

Disjoint between Intention and Implementation: The Safer Sex Conundrum of Gay Men in Penang, Malaysia

Felix, M. S.

Department of Society and Health, Faculty of Social Sciences and Humanities, Mahidol University, 73170 Bangkok, Thailand

ABSTRACT

Despite national plans and policies to reduce HIV infection rates in the nation, Penang remains a state with a high HIV infection rate within the gay male population. This research therefore, undertook to discover and analyse challenges of condom use faced by gay men in Penang. The research took the qualitative route of research design and collected data utilising the purposive method and snowball technique. Respondents were interviewed in-depth utilising a semi-structured questionnaire and 33 respondents were gathered until the point of data saturation was achieved. Data were analysed using a content analysis matrix and all data were secured via 128-bit encryption. The research gained clearance to proceed from the Ethics Committee of Universiti Sains Malaysia. Despite assertions of assertiveness and confidence in negotiating safer sex with sexual partners, the findings showed that respondents faced a myriad of challenges to negotiating condom use, as well as erratic condom use. The findings also showed that the respondents discarded safer sex when sexual desire was strong, that they had multiple sexual partners and had reservations when inquiring about the sexual history and HIV status of their sexual partners. However, there were no findings to indicate that the respondents discarded safer sex practices due to the availability of highly active antiretroviral therapy (HAART) or while under the influence of recreational drugs. Although the respondents recognised the value of practicing safer sex, there exists a disjoint between the intent to practicing safer sex and the actual execution. Personal choices derail the intent to practicing safer sex and signalling a need for an individualised approach to overcoming challenges to safer sex.

Challenges to the practice of safer sex come in various forms and need to be addressed via an individualised approach. National policy is vital to the reduction of HIV infection rates. Cognizance of how gay men make their safer sex choices is equally

ARTICLE INFO

Article history:

Received: 30 September 2015

Accepted: 29 August 2016

E-mail address:

drmarkfelix@gmail.com (Felix, M. S.)

vital in this endeavour. Implications of the findings for policy development and future research are discussed.

Keywords: Safer sex, gay, HIV, Malaysia, individualisation

INTRODUCTION

Policies and plans have been put in place in Malaysia to stem the rise of HIV infection among most at risk populations (MARF). As gay men fell under the umbrella of men who have sex with men (MSM), the policies and plans that focus on intervention and prevention through the National Strategic Plan (NSP) have targeted the gay male population of the nation through engagement of relevant stakeholders, civil society, risk reduction practices, testing and counselling services packaged specifically for gay men, monitoring and evaluation, reporting, detection and treatment, promotion of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) and healthy practices (Ministry of Health, 2004, 2006, 2011, 2015a, 2015b; Radziah, 2006).

The HIV/AIDS epidemic in Malaysia warranted the NSP of Malaysia for 2015 to 2030 to focus on achieving goals of having 90% of persons living with HIV (PLHIV) diagnosed, 90% of PLHIV treated with medication and 90% of the PLHIV population to have suppressed loads of HIV. The NSP for 2015 – 2030 also recognised that MSM was still a key affected population where sexual transmission was a key driver of HIV infection. There was an

increasing trend of infection from 7.1% to 8.9% and a decreasing trend of condom use from 74% to 57% within this population (Ministry of Health, 2015a, 2015b). However, while the NSP planned to be innovative and effective in its methods to decrease the transmission of HIV through the sexual route, it remained unclear as to what these innovative and effective means were, aside from repackaging testing and counselling services for gay men (Ministry of Health, 2015b). While it may be assumed that this repackaging would include continued promotion of condom use as well as education about PrEP and PEP, this assumption took for granted that gay men would consistently use condoms when engaging in penetrative sexual activity.

Based on these findings, this research puts forward the assertion that prevention of HIV among the gay male population is based on the personal choices in the sexual behaviours of gay men and not only in nationwide policies. The issue then becomes one of not only policy and available resources but also of personal choices that gay men make with regards to protecting themselves from HIV infection through the sexual behaviour they engage in. This research chose to focus on the gay male population in Penang as research by Mesquita et al. (2008) and UNGASS (2008, 2010) that the HIV rates among gay men in Penang had been increasing at a steady rate.

Due to moralistic and legal judgments (UNAIDS, 2000a; 2006a; 2006b; Baba, 2001; 2002; Scoville, 2004; TreatAsia,

2006; MacFarquhar, 2007; Rehman & Polymenopoulou; 2012; Owoyemi & Ahmad, 2013a, 2013b; Yodfallah, Tengku Aizan, Rahimah, & Siti Aisyah, 2014; Brown, Low, Tai, & Tong, 2015; Pandian, 2015; Wan Roslili, 2015), as well as discrimination due to the sexual nature of transmission of HIV (Ministry of Health, 2002; 2004; 2006; Shilts, 2007; UNAIDS, 1998a; 1998b; UNAIDS, UNICEF & World Health Organisation, 2004a; 2004b; 2006; 2008), the sexual behaviours that placed gay men at a high risk of HIV infection have remained largely hidden. This could have contributed to the decreased condom use among gay men from 74.8% in 2013 to 56.7% in 2014 (Ministry of Health, 2015a). As sexual behaviour covered many aspects and many acts (Acosta, 1975; Sanderson, 2003; Sell, 1997), this research chose to focus specifically on the sexual behaviour and condom use that gay men in Penang engaged in. This research was not geared towards questioning policy implementation per se initially, but found that the exploration of the sexual behaviour of gay men that placed them at risk of HIV infection would have implications that could affect policy change in the future.

BACKGROUND

Sexual behaviour and sexual activity

Sexual behaviour encapsulated expressed sexual desires and sexual practices (Jenkins, 2004; World Health Organisation, 2004). Sexual desires and sexual behaviour, based on assertions by the

World Health Organisation (2009a; 2009b), encompassed sex acts, gender identities, sexual orientation, eroticism, pleasure and intimacy. When expressed, sexual desires and sexual behaviour took the forms of individual thoughts, individual fantasies and specific sexual acts. This suggested that sexual behaviour was dependent on the individual and the way that the individual chose to express sexual desires. The individual expression of sexual behaviour took the forms of genital activity, sexual contact and also sexual conducts that led to orgasm (Sell, 1997), and for gay men, the individual expression of sexual behaviour led to various sexual acts that orbited the sexual acts of oral and/or anal sex (Sanderson, 2003).

The engagement in these sexual acts could be with casual sex partners and/or committed sex partners (Davies, et al., 1993). Motives for engaging in these acts fell into two distinct categories: psychosexual reasons and social-cultural reasons. Psychosexual reasons included pleasure, nurturing a relationship, expressing affection, exercising, overcoming boredom, inducing sleep, getting rid of an erection and compliance with partner's demands, as well as providing or receiving a reward or compliance. Socio-cultural reasons include social affirmation of gender identity, social affirmation of sexuality, social affirmation of desirability, social currency and demonstration of power (Donovan & Ross, 2000). In essence, there were a myriad of ways in which sexual behaviour of gay

men were expressed. There were also multiple reasons for which an individual would engage in sexual behaviour, as well as sexual activity with another individual or individuals.

High risk sexual behaviour of gay men

According to the studies conducted by Sarankov (2009) in Russia and the World Health Organisation (2009a), globally, high risk sexual behaviours for gay men include engaging in sexual activity with multiple sexual partners and in unprotected penetrative anal sex. The World Health Organisation (2009b) noted that for epidemiological purposes, the main mode of direct infection of HIV among gay men was unprotected penetrative anal sex even if unprotected penetrative sex was engaged in occasionally (Kelly et al., 1991). Penetrative anal sex was considered the most risky of sexual behaviours because fissures, miniscule cuts and abrasions occurred during penetrative anal intercourse due to the fragile lining of the anus. Should the insertive partner be HIV positive and ejaculate semen into the rectum of the receptive partner, the likelihood of HIV infection would high. However, if the insertive partner wore a condom throughout the penetration, the risk of infection was greatly reduced. In contrast, to this high risk sexual activity, sexual behaviour that carried low risk were mutual masturbation and oral sex with the receiver wearing a condom (UNAIDS 1998a, 1998b, 2000; Diggs, 2002; Sarankov, 2009).

Studies conducted by Vlahov and Celentano (2005) as well as Posada and Gomez-Arias (2007) found that the introduction of Highly Active Anti-Retroviral Therapy (HAART) and Anti-Retroviral Therapy (ART) caused relapse into high risk sexual behaviours among gay men. This was because the respondents of these studied viewed the HIV/AIDS epidemic as a manageable disease and compared it to other manageable diseases such as diabetes. Additionally, the use of recreational drugs reduced the vigilance of safer sex among practices in the sexual behaviours of gay men (Essein et al., 2004; Griensven et al., 2004; Hidaka et al., 2006; Lampinen, Matthis, Chan, & Hogg, 2007; Schwappach & Bruggman, 2008).

High risk sexual behaviour and safer sex guidelines for gay men

For the gay male population, safer sex guidelines included the constant and consistent use of condoms during penetrative sex (Tucker, Chang, & Tulskey, 2007; Van de Bij, 2007), careful selection of sexual partners, reduction of the number of casual sexual partners, negotiation of safer sex and open communication with sexual partners (UNAIDS, 2000a, 2000b; World Health Organisation, 2009a, 2009b). Careful selection of sexual partners means knowing their HIV status (ACON, 2009) and reduction of the number of sexual partners (Ainslie, 2002), while negotiation of safer sex and open communication with sexual partners means discussing condom

use, allowing and disallowing sexual acts, as well as engaging in only external sexual activities (AMFAR, 2008, 2009).

Challenges to these guidelines, as reported by scholars, included condom use interrupted spontaneity during sex (Beyrer et al., 1995), condoms limited pleasure (Beyrer, 2008), condom use marked a lack of trust and intimacy between sexual partners (Holmes, Levine, & Weaver, 2004; Ventura, Felipe, & Newman, 1998) and inaccessibility, as well as lack of durability of condoms for anal sex (UNAIDS, 2000b). Careful selection of partners, reduction of sexual partners and negotiations of safer sex were challenged by persuasion, threats, attractiveness and rejection of the present and potential sexual partners (UNAIDS, 2006b; World Health Organisation, 2009a, 2009b).

Intent to use versus actual use of condoms

Studies on intention to use condoms and actual condom use differ in their theoretical premise as well as findings, but suggest an interesting longitudinal pattern. Albarracin, Johnson, Fishbein, and Muellerleile (2001) used the theories of reasoned action and planned behaviour to test attitudes, behavioural norms and normative beliefs to predict condom use. The results of this research showed that while attitudes, behavioural norms and normative beliefs made the respondents acknowledge that condom use was important, they did not necessarily use condoms each time they

engaged in penetrative sexual activity. Interestingly, ten years after that research was published, Schutz et al. (2011) also used the theory of planned behaviour in a cohort study and their findings showed a positive relationship between acceptance of condoms, self-efficacy, past behaviour and intention to use condoms with actual condom use. This suggests that a positive relationship with and view of condoms increased condom use, and that attitudes and the corresponding behaviour to condoms has changed (and potentially can be changed) over time. In short, if gay men could be persuaded to view condoms as an ally and not an impediment, then the decreasing trend in condom use in Malaysia may be reversed.

METHODOLOGY

Sampling

As the nature of this research is sensitive and the individuals who are open to being respondents are small in number, the purposive sampling method and the snowball method were utilised to gather the respondents who met the criteria set for the research. All the respondents were self-identified gay men who were residents of Penang, Malaysia; are citizens of the country and above the legal age of consent at the time of this study. No age, educational or ethnic parameters were set for the research. The respondents were sought up to the point of data saturation was achieved. In total, the responses of 33 respondents were gathered.

Research tool and research analysis tool

All the respondents were interviewed using the in-depth interviewing method. This allowed the researcher to probe the respondents deeply on their sexual behaviours and condom use. This method also allowed the researcher to gather rich data that would allow him to understand the relationship that the respondents had with condoms, as well as their intimate use of it. This was necessary to the focus of the research and would glean appropriate, necessary and detailed data (Delaney, 2005; Barbour, 2008).

The questions posed to the respondents were designed to be semi-structured. This method of question design was chosen as it provides the researcher with opportunities to be flexible with the order in which the questions were presented to the respondents, as well as allows the researcher to ask supporting and probing questions wherever necessary (Berg, 2009). The questions in the semi-structured interview questionnaire focused on the following two topics and their respective sub-topics:

1. Types of sexual behaviour engaged in.
 - a. Safer sex practice implementation.
 - b. Non-implementation of safer sex practices.
2. Challenges to safer sex implementation.
 - a. Internal/personal challenges
 - b. External challenges/challenges created by another person/party

These questions were derived from the literature that was reviewed on safer sex as it pertained to the sexual behaviour of

gay men. The respondents were informed that the research was on risky sexual behaviours of gay men, but the author did not elucidate what was meant by safe and unsafe sexual behaviours so as not to influence the responses of the respondents.

Furthermore, it allowed the respondents to provide answers that were expressive and in-depth. All the interviews were audio-recorded, transcribed and analysed via a content analysis matrix. Verbatim responses, accurate transcription and a content analysis were important to capturing the experience of the respondents (Barbour, 2008) in terms of their condom use when engaging in sexual activities. The content analysis matrix allowed for analysis of the findings of the risky sexual behaviours of gay men as put forward in the literature reviewed. The content analysis matrix additionally allowed the respondents all the expressiveness of the respondents' responses to provide the answers sought by the questions put forward in this research (Delaney, 2005).

Privacy, confidentiality and ethical approval

As privacy and confidentiality are paramount, the in-depth interviews were managed within a private room or at a venue that was chosen by the respondent. Confidentiality is maintained through a signed consent form that met the guidelines of the Ethics Committee of Universiti Sains Malaysia, from whom ethical clearance was also received. All relevant information pertaining to the identity of the

respondents was locked within a secured and confidential location known only to the researcher. The privacy and security of the respondents was maintained through the use of assigned numbers instead of pseudonyms so that their ethnicity could not be ascertained.

Limitations

The research faced resistance from some of the respondents in opening up about the sexual activities they engaged in. While some openly shared with the researcher that they engaged in penetrative sex, others chose to equivocate and only mentioned that they placed a positive value on safer sex practices. Creating rapport with the respondents also had limitations as several respondents sought confirmation from the university in the form of a formal letter to be convinced that the research was legitimate and not a trap. Also, some respondents repeatedly asked if the confidentiality of their identity would be guaranteed during the interview process despite being assured several times by the researcher.

FINDINGS

Safer sex and condom use

The findings suggest that the respondents are aware that safer sex encapsulates condom use, knowing their sexual partners' sexual history and HIV status, as well as reduction of the number of sexual partners. In particular, condom use is noted among the respondents as the mainstay of safer

sex practices. The following interview excerpts from the respondents express their views on condom use.

What I do know about HIV and safer sex is that we must always use condoms. If we want to have oral sex we also have to use condoms so that we are safer. Actually, I am more of the receiving partner in anal sex and I always ask my partner to use a condom as it is safer for him and for me. – Respondent 1, Undergraduate, 22 years of age.

I think it is important to use condoms if you have anal sex. If your partner ejaculates in your rectal cavity and you are bleeding or when there is a tear you can contract HIV that way. – Respondent 2, Entrepreneur, late 30's.

The basic thing of safer sex is you must know about condoms. If we talk about anal sex we need to use condoms and the condom is just used one time. You must also use good quality condoms. – Respondent 3, Blue collar worker, mid 30's.

Successful condom use for safer sex requires negotiation with sexual partners. Based on the findings, the respondents stated that assertiveness and good communication while negotiating safer sex produced positive outcomes. The positive outcomes of the negotiation of condom use are best exemplified in the following interview excerpts.

To me, negotiating safer sex is like negotiating a business contract and I am very good at negotiating. I ask my partner to use a condom and I use one too. In the past before I got together with my present boyfriend I would ask a guy to put on a condom and would explain to him the benefits of doing so. If the guy did not want to put on a condom, then we would not have sex. Those are my conditions. I mean, you will not die from not having sex; it is not the end of the world. – Respondent 4, Entrepreneur, 39 years of age.

I am very straightforward. If he does not want to have safer sex then I will not have sex with him. There is no further negotiation. You take it or you leave it. – Respondent 5, Hotelier, 23 years of age.

Challenges to safer sex negotiation

The findings point out that the respondents face definite challenges in the negotiation of safer sex with their sexual partners. The following interview excerpts show some of the challenges faced by respondents when negotiating safer sex with their partners.

Sometimes the guy says that using condoms is a turn-off. That makes wanting to use a condom challenging. – Respondent 6, Professional, 23 years of age.

Usually the challenge I face is because he (sexual partner) says

that it is not comfortable. He says it makes us closer when we do not use a condom and also that it is more romantic. He says since we are both HIV negative why use condoms? This is the excuse he uses when he does not want to wear a condom. – Respondent 7, Undergraduate, 22 years of age.

The other person will say that it will lessen their pleasure. That is the usual complaint I get when I tell the other person to put on a condom. – Respondent 8, Professional, 46 years of age.

My partner does not like to use condoms during sex; he says it is a sign of mistrust between us. He often accuses me of infidelity when I try to negotiate condom use. He says I want him to use a condom because I have been unfaithful and have been sleeping with a lot of men when he is not around. – Respondent 9, Undergraduate, 22 years of age

Erratic use of condoms

Other findings in the data show that condom use by some other respondents is erratic, leading to the risky behaviour of engaging in penetrative anal sex without the use of condoms. The reasons for the erratic use of condoms range from familiarity with sexual partner, lack of sensation, desirability of sexual partner, lack of availability, sex outside a primary relationship and fear of

rejection by a sexual partner. The following interview excerpts are the most detailed of these findings that were shared with the researcher.

To be honest I do not practice safer sex even though I know I have to use condoms. If it is sex with a new partner then I use a condom but if I already know the person and am familiar with him then I do not use a condom. I realize that I may get infected from familiar sexual partners, but I still do not want him to wear a condom because the sensation is different. – Respondent 10, Undergraduate, 25 years of age.

I use it (condom) for anal sex. If I see the guy is different or *Mat Salleh* (Caucasian), then if I give him a blowjob I use condoms. If the guy is handsome and muscular and I am very sexually excited, I do not use a condom. But for older guys, I use condoms or if I feel there is something different about the guy, then I use condoms. – Respondent 11, Undergraduate, 26 years of age.

There are times when I use condoms and there are times when I do not use condoms. Most of the time I use it but sometimes if it is not available or my supply is finished then I do not use condoms. – Respondent 1, Undergraduate, 22 years of age.

Normally like for my boyfriend of many years it depends on him. Sometimes we use condoms and sometimes we do not. Because we have an open relationship, I also have sex outside of the relationship. I try to have sex with condoms when I have sex with other guys. – Respondent 12, Professional, 35 years of age.

Some of the partners I have I tell them not to insert into me, but they feel that they want to so they forcefully insert so it is very painful. No, they are not wearing a condom. I do not want them to penetrate me but they still want to. Even though I do not want them to penetrate me without a condom I feel as if I have to let them to please them. I let them do this because I want to please them, and I do not want them to be angry. If I do not let them do what they want they may reject me. – Respondent 13, Professional, 32 years of age.

Desire, multiple sexual partners, sexual history and HIV status

The data showed that the respondents allow desire to overcome consideration of safer sex and have multiple sexual partners, challenges in discussing sexual history and inquiring about the HIV status of their sexual partners. First, the following interview excerpts highlight the finding that sexual desire often overrides any consideration of safer sex.

I think it is in the heat of the moment where some people are so driven by lust that they forget to talk about safer sex. They may have talked about it before but when the moment comes to do it they give in to lust and forget to use protection. You may meet someone a few times and be so full of desire that you choose to forego safer sex and just do it. – Respondent 14, Graphic Designer, 31 years of age.

When I think of wanting sex I forget all about AIDS. When I want to *main* (have sex) I think of it, but when I actually get sex I do not think any more about safer sex. I am afraid of being infected but I still want to have sex. – Respondent 10, Undergraduate, 25 years of age.

The findings on the multiple sexual partners of the respondents are shown in the next set of interview excerpts.

Let us not go there, really. Let me put it this way, quite a lot. – Respondent 14, Graphic Designer, 31 years of age.

Many, many, many. When I was in Singapore I had all the freedom I wanted and being a creative person I always want something different all the time. That includes sexual partners as well. I need the change. – Respondent 15, Educator, 36 years of age.

I would say above one hundred sexual partners. – Respondent 16, Professional, 36 years of age.

I have not had any long-term or short-term relationships. I have had a lot of one night stands, exactly how many I do not know. If I had to estimate the number of sexual partners I have had I would say between 150 and 180. – Respondent 13, Professional, 32 years of age.

The next set of findings is on the discussion of respondents with their sexual partners regarding their own sexual history and that of their sexual partner, as well as inquiry regarding the HIV status of their partner.

I do not really ask. After all, if he is clean, it must mean that he does not have HIV or any other *penyakit kelamin* (sexually transmitted disease). – Respondent 10, Undergraduate, 25 years of age.

How do I ask such questions? It is embarrassing, so *malu* (shameful) and not giving face to the guy, as if I think he has AIDS and will give it (HIV) to me on purpose. Look, I am selective in my sexual partners, so I do not need to ask such questions. Like I said, it is so *malu*. – Respondent 17, Self-employed, 44 years of age.

It is a tricky situation. I do not ask how many sexual partners a man has because I do not want to share my “secret number” with him. What if he thinks I am a slut and will not have sex with me? So, I avoid asking him about how many sexual partners he has so that he will not ask me the same question either. – Respondent 18, Professional, 40 years of age.

Let me answer your question this way: it is better if I do not know his HIV status. This is not because I do not want to be safe, but because I honestly do not know my HIV status either. Plus, why would you tell a sexual partner the truth about HIV status unless it becomes serious and you decide to take your series of sexual adventures to the level of making it a relationship? – Respondent 6, Professional, 23 years of age.

HAART, ART and Sexual Behaviour under the Influence of Drugs

While it was noted in the past work of scholars that the advent of HAART and ART had reduced the perception of HIV infection to that of a manageable disease among some gay male populations and therefore created unsafe sex practices, the use of HAART and ART was not reported in the findings as a justification for engaging in unsafe sexual practices. Additionally, none of the respondents reported the use of recreational drugs as the reason for engaging in unsafe sexual behaviours.

Summary of the Findings

Overall, the findings with regard to condom use show inconsistency between intent and actual use, with challenges that prevent or dissuade the respondents to practice consistent condom use. The disjoint suggested by the findings between intent to use condoms when engaging in sexual activity and actual use is summarised in the following table.

Table 1
Intent, challenges and actual condom use

Intent to use condoms	Challenges to condom use	Actual condom use
<ul style="list-style-type: none"> • Condoms were deemed a necessity for prevention of HIV infection. • Consistent use of condoms is necessary to prevent HIV infection. • Good quality condoms were necessary to prevent HIV infection. • Knowledge of tears in the rectal area led to high risk of HIV infection. • Open communication and negotiation were necessary to facilitate condom use. 	<ul style="list-style-type: none"> • Unwillingness of sexual partner to use condoms. • Condoms caused physical discomfort during sex. • Condoms lessened sensation during sex. • Condoms viewed as a sign of mistrust and infidelity. • Inconsistent discussion with sexual partner regarding sexual history and necessity for condom use. 	<ul style="list-style-type: none"> • Inconsistent condom use based on level of familiarity with sexual partner. • Inconsistent condom use so as not to displease or anger sexual partner. • Inconsistent use of condoms based on level of sexual attraction felt for sexual partner. • Inconsistent use based on level of lust or sexual desire for sexual partner.

DISCUSSION

The findings suggest that there is a disjoint between the appreciation of the necessity of safer sex and the actual application and implementation in terms of sexual behaviours. This disjoint occurs when the respondents' attempts to practice safer sex are derailed through various challenges. Joint responsibility of the utilization of safer sex in sexual behaviour does not always exist when sex is engaged in as shown in the findings. This is despite expressed assertiveness and confidence in negotiating safer sex practices. This set of findings point out that the respondents intended to use condoms when they engage in sexual behaviour. As the theory of planned behaviour and the study by Schutz et al. (2011) outlines, the attitudes and normative behaviours that recognise the importance of condom use are acknowledged. However, the actual outcome remains to be decided by extenuating factors that are external to the respondents.

Based on the findings, three main points may be raised. The first is that while the respondents are aware of the importance of safer sex, they do not necessarily implement the practices of safer sex constantly in their sexual behaviour. The second is that challenges to safer sex practices may derail the intentions of the respondents to place safer sex practices in motion within the sexual behaviour they engage in. The third is that constant and consistent application of safer sex into the sexual behaviour of the respondents is a matter of personal choice. In other words, to know about safer sex is a

choice, and to practice safer sex constantly and consistently is another. Based on the findings, there is a disjoint between these two choices for the respondents. This disjoint is of concern within both the theory of planned behaviour and the context of the goals of the NSP, specifically because the intended safer sex behaviours are not followed through with and if they are not then the goals of the NSP cannot be achieved by the year 2030. While the present NSP recognises that sexual transmission is the main driver of HIV infection in the MSM population and that the MSM population is still an MARP, it has to take further steps of engagement with the MSM community to manage the challenges faced by this community with regard to consistent condom use.

On an intrinsic level, the respondents consciously choose between valuing safer sex and practicing safer sex based on the context or situation they are in with their sexual partner. They also consciously choose between wanting to safeguard their health and wanting to enjoy the sexual behaviour they engage in with abandon. While this research began with the intent to identify the sexual behaviours of the respondents, what is more significant is that the research finds that gay men are bound by the choices they make between the knowledge they have regarding safer sex practices and the actual execution of safer sex practices in their sexual behaviour. This signals an individualised approach to safer sex as well as autonomy of thought in implementing safer sex practices. As

such, recommendations based on the findings include individualization of safer sex messages to the gay male population via the internet media that take into account the challenges they face, as well as training and counselling by the relevant government bodies and non-governmental organizations (NGOs) to assist members of the gay male population in addressing individualized challenges.

Implications for the policy

In light of the goals of the NSP to end the AIDS epidemic in Malaysia by the year 2030, the findings of this research show that aside from the previously mentioned strategies that are put in place, it is necessary to understand that condom use is a personal decision that is often detoured by various arguments. To ensure that the policies put into place are effective, it becomes imperative that continued rapport with members of the gay community becomes a lynchpin to understanding the challenges faced by gay men in the context of consistent condom use. The purpose of the NSP would be defeated if policies are implemented, but the individual and actual challenges of gay men within the context of condom use are not fully understood from a grassroots standpoint. This approach of more deep engagement with the gay community would be an innovative and effective way of decreasing HIV infection among gay men.

The component of open communication needs to be stressed in educational programs for gay men, with an emphasis

for negotiation of condom use with their sexual partners. This effort, from a policy perspective, may include empowerment to choose to refuse to give into the reasons given by sexual partners for not wanting to use condoms when engaging in sexual activity. Empowerment may come in the form of support groups, educational programs and targeted marketing campaigns that focus on gay men. The latter may be executed via allied organizations, entertainment areas frequented by gay men and media frequently utilised by gay men. This may be another innovative way for approaching the issue of decreasing HIV infection among the gay male population.

Policy makers should also take into consideration that outreach efforts involving distribution of condoms do not necessarily equate condom use. When taken into the perspective of gay men having multiple sexual partners and assessing whether to use condoms for sexual activity or not, mechanisms should be put into place to measure the effectiveness of condom distribution against actual condom use. Community programs where information on distribution of condoms versus use of condoms by gay men would assist this effort to some extent, but on a larger scale, innovation using information technology (IT) and smart phone applications can assist in tracking this information. Additionally, such IT and smart phone applications may be developed to create support groups that remind gay men to consistently use condoms, irrespective of who their sexual partners are, irrespective of the level of

desirability that a sexual partner has and irrespective of the level of familiarity they have with the sexual partner.

Future research

Future research along the lines of psychosexual and psychosocial needs of gay men within the context of sexual engagement with sexual partners would, in the opinion of the researcher, enhance efforts of reducing the HIV infection rate among gay males especially within the context of condom use. Other areas of future research that would aid policy making would be the combined use of condoms, PrEP and PEP in reducing HIV infections among the gay male population; and longitudinal studies of the effectiveness of such a combination. Additionally, future research may investigate the rate of use of condoms from an attitudinal and behavioural standpoint based on the theory of planned behaviour, and this research should be conducted longitudinally. The changes in attitude and behaviour from this research would aid policy makers in adjusting policy to meet the changes in attitude and behaviour within the gay male population.

CONCLUSION

The disjoint between intention and implementation of safer sex practices based on the sample population is seen at two levels in this research. First, despite national policy implementation to reduce the HIV infection rate within the gay male

population, it is the gay men themselves and not the national policy that makes the decision to engage constantly and consistently in safer sex practices. Second, in the sample population of the research, there is the intent to practice safer sex, although the intention is not perfectly executed into consistent implementation due to challenges from internal (personal) and external (sexual partner) motivations. It cannot be denied that national policy is vital to the reduction of HIV infection rates. However, cognisance of how gay men make their safer sex choices is equally vital in this endeavour.

REFERENCES

- ACON. (2009). *HIV/AIDS men who have sex with men and transgender people in the Pacific: Recommendations for an improved response*. Pacific Sexual Diversity Network: New South Wales, Australia.
- Acosta, F. X. (1975). Etiology and treatment of homosexuality: A review. *Archives of Sexual Behaviour*, 4(1), 9–29.
- Ainslie, D. C. (2002). AIDS and sex: Is warning a moral obligation? *Health Care Analysis*, 10(1), 49–66.
- Albarracin, D., Johnson, B. T., Fishbein, M., & Muellerleile, P. A. (2001). Theories of reasoned action and planned behavior as models of condom use: A meta-analysis. *Psychological Bulletin*, 127(1), 142 – 161.
- AMFAR. (2008). *The MSM initiative global consultation on MSM and HIV research*. New York, NY: AMFAR.

- AMFAR. (2009). *The MSM initiative ensuring universal access to comprehensive HIV services for MSM in Asia and the Pacific determining operations research priorities to improve HIV prevention, treatment, care and support among men who have sex with men*. New York, NY: AMFAR.
- Baba, I. (2001). Gay and lesbian couples in Malaysia. In G. Sullivan & P. A. Jackson (Eds.), *Gay and Lesbian Asia: Culture, identity, community* (pp. 143-163). USA: Harrington Park Press.
- Baba, I. (2002). Psychological aspects of HIV/AIDS prevention: A look at Community AIDS Services Penang (CASP). *HIV/AIDS - The Realities The Challenges*. Malaysia: Malaysian Ministry of Health.
- Barbour, R. (2008). *Introducing qualitative research A student guide to the craft of doing qualitative research*. London, UK: Sage Publications.
- Berg, B. L. (2009). *Qualitative research methods for the social sciences* (7th Ed.). Boston, MA: Allyn and Bacon.
- Beyrer, C., Eiumtrakul, S., Celentano, D. D., Nelson, K. E., Ruckphaopunt, S., & Khamboonruang, C. (1995). Same-sex behaviour, sexually transmitted diseases and HIV risks among young northern Thai men. *AIDS*, 9(2), 171-176.
- Beyrer, C. (2008). Hidden yet happening: The epidemic of sexually transmitted infections and HIV among men who have sex with men in developing countries. *Sexually Transmitted Infections*, 84, 410 – 412.
- Brown, J., Low, W. Y., Tai, R., & Tong, W. T. (2016). Shame, Internalized Homonegativity, and Religiosity: A Comparison of the Stigmatization Associated with Minority Stress with Gay Men in Australia and Malaysia. *International Journal of Sexual Health*, 28(1), 28-36.
- Davies, P. M., Hickson, F. C. I., Weatherburn, P., Hunt, A. J., Broderick, P. J., Coxon, T. P. M., McManus, T. J., & Stephens, M.J. (1993). *AIDS: The second decade*. London: The Falmer Press.
- Delaney, T. (2005) *Contemporary social theory Investigation and application*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Diggs, J. R., (2002). *The health risks of gay men*. Corporate Resource Council: USA.
- Donovan, B., & Ross, M. W. (2000). Preventing HIV: determinants of sexual behaviour. *The Lancet*, 355(9218), 1897-1901.
- Essein, E. J., Ross, M. W., Williams, M. L., Meshack, A. F., Fernandez-Esquer, M. E., Peters, R. J. & Ogungbade, G. O. (2004). Primary source of income is associated with differences in HIV risk: Behaviours in street recruited samples. *International Journal for Equity in Health*, 3(5), 1 – 7.
- Griensven, F., Kilmarx, P. Jeeyapant, S., Manopaiboo, C., Korattana, S., Jenkins, R., Uthavivoravit, ... Mastro, T. (2004). The prevalence of bisexual and homosexual orientation and related health risks among adolescents in northern Thailand. *Archives of Sexual Behaviour*, 33(2), 137 - 147.
- Hidaka, Y., Ichikawa, S., Koyano, J., Urao, M., Yasuo, T., Kimura, H., ... & Kihara, M. (2006). Substance use and sexual behaviours of Japanese men who have sex with men: a nationwide internet survey conducted in Japan. *BMC public health*, 6(1), 239-246.
- Holmes, K. K., Levine, R., & Weaver, M. (2004). Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organization*, 82(6), 454-461.
- Jenkins, C. (2004). *Male sexuality, diversity and culture implications for HIV Prevention and care*. Switzerland: UNAIDS.

- Kelly, J. A., Kalichman, S. C., Kauth, M. R., Kilgore, H. G., Hood, H. V., Campos, P. E., ... St Lawrence, J. S. (1991). Situational factors associated with AIDS risk behavior lapses and coping strategies used by gay men who successfully avoid lapses. *American Journal of Public Health, 81*(10), 1335-1338.
- Lampinen, T., Mattheis, K., Chan, K., & Hogg, R. (2007). Nitrate inhalant use among gay and bisexual men in Vancouver during a period of increasing HIV incidence. *BMC Public Health, 7*(35), 1 - 6.
- MacFarquhar, N. (2007, November 7). Gay Muslims find freedom of sorts in US. *The New York Times*. Retrieved from <http://www.nytimes.com/2007/11/07/us/07gaymuslim.html>
- Majid, W. R. A. (2015). Rights demanded by LGBT people: a preliminary refutation. *TAFHIM IKIM Journal of Islam and the Contemporary World, 8*, 37 – 61.
- Mesquita, F., Jacka, D., Ricard, D., Shaw, G., Tieru, H., Yifei, H., ... Singh, N. (2008). Accelerating harm reduction interventions to confront the HIV epidemic in the Western Pacific and Asia: The role of WHO (WPRO). *Harm Reduction Journal, 5*(26), 1 – 13.
- Ministry of Health. (2002). *National policy on HIV/AIDS*. Malaysia: Ministry of Health.
- Ministry of Health. (2004). *Malaysia National Strategic Plan on HIV/AIDS 2006 – 2010*. Malaysia: Ministry of Health.
- Ministry of Health. (2006). *Malaysia National Strategic Plan on HIV/AIDS 2006 – 2010*. Malaysia: Ministry of Health.
- Ministry of Health (2011). *National Strategic Plan on HIV/AIDS 2011 – 2015*. Malaysia: Ministry of Health.
- Ministry of Health Malaysia (2015a). *Global AIDS Response Progress Report Malaysia*. Malaysia: Ministry of Health.
- Ministry of Health Malaysia (2015b). *National Strategic Plan 2016 – 2030 Together we can end AIDS epidemic by 2030*. Putrajaya, Malaysia: Ministry of Health.
- Momtaz, Y. A., Hamid, T. A., Ibrahim, R., & Akahbar, S. A. N. (2014). Racial and socioeconomic disparities in sexual activity among older married Malaysians. *Archives of gerontology and geriatrics, 58*(1), 51-55.
- Owoyemi, M. Y., & Ahmad Zaharuddin, S. A. S. (2013a). LGBT; nature or ideology: the view of a former LGBT practitioner in Malaysia. *Research Journal of Biological Sciences, 8*(4), 104 – 111.
- Owoyemi, M. Y. & Ahmad Zaharuddin, S. A. S. (2013b). Natural instinct and control: the impact of nature and society on LGBT practitioners: the view of a former LGBT practitioner. *Current Research Journal of Biological Sciences, 5*(5) 242 – 247.
- Pandian, S. (2015). Does policies matter in voting behavior: findings from selected university students in Malaysia. *Research Journal of Applied Science, 10*(5) 176 – 180.
- Posada, I. C., & Gómez-Arias, R. D. (2007). Market and risk: stages of HIV transmission among men with homosexual behaviors. Medellín, 1993-2006. *Colombia Médica, 38*(3), 222-236.
- Radziah, T. (2006). The State of the Epidemic in Malaysia. In T. Yamamoto & S. Itoh (Eds.), *Malaysia fighting a rising tide: The response to AIDS in East Asia* (pp. 195-206). Tokyo, Japan: Japan Centre for International Exchange.
- Rehman, J., & Polymenopoulou, E. (2012). Is green part of the rainbow? Sharia, homosexuality and LGBT rights in the Muslim world. *Fordham International Law Journal, 21*(Nov), 1 – 49.
- Sanderson, T. (2003). *The gay man's Kama Sutra*. United States, USA: St Martin's Press.

- Sarankov, Y. (2009). *Medical aspects related to LGBT health social work with people practicing same-sex relations, theory, methodology, best practice*. Ukraine: International HIV/AIDS Alliance in Ukraine.
- Schutz, M., Godin, G., Kok, G., Vézina-Im, L. A., Naccache, H., & Otis, J. (2011). Determinants of condom use among HIV-positive men who have sex with men. *International Journal of STD and AIDS*, 22(7), 391-397.
- Schwappach, D. L., & Bruggmann, P. (2008). An integrated model of care to counter high incidence of HIV and sexually transmitted diseases in men who have sex with men—initial analysis of service utilizers in Zurich. *BMC Public Health*, 8(1), 180-188.
- Scoville, C. E. G. (2004). *An assessment of HIV prevention work for the MSM population in Kuala Lumpur submitted to the Malaysian AIDS Council, PT Foundation and other interested groups and individuals*. United States, USA: Duke University.
- Sell, R. (1997). Defining and measuring sexual orientation: A review. *Archives of Sexual Behaviour*, 26(6), 643 – 658.
- Shilts, R. (2007). *And the band played on* (20th Anniversary edition). United States, USA: St. Martin's Press.
- TreatAsia. (2006). *MSM and HIV/AIDS risk in Asia what is fuelling the epidemic among MSM and how can it be stopped special report*. New York, NY: AMFAR AIDS Research.
- Tucker, J. D., Chang, S. W., & Tulskey, J. P. (2007). The catch 22 of condoms in US correctional facilities. *BMC public health*, 7(1), 296-298.
- UNAIDS. (1998a). *AIDS and men who have sex with men UNAIDS point of view UNAIDS Best Practice Collection*. Geneva, Switzerland: UNAIDS.
- UNAIDS. (1998b). *Relationship of HIV and STD declines in Thailand due to behavioural change A synthesis of existing studies*. Geneva, Switzerland: UNAIDS.
- UNAIDS. (2000a). *AIDS and men who have sex with men UNAIDS technical update UNAIDS Best Practice Collection*. Switzerland: UNAIDS.
- UNAIDS. (2000b). *Evaluation of the 100% condom program in Thailand UNAIDS Case Study*. Switzerland: UNAIDS.
- UNAIDS. (2006a). *International guidelines on HIV/AIDS and human rights 2006 consolidated version*. Switzerland: UNAIDS.
- UNAIDS. (2006b). *Policy brief HIV and sex between men*. Switzerland: UNAIDS.
- UNAIDS, UNICEF & WHO. (2004a). *Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections 2004 update Malaysia*. Switzerland: UNAIDS.
- UNAIDS, UNICEF & WHO. (2004b). *Malaysia epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases 2004 update*. Switzerland: UNAIDS.
- UNAIDS, UNICEF & WHO. (2006). *Malaysia epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases 2006 update*. Switzerland: UNAIDS.
- UNAIDS, UNICEF & WHO. (2008). *Malaysia epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases 2008 update*. Switzerland: UNAIDS.
- UNGASS. (2008). *Country progress report Malaysia January 2006 – December 2007*. Switzerland: UNAIDS.
- UNGASS. (2010). *Country progress report Malaysia January 2008 – December 2009*. Switzerland: UNAIDS.

- Van der Bij, A. K., Kolader, M. E., de Vries, H. J., Prins, M., Coutinho, R. A., & Dukers, N. H. (2007). Condom use rather than serosorting explains differences in HIV incidence among men who have sex with men. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 45(5), 574-580.
- Ventura-Felipe, E. M., & Newman, S. P. (1998). Influence of HIV status on sexual behaviour among males. *Revista de Saude Publica Journal of Public Health University of Sao Paulo*, 2(6), 22 - 34.
- Vlahov, D., & Celentano, D. D. (2005). *Access to highly active antiretroviral therapy for injection drug users: Adherence, resistance and death*. United States, USA: Center for Urban Epidemiological Studies.
- WHO. (2004). *Rapid assessment and response guide on HIV and men who have sex with men*. Switzerland: World Health Organization.
- WHO. (2009a). *HIV/AIDS in the South-East Asian region*. India: Regional Office for South-East Asia.
- WHO. (2009b). *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations report of a technical consultation 15-17 December 2008*. Switzerland: World Health Organization.