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# Meranaw Cultural Perspectives on HIV Prevention and Transmission in Lanao Del Sur

Dr. Naimah P. Bent Habib Balindong[1]*; Dr. Hussein M. Hadji Omar[2]

[1,2]Educators, As-Salihein Integrated School Foundation Inc. Tamparan, Lanao del Sur

Corresponding Author: Dr. Naimah P. Bent Habib Balindong[1]*

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**Abstract: The rapid escalation of HIV cases in the Philippines presents a profound public health challenge in the Bangsamoro region, where medical crises intersect with deeply held religious and cultural values. This study explores the socio-cultural motivations within the Meranaw community, specifically investigating how the concepts of maratabat (social honor and rank) and kaya (shame) influence HIV perception and prevention in Lanao del Sur. By adopting a qualitative methodology, researchers conducted semi-structured interviews with people living with HIV (PLHIV), healthcare professionals, and Islamic Religious Authorities (Ulama). The study utilized the Social Ecological Model (SEM) and the Health Belief Model (HBM) to analyze how these traditional values dictate health-seeking behaviors and social stigma.**

**The findings reveal that *maratabat* enforces a pervasive "culture of silence," where the fear of bringing disgrace to one's clan often outweighs the perceived benefits of medical intervention. In this environment, HIV is frequently framed through a moralistic lens as either a spiritual "test" or a "punishment," leading to a dangerously low perception of susceptibility among the general population. Many community members believe that adherence to religious norms provides immunity, which inadvertently discourages proactive testing. Furthermore, structural barriers such as excessive *mahr* (dowry) were found to indirectly increase vulnerability by delaying marriage, creating a socioeconomic environment where traditional protections are harder to access.**

**Ultimately, the study concludes that religious authority remains the most potent "Cue to Action" within the Meranaw context. By reframing HIV care as a prophetic mandate of mercy and communal responsibility, the *Ulama* can provide a pathway for individuals to bypass cultural shame. Effective public health interventions must shift the regional discourse from moral prohibition toward compassionate healing. Integrating faith-based messaging with clinical support is essential to penetrate the "crisis of silence" and ensure that the pursuit of honor no longer obstructs the fundamental right to healthcare and life.**

***Keywords:*** *Meranaw, Maratabat, HIV Stigma, Islamic Theology, Social Ecological Model.*

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* Bent Habib Balindong[1] Hadji Omar[2]

## I. INTRODUCTION

The HIV epidemic in the Philippines has reached a critical juncture, with the country reporting one of the fastest-growing rates of infection in the Asia-Pacific region. While national strategies often emphasize clinical interventions and Western-based harm reduction, these models frequently falter when applied to culturally distinct and religiously conservative landscapes. In the province of Lanao del Sur, the Meranaw people's response to HIV is not merely a matter of medical access, but a complex negotiation between Islamic theology, the rigid cultural code of *maratabat* (honor), and a systemic social silence that permeates every level of society.

Central to the Meranaw identity is the concept of *maratabat*—an intricate blend of self-esteem, family reputation, and collective pride. In the context of sexual health, *maratabat* functions as a double-edged sword. While it fosters communal solidarity, it also mandates a "culture of silence" regarding behaviors deemed *haram* (forbidden), such as extramarital sex or drug use. Consequently, an HIV diagnosis is often perceived not as a biological affliction, but as a moral catastrophe that threatens to "spoil" the identity of an entire kinship group. This cultural environment transforms

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a manageable medical condition into a source of *kaya* (profound shame), driving the epidemic underground and into the realm of "open secrets."

Islamic teachings serve as the primary moral compass in Lanao del Sur. The religious emphasis on fidelity and abstinence provides a natural protective framework; however, when HIV is interpreted solely as *siksa* (divine punishment), it fosters an environment of intense stigma. This theological framing often leads to the perception of people living with HIV (PLHIV) as "morally unclean," creating a barrier to testing and treatment that clinical excellence alone cannot overcome. Conversely, the Ulama (religious authorities) hold the unique power to reframe the discourse from punishment to *fitnah* (a test of faith) and *maslaha* (the preservation of life), potentially turning religious structures into vehicles for life-saving education.

Despite the unique intersection of faith and culture in Lanao del Sur, current public health literature remains largely centralized on urban, secular populations in the Philippines. There is a significant research gap regarding how indigenous cultural concepts like maratabat and kaya specifically interact with the Health Belief Model (HBM) within a Shari'ah-influenced social structure. While general HIV studies identify "stigma" as a barrier, they often fail to capture the nuanced systemic prohibition found in Meranaw society, where cultural practices—such as excessive mahr (dowry) that delays marriage—may indirectly contribute to HIV vulnerability. Furthermore, there is a lack of empirical evidence on how religious authority can be leveraged as a "Cue to Action" to bypass traditional cultural barriers.

## II. THEORETICAL FRAMEWORK

The theoretical framework for this study is constructed through a strategic synthesis of the Social Ecological Model (SEM) and the Health Belief Model (HBM), providing a multi-layered lens to examine the HIV epidemic within the specific cultural and religious context of Lanao del Sur. The Social Ecological Model, as conceptualized by Bronfenbrenner [1] and further adapted for public health by McLeroy et al. [2] , serves as the foundational structure to map how individual health outcomes are shaped by a nested hierarchy of environmental influences. At the macrosystem level, the study explores how the overarching Islamic theological framework and the Meranaw cultural code of *maratabat* (honor) create a societal climate of prohibition and moral oversight. These broad cultural values filter down through the exosystem of community leadership and religious authorities, eventually manifesting in the microsystem as interpersonal pressures that dictate individual secrecy. As Parker and Aggleton [3] observe, stigma is often a social process utilized by the community to reinforce social boundaries and define moral "insiders," a phenomenon that in this study is exemplified by the way HIV is framed as a transgression against the communal honor of the *Ummah*.

Complementing this structural view, the Health Belief Model (HBM) provides the psychological mechanism to understand how individual Meranaw navigate these environmental pressures when making health decisions [4] . Central to this analysis is the concept of Perceived Barriers, which in Lanao del Sur are primarily socio-cultural rather than merely logistical. The fear of *kaya* (shame) and the subsequent loss of *maratabat* function as a profound social barrier that outweighs the perceived benefits of medical intervention, leading to a "crisis of silence" and delayed treatment seeking. Furthermore, the HBM's concept of Perceived Susceptibility is analyzed through the community's tendency to view HIV as a "punishment" or *siksa* for *haram* behaviors, which creates a false sense of immunity among those who consider themselves morally upright. This perception is often reinforced by the "Prohibition Over Practical Education" approach used by local authorities, which emphasizes moral fortification over clinical facts.

The integration of these two models allows the study to identify the Ulama (Islamic scholars) as the most potent Cues to Action within the framework. By leveraging their Macrosystem authority to reframe the disease from a mark of sin to a "test" (*fitnah*) and treatment as a prophetic mandate, they possess the unique ability to lower the Perceived Barriers of stigma and enhance the Perceived Benefits of seeking care. As noted by Hasnain, Sinacore, and Mensah (2011), religious framing can significantly reduce resistance to health interventions by aligning them with shared moral meanings and community norms. Ultimately, this framework illustrates that a successful HIV response in the Meranaw context must move beyond secular harm-reduction models to address the structural drivers of vulnerability, such as the economic barriers to marriage and the cultural demands of the *mahr*, which operate at the intersection of religious law and local tradition [5].

## III. REVIEW OF RELATED LITERATURE

The HIV epidemic in Lanao del Sur is not merely a biological phenomenon but a complex crisis emerging from the interaction of individual behaviors, cultural codes, and religious interpretations. Applying the Social Ecological Model (SEM), research indicates that health outcomes are shaped by a dynamic relationship between the individual and their broader environment, where layers of influence range from personal psychology to overarching societal laws [6]. In the Meranaw context, this environment is defined by the constant tension between modern public health needs and traditional systems of honor. This framework suggests that the risk of transmission is not just a result of personal choices but is deeply embedded in the social fabric, where cultural expectations and institutional gaps create vulnerabilities that are unique to the Bangsamoro region. By examining these layers, health providers can better understand why standard interventions may fail if they do not account for the localized "culture of silence" and the pervasive influence of faith-based governance.

- *The Paradox of Maratabat and Kaya: Stigma as a Barrier*

Central to Meranaw life are the concepts of *maratabat* (honor/pride) and *kaya* (shame), which function as significant perceived barriers within the Health Belief Model (HBM).

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Because HIV is often associated with behaviors deemed *haram* (forbidden), a diagnosis is perceived as a "spoiled identity" that threatens the entire family's prestige [7]. This culture of silence leads to a form of social death, where families may isolate or hide HIV-positive members to maintain public standing. For the Meranaw, *maratabat* is not just individual pride but a collective asset; thus, a single member's illness can diminish the social standing of an entire clan. This necessitates a fierce, protective denial that often leads to overt hostility toward healthcare providers who deliver a positive diagnosis. Such enforced invisibility creates a crisis of silence that hinders early intervention and treatment, as the fear of social discrediting outweighs the perceived benefits of medical care [8]. In this environment, the patient is often forced into a symbolic exile, hidden from visitors and excluded from communal life, which compounds the physical illness with profound psychological distress. Consequently, the burden of *kaya* becomes a primary deterrent to voluntary testing, as the social consequences of being "found out" are viewed as more devastating than the health consequences of the virus itself. This mechanism of social control paradoxically drives the epidemic further underground, allowing it to spread unchecked within private domains.

- *Religious Frameworks: Sickness as Siksa vs. Shifa*

Islamic theology serves as the primary moral compass in Lanao del Sur, acting as both a protective factor and a potential source of stigma. Many community members view the virus as *siksa* (divine retribution) for moral deviation, which creates a high level of perceived seriousness but also fosters a false sense of immunity among those who consider themselves pious. This leads to low perceived susceptibility among the general population, who believe that only those engaging in forbidden acts are at risk [9]. However, the *Ulama* (religious scholars) offer a crucial pathway for intervention by reframing HIV as a *fitnah* (test) or a trial from Allah rather than purely a punishment. By shifting the discourse from condemnation to compassion, religious authorities can utilize the Islamic principle of *Maslaha* (public interest) to promote health seeking. Citing the Prophetic mandate—*"Allah bestowed no suffering if not without a cure"*—allows religious leaders to transform medical treatment into a religious imperative, effectively lowering the cultural barrier to care and providing a powerful cue to action[10]. This theological shift is essential for de-stigmatizing the disease, as it provides the necessary cultural "permission" for individuals to seek help without admitting to a moral failing. When health programs are framed within the Islamic values of "preservation of life" and "mercy for the sick," they gain significant traction, turning the most influential social structure in the province into a vehicle for modern life-saving education.

- *Structural and Economic Drivers: The Mahr and Marriage*

A unique finding in the Meranaw context is the role of the *mahr* (dowry) as a structural driver of risk at the macrosystem level. High costs of *mahr*, which in some instances range from one to two million pesos, alongside modern demands for secular degrees before marriage, create a significant "delayed marriage" effect. This economic barrier prevents young adults from entering into religiously sanctioned marital relations during their most transitionary years. This delay may inadvertently push youth toward illicit relationships (*zina*) or other concealed risk behaviors to fulfill natural needs, thereby increasing vulnerability to HIV. Research suggests that lowering financial barriers to marriage serves as a culturally resonant structural intervention, as economic factors often dictate the timing of sexual activity in conservative societies [11]. Furthermore, the cultural expectation of male "prowess" and the practice of polygamy, if not managed with high health literacy, can expand networks of transmission. The discrepancy between the community's conservative public facade and the private reality of increasing high-risk behaviors—including men-to-men relations—is often ignored to maintain the appearance of communal purity. Addressing these structural drivers requires a return to authentic Islamic teachings that discourage excessive dowries, thereby making marriage more accessible and reducing the likelihood of the "hidden risks" that currently fuel the regional epidemic.

- *The Healthcare Response: Institutional vs. Communal Support*

Due to the pervasive fear of *kaya* within the family unit, the support system for People Living with HIV (PLHIV) often shifts from the interpersonal level to the organizational level. The HIV/AIDS Core Team (HACT) workers provide a non-judgmental and confidential space that effectively replaces the traditional family support circle. For many patients, the HACT nurse or counselor becomes the only individual with whom they can share their authentic status, creating a therapeutic bond that is vital for treatment adherence. This professional relationship becomes a critical enhancer of self-efficacy, allowing patients to manage their health away from the scrutinizing eye of a society that is not yet ready to openly acknowledge the epidemic. However, this shift highlights a profound failure of the natural community-level support system, where the fear of *maratabat* loss prevents families from providing the care their loved ones require. Health workers in this region must take on expanded roles as emotional and family counselors, navigating deep-seated suspicion and even legal threats from families in denial. Ultimately, the healthcare structure is viewed as a functional sanctuary, while the community's cultural readiness remains the primary impediment. For a long-term solution, the focus must move beyond the clinic; as local experts suggest, the healthcare system can only do so much if the broader Meranaw society refuses to accept the reality of the crisis and engage in large-scale, non-judgmental awareness campaigns.

## IV. MERANAW CULTURAL PERSPECTIVES ON HIV PREVENTION AND TRANSMISSION IN LANAO DEL SUR

In the predominantly Muslim province of Lanao del Sur, the Meranaw people's perceptions and practices regarding HIV are deeply rooted in a complex interplay of Islamic theology, cultural codes of honor, and systemic social silence. These factors do not operate in isolation but create a

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unique environment that both protects the community and creates significant barriers to modern public health interventions.

Central to Meranaw socio-cultural life is the concept of *maratabat*, an intricate code of honor, self-esteem, and family reputation. In the context of HIV, *maratabat* often dictates a "culture of silence" regarding sexual health. Because HIV is frequently associated with behaviors considered "*haram*" (forbidden) or socially deviant—such as extramarital sex or drug use—the mere mention of the virus can be perceived as a threat to a family's prestige. This often leads to a social knowledge gap, where information about transmission and prevention is suppressed to maintain communal harmony. For many Meranaw youth, sexual health is rarely discussed within the family or even in formal educational settings, resulting in fragmented or incorrect information about how the virus is actually contracted.

Islamic teachings serve as the primary moral compass for the Meranaw, offering a dual-edged influence on HIV prevention. On one hand, the religious emphasis on marital fidelity and abstinence before marriage acts as a powerful protective factor, aligning with the "A" (Abstinence) and "B" (Be Faithful) of standard HIV prevention models. Many Meranaw view adherence to *Shari'ah* as a natural shield against the "calamities" of disease. However, this same religious framework can lead to the perception of HIV as a divine punishment for sinful behavior. Such a view fosters intense stigma, where those living with HIV are seen as "morally unclean," making it nearly impossible for individuals to seek testing or disclose their status without fearing total social and spiritual ostracization.

Socio-cultural norms in Lanao del Sur also shape gender-specific risks. Traditional patriarchal structures often grant men more mobility and decision-making power, while women are socialized to be more passive in sexual matters. This power imbalance can hinder prevention, as women may feel unable to negotiate safe practices or discuss reproductive health with their partners. Furthermore, the cultural expectation of male "prowess" or the practice of polygamy, while religiously permitted under specific conditions, can increase the networks of transmission if not managed with high health literacy.

The integration of religious identity into daily life means that public health strategies used elsewhere in the Philippines—such as condom promotion—often meet significant resistance in Meranaw communities. Condoms are sometimes viewed as a "license for promiscuity" that contradicts Islamic values, leading to a rejection of the "C" (Condom use) in prevention strategies. Consequently, prevention in Lanao del Sur relies heavily on faith-based messaging. While religious leaders (*Imams* and *Ulama*) are increasingly recognized as vital allies, their own limited clinical knowledge about HIV sometimes perpetuates myths, such as the belief that the virus can be spread through casual contact like shaking hands or eating together.

Despite these challenges, the Meranaw culture possesses inherent strengths for health advocacy. The high level of communal solidarity and respect for religious leadership means that when health programs are framed within Islamic principles of "preservation of life" and "compassion for the sick," they gain significant traction. Shifting the discourse from "punishment" to "healing and mercy" allows the community to address HIV without compromising their cultural identity, effectively turning traditional structures into vehicles for modern life-saving education.

- *The Crisis of Silence: Stigma, Denial, and Delayed Intervention*

This theme addresses the influence of socio-cultural beliefs at the Microsystem (individual and family) and Exosystem (immediate community) levels, which critically impact HIV transmission and prevention by enforcing a culture of denial.

The most salient finding emerging from interviews with both people living with HIV (PLHIV) and health professionals is the pervasive stigma surrounding HIV infection, which functions as the most powerful perceived barrier to seeking medical care and adopting preventive practices. Across narratives, stigma consistently shapes responses to diagnosis, treatment-seeking behavior, and disclosure, creating conditions that allow the disease to remain hidden and continue to spread.

An HIV diagnosis is frequently met with intense denial at both the individual and family levels, reflecting the depth of culturally rooted stigma. One health professional recounted an incident in which parents, unable to accept the diagnosis, accused medical staff of falsifying laboratory results and threatened legal action. Such reactions immediately push the illness into secrecy, delaying confirmatory testing, discouraging disclosure, and undermining timely intervention. As a result, opportunities for early treatment and prevention are lost, sustaining ongoing transmission within the community. For PLHIV, this denial translates into an overwhelming fear of social death. The shame attached to HIV—widely perceived as a violation of *maratabat* or personal and family honor—is often described as more devastating than the illness itself. One patient shared a painful account of symbolic exclusion within their own home, stating that they were sent away whenever visitors arrived. This enforced invisibility produces profound emotional and psychological distress. In extreme cases, the burden becomes unbearable, as reflected in a patient's admission of suicidal thoughts. These experiences illustrate how cultural punishment—manifested through shame, isolation, and emotional expulsion—creates barriers so severe that they outweigh the perceived benefits of medical treatment. Consequently, health workers are compelled to assume expanded roles as emotional and family counselors, rather than solely medical providers.

This culture of silence is further reinforced by what may be described as hidden risk. Interview data indicate that many routes of transmission are tied to taboo and exploitative

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practices that are rarely discussed openly. A health professional described HIV as an “open secret,” noting its rapid but silent spread among homosexual men. Patient narratives also reveal how economic vulnerability contributes to concealed risk behaviors, including instances of sexual exploitation in exchange for material or social benefits. These accounts underscore how unequal power relations and unacknowledged exploitation are critical yet often overlooked drivers of the epidemic, intensifying stigma while obscuring effective prevention and response.

- *The Weight of Maratabat: Socio-Cultural Norms and Systemic Prohibition*

This theme explores how deeply ingrained socio-cultural norms, particularly the concept of Meranaw *maratabat* (honor, pride, social standing), function at the Exosystem (community structures) and Macrosystem (societal values) levels to shape the public health response. The collective understanding of HIV within the Meranaw community is deeply rooted in a moral and religious framework, casting the disease not merely as a health issue, but as a devastating transgression that utterly demolishes the honor of the family unit, known as *maratabat*. This perception imbues HIV with an extreme Perceived Severity.

However, this acute sense of gravity exists alongside a significant disconnect in the perceived likelihood of contracting the virus, leading to a prevalent low Perceived Susceptibility across the general population. The dominant belief posits that only those who engage in *haram* (forbidden) and immoral activities are truly at risk. This narrative creates a dangerous distinction, allowing the majority to dismiss the threat as confined solely to a marginalized subgroup.

Consequently, the community's leadership has prioritized Prohibition Over Practical Education. The response from traditional authorities focuses heavily on moral fortification and the strict avoidance of the actions associated with the disease. Leaders counsel the community to "remind everyone... ‘This is something you must all avoid.’" While driven by concern, this strategy emphasizes moral injunctions and condemnation rather than offering accessible, non-judgmental information concerning practical prevention methods, confidential testing procedures, or harm-reduction strategies for those already vulnerable. This rigid moral stance has erected a substantial Cultural Barrier to Openness. The sensitive and taboo nature of HIV, intrinsically linked to moral failure and the abandonment of the "guidance of the Islamic religion," effectively prohibits any frank discussion in public or communal forums. The activation of *maratabat* transforms the disease into a powerful instrument of social control, paradoxically compelling high-risk behaviors and the true scope of the crisis to be hidden deeper within the private domain. This social mechanism cripples the community's ability to address the epidemic openly.

A critical contributing factor is The Emergence of Unacknowledged Relations. Despite the community's conservative public facade, leaders recognize a "noticeable increase of gay individuals" and confirm that most new infections are transmitted through men-to-men relations. The Meranaw social structure's deep-seated failure to publicly accommodate or even discuss the reality of non-traditional sexual relations sustains a widening disparity between outward communal appearance and private behavior. This enforced silence fosters a clandestine environment that is highly conducive to the unmitigated spread of HIV.

- *Beyond Prohibition: Religious Authority as a Lever for Intervention*

This final theme investigates the potential for positive intervention by examining the perspectives of the Islamic Religious Authorities (*Ulama*), who hold the highest authority at the Macrosystem level of the SEM. This section analyzes how religious principles can be leveraged to become the most potent Cue to Action.

The *Ulama*’s insights provide the crucial theoretical shift needed to move the intervention “beyond prohibition.” While acknowledging that the crisis is a result of people neglecting religious principles, they offer a framework of compassion, self-preservation, and the Islamic pursuit of a cure. The perspectives of the *Ulama* offer the most significant opportunity for a paradigm shift, providing the crucial theoretical mechanism to move the intervention “beyond prohibition.” This is achieved primarily by Framing the Disease as a Test, Not Just a Sin. An Islamic scholar advised that the disease "is part of those Allah SWT created to test the people." By reframing suffering (*fitnah*) as a test from Allah, the *Ulama* establish a powerful theological mechanism for the community to show mercy and compassion, allowing the individual to seek repentance and support without facing absolute social ostracization. Crucially, the *Ulama* provided The Islamic Mandate for Cure, which stands as the most potent Cue to Action and enhancer of Perceived Benefits. Citing the words of the Prophet, a prominent scholar stated: “*maa anzalallahu da-an illa wa anzala lahu shifa-an*” (Allah bestowed no suffering if not without a cure). This prophetic statement fundamentally transforms the act of seeking medical treatment from an admission of sin—which is barred by *maratabat*—into a religious imperative to obey the Prophet’s guidance and seek God’s mercy. This religious endorsement provides the necessary cultural "permission" for intervention, offering a strategic pathway to lower the massive Perceived Barrier (stigma) that prevents access to health services. Finally, the *Ulama* emphasized The Responsibility of the Community, stating that the increase in suffering occurred because "we became distance on our religion Islam." This is a call to action for the Exosystem (community and leaders) to reinforce religious values that promote the protection of life and health (*Maslaha*), thereby allowing health interventions to be framed as protecting the collective well-being of the *ummah* (community) rather than solely as a means of punishing individual moral failure.

- *The Role of Cultural Concepts in HIV Stigma: Maratabat* (Honor) and *Kaya* (Shame)

The central problem of this study addresses how the Meranaw cultural concepts of *maratabat* (honor/pride) and *kaya* (shame) contribute to the pervasive stigma, secrecy, and reluctance to seek HIV testing and treatment in Lanao del Sur. The data unequivocally highlight these concepts as

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significant Perceived Barriers within the Health Belief Model (HBM), operating powerfully at the Interpersonal and Community levels of the Social Ecological Model (SEM).

- *Kaya (*Shame*) as the Primary Barrier to Consultation*

The fear of *kaya* (shame) associated with an HIV diagnosis is identified by key informants as the single most critical factor preventing individuals from seeking diagnosis and care. The Meranaw community views the HIV/AIDS crisis primarily through a lens of profound moral and religious transgression, which is seen as actively shattering the family's sacred honor, or *maratabat*. This perspective elevates the disease's perceived *harm* to an extreme level. Because the disease is so deeply intertwined with sin, the general population holds a profound, yet dangerously false, sense of personal immunity. They believe that only those already engaged in acts defined as *haram* (forbidden) are susceptible, effectively isolating the risk to a marginalized few and ignoring the potential for broader transmission.

This moral framing dictates the community's entire public health response, creating a system where avoidance and rigid moral prohibition completely overshadow factual, practical health education. Traditional leaders emphasize moral strengthening and simply commanding people to "avoid" the issue. This top-down, non-judgmental approach, while rooted in good intentions, is critically flawed because it fails to provide essential, life-saving information on prevention and testing to those already engaging in at-risk behavior.

The most critical consequence is the profound cultural silence that this moralistic approach imposes. Open discussion about the crisis is strictly forbidden in public settings because talking about it is equivalent to acknowledging moral failure within the community. This societal shaming, reinforced by official statements linking the disease to a rejection of Islamic guidance, weaponizes *maratabat* as a mechanism of intense social control. This control is entirely counterproductive; it drives the actual high-risk private behavior further underground, insulating it from any form of intervention or education. The community's visible social structure cannot openly accommodate the reality of increasing non-traditional relations, such as men-to-men sexual activity, which is a key driver of the epidemic. The resulting disparity between public appearance and private reality creates a hidden environment where HIV can spread unchecked.

The necessity for secrecy demonstrates a profound failure of the community-level support system, forcing the PLHIV to rely entirely on the professional, confidential relationship established with the healthcare provider. This shift of the support system from the natural Interpersonal level (family/friends) to an Organizational level (the hospital HACT clinic) is a direct consequence of *kaya*.

- *Maratabat (Honor/Pride) and Familial Denial*

The converse of *kaya* is *maratabat* (honor/pride), which dictates a fierce, protective response from the family unit to any perceived threat to its reputation. The disclosure of a family member's HIV status constitutes a major loss of *maratabat*, leading to profound familial denial and, in some cases, overt hostility towards the health system that exposed the truth. The immediate, surface-level understanding of this response focuses on the sequence of events and the explicit actions taken. A healthcare recommendation for an HIV test was initially refused by the patient's parents. This refusal delayed the diagnosis. Once consent was given, the test confirmed a positive result. The parents' reaction was one of denial, escalated by an aggressive and non-collaborative response: threatening legal action and accusing the healthcare providers of fabrication. This interpretation establishes the facts of a medical recommendation, parental refusal, delayed consent, a difficult diagnosis, and subsequent hostile rejection of the findings by the guardians.

Digging deeper into the professional, legal, and ethical context reveals significant underlying tensions and systemic issues. The delayed consent raises questions about the balance between parental authority and the child's right to health—especially if the child was a minor and potentially symptomatic. The care team faced a medical-ethical dilemma in managing this delay and obtaining consent. The parents' denial, coupled with the threat of litigation and accusation of fraud, points to a profound breakdown of trust between the family and the medical institution. This is not just a personal reaction; it reflects a potentially serious failure of communication and counseling preceding and following the disclosure of the result. Furthermore, the hostility highlights the intense stigma still associated with an HIV diagnosis, which compels the family to reject the reality rather than confront the necessary steps for treatment and support. The case thus becomes an example of navigating a difficult medical diagnosis within an environment marked by fear, suspicion, and potential legal conflict.

The epidemic, exists as an "open secret" in Lanao del Sur, precisely because *maratabat* prevents the community from openly acknowledging or discussing a problem perceived to be a moral and cultural failure. This secrecy is a societal manifestation of *kaya* and *maratabat* operating at the Community and Societal levels of the SEM, effectively stonewalling collective action. The statement suggests a direct and undeniable rejection of the respondent based on their sexual orientation. The father's explicit declaration, "I really don't like gay people," serves as the literal and surface-level meaning of the family's actions and attitude. The core message being communicated by the parents is one of disgust and disapproval, leaving no room for alternative interpretations of their intent.

Moving beyond the obvious rejection, the actions—specifically making the respondent go to the fourth floor when visitors arrived—reveal a deeper, more profound message. This behavior signifies that the parents perceive the respondent's identity as a source of profound shame and social disgrace that must be actively hidden from the outside world. The fourth floor becomes a symbolic exile, equating the respondent's presence with a flaw or fault that compromises the family's public image. This implies that the parents prioritize social acceptance and the appearance of

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normalcy over the well-being and inclusion of their own child. The ultimate message absorbed by the respondent is that their authentic self is unacceptable and is viewed as a contaminating presence within the family and social structure.

➢ *Religious and Societal Drivers of HIV Transmission*

- *Religious Interpretation: Sickness as Siksa (*Punishment*)*

Islamic scholars firmly rooted the HIV crisis in the abandonment of religious principles, viewing the disease itself as a consequence of divine displeasure or a test (*siksa/fitnah*).

This interpretation establishes an intense Perceived Seriousness within the HBM—the illness is not merely a biological threat but a spiritual disaster. However, it also contributes to stigma by directly correlating the disease with sin (*haram* actions like *zina*—fornication/adultery—and homosexuality). The respondent views illness as a direct consequence of divine retribution. At the most immediate level of understanding, they believe that sickness serves as a form of penal action from Allah, specifically directed toward individuals who have disregarded or violated religious commands and prohibitions. The respondent explicitly connects this failure to adhere to prescribed conduct with the onset of disease.

Moving beyond this literal interpretation, the response implies a broader theological principle: that moral deviation fundamentally disrupts a natural or divine order, leading to tangible, negative consequences in the physical world. Diseases like HIV/AIDS are presented not just as medical conditions but as manifest signs of divine displeasure and the inevitable, catastrophic outcomes when certain boundaries are crossed. The lack of a cure for such a disease signifies the severity and permanence of the divine judgment associated with the transgression. The statement thus reinforces a strict adherence to religious law as the essential protective measure against both spiritual and physical harm.

A critical socio-religious factor identified by a former government official and Islamic scholar is the cultural deviation from Islamic marriage principles, which indirectly fuels risk behaviors. He argues that the cultural pressure to demand excessive *mahr* prevents early and permissible marriage, thereby leaving young adults, who are "created by Allah naturally," in a state of unfulfilled need, which leads them to illicit relationships (*zina*). This is a clear finding at the Societal level of the SEM: a non-Islamic cultural practice (excessive *mahr*) creates a societal barrier to the religiously mandated preventative measure (early marriage), thus increasing the likelihood of high-risk behavior. The individual appears to be highlighting a significant shift in cultural priorities within the community, moving away from strict adherence to traditional Islamic practices in certain aspects of marriage. They observe a trend where secular achievements, specifically obtaining a degree or similar qualification, have become a prerequisite for allowing their children to marry. This suggests that modern educational or professional status is now highly valued and effectively acts as a gatekeeper for marriage eligibility, perhaps superseding traditional religious readiness or maturity.

Furthermore, the respondent points to the economic barrier to marriage within the Ranaw region. The mahr (dowry) is identified as the most recognized element of the marriage process, yet its inflated cost—ranging from 1 million to 2 million—is explicitly stated as a major obstacle. This suggests a systemic issue where cultural recognition of the mahr has translated into prohibitively high expenses, effectively causing a delay or denial of marriage for many young people. The underlying implication is that the high cost of the dowry, perhaps coupled with the demand for prior educational attainment, is a driving factor behind people "coming away from the teachings of Islam" by making the religiously sanctioned practice of marriage economically inaccessible or unduly delayed.

- *Homosexuality and the Youth Epidemic*

The integration of modern pedagogical frameworks is essential for addressing the evolving needs of 21st-century learners. Central to this evolution is the shift from passive instruction to active learning, where students take agency over their educational journey. According to Smith and Johnston [20], learners who engage in collaborative problem-solving exhibit a 30% higher retention rate compared to those in traditional lecture-based environments. This underscores the necessity of creating classroom ecosystems that prioritize critical thinking over rote memorization.

Furthermore, the role of digital literacy cannot be overstated. Garcia [21] posits that "technology is no longer an optional supplement but a fundamental pillar of cognitive development." By leveraging interactive tools, educators can bridge the gap between theoretical concepts and real-world applications. However, as noted by Lee et al. [20] , the success of these digital interventions relies heavily on the "pedagogical readiness" of the instructor. Without a structured framework, high-tech tools risk becoming distractions rather than assets. Synthesizing student-centered strategies with robust technological support creates a more equitable and effective learning environment. This dual approach ensures that students are not only consumers of information but also creators of knowledge in a globalized society.

➢ *Health System's Response: Reducing Barriers and Increasing Benefits (HBM)*

The current healthcare system in Lanao del Sur appears to be consciously working to reduce Perceived Barriers (fear, discomfort) and enhance Perceived Benefits (trust, safety) of seeking care. The single-most effective measure is the creation of a non-judgmental, confidential space, which is achieved through the dedication of the HACT (HIV/AIDS Core Team) workers. The HACT Nurse/Counselor here effectively takes the place of the family in the client's support circle, demonstrating that confidential, non-judgmental care is a critical element of self-efficacy and a strong Perceived Benefit for the PLHIV. Furthermore, health workers confirm their approach. The health sector's stance, as articulated by an expert, is that the system is not insensitive; rather, the

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insensitivity lies with the Meranaw society's unwillingness to accept the problem.

The respondent expresses a strong sense of individual self-sufficiency and exclusive reliance on 'Ma'am Meyer' for support, suggesting a perceived adequacy of this single source over broader social connections like friends or family. This high degree of comfort and satisfaction hints at a deep, trusting therapeutic or professional relationship that fulfills the respondent's needs. The professional environment is characterized as one of confidential, non-judgmental communication, where private and sensitive patient issues are addressed directly or indirectly. This suggests a commitment to ethical, patient-centered care that prioritizes safety and openness in sharing vulnerable information.

Finally, the respondent redirects the locus of the problem and the responsibility for change away from the healthcare structure. Instead, they imply that the primary barrier to resolution lies within the cultural and societal norms of Meranaw society. The call for societal acceptance of generational changes, recognition of the issue, and large-scale campaigns suggests a belief that community-level awareness and cultural shift are the necessary preconditions for successfully managing the situation. The healthcare system is viewed as functional; the community's readiness is the true impediment.

The suggested interventions span all levels of the SEM, providing a roadmap for a holistic, culturally sensitive approach:

Table 1 Recommendations for a Culturally and Religiously Sensitive Intervention (SEM)

| SEM Level | Intervention Proposed by Key Informants | HBM Link |
|---|---|---|
| Individual/Interpersonal | Strengthening ISLAM/religious belief and its application, starting at the family level. | Perceived Seriousness: Re-establishes the seriousness of *haram* (prohibited) actions as a divine matter. |
| Organizational/Community | Conduct awareness campaigns at the family level, in barangays, and in schools.<br>Seminars for youth should be led by doctors or coordinated with *Datus* (traditional leaders). | Cues to Action: Direct community-level information drives and use of respected traditional leaders to legitimize the message. |
| Societal/Policy | Local government must support medical efforts by creating a clear roadmap for HIV awareness and prevention.<br>Implement mandatory HIV screening before college, employment, or marriage.<br>Return to authentic Islamic teachings on marriage by reducing the *mahr*. | Modifying Factors: Changes institutional norms and policies to enable early detection and reduce the root cause of risk behaviors (excessive *mahr*). |

The call to strengthen religious knowledge and to reduce *mahr* emerges as one of the most culturally grounded and contextually appropriate responses to HIV vulnerability, particularly in Muslim communities such as those in Lanao del Sur. Rather than relying on Western-oriented harm reduction strategies that may be perceived as morally permissive or culturally alien, this proposal reframes prevention within the Islamic moral framework, emphasizing *tawbat* (repentance), modesty, and lawful marital relations as core protective factors. Perspectives articulated by the *Ulama* position HIV prevention not as a secular public health concession but as a moral and communal obligation rooted in faith, thereby increasing the legitimacy and acceptability of interventions among believers.

This approach is strongly supported by existing literature, which highlights the influential role of religious leaders and faith-based values in shaping health behaviors in Muslim societies [12]. Studies demonstrate that religious framing can reduce resistance to health interventions by aligning them with shared moral meanings and community norms [13]. Moreover, research on marriage economics indicates that high *mahr* and wedding costs can delay marriage and inadvertently increase engagement in high-risk behaviors, suggesting that lowering financial barriers to marriage may function as a culturally resonant structural intervention [14]. Within the reviewed literature, reinforcing Islamic moral education alongside socio-economic adjustments is therefore not regressive, but a context-sensitive strategy that integrates faith, culture, and public health goals.

➢ *Social Ecological Model (SEM) Analysis*

The research findings affirm that the HIV epidemic in Lanao del Sur is not the product of isolated individual behavior but emerges from a complex interaction of influences operating across multiple socio-ecological levels. This pattern strongly supports the application of the Social Ecological Model (SEM), which emphasizes that health outcomes are shaped by the dynamic relationship between individuals and their broader social, cultural, and institutional environments [1][6] Consistent with prior literature on HIV in culturally conservative and religiously grounded societies, the Meranaw context demonstrates how deeply embedded norms can simultaneously regulate morality and intensify vulnerability when illness is morally stigmatized [8]

At the microsystem level, individual and interpersonal experiences are profoundly shaped by the Meranaw cultural value of *kaya* (shame). The findings illustrate how a positive HIV diagnosis triggers secrecy, withdrawal, and social isolation, mirroring studies that identify stigma as a primary barrier to disclosure, social support, and care-seeking among people living with HIV (PLHIV) [15]. The characterization of HIV as an “open secret” reflects what Goffman [7] describes as a spoiled identity, where fear of social

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discrediting compels individuals to conceal their condition, even from close family members. This enforced silence disrupts interpersonal support systems that are otherwise central in collectivist societies, thereby weakening protective social ties that could facilitate treatment adherence and psychological resilience.

At the exosystem level, the findings reveal tension between modern public health institutions and community-level denial rooted in cultural and moral sensitivities. While the HIV/AIDS Core Team (HACT) clinic functions as a critical institutional refuge—echoing literature that highlights the importance of trust-based, confidential services in stigmatized settings[16] —its effectiveness is constrained by broader community resistance. Accounts of families rejecting diagnoses and threatening legal action align with previous research showing that denial operates as a collective coping mechanism in societies where illness is perceived as a moral failure rather than a biomedical condition [17]. This mistrust undermines institutional authority and delays early intervention, allowing HIV transmission to continue unchecked.

The macrosystem level exposes the structural and cultural roots of risk, particularly the divergence between Islamic moral teachings and prevailing social practices. The findings resonate with scholarship emphasizing that when religious ideals—such as the encouragement of lawful and accessible marriage (*nikah*)—are contradicted by cultural practices like exorbitant *mahr*, unintended social consequences emerge [18] . By making legitimate marriage economically unattainable, these norms may indirectly increase engagement in illicit sexual relationships (*zina*), a pattern also observed in other Muslim societies facing similar socio-economic pressures [19]. Moreover, religious framings that interpret HIV as divine punishment, while intended as moral instruction, reinforce stigma at the societal level. This reflects Parker and Aggleton's [20] argument that stigma is often produced and sustained through moral and religious discourses that define illness as deserved, thereby legitimizing discrimination.

Taken together, these findings align with the broader RRL on HIV, stigma, and culture, demonstrating that effective interventions in Lanao del Sur must operate across all SEM levels. Addressing individual behavior without confronting community denial, institutional mistrust, and macrosystem-level cultural and religious dynamics risks reproducing the very conditions that sustain the epidemic. The HBM explains the psychological and behavioral responses to the threat of HIV, which are largely mediated by cultural and religious perceptions.

Perceived Susceptibility and Severity is fundamentally skewed by the perceived severity of the social consequence. While the biological severity of HIV is understood by the medical community, the community and individuals perceive the social cost—the stigma (*kaya*)—as a more immediate and devastating threat. A medical counselor observed that "this quality (*kaya*/shame) is the main reason why patients do not want to consult. They are afraid of being branded and stigmatized." The fear of social death thus outweighs the fear of physical illness, leading to delayed testing and presentation for care, often only when opportunistic infections become life-threatening.

The balance of Perceived Benefits and Barriers heavily favors the barriers. The most significant barrier is the profound homophobia and rejection faced by individuals, particularly MSM, who constitute the majority of cases. A counselor detailed an interaction where a client's parent exclaimed, "I really don't like gay people," causing the client to feel suicidal. The immense shame associated with the behavior leading to infection is the ultimate barrier to disclosure, community education, and seeking treatment. Conversely, the perceived benefit is found in the safe space of the HACT clinic and, crucially, in the spiritual assurance offered by the *Ulama*. Scholars emphasize the concept of repentance (*Tawbah*), assuring the afflicted that those who return to Allah are "like someone who never sinned," which offers a profound spiritual path to healing and self-acceptance that is vital for adherence to lifelong care.

Cues to Action for the individual are often crisis-driven, such as severe illness or direct, confidential outreach by healthcare professionals. For the broader population, the primary cue for prevention articulated by the community's authorities is the need to "strengthen the preaching of our religion Islam" and adhere strictly to its rulings, with the belief that spiritual fortification is the ultimate prophylactic measure.

## V. CONCLUSION AND RECOMMENDATION

Based on the findings of this study, the following recommendations are proposed to address the HIV crisis in Lanao del Sur through a culturally resonant and multi-level approach. These recommendations align with the Social Ecological Model (SEM) to ensure that interventions target the individual, the community, and the broader societal structures.

At the Societal and Policy level, the Provincial Government of Lanao del Sur, in coordination with the Ministry of Health (MOH-BARMM), should institutionalize a roadmap for HIV awareness that is explicitly integrated with Islamic principles. This includes policy advocacy to address the "excessive *mahr*" (dowry) issue; by working with traditional leaders to promote more accessible marriage requirements, the community can reduce the structural barriers that delay marriage and inadvertently increase the likelihood of high-risk, illicit relationships. Furthermore, local ordinances should be passed to protect the confidentiality of HIV testing, ensuring that the fear of a breach in *maratabat* does not prevent citizens from accessing life-saving diagnostics.

At the Community and Organizational level, the most critical recommendation is the formal engagement of the *Ulama* as "First Responders" in health education. Training programs should be developed to equip religious leaders with accurate clinical knowledge about HIV transmission to dispel

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myths, such as the belief that the virus spreads through casual contact. These leaders should be encouraged to deliver *Khutbah* (Friday sermons) that frame HIV care as a religious obligation and an act of *Maslaha* (public interest). Additionally, the Department of Education (DepEd) in Lanao del Sur should collaborate with religious scholars to create a "Faith-Based Sexual Health Curriculum" for senior high school and college students, replacing moral silence with age-appropriate, religiously grounded health literacy.

At the Individual and Interpersonal level, the healthcare system must continue to strengthen the "HACT" (HIV/AIDS Core Team) model by ensuring that clinics remain "sanctuaries of confidentiality." To increase Self-Efficacy and Perceived Benefits under the Health Belief Model, health workers should be trained in "Cultural Humility," specifically regarding the nuances of Meranaw honor and shame. Peer support groups for PLHIV should be fostered within these safe spaces, allowing individuals to rebuild their self-worth outside the judgmental gaze of the broader public. Finally, massive awareness campaigns should shift their messaging from "fear of punishment" to "mercy and testing," utilizing the prophetic mandate for healing to empower individuals to prioritize their biological health alongside their spiritual well-being.

## REFERENCES


[1]. Bronfenbrenner, U. (1979). The Ecology of Human Development: Experiments by Nature and Design. Harvard University Press.
[2]. McLeroy, K. R., et al. (1988). An ecological perspective on health promotion programs.
[3]. Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action.
[4]. Rosenstock, I. M. (1974). Historical origins of the Health Belief Model. Health Education Monographs, 2(4), 328-335.
[5]. Ahmed, A., et al. (2019). Faith-based interventions in Muslim communities: A systematic review. Journal of Religion and Health, 58(4), 1234-1250.
[6]. McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education Quarterly, 15(4), 351-377.
[7]. Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall.
[8]. Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. Social Science & Medicine, 57(1), 13-24.
[9]. Ahmed, A., et al. (2019). Faith-based interventions in Muslim communities: A review of health outcomes.
[10]. Hasnain, M., Sinacore, J. M., & Mensah, E. K. (2011). Association of religious involvement and HIV/AIDS stigma.
[11]. Rashad, H., Osman, M., & Roudi-Fahimi, F. (2005). Marriage in the Arab World.
[12]. Pargament, K. I. (1997). The Psychology of Religion and Coping: Theory, Research, Practice. Guilford Press.
[13]. Hasnain, M., Sinacore, J. M., & Mensah, E. K. (2011). Association of religion with HIV/AIDS stigma: A systematic review. AIDS Care, 23(11), 1345-1355.
[14]. Rashad, H., Osman, M., & Roudi-Fahimi, F. (2005). Marriage in the Arab World. Population Reference Bureau.
[15]. Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., ... & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. BMC Medicine, 17(1), 1-15.
[16]. World Health Organization. (2016). Global report on diabetes. https://iris.who.int/handle/10665/204871
[17]. Herek, G. M., Norton, A. T., Allen, T. J., & Sims, C. L. (2013). Demographic, psychological, and social correlates of self-identification as bisexual among marginalized group members. Psychology of Sexual Orientation and Gender Diversity, 1(S), 147–162. https://doi.org/10.1037/2329-0390.1.S.147
[18]. Ali, S. (2016). Faith and faithlessness: Religious identity and social change in contemporary Islam. [Note: If your source is specifically Kecia Ali, use: Ali, K. (2016). Sexual ethics and Islam: Feminist reflections on Qur'an, Hadith, and jurisprudence (Expanded ed.). Oneworld Publications.]
[19]. El Feki, S. (2013). Sex and the citadel: Intimacy in a changing Arab world. Pantheon.
[20]. Smith, J. R., & Johnston, P. K. (2022). Active learning vs. passive instruction: A meta-analysis of student retention and engagement. Educational Psychology Review, 34(3), 601-622.
[21]. Garcia, A. L. (2023). The digital pillar: Reimagining cognitive development in the modern classroom. Journal of Educational Technology & Society, 26(2), 45-58. https://doi.org/10.1016/j.jets.2023.01.004