

Chapter 2

Background

Malaysia's Historical Context

Malaysia, a country in South East Asia, has a rich culture with a history over the past 100 years that shows it progressing from a colonised nation to one that has developed economically and now is democratically ruled. Malaysia, like a number of countries, was under British colonial rule and many critics have described the impact of colonialism on Muslim societies, both during the time of the empire and in the decades succeeding it. In discussing the effects of colonialism on the Muslim world, Fuller (2012) argues that imperial rule both distorted cultured traditions whilst at the same time the role of the imam was denigrated. Decolonization, although accompanied by a relinquishing of imperial power, hegemony and foreign rule on countries, still meant that external input occurred via organisations such as the World Bank and the International Monetary Fund (Fuller 2012). It is worth noting that the historical context of organisations such as the World Bank and the United Nations has led many communities, even to this day, to be sceptical of the motives of outside organisations even in the form of aid, development and global health initiatives.

Commentators such as Roy (2004), Said (1979), Freire (1996) and Fanon (2008) have discussed at length the intricacies of empire, colonisation and the 'other' on societies, people and places with discourses relating to the perception of East versus West and the apparent 'clash of civilisations' that renders values of the East flagrantly at odds with those of the West. Whilst Verma (2002), in reference to the Association of South East Asian countries (ASEAN), discusses the move towards intrinsic 'Asian values', drawing 'cultural boundaries between the West and Asian countries'.

Understanding colonialism as a historical context is commented on by a number of Malaysian academics who note how this period is crucial to understanding certain issues today, including those relating to sexuality, and that the legacies both of

being a former British colony and of being a Muslim majority state are highly significant (Shah 2012). In addition, academics, such as Lee, argue that Malaysia's evolution towards technology, globalisation and capitalism has an important role (Lee 2011). The predominant religion in the country is Islam, of the Ibn Shafi school of thought, which has a ubiquitous influence on Malay society and everyday life. In addition, as Malaysian academic Shah describes, Islam is also a 'powerful shaper of policies and public opinion in Malaysia' (Shah 2012), which often relate to sexuality and HIV. Nevertheless, before delving into these areas further, we provide a succinct update on the HIV epidemic globally, within the Muslim world and in the Asia Pacific region.

The Global HIV Epidemic, the Muslim World and Asia Pacific

It is estimated that in 2016, there were 36.7 million people living with HIV globally and 1.8 million people newly infected with HIV (UNAIDS 2017). The HIV epidemic is characterised by rapid geographical changes in its disease dynamics as well as breaking new grounds in science, both in treatment and prevention. Notwithstanding this, HIV has also been a disease that has been surrounded by fear, controversy, stigma and discrimination; this has particularly been the case when associations between morality and religion have occurred. HIV has affected many communities associated with a religious affinity, including those who affiliate themselves with Islam and the Muslim world.

However, the epidemiological evidence does suggest that HIV prevalence is lower amongst Muslims (Gray 2003). Limits on sexual activity may have an influence on transmission of sexually transmitted diseases; the following of certain Islamic rulings, if adhered to, such as male circumcision, can reduce transmission of HIV. In the analysis conducted by Gray of existing research with Muslim populations in Sub-Saharan Africa, which including 38 studies, six of seven studies observed a negative relationship between HIV prevalence and Islam. A study in Kenya showed that male circumcision, often a requirement of certain religious groups, 'significantly reduces the risk of HIV acquisition in young men in Africa' (Bailey et al. 2007). The protective effect was estimated to be in the region of 60% and male circumcision has been rolled out in many parts of Africa. In addition, a study by Kagimu et al. (2012) undertaken in Uganda showed that *sujda* (a mark on the forehead caused by repeatedly prostrating in prayer) and fasting were associated with lower HIV infections.

The Middle East is often considered the epicentre of the Muslim World and frequently anecdotally classed as a place where 'HIV does not exist'. Obermeyer discusses the low prevalence of HIV in the Middle East and also recognises that there is 'no room for complacency' with some of the earlier views revealing a denial of the existence of HIV in the region and the perception that HIV was imported from other countries which were sexually immoral and that Islam itself was protection enough (Obermeyer 2006). Furthermore, Obermeyer examined how some of the practices

that were routine amongst Muslims resulted in decreased HIV transmission; these practices included low alcohol intake, which reduces disinhibition and risky behaviour, as well as male circumcision, whilst other practices, such as moralizing, gender inequality and vulnerability of women, had rather more negative results.

Nevertheless, there is a growing realization that the Middle East and North Africa 'are not immune to HIV' and consequently there has been an engagement with religious leaders, imams, priests and civil society as well as those affected with HIV to train imams and priests to sensitize the congregation about HIV, including Friday sermons (El Feki 2006). However, there is a big gulf between those people who have acquired HIV through 'respectable' avenues such as blood transfusions than those who have acquired HIV through means that are deemed less palatable.

In 2010, Abu-Raddad and colleagues undertook a systematic review of studies relating to HIV, Sexually Transmitted Infections (STIs) and risk behaviours in the Middle East and North Africa and found that there was evidence of HIV prevalence in certain high risk groups such as IVDUs (Intravenous drug users), Men who have Sex with Men (MSM) and female sex workers (Abu-Raddad et al. 2010). The study also showed that MSM were the most hidden and stigmatized of all HIV groups in the Middle East and North Africa, with low levels of condom use; they served as a bridging population (a population that carries HIV in high incidence groups to the rest of society) and included fishermen, truck drivers and the clients of sex workers. More recently, Mumtaz and colleagues conducted a review of HIV in the Middle East and North African region which showed that there are new data to suggest that there are growing HIV epidemics in key populations such as MSM, IVDUs and female sex workers with a low prevalence elsewhere (Mumtaz et al. 2014). It has been estimated that within the region concentrated HIV epidemics are emerging amongst MSM, with up to 28% of those living with HIV being from the MSM community (Mumtaz et al. 2011). Yet, in many parts of the Middle East and North Africa there is legislation against Men who have Sex with Men making it difficult for health care workers to tackle HIV; whilst some countries such as Lebanon, Tunisia and Morocco have been more open to dealing with these issues, other countries can be more hostile (Burki 2011). Although the World Health Organisation has guidelines against discrimination against Men who have Sex with Men, these are not always implemented in many countries (WHO 2011).

Rajabali and colleagues discuss HIV and Men who have Sex with Men in Pakistan, another Muslim country where culture and society impact on everyday life, including that of sexual life, where sex outside marriage and homosexuality are taboo; thus, many believe that HIV 'cannot be a problem in the Muslim world' (Rajabali et al. 2008). The authors highlight the fact that although these practices are considered against Islam the condemnation serves to drive behaviour underground and places policy makers in a predicament of how best to respond (Rajabali et al. 2008). Furthermore, there were myths that anal sex does not constitute 'having sex' and that carrying a condom was difficult, with only 32% of MSM reporting using a condom at last sexual interaction (Rajabali et al. 2008).

Notwithstanding this, the Muslim World is not homogenous; society and cultural attitudes vary depending on the region, whether it is the Middle East and North

Africa or countries within the Indian subcontinent such as Pakistan. However, the factor of Islam, or at least the perception of Islam and how it should be practised, contributes to issues such as denial, moralization and some structural issues which influence HIV prevention to a greater or lesser degree. Furthermore, many of the issues highlighted are similar to those experienced in Malaysia and other countries in South East Asia, which will be discussed later in the course of this chapter.

UNAIDS estimates that in Asia and the Pacific in 2016 there were 5.1 million people living with HIV and 270,000 new HIV infections (UNAIDS 2017). In addition, UNAIDS describes the response to HIV/AIDS in Asia Pacific as 'mixed', with areas of definitive progress in terms of a reduction of new HIV infections, while there are also growing epidemics among key populations such as MSM, so that there is a need to target HIV prevention activities on the key populations at highest risk (UNAIDS 2013). Dokubo et al. (2013) conducted a systematic review which highlighted the high HIV incidence among commercial sex workers, intravenous drug users and Men who have Sex with Men. In addition, factors associated with HIV infection among MSM included having multiple sexual partners, receptive anal sex and syphilis infection either currently or historically, whereas in the general population the factors were engaging in sexual activities with commercial sex workers, not using condoms during sex consistently and multiple sexual partners as well as recent genital ulceration.

HIV in Malaysia and High Risk Groups

The first case of HIV in Malaysia was documented in 1987 (Goh et al. 1987) and by December 1990 there were 750 cases of HIV infection, predominantly amongst drug users. Brettle (1992) first described some of the problems associated with HIV infection in Malaysia in the early '90s, including a 'reluctance to discuss sexual and drug related matters which is partly based on the teachings of Islam' and warned that Malaysia had to find a solution which would be acceptable to an Islamic society; those issues are just as relevant now as they were then (Barmania and Aljunid 2016).

The HIV/AIDS epidemic in Malaysia is focused mainly on at risk populations comprising Intra Venous Drug Users (IVDUs), sex workers and the transgender population (UNGASS 2012). In the early days of the epidemic in Malaysia, IVDU was the main driver of the epidemic; however, now there is a shift towards sexual transmission and in 2011 sexual transmission became the main driver of HIV infection with ratio of six sexual transmissions for every four as a result of IVDU transmissions (UNGASS 2012), most likely the result of harm reduction programmes for IVDU and needle exchange. Although, IVDUs are still considered a high risk group in Malaysia, other high risk groups include transgender (TG) individuals, Men who have Sex with Men (MSM) and Sex Workers; increasingly, Malaysian women are considered vulnerable to HIV with the feminization of the epidemic (Talib 2006).

Malaysia is marked by confined epidemics amongst key populations, such as IVDUs, MSM, sex workers, transgender individuals and vulnerable women. With

regards to intravenous drug users, Malaysia is considered a country that has a ‘mega epidemic’ of HIV (Beyrer et al. 2010). However, in high risk groups there may often be an overlap between one subpopulation and another or one group may have multiple high risks.

Men Who Have Sex with Men

A major series on HIV amongst MSM highlighted the need to focus on this key group (Beyrer et al. 2012). In addition, Beyrer and colleagues undertook another review which showed that there are epidemics of HIV in MSM communities amongst most low, middle and upper income countries, with current prevention strategies ill-equipped to deal with such a spread, complicated by factors such as high numbers of sexual partners and intoxicant use during sex (Beyrer et al. 2013). In addition, there are a number of biological factors that predispose MSM to being vulnerable: the high transmission efficiency of receptive anal intercourse, the fact that men unlike women can be both receptive of anal sex (high risk for acquiring HIV) and insertive for anal sex (high risk for transmission of HIV), plus the large MSM networks (Beyrer et al. 2013). There are also social and structural factors such as denial and stigma towards MSM and limited funding for such groups that make access to such HIV prevention services and their existence in the first place more difficult (Beyrer et al. 2013).

In Asia the prevalence of HIV amongst Men who have Sex with Men is rising (Lim and Chan 2011) with associations of additional risky practices such as illicit drug use (Wei et al. 2012). Furthermore, amongst MSM in Asian countries such as Malaysia, those who are MSM are often ‘hidden’ and less likely to disclose their sexual behaviour, more likely to favour opting for HIV testing in community-based centres rather than health care based settings, in part due to culture and stigma (Koh and Kamarulzaman 2011). Furthermore, in Malaysia, despite the incidence of HIV transmission as a result of male-to-male sex being 19%, only 0.2% of the total HIV prevention budget was devoted to this specific high risk group (UNAIDS 2013).

More recently, there have been a couple of bio behavioural surveillance studies looking at MSM in Malaysia. Kanter and colleagues undertook a study looking at the risk behaviours and HIV prevalence among 517 Men who have Sex with Men in Kuala Lumpur recruited through venues which MSM are likely to frequent, such as clubs, massage parlours, saunas and a park; 47% of these individuals were Muslim (Kanter et al. 2011). 3.9% of those tested positive for HIV and some of the common risk behaviours included unprotected anal sex with a steady male partner, unprotected receptive anal sex with more than one partner and anal sex under the influence of alcohol or recreational drugs, referred to colloquially as ‘chem sex’ (Bourne et al. 2014). The study concluded that there was a ‘clear and urgent need’ to provide HIV education within the MSM community and that while groups such as the Pink Triangle Foundation have the relevant connections with the community they serve, they are limited with respect to financial and technical resources. In addition, Malays

were more likely than their Chinese counterparts to be HIV positive and engage in unprotected anal sex with a casual male partner.

Another multi-ethnic study looked at the prevalence of unprotected sex among MSM in Penang; out of a convenience sample of 350, 284 were Malay, with the most common means of finding sexual partners being through the internet (Lim et al. 2013). Forty percent of participants had not been exposed to any form of prevention activities or information and 70% had never been tested for HIV, while most participants (over 80%) had unprotected anal intercourse. It was concluded that active surveillance amongst MSM is required; there was also speculation of the possibility of an 'explosive HIV epidemic among MSM' which called for greater provision of HIV prevention within this group.

Koh and Yong looked at the perception of HIV risk amongst MSM at a community-based voluntary counselling and testing centre in Kuala Lumpur, operated by the Pink Triangle Foundation, a longstanding NGO which works with at risk communities including MSM (Koh and Yong 2014). Out of 423 clients who received voluntary counselling and testing, 8.5% (36 clients) described themselves as high risk, while 24 when tested were found to be HIV positive (9.4%), with a positive correlation seen between risk perception and HIV infection amongst clients. Clients who rated themselves as high risk for being infected with HIV were not only significantly associated with engaging in higher risk behaviour but were 17 times more likely to be infected with HIV than those who rated themselves as low risk. This is an important finding because it shows that MSM were able to perceive their risk accurately and given limited resources it is plausible that prevention strategies could be targeted for those who see themselves as being high risk, with the aim of altering sexual practices.

Furthermore, within the high risk group classed as MSM there are added high risk behaviours such as having unprotected receptive anal intercourse with internal ejaculation (Lim et al. 2012). Lim and colleagues undertook an internet study looking at 10,413 men across Asia; of the 7311 who had receptive anal intercourse, 47.5% had internal ejaculation and this was associated with less than high school education and use of the internet to seek sex partners. Malaysia was included in this study and it was found that Malaysia had high rates of unprotected receptive anal intercourse with internal ejaculation (51.9%) compared to the overall prevalence of 47.5%. The authors also conclude that in more traditional groups, culture and religion can make MSM less likely to be involved in prevention programmes for fear of being found out as being gay, and so constitutes a lost opportunity.

In fact, the Asia Pacific Coalition on Male (APCOM) sexual health concluded that Islam influences both how homosexuality is viewed by the general public, sexual risk taking behaviours by MSM and also contributes to a fatalistic idea that HIV is their 'fate' MSM (APCOM 2012b discussion paper). Furthermore, Malay Muslim MSM, due to social and cultural pressures, may engage in intercourse with female partners for fear of looking out of place amongst their community (APCOM 2012a country brief). In addition, the coalition discusses Islam and sexual diversity and access to health services in their discussion paper and claims that Orthodox Islam has an overwhelmingly powerful influence on Muslims. They argue that the story of

Sodom and Gomorrah (story of Lot) is the cornerstone of the condemnation of homosexuality by the Abrahamic faiths; however, another reading is that the people of Lot were destroyed because of exploitation, xenophobia and sexual coercion of men (APCOM 2012b discussion paper). In any case, it is the conflicting identities of having sex with men and being a Muslim that can make MSM more vulnerable to HIV; by being forced into heterosexual marriage because of social pressure, they can seek extra-marital affairs as an outlet in the form of having sex with strangers, multiple partners or paid sex, thus being more vulnerable to HIV infection. Furthermore, associated guilt and self-stigmatisation can affect mental health, leading to depression, anxiety and suicide (APCOM 2012a; 2012b).

However, some authors argue that without a progressive opinion, the only two options for a same sex Muslim would be to convert to heterosexual behaviour or reject Islamic society. Some have concluded that same 'sex sexuality is put on the same level as adultery and/or fornication; it is not worse than either of these two activities' and is a 'sin like any other' (Jamal 2008). There are more progressive interpretations of the Story of Lot from both the Hebrew bible and the Qur'an. Nevertheless, such progressive interpretations are generally seen as an abomination to the majority of Muslims. All this highlights two main points: firstly, that there are differing perceptions of Islamic practice, along the progressive-conservative spectrum; and secondly that such condemnation may make MSM question their faith to such an extent that they chose to leave Islam altogether, a sin that is considered graver than any other.

Female Sex Workers

Another key group considered to be particularly vulnerable to HIV in Malaysia are sex workers (UNGASS 2014). A comprehensive systematic review and meta-analysis of the global burden of HIV among female sex workers in low and middle income countries was undertaken by Baral and colleagues which included Malaysia in its analysis (Baral et al. 2012). The study highlighted that although HIV infection in female sex workers varies across the region, there is a substantial increase in the odds ratio of HIV amongst sex workers compared to the general female population (Baral et al. 2012). Malaysia was found, based on the IBISS 2009 report, to have an odds ratio compared with HIV prevalence among the general female population of 81; HIV prevalence amongst sex workers in Malaysia was found to be 10.7% in a sample of 552 (IBISS 2009). The Baral et al. study concluded that there was an 'urgent need to scale up access to quality HIV prevention programming' as well as taking into consideration some of the structural and societal environments, stigma, discrimination and legalities that sex workers are faced with (Baral et al. 2013; Baral et al. 2014). There is a growing consensus that sex work is work, and that a greater emphasis should be placed on providing access to health care rather than moralising those in the industry (Empower 2012).

Transgender Women

Another of the key groups considered to be high risk of acquiring HIV in Malaysia are transgender women, those assigned male at birth but who identify with being women. Baral and colleagues recently undertook a meta-analysis and systematic review to assess the relative HIV burden in transgender women worldwide including in countries within the Asia Pacific region (Baral et al. 2012). The authors found the pooled HIV prevalence to be 19.1% in 11,066 women worldwide; in 7197 transgender women sampled in ten low and middle income countries the HIV prevalence was 17.7% and the odds ratio for being infected with HIV in transgender women compared with all adults of reproductive age across the 15 countries was 48.8. The authors also noted that transgender women were often not included in national HIV surveillance, yet prove a ‘very high burden population for HIV’, requiring ‘urgent need of prevention’; transgender women often engage in high risk receptive anal sex with men, making them more vulnerable to acquiring HIV as well as being susceptible to stigma and discrimination in health care settings which acts to hinder access to prevention and treatment. In Malaysia, the local term for male to female transgender women is ‘*mak nyah*’ and it is estimated that there are 10,000–20,000 in the country, with the majority being Malay Muslims (Teh 2008). In 2002, Teh studied 507 *mak nyah* and found that over 92% received payment for sex, although only 54% claimed they were sex workers; the study was the first large scale piece of research to assess HIV/AIDS knowledge amongst this group (Teh 2002). Teh also undertook research in 2007 with 15 *mak nyah* in Malaysia and found that all respondents had heard of HIV/AIDS but lacked in-depth information and that this was not of paramount concern to them when compared to primary problems of employment and discrimination (Teh 2008). In addition, although condoms were carried they were seldom used due to issues such as clients’ refusal, getting paid more for not using condoms, oral sex or perceptions of clients’ health (Teh 2008). Overall, there has been a dearth of research regarding HIV amongst transgender women in Malaysia, although there has been some research regarding human rights.

Some have argued that historically transgender women were more accepted in Malaysian society than today (Lee 2011). Research conducted among members of the Lesbian, Gay, Bisexual and Transgender (LGBT) community in Malaysia including 13 transgender women found that they were subject to discrimination by Islamic religious officials with some transgender women feeling reluctant to access medical services due to being verbally abused, stared at or ill-treated by health professionals (KRYSS 2012). Human Rights Watch (2014) published a report that recounted alleged human rights abuses against transgender people in Malaysia; it catalogued some of the issues relating to health care: inappropriate touching or refusing to touch transgender women as patients as well as the fact that many transgender women felt discriminated at school and had lower levels of education. More specifically, Human Rights Watch recommendations to the Ministry of Health included training for health personnel on non-discrimination towards transgender people, establishing a national task force on HIV through sexual transmission and

conducting off-site HIV testing for transgender people in ‘safe spaces’. It is estimated that the prevalence of HIV among transgender women in Malaysia is 5.7% and it has been suggested that this could be underreported or underestimated (UNGASS 2014). Although most religious leaders would conclude that there is no such thing as a third gender other than that of *khunsa* (indeterminate sex), Islamic scholar Professor Hashim Kamali does discuss the need to look at issues surrounding transgenderism and justice in Malaysia through the prism of compassion, fairness and science (Kamali 2011).

Vulnerable Women and Other Groups

In Asia promoting the rights of women and girls, including female sex workers, women who use drugs and transgender women and girls in general, is important for preventing HIV (UN Women 2013). Low and Wong (2014) state that the primary risk factor faced by women in acquiring HIV is their ‘inability to control when and whether to be sexually active’, with gender disparities at its foundation as well as forced and unsafe sex. A Malaysia country brief, specifically focussing on HIV and key affected women and girls, highlighted some of the social and economic factors that render Malaysian woman and girls more vulnerable to HIV, due to gender dynamics, the more submissive role of woman in society and a lack of awareness of HIV and AIDS (UN Women Malaysia 2013). In addition, due to economic factors and limited education, some women may enter into sex work for economic reasons; with little sex education, women may be less able to negotiate safer sex in such situations, including condom use and saying no altogether (UN Women Malaysia 2013).

Knowledge and Perceptions of HIV in Malaysia and of Sex Education

There have been a number of studies undertaken in Malaysia looking at the knowledge of people with regards to HIV and at perceptions towards those living with HIV. Jahanfar et al. (2010) looked at the sexual behaviour, knowledge and attitudes of non-medical university students towards HIV/AIDS in Malaysia, undertaking a cross-sectional study amongst 530 university students randomly sampled using a self-administered questionnaire. Although knowledge was considered high amongst this group, information from parents and medical profession was found to be low and the main source was from the internet. Rahnama et al. (2011) undertook a cross-sectional study of 1773 respondents at a public university to assess attitudes surrounding HIV; only 19.5% said they would inform partners or family if diagnosed with HIV. Furthermore, the study found that 93% approved of screening for HIV as

a prerequisite for marriage, feeling that it should be compulsory; 91.6% believed that premarital HIV testing can protect men and women from HIV.

Zulkifli and colleagues examined knowledge, attitudes and beliefs related to HIV among adolescents in Malaysia and found that although knowledge was high, there were misconceptions about HIV transmission (Zulkifli and Wong 2002). The authors concluded that knowing about HIV/AIDS is not protective in itself and call for a critical review of HIV prevention programmes which openly address risk taking behaviours without moral judgement. In addition, Wong, in a cross-sectional study of 2271 people in Malaysia, found that ethnicity was a factor in HIV transmission knowledge, with Malays scoring lower than other ethnicities (Wong 2013).

Various studies have looked at sex education in Malaysia. An analysis of sex education in schools across Malaysia was conducted in 2011; this sampled 380 university students and compared participants' own experience of sex education compared with the standard UNESCO technical guidelines on sexuality education which had been undertaken by the students (Talib et al. 2012; UNESCO 2009). The authors categorically stated that 'it can be said in its entirety that sex education is not taught in classes across the nation', based on their finding that 85% of respondents felt that current teaching was 'unclear' and 'limited', even though sexuality education was provided in schools often in Science, Biology or Islamic studies classes. Ninety percent of those respondents felt that sexuality education should be implemented in Malaysian schools, taught separately (as a subject) at form 3 and relating it to an Islamic perspective (Talib et al. 2012). Sex education was examined by Low and colleagues who undertook a qualitative study of 31 Malaysian adolescent boys between the ages of 13 and 17 years in Klang valley; they concluded that in Malaysia programmes referring to sexual health were 'scanty' (Low et al. 2007). Boys were found still to hold onto traditional views that sex should only be between husband and wife, sexual activity should be deferred till marriage and 'premarital sex only happened in the West'. Conforming to social norm, parents were categorically not a source of information; rather, peers, the internet and newspapers were cited instead.

Harm Reduction in Malaysia

Malaysia started to follow in the footsteps of other countries by proposing harm reduction in response to increasing cases of HIV with a Needle Syringe Programme (NSP) and Methadone Maintenance Therapy (MMT) (Rao 2010). These were seen to be against the teachings of Islam and some feared they would encourage drug use, but subsequently Malaysia has been looked upon favourably in terms of its political leadership, commitment and partnership, with Rao commending Malaysia for its supportive role in implementing needle exchange from 2005. In fact, other countries such as Bangladesh and Maldives have undertaken study visits to Malaysia with the aim of learning and replicating good practice in their own countries. They chart that coverage has even included mosques, noting that as a Muslim majority

population ‘the involvement of the religious organizations and leaders has played a pivotal role in gaining support for the harm reduction program in the country’ (World Bank 2011). Furthermore, in 2013 the World Bank group undertook an extensive cost effectiveness analysis study of the harm reduction programme in Malaysia and concluded that the “MMT and NSP as implemented in Malaysia are cost effective and are expected to produce net cost savings to the government in the future” and continued as a strategy to limit the transmission of HIV among those people who inject drugs (World Bank 2014). However, as Reid and colleagues explain, the introduction of harm reduction and needle exchange programmes was not without its challenges, with the government initially rejecting the proposal, deeming it would encourage drug use; however, due to NGO pressure there was a shift in the government, although still difficulty promoting such a stance amongst Islamic religious leaders (Reid et al. 2007).

Kamarulzaman and colleagues discuss the issues of Islam and harm reduction, highlighting the tensions given that drug abuse is forbidden yet drug use is prevalent in many Muslim countries, as is HIV. They utilised Islamic principles such as the importance of preservation of man and limiting harm (*darar*), and in some situations ‘a lesser harm may be tolerated to eliminate a greater harm’ as well as the principle of ‘*maslaha*’, that public interest should be prioritized over personal interests, to justify harm reduction (Kamarulzaman and Saifuddeen 2009). Important as many objections to HIV prevention approaches are, due to objections on Islamic grounds or anticipated objections, Islam has always been practical and forward thinking and there exists a complex set of principles which are available for promoting harm reduction in Muslim countries (Kamarulzaman and Saifuddeen 2009). Todd and colleagues argue for ‘harm reduction adapted to the context of the local culture’ and argue that although Islam is against premarital sex and intoxicant use, it is also not ‘monolithic’; they argue for greater dialogue between harm reduction providers and religious leaders with an emphasis on Islamic beliefs in mercy (Todd et al. 2007).

Memooona Hasnain (2005) highlights some of the cultural issues such as the foreboding role of religious leaders and the gap between Islamic theory and practice. Hassnain also highlights that countries with a high HIV prevalence, such as Uganda, have concluded that the need to preserve life overrides the sin, if any, of using condoms. Narayan and colleagues explain how the current drug policy in Malaysia came about, slowly and with great difficulty; the NGOs were fundamental in producing change and is important to learn from history with a view to reducing the sexual transmission of HIV (Narayan et al. 2011). The authors critically examine the forces and factors that ultimately caused a transition from the punitive approach that had previously existed; ultimately, there was something of a competition between three stakeholders: the state, a vocal Muslim lobby and the NGOs. This took place within a growing acknowledgment that the attempts at the time to curb HIV were simply not effective enough. Notwithstanding this, although great strides have been made in harm reduction amongst IVDUs, utilising Islamic principles of preservation of life, the same cannot be said of prevention of HIV attributed to sexual transmission (Science 2014); this remains significantly underfunded in comparison (Kamarulzaman 2013).

Islamic Engagement

In general, there has been a lack of engagement by Muslims and Muslim organisations with HIV, one argument for why this is provided by Eekelen and Mould (2011):

Few development organisations with a Muslim identity work in the field of HIV. This is largely because HIV is associated with drugs and sex outside marriage, and therefore has the potential of alienating the organisations' sponsors and employees.

A further barrier to effective engagement is that Muslim affiliated organisations and professionals can find it hard to integrate and access the highly secular 'HIV world', such as the International Aids Conference; yet, by not participating they essentially ostracise themselves as 'meaningful stakeholders'. However, Islamic jurisprudence has been utilized in HIV prevention, for example, *ikhthiar akhaffa-dararain* or choosing 'the lesser of two evils', as well as principles of mercy and forgiveness to counteract stigma and discrimination:

Allah's Messenger (may peace be upon him) said: A prostitute saw a dog moving around a well on a hot day and hanging out its tongue because of thirst. She drew water for it in her shoe and she was pardoned (for this act of hers) (Hadith from Muslim. Book 26, Chapter 38, 5578)

Whoever kills a human being ... it shall be as though he had killed all mankind; and that whoever saves a human life, it shall be as though he had saved the life of all mankind. (Al Quran, Surah al Maidah, Chapter 5, Verse 32)

Religious professionals have the potential to use *khutbahs*, religious classes, pre-marital courses and religious radio programmes to disseminate information as they are respected and trusted in the community to deliver accurate information. Often, religious leaders are reluctant to speak about social issues such as HIV as they fear that 'speaking about the illicit reality of sex is tantamount to doing it' (Long 2009). Religious leaders have been key players in the fight against HIV in predominantly Muslim regions, such as the Middle East (McGirk 2008) and were identified as one of the key stakeholders and potential advocates in the fight against HIV/AIDS (Kanda et al. 2013; UNDP 2006).

There have been other ways in which an Islamic approach to tackling HIV has been proposed, such as incorporating the evidence of the *Qu'ran* and *Hadith* (Ibrahim 2014), even justifying condom usage under the ruling that 'necessity permits the forbidden', but ultimately an effective prevention strategy is believed to be following Islam itself, demonstrating a direct linkage between power, religion and policy. Many believe that Islamic religious leaders should be involved in HIV prevention. In 2011, the Malaysian AIDS Council produced a short report titled *Responsible religious response to HIV and AIDS in Malaysia* calling for a 'greater involvement by religious authorities' (MAC 2011). MAC partnered with religious departments at both national and state levels, including JAKIM (the religious policy making department). Subsequently, they produced the HIV and Islam programme in 2009, the objectives of which were to increase political leadership amongst Muslim leader efforts to educate religious leaders, to tackle stigma and discrimination and to

harmonise efforts with other stakeholders. The HIV and Islam manual (JAKIM 2011) provided training for religious leaders on issues such as spreading AIDS awareness and preventing HIV from an Islamic perspective, and produced practical guidelines on funeral rituals and a reiteration of the message against stigma and discrimination (MAC 2011). In addition, it helped with training religious leaders and conducting workshops nationwide and ensuring a greater profile for HIV on World Aids Day in mosques and in Friday *khutbahs*. It is also worth noting that the role of Islamic leaders in Malaysia differs compared to some other Muslim countries as these leaders are governed and salaried by a central authority, introducing a new power dynamic.

Access to HIV Services and the Importance of Environment

Dangerfield et al. (2015) undertook a study looking at the awareness and utilization of the HIV services of an AIDS community-based organisation, the PT Foundation, in Kuala Lumpur from 614 MSM who were reached through their own outreach services. Amongst them nearly half had never heard of the PT Foundation, of those who had heard of the organization 12.9% had visited it and 63.2% of MSM on outreach believed they didn't know about HIV transmission. The authors acknowledge that having an organisation such as the PT Foundation which is managed by the MSM community makes it more sensitive to their needs (Dangerfield et al. 2015). Providing HIV prevention to populations that are most at risk, such as IVDUs, MSM and sex workers, combined with stigma and criminalization can make access to services for these groups difficult (Beyrer et al. 2011). Furthermore, potential service users become reluctant to utilise existing services, rendering those at highest risk less able to access care (Beyrer et al. 2011). Certain atmospheres can facilitate or hinder access to HIV prevention services, as well as wider issues such as the social environment and the law. There has been interest by authors and social scientists such as Auerbach regarding the structural and social interventions available to prevent HIV, such as laws and institutions to create enabling environments where individuals can protect themselves from HIV (Auerbach 2009). However, there is an awareness that changing social norms, laws and policies takes time and often the social interventions that may be best placed to decrease the incidence of HIV are quite likely those that relate to marginalised groups such as sex workers where public support may be low. Thus, Auerbach cites the central dilemma that 'weighing public health imperatives against societal mores and norms involves uncomfortable political calculation that most elected officials would prefer to avoid'. There have also been calls for a rights-based approach to HIV programming and this looks at the legal and policy environment as well as the right to health, whether this is available and accessible and whether those who are vulnerable are reached (Gruskin and Tarantola 2008).

In Malaysia, a consultation was conducted in 2013 indicating that some of the current laws may not provide the ideal enabling environment for HIV services (UN

Malaysia 2014). Some of these laws pertained to Men who have Sex with Men (*'liwat'*) and sex work (referred to in Malaysian law as prostitution), which are both offences against the national penal code and federal *Shariah* (in Malaysia termed *Syariah*) criminal system. In addition, under the *Syariah* criminal system any 'male posing as a woman for immoral purposes' is guilty of an offence (*Syariah* 1997); this is the Act mostly related to transgender women.

Condom Promotion and Premarital HIV Testing

In Malaysia it is commonly acknowledged that condom promotion is not significantly utilised as a means of HIV prevention (NCPI 2014); condom promotion is fragmented, sporadic, certainly not consistent. This approach by Malaysia with respect to condom usage differs substantially compared to the policy as stipulated by WHO, UNFPA and UNAIDS which cites condom use as a 'critical element' in HIV prevention and treatment and consider the latex condom to be the single most efficient method to reduce sexual transmission of HIV and advises it to be readily accessible (UNAIDS 2009). In fact, following a technical review the WHO concluded that there was a significant demand for additional lubricant, especially for MSM during anal intercourse to prevent condom breakage, whilst acknowledging that in the absence of such lubricants, products such as baby oil, lotions and petroleum jelly should not be used with condoms (WHO 2012).

One of the policies in place to prevent the spread of HIV in Malaysia is the premarital testing of prospective Muslim married couples. Johor was the first state in Malaysia to initiate screening in 2001. The rationale for the testing is as a means to limit the spread of HIV from spouse to spouse or to children. Tan and colleagues discuss the cost effectiveness of HIV screening in the general population in the form of premarital HIV testing and acknowledge there has not been any cost effective analysis on premarital HIV testing amongst Muslim couples (Tan and Koh 2008). However, the authors argue that the test is only useful at one point in time and does not guarantee that individuals may not be exposed in the future. Also, there are issues as to whether confidentiality can be kept when religious officers are involved and a marriage is not just the union of two individuals, but of two families.

Islamic scholar Professor Hashim Kamali in the early days of the implementation of the pre-marital HIV screening programme discussed the issues relating to mandatory HIV testing and the passing of the Johor Islamic Religious Council fatwa that made HIV testing compulsory for all Muslim couples planning to wed in Johor (Kamali 2001). He specified the justification as under the rule of '*maslaha*' (public interest), intended to protect 'religion, life, property, intellect and lineage'.

However, there have been objections on the grounds of human rights and by international organisations such as the WHO. Mandatory testing of HIV (as in the case of premarital HIV testing for Muslim married couples) is 'never sanctioned and is opposed by WHO, UNAIDS and UNHCR' (UNHCR 2014), although it notes that mandatory testing of blood, blood products or organs is ethical and necessary.

It has been argued that all HIV testing services should follow the '5 Cs' of informed consent, confidentiality, counselling, correct test results and connection to HIV services both those of prevention and those of treatment (UNHCR 2014). The Open Society Institute (Open Society 2000) has discussed the rising number of groups, including religious organisations and Muslim countries such as Bahrain and Saudi Arabia, that have adopted mandatory HIV premarital testing but maintains that such actions not only compromise the principles of HIV testing but are also against human rights, especially the right to marry and family.

In addition, some have argued against such policies in Asia and the Middle East, for example in India, arguing that there is the potential for increased risk of stigma and discrimination of those with HIV, of limiting women's rights as well as denigration of human rights, and have concluded that the ultimate responsibility lies with the individual (Malhotra et al. 2008). Malhotra and colleagues have also argued that the state's role is to create an enabling environment to obtain information about HIV and is 'conducive to voluntary counselling and testing, rather than through coercive mandatory testing strategies'.

Ganczak undertook a study showing the impact of premarital HIV testing from selected countries in the Arab peninsula and found that there was high social acceptability of HIV testing amongst young Emirates who showed a vulnerability to HIV (Ganczak 2010). Although in such Muslim countries premarital sex is contrary to the teachings of Islam, the acceptance of such a test acknowledges that some Muslims do engage in such activities and that testing may be an entry point and serve to provide a platform to educate on HIV/health issues and an opportunity for HIV surveillance.

Gruskin argues that for a rights-based approach to HIV there should be participation, which is free, active and includes the key affected communities and greater involvement of people living with HIV at 'every stage of HIV policy making and programming' and that this is seen as crucial for an effective response; however, this is often absent in many countries (Gruskin and Tarantola 2008). A strong civil society is important in creating changes in health policy, including in the HIV arena where civil organisations such as Treatment Action Campaign (Barmania and Lister 2013) have been vital. In addition, UNAIDS has guidelines on the participation of civil society to hold governments to 'account' and inclusion of PLHIV in policy making (UNAIDS 2011). This participation should extend to research and publication, says Choy (2014), who calls for the NGO community and advocacy groups in Malaysia to describe their work and successes to ensure leveraging of funds.

Conclusion

There has been growing appreciation that a 'one size fits all' model will not cater to all cultures and religious contexts and that religion itself can be utilised to help prevent disease (Husseini and Laporte 2001). While there has been a significant amount of research on HIV in Malaysia over the past 15 years (Choy 2014), there is little

relating to the intersection of HIV and Islam in Malaysia. Religion, in this case Islam, needs to be taken seriously when thinking of how we deal with HIV in general and in a predominantly Muslim country in particular, such as Malaysia. The reasons for doing so are numerous and far reaching not just because there are links between Islam and behaviour but also because Islam affects the political and social environment. Some countries are able to navigate some of the more sensitive areas where Islam and public health intersect (Webster 2013); others may have more difficulty. Fundamentally, there are conflicting views on sexuality between the sexually liberal HIV community and the more conservative Muslim community, which can make it difficult for the latter to participate and engage with the former.

Notwithstanding this, there are some professionals from a Muslim background who have managed to navigate both worlds, i.e. the HIV community and the religious community, such as the Alaei brothers from Iran (McGirk 2008). This adds weight to the argument that such research/work needs to come from the inside, from those who understand the culture and context in order for policy change to be accepted by the local community; measures should be instigated from within the community rather than outside of it.

Islam and HIV prevention do not necessarily have to be at diametrically irreconcilable poles; there can, in fact, be a medium in between where collaboration and effective engagement are possible. Effective engagement in HIV research by Muslims for Muslims, where currently there is a paucity of knowledge, will ultimately improve practice and aid HIV prevention. This study adds to what is known about HIV in Muslim populations and specifically enters uncharted territory to look at the significance of religion to sexual health. This study critically analyses how Islam plays a role in shaping health policies and perceptions related to HIV prevention in Malaysia in the real world, charts how this role influences policy, process and power and examines how this influence is exerted both directly and indirectly in practice. The study takes a neutral perspective, but addresses the gap of knowledge of Islam and HIV, examining how religion can be a determining factor to health—something which has hitherto been not extensively discussed.

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