Cultural Care for People Living with HIV/AIDS in Muslim Communities in Asia: A Literature Review

Kusman Ibrahim, Praneed Songwathana

Abstract: The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have obtained a great deal of attention worldwide over the past three decades. Numerous studies have been conducted to address this pandemic virus and disease, yet the number of infected individuals is increasing, particularly in developing countries, including those that are predominantly Muslim. Muslims historically have shown a unique response to HIV/AIDS due to their belief that their Islamic faith protects them from contracting the virus. Therefore, understanding the interface, among cultural beliefs, prevention and care for individuals with HIV/AIDS, is crucial for health care providers to develop culturally appropriate models of prevention, care and treatment. However, care that is culturally congruent for individuals with HIV/AIDS remains largely unexplored among Muslims in Asia. The purpose of this review of the literature was to examine cultural beliefs in relation to caring practices for people with HIV/AIDS in Muslim communities in Asia. Recommendations and implications for health care providers are highlighted, and the need for future research is suggested.

Thai J Nurs Res 2008; 13(2) 148 - 157

Key words: culture, caring, HIV/AIDS, Muslims, Asia

Introduction

The presence of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has reached pandemic proportions, affecting millions of men, women and children around the world. In 2007, an estimated 33.2 million people were living with HIV/AIDS (PLWHA) worldwide.[1] The Joint United Nations Program on HIV/AIDS (UNAIDS) has reported the total HIV population of North Africa, Middle East and predominately Muslim Asian countries to be nearly 1 million.[2] It seems no country has been unaffected by HIV/AIDS, including predominantly Muslim countries.

Some Muslims believe they will not contract HIV/AIDS, because of the religious and cultural norms of Islam prohibit engagement in high risk behaviors that can lead to HIV/AIDS. Trinitapoli and Regnerus[3] point out that involvement in religious practices might reduce the risk of HIV infections in men, which, subsequently, may lead to a decreased incidence of women contracting HIV/AIDS from their husbands. However, a gap often exists between religious teachings and actual

Kusman Ibrahim, *PhD Candidate, RN, Prince of Songkla University, Hat Yai, Thailand.*
Correspondence to: Praneed Songwathana, *PhD, RN, Associate Professor, Faculty of Nursing, Prince of Songkla University, Hat Yai, Thailand.* ***E-mail:*** *praneed.s@psu.ac.th*

practices. As a result, HIV/AIDS and other sexually transmitted diseases occur.

Although predominantly Muslim communities may share similar Islamic beliefs, local cultures and conditions may lead to the people practicing their beliefs via different and unique perspectives. In regard to prevention and care for HIV/AIDS, issues such as stigma, discrimination, misinformation about diseases, poverty, the presence of refugees and economic instability remain strong and may interfere with successful efforts toward tackling HIV/AIDS.[4] Prevention modalities, such as condom use, sterile needle programs and methadone substitution therapy, which have been implemented successfully in many non-Muslim communities, continue to be debated and often rejected by some Muslim leaders. Thus, it is not surprising that cultural practices and religious beliefs have been noted to be contributing factors in the way people engage in risky behavior.[5-7]

Asia is known as the most populous Muslim region in the world and has been recognized as having the second largest population living with HIV/AIDS. Previous studies have highlighted, within specific settings, the importance of culture in relationship to HIV/AIDS prevention.[5, 8] However, little is known about the uniqueness of the impact of the culture of Muslim communities in Asia in regards to caring for PLWHA. This review of the literature attempts to describe culturally appropriate factors related to the care of PLWHA in Muslim communities in Asia.

Review of Literature Method

Review of the literature involved an electronic search, using CINAHL, Science Direct, Blackwell Synergy and Goggle Scholar, for information related to care of individuals with HIV/AIDS. The search sites were selected because they are known to provide full text access and be readily available in the researchers' university library. Key words used included: "HIV/AIDS and Muslim countries;" "caring/care and HIV/AIDS;" and, "caring and Islam/Muslim." Relevant clinical articles, research studies, books and website references, published within the past 10 years and available in the university library, were retrieved and reviewed. This review is presented with respect to: HIV/AIDS epidemics in predominantly Muslim countries in Asia; Islamic beliefs and the Muslim culture of care; caring for PLWHA in Muslim communities; implications for nursing care and research; and, conclusions.

HIV/AIDS Epidemics in Predominantly Muslim Countries in Asia

The review of the literature regarding HIV/AIDS epidemics in predominantly Muslim countries in Asia addressed only those countries where Muslims comprise over fifty percent of the population. These countries include: Afghanistan, Pakistan, Bangladesh, Malaysia, Brunei Darussalam, and Indonesia. Each of these countries, between 1980 and the early 1990's, indicated having no, or a limited number of, reports of HIV/AIDS.[4, 9] However, between 2003 and 2005, both the World Health Organization (WHO) and UNAIDS estimated that a significant number of PLWHA existed within these countries.[9] Indonesia, with the world's largest population of Muslims, reported an increase of 60,000 cases (110,000 to 170,000) of HIV/AIDS between 2003 and 2005.[9] Similar increases were reported in Malaysia, Pakistan and Bangladesh, although less than 100 PLWHA were reported in Afghanistan and Brunei Darussalam the end of 2005.[9]

Although the number of PLWHA has been estimated to be far greater than the reported

number of cases,[10] due to the limited number of studies that have been undertaken, the actual number of HIV/AIDS cases in predominantly Muslim countries in Asia has been difficult to determine. Thus, most publications related to HIV/AIDS cases in these countries have had to rely on governmental estimations, rather than on accurate numbers.

Although some predominantly Muslim countries in Asia have reported a low prevalence of HIV/AIDS, many individuals within these countries partake in behaviors which may fuel an HIV/AIDS epidemic. Vulnerability factors, such as post-conflict experiences, presence of foreign militaries, limitations of health and educational infrastructures, low social economic status of women, production of opium and lack of access to employment opportunities, may contribute to HIV/AIDS epidemics among displaced populations in Afghanistan.[11-13] In Pakistan, a high rate of migrant workers, hidden practices of commercial sex workers, drug users, lack of knowledge about HIV/AIDS, unsafe needle usage in health care facilities, unscreened blood transfusions and inadequate treatment of sexually transmitted diseases have been identified as major contributors to the spread of HIV/AIDS among the population.[14] In addition, Caldwell and associates found that one-quarter of single males and a significant number of married men, in Chittagong Bangladesh, had sexual relations with prostitutes.[15]

Homosexual activities also have been found to be prevalent among men who continue to engage in sexual relations with their wives, female sex workers and/or girl friends.[16] However, HIV infections contracted through injection of illicit drugs have been found to be more predominant, in Malaysia and Indonesia, than heterosexual or homosexual activities.[12, 17] Also, in Indonesia, the practice of sharing needles, among injected drug users (IDUs), has enhanced the spread of HIV/AIDS.[18]

The number of cases of HIV/AIDS in predominantly Muslim countries, including those in Asia, has increased each year.[4, 19, 20] Governments of these countries are aware of this increase and have established guidelines for development and implementation of HIV/AIDS prevention, care and treatment programs.[20] Although the governments in Malaysia and Indonesia have reported a need to adequately address cultural and religious issues in combating HIV/AIDS,[17, 21] discrepancies have been found to exist between their governmental policies and health care practices.[22, 23]

Islamic Beliefs and the Muslim Culture of Care

There are approximately 1.3 billion Muslims worldwide, including individuals from different races, nationalities and cultures.[24] Muslims are connected by their common Islamic faith, heritage and belief in: one God; angels; God's revealed books; prophets through whom God's revelations were brought to mankind; a day of judgment; individual accountability for actions; God's complete authority over human destiny; and, life after death,[24] Muslims view the Qur'an as a record of the exact words, revealed by God through the Angel Gabriel, to the Prophet Muhammad and on to the people.[25] Thus, the Qur'an serves as the prime source of every Muslim's faith and life practices.

Islam is a religion that incorporates ritual practices and guidelines for a complete way of life, and is reflected in Muslim cultural beliefs and practices.[26] The five pillars of Islam include: faith (*sahadah*), prayer (*shalat*), concerns for the needy (*zakat*), self-purification (fasting), and pilgrimage, by those who are able, to Makkah.[25, 27] In a Muslim's world, Islam defines culture, and culture gives meaning to every aspect of an individual's

life, including his/her behaviors, perceptions, emotions, language, family structure, diet, dress, body image, concepts of space and time, and attitudes toward health and illnesses.[4]

Each aspect of a Muslim's life has implications for the delivery of health care. Muslims view health, illnesses, suffering, and dying as part of life and as a test from Allah (God).[28] They are encouraged to receive illness, suffering and death with patience, meditation and prayers. In addition, Muslim's believe they are to consider illness and suffering as atonements for sins, and death as a part of their journey to meet God.[24, 28] Seeking appropriate treatment and care for a sick person is strongly encouraged in Islam. Moreover, health, illness and caring are considered part of the human experience of performing worship activities while on earth.[28]

Muslims' view about caring is embedded in the theological framework of Islam. The notion of caring in Islam is basically grounded in the belief that providing care to others is a service to God, which should be given freely and without ties to commercialism.[24] Caring is seen as a natural outcome of having love for Allah and the Prophet Muhammad, and refers to having the will to be responsible, sensitive, concerned, motivated and committed to acting the right way in order to achieve perfection in life.[24] In doing so, Islam advocates that believers should follow the guidelines delineated in the Qur'an and the Sunnah (the prophetic traditions of Muhammad).[28] Followers of Islam believe that the Prophet Muhammad (Peace Based Upon Him) was sent to provide mankind examples of how to live, including matters of health and personal hygiene.[28]

There are several Islamic traditions related to health care practices which coincide with specific traditions that occur along the human life span.[28, 29] For example, Islam views marriage as sacred and family as the foundation of society, which provides stability and security to individuals and families.[30] Men are seen as the protectors of women and play an important role in decision-making, as it relates to giving consent for health care treatment. Both one's immediate family and community elders are required to be involved when decisions are made regarding important health care treatments.[31]

Homosexuality is condemned, and considered sinful and punishable by Allah. Muslim couples are encouraged to have children, sex outside of marriage is discouraged and contraception and family planning are allowed.[31] When contraception and family planning are discussed, health care professionals can present appropriate methods to either the wife or husband.[31]

Abortion is not permitted, except if the pregnancy threatens the life of the mother, since children are perceived as a gift from Allah.[31] Thus, Islamic practices are encouraged with newborns. The practices include: *adhaan* (the call to prayers) in the right ear, *iqaamah* (the announcement of the initiation of prayers) in the left ear, *tahnic* (placing a few drops of sweet liquid or honey on the tongue) and *aqiqah* (shaving the baby's head, naming the baby, and sacrificing sheep).[29] Boys are circumcised, generally between the ages of seven and twelve, to enable them to maintain cleanliness through washing (*wudlu*) and to prevent urine from collecting in the foreskin.[29]

Muslims prefer to be cared for by a member of the same gender.[31] In addition, the Islamic faith emphasizes cleanliness, which includes: washing the genital area with running water prior to any type of worship; eating with the right hand; and, consuming only permissible (*halal*) food. Forbidden, or non-permissible (*haram*), foods and items, include pork, non-halal meat, alcoholic beverages, gelatin products and illegal drugs.[32]

Throughout Islam, human life is regarded as precious and the will of Allah should be allowed to

prevail.[28] Thus, the taking of a life through suicide or euthanasia is considered a major sin.[33] However, a person certified as brain-stem dead should not be artificially kept alive; resuscitation is allowed; and, organ and blood transfusion donations are acceptable.[33]

Muslims believe in life after death and the Day of Judgment.[25, 27] Terminally ill patients are to be treated with sympathy and compassion, and their spiritual needs are to be accommodated.[28] When one is dying, privacy of the individual is encouraged during the declaration of faith and recitation of the Quran. Upon death, the person's eyes and mouth are to be closed; the limbs of the body are to straightened; a complete ritual body washing is to be done by a family member or person of the same gender; the body is to be covered with a plain sheet; and, prayers are to be said.[29] Some Muslims may request that non-Muslims not touch the body and that the body be buried as soon as possible after death.[25]

Caring for PLWHA in predominantly Muslim communities

The spread of HIV/AIDS not only is a health problem, but also impacts cultural beliefs and religious practices, which touch all aspects of the life of Muslims. Some Muslims believe that: HIV/AIDS is a punishment from God for bad behavior and/or sins committed,[34] and the only way to become infected is through illicit drug use, male-to-male intercourse and/or extra-marital sexual activity. Such incorrect beliefs contribute to stigmatization and discrimination toward PLWHA, and appear to be more pronounced within Muslim communities than in other populations.[4]

Among non-Muslim populations, the knowledge and attitude people have about HIV/AIDS have been noted to be determinants regarding one's willingness to care for PLWHA.[35, 36] However, in Muslim communities, whether one does or does not willingly care for PLWHA appears inconsistent and dependent upon the community. For example, negative attitudes toward PLWHA have been found to exist among the Tunisians.[37] However, among both Turkish and Iranian people, positive attitudes toward PLWHA was found to exist where adequate knowledge about HIV/AIDS was available.[38, 39]

Unfortunately, little information was locatable, regarding the level of knowledge about HIV/AIDS and attitudes towards PLWHA among individuals in predominantly Muslim communities in Asia. Although information regarding caring practices for PLWHA in Muslim communities is limited, knowledge gained from prior studies regarding caring practices among non-HIV/AIDS populations, within the context of the Islamic faith, can be utilized to better understand how Muslims care for those with chronic illnesses. For example, Islamic religious practices and cultural norms are factors that have been shown to influence individuals providing care to family members with schizophrenia.[40] Such family caregivers have been found to interpret caring as love and concern, obligation of family members, acceptance as prescribed by Allah and a test of patience set by Allah. Prayers, seeking folk treatments and using modern medicine also have been identified as types of caring activities among the family caregivers of family members with schizophrenia.[40]

Islam highly values life and discourages one from having a sense of hopelessness or abuse regarding life.[41] Therefore, when Muslims become HIV positive or develop AIDS, other Muslims are supposed to care for them, since they are part of the Muslim community. Muslims are not supposed to avoid or neglect those with HIV/AIDS because of their disease.[41] Rather Muslims believe that so they can lead a life with dignity, PLWHA should be given attention, care, love and affection. Muslims believe they do not have a right to judge or

condemn those with HIV/AIDS, since it is up to Allah Almighty whether to forgive or punish.[41, 42] Love and compassion are viewed as the qualities of a good Muslim, and people with HIV/AIDS cannot be denied these powerful emotions. Visiting and caring for the sick is highly recommended by the Prophet Mohammed. Since PLWHA need compassion, love, support, and affection, Muslims should feel comfortable embracing them.[41, 43]

The practices of Muslims, in some areas of Asia, continue to be influenced by local cultural beliefs that have been derived from previous traditions. Concepts of spirituality, respect for ancestors, beliefs in spirits and mystics, and gender relations are examples of beliefs that are derived from pre-Islamic beliefs.[26] Asian cultures stress maintenance of social and religious harmony with the universe, which influences one's attitude toward health and disease.[44] For example, since HIV/AIDS has been viewed as an immoral disease, seeking health care for the illness or disclosing the presence of a sero-positive status can bring embarrassment to one's family and community. In order to "save face' in the family and community, those with HIV/AIDS often become isolated or are totally rejected by the community. Stigma and discrimination towards PLWHA and HIV/AIDS care continues to exist within villages, healthcare facilities and employment sectors in Indonesia[23] and Thailand.[45]

Implications for Nursing Care and Research

Nurses are the largest group of healthcare providers worldwide and have the greatest opportunity to care for PLWHA regardless of social-economic status, religious beliefs or cultural backgrounds. Nursing, as a transcultural, humanistic and scientific care discipline and profession, plays a central role in meeting the care needs of the increasing number of HIV/AIDS patients from diverse cultures.[46] Caring usually is an embedded value in the culture of populations.[47] It is important for nurses to understand the culture of the population from which their patients come, so as to be better able to develop caring modalities that are congruent with the culture of the respective population. Caring modalities that are not congruent with the patients' cultural beliefs may lead to cultural shock, uncooperative behavior and difficulties in achieving nursing care goals.[47]

Limited publications, regarding caring for people with HIV/AIDS in predominantly Muslim countries in Asia, were located. However, the importance of incorporating cultural beliefs and acknowledging the role of religious leaders, in the development of prevention and care delivery programs for PLWHA, have been emphasized.[4, 19, 48, 49]

Although Muslims in predominantly Muslim countries are known to share similarities regarding cultural beliefs derived from Islam, rapid globalization and the presence of local cultural practices may influence their interpretation of the Islamic tenets. Thus, it is important for health care providers to identify and describe how these factors influence health care delivery within a respective community. Therefore, nurses need to understand local cultural views related to the provision of care for PLWHA and to assure the health care delivered is culturally congruent.

Conclusions

HIV/AIDS has spread worldwide. The predominantly Muslim countries in Asia are no exception, since some Muslims engage in behaviors that place them at risk of contracting HIV/AIDS. Islamic beliefs and traditions shape the culture and way of life of Muslim people, and directly

influence their health care practices. However, misperceptions and lack of knowledge about HIV/AIDS continue to exist among many Muslims, and leads to stigmatization, discrimination and neglect of PLWHA.

Although the governments of predominantly Muslim countries in Asia are aware of the increasing number of PLWHA within their respective country, the effectiveness of implementing programs related to HIV/AIDS prevention and treatment continue to need development and implementation. Nurses in particular, as professional caregivers, are expected to play a significant role in the care of PLWHA through prevention, health care delivery, and education of individuals, families and communities. Understanding the cultural beliefs of a particular population is crucial to the development of culturally appropriate care. Since there is limited knowledge on the issues of cultural beliefs and caring for PLWHA in predominantly Muslim communities in Asia, research needs o be conducted to explore this phenomenon.

Acknowledgements

The authors gratefully acknowledge the research grant provided by the Prince of Songkla University.

References

1. UNAIDS/WHO. *AIDS* epidemic update: December 2007. Geneva: UNAIDS; 2007.
2. UNAIDS. *HIV* infection rates decreasing in several countries but global numbers of people living with HIV continues to rise. Press Release 21; November 2005.
3. Trinitapoli J, Regnerus MD. Religion and HIV risk behaviors among married men: Initial results from a study in rural Sub-Saharan Africa. J Sci Stud Relig. 2006;45(4):505-28.
4. Hasnain M. Cultural approach to HIV/AIDS harm reduction in Muslim countries. Harm Reduct J. 2005;2(23):1-8.
5. Lee K, Keiwkarnka B, Khan MI. Focusing on the problem instead of the solution: How cultural issues in North Thailand continue to influence HIV/AIDS infection and infected patients' quality of life and treatment by health providers. J Public Health Dev. 2003;11(1): 119-34.
6. Moreno CL. The relationship between culture, gender, structural factors, abuse, trauma and HIV/AIDS for Latinas. Qual Health Res. 2007;17(3):340-52.
7. Wolffers I. Culture, media and HIV/AIDS in Asia. Lancet. 1997;349:52-4.
8. Hare ML, Villarruel AM. Cultural dynamics in HIV/AIDS prevention research among young people. J Assoc Nurses AIDS Care. 2007;18(2):1-4.
9. WHO. Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections. [cited 2007 Nov 20]. Available from: http://www.who.int/ globalatlas/default.asp.
10. Ahmadzai Z. HIV situation in Afghanistan. [cited 2007 Nov 10] Available from: http://www.youandaids.org.
11. Bergenstrom A. Afghanistan: HIV/AIDS vulnerability and prevention. J Health Manage. 2003;5(2):215-24.
12. Riono P, Jazant S. The current situation of the HIV/AIDS epidemic in Indonesia. AIDS Edu Prev. 2004;16(Supplement A):78-90.
13. Ryan JM. Health care in Afghanistan. World J Surg. 2005;29:s77-9.
14. Khawaja ZA, Gibney L, Ahmed AJ, Vermund SH. HIV/AIDS and its risk factors in Pakistan. AIDS. 1997;11:843-8.
15. Caldwell B, Pieris I, Khuda B, Caldwell J, Caldwell P. Sexual regimes and sexual networking: The risk of an HIV/AIDS epidemic in Bangladesh. Soc Sci Med. 1999;48:1103-16.
16. Khan SI, Rodd NH, Saggers S, Bhuiya A. Men who have sex with men's sexual relations with women in Bangladesh. Cult Health Sex. 2005;7(2):159-69.
17. Huang M, Hussein H. The HIV/AIDS epidemic country paper: Malaysia. AIDS Educ Prev. 2004;16 (Suppement A) :100-9.

18. Pisani E, Dadun, Sucahya PK, Kamil O, Jazant S. Sexual behavior among injection drug users in 3 Indonesian cities carries a high potential for HIV spread to non injectors. J AIDS. 2003;34(4):403-6.
19. Todd CS, Nassiramanesh B, Stanekzai MR, Kamarulzaman A. Emerging HIV epidemics in Muslim countries: Assessment of different cultural responses to harm reduction and implications for HIV control. Curr HIV/AIDS Rep. 2007;4:151-7.
20. UNAIDS. Country situation analysis. [cited 2007 Nov 15]. Avalaible from: http://www.unaids.org/en/Regions_Countries/ Countries.asp.
21. National AIDS Commission. National HIV/AIDS strategy 2003 - 2007. Jakarta: Office of the Coordinating Minister for People's Welfare/National AIDS Commission, Indonesia; 2003.
22. Foong ALS, Ng SF, Lee CKC. Identifying HIV/AIDS primary care development needs. J Adv Nurs. 2005;50(2):134-42.
23. Merati T, Supriyadi, Yuliana F. The disjunction between policy and practice: HIV discrimination in health care and employment in Indonesia. AIDS Care. 2005; 17(Supplement 2):S175-9.
24. Rassool GH. The crescent and Islam: Healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. J Adv Nurs. 2000;32:1476-82.
25. The Islamic Affairs Department, The Embassy of Saudi Arabia, Washington DC. Understanding Islam and the Muslims. [cited 2007 Jun 26]. Available from: http://www.islamicity.com/Mosque/uiatm/ un_islam.htm# WII.
26. Martin RC, ed. Encyclopedia of Islam and the Muslim world. New York: The Gale Group Inc.; 2004.
27. Ibrahim IA. A brief illustrated guide to understanding Islam. Houston: Darussalam; 1997.
28. Athar S. Information for health care providers when dealing with a Muslim patient. [cited 2007 Dec 5]. Available from: http://www.islam-usa.com.
29. Amjad M. General Muslim customs and traditions. [cited 2007 Dec 5]. Available from: http://www.understanding-islam.com.
30. Luna LJ. Arab Muslims and culture of care. In: Leininger M, McFarland MR, editos. Transcultural nursing: Concepts, theories, research & practices. New York: McGraw-Hill; 2002. p.301-11.
31. Akhtar SG. Nursing with dignity. Part 8: Islam. Nurs Times. 2002;98:40-2.
32. The Islamic Council of Queensland. Health care providers handbook on Muslim patients. Queensland: Islamic Council of Queensland; 1996.
33. Euthanasia. [cited 2007 Jan 16]. Available from: http//www.unn.ac.uk/societies/islamic.
34. Lake S, Wood G. Combating HIV/AIDS in eastern Sudan. The case for preventive action. Woking Surrey: Ockeden International; 2005.
35. Lohrmann C, Valimaki M, Suominen T, Muinonen U, Dassen T, Peate I. German nursing students' knowledge of and attitudes to HIV and AIDS: Two decades after the first AIDS cases. J Adv Nurs. 2000;31(3):696-703.
36. Williams AB, Wang H, Burgess J, Wu C, Gong Y, Li Y. Effectiveness of an HIV/AIDS educational programme for Chinese nurses. J AdvNurs. 2006;53(6):710-20.
37. Tebourski F, Alaya DB. Knowledge and attitudes of high school students regarding HIV/AIDS in Tunisia: Does more knowledge lead to more positive attitudes? J Adolesc Health. 2004;34:161-4.
38. Ayranci U. AIDS knowledge and attitudes in a Turkish population: An epidemiological study. BMC Public Health. 2005;5(95): 1-10
39. Montazeri A. AIDS knowledge and attitudes in Iran: Results from a population-based survey in Tehran. Patient Educ Couns. 2005;57:199-203.
40. Vanaleesin S. Family care givers' caring for persons with schizophrenia from Islamic perspectives [dissertation]. Hat Yai (Songkhla): Prince of Songkla Univ.; 2007.
41. HIV, AIDS and Islam. [cited 2007 Sept 15]. Available from: http://www.positivemuslims.org.za/hivaidsis.htm.
42. Mohamed N. Tackling AIDS through Islam. [cited 2007 Nov 19]. Available from: http://www.islamonline.net.
43. Yaqut MM. Caring for people with special needs in Islam. [cited 2007 Feb 2]. Available from: http://makkah.wordpress.com/2007/06/14/caring-for-people-with-special-needs-in-islam.

44. Bhattacharya G. Health care seeking for HIV/AIDS among South Asians in the United States. Health SocWork. 2004;29:106-15.
45. Songwathana P. Kinship, karma, compassion and care: Domiciliary and community based care of AIDS patients in southern Thailand [dissertation]. Brisbane (Queensland): University of Queensland; 1998.
46. Leininger M. Culture care diversity and universality: A theory of nursing. Sudbury: Jones and Bartelet Publishers; 2001.
47. Leininger M. Essential transcultural nursing care concepts, principles, examples and policy satements. In: Leininger M, McFarland MR, editors. Transcultural nursing: Concepts, theories, research and practice. 3rd ed. New York (NY): Mc Graw-Hill Medical Publishing Division; 2002:45-70.
48. Gatrad AR, Sheikh A. Risk factors for HIV/AIDS in Muslim communities. Diversity Health Soc Care. 2004;1 (1):65-9.
49. Kagimu M, Marum E, Wabwire-Mangen F, Nakyanjo N, Walakira Y, Hogle J. Evaluation of the effectiveness of AIDS health education interventions in the Muslim community in Uganda. AIDS Educ Prev. 1998;10: 215-28.

วัฒนธรรมการดูแลผู้ติดเชื้อและผู้ป่วยเอดส์ ในบริบทสังคมมุสลิมแถบเอเชีย:การทบทวนวรรณกรรม

Kusman Ibrahim, ประณีต ส่งวัฒนา

บทคัดย่อ: ในระยะ 30 ปีที่ผ่านมา การติดเชื้อเอชไอวีและโรคเอดส์ยังคงได้รับความสนใจทั่วโลก มีการศึกษามากมายที่เน้นการระบาดของเชื้อไวรัสนี้ ซึ่งสะท้อนให้เห็นถึงจำนวนผู้ติดเชื้อที่พบมากขึ้นอย่างต่อเนื่อง โดยเฉพาะในประเทศที่กำลังพัฒนารวมทั้งประเทศที่มีชาวมุสลิมเป็นส่วนใหญ่ ประชาชนมมุสลิมมีการตอบสนองต่อการติดเชื้อเอชไอวีที่เฉพาะและเป็นเอกลักษณ์บนพื้นฐานความเชื่อที่ว่าศาสนาช่วยในการปกป้องไม่ให้ประชาชนมีความเสี่ยงต่อการติดเชื้อ ดังนั้นความเข้าใจเกี่ยวกับความเชื่อทางวัฒนธรรม การป้องกันและการดูแลผู้ติดเชื้อและผู้ป่วยเอดส์มีความสำคัญต่อผู้ดูแลเพื่อพัฒนารูปแบบการดูแลผู้ติดเชื้อและผู้ป่วยเอดส์ที่สอดคล้องกับวัฒนธรรม อย่างไรก็ตาม องค์ความรู้ในการดูแลผู้ติดเชื้อและผู้ป่วยเอดส์ที่สอดคล้องกับวัฒนธรรมของกลุ่มมุสลิมที่อาศัยในแถบเอเชียยังมีน้อย การทบทวนวรรณกรรมครั้งนี้จึงมีวัตถุประสงค์เพื่อวิเคราะห์ความเชื่อทางวัฒนธรรมที่เกี่ยวข้องกับการดูแลผู้ติดเชื้อและผู้ป่วยเอดส์ในบริบทสังคมมุสลิมของประเทศแถบเอเชีย ผลการศึกษานี้จะนำไปสู่ข้อเสนอแนะและการประยุกต์ใช้ของทีมสุขภาพและนำไปสู่การวิจัยพัฒนาต่อไป

วารสารวิจัยทางการพยาบาล 2009; 13(2) 148 – 157

คำสำคัญ: วัฒนธรรมการดูแล ผู้ติดเชื้อและผู้ป่วยเอดส์มุสลิม

***Kusman Ibrahim**, PhD Candidate, RN, บัณฑิตวิทยาลัย มหาวิทยาลัยสงขลานครินทร์ หาดใหญ่ ประเทศไทย*
***ติดต่อที่ : ประณีต ส่งวัฒนา**, PhD, RN, รองศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ หาดใหญ่ ประเทศไทย*
***E-mail:** praneed.s@psu.ac.th*