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HIV prevention and public morality in Pakistan: The secular normativity of development

Abstract

Religious leaders, development experts and state officials in Pakistan were brought together on shared platforms to negotiate a morally-appropriate but scientifically informed response to HIV. Instead of dialogue and negotiation in line with the secular ideal of development, the moral authority of the religious figure compelled others to forefront the conservative in them, thereby undermining the goal of HIV prevention in the country. The everyday practices of state officials and health experts were already infused with Islamic public morality but the inclusion of religious leaders resulted in acceptance of their conservative position on HIV, gender and sexuality. Through the case study of an Inter-Religious Council on HIV, I argue that intervention strategies which specifically involve religious leaders end up enabling systematic marginalization of those who are already at a greater risk HIV.

Keywords: HIV/AIDS; public morality; stigma; religious leaders; health; Pakistan

Colleagues at the National AIDS Control Programme (NACP) of Pakistan, where I carried out fieldwork on the politics of Pakistan’s HIV prevention in 2010-12, would joke about sharing policy platforms – workshops, meetings and conferences – with religious leaders whom they derisively called maulvis1. ‘Keep me away from these maulvis!’, said one, throwing up his arms in exasperation, when another came in our room to complain about how his day had been ruined by a meeting with a group of them. Despite these reservations, religious leaders were ubiquitous in Pakistan’s HIV prevention efforts, in stakeholder meetings, as well as in the space afforded to them in policy documents, press briefings and presentations, and in the gossip, jokes and apprehensions that circulated about them in policy corridors. In 2004, the Pakistani government launched a Religious Leaders Initiative for HIV and AIDS, and registered it as an NGO named as ‘Inter-Religious Council on HIV/AIDS’.

1(singular = maulvi) is an Urdu/Punjabi term for prayer leaders and imams in mosques. Other terms for religious figures in Pakistan include maulana, alama, mufti and ulama, conveying people who are regarded as scholars of considerable learning and authority in matters of religion. Sometimes they are all collectively referred to as maulvis, which in this case would translate as clergy. My analysis of the multivalent role of maulvis in HIV/AIDS policy-making and responses picks up on the more ambivalent figuring of maulvis in popular discourse, where they are both venerated as well as to some extent ridiculed.
Later on, ‘HIV/AIDS’ was dropped from the name and the NGO became known as Inter-Religious Council on Health. The establishment of this NGO by the Pakistani government and donor agencies was an effort to engineer a degree of participation of religious figures in Pakistani civil society organizations for HIV prevention as they had hitherto not concerned themselves with the issue of HIV/AIDS. This move was part of the UNICEF Asia Regional Initiative on Faith Motivated Action on HIV/AIDS Prevention, which was conceived in Katmandu, Nepal, in the early 2000s by transnational public health and development experts (UNICEF 2003). Like the idea of ‘risk groups’ in global HIV prevention (Mahajan 2008), the policy of involving religious leaders in HIV prevention also ‘travelled’ (Mosse 2011) across the globe. Similar initiatives in Senegal, Uganda and Thailand were presented as examples of best practice to be followed and as a justification for setting up this NGO.

In this paper, I argue that health and development projects which seek to involve religious leaders as key stakeholders because of the religious and cultural sensitivity of their interventions, are based on flawed assumption of religious morality emanating solely from these leaders. I contend that the religious morality around HIV prevention in Pakistan was diffused within the society, in the form of the cultural idioms that guide everyday practice of individuals. These individuals included state bureaucrats, health experts, NGOs members, HIV positive people and those who were placed under epidemiological risk groups, as this paper shows. The inclusion of religious leaders in HIV prevention responses was an unhelpful addition, with detrimental effect, as I will argue in the following. The involvement of religious leadership in HIV prevention projects requires the identification of amenable leaders yet their involvement in the project I describe here could not foster rational dialogue or persuade them to work towards a shared vision of HIV prevention. Instead, this intervention ended up narrowing the space for critical deliberation. In this paper, I draw out the inequitable repercussions of involving religious leaders in health-related projects through an account of the Inter-Religious Council on Health – the above mentioned NGO. Contrary to the rationale of this intervention, when religious leaders, health experts and state officials came together to guide HIV prevention, the dynamic did not so much resemble that of a reasoning public in a secular arena of development than that of the moral authority of the religious figure compelling others to forefront the conservative in them.

I argue that projects like these which distinguish between religion and development as separate realms that are either irreconcilably antagonistic, or require planned action to forge some complementarity are based on a flawed secular normativity of development. The
ethnography in the following pages demonstrates that the religious moral element is always already there in the working of health and development projects through conflicting and complex moralities of the individuals who work in them. It shows that rather than bringing conservative religious leaders onboard with the goal of HIV prevention, the moral positions of the individuals involved in this project – its instigators and implementers as well as its subjects – remained grounded in simultaneous religious and secular values. I argue that the involvement of religious leaders in HIV prevention in Pakistan ended up perpetuating the existing discriminatory moral and legal framework, thus enabling systematic marginalization of those who were already at the receiving end of social inequalities. Conservative religious discourses became more entrenched in policy frameworks and practices through the inclusion of religious leaders in HIV policy forums. This case study from Pakistan has wider relevance for similar international health interventions across the world which seek to instrumentalise the religious for achieving health and development goals.

The Inter-Religious Council on Health

So many diseases have arrived here, but if we conform to the Islamic way of life we can avoid them; these include HIV.

A message along these lines, as paraphrased by an NACP colleague who worked closely with the Inter-Religious Council on Health (henceforth ‘Religious Council’), was common in HIV awareness sessions held jointly by the religious leaders and the government’s HIV prevention staff. These sessions which held across Pakistan, focused on HIV being a result of people moving away from religion and the virtues of early age marriage for countering the further spread of the epidemic. Both of these stances are contradictory to the mainstream international development and health discourses, yet the NACP colleagues went along with these being emphasized in those joint awareness sessions. As for the established means of HIV preventions such as condom use, according to one colleague, any mention of condoms in these sessions was seen as a recipe for failure.

My colleagues at the NACP often complained jokingly about having to spend time with religious leaders in HIV awareness and advocacy sessions because they doubted their ability to influence public opinion on matters related to HIV and AIDS. Yet, they maintained this collaboration on the official assumption that these religious leaders had great influence on public opinion and people’s behaviours. This official assumption was partially based on a
UNICEF (2003) working paper on ‘Faith-Motivated Actions on HIV/AIDS Prevention and Care for the Children and Young People in South Asia’ which posited that an unexpected number of religious leaders of different faiths across South Asia had expressed strong desire to learn about HIV prevention and to reach out to those in need of support. This working paper presented Thailand and Uganda, where ‘monks, prelates and priests lead the way’ (p. 24), as great success stories and as models for South Asian countries to follow. The working paper noted that ‘it may not be farfetched to consider how informed knowledge can support rather than stand in the way of honouring the scriptures in the most caring and compassionate of religious traditions’ (p. 22, emphasis added). By ‘informed knowledge’, UNICEF meant ‘scientific information about medical and social causes of AIDS’ (p.24) which would be imparted on selected religious leaders by HIV experts who would then spread this knowledge to common people through the pulpit of their mosques and influence a change in their behaviour. The power of informed knowledge was uncritically assumed in this policy template which was clearly a part of the travelling rationalities of development (Mosse 2011).

By the time I started my fieldwork in 2010, the Religious Council project had run its course but the presence of the religious leaders on HIV prevention policy corridors was still lingering on. The Religious Council had been shut down due to lack of funds and allegations of corruption, yet the NACP continued to provide a desk to a local religious leader in its Islamabad office located within the National Institute of Health to liaise with religious seminaries for holding periodic awareness and advocacy sessions. An expatriate staff member of UNICEF, who was closely linked to setting up and overseeing the Religious Council, told me upon reflection:

Religious leaders don’t take the message forward. They might be [initially] enthusiastic but after that, it doesn’t go anywhere. That was our problem… There were a lot of issues in working with them… We took them to South Africa on an exposure visit, I had to babysit X [a major religious scholar]…. He said to the head of

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2 I undertook ethnographic fieldwork on Pakistan’s HIV response in 2010-12, during which I was based at the National AIDS Control Programme (NACP) in Islamabad as an anthropologist. This gave me intimate access to HIV policy forums and to spaces of interaction among various stakeholders of HIV preventions and AIDS control. I carried out in-depth interviews with NGOs and international health and development agencies staff, health experts, government bureaucrats, freelance consultants, CBO leaders and HIV positive people. Ethical approval for my doctoral fieldwork was given by the School of Oriental and African Studies, at the University of London.
UNICEF in South Africa “well is it not that women get raped because they are not wearing enough clothes?” [gestures disgust while reporting this]… Some of them were great, like there was this guy from Balochistan, he was like “oh, yeah, yeah”. He liked to sit on our child protection life skill committee, but when we would ask him “would you introduce this [life skills] course in your madrassa?” he would say, “oh, yes, no, but, we will start it, but… you know”. So, there was a lot of “yes, yes, yes”, but then going back to their constituency and passing on these massages didn’t happen.

Like this UNICEF official, many of my NACP colleagues shared their frustration with this project. One of them said, ‘in front of us, they [the religious leaders] say that they agree with us, but when they go back to their mosques, madrassa and communities, they say that “these things [talking about HIV] should not happen”’. Revealingly, this colleague had himself strategically limited the mention of condoms in his advocacy sessions with them to a discussion of HIV-positive married couples only. He said he did so to avoid offending his audience who might consider an unqualified mention of condoms as tantamount to the promotion of beyhayai (immorality).

The NACP commissioned a third party evaluation of the Religious Council’s HIV awareness sessions. According to the evaluation report only on a few occasions did these religious leaders publically speak about HIV in their communities, and that even this was done ‘in the context of denunciation of sexual immorality, condemnation of modernity and western civilization, and a call for the implementation of Islamic Shari’ah as the only way out of the “moral morass”’ (NACP 2008: 30). Thus HIV/AIDS had come to be seen as a moral morass. The religious leaders questioned the HIV donors’ intentions for funding condom promotion in the country, sensing it as a western conspiracy against Muslims. They lamented what they saw as a lack of action by the government on shutting down internet clubs, video games and DVD shops which they thought were fahashi kay adday (dens of obscenity) that spread western forms of immorality, and thereby western diseases like HIV/AIDS. One religious scholar, quoted in the evaluation report, suggested that one should simply forget the idea of getting religious leaders to speak about sex in any helpful manner because sex as a theme was unworthy of the sanctity of the mimber (pulpit). The report raised questions on the reinforcement of a self-righteous sexual moralism through the formation of the Religious Council and a lack of a shift in the position of religious leaders regarding HIV related stigma or willingness to talk about it in open and helpful manner. Indeed, if there was a shift, it was
in opposite direction as exemplified by my NACP colleague limiting his discussion of
condoms in the presence of religious leaders.

This shift could also be seen in the content and tone of the messages included in an
HIV/AIDS information kit that was jointly developed by the Religious Council and the
NACP. The joint HIV awareness session mentioned above were based on this kit and were
sponsored by the UNICEF in Pakistan. This information kit was in circulation at the office of
the national and regional AIDS control programmes by the time of my fieldwork (Fig 1). The
booklet contained sections titled as; ‘some facts about sexual perversion and the presence of
HIV/AIDS among the Muslim Ummah’ and ‘unnecessary delay in marriage’ which,
according to the information kit, ‘increases the trend of illegitimate relationships and
homosexuality’ which is ‘totally un-Islamic, and [is] increasing [in Pakistan]’. It claimed that
‘foreign-imported culture and obscene literature [is] affecting our present generation with the
process of modernisation, taking us far beyond our moral and spiritual norms, with the
obvious result’ (NACP and UNICEF 2004:16). Through this booklet one could see the shift
in the NACP’s position away from scientific public health knowledge about HIV/AIDS to
conservative religious discourse on morally-sensitive issues such as same-sex sexual
relations, early age marriages and othering of HIV/AIDS as a western disease.

Organizing religious leaders into a civil society organization as an NGO for HIV prevention
under the name of Inter-Religious Council on HIV/AIDS, giving them access to scientifically
informed knowledge and funds to disseminate that knowledge, and making them a key
stakeholder in Pakistan’s HIV prevention policy did not lead to a change in their outlook on
HIV/AIDS or an effective response to the epidemic. In fact, HIV came to be cast as a moral
abomination, rather than a public health problem, and thus, the effort was unhelpful for HIV
prevention.

**Why religious leaders in HIV prevention?**

Religious leaders have been identified as one of the ‘key stakeholders’ in health-related and
other development projects because of their actual or perceived influence with ordinary
people, and as resourceful gatekeepers in local communities. This practice is driven by the
participatory development approach (Nelson and Wright 1995), which seeks to make
development processes locally relevant and meaningful by drawing local communities into
designing and implementing projects. The US President’s Emergency Plan for AIDS Relief
(PEPFAR) under President George W Bush resulted in a major boost for the involvement of
religious figures in global health initiatives through Faith-Based Organizations. Historically, they have also been used as ‘key stakeholders’ in family planning programmes across South Asia (Varley 2012; Jeffery 2008). They have been involved in similar ways in achieving developmental goals other than those related to health, ranging from conflict resolution and state building (Sisk 2011) to microfinance and women’s empowerment (Faraizi 2015: 44).

Besides their role as cultural brokers for religiously sensitive interventions, religious leaders have served as resource persons or contact points for public health and development agencies to reach very large numbers of their followers. For example, blood banks in Northern India have found useful allies in Hindu gurus who instruct their followers, in the thousands, to help reach blood donation targets (Copeman 2009). Similarly, for campaigns against HIV in India, religious leaders have been used by the government as ‘force multipliers’ because of their sheer numbers and reach in the communities (Mehta and Pramanik 2010). Church-based organizations in a number of African countries have been praised as channels for community support for AIDS patients and for taking care of the sick (see Klaits 2010). At the same time, however, their role in promoting ineffective methods of HIV prevention, such as the common over-emphasis on faithfulness and sexual abstinence while condemning condom use, has been trenchantly criticized (Beckmann et al. 2014).

Feminist scholars in Pakistan have pointed out negative impacts of the use of religion in development projects. For example, a USAID-funded ‘Behind the Veil’ project for women’s empowerment in 2004 aimed at enabling the financial empowerment of ‘home-bound’ women by working with husband-wife teams (USAID 2008). The project encouraged enterprising women to liaise with other women embroiders in their communities, while their husbands were made in-charge of dealing with wholesalers. Thus, husbands became subcontractors who made more money than their wives or the embroiderers, whose earnings remained far below the minimum wage. According to its critics, this project further entrenched patriarchal relations and labour oppression in the name of ‘respecting the veil’ as a matter of cultural and religious sensitivity (Zia 2011). The success of this project was measured in terms of sales projections, while the power relations in the husband-wife partnerships, and the project’s failure to create the conditions for women’s mobility were ignored. Zia calls this project as part of a ‘donor-driven Islam’, which involves projects that amount to ‘rent-a-maulvi’ schemes for contraceptive distribution or gender-related projects. This, she argues, has resulted in the ‘empowerment of a traditionally-discredited local clergy’ and ‘legitimizing conservatism’ (Zia 2011: i).
Why are religious leaders sought after as key stakeholders, if their involvement in these projects has been documented to have such uneven effects on achieving health and development goals? In addressing this question, I draw out the secular problematic of development, by which I mean the notion that development and religion are somehow incompatible because one stems from secular rationality, scientific reason and progress, while the other is based on doctrine, emotion and irrationality and backwardness. For a long time, mainstream development treated religion with hostility or outright rejection, despite the historical link between theology and economics that goes beyond the current liberal and Marxist approaches to economy and society – both of which relegate religion to the illusionary realm (see Bornstein 2005: 3). To redress this presumption of incompatibility between religion and development, and in recognition of religion’s influence over ordinary peoples’ lives, has come a recent emphasis, in international health and development, on carving out a novel positive role for religious leaders in its projects, especially in projects touching on culturally-sensitive issues (see Tomalin 2006).

These attempts to incorporate religion in development are not hostile towards religion, yet they maintain a separation between the two where religion remains the other of development which ought to be tamed and put at its service through selective acts of inclusion, as exemplified by the formation of the Religious Council. Development projects that try to bring religion and development together often anticipate that the religious element should enter the secular development arena for the purpose of re-educating religious figures, through rational debate and persuasion, to make them leave behind their dogmatic beliefs. This is problematic on at least two major counts. The ‘rituals of development’ (Tennekoon 1988), and the recent revering of neoliberal rationality, efficiency, transparency and accountability as if they were ‘articles of faith’ (Pisani 2008), make development ideals arguably little different from religious dogma. Secondly, the view that scientific knowledge, as universal truth, will come to replace traditional beliefs is actually a moral claim which, like scientific knowledge itself, is a product of specific institutional practices and relationships.

This teleological view of scientific rationality triumphing over everything else ignores the ‘moral eddies’ (Pigg and Adams 2005: 2) that are created in the wake of the rationalizing projects of development. As Deneulin and Bano (2009) note, ‘there is no separation between religion and development’ on the ethnographic ground, and as Linden (2007) has argued, the distinction between ‘faith-based’ and ‘secular’ organizations is not straightforward. The idea that religious beliefs would hold people back from development, and that therefore, the
The strategy of involving religious leaders in HIV prevention in Pakistan hoped to engage a certain kind of Islam which can play a positive role in modern society; a ‘civil Islam’ (Hefner 2011) or the Islam that is ‘willing to enter the public sphere for purposes of rational debate with opponents who are to be persuaded rather than coerced’ (Asad 2003, p.183). However, in practice, the Religious Council comprised of a set of religious leaders akin to those Islamists who repackage some of their religious teachings in order to appeal to the modern sensibilities of the ordinary people (cf. Ahmad 2012; White 2011: 27). They used state-sponsored forums to augment their own faith-based agendas, thus legitimizing their conservatism through association with state offices, rather than lending legitimacy to state officials for their interventions for HIV prevention, as I describe below.

The moral landscape of HIV prevention

Pakistani law criminalizes the non-therapeutic use of drugs, sex outside marriage, homosexuality and prostitution (GoP, UNDP, and Team 2015, 52-53). For example, Section 377 of the Pakistan Penal Code, titled ‘Unnatural offences’, punishes anal intercourse or ‘carnal intercourse against the law of nature’ with imprisonment for life. Indeed, it is a conundrum for the Pakistani state that, for the purposes of HIV prevention, it must work with groups of sex workers, people who inject drugs, transgender people and MSM (men who have sex with men) who are actually criminalized by the law as well as ostracized by society. These groups suffer high levels of discrimination and violence, including harassment, intimidation, arrest, incarceration, and the demand of bribes and sexual favours by police authorities (Mayhew et al. 2009).

The Pakistan Penal Code was inherited from the British colonial administration’s Indian Penal Code, which was introduced in 1862 in an attempt by the colonizers to impose Victorian values on Indian polity and society (Misra 2009). Adding further to the severity of these colonial-era laws, General Zia-ul-Huq made extramarital sex (zina) punishable by death under the infamous Hudood Ordinances in 1979, as part of his attempt to Islamize the
Pakistani state and its society during his military dictatorship (Jahangir and Jilani 1990). Distributing condoms to transgendered people, MSM, and unmarried men and women can be construed as a criminal conspiracy for facilitating illegal sex, a charge that is punishable with imprisonment under the penal code section 120B, for aiding and abetting a crime. As one of my colleagues at the NACP said in a lighter mood, alluding to the quandary of the state officials in working with the ‘risk groups’ of HIV, ‘even the government is breaking the law; giving a condom to an MSM is actually breaking the law’.

In this context of dominant Islamic public morality and legal framework, the question for Pakistan’s HIV/AIDS response has been not just how to prevent the contagion of bodies, but also the contamination of the body politic itself. The imperative was of preventing the spread of HIV from the ‘risk groups’ to the ‘general population’: the moral majority. Initially, the immorality associated with HIV was such that Pakistani health policy denied its presence altogether, in this Islamic republic, and made it out to be a foreign disease. When the numbers of HIV positive people increased in 1990s, the government started a media campaign comprising of HIV prevention messages, but these messages were not explicit about the modes of transmission of the virus. People were invited to call a dedicated hotline for more information which received hundreds of calls and letters every day (Lynn 1994). Later on, in early 2000s, an HIV/AIDS Surveillance Project (HASP) was set up with the assistance of the Canadian International Development Agency (CIDA) to identify the ‘risk groups’ of HIV in accordance with international templates. The definitions of the risk groups were ‘guided by broad international classifications, with existing local research merely confirming risky behavior in pre-defined groups rather than providing definitions from inductive research’ (Zaidi 2008, 68). Thus, the international templates for identifying risk groups were used to fix the disease on the already marginalized populations of injecting drug users, transgender people (hijray) and sex workers in large urban centers.

In the offices of the NACP, some of my colleagues privately expressed skepticism about the pinning of HIV risk behaviours to these so-called ‘risk groups’. As one said about the criteria for inclusion in MSM category, ‘things happen in childhood, you know. If MSM includes those who ever had male-to-male sex, then we are all MSM!’ Comments like these were at the same time full of contempt concerning same-sex sexuality, and accepting of its common occurrence throughout society. Indeed, research indicates that, despite the punitive legal framework, there is a tacit acceptance of homosexuality in rural and urban areas of Pakistan.
provided that it is not talked about (De Lind van Wijngaarden, Rani, and Iqbal 2010). The taboo on public discussions of sexuality coexists with the existence of sexually-charged subcultures among men (Walle 2004). However, in the view of the law and the dominant Islamic morality, maintaining same-sex sexual relations is unforgiveable transgression and non-therapeutic drug use is an unacceptable aberration. Furthermore, in the policing of these practices, the focus comes to be only on low-class suspected sex-workers and gender and sexuality non-conforming people such as transgender people or hijray. Difficulties of these marginalized populations have been further compounded by their designation as ‘risk groups’ for HIV. Indeed, the epidemiological gaze has been fixing on them in ways which reduced all hijray to sex workers and opened the gate of typologizing female sex workers into subcategories such as ‘street-based’ and ‘brothel-based’ (Emmanuel et al. 2010, S83) trapping them within a matrix of ever-refined risk categories.

In their dealings with members of the ‘risk groups’, my colleagues at the NACP reiterated the wider social contempt, compounding their othering as social outcasts even though they might privately accept non-conformity to the dominant Islamic morality, and even though the international templates for rights-based HIV prevention involved working in partnership and collaboration with these groups. When HIV positive people and members of the ‘risk groups’ were invited to stakeholder meetings as part of donor-instigated participatory policy dialogue, many colleagues in the government expressed the opinion that these representatives of the ‘risk groups’ were morally suspect, in addition to being ‘illiterate’ and ‘backward’. Their scorn often surfaced in private conversations, or in a guarded ways in official meetings. On one occasion, a consultant at the NACP advised me to interview ‘real PLHIVs’ (People Living with HIV) for my research, instead of what she called the professional ones – i.e. those I met in NGOs and policy circles. Therefore, although these activists were elevated by the donor community to be role models for other HIV positive people, she argued that ‘professional PLHIVs’ never disclosed their real routes of contracting HIV to the public, thus furthering stigma rather than countering it: ‘when these people come here on the official forums, they start everything with “Auzubillah” [in the name of Allah], but we know who these people are, what’s their background and how they acquired HIV’, she said vehemently. Indeed, her own commitment to countering stigma seemed far from secure. She gossiped that a prominent PLHIV leader had been indulging in an alcohol and sex party with younger MSM in a hotel on the eve of an official HIV prevention event at a hill station near
Islamabad. For her, this was scandalous because of the legal and moral prohibition of alcohol consumption and sex between men.

Another colleague told me that the idea of empowering MSM was ‘disgusting’ because they were ‘sinners’. Another snubbed an MSM activist in an official meeting of stakeholders when the activist asked for increasing the level of government support for MSM organizations. He told this activist in front of others: ‘this [sex between men] is against the law of Quran! How can we support you in something that is against Allah Subhanatalla?’3 On another occasion, I learnt that during a high-level regional meeting of South Asian countries, Pakistan had objected to the use of the acronym CABA for ‘Children Affected By AIDS’ in a South Asia HIV prevention strategy document, because, as someone said in the meeting, ‘it sounds too much like Ka’aba [the ‘house of God’, the cube-shaped black-clad building in the Al-Haram mosque in Mecca]’. Pakistani AIDS officials feared the acronym CABA would not go well with the Pakistani public because of the immorality in which HIV was shrouded. The alternative, they suggested, was CHABA, which sounded different to the original acronym.

Thus, the government department charged with HIV prevention was infused with the pervasive Islamic public morality that cast HIV/AIDS as an immoral disease, disavowed HIV positive people and those who were at a higher risk of acquiring it, and treated them with contempt. In the offices of the NACP, my colleagues castigated members of the so-called ‘risk groups’ for their presumed sins, their loose morals and irresponsible behavior. At the same time, when grant proposals for international donors, such as The Global Fund for AIDS, TB and Malaria (GFATM), were prepared through a participatory process under the GFATM-mandated Country Coordination Mechanism, great care was taken by these very same officials, experts and consultants to include ‘participation’, ‘consultation’, and ‘target groups’ as key words. This helped them win grants from international donors. They carefully highlighted phrases like ‘the rights of sexual minorities’ in their proposals and presentations to donors, whilst at the same time, it was clear that many staff at the NACP were unconvinced about accepting these socially marginal individuals as partners in health policymaking and implementation.

3 Translates as ‘May He be praised and exalted’.
HIV/AIDS officials and health experts aligned themselves formally to the discourse of human rights, sexual freedoms, individual liberty, and civil society, but their actions on the ground were pragmatic within the context of dominant Islamic public morality rather than attempting to insist on these ideals. Importantly, the vernacular form of development that they carried out in their working lives allowed them private resentments and compromises; sometime even the most illiberal viewpoints coexisted with official commitment to strengthening liberal values of international health and development. Furthermore, this coexistence was true not only for the health and development experts and state officials, but also for religious leaders. Recall the religious leader from Balochistan who liked to sit on the child protection life skills committee of the government but did not introduce life skills curriculum in his madrassa, according to the UNICEF focal person quoted above. He was not very different from those officials and experts who liked to annotate their project proposals with terms like ‘rights of sexual minorities’ and ‘gender equality’ at the same time as they continued to castigate members of risk groups of HIV and people living with AIDS, back in their offices for not disclosing the real routes of their HIV infection or for being sinners.

The targets of HIV interventions, the members of risk groups themselves, were also not bought solely into the discourse of rights, sexual freedoms, liberal values and civil society, neither were they singularly wedded to other aspects of the secular morality of international development. For example, I interviewed a husband-wife couple who ran a sex workers’ Community Based Organization in the red-light area of Lahore. During the interview they disdainfully talked of an incident in a sex worker’s HIV/AIDS sensitization workshop where a slogan ‘Sex workers Zindabad’ (long-live sex workers) was raised. As the husband uttered these words, narrating the event, the wife, who was herself from the sex workers community, took a deep breath, rolled her eyes and touched her ears, muttering ‘Allah Muuaf Karee’ or ‘Allah forgive us’ to show her disapproval of the idea ‘long-live sex workers’.

**A strategic coming together**

Ethnographic work from other parts of the world has shown the emergence of new Islamic discourses around HIV such as ‘Positive Muslim’ and a ‘Theology of Compassion’ which have provided alternatives to conservative religious values (Svensson 2014). However, these developments have taken place in the context of very different and more dramatic realities of HIV in Southern Africa, where the epidemic has soaked through the social fabric of those
According to Dilger, Burchardt and van Dijk, the existential questions and concern of deep-seated anxieties, desires, hopes and fears posed by the HIV epidemic in Africa are ‘reshaping religious thought and praxis, [producing] new “theologies” of sexuality, the body, and health and healing in various African religious traditions’ (p.373). This is not the case in the majority of Islamic societies outside Africa, including Pakistan, where the epidemic is concentrated in ‘risk groups’ and HIV/AIDS is still seen as the disease of the morally degenerate. The Pakistani context is characterized by explicit legal sanctions against HIV risk behaviours and the ‘risk groups’ in spite of which the HIV response included these socially and legally excluded groups in policy forums and discussions. The experts and officials often modified or subverted the international development guidelines in order to be able to operate in this legal and moral context – vernacular development, as I have called it above. Nonetheless, they also attempted to undercut the dominant morality, making quiet connections to the ‘risk groups’ where possible. This pragmatism and compromise was not only seen among the policy instigators and implementers but also among the policy subjects, the ‘risk groups’ themselves.

Many officials in Pakistan’s HIV/AIDS bureaucracy that I worked with were not convinced that public funds should be spent on organizing morally objectionable individuals – the ‘risk groups’ of HIV – for their empowerment. Some even objected to spending limited resources for health on a disease like HIV/AIDS whereas there were so many other morally unproblematic pressing health needs. Yet, they maintained their collaborations with religious leaders through the Religious Council as well as with MSM and sex workers through their NGOs. Their official and private positions slid into one another in unpredictable ways. Sometimes they did foot-dragging to show their disapproval of sharing policy platforms with maulvis, or they gossiped about the wastefulness of meetings with them, and sometimes, they seized the opportunity to weigh in with their own piety in the presence of religious leaders, or alternatively, their liberal credentials by accepting sexual rights discourse on these forums, to consolidate their position as authentic and reasonable cultural brokers for development projects – as intermediaries capable of fathoming the gap between the distinct moral worlds of the Islamic public and the development project. Religious leaders, on their part, also selectively toned down their religious rhetoric or even emulated their counterparts from the development sector in accepting the discourse of human rights, gender equality and universal humanity in these interactions, in order to make this coming together work for them. But they did not take these messages back to their constituencies – the madrassa, the mosque and the
congregation. Members of risk groups such as MSM and sex workers paid simultaneous lip service to discourse of sexual freedom and gender equality, and religious moral discourse.

Thus, HIV prevention in Pakistan was a strategic coming together and, to an extent, mutual emulation, rather than the reasoning public of normative development where debate and discussion should inevitably lead to the triumph of scientific knowledge and secular rationality. It involved ‘value-centered political processes’ (White 2011, 27) rather than adhering to scientific knowledge as a binding principle or being guided by the ‘forceless force of a better argument’ (Habermas 1970, 137). Far from being ‘shaped’ by the space of civil society in which they were brought together by their international donors, such as the UNICEF, for the common good of society (Piliavsky 2013, 117), these so-called ‘stakeholders’ in Pakistan HIV prevention– health experts, state officials, religious leaders, members of risk groups – used religious and secular ideologies selectively, to evolve responses that may not find a neat fit with the dominant Islamic public morality or the secular morality of development.

Conclusion

The UNICEF (2003) working paper, which I referred to in the beginning, had emphasized the willingness of religious leaders across South Asia to ‘do more’ for HIV prevention. Their enthusiasm ‘encompassed’ a willingness to address controversial issues through dialogues, to seek and receive scientific information about the medical and social causes of AIDS; to accept as children of true faith, people living with HIV/AIDS; and to attack stigma and discrimination’ (UNICEF 2003, 24). When this willingness to address HIV was put to test in Pakistan, rather than dialogue and the advance of scientific rationality and rights-based approaches, we saw the compounding of conservative religious discourses in HIV prevention, as exemplified in the playing-down of HIV prevention messages such as condom promotion, and the acceptance of the religious leaders’ discourse on HIV/AIDS, linking HIV to video games and western modernity, and endorsing early age marriages as the best prevention strategy. Interventions like the Inter-Religious Council on Health may appeal to particular strands of development, such as ‘participatory development’, ‘multi-sectoral approaches’ or ‘religion and development’, with their emphasis on making development culturally and religiously sensitive, but these projects, which come with the backing of UN organizations, provide legitimacy to religious conservatism and end up as a distraction from more relevant
and pressing issues such as the need to reform discriminatory laws, thus further jeopardizing the lives of those who are already at the margins of the Islamic state and the society.

The meeting forums, working groups, and committees that brought state officials and religious leaders together to discuss the best ways to overcome HIV did not turn their participants into a reasoning public in the Habermasian sense as anticipated under development’s secular rationality – and as crystallised here in UNICEF’s hope for ‘creating the space for dialogue, exploring, understanding and respecting the feelings and behaviors of adolescents’ (UNICEF 2003, 24). In fact, HIV came to be regarded more of a moral morass than an epidemic, and, in the presence of religious discourse on shared policy platforms, state officials and members of risk groups were compelled to forefront their own religiosity in order to prove their credentials of ‘good’ Muslims. Sometimes, these forms of self-presentation extended beyond meetings with religious leaders and into other forums, such as discussions with members of high-risk groups and HIV positive individuals – as indicated by the outburst of the AIDS official who said that he would not support MSM because they acted against the laws of Quran. This clearly does not bode well for the HIV prevention in a country where sexual and gender minorities are routinely persecuted (Mayhew et al. 2009) and where local outbreaks of HIV are frequent (Sohail 2019).

It is not just the religious leaders who may uphold conformity with divine models of moral conduct, and the faculties of reasoning, rationality and debate are neither the preserve of secularism, nor do they always lead to secularization. Recall the religious leader quoted in the NACP’s evaluation report who was critical of his own colleagues, and the state official who was angry over the government’s support for MSM organizations for being against the law of the Quran. A morally-appropriate response to HIV/AIDS which meets local approval emerges from the conflicting, complex and situational moralities of individuals rather than those fixed in religion or development. In Pakistan, in the moral configurations following the UNICEF-sponsored initiative for HIV prevention, phrases like ‘sexual perversion’ to describe male-to-male sex were added in the state-endorsed information kit. The information kit also endorsed ‘othering’ of the disease by associating it with foreign cultures and western modernity. Similarly, the discourses of early age marriage as an HIV prevention strategy and linking of condom use exclusively to married HIV-positive husband-wife couples, were accepted by state officials. Thus, the outcomes of this particular configuration for HIV prevention were insensitive to issues of gender equality and sexual rights.
The ancillary role given to religion in the secular normativity of development is thus not only theoretically problematic, it also creates a particular form of polity, reproducing the power of the clergy in the state apparatus. Attempts to engineer a reasoning public in this way maybe symptomatic of a polity that is already religious, but this emphasis on involvement of religious leaders always already *presumes* them as relevant and powerful, and therefore, creates them as such. The banality of these strategies becomes nowhere more obvious than HIV prevention in Pakistan where religious leaders, who had thus far not concerned themselves with HIV, were first coached into understanding HIV as the most stigmatized disease and its association with already socially, morally and legally marginalized ‘high risk’ groups. They were, then, invited to become key stakeholders and given funds to set up an NGO for HIV prevention. Similar involvement of religious leaders happens not just in HIV-related projects, nor only in Muslim majority countries, as noted above. The secular normativity of development erroneously sees religion as development’s other, hence the need to win it over. However, in doing so, development projects engage selectively with groups that are thought to be amenable to the secular morality of development – sometimes delineating these groups from ‘immense plurality’ of a religious tradition (see Mehta and Pramanik 2010). However, unfortunately, even these most amenable of religious leaders use these sponsored forums to legitimize their own conservatism, to the detriment of the most vulnerable sections of society whom these interventions seek to serve.
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120-B. Punishment of criminal conspiracy: (1) Whoever is a party to a criminal conspiracy to commit an offence punishable with death, imprisonment for life or rigorous imprisonment for a term of two years or upwards, shall, where no express provision is made in this Code for the punishment of such a conspiracy, be punished in the same manner as if he had abetted such offence. (2) Whoever is a party to a criminal conspiracy other than a criminal conspiracy to commit an offence punishable as aforesaid shall be punished with imprisonment of either description for a term not exceeding six months, or with fine or with both.