“You Have to Keep Yourself Hidden”: Perspectives From Malaysian Malay-Muslim Men Who Have Sex With Men on Policy, Network, Community, and Individual Influences on HIV Risk

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\section*{ABSTRACT}
Malay-Muslim men who have sex with men (MSM) are marginalized and hidden in Malaysia, a predominantly Muslim country in southeast Asia. We explored the policy, network, community, and individual factors related to HIV infection among Malay-Muslim MSM through 26 in-depth interviews and one focus group discussion (\(n = 5\)) conducted in Kuala Lumpur and Kota Bharu between October 2013 and January 2014. As religion plays an important role in their lives, participants viewed homosexuality as a sin. Low risk perception and misconceptions about HIV/AIDS were common, and most participants expressed reluctance to consult a doctor unless they had symptoms. Additionally, buying condoms was embarrassing and anxiety-producing. Fear of discrimination by health care providers and community hindered participants from disclosing sexual behaviors and accessing health services. Homophobic comments and policies by the government and religious leaders were concerns of participants. A safe and enabling environment is needed to reduce HIV risks among Malay-Muslim MSM.

\section*{KEYWORDS}
Malay-Muslim; homosexuality; stigma; discrimination; HIV/AIDS

The HIV epidemic in Malaysia, an upper-middle income country in Southeast Asia, remains concentrated in key populations with increasing sexual transmission, especially among men who have sex with men (MSM). National surveillance data suggest that sexual transmission in MSM has increased from 30\% to 45\% between 2012 and 2014 of new cases, making MSM an important high-risk group for whom to target HIV prevention and
treatment efforts (Malaysian AIDS Council, 2017). In Malaysia’s capital, Kuala Lumpur, a 2009 biobehavioral survey of MSM found extraordinarily high-risk behaviors among a “hidden” subgroup of Malay-Muslim MSM, relative to other MSM (Kanter et al., 2011). Specifically, Malay-Muslim MSM reported more condomless anal intercourse (CAI) with casual partners and were significantly more likely to be HIV positive when compared other MSM (Kanter et al., 2011). Another 2010 study in Penang found that 83% of Malay-Muslim MSM reported CAI with either regular or casual partners (Lim et al., 2013), with one fifth of these MSM not believing that HIV can be transmitted through CAI, and 75% of participants had never been tested for HIV.

Malaysia, a middle-income country of 32 million people of multicultural heritage, comprises Malays (50.4%), Chinese (23.7%), indigenous people (11.0%), Indian (7.1%), and others (7.8%; Department of Statistics Malaysia, 2010). Although not an Islamic state, Islam is codified as the official religion of the federation (Federal Constitution, 1957). In Malaysia’s multiethnic society, religion coincides with ethnicity: 61.3% of populations are Muslim who majority are Malay, 19.8% are Buddhist (majority ethnic Chinese), 9.2% Christians (non-Malays), and 6.3% Hindu (majority ethnic Indians; Department of Statistics Malaysia, 2010). Malay refers to the majority ethnic group of Malaysians who are constitutionally defined as Muslim (Federal Constitution, 1957). The Malay ethnicity and Muslim identity are so inextricably linked that any non-Malay who converts into Islam is sometimes referred to as “masuk Melayu” (becoming Malay). Malay Malaysians are mandated by the Constitution to be Muslim, and they face severe punishments if they wish to convert to another religion.

In Malaysia’s predominantly Muslim society, homosexuality remains a social taboo and is illegal constitutionally and by Sharia law. For Muslims, anal sex between men or “liwat” is considered a sin, a transgression that is punishable under Sharia law (Ali, 2006) but rarely enforced in Malaysia. Statutorily, penal code 377 penalizes “carnal intercourse against the order of nature” and subjects any offender to whipping and imprisonment for a maximum of 20 years. Under this British colonial law, the former Deputy Prime Minister, Anwar Ibrahim, was convicted twice for committing sodomy. During his trials, Anwar was negatively portrayed as a “sodomite” on local media, reinforcing negative attitudes toward MSM (Fernandez, 2015). Furthermore, the Islamic religious authorities have increased moral and sexual policing in the Muslim communities. For example, with the goal “to prevent future homosexuality,” religious authorities send Malay-Muslim schoolboys who appear effeminate to a 4-day camp to be taught masculine behaviors (Flock, 2011). The Ministry of Education also warned parents whose children express behaviors stereotypical of gay men, such as wearing V-neck, sleeveless tops and carrying
big handbags, to reform their behaviors (Mosbergen, 2012). Homophobia expressed by institutions and high-level officials continue to support a social climate where open expression of sexual orientation is avoided. Further evidence suggests that violence against LGBT youth in Malaysia is mounting, with an effeminate 18-year-old being murdered by his classmates (Lang, 2017).

Although Islam is the official religion of the state, Malaysia was founded as a secular, democratic country with multicultural and pluralistic society. It is in the religious diversity context in which Islam as a tradition has been interpreted and practiced. However, in the past 30 years, Malaysia has witnessed the rise of Islamic orthodoxy and the policing by the religious authorities (Barrs & Govindasamy, 2010; Othman, 1998). The increasing Islamization in Malaysia can be understood in the historical context of colonization, urbanization/industrialization, inter and intra-ethnic relations, and international politics (Lee, 2011). The colonization by the British left the constitutional monarchs in the Malayan states with little power except in the areas of Malay custom and religion (Islam). Similar to the bureaucratization of many parts of life during the British colonial time (from the end of the 19th to mid-20th century), Islam began to be institutionalized but religious matters were only controlled by the states (Lee, 2011). It was only in 1916 that the first Council of Religion and Malay Custom was established in Kelantan, the northeastern state of peninsular Malaysia. During the British colonization period, a large number of Indian and Chinese migrants arrived in Malaya. While being used as a political and identity marker for the Malays against the British, Islam was subsequently used politically to differentiate the Malays from Chinese and Indian diasporas after independence (Barrs & Govindasamy, 2010).

The rapid economic development in Malaysia has provided education and employment opportunities to women, resulting in the rise of status of Malay-Muslim women. The change of gender role and power has created moral anxiety among conservatives who sought to police sexualities of Malay-Muslim women (Ong, 1987, 1990). Islamic civil and religious authorities have been established to regulate sexual and moral codes (Lee, 2011), and they have become increasing less tolerant to progressive voices (Akyol, 2017). Non-heterosexual identities and behaviors have been considered a pathology of excessive individualistic and materialistic Western culture, and a symptom of decline in morality in modern society (Mahatir & Ishihara, 1995). Sexual and gender diversity is often claimed to be a threat to Islam as it undermines the authority of authoritarian government to unify Muslim (Baharom, 2012; Williams, 2010). The convergence of politics, religion, and homophobia render Malay-Muslim MSM and other sexual minorities an easy target for legal discrimination and stigmatization (Backer, 2005; Williams, 2010). For example, both the Department of Islamic Development and former prime minister have openly denounced LGBT people as “deviants” as they are against the principles of Islam (Baharom, 2012; Zahidi, 2013).
In this context, stigma and discrimination among MSM is high, which may impede access to HIV prevention and treatment services and consequently increases vulnerability to HIV infection (Altman et al., 2012). This scenario is especially poignant in low- and middle-income countries where MSM endure restrictive and oppressive environments (Beyrer et al., 2012). Though approaches vary, some Islamic leaders view HIV infection as a result of deviation from religious guidelines, rejecting homosexual relationships and not accepting condom use outside of marriage (Ansari & Gaestel, 2010), subsequently inhibiting efforts to address HIV prevention and treatment (Abu-Moghli, Nabolsi, Khalaf, & Suliman, 2010; Balogun, 2010). Despite incorporating harm reduction strategies to support people who inject drugs, attention to MSM is lacking in Malaysia, in part due to discomfort with homosexual behavior (Kamarulzaman, 2013). The Malaysian government has developed A Manual on HIV/AIDS in Islam for the use of religious leaders, which encourages reducing stigma and discrimination against people affected by HIV, but describes condom use for unmarried couples as unacceptable (Department of Islamic Development of Malaysia, 2011). Religious perspectives contribute to the stigma experienced by MSM (Shaw et al., 2018) and shape the health policies in Malaysia (Barmania & Aljunid, 2016).

In this setting of heightened HIV prevalence and risk in Malay-Muslim MSM, to our knowledge, no formal study has explored the lived experiences of Malay-Muslim MSM through the multilevel context related to HIV vulnerability. The current study examines the multilevel HIV risk environment among Malay-Muslim MSM at policy, network, community, and individual levels, drawing from a modified socioecological model. We build on a systematic review demonstrating that on the individual level, increased religiosity is associated with lower HIV sexual risks (Shaw & El-Bassel, 2014), yet, structurally, where religion and law reinforces stigma and discrimination of vulnerable groups at risk for HIV, HIV prevalence is increased (Oldenburg et al., 2018). Previous studies from Senegal (Niang et al., 2003) and Pakistan (Rajabali, Khan, Warraich, Khanani, & Ali, 2008) reported that denial, social stigmatization, and homophobia may put Muslim MSM at elevated risk for HIV transmission. The mechanism by which religion may influence HIV risks remains poorly understood, especially among MSM (Lassiter & Parsons, 2016). Therefore, the aims of this study are to qualitatively explore the multilevel influences of HIV risk among Malay-Muslim MSM. Findings will guide future interventions to reduce HIV transmission among Malay-Muslim MSM.

Methods

From October 2013 to January 2014, 26 in-depth interviews and one focus group discussion (n = 5) were conducted in Kuala Lumpur, Malaysia’s capital, and in Kota Bharu, a city in Malaysia’s most conservative state. Initially, focus group discussions (FGD) were planned to collect data on
community norms surrounding condom use and risk behaviors (Kruger & Casey, 2000), but after the first FGD, interviews were subsequently changed to in-depth interviews, which are more suitable for collecting sensitive information from vulnerable and marginalized populations (Liamputtong, 2007).

Participants were recruited through referral from NGO volunteers and research staff. Eligible participants had to self-report being biologically male, aged 18 or older, of Malay ethnicity, and had oral or anal sex with another man in the past 12 months. The term MSM was used as an umbrella term to cover all MSM irrespective of participants’ preferred sexual identity or label. Because virtually all Malaysian Malays are Muslim, we did not use religion as part of the selection criteria. A short questionnaire was used to collect data on sociodemographics, sexual and drug use behaviors, knowledge on HIV/AIDS, religious practice, and mosque attendance. Participation in the study was voluntary and anonymous, and participants were paid RM50 (USD15) for their time and effort.

The in-depth interviews were conducted in private settings and lasted for 1 to 1.5 hours, while the FGD lasted for 2.5 hours at the research center. All interviews and FGD were conducted by a trained qualitative researcher in Malay, English, or in a mixture of both languages depending on the choice of participants. The interviews and discussions were based on a semistructured guide that allowed flexibility and exploration in specific areas (Gorden, 1992), including sexual identity, sexual practices, sexual scripts (“Can you tell us about the typical scenarios where Malay-Muslim MSM hook up with other men?”), sexual venues (“Where do you find sex partners?”), HIV testing, HIV-related knowledge and attitudes (“Do you think condomless anal sex is common among Malay gay men?”), and issues related to being MSM and Malay in Malaysia (“What is it like being Malay and homosexual in Malaysia?,” “What are the issues and concerns you have as a Malay gay man?”). Questions sought to identify HIV risks that occur across the socio- ecological risk environment, focusing on individual-level risk behaviors, network level norms about condomless sex and venues for relationships, community-level access to HIV testing and HIV-related knowledge, and at the broadest policy and epidemic levels, perspectives on being MSM and Malay in Malaysia. The research team consulted a Community Advisory Board, made up of community leaders and health providers who serve MSM, in developing the field guide. We conducted a mock focus group discussion with NGO staff to pilot test the order and content of the interview questions.

Before the beginning of in-depth interviews and the FGD, we explained the benefits and potential risks associated with the study as well as the procedures of interviewing, recording, and data storage. To protect their anonymity, we asked the participants to use only fictitious names during the in-depth interviews and FGD. Similarly, we obtained
verbal informed consent instead of written informed consent to protect their anonymity.

Eleven in-depth interviews and one FGD were conducted in Malay; 15 in-depth interviews were conducted in English. All in-depth interviews and FGD were audio-recorded and transcribed verbatim. Transcripts in Malay were translated to English before analysis. All transcripts were reviewed and categorized into themes guided by thematic analytic approach (Braun & Clarke, 2006). A code book containing 30 predefined themes related to research hypotheses based on the qualitative field guide was developed. During the coding process, the principal investigator (SHL) and secondary coder regularly discussed codes to allow further revision and refinement of codes to identify new themes and relationships within major themes. Additionally, the emergent themes were identified through discussions between SHL and SS, who reviewed and analyzed the transcripts independently and met to discuss emergent themes.

This article is situated within the modified social ecological model (m-SEM), a theoretical framework that describes and categorizes the drivers of HIV infection among vulnerable populations including MSM (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013). The m-SEM examines how HIV risks occur across levels of experience, including: (1) individual, (2) network, (3) community, (4) policy, and (5) stage of the epidemic. The individual level refers to biological and behavioral factors associated with transmission, while the network level attends to group factors that may predispose individuals to risk, as well norms among friends and family members that may lead to reductions in risk. The community level addresses access to information, prevention, and treatment, while the public policy level attends to government and organization influences on service access and information. The final level, epidemic stage, draws on population trends and infection rates (Baral et al., 2013). The m-SEM is a useful guide for characterizing and understanding the HIV context among MSM, and subsequently can be used to inform prevention strategies. The model is especially useful for addressing the multiple social and structural driver of HIV. For example, the higher-order risk factors, like the structural and policy-level factors, may be more important in influencing the ability of MSM to protect their health. Individual- and network-level factors, however, may be more amenable to immediate intervention. The m-SEM was used to organize the themes, from the innermost, individual layer, followed by broader community and network layers, and, finally, the most distal, public policy layer (see Figure 1). Illustrative quotations were selected to represent the themes in the narratives provided by the participants. The study protocol was approved by the University of Malaya Medical Ethics Committee (MEC ID: 1009.1)
HIV Epidemic Stage

Criminalization by civil law and Sharia law, political homophobia

Discrimination by religious community and health care providers, dual stigma of homosexuality and HIV

High level of unprotected anal intercourse, sauna and social media, poor sexual communication

Unprotected anal intercourse, internalized homophobia, lack of HIV/AIDS knowledge, apathy about HIV/AIDS, embarrassment to bu

<table>
<thead>
<tr>
<th>Stage of Epidemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
</tr>
<tr>
<td>Community</td>
</tr>
<tr>
<td>Network</td>
</tr>
<tr>
<td>Individual</td>
</tr>
</tbody>
</table>

*Figure 1.* Modified socio-ecological for HIV risk in MSM adapted from Baral et al. (2013).
Participants’ sociodemographics

The majority of participants were relatively young (median age 28); over one quarter of participants had never been HIV tested, and of those who had been tested ($n = 21$), two self-reported to be HIV-positive (see Table 1). About one quarter did not use a condom during their most recent episode of anal sex with a male partner. All participants reported to be Muslim with a range of adherence to, or participation in, religious practices. For example, six participants reported that they prayed five times daily, and three participants reported that they did not attend Friday prayers at the mosque. Over half wished that they were not gay, a crude proxy for internalized stigma, and many were afraid that family and friends would find out about their sexual orientation (see Table 2).

Results

Public policy-level risks

Political issues and homophobic government programs

Participants frequently noted that homosexuality is not accepted by Malaysian society, particularly by the government and religious authorities. Discriminatory policies and attitudes of the Malaysian government and society toward MSM were described as challenges they faced.

Whoever’s effeminate has to go to the [corrective] camps... if I was still a teenager at school, I would feel threatened, and all teachers will seek us to mold us. It is not good when there are political issues like these. (30 years old, university graduate)

Criminalization of homosexual activities (statutory sodomy and Sharia laws)

Participants stated that they could not be open about their sexual orientation because of fears about religious, cultural, and official legal prohibitions against homosexuality. Participants mentioned that penal code 377B and Sharia law criminalize anal sex between men. When discussing public venues where MSM meet in Kuala Lumpur and Kota Bharu (e.g., cruising park, lake, clubs, public toilets, saunas, massage centers), they asserted that these venues are targeted by police and religious authorities. One participant noted: “Because nowadays like, massage places... I mean sorry, police came to raid most of the time so the management is taking higher precaution to avoid this thing from happening” (28 years old, some college).

Community-level risks

Religion, stigma, and discrimination

Participants stated that men having sex with men is haram (forbidden) and berdosa (sinful) in Islam. A few added that being gay is not an ordinary sin;
one stated that it is an “ultimate sin” and one will “go to hell.” As one participant described, “It is like a very big sin. Second, they are afraid of the law in Malaysia. Being gay is wrong in Malaysia. To be gay as a Muslim is wrong, to be gay in the society is wrong” (25 years old, university graduate).

Participants also reported experiences of discrimination and violence as sexual minorities living in Malaysia. A participant from Kelantan, a conservative state comprising mostly Malay-Muslim populations, reported being beaten by strangers on the street because of his sexual orientation:

<table>
<thead>
<tr>
<th>Table 1. Sociodemographic characteristics of in-depth interviews and FGD participants (n = 29*).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td><strong>Living in</strong></td>
</tr>
<tr>
<td>Kuala Lumpur</td>
</tr>
<tr>
<td>Kota Bharu</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
</tr>
<tr>
<td>Single, not living with partners</td>
</tr>
<tr>
<td>Single, living with partners</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorced/separated</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
</tr>
<tr>
<td>Secondary</td>
</tr>
<tr>
<td>Some college/A level</td>
</tr>
<tr>
<td>College/University</td>
</tr>
<tr>
<td>Postgraduates</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
</tr>
<tr>
<td>Full-time</td>
</tr>
<tr>
<td>Part-time</td>
</tr>
<tr>
<td>Student</td>
</tr>
<tr>
<td>Unemployed</td>
</tr>
<tr>
<td><strong>Monthly income</strong></td>
</tr>
<tr>
<td>&lt; RM2000 (USD 610)</td>
</tr>
<tr>
<td>RM 2001–3000 (USD 611–915)</td>
</tr>
<tr>
<td>RM 3001–4000 (USD 612–1220)</td>
</tr>
<tr>
<td>RM 4001–5000 (USD 1221–1525)</td>
</tr>
<tr>
<td>&gt; RM5000 (USD 1525)</td>
</tr>
<tr>
<td><strong>Ever tested for HIV</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Self-reported HIV status (n = 21 among those who tested for HIV)</strong></td>
</tr>
<tr>
<td>Positive</td>
</tr>
<tr>
<td>Negative</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>Last sexual encounter (last time had sex with men)</strong></td>
</tr>
<tr>
<td>Yesterday</td>
</tr>
<tr>
<td>In the past week</td>
</tr>
<tr>
<td>In the past month</td>
</tr>
<tr>
<td>In the past 6 months</td>
</tr>
<tr>
<td><strong>Consistent condom use while having sex with men in the past 3 months</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Condom use for anal sex in last anal sex (n = 26)</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
They saw me by the road... they know some of us already have kids or a wife, but [we are] still looking for guys. So they feel annoyed. I don’t know what they were thinking at that time, they just beat me up. (32 years old, university graduate)

Another participant received death threats from the Malay community after discussing his homosexuality on social media:

They wrote in the blogs, they said, “How to kill a gay Malay.” They said these stories about me and in general how to kill a gay Malay. That was said as a threat, it’s like propagating or asking other people to kill a gay...There were a lot of these hate emails, hate messages... people were saying gay people should be killed. (35 years old, university graduate)

**HIV stigma and discrimination**

High levels of stigma surrounding HIV also prevent Malay-Muslim MSM from seeking information about HIV or getting tested to learn their HIV status. Some Malay-Muslim MSM avoid getting tested for HIV for fear of discrimination by the health care providers. A participant pointed out his experience undergoing HIV testing:

It was horrid. It was horrible. It was awful. They didn’t do all the pre-test and post-test counseling. After they have drawn your blood and they preach, preach, preach. And when you come back for test result they said, “you’re negative but you shouldn’t be doing this, you shouldn’t.” You know they preach [to] you. (34 years old, postgraduate)

Malay-Muslim MSM who are HIV-positive may endure additional stigma and discrimination because of their HIV status. One HIV-positive participant shared that he had difficulty in seeking employment:

<table>
<thead>
<tr>
<th>Table 2. Religious practice and personal and perceived societal attitudes toward homosexuality (n = 29*).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you go to the mosque for Friday's prayer?</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Occasionally</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Sometimes I wish I were not gay</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>I am afraid that family and friends will find out about my sexual orientation</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>In general, in Malaysia people perceive gay men or MSM as sinful</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No comment</td>
</tr>
</tbody>
</table>

*Two participants did not take the questionnaire and were therefore excluded from the table. FGD = focus group discussion.

They saw me by the road... they know some of us already have kids or a wife, but [we are] still looking for guys. So they feel annoyed. I don’t know what they were thinking at that time, they just beat me up. (32 years old, university graduate)
If you are gay [but not infected with HIV], the discrimination is lower compared to the those [who are] infected. And for the HIV-infected, like me, if you are dealing with a job that requires you to have a medical check-up so it will be difficult actually...it’s not really affecting the company or the people who are working together [with you] but sometimes they feel that whenever they have an HIV person in the office they can be infected. I think it’s more like that people are very narrow-minded, so to be safe they don’t hire people like us. (28 years old, college graduate)

Family pressure
A couple of participants said that although being gay was a sin, it was an even greater sin when one’s homosexual identity was exposed. Hiding one’s sexual identity and passing as heterosexual were common strategies to avoid stigma and discrimination. Some participants said that they were happy living a secretive sexual life while masquerading as a heterosexual man in the workplace and in the larger community. As one participant stated:

But if you just dress like a normal guy then [there] should be no problem... you maintain your secrecy, don’t let people know who you are...you just do your sexual life at night time... in the society and in the community, you just pretend that you are straight. It’s a good thing actually. (28 years old, college graduate)

Marriage and procreation were said to be an important cultural norm in the Malay community. Indeed, participants recounted stories where Malay-Muslim MSM continue clandestine homosexual relationships after marriage. Coming out to their parents and family was difficult because participants said that it would bring shame and agony to the family, relatives, and community:

Imagine if they knew, how heart-breaking it can be? and how embarrassing it could be to them? Not only to them, the other people would say “you don’t know how to take care of your children,” “you raised your children like this?” You don’t want your family to be commented this way. (25 years old, university graduate)

To some men, hiding one’s sexuality from family and the expectation to marry a woman were their immediate and primary concerns. The pressure could be so high that it became stressful for them, as illustrated by this participant:

You have to keep yourself hidden from your family, even though your family might [already] know who you are, but I feel that they assume that you will marry one day in the future. I have to be not me... [sigh] too much secrecy! Only you know and your friends of the same type know who you are. But a lot of pressure, you have to keep this a secret from your family. (30 years old, university graduate)

Community norms
The majority of the participants said condomless anal intercourse was common among Malay-Muslim MSM. One participant estimated that as high as 80% of Malay-Muslim MSM do not use condoms while having anal sex.
Common reasons for not using condoms include lack of sensation or comfort while using condoms, “heat of the moment,” and ignorance or lack of awareness about HIV transmission. Additionally, feeling invincible, “playing by luck,” or “do-not-care” were attitudes associated with not using condoms—for example, “A lot of people have degrees nowadays even, they don’t really bother and say ‘its luck or fate, if I got it then I got it.’ It’s quite typical” (35 years old, postgraduate). A participant described other Malay-Muslim MSM putting sexual pleasure over precaution and personal health: “they think nothing, nothing about themselves and nothing about future things that might happen, for now sex is the most important, so what might come in the future, put it aside first” (23 years old, university graduate).

**Network-level risks**

**Saunas and social media as risk environments**
Malay-Muslim MSM appear to inhabit small, fragmented networks. According to the participants, there are no formal social groups of Malay-Muslim MSM and no visible role models or gay rights advocates in the community. In terms of the risk environment, participants pointed out that condomless anal sex was common in the few gay saunas operating in Kuala Lumpur. They observed that condoms and lubricants are not available at the sauna, and most clients do not bring condoms to the sauna. Participants also said that the social space of MSM has moved from a physical to virtual one, such as gay portals, Facebook, and smartphone applications (WeChat, WhatsApp, Grindr, Hornet, Jack’d), which are popular for casual sex.

It would definitely be Grindr. Look at the apps they have now on [their] smartphones. I think that’s the in-thing right now, I mean that’s the easiest and the easiest [way to get] hook up ever. So, I tried Grindr, I tried a few things. (34 years old, postgraduate)

**Trust and lack of sexual communication between partners**
Another important factor related to condom use was trust within relationships. Some participants were less likely to use condoms with trusted partners or regular sex partners. These men considered themselves to be at low risk for HIV even though they did not use condoms. As one participant put it,

I trust people easily, I trust my partner, but I am not sure how he did it with his ex-boyfriend, but for me, when I am having sex with my partner, I seldom use condoms. (21 year old, university graduate)

Participants in the study also revealed that sexual communication and negotiation about condom use were rare among them and their sexual partners. They perceived that most Malay-Muslim MSM do not discuss HIV and STI
before sexual intercourse, and others make assumptions about partner’s HIV status based on their appearances. According to the participants, most Malay-Muslim MSM are not proactive in negotiating condom use. They rely on their sexual partners in making decisions on condom use.

**Individual-level risks**

With respect to sexual identity, more participants identified themselves as PLU (People Like Us) than “gay.” PLU was said to be a less stigmatizing code name for “gay.” Participants also talked about other derogatory terms that have been used to label them, such as “sotong” (squid), “donut” (doughnut), and “pondan” (sissy). Some men used subtle languages such as “play” or “having fun” when referring to their sexual behavior and described it as *nafsu*, a pejorative term meaning carnal desire or animalistic lust. Some confessed that they have resisted the carnal desire, or temptation to have sex with men, and believed that it was a test from God to resist such temptation. Several participants expressed considerable internalized homophobia and wished to change their sexual orientation; they wanted to marry women and leave the gay world when they get older.

Yes, because I am a Muslim, I know that this is a sinful act, but, I try to, because sometimes that we cannot blame the creator for being born gay, this thing is actually from ourselves... because we know that it is sinful and it is forbidden by the religion, so we try our best not be gay until we are old. What I believe is that until one day that I will have enough with all [of] this, maybe [when I am] around 40 or something like that... [I'll be] enough with this thing and it's time to turn the other way around... [and] leave the PLU [people like us] world behind. (28 years old, college graduate)

As noted by the participants, religion was central to their identity, and it was the basis of the moral code and guidance for their behaviors and health beliefs. A few participants stated that getting infected with HIV was a punishment from Allah for being homosexual and was a way to redeem themselves from committing a grave sin. One participant said,

HIV is a catharsis, meaning a purification and purgation of the soul. Because in Islam, illnesses are God’s way of redemption, I believe in that... So when God gives [you] HIV, you have to think... If you want guys, there will be no prophet for you... the prophet Muhammad will not consider anyone who practice homosexuality to be his follower... hence, He will not help those who practice homosexuality...there are verses in Quran and Hadith⁴ Sahih condemning the act of homosexuality. (23 years old, university student)

Therefore, a sense of guilt and self-blaming may be common for HIV-positive Malay-Muslim MSM. As one participant described stigma associated with HIV:
They said, “I brought this upon myself.” It’s hard because that are the values they have, the only values they know of. You’re gay, if anything happens to you, it’s your fault you know. So that’s the stigma, I won’t say [it is] stereotyping but [there are] unfortunate things they would associate with Malay [gay] men. I don’t know about other races, but Malay men I can say that. (34 years old, postgraduate)

*Lack of awareness or knowledge about HIV*

Some participants pointed out that level of HIV knowledge is low among most Malay-Muslim MSM, particularly in the rural area. Fatalism and misconceptions about HIV transmission were common. Participants said that most Malay-Muslim MSM shy away from prevention messages related to HIV and do not want to seek health care unless they have developed symptoms of HIV and sexually transmitted infections.

*Shame and stigma associated with condom acquisition*

Participants said buying condoms was anxiety-producing because they wanted to avoid embarrassment and judgment from cashiers or other customers. One participant revealed that there is a stigma associated with buying condoms, and buying condoms was embarrassing, especially because he was young and unmarried:

> We shouldn’t have sex before we get married, it is very embarrassing for a person to go to 7-Eleven just to buy condoms. So, to avoid that, they just go and have sex without condoms, rather than embarrassing themselves. Because there is a stigma that they are afraid of being asked, "Why do you buy this?" (28 years old, college graduate)

Another participant said that he would only go and buy condoms in the middle of night and from a shopkeeper who was not ethnic Malay to avoid shame:

> The reasons for not using condoms... first they are embarrassed to buy [condoms], then, they [are] just led by their [sexual] desires. Even for me I am embarrassed... frankly speaking, I am embarrassed to buy condom, lubricant... even if I want to buy, I will go, in the middle of the night and I will make sure that either the shopkeeper is Chinese or Indian. If the shopkeeper is a Malay, I will not enter to buy. (21 years old, university graduate)

*Discussion*

The current study explored the individual, network, community, and public policy-level risk factors related to HIV infection among Malay-Muslim MSM in Malaysia. Behavior is influenced by understanding of service availability, available social support, and group expectations. At the individual level, internalized homophobia, personal health beliefs, misinformation about HIV/AIDS, lack of condom use and sexual communication, and anxiety
associated with buying condoms openly were salient themes. At the network level, interactions with peers and use of saunas, novel social media, and mobile applications composed the emerging risk environment for sexual networking. These network venues not only pose increased risk for Muslim-Malay MSM but also provide an opportunity for intervention. Network norms are shaped by the availability of information and implementation of policies. At the community level, family obligations to be married and discrimination by the community and within health care settings were salient concerns. Such community norms are less amenable to intervention until structural and policy influences change. Finally, discriminatory laws and negative attitudes by the political and religious authorities were policy-level factors that marginalize Malay-Muslim MSM. In settings with increasing policy and legal impediments for MSM, the prevalence of HIV increases (Oldenburg et al., 2018). None of these risk levels are experienced in isolation by participants, and it is important to note that these risk levels intersect and influence each other.

Although the Qur’an does not explicitly address homosexual identities and desires, the dominant discourse on homosexuality in the Muslim world remains traditional—that homosexuality is a major sin (“khabā’ir”; Ali, 2006), condemnable, and punishable (Eidhamar, 2014), a view endorsed by most participants. At the individual level, Malay-Muslim MSM may be conflicted about their religious and sexual identities. Anthropologist Boellstorff (2005) found that the incommensurability of “gay” and “Muslim” identities was the dominant view among gay Muslim in Indonesia. Participants provided examples of conflicting behaviors related to religious dogma, which shows tension between homosexual desire and adherence to Islamic teaching, supporting that Muslim MSM may compartmentalize their conflicting identities as coping mechanism (Jaspal & Cinnirella, 2010).

In the current study, Malay-Muslim MSM apparently adopted a range of strategies to cope with conflicting identities. For example, some Malay-Muslim MSM were said to be able to detach their sexuality from religion, while some men could integrate their sexual practices with religion (Meladze & Brown, 2015). A few participants in the study became less religious and rejected the social and cultural expectation of being an ideal Muslim (heterosexual) man. Lastly, some participants accepted and internalized negative attitudes toward homosexuality within themselves. A recent study found that Malaysian MSM reported higher levels of shame, internalized homonegativity, and religiosity compared to their Australian counterparts (Brown, Low, Tai, & Tong, 2016). In our study, participants avoided self-categorization as “gay” but rather dismissed their sexuality as “this gay thing,” or a temporary phase of life, which they hoped would change when they grow older. Among these men, passing or acting like heterosexual men was indicated as a strategy
to avoid stigma and discrimination ("Be smart, it’s good that you can pass"). In avoiding to speaking directly on highly taboo topic, a few participants described their behaviors as “sexual urges” rather than as part of their identity.

Internalized homophobia has been shown to be associated with condomless anal intercourse among MSM in Uganda (Ross, Kajubi, Mandel, McFarland, & Raymond, 2013), and sexual stigma was associated with clinically significant depressive symptoms and sex work among Indian MSM (Thomas et al., 2012). These findings support the notion that sexual stigma and internalized stigma increase HIV risk behaviors among MSM, especially in a context where homosexuality is severely stigmatized. Furthermore, there is also mounting evidence that stigma raises barriers for MSM to access HIV information, HIV testing, and treatment. A large online study of MSM across 38 countries in Europe found that structural stigma, measured by laws and policies affecting MSM, was associated with lack of HIV/STI testing, not using condoms at last sexual intercourse, and not discussing sexual behavior during HIV testing (Pachankis et al., 2015). Findings from the current study also support previous studies that fear of identification as MSM prevent MSM from accessing sexual health services (Arreola et al., 2015; Pyun et al., 2014).

In the present study, some Malay-Muslim MSM were afraid to know their HIV status; they would go for testing or see a doctor only if they experienced symptoms. These men feared additional discrimination when they were found to be HIV-positive. HIV/AIDS-related stigma and discrimination remain strong in Malaysian society. In a large computer-assisted telephone survey in Peninsular Malaysia, 78.8% of respondents were “very concerned” to “somewhat concerned” with regard to being stigmatized or discriminated against if they were infected with HIV (Wong, 2013). The level of HIV self-stigma was twice as high among the Malay respondents than other ethnic groups. Certain religious belief such as “HIV as a punishment from God for deviant behavior” may hinder Malay-Muslim MSM from knowing their status (Wong, 2013).

At the community level, participants mentioned that it is common for Malay MSM have heterosexual marriage and children while having clandestine homosexual relationships. Many Malay-Muslim MSM bear intense family and community pressure to marry a woman and procreate, similar to the experience of MSM in China (Feng, Wu, & Detels, 2010; Koo et al., 2014), India (Mimiaga et al., 2015), and Indonesia (Boellstorff, 2005). Many Muslim men believe that it is the way to express piety in Islam (Boellstorff, 2005). Therefore, bisexuality may be common among Malay-Muslim MSM. For example, one quarter of Malay-Muslim MSM in a study in Penang reported having female sexual partners in the past year (Lim et al., 2013). To maintain family harmony and have children, these men may not use
condoms with their wives. The covert nature of the homosexual relationship outside of heterosexual marriage may indeed endanger personal health and increase HIV/STI transmission among MSM as well as their female partners (Koo et al., 2014).

At the policy level, participants seemed to be afraid of being accused of breaking the law or being sent to a camp. Participants recalled that the imprisonment of the former opposition leader was a widely known example of how the sodomy law can be used to persecute a citizen engaging in homosexual behaviors in Malaysia. Participants reported that negative messages issued by some political and religious leaders against LGBT individuals have further stigmatized the sexual minorities in Malaysia. Public shaming remains a centerpiece social control to reinforce a heteronormative culture. For example, targeting effeminate boys and sending them for masculinity training and warning parents to watch for evidence of homosexuality in their children reinforces stigma and promotes frank discrimination. A body of research has concluded conversion therapy, including using religion-based methods, to be without scientific basis and detrimental to the mental health and development of these children (Cramer, Golom, LoPresto, & Kirkley, 2008). Medical professionals have warned about the use of conversion therapy to change sexual orientation or gender identity (Just the Facts Coalition, 2008). The scientific evidence is, however, currently ignored by some religious leaders.

The hidden nature of MSM presents a challenge to researchers because many of these individuals do not want to be identified. Social networks of Malay-Muslim MSM remain small and hidden. As open discussion on sexuality is a cultural taboo, our research team found that one-on-one interviews were more acceptable to Malay-Muslim MSM. Moreover, our study was limited primarily to educated Malay-Muslim MSM who were able to be identified through NGOs, suggesting that these findings represent the most optimistic scenario. Our study relied on social networks of research assistants and that of an AIDS NGO for recruitment. Therefore, this sample of Malay-Muslim MSM may have been more likely to have overcome social stigma, have better knowledge in HIV/AIDS, and have a better self-concept as sexual minority. Nevertheless, we found that some participants experienced internalized stigma, did not use condoms during anal sex, and possessed misconceptions about HIV/AIDS. MSM in the study did not report recreational drug use such as methamphetamine use for sex. MSM who use drugs are a hard-to-reach population because of additional stigma and illegality of drug use (Lim, Akbar, Wickersham, Kamarulzaman, & Altice, 2018). As the research questions of the present study center around HIV risks, we did not examine protective factors such as socioeconomic background, social support from other MSM, and so on. Future studies need to elucidate the
modes of resiliency to avoid further stigmatization of this under-studied population.

Although the present study did not examine the use of new prevention methods such as treatment as prevention or pre-exposure prophylaxis (PrEP), negative attitudes against HIV and MSM at social and structural levels will most likely to impede uptake of these prevention methods. Indeed, efforts to introduce PrEP for high-risk MSM in Malaysia have yet to garner sufficient political support for implementation (Bourne et al., 2017; Lim et al., 2017). Interventions to reduce HIV stigma, dispel misconceptions of HIV/AIDS, and promote the benefits of early testing and treatment are urgently needed. Formal training on the importance of HIV testing, treatment as prevention, and PrEP should be targeted to religious leaders who can disseminate prevention messages to their congregations (Maulana, Krumeich, & van Den Borne, 2012). As indicated by the participants, religion plays a major role in their lives and their perception toward HIV infection. A more liberal approach in Islamic interpretation on homosexuality (Eidhamar, 2014; Hendricks, 2013) and emphasis on the Islamic principles of compassion and preservation of human life should be promoted to enact HIV prevention strategies for Malay-Muslim MSM (Barmania & Aljunid, 2016). Meaningful dialogue among the stakeholders, including policy makers, religious leaders, community members, and medical providers who serve MSM, can be useful in reducing mistrust and promoting understanding of health needs of Malay-Muslim MSM (Barmania & Aljunid, 2016).

To improve health services for Malay-Muslim MSM, medical providers must be sensitive to the psychosocial needs of Malay-Muslim MSM so that they can deliver the services without judgment and discrimination (Mayer et al., 2012). A study of Malaysian medical students suggest high levels of negative attitudes toward MSM (Jin et al., 2014) and a propensity to discriminate against them (Earnshaw et al., 2014). Medical providers who do not condone the behaviors of Malay-Muslim due to personal religious beliefs should choose to opt out in delivering the service so that they can maintain their professional duties (Barmania & Aljunid, 2016). Lastly, venue-based interventions such as provision of condoms and lubrications at saunas may be useful to increase availability and accessibility of condoms and lubricants. Such efforts in Malaysia, however, may be challenging since carrying multiple condoms may be associated with sex work, which is illegal and has been used by the police to shut down these saunas.

**Conclusions**

The present study builds on the previous quantitative study of Malay-Muslim MSM in Penang (Lim et al., 2013) and provides rich contextual data on the multilevel factors that increases the risks of HIV infection. Prevention work
for MSM is challenging in a predominantly Muslim country such as Malaysia because Islam plays an important role in shaping health policies and HIV prevention strategies (Barmania & Aljunid, 2016; Kamarulzaman, 2013). HIV programs specifically available for MSM are only minimally funded by the Ministry of Health of Malaysia. In 2011, prevention program for MSM constituted a mere 1% of the budget compared to 58% for harm-reduction programs for people who inject drugs (Suleiman, 2012). Lack of political willpower in addressing the increasing epidemic among MSM leaves the burden of HIV prevention work to be borne by NGOs, which conduct outreach and community-based HIV testing with scarce financial support and minimal scale. The few programs for MSM that are funded by the Ministry of Health have to be implemented covertly to avoid jeopardizing other stakeholders and losing funding. Our findings suggest that policy-level intervention will have the greatest impact in reducing HIV risks; decriminalization of homosexual behaviors and creating a safe and enabling environment will be needed for MSM to seek HIV prevention and treatment.

Notes

1. A Hadith is a saying or act ascribed to the Islamic prophet Muhammad.

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Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

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