# The Muslim Face of AIDS

*AIDS does not discriminate by religion or citizenship. Yet, for years, leaders of Muslim countries have denied the pandemic's threat to their societies. While they looked the other way, HIV quietly crept into the most vulnerable populations in the most volatile parts of the world. Muslim leaders must now address the threat—or risk losing their community of believers to a global plague.* | **By Laura M. Kelley and Nicholas Eberstadt**

On a cold December evening in the southern Iranian city of Kerman, the stars blazed overhead as a father took his son's life. Enraged, and with an ax in hand, the head of a prominent Iranian family chopped his child to pieces for bringing shame upon his relatives. The son's crime? Contracting HIV, the virus that causes AIDS. In a country where, in some parts, nearly 60 percent of HIV-positive citizens take their own lives within the first year of their diagnosis, the 23-year-old son faced little chance of acceptance, even from his family.

That tragic story is just one of the many being told as the deadly contagion unfolds across the massive Islamic expanse, from Morocco to the Philippines. In the years immediately ahead, the AIDS pandemic will exact a grim toll on a number of vulnerable populations

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with volatile polities—places unlikely to cope with the significant social stresses and economic burdens that AIDS can cause.

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 1 million people today. At the end of 2003, UNAIDS estimated that up to 420,000 people in Mali, 180,000 in Indonesia, 150,000 in Pakistan, and 61,000 in Iran had HIV/AIDS. Those numbers, however, are severely understated. UNAIDS figures depend upon surveillance data; thus a lack of information can be taken as a lack of infection. UNAIDS data on the number of people living with HIV/AIDS are completely missing for Afghanistan, Turkey, and Somalia, all countries with large at-risk populations. Moreover, UNAIDS' HIV estimates are determined by conferring with local governments, and politicians who do not wish to allocate domestic resources to HIV/AIDS programs (or to deter foreign investors) can downplay its reach or simply refuse to admit its presence. Although the prevalence rates of Muslim infections may seem small when compared with the tragedy that is unfolding in southern Africa, they stand in sharp contrast to official estimates that suggest no disease at all.

An instructive tale for the Muslim world lies in the differing responses to HIV/AIDS in Thailand and South Africa. In the early 1990s, both countries had an official national prevalence of between 2 and 3 percent. Thailand embarked on an aggressive anti-HIV campaign that reached all sectors of society. AIDS education programs were delivered in schools as well as in brothels, and senior political leaders delivered AIDS-prevention messages as a part of almost every public address. As a result of this campaign, HIV rates remained low throughout the 1990s. By comparison, South Africa did little to halt the spread of HIV until the dawn of this millennium and now has the nightmarish task of controlling a disease that already infects nearly a quarter of its adult population. The Muslim world now must decide if it will replicate Thailand's relative success, or follow South Africa's deadly path.

## IT COULDN'T HAPPEN HERE

The first cases of HIV in the region were officially recorded in Bahrain, Qatar, Iran, and several other Muslim states in the mid-1980s. Despite identifying the disease early on, many countries still have not launched treatment or public health education programs to prevent its further spread. One major reason for this lack of action has been assumptions that premarital sex, adultery, prostitution, homosexuality, and intravenous drug use 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.

In 1995, for example, Indonesia's Council of Ulemas urged that condoms only be sold to married couples with prescriptions from general practitioners. It was felt that strong religious convictions would prevent people from having extramarital sex. Members of the international public health community, for their part, have not only seemed to accept the presumptions behind those arguments but on occasion have also espoused them. As recently as February, an official in Pakistan's National AIDS Control Programme asserted that HIV prevalence was lower in Pakistan than in other countries thanks largely to "better social and Islamic values."

Islamic culture and Muslim beliefs, unfortunately, are not sufficient to inoculate populations against the

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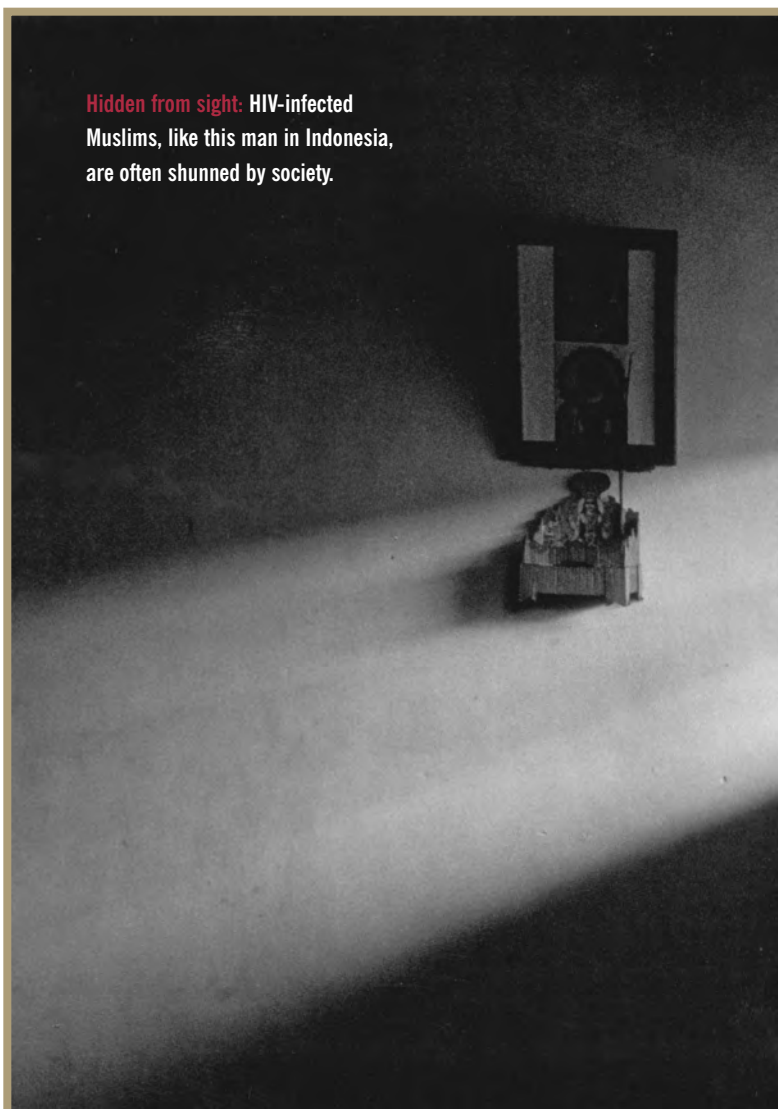

**Hidden from sight:** HIV-infected Muslims, like this man in Indonesia, are often shunned by society.

spread of HIV. The trajectory of the virus in predominantly Muslim regions of the sub-Sahara proves this point. In Nigeria, 6 to 10 percent of adults are infected, and between 10 to 18 percent of adults in Ethiopia are HIV-positive. Both are countries in which fully half of the people practice some form of Islam.

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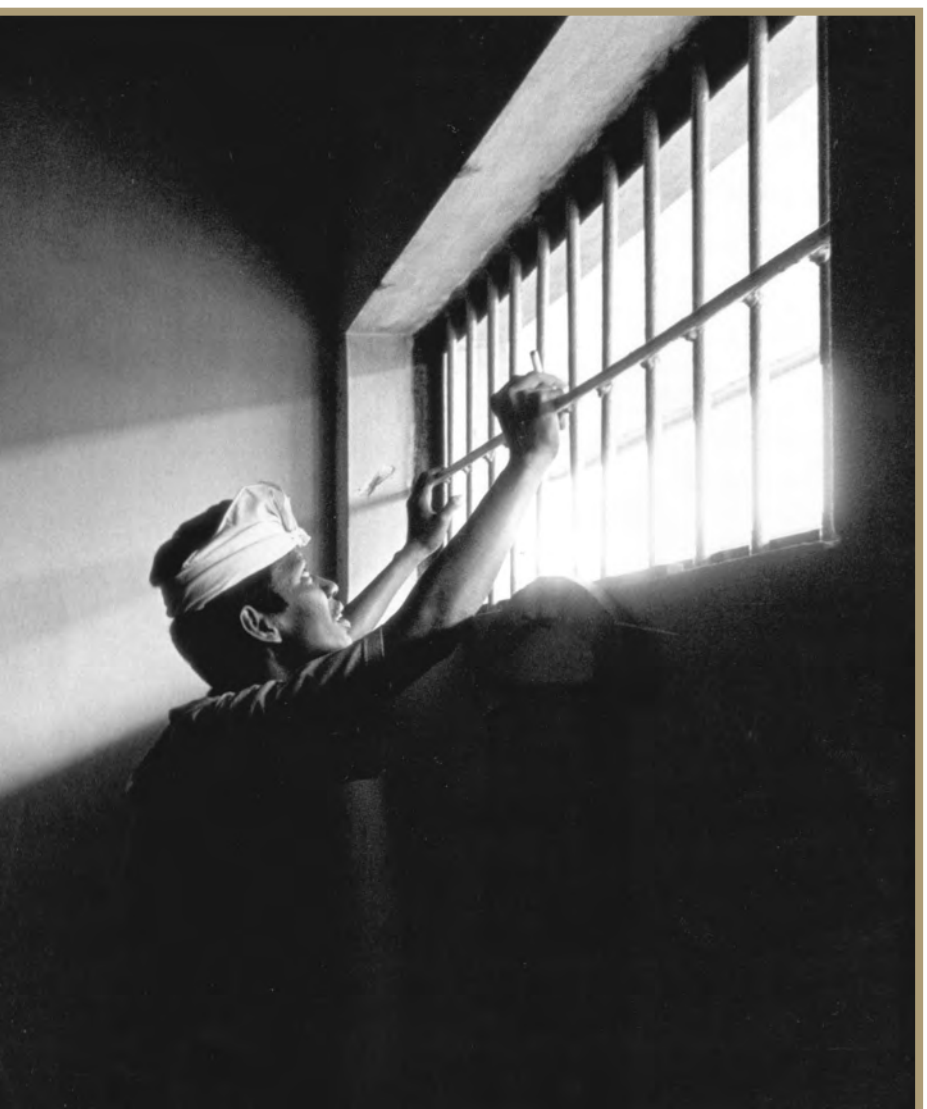
Although the HIV epidemic in Muslim Africa should have sounded a wake-up call to other Islamic communities, few Islamic authorities north of the Sahara seem to have heard the alarm.

For all the diversity within the more than 1 billion-strong Muslim world—from Albania and Turkey in Europe, across Northern Africa and through the Persian Gulf, and to Malaysia and Indonesia in South Asia—a couple of common features have kept its efforts to combat the disease frozen in time. One is that there is no prescribed separation of faith and state in many Islamic countries today: The Koran is consulted not only as a religious text but also as a source of law, a guide to statecraft, and an arbiter of social behavior. Although such reliance on the Koran may help leaders envision an ideal human society (one with low rates of drug abuse, prostitution, and other types of crime), it also often keeps them from providing civic assistance to counter real social problems.

Another common factor that contributes to a slow response to HIV/AIDS is the relative absence of firmly rooted or functional democratic systems in many Muslim countries. Citizens of these countries simply do not expect their governments to provide social services to mitigate the impact of HIV/AIDS. Taken together, these two tendencies—political primacy of the Koran and weak or absent democracy—have cost Muslim leaders valuable time in the fight against the epidemic.



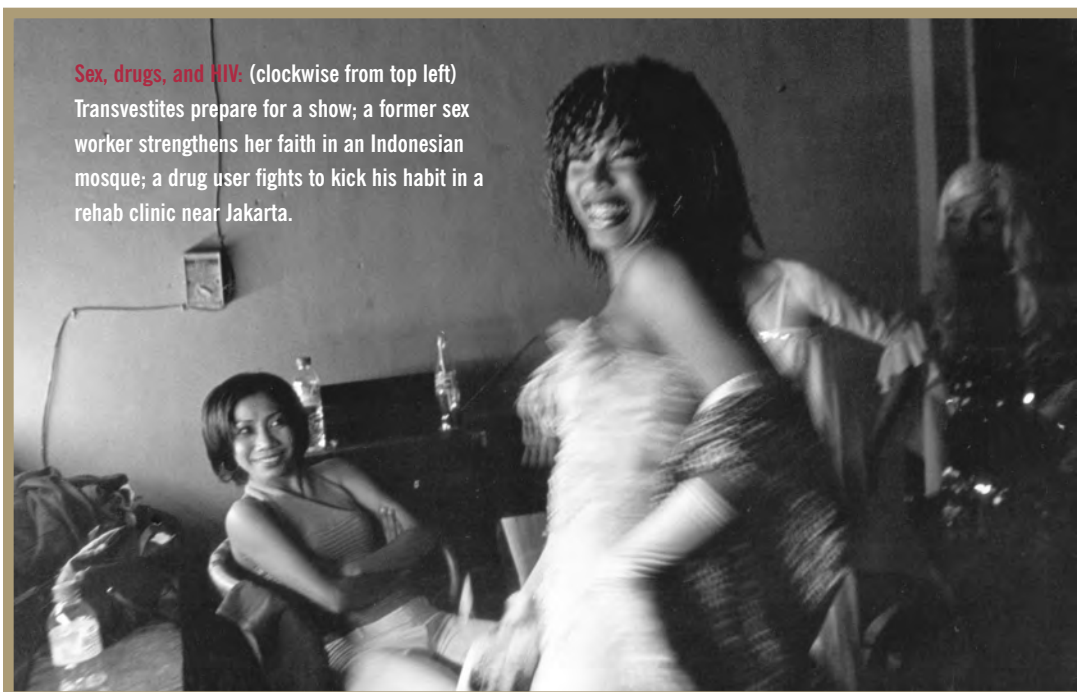
## TACKLING THE TABOO

Although many Muslim leaders have done little to control HIV/AIDS other than deport the foreigners that they blame for the disease, a handful of leaders have acknowledged their epidemics and are working diligently to find ways to control infections. One of the Muslim governments that does seem to be responding to its gathering HIV problem is, surprisingly, "axis of evil" member Iran. Although the social stigma associated with the disease remains quite severe—until 2001, workers could be fired from their jobs for being HIV-positive, and throughout 2002, doctors and hospitals could refuse to treat AIDS patients—recent government actions paint a more promising picture. Iran's President Mohammad Khatami and his administration have been very forthcoming about the extent of the

epidemic and the urgent need to control the further spread of the disease. HIV education is now offered as a standard part of the health curriculum in many Iranian public schools, and lectures about how to prevent the disease are also given to couples who apply for marriage licenses. Perhaps surprising, given the Iranian regime's strict conservative reputation, needle-exchange programs also have been offered in high drug-use areas of Tehran, and syringes are now sold over the counter in many pharmacies. Hopefully, the incoming administration will continue HIV education and prevention efforts.

Yet, spread of the disease among prostitutes and their clients remains a challenge for Iran. Officials are not even sure how many commercial sex workers there are, and estimates range from 30,000 to more than 300,000. Creating social welfare programs and communicating alternative, safer behaviors for poor or troubled women and girls could reduce the number of prostitutes and levels of transmission in this difficult-to-reach group, thus preventing the further spread into the general population.

Another Muslim society has seen considerable progress in HIV education and prevention efforts within gay and bisexual networks and commercial sex circles. In Bangladesh, recent surveys have found that knowledge of HIV and its transmission is low among both male and female sex workers, and efforts to increase condom use are under way around the country. Since 1997, the Bandhu Social Welfare Society has provided safer-sex promotion activities for more than 76,000 homosexual and bisexual men. Some officials hope to expand this successful nongovernmental organization from six cities where anti-HIV and anti-STD education and prevention are offered to a national program. The Bangladeshis have also successfully experimented with awareness programs in the social and religious center of each community: the mosque. Because imams play an important role in shaping values, training them to educate people to the dangers of HIV seems natural. With assistance from the Islamic Foundation, the Islamic Medical Mission, and the United Nations Development Programme, thousands of religious leaders—including some women—are now trained to deliver anti-HIV and anti-STD educational and prevention messages.



**Sex, drugs, and HIV:** (clockwise from top left) Transvestites prepare for a show; a former sex worker strengthens her faith in an Indonesian mosque; a drug user fights to kick his habit in a rehab clinic near Jakarta.

Unfortunately, the efforts of Iran and Bangladesh far outpace those of other Muslim countries. Little or no surveillance data are available on the disease in many countries with significant higher-risk populations of intravenous drug users—Afghanistan and Iraq among them. 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 infection after decades of blaming foreigners for the disease.

## GUARDING THE FAITHFUL

A look at the latest UNAIDS update for Muslim nation statistics is telling for its lack of information: a handful of cases here, empty columns there. But all these blank pages cannot mask the toll AIDS is taking, and will take, on the Muslim world. If Muslim societies are to respond effectively to their own still-gathering domestic HIV epidemics, they must begin mounting aggressive HIV/AIDS surveillance programs. To control the epidemic, sweeping legislative and social changes are also required. Following the example of Iran, conservative and fundamentalist regimes must harness their religious piety to deal with this urgent social need. In addition to teaching safer behaviors to higher-risk groups, social messages can be crafted to teach people that they can still be good Muslims and care for those infected with this disease. Counselors for an Egyptian hotline encourage callers to accept acquaintances and family members

with AIDS by reminding them of the relationships they shared before the diagnosis. By stressing similarities between the infected and the non-infected, the counselors encourage greater social acceptance of the disease.

In the Muslim world, as everywhere else, battling HIV/AIDS is in part a women's issue. Islamic women must refuse to be infected and die in silence. They must embrace the fight against this disease at all levels of society. Married women must talk to their husbands who work as remittance laborers overseas and urge them to avoid extramarital sexual contact (or use condoms if they do stray).

HIV/AIDS education and control efforts could also become part of each citizen's *zakat*, or charity giving. In nations that use taxes as part of their zakat, some portion of the contributions could establish AIDS awareness and treatment programs. 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 could stand to improve its image.

Domestic or international, anti-AIDS action for the Muslim world must be planned and implemented soon. Unchecked, HIV/AIDS will continue to spread through Muslim countries—destroying families and deepening poverty—until it has ruined the very fabric of these societies. Muslim countries must acknowledge that contemporary societal ills are serious domestic issues, but also that modern public health and scientific measures can help them conquer this disease. And those of us in the West must respect the fundamental fact that socially conservative societies will adapt to some issues but will not necessarily buy what we mean by "modernity" wholesale.

Islamic countries are at a crossroads. They can choose to act slowly and mount only superficial education and prevention programs. Or they can choose to confront this killer virus that threatens their community of believers. After a shaky start, the formidable powers of national religious leaders can be harnessed to educate people to protect themselves. Most important, these countries have to reach out to their most vulnerable—to the people who are most at risk—to stop the continued spread of the disease. If they don't, AIDS will exact an even greater toll among the faithful. FP

## Want to Know More?

This article is based on a forthcoming report by the authors from the National Bureau of Asian Research. Nicholas Eberstadt and Laura M. Kelley have published several articles detailing predictions and warnings about the spread of HIV/AIDS, especially in the developing world. Eberstadt examines the pandemic's spread to Russia, China, and India in **"The Future of AIDS"** (*Foreign Affairs*, November/December 2002), and Kelley is the primary author of ***The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China*** (Washington: National Intelligence Council, 2002).

For a general overview of the toll that HIV and AIDS are taking in many parts of the Muslim world, see **"HIV/AIDS in the Middle East and North Africa: A Primer"** (*Middle East Report*, Winter 2004), by Sandy Sufian; and ***HIV/AIDS in the Middle East and North Africa: The Costs of Inaction*** (Washington: World Bank, 2003), by Carol Jenkins and David A. Robalino.

Although statistics of HIV prevalence rates in many Muslim countries are often incomplete or inaccurate, several sources provide reliable general data. See, for instance, the Web sites of the Joint United Nations Programme on HIV/AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and HIV InSite, which features the ***Middle East and North Africa Comprehensive Indicator Report***.

Tina Rosenberg confronts much of the conventional wisdom about the AIDS pandemic in **"Think Again: AIDS"** (FOREIGN POLICY, March/April 2005), and Keith Hansen illustrates the soaring incidence of AIDS throughout the world in **"A Plague's Bottom Line"** (FOREIGN POLICY, July/August 2003).

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