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HIV/AIDS

# **Country Report MALAYSIA**

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## Table of Contents

<b>I. STATUS AT A GLANCE.....</b>	<b>1</b>
<b>II. OVERVIEW OF THE AIDS EPIDEMIC.....</b>	<b>5</b>
A. PREVALENCE .....	8
B. MODE OF TRANSMISSION.....	10
<i>B (i). Substance Abuse and HIV/AIDS.....</i>	<i>11</i>
C. DEMOGRAPHIC PROFILE .....	13
D. HIV/AIDS AND WOMEN.....	15
E. KNOWLEDGE, ATTITUDES AND BEHAVIOUR.....	17
<b>III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC.....</b>	<b>19</b>
<b>IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE UNGASS GOALS/TARGETS.....</b>	<b>24</b>
<b>V. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS.....</b>	<b>27</b>
<b>VI. MONITORING AND EVALUATION ENVIRONMENT .....</b>	<b>29</b>
<b>REFERENCES .....</b>	<b>31</b>
<b>ANNEX I: CONSULTATION/PREPARATION PROCESS .....</b>	<b>34</b>
<b>ANNEX II: NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRES .....</b>	<b>35</b>
<b>ANNEX III: CORE INDICATOR RETURN FORMS .....</b>	<b>62</b>

## I. STATUS AT A GLANCE

The rise in HIV/AIDS has continued unabated since the first three cases of HIV in Malaysia were diagnosed in 1986. In recent years, the numbers reported have increased at an average rate of about 500 to 600 per month, and more than 7,000 have died. As of December 2004, official reports document 64,439 people with HIV/AIDS in Malaysia (Ministry of Health 2005). Despite efforts in the national response to contain the spread of this infectious disease, the United Nations MDG Report 2005 concluded that Malaysia has achieved commendable successes towards all the MDGs except in halting and reversing the spread of HIV/AIDS (UNDP 2005). There is a serious concern that the HIV/AIDS situation may escalate to a general epidemic in the near future.

Presently, Malaysia is labelled as a country with a “concentrated epidemic” based on a relatively low rate of infection in the general population as measured by a prevalence of less than 0.1% from mandatory testing of antenatal mothers in government clinics. On the other hand, reports have cited HIV infection rates ranging from 7% to 19% among high-risk groups, such as, prison inmates, sex workers (SWs), drug users and IDUs (MOH 2004b, UNODC 2004, Sattler 2004; Ahamad 2004). For the past 20 years or so, the profile of HIV-positive persons has been consistently predominantly young, male, of Malay ethnicity, and heterosexual.

While the present numbers in Malaysia appear small on a global scale, the relative size and population group most affected, i.e., young men, belie a scale of potential serious impact for a small, developing country that is aiming for developed status by 2020. In addition, most HIV infections in Malaysia occur among heterosexual men, which extend the risk of sexual transmission to women and, by vertical transmission, to infants. The extended latent period, ignorance or denial of risk, and the attached deep and pervasive stigma, are but a few of the biological and social factors that hamper efforts in prevention and control.

Since HIV/AIDS affects Malaysians in their prime productive years, the disease subverts human capital investments and productive resources. The cost of HIV medication alone, estimated at RM218-RM440 (approx. USD57-115) per patient per month using generic drugs (Ministry of Health 2004a), for the remaining lifetime of those with HIV, constitutes a significant burden. The Ministry of Health estimates that it would cost RM15-26 million (approx. USD4-7mil) to provide all three drugs which comprise the Highly Active Anti-Retroviral Therapy (HAART) for the 4,000 patients, currently, who may benefit from it. HIV has gained a place among other chronic ailments requiring protracted treatment and support; the critical differences being that HIV is infectious, bears a pervasive social stigma and entails very costly clinical management. On top of that, HIV may present with tuberculosis as a co-infection, i.e., an added health hazard for infected and non-infected family members.

Besides the direct medical costs, there are also affiliated costs, namely, sick days from school or work, hospitalisation, transport and lodging costs for specialised medical care, loss of income, loss of career advancement, school withdrawal, psychological/emotional trauma, social stigma and marginalisation, for the individual and his/her family. Without a doubt, HIV/AIDS has a multi-dimensional impact on countries as studies have shown for Africa where countries have generalised epidemics (AVERT 2005).

Various studies on knowledge, attitudes and behaviour indicate a fairly good level of knowledge among the general population and high-risk groups; averaging more than 70% among study samples, with almost 100% knowledge among younger respondents. By and large, knowledge was measured by correctly identifying at least three modes of HIV

transmission. However, gaps and misconceptions still abound along with correct information. If the C/LPE Indicator 5 for knowledge was computed for these study findings, i.e., percent who gave correct answers to all five questions comprising two on transmission routes and three common misconceptions<sup>1</sup>, the proportion of Malaysians with knowledge would decline. Furthermore, most studies have been based on purposive samples, the data from which cannot be generalised to the Malaysian population. Another shortcoming is the lack of data on rural populations, who still comprise the majority in this country.

Plans are underway to include selected knowledge and behaviour questions in the next round of the National Health and Morbidity Survey III, currently in its third stage of pre-testing and scheduled for 2006<sup>2</sup>. This is a nation-wide survey undertaken at 10-year intervals, previously in 1996. This survey is implemented by the Public Health Institute of the National Institutes of Health. The World Health Survey 2002, a WHO initiative in 70 countries, including Malaysia in 2003, also contains limited population-based data on high-risk sexual practices, namely, condom use in risky sex<sup>3</sup>. Neither of these extensive surveys is specifically focussed on HIV/AIDS. Moreover, based on the UNGASS (2001) target for knowledge levels to reach 90% by 2005 among the general population, it is evident that much more resources need to be expended on disseminating accurate information, dispelling misconceptions, and changing attitudes and behaviour.

There has also been no nation-wide population-based survey on high-risk groups to determine base-line levels of knowledge and practices, in the form required in the Core Indicators, much less routinely to monitor trends and evaluate changes. For Malaysia, only one high-risk group is recognised officially, i.e., IDUs, based on HIV-prevalence greater than 10% among those tested. Routine behavioural surveillance surveys in the second generation HIV/AIDS surveillance system, however, have included SWs, as well as IDUs, but not men who have sex with men (MSM) who constitute a small minority of cases, thus far. More critically, in spite of relatively high awareness, indicators of appropriate preventive behaviours, e.g., consistent condom use in high-risk sexual episodes, avoiding use of shared needles, have not followed suit.

A consultative workshop was held for the preparation of the UNGASS country report comprising key members from both Government and non-Government organisations. The workshop was attended by top-level representatives of the main Government agencies and civil society involved in HIV/AIDS (Annex I). This workshop was organised to share information, gain consensus on the NCPI questionnaires and the Core Indicators, and identify challenges and support required, towards the completion of this report.

In terms of the Core Indicators (C/LPE Indicators), the only source of relevant information on high-risk groups is the Ministry of Health from the first Behavioural Surveillance Survey (BSS) undertaken in 2004 covering 800 IDU and 845 CSW respondents in four states. No population-based survey has been conducted on high-risk groups for the eight indicators (four indicators on knowledge and four on practices) applied to concentrated, low prevalence epidemic (C/LPE) countries.

The BSS sourced respondents through key informants and non-Government organisations working for these target groups with a questionnaire modified from another international organisation (FHI – Family Health International). Relevant questions were phrased differently and elicit slightly different responses than requested in the UNGASS Core

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<sup>1</sup> (1) HIV can be avoided by having sex with only one faithful, uninfected partner; (2) HIV can be avoided by using condoms; (3) A healthy looking person can have HIV; (4) A person can get HIV from mosquito bites; (5) A person can get HIV by sharing a meal with someone who is infected.

<sup>2</sup> Personal communication with official from Institute of Public Health; December 2005

<sup>3</sup> Personal communication with official from Health Information Unit, Institute of Public Health; December 2005.

Indicators, e.g., C/LPE Indicator 6 requires responses on condom use with the last client whereas the FHI protocol refers to frequency of condom use in the last month. Hence, the data are not comparable. The non-comparability of survey/study results applies to research undertaken by academic institutions as well, whereby different researchers develop their own or use existing questionnaires from various sources. NGOs rarely conduct research on or collect data from their target groups but would benefit from this activity, particularly for monitoring and evaluation purposes.

The national response to HIV/AIDS has been two-pronged from its emergence in the mid-Eighties from both government and civil society initiatives with private sector contributions, especially from large corporations. Civil society support and participation has come from a range of sources, including NGOs, Community-Based Organisations (CBOs), professional bodies, religious institutions, and social and humanitarian clubs.

The Malaysian Government responded in a timely fashion by setting up a National AIDS Task Force in 1985. This was before the first case was detected, and was at a time when the HIV/AIDS agenda was a growing priority in the international arena arising from the epidemics in the West. This National AIDS Task Force comprised officers from various agencies and non-Government organisations. Further, an Inter-Ministerial Cabinet Committee on AIDS was formed in 1992 comprising Ministers from various Ministries to advise the Cabinet on policies, issues and strategic plans. Thereafter, the Task Force was replaced by a National Coordinating Committee on HIV/AIDS to facilitate collaborative inter-sectoral efforts, and a National Technical Committee on AIDS in 1993 to implement patient care, prevention and control, surveillance, laboratory services, training and research (UNDP 2005). A State Coordinating Committee was formed under the State Secretary which was responsible for the implementation and coordination of AIDS Prevention and Control activities locally through district committees (MOH 2004b). Civil society, including NGOs, CBOs and others liaise and communicate with the Government machinery at all levels, except the Cabinet Committee.

In terms of NGOs, several organisations have been founded, representing different focal groups, e.g., drug users, transsexuals, sex workers (male, female and transgender/transsexuals), MSM, PLWHAs, leading to the formation of the Malaysian AIDS Council in 1993 as an umbrella body to provide leadership and represent various focal groups (partner organisations – POs) in a larger, more coordinated force in services and advocacy. This coalition, the formation of which was facilitated by the Ministry of Health, now comprises 40 member affiliates all over the country. MAC, however, does not provide support to NGOs that are not partner organisations. Another established NGO with wide coverage that plays a significant role is the Federation of Family Associations of Malaysia (FFPAM), an umbrella body that sets direction, policy and programme implementation to its state affiliates (Family Planning Associations in every state) on reproductive and sexual health issues, including HIV/AIDS.

In fact, in the early part of the epidemic, the non-Government sector took the lead in addressing issues deemed sensitive, such as, providing services and/or shelter to PLWHAs, sex workers, homosexuals and drug users, and condom promotion. Although the Government's AIDS efforts on sex workers and drug users are visible, NGOs continue to be the source of services for the homosexual community (Ismail 2001). At present, however, these are confined to large urban areas, notably, Kuala Lumpur; which precludes access by a majority who may benefit from it. The National Health and Morbidity Survey II, carried out in 1996 by the Ministry of Health, found that 19.9% of adolescent respondents had reported homosexual experiences (13.7% among males, 6.2% among females). Although a portion of these may have been experimental experiences among those of heterosexual orientation, the findings, nevertheless, suggest that there is an unmet need for resources and support services for this group.

Malaysia also benefits from established links to the world community and international agencies, such as the World Health Organisation, United Nations agencies, and others. The level of technical and financial resources in the country has allowed for active participation by Government staff, academia and NGOs in conferences, dialogues, networking and training opportunities to exchange information and strengthen local expertise. Regional networking and cooperation are essential with increasingly mobile populations. Malaysia has also hosted a major international meeting on HIV/AIDS organised by MAC and the Ministry of Health. However, as a middle-income country with a concentrated low prevalence, Malaysia does not qualify as a recipient of overseas development aid. For example, the United Nations Global Fund for HIV/AIDS omitted Malaysia in its first and second rounds of disbursement.

The lead agency for policy, programmes, and funding for HIV/AIDS has, and continues to be, the Ministry of Health Malaysia. The Director-General of Health headed the first National Task Force, and thereafter, the National Technical Committee on AIDS, whereas the National Coordinating Committee on AIDS is chaired by the Secretary-General of Health. In other words, the responsible agency overseeing the HIV/AIDS policies and programmes fall primarily under the jurisdiction of the Health Ministry, even though it is recognised, and stressed, as a disease with a multi-dimensional impact necessitating multi-sectoral coordinated approaches in prevention and control. In sum, HIV/AIDS has not been positioned as a national development issue in Malaysia's national response.

However, the most recent National Strategy Plan on HIV/AIDS (2006-2010) submitted to the Cabinet includes a revision to shift the highest authority, currently with the Ministry of Health, to the Deputy Prime Minister, in order to upgrade and improve inter-sectoral coordination in implementing multi-sectoral approaches to HIV/AIDS prevention. This illustrates the Government's continued commitment to the issue.

Many challenges continue to hamper efforts in HIV/AIDS prevention and control. Participants in the UNGASS workshop from both Government and non-Government sectors identified the major issues for the preparation of this report. Briefly, the main challenges remain shortage of skilled manpower for patient care; negative public perceptions and stigma; lack of political will; absence of a research-based culture in policy and programmes; lack of skills in research, monitoring and evaluation; insufficient local research and even less follow-up; poor or non-existent M&E; poor participation of PLWHAs in policy and programme development; poor response among HIV-positive persons and other targeted communities to accessing treatment and services, and unsupportive laws.

In terms of support, financial support is still needed in this country from Government and international sources, especially for NGOs. Since Malaysia no longer qualifies for much development aid, sources of funding are more limited. The Government funds most of patient care, but research funds for social and behavioural aspects of HIV/AIDS are relatively small, and for M&E practically non-existent. Requests for funding must include a component for monitoring and evaluation at the outset. GOs have access to considerable funds to undertake large scale research studies; however, the dissemination of research findings tends to be limited. GOs and NGOs are requested to share information more regularly, especially to identify best-practices. Representatives of UN and international agencies need to be more familiar with the Asian face of HIV/AIDS, and provide technical expertise that is appropriate to the region's needs.

Support is particularly needed to enable PLWHAs and other targeted communities to participate in HIV/AIDS programmes, and in policy and programme development. There is no institutionalised set-up at present to include PLWHAs in the various stages of policy and programme formulation.

Malaysia, through the Ministry of Health, has an established health information management system that routinely collects data on HIV/AIDS through various sources. HIV cases are notified by law to the nearest health authority with selected socio-demographic data and risk factors. The Ministry also collects data from other routine surveillance sources and special surveys, including Behavioural Surveillance Surveys on high-risk groups. The findings are reported routinely in monthly and annual reports, and general statistics are posted on the web-site for public access.

Beyond routine reporting of health/hospital statistics and surveillance data, it is clear that data related to HIV are not utilised for Monitoring and Evaluation purposes. Specific projects are evaluated for its end outcome, e.g., PROSTAR after 10 years in operation, rather than via a systematic approach measuring process and outcome indicators routinely at intervals from the start. Evaluation reports for Government projects tend to remain in-house information that is not shared. Hence, programme managers not within the Public Health system cannot learn from the experiences.

The Ministry of Health and National Institutes of Health, as the gate-keepers of essential data on HIV/AIDS, are constrained by skilled manpower resources. The technical expertise at these agencies comprises, in large part, medical doctors who have undergone public health training and/or other relevant specialisation. As such, there are constraints on how much research and analysis can be achieved since there are limited numbers of medical doctors overall. These institutions may benefit from developing a larger cadre of non-medical staff with expertise in public health, notably, epidemiology, survey research, data analysis and evaluation that can meet the research and M&E needs for policies and programmes.

Another option would be to link up with research centres in academic institutions or private companies dedicated to on-going research for specific areas. This set-up currently exists for road safety, for example, where one or more academic institutions has access to the Royal Malaysian Police Force's large data base on road traffic accidents. It is also felt that the growing accumulation of data on HIV/AIDS cases could be much better utilised, in terms of analyses for local studies, and monitoring and evaluation, if it were made available to interested parties, such as, academic researchers and programme managers outside the Ministries and government statutory bodies.

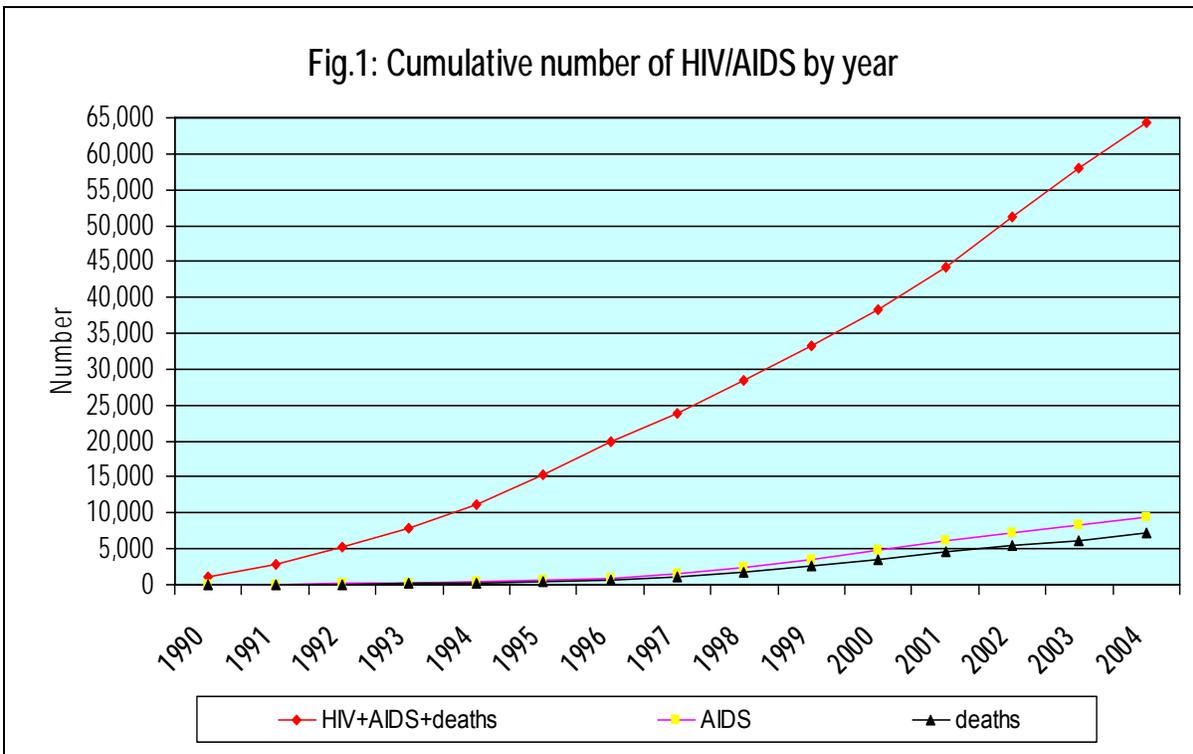
## **II. OVERVIEW OF THE AIDS EPIDEMIC**

HIV/AIDS is a notifiable disease under the Prevention and Control of Infectious Diseases Act 1988 (Act 342). It falls under the purview of the Ministry of Health Malaysia under which data are submitted, compiled and reported routinely. This Ministry is the official source of data on HIV infections for the country and the lead national agency for policies and programmes in prevention, treatment and control. Unless otherwise stated, all data in this report are from the Ministry of Health Malaysia (AIDS/STD Division, Department of Public Health).

In terms of epidemiology, it should be noted that data on HIV/AIDS in Malaysia are only available up to 2003 at the time of preparing this country report. The total numbers of cases are available up to 2004. The UNGASS reporting document focuses on the period 2003 to 2005 for which data are not yet complete.

From three cases identified in 1984, there are currently 64,439 reported cases of HIV infections up to December 2004. Figure 1 shows this steady increase in overall HIV cases,

including AIDS and deaths not previously notified as HIV, for the years 1990 to 2004 for which published data are available.

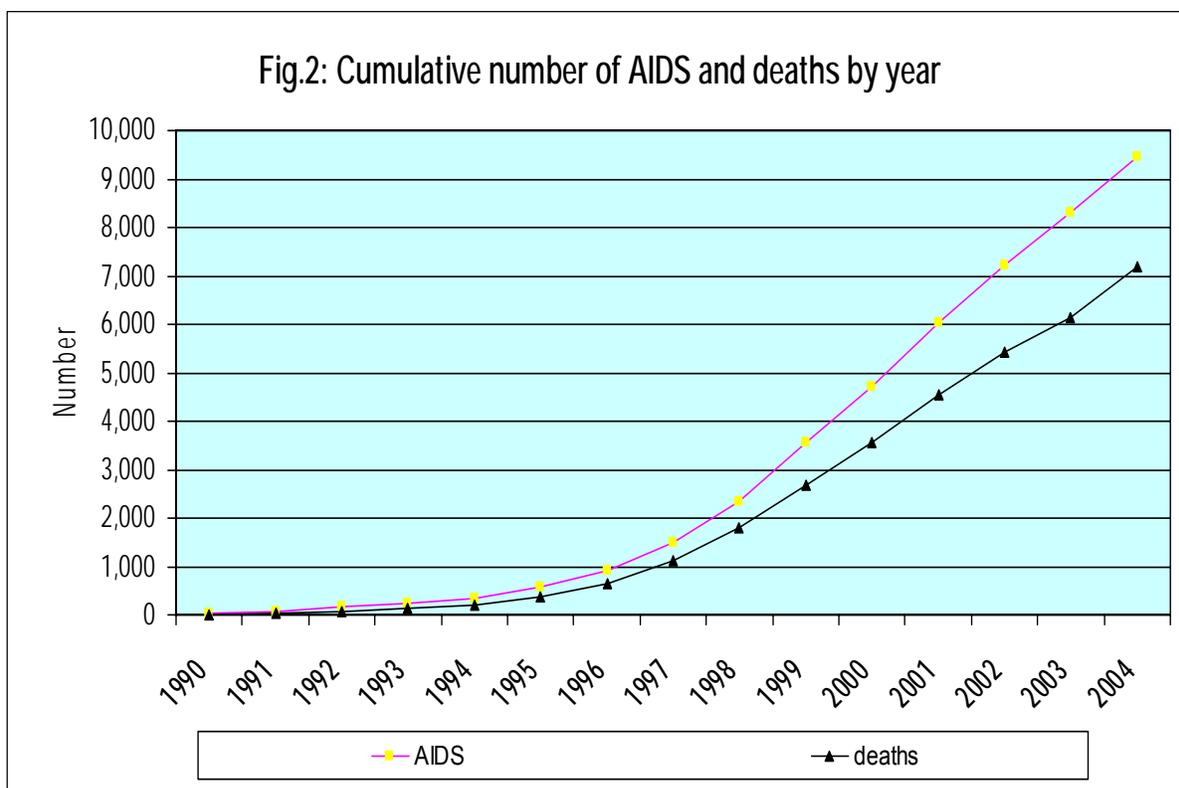


The implementation of mandatory testing of sub-groups in the population (Table A) and increased capabilities for testing throughout the country have increased the number of infections detected during the 1990s. All persons taken in by police for suspected drug possession or use, and prostitution are tested. Since 1998, all women seeking antenatal care in government facilities are also tested. In terms of coverage, more than 90% of antenatal patients in government facilities were tested for HIV in 2002 (Ministry of Health data). Although the practice is encouraged among private practitioners and hospitals, the proportion of antenatal women tested for HIV by private care-providers is not documented.

<b>Table A: Mandatory HIV Testing – List of Groups</b>
1. Women receiving antenatal care in government facilities (private practitioners are encouraged to screen their antenatal patients)
2. Blood donors
3. Inmates of drug rehabilitation centres
4. High-risk prison inmates (drug users, drug dealers and sex workers)
5. Confirmed tuberculosis cases
6. STD cases
7. Patients with suspected clinical symptoms, and
8. Traced contacts of infected persons.
Source: Ministry of Health Malaysia

The number of deaths diagnosed as AIDS has risen from 14 in 1990 to 7,195 up to December 2004 (Fig.2). As Figure 2 shows, the gap between the number of AIDS cases and deaths has widened since 1995. This is indicative of the efficacy of treatment measures. The treatment of choice is Highly Active Anti-Retroviral Therapy (HAART). Since 2004, the availability of anti-retroviral therapy (ART) has increased due to the importation of cheaper drugs. Yet, only about 3,000 HIV cases receive ART, while others do not access it. Many drug users, for example, do not come forward for treatment.

Barriers to accessing treatment need to be identified and overcome, e.g., fears of criminal action being taken against drug abusers if they come forward for medical treatment. The fear of criminal prosecution and other social and economic barriers suggest an essential need for the expansion of outreach activities to include medical treatment. Currently, HIV/AIDS treatment is available from selected hospitals and health care centres. Support should be provided to enable PLWHAs to access treatment, in the course of which, other support services can be provided, such as education and counselling. The creation of an

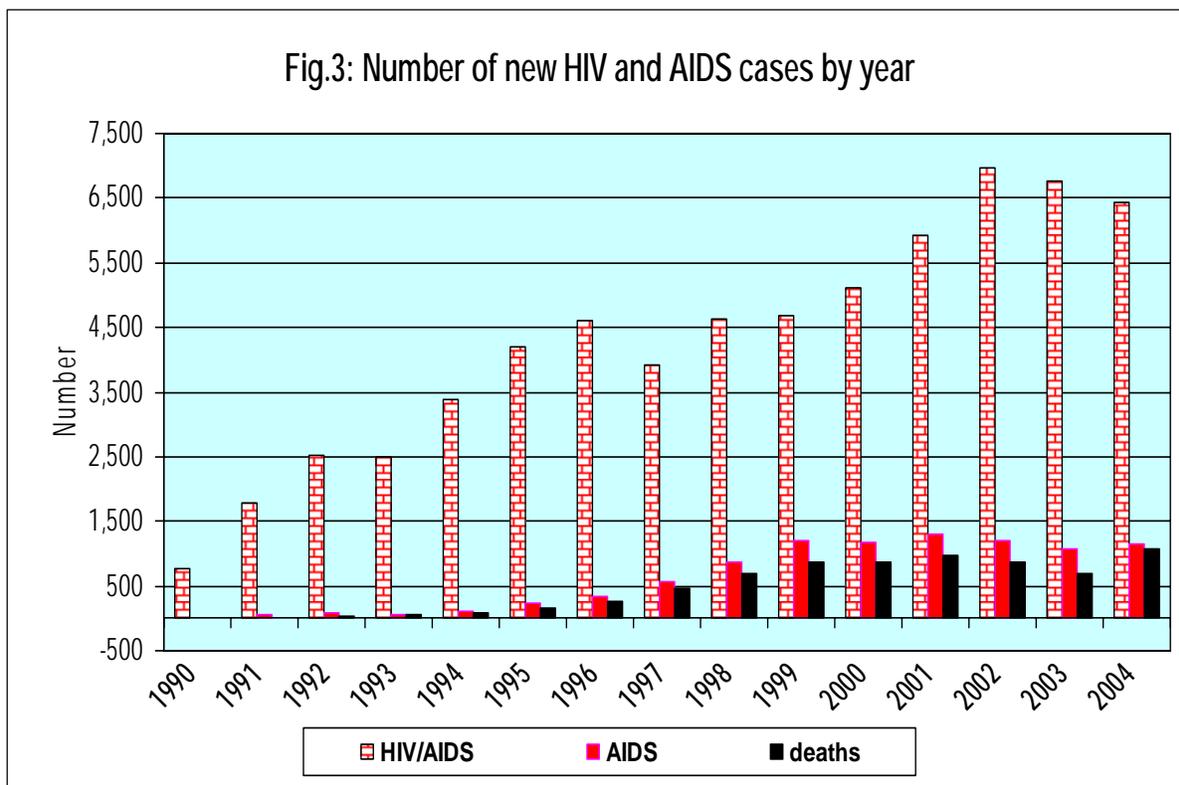


enabling environment is critical for PLWHAs and other targeted communities to participate in primary and secondary HIV/AIDS prevention efforts.

A relevant point in this regard is the completeness and quality of mortality data. For Malaysia, less than half of all deaths are medically inspected and certified. There are ongoing efforts to improve the completeness of mortality data. Vital Statistics data show that for the 1990s (1991 to 1998 for which data were published), an average of 40% of deaths in Malaysia were medically certified. For example, in 1998, uncertified deaths numbered 54,597. About half of these comprised deaths from old age (>65yrs) not classified under other categories. Among the remainder, the major non-medically certified cause groups include cancers, heart attacks, fever and road traffic accidents. More to the point, the bulk (about 8,000 deaths each year) were uncertified deaths listed under unknown causes. Potentially, these may include deaths related to AIDS. The completeness of death registration and certification varies between states depending on the level of socio-economic development. The more rural states, particularly in East Malaysia, have higher rates of non-medically certified deaths.

In terms of new HIV cases, the trend shows relatively steep annual increments up to the mid-nineties. It is likely that this initial steep rise was contributed by increased capabilities and/or enforcement in HIV testing and surveillance among sub-groups of the population. In the second half of the 1990s, the numbers appear to plateau at around 4,500 new infections per year, followed by another rise from 2001 to a higher plateau at around 6,000 to 6,500 annually (Fig.3).

The 1990s was a time of active mass media campaigns against HIV/AIDS, the visibility of which has since abated. Obviously, the outcome of those campaigns, if any, has been offset by the expansion of testing for high-risk groups, in particular, drug users. The first upswing in trend around 1995 coincides with the MOH's active screening programme



among special groups, including prison and drug rehabilitation inmates. The second upswing around 2002 coincides with the use of rapid HIV test kits for routine surveillance. Essentially, the faster turn-around of results enabled more people to be tested in a period of time, hence, raising the number of HIV cases detected.

At the same time, AIDS cases have increased but numbers have appeared to stabilise since 1999 despite increasing numbers of HIV infections (Fig.3). This may be attributed to HIV drug therapy, which is fully subsidised by the Government for selected groups (Table B), and partially subsidized (one drug, zidovudine, provided free) for others.

<b>Table B: Government Fully Subsidized Highly Active Anti-Retroviral (HAART) Drug Therapy – List of Groups</b>
<ol style="list-style-type: none"> <li>1. HIV-positive mothers diagnosed through antenatal screening</li> <li>2. HIV-positive infants</li> <li>3. Infected persons through contaminated blood or blood products</li> <li>4. Health personnel through occupational exposure</li> <li>5. Government servants</li> </ol>
Source: Ministry of Health Malaysia

## A. Prevalence

In terms of prevalence in the general population, three sources of data provide some indicators. In the national Prevention of Mother to Child Transmission Programme implemented since 1998, HIV prevalence ranged from 0.02% to 0.04% up to 2004, with

progressively higher proportions of women screened over the period (49.7% in 1998 to 97.6% in 2004) (MOH 2004b). Although this covers only women attending government maternity clinics, it is estimated that more than 70% of women in the country seek antenatal care at government clinics; more so, among rural women (Ahamad 2004).

From mandatory premarital screening of couples in the state of Johor implemented since 2001, HIV was confirmed in 0.16% of a total of 77,493 people tested from 2001 to 2004 (MOH 2004b). This programme was enforced by the State religious department with cooperation from the State Department of Health. The primary aim of this programme was to protect and prevent transmission to an intended spouse. It includes counselling services.

The MOH's Voluntary Screening Programme, piloted in Johor in 2001 and expanded nation-wide since 2003, found HIV-positive rates ranging from none in Sabah and Kuala Lumpur to a high of 4.31% in Kelantan, followed by 2.26% in Johor (MOH 2004b). However, in total, this programme attracted only 5,314 people over the two-year period with varying numbers tested in each state. The reasons for utilising this service, i.e., these may represent a biased group.

In contrast, much higher prevalence rates are found among selected risk groups (Table C) from surveys and studies conducted by the Ministry of Health. Thus, Malaysia has been classified as having a concentrated epidemic.

<b>Table C: HIV Prevalence Rates Among High-Risk Groups</b>				
<b>Survey group</b>	<b>Source</b>	<b>Year</b>	<b>N</b>	<b>% HIV-positive</b>
Drug users and prison inmates	National Screening Programme in 27 drug rehabilitation centres and 33 prisons	1996	-	14.3
		1997	-	16.4
		1998	-	13.2
		1999	-	17.9
		2000	9,500	19.6
		2001	35,763	13.2
		2002	50,351	10.3
Drug users	National Screening Programme in rehabilitation centres in 11 states	2002	12,532	16.8
SWs	HIV Sentinel Surveillance  Ad-hoc survey in Kuala Lumpur (65% transsexuals 35% female)	1996	2000	6.3
		2000	208	11.5
Fishermen	Survey in Pahang, Perlis, Kedah (northern region)	1998	542	1.7
Long distance drivers	Survey in Pahang, Kelantan, Terengganu (east coast)	2000	906	3.7
Factory workers	Survey in Selangor, Negeri Sembilan, Melaka (west-central region)	2001	3,000	0.0
Sources: MOH (2004b), Ahamad (2004)				

The Malaysian data on HIV/AIDS are disaggregated by likely mode of transmission, sex, ethnic group and age. These background profiles are described below.

## **B. Mode of Transmission**

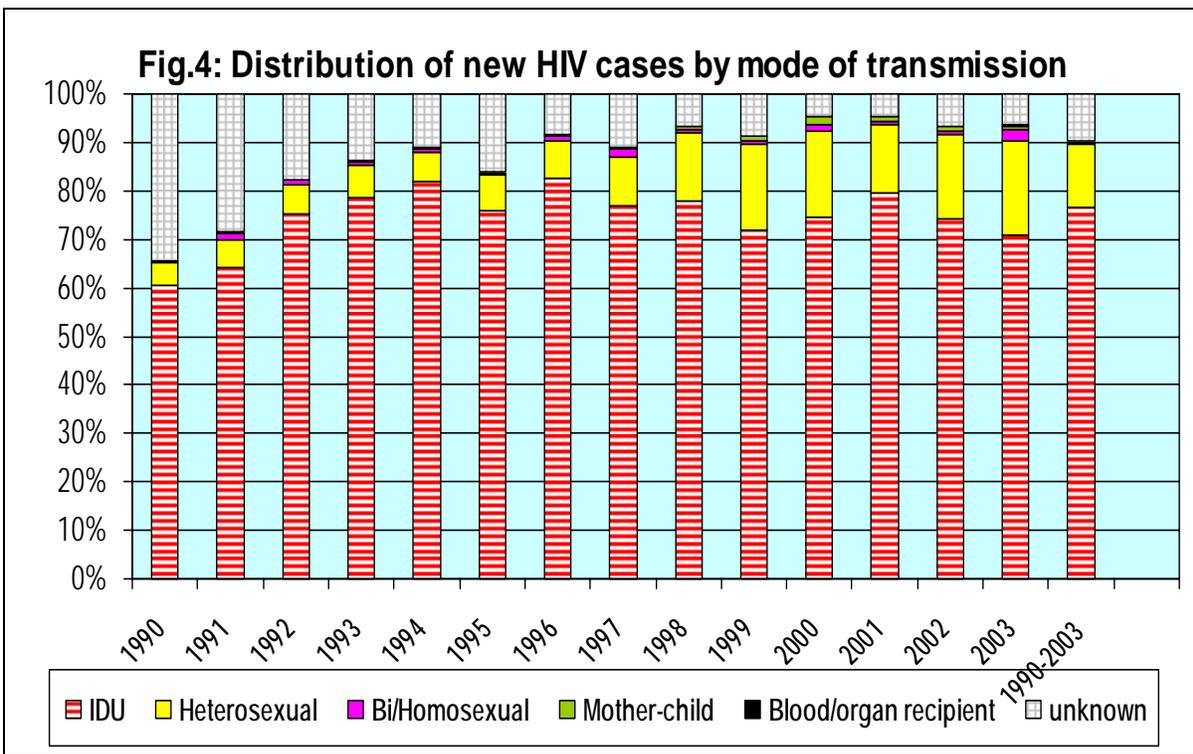
The main modes of transmission by which cases are classified are via:

1. Intravenous drug use
2. Heterosexual transmission
3. Bi- or homosexual transmission
4. Vertical transmission from mother to infant
5. Contaminated blood and blood products
6. Organ transplants
7. Unknown

The trend by mode of transmission is shown in Figure 3. There are two salient points in the pattern of annual new infections by mode of transmission from 1990 to 2004.

First, the main channel for HIV infection in Malaysia is related to intravenous drug use (IDU). Consistently, more than 75% of all new HIV infections are detected among intravenous drug users (IDU) (Fig.4).

Secondly, the proportion of infections with unknown causes has decreased over time, as capabilities in testing and classification improve in the country. The decline in unknown causes has corresponded with increases in the proportion listed under heterosexual and homosexual transmission. Thus, seen on its own, the proportion of heterosexual transmissions of HIV appears to have risen considerably when, in fact, a portion of the increments has been due to improved reporting.



The preponderance of IDUs in the data is attributed partly to the fact that drug users are tested for HIV by law when they opt for treatment or when they enter the criminal justice system; hence, biasing the numbers detected among them. The direct route of infection among this group is most likely through infected needles or other objects involved in using drugs intravenously, but may also be associated with high-risk sexual activities.

With regards to sexually transmitted infections, it is clear that heterosexual transmission dominates HIV infections in Malaysia, rather than infections via other sexual routes, namely, men having sex with men. In 2003, however, the number of HIV infections classified via bi-/homosexual activities nearly tripled from 51 cases to 151. As a percentage of the previous year, this far exceeded increases in other modes of transmission (MOH 2003). Further data will be needed to assess whether or not this reflects a sustained increase among this group.

Although the percentage of HIV cases attributed to MSM is relatively low, there is a perception among NGO workers<sup>4</sup> that the number of HIV-positive cases among MSMs has increased of late. There are a lot of entertainment and recreational outlets for the MSM community, particularly, in urban centres, including bars and massage parlours. Local or City Council prohibitions on condom distribution has hampered efforts targeted at this group. Condom vending machines or sale of condoms, for example, are not allowed on these premises as they project the image of promoting sex. This is clearly an obstacle for prevention.

Other non-sexual routes of transmission occur at a fairly low rate. As mentioned earlier, the rate of HIV infection among pregnant women is used as a proxy for the rate in the general population. In this case, the rate of 0.04% from antenatal testing in Malaysia is regarded as low.

**B (i). Substance Abuse and HIV/AIDS**

The significance of substance abuse and dependence in the issue of, and fight against, HIV/AIDS in Malaysia deserves further mention. With regards to substance abuse, there

<sup>4</sup> UNGASS Workshop discussions

are an estimated 897,624 drug users and 40,815 IDUs in the country (MOH/WHO/UUM 2003). Furthermore, most IDUs in Malaysia begin as non-injecting users, so the remaining 75% forms a pool of potential intravenous users over time.

A HIV screening programme in drug rehabilitation centres in 11 states showed an overall HIV prevalence of 16.8% among the 12,532 drug users, ranging from 8% in Selangor centres to 34.5% in Kelantan (Ahamad 2004). Based on the data for drug users, HIV prevalence was estimated to be 20% among IDUs; with a high of 41.2% in Kelantan. Further analysis found higher HIV prevalence rates among drug users at centres in the East coast and South compared to the West and North regions (Ahamad 2004). This may be a reflection of the socio-demographic profile of centre residents in each state, e.g., Selangor has a centre for adolescents which may explain far lower HIV rates. Nonetheless, the reasons for these regional variations need to be evaluated as it has important implications for policy and services.



Drug users are also at risk from being infected through unsafe sexual behaviour, i.e., unprotected sex with multiple and/or casual sex partners, sex workers and providing paid sex, not to mention, the risk of infecting their sex partners in turn. It is estimated that about 80% of HIV infections among IDUs are through needle sharing, with the remainder likely from sexual transmission (Ahamad 2004).

Substance abuse is a punishable crime under various laws (Table D). The enforcement of these laws falls under the National Narcotics Agency, Ministry of Internal Security. At the same time, these laws also have implications for harm reduction programmes, which is currently in its pilot stage under the Ministry of Health and MAC.

The actual number of new drug dependents registered remained above 7,000 throughout the Eighties and escalated even higher since the mid-nineties to 25,243 up to October 2005 (National Narcotics Agency 2005). The majority were classified as heroin (43.3%) and morphine (25%) users.

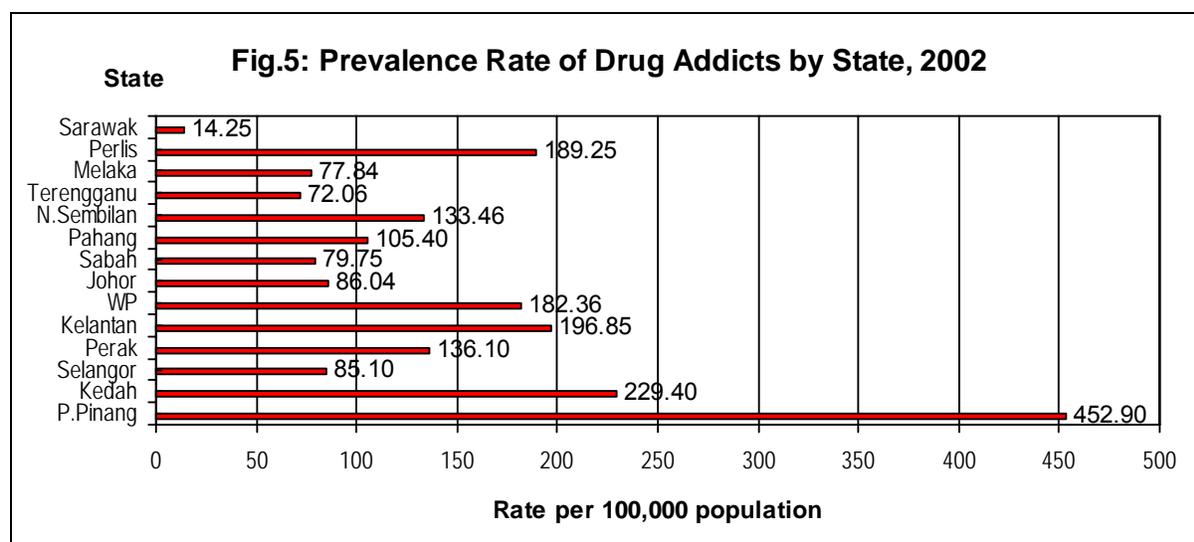
Data from the National Narcotics Agency shows that the majority among those registered consistently are young Malay men, i.e., not surprisingly, the same demographics underlying HIV/AIDS infections as these comprise primarily substance abusers. Added to

this burden are the thousands more relapse cases every year. This testifies to the failure of anti-drug efforts and available treatment and rehabilitation thus far.

**Table D: Malaysian Laws on Drugs**

- Dangerous Drugs Act, 1952
- Poisons Act, 1952
- Dangerous Drugs Act (special preventive actions) 1985
- Drug Dependents (Treatment and Rehabilitation) Act, 1983; amended 1998
- Dangerous Drugs Act (Forfeiture of Property) Act, 1988

In terms of rate of drug abusers registered per population, locations with the highest figures are Penang, by far (452.9 per 100,000 population), followed by Kedah (229.4 per 100,000), Kelantan (196.8 per 100,000) and Kuala Lumpur (182.4 per 100,000) (Fig.2). These rates appear to correspond to a bipolar distribution in terms of socio-economic level, i.e., the locations at highest risk being the two most developed cities (Penang and Kuala Lumpur) and the two least developed (relatively rural) states (Kedah and Kelantan) in Peninsular Malaysia. Geographically, however, these 'high-risk' areas are all in the north and north-east, except for Kuala Lumpur, the capital city. Thus, the drug problem may be associated with proximity and easy accessibility to source countries, such as Thailand, a major route in the drugs trade, in particular, for heroin and its products.



Source: Drug abusers data - National Narcotics Agency, Ministry of Home Affairs. <http://www.adk.gov.my/> (Jan 2005)

Population data - Vital Statistics Malaysia, 2003. Department of Statistics Malaysia. Putrajaya.

### C. Demographic Profile

The HIV data in Malaysia are also disaggregated by selected socio-demographic characteristics, namely, sex, age and race (Table E).

**Table E: Distribution of new HIV and AIDS cases in Malaysia, 2003**

Variable	Groups	New HIV cases		New AIDS cases		Cumulative HIV		Cumulative AIDS	
		No.	%	No.	%	No.	%	No.	%
Sex	Male	6,083	90.04	939	87.27	54231	93.48	7,594	91.56
	Female	673	9.96	137	12.73	3781	6.52	700	8.44

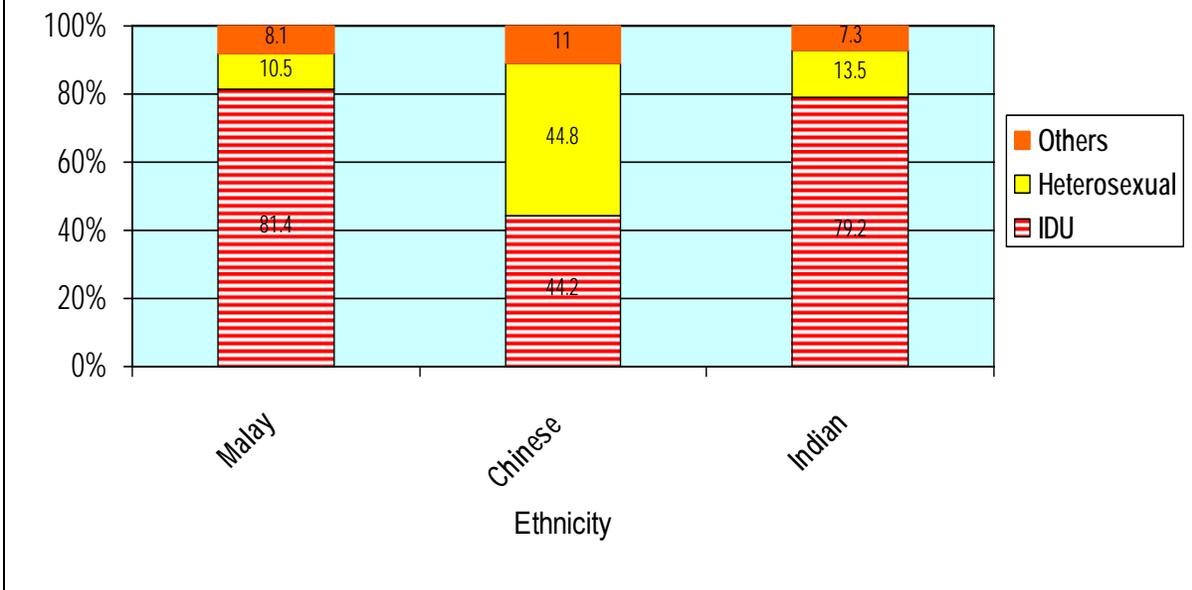
Race	Malay	4,847	71.74	651	60.5	42,068	72.52	4,996	60.24
	Chinese	988	14.62	276	25.65	8746	15.08	2,333	28.13
	Indian	508	7.52	62	5.76	4,886	8.42	584	7.04
	Others	127	1.88	35	3.25	684	1.18	199	2.4
	Foreigners	286	4.23	52	4.83	1628	2.81	182	2.19
Age-group (years)	<13	61	0.90	19	1.77	464	0.8	134	1.62
	13-19	78	1.15	4	0.37	902	1.55	190	2.29
	20-29	2,192	32.45	210	19.52	21,295	36.71	1,727	20.82
	30-39	2,819	41.73	485	45.07	24,791	42.73	3,723	44.89
	40-49	1,246	18.44	255	23.7	8281	14.27	1,882	22.69
	≥ 50	304	45.0	97	9.01	1,596	2.75	609	7.34
	unknown	56	0.83	6	0.56	683	1.18	29	0.35
TOTAL		6,756	100	1,076	100	58,012	100	8,294	100
Source: Ministry of Health Malaysia									

Among reported cases, the large majority of HIV infected persons are men. Compared to the breakdown by race of the total male Malaysian population (53.5% Malay (*Bumiputra*)-Malaysians, 11.7% other *Bumiputra*, 26% Chinese-Malaysians, 7.5% Indian-Malaysians, 1.35% others – Vital Statistics, 2003), it is evident that there are proportionately more Malays and fewer Chinese-Malaysians among HIV-infected persons in the country. As widely recognised, this over-representation of Malay HIV-infected males is linked to the higher rate of substance abuse among Malays, described above.

There is a clear difference in the profile of mode of HIV transmission by race. Whereas the majority of HIV infections among Malay- and Indian-Malaysians are associated with IDU, heterosexual transmission plays a larger part amongst Chinese-Malaysians (Fig.6). This suggests that different approaches should be targeted at various sub-groups in the population.

It is also postulated that the breakdown by mode of transmission among Chinese Malaysians may better reflect the distribution of risk among the general population as detections are less biased towards drug users among this group. In other words, the data points to the significance of heterosexual transmission of HIV in this country.

**Fig.6: Distribution of new HIV cases by race and mode of transmission, Malaysia, 2002**



Source: UNDP (2005) MDG 6. Combat HIV/AIDS, malaria and other diseases. In: Malaysia. Achieving the Millennium Development Goals. Successes and Challenges. Kuala Lumpur: United Nations Development Programme; p159, based on Ministry of Health data.

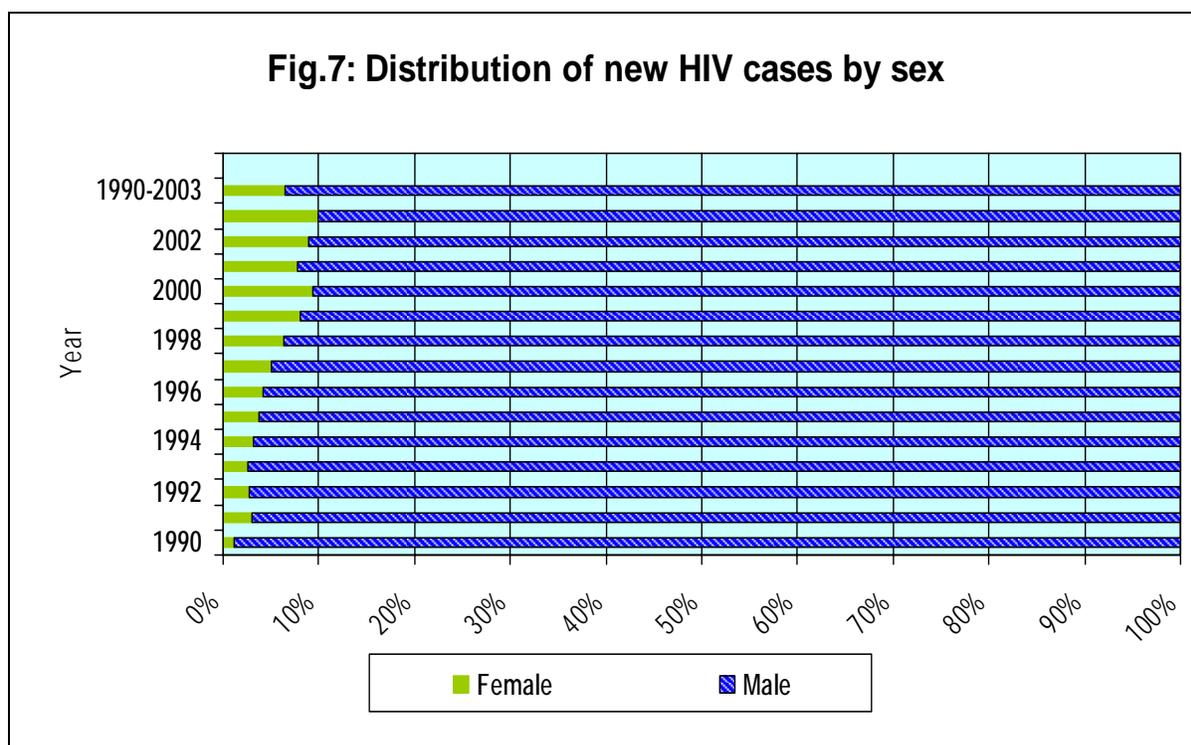
By age, most HIV infections occur primarily among men aged 20 to 39 years, i.e., potentially, the most economically productive group. This represents a drain in human resources, should the infection not be managed and full-blown AIDS develops, thereby, shortening life expectancy. In addition, these men are sexually active and risk infecting their partners if they don't adopt consistent life-long safe practices.

To summarise, the profile of HIV-infected persons in this country is largely male, Malay, between 20 to 39 years of age. For the past two decades, 70% or more of HIV infections consistently fall under those demographics.

#### **D. HIV/AIDS and Women**

While HIV cases have continued to be overwhelmingly male, the percentage of women has increased from 1.4% in 1990 to nearly seven percent (3,781 cases) in 2003. This rise is concomitant with the rise in percentage of infections classified as heterosexual. In terms of AIDS, the number of women diagnosed increased from two in 1991 to 700 in 2003, representing about eight percent of all AIDS cases (Fig.8). Up to 2003, 420 women have died from AIDS.

**Fig.7: Distribution of new HIV cases by sex**



Source: Ministry of Health Malaysia (various years)

In contrast to infections among men, 64% of infections in women were categorised as sexually transmitted and only 20% as via intravenous drug use (UNDP 2005). That is, most women were infected by a sex partner or spouse.

The specific biological and social vulnerabilities of women with regards to sexually transmitted infections, including HIV, are well recognised. In particular, women bear a disproportionately greater share of reproductive health problems and health care needs based on their social differences. The World Health Organisation points out that reproductive and sexual health account for 20% of the global burden of ill-health for women and only 14% for men (WHO 2004a).

Based on the greater risk of HIV infections among Malays, and Malay men, in particular, a few states are considering, or have mandated, compulsory HIV testing for Muslim couples registering for marriage as a step in controlling HIV transmission. Mandatory testing raises issues of privacy and civil rights, particularly, with regard to potential abuse of information. People rightly fear that their HIV status will be used against them in employment and access to other services, such as insurance.

The assurance of confidentiality is a critical measure in encouraging people to undergo HIV testing. Ideally, HIV and STD testing should be voluntary and based on informed consent. Sexually active men and women should practise protected sex and have routine health care examinations. Unfortunately, normal emotional relationships tend to begin with a measure of trust without aspersions on a partner's sexual history or health status. Moreover, women tend to be in a subordinate position and cannot, in most cases, demand their partner to undergo HIV screening nor use condoms. This assumes that they are aware of such matters or perceive it to be relevant to them; a presumption that may not apply to many women who are less educated or who come from rural areas. The widespread attitude that condoms are associated with promiscuous or immoral behaviour serves as an obstacle to its practice by men, and to women's demand for it to be used.

## **E. Knowledge, Attitudes and Behaviour**

Numerous surveys have attempted to assess knowledge, attitudes and practices or behaviour (KAP or KABP) related to HIV/AIDS among Malaysians, particularly, among youths (cited in Narimah et al 2003). Thus far, most studies have been based on purposive samples that cannot be generalised to the Malaysian population as a whole. In particular, there is little information on rural populations, which comprise the majority of Malaysians.

There has been no population-based survey on HIV/AIDS specifically. The Third Round of the National Health and Morbidity Survey conducted by the Ministry of Health, scheduled for 2006, includes limited questions on knowledge and practices relevant to HIV/AIDS.

Among published studies, a relatively high level of awareness of HIV/AIDS has been reported among the Malaysian public sampled in various locations in Malaysia (NPFDB 1995; Scott et al 1993; Haliza & Mohd. Sukur 2002), and among selected high-risk groups, notably, sex workers, IDUs and transsexuals (Fauziah MN et al 2003; Teh 2000; Ismail 1998). More than 75% of study samples have heard of HIV/AIDS and can name at least three routes of transmission. Knowledge appears to be higher among adolescents (Narimah et al 2003; Zulkifli et al 1995). The National Study on Reproductive Health and Sexuality 1994/95 revealed that 98% of adolescent respondents had heard about AIDS compared to 65% who had heard of STDs (Narimah et al 2003). There were no significant differences between rural and urban adolescents.

It is noteworthy that levels of knowledge was reported to be higher - more than 90% - among adolescents surveyed in schools compared to those of similar age who have left school (Zulkifli et al 1995). Secondary school children receive some information on HIV/AIDS from Year Five through Moral Education, Physical Education and Science under the curriculum (MOE 2005). Another study among members of the public also found a higher proportion with HIV/AIDS knowledge from locations on the more developed west coast compared to the relatively rural east coast of Peninsular Malaysia (Haliza & Mohd. Sukur 2002).

Clearly, the depth of knowledge needs to be raised. Several of the studies report gaps and misconceptions in knowledge, even among adolescent school children who are exposed to information about HIV/AIDS through the curriculum (cited in Narimah et al 2003). Also, many IDUs were aware of needles as a source of infection but not other shared injecting equipment (Reid et al 2005). These gaps in knowledge and misconceptions need to be rectified.

There is little information on knowledge, attitudes and practices in rural areas. Haliza and Mohd Sukur (2002) found, not only lesser knowledge about HIV, but also more negative attitudes towards those with HIV or AIDS among respondents in the east coast sample (Marang and Kota Baru). In a qualitative study on reproductive health and rights among men, it was evident that Malay rural poor men in Kelantan were not overtly conscious about condoms as a means of preventing STDs and HIV, compared to rural poor Indian-Malaysian men and urban men of all races (Wong et al 2003).

There is a need to assess the level of awareness in rural areas in light of rural-urban migration, especially among youths, from less developed to more developed areas within the country. Furthermore, based on the desired UNGASS target of 90% awareness of HIV/AIDS by 2006, it is clear that more IEC efforts need to be expended in this country, and in more effective ways.

With regards to unsafe practices, studies on high-risk groups show that unprotected sex and needle-sharing remain prevalent among sex workers and IDUs even when they are

aware of HIV and AIDS (Fauziah MN 2003, MOH 2004b). The Ministry of Health's recent Behavioural Surveillance Survey on high-risk groups (IDUs and sex workers) found that almost 80% of their respondents knew about HIV/AIDS, yet 68% of IDUs always shared needles (with 79% only using water to clean needles) and 49% of sex workers did not always use condoms (MOH 2004b). Furthermore, with fewer clients per week, progressively lower proportions of sex workers reported consistent condom use (about 60% with one or less client per day compared to more than 80% with four or more clients per day). Consistent condom use was lowest among sex workers with non-paying clients (17.7%). Of further concern, consistent condom use was found to be less frequent among female than male sex workers (e.g., 71% of male and 75% of trans-gender sex workers compared with only 40% of female sex workers reported consistent condom use with anal sex) (MOH 2004b).

In addition, the Institute for Health Systems Research, National Institutes of Health, conducted a nation-wide survey in 2003 as part of the World Health Organisation's World Health Survey 2002 which elicited some data related to sex (when, with whom, and condom use)<sup>5</sup>. In Malaysia, this survey covered 6,038 respondents aged 18 to 49 years using a multi-stage random sampling of households<sup>6</sup>. The WHO headquarters computed estimates for "risky sex" in the last 12 months - "percentage of respondents who had sex in the last year with someone they did not live with, and who did not use condoms on the last occasion" (WHO 2003). More than twice as many men (5.4%) than women (2.3%) reported having sex with someone other than the person they lived with (including commercial and casual sex) in the last 12 months, and more men (40.6%) than women (26.7%) reported using a condom on the last occasion. These indicators were also higher among urban than rural respondents. Although the prevalence of sex with a non-regular partner was quite low, the relatively poor condom use (risky sex) among the general population, especially among women, is cause for concern.

The Behavioural Surveillance Surveys, thus far, have not included MSM as a target group. In fact, at the point of preparing this report, no study has focussed on homosexuals in the context of HIV/AIDS, except for some relevant data from a recent national study on sociological aspects using qualitative enquiry by the Ministry of Women, Family and Community Development. The results of this study have not been disseminated.

It is recognised that the reliability of self-reported data on such sensitive topics may be questionable, especially when interviewers represent authority figures. It is possible that behaviours are over- or under-reported based on their perceived social value. The response reliability of respondents, and between sub-groups, needs to be validated.

Be that as it may, studies in Malaysia indicate that knowledge of HIV/AIDS is not translated into appropriate behaviour to prevent disease transmission. In particular, sexual transmission of HIV has increased relatively more than via drug use. In a "concentrated epidemic", the general population receive the message that HIV/AIDS is confined to certain groups labelled "high-risk". This widespread perception is, in itself, an obstacle to the control of HIV/AIDS. The lay-person tends not to perceive him/herself to be at risk because he/she does not fall into one of the high-risk groups, namely, intravenous drug users, sex workers, homosexuals or transsexuals. Thus, messages to avoid sharing needles and practise safe sex are seen as irrelevant. Even among those who do have multiple sex partners and casual sex, there may be denial if their sex partners are perceived as "ordinary people" who do not fall into those high-risk categories. Youths, among whom the risk of infection is highest, also tend to be risk-takers, more so young men regardless of their sexual orientation.

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<sup>5</sup> <http://www.who.int/entity/healthinfo/survey/whslongindividuald.pdf>

<sup>6</sup> Personal communication with Institute of Health Systems Research, National Institutes of Health, Ministry of Health Malaysia.

Preventive strategies are challenged by the need to change perceptions of personal risk and promoting risk-reducing behaviour as normal and desirable. Basic principles of behaviour recognise that attempts to change behaviour are more difficult when it involves persuading people to adopt practices that, tangibly, reduce their pleasure or increase pain as an immediate consequence. The possibility of becoming infected with a disease, even a fatal one, is a distant consequence, hence, has a weaker influence on behaviour. Notably, men feel that condoms reduce their sexual pleasure physically, or mentally, if they associate condoms with prostitutes, while IDUs are driven by the overwhelming need to attain euphoria and avoid the highly tangible physical pain of withdrawal. Hence, taking the extra time and effort to clean needles and other IDU equipment properly is a difficult, if not impossible, practice for most IDUs. The evidence-based harm reduction strategy for IDUs currently advocated by international organisations (WHO 2004b; WHO 2004c; WHO/UNODC/UNAIDS 2004; IFRCRCS 2003), and recently adopted by the Ministry of Health, takes cognizance of the life circumstances unique to IDUs in recommendations on secondary prevention (Adeeba K & Rusli, undated).

### **III. National response to the AIDS epidemic**

The national response to HIV/AIDS has been collaboration between the Government, non-Government organisations and civil society with support from international agencies since its emergence. The response to HIV/AIDS has had, and continues, to address the biological aspect of this disease enmeshed with its complex social, ethical and legal layers. Conflicting views and principles on political, religious, moral and scientific/medical grounds add another dimension of problems to overcome in formulating policies and implementing programmes against HIV/AIDS.

The pervasive notion that HIV/AIDS afflicts certain sub-groups through socially undesirable or unacceptable means attaches a stigma to those with HIV, and consequent denial of risk among those outside these high-risk groups. Negative perceptions build a formidable barrier to taking steps critical to prevention, such as, voluntary HIV testing and open communication between sex partners about sexual history and taking precautions (MOH 2000). Stigma also causes families and friends to deny help and avoid contact with PLWHAs, and incite suggestions by some to isolate those with HIV or AIDS as a control measure. Such widespread negative public attitudes have held back Government action.

For this reason, civil society, particularly NGOs and CBOs focussed on HIV/AIDS, have played a pivotal role from the start in mobilising action and advocacy, particularly for issues deemed sensitive for open Government action. This includes the promotion of condoms and clean needles, and services to sexual minorities and sex workers.

Another issue spear-headed by civil society is human rights; the rights of citizens pertinent to HIV/AIDS issues and of PLWHAs. In 1995, the Patient's Charter was formulated as a Memorandum of Understanding between the Federation of Malaysian Consumers Associations, The Malaysian Medical Association, The Malaysian Dental Association and The Malaysian Pharmaceutical Association (MMA 1995). Following that, the HIV/AIDS Charter for Doctors was announced in 1997 by the Malaysian Medical Association AIDS Action Committee in consultation with all medical professional bodies and the Malaysian AIDS Council (MMA 1997).

The major events in the national response to HIV/AIDS are summarised in Table F. These comprise Government and civil society initiatives in partnership.

**Table F: Chronology of main events in the national response to HIV/AIDS**

Year	Event
1985	The Government forms the National AIDS Task Force, an Inter-sectoral Committee chaired by the Director-General (DG) of Health.
1988	The Government adopts The First National Strategy Plan and implements the HIV/AIDS Surveillance Programme by the Ministry of Health (MOH)
1991	The "Prevent AIDS Now" mass media campaign is launched nation-wide targeted at the general public.
1992	The Inter-Ministerial Level Cabinet Committee on AIDS is formed chaired by the Minister of Health (MOH) comprising membership of Ministers from the Ministries of Education; Information, Youth and Sports; National Unity and Social Development; Culture, Art and Tourism; Home Affairs; Rural Development and the Minister in the Prime Minister's Department for Islamic Affairs. This Cabinet Committee meets once in two years.
1993	<p>The MOH facilitates the formation of the Malaysian AIDS Council (MAC), an umbrella body of NGOs focussed on various aspects of HIV/AIDS, now comprising more than 30 affiliates.</p> <p>The National AIDS Task Force is replaced by: (1) the National Coordinating Committee on AIDS chaired by the Secretary-General of Health and (2) the National Technical Committee on AIDS chaired by the DG of Health</p> <p>The Cabinet issues a directive for the formation of the AIDS/STD Section under the Division of Disease Control, Department of Public Health, MOH</p> <p>The launch of the MOH's second annual Healthy Lifestyle Campaign focussed on HIV/AIDS</p> <p>Malaysia joins ASEAN Task Force on HIV/AIDS</p>
1994	Sentinel surveillance among antenatal mothers in government clinics
1996	<p>Sentinel surveillance among TB and STD patients in government health centres.</p> <p>The launch of PROSTAR (<i>Program Sihat Tanpa AIDS Remaja</i>; Healthy Youths Without AIDS Programme) – a nation-wide peer programme for raising awareness among youths on HIV/AIDS through PROSTAR clubs.</p>
1997	Routine screening of all TB and STD patients in government health centres
1998	The MOH implements antenatal screening in Government medical facilities nation-wide under the Prevention of Mother to Child Transmission Programme.
2000	<p>Formulation of the Second National Strategy Plan (minor modifications)</p> <p>Formation of the Malaysian AIDS Foundation, a charitable Trust under the Malaysian AIDS Council</p> <p>The MOH and MAC convene the Fifth International Conference on HIV/AIDS: Taking Stock and Moving Forward</p> <p>The MOH pilots a Voluntary HIV Screening Service at community health clinics in Johor state (now expanded nation-wide)</p>
2001	<p>The Malaysian Government adopts the UNGASS Declaration of Commitment on HIV/AIDS</p> <p>The Malaysian Government signs the ASEAN Declaration on HIV/AIDS</p> <p>The UNDP, MOH, MAC and the Department of Islamic Religious Affairs</p>

	<p>initiated a three-year project to involve Islamic religious leaders in the response to HIV/AIDS</p> <p>The MOH, Department of Occupational Safety and Health (DOSH), Malaysian AIDS Council (MAC) and UNAIDS develops The Code of Practice for the Prevention of HIV/AIDS in the Work-Place</p>
2002	<p>The 2<sup>nd</sup> International Muslim Leaders' Consultation (IMLC) on HIV/AIDS was convened in Kuala Lumpur</p> <p>FFPAM, through Kedah FPA, implements HIV/AIDS prevention Through Sexual and Reproductive Health Education for Rural Youth project – Training of Trainers camps for 10 secondary schools in Kedah</p>
2003	<p>The Ministry of Health implements the first Behavioural Surveillance Survey on high-risk groups, namely, sex workers and IDUs (2<sup>nd</sup> BSS scheduled for 2006)</p> <p>MAC forms the Harm Reduction Working Group to advocate programmes</p>
2004	<p>The UNFPA launches the project “Protecting Young Malaysians From HIV and STIs” implemented by the Federation of Family Planning Associations, Malaysia, the Ministry of Health, and the National Population and Family Development Board focussed on youths aged 10-24 years in four states (Penang, Selangor/Kuala Lumpur, Kelantan and Sabah)</p>
2004/05	<p>Formulation of the Third National Strategy Plan (major modifications).</p>
2005	<p>The Ministry for Women, Family and Community Development launches the Project on Exploring the Needs and Issues of Homosexual Men and Women in Malaysia</p> <p>The Ministry of Health announces the adoption of the Harm Reduction Programme for IDUs, including provision of clean needles in a managed health care setting</p>

On the Government's response, a detailed description is provided by the Ministry of Health on the organisational response which comprise the following (MOH 2004b):

### **Institutional**

- Establishing a national policy-making body
- Establishing an Inter-Ministerial Committee on AIDS
- Cooperating in setting up the Malaysian AIDS Council, an umbrella organisation of NGOs working in HIV/AIDS, to complement Government programmes and facilitate coordination
- Establishing a dedicated Section on AIDS/STD under the Department of Infectious Diseases, Public Health Institute, Ministry of Health, responsible for the national HIV/AIDS Prevention and Control Programme.

### **Surveillance**

- Screening of blood and blood products
- Passive surveillance under the Prevention of and Control of Infectious Diseases Act 1988 (section 10, ACT 342) at community-level where any known case must be reported to the nearest District Health office/authority.
- Active surveillance in collaboration with the Anti Narcotics Agency, Department of Prisons Malaysia, and other agencies under various programmes for mandatory and voluntary HIV screening of special groups.

- Mandatory testing of antenatal mothers under the Prevention of Maternal to Child Transmission programme through community-based government maternal child health (MCH) clinics, with counselling services and free antiretroviral drugs to infected mothers and their infants.
- Special surveys in collaboration with international and local agencies focussed on specific target groups suspected at risk, namely, sex workers (SWs), STD patients, youths, IDUs, long distance lorry drivers, fishermen and factory workers
- Behavioural Surveillance Surveys among SWs and IDUs (first round completed in 2004, second round scheduled for 2006)
- Consensus on HIV epidemiology with technical and financial assistance from the WHO. Three rounds undertaken in 1998, 2000 and 2003 to estimate the number of people living with HIV in the country.
- Sentinel surveillance among specific groups, i.e., antenatal women, STD and TB patients, was initiated in 1996 and has since been assimilated into routine surveillance for all three groups.
- Voluntary, anonymous, free HIV screening services through health clinics piloted in one state (Johor) in 2001 and expanded nation-wide since 2002.

### **Operational**

- Integrating management of HIV patients at Primary Health Care (PHC) level since 2000; 240 community Health Clinics have been upgraded to provide risk assessment, HIV testing, counselling, medical examination, treatment, follow-up, case notification, contract tracing, referral and home visits by trained health personnel. In 2004, 7,685 clients utilised this service, 770 of which were HIV-positive.
- Integrating management of STDs in primary care since 1996 to encourage clients to seek treatment for STIs at PHC clinics, and introducing the Modified Syndromic Approach (MSA) of STI Management in 1999. Currently, 120 Health Clinics are applying MSA management.
- Training of clinical specialists in Infectious Diseases, including Family Medicine Specialists. Currently, about 20 physicians nation-wide are involved in HIV/AIDS management, and 67 Family Medicine Specialists have undergone training attachments.
- Issuing directive in 2004 to all State Directors of Health to treat more HIV/AIDS patients in their public hospitals and increase the number on antiretroviral treatment (ARV).

### **Prevention**

- Health education and promotional activities on HIV/AIDS/STDs through the Healthy Lifestyle Campaign, an annual theme that was focussed on HIV/AIDS in annual World AIDS Day events, PROSTAR events, HIV counselling courses, media campaigns and IEC activities targeted at youths, inmates of correctional institutions through forums and seminars.
- Establishing PROSTAR – Programme for Healthy Youths without AIDS – via peer to peer youth clubs, and in 2004, a PROSTAR Youth Centre, piloted in Kedah. The Youth Centre is a one-stop centre to provide services to youths to discourage involvement in undesirable activities and encourage healthy living.

In brief, the civil society response focuses on education, counselling, shelter, outreach, advocacy, providing channels for the participation of target communities, providing funds and fund-raising. NGOs and CBOs, in particular, have enabled marginalised groups, such as drug users, IDUs, transsexuals and SWs to have a voice that otherwise would not be heard because of the many social and economic barriers they face. Efforts to involve PLWHAs in all stages of policy and programme development have been largely initiated by civil society.

The extent of coverage, however, is more limited compared to Government organisations (GOs) because of funding and manpower constraints. Only FFPAM and MAC have nationwide coverage while others have plans to broaden their outreach and upscale. Many participate in public events, e.g., World AIDS Day, and have a visible presence in local communities. One aspect civil society has little role in is the provision of medical care and drugs for HIV and AIDS patients. The Government funds and provides the bulk of treatment. Some of the initiatives from civil society are summarised as follows:

### **Services and target groups**

- Provide support services for focal groups, most of whom are not served by GOs, namely:
  - PLWHAs and their families
  - Lesbians, bisexuals, gays, transsexuals (LBGTs)
  - Sex workers – males, females, transgender/transsexuals
  - Drug users and IDUs
- Shelter for PLWHAs and homeless sex workers
- Operating voluntary drug rehabilitation centres, including Therapeutic Communities
- Counselling
- Referrals to physicians and medical care
- Networking and linking up clients to relevant services/agencies
- Operating e-group discussions on relevant issues and problems
- Facilitating a “buddy support system”
- Cooperation and collaboration with GOs in programme development and implementation

### **Education and training**

- Information, Education and Communication (IEC) for the public as well as focal groups, such as awareness campaigns in public places, schools and work-places
- Behavioural Change Communication (BCC)
- Development and dissemination of informational materials
- Promotion of safe sex and condom use
- Training IDUs to clean needles and other drug-using equipment
- Training of trainers camps for youths in reproductive and sexual health, including HIV/AIDS
- Education and training for PLWHAs and other targeted communities

### **Advocacy and public relations**

- Promoting human rights and access to treatment and other services
- Advocating new approaches, such as Harm Reduction
- Spokesperson for HIV-positive people, especially on treatment issues and problems
- Promoting greater involvement of people with AIDS
- Playing media watch-dog and issuing prompt public responses to counter negative perspectives on HIV/AIDS, PLWHAs and other targeted communities that appear in the mass media
- Promoting human rights for sex workers (female, male, transgender/transsexuals)
- Involving sex workers in the process of policies and decision-making

### **Research and fund-raising**

- Participation in local research teams as resource persons, advisors or sourcing respondents
- Fund-raising
- Fund administration and distribution (MAC)

Some have community-based centres (such as PT Foundation's Drop-In Centre, PEMADAM centres) and/or Phone-In services (PT Foundation). The FFPAM is an established body in the country since 1958 with a state affiliate (Family Planning Association – FPA) in every state. Its main focus has evolved from population and family planning to reproductive and sexual health, including HIV/AIDS. It was a founding member of MAC.

As the umbrella body for many organisations, the Malaysian AIDS Council (MAC) has three main functions:

- Coordination
- Representation
- Advocacy

MAC currently has 40 affiliates or associate organisations. MAC receives funds from various sources and administers its distribution. At present, it is also funding 88 projects, eight of which are for marginalised communities. The programme interventions match the focus areas identified in the National Strategy Plans for HIV/AIDS. MAC was involved in many key stages in the national response. Most recently, it was also instrumental in promoting the concept of harm reduction for IDUs comprising methadone replacement and needle exchange. The Ministry of Health has accepted the proposal and this project is in its pilot stage.

There are many other individual organisations that have contributed to the national response, including the private sector, not least by providing funds or raising funds, and implementing HIV/AIDS policies at the work-place.

#### **IV. Major challenges faced and actions needed to achieve the UNGASS goals/targets**

Major challenges have been identified towards reversing and halting the spread of HIV/AIDS. These can be described as arising from technical, financial, operational and social constraints. These also apply in different forms to GOs and civil society members, particularly organisations focused on HIV/AIDS.

##### **Political Will**

There is documented evidence of political commitment in the Malaysian situation. However, such commitment has not been matched by financial and technical resource allocations.

At its present status of low and concentrated prevalence, HIV/AIDS has not invoked a sense of urgency among policy-makers and authorities. The fact that it continues to be relatively confined to specific sub-groups of the population, i.e., drug users or drug abusers, sex workers and homosexuals, distances the majority who do not fall into those categories from the problem of HIV/AIDS. The image of a drug addict, particularly, an intravenous drug user, as an unproductive member of society, living on the streets, committing crimes to sustain his/her drug use habit, reinforces the perception that drug addiction and its consequence on HIV infection are self-inflicted. With the same effect, HIV infection is also associated with what is perceived to be sexually deviant behaviour, particularly in a conservative culture. The high level of stigma that ensues leads to inaction.

##### **Stigma and discrimination**

The conservative climate in this country is upheld by religious beliefs which subsume strong views on issues pertinent to HIV/AIDS, such as homosexual practices, premarital sex, multiple partners, commercial sex, drug use, and condom use. The non-acceptance of diverse sexualities is intransigent. Although the same proscriptions apply to other major religions in the country, only Islamic laws empower religious authorities to arrest Muslims for various moral offences, such as consuming alcohol, sex between unmarried couples and homosexual acts. This moral policing also targets transgender/transsexual communities. There have been efforts to educate religious leaders on HIV/AIDS to gain a more sympathetic understanding and dispel misconceptions. One of the aims is to recruit religious leaders, who are influential members of society, in the effort to change public perceptions and de-stigmatise the disease. For example, efforts to raise awareness among religious authorities in Kuala Lumpur on transsexuals have led to fewer raids by the Religious Authority in Kuala Lumpur.

Pervasive stigma and failure to comprehend the HIV epidemic as a development issue also lead to resistance in accepting primary or secondary prevention strategies, notably, Harm Reduction for IDUs that are viewed as extreme despite compelling evidence to the contrary. Changing this mind-set continues to be a challenge in HIV/AIDS prevention and programmes.

PLWHAs are still on the fringe of the HIV/AIDS agenda. Those who are open about their status and who are actively involved with HIV/AIDS work are in the minority. This lack of visibility has its roots in stigma and negative public perceptions but, at the same time, adds to it. Policies and programmes on HIV/AIDS would benefit from greater participation from the PLWHA community. The challenge is in mobilising fuller participation from a group that feels marginalised, lacking in confidence, and possibly apathetic. This is especially the case for Malaysia where the majority of HIV-positive persons are IDUs who generally have low education and social status. Another barrier is the fear of criminal prosecution in the process of accessing mainstream services. Their social and economic realities must be recognised as these are strong forces preventing access to resources and participation in the national response to HIV/AIDS.

### **Enabling Environment**

There are several challenges to creating an enabling environment for Malaysia to respond effectively to HIV/AIDS. Some of these are described below:

- **Shortage of skilled manpower**

Measures have been taken to increase the number of physicians and nurses trained in infectious diseases, and specifically for HIV/AIDS and TB, but the training process is lengthy. Furthermore, skilled medical and health staff tend to prefer living in urban centres, hence, rural health centres areas are continually under-staffed. The decentralisation of treatment to community health centres also adds to the burden of health workers who are already inundated with a host of other tasks, such as the 3X5 Initiative, DOTS, Safe Motherhood, child immunisations, etc., not to mention the administrative tasks that go with each.

Although the MoH has access to experts through its wide international network, the technical assistance received is not always appropriate. More often than not, international agencies provide consultants whose expertise lies in the African, not the Asian, model of the epidemic. Hence, technology transfer is limited.

- **Insufficient or inaccessible local research and data**

Although research is carried out in the country, largely by GOs and academia, the scale of most studies and sampling methodologies often limit the usefulness of the outcomes/results. In particular, survey research on population-based samples is very costly; hence, large-scale surveys are only within the capabilities of GOs. With respect to HIV/AIDS, this is primarily done by the Ministry of Health. Often, studies/surveys are carried out in collaboration with academic institutions (for technical input) and NGOs (e.g., for sourcing respondents) but the data and results are not always disseminated, or widely enough. Research is also carried out by different GOs, the outcomes of which, again, are not widely disseminated, even between GOs. A National Clearinghouse on HIV/AIDS related literature which holds all available reports and data related to HIV/AIDS would facilitate information seeking and sharing.

Furthermore, the extent of data analysis and utilisation is constrained by the time availability of GO staff. Ministry of Health officials are primarily medical doctors, hence, units and departments tend to be small since there is a shortage of medical doctors overall in a developing country. Notably, the AIDS/STD Unit of the Ministry is staffed by three medical doctors. In the event of a critical health emergency, such as, SARS or the potential influenza epidemic, these limited skilled human resources will be diverted.

As with police data on road traffic accidents, the rich databases from GOs should be made available to interested users for purposes of research and recommendations. There should be ways to overcome the issue of potential misuse and abuse of data, e.g., by incorporating legally binding controls into agreements between parties on objectives and intent.

Of equal importance, research findings tend not to be presented in formats useful to programme managers and workers on the ground. Scientific data need to meet the needs of programme managers, especially those who have a limited understanding of scientific or quantitative information.

NGOs and CBOs rarely have the resources to undertake systematic data collection and analysis. Yet, appropriate data management are important tools in decision-making, setting new directions and strategies, and for accountability. Many of these organisations are service-orientated, but particularly as these organisations expand, this aspect of organisational development must be addressed. Every programme should have an in-built data management system measuring both process and outcome indicators for monitoring and evaluation. Research needs obviously require additional and specific allocation of funds.

- **Limited funding**

The availability of funds for HIV/AIDS research is another challenge in Malaysia. The main source of research funds for academic institutions and statutory bodies is the Intensive Research for Priority Areas (IRPA) administered by the Ministry of Science, Technology and Environment. Towards national aspirations for industrialisation, this source of funding places a priority on Research and Development for a commercially viable product. Socio-behavioural research, which is important in understanding the complex processes in HIV/AIDS, does not meet this criterion. IRPA funds are also not available for monitoring and evaluation research. At the same time, Malaysia's economic progress has removed it from the list of aid recipient countries and funds from donor countries.

NGOs in particular have more limited sources and quantum of funds for operating their programmes. Funding for NGO programmes come from several sources, including the Government, international agencies, such as UNDP, UNFPA and UNICEF, as well as

private contributions. Again, Malaysian NGOs suffer from being excluded from large donor organisations, such as USAID. At the same time, the absence of an established M&E system may discourage donor agencies based on the lack of accountability on the usefulness and impact of a programme.

GOs sometimes have funds not spent for an allocated item in a given budget year but are restricted in their ability to transfer funds across budget items even within their own department or unit. These are administrative constraints.

### **Intractable Drugs Problem and Progression to Intravenous Use**

The National Anti-Drug Agency (NADA) has limited expertise in drug prevention and rehabilitation. Despite the actions taken thus far in drug prevention, including its inclusion in the secondary school curriculum, the demand for drugs has not declined. At the same time, the NADA (National Anti-Drug Agency) operates One-Stop Drug Rehabilitation Centres (*Pusat Serenti*) in all states, yet the rehabilitation model has not been successful as measured by the high proportion of relapse cases re-entering the system. There are others who escape detection. The strategies and programmes, thus far, have continued despite little evidence of success.

It is felt that the anti-drug effort can benefit from upgrading its expertise in research and programme monitoring and evaluation. Drug-related and socio-demographic data are collected on all drug users in its system that have come in voluntarily or through the criminal justice system. Yet, very little of the data is utilised except to report monthly and yearly statistics. The data-base should be reconstructed such that it can be better utilised for on-going research, monitoring and evaluation.

### **Incompatible Legal Frameworks**

The National AIDS Committee also does not have a legal mandate, unlike its counterpart, for example, in the Philippines. This would strengthen its position and ability to mobilise action in other sectors. There are also existing laws that are barriers to HIV/AIDS prevention and control, such as legal restrictions on:

- condom advertising which has been imposed for decades based on its perceived association with immoral activities (namely, casual and commercial sex)
- providing needles outside of a health setting
- explicit illustrations of genitalia/sex organs in informational materials which is construed as pornography

## **V. Support required from country's development partners**

HIV/AIDS has not been strategically positioned as a national development issue. Hence, it remains within the jurisdiction of the MoH and not integrated into other sectors. To facilitate multi-sectoral strategies and inter-sectoral coordination, the National AIDS Coordinating Committee should be chaired by an authority above the level of a single Ministry. The most recent National Strategy Plan, 2006, proposes that the National Coordinating Committee on HIV/AIDS be shifted to the Deputy Prime Minister. Although the Ministry of Health remains the main implementing agency for technical and health-related issues, the Deputy Prime Minister's office will be the main agency responsible for policy implementation, coordination, monitoring and evaluation across sectors. If approved by Cabinet, it will be a cornerstone in the Declaration of Commitment on HIV/AIDS.

More support is needed to raise awareness among parliamentarians and persuading policy-makers of the urgency of the HIV/AIDS epidemic. International agencies, such as

UN organisations and WHO are visible in sponsoring awareness campaigns, conferences and dialogues, which are officiated by politicians, yet HIV/AIDS has not been an explicit part of the agenda for any political party, much less the party representing the interests of Malays who are most affected by HIV. As respected members of the international community, UN agencies are requested to put more efforts into advocacy and influencing the political body from top-down.

The significant role religion plays in this country calls for support from the highest religious authority, i.e., the Sultans<sup>7</sup> and King, to institutionalise understanding of HIV/AIDS issues in Islamist laws, and assist in dispelling misconceptions and stigma. More effective ways in education and prevention must be identified to reduce the stigma attached to HIV/AIDS, which is a formidable obstacle in the fight against HIV/AIDS.

PLWHAs and other targeted communities should be more involved in decision-making, planning and implementation of policies and programmes as their feedback and input are relevant to potential pitfalls in a particular approach and to factors influencing its success. NGOs call for PLWHAs and other targeted communities to be accepted as equal partners and as community consultants, i.e., for GOs and international agencies to recognise their knowledge and experiences.

At the same time, the PLWHA and other targeted communities are at an early stage in their organising and need a lot of support in capacity-building and expanding their membership. International agencies and GOs can provide some of this support and resources.

Representatives of the UN and other international agencies are also encouraged to join the grassroots so that they are better able to understand the local context and identify technical expertise that is most appropriate and identify funding priorities. Sometimes, international consultants cannot provide the needed assistance because their expertise is based on the African model of HIV/AIDS.

Although GOs have increased the training of medical doctors in infectious diseases and integrated HIV/AIDS patient care at primary health care level, more resources are required to upgrade nursing care and technical support for research, and monitoring and evaluation (M&E). Both GOs and NGOs require capacity-building in research skills, particularly, for incorporating M&E as an on-going process planned at the stage of project/programme planning and carried out routinely at timely intervals. This evidence-based practice needs to be institutionalised for both GOs and NGOs.

For GOs which have research expertise, support is needed in the form of research assistants with skills in data analysis and report writing. This will assist GO officers, who are mainly a small cadre of medical doctors in the Ministry of Health, to produce reports in shorter time.

Besides operations research, technical and financial support is also needed for basic research, such as socio-behavioural research on HIV/AIDS and drug abuse/dependence, and sociological research on PLWHAs, sex workers and transgender/transsexuals. This will deepen the understanding of the characteristics and processes leading to drug use, its progression to addiction and to intravenous use, as well sexual practices in the local context to enable early interventions. Valid and reliable local research is also lacking on factors influencing public perceptions on HIV/AIDS, risk-taking behaviour and barriers to

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<sup>7</sup> Malaysia is a constitutional monarchy whereby 11 states are ruled by a Sultan and the others by Governors. The Sultan is the Head of religion in his state. The King is appointed at the Conference of Rulers by his counterparts on a rotation basis and is the head of religion for the country.

behaviour change. These provide an evidence-based approach for formulating more effective strategies.

NGOs will benefit from closer cooperation and support from local academic institutions with the necessary skills, particularly, in research and M&E, on an on-going basis. This includes training its staff in information gathering and data management. Academic or private sector institutions can also help by designing user-friendly software. The usefulness of research findings is increased if there was information sharing between and within organisations, especially for identifying best practices.

NGOs also require more funding support from GOs. The financial resources may be available but GOs are constrained by how they can disburse it, with good reason. The stringent rules on funds allocation should be made more flexible so that GOs can transfer unused funds to other needed categories and to their NGO partners while still maintaining accountability.

## **VI. Monitoring and evaluation environment**

The purposes of monitoring and evaluation (M&E) are to assess the relevant situation in a continuous manner and identify any changes resulting from policies, programmes or other significant events, such as, technological advances or drug pricing. Thus, an effective M&E system allows for accountability for funding and resource allocations, and timely responses to policy or programme outcomes and impact (UNAIDS 2000). Many M&E tools have been developed for HIV/AIDS after countries world-wide experienced more than two decades of this, hitherto, new disease.

Surveillance involves an on-going process of data collection and analysis. Malaysia has put into place a sound surveillance system within an established health information management system (HMIS). All cases of HIV infection must be notified to the nearest District Health authority as mandated by law. Since 1993, each state has a HIV/AIDS Unit which compiles data from all districts for the national AIDS/STD Unit of the MOH Department of Public Health, Division of Infectious Disease Control. Data collected comprise sex, age, date and place of occurrence, date of confirmation, contact information, associated risk factors, name, address and actions taken against the spread of disease. Sentinel surveillance was implemented in 1994 for women in antenatal care clinics, STD patients, tuberculosis (TB) patients, and dissolved as these target groups were incorporated into routine surveillance systems by end 1997.

This community-level three-tiered process, however, takes time to complete for all states. Nonetheless, data for the preceding year is made available for analysis in the current year.

Second generation surveillance relating behavioural data to disease outcomes (HIV/STI data) have not been undertaken. Only one round of Behavioural Surveillance Surveys (BSS) has been completed. Succeeding rounds of BSS will enable further analysis of associations between trends in preventive behaviour and HIV/STI incidence and prevalence (outcomes).

Monitoring is defined as routine tracking of priority information about a programme and its intended outcomes, including maintaining records and issuing reports on inputs and outputs, as well as health facility observations and client surveys (process monitoring) (UNAIDS 2000). Inherent in this activity are clearly defined goals and objectives. Evaluation is defined as a collection of activities designed to specifically relate a programme, project or intervention to its intended outcomes (UNAIDS 2000). This involves

a sequence of process, outcome and, finally, impact evaluation. Again, it is imperative that specific objectives and targets are clearly defined at the outset.

In Malaysia, the responsibility for surveillance, monitoring and evaluation for HIV/AIDS strategies and programmes lies with the Ministry of Health as the lead government agency for policy planning and implementation nation-wide. Basic statistics from the surveillance system are analysed and presented in monthly and annual reports. Some statistics are also available on the Ministry's website with public access. Monitoring and evaluation activities are carried out by key agencies implementing programmes. These are presented in project reports according to designated reporting schedules, notably, inception, interim, final reports. For the most part, however, GO reports are not widely disseminated. Furthermore, raw data are not accessible to interested researchers to analyse.

In reality, much of the data collected on HIV/AIDS is surveillance data with little analysed for M&E purposes. M&E capabilities and practice are generally poor for both GOs and NGOs. NGOs are constrained by limited research skills as well as funding for research, whereas GOs are constrained by their limited staff, albeit with research skills. A National Coordinating Agency, with specific percentage of funds allocated per project, should be set up for systematic monitoring and evaluation for all policies and programmes on HIV/AIDS. These data should also be made easily available to users.

The rich body of data collected over a period of 20 years, however, is confined essentially to GOs, primarily MOH, and its capabilities in utilising and analysing the data. It is felt that more evaluative and impact analyses can be achieved if the MOH data, without personal identifiers, were made available to other researchers with explicit controls on misuse of data and protection of identities. There should also be more effort in disseminating and sharing data and research outputs, especially to HIV/AIDS programme managers and affected communities (end-users).

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## Annex I: Consultation/Preparation Process

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

a. NAC or equivalent	<b>YES</b>	NO
b. NAP	YES	<b>NO</b>
c. Others (please specify)	YES	<b>NO</b>

2. With inputs from

Ministries:		
Education	YES	<b>NO</b>
Health	<b>YES</b>	NO
Labour	YES	<b>NO</b>
Foreign Affairs	YES	<b>NO</b>
Others (Women)	<b>YES</b>	NO
Civil society organisations	<b>YES</b>	NO
People living with HIV/AIDS	<b>YES</b>	NO
Private sector	YES	<b>NO</b>
United Nations organisations	<b>YES</b>	NO
Bilaterals	YES	<b>NO</b>
International NGOs	YES	<b>NO</b>
Others (Academic Institutions)	<b>YES</b>	NO

3. Was the report discussed in a large forum? **YES** NO

4. Are the survey results stored centrally? YES  
**NO**

5. Are the data available for public consultation? YES  
**NO**

Name : Dr Siti Norazah Zulkifli  
 Title : Public Health Consultant  
 Date : 28 December 2005  
 Signature : Siti Norazah Zulkifli, ScD

# Annex II: National Composite Policy Index Questionnaires

## National composite policy index questionnaire PART A

### I. Strategic plan

#### 1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?

(Multisectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below.)

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

1.1 IF YES, which sectors are included?

Sectors included	Strategy/Action framework		Focal point/Responsible	
Health	Yes ✓	<del>No</del>	Yes	<del>No</del>
Education	Yes	<del>No</del>	Yes	<del>No</del>
Labour	Yes	<del>No</del>	Yes	<del>No</del>
Transportation	<del>Yes</del>	No	<del>Yes</del>	No
Military	Yes	<del>No</del>	<del>Yes</del>	No
Women	Yes	<del>No</del>	Yes	<del>No</del>
Youth	Yes	<del>No</del>	<del>Yes</del>	No
Others to specify <sup>8</sup>	Yes	No	Yes	No

*Comments:* Ministry of Internal Security

- National Anti-Drug Agency	Yes	No
- Dept. of Immigration	Yes	No
- Ministry of Information	Yes	No

1.2 IF YES, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (Yes/ No)

<p><b>Programme</b></p> <p>a. Voluntary counselling and testing?</p> <p>b. Condom promotion and distribution?</p> <p>c. Sexually transmitted infection, prevention and treatment?</p> <p>d. Blood safety?</p> <p>e. Prevention of mother-to-child transmission?</p> <p>f. Breastfeeding?</p> <p>g. Care and treatment?</p> <p>h. Migration? * YES for migrant workers only</p> <p><b>Target populations</b></p> <p>i. Women and girls? * NOT for girls</p> <p>j. Youth?</p> <p>k. Most at risk populations<sup>9</sup>?</p> <p>l. Orphans and other vulnerable children?</p> <p><b>Cross-cutting issues</b></p> <p>m. HIV/AIDS and poverty?</p> <p>n. Human rights?</p> <p>o. PLHA involvement?</p>	<p>a. Yes (MOH)</p> <p>b. No</p> <p>c. Yes (Only Rx)</p> <p>d. Yes</p> <p>e. Yes</p> <p>f. Yes</p> <p>g. Yes</p> <p>h. No</p> <p>i. Yes (women)</p> <p>j. Yes</p> <p>k. Yes</p> <p>l. No</p> <p>m. Yes</p> <p>n. Yes</p> <p>o. No</p>
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<sup>8</sup> Any of the following: Agriculture, Finance, Human Resources, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

<sup>9</sup> Most-at-risk populations are groups that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, moto-taxi drivers, etc.)





## 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. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government	Yes	<del>No</del>
Other high officials	Yes	<del>No</del>

### 2. Does your country have a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)\*

<del>Yes</del>	No ✓	N/A
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2.1 IF YES, when was it created? Year:

2.2 Does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Including civil society	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Date of last meeting of the Secretariat	Date:	

*Comments:* National AIDS Committee (National HIV/AIDS Technical Committee and National HIV/AIDS Coordinating Committee have no legal statute

### 3. Does your country have a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes?

Yes ✓	No	N/A
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3.1 IF YES, does it include?

Terms of reference	Yes	<del>No</del>
Defined membership	Yes	<del>No</del>
Action plan	<del>Yes</del>	No
Functional Secretariat	Yes	<del>No</del>
Date of last meeting	Date: 2004	

Comments: [Action Plan only for Ministry of Health](#)

**4. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
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4.1 IF YES, does it include?

Terms of reference	Yes	<del>No</del>
Defined membership	Yes	<del>No</del>
Action plan	Yes	<del>No</del>
Functional Secretariat	Yes	<del>No</del>
Date of last meeting	Date: Dec 2005	

Comments: [The Malaysian AIDS Council](#)

Overall, how would you rate the political support for the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	<b>7</b>	8	9	10
2003	Poor										Good
	0	1	2	3	4	<b>5</b>	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i> <a href="#">The Government has expressed support for the MDG goals with the Prime Minister overseeing progress</a>											

### III. Prevention<sup>10</sup>

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

<del>Yes</del>	<del>No</del>	<del>N/A</del>
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2. In the last year, did you implement an active programme to promote accurate HIV and AIDS reporting by the media?

<del>Yes</del>	No
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*Comments:*

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

<del>Yes</del>	No	<del>N/A</del>
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- 2.1 Is HIV education part of the curriculum in:

primary schools?

<del>Yes</del>	No
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secondary schools?

Yes	<del>No</del>
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- 2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

<del>Yes</del>	No
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*Comments:*

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

<del>Yes</del>	No	<del>N/A</del>
----------------	----	----------------

<sup>10</sup> Strategies/policies discussed under Prevention may be included in the national strategy/action framework discussed in 1.1 or separate

3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including: - Risk reduction information, education and counselling? - Needle and syringe programmes? - Treatment services? - If yes, drug substitution treatment?	Yes Yes Yes Yes Yes	No No No No No	N/A N/A N/A N/A N/A
Men who have sex with men?	Yes	No	N/A
Sex workers?	Yes	No	N/A
Prison inmates?	Yes	No	N/A
Cross-border migrants, mobile populations	Yes	No	N/A
Refugees and/or displaced populations?	Yes	No	N/A
Other most-at-risk populations? <i>Please specify</i> Transsexuals	Yes	No	N/A

Comments: Strategy for most-at-risk populations is confined to testing (detection) at present but is expanded in the next National Strategy Plan.

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)

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

4.1 Do you have programmes in support of the policy or strategy?

A social-marketing programme for condoms?	Yes	No
A blood-safety programme?	Yes	No
A programme to ensure safe injections in health care settings?	Yes	No
A programme on antenatal syphilis screening	Yes	No
Other programmes? <i>Please specify</i>	Yes	No

Comments:

Overall, how would you rate policy efforts in support of prevention?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: Harm Reduction programme initiated (pilot stage) for IDUs comprising clean needle provision and methadone replacement											

**5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?**

*(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).*

		2003	2005
a.	A programme to promote accurate HIV and AIDS reporting by the media.	a.	a.
b.	A social-marketing programme for condoms	b.	b.
c.	School-based AIDS education for youth	c. ✓	c. ✓
d.	Behaviour-change communications	d.	d.
e.	Voluntary counselling and testing	e.	e. ✓
f.	Programmes for sex workers	f.	f.
g.	Programmes for men who have sex with men	g.	g.
h.	Programmes for injecting drug users, if applicable	h.	h.
i.	Programmes for other most-at-risk populations	i.	i.
j.	Blood safety	j. ✓	j. ✓
k.	Programmes to prevent mother-to-child transmission of HIV	k. ✓	k. ✓
l.	Programmes to ensure universal precautions in health care settings	l. ✓	l. ✓
m.	Other: <i>(please specify)</i>	m.	m.

<b>Overall, how would you rate the efforts in the implementation of HIV prevention programmes?</b>												
2005		Poor										Good
		0	1	2	3	4	5	6	7	8	9	10
2003		Poor										Good
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i> <a href="#">New National Strategy Plan 2006-2010 includes broader prevention strategies</a>												

#### IV. Care and support<sup>11</sup>

1. Does your country have a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counselling and testing, psychosocial care, access to medicines, and home and community-based care.)

<del>Yes</del>	No	<del>N/A</del>
----------------	----	----------------

2. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

		2003	2005
a.	HIV screening of blood transfusion	a. ✓	a. ✓
b.	Universal precautions	b. ✓	b. ✓
c.	Treatment of opportunistic infections (OI)	c. ✓	c. ✓
d.	Antiretroviral therapy (ART)	d. ✓	d. ✓
e.	Nutritional care	e. ✓	e. ✓
f.	Sexually transmitted infection care	f. ✓	f. ✓
g.	Family planning services	g. ✓	g. ✓
h.	Psychosocial support for people living with HIV and their families	h.	h.
i.	Home-based care	i.	i.
j.	Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. ✓	j. ✓
k.	Cotrimoxazole prophylaxis among HIV-infected people	k.	k.
l.	Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. ✓	l. ✓
m.	Other: <i>(please specify)</i>	m.	m.

*Comments:* Policy/strategy on care and support is not comprehensive. Cotrimoxazole prophylaxis provided only in hospitals, not for HIV-infected prison inmates. Post-exposure prophylaxis only for occupational exposures, not rape.

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i> Wider availability of ARV therapy through cheaper drugs in 2004											

<sup>11</sup> Strategies/policies discussed under Care and Support may be included in the national strategy/action framework discussed in 1.1 or separate.



**V. Monitoring and Evaluation**

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

<del>Yes</del>	No ✓	<del>In progress</del>	<del>Years covered:</del>
----------------	------	------------------------	---------------------------

1.1 *IF YES*, was it endorsed by key partners in evaluation? **Yes** **No**

*Comments:*

1.2 Was the Monitoring and Evaluation plan developed in consultation with civil society, people living with HIV? **Yes** **No**

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

a data collection and analysis strategy	<b>Yes</b>	<b>No</b>
well defined standardized set of indicators	<b>Yes</b>	<b>No</b>
guidelines on tools for data collection	<b>Yes</b>	<b>No</b>
a strategy for assessing quality and accuracy of data	<b>Yes</b>	<b>No</b>
a data dissemination and use strategy	<b>Yes</b>	<b>No</b>

**3. Is there a budget for the Monitoring and Evaluation plan?**

<b>Yes</b>	<b>No</b>	<b>In progress</b>	<b>Years covered:</b>
------------	-----------	--------------------	-----------------------

3.1 *IF YES*, has funding been secured? **Yes** **No**

**4. Is there a Monitoring and Evaluation functional Unit or Department?**

<b>Yes</b>	<b>No</b>	<b>In progress</b>
------------	-----------	--------------------

*IF YES,*

Based in NAC or equivalent? **Yes** **No**  
 Based in Ministry of Health? **Yes** **No**  
 Elsewhere? *Please specify* **Yes** **No**

4.1 If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department? **Yes** **No**

*Comments:*

4.2 Is there a full-time officer responsible for monitoring and evaluation activities of the national programme?

<b>Yes full time</b>	<b>Yes part-time</b>	<b>No Monitoring and Evaluation Officer</b>
----------------------	----------------------	---

4.3 IF YES, since when? : Year \_\_\_\_\_

**5. Is there a committee or working group that meets regularly coordinating Monitoring and Evaluation activities?**

<b>Yes regular</b>	<b>Yes irregular</b>	<b>No</b>	<b>Date last meeting:</b>
--------------------	----------------------	-----------	---------------------------

5.1 Does it include representation from civil society, people living with HIV? **Yes**      **No**

**6. Have individual agency programmes been reviewed to harmonize Monitoring and Evaluation indicators with those of your country?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

**7. To what degree (Low to High) are UN, bi-laterals, other institutions sharing Monitoring and Evaluation results?**

<b>Low</b>	<b>High</b>
0	10

Comments:

**8. Does the Monitoring and Evaluation Unit manage a central national database?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

8.1 IF YES, what type is it? \_\_\_\_\_

**9. Is there a functional\* Health Information System?**

National level	<b>Yes</b>	<del><b>No</b></del>
Subnational*	<b>Yes</b>	<del><b>No</b></del>

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

Comments: Malaysia has a well-established Health Management Information System (HMIS) but no M&E system specifically for HIV/AIDS policy and programmes.

**10. Is there a functional Education Information System?**

National level

~~Yes~~

No

Subnational\*

~~Yes~~

No

\* If yes, please specify the level, i.e., district

**11. Does your country publish at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports?**

Yes

No

N/A

**12. To what extent strategic information is used in planning and implementation?**

Comments: Evaluation reports present limited univariate and bivariate statistics on surveillance data

**13. In the last year, was training in Monitoring and Evaluation conducted**

At national level?	<del>Yes</del>	No
At subnational level?	<del>Yes</del>	No
Including civil society?	<del>Yes</del>	No

Overall, how would you rate the monitoring and evaluation efforts of the HIV and AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

# National composite policy index questionnaire PART B

## I. Human rights

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

~~Yes~~ No ~~N/A~~

Comments:

2. Does your country have non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e., groups such as injecting drug users, men who have sex with men, sex workers, youth, mobile populations, and prison inmates)?

~~Yes~~ No ~~N/A~~

IF YES, please list groups:

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

Yes No ~~N/A~~

IF YES, please list groups: Existing, long-standing laws prohibit condom distribution outside healthcare settings; Printing Act controls graphic illustrations of genitalia in non-medical print media (obstacle for IEC and condom promotion); Dangerous Drugs Act prohibit distribution of syringes outside of healthcare setting (obstacle for programmes with IDUs); mandatory prenuptial HIV testing procedures state religious (Islamist) authorities (2 states) encourage some to avoid marriage in those states to avoid being tested.

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

~~Yes~~ No ~~N/A~~

Comments: Human rights aspect included in 2006 National Strategic Plan (yet to be approved by Cabinet).

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation?

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
----------------	---------------	----------------

---

*IF YES, please list groups:*

PWLHAs – greater involvement proposed in 2006 National Strategic Plan although Government is not a signatory to GIPA

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
----------------	---------------	----------------

---

*Comments:*

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
----------------	---------------	----------------

---

*Comments:*

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
----------------	---------------	----------------

---

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

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
----------------	---------------	----------------

---

- 9.1 *IF YES*, does the ethical review committee include civil society and people living with HIV?

---

<del>Yes</del>	<del>No</del>	<del>N/A</del>
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*Comments:* Only civil society, not PWLHAs

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**10. Does your country have the following monitoring and enforcement mechanisms?**

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and programme development reform	<b>Yes</b>	<b>No</b>
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV- and AIDS-related issues within their work	<b>Yes</b>	<b>No</b>
Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses	<b>Yes</b>	<b>No</b>
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	<b>Yes</b>	<b>No</b>

**11. Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

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

Legal aid systems for HIV and AIDS casework	<b>Yes</b>	<b>No</b>
State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV and AIDS in areas such as discrimination	<b>Yes</b>	<b>No</b>
Programmes to educate, raise awareness among people living with HIV and AIDS concerning their rights	<b>Yes</b>	

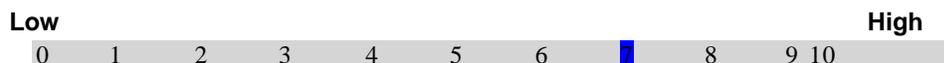
**13. Are there programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance?**

<b>Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?</b>											
2005	Poor										Good
	0	1	<b>2</b>	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	<b>1</b>	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: <b>There are programmes but these have not been implemented systematically.</b></i>											

<b>Overall, how would you rate the effort to enforce the existing policies, laws and regulations?</b>											
2005	Poor										Good
	0	<b>1</b>	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	<b>1</b>	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

## II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?



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



3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?



4. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:

Yes No N/A

Month \_\_\_\_\_ Year 2004

5. To what extent your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which people living with HIV and care givers participate?*



Overall, how would you rate the efforts to increase civil-society participation?										
2005	Poor									Good
	0	1	2	3	4	5	6	7	8	9 10
2003	Poor									Good
	0	1	2	3	4	5	6	7	8	9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: <u>More open attitude and increased efforts to involve civil society.</u>										

### III. Prevention

#### 1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).

		2003	2005
a.	A programme to promote accurate HIV and AIDS reporting by the media.	a. ✓	a. ✓
b.	A social-marketing programme for condoms	b.	b.
c.	School-based AIDS education for youth	c. ✓	c. ✓
d.	Behaviour-change communications	d.	d.
e.	Voluntary counselling and testing	e.	e. ✓
f.	Programmes for sex workers	f.	f.
g.	Programmes for men who have sex with men	g.	g.
h.	Programmes for injecting drug users, if applicable	h.	h.
i.	Programmes for other most-at-risk populations <sup>12</sup>	i.	i.
j.	Blood safety	j. ✓	j. ✓
k.	Programmes to prevent mother-to-child transmission of HIV	k. ✓	k. ✓
l.	Programmes to ensure universal precautions in health care settings	l. ✓	l. ✓
m.	Other: <i>(please specify)</i>	m.	m.

Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: <a href="#">Implementation of VCT programmes</a></i>											

<sup>12</sup> Please define

**IV. Care and support**

**1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?**

		2003	2005
a.	HIV screening of blood transfusion	a. ✓	a. ✓
b.	Universal precautions	b. ✓	b. ✓
c.	Treatment of opportunistic infections (OI)	c. ✓	c. ✓
d.	Antiretroviral therapy (ART)	d. ✓	d. ✓
e.	Nutritional care	e. ✓	e. ✓
f.	Sexually transmitted infection care	f. ✓	f. ✓
g.	Family planning services	g.	g.
h.	Psychosocial support for people living with HIV and their families	h.	h.
i.	Home-based care	i.	i.
j.	Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. ✓	j. ✓
k.	Cotrimoxazole prophylaxis among HIV-infected people	k. ✓	k. ✓
l.	Post exposure prophylaxis (e.g., occupational exposures to HIV, rape) * <b>NOT FOR RAPE</b>	l. ✓	l. ✓
m.	Other: <i>(please specify)</i>	m.	m.

<b>Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?</b>											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: <b>Treatment has improved but not other aspects of care</b></i>											

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

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

2.1 Which of the following activities have been implemented under the orphan and other vulnerable children programmes?

	2003	2005
School fees for orphans and vulnerable children		
Community programmes		
Other: <i>(please specify)</i>		

*Comments:* There is no specific OVC programme but primary schooling is free.

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?												
2005	Poor											Good
	0	1	2	3	4	5	6	7	8	9	10	
2003	Poor											Good
	0	1	2	3	4	5	6	7	8	9	10	
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

## Annex III: Core Indicator Return Forms

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### C/LPE: Indicator 4 Most at risk population – Prevention programmes

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Data source

Data source type

Data collection period

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PART I: Most at risk

Data requirements population # 1 (IDUs)

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<25 25+ All ages

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#### NUMERATOR

1. Number of respondents exposed to peer education	NA	NA	NA
2. Number of respondents exposed to targeted mass media	NA	NA	NA
3. Number of respondents exposed to STI screening and treatment	NA	NA	NA
4. Number of respondents exposed to HIV counselling and testing	12	123	135
5. Number of respondents exposed to substitution therapy and safer injection practices for IDU	NA	NA	NA

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6. Number of respondents who have participated in at least one HV prevention programme in the last one month

	<input type="text" value="12"/>	<input type="text" value="123"/>	<input type="text" value="135"/>
--	---------------------------------	----------------------------------	----------------------------------

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#### DENOMINATOR

7. Total number of the IDUs

	<input type="text"/>	<input type="text"/>	<input type="text"/>
--	----------------------	----------------------	----------------------

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PART II:  
Indicator computation

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#### INDICATOR SCORES BY MOST AT RISK POPULATION

3. Divide the number of respondents in a given most at risk population who have participated in at least one HIV prevention programme in the last month (line 6) by the total number of respondents (line 7) and multiply the result by 100

---

---

**C/LPE: Indicator 4** **Most at risk population – Prevention programmes**

---

Data source

Data source type

Data collection period

---

PART I:  
Data requirements Most at risk  
population #2 (CSWs)  
<25    25+    All ages

---

NUMERATOR

1. Number of respondents exposed to peer education	NA	NA	NA
2. Number of respondents exposed to targeted mass media	NA	NA	NA
3. Number of respondents exposed to STI screening and treatment	NA	NA	NA
4. Number of respondents exposed to HIV counselling and testing	126	563	689
5. Number of respondents exposed to substitution therapy and safer injection practices for IDU	NA	NA	NA

---

6. **Number of respondents who have participated in at least one HIV prevention programme in the last one month**

	<input type="text" value="126"/>	<input type="text" value="563"/>	<input type="text" value="689"/>
--	----------------------------------	----------------------------------	----------------------------------

---

DENOMINATOR

7. <b>Total number of the CSWs</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>
------------------------------------	----------------------	----------------------	----------------------

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PART II:  
Indicator computation

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INDICATOR SCORES BY MOST AT RISK POPULATION

<div style="border: 1px solid black; background-color: #e0e0e0; padding: 5px;"> <p>3. Divide the number of respondents in a given most at risk population who have participated in at least one HIV prevention programme in the last month (line 6) by the total number of respondents (line 7) and multiply the result by 100</p> </div>	<input style="width: 60px; height: 25px;" type="text"/>
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**C/LPE: Indicator 5** **Most at risk populations:  
Knowledge about HIV prevention**

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**Data source** Behaviour Surveillance Survey, Labuan, Malaysia 2005 (LEG project)

**Data source type** Survey – purposive sample of commercial sex workers CSWs

**Data collection period (day/month/year)** 18 Jul 05                      22 Jul 05

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**PART I:** **Most at risk  
population #2 (CSWs)**  
Data requirements

---

**NUMERATOR**

Instructions:  
 i. Select only those respondents who gave answers (including “don’t know” to all 5 questions  
 ii. Lines 1-5: enter the number of respondents who gave the correct answer  
 iii. Line 6: enter the number of respondents who gave correct answers to all 5 questions

- |  |     |
|--|-----|
| 1. HIV can be avoided by having sex with only one faithful, uninfected partner                 | 55  |
| 2. HIV can be avoided by using condom  | 85  |
| 3. A healthy looking person can have HIV   | 101 |
| 4. A person can get HIV from mosquito bites  | 69  |
| 5. A person can get HIV from mosquito bites  | 74  |
| <hr/>  |     |
| 6. <b>Numbers of respondents giving the correct answers to all of the above five questions</b> | 7   |
- 

**DENOMINATOR**

- |   |     |
|---|-----|
| 7. Number of respondents who gave answers (including “don’t know”) to all of the above 5 questions or had never heard of AIDS | 168 |
|---|-----|
- 

**PART II:**  
Indicator computation

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INDICATOR SCORES BY MOST- AT-RISK POPULATION

9. Divide the number of respondents who gave the correct answers to all 5 questions (line 6) by the number who answered all 5 questions (line 7) and multiply the result by 100	4.17
---	------

**C/LPE: Indicator 8** **Injecting drug users: safe injecting and sexual practices**

**Data source** Behaviour Surveillance Survey (BSS), Malaysia 2004  
**Data source type** Survey – purposive sample of intravenous drug users IDUs

**Data collection period (day/month/year)** 1 Apr 04 30 Apr 04

<b>PART I:</b>	<b>Males</b>	<b>Females</b>	<b>Both</b>
<b>sexes</b>			
Data requirements	<25 25+ All ages	<25 25+ All ages	<25 25+
All ages			

**NUMERATOR**

Instructions:

- i) Line 1: enter the number of respondents who stated that they had injected drugs in the last month
- ii) Line 2: enter the number of injecting drug users (line 1) who stated that they had never shared drug injecting equipment in the last month
- iii) Line 3a: enter the number of all injecting drug users (line 1) who stated they had had a sexual partner in the last month
- iv) Line 3b: enter the number of injecting drug users who never shared injecting equipment in the last month (line 2) who stated that they had had a sexual partner in the last month
- v) Line 4a: enter the number of all injecting drug users (line 1) who answered "yes" to the question in line 3 and who reported using condom on the most recent occasion they had sex
- vi) Line 4b: enter the number of injecting drug users who never shared injecting equipment in the last month (line 2) and answered "yes" to the question in line 3 who reported using condoms on the most recent occasion they had sex

1. Injected drugs sometime in the last month 686 799	112 679 791	1 7 8	113
2. Injecting drug users in the last month who avoided sharing injecting equipment in the last month 179 220	40 174 214	1 5 6	41
3a. Injecting drug users in the last month who had had sexual intercourse in the last month 265 326	60 260 320	1 5 6	61
3b. Injecting drug users in the last month who avoided sharing injecting equipment but had sexual intercourse in the last month 83 102	18 79 97	1 4 5	19
4a. Injecting drug users in the last month who used condoms during the most recent sexual intercourse (in the last month)			
4b. Injecting drug users in the last month who never shared injecting equipment and used condoms during the most recent sexual intercourse (in the last month)			

**5. Avoided sharing injecting drug equipment and used condoms during the most recent sexual intercourse in the last month (line 4b)**

6. Avoided sharing injecting drug equipment and either avoided having sex or used condoms during most recent sexual intercourse (all in the last month)  
(line 2-line 3b+line4b)

**DENOMINATOR**

**7. Numbers of respondents who reported  
having injected drugs in the last month  
and having had sex in the last month**

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**PART II:**

Indicator computation

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INDICATOR SCORES BY SEX AND AGE-GROUP

8. Divide the number of respondents who reported having avoided shared injecting drug equipment and avoided having unprotected sex in the last month (line 5) by the total number who reported having injected drugs and having had sex in the last month (line 7) and multiply the result by 100