

From Churches to Mosques: We Need to Include Every Faith Community in the Fight Against HIV

By Storm Hurwitz

MONTÉ, A SIXTY-TWO-YEAR-OLD gay man and client of GMHC, sat gazing out of the floor-to-ceiling windows overlooking the construction of the new Hudson Yards on Manhattan's West Side and recalled witnessing the tragedies of 9/11. He spoke of his innate desire to help the survivors of the attacks but noted, "I knew they didn't want my blood because I had been [HIV] positive already, and so I wanted to go downtown to help search for people, but they wouldn't even let you below 14th Street. I thought it was such a horror."

On his way home on 9/11, Monté noticed a church flying a rainbow flag, indicating its acceptance of the lesbian, gay, bisexual, and transgender (LGBT) community. The Sunday after 9/11, he returned to that church to attend a service. The experience of attending a church that welcomed him transformed his relationship to faith and God, creating a new desire to explore his spirituality. Shortly thereafter, he began volunteering and ushering at church services.

Tears filled Monté's eyes as he recollected his church's response when he became sick with Pneumocystis Pneumonia (PCP), a serious illness common to those living with HIV and AIDS:

They put me on the prayer list. The pastor came every other day to pray with me, to talk and see how I was. All of a sudden, there was someone from the church with me, and I was floored by that. It made me feel like I had found the right institution or place that was comforting for my life—for the way I live, for the way I am. It made me feel, first of all, special. It made me feel that they saw something in me that needed to be held onto. It made me feel part of a family again. You know I haven't had family since I was twenty-one. But, in the past 15 years, I found the place where I have family.

While Monté's story is positive, it represents a minority response to HIV by faith-based communities. According to the New York City Department of Health and Mental Hygiene (NYC DOHMH), "despite the 2010 National HIV/AIDS Strategy's calls for new partnerships with faith-based institutions, evidence-based models for such partnerships are still lacking." To address this deficit, NYC DOHMH has incorporated faith-based organizations (FBOs) in a funding initiative that will split \$1.8 million between several contractors each year for the next three years. Grantees will be responsible for subcontracting to between 10 and 50 FBOs, each of whom could receive up to \$10,000 annually to provide HIV and Hepatitis C prevention, care, and support, while working to reduce HIV-related stigma.

Monté's story is one of many among GMHC clients that illustrate how faith can be important to people living with HIV and AIDS. Black Americans, particularly men who have sex with men (MSM), are not only disproportionately affected by HIV, but also are more likely to be devout than persons from other racial/ethnic backgrounds. According to a survey by the Pew Research Center, nearly 80 percent of black Americans say religion is "very important" in their lives, compared to 56 percent of all U.S. adults. Nearly half (45 percent) of unaffiliated black Americans say religion is "very important," roughly three times more than the rest of the religiously-unaffiliated population overall. We see from Monté's experience and this available research that faith can play a large role in HIV and AIDS prevention and support services.

To further learn about current and future efforts to incorporate FBOs in the fight against HIV, I attended a New York State Department of Health's AIDS Institute conference in March titled, *Intersection of Faith & Health: Opening the Door to Health and Wellness for Gay Men and MSM*. The conference was limited to the framework of black American communities and

primarily spoke to the role of Christianity in HIV prevention. While this addressed faith issues for many black Americans, it neglected the large population of black Muslims in the U.S. who are also affected by HIV and AIDS.

It's critical that the role of FBOs in HIV prevention is, as the word 'prevention' indicates, preventative—not solely reactive. In order to accomplish this, the NYC DOHMH, in combination with the organizations that are granted funding for its revised faith-based initiative, must take into account the current and changing religious affiliations of black communities in the New York Metropolitan area. If they do not, they risk designing reactionary measures that fail to account for the large and growing population of Muslim black immigrants coming to the U.S. from Africa.

Immigration from Africa is increasing due to global civil unrest, wars, and economic and social struggles. The Migration Policy Institute found that, in 1980, the total U.S. black, African-born population was approximately 64,000. This number rose to 1.1 million by 2009. According to a report prepared for the Priority Africa Network, immigrants from North Africa accounted for at least 65 percent of the growth of the total African immigrant population in the New York metropolitan area.

Given this significant growth, it's important to consider the religious affiliation of these immigrants, particularly in the context of faith-based HIV prevention efforts. According to the Pew Research Forum, the majority of North African countries are home to over 200 times as many Muslims as Christians. With the level of growth our population is experiencing from this part of the world, it's critical that we integrate Islam into our conversation about the role of FBOs in prevention. One challenge we face in this process is that there are little-to-no data on the prevalence of HIV among Muslims in the U.S.

In an article for *The American Muslim*, Asghar Ali Engineer recalled his experience attending a 2007 conference, in Johannesburg, South Africa, on the connection between HIV and Islam. Despite popular opinions to the contrary—largely assumed because of Islamic principles regarding sexual activity and drug use—he stated that by the end of the conference he had realized the extent to which Islam is affected by the HIV pandemic.

Asghar recalled being surprised when some of Muslim women declared at the conference that they were HIV positive and spoke of their difficulties navigating the stigma at the intersection of HIV and Islam. Fortunately, this discussion is increasing. For example, the Joint United Nations Program on

HIV/AIDS (UNAIDS) hosted a Red Gala Dinner at the Fairmont Hotel in Cairo, Egypt—a majority Muslim country—in 2012.

While these steps are encouraging, how does this increase in HIV and AIDS awareness among Muslims apply to the current and future situation for immigrants to the U.S.? We know immigrants face a wide range of issues and stigma when entering this country, and young black MSM that are North African-born and Muslim likely face overlapping stigma based on their immigration status, religion, sexual orientation, and HIV status, both within and outside of their communities. Specifically, the World Health Organization (WHO) reports that young black MSM are less likely to be tested for HIV, disclose their HIV status, and take antiretroviral medications.

Despite the data indicating the level of need for this population, the NYC DOHMH does not seem to be actively addressing the intersections of immigration, Islam, and HIV. During the 2014 fiscal year, through the previous version of its HIV/AIDS Faith-Based Initiative, only four out of 115 of the FBO sub-grantees were Islamic, and only \$27,600 (1.8 percent) of the \$1,500,000 total was granted to those Islamic FBOs.

Of course, these are complex issues that extend beyond a single department of health program, and organizations do exist in the U.S. that are directly combating HIV and AIDS in Muslim communities. For example, the Islamic Health Support HIV/AIDS Network's (I.H.S.A.N.), mission statement reads, "[I.H.S.A.N.] will bring awareness to the social issue of HIV/AIDS within the fold of Islam, offering education, prevention, support programs, and referrals to other agencies. We strive to reduce the rate of HIV infection, get more people tested and aware of their HIV status, [and] educate teens and those affected by the virus directly or indirectly." Their website further outlines its work in "An Islamic Perspective on HIV/AIDS" and "The Social Realization in Islam."

In addition to some Islamic organizations directly combating the HIV and AIDS epidemic, others are calling for a decrease in stigma surrounding LGBT individuals in their faith community. One example is the Islamic Society of North America, the largest U.S.-based Muslim organization, which supported the passage of the Employment Non-Discrimination Act. Extending that milestone to a focus on HIV and AIDS could be the next step. However, government and foundation funders focused on HIV and AIDS also need to take the lead in more actively working with and supporting these Muslim organizations.

The change Monté experienced in his life because of that Christian church flying a rainbow flag is a

strong indicator of how powerful the efforts of FBOs can be. However, Muslim young black MSM are far less likely to find a Mosque flying a rainbow flag, so it's critical for HIV prevention and treatment efforts to extend beyond Christian FBOs and include Islamic organizations.

So how can we go about including the black Muslim community in HIV prevention funding and programming? While there is no easy answer, it's important that we do not let the overwhelming nature of this question block us from attempting to solve it. There are many challenges to overcome in order to address stigma and discrimination related to

immigration, the Islamic faith in the U.S., HIV, and LGBT people. But it's crucial to remember that these challenges are exactly why it's time for this work to begin. Through partnerships with organizations such as I.H.S.A.N. and the Islamic Society of North America, the U.S. can be a leader in involving Muslim communities in the fight to end HIV and AIDS. By encouraging our health departments, funders and foundations to continue providing resources, services, attention, research, and action to organizations of every faith, we can bring the needed awareness, support, and change to every community required to end this epidemic. ■



Making the Cut: Should Neonatal Male Circumcision be a Recommended HIV-Prevention Tool in the United States?

By Jordan Sang

FOR SOME, it's a revered and ancient expression of religious faith and tradition. Others believe it's not only medically unnecessary, but also a violation of human rights. In the U.S., debate over neonatal (newborn) male circumcision is more likely to happen among bloggers or at the doctor's office than among the body politic. That changed in December 2014 when the U.S. Centers for Disease Control and Prevention (CDC) published their first-ever recommendations on male circumcision and the prevention of HIV and other sexually-transmitted infections.

While the recommendations stop short of telling all parents to circumcise their newborn sons, the report states: "It is essential to maximize the impact of all available prevention options," and that "male circumcision is one strategy that may help reduce the continued spread of HIV in the U.S." And according to Dr. Jonathan Mermin, Director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB prevention, "The scientific evidence is clear that the benefits [of circumcision] outweigh the risks."

Recent studies from Sub-Saharan Africa do support circumcision as an effective HIV-prevention tool among heterosexual men, and the CDC cites them to support its recommendation that all uncircumcised males and parents and guardians of newborn males in the U.S. should be counseled by doctors on the benefits and risks of circumcision, including reduced risk of HIV infection.

The fight against HIV must include all available, scientifically-supported prevention options, such as

condoms and pre- and post-exposure prophylaxis (PrEP and PEP), as well as Treatment as Prevention, which ensures that those who are HIV-positive reach viral suppression. But does the scientific evidence support routine male circumcision as an HIV-prevention tool in the U.S? What about the research on medical risks and complications associated with circumcision, as well as ethical concerns? It's critical to assess these issues when considering the breadth and potential affects of the CDC's recommendations.

History and Background

Circumcision rates in the U.S. have always fluctuated, but it wasn't until the mid-twentieth century that neonatal male circumcision became common. In the 1940s, approximately 70 percent of male infants in the U.S. were circumcised at birth. That proportion reached 90 percent—the highest historical rate—in the 1970s, and it has since dropped to around 60 percent today. Unlike most countries with high neonatal male circumcision rates, procedures in the U.S. are usually performed for non-religious purposes. Circumcision in the U.S. is culturally accepted and considered the norm, though rates differ by region. The lowest rates in the U.S. are in the West and the highest are in the Midwest and North East. Prevalence is also higher among white males than among Hispanic or black males.

Outside of religious tradition, the biological justification often cited is that a circumcised penis is easier to clean and reduces the risk of collecting

bacteria and viruses under the skin. In fact, the foreskin contains a large number of Langerhans cells, which some research indicates are susceptible to and targeted by HIV. However, research also indicates that Langerhans cells have a protective effect against HIV by secreting Langerin, a natural barrier.

International public health and professional medical associations largely disagree with the CDC's new recommendations. The Canadian Pediatric Society believes that "circumcision of newborns should not be routinely performed," and the British Medical Association reports that "the medical harms or benefits [of circumcision] have not been unequivocally proven." Similarly, the Royal Australian College of Physicians released a statement in 2010 that concluded, "After reviewing the currently available evidence, the RACP believes that the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand." Additionally, the Pediatric Society of New Zealand, Royal Dutch Medical Society, and Central Union for Child Welfare in Finland have issued policy statements opposing routine neonatal male circumcision.

Risks

Circumcision is a generally safe procedure, but it still carries risks that range from extensive scarring to more severe complications that can lead to difficulty urinating, sexual dysfunction, and, in rare cases, even death. These risks are often associated with specific circumcision practices. For example, since 2000, 13 infants in the U.S. have been infected with herpes by rabbis who used their mouth to help stop the bleeding during a *bris* (Jewish circumcision ceremony). Two of the 13 infants suffered brain damage and an additional two died as a result of the infection. In total, there are an estimated 117 annual, neonatal, circumcision-related deaths in the U.S.

Peer-reviewed studies have also linked sexual dysfunction to circumcision. Removing the foreskin also removes thousands of Meissner's Corpuscles, nerve receptors that are touch-sensitive cells also found on the lips and fingertips. The effects of exposing the head of the penis and removing these nerves leads to keratinization and the reduction of sensitivity. In fact, a study of 138 men circumcised as adults assessed sexual pleasure and circumcision. After they were circumcised they reported a 48 percent decrease in masturbatory pleasure and 20 percent reported that their sex life worsened.

Additionally, a Danish study of 5,222 men found that those who were circumcised were more likely to report difficulty achieving orgasm, as well as pain

during intercourse. In the same study, the sexual partners of men who were circumcised reported less fulfillment in their sexual needs than the partners of uncircumcised men. Another study found circumcised men were 4.53 times more likely to report erectile dysfunction and more likely to report using erectile enhancement drugs than those who are uncircumcised.

In addition to these physical risks, a growing body of peer-reviewed research indicates that circumcision may be associated with psychological and neurological health issues. One study found that the stress and pain caused by circumcision can double a boy's risk for developing autism spectrum disorder (ASD). Another study found that the pain and trauma associated with circumcision may also lead to post-traumatic stress disorder (PTSD) and feelings of victimization and sexual assault. Of the 1,577 boys included in that study, 68 percent were circumcised under medical procedures and the remainder were circumcised during a religious ceremony or ritual circumcision. Almost 70 percent of those who experienced ritual circumcision and over 50 percent of those who experienced medical circumcision fulfilled the DSM-IV criteria for a diagnosis of PTSD. Additional psychological health issues associated with circumcision include depression, anxiety, and interpersonal difficulties.

Ethics

Apart from the physical and mental risks and complications that can be caused by circumcision, there are ethical issues associated with the CDC's recommendation specific to neonatal male circumcision because a child is unable to consent. Medical ethicists have framed neonatal circumcision as a human rights and social justice issue that violates the right to bodily integrity. They argue that it's a form of medical violence because it electively removes healthy tissue and can lead to severe, negative health outcomes.

Nonetheless, parental rights and religious freedom for parents are also important to consider. While parents are free to express their religion, does that right extend to circumcision? Do parental rights trump the human rights of the child? According to the Committee on Bioethics of the American Academy of Pediatrics, "Constitutional guarantees of freedom of religion do not permit children to be harmed through religious practices, nor do they allow religion to be a valid legal defense when an individual harms or neglects a child." The 1944 U.S. Supreme Court case, *Prince v. Massachusetts*, also offers precedent regarding parental rights applicable to this debate. The Court

ruled that parental authority is not absolute and can be restricted if it's in the best interest of the child's welfare: "The right to practice religion freely, does not include liberty to expose...a child...to ill health or death."

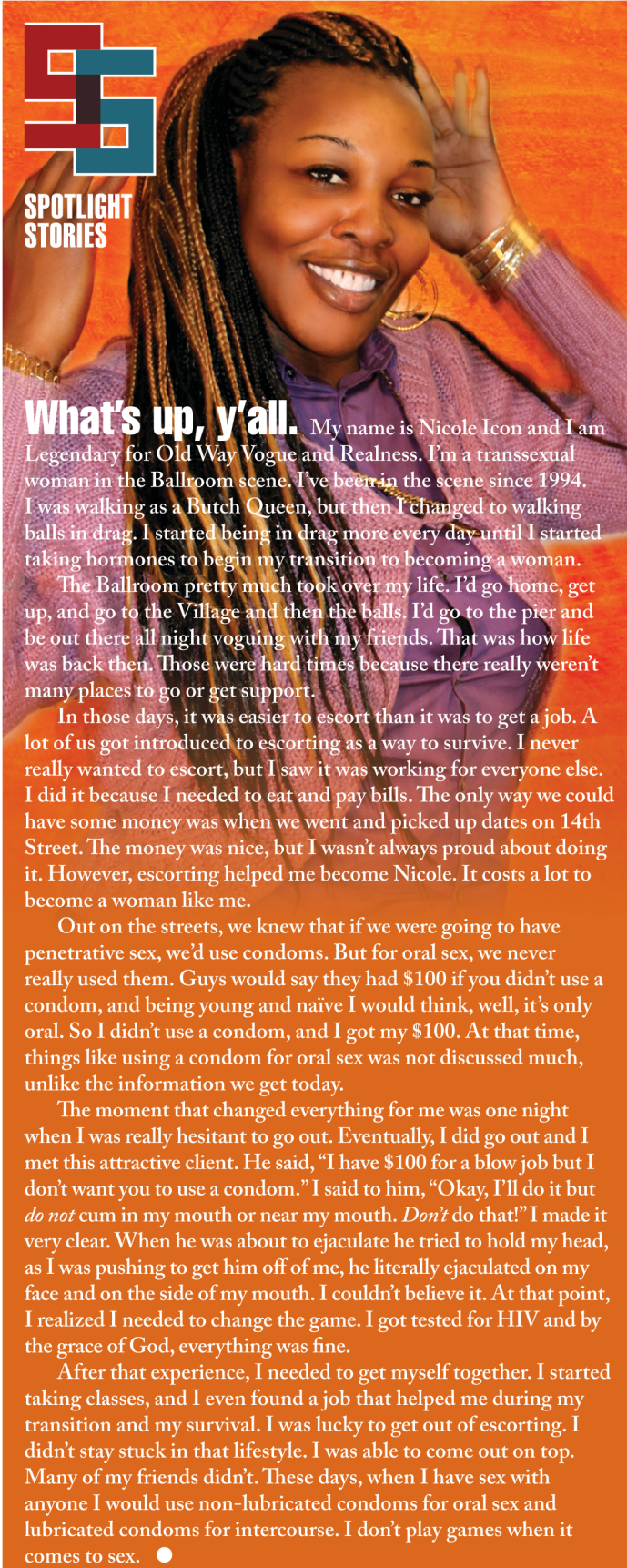
Ethicists also cite the specific articles included in the United Nations Convention on the Rights of the Child and the Universal Declaration of Human Rights when opposing routine neonatal male circumcision, including the right to liberty, security of person, and freedom from torture or cruel, inhuman, or degrading treatment. Accordingly, in 2013, Norway, Sweden, Finland, Greenland, Iceland, and Denmark released a joint statement declaring that "circumcision, performed without a medical indication, on a person who is incapable of giving consent, violates fundamental medical-ethical principles, not least because the procedure is irreversible, painful and may cause serious complications. There are no health-related reasons for circumcising young boys in the Nordic countries." These nations are currently working towards banning all non-medically necessary circumcisions for infants.

Ethical challenges to circumcision are also supported by one of the most common justifications—parents simply want their sons' penises to look like their fathers'. However, cosmetic justification for circumcision loses standing when that logic is applied to other situations. For example, if a father has a different eye color or hair color than his son, would he make his son use colored contacts or dye his hair to match? If a father were missing a toe or had an amputation, would he want his son to undergo surgery to remove a toe or leg to look like him?

Even more challenging is the gap in belief and ethical condemnation between male and female circumcision, often referred to as "female genital mutilation" (FGM). Like male circumcision, FGM has historic, religious, and cultural roots, and it's also justified as a rite of passage and/or necessary for hygiene and social acceptance. Both have also been used as a method for controlling and preventing sexual expression, including masturbation. While FGM is condemned in the U.S., male circumcision is not similarly challenged.

GMHC recently produced a series of "Spotlight Stories" cards featuring gay, lesbian, bisexual, and transgender youth of color talking about their experiences negotiating safer sex. The Spotlight Story to the right has been reformatted to fit this publication.

This project was funded by the New York City Department of Health and Mental Hygiene through a contract with Public Health Solutions.

A graphic titled "SPOTLIGHT STORIES" featuring a portrait of Nicole Icon, a Black woman with long braids, smiling and posing with her hand near her face. The background is a warm orange-red gradient. The text "What's up, y'all." is prominently displayed over the image, followed by a first-person narrative about her experience as a transsexual woman in the Ballroom scene.

SPOTLIGHT STORIES

What's up, y'all. My name is Nicole Icon and I am Legendary for Old Way Vogue and Realness. I'm a transsexual woman in the Ballroom scene. I've been in the scene since 1994. I was walking as a Butch Queen, but then I changed to walking balls in drag. I started being in drag more every day until I started taking hormones to begin my transition to becoming a woman.

The Ballroom pretty much took over my life. I'd go home, get up, and go to the Village and then the balls. I'd go to the pier and be out there all night voguing with my friends. That was how life was back then. Those were hard times because there really weren't many places to go or get support.

In those days, it was easier to escort than it was to get a job. A lot of us got introduced to escorting as a way to survive. I never really wanted to escort, but I saw it was working for everyone else. I did it because I needed to eat and pay bills. The only way we could have some money was when we went and picked up dates on 14th Street. The money was nice, but I wasn't always proud about doing it. However, escorting helped me become Nicole. It costs a lot to become a woman like me.

Out on the streets, we knew that if we were going to have penetrative sex, we'd use condoms. But for oral sex, we never really used them. Guys would say they had \$100 if you didn't use a condom, and being young and naïve I would think, well, it's only oral. So I didn't use a condom, and I got my \$100. At that time, things like using a condom for oral sex was not discussed much, unlike the information we get today.

The moment that changed everything for me was one night when I was really hesitant to go out. Eventually, I did go out and I met this attractive client. He said, "I have \$100 for a blow job but I don't want you to use a condom." I said to him, "Okay, I'll do it but *do not cum* in my mouth or near my mouth. *Don't do that!*" I made it very clear. When he was about to ejaculate he tried to hold my head, as I was pushing to get him off of me, he literally ejaculated on my face and on the side of my mouth. I couldn't believe it. At that point, I realized I needed to change the game. I got tested for HIV and by the grace of God, everything was fine.

After that experience, I needed to get myself together. I started taking classes, and I even found a job that helped me during my transition and my survival. I was lucky to get out of escorting. I didn't stay stuck in that lifestyle. I was able to come out on top. Many of my friends didn't. These days, when I have sex with anyone I would use non-lubricated condoms for oral sex and lubricated condoms for intercourse. I don't play games when it comes to sex. ●

SEROZERO

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HIV Prevention

The use by the CDC of studies from Africa as justification for recommending circumcision as an HIV-prevention tool in the U.S. is comparing apples to oranges. While studies in Sub-Saharan Africa associate circumcision with a 50 to 60 percent reduction in risk for HIV, they don't take into account the differences in the epidemic in the U.S.

In 2012, there were approximately 469,000 new HIV infections in South Africa, compared to approximately 50,000 in the U.S. In South Africa, HIV transmission is primarily spread through heterosexual sexual intercourse, and men who have sex with men (MSM) comprise only 9.2 percent of new infections. By contrast, in the U.S., MSM comprise 63 percent of new infections; only 10 percent of new infections occur through heterosexual sex.

Most importantly, the studies from Africa have only associated circumcision with a reduction in HIV risk among heterosexual men. There is little to no research on the effectiveness of circumcision for MSM or for men who are HIV positive. In the U.K., the epidemic is also concentrated among MSM. Yet, after the release of the African studies the British HIV Association concluded that the benefits of circumcision as a public health intervention are minimal and should not take away resources from interventions that have proven effective.

It's important to note that circumcision alone does not equate to lower rates of HIV, just as lower circumcision rates do not equate to higher rates of HIV. Europe has low circumcision rates in general and, collectively, some of the lowest rates of HIV in the world. Finland, in particular, has a less than 1 percent circumcision rate and approximately 0.1 percent of its adult population is infected with HIV. Comparatively, the U.S. has a 60 percent circumcision rate and approximately 0.5 percent of its adult population is HIV-infected.

It's also important to note that all of the existing peer-reviewed studies on circumcision as an HIV-prevention tool focus on adult males, so it's unclear whether neonatal circumcision guarantees the same protective effect. It's also impossible to determine at birth which infant males will engage in more risky sexual behaviors as adults or what their sexual orientation is. Thus, it's erroneous to believe that all male circumcised children will receive—or will even require—the same purported preventative benefits as adults.

Conclusion

In its recommendations, the CDC admits that “[M]ost new HIV infections in the United States are attributed to male-male sex, a population for whom male circumcision has not been proven to reduce the risk of HIV acquisition.” There are better-proven, less expensive, and less invasive interventions that are more effective at preventing new HIV infections in men—gay or straight—including female and male condoms, Treatment as Prevention, and PrEP and PEP. In fact, studies of PrEP show at least a 90 percent reduction in HIV risk when taken as prescribed, compared to the 50 to 60 percent reduction found by the studies in Africa of men who were circumcised as adults. Compared to circumcision, PrEP is also non-invasive, not permanent, and applicable to heterosexual, gay and bisexual men, and men and women of transgender experience.

The CDC also does not address the growing body of peer-reviewed research on the psychological and neurological health issues, ethical concerns, associated sexual dysfunctions or recommendations of medical professional organizations in Europe regarding neonatal male circumcision. The CDC should revise its recommendations to more directly address these concerns so that physicians and families can be better informed when they decide for future generations of infant boys whether circumcision is a benefit. In the interim, HIV advocates, healthcare specialists, and policy makers may have more of an impact on our collective goal to end this epidemic by focusing on more proven HIV-prevention tools. ■