

Engagement of Muslim Religious Leaders for the Prevention of HIV/STI in Mumbai, India

Introduction

In reproductive health and HIV related research, gender and conservative gender norms play a significant role in reducing married women's ability to negotiate protective behaviors with their partners and to use protective measures in the event that they or their partners are involved in sexual risk behaviors. Changing gender norms to support greater relational equity for women has been shown to reduce HIV risk, and to improve marital relationships. Change and sustaining change in gender norms to endorse greater relational equity is highly challenging, especially in conservative environments. Several approaches focus on women's economic empowerment or individual level interventions to enhance women's coping or negotiation skills, and limited with men. However, there is general agreement that such efforts must be accompanied by broader community wide efforts to support both women and men in their efforts to move toward more positive support of change. Such efforts require building or enhancing community capacity to promote and support gender equity and working with community organizations that have the greatest potential to strengthen existing efforts to embed new efforts in to their organizational practices.

Mosque committee and Imams play an influential role in predominantly Muslim communities. Despite this influence, interventionists are reluctant to engage this sector in HIV prevention because they expect opposition to messages concerning sexuality and sexual health. This attitude reduces the potential impact of prevention programs in predominately Muslim communities. This paper describes a multilevel research and intervention project in which a significant component of community intervention involved the Muslim religious sector.

This paper describes an approach that builds partnerships with Imams for gender norms change designed to reach both women and men simultaneously. The paper describes the approach to gender norms change messages, how to develop appropriate gender norm messages that emphasize male-female equality and support negotiation between husbands and wives, how to work with organizations to embed the messages they have generated in their regular activities, how the messages are delivered, and what the community response has been. Throughout the

paper will describe differences and similarities in message delivery and development for male and female audiences, and intra institutional differences requiring sensitivity of approach in message development and delivery. Communications theories will be used to frame message delivery for maximum impact in the Indian urban context.

Objectives:

- Establishing partnerships with religious sectors of the community for the integration, institutionalization and dissemination messages related to the promotion of gender equality and HIV prevention
- Changing gender norms in the community that support gender equity and sexual risk reduction.
- Reaching of these positive norms to both men and women, especially men and prioritizing women's health and spreading accurate information about it in the community

Assessing Community Capacity for Gender Norms Change

The term “community assessment” is used in a variety of ways to refer to identification of community problems (problem based), to identify community assets (assets based), to identify the resources and capacities available to accept, support and sustain intervention innovations introduced externally or in collaboration with the community, and to determine what resources are available to accept and support evidence-based interventions. In sum, the concept is used to refer to assets that can support an effort, and liabilities or gaps with respect to ability to support the effort. Schensul, Berg and Nair for example, define *community assessment* to include the process of identifying and understanding a community's strengths or assets, problems and liabilities socially and culturally, organizationally, politically, historically and systemically (Kretzman & McKnight, 1993; Van Willigen, 2005). S. Schensul (2009) describes a process of identifying community resources and assets at multiple levels through the use of ethnography, a process endorsed by Aronson et al (2007) and others. Kretzman and McKnight focus on the social/organizational resources that constitute community assets (organizations, institutions). Others such as Yosso (2005), refer to various forms of cultural, linguistic and social capital. Community assessment is conducted with a value set in mind; locating the community

organizations, leaders and cultural resources that can contribute to the development and implementation of health and community development efforts and that could interfere with them or present obstacles to them along the way. Community assessment helps to assess the capacity of the community to engage with, and participate in implementing a project or program. Some degree of collaboration is characteristic of community assessments in part to gain access, and to learn from local experts what constitutes community assets in relation to the project at hand, and in part to gain cooperation or buyin for the planned effort.

Strengthening Community Capacity Building in Health

There is an extensive literature on community capacity building in economic development, health and overall. Here we focus on community capacity for health problem solving, a concept that refers to the ability to develop, partner in, accept, implement and sustain health improvement interventions. Researchers may focus on one or more of these domains. There is general consistency across multiple researchers regarding the critical components of community capacity in general or specifically with respect to health. First, capacity building refers to the behavior of individuals who can take leadership or work in collectives to address and solve a community problem. Second it refers to the ability of community groups to work alone or collectively to address problems (Bopp et al., 1991). Some researchers, Labonte and Laverack, for example, include the presence and ability of “health promotion practitioners” to assist individuals and community groups in health problem solving (2001) groups to work. They also include the “capacity of health organizations governmental or otherwise to assist community groups in this process and to support health promotion practitioners”. In other words, they take a multilevel approach to capacitation, arguing that insiders (community residents and groups), and outsiders (health promotion practitioners and health organizations) must work in concert for effective capacity building and sustainability.

Laverack and Labonte mention nine different areas of community capacity, which have implications for capacity building or strengthening. These include: 1) improving community participation; 2) developing local leadership; 3) building empowering organizational structures; 4) increasing community members’ problem assessment capacities; 5) enhancing community members’ ability to query and criticize; 6) improving community resource mobilization; 7)

strengthening community links to other organizations and people; 8) creating an equitable relationship with outside agents; 9) increasing community control over program management. Other researchers refer to community knowledge, skills, resources and power but don't discuss how these are operationalized (Moya et al. (Assessing local capacity for health intervention Moya L. Alfonsoa,!, Jen Nickelsona, David L. Hogebooma, Jennifer Frenchb,Carol A. Bryanta, Robert J. McDermotta, Julie A. Baldwin)

Chaskin provides a more comprehensive model suggesting moderating and mediating factors that intervene between community capacity (as indicated by sense of community, commitment, ability to solve problems, and access to resources) and desired outcomes. These variable domains include levels of social agency through which community capacity is activated or delivered (individuals, organizations and networks), strategies (leadership and organizational capacity), community decision processes and desired outcomes (2001). Organizational social agency is especially important with respect to going beyond provision of required services to a vision of engagement in problem solving in association with networks of other organizations and issues. The functions of community capacity relate specifically to the accomplishment of specific health outcomes, and forward movement with respect to other related outcomes. Strategies for building community capacity include leadership development, organizational development, community organizing and fostering relationships among organizations. Other domains (such as socioeconomic and other community status characteristics are moderators, influencing the process and desired outcomes. The model is useful identifying exactly where the specific components of an intervention are situated in relation to all of the processes leading to desired outcomes.

The work reported on in this paper focuses on assessing and strengthening community capacity for change in a central area of health promotion for HIV prevention in South Asia: gender equity. It presumes that improving gender equity by promoting improved relational capacity between married men and women at multiple levels will reduce the types of intramarital conflict that lead to sexual risks among married men with consequent negative effects for women. The paper concentrates on work done at the "community level" primarily with groups of Muslim religious organizations from the community that were identified as having potential for collaborating in

the development of intervention components, delivering them, and sustaining them, with positive community level outcomes.

Methods: The data for this paper is drawn from an Indo/US, NIMH-funded project (2007-2013), involving individual counseling and group couples' intervention based in a women's health clinic in the study community. The project included community intervention, recognizing that individual and familial change was not sustainable without engaging religious leader and change in community norms regarding HIV and gender equity. Engagement with Imams began with interviews, sensitization, training and workshops to craft community messages. These messages were delivered by the Imams as a part of the *takrir* (lecture) in *jumma namaz* (each Friday prayer) Imams meetings, community meeting with general population and during key community events where messages conveyed and leaflets were distributed that focused on HIV prevention, sexual risk, improving women's health and decreasing domestic violence. To assess the impact, the content of the *takrir* was recorded and post-*takrir* interviews with men attending the mosque were conducted. To assess the impact on the community and on the Imams, a Gender Equity Scale (GES) was developed and administered to cross-sectional random samples in the community men and women and Imams in 2009, 2010 and 2011.

Assessing and Strengthening Social Agency

The study team had a long history of work in the intervention community starting in 1996. Thus they were familiar with its history, prior AIDS work. In the first phase of the community assessment project staff discussed which sectors might collaborate with the project, and their "reach" in terms of both women and men. To move beyond staff knowledge, the study team conducted in-depth and semi structure interviews and community Norms survey with following individuals. However all data were not used in this paper. More focus was given in involvement of religious sector.

Table No 1

Sr no	Type of data	Respondents
1	Mapping excise of community	Maps 45 Mosque 12 Madersa
2	Kay informant interviews	16 men and women from NGO& community
3	In-depth Interviews	45 married women and 36 married men
4	In-depth Interviews	18 Imams and 6 Alima
5	In-depth Interviews	25 Health Care providers

6	Semi structure interview	60 Men came out from Mosque soon after <i>takrir</i>
7	Community Norm Survey	601 Men & Women 2009,2010, 2011

During the in-depth interview with men issues related to women's health problem, treatment seeking behavior, husband involvement and support in women's treatment, husband involvement in domestic work, marital communication, violence and question related to societal normative statements were asked. While interviewing with NGO staff, questions related to NGO aim, area of work, nature of NGO work activities, willingness to work with us. While interviewing with Imam and Alima, primary focus was to understand how they interacting with group of women and women what issue they discuss and scope and willingness to work with our program. Men attending *takrir* were ask what message they got from Imam related to gender and HIV. Community survey was carried out primarily with 29 normative statements on 4 scale related to gender equality, that will detail in later part.

The Study Community

The study community consists of approximately 500,000 people living in dwellings varying in type, with the majority being *pucca* (permanent structures constructed of concrete, including floor, walls, and roofs) or semi-*pucca* (partly concrete, but supplemented with "found materials" such as corrugated metal sheets or wood, sometimes with a dirt floor). Almost 90% of the dwellings consist of one room with a small portion of the space for cooking and bathing. The poorest residents in the community live in houses of entirely found materials (*katcha*) close to dumps and bogs. About two-thirds of the people are migrants to Mumbai, particularly from impoverished northern Indian states. Most men are daily wage workers, small shopkeepers, vegetable/fruit vendors, tailors, hawkers, auto rickshaw (3-wheel taxi) drivers, truck drivers and low-level civil servants. Average income has been bit increased over the past five years from Rs. 3500 (US\$80) Rs. 4800 (USD100) per month. An increasing number of women (28% as opposed to a previous survey in 2006 of 4%) are involved in generating cash income from work at home and/or outside the home. They receive minimal wages for tasks such as embroidering, sewing, cooking or selling vegetables and fruit. The population is primarily Muslim (80%), Hindu (16%) and a small percentage of Christians and Buddhists. The Islamic religious institutions include over 45 mosques (*masjid*) with large congregations ranging up to 2500. A number of mosques

have *madrassas* where students are taught the Koran as well as secular subjects, and some have schools for *Imams* and *Aalimas*, (male and female religious scholars, respectively) who provide religious instruction to members of the community. Within the community-service sectors, five NGOs work to address issues related to health care, awareness and prevention of HIV/AIDS/STIs, family counseling, primary health care, prevention of tuberculosis, women's empowerment, and adolescent sexual health.

The Rationale for community intervention:

Most of people living or working in study community visit to mosques for *Namaz* (Prayer) and *Takreer* (Religious lecture) on regular basis. Average 500-1000 men attend *Takrir* and *Namaj* (prayer in each Friday in each mosque). In "*Takreer*," Imams of the Mosques are speaking about many social issues including healthy marital relationship, substance abuse, extramarital relationship, dowry divorce etc. To understand about the location of institutions in the community, mosques, a detailed mapping exercise was carried out and all the minor and major entities related to program were mapped.

Approaching the mosques: The research team met with the leadership committees of 45 mosques and explored the potential and their willingness to associate with RISHTA HIV prevention program. We found with some hesitation (avoid to openly talk on sexuality) all the mosques committees permit us to describe more about RISHTA issues with mosque committee and Imams who conducts *Namaj* and *Takrir*. In the next step based on interview guide lines all the Imams (45) were interviewed. Mainly interviews were focused to know more about the pattern of Mosque, ongoing regular activities through mosque, their opinion on RISHTA focal issues and the, demographic detail of men coming in the mosque every day or on particular day such as on Friday/Sunday for *namaz* and *takreer* (Religious preach). Study tried to understand religious sector willingness to associate with RISHTA program, support and promote in spreading positive messages. Most important things was to understand their opinion on HIV, gender equity and equality, women's health and empowerment. We also try to understand what the Koran" says about gender equity and women's empowerment.

Process of developing messages: - All the collected data during formative phase were analyzed and core issues were identified to develop the messages. Initially RISHTA team discussed on the identified issue in the office and decided to share identified issues with Imams. A full day workshop was organized on dated October 14, 2009 in ICRW Mumbai office. A total 34 Imams were participated. Workshop was focus to explain about formative research findings and need of community. Identified concept was them to draft messages separately (in three group). Imams drafted messages and discussion was held to select important messages from the about 40 draft messages. In the next step issues and drafted messages were shared with mosque committee members. Next meeting was held in one of the Mosque in the community on dated November 4, 2009. These imams and 9 committee members were present in this meeting. In this meeting they have suggested some modification in draft messages and identified few appropriate messages from the Islamic perspective that can be shared with community populations.

Capacity building with different groups of Imams:- In next round, study organized four capacity building exercise in November and December 2009. It was organized in four different Mosques. Capacity building was more focused on understanding their opinions about women's issue and gender. It was begun with free list, pile sort and selecting the mode of spreading messages. Few renowned Muslim scholar were invited for this exercise and to bridge the gap between program and religious leader.

Spreading of messages: Takrir is a one of the fixed activity in which a pre-decided messages delivered by Imam on each Friday prior to *Jumma's Namaz*. Imams preach more frequently about social issues like marital relationship, alcohol, violence, extramarital relationship, health, theft, sins and robbery from Islamic point of view. Some of mosques arrange religious programs on some religious occasions and outside. The messages were started disseminating during such religious lecture. Distribution of hand bill is very known and old method for conveying any message/information among the people at individual level. It was seen anything written in Urdu, Muslim population paying special attention to read such things. Therefore messages were printed in Urdu to spread through mosque and Imams. Spreading of messages was continuing over period of two years. One study project staff continues visits one Mosque to another Mosque on each Friday, observe and interview Takrir attendees.

Implications for working with Mosques in a community: In the beginning while meeting with the mosque committees and Imams, it looks somewhat risky and challenging task to motivate them about spreading of any message from Mosque, but over the period of time team found that working with Imam and Mosque is not such a much difficult task. We feel *Devandi* Muslim are quite liberal but *Siya* and *Sunni* were little conservative. *Devbandi* Muslim talks freely about ideal family size and highlighting women's mobility and education; however other two groups were more active in distributing of handbills. In of Mosque committee belonging from *Shiya* was refused cooperate with us.

Alimas: Allimas are the female religious leaders of the Muslim community. They preach Islamic teachings to the Muslim female group. Generally such gatherings are conducted on Fridays known as *Ijtema*. Around 200 women attend the gathering in complete *purdah*. This gathering is to give women knowledge about Islam and its preaching's related to the months and relevant events in Islam. We organized two orientation workshops on dated February 9, 2010 and March 5th, 20120 about reproductive health through WHC doctor, and suggest then to speak with women and suggest then to obtain services of WHC if needed. This Altima's were little helpful in recruitment of cases in RCT. Project female staff attended 6 gathering and distributed handbills about WHC.

Methodology: Evaluation;

In the first step of formative research phase, in-depth interviews were conducted with married women (n=45), married men, 21-40; (n=36), key informants, Imams (n=16) and health service providers (n=27). Informed consent was obtained, and interviewees were debriefed about the purpose of the research. All interviews were conducted one-on-one, open-ended and centered on individual health issues, life situations, and marital/family dynamics affecting sexual and reproductive health and women's empowerment. These questions were designed to elicit open-ended personal narratives that could provide a composite picture about women's roles and expectations in relation to husband and family, and to discover more general community expectations about gender through a comparison of narratives across numerous respondents. Women were interviewed in their homes by female interviewers when husband and children were not present over two to three visits lasting about 1-1.5 hours for each visit. When privacy

could not be maintained, a subsequent visit was scheduled. Interviews with men were conducted by male interviewers in either private or public settings (with privacy) in the community in one or two visits lasting from 1-1.5 hours each, with the more focused aim of identifying knowledge of and involvement in women's health issues. Interviews with healthcare providers took place within their own private clinics in the community, over one visit lasting about 1-1.5 hours in between or over the course of meeting clients. These interviews were designed to elicit providers' diagnostic and treatment practices, as well as their explanatory models of common illnesses faced by women in the community. In-depth interviews with above mention respondents were intended to triangulate information about gender norms and expectations within the community.

In the second step, transcripts from in-depth interviews were analyzed inductively, using a grounded approach involving the progressive abstraction of themes from raw data (Strauss & Corbin, 1990). Interview notes were transcribed by interviewers into English from notes written in Hindi. These translated notes were then entered into the Atlas.ti qualitative data analysis software program (Muhr, 2004). The data were coded independently and cross-checked by the authors and other collaborators. The goal of this analysis, from the perspective of instrument development, was to identify expectations related to gender embedded in women's personal narratives and life histories. For example, a woman's account of having an argument with her husband over making a trip to the clinic without seeking her husband's permission generated the statement: "A woman should seek permission from her husband before seeking treatment for a health problem." Similarly like "*A wife should eat after her husband and children have had their food*" "*A woman should work only with other women outside of the house,* "*Wife can be beaten up if she does not listen to (obey) her husband*" "*A woman should always cover their head before stepping out of the house*" "*A wife should take permission from the husband when she goes out of house*"

A list of 150 proscriptive statements about gender norms was generated from all interviews, structured around the phrase: "A woman or man should (or should not)..." Statements covered issues related to marital communication, women's and men's roles and expectations regarding sex, health and health-access issues related to beliefs about sex, gender expectations governing

women's mobility and decision-making about personal and family concerns, gender issues in food acquisition and distribution, expectations about women's work within and outside the home, and beliefs about and experiences of spousal violence. The list of statements was reduced by eliminating redundant statements, resulting in 81 proscriptive items that were pilot tested with 101 respondents in the community who reported their agreement with each statement on a four-point Likert scale. The data were analyzed using SPSS v. 18.0 (SPSS, Inc, 2010).

Results from the pilot survey were used to further reduce the questionnaire by eliminating items with little variation across respondents, items with a significant positive skew (thereby leaving no room for positive change), items contributing to lower scale reliability using Cronbach's alpha analysis, and also those items that interviewers in the field reported were confusing to respondents, resulting 29-items of the Gender Equity Scale (GES). All in-depth interviews and the Gender Equity survey were conducted in Hindi by RISHTA field staff.

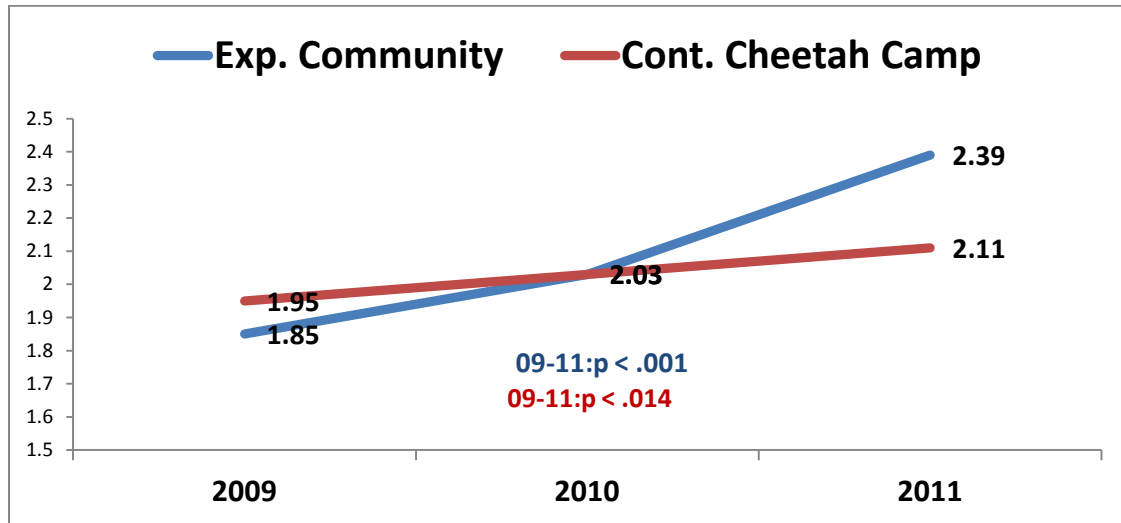
The instrument was then administered to a stratified random sample of men and women (n=601, aged 21-60), with 450 from the study community and 151 from a nearby control community. This sample was gathered by selecting pocket, sub pocket and further every fifth household within geographical sub-areas of the community, taking into account population density and greater or lesser coverage by CBO/NGOs and mosques. In addition, special groups were selected including: individual women participants in the randomized controlled trial (n=845); members of CBOs/NGOs in the study communities (n=35); community health volunteers (CHVs; n=24), *Anganwadi teachers* (n=42); *Imams* (n=48) and *Aalimas* (n=19) as a base line. Data was analyzed and community health volunteers group scored heights rank, it means they found more gender equitable. Imams group found less score, it means Imams group have reported conservative opinion. Rest other group were more likely similar to each other.

Results

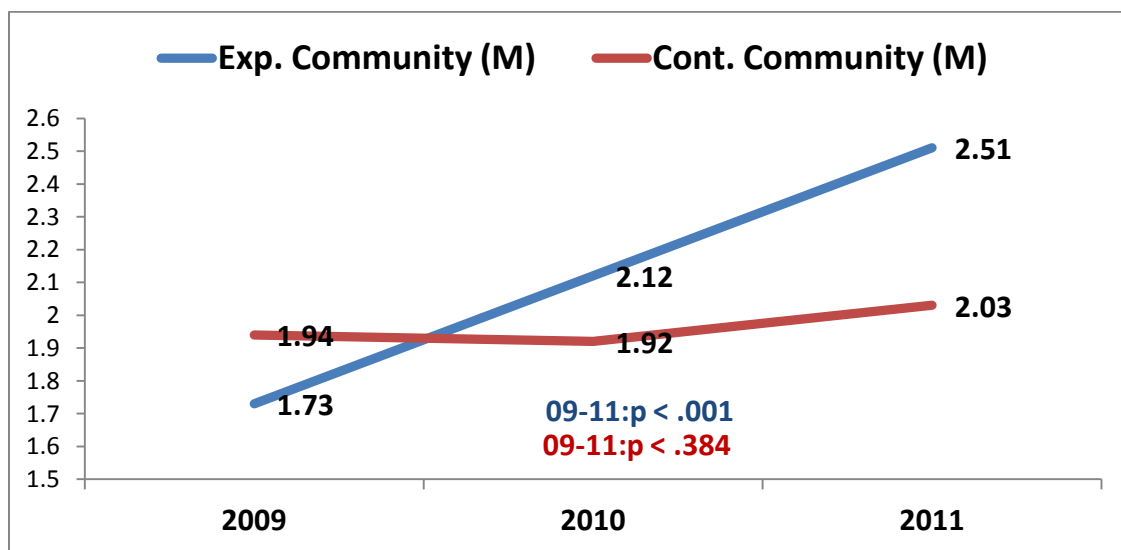
Community-level Intervention Findings

- There was a significantly greater improvement on the gender-equity perceptions in the study (experimental) community, where community education and messaging was

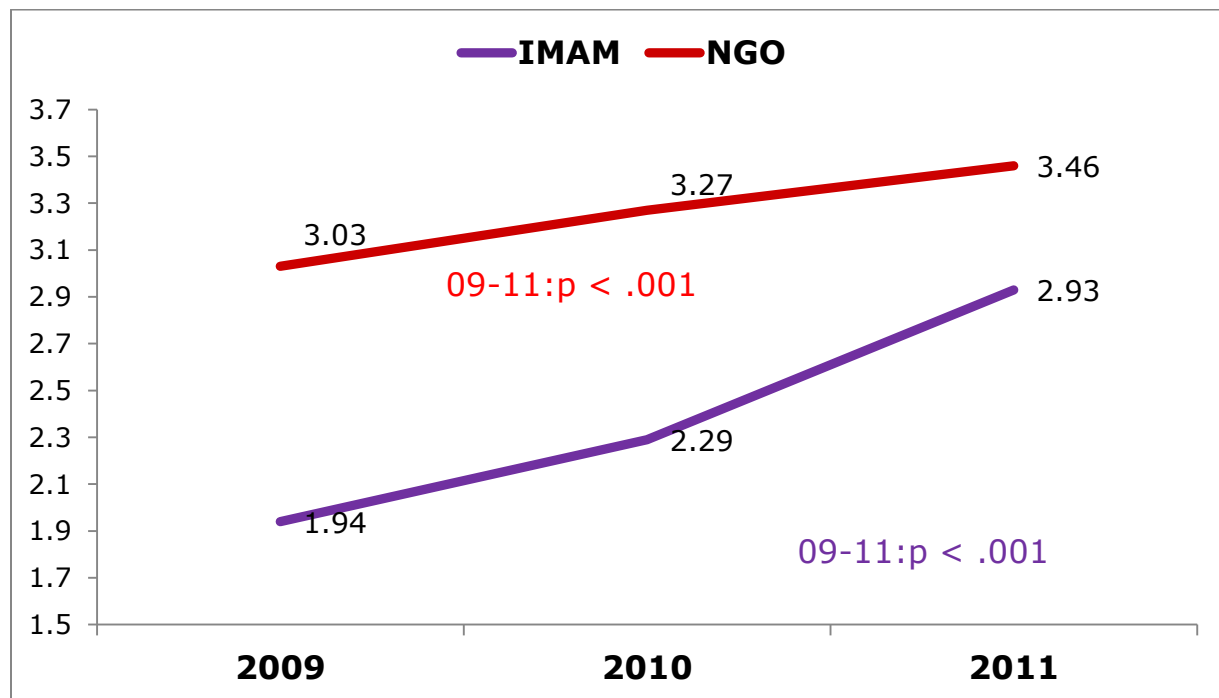
conducted through the Imams than in the control community where there was no intervention



- Much of the improvement in the study community was a function of very significant positive changes in attitudes towards gender equity among men in the study community as compared to men in the control community:



- Women in the study community showed no significant differences in attitudes concerning gender equity as compared to women in the control community.
- The baseline values for Imams in the study community showed this group to be at the lowest level in terms of gender equity. By the third year, and after extensive work by RISHTA with Imams in the study community, they showed significant positive change. NGO staff at baseline (2009) showed the most positive gender attitudes of any group in the study community but also showed significant improvement in the second and third years.



Challenges:-

Although mosques/Imams are a very effective way for reaching of norms in the community, however it was a challenging and difficult job to reach the Imams and convince them to participate in the project activities. As such Muslim community is a highly religious and an adamant community, the few Imams is especially rigid for change. Some of the norms which are

emphasized in the project program at the clinic level by health care provider and counselor are not accepted by the Imams, especially issues related to contraception and family size.

Although all Imams agree on the issue of women's well being, but there is no full consensus among the Imams on the issues like gender equality. Good thing was that most of the Imams agree that women can work outside in the house and support the family. They also emphasize that they should be working with women only, and should not mix among men. Although they were disapproved and openly discuss about extramarital sex in the *Takrir*, But fell reluctant to talk about marital sex.

In the begging there was rigidity on the part of Imams to accept the RISHTA program earlier, as they consider themselves superior and more knowledgeable.

Conclusion:- Imams showed a highly significant positive change ($p < .001$) in gender attitudes over the measurement period. Results in the study (experimental) community, as compared to the control community, showed a highly significant ($p < .001$) positive change for men, and little change for women. Qualitative data on the *takrir* and the post-*takrir* interviews indicated that men had heard and taken seriously the messages of HIV prevention, sexual risk behavior and gender equity. The results of this project component demonstrate that it is necessary and highly productive to involve the Muslim religious sector in HIV/STI prevention with the right approach, especially to reach men in a Muslim community.