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The Divergence of Faith and Practice: Bridging the Gap Between Islamic Sexual Morality and Public Health Realities in Lanao del Sur

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Abstract

In the deeply religious and conservative province of Lanao del Sur, HIV is transformed into a catalyst for profound social rejection and extreme denial through the Meranaw cultural imperatives of maratabat (honor) and kaya (shame). This environment forces high-risk demographics, particularly Men who have Sex with Men (MSM), into a "clandestine reality" where the fear of family dissolution and societal ostracization outweighs the drive for medical care. Existing institutional interventions frequently fail because they lack the necessary cultural and religious legitimacy to penetrate these deep-seated socio-cultural barriers.

The research seeks to address the critical disconnect between the availability of clinical services and the sociocultural factors that prevent their utilization. By applying the Social Ecological Model and the Health Belief Model, the study aims to identify a path forward that bridges the divide between formal public health strategies and the traditional religious values of the Meranaw people. The study utilizes a qualitative research design that gathers insights from a cross-section of influential stakeholders, including medical professionals, religious leaders known as the Ulama, and community elders or Datus. This multi-perspective approach allows for a comprehensive analysis of how health-seeking behavior is influenced by both the formal medical system and traditional leadership structures.

Findings reveal that the Ulama and Datus hold the significant authority required to reframe the HIV narrative by invoking the Shariah mandate of Hifzul Nafs, or the protection of life, to sanction medical treatment. The research suggests that effective intervention must include the co-creation of culturally sensitive materials, the institutionalization of family counseling at the Amai Pakpak Medical Center to mitigate domestic rejection, and the utilization of traditional communication channels to reach vulnerable youth populations. The study demonstrates that a sustainable HIV response in Lanao del Sur requires a synergistic partnership between the formal health system and traditional religious structures. By leveraging Islamic ethics of compassion and preservation, the proposed framework seeks to dismantle the "open secret" of the epidemic, thereby lowering perceived barriers and enhancing the self-efficacy of affected individuals within their specific socio-cultural landscape.

Keywords: HIV/AIDS, Meranaw Culture, Islamic Bioethics, Socio-Cultural Barriers, Health Belief Model

1. Introduction

The global HIV/AIDS epidemic remains one of the most persistent public health challenges of the modern era, yet its impact and the effectiveness of interventions are profoundly shaped by local socio-cultural landscapes. In the context of Lanao del Sur, Philippines, the intersection of scientifically-based public health delivery and a deeply religious, conservative Meranaw society creates a complex systemic gap. While the medical community recognizes a rising trend in infections, particularly among the Men-who-have-sex-with-men (MSM) demographic, the response is hindered by a "culture of secrecy" and profound institutional barriers. This study explores the systemic challenges of implementing HIV interventions within a framework where secular health goals often clash with traditional and religious norms.

Guided by the Social Ecological Model (SEM) and the Health Belief Model (HBM), this research investigates how cultural imperatives such as maratabat (honor) and kaya (shame) act as formidable barriers to health-seeking behavior. These socio-cultural enforcements often lead to the isolation of Persons Living with HIV (PLHIV), as the perceived risk of family dissolution and social ruin outweighs the perceived benefits of early diagnosis and treatment. Consequently, health facilities like the Amai Pakpak Medical Center often become the last refuge for individuals who are not only physically ill but are also facing catastrophic social injury and existential crises.

The Central to this study is the untapped authority of religious and traditional leaders. The findings suggest that a standard, culturally non-specific public health model is insufficient in this region. Instead, there is a critical need for a "theological reframing" of the HIV narrative. By shifting the discourse from moral condemnation to the Islamic principles of Hifzul Nafs (protection of life) and fitnah (test/affliction), the intervention can move beyond prohibition toward a mandate for cure and compassionate care. This research aims to bridge the gap between clinical necessity and cultural legitimacy, proposing a multi-sectoral strategy where the Ulama and Datus serve as primary cues to action, ensuring that life-saving interventions are both medically accurate and religiously sanctioned.

2. Theoretical Framework

The study further incorporates Symbolic Interactionism to interpret how the Meranaw social fabric constructs the meaning of health and illness. This theory posits that individuals act toward things based on the meanings those things have for them, which are derived from social interaction [1]. In Lanao del Sur, an HIV diagnosis is not viewed merely as a biological condition; it is a "symbolic death" within the community. The concepts of maratabat (honor) and kaya (shame) serve as the primary symbolic filters through which the disease is interpreted. Under this lens, the "extreme denial" observed in families is a collective effort to manage a "spoiled identity" and protect the family's social standing [2]. The hospital thus becomes a site of symbolic negotiation where health workers must translate clinical data into a language that does not violate the patient's cultural self-worth. By understanding these symbols, the study

identifies how religious reframing—transforming the symbol of HIV from "sin" to "fitnah" (a divine test)—can fundamentally alter social behavior and acceptance.

Complementing this is Minority Stress Theory, which provides a framework for understanding the unique psychological burden carried by marginalized demographics in conservative environments. This theory suggests that members of stigmatized groups experience chronic stress due to distal stressors like objective prejudice and proximal stressors such as the expectation of rejection and internalized stigma [3]. The "existential pain" and suicidal ideation reported by health personnel are analyzed as manifestations of these accumulated stressors. The framework highlights that the primary source of suffering is a "catastrophic social injury" caused by systemic alienation rather than inherent pathology. By integrating Minority Stress Theory, the study shifts the intervention focus from individual mental health to the systemic alleviation of social pressure, justifying the need for the "Religious Imperative for Hifzul Nafs" to provide a protective theological shield against communal rejection and boost the individual's resilience within a hostile social climate.

3. Review of Related Literature

The intersection of religious doctrine and public health outcomes represents one of the most complex challenges in contemporary sociological and health research, particularly within the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM). In Lanao del Sur, the tension between Islamic sexual morality and the pragmatic realities of public health creates a unique landscape where traditional values often collide with modern health crises, such as rising HIV/AIDS rates, teenage pregnancy, and reproductive health inequities. Understanding this divergence requires an examination of the theological foundations of Islamic ethics, the socio-cultural specificities of the Meranaw people, and the institutional barriers that prevent effective health interventions.

3.1 The Theological Framework and Meranaw Identity

Islamic sexual morality is rooted in the concept of Haya (modesty) and the sanctity of the family unit. According to Ali [4], sexual relations in Islam are strictly governed by the framework of Nikah (marriage), and any deviation—such as Zina (premarital or extramarital sex)—is viewed not only as a social transgression but as a spiritual violation. In Lanao del Sur, these religious tenets are deeply intertwined with the Meranaw concept of Maratabat (social honor and rank). Disabatun [5] argues that for the Meranaw, preserving the sexual purity of family members is inextricably linked to the preservation of the family's lineage and standing in the community. Consequently, the discourse surrounding sexual health is often shrouded in silence, as the mere acknowledgment of sexual activity outside of marriage is perceived as an admission of shame. This cultural veil makes the implementation of public health programs, which often require explicit discussions regarding contraception and safe sex, exceptionally difficult.

3.2 The Gap in Reproductive Health and Family Planning

The divergence between faith and practice is most visible in the realm of family planning and reproductive health. While the Philippine Reproductive Health (RH) Law of 2012 sought to universalize access to contraception, its reception in Lanao del Sur has been lukewarm at best and hostile at worst. Many local

religious leaders, or Ulama, have historically viewed modern contraception as a Western imposition that contradicts the Islamic injunction to multiply the Ummah (community). However, Abas and Ibrahim [6] note that this is not a monolithic view; many scholars argue that Tahdid al-Nasil (birth spacing) is permissible for the health of the mother and child. Despite these nuanced theological interpretations, the grassroots reality remains one of hesitation. The 2017 National Demographic and Health Survey (NDHS) highlighted that the BARMM region, including Lanao del Sur, consistently records the lowest contraceptive prevalence rates and the highest unmet needs for family planning in the Philippines. This gap is not merely a result of a lack of supplies but a profound "cognitive dissonance" where individuals may recognize the economic or physical need for birth spacing but fear the spiritual repercussions of using modern methods.

3.3 The Crisis of Silence: HIV/AIDS and STIs

A more urgent manifestation of this divergence is the rising incidence of HIV and other Sexually Transmitted Infections (STIs) in the region. Traditionally, Lanao del Sur was considered a low-prevalence area due to strict social codes. However, globalization, internal displacement due to the Marawi Siege, and increased mobility have altered the risk profile of the population. Mangotara [7] points out that the "myth of immunity"—the belief that a religious society is inherently protected from "vices" of the secular world—has led to a lack of testing and surveillance. Public health realities suggest that high-risk behaviors, including Men who have Sex with Men (MSM) and Injecting Drug Use (IDU), exist within the shadows of the community. Because the prevailing morality dictates that these behaviors do not exist among the "pious," health facilities in Lanao del Sur often lack the specialized, non-judgmental services required to reach these hidden populations. The stigma associated with these conditions is so severe that patients often seek treatment in distant cities like Cagayan de Oro or Iligan to avoid being recognized, thereby delaying care and contributing to the further spread of infections within their home province.

3.4 Adolescent Sexuality and Teenage Pregnancy

The issue of teenage pregnancy further complicates the relationship between faith and public health. In Lanao del Sur, the practice of Kapanganakan (traditional courtship) has evolved with the advent of social media, leading to an increase in early sexual debut. While Islamic law allows for early marriage under certain conditions, contemporary public health standards emphasize the risks of early pregnancy to maternal mortality. Basher [8] observes that when premarital pregnancies occur, the community's response is often a "shotgun marriage" to "cleanse" the sin and restore Maratabat. While this fulfills a moral requirement, it often traps young women in a cycle of poverty and ends their education, creating a public health reality that contradicts the long-term goal of community empowerment. The refusal to provide comprehensive sexuality education (CSE) in local Madaris (Islamic schools) means that youth are entering these situations without basic knowledge of their own biology or the consequences of their actions, relying instead on peer-to-peer information that is often inaccurate.

3.5 Bridging the Gap: The Role of Religious Leaders

Scholars increasingly argue that the bridge between faith and public health must be built by the religious leaders themselves. The concept of "Islamicized Public Health" is gaining traction, where health

interventions are framed within the context of Maqasid al-Shari'ah (the higher objectives of Islamic law), which include the preservation of life and progeny. Hadji Sali [9] suggests that when Imams incorporate health messages into their Friday khutbahs (sermons), the community is more likely to accept interventions like vaccinations or maternal health check-ups. In Lanao del Sur, the Integrated Provincial Health Office (IPHO) has begun collaborating with local Ulama to create a fatwa (religious ruling) that supports immunization and certain maternal health practices. This indicates that the gap is not insurmountable but requires a shift from a "secular-top-down" approach to a "faith-integrated" model.

4. The Systemic Response: Bridging the Socio-Cultural Gap

4.1 Institutional Barriers to Intervention (HBM)

Health personnel identified significant obstacles that prevent effective public health Cues to Action (like testing or seeking treatment) from reaching the target population. Firstly, the lack of open acknowledgement of the MSM demographic is a massive barrier. As the public health system cannot openly target this high-risk group due to cultural prohibitions, interventions remain generalized and ineffective. Secondly, the existing health facilities often become the last refuge for individuals facing total family dissolution. A public health worker noted that the hospital, APMC, is now dealing with patients who are not just physically ill, but who are emotionally and socially ostracized, leading them to crisis points, which strongly suggests that the Perceived Barriers (social and religious stigma) are so high that they overshadow the Perceived Benefits of treatment until the disease has progressed significantly, or until the individual is at the point of mental health crisis. The immediate, surface-level meaning is a direct report of observable client behavior: clients begin expressing suicidal ideation ("I want to die") and manifest clinical depression. This is a clear, factual recounting of events witnessed by the respondent in their professional capacity.

Moving beyond this literal recounting, the underlying, deeper interpretation points to a critical psychological dynamic: the expression of a death wish is not merely a symptom of depression, but a profound reaction to the loss of a foundational social anchor—the family. The clients' self-destructive expressions stem from an internalized feeling that their existence is unwelcome or unvalued. The emotional weight of the rejection is so immense that it obliterates their will to live, signaling that the primary source of their suffering is not an inherent mental illness, but an external, catastrophic social injury. The reported symptoms are a desperate communication of existential pain rooted in systemic alienation.

4.2 The Path Forward: Culturally-Sensitive Intervention

To bridge the gap, the need for culturally-sensitive messaging was repeatedly emphasized, indicating a demand for a Cues to Action that respects the local context. A proposed solution by the Philippine Medical Association–Lanao del Sur (PMALDS) was mentioned: a project on HIV awareness among high school and senior high school students. This targets the youth, identified by a Community Leader as the most impulsive and curious demographic: "it really affects the youth—those in their teenage years up to early adulthood, who are often the most impulsive or curious." Targeting this group through an institutional approach (schools) represents a crucial move toward the Community/Institutional level of the SEM, using neutral, educational settings to bypass the severe family-level stigma.

The Ulama provided the crucial doctrinal framework for a sensitive intervention: while they prohibit the act, they support the cure. Interventions must therefore shift the language from moral judgment to health protection and Islamic duty to preserve life (hifdh al-nafs). This involves developing educational materials that are vetted by the Provincial Ulama Council (PUC) and delivered by the Datus and community leaders.

The findings are synthesized into three overarching themes that correspond to the interwoven cultural, religious, and public health dimensions of the HIV crisis in Lanao del Sur

4.2.1. The 'Open Secret' and Extreme Denial

Medical professionals described the HIV situation in Lanao del Sur as an "open secret." While the medical community is aware of the rising cases, including a large cohort enrolled in treatment, public acknowledgment is severely hampered by cultural and religious sensitivities surrounding the primary mode of transmission. This denial operates at both the individual and family levels, directly influencing HBM constructs. A key informant from the medical field shared a harrowing account of parental denial which rooted in a perceived high severity of the disease (shame, social ruin) and a low perceived susceptibility, "it won't happen to my child" acts as a primary barrier to diagnosis and treatment. The immediate and explicit information provided by the respondent is that a patient's parents initially opposed an HIV test recommendation, later relented, and were then faced with a positive result. Their reaction was one of denial, manifesting as a threat of legal action based on an accusation that the results were intentionally falsified.

Delving deeper, this response implicitly suggests significant underlying issues regarding parental autonomy versus medical necessity in a sensitive healthcare context. The initial refusal indicates a profound fear or stigma associated with HIV/AIDS, or perhaps a lack of trust in the healthcare providers. The subsequent threat of legal action, even after consenting to the test, reflects an extreme emotional response—likely a combination of grief, anger, and deep-seated inability to accept a life-altering diagnosis. This behavior points to a fundamental breakdown in the patient-provider relationship and highlights the intense psychological and social pressures surrounding HIV diagnosis, where externalizing blame onto the medical team becomes a coping mechanism for the parents' internal distress and denial of their child's reality.

4.2.2. Interpersonal Isolation and Shame as Coercion

The data reveals that stigma extends beyond denial into active, punitive rejection within the family unit, which should ideally be the primary support system. A public health worker recounted their role shifting to that of a family counselor due to severe shaming in which isolation is a direct consequence of the community's lack of compassionate care and failure to recognize the affected person as an al-mus'ab (one who is tested by affliction), a concept later explored by the Ulama. The fear of this rejection prevents PLHIV from acting as Cues to Action for others, this reluctance highlights low Self-Efficacy in terms of prevention advocacy due to personal and family-level persecution.

4.3 Socio-Cultural Drivers and Health System Gaps

The interviews confirmed the prevailing transmission pathway in the region is male-to-male relations, a fact acknowledged by both medical staff and community leaders. A public health worker

highlighted the economic vulnerability that intertwines with transmission risk, a critical finding for intervention design points to deep-seated socio-economic factors that lower Perceived Barriers (e.g., reluctance to engage in risky behavior) for vulnerable youth, driven by power imbalances and poverty. The problem is not merely behavioral but is rooted in vulnerability and coercion. Furthermore, a traditional leader and government official acknowledged the scale of the challenge particularly the initial account, suggests a literal understanding of the situation. The individual is describing a specific event: a vulnerable patient was exploited by a computer shop manager for sexual favors in exchange for using the computers. The context of the abuse is tied directly to the specific, recounted details—a homosexual man, a computer shop, free games, and sexual abuse. The focus rests on the who, what, and where of the narrative as presented by the patient.

Moving beyond the specific event, the respondent generalizes this singular experience into a broader, socio-cultural commentary. They link the patient's account to a perceived general trend—the "noticeable increase of gay individuals" in Lanao—and then connect this perceived demographic shift to a broader claim about health or morality, specifically that "most of the cases" (likely referring to disease transmission, given the context of "men-to-men relations") are linked to homosexual activity. The original, specific trauma is now used to support a more expansive, often moralistic or fear-driven, interpretation about a social group and its perceived impact on public well-being. This level of understanding translates a specific personal tragedy into a social-diagnostic statement concerning an entire community. This political acknowledgment provides a crucial entry point for Community-level interventions.

The findings demonstrate a critical gap in the existing organizational response: the exclusion of powerful cultural and religious structures. While the Amai Pakpak Medical Center (APMC) and the City Health Office (CHO) are conducting essential work (counseling, testing), their efforts often stop at the door of traditional authority. A medical expert noted a planned initiative while beneficial, this type of intervention lacks the cultural sanction required for widespread adoption. Traditional leaders themselves recognized the need for greater involvement. This suggests that health system efficacy (Organizational SEM) is contingent upon coordinating with Traditional Leadership (Community SEM). The PMALDS's proposed project fundamentally aims to educate students about HIV, which is an immediate, surface-level objective derived directly from the statement.

However, the deeper significance reveals a strategy of community mobilization and cultural adaptation. The project is not meant to exist in isolation; it seeks to leverage established local authority and traditional networks. By specifically calling for the involvement of the Datus (traditional leaders), the answer indicates an understanding that sustainable awareness requires endorsement and dissemination through highly respected community channels, not just formal institutions. The Datus' involvement—spreading reminders in mosques and community gatherings—is the crucial mechanism for moving the message from a school-based program to a broadly accepted community norm, ensuring the information reaches the wider, non-student population in a manner that respects local custom and maximizes impact. This approach recognizes that mere information transfer is insufficient; genuine change requires social and religious legitimization to overcome potential stigma or resistance.

4.3.1 HIV as a Fitnah (Test) with a Mandate for Cure

The Ulama provided a theological framework that offers hope and resilience, directly challenging the narrative of sin and punishment that fuels stigma. They contextualized affliction within the faith, wherein this perspective mitigates the Perceived Severity of social judgment and provides a Cue to Action rooted in faith. Crucially, the Ulama emphasized the Prophet's teaching on healing and responsibility. This statement—"start no harm, cure it"—provides a strong religious mandate for prevention (no harm) and treatment (cure it), effectively sanctioning the work of public health professionals and legitimizing the search for a cure (treatment adherence). This respondent views suffering as an inherent part of the human experience, divinely orchestrated to test one's faith and character. The challenges faced are not arbitrary misfortunes, but rather a deliberate mechanism put in place by the Creator to evaluate and refine individuals. This perspective elevates trials from mere hardship to an opportunity for spiritual growth and demonstration of sincerity.

Furthermore, the response strongly asserts a belief in a universal remedy for every tribulation. Even if the solution is not immediately apparent through conventional, worldly means like medical expertise, the respondent maintains that a cure exists. The reference to the prophetic saying, which broadly implies avoiding harm and reciprocity of injury, underscores a principle of divine justice and balance. This tradition is invoked to support the idea that life's difficulties are not insurmountable or purposeless. The underlying message is one of hope and ultimate certainty—that for every test, there is an intended lesson, and for every pain, a path to healing, known or unknown.

4.3.2 The Religious Imperative for Hifzul Nafs (Protection of Self)

The Islamic scholars stressed that one of the core objectives of Shariah is the protection of life (Hifzul Nafs). This principle offers a culturally legitimate foundation for prevention messages. Instead of focusing solely on the prohibition of specific acts (which often drives behavior underground), the message can be framed around the religious obligation to protect one's self and community from harm, shifting the Perceived Benefit of prevention from mere personal safety to religious fulfillment. The respondent views the story as a reflection of core Islamic teachings, specifically the principle of Hifzul Nafs (preservation of the soul/self), which mandates self-care as a religious duty. This is the most immediate layer of meaning, where the narrative directly illustrates the concept of personal welfare as a divine injunction. The respondent sees the story's literal content—the act of caring—as equivalent to following a foundational religious law.

Moving deeper, the answer suggests the story's true ethical purpose extends beyond the individual. By linking self-care to the welfare of the family and the community, the response implies that the story teaches a progression of moral obligation. Caring for oneself is not a selfish act but the necessary first step and foundation for fulfilling the larger communal responsibility (Khalifah or stewardship) inherent in Islam. The self, family, and community thus become concentric circles of ethical action, showing that the story's ultimate aim is to cultivate a robust and interconnected Muslim society founded on reciprocal care, reflecting the holistic nature of the deen (way of life).

4.4 Components of a Culturally and Religiously Sensitive Intervention

The findings from the multi-sectoral interviews strongly indicate that a successful intervention must transcend clinical public health approaches and integrate deep cultural and religious legitimacy. The components below are directly formulated to address the multi-layered drivers of the epidemic, as guided by the SEM and HBM, thus answering the Statement of the Problem.

The first critical component addresses the Societal and Community Level of the SEM, aiming to dismantle the profound social stigma and denial that prevents access to care, thereby addressing the HBM constructs of Perceived Severity and Barriers. This requires formalizing a powerful partnership between the Provincial Ulama Council and the Federation of the Royal Sultanate (Datus) to issue a unified, public declaration. The Content of this declaration is crucial: it must leverage the Ulama's theological framing of HIV as a fitnah (test) and pivot the discourse to the Islamic mandate for compassionate care (Ihsan) and the inherent obligation of self-protection (Hifzul Nafs). By utilizing this framework, the intervention moves "beyond prohibition" to religiously sanction health-seeking behavior. As a Mechanism, the Datus and Ulama will function as primary Cues to Action, integrating these sanctioned, sensitive health messages directly into Khutbah (sermons), community gatherings, and traditional consultations.

The second component focuses on the Interpersonal and Organizational Level of the SEM, designed to combat family rejection and the underlying socio-economic vulnerabilities that hinder health-seeking behavior, thus bolstering HBM Self-Efficacy. The Action requires the institutionalization of Family and Couple Counseling as a mandatory component of HIV post-test services at the Amai Pakpak Medical Center (APMC). The public health workers, who already find themselves acting as "family counselors," will use this Mechanism to leverage the newly sanctioned religious and cultural messages (from Component 1) to actively promote acceptance and support within the home. This crucial step moves the intervention beyond clinical walls. Furthermore, there must be a Focus on implementing routine screening for coercion, abuse, and economic vulnerability among high-risk youth, ensuring they are linked not only to clinical care but also to essential social and livelihood support programs, such as those offered by BARMM’s Ministry of Social Services, to mitigate the drivers of risk.

Finally, Component 3 targets the Individual and Community Level by focusing on education to raise Perceived Susceptibility and Benefits among the youth through accepted local communication channels. The Action is to implement the proposed HIV awareness project for high school and senior high students, but this must be done with direct Ulama and Datu sanction and co-creation of the curriculum. The Content is vital; it must avoid aggressive or alienating language, instead framing prevention around the Meranaw code of conduct and the Islamic concept of protection of the self and lineage (Hifzul Nafs). The Mechanism involves the utilization of local Meranaw media formats, such as radio dramas or community videos, and requires the direct involvement of reputable Datus and young Islamic graduates to deliver the content. This approach ensures the messages are not only medically accurate but are also highly culturally relevant and religiously acceptable, maximizing their impact within the community.

The three proposed components form a synergistic whole, moving the focus from moral condemnation to a public health strategy grounded in Islamic principles and Meranaw social structures, ultimately fulfilling the research objective of developing culturally and religiously sensitive interventions.

This analysis of the qualitative data, guided by the Social Ecological Model (SEM) and the Health Belief Model (HBM), revealed a complex and multi-layered interplay between Meranaw socio-cultural structures, Islamic doctrine, and the public health challenge of HIV in Lanao del Sur.

4.4.1 The Cultural Imperative: Maratabat, Kaya, and the Enforcement of Secrecy

The data unequivocally demonstrate that Meranaw socio-cultural perceptions, beliefs, and practices (What are the socio-cultural and religious perceptions, beliefs, and practices of the Meranaw people in Lanao del Sur that influence the transmission and prevention of HIV?) constitute the most formidable barriers to effective HIV prevention and compassionate care. At the heart of this resistance are the cultural imperatives of maratabat (honor/pride) and kaya (shame) (How do cultural concepts such as maratabat (honor/pride) and kaya (shame) contribute to the stigma, secrecy, and reluctance to seek HIV testing and treatment in the community?). These concepts are not passive beliefs; they function as powerful social enforcement mechanisms. HIV is universally perceived as a violation of familial maratabat and a catalyst for profound kaya (shame), leading to the isolation of PLHIV and the transformation of the epidemic into a clandestine reality. This environment of absolute secrecy actively prevents individuals from accessing testing, disclosure, and antiretroviral therapy (ART). From the perspective of the HBM, the necessity of preserving family honor (Perceived Barrier) consistently outweighs the Perceived Benefit of seeking life-saving medical care, thus explaining the widespread delay in health-seeking behavior observed within the community.

4.4.2 The Untapped Authority of Religious Leadership

The study highlights the critical yet underutilized role of religious leaders (Ulama) and other influential community figures in shaping public perceptions and responses to HIV within culturally conservative settings. While public health professionals provide essential medical knowledge, their messages often lack resonance due to limited cultural and religious legitimacy, reducing their effectiveness in addressing sensitive sexual health issues (Herek, 2002; Parker & Aggleton, 2003). In contrast, the Ulama command significant moral authority, enabling them to influence deeply entrenched norms and attitudes (Abdul Rashid, 2019). Findings suggest that meaningful attitudinal change regarding HIV stigma is contingent upon a unified religious discourse that reframes the condition within Islamic ethical frameworks, particularly emphasizing Hifzul Nafs, the protection of life and self (Esposito, 2018). Currently, the absence of a cohesive theological stance against HIV-related discrimination allows moralistic interpretations to persist, inadvertently reinforcing stigma and social exclusion (UNAIDS, 2021). Previous research underscores that culturally congruent interventions—those endorsed by trusted religious authorities—significantly enhance community acceptance of health initiatives and reduce barriers to care (Berkley-Patton et al., 2010). This convergence of moral authority and public health expertise offers a potent mechanism for mitigating stigma, suggesting that collaborative strategies between health workers and Ulama could transform HIV discourse from condemnation toward compassion. Integrating religiously sensitive frameworks within health promotion aligns with broader evidence emphasizing the role of community leadership in shaping health behaviors, particularly in contexts where religion permeates social and moral life (Karam et al., 2019). Leveraging this influence represents both a culturally grounded and ethically coherent approach to combating HIV-related stigma.

4.4.3 The Critical Gap Between Doctrine and Public Health Reality

The research identified a critical operational gap between Islamic doctrine on sexual morality and the public health realities of HIV transmission (What are the specific gaps between Islamic doctrine on sexual morality and the public health realities of HIV transmission in Lanao del Sur?). Although Islamic texts firmly prohibit sexual promiscuity, the reality of HIV transmission in the region necessitates a public health approach that acknowledges the current situation. The present community discourse focuses heavily on prohibiting the behavior, but fails to provide adequate non-judgmental services (harm reduction, testing, and care) for those already at risk or affected. This doctrinal/real-world schism demands a theological reframing—shifting from purely punitive religious rhetoric to one that emphasizes the universal Islamic principles of public welfare (maslaha), human dignity, and the imperative to save life. This reframing acts as the necessary Cue to Action (HBM) at the societal level to legitimize intervention efforts.

4.4.4 Establishing the Intervention Imperatives

The synthesis of findings across the individual, interpersonal, community, and societal levels (SEM) dictates that a standard, culturally non-specific public health model will be ineffective in Lanao del Sur. To answer the final research question (Based on the findings, what are the key components of a proposed set of culturally and religiously sensitive interventions that can effectively promote open dialogue, prevention, and compassionate care for PLHIV in Lanao del Sur?), the data establish three key imperatives that must form the backbone of the proposed interventions:

Legitimize the Message. Intervention messages must be co-created and officially endorsed by the highest religious and traditional authorities (Ulama and Datus) to gain penetration and acceptance at the Community and Societal Levels (SEM).

Mitigate Cultural Shame: Intervention design must prioritize discreet, culturally appropriate avenues for counseling, testing, and treatment to directly lower the Perceived Barrier (HBM) associated with kaya and maratabat.

Theologically Reframe the Narrative: The core communication strategy must shift the community narrative from moral judgment and fear to one of compassionate care and responsibility grounded in Islamic ethics, operating primarily at the Interpersonal Level (SEM).

5. Conclusion

The findings of this study underscore that the HIV crisis in Lanao del Sur is not merely a clinical challenge but a profound socio-cultural and systemic dilemma. Guided by the Social Ecological Model (SEM) and the Health Belief Model (HBM), the research reveals that the primary obstacles to effective public health delivery are deeply rooted in the Meranaw constructs of maratabat (honor) and kaya (shame). These cultural imperatives enforce a pervasive environment of secrecy and denial, where the perceived barrier of social ruin consistently outweighs the perceived benefits of life-saving medical intervention. Consequently, the epidemic remains an "open secret," driven underground by the fear of family dissolution and societal ostracization, which often leads patients to severe psychological crises and suicidal ideation.

A critical gap exists between secular health interventions and the traditional religious structures that govern Meranaw life. Current efforts by medical institutions are frequently hampered by a lack of cultural sanction, leaving healthcare workers to manage not only physical illness but also the catastrophic social injuries of stigma. However, the study identifies a powerful, untapped pathway for progress through the moral authority of the Ulama and traditional Datus. By moving beyond moralistic prohibition, religious leaders can provide a transformative theological framework that reframes HIV through the lens of Hifzul Nafs (the protection of life) and fitnah (a divine test). This shift transitions the discourse from one of condemnation to a mandate for compassionate care and treatment adherence.

Ultimately, the study concludes that a standard, culturally non-specific public health model is insufficient for this region. To effectively bridge the socio-cultural gap, interventions must be multi-layered and synergistic. This requires the formal integration of traditional leadership into public health messaging, the institutionalization of culturally sensitive family counseling to combat interpersonal isolation, and the creation of educational programs that resonate with the Meranaw code of conduct. By leveraging the principles of Shariah and the social structures of the Sultanate, the response to HIV can be legitimized, shifting the community narrative toward a holistic, religiously grounded strategy that preserves both the health and the dignity of the people of Lanao del Sur.

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