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The Role of Ulama and Communal Figures in Mediating the Social Integration of Populations Navigating Chronic Health Crises

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Abstract

The HIV/AIDS epidemic in Lanao del Sur is an "open secret," driven by a "culture of denial" that frames the disease as a moral failure, leading to "social death" and profound isolation for People Living with HIV (PLHIV). The fear of Kaya (shame) and familial rejection fuels suicidal ideation.

A critical tension exists between strict Islamic prohibitions and the pragmatic needs of healthcare. Current interventions fail due to a lack of alignment with local moral authorities: the Ulama (religious scholars) and traditional Datus. These leaders, while currently reinforcing stigma, are the most legitimate gatekeepers for change.

Utilizing the Social Ecological Model (SEM) and Health Belief Model (HBM), the study highlights the Ulama's dual role: they perpetuate biases but also offer a psychologically resonant framework for coping through Tawbah (repentance) and Sabr (patience). Stigma entering the family unit creates a structural barrier, as family honor may be prioritized over medical care.

Effective intervention requires an "institutionalized, culturally-grounded roadmap." The Ulama and Datus must be transformed into "champions of empathetic, faith-based advocacy" by leveraging the Islamic maxim Lā darara wa lā dirār (the duty to prevent harm). This pivot from punitive discourse to a "doctrine of compassion" is vital to re-anchor the community in mercy and collective resilience, transforming HIV from a clandestine reality to a shared social responsibility.

Keywords: Faith-Based Advocacy, HIV-Related Stigma, Ulama and Traditional Leadership, Meranaw-Islamic Context

1. Introduction

The HIV/AIDS epidemic in Lanao del Sur presents a complex challenge that transcends biomedical boundaries, deeply embedding itself within the socio-cultural and religious fabric of the Meranaw people. While global public health frameworks emphasize individual rights and secular prevention, the reality in faith-centered societies is that health behaviors are governed by moral mandates, traditional leadership, and the pervasive influence of the Ulama. This study is driven by the urgent need to address a "clandestine reality"—an environment where HIV is treated as an "open secret," masked by a culture of denial, profound social stigma (Kaya), and the threat of "social death."

Central to this investigation is the dual role of religious and community figures. Currently, traditional discourse often frames HIV through the Doctrine of Prohibition, equating infection with divine

punishment for moral transgressions such as zina (extramarital relations). This moralization creates significant barriers to care; when the family—the primary support unit—perceives illness as a threat to communal honor, the result is often isolation, neglect, and a breakdown of the immediate support system. This study posits that these very gatekeepers, who currently reinforce stigma, are the most strategically positioned agents for reform.

This study lies in the potential to bridge the gap between Islamic doctrine and modern public health frameworks. By utilizing the Social Ecological Model (SEM) and the Health Belief Model (HBM), the research explores how theological concepts like Rahmah (compassion), Tawbah (repentance), and Sabr (patience) can be leveraged to reframe HIV from a symbol of shame into a catalyst for spiritual resilience and collective responsibility. Furthermore, it examines the role of traditional authority, such as the Datus, in institutionalizing awareness through culturally grounded roadmaps.

Ultimately, this study seeks to provide a roadmap for a unified, multisectoral response. By moving beyond fragmented efforts and addressing structural drivers—such as the socio-economic pressures of high mahr (dowry) that delay marriage—the research aims to transform religious and community leaders from enforcers of stigma into champions of empathetic, faith-based advocacy. Success in curbing the epidemic in Lanao del Sur depends not on secular compromise, but on a morally coherent response where faith becomes the primary engine for healing, disclosure, and protection.

2. Theoretical Framework

This study integrates the Social Ecological Model (SEM) and the Health Belief Model (HBM) to analyze the complex interplay between religious doctrine, cultural identity, and public health in Lanao del Sur. By utilizing these frameworks, the research explores how the lived experiences of People Living with HIV (PLHIV) are shaped by a multifaceted environment where faith-based authority acts as both a source of stigma and a potential pathway for resilience.

At the core of the study is the Social Ecological Model, which posits that health behaviors are influenced by nested levels of influence: individual, interpersonal, community, and societal. The analysis reveals that in Meranaw society, the Societal and Community levels—governed by the Ulama and traditional Datus—exert a dominant influence over the Interpersonal level, specifically family dynamics. When religious leaders frame HIV through the "Doctrine of Prohibition," it increases the Perceived Severity of the disease within the Health Belief Model, transforming a medical condition into a "social death." This heightened severity, coupled with the cultural concept of Kaya (shame), creates a clandestine reality or "open secret" where individuals internalize stigma, thereby reducing their Cues to Action for testing and treatment.

However, the framework also identifies a "Doctrinal Imperative" for reform. While the HBM suggests that perceived barriers (social rejection and moral judgment) currently outweigh the perceived benefits of care, Islamic theological constructs such as Tawbah (repentance) and Rahma (mercy) offer a culturally grounded mechanism to shift this balance. By integrating the Ranao System of traditional authority with biomedical frameworks, the study proposes a synthesis where religious scholars and community figures transition from enforcers of stigma to champions of faith-based advocacy. This theoretical intersection suggests that sustainable health interventions in faith-centered contexts must align medical necessity with the moral and spiritual vocabularies of the community.

3. Scope and Limitation of the Study.

This study focuses on the socio-cultural and religious drivers of HIV-related stigma within the Meranaw

community in Lanao del Sur. It specifically examines the dual role of the Ulama (religious scholars), traditional Datus, and local government officials in shaping public health perceptions. The scope is limited to analyzing how Islamic doctrines—such as zina (prohibition), tawbah (repentance), and rahma (mercy)—and cultural practices, influence HIV prevention, disclosure, and treatment adherence.

Limitations of the study include the clandestine nature of the epidemic; due to the "open secret" status of HIV in the region, data may be influenced by the pervasive culture of denial and the intense fear of "social death" among participants. The study does not provide a clinical biomedical analysis of HIV/AIDS but rather a qualitative exploration of the Social Ecological Model (SEM) and Health Belief Model (HBM) frameworks. Furthermore, findings are context-specific to the Meranaw-Islamic framework and may not be fully generalizable to Muslim communities with different cultural traditions or more secular governance structures. The reliance on self-reported narratives from a stigmatized population also presents inherent challenges regarding complete disclosure.

4. Review of Related Literature

4.1 The Dual Influence of Religious Leadership in Health Discourse

Religious leaders, particularly the Ulama, occupy a central position in the social and moral architecture of Muslim societies. Research indicates that in faith-centered communities, religious figures act as primary gatekeepers of information, where their endorsements can either facilitate or obstruct public health initiatives. According to Ali and Miller [23], the Ulama reinforce normative moral frameworks that emphasize chastity and accountability to Allah, positioning moral conduct as a form of "primary prevention." This aligns with the broader literature suggesting that in conservative settings, religious norms often shape risk perception more effectively than secular biomedical messaging. However, this authority carries a dual burden. While religious discourse can enforce prohibitions against behaviors deemed haram, it also provides the most culturally resonant framework for coping with chronic illness. Islamic theological concepts such as sabr (patience) and tawba (repentance) allow individuals to frame illness as a divine test rather than a mere moral failure. Ahmed [22] argues that faith-based meaning-making is critical for reducing psychological distress and fatalism among people living with HIV (PLHIV). Therefore, the Ulama are not merely enforcers of social boundaries but essential mediators who can bridge the gap between traditional doctrine and modern healthcare frameworks. When these leaders adopt compassionate, non-punitive messaging, they significantly reduce community stigma and encourage health-seeking behavior, ensuring that interventions are perceived as morally coherent rather than secular impositions.

4.2 The Moralization of Illness and the Architecture of Stigma

The framing of HIV as a "punishment of Allah" or a consequence of "moral failure" represents a significant structural barrier in many conservative societies. This moralization of disease transforms a public health concern into a manifestation of divine justice, which inevitably legitimizes social exclusion and stigma, or kaya. Literature on HIV-related stigma consistently demonstrates that when an illness is equated with public moral transgression, it intensifies internal and external shame. As noted by Zulkifli et al. [24], religiously framed stigma often makes disclosure a threat to one’s moral standing and family honor, rather than just a personal health choice. This dynamic creates what scholars call "social death," where the fear of rejection outweighs the fear of the disease itself. This internalization of judgment drives the epidemic underground, artificially depressing perceived susceptibility and creating an "open secret" environment. In such contexts, the family structure—which theoretically serves as a support system—often becomes

the primary source of trauma. The tension between strict doctrine and the pragmatic need for protection often leads to a breakdown in the immediate support system, where family members may choose isolation and denial over medical intervention to preserve communal prestige. Successful reform, therefore, requires a shift toward the "Doctrinal Imperative" of mercy and the prevention of harm (Lā darara wa lā dirār), refocusing religious authority on the preservation of life and collective resilience.

4.3 Socio-Cultural Drivers: Economic Barriers and the Delay of Marriage

critical but often overlooked driver of health risk in traditional Muslim communities is the intersection of economic expectations and marital institutions. In many Meranaw and broader Islamic contexts, marriage is increasingly viewed as an elite milestone rather than a basic religious rite. Research indicates that when cultural practices—such as the demand for exorbitant mahr (dowry) and high educational or professional requirements—become prerequisites for marriage, they create significant socio-economic barriers. According to Ibrahim and Hassan [25], the delay of marriage well beyond biological and social readiness creates a "behavioral vacuum" where informal and illicit relationships may become normalized as adaptive responses. This misalignment between religious ideals (facilitating marriage) and cultural reality (obstructing it) increases the population's vulnerability to health risks, including HIV. Classical Islamic jurisprudence emphasizes the principle of aysaruhunna baraka (the most blessed marriage is the easiest), yet contemporary social prestige often overrides this mandate. As noted by Sambo et al. [26], addressing the HIV epidemic in such contexts requires a "macrosystemic" approach that reforms the cultural environment constraining individual choice. By recalibrating social values to prioritize moral accessibility over social status, communities can restore the protective function of the family unit and reduce the prevalence of high-risk behaviors.

4.4 Institutional Responses: Integrating Traditional Authority and Governance

The sustainability of public health interventions in regions like Lanao del Sur depends heavily on the integration of traditional authority structures with formal government health systems. In societies where social norms are mediated by respected elders and titled leaders, such as the Datus and Sultans, biomedical messaging alone often fails to gain traction. Studies on faith-based health initiatives demonstrate that community acceptance increases exponentially when local leaders serve as the primary communicators of information. According to Khalid [27] , traditional leaders possess a "cultural legitimacy" that external NGOs and state agencies lack; they can frame health-seeking behavior not as a secular compromise, but as a moral obligation to protect the community. The Social Ecological Model (SEM) highlights that for an intervention to be effective, it must operate at the Community Level by leveraging pre-existing, trusted channels such as the Ranao System. Furthermore, the involvement of local government units (LGUs) is essential to institutionalize these efforts through official roadmaps and funding. When traditional leadership and state governance work in tandem, they can shift the discourse from secrecy and fear toward responsibility and collective action. This multisectoral approach ensures that HIV programs are not only scientifically sound but also culturally grounded and socially sustainable [28].

5. The Role of Religious Leaders and Community Figures

The analysis directly confirms that Ulama and community leaders exert a dominant influence on local attitudes. As primary gatekeepers of social and moral discourse, these figures currently function as significant sources of stigma, often reinforcing traditional biases that marginalize specific groups. However, their authority also presents a strategic opportunity for reform. Because their influence is deeply embedded in the social fabric, these leaders are uniquely positioned to serve as agents of change. By

pivoting toward culturally-grounded support systems, they can reinterpret community values to foster inclusivity and psychological well-being. Ultimately, the study highlights that any successful intervention must engage these leaders, transforming them from enforcers of stigma into champions of empathetic, faith-based advocacy. This shift is essential for bridging the gap between traditional leadership and modern support frameworks.

5.1 The Ulama and Islamic Scholars: The Dual Influence of Guidance and Stigma

The Ulama occupy a uniquely dual and influential position in Muslim societies, particularly in conservative and faith-centered contexts such as Lanao del Sur. On one hand, they act as moral guardians who articulate and enforce Islamic prohibitions against behaviors commonly associated with HIV transmission, including zina (extramarital sexual relations), substance abuse, and other practices deemed haram. Through khutbahs, madrasah instruction, and community guidance, the Ulama reinforce normative moral frameworks that emphasize chastity, self-discipline, and accountability to Allah, positioning moral conduct as a form of primary prevention. This preventive role aligns with existing literature that recognizes religious norms as powerful regulators of health-related behavior in Muslim communities, often shaping risk perception more strongly than biomedical messaging alone [1][2]

Simultaneously, and more critically, the Ulama provide the most culturally legitimate and psychologically resonant framework for coping with HIV once infection has occurred. Islamic theology offers concepts such as tawba (repentance), sabr (patience), and qadar (divine decree), which enable individuals living with HIV to interpret illness not solely as moral failure but as a test from Allah that can be met with spiritual resilience and moral renewal. Studies on religion and health consistently show that faith-based meaning-making reduces psychological distress, shame, and fatalism among people living with chronic illness, including HIV [3][4]. In Muslim settings, religious coping mediated by trusted clerics has been shown to improve treatment adherence and emotional well-being by reframing illness within a redemptive and hopeful theological narrative [5].

This dual role is particularly important in contexts where stigma is deeply embedded. While moral discourse can unintentionally reinforce blame, the Ulama also possess the theological authority to counteract stigma by emphasizing compassion (rahmah), the prohibition of judgment, and the obligation to care for the sick. Islamic jurisprudence and prophetic traditions stress that illness expiates sins and that shaming the afflicted is itself a moral transgression. Literature on faith-based HIV interventions highlights that when religious leaders adopt compassionate, non-punitive messaging, they can significantly reduce community stigma and encourage health-seeking behavior [6][7].

Within the broader review of related literature, this positions the Ulama not merely as enforcers of moral boundaries but as essential mediators between religious doctrine and public health. Their involvement bridges the perceived divide between biomedical approaches and Islamic values, ensuring that interventions are not interpreted as secular compromises but as morally coherent responses rooted in faith. As noted in studies from Muslim-majority regions, public health programs that actively engage religious scholars demonstrate higher community acceptance and sustainability compared to externally imposed models [8]. Thus, the Ulama ’s dual function—both preventive and therapeutic—emerges in the literature as a culturally indispensable mechanism for addressing HIV in settings where religion remains the primary source of moral authority, social meaning, and emotional support.

5.2 The Doctrine of Prohibition and Sin

The dominant religious discourse on HIV within the community is frequently framed through the lens of divine consequence, positioning the disease as a manifestation of moral failure rather than a public health

concern. As articulated by one prominent scholar, HIV/AIDS is described as "part of the punishment of Allah" for individuals who do not refrain from illicit behaviors. This interpretation draws heavily on doctrinal teachings that emphasize the avoidance of the "small steps that lead to zina," including the normalization of premarital relationships, same-sex relations, and unsupervised interactions between men and women. Within this framework, prevention is understood primarily as moral discipline and religious obedience, reinforcing the belief that strict adherence to Islamic values serves as the ultimate protective factor against infection. While such discourse is intended to preserve communal morality, its practical consequences extend far beyond prevention and deeply shape social responses to people living with HIV (PLHIV).

By framing HIV as a direct outcome of sinful behavior, the discourse implicitly equates infection with public moral transgression. This moralization legitimizes stigma (kaya) by portraying PLHIV not as individuals in need of care and compassion but as cautionary examples of religious failure. Studies on HIV-related stigma consistently demonstrate that moral judgments intensify social exclusion, leading to shame, secrecy, and social withdrawal among affected individuals [9][10]. In faith-based contexts, this stigma is often magnified because illness becomes intertwined with notions of divine justice, making disclosure not merely a personal risk but a threat to one's moral standing and family honor.

The internalization of this judgment produces profound isolation among PLHIV, who may avoid seeking medical care, psychosocial support, or even confiding in family members for fear of being labeled sinful or immoral. Research in Muslim-majority settings shows that religiously framed stigma is a significant barrier to HIV testing, disclosure, and treatment adherence, as individuals fear social rejection more than the disease itself [11] [12]. This dynamic undermines public health efforts by driving the epidemic underground, where silence and fear replace early intervention and prevention.

Importantly, this moral framing also narrows the scope of acceptable responses to HIV, prioritizing condemnation over compassion and repentance over care. While Islamic teachings also emphasize mercy (rahma), forgiveness, and the protection of life, these values are often overshadowed by punitive interpretations in HIV discourse. As a result, moral judgment becomes a structural barrier to disclosure and care, reinforcing stigma and perpetuating vulnerability rather than reducing transmission or supporting healing [13].

Crucially, the Ulama also provide the necessary spiritual antidote to despair. Another scholar advised PLHIV to focus on repentance (Tawbah), stressing that a sincere return to Allah makes one "like someone who never sinned." This theological path offers acceptance and a future beyond the immediate social judgment, shifting the focus from public shame to a private, spiritual covenant with God. This narrative of divine mercy is the most potent counter-stigma tool available within the Meranaw-Islamic context, confirming that the spiritual health of the PLHIV is intrinsically linked to their physical adherence to treatment.

5.3 Community Leaders and Government Officials: Socio-Cultural Drivers and Institutional Response

Traditional and political leaders contribute by identifying structural and cultural drivers of the epidemic and by proposing institutional solutions.

A highly respected former official identified the entrenched practice of demanding exorbitant mahr as a central socio-economic driver of the present moral and public health crisis. According to his account, marriage in many communities has been transformed from a religiously encouraged institution into an elite milestone that requires academic credentials, stable employment, and substantial financial capital.

This cultural expectation delays marriage well beyond biological and social readiness, particularly for young men, and unintentionally creates conditions in which informal and illicit relationships become normalized. When the halal pathway is rendered financially inaccessible, individuals are left navigating desires and relationships outside the moral framework that Islam prescribes, increasing vulnerability to social and health risks.

This critique reframes the problem away from individual moral failure and toward collective cultural responsibility. Classical Islamic teachings consistently emphasize that marriage should be facilitated rather than obstructed, with prophetic traditions stressing that modest dowries are a source of greater blessing, captured in the principle "aysaruhunna baraka" [14]. By contrast, contemporary practices that equate marital worth with wealth represent a cultural deviation rather than a religious mandate. Scholars have long argued that when religious norms are distorted by social prestige and material competition, communities inadvertently undermine the very ethical safeguards intended to preserve social order [15].

Importantly, this perspective situates the solution at the macrosystemic level of culture and values, rather than relying solely on prohibitive or punitive approaches aimed at individuals. Social science literature demonstrates that individual behavior is profoundly shaped by broader cultural expectations, economic structures, and normative pressures [16]. When marriage is culturally delayed, alternative relational arrangements emerge as adaptive responses, even when they conflict with religious teachings. Addressing such outcomes therefore requires reforming the cultural environment that constrains choice, not merely intensifying moral exhortation.

By advocating a return to the Islamic ethic of simplicity in marriage, the former official implicitly calls for a recalibration of social values that prioritize moral accessibility over social status. This approach aligns with findings that culturally congruent interventions rooted in local religious frameworks are more effective and sustainable than externally imposed models [17]. Reducing mahr expectations thus becomes not merely a religious recommendation, but a structural intervention that restores marriage as a realistic, protective institution and reanchors community life in principles of mercy, moderation, and collective responsibility. Such reform strengthens families, reduces risk behaviors, and reaffirms faith as a living social guide ethic.

Leaders from the medical, traditional, and community sectors consistently emphasized the need for a unified and institutionalized response to HIV that moves beyond fragmented or informal efforts. A medical doctor stressed that Meranaw society must confront the realities facing the younger generation by openly acknowledging the problem and initiating large-scale campaigns aimed at containment and prevention. Crucially, these efforts were framed as needing official legitimacy, with local government units urged to develop a clear, culturally grounded roadmap that institutionalizes HIV awareness, testing, and education programs. Such state-backed initiatives are viewed as essential for shifting HIV discourse from secrecy and fear toward responsibility and collective action, a transition shown to be vital in contexts where stigma suppresses health-seeking behavior [18].

At the community level, a traditional leader highlighted the strategic role of Datus in disseminating accurate information during community assemblies and mosque gatherings. This proposal reflects the importance of integrating traditional authority structures with formal health systems, particularly in societies where moral guidance and social norms are mediated by respected elders and religious figures. Studies demonstrate that when public health messaging is delivered through trusted local leaders, community acceptance increases and resistance rooted in cultural or religious concerns is significantly reduced [19][20].

Collectively, these perspectives underscore the necessity of coordinated, multisectoral engagement that aligns governance, cultural leadership, and medical expertise. By replacing silent moral judgment with organized, fact-based education and prevention strategies, communities can foster environments where HIV is addressed as a shared social and public health concern rather than an individual moral failing, thereby strengthening prevention outcomes and long-term community resilience [21].

5.4 The Clandestine Reality: HIV as an "Open Secret"

The initial and most critical finding across all respondent groups is the pervasive culture of denial and secrecy surrounding HIV/AIDS, which effectively masks the epidemic and is directly addressed by the Interpersonal and Community levels of the SEM, and the constructs of Perceived Susceptibility and Perceived Severity in the HBM.

Data from the PLHIV and public health workers illustrate that the primary driver of delayed diagnosis and treatment is the individual's profound fear of social and familial rejection. This fear elevates the Perceived Severity of the disease from a medical condition to a catalyst for "social death."

One public health worker noted that HIV in Lanao del Sur is an "open secret" and is "silently spreading fast among homosexual men." This clandestine nature forces individuals to internalize their risk, often leading to deep denial.

The narrative of patient denial is particularly strong, with one medical expert recounting a case where a young client was repeatedly admitted for respiratory infections, yet their parents refused consent for an HIV test. Even after a positive result, the parents remained "in denial and even threatened us with legal action, claiming we fabricated the results." This extreme denial suggests that the cultural shame associated with the mode of transmission (often perceived as zina or homosexuality) is a greater threat to the family's honor than the disease itself.

The PLHIV narratives reinforce this fear, with one respondent acknowledging the emotional burden: "I don't really give advice (to others)," indicating that the fear of disclosure and the resulting shame (Kaya) prevents even peer-to-peer risk reduction advice. This low disclosure rate artificially depresses the Perceived Susceptibility of the general population, maintaining the false illusion that "it won't happen to me" because the visible evidence of the epidemic is hidden.

At the interpersonal level, the findings reveal that the family structure, which should be a source of support, is often the primary source of trauma and a significant barrier to care (HBM).

Public health workers recounted the extreme lengths they must go to mediate family conflict which highlights the severity of the family-based stigma, pushing PLHIV towards suicidal ideation. The health workers are forced to function as family counselors and mediators, a role that exhausts resources and personnel: "Naging family counselor na kami tuloy." The burden of absorbing this negative emotional labor leads to burnout: "pagdating sa bahay is yung pagod na pagod ka. Minsan pa nga umiiyak talaga ako nung magcounsel ako." The respondent's account reveals the profound emotional and psychological distress experienced by the child due to his father's rejection and the resulting family shame. The family's need for professional counseling underscores the severity of the situation and the father's deeply ingrained bias against gay people, which created a hostile home environment. The child's statement, "Ma'am, I can't handle this anymore, I'm going to kill myself," is a direct cry for help, signifying a breakdown in his coping mechanisms and an imminent danger to his life.

The parents' action of isolating him—sending him to the fourth floor during visits—is a tangible manifestation of their internalized homophobia and social fear. This act represents a systematic effort to conceal the child's identity and existence from their social circle, treating him as a source of shame rather

than a family member. The reported event is not merely an isolated incident of conflict but points to a pattern of abuse, neglect, and systemic invalidation within the domestic sphere, driven by societal prejudice. This deeply damaging experience demonstrates how societal intolerance filters down to destroy individual well-being and family cohesion.

This demonstrates a critical failure at the Interpersonal level of the SEM: the lack of family acceptance becomes the ultimate social determinant of health, transforming a treatable condition into a public health crisis due to the breakdown of the immediate support system.

5.5 The Doctrinal Imperative: Prohibition versus Protection

The core gap identified in the Statement of the Problem lies in the tension between strict Islamic doctrine (prohibition) and the pragmatic need for public health protection. The data from the Ulama and Community Leaders provides insight into this central conflict, primarily operating at the Community and Societal levels of the SEM.

5.5.1 Ulama and Islamic Scholars: Emphasizing I'tikaf (Self-Restraint)

The Islamic scholars (Ulama) strongly framed the HIV crisis as a consequence of straying from religious law, or fitnah (trial/suffering), and emphasized the Islamic duty of prevention and self-restraint (I'tikaf).

One prominent scholar attributed the crisis to a fundamental breakdown. The focus here is entirely on the prohibition of non-marital sexual acts (zina) and the correct Islamic family structure (heterosexual marriage). For the Ulama, the intervention must be a return to the Shari'ah, believing that this return would naturally eradicate the disease by removing its transmission vector. The respondent's statement, which asserts that people are straying from the guidance and path of Islam in their way of living, provides a direct and explicit explanation for a perceived societal issue. This is the surface-level meaning; the stated cause of the problem is the deviation from Islamic teachings and practices.

Taking a step back, the underlying inference and conceptual structure of the response is that adherence to the tenets of Islam is presented as the foundational solution or preventative measure for the current malaise. The respondent establishes a causal relationship where societal problems are the **effect** and religious non-adherence is the **cause**. The statement, "Our religion Islam has commanded the building of the home for the man and the woman," is provided as a concrete example of this essential guidance being neglected. This illustrates a belief that the perceived societal breakdown originates from the erosion of the prescribed, religiously mandated structure for the family unit, which is framed as the core foundation for a righteous life. The essential message is that a return to religious obedience is necessary to restore order. However, a message of compassion was also present, framed within the concept of Allah's mercy. Strict prohibition on the act, yet divine compassion for the person suffering, is the critical doctrinal bridge that a sensitive intervention must utilize. The Ulama's adherence to doctrine creates the societal gap, but their recognition of the existence of suffering and the need for cure and saving the people provides the opening for partnership. This respondent's perspective emphasizes a profound reliance on divine providence and a belief in an ultimately benevolent order. The initial statement establishes a foundational spiritual principle: every affliction is inherently accompanied by a remedy, even if that remedy is currently beyond conventional scientific or medical detection. This suggests that while human knowledge (represented by doctors) may be limited, a complete cure nonetheless exists in the greater cosmic scheme.

The subsequent reference to the Prophet Muhammad's saying, "Lā darara wa lā dirār," highlights a core ethical and legal obligation in Islamic jurisprudence: the prevention and mitigation of harm. This maxim is applied dynamically, indicating that if harm is initiated (or exists, such as the suffering mentioned),

there is a mandatory duty to seek its remedy. For those afflicted (mus'ab), the respondent frames their communal effort—"our preaching"—not just as religious instruction, but as a direct, practical action to rescue and safeguard the wider community, implying that the purpose of addressing individual suffering is ultimately a collective one. The message is one of hope, responsibility, and divinely assured resolution, extending beyond the immediate physical ailment to embrace spiritual and communal well-being.

5.5.2 Community Leaders and Governance: Need for Traditional Authority

Community leaders, including the Federation of the Royal Sultanate and members of the Province of Lanao del Sur, underscored the necessity of integrating traditional Mëranaw authority (Ranao System) into public health efforts (SEM: Community Level).

One leader advised leveraging Datus (traditional leaders) and community structures to disseminate information, highlights a key cultural mechanism: information delivery is most effective when channeled through recognized figures of authority (Datus, Sultans, and Imams), who command respect in a way that external government or NGO entities may not. The challenge lies in translating the traditional leaders' message of avoidance and prohibition into effective, non-judgmental public health messaging that incorporates information on prevention, testing, and treatment. The respondent suggests that community leaders—the Datus—must take an active and visible role in disseminating the message because the message's relevance is deeply rooted in the Meranaw identity and their original connection to Lanao. Their involvement is seen as a way to legitimize and amplify the call for avoidance within the specific cultural and social context of the community.

The explicit mention of using established community forums like gatherings, mosques, and community meetings indicates a strategy to leverage pre-existing, trusted channels to reach the broadest audience efficiently.

Furthermore, the proposal that Datus should use their own children to spread the message—by reminding them to "avoid this"—serves as a powerful, non-verbal endorsement. This transforms the message from a general public service announcement into a personal, familial imperative that underscores the moral obligation and the seriousness of the issue. It frames the instruction as an essential lesson to be passed down and enforced within the family unit, positioning the Datus as not just political leaders, but as moral and cultural stewards responsible for their community's collective well-being and future conduct. This reliance on the Datu's authority and social network is fundamental to the envisioned awareness campaign.

6. Conclusion

The findings of this study underscore a complex socio-religious landscape where tradition, faith, and public health intersect in the lives of the Meranaw people. The response to HIV in Lanao del Sur is currently defined by a profound tension: while Islamic doctrine and traditional leadership provide the primary moral and social framework for the community, they simultaneously act as the most significant sources of stigma and the most promising avenues for systemic reform.

Religious and community figures serve as the ultimate gatekeepers of social discourse. Currently, the "Doctrine of Prohibition" often frames HIV as a divine punishment for moral failure, which inadvertently drives the epidemic underground. This framing elevates the perceived severity of the disease from a medical issue to a "social death," leading to extreme denial among families and life-threatening isolation for individuals living with HIV. However, the authority of the Ulama and Datus is a dual-edged sword. Their deep integration into the social fabric means they are the only actors capable of providing a culturally legitimate framework for compassion. By emphasizing theological concepts like Tawbah (repentance) and

Rahmah (mercy), these leaders can transform HIV from a mark of shame into a journey of spiritual resilience and medical adherence.

The study reveals that the HIV crisis is not merely a matter of individual behavior but is rooted in structural cultural pressures. The rising cost of marriage, for example, creates socio-economic barriers that unintentionally normalize informal relationships, increasing community vulnerability. This shift in perspective—from individual sin to collective cultural responsibility—is essential for long-term prevention. Furthermore, the "open secret" nature of the epidemic in Lanao del Sur highlights a breakdown in the interpersonal level of the Social Ecological Model, where the family, fearing for its honor, often becomes a source of trauma rather than support. Addressing HIV in this context requires a multisectoral, faith-based advocacy model that bridges the gap between biomedical realities and Islamic values. Public health initiatives must be institutionalized through local government roadmaps that carry the endorsement of traditional Sultanates and the Ulama. Messaging must pivot from punitive condemnation to a "Protective Mandate," utilizing the Islamic principle of preventing harm to justify testing and treatment as moral obligations. Strengthening the role of the Ulama as mediators of mercy can reclaim the family unit as a protective space, ensuring that clinical care is supported by spiritual peace.

In conclusion, the path forward lies not in secularizing the response, but in re-anchoring public health within the compassionate ethics of Islam. Only by transforming traditional leaders from enforcers of stigma into champions of empathetic advocacy can the community break the cycle of silence and foster a resilient environment of care, prevention, and hope.

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