Survey Response Details

Response Information

Started: 3/24/2010 3:24:36 AM
Completed: 3/25/2010 12:10:33 AM
Last Edited: 3/29/2010 11:06:36 PM
Total Time: 20:45:57.0800000

User Information

Username: ce_MY
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Response Details

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1) Country

Malaysia (0)

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

Dr. Shaari Ngadiman, Deputy Director of Disease Control and Head of AIDS/STD Section

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7) Date of submission:

Please enter in DD/MM/YYYY format

30/03/2010

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8) Describe the process used for NCPI data gathering and validation:

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

briefing on the UNGASS process was organised by the Ministry of Health on 19 November 2009 for both Government and civil society stakeholders. The intention was to ensure that all partners understood the process and was also able to participate as much as possible in providing input and information to the development of the report. The first consultative meeting to discuss the NCPI and narrative component of the report was held on 22 December 2009 and was attended by civil society stakeholders who included representatives of various communities of most-at-risk populations, People Living With HIV, advocacy groups, community based organisations as well as a number of various multilateral organisations. The Malaysian AIDS Council (MAC), the lead coordinating HIV non-governmental organisation in the country with 43 NGOs working on HIV and AIDS related issues as its partner organisation, tasked itself to ensuring the coordination of the civil society responses to Part B of the NCPI Questionnaire. As a result of the earlier briefing conducted in November, Part B was able to be presented to the participants as a draft completed with inputs from the different partner organisations of MAC. It was further improved upon through the deliberations of this workshop. The discussions which followed also included content for the different parts of the narrative section. As in the previous 2008 process, resource persons from the Ministry of Health were made available on hand during the civil society consultation workshop to ensure that information concerning available policies and practices would be available for reference if necessary. These resource persons were advised and reminded to not influence the outcome of the discussions among the civil society stakeholders. The second consultative meeting involved Government stakeholders from the different Ministries and agencies. These included representatives from the Ministry of Health, Ministry of Women, Family and Community Development, National Anti Drug Agency, Department of Islamic Development and Royal Malaysian Police. Part A of the NCPI and the narrative content were discussed with participants of this workshop with AIDS officers from the different states as well as the AIDS/STD Section of the Ministry of Health taking the lead in the deliberations. The questionnaire was completed through joint discussions with all those in attendance.

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

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

10)

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

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

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11)

NCPI - PART A [to be administered to government officials]

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	Ministry of Health	Dr. Norhizan Ismail, Chief Deputy Director (AIDS/STD)	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 2	Ministry of Health	Md. Amidon Damit, Health Education	A.I, A.II, A.III, A.IV, A.V
Respondent 3	Ministry of Health	Dr. Fazidah Yuswan, Chief Deputy Director (NSEP Manager)	A.I, A.II, A.III, A.IV, A.V
Respondent 4	Selangor Health Dept	Dr. Masitah Mohamed, Public Health Specialist	A.I, A.II, A.III, A.IV, A.V
Respondent 5	Selangor Health Dept	Dr. Salmah Nordin, Family Health Specialist	A.I, A.II, A.III, A.IV, A.V
Respondent 6	Royal Malaysian Police	ASP. Mohd Husni Maarof, Enforcement	A.I, A.II, A.III, A.IV, A.V
Respondent 7	Prisons Department	Mr. Sazali	A.I, A.II, A.III, A.IV, A.V
Respondent 8	Ministry of Defence	Representative	A.I, A.II, A.III, A.IV, A.V
Respondent 9	Ministry of Youth and Sports	Mr. Mazlan Mohamed, Youth and Sports Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 10	Ministry of Human Resource	Representative, Department of Safety and Hazards.	A.I, A.II, A.III, A.IV, A.V
Respondent 11	Ministry of Information	Ms. Azzurin	A.I, A.II, A.III, A.IV, A.V
Respondent 12	Ministry of Women, Family and Community Development	Ms. Vassundira, Chief Assistant Secretary, Social Policy Section	A.I, A.II, A.III, A.IV, A.V
Respondent 13	Department of Islamic Development	Representative	A.I, A.II, A.III, A.IV, A.V
Respondent 14	National Anti Drug Agency	Representative	A.I, A.II, A.III, A.IV, A.V
Respondent 15			
Respondent 16			
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			
Respondent 21			
Respondent 22			
Respondent 23			
Respondent 24			
Respondent 25			

13)

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	Malaysian AIDS Council/ SAHABAT	Datuk Zaman Khan, MAC Vice President & President of SAHABAT	B.I, B.II, B.III, B.IV

14)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	Malaysian AIDS Council	Dr. Sourabh Malandkeer, Senior Executive, M&E	B.I, B.II, B.III, B.IV
Respondent 3	Malaysian AIDS Council	Ms. Manohara, Programme Manager	B.I, B.II, B.III, B.IV
Respondent 4	Malaysian AIDS Council	Mr. Mohammad Shahrani Mohamad Tamrin, Senior Executive	B.I, B.II, B.III, B.IV
Respondent 5	Malaysian AIDS Council	Mr. Shahruddin Ali Umar	B.I, B.II, B.III, B.IV
Respondent 6	Malaysian AIDS Council	Ms. Jenitha Santirasekaran, Manager, Sex Worker/ TG	B.I, B.II, B.III, B.IV
Respondent 7	Malaysian AIDS Council	Ms. Malini Sivapragasam, Executtive, Sex Worker/ TG	B.I, B.II, B.III, B.IV
Respondent 8	Malaysian AIDS Council	Arokiam a/L Arokium Das, Executive Committee Member	B.I, B.II, B.III, B.IV
Respondent 9	MTAAG+	Mr. Edward Low, Director,	B.I, B.II, B.III, B.IV
Respondent 10	PT Foundation	Mr. Raymond Tai, Active Executive Director	B.I, B.II, B.III, B.IV
Respondent 11	PT Foundation	Mr. Khairuddin Mahmud, Programme Manager	B.I, B.II, B.III, B.IV
Respondent 12	Federation of Reproductive Health Associations Malaysia	Lim Shiang Keng, Acting Executive Director	B.I, B.II, B.III, B.IV
Respondent 13	Asia Pacific Council of AIDS Service Organisations (APCASO)	Liew Moi Lee, Coordinator	B.I, B.II, B.III, B.IV
Respondent 14	Malaysian CARE	Pax Tan, Executive Committee Member	B.I, B.II, B.III, B.IV
Respondent 15	PROSTAR	Ms. Rooslina Ahmad, Secretary of PROSTAR Puchong	B.I, B.II, B.III, B.IV
Respondent 16			B.I, B.II
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			

Respondent 21
Respondent 22
Respondent 23
Respondent 24
Respondent 25

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15)

Part A, Section I: STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

Page 7

16)

1.1 How long has the country had a multisectoral strategy?

Number of Years

12

17)

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

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	No
Labour	Yes	No
Transportation	No	No
Military/Police	Yes	Yes
Women	Yes	Yes
Young people	Yes	No
Other*	Yes	Yes

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18) **Part A, Section I: STRATEGIC PLAN**

Question 1.2 (continued)

If "Other" sectors are included, please specify:

National Service, Dept. of Islamic Development, National Anti-Drug Agency, Dept. of Immigration, Ministry of Information, Dept. of Social Welfare, Department of Prisons, Attorney General Chambers, Economic Planning Unit, Ministry of Higher Education, Ministry of Education, Ministry of Finance

19)

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

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

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20)

Part A, Section I: STRATEGIC PLAN

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

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

21)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

22)

Part A, Section I: STRATEGIC PLAN

Question 1.4 (continued)
IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2004

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23)

Part A, Section I: STRATEGIC PLAN

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

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

24)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

25)

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme?	Yes
e. A monitoring and evaluation framework?	Yes

26)

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

Active involvement (0)

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27)

Part A, Section I: STRATEGIC PLAN

Question 1.8 (continued)

IF active involvement, briefly explain how this was organised:

Civil society participation was present at every stage of the development of the National Strategic Plan on HIV/AIDS (2006-2010). Consultations with key community based organisations and individuals were conducted to insure their inputs and concerns were reflected into the final document. Besides the consultation phase of NSP development, key civil society representatives were also involved and participated in the finalisation of the National Action Plan 2010 framework. In addition to that, the role of civil society has been embedded into the planning, implementation, monitoring and assessment of the activities linked to the NSP. At state and district levels, AIDS officers of the Ministry of Health work closely with their civil society counterparts in the planning and implementation of programmes. All proposals submitted for funding consideration under the NSP now require the endorsement of the AIDS officer under whose area of responsibility the proposed programme would be implemented.

28)

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

Yes (0)

29)

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

Yes, some partners (0)

Page 13

30)

Part A, Section I: STRATEGIC PLAN

Question 1.10 (continued)
IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

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

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31)

Part A, Section I: STRATEGIC PLAN

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development

Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes (0)

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32)

Part A, Section I: STRATEGIC PLAN

2.1 *IF YES*, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes
b. Common Country Assessment / UN Development Assistance Framework	N/A
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	N/A
e. Other: Please specify	

33)

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

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

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34)

Part A, Section I: STRATEGIC PLAN

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

Yes (0)

Page 17

35)

Part A, Section I: STRATEGIC PLAN

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

2 (2)

36)

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

Yes (0)

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37)

Part A, Section I: STRATEGIC PLAN

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

Behavioural change communication	Yes
Condom provision	No
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: Please specify	

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38)

Part A, Section I: STRATEGIC PLAN

Question 4.1 (continued)
If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

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

39)

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

No (0)

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40)

Part A, Section I: STRATEGIC PLAN

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

Yes (0)

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41)

Part A, Section I: STRATEGIC PLAN

6.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	

42)

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

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

43)

Briefly comment on how they pose barriers:

As above

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44)

Part A, Section I: STRATEGIC PLAN

7. Has the country followed up on commitments towards universal access made during

the High-Level AIDS Review in June 2006?

Yes (0)

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45)

Part A, Section I: STRATEGIC PLAN

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

Yes (0)

46)

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

Yes (0)

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47)

Part A, Section I: STRATEGIC PLAN

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

Estimates of current and future needs (0)

48)

7.4 Is HIV programme coverage being monitored?

Yes (0)

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49)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

50)

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

Yes (0)

Page 27

51)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (b) (continued)
IF YES, for which population groups?

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

52)

Briefly explain how this information is used:

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

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53) **Part A, Section I: STRATEGIC PLAN**

Question 7.4 (continued)
(c) Is coverage monitored by geographical area?

Yes (0)

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54)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (c) (continued)
IF YES, at which geographical levels (provincial, district, other)?

District, State and National

55)

Briefly explain how this information is used:

The information concerning geographical areas is utilised to determine where services and interventions are most needed in response to clearly defined priorities. Together with coverage data, this information is utilised to make informed decisions concerning the type of programmes needed, for whom and where. The geographical information is particularly of critical use when determining priorities concerning resource allocation for areas such as those in East Malaysia, which are considered hard to reach and remote.

56)

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

Yes (0)

Page 30

57)

Part A, Section I: STRATEGIC PLAN

Question 7.5 (continued)
Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

8 (8)

58)

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

The expansion and upscaling of both the Methadone Maintenance Therapy (MMT) and Needle Syringe Exchange Programme (NSEP) was a particularly key achievement in the national HIV programme. In 2008, the MMT intervention broke new ground, particularly as it involved the provision of these services for detainees in incarcerated settings, namely drug rehabilitation centres and prisons. In 2009, ARVs were also made available to prisoners who were confirmed with HIV. The engagement with Muslim religious leaders together with the Ministry of Women, Family and Community Development, brought about more care and support programmes for infected and affected communities. The past two years have seen dramatic improvements which include the setting up of shelters supported by the abovementioned Ministry and the Department of Islamic Development (JAKIM).

59)

What are remaining challenges in this area:

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

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60)

Part A, Section II: POLITICAL SUPPORT

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

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

61)

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

Yes (0)

Page 32

62)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

2005

63)

2.2 IF YES, who is the Chair?

Name	Dato' Sri Liow Tiong Lai
Position/title	Minister of Health

64)

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

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	No
have an action plan?	Yes
have a functional Secretariat?	Yes
meet at least quarterly?	No
review actions on policy decisions regularly?	No
actively promote policy decisions?	Yes
provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	No

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65)

Part A, Section II: POLITICAL SUPPORT

Question 2.3 (continued)
If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

14

66)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

1

67)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?

Please enter an integer greater than or equal to 1

1

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68)

Part A, Section II: POLITICAL SUPPORT

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

Yes (0)

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69)

Part A, Section II: POLITICAL SUPPORT

Question 3 (continued)
IF YES, briefly describe the main achievements:

The Malaysian AIDS Council (MAC) has, for the past 17 years, been able: • To coordinate the activities of NGOs and CBOs working on HIV and AIDS in the country. • To work with the Ministry of Health in contributing towards the development, implementation, monitoring and assessment of HIV related policy. • To highlight the issues and concerns of marginalised communities to policy and decision makers at the highest levels of the Government. • To act as a critical partner in the implementation of the Government's harm reduction programmes.

70)

Briefly describe the main challenges:

• The MAC has an outstretched secretariat which is tasked to do multiple functions across a wide range of programmatic issues (from implementing the harm reduction programme to the monitoring of the entire civil society component of the national AIDS programme under the government grant (between RM 4 million (USD 1.2 million) – RM 14 million (USD 4.1 million)). • No proper assessment has been done to measure the impact and effectiveness of interventions led by the MAC despite being in operation for 17 years. Programmes are tied and determined by available grant money. However, a monitoring and evaluation framework has been put in place to begin the

process of reporting back on the effectiveness and impact of programmes.

71)

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

Please enter the rounded percentage (0-100)

14

72)

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

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity-building	Yes
Providing financial support to participate in conferences and study visits; Provides yearly financial support (Needle Syringe Exchange Programme (NSEP), government grants to civil society organisations	Yes

73)

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

Yes (0)

Page 36

74)

Part A, Section II: POLITICAL SUPPORT

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

Yes (0)

Page 37

75)

Part A, Section II: POLITICAL SUPPORT

Question 6.1 (continued)
IF YES, name and describe how the policies / laws were amended:

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

76)

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

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

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77)

Part A, Section II: POLITICAL SUPPORT

Question 6.1 (continued)
Overall, how would you rate the political support for the HIV programmes in 2009?

9 (9)

78)

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

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

79)

What are remaining challenges in this area:

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

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80)

Part A, Section III: PREVENTION

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

Yes (0)

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81)

Part A, Section III: PREVENTION

1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)
c. Be faithful (0)
g. Avoid commercial sex (0)
h. Abstain from injecting drugs (0)
j. Fight against violence against women (0)
k. Greater acceptance and involvement of people living with HIV (0)
l. Greater involvement of men in reproductive health programmes (0)
n. Know your HIV status (0)
o. Prevent mother-to-child transmission of HIV (0)

82)

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

Yes (0)

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83)

Part A, Section III: PREVENTION

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

Yes (0)

84)

2.1 Is HIV education part of the curriculum in:

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

85)

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

Yes (0)

86)

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

Yes (0)

87)

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

Yes (0)

Page 42

88)

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

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

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	Sex workers, Other populations
Drug substitution therapy	Injecting drug user
Needle & syringe exchange	Injecting drug user

Page 43

89) **Part A, III. PREVENTION**

Question 3.1 (continued)
You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

Transgender persons

Page 44

90)

Part A, III. PREVENTION

Question 3.1 (continued)
Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

7 (7)

91)

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

The decision by the Cabinet Committee on AIDS to support the scaling up of the NSEP (Needle and Syringe Exchange Programme)and MMT (Methadone Maintenance Therapy): o MMT to be extended to drug rehabilitation centres, prisons and drug drop-in centres. o NSEP to increase its number of sites and to cater to more clients.

92)

What are remaining challenges in this area:

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

Page 45

93)

Part A, III. PREVENTION

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

Yes (0)

Page 46

94)

Part A, III. PREVENTION

Question 4 (continued)

IF YES, how were these specific needs determined?

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

95)

4.1 To what extent has HIV prevention been implemented?

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

Page 47

96)

Part A, III. PREVENTION

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

7 (7)

97)

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

Despite the existence of multiple programmes catering to more target populations, those coming from marginalised and most at risk populations (e.g. MSM, sex workers, mobile populations) are often left out of the coverage of these prevention interventions. Numerous gaps exist which are primarily related to prevention programmes such as the absence of condom promotion and the over reliance on NGOs and CBOS to fill in national response. Prevention efforts were boosted by the

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

98)

What are remaining challenges in this area:

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

Page 48

99)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

Page 49

100)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1.1 IF YES, does it address barriers for women?

No (0)

101)

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

Yes (0)

102)

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

Yes (0)

Page 50

103)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 2 (continued)
IF YES, how were these determined?

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

104)

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

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

Page 51

105)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

106)

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

No (0)

Page 53

107)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

7 (7)

108)

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

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

109)

What are remaining challenges in this area:

The escalating costs related to management of HIV is translated and shared by both the Government and patient. Though the treatment regime is subsidised by public funds, there is concern that this is unable to continue due to escalating public healthcare costs and a uncertain economic climate. Care and support programmes continue to be almost solely dependent on NGO services which are limited in coverage and availability. These services are also often located in urban centres. Those coming from rural areas are forced to travel at great distance to access these services.

Page 54

110)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

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

No (0)

Page 57

111)

Part A, Section V: MONITORING AND EVALUATION

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

Yes (0)

Page 58

112)

1.1 IF YES, years covered:
Please enter the start year in yyyy format below

2006

113)

1.1 IF YES, years covered:
Please enter the end year in yyyy format below

2010

114)

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

Yes (0)

115)

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

Yes (0)

116)

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

Yes, most partners (0)

Page 60

117)

Part A, Section V: MONITORING AND EVALUATION

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	No
a data analysis strategy	No
a data dissemination and use strategy	

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118)

Part A, Section V: MONITORING AND EVALUATION

Question 2 (continued)
If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

119)

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

Yes (0)

Page 62

120)

Part A, Section V: MONITORING AND EVALUATION

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

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

5

121)

3.2 IF YES, has full funding been secured?

Yes (0)

122)

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

Yes (0)

Page 64

123)

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

No (0)

Page 65

124)

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

In lieu of a national M&E assessment, exercises intended to identify priorities for M&E are

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

125)

5. Is there a functional national M&E Unit?

No (0)

Page 66

126)

Part A, Section V: MONITORING AND EVALUATION

Question 5 (continued)
IF NO, what are the main obstacles to establishing a functional M&E Unit?

Limited manpower available to undertake the task of M&E as a separate unit/ department. M&E is currently integrated into existing HIV and AIDS programming. Other units already having pre-existing M&E and oversight functions such as the Audit Department.

Page 69

127)

What are the major challenges?

As stated before

Page 70

128)

Part A, Section V: MONITORING AND EVALUATION

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

Yes, but meets irregularly (0)

129)

6.1 Does it include representation from civil society?

Yes (0)

Page 71

130) **Part A, Section V: MONITORING AND EVALUATION**

Question 6.1 (continued)
IF YES, briefly describe who the representatives from civil society are and what their role is:

The representation of civil society and people living with HIV is through the presence of the Malaysian AIDS Council (MAC) in the working group. MAC is charged with ensuring that the views and concerns of its constituents are accurately represented and conveyed. As the main coordinator of NGOs and CBOSs responding to HIV, MAC is provided with an annual government grant (RM 6 – 14 million) which the institution is tasked to disperse to other organisations working on the different aspects of the national response. In relation to that, MAC is given the responsibility to report back on the individual projects utilising the various national progress indicators as part of M&E. It is also given the responsibility of providing feedback to the Government in relation to M&E.

131)

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

Yes (0)

Page 72

132)

Part A, Section V: MONITORING AND EVALUATION

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

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

133)

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

Yes, all of the above (0)

Page 73

134)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 74

135) **Part A, Section V: MONITORING AND EVALUATION**

For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

For Question 7.3, you have indicated "Yes" to "subnational level", please specify at

what level(s)?

District, State and National

136)

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

Yes (0)

137)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

138)

Provide a specific example:

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

139)

What are the main challenges, if any?

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

Page 75

140) **Part A, Section V: MONITORING AND EVALUATION**

9.2 To what extent are M&E data used for resource allocation?

1 (1)

141)

Provide a specific example:

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

142)

What are the main challenges, if any?

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

Page 76

143)

Part A, Section V: MONITORING AND EVALUATION

9.3 To what extent are M&E data used for programme improvement?:

2 (2)

144)

Provide a specific example:

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

145)

What are the main challenges, if any?

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

Page 77

146) **Part A, Section V: MONITORING AND EVALUATION**

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

Yes, but only addressing some levels (0)

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147) **Part A, Section V: MONITORING AND EVALUATION**

For Question 10, you have checked "Yes, but only addressing some levels", please specify

at service delivery level (0)

148)

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

At national level?	No
At subnational level?	No
At service delivery level including civil society?	Yes

Page 79

149) **Please enter the number of people trained <u>at service delivery level including civil society.</u>**

Please enter an integer greater than 0

12

Page 80

150)

Part A, Section V: MONITORING AND EVALUATION

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

Yes (0)

Page 81

151) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
IF YES, describe what types of activities:

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

Page 82

152) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
Overall, how would you rate the M&E efforts of the HIV programme in 2009?

5 (5)

153)

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

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

have been organised.

154)

What are remaining challenges in this area:

There remains a challenge in improving the quantity and quality of technical capacity in both government and civil society bodies.

Page 83

155)

Part B, Section I: HUMAN RIGHTS

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

No (0)

Page 84

156)

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

Yes (0)

Page 85

157)

Part B, Section I. HUMAN RIGHTS

2.1 *IF YES*, for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex Workers	No
f. prison inmates	No
g. Migrants/mobile populations	No
Other: Please specify	

158)

IF YES, briefly explain what mechanisms are in place to ensure these laws are

implemented:

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

159)

Briefly describe the content of these laws:

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

160)

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

There are a number of governmental and civil society mechanisms in place which allow for redress of laws, issues and complaints: 1. The individual relevant Ministries have their individual public complaints mechanisms which allow members of the public to lodge complaints and to seek redress. 2. The civil society mechanisms which exist include seeking redress through the entities such as the Malaysian Medical Association, Bar Council, and Human Rights Commission for Malaysia. Specific NGOs which advocate issues are also used to seek support and to further advocate in behalf of the individual.

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161)

Part B, Section I. HUMAN RIGHTS

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

Yes (0)

Page 87

162)

Part B, Section I. HUMAN RIGHTS

3.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No

c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	

163)

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

Penal Code 377A & B – the introduction of the penis into the anus or mouth of the other person is said to commit carnal intercourse against the order of nature. Maximum penalty 20 years imprisonment and liable to fine and whipping Section 21 of the Minor Offences Act 1955 – Transgender persons could be charged with indecent behaviour, if they are found to be cross-dressing. The term 'indecent behaviour' has not been defined in the Act, and therefore, it is up to the discretion of the police to determine what constitutes 'indecent' behavior. Drug Dependant Act (Treatment & Rehabilitation) 1983 – Any police officer is able to detain a person under suspicion of being a drug user for not more than 24 hours for administration of a urine drug test. Dangerous Drugs Act 1952 – self administration of drugs is punishable with a fine and/ or imprisonment Dangerous Drugs Act 1952 – it remains illegal to carry injection equipment without a medical prescription and possession of needles is punishable with imprisonment

164)

Briefly comment on how they pose barriers:

Fear of persecution and discrimination makes it difficult to reach out to MSM and transgender persons. Religious bodies and laws enforcement agencies less likely to cooperate as MSM & TG sexual behaviour is considered unacceptable by society. Although there is no existing law or policy against individuals carrying condoms, women in particular are subject to accusations of soliciting for sex or being branded a sex worker. This could result in overnight detention or harassment by law enforcement officers. Such evidentiary use of the condom, discourages sex workers from using them as well as brothels from providing them on the premises. This also applies in a similar fashion to MSM where spas and massage centres refuse to supply condoms for fear of legal action being taken on them resulting in the loss of their operating licence and depriving them of business. Current laws stipulate for compulsory drug treatment and provide for punishment of drug users with canning and imprisonment should the person relapse after discharge from government run drug rehabilitation centres (DRC). Civil society groups believe that treatment for drug addiction should be an option and not compulsory under the law. Clients of the Needle Syringe Exchange Programme (NSEP) become 'easy targets' for law enforcement officers. As the latter continues to have the authority to detain persons suspected to be drug users, this could discourage effective utilisation of the programme by the IDU community as they could be arrested while being in the vicinity of the NSEP centre. The carrying of syringes and needles, outside of healthcare settings, is still technically illegal despite the existence of a government Harm Reduction programme. This results in complications and contradictory messages whereupon a government programme is encouraging the exchange and use of clean needles and syringes while law enforcement bodies are told that the usage of drugs and the carrying of drug paraphernalia are barred under the law. However, due to the NSEP, the active enforcement of this legislation was reportedly relaxed. The existence of laws which are in direct contradiction with the activities of the Government initiated NSEP continue to send contradictory signals to law enforcement bodies and judiciary. This could present itself as a significant obstacle in successfully ensuring the sustainability and continued existence of the programme. Laws and regulations which especially govern and restrict communication of HIV awareness and prevention messages are of particular concern. The use of particular text and explicit graphics (such as putting on a condom on a penis) in such messages could be considered and subject to legal prosecution for the use of pornography under legislation which governs the print media. Though the

NSP under Strategy 5 recognises the existence and vulnerability of the MSM population, their sexual behaviour is subject to prosecution under existing legislation (Penal Code 377 on the issue of sodomy). Mandatory testing of foreign workers continue to conducted, screening for HIV and other infectious diseases such as Hepatitis B & C as well as tuberculosis. Despite being recognised as a vulnerable population under Strategy 5 of the NSP, there is no pre and post test counselling. In most cases, the individual has no knowledge of their medical tests and are only told whether they are medically fit to work and be employed in Malaysia. Failing such screening tests result in deportation of the individual.

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165) **Part B, Section I. HUMAN RIGHTS**

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

Yes (0)

Page 89

166)

Part B, Section I. HUMAN RIGHTS

Question 4 (continued)
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

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

167)

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

Yes (0)

Page 90

168)

Part B, Section I. HUMAN RIGHTS

Question 5 (continued)
IF YES, briefly describe this mechanism:

Various civil society organisations (CSOs) as well as entities such as the Bar Council and Legal Aid Centre are active in the recording and documentation of such cases. However to ensure that cases are brought to a higher level to address the issue, it is very often dependent on the PLHIV or persons affected by the discrimination to proceed. However, the reality is that if a person who is

living with HIV suffers discrimination as a result of stigma, it is often considered hard to prove. Documentation continues to be a problem as people who suffer such discrimination are reluctant to proceed further due to the risk of exposure of one's status. Practical problems abound with regards to addressing HIV related acts of discrimination. Advocacy is done through reports lodged to relevant ministries, the use of the media and engagement with the legal system. Relevant ministries such as the Ministry of Human Resource have in-built mechanisms (e.g. Code of Practice on HIV/AIDS in the Workplace) for redress by PLHIV within the context of the working environment.

169)

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

Yes (0)

Page 91

170)

Part B, Section I. HUMAN RIGHTS

Question 6 (continued)
IF YES, describe some examples:

For the past 17 years, the Malaysian AIDS Council (MAC) which was originally set up by the Government, has acted as the secretariat and main actor which deals directly with civil society organisations working with the PLHIV community, most-at-risk populations (MARPS) and other vulnerable populations. These various communities were involved and consulted extensively in the formulation and design of the MAC Strategic Plan 2008 -2010. The past four years have seen increased and improved involvement and participation of MARPs in the design of both programme and policy. The formulation of the NSP and the development of the NSEP are clear examples of how these communities were able to be involved and work together with their Government counterparts and play an active role in the design, implementation and monitoring of interventions. The different CBOs working with the various communities are coordinated by the MAC via its mandate given by the Government. Over the past few years, the Government has also provided substantial financial support to CBOs for the implementation and execution of programmes related to MSMs, SWs, IDU, transgender persons, etc.

171)

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

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

Page 92

172)

Part B, Section I. HUMAN RIGHTS

Question 7 (continued)

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

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

173)

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

Yes (0)

Page 93

174)

Part B, Section I. HUMAN RIGHTS

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

No (0)

175)

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

Yes (0)

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176)

Part B, Section I. HUMAN RIGHTS

Question 9 (continued)
IF YES, briefly describe the content of this policy:

Under Strategy 1 of the National Strategic Plan on HIV/AIDS 2006-2010 (NSP), the Government is committed to ensure equal access to treatment, care and other support services, guaranteed confidentiality, and access to voluntary counselling and testing. The NSP's Strategy 1 to 6 clearly indicates that all MARPs and other subpopulations identified under the strategic framework wil have equal access to HIV prevention, treatment, care and support services.

177)

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

Yes (0)

Page 95

178)

Part B, Section I. HUMAN RIGHTS

Question 9.1 (continued)
IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

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

179)

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

No (0)

180)

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

Yes (0)

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181)

Part B, Section I. HUMAN RIGHTS

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

No (0)

182)

IF YES, describe the approach and effectiveness of this review committee:

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

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183)

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

Yes (0)

184)

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

No (0)

185)

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

No (0)

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186)

Part B, Section I. HUMAN RIGHTS

Question 12 (continued)
IF YES on any of the above questions, describe some examples:

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

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187)

Part B, Section I. HUMAN RIGHTS

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

188)

– Legal aid systems for HIV casework

Yes (0)

189)

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

No (0)

190)

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

Yes (0)

191)

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

Yes (0)

Page 100

192)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
IF YES, what types of programmes?

Media	**Yes**
School education	**No**
Personalities regularly speaking out	**Yes**
Other: please specify	

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193)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

5 (5)

194)

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

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

195)

What are remaining challenges in this area:

Need to review existing labour legislation to address the issue of stigma & discrimination of PLHIV at workplace. This would strengthen implementation and adherence to the existing Code of Practice on Prevention and Management of HIV/AIDS at the Workplace, which was initiated by the Ministry of Human Resource. The abovementioned Code of Practice, though already in existence for several years, needs to be further promoted and encouraged for adoption by the private sector. Need to identify and recommend review of laws and regulations which may have an impact on effective implementation of the Needle Syringe Exchange Programme (e.g. Dangerous Drugs Act 1952 which criminalises the use and possession of syringes and needles without a medical prescription. Need to encourage involvement of PLHIV or MARPS in the ethical committee review for HIV research protocols Although there has been improved involvement and acceptance from Department of Islamic Development (JAKIM), the state religious authorities need to be better engaged on HIV related issues. There is a continual need to sensitize and involve all stakeholders who work directly or have direct contact with MARPs such as the local government authorities, prisons department, religious authorities, law enforcement bodies (e.g. police), National Anti Drug Agency (NADA) and immigration department.

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196)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

7 (7)

197)

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

Much of the achievements in this area has been linked to the engagement of Muslim religious

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

198)

What are remaining challenges in this area:

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

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199)

Part B, Section II: CIVIL SOCIETY* PARTICIPATION

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

4 (4)

200)

Comments and examples:

Civil society organisations, usually under coordination of the Malaysian AIDS Council, have been able to be engaged in dialogue with key decision makers and political figures such as the Prime Minister, Minister of Health and other Ministers. Political leaders are also often open to attending HIV related functions organised by civil society organisations. The heads of government bodies (e.g. Department of Islamic Development, Islamic Religious Department of Wilayah Persekutuan, Ministry of Women, Family and Community Development, Human Rights Commission and police) through advocacy meetings and workshops. A key result of this engagement has been the commitment in 2008 by the Ministry of Women, Family and Community Development to support the setting up of 7 shelters for women & children who are PLHIV and affected by HIV. This was later expanded to 15 shelters in 2009. The Department of Islamic Development has also now committed itself to setting up a shelter home for Muslims living with HIV/AIDS in 2010. During Malaysia's recent participation in Round 9 of the Global Fund, a working group comprised mainly of civil society actors advocated to the Government as to the virtues of submitting a country proposal for grant consideration. A large amount of advocacy was conducted with the Ministry of Health which later resulted in the setting up of Malaysia's first properly constituted Country Coordinating Mechanism (CCM) which is now chaired by the Deputy Minister of Health. As a result of this civil society lead initiative, the Government is now committed to participating in the

Global Fund rounds.

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201)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

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

4 (4)

202)

Comments and examples:

Through coordination of the Malaysian AIDS Council (MAC) and working with the Ministry of Health, civil society representatives have been extensively involved in the planning and budgeting process for the annual activity plan. To assist in this engagement, MAC has introduced the "cluster" concept to improve upon civil society ownership and participation on key issues as well as functioning as a form of community consultation. Within each cluster, community representatives are expected to contribute towards the identification of priorities as well as monitoring of activities and interventions.

Page 105

203)

a. the national AIDS strategy?

4 (4)

204)

b. the national AIDS budget?

4 (4)

205)

c. national AIDS reports?

4 (4)

206)

Comments and examples:

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

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207)

a. developing the national M&E plan?

0

208)

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

1 (1)

209)

c. M&E efforts at local level?

3 (3)

210)

Comments and examples:

Though there was no prior consultation with any non-governmental HIV organisation including the Malaysian AIDS Council (MAC) in developing the preliminary M&E framework, the latter and its partner organisations have been included in later discussions concerning the monitoring of progress in responding to the HIV epidemic. They have also been able to contribute in presentation of national data. MAC has an M&E capacity which was fully established in 2007 and whose system migrated online in 2009. It currently oversees data reported from all projects and programmes of all civil society organisations receiving the Government HIV grant. This programme monitoring capacity now contributes substantially to the national understanding of socio-behavioural data gathered through programmes and interventions with MARPs.

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211) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

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

4 (4)

212)

Comments and examples:

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

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213)

a. adequate financial support to implement its HIV activities?

3 (3)

214)

b. adequate technical support to implement its HIV activities?

3 (3)

215)

Comments and examples:

Under the NSP, Government funding increased almost three fold in 2009 compared to the previous year. However, the funding was still considered inadequate to implement upscaling of existing programmes. A number of NGOs including the Malaysian AIDS Council and PT Foundation were able to access technical support from partners from international non-government organisations such as the International Planned Parenthood Federation (for monitoring and evaluation related work), and Open Society Institute (OSI) (for the harm reduction initiative) and from agencies such as the World Bank (for IBBS).

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216) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

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

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

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217)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

Question 7 (continued)
Overall, how would you rate the efforts to increase civil society participation in 2009?

8 (8)

218)

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

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

219)

What are remaining challenges in this area:

The effectiveness of cluster has yet to be evaluated since it is still fairly new. Most CBOs are still adapting to the idea of group representation of specific issues. As such, some of them still prefer bilateral discussions with key interlocutors such as the Government. Most CBOs require more capacity building in key technical areas as well as project management skills. The uncertain environment created as a result of unsustainable funding subjected to yearly Government approval has resulted in de-motivating and discouraging potential and current community leaders from continuing on. There is a concern that skilled and experienced civil society personnel are unable to be retained adequately to ensure quality participation and involvement in activities and initiated.

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220)

Part B, Section III: PREVENTION

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

Yes (0)

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221)

Part B, Section III: PREVENTION

Question 1 (continued)
IF YES, how were these specific needs determined?

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

222)

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
Blood safety	Agree

Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Don't agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Don't agree
HIV testing and counselling	Don't agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Don't agree
Reproductive health services including sexually transmitted infections prevention and treatment	Don't agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	

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223)

Part B, Section III: PREVENTION

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

5 (5)

224)

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

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

225)

What are remaining challenges in this area:

Financial constraints – though almost all NGO HIV programmes are provided funding support by the Government, the amount continues to be a shortfall to what is actually needed. As a result, frequently service providers/ NGOs are unable to adequately train their staff on issues related to MARPS as well improve their capacity in HIV programming. As such, NGOs are forced to diversity their funding to enable them to financially self sustain themselves. Limited coverage of existing HIV prevention programmes - For example, the population of SW was estimated to be 50 000. However, current programmes were able to reach only almost 7 000 last year. The size of the respective communities/ targeted populations (SW, TS, MSM) also vary from location to location and are found to be mobile. Although prevention programme are available, they provide scarce coverage. Clients of sex worker are not included in existing prevention programme. One reason for this omission which has been cited is due to the lack of negotiation skills of sex workers. Social and cultural challenges – Socio-cultural and religious norms provide formidable challenges to HIV prevention programmes and efforts to mitigate the impact of HIV. For example sex is not openly discussed as it is considered impolite and disrespectful. This often prevents discussions with

adults and adolescents about HIV prevention. Similarly, sex workers, drugs users, men who have sex with men are socially and culturally perceived as being of bad character. This jeopardise access and utilization of HIV prevention and treatment services. In addition to this, Malaysia is also an Muslim majority country and it is a challenge to find a way to work around religious barriers. This stigma also drives many MARPs underground and makes it difficult to design and implement effective HIV programmes.

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226)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

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

Yes (0)

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227)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1 (continued)
IF YES, how were these specific needs determined?

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

228)

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

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Don't agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Don't agree
Sexually transmitted infection management	Don't agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Agree

TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Don't agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Don't agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

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229)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

6 (6)

230)

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

Better collaboration from religious bodies and other relevant government agencies, especially related to welfare, on the issue of care and support for PLHIV. In 2009, the Department of Islamic Development indicated its commitment to building a shelter home for homeless Muslims living with HIV by 2010. The Ministry of Women, Family and Community Development began funding 7 shelters for women and children infected and affected by HIV. This initial number of shelter homes was expanded to 15 in 2009.

231)

What are remaining challenges in this area:

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

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232)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

2. Does the country have a policy or strategy to address the additional HIV-related

needs of orphans and other vulnerable children?

Yes (0)

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233)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

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

No (0)

234)

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

No (0)

235)

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

No (0)

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236)

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

1 (1)

237)

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

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

238)

What are remaining challenges in this area:

3 shelter homes for infected and affected orphans are available but there continues to be a dearth of skilled and trained staff to address the impact of HIV/AIDS on children, particularly when dealing with emotional support and counselling. Shelters are limited in capacity whereupon very few facilities are available for them once the children reach adolescent phase. There are reportedly

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