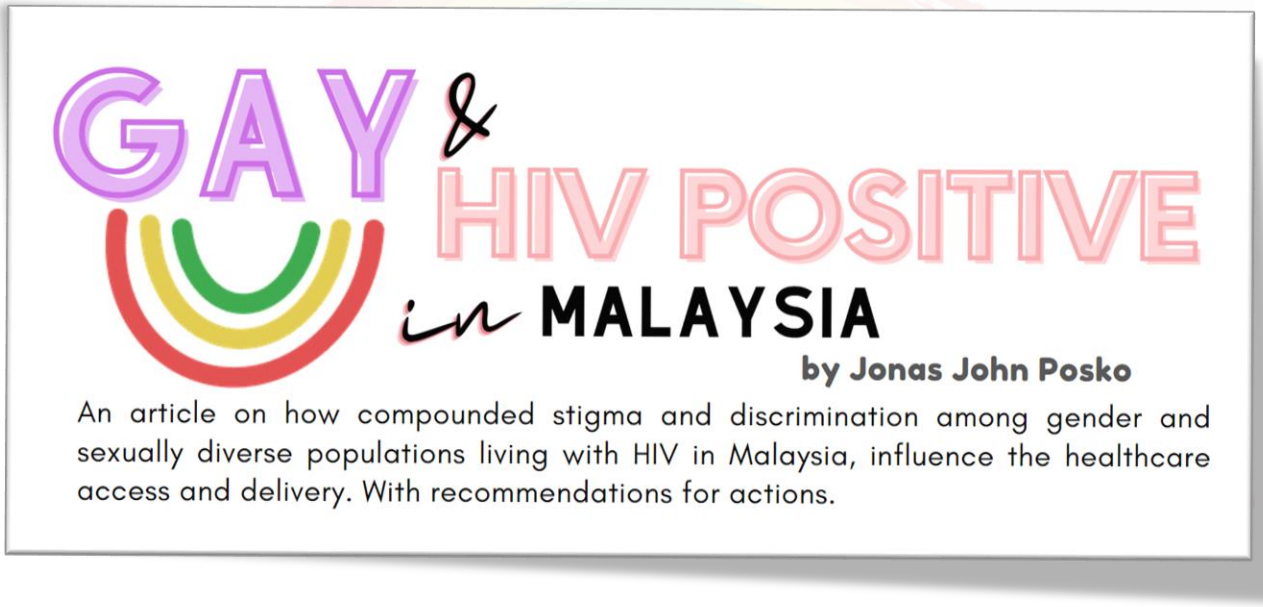

Background:

In the past decade, Malaysia observed gradual changes in the HIV epidemic landscape. We saw the initial cumulative HIV cases predominantly among PWID (Persons-who-inject-drugs), who contribute 70-80% of all newly reported cases. This could be explained by Malaysia's geographic proximity and accessibility to the Golden Triangle, making it an ideal transit point for drug distribution and drug pushers.

Nearing the 21st century, a gradual decline in new HIV cases among PWID was observed, falling to a total number of cases of 3% in 2018(1). Currently, the number of reported new cases is progressively shifting towards sexual transmission causes, witnessing a considerable leap of around 90% of total reported cases in 2019(2). A closer look reveals that the burden of the HIV epidemic worldwide is very much prevalent among Men who have sex with men (MSM) as compared to other adult populations(3). In Malaysia, the majority of new HIV infections are reported among MSM, which is a significant increase from only 18% in 2010 to 66% in 2019(1).

The question arises. How did Malaysia, which was once upon a time one of the five countries(4) described as having a “mega-epidemic” in HIV among injecting drug users, successfully reduce its number among PWID gradually?
It may be very much contributed by the success of the National Harm Reduction program introduced in 2005(5) which introduced methadone maintenance therapy and the needle syringe exchange program. Or even at grassroots levels that see many public health initiatives which increase the flow of people living with HIV (PLHIV) through the HIV treatment cascade, resulting in most PWID living with HIV (90.4%) being aware of their status(6).

How then should we approach this new shift in the HIV epidemic, particularly among the MSM population?
The solution lies in good public health initiatives and targeted policies.
But what defines a good public health model?

The Social Determinants of Health

Many healthcare models approach large scale health issues with a heavy emphasis on targeting the 'Entire population' as opposed to addressing the "inequalities in health between population groups".

For example, our current approach towards tackling the HIV epidemic is by identifying the risk of transmission among key population and general population groups. Key population are at higher risk of HIV infection due to specific higher-risk behaviours, and who frequently face legal and societal challenges due to those behaviours. The five key populations are MSM, PWID, people in prisons and other closed settings, sex workers, and transgender people(7). With an “entire population” approach, could there be certain social determinants that are not being successfully addressed in between these population groups?

In Malaysia, the health and social service public policies fail to normalize discussions of sex and gender at the state level. In fact, much of Malaysia's health policies and laws are constructed in the climate of homo/bi/transphobia, hetero-sexism and/or cis-genderism. The downstream impact of stigma and discrimination particularly among the MSM community in Malaysia unravels multiple oppressions which compound to the negative health effects faced by the community.

A study by Mule et al. in Canada(8), describes the adverse impacts of social injustice such as homophobia among the LGBT (Lesbian, gay, bisexual, transgender) population which inadvertently results in internalization and externalization of discrimination.

Internalization describes the discrimination received by an individual from marginalization and stigmatization from the community, which breed the seeds for self-deprecating emotions such as low self-esteem, self-denial, fear. insecurity, powerlessness, guilt, shame, and inner turmoil. The cognitive theory of depression states perceived low self-worth is a key cause of depression(9).

Externalization on the other hand occurs in the context of societal discrimination involving individual acts towards the LGBT community such as violence, harassment, peer or family rejection, abuse, and bullying. As well as systemic discrimination such as lack of LGBT community resources, social exclusion, bias in healthcare providers, ignorance of LGBT health related issues or erasure from research altogether. This is exemplified by a prominent governmental statement in 2012 in Malaysia that denounced LGBT people as “deviants” as they are against the principles of local religion(10).

Disregard of LGBT health issues is a public health and economic crisis. In Canada, a study revealed that the health care system has been estimated to result in close to 5,500 premature deaths and close to $8B in annual costs due to the systemic lack of recognition of LGBT peoples.(8).

To make matters worse, the stigma of being MSM coupled with the stigma of being HIV positive, poses further challenges in health seeking behaviour.
Turan et al. utilizes the HIV Stigma Framework which dissects the stigma PLHIV face regularly. Perceived community stigma leads to internalization of stigma, which leads to stigma anticipated from the community, which in turn was associated with lower medication adherence. It is a detrimental cycle which cause poor health seeking behaviours and overall lower quality of life.(9)

PLHIV who are afraid of being stigmatised may withdraw from social relationships to avoid being discriminated against, leading to social isolation and fewer options for social support.

Health Outcomes: Goals for HIV/AIDS

With the new UNAIDS target of achieving 95-95-95 status by 2030(7), whereby 95% of PLHIV should know their status, 95% of them linked to receiving treatment, and 95% of them to be virally suppressed, a whole new approach is warranted. In 2019, Malaysia secured a score of 89%-56%-85% with regards to this HIV cascade(2). Which shows, only 56% of people who test positive for HIV receive treatment. How are we to achieve the 95-95-95 target by UNAIDS, if stigma and discrimination among the MSM community living with HIV still stand as significant hurdles towards receiving optimum care?

Recommendations for Actions

Aside from the medical profession and its direct provision of health care, the media, plays an important role in bridging the information gap between health care practitioners and the public. Other influential stakeholders include governmental agencies and public health campaigns, as well as non-governmental organisations (NGOs) with the ability to initiate action.

1) Governmental Policies

Looking from an upstream-downstream approach, governmental policies need to be changed. Not far from home, when the epidemic began, Thailand was one of the first Asian countries to bear the burden of the disease. Their response, however, was very different.
The country quickly launched various national level programmes(11) such as promoting 100% condom use as well as educating and providing health services for testing and treatment among sex workers regarding sexually transmitted diseases (STDs) rather than condemning the community.

Not only that, Thailand also gradually shifted the supervision of the HIV/AIDS programme from the Ministry of Public Health to the Prime Minister’s office with

an increase in allocated budget from US$1 million in 1988 to US$44 million in 1993, making HIV/AIDS a national agenda whereby each ministry is required to allocate a budget line for HIV control. This ground breaking public health response in 1992 was estimated to have prevented 158,000–225,000 deaths in the 2001–2006 period(11). By 2015, Thailand secured a score of 89%-72%-82% with regards to the UNAIDS HIV cascade goal, whereby 72% of HIV positive patients were linked to care.

This is in complete contrast with the moralistic approach of preaching non-marital sexual abstinence as well as enforcing religious programmes for sexual and gender identity rehabilitation which dominate the rhetoric in Malaysia. This approach does not work for a communicable disease problem, it only propagates the cycle of stigma and discrimination discussed earlier.

Furthermore, placing the HIV/AIDS committee under the Prime Minister's Department provides a more economical approach towards comprehensive inter-ministerial interventional programmes as opposed to being under the Ministry of Health (MOH) which deal with various other health issues concurrently.

2) Government Funded Programmes

a. PROSTAR

With regards to governmental organized programmes, prevention is given top priority considering the absence of cure or vaccine. The key to preventing stigma is education, however misconceptions still exist.

In a study by Wong et al.(12), most respondents in Malaysia believe that PLHIV can be recognized by appearance and that HIV could be transmitted by mosquito bites. Concerning the subject matter of HIV, females showed more knowledge than males, those from urban areas more compared to rural areas and the elderly group more than the younger population.

The 'Keep healthy without AIDS' programme for teenagers is the most comprehensive HIV/AIDS prevention programme available targeting Malaysian youth (Program Sihat Tanpa AIDS untuk Remaja or PROSTAR). PROSTAR, facilitated in 1995 under the Ministry of Education, grooms peer educators, who are then expected to lead appropriate activities for other youth.

However, the same study(12) indicates that most young people were not members of PROSTAR, and only 23% cite it as their information source for HIV. The challenges vary. Cultural complexities and the difficulties of communicating the subject of sexual health such as the ability to negotiate condom use need to be addressed. Targeted programmes need to infiltrate hard to reach communities, especially rural Malay-Muslim MSM, where the level of HIV knowledge is low.(10). More science backed training of peers and educators is needed to remove the stigma around the conversation of sex and gender, as taking a moralistic approach to simply deny the existence of sexual activity

among young people. will not stop the fact that unmarried persons, most of them young, will have sex regardless.

b. Community Based Rapid Testing

With regards to the UNAIDS 95-95-95 target, rampant testing (rapid test) with an economic approach is needed to diagnose and link all positive cases to care. Testing with pre and post-test counselling is currently available free of charge at all Malaysian government health clinics. However, funding becomes an issue. The government allocates funding for HIV testing to less cost-effective programs such as mandatory pre-marital screening which saw, only 219 HIV infections identified from conducting mandatory premarital testing on nearly 250,000 individuals in 2011(6). The government needs to prioritize more community-based rapid testing programs that support outreach workers and NGOs to reach out to the MSM community, for anonymous testing (which has better demand due to confidentiality(12)), to link them to care at the earliest.

Non-governmental efforts: the MAC

A total of 46 partner NGOs in Malaysia are currently registered under the umbrella of the Malaysian AIDS Council (MAC)(13). This positive venture helps MAC channel government funds to NGOs for quality interventions such as the HIV and Islam Manual in 2009 that institutionalise HIV and AIDS education into the formal training of new Muslim leaders as well as providing shelter Homes for Muslim PLHIV. This forms much needed partnerships between religious authorities and grassroots HIV movements to have conversations regarding HIV/AIDS in the public health context.

Targeted Programmes for Healthcare workers (HCW)

Health seeking behaviour can be further jeopardized if stigma persists at places of health delivery. According to a review(14), interventions addressing fear-based stigma reduction among HCW through HIV education and universal precautions were effective in reducing both social and fear-based stigma towards PLHIV. Interventions include:

- training popular opinion leaders through group discussions, games, and role-plays
- professionally assisted peer group interventions
- modular interactive training and discussions
- participatory self-guided assessment and interventions
- contact strategy with information giving and empowerment,
- workshops comprising didactic lectures.

Reducing stigma in health centres, promotes good health seeking behaviour among PLHIV.

Conclusion

A moralistic approach of over 30 years towards tackling the HIV epidemic has taught us many lessons. The most important being, it does not work. Mirroring our neighbour Thailand, realistic approaches are needed. Condoning healthy sexual discussions and condom availability for example are the basic steps needed for prevention, not precursors to sin or evil. If Malaysia has proven her grit and resilience in bringing down the numbers among PWID and mother to child transmission(15), she can do the same with key population groups, particularly the MSM community, as we strive towards UNAIDS target of 95-95-95 in 2030.

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