



The Role of Religious Leaders in the Fight Against HIV/AIDS*

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This paper reports on the impact of the UNDP supported “Islam and HIV/AIDS” project conducted between 2001 and mid-2005. It provides some insight into the project’s strategies and its overall effectiveness. Achievements are considered in terms of project objectives and the impact it has had on the level of commitment and involvement of Islamic religious leaders in HIV/AIDS prevention, care and support. The paper also discusses the role of Islamic leaders in changing behavior and provides suggestions for building on the work that has been done.

HIV/AIDS in a Global Perspective

It is 25 years since the first case of HIV was detected and the deadly virus continues to spread across the world. Globally, the number of people infected to date is 38.6 million. Of these, 17.3 million are women, and 2.3 million are children under the age of 14. The number of children orphaned by this disease has now reached 15.2 million¹. From countries that have been most affected in Southern Africa, such as Swaziland, Lesotho and Zimbabwe, with prevalence rates between 20 to 33%, there are harsh lessons to be learnt about the devastating impact of this disease on families and communities, as well as socio-economic development. The HIV virus, like any other, has no boundaries and does not distinguish between class or religion. If the world is to achieve the Millennium Development Goal to halt and begin to reverse the spread of HIV by 2015, a great deal more needs to be done.

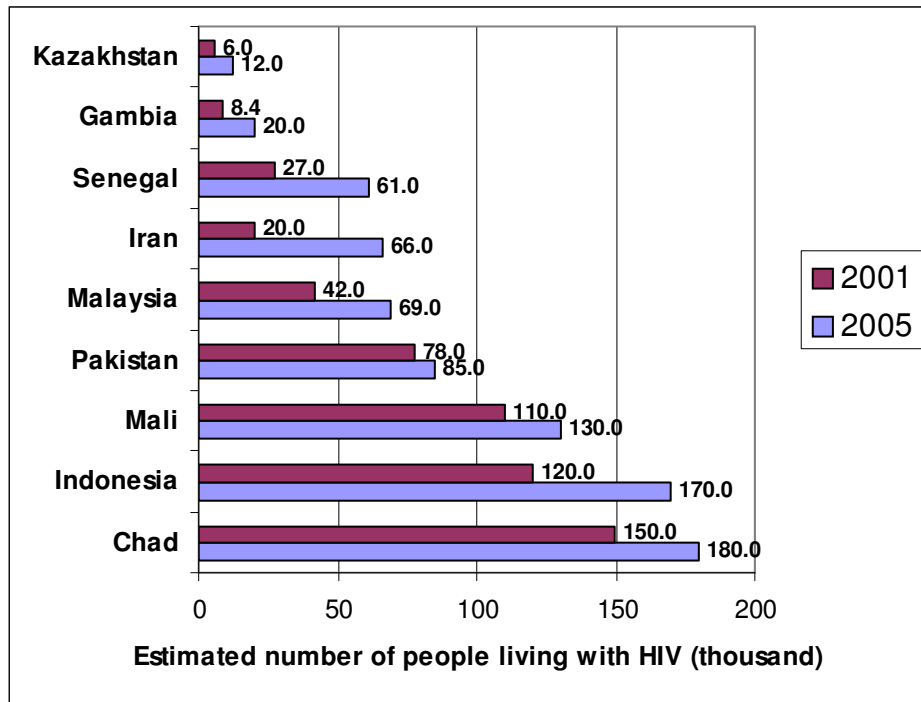
With few exceptions, Muslim countries have responded indifferently to the threat of HIV/AIDS². There continues to be denial combined with a sense of blame directed towards people who contract the disease. While in many Muslim countries the situation has not yet reached epidemic proportions, there is a need to take heed of this burgeoning threat. Examples of majority Muslim countries that suffer relatively high rates of HIV are Mali and Gambia in West Africa, and Djibouti in East Africa, with HIV prevalence rates of 3.1, 2.4 and 1.7% respectively. And Cote D’Ivoire, which is approximately 50% Muslim, suffers an even higher infection rate of 7.1%. These rates imply that it is not only possible for HIV to be a problem for Muslim countries, but that it can place the entire society at grave risk.

¹ 2006 Report on the global AIDS epidemic, UNAIDS/WHO, May 2006.

² Hasnain M. Cultural Approach to HIV/AIDS Harm Reduction in Muslim Countries. Harm Reduct J. 2005; 2: 23.

Islamic religious values alone cannot inoculate people against the disease. However, knowledge, awareness and the willingness to act can make the difference between success in combating the disease and developmental decline. Several Muslim countries are poor and backward in many respects compared to the Western world^{3,4}. One factor in this is that they fail to deliver basic social services, including programmes to prevent the spread of HIV/AIDS⁵. Unlike many other Muslim majority countries, Malaysia possesses a forward thinking Muslim leadership with strong government systems in place. This strength needs to be fully harnessed to enhance the still-weak national response against HIV/AIDS.

Figure 1. HIV/AIDS is rising in these Muslim majority countries...



Source: UNAIDS

³ Prime Minister Abdullah Haji Ahmad Badawi. Speech at the Opening Session of the Meeting of the OIC Commission of Eminent persons. 27th January 2005.

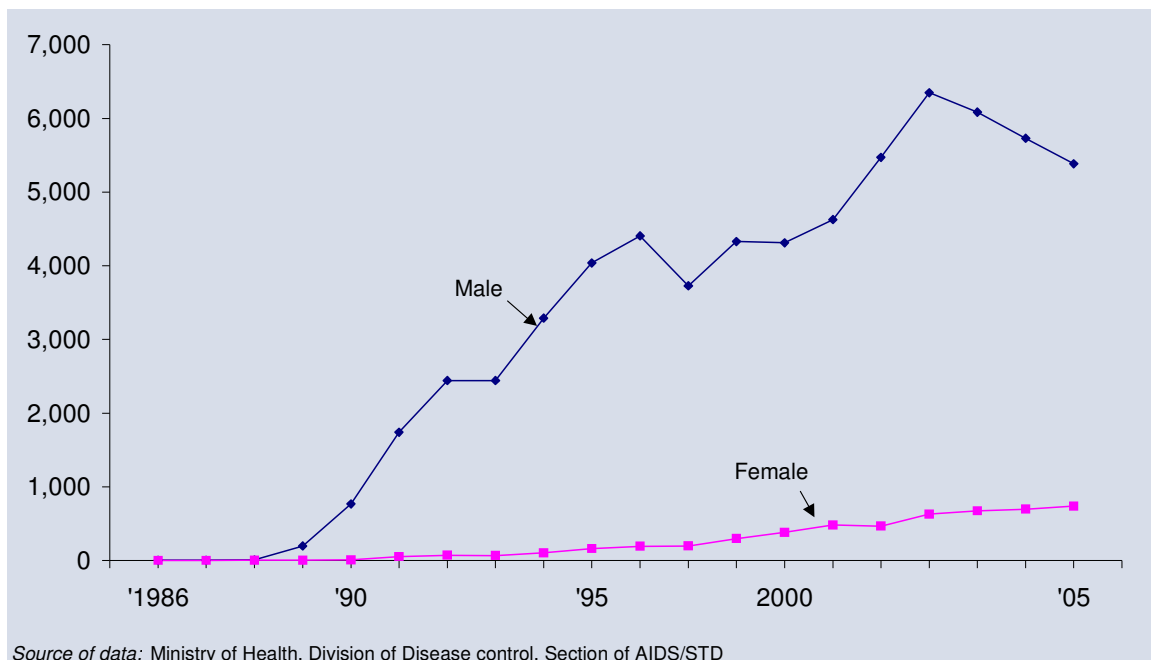
⁴ President Pervez Musharraf. World Islamic Economic Forum (WIEF). November 2006.
www.presidentofpakistan.gov.pk. Accessed 20th November 2006.

⁵ Kelley LM, Eberstadt N. The Muslim face of AIDS. Foreign Policy. July/August 2005.
www.foreignpolicy.com. Accessed 18th November, 2006.

Summary of Current Situation in Malaysia

According to the Ministry of Health Malaysia, by the end of 2005 there were 70,559 recorded HIV/AIDS cases⁶. Of these, 11.6% were women. According to the UNAIDS, for 2005 the estimated prevalence now stands at 0.5%, an increase from 0.4% in 2003⁷. Among 6,120 new cases in 2005, 73% were to persons aged between 20 and 39, and 12% were women.⁸ The prevalence of HIV infection among women has shown an increase over time (**Figure 2**), whereas the proportion of women involved in high risk activities remains the same. The feminization of the HIV/AIDS epidemic that has been seen globally has reached Malaysia. It is influenced by the biological predisposition of women, coupled with the imbalance of power in gender relations in general, and sexual behavior in particular.

Figure 2. Percentage of women infected by HIV has tripled in the last decade⁹.



The dominant mode of transmission of HIV/AIDS in Malaysia continues to be through injecting drug use. Among the 70,559 HIV cases, 65.5% were due to injecting drug use (IDU). In Malaysia, these two epidemics are inextricably linked and it has been

⁶ HIV/AIDS Reporting System: MALAYSIA, Ministry of Health. <http://www.dph.gov.my/aids> Accessed 4th August 2006.

⁷ UNAIDS. 2006 Report on the Global AIDS Epidemic.

⁸ MOH Communication. Presentation by Dr. Hj. Jalal b. Halil Khalil. HIV/AIDS and STI section.

⁹ HIV/AIDS Reporting system: Malaysia. www.dph.gov.my. Accessed 16th August 2006.

recognised that the main obstacle to controlling the spread of HIV/AIDS is the failure to contain drug dependence¹⁰. In 1990, the number of new addicts and repeat addicts was 7,389 and 11,921 respectively. By 2005, the corresponding figures had risen markedly to reach 15,389 and 17,419 respectively¹¹.

HIV/AIDS and Malay Muslims

Among HIV/AIDS cases there is a greater proportion of Malay Muslim men, 72.8% in 2005¹² (whereas Muslims represent only 60.4% of the Malaysian population¹³). Among drug abusers, the Malays are again over-represented making up 68% of all drug addicts (**Table 2**). Studies suggest that Malays are over-represented among people who are both IDUs and are HIV positive^{14,15,16}. Experience based on interviews with those concerned with HIV/AIDS at the local level confirms the message of the empirical data. The issue has also been recognized by leaders of the Malay community as posing a serious threat to the fabric of Malay society.^{17,18}

¹⁰ Huang M and Hussein H. *AIDS Educ Prev*. 2004 Jun; 16(3 Suppl A): 100-9

¹¹ National Narcotic Agency, website: www.adk.gov.my. Accessed August 4th, 2006.

¹² HIV/AIDS Reporting System: MALAYSIA, Ministry of Health. <http://www.dph.gov.my/aids> Accessed 16th November 2006.

¹³ Department of Statistics Malaysia. www.stats.gov.my.

¹⁴ Perngmark P, Celentano DD, Kawichai S. Risk factors for HIV infection among drug injectors in southern Thailand. *Drug and alcohol dependence*. 2003, vol. 71, No.3, pp. 229-238

¹⁵ Fauziah MN, Anita S, Sha'ari BN, Rosli BI. HIV-associated risk behavior among drug users at drug rehabilitation centres. *Med J Malaysia*. 2003 Jun; 58(2): 268-72

¹⁶ Mohammad Z, Naing NN. Characteristics of HIV-infected tuberculosis patients in Kota Bharu Hospital, Kelantan from 1998 to 2001. *Southeast Asian J Trop Med Public Health*. 2004 Mar; 35(1): 140-3.

¹⁷ Rahimah Idris, UMNO General Assembly speaker. 17th November, 2006.

¹⁸ Datuk Seri Najib Tun Razak, closing arguments, UMNO General Assembly. 17th November, 2006.

Table 2. Malays make up the majority of drug addicts in Malaysia¹⁹

Drug Addicts by Ethnicity:		
Jan-Dec 2005		
Ethnicity	Total	%
Melayu	22,344	68.1
Cina	5,131	15.6
India	3,228	9.8
Pribumi Sabah	1,222	3.7
Lain-lain Bangsa	662	2.0
Pribumi Sarawak	122	0.4
Warga Asing	99	0.3
	32,808	100.0

Source: PEMADAM.

Although IDU has been driving the epidemic among Malay men, there are rising concerns that HIV/AIDS is being transmitted to wives and partners of IDU men. Studies indicate that 20% or more of IDUs are married^{20,21}, and this could be one of the reasons for the increase in HIV/AIDS among women. Monogamous relationships may be the norm among a proportion of Malays, but this does not preclude serial monogamy due to the death of a spouse, or divorce which is increasingly common. Sex outside of marriage, while considered “berzina” (fornication) by the religion, is not uncommon.

Mandatory HIV tests for Muslim couples have begun in certain states like Johor attempts to address this issue. However, it needs to be emphasized that unlike knowledge and the ability to act on information, a single HIV test prior to marriage does not protect the couple over the long term. Hence, the need for a strong effort to increase knowledge, awareness and behavior among high risk groups.

Background to and aims of UNDP’s Islam and HIV/AIDS Project

One of the steps taken by the Malaysian Government to reinforce its fight against HIV has been to commit to a National Strategic Plan which calls for a multi-sectoral action plan. The National Strategic Plan on HIV/AIDS, 2006-2010, acknowledges the threat

¹⁹ PEMADAM. www.pemadam.org.my Accessed 21st November 2006.

²⁰ Mohammad Z, Naing NN. Characteristics of HIV-infected tuberculosis patients in Kota Bharu Hospital, Kelantan from 1998 to 2001. *Southeast Asian J Trop Med Public Health*. 2004 Mar; 35(1): 140-3

²¹ Dr Zainuddin Abd Wahab. *Epidemiology and Behavioural Study of HIV Infection among drug users in peninsular Malaysia*. Disease Control Division. Ministry of Health, Malaysia. Jan 13, 2003. www.dph.gov.my/aids. Accessed Nov 16, 2006.

posed by HIV/AIDS to human security and provides a roadmap for gaining control over this disease. An aggressive and multi-faceted government-led approach to preventing the disease is essential. However, even a full-scale, government-led strategy, along with programmes and advocacy efforts by NGOs, is not enough to achieve effective results without the support and action of all sectors of society, the corporate sector, local authorities, political leaders, and, importantly, religious leaders.

About the project

The UNDP supported “Islam and HIV/AIDS” project was led by the AIDS Unit of the Ministry of Health with the support of the Malaysian AIDS Council (MAC) and involved , Department for the Advancement of Islamic Affairs (Jabatan Kemajuan Islam Malaysia, JAKIM) at the National level and the State Religious Departments, (Jabatan Agama Islam Negeri, JAIN) as well as UNDP. Representatives of these bodies formed the Technical Working Committee and participants included Islamic religious professionals at all levels, including state muftis, and imams of local mosques.

The project’s aim was to mobilize and harness support of religious leaders for HIV/AIDS prevention, care and support. Since the majority of Malaysians are Muslims, and the reality that the majority of those affected by injecting drug use and HIV are Malay Muslims, it is expedient that the leadership of religious professionals be sought in helping to reverse the rising prevalence trend. This included federal and state religious department officials, imams of mosques, religious teachers and other Islamic religious professionals considered necessary to reach out to as many youth and healthy adults as possible to convey the key messages that will lead to better understanding of how HIV/AIDS is spread and about preventive steps.

The project followed from an “Islam and HIV/AIDS Colloquium” held in 1999 organized by the MAC, where Muslim leaders recognized the need to commit themselves to preventing the spread of HIV/AIDS. Fifty participants including state Muftis, Fatwa Council members, JAKIM officers and Muslim scholars agreed upon a resolution that was based upon (i) acceptance that HIV/AIDS is a critical issue;(ii) awareness that a spiritual approach can help address the challenges;(iii) acknowledgement of the need to show compassion, love and patience to PLWHAs and (iv) the need to identify the role of ulama/religious leaders in preventing the spread of HIV/AIDS.

The project that was undertaken between 2001 and mid-2005, was intended to mobilise the Muslim leadership of the country in support of efforts to prevent HIV/AIDS. The project objectives were (i) to develop a methodology for increasing awareness of HIV/AIDS among religious leaders and within Muslim communities, (ii) to enhance the knowledge of the disease and to promote appropriate action for prevention, care and support, and (iii) to develop a strategy for building the commitment and increasing the involvement of Islamic religious leaders.

As part of the project, Malaysian Muslim leaders visited a highly successful HIV/AIDS prevention project led by the Islamic Medical Association of Uganda (IMAU) and Muslim religious leaders. A key output was a comprehensive training manual, developed to help achieve the above project objectives. Subsequently the training manual was introduced and piloted at workshops in six locations or zones: Northern, Central, Southern, Eastern, Sabah and Sarawak.

METHODOLOGY

Interviews were conducted with key individuals to assess the project outcome, including members of the Project's Technical Working Committee, as well as participants of the training workshops. Initials of interviewees have been changed to protect their confidentiality.

FINDINGS

Table 3. Summary of interview findings.

	Category	Summary	Comment
1	Achievement of objectives		
(a)	Increase in knowledge on HIV and prevention methods	Project successful	>Condom info useful but contentious
			>Mandi jenazah info helpful but never used
(b)	Reduce stigma and discrimination	Partial success	>Knowledge helped reduce level of stigmatization and discrimination
			>Negative attitudes persist for some
			>Needs more work and support from higher authority, some motivated
2	Assessment of impact	Varying degrees of impact	>Depended upon prior openness
			>Human factor, personal experience important
			>Peers opinions count
3	Usefulness of training and training manual	Useful	>Particularly for those who need to use info in their daily work
4	Project continuity	Generally lacked continuity but all expressed interest to move forward	>Many reasons for poor continuity: organizational support key element
			>A few good but discreet examples
5	Role of Islamic leaders and religious professionals		
(a)	In general	All recognized important role	>Emphasis that work needs full sanction of higher authority
(b)	Advocacy on special issues		
(i)	Condom use	OK within marriage but contentious otherwise	>Possible solution: Joint talks with medical personnel
(ii)	Injecting drug use	Full support for advocacy effort	>Not considered a sensitive issue
6	Project challenges	Several identified	>Coordination with Federal and State
			>Level of motivation influenced result

1) Achievement of Objectives

a) Increase knowledge among the participants and provide clear explanations regarding transmission of HIV/AIDS and methods that can be used to avoid infection

All interviewees expressed that the project was successful in this respect, and workshop participants gained greater knowledge about the HIV/AIDS. “I understand now that HIV is the virus and AIDS is the disease” [ZI]. Participants also felt that they received clear information about the method of transmission of HIV/AIDS and prevention strategies both in terms of IDU and sexually transmitted HIV.

Although knowledge about condom use was considered useful, several said that they would not speak in public about condom use in non-marital sex as this was “haram” (forbidden) in Islam. Others said that in smaller groups of audiences who are at risk, or in certain situations, it may be something that they may cautiously advise out of necessity while still stressing that sex outside of marriage is haram [NB, AH, ZI]. As part of knowledge about prevention strategies, part of the workshop taught participants how to conduct “mandi jenazah” (a ritual bath for the deceased). This was considered useful information but none had ever been called upon for this duty since the workshop, while only one was aware of a colleague who had been asked to perform the ritual[AH].

b) Reduce stigma and discrimination

Most participants felt that this objective was only partially achieved [QJ, AL, TT, NT, ZI, IU, BK, NB, IT]. Regardless of the persisting stigma and discrimination, knowledge of the scientific facts and other relevant information was felt to have improved attitudes among the participants [QJ, AP]. Participants understood that it is “not just a disease of wrong-doers” [QJ]. There seemed to be less blame on PLWHA [QJ] and participants understand that some of those infected repent their mistakes, while others may have been infected through no fault of their own, such as monogamous wives of infected men and children [NT]. However, this acceptance often did not seem to extend to people who may have been involved or continue to participate in high risk activities, especially when their behaviour was known to the rest of the kampong folk [IU, AH]. Nonetheless, even a slight improvement in attitude was considered worthwhile, “ulamas no longer make religious rulings (Hukum) and Fatwas blindly” and they no longer shun PLWHAs as if “orang takut pada harimau” (as if they are wild beasts/tigers) [QJ].

There was evidence of both a positive and a negative attitude towards PLWHAs from comments made, such as “PLWHAs are also our children, they should be accepted and persuaded towards the right path” [ZI]; “As Muslim leaders and advisers we are the ones who should approach others, but there are some of us (religious professionals) who have a sense of disgust (“rasa jijik”). Others feel angry because they have not listened to repeated advice” [NB]. One interviewee still felt that PLWHAs should be separated from the rest of society.

Reducing stigma was considered a difficult task and a lot more needed to be done to overcome this. Workshops of a few days cannot be expected to reduce long-held beliefs significantly [AL]. A critical part of reducing stigma and discrimination would be for imams and religious leaders to lead by example and reach out to PLWHAs. However, for this they would need increased resources and support including in terms of budget. It is hoped that further along the line that Baitul Mal donations (religious tithes) can be used for this purpose [GJ].

There was support for this type of direct action and outreach among interviewees. “For problem areas, it is possible to go door-to-door and talk to people” [BK]. It was felt that the target of outreach should also include those at risk especially young people. “Even though it is harder to do, the ‘personal touch’ is necessary. Religious professionals need to get close to young people in order to help them” [NB]. According to one senior ulama, “there cannot be the expectation that everyone will come to the mosque, so we must to reach out to them in ways that they understand such as using Islamically “moderate” forms of entertainment like nasyid groups and popular celebrities in order to encourage people to come to events...We should also conduct school holiday programmes that are of interest, including physical and fun activities for children in order to encourage them” [BK].

2) Assessment of impact - Whether the project made an impact (positive/or negative) on participant personally and on colleagues

To some degree, the degree of openness of an individual towards the issue of HIV/AIDS prior to the project determined how much benefit they would derive from the workshops and experience. For those who had a positive experience, it appeared that an important

factor in determining the impact on individuals was the personal and human experience. For key leaders in the project, the visit to Uganda, observing first hand the devastating impact on society had an enormous impact on their motivation to act [QJ, BK]. For others who joined as participants, the greatest impact was felt when meeting and socializing with a PLWHA who was part of the workshop, sometimes without realizing at first the person's HIV status [AH, AL, KT]. In addition, having their own peers, among the imams and senior ulama, talk about the issue was effective [AL].

3) Usefulness of the Training and Training Manual

The content of the manual was overall considered useful and informative. Even though several felt that not all the information could be conveyed directly to the Muslim public, having all the information in the manual was reassuring as it became a reference tool. Participants felt more confident in being able to talk about HIV, answer questions, and correct myths and misunderstandings [IT]. Religious professionals who conduct counselling sessions or are called upon to give speeches and write khutbahs (sermons) found it particularly useful [NB, AH]. One marriage counselor found the knowledge especially helpful. His personal observation of a particular district in his state, was that 30% out of 45 couples requiring counseling had drug related problems in their marriage. He also felt the manual would become even more useful when pre-marital testing is implemented in the state [AH].

4) Project Continuity

All of the people interviewed stated that they would have liked to see the project continued beyond the workshops that were conducted. Some examples of efforts beyond the workshops were: (i) khutbah Jumaat that contained HIV/AIDS message conducted in 2004 in several states [TT, NB]; (ii) A talk delivered to a local college by one workshop participant [AH], (iii) In Sabah, talks regularly delivered about HIV/AIDS in jails, SERENTI detention centers and Henry Gurney schools [TT]; as well as (iv) exhibitions in mosques about drug use, including injecting drug abuse [TT]. These were examples of discrete efforts, but in general it was felt that this project did not reach its full potential in terms of outreach to the Muslim public [QJ].

All voiced that the project needed to be continued in an organized manner which is to include state and federal religious authorities. This would ensure that the message

reached district level religious professionals and finally to the public [NB, AH, IT]. Expansion of the project cannot depend on individual effort without directive and support from higher authority [AH, NB].

5) Discussion of the role of Islamic leaders and religious professionals in HIV/AIDS prevention, treatment and care.

a) In general

All who were interviewed felt that imams and ulamas have a great role to play. This is because an imam is well respected and trusted [QJ, IT, AH, NB] and a key member of a community “tak ada imam, tak sempurna kampung” (without an imam, the kampung is not complete) [QJ]. However, in order to convey the message about HIV/AIDS they need to be given the right knowledge and guidance to do so as this project had begun to do [IT, AI]. And imams also need to be prepared to learn and to teach simultaneously [NB].

Unlike in Uganda or in some Muslim countries, imams, ulamas and other religious professionals in Malaysia are governed and often salaried by a central authority, that is JAKIM at the federal level, and JAIN at the state level [QJ]. The work of religious professionals in any state must be sanctioned by the authority that they are directed by. In order to have a systematic programme and encourage greater participation by religious professionals, these institutions need to be fully involved and recognize HIV/AIDS work as part of their ongoing programme. [QJ, NB, AH, AP, AI]. In addition, the imam needs to be able to have the support of other leaders in the kampung, such as the kampung head, committee members (JKK) and RELA members [QJ].

b) Advocating on special issues

i) Condom use

All the interviewees agreed that they would be willing to advocate for condom use in the context of marriage when one partner is known to either have HIV or at risk of HIV by being involved in high-risk behaviours. Even though prior to the workshop there were many who were not comfortable using the word “condom”, this in itself was no longer a problem. However, the context of the recommendation for its use remained contentious. For several individuals, speaking about condom use in non-marital sex was not possible, particularly in a speech to large groups, due to very closely held personal convictions about Islamic ruling (Hukum). Several others confided that they could mention this in a

small group or if the audience was clearly known to be at risk while stressing that this was still Islamically sinful [MA, ZG, SS]. The dilemma could potentially be solved by teaming-up with medical professionals during talks to convey the message about condom use in general [AL, NT, AH].

ii) Injecting Drug Use

All interviewees felt that drug abuse could be discussed openly by imams and religious leaders and they did not consider this to be a sensitive issue. Since drug use is against the teachings of Islam, the topics of drug use in general, injecting drug use and needle sharing is a topic that imams and religious leaders should talk about without hesitation [NT, TT, AH, ZI, IT]. What may have had an impact on this was that several had either known of someone in the community who was an addict, or had direct experience like counseling drug addicts and their wives.

6) Project challenges

Even though JAKIM is the federal authority and the JAINs are the state level authority, they are effectively independent of each other so working together along with other stakeholders proved challenging at times [KT]. In addition, the institutional styles of the different stakeholders in the project were occasionally a source of tension. Some of the ulamas felt that a more tactful approach was more effective [IT]. It was counter-productive to compel imams and religious professionals to take on the same perspective as the other stakeholders. Sometimes culturally sensitive issues like condom use became points of heated debate rather than focussing on solutions for the difference in opinion [NT, IT, QJ].

The religious and cultural sensitivities were also a hurdle. Key religious leaders at the highest level had to overcome these issues first. The development of the manual helped, in part, to achieve this [KT]. Once this was achieved, there was generally good acceptance of the project among the religious leaders at the highest level [NT]. However, some state religious departments were more motivated than others, such as Sabah and Johor. [QJ, AL, NT, KT]. Sabah sent a high number of participants who were very keen to learn about HIV/AIDS, while Johor invited trainers back to do a second workshop for the state.

The success of the project in each state depended on the level of commitment and motivation of the state religious authority. The project did not achieve its full potential in its execution partly due to the challenge of coordination with different authorities with varying interest level [NB, IT]. Participants in the workshops were not always the most appropriate [AL]. Invitations to the workshop were sometimes sent unsystematically, so that heads of departments were not invited or could not attend, whereas this would have been more strategically meaningful [AI].

As can be expected, there remains some misunderstandings about the disease and inaccuracies that will need to be further corrected. Examples were that (i) HIV can spread through “wet” means, that is why need to use gloves when conducting a ritual bath for deceased PLWHA (ii) That all the belongings of a deceased PLWHA need to be burnt or those using them risk getting infected.

NEXT STEPS

In order for Muslim religious leaders in Malaysia to play a more effective role in the prevention, care and support for HIV/AIDS, there needs to be several important elements in place.

1) Support from the highest authorities critical

Since the practice of Islam in Malaysia is managed by the government through the Minister for Islamic Affairs and JAKIM, and within each state by the JAIN, it is essential that these institutions are fully involved and recognize HIV/AIDS work as part of their departments’ programme [QJ]. The JAINs especially need to be strategically involved to ensure delivery to the Muslim public. Religious professionals at the local level are not permitted to conduct activities on their own and without sanction [AI, NB]. Thus, it would be appropriate to include HIV/AIDS related activities as part of the annual performance review (Sasaran Kerja Tahunan) of religious professionals at the state level [OG, NT]. Further to this, since the JAINs come under the purview the State Government, there needs to be political will to ensure that HIV/AIDS prevention, care and support can become an integral part of the departments aims.

2) Achieving “Buy in”

Achieving “buy-in” needs to take into account the perspective of the religious leaders

and a reasonable expectation of their capacity. This must be recognized and solutions to sticky problems sought where possible, such as teaming up with medical professionals when holding group talks. A small step forwards with religious leaders speaking up about HIV/AIDS could mean a great deal in destigmatizing the issues surrounding the discussion about HIV/AIDS and reducing the sense of taboo among Malay Muslims. Perhaps when this first hurdle is overcome, there can be a balance struck regarding other issues that were glanced over in this project, such as gender, reproductive health and sexuality in relation to HIV/AIDS [AL, OG].

3) Ownership

There needs to be a strong sense of ownership of the project by the religious authorities. Instead of having the MOH or MAC take the lead role, the religious authorities and agencies should be given the lead with full support of the agencies. In order to achieve this, JAKIM at the Federal level, and JAIN at the state level, should be encouraged to identify the role that they see is the most appropriate for them and identify the issues that they would like to address and how. The existing manual should be used in the manner that they see fit and modified accordingly [NT, IU].

4) Reducing stigma and discrimination

Reducing stigma and discrimination is a very important role that can be played by the religious leaders particularly since this is such a difficult issue to overcome. The most effective way for imams and ulamas to achieve this would not only be to talk about the issues in public frequently and with as much forthrightness as possible, whether in their talks and lectures at mosques or on radio and television. They also need to be seen as leading by example by reaching out in person to PLWHAs to offer help and support whether spiritual or material. However, in order to do this, they will need to have budgetary support from federal and state authorities, or going a step further, from the Baitul Mal donations. In addition, they would need support from other local officials such as kampung heads and committee members. This will require commitment and political will at the state level.

5) Other suggestions:

Several suggestions were put forward by interviewees

- a) Since there are a number of changes in HIV/AIDS at the global and local level

- since 2001 when it was developed, the manual should be updated with information about drug use and HIV, recent epidemiologic facts and new treatment recommendations.
- b) Activities that the religious professionals can use to further spread the message are through:
 - i) Khutbah jumaat (Friday sermons) as has been done previously [NB, AL].
 - ii) Through religious classes held by the mosques [ZI].
 - iii) Through pre-marital courses particularly in view of pre-marital testing that is to be conducted in all states [AH].
 - iv) Through religious radio programmes [NB]
 - c) Linkages should be made with other agencies and Ministries in order to maximize the reach of the project, for example with KEMAS, which is part of the Rural Development Ministry. A link with the Ministry of Higher Learning could provide training to students attending early courses at universities.
 - d) To ensure project continuity, there needs to be follow-up of local level activities by a salaried project manager/coordinator for at least 3 years to update the HIV/AIDS manual and to build the capacity of religious leaders in addressing the challenges of HIV/AIDS. There needs to be project sponsorship or budget allocation available as projects as ambitious as this cannot achieve a footing in a short period of time. The project manager/coordinator should be tasked with calling local level leaders on a regular basis to follow-up and provide some support for activities.
 - e) Local imams and religious professionals who are highly receptive should be identified as good examples of leadership in the field. There needs to be publicity to highlight any good work that is done. If possible, reduction in HIV prevalence rates in their local area as a result of efforts should be emphasized [AL]
 - f) Publicity and creating a “buzz” should be an element at every training that is held. To do this, training events should be communicated to the media and minor events should be held (such as an open forum, exhibition, distribution of pamphlets) for local community leaders. Hotel workers where the workshop is held should also be included in the minor events since they are accessible and are an appropriate age group with higher risk [AL].
 - g) Conduct a review of the process of pre-marital HIV testing for Muslim couples as the lack of confidentiality has created problems for potential couples [NT, AH].

DISCUSSION

The role of religious leaders in HIV/AIDS prevention care and support

Muslim religious leaders have a great role to play in HIV/AIDS prevention care and support. Due to the respect accorded to them, their involvement and role modeling is highly visible and can have a strong impact on the Muslim public. As a trusted source of information, they can help to increase the level of knowledge and awareness about HIV/AIDS and prevention methods. It is known that knowledge alone is not enough to effect behaviour change, particularly related to reproductive health issues like HIV/AIDS, also known as the knowledge-behaviour gap.²² In order for behaviour change to take place, people who receive information need to know that if they decide to change that their communities will support them. The public needs to know that influential people including religious leaders approve of their actions. Thus, religious leaders can help bridge the knowledge-behaviour gap and affect behaviour change. All interviewees expressed a strong interest to be more involved and recognized the necessity. However, in order to perform as effective role models, they need to be given the right tools, such as information and training. And they also need to be given the material and organizational support by the government and political system.

One of the most important areas that religious leaders must play a role is in reducing stigma and discrimination²³. Although this is a very complex issue that cannot be eliminated easily, the influence of religious leaders can help to overcome the negative views held by society. In order to achieve this, once again, role modeling is an important factor. When religious leaders take a personal stand and extend themselves to PLWHAs, the public will learn that such behaviour is not only acceptable but noble in the eyes of religion.

Meanwhile, stigma and discrimination among religious leaders themselves may still need to be overcome. Some of this could be addressed through meeting and socializing with PLWHAs during workshops, as was done previously, or going on a field visit to meet particularly with women and children with HIV AIDS. In addition, bringing in fellow

²² Best practices in Egypt. Creating a movement for change (Behaviour-change communication). <http://www.rhcatalyst.org>. Accessed 23rd November 2006.

²³ Patterson G. Church Leadership and HIV AIDS. The new commitment. Discussion Paper 001.

religious leaders from other countries who have been successful in this area to talk about their perspective and experience may be motivational. Granted, not all religious leaders will overcome their own stigmatization of PLWHAs and there should be a realistic expectation of this. There should not be further pressure on those who do not want to participate, as trying to change the behaviour of those who do not want to change could become a waste of time and resource.

On the other hand, there needs to be an adequate system in place to identify, encourage and support those who are motivated to change and play lead roles. In order to do this effectively, key stakeholders, such as PLWHAs need to be involved. These are people who can help these leaders identify their most useful role and provide feedback for them to improve.²⁴ As stated by some of the interviewees, in encouraging better advocacy from religious leaders, there is a need to be helpful and supportive, as opposed to cynical and judgemental. Furthermore, in order to encourage more proactive behaviours from religious leaders, they need to be given ownership of the issue and allowed to identify the areas that they want to work in, and the specific role that they wish to play²⁵.

Religious leaders have been successful in a few other Muslim countries and communities, such as Senegal, Iran and Uganda^{26,27}. In Senegal, when political leaders realized that a change in sexual behavior was necessary to contain HIV/AIDS they undertook multiple strategies, an important one of which was to enlist the support of religious leaders. Religious leaders were given training to equip them with knowledge for advocacy work. HIV/AIDS then became a regular issue of Friday prayer sermons in mosques throughout the country and religious leaders talked about HIV/AIDS on television and radio. Brochures and information were distributed through religious teaching programmes. Since the early 1980s, Senegal has managed to keep their HIV prevalence rates low less than 1% in 2005 compared to their West African neighbours.

²⁴ Marshall Goldsmith. Coaching for behavioral change (Adapted from the Art and Practice of Leadership Coaching, edited by: H Morgan, P Harkins and M goldsmith, Wiley 2005)

²⁵ Ibid.

²⁶ Hasnain M. Cultural Approach to HIV/AIDS Harm Reduction in Muslim Countries. Harm Reduct J. 2005; 2: 23.

²⁷ Lom MM. Senegal's recipe for success: Early mobilization and political commitment keep HIV infections low. *Africa Recovery*, Vol.15# 1-2 (June 2001), page 24

In Iran, similar to Malaysia, the prevalence of HIV/AIDS is driven by injecting drug use. In 2002, under the leadership of President Khatami, the Islamic government administration recognized the urgent need to control the spread of disease. HIV Education became part of the curriculum of public schools and couples applying for marriage licenses were given information. In addition, the needle-exchange programmes were offered in high drugs use areas²⁸. There still remains a taboo around the discussion of sexually transmitted HIV, which is on the rise, but the steps taken above have been significant. Meanwhile, in Uganda, where Muslims are a minority of about 12%²⁹ efforts of Muslim leaders in collaboration with Muslim medical professionals helped to reduce incidence among Ugandan Muslims from 18% in the early 90's to the current rate of 6%³⁰.

CONCLUSIONS

As a moderate and progressive Muslim country that espouses the concept of a forward thinking and moderate Islam, called “Islam Hadhari” or Civilisational Islam, it would be appropriate that Malaysia’s religious leaders play a greater role in HIV/AIDS prevention, care and support. Due to the respect accorded to this group of individuals, their example as role-models, they can help not only to increase knowledge but to effect behavioural change among the Malay Muslims, among whom HIV/AIDS has had the highest impact.

There is a need to reinvigorate and move forwards with the “Islam and HIV/AIDS” project. In order to achieve this, there is a need to ensure that all religious leaders at all levels are given the right tools to become advocates. There must be material (budgetary), organizational and political support for the programme. Those who are motivated should be identified and given recognition for their effort. As well, it should be clear that ownership of the programme belongs to the relevant authorities and the religious leaders themselves with the full support from other stakeholders such as MOH, MAC and PLWHAs. The owners are then empowered to identify the issues that they wish to take on and the role they are to play.

²⁸ Kelley LM, Eberstadt N. The Muslim face of AIDS. Foreign Policy. July/August 2005. www.foreignpolicy.com. Accessed 18th November 2006.

²⁹ US Department of State. www.state.gov. Accessed, 26th November 2006.

³⁰ Farrell M. Condoms and AIDS Prevention: A comparison of three faith-based organizations in Uganda. AIDS and Anthropology Bulletin. 2003;15:3.

Although the “Islam and HIV/AIDS” project, which ended in 2005, did not fully achieve its full potential, it laid very useful groundwork for the future. At this juncture, there appears to be strong interest and recognition of necessity among religious leaders and professionals in taking the project to the next level.