

The Dynamics of HIV/AIDS in the Islamic Republic of Iran

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Princeton University*

Christine Blauvelt

Advised by Professor João Biehl

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Introduction

This paper will attempt to unveil the complex ways that HIV/AIDS is constituted in the Islamic Republic of Iran. Without personal fieldwork experience in this country, I have based my work on a critical and in depth evaluation of previous research. In this literature review, I rely on accounts from a variety of actors and institutions, including public health officials, the Iranian State, religious leaders, and members of the general community. I will pay particular attention to differences in language and discourse. By disentangling knowledge translation across various social contexts, I hope to identify some of the tensions surrounding prevention and treatment of HIV in Iran. Moreover, by tracing the history of the disease in Iran, I aim to grasp the successes and limitations of different public health campaigns. Finally, I will examine other reproductive health issues in Iran and surrounding nations as a lens for characterizing the social and political dynamics of HIV/AIDS in the Islamic Republic of Iran.

According to a 2006 conference sponsored by the United Nations Development Program (UNDP), a new HIV infection occurs every ten minutes in the Middle East and North Africa (Radwan 2006). In 2007, there were a reported 44,000 new HIV infections in this region (Baijal 2009, 8). Many public health experts argue that these statistics may not reflect the full extent of the disease; the actual numbers may be even higher given the low rate of HIV screening and the lack of accurate data and surveys. Local and international health organizations have strived to raise awareness about the issue by disseminating research findings to policy makers and the general public. Nonetheless, many public health officials maintain that the response thus far has been unsatisfactory. Khadija Moalla, the

coordinator for the UNDP on HIV/AIDS in the Arab States, asserts that “there is a silence, denial, stigma, and discrimination regarding HIV in the Arab world” (Radwan 2006).

The issue of HIV in the Middle East and North Africa (MENA) has only recently gained attention in the public health literature. Some of the commonly mentioned risk factors for the MENA region include: war-related and labor migration, rapid urbanization, poverty, blood safety, and a growing population of youth. High-risk populations consist of injecting drug users (IDUs), men who have sex with men, and female sex workers. In addition, ethnographic and historical studies have referenced religious and cultural traditions that might pose a barrier to HIV/AIDS interventions, in particular because the disease and its modes of transmission are often associated with homosexuality, sex outside of marriage, commercial sex, and drug use, which are considered sinful behaviors and are prohibited by Islamic law (*Shari'a*) (Mohammadpour 2009, 252). After watching a program about sexually transmitted diseases on the television news network *Al-Jazeera*, one young Iraqi woman lamented in her online blog that, “AIDS victims [in the Arab World] die in silence, quarantined in rooms made of shame and guilt” (Anwar 2008).

Therefore, public health initiatives have recently focused on tackling the social stigma of HIV/AIDS, which is frequently cited as the foremost barrier to care for those at risk. As Khadija Moalla explained in a personal correspondence, public health centers for free voluntary HIV testing and counseling are easy to locate, but they are heavily underutilized due to negative value-based assumptions about the modes of HIV transmission. For instance, during the process of medical examination and HIV testing, people may not want to admit to using illicit drugs or to engaging in certain sexual practices. Indeed, health care providers may hold the same stigmatizing attitudes as the rest of the community.

Similarly, there is uncertainty and concern about the confidentiality of health care information, especially in a society where HIV sufferers are often shunned (Hasnain 2005, 5).

The literature on the Middle East and North Africa has also described unique challenges for protecting female reproductive health due to gender inequalities that compromise women's civil, legal, and sexual rights. According to estimates by UNAIDS, women account for approximately 220,000 of the 480,000 HIV-infected people in the Middle East and North Africa (Sufian 2004). There are several factors that may put women at high risk of HIV infection. For instance, many women in the MENA region are less educated than men, so strategies to include sex education in schools may be ineffective for preventing transmission in women. Further, ethnographic and legal studies have found that women are often considered inferior to men in these societies, potentially leaving them more vulnerable to violence and coerced sex (Hasnain 2005, 5). As in many parts of the world, women may have less power to negotiate methods of HIV prevention (including condom use). Moreover, some studies have found that 4 out of 5 HIV-positive Arab women were infected by their husbands (Radwan 2006). Women who test positive for HIV may become even more vulnerable to physical and emotional injury or to abandonment by their families or husbands. As a result, it is believed that many women in MENA nations avoid HIV testing, since the results can cause more harm than good. Therefore, some public health institutions have endeavored to transform laws that would protect women's rights, specifically regarding marriage, inheritance, and property. The objective of these initiatives is to promote women's employment, income, and livelihood opportunities, which will hopefully empower women and encourage them to learn their HIV statuses.

Although the public health literature has implicated the aforementioned risk factors, these generalizations may not apply to all regions of the Middle East and North Africa. Patients' receptions of medical interventions often depend on divergent, and sometimes entrenched, notions of disease and health. In fact, the status of HIV/AIDS varies widely between countries as a result of differing government ideologies and laws, economic conditions, national histories, current events, existing health programs, and regional cultural values. Many public health advocates emphasize the need for new strategies to combat HIV in the Middle East and North Africa, ones that take into account the local state of affairs, the specific ways that people are positioned in the community, and the pressures that society places on its members. Therefore, I will focus on the challenges for addressing HIV/AIDS in one particular country: *the Islamic Republic of Iran*.

The first reported case of HIV/AIDS in the Islamic Republic of Iran occurred in 1987 after a blood transfusion for a six-year-old child with hemophilia (Integrated Regional Information Networks 2002). However, the issue of HIV/AIDS is only recently receiving attention from the Iranian government after years of resistance and denial. The assumption that regional rates of HIV infection are low has led government officials to dismiss the disease as low-priority compared with other pressing issues like the economy, war, unemployment, and education. However, as stated in a 2003 World Bank report, "low prevalence does not equate to low risks" (Sufian 2004). The number of HIV infections in Iran has increased dramatically, with health ministry figures of over 20,000 individuals registered as HIV-positive and at least 3,400 deaths from AIDS since 2009 (Agence France-Presse).

Recent reports have described the epidemiology of the HIV/AIDS epidemic in Iran, attempting to identify the patterns and trends of infection, the populations most affected, and factors that increase susceptibility. The Iranian Health Ministry reports that 93% of Iranians diagnosed with HIV are men, and 38% of cases are in the 25 to 34 year-old age group (National AIDS Committee Secretariat 2010). The modes of transmission for registered cases since 1986 include: *injecting drug use with infected equipment* (69.8%), *sexual intercourse* (8.5%), *unsafe blood transfusions* (1.2%), and *mother-to-child transmission* (0.6%). For cases registered in the year 2008, transmission was attributed to: *injecting drug use with infected equipment* (76.6%), *sexual intercourse* (13.3%), and *mother-to-child transmission* (0.8%).

Many international aid organizations contend that these statistics are underestimates due to weak public surveillance and poor-quality data about the prevalence of HIV/AIDS in the region (Sufian 2004). For instance, UNAIDS projects that 72,000 to 110,000 Iranians are HIV-positive, which is four to five-fold greater than the number of registered individuals in official health ministry reports (UNAIDS 2010, 196). Without systemic methods of generating information about the size and demographics of affected populations, it is difficult to measure the scope of the epidemic, as well as characteristics of those infected with HIV (including gender, age, and sexual practices) and the modes of transmission. The 'picture' of HIV in Iran may differ from the health ministry's official records, depending on which groups of individuals are being screened for HIV and which are being left out.

In the following sections, I will explore the various trajectories through which HIV/AIDS is publicly and privately acknowledged in the Islamic Republic of Iran, with a

particular focus on the relationship between public health and religion. The situation in Iran may challenge (or at least complicate) the common assumption that religion hinders scientific progress and medicine. Although the Islamic Republic of Iran relies on religious principles to justify laws and to create moral codes of conduct, this does not necessarily indicate that the interests of a theocratic state are antithetical to those of a secular government. In fact, religion may serve to reinforce social policies, including public health imperatives. This paper will develop a critical perspective of the ways that public health discourses on HIV/AIDS in the Islamic Republic of Iran have shifted in recent years, reflecting the fluidity of medicine, religion, and politics within this nation.

Drug Use in Iran

The majority of registered HIV cases in Iran were reportedly transmitted through unsafe injecting drug practices. Currently, Iran has between 1.5 and 6 million drug users, of which 150,000 to 600,000 are injecting drug users (*IDUs*) (PBS Frontline). The wide range in these statistics can likely be attributed to the fact that drugs are illegal in Iran, which makes accurate surveillance difficult. There is a long history of substance use in Iran, dating back centuries ago (Nissaramanesh 2005, 1). Iran was once a major global center of opium cultivation and distribution, with opium accounting for nearly a quarter of the nation's export revenues in the 1920s (Calabrese 2007, 1). By the mid-twentieth century, over ten percent of Iranian adults were drug users, including 1.3 million regular opium users (Nissaramanesh 2005, 1).

In 1955, efforts were made to combat opium misuse with the "Law on Prohibition of Opium Poppy Cultivation and Taking Opium." However, the official banning of illicit substances only increased smuggling, in large part because Iran is along the major drug trafficking routes from Afghanistan to Europe and Asia (Van Heuvelen 2009, 4). As such, the prohibition law was relaxed in 1969 under the Shah's regime, which permitted limited use and cultivation of opium but declared the smuggling of opium to be a capital offense punishable by death. Moreover, from 1974 to 1977, detoxification programs were established throughout Iran, serving approximately thirty thousand patients (Nissaramanesh 2005, 4). From this historical overview, it seems that Iran in the 1970s was socially opposed to drugs but nevertheless provided rehabilitation support for addicts as the 'lesser of two evils.' The complex and fascinating socio-political landscape of pre-

revolutionary Iran can be extracted from the following excerpt, which comes from the proceedings of the 1972 *Seminar on Public Health and Medical Problems Involved in Narcotics Drug Addiction*, held in Tehran and sponsored by the Central Treaty Organization.

“The addicts hold no respect for social traditions and beliefs and do not care about the realities of life. We all know that our future lies in the hands of our youth, but addiction is their great enemy. ... Drug addiction is not the perversity of an evil character; it is the consequence of psychic and personal crises with the myriad of influences of the victim’s social, economic, genetic, and cultural background ...Facilities for the registration, diagnosis, treatment, aftercare, etc. of drug-dependent individuals and groups should be regarded as an indispensable and integrated part of the health and social services structure of any community in which drug abuse exists.”

– Mehdi Sarraf, Chief of Medical & Rehabilitation Institutions, Ministry of Health, Tehran

This passage suggests that drug addiction was viewed as a chronic psychological disease, based on biology and the patient’s mental health rather than morality (“evil character”). Therefore, treatment programs were focused on re-establishing addicts as productive members of society. Even though drug addiction was still publicly denounced (as shown by the harsh language, “no respect for social traditions” and “great enemy”), pre-revolutionary Iran seems to have adopted a pragmatic approach that reduced risks instead of alienating drug addicts from mainstream society.

However, this promising situation for drug users deteriorated following the Islamic Revolution in 1979, when Iran established a theocratic system of government under Ayatollah Khomeini. The theocratic state imposed stringent campaigns against all forms of substance abuse as part of the *jihad* against sin, asserting that addiction was counter-revolutionary and anti-Muslim (Rosenberg 2010). As such, drug treatment programs were suspended and hundreds of thousands of drug users were forced into compulsory

'rehabilitation' camps. Laws against drug use and dealing were strictly enforced with severe penalties, including fines, incarceration, corporal and capital punishment. Many individuals faced lashes and life imprisonment, even for moderate drug offenses. The following is an excerpt from a 1980 TIME magazine article entitled "Iran: War on Drugs", which described an incident in a Tehran courtroom headed by Ayatollah Sadeq Khalkhali, the former head of Iran's Revolutionary Courts:

"I shall exterminate you vermin! Then, without permitting a word to be spoken in their defense, he meted out the sentences. "Those two – execution," he barked. "This one – life imprisonment. The other two – 100 lashes each." As Islamic guards led out the two men to be whipped, the judge called out after them, "Remember, every lash must draw blood." With that five-minute trial, Ayatullah Sadegh Khalkhali, Iran's notorious "hanging judge," dispensed summary justice to five more accused drug traffickers. In just six weeks, Khalkhali's firing squads have executed 120 convicted opium and heroin dealers"

The callous and unforgiving discourse in this passage reflects the punitive atmosphere that pervaded in post-revolutionary Iran. As opposed to the previous era's emphasis on therapeutic rehabilitation and medical care, the new regime employed correctional treatment and disciplinary action. Unfortunately, the strict drug laws only exacerbated the situation, counter to their intention to reduce substance abuse and trafficking in the Islamic Republic of Iran. Due to fear of being caught, many injecting drug users practiced underground, which often meant that individuals shared the same needles (Rosenberg 2010). Unsafe injecting practices increased the threat of HIV spreading throughout drug communities, and ultimately to the general population through sexual transmission.

In addition, the enforcement of drug laws has placed substantial pressure on the criminal justice system, which has both economic and health repercussions. A Rapid

Situation Assessment (RSA) of 10 urban centers in Iran, conducted in 1998, found that 73 percent of injecting drug users had a history of imprisonment, compared with only 36 percent of non-injectors (Nissaramanesh 2005, 3). Moreover, in 2000, the legal system processed over 80,000 drug offenders. These figures are important because Iranian prisons are havens of needle sharing, and therefore particularly hazardous for HIV transmission. In fact, one prison surveyed in 2001 found that 63 percent of inmates who were IDUs tested positive for HIV. Of the injecting drug users who participated in the RSA 1998 study, nearly half admitted to sharing syringes and needles. Although 88 percent reported using cleaning techniques, most were insufficient, including wiping with fingers or a cloth and rinsing with saliva or water. Until the year 2000, there was no support for drug users to obtain clean needles or methadone treatment for addiction. Without harm reduction and anti-drug programs, the number of addicted individuals increased each year, with serious effects on the spread of HIV.

In addition to a higher prevalence of substance abuse, the categorization of users has shifted in recent years. In the past, drug users were typically older men who smoked opium or drank opium in coffee and tea. This behavior occurred in traditional settings as a socially acceptable activity (Nissaramanesh 2005, 2). The typical Iranian drug addict is now an urban male, around thirty years old, married, and employed (Esack 123). This profile is quickly being altered to include a growing number of women, youth, and homeless drug addicts. In addition, the types of substances have changed since the twentieth century, particularly with increases in heroin dependency and injecting drug use (Calabrese 2007, 2). In 2000, the Taliban in Afghanistan placed a ban on the cultivation of opium. As a result, there was a dramatic reduction in the availability of opium and prices

rose significantly. This in turn led opium-users to either enroll in treatment centers for substance abuse (which were inaccessible for many) or to turn to heroin as an alternative.

Faced with an alarmingly high number of drug addicts, the Islamic Republic of Iran has taken a more pragmatic approach to dealing with substance abuse, moving away from the severe punitive-focused policies of the post-revolutionary era. Emphasis is placed on the decriminalization of drug addiction. Laws implemented in the 1990s have granted exemptions from penal punishments for drug users who seek rehabilitation. In addition, religious leaders and prominent officials in the Iranian government have made public declarations of their commitment to harm reduction. As Iran's Special Advisor to the United Nations, Paimaneh Hastaei, declared in an October 2004 official statement, "In an attempt to strike a balance between prevention, treatment, and law enforcement activities, the Islamic Republic of Iran has assumed that demand reduction is as important as supply reduction" (Calabrese 2007, 10). Notably in January 2005, Justice Minister Ayatollah Mohammad Esmail Shoshtari submitted an appeal to prosecutors, supporting harm reduction programs as "needed and fruitful" public health interventions (Calabrese 2007, 13).

Although substance abuse is still considered a crime in Iran, there is increasing acceptance of drug addiction as a medical condition (Nissaramanesh 2005, 4). It appears that the nation has adopted a treatment-oriented medical paradigm that emphasizes harm reduction. In an effort to reduce the demand for illicit substances, the Iranian government has established abstinence-based centers, 'Narcotics Anonymous' support groups, outpatient clinics, and community-based drop-in centers to provide a means of outreach to drug users. These centers supply reliable information about drug use and the risks of HIV

infection, in addition to clean needles, condoms, and substitution treatments like buprenorphine tablets and methadone. In 2003, there were eighty-eight outpatient treatment centers run by the State Welfare Office and more than fifty centers sponsored by the Ministry of Health (Calabrese 2007, 12). Moreover, more than sixty “Triangular Clinics” have been established for the health concerns of high-risk populations (including sex workers, ex-convicts, and drug users). These “Triangular Clinics” provide integrated care for HIV/AIDS, STDs, and substance abuse. Finally, Iran is one of only twenty-two countries worldwide that has established harm reduction programs for prisoners (Calabrese 2007, 11). The Iranian government provides access to clean needles and treatment for incarcerated drug addicts, as well as peer counseling and information hotlines.

Especially from an anthropological view, it is fascinating to explore how drug addiction became redefined as a chronic biological disease rather than a moral religious infraction, which suggests that religion and medicine are intimately connected and simultaneously evolving. The issue of ‘medicalization’ has been studied extensively by several anthropologists, including Margaret Lock who explains that notions of “normal” and “abnormal” are fundamentally tied to cultural and political constructions of the “moral order” (Lock 2000, 259). As such, categories of health and illness cannot be separated from the context in which they exist; definitions of disease and non-disease vary over time and place. This is especially true for mental disorders like addiction, which are often not categorized as ‘real’ illnesses. They are frequently considered ailments of the mind, with no diagnostic test to prove their existence. The medicalization of substance abuse brings several issues to the forefront of the discussion, namely regarding the production of scientific knowledge and the importance of socio-cultural factors. There is a profound

interplay between health communication and bodily states; the use of disease categories affects the way that illness is experienced, diagnosed, and treated. In his lectures Security, Territory, Population, Michael Foucault argues that power is not just negative or repressive – it positively constitutes what is normal and right in the specific social context that it is embedded within (Foucault 2007).

However, it is important to consider what is at stake when decisions are made about what constitutes disease. The practice of seeing certain conditions as medical problems can lead to new ways of addressing the illness. For instance, a biomedical conceptualization can be used to legitimize and to normalize drug rehabilitation therapy, which may mitigate the stigma associated with substance abuse by removing the blaming factor (Parsons 1951). Through the process of medical examination, drug abuse and addiction are portrayed as illnesses that need treatment, rather than conscious violations of social and moral codes. With the creation of ‘drug use’ as a disease-like state, “attention is deflected away from the social arrangements and political forces that contribute to the incidence of distress and disease” (Lock 2001, 481).

On the other hand, sociologist Renée Fox warns that medicalization can be oppressive: “Casting persons in the sick role is regarded as a powerful, latent way for the society to exact conformity and maintain the status quo” (Fox 1994, 404). Placing a medical diagnosis on social deviations (like drug addiction) is a way of accounting for disruptions of the social order. As such, substance abuse is not viewed as a problem with society itself, but as a biological aberration enclosed in the individual. Margaret Lock expands on this idea, contending that “subjectivity and symptom reporting are subsumed into medical pathologies ... the focus of attention is on the bodies of individuals, who are

essentially made responsible for their own condition” (Lock 2001, 481). Therefore, political struggles are often reflected in medical practices, as bodies become contested sites of local social and moral worlds.

Indeed, the medicalization of drug addiction in the Islamic Republic of Iran coincides with several socio-political paradigm shifts that have occurred since the anti-Western and pro-religious movements of the 1979 revolution. The revision in drug policies from imprisonment to treatment reflects a broader movement in the way that public health aligns with theocratic concerns. The Islamic State has maintained traditional values, while simultaneously responding to certain social issues in rather secular ways (Nissaramanesh 2005, 1). In fact, the Iranian government of the 1990s explored Western models of drug treatment and promoted partnerships with nonprofit agencies in the United States and other countries. Despite the fact that drugs are *haram* (prohibited by sacred law), the Islamic Republic of Iran seems to acknowledge the insufficiency of a religious-based, abstinence-only approach. Rather, the government promotes Islamic teachings, while concurrently providing a means for drug addicts to seek treatment rather than shunning them. The Iranian theocracy’s response to substance abuse appears to challenge the notion that a conservative religious administration is necessarily a hindrance to progressive healthcare, contrary to what much of the public health literature on Iran seems to suggest. Indeed, the theocratic government and modern medicine coexist in the form of harm reduction programs.

Moreover, based on a review of drug addiction and legal policies in Iran, it seems that the implementation of preventive and treatment services for narcotics users is not a *loosening* of theocratic ideas, but instead an *affirmation* of them. The orthodox idea that

'the body belongs to God' (Hamdy 2006, 484) is one of Islam's primary reasons for prohibiting drug-use. Illicit substances are viewed as anti-Muslim since they cause damage to the body, which also explains why tattoos and piercing are denied under Islamic law (Robinson 2006). In addition, all intoxicants (*khamr*) are banned since they impede one's judgment and lead one astray from Allah. In the words of the second caliph, Umar ibn al-Khattab, "*Khamr* is what befogs the mind" (al-Qaradawi 1997, 93). Seeing the widespread presence of drug use in Iran and its debilitating effects, the theocracy found it essential to put harm reduction programs into place to stop the cycle of bodily and psychological harm. Rather than shaming and isolating drug users, the Islamic Republic of Iran decided to 'heal' these people, which I would argue is actually an expression of religious values rather than a turning away from them. The theocracy is selecting the 'lesser of two evils,' a dictum that is supported by the Qur'an, albeit in a different context than substance abuse: "*If one is forced by necessity, without willful disobedience, nor transgressing due limits, then he is guiltless. For God is oft-forgiving, Most Merciful*" (Sodiq 2011, 364). Thus, the use of harm reduction is not a contention against orthodox values, but rather a verification of them. The treatment of drug addiction is portrayed as a 'spiritual cleansing' per se. In this way, science and medicine are used to strengthen religious values. The anti-drug campaigns are essentially aimed at people who have strayed from Islam, with the goal of bringing them back to their essence as followers of Allah.

Although the Islamic Republic of Iran is often applauded for its progressive approach to addressing drug use, the government's support of harm reduction programs is volatile, and there are no laws guaranteeing the rights of drug users to sustained medical care or to freedom from discrimination. For example, consider the doctors Arash and

Kamiar Alaei, who were Iranian brothers at the forefront of efforts to establish “Triangular clinics” in Iran (McGirk 2008, 280). In 2003, they elicited government support to establish health clinics on a national scale that would provide integrated care for drug addiction, HIV, and sexually transmitted diseases. Moreover, they were able to convince the Iranian religious leaders to approve their policy for needle exchange and condom distribution in drug rehabilitation clinics. However, the state of harm reduction in Iran has become more precarious since August 2005, when President Mahmoud Ahmadinejad first took office (Rosenberg 2010). Many important government officials who support harm reduction have been fired or have left office, and some of the major triangular clinics have been forced to close due to budget cuts. Moreover, the Alaei brothers were arrested at the end of 2008 after being accused of plotting to overthrow the Iranian government. The brothers were subjected to an unfair trial and given three and six-year prison sentences. Joe Amon, the director of the HIV/AIDS program at Human Rights Watch, has remarked that “Iran’s human rights record has reached new lows” (Esfandiari 2009) as a result of this case. Kaveh Khoshnod, an Iranian-American assistant professor at the Yale School of Public Health, also commented that, “Trust is the cornerstone of harm reduction ... Drug users are watching the same footage as everyone else. They see thousands of people being beaten up. It has an impact on them, too – an erosion of trust” (Rosenberg 2010). Despite progress in Iran to support drug rehabilitation, much work has to be done to ensure the stability of these programs and to protect human rights.

Moreover, the nation still fails to address other affected populations who are becoming increasingly infected with HIV. Injecting drug users represent the highest-risk population for HIV/AIDS, constituting about two-thirds of the reported cases. However,

Iran's singular focus on harm reduction leaves a significant proportion of the population unaccounted for. What other conditions place Iranians at risk for transmission? Importantly, what can we learn about the state of the Iranian theocracy from its silence and denial of these issues?

Sexual Transmission of HIV

Although injecting drug use accounts for the majority of registered cases of HIV transmission in Iran, a significant proportion (8.5%) are also attributed to sexual contact (National AIDS Committee Secretariat 2010). Moreover, there is increased speculation that cases with unknown or unspecified paths of infection (approximately 20% of the reported cases) are in fact due to sexual transmission. It is possible that individuals might refrain from reporting sexual activities to medical staff, especially given the high stigma associated with certain behaviors (pre- and extra-marital sex, male-to-male sexual activity, and commercial sex work). Social and religious taboos make it difficult to assess the profile of sexual behaviors in Iran, which further compound the challenges of identifying populations at risk for HIV. In addition, the majority of HIV testing is available in settings for drug abuse treatment, so individuals with high-risk sexual behaviors may be underrepresented in national estimates of HIV prevalence.

The risk of sexual transmission may be particularly high for individuals whose spouses are injecting drug users. The 1998 Rapid Situation Assessment (RSA) study found that, among male injecting drug users (IDUs), approximately one-half were married (Nissaramanesh 2005, 4). Moreover, one-third of married IDUs admitted to having had extramarital sex, most commonly with sex workers. Around seventy percent of the unmarried men were sexually active, and they were particularly involved in high-risk sex (74% with sex workers and 30% with other men). A 2004 follow-up RSA reported that 59% of IDUs had sex in the one-month period prior to the study; and 43% of male IDUs interviewed had engaged in pre- or extra-marital sex (Mokri 2008, 588). Furthermore,

only 16.5% of interviewees reported using condoms consistently. Another study (Zamani et. al 2006) provides further evidence of this tendency; the authors found that only 53% of sexually active male IDUs (88 of 167) had *ever* used a condom during sex.

Iranian law has official legislative prohibitions of *both* drug use and certain sexual activities (extra-marital or same-gender sex). Yet, the government has taken progressive steps towards drug harm reduction, while hesitating to broach topics regarding sex. Drug abuse (particularly of opiate narcotics) has persisted in Iran for hundreds of years, at least as far back as the sixteenth century (Mehryar 2007, 358). Although these substances are now considered illicit (by legal and religious standards), they were once commonplace and socially acceptable. As such, there is more open dialogue about the issue, resulting in general recognition that drug use still exists in Iran. On the other hand, the public health literature suggests that there is a *denial* of sexual activity outside of marriage. For instance, the Iranian government does not keep official records on sexual health, pregnancies, and abortions for females under the age of 15, since they are still considered children and are therefore not supposed to be sexually active (Greene 2002, 33). In Iran, the persistent stigmatization of many sexual behaviors makes it difficult to engage in discussions about safe sex practices. This might explain why national programs to prevent and treat drug addiction can exist, while efforts on the part of the Iranian theocracy to distribute information about the health risks of sexual activity are controversial and largely absent.

In fact, the Iranian's government's initiatives to provide sex education are largely directed at married couples, which disregards the populations that are often at the highest risk for HIV transmission (youth, men who have sex with men, and commercial sex workers). For instance, Iran has established a mandatory premarital sex education and

counseling program for all couples intending to marry (Greene 2002, 34). The course is a means of providing sensitive information about sexual and reproductive health issues, and it covers topics ranging from contraception, to reproductive anatomy, to partner communication. Although some people view these programs as innovative developments (since they create an open environment for Iranians to learn about sexual issues), they nevertheless reflect the false notion that sex only occurs within heterosexual marriage unions in Iran. These programs do not address the needs of individuals who are having pre- or extra-marital sex or same-gender sex.

Furthermore, there have been inadequate efforts to incorporate formal sex education into schools, often due to widespread beliefs that providing accurate information to adolescents about sex and reproduction might promote illicit premarital relations (Joseph 2006, 143). Although the field of public health emphasizes teaching individuals about their bodies and sexuality, the religious standpoint tends to be that sex is not a topic of discussion for young people. Sex education is a point of unresolved conflict between the public health approach and the theocratic perspective on appropriate behavior. As a result, there are few opportunities for Iranian youth to ask questions and to correct their misconceptions regarding sexual health. Although the Iranian Ministry of Education announced that school curriculums would include sex education beginning in the fall of 2001, studies since then have revealed significant gaps in adolescents' knowledge of HIV/AIDS prevention and treatment.

For instance, a study (Tavoosi 2004, 1) of high school students in Tehran reported erroneous beliefs about the routes of transmission: *mosquito bites* (33%), *sneezing and coughing* (23%), *public swimming pools* (21%), and *public toilets* (20%) were incorrectly

selected as ways that HIV infection can be spread. Similar results were found in a study of male and female students studying at the Qazvin University of Medical Sciences and the Iman Khomeini International University (Simbar 2005, 890). The students reported the following HIV prevention methods: *applying moral principles* (75%), *using condoms* (49%), *avoiding using syringes and blades* (61%), and *abstaining from sex* (17%). The data suggest that a higher percentage of students knew about the risks of injecting drug use than about the risks of unprotected sex, which might reveal something about the knowledge and attitudes of Iranians towards HIV/AIDS. These statistics could be used to support the notion that drug use is less condemned by Iranian society than pre- or extra-marital sex, resulting in greater support for drug harm reduction programs and ultimately, an increased awareness about the modes of HIV transmission associated with injecting drug use. Furthermore, the overwhelming majority of students believed that following “moral principles” would protect them from HIV infection, which might illustrate the strength of religious values embedded in Iranian society and the ways that these principles might influence their responses. However, it is also possible that the participants were simply stating the ‘*right*’ answer. When reading public health literature, it is important to consider how people get the empirical evidence upon which they base their conclusions. How are the data produced, what is the validity of numbers, and what are the socio-political factors that influence how statistics are generated and interpreted? Although data in the public health literature suggests a widespread ignorance about safe sexual practices in Iran, it is extremely difficult to measure the true value of these numbers due to the potentially biasing effects of political and cultural norms.

Nonetheless, this study does suggest that religious language is being used to promote HIV/AIDS prevention, which could help explain the acute social stigma against HIV-positive people in Iran. This moralizing discourse may be a principal barrier to HIV/AIDS prevention and treatment in Iran. By presenting HIV in a context of Islamic devotion, the disease might be equated with debauchery and impious behavior. The public health literature asserts that stigma prevents people from becoming tested in the first place, and it often results in substandard medical care for those that do. This raises a larger question in the field of medical anthropology: How can the *language* of health care disseminate certain attitudes, and what is its role in maintaining health disparities? A recent study conducted in HIV care clinics in Tehran documented the negative value-based assumptions about individuals living with HIV (Rahmati-Najarkolaei 2010). The subjects experienced various forms of discrimination from their health care providers, including refusal of care and second-rate services, excessive use of safeguarding and precautions, and psychological abuse and blaming. For instance, providers often presumed that HIV infection resulted from taboo sexual behaviors, such as homosexuality, prostitution, and adultery. One young Iranian woman in this study recounted being interrogated by her female doctor: “They blame me for doing something sinful. I am married. I have never had any relationships out of wedlock” (Rahmati-Najarkolaei 2010, 5). Most participants referred to the concept of religious sins (*gonah*) as they correspond to HIV transmission (Rahmati-Najarkolaei 2010, 8). The disease is moralized in health care settings and viewed as a product of wrongdoing, which shifts the blame onto the patient and disregards the social conditions that might increase vulnerability. Another patient remarked, “They look at you as if you are a lunatic who deserves to get this horrible disease” (Rahmati-

Najarkolaei 2010, 5). In addition to being humiliated and castigated, these individuals are often denied standard medical care, which makes them even more susceptible to poor health. One participant reported being mistreated and misjudged by her medical providers: “They hesitated to examine me. I heard my nurse saying to herself that I came here to infect them too” (Rahmati-Najarkolaei 2010, 4). This instance illustrates the pervasive notion that people with HIV are immoral, debased members of society. This ‘picture’ of the disease poses serious barriers for the prevention and treatment of HIV/AIDS in Iran.

Instead of challenging social norms and spreading awareness about HIV/AIDS, medical professionals appear to play a significant role in *perpetuating* stigma and misconceptions. To begin with, professions that study the body or religion (physicians and the clergy) are held in great esteem in Iranian culture. Thus, most Iranians readily accept their doctors’ opinions, including their perceptions and attitudes towards HIV/AIDS. Moreover, in Iranian Shi’a-Islamic culture, the physician is the only exception to the rules of *mahram*, which prohibit one from exposing his or her body to individuals other than spouses or close relatives (Rahmati-Najarkolaei 2010, 9). According to Iranian Islamic traditions, a *mahram* is an individual who one cannot marry on the account of consanguinity, which includes blood relatives, in-law relatives, and wet nurses (Mehryar 2007, 359). The *mahram* relationship is characterized by compassion, reliance, and selflessness. As such, for the physician to be akin to the *mahram* indicates a close and mutual trust between the patient and provider. In this context, healthcare professionals in Iran are socially recognized as a patient’s consultant and confidante. Therefore, the doctor’s rejection of HIV-positive patients represents a highly degrading and humiliating

situation. To be dismissed by one's caretaker is more psychologically debilitating than to be denied most other kinds of services. As a young Iranian housewife deplored, "This hurts your spirit. When the doctor does not care about me, when she/he doesn't communicate with me effectively, what should I expect from other people?" (Rahmati-Najarkolaei 2010, 6).

The impact of the patient-provider relationship and discrimination among doctors has been studied in the context of medical anthropology, particularly in João Biehl's research of AIDS treatment in Brazil. In Will to Live, Biehl observed a triage system and a "politics of survival" (Biehl 2009, 47) that left certain individuals unaccounted for, both epidemiologically and medically. Community-run AIDS centers were often overrun with homeless patients and those who had been rejected by surgeons and psychiatric units. These individuals were cast aside as noncompliant or untreatable. As one immunologist explicated: "AIDS is a disease that does not deserve direct investment. It is a fatal disease; the person will die anyway ... furthermore, he is a faggot, a drug user, a marginal, so why should I treat this individual? He must die" (Biehl 2009, 216). Biehl suggests that there are value systems that lie within medical infrastructures, and he challenges the notion that physicians are nondiscriminatory in terms of whom they treat. Similarly, Iranian healthcare providers often have the same religious and moral assumptions as the rest of the population with regards to HIV/AIDS. In this way, patients with HIV are often abandoned by the health care system, which causes further deterioration of their mental and physical well being. Moreover, since science is generally tied to objectivity, the physician's negative attitude toward the disease may generate the notion that individuals with HIV are undeserving of standard medical care as a matter of biological fact. As the

aforementioned informant in Biehl's study pointed out, "The person will die anyway ... He must die."

In the Islamic Republic of Iran, the role of religious norms in shaping medical practices is complex, multilayered, and often contradictory. For example, the national drug harm reduction programs are counter-evidence to the idea that religion inherently opposes modern medicine. They challenge the pervasive sentiment that Islam constrains scientific progress. On the other hand, the stigmatization of certain sexual activities in Iran *does* pose a significant barrier to HIV prevention and treatment. These taboos stem largely from the moralization of sex; Islamic society propagates the idea that sin and indulgence cause HIV infection. Thus, although religion is not necessarily in opposition to public health, it can complicate the issue.

Reproductive Health and the Evolving Muslim Identity

Iran's pragmatic approach to drug addiction contrasts with its response to sexual health, which reveals some of the broader cultural tensions towards issues of reproduction and sexuality. By looking at other reproductive health issues in Iran and other parts of the Muslim World, I will attempt to provide a framework for understanding the complexities of HIV/AIDS policies. Through this comparative analysis, we can gain insight into how theological tenets might be in opposition with public health policies, and similarly, how religion might be used to supplement and strengthen medical interventions. Moreover, we can begin to think of new ways that HIV/AIDS programs can be constructed in Iran, so that they are religiously sound and culturally acceptable.

Rapidly evolving biotechnologies have often provoked ethical quandaries in Iran, raising difficult questions about what constitutes Islamic tradition. It is insufficient to claim that religion directly opposes modern medicine, or that resistance to scientific developments is the result of "backwards" thinking. By reducing the issue to such singular logic, one disregards the complex processes through which theological scriptures are interpreted and re-interpreted over time. Many modern-day issues are not explicitly addressed in ancient texts. Thus, Iranian society has continuously discovered new ways of making sense of Islamic tenets to produce novel traditions and customs. Religious texts are construed in various ways to match diverse and changing social needs. In other words, the Muslim identity itself is persistently being contested and reconstructed.

Islamic Sacred Law (*Shari'a*) derives from the *Qur'an*, the *Hadith* (the sayings of the Prophet Muhammad), and the *Sunnah* (the Prophet's actions and actions done with his approval). Various schools of jurisprudence hold different standards for how the *Shar'ia* laws are defined, most importantly in the extent to which independent legal judgment (*ijtihad*) is permitted (Obermeyer 1994, 42). Since the aforementioned scriptures are often ambiguous, the same text can be used to legitimate divergent ideologies. As such, different political centers and religious sects may not share the same legal codes due to their disparate interpretations of Islamic doctrine. In many cases, the impact of Islam on lifestyle choices is a function of political context; the State ultimately decides how these issues are defined, more so than the religion itself.

Issues of reproductive health have been particularly difficult to legislate due to the ambivalent nature of Islamic texts. Topics regarding sex and the body are extremely sensitive in Islam, leading to extensive debate about which behaviors are sanctioned under sacred decree and which are *haram* (forbidden). For instance, Iranian attitudes towards family planning and contraception have shifted multiple times, primarily reflecting changes in political paradigms. Following the Iranian Revolution of 1979, the newly established administration rejected Western cultural influences and redefined the nation's social values, particularly pertaining to the role of women in Iranian society (Moghadam 2004a). The new theocratic government instituted policies that restricted women's rights and celebrated 'traditional Islamic' values. Women were excluded from many fields and professions (Mahdi 2004, 434), especially from the legal system (female judges were banned and women were discouraged from being lawyers). The theocratic government discouraged women's involvement in the workplace and instead promoted their family

roles; fertility was portrayed as a basic Islamic value. The Family Protection Acts of 1967 and 1973 were subsequently repealed, which eliminated policies that had previously restricted polygyny, increased the age of marriage for girls, and given women the right to divorce (Moghadam 2004b, 1). Importantly, these policy changes limited access to contraceptive methods like condoms, which not only prevent pregnancy but also avert the spread of sexually transmitted diseases. In the new regime, women became symbols of societal transformation and the eradication of moral corruption, but this came only at the expense of human rights and reproductive autonomy (Moghadam 2004b, 2).

The suspension of family planning practices was, however, more a reflection of the social atmosphere of post-revolutionary Iran than an enforcement of deep-rooted Islamic tradition. Although the change in policy was justified on religious grounds, *Shar'ia* laws do not explicitly oppose contraception and little is mentioned about the issue in the theological texts. In fact, one of the few acknowledgments of family planning is a well-known *hadith* in which the Prophet Muhammad condones the primitive birth control method of withdrawal, "coitus interruptus" (Obermeyer 1994, 43). The scripture tells the story of Onan who says to the Prophet, "I dislike her becoming pregnant, yet I have the desires of men" (Corson 1994, 396). Although the Jews believed that withdrawal "constitutes killing a life in miniature form," the Prophet contested, "If God wishes to create it, you can never change it." In other words, this text actually sanctions birth control under Islam.

It was primarily the *political* climate of the revolution that constrained reproductive health choices, although religion was used as a rationale. The post-Revolution's pronatalist policy led to a dramatic increase in the fertility rate, and the Iranian population

grew at an unprecedented rate of 3.9 percent annually from 1976 until 1986, according to national census data (Obermeyer 1994, 47). In fact, the 1986 census indicated a total fertility rate of 7.1 births per Iranian woman (Jalal Abbasi 2002, 3). This trend continued until the early 1990s, which saw the reintroduction of national programs for distributing birth control (Jalal Abbasi 2002, 5).

In the same way that pro-natalism was a reflection of political ideology, the government's reintroduction of family planning services in 1988 was linked intimately to the shifting social needs of Iranian society. The massive population growth of the previous decade was unmanageable and potentially disastrous, especially coupled with an Iranian economy devastated by the war with Iraq and by inept and inconsistent economic policies. Within two months of the end of the Iran-Iraq war, the Islamic Consultative Assembly (*Parliament*) initiated a National Birth Control Policy with a five-year plan to reduce population size, to encourage birth control use, to increase women's education, and to advance the "participation [of women] in the socioeconomic management of family and society in general" (Plan and Budget Organization 1989, 18).

The fertility rate in Iran declined significantly as a result of these initiatives, reaching one of the lowest rates in the Middle East (2.96 according to the 1996 census) (Jalal Abbasi 2002, 30). The program also improved basic health indicators, producing declines in infant mortality (from 45 to 26 deaths per 1000 live births), child mortality (from 56 to 33 deaths), and maternal mortality (from 91 to 40 deaths) from 1988 to 2000 (Mehryar 2007, 354). Indeed, the campaign was promoted through the slogan, "*Farzand Kamtar, Zendegi Behtar*," which means 'Fewer Children, Better Life'. According to a Population and Health Survey conducted in 2000, nearly 75 percent of married women

ages 15 - 49 were using a contraceptive, and most of these (55 percent) were using modern birth control methods including pills, injections, sterilization, condoms, and IUDs (Ministry of Health and Medical Education 2003). In fact, Iran is one of the few countries in the region that legally permits both tubal ligation and vasectomy, while nations like Jordan and Egypt do not allow either. Many Islamic religious leaders in the Middle East reject sterilization on the basis that it causes permanent harm to the individual; only to the extent that contraceptive methods are reversible are they condoned. However, Iran has expressed a distinctively accepting attitude towards the issue of sterilization.

In response to current social and political needs, the Iranian theocracy revised its stance on family planning and reinterpreted the religious texts to promote better living conditions. This example illustrates the broader notion that Islam is *not* static or binding. Rather, religion and society are mutually constructive. Islamic tenets and the everyday social realities of Iran are formed as products of each other.

The mutable and historically situated nature of Iranian Islam is also evident in the way that infertility is currently being addressed, compared with other nations in the region. In many parts of the Muslim World, male infertility is highly stigmatized since paternity is a major contributor to one's masculine identity. As anthropologist Marcia Inhorn explains, "Middle Eastern men achieve social power in the patriarchal, patrilineal, patrilocal, endogamous extended family through the birth of children, especially sons, who will perpetuate patrilineal structures into the future" (Inhorn 2004, 170). In other words, fertility is often tied directly to virility. Inhorn has based much of her research on this topic, looking specifically into the ways that new reproductive technologies are simultaneously promising and problematic. Medical advances designed to overcome male

infertility can help prevent the emasculating condition of childlessness for Middle Eastern men (Inhorn 2004, 162). For instance, an intracytoplasmic sperm injection (ICSI) is an *in vitro* fertilization procedure in which a single sperm is inserted directly into the egg. This reproductive technology can be effective in cases when the male's sperm cannot penetrate the egg (American Pregnancy Association 2007). However, Inhorn reports that usage of such services is often shrouded in secrecy: male infertility treatment for Egyptian men is seen as “embarrassing,” “sensitive,” and “private” (Inhorn 2004, 170). Individuals experienced *ana mish raagil* – “I am not a man.”

In addition to being socially stigmatized, assisted reproductive technologies (ARTs) using third-party donations are illegal in most Middle Eastern countries, particularly those with Sunni Muslim majorities (Inhorn 2004, 174). Based on interpretations of the Islamic scriptures, Sunni Muslim religious scholars strictly prohibit alternative approaches to family formation for infertile couples, such as donations of sperm, eggs, embryos, and surrogate uteruses, as well as the legal adoption of orphans. Inhorn attributes these restrictions to “patrilineal kinship ideologies” (Inhorn 2004, 174). Islamic culture emphasizes the importance of *biological* paternity. This mindset was often reflected in Inhorn's conversations with Egyptian and Lebanese informants, who declared that a child produced from donor gametes “will not be my son” (Inhorn 2004, 174).

Interestingly, the Islamic Republic of Iran is the only Muslim nation in which *in vitro* fertilization using third-party donations of gametes and embryos has been authorized by both legal authorities and religious leaders (Abbasi-Shavazi 2008, 5). These practices are legitimized through the Shi'ite application of *ijtihad*, or individual religious reasoning. This grants Shi'ite religious leaders a large degree of freedom and flexibility in interpreting

theocratic texts, which in turn has generated pragmatism and acceptance towards technological innovations. Although *ijtihad* also constitutes a large portion of Sunni Islamic tradition, the Sunni Muslim clerics tend to give considerable precedence to the scriptures (Abbasi-Shavazi 2008, 5). The majority of Iranian citizens are Shi'ite Muslims. Therefore, through the exercise of *ijtihad*, Iran's Muslim spiritual leaders overturned the previous *fatwa* banning assisted reproductive technologies. Towards the end of the 1990s, Ayatollah Ali Hussein Khamanei issued a new *fatwa* approving egg and sperm donations, although the child in such cases is considered adopted and can only inherit from his or her biological parents (Inhorn 2006, 234). This example illustrates a broader point that the relation between religion and medicine is highly complex, shaped by multiple factors, and not determined *a priori*. The variety of ways that assisted reproduction is understood in Middle Eastern countries shows that there is no singular relationship between Islam and medicine.

Moreover, in order to reduce the stigma associated with donated eggs, many Iranian men with infertile wives are turning to the practice of temporary marriage (called *mut'a* or *sigheh*), which is permitted by Shi'a Islam but not recognized by Sunni religious leaders. This practice allows Iranian couples to accept gamete donations, while still having a child that is not born out of wedlock (Inhorn 2004, 436). Thus, a *muta'a* is often highly recommended between the husband and the egg donor. In such cases, the egg donor becomes a second wife to the husband from the time that eggs are retrieved until the transfer of fertilized embryos into the wife's uterus (Inhorn 2004, 176). This new application of the Islamic tradition of *mut'a* demonstrates how novel religious practices are being invoked in the face of emerging biomedical procedures. As Marcia Inhorn points out,

“the global is always imbued with local meaning, such that local actors, living their everyday lives at particular historical moments in particular places, mold the very form that global processes take” (Inhorn 2006, 429).

The permissibility of Iranians towards reproductive technology is especially interesting in the context of the nation’s family planning initiatives. In an apparent contradiction, the Islamic Republic of Iran has implemented population control measures, while simultaneously sanctioning the use of infertility treatments. Moreover, contraceptive methods and assisted reproductive technologies are *both* promoted through a religious discourse. This seems to support the notion that Islam in Iran actively responds to contemporary public interests, rather than relying on traditional interpretations of the scriptures. *Ijtihad* enables the Shi’ite Muslim spiritual leaders in Iran to reassess Islamic law so that it remains relevant to current conditions.

The ‘Muslim identity’ in Iran is constantly in flux, as exemplified by the fact that Iran’s policies on family planning and fertility treatment have fluctuated in tandem with shifts in political ideologies, social values, and the collective needs of the community. In essence, the religious, political, and medical practices in Iran are constantly *evolving* through time and place. Moreover, they exist *in relation* to each other, and the interweaving of these three core aspects of Iranian society implies that an understanding of any one issue can only be understood in the context of the other two.

The Role of Islam and Politics in the Fight Against HIV/AIDS

The fact that cultural norms and standards of social acceptability are constantly changing affords possibilities for altering the dynamics of HIV/AIDS treatment and prevention in the Islamic Republic of Iran. Emerging biotechnologies in Iran and the surrounding nations reflect the fluidity of political and religious doctrines. However, the intertwining of medicine with religion and politics also means that health initiatives in Iran are often complicated by tensions between the Iranian State and the clerical establishment. These conflicts must be considered when proposing strategies and programs for controlling HIV/AIDS in Iran. One must examine the convergences and divergences between “divine” interpretations of Islam (*according to religious leaders*), the “official” laws of an Islamic society (*according to government officials*), and the “unofficial” discourses and practices based on what actually occurs in local populations.

There can be little debate about the prominence of religion in Iranian society. Individual belief practices and political-legal structures are largely guided by *Shari'a*, or Islamic Law. Thus, spiritual authorities should be involved in efforts to quell a rising HIV/AIDS epidemic in Iran, especially since they have traditionally set standards for reproductive practices. The Iranian clergy should be encouraged to develop a religious discourse for HIV/AIDS prevention and treatment programs. Historically, Iran’s Shiite jurisprudence has adjusted its codes of conduct in a progressive manner to accommodate the changing needs of Iranians (Khalaji 2010). Many times, pragmatic considerations about public interests have taken precedence over theoretical or moral arguments. Therefore,

public health initiatives should not *challenge* the authority of religious institutions, but rather, should *collaborate* with them to educate Iranian citizens about the practical consequences of their reproductive behaviors. In the fight against HIV/AIDS, Muslim religious leaders should be mobilized to create healthier conditions for Iranians.

Perhaps the Iranian clergy can have the most substantial impact on reducing the stigmatization of the disease. There are several barriers to accessing care for HIV/AIDS in Iran, but the most pervasive is the *shame* associated with a positive HIV test result, which often leads to delays in diagnosis and treatment. In the words of an HIV-positive Iranian woman, “If people want to wish someone the worst luck, they would wish him to get AIDS. You know, I couldn’t accept the bitter reality about myself until the time I observed some symptoms ... Then I was forced to test” (Mohammadpour 2009, 252). In the same study, another informant explained, “They say you are HIV-positive because you are irresponsible, addict, dirty, and so on” (Mohammadpour 2009, 253). Having the disease brings about humiliation, disgrace, and indignity on the part of infected individuals, primarily since there is a widespread perception that having HIV is synonymous with being ‘anti-Muslim.’

For this reason, Iranian religious leaders can play a crucial role in addressing negative value-based assumptions about HIV/AIDS. Particularly given their influence within the community, religious leaders can promote an accepting attitude towards HIV-positive individuals, which in turn might generate a more open environment for Iranians to seek sex education, prevention methods, testing, and medical management of the disease (McGirk 2008). In fact, a recent study in Iran showed that HIV-infected patients with spiritual beliefs were less likely to develop isolation, depression, or suicidal thoughts

(Mohammadpour 2009, 256). Compassion and support from religious institutions may enable these individuals to cope with the physiological and psychological challenges of HIV.

Public health interventions often operate under the assumption that health disparities arise from a lack of knowledge or a scarcity of medical services. However, this does not fully embody the problem, since technological approaches are futile unless they align with local norms and cultural values. For example, although Iran's family planning program has been well-received by the Shiite majority, it has been significantly less successful among ethnic and religious minorities, such as Afghan refugees who are predominantly Sunni Muslim (Tober 2006). Iran's family planning programs operate in accordance with the Shi'a religious system, which has several fundamental departures from Sunnism. Therefore, *fatwas* issued by the Shi'a clergy in Iran to define the parameters of medical treatment are often rejected by Sunni Afghans, who tend to favor a more literal interpretation of Islamic texts over individual reasoning. As Iranian health officials and medical providers explain, "Many Afghans don't use contraception because they are Sunni, and it is against their religion" (Tober 2006, 53). Of course, the issue should not be reduced to religious differences alone, since there are a variety of other factors involved including culture, experiences of war, and rates of infant mortality. However, decisions about whether to use family planning are considerably informed by Iranian Shi'a clerical support of family planning, which is based on religious discourse that falls outside the frame of Afghan Sunni beliefs.

Important public health lessons can be drawn from the resistance of Afghan refugees towards Iran's family planning services, namely that initiatives cannot succeed if they are incompatible with cultural values. Despite being easily attainable and free-of-

charge, contraception is frequently under-utilized by ethnic and religious minorities in Iran. This example highlights the fact that health care is not just about *availability*, but also about the *acceptability* of services. Therefore, initiatives to address HIV/AIDS in Iran by increasing access to testing and treatment may be insufficient; the establishment of health facilities does not guarantee that they will be used. Rather, since religion constitutes such a large part of Iranian culture, the clerics should be engaged in HIV/AIDS programming in order to construct policies that are both medically effective and culturally appropriate.

In addition, the discrepancy in family planning usage between Afghan Sunnis and Iranian Shiites reflects the diverse interpretations of Islam, which vary widely across Muslim societies and between Islamic sects. As the religion continues to expand globally, different communities have developed divergent practices, based on local norms and morally imbued understandings of the sacred texts. Therefore, initiatives to address HIV/AIDS are complicated by the multiplicity of local religious moralities; what is meant to be a “good Muslim” cannot be singularly defined in complex Islamic societies like Iran.

Public health initiatives are also problematized by the ambiguous parameters of a theocratic government. The hypothetical framework of a theocracy is one in which religious leaders specify moral codes, while the government takes on the role of enforcing them. However, in reality, there is a substantial divide between the clerics and the State officials in the Islamic Republic of Iran, so the opinions of religious leaders may not reflect the legal policies and programs that are actually being implemented. This is relevant to our discussion of HIV/AIDS, because working with the clergy to reduce stigma does not ensure that the theocratic government will respond in the same way. Scholars of Iranian history have implicated a fundamental tension between the clerical establishment and the

government, which dates back to the inception of the theocratic political regime. As a result of the politicization of religion, there is much uncertainty over the clergy's relationship to the political power and about who holds higher authority. As Yousra Fazili remarks, "this is neither a matter of secularism versus religion nor clerics versus non-clerics; it is a struggle *within* the religio-political establishment" (Fazili 2010, 41). The crux of the argument is whether there is a moral basis of legitimate political authority. In other words, can (and should) the clergy and the government be one and the same? At the most basic level, most modern jurists agree that an Islamic government is one that enforces *Shari'a*, or Islamic law. However, there is little consensus over the extent to which *Shari'a* should be implemented into legal practice. Moreover, there are disagreements about what legal terms are actually specified by *Shari'a*, which arise primarily from *ijtihad* – the Shiite practice of using individual reasoning to interpret the sacred texts. Interestingly, the Iranian theocracy appears to *disempower* its religious leaders, which is in direct contrast with the theoretical framework of this type of political institution. As Iranian journalist Mehdi Khalaji explains, "any clerical opposition to the theocratic regime [is] seen as an internal fight between clerics, with both parties able to damage each other's religious legitimacy and prestige" (Khalaji 2010, 4).

Matters of healthcare are both religious and political in nature. Thus, in the context of HIV/AIDS policies, the major question is whether Islamic law (*as defined by religious leaders*) or customary law (*as defined by the State*) has greater influence on society. The construction of HIV/AIDS programs that are compatible with Iranian society is part of an ongoing debate over the moral basis of power and authority. Surprisingly, bureaucratic officials in recent years have been *more* resistant to progressive medical policies than the

Iranian clergy (Khalaji 2010). Indeed, many of the recent obstacles to developing HIV/AIDS policies have been the direct result of political resistance, not just religious opposition. Efforts to gain the support of religious leaders may be unprofitable if the government withdraws its financial support of health programs. For example, as previously discussed (pp. 14–15), the current administration under President Ahmadinejad is largely responsible for the decline of triangular clinics for drug abuse, HIV, and STDs. On the other hand, therapeutic goods and services (like HIV testing and free antiretroviral drugs) may be under-utilized without the approval of the clergy if notions of impiety and immorality remain attached to HIV/AIDS treatment.

In sum, the tensions between religion and politics add another dimension to the issue of HIV/AIDS in Iran, which interfere with the development of testing and treatment programs. There is often dissent between the clerical establishment and the theocratic state about hierarchies of power and about interpretations of *Shari'a*, which may lead to further complications in the way that standards for medical practices are defined. Moreover, religions are seldom univocal on matters political, and Islam is no exception. There is a diversity of competing perspectives within the Islamic Republic of Iran, and it is erroneous to assume universality in the relationship between religion and politics.

Conclusion

In order to address the issue of HIV/AIDS in Iran, we must ask the question: What are the manifold conditions that place people at greater risk of infection? Is the spread of HIV due to opposition from Islamic religious leaders, or is it *really* due to oppressive socio-political factors and fluctuating material conditions? As I have demonstrated throughout this paper, social realities in the Islamic Republic of Iran are continually evolving: *health care practices* change with new biomedical technologies, *religious experiences* are redefined through the application of *ijtihad*, and *political ideologies* vary with new regimes and administrations. In addition, these factors are mutually constructive and cannot be understood independently of each other. Religious, medical, and political practices are being newly constructed through dynamic and integrated processes, such that they should not be perceived as separate, static entities.

Moreover, there are several contradictions that complicate the common assertion that religion impedes scientific progress and medicine. For instance, the Iranian religious leaders have not always been opponents of sexual and reproductive health care, as was seen in the case of family planning programs and fertility treatment. The clergy also supports harm reduction initiatives despite the religious prohibition of drug abuse. In addition, ideologies of the theocratic government do not necessarily align with those of the clerical establishment, contrary to the assumption that the Iranian theocracy implements Islamic law as defined by the clergy. Therefore, what might be viewed as religious opposition to HIV/AIDS programs may actually represent political resistance.

This paper has attempted to show that the 'Iranian identity' and the 'Muslim identity' are difficult to define and can vary by time and place. Consequently, public health imperatives to combat HIV/AIDS in Iran must take into account the intertwining of religion, politics, and medicine. Given the interplay between people and institutions and larger social processes, it is insufficient to brandish single-factor explanations or 'magic-bullet' solutions. The conditions that create susceptibilities to HIV/AIDS are complex, multi-layered, and constantly in flux.

Honor Code:

This paper represents my own work in accordance with University regulations.

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