GLOBAL AIDS RESPONSE PROGRESS REPORT

MALAYSIA 2016

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COUNTRY RESPONSES TO HIV/AIDS

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The Global AIDS Response Progress Report 2016

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Foreword

The implementation of NSP 2011-2015 has come to the end and NSP for Ending AIDS (NSPEA) 2016-2030 leads us to a new era. Our almost three-decade long response to the HIV epidemic has remarkable achievements but there are still unfinished business and new challenges await.

Backed by strong political support, workable policy, undivided participation and perseverance (4P), the country witnessed countless new policy turned into action; all geared towards preventing and controlling the menace. By 2015, for the first time in history, Malaysia has successfully halved the new infections in 2000.

New HIV infections continue to decline. Progress has been dramatic in stopping new infection among children and we are one step closer to eliminate new infections among children. However, progress in combating HIV among key populations has been uneven. While HIV prevalence among people who inject drugs is declining, sexual transmission of HIV shows the opposite. More than half do not know their status and treatment coverage has not reached target.

We have a fragile five-year window to build on rapid results. But we are confident that ending AIDS will be realized if we combine efforts. Everyone must be counted and reached – this is the way forward. Modelling and past achievements are evidence that HIV prevention works. Increased access to treatment, in combination with HIV prevention focusing on key populations will significantly drive down new infections.

Datuk Dr. Noor Hisham Bin Abdullah
DIRECTOR GENERAL OF HEALTH MALAYSIA

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AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BSS	Behavioral Surveillance Survey
CBO	Community-based Organization
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FRHAM	Federation of Reproductive Health Associations of Malaysia
HIV	Human Immunodeficiency Virus
KP	Key population
PWID	People who inject drugs
IBBS	Integrated Bio-Behavioral Surveillance
MAC	Malaysian AIDS Council
MDGs	Millennium Development Goals
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MTCT	Mother-to-child transmission
MWFCD	Ministry of Women, Family and Community Development
NADA	National Anti-Drug Agency
NGO	Non-Government Organization
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan on HIV/AIDS
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TAPS	Treatment Adherence Peer Support
TB	Tuberculosis
TG	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
UNTG	United Nations Theme Group on HIV
VDTS	Venue-Day-Time- Sampling
WHO	World Health Organization

CHAPTER 1 – TAKING A LEAP, ONE STEP AT A TIME

1.1 The milestone

For more than 2 decades, Malaysia has many success stories about its struggle to halt and reverse the HIV epidemic. Dated as far back in 1985, the earliest response started with the establishment of the country's National Task Force before the first case made its debut. Backed by strong political support, workable policy, undivided participation and perseverance (4P), the country witnessed countless new policy turned into action; all geared towards preventing and controlling the menace (table 1). By 2015, for the first time in history, Malaysia has successfully halved the new infections in 2000 (22 per 100,000 population).

Table 1. Major milestone of the country's responses on HIV/AIDS and corresponding infection rate

Year	National Response	Infection Rate in the corresponding year (per 100,000 pop.)
1985	National AIDS Task Force established	0.00
	National Surveillance System established; HIV/AIDS as notifiable disease	
1986	**First case reported**	0.02
	HIV screening initiated in prisons and drug rehabilitation centers	
1988	First National Plan of Action on AIDS developed	0.05
1990	HIV Screening Programme started for prisoners, inmates of drug rehabilitation centers, TB/STI patients, sex workers, antenatal (sentinel)	4.30
	Provision of AZT treatment for health care worker exposed to HIV	
1991	1st National Healthy Life Style Campaign on AIDS	9.67
1992	Inter-Ministerial Committee on AIDS	13.17
	National Coordinating Committee on AIDS	
	National Technical Committee on AIDS	
	AIDS/STD Section established in Min. of Health	
	Malaysian AIDS Council established	
1997	AZT available in government Health Clinics	18.03
1998	Revised Plan of Action on HIV/AIDS	20.70
	Prevention of Mother-to-Child Transmission (PMTCT) Programme	

2000	Cabinet Committee on AIDS (CCA) HIV Management at Primary Care Programme Anonymous HIV test programme MDG 6 Target: "Halve new HIV infection by 2015"	**21.74**
2002	Premarital HIV Screening – Pilot by Islamic Religious Dept	28.45
2003	Government partnership with MAC through funding scheme	26.97
2004	Provision of Free two (2) ART to limited patients	25.12
2005	Harm Reduction Programme incepted	23.42
2006	1st National Strategic Plan for HIV and AIDS (2006 – 2010) Provision of Free first line ART to all Malaysians	21.88
2009	National AIDS Registry implemented	10.88
2010	ARV treatment initiation revised from CD4 200 to 350 cells/µL National Premarital Screening Programme	12.93
2011	2nd National Strategic Plan for HIV and AIDS (2011 – 2015) Treatment Option B+ for PMTCT Provision of isoniazid prophylaxis for PLHIV	12.18
2013	City Getting to Zero project – Melaka Historical City	11.42
2015	HIV screening programme at 1Malaysia Clinic (MDG 6 target – achieved)	**10.90**

1.2 Epidemic Snapshot

People who inject drugs (PWID), female sex workers (FSW), transgender people (TG) and men who have sex with men (MSM) represent the populations most affected by the epidemic with infection rates exceeding 5%. A large proportion of them are above 25.

There are an estimated 92,895 people living with HIV (PLHIV) at the end of 2015 in which 90,603 (97.5%) have been notified through the surveillance system (table 2). Five (5) states – Johor, Selangor, Kelantan, Pahang and Terengganu account for almost two thirds (62%) of all PLHIV in Malaysia (figure 1). In general, PLHIV in this country is predominant among males (89%) but over time, this pattern progressively shifted towards increasing infection rates in female with male/female ratio declining from 9.6 in 2000 to 5.5 in 2015.

In IBBS 2014 the prevalence among PWID, while nationally slowly declining, was highest in Kelantan (44.7%), Terengganu (30.0%), Johor (27.1%) and Kuala Lumpur (21.3%), and lowest in Melaka (1.7%) and Penang (1.6%). Among FSW the prevalence was highest in Kuala Lumpur (17.1%) and Pahang (14.5%) and lowest in Perak (0.6%), but had been increasing rapidly in Sabah (from 1.1% in 2012 to 6.7% in 2014) and Sarawak (from 0.7% to

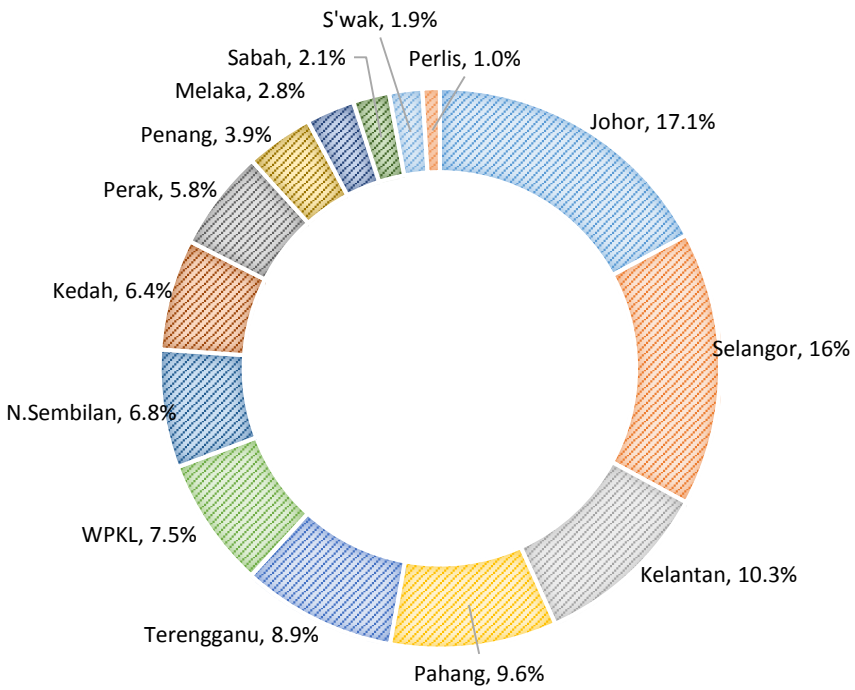
6.7%). Among MSM and TG, the HIV prevalence was highest in 2014 in Kuala Lumpur for MSM at 22.0% (up from 10.2% in 2012), and for TG at 19.3% (up from 4.8% in 2012); and in Johor for MSM at 15.7% and for TG at 10.6%.

Table 2. Overview of the HIV epidemic, Malaysia 2015

Indicator	Number [%]
Cumulative number of reported HIV infections	108,519
Cumulative number of reported AIDS	22,485
Cumulative number of reported deaths related to HIV/AIDS	17,916
Estimated people living with HIV [EPP 2016]	92,895
Total number of people living with HIV [surveillance data]	90,603
Reported new HIV infections	3,330
HIV notification rate (per 100,000)	10.9
Women reported with HIV	512
Children under 13 years living with HIV	956
People living with HIV receiving ART as of December 2015	25,700
Estimated adult (15+) HIV prevalence [EPP 2016]	0.4%

Source: Ministry of Health Malaysia

Figure 1. People living with HIV in Malaysia, 2015



As informed by the national surveillance system, new HIV infection has declined by 50% between 2000 and 2015 (figure 2), while the number of HIV/AIDS related deaths stabilized during the same period. Malaysia has made a significant progress in expanding its availability and accessibility of antiretroviral since it became the integral component of continuum of care, treatment and prevention in 1990. By the end of 2015, about 25,700 PLHIV were on life-saving antiretroviral therapy (ART). Women were more likely to get ART (70%) compared to men (23%). The country's epidemic snapshot is depicted in figure 3.

Figure 2. Reported HIV, AIDS and HIV/AIDS related deaths, Malaysia 1986-2015

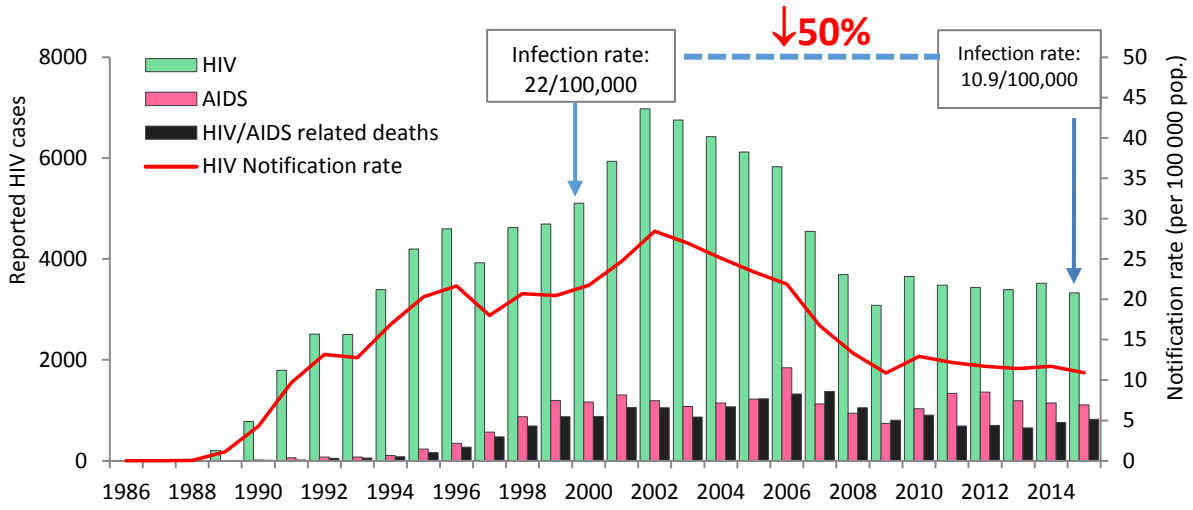
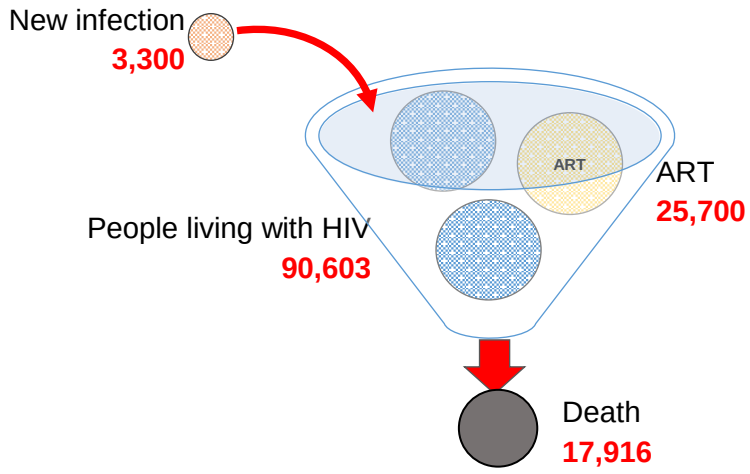
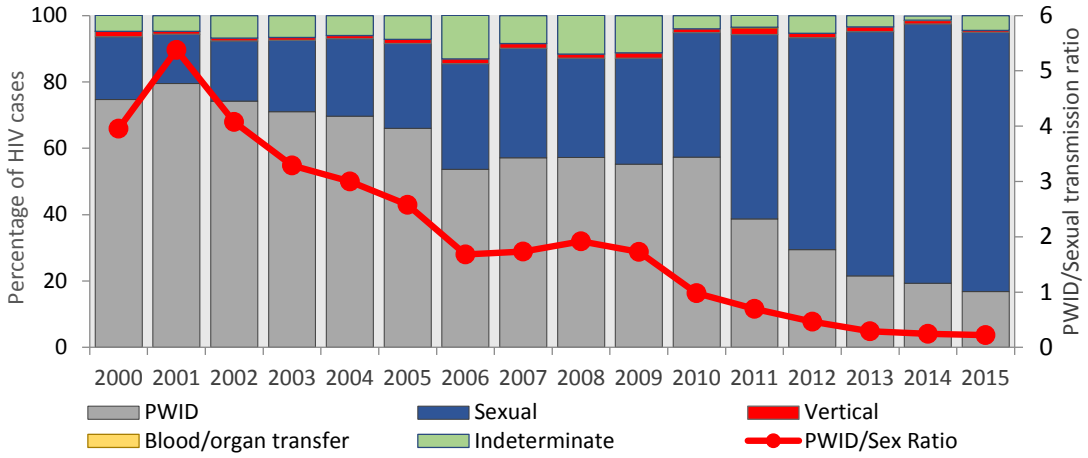


Figure 3. Snapshot of HIV epidemic in Malaysia 2015



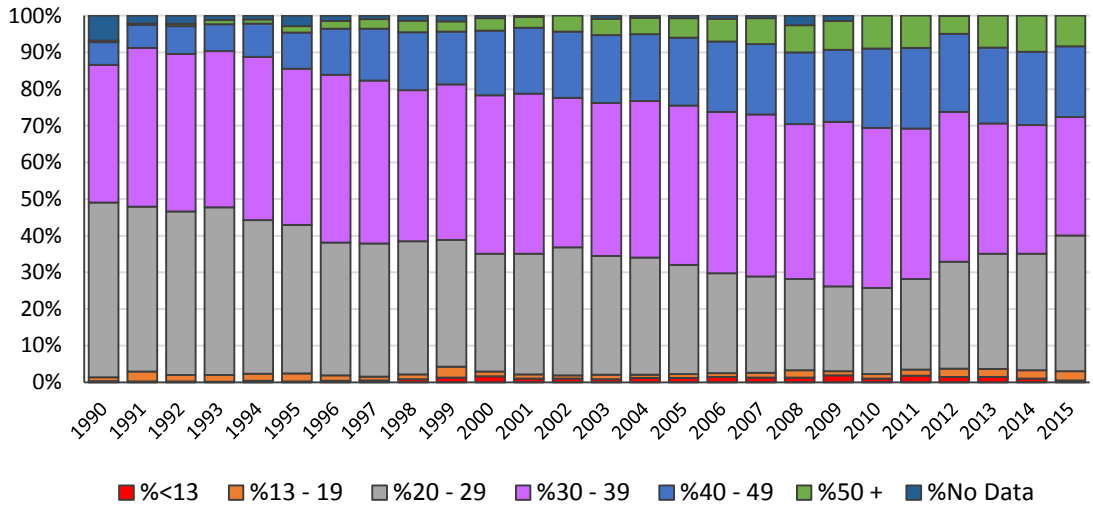
The country's epidemic was largely driven by PWID at the early phase, but this pattern has shifted to increasingly more sexual transmission with PWID/sexual transmission ratio declining from 4 in 2000 to 0.2 in 2015 (figure 4).

Figure 4. Changing trend of HIV transmission mode, Malaysia 2000-2015



The bulk of the infections (75%) comprise of young people aged 20 to 39 while children under 13 consistently remains approximately 1% of HIV infections from 1986 to December 2015 (figure 5).

Figure 5. Distribution of reported HIV by age group, Malaysia 2000-2015



CHAPTER 2 – GETTING TO ZERO: WHAT HAVE WE ACHIEVED?

Overview of indicators (UNGASS/WHO/MDG)

The following table shares the overview of Malaysia's reporting on Global AIDS response progress report (GARPR) core indicators, summarizing the progress made over the past two years.

Table 3. Overview of Global AIDS Response indicators

Indicators		2014	2015	Comments
HIV prevention among general population				
1.1	Percentage of young women & men aged 15–24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	40.8%	NA	Country wide survey in secondary school (unpublished)
1.2	Percentage of young women & men aged 15-24 who have had sexual intercourse before age of 15	NA	NA	
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with > 1 partner in the past 12 months	NA	NA	
1.4	Percentage of women and men aged 15-49 who had > 1 sexual partner in the past 12 months who used a condom during their last intercourse	NA	NA	
1.5	Percentage of PLHIV who know their status (including data from case-based reporting)	NA	97.5%	New indicator
1.6	HIV prevalence among women attending antenatal clinics in the general population	0.06%	0.05%	New indicator
1.20	Number of new HIV infections in the reporting period per 1000 uninfected population	NA	0.17	New indicator Spectrum 2016
Key populations				
2.1	(a) PWID (b) Female sex worker (c) Transgender (d) MSM	170,000 21,000 24,000 170,000		2002 (modelling) 2014 (Delphi) 2014 (Delphi) 2006 (national survey)
Sex workers				
2.2	Percentage of SW reporting use of a condom with their most recent client	84.5%	NA	IBBS 2014 (n=849)

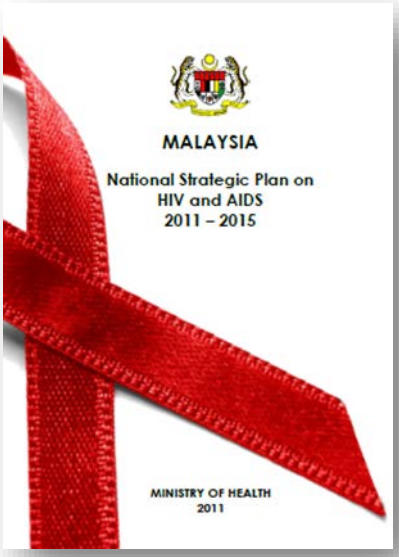
2.3	Percentage of SW who received an HIV test in the past 12 mo. and know their results	49.4%	NA	IBBS 2014 (n=849)
2.4	Percentage of SW who are living with HIV	7.3%	NA	IBBS 2014 (n=849)
Men who have sex with men (MSM)				
2.5	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	56.7%	NA	IBBS 2014 (n=531)
2.6	Percentage of MSM that received an HIV test in the past 12 mo. and know their results	40.9%	NA	IBBS 2014 (n=531)
2.7	Percentage of MSM who are living with HIV	8.9%	NA	IBBS 2014 (n=531)
People who inject drugs				
2.8	Number of needles and syringes distributed per person who inject drugs per year by NSEP	31	29	Based on estimated PWID
2.9	Percentage of PWID reporting the use of a condom the last time they had sexual intercourse	20.8%	NA	IBBS 2014 (n=1445)
2.10	Percentage of PWID reported using sterile injecting equipment the last time they injected	92.8%	NA	IBBS 2014 (n=1445)
2.11	Percentage of PWID that have received an HIV test in the past 12 mo. and knew their results	37.8%	NA	IBBS 2014 (n=1444)
2.12	Percentage of PWID living with HIV	16.3%	NA	IBBS 2014 (n=1445)
2.13	Percentage of PWID receiving OST	44%	50.4%	Based on population size estimate of PWID (170,000)
Prisoners				
2.14	Percentage of inmates/detainees who are living with HIV	0.45%	0.45%	New indicator
Transgender people				
2.15	Percentage of TG who are living with HIV	5.6%	NA	IBBS 2014 (n=1247)
Prevention of mother-to-child transmission (PMTCT)				
3.1	Percentage of HIV positive pregnant women who received ARV to reduce the risk of mother-to-child transmission	78.1%	81%	MOH antenatal surveillance data and spectrum (EPP)
3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	68.5%	62.9%	MOH antenatal surveillance data & estimations (EPP)
3.3	Estimated percentage of child HIV infections from HIV+ women delivering in the past 12 months	5%	4.8%	Spectrum 2016
3.3(a)	Registered percentage of child HIV infection from HIV+ women delivering in the past 12 months	1.3%	0.8%	PMTCT programmatic data

3.4	Percentage of pregnant women with known HIV status	100%	100%	PMTCT programmatic data
3.5	Percentage of pregnant women attending antenatal clinics whose male partners were tested for HIV during pregnancy	38%	31%	Survey in selected sites
3.7	Percentage of HIV-exposed infants who initiated HIV prophylaxis	99%	97%	PMTCT programmatic data
3.9	Percentage of HIV-exposed infants who started on CTX prophylaxis within 2 months of birth	99%	77%	PMTCT programmatic data
Treatment				
4.1	Percentage of adults and children currently receiving ARV among all adults and children living with HIV	21%	28%	M&E Data EPP 2015
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV	89%	95.3%	Cohort survey in selected sites
4.2(a)	Percentage of adults and children with HIV known to be on treatment 24 months after initiation of ARV in 2013	87%	92%	Cohort survey in selected sites
4.2(b)	Percentage of adults and children with HIV known to be on treatment 60 months after initiation of ARV in 2010	71%	73.2%	Cohort survey in selected sites
4.3	Percentage of people currently receiving HIV care	100%	100%	New indicator
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL in 2014 (late diagnosis)	53%	42.5%	Study at selected sites
4.6	Percentage of adults and children receiving ARV who were virally suppressed in the reporting period (2015)	81.7%	84.9%	New indicator
4.7	Total number who have died of AID-related illness in 2015	756	820	New indicator
AIDS Spending				
6.1	Domestic and international AIDS spending by categories and financing sources	**2014:** **Total: 195,704,813.03** Domestic Public: RM 184,902,731.22 (94%) Domestic Private: RM 1,835,679.81 (1%) International: RM 8,966,402.00 (5%)	**2015:** **Total: 202,137,204** Domestic Public: RM 192,907,428 (95%) Domestic Private: RM 1,190,763 (1%) International: RM 8,039,013 (4%)	

Stigma and discrimination				
8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards PLHIV[a] [a]*Number of respondents who respond 'No' to either of the two questions:* *1. Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?* *2. Do you think children living with HIV should be able to attend school with children who are HIV -ve?*	54.3%	NA	Community based survey 2015
HIV and other diseases				
Tuberculosis				
11.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	9.5%	NA	estimates
11.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	9.5%	9.0%	M&E Data
11.3	Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period	43%	71%	M&E Data
Hepatitis				
11.4	Proportions of person in HIV care who were tested for HBV	NA	21%	Surveillance Data
11.5	Proportion of HIV-HBV co-infected persons currently on combined treatment	NA	NA	
11.6	Proportion of people in HIV care who were tested for hepatitis C virus (HCV)	NA	21.8%	Surveillance Data
11.7	Proportion of people diagnosed with HIV/HCV coinfection started on treatment for HCV during a specified time frame (e.g. 12 months)	NA	NA	
Sexually transmitted infection				
11.8	Percentage of women accessing antenatal care services who were tested for syphilis at first visit	98.9%	99.8%	M&E Data
11.9	Percentage of antenatal care attendees who were positive for syphilis	0.06%	0.01%	M&E Data
11.10	Percentage of antenatal care attendees positive for syphilis who received treatment	100%	100%	M&E Data
11.11	Percentage of reported congenital syphilis cases (live births and stillbirth)	0%	0%	M&E Data
11.12	Percentage of men reporting urethral discharge in the past 12 months	0.01%	0.01%	M&E Data
11.13	Percentage of adults reported with genital ulcer disease in the past 12 months	0.001%	0.002%	M&E Data

2.2 The National Strategic Plan (NSP 2010 – 2015) – Country's responses

The implementation of NSP 2011-2015 has come to the end and is now replaced with the new National Strategic Plan for Ending AIDS 2016-2030. Targeted across all priority programmatic areas, the previous NSP (2011-2015) sought to prevent and reduce the risk and spread of HIV infection, improve quality of life of PLHIV, and reduce the social and economic impact resulting from HIV and AIDS on the individual, family and society. Many targets have been achieved in line with the MDG 6 as well as in the United Nation General Assembly Political Declaration on HIV/AIDS 2011, but there are still significant areas that need to be realigned and reformed in order to close the AIDS chapter in this country especially in the area of ARV coverage and prevention programmes to key populations. Summary of achievements based on five focus areas are as follow.



2.2.1 Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations

(a) Prevention of HIV transmission through sharing of needles and syringes

In October 2005, Malaysia implemented harm reduction programme for the first time through Opiate Substitution Therapy (OST), later in February 2006 Needle Syringe Exchange Programme (NSEP) follow suit. OST is provided at both government and private health facilities while NSEP is mainly provided at NGO outreach points. Significant progress was shown with increasing sites and clients over the last few years (figure 6-8). As of end 2015, both OST and NSEP reached at least 145,450 (85%) persons out of estimated 170,000 PWID. Integrated Bio-Behavioral Survey (IBBS) 2012-2014 revealed a significant decline of HIV prevalence among PWID (figure 9). The survey also found that more than 90% used clean needles at last injection (97.5% in 2012, 92.8% in 2014).

Figure 6. Cumulative number of registered clients on OST, Malaysia 2006-2015

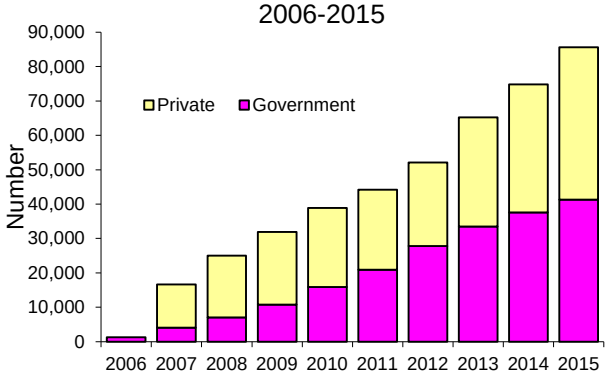
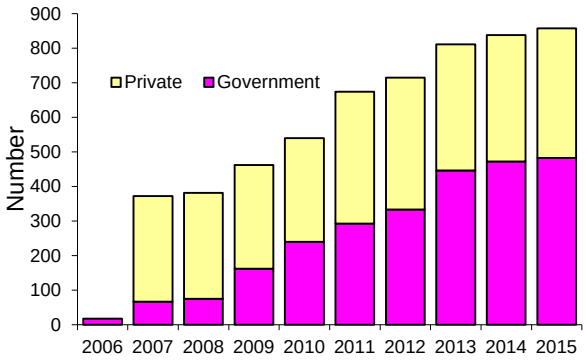


Figure 7. Cumulative number of OST facilities, Malaysia 2006-2015



Outreach worker providing clean needles and syringes along with education on HIV

Figure 8. Cumulative number of registered clients on NSEP, Malaysia 2006-2015

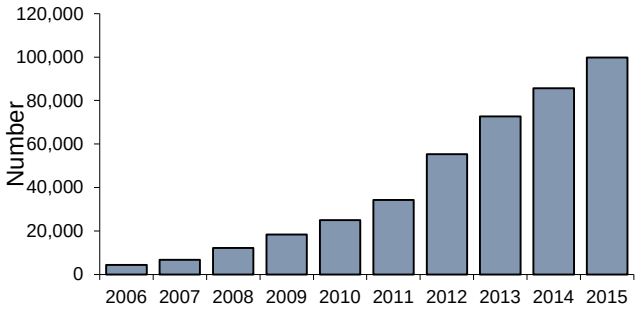
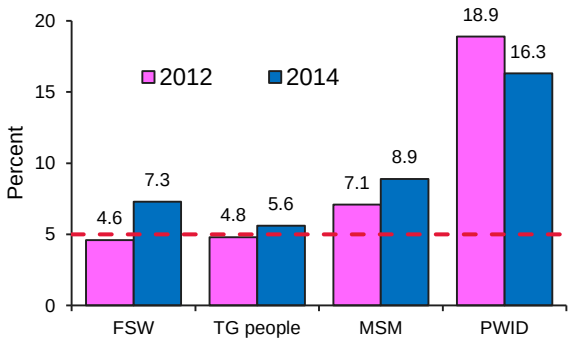


Figure 9. HIV prevalence among KP, IBBS 2012-2014



(b) Prevention of HIV transmission through unprotected sex – partnership with NGO

In 2015, notification of infection through PWID route significantly declined from 70-80% in 1990s to 16.8%, signaling a rise in sexual transmission among the key populations including FSW, MSM and TG. Realizing the changing pattern of transmission from PWID to sexual, the NGOs through the Malaysian AIDS Council with the support from the Ministry of Health and Global Fund scaled up the coverage of its targeted community-based interventions that include among others, STI prevention services, information, education and Behaviour Change Communication (BCC), referral to sexual reproductive health (SRH) services, outreach and peer education, encouraging HIV testing through voluntary testing and counselling.

Figure 10. Number of key populations reached by NGO, Malaysia 2012 - 2015

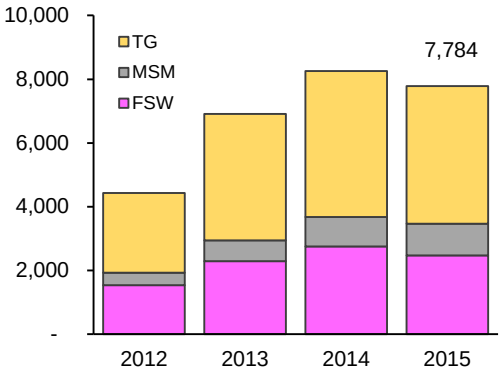
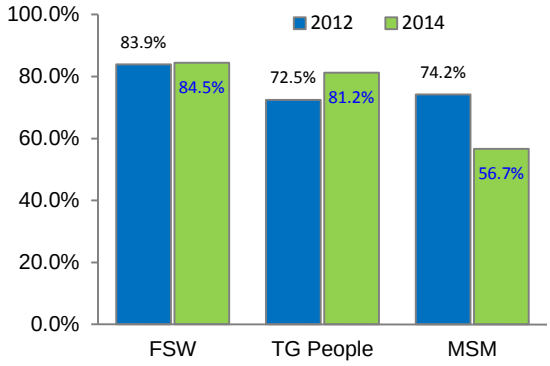


Figure 11. Condom use pattern at last sex among KP, IBBS 2012 - 2014



In 2015, based on programmatic data, a total of 7,784 clients had been reached among FSW, MSM and TG (figure 10). IBBS 2014 indicated only 13.4% - 39.0% of key populations had received condom with information related to HIV (table 4). This goes to tell that substantial proportion of KP have not been reached with prevention programme and quality prevention kit (condom and BCC) were inadequately disseminated.

Table 4. Pattern of prevention kit coverage among key populations, IBBS 2014

Prevention kit received in the last 12 months	FSW (n=849)	MSM (n=531)	TG (n=1096)
Received condom only	27.4%	18.6%	27.3%
Received condom and BCC	30.0%	13.4%	39.0%
Received BCC only	2.2%	4.5%	1.5%
Did not received prevention kit	40.3%	63.5%	32.3%

Overall, the safer sex practices have improved slightly among FSW and TG while among MSM, condom use behavior was not getting any better (figure 11). IBBS survey in 2012 and 2014 found overlapping risk among key populations with alarming trend in alcohol and psychotropic drugs used prior to having sex (figure 12 & 13). These overlapping risks certainly impede the proper use of condom during sexual intercourse.

Figure 12. Alcohol consumption before sex, IBBS 2012-2014

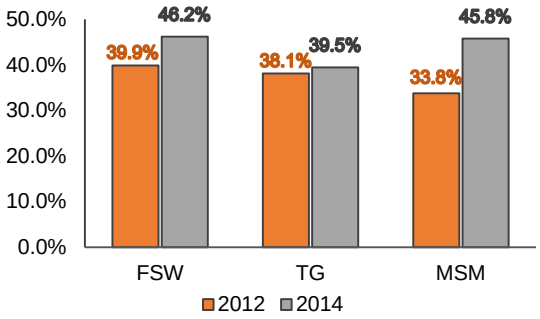
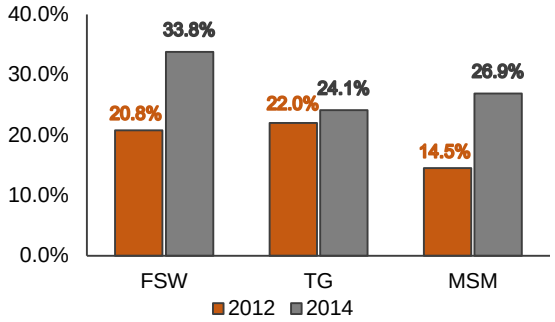


Figure 13. Psychotropic drugs use before sex, IBBS 2012-2014



(c) Prevention from mother to child transmission of HIV (PMTCT)

Following a pilot project in 1997, PMTCT programme became the country's key program where screening among antenatal mother was implemented country wide in 1998. Aiming at preventing vertical transmission, all HIV positive mothers were given free ARV and HIV-exposed infants given ARV prophylaxis. To further interrupt vertical transmission, HIV-exposed infants were also given free replacement feeding up to 2 years of age. Beginning 2011 the government adopted treatment option B+ for HIV infected mothers. The timeline of PMTCT implementation is depicted in figure 14.

For more than a decade, above 95% pregnant mothers in Malaysia were tested for HIV with seroconversion rate remained at average of 0.06% (figure 15). In 2015, about 99.4% (318) of HIV infected pregnant women had received ART to prevent MTCT and 96.9% (251) HIV-exposed infants delivered were given ART prophylaxis. As much as 95.8% infants delivered in 2015 had virological test done within 2 months of birth. Through vigorous activities outlined in the National Strategic Plan 2010-2015, the vertical transmission rate has fallen below 2% since 2011 and achieved the lowest rate at 0.77%

in 2015 (figure 16). The country is in high hope to achieve formal certification of elimination of vertical transmission of HIV by 2018.

Figure 14. Timeline of PMTCT programme, Malaysia 1998-2015

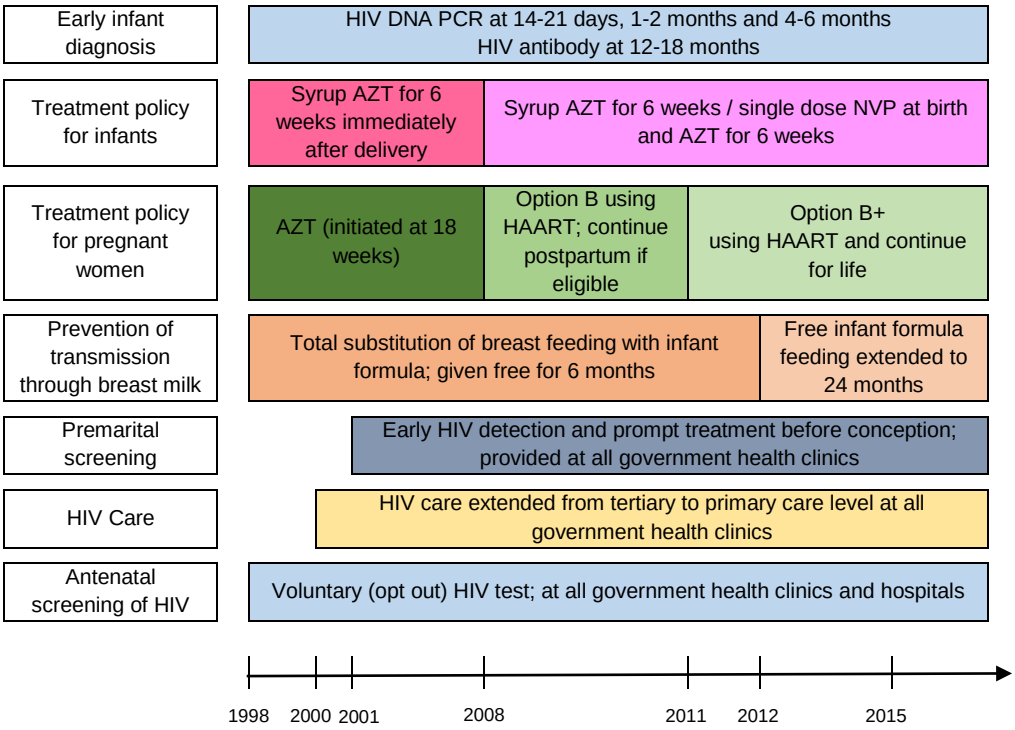


Figure 15. Antenatal HIV screening, Malaysia 1998-2015

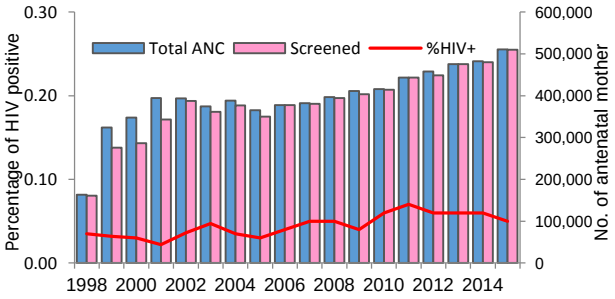
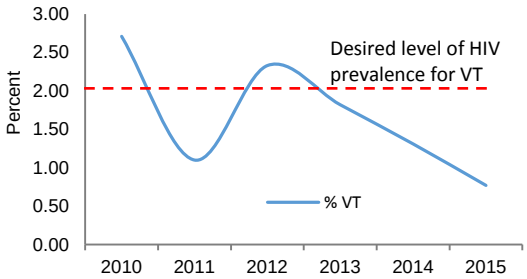


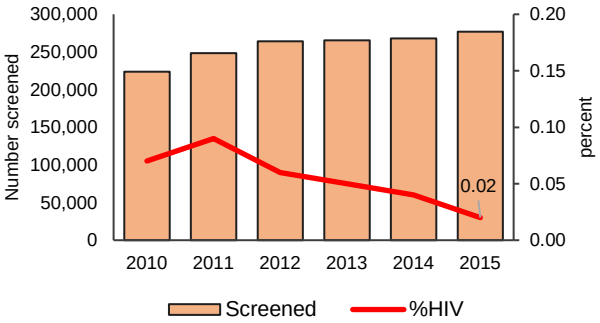
Figure 16. Vertical transmission, Malaysia 2010-2015



To promote primary prevention of HIV, pre-marital HIV screening was initially introduced by the Islamic Council in 2001, started with Johor later expanded to other states country-wide but the program was limited for Muslim couples only. In 2009, this program was made

available in Health Clinics for all regardless of faith. This programme also aim at advocating awareness among mother-to-be and spouses-to-be so that HIV treatment could be initiated at early marriage life before conception; thus better outcome to infants. Over the years, increasing numbers were being screened and the seroconversion rate has been declining (figure 17).

Figure 17. HIV seroconversion rate from pre-marital screening, Malaysia 2010 - 2015



2.2.2 Improving the quality and coverage of testing and treatment

Malaysia has made a significant progress in expanding the availability and accessibility of antiretroviral (ARV) in the country beginning with free monotherapy in 2001. A year later, in 2002, the government adopted a HAART policy with following strategy[1].

(a) Provide free HAART to patients with CD4 count <400
(b) Bring prices of HIV drugs down through negotiations with patent holder
(c) Encourage local production of HIV drugs that are not patented in Malaysia
(d) Consider the use of 'Rights of Government' under the Patents Act 1983 (i.e. the 'Government Use' option)

Through the initiative of Ministry of Health, Malaysia became the first country to issue compulsory license in 2003.

As of December 2015, about 25,700 (28%) PLHIV had received ARV (figure 18 and 19). To scale up access to HIV screening and treatment, HIV care has been integrated in health services provided at Primary Care, along with the desire to make health care accessible, acceptable and affordable to the whole community, especially the KPs. As of December 2015, about 90% (225) of Family Medicine Specialist country wide have been trained in

[1] Chee Yoke Lin. Malaysia's Experience in Increasing Access to Antiretroviral Drugs: Exercising the 'Government Use' Option. TWN. Intellectual Property Right Series.

HIV care and 50 mobile CD4 point of care test have been placed in primary care clinics; all geared towards improving health and outcome of PLHIV.

Figure 18. Antiretroviral coverage, Malaysia 2004-2015

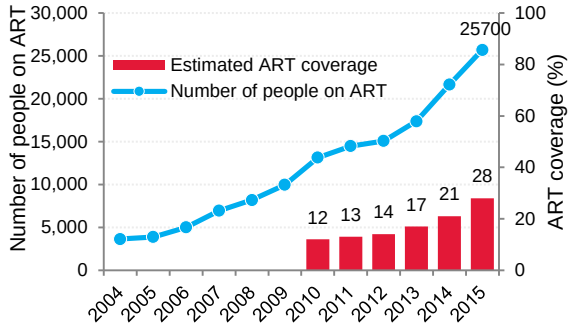
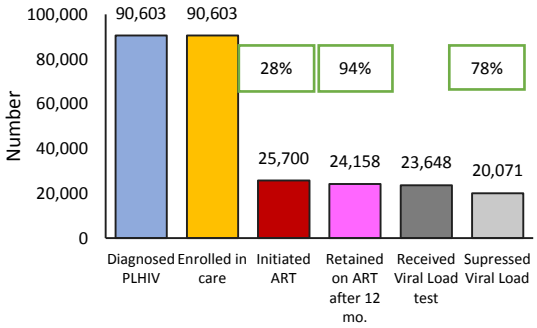


Figure 19. Cumulative cross-sectional cascade for HIV treatment and care, Malaysia 2015



To compliment and support ART delivery, retention in care and adherence to treatment, the government in partnership with the Malaysian AIDS Council, introduced the Treatment Adherence Peer Support Programme (TAPS), a critical enabler in ensuring treatment literacy, adherence and outcome among KPs. In 2015, TAPS reached out to a total 5,397 clients living with HIV in 32 treatment centers through 12 Partner Organizations.

In effort to scale up HIV test and treatment, VCT services was made part of health services provided at no cost in 1,039 government health clinics and 141 government hospitals. The uptake of VCT services escalated more than 3-fold from 2011; whilst the HIV seroconversion declined steadily to the lowest at 0.19% in 2015 (figure 20).

The government through NGO advocates regular HIV screening for key populations, but the uptake of this service in the last 12 months had remained under 50% (IBBS) (figure 21). Thus, to increase HIV test uptake among key populations, STI Friendly Clinics initiated in 2015 marked another important milestone in enhancing the national response to the rise of sexual transmission of HIV. Provided at government clinics, this service aims to increase uptake and regular HIV and STI screenings amongst the key populations.

Figure 20. HIV seroconversion rate from government VCT centres, Malaysia 2011 - 2015

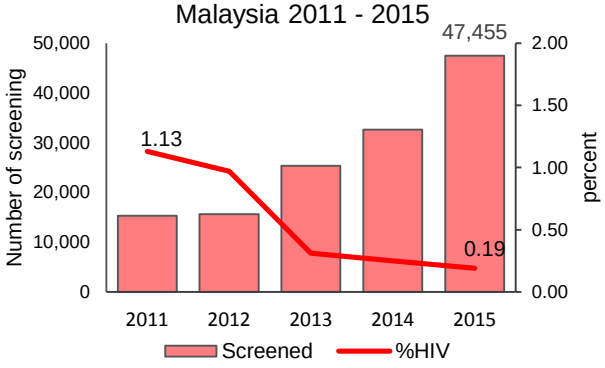


Figure 21. Key populations who had HIV test in the last 12 months and know result, IBBS 2012 - 2014

2.2.3 Upscaling access to care, support and social impact mitigation programmes for People Living with HIV and those affected

Over the past five years, Malaysia observed impactful collaborative efforts with religious bodies and other relevant government agencies, especially on issues related to welfare, care and support for Muslim PLHIV. Substantial number of Muslim religious leaders were exposed to HIV awareness through 'HIV and Islam' training based on Islamic teaching initiated by Department of Islamic Development (JAKIM) annually since 2011. As of December 2015, more than 5,000 (39%) Islamic Affair Officers, Imam, *Takmir* teachers, Holders of Islamic teaching credentials (mosque, *surau* and *madrasah*) and leaders of Muslim community were trained country-wide.

The success in educating Muslim religious leader has ignited the spirit to provide service beyond HIV awareness. Shelter homes for Muslim key populations are being established with funding from State Islamic Councils in Terengganu, Selangor and Melaka. In addition to providing care and support through shelter homes, religious leaders have started outreach work to key populations and provide behaviour change communication based on the example of the Prophet Muhammad (pbuh) as well as spiritual support. In Selangor, the Islamic Council (MAIS) has included LGBT and sex workers as recipient of tithe (*zakat*) since 2011.

Mukhayyam is a special program aimed at creating awareness on principles of Islamic teaching, self enhancement apart from HIV awareness. Targeting key populations, enrolment to this program is voluntarily. Many who attended this program have reported change in behaviour to less risky or risk free but there has been no data to support this claim.

In terms of care and support services, since its implementation in the 2000s, TAPS has proven its impact by tremendously increasing the number of PLHIV engaged at all levels

of the HIV care continuum. Between 2012 and 2015, TAPS reached out to a total 12,940 clients living with HIV in 32 treatment centers through 12 Partner Organizations. Funds are allocated by the MOH on an annual basis for community-based organizations through the Malaysian AIDS Council for successful implementation of TAPS.

Increasing treatment adherence, improving health condition, facilitating employment and eventual reintegration of PLHIV into society are amongst the key strategies deployed by HIV Continuum of Care Homes operated by the partner organisations of the Malaysian AIDS Council. Between year 2012 and 2015, the partner organisations operated 11 homes serving a total of 1,208 residents. A total 701 of these residents were PLHIV, out of whom 506 (72%) were on ARV.

These homes were predominantly funded by the Government (Ministry of Women, Family and Community Development) and complemented through grants from other sources. Services provided by these homes included basic nursing care, palliative care, medical referrals, bereavement counselling, and psychosocial and spiritual support services.

In its attempt to build self-esteem and role models among the residents, these shelter homes also offer opportunities for various life skills classes to assist as many residents as possible in developing skills needs to establish independent living patterns, secure meaningful employment and function successfully in society. More importantly, these shelters enabled children and adolescents to stay in school, and assisted their transition to tertiary education ensuring self-sufficiency in the future. These shelters successfully conducted 332 training, 410 stakeholder meeting, 524 counselling and 1643 support sessions.

2.2.4 Maintaining and improving an enabling environment for HIV prevention, treatment, care and support

It is essential to create HIV awareness and understanding that subsequently reduce risk taking as well as stigma and discrimination. Prevention and treatment programmes are more effective when operated in an enabling environment which does not stigmatise and discriminate against those most at risk and those affected.

HIV remains as an important concern in the country's development plan in which health awareness on HIV prevention will continue to be promoted with the cooperation of Ministry of Health and NGOs. The participation of NGOs / CBOs in planning and decision-making process has improved greatly over couple of years. Civil society is being represented at the National Coordinating Committee on AIDS Intervention (NCCAI) and the Country Coordinating Mechanism (CCM). In the former, 32% of the committee members (8 out of 25) are represented by civil society representatives (youth, women, MSM, PWID, sex workers, PLHIV and transgender).

To support enabling environment at work place, Code of Practice on Prevention and Management of HIV/AIDS at the Workplace was produced by Ministry of Human Resource as a guideline to employer and employee in managing issues pertaining to HIV at the workplace.

2.2.5 Improving the quality of strategic information through monitoring, evaluation and research

Malaysia surveillance system on HIV started in 1986. The surveillance system has evolved from manual-based notification to electronic notification (e-notis) in 2001 and finally a web-based National AIDS Registry established in 2009. Based on case reporting, over time the quality of information collected had improved tremendously. With implementation of point of care test for CD4 at primary care, this system has been recently upgraded to include expanded case information on ART, co-infections and lab results. The responsibility of HIV surveillance is with the HIV/STI Sector of the Ministry of Health.

With the establishment of national Monitoring and Evaluation (M&E) unit within HIV/STI Sector of Ministry of Health, HIV programmes monitoring is more systematic and comprehensive that include monitoring of programmes from private sectors and NGO. The analysis and use of M&E data has enabled for justification and institutional support from the Cabinet Committee on AIDS for the scaling up of interventions.

CHAPTER 3 – VULNERABLE AND AT RISK POPULATION

3.1 Key Populations

HIV epidemic in Malaysia is concentrated among the key populations - PWID, FSW, MSM and TG. IBBS is conducted at regular interval among these key populations mainly to track the behavioural and HIV prevalence trend. Summary of IBBS results are in table 5. The population size estimate for these key populations are summarized in table 6.

Table 5. Behavioral trend among key population, 2009-2014

Injecting Drug Users	**2009 (n=630)**	**2012 (n=1906)**	**2014 (n=1445)**
HIV prevalence	22.1%	18.9%	16.3%
Duration of injecting (median year)	NA	10	15
Median number of injection/day	NA	3	2
Used sterile needle during last injection	83.5%	97.5%	92.8%
Received Needles/Syringes in the past 12 months	NA	77.8%	75.3%
Condom use with most recent partner	19 - 58%	26.7%	28.0%
Visited FSW in the last 12 months	NA	8.9%	10.4%
Had been diagnosed with STI in the past 12 months	NA	NA	0.4%
Knowledge on modes of transmission	49.7%	53.8%	58.3%
Tested in the past 12 months and knew results	60.8%	64.5%	37.8%
Reached with prevention programme[2]	NA	68.9%	64.8%
Received ARV	NA	NA	5.0%
Had enrolled in MMT programme	NA	NA	34.5%

Female sex workers	**2009 (n=551)**	**2012 (n=864)**	**2014 (n=839)**
HIV prevalence	10.5%	4.2%	7.3%
Duration of sex work (median year)	NA	6	7
Number of day work/week	NA	5	5
Number of client in the past 1 week	NA	6	7
Condom use with most recent client	60.9%	83.9%	84.5%
Received condom in the last 12 months	NA	50.3%	57.5%
Used psychotropic drugs before sex	38.5%	20.8%	33.8%
Consumed alcohol before sex	35.9%	39.9%	46.2%
Injected drugs in the last 12 months	5.6%	4.2%	7.2%
Had been diagnosed with STI in the past 12 months	NA	NA	6.5%
Knowledge on modes of transmission	38.5%	35.4%	39%
Tested in the past 12 months and knew results	46.1%	32.4%	49.4%
Reached with prevention programme[3]	NA	44.9%	49.9%
Received ART	NA	NA	1.8%

[2] Reached with intervention programme' refers to PWID who received free N/S in the last 12 months and know where to go for HIV test
[3] Reached with intervention programme' refers to FSW who received free condom in the last 12 months and know where to go for HIV test

Men who have sex with men (MSM)	2009[a] (n=529)	2012 (n=365)	2014 (n=531)
HIV prevalence	3.9%	7.1%	8.9%
Duration of risk behavior (median year)	NA	7	7
Ever being paid for anal sex in the last 12 months	NA	19.5%	39.4%
Condom use with most recent partner	55-63%	74.2%	56.7%
Received condom in the last 12 months	NA	52.9%	39.2%
Injected drugs in the last 12 months	6%	3.6%	2.8%
Used psychotropic drugs before sex	23.8%	14.5%	26.9%
Consumed alcohol before sex	23.2%	33.8%	45.8%
Had been diagnosed with STI in the past 12 months	NA	NA	8.1%
Knowledge on modes of HIV transmission	NA	44.5%	47.8%
Tested in the past 12 months and knew results	41%	47.1%	40.9%
Reached with intervention programmes[4]	NA	43.8%	30.7%
Received ART	NA	NA	1.9%

[a] In 2009, the method used was venue-based time sampling

Transgender (TG)	2009 (n=540)	2012 (n=870)	2014 (n=1247)
HIV prevalence	9.3%	4.8%	5.6%
Duration of risk behavior (median year)	NA	7	11
Had received money for sex with man	83.7%	83.8%	86.6%
Condom use with most recent client	67 - 95%	72.5%	81.2%
Received condom in the last 12 months	NA	74.4%	74.8%
Injected drugs in the last 12 months	3.1%	2.1%	1.0%
Used psychotropic drugs before sex	32.8%	22.0%	24.1%
Consumed alcohol before sex	35.9%	38.1%	39.5%
Knowledge on mode of HIV transmission	37.2%	40.6%	38.1%
Tested in the past 12 months and knew results	48.6%	35.5%	46.7%
Reached with intervention programmes[5]	43.7%	64.3%	64.1%
Received ART	NA	NA	3%

Table 6. Population size estimates for key population

Key Population	Population estimate	Year of estimate; method
PWID	170,000	2002, multiplier
FSW	21,000	2014, Delphi
TGSW	24,000	2014, Delphi
MSM	170,000	2006, National survey

[4] 'Reached with intervention programme' refers to MSM who received free condom in the last 12 months and know where to go for HIV test

[5] 'Reached with intervention programme' refers to TG who received free condom in the last 12 months and know where to go for HIV test

3.2 Young key populations

Young populations are vulnerable to HIV exposure and transmission due to several factors - mobility, living situation (young people who live on the street), exploitation (young people who are sexually exploited and/or trafficked) and abuse. As defined by UNAIDS[6], young populations at higher risk of HIV exposure is anyone between the ages of 10 and 24 years who is most likely to be exposed to HIV or to transmit it.

In general, parental consent is strictly required for minors (below 18) to get HIV test, hence available survey data is limited to above 18 only. From the last round of IBBS (2014), it was found that close to half MSM (47.8%) were among young people aged 18 – 24 years while the PWID were mostly older adult aged 25 years and above (table 7). Summary on other key populations and safe practices is reflected in table 7.

The National Surveillance data captured all reported HIV cases regardless of age. As depicted in table 8, the proportion of reported PWID who are below 25 has been stable at 3% (table 8); whilst those acquired infection through heterosexual contact who are below 25 were declining. Unlike previous two risk behaviours, cases acquired infection through homosexual / bisexual contact who are below 25 seemed increasing.

Table 7. Summary of key populations by age group, IBBS 2014

Key populations	<25 years	25+ years	Total
PWID	44 (3%)	1401 (97%)	1,445
- use clean N/S during last injection	42 (95.5%)	1,299 (92.7%)	1,341
FSW	192 (22.6%)	657 (77.4%)	849
- Use condom with last client	150 (78.1%)	567 (86.3%)	717
MSM	254 (47.8%)	277 (52.2%)	531
- Use condom with last client	144 (56.7%)	157 (56.7%)	301
TG	362 (29%)	885 (71%)	1,247
- Use condom with last client	279 (77.1%)	733 (82.8%)	1,012

Table 8. Distribution of reported HIV infection by key population disaggregated by age

Risk Behaviour	Age	2012	2013	2014	2015
PWID	<25	40 (4%)	25 (3%)	18 (3%)	15 (3%)
	25+	974 (96%)	703 (97%)	662 (97%)	546 (97%)
Heterosexual	<25	215 (14%)	252 (14%)	212 (12%)	170 (12%)
	25+	1,323 (86%)	1,491 (86%)	1,556 (88%)	1,228 (88%)
Homosexual/ Bisexual	<25	164 (25%)	203 (27%)	278 (28%)	350 (29%)
	25+	490 (75%)	552 (73%)	706 (72%)	853 (71%)

[6] UNAIDS. (2011) UNAIDS Terminology Guidelines. Geneva, Switzerland. Accessed at: http://www.UNAIDS.org.

CHAPTER 4 – CO-INFECTIONS

4.1 TB and HIV

Tuberculosis (TB) is the most common opportunistic infection in PLHIV worldwide. The risk of developing TB is estimated to be between 26 and 31 times greater in PLHIV than among those without HIV infection[7]. As part of disease control and prevention measures, HIV test for TB (and STI) patients is offered by health provider since 1997, whilst TB screening among PLHIV begun in closed settings in 2003. In 2010, isoniazid prophylaxis was started to reduce morbidity and mortality of TB/HIV co-infection. Opposite to HIV trend, TB cases in Malaysia is increasing annually, whilst TB/HIV prevalence is scaling down from peak of 10.3% in 2008 to 5.9% in 2015.

Figure 22. New TB, HIV and prevalence of TB/HIV, Malaysia 2000-2015

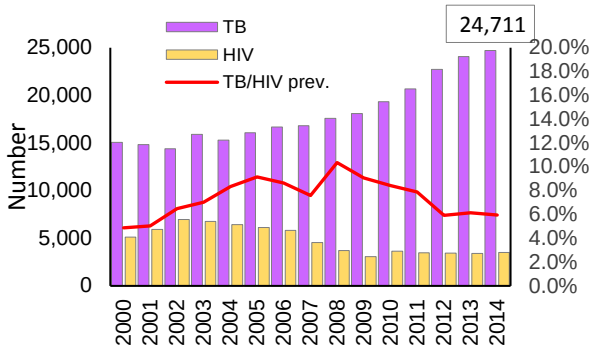
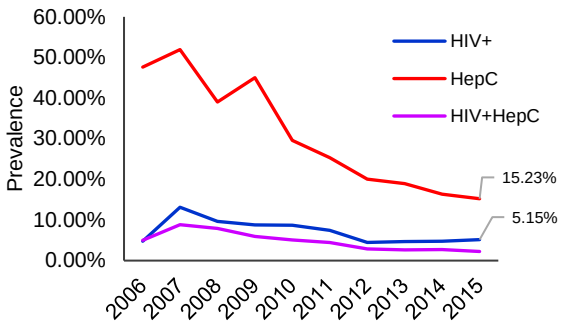


Figure 23. Hepatitis C, Hepatitis B and HIV prevalence among MMT users in government clinics, Malaysia 2006-2015



4.2 Hepatitis C, TB and HIV infections among PWID

Screening of HIV, Hepatitis C and TB were routine requirement for new enrolment of MMT client in government clinics since the inception of Harm Reduction programme in 2006. Programmatic data indicates that Hepatitis C prevalence was highest in 2007 (51.9%), but this rate had since declined to reach 15.2% in 2015. HIV infection was also declining. This trend correlates well with changes in injecting practices among PWID ever since clean needles and syringes were accessible beginning 2006.

[7] http://www.who.int/hiv/topics/tb/en/

CHAPTER 5 - FINANCING THE HIV AND AIDS RESPONSES

Since the beginning of the epidemic, HIV responses in the country rely heavily on domestic purse (95%). In 2015, the total expenditure was RM202.1 million (USD50.5 million), an increase of 4% compared to the previous year and majority came from domestic fund (96%) (table 9). Majority of AIDS expenditure was spent on target 4 (65%) as the government aims to up-scale the ART coverage (table 10).

Table 9. Source of approximate AIDS expenditure 2014-2015

Source of Funding	2014 (RM)	%	2015 (RM)	%
Domestic Public	184,902,731	94	192,907,428	95
Domestic Private	1,835,680	1	1,190,763	1
International	8,966,402	5	8,039,013	4
Total	**195,704,813.03**	**100**	**202,137,204**	**100**

Figure 24: Total AIDS Spending by year, Malaysia 2012 - 2015

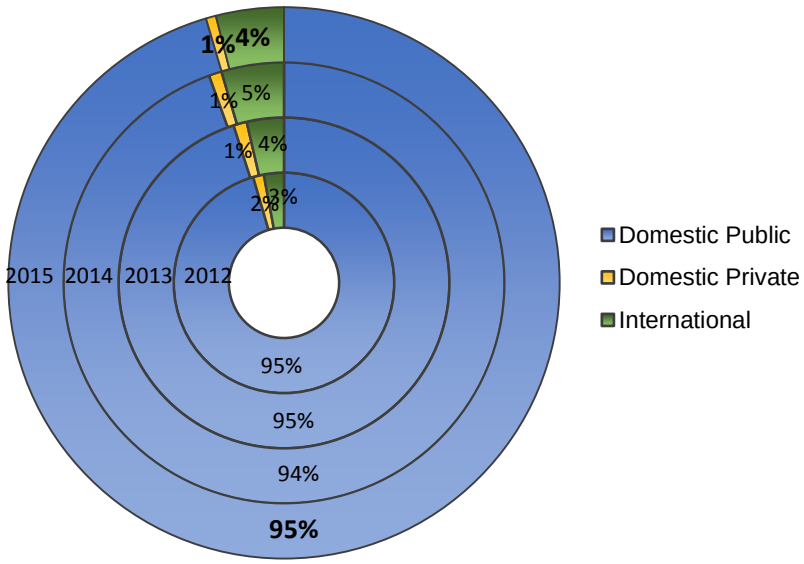


Table 10. AIDS Spending Category – Approximate total expenditure from Domestic (Public and Private) and International Sources

TEN TARGETS / categories		2014 (RM)	%	2015 (RM)	%
1	Reduce sexual transmission of HIV by 50% by 2015	10,344,385	5.3	5,983,860	3.0
2	Reduce transmission of HIV among PWID by 50% by 2015	30,783,416	15.8	25,116,171	12.4
3	Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal death	12,691,311	6.5	1,218,850	0.6
4	Reach 15 million PLHIV with lifesaving antiretroviral treatment by 2015	128,336,731	65.7	140,336,686	69.4
5	Reduce TB deaths in PLHIV by 50% by 2015			238,866	0.1
6	Close the global AIDS resource gap by 2015 and reach annual global investment of USD22-24 billion in low- and middle-income countries	5,638,025	2.9	25,498,074	12.5
8	Eliminate stigma and discrimination against PLHIV through promotion of laws and policies that ensure full realization of all human rights and fundamental freedoms	1,027,783	0.5	702,962	0.3
9	Eliminate HIV-related restrictions on entry, stay and residence				
7	Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV	6,191,803	3.2	388,450	0.2
10	Eliminate parallel system for HIV-related services to strengthen integration of AIDS response in global health and development efforts, as well as to strengthen social protection systems				
	Addendum items / Non-core / others	384,643	0.2	2,653,285	1.3
	TOTAL	**195,398,097**	**100**	**202,137,204**	**100**

Partnership through Government and Non-Government (GONGO) collaboration

The Malaysian AIDS Council, in its pivotal role as a central point for coordination, develops and promotes strategic partnerships amongst its partner organisations, government, public sector and corporate bodies to expand and improve treatment, care and support services for the key populations in Malaysia.

For more than 20 years, MAC has been working with various policymakers, service providers, and government institutions to implement enabling measure for the prevention, treatment, care and support of those living with and affected by the HIV and AIDS epidemic. MAC works closely with political leaders to establish and maintain public policies and structural environments that recognize human dignity and respects gender preferences, while ultimately seeking to help reduce stigma and discrimination against people living with AIDS.

Through these years, the MOH initiated Government – Non Government Organization (GONGO) partnership has demonstrated tremendous collaborative efforts in collectively mapping the way forward. The GONGO partnership places great emphasis on strengthening ties with non-governmental organizations, mobilizing the community members and actors in joining forces and building their capacity for a more sustainable and effective response to the epidemic.

While most part of the Asia Pacific is threatened by sustainable funding for its HIV and AIDS programmes, Malaysia has witnessed successes in reduction of new infections and AIDS-related deaths and increase in treatment coverage and support, mainly due to MOH's prioritization of the key populations (KPs) in its national response to HIV and AIDS. The MOH through annual funding has allotted more than 85 million (USD27 million) since year 2003 for implementation of prevention and treatment, care and support programmes amongst the KPs in the country. This fund is disbursed through MAC to more partner organizations to implement high-impact prevention programmes that include:

- Needle & Syringe Exchange Programme (NSEP)
- Methadone Maintenance Therapy (MMT)
- Prevention and treatment of HIV and other sexually transmitted infections amongst sex workers, transgender and men who have sex with men population
- Treatment Adherence Peer Support Programme

CHAPTER 6 - STIGMA AND DISCRIMINATION

HIV/AIDS stigma exists around the world in a variety of forms, including ostracism, rejection, discrimination and avoidance of HIV infected people etc. In 2014, Stigma Index assessment was incorporated in IBBS study. The study observed notably high level of internalized stigma among KPs in Malaysia; most prominent among PWID. Overall, about half KPs felt ashamed (56%), felt guilty (47.3%) and blamed own self (47%) because of their behaviour and appearance and quite a substantial proportion had low self-esteem (38.7%) and felt they should be punished (20.4%) (Figure 15).

Figure 25. Internal stigma among key populations, Malaysia 2014

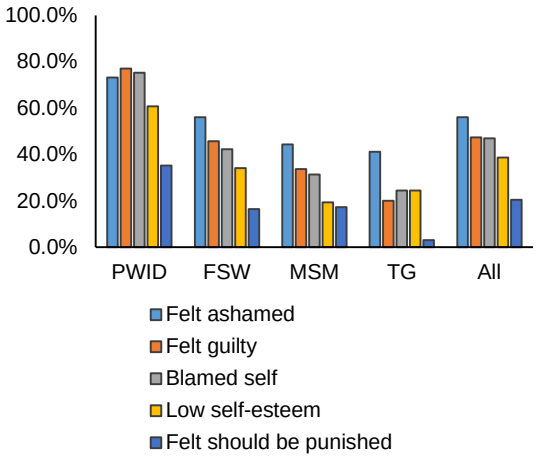
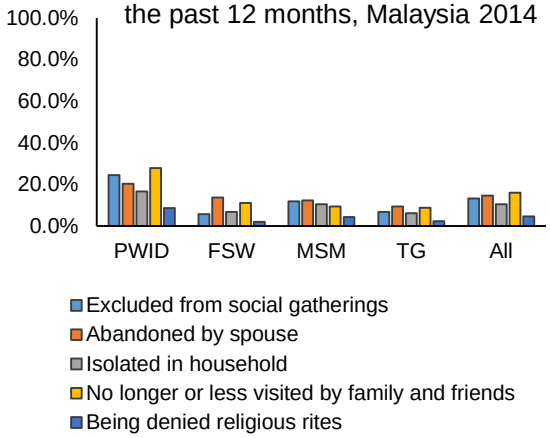


Figure 26. Exclusion from family, religious and community activities experienced by key populations in the past 12 months, Malaysia 2014



On contrary to internal stigma, majority of KPs did not significantly experienced stigma and discrimination in familial and community interactions as illustrated by low percentages (2% to 27%) reported being excluded from social gathering, or being abandoned by spouse, or being isolated in household, or being no longer visited or less visited by family and friends, or being denied by religious rites or services (Figure 16).

Majority of KPs in Malaysia claimed they were subject to gossip (50.2%) or the target of verbal insult (38.4%) more than physical assault (10.6%) or threatened with violence (11.6%) (Figure 17). The Stigma Index also revealed that KPs in Malaysia did not prominently have trouble in their workplace and have issues in securing property (Figure 18). About 29% of PWID reported had lost a job or customer, while other KPs had no problems on maintaining jobs or customers, regardless of their behaviour and appearance.

Figure 27. Physical and verbal harassments experienced by key populations in the past 12 months, Malaysia 2014

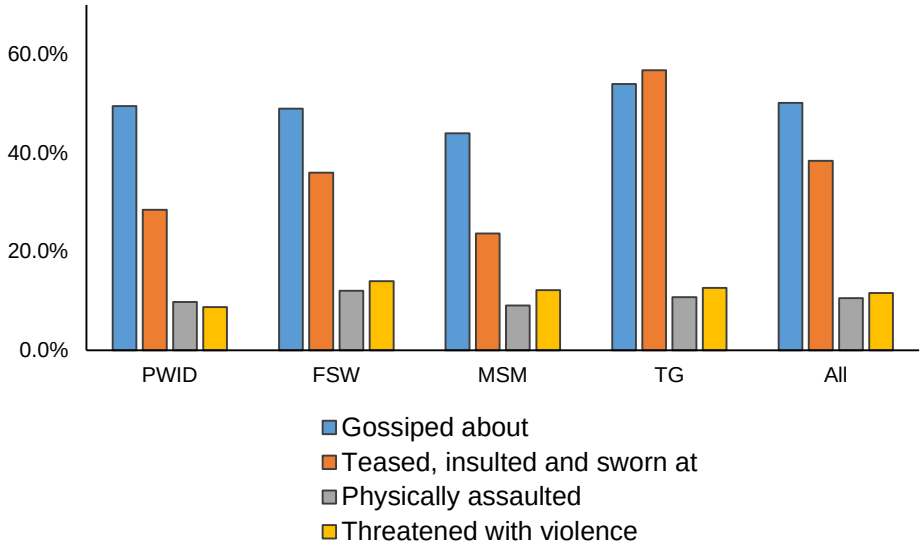
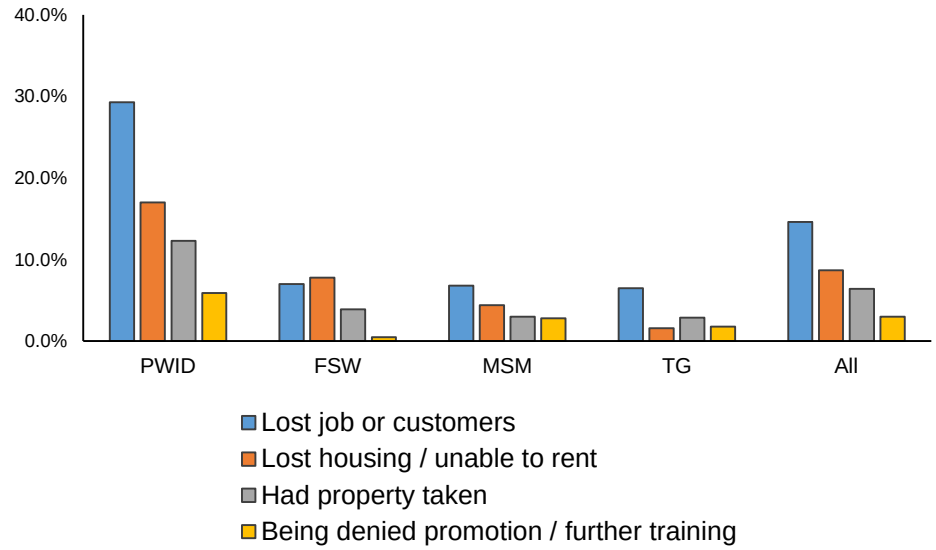


Figure 28. Stigma and discrimination among key populations in the past 12 months, Malaysia 2014



CHAPTER 7 – THE WAY FORWARD

Malaysia had achieved the MDG 6 target on HIV – reduction of new HIV cases by 50%. But there is still a huge gap in HIV treatment, care and prevention coverage for some key populations. These gaps and challenges continued as focus areas in the new strategic plan to end AIDS by 2030. Among the challenges are:

a) Expansion of HIV screening services beyond the traditional health care system.

b) Accelerating treatment. The country need to find innovative and practical ways to close the treatment gap through introduction of 'Treat ALL' policy.

c) Mitigate sexual transmission of HIV among key populations. Study has revealed that persistent condom use is still a big problem among key populations especially among MSM. Increase in substance and alcohol use prior to sex have added more risk of transmission; thus must be addressed.

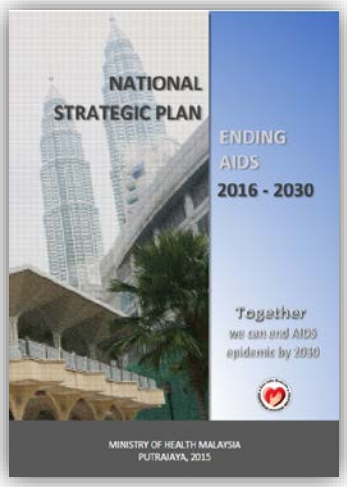
d) There is still a large gap in TB/HIV care. Low early TB screening and awareness is observed to lead to late TB diagnosis resulting in high mortality among PLHIV due to TB.

The National Strategic Plan for Ending AIDS (NSPEA) 2016-2030

Launched by the Honorable Deputy Health Minister in December 2015 in conjunction with World AIDS Day, this blueprint outlined key strategies to end AIDS in Malaysia. Developed through a diverse consultative process, the New National Strategic Plan for 2016-2030 adopts the "Ending AIDS" as the vision for Malaysia getting to the "Three Zeros: Zero new infections, Zero discrimination and Zero AIDS related deaths".

In the NSPEA Malaysia commits to Fast Tracking the HIV and AIDS response. The first fast tracking phase of the NSPEA, during 2016-2020, aims to reach the 90-90-90 targets:

- 90% of key populations tested for HIV and knowing their results
- 90% of people infected with HIV placed on ART, and
- 90% of these adhering to treatment with suppressed viral load. The fast tracking phase also aims to reach 80% of key populations with effective prevention.



Malaysia commits to "Ending AIDS" by 2030 through achieving the 95-95-95 target: 95% of key populations tested for HIV and knowing their results, 95% of people infected with HIV placed

on ART, and 95% of these adhering to treatment with suppressed viral load. The commitment includes reaching 90% of the key populations with effective prevention.

NSPEA 2016-2030 in the making, 2015

The launching of NSPEA 2016-2030 by the Deputy Minister of Health during World AIDS Day celebration in Penang, December 2015

HIV/STI Sector
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Ministry of Health Malaysia
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