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To cite this article: Stacey A. Shaw, Olivia Cornwell, Sin How Lim, Rumana Saifi, Lik Teng Ung & Adeeba Kamarulzaman (2018): “Allah will decide my life and death”: Religion and spirituality among populations at risk for HIV in Malaysia, Journal of Religion & Spirituality in Social Work: Social Thought, DOI: 10.1080/15426432.2018.1447419

To link to this article: https://doi.org/10.1080/15426432.2018.1447419

Published online: 22 Mar 2018.
"Allah will decide my life and death": Religion and spirituality among populations at risk for HIV in Malaysia

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ABSTRACT

We examined the influence of religion and spirituality on HIV risk contexts through in-depth interviews with men who have sex with men (n = 10) and female commercial sex workers (n = 10) in Malaysia. Using a grounded theory approach, five themes emerged from the interviews: (a) religion encourages caring for health, (b) health is influenced by a higher power, (c) prayer is a conduit to health assistance, (d) stigma is compounded by religion but it does not limit one's spirituality, and (e) religion is not but should be incorporated into HIV campaigns. Incorporation of spirituality in service provision and addressing stigma is warranted.

INTRODUCTION

Malaysia is a multicultural, multireligion society constituting a Muslim majority population where Islam is deeply influential in political and social realms (Lee, 2011). Malaysia’s political system integrates both civil law as well as religious Sharia law, which has implications for the legal treatment of groups who are at the margin of religious-based society, such as men who have sex with men (MSM), commercial sex workers (CSW), and people who inject drugs (PWID). Under the penal code, homosexual relations are considered illegal (Beyrer & Baral, 2011; Godwin, 2010; Lee, 2011), and many states specify that commercial sex is illegal for Muslims (UN, 2014). As in other Southeast Asian countries, harm reduction approaches serving MSM and sex workers receive limited government support (Kamarulzaman, 2013). MSM often experience stigma and discrimination from health providers, police, and the broader society (Godwin, 2010; Teh, 2008). CSW experience police harassment as well as physical and sexual violence (Loeliger et al., 2016; UN, 2014). This risk environment involves fears and stigma that limits access to HIV prevention and treatment services among MSM, CSW, and PWID.
(Beyrer et al., 2012; Godwin, 2010), despite the concentration of HIV within these populations.

The HIV prevalence rate for adults in Malaysia is approximately 0.4% (UNAIDS, 2016). Illicit drug use is increasing in Malaysia (MAC, 2015) and an estimated 19%–45% of PWID are HIV positive (Chawarski, Mazlan, & Schottenfeld, 2006; Kamarulzaman, 2009). Though injection drug use was the primary route of transmission in the initial phase of the epidemic, in recent years a majority of new infections occur through sexual activity (Singh, Chawarski, Schottenfeld & Vicknasingam, 2013). Among MSM in Malaysia, HIV prevalence is estimated to be between 3.9%–12.8%, with high rates of risk behaviors including illicit drug use and multiple partnering suggesting HIV transmission is on the rise (Kanter et al., 2011; Lim et al., 2013). Among CSW, HIV prevalence is approximately 10.7% (Baral et al., 2012), although a lack of access to treatment and underreporting may conceal the actual percentage of those infected (IAS, 2013).

Attention toward religion as a component of health and social well-being has grown in recent years (Koenig, King, & Carson, 2012). Theoretical models that highlight multilevel influences on behavior can incorporate a focus on religious influence. For example, the structural risk environment model attends to the complexity of risk contexts, emphasizing factors exogenous to the individual including social norms, social capital, poverty, and policing (Rhodes, 2002; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). This model coincides with the ecological framework, which highlights the multiple micro, mezzo, and macro systems as well as their interactions that influence individual experience (Bronfenbrenner, 1992). Research with MSM emphasizes the importance of attending to intersecting risk factors and cultural contexts including religion and spirituality and examines how religion influences micro-, mezzo-, and macro-levels risk contexts (Lassiter & Parsons, 2016). In Malaysia where religion influences political and social life as well as individual practices, we anticipated that religion and spirituality permeate individual and social contexts of people who face HIV risk (Osteria & Sullivan, 1991). MSM in the United States have described the importance of spirituality in their lives, challenges including stigmatization within religious communities, and the importance of prayer and faith in coping (Foster, Arnold, Rebchook, & Kegeles, 2011; Jeffries et al., 2014).

While both religion and spirituality share an emphasis on a higher power, religion may be conceptualized as institutionalized patterns of beliefs, values, and behaviors while spirituality emphasizes transcendence, including search for purpose and the meaning of life (Canda & Furman, 2010; Koenig et al., 2012). Religion and spirituality often incorporate prayer, which helps to create and maintain a relationship with a higher power (Koenig et al., 2012). Both religion and spirituality likely influence HIV outcomes by
intersecting with individual behaviors, social contexts, and structural level conditions including policies and institutional contexts (Lassiter & Parsons, 2016).

Research on the relationship between religion and HIV has historically focused on (a) how religiosity influences individual HIV risk behavior, where religion is most often but not always found to be protective (Billioux, Sherman, & Latkin, 2014; Koenig et al., 2012; Nguyen et al., 2016; Shaw & El-Bassel, 2014); or (b) how religion influences stigma, where religion is most often found to increase stigma or barriers (Mbonu, Van Den Borne, & De Vries, 2009; Pan et al., 2016; Varas-Díaz et al., 2014). Alternately, the bulk of the literature on spirituality and HIV examines coping and necessary social supports among people living with HIV (Cotton et al., 2006; Doolittle, Justice, & Fiellin, 2016; Pargament et al., 2004; Szafalarski, 2013; Waluyo, Culbert, Levy, & Norr, 2015; Zou et al., 2009). Each of these bodies of research recognizes the importance of religion/spirituality in shaping attitudes and behaviors although the emphasis varies from individual behavior, individual coping, or societal norms and social supports.

We conducted qualitative interviews with MSM and CSW, including participants who injected drugs, to examine how religion and spirituality shaped their understanding of HIV infection and HIV risk behaviors. Our specific aims were to examine the following among MSM and CSW in Malaysia:

- how religion and spirituality influence individual, social, and structural risk factors to HIV acquisition; and
- the role of religion and spirituality in HIV prevention efforts.

**Methods**

To reach participants we collaborated with nongovernmental organizations (NGOs) SEED (Pertubuhan Pembangunan Kebajikan dan Persekutuan Positif Malaysia) and PT Foundation (formerly Pink Triangle Sdn. Bhd) that provide HIV prevention and other supportive services to CSW and MSM, respectively (PT Foundation, 2014; SEED, 2015). The organizations posted flyers describing the study, including aims and eligibility criteria, in their offices. Eligibility criteria included being 18 or older, living in Malaysia, and either engaging in commercial sex work, injection drug use, or unprotected anal sex with a man in the prior 90 days, or identifying as a man who has sex with men. Participants with any religious or nonreligious beliefs were welcomed. Interviews were conducted at the NGO offices in a private location, or at another location of the participants choosing, where participants gave informed consent and were interviewed by a research assistant who spoke their language of choice, either Malay or Bahasa Melayu, Chinese, or
English. Participation was voluntary and confidential. All participants received 30 Malaysian Ringgit (approximately $7) for their time. Interviews were conducted from January through May of 2016. All study procedures were approved by the Medical Ethics Committee of the University of Malaya Medical Center.

At the beginning of the interview, participants were asked a series of screening and sociodemographic questions. In addition to sociodemographic characteristics including age, education, ethnicity, relationship status, and employment status we asked whether participants were born biologically male or female, and whether participants self-identify as male or female. To assess homelessness we asked whether the participant had always had a regular place to sleep in the past 90 days. We also asked participants whether, in the prior 90 days, they had injected drugs; had sex with a man; had unprotected anal sex; or received money, drugs, or other goods for sex. We also asked what religious tradition, if any, described their current religion, and how often they attended either a mosque, church, or temple. Chi-square and independent sample t-tests examined differences in sociodemographic characteristics between MSM and CSW participants.

The interview field guide included a list of questions with possible probes, examining the role of religion in their upbringing, current engagement in religious practices, the influence of religion and spirituality on their life and health, and the influence of religion on views about gender and sexual relationships. We also asked participants to consider whether religion and spirituality influence specific high-risk situations, including having sex without a condom with a casual partner, and sharing unsterilized needles. We then asked whether the participant had experienced stigma or discrimination when seeking health-related services. Finally, we asked about the benefits and drawbacks of sharing HIV prevention and treatment information within religious settings such as a mosque or church, and solicited perspectives on designing an HIV prevention campaign in these settings.

Interviews were audio-recorded and transcribed verbatim, then portions of the interviews in Malay (Bahasa Melayu) or Chinese were translated into English. Data were then analyzed in NVivo version 11 using a grounded theory approach, where line-by-line open coding led to the identification of common themes. After identifying all themes present in the interviews, including topics of religion, health, and areas of support and risk, we examined trends among MSM and CSW, including trans-female sex workers and cisgender sex workers. Codes that were prevalent among each of the groups of respondents were analyzed again in an effort to determine patterns and common beliefs or ideas.
Results

Twenty participants completed interviews, including ten MSM and ten CSW. Of the CSW, six were cisgender and four were trans-women. Participant’s average age was 37. Half had completed college or university. More than half of participants identified as ethnically Malay (55%), while others were Chinese, Indian, or Orang Asli (see Table 1). Half of participants were single while 20% were in a committed relationship. Most were employed, either full time (40%) or part time (40%). Over one third of participants had experienced homelessness in the past 90 days. Regarding religious affiliation, 70% identified with Islam, 10% with Catholicism, and 5% (n = 1) each identified

Table 1. Sociodemographic characteristics of MSM and CSW participants.

<table>
<thead>
<tr>
<th>Sociodemographic characteristics</th>
<th>Total</th>
<th>MSM (10)</th>
<th>CSW (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average (SD)</td>
<td>36.6 (12.7)</td>
<td>31 (10.9)</td>
<td>42.1 (12.5)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than secondary school</td>
<td>7(35%)</td>
<td></td>
<td>7(70%)</td>
</tr>
<tr>
<td>Secondary school (SPM/STPM)</td>
<td>3(15%)</td>
<td>1(10%)</td>
<td>2(20%)</td>
</tr>
<tr>
<td>College or University</td>
<td>10(50%)</td>
<td>9(90%)</td>
<td>1(10%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malay</td>
<td>11(55%)</td>
<td>5(50%)</td>
<td>6(60%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>3(15%)</td>
<td>3(30%)</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>3(15%)</td>
<td></td>
<td>3(30%)</td>
</tr>
<tr>
<td>Orang Asli</td>
<td>3(15%)</td>
<td>2(20%)</td>
<td>1(10%)</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10(50%)</td>
<td>5(50%)</td>
<td>5(50%)</td>
</tr>
<tr>
<td>Divorced/Widowed</td>
<td>5(25%)</td>
<td>1(10%)</td>
<td>4(40%)</td>
</tr>
<tr>
<td>In a committed relationship</td>
<td>4(20%)</td>
<td>3(30%)</td>
<td>1(10%)</td>
</tr>
<tr>
<td>Other</td>
<td>1(5%)</td>
<td>1(10%)</td>
<td></td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>8(40%)</td>
<td>7(70%)</td>
<td>1(10%)</td>
</tr>
<tr>
<td>Part time</td>
<td>8(40%)</td>
<td>1(10%)</td>
<td>7(70%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>4(20%)</td>
<td>2(20%)</td>
<td></td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless in last 90 days</td>
<td>7(35%)</td>
<td>2(20%)</td>
<td>5(50%)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>14(70%)</td>
<td>6(60%)</td>
<td>8(80%)</td>
</tr>
<tr>
<td>Catholic</td>
<td>2(10%)</td>
<td>2(20%)</td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>1(5%)</td>
<td></td>
<td>1(10%)</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1(5%)</td>
<td>1(10%)</td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>1(5%)</td>
<td>1(10%)</td>
<td></td>
</tr>
<tr>
<td>Hindu and Christian</td>
<td>1(5%)</td>
<td></td>
<td>1(10%)</td>
</tr>
<tr>
<td><strong>Religious attendance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly or more</td>
<td>5(25%)</td>
<td>3(30%)</td>
<td>2(20%)</td>
</tr>
<tr>
<td>Monthly or more</td>
<td>1(5%)</td>
<td></td>
<td>1(10%)</td>
</tr>
<tr>
<td>Rarely</td>
<td>11(55%)</td>
<td>5(25%)</td>
<td>6(60%)</td>
</tr>
<tr>
<td>Never</td>
<td>3(15%)</td>
<td>2(20%)</td>
<td>1(10%)</td>
</tr>
<tr>
<td><strong>Injection drug use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2(10%)</td>
<td>1(10%)</td>
<td>1(10%)</td>
</tr>
</tbody>
</table>

Note. MSM = men who have sex with men; CSW = commercial sex workers; SPM= Sijil Pelajaran Malaysia; STPM= Sijil Tinggi Persekolahan Malaysia.
*p < 0.05, t-test, chi-square.
as Hindu, Buddhist, Protestant Christian, or Hindu and Christian. More than half of participants (55%) said they attended religious services rarely, although 25% attended weekly or more (see Table 1). Two participants (one MSM, one CSW) reported injection drug use in the prior 90 days while another two (both trans-female CSW) described smoking heroin or using methamphetamines such as ice.

Some sociodemographic characteristics varied among MSM and CSW participants. MSM tended to be younger than CSW and were more highly educated, with 90% of MSM having completed college or university, compared to 70% of CSW who had completed less than secondary school. MSM were also more likely to have full time employment (see Table 1).

Participants expressed varying levels of religiosity, with many emphasizing the importance of prayer and religious engagement in private or public settings including a mosque, temple, church, religious study groups, on TV, on the Internet, or on a mobile phone. Most participants did not distinguish between religion and spirituality, and religious experience and identity was embedded in cultural and familial practices, for example, with participants describing being Muslim and agnostic but praying or fasting regularly, or drawing from diverse religious texts such as the Koran and the Bible. Most participants recounted religious experiences during childhood in their family of origin.

The following themes emerged regarding the connection between individual level risk practices and religion/spirituality: (a) religion encourages caring for health, (b) health is influenced by a higher power, and (c) prayer is a conduit to health assistance. Additional themes emerged regarding societal or structural level contexts, including that (d) stigma is compounded by religion but it does not limit one’s spirituality and (e) religion is not but should be incorporated into HIV campaigns.

**Religion encourages caring for health**

Respondents from various religious backgrounds explained that maintaining health and healthy practices such as exercising, eating well, and abstaining from drugs were encouraged in their religious contexts. Using similar language around “taking care,” a transgender sex worker described, “the religion always asks you to take care of yourself” and an MSM participant said, “so [within] religion, we know we have to take care of our health.”

A Buddhist MSM participant described how religion informs efforts to care for his health:

… part of being a good Buddhist is to actually do good and to be good, and of course that encompasses health as well. You have to look after yourself, and every
other way, you don’t blame anyone else … I think there’s a responsibility that each of us [has] to do the best we can to look after our health.

The need to take care of health was tied to one’s relationship with a higher power. As a Muslim CSW participant described, “I pray to be healthy always.” A transgender CSW participant (Hindu and Christian) described a connection between religion, health, and prayer:

Religion taught us to take care of ourselves all the time. Ok. So it’s not like, you can be so free like that. So you have to take care of your health … Don’t say that you had done something, let’s say you already [had] sex without a condom, when you get sick then you go and seek for … then you go and complain to God. Why [did] this happen? Let’s say I’m good in praying. Just because I didn’t use condom, I can go and be mad at God. Ask him why I got sick. That’s not fair … Because you have to always take care.

This participant cites the importance of taking care of one’s health, including using condoms, which is in part ascribed to religious teaching. She suggests it would be unfair to blame God if one fails to take protective measures and becomes sick.

When asked about specific risk situations, including injection drug use and condom use, most participants said religion and spirituality did not influence whether they avoided risk, stressing instead health and self-awareness as major motivators. However, a few participants described health outcomes as linked to religious understanding, such as an MSM participant who described infection as a punishment from God for not protecting one’s health, “God already warn[ed] me, if you do a bad thing, then you will get your reward, which is like syphilis, chlamydia, things like that.”

Regarding religious influence on risk contexts more broadly, findings were inconclusive. One Muslim MSM participant felt his early religious involvement limited his exposure to drugs and sex. However, another Muslim MSM participant said religious views limit condom use, “For me, [condom use] for health no problem. But from religious perspective, [allowing condom use] it’s like encouraging us to do [raw or unsafe] sex.” Preventing HIV transmission may be more difficult for those who are unable to access or use condoms because of religious prohibitions or stigma.

**Health is influenced by a higher power**

Participants described a higher power as influencing the challenges, diseases, and health problems that they and others face in their lifetime. An HIV-positive Muslim CSW explained how her life and death are ultimately decided by Allah:
My life and death is on Him. Not from the medicine. Doctors only can suggest and advise me. But Allah will decide my life and death... [HIV] is a test from Allah for me. He wants to test my strength. Either I remembered Him or not. [Allah said to me] “As long as I never test you, you will not remember Me.” It is a test for me. As for me HIV is nothing... He [Allah] will take my life whenever He wants. In this case, a life challenge such as HIV infection is viewed as a test to remember Allah, an opportunity to enhance one’s spirituality. HIV infection could also be viewed as punishment from a higher power. For example, as an MSM participant described, “from the religious [perspective], the God will give you a disease or written from what you [did], you know [if you did a] wrong deed. So you will get STI for example, you will get HIV.” Looking to others who are infected with HIV, a Hindu CSW said, “They also are human. They never ask to have diseases. God already determined it, right?” God was thus viewed as determining individual health and fate.

The religious framing of major life events such as an HIV diagnoses also enabled identification of positive outcomes. An HIV-positive MSM participant described how his diagnosis changed him and his family:

... one thing I know everything has a purpose... I was going through a really bad path. And then that really help me back. So I, and the miracle was not only on me. My brother was also going through a very bad path. And then, he managed to get out of it... even though it [HIV diagnosis] seems like a bad thing, but at the end, when you realized it, God have that kind of purpose for giving me this kind of [disease]. People call this scary, they call it terrifying. But I accepted it and I am really happy being like this. I think it changed me a lot. So, it also broke every ego, it broke every ego in me. And then it fixed my relationship, my relationship with my family. So, there’s a silver lining in everything... I believe this is because as a Christian, I see, I see hope in whatever that seems disastrous.

Particularly among those who were HIV positive, the influence of a higher power enabled acceptance and meaning making.

**Prayer is a conduit to health assistance**

Most participants described praying for health, comfort, and assistance. As a Muslim CSW participant said, “... I drop my tears. I can’t control it whenever I pray. I also ask for my health.” Female CSWs described, “I pray for my health... I ask to be healthy” and, “He [Allah] is the one who create it [life]. If we don’t ask from Him, to whom we should ask?”

A trans-female CSW described the role of prayer as a means of intervention to protect one’s health:

Let’s say at time when I was in the lock up I had a very bad toothache... I just pray. I pray anywhere. On the second time I [was] arrested my blood pressure [was high]... So I just pray. I [feel] really flat (down) when I was there, feel like I want
to give up … Then when I heard that I will be released, so I think the spiritual thing really helps.

Prayer is thus seen as a way to access intervention and support from a higher power. A number of participants stressed the importance of prayer as a way to become calm, with one Muslim MSM participant suggesting prayer helps him maintain control, “When I talked to God, I feel I think I am calm, I am not that tempered, I can [be in] control.” A Catholic MSM further described prayer as promoting a feeling of calm and subsequently promoting physical health:

I think it’s all related, because [if] you emotionally are not healthy or spiritually [are] not healthy, your physical health will be affected. And, that’s why when you pray, you feel a bit calm. You feel the calmness in your heart. When you are praying in your heart, then you start to feel well, so but if you don’t pray for a long time, you feel, there’s darkness.

For many of the respondents, prayer is the process that connects them to a higher power, which in turn can bring greater physical and emotional health to their lives.

**Stigma is compounded by religion but it does not limit one’s spirituality**

Participants described links between religion and stigma. An MSM participant explained, “I find religious people and authority are very, are the most stigmatizing people on HIV and AIDS.” Some participants described feeling stigmatized in medical and social settings due to nonconforming identities or behavior, expressing concerns about following Shariah law, the Department of Islamic Development Malaysia (JAKIM), and religious camps promoting heterosexuality. A CSW participant said, “The doctor, nurse will look [down] at me … They will be afraid to touch me.” Another participant said doctors, “put their belief first rather than being a doctor,” although many also said they had not experienced stigma in medical settings.

Despite attributing stigma to religious people and organizations, participants emphasized their religiosity/spirituality as independent of other’s views. A Hindu and Christian trans-female CSW referred to negative attention saying, “I don’t care actually … especially if I go to temple or, anywhere they kind a look at me as I’m different.” An MSM participant explained, “Religion is based on one’s own principle. It doesn’t have anything to do with other people.” An MSM participant described the difficulty of feeling rejected socially, and emphasized an individual relationship with God through prayer as more important than participating in a religious community, saying, “as long as we [are] close to God, we pray, we remember Him, that’s enough.” Furthermore, from an MSM
participant, “the Bible says, if you stay in your room and really pray in
your heart, it’s worth more than going to church.”

Additionally, a trans-female CSW participant described the importance of
God’s acceptance in spite of rejection from others, saying:

... hold tightly [to] the religion. Remember Allah [is] the one and only. Even I as
[am] transgender, Allah is the one ... How bad he or she [is], how dirty the person
[may be], that is only in what people see not on God’s view. As for Him, we are
clean, I think like that. Because people don’t understand ...

Another trans-female CSW participant echoed the sentiment, saying, “I
see this [religion] is between I and God.” While some participants appeared
to have moved away from religious practice due to stigmatizing experiences,
for most a relationship with a higher power remained salient and was not
affected by societal stigma, even when stigma was religiously based.

Religion is not but should be incorporated into HIV campaigns

Participants said religious communities were not engaged in HIV prevention
efforts, and most said they would like to see information about HIV provided
in religious contexts. For example a trans-female CSW described, “I think
every religion should [respond to HIV], the disease [does] not know what
religion you are, so everybody has to educate [people].” Participants stated it
would be helpful for religious institutions to be involved in campaigns
promoting information about the risks of HIV and education on how to
take care of their health and reduce risk behaviors. Multiple venues were
called for, as an MSM participant described,

my personal view is that [prevention information] should be available everywhere,
including mosque and church and temple and, there should be a video and all
kinds of audio visual tools available. I [encourage] all the religions to encourage
people to reduce harm, and to seek treatment.

An MSM participant explained the benefit of receiving information from
religious settings, “Because it comes from the church, so it must be good, I
must follow what the church says” and another stated, “Do [a] talk or do a
forum near the mosque about HIV/AIDS, STI. Maybe people will, people will
accept, people will see that ...”

Others emphasized more specifically what needs to be addressed in reli-
gious settings, for example an MSM participant said:

... We need to create spaces, [for] people who are, who are, strong believers of
Islam or Christianity, [they] need to know that there are alternative points of view
in those religions that actually encourage a more nurturing [approach] and support
the whole issues [of] positive sex and sex with responsibility, and therefore sex with
protection.
A few participants felt that religious spaces were the wrong place to give out this information, stressing that HIV prevention information would be more appropriate in educational settings. A Christian MSM participant explained that the stigma of having sex outside of marriage is too strong in a church and that it is impractical for them to offer sexual health information, “why would they, why would they get sexual information from church? Sexual health information. Because it’s a huge stigma in church.” An MSM participant pointed to universities as a better educational venue, “always start with the University. That’s when [people] get very wild. That’s when they explore things. When you go to [reach people at] the age [when] they are working, it’s a bit too late.” Additionally, a Muslim participant said introducing these topics would be especially difficult at mosques in rural areas due to lower levels of education.

Some participants described specific strategies to promote safe sex practices such as emphasizing God rather than religion in messaging and using prosafe sex interpretations. A nonpracticing Catholic participant suggested that whether you are a Muslim or a Christian, “you are commanded by your God to know about safe sex and, you know, prevention of sexually transmitted diseases.” While participants liked the idea of religious involvement in HIV prevention, some also acknowledged challenges. A Muslim MSM said, “I think religion is a flexible way that you can use to promote good things, like safe sex and everything. But you have to be very cunning about it, and especially in term of religion in Malaysia, especially in Islam.” This sentiment points to barriers to incorporating HIV prevention content within religious settings in Malaysia. While both MSM and CSW participants discussed potential benefits of including religion in prevention campaigns, only MSM participants described concerns about doing so.

**Discussion**

We observed significant sociodemographic differences between the subsamples of MSM and CSW. The former were likely to be younger, employed full time, and highly educated. These differences were apparent in the articulateness of respondent’s reflections and the length of their responses, where MSM tended to share more information and were more likely to have already reflected on the questions of interest. Other research with these key populations in Malaysia has identified similar sociodemographic trends. Studies among MSM in Kuala Lumpur, and in Penang, Malaysia have found that the majority of participants have completed at least some tertiary education (Kanter et al., 2011; Koh & Yong, 2014; Lim et al., 2013), while qualitative research among cis- and trans-gender sex workers suggests most have completed at least some secondary education (Lall et al., 2017; Teh, 2008). These differences suggest studies are reaching samples of MSM who are highly educated, who may also
be more open regarding sexual identity and more willing to participate in research studies. Differences in social context and resources likely influence perspectives toward the intersections of religion and health. For this research, we included themes that were salient to all participants.

Findings among MSM and CSW suggest that religiosity and spirituality comprise important aspects of a participant’s life experience and understanding of HIV (Koenig et al., 2012; Shaw & El-Bassel, 2014). While religiosity may not frame decisions around condom use in the moment of a sexual encounter, participants saw religion as promoting the importance of caring for one’s body and maintaining healthy behaviors. They viewed a higher power as overseeing health, which was especially meaningful for HIV-positive participants. Prayer was considered a pathway through which to access support and guidance, and was fundamental to health and well-being for many, if not specifically linked to risk practices. A recent study among people living with HIV in Malaysia found that a high God locus of control, or a higher level of belief that God controls one’s health outcomes (Wallston et al., 1999), was associated with both positive religious coping (secure relationship with higher power) and negative religious coping (i.e., tension or struggle with a higher power; Siah & Tan, 2017). They also found that negative religious coping mediated the effects of high God locus of control on quality of life, suggesting those with high God locus of control may be more likely to use negative religious coping, which has a negative impact on life quality (Siah & Tan, 2017). High God locus of control was also associated with positive religious coping, but the latter was not associated with quality of life (Siah & Tan, 2017). Although the study did not examine how high God locus of control influences health risk behaviors, results appear to contradict our finding that participants found beneficial meaning and strength from attributing control over health to a higher power and relying on practices of prayer to access support, realities that appeared to be central to their quality of life as well as their health. Our study was not focused specifically on HIV-positive participants however, and we did not explicitly ask about negative and positive influences of religion, only about the influence of religion generally. Additional research is needed to examine how various forms of religious/spiritual practices (or coping) interact; how interactions vary according to religiosity, affiliation, and HIV status; and how practices influence overall well-being as well as HIV risk behaviors. As religion and spirituality are salient components of experience for many people affected by or at risk of HIV, social workers and other service providers can examine how religious practices and supports may help and/or hinder individual clients in coping with risks and diagnoses.

Study findings coincide with research suggesting religion plays a role in stigmatizing perspectives and actions in Malaysia (Godwin, 2010; Loeliger et al., 2016; Teh, 2008; UN, 2014). However, most participants expressed that
their religiosity or spirituality was independent of others’ views or beliefs. In our sample, spirituality appeared to remain salient as a means of support even when religious communities are less welcoming. Individual spirituality may become more salient as a means of support when religious communities are less welcoming. Rejection from religious communities may even lead to a deepening of spirituality or a more personalized relationship with God. Believing that a higher power is in control, and accessing that power through prayer, may allow individuals to feel a greater sense of internal control around their health and well-being rather than depending on external agents of control including people and institutions of power (Koenig et al., 2012). Drawing on understanding of the eco-systemic framework and structural risk environments (Bronfenbrenner, 1992; Rhodes, 2002; Rhodes et al., 2005) this finding may suggest that individual and social level religious and spiritual experiences can intersect in oppositional ways, where a deficit in social level religious support leads to a strengthening of individual spirituality. But it is not clear how this compensation may influence health risk behavior. Further research is needed on how CSW and MSM navigate religious stigma and how spirituality may compensate for community deficits. In assisting individuals affected by stigma, social work and community health workers can recognize that the experience of rejection from a religious community may not coincide with rejection of religious beliefs or spiritual practices. According to needs preferences, service providers can support people’s evolving religious paths, advocate for increased community inclusion, and raise awareness in an effort to shift stigmatizing attitudes.

While recognizing religiously based stigma, most participants also expressed interest in seeing religious bodies further address HIV prevention. These findings echo those from other researchers calling for incorporating religiosity/spirituality in risk reduction interventions among at-risk groups (Watkins et al., 2016). The possibilities for religious involvement in HIV education are broad and require context specific adaptation. Islamic thought permeates government policy surrounding HIV in Malaysia, where solutions such as condom distribution conflict with perspectives on acceptable marriage and sexual practices (Barmania & Aljunid, 2016). The Malaysian government has promoted premarital HIV testing and a manual on HIV/AIDS in Islam to be used by religious leaders. The manual encourages reducing stigma and discrimination against people affected by HIV, but again, condom use for unmarried couples is considered unacceptable (JAKIM, 2011). Religious camping retreats implemented by JAKIM incorporate content from this manual and seek to reduce HIV risk among transgender, MSM, and lesbian participants while promoting heterosexuality (Shaw, Saifi, Lim, Saifuddeen, & Kamarulzaman, 2017). Participant discussion in this study about these religious camps was mixed, and raise concerns about their role
in propagating stigma. Further research on HIV prevention efforts within government-run religious contexts in Malaysia is needed.

While participants in this study suggested religious organizations should play a greater role in promoting HIV prevention and education, the lack of acceptance of non-traditional gender and sexual identities as well as harm reduction approaches among many political and religious leaders in Malaysia (Barmania & Aljunid, 2016) suggests such a shift may be difficult. Non-governmental organizations in Malaysia play an important role in filling this gap and supporting people at risk of acquiring HIV. Health and social service providers in Malaysia have been at the forefront of providing supportive and welcoming spaces, improving community awareness, and seeking to reduce stigma. Their critical efforts could benefit from wider support and partnership from government and religious leaders. Innovative and collaborative efforts that draw upon religious and cultural strengths are needed. One example that warrants increased research and support is a methadone-maintenance program implemented within a mosque setting, which demonstrated promise in supporting clients despite political challenges in program implementation (Rashid et al., 2014). Despite challenges in doing so, additional initiatives that seek ways to improve services and combat stigma are needed.

**Limitations**

Due to limited research on religiosity and HIV risk behavior as well as ethnic and religious diversity in Malaysia, we chose to include participants from diverse religious backgrounds and risk groups in the study. Although this was part of the research design, the accompanying limitations of the study need to be mentioned. As we combine findings with participants with diverse religious identities, with some represented by few or one participant, the study is limited to examining trends across religions, not fully representing or probing any one system of belief. We also included participants from different risk groups, who have varying sociodemographic backgrounds and face unique social barriers. We assume that there is commonality in social processes of how religion affect HIV risks in this at-risk populations as they are socially marginalized by the society and the religious institutions. However, additional research is needed to better understand how religion/spirituality influences risk contexts of specific groups such as transgender sex workers. With the diversity of experiences across the sample, we are not certain that saturation was reached on all themes examined. Additionally, although a number of participants described being HIV positive during the course of the interviews, we did not assess HIV status across all participants, limiting our ability to more specifically examine HIV status and religiosity.
Conclusions

This research underscores the importance of religion and spirituality in the lives of CSW and MSM in Kuala Lumpur, Malaysia. An individual relationship with God or other higher power, particularly through prayer, was an important foundation for many participants, influencing how they conceptualize health. Social workers and other service providers serving MSM and CSW should be aware of the importance of religion and spirituality to individual understandings of health and well-being. Among people living with HIV, health care and other providers can be aware of the potential importance of spiritual coping resources. Individuals may rely on religious and spiritual frameworks to find meaning and direction regardless of whether they conform to dominant religious conceptions of appropriate sexual identity and behavior or whether they participate in formal religious settings. Efforts to reduce stigma among religious communities are also needed, as is research on the impact of religious efforts to address HIV in Malaysia. With attention to both the person and the broader environment, social service providers can seek to understand and empower the whole person, including their religiosity and spirituality, while also seeking to increase social acceptance.

Note

1. Some participants utilized the titles of God and Allah interchangeably.

Acknowledgments

We appreciate the time and willingness of participants to share their experiences and views. We also wish to acknowledge NGOs’ Pertubuhan Pembangunan Kebajikan dan Persekutaran Positif Malaysia (SEED) and PT Foundation (formerly Pink Triangle Sdn. Bhd.) who assisted with study recruitment and reflection on study implications.

Funding

This work was supported by the Centre of Excellence for Research in AIDS at the University of Malaya under grant number: UMRG-RP009.

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