Scaling Up Towards Universal Access to Prevention, Treatment, and Care and Support

MALAYSIA

Report of a consultative meeting facilitated by UNDP

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Acronyms

ARV	Anti-Retroviral therapy
ASEAN	Association of South East Asian Nations
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
DOSH	Department of Occupational Health and Safety
EPU	Economic Planning Unit
FFPAM	Federation of Family Planning Associations of Malaysia
FMS	Family Medicine Specialist
GIPA	Greater Involvement of Persons with AIDS
HAART	Highly Active Acute Retroviral Therapy
HMIS	Health Management Information System
IDU	Intravenous Drug Use/User
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MAC	Malaysian AIDS Council
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSM	Men having Sex with Men
NACA	National Advisory Committee on AIDS
NGO	Non-Government Organisation
NSP	National Strategic Policy
OVC	Orphaned and vulnerable children
PCA	Prime Ministerial Committee on AIDS
PHC	Primary Health Care
PLWHAs	People Living With HIV AIDS
SWs	Sex Workers
TCA	Technical Committee on AIDS
UNAIDS	United Nations Programme on AIDS
UNGASS	United Nations General Assembly Special Session

Status of national response

There are 67,528 cumulative cases of HIV/AIDS reported in Malaysia up to June 2005[1]. For the last five years, the number of newly detected HIV cases has been at an average of 6000 to 6900 per year. Since the disease emerged in 1986, the profile of HIV infection has remained consistently driven by the injecting drug users (IDUs), male, young people aged 20-39 years and among the Malay ethnic group. While the highest HIV prevalence rate persists among the Injecting Drug Users, we are very concerned about the increasing trend of heterosexual transmission from 4.9% in 1990 to 19.8% in 2004 as well as the rising proportion of women infected with HIV from 1.2% to 10.8% respectively. Thus Malaysia faces many challenges not just in prevention but also in the treatment, care and support of those infected and affected with HIV/AIDS..

Malaysia responded promptly to the emergence of the first few cases of HIV/AIDS in 1986. The national response can be summarised as collaboration between Government and civil society with strong linkages to international agencies. Malaysia has demonstrated a commitment to HIV/AIDS as signatory to the Millennium Declaration on the MDGs (2000), the UNGASS Declaration of Commitment on HIV/AIDS (2001) and the ASEAN Declaration on HIV/AIDS (2001).

The Government has had the lead role in policy-making and programme implementation. A National AIDS Task Force comprising representatives from various public agencies and NGOs was set up in 1985 in response to the international concern over the epidemics in the West, and the first Plan of Action formulated in 1988. Thereafter, an Inter-Ministerial Cabinet Committee on AIDS was formed in 1992[a] and the National AIDS Task Force was replaced in 1993 with a (1) National Coordinating Committee on HIV/AIDS and (2) National Technical Committee on HIV/AIDS. Both these Committees are chaired by the MoH (Secretary-General and Director-General, respectively). A State Coordinating Committee responsible for the implementation and coordination of AIDS prevention and control activities at state level was set up in all 13 States. The first National Strategy Plan was adopted in 1998 and the fourth drafted in 2005 (NSP 2006-2010). In terms of preventive strategies, the Government has launched nation-wide campaigns and included HIV/AIDS information in the secondary school curriculum.

Civil society and private sector have contributed significantly to the national response on HIV/AIDS in terms of services (support, shelter, counselling, BCC, outreach, organising) and fund-raising. In 1992, the MoH initiated the formation of an umbrella body (MAC) to coordinate the HIV/AIDS works organized by various CBOs and NGOs, thus reflecting a closed partnership between Government and civil society in the fight against HIV/AIDS. NGOs and CBOs spearheaded actions on issues deemed sensitive for Government action, notably, providing preventive, care and support services including information, education and communication on HIV/AIDS and condom promotion to PWLHAs (most of whom are drug users), SWs, MSM, drug users, and foreign workers. Civil society and the Government were also proponents in promoting human rights *vis a vis* HIV/AIDS and, most recently, Harm Reduction measures for IDUs. In 2005, the

[a] Membership comprising Ministers from Education; Youth and Sports; National Unity and Social Development; Culture, Art and Tourism; Home Affairs; Rural Development; and the Prime Minister's Department for Islamic Affairs

MoH initiated two pilot programmes - (1) provision of clean needles and syringes and condoms programme implemented by MAC, and (2) substitution therapy programme.

Malaysia strongly advocates for multi-sectoral approach in its effort to fight the HIV/AIDS epidemic. The newly revised National Strategic Plan on HIV/AIDS 2006-2010 (draft)[2], provides stronger leadership framework by proposing the formation of a Cabinet Committee on HIV/AIDS chaired by the Deputy Prime Minister, in line with the second "Three Ones" principle[3], a National Advisory Committee on AIDS (NACA) chaired by the Minister of Health, and Technical Committee on AIDS (TCA) chaired by the Director-General of Health. Both the NACA and TCA are to have representation from Government and civil society members. With this highest level of commitment and leadership, we will jointly work to reverse the epidemic through the following actions;

1) Relieve the socio-economic impact of the epidemic
2) Reduce the vulnerability of people most at risk of HIV infection
3) Achieve agreed targets for the prevention of HIV infection
4) Ensure that care and support are available to people infected and affected by HIV/AIDS
5) Provide affordable and accessible preventive, diagnostic and curative commodities
6) Mobilize adequate financial and human resource

Major challenges

A consultative meeting with key stakeholders was convened in December 2005 whereby major challenges in reducing and halting HIV/AIDS in this country was shared. These challenges are summarised as follows[4]:

Expanding multi-sectoral action

HIV/AIDS should not be viewed as a mere health issue. Its social and economic impact requires instant impetus for a multi-sectoral response on HIV/AIDS prevention, treatment, care and support. As the government has limitations in reaching vulnerable communities, We need to further focus on inspiring non health sectors, the business, the private, and communities themselves to become the changing agents in the fight against HIV/AIDS. HIV/AIDS should be perceived as relevant to the scope of the National Anti-Drug Agency in relation to drug abuse, the Ministry of Education in relation to HIV/AIDS education, The Ministry of Labour in relation to HIV prevention in the work-place, Department of Social Welfare in relation to care and support programs, and the NGOs for their community-based works. Ranking HIV/AIDS as a priority issue in the Government agenda, is crucial for enhancing wider coordinated and accountable multi-sectoral action, and appropriate allocation of resources. An impact and cost-benefit analysis of HIV/AIDS is of great value for better planning, and expanding greater multi-sectoral commitment on the war against HIV/AIDS. Moral and religious values also have an important role to play. We should not omit these resources when it is now desperately needed.

Accessing funding and resource allocations

As a leading implementing agency, the Ministry of Health receives the most of government funding for HIV/AIDS preventive and curative programs. However, government fund to MAC, as a coordinating body of the local NGOs, has been significantly increased to further support community-based HIV/AIDS related activities. Nevertheless, as we come close to scaling-up our response, more financial and technical resources are needed to support additional partners from both civil societies, and non health sectors. More funding and technical supports are needed for HIV/AIDS program implementation, epidemiological and socio-economic research, needs assessment, cost-benefit analysis, HIV/AIDS surveillance, and program monitoring and evaluation.

As a middle-income nation with concentrated HIV prevalence status, Malaysia has been left out in the disbursement of international development assistance funds, such as the Global Fund on AIDS, and international sources of research funds. This is a serious drawback for our HIV/AIDS programmes, not only in terms of scaling up the response, but also in attracting qualified and experienced human resources for managing and implementing HIV/AIDS programmes.

Upgrading technical capabilities

Research and M&E

There is insufficient expertise and resources for the on-going research in programme development, M&E and cost-benefit analyses, more so for civil society organisations. Both GOs and NGOs need to develop this capability and institutionalise evidence-based practices.

All of the available surveillance data on HIV/AIDS is maintained by the MoH AIDS/STD Section which compiles data routinely through its HMIS, mandatory reporting and special surveys. As mentioned, this section needs to expand its technical expertise or establish collaboration with appropriate research institutions to better utilise HIV/AIDS data for formulating policies and programmes.

Healthcare capacity

The Government continues to increase the number of medical personnel specialised in HIV/AIDS patient management. These comprise Infectious Diseases specialists, General Practitioners, paediatricians, Family Medicine specialists and paramedics trained in HIV patient management. At the same time, the number of private healthcare sources of treatment is expected to increase. HIV patient management has been decentralised and integrated into government Primary Healthcare settings. However, although government healthcare manpower is continually being expanded, there is much need for other sources of healthcare and support, e.g., private medical sources, NGOs, to complement government actions in order to scale up treatment, care and support in line with the goals of Universal Access. Community-based care and support from NGOs/CBOs is an important aspect of continuing care, adherence to long-term treatments and scaling up treatment access.

The high cost of drugs (treatment, ARV, second-line, and substitution drugs), preventive devices (condoms, needles, syringes) and laboratory tests is another barrier to increasing access to treatment. Access to these commodities should not be restricted by trade and patent related issues. We very much hope that the global community will redress this inequity so that deaths resulting from AIDS, and its impact on families and societies will be lessened, if not altogether prevented.

Dispelling stigma and misconceptions

Various purposive sampled surveys have shown a relatively high level of knowledge on HIV and its modes of transmission among Malaysians but misconceptions and stigma remain pervasive. Unwittingly, the fact that HIV is relatively confined, at present, to selected high-risk groups fosters a widespread perception among Malaysians that they are not at risk as long as they and their partners are not under those high-risk categories, even if they have multiple partners or casual sex. Substance abuse and its progression to IDU, critically linked to HIV transmission in this country, have also not been controlled effectively. Despite awareness on HIV/AIDS, preventive behaviour remains poor. Recent Behaviour Surveillance Surveys, for example, have found that condom use is not common or consistent among users, and among high-risk groups.

More efforts are needed to raise awareness and change attitudes among Malaysians, and mobilise the influence of religious leaders and authorities, including Heads of State, in controlling HIV/AIDS and dispelling stigma and discrimination. Religious authorities in Malaysia need to view and direct attention and resources to substance abuse and HIV/AIDS.

Increasing participation of PLWHAs

There is a need for more PLWHAs to be actively involved in planning, and implementing outreach, DIC, and community works to effectively motivate access to treatment, care and support. For example, continuity rates of ARV treatment are higher when there are active support networks. PLWHAs are also needed to actively participate in planning and implementing advocacy programs to fight stigma and discrimination, and ensuring that PLWHAs will have full access to health, and social services. Any potential PLWHA should receive the necessary supports, to enable and empower them to ply an effective role in the universal access to HIV/AIDS related programs.

Harmonising public health interests in laws and regulations

There are certain laws and practices that hamper HIV prevention and control programmes, e.g., prohibitions by selected local city/town councils related to drug abuse and prostitution. Notably, elements of the Harm Reduction Programme initiated in 2005 (pilot stage) need to be harmonised with existing laws related to supply and demand reduction, viz., the Dangerous Drugs Act 1952, Poisons Act 1952, Dangerous Drugs Act 1985, 1988, Drug Dependents Act 1985, 1998. On the other hand, although the Code of Practice for the Prevention of HIV/AIDS in the Workplace has been developed by the MoH, DOSH, MAC and UNAIDS in 2001, yet it needs to be widely translated into action by all government and non government agencies including private and industrial sectors.

Solutions proposed to overcome major challenges

Measures to overcome some of the major constraints in Malaysia, described above, have been proposed in the recent NSP 2006. The NSP 2006 was the outcome of consultative processes, including key stakeholders from Government and civil society. The proposed solutions are summarised in Table A.

Table A
Major Challenges and Solutions towards Achieving Universal Access in Prevention, Treatment, Care and Support, Malaysia

Challenge	Proposed strategy
Expanding multi-sectoral action	Establish a re-organised National AIDS Authority (NAA) comprising by 2007: (i) Prime Ministerial Committee chaired by the Deputy Prime Minister, (ii) National Advisory Committee on AIDS (NACA) chaired by the Minister of Health, (iii) Technical Committee on AIDS (TCA)[b] chaired by the Director-General of Health. The NAA will be responsible for overall coordination, policy analysis and advocacy, M&E and reporting, maintaining linkages with state and district authorities, and facilitating information-sharing among committees
Increasing funding	Increase request for funding from central budgetary allocation. grants from Foundations, business sector, UN agencies and bilateral donors
Collaboration to reduce cost of commodities	On-going price negotiations with request for regional-level mediations
Enhancing research capabilities	1. Set up a Surveillance Unit within the NAA which will operate a nation-wide surveillance network with participating hospitals, existing epidemiological centres and/or academic institutions (Network Collaborating Partners). The surveillance activities will be an expansion of current programmes of: (i) case-based, (ii) serum-based, (iii) BSS, (iv) STI surveillance. A priority is to narrow the gaps in epidemiological data and seek assistance to improve surveillance systems and diagnostic services 2. Develop social and behavioural research as basis for programme design and interventions and establish research partnerships with proven institutions and overseas research consortiums
Strengthening M&E	Develop key indicators in line with UNGASS/MDG framework by all implementing partners and institute a routine reporting system for targets and outcomes of interventions
Expanding healthcare capacity (with increased access)	On-going training of clinical manpower and plans to increase training of multipliers such as health professionals, outreach workers, peer educators
Increasing participation of PLWHAs	1. Proposal to include the six targeted vulnerable population groups among civil society representatives on NACA and TCA 2. Increase participation of PLWHAs in treatment programmes with expansion of community-based healthcare, social and support services
Dispelling stigma and misconceptions	Selected questions related to HIV/AIDS are included in the next (decadal) National Health and Morbidity Survey to be undertaken in 2006/2007 by MoH to collect population-based data useful for developing and targeting IEC activities
Harmonizing laws and policies	Proposals for legal reforms (from imprisonment to treatment and community justice programmes) from the criminal justice system for substance abusers with minor offences, and reinforce strategies in the present National Drug Strategy.

[b] NACA membership to include Secretaries/Directors-General of various Ministries (Finance; Internal Security; Defence; Housing and Local Government; Rural and Federal Territory Development; Health; Information; Human Resources; Women, Family and Community Development; Education; Youth and Sports), and senior representatives from civil society including business consortiums, faith-based organizations, umbrella NGOs, UN Theme Group on HIV/AIDS

Malaysian Roadmap towards Universal Access

In terms of scaling up HIV prevention, treatment, care and support towards universal access for all those who need it by 2010, a national Plan of Action is currently being developed by MoH for government endorsement in March 2006. This Plan of Action will have target indicators and will form the basis for refining the country roadmap towards 2010 goals.

At this stage of the planning process, the national goals outlined in the NSP 2006 form the foundation of the Malaysian roadmap towards universal access in prevention, treatment and support. The national goals defined in the NSP 2006 are to: (1) prevent HIV transmission, (2) reduce morbidity and mortality related to HIV/AIDS, and (3) minimise the impact of HIV/AIDS on the individual, community and nation. The aims are to achieve the following UNGASS targets by 2010[5].

- Reduce new HIV infections in the following groups -
  - Youths aged 15–24 years
  - Adults aged 25–49 years
  - IDUs
  - Infants born to HIV-infected mothers
  - Vulnerable populations (SWs, transsexuals/transgender and MSM)
- Increase survival rates of PLWHAs with new HAART drugs
- Establish a specific programme for the protection and support of OVCs

The essential components of this roadmap foundation are described in Table B. Specific targets will be added to the roadmap with the completion of the Plan of Action.

Table B
Foundation of the Malaysian Roadmap 2006-2010 towards Universal Access in Prevention, Treatment, Care and Support

Compo-nent	Objective	Activities
Prevention	a. Reduce the number of HIV infections among youths aged 15-24 years	• Increasing access to life skills education; youth-friendly health and social services; and providing a supportive environment for HIV prevention
	b. Reduce number of HIV infections among adults aged 25-49 years	• Strengthening HIV/AIDS workplace policies and programmes and IEC
	c. Reduce number of HIV infections among IDUs	• Implementing the Harm Reduction Programme; Substitution Therapy Programme; complementary VCT services; risk reduction counselling; safer sex information; condom social marketing
	d. Reduce proportion of infants born to HIV-infected mothers	• Early diagnosis and treatment of pregnant mothers
	e. Reduce number of HIV infections among marginalised and vulnerable groups (SWs, MSM,	• Increase access to HIV/AIDS, reproductive and sexual health IEC; condom social marketing; 100% condom policy; increase number and geographical coverage of VCT services, including mobile units;

Table B Foundation of the Malaysian Roadmap 2006-2010 towards Universal Access in Prevention, Treatment, Care and Support		
Compo-nent	**Objective**	**Activities**
	transsexuals/ transgender, displaced persons, refugees, migrant labourers, indigenous peoples)	increase coverage and quality of outreach programmes
Treatment, care and support	a. Increase proportion of PLWHAs receiving ARV, including HAART	• Scale up community-based and primary healthcare outlets, closed settings (prisons, drug rehabilitation centres) • Scale up MOH VCT services in community-based settings
	b. Strengthen care and support services to help PLWHAs live longer and have more productive lives, and their families	• Expand the scope of care and support services to include key interventions: home-based care; palliative care; psychosocial support; stigma reduction; legal support; nutrition programmes; micro-enterprise and income-generating programmes • Expand care and support services for marginalised and vulnerable groups to all states
	c. Provide support to OVCs and infected children through appropriate non-Health sectors, such as Department of Social Welfare	• Appropriate counselling and psychosocial support • HIV/AIDS treatment and care for infected children • Ensure enrolment in schools and access to shelter, good nutrition, health and social services • Active and visible policy of non-discrimination and de-stigmatisation of OVCs

References

[a] MOH (2006). Section of AIDS/STD, Division of Disease Control, Department of Public Health, Ministry of Health Malaysia. http://webjka.dph.gov.my/aids/; 25/01/2006.
[a] Government of Malaysia (2005). National Strategic Plan on HIV/AIDS 2006-2010. Draft for consultation.
[a] UNAIDS (2005). The "Three Ones" in action: where we are and where we go from here. Geneva; The Joint United Nations Programme on HIV/AIDS. ISBN 92 9 1734 18 7.
[a] UN Country Team (2005). United Nations General Assembly Special Session on HIV/AIDS Monitoring the Declaration of Commitment on HIV/AIDS. Country Report Malaysia.
[a] Achieving the MDGs Report, EPU Prime Ministers Department, January 2005.