Islam and HIV related social services in Malaysia

Stacey A. Shaw, Rumana Saifi, Sin How Lim, Shaikh M. Saifuddeen & Adeeba Kamarulzaman


To link to this article: http://dx.doi.org/10.1080/15426432.2017.1300078

Published online: 19 May 2017.
ARTICLE

Islam and HIV related social services in Malaysia

Stacey A. Shaw, PhD, Rumana Saifi, PhD, Sin How Lim, PhD, Shaikh M. Saifuddeen, PhD, and Adeeba Kamarulzaman, FRACP

School of Social Work, Brigham Young University, Provo, Utah, USA; Centre of Excellence for Research in AIDS (CERiA), Kuala Lumpur, Malaysia; Centre for Science and Environment Studies, Institute of Islamic Understanding Malaysia, Kuala Lumpur, Malaysia and Academy of Islamic Studies, University of Malaya, Kuala Lumpur, Malaysia; Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

ABSTRACT

We review HIV prevention and treatment efforts involving Islam in Malaysia. The Department of Islamic Development Malaysia (JAKIM) conducts HIV-related workshops with Muslim leaders and lesbian, gay, bisexual, and transgender (LGBT) communities. A methadone maintenance treatment (MMT) project was implemented in a mosque in Kuala Lumpur, incorporating religious and social supports alongside provision of health services. Additional services including premarital HIV testing are discussed. Islamic values point to the need for compassion, nonjudgment, and taking action to improve lives, while reluctance to support harm-reduction strategies among sexual minorities highlights the important role of community advocates and social workers within nongovernmental organizations.

ARTICLE HISTORY

Received 11 June 2016
Accepted 23 February 2017

KEYWORDS

HIV; Islam; religion; Malaysia

Contexts of HIV risk in Malaysia

The HIV prevalence rate among adults in Malaysia is approximately 0.5% (UNAIDS, 2014), with the epidemic concentrated among key populations including people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (Ministry of Health, 2015). Illicit drug use is growing in Malaysia (MAC, 2015) and an estimated 19%–45% of PWID are HIV positive (Chawarski et al., 2006; Kamarulzaman, 2009). High rates of unsafe injection practices have been observed among PWID, most of whom use heroin and amphetamines (Vicknasingam et al., 2009; Wickersham et al., 2015). Though injection drug use has historically been the primary route of transmission, a majority of new infections now occur through sexual activity (Singh et al., 2013). Among MSM, HIV prevalence is estimated to be 3.9% (Kanter et al., 2011) to 12.8%, with high rates of risk behaviors including illicit drug use and multiple partnering suggesting HIV transmission is escalating (Kanter et al., 2011; Lim et al, 2013). Among sex workers, HIV prevalence is approximately 10.7%
(Baral et al., 2012), although underreporting and lack of access to treatment may obscure the actual percentage of those infected (IAS, 2013).

Malaysia’s political system incorporates both civil law and religious Sharia law. Over the past few decades, Islam has become an increasingly important component of political and social structures in Malaysia (Lee, 2011; Nair, 2013). Homosexual relations are deemed illegal as part of the penal code (amfAR, 2011), while many states stipulate that commercial sex is illegal for Muslims (UN, 2014). MSM experience stigma and discrimination from health providers, police, and society at large (Godwin, 2010; Teh, 2008), and may choose to hide their status from family and friends. Commercial sex workers (CSW) frequently experience police harassment, physical and sexual violence, and other injustices (Loeliger et al., 2016; UN, 2014). A climate of secrecy and fear related to stigma has impeded vulnerable populations such as MSM and CSW from accessing HIV prevention and treatment services (Beyrer et al., 2012; Godwin, 2010).

Although drug users often experience police harassment, comprehensive treatment services, including Methadone Maintenance Therapy (MMT) is provided nationwide by the Ministry of Health (Kamarulzaman, 2009). An estimated 27,000 received MMT of approximately 170,000 PWID (Singh et al., 2013). Needle and syringe programs are also widespread and growing (Harm Reduction International, 2014). Opioid Substitution Therapy has been tested with prison populations, with limited current availability to prisoners (Ghani et al., 2015; Wickersham, Marcus, Kamarulzaman, Zahari, & Altice, 2013; Wickersham, Zahari, Azar, Kamarulzaman, & Altice, 2013). These efforts to reach communities at risk of acquiring HIV are commendable and have contributed to risk reduction among beneficiaries (IAS, 2013).

In Malaysia, like other Southeast Asian countries, religion is deeply embedded in political and social realms. As in Indonesia and Iran, harm reduction approaches serving PWID have received higher levels of support in Malaysia than have programs serving female sex workers (FSW) and MSM (Kamarulzaman, 2013). Like other Muslim majority countries, increased attention to HIV nationally has been coupled with prejudice stemming from moral views regarding HIV (Kamarulzaman, 2013). Major gaps in national responses to HIV prevention remain, where few Islamic countries specifically attempt to engage PWID, MSM, and FSW (Abu-Raddad et al., 2010). The Malaysian government policy to address HIV is informed both directly and indirectly by Islamic conceptions of life and relationships (Barmania & Aljunid, 2016). The connectivity of Islam to HIV prevention and treatment efforts in Malaysia has relevance for helping professionals who work with religious individuals, who work within religious contexts, or who seek to understand linkages between religion and health. This article examines experiences, successes, and challenges of religiously based efforts to fight
HIV in Malaysia. We review published and unpublished literature regarding HIV prevention and treatment efforts involving Islam in Malaysia. Findings from the present study have implications for global efforts to address HIV within Islamic and other religious communities.

**Religion and HIV risk**

As a social, cultural, and political factor, religion impacts the way in which communities understand and respond to HIV (Baral et al., 2013; Hasnain, 2005; Zou et al., 2009). Structural factors such as sexual violence, policing, incarceration, drug treatment availability, drug use laws, immigration policies, stigma, and discrimination (Baral et al., 2015; Gupta et al, 2008; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Shannon et al, 2015) shape where and how risk happens, and whether people receive needed assistance. Religion coincides with numerous cultural factors, influencing perspectives on prevention approaches (Agadjanian, 2005), treatment adherence (Wanyama et al., 2007; Wasti et al, 2012) and stigma toward people living with HIV (Hossain & Kippax, 2009; Mbonu, Van Den Borne, & De Vries, 2009; Rahmati-Najarkolaei et al, 2010; Watt et al, 2009). Higher levels of religiosity have been associated with lower levels of sexual HIV risk behavior (Shaw & El-Bassel, 2014), although the influence of religiosity among high risk communities, where services and research are increasingly focused (Piot et al, 2015), is less clear. Religious organizations may play a role in promoting HIV prevention (Francis & Liverpool, 2009; Garcia & Parker, 2011; Green, 2003; Maulana et al, 2009) and spirituality is a component of coping among some people living with HIV (Koenig et al, 2012 Maman et al, 2009; Pargament et al, 2004). However, the role of religious organizations in caring for people with HIV has been limited (Agadjanian & Sen, 2007; Watt et al, 2009; Westh & Noordien, 2008) and religious beliefs may contribute to stigma and discrimination (Mbonu et al., 2009). Religion may be associated with both risk and protection for acquiring HIV among Muslims (Hasnain, 2005). The hypothesis that Islamic religious affiliation has an inverse relationship with HIV seropositivity was proposed in the 1990s (Lenton, 1997; Ridanovic, 1997) and was supported in the African context, where Muslims had lower HIV prevalence rates than non-Muslims, recognizing that several Islamic tenets and practices, particularly circumcision, have protective effects against sexual transmission of HIV (Gray, 2004). Alternately, challenges in discussing prevention and promoting treatment exist among some groups of Islamic leaders (Abu-Moghli et al., 2010; Balogun, 2010). HIV-related messages presented within religious settings may promote abstinence and fidelity, where leaders may not discuss or accept condom use outside of marriage (Ansari & Gaestel, 2010) nor acknowledge a wider range and combination of behavioral strategies necessary to address the HIV epidemic (Coates et al,
Additionally, rejection of homosexual relationships, drug use, and sex work pose difficulties for enabling dialogue and exploring protective programs among key at-risk populations. While some religious leaders view HIV infection as a result of deviation from religious guidelines, other leaders consider they have a role in responding to the epidemic and assisting those who are infected (Ansari & Gaestel, 2010). As the practice of religion varies by place and context, so does the approach to discussing sexuality. Where religion comprises a component of the political structure, as in Malaysia, attention to the influence of religious ideology on policy and programmatic response is critical.

**Islamic HIV prevention efforts in Malaysia**

In response to the HIV epidemic in Malaysia, initiatives have been implemented by the Muslim community and political leaders. Starting in 1992, the Malaysian AIDS Council has managed efforts between government, non-governmental organizations (NGO), and international organizations to coordinate services, build capacity, and advocate for improved access to health care and protections for those living with HIV (MAC, 2016). Efforts to address the experiences of people living with HIV and the need for sensitization and partnership in advocacy have led to support for harm reduction approaches in Malaysia (Busza, 1999). The following sections highlight key HIV-related programs directed to the Muslim population in Malaysia.

**Premarital HIV testing (2001)**

Johor became the first state in Malaysia to implement premarital HIV testing among Muslim couples in 2001. Mandatory HIV-testing was a response to growing HIV infection through heterosexual transmission, especially among Muslims and married women in Johor (Khebir, Adam, Daud, & Shahrom, 2007; Tan & Koh, 2008). Strengths of the premarital testing program included an early opportunity to detect HIV, HIV education at screening sites, awareness raising among the general population, service integration within existing government health systems, informed decision making prior to marriage, and potential reduction of maternal to child HIV transmission (Khebir et al., 2007). A number of drawbacks with premarital testing are apparent. Although HIV prevalence in premarital screening (0.17%) has been found to be higher than that identified in antenatal screening (0.05%), cases identified remain few (Khebir et al., 2007, Tan & Koh, 2008). Couples may travel to neighbouring countries such as Thailand to marry in order to avoid testing and disclosure. Premarital HIV testing was initially opposed by the Malaysian Ministry of Health and NGOs, but it has become compulsory in almost all parts of Malaysia. Confidentiality is also a concern as test results
are processed through several tiers and multiple individuals, and results may be known to parents and other family members due to family involvement in marital processes (Tan & Koh, 2008).


A manual on HIV/AIDS in Islam was developed by the Department of Islamic Development Malaysia (JAKIM) in collaboration with the Ministry of Health and the Malaysian AIDS Council (JAKIM, 2011). The manual is recommended for use by religious teachers and authorities at all levels and draws from the teachings in Quran to recommend community service activities, presentations, or workshops on topics such as HIV, prevention, support & treatment, stigma & discrimination, and the responsibility of Muslims in the fight against HIV. Problem scenarios, case studies, and action plans are provided for use in discussion and training, as are tasks to evaluate and challenge personal assumptions. In response to frequently asked questions, the manual acknowledges that HIV is a health issue within Muslim countries that needs to be addressed (p. 100), and discussion about sex and intimate matters does not violate concerns about decency when such matters are essential for preserving health and life (p. 101). The importance of providing support for people affected by HIV is highlighted, where “stigma and discrimination against PLHIV/AIDS is sin” (p. 73). Condom use is recommended “only for legitimate couples” and “drug use is forbidden” (p. 43). The behavioral change notion that the “program introduces new behavior to them. The people move on to a healthier and safer way of life” is questioned and an approach involving “loving, patience, kindness, modesty, and caring” is recommended. Support for a gentle, forgiving, innovative approach to promoting behavior change is drawn from the following Hadiths: (a) Shall I not tell you of the person for whom Hell is forbidden?—Hell is forbidden for every person who is tolerant, unpretentious, and pleasant (Hadith by Ahmad and Al-Tarmidhi); (b) May Allah, forgive my people, for they do not know (Hadith by al Bukhari); and (c) Give glad tidings [to people] and do not repel them away (Hadith by al Bukhari; p. 50). The JAKIM manual (2011) also describes Muslim efforts to prevent HIV in Uganda, South Africa, Indonesia, and Singapore, as well as conferences or consultations held in Malaysia, Indonesia, or Uganda with Muslim leaders from 1998 through 2009. Particular responsibilities are noted to “contribute to the community” (p. 94), “offer help to people in need” (p. 95), and see “pain and suffering from HIV/AIDS as a test from Allah SWT” (p. 92).

Currently, JAKIM utilizes the manual to conduct workshops with Muslim leaders across Malaysia, conducting 6–8 three-day workshops per year with 40–50 attendees per workshop. Workshops are conducted to increase community understanding surrounding HIV and raise awareness of the needs and
circumstances of FSW, MSM, and PWID. Further supports following these workshops are available at the state level (JAKIM, 2016, personal communication). Notably, this manual is also utilized in 3-day camping retreats conducted 6–8 times per year with participants who are lesbian, MSM, or transgender. Recruited through community outreach, generally 30–35 participants attend, where they receive Islamic lessons, discuss HIV risk, and seek to build self-esteem. For people seeking to quit commercial sex work as a source of income, some scholarship and small business supports are provided. Weekly informal religious discussions (Usrah) are also available in Putrajaya (the administrative district of Malaysia) and Kuala Lumpur (JAKIM, 2016, personal communication). Although some local NGOs reject the retreats as harmful in their emphasis on “correct” gender and sexual identities and their exclusion of proven harm reduction approaches such as condom use, JAKIM stresses the voluntary nature of such services and that the workshop may be useful for certain individuals.

The spiritually enhanced drug addiction rehabilitation (SEDAR) project (2011)

Starting in 2011, an Islamic inspired MMT project was implemented in a mosque in Kuala Lumpur, Malaysia. The World Health Organization (WHO, 2011) recognized the SEDAR model as a best practice in Asia for managing addiction and easing stigma and marginalization of drug users. The central feature of this approach was to offer a “one-stop service center” combining MMT with religious and psychosocial counseling from a local mosque complex (Rashid et al., 2014). The SEDAR project was developed through partnership efforts across public and private sectors along with community members. With the support of the Ministry of Health and oversight of religious leaders, the Malaysian AIDS Council, addiction specialists, and other stakeholders developed a Brief Spiritual Intervention (BSI) using Islamic teachings. BSI and religious counseling services were provided alongside MMT, peer counseling, and medical checkups.

A pilot study of 36 Muslim men from the SEDAR project found high levels of retention at 12 months (80%), reductions in drug use, improvements in overall health, and satisfaction with services, including religious components (Rashid et al., 2014). Despite its apparent strengths and anecdotal successes, the program experienced opposition from new leadership whose negative perceptions may have stemmed from ideological resistance rather than religious beliefs (Rashid et al., 2014). Despite limitations in sample size and lack of a comparison group, the pilot project demonstrated the feasibility of providing MMT services in a mosque setting. Engagement of religious leaders and the initial success of the mosque-based program implies innovative service strategies to fight HIV can be useful in Malaysian context.
Other programs

The Istana Budi Shelter and Treatment Centre was started in Kuang in 2007 by an NGO to provide shelter for Muslims living with HIV, providing shelter for approximately 20 participants (JAKIM, 2016). Additionally, the NGO, Positive Warrior Malaysia, supports HIV positive Muslims in building self-esteem, addressing and reducing stigma by providing peer support (Positive Warriors, 2017).

Discussion

Islamic beliefs and values can align with social work values to promote HIV risk reduction in community, religious, and healthcare settings, as well as in the development of health and social policy concerning key populations who are Muslim, with implications for non-Muslims as well. Drawing from the Quran and the Sunnah, principles regarding the importance of protecting and preserving faith, life (which includes dignity), intellect, progeny, and property, Islamic perspectives coincide with the desire of public health/social work professionals to reduce harms and promote protection (Saifuddeen, Rahman, Isa, & Baharuddin, 2014). Basic principles derived from the Sharia such as, “no one should be hurt or cause hurt to others,” “a lesser harm may be tolerated in order to eliminate a greater harm,” “necessities overruling prohibition,” “harm must be treated and benefits must be brought forth,” “public interest takes priority over personal interest,” and “looking after the general good” serve as guidelines for HIV prevention and treatment (Kamarulzaman & Saifuddeen, 2010).

Despite the links between Islamic belief and harm reduction, challenges limit the contribution of religious bodies to effective HIV prevention and treatment efforts. As Islam prohibits sexual intercourse between nonmarried people, there exists a refusal to support condom use for nonmarried people (JAKIM, 2011), post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP). Access to HIV prevention and treatment services for MSM, transgender, and CSW face particular challenges where prohibitive religious ideology leads to prejudice, discriminatory practices, and criminalization, inhibiting the ability of comprehensive protective strategies to reach individuals at risk. Additionally, nonreligious NGOs in Malaysia may struggle with religio-political influence over their programs and participants. The challenge is to find the meeting point between Islamic beliefs and harm reduction approaches in order to effectively support people at risk of acquiring HIV as well as people living with HIV who need treatment and support. Community advocates and social workers within NGOs in Malaysia are engaged in ongoing dialogue with religious government officials, advocating for rights and treatment, as well as access to religious support when requested.
Looking ahead, endeavors to improve the lives and health outcomes of key populations affected by HIV in Malaysia can be strengthened through national and local responses. Policies regarding key at-risk populations can be guided by Islamic ethics of seeking to preserve life and promote health. Drawing from established research on effective harm reduction approaches, support for condom use regardless of sexual or gender identity, PEP, and PrEP are warranted. Where religious organizations do not accept lesbian, gay, bisexual, and transgender (LGBT) individuals (Goh, 2012), there may be individual religious leaders or groups who are able to help people develop their faith in a life-affirming manner, while also promoting health and well-being. If religious leaders are unable to support wide ranging protective solutions, nonreligious NGOs should be supported in their ongoing efforts to ensure such resources are available (Dangerfield et al., 2015).

National-level attention is needed toward religiously informed attitudes that inhibit and promote access to HIV prevention information and services (Tham & Zanuddin, 2014). In a study of injection drug users in Malaysia who were not receiving treatment, Vicknasingam et al. (2009) found that ethnically Malay Muslim men formed a disproportionately large share of those not accessing treatment, and suggests efforts to overcome negative perceptions of harm reduction programs among Muslim men are needed. The SEDAR project (Rashid et al., 2014) deserves additional research and scale-up within Muslim communities with high numbers of heroin users. Negative views about people with HIV or people who use drugs are perpetuated on multiple levels as labeling and stereotyping influences discrimination that occurs within institutions, in individual encounters, and internally (Earnshaw et al., 2016; Mahajan et al., 2008). State-level enactment of stigma toward nonheteronormative communities (Lee, 2011) is harmful and does not coincide with Islamic values of life and dignity.

Where services are provided, Islamic values point to the need for compassion, nonjudgment, and taking action to improve lives, which coincide closely with core social work values of human dignity, social justice, and service. Religious leaders benefit from tools such as the Manual on HIV/AIDS in Islam (JAKIM, 2011) and need additional resources that describe the benefits of harm reduction approaches for key at-risk populations. While Malaysia has integrated a number of harm reduction strategies to support PWID, attention to MSM and CSW is lacking, in part due to discomfort with nonheteronormative sexual behaviors and sexuality outside of marriage (Kamarulzaman, 2013). Research is needed that examines the influence of religiously oriented programs such as trainings with religious leaders and retreats with at-risk communities. Research regarding the perspectives of MSM, CSW, PWID, and others affected by HIV toward religion as a component of services is also essential. Religious leaders hold an influential position from which to introduce notions of acceptance and health promotion (Mahajan et al, 2008),
and their attitudes toward sexual minorities may promote or suppress the tolerance of LGBT individuals within an organization as well as influence policy development and implementation of HIV prevention. In settings influenced by religious political structures such as Malaysia, it may be difficult to separate contentious influences of religion or particular religious individuals from the life-affirming nature of Islam. We encourage social workers and community health workers to continue advocating for policies and services that holistically promote health, equity, and respect for all.

References


