, with immature system of defense, against germs, and their proper nutrition is very important. The defense system of children can develop in two years. In parallel with this fact the Glorious Qur'an advices breast feeding period of two years, in addition to this the first practices of quarantine can be seen in Islam. As a result of the destruction of nature and degeneration of the naturel harmony among living creatures, old infections like Crimean-Congo Hemorrhagic Fever (CCHF) has started to be seen again. All those matters considered we should pay attention to the caution of the Glorious Qur'an for the protection of natural balances.

**Keywords:** *Balance of nature, Islam and health, Islam and cleanliness*

Mankind and the universe have been created based on extremely sensitive scales and balances. Mankind is the sole creature with the ability to disrupt these balances with its own freewill. Religion adverts to this aspect of mankind and advocates to abstain from extremes and to be moderate in lifestyles.

The religion of Islam begins with the order <Read> (Iqra) <sup>1</sup>, and emphasizes to be respectful to these balances laid out to mankind <sup>2</sup>, which was created in perfect form and thus revealed to all creatures <sup>3</sup>. Human health calls upon mankind to be in reconciliation with his own inner world and with his environment. In retrospect, the religion of Islam organizes mankind's multi-dimensional relation with Allah (SWT) and worldly beings and has granted him a high consciousness of responsibility. Those who are aware of this consciousness direct themselves to perform good deeds for themselves and for their surroundings and avoid destructive deeds and actions. It is this notion that allows for the ink of a scholar to be held above the blood of a martyr.

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The operative effects of the religion of Islam on health issues can only be evaluated within the total perspective of this religion. Aside from several principles in Islam that affect health directly, one principle of cleanliness well proves Islam to be a health conscious religion. Islam is equipped with an overall, deep and effective point of view concerning the prevention of communicable diseases. The comments and suggestions foreseen in Islam concerning this issue have been laid out in many stages, and allows for easy comprehension and application for every member of society. Despite all scientific and technological developments mankind has not found a more effective method to fight communicable diseases than that displayed to us in Islam.

Islamic principles concerning the control of germ breeding sources, their prevention and the safeguarding of the body's immunity system and its proper function are outstandingly effective.

### **Controlling Germ Breeding Sources**

Germs nestle in filthy and organic elements and tend to breed rapidly where proper humidity and temperature conditions are available. Clean environments are generally germ free. Thus, the most effective way to fight germ sources is cleanliness.

Islam is a religion based on principles of cleanliness. The fundamental principle of all forms of worship is cleanliness. Consequently, the most effective method of preventing germ breeding sources is cleanliness. Worship cannot

be performed in a body, clothing or surrounding that is not clean. Cleanliness includes all aspects of life such as body, clothing, home and surroundings.

After the first revelation of the Quran,<sup>1</sup> one of the following revelations is the words that states (keep your clothing clean)<sup>4</sup>.

The most important means of catching and spreading germs are through the hands. Thus, the most effective method of preventing infections is by keeping our hands clean. Hand, mouth and teeth hygiene is a topic of extreme importance in Islam. Germs can easily breed in proper body temperature where proper nutrition is found. Food particles and scraps that remain in the hands and mouth after meals provide a favorable environment for germs. Consequently, washing the hands, mouth and brushing teeth after meals is as important as washing up before meals.

There are at least 100 Ahadith regarding tooth brushing (the use of miswaq). Dentists consider tooth brushing once or twice a day to be sufficient, whereas the Prophet (PBUH) suggested the use of miswaq in many instances (when you wake up and at the time of performing ablution before prayers, before reading Glorious Qur'an). It is well known today that germs that cause tooth decay, gum and oral diseases are found in saliva, and these germs stick to the surface of teeth and form tooth plaque (biofilm). Frequent tooth brushing with miswaq

prevents this activity which continues even after meals, which is a further proof of Islam's miraculous sides.

Body cleanliness, the removal of body accesses and over growth (hair, nails), circumcision, lavatory hygiene (to cleanse with water), washing hands before and after meals, mouth and tooth hygiene are among Islam's routine rules and conventions.

There are past publications, specifically written by Christian doctors, indicating that Muslims who abide by Islamic rules never catch leprosy.

The benefits of circumcision are now accepted by non-Muslims and the application is becoming widely adopted.

Among the most common sources of communicable diseases are human and animal excretions. According to Islam such excretions are considered filthy and unsanitary and will besmear water and any other object it may be in contact with. Urinating or defecating in places where people tend to sit and relax, roads they will pass by, fountains and water fronts they will use and under trees has been forbidden in Islam and such behavior is condemned.

It is commanded in the Glorious Qur'an to keep places of worship clean<sup>5</sup>.

Water and food constitute an important place among the sources of infections. There are several verses in the Glorious Qur'an that state that food and beverages should be kept clean, halal, and should

be consumed moderately<sup>(6-9)</sup>. Dead animals carcasses, blood and pork meat are among the biggest sources of germs and any animal slaughtered without the name of Allah is considered to be forbidden (haram) in Islam<sup>10</sup>.

The first applications of quarantine in history were encountered in Islam.

Protecting babies whose immune system have not yet developed against infections, and providing them proper nourishment is of extreme importance. Since it takes nearly two years for a baby's immune system to develop fully, poor nutrition and environmental conditions allow for microbial illnesses to spread in large proportions. Breast milk is not only germ free but it is the most appropriate nutrition for babies. The Glorious Qur'an<sup>11</sup> states that the breast feeding is a baby's fundamental right, and suggests that a baby should be breast fed for a period of two years. The World Health Organization (WHO), and UNICEF have suggested that the ideal target for the 21st century is that babies should be breast fed for a period of two years, and this should only be complimented with other nutritional food products after 4-6 month. Especially, in the case of premature and low weight babies, breast feeding is considered a life-saver against dangerous infections.

Diseases that are spread through non-marital sexual relations are considered among the major problems of the Western and many other parts of the world. The religion of Islam forbids

out of wedlock and unnatural sexual relations and safeguards society from these disasters by encouraging marriage and conjugal community.

Sexual intercourse is forbidden throughout the duration of a woman's menstrual period. During this period secretions are infested with germs and an "open wound surface" (the denuded endometrium) favors infections.

Unnatural methods of sexual intercourse carry high inflection risks. The rectal mucosa is extremely sensitive to infections. 40% of the AIDS cases in the United States are found in homosexual men which is a clear indication of this fact.

The use of intravenous illicit drugs, genital lesions and men that have not been circumcised are among other risk factors for AIDS. The prepuce acts as

a natural reservoir for secretions and germs and facilitates infection.

Other important dimension of infection protection is preserving ecological balances. The destruction of nature and the disorder of relations between creatures bring to order forgotten diseases from the past and bring forward new unknown diseases. Just as there is a balance between creatures, there is a balance that exists between chemical elements and molecules. Disrupting the natural conformation of foods and beverages by means of hormones and chemicals, feeding animals, that should be fed by plants and herbs, with animal based feed grain causes pathological protein diseases such as mad-cow disease. Similar problems remind us of the importance of Qur'an's warnings to abide by these balances and guidelines<sup>2</sup>.

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# HIV/AIDS Prevention: An Islamic Perspective

## Experience from South Africa

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**Mahomed Ebrahim, Suraiya Nawab**

### Abstract

HIV/AIDS is a global problem of epidemic proportions. The need for an Islamic approach to address the epidemic is vital. The Muslim AIDS Program (MAP) was initiated in Gauteng, South Africa in 1998 as a pilot project. A tripartite alliance between the Jamiatul Ulama, the Islamic Careline (sisters in a counseling service) and the Islamic Medical Association of South Africa (IMASA) has resulted in the MAP initiative. Since then the program has gained ground in most of the major provinces in South Africa.

Training of volunteers, community awareness and life skills school programs, madrasa and outreach volunteer training has been ongoing. Capacity building in poorer areas is essential and has impacted on non-Muslims as a dawah initiative. The MAP program is in partnership with the South African National Department of Health's program. Evaluation of the program's impact, content, relevance and updating is done on a regular basis. A care center for women and children with HIV/AIDS who are destitute and require care (medical, counseling and support) has been in existence in Johannesburg since July 2003. Promotion of abstinence in all communities has been a step in the right direction with MAP being supported by the government as part of the Islamic approach.

### Introduction

The disease entity HIV and AIDS (Acquired Immune Deficiency Syndrome) evokes many and varied reactions. Much has been written and said about this condition and large amounts of monies have been spent trying to find a cure for it. Yet AIDS has progressed relentlessly since its first official debut in the early eighties<sup>1</sup>. No country, nation or community is exempt from its serious medical, social and ethical consequences. AIDS is a communicable venereal disease and it is a well established fact that the vast majority of cases are transmitted by promiscuity, sodomy, fornication and adultery. Yet it is surprising that moralizing about AIDS or any other sexually transmitted disease is taboo in present day society. Accordingly, the real issue in AIDS prevention is not adequately addressed. Islam as well as other religious groups address the root of the problem and as such are capable of delivering constructive suggestions for solutions to the AIDS dilemma. The religious groups if heeded can assist in the further prevention of infection and in the comprehensive management of infected persons.

The vast majority of methods by which AIDS is transmitted viz. drug abuse, sexual promiscuity including homosexuality are forbidden in Islam. The Islamic system promotes fidelity in marriage, and there is a clear emphasis on a healthy family structure. Pre-marital and extra-marital sex is uncompromisingly forbidden. Sexual desires are to be channelled through an early and sound marital life. The holy book of Islam, the Glorious QUR'AN states:

*"Let those who find not the wherewithal for marriage keep themselves chaste. . ."*<sup>2</sup>.

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In the short term, the slogan of Safe Sex may slow down the spread of AIDS; however, in the long term the message 'Save Sex' / 'don't experiment with sex at all until you are married (in a closed relationship) and avoid drugs completely' is better.

'Don't share needles' is not enough; 'Don't take drugs at all' is better.

Religion must play an important role in the campaign against drug abuse, promiscuity and other immoral behaviors. Religious beliefs and moral codes should actively encourage virtuous attitudes and chastity within every community. These activities would ultimately prove to be the most effective form of prevention in the global fight against HIV and AIDS. The Muslim initiative is an excellent vehicle for the stemming and prevention of the HIV/AIDS epidemic.

The Muslim AIDS Program (MAP) contribution in this regard consists of the development and dissemination of specific AIDS awareness materials which are used in the training and educating of facilitators in order to effectively implement a religious response to HIV and AIDS. The establishment of professional counseling and care giving facilities for people living with AIDS (PLWA) is also an important humanitarian function, and is regarded as a priority of the Muslim AIDS program. Ongoing seminars and workshops help in keeping the public aware and informed about the dreaded disease. The joint

partnership between Jamiatul Ulama, together with the Islamic Medical Association of South Africa (IMASA) and Islamic Careline provides a well-rounded approach because religious, medical, psycho-social avenues and expertise are utilised.

The establishment of a formal structure within the Muslim community has considerably enhanced the national struggle against HIV/AIDS. One of the aims of this struggle is to mobilize a religious response to HIV/AIDS. We have, as a minority community in South Africa achieved much more in the field of awareness and attitudinal changes to the perceptions and myths around the issues of HIV and AIDS. Moreover, the Muslim AIDS Program has been implemented at grassroots level and positively impacts in stemming the tide of this global pandemic.

### **National Department Of Health Program**

The National Department of Health program encompasses the following <sup>(3,4)</sup>:

- ABC approach i.e. promoting Abstinence, Being faithful, and Condom use
- Antiretroviral therapy for infected persons
- Prevention of mother to child transmission of HIV
- Condom distribution
- Promotion of safe sexual behaviour
- Promotion of comprehensive case



management at Primary healthcare level

- Specific interventions for high risk populations
- Promotion of healthy lifestyles

### Islamic Program

The Islamic program promotes:

- A. Abstinence** from sexual contact until marriage
- B. Being faithful** in one's marriage bond.
- C. Commitment, Compassion** and promoting Circumcision

A historical perspective of MAP can be summarized as follows:

- In 1996, The Department of Health invited religious groups to get together to share ideas to curb HIV/AIDS epidemic
- In September 1997, Religious Aids Program was launched including all the major religions.
- In April 1998, 3 Muslim groups launched Muslim AIDS Program (MAP)

IMA of South Africa – Medical aspects

Jamiatul Ulama – Islamic Shariah input

Islamic Careline – Behavioral aspects – including: awareness, care, counseling etc.

The Program started in earnest in 1998. Workshops were conducted which included the following:

- Facts about AIDS
- Attitudes towards those living with AIDS
- Sexuality in Islam
- Death and dying
- Pre and post test counseling
- Home-based care
- Legal aspects of HIV/AIDS

### Muslim AIDS Program (MAP)

The specific goals and objectives of (MAP) are:

- To further develop and enhance the present value-based program in order to prevent HIV/AIDS infections.
- To train more volunteers on an ongoing basis in order to implement the program at community/grassroots level.
- To increase the number of AIDS awareness workshops in all areas and communities.
- To establish AIDS information and resource centers in various geographical areas to serve the needs of all those infected and affected with HIV/AIDS.
- To provide adequate counseling, hospice and palliative care for PLWA.

- To implement an effective schools outreach program, this would include relevant sex education and life skills components.
- To use appropriate role models from the sports sector who are committed and willing to participate in the program.
- To promote education to primary health practitioners in the pathogenesis, diagnosis, counseling and management of HIV/AIDS.

### **Identification Of Strategic Objectives For MAP**

Target groups for awareness and mobilization needed to be realistic and accessible. Religious leaders, youth, women's groups were identified. MAP offered interactive and experiential workshops that would dispel myths, provide information and motivate commitment amongst key role players. MAP workshops were specifically structured to teach people to be non-judgmental, compassionate, accepting, etc. People needed to be taught to talk about issues like sex and sexuality in an environment of safety and purposeful discussion.

The use of religious knowledge and cultural lifestyle to promote the need for Muslims to become involved was imperative. The basic primary modes of transmission of high risk or promiscuous sexual behaviour and intravenous drug use were discussed. Both are emphatically forbidden in Islam and implied that Muslims "should" remain

safe. The reality is that these are both prevalent to a certain extent in Muslim society as was gathered from statistics at the Islamic Careline and the IMASA, which are both joint project partners of MAP.

MAP was always keen to contribute to the HIV/AIDS pandemic from a multi-faith perspective. All major religious groups have the same basic message regarding abstinence, being non-judgmental, showing compassion and care. By sharing challenges and success we were able to mobilize a specific faith based approach that would enhance and formulate the overall religious response to the pandemic.

### **Needs Analysis in the Muslim Community**

A needs assessment at the beginning of the project showed that HIV and AIDS information was necessary for the Muslim community. The perception that HIV/AIDS does not affect Muslims was apparent amongst members of the community. Many persons had the attitude of non – involvement because of an unrealistic fear of becoming infected by participating in the program. Denial of the problem within the community was also noted. There was an alarming lack of knowledge about facts regarding HIV and AIDS. There appeared to be false hope that just being Muslim will protect us from infection. Men seemed to be more reluctant to get involved than women and this was attributed to the perception that HIV/AIDS was a social responsibility rather than a universal

crisis that required urgent intervention.

### Activities of MAP

The various activity areas of MAP are workshops, life skills programs at schools, volunteer program, home-based care, MAP Care-center, counseling and community awareness.

#### 1. Workshops

These include those for HIV/AIDS training, educating religious and community leaders, conducting life skills program, providing HIV/AIDS education for the workplace and disseminate information to different communities.

#### 2. Life Skills Program

This program is necessary for successful living and learning management of stressful situations.

The promotion of physical and mental wellbeing, in young people, as they face the challenges of life is essential. Young people should be empowered to take more responsibility for their own actions and make informed choices for their future.

The program focuses on prevention of further infection by developing and implementing a comprehensive Life Skills program for youth with the considering that women and youth are the groups more susceptible to infection. The holistic life skills program includes the following topics: self concept, assertiveness, decision making, facts regarding HIV and AIDS,

as well as sex and sexuality.

The promotion of spiritual, moral, cultural, mental and physical development of the individual using a holistic approach is essential. The information needs to be Islamically sound and factually correct. It has to be learner centered, practical and sustainable. The program should allow the youth to express concerns and feelings and impact on behavior change with appropriate knowledge, skills, values and attitudes.

The “No Apologies” life skills program, targeted at young adults is abstinence-based program which teaches young people to make informed choices for their future. It includes topics such as character building, sex and sexuality, media influence as well as marriage matters. The following acronym is useful:

- L – Learning to love Allah and other human beings.
- I – Identify them as part of a dynamic religion.
- F – Foster pride and dignity to young Muslims.
- E – Empower them to become faithful in their actions
- S – Sensitize youth to Islamic lifestyles and value systems.
- K – Kindness and compassion as part of Islam.
- I – Instill respect and responsibility

- L – Listening skills form part of being empathetic.
- L – Lessons for coping skills & for making informed choices.
- S – Socializing according to Islamic value system and moral code

### 3. Volunteer Program

Active recruitment of volunteers from outreach activity is essential to impact on the communities.

Capacity building of volunteers, support and structured supervision was undertaken and is ongoing, with lay volunteers undergoing training in active listening and counseling. They are also involved in home based care, fund-raising initiatives, and relief at the care center.

### 4. Home Based Care (HBC)

This is an outreach program. The MAP managers go to resource poor areas and recruit and train volunteers to provide HBC. Training is provided by MAP in conjunction with specialist HBC organizations whilst supervision is carried out by MAP. Furthermore MAP provides food parcels and basic care for the affected persons who are being cared for at home. The beneficiaries of this program are PLWAs in informal settlements and in peri-urban areas of large cities.

### 5. Care And Counseling

This includes offering **Help**, empathy and support to promote **Healing**.

Making **Information** on various aspects available, including contact numbers of care giving centers. Regular **Visits** by volunteer councilors to PLWA should include support (physical and economic) and prayer. The acronym **HIV** is useful.

Advocating the teachings of the Qur'an and Hadith, and encouraging the focus on Allah (SWT). The Integrity of care and counseling of PLWA should not be compromised and offering to strengthen self worth. Aspects of Death and the process of Dying should be explored at some stage, using examples from Qur'an and Hadith. The Spiritual needs of the person should be borne in mind and encouragement to engage in Dua , Zikr, and the beautiful (99 ) names of Allah (SWT) The acronym AIDS is useful.

### 6. Community Awareness

The most important pre-conditions are:

Awareness: People need to be made more aware of the situation in their local community as well as in the general community.

Motivation: People need to be inspired. They need to feel the personal benefits in order to encourage their involvement in the process.

Activities include:

A day or week is set aside for special focus on a specific issue; arranging talks, discussions and debates on the issue; inviting dynamic, well-known experts in the field, to talk to the community.

Exhibit and distribute posters and pamphlets on the issue on a regular basis.

### **7. The MAP Orphan and Vulnerable Children Program**

The AIDS pandemic has resulted in the deaths of twenty five million people and a further forty million are now living with the disease. The epidemic has also had a devastating effect on the lives of children. More children are caring for their sick parents and even more are made vulnerable through the impact of the epidemic on their communities. These children need support from the community. MAP offers counseling services as well as basic poverty alleviation assistance for PLWA and their families.

MAP is running two Orphans and Vulnerable Children's (OVC) programs in Soweto and Fordsburg. We try to normalize the lives of the children as far as possible. The program endeavours to strengthen their coping mechanisms, as well as the challenges of addressing the needs of orphans and other children made vulnerable by HIV/AIDS.

The program addresses some of the following:-

- Withdrawal from school
- Discrimination and stigma
- Emotional needs and grief over illness and death of parent(s)
- Increased poverty
- Lack of adequate nutrition
- Loss of property and inheritance rights
- Material needs
- Shelter needs
- Inadequate health care
- Vulnerability to physical and sexual abuse
- Children become care providers for sick parents or for younger siblings
- Children may have to resort to various forms of labor
- Loss of parenting
- Homework and supervision

The project has been initiated by MAP in partnership with appropriate government departments. It has resulted in a most fulfilling and rewarding exercise and a much needed support for the Gauteng Provincial strategy in combating HIV and AIDS in the province.

### **8. Muslim AIDS Program Care Center**

The MAP Care Center was established in July 2003 as there was a dire need for a place where PLWA's in the Muslim community would be welcomed and assisted in overcoming some of the difficulties they face living with the disease.

The Islamic Careline, in conjunction with the Jamiat-ul-Ulama and IMASA, have successfully managed to implement such a service. The premises currently accommodate females and children who are infected or affected by HIV and AIDS. There are specific criteria that need to be met in order for a person to be accommodated at the MAP Care Center. These include a referral from a social worker, a doctor, a health professional or hospital, a recent HIV status and a TB assessment report,

a recent pregnancy test result and an authentic identity document.

### Services

The counselors of the Islamic Careline offer confidential counseling and support. According to one resident, she feels a sense of respect and self worth when she attends her counseling sessions at the Careline. She also feels better equipped to continue living a meaningful life since being accommodated at the MAP Care Center.

### Spiritual Development

The Jamiat-ul-Ulama (Fordsburg) plays a pivotal role in the spiritual development of the residents. They are encouraged to attend Islamic classes at the Jamiat offices. Any Shariah matters regarding MAP activities are referred to the Jamiat for approval. The Jamiat also manages and supervises any renovations and maintenance that may be required at the premises.

### Medical Care

The Islamic Medical Association plays an important role in the clinical management of the MAP Care Center residents. Doctors volunteer their professional services and make available a limited amount of medication. Two doctors are on a 24-hour stand by, in the event of emergencies. All health professionals such as dieticians, psychologists and alternative health practitioners are also available for the needs of the residents.

The MAP Care Center provides PLWA's

with a sense of belonging without fear of being judged or criticized. The MAP Care Center has become a place where children play and laugh and are given equal attention and parental and love by all the adults. This helps ensure positive development in all aspects of a child's life. The children are afforded quality education at schools in the area as well as supervised Madrassa (Islamic education) daily programs.

### **The Way Forward**

Unchecked, HIV/AIDS will continue to spread, destroying families and deepening poverty. The social stigma attached to HIV/AIDS exists in all societies but maybe more pronounced in Muslims. This prevents those at risk from coming forward for appropriate counseling, testing, and treatment.

Islam places a high value on chaste behavior and prohibits sexual intercourse outside of marriage. It specifically prohibits adultery, homosexuality, and the use of intoxicants. Muslim leaders need to be more active in propagating abstinence from use of illicit drugs and unlawful sexual practices.

Every Muslim healthcare professional should implement the MAP program in their workplace.

The IMASA needs to establish MAP offices in every province of South Africa and in other African countries. We need to integrate our prevention and treatment strategies, within existing social, cultural and religious

frameworks. There is a need to provide and sustain appropriate healthcare resources and infrastructure for successful prevention and treatment programs. HIV/AIDS education and encouraging all people to get tested is extremely important.

An area of work is to define the extent of the HIV/AIDS problem amongst Muslims and to address the issue of stigma and under reporting. We need to implement mandatory HIV testing before marriage.

The majority of funds for HIV programs are from non-Muslim sources (e.g. USA) and this causes problems with maintaining Islamic principles in programs. Therefore there is a need for obtaining funding from local Muslim sources. Zakaat funds may be utilized.

### **The Way Forward – “Islam Has The Cure”**

There are 2 dimensions to this assertion:

#### **1) In order to prevent infection we need to follow the Islamic injunctions:**

*“And do not destroy yourselves for indeed Allah is unto you most merciful”<sup>(5)</sup>*

*“And do not come near to adultery, verily it is an immoral act and an evil path.”<sup>(6)</sup>*

*“What! Of all the creatures, do you approach males and leave the spouses whom your Lord has created for you?”<sup>(7)</sup>*

The Prophet (SAW) said:

“Marriage is of my sunnah and those who do not follow my sunnah are not of me.”<sup>(8)</sup>

“Every intoxicant is khamr and every

khamr is haram (forbidden).<sup>(9)</sup>

#### **2) For those unfortunate to be infected:**

We need to encourage an increased level of spirituality that draws one close to Allah (SWT). We need to assist others by having a compassionate attitude and providing care. Those infected through promiscuity, need constant and sincere repentance including a heightened sense of Allah consciousness.

### **Conclusions**

This paper outlined the South African government's program for HIV/AIDS, then presented an overview of the origins of MAP and outlined its activities and challenges faced in South Africa. There is urgent need to expand the program to other countries and members of the Federation of Islamic Medical Associations (FIMA).

The Muslim AIDS Program (MAP) has developed into an important outreach for the prevention and management of HIV and AIDS in South Africa. MAP from its outset committed itself to both the management and prevention of this devastating pandemic. We are confident that the partnership between MAP and the South African government continues to make a positive contribution to the national fight against HIV and AIDS in our country. We remain eternally grateful to Almighty Allah who has given us the opportunity to serve His creation and we hope and pray that He Blesses all those involved in the program for their untiring efforts and support.

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# An Update On The Implementation Of The Islamic Approach To HIV/AIDS

*Magid Kagimu*

## Background

The Islamic approach to HIV/AIDS is a concept that Muslim communities use in their efforts to combat HIV/AIDS. The term concept refers to a mental image or construct developed to symbolize ideas, persons, things, events or processes. In order to move from the abstract level to the concrete level of observation and implementation scientists give concepts operational definitions. Operational definitions indicate the precise procedures or operations to be followed when measuring or assessing a concept<sup>1</sup>.

It has been observed that religion and spirituality play a central role in HIV/AIDS prevention, treatment and care and support. However, challenges remain in defining and assessing this role scientifically<sup>2</sup>. The Islamic Medical Association of Uganda which has been using the Islamic approach to HIV/AIDS in addressing AIDS related issues for over 18 years made an operational definition for this concept<sup>3</sup>. This definition was discussed and consolidated during the 3<sup>rd</sup> International Muslim Leaders Consultation on HIV/AIDS which took place in Addis Ababa Ethiopia in July 2007. This consultation which was organized by the Islamic Medical Association of Uganda in conjunction with the Ethiopian Islamic Affairs Supreme Council and attended by over 150 participants from 29 countries provided important insights into issues related to the concept of the Islamic approach to HIV/AIDS and how it should be put into practice<sup>4</sup>. This article highlights some of these issues.

## Operational definition of the Islamic Approach to HIV/AIDS

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

### 1. Believing in Allah and Prophet Muhammad (PBUH)

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. There are many verses in the Holy Qur'an which support this<sup>5</sup>.

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## 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 treatment, as well as 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 <sup>6,7,8</sup>.

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

There is an Islamic teaching in the Holy Qur'an discouraging adultery, which can be a predisposing factor for HIV transmission <sup>9</sup>.

It 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 behavior that may increase risk of HIV infection. Marriage is encouraged but people must have the means to marry including testing for HIV infection <sup>10</sup>.

## 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 behaviors <sup>11</sup>.

In addition, 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. Their teachings are deep and able to reach people's souls.

## 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 behavior 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 (PBUH). 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 <sup>12</sup>.

People living with HIV/AIDS

(PLWHAs) should be at the forefront of this Jihad by participating in all prevention, treatment, care and support efforts using this concept. The enemy in this Jihad is shaitan (satan) and Allah provides guidance on how to handle this enemy<sup>13</sup>.

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 Al-Nafs by controlling his or her behavior. 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.

### **Implementation of the Islamic approach to HIV/AIDS.**

The implementation of the operational definition of the Islamic approach to HIV/AIDS requires proper planning. This involves doing a situation analysis, setting goals, objectives and activities, setting up a monitoring and evaluation system and then mobilizing resources to implement the plans. The planning can be done for any HIV/AIDS related issues such as HIV prevention, treatment, care and support, stigma and discrimination and life skills. An example of planning to implement the Islamic approach

to HIV/AIDS prevention which was outlined by participants of the 3<sup>rd</sup> IMLC is described below.

### **Planning for the Islamic approach to HIV/AIDS prevention:**

#### **I. Situation analysis:**

The benefits of the Islamic approach to HIV/AIDS prevention (IAA prevention) are as follows:

Benefits of believing in Allah and Prophet Muhammad (PBUH)

- Guides behavior of Muslims.
- It is the cornerstone of the Islamic approach to AIDS.
- Encourages obedience to Allah and Prophet Muhammad<sup>14</sup>.

#### **Benefits of acquiring scientific knowledge about HIV/AIDS**

- Correct knowledge empowers individuals and communities to avoid known risk factors for acquiring HIV infection.

#### **Benefits of making use of Islamic teachings and practices**

- Promotes avoiding adultery, fornication, alcohol and narcotic drugs
- Encourages individual to put in his or her mind that Allah is always watching him or her<sup>15,16</sup>.

#### **Benefits of forming partnerships with religious leaders**

- Makes use of these leaders to teach individuals and communities
- Information will reach a wide

number of people

- Provides continuous reminders about good and bad behaviors

### **Benefits of making use of the concept of Jihad Al- Nafs**

- Helps in controlling temptations

The indicators of successful implementation of the Islamic approach to HIV/AIDS prevention in the individual, family and community are as follows:

- Individual
  - Abstinence from sex outside marriage
  - Reduced drug abuse
  - Avoiding bad company that practices risky behaviors.
  - Regular practicing of pillars of Islam (Prayers, fasting, performing Haj, paying zakat)
- Family
  - Fearing Allah
  - Reduced stigma, discrimination
  - Acceptance of HIV positive individuals
  - Acceptance of HIV counseling and testing
  - Parents become more courageous and communicate with children about risky behaviors.
  - Reduction in risky cultural practices

- Community
  - Reduced HIV infection rates (Long term indicator)
  - Encourages HIV testing especially before marriage
  - Timely marriages (not too early, not too late)
  - Community is considerate to PLWHAs
  - Teenage pregnancies reduced

The mandate to implement the Islamic approach to HIV/AIDS prevention at the individual, family and community levels is given by the following:

- Individual
  - Allah
  - Individual's conscience
- Family
  - Allah and Prophet Muhammad (PBUH)
  - Parents
- Community
  - Allah
  - Community leaders
  - Governments leaders

The target communities for the Islamic approach to HIV/AIDS prevention are as follows:

- Children
- Youth
- Women
- Men
- Disadvantaged people
- PLWHAs

- Sex workers
- Intravenous drug users ( IDUs )

The needs of the target communities as far as the Islamic approach to HIV/AIDS prevention is concerned are as follows:

- 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 and Consideration
- Women
  - Economic empowerment
  - Education
  - Teaching them to protect themselves
  - Appropriate health services for women
  - How to preserve modesty <sup>17</sup>.
- Men
  - How to preserve modesty <sup>18</sup>
  - How to lower gaze when meeting opposite sex in accordance to Islamic

teachings

- Islamic education
- PLWHAs
  - Education, care and support
  - Sex workers
  - Economic empowerment
  - Capacity building to resist temptations
- Intravenous drug users (IDUs)
  - HIV Counseling and testing
  - Capacity building to resist temptations

The strengths and weaknesses of these target groups as far as implementing the Islamic approach to HIV/AIDS prevention is concerned are as follows:

### 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 behaviors
  - Aggressive
  - Arrogant
- Women:
  - Vulnerable to men's negative influences
  - Emotional

The weaknesses of those who are unable to consistently and correctly implement the Islamic approach to AIDS prevention should be handled as follows:

- Patience, care, counseling, education
- Islamic teachings<sup>19</sup>.
- Experience sharing
- Control (particularly for children)
- Family guidance
- Spiritual guidance

The priority issues that need to be addressed in the Islamic approach to HIV prevention for the target communities are as follows:

- Children
  - Love, care, protection and Islamic teachings
- Youth
  - Education (scientific and religious)

- Counseling
- Women
  - Dignity, care and support by the society
  - Empowerment
  - Education
- Men
  - Education
  - Better understanding of the needs of women and children
  - Counseling

## **II. Setting goals, objectives and activities of the Islamic approach to HIV/AIDS prevention:**

The major goal of the Islamic approach to HIV prevention for the individual, family and the community is the following:

- To prevent new HIV infections by using the IAA.

The major objectives of the Islamic approach to HIV prevention for the individual, family and the community include the following:

- To increase the knowledge of 50% of the community regarding IAA prevention within 3 years
- To have 30% of the community tested for HIV within 3 years
- To have 50% of Imams, mosque administrators, youth associations, female and male Madrasa teachers well-grounded in the use of the IAA prevention within 3 years (depending on the setting)

The major activities needed to achieve the goal and objectives of the Islamic approach to HIV/AIDS prevention for the individual, family and community are given in the example below in table 1. The example is for a mosque community

with 100 households, 5 people in each household, an HIV prevalence of 5% and a budget of US\$. 1,000 or equivalent in local currency. The workplan can be adjusted depending on setting, and available resources.

**Table 1: Example of work plan for activities at the mosque level**

Activity	By Who	When	Motivation	Cost
Advocacy meeting with the Imams and community leaders	Community Coordinator	July-October 2007	Reward from Allah, transport , approval by the Imam and refreshments	\$ 10
Follow up meeting with Imams and chief administrator	Imam	July-October 2007	Reward from Allah, transport , approval by the Imam and refreshments	\$ 50
Developing training manual to cater for all goals and objectives	Community Coordinator	October-December 2007	Reward from Allah, transport , approval by the Imam, allowances and refreshments	\$ 200
Training of trainers	Community Coordinator	December 2007	Reward from Allah, transport , approval by the Imam, allowances and refreshments	\$ 200
Community information, education and communication, through sermons, video shows, drama, songs, group discussion, home visits, mass media etc.	Community Coordinator	On going process to 2010	Reward from Allah/ incentives/refreshment/ IEC materials	\$ 400
Monitoring and Evaluation	Community Coordinator	On going process to 2010	Reward from Allah/ incentives/refreshment/ monitoring forms	\$ 140
<b>Total</b>				<b>\$1,000</b>

The channels of communication that should be used to implement the IAA prevention by the individual, family and community include the following:

- Religious sermons
- Electronic and print media
- Posters and leaflets
- Home visits
- Support groups
- Using influential and charismatic leaders
- PLWHAs
- Madrasa
- Religious Social gatherings

The partners and alliances that are needed to network with in implementation of the IAA prevention in the target communities include the following:

- Donor agencies
- Government
- Medical experts and associations
- Other faith communities
- Media persons

The benefits of networking between communities and health facilities in the implementation of the IAA prevention include the following:

- Sharing information
- Referral of clients for services

The types of interactions with other faiths that can enhance the use of the IAA prevention by the individual, family and community are as follows:

- Interfaith dialogue
- Peaceful co-existence
- Sharing medical services
- Mutual understanding
- Experience sharing
- Joint resource mobilization
- Sharing resources

There are Islamic teachings and guidance to support this <sup>(20)</sup>.

These verses encourage avoiding insulting other people even when they do not believe in one God. Indeed Allah may make them your friends, if He so wills.

More guidance comes from Abubakar, the first Caliph, given to Yazid bin abu Sufyan while the latter was engaged in Jihad <sup>(21)</sup>.



### III. Monitoring and evaluation, resource mobilization, resolutions and commitments:

The data that needs to be collected to monitor the process of implementation of the Islamic approach to HIV/AIDS prevention by the individual, family and community is shown in the example in table 2 below:

**Table 2: Process indicators for prevention programs using the IAA**

Activity	Indicator
Advocacy meeting with the Imams and community leaders	<ul style="list-style-type: none"> <li>No. of Imams and community leaders at the meeting</li> <li>No. of meetings held</li> <li>Report of meetings</li> </ul>
Follow up meeting with Imams and chief administrator	<ul style="list-style-type: none"> <li>No. of Imams, community leaders, participants at the meeting</li> <li>No. of meetings held</li> <li>Reports of meetings</li> </ul>
Developing training manual to cater for all objectives	<ul style="list-style-type: none"> <li>Training manual developed and pre-tested</li> <li>No. of copies printed and circulated</li> </ul>
Training of trainers	<ul style="list-style-type: none"> <li>No. of trainers trained</li> </ul>
Training of Imams and community educators	<ul style="list-style-type: none"> <li>No. of Imams and community educators trained</li> </ul>
Community information, education and communication through sermons, songs, drama, video shows, group discussion etc.	<ul style="list-style-type: none"> <li>No. of participants</li> <li>No. of workshops done</li> <li>No. of songs and poems developed</li> <li>No. of sermons done</li> </ul>
Monitoring and Evaluation	<ul style="list-style-type: none"> <li>Reports indicating outcomes (successes and challenges)</li> <li>Monitoring and Evaluation system documents</li> </ul>

The data that need to be collected to evaluate the outcome of implementing the Islamic approach to HIV/AIDS Prevention is shown in table 3 below:

**Table 3: Outcome Indicators for prevention programs using the IAA**

IAA Component	Indicators
Believing in Allah and Prophet Muhammad (PBUH)	<ul style="list-style-type: none"> <li>• Proportion of people who report using the belief in Allah in the prevention of HIV/AIDS</li> <li>• Proportion of people who use preventive methods (e.g. abstinence and faithfulness in marriage) using Allah's guidance</li> <li>• Proportion of people who are avoiding drug abuse using Allah's guidance.</li> </ul>
Learning the scientific knowledge	<ul style="list-style-type: none"> <li>• Proportion of people with the correct scientific knowledge about modes of transmission and prevention of HIV/AIDS as a result of IAA</li> <li>• Proportion of people who are going for treatment and rehabilitation for drug abuse in accordance with IAA</li> </ul>
Making use of Islamic teachings and practices	<ul style="list-style-type: none"> <li>• Proportion of people who care for PLWHA to support positive prevention</li> <li>• Proportion of people who are practicing the pillars of Islam (prayers, fasting, zakat, Haj)</li> <li>• Proportion of discordant married couples using HIV prevention methods in accordance with IAA <sup>(22)</sup>.</li> </ul>
Forming partnerships with and making use of religious leaders and their administrative structures	<ul style="list-style-type: none"> <li>• Proportion of people who participate in community activities related to HIV/AIDS prevention in accordance with IAA</li> <li>• No. of support groups for positive prevention</li> </ul>
Concept of Jihad Al-Nafs	<ul style="list-style-type: none"> <li>• Proportion of people who report using the concept of Jihad Al-Nafs in their HIV prevention methods (abstinence and faithfulness in marriage)</li> <li>• Proportion of people who are avoiding drug abuse by using the concept of Jihad Al- Nafs.</li> <li>• Proportion of people who care for PLWHA (support HIV prevention among HIV positive clients) by using the concept</li> <li>• Proportion of people tested for HIV voluntarily by using the concept.</li> </ul>

**The Impact indicator of IAA prevention is as follows:**

HIV incidence (new cases) among targeted groups will reduce.

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 include the following:

- Financial
  - Money
  - Zakat for the poor
  - Endowment (Waqf)
  - Local and International donor agencies
- Human
  - Imams and other religious leaders
  - Volunteers
  - Family members
  - Community members
- Technical
  - Medical personnel
  - Counselors
  - Teachers
  - Training materials
  - IEC materials

These resources can be attracted and accessed through the following avenues:

- Writing project proposals
- Mobilizing the community
- Organizing fund raising activities
- Accountability for resources acquired

The resolutions and commitments that should be made regarding enhancing of the Islamic approach to HIV/AIDS

prevention by the individual, family and community include the following:

### **Resolutions**

- To implement IAA prevention in our communities guided by the strategic framework
- To continue exchanging experiences 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 plans
- To encourage respective governments and international organizations to support and finance the IAA prevention strategy

### **Commitment**

- To popularize and implement IAA prevention in our different countries and communities.

This commitment is especially relevant to Islamic Medical Associations (IMAs) world-wide. IMAs play a critical role in providing technical guidance to the communities in the implementation of the Islamic approach to HIV/AIDS. They need to conduct scientific observations and document the findings so that target communities can have evidence based guidance in implementing the IAA prevention.

## **Implementing the Islamic Approach to HIV/AIDS (IAA) through the network model for improving AIDS service**

### **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 what some authorities call “the network model” for improving HIV/AIDS service delivery.

### **Islamic approach to HIV/AIDS network model for improving AIDS services:**

The “**network model**” concept can be implemented in line with Islamic principles. This is what is called “**the Islamic approach to HIV/AIDS network model for improving AIDS services**”. It includes the following components:

#### **I. Health facility:**

At the health facility 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 include the following:

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:**

Imams and their assistants are trained on how to educate their communities on issues of HIV/AIDS prevention, treatment, care and support. The training is done using a curriculum which has both scientific information as well as Islamic teachings. The Imam and his team who are called “**community educators**” educate their communities through sermons during Juma prayers, home visits, group talks, mini-lectures and mass media. In addition, they refer patients and clients to health facilities.

### III. Linkages between community and health facility:

#### a) From community to health facility:

The Imam and his team refer clients to health facilities using referral cards, letters or phone calls. Sometimes they escort the clients to the health facility. The clients themselves take the referral cards and letters to the hospital.

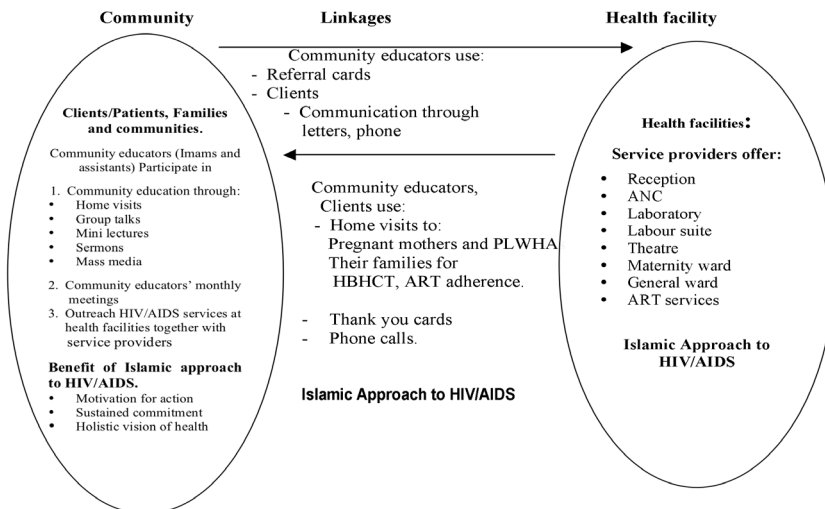
#### b) From health facility to communities:

Service providers refer clients back to the community educators through “thank you cards”, letters

and phone calls sometimes. The service providers also provide home based AIDS services 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. The Imams and their assistants provide ongoing care and support to clients and their families after the visit of the service providers..

A diagram depicting the Islamic faith based network model for improving AIDS services is indicated in figure 1 below:

**Figure 1:** Islamic Approach to HIV/AIDS network model for improving AIDS services



ART = Anti-retroviral treatment  
 HBHCT = Home based HIV Counseling and Testing  
 PLWHAs = People Living with HIV/AIDS  
 ANC = Antenatal Care

## Conclusion

The IAA 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 should 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.

## Resolutions of Country Community Coordinators of IAA

Effective implementation of the Islamic Approach to HIV/AIDS is a joint effort requiring resolutions and commitments to be made at local, national and international levels. With regards to the latter, representatives of the international Muslim community made the following resolutions:

The 3<sup>rd</sup> International Muslim Leaders' Consultation on HIV/AIDS took place in Addis Ababa, Ethiopia, from 23<sup>rd</sup> – 27<sup>th</sup> 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 (PBUH)
  - 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 IAA.
5. To endeavor to mobilize all Islamic educational institutions to use the IAA.
6. To conduct research to evaluate the outputs, outcomes and impact of the IAA in Muslim communities.

7. That stigma, denial and discrimination against people living with HIV/AIDS (PLWHAs) is unacceptable in IAA.
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 and those in 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 with 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.

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6. The Glorious Qur'an, Chapter 96, Verse 1-5. Chapter 20, Verse 114.
7. Ibn Majah # 40.
8. Tirmidhi # 2835.
9. The Glorious Qur'an, Chapter 17, Verse 32.
10. The Glorious Qur'an, Chapter 24, Verse 32-33.
11. The Glorious Qur'an, Chapter 3, Verse 104, Chapter 4, Verse 59-64.
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13. The Glorious Qur'an, Chapter 7, Verse 200-206. Chapter 114, Verse 1-6.
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15. The Glorious Qur'an, Chapter 2, Verse 219, Chapter 5, Verse 90-92.
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22. The Glorious Qur'an, Chapter 2, Verse 195.



## APPENDIX 1

### ISLAMIC TEACHINGS THAT SUPPORT IMPLEMENTATION OF THE ISLAMIC APPROACH TO HIV/AIDS.

**These teachings are given here for quick reference especially for those who may not find it easy to access the original sources.**

**Ref: 5:**

#### **The Glorious Qur'an: 10:3**

“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?”

#### **The Glorious Qur'an: 3:164**

Allah did confer a great favour on the Believers when He sent among them an Apostle from among themselves, rehearsing to them the signs of Allah, sanctifying them, and instructing them in scripture and wisdom, while before that, they had been in manifest error.

#### **The Glorious Qur'an: 33:21**

You have indeed in the Apostle of Allah a beautiful pattern of conduct for anyone whose hope is in Allah and the final day, and who engages much in the Praise of Allah.

**Ref. 6:**

#### **The Glorious Qur'an : 96:1-5**

“ 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.”

#### **The Glorious Qur'an: 20:114**

“High above all is Allah, the King, the Truth. Be not in haste with the Qur'an before its revelation to you is completed, but say, “O my Lord, advance me in knowledge.”

**Ref. 7:**

#### **Hadith: Ibn Majah # 40**

Anas Ibn Malik relates from the Prophet (PBUH) when he addressed the issue of knowledge “Seeking knowledge is compulsory upon every Muslim and Muslimah,” (Ibn Majah #240, the hadith is Sahih)

**Ref. 8:**

#### **Hadith: Tirmidhi # 2835**

Anas reported from the Prophet (PBUH) “Whoever treads on a path in search of Islamic knowledge, Allah will ease the way to paradise for him; the angels will lower

their wings, pleased with this seeker of knowledge, and everyone in the heavens and on earth will ask forgiveness for the knowledgeable person, even the fish in the deepest of waters will ask for his forgiveness. The superiority of the knowledgeable man over the worshipper in Islam, is like the superiority of the full moon over the rest of the planets. And the scholars are the inheritors of the Prophets, but the Prophets did not leave behind wealth but they left behind knowledge. And whoever takes firm hold of this is a very fortunate man”. (Abu Dawud, Ibn Majah, Tirmidhi #2835 – Sahih hadith.)

**Ref. 9:**

**The Glorious Qur'an: 17:32**

“Do not come near to adultery. For it is a shameful deed and an evil, opening the road to other evils”

**Ref. 10:**

**The Glorious Qur'an: 24:32**

Marry those among you who are single, or the virtuous ones among yourselves, male or female,. If they are in poverty, Allah will give them means out of His grace, for Allah is ample-giving and He knows all things. Let those who find not the wherewithal (means) for marriage keep themselves chaste, until Allah gives them means out of His grace.

**Ref. 11:**

**The Glorious Qur'an: 3:104**

“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”

**The Glorious Qur'an: 4:59**

O you 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.

**Ref. 12:**

**Hadith: Al-Zuhd al Kabir # 373, 374**

Some troops came back from an expedition and went to see the Messenger of Allah Sallallahu alayhi wa-salaam. He said: “You have come for the best, from the smaller Jihad (al-jihad al-asghar) to the greater Jihad (al-jihad al-akbar)”. Someone said, “What is the greater jihad?” “The servant's struggle against his lust” (Mujahadat al-abdi hawah). Al-Bayhaqi narrated it in al-Zuhd al-Kabir (Haydar ed. p. 165 #373 & p. 198 #374)

**Ref. 13:**

**The Glorious Qur'an: 7:200-206**

If a suggestion from Satan Assail your (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.

### **The Glorious Qur'an: 114: 1-6**

Say I seek refuge with the Lord and Cherisher of mankind. The King or Ruler of mankind. The God or Judge of mankind. From the mischief of the whisperer of evil, who withdraws after his whisper. Who whispers into the hearts of mankind among Jinns and among men.

**Ref. 14:**

### **The Glorious Qur'an: 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 spend out of what we have provided for them, and who believe in the revelation sent to them 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.

**Ref. 15:**

### **The Glorious Qur'an: 2:219**

They ask you concerning wine and gambling. Say: "In them is great sin, and some benefit, for men; but the sin is greater than the benefit". They ask you how much they are to spend; Say: "What is beyond your needs". Thus does Allah make clear to you His signs: in order that you may consider.

### **The Glorious Qur'an; 5:90-92**

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. Satan's plan is but to excite enmity and hatred between you, with intoxicants and gambling, and hinder you from the remembrance of Allah, and from prayer. Will you not then abstain? Obey Allah, and obey the Messenger, and beware of evil: If you do turn back, know you that it is our Messenger's duty to proclaim the message in the clearest manner.

**Ref. 16:**

**Hadith:**

Narrated Ibn Umar: Allah's Messenger said, once three persons from the previous nations were traveling, and suddenly it started raining and they took shelter in a cave. The entrance of the cave got closed suddenly by the falling of a huge rock while they

were inside. They said to each other, O You! Nothing can save you except the truth, so each of you should ask Allah's help by referring to such a deed as he thinks he did sincerely (i.e. just for gaining Allah's pleasure). So one of them said 'O Allah! You know that I had a laborer who worked for me for one faraq i.e. three SA of rice, but he departed, leaving it i.e. his wages. I sowed that faraq of rice and with its yield I bought cows for him. Later on when he came to me asking for his wages, I said to him, go to those cows and drive them away. He said to me, but you have to pay me only a Faraq of rice. I said to him, go to those cows and take them, for they are the product of that faraq of rice. So he drove them. O Allah! If you consider that I did that for fear of You, then please remove the rock. The rock shifted a bit from the mouth of the cave. The second one said, 'O Allah, You know that I had old parents whom I used to provide with the milk of my sheep every night. One night I was delayed and when I came, they had slept, while my wife and children were crying with hunger. I used not to let them i.e. my family drink unless my parents had drunk first. So I disliked to wake them up and also disliked that they should sleep without drinking it, I kept on waiting for them to wake till it dawned. O Allah! If you consider that I did that for fear of You, then please remove the rock. So the rock shifted and they could see the sky through it. The third one said, 'O Allah! You know that I had a cousin i.e. my paternal uncle's daughter who was most beloved to me and I sought to seduce her, but she refused, unless I paid her one hundred dinars i.e. gold pieces. So I collected the amount and brought it to her, and she allowed me to sleep with her. But when I sat between her legs, she said: Be afraid of Allah, and do not deflower me but legally. I got up and left the hundred dinars for her. O Allah! If you consider that I did that for fear of you then please remove the rock. So Allah released them (removed the rock) and they came out of the cave. (Sahih Al-Bukhari, 4/3465 O.P. 671).

**Ref. 17:****The Glorious Qur'an 24:31**

And say to the believing women that they should lower their gaze and guard their modesty; that they should not display their beauty and ornaments except what must ordinarily appear thereof; that they should draw their veils over their bosoms and not display their beauty except to their husbands, their fathers, their husband's fathers, their sons, their husbands' sons, their brothers or their brothers' sons, or their sisters' sons, or their women, or the slaves whom their right hands possess, or male servants free of sexual urge, or small children who have no carnal knowledge of women; and that they should not strike their feet in order to draw attention to their hidden ornaments. And O you believers, turn you all together towards Allah, that you may attain Bliss.

**Ref. 18:****The Glorious Qur'an: 24:30**

Say to the believing men that they should lower their gaze and guard their modesty, that will make for greater purity for them; And Allah is well acquainted with all that they do.

**Ref. 19:****The Glorious Qur'an: 4:145-152**

The hypocrites will be in the lowest depths of the fire. No helper will you find for

them, except for those who repent, Mend their life, hold fast to Allah and make their religious devotion, Sincere to Allah. If so they will be numbered with the believers and soon will Allah grant to the believers a reward of immense value. What can Allah gain by your punishment if you are grateful and you believe? No it is Allah that recognizes all good and knows all things. Allah does not like that evil should be uttered in public except by one who has been wronged, for Allah is He who hears and knows all things. Whether you do openly a good deed or conceal it or cover evil with pardon, surely Allah is ever pardoning, powerful. Those who deny Allah and His messengers, and wish to separate between Allah and His Messengers, saying: “We believe in some but reject others”,. And wish to take a course midway,. They are in truth unbelievers; and we have prepared for unbelievers a humiliating punishment. To those who believe in Allah and His messengers and make no distinction between any of the messengers, we shall soon give their due rewards. For Allah is oft-forgiving Most Merciful.

### **The Glorious Qur'an: 2:262-263**

Those who spend their wealth in the cause of Allah, and follow not up their gifts with reminders of their generosity or with injury for them their reward is with their Lord. On them shall be no fear nor shall they grieve. Kind words and covering of faults are better than charity followed by injury. Allah is free of all wants, and He is most forbearing.

### **The Glorious Qur'an: 24:18-21**

And Allah makes the signs plain to you, for Allah is full of knowledge and wisdom. Those who love to see scandal circulate among the Believers, will have a grievous chastisement in this life and in the hereafter; Allah knows, and you know not. Were it not for the Grace and Mercy of Allah on you, and that Allah is full of kindness and mercy, you would be ruined indeed. O you who believe, follow not satan's footsteps; if any will follow the footsteps of satan, he will but command what is shameful and wrong, and were it not for the grace and mercy of Allah on you, not one of you would ever have been pure; but Allah does purify whom He pleases and Allah is One who hears and knows all things.

### **Ref. 20:**

### **The Glorious Qur'an: 6:102-108**

That is Allah, your Lord. There is no god but He, the Creator of all things, then worship you Him and He has power to dispose of all affairs. No vision can grasp Him, but His grasp is over all vision, He is subtle well-aware. Now have come to you, from your Lord proofs to open your eyes if any will see, it will be for the good of his own soul. If any will be blind, it will be to his own (harm). I am not here to watch over your doings. Thus do we explain the signs by various (ways) that they may say, you have learnt this from somebody and that We may make the matter clear to those who know. Follow what you are taught by inspiration from the Lord. There is no god but He and turn aside from those who join gods with Allah. If it had been Allah's will, they would not have taken false gods, but we made you not one to watch over their doings, nor are you set over them to dispose of their affairs. Insult not you those whom they call upon besides Allah, lest they out of spite insult Allah in their

ignorance. Thus have we made alluring to each people its own doings. In the end will they return to their Lord and He shall then tell them the truth of all that they did.

**The Glorious Qur'an: 60:7-9**

It may be that Allah will grant love and 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.

**Ref. 21:**

**Abubakar (RAA):**

“When you travel, do not drive your comrades so much that they get tired on the journey. Do not be angry upon your people and consult them in your affairs. Do justice and keep them away from tyranny and oppression, because a community that engages in tyranny, does not prosper, nor do they win victory over their enemies. When you become victorious on your enemies, do not kill their children, old people and women. Do not go even closer to their date palms, nor burn their harvest, nor cut the fruit bearing trees. Do not break the promise once you have made it, and do not break the terms of treaty, once you have entered into it. You will meet on your way people in the monasteries, the monks engaged in the worship of Allah, leave them alone and do not disperse them. Let them please themselves and do not destroy their monasteries, and do not kill them. May Peace of Allah be upon you”.

**Ref. 22:**

**The Glorious Qur'an: 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”.

# Protection of Our Youth From STIs and HIV/AIDS

## A project implemented in the Middle East

*Abdul Hamid Al-Qudah, and Aly Misha'el*

### Abstract

Local and regional statistics of sexually transmitted infections (STIs) and HIV/AIDS reveal relatively low prevalence in the Middle East, North Africa and probably other Islamic countries. There is a widespread belief that Islamic culture and values have significant effects in limiting the spread of STIs and HIV/AIDS pandemic in this part of the world.

This concept has created a general belief that Muslim societies are not susceptible to this world menace. But other concerned people consider this line of thinking a dangerous one that leads to complacency in dealing properly with sound and organized protective measures. To fill this serious gap, we designed a strategy of prevention based on education and capacity building of qualified and dedicated local community workers/ leaders who will continuously and professionally work in their respective society sectors, especially the youth.

Outlines of this activity, which is now two years old, and future plans, are presented.

**Keywords:** *Sexually transmitted infections, HIV/AIDS epidemiology, protection against STIs.*

### Introduction

Sexually transmitted infections (STIs), including HIV/AIDS, are global pandemics that respect no borders. Globalization and contemporary lifestyles removed boundaries between nations and communities. The whole world societies became open and vulnerable.

International and regional statistics reveal the global STIs prevalence to be around (750) million people, with two million new cases daily<sup>(1-8)</sup>. By the end of 2006, the distribution of these STIs were approximately as follows:

- Gonococcal infections: 250 million.
- Syphilis: 50 million.
- Chlamydial infections: 400 million.
- HIV/AIDS: 40 million.

This is in addition to other STIs, such as genital warts, chancroid, lymphogranuloma venereum (LGV) ... etc, estimated at 45 million people.

Specially alarming is the increased prevalence of more than 50% in the 15-25 years of age<sup>(9,11)</sup>.

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From many sources, the following figures represent a rough estimation of modes of acquiring HIV/AIDS<sup>(5,7,8-13)</sup>:

- 72%: By adultery ( Zina ).
- 8%: By homosexuality.
- 8%: By drug injections.
- 4%: By transfusion of blood and its products.
- 8%: By unknown modes.

In USA and UK homosexuality plays a major role in spreading of HIV/AIDS.

This signifies that at least 88% of individuals are infected through involvement in forbidden ( Haram ) acts.

Moreover, the estimated annual global expenditure to deal with STI<sup>s</sup> patients is estimated at 150 billion US dollars. In 2005, the global expenditure on HIV/ AIDS alone was 8 billion USD <sup>(2,4,11,14)</sup>.

The statistics derived from national and international sources indicate that STI<sup>s</sup>, including HIV/AIDS prevalence in the Middle East, North Africa and probably other Islamic countries, are relatively lower than other parts of the world.

The annual HIV/AIDS report of the World Health Organization – Eastern Mediterranean Region (WHO – EMRO) revealed the following statistics as of December 2006 <sup>(15)</sup>:

- The global estimate for people living with HIV ( PLWHA ) was ( 39.5 ) million.

- Every day, ( 67,000 ) adults and children are newly infected.
- Every day ( 58,000 ) adults and children deaths occur due to AIDS.
- The estimated number of PLWHA in the Eastern Mediterranean Region was ( 670,000 ).
- In the majority of countries in this region, except Sudan and Djibouti, the estimates show low HIV prevalence of less than 0.1% in adults.

Some workers ascribe that to the influence of Islamic culture and values, which prohibit extramarital sexual relationships as well as narcotic drug use, therefore limiting the spread of STI<sup>s</sup> in this part of the world.

This widespread belief helped generating a general, but false concept, that contemporary Muslim societies are not susceptible to STI<sup>s</sup>, including HIV/ AIDS infections.

This line of thinking, however, has led to complacency in dealing properly with this global problem, and eventually created a low public awareness and carelessness towards the protective measures.

This is, therefore, an extremely dangerous attitude, since the transmission and spread of these infections, especially HIV/AIDS, may proceed undetected and unabated <sup>(16)</sup>.

This attitude, described by some concerned people as an Ostrich



approach, is self-defeating, when evidence exists that STI<sup>s</sup> and HIV/AIDS have actually penetrated our societies.

Overwhelming evidence strongly suggests that a significant proportion of our populations, especially the youth, are engaged in lifestyles and activities that ultimately lead them to contract such infections. These lifestyles and socio-behavioral factors include:

- 1- The widespread waves of travel of sizeable numbers of Muslim youth to various regions of the world without proper orientation.
- 2- The tourism, imported work-forces and business movements to and from areas with increased prevalence of STI<sup>s</sup> and HIV /AIDS.
- 3- Recent noticeable change in many Muslim societies family structure and commitment to ethical and religious guidance.

HIV/AIDS is not just a virus-induced disease. It is a sign indicating serious breakdown of socio-moral and behavioral standards of societies.

A sound strategy of prevention should be adopted by our health authorities, concerned NGO<sup>s</sup>, and organized medical professionals at large, which should include proper education, orientation, as well as proper screening and testing of vulnerable or exposed individuals, with balanced, well designed policies.

Education and awareness activities should proceed hand-in-hand with

improvement of commitment and quality of individual's faith and belief in our moral standards. Instilling these values in our youth to build up their sense of accountability and responsibility is a cornerstone in any meaningful protective effort.

The golden rule " Prevention is better than cure " is significantly valid in dealing with this moral and behavioral menace.

### **Filling the gap**

To fill this serious gap in the Middle East , and to supplement the official efforts, if any, we designed a strategy of prevention that depends principally on a well designed moral, spiritual and educational model, that was implemented in March 2006, and will last as long as needed.

Main aims of the activity:

- To raise the general public awareness by various available means.
- To train a satisfactory number of well educated volunteers to become dedicated local community workers/ leaders who will continuously and professionally work in their respective sectors of society, especially among the youth.
- To spread the activity to other concerned countries and communities.

### **Achievements so far:**

- Number of qualified graduates: 550.

- Number of trained teams: 20: (11) female and (9) male teams. Each team included 25-30 youth leaders, alternated male and female groups.
- Courses conducted:  
In Jordan: 12 courses.  
In Qatar: 2 courses.  
In Bahrain: 2 courses.  
In Sudan: 2 courses.  
In Algeria: 2 courses.

Government, nongovernmental organizations, and educational institutions discovered the value of this project and requested collaboration in its widening and continuity. We currently have invitations and memoranda of understanding to expand this activity to several countries of the region.

With this collaboration, the selected volunteering trainees included:

- Imams of mosques.
- Social workers.
- Educators and school teachers.
- Medical professionals.

Qualifications of trainees received careful scrutiny to ensure graduation of qualified and professional community leaders. Candidates should be university graduates who are ready and motivated for voluntary work, with genuine interest in dealing with youth problems. Training was designed to provide them with qualifications and proper attitudes to properly address the youth, and to promote and lead teams

in the community.

Training courses characteristics:

- One full week, from 8.00 AM to 6.00 PM.
- Comprehensive lectures, seminars and open discussions.
- Case studies.
- Printed materials, books, CD<sup>s</sup>.
- Final workshops.
- Graduation ceremony and FIMA certificates.

The trainees receive systematic scientific information on:

- STI<sup>s</sup> and HIV/AIDS: Information on the infectious organisms and modes of infection.
- International and local statistics.
- Protection activities conducted worldwide.
- Treatment and care of affected people worldwide.
- International reactions and attitudes toward the problem.
- Islamic teachings and guidance towards protection and management.
- Basic Islamic Jurisprudence related to this issue.

Graduates are also equipped with a wealth of educational materials, including recordings of updated scientific and epidemiologic knowledge,

books, publications, references in Islamic guidance / Jurisprudence, and training in moral and spiritual support, to help them in their leading community work.

Graduates are requested to give at least ( 10 ) lectures / presentations / seminars per year, to their local youth community: Schools, colleges, camps, clubs, youth centers and mosques.

**Activities provided by graduates so far:**

- Lectures, seminars in local communities: 5000.
- Functional websites: 4.

- Media talks / presentation: > 100.
- Newspaper / Journal interviews: > 50.

**Near future plans:**

- To extend the activity to more countries.
- To graduate 1000 volunteers / community leaders.
- To ensure 10,000 lectures / presentations annually.

We believe this to be a uniquely useful strategy which should be conducted with perseverance and continuity in a sincere effort to combat the worldwide spread of this pandemic.

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# RUMAH SOLEHAH – MALAYSIA

## Half Way Home For Women And Children With HIV/AIDS

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***Musa bin Mohammad Nordin***

### **Abstract**

Rumah Solehah (RS) is a half way home for women and children living with HIV/AIDS. Since July 1998, more than 100 women and 50 children have “graduated” from RS. Presently, we have 22 children, 3 months to 9 years old and 8 women.

We bought our own home in Kampung Pandan in 2007. We have a second home in Cheras and started a third home in Kuala Terengganu in August 2007.

The home and family ambience of RS has offered our women and children the opportunity to cherish the joy and happiness of family life and caring for each other.

RS received the Tun Dr. Siti Hasmah Special Mention Award 2004 for excellence in care and support at the grass-root level. With the inevitable surplus of HIV/AIDS infected and affected children, the challenges to RS will continue to be a daunting and awesome one. Together we can make a difference to the lives of these little and innocent souls.

### **Introduction**

Some 26 years into the syndrome complex, the WHO estimate 39.5 million people living with HIV/AIDS (PLWHA), 4.3 million new infections in 2006 alone. About 530,000 HIV-positives in 2006 were children under 15.

And to address the “missing face of the child in the AIDS pandemic”, UNICEF in 2006 launched Unite for Children, Unite Against AIDS. The 3 key strategies being prevention of mother-to-child transmission, ensuring treatment for HIV-positive children and caring for the inevitable surplus of AIDS orphans.

Since HIV infection in children mirrors closely the prevalence of women acquiring the disease, keeping mothers free from HIV/AIDS and preventing the transmission of HIV from infected mothers to their offsprings is of paramount importance.

From 2001-2005, there were 6-7 thousand new HIV cases annually in Malaysia, 17 – 19 cases per day; 2 of whom were women. There is a worrying trend in heterosexual transmission, 22.1% in 2005 vs 4.8% in 1990. More alarmingly, the proportion of women being infected had increased ten fold, 1.2% in 1990 vs 12% in 2005.

The Ministry of Health (MOH) initiated antenatal HIV screening in 1998.

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Till the end of 2005, 865 (0.034%) mothers were confirmed HIV infected. In 2005 alone, 107 (14.5%) out of 737 HIV-positive women were pregnant mothers. About 4% of babies delivered to these mothers were found to be infected. In 1998, we organized a half way home for HIV/AIDS Rumah Solehah(RS).

There is a medical director ( Dr. Saadiah Sulaiman), a supervisor (Puan Wan Hava (Kak Wan) and a committee member (Dr. Kamarul), in addition to myself as the chair person. Our experience with the 100 women whom we have sheltered in Rumah Solehah showed that the majority acquired the virus heterosexually from their IVDU (intravenous drug users) husbands or partners. All of the HIV-positive children in our care acquired HIV vertically from their mothers. This unfortunately is the domino effect of the heroin culture, which contributes 75% of the HIV/AIDS data base and which needs to be expeditiously addressed by the respective government agencies which to date has been a dismal failure.

The first reported case of pediatric AIDS in Malaysia in 1986 was a 6 year old hemophiliac boy who had received contaminated blood products. Till Dec. 2005, a cohort of 424 HIV-positive children were followed up in specialist pediatric clinics throughout the country with 49% reviewed in KL, Johor and Kelantan alone. Some were diagnosed HIV-positive in late infancy when they were investigated for

recurrent infections or failure to thrive. Their mothers were often not screened antenatally. 302 (71%) of the cohort are on antiretrovirals. Globally, only one in ten children needing antiretrovirals have access to treatment.

With newer antiretrovirals and aggressive management of opportunistic infections the survival of these children have improved tremendously. We have yet to lose a child in Rumah Solehah to AIDS or its complications. Vigilant supervision, medications 3-4 times daily, scheduled visits to the Pediatric Institute and the occasional ER visit keeps the virus at bay.

Eleven children are attending school ferried by an MPV donated by Big Tree. The teachers and school administrators are fully cognizant of their condition and have been most supportive. The children know exactly what to do should a blood related incident occur. There was a sole protest from a member of the PTA which was diffused with tact and understanding.

Fifty one (59%) of the HIV-positive children in Klang Valley are cared for by their parents or extended families. Twelve (14%) have been adopted legally by couples oblivious of the babies' HIV status at birth. Twenty two (25%) are in foster homes managed by NGOs. Only one child is nursed in a government social welfare home.

Amin, now five years old was found wandering the streets of Chow Kit, abandoned at the age of two. He is street

wise, bright and studies well. His other house mates in our home were either abandoned in the streets or at birth or orphaned. It is estimated that some 6-10 thousand children had been orphaned because of HIV/AIDS. Their long-term survival and a near normal quality of life would depend largely on their immediate or expanded family support. Failing this, the next best would be foster care in a dedicated home with trained and live in care givers, simulating a home and family ambience, cherishing the joy and happiness of family life and caring for each another.

When Rumah Solehah was initiated in 1998, the national mood on HIV/AIDS was shrouded with fear, hostility and indifference. The Ministry of Health gave us a grant whilst the then Ministry of Social Welfare did not want to know. We sourced further funds from the embassies of Britain, New Zealand, Canada, Japan and Australia since Malaysians then were not quite forthcoming. These extra funds were invested in various financial initiatives to ensure some form of long term fiscal independence. Our economic projects include coin operated laundry and drying machines in various universities, housing estates and in our shop lot, which doubles as our office. The supervisor Ms Kak Wan along with other ladies run this business.

Well over 100 women have “graduated” from Rumah Solehah. Many have returned to their families and the wider society. Others have found decent

jobs and are self supporting. The nine women currently resident continue the family traditions of our home and help to care for the 22 children with the other caregivers.

The demand for shelter and homes for HIV-positive children and AIDS orphans far outstrip the numbers available. Not infrequently, our two homes in Cheras have to refuse requests for placements. Our third home in Kuala Terengganu will soon foster children from the East Coast, thanks to a grant from Johnson & Johnson Company.

**The following is a brief outline of RUMAH SOLEHAH, its operation and accomplishments**

1. Whilst a few homes of similar intent mooted in the 1990's have failed, RS has braved the difficult circumstances and passed the test of time.
2. Well over 100 women infected or affected by HIV/AIDS, of all races and religions, have “graduated” from RS. These women came from the streets and engaged in high risk behaviors eg commercial sex workers, intravenous drug users (IVDU) or were abandoned and ostracized by their families and communities. Many have now returned to their families and the wider society. Others have found decent jobs and are self-supporting. A few have died. Currently, there are 9 residents.

3. RS is not a hospice. On the contrary, RS has provided a home for these women to rejuvenate their self esteem, and feelings of self worth; to rediscover the joy of life and living. The home and family ambience of RS has offered these unfortunate women the opportunity to cherish the joy and happiness of family life, caring for each other and sharing in the upkeep of their home.
4. Many of these graduates of RS are now actively involved in creating awareness on the dangers of HIV/AIDS. They have become champions of the HIV/AIDS cause traveling across the country to disseminate the message of HIV/AIDS and healthy lifestyles.
5. The activities of RS have been featured in many TV programs and write ups in the mainstream press and magazines.
6. Many university students, both under and postgraduates have taken up the RS project as their field study.
7. RS has attracted many individuals, NGOs, professional organizations, student organizations to volunteer their services in the home. MERCY Malaysia regularly sends teams to volunteer their services to RS.
8. With the inevitable surplus of HIV/AIDS infected or affected children and orphans, RS opened their home to the first HIV child in 2001. Since then over 50 children have been cared for in RS. RS gets referrals from all over the country, from doctors, the welfare homes, Pengasih and the Malaysian AIDS Council. Currently there are 22 children in RS.
9. A second home was opened in 2004 to cater for the increasing number of children. They have taken on board a most challenging task to address not only the daily sustenance of these children but also their educational needs and to ensure their optimal physical, emotional, spiritual and cognitive development. A TALL ORDER BY ANY STANDARDS !.
10. A third home was started in Kuala Terengganu in August 2007 to cater for the surplus of HIV/AIDS cases in the east coast of Peninsular Malaysia
11. In our humble beginnings only the Ministry of Health provided us with a decent but regular grant. This was however insufficient to meet the every growing number of residents and activities of RS. And especially with our expansion to a child shelter home in 2001.
12. In the late 1990s, when the national mood was one of "indifference to persons living with HIV/AIDS" (PLWHA); RS sourced funding from the foreign embassies. The British, Canadian, New Zealand, Japanese and Australian embassies donated generously.
13. The monies were invested in

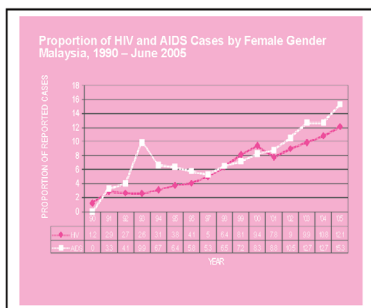
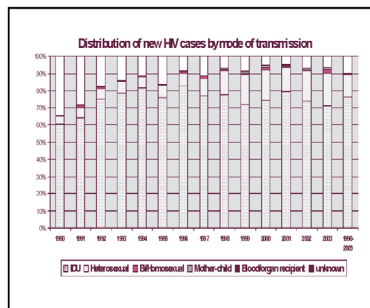
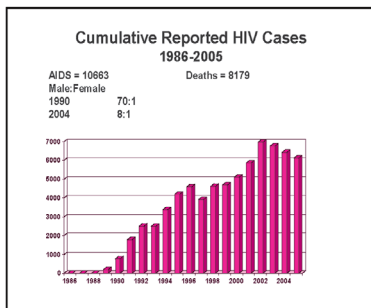


various financial initiatives to ensure some form of long term financial independency. Some of the economic projects include coin operated laundry and drying machines in various universities and housing projects; photocopying and book binding services, sewing services. RS now owns a shop lot which has a self service laundry and drying services; which also doubles as the office of the supervisor.

14. More recently, the generosity of fellow Malaysian have been forthcoming.
  15. The Islamic Medical Association of Malaysia has kick start a project called "TAKAFUL WAQF RUMAH SOLEHAH". Currently, about 250 members have deposited monies each month (deducted from salaries/credit cards) to be made as waqf (endowment) to RS. This is expected to increase further as the nobility of these contributions is marketed widely.
  16. Whilst many have failed, Rumah Solehah is now into her 10<sup>th</sup> year of operations. RS continues to attract visitors nationally and world wide, as a model of a dedicated HIV/AIDS institution :
- a. that has expanded from a shelter home for women to now addressing the needs of children with HIV/AIDS;
  - b. that has seen her residents "graduate" to be with their families and the wider society and some of the children have been accepted by their families/ extended family members or fostered/adopted;
  - c. that has laid out concrete plans for their institution's viability, financially and human resource wise;
  - d. that has remained within the fraternity of the Malaysian AIDS Council and her election into the executive committee in 2004, further reinforces this resolve of sharing, caring and learning.
17. Tax exemption is available to all donors.

# MALAYSIA HIV/AIDS STATISTICS

( 1986 – 2005 )

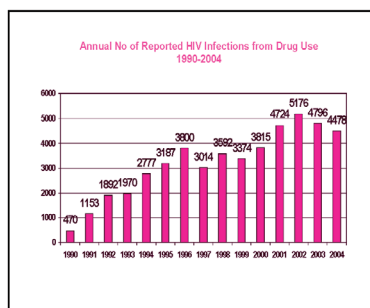


**HIV infection amongst antenatal women : 1998 to 2004**

	1998	1999	2000	2001	2002	2003	2004	Total
Screened	61,367	216,000	263,390	340,000	355,411	301,020	377,000	2,163,788
Positive	56	95	85	75	141	177	136	752
% Positive	0.04	0.02	0.03	0.22	0.04	0.06	0.07	0.03

**HIV Prevalence – Incarcerated Settings 2001-2004**

	Drug Rehabilitation Center				Prison			
	2001	2002	2003	2004	2001	2002	2003	2004
Screened	6,749	12,532	12,808	11,790	27,160	37,819	54,995	52,588
Positive	1,436	2,101	2,083	2,164	3,113	3,076	3,759	2,789
Percent	16.4	16.8	16.3	18.4	11.5	8.1	6.8	5.3





الإتحاد العالمي

الإتحاد العالمي للجمعيات الطبية الإسلامية  
FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS

FIMA CONTINUOUS CAMPAIGNS AGAINST  
HIV/AIDS:

HOLISTIC AND UNIVERSAL

**FIMA**  
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- \* Regionalization Of Fima
- \* An Islamic Socio-cultural Perspective On Aids Crises.



الإتحاد العالمي للجمعيات الطبية الإسلامية  
FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS

FIMA/HAYAT

INTERNATIONAL SCIENTIFIC CONVENTION:  
HIV/AIDS BIOETHICS

JULY 13-16, 2007  
ISTANBUL - TURKEY

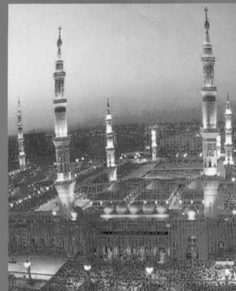
Islamic Medical Association of Uganda

### AIDS education through Imams:

*A spiritually motivated  
community effort  
in Uganda*



### STRATEGIC FRAMEWORK FOR COORDINATION OF THE GLOBAL ISLAMIC RESPONSE TO HIV/AIDS



FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS



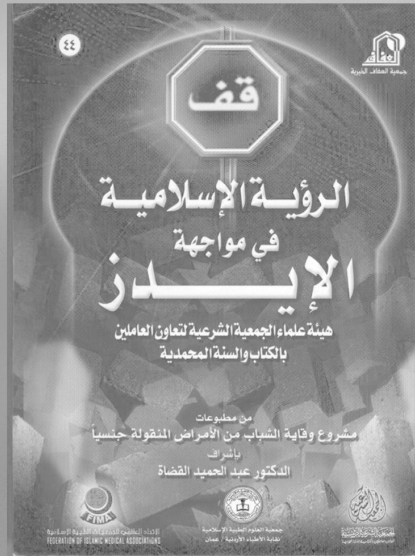
Islamic Medical  
Association of Uganda

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## 1st International Muslim Leaders' Consultation on HIV/AIDS

1<sup>st</sup> - 4<sup>th</sup> November 2001

Kampala, Uganda



بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ  
الاتحاد العالمي للجمعيات الطبية الإسلامية  
FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS

أنشطة مجابهة مرض نقص المناعة المكتسب (الإيدز) في أفريقيا  
(HIV / AIDS)



الاتحاد العالمي للجمعيات الطبية الإسلامية  
FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS

مشروع وقاية الشباب  
من  
الأمراض المنقولة جنسيا



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