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Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World

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Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World

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FOREWORD

This report by Laura Kelley and Nicholas Eberstadt strikes a very timely and welcome note in two respects.

First, their pioneering research looks at the horribly familiar problem of HIV/AIDS from a unique perspective by focusing on a region and culture which we have not traditionally associated with HIV/AIDS—the Muslim world. What is especially troubling to behold is the reluctance to admit that Muslims engage in exactly those same dangerous behaviors that support the transmission and spread of HIV/AIDS elsewhere. This attitude of denial is deeply rooted in the cultural and religious attitudes of Islam and supported by the many authoritarian regimes that populate the Muslim world. This reluctance even to recognize the problem will only accelerate the epidemic and make it more difficult for the international community to provide meaningful support and treatment. Another sobering implication is that HIV/AIDS is now truly a global crisis in terms of both geography and impact.

Second, the publication of this NBR Special Report coincides with the inaugural Pacific Health Summit to be held in Seattle on June 8–10, 2005. The Summit will bring together the best minds in science, policy, medical practice, public health, and industry to launch a transformation of healthcare focused on the early detection and treatment of disease through emerging science and technologies. To accomplish this important but challenging task, we will need to create fundamentally new levels of organization, collaboration, and teamwork. This effort—whether aimed at infectious diseases such as HIV/AIDS or chronic diseases such as cancer and diabetes—must cut across lines of socioeconomic, culture, religion, and nationality. Our hope is that informed and effective health policies—based on insightful research such as that provided here by Kelley and Eberstadt—can be joined with powerful new science and technologies to shift emphasis toward a preventive model for global healthcare.

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EXECUTIVE SUMMARY

Topic:

This report examines the ever-growing HIV/AIDS crisis in the Muslim world, a heretofore largely unexplored problem that poses potentially serious dangers at the national, regional, and international levels.

Main Arguments:

- Despite the fact that the Muslim world is home to many of the behaviors—such as premarital sex, adultery, prostitution, homosexuality, and intravenous drug use—which have helped spread the HIV virus in other countries and regions around the world, many governments in the Muslim world have been slow to respond to the rapidly spreading disease.
- Two characteristics of the Muslim world in particular are resulting in both a denial of the problem and a lack of pro-active organized efforts for infection control: 1) the fusion of faith and statecraft in many Islamic countries and 2) weak or absent democratic practices.
- Government response has varied: some countries like Iran and Bangladesh have been relatively proactive in admitting to and beginning work on the problem, while others have been much more passive.

Policy Implications:

- The successes of Thailand's aggressive anti-HIV campaign contrasts starkly with the dramatic mushrooming of the crisis brought on by South Africa's reluctance to tackle the problem—a difference which clearly demonstrates the need for countries in the Muslim world to tackle these problems now.
- If leaders continue to ignore the problem, AIDS could debilitate or even destabilize some of these societies by killing large numbers of people in the 15 to 49-year age group, thereby depriving these countries of some of their best, brightest, and most economically productive members.
- One immediate need is to make good faith efforts to survey for infection all commercial sex workers, drug abusers, and those with alternative sexual lifestyles—not simply those who identify themselves as being either infected or possibly infected.
- Sweeping legislative and social changes—such as protecting the legal rights of the infected, promoting safer alternative behaviors among high-risk groups, and spreading the message that being a good Muslim can include taking care of those infected by the disease—would be helpful in combating the spread of HIV. HIV/AIDS education and control efforts could also become part of each citizen's *zakat* (charity duty).
- The international community can also assist by helping poorer countries establish social programs, advising on the public health infrastructure required to support successful treatment, or simply sharing experience in drug treatment and behavioral change efforts—all steps which would be most effective if tailored to local needs.

Introduction

The newest phase of the global AIDS pandemic is the unfolding of the contagion across the great Islamic expanse. In the years immediately ahead, the HIV/AIDS pandemic threatens to wash through the Muslim world. The disease will exact a grim toll in a number of vulnerable populations living within volatile polities—places unlikely to cope well with the significant new social stresses and economic burdens brought on by HIV/AIDS.

The Muslim world consists of more than fifty countries in which forty percent or more of the populace practices some form of Islam. It stretches across three continents and encompasses many hundreds of cultures. From Albania and Turkey in Europe, across countries bordering the Sahara in Northern Africa, and through the Persian Gulf and South Asia to Malaysia and Indonesia in the east, the Muslim world is home to over one billion people [see **Figure I**].

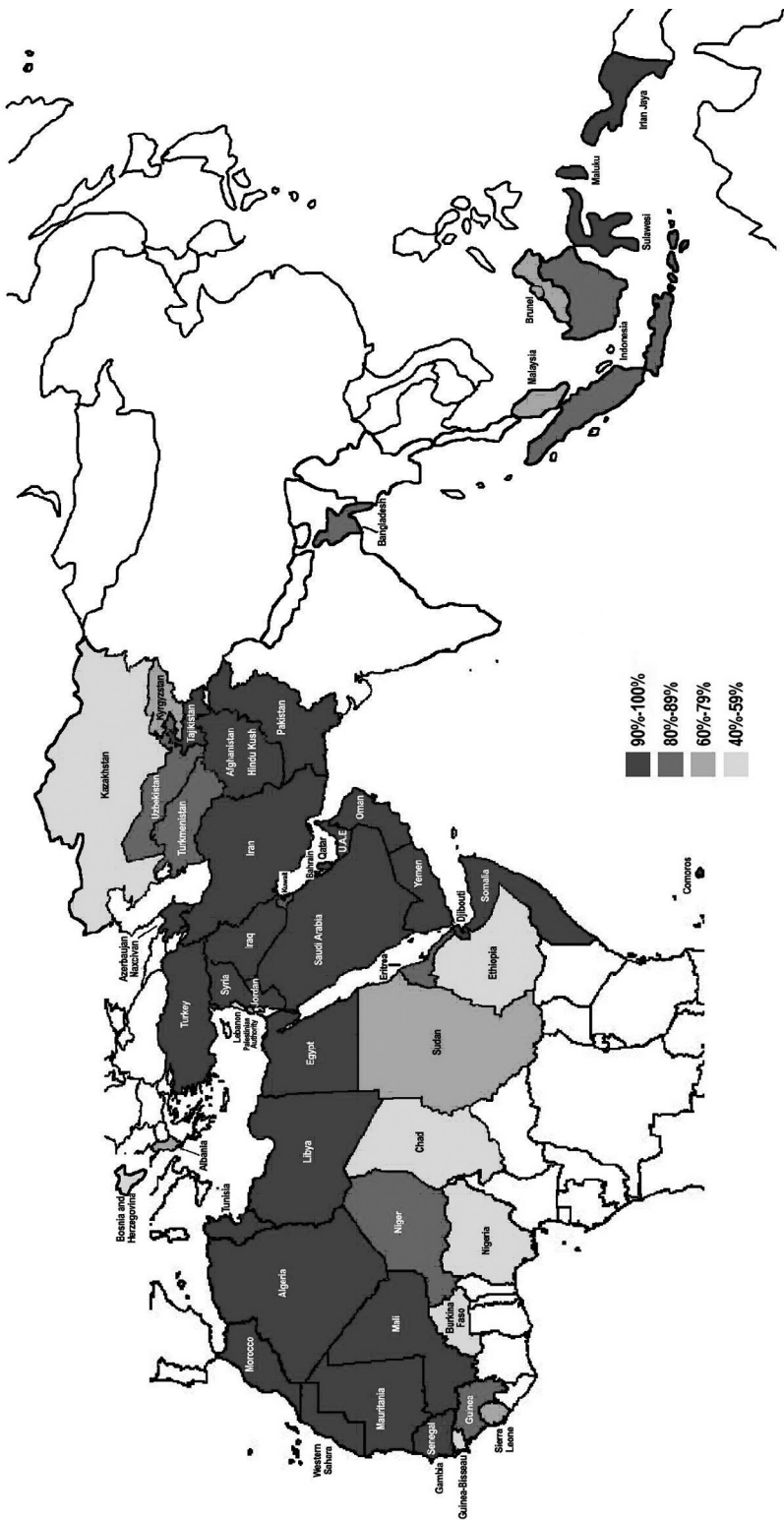
Although no official confederation of states exists, Islamic inhabitants in the Muslim world are bound together as a community of believers called the *umma*. Muslims everywhere are joined by faith in the one god and Muhammad as his prophet. The Qur'an says "The believers are a band of brothers," and opposition movements in some places call themselves "Islamic brotherhoods." Evidence of the influence of the *umma* was seen in the insurgent warriors who came in from all over the Muslim world to defend Islamic Afghanistan from foreign invaders in the 1980s, and again to defend Bosnia-Herzegovina in the 1990s.

While the inhabitants of this *Dar-al Islam*, or House of Islam, share similar religious beliefs, their social and economic backgrounds vary widely. They cannot be cast in the mold of a single ethnic group or a single political system. In recent years, the term "Muslim" has increasingly connoted violent extremism to Western audiences. Of course, most Muslims are not fanatics or revolutionaries seeking to opt out of the world system any more than most are sheiks luxuriating in vast oil wealth. In fact, the majority of Muslims today are non-Arabs, and most live outside the Middle East—nearly 400 hundred million reside in the three countries of Indonesia, Malaysia, and Bangladesh alone.

However, for all the diversity within the Muslim world, there are still common features. First, there is no prescribed separation of faith and state in many Islamic countries today: the Qur'an is consulted not only as a religious text but also often as a source of law, a guide to statecraft, and an arbiter of social behavior. A second feature is the relative absence of firmly rooted democratic systems. Autocratic rule is much more characteristic within the Muslim world than outside it; in many Muslim settings today "democracy" means ascertaining and

Figure I

Percentage of Muslims in Populations of Select Countries



Source: CIA World Fact Book, 2004

applying the will of the people only with the prior approval of the existing (and often non-elected) leadership.

Taken together, these two tendencies—political primacy of the Qur'an and weak or absent democracy—have made many governments in the Muslim world slow to respond to the HIV/AIDS epidemic. Though official responses to the epidemic are limited, the behaviors and general societal ills which help spread the disease are certainly present. Unacknowledged and unchecked, these behaviors have allowed the disease to follow the same pathways it followed in Sub-Saharan Africa. If the leaders of countries in the Muslim world continue to ignore the problems underlying this epidemic, AIDS will destabilize some of these societies by killing large numbers of young people, including some of the best and the brightest members of these countries—men and women between the ages of 15 and 49, people who are bearing the next generation and who are in the most economically productive stage of their lives.

How Many Are Infected?

Already a generation into the worldwide HIV epidemic, it is still impossible to describe with any accuracy the magnitude of the AIDS problem in the Islamic expanse. Officially, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates the total HIV population of North Africa, the Middle East, and predominantly Muslim Asia at nearly one million people today. That number, however, is severely understated because UNAIDS figures depend upon inadequate surveillance data—thus causing a lack of information to be construed as a lack of infection.

Indeed, systematic surveillance of HIV is sorely lacking in most of the Muslim world. Testing is done within limited populations (such as prisoners), on a volunteer basis, or piecemeal (often with foreign funding) by scientists and public health officials who—in hopes of stopping its spread—are trying to comprehend the extent of the epidemic in their own countries. In countries with notoriously poor testing, a low HIV-prevalence is not necessarily indicative of a small public health problem, but is more likely due to inadequate testing and reporting.

Additionally, national HIV statistics (or statistics of any other disease) often do not reflect the extent of the disease in individual cities or towns or amongst select groups of people. For example, national infection rates in Malaysia, as cited in UNAIDS databases, hold national infection rates to be under one percent of adults. However, this statistic masks the fact that more than 36 percent of commercial sex workers in Malaysia's northern Perlis State were al-

ready HIV-positive in 1996.¹ Moreover, the HIV totals published by UNAIDS are numbers negotiated with local governments—thus, leaders of governments that do not want to hear bad news can potentially influence published figures concerning their countries.

Although the first cases of HIV/AIDS were officially recorded in the Muslim world in the mid 1980s,² many countries still have not launched comprehensive surveillance, treatment, and public health education programs designed to prevent further spread of the epidemic. One major reason for this lack of action has been assumptions that premarital sex, adultery, prostitution, homosexuality, and intravenous drug use (IVDU) do not occur in the Muslim world—or happen so infrequently that the risk of the disease gaining a foothold in these countries is low. Throughout the 1980s and much of the 1990s such opinions were promulgated by religious conservatives in predominantly Muslim countries.³ For example, in 1995, Indonesia's Council of Ulemas urged that condoms only be sold to married couples—and then only by prescription from a general practitioner; the belief was that strong religious convictions would stop people from having extramarital sex.⁴ These deeply-held convictions have carried over into the new century. In 2001, for example, a council of Islamic clergy in northern Nigeria urged Muslims to boycott a U.S.-backed seminar on HIV/AIDS, claiming that attendance would increase promiscuity among ordinarily upright believers.⁵ At the governmental level, one official in Pakistan's National AIDS Control Programme recently asserted that the reason HIV prevalence was lower in Pakistan than in other countries was largely due to "our better social and Islamic values."⁶ Moreover, members of the international public health community have not only often seemed inclined to accept such arguments, but on occasion have also espoused them.

Unfortunately, Islamic culture and Muslim beliefs are manifestly not enough to inoculate human populations against the spread of HIV. The tragic trajectory of HIV infection in sub-Saharan Africa—including predominantly Muslim regions of the sub-Sahara—proves this point. In Nigeria's Kano province,

¹ U.S. Census Bureau, "HIV/AIDS Surveillance Database," June 2000.

² M.K. Al-Haddad, B.Z. Baig, and R.A. Ebrahim, "Epidemiology of HIV and AIDS in Bahrain," *J Commun Dis*, 29, no. 4 (December 1997), 321–28; and U.S. Census Bureau, "HIV/AIDS Surveillance Database," 2003.

³ P. Kandela, "Arab Nations: Attitudes to AIDS," *Lancet* 341, no. 8849 (April 3, 1993), 884.

⁴ Reuters, "Indonesia Denies Condom Campaign Promotes Free Sex," August 15, 1995.

⁵ "Tinderbox in Northern Nigeria," *Population Today* 29, no. 2 (February/March 2001), 7.

⁶ "Pakistani Health Care Workers Traveling to India To Learn About HIV/AIDS Treatment," *Kaisernetwork.org*, Daily HIV/AIDS Report, February 11, 2005, http://www.kaisernetwork.org/daily_reports/rep_hiv_recent_rep.cfm?dr_DateTime=02-11-05&show=yes#28101.

for example, adult HIV prevalence was nearing four percent at the same time local *mullahs* (Islamic clergy) were urging a boycott of the HIV/AIDS meeting. Though the HIV epidemic in Muslim Africa should have sounded a wake-up call to other communities in the Islamic expanse, few Islamic authorities north of the Sahara seem to have heard the alarm. Consequently, the denial of risk, coupled with the lack of infection control, is allowing HIV/AIDS to spread from high-risk to lower-risk groups and to make inroads across broad sectors of these societies.

In North African, Middle Eastern, and Asian Muslim societies, as in many other places affected by HIV, the disease first became common among IVDUs, homosexuals, and prostitutes and their clientele before spreading into the wider community. In 1999 14% of intravenous drug users in Bogor, Indonesia were infected,⁷ and 4.5% of people under treatment for a sexually transmitted infection in Qatar were also found to be HIV-positive.⁸ In 2000, twenty percent of female commercial sex workers tested in Dhaka, Bangladesh were found to be HIV-positive.⁹ Most alarmingly perhaps, in that same year one percent of women reporting to a prenatal health clinic in Tamanrasset, Algeria for routine checkups tested HIV-positive.¹⁰ This indicates that HIV has already become established enough in the community to infect married women with no known risk factors.

Response to the Crisis: A Tale of Two (Limited) Successes

Governmental response to this growing crisis has been as varied as the countries and cultures themselves. Some leaders have acknowledged their epidemics and have worked diligently to find ways to control infections; others have, until recently, done little to control HIV/AIDS other than to deport the foreigners they blame for the disease.

Interestingly enough, one of the Muslim governments that seems to be responding to its gathering HIV problem is Iran. Iran's President Khatami and his administration have been very forthcoming in the press in recent years about

⁷ U.S. Census Bureau, "HIV/AIDS Surveillance Database," September 2004.

⁸ P.N. Shrestha, "WER Global Update of AIDS Cases Reported to WHO," WHO/EMRO/ASD, 1999.

⁹ S. Sultana, Fakir Rahman et al., "Concealed Carrier of HIV/AIDS in Bangladesh among the Floating Sex Workers" (paper presented at the Thirteenth International AIDS Conference, Durban, South Africa, July 9–14, 2000).

¹⁰ E.G. Fares et al., "Epidemiological Surveillance of HIV/AIDS in Algeria, North Africa Based on the Sentinel Sero-surveillance Survey" (paper presented at the Fifteenth International AIDS Conference, Bangkok, Thailand, July 11–16, 2003).

both the extent of the epidemic and the urgent need to control further spread of the disease.¹¹ Iran has also passed laws to protect the rights of the infected and reduce the social stigma associated with the disease; note that as recently as 2001, workers could be fired from their jobs for being HIV-positive,¹² and doctors and hospitals could refuse to treat AIDS patients.¹³ Still, the stigma of AIDS is literally “deadly” in Iran: almost 60% of HIV-positive Iranians take their own lives within the first year of their diagnosis.¹⁴

Recent developments, however, paint a more promising picture. HIV-education is now offered as a standard part of the health curriculum in many Iranian public schools,¹⁵ and lectures on how to prevent the disease are also given to couples who apply for a marriage license.¹⁶ Despite the Iranian government’s conservative reputation, needle exchange programs have actually been offered in high drug-use areas of Tehran,¹⁷ and syringes are now sold as over-the-counter items in many pharmacies.¹⁸ Drug treatment programs are also being strengthened throughout the country (although recidivism rates for graduates of these programs are still quite high).¹⁹

The spread of the disease among prostitutes, or “commercial sex workers” (CSW), and their clientele is, however, an ongoing challenge for Iran as it is for many other Muslim nations. Iranian officials are not even sure of how many CSWs there are, with estimates ranging from 30,000 to over 300,000.²⁰ Creating social welfare programs for poor or troubled women and girls would potentially

¹¹ Agence France-Presse, “Iran’s Khatami Gives Blood, Warns Against AIDS,” August 4, 2001.

¹² Agence France-Presse, “Iran Organisation Warns Against Expulsion from Work of HIV Patients,” October 8, 2001.

¹³ Agence France-Presse, “Iranian Doctors Ordered Not to Turn Away AIDS Patients,” December 30, 2002.

¹⁴ K. Alaei et al., “The Assessment of Epidemiology of Mortality in HIV Positive Patients Submitted to HIV/AIDS Care Center in Kermanshah Province from April 2000 Until Nov. 2001” (paper presented at the Fourteenth International AIDS Conference, Barcelona, Spain, 2002).

¹⁵ Ali Akbar, “Official Says AIDS Awareness in School Curriculum is Iran’s New Revolution,” Associated Press, April 15, 2002.

¹⁶ Jim Muir, “Tackling AIDS in Iran,” BBC News, March 22, 2002.

¹⁷ Agence France-Presse, “Iranian Government to Distribute Free Syringes to Drug Addicts,” August 12, 2003.

¹⁸ “Official Says 50,000 Addicts Treated Across Iran,” *Teheran IRNA in English*, August 31, 2002.

¹⁹ Siavosh Ghazi, “Iran-AIDS: Iran Wakes Up to AIDS as Dirty Needles Spread Disease,” Agence France-Presse, December 1, 2002.

²⁰ Nazila Fathi, “To Regulate Prostitution, Iran Ponders Brothels,” *New York Times*, August 28, 2002.

reduce the number of CSWs, and communicating safer behaviors to them would reduce the transmission rate of this difficult to reach group.

In contrast, considerable progress in HIV education and prevention efforts within gay and bisexual networks and commercial sex circles has been recorded in another Muslim society: Bangladesh. Though recent surveys have found that knowledge of HIV/AIDS and its methods of infection is low among both male and female sex workers in Bangladesh,²¹ efforts to increase condom use are underway around the country.²² In Bangladeshi brothels, underage girls have been found to be HIV-positive, and anti-prostitution and anti-trafficking programs are trying to liberate minors from this horrible fate.²³ Since 1997 the Bhandu Social Welfare Society has provided safer-sex promotion activities for over 76,000 homosexual and bisexual men. Efforts are underway to expand this successful NGO from nine centers in six cities to a potential nationwide program.²⁴

In the wider Bangladeshi society, actual behavior often stands in extreme contrast to the social conduct expected in a Muslim society. Bangladeshi youth have a rather permissive view of premarital sexual relations, and report multiple partners, casual romantic relationships, and sometimes even paying for sexual experiences.²⁵ In order to educate and to prevent the spread of HIV/AIDS and other STDs among young people, the Bangladeshis have successfully experimented with placing awareness programs in mosques—the social and religious center of each community.²⁶ Since *imams* (religious leaders) play such an important role in shaping social and religious values, training them to educate people to the dangers of HIV/AIDS is a natural step. With assistance from the Islamic Foundation, the Islamic Medical Mission, and the United Nations Development

²¹ R. Ulla, "The Level of Knowledge on HIV and AIDS of Sex Workers in Bangladesh" (paper presented at the Fourteenth International AIDS Conference, Barcelona, Spain, 2002).

²² P. Piwoo, "Condom Use Dynamics in Brothel Situation" (paper presented at the Fifteenth International AIDS Conference, Bangkok, Thailand, 2003); and S.M. Enamul Hoque, Shahnaj Begum, Hazera Begum, "Female Condom, a Device of Feeling Empowerment: An Experience from Dhaka, Bangladesh" (paper presented at the Fifteenth International AIDS Conference, Bangkok, Thailand, 2003).

²³ I. Basu, "Violence of Trafficking for Prostitution and Girls Who Are Living with HIV/AIDS" (paper presented at the Fifteenth International AIDS Conference, Bangkok, Thailand, 2003).

²⁴ M.R. Ahmed, "Scaling Up An MSM CBO to a National HIV/AIDS MSM Organisation: Means and Methods—A Replicable Process" (paper presented at the Fifteenth International AIDS Conference, Bangkok, Thailand, 2003).

²⁵ K. Hasan, "Adolescent Sexual Behavior and Treatment Practice in Bangladesh—Breaking the Misconception" (paper presented at the Fourteenth International AIDS Conference, Barcelona, Spain, 2002).

²⁶ Ranjit Dev Raj, "Development Bulletin—Bangladesh: Mullahs Roped In to Fight HIV Spread," Inter Press Service, December 16, 1998.

Programme (UNDP), thousands of religious leaders—including a few female leaders—have been trained to deliver educational and prevention messages designed to combat HIV and other STDs, messages they now deliver on a regular basis.²⁷ These teachings discourage prostitution and homosexual activity, but in cases of existing STD, and especially HIV, infection they also promote condom use to prevent the spread of infection to wives and even their unborn children. Recent efforts include expanded training for female religious leaders on how to educate women as well.

Unfortunately, the efforts of Iran and Bangladesh far outpace those of other Muslim countries. Little or no surveillance data is available on the disease in many countries with significant populations of high-risk IVDUs, such as Afghanistan and Iraq. After decades of blaming foreign workers and visitors for the disease, Saudi Arabia and other states in the Persian Gulf have only recently begun to admit that they have a small but persistent domestic locus of infections.²⁸ The Levant states have also been slow to address these problems, despite having high levels of prostitution and sizeable but unacknowledged populations of bisexual men.

Future Potential Efforts and Impact

The future impact of HIV on Islamic countries may be severe. Both Iran and Bangladesh—countries on the forefront of the Islamic worlds' response to HIV—will, despite their efforts, still face rising numbers of sick and dying AIDS victims. Iran's emergence as a regional power could be slowed or perhaps even derailed by a heavy HIV/AIDS burden; in Bangladesh the epidemic will likely continue to mire the country in the grip of widespread poverty. In the Persian Gulf states, an increased HIV/AIDS burden may disrupt the flow of migrant workers and impact remittances home. With potentially decreased foreign labor, these states will have to diversify their economies by using domestic labor sources, thus increasing the cost of labor. A rampant AIDS epidemic in Indonesia will add one more burden to a society already under huge social pressures, will stimulate ethnic tensions, and could contribute to the disintegration of the state.

²⁷ F. Usmani, "Advocating for Reproductive Health, Gender and HIV/AIDS Prevention: A Program Intervention With Religious Leaders in Bangladesh" (paper presented at the Fourteenth International AIDS Conference, Barcelona, Spain, 2002).

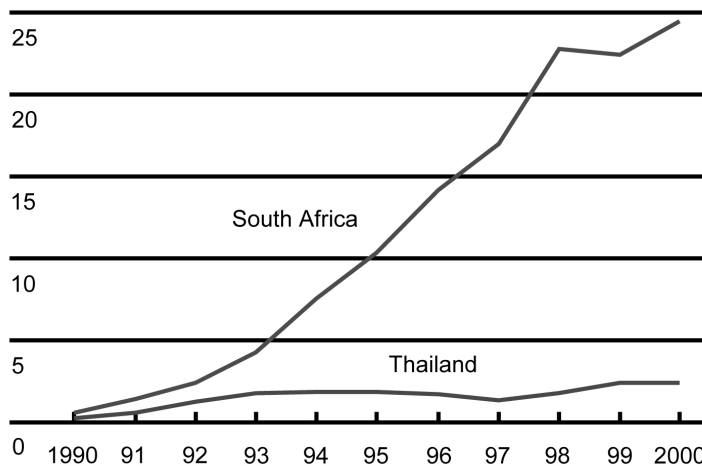
²⁸ Such a statement was made by Saudia Arabian Deputy Minister of Health for Preventive Medicine H.E. Dr. Yacoub bin Youssouf Al-Masruwah before the Twenty-Sixth Special Session of the UN General Assembly on HIV/AIDS, New York, June 27, 2001.

Finally, there is the prospect of an explosion of HIV/AIDS in fragile, nuclear-armed Pakistan.

None of these outcomes are predetermined, however. With cooperative and comprehensive efforts, HIV/AIDS can eventually be brought under control. Continued inaction and half-measures, however, will allow the disease to continue to spread. The differing response to HIV/AIDS in Thailand and South Africa is an instructive tale for the Muslim world. In the early 1990s, both countries had a low official national prevalence of HIV/AIDS. Thailand—backed by a great deal of assistance from the international public health community—embarked on an aggressive anti-HIV campaign that reached all sectors of Thai society. AIDS education and behavioral change messages were delivered in schools as well as in brothels. Spearheaded by members of the royal family, senior political leaders began to deliver AIDS prevention messages as a part of almost every public address. As a result of this continued campaign, HIV rates remained low throughout the 1990s. By comparison, South Africa did little to control the spread of the disease until the dawn of the new millennium, and now has the nightmarish task of controlling a disease that has already infected nearly a quarter of the country's adult population [see **Figure II**].

Figure II

HIV/AIDS in South Africa and Thailand: Effect of Education and Treatment Programs



Source: UNAIDS

If Muslim countries are to respond effectively to their own ongoing domestic HIV epidemics, it is imperative that they begin to mount aggressive HIV/AIDS surveillance programs. A perusal through the latest UNAIDS update for

Muslim nation statistics is telling for its lack of information—offering only a handful of cases here, empty columns there. The time has come for leaders in these countries to undertake a comprehensive assessment of the extent of the epidemic in their countries. They must, in good faith, survey not only those who identify themselves as being infected or possibly infected but rather all of their citizens—including commercial sex workers, drug abusers, and those with alternative sexual lifestyles.

Sweeping legislative and social changes will also have to be made in order for Muslim nations to achieve success in controlling the epidemic of HIV/AIDS. Following the example of Iran, conservative and fundamentalist regimes can find ways to harness religion as a means to help deal with this urgent social need. In addition to teaching safer behaviors to higher-risk groups, social messages can be crafted to teach the general population that caring for the infected and sick is entirely consistent with the Muslim faith. In addition to educating people about the disease, social messaging programs will also allow HIV-infected people to conduct themselves with dignity and not be pressured into suicide.

In the Muslim world, as in every other place on earth, battling HIV/AIDS is in part a women's issue. Islamic women must refuse to be infected and, if infected, refuse to die in silence. They must instead embrace the fight against this disease at all levels of society. Married women must communicate with their husbands working as remittance laborers overseas and urge them to avoid extra-marital sexual contact (or avoid endangering their loved ones if they do stray). Women who live in economic comfort must be compassionate to less fortunate women and acknowledge that the tragedies of trafficking and poverty often lead to lives as prostitutes. Only after CSWs are acknowledged as a part of society can programs be constructed to protect them.

HIV/AIDS education and control efforts could also become part of each citizen's *zakat* (charity duty). In nations that use taxes as part of their *zakat*, some portion of these contributions could be used to establish HIV/AIDS awareness and treatment programs. Additionally, wealthy countries could help poorer countries establish such programs, and countries with experience in drug treatment and behavioral change efforts could assist those nations which have need but little experience.

Opportunities also exist for the United States and other Western countries to assist Muslim societies grappling with this crisis. In cooperation with Muslim leaders, the West can assist in the design and implementation of culturally acceptable and appropriate behavioral change and counseling programs. Pharmaceutical treatment could be expanded in Muslim areas that already have modern public health systems. In regions lacking adequate care, the United States could

assist in designing the public health infrastructure necessary to support successful treatment programs. In addition to stemming the tide of HIV/AIDS, efforts like these could also help reduce maternal and child mortality, and improve the general quality of life. Helping Muslim societies confront their own HIV/AIDS problem might actually become an avenue of positive engagement for the United States in regions where America needs to improve its image.

Islamic countries are at an HIV/AIDS crossroads. They can choose, for instance, to act slowly or even not at all in setting up education and prevention programs, or they can decide to confront this killer virus threatening their *umma*. The formidable powers of national religious leaders can be harnessed to educate people to protect themselves. Health education in schools can improve knowledge of the disease and its transmission amongst the young. Most importantly, these countries have to reach out to some of the most vulnerable members of society—people with “alternative lifestyles.” If these governments choose to ignore such marginalized people, then they will be ignoring the greater part of the problem, and AIDS will win.

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