

Islam and AIDS



Islam and AIDS

Between scorn, pity
and justice

EDITED BY
FARID ESACK AND SARAH CHIDDY



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For
Shukria in Lahore,
Faghmeda in Cape Town,
and
Waheedah in Philadelphia



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FOREWORD

*Peter Piot, Executive Director of UNAIDS and
Under Secretary-General of the United Nations*

This anthology, *Islam and AIDS – Between Scorn, Pity and Justice*, is a significant contribution to the discussion on religion and AIDS in general and, more specifically, the discussion on Islam and Muslims and AIDS. It is part of a welcome trend among religious communities to reflect on the challenges presented by the AIDS epidemic and provide support to people living with HIV.

As the editors stress, this collection contains a wide variety of opinions. Each contributor is alert to the enormous intellectual, moral and theological challenges arising from this epidemic.

At UNAIDS we believe in the important role that religious communities and faith-based organizations have to play in responding to AIDS, and have a long and valued relationship with Positive Muslims, the initiators of this publication. There are five main reasons for this.

First, religion continues to play a pivotal role in many societies, and engagement with clergy and religious institutions is therefore vital to the work of those seeking to address significant social issues. The role of religion is particularly important when societies are confronted with new, “unfathomable” events. Often, people look to religious leaders to explain what is happening, and to provide a framework for dealing with it.

Second, religious institutions such as temples, mosques, and churches are traditionally respected as educators. In many parts of the world, religious leaders have played a key leadership role in their communities for centuries, connecting with their constituents once a week – a feat rarely attained by activists, academics, or politicians.

Third, AIDS presents a number of serious challenges regarding issues such as disease as divine retribution or grace, taboos, silence

about sin, sex and sexuality. Religious thinkers and theologians need to ask what this means for their traditions, and what their traditions mean for AIDS.

Fourth, some forty percent of all AIDS care is provided by religious groups.

Fifth, many of those affected by AIDS have strong religious beliefs. Many people living with HIV report that the first thought that occurred to them was to run to God and demand to know “what sin they have committed.” Others find much comfort and support in their religious belief and faith community

At UNAIDS, we try to bring science – including social and political science – together with religion, to strengthen and deepen our collective response to the epidemic. In April 2008 we held a consultation in Geneva with faith-based partners to reach new levels of effectiveness in addressing AIDS. At a regional and country level we have approximately sixty Partnership Officers working with regional and national interfaith networks, religious leaders, and non-governmental organizations with religious affiliations delivering AIDS services – often in remote rural communities.

One important focus of all our work is to eliminate the prejudice, stigmatization, and discrimination that still prevail in too many societies against people living with HIV.

Another is to take concrete action against the injustices and inequalities that fuel the spread of AIDS. It is shameful to discriminate against gay men, migrants, ethnic minorities, injection drug users, sex workers – people who often end up pushed out to the margins of mainstream society and therefore at higher risk of HIV. It is shocking that society continues to tolerate the suppression of women, and to do so little to protect them from violence – in the street and in the home.

Unless we get better at dealing with social vulnerability, and make it possible for these people to get the support they need, we will be hard-pushed to make lasting progress towards universal access to HIV prevention, treatment, care, and support. This is a theme that underpins all we do.

Religious leaders and institutions have, since the earliest days of the epidemic, played a remarkable role in providing care, services, and education for those who have been affected by it. The challenge now is to deepen this concern, to come up with effective, open, and non-judgmental responses.

One of the major themes that is evident from this collection of articles is that AIDS is not just an emergency, it is an issue that will be with us for decades to come, and something on which all sectors of society need to take action if we are to make any inroads on the epidemic. United Nations Secretary-General Ban-Ki Moon recently addressed some religious leaders, describing the continuing AIDS epidemic as a “moral scar on our conscience” and speaking of our shared “sacred duty” to take action. I hope this anthology will encourage more people to fulfil this duty, and heal that “moral scar.”



INTRODUCTION

Saleem¹ of Rylands in Cape Town was certified HIV positive with full blown AIDS. While still in the care of Grootte Schuur Hospital, his parents, two brothers and a sister rejected him. He was told not to return home, and to find his own way. The hospital could do no more for Saleem. He was taken in and cared for by a hospice run by non-Muslim social workers. Repeated attempts by the social workers and Saleem to contact his family led to no response. Saleem was so disgusted and felt so dejected by his Muslim family's attitude that he decided to renounce the Islamic faith. He drew up a will in which he stated that he wished to have his body cremated. By the time his parents reached Goodall & Williams cremation centre in Maitland to claim his body, they were offered Saleem's ashes in an urn. His parents refused to pay for the urn, so the ashes were transferred into a paper bag. His Muslim parents did not know what to do with the paper bag of ashes. Saleem was only twenty-nine years of age.

(Ahmed, 2000, p. 1)

The above story was told in an early *Positive Muslims* (est. 2000) publication by Abdul Kayum Ahmed, one of the organization's co-founders. It was – and regrettably, remains – a not atypical story, as is evident from a number of the articles in this volume. Mercifully, it is a response to *Persons Living with HIV (PLWHIV)* that is becoming less and less frequent among Muslims. This, in turn, is an indication both of a growing trend towards greater compassion and of more obvious indications of the reality of HIV in Muslim communities and countries.

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NOT US . . .

Like many others, Muslim societies, and those approaching the pandemic as Muslims, have responded to AIDS in a clearly discernable pattern: first ignorance and denial, then scorn and pity. For most of the decade after the virus was first detected in 1983, the vast majority of Muslims were simply unaware of the pandemic. More recently, a greater recognition of the prevalence of HIV among Muslims has been slowly spreading through many parts of the Muslim world. As information about the reality of AIDS and people living with it becomes more common, Muslims often respond by suggesting that it is still not “our problem.” A few years ago, at a time when HIV was already becoming common in South Africa, an imam (religious leader), upon being asked what he knew about AIDS, replied “I once saw a story about it on TV when that actor [Rock Hudson] in Hollywood died of AIDS.” The underlying message was that “it’s on TV, not in real life; it was an actor, not an ordinary person; it was in Hollywood, not here.” When the reality of the pandemic creeps closer to Muslims, the parameters of denial are pushed even further back: “It happens, yes, but to others, in other societies” (in “America” or “Africa”). When Muslims are actually living in America, the suggestion is often that it happens in “White America,” “homosexual America,” or to the “African-Americans” – certainly not *us*. When it becomes evident that AIDS actually *is* prevalent in these Muslim communities or countries, refuge is sought by confining it to “core groups” – an imagined sub-strata of society who are not “really Muslim”: “immoral people”, sex workers, drug addicts, prisoners, homosexuals, immigrants, migrant laborers, etc.

IT *IS* WITH US!

Before continuing with our reflections on the way Muslims have responded to the pandemic, let us make a few observations about HIV prevalence among Muslims. When looking at reported prevalence rates for predominantly Muslim countries, and the problems connected with reporting, we are wary of reductive explanations which attribute everything to the religious commitment of the majority. These countries are quite often at a particular place on a

development trajectory, which means that while being Muslim may be a factor in how they are reporting or responding to the pandemic, an equally valid factor may be their socio-economic position. While there have been significant recent improvements, epidemiological surveillance in many Muslim countries remains limited (Obermeyer, 2006) and several Muslim countries, including Saudi Arabia, Kuwait, the United Arab Emirates, and Qatar, have no official statistics on HIV prevalence.

The Middle East and North Africa reported small numbers for HIV, with most infections occurring in men and in urban areas. While unprotected paid sex is a key factor in the HIV epidemics in most of the Muslim world, exposure to contaminated drug injecting equipment is the main route of transmissions in countries such as Afghanistan, Iran, Libya, Algeria, Morocco, Pakistan, and Syria (UNAIDS, 2007, 35). The country in South-East Asia with the fastest growing HIV epidemic is Indonesia – also the country with the largest Muslim population in the world – where most infections are due to the use of contaminated injecting equipment, unprotected paid sex, and, to a lesser extent, unprotected sex between men (ibid.). Similarly, HIV numbers are rising in the Muslim countries of central Asia such as Azerbaijan, Kazakhstan, Kyrgyzstan, and Tajikistan. Uzbekistan now has the largest epidemic in Central Asia, and, according to UNAIDS, “the epidemic is likely to continue to grow, given the high level of injecting drug use and sex with non-regular partners” (ibid.).

Relatively few studies have been undertaken to ascertain HIV prevalence amongst Muslims as a religious group, or on the definitive impact of Islam as a religion on sexual conduct that could increase or lessen susceptibility. What is also largely unexplored is the relationship between Muslim identity and HIV prevalence. To date, the most significant study is the much cited 2004 survey by Peter B. Gray of published journal articles containing data on HIV prevalence and religious affiliation in East Africa. This survey showed that six out of seven such studies indicated a negative relationship between HIV seropositivity and being Muslim (Gray, 2004). In Gray’s study this relatively lower Muslim HIV seropositivity is attributed to the following factors: a) religious constraints on extra-marital sexual behavior, including homosexual sex; b) male circumcision; c) the Islamic prohibition on alcohol consumption; and d) personal hygiene (ibid., 1752).

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BUT ONLY THE SINFUL ONES AMONG US . . .

Early ignorance of the modes of HIV transmission, its initial identification with homosexual activity, and its immediate association with death contributed substantially to the anxiety with which people responded to the pandemic and its modes of transmission. A literature scan covering both the Internet and written sources clearly indicates that the dominant, while not exclusive, Muslim voices that have emerged in response to the AIDS pandemic argue that the virus is a form of God's vengeance on a sexually perverse and/or immoral group of people as punishment for their sins (Desai, 2004). While the language of these voices is peculiarly Muslim, and the responses – usually offered as “cures” or “solutions” – are framed in Islamic terms, this response is not unlike the dominant voices from other religious traditions.

A relatively early and insightful survey of some of the prominent Islamic positions on HIV and AIDS is rendered in Ersilia Francesca's article, “AIDS in Contemporary Islamic Ethical Literature” (2002). The author includes perspectives by diverse Islamic voices such as *Majallat al-Azhar*, the journal of the University of Al-Azhar in Egypt, and the Jami'atul 'Ulama (Council of Religious Scholars) of South Africa. Initially, all that could be found in Islamic literature was a condemnation of AIDS as a disease of homosexuals. One statement, attributed to an anonymous US surgeon, parallels the views of many a religious leader: “We used to hate faggots on an emotional level. Now we have a good reason” (Allen, 2000, xviii). Later, through the 1990s, extra-marital sexual practices – often portrayed as Western based promiscuity – were blamed as the cause of AIDS amongst Muslims. Quite simply, as some put it, “those people deserved to die.” Their admonitions echo the words of Thomas Dekker, who warned his fellow citizens in 1630, when England was gripped by a bubonic plague, “Only this antidote apply: Cease vexing Heaven and cease to die!” (cited in Allen, 2000, xx).

This line of argument has had a devastating impact on Muslims like Saleem, whose story was recounted above, who are living with HIV and fear rejection, isolation, and even violent reactions from their fellow Muslims and families should they reveal their HIV positive status. Stigmatization and judgmentalism place an enormous additional burden on those who are HIV positive, and contribute immensely to the reluctance to disclose one's own positive status.

In the words of Faghmeda Miller, the first South African Muslim to disclose her HIV positive status, “I realised that in most cases it is not the virus that is killing the person but the stigma attached to it and the ignorance of our people” (cited in Heard, 2000).

There has regrettably been no shortage of glib “Islamic” reasons for being judgmental and withholding compassion. Scorn is often transformed into pity when people are in contact with someone who defies their preconceptions of the “usual suspects”: when the person living with HIV emerges as a *hijab*-clad widow, or a young orphan, or at the end of a workshop where they have met, discussed, and had meals with an HIV positive person. Shukria Gul, a Pakistani Muslim woman, speaks of an imam she encountered at a workshop in Peshawar. Exasperated by the sympathetic tone of the discussion on persons living with HIV, he said “All HIV patients should just be shot, that’ll solve the problem.” “On the last day of the workshop,” says Shukria, “when I revealed that I was HIV positive, he stood up and apologised to me for what he’d said” (http://news.bbc.co.uk/2/hi/south_asia/3239330.stm).

BEYOND PITY

While admittedly a much better response than wanting someone dead, pity is hardly an adequate response. It turns the other person into a victim, where we only see his or her HIV positive status. Pity is not about recognizing the fullness of the other person; it is not about how one’s own life can be enriched by the other person; it is not about seeing our own weaknesses and frailty reflected in the other person. It often emerges from, and entrenches, patronizing others and is nearly always a smokescreen for feelings of superiority.

A number of Muslims engaged in HIV intervention work are increasingly speaking of a “theology of compassion” – a term first used in the literature of Positive Muslims in 2000 and, subsequently, in the material of the Malaysian AIDS Council. The most significant indication of the emergence of a compassionate approach as a new “mainstream” voice was the broad consensus reached at a UNDP conference of religious leaders held in Cairo in 2004, and an Islamic Relief Worldwide conference held in Johannesburg in late 2007. The

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Cairo conference, held under the theme of “Compassion in Action,” declared that “illness is one of God’s tests; anyone may be afflicted by it according to God’s sovereign choice. Patients are our brothers and sisters and we stand by them seeking God’s healing for each one of them” (UNDP, 2005, 33). An approach rooted entirely in compassion is, however, not without its inadequacies.

The relationship is still primarily with the “other” as “victim.” This ignores the heart of what makes us human: agency, the ability to take charge of and control our own lives. Thus compassion must simultaneously construct a discourse both of agency and of the rights of HIV positive persons. A mere appeal for mercy and compassion towards the “sick” or “diseased other” is itself dehumanizing, for it simply transforms people from being objects of medical surveillance (classification, examination, treatment, statistics, etc.) into objects of theological surveillance, objects who plead for mercy for the sins of the body, as if the bearing of the disease is a public confession that, once made, will entitle the sufferer to public compassion.

IT’S ALSO ABOUT JUSTICE

A number of essays in this volume argue for an Islamic response to the pandemic that transcends the personalist, individualist approaches and takes seriously socio-economic justice and the systemic roots of disease. While justice is a dimension to the AIDS pandemic that is still struggling to be born in the Muslim world, it is something deeply rooted in Islamic theology and is one of the characteristics of God. Justice is, indeed, one of the reasons why the universe was created: “And God has created the heavens and the earth in truth and [has therefore willed] that every human being shall be recompensed for what he/she has earned and none shall be wronged” (Q. 45:22). Blaming individuals and responding with solely moralistic and behaviorist solutions is relatively easy. Yet doing so ignores the fact that there is more driving this pandemic than simple moral choices. We must also ask how the structures of power in the world today – including the dominant economic system that reduces people to commodities and Black people and women to half the value of White people and men – contribute to the spread of viruses such as HIV. When we see the way in which the HIV pandemic is

laying an entire continent to ruin, we must ask serious questions about the socio-economic conditions that allow the disease to spread and drive women onto the streets to sell their bodies to feed their starving children.

The AIDS crisis is at the extreme edge of a crisis of human health around the world. It will not be stopped or significantly slowed as long as we are controlled by economic systems that put profit and greed ahead of people. A global healthcare system that is truly consistent with a commitment to human rights is one in which the same treatment is available to all regardless of their race, religion, nationality, gender, sexual orientation, or ability to pay. Moreover, no matter what measures are adopted to stop one health crisis, the conditions which breed new crises – unemployment, poor sanitation, poor housing, lack of clean water, malnutrition – are continually being reproduced by economic systems that put profit ahead of people. So long as the obscenity exists whereby a minority can pay for good medical care while others cannot even find clean water, talk of a real solution is impossible. The resources for a global healthcare system that puts human needs first do exist today. The struggle for justice is a struggle to make these resources accessible to all.

A theology of compassion, responsibility, and justice must thus make the connections between compassion on the one hand, and power or, more appropriately, the lack of it, on the other. AIDS (or any other disease) is not an isolated entity; the pandemic is just as much about a crisis and collapse of all social security structures in society as it is about a crisis and collapse of the immune system in the body. In many ways, the actual disease is one tragic symptom of the major injustices in the world, particularly the growing gap between the rich and the poor. The context of our struggle to bring dignity to those living with this condition is part of a larger one where the obscured connections between disease and socio-economic conditions and processes are interrogated. This book seeks to do just that within a framework of Islam and being Muslim.

THE VOICES IN THIS COLLECTION

As with all anthologies, not all of the voices in this volume agree; indeed, some articles directly challenge each other. It is the nature

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of such a seminal project, however, to include such variety, and we hope that our selection manages to give the reader a fuller picture of the existing Muslim responses to HIV and AIDS while privileging a comprehensive response based on responsibility, compassion, and justice. What is unmistakable is that each contributor takes seriously both the severity of the pandemic and the need for Muslim individuals, communities, countries, and their allies to make a real contribution to solving this global problem.

In “Afflicted by God? Muslim Perspectives on Health and Suffering,” **Abdulaziz Sachedina** considers two apparently contradictory understandings of the purpose of suffering found in the Qur’an and the *Sunnah* (Prophet Muhammad’s precedent): the conviction that suffering is a test or an exercise to strengthen humans, and the conviction that suffering is punishment for disbelief or sin. These differing explanations of the theological reasons for suffering lead to conflicting approaches to how humans should respond to affliction. Professor Sachedina argues that contemporary Muslim biomedical ethics have come to accept both divine justice and moral agency, and that this involves a mandate to cure disease and care for the sick. He places the pandemic at the centre of this theological–ethical debate and finds hope in some of the responses of the Islamic medical community.

Malik Badri, one of the earliest and most widely-read Muslim scholars to address the AIDS crisis, exemplifies a widespread Muslim approach to the AIDS pandemic. From the early stages of our conception of this volume it was clear to us that it would be incomplete without a contribution from Professor Badri. His voice is important both because of his seminal work in the field and because we hope that the presence of his article will help the reader navigate other contributors’ disagreements with his positions. The article as it appears here is a synthesis of Badri’s main ideas and arguments, the most striking of which is his assertion that the pandemic is a sign of divine retribution for the (homo)sexual revolution in the West, and that the most effective response to this crisis in Muslim countries is to strengthen Islamic values. These are the claims that Norwegian social anthropologist **Sindre Bangstad** takes up in “AIDS and the Wrath of God.” Dr. Bangstad offers a critique of Badri’s work and reflects on him as a pioneer in the field of the “Islamization of knowledge,” a project that sets itself up in opposition to what it regards as “Western modernity’s infringement on ‘Islam’.”

One of the widely invoked proof-texts for the idea that AIDS is divine retribution for sexual promiscuity is a hadith (prophetic tradition) found in the collection of Ibn Māja, which suggests that when *fāhishah* – often translated as fornication and/or homosexuality – is performed openly, new diseases and epidemics will become “widespread.” In her article “When *Fāhishah* Becomes Widespread: AIDS and the Ibn Māja Hadith,” **Nabilah Siddiquee** calls this interpretation into question, interrogating the implications of divine collective punishment, and suggesting that *fāhishah* may refer to a larger swathe of sins than simply transgressive sex. She offers an interpretation that grounds the hadith in the context of Islamic social justice, arguing that when it is read in full, the hadith offers Muslims a more “productive approach” to the pandemic. This close textual reading leads into **Mohammad Hashim Kamali**’s consideration of what Islamic Law might say about AIDS. While in modernist discourse the details of the Shari‘ah and the maxims of the law may hold less significance, the vast majority of Muslims worldwide look to the Shari‘ah as authoritative on how to answer the difficult questions that face our age. Professor Kamali’s voice speaks clearly to the need to bring AIDS into conversation with normative traditional scholarly Islam.

The next four articles address the crucial topics of Islam, gender, and sexuality. Much attention has been given recently to the “feminization” of the AIDS pandemic. This is traceable both to the fact that women are biologically more susceptible than men to the HI virus, and to the gendered power imbalances that shape women’s lives. **Clara Koh**’s article offers a broad introduction to these realities, highlighting attempts to downplay the impact of AIDS in Muslim societies, the volatile and contested terrain of the Muslim woman’s rights, and the promise and the limitations of Islamic feminism. Koh’s article is followed by a close look at the particular intersection of HIV, AIDS, gender, and patriarchy, and Islam in Malaysia. **Marina Mahathir** draws her expertise both from scholarly sources and from many years as an AIDS activist. She is critical in her evaluations of the world’s obsessive interest in the state of AIDS in the Muslim world, adamant in her conviction that it is “poverty, denial, and social inequalities – not religion per se” that create the necessary conditions for HIV epidemics, and certain in her perspective that the human and patriarchal interpretations of Islamic law as enacted in Malaysia seriously compromise women’s health and ability to protect themselves from the HI virus.

But where are men in this pandemic? **Trad Godsey**'s article faces this question, indicting forms of masculinity that hurt both women and men by glorifying male strength and power. Through an examination of Islamic sources, Godsey suggests that the Prophet Muhammad offers a very different – and mutually liberating – picture of masculinity.

As the articles written by Badri, Bangstad, and Siddiquee all demonstrate, AIDS has been associated with homosexuality in the public imagination since the early days of the pandemic. While it can no longer be argued that gay men and injecting drug users make up the majority of people with HIV worldwide, AIDS still equals homosexuality in many people's minds. Professor **Scott Siraj al-Haqq Kugle** and **Sarah Chiddy** explore the topic of what the Qur'an, *Sunnah*, and Islamic ethics might have to say about male homosexuality in a time of AIDS. Their article provides a sensitive navigation of difficult terrain and argues that any justice-based approach to the pandemic must take seriously the experiences of homosexual Muslims, and that addressing the stigma associated with them is an essential part of being able to speak honestly about the pandemic.

No serious consideration of AIDS can afford to ignore the power of silence and denial. Muslim societies – like many other tradition-based communities – have strong cultural taboos which suggest that speaking about illicit sexual activity is tantamount to condoning it. Drawing from her own scholarly and vocational experience negotiating religious ideals and daily realities in Catholicism, **Kate Henley Long** proposes a theological look at the questions of sin and silence. She considers the work of a performance troupe of Muslims in the Chitral region of Pakistan who, through their music, demystify and comment on some of the political tensions in the region. Long suggests that if storytelling emerges authentically from local communities, it can be an invaluable way to relieve some of the fear, anxiety, and stigma that AIDS evokes in many Muslims.

A thread that ties many of these contributions together is the devastating confluence of poverty with the spread of HIV, which invariably and disproportionately affects the most marginalized people throughout the world. These people often do not have access to basic health care, food and shelter, clean water, and reliable income, and it is in these circumstances that an HIV diagnosis is the most deadly. **Caitlin Yoshiko Buysse** and **Kabir Sanjay Bavikatte** both put the demands of economic justice at the centre of a Muslim response to

the pandemic. Buysse points to the Qur'anic mandates for the right of the poor to wealth, the principle of distributive justice, and the prohibition of usury to suggest a powerful vision of how the Qur'an calls Muslims to respond to poverty. Her critique of the role of the pharmaceutical industry is an excellent introduction to Bavikatte's reflection on the largely economic structures that make certain people far more vulnerable to HIV and its attendant illnesses than others.

The final two articles in this volume turn the conversation to the most prevalent mode of HIV transmission in the Muslim world: injecting drug use. **Chris Byrnes'** article skilfully weaves personal narrative with UN facts and figures, NGO studies, and basic HIV science to speak sensitively about the risk for HIV transmission within drug using communities and beyond. Pointing to studies based out of Pakistan, Iran, Malaysia, Saudi Arabia, and Bangladesh, he dispels the myth that injecting drug use does not take place in Muslim countries, and points to a number of highly successful Muslim community responses.

This book is dedicated to three women on different sides of the globe – Faghmeda Miller in Cape Town, Shukria Gul in Lahore, and Waheedah El-Shabazz in Philadelphia. It is Waheedah's story that guides **Laura McTighe's** compelling treatise on the power that an Islamic theology of liberation can bring to the world of HIV, addiction, and the fight against injustice. McTighe's article draws from and builds on the work of Islamic liberation theologians such as Ali Shari'ati (1933–1977), Asghar Ali Engineer, and Farid Esack, and is the first work to consider Islamic liberation theology seriously in an American context.

The conclusion to this volume is provided in the form of an Afterword by Professor **Kecia Ali**, who reflects on all of the articles and provides some of her own thoughts on the necessity and value of idealism as we struggle as Muslims to figure out responses to the AIDS pandemic.

In putting together this volume we were acutely aware of the very many dimensions to the question of Muslims, Islam, and AIDS. We have tried to cover some of them here and are cognizant of many inadequacies in our attempts – in terms both of the subjects covered and the people covering them. None of the authors, for example, are known to be HIV positive, and while many attempt to speak from the margins, their own privileged position in the academy or as inhabitants of the First World limit their ability to do so with

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authenticity. In the face of the enormous challenges presented to humankind by this pandemic, inadequacy is not a crime. Complacency and indifference are.

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