

Nati
**National Situational Assessment
of HIV Financing in**

Malaysia



Executive Summary >

Sustainable HIV Financing in Transition (SHIFT) Programme is a two-year regional advocacy programme funded by the Global Fund. Beginning in January 2017 the goal is to empower civil society and communities, especially key population communities, to advocate for sustainable HIV financing in four Southeast Asian countries: Indonesia, Malaysia, the Philippines and Thailand.

To better understand the four countries' HIV financing a National Situational Assessment, which studied published data, was conducted in the middle of 2017. A total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were reviewed, including National AIDS Spending Assessments (NASA) and Global AIDS Response Progress Report (GARPR). The availability and sufficiency of HIV financing resources, as well as how funding resources are allocated in Indonesia, Malaysia, Thailand and the Philippines was examined. The following findings provides an overview of the key themes across the four countries.

Key Findings

I. Increasing Domestic Financing of National HIV responses

The four SHIFT countries of Indonesia, Malaysia, the Philippines and Thailand are seeing a trend towards more domestic spending on HIV. Between 2010 and 2015, the Philippines' domestic spending rose 286%, the biggest funding increase of any SHIFT country, however, this increase came as new HIV infections doubled over the same period¹.

Malaysia funds the bulk of its HIV programmes, at 96% in 2015. This is followed by Thailand with 89% (2015), Philippines with 74% (2015) and Indonesia with 57% (2014)². Indonesia in particular recorded a shift from mainly international funding to domestic financing beginning in 2013, with more than half of its HIV response funded domestically by 2015³.

While the trend is moving towards greater domestic government support, a significant amount of that expenditure goes towards provision of care and treatment, ranging from 33% in Indonesia for 2014 to 67% in Thailand for 2015⁴. Compared to investing in prevention, especially for key populations, healthcare provisions for HIV care and treatment remains the predominant expenditure categories. The obvious utility of treating diseases aside, healthcare provision fits well within the mandate of the government and state as providers of healthcare, without the political sensitivity of spending on stigmatised or criminalised populations. However, this overshadows the importance of the prevention approach needed to stall and reverse the epidemic, and especially the gains made possible when investing in the most affected populations.

1. UNAIDS (2017). Press Release: UNAIDS report indicates new HIV infections in the Philippines have doubled in the past 6 years, 1st August 2017.
2. UNAIDS DataHub (2017). Country Snapshots 2017.
3. NASA Indonesia (2015).
4. UNAIDS DataHub (2017). Country Snapshots 2017.

II. Allocative Efficiency and the Issue of Investing in Key Populations Prevention

Despite the growing epidemic and the financial burden of HIV, investment in prevention spending for key populations is low. Figure 3 illustrates prevention spending across the three key populations in the four SHIFT countries. Of note in advocating for efficient, targeted investment is the current MSM prevention spending. Although 50% to 80% of new infections affect MSM in the four SHIFT countries⁵, only an average of 10% of domestic HIV prevention investment is spent on MSM.

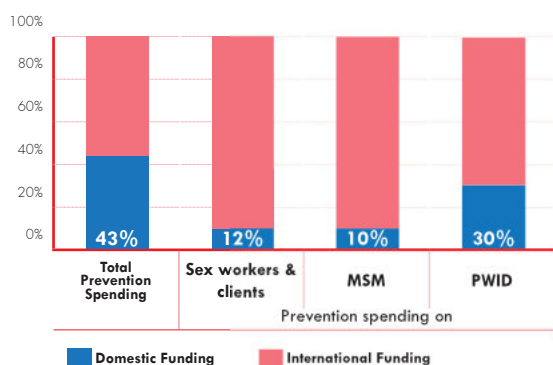


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015⁶

HIV prevention activity delivers the biggest impact and return on investment if it is targeted at the key populations of MSM, sex workers and PWID who are disproportionately affected by the epidemic. However, countries in the region fail to allocate appropriate resources for key populations, with an estimated 8% of overall HIV spending in Asia and the Pacific going towards prevention for key populations⁷. A case worth noting is the response in the Philippines to the rapidly growing epidemic. Four out of five new HIV infections are MSM, but despite the disproportionately high risk of infection, only 8% of HIV spending was allocated to MSM prevention programmes⁸.

As seen in Figure 3 above, the bulk of prevention spending in key populations is supported by international donor funding. This raises the issue of sustainability and the potential impact on the epidemic once international donors exit and countries transition to domestic financing. This has been observed in Romania by the Eurasian Harm Reduction Network. A dramatic increase in HIV prevalence among PWID was recorded, with it rising from 1.1% in 2009 (prior to end of Global Fund support), to 6.9% in 2012 and spiking at 53% in 2013 in the years after Global Fund exit⁹. The risk of prevention for key populations to fall through the cracks in this transition stage warrants an urgent allocative efficiency analysis and evidence-based advocacy to ensure an effective response to HIV.

III. Accessibility of Domestic Financing Sources

In the SHIFT countries, with the exception of Malaysia, civil society access to domestic financing remains an ongoing challenge. Prohibitive conditions such as stringent registration criteria, CSO accreditation, absence of enabling laws and policies as well as government attitudes towards CSOs further complicates the issue.

Feedback from country partners noted key constraints between CSOs and governments. There is a lack of government trust in CSOs, largely due to concerns over financial management and issues of corruption. In the Philippines the pork barrel corruption scandal involving government officials establishing fake NGOs to channel funds illegally has resulted in a crackdown and tightening of NGO laws¹⁰, resulting in more stringent rules and barriers to CSO registration¹¹. CSO and country partner representatives distrust government agencies to make evidence-based decision in HIV financing, especially when it relates to financing key populations who are potentially criminalised or marginalised.

5. UNAIDS DataHub (2017). Men Who Have Sex Men 2017 Slides.

6. UNAIDS DataHub (2017)

7. WHO (2016). HIV financing status in selected countries of the Western Pacific Region (2009-2015).

8. UNAIDS DataHub (2017). Philippines Country Snapshot 2016.

9. Eurasian Harm Reduction Network (2016). The Impact of Transition from Global Fund Support to Governmental Funding On The Sustainability of Harm Reduction programmes.

10. Francisco, K & Geronimo, J (2013). Why fake NGOs got away. <https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away>

11. Philippines country partner ACHIVE noted that organisational registration can take up to 2 years.

Furthermore, understanding budget processes and meaningful engagement in budget advocacy has been limited. This is reflected in the complex structures and power brokers of the budgetary process that CSOs have traditionally been excluded from. However, in Indonesia and the Philippines budget advocacy and accountability NGOs, such as Seknas Fitra and Social Watch Philippines, have led community level engagement to 'democratise' the budget process. This has made complex information more widely accessible allowing CSOs to undertake and engage in budget advocacy.

An exception to the rule of domestic financing channels is the case in Malaysia, where a government-operated NGO - the Malaysian AIDS Council (MAC) was set up to allocate funds to CSOs¹². However, even as MAC supports CSOs and actively includes key population representatives in its decision-making structures, many CSOs who are recipients question MAC's ability and willingness to advocate on complex issues and to represent civil society in its engagement with the government. As noted by other SHIFT country partners, a principle function of CSOs rests in its ability to advocate on behalf of the communities it represents, as well as serving as a watchdog to hold governments to account on delivering meaningful CSO engagement on national HIV responses.

Government funding may create a conflict of interest and put the CSO's independence at risk and make it a toothless watchdog. As one community respondent put it: "you don't bite the hand that feeds you"¹³.

IV. Socio-Cultural and Political Contexts

In Asia, and especially in the SHIFT countries, illiberal governments and populist policies impact the ability of CSOs to advocate for their needs. Elements of military and religious governance operate in the SHIFT countries, hampering the ease of advocacy especially for key populations who are criminalised or discriminated against.

Criminalisation further marginalises key populations. It prevents organisations representing them to fully engage, both on the legislative front, where they are unable to legally participate as political citizens, as well as on the socio-political front, where perceptions and conservative ideologies dominate the decision-making and resource-allocation table.

This is especially observable in the Philippines with the "War on Drugs" – a populist policy criminalising drug use - effectively rules out any investment and advocacy for PWID and their programmes¹⁴. In Indonesia and Malaysia, gay people and LGBT issues are routinely targeted under conservative Islamic justifications, in addition to being used as political instruments to demonise and advance dominant political influence during election periods^{15 16}. This situation presents a major challenge for CSOs to advocate for investment in key populations, especially MSM and transgender people. It makes these communities, and their need for greater domestic HIV financing, invisible.

A further socio-cultural challenge is governments viewing CSOs with suspicion. CSOs are often perceived, as antagonistic towards governments, given that successes generated by CSOs imply a certain loss of face for the government and implies the government failed to meet the needs of their citizens¹⁷. This demonstrates the need for an advocacy strategy that shifts the relationship from adversarial to a mutually beneficial one, focused on the bottom line of controlling the country's HIV epidemic.

In particular, the economic argument for investment in key populations, the return on investment and the potential to mitigate the epidemic escalating are advocacy in-roads that warrant further exploration. The SHIFT programme will explore these ideas by analysing the cost of criminalisation and country case studies, in order to inform advocacy initiatives in the SHIFT countries and will share findings across the region with key partners and stakeholders.

12. Ministry of Health Malaysia (2016). The Global AIDS Response Progress Report 2016.
13. Pers. Comms. (2017). Regional Forum on CSO Financing Mechanisms and Progress Review, 4 – 6 September 2017.
14. Human Rights Watch (2017). "License To Kill". <https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-dutertes-war-drugs>
15. Azlee, A. (2016). Anthropologist: Solidarity the only way to stop victimisation of LGBT. The Malay Mail Online. <http://www.themalaymailonline.com/print/malaysia/anthropologist-solidarity-the-only-way-to-stop-victimisation-of-lgbt>
16. Hutton, J (2017). Indonesia's Crackdown on Gay Men Moves From Bars Into the Home. The New York Times. <https://www.nytimes.com/2017/12/20/world/asia/indonesia-gay-raids.html>
17. Kingston, J. (2017). Civil society across Asia if flowering but fragile. The Japan Times. <https://www.japantimes.co.jp/opinion/2017/04/29/commentary/civil-society-across-asia-flowering-fragile/#.WiDvyBOCzOQ>

Malaysia

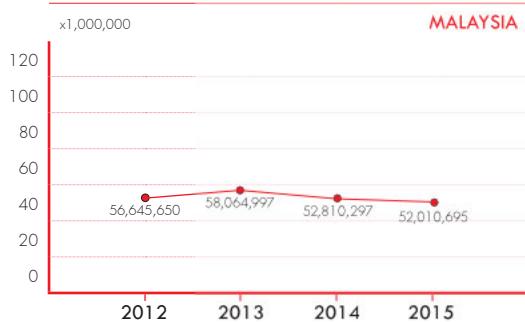
MALAYSIA

I. Background Trends

Health expenditure per capita (current USD)	2014	455.83
Share of public health expenditure in government expenditure	2014	6.45%
Share of public health expenditure in total health expenditure	2014	55.2%
Share of total health expenditure in GDP	2014	4.2%

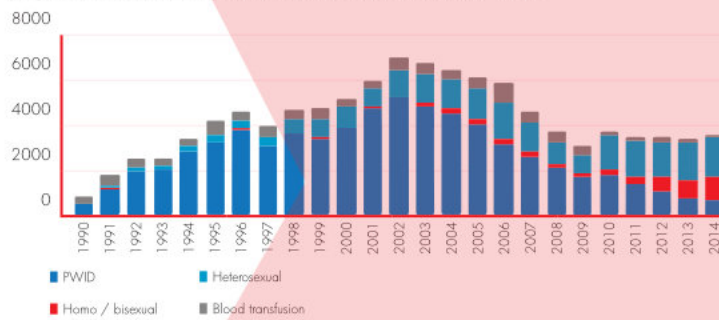
As a country shifting from upper-middle to high-income status, Malaysia is not short of resources for healthcare. With a population of 31 million, health expenditure per capita for Malaysia is at USD 456, the highest among the four SHIFT countries. Malaysia's total share of GDP on health expenditure however remains low for an upper-middle-income country.

Total HIV expenditure (USD Million)

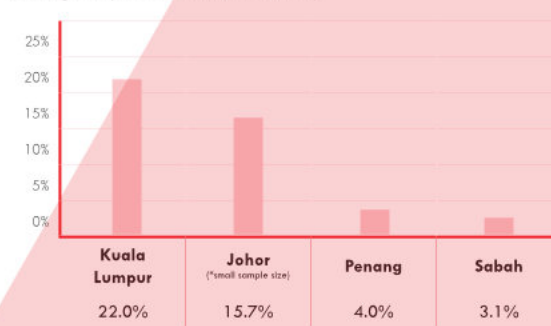


According to HIV estimates and projections, there were 92,895 people living with HIV and 5,200 new infections in 2015. The HIV prevalence (age 15-49, medium estimate) is 0.4%. The majority of HIV reported cases were from five states, including: Johor, Selangor, Kelantan, Pahang and Terengganu. The epidemic in Malaysia is still concentrated among key populations. As of the 2014 IBBS, the HIV prevalence was highest among PWID (16.6%), followed by MSM (8.9%), female sex workers (7.3%) and transgender people (5.6%). The case reporting suggests that number of HIV infections among MSM would grow fastest. In 2014, MSM accounted for 30% of all reported HIV infections in the country (Figure 1 and 2)³⁹.

Reported HIV cases by mode of transmission, 1990-2014

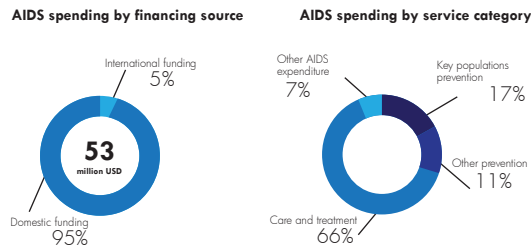


High HIV prevalence among MSM in big cities in Malaysia (Source: IBBS, 2014)



39. MOH Malaysia (2016). Global AIDS Response Progress Report: Malaysia 2016 country response to HIV/AIDS. Reporting period: January 2015 - December 2015. HIV/STI Section - Disease Control Division, Minister of Health of Malaysia

II. HIV Financing: Domestic vs. International



The Government of Malaysia has led its HIV response with relatively few international resources since the beginning of the epidemic⁴⁰. In 2014, 17% of total expenditure was invested in key population prevention⁴¹.

III. Key Populations Epidemiology vs. HIV Expenditure

Disaggregated expenditure data for 2014 shows the share of domestic vs. international funding for each population. Of particular note is MSM: while having a sizeable share of domestic funding, the actual amount is very small, only USD 7,300 out of USD 16,000. Again, this spending is disproportionate to the epidemiological trends seen in recent years, with the increasing incidence in MSM.

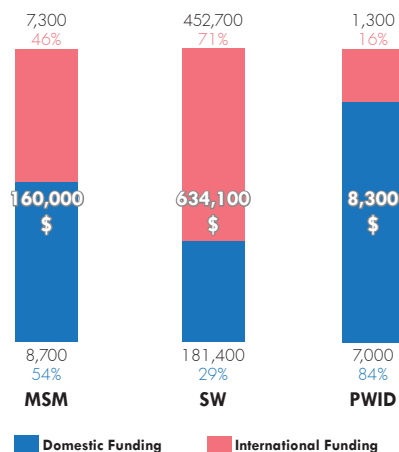


Figure 1: Share of HIV Financing for Key Populations Programmes in 2014

IV. HIV Financing Mechanisms

Unlike other regional counterparts, HIV programmes in Malaysia are heavily financed by public funding from the Ministry of Health⁴². Domestic financing accounts for 89% of the total HIV spending. Other sources of funding such as domestic, private and international sources contribute to between 2% and 5% of the HIV national expenditure, see figure below.

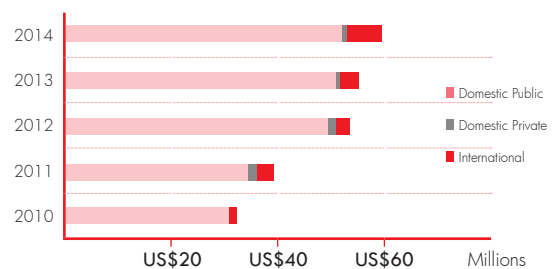


Figure: Malaysia HIV Financing based on Sources, 2010-2013⁴³

A retrospective financial report showed that HIV expenditure increased by 86% in 2014 (Table 3). In a yearly basis, more than 50% of the expenses went to care and treatment and at least 25% in prevention. However, from 2012 onwards, spending on prevention shrunk to less than 20%. The health system strengthening is the third most spent component ranging from 12% to 15% while other components such as enabling environment, human resources, social

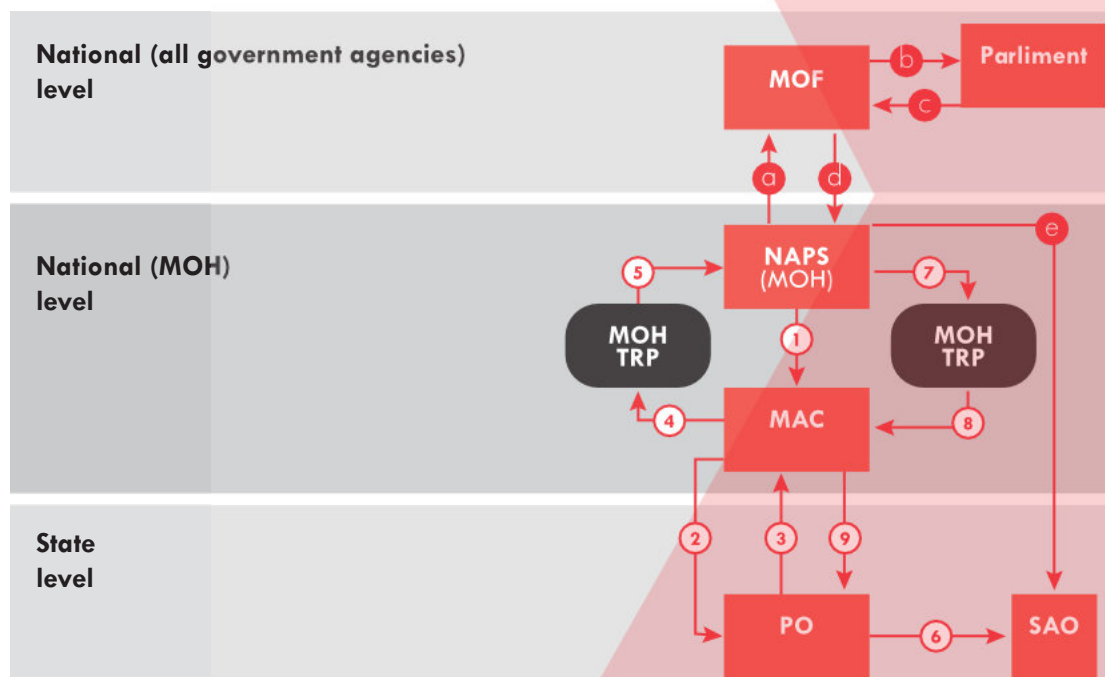
40. Huang M, Hussein H. The HIV/AIDS epidemic country paper: Malaysia. AIDS Educ Prev. Guilford Press; 2004;16: 100-109
 41. UNAIDS DataHub (2017). Country Snapshot: Malaysia
 42. Ministry of Health (2014). Country Progress Report Malaysia, 2010-2013
 43. Ministry of Health (2016)

Malaysia

AIDS SPENDING CATEGORY	2010	2011	2012	2013	2014
Prevention	8,420,996.86	9,881,368.81	7,972,887.05	9,729,816.76	9,072,615.78
Care and treatment	16,755,458.09	21,641,136.25	37,168,187.40	36,052,496.06	38,604,743.89
Orphans and vulnerable children (OVC)	623,586.14	790,880.79	1,072.51	817,215.30	861,247.58
System Strengthening and programme coordination	4,458,259.26	4,763,892.29	8,022,242.04	8,574,517.44	9,226,362.25
Incentive for Human Resources (HR)	626,671.20	491,298.34	608,288.43	555,150.06	604,293.24
Social protection and social services including Orphans and Vulnerable (SSPS)	660,066.01	782,119.21	723,262.84	626,382.98	606,060.61
Enabling environment	293,012.28	1,521,959.39	157,468.26	140,466.28	211,489.24
Research	1,650.17	1,655.63	109,758.31	-	117,682.27
Total	31,839,700.00	39,874,310.72	54,763,166.84	56,496,044.88	59,304,494.85

Table: Malaysia AIDS Spending Category, 2010-2013 ⁴⁴

V. National Budget Mechanisms



Process	Descriptions
1	MOH inform MAC to submit proposal
2	PO requested to submit the proposal with the budget within the given deadline.
3	PO submit proposal to MAC
4	MAC's Internal Technical Review process involved few processes. Firstly, the proposal will be reviewed by respective MAC's focal point and clarified with POs if there's any query. After the clarification process, all proposals will be compiled and reviewed by MAC's technical panel which consist of Executive Director, Programme Director and representative from M&E and Audit department. The proposals are reviewed and discussed by MAC's internally and recommend approval based on the M&E achievements, financial performance, POs capacity and other related criteria.
5	MAC submit proposal together with MAC' recommendation for approval for MOH
6	To get support from State AIDS Officer, PO is recommended to meet their respective State AIDS Officer to explain their proposal prior to the MOH technical review process.

7	The National AIDS Programme Secretariat which is the HIV/STI Sector of Control Disease Division of MOH, will review the recommended proposal submitted by MAC. The technical review process includes the State AIDS Officer and MAC focal points as the panel reviewer. POs are given the opportunity to present their proposal to MOH directly and justify of any queries raised by the panels.
8	MOH finalised and notified MAC of the approved proposal.
9	MAC will then inform successful PO. This process includes organisation assessment on the successful PO and negotiation on budget breakdown.
a	Government agencies, including the MOH submit proposals to the Treasury
b	After review and approval by the Minister of Finance and Cabinet, the proposal budget will be presented and debated in the Parliament
c	Approved budget by Parliament
d	The Ministry of Finance will produce the General Warrant to government agencies to proceed with approved budget
e	The HIV/STI Sector of Control Disease Division of Ministry of Health will decide approved funding for respective states and distribute accordingly. Approved funding is usually based on past expenses. At state level, the State AIDS Officer will distribute funding to respective district, also based on past expenses.

Funding Allocation Processes

In Malaysia, the HIV funding allocation process is a top-down approach. The fiscal year for all institutions in Malaysia runs from January through December. The Government budget is prepared on a yearly basis. Budget planning commences in the first quarter of the calendar year and proposals are submitted to the Treasury by the end of the first quarter of the year. The Treasury evaluates the proposals and a consolidated national budget is tabled to Parliament by September. Approved funds are disbursed by early January of the following year to Heads of Departments.

Once approved by cabinet, the budgetary funds for the National Strategic Plan for HIV/AIDS (2006-2010) are managed in total by the National AIDS Programme Secretariat (NAPS), the AIDS/STI Sector of the Disease Control Division, and the Ministry of Health. The AIDS/STI sector reports directly to the Director of Disease

Control Division and the Deputy Director General of Health (Public Health). The Section serves as the secretariat to the Ministerial, Technical and Coordinating committees and coordinates and streamlines the national response supported by the AIDS Officers in every state. The funds are then distributed to government agencies.

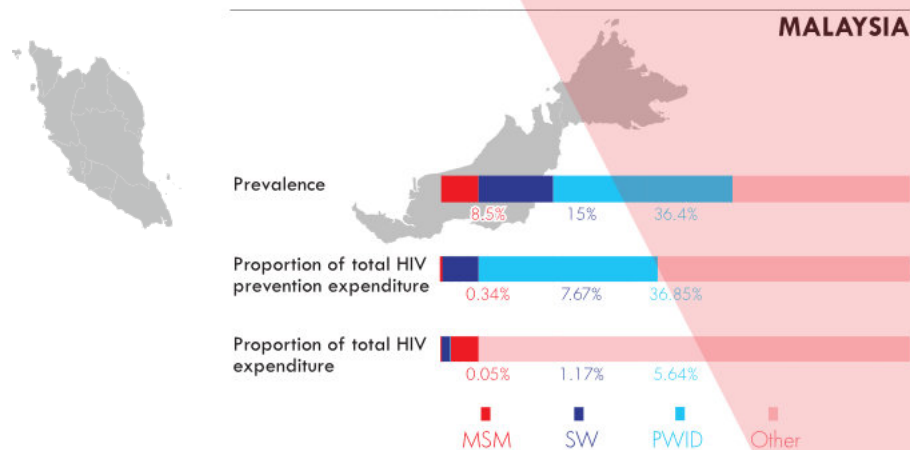
However, the Ministry of Health grants for civil society are decided by the AIDS/STI sector which is disbursed and managed through the Malaysian AIDS Council. The civil society grant funding cycle process commences every October and advance payments to project implementers are scheduled to be disbursed in January. Programme reporting deadlines are five days after the completion of each calendar quarter.

Malaysian AIDS Foundation (MAF)

While the national budget mechanism provides a centralised government funding source, MAC established a dedicated fundraising arm, the Malaysian AIDS Foundation (MAF), to help bridge gaps in government funding for HIV programmes. Established in 1993, MAF works closely with corporate organisations and institutional funders to raise funds for MAC's 47 partner organisations. Activities supported by the fund include shelter homes for PLHIV, needle and syringe exchange programme (NSEP) for injecting drug users and outreach programmes for marginalised communities.

Malaysia

VI. Analysis

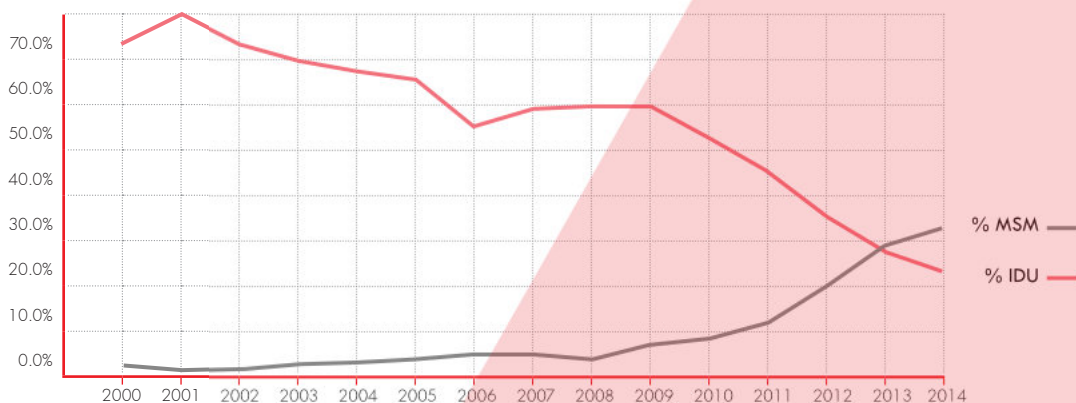


Mismatch between HIV expenditure and disease burden

Data collected from AIDS Info Online for 2014 indicates only a prevalence rate, with no proportion of new cases (see below). Based on IBBS (2012) data, the HIV epidemic in Malaysia is concentrated with a very high burden in MSM, supplanting PWID as the main driver of new HIV cases. There is also a correspondingly low coverage on ART for MSM, despite excellent care, investment in treatment and infrastructure.

While acknowledging the high HIV financing investments in Malaysia, the issue of investing in key populations remains a political obstacle. Religious conservatism in political leadership hampers public funding going to community-based interventions. A robust key populations-focused response is thwarted by high levels of stigma and discrimination, especially in the Muslim community, and a poor CSO environment which is challenged in maintaining financial sustainability with on-going operational costs and limitations of management.

Proportion of reported cases by mode of transmission – comparison between MSM and PWID, 2000 - 2014



Population size

An up-to-date estimation of the size of the key populations is not available. According to a survey conducted in 2006, and reported in the GARPR 2016, the MSM population would be approximately 170,000. This would account for 2.3% of males aged 15-49 years having practiced same-sex behavior⁴⁵.

Currently, a survey of the population size is being undertaken by MOH with support from Global Fund, with the report expected in the coming year.

Civil Society Engagement

Involvement of key civil society stakeholders in national level policy and programme development continues to be dependent on issues of capacity and relevance. Currently, the highest decision-making body related to HIV and AIDS policies in the country is led by the National Coordinating Committee in AIDS Intervention (NCCAI). It's chaired by the Ministry of Health with membership including all the Secretary Generals of relevant ministries and agencies as well as civil society representatives, including the Malaysian AIDS Council.

Civil society is also represented on the Country Coordinating Mechanism (CCM) which provides governance for Global Fund related programme. Key population representatives (e.g. sex workers, PLHIV and transgender) have been elected onto the CCM by their respective communities. MAC and its partner organisations were involved with the development of the National Strategic Plan Ending AIDS 2016-2030, as well as a member of the Harm Reduction Committee and Technical Review Panel for HIV funding for CSO.

At the sub-national level, civil societies are actively involved in regular stakeholder meetings, but the discussion is focused on environmental issues, such as raids by enforcement officers on key populations which hamper the quality of HIV service delivery. Since the HIV budgeting process at National AIDS Programme Secretariat (NAPS) is a top-down approach, little opportunity is provided when it comes to HIV budget discussion at the MOH state level.

CSO Participation in Budget Negotiation

Through MAC's GONGO⁴⁶ financing model, several windows of opportunity are available to CSOs to negotiate in the budgeting process. Firstly, after a submission of proposal to MAC, Partner Organisations (PO) are actively sought for clarification and finalising the budget prior to internal technical review. Secondly, during the MOH technical review, POs are given the opportunity to present and justify their proposal before the MOH decides. POs could also meet their respective state AIDS officer to get their buy-in prior to the MOH technical review.

With the long-standing engagement between POs and MAC, and the space provided for in the decision-making processes within this financing mechanism, there exists further opportunities to fine tune the efficacy of MAC to advocate for civil society responses. An issue raised by CSOs is the inability for MAC to be fully critical of the government, considering the source of its financing is from the government. With more evidence collection and improved data on cost effectiveness of harm reduction programmes, for example, a stronger case can be made for investing in growing epidemics among key populations.

45. MOH & WHO (2009). National consensus workshop on estimation and projection of the Malaysian HIV epidemic, Kuala Lumpur
46. GONGO: government organised non-governmental organisation

Acknowledgements:

APCOM would like to acknowledge Min Fuh Teh, Strategic Information Officer, as the lead author of this report, as well as recognising the valuable contribution of peers at APCOM who provided feedback for this report: Inad Rendon, Senior Programme Manager, and Ryan Figueiredo, Deputy Director.

We would also like to acknowledge the Australia Federation of AIDS organisations (AFAO), the principal recipient of this project, for overseeing the SHIFT Programme. We recognise the valuable contribution of the staff at AFAO who reviewed and provided feedback for this report before publication: Rebecca Gupta-Lawrence, Programme Officer, Greg Gray, Technical Advisor, Jenny Xia, M&E Officer and Joselyn Pang, International Programme Manager.

We wish to acknowledge our SHIFT country partners - the Indonesian AIDS Coalition (IAC), the Malaysian AIDS Foundation (MAC), the Thai National AIDS Foundation (TNAF) and Action for Health Initiatives Inc. (ACHIEVE) in the Philippines, for their significant contribution, feedback and support in providing insights from a localised context. A thank you to Sekretariat Nasional Forum Indonesia Untuk Transparansi Anggaran (Seknas Fitra) as well for the data support and technical input for the Indonesian section of this report.

A special thanks goes to the UNAIDS Data Hub Team, specifically Taoufik Bakkali, Technical Manager and Regional Programme Adviser, Dr. Khin Cho Win Htin, Lead Data Specialist, and Dr Ye Yu Shwe, Data Specialist for providing sources of data and technical input that were included in this report.

Finally, we would like to extend our sincere appreciation to all stakeholders for investing their trust in this project and for sharing their opinions, views, evidence, and data, ultimately making this report possible.



Lead Author: Min Fuh Teh
Design and layout: Andrey Tan, Philips Loh, and Vaness Silpakhon Kongsakul
Project Managers: Inad Rendon and Ryan Figueiredo

Map Disclaimer: The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever on the part of APCOM concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Every effort is made to ensure this map is free of errors but there is no warrant the map or its features are either spatially or temporally accurate or fit for a particular use. This map is provided without any warranty of any kind whatsoever, either express or implied.



Regional Partners:



Country Partners:

