hand in hand: partnering with spiritual leaders in preventing HIV transmission and eliminating stigma in migrant and refugee communities

Multicultural Sexual Health Network (MSHN) report

produced by
Multicultural Health & Support Service (MHSS)

Centre for Culture, Ethnicity & Health (CEH)

T: +61 3 9418 9929
E: enquiries@ceh.org.au

Report for the 3rd MSHN forum
May 2014

multicultural health & support service

centre for culture, ethnicity & health

Introduction

On 11 March 2014, 45 participants gathered for the 3rd Multicultural Sexual Health Network (MSHN) forum at the Department of Health in Melbourne. The meeting focused on establishing stronger partnerships between service providers and faith-based institutions in addressing HIV risks and stigma in high prevalence migrant and refugee communities.

The forum was informed by the recognition that spiritual leaders have an important role to play in preventing HIV transmission, tackling stigma and providing care to people living with HIV (PLHV). As faith-based institutions are grounded in their communities, spiritual leaders have great influence over their congregations and enjoy credibility among community members. As a result, spiritual leaders and their institutions have an opportunity to make a real difference in addressing HIV/AIDS.

The forum attendees represented a variety of sectors including health, youth, education, settlement, government and faith organisations.

The forum was divided into two sessions:

- Session 1: Presentation by key note speakers
- Session 2: Panel discussion and questions and answers.

Presentations

HIV epidemic in migrant and refugee communities in Victoria by Carol El-Hayek, Manager, Infectious Disease Surveillance, Centre for Population Health, Burnet Institute

Carol presented information about the global prevalence of HIV[1] and the population groups most vulnerable to HIV in Australia.[2] She highlighted the following:

- Globally, approximately 34 million people were living with HIV at the end of 2012. Sub-Saharan Africa and South-East Asia regions have the highest number of PLHV in the world.
- In Australia, there are approximately 29,700 PLHV.
- In 2013, there were 1,250 new HIV diagnoses in Australia: 55% of these people were Australian-born; 42% were born overseas; and 13% did not identify their countries of birth. Of those born overseas, the majority were born in South-East Asia (17%) and sub-Saharan Africa (8%).

---

[1] For Global HIV/AIDS prevalence, see UNAIDS (2013), *Global report: UNAIDS report on the global aids epidemic,* http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf (accessed 24 March 2014)

[2] For more information about HIV/AIDS prevalence in Australia, see The Kirby Institute for Infection and Immunity in Society (2013), *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2012,* http://www.kirby.unsw.edu.au/surveillance/2013-annual-surveillance-report-hiv-viral-hepatitis-stis (accessed 6 May 2013)

- In Australia, HIV is mainly transmitted through male-to-male sex. However, there are differences in HIV transmission across States. For example, in Victoria, men who have sex with men are at the greatest risk of HIV infection, while in Western Australia, both homosexual and heterosexual men are equally vulnerable.
- The rate of HIV infection among indigenous Australians is comparable to that of non-indigenous Australians.
- There are approximately 6,400 people living with HIV in Victoria; 14% of these people live in regional Victoria.
- In Victoria, South-East Asian men and sub-Saharan Africa women are disproportionally affected by HIV. In both groups, the rate of HIV infection is higher than that for the Australia-born population.
- An analysis of some socio-demographic characteristics of HIV positive migrants and refugees who settled in Victoria between 2009 and 2013 showed that:
  - Most PLHV were diagnosed within five years of settlement and during their first HIV test.
  - Almost half of PLHV were South-East Asian men who were having sex with men, and two-thirds of them contracted HIV in Victoria.
  - Half of the South-East Asian men living with HIV (approximately 100 men) were aged between 20 and 29 years, and a quarter of them were diagnosed when tested for immigration purposes.
- Approximately 90% of HIV positive women from sub-Saharan Africa acquired the infection overseas.

Anglican Church response to HIV in multicultural communities in Victoria by Reverend Stephen Delbridge, Anglican Chaplain, Royal Melbourne Hospital and Coordinator of Anglican Health Chaplains

Stephen reported that the involvement of the Anglican Church in addressing HIV/AIDS started in South Africa in the late 1980s. Since then, the Church has been a leader in advocating for ways to prevent HIV transmission and providing care and support to PLHV in Africa. He noted that prior to this involvement, the Church administration condemned PLHV and blamed them for the disease. However, this is no longer the case and the Church leadership acknowledges that *'HIV is not a punishment from God, that our Christian faith compels us to accept that all persons, including those who are living with HIV/AIDS, are made in the image of God, they are children of God, we are called to work with all who are affected by this disease to offer support and compassion, and to bring the Christian message of love, forgiveness and hope to the world'.* Stephen told the forum that the Anglican Church in Melbourne was committed to addressing HIV stigma. He highlighted the 2002 Anglican Church declaration of combatting HIV in Africa as a guiding principle in the Church's efforts to address HIV in Victoria:

> Stigma is the silent killer…We call for an end to stigma and discrimination against those who are HIV [positive] and their families…Silence feeds denial and shame…. Our Church has declared stigma as a sin before God and Human kind. We will uphold

> the dignity and worth of all people as children of God, especially those living with AIDS.[3]

Stephen said that the Anglican Church in Melbourne has approximately 50 congregations of migrant and refugee communities who worship in their first languages every Sunday. He acknowledged that the Church did not have any specific HIV projects and that there were very limited, if any, discussions about HIV in these congregations. However, he emphasised the Church's commitment to addressing HIV in multicultural communities. He noted that it was important for the Church to partner with government and non-government agencies to develop a collective response to addressing HIV/AIDS among Anglicans.

Islamic perspective on HIV prevention by Lina Ayoubi Hospital Chaplaincy Coordinator, Islamic Council of Victoria

Islam does not support promiscuity, drug use and any sexual relationships outside the sanctity of marriage. However, Lina reported that Islam also acknowledges the weakness in human beings and that not all Muslims adhere to the teachings at all times. She noted that '*risky behaviours that may not be allowed by Islam are indeed practised by some, especially the youth…therefore] we need to put [harm reduction] measures in place to help them'*. Importantly, Lina noted that she was so much more aware of HIV in the 1980s due to the many advertisements about the topic at the time. However, she rarely come across such advertisements today. This results in the perception among many people from her community that HIV is no longer an issue in Australia. To address HIV in Muslim communities, Lina encouraged all Muslim leaders to:

- Acknowledge that HIV is affecting the community
- Acquire knowledge about HIV and raise awareness of the disease in the community by incorporating HIV prevention messages in religious teachings
- Actively participate in eliminating HIV stigma, initiate collaborative models of prevention and harm-minimisation, care for PLHV and provide appropriate health care resources and infrastructure to cater for HIV positive Muslims
- Encourage the community to look after the sick and pray for them as commanded in the Islamic traditions. The *Hadith* provides many illustrations by Prophet Mohamed that urge all Muslims to maintain the practice of visiting the sick. This brings blessings not only to the sick person but also to the person visiting.

Lina also urged service providers to be culturally sensitive to the needs of community members, '*to listen to patients and families, to demonstrate sensitivity and empathy, respect [people's] values and beliefs, and remain flexible…to accommodate the needs of [HIV positive Muslims*]'. As an example, she recommended that during Ramadan—a season when all Muslim are required to fast for the whole day—a service provider working with Muslims living with HIV/AIDS should be sensitive to the spiritual needs of these clients and provide medicine before sunrise or after sunset.

[3] For statements on the Anglican Church's commitment to addressing HIV, see Council of Anglican Provinces in Africa (2002), *Statement from CAPA AIDS board meeting*, http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-provinces-in-africa (Accessed 20 March 2014)

Buddhist perspective on HIV prevention by Hojun Futen, Healthcare Chaplaincy Coordinator, Buddhist Council of Victoria

Hojun explained that there is no governing body in Buddhism and no central committee with authority over all temples or priests. There are three main Buddhism sects: *Theravada* (in South Asia and South-East Asia)**,** *Mahayana* (in East Asia) *and Vajrayana* (in Tibet, Bhutan, Mongolia and the Russian republic of Kalmykia) and many schools under each of these sects. Therefore, despite the core tenets that guide Buddhism, some practices vary from one community to another. Nonetheless, these core tenets can play a major role in addressing HIV in the community. For example, Buddhists are to avoid sexual misconduct (such as adultery and rape) because it leads to emotional harm, and to abstain from intoxicants that cloud judgement and cause heedlessness. In addition, the belief in *Karma*—the principle of cause and effect—is a fundamental doctrine in Buddhism. Hojun noted that there are many types of *Karma* (the *karma* that creates, the *karma* that supports, the *karma* that obstructs and the *karma* that destroys), which can be positive or negative: *'the Karma that supports might be supporting a negative outcome for the actions that you have committed. [For example], having unprotected sex once is creating a negative karma. Continuing to [have unprotected sex] is supporting it—[that is], you are increasing the likelihood of catching a sexually transmitted disease or causing harm to another…doing good obstructs the idea of negative karma coming to effect'.* Therefore, he noted, the use of condoms in preventing diseases and pregnancy is supported in Buddhism.

Hojun further noted that wisdom and compassion are two main pillars of Buddhism: *'wisdom presents as compassion; wisdom moves through your hearts and enacts as compassion in the world'.* Therefore, Buddhism challenges people to end the suffering of others. Hojun urged all Buddhists to act with compassion and provide appropriate care and support to those infected with and affected by HIV. He believed that member temples forming the Buddhist Council of Victoria are in a position to lead other temples in preventing HIV and providing care and support to PLHV in Victoria's Asian communities.

Called to serve by Marg Hayes, Coordinator, Catholic HIV/AIDS Ministry

Marg observed that the Catholic Church has been active in providing education and caring for PLHV through the Catholic HIV/AIDS Ministry. However, the ministry has faced a major challenge in reaching out and providing pastoral care and support to newly arrived migrants and refugees who test HIV positive. Therefore, the MSHN forum serves as an important meeting to nurture partnerships that will enable the ministry to reach out to migrant and refugee communities. Marg said that the ministry was fully committed to the UNAIDS strategic vision of 'Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths by 2015'. [4] She believed that Catholic Church leaders should be at the forefront of addressing HIV stigma and upholding the dignity of every person, and to *'get the message across to the people living with HIV that they are people of dignity, that they*

[4] UNAIDS (2010), Getting to zero: 2011–2015 Strategy Joint United Nations Programme on HIV/AIDS, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf (Accessed 15 April 2014)

are people to be respected, they are people who are welcome in our faith communities'. She asserted that church leaders had a responsibility to encourage people to test for HIV and seek treatment, and to create an environment, particularly during pastoral discussions, where people felt comfortable to talk about their HIV status without the fear of being judged. To make churches in Australia a welcoming place to PLHV, Marg suggested leaders could commit themselves to:

- Being aware of and acquiring knowledge about HIV
- Speaking about HIV in their churches
- Speaking to other church leaders about HIV
- Providing awareness about how HIV is transmitted
- Addressing gender inequality and violence against women to curb HIV transmission
- Listening to people living with HIV/AIDS and learning from them
- Speaking to political leaders about HIV
- Advocating for the rights of PLHV.

For more resources on the role of churches in addressing HIV, Marg referred spiritual leaders to the ecumenical advocacy alliance site: http://www.e-alliance.ch/en/s/hivaids/resources/

Podcasts for the forum speakers can be accessed at http://ceh.org.au/our-programs/our_programs_mhss/mshn#forum

Summary of panel discussion and questions and answers session

Participants noted that many community members do not know about HIV or their vulnerability to the disease in Australia and that some community members feel shame and guilt about living with or taking care of PLHV

Spiritual leaders expressed a need to be informed on key health-related issues, specifically Blood Borne Viruses and Sexually Transmitted Infections (BBV/STIs). They also identified the need for support in starting the conversation about these issues and HIV with their respective congregations. They identified an opportunity for them to make a real difference in addressing HIV and the debilitating effects of stigma.

Representatives from the service sector, particularly those in the BBV/STI sector, expressed a need for more partnership initiatives with faith-based institutions in preventing HIV, providing care and support to PLHV and their families, and eliminating HIV/AIDS-related stigma.

Recommendations

During the panel discussion and questions and answers session, participants proposed the following recommendations:

Initiating strategic partnerships

- That MHSS seeks support to work in collaboration with spiritual leaders to address HIV stigma, build capacity and raise awareness
- That faith-based institutions and service providers initiate strategic partnerships to build the capacity of spiritual leaders in preventing HIV transmission, developing policies, addressing HIV stigma and providing care and support to people affected by HIV and PLHV

Social marketing

- That MHSS seeks support to undertake a social marketing strategy to address HIV, BBV/STI prevention in partnership with faith-based institutions

Break the silence around HIV stigma

- That spiritual leaders address HIV stigma in their communities by initiating discussions about HIV/AIDS prevention, encouraging people to go for testing and incorporating the message of hope, compassion, healing and reconciliation in their religious teachings

End discrimination against PLHV

- That spiritual leaders actively involve PLHV in faith activities, such as spiritual outreach and discussions, as a way of affirming and enhancing the dignity of those infected with HIV, and fighting HIV stigma

MHSS acknowledges support from the Victorian Department of Health and the participation of the following organisations/departments at the forum:

1. Anglican Church
2. Alfred Health
3. Australian Red Cross
4. Australian Federation of AIDS Organisations (AFAO)
5. Buddhist Council of Victoria
6. Burnet Institute
7. Catholics AIDS Ministry
8. Deakin University
9. Department of Health
10. HIV CALD Service, Alfred Hospital
11. Islamic Council of Victoria
12. Family Planning Victoria
13. Kurdish Media Representative in Melbourne
14. Living Positive Victoria
15. Macedon Ranges and North Western Melbourne Medicare Local
16. Monash Health
17. Positive Women Victoria
18. St Vincent Health
19. Victoria AIDS council
20. Women's Health West