United Nations Children's Fund
Regional Office for South Asia

FAITH-MOTIVATED ACTIONS ON HIV/AIDS PREVENTION AND CARE FOR CHILDREN AND YOUNG PEOPLE IN SOUTH ASIA:

A REGIONAL OVERVIEW

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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CONTENTS

EXECUTIVE SUMMARY

Nearly 5 million people in South Asia are infected with HIV/AIDS as of end 2003.

HIV/AIDS plunges life into a daily ordeal for these millions, with millions more of family members bearing the brunt of care, and the cost of care.

Those affected have watched their husbands or wives, or children or relatives sicken, and die. A great unknown number have perished, including infected newborns coming into the world with the imminent prospect of death. Those infected who live on struggle silently, fighting opportunistic infections, or worsening tuberculosis, or other diseases that prey on their bodies' weakened immunity. As AIDS progresses in adults, a growing number of children are left with the inevitability of becoming orphans. Yet they are ostracized, discriminated, forced to live in shame because AIDS, unlike all other diseases, is singularly stigmatized.

The epidemic, however, has shown no sign of stopping. Infection rates in the region continue to soar. In India alone the number of people infected with HIV has swelled since the first case was detected in 1986 to 4.58 million by the end of 2002 [1&2]. The country's low general population prevalence, at 0.8%, masks a potentially explosive condition. The same is true for all of the other countries in South Asia – Afghanistan, Bangladesh, Bhutan, the Maldives, Nepal, Pakistan and Sri Lanka – where HIV/AIDS prevalence seems minuscule compared to the world's current epicenter, Sub-Saharan Africa. It is, for the time being.

HIV transmission pattern in various countries has been marked by sudden increases among people with high-risk behaviours, where the epidemic quickly breaks away and spreads to the general population. In some parts of South Asia, this is already the case. Commercial sex workers or brothel clients or truck drivers no longer form the bulk of new infection cases. The epidemic profile is shifting towards wives, women infected by their husbands, the only sexual partners they have ever known. And many are young children, infected at birth by mothers unaware of their HIV status. Many are adolescent girls, sexually exploited and sold into the sex trade; and many are average young people who have unwittingly fallen into the drug trap.

The scenario in Africa seems about to be reenacted in South Asia on a massive scale if efforts are not intensified to stem the growing waves of HIV infections.

Faith-Based Organizations (FBOs) and religious leaders the world over, following the precept of compassion, have responded in various ways to the epidemic, helping the public sector and individuals cope with its social and economic consequences. They either work independently or alongside governments, which have pledged accelerated actions in global and regional forums, in particular, the UN Special Session on HIV/AIDS in 2001, the UN Special Session on Children in 2002 and the UNICEF/UNAIDS High-Level Conference on HIV/AIDS in South Asia, in February 2003. The latter, acknowledging the likelihood of a huge and explosive scenario in the region, also identified the need for strong leadership at all levels of society and the participation of civil society, the business and religious communities, women's religious groups and activists. Its Declaration, the "Kathmandu Call for Actions Against HIV/AIDS in South Asia," was adopted by all eight South Asian countries, by 180 senior government leaders, parliamentarians, religious leaders, business leaders, activists, people living with HIV/AIDS, young people and partners from NGOs, bilateral and international agencies.

The first “Interfaith Consultation on Children, Young People, and HIV/AIDS in South Asia” is a follow up to this commitment. To facilitate the Consultation, UNICEF has commissioned a series of assessments in eight countries of South Asia to look at current activities of FBOs and perception of religious leaders, along with views of communities, towards HIV/AIDS and possible actions.

The assessments are largely an outcome of desk review and interviews, and the sample represents major faiths in the region—Hinduism, Buddhism, Islam as well as Christianity and Baha’i. The countries studied are: Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka. This overview distills from the country assessments, current activities and perceptions of religious groups, with the aim to understand the opportunities and constraints in expanding the role of religious leaders and faith-based organizations in HIV/AIDS prevention and care, targeting children and young people in South Asia.

Opportunities and constraints

An impressive majority of respondents across all religions were willing to raise awareness and spread knowledge of HIV/AIDS among followers and local communities. Many, including Buddhist monks and Imams are already engaged in some form of information sharing with believers. Volunteers of the Christian-faith are supporting not only reproductive health education but also hospices for people with HIV/AIDS. A number of Imams have expressed their wish to do more as long as government departments approach them and recognize their potential contributions. Training for religious leaders is an area identified by many as both needed and a positive step forward. Financial assistance is essential to expanding the role of FBOs in HIV/AIDS prevention and care.

There are apparent misconceptions about HIV/AIDS, though with geographic differences. Religious leaders residing in rural and remote areas tend to regard AIDS as a divine punishment for sin or consequence of immoral behaviour. Those in urban areas tend to accept the scientific explanation of AIDS. There is also a difference between religious leaders who have been given orientation on HIV/AIDS and those not. The former carry a more positive view about AIDS as a disease associated with ignorance and poverty, and display a supportive attitude toward those affected. The untrained shows inconsistent understanding of the causes and symptoms of HIV/AIDS, including blames on women for spreading the virus. Among those holding a negative view, there is ambivalence about extending compassion and help to people who are “reaping the fruit of bad behaviours”. Some also express reluctance to network with non-faith-based organisations.

Religious activities in other regions

The experiences of other regions attest further to the power and strength of faith-based groups’ interventions. This overview contains a section that also looks at experiences of religious communities in other regions in HIV/AIDS prevention, care and support. For instance, how Buddhist monks in Southeast Asia were battling stigma of HIV/AIDS in their own communities; how new organisations serving orphans and vulnerable children have joined thousands of Christian and Islamic faith-based groups in their tireless struggle with the epidemic in Sub-Saharan Africa for more than a decade, and how interdenominational church groups in Latin America are working together to serve young people, and extend their arms to people living with HIV/AIDS.

HIV/AIDS IN SOUTH ASIA: EARLY ACTIONS ARE KEY

Low Prevalence is no cause for comfort

HIV/AIDS prevalence in the eight countries of South Asia approximates 1% compared to 8.8% in Sub-Saharan Africa, the world's epicenter [3]. But the current scenario is no cause for complacency. Low prevalence in populous countries can seriously distort understanding of the epidemic. About 4.58 million people are estimated to be living with HIV/AIDS in India alone, the second highest in the world, after South Africa [4]. And in 2002, at least 300,000 people in the country acquired HIV [5].

The current prevalence in South Asia masks a complex picture where geography, cultural tradition, and religions offer no guarantee for shielding the region, and each nation, from a virus that knows no borders. It obscures serious epidemics in some provinces and states, among high-risk groups such as commercial sex workers and injecting drug users where infection rates are high and still rising, and now, more frequently, among low-risk groups like housewives and newborns.

A study conducted by the National AIDS Control Organization of India (NACO) indicates that young women being infected are primarily monogamous who have unknowingly contracted the virus from their partners [6]. In states such as Andhra Pradesh, Karnataka, Maharashtra, Manipur and Nagaland, HIV prevalence among pregnant women has crossed the 1% threshold[7]. Of the roughly 27 million pregnancies that occur annually in India, at least 100,000 women test HIV positive. This is likely to lead to about 30,000 infected infants and a further 70,000 children orphaned by AIDS [8].

In neighbouring Bangladesh and Nepal, high-risk behaviours in parts of the population are driving the epidemic even though national HIV prevalence is below 1%. In Pakistan, a recent study among drug users in Quetta found that 55% had used unclean injection equipment, with roughly the same percentage having visited commercial sex workers. However, only 4% have ever used a condom, and only 16% of the drug users have heard of AIDS [9].

More than just a public health concern, HIV/AIDS is a social and development issue. Poverty, gender discrimination, and overall inequities are underlying factors that fuel the epidemic. Literacy rate among girls and women in South Asia is the lowest in the world, at 61% in 2000[10]. Poor socio-economic status curtails their ability to negotiate for safer sex; it also makes them an easy target for sexual exploitation. NACO estimates that girls and women make up 20% – 25% of all HIV infections in India, and the infection gap between genders is narrowing.

Among those increasingly affected are not only women but adolescents. HIV infection among adolescents, currently estimated at 1.25 million in South Asia, is high in proportion to the general population. In Nepal, one-third of reported HIV positive cases are women, of whom 33 per cent are adolescents. In Maharashtra and Andra Pradesh of India, about 30% – 50% of HIV positive women who attend antenatal clinics are below 20 years of age. And the rising number of mothers infected spawns an increasing number of children born with HIV. Limited data gathering estimates there are about 174,100 children below 14 years old who live with HIV/AIDS in the region. Infants born to infected mothers are almost certain to succumb to the virus, a trend that is reversing all of the gains made in the reduction of infant and child mortalities.

Even more alarming is the fact that the majority of those infected do not know they are HIV positive. Ignorance of HIV/AIDS, deprivation of access to information and the right to protect themselves from unsafe sex, stigma attached to the disease, and limited testing facilities are realities that South Asia must confront in efforts to contain the virus.

End 2001 Estimates of HIV/AIDS Prevalence in South Asia

Country	Adult Prevalence rate (15-49 years)	Numbers of adults & children living with HIV/AIDS	Number of women living with HIV/AIDS (15-49)	Number of children living with HIV/AIDS (0-14 years)	Number of children orphaned by HIV/AIDS (0-14 years)
Afghanistan	-	-	-	-	-
Bangladesh	<0.1%	13,000	3,100	310	2100
Bhutan	<0.1%	<100	-	-	-
India	0.8%	3,970,000	1,500,000	170,000	-
Maldives	0.1%	<100	-	-	-
Nepal	0.5%	58,000	14,000	1,500	13,000
Pakistan	0.1%	78,000	16,000	2,200	25,000
Sri Lanka	<0.1%	4,800	1,400	<100	2,000

Source: Report on the Global HIV/AIDS Epidemic, UNAIDS, 2002

Taking early actions is crucial because firstly, a concentrated epidemic, without extraordinary interventions, can rapidly spill across to the larger, general population. Secondly, it is not only absolute numbers that indicate the presence of an epidemic, but the rate of growth. South Asia has one of the fastest growing AIDS epidemics in the world. Since 1992, infection rate as a whole has escalated from 5% in population groups at high risk to 1% of the general population in certain states of India and parts of Nepal. Among the public, the fastest increase is found in women and adolescents.

Who is at risk and why?

In South Asia, unprotected sex with a person who is HIV positive is the most common and direct mode of transmission, accounting for 75% of infections. The transfer of infected blood through unsterile needles in injected drug use or blood transfusion is the second and growing means of spreading HIV infections in the region.

HIV is transmitted in the countries of the region:

- Through unprotected sex (75-80%)
- Sharing of infected needles by drug users (5-10%)
- Transfusion of infected blood (5-10%)
- From mother to child at time of delivery/breast feeding (less than 1%)

The challenge of individual behaviour change is daunting enough, along with overwhelmingly negative attitude toward the disease and discrimination against women. HIV/AIDS is also tied to deeper issues, economic social and cultural conditions, values and practices that create a fertile breeding ground for the virus. The combination of poverty, social exclusion and gender inequalities make women and children most vulnerable to infection. As the epidemic spreads from people with high risk behaviour into the general public, the epidemic will be more difficult to control.

a. Poverty

Home to over a billion people in the world, South Asia also has 40% of the world's absolute poor, subsisting on less than 1$ per day [11]. Poverty is both a contributory cause and a consequence of HIV/AIDS. The poor tends to be caught in a vicious cycle of illiteracy, unemployment, frustrations and diseases; and the cost of care for HIV/AIDS further impoverishes the affected poor. At the macro level, the cost of AIDS will erode the gains in net primary education, GNP and mortality reduction.

b. The burden of HIV/AIDS on women

Gender discrimination and abuse sharply restrict women's ability to control their lives and increase their susceptibility to HIV infection. Nearly 36% of all people living with HIV/AIDS in the world are women [12]. Though there is no gender disaggregated data for the region as a whole, the general deprivations of women's rights, including poor literacy, low socio-economic status and policies that foster unequal participation, including inheritance and property laws that discriminate against women, are conditions that make them vulnerable to HIV and that increase their HIV risks. Many poor and/or illiterate women in the region have little means of supporting themselves or their family other than sex work. And for an equal number of others, their only HIV risk is unprotected sex with their husband or partner. Uneducated women often have little idea about how HIV is transmitted. Whereas unmarried girls and women, unexposed or discouraged from exploring sexual matters before marriage, tend to have few means or interest in accessing information or services about HIV/AIDS

Sexual and other forms of violence, including wife burning, honour killings and wife inheritance are practiced with impunity, or even as an acceptable norm in some places. The physical and emotional burden of HIV-positive women is furthered endangered by stigma and ostracism. Despite monogamy, married women are often blamed for HIV infection, even though it could well be brought on by their partner or husband, or from blood transfusion and other causes. HIV positive women may be thrown out of the house, denied medical attention, and if pregnant forced to abort the fetus. Regardless of their HIV status, women also shoulder a disproportionate burden of care, especially when someone in their family is affected by HIV/AIDS.

c. Adolescents

Globally, the infection rates among young people are rising disproportionately to the general population. In South Asia, more than 1.25 million young people are living with the disease, and the number of new infections among this group in 2000 was 260,000[13]. In India, over 50% of all new infections occur among people below 25 years [14]. Drug use, a secondary cause of spreading HIV transmission is increasingly common among adolescents.

Estimated number of young people under 25 living with HIV/AIDS in South Asia (1999)	
Bangladesh	4,000
India	1,200,000
Nepal	1 1,000
Pakistan	2 4,000
Sri Lanka	2,500

Source: Report on the Global HIV/AIDS Epidemic, UNAIDS, 2002

Currently, the rate of infection between boys and girls in South Asia is about equal, although globally the rate of girls' infection is rising more rapidly. Adolescent girls suffer the double disadvantage of being both females and children, and are susceptible to all kinds of abuses and exploitation, given pervasive gender biases in South Asia.

Estimated HIV prevalence (%) in young people, South Asia, 2000 – 2001

Country	End 1999				End 2001			
	Female (15-24)		Male (15-24)		Female (15-24)		Male (15-24)	
	From	To	From	To	Low estimate	High estimate	Low estimate	High estimate
Afghanistan	-	-	-	-	-	-	-	-
Bangladesh	<0.01	0.01	<0.01	0.02	0.01	0.01	0.01	0.01
Bhutan	-	-	-	-	-	-	-	-
India	0.40	0.82	0.14	0.58	0.46	0.96	0.22	0.46
Maldives	-	-	-	-	-	-	-	-
Nepal	0.13	0.26	0.06	0.23	0.18	0.38	0.17	0.36
Pakistan	0.03	0.06	0.02	0.10	0.03	0.07	0.04	0.08
Sri Lanka	0.03	0.07	0.02	0.07	0.03	0.04	0.02	0.03

Source: Reports on the Global HIV/AIDS Epidemic, UNAIDS 2000 & 2002

The value and practices of son preference are spurring incidents of foeticide, infanticide and early marriage of girls, which are common, largely accepted and not perceived as violations of human rights. Son preference also deprives girl children the opportunities for and fundamental right to education. Cultural ideals of femininity, such as innocence and ignorance, combined with the sexual license of men leave unmarried girls vulnerable to the dangerous myth that sex with a virgin will cure AIDS. There are many instances where girls are forced into marriage with older men which can increase their risk of HIV infection. The stigma attached to AIDS also bars many girls from seeking information or health services in order to protect their reputations, contributing to the risk of infection.

Among the sharpest increases of HIV infection has been antenatal women. In Bangladesh, nearly 50% of 18-year olds are pregnant or young mothers. And an AZT feasibility study in India revealed that 80% of antenatal women in the programme were under 25 years of age (NACO 2003). These factors have a disheartening affect on both the future lives of girls themselves and the health status of their newborn children.

REVIEW OF COUNTRY ASSESSMENTS

Objectives, methodology and limitations of the assessments

Conducted in eight countries of South Asia - Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, Sri Lanka – the assessments were commissioned by UNICEF ROSA in partnership with UNICEF country offices to prepare for this Interfaith consultation. Each of them consisted of a review of faith-based organisations' (FBOs) activities along with interviews. The aim was to gain a clearer idea of respondents' understanding and perception of the nature and causes of HIV/AIDS, what needs to be done, and what religious-based initiatives are being implemented in HIV/AIDS prevention and care.

Consultants from the NGO and academic communities were contracted to prepare the country assessments between August and October 2003. The methods of collecting information combined a review of available literature and multiple personal interviews. The latter ranging from in-depth conversations with religious leaders of all faiths to focus group discussions with representatives from faith-based organisations and stakeholders, including students, teachers, fathers, mothers, girls, and boys from different religious groups. It also included representatives of government, NGOs, and UN agencies.

Respondents were asked to identify and gauge the strengths and constraints of faith-based responses and ways they could be enhanced. Consultants, however, confronted certain constraints that limited their ability to gain a holistic picture of religious groups' involvement in HIV/AIDS prevention, care and support. These included shortage of time, vast distances to cover in some countries and issues of security in others such as Nepal, Sri Lanka and Afghanistan, confining many of the interviews closer to the capitals.

Profile and structure of religions in the region

The country assessments provided rich details of sects and sub-sects of various religions, including cults and traditional healers. This paper focuses on practitioners of Hinduism, Islam and Buddhism, the three major religions of South Asia, as well as followers of Christianity and the Baha'i faith.

Identification of some categories

a. Religious Leaders

The term 'religious leader' is variously defined by different respondents. Some refer to Imams at the local level as religious leaders; others address the top of the ecclesiastic hierarchy such as senior abbots or Muftis who may have important political and social as well as religious roles. These differ from country to country. They have in common the ability and power to make decisions, act as role models and lead the spiritual path down to the community and grassroots. Because of the difficulty in giving specific identity to each, this review uses the collective term "religious leaders" interchangeably to describe all.

The collective term also comprises Imams, priests and pusari, often regarded as religious foot soldiers with close connection to communities. This category of religious leaders carries

a great deal of influence over matters of the soul as well as day-to-day lives of believers. They deliver sermons, educate children, provide for the sick, serve as spiritual advisors and officiate at special occasions, e.g. marriages and funerals.

b. Faith-Based Organisations (FBOs)

Largely voluntary, faith-based organisations range from those directly associated with religious institutions to those inspired by religious values but not necessarily identified with specific religious rituals or traditions. Semi-secular faith-based organisations are common in South Asia. The Maldives, for example, has no faith-based organisations and the Supreme Council for Islamic Affairs is the main authority for religious advice and activities. The Ministry of Religious Affairs of Bangladesh is responsible for supporting, promoting and maintaining religious activities of various faith-based groups, including organizing visits for Haj that takes place in Mecca, Saudi Arabia.

Some organisations, such as the Sarvodaya Movement in Sri Lanka, attest to the blurring of lines between faith-based and secular organisations. On the one hand, its activities are inspired and informed by Buddhist doctrines and clergy; it is also self-consciously multi-religious in constituency, non-sectarian in providing services and "modernist" in its developmental outlook.

Gomdays in Buddhist Bhutan are local monasteries where gomchens, or lay monks, study under a lama or lopen (teacher). They are a category of faith-based organisation outside the main orbit of formal theocratic establishments. Gomchens are professional non-celibate practitioners who raise families and are easily accessible to the people, especially in the rural areas. In addition, there are many non-state funded faith-based organisations in Bhutan. Most of them are supported by communities themselves and some private religious institutions.

An overview of FBOs and their activities

About 50 faith-based programmes and projects in eight countries were assessed to obtain a sense of the nature and range of their HIV/AIDS-related activities. This small and limited sample is intended to serve as a start; it by no means represents fully the scope and range of faith-based work in the vast region. Neither can this paper cover every FBO and its activities nor all of the FBOs' work in detail, in the interest of maintaining concision as an overview.

The programmes and projects supported by FBOs or state-sanction religious institutions vary in size and population reach, and range from independently-run to those in partnership with government agencies or international NGOs; from advocacy and awareness-raising to programmes of care and support for people living with HIV/AIDS and the elimination of stigma and discrimination.

From the review it is apparent that while national AIDS prevention and control policies exist in all eight countries, there have been few systematic, concerted efforts to engage faith-based organizations for prevention, care and support. Many FBOs, especially those of the Christian faith, have initiated such programmes or activities voluntarily, and primarily from a tradition of welfare and charitable services to the poor and needy. A number of them are taking actions to work concertedly with other Christian organizations as the need for a unified response to AIDS becomes more apparent, and their approach more developmental rather than charity-based. The National Council of Churches of India is a good example, which has

made the call for a joint response at the Ecumenical Church Leaders Conference on HIV/AIDS in 2003, and set up a coordinating desk called “National Christian Council for Combating HIV/AIDS”.

The exceptions are countries where state-sanctioned religions give faith-based organizations a natural place in their national response to HIV/AIDS. The Imam Training Academy, set up by the Islamic Foundation of Bangladesh, a constitutional body of the Ministry of Religious Affairs, for instance, has introduced reproductive health and HIV/AIDS-related topics in its training curriculum for Imams. Through a Training of Trainers (TOT) approach, the Academy has trained over 40,000 Imams to date, who are expected to deliver HIV/AIDS messages to their musullis (people who offer prayers at the mosques) and during Khutba (lecture before prayers at the mosque), emphasizing the virtue of monogamous relationship in HIV/AIDS prevention. In Bhutan, HIV/AIDS training and advocacy is now a part of the Bhutan government’s national Religion and Health Programme**,** which began in 1989. The programme, which trains religious groups as primary communicators of HIV/AIDS prevention messages, has the full support of the Buddhist Chief Abbot, Je Kempo and now includes monks in key staff positions as project directors. The Je Khempo has supported HIV/AIDS advocacy efforts, and endorsed involvement of religious groups in awareness-raising of various forms of HIV/AIDS transmission, including mother-to-child.

The Supreme Council of Islamic Affairs in the Maldives also supports national HIV/AIDS programmes undertaken by the Department of Public Health. It has not yet initiated any of its own HIV/AIDS related programmes, but has expressed readiness to do so.

Size of FBOs and scope of work

The faith-based organisations surveyed range from small organisations to very large networks with a huge population reach. The Christian Aid Network Alliance (CANA) in India, for instance, comprises 350 Christian organisations working on HIV prevention, in particular. It serves as a resource centre, conducts training, advocacy and action research and economic empowerment for members. The Buddhist Child Home in Nepal, on the other hand, supports 21 children who have been abandoned or displaced, and provides basic education on HIV.

A large percentage of faith-based organisations active in HIV/AIDS, as found in the assessments, are Christian-based. Several among them are with international parent organisations, although their service is non-sectarian. These include the Catholic Relief Service, the Salvation Army, Caritas and World Vision. The majority address advocacy and HIV/AIDS prevention, with training and sensitisation of religious leaders and disseminating literature or messages in the media. In Nepal, the Sakriya Sewa Samaj or United Mission to Nepal, has developed teaching aids and materials now used by the government for HIV/AIDS education. The mission runs projects in various parts of the country, and also works actively to promote inclusion and acceptance of people with HIV/AIDS in the society.

In India, a number of religious-based institutions support a remarkable range of HIV/AIDS services in different states. Other than CANA, the Catholic Bishop’s Conference of India and the Christian Medical Association each has a huge network around the country, promoting sexual health education in schools, home-based care for people living with HIV/AIDS, antenatal clinics and detoxification centres.

The Emanuel Hospitals Association (EHA), created in 1994, operates 25 projects in 12 states, primarily in the poorest areas of north and northeast. Its 1500-member staff (trained doctors,

nurses, project officers) carry a huge burden of a diverse range of HIV/AIDS-related services, focusing on whole person care within the context of Christian values—family, love and monogamy. The EHA also conducts training for more than 15 organisations and runs two primary schools. The Association also provides outreach services to intravenous drug users and commercial sex workers, as well as promotes needle exchange. Interventions targeting young people include the formation of girls' groups, antenatal clinics, support for non-formal education, literacy programmes and peer education on HIV/AIDS prevention.

HIV/AIDS advocacy and communication

The majority of FBOs involved in HIV work place a strong emphasis on advocacy, communication and training. The EHA, CANA, the Christian Medical Association of India, the Catholic Bishops Conference, and the National Council of Churches of India are all running programmes on HIV/AIDS prevention and education targeting different audiences, ranging from followers to pastors, school children and people with HIV/AIDS. The Snodical Board of Health Services, under the Churches of Northern India, also supports radio talk shows and rallies to raise awareness of HIV/AIDS. Similar works are also undertaken by the World Vision, CARITAS and Salvation Army in Bangladesh, and a number of FBOs in all other countries.

The Rural Urban Partnership (RUP) in Nepal is a Muslim community awareness-raising programme, sponsored by UNDP to enhance the knowledge of rural Imams in HIV prevention. Materials are prepared in local languages and local clerics are trained to conduct awareness-raising activities before their Friday sermons.

The Imam Training Academy, in Bangladesh was established by the Ministry of Religious Affairs to assist imams better in assisting their congregations. Training, which includes poultry management, forestry, human rights and legal rights of women, has expanded to include curricula on HIV/AIDS. It also contains issues related to young people, such as prohibition of early marriage, gender and children's rights and trafficking of children. Since 2001, 100 imams have been trained about HIV.

The Islamic Research Cell (IRC), a section of the Family Planning Association of Bangladesh (FPAB) is an NGO affiliated to the International Planned Parenthood Federation. With the support of 758 professionals and 3,000 volunteers, the IRC has been training Imams in reproductive health since 1993. HIV training includes equal rights for wives and the protective role of condoms. It emphasizes use of condoms only among married people and adults who engage in high-risk behaviour; and prohibits its use and promotion in programmes for young people.

a. Programmes targeting children and young people

Only about 10 organisations of those covered by the assessments, are working directly with adolescents, children and young people in HIV prevention and few of these go beyond traditional preaching of values. Most of the programmes are relatively perfunctory, linked to religious education and mass messages. Survey responses indicate that this may be due to discomfort on the use and discussion of condoms and the lack of knowledge on how to handle the subject with young people.

World Vision in Bangladesh has reached more than 10,000 adolescents and youth with health and HIV prevention education. The Baha'i community in India networks with the KIDAVRI, made up of 7 organizations targeting adolescent health, and support HIV workshops in

schools. The Baha'i Centre in Nepal teaches moral values to young people as a means of introducing HIV/AIDS education. At the RUP in Nepal, Muslim children are educated about HIV/AIDS through Madarasas; women and girls are instructed by the female leaders of their local organisation.

Jamat Ud Dawa and Jamia Salfia in Pakistan run schools and colleges throughout the country, focusing on educating youth to live in accordance with Islamic teaching. Although they do not yet address HIV/AIDS, they have expressed interest in doing so.

b. Programmes targeting groups with high-risk behaviours

Caritas in Pakistan and Lutheran World Service in Nepal work with people with high risk behaviour, including commercial sex workers, pimps and migrant workers at the Indian border area. The Salvation Army focuses on counseling, care and support for people living with HIV/AIDS and provides community education to eliminate stigma and discrimination. The Emanuel Hospitals Association in India provides outreach services to IDUs, truckers, commercial sex workers, and support needle exchange programmes. The World Vision in Bangladesh delivers HIV/AIDS prevention education to deep sea fishermen and their spouses, rickshaw pullers, and spouses of migrant workers. The YMCA in Sri Lanka runs a condom promotion programme targeting sex workers. The Richmond Fellowship in Nepal rehabilitates drug and alcohol users, and now people with HIV/AIDS with spiritual counseling to help build self-confidence.

HIV/AIDS care and support

Care and support are pressing needs as AIDS advances in people infected, but few FBOs under review are in the financial position to support them. In Nepal, the Karuna Hospice, a Roman Catholic mission, provides care, including basic medicine, to HIV positive females and children. The EHA, Christian Medical Association of India and Catholic Bishops Conference of India train parishes and churches in care and support, and supports centers that provide food, shelter, medicines and medical care to people with HIV/AIDS.

Lanka Plus in Sri Lanka is the only organisation surveyed that has reported having among its staff, people living with HIV/AIDS. Not only that, it is also keen to increase its religious response to HIV. The organisation's General Secretary said that many people do not report their HIV status for fear of stigma and ostracism, which could be worse than death. "AIDS does not kill someone instantly, but stigma does," he said. Since tested HIV positive, he has been abandoned by his wife, forbidden to see his child, with his social contacts limited to a handful of family members and friends.

FBOs active in community services without HIV/AIDS interventions

A number of FBOs currently support health or religious education, drug abuse and rehabilitation, and welfare services without a component on HIV/AIDS. But their engagement in community support holds promises for future activities on HIV/AIDS. The Mithuru Mithuro in Sri Lanka, which operates a drug prevention and rehabilitation centre, is a good example. Although it has not yet introduced HIV issues, its sensitive, culturally-appropriate and spiritually-inspired approach to health promotion and self-respect among drug users is a natural entry point.

In India, the Hindu Vivekananda Sewa Sansthan serves huge numbers of people all over the country with a focus on education of women and children. It operates schools that include

vocational guidance classes for girls and young women, basic health and nursing, meditation, yoga and traditional medicines. The Sansthan also runs schools for tribal children in rural Rajasthan, along the tribal belt of Madhya Pradesh. Several other Hindu faith-based organizations interviewed, including the Chinmaya Mission, the Hari Har Schools, Bal Vihars and Chinmaya Yuva Kendra, support educational and charitable programmes in many Indian states, targeting students and young people, and in most cases, the poor. They represent a group with considerable reach and contribution that have remained untapped for HIV/AIDS prevention and care.

In Afghanistan, FBOs are virtually non-existent after twenty years of civil war and social unrest. The Ministry of Health has conducted HIV/AIDS training for a number of Imams, and religious leaders interviewed have expressed readiness to promote HIV/AIDS prevention education if trained. The country has reported 7 HIV positive cases so far, and identified blood safety as well as drug use as key issues to tackle for HIV prevention.

Perception of HIV/AIDS

Responses from all countries were overwhelmingly consistent. This section reviews the constraints and opportunities for enhancing FBOs' response to the epidemic in the light of their attitude and perception toward HIV/AIDS.

Constraints in promoting HIV/AIDS prevention, care and support

a. Misconceptions about the nature and causes of HIV/AIDS

Although the level of understanding about the nature and causes of HIV/AIDS varied, respondents indicated a need for better and more accurate information. Most of them referred to the media—newspapers, TV, magazines, journals, radio—as their main source of information. One religious leader in Pakistan, who understood the medical causes of HIV/AIDS, stated his source as a meeting he attended in 1997 between doctors and Ulema, the head of religious institutions.

Addressing its nature and symptoms, respondents identified AIDS as a dangerous and incurable disease that destroyed one's immune system. A few mentioned blood but were unsure of the connection. Some were unaware of the symptoms and others said that "the infected person goes from weak to weaker." One respondent cited "mental stress and restlessness, perhaps caused by having sexual intercourse at times forbidden by Shariah." A respondent from Pakistan pointed out that religious leaders in urban areas and those better educated were more knowledgeable about the pathological and scientific aspects of AIDS.

Community members in Nepal who formed part of the focus group discussions perceived HIV/AIDS as "a dangerous disease", transmitted through sexual contacts and drug use; it was "also a disease of young people and men, because they were mostly drug users."

When asked about the epidemic's potential, many respondents believed HIV/AIDS to be rare in their country, suggesting that the disease was more of a European and African issue, not theirs. Some cited the growing expatriate community as an impending threat and urged testing foreigners in order to spare local population the scourge of AIDS.

Other than the common mode of transmission, respondents pointed out the lack of health facilities, unhygienic conditions in barbershops and unsterile syringes carrying contaminated

blood, as factors that increased transmission risk. Respondents from Afghanistan believed that AIDS could be transmitted by "touching a breast, tattooing, pregnant mother to child (without first being infected), sex with animals, sharing clothes, having telephone conversation, and sharing toothbrushes, syringes, needles and food with an infected person." In Pakistan, the epidemic was compared to Hepatitis B and C, currently a growing health threat.

b. HIV/AIDS as a consequence of sin

The majority of faith-affiliated respondents in all eight countries also attributed the cause of AIDS to moral decline and sexual corruption. Direct expressions varied from "divine punishment" to "karmic retribution" for "disobedience" or "indulging in sinful," "unnatural" or "evil" acts. And one Protestant leader in Bangladesh noted that "Christianity considers HIV/AIDS to be God's condemnation of homosexuality. "

Respondents in all religions in all countries were unwavering in their beliefs that sex within marriage was the only acceptable and moral behaviour. Premarital sex "promotes perversion and destroys the institution of marriage," according to some. Buddhist girls said that a girl who committed sexual act before marriage would be labeled a "broken container;" People would hate and ostracize her. One Hindu leader stressed "one-woman celibacy;" In Islam, any sexual partnership outside of marriage was considered "zina" or illicit, and was often met with severe punishment, in particular, for women.

One assessment noted in its conclusions that strict tenets around sexual behaviours, promiscuity and relationships, which were immediately associated with HIV, prevented people from sharing their concerns, especially their HIV status. "This further leads to a sense of shame and fear amongst individuals, who might be in need of the support of faith, its leaders and its congregations."

Women and girls: While many religions honoured women, religious interpretations and practices often rooted in steep traditional biases could do just the opposite. Sex workers were labeled by some respondents as people who "plant the germ of infection" in their male clients and married women were often blamed not only for their own infections, but for those of their husbands. Solutions mentioned in the interviews ranged from stoning of adulterous women, to increasing early marriages for girls, and the "imperative of keeping women inside the safety and confines of their homes."

The prevailing views, which largely associated HIV/AIDS with "immoral acts", did not take into account the increased occurrence of HIV cases among women in monogamous relationship and newborn. And many of these new cases were among the "poor and sick" that nearly all of the FBOs had been serving, and it would be an area for further education, in particular, among religious leaders.

Young people: Conservative cultural values, rather than religions, could also prevent young people from getting the accurate and supportive information they needed. One study noted the socially-constructed expectation that "young people will neither engage in nor discuss sex outside of marriage." In Sri Lanka, senior religious leaders expressed reluctance to introduce the subject of HIV/AIDS to children or youth, resulting in the shift in focus toward active adult population, leaving children and young people largely out of their agenda. Despite its strong youth programme, the Family Planning Association of Bangladesh had not yet introduced open discussion among young people or targeting its Imam training curriculum on youth.

Condom use: The issue of condoms was raised frequently. Overall, religious leaders expressed reluctance to promote condoms as part of preventive education because it would "promote sexual liberty." Most regarded condoms as suited only to couples within marriage.

c. Stigma and discrimination against people living with HIV/AIDS

Ignoring or even perpetuating stigma and discrimination was another constraint that came up in the assessments. Strong social sanction often resulted in ostracism of people living with HIV/AIDS. They were barred from families, communities and denied opportunities for livelihood, if not confined to jail. Medical service providers might refuse to treat those who were HIV positive, including mothers. According to a faith-based organisation representative from India, stigma and discrimination also affected the sisters, doctors and volunteers who were serving people living with HIV/AIDS, as they were often viewed with doubt and suspicion.

Endorsing the Statement by Faith-Based Organizations, facilitated by the World Council of Churches at the 2001 UN Special General Assembly on HIV/AIDS, spokespeople from Islamic and Lutheran churches acknowledged that faith-based organisations "have not always responded appropriately to the challenges posed by HIV/AIDS. We deeply regret instances where FBOs have contributed to stigma, fear and misinformation," they said.

Several respondents acknowledged their own negative distinctions between people living with HIV/AIDS and those with other illnesses. One Islamic leader, for example, said that a person infected by a dangerous disease is taken care of by society. However, he added, "if a person has a history of bad behaviour, especially sexual behaviour, and contracts HIV, then nothing is done for that person." In Bangladesh, the assessment indicated that many people perceive those living with HIV/AIDS as "sinners," and persons of "immoral character".

Other constraints: Funding, networking, partnering and building trust with the non-faith-based world

Faith-based organisation representatives in some countries, already working in HIV/AIDS cited other related constraints that limited their effectiveness.

While faith-based voluntary commitment was seen as a strength that provided continuity, stability and low-cost results, the downside was also noted. Commitment to faith could also produce a mindset that "shies away from seeking funds," according to respondents from India and elsewhere. In this context, respondents also noted a tendency for conducting ad hoc activities without sufficient planning.

Depletion of donor's support, on the other hand, could also affect the continuity of good initiatives. The Sarvodaya Movement of Sri Lanka, for instance, had trained 1,500 monks to integrate relevant HIV messages in routine sermons after conducting an assessment of Buddhist scriptures on sexuality and sexual health. Following a spurt of activity in 1995 – 96, the Movement had dwindled primarily due to the lack of funding and diversion to other important priorities.

A faith-based organization suggested that raising funds would require networking outside their own groups, making their work visible and running a professional service based on certain measurable outcomes. Such an approach was debated among those who feared a loss of faith and service in becoming more "professional" and those who sought the widest possible reach without seeing a conflict between faith and professionalism.

A related constraint and debate revolved around the issue of networking, both within the religious community and with non-faith-based NGOs and others. Some respondents mentioned a lack of community outreach programmes and insufficient coordination with community-based activities conducted by other agencies. This limited the exchange of expertise and skills, they said, and also narrowed the scale and quality of work undertaken by faith-based organisations.

Respondents also pointed to the continued mistrust between religious and non-faith-based communities. On the one hand, according to one interviewee, faith-based organisations are deemed unable to "drop the garb of pushing a religious agenda." On the other hand, religious leaders said that many NGOs and development agencies spoke only of condoms and did not respect the spiritual values that religions offered.

Opportunities, lessons and way forward

Negative perceptions aside, the assessments showed tremendous opportunities to enhance the work of faith-based organisations and further involved religious leaders of all faiths and at all levels. Respondents acknowledged their own power and influence and pointed to scriptures and traditions of service, noting that religious channels and platforms could be used to prevent HIV and to provide care and support to people living with HIV/AIDS.

a. Recognition of FBOs' role and potential for greater response

A number of Muslim respondents said religious leaders were ready to do more to prevent HIV/AIDS from hurting their countries if the government would approach them and provide training. Many held the views that FBOs should not only be more active in raising awareness, such as through the Friday sermons, they should also help reduce stigma and discrimination associated with HIV/AIDS. The assessments showed that Imams that had undergone training or orientation about AIDS looked upon the disease with greater objectivity and sympathy. And a good number of Imams interviewed, including those in Afghanistan, expressed the willingness to be trained. It pointed to training as an important intervention needed to broaden religious leaders' role in prevention, care and support. Further, religious leaders who resided in urban areas also tended to be more receptive of HIV/AIDS, and their exposure to information and the media had certainly helped increase acceptance of the disease, although it did not always guarantee accurate knowledge of the technicalities and the epidemic. In addition, official recognition of FBOs' as partners, specifically, giving them a definite role in planning and implementing national AIDS programmes would motivate a greater number to join in the effort.

b. Turning religions' enormous sway into a force that alters the course of HIV/AIDS

The global power and reach of religions is widely recognised; and it is especially true in South Asia. While several countries identify themselves as secular, in all eight countries, government and religions are closely intertwined, if not inseparable.

In Bangladesh, the Ministry of Religious Affairs is responsible for supporting, promoting and maintaining religious activities of Islam, as well as other religions. The Ministry organises major festivals and promotes an Islamic way of living, through the training programmes for heads of mosques and other activities. Although it is not yet engaged directly in HIV/AIDS related activities, it has endorsed the introduction of HIV/AIDS orientation to Imams.

Religious leaders command the respect, obeisance and trust of more than a billion followers in the region. They influence public policy and "mold social, moral and spiritual values." They have the power to promote "knowledge and understanding, help find resources for spiritual and social care," and mobilise action from the grassroots up to the national level. Religious institutions pride themselves on providing religious education to the people to keep them from "walking on the immoral paths."

Located in every corner of their countries, mosques temples and churches possess the human, physical and sometimes financial resources needed to support and implement small and large scale initiatives. They have a special ability to leverage huge volunteer support with minimal effort and in a very cost-effective manner.

c. Religious scriptures promote care and compassion

All religions provide important ethical and moral precepts for living, for "interpreting and coping with life's celebrations and milestones, joyous and sad, from birth to death." And all religions emphasize compassion and mercy to others. Lord Buddha delineates the four Noble Truths of Suffering: "Birth, old age, death and sickness", and encourages the act of giving, offering, benevolence, patience and wisdom, among others, in the eightfold path to Enlightenment. Islam's Holy Prophet says: "Then he is of those who believe and charge one another to show patience, and charge one another to show compassion." [Shakir 90:17]. Seyyed Hossein Nasr, in the "Heart of Islam", says "it is impossible for a Muslim to pray to God or even to think of God without awareness of this essential dimension of Compassion and Mercy," (pages 204 – 207).

Lord Krishna says in Bhagavad Gita: "Do not get angry or harm any living creature, but be compassionate and gentle; show good will to all. Cultivate vigor, patience, will, purity; avoid malice and pride. Then, you will achieve your destiny." The Baha'u'llah says: "Human beings should be freed from all kinds of prejudices," and calls for harmony and universal peace among them. Christianity encourages practice of compassion: "Let us not love with words or tongue, but with actions and in truth [1 John 3:18]."

The teachings of all great religions are consistent with the need for care and support of people with HIV/AIDS. Prejudices and biases are often born of misconception, misunderstanding and superficial judgments that exacerbate mental distress, denial and ostracism of those affected by HIV/AIDS. Further, their conditions of suffering are not at odds with the scriptures' and religions' disposition for benevolence on any living beings. A huge challenge is thus to reorient the thinking of FBOs and religious practitioners towards compassion, care and commitment to the sanctity of life.

d. Religions supports social services —laying the groundwork for HIV prevention and care

The tradition of serving those who are poor, sick and dying has been passed down for ages in all great religions. Mosques, shrines, temples and churches are not only centres of worship, they are "centres of learning," "nuclei of social activities" and "custodians of culture and tradition." In addition to meeting spiritual needs, they undertake many services, including religious education for children and youth, counseling, caring for the poor and the sick, with selfless support for people suffering from a multitude of serious, and even contagious illnesses.

Pundit N. P. Pokhrel noted that the Hindu religion has great compassion for the sick, and it should naturally include those with HIV/AIDS. Lord Krishna says "a sick person should be given treatment and be cured. Those who have no eyesight should be given eyes….." Young Hindu fathers said that the Hindu scriptures explicitly dictate that sufferers should be looked after and supported, including persons with HIV/AIDS.

In India, according to the assessment, the Christian faith, which is a relatively tiny minority constituting about 2.3% of the total population, has made "remarkable contributions" in healthcare, education and social action around HIV/AIDS. Many are working tirelessly in the poorest, most remote and isolated regions of the country to address issues around HIV/AIDS prevention, care and support. FBOs of this faith are in fact going beyond "charity" toward a more developmental approach, "running extensive and thorough programmes" with the view to make an impact.

In Bhutan, religious institutions and communities play a special role during times of illness. Buddhist clergy have always been involved in social welfare activities and civic responsibilities. Their formal participation in health programming began in 1987 with child immunisation, rural sanitation and nutrition programmes and has since extended to family planning, and STD, tobacco, alcohol and substance abuse control programmes. Religious communities have also participated in HIV/AIDS advocacy programmes with support from His Holiness the Je Khempo and other senior lams and Lopens.

In Nepal, many religious institutions have their own schools, hospitals, clinics and orphanages. While some may be reluctant to discuss sexuality issues or to promote condoms, respondents indicated "they can at least be mobilised to provide other services, especially for care and support." The Muslim community, for example, has its own resource base to take care of its members in times of need. The Sakriya Sewa Samaj (United Mission to Nepal) is among the first to provide HIV testing facilities in various part of Nepal where such services are still few and far between.

In Pakistan, involvement of Ulema in social mobilisation of Maternal and Neonatal Tetanus (MNT) and polio eradication (National Immunization Days-NIDs) reflect success stories of religious leadership in heath, education and other development issues.

The assessments also show that the majority of religious leaders and faith-based organisations are increasingly interested in participating in HIV prevention programmes. In one area of Bangladesh, for example, it was religious leaders who first expressed a desire to be included in HIV prevention campaigns. They described their absence as an "unexpected gap" and a programmatic "weakness."

e. Young people need help and support

Adolescents and young people everywhere, especially girls face growing risks and vulnerability to HIV/AIDS. In South Asia, many have already articulated these concerns and engaged themselves in creative, innovative activities that range from running HIV/AIDS prevention clubs to young people's radio programmes. But faith-based organisations interviewed in the country assessments have not demonstrated a clear focus on programmes designed to meet young people's needs. On the other hand, young people interviewed expressed their deep belief in religious values and its role in their lives. They also articulated respect for religious leaders and the desire for guidance.

The views are shared by young representatives at the South Asia Regional Forum for Young People on HIV/AIDS on 15 – 18 December 2002, in Kathmandu, Nepal. In their Declaration, they urged: "Governments to ensure that parents, community and religious leaders are given the proper training in providing sexual reproductive health education, including HIV/AIDS, the use of condoms and protection from drug use, to students before young people are sexually active, and before most of the students drop out of school."

Religious leaders in all countries agreed that they wanted to stem the tide of HIV/AIDS and expressed their own desires for a greater opportunity to work with young people. They noted their complementary role in discussing issues that were often difficult to broach with family members and relatives. They also felt they could play a role in advising younger generations about safe sexual conduct.

In Pakistan, some of the Ulema interviewed spoke of the need to educate the younger generation about HIV/AIDS and reproductive health. They cautioned, however, about the negative effects of HIV/AIDS prevention activities if not handled with great sensitivity and within the social and religious norms of Islam. Addressing the absence of such a curriculum at schools, several teachers suggested that it be reserved for college level classes where students were more mature. Others agreed to the positive effects of such education, arguing that it would save the young generation from sexual diseases. And still others said that this knowledge "was going to reach the younger people anyway, so there was no harm imparting it."

A few respondents pointed out different measures to reduce young people's vulnerability from HIV/ AIDS. These ranged from a concerted awareness-raising drive through the media to spreading information in Friday sermons. They stressed value-based behavioral change and involvement of family, communities and religious leaders. Young people, they said, could be better integrated in religious institutions and given the opportunity to work as HIV/AIDS activists in their communities, especially in exercising peer influence and as peer educators.

Having reviewed the nature of FBOs' involvement in HIV/AIDS prevention, care and support, as well as prevailing perceptions of the disease in South Asia, the next section looks what actions have been taken by religious groups in other parts of the world.

HIV/AIDS RELATED FAITH-BASED ACTIVITIES IN OTHER REGIONS

Collaboration is the heart of the matter

Working together, religious and secular sectors can form a powerful force. While faith-based organisations can offer spiritual power and human resources and a wide reach, secular institutions can buttress the effort with medical and scientific knowledge, technical skills and financial support.

Globally, collaboration among faiths and between the faith-based communities and NGOs, governments, donors, the private sector UN agencies are growing daily. Workshops and seminars for and by leaders of Buddhist, Christian, Hindu, Muslim and other faith groups, have contributed directly to awareness raising and knowledge of HIV/AIDS among different target groups. Increased support from donor governments and agencies has enabled faith groups to follow up and expand their efforts.

This section of the paper offers shared experiences and useful lessons for South Asia from faith-based activities in sub-Saharan Africa, East Asia and Latin America and the Caribbean.

Sub-Saharan Africa

Faith communities have been actively responding to the HIV/AIDS epidemic for nearly two decades. The crisis has spurred a continuous growth in number as small and large organisations work tirelessly in every area of the region and every area of HIV/AIDS. These organizations provide care, support and services, home visits and counseling for people living with HIV/AIDS and their families; they fight stigma and discrimination; provide prevention education to adolescents and young people, as well as working to redress the underlying causes of illiteracy, sexual abuse, child labour, and trafficking of girls and women.

Orphans have long been at the heart of the church's history of service and of the scriptures. Today, as the number of children orphaned by AIDS approaches nearly 3 million and is expected to more than double by the end of the decade, the pressure for care and support is mounting. A recent study surveyed nearly 700 FBOs in six countries, where over 7,800 volunteers supported more than 139,000 orphans, mostly through community-based initiatives that involved spiritual, material and psychosocial support. Nearly two-thirds of those surveyed were established between 1999 and 2002 [15].

Church leaders in Africa are also speaking out and taking new actions. 'AIDS is a disease, not a sin', was declared by Archbishop Bonifatius Haushiki, head of Namibia's Catholic Church. Archbishop Ndungane, head of the Anglican Communion in southern Africa has, along with his bishops, voluntarily tested for HIV. Kevin Dowling, Catholic bishop in South Africa, has said about condom use that: "Simplistic attitudes blind us to the realities of life for millions of poor people. In this terrible pandemic, should we focus all our efforts on proclaiming an ethic of sexuality or also on the ethic of preserving and saving life?"

AIDS education in Uganda that combines science and spirit

In Uganda, the well-known and highly praised Family AIDS Education and Prevention through Imams (FAEPTI) of the Islamic Medical Association of Uganda (IMAU) joined the government's comprehensive and multi-faceted attack on the epidemic. Between 1992 and 1997, IMAU trained and supervised over 8,000 religious leaders and their teams of volunteers who have made repeated home visits to over 100,000 families in 11 districts.

Combining public health messages with Islamic teachings, IMAU's partnership with local imams had contributed to increased understanding of risks associated with Muslim practices of ablution of the dead and the use of unsterile instruments in circumcision. It also resulted in a significant reduction in self 'reported sexual partners and an increase in condom use. Key to IMAU's success was the support and mobilisation of Muslim leaders from imams to county sheikhs, district Kadhis and His Eminence the Mufti, who declared a "Jihad" on AIDS.

The project overcame several challenges common in many parts of the world. This included: breaking the taboo of discussing sexuality once communities understood the risk to their families and communities; sustaining interest of volunteers through income generating activities; involving women in equal numbers on the local teams as project staff came to agree that the women volunteers are most energetic and effective.

The project sensitised Islamic leaders about the role of condoms without compromising spiritual values. Spending one year in dialogue first, Islamic leaders agreed that education on the responsible use of condoms was acceptable, within Islamic teachings and the necessity to defend communities against AIDS.

East Asia

Buddhist Leadership Initiative (BLI) in the Mekong sub-region

In the early 1990s, as people in communities of Northern Thailand began to fall sick and die from AIDS, Buddhist monks responded with a range of care and prevention activities. The most well known of these was the hospice at Wat Phra Baht Nam Phu started in 1992 with the support of the International Network of Engaged Buddhists and AusAID. The 'Northern AIDS Prevention and Care Program' (NAPAC) was among the first non-government organizations to see the potential of monks' involvement at grassroots level and seek to develop this with small grant funding, supporting 10 projects run by or with monks in 1993-4.

In 1997, UNICEF Thailand funded a Chiang Mai-based NGO, Sangha Metta, to train monks in awareness raising, prevention education, participatory social management skills, as well as tolerance, acceptance and spiritual support for people living with HIV/AIDS. Using the Four Noble Truths as the framework (suffering, the cause of suffering, the cessation of suffering and the paths leading to the cessation of suffering, with suffering replaced by HIV/AIDS.) the Sangha Metta has trained over 2,500 monks and nuns. The monks and nuns were then able to apply their new skills to meeting local needs and day-to-day activities of their congregants. They garnered the support of police, health workers, teachers, and other community leaders to establish youth training camps, income generating activities for HIV positive women and other HIV/AIDS related activities. In these areas, stigma and ostracism around HIV are now reported to be rare. People are more willing to disclose their HIV status, as the community is more receptive and less discriminatory of AIDS.

Using Sangha Metta as a technical specialist in training, the UNICEF East Asia and the Pacific Regional Office (EAPRO) introduced the BLI to Yunan Province China (1999), Laos (2000) and Cambodia (2001), working in close cooperation with governments and national Buddhist associations.

The Metta Dhamma Project in Laos has shown what is possible through a team approach, according to a 2003 evaluation of the BLI (UNICEF 2003). Collaborating with the National Buddhist Association, NGOs, government sectors and UNICEF, the Savannaket hospital, for example, established a self-help group for HIV positive people, enabling monks to meet and provide them with counseling and meditation training.

Still, negative attitudes and reservations persist in the wider community towards monks getting involved in HIV activities, which it was said, goes against their "higher order" activities. The monks have answered that they are responsible for the spiritual and emotional wellbeing of all their congregation, not just people who are HIV negative.

In Cambodia, the first country in the region to establish a national policy on religious response to the HIV epidemic, the BLI has achieved some noteworthy successes. These include improvements in the mental health of people living with HIV/AIDS and a reduction in stigma and discrimination.

Overall, the evaluation indicated significant gains in changing attitudes and activities of monks towards people living with HIV/AIDS. A major challenge across the board, however, has been the need to improve life skills for prevention education.

Community members said that prevention teachings were largely moral preaching. In the early stages, the Siiipsong Banna tribes in China's Yunan Province and in parts of Thailand, used fear tactics to influence behaviour, by presenting graphic and gruesome depictions of what AIDS can do to the body. In Cambodia, the evaluation noted that young people, the age group most at risk of HIV infections are not attending temples and therefore not being reached by the monks. The newness of the projects and the scope of training were cited as contributing factors. Monks said that many of the trainings were too short, too crowded and perfunctory. The evaluation also suggested greater emphasis on care and support for people living with HIV/AIDS and their families in the training.

Latin America and the Caribbean

The rapid HIV/AIDS growth rate of 25% in the region is causing grave concern. The powerful political and social influence of the Catholic Church, its pervasive presence and the approximately 88% of Latin Americans who identify themselves as Christians, make religious-based initiatives critical. As more of its members are living with HIV/AIDS, the Church is increasingly challenged and motivated to develop prevention and care strategies and to include people living with HIV/AIDS in the life of their congregations.

Religious based initiatives in Latin America and the Caribbean region are widespread and effective, although most are not well known. They range from small parish programmes to large hospital-based management and care; they include individual acts of service, regional networks and collaboration with multi-lateral international agencies.

The Lutheran Church in Chile, for example, works through a local NGO to provide HIV/AIDS education to some of the poorest communities, creating local neighborhood networks that teach women how to develop HIV/AIDS education and prevention activities.

Sector Religioso Contra el SIDA (SERECSIDA) is a 9 year old Panamanian network of organisations from six Christian denominations. It provides information, coordinates an HIV/AIDS prevention campaign among adolescents and trains religious and lay leaders to provide pastoral counseling to people living with HIV/AIDS and their families.

La Lucila Baptist Church in Buenos Aires, Argentina, has incorporated self-help groups and hospice care for people living with HIV/AIDS into its drug rehabilitation programme. In the Dominican Republic, the nuns of the Religiosas Adoratrices care for women living with HIV/AIDS at the mission and visit others in their homes. Christian health professionals in Cuba have formed a group of volunteers to undertake prevention and care activities for people in their area living with HIV/AIDS.

Although, barriers remain to collaboration between the Church and multilateral, governmental and non-governmental organizations in Latin America, religious-based initiatives can play a key educational role in facilitating further growth and openness. Difficult ethical issues can be resolved sufficiently to allow collaboration and compromise, if addressed with mutual respect.

Lessons from other regions

The brief descriptions of religious activities in sub-Sahara Africa, East Asia and Latin America and the Caribbean provide mere glimpses, and in no way represent the full depth and scope of religious involvement. Even within vastly different contexts, a more complete look would reveal a plethora of common ground with religious communities of South Asia. This includes a similarity of struggle across faiths; a sense of urgency matched by a pace that allows each to find their comfort zone; and respect for diverse solutions and tools to unlock the trap of old ideas that may be preventing rather than actuating the deepest spiritual values. These experiences offered a number of lessons that could be of great value to the religious leaders of South Asia. For example:

- Combining medical information with spiritual values;
- Partnerships among religions and with non faith-based communities;
- Sustaining volunteer commitment through income generating activities;
- Encouraging open dialogue about condoms that result in individual and diverse solutions;
- Support by muftis, bishops and other ‘higher ups’ for community based efforts;
- Training for monks to support greater sensitivity.

Turning challenges into opportunities

The battle against AIDS faces formidable obstacles, not the least of which is societal conservatism about its predominantly sexual-related causes, compounded by inadequate and incorrect information. Religious leaders are not alone in facing barriers to effective action, such as those described earlier. But whether they are internally or externally imposed, if the will is there, so are the means to overcome them. Acknowledging the need for better information and training on which to base decisions and actions is a big step. It may not be farfetched to consider how informed knowledge can support rather than stand in the way of honouring the scriptures in the most caring and compassionate of religious traditions.

THE LEADERSHIP RESPONSE: RELIGIOUS LEADERS AND FAITH-BASED ORGANIZATIONS TAKING ACTIONS IN THE FIGHT AGAINST HIV/AIDS

AIDS is an epidemic that cannot be halted by awaiting all conditions of poverty be lifted. Effective actions to keep the prevalence below 1% in the general population are of great urgency. The longer actions are delayed, the harder it is to halt the escalating pace of HIV transmission.

There is a growing recognition that faith-based communities represent a potentially powerful, but currently under-utilised resource South Asia's response to HIV/AIDS. Faith-based organizations worldwide are, however, becoming increasingly sensitised and committed to expanding their roles and contributions to the fight. Religious leaders are particularly poised to reduce the vulnerability of and impact on children and young people because of their influence in society and more importantly, social, moral and spiritual values.

Some religious leaders and faith-based organisations have already risen to the challenge. In East Asia, for example, the Buddhist Leadership Initiative has mobilised a growing number of monks, nuns and lay teachers in the Mekong sub-region to engage in activities of care and support. The First and Second International Muslim Leadership Consultations (Uganda, 2001 and Malaysia, 2003) explored the application of Islamic principles and teachings in HIV prevention and care and support for people living with HIV/AIDS.

Christian churches worldwide have been deeply engaged in the cause for HIV/AIDS. The World Council of Churches has produced major policy guidance and resources for churches around the world to expand their programmes. The Anglican Communion has made HIV/AIDS a key global priority. The Catholic Church, through its Bishops' Conferences, has engaged the bulk of its widespread health and educational institutions in Latin America, Africa, the Philippines and India in the full range of HIV-related interventions.

This Consultation is a follow-up to the South Asia High Level Conference and to the Second International Muslim Leaders Consultation on HIV/AIDS. Its objectives are to provide a regional platform for regional faith-based leaders to discuss issues related to HIV/AIDS; to share their experiences and enhance their role, responsibility and future actions — particularly in relation to prevention among children and young people; and to mitigate the impact of HIV/AIDS on those infected and affected.

CONCLUSION

The many successful, meaningful initiatives spawned by faith-based organizations around the world, including those in South Asia as synthesized in this paper, offer promises for a new level of battle against HIV/AIDS. It is clear that the intent and tradition of all religions, with compassion as the mainspring for all services to the needy, are wholly consistent with the need for care of people with HIV/AIDS. It is also inherent to their need for support, and courage, to confront daily and devastating violations of their basic human rights brought on by stigma and discrimination. Religious leaders have said that they want to do more. And their contributions are certainly, pressingly needed.

Faith-based activities in the region vary in scope and reach. Misconceptions, lack of information and certain traditional beliefs stand in the way of effective approaches to prevent the most affected groups from receiving support and help: young people and women who make up more than half of the people affected by AIDS and whose number is steadily growing.

Young people have expressed their respect for religious values, the role of religion in their lives and their desire for information and encouragement from their Imams or Priests. The ability to fulfill that wish will be an important step in the joint battle against HIV/AIDS. Creating the space for dialogue, exploring, understanding and respecting the feelings and behaviours of adolescents will bolster, not diminish, the deepest spiritual values and practices.

It should be noted that resistance to change is nothing new or is it confined to South Asia. There is much to learn from other regions experiences that are positive and hopeful. They reflect a long and ongoing journey that demonstrates a change in mindset from one of resistance, denial and isolation, to open debates and acceptance, interdenominational collaboration and partnerships with non-religious communities, in a spirit of mutual learning.

There are also unexpected numbers of religious leaders who have made explicit their aspirations to learn, question, reach out, and respond to those in need, in order to more meaningfully and productively assist the community they serve.

That willingness is now being put to the test.

It encompasses a willingness to address controversial issues through dialogues, to seek and receive scientific information about the medical and social causes of AIDS; to accept as children of true faith people living with HIV/AIDS; and to attack stigma and discrimination. It also entails encouraging those who are HIV positive to come forward, including members of their own religious communities, without fear of revealing their HIV status. This is what encourages monks, prelates and priests to lead the way in Thailand, in Uganda and elsewhere.

Ultimately, the best solutions do not come from outside. They come from the heart, from faith and love for humanity of religious leaders and followers themselves. The battle with AIDS is not a one-sided affair that is confined to the Ministry of Health. The world community cannot end the scourge of AIDS without the help of religious leaders and their access to the billions of faithful who look to them for guidance. Religious communities and religious leaders are in a distinct position to influence behaviour and attitudes. They wield considerable influence on government leaders and national policies, as well as have significant leverage over the population at large in these countries.

Nor can religions hold on to the euphoric belief that this epidemic does not affect them, or their own officials, and that they need not the support of technical and financial expertise, or the knowledge to carry off the fight.

South Asia now has the window of opportunity to halt the growth of HIV infection rate. Although stigma and fear of ostracism, and inadequate disease surveillance continue to hamper data tracking for a representative and accurate account of the number of people infected and affected, the region has taken momentous steps over the past decade. All countries in the region have now established HIV/AIDS policies and programmes, supported by multi-donors initiatives, to contain the epidemic. Prevention, access to services and the creation of an enabling environment are accepted as major strategies for reaching people with high risk behaviour; along with mass media campaigns and outreach to empower the population with knowledge, as well as life skills for young people to make informed choices.

The time is opportune for religious communities to join in the fight. All governments, including religious groups and civil society organizations in South Asia, have pledged for actions in various global and regional forums. They have reaffirmed determination to invest in prevention everywhere, particularly among the young, to care for those whose lives have been devastated by AIDS, and to meet time bound goals and targets.

This Interfaith Consultation aims to accelerate actions, to enhance and bring the strengths of religion, its compassion and tradition of service to the young and old, sick and poor, to the fold of one of humankind's greatest scourges.

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