

HIV & AIDS
in the
Muslim
World

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Key Demographic Details About The Muslim World

- **Transnational:** Spread across three continents; home to over 1.3 billion people bound together by faith
- **Largely Asian:** Nearly three quarters of a billion people in Indonesia, Malaysia, Bangladesh, India, Pakistan and Iran
- **Mostly Young:** Many countries have significant proportions of young people
- **Rapidly Urbanizing:** Cities growing rapidly, sometimes include large urban slums
- **Highly Mobile:** Male and female remittance labor is relatively common
- **Many Refugees:** Millions of people displaced by conflict

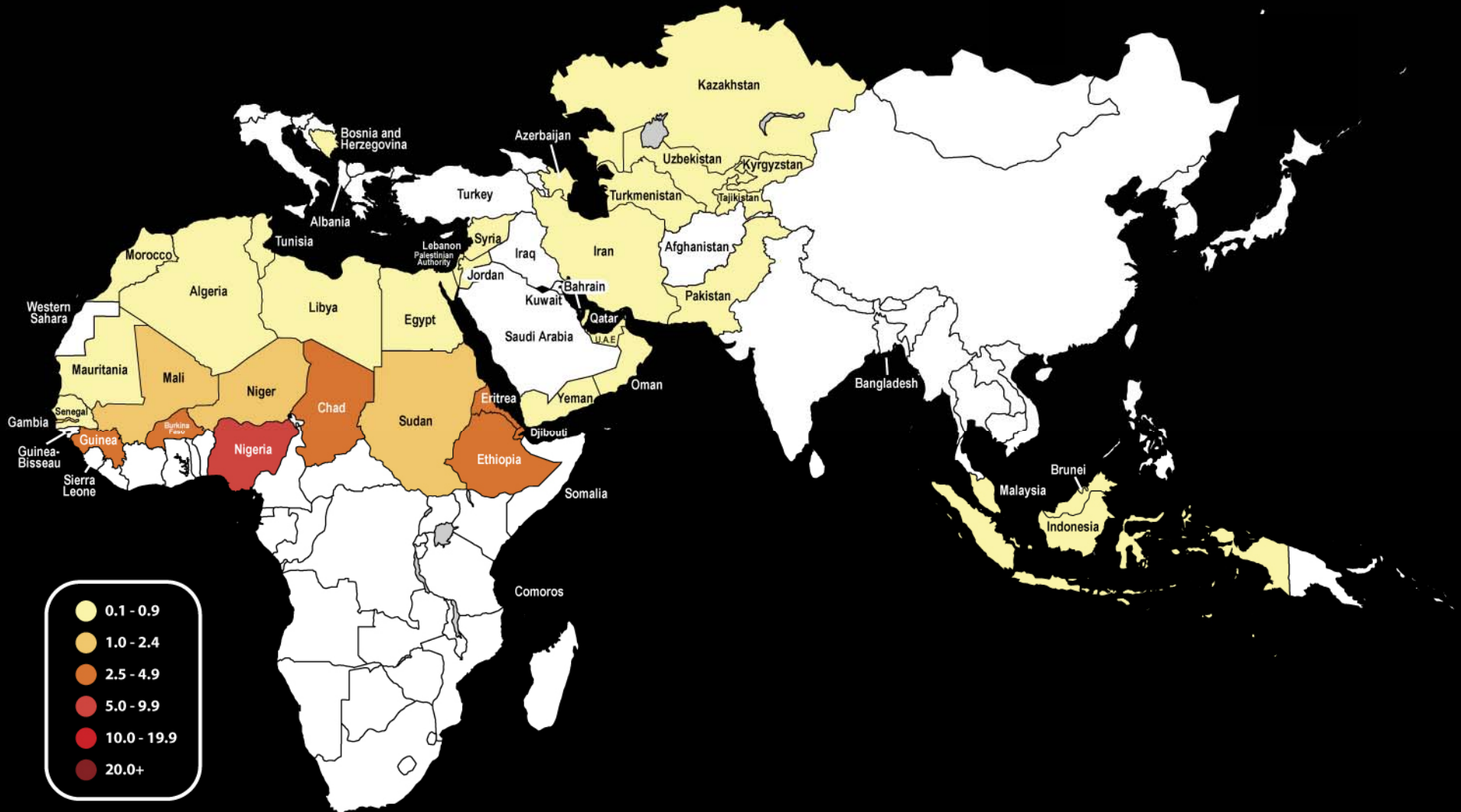
Key Political and Social Issues in The Muslim World

- **Absent or Fragile Democracy:** Autocratic rule common. The social contract between government and citizens is inherently different from those in democratic states
- **Political Primacy of the Qu'ran:** In many states the Qu'ran is consulted as a religious text, a source of law, a guide to statecraft and an arbiter of social behavior
- **Low Levels of Development:** Health system capacity often poor. Even countries attempting deliver HIV/AIDS-related health services typically find this difficult
- **Gap Between Expected and Actual Behaviors:** Behavioral standards are extremely rigorous and reinforced by family and community expectations. Behaviors that spread HIV/AIDS are present but often unacknowledged

HIV/AIDS in The Muslim World

- Two Decades Old: First cases recorded in the mid 1980s
- Foreigners Blamed: Imported blood supply and foreign visitors and workers seen as sources of early infections. Infected foreigners deported; Blood supply still may be unsafe
- Severe Social Stigma: Infected individuals and their families are ostracized. In many countries, HIV+ people can be denied medical treatment and can be fired from their jobs. Suicide in year following diagnosis not uncommon
- Governmental Reluctance to Address Crisis: Some Muslim states still do not have national HIV programs. Action impeded by the view that addressing epidemic in highest-risk groups implies condoning behaviors

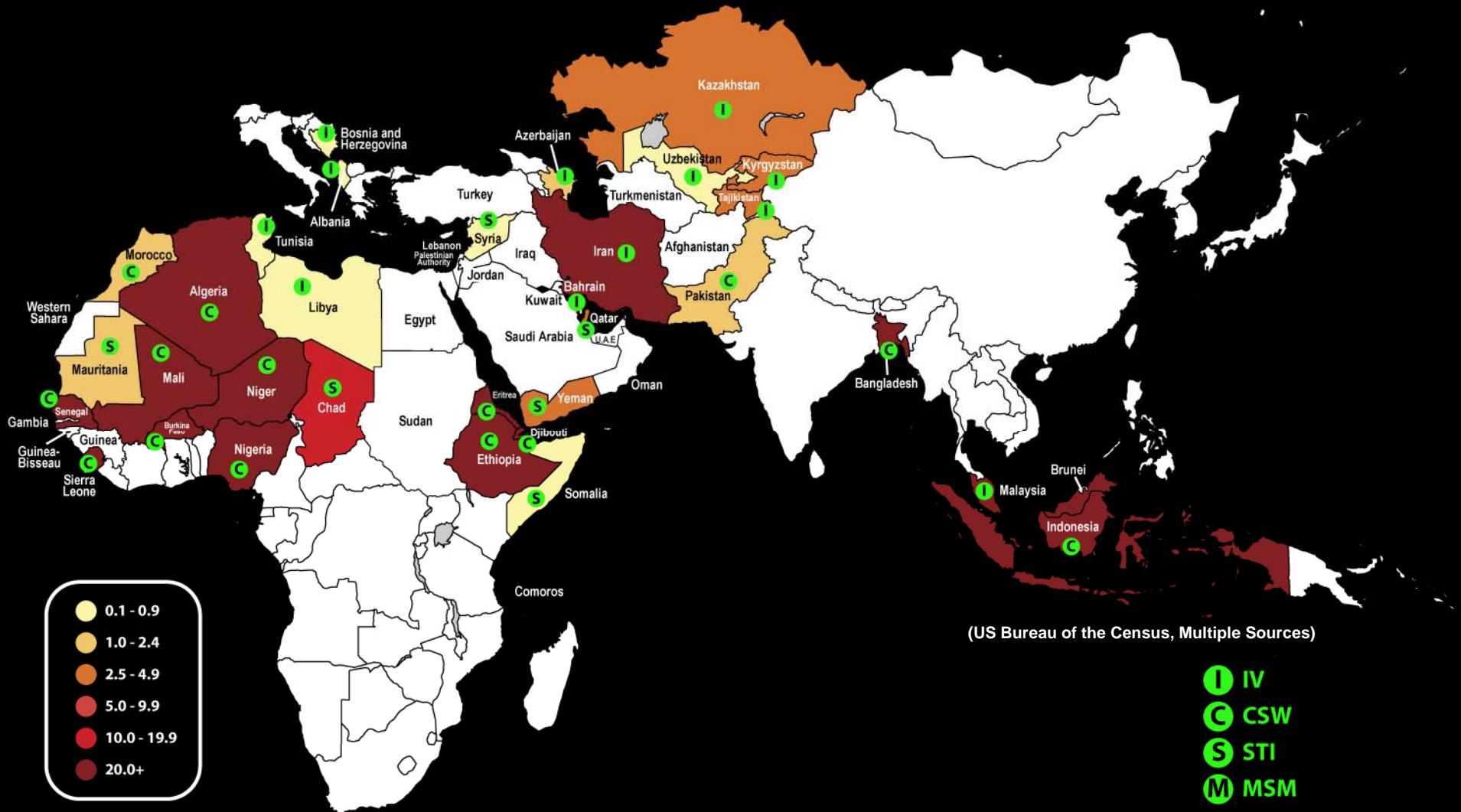
Official Adult Prevalence of HIV/AIDS in Select Muslim Countries (UNAIDS, 2004)



Official Prevalence of HIV/AIDS in High-Risk Groups in Select Muslim Countries (UNAIDS, 2004)



Prevalence of HIV/AIDS in High-Risk Groups in Select Muslim Countries



(US Bureau of the Census, Multiple Sources)

Infection Transmission Varies Between Muslim Countries

- **Intravenous Drug Use:** Some countries grow and process drugs, others are sites for transshipment and still others are end users
- **Commercial Sex Workers:** Male and female sex workers. Most have poor knowledge of transmission; few require condom use from clients
- **Unsafe Homosexual Sex:** Significant but largely unacknowledged populations of homosexual or bisexual men. Safer sex practices not widespread
- **Unsafe Heterosexual Sex:** Taking place outside of commercial sex circles. Key source of infection spread outside of higher risk groups
- **Mother-to-Child Transmission:** Low but rising levels

Infection Surveillance is Inadequate

- Low Levels of Surveillance: Sometimes absent, poorly executed or done piecemeal. Poor infection surveillance has led many to believe that there is little or no HIV/AIDS in the Muslim World
- Wrong Groups Tested: Some countries test blood donors and STI patients. (Best to test pregnant women and high risk groups)
- Expanded testing of TB patients will probably reveal unrecognized HIV infections
- Improvement Crucial to Control: Surveillance must be strengthened. Sentinel sites necessary

Knowledge and Use of Prevention Methods in General Population is Often Poor

- Misconceptions about Transmission: Egyptian STI patients identified insect bites and personal contact as possible routes of infection; 60% failed to mention condoms as a preventative measure
- Gap Between Knowledge and Implementation: Many prostitutes (commercial sex workers--CSWs) in Bangladesh knew that condoms prevented transmission of HIV but only 11% reported using them
- Concern High: Although knowledge may often be poor, many surveyed are concerned about HIV/AIDS and worried that they may contract the disease

AIDS-Related Social Stigma is Severe

"I just pray that God ends my life as soon as possible before more symptoms show. I don't want to create problems for my family."

- Causes delays in testing and seeking healthcare
- Sixty percent of patients in a clinic in Kermanshah (Iran) committed suicide within a year of their HIV + diagnosis
- Violence directed against the infected occurs

Treatment Not Widely Available

- Usually Expensive: World Bank estimates the cost of AIDS treatment at 2-3 times per capita GDP for most Middle Eastern and North African countries
- Difficult to Access: Public programs are rare; most treatment provided by private physicians. Highest risk groups at most severe disadvantage, but confidential referrals do occur through social networks

Potential Impact of HIV/AIDS Epidemic in The Muslim World

- Widespread Loss in Confidence: Governments that fail to meet the medical and social challenges of HIV/AIDS risk erosion of public legitimacy/authority
- Some countries' emergence as regional powers – Iran, Nigeria and Malaysia - may be slowed. Much needed foreign investment may be delayed
- Many countries – like Bangladesh - may find progress against poverty impeded. Development and public health strides of the last three decades risk stalling
- Gulf States risk loss of foreign labor base

Mosque-based Counseling

- Harnesses positive and powerful influence of imams and female leaders to deliver HIV/AIDS education
- Discourages behaviors that spread disease but counsels condom use for existing STI or HIV infection

Educating & Empowering Women and Girls

- Enforced minimum compulsory education for girls
- Female literacy to be raised to male rates
- Counseling for women who work as remittance laborers
- Outreach to women in the community or in the workplace

Programs to Help IVDUs

Immediate
Need

- Needle exchange programs
- Methadone maintenance programs
- Programs to break all drug dependency need strengthening
- Each contact with IVDUs provides opportunities to counsel about the spread of HIV/AIDS

Long-
Term Goal

Programs to Uplift CSWs

- Outreach to educate CSWs on HIV/AIDS transmission and prevention urgently needed
- Efforts must include male CSWs as well as female
- Poverty alleviation campaigns directed specifically at women can reduce prostitution
- More and stronger efforts for stopping the trafficking of women and children

Programs to Assist MSM

- Outreach to educate MSM on HIV/AIDS transmission and prevention urgently needed
- Programs in Morocco and Bangladesh could be models for other countries
- Assistance from International Community or NGOs available

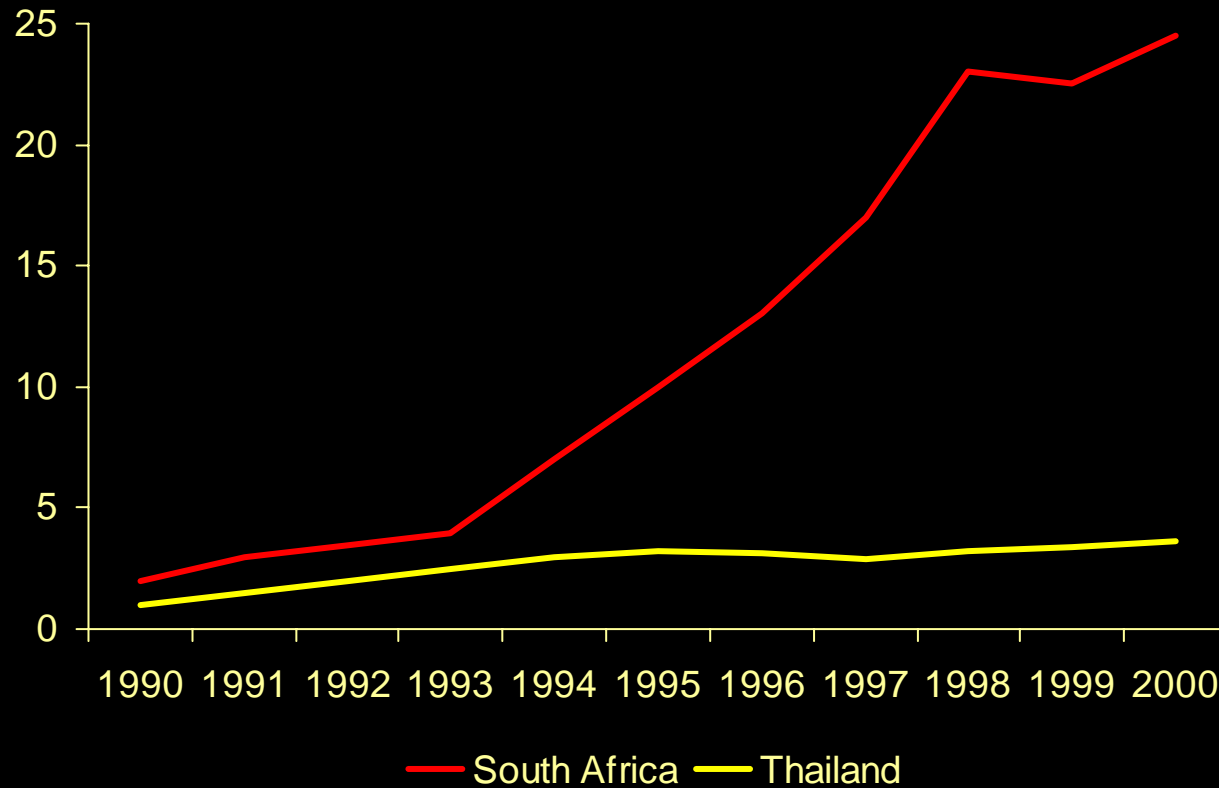
Public Treatment Programs

- Expanded, subsidized treatment should be accompanied by viral strain typing and resistance testing
- Community-based DOT has been successfully tested in resource-poor settings for HIV/AIDS treatment delivery

Stigma Reduction Efforts

- Legislative changes to ensure continuity of health services, jobs, insurance etc. for the infected
- HIV/AIDS knowledge as part of school-based health education programs
- Social messaging to encourage acceptance of infected
- Acknowledgement of MSM as part of society
- Better understanding of the problems that lead to lives as CSWs

Muslim Nations are at an HIV/AIDS Crossroads



Many Opportunities Exist for International Cooperation

Within
the
Muslim
World

- Wealthy countries can give monetary assistance to poor countries to help them construct HIV/AIDS prevention and treatment programs
- States with experience in designing and delivering HIV-related education, prevention and treatment programs can assist countries with little experience

With
International
Community
and Western
Countries

- Western countries can work with Muslim leaders to craft appropriate and acceptable programs
- US may be able to use cooperation on HIV/AIDS as an avenue of positive engagement with Muslim nations