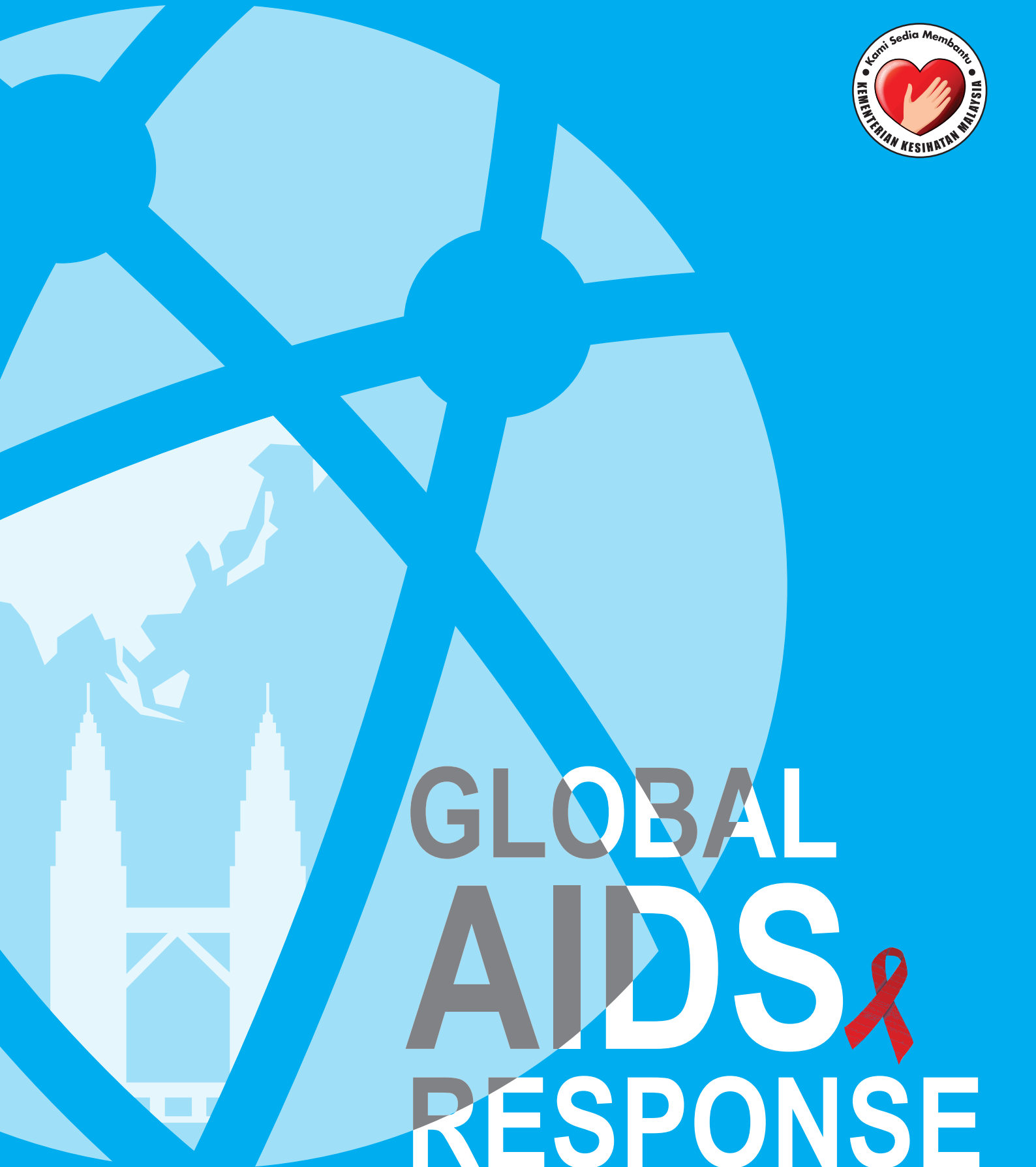

GLOBAL AIDS RESPONSE PROGRESS

REPORT MALAYSIA 2015

MALAYSIA 2015

COUNTRY RESPONSES TO HIV/AIDS

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The Global AIDS Response Progress Report 2015

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Foreword

The nation has come a long way since the early days of HIV and AIDS epidemic in the country. Significant progress has been made at each step of the HIV treatment cascade, starting from HIV testing, through enrolment and retention in care, right up to achievement of viral load suppression in the past 15 years. We need to look no further than the most recent progress we have made in the HIV response to attest to this. Malaysia successfully realized its MDG6 target aimed at reducing, by half, the rate of new HIV infections by 2015.

Determined leadership with strong commitment and optimism among the key players – government, non-governmental organizations and civil societies backed by commendable political will allowed Malaysia to demonstrate a remarkable reduction in new HIV infection rate from 22 cases for every 100,000 populations in 2000 to 11.7 cases for every 100,000 populations in 2014.

Today there are 46% fewer new HIV infection than there were 15 years ago. Today there are 54% fewer new HIV infection among children below 13 years than there were 15 years ago. We are confident we can get to zero new HIV infections among children soon. Reaching MDG6 is not the end but a beginning of a meaningful journey to end AIDS. We will not be complacent but continue to thrive towards reversing and ending the epidemic despite the milestones achieved.

This report is testament to the growing body of evidence demonstrating that ending AIDS epidemic as a public health threat by 2030 is certainly doable though it appears ambitious. Last but not least, we would like to acknowledge the tremendous contribution and efforts that went into the preparation of this report. We would like to especially thank the HIV/STI Sector for their relentless effort in coordinating and drafting this report.

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DIRECTOR GENERAL OF HEALTH MALAYSIA

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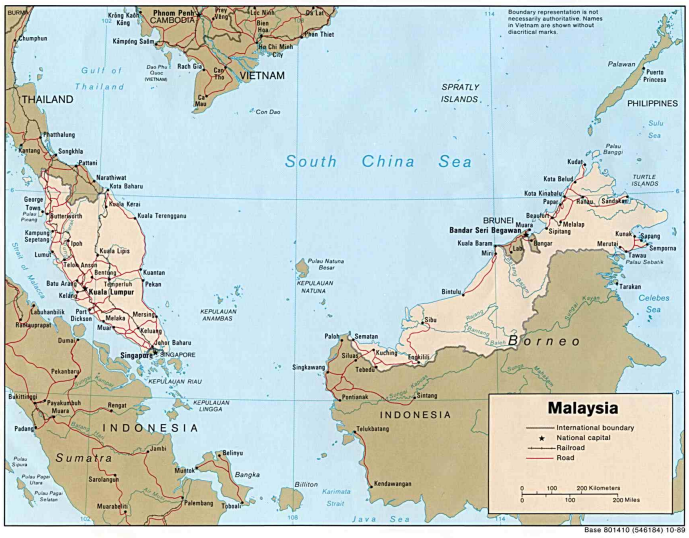
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BSS	Behavioral Surveillance Survey
CBO	Community-based Organization
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FRHAM	Federation of Reproductive Health Associations of Malaysia
HIV	Human Immunodeficiency Virus
KP	Key population
PWID	Injecting Drug Use/User
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
NPFDB	National Population and Family Development Board
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
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
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 - STATUS AT A GLANCE

1.1 Country Profile

Malaysia consists of two geographical regions divided by the South China Sea: the peninsular Malaysia (or West Malaysia) on the Malay Peninsula bordered by Thailand on the north and Singapore in south, and Malaysian Borneo (or East Malaysia) located on the northern part of the island of Borneo, bordering Indonesia and surrounding the Sultanate of Brunei. With land area of 329,847 km^2, Malaysia comprises of 13 states and 3 federal territories with estimated total population of about 30.3 million[1].

The Malay make up Malaysia's largest ethnic group which is more than 50% of total population. The second largest ethnic group, the Malaysian Chinese form 23% of the population while the Indians form 7% of the population. The rest are indigenous (12%), other ethnics and non-citizen.



Malaysia is a multi-religious country with Islam being the most widely professed religion (61.3%). As a multi-racial nation, other religions embraced were Buddhism (19.8%), Christianity (9.2%) and Hinduism (6.3%).

Since independence, the Malaysian healthcare system has provided a critical and invaluable service to Malaysians via an extensive network of public and private facilities, an effective rural health delivery system, highly specialized care at regional

[1] Department of Statistics Malaysia Official Portal. Selected Demographic Statistic Estimates 2014.

level and successful health promotion and preventive strategies. Accessible through 355 hospitals (141 government and 214 private), 7,832 clinics with doctors (1,031 public and 6,801 private) and 2,075 community clinics run by paramedics (Community Clinics and 1Malaysia Clinics), the Malaysian health care has improved over years with doctor to patient ratio of 1:633[2]. Within this dual health care system, the Ministry of Health plays the role of funder, provider and regulator. With commencement of the 10th Malaysia Plan: 2011-2015 (10MP), the government is committed to improve the standard and sustainability of quality of life of Malaysian nation.

1.2 Overview of the epidemic

The first case was reported in Malaysia in 1986. Since then, HIV has become one of the country's most serious health and development challenges. At the beginning of the epidemic, injecting drug users was key driven factor that charted the graph by leaps and bounds as the country's responses focused more on creating awareness and early detection through screening programmes in prisons and drug rehabilitation centers country wide.

Over period of 29 years, the country has observed tremendous biomedical and behavioral advances in the HIV prevention, diagnosis, and treatment. As a result, there has been a significant reduction of new cases by almost half from 28.4 per 100,000 populations in 2002 to 11.7 cases per 100,000 populations in 2014[3]. Malaysia is a country with concentrated HIV epidemic with infection rates remains high above 5% among key populations (KPs) especially among PWID, female sex workers, transgender and men sex with men (MSM) population. By 2013, Malaysia has enjoyed almost 50% decline in new HIV cases since its peak in 2002 (6,978 cases). But in 2014, new cases has edged up from 3,393 in 2013 to 3,517 HIV.

[2] Malaysia Heath Facts 2014
[3] Ministry of Health Malaysia Surveillance Data

Malaysia is estimated to have about 91,848[4] people living with HIV (PLHIV) by end of 2014. During the same period, the national surveillance system had reported a cumulative of 105,189 HIV cases, 21,384 AIDS and 17,096 deaths related to HIV/AIDS giving total reported PLHIV of 88,093 cases[5] (table 1) or 96% of estimated PLHIV.

Table 1.Overview of the HIV epidemic in Malaysia 2014

Indicator	Number [%]
Cumulative no. of reported HIV infections since first detection in 1986	105,189
Cumulative no. of reported AIDS since 1986	21,384
Cumulative no. of reported deaths related to HIV/AIDS since 1986	17,096
Estimated no. PLHIV [AEM 2015]	91,848
Total number of PLHIV [surveillance data]	88,093
New HIV infections detected in 2014	3,517
Notification rate of HIV (per 100,000) in 2014	11.7
Women reported with HIV in 2014	697
Cumulative no. of women reported with HIV as of December 2014	11,653
Children aged under 13 with HIV in 2014	38
Cumulative no. of children under 13 with HIV as of December 2014	1,114
Estimated no. PLHIV eligible for treatment [AEM 2015]	42,408
No. PLHIV receiving ART as of December 2014	21,654
Estimated adult (15+) HIV prevalence [AEM 2015]	0.41%

Source: Ministry of Health Malaysia

In general, PLHIV in this country is predominantly male (89%). As the epidemic spread, the pattern progressively shifted towards increasing infection rates in female with male/female ratio from 9.6 in 2000 to 4.5 in 2010 to 4.0 in 2015.

[4] AIDS Epidemic Model, Malaysia 2015
[5] Ministry of Health Malaysia Surveillance Data 2014

During the earlier phase, the country's epidemic was driven by PWID. With the highest PWID/sexual transmission ratio reached at 12.2 in 1994, this pattern has since shifted to increasingly more sexual transmission with PWID/sexual transmission ratio now declined to 3.9 in 2000 to 0.2 in 2014.

About 34.3% of reported infections are amongst young people aged 13 to 29 years old while children under 13 years consistently contributed approximately 1% of cumulative total of HIV infections from 1986 to December 2014.

1.3 Policy And Programmatic Response

In facing up to the scourge of HIV/AIDS, the government has initiated response well before the first case of HIV was reported in 1986. This was marked with formation of National AIDS Task Force in 1985, an inter-sectoral committee chaired by the Director General of Health. This task force was responsible in formulating policies, strategies as well as assuming the role of national HIV/AIDS prevention and control programme coordinator. During the same year, HIV, AIDS and death related to HIV/AIDS were included into the list of notifiable diseases under the Prevention and Control of Infectious Diseases Act[6] that led to increasing notification following screening programmes among high risk populations.

In 1992 the Government established Inter-ministerial Committee on HIV/AIDS in effort to strengthen the National Collaborative action on HIV/AIDS. Chaired by the Honorable Minister of Health, this committee assisted by the National HIV/AIDS Technical and Coordinating Committees has taken over the function of the earlier National Task Force on HIV/AIDS. This committee was entrusted with the advising the Cabinet on all matters pertaining to HIV/AIDS prevention, control and management in Malaysia. Following the restructuring of the Public Health Division in 1993, an AIDS/STD Section was created under the Disease Control Division which

[6] Law of Malaysia. Act 342 Prevention and Control of Infectious Diseases Act 1988

serves as the secretariat to the ministerial, technical and coordinating committees on HIV/AIDS. Currently, this section coordinates and streamline national responses, including those carried out by NGOs.

Recognizing the pivotal role of civil society in complementing the Government's fight against the epidemic, the MOH crafted a unique, meaningful opportunity for greater involvement of the community and its actors through the establishment of the Malaysian AIDS Council (MAC) in year 1992. The year 2002 had witnessed very encouraging commitment from various non-health agencies. Working relationships with the NGOs have been tremendously strengthened with the Government commitment to fund the NGO programmes for key populations.

At the initiative of the MOH, in 2003 Malaysia became the first country to issue a compulsory license following the adoption of the Doha Declaration on Trade-related aspect of Intellectual Properties (TRIPS) and Public Health by the 2001 Ministerial Conference of the World Trade Organization.

1.3.1 National commitment and National Strategic Plan (NSP)

Strong political commitment and leadership at highest level are keys to successful response to the epidemic. This was translated into the country's first NSP in 2000. Under this strategic framework, the Cabinet Committee on HIV/AIDS (CCA) led by the Deputy Prime Minister was established. December 2008 marked the involvement of MAC as committee member representing the voices of civil societies and other communities they represented.

The CCA was restructured in 2009 and was replaced by the National Coordinating Committee on AIDS Intervention (NCCAI) chaired by the Minister of Health. With latest revision, NSP 2011-2015 continues to provide a common ground and emphasis on an integrated and comprehensive approach addressing the needs of prevention, treatment, care and support for infected and affected quarters. As the

current NSP is approaching the end of its timeline, the country is now geared in preparing for the new NSP – 'Ending AIDS by 2030'.

Another highest coordinating body where civil society is represented is the Country Coordinating Mechanism (CCM), a national consensus body with Deputy Minister of Health as the de facto chair. The formation of the CCM was mandated in 2009 by the Cabinet that provides governance for all programmes and activities related to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) in Malaysia.

The responsibility for the overall coordination, monitoring, evaluation and reporting of Malaysia's HIV and AIDS responses is currently tasked to the HIV/STI Sector of the Disease Control Division, Ministry of Health. Currently, the HIV/STI Sector function as the National AIDS Programme (NAP) Secretariat supported by the AIDS Officers at every state. Similar mechanism is being implemented at every state and districts.

1.3.2 Multi-sectoral engagement in the HIV response

Given the mandate by the Government under the NSP, much of the leadership in responding to the epidemic continues to be shouldered by the Ministry of Health. However, the level of multi-sectoral engagement has improved over the several years. Non-health sectors i.e. the Ministry of Women, Family and Community Development (MWFCD), National Anti-Drug Agency (NADA), Department of Islamic Development (JAKIM), Ministry of Home Affairs, and the Information Ministry now form part of the key stakeholders in the country involved in the national HIV prevention and control programmes.

The involvement of religious leaders, especially Muslim religious leaders has got better over the past few years. Numerous advocacy and investment in programming was done to mobilize and harness the support of Islamic religious leaders in HIV prevention and the provision of care and support. There have been remarkable

developments of programmes by JAKIM which involve a number of religious bodies engaging KPs such as female SW, TG and MSM through the availability of religious classes and programmes. Building on the successes of the "Islam and HIV/AIDS" project which was first initiated between 2001 to mid-2005, Muslim religious leaders have since involved in not only the implementation of HIV awareness programmes but also proactively established care and support facilities from financial and welfare assistance to shelters for Muslim PLHIV. The success of "Islam and HIV/AIDS" programme has also gained recognition in other Muslim countries worldwide.

1.3.3 Care and treatment

Malaysia has witness a transformation in care and treatment to PLHIV that benefit both the patient and the country. With respect to ARV, two (2) significant achievements have been accomplished, first, the availability and provision of first line ARV treatment at no cost for those are eligible, second the availability of ARV treatment for incarcerated populations specifically for prisoners with HIV as well as inmates in drug rehabilitation centers. Currently, the second line regime is also heavily subsidized by the government.

The policy to provide free 1st line ARV to all PLHIV in 2006 marked an important milestone in the national response to the HIV epidemic followed by a shift in ARV initiation from CD4 200 to 350 cells/μL in 2010. Latest development in prevention of transmission to sexual partner - implementation of treatment for serodiscordant couple introduced in Consensus Guidelines on Antiretroviral Therapy 2014.

Existing services has taken a step further by integrating the management of HIV in Primary Care, along with the desire to make health care accessible, acceptable and affordable to the whole community, especially the KPs. This is expected to facilitate the public's access to HIV screening, care and treatment for PLHIV. The services are available at almost 100% of all public health clinics with Family Medicine Specialist. All these clinics have been well equipped with all the resources needed including trained healthcare personnel and point of care test – Rapid HIV test and CD4.

To ensure treatment adherence, the government has invested in Treatment Adherence Peer Support Programme (TAPS). Through volunteers, this service provide psychosocial support to KPs in understanding treatment challenges as well as 'patient navigator' that help new patient to navigate and understand the flow of the hospitals services.

1.3.4 Resource mobilization

The MOH recognizes the pivotal role of civil society in complementing the Government's effort to effectively respond to the epidemic. To ensure this, the government continue to support the civil societies through funding mechanism allocated every year for HIV/AIDS responses through MAC. Guided by the NSP 2011-2015, MAC continues to oversee the implementation of high-impact HIV prevention programme by NGO, with the aim of providing 80% service coverage for key populations, where 60% of those covered practice safe behavior consistently by 2015. Since 2003, through MAC the government has extended its funding to more than 30 NGO every year amounting to more than RM 80 million (USD 27 million).

1.3.5 HIV intervention through harm reduction

Harm reduction programme was commenced in Malaysia in October 2005 with the startup of Opiate Substitution Therapy (OST), followed by Needle Syringe Exchange Programme (NSEP) on February 2006. These two main components of harm reduction programme remain the cornerstone of the Malaysian Government's HIV prevention strategy. This programme is currently being implemented in partnership with NGOs, CBOs and private health practitioners. Significant successes which have been attributed to increased sites and clients over the last few years have made this one of the programmes which has managed to get worldwide attention. OST is being served at government facilities under the Ministry of Health Malaysia as well as Ministry of Education. Is also being introduced at the National Anti-Drug Agency (NADA) service centers and incarcerated settings specifically prisons. NADA has

introduced a new way of managing drug user from compulsory rehabilitation centers to voluntary open access services namely Cure and Care Clinic, Cure and Care Service Centre and Caring Community House since 2007. OST has also been expanded in prison set up; beginning with only 1 prison in 2008 and has expanded to 18 by 2014. Methadone is the main drug of choice at these facilities. Buprenorphine and Methadone are being widely used in OST at private clinic run by qualified and trained private practitioners. About 160,509 (94.4%) injecting drug users have been reached in this programme since its implementation.

1.3.6 PMTCT programme

In 1998, Prevention of HIV from mother to child became the country's key program where screening among antenatal mother was implemented country wide. To ensure result i.e. prevention of vertical transmission, HIV positive mothers were given free antiretroviral therapy, ART prophylaxis given to HIV-exposed infants and routine PCR test was strictly observed. To further prevent transmission through breast milk, HIV-exposed infants was given free formula feeding. This programme also provides HIV test and counselling for spouses. Coverage of these mothers through public facilities improved from 49.7% in 1998 to almost 100% in 2014. Beginning 2011 the government adopted treatment option B+ for HIV infected mothers and the HIV exposed infants are getting free replacement feeding for extended period of 2 years since 2012.

1.3.7 Involvement of key populations and civil society

Understanding and recognizing the varied and vital roles of community actors in health support and promotion amongst the key population that drives the epidemic, the MOH extended the CCA membership to MAC. MAC, established in year 1992 under the initiatives of MOH functions as an umbrella organization to support and coordinate the efforts of NGOs, civil society and community based organizations working on HIV and AIDS issues in the country.

The inclusion of MAC as a committee member by MOH in December 2008 to represent the voices of civil societies in KPs marked a momentous move in further strengthening the community systems for a more effective response to the epidemic. Through this inclusion, the MOH highlighted to the nation how meaningful involvement of community actors at the national level can contribute to a balanced mix of interventions that maximizes the use of resources, minimizes duplication of effort and effectively improves health outcomes.

MOH's commitment has been a major factor for this improved engagement of the community and its actors. This move certainly created a stage for community systems strengthening effort aiming to enable communities to play a full and effective role alongside health systems to date.

1.3.8 Increased availability and improvement of quality strategic information

Malaysia has an in-built surveillance system for many years before the establishment of HIV/STI Sector in Ministry of Health. As for HIV, much progress has been made in understanding the HIV epidemic and KPs, particularly vulnerability to HIV and STI infection and the need for specific essential services. Over 25 years, a number of surveillance related activities have been in place namely:

(a) Case notification

All HIV, AIDS and AIDS-related death diagnosed by registered medical practitioners are required to be reported manually to the Ministry of Health as stipulated in the Prevention and Disease Control Act 1988. A nominal case reporting, this surveillance system aimed to better characterize the populations in which HIV have been newly diagnosed and also for public health follow up. Source of notifications include health facilities, routine HIV screening program among drug users in drug rehabilitation centers and prisons, TB and STD patients, women attending antenatal clinics and blood donors. This system was upgraded to web-based notification in 2001.

(b) National AIDS Registry

The Ministry of Health established the National AIDS Registry (NAR) in 2009. Intended to replace the existing surveillance system, the internet-based registry is designed to function as streamlined and effective national HIV programme monitoring mechanism and able to capture detailed disaggregated data continuously and systematically. The registry captures data on each HIV patient relating to their socioeconomic background, risk factor, date of confirmation, contact information, AIDS-related symptoms and so on.

(c) Behavioral Surveillance System

Malaysia had begun implementing the third generation surveillance system (Behavioral Surveillance System) among KPs for the first time in 2004 under the auspices of Ministry of Health Malaysia. Biological component (HIV test) was integrated in the survey in 2012. Currently, integrated bio-behavioral surveillance survey (IBBS) is complementing the National Surveillance System and conducted periodically.

1.4 Overview of Indicators (UNGASS/WHO/MDG)

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

Table 2. Overview of Global AIDS Response indicators

	Indicators	2013	2014	Comments
Target 1. Reduce sexual transmission of HIV by 50 percent by 2015				
General population				
1.1	Percentage of young women & men (15–24 years) who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission	30.8%	40.8%	Country wide survey in secondary school (unpublished)
1.2	Percentage of young women & men (15-24 years) who have had sexual intercourse before age of 15	1.0%	NA	HIV-related knowledge among PLKN trainees 2013 (unpublished).

	Indicators	2013	2014	Comments
1.3	Percentage of adults (15–49 years) who have had sexual intercourse with > 1 partner in the past 12 months	NA	NA	
1.4	Percentage of adults (15-49 years) who had > 1 sexual partner in the past 12 months who report use of condom during their last intercourse	NA	NA	
1.5	Percentage women & men (15-49 years) who received an HIV test in the past 12 months and know their results	100%	100%	M&E data (screening of premarital, antenatal, VCT, prisoners, inmates of DRC, TB & STI patients, contacts of HIV+ and blood donor)
1.6	Percentage of young women aged 15-24 who are living with HIV	0.06%	0.08%	Data from antenatal surveillance 2014 country wide and covers rural and urban
Sex Workers				
1.7	Percentage of SW reached with HIV prevention programmes (*Number of SW who know where to get HIV test and had received condom in the last 12 months*)	48.1%[a]	49.9%[b]	[a]IBBS 2012 (n=864) [b]IBBS 2014 (n=849)
1.8	Percentage of SW reporting use of a condom with their most recent client	83.9%[a]	84.5%[b]	[a]IBBS 2012 (n=864) [b]IBBS 2014 (n=849)
1.9	Percentage of SW received an HIV test in the past 12 mo. and know their results	32.8%[a]	49.4%[b]	[a]IBBS 2012 (n=854) [b]IBBS 2014 (n=849)
1.10	Percentage of SW who are living with HIV	4.2%[a]	7.3%[b]	[a]IBBS 2012 (n=864) [b]IBBS 2014 (n=849)
Men who have sex with men (MSM)				
1.11	Percentage of MSM reached with HIV prevention programmes (*Number of MSM who know where to get HIV test and had received condom in the last 12 months*)	43.8%[a]	30.7%[b]	[a]IBBS 2012 (n=365) [b]IBBS 2014 (n=531)
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	74.8%[a]	56.7%[b]	[a]IBBS 2012 (n=365) [b]IBBS 2014 (n=531)
1.13	Percentage of MSM that received an HIV test in the past 12 mo. and know their results	76.8%[a]	40.9%[b]	[a]IBBS 2012 (n=365) [b]IBBS 2014 (n=531)
1.14	Percentage of MSM who are living with HIV	7.1%[a]	8.9%[b]	[a]IBBS 2012 (n=365) [b]IBBS 2014 (n=531)

	Indicators	2013	2014	Comments
Transgender persons (TG)				
1.11	Percentage of TG reached with HIV prevention programmes (*Number of TG who know where to get HIV test and had received condom in the last 12 months*)	64.3%[a]	64.1%[b]	[a]IBBS 2012 (n=870) [b]IBBS 2014 (n=1247)
1.12	Percentage of TG reporting the use of a condom the last time they had anal sex with a male partner	72.5%[a]	81.2%[b]	[a]IBBS 2012 (n=870) [b]IBBS 2014 (n=1247)
1.13	Percentage of TG that received an HIV test in the past 12 mo. and know their results	35.5%[a]	45.7%[b]	[a]IBBS 2012 (n=870) [b]IBBS 2014 (n=1247)
1.14	Percentage of TG who are living with HIV	4.8%[a]	5.6%[b]	[a]IBBS 2012 (n=870) [b]IBBS 2014 (n=1247)
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015				
2.1	Number of syringes distributed per PWID per year by NSEP	24 *(55)*	31 *(61)*	M&E – based on estimated PWID *(based on registered PWID)*
2.2	Percentage of PWID who report the use of a condom at last sexual intercourse	26.7%[a]	20.8%[b]	[a]IBBS 2012 (n=1906) [b]IBBS 2014 (n=1445)
2.3	Percentage of PWID reported using sterile injecting equipment the last time they injected	97.5%[a]	92.8%[b]	[a]IBBS 2012 (n=1906) [b]IBBS 2014 (n=1445)
2.4	Percentage of PWID that have received an HIV test in the past 12 mo. and knew their results	64.5%[a]	37.8%[b]	[a]IBBS 2012 (n=1906) [b]IBBS 2014 (n=1444)
2.5	Percentage of PWID living with HIV	18.9%[a]	16.3%[b]	[a]IBBS 2012 (n=1906) [b]IBBS 2014 (n=1445)
2.6	Number of people on OST	65,249	74,816	M&E
Target 3. Elimination of mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Percentage of HIV positive pregnant women who received ARV to reduce the risk of mother-to-child transmission	85.5%	78.1%	MOH antenatal surveillance data and estimations (EPP)
3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	68.3%	68.5%	MOH antenatal surveillance data & estimations (EPP)
3.3	Mother-to-child transmission of HIV (modelled) –% of child infections from HIV+ women delivering in the past 12 months	8%	5%	EPP 2014 & 2015

	Indicators	2013	2014	Comments
3.3(a)	Percentage of child HIV infections from HIV+ women delivering in the past 12 months	1.8%	1.3%	MOH antenatal surveillance data
Target 4. Reach 15 million people living with lifesaving antiretroviral treatment by 2015				
4.1	Percentage of eligible adults and children currently receiving ARV (MDG indicator)	45% (17,369/ 38,420)	48% (21,654/45,476)	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	95.1% (2,360/ 2,482)	89% (2,685/ 3,018)	Cohort survey in selected sites
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/μL in 2014 (late diagnosis)	NA	53%	Study at selected sites
Target 5. Reduce TB deaths in people living with HIV by 50 percent by 2015				
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	21.8% (407/ 1,867)	19.7% (453/ 2,300)	Survey at selected sites
5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	NA	9.5% (453/ 4,790)	M&E Data
5.3	Percentage of adult and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	28% (923/ 3,296)	43% (2,063/ 4,790)	M&E Data
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	88.8% (7,017/ 7,903)	88.2% (4,790/ 5,433)	M&E Data

	Indicators	2013	2014	Comments
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low-and-middle-income country				
6.1	Domestic and international AIDS spending by categories and financing sources	**Total:** **180,871,987.67** Domestic Public : RM 171,705,624.34 (95%) Domestic Private: RM 2,427,169.63 (1%) International: RM 6,739,193.70 (4%)	**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%)	Refer AIDS Spending Matrix in annex 1

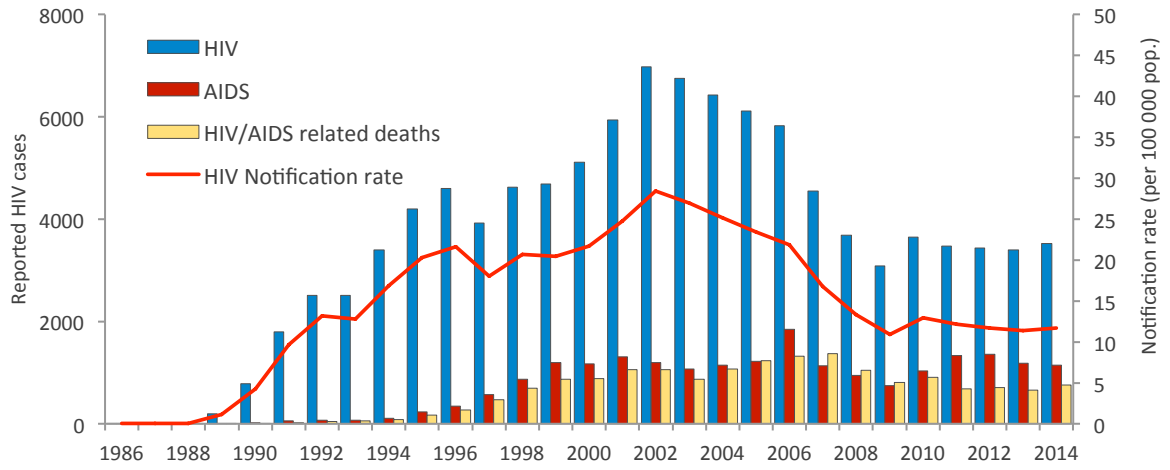
CHAPTER 2 - OVERVIEW OF THE EPIDEMIC

2.1 The epidemic overview

Malaysia is a country with concentrated HIV epidemic with infection rate remains high above 5% among key populations (KP) especially among PWID, FSW, TG and MSM population. Since the first case of HIV/AIDS reported in this country 29 years ago, number of people living with HIV (PLHIV) in 2014 is estimated at 86,324 (EPP 2014). Based on surveillance data (as of end 2014) Malaysia had a cumulative number of 105,189 HIV, 21,384 AIDS cases and 17,096 deaths related to HIV/AIDS, thus giving reported PLHIV of 88,093 cases.

The annual number of reported new HIV cases has been on a steady decline from a peak of 6,978 in 2002 (Figure 1) but this decline has since stalled in 2010. As of end 2014, there were 3,517 new HIV cases reported to the Ministry of Health, approximately halve of what was reported in 2002 with average of 9 new cases each day. The notification rate of HIV also continues to experience a decrease from 28.4 in 2002 to 11.4 in 2013 but edged up to 11.7 cases per 100,000 populations in 2014.

Figure 1. Reported HIV and AIDS-related deaths, Malaysia 1986 – 2014

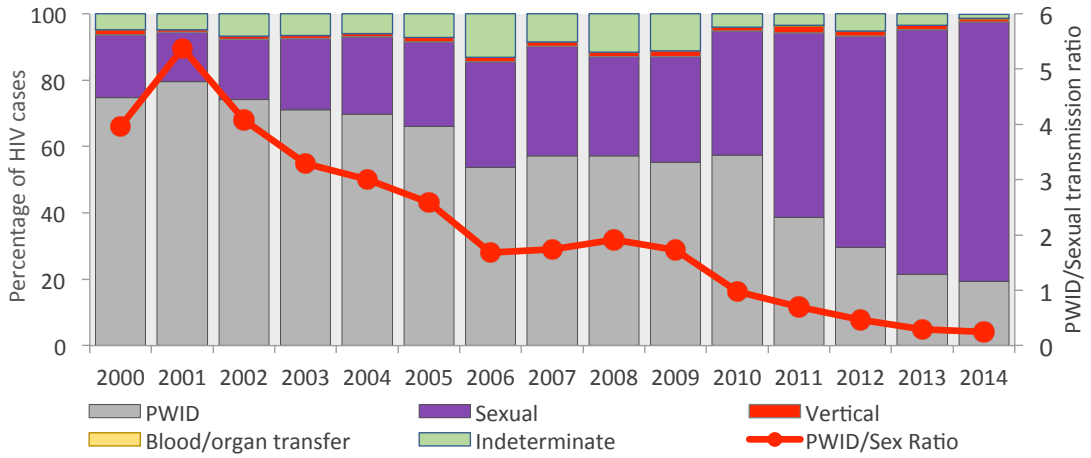


There has been a steady decline in the number of AIDS-related deaths reported. The reduction has been directly attributed to the introduction of more affordable and accessible first and second line antiretroviral (ARV) treatment. As of end 2014, there were 21,654 PLHIV on treatment which is 51% of the estimated number of PLHIV eligible for ARV treatment (42,408)[7].

PLHIV in Malaysia is predominantly male as they constitute 89% of cases of whom majority are PWID. However, the trend of infection by sex has changed with increasingly female acquiring infection with male/female ratio decreasing from 9.6 in 2000 to 4.5 in 2010 and to 4.0 in 2014.

In the earlier phase of the epidemic, PWID was the key driving factor. With rigorous implementation of harm reduction programmes since 2005, the country is shifting progressively from PWID predominant to more sexual transmission with PWID/sexual transmission ratio of 3.9 in 2000 to 1 in 2010 and to 0.2 in 2014 (figure 2).

Figure 2.Reported HIV cases by mode of transmission and PWID/Sexual transmission ratio, Malaysia 2000-2014



[7] AIDS Epidemic Model, Malaysia 2015 (unpublished)

About 34% of reported infections are amongst young people aged between 13-29 years old and constantly around 1% amongst less than 13 years old in 2014 (Figure 3). However, the age-specific HIV prevalence showing a stabilizing trend for all age group (figure 4).

Figure 3. Distribution of reported new HIV cases by age group, 1990 – 2014

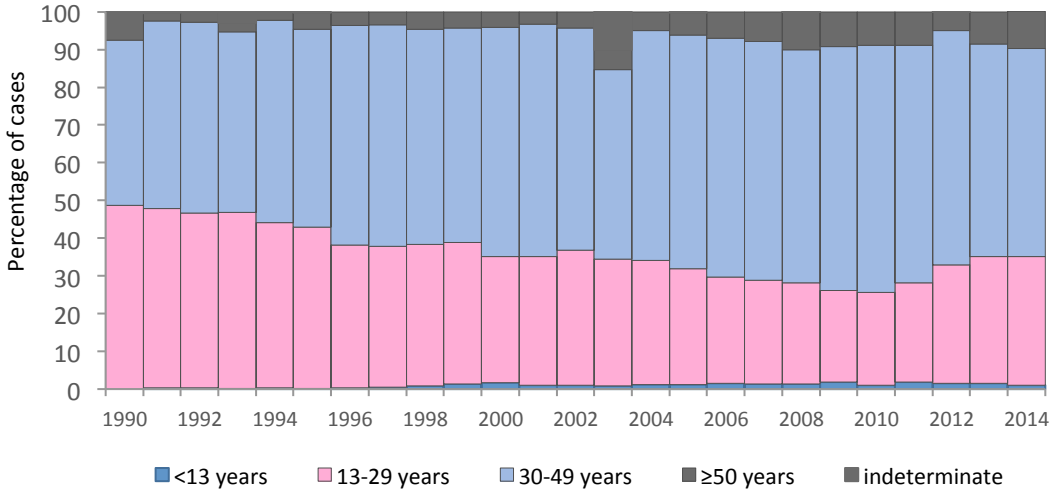
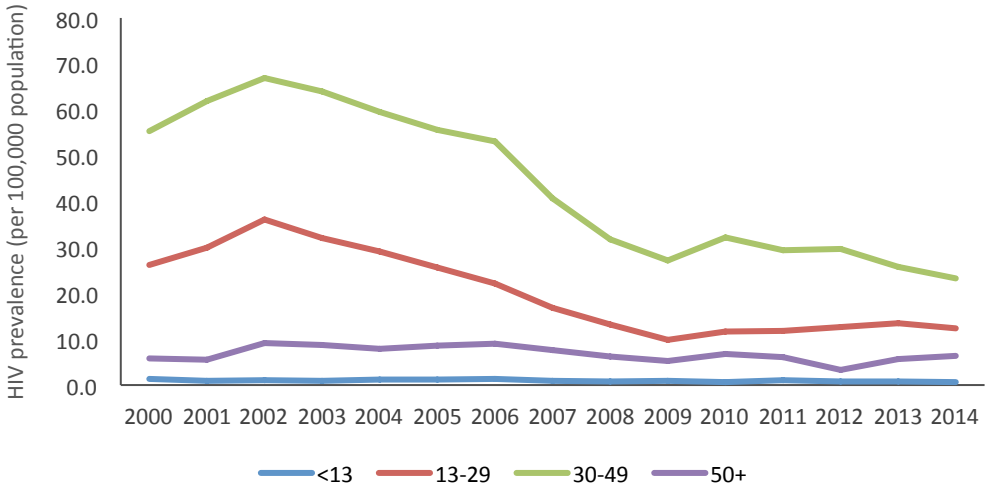
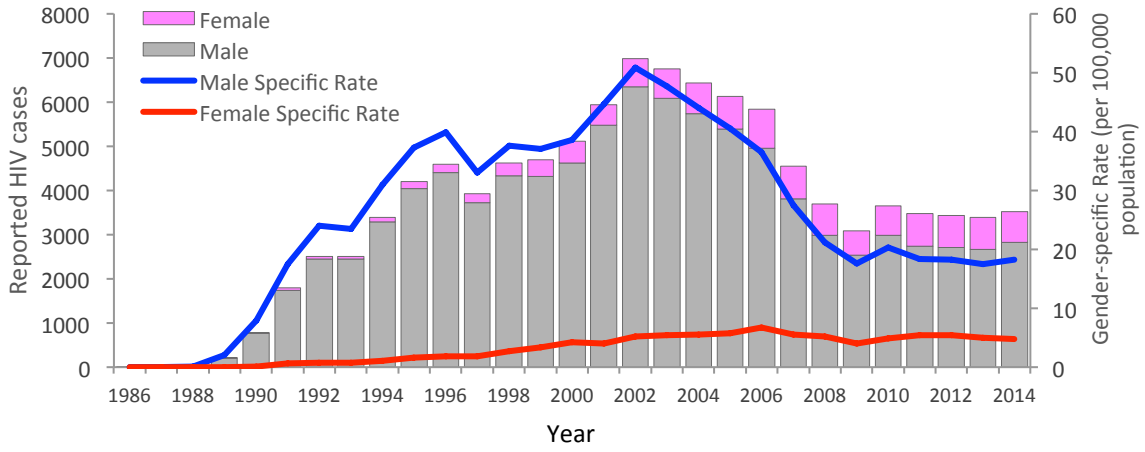


Figure 4. Age-specific HIV Prevalence, Malaysia 2000-2014



Male continue to represent the majority (89%) of all HIV cases in Malaysia but the infection rate among both seemed stabilized (Figure 5) for the last five years. In 2014, amongst men, 23.7% acquired infection via injecting drug use and 74.6% through sexual mode while amongst women, majority acquired through heterosexual transmission (92.4%).

Figure 5.Gender-specific HIV Prevalence, Malaysia 1986 – 2014



2.2 HIV Testing

HIV screening has started as early as 1985. Provided for free in all government health facilities, HIV test can be accessed in 1,039 health clinics and 141 hospitals inclusive of non-MOH hospitals. The Ministry adopted voluntary and confidential HIV test (VCT) as well as Provider Initiated Testing and Counselling (PITC).

Among the screening programmes that has been implemented are routine HIV screening of all donated blood, blood products and organs, an opt-out antenatal screening and routine screening of inmates in drug rehabilitation centers and prisons, TB and STI cases, clients of harm reduction programme, contacts of cases

and voluntary screening for premarital couples. With the initiative of state Islamic religious department, premarital HIV screening for Muslim couples started in 2001. Began with only one state, this screening programme was later expanded countrywide in 2007 and were made accessible to anybody who wishes to undergo premarital HIV screening, irrespective of faith.

Over the past five years, an average of 1.3 million HIV screening was conducted (Figure 6). In 2014, about 1,439,855 men and women aged 15 and above had received HIV test and counseling and know the result, out of which 1,321 (0.09%) were HIV positive. Despite strengthening the surveillance programme and intensified screening activities, the detection rate of HIV is decreasing. This figure is compatible with the declining HIV reported cases through the surveillance system. It also validated the reduction in HIV cases in the country as estimated through estimation and projection exercise. Based on surveillance data and screening activities, it was clearly shown that the cases in this country are still confined within the KPs and that the prevalence among relatively low risk population as demonstrated through screening program is still low between 0.02 to 0.11% (Figure 7).

Figure 6. HIV Screening in Malaysia, 2000 - 2014

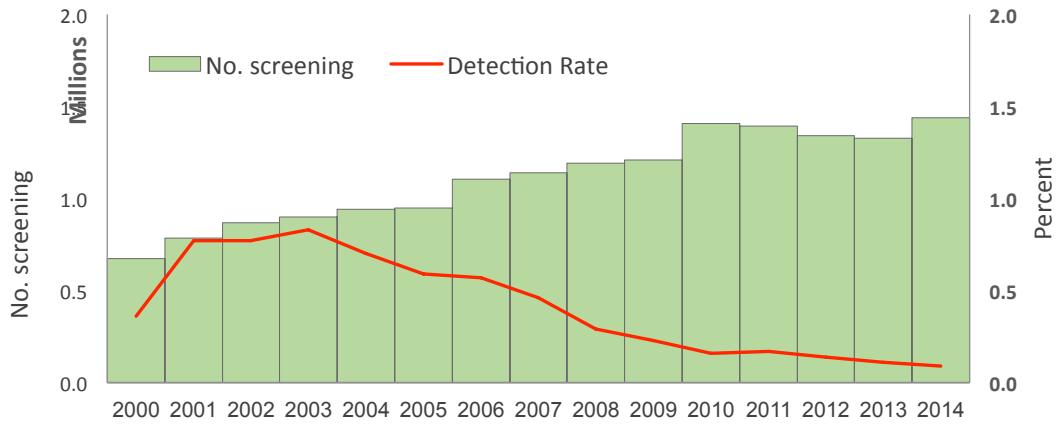
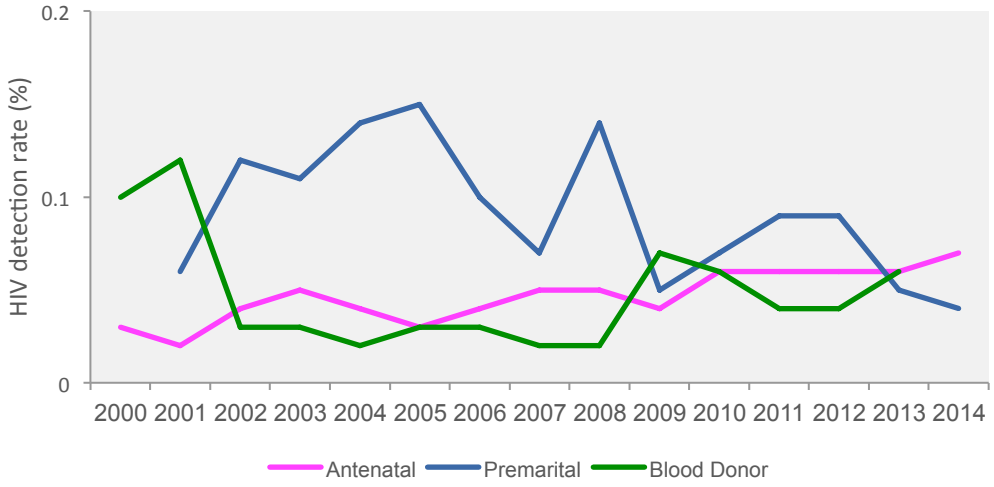


Figure 7. HIV prevalence of selected screening programmes, Malaysia 2000-2014



2.3 Key Populations (KPs)

Being a country with concentrated HIV epidemic among KPs, the Ministry of Health has incorporated behavioural surveillance survey into the existing surveillance system. Hence, Behavioural Surveillance Surveys were adapted for this purpose beginning in 2004 which was later followed by the use of Integrated Bio-Behavioural Surveillance (IBBS) studies. The first round of IBBS survey was conducted in the Klang Valley in 2009 focusing on three key populations (PWID, FSW and TG). The second and third round of IBBS have been successfully carried out countrywide in 2012 and 2014. The key findings of IBBSs are summarized in table 3.

Table 3. Behavioral trend among key-affected population, 2009-2014

Injecting Drug Users	2009 (n=630)	2012 (n=1906)	2014 (n=1445)
HIV prevalence	22.1%	18.9%	16.6%
Tested in the past 12 months and knew results	60.8%	64.5%	37.8%
Duration of risk behavior (median year)	NA	10	15
Used sterile needle during last injection	83.5%	97.5%	92.8%
Condom use with most recent partner	19 - 58%	26.7%	28.0%
Knowledge on modes of transmission	49.7%	53.8%	58.2%
Received N/S in the past 12 months	NA	77.8%	75.3%
Know where to get HIV test	NA	86.5%	84.2%
Reached with prevention programme[8]	NA	68.9%	64.8%

Female sex workers	2009 (n=551)	2012 (n=864)	2014 (n=839)
HIV prevalence	10.5%	4.2%	7.3%
Tested in the past 12 months and knew results	46.1%	32.8%	49.4%
Duration of risk behavior (median year)	NA	6	7
Condom use with most recent client	60.9%	83.9%	84.5%
Injecting drugs	5.6%	4.2%	7.2%
Used narcotics before sex	38.5%	20.8%	33.8%
Consumed alcohol before sex	35.9%	31.8%	46.2%
Knowledge on modes of transmission	38.5%	35.4%	39%
Received free condom in the last 12 months	NA	50.3%	57.5%
Reached with prevention programme[9]	NA	44.9%	49.9%

Men who have sex with men (MSM)	2009 (n=529)	2012 (n=365)	2014 (n=531)
HIV prevalence	3.9%	7.1%	8.9%
Tested in the past 12 months and knew results	41%	47.1%	40.9%
Duration of risk behavior (median year)	NA	7	7
Condom use with most recent partner	55-63%	74.2%	56.7%
Injecting drugs	6%	3.6%	2.8%
Used narcotics before sex	23.8%	14.5%	26.9%
Consumes alcohol before sex	23.2%	33.8%	45.8%
Knowledge on modes of HIV transmission	NA	44.5%	47.8%
Received free condom in the last 12 months	NA	52.9%	39.2%
Reached with intervention programmes[10]	NA	43.8%	30.7%

[8] '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
[9] 'Reached with intervention programme' refers to FSW who received free condom in the last 12 months and know where to go for HIV test
[10] 'Reached with intervention programme' refers to MSM who received free condom in the last 12 months and know where to go for HIV test

Transgender (TG)	2009 (n=540)	2012 (n=870)	2014 (n=1247)
HIV prevalence	9.3%	4.8%	5.6%
Tested in the past 12 months and knew results	48.6%	35.5%	46.7%
Duration of risk behavior (median year)	NA	7	11
Sex worker	83.7%	83.8%	86.6%
Condom use with most recent client	67 - 95%	72.5%	81.2%
Injecting drugs	3.1%	2.1%	1.0%
Used narcotics 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%
Received free condom in the last 12 months	NA	74.4%	74.8%
Reached with intervention programmes[11]	43.7%	64.3%	64.1%

2.3.1 Injecting Drug User (PWID)

It is estimated that there are about 170,000 PWID in the country. The HIV screening activity among PWID in DRC started as early as 1989 and further strengthened in 1996. At the beginning of the epidemic, PWID was the main driver bearing the brunt of about 70-80% of all new reported cases. The trend of reported cases among PWID has started to decline constantly beginning 2004, and reached 19.3% in 2014. Similar pattern has been observed in the three cycles of IBBS where HIV prevalence showed declining pattern from 22.1% to 18.9% to 16.6% with using of clean needles for injection maintained high above 90%. Slightly above one third (37.8%) of PWID have been tested in the last 12 months and knew the result. Through country wide screening progamme incepted as early as 1989, most of the PWID have come into contact with HIV test somewhere in their life either in rehabilitation center, prison, out-patient or MMT service outlet. Result of IBBS supported that most of PWID in Malaysia have been tested for HIV more than a year ago and stay in that behavior (of injecting) for median of 15 years (chronic injector).

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

2.3.2 Sex Workers

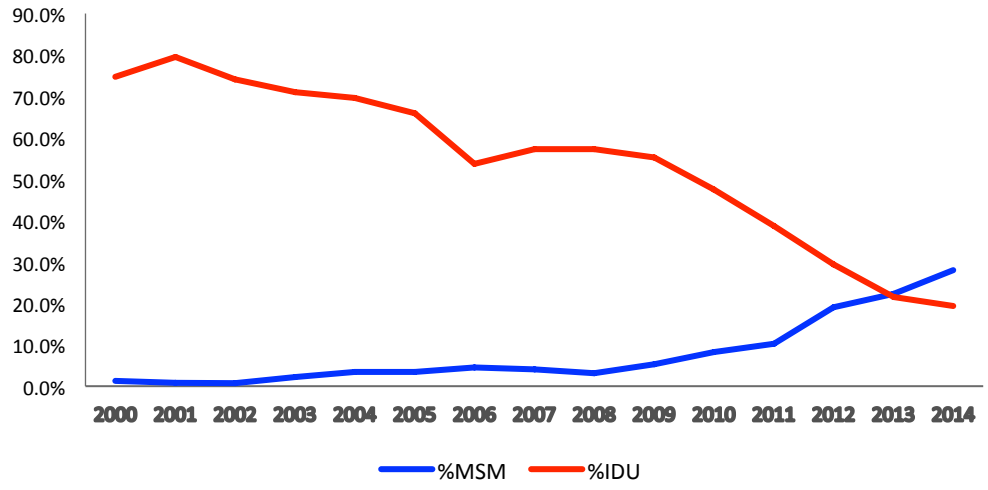
It has been estimated in the last consensus in 2014 that the sex workers population size in Malaysia is about 45,000 out which 21,000 were female sex workers (FSW) and 24,000 were transgender sex workers[12]. Sex worker accounts for approximately 0.6% of total reported cases or 658 of the 105,189 cases reported thus far. Comparing to PWID, the number of cases reported among sex workers are grossly under reported as sex workers may not identify themselves as such but may be categorized by risk factor – heterosexual, homosexual or bisexual in the surveillance system. Preventive behaviour as reflected by condom use with their last client has certainly got better over years (table 3). But with the worrying trend of narcotics and alcohol use prior to sex, proper condom use may be impeded. Knowledge on HIV transmission (39%) is certainly something that need to be strengthened in the coming year with focus on alcohol and substance use.

2.3.3 Men Who Have Sex With Men (MSM)

In the National HIV surveillance system, MSM are grouped as homosexual/bisexual. Opposite of PWID, the cases reported among MSM is showing an increasing pattern with significant rise in the last couple of years (figure 8). By end of December 2014, there were cumulative of 4,799 (4.6%) MSM reported. The trend reported by National Surveillance among MSM is supported by the findings of two IBBS survey (2012 and 2014) that observed an escalation of HIV prevalence from 7.1% to 8.9%. This finding is complimented by reducing trend in condom use from 74% in 2012 to 57% in 2014. The behaviour of not able to protect oneself or client through proper use of condom is aggravated by increasing trend of alcohol and narcotics use prior to sex among this key population.

[12] Consensus 2014 (unpublished)

Figure 8. Proportion of reported cases by mode of transmission – comparison between MSM and PWID, 2000-2014



2.3.4 Transgender (TG)

The estimates of TG population in this country is unclear but the latest consensus in 2014 had estimated TG sex worker at about 24,000[11]. TG are often stigmatized and discriminated by society. The number of HIV cases within this population is unknown as TG is normally not being picked up by the surveillance system but based on IBBS studies in 2012 and 2014, the HIV prevalence among TG population is on the rise (table 3). Unlike the MSM, condom use behaviour among TG is certainly better (81.2%). However the increasing trend of narcotics and alcohol use prior to sex is worrying (table 3) as it may impede proper use of condom.

2.3.5 Young key populations

Young key 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[13]. These populations are certainly vulnerable as increased risk of HIV exposure and transmission is linked to various kinds of mobility, living situation (young people who live on the street), exploitation (young people who are sexually exploited and/or trafficked) and abuse.

As in most countries, the data on young population aged 18 years and younger is limited as any survey on this age group strictly require consent from parents. The IBBS limit respondent to those aged 18 years and above, however it gave some insight on the young people aged 18 – 24 years and their risk behaviour. The last round of IBBS (2014) found quite a substantial proportion of MSM (47.8%) were among young people aged 18 – 24 years while the PWID were mostly older adult aged 25 years and above (table 4).

With respect to behaviour at risk of HIV exposure, unlike the other counterparts, young PWID was found to be better off compared to older PWID when it comes to using sterile needles and syringe. Whilst condom use with last client was much lower with young FSW and TG however, it did not make any age difference for MSM population.

From total of 105,189 cumulative HIV cases reported thus far in the national surveillance data, some 2,695 (2.6%) individuals were aged 19 years and below. In 2014, there are 117 cases (3.3%) among young people (19 years and younger) of 3,517 new reported HIV cases for that year. The proportion of young PWID (3%) reported in the national surveillance seemed to be in agreement with the IBBS findings (table 5). As for those acquiring infection through homosexual or bisexual behaviour, the surveillance data found that about 25% were young people and the trend is increasing.

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

Table 4. Summary of key populations by age group, IBBS 2014

Key populations	<25 years	25+ years	Total
PWID (ALL)	44 (3%)	1401 (97%)	1445
- use clean N/S during last injection	42 (95.5%)	1299 (92.7%)	1341
FSW (ALL)	192 (22.6%)	657 (77.4%)	849
- Use condom with last client	150 (78.1%)	567 (86.3%)	717
MSM (ALL)	254 (47.8%)	277 (52.2%)	531
- Use condom with last client	144 (56.7%)	157 (56.7%)	301
TG (ALL)	362 (29%)	885 (71%)	1247
- Use condom with last client	279 (77.1%)	733 (82.8%)	1012

Table 5. Summary of HIV reported (surveillance) by mode of transmission and age group

Risk Behavior	2012			2013			2014		
	<25	**25+**	**Total**	**<25**	**25+**	**Total**	**<25**	**25+**	**Total**
PWID	40 (4%)	974 (96%)	1014	25 (3%)	703 (97%)	728	18 (3%)	662 (97%)	680
Heterosexual	215 (14%)	1323 (86%)	1538	252 (14%)	1491 (86%)	1491	212 (12%)	1556 (88%)	1768
Homosexual/ Bisexual	164 (25%)	490 (75%)	654	203 (27%)	552 (73%)	755	278 (28%)	706 (72%)	984

2.4 Recent trends in the epidemic

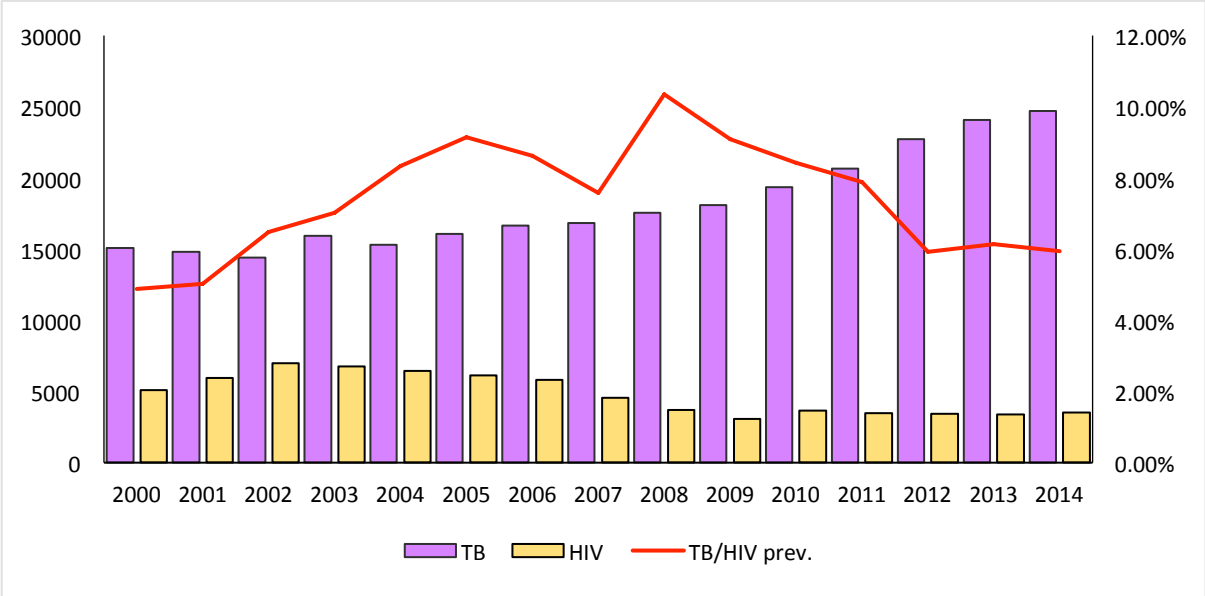
2.4.1 HIV/TB Co-infection

Tuberculosis (TB) remains a public health challenge in Malaysia with constantly increasing infection reported annually (Figure 8). Patients with HIV are highly vulnerable to TB, because of their weakened immune systems. As part of its disease control and prevention measures, the Government currently conducts

routine TB-HIV screening for all new inmates in closed settings such as prisons and drug rehabilitation centres, which was started in 2001. From 1990 to 2014, the number of TB/HIV co-infection reported nationwide has increased from six (6) to 1,468 cases[14]. Without treatment, as with other opportunistic infections, HIV and TB co-infection would shorten the life of the person infected. In effort to reduce morbidity and mortality of TB/HIV co-infection, the government has started Isoniazid prophylaxis in 2010.

The number of TB cases detected annually has been on the rise constantly and in the last couple of years new cases reported was well above 24,000; relatively high compared to HIV with ratio of TB/HIV cases of 3:1 in 2000 to 7:1 in 2014. In 2014, about 24,711 new TB cases were registered in Malaysia with reported TB-HIV co-infection of 5.9%. It was estimated that in 2012, about 23,027 people infected with TB, TB incidence without HIV about 2.4 per 1000 population and TB/HIV co-infection about 8%.

Figure 9. New TB, HIV and prevalence of TB-HIV Co-infection, Malaysia 1999-2014



[14] Ministry of Health Malaysia. TB surveillance data 2014.

2.4.2 Increase trend of reported HIV infection through sexual transmission

The country's epidemic was greatly determined by injecting drug use. However, there is a shift in the notification to progressively increasing in sexual transmission. Notification of infection through PWID route had declined significantly from 70-80% in 1990s to 19.3% in 2014 (table 6).

Increasingly, more new reported cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by both heterosexuals and homosexuals. Combined, sexual transmission of HIV is currently responsible for more than three quarter of new HIV cases.

Table 6: Percentage of new HIV cases by risk factor

Risk factor	1990	2000	2010	2014
Injecting drug use	470 (60.4%)	3,815 (74.7%)	1,737 (47.6%)	680 (19.3%)
Sexual transmission	41 (5.3%)	964 (18.9%)	1,773 (48.5%)	2,752 (78.3%)
Heterosexual	38 (4.9%)	902 (17.7%)	1,472 (40.3%)	1,768 (50.3%)
Homosexual	3 (0.4%)	62 (1.2%)	301 (8.2%)	984 (28%)

Source: Ministry of Health (2014)

As of December 2014, HIV notification attributed to heterosexual intercourse constitutes of 21.8% cumulative cases. However, there is significant 10 fold increase in reporting of new cases acquired through heterosexual contact from 4.9% in 1990 to 50.3% in 2014. As part of the prevention of mother-to-child-transmission (PMTCT) programme in 2014, close to 500,000 pregnant women were screened and 349 individuals were detected with HIV. Similarly, there has been a huge jump in the reporting of new cases acquired through homosexual intercourse during the last 4 years (table 4) from 0.4% in 1990 to 28% in 2014.

2.4.3 HIV and Women

As of December 2014, about 11,653 women and girls in Malaysia have acquired HIV since 1986. The profile of the Malaysian HIV epidemic has progressively shifted from predominantly male to increasing infection among female[15].The gender-specific rate was clearly showing a downtrend of new infection among males beginning 2003, but infections among females are slowly taking its toll. However, both rates seemed stabilizing for the past couple of years.

Based on the National Surveillance System, new HIV cases has declined beginning 2003. But the proportion of female/male has shifted to increasing infection among female with ratio of 1:99 in 1990 to 1:4 in 2014. In 2014, the Ministry of Health recorded 697 new HIV cases and 183 AIDS cases among females in Malaysia. The MOH profile of female HIV cases in 2014 indicated that close to 20% were young (<25 years), about half (45%) were Malays, 92% had acquired HIV through heterosexual transmission and 40% were housewives.

[15] *Ministry of Health Malaysia and UNICEF (2008). Women and girls confronting HIV and AIDS in Malaysia*

CHAPTER 3 - ESTIMATION AND PROJECTION OF HIV EPIDEMIC

3.1 Background

HIV/AIDS estimates and projections provide invaluable data on the epidemic and the future burden of HIV to inform program planning and evaluation. The fourth round of estimation and projection was conducted in February 2015 by National HIV Estimate Team at the Ministry of Health Malaysia using Estimation and Projection Package (EPP) Version 5.3. The team consist of relevant Public Health Physicians, epidemiologist and M&E expert. Consultations with relevant stakeholders and program managers were carried out to consolidate and validate the data inputs with assistance from UNAIDS Regional Office and East-West Centre Hawaii.

Similar to the previous rounds of estimates and projections process, seroprevalence data, programmatic data, population size estimates, behavioural studies and pertinent data from ad hoc studies were entered into the EPP to generate estimation of PLHIV, new infections, AIDS deaths, number of adults, and children needing treatment, the need for preventing mother to child transmission (PMTCT) and the impact of antiretroviral treatment on survival.

3.2 Data sources

Programmatic data including ART coverage were updated to the latest while other data Information for sub-populations were gathered mostly from surveillance activity at national level, selected sites and behavioural or ad-hoc surveys were input into the epidemic structure (table 6). However, there is limited or none surveillance or survey done for client of sex worker. Therefore, the prevalence for this sub-population is assumed at one third of FSW prevalence which is agreed through consensus meeting.

More representative sites will be added in the next round as screening of key populations will be incorporated into VCT programme beginning 2014. Population-specific HIV prevalence curves were fitted to the surveillance data to produce best estimates and model was calibrated for TG (adjust prevalence to IBBS 2012), low risk male (scale to factor 0.56), low risk female (scale to factor 0.47), female sex worker (scale to factor 0.42) and indirect female sex worker (scale to factor 0.42).

3.3 National HIV infection estimates and projections

Based on program coverage, the current prevention intervention for KPs were reaching 52% of PWID, 52% of FSW, 49% of TGSW and 38% of MSM (figure 10). Treatment coverage was reaching only 44% of PLHIV in need. Majority of PLHIV in Malaysia were among PWID who either not knowing their HIV status or not started on ART for fear that they may not be able to adhere to the regime. With intervention efforts fixed at the present levels in AEM, it is predicted that the new HIV cases will decline and stabilize from 2014 onwards. This could be due to declining new cases among PWID given the change in substance use from injecting to oral drug. At the same time HIV cases among other risk groups increase as more get tested and treated early. This projection tells that the HIV transmission is still ongoing however, AIDS-related death and HIV prevalence gradually declining (figure 11).

As for mode of transmission, PWID remains as the main driver of the epidemic that contribute to about 54% of total cases in 2013 and increasing thereafter (figure 12). The number of cases among MSM and low risk female (LRF) are expected to increase and inversely, number of cases among low risk male (LRM) declining (figure 12). We assume that LRM acquire infection from FSW, thus, this decline could be due to increasing condom use among FSW (IBBS 2012). HIV transmission among the low risk female (LRF) most probably comes from their male PWID partner as reported in our programmatic data on antenatal screening.

Figure 10. Treatment and prevention coverage, 2013

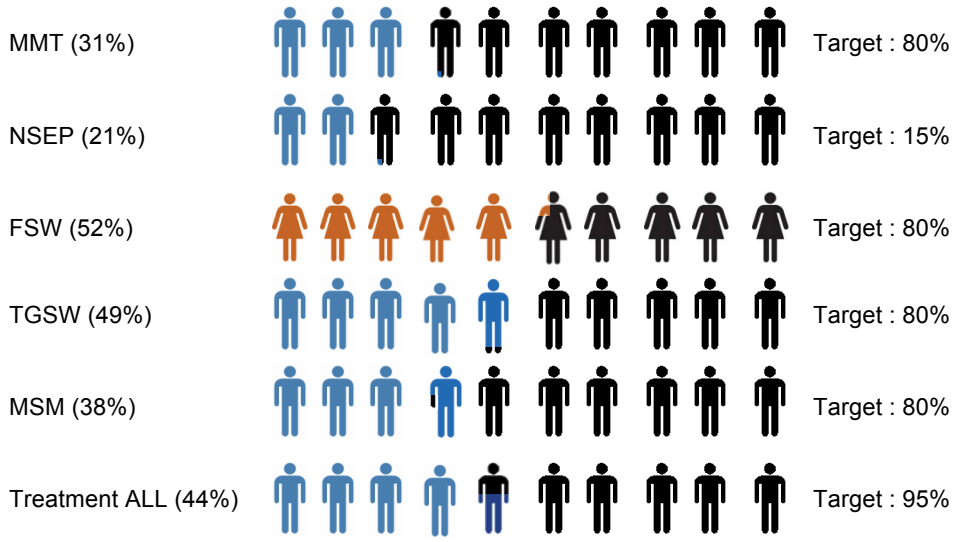


Figure 11. Estimated numbers of new HIV, PLHIV and AIDS-related death in Malaysia, 1986 - 2030

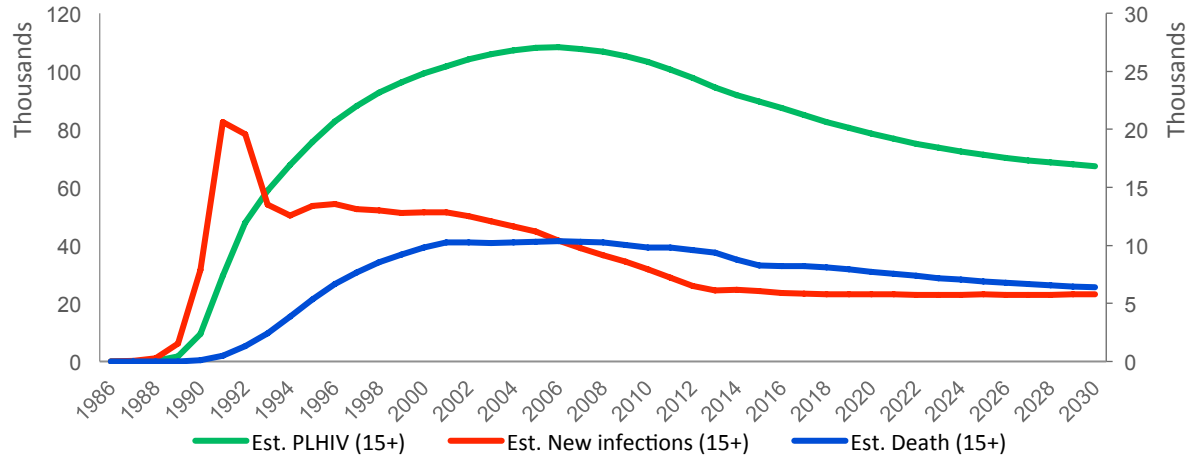
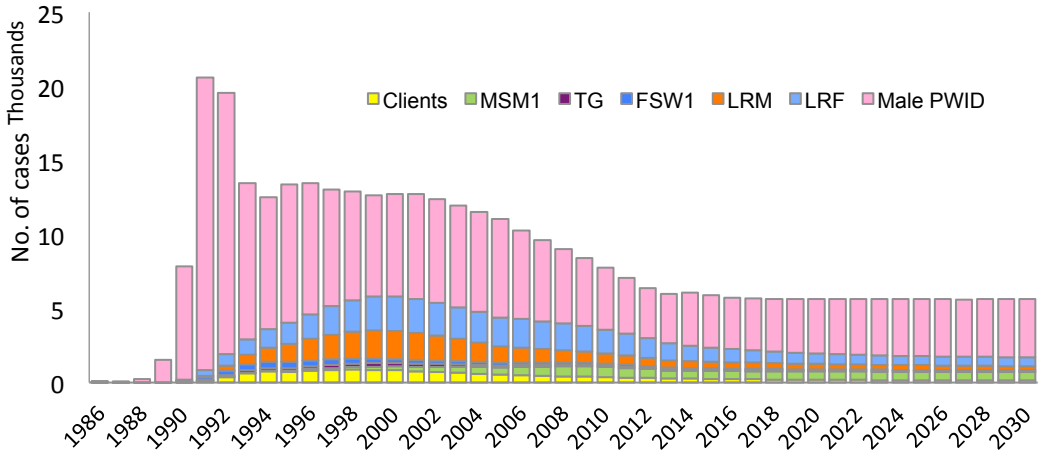


Figure 12. Estimated and projected number of cases by Mode of Transmission, Malaysia 1986 – 2030



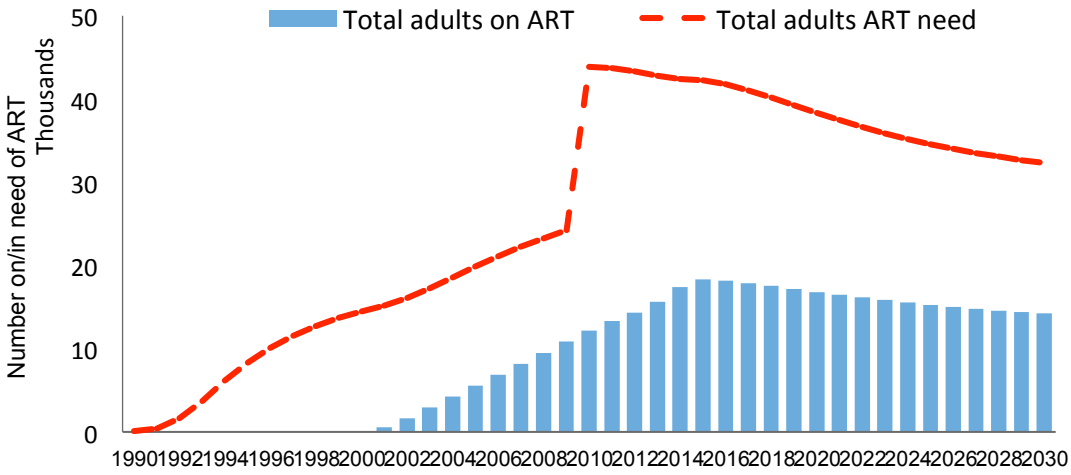
3.4 ARV treatment need and its impact on the epidemic

ART not only improves quality and saves life of PLHIV but also prevents transmission. Based on current ART coverage (at 44%) and projected forward, the AIDS-related deaths and new HIV infection decreases for a couple of decades and stabilized (figure 13). Figure 13 shows the trend of ART coverage and as summarized in table 7, it is projected that ART coverage barely reach half of those in need if intervention remain the same as in 2013.

Table 7. Overall impact of HIV epidemic

Sub-epidemic model	2000	2010	2013	2020	2030
PLHIV	99,175	103,319	94,399	78,480	67,277
New HIV infection	12,853	7,936	6,118	5,780	5,781
Annual AIDS related death	9,809	9,838	9,366	7,748	6,373
Number of PLHIV on ART	82	12,148	15,615	16,826	14,236
PLHIV in need for ART (CD4 < 350 counts)	14,487	43,842	42,764	38,350	32,305

Figure 13. Total adult ART coverage and need, Malaysia 1986-2030



3.5 Summary of key messages

At baseline scenario,

1. New HIV infection showed a smooth decline at the beginning but seemed to have reached plateau from 2014 onwards. AIDS-related death was declining but gradually.
2. Malaysia epidemic is largely contributed by PWID with increasing proportions reaching 62% by 2030.
3. The infections among MSM continue to climb slowly in the range of less than 10%. In opposite, infections among LRM, LRF, clients of FSW and TG are declining.
4. This model showed that more than 50% PLHIV still did not get ART; this explain the slow decline of AIDS-related death

Table 8. Summary estimates of Malaysian HIV epidemic (AEM 2015)

Estimates	2013	2014	2015	2016	2017	2018	2019	2020	2030
Total HIV (15+)	94,399	91,848	89,643	87,279	84,897	82,603	80,449	78,480	67,277
New HIV infections (15+)	6,118	6,204	6,055	5,878	5,819	5,791	5,778	5,780	5,781
Annual AIDS death (15+)	9,366	8,755	8,260	8,242	8,200	8,085	7,932	7,748	6,373
Prevalence adult (%)	0.43	0.41	0.39	0.38	0.36	0.35	0.33	0.32	0.24
HIV adult female (15+)	21,013	20,544	20,081	19,510	18,847	18,126	17,371	16,610	10,942
Annual ART need (15+)	42,764	42,408	42,235	41,763	41,041	40,183	39,265	38,350	32,305
Adult ART coverage (%)	39	44	43	43	44	44	44	44	44

CHAPTER 4 - NATIONAL RESPONSE TO THE AIDS EPIDEMIC

4.1 National and political Commitment

The national response to HIV dated as far back in 1985. HIV, AIDS and death related to HIV/AIDS was listed as notifiable diseases under the Prevention and Control of Infectious Diseases Act[16]. Raising awareness on HIV/AIDS and early detection has been the primary focus of MOH since the formulation of Plan of Action in 1988.

The first National Strategic Plan (NSP) on HIV/AIDS was endorsed as the country's master plan in 2000. Since then, there has been several series of NSP with latest revision, NSP 2011-2015 serves as the country's common action framework on HIV and AIDS. Midway through the implementation of the current NSP, a reviewing process was undertaken in January through to the end of May 2013. The reviewing exercise was undertaken to look at HIV/AIDS situations and implementation of policies, plans and program. It also assessed remaining gaps and challenges to improve the HIV/AIDS responses as well as to identify next steps to be undertaken in order to reach the targets set.

The responsibility for the overall coordination, monitoring, evaluation and reporting of Malaysia's HIV and AIDS responses is currently tasked to the HIV/STI Sector of the Disease Control Division, Ministry of Health. The HIV/STI Sector function as the National AIDS Programme (NAP) Secretariat supported by the AIDS Officers at every state. During the earlier days, the design and development of the HIV/AIDS National Prevention and Control Program was sole responsibility of the Ministry of Health. Over period of time, this response has matured to include wider group of stakeholders including non-health sectors within government organizations, non-government organizations, civil society, private agencies, bilateral and international agencies.

[16]Laws of Malaysia Act 342. Prevention and Control of Infectious Diseases, Act 1988.

The government and key stakeholders have agreed that the new National Strategy on HIV should be able to sustain and upscale the achievements and commitments, while at the same time be able to address concerns and identified gaps as well as respond more effectively to the needs of its stakeholders, especially those of civil society and key populations.

The objectives of the NSP 2011-2015 are as follows:

a) To further reduce by 50% the number of new HIV infections by scaling up, improving upon and initiating new and current targeted and evidence based comprehensive prevention interventions

b) To increase coverage and quality of care, treatment and support for People Living with HIV and those affected

c) To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.

d) To create and maintain a conducive and enabling environment for government and civil society to play meaningful and active roles in decreasing stigma and discrimination.

e) To further increase general awareness and knowledge of HIV, and reduce risk behavior for at risk and vulnerable populations.

The NSP 2011-2015 strives to sustain the progress and achievements made over the past strategic framework. To do so, this NSP targets to achieve the following indicators:

a) Comprehensive HIV prevention programmes are able to effectively cover 80% of most at risk populations.

b) 60% of most at risk populations use condoms consistently.

c) 60% of most at risk populations, who are also injecting drug users, use clean injecting equipment.

d) All cases of vertical HIV transmission are able to be prevented with all HIV positive pregnant mothers receiving treatment and children born receive ARV prophylaxis.

e) Provision and access to comprehensive services for at least 80% of People Living with HIV who are eligible for ARV treatment, care and support which are non-discriminatory and professional.

Given the mandate by the Government under the NSP, much of the leadership in responding to the epidemic continues to be shouldered by the Ministry of Health. However, the level of engagement from non-health sectors, NGO, civil societies, private agencies, bilateral and international agencies has risen tremendously over the past five years.

4.2 Financing the HIV and AIDS responses

HIV responses in the country depend heavily on domestic purse (95%). The resources required to implement the NSP were calculated based on expected coverage and impact goals as derived from estimates of the number of people receiving each service and the cost per person. Service estimates are based on the population in need of the service or programme and the coverage level to be achieved that is assumed to increase from the baseline levels to the planned targets. The unit costs for these services are based on existing interventions currently being implemented by agencies and organisations.

Information on expenditure was collected using AIDS spending format aggregated by category from all key players – government, non-government, civil society and bilateral agency. In general, the total expenditure has increased every year (table 9) and in 2014, total expenditure was calculated at around RM196 million (USD56.6 million), an increase of 5% compared to the previous year. Of the country's

expenditure, 94% was contributed by domestic public fund or around RM185 million (USD 48.7 million) while international fund contributed to only 5% (figure 14).

With regard to individual components of AIDS expenditures, no significant changes were observed in spending by function in the last 2 years (figure 15). Majority of AIDS expenditure was spent for care and treatment (65%) as the government aim to up-scale the ART coverage (table 10).

Table 9. Source of approximate AIDS expenditure 2013-2014

Source of Funding	2013 (RM)	%	2014 (RM)	%
Domestic Public	176,705,624.34	95	184,902,731.22	94
Domestic Private	2,427,169.63	1	1,835,679.81	1
International	6,739,193.70	4	8,966,402.00	5
Total	**185,871,987.67**	**100**	**195,704,813.03**	**100**

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

AIDS Spending Category	2013 (RM)	%	2014 (RM)	%
Prevention	32,011,097.15	17.2	29,939,632.08	15.3
Care and treatment	118,612,712.05	63.8	127,395,654.84	65.1
Orphans and vulnerable children	2,688,638.34	1.4	2,842,117.00	1.5
System strengthening and programme coordination	28,210,162.38	15.2	30,446,975.42	15.6
Incentives for Human Resources	1,826,443.69	1.0	1,994,167.68	1.0
Social Protection and Social Services including Orphans and Vulnerable	2,060,800.00	1.1	2,000,000.00	1.0
Enabling Environment	462,134.06	0.2	697,914.50	0.4
Research	0.00	0	388,351.50	0.2
TOTAL	**185,871,987.67**	**100**	**195,704,813.03**	**100**

Figure 14: Total AIDS Spending by year, Malaysia 2011 - 2014

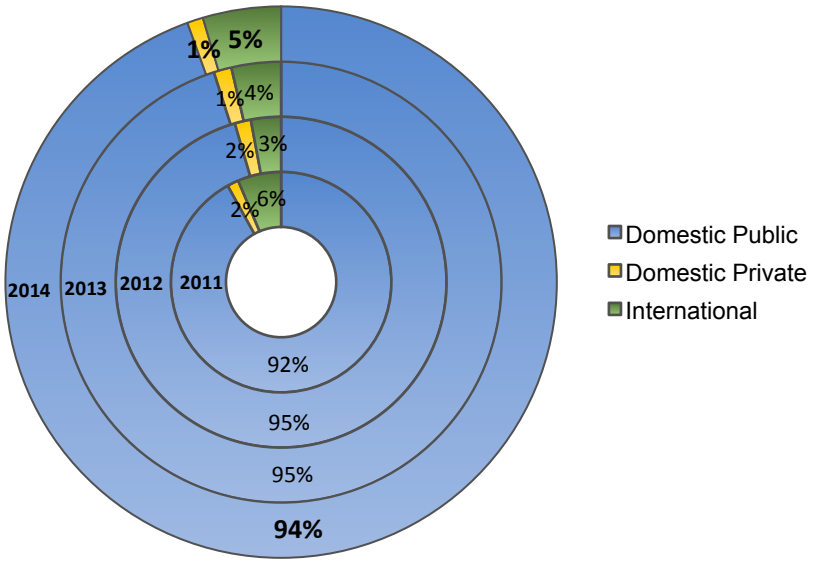
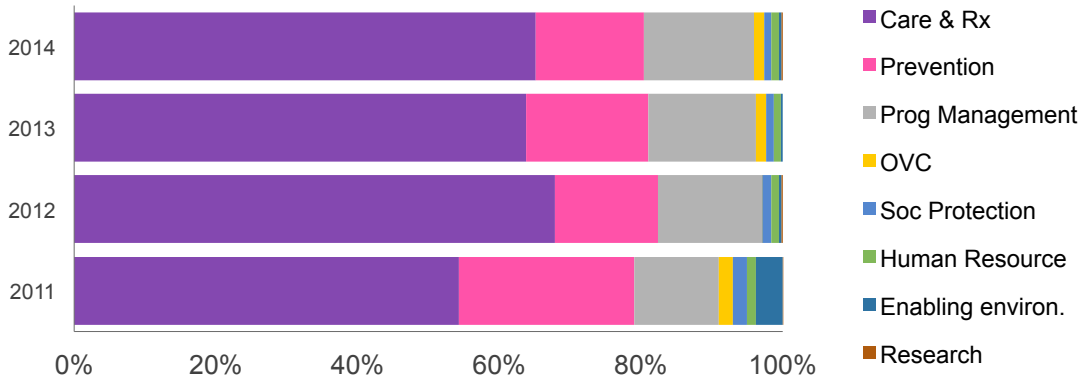


Figure 15. AIDS spending by function, Malaysia 2011-2014



4.3 Upscaling programmes among key affected and vulnerable populations

HIV prevention efforts as outlined in NSP 2011 – 2015 focus on addressing the three primary prongs of HIV transmission in Malaysia, namely the sharing of needles and syringes through injecting drug use, unprotected sexual intercourse, amongst key populations and vulnerable populations and advocacy amongst the most-at-risk youth populations.

4.3.1 Prevention of HIV transmission through harm reduction

Harm reduction initiatives involving Opiate Substitution Therapy (OST) and needle and syringe exchange program (NSEP) have been part of the Malaysian response for several years. Together, these programmes aimed at reaching out at least 102,000 (60%) persons out of estimated population of 170,000 PWIDs by 2015. Provision of harm reduction services continues and up-scaled through 692 NSEP sites and 838 OST outlets established in government health facilities, NGO sites, private health facilities, National Anti-Drug Agency (NADA) service outlets and prisons.

Implemented country wide in February 2006, and now entering its eighth year of operation, the NSEP is mainly provided by the NGO (78%). By end of 2014, as many as 85,693 PWID had benefitted from NSEP programme provided through 540 and 152 NSEP outreach points run by both NGO and government clinics. Average distribution of needle and syringe had reached about 285 per regular NSEP client per year. For the past two years, the government is trying its best to provide ART among PWID by promoting VCT and OST (to ensure better adherence to treatment) among NSEP client. Last year, referral to VCT and OST have reached 21% for VCT and only 5% for OST.

The government has fully adopted MMT programme after the successful pilot project in 2006. By end of 2014, about 74,816 PWID benefitted this programme through 838 MMT centres provided by government hospitals and clinics (47%), private healthcare practitioners (44%), the National Anti-Drug Agency (NADA) service centres (7%), and prisons (2%). In short, HR programme has reached out to total of 160,509 (94% of estimated 170,000) PWID country wide.

4.3.2 Prevention of sexual HIV transmission

To address the rise of sexual transmission of HIV, the NGO through MAC amplified their work to deliver effective sexual and reproductive health services and communication for behaviour change to key populations vulnerable to sexual transmission of HIV, namely sex workers (SWs), men who have sex with men (MSM) and transgender persons (TG). In 2014, about 8,584 KPs were reached out through 165 outreach points and about 2.2 million condom were distributed.

In addressing sexual transmission of HIV, coverage of interventions has improved through sexually transmitted infection (STI) prevention services, including education, testing and access to free condoms; information, communication for behaviour change; community sensitisation and provision of sexual reproductive health (SRH) education and other essential SRH services; outreach and peer education; encouraging HIV testing through voluntary testing and counselling; counselling and psychosocial support.

The IBBS 2014 revealed that understanding on prevention of HIV through sexual transmission and rejecting major misconceptions about HIV transmission among key populations (FSW, TG and MSM) was not satisfactory (38% - 58%). Except for MSM, the pattern of condom use with recent partner has shown an increase in the range of 57% to 87%. Despite wide access to HTC provided in government facilities, the HIV test uptake has been below 50%.

4.3.3 Prevention of mother to child transmission (PMTCT)

In 1998, PMTCT became the country's key program when it was incepted country wide in all government and some private health facilities. Services rendered under this programme include antenatal HIV screening, treatment, care and support for pregnant women with HIV and their partners/spouses. PMTCT programme targeting not only mothers attending antenatal care but also those who had missed antenatal care i.e. in labour room. To ensure result - prevention

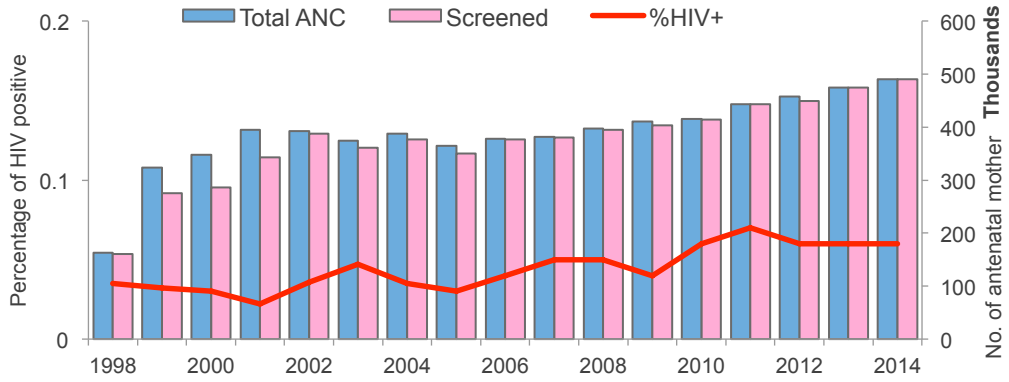
of vertical transmission, HIV positive mothers are given free antiretroviral therapy, ART prophylaxis given to all HIV-exposed infants and routine PCR test was strictly observed. To further prevent transmission through breast milk, HIV-exposed infants are given free formula.

Screening coverage at public facilities improved substantially from 49.7% in 1998 to almost 100% in 2014. Beginning 2011, the country adopted treatment option B+ to all HIV positive pregnant mothers regardless of nationality and HIV exposed baby get free replacement feeding for 2 years beginning 2012.

In 2014, about 489,933 or 85% estimated pregnant women (575,604)) had undergone PMTCT program at 1,039 government health facilities (Figure 16). With 100% coverage of pregnant women attending antenatal care in 2014 in government health facilities, 324 were with HIV out of which 150 were known cases (46.3%). The overall prevalence of HIV among pregnant women in 2014 was 0.06% but much lower among newly detected mothers (0.03%). In effort to eliminate vertical transmission, MOH had started HIV screening to also include mothers who had missed antenatal booking whom appear in labour room (unbooked). In 2014 about 9,657 unbooked pregnant women with unknown HIV status were screened in labour room with HIV prevalence at 0.1% (14 cases); much higher than among booked mothers (0.06%).

A total of 349 pregnant women received triple ARV in 2014 (including 58 pregnant women detected late in 2013) to prevent mother-to-child transmission. All 349 HIV exposed infants born in 2014 were given ARV prophylaxis resulting in 344 (98.6%) mother-to-child transmission infections being averted. Obviously, with PMTCT intervention, the transmission rate was reduced to 1.3% compared to 30-40% had there been no intervention. Screening of male partner of antenatal mother has not taken off completely. In Kedah, Terengganu and Penang where it has been implemented, about 38% of male partner agreed to screening with HIV prevalence at 0.02%.

Figure 16. Antenatal HIV screening, Malaysia 1998 - 2014



4.4 Upscaling of testing and treatment

The Government continues to support a decentralized approach to health services which includes community-based and primary health care through to hospital-based care. It provides psychosocial support including voluntary, counselling and testing (VCT), nutritional support and treatment for common opportunistic infections. Malaysia has started integration of services at primary care level since 1960s. Among the activities that have been well integrated into Maternal and Child Health Clinics is the screening of syphilis among antenatal mothers, PMTCT, VCT, TB and HIV care.

Currently, all government hospitals and health clinics are providing ART either on site or through referral. In addition, every year health staffs including Infectious Disease Physicians, Family Medical Specialists, nurse and medical assistant counsellors are trained and distributed to various hospitals and clinics to assist in testing, treatment and counselling.

As of December 2014, there were 21,654 PLHIV (or 47% of all eligible PLHIVs) already receiving ART. The ARV treatment program has also been extended to include prisons and detention centres since 2009. Among those on ART, 87.0% are still alive and known to be on treatment 24 months after initiation. There is indeed a need for better treatment education for PLHIV who are just initiating or currently on treatment. This is to assist in addressing the issue of adherence which is a consistent problem with PLHIV who do not understand the need to adhere to treatment protocol. To overcome issue of ARV literacy, Treatment Adherence Peer Support Programme is of great advantage.

In effort to build capacity both in provision of screening and treatment, the government has taken bold step in acknowledging HIV counselling as one of many post-basic courses offered for allied health since 2009. HIV screening is currently made available in all government health facilities at no cost through VCT or anonymous HIV screening, premarital screening, screening for TB/STI patients, contacts of PLHIV and inmates of Drug Rehabilitation Centres and prisons. In 2014 about 1,382,971 screening have been conducted with seroprevalence of 0.1%.

The Government's achievements in the area of HIV treatment have been particularly impressive. Health services in the hospital and primary healthcare systems are of high standard, especially those relating to clinical management of HIV. Strong measures are in place to ensure blood supply safety whereupon testing of blood products is consistently conducted. This commitment would take on the form of improving the availability of treatment and lowering the actual cost of treatment. It also aimed to obtain the widest range of ARV drugs at the best possible cost to the Government.

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

Majority of the government's achievements have been from the treatment perspective. But there are still gaps with regards to the delivery of care and support. This has been effectively delegated to Partner Organizations under coordination of Malaysia AIDS Council that are primarily funded by the government.

In effort to improve linkages to care and health services as well as adherence to ART, Treatment Adherence Peer Support Programme has been established (previously Hospital Peer Support Program). Initiated by the Ministry of Health Malaysia, this programme envisage that early treatment of HIV infection coupled with information and education about antiretroviral treatment and adherence, emotional management and healthy living with HIV could markedly decrease onward HIV transmission. The TAPS Programme providing PLHIV with personalized information and emotional support, helping them integrate adherence into their life situations has been tremendously successful in increasing the number of PLHIV engaged at all levels of HIV care continuum. It addressed poor engagement of PLHIV with healthcare and social services that may limit the effectiveness of the country's response to the HIV epidemic.

Through TAPS, peer support is provided by trained peer workers who themselves are PLHIV adhering to treatment. Peers whom are viewed as credible because of their life experiences that are similar to those encountered by the PLHIV are engaged to provide informal counselling and social support, serve as a role model to help clients adhere to ART, provide practical tips for managing ART and adherence, help clients navigate the health system, and facilitate communication with other related service providers. In year 2014 alone, TAPS reached out to a total 4,924 clients living with HIV in 24 treatment centres through 10 Partner Organizations.

Increasing treatment adherence, improving health condition, facilitating employment and eventual reintegration of PLHIV into society are amongst the key strategies deployed by shelter homes operated by the Partner Organisations of MAC. In year 2014, the Partner Organisations operated 16 shelter homes serving a total of 625 residents. A total 355 of these residents were PLHIV, out of whom 254 (71%) were on ARV.

These shelter 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 offered 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.

Collaboration from religious bodies and other relevant government agencies, especially related to welfare, on the issue of care and support for PLHIV has improved significantly over last couple of years. The success in educating Muslim religious leader through 'HIV and Islam' Manual by Department of Islamic Development (JAKIM) has ignited the spirit to provide service beyond HIV awareness. JAKIM is now taking another leap in providing shelter home for homeless Muslims living with HIV called Ilaj Home, a signature project of JAKIM. This seven-storey shelter home will be able to cater approximately 100 residents when the construction is completed in 2015.

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

Prevention and treatment programmes are more effective when operating in an enabling environment which does not stigmatise and discriminate against those most at risk and those affected. Creating and maintaining a better understanding of HIV to reduce risk taking as well as stigma and discrimination are therefore essential. It is important to establish and maintain an enabling public policy and structural environment which will help to reduce HIV stigma and discrimination, respects human dignity, gender and sexuality and is supportive to HIV programmes and interventions.

HIV remains as an important concern in the 10th Malaysian 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 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, 31% of the committee members (8 out of 26) 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.

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

Malaysia has established National HIV Surveillance system to assist in programmes and epidemic evaluation since 1986. Based on case reporting, over time the quality of information collected has improved with the use of electronic and web-based National AIDS Registry (NAR). NAR was developed in 2009 as a manual based registry and started its first web-based function in July 2010. Having many benefits, NAR plays major roles in telling a story from the database by quantifying the magnitude of HIV infection, understanding how HIV is spreading – or might potential spread, status of HIV/AIDS treatment and prophylactic treatment, ultimately assisting in HIV/AIDS program planning, advocating for prevention and care services and aiding in program evaluation.

With implementation of point of care test for CD4 at primary care, this system has recently being 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. This include monitoring of programmes from private sectors and NGO through MAC supervision and were submitted on regular basis. 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.

4.8 GONGO (Government-Non Government partnership)

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 the 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 partnerships 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 80 million (USD27 million) since year 2003 for implementation prevention and treatment, care and support programmes amongst the KPs in the country. This fund is disbursed through MAC to more than 30 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

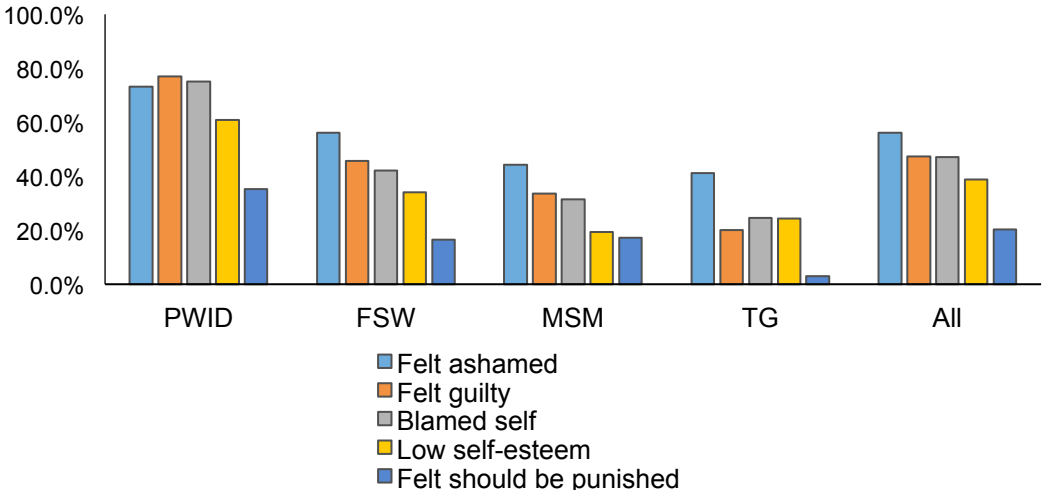
Undoubtedly, the MOH recognizes the pivotal role of civil society in complementing the Government's effort to effectively respond to the epidemic. The MOH crafted a unique, meaningful opportunity for greater involvement of the community and its actors to be part of the national response through the establishment of the Malaysian AIDS Council (MAC) under its initiative in year 1992.

4.9 Stigma and discrimination

HIV-related stigma is a degrading attitude of the society that discredits a person or a group because of HIV and its related behaviour. The resulting coping behaviour of affected person results in internalized stigma. This perceived or internalized stigma is equally destructive whether or not actual discrimination occurs as this often distance the key populations (KPs) from accessing the health care services provided by the government. HIV/AIDS stigma exists around the world in a variety of forms, including ostracism, rejection, discrimination and avoidance of HIV infected people etc.

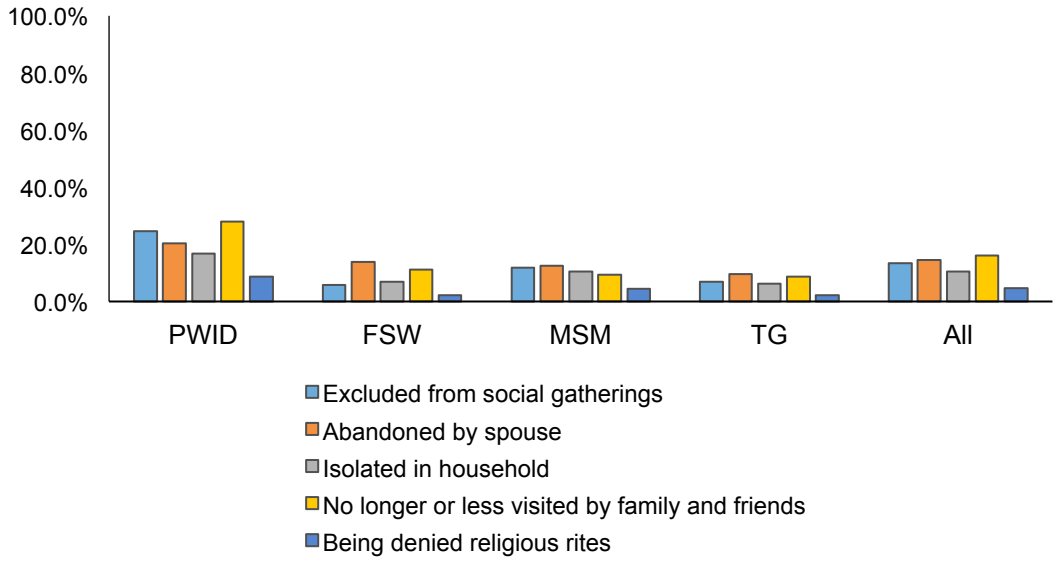
For the first time in 2014, the country included Stigma Index assessment in IBBS among KPs. The study observed notably high level of internalized stigma among KPs in Malaysia; most prominent among PWID. Overall, about half KPs felt ashamed (56%), felt guilty (47.3%) and blamed own self (47%) because of their behaviour and appearance and quite substantial had low self-esteem (38.7%) and felt they should be punished (20.4%) (Figure 17).

Figure 17. Internal stigma among key populations, 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 18).

Figure 18. Exclusion from family, religious and community activities experienced by key populations in past 12 months, Malaysia 2014



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 19). The Stigma Index also revealed that KPs in Malaysia did not prominently having trouble in their workplace and having issues in securing property (Figure 20). 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 19. Physical and verbal harassments experienced by key populations in past 12 months, Malaysia 2014

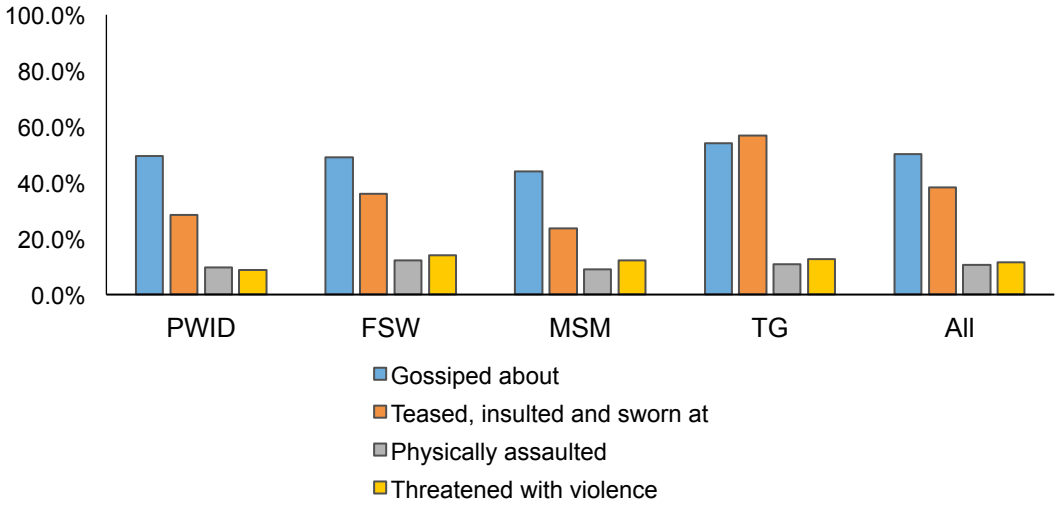


Figure 20. Stigma and discrimination among key populations in the past 12 months, Malaysia 2014

CHAPTER 5 - KEY CHALLENGES

The country has reached the AIDS MDG 6 target but there are still big challenges awaiting. Indeed, these challenges need to be considered and acted upon as they may impede the country aspiration to end AIDS by 2030.

a) Promoting HIV test among key populations. Intensifying HIV test through community-based testing and use of point-of-care diagnostic tests at primary care would be the way forward if the country wish to end AIDS. This can be achieved by expanding testing centres in all I Malaysia Clinics as well as in NGO set-ups (run by trained paramedics)

b) Accelerating treatment coverage. A big challenge awaits in initiating ART among active PWID as currently most PWID have little access to life-saving treatment though they are the largest that contribute to the epidemic. There is indeed a grave need to find ways to include PWID in the treatment circle; the use of Case Managers (by NGO) that provide support and ensure compliance especially among PWID can be helpful. At the same time, creative means to persuade PWID on NSEP to taking MMT will certainly assist greatly in initiating ART among this key population. For non-PWIDs, majority started ART late (median CD4 180µL), thus promoting early HIV test can be of benefit with regard to early treatment and eventually arrest HIV from being transmitted to general population.

c) Improving HIV knowledge among young people. Although the HIV prevalence among young people in general population remain stable over years, the faces of HIV among key populations especially MSM is obviously getting younger (below 25 years). With the changing drug use pattern from injecting to using oral ATS, certainly it gives the country a huge challenge ahead not only in the area of HIV prevention but also substance abuse.

d) Mitigate sexual transmission of HIV among key populations through comprehensive prevention packages. Awareness and understanding about HV/STI resulting in proper and consistent condom use and HIV testing should be

the future measure of outcome. Increasing substance and alcohol use prior to sex must be addressed aggressively as this will impede proper and consistent condom use.

e) Dual elimination of vertical transmission of HIV and congenital syphilis. Malaysia has established high quality PMTCT since 1998 but limited to government health facilities only. To end AIDS, PMTCT must continue and made available in all health facilities country wide.

f) There is still a large gap in TB/HIV care notably low early TB screening and awareness leading to late TB diagnosis resulting in high mortality among PLHIV due to TB.

g) Eliminating stigma and discrimination among key populations (internalised stigma) as well as within the community and health care providers. There is a need to define better outcome indicators that allow programmes to measure progress on stemming stigma and discrimination in the work place and in the community.

CHAPTER 6 - SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

In responding to the HIV epidemic in Malaysia, development partners, both bilateral and multilateral agencies, have been providing support, including financial and technical assistance. In 2014, a number of activities covering multiple areas in AIDS response were carried out by the United Nations Theme Group on HIV/AIDS in Malaysia.

A series of training workshops was organized to strengthen the capacity of the Ministry of Health to produce quality strategic information for informed policy and programmatic decision making. This includes training workshops estimation and projection, and AIDS Epidemic Model that is used in the formulation of the National Strategic Planning for Ending AIDS in Malaysia (2016-2030). Support was also given to increase the capacity of civil societies in the area of monitoring and evaluation as well as programme planning and financial management.

Promotion of enabling environment including eliminating stigma and discrimination continues to be a priority. The Theme Group works closely with the national human rights institutions and civil societies to ensure the full realization of all human rights principles, including right to health among key populations. Among the activities were training of health care providers on MSM and transgender friendly services and participation in national forum such as forum on universal access to health, national stakeholders meetings, World AIDS Day, etc.

Protect the Goal project supported by Asian Development Bank and Asian Football Federation, a HIV and AIDS awareness campaign through football, was launched with emphasis on the combination of HIV prevention and reproductive health information for young people. A number of UN Cares sessions were conducted to create awareness on HIV and AIDS among UN staff.

In addition, technical supports were also provided through the Country Coordinating Mechanism (CCM) on implementation of the Global Fund for AIDS, Tuberculosis and Malaria programme, as well as through the Technical Review Committee of the Ministry of Health Grants for CSOs to ensure that resources are targeted where they deliver the greatest impact.

The Theme Group on HIV/AIDS consists of United Nations agencies in Malaysia – World Health Organization (WHO), the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), the United Nations University – Institute for International Global Health (UNU – IIGH) and International Organization for Migration (IOM).

Country : Malaysia **Year : 2013**

ANNEX 1

Name of local currency : MYR

Currency expressed in : RM Average exchange rate for the year (local currency to USD) : 3.80

2013 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
TOTAL	**185,871,987.67**	**176,705,624.34**	**176,705,624.34**	**0.00**	**0.00**	**6,739,193.70**	**0.00**	**539,614.88**	**6,199,578.82**	**2,427,169.63**	**2,121,874.37**	**305,295.26**
1. PREVENTION	**32,011,097.15**	**25,723,847.00**	**25,723,847.00**	**0.00**	**0.00**	**5,432,820.60**	**0.00**	**135,446.00**	**5,297,374.60**	**854,429.55**	**854,429.55**	**0.00**
1.01 Communication for social and behavioural change (BCC)	**5,880,557.00**	5,874,051.00	5,874,051.00	0.00	0.00	6,506.00		6,506.00	0.00	0.00	0.00	0.00
1.02 Community/social mobilization	**275,520.70**	186,255.70	186,255.70	0.00	0.00	89,265.00		89,265.00	0.00	0.00	0.00	0.00
1.03 Voluntary counselling and testing (VCT)	**121,930.00**	121,615.00	121,615.00	0.00	0.00	315.00		315.00	0.00	0.00	0.00	0.00
1.04 Risk-reduct. & prevention act. for vulnerable & accessible pop.	**64,690.00**	64,690.00	64,690.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.05. Prevention - Youth in school	**688,890.80**	688,890.80	688,890.80	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.06 Prevention - Youth out-of-school	**423,294.00**	423,294.00	423,294.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.07 Prevention of HIV transmission aimed at PLHIV	**587,250.00**	587,250.00	587,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.08 Prevention programmes for sex workers and their clients	**2,410,812.07**	257,340.00	257,340.00	0.00	0.00	2,073,383.10		0.00	2,073,383.10	80,088.97	80,088.97	0.00
1.09 Programmes for men who have sex with men	**429,337.79**	71,026.00	71,026.00	0.00	0.00	39,360.00		39,360.00	0.00	318,951.79	318,951.79	0.00
1.10 Harm-reduction programmes for injecting drug users	**14,440,828.90**	10,798,401.40	10,798,401.40	0.00	0.00	3,223,991.50		0.00	3,223,991.50	418,436.00	418,436.00	0.00
1.11 Prevention programmes in the workplace	**96,158.10**	96,158.10	96,158.10	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.12 Condom social marketing	**644,242.79**	607,290.00	607,290.00	0.00	0.00	0.00		0.00	0.00	36,952.79	36,952.79	0.00
1.13 Public and commercial sector male condom provision	**46,250.00**	46,250.00	46,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.14 Public and commercial sector female condom provision	**0.00**	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.15 Microbicides	**0.00**	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.16 Prevention, diagnosis and treatment of STI	**199,150.00**	199,150.00	199,150.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.17 Prevention of mother-to-child transmission	**2,959,653.00**	2,959,653.00	2,959,653.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.18 Male Circumsicion	**0.00**	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.19 Blood safety	**331,350.00**	331,350.00	331,350.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.20 Safe medical injections	**39,000.00**	39,000.00	39,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.21 Universal precautions	**209,232.00**	209,232.00	209,232.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.22 Post-exposure prophylaxis	**25,000.00**	25,000.00	25,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.23 Pre-exposure prophylaxis	**0.00**	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.98 Prevention activities not disaggregated by intervention	**6,260.00**	6,260.00	6,260.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.99 Prevention activities not elsewhere classified	**2,131,690.00**	2,131,690.00	2,131,690.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2. CARE AND TREATMENT	**118,612,712.05**	**118,098,203.42**	**118,098,203.42**	**0.00**	**0.00**	**208,656.00**	**0.00**	**208,656.00**	**0.00**	**305,852.63**	**305,852.63**	**0.00**
2.01 Outpatient care	**115,180,610.05**	114,666,101.42	114,666,101.42	0.00	0.00	208,656.00	0.00	208,656.00	0.00	305,852.63	305,852.63	0.00
2.01.01 Provider- initiated testing and counselling	**47,000.00**	47,000.00	47,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.02 OI outpatient prophylaxis and treatment	**319,382.00**	319,382.00	319,382.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.03 Antiretroviral therapy	**93,760,227.93**	93,271,744.30	93,271,744.30	0.00	0.00	182,631.00		182,631.00	0.00	305,852.63	305,852.63	0.00
2.01.04 Nutritional support associated to ARV therapy	**278,472.54**	278,472.54	278,472.54	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.05 Specific HIV-related laboratory monitoring	**18,188,252.58**	18,188,252.58	18,188,252.58	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.06 Dental programmes for PLHIV	**2,500,000.00**	2,500,000.00	2,500,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.07 Psychological treatment and support services	**1,250.00**	1,250.00	1,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.08 Outpatient palliative care	**0.00**	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.09 Home-based care	**46,025.00**	20,000.00	20,000.00	0.00	0.00	26,025.00		26,025.00	0.00	0.00	0.00	0.00

2013 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
2.01.10 Traditional med. and informal care and treatment services	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.98 Outpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.99 Outpatient Care services not elsewhere classified	40,000.00	40,000.00	40,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02 In-patient care	3,432,102.00	3,432,102.00	3,432,102.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.01 Inpatient treatment of opportunistic infections (OI)	3,432,102.00	3,432,102.00	3,432,102.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.02 Inpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.98 Inpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.99 In-patient services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.03 Patient transport and emergency rescue	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.98 Care and treatment services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.99 Care and treatment services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3. ORPHANS AND VULNERABLE CHILDREN (OVC)	**2,688,638.34**	**1,705,208.00**	**1,705,208.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**983,430.34**	**902,439.04**	**80,991.30**
3.01 OVC Education	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.02 OVC Basic health care	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.03 OVC Family/home support	360,000.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	360,000.00	360,000.00	0.00
3.04 OVC Community support	158,839.45	0.00	0.00	0.00	0.00	0.00		0.00	0.00	158,839.45	128,839.45	30,000.00
3.05 OVC Social services and Administrative costs	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.06 OVC Institutional Care	2,169,798.89	1,705,208.00	1,705,208.00	0.00	0.00	0.00		0.00	0.00	464,590.89	413,599.59	50,991.30
3.98 OVC services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.99 OVC services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4. SYSTEM STRENGTHENING & PROGRAMME COORDINATION (SUB-TOTAL)	**28,210,162.38**	**27,319,157.73**	**27,319,157.73**	**0.00**	**0.00**	**831,851.50**	**0.00**	**39,117.28**	**792,734.22**	**59,153.15**	**59,153.15**	**0.00**
4.01 National planning, coordination and programme management	1,894,499.23	1,855,381.95	1,855,381.95	0.00	0.00	39,117.28		39,117.28	0.00	0.00	0.00	0.00
4.02 Admin. & transaction costs assoc. w mx. and disbursing funds	635,903.49	227,355.15	227,355.15	0.00	0.00	380,085.94		0.00	380,085.94	28,462.40	28,462.40	0.00
4.03 Monitoring and evaluation	838,535.03	395,196.00	395,196.00	0.00	0.00	412,648.28		0.00	412,648.28	30,690.75	30,690.75	0.00
4.04 Operations research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.05 Serological-surveillance (Serosurveillance)	230,000.00	230,000.00	230,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.06 HIV drug-resistance surveillance	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.07 Drug supply systems	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.08 Information technology	12,474.00	12,474.00	12,474.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.09 Patient tracking	90,170.00	90,170.00	90,170.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.10 Upgrading and construction of infrastructure	93,500.00	93,500.00	93,500.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.11 Mandatory HIV testing (not VCT)	170,000.00	170,000.00	170,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.98 Prog. Mx & Admin. Strengthening not disaggregated by type	24,018,794.63	24,018,794.63	24,018,794.63	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.99 Prog. Mx & Admin. Strengthening not-elsewhere classified	226,286.00	226,286.00	226,286.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5. INCENTIVES FOR HUMAN RESOURCES	**1,826,443.69**	**1,716,973.69**	**1,716,973.69**	**0.00**	**0.00**	**109,470.00**	**0.00**	**0.00**	**109,470.00**	**0.00**	**0.00**	**0.00**
5.01 Monetary incentives for human resources	73,100.00	73,100.00	73,100.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5.02 Formative education to build-up an HIV workforce	60,126.50	60,126.50	60,126.50	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00

2013 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
5.03 Training	1,054,234.00	944,764.00	944,764.00	0.00	0.00	109,470.00		0.00	109,470.00	0.00	0.00	0.00
5.98 Incentives for Human Resources not specified by kind	538,983.19	538,983.19	538,983.19	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5.99 Incentives for Human Resources not elsewhere classified	100,000.00	100,000.00	100,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6. SOCIAL PROTECTION AND SOCIAL SERVICES EXCLUDING ORPHANS AND VULNERABLE CHILDREN	**2,060,800.00**	**2,000,000.00**	**2,000,000.00**	**0.00**	**0.00**	**60,800.00**	**0.00**	**60,800.00**	**0.00**	**0.00**	**0.00**	**0.00**
6.01 Social protection through monetary benefits	60,800.00	0.00	0.00	0.00	0.00	60,800.00		60,800.00	0.00	0.00	0.00	0.00
6.02 Social protection through in-kind benefits	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.03 Social protection through provision of social services	2,000,000.00	2,000,000.00	2,000,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.04 HIV-specific income generation projects	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.98 Soc. Protect. services & soc. services not disaggreg.by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.99 Soc. Protect. services & soc. services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7. ENABLING ENVIRONMENT	**462,134.06**	**142,234.50**	**142,234.50**	**0.00**	**0.00**	**95,595.60**	**0.00**	**95,595.60**	**0.00**	**224,303.96**	**0.00**	**224,303.96**
7.01 Advocacy	286,032.56	15,580.00	15,580.00	0.00	0.00	95,595.60		95,595.60	0.00	174,856.96	0.00	174,856.96
7.02 Human rights programmes	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.03 AIDS-specific institutional development	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.04 AIDS-specific programmes focused on women	52,000.00	52,000.00	52,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.05 Programmes to reduce Gender Based Violence	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.98 Enab. Environ. & Community Dev. not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.99 Enab. Environ. & Community Dev. not elsewhere classified	124,101.50	74,654.50	74,654.50	0.00	0.00	0.00		0.00	0.00	49,447.00	0.00	49,447.00
8. RESEARCH	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
8.01 Biomedical research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.02 Clinical research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.03 Epidemiological research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.04 Social science research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.05 Vaccine-related research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.98 Research not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.99 Research not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00

Country : Malaysia **Year : 2014**
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2014 AIDS SPENDING CATEGORIES	TOTAL	Public Sources			International Resources					Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	Internat. (Sub-Total)	Bilat	Multilaterals		All other Intl.	Private (Sub-Total)	Household funds	All Other Private
							UN Agencies	Global Fund				
TOTAL	195,704,813.03	184,902,731.22	181,851,976.07	3,050,755.15	8,966,402.00	0.00	700,497.00	6,112,202.00	2,153,703.00	1,835,679.81	650,507.00	1,185,172.81
1. PREVENTION	29,939,632.08	23,487,628.08	22,732,228.08	755,400.00	6,381,884.00	0.00	259,806.00	4,915,932.00	1,206,146.00	70,120.00	70,120.00	0.00
1.01 Communication for social and behavioral change (BCC)	6,111,466.50	6,111,466.50	6,111,466.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.02 Community/social mobilization	1,052,880.20	1,039,580.20	1,039,580.20	0.00	13,300.00	0.00	13,300.00	0.00	0.00	0.00	0.00	0.00
1.03 Voluntary counselling and testing (VCT)	1,510,790.00	1,510,790.00	1,510,790.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.04 Risk-reduct. & prevention act. for vulnerable & accessible pop.	125,408.00	34,500.00	34,500.00	0.00	90,908.00	0.00	90,908.00	0.00	0.00	0.00	0.00	0.00
1.05. Prevention - Youth in school	606,390.80	606,390.80	606,390.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.06 Prevention - Youth out-of-school	416,293.00	261,445.00	261,445.00	0.00	154,848.00	0.00	154,848.00	0.00	0.00	0.00	0.00	0.00
1.07 Prevention of HIV transmission aimed at PLHIV	218,880.00	218,880.00	218,880.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.08 Prevention programmes for sex workers and their clients	2,296,195.00	621,200.00	621,200.00	0.00	1,674,995.00	0.00	0.00	1,674,995.00	0.00	0.00	0.00	0.00
1.09 Programmes for men who have sex with men	101,269.00	12,200.00	12,200.00	0.00	27,069.00	0.00	0.00	27,069.00	0.00	62,000.00	62,000.00	0.00
1.10 Harm-reduction programmes for injecting drug users	11,034,166.98	6,956,911.98	6,956,911.98	0.00	4,069,135.00	0.00	750.00	2,862,239.00	1,206,146.00	8,120.00	8,120.00	0.00
1.11 Prevention programmes in the workplace	56,755.00	56,755.00	56,755.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.12 Condom social marketing	44,000.00	44,000.00	44,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.13 Public and commercial sector male condom provision	23,250.00	23,250.00	23,250.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.14 Public and commercial sector female condom provision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.15 Microbicides	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.16 Prevention, diagnosis and treatment of STI	168,950.00	168,950.00	168,950.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.17 Prevention of mother-to-child transmission	2,984,070.00	2,984,070.00	2,984,070.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.18 Male Circumcision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.19 Blood safety	259,761.60	259,761.60	259,761.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.20 Safe medical injections	20,000.00	20,000.00	20,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.21 Universal precautions	172,157.00	172,157.00	172,157.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.22 Post-exposure prophylaxis	10,000.00	10,000.00	10,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.23 Pre-exposure prophylaxis	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00
1.98 Prevention activities not disaggregated by intervention	374,819.00	23,190.00	23,190.00	0.00	351,629.00	0.00	0.00	351,629.00	0.00	0.00	0.00	0.00
1.99 Prevention activities not elsewhere classified	2,352,130.00	2,352,130.00	1,596,730.00	755,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. CARE AND TREATMENT	127,395,654.84	127,095,101.84	127,095,101.84	0.00	300,553.00	0.00	300,553.00	0.00	0.00	0.00	0.00	0.00
2.01 Outpatient care	123,200,342.84	122,899,789.84	122,899,789.84	0.00	300,553.00	0.00	300,553.00	0.00	0.00	0.00	0.00	0.00
2.01.01 Provider- initiated testing and counselling	225,889.00	225,889.00	225,889.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.02 OI outpatient prophylaxis and treatment	226,415.00	226,415.00	226,415.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.03 Antiretroviral therapy	102,201,652.00	101,941,099.00	101,941,099.00	0.00	260,553.00	0.00	260,553.00	0.00	0.00	0.00		0.00
2.01.04 Nutritional support associated to ARV therapy	653,685.64	613,685.64	613,685.64	0.00	40,000.00	0.00	40,000.00	0.00	0.00	0.00	0.00	0.00
2.01.05 Specific HIV-related laboratory monitoring	19,803,418.20	19,803,418.20	19,803,418.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.06 Dental programmes for PLHIV	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

2014 AIDS SPENDING CATEGORIES	TOTAL	Public Sources			International Resources					Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	Internat. (Sub-Total)	Bilat	Multilaterals		All other Intl.	Private (Sub-Total)	Household funds	All Other Private
							UN Agencies	Global Fund				
2.01.07 Psychological treatment and support services	3,952.00	3,952.00	3,952.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.08 Outpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.09 Home-based care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.10 Traditional med. and informal care and treatment services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.98 Outpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.99 Outpatient Care services not elsewhere classified	85,331.00	85,331.00	85,331.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02 In-patient care	3,775,312.00	3,775,312.00	3,775,312.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.01 Inpatient treatment of opportunistic infections (OI)	3,775,312.00	3,775,312.00	3,775,312.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.02 Inpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.98 Inpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.99 In-patient services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.03 Patient transport and emergency rescue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.98 Care and treatment services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.99 Care and treatment services not-elsewhere classified	420,000.00	420,000.00	420,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3. ORPHANS AND VULNERABLE CHILDREN (OVC)	**2,842,117.00**	**2,513,306.00**	**2,513,306.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**328,811.00**	**328,811.00**	**0.00**
3.01 OVC Education	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.02 OVC Basic health care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.03 OVC Family/home support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.04 OVC Community support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.05 OVC Social services and Administrative costs	328,811.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	328,811.00	328,811.00	0.00
3.06 OVC Institutional Care	2,513,306.00	2,513,306.00	2,513,306.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.98 OVC services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.99 OVC services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. SYSTEM STRENGTHENING & PROGRAMME COORDINATION (SUB-TOTAL)	**30,446,975.42**	**27,646,730.61**	**27,449,375.46**	**197,355.15**	**1,689,894.00**	**0.00**	**60,000.00**	**1,102,655.00**	**527,239.00**	**1,110,350.81**	**0.00**	**1,110,350.81**
4.01 National planning, coordination and programme management	580,044.00	421,928.00	421,928.00	0.00	60,000.00	0.00	60,000.00	0.00	0.00	98,116.00	0.00	98,116.00
4.02 Admin. & transaction costs assoc. w mx. and disbursing funds	2,340,139.46	245,455.15	48,100.00	197,355.15	1,260,669.00	0.00	0.00	866,035.00	394,634.00	834,015.31	0.00	834,015.31
4.03 Monitoring and evaluation	560,461.00	369,140.00	369,140.00	0.00	191,321.00	0.00	0.00	58,716.00	132,605.00	0.00	0.00	0.00
4.04 Operations research	1,000.00	1,000.00	1,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.05 Serological-surveillance (Serosurveillance)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.06 HIV drug-resistance surveillance	300,000.00	300,000.00	300,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.07 Drug supply systems	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.08 Information technology	53,202.50	19,670.00	19,670.00	0.00	0.00	0.00	0.00	0.00	0.00	33,532.50	0.00	33,532.50
4.09 Patient tracking	38,850.00	38,850.00	38,850.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.10 Upgrading and construction of infrastructure	156,700.00	156,700.00	156,700.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.11 Mandatory HIV testing (not VCT)	20,000.00	20,000.00	20,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.98 Prog. Mx & Admin. Strengthening not disaggregated by type	26,301,178.46	25,978,587.46	25,978,587.46	0.00	177,904.00	0.00	0.00	177,904.00	0.00	144,687.00	0.00	144,687.00
4.99 Prog. Mx & Admin. Strengthening not-elsewhere classified	95,400.00	95,400.00	95,400.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5. INCENTIVES FOR HUMAN RESOURCES	**1,994,167.68**	**1,723,334.68**	**1,625,334.68**	**98,000.00**	**206,688.00**	**0.00**	**0.00**	**60,578.00**	**146,110.00**	**64,145.00**	**0.00**	**64,145.00**

2014 AIDS SPENDING CATEGORIES	TOTAL	Public Sources			International Resources					Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	Internat. (Sub-Total)	Bilat	Multilaterals		All other Intl.	Private (Sub-Total)	Household funds	All Other Private
							UN Agencies	Global Fund				
5.01 Monetary incentives for human resources	287,865.00	223,720.00	223,720.00	0.00	0.00	0.00	0.00	0.00	0.00	64,145.00	0.00	64,145.00
5.02 Formative education to build-up an HIV workforce	41,171.37	41,171.37	41,171.37	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5.03 Training	1,106,748.43	900,060.43	802,060.43	98,000.00	206,688.00	0.00	0.00	60,578.00	146,110.00	0.00	0.00	0.00
5.98 Incentives for Human Resources not specified by kind	552,921.88	552,921.88	552,921.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5.99 Incentives for Human Resources not elsewhere classified	5,461.00	5,461.00	5,461.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6. SOCIAL PROTECTION AND SOCIAL SERVICES EXCLUDING ORPHANS AND VULNERABLE CHILDREN	**2,000,000.00**	**2,000,000.00**	**0.00**	**2,000,000.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
6.01 Social protection through monetary benefits	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.02 Social protection through in-kind benefits	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.03 Social protection through provision of social services	2,000,000.00	2,000,000.00	0.00	2,000,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.04 HIV-specific income generation projects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.98 Social protection services and social services not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.99 Social protection services and social services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7. ENABLING ENVIRONMENT	**697,914.50**	**112,654.50**	**112,654.50**	**0.00**	**323,007.00**	**0.00**	**65,905.00**	**33,037.00**	**224,065.00**	**262,253.00**	**251,576.00**	**10,677.00**
7.01 Advocacy	499,818.00	13,500.00	13,500.00	0.00	224,065.00	0.00	0.00	0.00	224,065.00	262,253.00	251,576.00	10,677.00
7.02 Human rights programmes	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.03 AIDS-specific institutional development	4,500.00	0.00	0.00	0.00	4,500.00	0.00	4,500.00	0.00	0.00	0.00	0.00	0.00
7.04 AIDS-specific programmes focused on women	85,905.00	24,500.00	24,500.00	0.00	61,405.00	0.00	61,405.00	0.00	0.00	0.00	0.00	0.00
7.05 Programmes to reduce Gender Based Violence	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.98 Enabling Environment and Community Development not disaggregated by type	33,037.00	0.00	0.00	0.00	33,037.00	0.00	0.00	33,037.00	0.00	0.00	0.00	0.00
7.99 Enabling Environment and Community Development not elsewhere classified	74,654.50	74,654.50	74,654.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. RESEARCH	**388,351.50**	**323,975.50**	**323,975.50**	**0.00**	**64,376.00**	**0.00**	**14,233.00**	**0.00**	**50,143.00**	**0.00**	**0.00**	**0.00**
8.01 Biomedical research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.02 Clinical research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.03 Epidemiological research	338,208.50	323,975.50	323,975.50	0.00	14,233.00	0.00	14,233.00	0.00	0.00	0.00	0.00	0.00
8.04 Social science research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.05 Vaccine-related research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.98 Research not disaggregated by type	50,143.00	0.00	0.00	0.00	50,143.00	0.00	0.00	0.00	50,143.00	0.00	0.00	0.00
8.99 Research not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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