# UNGASS COUNTRY PROGRESS REPORT

# MALAYSIA

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# Acronyms

| | |
|---|---|
| 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 |
| FFPAM | Federation of Family Planning Associations of Malaysia |
| HAART | Highly Active Acute Retroviral Therapy |
| HIV | Human Immunodeficiency Virus |
| IDU | Injecting Drug Use/User |
| 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 |
| 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 |
| PROSTAR | *Program Sihat Tanpa AIDS Remaja* (Healthy Programme Without AIDS for Youth) |
| SRH | Sexual Reproductive Health |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| SW | Sex Worker |
| TB | Tuberculosis |
| UNAIDS | The 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 |
| WHO | World Health Organisation |

# II. Status At A Glance

*Consultation and participation in the preparation of the report*

The need to have a more inclusive process with better representation from both civil society and government stakeholders dominated much of the thinking behind this round of UNGASS reporting. 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, verify and to vet the completed inputs as well as presentation of the draft and final report. These were:

- *22 November - Preparatory consultation with relevant Government stakeholders* (narrative discussion + NCPI Part A)

- *24 November - Preparatory consultation with civil society stakeholders* (narrative discussion + NCPI Part B)

- *18 December - Presentation of draft Country Progress Report and consultation with key government and non-government stakeholders.*

A decision was made to initially separate the discussions with the Government and non-government stakeholders to create a "safe space" for both in which the atmosphere would be more conducive and comfortable for participants to have their deliberations without much contention. Resource persons from the Government were made available on hand during the civil society consultation workshop to ensure that information concerning available policies and practices would be on hand for reference should it be required. However, these resource persons were advised to not influence the outcome of the discussions among civil society.

This process was a first for many stakeholders involved in the response to HIV in Malaysia and was immediately appreciated by both civil society and government representatives. A number of comments were documented during this consultation which included:

"*The process gave a better understanding and view of the true situation ….in Malaysia by listening to the inputs from both government and civil society.*"

NGO Representative, consultation workshop 18 December

"*The consultation was very open and informative allowing us to be updated on what is currently happening on HIV/AIDS in Malaysia. At the same time, we can know and prepare for what is expected of us…* "

Government representative, consultation workshop 18 December

The information sharing as well as inclusive and consensus building approach for the development of the UNGASS country progress report was also appreciated. It resulted in an improved understanding and realisation of the scale of achievements thus far in the Malaysia response by government and civil society stakeholders as well as the current gaps and challenges. An issue of critical importance which emerged predominantly during the deliberations was the large amount of financial resources made available by the government for the fulfilment of the 5 year national strategic plan.

Government representatives who partook in the process were primarily key stakeholders from the relevant and critical Ministries such as Health; Women, Family and Community Development; Education; and Defence. Despite the multi-ministerial representation, much of the discussions and technical deliberations were still very much led by the Ministry of Health, which represents a continued challenge to mainstream the issues of HIV across the board.

Civil society representatives were predominantly from partner organisations affiliated to the Malaysian AIDS Council, an umbrella body for more than 40 NGOs working on HIV and AIDS related issues. A number of individuals (academicians and community experts) working on specific concerns related to sex work and transgender issues were also present to provide input to the consultation process.

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 Children's Fund (UNICEF) office in Malaysia.

*Overview of UNGASS Indicators*

**Overview of UNGASS Indicators**

| Indicators | Main Data Source | Status: 2006-2007 | Comments |
|---|---|---|---|
| **National Commitment and Action Indicators** | | | |
| 1. AIDS spending, by categories and financing sources | AIDS Spending Report | RM 200 million out of a RM 500 million budget allocation has been earmarked for 2006 & 2007. | AIDS spending for Malaysia is broadly reported as the expenditures are not reported in a format similar to that required of this report. |
| 2. National Composite Policy Index (NCPI) | National Composite Policy Index (NCPI) Workshops (government; NGOs; Multilateral and bilaterals) | See attached NCPI data | The NCPI was 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 | 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. | - |
| 5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission | Programme Monitoring (National PMTCT Programme) | 100% of 328 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 treatment for TB and HIV | National HIV/AIDS Treatment Registry (NHATR) | 33.5% of HIV positive TB cases receive treatment for TB & HIV. | - |

| Indicators | Main Data Source | Status: 2006-2007 | Comments |
|---|---|---|---|
| 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results | 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. | |
| 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results. | IDU & MSM – Programme Monitoring<br><br>SW – No data available | 100% of 21 497 IDUs and MSM are screened for HIV and are aware of their status. | - |
| 9. Percentage of most-at-risk populations reached with HIV prevention programmes | Data not available | Data not available | Studies examining the questions required are not available. |
| 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 | No data is available as the OVC category does not formally exist. As such, no tracking has been done. |
| 11. Percentage of schools that provided life skills-based HIV education within the last academic year | Data not available | Data not available | Current life skills-based HIV education initiatives exist only at the pilot stage, which involve only 20 schools.<br><br>No relevant data exists beyond the pilot. |
| **Knowledge and Behaviour** | | | |
| 12. Current school attendance among orphans and among non-orphans aged 10–14 | Data not available | Data not available | Current tracking by Ministry of Education does not breakdown school attendance into orphans and non-orphans (as defined by UNGASS reporting guidelines). |
| 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | Data not available | Data not available | Current surveys do not address the questions required by this report. |
| 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 – BSS<br>SW – BSS (2004) | IDUs – 98.4%<br>SW – 78.4%<br>MSM – Not available | Due to the lack of studies of the MSM population, no data is able to be inputted for the MSM component of this indicator. |
| 15. Percentage of young women and men who have had sexual intercourse before the age of | Data not available | Data not available | No data exists for this indicator. Current studies examine sexual debut |

| Indicators | Main Data Source | Status: 2006-2007 | Comments |
|---|---|---|---|
| 15 | | | before the age of 20 and not 15. |
| 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 | 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 | 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 | BSS (2004) | 35.4% of sex workers reported using a condom with their most recent client | - |
| 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | Data not available | Data not available | No data exists for this indicator as anal sex is currently not examined nor included in available studies. |
| 20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected | BSS – IDU (2004) | 27.6% reported using sterile injecting equipment the last time they injected. | - |
| 21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse | BSS – IDU (2004) | 5.1% reported using a condom during last sexual intercourse. | - |
| **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. | - |
| 23. Percentage of most-at-risk populations who are HIV infected | IDU - Sentinel Surveillance<br><br>MSM – VCT site survey | SW – No data available<br>MSM – 7.1%<br>IDU – 11.0% | - |
| 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | Sentinel Surveillance | 1058 patients began ART.<br><br>920 still alive after 12 months of ART | - |
| **Global Commitment and Action Indicators** | | | |
| 25. Amount of bilateral & multilateral financial flows | Data not available | Data not available | - |

| Indicators | Main Data Source | Status: 2006-2007 | Comments |
|---|---|---|---|
| (commitments and disbursements) for the benefit of low and middle income countries | | | |
| 26. Amount of public funds for research and development of preventive HIV vaccines and microbicides | Data not available | Data not available | - |
| 27. Percentage of transnational companies that are present in developing countries that have workplace HIV policies and programmes | Data not available | Data not available | - |
| 28. Percentage of international organizations that have workplace HIV policies and programmes | Data not available | Data not available | - |

Despite having a multi-sectoral framework to respond to the HIV epidemic since 1998, the lack of adequate and sufficient financial and technical resources to support the previous National Strategic Plan (NSP) resulted in diminished achievements and few objectives reached. However, the awareness in 2005 that Malaysia was unable to achieve the sole Millennium Development Goal addressing HIV and AIDS (MDG 6) served as a wakeup call for the country.

A new sense of urgency and commitment in responding to this challenge 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-sectoral strategy covering issues from young people's vulnerability to the delivery of healthcare services and antiretroviral treatment. The role of civil society has also been embedded into the planning, implementation, monitoring and assessment of the activities linked to the NSP.

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. 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 is considered a major boost and sends a strong signal of much needed political support for the introduction of innovative and occasionally controversial programmes such as the Needle and Syringe Exchange Programme (NSEP).

The Government's decision to support and implement the NSEP and the Methadone Maintenance Therapy (MMT) in partnership with relevant non-governmental organisations (NGOs) and community based organisations (CBOs) represents a significant milestone in HIV prevention work in Malaysia. Its continued commitment to these programmes has been in the face of popular opinion and strong opposition. Recently in 2007, a decision by the Cabinet Committee on AIDS was reached to support the scaling up of the NSEP to increase its number of sites and clients as well as the extension of the MMT services into drug rehabilitation centres, prisons and drug drop-in centres.

The recognition under the NSP of marginalised and most at risk populations (MARPs) such as sex workers, men having sex with men, transsexuals, refugees, legal and illegal migrants as being vulnerable to HIV also represents a major achievement. Programmes working with these communities are now able to access the large amount of funding which exists under the NSP.

The last few years have also seen an increase in the willingness of religious leaders and organisations, particularly those of Muslims, to acknowledge the reality of HIV and AIDS in Malaysia. The reality that the majority of those living with HIV and AIDS in the country being Malay Muslims has spurred the development of new programmes which engage and sensitise Muslim leaders to the issues and the methods of preventing the spread of the HIV. These programmes also sought to assist them in their efforts to inform their communities and take care of those affected and those with HIV.

A major accomplishment within the period of this report has been the availability and provision of first line ARV treatment at no cost for those who need it. The Government through bilateral discussions with pharmaceutical companies, importing of generic drugs as well as the local production of specific ARVs has also made it possible for partial subsidisation to be provided for second line ART.

Nevertheless, formidable challenges abound as issues of stigma, discrimination, silence, denial and ignorance continue to contribute to the sustained and continued spread of the epidemic. The response thus far continues to be dwarfed by the scale and multifaceted aspects of the epidemic.

Both government agencies and civil society organisations are experiencing tremendous pressure to respond in light of this renewed national commitment. As a result, expectations have become significantly higher. However, high turnover of key technical personnel, outstretched and overburdened secretariats complicate and limit the ability to upgrade and scale up current programmes beyond existing and available capacity. This limitations also restrict and influence the stakeholders' ability, particularly those of civil society, to participate in key decision making processes.

Resource priorities are limiting the coverage of HIV and AIDS related services, and their accessibility and affordability to the vulnerable population. The non-governmental organisations which carry out community support services, already limited due to their scale and coverage, are unable to meet the increasing demand for HIV related services such as palliative care, which is often left to community based organisations (CBOs) to provide. In addition to that home based care services and programmes dealing with OVCs (orphans and other vulnerable children) are largely provided by NGOs.

Although HIV and AIDS are integrated into the national development plans such as the 9$^{th}$ Malaysia Plan and National Health Policy, the strategy to address the epidemic is still very health sector centric and yet to be truly multi-sectoral. Much of the burden in responding to the epidemic continues to be shouldered by the Ministry of Health and small number of key NGOs such as the Malaysian AIDS Council. Although the achievements from the perspective of ARV treatment are considered exemplary and widely lauded, progress in other areas such as prevention, care and support have not progressed at the same rate. Though there are substantial financial resources allocated under the NSP, much has yet to be tapped into. As can be seen from the NCPI responses, many relevant components of the Government have yet to develop costed action plans which specifically address HIV.

Effective prevention of new cases amongst IDUs appears to be undermined by an increase in sexually transmitted HIV. Despite having strategies which promote HIV communication of key messages such as the need to be sexually abstinent and to be faithful, the issue of condoms and safer sex, and the explicit promotion of condoms remains conspicuously absent within the response framework. Widespread public marketing of relevant and common HIV messages such as 'use a condom when having sex' are expected by the government to be done mostly by NGOs and CBOs.[1] However, these bodies are often restricted by their available human resources and have limited geographical coverage.

Reaching out to marginalised and most-at-risk populations (MARPs) remains a significant challenge for both the Government and NGO programmes. The prevention programmes involving MARPs such men who have sex with men (MSM) and sex workers are provided by CBOs and NGOs and supported by the governments. For the IDUs, the governments play a major role in providing programmes in the drug rehabilitation centres, prisons and through needle syringe exchange programme (partnership with NGOs) and methadone maintenance therapy. Although populations such as MSM, are better served by NGOs, the latter is often forced to prioritise and restrict coverage due to the previously mentioned limitations. As a result, interventions are often focused in a particular location with good results or scattered with mixed outcomes.

An additional challenge is the emerging vulnerable sub-populations recognised under the NSP which include legal and illegal migrants, refugees and migrant labourers. Efforts to extend the coverage of existing services to include these groups are marginal at best due to overstretched and limited NGO resources.

Involvement of key civil society stakeholders in national level policy and programme development continues to be limited due to issues related to capacity, relevance and interest. Representation of PLHIVs and other communities at the national level is still depended on a third party, the Malaysian AIDS Council.

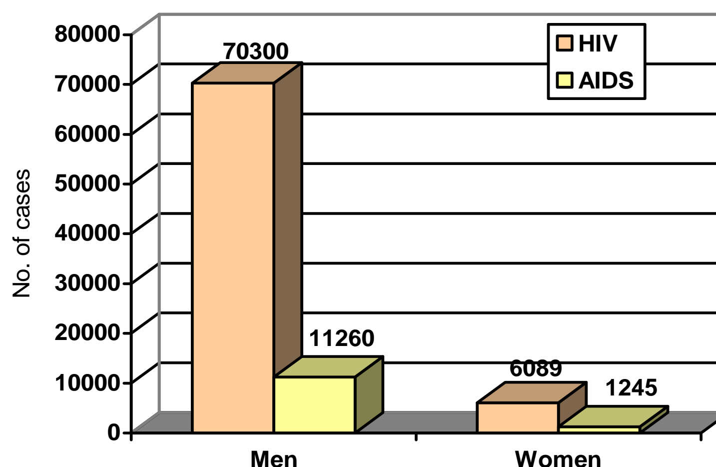
The accomplishments made by Malaysia since the previous UNGASS Country Progress Report have been many and with the leadership demonstrated and represented both in the Government and civil society organisations, opportunities to reverse the spread of HIV exist. However, sustained political support and will are necessary to ensure the continuance and nationwide scaling up of existing pilot HIV interventions and to continue the provision of free and subsidised ART. The civil society organisations must continue to advocate for involvement and participation in the planning, implementation and monitoring of interventions at all levels.

[1] New Straits Times (2007). "*Health Ministry cannot promote condom use to prevent spread of HIV, Official says*". 21st May 2007.

# III. Overview of the AIDS Epidemic

*NOTE: The epidemiology data on the HIV epidemic in Malaysia is only available up to December 2006 at the time of report preparation.*

**Figure 1 :Total HIV and AIDS Cases in Malaysia**




Source: Ministry of Health 2007

The HIV epidemic in Malaysia has since 1986 been predominantly male and spread through the sharing of injecting equipment among drug users. An average of 5,640 new HIV cases have been reported for the past 10 years, resulting in a cumulative reported total of 76,389 people with HIV, 12,505 of those later developed AIDS and 9,155 have since died. Of late, the annual number of new HIV cases has been on a steady decrease from almost 7,000 in 2002 to 5,830 by December 2006.

An examination of the HIV and AIDS data from each state reveals that there are two main trends of HIV infection occurring in Malaysia. The majority of states have IDU driven epidemics but a number have heterosexual transmissions either equally contributing or leading HIV infection. States like Sabah and Sarawak have reported 76.1% and 87.8% of their HIV cases respectively being transmitted through this route in 2006.

**Table 1: Overview of the epidemic**

| | |
|---|---|
| Cumulative number of HIV infections since 1986 | 76 389 |
| Cumulative number of AIDS related deaths since 1986 | 9 155 |
| Women with HIV as of Dec 2006 | 6 089 |
| Children under 13 with HIV as of Dec 2006 | 1 786 |
| New HIV infections detected in 2006 | 5 830 |
| AIDS related deaths in 2006 | 976 |
| Estimated adult (aged 15-49 years) HIV prevalence | 0.4% |

Source: Ministry of Health 2007

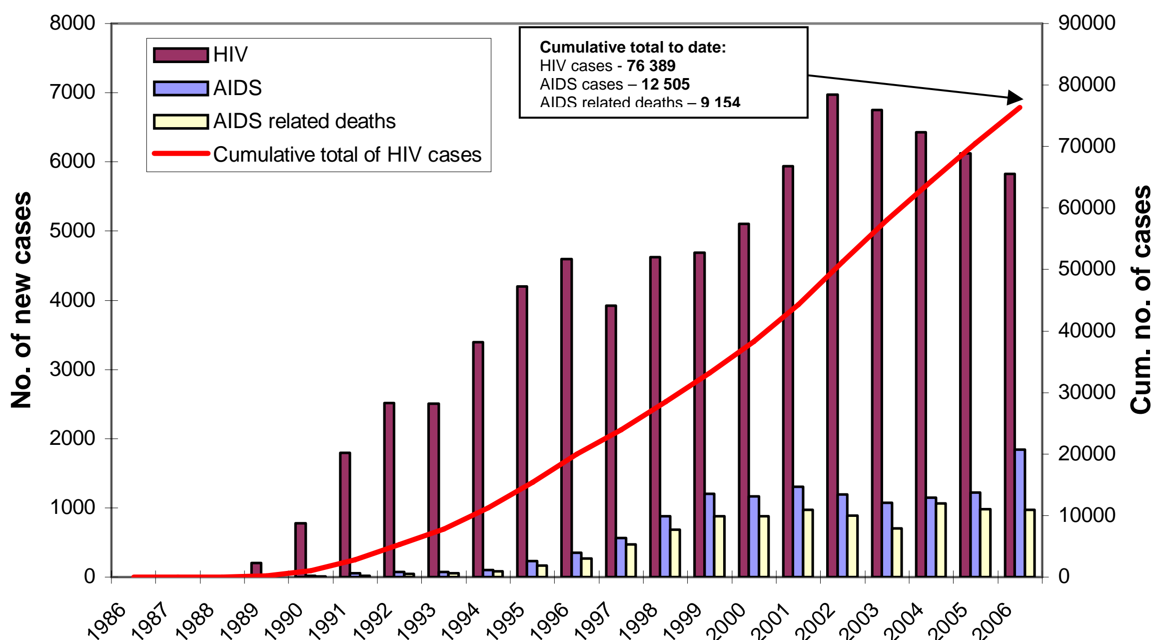
The reported number of men newly infected has also decreased during this period. However, women continue to experience a steep increase in the number of new HIV cases. By 2006, women and girls made up almost one fifth of newly infected persons nationwide as opposed to being barely 5% ten years ago.

Based on reported data from the Ministry of Health, most HIV infections among women in Malaysia have occurred through heterosexual intercourse (63.9% in 2002). On the other hand, the main mode of male HIV transmission continues to be via injecting drug use where nine out of ten infections are men. Alarmingly, 27.4% of total new HIV cases in 2006 as compared to 10.2% ten years ago, were found to be transmitted via the heterosexual route.

This significant amplification represents a possible recent development in 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. However, there remains limited data available to support this conjecture.

As of December 2006, after more than 20 years into the HIV epidemic in Malaysia, the country has recorded a total of 76 389 persons with HIV since the first reported cases in 1986. Most reported infections occur among young heterosexual males, between the ages of 20-39. 75% of the cumulative HIV cases were reported among injecting drug users. 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 continues to classify Malaysia as having a concentrated HIV epidemic.[2, 3]

**Figure 2: The Malaysian HIV Epidemic (1986-2006)**




Source: Ministry of Health (June 2007)

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[2] Ministry of Health (2007). *Summary of HIV AIDS Cases - Reported by Year 2006*

[3] UNDP (2005). *Achieving the Millennium Development Goals. Success and Challenges*. The UN Country Team Malaysia and the Economic Planning Unit, Government of Malaysia

Screening for HIV is conducted throughout the country via a number of national health programmes which has resulted in improvements in the overall understanding of the HIV epidemic in Malaysia. 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 and compiled by the Ministry of Health. Though HIV remains a notifiable disease under the Prevention and Control of Infectious Diseases Act of 1988 (Act 342), significant efforts by the Ministry have been made to encourage the adoption of a voluntary, ethical and internationally acceptable approach to HIV screening.

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 predict the course of the epidemic.[4] In order to address this concern, the Ministry of Health decided to incorporate behavioural surveillance into the existing system. The Family Health International model for Behavioural Surveillance Surveys was adapted for use within the Malaysian context. It was strongly felt that monitoring HIV risk behaviour could play a vital role in determining the potential for the spread of HIV within the sub-group of interest and to other population sub-groups.

**Table 2: 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

Source: Ministry of Health 2007

It was also thought that monitoring behaviours would also inform and support HIV prevention among IDUs and sex workers. However, despite the first round of behavioural surveillance surveys with the latter population groups being conducted in 2004, much of the data collected remains underutilised in the planning, implementation and evaluation of HIV prevention programmes. Much of the current national response is still dependent on sentinel surveillance data which is utilised in the formulation of policies and the development of prevention, treatment, care and support programmes. There also remains a gap in the utilisation of data for the purpose of systematic monitoring and evaluation of the national response.

A HIV Voluntary Screening Programme, first piloted in 2001 and later expanded nationwide in 2003, As of 2006, more than 12,000 people yearly took advantage of this facility to know their HIV status. More than half (59.3%) of these individuals were male, around 80% were between the ages of 20 and 39. Prevalence was found to be around 0.76%.[5]

[4] Ministry of Health & WHO Western Pacific Region (2006). *Summary Findings of Behavioural Surveillance Surveys (BSS) in Malaysia*. AIDS/STD Section.
[5] Ministry of Health (2007). op. cit. (see reference 2)

Contributions to the national HIV surveillance data also include from the premarital screening of Muslim couples in the majority of states in Malaysia. This programme, which at its inception began from a single state in 2001 and is now conducted nationwide. In 2006, a total of 136,722 individuals were screened through this programme out of which 173 (0.13%) were confirmed to be with HIV.

A 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 90% of mothers who enrolled in the programme and are screened for HIV, the results from this mechanism contributes to the national surveillance database and forms the basis for prevalence estimations of the general population. Annually, an average of 0.03% of pregnant mothers were detected with HIV infections.

A number of national HIV estimation exercises were conducted in 2001, 2003 and 2004 utilising existing sentinel and limited behavioural surveillance data. The results: an estimate of between 77,000 adults and children living with HIV in Malaysia.[6]

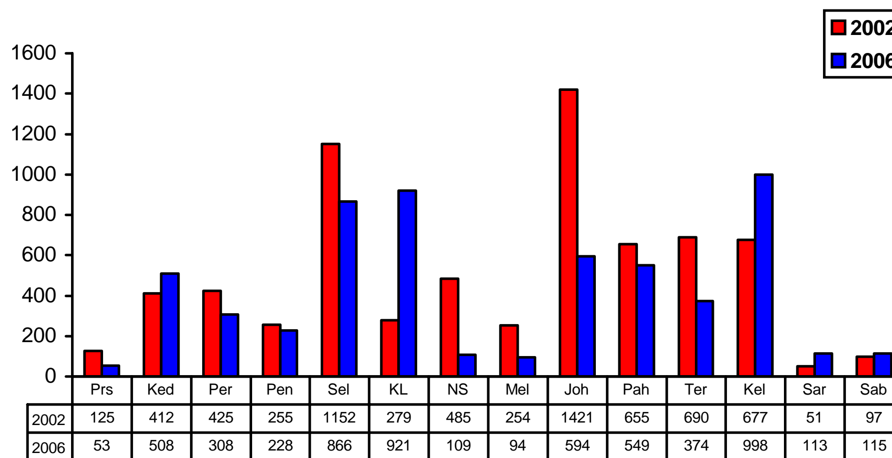
It must also be noted that the vast majority of HIV surveillance data compiled through the Government's system originates predominantly from the public sector. The surveillance system does receive notifications from the private healthcare system such as from private hospitals and clinics.

The continued absence of gender disaggregated data and analysis also greatly complicates the examination of the epidemic in Malaysia, particularly when understanding women and girls' vulnerability to HIV. The responses, experiences and the burden of disease are 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.

When the reported HIV cases are examined from the perspective of geographic distribution, we are experiencing two different HIV scenarios. In Peninsular Malaysia is driven primarily by injecting drug use while the latter has predominantly heterosexually transmitted cases whereas in Sabah and Sarawak (Borneo) have reported 76.1% and 87.8% of their HIV cases respectively being transmitted through this route in 2006.[7] Both situations require specific responses which take into consideration the factors involved in the spread of the local epidemic.

[6] Ibid
[7] Ibid

**Figure 3: Reported new HIV infections in 2002 & 2006 by states**




| | Prs | Ked | Per | Pen | Sel | KL | NS | Mel | Joh | Pah | Ter | Kel | Sar | Sab |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2002 | 125 | 412 | 425 | 255 | 1152 | 279 | 485 | 254 | 1421 | 655 | 690 | 677 | 51 | 97 |
| 2006 | 53 | 508 | 308 | 228 | 866 | 921 | 109 | 94 | 594 | 549 | 374 | 998 | 113 | 115 |

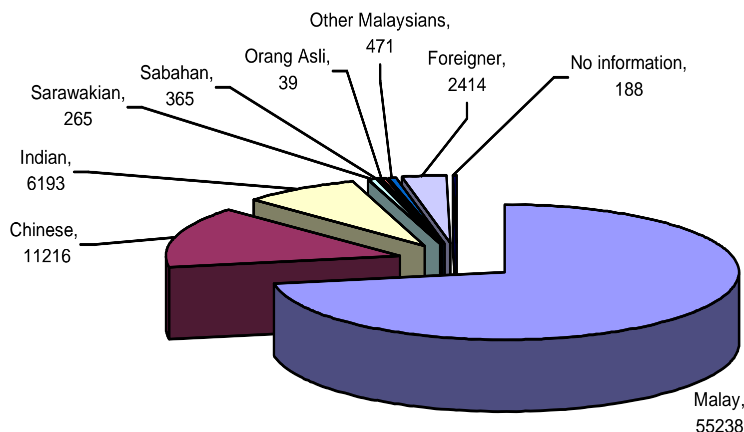
Source: Ministry of Health, Malaysia (June 2007)

Eight out of the 14 states in Malaysia have reported increases between 7.5% (Kedah) and 205% (Pahang) in the number of new reported cases among women. On the other hand, Perlis, Penang, Johor and the Federal Territory of Kuala Lumpur recorded decreases between the year 2002 and 2006. However, Kelantan, Kuala Lumpur and Selangor remain the top three regions whereupon HIV amongst women is highest compared to the other states recorded in 2006. Kelantan, with a cumulative total of 970 reported female cases of HIV, is the state with the highest number of women found to be infected since 1986.

When viewed by ethnicity, the majority of cases comprise of Malay men aged 20-39 (78%). HIV acquired through injecting drug use seems predominant amongst those of Malay and Indian ethnicity. However, Chinese Malaysians appear to be acquiring HIV through heterosexual transmission. These three ethnicities form the bulk of people with HIV in Malaysia. However, the epidemic has spread to the indigenous population as well as those living in the East Malaysia states, Sabah and Sarawak (Figure 4). The dynamics of the epidemic in these populations have been found to be entirely different and require a better understanding of the risk and vulnerability issues affecting them. These states are in fact experiencing an epidemic driven by heterosexual transmission which is in contrast to the IDU linked situation experienced in Peninsular Malaysia.

Though the Malaysian HIV epidemic continues to be described as being mainly driven by infection through the sharing needles among intravenous drug users, a dynamic has been developing over the past few years which may change this perception.

**Figure 4: Reported HIV Infections by Ethnicity (As of 2006)**




Source: Ministry of Health (June 2007)

There is no doubt that, for the moment, injecting drug use remains the predominant mode of HIV transmission in Malaysia. The composition 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 five years ago, when infection through the IDU route was 74.2% of all new reported HIV cases, 53.6% of all new infections were now attributed to injecting drug use in 2006.[8] 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 is currently responsible for more than a third of new HIV cases, the proportion of which is increasing each year.

The past few years have also seen a shift in the gender profile of those newly infected with HIV whereupon more women in Malaysia are becoming infected. Though men continue to form the majority of new cases (85% as of 2006), their proportion has been observed to be declining steadily each year. This is in sharp contrast to that of women whose numbers are experiencing a rapid incline. 2006 saw the highest number of female HIV cases reported since the beginning of the national epidemic, forming 15% of new cases that year. This increase corresponds to the trend of more reported heterosexually transmitted cases which are comprised mainly of women. There is a serious concern over the rising number of women with HIV who have the added risk of vertical transmission to infants.

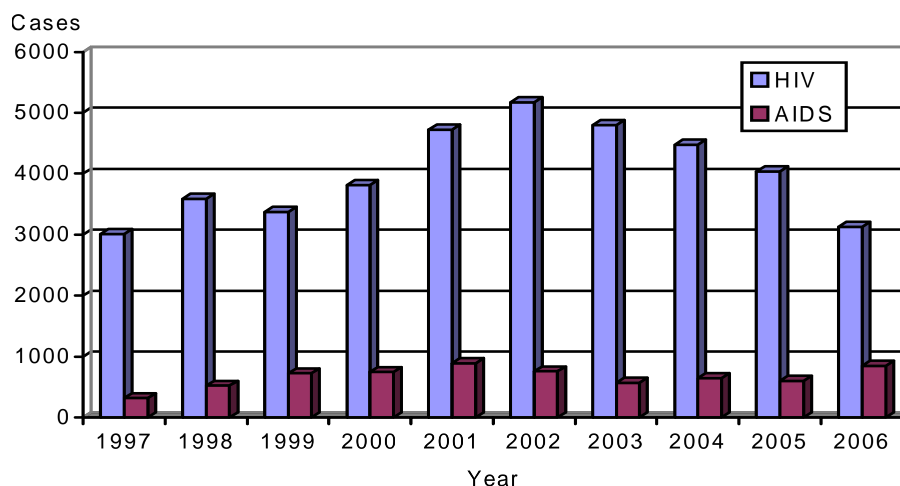
### *Injecting drug use*

Injecting drug use has long been seen as being responsible for the spread and in some countries, the dramatic exacerbation, of the HIV epidemic in Asia. In Malaysia, the rapid spread of the epidemic since the 90s has been attributed to the use and sharing of contaminated injecting drug equipment. The profile of injecting drug users continues to be predominantly

[8] Ibid

male, young, of Malay ethnicity and heterosexual. Women represent a small segment of the Malaysian profile of drug users (around 2%) and they remain an unknown quantity due to the lack of available data and studies.

**Figure 5: New HIV and AIDS cases among IDUs (1997-2006)**




Source: Ministry of Health (June 2007)

3127 new cases of HIV amongst injecting drug users were detected in 2006, bringing a cumulative total of 52 407 persons from this population reported with HIV. In that same year, 13058 drug users were newly detected by the National Anti-Drug Agency. However, based on the reported HIV data from the Ministry of Health as seen in Figure 5, there has been a consistent decrease of new reported HIV cases among IDUs in the past five years.

Known HIV prevalence in this population is still limited to earlier studies and surveillance conducted. A study conducted in 2002, screened inmates in the 28 drug rehabilitation centres (DRC) nationwide. It showed a HIV prevalence of 16.8% among the 12,532 respondents of the study. However, this finding was found to differ drastically according to the geographical location of the individual DRC in question resulting in the prevalence to range from 8% in one state and 41.2% in another. According to the National Anti Drugs Agency, as of February 2007, there are currently 654 inmates living with HIV in its DRCs.[9] Nineteen of who are women.

It is possible for there to be female cases of HIV yet unseen as many female IDUs stay secluded and rely on the male partner to source for drugs. Women and girls as drug users face tremendous social stigma, discrimination and shame which are exacerbated by the occurrences of sexual violence and mistreatment, domestic violence and spousal abuse, human trafficking and lower social status.[10] These circumstances make it less likely for them to seek information, education, and healthcare services, which increase their risk and exposure to HIV infection.

There is currently a dearth of studies aimed at clarifying the behaviour of the vast majority of injectors, particularly data to indicate whether drug users are sexually active. A common belief is prevalent whereupon a drug user is thought to be less likely to engage in sexual activities. However, a report by the Cabinet Subcommittee for the Treatment and Rehabilitation of Drug

[9] National Anti-Drugs Agency (2007*). Buletin Dadah (Bil. 2/2007)*
[10] 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

Users found that 77.6% of IDUs at DRCs were sexually active.[11] It also indicated that only 18.7% used a condom during sex. A 2006 Behavioural Surveillance Survey (BSS) conducted with IDUs indicated that 37% of respondents had had sex in the last month; 15% had bought or sold sex in the last month; and 12% of the men had purchased or sold sex.[12] All of the female respondents involved in the survey had bought or sold sex.

The overall situation and status of the wives and sexual partners of injecting drug users found to be with HIV is generally unknown.

***Sex work***

According to UNAIDS, sex workers are defined as “female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating."[13]

The cumulative number of sex workers found to have acquired HIV since the beginning of the epidemic was 457 or 0.6% of the 76,389 HIV cases seen thus far. The number of HIV cases reported among sex workers is overshadowed by the larger proportion of drug users reported to be infected and forming the bulk of the HIV and AIDS picture of the country. Any current understanding of the commercial sex work industry in the country is in part derived from the limited amount of research conducted and available in the context of responding to HIV. A number of key studies conducted with female, male and transsexual commercial sex workers indicated that HIV prevalence amongst those selling sex was above 5%.[14]

The yearly increases in the number of heterosexually transmitted HIV cases (currently accounts for almost a third of all new infections) as well as the fact that more women and girls are reported infected with HIV each year are strong indicators of new trends linked to the spread of the Malaysian epidemic through sex. As such, an issue which needs to be considered and discussed is how to engage this larger and mostly unseen population which is involved in the purchase or selling of sex. 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 tend to 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.

Almost 20% of female respondents of a BSS conducted by the Ministry of Health amongst commercial sex workers in 2004 also reported using drugs in one form or another. 16% of those using drugs indicated that they had injected. A recent study in 2007 conducted amongst female sex workers, also indicated that drug use and in particular, the sharing of needles was prevalent in this population[15]. Despite these results, 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.

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[11] Rozaidah Talib (2006). *Malaysia: Fighting a Rising Tide: The Response to AIDS in East Asia* (eds. Tadashi Yamamoto and Satoko Itoh). Tokyo: Japan Centre for International Exchange, 2006, pp. 195-206.
[12] Adeeba Kamaruzzaman (2007). *Experiences on Harm Reduction of Substance Abuse in Malaysia*, July 2007
[13] UNAIDS (2002). *Sex work and HIV/AIDS.* UNAIDS Technical Update. Geneva
[14] Ministry of Health (2005). *Report of Behavioural Surveillance Survey in Malaysia – Commercial Sex Workers (First Round 2003-2004).*
[15] Khartini Slamah (2007). *Report on HIV/AIDS and Female Sex Workers in Malaysia*. May 2007

Though there are HIV programmes for female and transsexual sex workers, male sex workers are generally not beneficiaries of such interventions. This usually results in their being excluded from HIV prevention and awareness programme which increases their vulnerability and risk of acquiring HIV.

### *Vulnerable and most-at-risk populations*

*Children*

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[16], are an unknown quantity in Malaysia. No national study or survey has been conducted thus far to estimate the number of children affected by HIV in the country.

In 2006, children below 19 years of age made up 2.5% of 5830 new reported HIV cases for that year. Of the 76,389 cumulative total of HIV cases since 1998, 1,786 were individuals belonging to this age group. 60% were found to be between the ages of 13-19 years. However, an earlier UNAIDS report in 2001 estimated that the number of AIDS orphans in the country was estimated to be as high as 14 000.

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 0.04% as of December 2006. Coverage of this initiative improved from 49.7% in 1998 to 99.6% in 2006.[17] Although it covers only women attending government hospitals and clinics receiving antenatal care, it is estimated that more than 65% of women, especially those living in rural areas, in the country seek antenatal care at government healthcare facilities.

*Men having sex with men (MSM)*

Though the population of men having sex with men (MSM) contributes to the overall picture of the HIV epidemic in Malaysia, it continues to be a group which is poorly understood. Under existing epidemiological classification, MSM are considered to be in the homosexual/ bisexual category. An observation by NGOs and CBOs working with the community and based on data collected from field sites conducting VCT, is that the number of HIV cases among MSM has increased in the past few years.

*Transsexuals*

Transsexuals are labelled as sexual deviants and generally shunned by society in Malaysia.[18] 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 is unknown as to how many cases of HIV are seen or estimated within this population as the classification is integrated into those of men.

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[16] UNAIDS (2006). *AIDS Epidemic Update.*
[17] Ministry of Health (2007). *PMTCT Review Report.*
[18] Teh (2007). *Exploring HIV related needs for safety among transsexuals or mak nyahs*

*Migrants*

An estimated 2.1 million registered immigrant workers and 500,000 illegal workers currently reside in Malaysia.[19,20] 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.

**Table 3: HIV Screening of Migrant Workers in Malaysia (2000-2004)**

| Year | No. of persons screened | HIV | |
|---|---|---|---|
| | | + ve | % |
| 2000 | 525 681 | 98 | 0.0186 |
| 2001 | 500 133 | 91 | 0.0182 |
| 2002 | 402 831 | 122 | 0.0303 |
| 2003 | 716 157 | 286 | 0.0399 |
| 2004 | 909 273 | 337 | 0.0317 |
| **Total** | **4 158 034** | **1 192** | **0.0287** |

Source: Ministry of Health (2004)

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 2004, 0.03% all of those who were screened tested positive for HIV.

*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 captured through the existing HIV surveillance system.[21] 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 138 persons (as of October 2007). [22] A recent development has been observed whereupon more children are found to be with HIV in this population.Ten percent of paediatric HIV cases currently seen at the Malaysian Paediatric Institute are refugees.

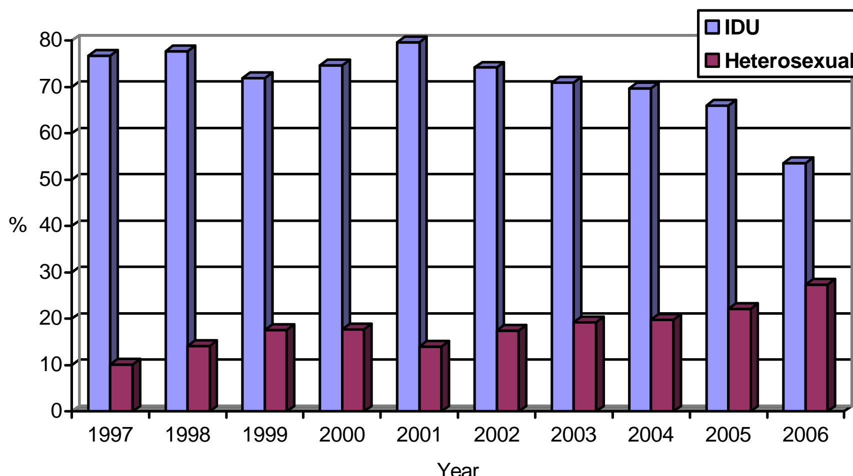
### ***Recent trends in HIV transmission***

*The increase in heterosexual cases*

Based on the reported Ministry of Health data, there are two main modes of transmission which can be observed to be prevalent in Malaysia, namely injecting drug use and heterosexual intercourse.

[19] 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
[20] Ministry of Human Resource (2007). Personal communication. October 2007
[21] Ministry of Health (2005). *National Strategic Plan on HIV/AIDS 2006-2010*, (October 2005) pg 14
[22] Ibid

**Figure 6: Percentage of new HIV cases attributed to IDU & Heterosexual transmission (1997-2006)**




Source: Ministry of Health (2007)

Figure 6, demonstrates a clear trend from 2001 whereupon fewer annual cases attributed to the IDU route were detected. However, the proportion of heterosexually acquired cases can be observed to have steadily and consistently increased.

As of December 2006, HIV transmission attributed to heterosexual intercourse constitutes 15.3% of cumulative cases.[23] However, this same year saw the significant increase of newly infected cases acquired through heterosexual contact from 17.5% in 2002 to 27.4% in 2006. Heterosexual transmission now accounts for nearly a third of newly reported HIV cases in Malaysia.

A Ministry of Health report in 2003, reported that for 2002, 63.9% of cases seen amongst women for that year were acquired through heterosexual intercourse.[24] Three out of every five cases of women found to be with HIV contracted it through this form of sexual contact. Intravenous drug use followed with 20% and other risk factors at 16%.

The same report indicated a dynamic of the female scenario seen in Malaysia whereupon viewed from an ethnic perspective, the majority of cases were among Malay women (54.8%) who acquired HIV mainly through heterosexual contact (56%). For each of the two other main ethnic groups in the country, namely Chinese and Indians, this mode of transmission was responsible for the majority of female cases seen in their respective communities. The proportion of female cases for 2002 via heterosexual contact and through injecting drug use were found to have both increased significantly from the previous year.

As part of the prevention of mother-to-child-transmission (PMTCT) programme in 2002, antenatal screening conducted with almost 360 000 pregnant women detected 141 individuals with HIV. 86% of the women were found to have acquired HIV through heterosexual contact.

[23] Ministry of Health (2007). op. cit. (see reference 2)
[24] Ministry of Health (2003). *Report to the Director General - AIDS/ STI Unit.*

The overlap between the two main risk behaviours, injecting drug use and sex work, first mentioned in the earlier section is certainly occurring in the country. Information from community based organisations, clinicians and studies conducted in the field seem to indicate that injecting drug users are engaging in sex or providing sexual services. To what extent and scale it is occurring is currently unclear. There is currently a dearth of studies aimed at identifying the behaviour of the vast majority of injectors, particularly data to indicate whether drug users are sexually active. As a result, a common belief is prevalent amongst a number of government agencies and non-governmental organisations engaged in the rehabilitation of drug users and law enforcement, whereupon a drug user is thought to be less likely to engage in sexual activities. However, a study conducted in 2007 amongst female sex workers indicated that drug use and the practice of sharing needles were prevalent in this population. Female injectors were found to be selling sex to finance their drug use.[25]

These observed trends reflect an alarming rate of HIV infection amongst women via heterosexual transmission which differs from that of the men. The main mode of male transmission is via intravenous drug use.[26] Although, more men are currently infected than women (nine out of ten infections are in men), this masks the fact that the proportion of women, who are predominantly acquiring HIV through heterosexual intercourse, continues to grow rapidly and consistently each year.

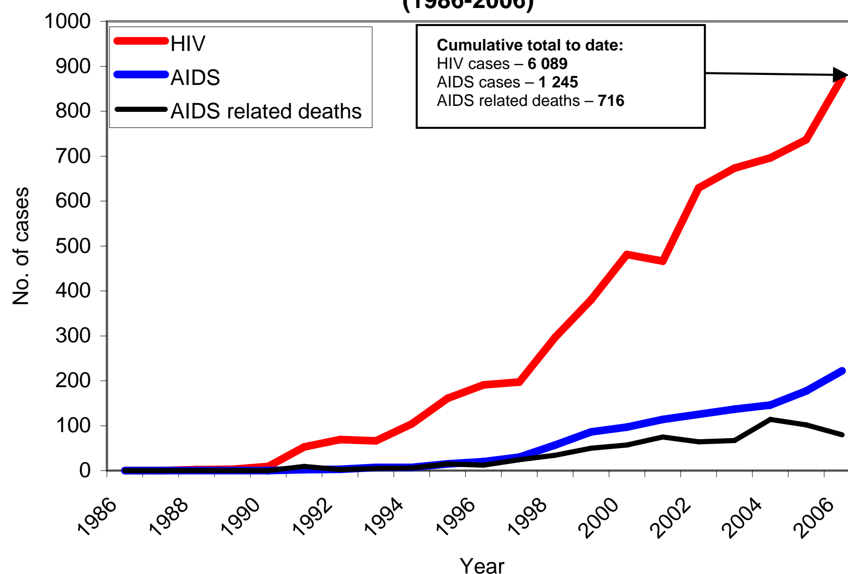
*Feminisation of the Malaysian HIV epidemic*

Women remain one of the fastest growing populations being infected with HIV in Malaysia. Though as of December 2006 the proportion of women and girls reported to have been infected with HIV remains less than 10 percent of the cumulative total, the past five years have seen dramatic increases in the number of new cases documented amongst women.

Figures and analysis conducted and interpreted from a gender perspective are less common. When done so, it can be seen that undoubtedly the Malaysian HIV epidemic is escalating but the profile of those newly infected and affected is slowly changing.

Interestingly, the epidemic has in fact seen a gradual decrease in new reported annual HIV cases as shown in Figure 2 earlier. Though an average yearly decrease of 4.35% has been observed for the past five years, the incidence profile has slowly shifted from male to increasingly becoming female.[27] As indicated in Figure 7 below, the number of women and girls newly infected with HIV increased by 39% from 629 cases in 2002 to 875 in 2006 which in itself represents a jump of 344% from the 197 new cases seen in 1997.

[25] Khartini Slamah (2007). op. cit. (see reference 15)
[26] World Health Organisation (2004). *Consensus Report on STI, HIV and AIDS Epidemiology – Malaysia*
[27] Ministry of Health (2007). *Women and girls confronting HIV and AIDS in Malaysia.* Unpublished.




Source: Ministry of Health (June 2007)

Meanwhile, the number of reported AIDS cases amongst women also increased by 78% within the 2002 – 2006 period. By December 2006, a total of 6089 women were reported to have been infected with HIV compared to 70300 men. 1245 cases of AIDS and 716 AIDS related deaths were also seen amongst women and girls. The trend of increasing numbers of women and girls newly infected with HIV can be clearly seen in Figure 6 which clearly indicates that this movement is increasingly rapid and rising steeply.

However, it has been argued that the increase in coverage and accessibility of HIV testing for women has contributed to the increase in the number of reported female HIV infection.[28]

The proportion of reported new HIV infections attributed to women can be seen to have steadily increased each year. Only ten years ago, men accounted for more than 96% of new HIV cases. However, from 4.15% of all female HIV infections reported in 1996 to 15.01% in 2006, this increase of 262% represents an alarming trend in new infections occurring each year which is strongly linked to women. By the end of 2006, the Ministry of Health recorded the highest numbers of reported incidences of new infections with 875 HIV and 222 AIDS cases among adolescent and adult women in Malaysia. Based on these official statistics from the Ministry of Health, in the past 10 years alone, women have moved from those least affected by HIV to those in whom the disease is spreading fastest.

When segregated according to occupation, a Ministry of Health HIV and AIDS report for 2002 indicated that the majority of women detected with HIV in that year were found to be housewives (26.3%), followed by industrial workers (4.1%), sex workers (2.8%), private sector workers (2.0%), government servants (1.8%) and students (1.0%). In some states, HIV was found to have been mainly acquired by those previously thought to be least likely to be infected, namely housewives. In states such as Johor, this group of women form the majority of female cases seen in this state.

[28] Ministry of Health (2006). *National Strategic Plan on HIV/AIDS 2006-2010*

There have been cases of women with HIV and AIDS reported from all states and territories in Malaysia. As of December 2006, 6 089 women in Malaysia have acquired HIV since 1986. 59% of this number was reported within the past five years of 2002 – 2006. 65% of female AIDS cases and 59% of women who have died of AIDS related conditions to date were reported within the same period.[29] A reduction in the ratio of infected males to infected females can also be observed from the reported data: from 10:1 in 2002 to 5:1 in 2006.

[29] Ministry of Health (2007). op. cit. (see reference 2)

# IV. National response to the AIDS epidemic

Despite having a multi-sectoral framework to respond to the HIV epidemic since 1998, the lack of adequate and sufficient financial and technical resources to support the previous National Strategic Plan (NSP) resulted in diminished achievements and few objectives reached.

However, the awareness in 2005 that Malaysia was unable to achieve the sole Millennium Development Goal addressing HIV and AIDS (MDG 6) served as a wakeup call for the country. In 2006, the Ministry of Health (MOH) acknowledged that efforts at preventing the spread of HIV had failed.[30] Prior to 2006, it realised that only limited coverage had been achieved for the prevention, treatment and care of HIV related illness. Community based support was also found to be insufficient to assist the Ministry's efforts at prevention.

Realising this situation, MOH, in collaboration with governmental and non-governmental agencies as well as other ministries, developed the National Strategic Plan (NSP) on HIV/AIDS 2006-2010 to provide a framework for Malaysia's response to HIV and AIDS over five years.

This NSP, which replaces the previous HIV/AIDS National Strategic Plan first developed in 1998 and reviewed in 2001, now provides a common basis for the coordination of the work of all partners involved in the national response. It is intended to adopt an approach integrating the efforts for prevention, treatment and care.

The objectives of the NSP are as follows:[31]

- 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 will be discussed within the framework and context of the National Strategic Plan on HIV/AIDS. This framework outlines six main strategies:

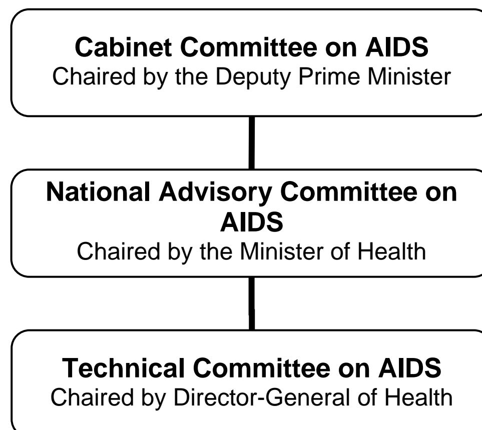
- Strategy 1: Strengthening leadership and advocacy
- Strategy 2: Training and capacity enhancement
- Strategy 3: Reducing HIV vulnerability among injecting drug users (IDUs) and their partners
- Strategy 4: Reducing HIV vulnerability among women, young people and children
- Strategy 5: Reducing HIV vulnerability among marginalised and vulnerable groups
- Strategy 6: Improving access to prevention, treatment, care and support

[30] Ministry of Health (2006). *National Strategic Plan on HIV/AIDS 2006-2010*
[31] Ibid

***Strategy 1: Strengthening leadership and advocacy***

Malaysia has upgraded its existing framework for managing the country's response to HIV. In 2005, as a result of strong advocacy work, the Government realised that a successful response to the epidemic required stronger political commitment and leadership at the highest level.

**Figure 8: National HIV and AIDS Framework**




Source: Ministry of Health (2006)

This is now represented by the Cabinet Committee on AIDS which operates at the Cabinet level and chaired by the Deputy Prime Minister. It functions as a forum for discourse and decision-making at the highest level on HIV and AIDS related policies. This body has been made responsible for ensuring the development and implementation of policies. It meets annually and includes recent landmark decisions such as the scaling up of the Needle Syringe Exchange Programme.

The National Advisory Committee on AIDS (replaces the previous National Co-ordinating Committee on AIDS) is chaired by the Minister of Health, and functions as a high level advisory body to the Cabinet Committee on AIDS. 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 this advisory committee comprises the senior leadership of the relevant Ministries and senior representatives from civil society organisations. It meets at least biannually and reports to the Cabinet Committee on AIDS.

The Technical Committee on AIDS is an existing body from the previous HIV and AIDs framework. Its main function is to develop the annual work plan and budget in the context of the NSP, and to review technical issues in relation to the implementation of interventions. The membership of this body includes Directors of Ministries and working level representatives from civil society. It meets at least biannually and reports to the National Advisory Committee.

One of the key weaknesses of the implementation of the previous NSP, was the severe lack of resources allocated to its execution by the relevant ministries. No extra funding was identified for the implementation of the plan. It was assumed that the various ministries would incorporate HIV and AIDS related programmes within their existing programmes utilising existing allocations. 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.[32] In the current framework, an allocation of RM 500 million (USD 150 million) has been made available for the next five years

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. 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.
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However, it is necessary to note that civil society participation is very limited within the existing policy framework. The Malaysian AIDS Council (MAC) remains the sole civil society representative involved in the Technical Committee on AIDS as well as the National Advisory Committee on AIDS. Though the opportunity to increase civil society participation has been provided in the past, the issue of whether NGOs and CBOs have sufficient capacity to contribute at these levels has been raised. As such, MAC has been entrusted to represent the issues and concerns of the civil society organisations working on HIV and AIDS, including people living with HIV.

***Strategy 2: Training and capacity enhancement***

The Government has recognised that there is a need to improve the existing capacity of the healthcare system and to support NGOs in improving their capacity to cater to the developing HIV situation in the country. Of particular concern and urgency, is the existing HIV surveillance system which is used to advocate for and develop new policies as well as is utilised in the review of existing interventions.

As a result of existing gaps in the national HIV surveillance system, strategic information such as behavioural data necessary to plan and implement a comprehensive response to HIV is scarce and ad-hoc at best. As a result, most of the interventions 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. With support from United Nations partners such as WHO and UNICEF, Malaysia has focused on developing and strengthening its HIV surveillance system to improve the understanding of its own epidemic.

There is a major dearth of research concerning the constituencies for which HIV interventions are designed for. Despite being acknowledged for many years as being populations vulnerable to HIV and being most at risk, the lives and needs of sex workers, IDUs, transsexuals and MSM communities remain, within the exception of a few CBOs, relatively unknown. As such, there is often a discordant situation between official HIV prevention policy and what is actually needed in the field to respond effectively.

Due to the limited relevant technical expertise in the area of HIV social science research within both Government and non-government entities, the impact of HIV interventions is largely unknown. The vast majority of these HIV programmes conducted in the past and present have no proper baseline data and no monitoring and evaluation framework.

[32] Ministry of Health (2006). *National Strategic Plan on HIV/AIDS 2006-2010.*

However, upon reflection, it can be seen that the technical capacity of HIV treatment has far surpassed that of other areas such as prevention, care and support. Institutionalised training for clinical HIV management is now available, for example, Family Medicine specialists have been trained to enable them to handle the provision of ART in health clinics.[33]

Other areas, particularly those that are non-clinical treatment related, remain left behind and what capacity there is often unsustainable due to a dependence on external consultants. With the exception of clinical HIV expertise, capacity building on the social science of HIV also appears to not be institutionalised and is conducted on a case-by-case and ad-hoc basis.

Nevertheless, 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.

Civil society organisations, despite a number of them being very experienced in the field of HIV, generally remain weak in terms of technical expertise. Of particular concern is the Malaysian AIDS Council (MAC) which is tasked by the Government to play a major role in responding to the local HIV epidemic. Most of MAC's staff remain themselves untrained technically in the area of HIV and AIDS, despite the organisation having a mandate of providing training and tasked to develop the technical capacity of its 42 Partner Organisations.[34] It is therefore dependent on an unsustainable approach involving the recruitment of external consultants and experts to advocate and to contribute to policy development at a higher level.

***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 scale up of the existing methadone maintenance therapy (MMT) programme as well as the introduction of the Needle Syringe Exchange Programme (NSEP).

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 2006 and catered to more than 1200 individuals. Around 22% of those enrolled were with HIV. The next phase which represents a scale-up of the earlier programme began in 2007 and currently involves more government hospitals, primary care clinics and general practitioners, and aims to provide service for 5000 persons. In 2007, pilot testing began towards the provision of MMT in incarcerated settings, specifically prisons.[35]

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[33] Ministry of Health (2007). *Rapporteur's Report.* 1st National AIDS Conference.
[34] Jenkins, C. (2007). *Development of thematic reports, a country profile and strategic action plan on the MSM, SW and TG communities in Mlalaysia*. July 2007
[35] Ministry of Health (2007). op. cit. (see reference 33)

The Needle Syringe Exchange Programme (NSEP) pilot has been taking 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 has thus far been 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 15,000 drug users with free syringes and condoms, is currently the centrepiece of the Government's prevention intervention.[36] Besides the provision of syringes and condoms, it also provides access to and education on sterile injection equipment and safer injecting techniques.

The Government's commitment to the harm reduction approach is best illustrated through its allocation of RM 300 million (USD 90 million) for these programmes. 60% out of the total RM 500 million (USD 150 million) made available to the country's HIV and AIDS response for five years has been earmarked for harm reduction programmes.[37] 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. Expansion of coverage and availability of services of those two interventions are urgently required and are currently being done.

***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 women-specific HIV prevention programmes available in Malaysia. Reliance is on the general HIV and AIDS awareness and prevention programmes which cover issues affecting both men and women in relation to their vulnerability to HIV.

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.[38] Over 65% of total antenatal mothers nationwide were found to utilise government antenatal facilities. With coverage of 99.5% of this proportion (as of December 2006), the programme has been able to successfully reduce the incidence of MTCT to 3.8% among women enrolled in the programme. More than 2.9 million mothers were screened for HIV through this initiative (1998-2006), through which 0.02% to 0.04% were detected with HIV.

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.[39] 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.

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 incidence of MTCT among 65% of all antenatal mothers, the other significant 35% remains unaddressed. With more than an

[36] Bernama. *15,000 Drug Addicts Targeted For Harm Reduction Programme*. 29 November 2007. http://web7.bernama.com/bernama/v3/news.php?id=299285
[37] Ministry of Health (2007). op. cit. (see reference 15)
[38] Ministry of Health (2007). *PMTCT Review Report.*
[39] Ibid

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.[40]

With regards to young people, the Ministry of Health continues to conduct a healthy lifestyle campaign which involves the 'promotion of good moral values' and healthy lifestyle practices, early detection, effective counselling as well as mobilising community support and participation. HIV education has been incorporated into various existing programmes such as school health programmes and healthy lifestyle campaigns.

The most extensive HIV programme with young people currently active is PROSTAR or *Program Sihat Tanpa AIDS untuk Remaja* (Healthy Programme without AIDS for Youth). Targeting youth between the ages of 13-25, its main objective is to empower them to become peer educators who disseminate HIV and AIDS information while promoting healthy lifestyle practices. Since its inception in 1996 till December 2006, a total of 6,440 PROSTAR activities have been carried out, benefiting nearly 884,865 youths.[41] The programme currently has 104 district branches and maintains a presence in 1,395 schools across the country.

The programme has since evolved and developed innovative activities which now involve young people from marginalised groups, those who are out of school, women and girls who are living with HIV as well as engaging religious leaders.

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 nationwide in 2007, 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 HIV and AIDS.

***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. Programmes with groups such as those identified under this strategy (i.e. sex workers, MSM, transsexuals, migrants, displaced persons and refugees) remain the domain of local NGOs and international bodies such as the UNHCR.

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 provided by CBOs and NGOs, who are tasked by the Government to do so. One such example is PT Foundation (previously known as Pink Triangle), an organisation which works with several marginalised communities including sex workers, drug users, MSM, transsexuals and PLHIV. Although these populations are better served by these organisations, the latter is often forced to prioritise and restrict coverage due to limited human and financial resources. As a result, interventions are often focused in a particular location with good results or scattered with mixed outcomes. Such programmes are also often concentrated in urban areas where the related NGO has a presence as opposed to rural locations which remain underserved.

[40] UNAIDS (2001). *AIDS Report 2001.*
[41] Ministry of Health (2007). op. cit. (see reference 15)

Despite being identified as a marginalised and vulnerable population under the National Strategic Plan on HIV/AIDS 2006-2010, no HIV prevention programme involving sex workers has been developed by the Government thus far. It is instead left to the NGOs and CBOs working with this community to continue to develop outreach programmes which cater to the needs and concerns of sex workers.

Though male sex workers certainly exist in the Malaysian sex industry as evident from CBO surveys and outreach personnel, their situation is largely unknown and the response and activities related to this is limited.

Very few credible studies concerning male and female sex workers in Malaysia are available. Those, which examine this issue, gain access to only institutionalised or incarcerated women, i.e. those in prison or moral rehabilitation centres.[42] The absence of such studies particularly those concerning male sex workers, even by CBOs which work with this community, represents a major deficiency in understanding and addressing the HIV situation amongst the sex worker population. It is unknown as to whether the interventions conducted thus far by the NGOs and CBOs involved have been successful in preventing the spread of HIV within this group.

Very few studies related to the MSM population have been conducted and fewer still organisations servicing this community in Malaysia. As a result, though this population is identified within the framework of the NSP, MSM remain among the most poorly understood of the MARPs.

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. Despite indications that the level of awareness of HIV and of safer sex practices is relatively high in this population, most MSM do not identify themselves as being at risk. As such, usage of condoms during anal sex is reportedly low and inconsistent. Given that some MSMs also engage in sexual activity with women or even have families, larger communities could also be affected.

Organisations such as PT Foundation remain the only few organisations which work with the MSM population and have the resources and capacity to produce and distribute HIV prevention information.[43] PT Foundation's MSM programme includes a drop-in centre, a support group, a telephone counselling service, and an outreach program.

Though gay businesses, such as bars and clubs, are frequented by thousands of MSMs, limited sustained HIV prevention work exists in these venues.[44] 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. 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.[45]

[42] Jenkins, C (2007). op. cit. (see reference 34)
[43] Scoville (2004). *An assessment of HIV prevention work for the MSM population in Kuala Lumpur.*
[44] Ibid
[45] Ibid

The number of transsexuals with HIV in Malaysia is unknown. Nevertheless, their vulnerabilities to HIV infection are relatively well known through contemporary local studies of this population. Large sections of the transsexual community are sex workers or have ever received payment for sex.[46]

The level of HIV and AIDS knowledge in this community remains low and safer sex during oral and anal sex is largely not practiced. The possibility of acquiring HIV is not seen as an issue of concern as there are other immediate pressing problems such as financial difficulties and societal discrimination.

Despite the findings of studies concerning transsexuals which have indicated that the issue of HIV vulnerability in this community is critical, very few comprehensive programmes have been made available to address this concern. Most, if not all current programmes to date, continue to be centred around the transsexual outreach services provided by PT Foundation and are available solely in the country's capital, Kuala Lumpur. These services are a component of the sex worker outreach programme, thus addressing their vulnerability in working in that particular area. However, no other NGO offers such services and conducts outreach work, support groups, drop-in centres and shelters, in any other part of Malaysia.

Due to the Government's concern over the potential health risks to Malaysians posed by an estimated 2.1 million registered immigrant workers and 500,000 illegal workers currently residing in the country[47], a policy was constituted whereupon foreign workers currently 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.[48]

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.[49] 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. Treatment, medical assistance or post-test counselling are provided.[50] Women make up the majority of unskilled and semi-skilled migrants who undergo the screening. Professionals and expatriates are exempted and do not undergo any sort of medical testing or screening.

It may be necessary to re-examine these policies as they may run contrary to the intentions and objectives of the NSP strategy 5 addressing marginalised and vulnerable groups which is inclusive of migrant workers.

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[46] Teh (2007). *Exploring HIV related needs for safety among transsexuals or mak nyahs.*
[47] 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
[48] Ibid
[49] 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)*
[50] Ibid

With regards to the refugee population in Malaysia, the United Nations High Commissioner for Refugees (UNHCR) has currently registered 37,938 persons of concern as of October 2007.[51] This population includes 12,880 Rohingya Muslim refugees from Myanmar, 19,314 other persons of concern from Myanmar, and 5,744 individuals from other countries. 7,003 or 18.5 % of this population are women and 9,408 children (25%).

UNHCR and several Malaysian health NGOs (e.g. Malaysian Care, A Call To Serve (ACTS) Malaysia and Catholic Welfare Services) provide HIV related prevention and response programmes through visits to detention centres and mobile clinics conducted in jungle and urban settlements.[52] This includes a voluntary counselling and testing (VCT) campaign to raise awareness about HIV and AIDS and to provide testing services as well as psychosocial counselling for those living with HIV. 23% of those reached in this campaign were women.

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 and asylum seekers with HIV are also able to benefit from related and appropriate medical treatment for free.[53]

### *Strategy 6: Improving access to prevention, treatment, care and support*

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 are 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. It also aimed to obtain the widest range of ARV drugs at the best possible cost to the Government.

The Cabinet Committee on AIDS chaired by the Deputy Prime Minister of Malaysia, made a determination that it would focus on improving the availability of treatment and lowering the actual cost of ARV treatment. The Committee 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, 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

[51] UNHCR (2007). *Personal communication.* 13 November 2007.
[52] Ibid
[53] US Committee for Refugees and Immigrants (2006). *Country Report – Malaysia.* http://www.refugeereports.com/countryreports.aspx?id=2008

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. 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. As October 2007, 6590 cases being treated with ARV.

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 Government has made it possible for a local pharmaceutical company to produce a generic ARV combination drug since 2006.

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 treatment accessible to all patients at no charge at government hospitals and clinics. However, the cost of undergoing second line treatment is bourn mainly by the patient and is relatively more expensive. Two drugs are available at no cost while the third is paid for by the patient.

**Table 4: 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
6. Inmates in the drug rehabilitation centers that need the 2nd line drugs.

Source: Ministry of Health (2007)

However, the negotiations conducted by the Government affect only treatment programmes under the government. The reduction in prices for ARV treatment does not necessarily affect the private healthcare sector. However, more than 90% of patients eligible for ARV treatment options undertake treatment through government hospitals and health clinics.

Nevertheless despite the availability of ARV treatment at relatively low cost, obstacles to access continue to exist. Patients are required to travel significant distances to healthcare centres which provide ART. 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,

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. Since the end of 2007, pilot testing is currently being carried out to provide ARV treatment and methadone substitution therapy in prisons. 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.

Despite these many achievements in improving access to and affordability of treatment, it is sobering to note that out of an estimated 15000 PLHIV who would meet the criteria for treatment, more than 6000 are currently receiving ART. It remains uncertain as to why the situation is as such. It may be due to the fact that the majority of PLHIV are IDUs who are either in incarcerated settings or unable to adhere to a treatment regime.

# V. Best practices

***Provision of ARV treatment***

Since 2006, as part of the strategies outlined in the framework of the National Strategic Plan on HIV/AIDS 2006-2010, first line antiretroviral drugs are accessible to all patients at no charge at government hospitals and clinics. Accomplished via the Government's direct negotiations with the multinational pharmaceutical companies without the need to amend existing intellectual property laws, this approach did not exclude the possibility of compulsory licensing for specific drugs. Coupled with the importing of generic drugs and the local production of specific ARVs, this approach has allowed the cost of HAART to be dramatically reduced. The reduction allowed for a wider range of ARV drugs to be subsidised by the government, making it possible to provide free first line treatment for all clinically eligible patients. However, more than 90% of patients undergoing ART undertake treatment through government hospitals and health clinics.

With IDUs representing 72.7% of the cumulative total of recorded HIV cases and 53.6% of new cases in 2006, HIV positive drug users are not excluded from access to ART under the Ministry of Health's national antiretroviral guidelines. Since September 2004, HIV positive drug users in drug rehabilitation centres (DRC) are 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. In addition to this development, since the end of 2007, pilot testing has begun to provide ARV treatment and methadone substitution therapy in prisons.

No formal legislation has been enacted regarding exiting policy practices as they affect access by drug users to sterile injecting equipment, substance therapy, access to antiretroviral therapy and other treatment and care services. As a result, occasional complications arise as drug use is still criminalised under existing legislation.

***Engaging Islamic religious leaders***

The last few years have also seen an increase in the willingness of religious leaders and organisations, particularly those of Muslims, to acknowledge the reality of HIV and AIDS in Malaysia. The reality that the majority of those living with HIV and AIDS in the country being Malay Muslims has spurred the development of new programmes which engage and sensitise Muslim leaders to the issues and the methods of preventing the spread of the HIV. Community leaders, especially religious leaders, have a major role to play in prevention programmes and activities. These programmes also sought to assist them in their efforts to inform their communities and take care of those affected and those with HIV.

One such programme was the "Islam and HIV/AIDS" project led by the AIDS/STD Unit of the Ministry of Health with the support of the Malaysian AIDS Council and the United Nations Development Programme (UNDP), which involved key stakeholders from the Islamic institutions. These 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.

The "Islam and HIV/AIDS" project which was conducted between 2001 to mid-2005 aimed to mobilise and harness the support of Islamic religious leaders for HIV prevention and the

provision of care and support. These leaders included federal and state religious department officials, imams of mosques, religious teachers and other religious professionals at all levels, including state muftis, and imams of local mosques. Due to the respect accorded to this large group of individuals, their example as role models, the potential of their playing a pivotal role in increasing the level of awareness was further enhanced by the possibility of effecting behavioural change on their respective congregations. Religious leaders in Malaysia can be very influential on the attitudes of their communities towards PLHIV and MARPs.

This project was successfully able to sensitise religious leaders to the issues and the methods of preventing the spread of the disease as well as to provide them with the tools to inform their communities and take care of those infected and affected. A comprehensive training manual was developed in collaboration with the Department of Islamic Development and used as a resource material during workshops held nationwide.

Though the project ended in 2005, it has had a long term impact of increasing the level of awareness and information of a large number of individuals who are Muslim leaders in their respective communities. While the project was able to increase the participant's level of awareness and knowledge on HIV and prevention, it was less successful in changing attitudes of stigma and discrimination. The impact assessment of the "Islam and HIV/AIDS" project was varied and depended on the individual's personal experience in dealing with the issue. They are also better equipped to handle issues relating to condom use and injecting drug.

A permanent result of the project has been recognition by the Department of Islamic Development on the need to improve its understanding and engagement on the issue of HIV and AIDS in response to the increasing number of Malay Muslims living with HIV. 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 addition to the above engagement with religious leaders, premarital HIV screening has also been introduced 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 most states. It was initially introduced by a state religious department and is now currently supported by the Ministry of Health. Screening is conducted to provide an earlier opportunity in the detection of HIV and thus better possibilities for treatment. Premarital HIV screening has been considered, at both the policy and grassroots level, 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.

***Methadone Maintenance Therapy***

The first phase of the Methadone Maintenance Therapy (MMT) programme, launched at the national level in October 2005, involved 1241 patients in 8 government hospitals, 2 community health clinics and 7 private health practitioners. The programme was able to achieve a retention rate of 75% after 12 months of implementation. This result has been considered a major achievement when measured against WHO retention rate standards of 55-60% as well as against comparable programs in Poland, Lithuania and Ukraine.

All clients of the programme were closely monitored utilising WHO Quality of Life whose higher percentages indicated improved physical, psychological, social relationship and environmental factors over the treatment period. Survey results examining HIV risk behaviours also showed a

gradual decrease over a 3 month period. Patients on MMT are now able to take on full time employment.

The current scaling up of the MMT programme (currently in Phase 2), will enable an estimated 25,000 patients to be reached by 2010. However, the target determined by WHO/ UNAIDS is that 60% out of the IDU population should have access to the intervention in order for it to have an effective impact. This would mean that the existing programme would have to be further expanded to reach 72,000 people. Though this represents a significant challenge, the results thus far from the programme have created the rationale and argument for long-term commitment of resources by the Government and for the continued expansion of the coverage.

***Civil society and Government partnership in the Needle Syringe Exchange Programme (NSEP)***

The collaborative partnership developed between the community based organisations (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 one year old NSEP. 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 drop-in centres and programme sites.

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 development and delivery of the capacity building or training modules used to brief the relevant law enforcement agencies such as the Royal Malaysian Police and National Anti-Drug Agency.

The NGOs and CBOs are also involved in the ongoing monitoring and evaluation of the programme. One such study involved a BSS whose results indicated significant changes in reduced risky behaviour and improved knowledge on HIV and AIDS as a result of the current intervention.

The Government has emphasized that the key stakeholders, especially the CBOs, play a vital role in ensuring the success of the program at the operational level. Collaboration amongst the implementers, health officials and enforcement officials is continuously needed to ensure sustainability of this program.

***10 years of the Preventing Mother-To-Child Transmission (PMTCT) programme***

A Prevention of Mother to Child Transmission (PMTCT) programme implemented nationwide since 1998 at government health clinics and hospitals, also incorporates HIV screening utilising an opt-out approach. Coverage of those enrolled in the programme improved from 49.7% in 1998 to 99.6% in 2006. Although it covers only women attending government hospitals and clinics receiving antenatal care, it is estimated that more than 65% of women nationwide seek antenatal care at public healthcare facilities. Antenatal HIV cases from the private sector are also referred to the government medical system.

The PMTCT programme is depended on detection of HIV infection during the mother's antenatal period and ensures ARV prophylaxis for the child, safer delivery and infant feeding

practices. The programme has been able to successfully reduce the incidence of MTCT to 3.8%. More than 2.9 million mothers were screened for HIV through this initiative (1998-2006), through which 0.02% to 0.04% were detected with HIV. HIV positive mothers and infants born with HIV through this programme are given free ART (first and second line) for life.

## VI. Major challenges and remedial actions

### *The rise in sexual transmission*

As mentioned earlier, there are 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, 53.6% of all new infections were now attributed to injecting drug use in 2006.[54] Increasingly more new cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by both heterosexuals and MSM. 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.

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.

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

Involvement of key civil society stakeholders in national level policy and programme development remains limited due to issues related to capacity, relevance and interest. Representation of civil society at the national level is currently depended mainly on the Malaysian AIDS Council (act as an umbrella body for NGOs and civil society). The Malaysian AIDS Council (MAC) also involved in the Technical Committee on AIDS as well as the National Advisory Committee on AIDS. Though the opportunity to increase civil society participation has been provided in the past, the issue of whether NGOs and CBOs have sufficient capacity to contribute at these levels has been raised. As such, MAC has been entrusted to represent the issues and concerns of the civil society organisations working on HIV and AIDS, including people living with HIV.

[54] Ibid

The challenge is to encourage further and increased civil society participation while complimenting and improving on the existing arrangement. Capacity development activities of NGOs and CBOs remain largely programme specific and do not necessary enable participation at the policy level. Increased emphasis on capacity development by these organisations as well as more opportunities provided by the Government to partake in discussions should be part of future considerations.

***More research and studies needed***

- **The need for gender disaggregated data and analysis**
  Gender disaggregated data must be recorded in a standardised manner and routinely published and made available to researchers and individuals involved in the development, implementation and evaluation of HIV programmes and interventions. Gender disaggregated analysis should be incorporated on past, existing and future related health data. Such analysis will be useful to demonstrate how and why diseases affect women differently, the issue of the burden of disease, and the levels of access to women and men.

  Evidence gathered through examination of gender disaggregated data will be critical to assess and monitor the appropriateness of current responses and identify causal factors of discrimination and stigma. A better understanding of these issues are crucial to develop a more tailored and effective approach to the provision of HIV prevention, care and support in women and men.

- **More social science research to examine HIV related vulnerabilities and risk**
  More social science research is necessary understand the decisions and choices concerning vulnerabilities and risk. Research in this area will allow for evidence based interventions which respond to strengths and weaknesses in existing HIV prevention, care and treatment programmes. Findings from such research can be used to ascertain and respond to gaps and barriers such as sexual discrimination in the delivery of services, particularly in the area of HIV prevention.

  Many gaps continue to exist in our understanding of the dynamics of the HIV epidemic in Malaysia, particularly those concerning heterosexual transmission, women of marginalised communities and the effectiveness of existing interventions.

## VII. Support from the country's development partners

The Malaysian UN Theme Group (UNTG) on HIV/AIDS provides joint UN support for collaboration through close partnership with all key stakeholders in Malaysia. The Malaysian UNTG is currently chaired by the United Nations Population Fund (UNFPA) and comprises representatives from the United Nations Development Fund (UNDP), the World Health Organisation (WHO), the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF).

UNDP has been involved and concerned with measuring the impact of HIV and AIDS on national development for many years. It continues to provide the evidence for supporting multisectoral policy changes. UNDP was instrumental in supporting the "Islam and HIV/AIDS" project in 2001-2005 and responsible for the provision of the necessary funds as well as necessary technical support.

UNICEF has been an active partner in the Government's Harm Reduction intervention which comprise of the NSEP and MMT programmes targeted at IDUs, since the very beginning. UNICEF has also worked in partnership with the Government to enhance collaboration between law enforcement and other arms of Government to ensure the Harm Reduction initiative is supported by complementary policy frameworks and operating procedures. It also works with the Ministry of Health and Ministry of Education on issues of HIV and AIDS through its involvement in the PROSTAR programme as well as the piloting of the Life Skills based education module, assisting the government in evaluating PMTCT programme and supporting the first National AIDS Conference.

WHO has been a strong partner in strengthening the national surveillance capacity.[55] Regarding efforts to halt the spread of HIV within the country contexts, WHO has helped to carry out a broad range of effective approaches in STI management, includes strengthening of epidemiological surveillance including through its involvement in the first Behavioural Surveillance Survey in 2004.

UNFPA's HIV and AIDS involvement in Malaysia continues to be through the issue of young people and sexual reproductive health. Its projects are frequently implemented by the Federation of Family Planning Associations, Malaysia (FFPAM), which aims at improving the capability of young men and women in project areas in protecting themselves from HIV and STIs as well as improving the capacity of educators including young people in affecting behavioural change towards HIV and STI prevention among young people

UNHCR continues to provide limited support in the area of HIV and AIDS to asylum seekers and refugees.

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

## VIII. Monitoring and evaluation environment

As part of the National Strategic Plan on HIV/AIDS 2006-2010, the country now has a preliminary national Monitoring and Evaluation (M&E) plan covering the duration of the NSP. The M&E plan was developed in consultation with civil society organisation which was represented by the Malaysian AIDS Council.

Despite not having a dedicated M&E unit or department based within the HIV and AIDS framework of the Ministry of Health, a budget currently exists which goes towards the development of the M&E plan's various components:

- A data collection and analysis strategy
- HIV surveillance
- Well defined and standardised set of indicators
- A data dissemination and use strategy

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 a 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.

Nevertheless, there is a M&E working group, in place of a department, which meets regularly to coordinate national M&E activities. 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, conveyed and responded to.

As the main coordinator of NGOs and CBOSs responding to HIV, MAC is provided with a RM 4 million (USD 1.2 million) government grant for 10 years which the institution is tasked to disperse to 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.
- The current HIV data reporting framework utilised in Malaysia are incompatible to those used for the measurement of UNGASS as well as 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. M&E capabilities remain generally poor in both Government and non-government sectors.

# ANNEX 1: Consultation/preparation process for the Country Progress Report on monitoring the progress towards the implementation of 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, Higher Education, Information | **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: Datuk Dr. Hasan Abdul Rahman, Director
Disease Control Division, Ministry of Health, Malaysia

Date: 25 January 2008

Signature: ____________________ 28/01/08

Please provide full contact information:

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# ANNEX 2

## National Composite Policy Index Questionnaire

- **Part A**
- **Part B**

# NATIONAL COMPOSITE POLICY INDEX 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 1.3)

| **Yes** | No | Not Applicable (N/A) | Period covered: **2006 - 2010** |
|---|---|---|---|

| IF NO or N/A, briefly explain why<br><br>NOT APPLICABLE |
|---|

***IF YES,* complete questions 1.1 through 1.10; otherwise, go to question 2.**

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

Number of Years: **10 years**

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

| Sectors included | Strategy / Action framework | | 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 | **Yes** | No | **Yes** | No |
| Young people | **Yes** | No | **Yes** | No |
| Other*: | | | | |
| National Service | **Yes** | No | **Yes** | No |
| Dept. of Islamic Development Malaysia | **Yes** | No | **Yes** | No |
| National Anti-Drug Agency | **Yes** | No | **Yes** | No |
| Ministry of Housing & Local Gov. | 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,* ***how is the money allocated?***

NOT APPLICABLE

1.3 Does the multi-sectoral strategy/action framework 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. Specific vulnerable sub- populations[56] | **Yes** | No |
| d. Orphans and other vulnerable children | **Yes** | No |
| **Settings** | | |
| e. Workplace | **Yes** | No |
| f. Schools | Yes | **No** |
| g. Prisons | **Yes** | No |
| **Cross-cutting issues** | | |
| h. HIV/AIDS and poverty | **Yes** | No |
| i. Human rights protection | **Yes** | No |
| j. PLHIV involvement | **Yes** | No |
| k. Addressing stigma and discrimination | **Yes** | No |
| l. Gender empowerment and/or gender equality | Yes | **No** |

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

| | |
|---|---|
| **Yes** | No |

***IF YES***, when was this needs assessment /analysis conducted? Year: **2004**

*IF NO,* ***how were target populations identified?***

NOT APPLICABLE

[56] Sub-populations that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.5 What are the target populations in the country?

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

1.6 Does the multi-sectoral strategy/action framework include an operational plan?

| **Yes** (selected) | No |
|---|---|

1.7 Does the multi-sectoral strategy/action framework or operational plan include:

| | | |
|---|---|---|
| a. Formal programme goals? | **Yes** (selected) | No |
| b. Clear targets and/or milestones? | **Yes** (selected) | No |
| c. Detailed budget of costs per programmatic area? | **Yes** (selected) | No |
| d. Indications of funding sources? | **Yes** (selected) | No |
| e. Monitoring and Evaluation framework? | **Yes** (selected) | No |

1.8 Has the country ensured "full involvement and participation" of civil society[57] in the development of the multi-sectoral strategy/action framework?

| **Active involvement** (selected) | 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 the development, key civil society representatives were also involved and participated in the drafting of the National Strategic Plan (NSP). 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.

IF NO or MODERATE involvement, **briefly explain :**
NOT APPLICABLE

[57] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

1.9 Has the multi-sectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

| **Yes** (selected) | No |
|---|---|

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multi-sectoral strategy/action framework?

| Yes, all partners | **Yes, some partners** (selected) | No |
|---|---|---|

*IF SOME or NO*, ***briefly explain***

The **Expanded 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), 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 similar support from its Bangkok regional office.

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 and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?**

| **Yes** (selected) | No | N/A |
|---|---|---|

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

**a.) 9th Malaysia Plan (2006 – 2010)**
**b.) National Youth Action Plan**
**c.) National Health Policy**
**d.) National Adolescent Policy**

2.2 ***IF YES***, which policy areas below are included in these development plans?

✓ Check for policy/strategy included

| **Policy Area** | **Development Plans** | | | | |
|---|---|---|---|---|---|
| | **a)** | **b)** | **c)** | **d)** | **e)** |
| HIV Prevention | ✓ | | ✓ | ✓ | |
| Treatment for opportunistic infections | ✓ | | ✓ | | |
| Antiretroviral therapy | ✓ | ✓ | ✓ | | |
| Care and support (including social security or other schemes) | ✓ | | ✓ | | |

| | | | | | |
|---|---|---|---|---|---|
| HIV/AIDS impact alleviation | ✓ | | | | |
| Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support | | | | | |
| Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support | | | | | |
| Reduction of stigma and discrimination | ✓ | | | | |
| Women's economic empowerment (e.g. access to credit, access to land, training) | ✓ | | | | |
| Other: [write in] | | | | | |

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

| **Yes** (selected) | 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/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

| **Yes** (selected) | No |
|---|---|

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

| | | |
|---|---|---|
| Behavioural change communication | **Yes** (selected) | No |
| Condom provision | Yes | **No** (selected) |
| HIV testing and counselling* | **Yes** (selected) | No |
| STI services | **Yes** (selected) | No |
| Treatment | **Yes** (selected) | No |
| Care and support | **Yes** (selected) | No |
| Others: *[write in]* | Yes | No |

** What is the approach taken to HIV testing and counselling?* ***Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:***

- New military recruits undergo a mandatory health screening, which includes for HIV, upon enrolment.
- Any new 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.

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

| Yes | No |
|---|---|

5.1 Has the National Strategic Plan/operational plan and national HIV/AIDS budget been revised accordingly?

| Yes | No |
|---|---|

5.2 Have the estimates of the size of the main target population sub-groups been updated?

| Yes | No |
|---|---|

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

| Estimates and projected needs | Estimates only | No |
|---|---|---|

5.4 Is HIV and AIDS 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 sub-groups?

| Yes | No |
|---|---|

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

- Injecting drug users
- Women
- Young people
- Children
- People Living With HIV
- Commercial sex workers

(c) Is coverage monitored by geographical area?

| Yes | No |
|---|---|

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

- District
- State
- National

5.5 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 and AIDS programmes in 2007 and in 2005? | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | Poor | | | | | | | | | | Good | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 | |
| 2005 | Poor | | | | | | | | | | Good | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | **7** | 8 | 9 | 10 | |

*Comments on progress made since 2005:*

The development of the National Strategic Plan on HIV/AIDS (2006-2010) heralded a strong commitment from the government to address the sole unfulfilled Millennium Development Goal related to HIV and AIDS (MDG 6). Prior to the inception of the NSP, less than USD 10 million per annum was allocated by the Government to the HIV and AIDS response. A three-fold increase in this allocation, now more than USD 30 million per annum, has been made available to both government agencies and civil society organisations for the next five years in support of the implementation of the NSP. This commitment of USD 150 million signals a new priority and urgency on the part of the Government.

The existence of NSP Strategy 3 & 6 is highly significant:

- *Strategy 3 – Reducing HIV vulnerability among IDUs and their partners*
  Recognises the need and role of the Harm Reduction programmes (Needle Syringe Exchange Programme & Methadone Maintenance Therapy)

- *Strategy 5 – Reducing HIV vulnerability among marginalised and vulnerable groups*
  Recognises the existence of key most-at-risk populations (e.g. sex workers, MSM, transsexuals, refugees, legal and illegal migrants)

## II. Political support

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

**1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora 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 multi-sectoral HIV/AIDS management / coordination body? (National AIDS Council or equivalent)?**

| | |
|---|---|
| **Yes** | No |

*IF NO*, ***briefly explain:***

NOT APPLICABLE

2.1 ***IF YES***, when was it created? Year: **2005**

2.2 ***IF YES***, who is the Chair? **Datuk Sri Mohd Najib Tun Razak (Deputy Prime Minister of Malaysia)**

2.3 ***IF YES***, does it:

| | | |
|---|---|---|
| • have terms of reference? | **Yes** | No |
| • have active Government leadership and participation? | **Yes** | No |
| • have a defined membership? | **Yes** | No |
| • include civil society representatives? | Yes | **No** |
| o IF YES, what percentage? | | |
| • include people living with HIV? | **Yes** | No |
| • 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 national HIV/AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?**

| Yes | No |
|---|---|

3.1 ***IF YES***, does it include?

| | | |
|---|---|---|
| Terms of reference | Yes | No |
| Defined membership | Yes | No |
| Action plan | Yes | No |
| Functional Secretariat | Yes | No |
| Regular meetings | Yes | No |
| | **Freq. of meetings:** | |

*IF YES, what are the main achievements?*

The Malaysian AIDS Council (MAC) has, for the past 15 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 limited technical capacity available at the Malaysian AIDS Council and high staff turnover threaten the institutional capacity of this crucial institution and restricts its ability to contribute, particularly in policy development.
- The MAC has an outstretched secretariat which is tasked to do multiple functions across a wide range of programmatic issues (from implementing the pilot harm reduction programme to the monitoring of a RM 4 million (USD 1.2 million) government grant).
- No assessment has been done to measure the impact and effectiveness of interventions led by the MAC despite being in operation for 15 years. Programmes are tied and determined by available grant money.

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

Percentage: **15 – 20% in 2007**

**5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?**

| | | |
|---|---|---|
| • Information on priority needs and services | **Yes** | No |
| • Technical guidance/materials | **Yes** | No |
| • Drugs/supplies procurement and distribution | **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), RM4 million grant) to civil society organisations

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

| | |
|---|---|
| **Yes** | No |

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

| | |
|---|---|
| **Yes** | No |

6.2 ***IF YES***, which policies and legislation were amended and when?

- Prevention and Control of Infectious Diseases Act 1988 (ACT 342) Year: 2007

| Overall, how would you rate the political support for the HIV/AIDS programme in 2007 and in 2005? | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | Poor | | | | | | | | | | Good | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | **9** | 10 | |
| 2005 | Poor | | | | | | | | | | Good | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | **7** | 8 | 9 | 10 | |

Comments on progress made since 2005:

- The level of political involvement in the issue of HIV and AIDS has shifted from the Minister of Health to the highest levels of Government with the Deputy Prime Minister as the Chair of the Cabinet Committee on AIDS.
- The Prime Minister has publicly expressed his concern and his administration's commitment to address the challenge of the remaining MDG.
- The Government has provided the highest political public support and coverage for the Harm Reduction pilot programmes (NSEP & MMT) to overcome popular opposition due to the controversial nature of the interventions.

## III. Prevention

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

| **Yes** | No | N/A |
|---|---|---|

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

✓ Check for key message explicitly promoted

| Key message | |
|---|---|
| Be sexually abstinent | ✓ |
| Delay sexual debut | ✓ |
| Be faithful | ✓ |
| Reduce the number of sexual partners | |
| Use condoms consistently | |
| Engage in safe(r) sex | |
| Avoid commercial sex | ✓ |
| Abstain from injecting drugs | ✓ |
| Use clean needles and syringes | ✓ |
| Fight against violence against women | ✓ |
| Greater acceptance and involvement of people living with HIV | ✓ |
| Greater involvement of men in reproductive health programmes | ✓ |
| Other:<br>• Needle and syringe exchange | ✓ |

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

| **Yes** | No |
|---|---|

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

| **Yes** | No |
|---|---|

2.1 Is HIV education part of the curriculum in

| | Yes | No |
|---|---|---|
| • 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 <u>for vulnerable sub-populations</u>?**

| **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 for policy/strategy included

| | IDU | MSM | Sex workers | Clients of sex workers | Prison inmates | Other sub-pop* |
|---|---|---|---|---|---|---|
| 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 | |
| Needle & syringe exchange | ✓ | N/A | N/A | N/A | N/A | |

| Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005? | | |
|---|---|---|
| 2007 | Poor | Good |
| | 0 1 2 3 4 5 6 **[7]** 8 9 10 | |
| 2005 | Poor | Good |
| | 0 1 2 3 4 **[5]** 6 7 8 9 10 | |

Comments on progress made since 2005:

- 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.

**4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?**

| **Yes** (selected) | No |
|---|---|

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

NOT APPLICABLE

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

| HIV prevention programmes | The activity is available in | | |
|---|---|---|---|
| | all districts* in need | most districts* in need | some districts* in need |
| Blood safety | ✓ | N/A | N/A |
| Universal precautions in health care settings | ✓ | N/A | N/A |
| Prevention of mother-to-child transmission of HIV | ✓ | N/A | N/A |
| IEC on risk reduction | ✓ | N/A | N/A |
| IEC on stigma and discrimination reduction | ✓ | N/A | N/A |
| Condom promotion | N/A | N/A | N/A |
| HIV testing & counselling | ✓ | N/A | N/A |

| | | | |
|---|---|---|---|
| Harm reduction for injecting drug users | N/A | N/A | ✓ |
| Risk reduction for men who have sex with men | N/A | N/A | ✓ |
| Risk reduction for sex workers | N/A | N/A | ✓ |
| Programmes for other vulnerable sub-populations | N/A | N/A | ✓ |
| Reproductive health services including STI prevention & treatment | ✓ | N/A | N/A |
| School-based AIDS education for young people | ✓ | N/A | N/A |
| Programmes for out-of-school young people | ✓ | N/A | N/A |
| HIV prevention in the workplace | ✓ | N/A | N/A |
| Other:<br>• Faith-based interventions | ✓ | N/A | N/A |

*Districts or equivalent geographical/de-centralized level in urban and rural areas

| Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005? | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | Poor | | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 | |
| 2005 | Poor | | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | 10 | |

Comments on progress made since 2005:

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 complacent reliance on NGOs and CBOS to fill in the shortcomings in Government initiatives.

Prevention efforts were boosted by the existence of the Needle and Syringe Exchange Programme and the involvement of CBOs in its implementation.

## IV. Treatment, care and support

1. **Does the country have a policy or strategy to promote comprehensive HIV/AIDS 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** (selected) | No |
|---|---|

1.1 ***IF YES***, does it give sufficient attention to barriers for women, children and most-at-risk populations?

| **Yes** (selected) | No |
|---|---|

2. **Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

| **Yes** (selected) | No | N/A |
|---|---|---|

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

NOT APPLICABLE

***IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?**

- ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

| HIV and AIDS treatment, care and support services | The service is available in | | |
|---|---|---|---|
| | all districts* in need | most districts* in need | some districts* in need |
| Antiretroviral therapy | ✓ | N/A | N/A |
| Nutritional care | ✓ | N/A | N/A |
| Paediatric AIDS treatment | N/A | ✓ | N/A |
| Sexually transmitted infection management | ✓ | N/A | N/A |
| Psychosocial support for people living with HIV and their families | N/A | N/A | ✓ |
| Home-based care | N/A | N/A | ✓ |
| Palliative care and treatment of common HIV-related infections | N/A | ✓ | N/A |
| HIV testing and counselling for TB patients | ✓ | N/A | N/A |
| TB screening for HIV-infected people | ✓ | N/A | N/A |
| TB preventive therapy for HIV-infected people | ✓ | N/A | N/A |

| | | | |
|---|---|---|---|
| TB infection control in HIV treatment and care facilities | N/A | ✓ | N/A |
| Cotrimoxazole prophylaxis in HIV-infected people | ✓ | N/A | N/A |
| Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape) | N/A | N/A | ✓ |
| HIV treatment services in the workplace or treatment referral systems through the workplace | ✓ | N/A | N/A |
| HIV care and support in the workplace (including alternative working arrangements) | ✓ | N/A | N/A |
| Other programmes: | N/A | N/A | N/A |

*Districts or equivalent de-centralized governmental level in urban and rural areas

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

| Yes (selected) | No |
|---|---|

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

| Yes | No (selected) |
|---|---|

4.1 *IF YES*, for which commodities?:

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

| Yes | No (selected) | 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 needs of orphans and other vulnerable children? |
|---|
| 2007 Poor 0 1 2 3 4 **[5]** 6 7 8 9 10 Good |
| 2005 Poor 0 1 2 3 4 **[5]** 6 7 8 9 10 Good |
| Comments on progress made since 2005: |

## V. MONITORING AND EVALUATION

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

| **Yes** | Years covered: **2006 – 2010** | In progress | No |
|---|---|---|---|

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

| **Yes** | No |
|---|---|

1.2. Was the M&E plan developed in consultation with civil society, including people living with HIV?

| **Yes** | No |
|---|---|

1.3. 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 |
|---|---|---|---|

**2. Does the Monitoring and Evaluation plan include?**

| | | |
|---|---|---|
| a data collection and analysis strategy | **Yes** | No |
| behavioural surveillance | Yes | **No** |
| HIV surveillance | **Yes** | No |
| a well-defined standardized set of indicators | **Yes** | No |
| guidelines on tools for data collection | Yes | **No** |
| a strategy for assessing quality and accuracy of data | Yes | **No** |
| a data dissemination and use strategy | **Yes** | No |

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

| **Yes** | Years covered: **2006 – 2010** | In progress | No |
|---|---|---|---|

3.1 *IF YES*, has funding been secured?

| **Yes** | No |
|---|---|

**4. 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/Department?

- 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.
- There exists resistance within management to establish a separate M&E department. The belief being that M&E having already being integrated into programmes defeats the purpose of having a separate body to conduct and monitor M&E.

4.1 ***IF YES***, is the M&E Unit/Department based

| in the NAC (or equivalent)? | Yes | No |
|---|---|---|
| in the Ministry of Health? | Yes | No |
| elsewhere? | | |

4.2 ***IF YES,*** how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

| 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 permanent staff: | |
|---|---|

4.3 ***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/Department for review and consideration in the country's national reports?

| Yes | No |
|---|---|

*IF YES, does this mechanism work? What are the major challenges?*

NOT APPLICABLE

4.4 ***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 |

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

| No | Yes, but meets irregularly | Yes, meets regularly |
|---|---|---|

*IF YES, Date last meeting:* **16 November 2008**

5.1 Does it include representation from civil society, including people living with HIV?

| **Yes** | No |
|---|---|

*IF YES, describe the role of civil society representatives and people living with HIV in the working group?*

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 a RM 4 million ( USD 1.2 million) government grant 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.

**6. Does the M&E Unit/Department manage a central national database?**

| Yes | No | **N/A** |
|---|---|---|

6.1 IF YES, what type is it? **Programme based database**

6.2 IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

| **Yes** | No |
|---|---|

6.3 Is there a functional* Health Information System?

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

6.4 Does the country publish at least once a year an M&E report on HIV/AIDS, including HIV surveillance data?

| **Yes** | No |
|---|---|

**7. To what extent is M&E data used in planning and implementation?**

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

| *What are examples of data use?*<br><br>• 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.<br><br>• 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.<br><br>• The use of M&E data also allowed for the introduction of a nationwide anonymous HIV testing programme. |
|---|
| *What are the main challenges to data use?*<br><br>• Bridging the gap between the analysis and understanding of data and the formulation of effective programmes and policies in response. |

**8. In the last year, was training in M&E conducted**

| At national level? | Yes | **No** (selected) |
|---|---|---|
| IF YES, Number of individuals trained: *[write in]* | | |
| At sub-national level? | Yes | **No** (selected) |
| IF YES, Number of individuals trained: *[write in]* | | |
| Including civil society | **Yes** (selected) | No |
| IF YES, Number of individuals trained: **2** | | |

| Overall, how would you rate the M&E efforts of the HIV/AIDS programme in 2007 and in 2005? | | |
|---|---|---|
| 2007 | Poor | Good |
| | 0 1 2 3 **[4]** 5 6 7 8 9 10 | |
| 2005 | Poor | Good |
| | 0 **[1]** 2 3 4 5 6 7 8 9 10 | |

Comments on progress made since 2005:

- There has been discussion and planning leading to the development of preliminary monitoring and evaluation indicators.
- Workshops to establish common indicators which are linked to the NSP have been organised.
- However, a common M&E framework has yet to be agreed upon and finalised.

# NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

## PART B
[to be administered to representatives from nongovernmental organizations]

## I. HUMAN RIGHTS

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

| Yes | **No** (selected) |
|---|---|

1.1 ***IF YES****, specify:*

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

| **Yes** (selected) | No |
|---|---|

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

| Sub-population | Yes | No |
|---|---|---|
| Women | **Yes** (selected) | No |
| Young people | **Yes** (selected) | No |
| IDU | Yes | **No** (selected) |
| MSM | Yes | **No** (selected) |
| Sex workers | Yes | **No** (selected) |
| Prison inmates | Yes | **No** (selected) |
| Migrants/ mobile populations | Yes | **No** (selected) |
| 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 sub-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.

Existing monitoring mechanisms in place, are strictly dependent on NGO involvement and participation and, at times, leadership of a particular issue.

***IF YES,*** Describe any systems of redress put in place to ensure the laws are having their desired effect:

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 vulnerable sub-populations?**

| Yes | No |
|---|---|

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

| | | |
|---|---|---|
| Women | Yes | No |
| Young people | Yes | No |
| IDU | Yes | No |
| MSM | Yes | No |
| Sex workers | Yes | No |
| Prison inmates | Yes | No |
| Migrants/ mobile populations | Yes | No |
| Other: [write in] | | |

***IF YES,*** briefly describe the content of these laws, regulations or policies and how they pose barriers:

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.

The carrying of condoms itself may subject individuals to accusations of soliciting for sex

or being branded a sex worker. Though no specific legislation exists which prohibit the use and carrying of condoms, such items could be used as evidence to prosecute people accused of being sex workers or having illicit sex.

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.

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.

For transsexuals, prosecution of individuals for cross dressing and 'indecent behaviour' under Syariah and Civil Law results in them being hard to identify and for HIV prevention work to be further complicated.

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

| Yes | No |
|---|---|

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

| 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 record and documentation of such cases. 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 for redress by PLHIV and MARPs within the context of the working environment.

However, the reality is that if a person who is living with HIV suffers discrimination as a result of stigma, it is 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.

**6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?**

| Yes | No | N/A |
|---|---|---|

*IF YES*, describe some examples

The last two years have seen tremendous efforts to involve 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 play an active role in the design, implementation and monitoring of interventions. The Malaysian AIDS Council is also currently maintaining a desk in the Secretariat dealing specifically on issues pertaining to the marginalised and most-at-risk populations.

Financial support has also been provided for the implementation and execution of programmes related to MSMs, SWs, IDU, transsexuals, etc.

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

| | | |
|---|---|---|
| HIV prevention services | Yes | No |
| Anti-retroviral treatment | Yes | No |
| HIV-related care and support interventions | Yes | No |

*IF YES*, given resource constraints, briefly describe what steps are in place to implement these policies:

- Hospices and recovery facilities are being made available to cater to the increasing number of people with AIDS.
- A multisectoral approach for HIV prevention is being promoted between government ministries and the United Nations.
- Free first line treatment for ART is being made widely available at government hospitals & health centres.
- A multisectoral response utilising a faith-based approach is being called for to address the increasing burden of the epidemic.

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

| **Yes** | No |
|---|---|

9.1 Are there differences in approaches for different most-at-risk populations?

| **Yes** | No |
|---|---|

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

- For IDUs – addressing mainly drug addiction issues, harm reduction and treatment.
- Marginalised groups such as transsexuals – are reached via outreach programmes to enable access to prevention services.
- Prison inmates – are given access to treatment and referrals for counselling.
- 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/AIDS 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***

NOT APPLICABLE

**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 and AIDS-related issues within their work

  **Yes** (selected) | 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** (selected)

- Performance indicators or benchmarks for

  a) compliance with human rights standards in the context of HIV/AIDS efforts

  Yes | **No** (selected)

  b) reduction of HIV-related stigma and discrimination

  Yes | **No** (selected)

*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.
- Bar Council – The Legal Aid facility is able to consider HIV and AIDS cases as part of its portfolio. These Issues are linked discrimination.

**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** (selected)

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

- Legal aid systems for HIV and AIDS casework

  **Yes** (selected) | No

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

  Yes | **No** (selected)

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

  **Yes** (selected) | No

**15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?**

| **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 and AIDS in 2007 and in 2005?

| Year | Poor | | | | | | | | | | Good |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | 0 | 1 | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | **2** | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Comments on progress made since 2005:

- The National Strategic Plan on HIV/AIDS 2006-2010 is now available and being implemented. Issues of stigma, discrimination and human rights linked to HIV and AIDS are clearly spelt out and have already been identified as being of concern and needing response.
- Efforts are being made to reach out to marginalised communities to understand their needs and issues, particularly those which are hard to reach and whose behaviours have been criminalised (e.g. sex workers, MSM)
- More government funding has been made available for specific programmes to deal with human rights and HIV issues.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005?

| Year | Poor | | | | | | | | | | Good |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | 0 | 1 | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | 10 |
| 2005 | 0 | **1** | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Comments on progress made since 2005:

- The National Strategic Plan on HIV/AIDS 2006-2010 is now available and being implemented. Issues of stigma, discrimination and human rights linked to HIV and AIDS are clearly spelt out and have already been identified as being of concern and needing response.
- Efforts are being made to reach out to marginalised communities to understand their needs and issues, particularly those which are hard to reach and whose behaviours have been criminalised (e.g. sex workers, MSM)
- More government funding has been made available for specific programmes to deal with human rights and HIV issues.

## II. CIVIL SOCIETY[58] PARTICIPATION

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

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

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

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

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

a. in both the National Strategic plans and national reports?

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

b. in the national budget?

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

**4. Has the country included civil society in a National Review of the National Strategic Plan?**

| Yes | No | **N/A** |
|---|---|---|

***IF YES***, when was the Review conducted? Year: *[write in]*

**5. To what extent is the civil society sector representation in HIV/AIDS efforts inclusive of its diversity?**

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

List the types of organizations representing civil society in HIV and AIDS efforts:

- Organisation of people living with HIV
- Women's organizations
- Youth organizations
- Faith-based organizations
- Lawyers Council

[58] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

- Community-based organizations
- Organizations of 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 |

Selected: **2**

| Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005? | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | Poor | | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | **7** | 8 | 9 | 10 | |
| 2005 | Poor | | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 | |

Comments on progress made since 2005:

- The National Strategic Plan on HIV/AIDS 2006-2010 was developed in partnership with civil society organisations.
- Through the advocacy of CSOs and with government support and endorsement, more funds were allocated and made available.
- More resources were made available to organisations working with MARPs.
- Closer and improved collaboration with the Ministry of Health and civil society
- Increased empowerment of civil society organisations to do more innovative and sustainable interventions.

## III. PREVENTION

**1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?**

| **Yes** | No |
|---|---|

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

NOT APPLICABLE

***IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

| HIV prevention programmes | The activity is available in | | |
|---|---|---|---|
| | all districts* in need | most districts* in need | some districts* in need |
| Blood safety | X | | |
| Universal precautions in health care settings | X | | |
| Prevention of mother-to-child transmission of HIV | | X | |
| IEC on risk reduction | | X | |
| IEC on stigma and discrimination reduction | | | X |
| Condom promotion | | | X |
| HIV testing & counselling | | X | |
| Harm reduction for injecting drug users | | | X |
| Risk reduction for men who have sex with men | | | X |
| Risk reduction for sex workers | | | X |
| Programmes for other most-at-risk populations | | | X |
| Reproductive health services including STI prevention & treatment | | X | |

| | | | |
|---|---|---|---|
| School-based AIDS education for young people | | X | |
| Programmes for out-of-school young people | | | X |
| HIV prevention in the workplace | | | X |
| Other [write in] | | | |

**Districts or equivalent geographical/de-centralized level in urban and rural areas*

| Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005? | | |
|---|---|---|
| 2007 | Poor | Good |
| | 0 1 2 3 4 **5** 6 7 8 9 10 | |
| 2005 | Poor | Good |
| | 0 1 2 3 **4** 5 6 7 8 9 10 | |

Comments on progress made since 2005:

- The number of HIV and AIDS programmes in both the Government and non-government sectors have increased due to greater availability of funds.
- The implementation of the NSEP intervention among injecting drug users has begun and will soon be scaled up.

## IV. TREATMENT, CARE AND SUPPORT

**1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

| Yes (selected) | No |
|---|---|

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

NOT APPLICABLE

***IF YES,*** **To what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?**

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

| HIV and AIDS treatment, care and support services | The service is available in | | |
|---|---|---|---|
| | *all* districts* in need | *most* districts* in need | *some* districts* in need |
| Antiretroviral therapy | ✓ | N/A | N/A |
| Nutritional care | N/A | ✓ | N/A |
| Paediatric AIDS treatment | N/A | ✓ | N/A |
| Sexually transmitted infection management | ✓ | N/A | N/A |
| Psychosocial support for people living with HIV and their families | N/A | N/A | ✓ |
| Home-based care | N/A | N/A | ✓ |
| Palliative care and treatment of common HIV-related infections | N/A | ✓ | N/A |
| HIV testing and counselling for TB patients | ✓ | N/A | N/A |
| TB screening for HIV-infected people | ✓ | N/A | N/A |
| TB preventive therapy for HIV-infected people | N/A | N/A | ✓ |
| TB infection control in HIV treatment and care facilities | N/A | N/A | ✓ |
| Cotrimoxazole prophylaxis in HIV-infected people | ✓ | N/A | N/A |
| Post-exposure prophylaxis (e.g., occupational exposures to HIV, rape) | N/A | ✓ | N/A |

| | | | |
|---|---|---|---|
| HIV treatment services in the workplace or treatment referral systems through the workplace | N/A | N/A | ✓ |
| HIV care and support in the workplace (including alternative working arrangements) | N/A | N/A | ✓ |
| Other programmes: *[write in]*<br>• Orphanages (both +ve and affected children) | N/A | N/A | ✓ |

**Districts or equivalent de-centralized governmental level in urban and rural areas*

| Overall, how would you rate the efforts in the implementation of HIV and AIDS treatment, care and support programmes in 2007 and in 2005? |
|---|
| 2007 Poor … Good |
| 0 1 2 3 4 5 **6** 7 8 9 10 |
| 2005 Poor … Good |
| 0 1 2 3 4 5 **6** 7 8 9 10 |
| Comments on progress made since 2005:<br><br>Marginal progress whereupon government hospitals have experienced significant improvements. However, gap remains among private sector medical centres which are not totally compliant and participating in HIV and AIDS programmes. |

**2. What percentage of the following HIV and AIDS programmes/services is estimated to be provided by civil society?**

| | | | | |
|---|---|---|---|---|
| **Prevention for youth** | <25% | 25-50% | 50-75% | **>75%** |
| **Prevention for vulnerable sub-populations** | | | | |
| - **IDU** | <25% | 25-50% | 50-75% | **>75%** |
| - **MSM** | <25% | 25-50% | 50-75% | **>75%** |
| - **Sex workers** | <25% | 25-50% | 50-75% | **>75%** |
| **Counselling and Testing** | **<25%** | 25-50% | 50-75% | >75% |
| **Clinical services (OI/ART)*** | **<25%** | 25-50% | 50-75% | >75% |
| **Home-based care** | <25% | 25-50% | 50-75% | **>75%** |
| **Programmes for OVC**** | <25% | 25-50% | 50-75% | **>75%** |

*OI Opportunistic infections; **OVC Orphans and other vulnerable children

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

| 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]*