Malaysia

2010 UNGASS COUNTRY PROGRESS REPORT

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AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BSS	Behavioural Surveillance Survey
CBO	Community-based Organisation
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FRHAM	Federation of Reproductive Health Associations of Malaysia
HAART	Highly Active Anti Retroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use/User
IBBS	Integrated Bio-Behavioural Surveillance
ILO	International Labour Organisation
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
NCPI	National Composite Policy Index
NGO	Non-Government Organisation
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 Organisation

I. Status At A Glance

A. Stakeholder consultation and participation in report preparation

Malaysia initiated the process of consultation in preparation of the 2010 UNGASS Country Progress Report in early November 2009. It was a matter of priority and concern for both the Government and civil society partners that this report would be able to capture as much of the opinions and viewpoints of not only that of the Government but most importantly those of the many civil society stakeholders in the response to HIV in Malaysia.

The process of developing the 2008 document was again utilised by the Ministry of Health in its coordination of this report but further improved upon in this round of reporting. In particular, civil society actors took the critical lead in ensuring that as much data and narrative information concerning the progress over the past two years was included.

A series of workshops and working sessions were convened with government and civil society stakeholders to obtain data for Parts A and B of the National Composite Policy Index (NCPI) questionnaire as well as for the narrative component of the report.

An orientation and preparatory briefing on the UNGASS process was organised by the Ministry of Health on 19 November 2009 for both Government and civil society stakeholders. The intention was to ensure that all partners understood the process and was also able to participate as much as possible in providing input and information to the development of the report. The meeting was also intended to discuss and agree via consensus the broad areas which would be included in this round of reporting and provide the guidance for the consultations which would happen independently amongst the different sectors.

The first consultative meeting to discuss the NCPI and narrative component of the report was held on 22 December 2009 and was attended by civil society stakeholders who included representatives of various communities of most-at-risk populations, People Living With HIV, advocacy groups, community based organisations as well as a number of various multilateral organisations. The Malaysian AIDS Council (MAC), the lead coordinating HIV non-governmental organisation in the country with 43 NGOs working on HIV and AIDS related issues as its partner organisation, tasked itself to ensuring the coordination of the civil society responses to Part B of the NCPI Questionnaire. As a result of the earlier briefing conducted in November, Part B was able to be presented to the participants as a draft completed with inputs from the different partner organisations of MAC. It was further improved upon through the deliberations of this workshop.

The discussions which followed also included content for the different parts of the narrative section. As in the previous 2008 process, resource persons from the Ministry of Health were made available on hand during the civil society consultation workshop to ensure that information concerning available policies and practices would be available for reference if necessary. These resource persons were advised and reminded to not influence the outcome of the discussions among the civil society stakeholders.

The second consultative meeting involved Government stakeholders from the different Ministries and agencies. These included representatives from the Ministry of Health, Ministry of Women, Family and Community Development, National Anti Drug Agency, Department of

Islamic Development and Royal Malaysian Police. Part A of the NCPI and the narrative content were discussed with participants of this workshop with AIDS officers from the different states as well as the AIDS/STD Section of the Ministry of Health taking the lead in the deliberations. The questionnaire was completed through joint discussions with all those in attendance.

A key issue highlighted in the previous report was the lack of participation by other Government partners other than the Ministry of Health, in the preparation of the document. However, it has been a noticeable improvement that in this report, the participation of other Ministries and agencies has been frank, vigorous and energetic which reflects a more engaged, diversified and multi-ministerial role on the part of the Government in responding to the epidemic over the past two years.

On 26 January 2010, a workshop was convened with Government and civil society stakeholders to share with participants the results of the joint deliberations from both meetings. The narrative framework was shared and further improved upon. During this meeting, specific examples of good practices were identified and agreed together to be included and highlighted in the report. The challenges and remedial actions were also determined in the same manner.

The draft 2010 Country Progress Report was presented during a national UNGASS consensus workshop which was convened on 18 March 2010 to verify and vet the completed inputs. Participants to this workshop included key Government and civil society stakeholders as well as those coming from multilateral agencies and international NGOs such as the UN. A number of academicians and community resource persons working on specific concerns related to injecting drug users, sex work and transgender issues were also present to provide input to throughout the consultation process.

The approach utilising information sharing, inclusivity and consensus building for the development of the UNGASS country progress report has improved since the last process. The sources of data to report on the UNGASS indicators were also determined and collected from all sectors involved in HIV programmes as part of the HIV response. Much of the research data contained within this document originated from the efforts and work of civil society and community based organisations, working in partnership with Government agencies and academic institutions. Though data quality remains a continuing challenge, and is reflected appropriately in this report, it is not an exaggeration to describe the inputs from these stakeholders have been critical in improving the understanding and response to the epidemic in the past 2 years. The content of the narrative section was also consolidated through desk review and interviews.

Completing the National Funding Matrix remains a challenge. However, improved information flow from both Government and non-government stakeholders have resulted in a better picture of the availability of financial resources supporting the national response. The understanding and share of private sector financial contributions have also improved tremendously and is reflected appropriately in this report. As such, the financial breakdown for the national AIDS response for 2008 and 2009 is able to be approximated and reported accordingly in this report.

The UNGASS Country Progress Report was developed and prepared by the AIDS/STD Section of the Disease Control Division, Ministry of Health. Technical support in the formulation and preparation of the consultation process, consolidation of inputs and finalising of the report was provided by the United Nations Theme Group on HIV and AIDS.

B. Status of the epidemic

The first three cases of HIV in Malaysia were detected in 1986. As of December 2009, after more than 20 years into the HIV epidemic in Malaysia, the country has recorded a total of 87710 persons with HIV. An estimated 105 439 people are currently living with HIV.[1]In addition to that, a total of 13394 AIDS related deaths have been reported as of 2009.

The annual number of reported new HIV cases has been on a steady decline from a peak of almost 7 000 in 2002. The total number of new HIV cases has been fluctuating from 1996 to 2001, climbing again in 2002 and gradually descending until 2009. By December 2009, 3080 new cases were reported for that year. Currently, there are 9 new reported cases of HIV each day, where 2 are female while 7 are male. 6 persons acquired HIV through injecting drugs while 3 others were infected sexually.

The number of people reported to have developed AIDS, which at 1 842 cases was the highest in 2006, is also on the decrease, reporting only 741 new cases in 2009. The notification rate of HIV also continues to experience a decrease from 23.4 cases per 100,000 in 2005 to 10.8 cases in 2009. In 2007, it was recorded the highest number of HIV/AIDS related deaths since 1986 with 1,374 persons and in 2009 the HIV/AIDS related death was 805.[2]

Table 1: Overview of the Malaysian HIV Epidemic

Cumulative number of reported HIV infections since 1986	87 710
Cumulative number of reported HIV/AIDS related deaths since 1986	13 394
Women reported with HIV as of Dec 2009	8 091
Children under 13 with HIV as of Dec 2009	870
New HIV infections detected in 2009	3 080
HIV/AIDS related deaths in 2009	805
Number of PLHIV accessing ART	9 962
Estimated adult (aged 15-49 years) HIV prevalence	0.5%

Source: Ministry of Health 2010

Men represent the majority (90.8%) of cumulative HIV cases while women and girls account for less than 9.2% of this total. 35.9% of reported infections are amongst young people between the ages 13-29 years old. Most reported infections occur among young heterosexual males of Malay ethnicity, between the ages of 20 – 39 who inject drugs. Children aged 13 years below consistently comprised 1.0% of cumulative total of HIV infections from 1986 to December 2009.

Currently, cumulative reported cases of HIV transmission has been predominantly through injecting drug use (70.6 %), followed by heterosexual intercourse (16.9%) and homosexual or bisexual contact (2.0%).[3,4] However, 2009 data indicates that 55.2% of new HIV cases for that year were attributed to injecting drugs and 32.0% through sexual transmission (heterosexual and homosexual/ bisexual).

[1] Ministry of Health and World Health Organisation (2009). *National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic.* Revised version 20th March 2010.
[2] Ministry of Health (2010). *Statistics of HIV AIDS in Malaysia (1986 – 2009)*
[3] Ibid
[4] Ibid

The HIV epidemic in Malaysia is mainly driven by injecting drug use and heterosexual transmission. Amongst men, the main mode of HIV transmission continues to be via injecting drug use where HIV prevalence is estimated to be 22.1%.[5] On the other hand, the Ministry of Health reported that most HIV infections amongst women have occurred through heterosexual transmission (70%). Women and girls are increasingly getting infected with HIV, constituting around 18 percent of newly infected persons nationwide in 2009 compared to being barely 5 percent ten years ago.[6]

Examination of data from each state also reveals that there continues to be two main trends of HIV infection which are geographically distinct. The majority of states in Peninsular Malaysia have IDU driven epidemics but a number are increasingly having heterosexual transmissions either equally contributing or leading HIV infection. States such as Sabah and Sarawak, located in East Malaysia, have reported 97.7% and 83.6% of their HIV cases respectively being transmitted through this route in 2009.[7]

The magnitude of sexually transmitted infections (STIs) in Malaysia is very much under-represented. This is due to under-reporting and under diagnosis, asymptomatic manifestation of the disease as well as patients preferring to access the private healthcare facilities to treat STIs as opposed to seeking treatment at public hospitals and clinics. Some also prefer to self-treat through alternative medicine. Despite the existence of the Prevention and Control of Infectious Diseases Act of 1988 which requires reporting of incidences of syphilis, gonorrhoea, chancroid and HIV, most cases of STIs are not reported by private practitioners.

As HIV prevalence continues to be less than 1% but ranging from 3% to 20% among most at risk populations such as sex workers and drug users, the World Health Organisation (WHO) currently classifies Malaysia as having a concentrated HIV epidemic.[8, 9]

In the next few years, based on recent estimations and projections work, HIV in Malaysia is predicted to be increasingly spread through sexual modes of transmission while infections acquired through injecting drug use are expected to plateau. The number of reported cases attributed to MSM and heterosexual route of transmission is slowly increasing which is consistent with the HIV estimation and projections model developed for Malaysia. It is expected that this evolving picture of the HIV epidemic will present new and difficult challenges for HIV programming taking into consideration Malaysia's cultural and religious context and sensitivities.

C. Policy and programmatic response

The Malaysian response continues to be guided by the *National Strategic Plan on HIV/AIDS 2006 – 2010*. A new sense of urgency and national commitment in responding to the challenge of the sole unfulfilled sixth MDG resulted in the development and production of the 5 year National Strategic Plan on HIV/AIDS 2006-2010. This NSP, which was developed and drafted with the involvement of key civil society representatives in 2005 and 2006, incorporates a multi-

[5] Malaysian AIDS Council (2010) *Integrated Bio-Behavioural Surveillance (IBBS) survey with IDUs, SW, TG*. Powerpoint presentation. Presented on 11 March 2010
[6] Ministry of Health (2009). Op cit (see reference 2)
[7] Ibid
[8] Ibid
[9] Economic Planning Unit and UNDP (2005). *Achieving the Millennium Development Goals. Success and Challenges*. The UN Country Team Malaysia and the Economic Planning Unit, Government of Malaysia

sectoral strategy covering issues from young people's vulnerability to the delivery of healthcare services and antiretroviral treatment.

This framework provides a common basis for coordination and guidance of the work of all Government and non-governmental partners involved in the national HIV response as well as emphasises an integrated and comprehensive approach addressing the needs of prevention, treatment, care and support.

However, it is important to note that the NSP for this period has 3 main priorities. First and foremost, the document is aimed at securing commitment for the Harm Reduction Programme, specifically on the issue of needle exchange. It is the main HIV prevention programme and the focus of the NSP. As such, it is also the most funded. Secondly, the provision of subsidised ARV treatment for first line and second line regimes was deemed to be a central issue in light of the Government's decision to make available both generic and patented drugs for PLHIV. Finally, the identification and recognition of specific most at risk populations (MARPs) such as female sex workers, men who have sex with men, transgender persons, refugees, migrants as being vulnerable to HIV enabled for programmes to be developed for these groups as well as have access to public funding available under the NSP allocation.

Under this strategic plan, the Government provides an allocation of RM 500 million (USD 143 million) for a period of 5 years. This translates to RM 100 million (approximately USD 28 million) yearly which goes towards the funding of Government and non-government HIV prevention, care and support programmes. The funding also provides for the provision of antiretroviral treatment for almost 10 000 people living with HIV.

As stated in the previous report, under this strategic framework, the Cabinet Committee on HIV/AIDS (CCA) was established and chaired by the Deputy Prime Minister. At the end of 2008 the Malaysian AIDS Council was offered a seat on this committee with voting rights as a full member. This would allow for the voice of civil society and the different communities represented by MAC to be effectively heard by members of the Cabinet. In 2009, the entire policy and decision making structure was revised and the CCA was restructured and known as the National Coordinating Committee on AIDS Intervention (NCCAI) chaired by the Minister of Health. Civil society is also represented on this committee.

The increase in proportion of female HIV cases in Malaysia over the past five years has become an issue of utmost concern and a priority for the Government. As such, a Taskforce on Women, Girls and HIV/AIDS was set up in 2009, and is chaired by the Ministry of Women, Family and Community Development (MWFCD). The Taskforce is tasked to guide the actions of the Government in its response to addressing the behavioural and socioeconomic factors behind the sexual transmission of HIV.

The harm reduction programme, comprising the Needle Syringe Exchange Programme (NSEP) and the Methadone Maintenance Therapy (MMT,) remains the cornerstone of the Malaysian Government's HIV prevention strategy. Implemented in partnership with non-governmental organisations (NGOs), community based organisations (CBOs) and private health practitioners, it remains the better funded programme among all the HIV prevention activities. Though the programme continues to be below target levels, it has been able to scale up significantly with increased sites and clients as well as explore a number of key areas, namely the introduction of the MMT at National Anti Drug Agency service centres and incarcerated settings specifically prisons.

The engagement with and involvement of religious leaders, especially Muslim religious leaders has increased significantly since the last report. As religious leaders in Malaysia can be very influential on the attitudes of their communities towards PLHIV and MARPs as well as on other populations such as policy makers and healthcare practitioners, a lot of advocacy and investment in programming was done to mobilise and harness the support of Islamic religious leaders for HIV prevention and the provision of care and support. Building on the successes of the "Islam and HIV/AIDS" project first initiated between 2001 to mid-2005 which was first reported in the 2008 report, Muslim religious leaders have since not only been actively 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 past 2 years in particular have seen the remarkable development of programmes which involve a number of religious departments engaging most-at-risk populations such as female sex workers and transgender persons through the availability of religious classes.

In the period covered by this report, much progress has been made both in understanding the situation of most at risk populations (MARPs), particularly regarding vulnerability to HIV and STD infection and the need for specific essential services. Much improvement has been achieved in the reporting of UNGASS indicator data as a result of a number of surveys and research studies conducted in the past two years by a number of NGOs, such as the Malaysian AIDS Council, PT Foundation and Federation of Reproductive Health Associations Malaysia. Their work in conducting these studies and the subsequent findings have made it possible to report on behavioural indicators, previously unknown and often guessed at, which will be later used in influencing HIV programming with these specific populations.

In the area of treatment, a significant achievement has been the availability and provision of first line ARV treatment at no cost for those who need it. The second line regime is also partially subsidised by the Government. A significant development in this area has been the availability of HIV treatment in incarcerated settings namely in specific prisons and drug rehabilitation centres. The availability of such treatment coupled with an almost nationwide coverage possible through government healthcare facilities has resulted in almost 10 000 persons currently under ARV treatment. This falls short of the 13,642 (based on CD4 less than 200) persons estimated to need treatment. Treatment literacy remains a constant challenge for public healthcare practitioners as well as community based organisations working in this issue. 2009 also saw the revision of the ARV treatment initiation threshold from the CD4 level of 200 to 350. This revision of treatment protocol has significantly increased the number of persons estimated to be needing treatment and could further widen the gap between those who are on treatment and those who are not. However, of major concern for both the Government and civil society actors on this issue, is the large financial burden such a revision will entail on public funds in addition to ensuring that more people are able to access and adhere to treatment.

A glance at the list of partner organisations of the Malaysian AIDS Council indicates the large number of NGOs and CBOs working on HIV related issues with different communities in the field, ranging from sex workers, MSM to People Living with HIV. It has been an article of faith from the very beginning that the Government would handle the provision of ARV and the facilitation of essential healthcare for PLHIV as well as other communities. The NGOs are tasked with HIV prevention and awareness programmes, care and support activities for those infected and affected as well as complimenting the Government's efforts by supporting access to HIV treatment. Over the past two decades, these areas have been the focus of the work of the NGOs in the area of HIV.

Involvement of key civil society stakeholders in national level policy and programme development continues to be dependent on issues of capacity and relevance. However, the situation has improved since the last report as civil society is now represented at a number of policy and decision making levels including the National Coordinating Committee on AIDS Intervention and the Country Coordinating Mechanism. In the former, civil society is represented by the Malaysian AIDS Council while in the later several representatives (e.g. sex workers, PLHIV and transgender) have been elected onto the CCM by their respective communities. The completion of the National Composite Policy Index (NCPI) which was coordinated by the Malaysian AIDS Council and whose results are attached to this report, as well as the Ministry of Health organised workshops to discuss the content of the UNGASS report has enabled greater involvement of civil society in the report-making process. This progress should be continued for all strategic process related to the National Strategic Plan to ensure better engagement between all parties.

The importance of empowering and building capacity of civil society organisations became very clear with the participation of Malaysia in Round 9 of the Global Fund for AIDS, Tuberculosis and Malaria. A working group composed mainly of civil society representatives did most of the necessary advocacy to convince the Government as to the need to participate in the Global Fund process. This working group was the precursor to the formation of the Country Coordinating Mechanism. A country proposal for Round 9 was successfully developed and submitted to the Global Fund Secretariat. However, the proposal was not successful.

Another area of much improvement has been the multi-sectoral dimension of the response. Though much of the leadership in responding to the epidemic continues to be shouldered by the Ministry of Health (it was given the mandate by the Government under the NSP) and the Malaysian AIDS Council, the level of engagement has risen tremendously over the past two years. Other ministries and government agencies (such as Ministry of Women, Family and Community Development, Department of *Orang Asli* (Indigenous People) Affairs and the Religious Department) have been roped into being involved in the response to HIV. Participation of the private sector in key HIV programmes has also seen a major increase ranging from the funding of a financial assistance scheme to providing support for research.

The significantly increased availability of behavioural data amongst most-at-risk populations has also been due to the improved capacity of key NGOs, namely the Malaysian AIDS Council, PT Foundation and the Federation of Reproductive Health Associations Malaysia to conduct and coordinate the implementation of research. As a result, with funding utilised from both public, private and multilateral sources, a number of major critical studies were able to be carried out by these organisations which include the Integrated Bio-behavioural Surveillance (IBBS) study, the Venue Day Time Survey (VDTS) and the Estimates and Projections workshop, the results of which are all utilised in this report.

An area which has seen significant change has been in the area of care and support services specifically the availability of shelters and drop-in centres. Community based organisations are currently working in partnership with the Ministry of Women, Family and Community Development to provide essential support services for PLHIV.

Both government agencies and civil society organisations are currently experiencing tremendous pressure to show the results of the 5 year strategic plan on HIV and AIDS. As a result, expectations have become significantly higher. However, resource priorities of public funding continue to limit the coverage of HIV and AIDS related services, particularly those dealing with sexual transmission of HIV and their accessibility and affordability to the vulnerable

populations. Concern has been expressed as to whether many of the achievements made in the past few years are in fact financially sustainable due to the sole reliance on public funding. The vast majority of prevention programmes involving MARPs such as IDUs, men who have sex with men (MSM) and sex workers are conducted by CBOs and NGOs. Reaching out to these populations remains a significant challenge for both the Government and NGO programmes. As a result of inconsistent levels of funding, NGOs are often forced to prioritise and restrict coverage of existing programmes. As a result, interventions are often forced to confine themselves to certain geographical locations.

Legal challenges continue to exist in different contexts whereupon the harm reduction programmes co-exists with legislation which prohibits the possession of injecting drug equipment such as needles and syringes. Transgender persons continue to be prosecuted under civil law as well as religious laws for cross-dressing offences. Men who have sex with men continue to be under threat of criminal persecution for their sexual behaviour under existing laws. All of the abovementioned legal issues complicate existing interventions HIV programmes making it even harder to communicate and influence the targeted populations.

Issues of stigma, discrimination, denial and ignorance continue to have an impact on every programme of the NSP. The fear of being discriminated against or harassed has contributed to PLHIV not able or wanting to access treatment, sex workers denied condoms, and transgendered persons being arrested by religious authorities.

Additional challenges which continue to confront the national response include sustaining and scaling-up coverage of existing services, strengthening leadership and political will, maintaining current levels of financial commitment, developing efficient and transparent systems for allocation of financial resources and establishment of a national monitoring and evaluation framework.

As a result of many of the progress and accomplishments made by Malaysia in the duration of this report as well as the leadership demonstrated both in the Government and non-governmental organisations, it is possible to reverse the spread of HIV and achieve the sixth goal of the Millennium Development Goals within the next five years. However, it is necessary to ensure and maintain the levels of political support and financial resources needed to scale-up many of the existing HIV programmes.

D. Overview of UNGASS Indicators

The following table is an overview of Malaysia's reporting on UNGASS indicators and summarising the progress made over the past two years through comparison with the data reported in the 2008 document. It is important to note that much of the improved reporting in the 2010 report is due to data which has only become available in the past year due to the implementation of key Integrated Bio -Behavioural Surveillance studies and various surveys. As such, there will be marked differences between the two sets of data.

Table 2: Overview of UNGASS Indicators

Indicators	Main Data Source (2010)	Status: 2006-2007	Status: 2008-2009	Comments
National Commitment and Action Indicators				

Indicators	Main Data Source (2010)	Status: 2006-2007	Status: 2008-2009	Comments
1. Domestic and international AIDS spending, by categories and financing sources	AIDS Spending Report Malaysian AIDS Council	RM 200 million out of a RM 500 million budget allocation has been earmarked for 2006 & 2007.	Total (2008): RM 86 632 000 *Domestic Public* : RM 83 993 000 (96.95%) *Domestic Private*: RM 1 619 000 (1.87%) *International*: RM 1 020 000 (1.18%) Total (2009): RM 95 810 000 *Domestic Public* : RM 92 661 000 (96.79%) *Domestic Private*: RM 1 629 000 (1.7%) *International*: RM 1 020 000 (1.59%)	AIDS spending for Malaysia as far as possible based on available information and data.
2. National Composite Policy Index (NCPI)	National Composite Policy Index (NCPI) Workshops (government; NGOs; Multilateral and bilaterals)	See attached NCPI data	See attached NCPI data (Annex 2)	The NCPI Part A and Part B were completed through a series of consultation workshops involving stakeholders from government; NGOs and multilaterals.
National Programmes Indicators				
3. Percentage of donated blood units screened for HIV in a quality assured manner	National Blood Centre, KL	100% of donated blood is screened for HIV	100% of donated blood is screened for HIV	All blood products are screened by the National Blood Centre.
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	National HIV/AIDS Treatment Registry (NHATR)	51% receiving ART out of 13080 persons.	37.3% (9 962 of an estimated 26 722 needing treatment)	Previous figures based on past treatment initiation protocol of CD4 count of 250 cells/mm or less. This protocol has now been revised to 350. The current estimated figure of those needing treatment reflects this revision.
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	PMTCT programme monitoring	100% of 328 women received ART over the past two years.	100% of 347 women received ART over the past two years.	Pregnant women who undergo the PMTCT programme all receive ART
6. Percentage of estimated HIV-positive incident TB cases that received	National HIV/AIDS Treatment Registry (NHATR)	33.5% of HIV positive TB cases receive treatment for TB & HIV	30% of HIV positive TB cases received treatment for TB & HIV.	Compilation from 3 states. 1301 TB-HIV cases out of which 390 were treated with ARV

Indicators	Main Data Source (2010)	Status: 2006-2007	Status: 2008-2009	Comments
treatment for TB and HIV				and TB treatment
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	HIV Programme Monitoring	75% of 530 789 women and men aged 15-49 received a HIV test in the past 12 months and know their results.	98% of women and men aged 15-49 received a HIV test in the past 12 months and know their results.	Results from the Voluntary HIV Screening programme. 17 349 out of 17 641 persons in 2009 had a test and knew their results.
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.	IDU – IBBS (2009) SW – IBBS (2009) MSM – N/A	100% of 21 497 IDUs and MSM are screened for HIV and are aware of their status.	IDU : 33.0% SW : 19.96% MSM : N/A	The improved availability of anonymous VCT services has resulted in increased number of persons accessing the facility but fewer returning for their results.
9. Percentage of most-at-risk populations reached with HIV prevention programmes	IDU – IBBS (2009) SW – IBBS (2009) MSM – N/A	Data not available	IDU : 7.46% SW : 51.1% MSM : N/A	
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Data not available	Data not available	Data not available	Indicator is not relevant for country.
11. Percentage of schools that provided life skills-based HIV education within the last academic year	UNICEF & Ministry of Education LSBE Pilot Project	Data not available	0.2%	Current life skills-based HIV education initiatives exist only at the pilot stage, which remain involving only 20 schools. No relevant data exists beyond the pilot.
Knowledge and Behaviour Indicators				
12. Current school attendance among orphans and among non-orphans aged 10–14	Data not available	Data not available	Data not available	Indicator is not relevant for country.
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission	National Service Survey MOH (2008)	Data not available	22.6%	Survey conducted with 6000 National Service trainees (aged 17 – 19 years old)

Indicators	Main Data Source (2010)	Status: 2006-2007	Status: 2008-2009	Comments
of HIV and who reject major misconceptions about HIV transmission				
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IDU – IBBS (2009) SW – IBBS (2009) MSM – N/A	IDU : 98.4% (BSS 2002) SW : 78.4% (BSS 2004) MSM : Not available	IDU : 49.68% SW : 38.48% MSM : N/A	Questions administered in IBBS were formulated utilising UNGASS standard of 5 questions correctly answered.
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Lee LK, Chen PCY, Lee KK, Kaur J (2006)	Data not available	5.38%	Premarital sexual intercourse among adolescents in Malaysia: a cross sectional Malaysian school survey. *Singapore Medical Journal* (2006)
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Data not available	Data not available	Data not available	No current studies currently available to capture this data.
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Data not available	Data not available	Data not available	No current studies currently available to capture this data.
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	IBBS 2009	35.4% of sex workers reported using a condom with their most recent client (BSS 2004)	SW : 61.34%	-
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	MAC Programme Monitoring 2008	Data not available	21%	-
20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	IDU – IBBS (2009)	5.1% reported using a condom during last sexual intercourse (BSS 2004)	IDU : 27.8%	-
21. Percentage of injecting drug users	IDU – IBBS (2009)	27.6% reported using sterile injecting	IDU : 83.49%	-

Indicators	Main Data Source (2010)	Status: 2006-2007	Status: 2008-2009	Comments
who reported using sterile injecting equipment the last time they injected		equipment the last time they injected (BSS 2004)		
Impact Indicators				
22. Percentage of young women and men aged 15–24 who are HIV infected	Programme Monitoring (National PMTCT Programme)	0.1% of 298 367 antenatal clinic attendees tested whose HIV results were positive for HIV.	0.05%	-
23. Percentage of most-at-risk populations who are HIV infected	IDU – IBBS 2009 SW – IBBS 2009 MSM – VDTS 2009	SW : No data available IDU : 11.0% (sentinel surveillance) MSM : 7.1% (VCT site survey)	IDU : 22.06% SW : 10.53% MSM : 3.87%	-
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	National ART Programme Monitoring 2009	1058 patients began ART. 920 still alive after 12 months of ART. (ART Programme Monitoring 2007)	86.9%	-
25. Percentage of infants born to HIV-infected mothers who are infected	PMTCT programme monitoring 2009	Indicator was modelled by UNAIDS HQ	2.67%	-

II. Overview of the AIDS Epidemic

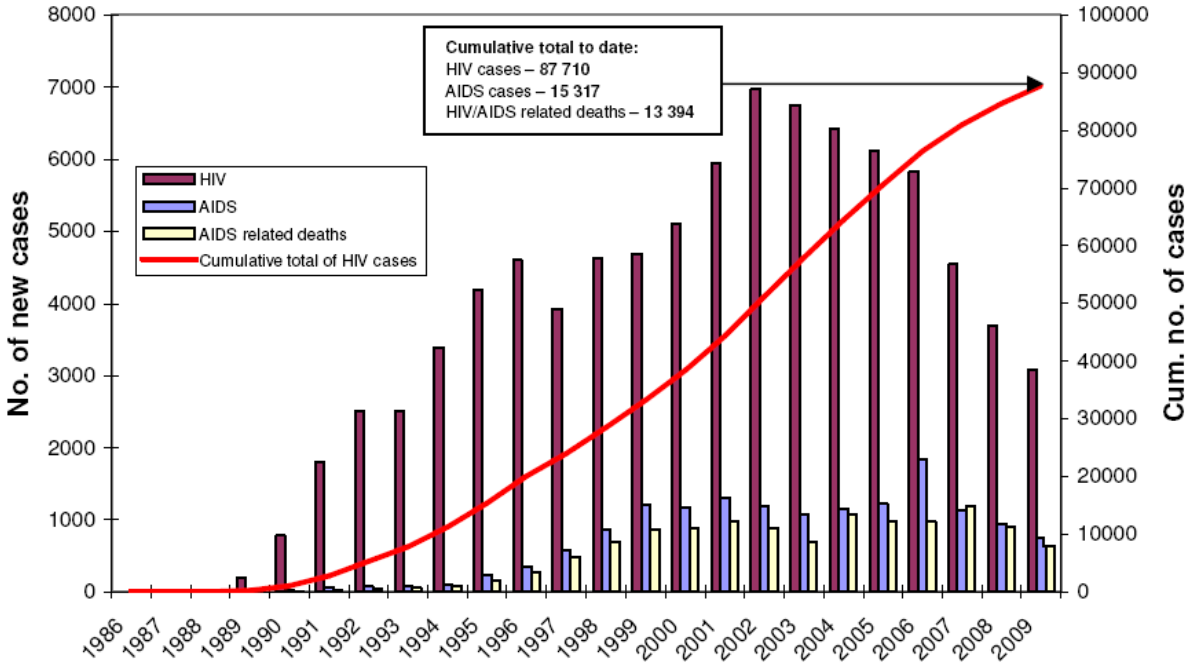
NOTE: The epidemiology data on the HIV epidemic in Malaysia is available up to December 2009 at the time of report preparation.

A. Epidemic overview

After more than 20 years since the first cases in 1986, Malaysia is currently classified by the World Health Organisation (WHO) as having a concentrated HIV epidemic, which initially was driven mostly by the sharing of injecting drug equipment but is now increasingly experiencing a third of new infections being transmitted sexually.

As of December 2009, 87 710 HIV cases have since been reported through the national HIV surveillance system. National adult HIV prevalence is currently at 0.5%. The HIV epidemic has been determined to be currently concentrated in 4 most-at-risk populations (with prevalence >5%) namely injecting drug users, female sex workers, MSM and transgender persons.[10]

Figure 1: The Malaysian HIV Epidemic (1986-2009)



Source: Ministry of Health (2010))

The annual number of reported new HIV cases has been on a steady decline from a peak of almost 7 000 in 2002. The total number of new HIV cases has been fluctuating from 1996 to 2001, climbing again in 2002 and gradually descending until 2009. An average of 3 931 new HIV cases have been reported for the past 5 years. By December 2009, 3080 new cases were reported for that year. Currently, there are 9 new reported cases of HIV each day, where 2 are

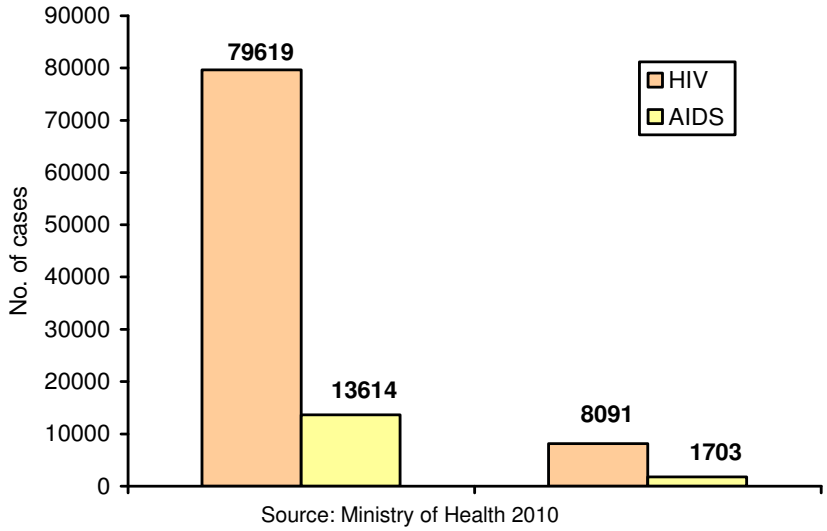
[10] Ministry of Health (2005). *National Strategic Plan on HIV/AIDS 2006-2010*, (October 2005)

female while 7 are male. For every 6 persons who acquired HIV through injecting drugs, 3 others were infected sexually.

The annual number of new reported HIV cases has been on a steady decrease from almost 7,000 in 2002 to 3080 by December 2009. The number of people reported to have developed AIDS, which at 1 842 cases was the highest in 2006, is also on the decrease, reporting only 741 new cases in 2009. The year 2009 recorded the lowest number of HIV/AIDS related deaths since 1999 with 805 deaths.

It is estimated that by 2010, Malaysia will have some 105 471 people living with HIV, and annual deaths numbering almost 6 000 persons. In 2015, there will be an estimated 119 471 PLHIV and 7 551 AIDS-related deaths[11].

Figure 2:Total Reported HIV and AIDS Cases in Malaysia



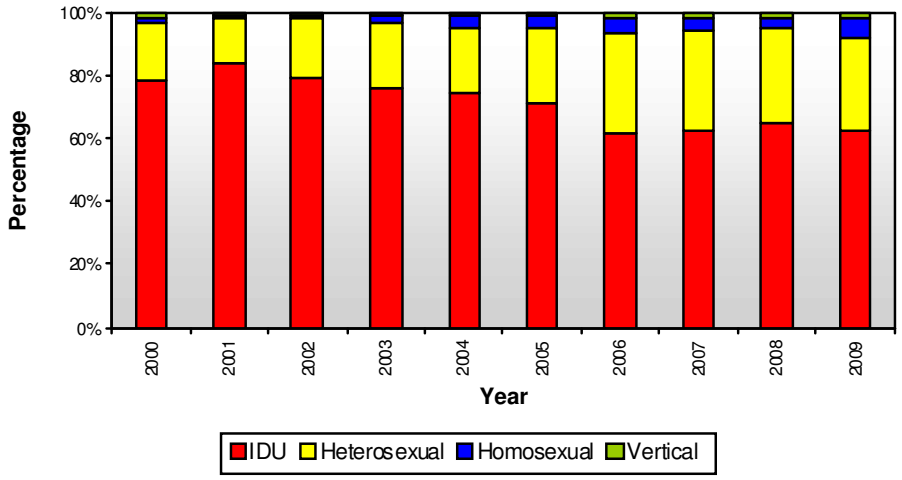
Source: Ministry of Health 2010

The reported number of men newly infected continues to decrease in this reporting period. This figure is currently more than 50% lower than what was reported in 2005 (5383 in 2005 and 2527 in 2009), a trend which is mirrored by the number of injecting drug users detected with HIV. As such, amongst men, the main mode of HIV transmission continues to be via injecting drug use where HIV prevalence is above 19%. Most reported infections occur among young heterosexual males of Malay ethnicity, between the ages of 20-39. 75% of the cumulative reported HIV cases were reported among injecting drug users. However, the Ministry of Health reported that most HIV infections amongst women have occurred through heterosexual transmission (70%).[12] In 2000, women and girls constituted 10% of new HIV cases. For the past 3 years, they now make up almost one fifth of newly infected persons nationwide.

A conjecture first proposed in the 2008 report remains a possible description for the Malaysian epidemic: fewer men continue to get infected with HIV through injecting drug use while more women are increasingly contracting the disease through heterosexual intercourse.

[11] Ministry of Health and World Health Organisation (2009). Op. cit (see reference 1)
[12] Ministry of Health (2010).Op cit (see reference 2)

Figure 3: HIV cases by risk factor (2000 - 2009)

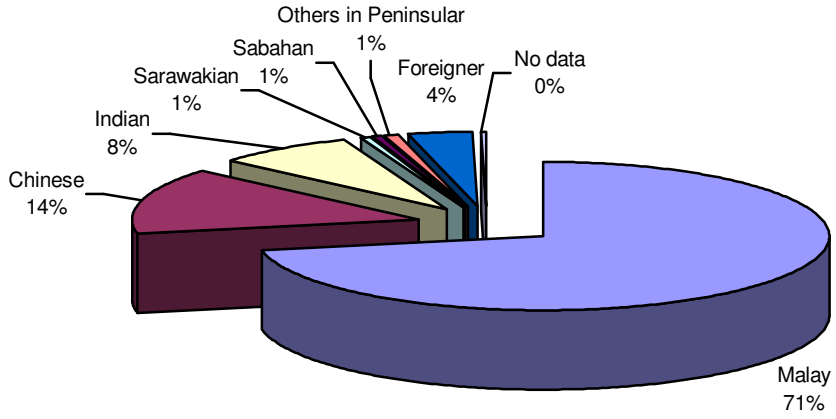


Source: Ministry of Health (2010)

From the perspective of ethnicity, Malays, Chinese and Indians form the majority of people acquiring HIV. Most of them reside in Peninsular Malaysia. The majority of HIV cases comprise of Malay men aged 20-39 (78%) who have predominantly acquired HIV through injecting drug use.[13] This appears to also be the case amongst those of Indian ethnicity. Chinese Malaysians continue to acquire HIV sexually both via heterosexual and homosexual transmission.

However, it must be noted that the epidemic has spread to the *Orang Asli* (indigenous) population as well as those living in the East Malaysia states, Sabah and Sarawak. The differences in these populations with regards to vulnerability and risk require a better understanding to ensure that interventions are able to be properly designed to address relevant concerns and needs.

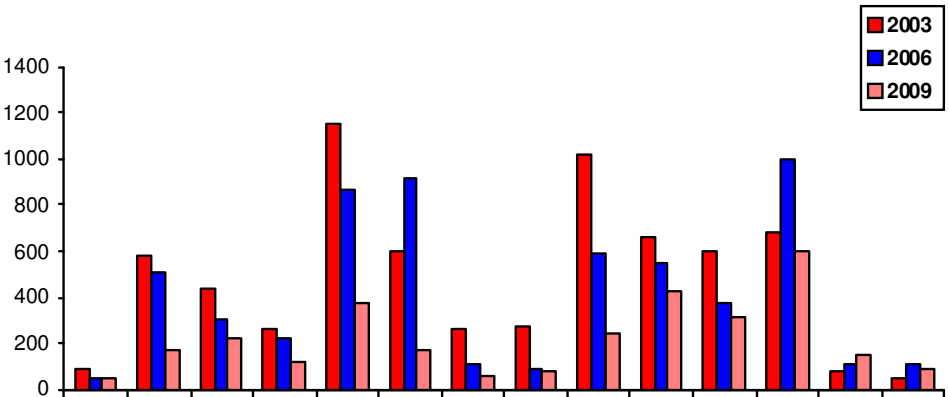
Figure 4: Reported HIV Infections by Ethnicity (as of 2009)



Source: Ministry of Health (2010)

[13] Ibid

Figure 5: Reported new HIV infections in 2003, 2006 and 2009 by states



	Prs	Ked	Per	Pen	Sel	WP	NS	Mel	Joh	Pah	Ter	Kel	Sar	Sab
2003	88	582	439	266	1155	599	265	269	1020	657	605	684	75	52
2006	53	508	308	228	866	921	109	94	594	549	374	998	113	115
2009	43	176	224	124	378	175	62	80	243	431	315	596	146	88

Source: Ministry of Health, Malaysia (2009)

Two different HIV scenarios emerge when the distribution of reported HIV cases is examined from a geographical perspective. Peninsular Malaysia's epidemic is mainly via injecting drug use while East Malaysia (which comprises the states of Sabah and Sarawak) has more HIV resulting from heterosexual transmission. It was first indicated in the 2008 document that Sabah and Sarawak reported 76.1% and 87.8% of their HIV cases respectively being transmitted through this route in 2006. They now report 97.7% and 83.6% respectively in 2009.[14] Both scenarios require specific responses and interventions which address the spread of HIV both through injecting drug use and sexual transmission.

Screening for HIV

HIV remains a notifiable disease under the Prevention and Control of Infectious Diseases Act of 1988 (Act 342). Screening for HIV is conducted throughout the country via a number of national health programmes. Table 2 indicates the routine testing conducted on selected groups of the population and collected through a health information management system, forming the bulk of the HIV and AIDS data submitted to, compiled and reported by the Ministry of Health. As far as possible, the Ministry has tried to encourage the adoption of a voluntary, ethical and internationally acceptable approach to HIV screening such as the Provider Initiated Testing and Counselling (PITC).

The HIV surveillance data compiled through the Government's system originates predominantly from the public sector. Despite HIV being a notifiable disease under the current legislation, data obtained and submitted from the private healthcare system such as from private hospitals, clinics and screening laboratories is marginal as most detected cases in these facilities are not reported. However, in the case of hospitals and clinics, these individuals found to be with HIV are usually referred to the Government healthcare system for further treatment.

[14] Ibid

Table 3: Routine HIV Screening

1. Women receiving antenatal care in government facilities
2. Blood donors
3. Drug rehabilitation centres (DRC) inmates
4. Prison inmates classified as high risk (i.e. drug users, drug dealers and sex workers)
5. Confirmed tuberculosis cases
6. Sexually transmitted disease (STD) cases
7. Patients with suspected clinical symptoms
8. Traced contacts of confirmed persons with HIV
9. Premarital couples
10. Migrant workers
11. Participants of harm reduction programme

Source: Ministry of Health 2010

The Anonymous HIV Voluntary Screening programme was first piloted in 2001 and later expanded nationwide in 2003. Screening is first carried out utilising a rapid test kit after which a reactive result is followed with a confirmation test. In 2009, 19 368 people accessed this facility to obtain their HIV status. 59% of those tested were male and 68.3% were between the ages of 20 and 39. 74% were of Malay ethnicity. For those found to be with HIV, the main risk factor was found to be injecting drug use (67%), followed by sexual transmission (31%). Prevalence was found to be around 0.28%.[15]

The premarital screening of Muslim couples programme began from a single state in 2001 and is now conducted nationwide in all states. In 2009, a total of 179 268 men and women were screened through this programme out of which 67 were confirmed to be with HIV.[16] Prevalence was 0.04%.

The Prevention of Mother to Child Transmission (PMTCT) programme implemented nationwide at government health clinics and hospitals, also incorporates HIV screening utilising an opt-out approach. With more than 70% of all pregnant mothers accessing the public healthcare facilities, for the period of 2007 – 2009, 98.1% (1 178 662 women) of them enrolled in the programme and were screened for HIV. 0.05% of them were found to be with HIV.[17]

Detailed gender and age disaggregated data has recently become available as a result of a revision of the national HIV reporting system. This data has been included as much as possible in the reporting of UNGASS indicators. Analysis of this data is critical to ensure a better understanding of how men and women are vulnerable to HIV infection in Malaysia.

[15] Ministry of Health (2010). Op cit (see reference 2)
[16] Ministry of Health (2010). *Premarital HIV screening in 2009*
[17] Ministry of Health (2010). *PMTCT HIV programme monitoring (as of December 2009)*

Estimations and Projections

National HIV estimation workshops were conducted in 2001, 2003 and 2004. The results of these exercises were mentioned in the 2008 report but were questionable at the time as they depended on limited sentinel and scarce amounts of behavioural surveillance data.

The *National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic* was held in May 2009 and organised by the AIDS/STD Section of the Ministry of Health in partnership with the World Health Organisation. The results from this workshop, endorsed by both the Ministry of Health and civil society stakeholders, provide the most recent and reliable estimates for identified most-at-risk and vulnerable populations. These were later revised in 2010 to reflect the availability of new data from the IBBS studies, the MOH's adoption of the revised WHO's guidelines on treatment as well as Spectrum software upgrades.

Figure 6

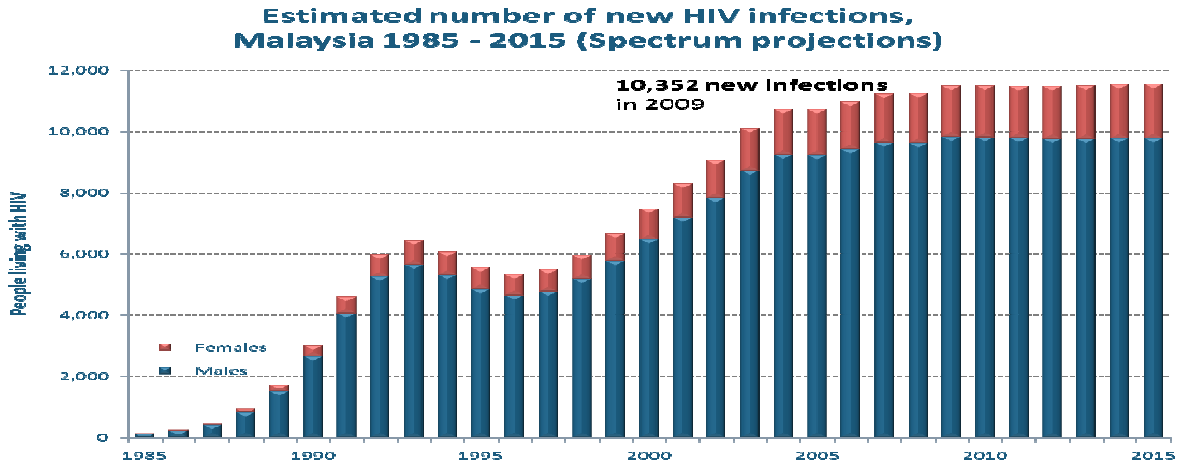
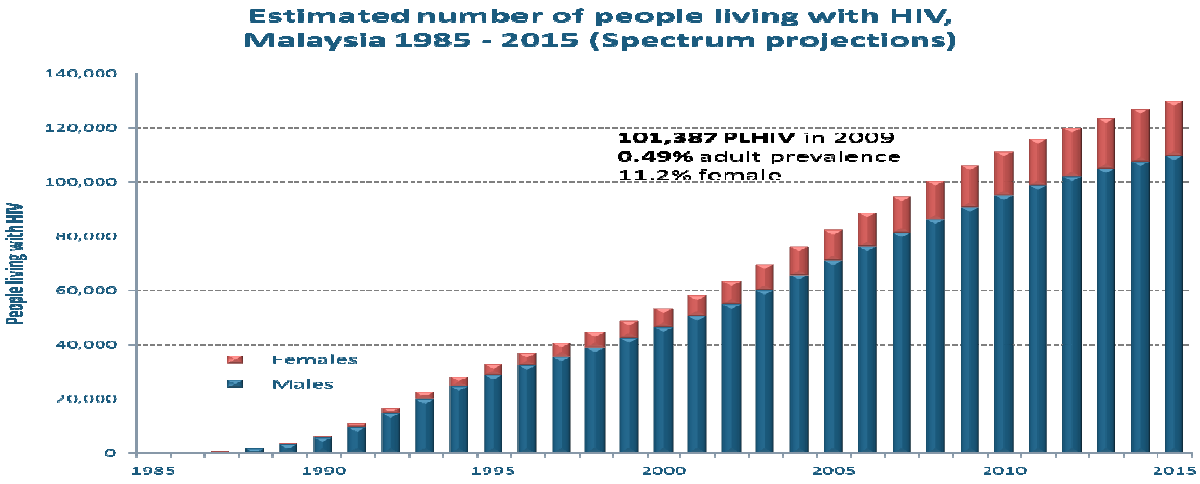


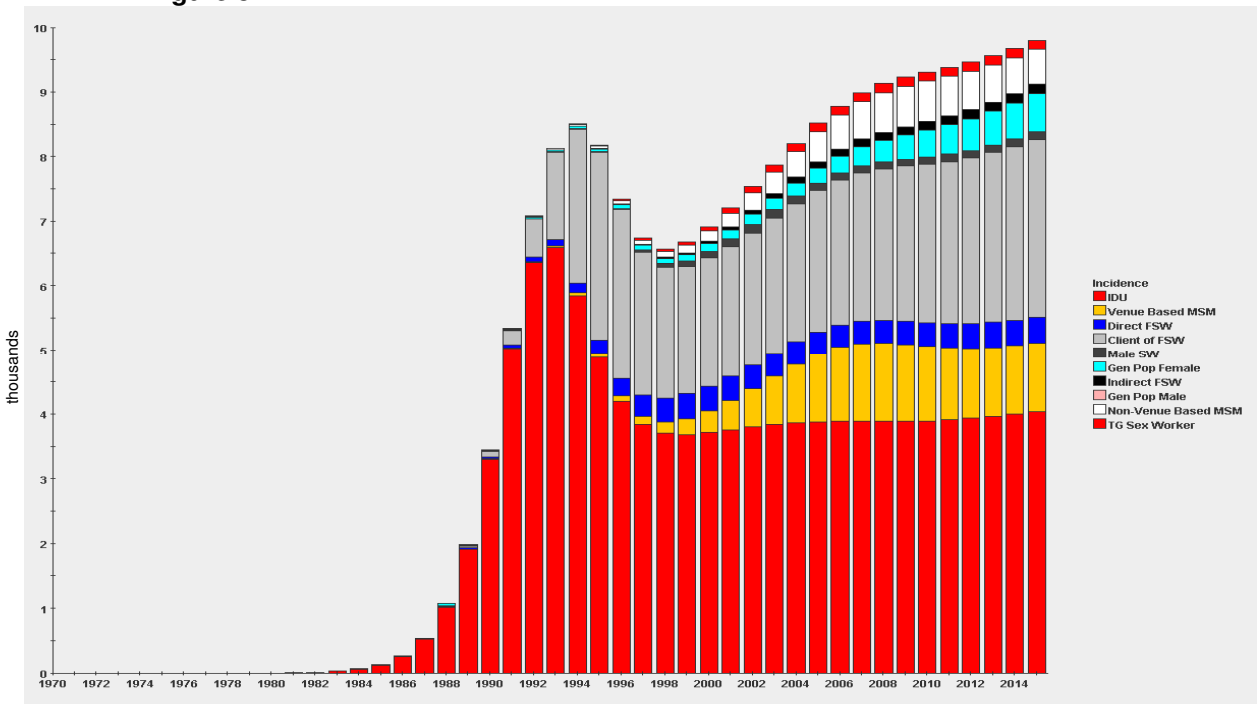
Figure 7



Source: National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic (2009)

According to the estimation model (refer Figure 6 and 8), the number of new HIV cases per annum is estimated to continue to experience a gradual increase between 2008 and 2015. The role of IDUs as an early driver of the Malaysian HIV epidemic is clearly demonstrated with the initial peak observed in the number of new HIV cases detected among IDUs before 1995. Beyond 1995, HIV among IDUs appears to have stabilised at 3,000 new infections per year.[18] On the other hand, the number of new cases amongst MSM (both venue based and non venue based) and clients of female sex workers appear to have increased significantly.

Figure 8: Distribution of new HIV cases, by sub-populations, Malaysia 1985 - 2015. (EPP estimates)



Source: National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic (2009)

The workshop was also able to provide estimates for ARV treatment and coverage as well as for the different MARPs which are reflected in the following section discussing the four identified groups.

The results from the estimation and projections model indicate a number of key findings[19]:

- Since 2008, the estimated number of new HIV infections among IDUs appears to be plateauing.
- For every single male detected with HIV, there are three other male cases which go undetected.
- The number of AIDS related deaths is expected to increase in the next 3-5 years, as disease progression delay catches up as a result of HIV infections from 10-15 years ago. Treatment coverage being at only 40% is also a factor in describing this trend. The large number of AIDS related deaths reported in 2009 could be an early indication of these phenomenons.
- The number of women living with HIV is higher than previously thought, but the proportion is stabilising which is consistent with the profile of a concentrated epidemic. For every 1

[18] Ministry of Health and World Health Organisation (2009). Op. cit (see reference 1)
[19] Ibid

female with HIV there are 3 new infections amongst males. This finding is consistent with the concern of women as intimate partners of IDUs, men who are clients of FSW and MSM.

- A revised needs and coverage estimate based on the WHO recommended criteria of CD4<350 for initiation of treatment has been conducted. This revision is expected to result in a higher treatment need, and lower coverage based on existing targets.

Table 4: Estimates of the Malaysian HIV Epidemic

	2009	2010	2015
• **Total People Living With HIV**	**101,387**	**105,471**	**119,471**
Male	89,986 (88.8%)	93,316 (88.5%)	103,694 (86.8%)
Female	11,401 (11.2%)	12,155 (11.5%)	15,778 (13.2%)
• **Total new infections/ year**	**10,352**	**10,375**	**10,410**
Male	9,102	9,122	8,799
Female	1,250	1,253	1,612
• **Total AIDS related deaths/ year**	**5,767**	**6,019**	**7,551**
Male	5,250	5,439	6,754
Female	517	560	797
• **Cumulative HIV cases**	**163,150**	**173,525**	**225,441**

Source: National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic (2009)

The hidden nature of the HIV epidemic, despite a strong case notification system in the healthcare structure, necessitates the use of epidemic estimation and projection based on comprehensive and continuing second generation surveillance within at-risk populations.

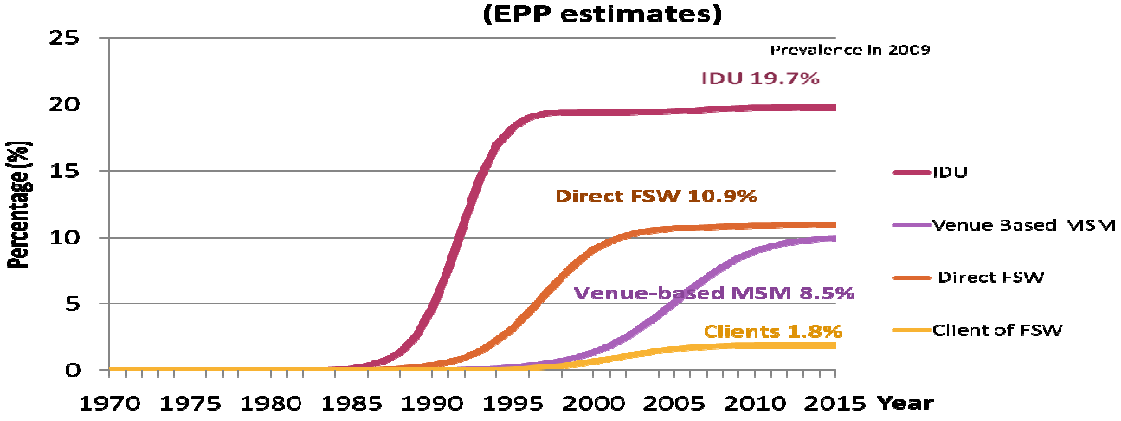
The notification rate as used within the context of the Malaysian epidemic is currently based on reported data which is under-represented as demonstrated by the estimations model. It is necessary to revise the use of this indicator and the epidemiological picture to reflect a current reality whereupon there has yet to be strong evidence that the epidemic is halted and reversed. At this point of time, the IDU epidemiological picture which indicates that the number of infections have plateaued is the nearest to achieving this. Infections among other MARPs which are acquiring HIV through sexual transmission are likely to continue to increase and yet are largely unreported.

B. Most-at-risk Populations (MARPs)

In 2002, it was decided that the existing HIV surveillance system, based on notification of newly diagnosed HIV infection and screening in sub-populations, did not adequately explain nor was the data obtained able to be utilised to predict the course of the epidemic.[20] As such, the Ministry of Health decided to incorporate the use of behavioural surveillance studies into the existing system. It was strongly felt that monitoring HIV risk behaviour could play a vital role in determining the future direction in the spread of HIV within the different most-at-risk populations. Behavioural Surveillance Surveys was adapted for this purpose beginning in 2004 which was later followed by the use of Integrated Bio-Behavioural Surveillance (IBBS) studies. The IBBS latter surveys which were conducted in the Klang Valley by the Malaysian AIDS Council with 3 target populations (injecting drug users, female sex workers and transgender persons) in 2009 have been particularly instrumental in providing a better description as to the vulnerabilities and behaviour of most-risk populations.

[20] Ministry of Health & WHO Western Pacific Region (2006). *Summary Findings of Behavioural Surveillance Surveys (BSS) in Malaysia*. AIDS/STD Section.

Figure 9: HIV Prevalence (%) among key at-risk populations (EPP estimates)



Source: National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic (2009)

As mentioned earlier, the outputs from these studies were later utilised in the National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic to produce a model of the local scenario (Figure 9). The estimated prevalence among the at-risk populations are as in the figure above.

The results of these surveys are also intended to inform and support the planning, implementation and evaluation of HIV interventions for the different most-at-risk populations. However, it must be noted that despite the improved availability of behavioural studies and findings from programme monitoring, much of the current national response particularly the formulation of policies and the development of prevention, treatment, care and support programmes is still dependent on sentinel surveillance data.

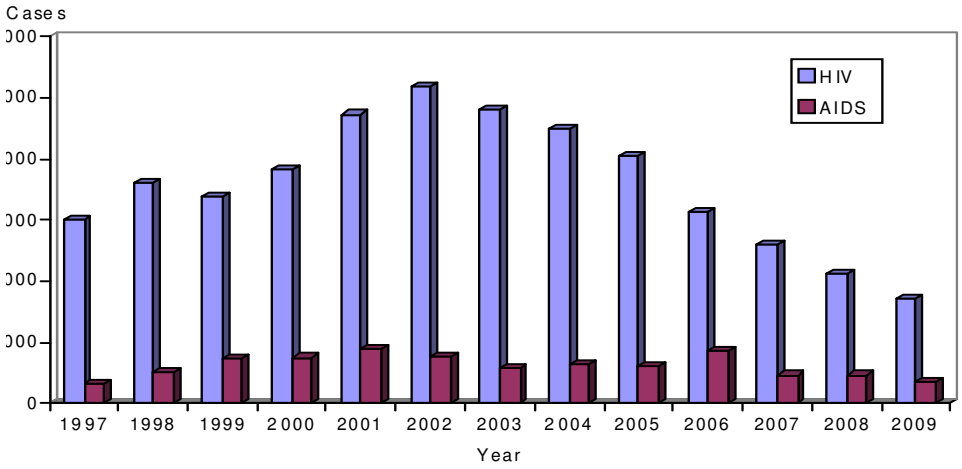
Injecting drug users (IDUs)

Since the beginning of the epidemic in Malaysia, the rapid spread of the HIV has been attributed to the use and sharing of contaminated injecting drug equipment among people who inject drugs. The profile of injecting drug users in the country continues to be predominantly male, young, of Malay ethnicity and heterosexual. Women comprise a small proportion of drug users (2%). Existing studies show that female drug users remain a minority in this population.

1 699 new cases of HIV amongst injecting drug users were detected in 2009, bringing a cumulative total of 61 947 persons from this population reported with HIV. As seen in Figure 10, reported HIV data from the Ministry of Health indicates a consistent decrease of new reported HIV cases among IDUs in the past seven years. The population of IDUs is estimated to be around 170 000 with a prevalence of 22.1%.[21]

[21] Malaysian AIDS Council (2010). Op. cit (see reference 5)

Figure 10: New HIV and AIDS cases among IDUs (1997-2009)



Source: Ministry of Health (2010)

It was previously described in the 2008 report that there was a dearth of studies aimed at describing the behaviour of injectors. The IBBS survey conducted by the Malaysian AIDS Council with 630 IDUs in 2009, goes a fair distance in addressing this concern and was able to bring forth a number of key findings concerning this population.[22] 83.5% reported using sterile injecting equipment the last time they injected. Half of them were also sexually active in the past year. Despite the fact that 88.9% of respondents demonstrated knowledge of condoms to prevent HIV infection only 27.8% used condoms during their last sexual encounter.

Programme monitoring conducted in 2009 of inmates in the 28 drug rehabilitation centres (DRC) found that there are currently 365 inmates with HIV. 349 are men and 16 female. HIV prevalence in this setting was found to be 7.9%.[23]

Despite the IDU respondents in the IBBS survey being 97.8% men, it is possible for there to be many female cases of HIV yet unseen amongst injectors. Women and girls as injectors face tremendous social stigma, discrimination and shame. They may also depend on their male partner to obtain drugs as opposed to seeking it out themselves. Together with the risk of sexual violence, harassment, spousal abuse, and lower social status, this makes them less likely for them to seek information and to access healthcare services, increasing their risk and exposure to HIV infection. [24] As such they may also fall outside the coverage of studies such as the IBBS.

Sex workers

The yearly increases in the number of heterosexually transmitted HIV cases which currently accounts for almost a third of all new infections, is a strong indicator of a new trend linked to the sexual spread of HIV in the local context. Therefore an issue of concern which must be addressed is the effectiveness of current HIV prevention programmes in the context of sex work.

[22] Ibid
[23] Ministry of Health (2010). Op cit (see reference 2)
[24] Centre for Harm Reduction. *Female drug use, sex work and the need for harm reduction.* http://www.chr.asn.au/freestyler/gui/files/female_drug_use.pdf

The cumulative number of sex workers reported to have acquired HIV since the beginning of the epidemic was 563 or 0.6% of the 87 710 HIV cases seen thus far. In comparison to the large proportion of injecting drug users reported to be infected with HIV, the number of HIV cases reported among sex workers is quire small. However, this is taken as a gross underreporting of this population as sex workers will not necessarily identify themselves as such and may also not come forward for treatment. Current studies also only involve female and transgender sex workers. As it is, the situation with male sex workers is currently largely unknown as they are often hard to identify. As such, they are left out of existing outreach and intervention programmes.

Similar to the situation in other countries, there are venue-based and non-venue based sex work. The former often takes place in locations such as hotels, streets, massage parlours, karaoke bar, brothel or even a home. Non-venue based refers to the offering of services through a medium such as mobile phone and Internet.

A Behavioural Surveillance Survey conducted with sex workers in 2003 indicated that HIV prevalence amongst those selling sex was above 5%.[25] A size estimation study of sex workers in Malaysia estimated the population of sex workers in Malaysia to be 60 000 whereupon 63.2% were found to be local sex workers while 36.8% were foreign.[26] They are estimated to have the second highest HIV prevalence rate at 10.5%.[27]

The IBBS conducted with sex workers in 2009 indicated that 10.5% of respondents were infected with HIV, 60.6% reported the use of a condom with their most recent client while 38.6% correctly identified ways to prevent sexual transmission of HIV. However, alarmingly 5.6% of survey respondents reported injecting drugs in the past year and a fifth of them had sexual partners who injected drugs. Almost 20% of female respondents of a BSS conducted by the Ministry of Health amongst sex workers in 2004 also reported using drugs in one form or another.[28] 16% of those using drugs indicated that they had injected. Besides the 2009 IBBS conducted with injectors and sex workers which asked questions concerning injecting drug use and sex work, no specific comprehensive study has yet been conducted to gauge the scale and degree of interaction between sex workers and injecting drug use, as well as drug users being involved in paid sex as clients or service providers. This sex work – injecting drug use scenario needs to be further discussed and addressed with appropriate programmes which recognise this reality.

Of particular concern is the largely neglected population of those who purchase sex: the clients. Most of the available literature as well as existing HIV prevention interventions focus on the women who provide sexual services. In other words, the men who demand for such services are left out and are often forgotten in favour of the more convenient and easily identified women who sell sex.

[25] Ministry of Health (2005). *Report of Behavioural Surveillance Survey in Malaysia – Commercial Sex Workers (First Round 2003-2004).*
[26] Lim Hock Eam, Ang Chooi Leng and Teh Yik Koon (2010). *Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work.* UNFPA Project
[27] Malaysian AIDS Council (2010). Op cit (see reference 5)
[28] Ministry of Health (2005). Op cit (see reference 26)

Men who have sex with men (MSM)

Under the existing classification utilised by the HIV surveillance system, MSM are considered to be in the homosexual/ bisexual category. There is an estimated 173 000 MSM in Malaysia.[29] In the previous 2008 report, an observation was made by NGOs working with the MSM community based on data collected from field sites conducting VCT that the number of HIV cases among MSM had increased in the past few years. Nevertheless, due to a dearth of studies examining the MSM community, the understanding of the HIV situation in this population was based on the abovementioned data which was limited as well as anecdotal information from outreach workers.

However in 2009, an adaptation of venue-day-time-sampling (VDTS) was applied to identify venues in Kuala Lumpur where men congregate for the purpose of meeting or soliciting sex from other men. The majority of the 517 respondents were Malays and Chinese (47% and 43.7% respectively) out of which 3.9% were found to be with HIV.[30] One in four reported having more than five male partners in the past six months. 44.9% of those who had unprotected sex with a casual partner were almost 3 times more likely to be with HIV compared to those who did not engage in that activity. 16.1% had had sex with a female partner in the past six months. Due to social pressures, cultural context and the fear of facing stigma, MSM very often have female partners (i.e. wives and girlfriends).

As a result of this study, a better understanding as well as a working baseline has been obtained of the situation affecting the MSM community. However, more such surveys need to be carried out in other locations to ensure a more comprehensive picture.

Transgendered persons (TG)

Transgendered persons or transsexuals are labelled as sexual deviants and often shunned by society in Malaysia.[31] As a result of such stigmatisation and discrimination, the majority of those in this community are unable to obtain employment and thus end up doing sex work. It was previously unknown as to how many cases of HIV were seen or estimated within this population. However, after the IBBS survey conducted with the transgender community in 2009, a better picture has emerged of this population.

From this survey, it was found that the population was experiencing a HIV prevalence of 9.3%.[32] Four out of 5 transgender persons were selling sex at some point of time last year. 94% of them used a condom during their last sexual encounter with a client. 37% of respondents knew how to prevent sexual transmission of HIV. However, it was reported that 11.7% had sexual partners who injected drugs while 3.1% had injected drugs in the past year.

As a whole, despite having a large proportion of respondents using condoms, the prevalence of HIV in this population is as stated above. This has lead to concerns that the effectiveness of HIV prevention programmes and intervention programmes are being compromised due to the reported practice of not using condoms with non-paying sexual partners (e.g. boyfriends, long term clients).[33]

[29] Ministry of Health and World Health Organisation (2009). Op cit (see reference 1)
[30] Kanter J, Koh C, Kiew R, Tai R, Izenberg J, Razali K and Kamarulzaman A (2009). Abstract: *Risk Behaviour and HIV Prevalence among MSM in a Predominantly Muslim and Multi-Ethnic Society: A Venue-Based Study in Kuala Lumpur, Malaysia.*
[31] Teh (2007). *Exploring HIV related needs for safety among transsexuals or mak nyahs*
[32] Malaysian AIDS Council (2010). Op cit (see reference 5)
[33] Lim Hock Eam, Ang Chooi Leng and Teh Yik Koon (2010). *Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work.* UNFPA Project

C. Emerging vulnerable populations

Most at risk young people

Children affected by HIV are termed as those below the age of 19 who are either living with HIV, lost one or both parents to AIDS, or whose vulnerability results in their survival and well being to be threatened by the disease[34]. To date, no national study or survey has been conducted to estimate the number of children affected by HIV in the country and to examine their vulnerabilities to HIV infection.

Of the 87 710 cumulative total of HIV cases since 1998, 2 122 (2.4%) were individuals aged less than 19 years old. 1.4% of all HIV cases were found to be between the ages of 13-19 years. In 2009, children below 19 years of age made up 3.1% (95) of 3 080 new reported HIV cases for that year. The vulnerabilities and situations encountered by both urban and rural children which expose them to HIV infection are many: sexual and physical violence, incest, sex work, human trafficking, underage and unprotected sex. Children with HIV have been reported to have faced stigma and are exposed to and experience acts of discrimination which could lead to ostracisation, exploitation, becoming homeless and loss of education.

The PMTCT programme involving antenatal mothers has been implemented since 1998. HIV prevalence indicated through screening conducted within this programme ranged from 0.02% to 0.05% and the sero-prevalence in 2009 was 0.05%. Coverage of this initiative in government healthcare centres improved from 49.7% in 1998 to 98.1% in 2009.[35] Though the programme covers only women attending government hospitals and clinics receiving antenatal care, it is estimated that more than 70% of women, especially those living in rural areas, in the country seek antenatal care at government healthcare facilities. As a result of this programme, 96% of children born to HIV positive mothers are born uninfected.

Migrant workers

An estimated 1.6 million registered migrant workers and around 500 000 undocumented workers currently reside in Malaysia.[36] A policy was implemented whereupon foreign workers currently undergo three mandatory medical screenings in the first two years of their arrival. These are conducted through a full medical screening which is inclusive for HIV. [37]

The HIV situation amongst migrants in Malaysia is currently unclear as screening is done for the purpose of detecting migrant workers who are considered medically unfit or pregnant and therefore qualify for deportation back to their countries of origin. As of 2009, 0.05% of those who were screened tested positive for HIV.[38]

Refugees

Despite being identified as a marginalised and vulnerable population under the National Strategic Plan on HIV/AIDS 2006-2010, data on incidence rates amongst refugees are not yet

[34] UNAIDS (2006). *AIDS Epidemic Update.*
[35] Ministry of Health (2007). *PMTCT Programme Monitoring*
[36] The Star (2010). "Drop in number of foreign workers". *The Star*. 9 February 2010
[37] Ministry of Health (2006). *Mandatory medical checks for alien workers in first two years*, 19 April 2006. http://www.moh.gov.my/MohPortal/newsFull.jsp?action=load&id=85
[38] Ministry of Health (2010). HIV and AIDS Statistics for Malaysia as of December 2009.

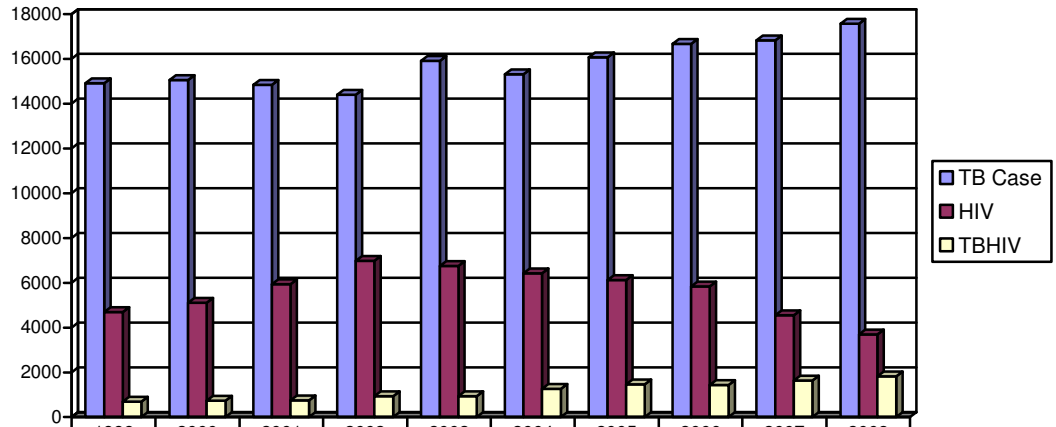
captured through the existing HIV surveillance system.[39] As monitored by the United Nations High Commissioner for Refugees (UNHCR) in Malaysia and other health NGOs working with the refugee community, the population of refugees living with HIV and AIDS is 268 persons (as of March 2010). [40]

D. Recent trends in the epidemic

Incidence increase of HIV/TB Co-infection

Tuberculosis (TB) remains a public health challenge in Malaysia with around 16 000 – 17 000 new cases reported annually. From 1990 to 2008, the number of HIV/TB co-infection reported nationwide has increased from 64 to 1 819 cases.[41]

Figure 11: New TB, HIV and TB-HIV Cases (1999 - 2008)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
TB Case	14908	15057	14830	14389	15912	15307	16066	16665	16825	17570
HIV	4692	5107	5938	6978	6756	6427	6120	5830	4549	3692
TBHIV	690	734	746	933	939	1263	1468	1438	1629	1819

Source: Ministry of Health (2009)

The number of TB cases detected each year is relatively quite high in comparison to the reported incidence of HIV. An average of 16 487 cases were reported over the past five years. In 2008, 17,570 new cases were registered in Malaysia, out of which 10,441 cases were infectious forms.[42] In 2008, 10.4% of all TB cases detected were also having a co-infection of HIV, a proportion which has been gradually increasing each year. Without treatment, as with other opportunistic infections, HIV and TB co-infection would shorten the life of the person infected. Patients with HIV are highly vulnerable to TB, because of their weakened immune systems. In 2005, 41% of deaths were attributed to this form of TB co-infection.

Despite the declining incidence of HIV, the number of HIV-TB co-infection cases appears to be increasing. The TB notification rate (per 100 000) was 63.1 in 2008 and has been more or less

[39] Ministry of Health (2005). *National Strategic Plan on HIV/AIDS 2006-2010*, (October 2005) pg 14
[40] UNHCR (2009). Personal communication
[41] Ministry of Health (2009) *TB Epidemiology in Malaysia*. Fuad Hashim. Powerpoint presentation
[42] Ibid

been consistent for the past five years.[43] As part of its disease control and prevention measures, the Government also currently conducts routine TB-HIV screening for all new inmates in incarcerated closed settings such as prisons and drug rehabilitation centres, which was started in 2001.[44]

Increase in HIV sexual transmission

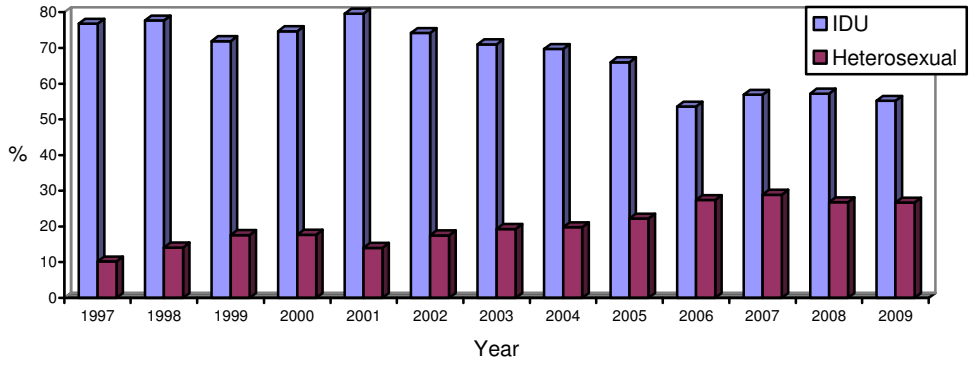
There is no doubt that, for the moment, injecting drug use remains the main mode of HIV transmission in Malaysia. The composition of the majority of reported HIV cases nationwide is made of individuals whose infection has been attributed to the use and sharing of contaminated needles in injecting drugs. Nevertheless, there are clear indications that sexual transmission is becoming a major factor in the future of the country's epidemic. Compared to ten years ago, when infection through the IDU route was 74.7% of all new reported HIV cases, this proportion has declined to 55.2% of all new infections are attributed to injecting drug use in 2009.[45]

Table 5: Percentage of new HIV cases by risk factor

Risk factor	1990	2000	2009
Injecting drug use	**60.4%**	**74.7%**	**55.2%**
Sexual transmission	**5.2%**	**18.8%**	**32.0%**
• Heterosexual	4.8	17.6	26.7
• Homosexual	0.4	1.2	5.3

Source: Ministry of Health (2010)

Figure 12: Percentage of new HIV cases attributed to IDU & Heterosexual transmission (1997-2009)



Source: Ministry of Health (2010)

Increasingly more new reported cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by both heterosexuals and MSM. Combined, sexual transmission of HIV continue to be responsible for more than a third of new HIV cases, a proportion of which is increasing each year.

Figure 12, demonstrates a clear trend from 2001 whereupon fewer annual cases attributed to the IDU route were reported. However, the proportion of heterosexually acquired cases can be observed to have steadily increased.

[43] Ibid
[44] Ibid
[45] Ibid

As of December 2009, HIV transmission attributed to heterosexual intercourse constitutes 16.9% of cumulative cases.[46] However, this same year saw the significant increase of newly infected cases acquired through heterosexual contact from 17.5% in 2002 to 26.7% in 2009. Heterosexual transmission now accounts for nearly a third of newly reported HIV cases in Malaysia.

A Ministry of Health profile of female HIV cases indicated that from 2003 – 2008, 70% of cases seen amongst women for that duration were acquired through heterosexual intercourse.[47] Three out of every five cases of women found to be with HIV were married. As part of the prevention of mother-to-child-transmission (PMTCT) programme in 2009, antenatal screening conducted with more than 4000 000 pregnant women detected 171 individuals with HIV and 86% of them acquired HIV through heterosexual contact.

The proportion of HIV cases reported as being homosexual/ bisexual appear to be quite consistent with estimations of the MSM population which indicate a prevalence of less than 10%. However, it is important to note that this population has increased in number and proportion over the past ten years. With more than 5% of all reported new cases in 2009 being from this route of transmission, there is concern that there is insufficient attention being drawn to HIV prevention amongst MSM and TG. Data from the VDTS also seem to indicate that self-identified MSM did not confine their sexual activity to amongst themselves but also had sex with women.

HIV and Women

There have been cases of women with HIV and AIDS reported from all states and territories in Malaysia. As of December 2009, 8 091 women and girls in Malaysia have acquired HIV since 1986. 45% of these cases were reported within the past five years. 50% of female AIDS cases and 53% of women who have died of AIDS related conditions to date were reported within the same period.[48] First reported in detail in the 2008 document, the incidence profile of the Malaysian HIV epidemic has slowly shifted from almost entirely male to having a higher proportion of female cases.[49] Only ten years ago, men accounted for more than 96% of new HIV cases. However, from female cases representing 4.15% of all reported incidences of HIV in 1996 to 18% in 2009, this increase represents an alarming trend in new infections occurring which is strongly linked to women and heterosexual transmission of HIV as discussed in the earlier section.

The ratio of males to females with HIV can also be observed from the reported data: from 10:1 in 2002 to approximately 5:1 in 2009. However, a constant reduction of new HIC cases occurred annually starting from year 2003, as discussed earlier. According to estimates, there should be 1 female per 3 new infections among males.[50] By the end of 2009, the Ministry of Health recorded 553 new HIV cases and 119 AIDS cases among adolescent and adult women in Malaysia. The MOH profile of female HIV cases indicated that three out of four women were between 20-39 years of age, most were married (60%) and 70% had acquired HIV through heterosexual transmission. By occupation, the highest group of women were housewives (40%). In states such as Johor, this group of women form the majority of female cases seen in this state. It was previously believed that this group would be least likely to be infected.

[46] Ministry of Health (2010). op. cit. (see reference 2)
[47] Ministry of Health (2009). *The Malaysian HIV and AIDS Epidemic.* UNGASS Preparatory meeting. 19 November 2009
[48] Ministry of Health (2010) op. cit. (see reference 2)
[49] Ministry of Health and UNICEF (2008). *Women and girls confronting HIV and AIDS in Malaysia.*
[50] Ministry of Health and World Health Organisation (2009). Op cit (see reference 1)

Overlap of risk behaviours: Injecting drug use and sex work

It is important to note that due to the nature of the Malaysian epidemic having a HIV prevalence of less than 1%, being concentrated in specific most-at-risk populations as well as the dynamics of sexual networking between the groups; it is unlikely that the situation will migrate to a generalised epidemic in the next few years. However, data gathered over the past few years have indicated that no sub-population is fully self-contained. Though transmission remains mostly through the sharing of contaminated injecting equipment among drug users, it is no longer possible to address specific populations individually without consideration of phenomenon such as the overlapping of risk behaviours involving injecting drug use and sex work amongst the most-at-risk populations.

An overlap of the two main risk behaviours, namely injecting drug use and sex work, is also being observed within the Malaysian epidemic. From non-governmental organisations' reports as well as studies such as the IBBS conducted with injectors and female and transgender sex workers, the selling of sex to procure drugs and the high number of IDUs buying sex were found to be common.[51] Needles are also shared between sex workers and clients who pay for sexual services with drugs. Needles and syringes are commonly shared while condom use was found to be generally low and infrequent.

Several sites in the Klang Valley as well as Northern and East Coast states have indicated that male and female drug users have been reported selling sex for money and to procure drugs.[52] They also share injecting equipment with other male and female injectors. A male injecting drug user later has unprotected sexual intercourse with his wife while purchasing sex elsewhere with drugs or money. Studies such as the Integrated Bio-behavioural Surveillance and Behavioural Surveillance Surveys conducted with injectors in 2002 and 2009 respectively indicate clearly that they are sexually active.

[51] Malaysian AIDS Council (2010). Op cit (see reference 5)
[52] Ministry of Health (2008) UNGASS Country Progress Report 2008.

III. National response to the AIDS epidemic

The *National Strategic Plan (NSP) on HIV/AIDS 2006-2010* replaces the previous HIV/AIDS National Strategic Plan first developed in 1998 and reviewed in 2001. The existence of a publically funded multi-sectoral framework to respond to the HIV epidemic has actually been present since 1998. However, due to the lack of adequate and sufficient financial and technical resources to support it, implementation of the national HIV programme resulted in diminished achievements and few objectives reached, particularly in HIV prevention.

However, the National Strategic Plan on HIV/AIDS 2006-2010 was born out of the realisation in 2005 that Malaysia was unable to achieve the sole Millennium Development Goal addressing HIV and AIDS (MDG 6) by 2015.[53] The response to this wakeup call was the NSP, which was developed and drafted with the involvement and participation of key civil society representatives in 2005 and 2006

It provides a common basis for the coordination of the work of all partners involved in the national response including the Government, non-governmental, private sector and multilateral stakeholders. Determined in consultation with relevant government and civil society partners, the NSP is an expression of strategic choices by all parties as to how the country's response to the HIV epidemic should look like over a period of five years. It outlines key national strategies and priorities which highlight the underlying challenges of the HIV response as well as providing guidance towards an integrated and comprehensive approach addressing the needs of prevention, treatment, care and support. The financing and implementation of the NSP is supported under the RM 230 billion allocation available to the national development plan, the 9th Malaysian Plan 2006 – 2010 (9MP).[54]

The objectives of the NSP are as follows:[55]

- To reduce the number of young people aged 15-24 with HIV
- To reduce the number of adults aged 25-49 with HIV
- To reduce the number of HIV infections in IDUs
- To reduce each year the number of HIV infected infants born to HIV infected mothers
- To reduce the number of people from the marginalised population (i.e. sex workers, transsexuals and MSM) with HIV
- To increase the survival and quality of life among people living with HIV

This section on the national response to the AIDS epidemic in Malaysia will be discussed within the framework and context of the National Strategic Plan on HIV/AIDS. This framework outlines six main strategies:

- Strategy 1: Strengthening leadership and advocacy
- Strategy 2: Training and capacity enhancement
- Strategy 3: Reducing HIV vulnerability among injecting drug users (IDUs) and their partners
- Strategy 4: Reducing HIV vulnerability among women, young people and children

[53] Economic Planning Unit and UNDP (2005). Op cit (see reference 9)
[54] Government of Malaysia (2006) *The Ninth Malaysian Plan (2006 – 2010)*
[55] Ministry of Health (2005). Op cit (see reference 11)

- Strategy 5: Reducing HIV vulnerability among marginalised and vulnerable groups
- Strategy 6: Improving access to prevention, treatment, care and support

A. Financing the response to HIV and AIDS in Malaysia

Domestic and international AIDS spending

In 2008, total AIDS expenditure was approximately RM 86.6 million, 96.95% was financed by Government funding and 3.05% by the private sector and international sources. In 2009, expenditure increased by RM 8.6 million.

Regarding sources of financing for HIV programmes, as indicated in the table below, in 2008 and 2009, the domestic public funding from the Government shouldered most of the AIDS related expenditure, whereas international and private sector contributions resources contributed to less than 1%.

Table 6: Source of approximate AIDS expenditure 2008 – 2009[56]

Source of Funding	Year 2008 (RM)	%	Year 2009 (RM)	%
Domestic Public	83 993 000	96.95	92 661 000	96.71
Domestic Private	1 619 000	1.87	1 629 000	1.70
International	1 020 000	1.18	1 520 000	1.59
Total	**86 632 000**	**100.0**	**95 810 000**	**100.0**

Domestic Public Funding

In terms of financial support and AIDS related expenditure, prior to the inception of the new NSP in 2006, less than USD 10 million per annum was allocated by the Government for the national response to HIV and AIDS. The bulk of this allocation was spent on the provision of HIV treatment and involved funding of HIV NGO prevention programmes which were small scale and with limited coverage.

A three-fold increase in this allocation, now totalling more than USD 30 million per annum, was made available to both government agencies and civil society organisations for the five years (2006-2010) in support of implementation of the NSP. With an annual budget of RM 100 million allocated to it, the costs of the national HIV programme translates to approximately RM 3.5 (USD 1) per capita per total population.

Government funding is channelled from the Ministry of Finance to the Ministry of Health which disburses the funds to other government ministries and departments. In the case of NGO related programmes, the MOH uses the Malaysian AIDS Council as the sole conduit for channelling the necessary funds to the individual NGOs. Though individual states, through the state AIDS officers, may have their separate HIV programmes, these activities are funded through allocations which are provided by the Federal Government. Individual Ministries may also utilise their own funding which is independent to that of the allocation under the NSP with the MOH. The amount indicated in the National Funding Matrix does not include salaries of the civil servants which fall under general administrative costs of the Ministry of Health.

[56] Ministry of Health (2010). 2010 UNGASS Country Progress Report, *National Funding Matrix*

Domestic Private Funding

Though information concerning the private sector is currently limited, what is known is that the majority of corporate entities engage the Malaysian AIDS Council and Malaysian AIDS Foundation to provide support for specific programmes (e.g. the Standard Chartered Pediatric AIDS Fund). Therefore information gathered on this is sourced mainly from the Malaysian AIDS Council and Malaysian AIDS Foundation which are the largest beneficiaries.

International funds

For the period of 2006 – 2010, funding allocated for HIV and AIDS programming in Malaysia from UN development partners (i.e. UNDP, UNICEF, UNFPA, UNHCR and WHO) is approximately USD 3.6 million.[57]

AIDS Spending Categories

For both 2008 and 2009, the majority of public funding was used in prevention programmes (44.85% and 47.76% respectively) and followed by the provision of care and treatment (40.10% and 37.39%, Harm reduction programs for both government and NGO run facilities were the major area of expenditure in HIV prevention.

Table 7: AIDS Spending – Approximate total expenditure from Domestic (Public and Private) and International Sources

Programme	Year 2008 (RM)	%	Year 2009 (RM)	%
• Prevention	38 855 000	44.85	45 761 000	47.76
• Care and treatment	34 741 000	40.10	35 819 000	37.39
• Orphans and vulnerable children	886 000	1.02	1 160 000	1.21
• Programme Management and Administration Strengthening	12 000 000	13.86	12 000 000	12.52
• Enabling environment	-	-	170 000	0.18
• Research	150 000	0.17	900 000	0.94
TOTAL	**86 632 000**	**100.0**	**95 810 000**	**100.0**

B. Strategy 1: Strengthening leadership and advocacy

A revised policy and decision making framework.

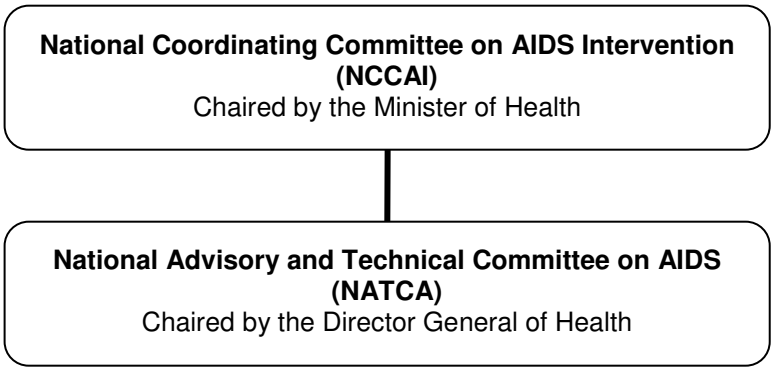
Under the National Strategic Plan on HIV/AIDS 2006-2010, the Cabinet Committee on HIV/AIDS (CCA) was established and chaired by the Deputy Prime Minister.[58] It functioned as a forum for discourse and decision-making at the highest level on HIV and AIDS related policies. It represented a strong commitment on the issue of HIV and AIDS, and also provided a strong political platform for advocacy at the highest levels of Government.

[57] Government of Malaysia (2009). *Country Proposal for Round 9 of the Global Fund for AIDS, Tuberculosis and Malaria.*
[58] Ministry of Health (2005*).* Op cit (see reference 11)

A remarkable development occurred at the end of 2008 whereupon the Malaysian AIDS Council was offered a seat on this committee with voting rights as a full member. This would basically enable a non-governmental organisation (i.e. MAC) to not only engage members of the Committee of ministerial rank but would also allow for the voice of civil society and the different communities represented by MAC to be effectively heard by members of the Cabinet.

However, before this development could be put into practice, the entire policy and decision making structure was revised with the intention of streamlining the functions of the different entities involved in HIV policy development.

Figure 13: Revised National HIV and AIDS Policy Framework



Source: Ministry of Health (2009)

Under this new revision which occurred in late 2009, the CCA was restructured and known as the *National Coordinating Committee on AIDS Intervention (NCCAI)* chaired by the Minister of Health. The NCCAI functions as the highest decision-making body on HIV and AIDS related policies. Its membership includes all the Chief Secretaries of the 16 Ministries and government agencies listed in the NSP as well as civil society representatives, including the Malaysian AIDS Council. The NCCAI has been made responsible for ensuring the development and implementation of policies.

The National Advisory and Technical Committee on AIDS, is actually a merging of the two bodies present in the previous framework namely, the National Advisory Committee on AIDS and the Technical Committee on AIDS. This committee, chaired by the Director General of Health, acts as a high level advisory body to the NCCAI. It provides a forum for discussion of policy issues relevant to increasing the success of Malaysia's response to the HIV epidemic as well as to review progress against the annual work plans and budgets. The membership of the NATCA is made up of key Ministry officials, subject matter experts, NGO and community representatives and the Director Generals and HIV Focal Points of the Ministries indicated in the NSP. It meets at least biannually and reports to the NCCAI.

In 2009, the Government also decided to make reporting on the progress of the HIV epidemic, one of a number of Key Performance Indicators (KPI) for the Ministry of Health. It is the only indicator assigned to the Disease Control Division and shows a certain amount of commitment and concern in ensuring proper attention to the issue.

Financial commitment

As reported previously, it was acknowledged that the successful implementation of the existing NSP would require a significant increase in the current level of resources allocated to respond to the epidemic.[59] The shortfalls of previous strategies were intrinsically linked to the small amount of funding available for programmes, particularly for HIV interventions conducted by NGOs. Prior to the inception of the new NSP, less than USD 10 million per annum was allocated by the Government for the national response to HIV and AIDS. In the current framework, an allocation of RM 500 million (USD 150 million) was made available for the period of 2006 – 2010. A three-fold increase in this allocation, now totalling more than USD 30 million per annum, has been made available to both government agencies and civil society organisations for the next five years (2006-2010) in support of implementation of the NSP. This commitment of USD 150 million represents a strong signal of much needed political support and commitment to address HIV and AIDS as a national agenda.

In many ways, the increased allocation and available funding under the current NSP became a huge challenge for many NGOs as they were required to increase capacity, improve reporting systems and up-scale dramatically to meet expectations of both the funder and communities. The Ministry of Health (as guardian and mandate keeper of the NSP) were tasked to ensure that grant disbursement systems were in place which were transparent, accountable and fair to all parties wanting to apply for funds available under the NSP. The past four years of the NSP from 2006 – 2009 have highlighted these challenges.

Further empowering civil society participation and involvement in HIV advocacy

It was previously reported in the 2008 document that civil society participation in the area of policy and advocacy was still very limited and heavily dependent on the Malaysian AIDS Council (MAC). MAC, under its mandate, represents the issues and concerns of the civil society organisations working on HIV and AIDS, including people living with HIV. However, there was concern that the different communities were not sufficiently engaged, empowered and lacked adequate representation. In 2008, a “cluster” mechanism comprising individual communities (e.g. Sex worker, MSM and TG clusters) and issues was introduced by MAC. Though it is still in early development, the concept is intended to improve participation, ownership and encourage meaningful involvement in the discussions affecting the different most-at-risk populations.

With that in mind, the Malaysian Network of People Living with HIV/AIDS (MyPlus) was also formed in August 2008 as an independent organisation by the Malaysian AIDS Council to mobilise the HIV positive community to be more involved in HIV advocacy and engage in meaningful participation in programmes and consultations. The intention would be that a national network would lead, complement and further strengthen the current efforts to achieve the goal of universal access to prevention, care and support services. MyPlus would also function as a public and political voice for the HIV positive community on issues affecting them.

Establishment of the Country Coordinating Mechanism (CCM) and participation in Round 9 of the Global Fund for AIDS, Tuberculosis and Malaria

In 2008, Malaysia became eligible to receive Global Fund grants for HIV and AIDS programmes under the revised Income Level and Cost-Sharing Eligibility Criteria. It is one of nine countries in the Middle Income Level category identified to have concentrated HIV epidemics. In Malaysia,

[59] Ministry of Health (2005). op cit (see reference 11)

the initiative to set-up a Country Coordinating Mechanism (CCM) and to participate in the Global Fund grant application process has been driven largely by the civil society.

The importance of empowering and building capacity of civil society organisations became very clear with the participation of Malaysia in Round 9 of the Global Fund for AIDS, Tuberculosis and Malaria. A working group composed mainly of civil society representatives did most of the necessary advocacy to convince the Government as to the need to participate in the Global Fund process. This working group was the precursor to the formation of the Counrty Coordinating Mechanism. The CCM itself, formed in March 2009, is a group comprising government officers, academicians, faith based organisations, representatives from the most-at-risk populations and PLHIV community, and the private sector. The CCM is currently chaired by the Deputy Minister of Health. A country proposal for Round 9 was successfully developed and submitted to the Global Fund Secretariat. Though the proposal was not successful for this round, was classified as a Category 3 and recommended for resubmission in Round 10, the experience working together in this modality demonstrated how such a multisectoral collaboration and partnership could work.

Establishment of the Taskforce on Women, Girls and HIV/AIDS

First described in the 2008 report and later in the joint Ministry of Health – UNICEF document titled *Women and Girls Confronting HIV and AIDS in Malaysia*, the increase in proportion of female HIV cases in Malaysia over the past five years has become an issue of utmost concern and a priority for the Government. It recognised that intimate partner transmission of HIV is increasingly becoming a major factor in the increasing proportion of women and girls becoming newly infected. It also acknowledged that this developing trend of feminisation of the epidemic is due to the lack of effective HIV prevention interventions which specifically address women's vulnerability to HIV and enable them to protect themselves, particularly from the sexual transmission of HIV.[60] As such it was felt that addressing this issue would require intensified specific policy action and intervention which address vulnerabilities related to HIV and AIDS, particularly those related to gender inequality and sexual reproductive health. A Taskforce on Women, Girls and HIV/AIDS was set up in 2009, and is chaired by the Ministry of Women, Family and Community Development (MWFCD). The Taskforce is tasked to guide the actions of the Government in its response to addressing the behavioural and socioeconomic factors behind the sexual transmission of HIV.[61] It is also tasked to bring together actors beyond the health and medical sphere and include bodies such as the Social Welfare Department, National Population, Family Development Board (NPFDB), Department of Islamic Development, Ministry of Information and other bodies which address issues such as teenage pregnancies, sexual violence and gender inequality.

Increased involvement of Muslim religious leaders

The engagement with and involvement of religious leaders, especially Muslim religious leaders has increased significantly since the last report. As religious leaders in Malaysia can be very influential on the attitudes of their communities towards PLHIV and MARPs as well as on other populations such as policy makers and healthcare practitioners, a lot of advocacy and investment in programming was done to mobilise and harness the support of Islamic religious leaders for HIV prevention and the provision of care and support for those with HIV and those affected. (see also *Best Practice*)

[60] Ministry of Health & UNICEF. (2008) *Women and Girls Confonting HIV and AIDS in Malaysia*
[61] Ministry of Women, Family and Community Development (2009). *Terms of Reference for the Taskforce on Women, Girls and HIV*.

Since the last report, Muslim religious leaders have since not only been actively 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. HIV as a topic has been institutionalised into the formal training of new Muslim leaders.[62] Working with several CBOs, the Department of Islamic Development (JAKIM) in particular has been an active partner in creating awareness of HIV issues among the Muslim public.

The past 2 years in particular have seen the remarkable and encouraging development of programmes which involve a number of religious departments engaging most-at-risk populations such as female sex workers and transgender persons.[63]

Table 8: Results of premarital screening in 2009

	Male		Female		Total	
Age	**No. Screened**	**No. confirmed +ve**	**No. Screened**	**No. confirmed +ve**	**No. Screened**	**No. confirmed +ve**
<10	0	0	0	0	0	0
10 – 14	2	0	61	0	63	0
15 – 19	2027	0	7115	0	9142	0
20 – 24	22643	1	31823	7	54466	8
25 – 29	39796	14	31632	3	71428	17
30 – 34	13407	14	8546	5	21953	19
35 – 39	5715	12	3724	0	9439	12
40 – 44	2907	7	2032	2	4939	9
45 – 49	1752	0	1167	0	2919	0
50 – 54	1199	1	792	0	1991	1
55 – 59	819	1	406	0	1225	1
60 +	1366	0	337	0	1703	0
TOTAL	**91 517**	**42 (0.05%)**	**87 751**	**17 (0.02%)**	**179 268**	**67 (0.04%)**

Source: Ministry of Health (2010)

In addition to the above engagement with religious leaders, premarital HIV screening has also been made a requirement for all Malaysian Muslims wanting to get married. This programme at its inception began from a single state in 2001 and is now conducted in all states. It was initially introduced by a state religious department and is now currently supported by the Ministry of Health and extended to all individual who wish to do premarital HIV screening voluntarily, irrespective of their religious background.

Screening is conducted to provide an earlier opportunity in the detection of HIV and thus provide the opportunity for better possibilities for treatment. Premarital HIV screening has been considered, by both policy makers and the general public, to be an effective measure in the early detection of HIV for the prevention of mother to child HIV transmission and through increased awareness helps reduce the chances of further transmission. In public polling conducted to gauge the public's support for this initiative, it was found that the majority of respondents were in favour of such a requirement. However, concern has been expressed to ensure that the implementation of this measure is in keeping with the human rights framework as well as safeguards the confidentiality of those being tested.

[62] Department of Islamic Development (2009). *UNGASS Government Stakeholder Discussions*, 23 December 2009.
[63] PT Foundation (2009). *UNGASS NGO Stakeholder Discussions*, 22 December 2009

Increased involvement of the private sector

There has always been some form of private sector involvement since the beginning of the epidemic in Malaysia. Very often this involves financial contributions to specific community based organisations with programmes working on certain HIV related issues such as MSM and children infected and affected with HIV. Both PT Foundation and the Malaysian AIDS Foundation have been supported by benefactors as part of corporate social responsibility (CSR) programmes. Body Shop Malaysia, for example, has been a long term supporter of PT Foundation and actively conducts fundraising initiatives through the sale of its products, and also played a part in the setting up of the Malaysian Business Coalition on AIDS (which in recent years has become inactive). M.A.C Cosmetics has also been active in providing support for HIV initiatives over the past several years.

However, remarkable progress has been observed to have occurred as of late in this area of the HIV response. A number of major corporate entities now actively engage in several programmes and initiatives which have far reaching benefits to alleviating the impact of the HIV epidemic in Malaysia. Many of these initiatives are through the Malaysian AIDS Council and Malaysian AIDS Foundation. In the area of advocacy, Mercedes-Benz Malaysia supports the Mercedes-Benz Malaysia Red Ribbon Media Awards which seeks to recognise achievements in media and communication in addressing the issue of HIV and AIDS through the medium of broadcast, print and electronic media as well as the perfoming arts.[64] Shell provided funding for research and the production of "Minding the Gaps", a publication discussing the HIV epidemic in Malaysia. L'Oreal Malaysia provides funding to support adolescents infected and affected by HIV through financial assistance to support their educational needs. In the area of care and support, the Standard Chartered Trust Fund has become the principal donor to the Standard Chartered Paediatric AIDS Fund.[65] The Fund provides a monthly allowance to children from low-income homes and a stipend which enables children living with HIV to receive life-saving treatment. Hong Leong Bank has explored supporting income generating activities for PLHIV and their families through the Business Assistance Scheme.[66] This scheme provides interest-free loans for these individuals to start small businesses and gain financial independence. Levi Strauss Foundation is also present in supporting various programmes which promote sensitisation and advocacy efforts on the issue of HIV as part of advancing the agenda of human rights. This has included development of the Malaysian component of the Positive Lives photography exhibition. CIMB Foundation has also extended its support to PT Foundation by providing financial support for improvement of the latter's outreach and community services facilities.

Finally, a major achievement in private sector involvement in the Malaysian response has been the representation of this sector on the CCM by Standard Chartered Malaysia.

C. Strategy 2: Training and capacity enhancement

Strategic Information

In this area, much progress has been made in addressing the gaps reported in the 2008 document. Of note has been the improved availability of strategic information in 2009. Strategic information such as behavioural data necessary to plan and implement a comprehensive

[64] Malaysian AIDS Council & Malaysian AIDS Foundation (2008). *2008 Annual Report*
[65] Ibid
[66] Ibid

response to HIV was previously scarce and ad-hoc at best. As a result, most of the interventions with most-at-risk populations prior to 2005 have been unfocused, sporadic and geographically limited, and it is debatable as to whether they were able to contribute in any way to the overall local response to HIV. Data for these populations on HIV prevalence, profiles of risk behaviour and vulnerabilities were often anecdotal, limited or simply not available.

In the period covered by this report, much progress has been made both in understanding the situation of most at risk populations (MARPs), particularly regarding vulnerability to HIV and STD infection and the need for specific essential services. Much improvement has been achieved in the reporting of UNGASS indicator data. Though there continues to be a major dearth of research concerning the most-at-risk populations in comparison to what is available in neighbouring countries, the past few years have seen the implementation of a number of behavioural studies and research with these communities. These efforts have improved the understanding of the Malaysian HIV epidemic and has enable for detailed descriptions of behaviour and risk to be developed which will be useful in HIV programming, policy and decision making as well as reporting on progress.

A number of key NGOs have played key roles in this effort, namely the Malaysian AIDS Council (MAC), PT Foundation and the Federation of Reproductive Health Associations Malaysia (FRHAM). Much effort has gone into improving the technical competencies of these NGOs to enable their staff to participate in action research as well as behavioural studies. Their work in conducting these studies and the subsequent findings have made it possible to report on behavioural indicators, previously unknown and often guessed at, which will be later used in influencing HIV programming with these specific populations. These include the following critical studies:

- Impact of HIV on People Living With HIV, Their Families and Community in Malaysia (2007)
- Integrated Bio-Behavioural Surveillance with injecting drug users, female sex workers and transgender persons (2009)
- Venue-Day-Time-Sampling (VDTS) survey with men who have sex with men (2009)
- Estimation and Projection of the Malaysian HIV Epidemic (2009)
- Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work (2010)

The abovementioned work has also involved collaboration with other external organisations and agencies such as WHO, UNFPA, UNICEF, the World Bank and the Foundation for AIDS Research (AmFAR).

There still exist concerns of the limited availability of technical expertise to conduct research and data collection. Scientific researchers in social science, epidemiology, medical treatment and other areas who are interested to conduct HIV related research are still scarce. There is still a high level of dependence on external resource persons and consultants.

Due to the limited relevant technical expertise in the area of HIV social science research within both Government and non-government entities, the vast majority of HIV programmes conducted in the past and present have no proper baseline data.

Investment in training and capacity building in technical areas and research should also be made to ensure that the gains and progress from the improvement in strategic information are able to be sustained and improved upon. It is also necessary to ensure that the findings from such research are able to be translated effectively into HIV programming and relevant policies.

The recently established Centre of Excellence for Research in AIDS (CERiA) at the University of Malaya provides an opportunity for this to occur. The Centre, staffed by clinicians, public health experts, social and basic science researchers attached to the university, is expected to undertake clinical and social science research and training in the field of HIV. It has already conducted several technical workshops and has taken the lead on several research areas such as understanding the vulnerability of East Coast fishermen and prisoners to HIV infection.[67] CERiA was also instrumental in the development and implementation of the VDTS research with MSM.

Detailed gender disaggregated data has also recently become available as a result of a revision of the national HIV reporting system by the Ministry of Health. This data has been included as much as possible in the reporting of UNGASS indicators. Analysis of this data is critical to ensure a better understanding of how men and women are vulnerable to HIV infection in Malaysia. The responses, experiences and the burden of disease appear to be different for men and women. Therefore it is necessary to emphasize the need for gender to be mainstreamed into any analysis of the epidemic to better understand how and why HIV affects women and men differently.

Advocacy

The context of recent interventions such as the Needle Syringe Exchange Programme (NSEP) has provided excellent opportunities to train and build capacity among law enforcement officials (e.g. Royal Malaysian Police and National Anti-Drug Agency) as well as religious leaders on HIV related issues such as stigma and discrimination. The membership of these agencies in the National Taskforce for Harm Reduction also provides an opportunity to further improve their understanding and support of HIV initiatives.

Programme and Monitoring and Evaluation Capacity

The up-scaling of programmes in 2008 and 2009 has severely stretched the limits of existing programmes and services as well as the capacity of existing NGOs. The increased funding which was made available in 2008 and 2009 funding at stake has produced much emphasis on transparency and accountability with proper reporting of expenditure and programme monitoring and evaluation. Input from NGOs indicates that their staff capacity needs to be significantly increased and improved upon to meet these heavy expectations.

In the area of monitoring and evaluation, 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 a more streamlined and effective national HIV programme monitoring mechanism able to capture detailed disaggregated data systematically. The AIDS/STD Section has also established a monitoring and IBBS research section whose responsibilities include the development and implementation of a national monitoring and evaluation framework. Since 2008, the Malaysian AIDS Council has been developing an online monitoring system and database that is providing increasingly valid and reliable data that feeds into increasingly critical program analysis.

[67] United Nations Theme Group on HIV (2009). Population at Risk: Fisherman and prisoners (CeRIA Presentation), S.Govindasamy. *Roundtable Stakeholder Consultation on HIV in Malaysia*, 16 November 2009.

D. Strategy 3: Reducing HIV vulnerability among Injecting Drug Use (IDUs) and their partners

Harm reduction initiatives involving drug substitution therapies have been a part of the Malaysian response for several years. However, they have previously been limited to small scale piloting as well as a limited number of private clinics. The realisation in 2005 that the MDG related to the reversal of the HIV epidemic would not be fulfilled, spurred the Government into accepting the argument that extraordinary measures needed to be undertaken to effectively address the situation.

Hence, full support by the highest level of Government was expressed towards the scaling up of the existing methadone maintenance therapy (MMT) programme as well as the introduction of the Needle Syringe Exchange Programme (NSEP) in 2006. Together, these programmes aimed at reaching 40 000 IDUs. This target actually falls short of the 60% coverage which WHO recommends in order for the programme to have an actual impact on the general epidemic.

In order to meet this target coverage, the programme would have to reach out to 102 000 persons out of an estimated population of 170 000 IDUs. Nevertheless, the encouraging results thus far from both programmes demonstrate the need for firm and long-term commitment of political will and financial resource by the Government to continue the expansion and scaling-up of the programme.

The Government's commitment to the harm reduction approach is best illustrated through its allocation of as much as RM 196 million (USD 56 million) for these programmes. Almost 40% out of the total RM 500 million (USD 143 million) was allocated and made available to the country's HIV and AIDS response for five years has been earmarked for harm reduction programmes.

However, it has been recognised by both Government and civil society that these two interventions, the MMT and NSEP, by themselves were inadequate to arrest the growth of the Malaysian epidemic and that other prevention programmes would also be needed. To address this issue, the expansion of coverage and availability of services of these two interventions became the focus during the past two years.

Methadone Maintenance Therapy (MMT)

The successful piloting of initial drug substitution therapies, particularly methadone, resulted in the Government fully adopting the programme. By end of 2005, it was decided that the methadone maintenance therapy (MMT) would be scaled up from the pilot stage to be available nationwide.

The first scale up phase of the methadone maintenance therapy (MMT) programme began in earnest in October 2005 and catered to more than 1200 individuals accessing a number of participating government hospitals, community health centres and private clinics. Around 22% of those enrolled were with HIV. After 12 months, the resulting retention rate of 75% was considered a major achievement based on the World Health Organisation's (WHO) standard retention rate of 55-60%.

Table 9: Availability of MMT (2006 – 2009)

Facilities	2006	2007	2008	2009
Govt hospitals	8	25	27	35
Govt clinics	2	32	32	77
Private clinics	7	9	9	14
NADA service centres	0	0	3	24
Prisons	0	0	4	12
Total	**17**	**66**	**75**	**162**

Source: Ministry of Health (2010)

The next phase of the MMT programme begun in 2007 and is a scale-up of the earlier programme. In 2007, pilot testing also began towards the provision of MMT in incarcerated settings, specifically prisons.[68] The programme currently involves more government hospitals and clinics, private healthcare practitioners and has been extended to the National Anti-Drug Agency (NADA) service centres, and prisons. After several years of implementation, the MMT programme has become a critical component of the HIV prevention strategy in Malaysia. The programme aims to provide service for 25 000 persons by 2010.

Table 10:Achievements of the MMT Programme (2006 – 2009)

	2006	2007	2008	2009
Targeted no. of clients (cumulative)	1 200	5 000	10 000	15 000
Registered clients/ year	1 241	2 777	3 047	3 665
Registered clients (cumulative)	1 241	4 018	7 065	10 730
Active clients	932	3 242	5 024	7 455
Retention rate (%)	**75.1**	**78.4**	**71.1**	**69.5**

Source: Ministry of Health (2010)

Needle Syringe Exchange Programme (NSEP)

Initiated in February 2006 and now entering its fourth year of operation, the Needle and Syringe Exchange Programme (NSEP), with its current target of servicing 15,000 drug users by 2010 with free syringes and condoms, is the focus of the Government's HIV prevention programme. It also provides access to and education on sterile injection equipment and safer injecting techniques as well as methadone and HIV treatment related services. However, by end 2009, 18,377 IDUs were enrolled in this programme.

The objectives of the NSEP are:

- to establish a framework for a comprehensive nationwide NSEP.
- to reduce the unsafe practice of sharing needles and syringes and other injecting equipment by to promote safe retrieval and disposal of used needles and syringes
- to reduce the risk of HIV and other sexually transmitted infections (STIs) through sexual transmission.
- to improve access to health and welfare services (including drug treatment and rehabilitation) for IDUs.
- to facilitate awareness and education about IDU issues and blood-borne viruses among NSEP staff, peer educators and the community.

[68] Ministry of Health (2007). Chief *Rapporteur's Report*. 1st National AIDS Conference.. December 2007

The implementation of the NSEP takes place in drop-in centres, outreach points and health clinics which supply sterile needles and syringes to IDUs. These facilities are also intended to act as a depository for the disposal of used injecting equipment. Many of the outreach workers employed by the NGOs which are implementers of the NSEP are also recovering drug users. As such, clients trust these outreach workers and cooperate well with them. (see also Best Practice section)

Gaps

There is a current concern that the spouses of IDUs are currently left out of the HIV response as there are very few programmes which cater to this very often "hidden" population. As there is increasingly more cases of women with HIV as a result of heterosexual transmission, this is a concern which has been identified from the very beginning. However, less than 40% of spouses whose partner are found to be with HIV and are IDUs currently go for HIV screening. They also tend to not access the existing DICs of the NSEP as they are found to be focused on men.

As research findings (BSS and IBBS) indicate that a significant proportion of IDUs are sexually active, free condoms are available through the programme.

E. Strategy 4: Reducing HIV vulnerability among women, young people and children

Despite this strategy indicating the need to address the issue of HIV amongst women, there are generally no general women-specific HIV prevention programmes available in Malaysia. This population is identified as belonging to one or more of the identified most-at-risk population. As such, they would fall under the coverage of programmes for those groups.

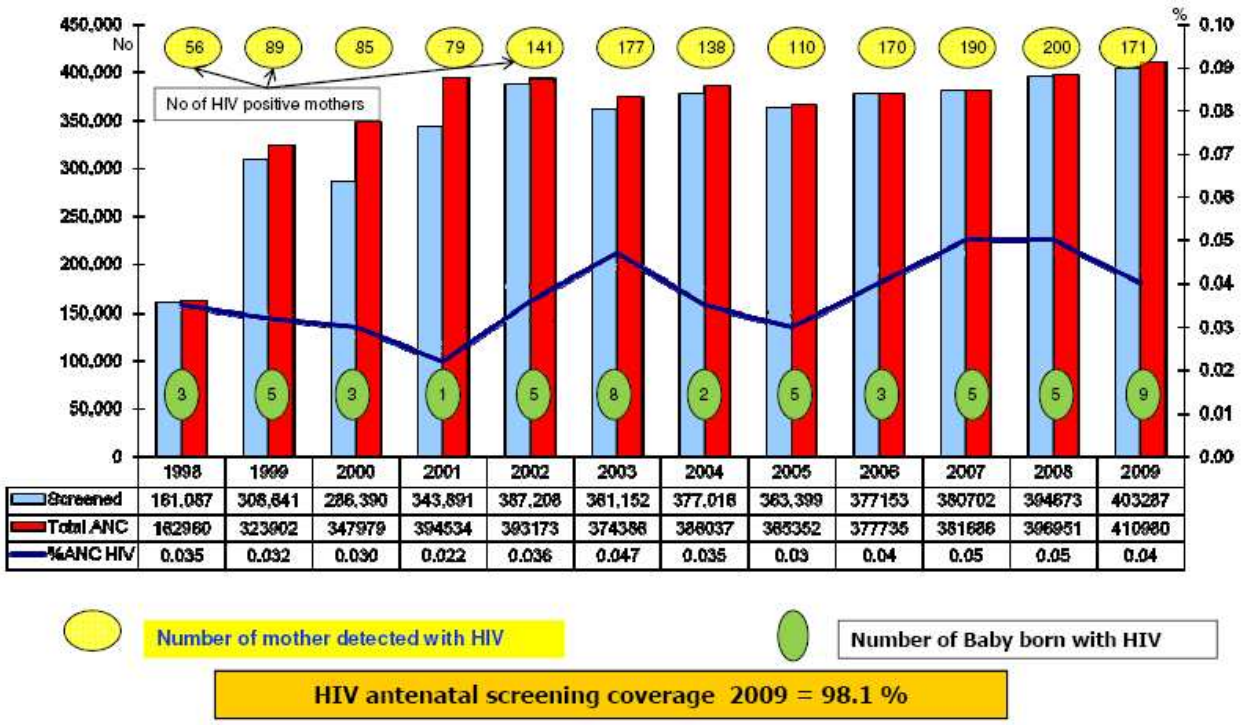
The prevention of mother-to-child transmission (PMTCT) programme

The prevention of mother-to-child transmission (PMTCT) programme in Malaysia introduced in 1998 is based strongly around ARV prophylaxis for the child, safer delivery and infant feeding practices. It is also depended on detection of HIV infection during the mother's antenatal period.[69] The programme is implemented nationwide since 1998 at government health clinics and hospitals, and incorporates HIV screening utilising an opt-out approach. Although it covers only women receiving antenatal care at these government facilities, it is estimated that over 70% of total antenatal mothers nationwide were found to utilise government antenatal facilities. Coverage of these mothers through the public facilities improved from 49.7% in 1998 to 99% in 2009. Antenatal HIV cases from the private sector are also referred to the government medical system.

With coverage of 98.1% of this proportion for 2009, the programme has been able to successfully reduce the incidence of MTCT to 4% among women enrolled in the programme. A total of more than 4.1 million mothers were screened for HIV through this initiative (1998-2009) thus far. Each year, 0.02% to 0.05% were found to be with HIV. HIV positive mothers and infants born with HIV through this programme are given free ART (first and second line regime) for life.

[69] Ministry of Health (2007). *PMTCT Review Report.*

Figure 14: Antenatal HIV Screening (1998 – 2009)



Source: Ministry of Health (2010)

A review of the programme in 2007 suggested that the programme is only reaching more highly motivated mothers as well as those at lower risk of acquiring HIV infection.[70] It was also found that general prevention of HIV cases amongst women and the provision of extended community-based care and support for family living with and affected by HIV were not integrated into the programme. Coverage also appears to not extend to MARPs such as IDUs and their partners.

Table 11: Comparison of results from the PMTCT programme (2001 & 2008)

	2001	2008
No. of pregnant women screened	343 030	394 673
No. found to be with HIV	79 (0.02%)	200 (0.05%)
No. of babies born with HIV	1	5

Source: Ministry of Health (2009)

The review also found that the majority of children affected by AIDS have been identified and referred for care and treatment from outside the PMTCT programme. This appears to indicate that while the programme has successfully addressed the provision of prevention of MTCT among 70% of all antenatal mothers, the other significant 30% remains unaddressed. With more than an estimated 6000 to 14000 children affected by AIDS (i.e. living with HIV, orphaned or abandoned), the need to address this group has been increasingly urgent.[71]

[70] Ibid
[71] UNAIDS (2001). *AIDS Report 2001.*

Introduction of HIV and AIDS into the curriculum of National Service trainees

Since September 2007, HIV and AIDS lectures aimed at inculcating awareness and behavioural change have been integrated for the first time into the syllabus of the annual National Service exercise. The National Service which involves almost 100,000 young people (aged 17-19 years) nationwide annually represents a unique opportunity to ensure that they are equipped with the necessary information, awareness and ability to make informed decisions, particularly on issues related to HIV and AIDS. A survey taken with 6 000 trainees of this programme indicated that 22.6% correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.[72]

Gaps in services for children living with HIV

To address the ongoing issue of the lack of sexual reproductive health education, the Ministry of Women, Family and Community Development has recently announced the formation of the National Reproductive Health and Social Education Policy. The policy is intended to assist in the delivery of reproductive health education, particularly to young people.

There is a need to include specific services for children living with HIV, which will require different types of activities and responses. At the moment, this area of concern is very much unaddressed. Children living with HIV face problems of stigma and discrimination from their peers and school authorities, and of treatment adherence. There is a need for programmes to address the needs of adolescents living with HIV in dealing with regular teenage problems such as boy-girl relationships and family issues in the context of their status.[73] The Ministry of Women, Family and Community Development currently run several programmes (Café@Teen) which address these issues. However, they do not as yet provide for children living with HIV. To date, there are also inadequate shelter homes for children infected and/or affected by HIV. As such, they are usually put together in adult shelters.

There are reportedly 2,207 children with HIV in Malaysia but only 430 children are covered by existing care and support programmes. There needs to be more similar programmes as well as better coverage to cater to the gap in providing support to children infected and affected by HIV.

F. Strategy 5: Reducing HIV vulnerability among marginalised and vulnerable groups

Reaching out to marginalised and most-at-risk populations (MARPs) remains a significant and formidable challenge. The role of NGOs and CBOs in implementing programmes with groups such as those identified under this strategy (i.e. sex workers, MSM, transgender, migrants, displaced persons and refugees) remains critical.

Prevention programmes for most-at-risk populations have increased over the last 2 years due to the greater availability of funding from the Government. For example, the SW/TG outreach programme has expanded to 4 new states from the previous 2; the NSEP programme have increased their coverage to 12 new sites and the outreach programme to MSM have also been able to extend to 1 new state.

[72] Ministry of Health (2009). *Perlaksanaan modul latihan HIV Program Latihan Khidmat Negara.* Powerpoint presentation.
[73] Azmi, S. (2009). *Response Review of the National Strategic Plan on HIV/AIDS 2006 – 2010.* August 2009.

Despite having a series of ambitious objectives under the NSP aimed at increasing access to HIV and AIDS related information, promoting condom use, increasing access to VCT, and increasing coverage and quality of outreach programmes, significant challenges and barriers remain. The vast majority of prevention programmes involving MARPs such as IDUs, men who have sex with men (MSM) and sex workers are mainly dependent on CBOs and NGOs.

One example is PT Foundation (previously known as Pink Triangle), an organisation which works with several marginalised communities including sex workers, drug users, MSM, transgender and PLHIV. Most of these organisations are often forced to prioritise and restrict coverage due to limited human and financial resources. Many NGOs are still unable to upscale their activities due to limited trained manpower, financial resources and capacity. They are also challenged by legal and policy environments which may prohibit implementation of evidence based programmes.

Pivotal role and involvement of the Ministry of Women, Family and Community Development

Since 2007, the Ministry of Women, Family and Community Development in partnership with PT Foundation, established a drop-in-centre, *Pusat Khidmat Sokong Sosial* (Social Support Services Centre), to provide a safe space, nutrition advice, HIV education, as well as support and care to transgender persons (TG), female sex workers (SW) and PLHIV. The partnership established between MWFCD and PTF is an encouraging step forward towards creating successful collaborations between GOs and NGOs. The smart partnership combines technical expertise and resources. As a result, the centres have been able to collect data, run job placement assistance, basic life skills and religious classes.

Men who have sex with Men (MSM)

The implementation and results from a number of studies such as the VDTS and Fridae.com surveys which have focused on MSM has considerably improved the understanding of the issues affecting this community in Malaysia.

While MSMs may not constitute the most affected community in Malaysia, HIV infection could be on the increase in this population. An observation made by NGOs and CBOs working with this community such as PT Foundation which runs a VCT site, is that the number of HIV cases among MSM has increased in the past few years. The results from the VDTS found that HIV prevalence amongst those sampled was 3.9%.

Despite indications that the levels of education and awareness of HIV in the MSM community are relatively high, most MSM do not identify themselves as being at risk. As such, usage of condoms during anal sex is reportedly low and inconsistent. The findings of the VDTS indicate that almost 50% did not use a condom during sex with casual partners. Given that some MSMs also engage in sexual activity with women and/ or inject drugs, larger communities could also be affected.

For more than 20 years, PT Foundation was the only organisation which worked with the MSM population and had the resources and capacity to produce and distribute HIV prevention information.[74] PT Foundation's MSM programme includes a drop-in centre, a support group, a telephone counselling service, and an outreach program. In the past few years, the number of organisations involved reaching out to the MSM community has extended to include the Penang

[74] Scoville (2004). *An assessment of HIV prevention work for the MSM population in Kuala Lumpur.*

Family Health Development Association (FHDA), an affiliate of the Federation of Reproductive Health Associations Malaysia, which currently runs a VCT for the local MSM community.

Though gay businesses, such as bars and clubs, are frequented by thousands of MSMs, no sustained HIV prevention work exists in these venues.[75] This is largely due to cultural and legal obstacles. Often in locations where sexual activity occurs such as in massage centres and saunas, dissemination of safer sex information continues to be a challenge. The presence of condoms on the premises of such places could easily used as evidence of illegal activity which could result in the establishment owners losing their operating licenses. The premises of such places are also regularly raided by local law enforcement.

Though the NSP under Strategy 5 recognises the existence and vulnerability of the MSM population, their sexual behaviour is subject to prosecution under existing legislation (Penal Code 377 on the act of sodomy). MSM issues related to vulnerability to HIV are difficult to address with existing laws which criminalised their sexual behaviour, as well as the situation related to stigma and discrimination which complicate any form of outreach conducted with this group.[76] PT's outreach programmes also face difficulty in engaging the non- Chinese MSM such as those of Malay ethnicity due to the stigma associated with being gay as well as cultural and religious issues. As such, they are often unknown and left out of key interventions.

Sex workers

A number of studies examining sex work in Malaysia has become available in the past two years have significantly increased understanding and the quality of response in addressing the HIV situation amongst the sex worker population. These include the IBBS and a number of size estimation studies. Previously what data was present depended on institutionalised or incarcerated women, i.e. those in prison or moral rehabilitation centres.[77] However, current studies are still limited due to the dependence on information from venue based direct sex workers. Very little continues to be known of indirect sex workers.

Criminalisation by law, particularly Syariah law, and stigmatisation by society creates possibilities for exploitation and abuse. This leads to the creation of an environment which acts to deter, complicate and challenge notions of HIV prevention such as condom promotion. The possibility of detention and accusations of prostitution by law enforcement personnel for the possession of certain quantities of condoms (more than three condoms at any one time) during raids deters female sex workers from having them easily available.[78,79]

Hence, though awareness of HIV related information and of safer sex practices are relatively high in this population, the environment may not be conducive for actual practice. In a 2009 FRHAM study, the main reason cited by sex workers for not using condoms was that they would lose their clients if they insisted on using condoms (43%).[80] 41.4% of the respondents were willing to have sex with their clients without using a condom for a price, particularly when 24.8% were willing to do so at the usual price they charge their clients.[81]

[75] Ibid
[76] Ibid
[77] Jenkins, C (2007). op. cit. (see reference 34)
[78] Personal Communication. *UNGASS Government stakeholder consultation*. 23 December 2009
[79] Federation of Reproductive Health Associations Malaysia (2010). *HIV and Sex Work: The Current Situation and Moving Forward.* In collaboration with UNFPA
[80] Ibid
[81] Ibid

Coupled with the reluctance of clients to use condoms as well as the challenge of negotiating its use, effective HIV prevention work with this community continues to be inconsistent. The lack of specialised sexual reproductive health services for female sex workers also continues to present a lost opportunity to arresting the spread of HIV and other STDs in this population.

Though male sex workers certainly exist in the Malaysian sex industry as evident from CBO surveys and input from outreach personnel, their situation continues to be largely unknown and unaddressed within the framework of the national response. As such, most studies and intervention work are with female sex workers.

Transgender Persons

The situation affecting transgender persons is relatively well known through contemporary local studies of this population. Large sections of the transgender community are sex workers or have ever received payment for sex.[82] Though the level of HIV and AIDS knowledge in this community remains low, condom use during transactional sex is often observed by transgender sex workers as indicated by the IBBS (condom use with last client was 95%).

Despite the findings of studies concerning transgenders which have indicated that the issue of HIV vulnerability in this community is critical, outreach and interventions with this group remain challenging. There are a number of comprehensive programmes which been made available to address this concern. Previously most, if not all current programmes, were centred on the transgender outreach services provided by PT Foundation and a few other NGOs available in the country's capital, Kuala Lumpur. Of late, there has been a significant increase in the number of organisations wanting to engage the transgender population. These include the Sarawak AIDS Concern (SACS), SAGA in Sabah, WAKE in Kuala Lumpur as well as several Federation of Reproductive Health Associations Malaysia affiliates across the country. Most of these services are centred in urban areas.[83] These services are a component of the sex worker outreach programme, thus addressing their vulnerability in working in that particular area.

Transgender persons can be charged with indecent behaviour under Minor Offences Act 1955, if they are found to be cross-dressing.[84] The term 'indecent behaviour' has not been defined in the Act, and therefore, it is up to the discretion of the police to determine what constitutes 'indecent' behavior. They can also be detained by religious authorities.

Migrants

As of December 2009, the Ministry of Home Affairs recorded 1.6 million registered migrant workers in the country working in different sectors.[85] There are also an estimated 500,000 illegal workers currently residing in Malaysia.[86,87] A policy was implemented whereupon foreign workers currently undergo three mandatory medical screenings in the first two years of their arrival. These are conducted through a full medical screening which is inclusive for HIV.[88]

[82] Teh (2007). *Exploring HIV related needs for safety among transsexuals or mak nyahs.*
[83] UNGASS NGO Stakeholder Consultations. 22 December 2009
[84] Government of Malaysia (1955). *Minor Offences Act 1955*.
[85] The Star (2010). "Drop in number of foreign workers". *The Star*. 9 February 2010
[86] Ministry of Health (2006). *Mandatory medical checks for alien workers in first two years*, 19 April 2006. http://www.moh.gov.my/MohPortal/newsFull.jsp?action=load&id=85
[87] Ministry of Human Resource (2007). Personal communication. October 2007
[88] Ministry of Health (2006). Op cit (see reference 84)

Table 12: HIV Screening of Migrant Workers in Malaysia (2004-2009)

Year	No. of persons screened	HIV	
		+ ve	%
2004	909 273	286	0.0317
2005	1 158 443	337	0.0290
2006	1 345 756	767	0.0569
2007	1 361 781	683	0.0501
2008	1 381 599	682	0.0494
2009	1 021 542	659	0.0645
Total	**7 178 394**	**3 414**	**0.0476**

Source: Ministry of Health (2010)

The HIV situation amongst migrants in Malaysia is currently unclear as screening is done for the purpose of detecting migrant workers who are considered medically unfit or pregnant and therefore qualify for deportation back to their countries of origin. As of 2009, 0.0476% of all those who were screened tested were positive for HIV.

Due to the Government's concern over the potential health risks to Malaysians posed by the large migrant community residing in the country[89], a policy was constituted whereupon foreign workers would undergo three mandatory medical screenings in the first two years of their arrival. This policy requires foreign workers to prove that they are healthy and free from infectious diseases (inclusive of HIV) and various non-communicable diseases in order to qualify for a work permit. First introduced in 2003, the policy now involves compulsory screening within the first month of arrival and at the end of the first and second year.[90]

Under this regulation, female migrant workers are subjected to mandatory screening for more than 15 infectious diseases and conditions including HIV, STDs, tuberculosis, malaria and pregnancy.[91] The Foreign Workers Medical Examination Agency (FOMEMA), a centralised agency in charge of these medical screenings, communicates the results to the Immigration Department which then notifies the employer of the employee's medical status. Should they be found to have tested positive for any of these diseases or be pregnant, they are subject to deportation. Provisions for treatment, medical assistance and post-test counselling have been developed in the case of deportation but remain difficult to access for migrants. Also, there is no referral system for migrants who are HIV positive or considered unfit, which hinders potential follow up, care and treatment in migrants' country of origin. Women make up the majority of unskilled and semi-skilled migrants who undergo the screening.

Refugees

Despite being identified as a marginalised and vulnerable population under the National Strategic Plan on HIV/AIDS 2006-2010, data on incidence rates amongst refugees are not

[89] Ministry of Health (2006). *Mandatory medical checks for alien workers in first two years*, 19 April 2006. http://www.moh.gov.my/MohPortal/newsFull.jsp?action=load&id=85
[90] Ibid
[91] National Council for Women's Organisations (2005). *NGO Shadow Report on the Initial and Second Periodic Report of the Government of Malaysia - Reviewing the Government's Implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*

captured through the existing HIV surveillance system.[92] As monitored by the United Nations High Commissioner for Refugees (UNHCR) in Malaysia and other health NGOs working with the refugee community, the population of refugees living with HIV and AIDS is 268 persons (as of March 2010). [93]

With regards to the refugee population in Malaysia, the United Nations High Commissioner for Refugees (UNHCR) has currently registered 82,400 persons of concern as of March 2010.[94] 76,200 are from Myanmar, comprising some 37,600 Chins, 18,200 Rohingyas, 5,100 Myanmar Muslims, 3,500 Mon, 3,200 Kachins and the remaining are other ethnic minorities from Myanmar. There are some 6,200 refugees and asylum-seekers from other countries.

UNHCR and several Malaysian NGOs (e.g. Malaysian Care, A Call To Serve (ACTS) Malaysia, Positive Living Community and Catholic Welfare Services) provide HIV related prevention and response programmes. This includes a voluntary counselling and testing (VCT) service in an NGO clinic, community health workers to raise awareness about HIV/ AIDS and to promote safer sex practices, adherence counselling support for PLHIVs and nursing home facilities

In an arrangement between the Government of Malaysia and UNHCR, refugees with relevant UNHCR documentation are able to receive medical services at government hospitals at half the cost usually charged to foreigners. In addition to that, refugees with HIV are also able to benefit from subsidised HIV related and appropriate medical treatment, with the regimes and viral load tests supported by UNHCR.[95]

G. Strategy 6: Improving access to prevention, treatment, care and support

Treatment

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.

The Government of Malaysia pledged its support to the World Health Organisation's "3 by 5" global campaign in 2003 and determined that it would focus on the issue of access to treatment and care for those living with HIV in the country. The Cabinet Committee on AIDS decided that this commitment would take on the form of improving the availability of treatment and lowering the actual cost of treatment.[96] It also aimed to obtain the widest range of ARV drugs at the best possible cost to the Government.

The Committee made a determination that it would focus on improving the availability of treatment and lowering the actual cost of ARV treatment. It empowered the Ministry of Health through its Pharmacy Department, to work in collaboration with the Ministry of International Trade and Industry to conduct negotiations to obtain the widest range of ARV drugs at the best possible cost to the Government. The provision of appropriate and relevant treatment options,

[92] Ministry of Health (2005). *National Strategic Plan on HIV/AIDS 2006-2010*, (October 2005) pg 14
[93] Ibid
[94] UNHCR (2010). *Personal communication.* 17 March 2010.
[95] Ibid
[96] Ministry of Health (2007). Personal communication with AIDS/STD Section

particularly Highly Active Antiretroviral Therapy (HAART), is easily the most costly long-term component of the national response to HIV.

As a result, since 2006, first line therapies involving nucleoside reverse transcriptase inhibitors (NRTIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs) were accessible for all patients at no charge at government hospitals and clinics. This was accomplished via the government's approach of direct negotiations with the pharmaceutical companies, at the same time exerting its right to implement compulsory licensing for specific drugs. Direct negotiations with these companies allowed for the Government to obtain the best possible compromise to ensure that the latest treatment regimes, particularly second line therapies, become available at low and affordable prices without unnecessarily violating intellectual property rights.[97] When necessary, generic ARV drugs, mostly from India, have also been made available to increase the options available to patients.

The effectiveness of this combined approach to improving the availability of HIV treatment can be best illustrated through the following example: In February 2004, Malaysia issued a "government use order" allowing for a local firm to import and supply government hospitals with three ARV drugs (didanosine, zidovudine, lamivudine and zidovudine) from an Indian firm, Cipla. According to the Ministry of Health, the average cost of treatment per month per patient dropped from USD 315 to USD 58, representing an 81% reduction. The number of patients who could be treated in government hospitals and clinics also increased from 1,500 to 4,000. As a result of this action, the multinational pharmaceutical companies also dropped the prices of their individual patented ARV drugs.

In addition to that, Malaysia has also exerted its right to implement compulsory licensing for specific drugs through the issuing of Cabinet directives. Although such action is external of current domestic intellectual property law, it is considered to be much faster and effective then amending existing legislation.

The combination of these initiatives has resulted in the cost of HAART being dramatically reduced benefiting both the Government and the individual patient. The reduction also allowed for a wider range of ARV drugs to be subsidised by the government, making it possible to provide first line and second line treatment accessible to all patients at no charge at government hospitals and clinics. However, the cost of undergoing second line treatment for a drug which is not listed in the Government's drug list is bourn by the patient.

Table 13: Groups who qualify for full governmental subsidy of 2nd line Highly Active Anti-Retroviral Therapy (HAART)

1. Mothers confirmed of being HIV positive.
2. Infants confirmed of being HIV positive
3. Persons infected through contaminated blood infusions or blood products
4. Healthcare personnel infected through occupational exposure
5. Government personnel

Source: Ministry of Health (2007)

However, these subsidies affect only treatment programmes under the government. The reduction in prices for ARV treatment does not affect the private healthcare sector, which also

[97] Ibid

offers ARV at non-subsidised prices. However, more than 90% of patients eligible for ARV treatment options undertake treatment through government hospitals and health clinics. There are currently 1 255 main Government hospitals and healthcare clinics as well as 209 private hospitals which are able to provide ART.[98].

Nevertheless despite the availability of ARV treatment at relatively low cost, obstacles to access continue to exist. Patients could be required to travel significant distances to healthcare centres which provide ART. For example, in Sabah and Sarawak, a patient may be forced to travel for 2 days to reach the designated hospital which has HIV treatment facilities. The cost of travel is a major deterrent and adds as a burden to those who do not posses full time employment. However, recent initiatives have been undertaken by the Ministry of Health to overcome this issue through capacity development of medical officers at health clinics to manage ART thus increasing access and coverage. One such example has been the expansion of ARV treatment to Primary Health Clinics (PHCs). The more accessible PHCs which are spread throughout the country have been enlisted to help make ARVs more easily available.

A recent development in Malaysia with regards to improving access to HIV treatment has been the extension of access to those living with HIV in prisons. This is in addition to the services already possible for drug rehabilitation centre internees who are living with HIV and are able to have access to HIV related treatment inclusive of CD4 follow-up and monitoring of ART.

In addition to that, since 1998, the Malaysian AIDS Foundation (MAF) has implemented the People Living with HIV/AIDS (PLHIV) Medicine Assistance Scheme intended to assist poor Malaysians living with HIV to undergo HAART with the primary objectives of helping them prolong and improve their quality of life. MAF subsidises one ARV to the selected patient to complement current ARV treatment accessed through government facilities.[99]

A challenging area of concern has been the need to increase treatment literacy and education among PLHIV. MTAAG+ (Positive Malaysian Treatment Access and Advocacy Group) has been working in addressing this issue through treatment education programmes which have included illiterate PLHIV in rural areas. They have also played a role in dialogues with government on the issue of access and affordability of ARV treatment.

These upscaling efforts have resulted in a total of 9 962 PLHIV on ARV by the end of 2009. However, it is sobering to note this still fall short of the estimated 26 722 PLHIV who meet the criteria for treatment indicating that the current coverage of the ARV programme is at 37.3%. It remains uncertain as to why the situation is as such. It has been indicated that the issue of stigma and discrimination remain formidable obstacles to PLHIV coming forth for treatment. Concerns include the perceived lack of confidentiality due to the proximity of the treating PHC with the person's community. In a study with 206 PLHIV respondents, 10% reported that healthcare workers disclosed their HIV status without their consent.[100] Also reported were incidences of refusal or delay in access to services, breeches in confidentiality and verbal abuse.[101] There is also 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.

[98] Ministry of Health (2010). *Annual Reporting Form 2010. Monitoring and Reporting on the Health Sector Response to HIV/AIDS. Malaysia.* Submitted March 2010.
[99] Malaysian AIDS Council & Malaysian AIDS Foundation (2009). *2008 Annual Report.*
[100] Kamarulzaman, A (2009). Antiretroviral therapy in Malaysia: Identifying barriers to universal access. *HIV Ther.* (2009) 3(6), 573 - 582
[101] ibid

Care and Support

It is important to note that the majority of the Government's achievements have been from the treatment perspective. Formidable gaps remain with regards to the delivery of care and support, which has been effectively delegated to the realm of the less well equipped and very resource strapped NGOs.

However, there has been better collaboration from religious bodies and other relevant government agencies, especially related to welfare, on the issue of care and support for PLHIV. In 2009, the Department of Islamic Development indicated its commitment to building a shelter home for homeless Muslims living with HIV by 2010. Department of Islamic Affairs Wilayah Persekutuan (JAWI) and the Islamic Religious Council (MAIWP) have also expressed its support for the establishment of hospices for religious outreach and to provide food.[102]

The Ministry of Women, Family and Community Development began funding 7 shelters for women and children infected and affected by HIV in 2008. This initial number of shelter homes was expanded to 15 in 2009.[103] The Department of Social Welfare has also begun extending financial assistance to PLHIV to facilitate the start of income generating activities (e.g. starting a taxi business).[104]

In several instances, care and support programmes are currently run by various NGOs such as KLASS and Prihatin in Kuala Lumpur and Kelantan respectively, who work together with government hospitals and health centres to assist in the delivery of care and support services. In the latter case, patients who attend the treatment at the hospital are then referred to Prihatin for follow-up support and services including treatment education and psychosocial support.

In 2008, the Malaysian AIDS Foundation established the Keep in School Scheme (KISS) programme to support poor children between the ages of 13 – 19 years infected and affected by HIV. The fund is aimed at providing these children the opportunity to continue their secondary school or vocational education by providing financial aid. Through this scheme, financial assistance and sponsorships are offered monthly to the children to meet daily needs such as food, clothing and schooling necessities as well as transport to seek HIV treatment.[105]

Since year 2005, the Kuala Lumpur AIDS Support Services Society and Positive Living PT Foundation have implemented a hospital peer support programme involving PLHIV providing support and assistance to others who are with HIV. The work has complemented the ARVT treatment provided by the hospital by providing information, peer support as well as assisting in psychosocial support in ensuring adherence to ARV. This kind of support may not necessarily be able to be accessed at the hospital due to the lack time and high patient load faced by the medical staff.

[102] UNGASS Government Stakeholder consultation workshop. 23 December 2009
[103] Ibid
[104] Ibid
[105] Ibid

IV. Best practices

The Needle Syringe Exchange Programme (NSEP)

The Needle Syringe Exchange Programme (NSEP) pilot took place in a successful partnership with community based organisations, law enforcement bodies and anti-drug agencies at several separate locations in Malaysia from 2006 till 2007. It was successful in achieving its pilot target objectives and is currently experiencing an increase in the number of new clients prescribing to the programme.

The NSEP, with its current target of servicing 25,000 drug users with free syringes and condoms, is currently the centrepiece of the Government's prevention intervention.[106] Besides the provision of syringes and condoms, it also provides access to and education on sterile injection equipment and safer injecting techniques.

Table 14: Availability of NSEP (2006 – 2009)

Facilities	2006	2007	2008	2009
NGO-based facilities				
• NSEP Site	3	5	9	12
• Outreach Point	42	64	106	206
NSEP Health Centre	0	0	6	22
Total	**45**	**69**	**121**	**240**

Source: Ministry of Health (2009)

Table 15: Achievements of the NSEP (2006 – 2009)

	2006	2007	2008	2009
Targeted no. of clients (cumulative)	1 200	7 200	10 800	15 000
Registered clients/ year	4 357	2 301	5 572	6 147
Registered clients (cumulative)	4 357	6 658	12 230	18 377
Return rate of needles (%)	**58.6**	**62.2**	**63.2**	**65.9**

Source: Ministry of Health (2009)

The collaborative partnership developed between the CBOs and NGOs working on drug user issues and government agencies involved in the Needle Syringe Exchange Programme (NSEP), has been both instrumental and critical to the operations of the NSEP, which is now coming to its fourth year in operation.

The immense political support and the necessary commitment involved in the setting up of the programme required for there to be properly documented evidence of its effectiveness and impact. As such, as most of the technical expertise and experience in harm reduction interventions reside with the CBOs, they have been involved in the design of the programme from the beginning. They are also involved in the ongoing monitoring and evaluation of the programme.

The formation of the National Taskforce on Harm Reduction has also allowed for other agencies such as the National Anti-Drug Agency and the Royal Malaysian Police to be engaged on this

[106] Bernama. *15,000 Drug Addicts Targeted For Harm Reduction Programme*. 29 November 2007. http://web7.bernama.com/bernama/v3/news.php?id=299285

issue as well as to provide coordination, harmonisation and problem solving.[107] The Government, through the Ministry of Health, provides support in the form of the necessary technical expertise and medical equipment while the CBOs, as the implementers of the NSEP, manage the NSEP sites and programme locations. Collaboration amongst the implementers, health officials and enforcement officials is continuously needed to ensure sustainability of this program.

Already this programme has had a number of impacts which include reduced sharing of injecting drug equipment and fewer IDUs using "port doctors" to facilitate their drug use (e.g. supplying used needles) which have resulted in decreased vulnerability to HIV infection.[108]

However, teething problems and challenges still abound, particularly those linked to awareness and sensitisation of law enforcement authorities. Due to public pressure as well as lack of awareness of the harm reduction programme, law enforcement bodies continues to occasionally conduct raids on NSEP sites thus causing disruption and distrust among IDUs from returning.

Institutionalised involvement of the Islamic religious welfare system

Building on the successes of the "Islam and HIV/AIDS" project first initiated between 2001 to mid-2005 which was first reported in the 2008 report, Muslim religious leaders have since not only been actively 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. This project, developed by the AIDS/STD Section of the Ministry of Health in partnership with the Malaysian AIDS Council and the United Nations Development Programme (UNDP), involved key stakeholders from the Islamic institutions as well as community leaders such as Imams at the grassroots level. The institutions engaged included the Department of Islamic Development (*Jabatan Kemajuan Islam Malaysia*) at the Federal level and State Religious Departments (*Jabatan Agama Islam Negeri*) at the State level. Though the project itself ended in 2005, the resulting HIV module has since been institutionalised into the formal training of new Muslim leaders.[109] The Department of Islamic Development (JAKIM) in particular has been an active partner in creating awareness of HIV issues among the Muslim public.

Though there has been a certain amount of challenges and setbacks in the engagement of these religious leaders (in one example, a high ranking religious official called for the quarantine of PLHIV to protect the general population), the past 2 years in particular have seen the remarkable and encouraging development of programmes which involve a number of religious departments engaging most-at-risk populations such as female sex workers and transgender persons.

The Islamic Religious Department for the Federal Territory (JAWI) in partnership with PT Foundation has made available religious classes for sex workers and others who are interested.[110] This outreach approach by the religious department has been much appreciated by the community as they are often bereft of their spiritual and religious needs as a result of discrimination and marginalisation in more conventional places such as mosques. JAKIM has also now made it practice for the Friday sermon closest to World AIDS Day to be about HIV

[107] Power, R (2006). Malaysian Needle Syringe Exchange Programme (NSEP) Monitoring and Evaluation (M&E) and National Up-Scale Report. *Review and Evaluation on Harm Reduction Programme in Malaysia*, World Health Organisation. June 2008.
[108] Azmi, S. (2009). *Response Review of the National Strategic Plan on HIV/AIDS 2006 – 2010.* August 2009.
[109] Department of Islamic Development (2009). *UNGASS Government Stakeholder Discussions*, 23 December 2009.
[110] PT Foundation (2009). *UNGASS NGO Stakeholder Discussions*, 22 December 2009

addressing related issues such as stigma and discrimination, and prevention. Friday sermons, which involve a large audience of men and are delivered by persons considered to be community or religious leaders, are used to communicate key HIV prevention and awareness messages. In 2009, as part of International AIDS Memorial, JAKIM also organised a panel discussion on HIV for a popular religious forum which was broadcasted on television. The forum was well received and discussed issues linked to vulnerabilities to HIV of MARPs as well as the issues faced by PLHIV and their families.

Extension of MMT and ART in incarcerated settings

Since September 2004, HIV positive drug users in drug rehabilitation centres (DRC) have already been able to have access to ART. One of the pilot projects involving the provision of ART within the setting of a Drug Rehabilitation Centre was recognised by the World Health Organisation as a Best Practice in the Asia Pacific region.[111]

In 2007, pilot testing began towards the provision of MMT in incarcerated settings, specifically in prisons.[112] This is in addition to the services already available for detainees who are living with HIV and are able to have access to HIV related treatment inclusive of CD4 follow-up and monitoring of ART. Currently there are 12 out of 31 prisons nationwide providing MMT and ART.

Prison officers have undergone health training programmes which provide basic information on HIV and AIDS as well as the provision of counselling materials for selected officers. A number of wardens in prison have also been formally trained in HIV counselling. An evaluation of the pilot is currently being carried out to determine the feasibility of up scaling the nascent programme to all prisons nationwide.

[111] Ministry of Health (2008). UNGASS Country Progress Report 2008.
[112] Ibid

V. Major challenges and remedial actions

Progress made on key challenges reported in the 2008 UNGASS country report

- *Involvement of civil society in policy and decision making*

Though involvement of key civil society stakeholders in national level policy and programme development remains limited due to issues related to capacity, relevance and interest; the avenues for participation has increased significantly over the past two years. Civil society representation is now possible at all levels of the national HIV policy development framework in both the National Advisory and Technical Committee on AIDS (NATCA) and National Coordinating Committee on AIDS Intervention (NCCAI). Community representation, including those from most-at-risk populations and PLHIV, is also present on the Country Coordinating Mechanism. MAC continues to play a critical facilitating role in coordinating this improved participation but is now also tasked with the responsibility of building the capacity of the different civil society stakeholders. This is to ensure that the participants and representatives have sufficient capacity to contribute at these levels

- *More research and studies needed*

As discussed under *Strategy 2: Training and Capacity Enhancement*, much progress has been made in addressing the gaps reported in the 2008 document. Of note has been the improved availability of strategic information in 2009. Strategic information such as behavioural data necessary to plan and implement a comprehensive response to HIV was previously scarce and ad-hoc at best. Data for these populations on HIV prevalence, profiles of risk behaviour and vulnerabilities were often anecdotal, limited or simply not available.

Though there continues to be a major dearth of research concerning the most-at-risk populations in comparison to what is available in neighbouring countries, the past few years have seen the implementation of a number of behavioural studies and research with these communities. These efforts have improved the understanding of the Malaysian HIV epidemic and has enable for detailed descriptions of behaviour and risk to be developed which will be useful in HIV programming, policy and decision making as well as reporting on progress. The work in conducting these studies and the subsequent findings have made it possible to report on behavioural indicators, previously unknown and often guessed at, which will be later used in influencing HIV programming with these specific populations.

There still exist concerns of the limited availability of technical expertise to conduct research and data collection. Scientific researchers in social science, epidemiology, medical treatment and other areas who are interested to conduct HIV related research are still scarce. There is still a high level of dependence on external resource persons and consultants.

Detailed gender disaggregated data has also recently become available as a result of a revision of the national HIV reporting system by the Ministry of Health. This data has been included as much as possible in the reporting of UNGASS indicators. Analysis of this data is critical to ensure a better understanding of how men and women are vulnerable to HIV infection in Malaysia.

Challenges in 2008–2009 and remedial actions

- *The rise in sexual transmission*

As mentioned earlier and the 2008 report, there are clear indications that sexual transmission is becoming a major factor in the future of the country's epidemic. Compared to five years ago, when infection through the IDU route was 74.2% of all new reported HIV cases, 55.2% of all new infections were now attributed to injecting drug use in 2009.[113] Increasingly more new cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by heterosexuals, MSM and transgender. Combined, sexual transmission of HIV is currently responsible for more than a third of new HIV cases, the proportion of which is increasing each year. This dynamic continues to represent a major challenge in future responses to the epidemic and should be the focus of the upcoming National Strategy on HIV and AIDS.

The rise in sexual transmission would require a further strengthening of commitment from the Government to undertake and improve upon programmes which specifically address the issue of sexual reproductive health, especially among young people. Policy-makers need to be better informed about the importance of adolescent health and sexual reproductive health, particularly within the context of HIV. They should also understand the serious consequences if this important issue is not addressed adequately.

What is of utmost concern is that based on existing surveys, young people have been found to have uneven knowledge on sexual reproductive health; and where knowledge is high, it was not being practiced. Sexuality education must not only ensure that awareness and knowledge is imparted but also accompanied by skills.

There needs to be clear and coherent policies and direction concerning sexual reproductive health issues which address issues such as the promotion of safer sex and the possession and use of condoms. If a woman is able to be accused and arrested for prostitution on the basis of possessing a certain number of condoms, such policies need to be clarified particularly as it involves prevention of HIV.

As issues relating to sexuality and young people are often contentious and linked to public morality, more must be done to further consult and engage religious leaders and other community leaders. The upholding of social and religious values and rulings should take into consideration the realities of an epidemic which is increasingly spread through sexual transmission.

- *Stigma and discrimination*

Stigma and discrimination continues to be an issue that not only affects the lives of PLHIV and those around them, but also present themselves as obstacles to the progress and implementation of HIV prevention, treatment, care and support programmes. From available studies and discussions with PLHIV, stigma and discrimination among health care workers at some clinics and hospitals remains an issue, however there was an improvement on that issues compared to two decades ago. Certain hospitals such as the Sungai Buloh Hospital, University Malaya Medical Centre have staff who are more friendly, supportive and less judgmental. Thus, PLHIV who

[113] Ministry of Health (2010). Op cit (see reference 2)

require treatment tend to favour these hospitals and healthcare facilities while other service locations are not utilized though they may be closer to the patients' home. Other facilities and support services provided for PLHIV also tend to be underutilized, mainly due to the fear of stigma and discrimination from the general public.

- *Limited financial resources*

Current financial resource priorities are limiting the coverage of HIV and AIDS related services, and their accessibility and affordability to the vulnerable population. The MOH is committed to continue to support NGO programmes as long as efficient reporting is carried out as required. However, it was felt that the provision of all funding for the national AIDS programme being solely dependent on the Government is not sustainable. It has been recommended that NGOs be able to raise funds from other sources which include the Global Fund.

VI. Support from the country's development partners

Over the years, Malaysia has received many types of support, including financial and technical assistance, from a number of development partners as part of the response to the HIV epidemic in the country. In the past, both bilateral and multilateral agencies have been major partners in prevention efforts, the strengthening of care, support and treatment mechanisms as well as working towards the creation and sustaining of an enabling environment.

Due to Malaysia now being categorised as an upper middle income country, access to and availability of the types of support able to be utilised have been severely limited. Though government HIV and AIDS programmes are largely unaffected by this development, the withdrawal or restricted participation of donors have severely affected civil society organisations, particularly community based organisations which depend on such aid as part of their funding sources and implementation of key interventions. For the period of 2006 – 2010, funding allocated for HIV and AIDS programming in Malaysia from multilateral agencies including UNDP, UNICEF, UNFPA, UNHCR and WHO is approximately USD 3.6 million.[114]

As such, the United Nations in Malaysia currently constitute the largest development partner and which provides support to national country partners bilaterally as well as jointly through the United Nations Theme Group on HIV (UNTG). Since the last UNGASS report two major changes have taken place. Firstly, in 2008, the UNTG, with support from UNAIDS, established the position of a HIV and AIDS Coordinator to strengthen the response of the national programme, which includes facilitation of policy dialogues between the government and non-government partners. The UNTG in Malaysia works towards providing coordination and overall policy and programmatic guidance to the resident UN agencies working in support of their respective national government and non-government partners.[115] It concentrates on ensuring the delivery of joint UN support and functions as an information exchange mechanism through close partnership with all key stakeholders including civil society organisations and the Government of Malaysia. Secondly, with the opportunity represented by the Global Fund, Malaysia established its first Country Coordinating Mechanism (CCM) and the UNTG provided support to guide the process of submission. The UNTG is also utilised to represent the UN system on the CCM to ensure harmonisation and to avoid duplication of planned and proposed Global Fund activities with existing UN supported programmes.

The UNTG comprises representatives from the United Nations Development Programme (UNDP), World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), and the United Nations University – Institute for International Global Health (UNU – IIGH).[116] UNICEF chaired the UNTG during the duration covered by this report from 2008 – 2009.

UNDP continues to monitor the impact of HIV and AIDS through strategic discourse and support of multi-sectoral policy changes as part of working towards achieving MDG 6. In collaboration with the Economic Planning Unit in the Prime Minister's Department, UNDP submitted an assessment report to the government on the impact of existing national HIV and AIDS programmes and provided recommendations on strengthening future national interventions.

[114] Government of Malaysia (2009). *Country Proposal for Round 9 of the Global Fund for AIDS, Tuberculosis and Malaria.*
[115] United Nations Malaysia (2009). *2009 – 2010 Strategic Framework for United Nations Theme Group on HIV support of the National Strategic Plan on HIV and AIDS 2006 – 2010.*
[116] Ibid

UNDP is currently providing funding support for the development of the upcoming National Strategy on HIV and AIDS 2011 – 2015. In late 2009, through the UNAIDS Programme Acceleration Funds, a small initiative was initiated with a local CSO to raise HIV and AIDS awareness among migrant workers and refugees in Peninsular Malaysia.

In the past few years, WHO's support of its main national government partner, the Ministry of Health, has resulted in a number of significant achievements, particularly in strengthening the availability and quality of strategic HIV and AIDS information and building national capacity in national surveillance and control of HIV and STIs. Working together with the AIDS/STD Section of the MOH, WHO jointly organised the National Consensus Workshop on HIV and AIDS held in May 2009. This workshop was able to produce basic estimates and projections of the HIV epidemic, including for the first time usable estimates and projections of most at risk and emerging populations at risk, which were later utilised in the development of the Country Proposal for submission to Round 9 of the Global Fund process. The output from this work is expected to influence decision making of key institutions, agencies and NGOs involved in the planning, implementation and monitoring and evaluation of HIV and AIDS related programmes, research, intervention, surveillance as well as allocation of funding resources. Besides this, WHO continues to provide technical support for the up-scaling of the overall national harm reduction programme and is a key partner of the MOH in the assessing its effectiveness in responding to the interlinked issues of opioid dependence, HIV and TB. [117]

UNFPA's engagement in HIV and AIDS issues in Malaysia continues to focus on prevention related initiatives and linking it to SRH concerns. Its recent programme includes working towards ensuring SRH and HIV prevention information and services among those involved in sex work. The 5 year commitment (2008-2012) to assisting country partners in addressing the issue of HIV and sex work, with the inclusion of access to SRH services, is currently being implemented through a CBO focused multi-stakeholder partnership involving among others the Federation of Reproductive Health Associations, Malaysia (FRHAM) (formerly known as Federation of Family Planning Associations, Malaysia (FFPAM) and PT Foundation. UNFPA has also positioned itself to assist in vulnerable areas experiencing a dearth as well as neglect of relevant HIV programmes, such as young people in juvenile homes. Relevant educational programmes on HIV and AIDS have also been incorporated in other UNFPA funded initiatives

Under the banner of its global campaign "Unite for Children, Unite Against AIDS", UNICEF works closely with the MOH and Ministry of Education (MOE) to support programmes targeting children. Working together with WHO, UNICEF provides technical support to MOH in the area of Prevention of Parent-to-Child Transmission (PPTCT) and in pediatric AIDS. Its support to MOH was particularly responsible for the setting up of the Taskforce on Women, Girls and HIV and AIDS after the release of the publication in 2008 on "Women and Girls: Confronting HIV and AIDS". This taskforce has been charged to provide the guidance and policy recommendations to ensure an effective response to the increasing proportion of women and girls becoming infected with HIV. UNICEF also worked together with MOH in the setting up of the National AIDS Registry which has enable for gender disaggregated data to be monitored, particularly those relating to women and girls.[118] UNICEF in Malaysia has also largely advocated for the well-being of children affected by AIDS and has begun the process of child protection reform which includes targeted interventions for those women and children most vulnerable to the epidemic.

[117] World Health Organisation (2007). *Country Cooperation Strategy – at a glance. March 2007*. Available at http://www.who.int/countryfocus

[118] United Nations Malaysia (2009). *2009 – 2010 Strategic Framework for United Nations Theme Group on HIV support of the National Strategic Plan on HIV and AIDS 2006 – 2010.*

UNHCR in Malaysia continues to provide limited support in the area of HIV and AIDS to asylum seekers and refugees. As previously noted, there remains a scarcity of programmes catering to this population, particularly those relating to HIV prevention and treatment. UNHCR currently works with several non-governmental organizations as well as relevant government agencies to provide HIV and AIDS care, support and treatment services to refugees and persons of concern. UNHCR has actively been promoting voluntary counselling and testing to the various at risk communities within the refugee population and has been facilitating access to HIV-related services, including care and treatment for several years. As a result of its engagement and close cooperation of the MOH, UNHCR was able to obtain access to medical support for persons of concern through the national healthcare system which includes subsidised access to ART and to free VCT services. To compliment this facility as well as part of its commitment to providing HIV related support, UNHCR provides funding allocations to subsidise the cost of the ART, follow-up monitoring of the treatment as well as shelter for persons of concern living with HIV.

VII. Monitoring and evaluation environment

As part of the National Strategic Plan on HIV/AIDS 2006-2010, the country now has a rudimentary national Monitoring and Evaluation (M&E) plan utilising indicators including those of the UNGASS process, covering the duration of the NSP.

Despite not having a dedicated M&E unit or department based within the HIV and AIDS framework of the Ministry of Health, HIV programme monitoring data is collected utilising a variety of instruments and sources, namely

- web-based National AIDS Registry
- comprehensive antenatal screening;
- Programmatic data from the Malaysian AIDS Council's Partner Organisations and the NSEP Programme via MAC M&E system
- Separate M&E system established for the NSEP
- Additional surveillance, monitoring and evaluation sources including screening of "blood donors, Muslim pre-marital registrants and Drug Rehabilitation Centre patients.

A number of reasons were cited as to why a dedicated M&E unit was not established as part of NSP framework. These included:

- Limited technical personnel were available to undertake the task of M&E as an entirely separate department.
- M&E is currently expected to be integrated into existing HIV and AIDS programming without the need for a separate mechanism altogether.
- It has also been the opinion that the other units in the Ministry already have pre-existing M&E and oversight structures such as the Audit Department. It was felt that it was unnecessary to establish an entirely new entity to conduct M&E activities. As such there exists active resistance within the Government management structure to establish a separate department altogether.

As the main coordinator of NGOs and CBOs responding to HIV, MAC is tasked to monitor the various government grants granted to itself and other organisations working on the different aspects of the national response. In relation to that, as part of M&E, MAC is given the responsibility to report back on the individual projects utilising the various national progress indicators as part of M&E. It is also given the responsibility of providing feedback to the Government on issues and concerns affecting its constituents

The analysis and use of M&E data from the two Harm Reduction programmes (NSEP & MMT) enabled for there to be justification and institutional support from the Cabinet Committee on AIDS for the scaling up of these interventions. M&E data was also utilised to introduce premarital HIV screening to address the issue of heterosexual transmission. It also enabled the Government to justify its stance in promoting such testing.

However, an assessment was conducted on the NSP framework in 2007 to ascertain whether the M&E mechanism in place was sufficient and utilised in the development, implementation and evaluation of programmes. Its findings were that:

- The current indicators developed and used by the Ministry of Health were unable to effectively measure the progress towards achievement of the NSP strategies and objectives.

- The indicators currently used by the Ministry of Health were process indicators and as such inadequate to measure against progress towards achieving the objectives of the NSP. The existing indicators are mainly to monitor the activities of stakeholders receiving NSP grants from the Ministry.
- The indicators used by stakeholders within the existing M&E framework were found to be incomparable to those used in other countries.

As of 2009, the Malaysian AIDS Council, working with the Ministry of Health, has since developed an online monitoring system and database to address the abovementioned concerns, which is working and is providing increasingly valid and reliable data that feeds into increasingly critical program analysis. The AIDS/STD Section has also established a monitoring and IBBS research section whose responsibilities include the development and implementation of a national monitoring and evaluation framework. Priority has been to ensure that all M&E systems are compatible in measuring progress against UNGASS and Universal Access indicators.

However, the main challenge to the use of the M&E data continues to be bridging the gap between the analysis and understanding of the data collected and translating that to the development and improvement of evidence based programmes and policies.

ANNEX 1: Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS*

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	**No**
b) NAP	**Yes**	No
b) Others (please specify)	Yes	**No**

2) With inputs from

Ministeries

• Education	**Yes**	No
• Health	**Yes**	No
• Labour	**Yes**	No
• Foreign Affairs	Yes	**No**
• Others: Women, Family and Community Development, Defence, Home Affairs, Information, Department of Islamic Development	**Yes**	No
Civil society organisations	**Yes**	No
People living with HIV	**Yes**	No
Private sector	Yes	**No**
United Nations organisations	**Yes**	No
Bilaterals	Yes	**No**
International NGOs	**Yes**	No

3)	Was the report discussed in a large forum?	**Yes**	No
4)	Are the survey results stored centrally?	**Yes**	No
5)	Are data available for public consultation	**Yes**	No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name/ title: DATO' DR HASAN ABDUL RAHMAN
Deputy Director General (PublicHealth),
Ministry of Health, Malaysia

Date: 26 March 2010

Signature: _____

Please provide full contact information:

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ANNEX 2 : National Composite Policy Index Questionnaire (Part A & Part B)

Country: MALAYSIA

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Name: Dr. Shaari Ngadiman
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Date of submission: 26 March 2010

NCPI Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:

A series of workshops and working sessions were convened with government and civil society stakeholders to obtain data for Parts A and B of the National Composite Policy Index (NCPI) questionnaire as well as for the narrative component of the report.

An orientation and preparatory briefing on the UNGASS process was organised by the Ministry of Health on 19 November 2009 for both Government and civil society stakeholders. The intention was to ensure that all partners understood the process and was also able to participate as much as possible in providing input and information to the development of the report.

The first consultative meeting to discuss the NCPI and narrative component of the report was held on 22 December 2009 and was attended by civil society stakeholders who included representatives of various communities of most-at-risk populations, People Living With HIV, advocacy groups, community based organisations as well as a number of various multilateral organisations. The Malaysian AIDS Council (MAC), the lead coordinating HIV non-governmental organisation in the country with 43 NGOs working on HIV and AIDS related issues as its partner organisation, tasked itself to ensuring the coordination of the civil society responses to Part B of the NCPI Questionnaire. As a result of the earlier briefing conducted in November, Part B was able to be presented to the participants as a draft completed with inputs from the different partner organisations of MAC. It was further improved upon through the deliberations of this workshop.

The discussions which followed also included content for the different parts of the narrative section. As in the previous 2008 process, resource persons from the Ministry of Health were made available on hand during the civil society consultation workshop to ensure that information concerning available policies and practices would be available for reference if necessary. These resource persons were advised and reminded to not influence the outcome of the discussions among the civil society stakeholders.

The second consultative meeting involved Government stakeholders from the different Ministries and agencies. These included representatives from the Ministry of Health, Ministry of Women, Family and Community Development, National Anti Drug Agency, Department of Islamic Development and Royal Malaysian Police. Part A of the NCPI and the narrative content were discussed with participants of this workshop with AIDS officers from the different states as well as the AIDS/STD Section of the Ministry of Health taking the lead in the deliberations. The questionnaire was completed through joint discussions with all those in attendance.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

There were a number of disagreements and disputes on a number of issues. However, as the development of the answers to the questionnaire was done through group work, issues of contention were settled through a deliberative process whereupon both opposing views would be given a certain amount of time for debate and discourse after which a consensus decision was undertaken by the group.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Participants answering the questionnaire understood and were able to answer the questions to the best of their abilities.

NCPI Respondents

NCPI – Part A (to be administered to government officials)

Note: Discussions were conducted through group work

Organisation	Names/ Position	Respondents to Part A				
		A. I	A. II	A. III	A. IV	A. V
Ministry of Health	Dr. Norhizan Ismail, Chief Deputy Director (AIDS/STD)	✓	✓	✓	✓	✓
Ministry of Health	Md. Amidon Damit, Health Education	✓	✓	✓	✓	✓
Ministry of Health	Dr. Fazidah Yuswan, Chief Deputy Director (NSEP Manager)	✓	✓	✓	✓	✓
Selangor Health Dept	Dr. Masitah Mohamed, Public Health Specialist	✓	✓	✓	✓	✓
Selangor Health Dept	Dr. Salmah Nordin, Family Health Specialist	✓	✓	✓	✓	✓
Royal Malaysian Police	ASP. Mohd Husni Maarof, Enforcement	✓	✓	✓	✓	✓
Prisons Department	Mr. Sazali	✓	✓	✓	✓	✓
Ministry of Defence	Representative	✓	✓	✓	✓	✓
Ministry of Youth and Sports	Mr. Mazlan Mohamed, Youth and Sports Officer	✓	✓	✓	✓	✓
Ministry of Human Resource	Representative, Department of Safety and Hazards.	✓	✓	✓	✓	✓
Ministry of Information	Ms. Azzurin	✓	✓	✓	✓	✓
Ministry of Women, Family and Community	Ms. Vassundira, Chief Assistant Secretary, Social Policy Section	✓	✓	✓	✓	✓

Development						
Department of Islamic Development	Representative	✓	✓	✓	✓	✓
National Anti Drug Agency	Representative	✓	✓	✓	✓	✓

NCPI – Part B (to be administered to civil society organizations, bilateral agencies, and UN organizations)

Note: Discussions were conducted through group work

Organisation	Names/ Position	Respondents to Part B			
		B. I	B. II	B. III	B. IV
Malaysian AIDS Council	Dr. Sourabh Malandkeer, Senior Executive, M&E	✓	✓	✓	✓
Malaysian AIDS Council	Ms. Manohara, Programme Manager	✓	✓	✓	✓
Malaysian AIDS Council	Mr. Mohammad Shahrani Mohamad Tamrin, Senior Executive	✓	✓	✓	✓
Malaysian AIDS Council	Mr. Shahruddin Ali Umar	✓	✓	✓	✓
Malaysian AIDS Council	Ms. Jenitha Santirasekaran, Manager, Sex Worker/ TG	✓	✓	✓	✓
Malaysian AIDS Council	Ms. Malini Sivapragasam, Executtive, Sex Worker/ TG	✓	✓	✓	✓
Malaysian AIDS Council	Arokiam a/L Arokium Das, Executive Committee Member	✓	✓	✓	✓
Malaysian AIDS Council/ SAHABAT	Datuk Zaman Khan, MAC Vice President & President of SAHABAT	✓	✓	✓	✓
MTAAG+	Mr. Edward Low, Director,	✓	✓	✓	✓
PT Foundation	Mr. Raymond Tai, Active Executive Director	✓	✓	✓	✓
PT Foundation	Mr. Khairuddin Mahmud, Programme Manager	✓	✓	✓	✓
Federation of Reproductive Health Associations Malaysia	Lim Shiang Keng, Acting Executive Director	✓	✓	✓	✓
Asia Pacific Council of AIDS Service Organisations (APCASO)	Liew Moi Lee, Coordinator	✓	✓	✓	✓
Malaysian CARE	Pax Tan, Executive Committee Member	✓	✓	✓	✓
PROSTAR	Ms. Rooslina Ahmad, Secretary of PROSTAR Puchong	✓	✓	✓	✓

National Composite Policy Index (NCPI) questionnaire

PART A
(to be administered to government officials)

I. STRATEGIC PLAN

1. **Has the country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?**
(Multi-sectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No	Not Applicable (N/A)

Period covered: **2006 – 2010**

***IF NO or NOT APPLICABLE*, briefly explain why**

NOT APPLICABLE

***IF YES*, complete questions 1.1 through 1.10; *If NO*, go to question 2.**

1.1 How long has the country had a multi-sectoral strategy/action framework?

Number of Years: **12 years**

1.2 Which sectors are included in the multi-sectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
Health	**Yes**	No	**Yes**	No
Education	**Yes**	No	Yes	**No**
Labour	**Yes**	No	Yes	**No**
Transportation	Yes	**No**	Yes	**No**
Military/Police	**Yes**	No	**Yes**	No
Women, Family and Community Dev	**Yes**	No	**Yes**	No
Young people	**Yes**	No	Yes	**No**
Other*:				
National Service	**Yes**	No	**Yes**	No
Dept. of Islamic Development	**Yes**	No	**Yes**	No
National Anti-Drug Agency	**Yes**	No	**Yes**	No
Dept. of Immigration	**Yes**	No	**Yes**	No
Ministry of Information	**Yes**	No	Yes	**No**
Dept. of Social Welfare	**Yes**	No	**Yes**	No
Department of Prisons	**Yes**	No	**Yes**	No
Attorney General Chambers	**Yes**	No	Yes	**No**

Economic Planning Unit	Yes	No	Yes	No
Ministry of Higher Education	Yes	No	Yes	No
Ministry of Education	Yes	No	Yes	No
Ministry of Finance	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding used to ensure implementation of their HIV specific activities?

In many instances, when there are no earmarked funds for HIV specific activities, the relevant government agency utilises its own pre-existing internal programme budget/ allocation when needed. This enables for projects to be proposed and implemented through an ad-hoc approach. E.g. the Ministry of Women, Family and Community Development has utilised its own allocation to fund the setting up and running of three DICs for women, PLHIV and transgender persons through a CBO.

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	Yes	No
b. Young women/young men	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex workers	Yes	No
f. Orphans and other vulnerable children	Yes	No
g. Specific vulnerable sub- populations	Yes	No
Settings		
h. Workplace	Yes	No
i. Schools	Yes	No
j. Prisons	Yes	No
Cross-cutting issues		
k. HIV/AIDS and poverty	Yes	No
l. Human rights protection	Yes	No
m. PLHIV involvement	Yes	No
n. Addressing stigma and discrimination	Yes	No
o. Gender empowerment and/or gender equality	Yes	No

1.4 Were target populations identified through a process of a needs assessment?

Yes	No

IF YES, when was this needs assessment conducted?

Year: **2004**

IF NO, how were target populations identified?

NOT APPLICABLE

1.5 What are the identified target populations for HIV programmes in the country?

- Injecting drug users
- Women
- Young people
- Children
- People Living With HIV
- Transgender
- Sex workers
- Men who have sex with men
- Mobile populations (legal & illegal migrants, displaced persons, refugees & migrant labourers)

1.6 Does the multisectoral strategy include an operational plan?

Yes	No

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	**Yes**	**No**
b. Clear targets and/or milestones?	**Yes**	**No**
c. Detailed costs for each programmatic area?	**Yes**	**No**
d. An indication of funding sources to support programme implementation?	**Yes**	**No**
e. A monitoring and evaluation framework?	**Yes**	**No**

1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

If active involvement, briefly explain how this was done:

Civil society participation was present at every stage of the development of the National Strategic Plan on HIV/AIDS (2006-2010). Consultations with key community based organisations and individuals were conducted to insure their inputs and concerns were reflected into the final document. Besides the consultation phase of NSP development, key civil society representatives were also involved and participated in the finalisation of the National Action Plan 2010 framework.

In addition to that, the role of civil society has been embedded into the planning, implementation, monitoring and assessment of the activities linked to the NSP.

At state and district levels, AIDS officers of the Ministry of Health work closely with their civil society counterparts in the planning and implementation of programmes. All proposals submitted for funding consideration under the NSP now require the

endorsement of the AIDS officer under whose area of responsibility the proposed programme would be implemented.

IF NO or MODERATE involvement, briefly explain why this was the case :

NOT APPLICABLE

1.9 Has the multi-sectoral strategy been endorsed by most external development partners (bi-laterals; multi-laterals)?

Yes	No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multi-sectoral strategy?

Yes, all partners	Yes, some partners	No

IF SOME or NO, briefly explain

The United Nations Theme Group on HIV/AIDS in Malaysia serves as the primary platform for interaction among United Nations Agencies and other major stakeholders in support of Malaysia's national response. Key agencies, specifically the United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), World Health Organisation (WHO) and the UN Population Fund (UNFPA), whose offices are present in Malaysia have developed specific intervention programmes to provide financial and technical support to the Government of Malaysia's 5 year plan. UNAIDS provides significant and similar support through the Regional Support Team – Asia Pacific.

A number of bilateral partners (e.g. foreign embassies) provide support to specific civil society projects dealing on issues of prevention as well as care and treatment.

2. Has the country integrated HIV into its general development plans such as in: a) National Development Plans, b) Common Country Assessments/ UN Development Assistance Framework, c) Poverty Reduction Strategy, d) sector wide approach?

Yes	No	N/A

2.1 ***IF YES,*** in which development plans is policy support for HIV and AIDS integrated?

a. National Development Plan	Yes	No	N/A
b. Common Country Assessment/ UN Development Assistance Framework	Yes	No	N/A
c. Poverty Reduction Strategy	Yes	No	N/A
d. Sector Wide Approach	Yes	No	N/A

e. Other	Yes	No	N/A

2.2 ***IF YES,*** which specific HIV related areas below are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV Prevention	**Yes**	No
Treatment for opportunistic infections	**Yes**	No
Antiretroviral therapy	**Yes**	No
Care and support (including social security or other schemes)	**Yes**	No
HIV impact alleviation	**Yes**	No
Reduction of *gender* inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	**No**
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	**No**
Reduction of stigma and discrimination	**Yes**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	**Yes**	No
Other: (write in)	Yes	No

3. Has the country evaluated the impact of HIV on its socio-economic development for planning purposes?

Yes	No	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low *High*

0 1 **2** 3 4 5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

4.1 ***IF YES,*** which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	**Yes**	No
Condom provision	Yes	**No**
HIV testing and counselling*	**Yes**	No
Sexually transmitted infection services	**Yes**	No

Antiretroviral treatment	Yes	No
Care and support	Yes	No
Others: *(write in)*	Yes	No

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling? (e.g. indicate if HIV testing is voluntary or mandatory etc):

- **New military and police recruits undergo a mandatory health screening, which includes for HIV, upon recruitment.**
- **Any new military or police recruit who undergoes such screening and whose tests are reactive for infectious diseases or has certain medical conditions, is deemed medically unfit and as such not considered for military service.**
- **Regular mandatory screening is conducted for existing active personnel. Should they tests be found reactive, they could be subjected to administrative punishment, court marital or dishonourable discharge.**

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	No

5.1 IF YES, for which subpopulation?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/ mobile populations	Yes	No
h. Other: (write in)	Yes	No

If YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly comment on the degree to which these laws are currently implemented:

NOT APPLICABLE

6 Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	No

6.1 IF YES, for which subpopulation?

a. Women	Yes	**No**
b. Young people	**Yes**	No
c. Injecting drug users	**Yes**	No
d. Men who have sex with men	**Yes**	No
e. Sex workers	**Yes**	No
f. Prison inmates	**Yes**	No
g. Migrants/ mobile populations	**Yes**	No
h. Other: Transgender persons	**Yes**	No

If YES, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

Laws and regulations which currently criminalise illegal drug use pose conundrums for law enforcement bodies. The possession of injecting drug equipment or drugs such as morphine without a prescription is technically illegal and subject to criminal prosecution. Currently, the policies concerning drug rehabilitation centres require a drug free environment. Introduction of the MMT into this setting is impossible without a revision of the said policies. The relevant Government agencies are currently has ongoing continuous dialogues with the different affected bodies in an effort to reconcile these legal impediments to HIV prevention programmes.

7 Has the country followed up on commitments towards Universal Access made during the High-Level AIDS Review in June 2006?

Yes	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes	No

IF YES, **for which population sub-groups?**

- **Injecting drug users**
- **Women**
- **Young people**
- **Children**
- **People Living With HIV**
- **Female sex workers**
- **Transgender persons**

Briefly explain how this information is used:

The information concerning coverage is utilised in the determination and prioritisation of resource allocation in support of programme implementation. The decision making as to which programme is supported by Government funding is influenced by the effectiveness and degree of existing and estimated coverage of current interventions. This information is also utilised in influencing and modifying the design of programmes.

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, **at which levels (provincial, district, other)?**

- **District**
- **State**
- **National**

Briefly explain how this information is used:

The information concerning geographical areas is utilised to determine where services and interventions are most needed in response to clearly defined priorities. Together with coverage data, this information is utilised to make informed decisions concerning the type of programmes needed, for whom and where. The

geographical information is particularly of critical use when determining priorities concerning resource allocation for areas such as those in East Malaysia, which are considered hard to reach and remote.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

The expansion and upscaling of both the Methadone Maintenance Therapy (MMT) and Needle Syringe Exchange Programme (NSEP) was a particularly key achievement in the national HIV programme. In 2008, the MMT intervention broke new ground, particularly as it involved the provision of these services for detainees in incarcerated settings, namely drug rehabilitation centres and prisons.

In 2009, ARVs were also made available to prisoners who were confirmed with HIV.

The engagement with Muslim religious leaders together with the Ministry of Women, Family and Community Development, brought about more care and support programmes for infected and affected communities. The past two years have seen dramatic improvements which include the setting up of shelters supported by the abovementioned Ministry and the Department of Islamic Development (JAKIM).

What are remaining challenges in this area:

- Issues of vulnerability resulting in sexual transmission of HIV affecting school going and out-of-school youth
- Issue of stigma and discrimination which hamper access and retention of IDUs in existing harm reduction programmes.
- The current economic climate threatens the availability and scale of public funding to support, maintain and sustain the different components of the national AIDS programme.
- The continued over dependence on the Ministry of Health to address the issue of HIV and AIDS. Continues to be a challenge to obtain the interest and buy-in of other Ministries.

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings, allocation of national budgets to support the HIV programmes; and, effective use of government and civil society organizations and processes to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	**Yes**	No
Other high officials	**Yes**	No
Other officials in regions and/or districts	**Yes**	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body? (i.e., a National AIDS Council or equivalent)?

Yes	No

IF NO, briefly explain:

NOT APPLICABLE

2.1 ***IF YES,*** when was it created? Year: **Originally in 2005. Revised in 2009**

2.2 ***IF YES,*** who is the Chair? **Dato' Sri Liow Tiong Lai (Minister of Health)**

2.3 ***IF YES,*** does the national multisectoral AIDS coordination body:

• have terms of reference?	**Yes**	No
• have active Government leadership and participation?	**Yes**	No
• have a defined membership?	**Yes**	No
o If Yes, how many members? **XX members**		
• include civil society representatives?	**Yes**	No
o IF YES, how many? **1 member**		
• include people living with HIV?	**Yes**	No
o IF YES, how many? (write in)		
• include the private sector?	Yes	**No**
• have an action plan?	**Yes**	No
• have a functional Secretariat?	**Yes**	No
• meet at least quarterly?	Yes	**No**
• review actions on policy decisions regularly?	Yes	**No**
• actively promote policy decisions?	**Yes**	No
• provide opportunity for civil society to influence decision-making?	**Yes**	No

• strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	**No**

3. Does the country have a mechanism to promote interaction between government, civil society organisations and the private sector for implementing HIV strategies/ programmes?

Yes	No	N/A

IF YES, what are the main achievements?

The Malaysian AIDS Council (MAC) has, for the past 17 years, been able:

- **To coordinate the activities of NGOs and CBOs working on HIV and AIDS in the country.**
- **To work with the Ministry of Health in contributing towards the development, implementation, monitoring and assessment of HIV related policy.**
- **To highlight the issues and concerns of marginalised communities to policy and decision makers at the highest levels of the Government.**
- **To act as a critical partner in the implementation of the Government's harm reduction programmes.**

IF YES, what are the main challenges for the work of this body?

- **The MAC has an outstretched secretariat which is tasked to do multiple functions across a wide range of programmatic issues (from implementing the harm reduction programme to the monitoring of the entire civil society component of the national AIDS programme under the government grant (between RM 4 million (USD 1.2 million) – RM 14 million (USD 4.1 million)).**

- **No proper assessment has been done to measure the impact and effectiveness of interventions led by the MAC despite being in operation for 17 years. Programmes are tied and determined by available grant money. However, a monitoring and evaluation framework has been put in place to begin the process of reporting back on the effectiveness and impact of programmes.**

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: **14% in 2009**

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

• Information on priority needs	Yes	No
• Technical guidance	Yes	No
• Procurement and distribution of drugs or other supplies	Yes	No
• Coordination with other implementing partners	Yes	No
• Capacity-building	Yes	No

Other:
- Providing financial support to participate in conferences and study visits
- Provides yearly financial support (Needle Syringe Exchange Programme (NSEP), government grants to civil society organisations

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes | No

6.1 ***IF YES,*** were policies and laws amended to be consistent with the National AIDS Control policies?

Yes | No

IF YES, name and describe how the policies/ laws were amended:

Prevention and Control of Infectious Diseases Act 1988 (ACT 342) was amended in 2007

Name and describe any inconsistencies that remain between any policies/ laws and the National AIDS Control policies:

- Muslim religious guidelines (under Syariah law) allow condom use but only for married couples. The national AIDS programme does not make any such distinction or limitation.
- Condoms are frequently used as evidence during detention or persecution of persons for illegal behaviour, e.g. evidence of sex work, premarital sex or MSM activity. The dissemination, awareness and promotion of condoms are a prominent part of all HIV programmes with MARPs.
- Penal Code 377 criminalises anal and oral sex with penalties which include imprisonment, fines and whipping. The continued existence of such legislation makes HIV prevention and behavioural change communication activities difficult.
- Transgender persons are often persecuted under the 1955 Minor Offences Act which terms cross-dressing as a form of indecent behaviour.
- Current drug laws (different sections under the Dangerous Drug Act of 1952) criminalises the self-administration of certain drugs, makes it illegal to be in possession of injection equipment and needles and allows for arbitrary detention.

Overall, how would you rate the *political support* for the HIV programme in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- The new Prime Minister has publicly expressed his concern and his administration's commitment to addressing the issue of HIV in Malaysia. This has been reiterated by the Minister of Health.
- The Government has provided the highest political public support and coverage for the Harm Reduction programmes (NSEP & MMT) to overcome popular opposition (which included Muslim religious leaders) due to the controversial nature of the interventions.

What are the remaining challenges in this area:

- Religious views concerning different aspects of the national AIDS programme (e.g. harm reduction, condom use for unmarried couples, transgender persons) continue to challenge the moral legitimacy of the respective programmes. Public opposition by key religious figures is often able to act as barriers which impede the implementation of HIV prevention programmes with most-at-risk populations. Each new religious leader needs to be sensitised anew and a lot of advocacy work invested.

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?

Check for key message explicitly promoted

a. Be sexually abstinent	✓
b. Delay sexual debut	✓
c. Be faithful	✓
d. Reduce the number of sexual partners	
e. Use condoms consistently	
f. Engage in safe(r) sex	
g. Avoid commercial sex	✓
h. Abstain from injecting drugs	✓
i. Use clean needles and syringes	
j. Fight against violence against women	✓
k. Greater acceptance and involvement of people living with HIV	✓
l. Greater involvement of men in reproductive health programmes	✓
m. Males to get circumcised under medical supervision	
n. Know your HIV status	✓
o. Prevent mother-to-child transmission of HIV	✓
Other:	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	No	N/A

2.1 Is HIV education part of the curriculum in

• primary schools?	Yes	**No**
• secondary schools?	**Yes**	No
• teacher training?	**Yes**	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes | No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes | No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations*?

Yes | No

IF NO, briefly explain:

NOT APPLICABLE

3.1 ***IF YES,*** *which sub-populations and what elements of HIV prevention* do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations* (transgender persons)
Targeted information on risk reduction and HIV education	✓	✓	✓		✓	✓
Stigma & discrimination reduction	✓	✓	✓		✓	✓
Condom promotion	✓	✓	✓			✓
HIV testing & counselling	✓	✓	✓	✓	✓	✓
Reproductive health, including STI prevention & treatment	✓	✓	✓		✓	✓

Vulnerability reduction (e.g., income generation)	**N/A**	**N/A**	✓	**N/A**	**N/A**	✓
Drug substitution therapy	✓	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Needle & syringe exchange	✓	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 6 **7** 8 9 10

Since 2007, what have been key achievements in this area:

The decision by the Cabinet Committee on AIDS to support the scaling up of the NSEP (Needle and Syringe Exchange Programme)and MMT (Methadone Maintenance Therapy):

- MMT to be extended to drug rehabilitation centres, prisons and drug drop-in centres.
- NSEP to increase its number of sites and to cater to more clients.

What are the remaining challenges in this area:

- The issue of providing comprehensive sexual reproductive health education, including information on HIV for children in school continues to be at an impasse. Though it has been under discussion by various levels of government, implementation of this policy has been erratic due to opposition from various parties on moral and religious grounds.

4. Has the country identified specific needs for HIV prevention programmes?

Yes | No

IF YES, how were these specific needs determined?

Consultation meetings with NGOs are conducted during annual planning meetings to ensure that the needs of HIV programmes are identified and outlined for support. The framework which guides the discussion is based on the national strategic plan as well as priorities identified for that particular year.

IF NO, how are HIV prevention programmes being scaled up:

NOT APPLICABLE

4.1 To what extent has HIV prevention been implemented?

HIV prevention programmes	The majority of people in need have access		
Blood safety	**Agree**	Don't Agree	N/A
Universal precautions in health care settings	**Agree**	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	**Agree**	Don't Agree	N/A
IEC on risk reduction	**Agree**	Don't Agree	N/A
IEC on stigma and discrimination reduction	**Agree**	Don't Agree	N/A
Condom promotion	Agree	**Don't Agree**	N/A
HIV testing & counselling	**Agree**	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	**Don't Agree**	N/A
Risk reduction for men who have sex with men	Agree	**Don't Agree**	N/A
Risk reduction for sex workers	Agree	**Don't Agree**	N/A
Reproductive health services including sexually transmitted infections prevention & treatment	**Agree**	Don't Agree	N/A
School-based AIDS education for young people	Agree	**Don't Agree**	N/A
Programmes for out-of-school young people	Agree	**Don't Agree**	N/A
HIV prevention in the workplace	Agree	**Don't Agree**	N/A
Other: • Faith-based interventions for Muslims	**Agree**	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5	6	**7**	8	9	10

Since 2007, what have been key achievements in this area:

Despite the existence of multiple programmes catering to more target populations, those coming from marginalised and most at risk populations (e.g. MSM, sex workers, mobile populations) are often left out of the coverage of these prevention interventions. Numerous gaps exist which are primarily related to prevention programmes such as the absence of

condom promotion and the over reliance on NGOs and CBOS to fill in national response.

Prevention efforts were boosted by the existence of the Needle and Syringe Exchange Programme and the involvement of CBOs in its implementation. The partnership of Government and civil society in this programme is a good example of how such relationships are able to improve the implementation of HIV interventions.

What are the remaining challenges in this area:

- Stigma and discrimination still prevail strongly at community as well as policy making levels. An example of such, is the objection of residents in the vicinity of a clinic participating in the MMT programme. Such acts impede or act as barriers which affect successful programme implementation.

IV. TREATMENT, CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support?** (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	No
■	

1.1 ***IF YES,*** does it address barrers for women?

Yes	No
	■

1.2 ***IF YES,*** does it address barrers for most-at-risk populations?

Yes	No
■	

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No
■	

IF YES, how were these determined?

The needs were determined through a consultative process which involved both Government and civil society stakeholders. This process was initiated during the development of the National Strategic Plan and the resulting framework is revised annually through discussions with key actors. The related civil society actors (e.g. community based organisations) are able to provide input which assists the Government in determining the required services and programmes needing funding support. As HIV treatment is conducted solely in government facilities, consultations with HIV specialists are conducted to determine the needs for HIV treatment.

IF NO, how are HIV treatment, care and support services being scaled up?

NOT APPLICABLE

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV and AIDS treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	**Agree**	Don't Agree	N/A
Nutritional care	**Agree**	Don't Agree	N/A
Paediatric AIDS treatment	**Agree**	Don't Agree	N/A
Sexually transmitted infection management	**Agree**	Don't Agree	N/A
Psychosocial support for people living with	Agree	**Don't Agree**	N/A

HIV and their families			
Home-based care	Agree	**Don't Agree**	N/A
Palliative care and treatment of common HIV-related infections	Agree	**Don't Agree**	N/A
HIV testing and counselling for TB patients	**Agree**	Don't Agree	N/A
TB screening for HIV-infected people	**Agree**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	**Don't Agree**	N/A
TB infection control in HIV treatment and care facilities	**Agree**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	**Agree**	Don't Agree	N/A
Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape)	**Agree**	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	**Don't Agree**	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	**Don't Agree**	N/A
Other programmes:	Agree	Don't Agree	N/A

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV/AIDS?**

Yes	No

4. **Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

Yes	**No**

IF YES, for which commodities?:

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 6 **7** 8 9 10

Since 2007, what have been key achievements in this area:

1st line ART continues to be provided to treatment eligible HIV patients at no cost while the 2nd line is partially subsidised by the Government. The high cost of this provision of treatment currently takes up a third of the entire national AIDS programme budget.

What are remaining challenges in this area:

- The escalating costs related to management of HIV is translated and shared by both the Government and patient. Though the treatment regime is subsidised by

public funds, there is concern that this is unable to continue due to escalating public healthcare costs and a uncertain economic climate.

- Care and support programmes continue to be almost solely dependent on NGO services which are limited in coverage and availability. These services are also often located in urban centres. Those coming from rural areas are forced to travel at great distance to access these services.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N/A

5.1 ***IF YES,*** is there an operational definition for OVC in the country?

Yes	No

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes	No

5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes	No

IF YES*,* what percentage of OVC is being reached? % *(write in)*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

2009 Very Poor Excellent

0 1 2 3 4 **5** 6 7 8 9 10

Since 2007, what have been key achievements in this area:

Not much has changed in this area since the last report. As prioritisation of Government funding has determined that the national AIDS programme would focus its energies on the most-at-risk populations, activities in this area have focused on life skills based education.

What are remaining challenges in this area:

- Though introduction of life skills based education has begun, it remains strictly limited to specific schools.
- Orphans and vulnerable children are frequently considered under the care and support category. However, very little has been done at the national level. At the level of civil society, a series of initiatives have begun to assist this population through grant programmes to support the cost of schooling, sustenance and others.

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes	In progress	No
■		

1.1 ***IF YES***, years covered: **2006 – 2010**

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes	No
■	

1.3 **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	No
■	

1.4 **IF YES**, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No
	■		

IF YES, but only some partners or IF NO, briefly describe what the issues are:

NOT APPLICABLE

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	**■ Yes**	**No**
***If YES,* does it address:**		
routine programme monitoring	**■ Yes**	**No**
behavioural surveys	**■ Yes**	**No**
HIV surveillance	**■ Yes**	**No**
Evaluation/ research studies	**■ Yes**	**No**
a well-defined standardized set of indicators	**■ Yes**	**No**
guidelines on tools for data collection	**■ Yes**	**No**
a strategy for assessing data quality (i.e. validity, reliability)	**Yes**	**■ No**
a data analysis strategy	**Yes**	**■ No**
a data dissemination and use strategy	**Yes**	**■ No**

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No
■		

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E activities?

5 – 10%

3.2 ***IF YES,*** has *full* funding been secured?

Yes	No

***IF NO*, briefly describe the challenges?**

NOT APPLICABLE

3.3 ***IF YES***, are M&E expenditures being monitored?

Yes	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes	**No**

***IF YES*, briefly describe how often a national M&E assessment is conducted and what the assessment involves:**

NOT APPLICABLE

***IF NO*, briefly describe how priorities for M&E are determined:**

In lieu of a national M&E assessment, exercises intended to identify priorities for M&E are conducted during programme planning sessions. M&E priorities are later determined through a series of consultations with the NGOs of the individual projects. However, as stated, there is no national level discussion of M&E as yet.

5. Is there a functional M&E Unit or Department?

Yes	In progress	**No**

***IF NO*, what are the main obstacles to establishing a functional M&E Unit?**

- **Limited manpower available to undertake the task of M&E as a separate unit/ department.**

- **M&E is currently integrated into existing HIV and AIDS programming.**
- **Other units already having pre-existing M&E and oversight functions such as the Audit Department.**

5.1 ***IF YES****,* is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	No
in the Ministry of Health?	Yes	No
Elsewhere?	Yes	No

5.2 F YES, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position (write in)	Full time/ Part time?	Since when?:
Position (write in)	Full time/ Part time?	Since when?:
Position (write in)	Full time/ Part time?	Since when?:
Position (write in)	Full time/ Part time?	Since when?:

Number of temporary staff:		
Position (write in)	Full time/ Part time?	Since when?:
Position (write in)	Full time/ Part time?	Since when?:

5.3 ***IF YES,*** are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

IF YES, briefly describe the data-sharing mechanism?

What are the major challenges?

NOT APPLICABLE

5.4 ***IF YES,*** to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low					*High*
0	1	2	3	4	5

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

The representation of civil society and people living with HIV is through the presence of the Malaysian AIDS Council (MAC) in the working group. MAC is charged with ensuring that the views and concerns of its constituents are accurately represented and conveyed.

As the main coordinator of NGOs and CBOSs responding to HIV, MAC is provided with an annual government grant (RM 6 – 14 million) which the institution is tasked to disperse to other organisations working on the different aspects of the national response. In relation to that, MAC is given the responsibility to report back on the individual projects utilising the various national progress indicators as part of M&E. It is also given the responsibility of providing feedback to the Government in relation to M&E.

7. Is there a central national database with HIV-related data?

Yes	No

7.1 ***IF YES***, briefly describe the national database and who manages it

The National AIDS Registry is managed by the AIDS/STD Section of the Ministry of Health. The registry captures data of each HIV patient relating to their socioeconomic background, status of HIV treatment and background information.

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above
b. Yes, but only some of the above
c. No, none of the above

7.3 Is there a functional* Health Information System?

National level	Yes	No
Sub-national level ***IF YES,*** at what level(s)? • **District** • **State** • **National**	Yes	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No

9. To what extent is M&E data used?

9.1 in developing/ revising the national AIDS strategy?

Low					*High*
0	1	2	3	4	5

Provide a specific example:

- **The analysis of M&E data from the Harm Reduction programmes (NSEP & MMT) created the argument for, firstly, their existence and secondly, institutional support for the scaling up of the abovementioned interventions.**
- **M&E data was utilised to introduce premarital HIV screening to address the issue of heterosexual transmission. It also enabled the Government to justify its stance in promoting such testing.**
- **The use of M&E data also allowed for the introduction of a nationwide anonymous HIV testing programme.**

What are the main challenges, if any?

- **Bridging the gap between the analysis and understanding of data and the formulation of effective programmes and policies in response.**
- **Technical capacity in M&E in both government and civil society partners is often inconsistent and requires major investment in capacity building. The civil society component, specifically the Malaysian AIDS Council's M&E unit is significantly strong whereas their counterpart at the AIDS/STD Section has only recently been setup and is currently bereft of trained and designated M&E personnel.**

9.2 for resource allocation?

Low					*High*
0	1	2	3	4	5

Provide a specific example:

- **The decision to fund the upscalling of the needles syringe exchange programme in Pahang was largely determined by the perceived success of the intervention there in reaching to a high number of injecting drug users, higher client return rate and large**

geographical coverage.

What are the main challenges, if any?

- **The use of strategic data in evaluating programmes for resource allocation is a skill set remains limited to a few persons and the use of M&E of data is inconsistent in the national AIDS programme. As such, though relevant M&E data is available to evaluate programmes for resource allocation determination exercises, they remain largely not utilised for this purpose.**

9.3 for programme improvement?

Low					*High*
0	1	**2**	3	4	5

Provide a specific example:

- **The number of clients at a MSM drop in centre (DIC) was seen to be dropping and becoming irregular. The number of MSM reportedly using condoms also was very low. It was discovered that the profile of a typical MSM accessing the DIC (middle-class, Chinese, with money, higher education) was no longer compatible with the location the DIC was in (lower class, red light district, large Malay ethnicity, lower education). As such clients were put off from coming to the DIC. Their higher education level also was seen to confer to the clients a sense of invulnerability to an issue perceived belonging to a different social strata. A proposal was made to relocate the DIC to a more suitable, friendly and appropriate location.**

What are the main challenges, if any?

- **Analysing the M&E data and knowing how it interacts with the programmes and knowing when to improve in response to the data.**

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

a. Yes, at all levels
b. Yes, but only addressing some levels
c. No

10.1 In the last year, was training in M&E conducted

At national level?	Yes	**No**
IF YES, Number of individuals trained: *(write in)*		
At subnational level?	Yes	**No**
IF YES, Number of individuals trained: *(write in)*		
At service delivery level Including civil society	**Yes**	No
IF YES, Number of individuals trained: **12**		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities:

- Briefings concerning monitoring and evaluation systems
- Evaluations conducted at the service delivery level

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?											
2009	Very Poor										Excellent
	0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- There has been discussion and planning leading to the development of common monitoring and evaluation indicators. UNGASS linked indicators have been used as part of the M&E framework at the service delivery level
- Workshops to establish common indicators which are linked to the NSP have been organised.

What are remaining challenges in this area:

- A common M&E framework has yet to be agreed upon and finalised.
- There remains a challenge in improving the quantity and quality of technical capacity in both government and civil society bodies.

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

PART B
(to be administered to representatives from civil society organisations, bilateral agencies, and UN organisations)

I. HUMAN RIGHTS

1. **Does the country have laws and regulations that protect people living with HIV against discrimination?** (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc)

Yes	**No**

1.1 ***IF YES,*** specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision::

2. **Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable sub-populations?**

Yes	No

2.1 ***IF YES,*** for which populations?

Women	**Yes**	**No**
Young people	**Yes**	**No**
Injecting drug users	**Yes**	**No**
Men who have sex with men	**Yes**	**No**
Sex workers	**Yes**	**No**
Prison inmates	**Yes**	**No**
Migrants/ mobile populations	**Yes**	**No**
Other: (write in)		

IF YES, **Briefly explain what mechanisms are in place to ensure these laws are implemented:**

- **There are specific Ministries whose portfolios include the populations stated above. However, though there are Ministries specific to young people and women (i.e. Ministry of Youth and Sports; and Ministry of Women, Family and Community Development), they have an overlapping mandate to ensure that the laws of the land are adhered to.**
- **Nevertheless though existing monitoring mechanisms are in place, they are strictly dependent on NGO involvement and participation and, at times, leadership of a particular issue (e.g. a NGO working against gender discrimination in the workplace**

often finds itself having to champion it on behalf of the persons affected)

Briefly describe the content of these laws:

- **Article 8 (2) of the Federal Constitution states "that there should be no discrimination against citizens on the ground only of religion, race, descent, gender or place of birth in any law or in the appointment to any office or employment under a public authority or in the administration of any law relating to the acquisition, holding or disposition of property or the establishing or carrying on of any trade, business, profession, vocation or employment." Therefore there is the possibility of obtaining a legal remedy to instances where such discrimination has occurred.**

Briefly comment on the degree to which they are currently implemented:

- **There are a number of governmental and civil society mechanisms in place which allow for redress of laws, issues and complaints:**

  1. **The individual relevant Ministries have their individual public complaints mechanisms which allow members of the public to lodge complaints and to seek redress.**

  2. **The civil society mechanisms which exist include seeking redress through the entities such as the Malaysian Medical Association, Bar Council, and Human Rights Commission for Malaysia. Specific NGOs which advocate issues are also used to seek support and to further advocate in behalf of the individual.**

3. **Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable sub-populations?**

Yes	No

3.1 ***IF YES,*** for which sub-populations?

Women	**Yes**	**No**
Young people	**Yes**	**No**
Injecting drug users	**Yes**	**No**
Men who have sex with men	**Yes**	**No**
Sex workers	**Yes**	**No**
Prison inmates	**Yes**	**No**
Migrants/ mobile populations	**Yes**	**No**
Other: (write in)	**Yes**	**No**

IF YES, **briefly describe the content of these laws, regulations or policies:**

- Penal Code 377A & B – the introduction of the penis into the anus or mouth of the other person is said to commit carnal intercourse against the order of nature. Maximum penalty 20 years imprisonment and liable to fine and whipping

- Section 21 of the Minor Offences Act 1955 – Transgender persons could be charged with indecent behaviour, if they are found to be cross-dressing. The term 'indecent behaviour' has not been defined in the Act, and therefore, it is up to the discretion of the police to determine what constitutes 'indecent' behavior.

- Drug Dependant Act (Treatment & Rehabilitation) 1983 – Any police officer is able to detain a person under suspicion of being a drug user for not more than 24 hours for administration of a urine drug test.

- Dangerous Drugs Act 1952 – self administration of drugs is punishable with a fine and/ or imprisonment

- Dangerous Drugs Act 1952 – it remains illegal to carry injection equipment without a medical prescription and possession of needles is punishable with imprisonment

Briefly comment on how they pose barriers:

- Fear of persecution and discrimination makes it difficult to reach out to MSM and transgender persons. Religious bodies and laws enforcement agencies less likely to cooperate as MSM & TG sexual behaviour is considered unacceptable by society.

- Although there is no existing law or policy against individuals carrying condoms, women in particular are subject to accusations of soliciting for sex or being branded a sex worker. This could result in overnight detention or harassment by law enforcement officers. Such evidentiary use of the condom, discourages sex workers from using them as well as brothels from providing them on the premises. This also applies in a similar fashion to MSM where spas and massage centres refuse to supply condoms for fear of legal action being taken on them resulting in the loss of their operating licence and depriving them of business.

- Current laws stipulate for compulsory drug treatment and provide for punishment of drug users with canning and imprisonment should the person relapse after discharge from government run drug rehabilitation centres (DRC). Civil society groups believe that treatment for drug addiction should be an option and not compulsory under the law.

- Clients of the Needle Syringe Exchange Programme (NSEP) become 'easy targets' for law enforcement officers. As the latter continues to have the authority to detain persons suspected to be drug users, this could discourage effective utilisation of the programme by the IDU community as they could be arrested while being in the vicinity of the NSEP centre.

- The carrying of syringes and needles, outside of healthcare settings, is still technically illegal despite the existence of a government Harm Reduction programme. This results in complications and contradictory messages whereupon a government programme is encouraging the exchange and use of clean needles and syringes while law enforcement bodies are told that the usage of drugs and the carrying of drug paraphernalia are barred under the law. However, due to the NSEP, the active

enforcement of this legislation was reportedly relaxed.

- The existence of laws which are in direct contradiction with the activities of the Government initiated NSEP continue to send contradictory signals to law enforcement bodies and judiciary. This could present itself as a significant obstacle in successfully ensuring the sustainability and continued existence of the programme.
- Laws and regulations which especially govern and restrict communication of HIV awareness and prevention messages are of particular concern. The use of particular text and explicit graphics (such as putting on a condom on a penis) in such messages could be considered and subject to legal prosecution for the use of pornography under legislation which governs the print media.
- Though the NSP under Strategy 5 recognises the existence and vulnerability of the MSM population, their sexual behaviour is subject to prosecution under existing legislation (Penal Code 377 on the issue of sodomy).
- Mandatory testing of foreign workers continue to conducted, screening for HIV and other infectious diseases such as Hepatitis B & C as well as tuberculosis. Despite being recognised as a vulnerable population under Strategy 5 of the NSP, there is no pre and post test counselling. In most cases, the individual has no knowledge of their medical tests and are only told whether they are medically fit to work and be employed in Malaysia. Failing such screening tests result in deportation of the individual.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

The guiding principle of National Strategic Plan on HIV/AIDS 2006-2010 clearly indicates that People Living With HIV have the same right to health care and community support as other members of society. They have the right to participate in any socio-economic activity, without prejudice and discrimination.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/ or other vulnerable subpopulations?

Yes	No

IF YES, briefly describe this mechanism

Various civil society organisations (CSOs) as well as entities such as the Bar Council and Legal Aid Centre are active in the recording and documentation of such cases. However to ensure that cases are brought to a higher level to address the issue, it is very often

dependent on the PLHIV or persons affected by the discrimination to proceed.

However, the reality is that if a person who is living with HIV suffers discrimination as a result of stigma, it is often considered hard to prove. Documentation continues to be a problem as people who suffer such discrimination are reluctant to proceed further due to the risk of exposure of one's status. Practical problems abound with regards to addressing HIV related acts of discrimination.

Advocacy is done through reports lodged to relevant ministries, the use of the media and engagement with the legal system. Relevant ministries such as the Ministry of Human Resource have in-built mechanisms (e.g. Code of Practice on HIV/AIDS in the Workplace) for redress by PLHIV within the context of the working environment.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples

For the past 17 years, the Malaysian AIDS Council (MAC) which was originally set up by the Government, has acted as the secretariat and main actor which deals directly with civil society organisations working with the PLHIV community, most-at-risk populations (MARPS) and other vulnerable populations. These various communities were involved and consulted extensively in the formulation and design of the MAC Strategic Plan 2008 -2010.

The past four years have seen increased and improved involvement and participation of MARPs in the design of both programme and policy. The formulation of the NSP and the development of the NSEP are clear examples of how these communities were able to be involved and work together with their Government counterparts and play an active role in the design, implementation and monitoring of interventions. The different CBOs working with the various communities are coordinated by the MAC via its mandate given by the Government.

Over the past few years, the Government has also provided substantial financial support to CBOs for the implementation and execution of programmes related to MSMs, SWs, IDU, transgender persons, etc.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	**Yes**	No
b. Anti-retroviral treatment	**Yes**	No
c. HIV-related care and support interventions	**Yes**	No

IF YES, **given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:**

- **Under the NSP, free services are provided for MARPs through community drop-in centres, outreach programmes and VCT centres. Prevention programme for other populations (e.g. women living in plantation area and youth with high risk behaviour) are also carried out through one-off awareness activities. However, many areas in Malaysia continue to not be covered under existing programmes for MARPs, particularly HIV prevention services due to limited funding, capacity and geographical coverage of NGOs.**
- **Though first line ARV treatment is available at no cost through government hospitals, PLHIV living in rural and remote areas often have limited or no access to nearby facilities which provide such services.**
- **At this time, one hospice and 15 shelter homes have been established and complimented by 8 hospital peer support group programmes, with the aim to provide support and care to the PLHIV community. However, the lack of committed, skilled and qualified counsellors remains as the main barrier for successful implementation of such care and support services. Most facilities are forced to solely rely on volunteer counsellors, who may be untrained or lack relevant experience. The activities of shelter homes are also limited with often no reintegration program for residents to assist them in returning to general society.**

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	**No**

9. Does the country have a policy to ensure equal access for most-at-risk populations and/ or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes	No

IF YES, **briefly describe the content of this policy**

Under Strategy 1 of the National Strategic Plan on HIV/AIDS 2006-2010 (NSP), the Government is committed to ensure equal access to treatment, care and other support services, guaranteed confidentiality, and access to voluntary counselling and testing.

The NSP's Strategy 1 to 6 clearly indicates that all MARPs and other subpopulations

identified under the strategic framework wil have equal access to HIV prevention, treatment, care and support services.

9.1 ***IF YES,*** does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable subpopulations?

Yes	No

IF YES, **briefly explain the differences:**

- **For IDU & DU – addressing drug addition and HIV prevention through harm reduction utilising the Needle Syringe Exchange Programme and Methadone Maintenance Therapy.**
- **For SW/TS/MSM – HIV prevention and intervention through VCT, telephone counselling, outreach programmes and community drop-in centres**
- **For youth with high risk behaviour – focusing on prevention through education and awareness programmes to facilitate behavioural change (e.g. life skill based education, sexual reproductive health)**
- **Indigenous population – awareness through seminars and talks conducted as part of outreach programmes to rural and remote locations**
- **For PLHIV - Treatment, care and support through shelter and hospital peer support programmes**
- **For prison inmates – are given access to ART and Methadone Maintenance Therapy treatment and referrals for counselling.**
- **For internees at drug rehabilitation centres (*Pusat Serenti)* – the provision of referral services and access to treatment.**
- **Community based organizations remain the dominant actor in the provision of HIV services to the undocumented population (e.g. refugees, migrant workers, undocumented migrants).**

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	No

11.1 ***IF YES,*** does the ethical review committee include representatives of civil society and people living with HIV?

Yes	**No**

IF YES, **describe the effectiveness of this review committee**

The ethical review committee is usually convened by research institutions during review of research applications. As such, the composition of such committees is usually made up of academicians and experts in the related fields.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	**No**

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts

Yes	**No**

IF YES, on any of the above questions, describe some examples:

- Human Rights Commission of Malaysia (SUHAKAM) – is able to adopt HIV and AIDS issues for redress. SUHAKAM was established by Parliament under the Human Rights Commission of Malaysia Act 1999, Act 597. Their main function is to inquire into complaints regarding violation of human rights including HIV-related issues.
- Bar Council – The Legal Aid facility is able to consider HIV cases as part of its portfolio. These Issues are linked to discrimination and denial of specific rights.

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes	**No**

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework

Yes	No

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	**No**

- Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	No

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?

Media	**Yes**	**No**
School education	**Yes**	**No**
Personalities regularly speaking out	**Yes**	**No**
Other: *(write in)*		

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Continuous engagement with religious bodies, particularly with Muslim religious authorities, has resulted in changes to their perception and attitude towards marginalized groups such as female sex workers and transgender persons.
- Aggressive involvement of state Islamic religious authorities, police, SUHAKAM, Bar Council as well as human rights activists and legal practitioners in 6 paralegal workshops have provided evidence that they are more well aware and sensitized in protecting the rights of sex workers and transgender persons.

What are remaining challenges in this area:

- Need to review existing labour legislation to address the issue of stigma & discrimination of PLHIV at workplace. This would strengthen implementation and adherence to the existing Code of Practice on Prevention and Management of HIV/AIDS at the Workplace, which was initiated by the Ministry of Human Resource.
- The abovementioned Code of Practice, though already in existence for several years, needs to be further promoted and encouraged for adoption by the private sector.
- Need to identify and recommend review of laws and regulations which may have an impact on effective implementation of the Needle Syringe Exchange Programme (e.g. Dangerous Drugs Act 1952 which criminalises the use and possession of syringes

and needles without a medical prescription.
- Need to encourage involvement of PLHIV or MARPS in the ethical committee review for HIV research protocols
- Although there has been improved involvement and acceptance from Department of Islamic Development (JAKIM), the state religious authorities need to be better engaged on HIV related issues.
- There is a continual need to sensitize and involve all stakeholders who work directly or have direct contact with MARPs such as the local government authorities, prisons department, religious authorities, law enforcement bodies (e.g. police), National Anti Drug Agency (NADA) and immigration department.

Overall, how would you rate the *effort to enforce* the policies, laws and regulations in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5	6	**7**	8	9	10

Since 2007, what have been key achievements in this area:

- Much of the achievements in this area has been linked to the engagement of Muslim religious authorities in implementation of the Islam & HIV module (developed in 2003 to train religious leaders on the issue of HIV and AIDS and responding to it in the community)
- The Department of Islamic Development (JAKIM) has taken the lead to establish a shelter home for homeless Muslims living with HIV.
- JAKIM has introduced Friday sermons to discuss the issue of HIV with the theme of promoting and the rights of marginalised communities and addressing stigma and discrimination.
- A State Religious Department (i.e. Islamic Religious Department of Wilayah Persekutuan) has begun religious classes for sex workers and transgender persons. This is an unprecedented development, which is being demonstrated as a good practice for emulation by other state religious departments.
- Improved engagement and advocacy with authorities, particularly law enforcement authorities (e.g. police, RELA, NADA), have resulted in better results for HIV prevention interventions.

What are remaining challenges in this area:

- There is a continual need to invest in sensitisation and engagement of religious authorities who work directly or have direct contact with MARPs.
- Though there has often been good cooperation obtained and awareness of HIV from the top management of the different enforcement bodies, very often the frontline personnel continue to be lacking in awareness and knowledge of HIV and AIDS issues. As a result, there continue to be incidences of discriminatory practices towards MARPs, particularly IDUs.
- There has been a large amount of investment and work conducted on public campaigns by the Malaysian AIDS Council, it continues to be a challenge to address stigma and discrimination of PLHIV amongst the general public.

II. CIVIL SOCIETY PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					*High*
0	1	2	3	**4**	5

Comments and examples:

Civil society organisations, usually under coordination of the Malaysian AIDS Council, have been able to be engaged in dialogue with key decision makers and political figures such as the Prime Minister, Minister of Health and other Ministers. Political leaders are also often open to attending HIV related functions organised by civil society organisations.

The heads of government bodies (e.g. Department of Islamic Development, Islamic Religious Department of Wilayah Persekutuan, Ministry of Women, Family and Community Development, Human Rights Commission and police) through advocacy meetings and workshops.

A key result of this engagement has been the commitment in 2008 by the Ministry of Women, Family and Community Development to support the setting up of 7 shelters for women & children who are PLHIV and affected by HIV. This was later expanded to 15 shelters in 2009. The Department of Islamic Development has also now committed itself to setting up a shelter home for Muslims living with HIV/AIDS in 2010.

During Malaysia's recent participation in Round 9 of the Global Fund, a working group comprised mainly of civil society actors advocated to the Government as to the virtues of submitting a country proposal for grant consideration. A large amount of advocacy was conducted with the Ministry of Health which later resulted in the setting up of Malaysia's first properly constituted Country Coordinating Mechanism (CCM) which is now chaired by the Deputy Minister of Health. As a result of this civil society lead initiative, the Government is now committed to participating in the Global Fund rounds.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the current activity plan (e.g., attending planning meetings and reviewing drafts)?

Low					*High*
0	1	2	3	**4**	5

Comments and examples:

Through coordination of the Malaysian AIDS Council (MAC) and working with the Ministry of Health, civil society representatives have been extensively involved in the planning

and budgeting process for the annual activity plan. To assist in this engagement, MAC has introduced the "cluster" concept to improve upon civil society ownership and participation on key issues as well as functioning as a form of community consultation. Within each cluster, community representatives are expected to contribute towards the identification of priorities as well as monitoring of activities and interventions.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

Low					*High*
0	1	2	3	**4**	5

b. the national budget?

Low					*High*
0	1	2	3	**4**	5

c. national AIDS reports?

Low					*High*
0	1	2	3	**4**	5

Comments and examples:

The National Strategic Plan on HIV/AIDS 2006 – 2010 clearly indicates that HIV prevention, particularly amongst most-at-risk populations, is dependent on the programmes and services of civil society organisations. To support this, the Government allocated RM 4 million (USD 1.1 million) in 2008 which later was increased to RM 13 million (USD 3.7 million). Civil society is consistently consulted by the Ministry of Health in the process of writing national AIDS reports.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response

a. developing the national M&E plan?

Low					*High*
0	1	2	3	4	5

b. participating in the national M&E committee/ working group responsible for coordination of M&E activities?

Low					*High*
0	**1**	2	3	4	5

c. M&E efforts at local level?

Low	*High*

0 1 2 **3** 4 5

Comments and examples:

Though there was no prior consultation with any non-governmental HIV organisation including the Malaysian AIDS Council (MAC) in developing the preliminary M&E framework, the latter and its partner organisations have been included in later discussions concerning the monitoring of progress in responding to the HIV epidemic. They have also been able to contribute in presentation of national data.

MAC has an M&E capacity which was fully established in 2007 and whose system migrated online in 2009. It currently oversees data reported from all projects and programmes of all civil society organisations receiving the Government HIV grant. This programme monitoring capacity now contributes substantially to the national understanding of socio-behavioural data gathered through programmes and interventions with MARPs.

5. **To what extent is the civil society sector representation in HIV efforts inclusive of diverse organisations (e.g. networks of people living with HIV, organisations of sex workers, faith-based organsiations)?**

Low *High*
0 1 2 3 **4** 5

Comments and examples

- Organisation of people living with HIV
- Women's organizations
- Youth organizations
- Faith-based organizations
- Lawyers collective council
- Community-based organizations
- Organizations working with most-at-risk populations (MARP) (including MSM, SW, IDU, migrants)
- Associations of medical professionals
- Humanitarian organisations

6. **To what extent is civil society able to access**

a. adequate financial support to implement its HIV activities?

Low *High*
0 1 2 **3** 4 5

b. adequate technical support to implement its HIV activities?

Low *High*
0 1 2 **3** 4 5

Comments and examples

Under the NSP, Government funding increased almost three fold in 2009 compared to the previous year. However, the funding was still considered inadequate to implement upscaling of existing programmes.

A number of NGOs including the Malaysian AIDS Council and PT Foundation were able to access technical support from partners from international non-government organisations such as the International Planned Parenthood Federation (for monitoring and evaluation related work), and Open Society Institute (OSI) (for the harm reduction initiative) and from agencies such as the World Bank (for IBBS).

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	**<25%**	**25-50%**	**50-75%**	**>75%**
Prevention for most-at-risk populations				
- **Injecting drug users**	**<25%**	**25-50%**	**50-75%**	**>75%**
- **Men who have sex with men**	**<25%**	**25-50%**	**50-75%**	**>75%**
- **Sex workers**	**<25%**	**25-50%**	**50-75%**	**>75%**
Testing and Counselling	**<25%**	**25-50%**	**50-75%**	**>75%**
Reduction of Stigma and Discrimination	**<25%**	**25-50%**	**50-75%**	**>75%**
Clinical services (ART /OI/)*	**<25%**	**25-50%**	**50-75%**	**>75%**
Home-based care	**<25%**	**25-50%**	**50-75%**	**>75%**
Programmes for OVC**	**<25%**	**25-50%**	**50-75%**	**>75%**

** ART = Antiretroviral Therapy; OI = Opportunistic infections;*
***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase *civil society participation* in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 **8** 9 10

Since 2007, what have been key achievements in this area:

- Establishment of the Country Coordinating Mechanism which features civil society representation of most-risk populations in a body chaired by the Deputy Minister of Health.

- Establishment of the "cluster" concept with the Malaysian AIDS Council in 2008 where NGOs are firmly represented, coordinated, is involved in programming and is able to partake in strategic discussions at the national level. The clusters are expected to take ownership of their individual issues (e.g. sex worker cluster works on all issues affecting sex workers including advocacy)
- Engagement of civil society in strategic planning has resulted in funding prioritisation of programmes for most-at-risk populations as compared to before.

What are remaining challenges in this area?

- The effectiveness of cluster has yet to be evaluated since it is still fairly new. Most CBOs are still adapting to the idea of group representation of specific issues. As such, some of them still prefer bilateral discussions with key interlocutors such as the Government.

- Most CBOs require more capacity building in key technical areas as well as project management skills.

- The uncertain environment created as a result of unsustainable funding subjected to yearly Government approval has resulted in de-motivating and discouraging potential and current community leaders from continuing on. There is a concern that skilled and experienced civil society personnel are unable to be retained adequately to ensure quality participation and involvement in activities and initiated.

III. PREVENTION

1. Has the country identified the specific need of HIV prevention programmes?

Yes	No

***IF YES*, how were these specific needs determined?**

These specific needs were determined through extensive consultation, discussions and meetings between the different NGOs and CBOs working on HIV issues and their counterparts at the Ministry of Health, Ministry of Women, Family and Community Development, Department of Islamic Development, HIV research groups (e.g. Centre of Excellence for Research in AIDS) and multilateral agencies such as those from the United Nations.

***IF NO*, how are HIV prevention programmes being scaled up?**

NOT APPLICABLE

1.1 To what extent has HIV prevention been implemented?

HIV prevention programmes	The majority of people in need have access		
Blood safety	**Agree**	Don't Agree	N/A
Universal precautions in health care settings	**Agree**	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	**Agree**	Don't Agree	N/A
IEC on risk reduction	Agree	**Don't Agree**	N/A
IEC on stigma and discrimination reduction	Agree	**Don't Agree**	N/A
Condom promotion	Agree	**Don't Agree**	N/A
HIV testing & counselling	Agree	**Don't Agree**	N/A
Harm reduction for injecting drug users	Agree	**Don't Agree**	N/A
Risk reduction for men who have sex with men	Agree	**Don't Agree**	N/A
Risk reduction for sex workers	Agree	**Don't Agree**	N/A
Reproductive health services including sexually transmitted infections prevention & treatment	Agree	**Don't Agree**	N/A
School-based AIDS education for young people	Agree	**Don't Agree**	N/A
Programmes for out-of-school young people	Agree	**Don't Agree**	N/A

HIV prevention in the workplace	Agree	Don't Agree	N/A
Other:	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2009 Very Poor Excellent

0 1 2 3 4 **5** 6 7 8 9 10

Since 2007, what have been key achievements in this area:

Prevention programmes for most-at-risk populations have increased over the last 2 years due to the greater availability of funding from the Government. For example, the SW/TG outreach programme has expanded to 4 new states from the previous 2; the NSEP programme have increased their coverage to 12 new sites and the outreach programme to MSM have also been able to extend to 2 new states.

What are remaining challenges in this area:

- Financial constraints – though almost all NGO HIV programmes are provided funding support by the Government, the amount continues to be a shortfall to what is actually needed. As a result, frequently service providers/ NGOs are unable to adequately train their staff on issues related to MARPS as well improve their capacity in HIV programming. As such, NGOs are forced to diversity their funding to enable them to financially self sustain themselves.

- Limited coverage of existing HIV prevention programmes - For example, the population of SW was estimated to be 50 000. However, current programmes were able to reach only almost 7 000 last year. The size of the respective communities/ targeted populations (SW, TS, MSM) also vary from location to location and are found to be mobile. Although prevention programme are available, they provide scarce coverage.

- Clients of sex worker are not included in existing prevention programme. One reason for this omission which has been cited is due to the lack of negotiation skills of sex workers.

- Social and cultural challenges – Socio-cultural and religious norms provide formidable challenges to HIV prevention programmes and efforts to mitigate the impact of HIV. For example sex is not openly discussed as it is considered impolite and disrespectful. This often prevents discussions with adults and adolescents about HIV prevention. Similarly, sex workers, drugs users, men who have sex with men are socially and culturally perceived as being of bad character. This jeopardise access and utilization of HIV prevention and treatment services. In addition to this, Malaysia is also an Muslim majority country and it is a challenge to find a way to work around religious barriers. This stigma also drives many MARPs underground and makes it difficult to design and implement effective HIV programmes.

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No

IF YES, **how were these specific needs determined?**

In the same discussions with those of HIV prevention, these specific needs were determined through extensive consultation, discussions and meetings between the different NGOs and CBOs working on HIV issues and their counterparts at the Ministry of Health, Ministry of Women, Family and Community Development and the Department of Islamic Development. Coordinated by the Malaysian AIDS Council, the CSOs were able to outline the increased need for more shelter homes and hospital peer support programmes to cater to the increasing number of PLHIVs.

IF NO, **how are HIV and AIDS treatment, care and support services being scaled-up?**

NOT APPLICABLE

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV and AIDS treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g.,	Agree	Don't Agree	N/A

occupational exposures to HIV, rape)			
HIV treatment services in the workplace or treatment referral systems through the workplace	**Agree**	**Don't Agree**	**N/A**
HIV care and support in the workplace (including alternative working arrangements)	**Agree**	**Don't Agree**	**N/A**
Other programmes:	**Agree**	**Don't Agree**	**N/A**

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?

2009 Poor Good

0 1 2 3 4 5 **6** 7 8 9 10

Since 2007, what have been key achievements in this area:

Better collaboration from religious bodies and other relevant government agencies, especially related to welfare, on the issue of care and support for PLHIV. In 2009, the Department of Islamic Development indicated its commitment to building a shelter home for homeless Muslims living with HIV by 2010.

The Ministry of Women, Family and Community Development began funding 7 shelters for women and children infected and affected by HIV. This initial number of shelter homes was expanded to 15 in 2009.

What remaining challenges in this area:

- There are currently 25 main Government hospitals and 9 healthcare clinics as well as 3 private hospitals which provide treatment facilities. There are also very few centres which provide facilities to conduct CD4 counts and viral load tests.
- Through the cost of ARV treatment is largely subsidised by the Government, PLHIV living in rural and remote areas have limited access to treatment due to the costs relating to transportation and financial limitations. For example, in Sabah and Sarawak, a patient may be forced to travel for 2 days to reach the designated hospital which has HIV treatment facilities. The cost of travel is a major deterrent and adds as a burden to those who do not posses full time employment.
- There is a lack of skilled and trained counsellors able to provide assistance for people living with HIV.
- There continues to be perceived stigma and discrimination from public and service healthcare providers.
- Lack of access to information on HIV treatment especially for PLHIV living in rural and remote communities.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children (OVC)?

Yes	No	N/A

IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES*,* what percentage of orphans and vulnerable children is being reached?

Data Not Available

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

Most of the achievements in this area have been made through civil society engagement with the private sector. This has seen the private sector providing financial assistance to children living with HIV or affected orphans. (e.g. the Standard Chartered Pediatric AIDS Fund currently provides assistance to 330 children, the L'Oreal Keep in School scheme supports 100 affected children to assist them in their education)

What are remaining challenges in this area:

- 3 shelter homes for infected and affected orphans are available but there continues to be a dearth of skilled and trained staff to address the impact of HIV/AIDS on children, particularly when dealing with emotional support and counselling.
- Shelters are limited in capacity whereupon very few facilities are available for them once the children reach adolescent phase.
- There are reportedly 2,207 children with HIV in Malaysia but only 430 children which covered under the abovementioned programmes. There needs to be more similar programmes as well as better coverage to cater to the gap in providing support to children infected and affected by HIV.

ANNEX 3 : National Funding Matrix (2008 & 2009)

Cover Sheet Indicator No. 1: National Funding Matrix — 2007, 2008 & 2009

Country	Malaysia
Date of Data Entry	15-Mar-10 (example: 20/08/2009)

1) Which institutions/entities were responsible for filling out the indicator forms?

Others (NAC or equivalent, NAP or Others)

If Others, please specify: Ministry of Health, supported by United Nations Malaysia

2) Who is the person responsible for submission of the report and for follow-up if there are questions regarding Indicator No. 1?

Name / title:	Dr. Shaari Ngadiman, Deputy Director of Disease Control & Head of AIDS/STD Section
Address:	Level 4, Block E10, Parcel E, Federal Government Administrative Complex, 6590 Putrajaya, Malaysia
Email:	drshaari@moh.gov.my
Telephone:	60388834387

3) Name of Local Currency: Malaysian Ringgit

4) Amounts reported in:

2007:		(Local Currency or US Dollars)
2008:	Local Currency	(Local Currency or US Dollars)
2009:	Local Currency	(Local Currency or US Dollars)

5) Amounts expresed in:

2007:		(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
2008:	Thousands (x 1,000)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
2009:	Thousands (x 1,000)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))

6) Average exchange rate with US dollars during the reporting cycle:

2007:		Local Currency per 1 US Dollar
2008:	3.50	Local Currency per 1 US Dollar
2009:	3.40	Local Currency per 1 US Dollar

7) Reporting cycle:

2007:		(Calendar Year or Fiscal Year)
2008:	Calendar Year	(Calendar Year or Fiscal Year)
2009:	Calendar Year	(Calendar Year or Fiscal Year)

8) Please indicate month and year (M/YYYY) of reporting cycle:

2007	Month	Year
From:		
To:		
2008	**Month**	**Year**
From:	1	2008
To:	12	2008
2009	**Month**	**Year**
From:	1	2009
To:	12	2009

9) Methodology used:

2007:		(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2008:	National Health Accounts/AIDS Sub-account	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
2009:	National Health Accounts/AIDS Sub-account	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)

10) Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

11) Budget Support: Is general budget support from an international source reported under Public Sources of financing (e.g. a bilateral donor to Ministry of Finance)?

2007:		(Yes or No)
2008:	**No**	(Yes or No)
2009:	**No**	(Yes or No)

Country:		Malaysia	
Reporting cycle:		Calendar Year	
Data Measurement Tool		National Health Accounts/AIDS Sub-account	
Amounts reported in:		Local Currency	
Please indicate month and year (M/YYYY)	From:	Month: 1	Year: 2008
	To:	12	2008
Name of Local Currency		Malaysian Ringgit	
Currency expressed in:		Thousands (x 1,000)	
Average Exchange Rate for the year (local currency to USD)		3.500	

Financing Sources

2008 AIDS Spending Categories	TOTAL Local Currency	Public Sources						International Sources							Private Sources (optional for UNGASS reporting)			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL Local Currency	86,632	83,993	83,993	0	0	0	0	1,020	0	1,020	0	0	0	0	1,619	1,619	0	0
1. Prevention (sub-total)	38,855	38,500	38,500	0	0	0	0	0	0	0	0	0	0	0	355	355	0	0
1.01 Communication for social and behavioural change	0	0						0							0			
1.02 Community mobilization	0	0						0							0			
1.03 Voluntary counselling and testing (VCT)	0	0						0							0			
1.04 Risk-reduction for vulnerable and accessible populations	0	0						0							0			
1.05. Prevention - Youth in school	0	0						0							0			
1.06 Prevention - Youth out-of-school	0	0						0							0			
1.07 Prevention of HIV transmission aimed at people living with HIV	0	0						0							0			
1.08 Prevention programmes for sex workers and their clients	0	0						0							0			
1.09 Programmes for men who have sex with men	0	0						0							0			
1.10 Harm-reduction programmes for injecting drug users	0	0						0							0			
1.11 Prevention programmes in the workplace	0	0						0							0			
1.12 Condom social marketing	0	0						0							0			
1.13 Public and commercial sector male condom provision	0	0						0							0			
1.14 Public and commercial sector female condom provision	0	0						0							0			
1.15 Microbicides	0	0						0							0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	0	0						0							0			
1.17 Prevention of mother-to-child transmission	0	0						0							0			
1.18 Male Circumsicion	0	0						0							0			
1.19 Blood safety	0	0						0							0			
1.20 Safe medical injections	0	0						0							0			
1.21 Universal precautions	0	0						0							0			
1.22 Post-exposure prophylaxis	0	0						0							0			
1.98 Prevention activities not disaggregated by intervention	0	0						0							0			
1.99 Prevention activities not elsewhere classified	0	0						0							0			
2. Care and Treatment (sub-total)	34,741	33,493	33,493	0	0	0	0	1,020	0	1,020	0	0	0	0	228	228	0	0
2.01 Outpatient care	33,493	33,493	33,493	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.01 Provider- initiated testing and counselling	0	0						0							0			
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0						0							0			
2.01.03 Antiretroviral therapy	32,500	32,500	32,500					0							0			
2.01.04 Nutritional support associated to ARV therapy	0	0						0							0			
2.01.05 Specific HIV-related laboratory monitoring	0	0						0							0			
2.01.06 Dental programmes for PLHIV	0	0						0							0			
2.01.07 Psychological treatment and support services	0	0						0							0			
2.01.08 Outpatient palliative care	0	0						0							0			
2.01.09 Home-based care	0	0						0							0			
2.01.10 Traditional medicine and informal care and treatment services	0	0						0							0			
2.01.98 Outpatient care services not disaggregated by intervention	993	993	993					0							0			
2.01.99 Outpatient Care services not elsewhere classified	0	0						0							0			
2.02 In-patient care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.01 Inpatient treatment of oppoetunistic infections (OI)	0	0						0							0			
2.02.02 Inpatient palliative care	0	0						0							0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0			
2.02.99 In-patient services not elsewhere classified	0	0						0							0			
2.03 Patient transport and emergency rescue	0	0						0							0			
2.98 Care and treatment services not disaggregated by intervention	1,248	0						1,020		1,020					228	228		
2.99 Care and treatment services not-elsewhere classified	0	0						0							0			

3. Orphans and Vulnerable Children (sub-total)	886	0	0	0	0	0	0	0	0	0	0	0	0	0	886	886	0	0
3.01 OVC Education	0	0						0							0			
3.02 OVC Basic health care	0	0						0							0			
3.03 OVC Family/home support	0	0						0							0			
3.04 OVC Community support	0	0						0							0			
3.05 OVC Social services and Administrative costs	0	0						0							0			
3.06 OVC Institutional Care	0	0						0							0			
3.98 OVC services not disaggregated by intervention	0	0						0							0			
3.99 OVC services not-elsewhere classified	0	0						0							0			
4. Program Management and Administration Strengthening (sub-total)	12,000	12,000	12,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.01 Planning, coordination and programme management	12,000	12,000	12,000					0							0			
4.02 Administration and transaction costs associated with managing and disbursing funds	0	0						0							0			
4.03 Monitoring and evaluation	0	0						0							0			
4.04 Operations research	0	0						0							0			
4.05 Serological-surveillance (Serosurveillance)	0	0						0							0			
4.06 HIV drug-resistance surveillance	0	0						0							0			
4.07 Drug supply systems	0	0						0							0			
4.08 Information technology	0	0						0							0			
4.09 Patient tracking	0	0						0							0			
4.10 Upgrading and construction of infrastructure	0	0						0							0			
4.11 Mandatory HIV testing (not VCT)	0	0						0							0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0						0							0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	0	0						0							0			
5. Human resources (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5.01 Monetary incentives for human resources	0	0						0							0			
5.02 Formative education to build-up an HIV workforce	0	0						0							0			
5.03 Training	0	0						0							0			
5.98 Incentives for Human Resources not specified by kind	0	0						0							0			
5.99 Incentives for Human Resources not elsewhere classified	0	0						0							0			
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0						0							0			
6.02 Social protection through in-kind benefits	0	0						0							0			
6.03 Social protection through provision of social services	0	0						0							0			
6.04 HIV-specific income generation projects	0	0						0							0			
6.98 Social protection services and social services not disaggregated by type	0	0						0							0			
6.99 Social protection services and social services not elsewhere classified	0	0						0							0			
7. Enabling Environment (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.01 Advocacy	0	0						0							0			
7.02 Human rights programmes	0	0						0							0			
7.03 AIDS-specific institutional development	0	0						0							0			
7.04 AIDS-specific programmes focused on women	0	0						0							0			
7.05 Programmes to reduce Gender Based Violence	0	0						0							0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0			
7.99 Enabling Environment and Community Development not elsewhere classified	0	0						0							0			
8. Research (sub-total)	150	0	0	0	0	0	0	0	0	0	0	0	0	0	150	150	0	0
8.01 Biomedical research	0	0						0							0			
8.02 Clinical research	0	0						0							0			
8.03 Epidemiological research	0	0						0							0			
8.04 Social science research	150	0						0							150	150		
8.05 Vaccine-related research	0	0						0							0			
8.98 Research not disaggregated by type	0	0						0							0			
8.99 Research not elsewhere classified	0	0						0							0			

Country:		Malaysia	
Reporting cycle:		Calendar Year	
Data Measurement Tool		National Health Accounts/AIDS Sub-account	
Amounts reported in:		Local Currency	
Please indicate month and year (M/YYYY)	From:	Month: 1	Year: 2009
	To:	12	2009
Name of Local Currency		Malaysian Ringgit	
Currency expressed in:		Thousands (x 1,000)	
Average Exchange Rate for the year (local currency to USD)		3.400	

Financing Sources

2009 AIDS Spending Categories	TOTAL Local Currency	Public Sources						International Sources							Private Sources (optional for UNGASS reporting)			
										Multilaterals								
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimburseable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL Local Currency	95,810	92,661	92,661	0	0	0	0	1,820	0	1,020	0	0	0	800	1,629	1,629	0	0
1. Prevention (sub-total)	45,761	45,761	45,761	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.01 Communication for social and behavioural change	0	0						0							0			
1.02 Community mobilization	0	0						0							0			
1.03 Voluntary counselling and testing (VCT)	0	0						0							0			
1.04 Risk-reduction for vulneerable and accessible populations	0	0						0							0			
1.05. Prevention - Youth in school	0	0						0							0			
1.06 Prevention - Youth out-of-school	0	0						0							0			
1.07 Prevention of HIV transmission aimed at people living with HIV	0	0						0							0			
1.08 Prevention programmes for sex workers and their clients	0	0						0							0			
1.09 Programmes for men who have sex with men	0	0						0							0			
1.10 Harm-reduction programmes for injecting drug users	0	0						0							0			
1.11 Prevention programmes in the workplace	0	0						0							0			
1.12 Condom social marketing	0	0						0							0			
1.13 Public and commercial sector male condom provision	0	0						0							0			
1.14 Public and commercial sector female condom provision	0	0						0							0			
1.15 Microbicides	0	0						0							0			
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	0	0						0							0			
1.17 Prevention of mother-to-child transmission	0	0						0							0			
1.18 Male Circumsicion	0	0						0							0			
1.19 Blood safety	0	0						0							0			
1.20 Safe medical injections	0	0						0							0			
1.21 Universal precautions	0	0						0							0			
1.22 Post-exposure prophylaxis	0	0						0							0			
1.98 Prevention activities not disaggregated by intervention	0	0						0							0			
1.99 Prevention activities not elsewhere classified	0	0						0							0			
2. Care and Treatment (sub-total)	35,819	34,500	34,500	0	0	0	0	1,020	0	1,020	0	0	0	0	299	299	0	0
2.01 Outpatient care	34,500	34,500	34,500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.01 Provider- initiated testing and counselling	0	0						0							0			
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0						0							0			
2.01.03 Antiretroviral therapy	32,500	32,500	32,500					0							0			
2.01.04 Nutritional support associated to ARV therapy	0	0						0							0			
2.01.05 Specific HIV-related laboratory monitoring	0	0						0							0			
2.01.06 Dental programmes for PLHIV	0	0						0							0			
2.01.07 Psychological treatment and support services	0	0						0							0			
2.01.08 Outpatient palliative care	0	0						0							0			
2.01.09 Home-based care	0	0						0							0			
2.01.10 Traditional medicine and informal care and treatment services	0	0						0							0			
2.01.98 Outpatient care services not disaggregated by intervention	2,000	2,000	2,000					0							0			
2.01.99 Outpatient Care services not elsewhere classified	0	0						0							0			
2.02 In-patient care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections (OI)	0	0						0							0			
2.02.02 Inpatient palliative care	0	0						0							0			
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0							0			
2.02.99 In-patient services not elsewhere classified	0	0						0							0			
2.03 Patient transport and emergency rescue	0	0						0							0			
2.98 Care and treatment services not disaggregated by intervention	1,319	0						1,020		1,020					299	299		
2.99 Care and treatment services not elsewhere classified	0	0						0							0			

3. Orphans and Vulnerable Children (sub-total)	1,160	0	0	0	0	0	0	0	0	0	0	0	0	0	1,160	1,160	0	0
3.01 OVC Education	0	0						0							0			
3.02 OVC Basic health care	0	0						0							0			
3.03 OVC Family/home support	0	0						0							0			
3.04 OVC Community support	0	0						0							0			
3.05 OVC Social services and Administrative costs	0	0						0							0			
3.06 OVC Institutional Care	0	0						0							0			
3.98 OVC services not disaggregated by intervention	0	0						0							0			
3.99 OVC services not-elsewhere classified	0	0						0							0			
4. Program Management and Administration Strengthening (sub-total)	12,000	12,000	12,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.01 Planning, coordination and programme management	12,000	12,000	12,000					0							0			
4.02 Administration and transaction costs associated with managing and disbursing funds	0	0						0							0			
4.03 Monitoring and evaluation	0	0						0							0			
4.04 Operations research	0	0						0							0			
4.05 Serological-surveillance (Serosurveillance)	0	0						0							0			
4.06 HIV drug-resistance surveillance	0	0						0							0			
4.07 Drug supply systems	0	0						0							0			
4.08 Information technology	0	0						0							0			
4.09 Patient tracking	0	0						0							0			
4.10 Upgrading and construction of infrastructure	0	0						0							0			
4.11 Mandatory HIV testing (not VCT)	0	0						0							0			
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0						0							0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	0	0						0							0			
5. Human resources (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5.01 Monetary incentives for human resources	0	0						0							0			
5.02 Formative education to build-up an HIV workforce	0	0						0							0			
5.03 Training	0	0						0							0			
5.98 Incentives for Human Resources not specified by kind	0	0						0							0			
5.99 Incentives for Human Resources not elsewhere classified	0	0						0							0			
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0						0							0			
6.02 Social protection through in-kind benefits	0	0						0							0			
6.03 Social protection through provision of social services	0	0						0							0			
6.04 HIV-specific income generation projects	0	0						0							0			
6.98 Social protection services and social services not disaggregated by type	0	0						0							0			
6.99 Social protection services and social services not elsewhere classified	0	0						0							0			
7. Enabling Environment (sub-total)	170	0	0	0	0	0	0	0	0	0	0	0	0	0	170	170	0	0
7.01 Advocacy	170	0						0							170	170		
7.02 Human rights programmes	0	0						0							0			
7.03 AIDS-specific institutional development	0	0						0							0			
7.04 AIDS-specific programmes focused on women	0	0						0							0			
7.05 Programmes to reduce Gender Based Violence	0	0						0							0			
7.98 Enabling Environment and Community Development not disaggregated by type	0	0						0							0			
7.99 Enabling Environment and Community Development not elsewhere classified	0	0						0							0			
8. Research (sub-total)	900	400	400	0	0	0	0	500	0	0	0	0	0	500	0	0	0	0
8.01 Biomedical research	0	0						0							0			
8.02 Clinical research	0	0						0							0			
8.03 Epidemiological research	0	0						0							0			
8.04 Social science research	900	400	400					500						500	0			
8.05 Vaccine-related research	0	0						0							0			
8.98 Research not disaggregated by type	0	0						0							0			
8.99 Research not elsewhere classified	0	0						0							0			