

HIV in Asia: cultural and theological perspectives

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christian
aid

We believe in life before death

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Preface

Two years ago I wrote a paper entitled *Theology and the HIV/AIDS Epidemic*¹, which aimed to set out a theological framework within which issues surrounding HIV and AIDS could be addressed. I was conscious that its subject-matter had a distinct bias towards the situation in Africa, not least because it was the African churches and church leaders who were clamouring for a theological perspective on the epidemic that was, and is, claiming millions of lives in their region.² And despite the ever-growing practical involvement of the African churches, relatively little work was then being done from a theological viewpoint, although this is fast changing.³

In the last couple of years there has been some slight cause for optimism in sub-Saharan Africa, as the number of people living with HIV has started to fall in countries such as Uganda,⁴ although factors such as the continuing war in northern Uganda suggest that this is a trend that may not continue. The situation in Asia, however, is very different.

Back in 2001 a UNAIDS report stated that 'south and south-east Asia are now an epicentre of the HIV epidemic. Of all the countries in this region, India is estimated to have the largest burden, with about 3.7 million infections.'⁵ Within a couple of years this figure had risen to an estimated 5.1 million.⁶ Yet because this still represents only a small proportion of the Indian population (which the 2001 census put at 1.029 billion and is now reckoned to be around 1.08 billion) it is widely denied there that HIV is a problem. Indeed, in contrast to sub-Saharan Africa, where the sheer number of people affected eventually forced national and religious leaders to acknowledge the existence of HIV and to demand action, across Asia, with the likely exception of Thailand, denial among faith leaders seems to be the norm rather than the exception.

There are of course further contrasts to be noted with respect to both the cultures and the religions of the two continents, and these have a major bearing on people's attitudes to those living with HIV. As far as Christian theology is concerned, it is essential to recognise the uniquely Asian perspectives that have been developed, and to acknowledge their importance in faith-based discussions of HIV.

This report will follow a similar structure to that used in 2004, but with some significant differences. The theological section has to take account both of Asian Christian thinking and of the presence of other major religions – Hinduism, Buddhism and Islam – in varying proportions across the region. It has also to recognise the cultural differences between countries within the region, and variations in the ways in which HIV is transmitted. The places referred to in detail are India, Bangladesh, Burma, Cambodia and Hong Kong.

I am most grateful to faith leaders and to Christian Aid's partners in these countries for generously giving their time to help me grapple with these questions. I would also like to thank staff of Christian Aid's Delhi office for facilitating travel and meetings, and staff of local and international NGOs who willingly shared their knowledge and expertise. Any errors of fact or interpretation are of course my own.

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HIV and Christian theology in an Asian context

Covenantal theology

The theological model set out in *Theology and the HIV/AIDS Epidemic* was taken from Karl Barth's work on creation and covenant.⁷ It highlighted the special covenant relationship established between God and humankind, not from the time of Noah but from the moment of creation, and the 'new covenant' represented in the coming of Jesus and his identification with the suffering of human beings. This relationship between God and humankind is in turn a pattern for relationships between human beings, with all the love and acceptance that this implies. The paper also drew on the work of Jürgen Moltmann, who followed Barth in emphasising covenantal relationships in order to encompass his treatment of suffering: where physical pain coupled with human rejection finds its supreme expression in the 'crucified God'.

Two aspects of Barth's model are particularly helpful in the discussion of HIV and AIDS. The first is the timelessness that it implies. By extending the notion of covenant back before the formal covenant events recounted in the Old Testament to creation itself, Barth no longer restricts it to the people of Israel but gives it a new universality. Among other things, this means that the feelings of chaos engendered by the HIV epidemic may be seen in proper perspective. God's eternal involvement in, and commitment to, his world and all his people enables us to look beyond the apparent breakdown of social structures, and reveals a timeless model for our relationships with one another, which necessarily includes people living with HIV.

A second element in this approach which holds a particular appeal for people living with HIV is the New Testament oneness with God and with his Son that is first stated in the Gospel of John (14.6-20). The metaphor created by Paul (1 Corinthians 12) of the church as Christ's body develops this idea and has been taken up by many churches in Africa in the slogan 'The Body of Christ has AIDS', acknowledging the fact of HIV and offering unqualified acceptance of those affected and infected by it.

However, any model of Christian theology reflects to a greater or lesser extent the culture from which it emerges. In the case of Moltmann, the human misery he encountered as a prisoner of war in the 1940s greatly influenced his formulation of suffering. And while in any religion there are some elements of belief that are non-negotiable and cannot be varied (the doctrine of the incarnation in Christianity would be an example), the way they are expressed owes much to the culture in which they are understood.

So the question arises, what new insights into Christian

faith and HIV are to be found in Asian theological thinking? And, if the covenantal model still proves to be appropriate to the Asian context, how might it be modified to accommodate those insights?

Local theology

Until quite recently, Asian Christian theology has followed a western model, almost without question. According to one author,⁸ this began to change with the emergence of liberation theology in Latin America in the late 1960s. Kavunkal comments:

Latin American writings found resonance among Asian theologians. They began to listen to the groans and cries of the dispossessed tribals, of the caste-ridden poor subject to marginalisation and untouchability, of the women discriminated against, of the children who have to pass their childhood working hard ... of the 'no-people' of Asia.

As has happened in all countries where liberation theology has had an impact, its influence has been most widely felt in approaches to the biblical texts, whether this is at the level of the study of hermeneutics in theological colleges, or in Bible studies run by local Christian groups. So the context of the poor and marginalised is used as a source of interpreting biblical truths. As Kavunkal puts it:

Asian theologians became convinced that the Word of God is to be read in the context of their history – with its gaping wounds of untimely death caused by hunger, malnutrition, violence, lack of health care and so on. As opposed to the economic and political oppression from which the Latin American church seeks liberation, Asian theology has the added burden of ushering in liberation from the vice of caste distinction.

All of which is directly relevant to a theological approach to HIV and AIDS in an Asian context, where discrimination based on caste is frequently reinforced by people's vulnerability to HIV.

Feminist theology and eco-feminism in Asia

It's important in Asia to convince churches that we're starting with the Bible. This means deconstructing traditional theology because some biblical teaching emphasises exclusion. So we teach that Christ dismantled

all that, eliminating discrimination and establishing a theology of the body of Christ.

*Dr Hope Antone, Christian Conference of Asia*⁹

A theology of the body of Christ with the inclusiveness that this implies is very much in line both with the covenantal model already outlined and with liberation theology. However, in an Asian context it is important to take account of the extent of the discrimination that needs to be countered. Discrimination against women seems to be a cultural given in most countries, and it goes largely unchallenged by the major religions. A Brahmavihara Buddhist in Cambodia, Beth Goldring, put it in the strongest possible terms when she spoke of 'the systemic degradation of women in Hinduism and Buddhism', concluding that 'Buddhism does nothing to prevent it'.

In Madurai, in southern India, a Christian theologian, the Revd Margaret Kalai Selvi, commented: 'The situation in India is contradictory: there are female goddesses attributed with great power and yet women are powerless. Even medical treatment is more accessible to men than women'.

It is hardly surprising, then, that recent Christian theological approaches to HIV in Asia should include a strong feminist element, focusing on the discrimination experienced by women in general as well as those who are HIV-positive.

Feminism in Asia

Some people are allergic to the word feminism because they think it's a western import. But it articulates for us something that has been missing in Asia, where women have been treated inhumanely. Although we've borrowed the word, in fact the spirit, the desire for equality, has always been around. We're currently trying to retrieve things in history that point even to men critiquing the teaching that puts women down, such as

the eleventh-century Confucian scholars. So the word may sound foreign but the spirit isn't. People are just using its foreignness as an excuse.

Feminism tries to break down all forms of discrimination. In practice, people who go in for feminist thinking are also willing to be proactive on HIV. They're ready to help, to go further, and they can empathise more with people who are affected.

Dr Hope Antone

Asian feminist theology has much in common with that formulated in other parts of the world, but it has its own

distinctive characteristics as well. Lilith M. Usog sums it up like this:

While Western feminist theologies speak from within a context in which Christianity is the dominant tradition, everywhere in Asia, except the Philippines and South Korea, Christians are but a tiny minority. Earlier feminist theologies had a tendency to universalize Western women's experiences as if they represented the lives of all women... Christian feminists in Asia realize that they cannot be gentle, passive and exotic females as portrayed in the global media; and neither can they be targets of Christian mission. They must claim back the authority to be theological subjects, reflecting God's liberating activities in Asia and articulating their own theology.¹⁰

This approach is fully compatible with a theology based on covenantal relations. But it does also highlight the particular challenges to these relations that exist within the Asian context. The institutionalised inequality of gender relationships in Asia is such that any change is likely to entail a radical cultural upset; and if that upset is perceived, however falsely, as being driven by 'foreign', especially American, thinking, then it is likely to be firmly resisted. Yet, as the African situation has shown, if HIV is not to spiral out of control, women must be empowered to resist infection as a matter of urgency. Hope Antone has commented that a lack of attention to educating girls means that 'many Asian women and girls have a taste of death even before death'.¹¹ When HIV is added into the equation of discrimination, her metaphor becomes even more deadly.

The guiding principle of feminist theology is the promotion of the full humanity of women.¹² In Asia this may now be set within a wider context of ecology, or eco-feminism. According to the Christian Conference of Asia (CCA), ecology does not just mean the environment: it has to do with all relationships between human beings and between human beings and nature. CCA's Executive Secretary for Justice and Development, Dr Lee Hong Jung, insists that ecology includes HIV and climate change, and health and development matters. A crucial concept is interdependency and his vision is of an 'ecologically conscious' human society: 'In theological terms this means wholeness: the fullness of life for all – shalom. There's an interconnectedness within creation'. Thus covenantal relations are extended to encompass human

beings, the natural world and God, and every aspect of their interrelationship. The HIV epidemic is well accommodated within this wider framework, as is that other immense challenge to global development and human survival, climate change.

Eco-feminism is an offshoot of such thinking, and is seen as an alternative to capitalist and socialist development:

As a convergence of environmental, feminist and spiritual concerns, eco-feminism bases itself on the new view of women and nature whereby 'it recognises the value of the feminine principle, that is, caring, nurturing and sustaining', thus making women the natural saviours of the environment. Women are seen as being closer to nature than men and hence are better in analysing and finding solutions to the environmental crisis.¹³

This too may be seen as a form of empowerment of women, further strengthening the extended covenantal relations that are characteristic of Asian feminist theologians and reminiscent of the thinking of some Latin American theologians.

The multi-faith context

In most Asian countries the dominance of one of the other world religions is likely to have some effect on the way in which Christian theology is formulated. In Kavunkal's words, 'In Asia theologians reflect to further the humanisation of the society, most of which finds God outside the Christian revelation'. And the nature of the relationship between faiths, whether cordial or hostile, may also be a factor to take into account in assessing the effectiveness of approaches to HIV.

Feminist theologians are adamant that the presence of several religions should inform women's struggle against discrimination: 'the situation of women in Asia, which is often reinscribed by cultures and religions, demands the crossing of religious boundaries'.¹⁴

Feminism in a multi-faith context

Because Christians make up less than three per cent of the Asian population, religious pluralism is another challenge for Asian feminist

theologies. Many Asian women theologians have found that Asian religious traditions are less institutionalized than Christianity in the West, and the boundaries between

different religions are more fluid. In their struggle for survival, poor and oppressed Asian women often transgress religious boundaries and assimilate many elements from different traditions. Living in a multireligious world, Asian women theologians have argued that they embody diverse traditions of shamanism, Buddhism, Hinduism, Confucianism, and Christianity

simultaneously. With multiple identities and heritages, they challenge us to move beyond doctrinal purity and artificial segregation of spiritual traditions of humankind. They insist that we must move beyond interreligious dialogue to religious solidarity, working for justice across religious traditions.

*Kwok Pui-lan
Asian Feminist Theologies¹⁵*

While the idea of losing doctrinal purity may be anathema to many Christian theologians in the West, in Asia there are hard choices to be made. The Principal of the Madurai Theological Seminary, The Revd Dr Mohan Larbeer, has suggested that a trinitarian model of relationships does not work in the South and he prefers a weaker model that relates to the person of Jesus alone:

[The model of the Trinity] is not acceptable in India because the Brahmin tradition has three gods doing three different things: creation, preservation and destruction. So the Trinity is a difficult concept for people who believe in other gods. But they can understand Jesus and his sacrifice.

Although others may wish to argue that it is the job of Christian theologians to articulate Christian theological principles uncontaminated by other philosophies, the contextual relevance of Dr Larbeer's statement is undeniable.¹⁶ Yet while the thinking of Barth, and particularly Moltmann, is trinitarian in essence, this is not an indispensable component of the covenantal relationships under discussion. To leave the third person of the Trinity out of account in dealing with relationships between human beings is not to deny his existence. And it is in the nature of interfaith dialogue to downplay issues that divide and concentrate instead on those that unite. In the words of a Burmese theologian:

In dialogue, there may possibly exist obstacles or differences that normally disturb the partners'

communication or relationship and yet there must be an 'interactive meaning' beyond those obstacles. The interfaith dialogue is not merely an outer communication between the two persons but the inner communication with what they believe in God or in the Mystery and the sharing of such inner convictions with one another at the deepest level. In fact, in any philosophy of dialogue, there is no imposition of one's own truth and view on the other. This is the miracle of dialogue.¹⁷

Thus, while inner convictions and doctrines of different religions remain unchallenged at a deep level, at the surface level of contextual theology in Asia, the interaction between them needs to be acknowledged if there is to be a genuine attempt to recognise the influence and input of those religions in the issue of HIV.

Suffering

We need to shift the thinking that someone hasn't behaved well

Lian Za Pao, Karuna Myanmar Social Services

(an agency of the Catholic Bishops' Conference, Yangon)

Across Asia there is a strong tendency to regard HIV as a moral question. Mr Lian, quoted above, maintained that the Catholic Church would not take the line that HIV infection is a punishment for immoral behaviour, but admitted that individual preachers might. It is well known that such attitudes are directly responsible for stigmatising people who are positive. But in Asia the suffering caused by this stigmatisation is increased, perhaps not deliberately but nonetheless inevitably, by cultural reticence.

Although reticence is not the same as denial, it has much the same effect, as we shall see in chapter 2. It is not in the psyche of many Asians to speak openly about sex, even between husband and wife, so, for example, the spread of knowledge about how HIV is transmitted is severely hampered.

Sadly reticence also frequently prevails when it comes to addressing the mental and physical suffering of people living with HIV. In the words of the Revd Peter Joseph of the Myanmar Council of Churches, 'It's very easy to say "God loves you" but very hard to say face to face "I love you". People lack the courage.'

'Love through the small things'

Paola, an Italian nurse, spent nearly four years working on the Maryknoll Fathers' 'Little Sprouts' programme in Phnom Penh which gives a home to children orphaned by HIV. Typically the youngest are HIV-positive.

'When the children arrive they look lost and hopeless. Often they don't even cry. They need good food, medicines, good hygiene and

especially love. They must have all these things. And without love it's no use. We give the children 100 per cent love through the small things. So you use every situation to confirm the love you have for the child. Many of the children have been sexually abused and no longer trust adults. Here they start to understand that this bad situation is over and they build up their self-esteem. We believe what they tell us and we respect them.'

This approach of compassion and love would be echoed in other religions. The unnamed authors of a booklet published by Positive Muslims comment:

Many of us view HIV and AIDS in purely personal morality terms as caused entirely by haram (prohibited) sexual activity. Other factors such as drug abuse, alcoholism, domestic violence, rape and the lack of bodily integrity of women (the fact that many married women have no choice in sexual relations with their husbands) are completely ignored. Furthermore, the role of poverty in the spread of the disease is overlooked as if Islam is only a set of rules about sex and is silent about human dignity and the social structures that work against it.¹⁸

Yet, the authors argue, this is not the true message of a faith that asserts the unconditional love of Allah and which Muslims are called to embody. A hadith qudsi that bears an unmistakable resemblance to Matthew 25:36ff¹⁹ states:

On the Day of Judgment Allah will ask: 'My servant, why have you not visited Me?' The person would reply: 'How could I visit You while you are the Lord of all humankind?' Allah will say: 'Did you not know that so-and-so was ill? And if you were to visit him you would have found Me there.'

Similarly, for many Buddhists, suffering and a compassionate response to suffering, is at the heart of their faith. Beth Goldring, already quoted, states: 'The Buddha reaches suffering and the way out of suffering... The reason the Buddha began to teach was because of human suffering, so people's pain puts them right in the middle of their faith.'

The members of staff of 'Little Folks', another project run by the Maryknoll Fathers in Phnom Penh for children affected by HIV, include both Christians (Catholic and Protestant) and Buddhists. Their response to the question, 'Where is God in this suffering?', reveals their common ground of faith:

Mrs Ngoun Phalla (a Christian who, with her husband, fosters five children aged between three and twelve, in addition to her own four children): 'When I go out and see people who are sick, I remember Jesus said that when you visit them you visit me. We believe that when we suffer it's in some way a contamination of the suffering of Jesus.'

Eng Kimly (a Buddhist who is a foster parent to six children in addition to his own two): 'We show love to each other through poverty and suffering. We understand the meaning of love when we have to suffer together. Loving one another in our suffering brings us closer together. I understand poverty but now I also see sickness and that inspires me to do more. The Buddha said, "If you want to serve me when I'm sick, serve your brothers when they are sick!"'

Such examples of people working together across religious boundaries and out of a similar conviction as to the nature of suffering and our human response to it, are sadly not common. In practice, across Asia, the major religions seem to be more comfortable working on their own and emphasising HIV prevention rather than caring for those affected, a situation which will need to change if the prevalence rate in the region continues to increase. The teaching of the Buddha includes the 'Five Precepts' of civic law: the third is to avoid sexual misconduct and the fifth is to refrain from intoxicants. Instructing young people on these issues is typically seen as the preferred response to HIV – with the virtually inevitable consequence that those who do become infected will suffer stigmatisation. Yet compassion is a religious duty, since a Buddhist is charged with behaving as a good person in his or her community.

Whether the notion of 'religious duty' is an adequate response to the diverse forms of suffering associated with HIV is debatable. However, some of the practical manifestations of this duty do seem to be more imbued with love and compassion than the term would normally suggest, and in Christian terms are a good example of covenantal relationships in action. How effective this is in combating the discrimination and stigma surrounding HIV in Asia is discussed in the next chapter.

Cultural injustice and the role of religious leaders: denial, discrimination and stigmatisation

The disease is mainly spread through immoral activities. It's the responsibility of church leaders to lead people to live a moral life, so they should teach people to be concerned about these diseases.

The Revd Romeo Chambugong, parish priest of Edilpur, Bangladesh.

HIV is not a curse by God but it comes because we're not following the principles laid down by God, by indulging in unnatural relationships.

Moulana Gulam Nabi Shah, an imam and writer of Islamic tracts, Hyderabad.

The attitudes of some religious leaders, such as those quoted above, are a serious obstacle to recognising the threat of HIV in many Asian countries. The experience of Africa, where rapidly rising prevalence rates forced the Christian churches to acknowledge that they had been wrong to emphasise immorality at the expense of compassion, seems unlikely to be widely repeated in Asia in the foreseeable future. Indeed, such a question tends to force these guardians of morality into ever greater stigmatisation, and 'we're not like those Africans' is a not uncommon reaction. In Asia it is difficult to dissociate denial that there is a problem from an inbuilt unwillingness to talk about its causes. And it is hard to disentangle discrimination against people who are HIV-positive from caste discrimination in India and, more generally, gender inequality. Denial and discrimination are widespread across the region, and have a variety of effects, all of which are contrary to the ideals expressed in Christian theology and in the other faiths as well.

Denial

The simplest form of denial is to point to local prevalence figures and to claim that HIV is insignificant – while other diseases are in much more urgent need of treatment, and therefore funding. In Bangladesh, a Muslim country, where the HIV rate is around 0.6 per cent, this type of denial is reinforced by the conviction that Muslims do not indulge in the 'immoral' activities that cause the virus to spread. The danger of relying on prevalence rates is illustrated by the case of India, where a rate of less than one per cent still translates into a huge number of infected people.

Yet many social problems that people mention as being more important still have some connection with HIV. Poverty

is an obvious example, although in countries where only the rich can afford hospital treatment, medical staff will deny that there is any link with poverty, simply because their only experience is of treating middle-class patients. In India, though, unemployment and migration are acute problems, and both have proven links to HIV infection.

'A small window of opportunity'

The global fight against HIV/AIDS is about 25 years old and it has taken all these years to learn one single lesson – that the response to AIDS requires a sustained, conscious, committed and above all society-wide effort in every part of the globe. Today [2004] India is

estimated to have 4.6 million people living with HIV/AIDS which suggests a death rate significantly higher than that due to malaria and TB combined... All are uniformly unequivocal on the fact that India has a very small window of opportunity to prevent the epidemic from taking the form it has in sub-Saharan Africa.²⁰

Despite stark warnings like this, denial and silence predominate, although in major cities and areas with higher HIV-prevalence rates, awareness at least is higher.

A second form of denial springs from the immorality message that is propagated by many Christian and Muslim leaders and echoed in Hindu circles. This style of preaching enables people to dismiss HIV as something that 'doesn't affect people like us', but that is confined to 'foreigners' or sex workers, men who have sex with men, and so on. Apart from contributing to the stigmatisation of vulnerable groups, this attitude is dangerous because it can imply that most people don't need to know about HIV prevention. Alternatively, some religious leaders use HIV as a threat: 'if you do bad things this bad thing will happen to you', but the result is much the same – a refusal to accept that HIV exists among their congregations, whatever their religion. From a theological point of view such attitudes point to a theology based not on love (God's love for us, our love for our neighbour) but on fear (fear of imminent death which carries overtones of divine punishment).

Instilling fear can have a devastating effect, as Tun Tun Aye, lecturer in pastoral care and counselling in Yangon, explains:

Two or three years ago the Burmese government put out posters saying there was no cure for HIV. This made people feel depressed and suicidal. The Burmese people

find it very hard to share their feelings and they are afraid of people knowing their status. Because they used to live in extended families it's important to them that their relatives accept them.

There are many stories in Burma of families rejecting someone with HIV, including giving the patient food at the end of a long bamboo cane. This rejection in turn becomes a source of fear.

The Revd Romeo Chambugong, quoted above, was adamant that immorality was the problem and attending church was the solution. He added that in his view the church should not reject anyone infected with HIV, but only on condition that they 'repented' first.

Another form of denial is the cultural reticence already discussed and which in some countries is found across all social groups. In Bangladesh, there is little openness to discussing sexuality and women feel particularly uncomfortable doing so. It seems that only male health professionals are perceived as having the authority to talk about sex. Even where people had undergone training in HIV awareness-raising, and were therefore very knowledgeable about the causes of HIV infection, remained constrained by their cultural habits when it came to passing that knowledge on. A group of women in Hyderabad who had received HIV prevention training from the Confederation of Voluntary Associations (COVA), said: 'We talk to our children *indirectly* by giving examples of what has happened to other people. We don't like to talk directly. When we talk to young married couples we ask for blessings upon them. And we suggest in a secret manner, to each one separately, that they should trust each other and be faithful.' They would not even contemplate a situation of talking about sex to an unmarried girl because 'keeping a boyfriend' is prohibited by their (Muslim) religion.

It is of course possible that such 'indirect' reference is recognised for what it is – a euphemistic way of referring to a taboo subject – and that the advice offered is heeded. But the danger is that keeping to cultural norms of discourse fails to challenge the culture itself. And one very risky aspect of that culture is that men commonly use sex workers for unprotected sex even though this is unacceptable to all the religions as well as socially unacknowledged.

The medical profession itself is not unaffected by these attitudes. Doctors will often allow fear to overcome medical knowledge and try to avoid treating patients with HIV. In India

doctors are not penalised if they refuse to treat people.

If denial in Asia seems closely bound up with sexual taboos, this fails to account for the spread of HIV through injecting drug use – something which is much more widespread in this region than elsewhere. Indeed, religious leaders tend not to acknowledge this in their pronouncements on HIV. This was typified in a statement by the imam Moulana Gulam Nabi Shah:

Disaster always follows if people do not follow the limits laid down by God. This is exemplified by Noah and also by the Arabic prophet Luth [3,500 years ago] whose kingdom was overturned when homosexuality and sodomy were practised. The AIDS disaster is due to promiscuity and unnatural relationships. The patient suffers terribly before death. The remedy is to get back to Islamic teaching on human relationships – this is the only way.

Yet it is thought that injecting drug usage accounts for up to ten per cent of HIV infections in India. A typical scenario, outlined by the Revd Dr Ban Makan, Executive Director of the Christian AIDS/HIV National Alliance (CANANA) in Delhi and a Baptist pastor, is that drug addicts are mostly men who bring the infection home to their wives. Moreover, if a man spends the family income on drugs, it then falls to the wife to earn a living, and sex work may be her only option.

In India, the north-eastern hill states are the worst affected by injecting drug usage and HIV. The infamous triangle is only 300km away from the state of Manipur and the border with Burma is long and porous. Drugs which previously went to Bangkok are being trafficked through to the main cities of north-east India. Dr Langkham of the Emmanuel Hospital Association (EHA) in Delhi, who comes from that area, estimates that in some areas every third home houses a drug addict. In 1990, 55 per cent of injecting drug users were HIV-positive and the figure now may be as high as 80 per cent.

Within that region the area worst affected is predominantly Christian. Dr Langkham's view is that spreading the message about HIV, whether in regard to drugs or sex, is only difficult within the church. But, he says, 'talking about it is one thing, providing the services, such as needles or condoms, is another'. He and his colleagues set up needle exchanges some years ago (a programme later taken up country-wide by the national government) and have initiated detox programmes. But, at 80 to 90 per cent, the relapse rate

is high and the rate is highest among Christians. His tentative explanation for that is that the church may be over-spiritualising the issue: 'the body can't follow what the spirit is saying'. This seems to imply that there is a need for religious leaders to recognise the reality of people's everyday lives and to adjust their preaching and teaching accordingly. The African churches have already been through this process, once they recognised that their clergy and congregations are themselves living with HIV.

Different countries in Asia reveal different forms of vulnerability to HIV. In contrast to India, Burma is one of the main producers of drugs (with poppies grown in the triangle along the border) and is also on the trafficking route, so dealing is an easy way to earn money. In Mytikina injecting drug usage has declined, as heroin has given way to the use of amphetamine tablets. This has reduced the likelihood of HIV transmission through shared needles, but there is a continuing risk of drug-induced behaviour change, in particular unsafe sex. All of which suggests that in Asia addicts are a growing vulnerable group, irrespective of the form of addiction involved. And by and large religious leaders have failed to reach out to this group in a way that both recognises their vulnerability to HIV and demonstrates compassion without apportioning blame.

Denial, then, is more complex in Asian countries than in African ones, because of their cultural tradition and because of the greater range of vulnerable people involved, which will be discussed further below. These factors can lead to what looks like double standards, although not necessarily in the sense of deliberate duplicity. For example, in Dhaka, a young man, Ali (not his real name), is a peer counsellor with the Ashar Alo society. He used to work in the Gulf, but lost his job when he tested positive. Part of his present job is to talk about how to live positively, which includes helping people to disclose their status. Yet Ali has kept his own status a secret, which most single people tend to do. He lives with his parents and he has told them he lost his job through visa problems and he can't afford to get married. It is apparently not unusual that his parents don't inquire too closely as to how he now spends his time. As a result Ali has not experienced the stigmatisation faced by many of his clients.

Discrimination

'Men are gold, women are cloth'

Traditional Cambodian saying

As already discussed, discrimination against women is inherent in culture and religion in Asia. In formulating his covenant theology, Barth showed that gender inequality is totally alien to the idea of partnership between human beings and between human beings and God. And while Christianity for most of its history has conspicuously failed to honour this ideal, in the face of widespread social change there has been at least some movement within the churches. In other religions, however, people tell a very different story, and in Asia the position of the faiths is reinforced by cultural tradition. Here women have accepted their role as subordinate, to the extent of using the saying above of themselves

In Cambodia, an organisation called Karol & Setha works with young people and couples to help break down these cultural barriers. (*Karol* means 'knowledge and reflection on life'; *Setha* means 'sexuality through a holistic approach'.) One of its co-founders, Myriam Frys-Denis, indicated the wide reach of discrimination against women:

Buddhism fosters inequality, because nuns can't attain nirvana, and Catholicism remains very conservative. A public health education programme is putting out the message that women are more at risk from HIV because they lack choice when men get infected. Women are told to say that a man should use a condom for reasons of birth control, but this lie leads to the breakdown of trust and destroys the couple. In any case most women don't dare to ask. So mass education may not be respecting couples. Public health isn't challenging the culture of prostitution – it's something people don't know how to do.

However, in Asia discrimination takes many forms, not all of them involving women. In every case justice alone requires that this is tackled head on. The complication that those affected are particularly vulnerable to HIV makes this a matter of extreme urgency.

Sex workers

Across the world sex workers are vulnerable to HIV, and the most vulnerable are the women and girls who come from

the poorest sectors of society. In south-east Asia, where the silent but widespread use of sex workers is endemic, the spread of HIV simply adds to the concern that surrounds the systemic exploitation of poor women in the region. The tacit acceptance of the sex industry has led to poor families raising a girl specifically for sex work in order to provide an income for the rest of the family. In Cambodia it is the already stigmatised Vietnamese immigrants who will freely admit to this, but according to Sherry Lile, a director of White Lotus, a small American NGO in Phnom Penh, the practice is also followed in poor Khmer families.

Burma has a huge sex industry which suggests that there must be a large number of men with multiple partners. It is thought that, in south-east Asia, at least one in ten men also have sex with men. But the Burmese language doesn't even have a word for this, even though such behaviour is temporarily acceptable at the annual 'mosquito' festival in Mandalay. In a country where only the government carries out HIV testing and decides what figures it will release, people are working in the dark when promoting HIV prevention and care. Trans-border sex workers are typically blamed:

Eight years ago it was true to say that HIV was coming across the border, but now it radiates out from Yangon and Mandalay rather than the border areas. It's time to move on from blaming Thailand: we're now fuelling the epidemic ourselves.

International NGO staff member

In the south of Burma, HIV may be imported by the seafaring community. Typically men travel to and from Thailand and use the same brothels as Thai seafarers.

The trafficking of women and girls across country borders for sex work increases the vulnerability of this group, who may not have the same access to prevention programmes as nationals. The NGO worker quoted above suggested that whereas Thai sex workers benefited from programmes in their own country, women trafficked from Burma did not, although some NGOs, including Christian Aid partners, do work with Burmese women in the border area.

At least some sex workers must be falling through the net offered by NGOs, and they are unlikely to receive much support from religious institutions either. However, there are hints of change in some areas. In Hong Kong, for example, Buddhist monks have come to realise that much of their

temple income is from money sent home by sex workers, and they are being forced to change their attitudes.

Even in an otherwise tolerant country sex workers tend to suffer discrimination. In Cambodia, it is argued that the country has suffered so much already that people with HIV are less discriminated against than might otherwise be the case. But sex workers remain a despised group.

Aravani

Aravani means male in form, female in psychological orientation. Aravani fall into four distinct categories, depending on the degree to which they have embraced a female identity. Those who have had a complete medical sex change are grouped at one extreme and transvestites at the other. Some of the problems affecting this whole group are peculiar to Indian culture, while others are the difficulties experienced worldwide by both men and women who feel that they have been born into the wrong gender.

Indian society sends out conflicting messages to aravani. In south India Hindus greatly respect them: they are seen as bringing good fortune and they are invited to bless newborn babies. Yet this does not seem to make them any less vulnerable to abuse. And in the north, discrimination against them is rife.

Outside their own community, aravani are commonly regarded as sex workers. This means that they suffer double discrimination: as transsexuals and as sex workers. Because of their distinctive appearance they are constantly at risk of violence and abuse. The masculine side of their personality leads them to fight back and this in turn leads to conflict with the police. One transsexual, Radi, from Aundipatty, Tamil Nadu, described the trail of discrimination like this:

At the moment one's feelings start to emerge, the family says be a boy. So you either have to compromise or run away. And even if your own family are accepting, friends and neighbours tease us and so we get beaten for it. Neighbours always start the problem. And families disinherit us. When we go out and get provoked that makes us angry and we fight back. But the impression people give is that it's always us starting the fights. Thugs force us to have sex. One transsexual was abused in three different offices and could only keep her job if she agreed to sexual exploitation, in spite of all her qualifications.

The problem was put in a nutshell by Aasha, another transsexual: 'Society refuses to understand – just brands us as sex workers and we become an outlet for the sexual feelings of the male community.'

With this group that is particularly vulnerable to HIV, prevention education centring on safe sex is not enough. Aravani need help in understanding and controlling their emotions and the potentially violent behaviour that puts them at further risk.

Dalits

Given that poor people are particularly vulnerable to HIV, in India this vulnerability is increased and reinforced by the caste system. The dalits fall outside the caste system. Also known as 'untouchables', they do the work that Hinduism considers to be polluting, whether this takes the form of disposing of dead bodies and cleaning up human waste, or working with leather, which is also regarded as a polluting activity.

There is a risk that existing HIV-prevention networks in India will not be able to reach dalits, since it is typically middle class people and not the poor who can be contacted in this way – an unfortunate effect of a class-conscious society. On the other hand, Arogya Agam in Aundipatty (Tamil Nadu) is a secular health and development organisation that has done pioneering work on HIV. It has been particularly active not only among dalits but also among the lowest of the low, the dalits of dalits (known in that area as arundathiar), who suffer discrimination even from their own people. (Dalits are traditionally given separate glasses at public tea stalls; arundathiar are given a glass within a glass.) A women's federation working in a village that is 100 per cent Christian, and where half the population are arundathiar works on empowering dalit women. The federation raises awareness about the risks of having multiple partners and encourages the formation of self-help groups.

The view of John Dalton, Secretary of Arogya Agam, is that all the factors spreading HIV are present in dalit villages. Male migration is a particular problem that has led to a high incidence of sexually transmitted infections.

John Dalton also draws attention to the double standard in people's attitude to dalits. Even the most 'untouchable' women are sexually exploited by non-dalits. So the poorest of the poor suffer discrimination not only because of their social position but also because their abusers can take refuge in the cultural silence that bedevils issues of sexuality in the region.

In Tamil Nadu, the principal of Madurai Theological Seminary, the Revd Dr Mohan Larbeer, is himself a dalit. His institution is unique in that its syllabus includes liberation theology in the form of reflection from a dalit point of view.

In dalit villages around Aundipatty HIV seems to be spread primarily by returning migrant workers, as up to 40 per cent of men undertake seasonal work in Kerala. There's some feeling that while people are well informed about HIV, this hasn't translated into behaviour change. Organisations such as Arogya Agam have had some success in reducing the stigma of HIV, but the deeply ingrained discrimination against dalits has persisted. Moreover, while HIV may at first have been associated with the lower castes, now it is also linked with low morality, so the dalits, like the aravani, suffer double discrimination.

In December 2003 representatives of Asian church leadership meeting in Indonesia published a statement of commitment on HIV and AIDS. A key paragraph begins:

Realising that religious and socio-cultural barriers have contributed to denial of and silence about HIV/AIDS we commit ourselves to:

- address the oppressive patriarchal system in the church, community and family
- remove the negative cultural barriers among Asians that creates stigma and discrimination...

There is arguably no group which suffers greater institutionalised discrimination than dalits. The dalit community as well as communities of tribal peoples, who are similarly vulnerable, need, as a matter of urgency, to see such commitments on HIV and AIDS honoured.

Foreign immigrants

Foreigners are typically blamed for the spread of HIV, probably wherever the virus is to be found. In some cases this may be an accurate assessment. The rising incidence of sex tourism (now increasingly undertaken by women as well as men) sees western men travelling round south-east Asia, in particular, in search of unprotected sex and sex with young girls, and this can only increase infection rates. And where a country has been to all intents and purposes closed to the outside world, for reasons of war or politics, the arrival of HIV may sometimes be traced back to when this situation changes.

In Cambodia, where the first recorded cases date from 1991, HIV is, rightly or wrongly, associated with UN soldiers.

In 1990 when the country was closed there was no HIV. In 1991 the borders opened and UNTAC troops brought in Vietnamese and Thai prostitutes, which resulted in an explosion of HIV. People didn't realise it was there because it took time for people to fall ill and they didn't know about it. Also the government denied it existed and it spread rapidly. There was no immediate awareness in the churches: they thought it only concerned foreign soldiers.

Bishop Emile Destombes, Catholic Bishop of Phnom Penh.

In Cambodia the Vietnamese community is a particularly vulnerable group. But this has little to do with the nationality of girls trafficked into the country for sex. It is an impoverished group who were already stigmatised as immigrants, having fled their own country during the war. Some speak no Khmer and most do not have full Cambodian citizenship, including children who have been born in the country.

The Catholic Church is working to overcome prejudice against these refugees, most of whom have been Catholics at some time in their lives. Vietnamese culture suggests that those who are HIV-positive are further stigmatised within their already stigmatised communities. For example, a fear of ghosts leads to people being put outside their houses to die. The Maryknoll Fathers, a Catholic NGO in Phnom Penh, are regular visitors to the communities along the Mekong River and include HIV-awareness talks in the Sunday Mass that they hold there.

In Bangladesh, Burmese refugees are cited as a cause of the spread of HIV. But, more generally, while women and children may be trafficked across all the country's borders, large numbers of people are also travelling throughout southeast Asia and the Middle East in search of work. Men may be tested for HIV when they leave Bangladesh, or else they are tested at their destination, typically the Gulf States, only to be deported without being told the reason (as was the case of Ali described on page 10 above). Similarly, many women as well as men travelling from Sri Lanka to the Middle East are forced to have HIV tests before they leave. In 2005 50 per cent of new infections in Sri Lanka were found through the mandatory testing of migrant workers to the Middle East,

mainly among women.

Blaming foreigners for the rise of HIV in a country has a dual effect: it adds to the hostility and discrimination often shown as a matter of course to such groups and it hinders prevention work, as people refuse to accept that they may themselves be infected.

Access to healthcare

HIV positive people are facing the same problem of discrimination as people suffering from leprosy used to.

Myint Swe, chairman of the Myitta Byuha Society, Yadena Metta Clinic, Yangon

Myint Swe, quoted above, previously worked with leprosy sufferers in Burma. Numbers of patients had fallen to 4,000 for the whole country when he recognised the need to transfer his skills and helped set up a Buddhist HIV organisation.

In Bangladesh, Dr Sahidur Rahman, advocacy adviser with UNAIDS in Dhaka, acknowledges that the Christian churches are working more effectively than Muslims or Hindus because of their experience in leprosy. In southern India, a voluntary organisation, the Hyderabad Leprosy Control & Health Society, has been running HIV-prevention programmes in the city's slums for the past three years, again drawing on their experiences with patients stigmatised by leprosy.

However, these examples are the exception rather than the rule. All too often people are turned away from clinics because of fear and ignorance on the part of medical staff. The Catholic Health Association of India has done its best to counter this by providing training, and claims that many hospitals now accept people who are HIV-positive. However, there is still much to be done in raising awareness about HIV among medical professionals. For example, doctors at the Vijay Marie Hospital in Hyderabad vehemently denied that there is any link between HIV and poverty, protesting that HIV was 'a middle-class disease'. This is undoubtedly due to the fact that their patients, mainly Muslim women, come from the middle and even upper middle classes, and have contracted HIV from their husbands.

Thus the vulnerability of the poor is increased through ignorance, and the stigmatisation of sex workers, who are seen, in this situation, as the source of infection, is increased. Dr Langkham (see page 9 above) is a medical doctor and

Baptist elder. He was previously district AIDS officer in the Manipur state government. He commented that there is widespread ignorance about the social dynamics of HIV: 'people don't know about the behaviour of the poor'.

In the Hindu religion lepers have traditionally been regarded as 'untouchables', defiling people with whom they are in contact, and the same attitude is shown towards people living with HIV. This stems from the belief that a person is affected because he or she has done wrong. This in turn leads to a fatalistic attitude, and there's no great impulse to care for people. In the past, Hindus have not been well represented in the medical profession, although there is evidence that this is changing. It should perhaps be born in mind that this stigmatisation is not restricted to leprosy and HIV. In the past it has applied to tuberculosis sufferers and even (in Bangladesh) to people affected by arsenic poisoning, where husbands would reject their wives once the characteristic spots began to appear.

In 2001 a study into HIV- and AIDS-related discrimination in India identified the following discriminatory factors in hospitals:

- refusal to provide treatment for HIV/AIDS-related illness
- refusal to admit for hospital care/treatment
- refusal to operate or assist in clinical procedures
- restricted access to facilities like toilets and common eating and drinking utensils
- physical isolation in the ward (eg separate arrangements for a bed outside the ward in a gallery or corridor)
- cessation of ongoing treatment
- early discharge from hospital
- mandatory testing for HIV before surgery and during pregnancy
- restrictions on movement around the ward or room
- unnecessary use of protective gear (gowns, masks etc) by health care staff
- refusal to lift or touch the dead body of an HIV-positive person
- use of plastic sheeting to wrap the dead body
- reluctance to provide transport for the body.²¹

The study concluded: '[This] reveals a depressing picture of widespread labelling and stereotyping and lack of care

throughout the health sector, with the possible exception of a small number of hospitals where good policies and practices have been established'. And while the authors added a number of recommendations relating to people living with HIV and members of marginalised groups, and some aimed at legislators, the main thrust of their conclusions was directed at the healthcare sector, which is urged to reduce discrimination, to challenge beliefs about modes of HIV transmission, and to address 'the diffuse and irrational sense of personal risk among ancillary staff'. Whether this 'sense of personal risk' is entirely down to ignorance is a matter of debate: it seems not unlikely that the deeply rooted cultural notion of untouchability has a part to play as well.

In Burma as in India, the fear of HIV that influences the behaviour of medical professionals has far-reaching effects:

Even the government medical doctors are afraid and they put a dead body in a bag as quickly as possible. The doctors' behaviour makes the situation more discriminating and more dangerous.

The Revd Peter Joseph

Amudha's story

'Once doctors said, "Why do they come to hospital? They're just going to die." This is changing.

'I was afraid when I heard I was HIV-positive. I had no courage. I hid within the four walls of my house. That was in 2000. It was only the next year, when I met other positive women, that I realised that it is we who can bring about change. We have to speak out.'

Amudha was happily married with three children when her husband fell ill. He and Amudha were both tested by the family doctor and found to be HIV-positive.

'Once we were diagnosed, the neighbours ignored us and the relatives stopped coming. People pointed at my children and said: they're the ones. No one came to our shop. When he suffered and died, people were pounding on the door for us to repay their debts. I tried to commit suicide by drinking pesticide, but my daughter took it out of my hands.'

With her children – then 15, 13 and 7 – Amudha moved to Bangalore, supporting the family on 35 rupees a day (£0.41/€0.60) rolling incense sticks. She sold her silver and wedding gifts to pay their school fees. Then she was introduced to the

Karnataka Positive People's Network (KNP), one of the four organisations supported by Christian Aid that make up the MILAN project in Bangalore.

Amudha recalls: 'We decided, if we speak openly, we can bring about change. So I got trained: how to speak, how to take my medicine, how to take care of myself. I had never spoken to men. If I had to travel, I never even knew which bus to take. Now I had to go out by myself, go out on the bus and learn Kanada [the local language in Karnataka state]. Gradually I was sent by KNP to many new places to speak about being positive.'

'There has been an enormous change since 2001. The doctors had told me to keep secret the fact that I was HIV-positive. They told others: "Why do these

people come to the hospital? They're just going to die.'" But today, the way doctors look at patients has changed.

When the *Deccan Herald*, a local newspaper, published an article about Amudha, she was inundated with text messages from people applauding her courage. 'You are a really brave woman', said one. 'I admire you, Amudha', said another. She speaks now: on television, on radio, to newspaper journalists. She's no longer confined to the four walls of her house.

'My children are my backbone. They are the ones who supported me to come out openly. "There may be many other mothers inside their four walls, dying of AIDS", they said to me. "You should set yourself as an example to them."'

The Statement of Commitment by Religious Leaders published at the International AIDS Conference in Bangkok in July 2004 contained the following clause:

We will involve people living with or directly affected by HIV, many of whom are members of our own religious communities, in the response to this pandemic.

Yet few religious organisations in south-east Asia currently involve HIV-positive people in their prevention programmes, and few, if any, religious leaders are able to disclose their status publicly. It would seem that a sea-change of the kind that took place in many African countries will be needed to bring this about. The Catholic Bishop of Phnom Penh, Emile Destombes, has noted the beginning of change:

In my parish a female secretary died. She seemed healthy but she had had a single relationship with an UNTAC soldier six years before. That made the young people think. Everybody knew her. We couldn't look away any more.

The bishop suggested that in his diocese at least there is now a greater openness in talking about HIV as everyone knows someone who is affected – the majority of them young people aged between 25 and 30.

Gender

For both men and women, the contexts and forms of HIV/AIDS-related discrimination, stigmatization, and denial appear to be influenced by wider social expectations and relationships. Women in particular tended to be seen as wives, mothers, daughters, and daughters-in-law before they were seen as HIV-positive women in their own right. The impact of HIV/AIDS for most men was cushioned by their privileged position in society, while for women it was intensified.²²

The significance of the gender discrimination that is inherent in Asian culture and religion has already been underlined. And it increases women's vulnerability to HIV in ways that are not immediately obvious.

For example, in Bangladesh, it is culturally only acceptable for men to have male friends. In many country areas this leads

Stigma and faith

There's a story about a senior Muslim who became infected by HIV, and who refused all treatment so that no one should know of his status.

Dr Janet Coleman, Servants to Asia's Poor, Phnom Penh

While there is anecdotal evidence of some HIV-positive religious leaders in south-east Asia, the stigma created by the religions themselves remains too great for such leaders to make this public. The Director of the Catholic Health Association of India says he has treated positive priests and nuns, but that if their status was known, their only option would be suicide.

to sex workers being brought in from the towns to have group sex, thereby putting the men's future wives at risk.

In general, the unspoken tolerance of men having sex outside marriage leads to a whole range of situations where women are at risk. The Revd Dr Ban Makan of the Christian AIDS/HIV National Alliance (CANA) in Delhi says that much needs to change:

Church congregations won't talk about their own behaviour: there are drug addicts in the churches but they won't talk about it because it's not Christian. Nor will they talk about sexual matters that are taboo in India. Yet a high percentage are engaged in extramarital affairs.

Theological colleges need to be prepared for the fact that some of their students will be positive. It's common for a young man to indulge in a promiscuous lifestyle and to use drugs, and then change. So the parents send him to theological college to serve the Lord and make amends for his previous way of living. He will be positive without knowing it and the churches need to be prepared for this.

In the face of all the discrimination, stigmatisation and silence in Asian countries, a rights-based approach to HIV would seem to be a fruitful way forward in combating this widespread cultural injustice. The challenge is to present this in a way that is acceptable to different faiths and to secular organisations, and in a way that can be integrated into their thinking.

Bringing life: with compassion and openness

We have a moral duty to offer care for positive people as well as prevention work. Previously, religious leaders had a hostile attitude to people with HIV: positive people were seen as sinful, guilty people who had to be avoided. But we have made them understand that we have a religious obligation to treat sick people and to ensure that HIV is not spread further.

Imam Abul Kalam Azad, Dhaka

The view expressed above is not one that is typically heard in Bangladesh. In countries with a low HIV-prevalence rate, organisations are stressing prevention not care. The prevailing moralistic attitude to HIV across all faiths encourages this trend. It is easier to tell people how to behave, albeit in veiled terms, rather than encourage them to care for those who, by the same token, are seen as having fallen short of their religious ideals. As a result, people who may be very knowledgeable about how HIV is spread appear to have little enthusiasm for caring for people who are affected. A group of imams in Dhaka (not including Abul Kalam Azad) who had been trained in HIV prevention saw their task in terms of a battle that they declared they were ready to fight. But there was little hint of compassion or understanding for the casualties of that battle.

Such an attitude contributes to denial and ignores reality. Although the prevalence rate in Bangladesh is below one per cent across the country, the statistics tell another story. For injecting drug users in central Bangladesh (including Dhaka) the rate is four per cent, and in the central area around the old city it is nine per cent.²³ So in the face of denial and even outright hostility, what can faith groups do to bring hope for people living with HIV?

Promoting openness

The challenge to break the silence on HIV in Asia is above all a challenge to cultural tradition. In Hong Kong, with its long-standing ties to a more open, western tradition, there is a real concern to give HIV and AIDS a higher profile. In collaboration with St John's Cathedral, Hong Kong, the Christian Conference of Asia (CCA – formerly based in Hong Kong but now in Thailand) produces worship materials each year for AIDS Sunday (the Sunday closest to 1 December) and this is observed by 116 member churches in 18 countries. They advocate a biblically based or theological approach to churches, sometimes in tandem with a rights-based approach which is more likely to appeal to secular groups.

Prawate Khid-arn, general secretary of the CCA, believes that recognition by the UN of the importance of a holistic approach that includes spiritual and ethical matters has opened the way for religious leaders to accept a significant role in HIV education, prevention and care. However, the role of CCA is simply a coordinating one: it does not work at grassroots level, which is where there is most activity. This commitment needs to be built on at a regional level, and CCA is encouraging religious leaders of all faiths to develop work with people living with HIV.

The only faith-specific institution working on HIV in Hong Kong is the HIV Education Centre based at St John's Cathedral. It works specifically with women – those born in Hong Kong, arrivals from mainland China, and Asian migrant workers, many of them from the Philippines. Their education and awareness-raising has done much to bring HIV into the open. But a survey on clergy attitudes to HIV that they conducted in 2003 showed that only 30 per cent thought that HIV should be on the curriculum for ordinands. While knowledge about HIV has improved among the clergy, this group still expresses concern about discussing sexuality.

Burma is moving towards greater openness as the number of infected people grows. It is felt that the eastern states are more open because there are more positive people there, including within the Christian churches. One positive pastor has come forward and takes an active part in programmes. So while positive people still find it very hard to admit to their status, there are an increasing number of people involved in counselling. Condom usage is also accepted for positive people (unlike in India and Bangladesh), even, in certain areas, among Catholics.

Yet openness is more than a willingness to talk about HIV and recognise its incidence. It also means asking some painful questions about people's actual behaviour, as opposed to the behaviour they display and advocate in their places of worship. For example, a 2004 survey in Bangladesh revealed that 33 per cent of students had had sex with commercial sex workers. Yet students are not seen as a high-risk group. Some forthright questions need to be asked and their answers acted upon, however uncomfortable that may be for the wider community.

Accepting responsibility

God loves us, but not as a tyrant. We have the freedom to behave responsibly. God isn't an umbrella to protect us. This was a problem with the tsunami. People gave thanks for their safety, but if you look at the map you'll see that we were lucky. We can't hang on to God like an umbrella. It's too easy to blame God and or wash our hands of responsibility. People punish themselves. So when the Chinese caught HIV from infected blood, it was their negligence that was to blame, not God.

Bishop Emile Destombes, Catholic Bishop of Phnom Penh

Taking responsibility in the context of HIV means more than responsible behaviour in sexual relationships, although that is also a vital component of HIV prevention. *HIV, AIDS and Islam* shows that this is as much a part of Muslim thinking as it is of Christian theology.

Because AIDS is a killer of so much joy and fun – the good things that Allah has made lawful for us – we have a responsibility to avoid harming our bodies and our souls when we make choices about our sexual behaviour. We also have a responsibility to create a world wherein people are free to make those choices. Such a world is not one wherein we are deprived of the freedom to look after our (sacred) bodies by the kinds of exploitative relationships that poverty has placed us in...

What does it mean when we say that every Muslim must take responsibility for his or her sexual life when many of our societies place women in positions where they cannot take any decisions – however small – about their lives? ... Only in a just world can we ensure that we have the freedom to take responsibility for our lives.²⁴

Responsible behaviour on the part of people who are, or may become, vulnerable to HIV is one thing. But it cannot end there. Not only individuals, but communities, faiths and governments are all called to act responsibly in addressing the HIV epidemic.

In this sense, responsibility has to do with the openness already discussed. Also, it is about recognising reality, not seeking to apportion blame, and, in terms of Christian theology, accepting the consequences of engaging in covenant-based relationships. It means acknowledging the presence of factors

that cause the HIV epidemic to spread and addressing them; and identifying and caring for people who are vulnerable to HIV.

In Asia, above all, taking responsibility means bringing into the open things that people would prefer to remain hidden. And it means taking a hard look at social structures as well as social conventions if they too are contributing to the spread of HIV. Faith groups may have to make a greater leap forward than secular organisations if they are to take a lead in such responsible openness, but having done so, they are well placed to demonstrate an effective response.

Responding to poverty

In Indian cities barbers' shops are a source of HIV transmission. With workers having to spend hours commuting, they often choose to visit such shops in between trains. But the barbers are poor and the use of unclean razors is a real hazard. They don't think about the wellbeing of their clients and they don't see HIV infection as their problem. One barber said, 'That is for big people like you to worry about'.

As already indicated in respect of Bangladesh, the link between HIV and poverty is not generally understood. According to Sagarika Chetty of the National Council of Churches in India, church congregations are content to be middle class and they don't want any links with what they see as 'the slums'. Ms Chetty comments, 'Social activism has yet to percolate down to many people'. In this Indian context, then, a highly developed class system, cultural reticence, fear or ignorance of HIV and inter-religious hostility all combine to make the situation of people living with HIV difficult in the extreme.

Prawate Khid-arn of the Christian Conference of Asia suggests that faith-based organisations need to recognise the links between different aspects of their work. While poverty and migration are key concerns, he argues that these need to be more closely related to their thinking on human rights, HIV and ethics. And coordination between these different sectors should lead on to coordinating the work of different faiths.

There is a strong imperative for faith-based organisations to respond to such concerns, particularly in countries such as Japan and South Korea where HIV is seen as a matter for the health services and where the poorest people may not have ready access to their facilities.

Considering sexuality

The hesitancy of all faiths, not only in Asia but worldwide, to address human sexuality has become a significant hindrance to the fight against HIV. As an African theologian has put it, 'The challenge to break the silence about human sexuality needs to be faced if we are to succeed in talking about HIV/AIDS'.²⁵ Although Christianity and Islam share a belief in the goodness of sexuality, this is rarely formulated other than in a strongly moralistic way, and in Asia it is rarely talked about.

The work of Karol & Setha in Phnom Penh is unusually wide-ranging in its approach and reflects particular cultural challenges. Human relationships are high on its agenda, and it uses the different expectations of women and men as a starting point. It works closely with couples, teaching them how to talk to each other. This is vital in a culture where it is normal for couples to live separate lives, and misunderstandings, even domestic violence, are a common outcome. It also works with parents who would expect to choose their children's partners. The complications of this reach way beyond the issue of arranged marriages: in a country where there are no state pensions parents have a vested interest in choosing sons-in-law who will be able to provide for them in their old age.

Karol & Setha treats HIV along with other sources of risk to young people, in particular drugs and peer pressure. The latter is important, as young men are frequently impelled into violence against women. The availability and use of condoms is also used to excuse gang rape by groups of young men. So Karol & Setha explores means of HIV prevention to complement condom use, because, in Myriam's words, 'abstinence is not possible and in Cambodia no one knows how to be faithful'. This involves developing personal values and psychological rules, in other words acknowledging sexuality and building up relationships.

As noted in *Theology and the HIV/AIDS Epidemic* this is not the place to engage in a full discussion of theology and sexuality, but it is worth emphasising that cultural factors in many Asian countries are likely to make such a discussion even more difficult than elsewhere.

Showing compassion

Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish. Compassion requires us to be weak with the

weak, vulnerable with the vulnerable and powerless with the powerless. Compassion means full immersion in the condition of being human.

From 'Tips for Care Givers', SCAN newsletter²⁶

Compassion features prominently in the teaching of all the main religions and few would disagree with the above formulation. But it is important to be realistic about the challenges that face people who want to act compassionately towards people living with HIV, particularly in cultures given to stigmatising and discrimination. Indeed the 'Tips for Care Givers' quoted above begin with the advice 'be tolerant'. Being 'vulnerable with the vulnerable' makes great demands on any care-giver, and all the more so when part of that vulnerability has to do with coping with hostility from all kinds of other people.

'Slowly we found we had more compassion and love'

Gladys Dive and Paw LuLu are HIV health workers in the Anglican diocese of Hpa'an, Burma. They train doctors and health workers in HIV prevention and they care for people suffering from AIDS-related illnesses.

'At first we weren't brave enough to take on this job. But we realised we had to do

something, and slowly, through personal contact with patients, we found we had more compassion and love. Now we want to do more. It's God's love that keeps us going. When you receive God's love it has to flow over onto other people. And when you provide education, positive people are able to mix with other people. They no longer feel isolated and alone.'

Also in Burma, Saw Lwe Gay, a Christian HIV coordinator, drew on St Paul as the inspiration for his work:

Galatians 6.2 says that we have to 'bear one another's burdens and... fulfil the law of Christ'. So to give care we need empathetic hearts. If God saves our lives, then we have to share our hearts, feelings and time with those in need. People with HIV are the least in this world, especially in Burma. These are our neighbours.

The Positive Muslims publication echoes these calls for compassion with admirable honesty.

Prophetic patience asks us to restrain our first instincts to protect ourselves and our families from HIV at any cost. It asks us to pause for a moment and question our paranoia. Is this hysteria founded on genuine understanding of the facts surrounding HIV and AIDS? Does our discrimination stem from a sense of self-righteousness? Are we truly embodying Allah's attributes of compassion and mercy or have we ignored them by holding onto our self-serving biases?²⁷

The writers go on to make the point that 'the Qur'an moves from the premise that only Allah is absolutely pure and that all of humankind is ultimately dependent on Allah's Grace. It therefore denounces self-righteousness and arrogance.'

Compassion does not happen automatically just because of one's religious beliefs. Prophetic patience may well be a necessary preliminary to compassionate care as well as an ongoing support in it.

A faith-based approach to HIV in Asia necessarily focuses on translating into reality the compassion advocated by the different religions. In this culture, compassion must include breaking the silence in order to end the stigmatisation of people living with HIV. But if that compassion and openness is to have a distinctive faith element, that will emphasise a real and living hope, then there are challenges for all the faiths in how they express their theology. This will be the subject of the final chapter.

Challenges for faiths

God, who comes alongside and lives within, we thank you for the privilege of being together...

We pray that your love will unite us into a community of grace and discovery. Please cleanse from us anything that would sap our strength for togetherness. Free us from negative imaginations and the barriers that sometimes keep us apart. In this time refresh in us the dream of a better world and put before us new possibilities for service. Renew in us your compassion so that we may be a people with loving purposes. We come together to be your alleluia in a troubled world. Amen.

From 'Stop AIDS: Keep the Promise, a liturgy for World AIDS Day 2005'²⁸

What teaching?

It is increasingly argued that discrimination against women and the stigmatisation of people living with HIV cannot be justified by the teaching of the major faiths. And there is a growing trend for religious leaders and thinkers to correct what they see as misinterpretations of basic teaching.

Islam

On the question of gender equality, some Islamic writers have urged commentators to return to the religion's primary source, the Qur'an, rather than focus on the past millennium when Islam was dominated by exclusively male scholars and thinkers, who had also been influenced by cultures antithetical to Islam. So, before the 20th century, women were discussed in law in the same terms as material possessions, and were regarded only in respect of service to men and their family.

A professor in Islamic Studies, Dr Amina Wadud, writes:

It is clear to me that the Qur'an aimed to erase all notions of women as subhuman. There are more passages that address issues relating to women – as individuals, in the family, as members of the community – than all other social issues combined... Islam brought radical changes regarding women and society, despite the deeply entrenched patriarchy of seventh-century Arabia. The Qur'an provides women with explicit rights to inheritance, independent property, divorce and the right to testify in a court of law. It prohibits wanton violence towards women and girls and is against duress in marriage and community affairs. Women and men equally are required to fulfil all religious duties, and are equally eligible for punishment for

misdeemeanours. Finally, women are offered the ultimate boon: paradise or proximity to Allah: 'Whoever does an atom's weight of good, whether male or female, and is a believer, all such shall enter into Paradise' (Q 40:40).²⁹

Dr Wadud also contrasts the Qur'anic account of creation with that of Genesis, pointing out that dualism (man and woman) is the 'primordial design for all creation'. There is no tradition of man having been created first. In the Garden of Eden both man and woman eat from the forbidden tree: the woman is not singled out for reprimand.

So-called Islamic feminism is a movement that has originated within Islam – it is not an attempt to impose a foreign culture or belief system from outside. It urges a return to primary sources and a reinterpretation of them to replace many centuries of patriarchal interpretation and practice. In the context of HIV this is important. Empowering women whose husbands are positive or who are positive themselves and freeing them from discrimination and stigmatisation does not threaten the Islamic religion and way of life. On the contrary, feminist scholars would argue, they are strengthened by this return to basic principles.

The publication by Positive Muslims suggests that Islam is undermined by the widespread Muslim attitude to HIV (see the extract on page 6 above). The writers also stress the compassion of Allah and of the prophet. In a passage that is reminiscent of Christian covenant theology, they argue that how people deal with those who are positive 'is not really a question about how we deal with them; it is really a question about the Deity that we try to serve and about us. How Compassionate and Just is Allah?' In other words there is an interrelationship between Muslims, positive people and Allah. The writers quote a co-founder of Positive Muslims: 'I once heard of a young man screaming at God for letting young children starve until he realised the starving children were God screaming at him for letting it happen'.³⁰

The Dhaka imam Abul Kalam Azad, quoted in chapter 3, is convinced both of the urgency of the HIV situation and of the responsibility of faith leaders in addressing it:

In our country people are very religious mentally if not in practice. People pay attention to anything said in the name of the religion, whether this is Muslim, Hindu or Christian. There are 200,000 mosques in Bangladesh and every village has at least one. On Fridays the mosques are

overflowing, even if people are not practising their religion at other times. There is a contradiction: people here are not honest in business or in government, but they are very honest in religion. So if the imam says only a few words it's taken as a message from God.

Hinduism

An HIV research worker in Bangalore, has commented on the lack of any single coherent Hindu attitude to the problem: 'The Hindu faith reflects what is largely prevalent in society and, inasmuch as there is no theology of suffering or theology of HIV, the result is that there is a default approval of stigmatisation against people living with HIV/AIDS. The same is true of gender injustice and discrimination against women.'³¹

Nonetheless, many Hindus in Asia are deeply concerned about the spread of HIV and some, not unlike some Muslims, are urging a return to core values, not in the interests of moralistic discrimination but in order to rediscover compassion:

Some religious organisations have already demonstrated leadership that produces meaningful changes in the lives of affected people. These organisations have also been responsible for leading their communities in revisiting such core religious values as compassion and understanding.

Karuna (compassion), *Shradha* (respect), and *Budh* (understanding) have been integral components of the Hindu tradition. Generations of parents and grandparents have shared these values with their families and communities.

The Hindu tradition is beginning to recognise the need for revisiting its core values, amplifying its voice of concern and compassion, and making a call of support for those living with AIDS. But how is this possible? Perhaps we need to look to God. Maybe there is some way that we can pause to give ourselves an opportunity to revisit what our traditions have taught us. This would allow us a way to reiterate voices of concern and compassion, and to offer our understanding towards informed action regarding those living with AIDS.³²

There are many Hindus, in India for example, working in the field of HIV, but the concept of a specifically Hindu organisation is a foreign one. It remains to be seen whether the religion's

tolerance of diversity will allow it to overcome deep-rooted stigmatisation, stemming from bad karma, with compassion.

Buddhism

'The Buddha reaches suffering and the way out of suffering.'

Beth Goldring runs a Buddhist chaplaincy project in Phnom Penh for destitute HIV patients, and she sees her role primarily as easing people's dying. She also believes that the teachings of the Buddha are misrepresented in the context of HIV. She quotes a patient who believed he had AIDS because of bad karma and that his next life will be even worse than this one. In Buddhist teaching karma relates to the moral law of cause and effect: 'if you do good you receive good'.

The Buddhist principle of doing good in order to help yourself as well as helping other people is applicable both to people living with HIV and to their carers – positive people are in no way disbarred from the possibility of the next life being better. The Buddhist-run Yadena Metta Clinic in Yangon works on prevention, treatment and care. They see their role as helping patients spiritually, teaching compassion and teaching positive people how to meditate and improve their mental state.

A Buddhist living with HIV: Ma Aye Mya Thida (32)

Ma Aye Mya is a widow and a volunteer counsellor at the Yadena Metta Clinic.

'I discovered I was positive two years ago when my husband fell ill. I have a two-year-old son who is not positive. I help at the clinic because I want to boost people's morale and show them you can still live with HIV.'

'When I found out I was positive it was a mental torment. But our Buddha

taught us to believe in the law of cause and effect. So I don't blame anyone: I can live with HIV and I don't have any negative attitudes towards anyone. I know there's no cure but if I'm good now I'll reap the benefits in the next life.

'I've been a good wife and mother and whatever I do is for other people. If I look after myself that will also help other people.'

'My experience has shown me that, whatever religion you are, if you can meditate you can achieve a certain level of mental relief.'

Christianity

Unlike the other major faiths, the question for Christianity is not so much one of recapturing an older basic teaching as choosing between theologies. The persistence of the message that HIV is a punishment for sinful behaviour may be due at least in part to the prevalence of that belief in the other religions. It may also have to do with the current low HIV prevalence rate: one of the factors provoking the change to a theology of compassion in the African churches was the sheer numbers of people affected by HIV among congregations and church leaders.

Potentially, though, Christian theology has a lot going for it in those countries where church leaders and thinkers have been open to a holistic approach to their regional culture. Fr Sebastien Ousepparampil, director of the Catholic Health Association of India in Hyderabad, recognises that the churches' failure to do this in the past is affecting their work in the present: 'The biggest mistake of the churches is that we have never become Indian. We remain foreign in our liturgy and activities. We could have integrated, for example, the festival of lights, but we remained distant. Hindus would call us foreigners.'

Fr Sebastien went on to say that Christians had won respect because of their healthcare and schools, but the incidence of 'paid conversions' across south-east Asia (associated particularly with Pentecostal and charismatic churches originating in the United States) has increased suspicion and hostility between faiths. In Cambodia this type of evangelism has resulted in so-called 'rice Christians' as some Christians and Mormons take advantage of the country's poverty to swell their numbers.

However, theologies such as the feminist theology being developed in Hong Kong, Thailand and Malaysia, probably because they originate with Asian thinkers and are not imported from the west, do seem to exemplify a dynamic and evolving way of thinking that is able both to accommodate new situations, such as the HIV epidemic, and to formulate practical and compassionate approaches to them.

The work of the Society for People's Action for Development (SPAD) in Bangalore has a Christian foundation and is particularly committed to addressing the vulnerability of women, as part of its work with the city's poorest people.

Acknowledging suffering

There is no virtue equal to compassion and no sin worse than causing pain to another. This is the essence of all the scriptures.

Lovers of God are always active in the service of others, compassionately sharing their sorrows.

Ramayana (Hindu scripture)

'Seeing each person as a sacred human being'

Fr Jim Noonan is head of the Maryknoll Community in Phnom Penh. He and his colleagues visit HIV patients in hospitals, at home and in their hospice, regardless of their religion. He described the relationship between his work and his faith.

'Over the years it has become difficult to separate faith and humanity. I relate increasingly to people on a familial basis – as if they're part of my own family. On a spiritual level, I've had the experience of cleaning up people who have been left to live in their urine and faeces for two to three days. I would clean the room, the bed and the person. One day when I came to wash one man I thought, "This is the body of Christ." And of course as a Catholic I have a great respect for the Eucharist. And this

body was to be treated in the same way: what a privilege to handle the body of Christ like this.

'Another time a woman on the ward was surrounded by so many doctors that I was too embarrassed to intervene. But I went back at the weekend and found that she was still in a bad state so I cleaned her up. She died a few days later, and when she was dying she asked "Where's uncle?" When I see how the simplest things that even I can do make people feel human again I hold it to be of great worth.

'The work demands seeing each person as a sacred human being who is of value in God's sight. It's a privileged moment when someone comes to you and entrusts their care to you. It's an awesome responsibility.'

While much needs to be done in the area of HIV-prevention work in Asia, the big challenge for people of faith would seem to be to move on to work wholeheartedly with people who are already living with HIV. This necessarily implies a shift away from the moralistic attitude that prevails so widely across all the faiths and demands that discrimination and stigmatisation

should be replaced by active compassion and a message of hope for the future.

The example of Maryknoll is striking not only because it is intensely moving to witness their work but also because it shows so clearly a willingness to put compassion for people's physical and spiritual needs first and to allow faith to speak through actions rather than words. Another member of the community quoted St Francis of Assisi: 'Preach the gospel at all times. Use words if you have to.'

In a context where organised Christianity in particular attracts suspicion and hostility this low-key approach to faith seems to be bearing fruit. It is an approach that has much to commend it if faith leaders are ever to adopt a more pragmatic and efficient approach to HIV prevention and care by working together.

Working together

'The churches don't think outside their own boundaries and they misunderstand mission, which they see as conversion and church planting, rather than in caring for the sick'

The Revd Dr Ban Makan (Delhi)

The extent to which the major faiths see HIV as something they should be concerned about varies across Asia, and it is probably true to say that the majority of churches, temples and mosques do not have it on their agenda. And where they do, the idea of combining across faith groups remains for most a largely foreign one. There are, of course, instances of individual faith groups doing important and effective work, and there are some cases of them working together, but the dominant impression is that the latter are the exception rather than the rule. Necessarily, though, the situation varies from country to country.

In India, while HIV is generally regarded to be the province of NGOs, the first initiative came from the Lutheran church and the National Council of Churches in India (NCCI). NCCI, based in Nagpur, is a facilitating body with the individual churches implementing their programmes. The main focus for their work is in the north east and on the Burmese border, two areas where HIV prevalence is high, targeting injecting drug users and sex workers. NCCI also encourages awareness programmes within the church, and carries out some education work through confirmation classes and ordination training. Sagarika Chetty of NCCI says that while churches are

increasingly willing to talk about the issue, much needs to be done with people living with HIV: 'People react to a new disease first with shock, and secondly in seeking self-protection. This prevents them from feeling any empathy with the sufferer.'

Long-standing hostility between faiths leads to suspicion of multi-faith initiatives, which people think may be a cover for forced conversions.

In Burma and Cambodia, understanding between Buddhists and Christians appears to be growing, thanks to some very specific initiatives. In Yangon, at the St Joseph's Catholic Major Seminary, this happens in several ways. At an academic level, Hindu, Buddhist and Muslim scholars all take part in courses relating to their religion. But at a more practical level, there is much interaction in the context of everyday life, where people celebrate, say, weddings together. The seminary also invites Buddhist monks to observe ordination services and Christmas celebrations.

Imam Abul Kalam Azad (quoted earlier page 17) is a programme director for national television in Bangladesh. He also works with a development NGO in setting up mosque-based poverty alleviation programmes. Since the International AIDS Conference in Bangkok in 2004 he has been working to bring together a national committee of different religious leaders, with the aim of running a joint project for sex workers. He is also involved in a pilot HIV prevention programme among uneducated rural people. His status as a well-known television personality has helped avert some of the criticism normally directed towards interfaith co-operation:

People have known me for a long time because of the television programme. They understand that I'm not compromising Muslim beliefs in doing this. But otherwise there are mixed attitudes to interfaith dialogue. Most people don't understand it. So information is important.

And it's encouraging for the general population if we can say something united – this carries more weight. We need to sit together to overcome misunderstandings.

As in sub-Saharan Africa, even if the hurdle of faiths working together can be overcome, the issue of HIV – particularly condom use – risks dividing them further. Dr A Z M Sahidur Rahman, advocacy adviser with UNAIDS in Bangladesh, and himself a Muslim, described how the government was training

imams in HIV work: 'They are OK with A and B but C is a challenge. A few exceptional Muslim leaders will support condoms; the rest preach on abstinence and fidelity'. The Muslim director of the Mescos Diagnostic Centre in Hyderabad was in no doubt where the origins of HIV lie: 'As long as you [the Christian West] allow women to walk bare on the streets there will be HIV'.

However, it would be unfair to suggest that negative attitudes to HIV and to condoms as a prevention mechanism are confined to Muslims: they are echoed across all the faiths, and while condom use is enthusiastically advocated in some quarters, cultural as well as religious sensitivities tend to make this a taboo subject. Because condoms are not used by married people, even the act of buying one is stigmatising, so organisations have to find other more discreet outlets. Arogya Agam in Tamil Nadu work through village volunteers who use phone boxes and general shops to sell condoms at a heavily discounted price, so that it is less obvious what people are buying.

This does, though, raise the possibility – and the challenge – of faiths learning about the importance of HIV prevention together. The SAVE framework developed by Christian Aid's partner Anerela+ (the African Network of Religious Leaders Living with or personally Affected by HIV and AIDS) may be a helpful way forward. SAVE stands for *safer* practices, *available* medications, *voluntary* counselling and testing, *empowerment* through education, and is felt to avoid the stigma surrounding the ABC (*abstinence, be faithful, use condoms*) approach.

The greater challenge may be to bring the faiths together in the first place. In Hyderabad the emergency of the Gujarat famine in 2002 was a starting point for faith leaders to come together, when a 'Faith Forum' was held to appeal for peace in the city. Between 12 and 18 religions were represented, which included different Hindu sects and Sikh sects as well as Muslims and Christians. It is said to have had an electrifying effect when for the first time the religious leaders issued a joint statement. It is to be hoped that the HIV epidemic does not have to reach crisis point before the same thing can happen again.

Conclusion

In Asian countries, as in Africa, there is great potential for faith-based communities to become agents for change: to take a lead in tackling the silence, discrimination and stigma that is causing so much suffering for people living with HIV, and to

provide compassion and support for all who are affected by it. Clearly, faith-based NGOs are working hard and making real progress in both these areas. But the capacity of churches, mosques and temples to do such work themselves seems to be limited. Furthermore, the view that HIV is the province of NGOs and not the churches, for example, remains widespread, and as such does not encourage those churches to tackle the silence and stigma in their midst.

The challenge for all the faiths in Asia is to acknowledge the potential benefits of working together in addressing those aspects of their culture – particularly reticence and discrimination – that are allowing HIV to spread unchecked in the region. And there is a further challenge to the Christian churches in particular to give full recognition in their theology to the interconnectedness that is characteristic of deep-rooted covenantal relationships between human beings, God and creation. The situation where 'women and girls have a taste of death even before death' is an affront to justice, and until this is tackled the HIV epidemic will continue to grow. In the face of this, the hope that should permeate Christian teaching, and the love and compassion advocated by all the main religions in the region have perhaps the most important role of all.

Endnotes

Preface

1 Christian Aid, 2004.

2 In 2005 there were close to 5 million new HIV infections worldwide. Of these, 3.2 million were in sub-Saharan Africa. (UNAIDS, *AIDS Epidemic Update*, December 2005.)

3 For example, the Anglican Church in Southern Africa (ACSA) has been instrumental in facilitating discussion and reflection in the region.

4 The UNAIDS report published in December 2005 cites Kenya, Uganda and Zimbabwe as the three sub-Saharan Africa countries where adult national HIV prevalence appears to be declining, concluding that 'East Africa continues to provide the most hopeful indications that serious AIDS epidemics can be reversed' (p 25).

5 UNAIDS, *India: HIV and AIDS-related Discrimination, Stigmatization and Denial*, August 2001, pp 7-8.

6 UNAIDS, December 2005, p 33.

HIV and Christian theology in an Asian context

7 Especially *Church Dogmatics III/1 (1945)* and *Dogmatics in Outline (1947)*.

8 Jacob Kavunkal, SVD in 'The Impact of Medellin and Puebla on Asian Theology', *Spiritus*, no 156, September 1999.

9 Throughout this paper all unreferenced quotations are taken from private conversations.

10 Lilith M Usog, 'Introduction to Feminist Theology', *In God's image, Journal of Asian Women's Resource Centre for Culture and Theology* (Kuala Lumpur) Vol 23 No 4, December 2004, p 26.

11 'Asian Feminism: Towards Partnership and Transformation', *Ibid*, p 55.

12 As expressed by Lilith M Usog (note 10 above) following Rosemary Radford-Ruether.

13 Cecilia Ng, 'The Woman Question: Problems in Feminist Analysis', *Ibid*, p 6.

14 Hope Antone, 'Asian Feminism: Towards Partnership and Transformation', *Ibid.*, p 58.

15 *In God's Image*, Vol 23 no 4, December 2004, p 30.

16 It should be said that Hinduism is also often regarded as monotheistic, with Siva, Vishnu and Brahma being manifestations of one God.

17 Samuel Ngun Ling, 'Interfaith dialogue: theological explorations from Myanmar context' [sic], *Ecumenical Resources for Dialogue*, ed. Samuel Ngun Ling (JRC Dialogue Series, 2004).

18 Positive Muslims, *HIV, AIDS and Islam: Reflections based on compassion, responsibility and justice*, 2004, p 26.

19 'I was sick and you took care of me, I was in prison and you visited me'. Then the righteous will answer him... 'when was it that we saw you sick or in prison and visited you?' And the king will answer them, 'Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me.'

Cultural injustice and the role of religious leaders: denial, discrimination and stigmatisation

20 'Universal Access to Health for the Marginalized', Catholic Association of India Annual Report 2003-4, p 22.

21 UNAIDS, *India: HIV and AIDS-related Discrimination, Stigmatization and Denial*, Geneva, 2001, p 16.

22 *Ibid*, p 42.

Bringing life: with compassion and openness

23 Information based on (unpublished) UNAIDS analysis of vulnerable groups in the country. Other vulnerable groups include rickshaw pullers, truck drivers, sex workers and men who have sex with men.

24 Positive Muslims, *HIV, AIDS and Islam*, p 36, 37.

25 Agrippa G. Khathide, 'Teaching and talking about our sexuality: A means of combating HIV/AIDS' in Musa W Dube (ed), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*, World Council of Churches, 2003, p 3.

26 'Tips for Care Givers', in *SCAN*, the quarterly newsletter of CANA (Christian AIDS/HIV National Alliance), Delhi, December 2005.

27 Note 24 above, p 32.

Challenges for faiths

28 Produced by the Christian Conference of Asia, the Hong Kong Christian Council and St John's Cathedral HIV Education Centre, Hong Kong.

29 Private communication.

30 Farid Esack, *On Being a Muslim*, p 12 (quoted in *HIV, AIDS and Islam*).

31 Personal communication.

32 'HIV/AIDS – The Human Dimension: Voices from the Hindu world', Shanti Ashram/World Conference of Religion and Peace (New York), undated.

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