

AIDS AND THE MUSLIM WORLD: A CHALLENGE

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ABSTRACT

According to UNAIDS the number of people living with HIV has risen from around 8 million in 1990 to approximately 34 million today. This advancing epidemic has largely hit Muslim nations where it still continues to be a fast increasing threat. In a Muslim environment, the societal problems in conjunction with cultural and religious norms make it difficult to create awareness in the society and use preventive strategies against this disease. This paper would try to define the extent of the HIV/AIDS problem in Muslim countries, outlining the major societal and cultural challenges associated with HIV/AIDS in these societies. Further it conducts an exploratory survey in Bangladesh amongst HIV infected participants to measure the societal, cultural and religious challenges they faced after being infected. Based on the results of the survey and conducting interviews with Non-governmental Organizations (NGOs) in Bangladesh, this paper would finally suggest recommendations that can work within the social, cultural and religious frameworks, to combat the problem in Muslim countries.

Keywords: AIDS, Muslim, Islam, Social Change, Culture

INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) is a killer more potent than any warfare - the deadly disease has claimed over 25 million lives in last the three decades, and there are 34 million people in the world living with AIDS today (UNAIDS,2012b) . The World Health Organization suggests that the numbers will rise further in the coming years. It looms as far more than a medical and biological problem because it is also intricately linked with the world's deep-rooted cultural and societal problems which prevent its eradication (Hasnain, 2005).

In some cases, transmission of AIDS is accidental, such as the vertical transmission from a mother to the child or through accidental infected needle injuries. However, in the majority of cases, AIDS spreads due to personal behavioural patterns such as unprotected sexual intercourse and sharing of infected needles (Palekar et al, 2007). To check the spread of AIDS, it is necessary for those affected by the virus, those at risk, and even those not at risk to jointly make efforts and adopt preventive measures.

With time, scientists and researchers have realised that social and cultural variables are important factors in one's behaviour which in turn is a big variable to HIV infection transmission. The ethical and moral issues related to HIV risk behaviours exist in all societies, but it is much more pronounced in Muslim countries. Thus understanding the role of social and cultural variables affecting HIV transmission in Muslim countries is critical for the development and implementation of successful HIV prevention programs in the future.

This paper defines the extent of HIV/AIDS problem prevalent in Muslim countries and discusses the major societal and cultural problems hindering the prevention of this deadly disease. To test the validity of these problems, the study conducted a survey with a help of

two NGOs helping AIDS victims in Bangladesh. Based on the results of the survey which identifies the cultural and societal problems and interviews with NGOs working in Bangladesh, the study makes recommendations within the social, cultural and religious framework of Islam, to help Muslim countries fight the growing problem of HIV/AIDS.

THE EXTENT OF THE PROBLEM IN THE MUSLIM WORLD

The Muslim world is widespread – it stretching across three continents and encompassing hundreds of cultures. In more than fifty countries, nearly forty percent or more of the populace practices Islam. 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 (Kelly & Eberstadt, 2005).

The first case of AIDS in the Muslim world was officially recorded in the mid 1980s; however, even now, most countries have not launched complete inspection, treatment, and education programs planned to prevent further spread of the epidemic. The Global Health Atlas published by the World Health Organization indicates evidence of the growing threat of an HIV/AIDS crisis in Muslim countries (WHO, 2008). This observation is concurred by the report from the National Bureau of Asian Research in the United States, which mentions the ever-growing numbers of those afflicted with HIV/AIDS in the Muslim world. These and other global epidemiological indicators portend the issue could pose a serious threat to the nations, geographical regions and the world in itself (Kelly & Eberstadt, 2005).

The number of AIDS victims is highest in Africa and it continues to have the highest HIV/AIDS incidence and prevalence rates globally. The southern region of Africa is in the worst shape. The HIV positive population is in the range of 10%-18% in Ethiopia, and 6%-10% in Nigeria; both nations have a nearly 40% Muslim population as per the last AIDS epidemic report by the UN (UNAIDS, 2012b).

Nigeria and Sudan, another majority Muslim country in Africa, already show evidence of an explosion in the epidemic rate scaling. In the rest of the world too, the epidemic is catching up. In Asia, the large Muslim population in India and China account for 138 million and 48 billion in the two most populated nations in the world. The HIV/AIDS epidemic is on the rise here too; thus the Muslim population will not be unaffected (CIA Population Index, 2012). It is estimated that 0.7 million people are currently living with HIV/AIDS in the Eastern Mediterranean Region, but only 14,198 AIDS cases have been officially registered since the start of the epidemic in the region (WHO, 2004). The under-reportage of HIV and AIDS cases in Muslim countries has a serious ill effect on the overall disease surveillance and monitoring, and hence prevention. The complacency of Muslim countries towards the alarming trends of HIV/AIDS cases can prove to be costly, both in terms of lives being lost and health care costs.

In Bangladesh, the first case of HIV/AIDS was recorded in the year 1989. Since then the number has just kept rising. The UNAIDS estimates that the number of people infected by HIV in the country is high at 12,000 and that the HIV rate in general adult population rose to 2% by 2012 (UNAIDS, 2012a). The overall presence of HIV in Bangladesh is less than 1%, however, due to limited access to counselling and the dominance of the social stigmas, many Bangladeshis are not aware of their HIV status. Although being at a lower level of risk, UNICEF predicts that Bangladesh remains extremely vulnerable to an HIV epidemic, given the socio-cultural status of the country. It is estimated that by 2025, Bangladesh will have an

HIV population equivalent to that of the worst stricken countries of Africa. The emergence of such an epidemic can prove to be futile for the poor nation.

THE ISSUES FACED IN FORMULATING PREVENTION

The issue of HIV/AIDS prevention in Muslim countries is a problem entangled with difficulties – firstly, there is no complete data set to study the rate of incidence, spread or mortality of HIV/AIDS cases. Some governments do not conduct health surveys which could help establish such a number. Others are not transparent in reporting these numbers or describing how they were collected. Consequently, the figures cannot be studied to come to some understanding of how the virus is persecuting the society.

Secondly, there are misconceptions about the disease and its causes, especially in developing countries, including the Muslim countries in our focus. Most people are ignorant and unaware that HIV infections can be transmitted in ways other than immoral sexual behaviours. Transmission also happens inadvertently, transmitted though mother to child, contact with contaminated blood or needles or through marital sex with an infected partner (Hasnain, 2005).

Thirdly, ignorance by the society and the government leads to the prevailing belief that the leading causes of HIV/AIDS, such as adultery, homosexuality, pre-marital sex, prostitution, and intravenous drug use do not occur in the Muslim world; even if they do happen, they are so infrequent that the risk of the disease spreading in these nations is insignificant (Kelly & Eberstadt, 2005). The surge of HIV/AIDS cases in these countries belies this believe – evidently, in spite of Islamic teachings, Muslims do engage in premarital or extra-marital activities that lead to them acquiring and spreading HIV. When education and counselling services are not readily and cheaply available, people have no option but to make uninformed decisions. In the current situation, the healthcare provisions by the government do not plan for the epidemic proportions of the HIV/AIDS contagion, and lack of social awareness makes citizens inured to the urgency or necessity of such a plan.

Fourthly, social taboos repress the awareness, prevention or care of HIV/AIDS. The unequal status of women in Muslim societies prevents them from realizing their legal, civil and sexual rights (Othman, 2006). Awareness is taboo – if a women talks about sexual matters, she is characterised as ‘loose’ and highly suspected of infidelity. Prevention is taboo – uneducated people claim that condoms go against the teachings of Islam, and women are not encouraged to speak or know of contraceptives. Care or acceptance of those afflicted by the HIV/AIDS virus is a further taboo – the associated social stigma is more pronounced in Muslim cultures than in any other culture (Parker & Aggleton, 2003), because of the great negative sanction for illicit sexual conducts. In general cases, if there is even a suspicion of illicit sexual conduct or any HIV/AIDS infection, the affected person(s) is discriminated against and shunned by the family as well as by the community (Hasnain, 2005). Some women indulge in commercial sex trade – another taboo – where the risk of getting infected by HIV is extremely high. Shunned by society and the government, these sex workers are not provided any health care or testing facilities; consequently, they spread the virus unchecked and are not treated when the disease is identified.

In addition to the issues mentioned and discussed above, the main challenges faced in the route to prevention of HIV/AIDS also include the grave concerns of poverty, mythical beliefs, lack of basic education, economic instability, internal conflicts, wars, lack of proper healthcare resources and infrastructure and even the intimidating role of religious leaders and activists. The following section tests the validity of discussed problems by conducting an

exploratory survey in Dhaka, Bangladesh amongst HIV infected people who were being helped by two local NGOs.

TESTING THE VALIDITY OF PROBLEMS: A CASE OF BANGLADESH

Sample

For the survey, 54 adult, 22 men and 32 women were employed to participate in this study. A survey was employed to test the nature of cultural and societal problems the participants faced when they were contracted with the virus. A questionnaire of fifteen categories was adopted to measure the responses of the participants. Questionnaires were sent out to two different NGOs in Bengali, national language of Bangladesh, and they distributed it to the participants. At a later stage the responses were emailed back and translated into English for coding and further analysis. Each NGO was given a letter of consent and the privacy of NGOs and strict participant confidentiality was maintained.

Measure

After surveying literature and talking with NGOs, the participants were provided with a list of fifteen likely cultural and societal problems they faced during their illness and in treatment. Each category was measured through a five point likert scale (1 = highly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = highly agree). The participants were asked to select multiple choices, if they felt it was a major problem they encountered. The composite measure yielded a coefficient alpha of 0.892.

RESULTS: MAJOR PROBLEMS FACED

When investigated about the major cultural and societal problems the participants faced during their illness, the results are interesting. Figure 1 presents the results for the top ten categories.

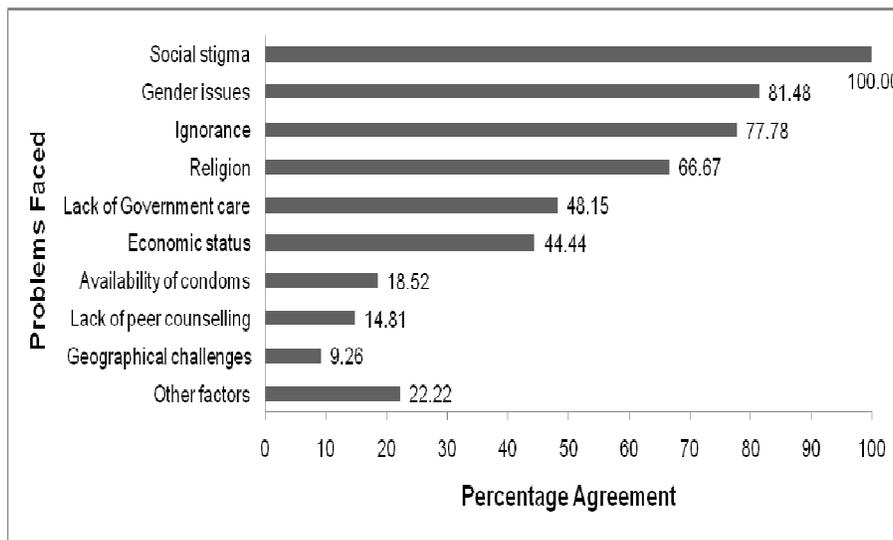


Figure 3. Major Problems Faced - Overall

The entire sample (100%, n=54) agreed that social stigma attached to AIDS was the primary problem they faced during their illness. This was followed by gender issues (81.48%, n =44) and ignorance (77.78%, n =42). Issues related to religion (66.67%, n =36) and lack of government care (48.15%, n =26) completed the top five faced problems. Few of the participants (44.44%, n =24) also felt that economic status was an important factor. Only a

few agreed to lack of availability of condoms (18.52%, n = 10) and lack of peer counselling (14.81%, n =8) to be major factors.

However, when we divided the data based on gender the results were different. Figure 2 and Figure 3 represents the responses of men and women respectively.

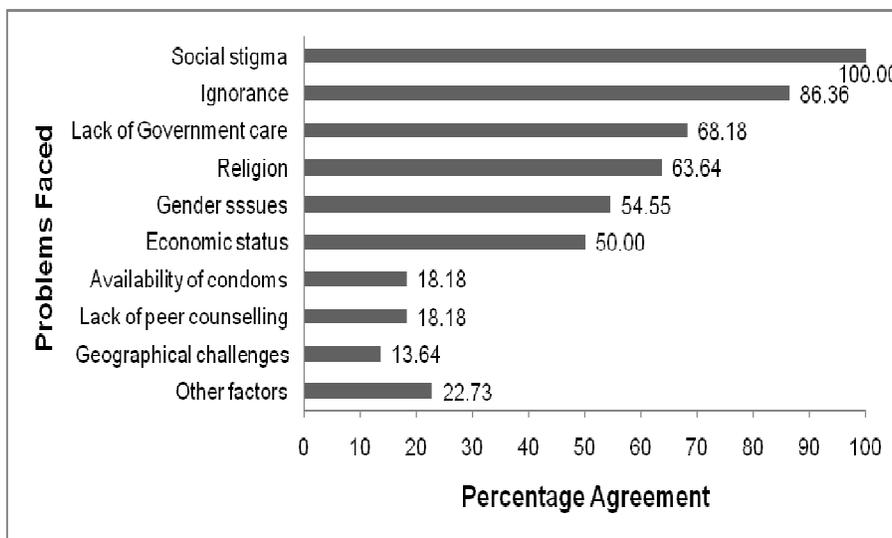


Figure 4. Major Problems Faced - Men

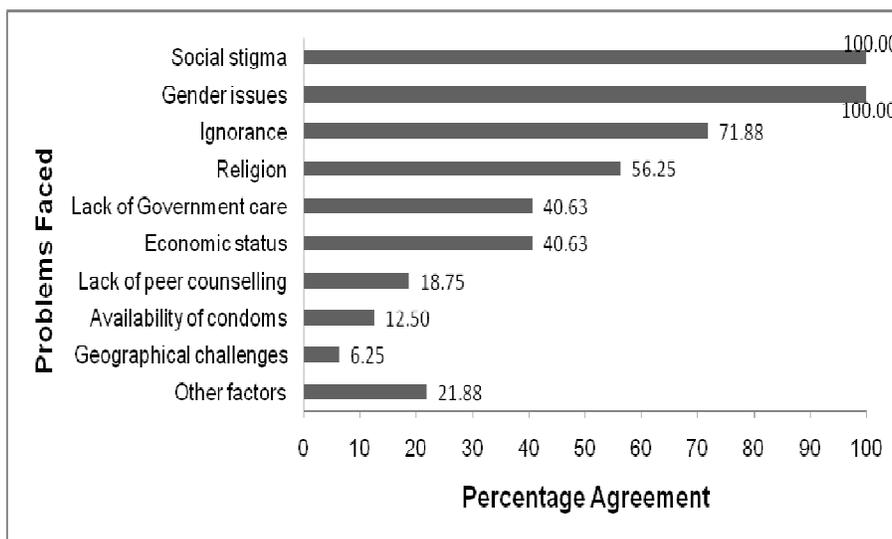


Figure 5. Major Problems Faced - Women

Both men and women agree that the social stigma attached to AIDS as the primary problem they faced but all the women (100%, n= 22) also admitted to facing gender issues and related problems in society. On the other hand, only 54.55% (n = 12) men faced gender issues or believed that being a man was a problem for them in prevention of AIDS in their society. Men (86.36%, n = 23) agreed more than women (71.88%, n =23) in ignorance being an important factor and also on the lack of government care (68.18%, n = 15). While both gender relatively agreed on religion (men =63.64%, n =14 and women, 56.25%, n = 18).

Our results validate the problems discussed earlier as social stigma, gender issues, ignorance and religious factors are the primary problems the participants faced in their experience.

RECOMMENDATIONS: THE ROAD AHEAD

The findings confirm that there is an emergent need for developing and implementing policies and effective programs that raise AIDS education and prohibit the stigmas surrounding it. Like most religions, Islam too condemns homosexuality and sex outside marriage. The most ideal protection is abstinence from sex and to remain faithful to one partner; however, the point should be recognized that there is a difference between ideal and real world situations – risqué behaviour, though disallowed by Islam, is indeed practised and makes the society vulnerable to HIV/AIDS.

The religious leaders in the Muslim community have a huge impact in the society with what they preach. Muslim governments should implement the practise of harm reduction in consultation with them to remove stigmas and illegal behaviour from the society. This approach has been implemented in some Muslim countries albeit with some discord among religious scholars. In countries such as Uganda and Indonesia, where the threat is rapidly rising, religious scholars are taking a more flexible stand to justify the usage of condoms and clean needles through Quranic and Hadith teachings. The clarification given to the public is that the sanctity and importance of life is greater than the sin of condom usage and this strategy should be used as emergency measure to prevent the epidemic (Kelly & Eberstadt, 2005).

However, in Muslim countries where the prevalence of HIV/AIDS is less or non-existent, the religious leaders believe that approving promotion of condoms will encourage sexual promiscuity. To end this controversy, the Organization of Islamic Countries (IOC), a 57 member group of Muslim countries from the Africa, Middle East, Caucasus, Balkans, Central Asia, Southeast Asia and South Asia should draft a regulation and design harm reduction strategies for the Muslim countries.

In order for prevention of HIV/AIDS and designing successful campaigns in the Muslim society it is important to note the critical roles these religious leaders play. Collaboration with the religious leaders and scholars will be the best step forward. However, there are critics of the same who believe that the work of religious leaders is not to speak about such immoral issues.

When asked, *“Shouldn’t the central body of Imams in the state take a collective action and make it mandatory to generate awareness about HIV/AIDS, especially in the villages?”* one of the most senior Imams seemed agitated and said:

“The work of an Imam is of utmost respect and it is highly dissolute of them to speak and preach about such immoral issues as HIV/AIDS.”

People who are against the ideas of the religious leaders and scholars are less and few. In Dhaka itself few NGOs that seeks to raise awareness about HIV/AIDS has been engaging Imams in their plan of actions for a couple of years now. This move has been highly successful.

One of the secretaries quotes:

“We thought about it a lot and then decided to involve the Imams because they are the most respected voices in our community. We have to realise that the rate of literacy is very low in our community and hence any campaign carried out in television or newspaper will work only to an extent. On the other hand this population respects an Imam and holds him in high esteem. So his voice will be a voice of power and belief. We organize frequent workshops where Imams turn out in large number to participate and learn. Then they go out and preach. It’s a simple but effective process.”

Involving religious leaders and scholars can be extremely beneficial. Studies and data from the past confirm the fact. In 1992, the Islamic Medical Association of Uganda designed an AIDS awareness campaign for the Muslim society in Uganda. The campaign involved twenty three trainers educating over 3,000 religious leaders and scholars, who then went back to educate their communities about HIV/AIDS during the religious gatherings (Farrel, 2003). After two years, the awareness level were tested and the studies found that there was a significant increase in accurate knowledge of HIV transmission, methods of prevention and the associated risk behaviours. Strikingly, there was also a notable reduction in self-reported sexual partners among young respondents of less than 45 years of age. In addition, there was a considerable increase in self-reported condom usage among males in urban areas. Reports in 2004 confirmed that there is a huge decline in HIV/AIDS prevalence among the members of the Muslim community in Uganda, with a drop from 18% in the 1990s to 6% in 2004 (Kelly & Eberstadt, 2005).

The Muslim nations need to come together in open. There is a lack of clear information in the Muslim nations as only a handful of cases are recorded. The major health organizations don't have a clear count of these nations. It is time for the leaders of these countries to realise the epidemic their nations are facing which needs urgent assessment. The system needs to get transparent, for both, the ones who are affected and the ones who are not.

One of the pro-active governments was the Iran government under President Mohammad Khatami in the years 2000-2005. The administration was very forthcoming about the extent of the epidemic in the nation and the urgent need to control and prevent further spread. The government also passed laws to protect the rights of the affected in order to reduce the social stigma and discrimination people face in Muslim societies. Mahmoud Ahmadinejad, who came to power after Khatami, has carried the good work ahead and recent developments look even more promising (Kelly & Eberstadt, 2005).

There is also an urgent need in Muslim countries for enhancing HIV prevention and therapeutic services for high-risk groups, such as drug abusers, commercial sex workers and those with alternative sexual lifestyles.

The Western world too needs to come forward and assist the Muslim societies grappling with this crisis. The West can cooperate with the Muslim leaders and design and implement culturally acceptable and appropriate behavioural change and counselling programs. Most of the Muslim countries lack the infrastructure to support a HIV/AIDS care – countries with better programs and infrastructure can help in designing and improving the public health systems in the Muslim countries that are lagging behind. An improvement in general public health system can also help reduce other health problems and in general raise the quality of life in these countries.

Limited attention has been paid to the manner in which social, economic and political variables restrict or enable individual behaviours related to AIDS. The association of variables such as social and human capital along with religiosity compels prevention of efforts to look beyond the traditional biomedical model of AIDS prevention. The prevention has failed in the past, or rather not worked at its best because not much research was done to note the critically important cultural dimensions. The models developed in the Western countries can be tailored and adjusted according to the local Muslim culture to address the needs of those who are at risk or are suffering from HIV/AIDS.

CONCLUSION

The threat of rising HIV/AIDS infection in the Muslim world is a major cause of concern. This problem needs effective education in public health method for controlling the spread of HIV/AIDS. There are many political, social and cultural barriers preventing the treatment services. There is an immediate need to cross these barriers. The goal of prevention is an ongoing process, open to change and flexible to adapt. Opening to such changes and adapting to such flexibilities within a difficult and rigid cultural and religious framework is not easy but there lies the challenge. One of the ways to reach out to the audience is through the religious teachings itself and in doing so the religious leaders play the most important role in the society.

An understanding of behavioural patterns and a provision of resources can help in providing them access to preventive measures against HIV/AIDS. For behavioural understanding – a multifaceted approach is required – in the high risk groups, it is important to understand that a few of the individuals will still choose to indulge in risqué behaviours. In the at-risk groups, the cultural taboos demand that social dynamics and practises of the population should be carefully considered. Measures can only be successful if special attention is paid to the cultural norms to gain insight into those factors that shape and define the peripheral realities for people indulging in risky behaviour. Effective counselling and education have been shown to change sexual behaviour and reduce the risk of HIV transmission even in high-risk groups.

The recommendations mentioned in the study included the fact that risk needed to be viewed within the context of the social subculture of Muslim countries in order to design strategies to reduce it. The Muslim countries need to come together, the religious leaders need to lead in true sense and with transparency in national governments along with some help from the western world this problem can be fought. However, none of the above will be successful without reducing the stigma HIV/AIDS brings along with itself in the Muslim countries.

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