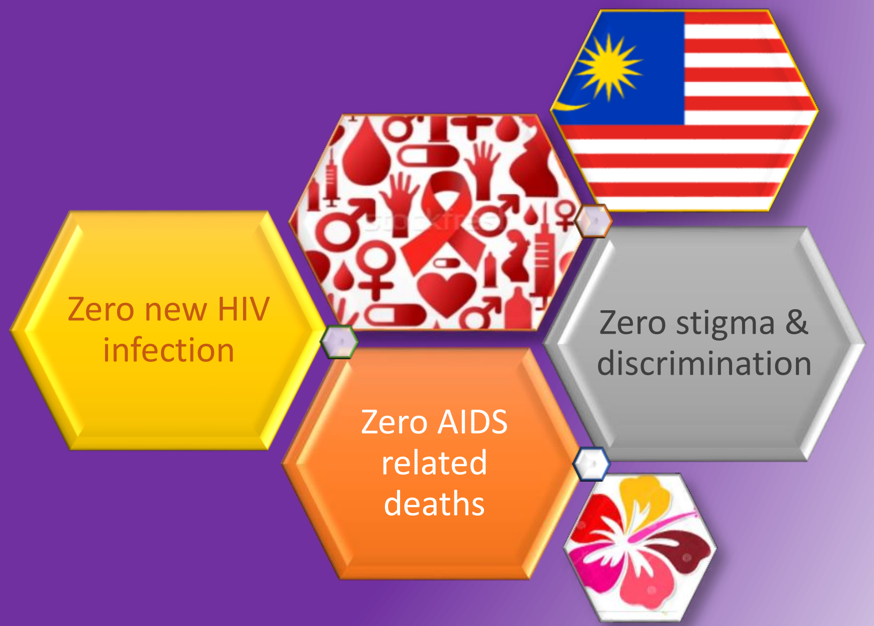

GLOBAL AIDS RESPONSE PROGRESS REPORT 2014

Malaysia

MALAYSIA 2014

COUNTRY RESPONSES TO HIV/AIDS

Reporting Period: January 2013 to December 2013

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The Global AIDS Response Progress Report 2014

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FOREWORD

It is our dream that children in Malaysia are not born with HIV. It is our dream that teenagers and adults are at lower risk of contracting HIV and those with the virus have access to life saving treatment. It is our dream to create a HIV-free generation. Endless and persistent efforts backed by strong political commitment and multi-sectorial strategies which provided an appropriate balance between prevention, treatment, care and support, Malaysia has many great stories to share.

It is with great pride that we submit this Country Report on Malaysia's responses to HIV and AIDS using global indicators for the period ending 31 December 2013. We are proud to say that we have managed to stabilize or reduce the rate of new HIV infections from 24.8 per 100,000 population in 2000 to 11.4 per 100,000 in 2013. Implementation of various screening programmes, PMTCT, Harm Reduction Programme, provision of free ARV, prevention of sexual transmission and others were the turning points that lead to significant reduction of new infections among adults and children.

Last but not least, we would like to acknowledge the tremendous contribution and efforts that went into the preparation of this report. We would like to especially thank the HIV/STI Sector for their tireless work in coordinating and drafting this report.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BSS	Behavioural Surveillance Survey
CBO	Community-based Organization
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FRHAM	Federation of Reproductive Health Associations of Malaysia
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
PWID	Injecting Drug Use/User
IBBS	Integrated Bio-Behavioural Surveillance
MAC	Malaysian AIDS Council
MDGs	Millennium Development Goals
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MTCT	Mother-to-child transmission
MWFCD	Ministry of Women, Family and Community Development
NADA	National Anti-Drug Agency
NGO	Non-Government Organization
NPFDB	National Population and Family Development Board
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan on HIV/AIDS
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TG	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
UNTG	United Nations Theme Group on HIV
VDTS	Venue-Day-Time- Sampling
WHO	World Health Organization

CHAPTER 1 - STATUS AT A GLANCE

1.1 Country Profile

With its land area totaling 329,847 sq km, Malaysia consists of Peninsular Malaysia and East Malaysia (the states of Sabah and Sarawak) which are separated by the South China Sea. Malaysia comprises 13 states and 3 federal territories with total population slightly less than 29 million. Of total population, 91.8% are Malaysian citizens with the Malay (63.1%) being the predominant ethnic group in Peninsular Malaysia while the Ibans constituted 30.3% of the total citizens in Sarawak and Kadazan/Dusun made up 24.5% in Sabah. It is a multi-religious country with Islam being the most widely professed religion in Malaysia (61.3%). As a multi-racial nation, other religions embraced were Buddhism (19.8%), Christianity (9.2%) and Hinduism (6.3%).

Since independence, the Malaysian healthcare system has provided a critical and invaluable service to Malaysians via an extensive network of public and private facilities, an effective rural health delivery system, highly specialized care at regional

level and successful health promotion and preventive strategies. Accessible through 349 hospitals (140 government and 209 private), 7,700 clinics with doctors (1,025 public and 6,675 private) and 2,009 community clinics run by paramedics (Klinik Desa and Klinik 1 Malaysia), the Malaysian health care has improved over years with doctor to patient ratio of 1:758[1]. Within this dual health care system, the Ministry of Health plays the role of funder, provider and regulator. With commencement of the 10th Malaysia Plan: 2011-2015 (10MP), the government is committed to improve the standard and sustainability of quality of life of Malaysian nation.

1.2 Overview of the epidemic

Since 1986 when the first HIV case made its debut, HIV has become one of the country's most serious health and development challenges. At the beginning of the epidemic, injecting drug users was key driven factor that charted the graph by leaps and bounds as the country's responses focused more on creating awareness and early detection.

Over period of 28 years, HIV prevention landscape has seen tremendous biomedical and behavioral advances in preventing, diagnosing, and treating HIV disease. As a result, there has been a significant reduction of new cases by more than half from 28.4 per 100,000 populations in 2002 to 11.42 cases per 100,000 populations in 2013[2]. Malaysia is a country with concentrated HIV epidemic with infection rates remains high above 5% among most-at-risk populations (MARPS) especially among PWID, sex workers, transgender and men sex with men (MSM) population.

In 2013, there were 3,393 HIV cases reported or average of 9 cases per day; a significant numbers reported but levelling off since the epidemic reached its peak in 2002 (6,978 cases).

[1] Malaysia Heath Facts 2013
[2] Ministry of Health Malaysia Surveillance Data

At the end of 2013, Malaysia was estimated to have 86,324[3] people living with HIV (PLHIV). By the end of 2013, Malaysia had reported a cumulative 101,672 HIV cases, 20,235 AIDS cases and 16,340 deaths related to HIV/AIDS, thus giving reported PLHIV of 85,332 cases[4] (table 1).

Table 1.Overview of the HIV epidemic in Malaysia 2013

Indicator	Number/ percentage
Cumulative no. of reported HIV infections since first detection in 1986	101,672
Cumulative no. of reported AIDS since 1986	20,235
Cumulative no. of reported deaths related to HIV/AIDS since 1986	16,340
Estimated no. PLHIV [EPP 2014]	86,324
Total number of PLHIV [surveillance data]	85,332
New HIV infections detected in 2013	3,393
Notification rate of HIV (per 100,000) in 2013	11.42
Women reported with HIV in 2013	728
Cumulative no. of women reported with HIV as of December 2013	10,956
Children aged under 13 with HIV in 2013	50
Cumulative no. of children under 13 with HIV as of December 2013	1,076
Estimated no. PLHIV eligible for treatment [EPP 2014]	38,418
No. PLHIV receiving ART (surveillance data) as of December 2013	17,369
Estimated adult (15 – 49 years) HIV prevalence [EPP 2014]	73,005 [0.44%]

Source: Ministry of Health Malaysia

Over a period of more than a decade, the country has observed a significant changing trend in HIV infections by sex. Early cases were concentrated among male but as the epidemic spread the pattern progressively shifted towards increasing infection rates in female with male/female ratio from 9.6 in 2000 to 4.5 in 2010 to 3.7 in 2013.

[3] HIV Estimations and Projections, Malaysia 2014
[4] Ministry of Health Malaysia Surveillance Data 2013

The country's epidemic during the early phase was forcefully driven by PWID. With the highest PWID/sexual transmission ratio reached at 12.2 in 1994, this pattern has since shifted to increasingly more sexual transmission with PWID/sexual transmission ratio now declined to 3.9 in 2000 to 0.3 in 2013.

About 34.3% of reported infections are amongst young people aged 13 to 29 years old while children under 13 years consistently contributed approximately 1% of cumulative total of HIV infections from 1986 to December 2013.

1.3 Policy And Programmatic Response

Tremendous biomedical and behavioral advances in preventing, diagnosing, and treating HIV disease have taken place over 28 years. In facing up to the scourge of HIV/AIDS, the government has initiated actions well before the first case of HIV was detected in 1986. This was marked with inclusion of HIV, AIDS and death related to HIV/AIDS into the list of notifiable diseases under the Prevention and Control of Infectious Diseases Act[5] that led to increasing notification following screening programmes among high risk populations.

To streamline National response, AIDS/STD Sector was established within the Public Health Division in Ministry of Health Malaysia in 1993. In 1992, Malaysia AIDS Council (MAC) was established under the auspices of the Ministry of Health to compliment the national responses with special focus on most-at-risk populations. Without doubt, the current prevention landscape provides a number of opportunities that were not available in 1986.

[5] Law of Malaysia. Act 342 Prevention and Control of Infectious Diseases Act 1988

During the earlier days, the design and development of the HIV/AIDS National Prevention and Control Program was sole responsibility of the Ministry of Health. Over period of time, this response has matured to include wider group of stakeholders including non-health sectors within government agencies, NGO, civil society, private agencies, bilateral and international agencies. The working relationships with the non-health agencies and the NGOs have been tremendously strengthened beginning 2002 marked by the government decision to allocate RM 40 million to MAC/NGO for period of 10 years beginning 2003.

1.3.1 National commitment and National Strategic Plan (NSP)

A successful response to the epidemic requires strong political commitment and leadership at the highest level. This was translated into the country's first NSP in 2000 whereby under this strategic framework, the Cabinet Committee on HIV/AIDS (CCA) was established and chaired by Deputy Prime Minister. December 2008 marked the involvement of MAC as committee member representing the voices of civil societies and other communities they represented.

The CCA was restructured in 2009 and being replaced by the National Coordinating Committee on AIDS Intervention (NCCAI) chaired by the Minister of Health. Civil society is also being represented on this new committee. With latest revision, NSP 2011-2015 continues to provide a common ground and emphasis on an integrated and comprehensive approach addressing the needs of prevention, treatment, care and support for infected and affected quarters. This NSP has been reviewed in 2013 involving key players (civil societies, government and non-government agencies and bilateral agency) whereby recommendations and amendments have been put forward to ensure that the country is on track in achieving the 3 inter-related 'Zero' and elimination of vertical transmission.

Another highest coordinating body where civil society is represented is the Country Coordinating Mechanism (CCM), a national consensus body with Deputy Minister of Health as the de facto chair. The formation of the CCM was mandated in 2009 by the Cabinet that provides governance for all programmes and activities related to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) in Malaysia.

The responsibility for the overall coordination, monitoring, evaluation and reporting of Malaysia's HIV and AIDS responses is currently tasked to the HIV/STI Sector of the Disease Control Division, Ministry of Health. Currently, the HIV/STI Sector function as the National AIDS Programme (NAP) Secretariat supported by the AIDS Officers at every state. Similar mechanism is being implemented at every state and districts. The Secretariat interacts and engages the other institutions within the Federal Government (and the civil society) through HIV Focal Points who are present in each of the relevant Ministries.

1.3.2 Multi-sectoral engagement in the HIV response

Given the mandate by the Government under the NSP, much of the leadership in responding to the epidemic continues to be shouldered by the Ministry of Health. However, the level of multi-sectoral engagement has improved over the several years. Non-health sectors i.e. the Ministry of Women, Family and Community Development (MWFCD), National Anti-Drug Agency (NADA), Department of Islamic Development (JAKIM), Ministry of Home Affairs, and the Information Ministry now form part of the key stakeholders in the country involved in the national HIV prevention and control programmes.

With the increase in proportion of female HIV cases in Malaysia over the past five years, MWFCD continues to play important role through its Taskforce on Women, Girls and HIV/AIDS. This taskforce is currently chaired by the Ministry of Women, Family and Community Development (MWFCD), mandated to guide the actions of the

Government in its response to addressing the behavioral and socioeconomic factors behind sexual transmission of HIV. Apart from awareness programmes, MWFCD has been instrumental in improving the overall response especially on matters pertaining to care and support services for PLHIV and those affected. An area which has seen significant change in the area of care and support services specifically the availability of shelters and drop-in centers. Community based organizations (CBO) are currently working in partnership with the MWFCD to provide essential support services for PLHIV.

The involvement of religious leaders, especially Muslim religious leaders has increased significantly over the past few years. Numerous advocacy and investment in programming was done to mobilize and harness the support of Islamic religious leaders in HIV prevention and the provision of care and support. There have been remarkable developments of programmes by JAKIM which involve a number of religious bodies engaging MARPs such as female SW, TG and MSM through the availability of religious classes and programmes. Building on the successes of the "Islam and HIV/AIDS" project which was first initiated between 2001 to mid-2005, Muslim religious leaders have since involved in not only the implementation of HIV awareness programmes but also proactively established care and support facilities from financial and welfare assistance to shelters for Muslim PLHIV. The success of "Islam and HIV/AIDS" programme has also gained recognition in other Muslim countries worldwide.

1.3.3 ARV treatment, resource mobilization and funding support

Malaysia is committed to provide and expand affordable access to ARV drugs and clinical care. Two (2) significant achievements have been accomplished, first, the availability and provision of first line ARV treatment at no cost for those who need it and second, the availability of ARV treatment for incarcerated populations specifically for prisoners with HIV as well as inmates in drug rehabilitation centers. Currently, the second line regime is also heavily funded by the government.

In 2010, the ARV treatment initiation threshold was revised from CD4 level of 200 cells/mm^3 to 350 cells/mm^{3}based on WHO protocol. This revision has significantly increase the number of PLHIV estimated to be in need of treatment and impose greater financial burden on public funds particularly in addition to ensuring that more people are able to access and adhere to treatment.

The government continue to support the civil societies through funding mechanism allocated every year for HIV/AIDS responses through MAC. Guided by the NSP 2011-2015, MAC continues to oversee the implementation of high-impact HIV prevention programme by NGO, with the aim of providing 80% service coverage for key affected populations, where 60% of those covered practice safe behavior consistently by 2015. Since 2003, through MAC the government has extended its funding to more than 30 NGO every year amounting to more than RM 72 million (USD 22.6 million). In addition to that, the government has funded an additional RM 2 million for HIV-related shelter homes since 2009 through Ministry of Women, Family and Community Development.

1.3.4 HIV intervention through harm reduction

The harm reduction programme, comprising the Needle Syringe Exchange Programme (NSEP) and the Opiate Substitution Therapy (OST), remains the cornerstone of the Malaysian Government's HIV prevention strategy. This programme is currently being implemented in partnership with NGOs, CBOs and private health practitioners. Significant successes which have been attributed to increased sites and clients over the last few years have made this one of the programmes which has managed to get worldwide attention. MMT is also being introduced at NADA service centers and incarcerated settings specifically prisons. NADA has introduced a new way of managing drug user from compulsory rehabilitation centers to voluntary open access services namely Cure and Care Clinic, Cure and Care Service Centre and Caring Community House since 2007. MMT has also being expanded in prison set up;

beginning with only 1 prison in 2008 and has expanded to 18 by 2013. About 137,935 (81.1%) injecting drug users have been beneficiaries of this programme so far.

1.3.5 PMTCT programme

Towards elimination of HIV vertical transmission by 2015, the prevention of mother-to-child transmission (PMTCT) in Malaysia was introduced nationwide in 1998 and is available at all government health clinics and hospital. Focusing on ARV prophylaxis for infant, safer delivery and infant feeding practices, this programme relied heavily on detection of HIV infection during pregnancy. Coverage of these mothers through public facilities improved from 49.7% in 1998 to almost 100% in 2013. The government adopted treatment option B+ for HIV infected mothers since 2011 and the HIV exposed infants are getting free replacement feeding for extended period of 2 years since 2012.

1.3.6 Mobilization and involvement of MARPs and civil society

Involvement of key civil society stakeholders in national level policy and programme development continues to be dependent on issues of capacity and relevance. Civil society is being represented at the NCCAI and the CCM. In the former, civil society is represented by MAC while in the later several representatives (e.g. sex workers, PLHIV and transgender) have been elected onto the CCM by their respective communities. MAC which function as an umbrella organization to support and coordinate the efforts of partner organizations (PO) working on HIV and AIDS issues, facilitates the collaboration with civil society organisations (CSO) in the implementation of the National Strategy on HIV and AIDS.

1.3.7 Increased availability and improvement of quality strategic information

Malaysia has an in-built surveillance system for many years before the establishment of HIV/STI Sector in Ministry of Health. As for HIV, much progress has been made in understanding the HIV epidemic and MARPs, particularly vulnerability to HIV and STI

infection and the need for specific essential services. Understanding the need for quality and strategic information to assist in programme planning, two units have been established under the purview of Sector HIV/STI - M&E and HIV Technical and Behavioral Research units. M&E unit managers programmes indicators as well as estimations and projections of HIV epidemic. HIV Technical and Behavioral Research unit manages the Integrated Biological and Behavioral Surveillance Study (IBBS) and other HIV technical research in the HIV/STI Section of Ministry of Health. Detailed disaggregated data has also become available as a result of a revision of the national HIV reporting system and the National AIDS Registry (NAR) by the Ministry of Health. The Internet-based NAR is designed to function as a more streamlined and effective national HIV programme monitoring mechanism and has recently strengthened to include ARV component.

1.4 Overview Of Indicators (UNGASS/WHO/MDG)

The following table shares the overview of Malaysia's reporting on Global AIDS response progress indicators and summarizing the progress made over the past two years through comparison with the data reported in the 2001-2013 documents.

Table 2. Overview of Global AIDS Response indicators

Indicators		2012	2013	Comments
Target 1. Reduce sexual transmission of HIV by 50 percent by 2015				
General population				
1.1	Percentage of young women & men (15–24 years) who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission	26.9%	30.8%	Nationwide survey in secondary school (unpublished)
1.2	Percentage of young women & men (15-24 years) who have had sexual intercourse before age of 15	NA	1.0%	HIV-related knowledge among PLKN trainees 2013 (unpublished).
1.3	Percentage of adults (15–49 years) who have had sexual intercourse with > 1 partner in the past 12 months	NA	NA	

Indicators		2012	2013	Comments
1.4	Percentage of adults (15-49 years) who had > 1 sexual partner in the past 12 months who report use of condom during their last intercourse	NA	NA	
1.5	Percentage women & men (15-49 years) who received an HIV test in the past 12 months and know their results	100%	100%	M&E data (screening of premarital, antenatal, VCT, prisoners, inmates of DRC, TB & STI patients, contacts of HIV+; blood donor not included)
1.6	Percentage of young people (15–24 years) who are living with HIV (country with generalized epidemic)			Not applicable
Sex Workers				
1.7	Percentage of SW reached with HIV prevention programmes (*Number of SW who know where to get HIV test and had received condom in the last 12 months*)	55.1%[a]	NA	[a]IBBS 2012
1.8	Percentage of SW reporting use of a condom with their most recent client	83.9%[a]	NA	[a]IBBS 2012
1.9	Percentage SW received an HIV test in the past 12 mo. and know their results	75.1%[a]	NA	[a]IBBS 2012
1.10	Percentage SW who are living with HIV	4.2%[a]	NA	[a]IBBS 2012
Men who have sex with men (MSM)				
1.11	Percentage of MSM reached with HIV prevention programmes(*Number of SW who know where to get HIV test and had received condom in the last 12 months*)	45.7%[a]	NA	[a]IBBS 2012
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	76.7%[a]	NA	[a]IBBS 2012
1.13	Percentage of MSM that received an HIV test in the past 12 mo. and know their results	79.1%[a]	NA	[a]IBBS 2012
1.14	Percentage of MSM who are living with HIV	12.6%[a]	NA	[a]IBBS 2012
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015				
2.1	Number of syringes distributed per PWID per year by NSEP	94	55	M&E
2.2	Percentage of PWID who report the use of a condom at last sexual intercourse	15.0%[a]	NA	[a]IBBS 2012
2.3	Percentage of PWID reported using sterile injecting equipment the last time they injected	97.5%[a]	NA	[a]IBBS 2012
2.4	Percentage of PWID that have received an HIV test in the past 12 mo. and know their results	78.4%[a]	NA	[a]IBBS 2012
2.5	Percentage of PWID living with HIV	8.7%[a]	NA	[a]IBBS 2012

	Indicators	2012	2013	Comments
Target 3. Elimination mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Percentage of HIV positive pregnant women who received ARV to reduce the risk of mother-to-child transmission	68.5%	85.5%	MOH antenatal surveillance data and EPP 2014
3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	100%	100%	MOH antenatal surveillance data
3.3	Mother-to-child transmission of HIV (modelled) –% of child infections from HIV+ women delivering in the past 12 months	18%	8%	EPP 2014
Target 4. Reach 15 million people living with lifesaving antiretroviral treatment by 2015				
4.1	Percentage of eligible adults and children currently receiving ARV (MDG indicator)	15,084/ 36,087 (42%)	17,369/ 38,420 (45%)	Estimation and projection 2014 M&E Data
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV	3093/ 3236 (95.6%)	2360/ 2482 (95.1%)	Cohort survey in selected sites
Target 5. Reduce TB deaths in people living with HIV by 50 percent by 2015				
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	434/4256 (10.2%)	407/1867 (21.8%)	Survey at selected sites

	Indicators	2012	2013	Comments
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low-and-middle-income country				
6.1	Domestic and international AIDS spending by categories and financing sources	**Total:** **176,266,082.23** Domestic Public : RM 168,083,236.00 (95%) Domestic Private: RM 2,853,763.00 (2%) International: RM 5,329,083.00 (3%)	**Total:** **180,871,987.67** Domestic Public : RM 171,705,624.34 (95%) Domestic Private: RM 2,427,169.63 (1%) International: RM 6,739,193.70 (4%)	Refer AIDS Spending Matrix in annex 1

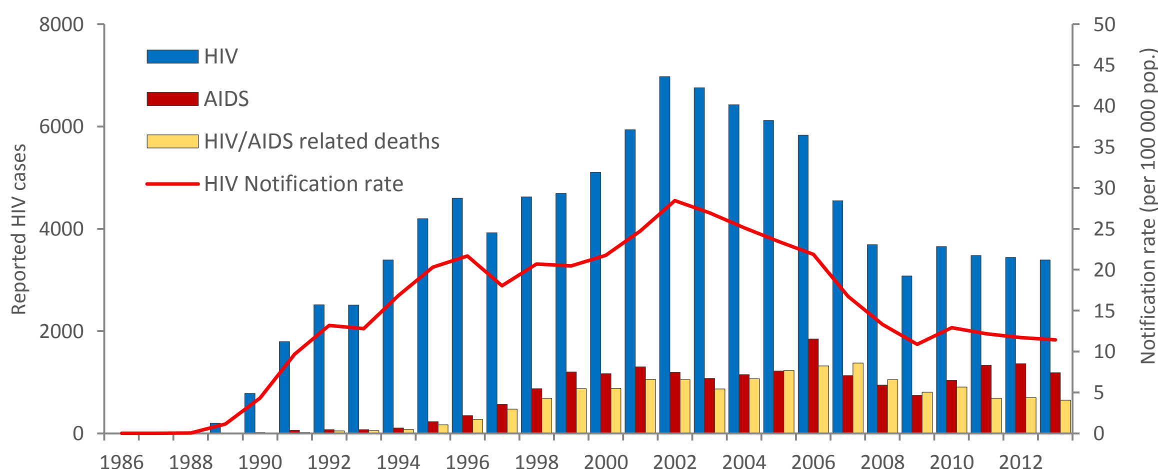
CHAPTER 2 - OVERVIEW OF THE EPIDEMIC

2.1 The epidemic overview

Malaysia is a country with concentrated HIV epidemic with infection rates remains high above 5% among most-at-risk populations (MARPS) especially among PWID, SW, TG and MSM population. Since the first case of HIV/AIDS reported in this country 28 years ago, number of people living with HIV (PLHIV) in 2013 is estimated at 86,324 (EPP 2014). Based on surveillance data (as of end 2013) Malaysia had a cumulative number of 101,672 HIV, 20,235 AIDS cases and 16,340 deaths related to HIV/AIDS, thus giving reported PLHIV of 85,332 cases.

The annual number of reported new HIV cases has been on a steady decline from a peak of 6,978 in 2002 (Figure 1). In 2013, there were 3,393 new HIV cases reported to the Ministry of Health, approximately halve of what was reported in 2002 with average of 9 new cases each day. The notification rate of HIV also continues to experience a decrease from 28.4 in 2002 to 11.4 cases per 100,000 populations in 2013.

Figure 1. Reported HIV and AIDS-related deaths, Malaysia 1986 – 2013

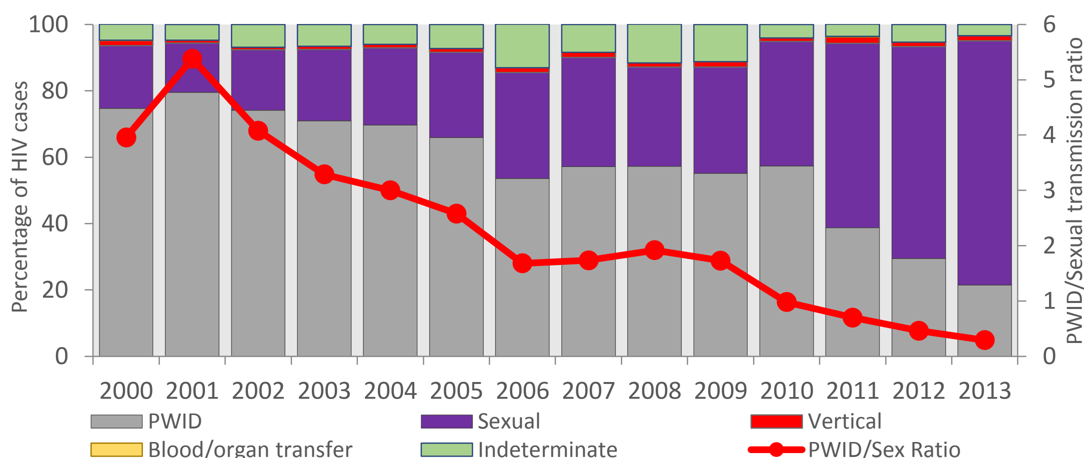


There has been a steady decline in the number of AIDS-related deaths reported. The reduction has been directly attributed to the introduction of more affordable and accessible first and second line antiretroviral (ARV) treatment. As of end 2013, there were 17,369 PLHIV on treatment which is 47% of the estimated number of PLHIV eligible for ARV treatment (37,274).

HIV in Malaysia is predominantly male as they constitute 78.5% of cumulative HIV cases of whom majority are PWID. However, the trend of infection by sex has changed with increasingly female acquiring infection with male/female ratio decreasing from 9.6 in 2000 to 4.5 in 2010 and to 3.7 in 2013.

In the earlier phase of the pandemic, PWID was the driven factor. With rigorous implementation of harm reduction programmes since 2005, the country is shifting progressively from PWID predominant to more sexual transmission with PWID/sexual transmission ratio of 3.9 in 2000 to 1 in 2010 and to 0.3 in 2013 (figure 2).

Figure 2.Reported HIV cases by mode of transmission and PWID/Sexual transmission ratio, Malaysia 2000-2013



About 34.3% of reported infections are amongst young people aged between 13-29 years old and constantly around 1% amongst less than 13 years old in 2013 (Figure 3). However, the age-specific HIV prevalence showing a stabilizing trend for all age group (figure 4).

Figure 3. Distribution of reported new HIV cases by age group, 1990 – 2013

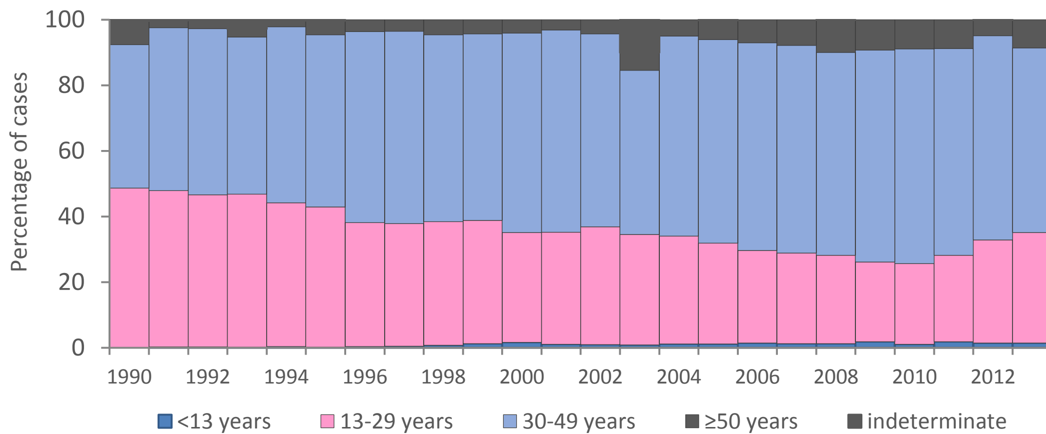
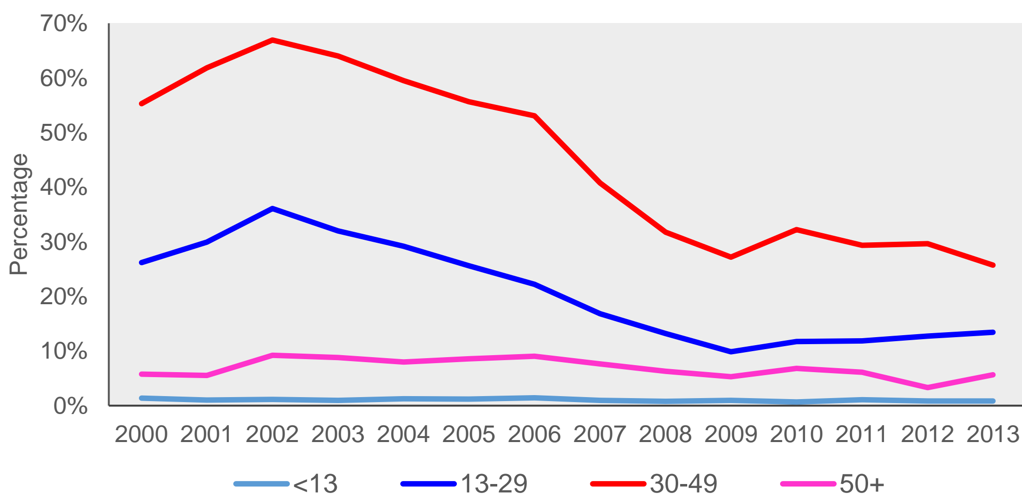
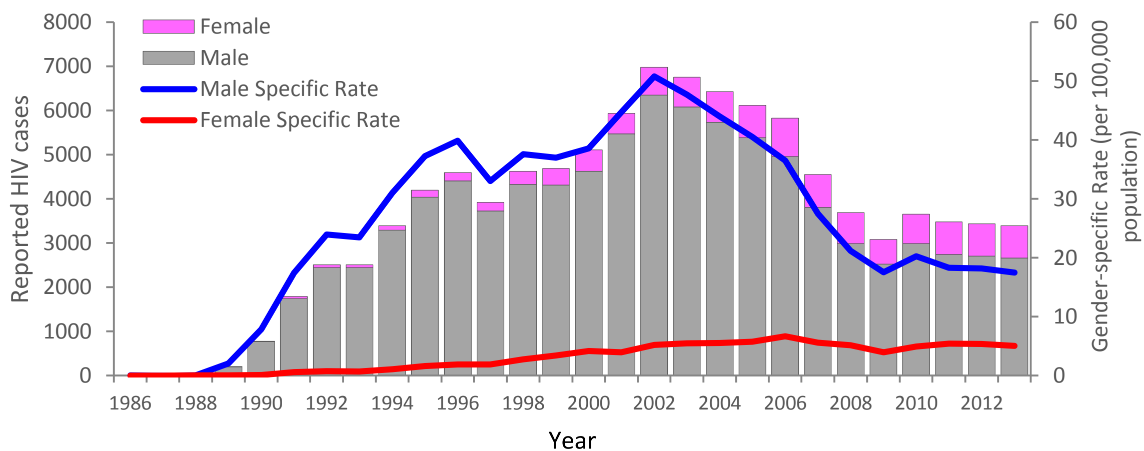


Figure 4. Age-specific HIV Prevalence, Malaysia 2000-2013



Male continue to represent the majority (78.5%) of cumulative HIV cases in Malaysia but the infection rate among both seemed stabilized (Figure 5) for the past couple of years. In 2013, amongst men, 21.5% acquired infection via injecting drug use and 73.6% through sexual mode. Most HIV infections amongst women occurred mainly through heterosexual transmission (51.4%).

Figure 5.Gender-specific HIV Prevalence, Malaysia 1986 – 2013



2.2 HIV Screening

HIV screening has started as early as 1985. Provided for free in all government health facilities (1,025 health clinics and 140 hospitals inclusive of non-MOH hospitals), the Ministry adopted voluntary and confidential HIV test (VCT) as well as Provider Initiated Testing and Counselling (PITC).

Among the screening programmes that has been implemented routine HIV screening of all donated blood, blood products and organs, an opt-out antenatal screening and routine screening of inmates in drug rehabilitation centers and prisons, TB and STI cases, clients of harm reduction programme, contacts of cases and voluntary

screening for premarital couples. With the initiative of state Islamic religious department, premarital HIV screening for Muslim couples began in 2001 in one of the 14 states in Malaysia. By 2007, is has been expanded nationwide in all government health centres. This screening is accessible to anybody who wishes to undergo premarital HIV screening, irrespective of faith.

Over the past five years, an average of 1.3 million HIV screening was conducted (Figure 6). In 2013, about 1,328,031 men and women aged 15 and above had received HIV test and counseling and know the result, out of which 1,412 (0.11%) were HIV positive. Despite maintaining surveillance programme and intensified screening activities, the detection rate of HIV is decreasing. This figure is compatible with the declining HIV reported cases through the surveillance system. It also validated the reduction in HIV cases in the country as estimated through estimation and projection exercise. Based on surveillance data and screening activities, it was clearly shown that the cases in this country are still confined within the MARPS and that the prevalence among relatively low risk population as demonstrated through screening program is still low between 0.02 to 0.11% (Figure 7).

Figure 6. HIV Screening in Malaysia, 2000 - 2013

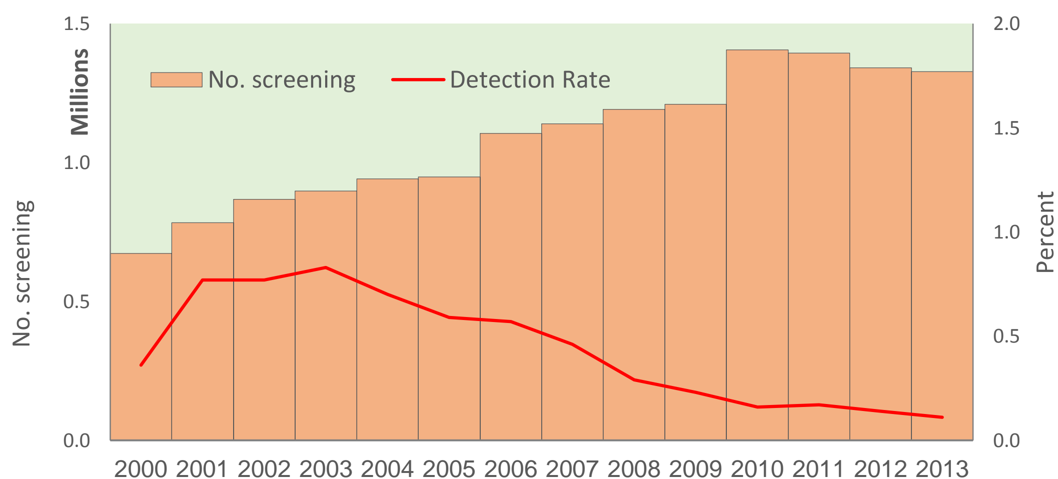
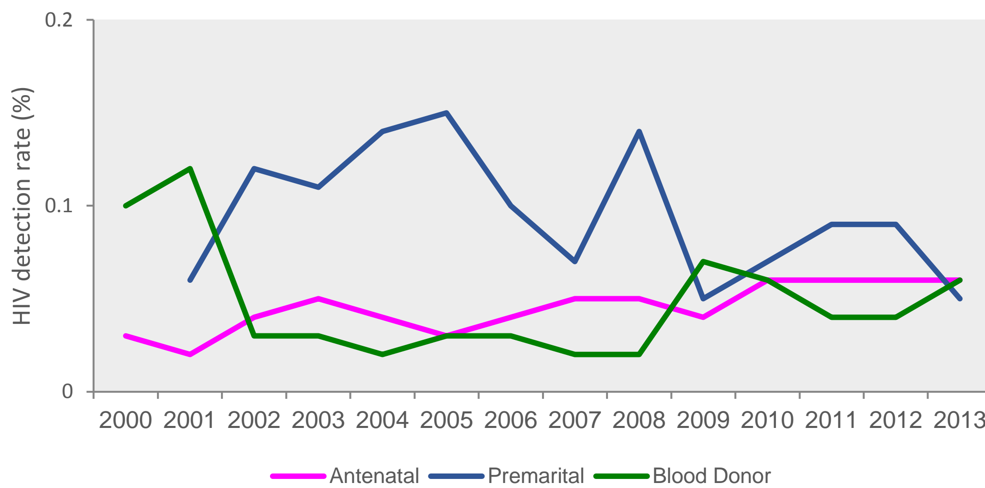


Figure 7. HIV prevalence of selected screening programmes, Malaysia 2000-2013



2.3 Most at Risk Populations (MARPS)

Being a country with concentrated HIV epidemic among MARPS, the Ministry of Health has incorporated behavioural surveillance survey into the existing surveillance system. Hence, Behavioural Surveillance Surveys were adapted for this purpose beginning in 2004 which was later followed by the use of Integrated Bio-Behavioural Surveillance (IBBS) studies. The first round of IBBS survey was conducted in the Klang Valley in 2009 focusing on three key affected populations (PWID, FSW and TG) and in 2012, nationwide IBBS survey covering PWID, FSW, TG and MSM were successfully carried out. The key findings of IBBSs are summarized in table 3.

Table 3. Changing behavioral trend among key-affected population, 2009-2012

Injecting Drug Users	**2009 (n=630)**	**2012 (n=1906)**
HIV prevalence	22.1%	18.9%
Used sterile injecting equipment	83.5%	97.5%
Tested and knew results	60.8%	64.5%
Sexually active	49.7%	45.7%
Condom use with most recent partner (paid – regular)	19 - 58%	25-72%
Paid for sex	15.1%	20.2%
Knowledge of modes of transmission	49.7%	53.8%
Reached out by intervention programmes	27%	86.5%
Female sex workers	**2009 (n=551)**	**2012 (n=864)**
HIV prevalence	10.5%	4.2%
Tested and knew results	46.1%	32.4%
Condom use with most recent client	60.9%	83.9%
Injecting drugs	5.6%	4.2%
Had sexual partners who inject drugs	20%	7.7%
Used recreational drugs before sex	38.5%	20.8%
Consumed alcohol before sex	35.9%	39.9%
Knowledge of modes of transmission	38.5%	35.4%
Reached out by intervention programmes	36.1%	57.8%
Men who have sex with men (MSM)	**2009 (n=529)**	**2012 (n=414)**
HIV prevalence	3.9%	12.6%
Tested and knew results	41%	51.2%
Condom use with recent partner (paid – consensual)	55-63%	42-77%
Injecting drugs	6%	5.3%
Used recreational drugs before sex	23.8%	24.6%
Consumes alcohol before sex	23.2%	33.8%
More than 6 male partners in the past 6 months	25.7%	8.6%
Sex with female partners	16.1%	13.9%
Knowledge of modes of HIV transmission	NA	40.4%
Reached out by intervention programmes	NA	56.8%
Transgender (TG)	**2009 (n=540)**	**2012 (n=929)**
HIV prevalence	9.3%	5.7%
Tested and knew results	48.6%	43%
Sold sex	83.7%	84.9%
Condom use with most recent client	67 - 95%	69 - 83%
Injecting drugs	3.1%	2.5%
Used recreational drugs before sex	32.8%	22.6%
Consumed alcohol before sex	35.9%	37%
Had sexual partners who inject drugs	11.7%	7.7%
Knowledge on HIV transmission	37.2%	40.2%
Reached out by intervention programmes	43.7%	79.1%

2.3.1 Injecting Drug User (PWID)

It is estimated that there are about 170,000 PWID in the country. The HIV screening activity among PWID in DRC started as early as 1989 and further strengthened in 1996. This screening activity had also expanded to include the harm reduction programme clients (NSEP and MMT) in 2005. At the beginning of the epidemic, PWID was the main driver bearing the brunt of about 70-80% of all new reported cases. This has started to decline constantly beginning 2004, and reached 39% in 2011. As of end 2013, about 66,774 cases were infected from sharing needle.

2.3.2 Sex Workers

A size estimation study of sex workers in Malaysia estimated the population of sex workers in Malaysia to be 60,000 out of which 40,000 were female sex workers (FSW) and 20,000 were transgender sex workers[6]. Sex worker accounts for approximately 0.6% of total reported cases or 635 of the 101,672 cases reported thus far. Comparing to PWID, the number of cases reported among sex workers are grossly under reported. Sex workers may not identify themselves as such but may be categorized by risk factor – heterosexual, homosexual or bisexual in the surveillance system.

2.3.3 Men Who Have Sex With Men (MSM)

In the National HIV surveillance system, MSM are grouped as homosexual/bisexual. As of December 2013, there were cumulative of 3,815 (3.7%) MSM reported. In 2009, a venue-day-time-sampling (VDTS) study was carried out among 517 respondents in Kuala Lumpur out of which 3.9% were found to be with HIV. An IBBS in 2012 involving five (5) states (Kuala Lumpur, Penang, Johor, Sabah and Sarawak) showed 3 times increased of HIV prevalence (12.6%).

[6] Lim et al. Size estimation for local responses in Malaysia for HIV prevention in sex work 2010 (unpublished)

2.3.4 Transgender (TG)

It is estimated that there are about 20,000 TG in this country[5]. TG are often stigmatized and discriminated by society. It was previously unknown as to how many cases of HIV were seen or estimated within this population. An IBBS in 2009 found HIV prevalence among this group at 10.2% and reduced to 5.7% in 2012.

2.3.5 Young population at risk

Vulnerable populations are populations most likely to be exposed to HIV or populations at higher risk of exposure. Of the total 101,672 cumulative HIV cases since 1986, some 2,578 (2.5%) were individuals aged 19 years and below. In 2013, there are 125 cases among young people of 3,393 new reported HIV cases for that year. The vulnerabilities and situations encountered by both urban and rural children that expose them to HIV infection are many: sexual and physical violence, incest, sex work, human trafficking, underage and unprotected sex. Children with HIV have been reported to have faced stigma and are exposed to and experience acts of discrimination which could lead to ostracisation, exploitation, becoming homeless and loss of education.

2.4 Recent trends in the epidemic

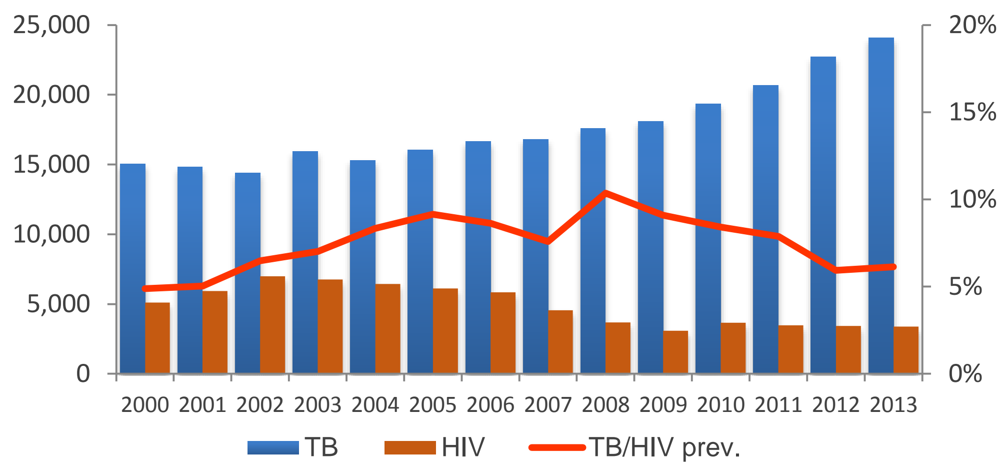
2.4.1 HIV/TB Co-infection

Tuberculosis (TB) remains a public health challenge in Malaysia with around 16,000 – 20,000 new cases reported annually (Figure 8). Patients with HIV are highly vulnerable to TB, because of their weakened immune systems. As part of its disease control and prevention measures, the Government currently conducts routine TB-HIV screening for all new inmates in closed settings such as prisons and drug rehabilitation centres, which was started in 2001. From 1990 to 2013, the number of

TB/HIV co-infection reported nationwide has increased from six (6) to 1,477 cases[7]. Without treatment, as with other opportunistic infections, HIV and TB co-infection would shorten the life of the person infected. In effort to reduce morbidity and mortality of TB/HIV co-infection, the government has started Isoniazid prophylaxis in 2010.

The number of TB cases detected each year is relatively quite high compared to HIV with ratio of TB/HIV cases of 3:1 in 2000 to 7:1 in 2013. An average of 20,000 cases was reported over the past five years. In 2013, about 24,071 new TB cases were registered in Malaysia with reported TB-HIV co-infection of 6.1%. It was estimated that in 2012, about 23,027 people infected with TB, TB incidence without HIV about 2.4 per 1000 population and TB/HIV co-infection about 8%.

Figure 8. New TB, HIV and prevalence of TB-HIV Co-infection, Malaysia 1999-2013



[7] Ministry of Health Malaysia. TB surveillance data 2013.

2.4.2 Increase trend of HIV through sexual transmission

There is no doubt that injecting drug use was the main driven factor for the country's epidemic. However, there is a shift to progressively increasing in sexual transmission. Infection through PWID route had declined significantly from 70-80% in 1990s to 21.5% in 2013 (table 4).

Table 4: Percentage of new HIV cases by risk factor

Risk factor	1990	2000	2010	2013
Injecting drug use	470 (60.4%)	3,815 (74.7%)	1,737 (47.6%)	728 (21.5%)
Sexual transmission	41 (5.3%)	964 (18.9%)	1,773 (48.5%)	2,498 (73.7%)
Heterosexual	38 (4.9%)	902 (17.7%)	1,472 (40.3%)	1,743 (51.4%)
Homosexual	3 (0.4%)	62 (1.2%)	301 (8.2%)	755 (22.3%)

Source: Ministry of Health (2013)

Increasingly more new reported cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by both heterosexuals and homosexuals. Combined, sexual transmission of HIV is currently responsible for more than two thirds of new HIV cases.

As of December 2013, HIV transmission attributed to heterosexual intercourse constitutes of 20.8% cumulative cases. However, there is significant increase in proportion of newly infected cases acquired through heterosexual contact from 4.9% in 1990 to 51.3% in 2013. As part of the prevention of mother-to-child-transmission (PMTCT) programme in 2013, close to 500,000 pregnant women were screened and 298 individuals were detected with HIV.

2.4.3 HIV and Women

As of December 2013, about 10,956 women and girls in Malaysia have acquired HIV since 1986. The profile of the Malaysian HIV epidemic has progressively shifted from predominantly male to increasing infection among female[8].The gender-specific rate was clearly showing a downtrend of new infection among males beginning 2003, but infections among females are slowly taking its toll. However, both rates seemed stabilizing for the past couple of years.

Based on the National Surveillance System, new HIV cases has declined beginning 2003. But the proportion of female/male has shifted to increasing infection among female with ratio of 1:99 in 1990 to 1:4 in 2013. In 2013, the Ministry of Health recorded 728 new HIV cases and 197 AIDS cases among females in Malaysia. The MOH profile of female HIV cases in 2013 indicated that more than two thirds (70.3%) were between 20-39 years of age, about half (45.7%) were Malays, 88.5% had acquired HIV through heterosexual transmission and 34.9% were housewives.

[8] *Ministry of Health Malaysia and UNICEF (2008). Women and girls confronting HIV and AIDS in Malaysia*

CHAPTER 3 - ESTIMATION AND PROJECTION OF HIV EPIDEMIC

3.1 Background

HIV/AIDS estimates and projections provide invaluable data on the epidemic and the future burden of HIV to inform program planning and evaluation. The third round of estimation and projection was conducted in February 2014 by National HIV Estimate Team at the Ministry of Health Malaysia using Estimation and Projection Package (EPP) Version 5.02. The team consist of relevant Public Health Physicians, epidemiologist and M&E expert. Consultations with relevant stakeholders and program managers were carried out to consolidate and validate the data inputs with assistance from UNAIDS Regional Office and East-West Centre Hawaii.

Similar to the previous rounds of estimates and projections process, seroprevalence data, programmatic data, population size estimates, behavioural studies and pertinent data from ad hoc studies were entered into the EPP to generate estimation of PLHIV, new infections, AIDS deaths, number of adults, and children needing treatment, the need for preventing mother to child transmission (PMTCT) and the impact of antiretroviral treatment on survival.

3.2 Sub-populations size

As the country's epidemic is still concentrated within PWID, female sex workers, TG sex worker and MSM, information on these sub-populations were crucial for the epidemic structure. These include population size estimates, HIV surveillance data over time, and estimates of how long people remain in that sub-population. There has been no changes in the population size estimates used for this round. The population size estimates were based on previous study done locally or based on regional estimates. The key parameters and justification of their use are summarized in table

5. The duration of remaining in the population was calculated based on current duration of stay (for each population) derived from recent behavioural study (2012) and multiplied with factor of 2. Thus, duration of remaining in the population for each population are 20 years for PWID, 15 years for MSM, 12 years FSW and 14 years TGSW.

3.3 Data sources

The primary data sources for this round have got better with more data points and additional sites available. Information for sub-populations were gathered mostly from surveillance activity at national level, selected sites and behavioural or ad-hoc surveys were input into the epidemic structure (table 6). However, there is limited or none surveillance or survey done for client of sex worker. Therefore, the prevalence for this sub-population is assumed at one third of FSW prevalence which is agreed through consensus meeting.

More representative sites will be added in the next round as screening of key affected populations will be incorporated into VCT programme beginning 2014. Population-specific HIV prevalence curves were fitted to the surveillance data to produce best estimates and model was calibrated for TG (adjust prevalence to IBBS 2012), low risk male (scale to factor 0.56), low risk female (scale to factor 0.47), female sex worker (scale to factor 0.42) and indirect female sex worker (scale to factor 0.42).

Table 5. Key input parameters on population size estimates in the HIV estimation model

Population	Estimated size	Notes
Injecting drug users	170,000	Global Fund proposal estimated size: 120,000 Denominator used in NSEP target setting: 80,000 – 120,000 Size estimation study (2003): 194,000 (range 104,486 – 135,506) DRC estimates: 13,000 – 25,000 Harm Reduction programme estimates: 120,000 Situation assessment 2004: 117,000 – 240,000 The value of 170,000 was agreed upon as a rough average of the range of estimates available, and also in being consistent with recent estimates used elsewhere.
Female sex workers	40,000	Based on 2009 HIV model by Lim et al (modified snowball sampling at multistate) and 55% local; 60% direct and 40% indirect (IBBS 2012)
TG sex workers	20,000	
MSM	173,000	Based on 1.9% reported through the NHMM III survey.
Clients of sex workers	600,000	National household probability surveys in 54 countries and behavioral surveys; 5-7% for S & SE Asia (Clients of sex workers in different regions of the world, www.stijournal.com). Malaysia is using 7% of total adult male (15-49)

Table 6. Primary data sources for HIV prevalence by sub-population

Population	Data sources
PWID	1. National HIV screening at DRC (1989-2006). Data from this source is still available but does not represent national prevalence since DRC change policy of taking in only new PWID beginning 2007. 2. Behavioural survey 3. HIV screening programme from NSEP sites
Direct FSW	1. HIV screening program in selected health centres 2. Behavioural and ad-hoc survey 3. National VCT programme
Indirect FSW	1. Behavioural survey 2. Special screening programme (Pahang)

Population	Data sources
TG sex worker	1. Behavioural survey 2. National VCT programme
MSM	1. VCT centre (PTF) 2. National VCT programme 3. Behavioural survey 4. Ad-hoc survey (PUSH project)
Client of SW	No surveillance or survey data available. Instead, HIV prevalence were assumed as one third of FSW prevalence of HIV
Low risk male	1. National premarital HIV screening programme 2. National Blood Bank
Low risk female	a) National antenatal HIV screening programme (PMTCT) b) National premarital HIV screening programme c) National Blood Bank

3.4 National HIV infection estimates and projections

Based on the estimates, 86,324 people were infected nationwide in 2013 which is about 0.44% of total Malaysian population. With better access to ARV treatment which prolongs life span of PLHIV, the total number of people living with HIV (PLHIV) is expected to increase to 91,733 in 2015. The prevalence of HIV among adults (15+) population is expected to slightly increased and stabilised at 0.40% by 2015 (figure 9). It must be recognized that this rate can only be reached with sustained and strengthened implementation of intervention programs.

Although the estimated number of males and females PLHIV has increased over time, but the number of infected males will remain around six (6) times higher than the number of infected females (Figure 10). For the past 28 years since the first case was detected in 1986, the efforts put in to combat HIV and the outcome is tantamount. With harm reduction programme implemented in 2005, the country is hopeful that it will be able to reverse the epidemic.

Figure 9. Estimated HIV prevalence (15+) vs Reported HIV prevalence (15+), Malaysia 1980-2020

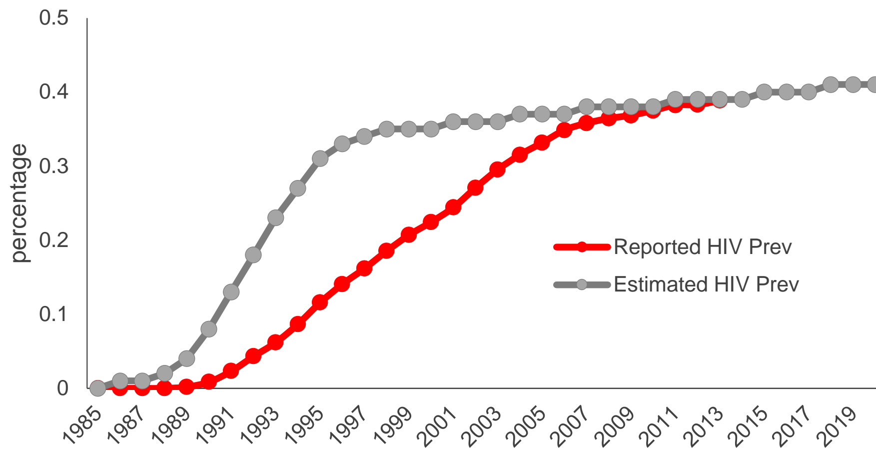
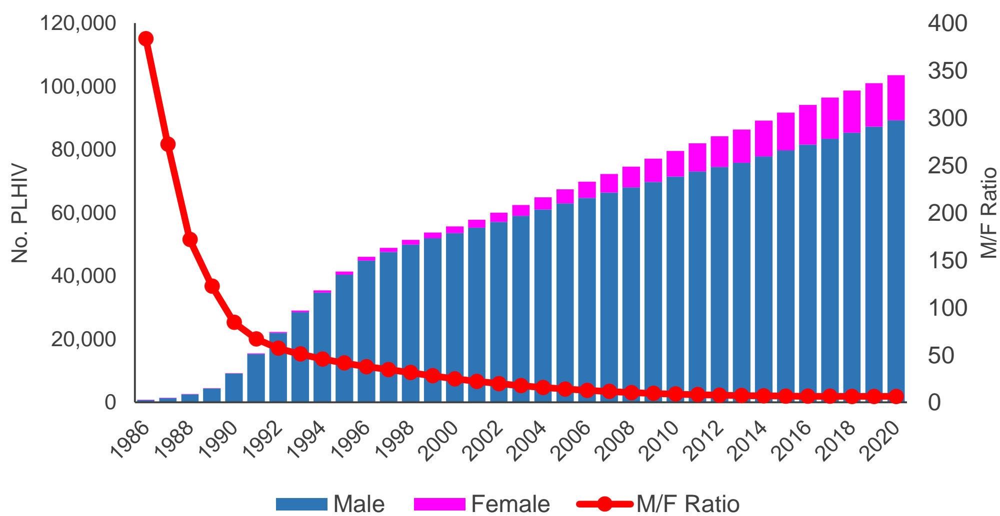


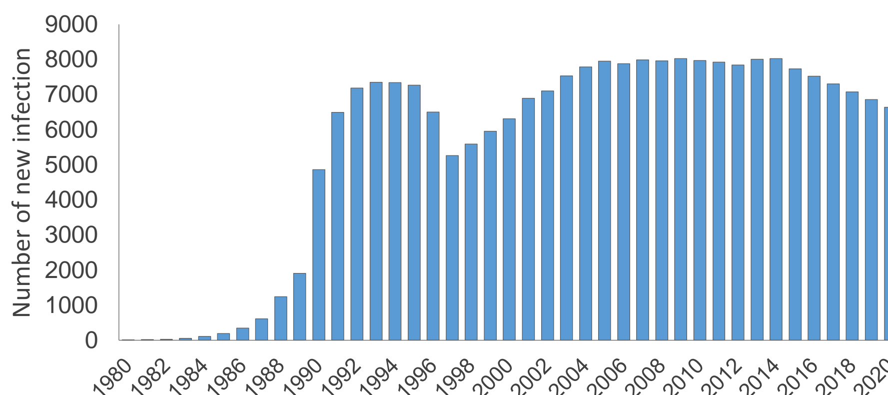
Figure 10. Estimated number of PLHIV by sex and male to female ratio, Malaysia 1980-2020



As shown in figure 11, the new HIV infection (adult 15+) is estimated to decline. This decline coincided with the implementation of harm reduction programme in 2005

targeted at the IDU that drove the epidemic in this country in the early phase and nationwide implementation of antenatal and premarital HIV screening.

Figure 11. Number of new HIV infections among adults 15+, Malaysia 1985-2020



3.5 ARV treatment need and its impact on the epidemic

The expanded ARV treatment has made a significant impact on mortality from AIDS and by 2015, a cumulative total of 14,764 deaths were averted since ART was started in 2002 (Figure 12). Figure 13 shows the number of PLHIV aged 15 years and older in need of ARV treatment in Malaysia. The number of people in need of ARV, as per the WHO-recommended threshold of CD4 350 cell/mm3, is expected to increase to 47,490 in 2015 from a baseline of about 39,696 PLHIVs in 2013. With coverage goal aiming at 80% for ARV treatment, HIV care and treatment services will need to expand in order to meet the needs of the increasing number of PLHIV requiring treatment.

Figure 12. Cumulative total of deaths averted by ART, Malaysia 2002-2015

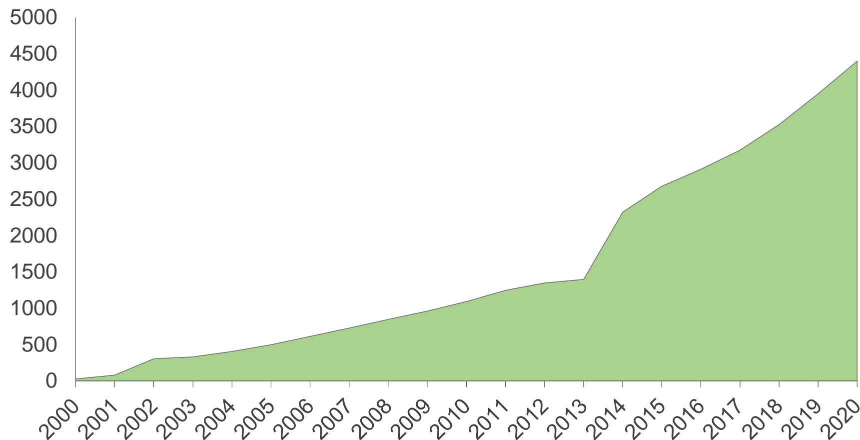
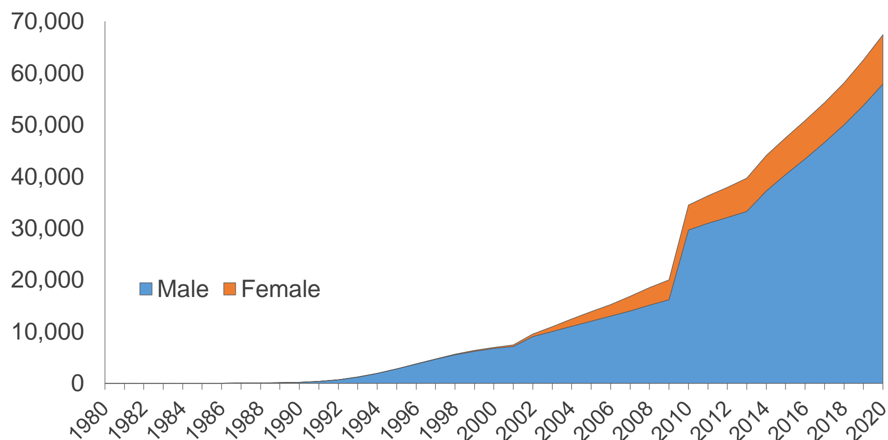


Figure 13. Estimated number of adults (15+) in need of ART by sex, Malaysia 1980-2020



3.6 Key affected populations

In general, the new HIV infections is set to decline from 2014 for all sub-populations except for low risk male and female sex workers there will be slight increase (Figure 14). The model shows that HIV prevalence among PWID, MSM, FSW and TG are stabilizing at approximately 14%, 9%, 3% and 6% respectively in 2013 through 2015

(figure 15). This implies a steady rate of new HIV infections among these key-affected populations.

Figure 14. New HIV infection by sub-population, Malaysia 2005 - 2020

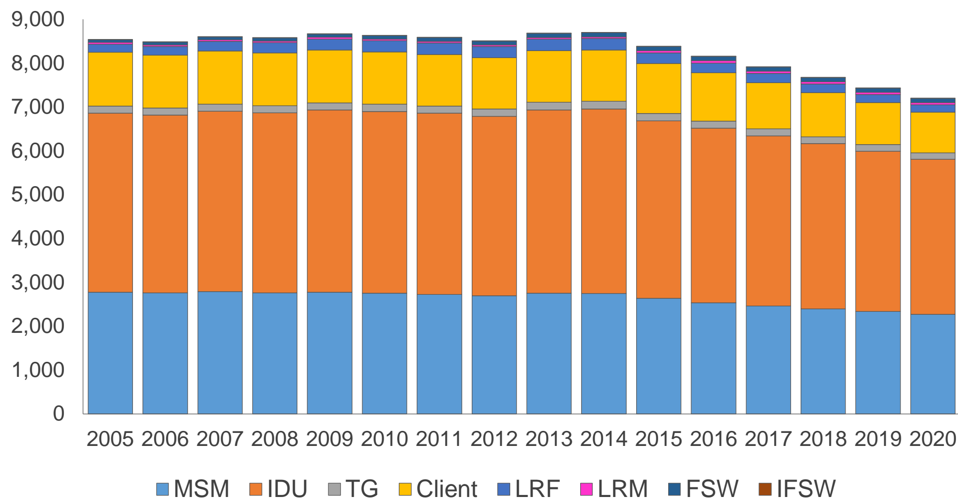
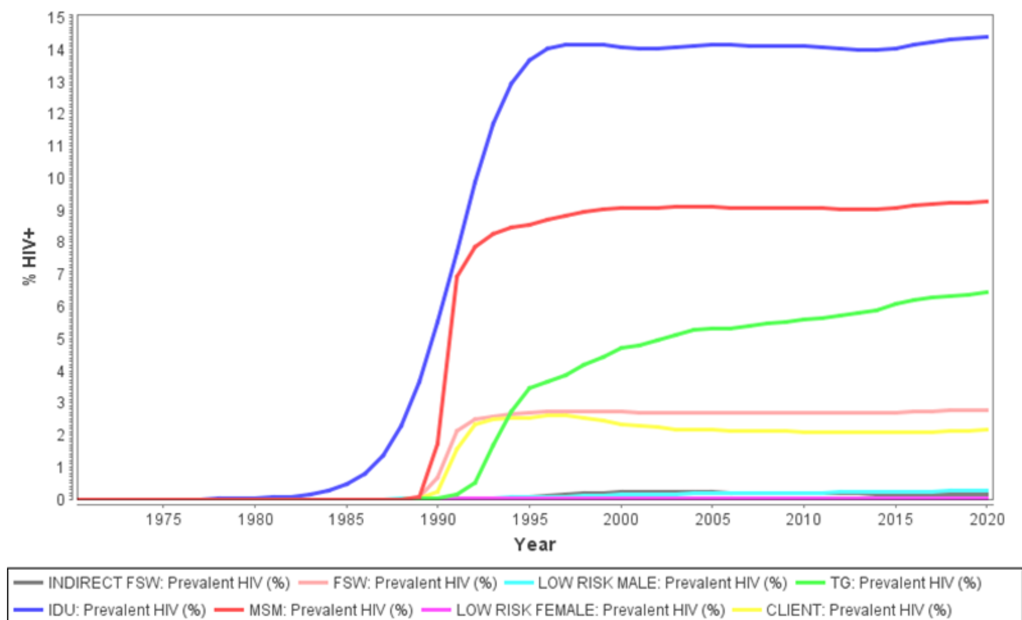


Figure 15. Estimated HIV prevalence among key affected population, Malaysia



3.7 Summary estimates of Malaysia HIV epidemic

Table 7 narrates summary of HIV/AIDS estimates in Malaysia for 2013 – 2020. The key findings from the estimation and projection (EPP 2014) can be summarized as follows:

a) Due to better ART coverage, the number of PLHIV is expected to increase and the number of AIDS deaths is expected to reduce beginning 2014.

b) The proportion of women newly infected with HIV is stabilizing at 13%.

c) The number of pregnant mothers needing PMTCT is estimated to stabilize in the next couple of years.

d) The HIV prevalence among key-affected populations - PWID, MSM, FSW and TG are stabilizing at 14%, 9%, 3% and 6% respectively in 2013 through 2015.

e) The number of children less than 15 years old living with HIV is expected to reduce from 746 in 2013 to 714 in 2015.

Table 7. Summary estimates of Malaysian HIV epidemic (EPP 2014)

Estimates	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total HIV	84,183	86,324	89,136	91,733	94,143	96,421	98,691	101,049	103,577
New HIV infections	7,865	8,035	8,052	7,761	7,550	7,324	7,097	6,870	6,654
Annual AIDS death	5,699	5,899	5,198	5,039	4,970	4,848	4,615	4,282	3,883
Prevalence adult (%)	0.44	0.44	0.44	0.44	0.44	0.44	0.45	0.45	0.45
Incidence (15-49) (%)	0.05	0.05	0.04	0.04	0.04	0.04	0.04	0.04	0.03
HIV adults (15+)	83,426	85,577	88,402	91,018	93,457	95,772	98,085	100,492	103,074
HIV adult female (15+)	9,329	10,120	10,907	11,580	12,159	12,649	13,099	13,554	14,029
New HIV adult (15+)	7,842	8,005	8,021	7,730	7,521	7,298	7,077	6,854	6,638
Annual AIDS death (15+)	5,684	5,881	5,178	5,017	4,948	4,828	4,597	4,266	3,870
HIV male (15-24)	4,115	4,038	3,963	3,858	3,750	3,640	3,529	3,414	3,292
HIV female (15-24)	1,109	1,148	1,183	1,201	1,211	1,213	1,207	1,196	1,181
HIV children (0-14)	755	746	733	714	685	649	606	557	504
AIDS orphan	58,039	57,125	55,960	54,187	53,050	52,187	51,519	50,937	50,349
ART eligibility (0-14)	539	546	545	532	511	485	453	415	395
ART eligibility (15+)	37,893	39,696	44,041	47,490	50,829	54,276	58,146	62,514	67,384
# Needing PMTCT	380	401	421	438	449	455	457	456	455

CHAPTER 4 - NATIONAL RESPONSE TO THE AIDS EPIDEMIC

4.1 National and political Commitment

The national response to HIV dated as far back in 1985. HIV, AIDS and death related to HIV/AIDS was listed as notifiable diseases under the Prevention and Control of Infectious Diseases Act[9]. Raising awareness on HIV/AIDS and early detection has been the primary focus of MOH since the formulation of Plan of Action in 1988.

The first National Strategic Plan (NSP) on HIV/AIDS was endorsed as the country's master plan in 2000. Since then, there has been several series of NSP with latest revision, NSP 2011-2015 serves as the country's common action framework on HIV and AIDS. Midway through the implementation of the current NSP, a reviewing process was undertaken in January through to the end of May 2013. The reviewing exercise was undertaken to look at HIV/AIDS situations and implementation of policies, plans and program. It also assessed remaining gaps and challenges to improve the HIV/AIDS responses as well as to identify next steps to be undertaken in order to reach the targets set.

The responsibility for the overall coordination, monitoring, evaluation and reporting of Malaysia's HIV and AIDS responses is currently tasked to the HIV/STI Sector of the Disease Control Division, Ministry of Health. The HIV/STI Sector function as the National AIDS Programme (NAP) Secretariat supported by the AIDS Officers at every state. During the earlier days, the design and development of the HIV/AIDS National Prevention and Control Program was sole responsibility of the Ministry of Health. Over period of time, this response has matured to include wider group of stakeholders

[9]Laws of Malaysia Act 342. Prevention and Control of Infectious Diseases, Act 1988.

including non-health sectors within government organizations, non-government organizations, civil society, private agencies, bilateral and international agencies.

The government and key stakeholders have agreed that the new National Strategy on HIV should be able to sustain and upscale the achievements and commitments, while at the same time be able to address concerns and identified gaps as well as respond more effectively to the needs of its stakeholders, especially those of civil society and key affected populations.

The objectives of the NSP 2011-2015 are as follows:

a) To further reduce by 50% the number of new HIV infections by scaling up, improving upon and initiating new and current targeted and evidence based comprehensive prevention interventions
b) To increase coverage and quality of care, treatment and support for People Living with HIV and those affected
c) To alleviate the socioeconomic and human impact of AIDS on the indivPWIDal, family, community and society.
d) To create and maintain a conducive and enabling environment for government and civil society to play meaningful and active roles in decreasing stigma and discrimination.
e) To further increase general awareness and knowledge of HIV, and reduce risk behavior for at risk and vulnerable populations.

The NSP 2011-2015 strives to sustain the progress and achievements made over the past strategic framework. To do so, this NSP targets to achieve the following indicators:

a) Comprehensive HIV prevention programmes are able to effectively cover 80% of most at risk populations.
b) 60% of most at risk populations use condoms consistently.

c) 60% of most at risk populations, who are also injecting drug users, use clean injecting equipment.

d) All cases of vertical HIV transmission are able to be prevented with all HIV positive pregnant mothers receiving treatment and children born receive ARV prophylaxis.

e) Provision and access to comprehensive services for at least 80% of People Living with HIV who are eligible for ARV treatment, care and support which are non-discriminatory and professional.

Given the mandate by the Government under the NSP, much of the leadership in responding to the epidemic continues to be shouldered by the Ministry of Health. However, the level of engagement from non-health sectors, NGO, civil societies, private agencies, bilateral and international agencies has risen tremendously over the past five years.

4.2 Mid-Term Review

In 2013, mid-way through implementation of the current NSP 2011-2015, a review was conducted to access the implementation of the national programme whether it is going in the right direction as outlined in the NSP 2011 - 2015 and Political Declaration on HIV/AIDS 2011. Apart from accessing progress and achievements, the mid-term review had documented concerns, gaps and constraints that intended to accommodate for reprogramming and adjustment of the current NSP to achieve 2015 targets. Through multi-sectorial workshops, in-country consultations and internal discussions, below are the priority areas for NSP focus between now and 2015.

4.2.1 Mitigating sexual transmission of HIV

The country acknowledges the increasing trend of HIV infection acquired through sexual exposure. Thus, a National Task Force on Mitigation of HIV

through Sexual Transmission was formed to look into innovative and effective ways to mitigate sexual transmission of HIV. The National task force will take into account the need for comprehensive preventive packages focusing on innovative behavior modification and its deliverables.

4.2.2 Upscale ARV treatment to achieve more than 80% eligible PLHIV

In realizing 'Zero AIDS-related deaths' and improving access to treatment, Malaysia is providing the first line treatment at no cost whilst the second line regimes are heavily subsidized. The Ministry of Health has extended this service to include health centers with specialist, prisons and Drug Rehabilitation Centers and currently proposing an extra allocation for laboratory active.

4.2.3 HIV among Most-at-risk young people (MARYP)

The National Task Force on HIV/AIDS for the Most-at-risk young people is a multi-state agency task force dedicated to the prevention of HIV and to the care of persons with HIV/AIDS among the most at risk young people. It provides an effective platform for networking, sharing information as well as to plan, execute and evaluate promotive, preventive, curative and rehabilitative HIV/AIDS programs pertaining to the most at risk young people. These will ensure prevention and reduction of the risk and spread of HIV infection among the most at risk young people, improve the quality of people living with HIV, and reduce the social and economic impact resulting from HIV and AIDS on the individual, family and society.

4.2.4 National Treatment Registry (NTR)

In view of a gap between the detection to treatment, care and support, new initiatives were develop in follow through PLHIVs. Among the initiatives are the use of National AIDS Registry (NAR), which was launched in 2010 and

registration of those PLHIV who are on treatment (National Treatment Registry, NTR). NAR is a real time web-based registration of all notified PLHIVs. On the other hand, NTR is operating as stand-alone registration of which it will be incorporated into NAR in 2014.

4.2.5 Male circumcision

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60% , and decreases the incidence and prevalence of herpes simplex virus 2 (HSV-2) and human papillomavirus (HPV). Being a Muslim country where circumcision or 'khitan' is seen as a 'requirement', most Muslim boys will have to undergo circumcision at the preferred age of seven although some Muslims are circumcised as early as the seventh day after birth and as late as puberty. With the proven benefits in reducing sexually acquired infection, the country will gear towards promoting male circumcision as an additional, important strategy for the prevention of heterosexually acquired HIV infection especially among non-Muslim men.

4.2.6 Extension of testing in the community by the community

Implementing HIV test in outreach and community settings, is feasible approach for reaching minorities and people at high risk for HIV infection. CBOs implementing testing programmes in non-clinical setting are often able to reach a large number of people at high risk for HIV infection. However, testing programme by CBO often using rapid test method should never be limited to giving out preliminary results. Provision of confirmatory test and linking those individuals with confirmed infection to follow-up and prevention services were the challenges for most CBOs. Currently there are few CBOs having trained health personnel in HIV testing and counseling and the linkages to follow-up care and preventive services.

4.2.7 GO-NGO Partnership

The Government has always acknowledge the role of civil societies in fighting against HIV/AIDS and this undivided support has been translated into a yearly funding scheme channeled to Malaysia AIDS Council (MAC) for implementation of HIV/AIDS programmes that is in line with the NSP. A total of RM 64.9 million (USD 21.5 million) has been disbursed to MAC for period of 10 years (2003 – 2012), in excess of 62% from the earlier commitment signed in 2002 (RM40 million) between the Government and MAC. The MTR acknowledges the increasing role that NGO continues to play in HIV works especially in addressing the need of MARPs. Therefore GO-NGO co-operation should be based on good partnership and cover all fields of joint national concern including periodic and systematic evaluation of their role and impact.

4.3 Financing the HIV and AIDS responses

With undivided government commitment comes the funding allocation. The resources required to implement the NSP were calculated based on expected coverage and impact goals as derived from estimates of the number of people receiving each service and the cost per person. Service estimates are based on the population in need of the service or programme and the coverage level to be achieved that is assumed to increase from the baseline levels to the planned targets by 2015. The unit costs for these services are based on existing interventions currently being implemented by agencies and organisations.

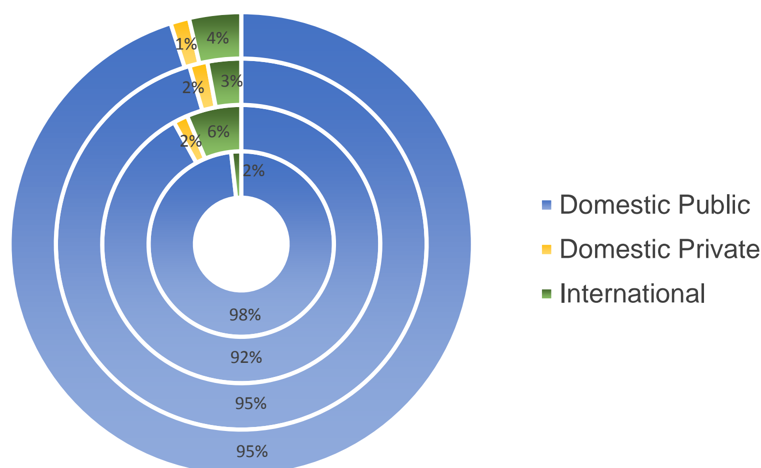
Information on expenditure was collected using AIDS spending format aggregated by category from all key players – government, non-government, civil society and bilateral agency. In general, the total expenditure has increased every year (table 8) and in 2013, total expenditure was calculated at around RM181 million (USD56.5 million), an increase of 2.6% compared to the previous year. Of the country's expenditure, 95%

was contributed by domestic public fund or around RM172 million (USD 52.3 million) while international fund contributed to only 4% (figure 16).

Table 8: Source of approximate AIDS expenditure 2012-2013

Source of Funding	2012 (RM)	%	2013 (RM)	%
Domestic Public	173,083,236.10	95	176,705,624.34	95
Domestic Private	2,853,763.20	2	2,427,169.63	1
International	5,329,082.93	3	6,739,193.70	4
Total	**181,266,082.23**	**100**	**185,871,987.67**	**100**

Figure 16: Total AIDS Spending by year, Malaysia 2010 - 2013

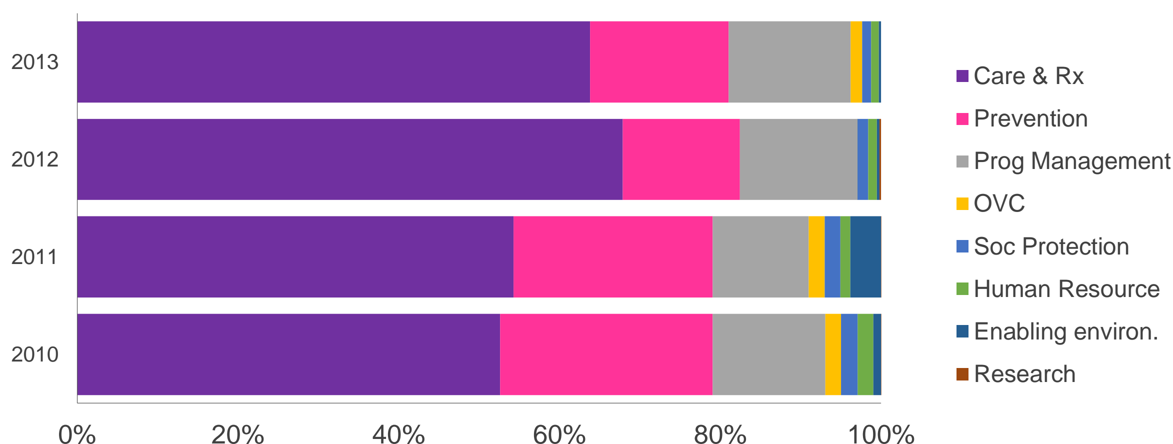


With regard to individual components of AIDS expenditures, no significant changes were observed in spending by function in the last 2 years (figure 17). Majority of AIDS expenditure was spent for care and treatment (66%) as the government aim to up-scale the ART coverage.

Table 9: AIDS Spending Category – Approximate total expenditure from Domestic (Public and Private) and International Sources

AIDS Spending Category	2012 (RM)	%	2013 (RM)	%
Prevention	26,390,256.14	14.6	32,011,097.15	17.2
Care and treatment	123,026,700.28	67.9	118,612,712.05	63.8
Orphans and vulnerable children	3,550.00	0.0	2,688,638.34	1.4
System strengthening and programme coordination	26,553,621.16	14.6	28,210,162.38	15.2
Incentives for Human Resources	2,013,434.70	1.1	1,826,443.69	1.0
Social Protection and Social Services including Orphans and Vulnerable	2,394,000.00	1.3	2,060,800.00	1.1
Enabling Environment	521,219.95	0.3	462,134.06	0.2
Research	363,300.00	0.2	0.00	0
TOTAL	**181,266,082.23**	**100**	**185,871,987.67**	**100**

Figure 17. AIDS spending by function, Malaysia 2010-2013



4.4 Improving the quality and coverage programmes among key affected and vulnerable populations

HIV prevention efforts as outlined in NSP 2011 – 2015 focus on addressing the three primary prongs of HIV transmission in Malaysia, namely the sharing of needles and syringes through injecting drug use, unprotected sexual intercourse, amongst key affected and vulnerable populations and advocacy amongst the most-at-risk youth populations.

4.4.1 Prevention of HIV transmission through harm reduction

Harm reduction initiatives involving Opiate Substitution Therapy (OST) and needle and syringe exchange program (NSEP) have been part of the Malaysian response for several years. Together, these programmes aimed at reaching out at least 102,000 (60%) persons out of estimated population of 170,000 PWIDs by 2015. Provision of harm reduction services continues and up-scaled through 728 NSEP sites and 811 OST outlets established in government health facilities, NGO sites, private health facilities, National Anti-Drug Agency (NADA) service outlets and prisons.

Initiated in February 2006 and now entering its sixth year of operation, the NSEP is mainly provided by the NGO (79%) and government health clinics (21%). The numbers of NSEP outreach points run by NGO are 576 while NSEP sites in government clinics are 152. As of 2013, this programme has reached out to 72,686 PWID with average distribution of needle and syringe about 522 per PWID in a year. However, in the past two (2) years, the proportion of clients being referred to VCT and MMT were increasing, at average of 17% for VCT and only 12% had changed to oral substitution therapy (OST). This programme need to be further improved for better outcome which is reducing the harm further through shifting from injecting drug to OST.

The government has fully adopted OST programme after the successful pilot project in 2006. As of 2013, this programme currently provided by government hospitals and clinics (46%), private healthcare practitioners (45%) and has been extended to the National Anti-Drug Agency (NADA) service centres (7%), and prisons (2%); altogether making up 811 OST centres throughout the country. This programme has reached out to 65,249 drug users nationwide. Through harm reduction services, a total of 137,935 drug users were reached out. Data from programme surveillance in Drug Rehabilitation Centres and Harm Reduction services in 2011 revealed HIV prevalence among PWID was 8.7%.

4.4.2 Prevention of HIV transmission through sexual contact

To address the rise of sexual transmission of HIV, the NGO through MAC amplifies its work to deliver appropriate sexual and reproductive health services and education to key affected populations (KAPs) who are more vulnerable to sexual transmission of HIV, namely sex workers (SWs), men who have sex with men (MSM) and transgender persons (TG). In 2013, about 6,500 KAPs were reached out through 193 outreach points and about 3.2 million condom were distributed.

In addressing sexual transmission of HIV, coverage of interventions has improved through:

- sexually transmitted infection (STI) prevention services, including education, testing and access to free condoms
- information, education and communication / Behaviour Change Communication community sensitisation provision of sexual reproductive health (SRH) education and other essential SRH services;
- outreach and peer education;
- encouraging HIV testing through voluntary testing and counselling;
- Counselling and psychosocial support;

Generally, the prevalence of HIV in the country among KAPs has reduced except in MSM. A survey in 2012 (IBBS) observed a reduction in HIV prevalence from 10.5% to 4.2% among FSW and from 9.3% to 5.7% among TG while among MSM, there was a whopping increase from 3.9% to 12.6%[10].

The IBBS 2012 also revealed that understanding on prevention of HIV through sexual transmission and rejecting major misconceptions about HIV transmission among key affected population (FSW, TG and MSM) was not satisfactory (35% - 40%). Inversely, the pattern of condom use with recent partner has shown an increase in the range of 72% to 84%; higher with paid partner but much lower with permanent or regular partner (25% - 69%).

4.4.3 Prevention of mother to child transmission (PMTCT)

Moving towards eliminating MTCT of HIV and congenital syphilis, Malaysia has established high quality PMTCT programme since 1997, available in all government and some of private health facilities. This programme provide services (screening, provision of ART, care and support for pregnant women with HIV and their partners/spouses) not only to mothers attending antenatal care but also to those who had missed antenatal care i.e. in labour room. Screening coverage at public facilities improved substantially from 49.7% in 1998 to almost 100% in 2013. Beginning 2011, the country adopted treatment option B+ to all HIV positive pregnant mothers regardless of nationality and HIV exposed baby get free replacement feeding for 2 years beginning 2012.

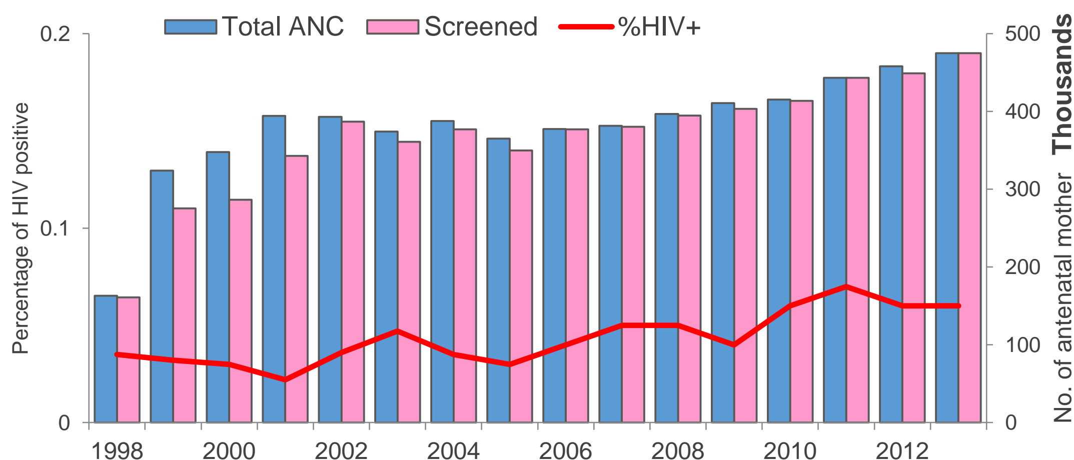
In 2013, about 475,233 or 80% estimated pregnant women (592,489) had undergone PMTCT program at 1,025 government health facilities (Figure 18). With 99% coverage of pregnant women attending antenatal care in 2013 in government

[10] *Integrated Bio-Behavioral Survey 2012 (unpublished)*

health facilities, 298 were with HIV out of which 118 were known cases (40%). The overall prevalence of HIV among pregnant women in 2013 was 0.06% but much lower among newly detected mothers (0.04%)[11]. In effort to eliminate vertical transmission, MOH had started HIV screening among 'missed-opportunity' mothers in labour room (unbooked). In 2013 about 13,996 pregnant women with unknown HIV status were screened in labour room with HIV prevalence at 0.1% (14 cases); much higher than among booked mothers (0.06%).

A total of 343 pregnant women received triple ARV in 2013 (including 45 pregnant women detected late in 2012) to prevent mother-to-child transmission. All 274 HIV exposed infants born in 2013 were given ARV prophylaxis resulting in 269 (98%) mother-to-child transmission infections being averted. Briefly, with PMTCT intervention, the transmission rate was reduced to 1.82% compared to 30-40% had there been no intervention. Screening of male partner of antenatal mother has not took off completely. In Kedah, Terengganu and Penang where it has been implemented, about 35% of male partner agreed to screening with HIV prevalence at 0.03%.

Figure 18. Antenatal HIV screening, Malaysia 1998 - 2013



[11] *Global AIDS Report 2014*

4.5 Improving the quality and coverage of testing and treatment

The Government continues to support a decentralized approach to health services which includes community-based and primary health care through to hospital-based care. It provides psychosocial support including voluntary, counselling and testing (VCT), nutritional support and treatment for common opportunistic infections. Malaysia has started integration of services at primary care level since 1960s. Among the activities that have been well integrated into Maternal and Child Health Clinics is the screening of syphilis among antenatal mothers, PMTCT, VCT, TB and HIV care.

Currently, all government hospitals and health clinics are providing ART either on site or through referral. In addition, every year health staffs including Infectious Disease Physicians, Family Medical Specialists, nurse and medical assistant counsellors are trained and distributed to various hospitals and clinics to assist in testing, treatment and counselling.

As of December 2013, there were 17,369 PLHIV (or 47% of all eligible PLHIVs) already receiving ART. The ARV treatment program has also been extended to include prisons and detention centres since 2009. Among those on ART, 92% are still alive and known to be on treatment 24 months after initiation. There is indeed a need for better treatment education for PLHIV who are just initiating or currently on treatment. This is to assist in addressing the issue of adherence which is a consistent problem with PLHIV who do not understand the need to adhere to treatment protocol. To overcome issue of ARV literacy, hospital peer support services are of great advantage.

In effort to build capacity both in provision of screening and treatment, the government has taken bold step in acknowledging HIV counselling as one of many post-basic courses offered for allied health since 2009. HIV screening is currently made available in all government health facilities at no cost through VCT or anonymous HIV screening,

premarital screening, screening for TB/STI patients, contacts of PLHIV and inmates of Drug Rehabilitation Centres and prisons. In 2013 about 1,328,092 screening have been conducted with seroprevalence of 0.11%.

The Government's achievements in the area of HIV treatment have been particularly impressive. Health services in the hospital and primary healthcare systems are of high standard, especially those relating to clinical management of HIV. Strong measures are in place to ensure blood supply safety whereupon testing of blood products is consistently conducted. This commitment would take on the form of improving the availability of treatment and lowering the actual cost of treatment. It also aimed to obtain the widest range of ARV drugs at the best possible cost to the Government.

4.6 Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.

Majority of the government's achievements have been from the treatment perspective. But there are still gaps with regards to the delivery of care and support. This has been effectively delegated to Partner Organizations under coordination of Malaysia AIDS Council that are primarily funded by the government.

In effort to improve coordination, linkages and referral among social, health and community based services at the community level, Hospital Peer Support Program (HPSP) has been established. HPSP delivers outreach services to hospital clients who require information and education about antiretroviral treatment and adherence, emotional management and healthy living with HIV. In short, HPSP has complemented the ARV treatment provided by the hospital by ensuring adherence to ARV. In 2013,

seven (7) Partner Organisations conducted the HPSP in 16 hospitals, reaching out to more than 2,708 clients living with HIV, their family and friends. This was achieved through 278 support group gatherings and peer support counselling sessions. The program standard operating procedure (SOP) has been drafted by MAC and widely used by the NGOs as guidance to standardize the operation throughout the country.

In 2013, Partner Organisations operated 18 shelter homes. These shelter homes were chiefly funded by the government (Ministry of Women, Family and Community Development) and complemented through grants from other sources. Services provided by the shelter home programme included basic nursing care, palliative care, medical referrals, bereavement counselling, and psychosocial and spiritual support services. In 2013, close to 400 PLHIV have been served by the shelter homes out of whom 304 (76%) were on ARV.

Collaboration from religious bodies and other relevant government agencies, especially related to welfare, on the issue of care and support for PLHIV has improved significantly over last couple of years. The success in educating Muslim religious leader through 'HIV and Islam' Manual by Department of Islamic Development (JAKIM) has ignited the spirit to provide service beyond HIV awareness. JAKIM is now taking another leap in providing shelter home for homeless Muslims living with HIV called Ilaj Home, a signature project of JAKIM. This seven-storey shelter home will be able to cater approximately 100 residents when the construction completed in 2015.

4.7 Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.

Prevention and treatment programmes are more effective when operating in an enabling environment which does not stigmatise and discriminate against those most

at risk and those affected. Creating and maintaining a better understanding of HIV to reduce risk taking as well as stigma and discrimination are therefore essential. It is important to establish and maintain an enabling public policy and structural environment which will help to reduce HIV stigma and discrimination, respects human dignity, gender and sexuality and is supportive to HIV programmes and interventions.

HIV remains as an important concern in the 10th Malaysian Plan in which health awareness on HIV prevention will continue to be promoted with the cooperation of Ministry of Health and NGOs. The participation of NGOs / CBOs in planning and decision-making process has improved over couple of years. Civil society is being represented at the National Coordinating Committee on AIDS Intervention (NCCAI) and the Country Coordinating Mechanism (CCM). In the former, 31% of the committee members (8 out of 26) are represented by civil society representatives (youth, women, MSM, PWID, sex workers, PLHIV and transgender).

To support enabling environment at work place, Code of Practice on Prevention and Management of HIV/AIDS at the Workplace was produced by Ministry of Human Resource as a guideline to employer and employee in managing issues pertaining to HIV at the workplace.

4.8 Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.

At the early phase of the epidemic, the country depended heavily on National HIV Surveillance system to assist in programmes and epidemic evaluation. Over time, the quality of this case reporting has improved with the use of electronic and web-based

National AIDS Registry (NAR). The responsibility of HIV surveillance is with the HIV/STI Sector of the Ministry of Health.

With the establishment of national Monitoring and Evaluation (M&E) unit within HIV/STI Sector of Ministry of Health, HIV programmes monitoring is more systematic and comprehensive. This include monitoring of programmes from private sectors and NGO through MAC supervision and were submitted on regular basis. The analysis and use of M&E data has enabled for justification and institutional support from the Cabinet Committee on AIDS for the scaling up of interventions.

In line with the *Three Ones Principle*, implementation of the National Strategic Plan is monitored and evaluated through the national HIV monitoring and evaluation framework, coordinated by the National AIDS Programme Secretariat that has been given the responsibility to monitor and evaluate the overall HIV/AIDS framework. Besides, the NAP Secretariat is also empowered to ensure that all relevant stakeholders report to the Secretariat on specific indicators as necessary and expected results and targets are monitored and evaluated periodically.

4.9 Future Plan NSP 2016-2020

Building on lessons learned and recommendations from the Mid-Term Review, the country is in the process of preparing for the NSP 2016-2020, involving multi-stakeholder – government agencies (health and non-health sectors), non-government organizations, private sectors, partner and multilateral organizations. The country envisage that the new NSP 2016-2020 will be endorsed in the third quarter of 2015 and will be a continuation of the previous NSP, as well as addressing the post MDG and materializing the 10 targets and elimination commitments pledged in the 2011 Declaration.

CHAPTER 5 - BEST PRACTICES

5.1 Harm Reduction – A way towards achieving a goal

The rapid spread of the HIV epidemic in Malaysia during the early phase was driven by PWID mainly due to sharing needles and syringes. With PWID being the major affected population, the government instituted a Harm Reduction Programme (HRP) which included Opiate Substitution Therapy (OST) and Needle and Syringe Exchange (NSEP). HRP started as a pilot project in October 2005. On April 12, 2006, it was implemented nationwide to reduce if not altogether halt HIV infection among PWID in the country. This was in line with Malaysia's commitment to the Millennium Development Goals (MDG) to reduce new HIV cases from 21.7 per 100,000 population in 2000 to 11.0 per 100,000 population in 2015.

HRP was entirely funded by the Malaysian government. Aside from OST and NSEP, HRP also provided other harm reduction services such as voluntary counselling and testing (VCT), the provision of antiretroviral (ARV) drugs, treatment for sexually transmitted infections (STIs), counseling, health education, social welfare, job placement, and rehabilitation. Today, HRP remains at the heart of Malaysia's response to HIV and AIDS. It is jointly implemented by the MOH, the National Anti-Drug Agencies (NADA), the Prison Department, the Ministry of Education (MOE), as well NGOs, and at the latest count, 365 general practitioners (GPs), all zealously working together to make the programme a major contributor to the HIV and AIDS response of the country.

To ensure that the HRP was implemented successfully, from the beginning, the interplay between and among the 3 Ps--Political Will, Policy and Participation—was addressed and managed.

Political Will. Commitment and support from the country's highest leaders played a major role in ensuring the success of the HRP. Besides Malaysia's commitments to international communities, such as the UN Declaration of Commitment on HIV and AIDS and to the Millennium Development Goals, the national leadership endorsed the National Strategic Plan on HIV/AIDS 2006-2010 on April 2006. This plan emphasized HRP as the way to reduce HIV vulnerability among PWID, and between them and their sex partners. The programme was further strengthened under the National Strategic Plan on HIV/AIDS 2011-2015, as well as the government's commitment to provide a specific budget allocation for HRP implementation.

The National Task force on Harm Reduction (NTFHR) Committee was established at the national level to ensure the proper monitoring of and consultation regarding the progress of HRP. The committee members consisted of selected government personnel, NGO representatives and private practitioners. Quarterly meetings were held during the initial stages of program implementation and currently, at least once a year. The committee members were later assigned to the implementation level for the same purpose (monitoring and consultation). Currently, People Living with HIV (PLHA) are involved in the Country Coordinating Mechanism (CCM).

Policies. Using a public health approach created a remarkable paradigm shift in the policy. Under this approach, harm reduction interventions and voluntary treatment options replaced the repressive focus on punishment and law enforcement. The public health approach that the government took considered the numerous drug-related harms among PWID that had health impacts on individuals and communities, such as transmission of HIV and STIs.

The HRP changed the perception of government and the public towards PWID, from criminals to patients in need of services and voluntary treatment options. It was the

platform that enabled PWID to come forward and access HRP services, and to participate in health promotion that contributed to positive behavioural change.

The shift enabled law enforcement officers and health professionals to cooperate and work together when dealing with drug related issues. The Malaysian Royal Police (MRP) and health professionals were communicating regularly before judicial actions were taken in situations related to the arrest of HRP patients/clients. Because of the public health approach, the MRP has included HRP as one of the subjects in the curriculum of police training. This consistently raised awareness about HRP among law enforcers. The police also conducted regular meetings with NGOs involved in HRP to ensure that HRP activities, in particular NSEP at outreach sites, ran smoothly.

Following the new policy, key government leaders from various involved agencies shifted their own programmes. NADA, for example, has transformed its programme from punishment to harm reduction and voluntary treatment options for drug users. It now offers OST services in 59 of its facilities. This process has been documented and is recognized as a major success for the country and the Southeast Asian region as a whole.

Participation in service delivery. Guided by the new policy, HRP was implemented by the government, NGOs, and private sector health professionals. The participation of private sector health professionals was deemed important to provide choices of service settings to PWID. Prior to the implementation of the HRP at each site (NGO, government, and private), proper training was carried out covering programme implementation and addressing issues of stigma and discrimination.

The delivery of harm reduction services, especially OST and NSEP, was integrated with existing services provided at the government's primary health care settings.

Government's secondary health care settings and private sector health providers concentrated on OST while NGO sites provided NSEP. The variety of service providers enabled PWID to have choices on where to go for harm reduction services. Continuous awareness and promotion of HRP at all health care settings has contributed to the reduction of stigma and discrimination toward PWID, thus ensuring HRP services could be provided smoothly. In cases where other health or social services were required, PWID were referred to other clinics or offices, including those operated by NGOs. This service delivery strategy optimised manpower, finances, as well as infrastructure, especially when the project ran in the same facility.

5.2 Enhancing prevention of HIV/AIDS through smart partnership with Islamic bodies

The HIV/AIDS epidemic poses new challenges to the religions all over the world including Malaysia. The religious leaders or the religious organizations have an important task and need to take necessary action in assisting country to curb the spread of HIV and at the same time alleviate the suffering caused by HIV/AIDS. As this group being trusted and respected in the society, their actions towards HIV/AIDS can be set as an example. With their strength and credibility together with closeness to the communities, they will be able to make meaningful difference in halting the spread of this disease. Therefore, any messages on HIV/AIDS imparted by religious leaders are important in dealing with the epidemic and at the same time, religion and health will give synergistic effects in aiming halting the epidemic.

Ministry of Health has been building partnerships (since 2006) with the policy making Department of Islamic Development (JAKIM), Religious Division, Prime Minister's Department; and State Religious Departments to provide greater support to the Malay Muslim population who have been hardest hit by the country's HIV epidemic. Among the activities planned at that time was to produce a training manual for Muslim religious leaders on HIV/AIDS, to work with NGOs to bridge the KAPs and the religious

agencies; and to advocate care and support to the KAPs either financial or moral support.

5.2.1 HIV and Islam Manual

The HIV & Islam Manual, used to institutionalise HIV and AIDS education into the formal training of religious leaders, was officially launched on 5 August 2010 at the Islamic Centre, Kuala Lumpur. Initiatives to develop the content of the Manual were jointly undertaken by the Department of Islamic Development Malaysia (JAKIM) and the Ministry of Health, with Malaysian AIDS Council (MAC) assuming an advisory role. The Manual discusses Islamic principles of HIV prevention, management of HIV in Islamic rituals, and most notably the religion's intolerance for stigma and discrimination. This manual is also loaded with critically important message about Islam's intolerance for stigma and discrimination, a huge barrier to HIV prevention, treatment and care in the Muslim community. It is also developed to institutionalise HIV and AIDS education into the formal training of new Muslim leaders. The manual covers issues such as the role of religious leaders in spreading messages of HIV and AIDS awareness, principles of HIV prevention from the perspective of Islam, and healthcare and welfare services available for the Muslim community.

5.2.2 Shelter Care for Muslim Living with HIV

With gaps in provision of support services for Muslim people living with HIV, several religious authorities have improved the availability of home based care services. The Selangor Islamic Religious Council (MAIS) took the lead in the effort to improve the availability and delivery of home-based HIV treatment and care services. The first shelter home for Muslims living with HIV, Istana Budi, opened in Kuang, Selangor, in 2010. Construction and operations of Istana Budi were entirely funded by MAIS. The 10,000 sq ft facility can accommodate up to 50 residents at one time. It is run by professional caregivers and offers rehabilitation services and basic nursing care besides basic Islamic teaching.

As for now there are several shelter homes has been in operation, with financial support from JAKIM and State Religious Departments.

5.2.3 Activities with other MARPs

One of the most highly stigmatised groups in Malaysian society is the transgender community who find themselves shunned by society and struggling to get employment. As a result they often resort to sex work and which increases their risks of HIV and vulnerability to violence. In an unprecedented move to improve the livelihoods of Muslim transgender, Dagang Halal, a food products and services company through a joint collaboration with JAKIM and NGO piloted an employment training programme for transgender. The aim is to increase greater social acceptance of transgender within the highly conservative Muslim community. The pilot provided transgender participants with HIV and AIDS education and religious and spiritual lessons, as well as professional skills and development training. At the end participants were given the opportunity to apply for jobs. Following the success of the pilot it has been replicated in other parts of the country and expanded to include former prisoners, people who use drugs and single mothers who are infected with or affected by the disease.

5.2.4 Mosque as sites for MMT program

A mosque in one of the country's most prominent universities in Kuala Lumpur is currently being used as a place to administer methadone treatment to people who use drugs. This is all part of the wider work being done by the state religious authorities and JAKIM to provide HIV education and spiritual support through outreach activities to those communities most at risk of HIV such as sex workers, transgender and people who use drugs

5.2.5 Advocacy and awareness

One of the most effective ways to communicate about HIV prevention and awareness to the Muslim public is through Friday sermons. JAKIM have now made it practice that for the Friday sermon closest to World AIDS Day should be about HIV. Since the start of the HIV & Islam programme in 2009, several one-hour HIV centred episodes have been broadcast on the highly popular '*Forum Perdana'* television talk show. There were also several camping activities known as "Mukhayyam" was conducted by JAKIM in collaboration with NGOs. This activity is targeted toward MARPS. The aim of this approach is to establish link with MARPs so that a better rapport will develop hence reducing stigma and discrimination. MARPs were also introduced with basic Islamic knowledge, moral values and discussion on other related social issues.

There are a lot more can be done in providing enabling environment for the infected and affected Muslim community in Malaysia through this smart partnership and co-operation; Ministry of Health, Religious authorities and NGOs. The work will continue to create an enabling environment for Muslim infected and affected by HIV and also MARPs not only to access HIV prevention, treatment and care and support but also to reduce stigma and discrimination of these groups in the community.

5.3 Investing in National AIDS Registry (NAR)

Malaysia national responses anchored upon strong and evidence based science. HIV/STI Sector, Ministry of Health (MOH) Malaysia has started its data collection from the first case of HIV. The HIV/AIDS national manual database has grown each year. Burden of monitoring case based surveillance manually were felt especially with a large number of cases even though Malaysia is known as having concentrated epidemic of HIV/AIDS. Therefore, manual monitoring of cases is impossible thus an urgent need to create an interactive web-based national HIV/AIDS registry was proposed. This is pivotal as data collected able to tell significant stories which is crucial

to ensure appropriate identification of issues and measures in assisting MOH to provide proper care and support for people living with HIV/AIDS and their affected family.

National AIDS Registry (NAR) of HIV/AIDS was developed in 2009 as a manual based registry and started its first web-based function in July 2010. NAR user comprises of selected health personnel in MOH. Each user is provided with a user ID and user password. Access of NAR by user is singular usage at any one time. To enhance security, NAR password encryption was built in NAR database. Accessibility of cases by each user is at their respective district only. State user will manage their state registered cases while MOH user cover the whole cases registered in Malaysia.

Notification of all communicable diseases is mandatory and spelled out under Section 10 of the Prevention and Control of Infectious Diseases (ACT 342), 1988. All records of the infectious diseases under the ACT 342 will be registered in the e-notis system and this includes cases of HIV, AIDS and death due to HIV/AIDS. Once registered in the e-notis, the said cases will be integrated into NAR. Investigation of patients will be carried out by Assistant Environmental Health Officers in their respective districts to obtain the case epidemiological data. The said data will be then transfer into NAR and investigation reports of each case will be recorded. This data tells us a story of the said case. Compilation of all cases (database) will create stories of HIV/AIDS in for the district, states and nation, consequently used for preventive and control measures.

NAR has many benefits. It plays major roles in telling a story from the database by quantifying the magnitude of HIV infection, understanding how HIV is spreading – or might potential spread, status of HIV/AIDS treatment and prophylactic treatment, ultimately assisting in HIV/AIDS program planning, advocating for prevention and care services and aiding in program evaluation.

NAR also avoid duplication registry of reported cases compared to previous stand-alone system registry recorded in the respective health districts by building its standard rules and mechanism into the system. Investigation information is also well kept and can be easily extracted when needed. It is well guarded and secured with trust handled by competent staffs from MOH. Abstracts and information from NAR can be used to generate good disease (HIV/AIDS) burden and comprehensive trends of HIV infection in Malaysia. It helps and compliment necessary preventive intervention so as the spreading of HIV among high risk groups will be well managed and contained.

5.4 Towards HIV-free children through PMTCT

Mother-to-child transmission (MTCT) is the most common source of HIV infection among children in developing countries. In the absence of any intervention, between 30%-45% of children born to HIV-infected mothers will themselves become infected with HIV during pregnancy, labour or delivery, or through breast feeding. Since 1998, Malaysia has taken noteworthy initiatives to counter the rise of HIV/AIDS through one program - Prevention of Maternal to Child Transmission (PMTCT). The goal of this program is to prevent vertical HIV/AIDS transmission to children towards realizing the vision of an HIV-free generation in Malaysia. Specifically, the program aims to fill up a shortfall in the HIV/AIDS prevention and care program in Malaysia through an appropriate remedial action, i.e., by eliminating Mother to Child HIV Transmission (MTCT) by 2015. Under this program, more than 75% of all antenatal mothers in Malaysia have been screened yearly.

Available at all government primary care clinics and hospitals, PMTCT is integrated in the perinatal and infant feeding intervention. Within the context of the Program, free HIV screening is routinely offered on an 'opt-out' basis to antenatal mothers, who are given pre-test counselling on a group basis and subsequent individual 'intra-test' counselling for those found reactive.

The PMTCT Program involves early detection of mother and baby, counselling, and provisional ARV. Provision exists for immediate screening (using the HIV Rapid Test Kits) for women in labour with no record of antenatal care or HIV testing. These strategies are supplemented by safer modes of delivery (generally caesarean section) and MOH support for replacement feeding of infants born to HIV positive mothers until the infant is two years of age.

HIV-positive antenatal mother will be put on HAART and closely followed up. HIV exposed baby will be given prophylaxis and HIV status will be monitored using PCR (polymerase chain reaction) antigen-based tests at birth, 3 months, 6 months, 12 month and 18 months of life. Meanwhile, follow-up care for the postnatal HIV-positive mother continues as her CD4 count continues to be monitored; and if eligible for it, she will be given ARV.

Since the PMTCT was implemented in Malaysia, the coverage on HIV antenatal screening among mother in government facilities has been impressive. The annual zero-prevalence target to counter HIV/AIDS among women places Malaysian mothers detected as HIV-positive at 0.02 to 0.07. With the intervention, vertical transmission has been reduced to 1.8% in 2013. For any infant born with HIV, thorough investigation was carried out using Quality Assurance Approach.

Since the implementation of PMTCT in Malaysia, many loopholes in our antenatal HIV program has been improved especially on HIV screening, care and treatment among both antenatal mothers and their future babies. Challenges will be managed and improved in the future for the betterment of the system. However, this impressive program has fastened Malaysia progress for HIV elimination of vertical transmission by 2015.

5.5 MAC fight against HIV/AIDS

For more than 20 years, Malaysian AIDS Council (MAC), which is a non-government organization, has been working with various policymakers, service providers, and government institutions to implement enabling measure enabling measures for the prevention, treatment, care and support of those living with and affected by the HIV and AIDS epidemic. MAC works closely with political leaders to establish and maintain public policies and structural environments that recognize human dignity and respects gender preferences, while ultimately seeking to help reduce the stigma and discrimination against people living with AIDS.

Government support to MAC through the years, especially by MOH, has been vital as the National Strategic Plan for HIV/AIDS 2011-2015 recognizes the need for synergy between the public sector and the grass root communities as crucial in the national effort to mitigate the HIV and AIDS infection among its key affected populations, the PWIDs, SWs, TGs and MSM. MAC's involvement of celebrities, provision of shelter homes for PLHIV, Peer support in hospitals, support for marginalized groups, and social reintegration of former prisoners are among the innovative, strategic and relevant initiatives MAC had continued to pursue in its fight against HIV/AIDS.

With MAC among its allies, the government may successfully realize its MDG 6 target of reducing the rate of new HIV infections in Malaysia to 11 cases for every 100,000 population by 2015.

5.6 City getting to Zero – Pilot Project Melaka

Melaka Historical City was chosen to be one of the eight participating ASEAN Member States for the ASEAN Cities Getting to Zero Project (G2Z). It was aimed to foster strong and sustainable political commitments to achieve the three inter-related zero –

zero new HIV infection, zero AIDS related deaths and zero stigma that is in line with the MDG target.

Malacca was chosen above other cities for several reasons. Among others - its political stability and world recognition as a developed state. Adding to this, this city has close and strong networking with non-health government agencies such as the City Council, the State Islamic Religious Council, Zakat Centre Malacca, Police Department, Prisons Department and other related agencies in all issues related to health including HIV/AIDS prevention and control programme. Being a small state and urban prominent, HIV screening, care and support services are easily available, accessible and affordable for the populations. Putting together political stability, extensive coverage of services and strong networking, Malacca is indeed the right choice to achieve City Getting to Zero.

Though the project is still at infancy stage, there is an overwhelming responses from other agencies, NGOs and individual to participate in this project leading to a very promising result of good collaboration and participation. Early indication of success or achievement can be seen in several activities which include an increase number of screening among MARPs, coverage of PLHIV seeking care, coverage of ARV, detection of high risk mothers in PMTCT programme and provision of early care and treatment. There was also increase coverage of IDU receiving harm reduction services and staffs are empowered with good knowledge on HIV and reduce stigma and discrimination towards their patients.

CHAPTER 6 - MAJOR AND KEY CHALLENGES

The evaluation and achievements analysis throws up a number of important challenges that need further attention. The key areas are:

a) The gaps in accurate knowledge within the young general population and key populations about HIV and AIDS is worrying, especially regarding the risks of transmission and use of alcohol and substance prior to sex. Unless this is reversed, Malaysia will not be equipped to make informed choices about their lifestyle and how they can both prevent becoming infected with HIV, as well as what they need to do to protect themselves and others once they do become infected.

b) Plans for scaling up testing and treatment will need adequate trained human resources, appropriate infrastructure and consistent budget allocation for ARV within the health sector as well as within the community. There is huge challenge to get PWIDs to wanting to change to OST. This will impact greatly on NSP target of achieving 100% eligible people on treatment by 2015.

c) To bring down sexual transmission of HIV significantly, the country need a special task force to look into innovative ways that can give high impact on behaviour change and improving coverage of comprehensive prevention packages to most at risk populations.

d) There is a clear objective and expressed need for coverage and integration of VCT, PMTCT, ART, TB and SRH services into all levels of the system, including primary care facilities. Much more investment in health system strengthening will be needed at primary care level in particular to materialize this (staffing, training, infrastructure, accreditation etc.)

e) There is still a large gap in TB/HIV care notably early TB screening and awareness leading to late TB diagnosis among PLHIV resulting in high mortality due to TB.

f) Moving towards eliminating MTCT of HIV and congenital syphilis, Malaysia has established high quality PMTCT since 1998 but limited to government health facilities only. Involvement of all private care facilities need a strong push factor.

g) NGO and multi-sectoral role in combating HIV/AIDS need re-invigorated and re-energized with new mechanism for smart partnership focusing on improving coverage of HIV related services for key populations including post-release detainees and community support groups.

h) Towards eliminating stigma and discrimination, there is a need to define better outcome indicators that allow programmes to measure progress on stemming stigma and discrimination in the work place and in the community, as well as measures for tackling gender based violence and its impact on women's (and children's) health. A clear operational plan with targets involving all key stakeholders needs to be developed, implemented and reported on.

CHAPTER 7 - SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

In responding to the HIV epidemic in Malaysia, development partners, both bilateral and multilateral agencies, have been providing support, including financial and technical assistance. The United Nations in Malaysia currently constitute the largest development partner and which provides support to national country partners bilaterally as well as jointly through the United Nations Theme Group. The United Nations Theme Group on HIV and AIDS in Malaysia continues to provide financial support and technical assistance to national country partners as well as working towards the creation and sustaining of an enabling environment for scaling-up HIV prevention, treatment, care and support.

The United Nations HIV and AIDS Theme Group consists of United Nations agencies in Malaysia: World Health Organization (WHO), United Nations Development Programme (UNDP), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), United Nations University – Institute for International Global Health (UNU – IIGH), and International Organization on Migration (IOM). The HIV and AIDS Theme Group ensures that coordination mechanisms are working effectively provides overall policy and programmatic guidance as well as reviews and provides recommendations to the UN Country Team's strategic directions on HIV and AIDS.

Activities under the 2013 Workplan were implemented utilising funding from the Resident Coordinator mechanism, the UNDP Asia-Pacific Regional Centre and UNAIDS. The Theme Group activities, implemented under the 2013 workplan resulted in some progress and achievements which included:

a) The Theme Group provides coordinated support to the Government of Malaysia and civil society partners in the implementation of the National Strategic Plan on HIV and AIDS 2011-2015. The Theme Group continues to provide technical and financial support during the mid-term review of the National Strategic Plan on HIV and AIDS in May 2013. This technical support included technical review meeting as well as national consultation with government and civil society organisations. In addition, the Theme Group also provided technical support for the mid-term review of the 2011 Political Declaration on HIV and on AIDS.

b) In October 2013, a training on Enhancing HIV, STI, and other Sexual Health Services for Men having sex with Men (MSM) and Transgender People in Asia and the Pacific: Training Package for Health Providers and Reduction of Stigma in Healthcare Settings, was conducted in collaboration with the Centre for Excellence for Research in AIDS, University Malaya (CERiA). The training is anchored on the emerging challenges facing MSM in terms of human rights, violence and vulnerability. It is recognized that access to health services and social support by MSM is a fundamental human right. The training has strengthened the capacity of health care providers to advocate for and support MSM and transgender people HIV-related programmes and deepened their understanding of the HIV prevention, care and treatment response for MSM and transgender people in the country and across the region to guide them towards effective use of these information to support policy development and rights-based HIV planning and programming.

c) In the 2011 Political Declaration: Intensifying our Efforts to Eliminate HIV/AIDS, governments are committed to review laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV. With funding support from the Global Fund for AIDS, Tuberculosis and Malaria, the ISEAN-Hivos Program initiative on review on policy and legal environments related to HIV was undertaken in Indonesia, Malaysia and Philippines. The

initiative in Malaysia is being undertaken by the HIV and AIDS Theme Group in collaboration with the Human Rights Commission of Malaysia (SUHAKAM). The initiative was designed to build upon the UNESCAP Resolutions 66/10 and 67/9 as well as the Asia-Pacific High Level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals. A consultation was held in October 2013 has brought together stakeholders, including civil societies, whom debated on policy and legal environments related to access to and delivery of HIV services in Malaysia.

d) The UN Cares programme continued in Malaysia. As part of enabling and empowering UN staff to respond to HIV within their professional and private lives, a number of briefing sessions with UN staff from all agencies and a photo exhibition were conducted.

e) The HIV and AIDS Theme Group is also involved in various committees such as the Country Coordinating Mechanism (CCM) of Global Fund for AIDS, Tuberculosis and Malaria, where the Chair of the HIV and AIDS Theme Group is also a member of the CCM. Technical assistance were provided to support Malaysia's involvement in the Global Fund processes - preparation of the Grant Agreement signing, implementation of the grant by the Principal Recipient and its Sub Recipient. The HIV and AIDS Theme Group also provides continuous technical feedback to the Global Fund Secretariat on issues related to the grant implementation in Malaysia.

The response of the UN to HIV and AIDS in Malaysia is not only provided via the Theme Group, but also via individual agency related work. Individual UN agencies such as UNFPA, UNHCR, UNICEF and WHO are also providing direct support to Government of Malaysia, civil society organisations and communities.

CHAPTER 8 - MONITORING AND EVALUATION ENVIRONMENT

In line with the National Strategic Plan, the country now has a national Monitoring and Evaluation (M&E) unit within HIV/STI Sector of Ministry of Health beginning 2010 that look into HIV programme monitoring using variety of instruments and sources as below.

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

The analysis and use of M&E data from the two Harm Reduction programmes (NSEP & MMT) has enabled for justification and institutional support from the Cabinet Committee on AIDS for the scaling up of these interventions. M&E data was also utilised to introduce premarital HIV screening to address the issue of heterosexual transmission. It also enabled the Government to justify its stance in promoting such testing. In addition to new development of M&E unit, the HIV/STI Sector of Ministry of Health has also established a unit that is responsible for all HIV technical and behavioural research including IBBS that has been decided periodically every two years. The next round of IBBS is expected in 2014.

As the main coordinator of NGOs and CBOs responding to HIV, MAC is tasked to monitor the various government grants granted to itself and other organisations working on the different aspects of the national response. In relation to that, as part of M&E, MAC is given the responsibility to report back on the individual projects utilising the various national progress indicators as part of M&E. It is also given the responsibility of providing feedback to the Government on issues and concerns affecting its constituents. In 2009, the MAC has since developed an online monitoring system and database that has improve on the data quality for use in critical program analysis.

ANNEX 1

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

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

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

2) With inputs from:

Ministries

Education	**Yes**	No
Health	**Yes**	No
Labour	**Yes**	No
Foreign Affairs	Yes	**No**
Others: Women, Family and Community Development, Defence, Home Affairs, Information, Department of Islamic Development	**Yes**	No

Civil society organisations	**Yes**	No
People living with HIV	**Yes**	No
Private sector	Yes	**No**
United Nations organisations	**Yes**	No
Bilaterals	Yes	**No**
International NGOs	Yes	**No**

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

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

Name/title: **DATUK DR. LOKMAN HAKIM BIN SULAIMAN**
Deputy Director General of Health (Public Health)
Malaysia

Date: **26 March 2014**

Signature: ______________________

Please provide full contact information:

Address: Deputy Director General of Health's Office, Level 12, Block E7, Complex E
Ministry of Health, Federal Government Administrative Centre,
62590 Putrajaya, Malaysia
Email: lokman.hakim@moh.gov.my
Telephone: +603-88832544
Fax: +603-88895601

ANNEX 2

National Commitments and Policy Instrument (NCPI) 2014

Country: MALAYSIA

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

Name: Dr. Sha'ari Ngadiman
Deputy Director of Disease Control (Communicable Disease) & Head of HIV/STI Section

Address: HIV/STI Section, Disease Control Division, Level 4, Block E10, Ministry of Health, Complex E
Federal Government Administrative Centre
62590 Putrajaya, Malaysia

Tel: +603 8883 4387

Fax: +603 8883 4285

Email: drshaari@moh.gov.my

Date of submission: 26 March 2014

National Commitments and Policy Instrument (NCPI)
Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:
A series of workshops and working sessions were convened with government and civil society stakeholders to obtain data for Parts A and B of the National Composite Policy Index (NCPI) questionnaire as well as for the narrative component of the report. An orientation and preparatory briefing on the reporting process was briefed during stakeholders meeting 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 discussions which followed also included content for the different parts of the narrative section. The report is coordinated fully by the HIV/STI Section of Ministry of Health. 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, AIDS Officers and District Health Officers. Part A of the NCPI and the narrative content were discussed with HIV/STI Section of the Ministry of Health taking the lead in the deliberations. The questionnaire was completed through joint discussions with all those in attendance.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
There were a number of disagreements and disputes on a number of issues. However, as the development of the answers to the questionnaire was done through group work, issues of contention were settled through a deliberative process whereupon both opposing views would be given a certain amount of time for debate and discourse after which a consensus decision was undertaken by the group.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
Participants answering the questionnaire understood and were able to answer the questions to the best of their abilities

NCPI Respondents

*[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]*

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

Organisation	Names/ Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Ministry of Health	Dr.Sha'ari Ngadiman Deputy Director Disease Control & Head of HIV/STI Section	✓	✓	✓	✓	✓
Ministry of Health	Dr. Anita Suleiman Senior Principal Assistant Director (Technical & Behavioural Research)	✓	✓	✓	✓	✓
Ministry of Health	Dr.Fazidah Yuswan Senior Principal Assistant Director (Harm Reduction)	✓	✓	✓	✓	✓
Ministry of Health	Dr. Salina Md Taib Senior Principal Assistant Director (M&E)	✓	✓	✓	✓	✓
Ministry of Health	Dr. Shanizan Mohd Zain Senior Principal Assistant Director (Medical Development Division)	✓	✓	✓	✓	✓
Ministry of Health	Dr. Sapiah Baharin Senior Principal Assistant Director (Family Health Development Division)	✓	✓	✓	✓	✓
Ministry of Health	Dr. Fatanah Ismail Senior Principal Assistant Director (Primary Care)	✓	✓	✓	✓	✓
Ministry of Health	Dr. Jiloris F. Dony Head of TB/Leprosy Section	✓	✓	✓	✓	✓
Ministry of Health	Dr. Nik Rubiah Nik Abd. Rashid Senior Principal Assistant Director (Family Health Development Division)	✓	✓	✓	✓	✓
Ministry of Health	Md. Amidon Awang Damit Health Education Division	✓	✓	✓	✓	✓
Selangor Health Dept.	Dr.Masitah Mohamed Selangor AIDS Officer	✓	✓	✓	✓	✓
WP Kuala Lumpur Health Dept.	Dr Mohd. Nasir Abd Aziz WP Kuala Lumpur AIDS Officer	✓	✓	✓	✓	✓
Malacca Health Dept	Dr Norhayati Md Amin Malacca AIDS Officer	✓	✓	✓	✓	✓

Organisation	Names/ Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Perak Health Dept.	Dr. Hairul Izwan bin Abdul Rahman Perak AIDS Officer	✓	✓	✓	✓	✓
Kedah Health Dept.	Dr. Zahariyah Yacob Kedah AIDS Officer	✓	✓	✓	✓	✓
Penang Health Dept.	Dr. Janizah Ghani Penang AIDS Officer	✓	✓	✓	✓	✓
Pahang Health Dept.	Dr.Rohaya Abd. Rahman Pahang AIDS Officer	✓	✓	✓	✓	✓
Negeri Sembilan Health Dept.	Dr. Zaini Ishak Negeri Sembilan AIDS Officer	✓	✓	✓	✓	✓
Terengganu Health Dept.	Dr. Mahani Nordin Terengganu AIDS Officer	✓	✓	✓	✓	✓
Kelantan Health Dept.	Dr. Hazura Mat Zubir Kelantan AIDS Officer	✓	✓	✓	✓	✓
Sabah Health Dept.	Dr. Khamisah Awang Lukman Sabah AIDS Officer	✓	✓	✓	✓	✓
Sarawak Health Dept.	Dr. Ruziana Miss Sarawak AIDS Officer	✓	✓	✓	✓	✓
Bentong District Health Office	Dr. Rosli Ismail District Medical Officer of Health	✓	✓	✓	✓	✓
Prisons Department	Mr. Anbalagan s/o Subramaniam	✓	✓	✓	✓	✓
Department of Islamic Development (JAKIM)	Mr. Zakuan Sawai	✓	✓	✓	✓	✓
Department of Islamic Development (JAKIM)	Mr. Arrahman Awang	✓	✓	✓	✓	✓
Min. Women Family and Community Development	Mdm Liah Pariuk	✓	✓	✓	✓	✓

NCPI – Part B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Note: Discussions were conducted through group work

Organisation	Names/ Position	Respondents to Part B			
		B. I	B. II	B. III	B. IV
Malaysian AIDS Council	Ms.Roswati Ghani Executive Director	✓	✓	✓	✓
Malaysian AIDS Council	Mr.Parimelazhagan Ellan Programme Director	✓	✓	✓	✓
Malaysian AIDS Council	Tamayanty Kurusamy M&E Manager	✓	✓	✓	✓
Malaysian AIDS Council	Ms. Manohara Subramaniam National Programme Manager	✓	✓	✓	✓
Malaysian AIDS Council	Mr.Gunasegaran	✓	✓	✓	✓
Malaysian AIDS Council	Ms. Shamala Chandrasekaran Senior Executive MARP2	✓	✓	✓	✓
Malaysian AIDS Council	Azhari Said Manager MARP1	✓	✓	✓	✓
Persatuan Kebajikan Komuniti IKHLAS	Zulkifli Zamri	✓	✓	✓	✓
PAMT	Fatimah Abdullah	✓	✓	✓	✓
PAMT	Nor Hazean Binti Adnan	✓	✓	✓	✓
PAMT	Lydia Rohaizad	✓	✓	✓	✓

National Commitments and Policy Instrument (NCPI)

PART A
[to be administered to government officials]

I. STRATEGIC PLAN

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

Yes	No

IF YES, what was the period covered *[write in]*: 2011 – 2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.
IF NO or ***NOT APPLICABLE***, briefly explain why.

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

1.1 ***Which government ministries or agencies have overall responsibility for the development and implementation of the national multisectoral strategy to respond to HIV?***
Name of government ministries or agencies [write in]: Ministry of Health

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military / Police	Yes	No	Yes	No
Social Welfare	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women, Family & Community Development	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Others [write in]:				
National Service	Yes	No	Yes	No
Dept. of Islamic Development	Yes	No	Yes	No
National Anti-Drug Agency	Yes	No	Yes	No
Dept. of Immigration	Yes	No	Yes	No
Ministry of Information	Yes	No	Yes	No
Department of Prisons	Yes	No	Yes	No
Attorney General Chambers	Yes	No	Yes	No
Economic Planning Unit	Yes	No	Yes	No
Ministry of Finance	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensu 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 internal programme budget/allocation when needed. In addition to that, some agencies receive special fund from MOH to implement HIV program.

1.3 Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women / young men	Yes	No
Other specific vulnerable subpopulations[31]	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

1.4 What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrant / mobile population	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women / young men	Yes	No
Other specific key populations / vulnerable sub-populations [write in]:	Yes	No

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

Yes	No

1.6 Does the multisectoral strategy include an operational plan?

Yes	No

1.7 Does the multisectoral strategy or operational plan include:

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

1.8 Has the country ensured "full involvement and participation" of civil society[5] in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

If active involvement, briefly explain how this was organised:
Civil society participation was involved at every stage of National Strategic Plan development. Consultations with CBOs and key-affected representatives were conducted to ensure their inputs and concerns were reflected into the strategic plan. In addition to NSP, CBOs and KAPs were also involved in Mid-Term review of NSP.

IF NO or MODERATE involvement, briefly explain why this was the case :
Not applicable

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

Yes	No	N/A

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

Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS or ***NO***, briefly explain for which areas there is no alignment/harmonization and why:
Not relevant

2.1 *Has the country integrated HIV in the following specific development plans?*

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/ UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National social protection strategic plan	Yes	No	N/A
Sector Wide Approach	Yes	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of *gender* inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care and support (including social security or other schemes)	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes		

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

Yes	No	N/A

3.1 IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent had the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	**2**	3	4	5

4. Does the country have a plan to strengthen health system?

Yes?
1. Country has implemented integrated health service delivery since independence 2. Improve health service delivery through improvement of accessibility, affordability, service quality, using current technology especially at point of care services. 3. Notification of communicable diseases including HIV/AIDS through web-based system but yet maintaining confidentiality

5. Are health facilities providing HIV services integrated with other health services

Area	Many	Few	None
a) HIV counselling and testing with sexual and reproductive health	**X**		
b) HIV counselling and testing and Tuberculosis	**X**		
c) HIV counselling and testing and general outpatient care	**X**		
d) HIV counselling and testing and chronic non-communicable diseases	**X**		
e) ART and Tuberculosis	**X**		
f) ART and general outpatient care	**X**		
g) ART and chronic non-communicable diseases	**X**		
h) PMTCT with antenatal care/maternal and child health	**X**		
i) Other comments on HIV integration:			

6. Overall, on scale of 0 to 10 (where 0 is "Very poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

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

Since 2011, what have been key achievements in this area:
1. The expansion and scaling up of both the Methadone Maintenance Therapy (MMT) and Needle Syringe Exchange Programme (NSEP) 2. ARVs were made available to prisoners who were confirmed with HIV 3. Training of trainers among Muslim religious leaders using "HIV and Islam" manual initiated by MOH, JAKIM and MAC. 4. Efforts towards development of shelter homes by non-health sectors particularly the Department of Islamic Development (JAKIM).
What challenges remain in this area:
1. Lack of focus and efforts on issues involving most-at-risk young people 2. Need comprehensive approach in reducing sexual transmission of HIV 3. Efforts and involvement of other non-health agencies are lagging behind

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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

	Yes	No
A. Government ministers	Yes	No
B. Other high officials at sub-national level	Yes	No

1.1 In the last 12 months, have the head government or other high level officials taken action that demonstrated leadership in the response to HIV?
(for example, promised more resources to rectify identified weaknesses in HIV response, spoke of HIV as human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
Among examples where head of government or other high officials have demonstrated leadership are: 1. Received ‘United Nations Malaysia Award 2013’ for significant efforts in achieving MDG target. 2. Commitment in achieving vertical elimination of HIV transmission by 2015 3. Commitment in achieving 3 inter-related Zero

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

Yes	No

IF NO, briefly explain why not and how HIV programmes are being managed:
Not applicable

2.1 IF YES:

IF YES, does the national multisectoral AIDS coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, what is his/her name and position title? **H.E. Datuk Dr. M. Subramaniam (Health Minister)**		
Have a defined membership?	Yes	No
IF YES, how many members? 20 members		

Include civil society representatives?	Yes	No
IF YES, how many? 1 member		
Include people living with HIV?	Yes	No
IF YES, how many? 1 member		
Include private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

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

Yes	No	N/A

IF YES, briefly describe the main achievements:
In combating HIV/AIDS, the government realized the role played by the NGO. This has led to the development of Malaysian AIDS Council (MAC) in 1992 as an umbrella body to coordinate activities by several NGOs on HIV/AIDS issues. The Malaysian AIDS Council (MAC) has been able: 1. To coordinate the activities of NGOs and CBOs working on HIV and AIDS in the country. 2. To work with the Ministry of Health in contributing towards the development, implementation, monitoring and assessment of HIV related policy. 3. To highlight the issues and concerns of marginalised communities to policy and decision makers at the highest levels of the Government. 4. To act as a key player in the implementation of the Government's harm reduction programmes and prevention activity among KAPs.
What challenges remain in this area:
1. Dependency of MAC on government fund 2. Programmes are tied and determined by available grant money.

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

9.3%

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

Capacity building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications and other supplies	Yes	No
Technical guidance	Yes	No
Other [write in]:	Yes	No
Provides yearly financial support - Needle Syringe Exchange Programme (NSEP), government grants to civil society organisations		

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

Yes	No
(selected: Yes)	

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

Yes	No
(selected: Yes)	

IF YES, name and describe how the policies/laws were amended:
1. Prevention and Control of Infectious Diseases Act 1988 (ACT 342) was amended in 2007 2. Infant feeding policy - for babies exposed to HIV, free replacement feeds are given for 2 years (instead of 6 months); amended in 2012
Name and describe any inconsistencies that remain between any policies/ laws and the National AIDS Control policies:
1. Penal Code 377 criminalises anal and oral sex with penalties which include imprisonment, fines and whipping. 2. Transgender persons are often prosecuted under the 1955 Minor Offences Act which terms cross-dressing as a form of indecent behaviour.

7. *Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?*

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9 (selected)	10

Since 2011, what have been key achievements in this area:
1. The Government has provided full commitment to increase ART coverage to 80%; this has led to increase in numbers of PLHIV receiving ART and planning to further increase the coverage through treatment as prevention strategy for discordant couple to begin with. 2. The government and relevant agencies through political support has established City Getting to Zero Project in Melaka Historical City in 2013. This concept will be expanded to include 3 more cities in 2014.
What challenges remain in this area:
Occasionally opposition by public figures occur and act as barriers which impede the implementation of HIV prevention programmes with most-at-risk populations.

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable group:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/ mobile populations Women	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women / young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

1.2 Does the country have a general (i.e. not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES, to question 1.1 or 1.2, briefly describe the content of the laws:

Briefly explain what mechanisms are in place to ensure these law are implemented:

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

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

Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Elderly person	Yes	No
Men who have sex with men	Yes	No
Migrants/ mobile populations Women	Yes	No

Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women / young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

Briefly describe the content of these laws, regulations or policies
1. Penal Code 377 criminalises anal and oral sex with penalties which include imprisonment, fines and whipping. 2. Transgender persons are often prosecuted under the 1955 Minor Offences Act which terms cross-dressing as a form of indecent behaviour.
Briefly comment on how they pose barriers
The possession of injecting drug equipment or drugs such as morphine without a prescription is technically illegal and subject to criminal prosecution. 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.

IV. PREVENTION

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

Yes	No

IF YES, what key messages are explicitly promoted?		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No

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

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

	PWID	MSM	Sex workers	Client of sex workers	Prison inmates	Other populations [trans-gendered person]
Condom promotion	✓	✓	✓	✓		✓
Drug substitution therapy	✓	✓	✓	✓	✓	✓
HIV testing and counselling	✓	✓	✓	✓	✓	✓
Needle and syringe exchange	✓	✓	✓	✓		✓
Reproductive health, including sexually transmitted infections prevention and treatment	✓	✓	✓		✓	✓
Stigma and discrimination reduction	✓	✓	✓		✓	✓
Targeted information on risk reduction and HIV education	✓	✓	✓		✓	✓
Vulnerability reduction (e.g. income generation)			✓			✓

2. gender-sensitive sexual and reproductive health elements?

Yes	No

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

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable subpopulations?

Yes	No

Briefly describe the content of this policy or strategy:

3.2 Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

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

Since 2011, what have been key achievements in this area:
1. Infant feeding policy - for babies exposed to HIV, free replacement feeds are given for 2 years (instead of 6 months); amended in 2012 2. Expansion of MMT program at Cure and Care Clinic under purview of National Anti-Drug Agency (NADA) and provision of MMT in prisons. 3. Expansion of NSEP sites to include wider area.
What challenges remain in this area:
The issue of providing comprehensive sexual reproductive health education, including information on HIV for children in school continues to be at an impasse. Though it has been under discussion by various levels of government, implementation of this policy has been erratic due to opposition from various parties on moral and religious grounds

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

Yes	No

IF YES, how were these specific needs determined?
Mid-Term review for NSP 2011-2015 conducted in 2013 has identified several key areas or specific needs especially among KAPs. Among others are: 1. Reduction of sexual transmission of HIV 2. Most-at-risk young population 3. Treatment as prevention

IF NO, how are HIV prevention programmes being scaled-up?
Not applicable

4.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	1	2	3	4	
Condom promotion	1	2	3	4	
Economic support e.g. cash transfer	1	2	3	4	5
Harm reduction for PWID	1	2	3	4	
HIV prevention for out-of-school young people	1	2	3	4	
HIV prevention in the workplace	1	2	3	4	
HIV testing & counselling	1	2	3	4	
IEC on risk reduction	1	2	3	4	
IEC on stigma and discrimination reduction	1	2	3	4	
Prevention of mother-to-child transmission of HIV	1	2	3	4	

Prevention for people living with HIV	1	2	3	4	
Reproductive health services including sexually transmitted infections prevention & treatment	1	2	3	4	
Risk reduction for intimate partners of key populations	1	2	3	4	
Risk reduction for men who have sex with men	1	2	3	4	
Risk reduction for sex workers	1	2	3	4	
Reduction of gender-based violence	1	2	3	4	
School-based AIDS education for young people	1	2	3	4	
Treatment as prevention	1	2	3	4	
Universal precautions in health care settings	1	2	3	4	
Other: Faith-based interventions for Muslim	1	2	3	4	

5. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the implementation of HIV prevention programmes in 2013?***

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

V. TREATMENT, CARE AND SUPPORT

1. ***Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?***

Yes	No

IF YES, briefly identify the elements and what has been prioritized
1. Malaysia provides affordable and accessible clinical care through the public health system, including free or subsidized ART. This include PLHIV in close setting. 2. All antenatal mothers are given free ART regardless of nationality. 3. The government has extended funding to peer support groups in effort to improve treatment literacy. Currently 9 support groups are financially supported.

Briefly identify how HIV treatment, care and support services are being scaled-up?
1. Expanding coverage of ARV treatment that also include PLHIV in closed setting 2. Decentralizing ARV from hospital-based to primary care setting 3. Expansion of HTC in community 4. The government is welcoming establishment of peer support group for HIV

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes (selected)	No

Please clarify which social and economic support is provided:
1. The Islamic Religious Department has distributed financial aid (Zakat) to PLHIV and their family 2. Welfare Department (under MWFCD) has also extended financial aid to PLHIV and their family

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

Yes (selected)	No

ily-based care and support | 1 | 2

care and support in the workplace

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

Yes	No (selected)

IF YES, for which comodities?
Not applicable

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Psychosocial support for people living with HIV and their families	1	2	3 (selected)	4	
Sexually transmitted infection management	1	2	3	4 (selected)	
TB infection control in HIV treatment and care facilities	1	2	3	4 (selected)	
TB preventive therapy for people living with HIV	1	2	3	4 (selected)	
TB screening for people living with HIV	1	2	3	4 (selected)	
Treatment of common HIV-related infections	1	2	3	4 (selected)	
Others [write in]:	1	2	3	4	

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9 (selected)	10

Since 2011, what have been key achievements in this area:
1. 1st line ART continues to be provided to eligible PLHIV at no cost while the 2nd line is heavily funded by the Government. The high cost of this provision of treatment currently takes up almost half of the entire national AIDS programme budget. In effort to increase coverage, ARV has been decentralized from hospital-based to primary care setting. 2. All antenatal mothers are given free ART regardless of nationality. 3. The government has extended funding to peer support groups in effort to improve treatment literacy.

What challenges remain in this area:
1. The escalating costs related to management of HIV is translated and shared by both the Government and patient. Though the treatment regime is heavily subsidised by public funds, there is concern that this is unable to continue due to escalating public healthcare costs including cost of drugs and uncertain economic climate. 2. Support services by the NGO are still limited to urban areas.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No	N/A

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

Yes	No

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

Yes	No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of OVC in 2013?

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

Since 2011, what have been key achievements in this area:
Not much has changed in this area since the last report. As prioritisation of Government funding has determined that the national AIDS programme would focus its energies on the most-at-risk populations, activities in this area have focused on life skills based education.
What challenges remain in this area:
Though introduction of life skills based education has begun, it remains strictly limited to specific schools. Orphans and vulnerable children are frequently considered under the care and support category. However, very little has been done at the national level. At the level of civil society, a series of initiatives have begun to assist this population through grant programmes to support the cost of schooling, sustenance and others.

VI. MONITORING AND EVALUATION

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

Yes	In Progress	No

Briefly describe any challenges in development or implementation:

***1.1 IF YES, years covered** [write in]:* 2011 - 2015

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

Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardized set of indicators that include sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

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

Yes	In Progress	No

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

5-10%

4. Is there a functional national M&E unit?

Yes	In Progress	No

Briefly describe any obstacle:
Not applicable

4.1 Where is the national M&E unit based?

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere [write in]:	Yes	No

4.2 How many and what type of professional staff are working in the national M&E unit?

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]:			
1. Public Health Physician			2010
2. Assistant Environmental Health Officer (Senior)			2010
3. Assistant Environmental Health Officer			2010
4. Clerical staffs			2010
	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]:			

4.3 Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data sharing mechanisms:
The M&E is discussed and disseminated quarterly and yearly.
What are the major challenges in this area:
Irregularity and discrepancy in data submitted by some partners.

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

Yes	No

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

Yes	No

IF YES, briefly describe the national database and who manages it:
The national database (National AIDS Registry) is managed by the HIV/STI Section of the Ministry of Health. The database consists of HIV patient related information that include socioeconomic characteristics, transmission mode, status of HIV treatment, treatment cohort etc.

6.1 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	Yes, but only some of the above	No. none of the above

IF YES, but only some of the above, which aspect does it include?
Not applicable

6.2 Is there a functional Health Information System[12]?

At national level	Yes	No
At subnational level	Yes	No
IF YES, at what level(s)? [write in] District , State /Provincial and National level		

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

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

7.2 Is HIV program coverage being monitored?

Yes	No

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

Yes	No

b) If YES, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?
1. PWID 2. Female sex worker 3. Transgender 4. MSM

[12] Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels?

Briefly explain how this information is used
This information is used for program planning and evaluation

a) Is coverage monitored by geographical area?

Yes	No

IF YES, for which population groups?
1. PWID 2. Female sex worker 3. Transgender 4. MSM

Briefly explain how this information is used
This information is used for program planning and evaluation

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

Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Others [write in]:		
For evaluation of intervention	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges if any:
1. Harm Reduction M&E data is used for monitoring and evaluation of the programme. The decision to fund activities is largely determined by the outcome of the program - number of injecting drug users, client return rate and geographical coverage. 2. M&E data has resulted in introduction of several programs such as premarital HIV screening, harm reduction program, anonymous HIV screening, preventive program for KAPs, communication for behavioural change program etc. 3. M&E data is the anchor for budget planning nationwide. The main challenge is to get KAPs to fully understand the importance of quality data and timely submission of M&E report/data.

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

At national level?	Yes	No
IF YES, what was the number trained:		

At subnational level?	Yes	No
IF YES, what was the number trained:		
At service delivery level including civil society?	Yes	No
IF YES, what was the number trained:		

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

Yes	No

IF YES, describe what type of activities:
Briefings concerning monitoring and evaluation systems and evaluations conducted at the service delivery level, implementation level (states and districts).

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluations (M&E) in 2013?

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

Since 2011, what have been key achievements in this area:
1. A national M&E unit has been developed within the Ministry of Health, not only to cater for all programmes indicators but also responsible for estimation and projection of the country's epidemic. 2. A National AIDS Registry (web-based) was developed in 2010 and further upgraded in 2013
What challenges remain in this area:
There remains a challenge in improving the quantity and quality of technical capacity in both government and civil society bodies.

National Commitments and Policy Instrument (NCPI)

PART B

[To be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. CIVIL SOCIETY[13] INVOLVEMENT

1. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?***

LOW				HIGH
1	2	3	4	5

Comments and examples:
CSOs works under coordination of the Malaysian AIDS Council (MAC), have been engaging in dialogue with key decision makers, cabinet member (parliamentarians and ministers) and international agencies such as WHO, GFATM, UNAIDS International HIV/AIDS Alliance etc. End of 2013, now there are 49 partner affiliated with MAC. The heads of government bodies (e.g. Department of Islamic Development, Islamic Religious Department of Federal Territory and Selangor, Ministry of Women, Family and Community Development, Human Rights Commission and law enforcement agencies) were reached through advocacy meetings, dialogues and workshops. Example. 1. Harm Reduction was made a component in the new police recruits curriculum. 2. There are 59 Cure and Care (C&C) centers operated under National Anti-Drug Agency (NADA-AADK) which are client-friendly. 3. There are currently 18 HIV shelter homes managed by MAC of which 14 were funded by the Ministry of Women, Family and Community Development. 4. The Department of Islamic Development (JAKIM), the Federal Territory and the Selangor Islamic Council have set up and operated a shelter home for Muslims living with HIV/AIDS. 5. Most religious state councils also give financial commitments either involved in psychosocial support projects or monthly financial assistance (RM250-300). 6. Training of trainers on HIV/AIDS responses according to The Manual HIV and Islam have been a regular agenda by JAKIM, MOH and MAC. 7. Community Welfare Department gives financial assistance (RM300) every month to eligible single parents. Beginning 2011, the Employers Providers Fund allows PLHIV to withdraw their funds if they need it for AIDS related sickness which has been extended to include second-line ART. 8. Adoption and implementation of HIV at Work Place Policy by Ministry of Human Resource. 9. Involvement of key-affected populations in Country Coordinating Mechanism.

[13]Civil society includes among others: networks and organizations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations ; AIDS service organizations; community-based organizations; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

2. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") 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)?***

LOW				HIGH
1	2	3	4	5

Comments and examples:
Through coordination of the Malaysian AIDS Council (MAC) and working with the Ministry of Health, civil society representatives have been extensively involved in the planning and budgeting process for NSP 2011-2015. The CSOs also involved in Mid-Term review on NSP 2011-2015 and National Stakeholder Meeting has been a regular agenda involving CSOs, MOH and other key stakeholders.

3. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention , treatment, care and support included in:***

a. The national HIV strategy?

LOW				HIGH
1	2	3	4	5

b. The national HIV budget?

LOW				HIGH
1	2	3	4	5

c. The national HIV reports?

LOW				HIGH
1	2	3	4	5

Comments and examples:
The National Strategic Plan on HIV/AIDS 2011– 2015 clearly indicates that HIV prevention, particularly amongst key-affected populations, is dependent on the programmes and services of civil society organizations. Civil society is consistently consulted by the Ministry of Health in the process of writing national AIDS reports and MAC has been involved as member of several task force and National Committee related to HIV.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

LOW				HIGH
1	2	3	4	5

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

LOW				HIGH
1	2	3	4	5

c. Participate in using data for decision-making?

LOW				HIGH
1	2	3	4	5

Comments and examples:
MAC has developed and implemented systematic M&E in consultation with MOH that assist in National M&E framework. MAC is currently monitoring and oversees more than 100 HIV projects by CSOs receiving the Government grant and other funders. This data is used as part of national reporting.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers and faith-based organizations)?

LOW				HIGH
1	2	3	4	5

Comments and examples:

There are currently 49 partner organizations affiliated with MAC. They comprise of :

1. Organisation of people living with HIV (MyPlus)
2. Women's organizations
3. Children organizations
4. Youth organizations
5. Faith-based organizations
6. Bar Council
7. Community-based organizations
8. Organizations working with KAPs
9. Associations of medical professionals
10. Humanitarian organisations

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW				HIGH
1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW				HIGH
1	2	3	4	5

Comments and examples:
Beside government funding, CSOs also getting funding from external funders namely GFATM, HIV/AIDS Alliance, corporate organizations such as Sime Darby, MAC Cosmetic, World Vision etc. In addition to monetory benefits, CSOs also received benefits in kind from NGC Gas, Medical Latex etc. And also technical support from TSF and Alliance Technical Hub.

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

Prevention for key-populations				
People living with HIV	< 25%	25 – 50%	51 – 75%	> 75%
Men who have sex with men	< 25%	25 – 50%	51 – 75%	> 75%
People who inject drugs	< 25%	25 – 50%	51 – 75%	> 75%
Sex workers	< 25%	25 – 50%	51 – 75%	> 75%
Transgendered people	< 25%	25 – 50%	51 – 75%	> 75%
Testing and Counseling	< 25%	25 – 50%	51 – 75%	> 75%
Reduction of Stigma and Discrimination	< 25%	25 – 50%	51 – 75%	> 75%
Clinical services(ART/OI)*	< 25%	25 – 50%	51 – 75%	> 75%
Home-based care	< 25%	25 – 50%	51 – 75%	> 75%
Programmes for OVC**	< 25%	25 – 50%	51 – 75%	> 75%

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

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

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

Since 2011, what have been key achievements in this area:
1. Active involvement of CSOs in Country Coordinating Mechanism (CCM) chaired by the Deputy Minister of Health. 2. Engagement of CSOs in numerous task force related to HIV at all levels - NSP, Task Force on Women & Girls, Inter-governmental agencies (JAKIM, other state Islamic Council, KPWKM, PDRM), Harm reduction, Adolescent Health, human rights on health and involvement in state Stakeholders meeting.

What challenges remain in this area:
1. Lack of KAP network at grass root level 2. Financial sustainability 3. Unable to retain skilled and experienced civil society personnel 4. Issues that hinders enabling environment for effective and meaningful engagement of KAP a. Lack of client-friendly services due to stigma and discrimination b. Lack of awareness, education and information and communication c. Absence of SOP for sexually-related HIV Prevention 5. Inadequate treatment literacy and access 6. Insufficient HIV linkages to services (SRHR, prison etc) 7. Lack of HIV prevention programmes and implementing partners to address sexual transmission targeted for MSM population 8. Existence of structural and social barriers leading to low uptake of HTC amongst KAPs

II. POLITICAL SUPPORT AND LEADERSHIP

1. ***Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?***

Yes	No

IF YES, describe some examples of when and how this has happened:
1. NSP development 2. Involvement in various National taskforce and committee – Harm Reduction, CCM, Woman and Children, Youth etc. 3. Withdrawal of fund from EPF for AIDS related medication

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/ young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

1.2 Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES, to Question 1.1 or 1.2, briefly describe the contents of these laws:
1. Children Act 2001 on OVC 2. People with Disabilities Act 3. Prison Act and Regulation 4. Section on Rehabilitation and Treatment for prisoner 5. Women and Girls Act 6. Domestic Violence Act 7. For young women, men and the general public, 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 occured.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
There are a number of governmental and civil society mechanisms in place which allow for redress of laws, issues and complaints: 1. The indivPWIDal relevant Ministries have their indivPWIDal 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, National Legal Aid Foundation, Bar Council, and Human Rights Commission for Malaysia, which will ensure the implementation of the law via different ministries. Specific NGOs which advocate issues are also used to seek support and to further advocate in behalf of the indivPWIDal.

Briefly comment on the degree to which they are currently implemented:
Moderate, as working relationship between ministries and CSOs mechanisms do sometimes have different in opinions, views and directions as Malaysia have strict beliefs and values, e.g. religion.

2. ***Does the country have laws, regulations or policies that present obstacles[14] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?***

Yes	No

2.1 IF YES, for which subpopulations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[15] *[write in]*:	Yes	No

[14]These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships"," laws that criminalize possession of condoms or drug paraphernalia";"loitering laws"; "laws that preclude importation of generic medicines";"policies that preclude distribution or possession of condoms in prisons";"policies that preclude on-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc

[15]Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g.(in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

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

Briefly comment on how they pose barriers:
Fear of persecution and discrimination makes it difficult to reach out to MSM and transgender persons. Religious bodies and laws enforcement agencies less likely to cooperate as MSM & TG sexual behaviour is considered unacceptable by society. Although there is no existing law or policy against indivPWIDals 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 PWID 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 1 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 indivPWIDal 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 indivPWIDal.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included:
1. Domestic Violence Act 1994 2. Women and Girls Act 3. National Policy on Women 4. National Policy on Youth 5. Penal Code 377 (Rape, Carnal Intercourse) 6. Code of Practice to prevent and eliminate sexual harassment at workplace 1999 7. CEDAW – Convention Elimination Discrimination against Women, Malaysia is one of signatory country and has been used in a recent court case.

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

Yes	No

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

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No

IF YES, briefly describe this mechanisms:
1. National Legal Aid Foundation (established 2011) 2. Legal Aid Centre under the Bar Council records and documents all discrimination cases. 3. Public Complaint under different ministries 4. Legal Aid Bureau 5. The Human Right Commission of Malaysia (SUHAKAM) Various civil society organisations (CSOs) as well as entities such as the Bar Council and Legal Aid Centre are active in the recording and documentation of such cases. However to ensure that cases are brought to a higher level to address the issue, it is very often dependent on the PLHIV or persons affected by the discrimination to proceed. However, the reality is that if a person who is living with HIV suffers discrimination as a result of stigma, it is often considered hard to prove. Documentation continues to be a problem as people who suffer such discrimination are reluctant to proceed further due to the risk of exposure of one's status. Practical problems abound with regards to addressing HIV related acts of discrimination.

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

6. ***Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).***

	Provided free of charge to all people in the country		Provided free of charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services[16]	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
Basically, prevention services are free-of-charge to all people. First-line medications are free but mainly for Malaysian and Permanent Residence at all government health care providers (HCP) and CSO and at a cost for UNHCR (Refugees, Asylum Seekers). Private HCP and GPs also do provide these services but only at a cost. All ANC mothers (regardless of nationalities) who are HIV positive being treated with ARV free of charge following our National Guidelines in 2011

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

Yes	No

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

Yes	No

8. ***Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?***

Yes	No

[16]Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

IF YES, briefly describe the content of this policy/strategy and the populations included:
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.Under Strategy 1 of the National Strategic Plan on HIV/AIDS 2011-2015, the goverment is committed to improve the quality and coverage of prevention programmes among most at risk and vulnerable populations. And this also stated in Strategy 2, 3 and 4.All key populations will receive support based on Health Rights under the MOH HIV Prevention programs, Shelter Home Policy of Ministry of Women, Social and Community Development and MAC's HIV Prevention programs.

8.1 IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
1. The government policy offers free HIV Screening for All. 2. For PWID – addressing drug addiction and HIV prevention through harm reduction utilising the Needle Syringe Exchange Programme (NSEP) and Methadone MaintenanceTherapy (MMT). 3. For SW/TG/MSM – HIV prevention and intervention through VCT, telephone counselling,outreach programmes, condom awareness, SRH/STI and community drop-in centres 4. 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) 5. For PLHIV - Treatment, care and support through shelter and hospital peer support programmes 6. For prison inmates – they are given access to ART and Methadone Maintenance Therapy treatment and referrals for counselling. 7. Changing approach from compulsory detention to voluntary-based rehabilitation using public health approach and evidence-based.

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

Yes	No

IF YES, briefly describe the content of the policy or law:
Not applicable

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

a. *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 (selected)	No

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

Yes	**No** (selected)

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

1. SUHAKAM was established by Parliament under the Human Rights Commission of Malaysia Act 1999, Act 597. It is an independent national institution for the promotion and protection of human rights. Among their functions are to pursue complaints regarding violation of human rights including HIV-related issues.
2. National Legal Aid Foundation, established in 2011
3. Bar Council

11. *In the last 2 years, have there been the following training and/or capacity-building activities:*

a. *Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[17]?*

Yes (selected)	No

b. *Programmes for members of the judiciary and law enforcement[18] on HIV and human rights issues that may come up in the context of their work?*

Yes (selected)	No

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

a. *Legal aid systems for HIV case work*

Yes (selected)	No

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

Yes	**No** (selected)

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

Yes (selected)	No

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[17]Including, for example, Know-your-rights campaigns–campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

[18]Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the workplace	Yes	No
Other*[write in]*: Islamic Religious Leaders, Law Enforcement Agencies	Yes	No

14. *Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?*

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

Since 2011, what have been key achievements in this area:
1. 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. 2. Series of workshops to religious leaders using 'Manual HIV and Islam' by Islamic Development Department in collaboration with MOH and MAC 3. MOH implemented ART to all HIV infected antenatal mothers regardless of nationality
What challenges remain in this area:
1. Adoption of Code of Practice on Prevention and Management of HIV/AIDS at ALL Workplace, which was initiated by the Ministry of Human Resource. 2. 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. 3. There is a continual need to sensitize and involve all stakeholders who work directly or have direct contact with KAPs such as the local government authorities, prisons department, religious authorities, law enforcement bodies (e.g. police), National Anti Drug Agency (NADA) and immigration department.

15. *Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?*

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

Since2011, what have been key achievements in this area:
1. Currently EPF, has extended the withdrawal to include second line ART 2. Adoption of several corporate bodies on the Code of Practice on Prevention and Management of HIV/AIDS at Workplace including Petronas
What challenges remain in this area:
1. Increase adoption of HIV at Work Place policy 2. Moving the effort to have a comprehensive program on reducing sexual transmission of HIV 3. Extension of Social Security Organization Protection Scheme (SOCSO) coverage to PLHIV

IV. PREVENTION

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

Yes	No

IF YES, how were these specific needs determined?
The current intervention works especially among PWID through Harm reduction Program. However, there is a need to have a comprehensive program that look into the sexual transmission.
IF NO, how are HIV prevention programmes being scaled-up?
Not applicable

1.1 *To what extent has HIV prevention been implemented?*

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	
Condom promotion	1	2	3	4	
Harm reduction for people who inject drugs	1	2	3	4	
HIV prevention for out-of-school young people	1	2	3	4	
HIV prevention in the workplace	1	2	3	4	
HIV testing and counseling	1	2	3	4	
IEC[19]on risk reduction	1	2	3	4	
IEC on stigma and discrimination reduction	1	2	3	4	
Prevention of mother-to-child transmission of HIV	1	2	3	4	
Prevention for people living with HIV	1	2	3	4	
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	
Risk reduction for intimate partners of key populations	1	2	3	4	
Risk reduction for men who have sex with men	1	2	3	4	
Risk reduction for sex workers	1	2	3	4	

[19]IEC=information, education, communication

School-based HIV education for young people	1	2	3	4	
Universal precautions in healthcare settings	1	2	3	4	
Other*[write in]*:	1	2	3	4	

2. ***Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?***

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

Since 2011,what have been key achievements in this area:
1. Partnership with the government in implementing HIV Prevention Programmes at all level – Harm reduction program, outreach program for KAPs and behavioral change communication initiatives. 2. Recipient of several funders both in-country and international – MOH, MWFCD, several private sectors, GFATM, International HIV/AIDS Alliance

What challenges remain in this area:
1. Lack of prevention program and implementing partners at grass root level for sexual transmission of HIV 2. Lack of comprehensive program for most-at-risk young people (MARYP) 3. Absence of Women & Girls program 4. Integration of SRHR in HIV prevention program 5. Underutilization of existing SRHR services 6. Financial sustainability 7. Lack of capacity building at implementers level 8. Retention of skilled human resource to implement prevention program 9. Restriction of intake of PLHIV at public shelter homes

V. TREATMENT, CARE AND SUPPORT

1. ***Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?***

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:
1. HAART given free to all first line, partial funded for second line (may apply medicine assistance scheme at MAF) 2. Government funded 7 Hospital Peer Support Program and 14 shelter homes 3. Financial assistance from the corporate sector for children infected and affected by HIV

Briefly identify how HIV treatment, care and support services are being scaled-up?
1. Scale up hospital peer support program sites 2. SOP for Hospital Peer Support Program (and there was discussion on changing the service to PLHIV Peer Support Program 3. Treatment literacy program 4. Capacity building to health care workers

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

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Anti retroviral therapy	1	2	3	**4**	
ART for TB patients	1	2	3	**4**	
Cotrimoxazole prophylaxisin people living with HIV	1	2	3	**4**	
Early infant diagnosis	1	2	3	**4**	
HIV care and support in the workplace (including alternative working arrangements)	**1**	2	3	4	
HIV testing and counseling for people with TB	1	2	3	**4**	
HIV treatment services in the workplace or treatment referral systems through the workplace	1	**2**	3	4	
Nutritional care	1	**2**	3	4	
Pediatric AIDS treatment	1	2	3	**4**	
Post-delivery ART provision to women	1	2	3	**4**	
Post-exposure prophylaxis for non-occupational exposure (e.g. sexual assault)	**1**	2	3	4	
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	**4**	
Psychosocial support for people living with HIV and their families	1	2	**3**	4	
Sexually transmitted infection management	1	2	**3**	4	
TB infection control in HIV treatment and care facilities	1	2	3	**4**	
TB preventive therapy for people living with HIV	1	2	**3**	4	
TB screening for people living with HIV	1	2	3	**4**	
Treatment of common HIV-related infections	1	2	3	**4**	
Other*[write in]*:	1	2	3	4	

1.2 *Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?*

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

Since 2011, what have been key achievements in this area:
1. Increase coverage of treatments to all Malaysian at all government hospitals 2. Screening of HIV for TB and screening TB for HIV 3. Screening STI for HIV
What challenges remain in this area:
1. Community-based testing 2. Absence of home-based care program 3. Restriction of PLHIV into public shelter homes 4. Self-stigma by PLHIV in accessing treatment 5. Adherence to ART

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

Yes	No

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

Yes	No

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

Yes	No

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

Yes	No

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

N/A

3. *Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programme in 2013?*

Very Poor										Excellen t
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
1. Increase coverage of treatments to all Malaysian at all government hospitals 2. Screening of HIV for TB and screening TB for HIV 3. Screening STI for HIV
What challenges remain in this area:
1. Community-based testing 2. Absence of home-based care program 3. Restriction of PLHIV into public shelter homes 4. Self-stigma by PLHIV in accessing treatment 5. Adherence to ART

Country : Malaysia **Year : 2012** **ANNEX 3**

Name of local currency : MYR

Currency expressed in : RM Average exchange rate for the year (local currency to USD) : 3.20

2012 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-National	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
TOTAL	181,266,082.23	173,083,236.10	173,083,236.10	0.00	0.00	5,329,082.93	0.00	0.00	5,329,082.93	2,853,763.20	350,058.31	2,503,704.89
1. PREVENTION	26,390,256.14	21,037,275.36	21,037,275.36	0.00	0.00	4,636,790.02	0.00	0.00	4,636,790.02	716,190.76	0.00	716,190.76
1.01 Communication for social and behavioural change	5,723,507.25	5,723,507.25	5,723,507.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.02 Community mobilization	58,260.59	45,797.00	45,797.00	0.00	0.00	0.00	0.00	0.00	0.00	12,463.59	0.00	12,463.59
1.03 Voluntary counselling and testing (VCT)	29,000.00	29,000.00	29,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.04 Risk-reduction for vulnerable and accessible populations	55,120.00	55,120.00	55,120.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.05. Prevention - Youth in school	625,434.90	625,434.90	625,434.90	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.06 Prevention - Youth out-of-school	267,430.50	267,430.50	267,430.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.07 Prevention of HIV transmission aimed at people living with HIV	347,338.80	293,338.80	293,338.80	0.00	0.00	0.00	0.00	0.00	0.00	54,000.00	0.00	54,000.00
1.08 Prevention programmes for sex workers and their clients	1,981,695.52	141,935.89	141,935.89	0.00	0.00	1,763,614.42	0.00	0.00	1,763,614.42	76,145.21	0.00	76,145.21
1.09 Programmes for men who have sex with men	58,595.60	39,100.00	39,100.00	0.00	0.00	0.00	0.00	0.00	0.00	19,495.60	0.00	19,495.60
1.10 Harm-reduction programmes for injecting drug users	12,331,550.52	8,904,288.56	8,904,288.56	0.00	0.00	2,873,175.60	0.00	0.00	2,873,175.60	554,086.36	0.00	554,086.36
1.11 Prevention programmes in the workplace	65,426.00	65,426.00	65,426.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.12 Condom social marketing	48,430.00	48,430.00	48,430.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.13 Public and commercial sector male condom provision	33,464.00	33,464.00	33,464.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.14 Public and commercial sector female condom provision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.15 Microbicides	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.16 Prevention, diagnosis and treatment of STI	197,838.00	197,838.00	197,838.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.17 Prevention of mother-to-child transmission	2,685,879.20	2,685,879.20	2,685,879.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.18 Male Circumsicion	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.19 Blood safety	523,212.00	523,212.00	523,212.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.20 Safe medical injections	14,000.00	14,000.00	14,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.21 Universal precautions	140,273.26	140,273.26	140,273.26	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.22 Post-exposure prophylaxis	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.23 Pre-exposure prophylaxis		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.98 Prevention activities not disaggregated by intervention	1,188,000.00	1,188,000.00	1,188,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1.99 Prevention activities not elsewhere classified	15,800.00	15,800.00	15,800.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2. CARE AND TREATMENT	123,026,700.28	121,673,695.51	121,673,695.51	0.00	0.00	0.00	0.00	0.00	0.00	1,353,004.77	0.00	1,353,004.77
2.01 Outpatient care	117,289,279.95	116,462,902.62	116,462,902.62	0.00	0.00	0.00	0.00	0.00	0.00	826,377.33	0.00	826,377.33
2.01.01 Provider- initiated testing and counselling	31,500.00	31,500.00	31,500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.02 OI outpatient prophylaxis and treatment	219,027.00	219,027.00	219,027.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.03 Antiretroviral therapy	94,550,692.07	94,275,500.07	94,275,500.07	0.00	0.00	0.00	0.00	0.00	0.00	275,192.00	0.00	275,192.00
2.01.04 Nutritional support associated to ARV therapy	1,556,905.00	1,556,905.00	1,556,905.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.05 Specific HIV-related laboratory monitoring	19,324,783.33	19,324,783.33	19,324,783.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.06 Dental programmes for PLHIV	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.07 Psychological treatment and support services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.08 Outpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.09 Home-based care	12,000.00	12,000.00	12,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.10 Traditional medicine and informal care and treatment services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.01.98 Outpatient care services not disaggregated by intervention	23,600.00	23,600.00	23,600.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

2012 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-National	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
2.01.99 Outpatient Care services not elsewhere classified	1,570,772.55	1,019,587.22	1,019,587.22	0.00	0.00	0.00	0.00	0.00	0.00	551,185.33	0.00	551,185.33
2.02 In-patient care	5,737,420.33	5,210,792.89	5,210,792.89	0.00	0.00	0.00	0.00	0.00	0.00	526,627.44	0.00	526,627.44
2.02.01 Inpatient treatment of opportunistic infections (OI)	2,860,085.00	2,860,085.00	2,860,085.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.02 Inpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.98 Inpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.99 In-patient services not elsewhere classified	2,877,335.33	2,350,707.89	2,350,707.89	0.00	0.00	0.00	0.00	0.00	0.00	526,627.44	0.00	526,627.44
2.03 Patient transport and emergency rescue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.98 Care and treatment services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.99 Care and treatment services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3. ORPHANS AND VULNERABLE CHILDREN (OVC)	**3,550.00**	**3,550.00**	**3,550.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
3.01 OVC Education	3,550.00	3,550.00	3,550.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.02 OVC Basic health care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.03 OVC Family/home support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.04 OVC Community support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.05 OVC Social services and Administrative costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.06 OVC Institutional Care	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.98 OVC services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3.99 OVC services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. PROGRAM MANAGEMENT AND ADMINISTRATION STRENGTHENING	**26,553,621.16**	**25,511,269.94**	**25,511,269.94**	**0.00**	**0.00**	**692,292.91**	**0.00**	**0.00**	**692,292.91**	**350,058.31**	**350,058.31**	**0.00**
4.01 Planning, coordination and programme management	1,772,861.22	1,414,379.25	1,414,379.25	0.00	0.00	358,481.97	0.00	0.00	358,481.97	0.00	0.00	0.00
4.02 Admin.& transaction costs assoc.w managing and disbursing funds	1,428,797.90	884,484.79	884,484.79	0.00	0.00	194,254.80	0.00	0.00	194,254.80	350,058.31	350,058.31	0.00
4.03 Monitoring and evaluation	356,429.57	216,873.43	216,873.43	0.00	0.00	139,556.14	0.00	0.00	139,556.14	0.00	0.00	0.00
4.04 Operations research	28,000.00	28,000.00	28,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.05 Serological-surveillance (Serosurveillance)	300,000.00	300,000.00	300,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.06 HIV drug-resistance surveillance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.07 Drug supply systems	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.08 Information technology	70,349.54	70,349.54	70,349.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.09 Patient tracking	135,065.30	135,065.30	135,065.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.10 Upgrading and construction of infrastructure	131,310.00	131,310.00	131,310.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.11 Mandatory HIV testing (not VCT)	25,000.00	25,000.00	25,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.98 Prog. Mx & Admin. Strengthening not disaggregated by type	22,274,807.63	22,274,807.63	22,274,807.63	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4.99 Prog. Mx & Admin. Strengthening not-elsewhere classified	31,000.00	31,000.00	31,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5. INCENTIVES FOR HUMAN RESOURCES	**2,013,434.70**	**1,744,234.70**	**1,744,234.70**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**269,200.00**	**0.00**	**269,200.00**
5.01 Monetary incentives for human resources	24,000.00	24,000.00	24,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5.02 Formative education to build-up an HIV workforce	361,702.00	92,502.00	92,502.00	0.00	0.00	0.00	0.00	0.00	0.00	269,200.00	0.00	269,200.00
5.03 Training	979,240.00	979,240.00	979,240.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5.98 Incentives for Human Resources not specified by kind	480,892.70	480,892.70	480,892.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5.99 Incentives for Human Resources not elsewhere classified	167,600.00	167,600.00	167,600.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

2012 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nati onal	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
6. SOCIAL PROTECTION AND SOCIAL SERVICES EXCLUDING ORPHANS AND VULNERABLE CHILDREN	**2,394,000.00**	**2,394,000.00**	**2,394,000.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
6.01 Social protection through monetary benefits	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.02 Social protection through in-kind benefits	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.03 Social protection through provision of social services	2,394,000.00	2,394,000.00	2,394,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.04 HIV-specific income generation projects	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.98 Soc. Protect. services & social services not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6.99 Soc. Protect. services & social services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7. ENABLING ENVIRONMENT	**521,219.95**	**355,910.59**	**355,910.59**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**165,309.36**	**0.00**	**165,309.36**
7.01 Advocacy	469,979.95	304,670.59	304,670.59	0.00	0.00	0.00	0.00	0.00	0.00	165,309.36	0.00	165,309.36
7.02 Human rights programmes	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.03 AIDS-specific institutional development	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.04 AIDS-specific programmes focused on women	51,240.00	51,240.00	51,240.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.05 Programmes to reduce Gender Based Violence	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.98 Enab. Environ. & Community Dev. not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7.99 Enab. Environ. & Community Dev. not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. RESEARCH	**363,300.00**	**363,300.00**	**363,300.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
8.01 Biomedical research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.02 Clinical research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.03 Epidemiological research	363,300.00	363,300.00	363,300.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.04 Social science research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.05 Vaccine-related research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.98 Research not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8.99 Research not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

2013	TOTAL	Public Sources				International Resources				Private Sources		
AIDS SPENDING CATEGORIES		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals		Private (Sub-Total)	Household funds	All Other Private
								UN Agencies	Global Fund			
TOTAL	**185,871,987.67**	**176,705,624.34**	**176,705,624.34**	**0.00**	**0.00**	**6,739,193.70**	**0.00**	**539,614.88**	**6,199,578.82**	**2,427,169.63**	**2,121,874.37**	**305,295.26**
1. PREVENTION	**32,011,097.15**	**25,723,847.00**	**25,723,847.00**	**0.00**	**0.00**	**5,432,820.60**	**0.00**	**135,446.00**	**5,297,374.60**	**854,429.55**	**854,429.55**	**0.00**
1.01 Communication for social and behavioural change (BCC)	5,880,557.00	5,874,051.00	5,874,051.00	0.00	0.00	6,506.00		6,506.00	0.00	0.00	0.00	0.00
1.02 Community/social mobilization	275,520.70	186,255.70	186,255.70	0.00	0.00	89,265.00		89,265.00	0.00	0.00	0.00	0.00
1.03 Voluntary counselling and testing (VCT)	121,930.00	121,615.00	121,615.00	0.00	0.00	315.00		315.00	0.00	0.00	0.00	0.00
1.04 Risk-reduct. & prevention act. for vulnerable & accessible pop.	64,690.00	64,690.00	64,690.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.05. Prevention - Youth in school	688,890.80	688,890.80	688,890.80	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.06 Prevention - Youth out-of-school	423,294.00	423,294.00	423,294.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.07 Prevention of HIV transmission aimed at PLHIV	587,250.00	587,250.00	587,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.08 Prevention programmes for sex workers and their clients	2,410,812.07	257,340.00	257,340.00	0.00	0.00	2,073,383.10		0.00	2,073,383.10	80,088.97	80,088.97	0.00
1.09 Programmes for men who have sex with men	429,337.79	71,026.00	71,026.00	0.00	0.00	39,360.00		39,360.00	0.00	318,951.79	318,951.79	0.00
1.10 Harm-reduction programmes for injecting drug users	14,440,828.90	10,798,401.40	10,798,401.40	0.00	0.00	3,223,991.50		0.00	3,223,991.50	418,436.00	418,436.00	0.00
1.11 Prevention programmes in the workplace	96,158.10	96,158.10	96,158.10	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.12 Condom social marketing	644,242.79	607,290.00	607,290.00	0.00	0.00	0.00		0.00	0.00	36,952.79	36,952.79	0.00
1.13 Public and commercial sector male condom provision	46,250.00	46,250.00	46,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.14 Public and commercial sector female condom provision	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.15 Microbicides	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.16 Prevention, diagnosis and treatment of STI	199,150.00	199,150.00	199,150.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.17 Prevention of mother-to-child transmission	2,959,653.00	2,959,653.00	2,959,653.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.18 Male Circumsicion	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.19 Blood safety	331,350.00	331,350.00	331,350.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.20 Safe medical injections	39,000.00	39,000.00	39,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.21 Universal precautions	209,232.00	209,232.00	209,232.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.22 Post-exposure prophylaxis	25,000.00	25,000.00	25,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.23 Pre-exposure prophylaxis	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.98 Prevention activities not disaggregated by intervention	6,260.00	6,260.00	6,260.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
1.99 Prevention activities not elsewhere classified	2,131,690.00	2,131,690.00	2,131,690.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2. CARE AND TREATMENT	**118,612,712.05**	**118,098,203.42**	**118,098,203.42**	**0.00**	**0.00**	**208,656.00**	**0.00**	**208,656.00**	**0.00**	**305,852.63**	**305,852.63**	**0.00**
2.01 Outpatient care	115,180,610.05	114,666,101.42	114,666,101.42	0.00	0.00	208,656.00	0.00	208,656.00	0.00	305,852.63	305,852.63	0.00
2.01.01 Provider- initiated testing and counselling	47,000.00	47,000.00	47,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.02 OI outpatient prophylaxis and treatment	319,382.00	319,382.00	319,382.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.03 Antiretroviral therapy	93,760,227.93	93,271,744.30	93,271,744.30	0.00	0.00	182,631.00		182,631.00	0.00	305,852.63	305,852.63	0.00
2.01.04 Nutritional support associated to ARV therapy	278,472.54	278,472.54	278,472.54	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.05 Specific HIV-related laboratory monitoring	18,188,252.58	18,188,252.58	18,188,252.58	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.06 Dental programmes for PLHIV	2,500,000.00	2,500,000.00	2,500,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.07 Psychological treatment and support services	1,250.00	1,250.00	1,250.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.08 Outpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.09 Home-based care	46,025.00	20,000.00	20,000.00	0.00	0.00	26,025.00		26,025.00	0.00	0.00	0.00	0.00
2.01.10 Traditional med. and informal care and treatment services	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.98 Outpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.01.99 Outpatient Care services not elsewhere classified	40,000.00	40,000.00	40,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00

2013 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals: UN Agencies	Multilaterals: Global Fund	Private (Sub-Total)	Household funds	All Other Private
2.02 In-patient care	3,432,102.00	3,432,102.00	3,432,102.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2.02.01 Inpatient treatment of opportunistic infections (OI)	3,432,102.00	3,432,102.00	3,432,102.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.02 Inpatient palliative care	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.98 Inpatient care services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.02.99 In-patient services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.03 Patient transport and emergency rescue	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.98 Care and treatment services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
2.99 Care and treatment services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3. ORPHANS AND VULNERABLE CHILDREN (OVC)	2,688,638.34	1,705,208.00	1,705,208.00	0.00	0.00	0.00	0.00	0.00	0.00	983,430.34	902,439.04	80,991.30
3.01 OVC Education	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.02 OVC Basic health care	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.03 OVC Family/home support	360,000.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	360,000.00	360,000.00	0.00
3.04 OVC Community support	158,839.45	0.00	0.00	0.00	0.00	0.00		0.00	0.00	158,839.45	128,839.45	30,000.00
3.05 OVC Social services and Administrative costs	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.06 OVC Institutional Care	2,169,798.89	1,705,208.00	1,705,208.00	0.00	0.00	0.00		0.00	0.00	464,590.89	413,599.59	50,991.30
3.98 OVC services not disaggregated by intervention	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
3.99 OVC services not-elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4. SYSTEM STRENGTHENING & PROGRAMME COORDINATION (SUB-TOTAL)	28,210,162.38	27,319,157.73	27,319,157.73	0.00	0.00	831,851.50	0.00	39,117.28	792,734.22	59,153.15	59,153.15	0.00
4.01 National planning, coordination and programme management	1,894,499.23	1,855,381.95	1,855,381.95	0.00	0.00	39,117.28		39,117.28	0.00	0.00	0.00	0.00
4.02 Admin. & transaction costs assoc. w mx. and disbursing funds	635,903.49	227,355.15	227,355.15	0.00	0.00	380,085.94		0.00	380,085.94	28,462.40	28,462.40	0.00
4.03 Monitoring and evaluation	838,535.03	395,196.00	395,196.00	0.00	0.00	412,648.28		0.00	412,648.28	30,690.75	30,690.75	0.00
4.04 Operations research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.05 Serological-surveillance (Serosurveillance)	230,000.00	230,000.00	230,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.06 HIV drug-resistance surveillance	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.07 Drug supply systems	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.08 Information technology	12,474.00	12,474.00	12,474.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.09 Patient tracking	90,170.00	90,170.00	90,170.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.10 Upgrading and construction of infrastructure	93,500.00	93,500.00	93,500.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.11 Mandatory HIV testing (not VCT)	170,000.00	170,000.00	170,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.98 Prog. Mx & Admin. Strengthening not disaggregated by type	24,018,794.63	24,018,794.63	24,018,794.63	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
4.99 Prog. Mx & Admin. Strengthening not-elsewhere classified	226,286.00	226,286.00	226,286.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5. INCENTIVES FOR HUMAN RESOURCES	1,826,443.69	1,716,973.69	1,716,973.69	0.00	0.00	109,470.00	0.00	0.00	109,470.00	0.00	0.00	0.00
5.01 Monetary incentives for human resources	73,100.00	73,100.00	73,100.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5.02 Formative education to build-up an HIV workforce	60,126.50	60,126.50	60,126.50	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5.03 Training	1,054,234.00	944,764.00	944,764.00	0.00	0.00	109,470.00		0.00	109,470.00	0.00	0.00	0.00
5.98 Incentives for Human Resources not specified by kind	538,983.19	538,983.19	538,983.19	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
5.99 Incentives for Human Resources not elsewhere classified	100,000.00	100,000.00	100,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00

2013 AIDS SPENDING CATEGORIES	TOTAL	Public Sources				International Resources				Private Sources		
		Public Sub-Total	Central / National	Sub-Nat.	All Other Public	Internat. (Sub-Total)	Bilat	Multilaterals: UN Agencies	Multilaterals: Global Fund	Private (Sub-Total)	Household funds	All Other Private
6. SOCIAL PROTECTION AND SOCIAL SERVICES EXCLUDING ORPHANS AND VULNERABLE CHILDREN	**2,060,800.00**	**2,000,000.00**	**2,000,000.00**	**0.00**	**0.00**	**60,800.00**	**0.00**	**60,800.00**	**0.00**	**0.00**	**0.00**	**0.00**
6.01 Social protection through monetary benefits	60,800.00	0.00	0.00	0.00	0.00	60,800.00		60,800.00	0.00	0.00	0.00	0.00
6.02 Social protection through in-kind benefits	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.03 Social protection through provision of social services	2,000,000.00	2,000,000.00	2,000,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.04 HIV-specific income generation projects	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.98 Soc. Protect. services & soc. services not disaggreg.by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
6.99 Soc. Protect. services & soc. services not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7. ENABLING ENVIRONMENT	**462,134.06**	**142,234.50**	**142,234.50**	**0.00**	**0.00**	**95,595.60**	**0.00**	**95,595.60**	**0.00**	**224,303.96**	**0.00**	**224,303.96**
7.01 Advocacy	286,032.56	15,580.00	15,580.00	0.00	0.00	95,595.60		95,595.60	0.00	174,856.96	0.00	174,856.96
7.02 Human rights programmes	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.03 AIDS-specific institutional development	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.04 AIDS-specific programmes focused on women	52,000.00	52,000.00	52,000.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.05 Programmes to reduce Gender Based Violence	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.98 Enab. Environ. & Community Dev. not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
7.99 Enab. Environ. & Community Dev. not elsewhere classified	124,101.50	74,654.50	74,654.50	0.00	0.00	0.00		0.00	0.00	49,447.00	0.00	49,447.00
8. RESEARCH	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
8.01 Biomedical research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.02 Clinical research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.03 Epidemiological research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.04 Social science research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.05 Vaccine-related research	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.98 Research not disaggregated by type	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00
8.99 Research not elsewhere classified	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00	0.00	0.00