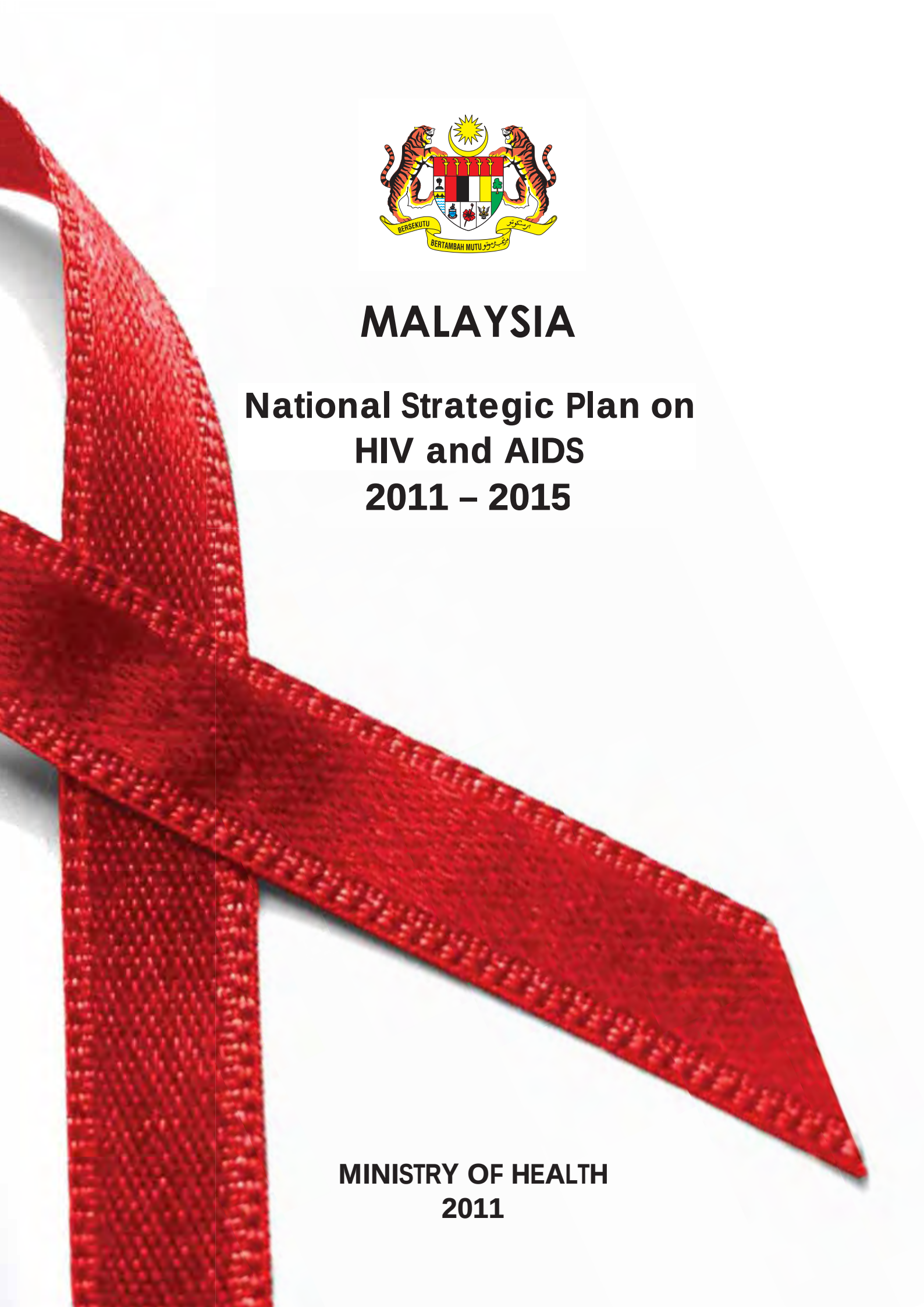

MALAYSIA

National Strategic Plan on HIV and AIDS 2011 – 2015

MINISTRY OF HEALTH
2011

MALAYSIA

National Strategic Plan on HIV and AIDS 2011 – 2015

Acknowledgement:

We acknowledge with gratitude and sincere thanks the significant inputs of MOH technical staff at Sector HIV/STI, State and District Level as well as to the UN family in Malaysia for their endless contribution. We are deeply indebted to officials of Government of Malaysia particularly the Ministry of Health, other government agencies such as Ministry of Women, Family and Community Development, Malaysia Department of Islamic Development (JAKIM), National Anti-Narcotic Agency, Royal Police of Malaysia, Legal Advisor, Ministry of Higher Learning, Ministry of Education, Ministry of Human Resource, Ministry of Defence, Ministry of Home Affairs and many others; and all Non-Government Organizations particularly Malaysia AIDS Council and its Partner Organizations, Academia and individuals for their views and valuable advice.

We greatly admire the dedication of all sectors, both government and non-government for their countless support.

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FOREWORD

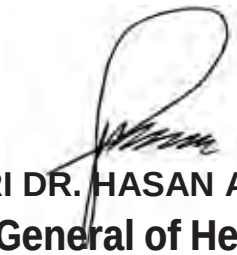
HIV/AIDS was first diagnosed in Malaysia in 1986. By the end of 2010, there was a cumulative figure of 91,362 HIV cases reported to the Ministry of Health out of which 77,064 people living with HIV. The epidemic peaked in 2002 with the rate of 28.5 per 100,000 population. Since then, there has been a steady decline and achieved at 12.8 per 100,000 population in 2010. The Government aims to reduce to 11.0 per 100,000 population by 2015.

With this NSP 2011-2015, we envisage that this target will be reached within the next couple of years and we aim to see a more significant decline by 2015. On reaching this target, it is important that comprehensive HIV prevention, treatment, care and support towards HIV/AIDS should be in place through strong political will, comprehensive policies and participation of the community.

The Government is confident that the new NSP 2011 – 2015 will be able to guide Malaysia towards fulfilling the objectives of the Millennium Development Goals (MDG), UNGASS and Universal Access (UA) targets. It is also intended to reflect the country's participation in fulfilling these international commitments.

In spite of significant achievements over the years, yet there is even more critical work ahead for all of us and Malaysia is committed to the United Nations pledge 'Getting to Zero' - zero new HIV infections, zero discrimination and zero AIDS-related deaths. Indeed, there is an urgent and greater need for a more concerted and coordinated effort between the multiple sectors concerned.

Thank you.



DATO' SRI DR. HASAN ABDUL RAHMAN
Director General of Health Malaysia

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CBO	Community-based Organisation
DIC	Drop-In Centre
DRC	Drug Rehabilitation Centre
FBO	Faith based organisation
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use/User
IBBS	Integrated Bio-Behavioural Surveillance
MAC	Malaysian AIDS Council
MARPs	Most At Risk Populations
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MMT	Methadone Maintenance Therapy
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organisation
PTCT	Parent-to-child transmission
MWFCD	Ministry of Women, Family and Community Development
NADA	National Anti Drug Agency
NAP	National AIDS Programme
NGO	Non-Government Organisation
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan on HIV/AIDS
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TG	Transgender Person
UA	Universal Access
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
UNTG	United Nations Theme Group on HIV
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Glossary of terms and definitions used in this document

Civil society refers to NGOs and informal groups (may include People Living with HIV (PLHIV), MARPs, vulnerable populations, women's organisations, faith-based organisations and advocacy groups) usually apolitical.

Cost estimates are financial estimations of how much is envisaged to be spent for a particular programme, usually not be considered as detailed budgets. (Detailed budgets are prepared for usually for Annual Work Plans itemising details of the budget).

Coverage is a measure of whether a programme is working in the right places and reaching its target population. For a programme to have a maximum impact on HIV prevention among most-at-risk populations, it must do both.

Evaluation is a rigorous, scientifically-based collection of information about programme activities, characteristics, and outcomes that determine the merit or worth of a specific programme. Evaluation studies are used to improve programmes and inform decisions about future resource allocations.

Impact evaluation looks at the rise and fall of disease incidence and prevalence as a function of HIV/AIDS programmes. The effects (impact) on entire populations can seldom be attributed to a single programme or even several programmes, therefore, evaluations of impact on populations usually entail a rigorous evaluation design that includes the combined effects of a number of programmes for at-risk populations.

Input indicators are used to monitor the amount and level of resources made available to the implementation of the National Strategic Plan on HIV and AIDS. These can be sourced from public, private and international sources. This indicator is critical in evaluating the sustainability of programmes and interventions.

Impact mitigation refers to programmes and activities which work towards decreasing the negative impact and direct consequences of HIV on MARPs, vulnerable persons and People Living with HIV such as illness, loss of employment, discrimination and death.

Impact indicators are used to evaluate the impact of programmes and interventions to the overall epidemic. These are measured using HIV prevalence amongst MARPs as well as the general population.

Incidence is defined as new infections per population at risk in a specified period of time.

Injecting drug users (IDU) refers to drug users who inject drugs and use drug equipment.

Intervention is a set of activities implemented by a project and that are often provided at the community level.

Men who have Sex with Men (MSM). Many men who have sex with men (MSM) engage in anal sex and often have multiple sexual partners; male-to-male sexual transmission is an issue of great importance to HIV prevention.

Monitoring is the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from record keeping and surveys – both population and client-based.

Outcome indicators are used to measure the effectiveness of implemented programmes in changing risk behaviours among most at risk populations, encourage prevention, treatment, care and support seeking behaviours. This indicator is critical to evaluate the effectiveness of programmes.

Output indicators are linked closely to the coverage of programmes of MARPs. This is often measured by the coverage achieved through behavioural change communication programmes, harm reduction interventions such as access to needles, syringes and condoms, utilisation of VCT, treatment, care and support services. This indicator is critical to evaluate the development and implementation of programmes.

Outreach services are those which take health information and services into the communities where most-at-risk populations live, or place where they congregate (such as back lanes where injecting drug use occurs or where pickups for transactional sex occur).

Prevalence is defined as the total number of cases of HIV at a point in time per base population.

Programme refers to an overarching national or subnational response to a disease and generally includes a number of projects.

Project refers to a mix of interventions with activities supported by resources and that often operates at the community level.

Transgender persons are refers to persons whose gender identity, expression, or behavior differs from the norms expected from their birth sex. The term “mak nyah” is commonly used within the Malaysian context to refer to persons of this category.

Universal Access refers to the global commitment to scale up access to HIV treatment, prevention, care and support which all governments agreed to when they adopted the Political Declaration on HIV/AIDS at the UN General Assembly in 2006. This involves the setting up of ambitious national targets set against key outcome areas – such as ART coverage, prevention of mother to child transmission, coverage of prevention programmes for most at risk groups and testing coverage.

Young person/ people refer to individuals within the ages of 15 – 24 years old.

Executive Summary

The National Strategic Plan on HIV and AIDS 2011 – 2015 (NSP) runs parallel and is harmonised with the aims and objectives of the 10th Malaysian Plan (10MP) for 2011 – 2015. This NSP will continue to place strong emphasis on strengthening the multi-sectoral collaboration undertaken under the previous strategic plans.

The HIV epidemic in Malaysia is driven by injecting drug use and sexual transmission occurring among most at risk populations such as drug users, sex workers, men who have sex with men and transgender persons. Operational research have shown that overlapping of injecting drug use and high risk sexual behaviour is occurring resulting in HIV infection between different segments of the populations. Studies and consensus discussions among experts have concluded that HIV in Malaysia is predicted to be increasingly spread through sexual transmission, though the infections acquired through injecting drug use (and other means e.g. vertical transmission) need to be monitored as well.

The review of the first National Strategic Plan on HIV and AIDS formulated in 1998 was done in 2001. The development of the National Strategic Plan on HIV/AIDS 2006 – 2010 in 2005 led to its implementation and use over the past five years, whilst this document (NSP 2011 – 2015) replaces the latter strategic document.

The lessons learnt and experience gained in the implementation and monitoring of the previous NSPs have shown that there are still a lot of opportunities to strengthen the commitment of all stakeholders. Various opportunities need to be enhanced to achieve greater harmonisation, coordination and alignment; maintain and sustain high levels of funding; achieve greater programme coverage, effectiveness, and efficiency; and to continue the provision of affordable treatment to those who need it. The NSP 2011–2015 intends to build upon the achievements and progress made during implementation of the previous strategic framework as well as address emerging issues and challenges.

The National Strategy on HIV and AIDS 2011 – 2015 comprises three main components:

1. The National Strategic Plan on HIV and AIDS 2011 - 2015
2. The National Action Plan on HIV and AIDS 2011 – 2015
3. The national monitoring and evaluation framework

The goals of the Malaysian NSP 2011 - 2015, are:-

1. To prevent and reduce the risk and spread of HIV infection
2. Improve the quality of life of People Living with HIV
3. Reduce the social and economic impact resulting from HIV and AIDS on the individual, family and society.

The specific objectives of the NSP2011-2015 are:-

1. 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
2. To increase coverage and quality of care, treatment and support for People Living with HIV and those affected
3. To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.
4. 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.
5. To further increase general awareness and knowledge of HIV, and reduce risk behaviour for at risk and vulnerable populations.

These objectives can only be meaningfully achieved and sustained under the commitments to UA and MDG after programmes worked towards achieving 80% service coverage among most at risk populations where 60% practice safe behaviours. To achieve these objectives, the NSP has adopted the following multisectoral strategies which provided an appropriate balance between prevention, treatment, care and support, namely:

Strategy 1	Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations
Strategy 2	Improving the quality and coverage of testing and treatment
Strategy 3	Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.
Strategy 4	Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.
Strategy 5	Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.

The execution and fulfilment of the following strategies will require renewed and strengthened commitment and multisectoral partnership of government, civil society and private sector stakeholders to work together in the spirit of consultation and collaboration under the 1Malaysia initiative.

CHAPTER 1
Introduction

1.1 Background

It is estimated that 34 million people currently live with HIV globally, and each year, it is estimated that 2.7 million more people become infected with HIV and 2 million die of AIDS. The 2009 Commission on AIDS in Asia Report stated that more than 5 million Asians currently live with HIV, and approximately 440,000 become infected each year. Yearly, about 300,000 persons die of AIDS-related diseases. The report indicates that the pandemic in Asia is entering its second growth phase, which is expected to result in increasing HIV prevalence and nearly 10 million Asians infected if prevention efforts are not expanded or fully implemented.

The Government of Malaysia is concerned by the continued spread of HIV in the country, particularly amongst most at risk populations (MARPs) identified mainly as injecting drug users (IDUs), sex workers (SW), transgender persons (TG) and men who have sex with men (MSM).

The National Strategic Plan on HIV/AIDS (NSP) 2006-2010, which was developed by the Government and drafted with the involvement of key civil society representatives in 2005 / 2006, incorporated a multi-sectoral strategy covering issues from young people's vulnerability to the delivery of healthcare services and antiretroviral treatment. Through this strategy, the Malaysia has made much progress in HIV prevention, particularly utilising the harm reduction approach which has begun to yield results in reducing the spread of the HIV epidemic. People living with HIV and in need of treatment are able to access first line treatment at no cost whilst the second line regimes at heavily subsidised as well.

While NSP 2006 – 2010 has made the promotion and implementation of harm reduction and the intervention with injecting drug users as the focus of its HIV prevention interventions, the NSP 2011 - 2015 will need to deal with a variety of new challenges, among which are expected higher incidences of sexual transmission of HIV/AIDS to be detected and the focus of concentrated epidemic that Malaysia is being classified with the emergence of populations at risk.

1.2 Rationale

Over the past five years, increased levels and additional sources of funding have made it possible to expand or upscale the support of HIV and AIDS interventions in the region, giving Malaysia avenues to accelerate the national response to the epidemic. Nevertheless, there remain gaps and opportunities for improvement in certain identified programmes.

The 2008 and 2010 UNGASS Country Progress Reports identified certain challenges in the national response to HIV and AIDS. These reports have also recognised the significant progress and positive

developments which have occurred in the last few years in Malaysia for example i.e. harm reduction interventions, the affordable treatment for PLHIVs, and the wide availability voluntary counselling and testing services.

The government and the key stakeholders have agreed that the next National Strategy on HIV should be able to sustain and upscale the abovementioned 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 most at risk communities.

The lessons learnt and experience gained in the implementation and monitoring of NSP 2006 – 2010 have also shown that there are opportunities could be tapped upon, namely to strengthen political commitment, to achieve greater harmonisation, coordination and alignment; maintain and sustain high levels of funding; and to continue the provision of affordable treatment to those who need it. The new strategic plan should achieve greater programme coverage amongst MARPs with high impact results, effectiveness, and efficiency.

The NSP 2011–2015 intends to build upon the achievements and progress made during implementation of the previous strategic framework as well as address emerging issues and challenges which threaten the sustainability of the abovementioned gains. It is also intended to guide Malaysia towards achieving the Millennium Development Goals, UNGASS and Universal Access targets.

1.3 Developing the National Strategy on HIV and AIDS 2011 – 2015

1.3.1 The Ministry of Health initiated the process of multisectoral consultation in preparation of the NSP in May 2010. It was a matter of priority and concern for all key stakeholders that this National Strategy on HIV and AIDS would be able to capture as much of the issues, progress and challenges experienced by both Government and civil society stakeholders in the response to HIV in Malaysia.

1.3.2 An orientation and preparatory briefing on the NSP development process was organised by the Ministry of Health on 21 June 2010 for Government, civil society stakeholders and UN agencies. The intention was to ensure that all partners understood the process and were also able to participate and contribute to the substance and overall development of the National Strategy. The meeting also provided guidance for the consultations which would happen independently amongst the different MARPs communities.

1.3.3 Six technical working groups (TWG) consisting of government and NGO stakeholders, discussed and recommended key areas for response under the new National Strategy on HIV and AIDS; identified gaps in current interventions, technical skills, capacity building and financial requirements under the existing NSP; and provided input in identifying priority areas, programmes and targets for the next 5 years. Issue papers were submitted in the following areas: HIV prevention amongst IDUs; MSM, transgender persons, sex workers, intimate partners; prevention amongst other populations (at risk youth, migrants, refugees); Treatment and PLHIV; Impact mitigation through care and support; and enabling environment (advocacy, policy, strategic information, research and surveillance). The findings of the TWGs were presented, consolidated and integrated into the strategic framework at the first national consultative workshop with stakeholders.

1.3.4 The first and second consultative meetings to develop the national strategic framework and the national action plan took place on 5-6 August and 20-21 September respectively and were attended by various government bodies and representative of MARPS.

1.3.5 A costing and budgeting workshop was organised as 11-12 October to ensure that the cost of the proposed interventions and activities contained within the national action framework was able to be properly estimated. A cost standardisation exercise was also conducted on 19 October. A monitoring and evaluation workshop was also convened on 1-2 November to develop a common understanding of monitoring and evaluation and to discuss the development of a common framework for use of government and civil society stakeholders to monitor, evaluate and manage AIDS programme, the results of which would be used for managing the AIDS response, improving performance and revising the national strategy and action plan.

1.3.6 The completed drafts of the individual components of the National Strategy on HIV and AIDS 2011 - 2015, consisting of the National Strategic Plan on HIV and AIDS, National Action Plan 2011 – 2015 and the national monitoring and evaluation framework were presented during a national workshop on 10 November.

The approach utilising information sharing, inclusivity and consensus building for the development of the National Strategy on HIV and AIDS has enabled many of the new developments in the Malaysian national AIDS programme to be properly reflected in the strategic document. The setting of clear, prioritized and evidence-driven national priorities which respond to the evolving dynamics of the Malaysian HIV epidemic was dependent on much of the strategic information and research data which became available over the past two years. Much of the research data utilised for priority originated from the efforts and work of civil society and community based organisations, working in partnership with Government agencies and academic institutions. Though obtaining data remains a continuing challenge, the inputs from government and civil society stakeholders have been critical in improving the understanding and response to the epidemic and form the backbone of the new strategy.

The National Strategy on HIV and AIDS 2011 – 2015 was developed and prepared by the AIDS/STI Sector of the Disease Control Division, Ministry of Health. Technical support in the formulation and preparation of the consultation process, consolidation of inputs and drafting of the document was provided by the United Nations Theme Group on HIV and AIDS.

CHAPTER 2
The Malaysian HIV Epidemic: Situation, response and challenges

2.1 The HIV situation in the country

The present

As of December 2010, an estimated 80,922 people (Estimation & Projection Model – EPP) are currently living with HIV. By the end of 2010, Malaysia had a cumulative figure of 91,362 of HIV cases, 16,352 AIDS cases and 14,298 deaths, thus giving reported people living with HIV (PLHIV) of 77,064.

The annual number of reported new HIV cases by the Ministry of Health has been on a steady decline from a peak of 6,978 in 2002. In 2010, there were 3,652 new cases reported to the Ministry of Health, approximately halve of what was reported in 2002. The notification rate of HIV also continues to experience a decrease from 27.0 in 2003 to 23.4 in 2005 and to 12.8 cases per 100,000 population in 2010. Currently, there are 10 new reported cases of HIV each day with a ratio of 2 females for every 8 males reported. In 2010, an average of 5 persons acquired HIV through injecting drugs while 5 others were infected sexually.

Table 1: Overview of the Malaysian HIV Epidemic (as of Dec 2010)

Cumulative number of reported HIV infections since 1986	91 362
Cumulative number of reported AIDS related deaths since 1986	14 298
Estimated number of people living with HIV (EPP & Spectrum model 2010)	80 922
Reported number of people living with HIV	77 064
Cumulative number of women reported with HIV	8 759
Cumulative number of children under 13 with HIV	909
New HIV infections detected in 2010	3 652
AIDS related deaths in 2010	904
Number of PLHIV currently on ART in 2010	13 981
Estimated PLHIV needing ART (CD4 <350) (EPP & Spectrum model 2010)	30 600
Estimated adult (aged 15-49 years) HIV prevalence (EPP & Spectrum model 2010)	0.42%
Notification rate of HIV (per 100 000)	12.6

Source: Ministry of Health, 2011

The decline in the number of AIDS related deaths has been directly attributed to the introduction of more affordable and accessible first and second line antiretroviral (ARV) treatment. It has been estimated that by end of 2015, Malaysia will have an estimated 81,946 people living with HIV.

Male continue to represent the majority (90%) of cumulative HIV cases in Malaysia. About 35% of reported infections are amongst young people between the ages 13-29 years old. Most reported infections occur among young heterosexual males, between the ages of 20 – 39 who inject drugs. However, in 2010 HIV infection through sexual transmission has exceeded the infection through injecting drug use. Children aged 13 years below consistently comprised 1% of cumulative total of HIV infections from 1986 to December 2010.

Figure 1: Reported HIV and AIDS-related deaths, Malaysia 1985 – 2010
Source: Ministry of Health, 2011

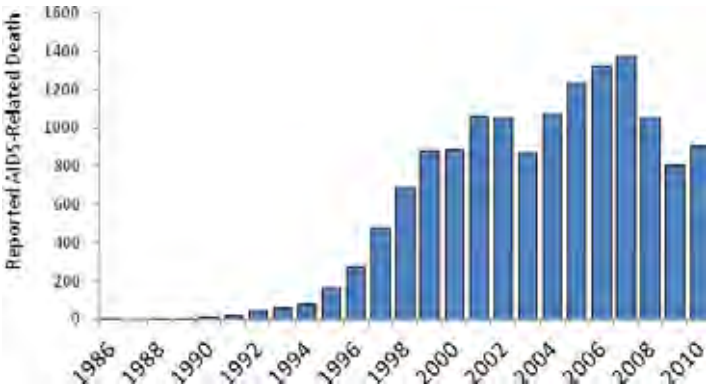
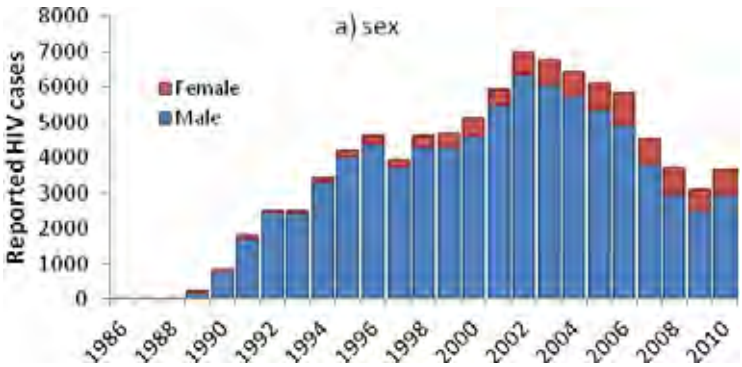
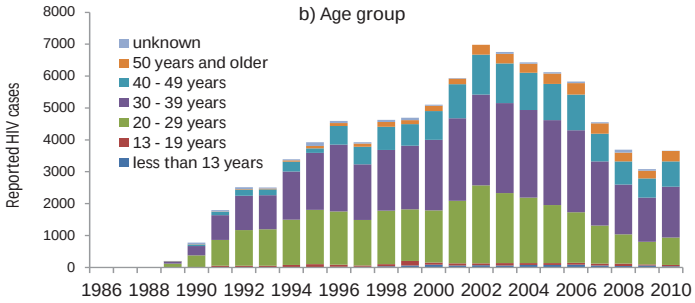
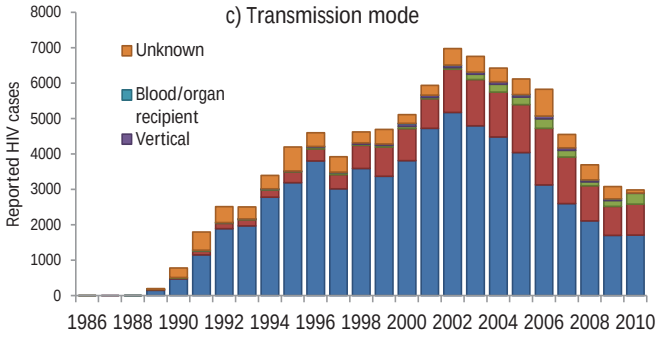


Figure 2: Reported new HIV cases in Malaysia, 1986 – 2010, disaggregated by sex, age group and transmission mode.
Source: Ministry of Health, 2011







Amongst men, the main mode of HIV transmission continues to be via injecting drug use (IDU) with HIV prevalence estimated to be 22.1% (IBBS 2009). The Ministry of Health reported that most HIV infections amongst women have occurred mainly through heterosexual transmission (70%). Women and girls are increasingly getting infected with HIV and constitute around 20% of newly infected persons nationwide in 2010 compared to being barely 5% ten years ago. There are also very few reported cases amongst the indigenous population (Orang Asli) which was 36 cumulative cases (0.04%).

The trends of HIV infection also appear to be geographically distinct. While the majority of states in Peninsular Malaysia have IDU driven epidemics, Sabah and Sarawak have more HIV resulting from heterosexual transmission (97.7% and 83.6% respectively) in 2010.

The HIV prevalence in Malaysia continues to be less than 1%, but it (HIV prevalence) ranges from 3% to 20% among the MARPs. The World Health Organisation (WHO) currently classifies Malaysia as having a concentrated HIV epidemic.

Most at risk populations

The HIV epidemic in Malaysia was initially driven by transmission among injecting drug users in the 1990s. During that period, up to 83% of annual newly detected HIV cases were attributed to injecting drug use. Cumulative reported cases of HIV transmission was predominantly among injecting drug use (70.6%), followed by heterosexual intercourse (16.9%) and homosexual contact (2.0%).[1] However, 2010 data indicates that 47.6% of new reported HIV cases for that year were attributed to injecting drugs while 48.5% was through sexual transmission (heterosexual and homosexual).

Most-At-Risk Populations (MARPs) refers to specific people or populations whose practices or behaviours put them at greater risk of HIV infection include high rates of unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with shared equipment. Thus in Malaysia, the population groups where these behaviours are concentrated include: injecting drug users (IDUs); female sex workers (FSWs), clients of FSWs; men who have sex with men (MSM); and transgender persons (TG). Included within this category, are partners, and spouses of the abovementioned populations as well as any group documented or projected to have HIV prevalence over 5%.

Vulnerable populations refer to persons subject to factors or conditions which increase the possibility of them engaging in risky behaviours. A person vulnerable to HIV can be defined as one who is susceptible to, or unable to protect themselves from, significant harm or exploitation linked with HIV infection. Vulnerable populations include various categories of young people (e.g. out of school youth, children of sex workers and injecting drug users, street children, young people in incarcerated settings, foster care and other institutional settings), migrant workers and refugee populations, and other undocumented persons.

In 2002, it was decided that the existing HIV surveillance system, based on notification of newly diagnosed HIV infection and screening in sub-populations, needed further strengthening, especially to predict the course of the epidemic. The Ministry of Health decided to incorporate the use of behavioural surveillance studies into the existing system. Through discussions and consensus meetings among local experts, it was recommended that monitoring HIV risk behaviour could play a vital role in determining the future direction in the spread of HIV within the different most-at-risk populations. 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.

Figure 3: HIV Prevalence (%) among key at-risk populations (EPP estimates 2011)

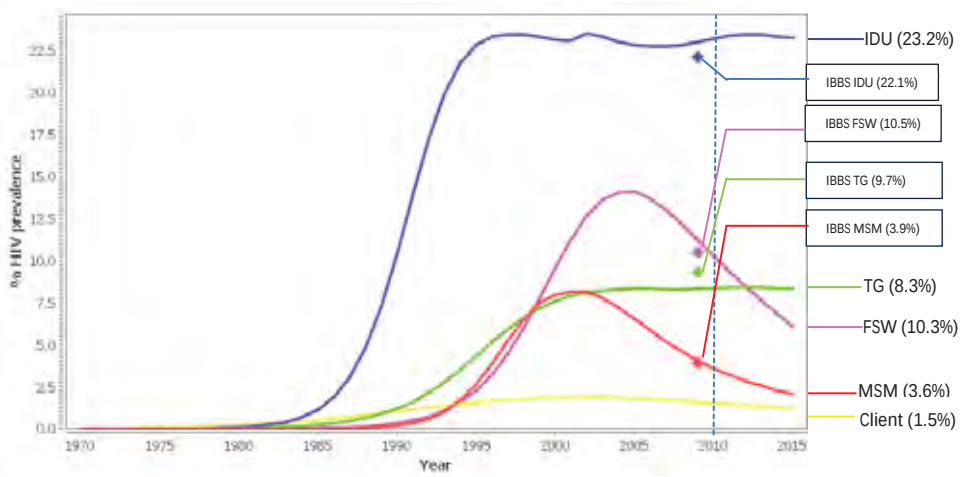


Table 2: Findings from bio-behavioural studies conducted in 2009

Population	Key findings
Injecting drug users (n=630)	HIV prevalence: 22.1% Used sterile injecting equipment: 84%; 27% through outreach programmes Tested and knew results: 33% Sexually active: 50%; Condom use with most recent partner: 28% Paid for sex: 15% Knowledge of modes of HIV transmission: 50%
Female sex workers (n=551)	HIV prevalence: 10.5% Tested and knew results: 20% Condom use with most recent client: 61% Injected drugs: 6% Had sexual partners who injected drugs: 20% Knowledge of modes of HIV transmission: 39% Reached through intervention programmes: 12%
Transgendered (n=540)	HIV prevalence: 9.7% Tested and knew results: 19% Sold sex: 84%; condom use with most recent client: 95% Injected drugs: 3% Had sexual partners who injected drugs: 12% Knowledge of modes of HIV transmission: 37% Reached through intervention programmes: 65%
Men who have sex with men (n=529)	HIV prevalence: 3.9% Condom use: 55-72% More than 6 male partners in the past 6 months: 26% Sex with female partners: 16% Knowledge of modes of HIV transmission: 80%

Source: Ministry of Health (2010). HIV Epidemic in Malaysia. Powerpoint presentation presented by Dr. Shaari Ngadiman, at 1st Consolidation and Consultation Workshop, 5-6 August 2010.

Figure 4 above shows the HIV epidemic in Malaysia is driven by injecting drug use and sexual transmission occurring among MARPs. There is also clear evidence based on operational research that overlapping of injecting drug use and high risk sexual behaviour is occurring resulting in HIV infection between the different populations. Based on the evidence, the government has taken steps towards targeting increasing existing coverage of IDUs under the NSEP programmes. Relevant government healthcare facilities in recent years have also been upscaled the NSEP and MMT programmes thus eventually bringing down the costs of existing IDU related intervention programmes and activities.

The future

Based on recent HIV estimations and projections modelling conducted by the Ministry of Health, sexual transmission of HIV in Malaysia is predicted to be on the rise, while the newer cases of HIV infection through IDU are expected to plateau. The proportion of reported cases attributed to MSM and heterosexual route of transmission is slowly increasing which is consistent with the results of the HIV estimation and projections model for Malaysia, which was tabulated in 2011.

Table 3: Estimates of the Malaysian HIV Epidemic (EPP 2010)

	2010	2015
• **Total People Living With HIV**	**80,922**	**81,946**
Male	65,669 (81.1%)	62,898 (76.8%)
Female	14,739 (18.9%)	19,048 (23.2%)
• **Total new infections/ year**	**7,516**	**6,699**
Male	5,751	4,692
Female	1,766	2,007
• **Total AIDS related deaths/ year**	**6,741**	**6,335**
Male	5,698	5,137
Female	1,042	1,199

Source: National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic (2011)

The key findings from the estimation and projection 2011 (EPP) workshops are as follows:-

1 Since 2008, the estimated number of new HIV infections among IDUs appears stabilized.

2 For every single male detected with HIV, there are two other male cases which would go undetected.

3 The number of AIDS related deaths is expected to decrease in the next 3-5 years, as accessibility to antiretroviral treatment and preventive activities increased.

4 The number of women living with HIV is higher than previously thought. It estimated that there is 1 female newly infected with HIV for every 3 males infected.

5 Revised needs and coverage estimates based on the adoption of WHO's recommended criteria of CD4<350 for ARV treatment initiation, indicate a higher financial allocation is needed for the provision of ARV.

It is expected that the evolving phenomena of the HIV epidemic (particularly that of sexual transmission of the disease), will pose newer challenges for HIV programming taking into consideration Malaysia's cultural and religious context and sensitivities.

2.2 The national policy and programmatic response

The Malaysian HIV response over the past five years has been guided by the *National Strategic Plan on HIV/AIDS 2006 – 2010* which was drafted via multi-sectoral approach incooperating issues ranging from young people's vulnerability to the delivery of healthcare services and ARV treatment. This framework provided a common ground and emphasis on an integrated and comprehensive approach addressing the needs of prevention, treatment, care and support.

As a result of many of the progress and accomplishments made by Malaysia in the duration of the NSP 2006-2010, the country is well on its mark to achieve the sixth goal of the MDG (Millennium Development Goals) within the next five years. There are however, still many challenges which lay ahead, thus maintaining the political support and further up-scaling financial resources are indeed crucial.

2.2.1 *Strengthening the national commitment and supporting the NSP 2006 – 2010***.**

The Cabinet Committee on AIDS (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.

The increase in proportion of female HIV cases in Malaysia over the past five years has made the government to revive the 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 behavioural and socioeconomic factors on the sexual transmission of HIV.

2.2.2 Multi-sectoral engagement in the HIV response

Malaysia has taken the multi-sectoral approach when addressing the issues and challenges on HIV/AIDS. Non-health sectors i.e. the Ministry of Women, Family and Community Development, National Anti Drug Agency (Home Affairs Ministry) Department of *Orang Asli* (Indigenous People) Affairs, the Department of Islamic Development (JAKIM), the Prison's Department, and the Information Ministry now form part of the key stakeholders in the country involved in the national HIV prevention and control programmes. The Ministry of Women, Family and Community Development has been instrumental in improving the overall response especially on matters pertaining to care and support services for PLHIV and those affected.

2.2.3 ARV treatment, resource mobilisation and funding support

The Government has provided an allocation of RM 500 million (USD 143 million) for a period of 5 years during the NSP 2006-2010. This translates to RM 100 million (approximately USD 28 million) yearly which goes towards funding of Government and non-government HIV prevention, care and support programmes.

A bulk of the funds also provides for the provision of ARV treatment for almost 10,000 people living with HIV. During the NSP 2006-2010, two significant achievements have accomplished, firstly, the availability and provision of first line ARV treatment at no cost for those who need it and secondly, the availability of ARV treatment for incarcerated populations specifically for HIV+ prisoners as well as inmates in drug rehabilitation centres. Currently, the second line regime is also heavily subsidised by the government.

2.2.4 The harm reduction programme

The harm reduction programme, comprising the Needle Syringe Exchange Programme (NSEP) and the Methadone Maintenance Therapy (MMT,) remains the cornerstone of the Malaysian Government's HIV prevention strategy. This programme is currently being implemented in partnership with non-governmental organisations (NGOs), community based organisations (CBOs) and private health practitioners. Significant successes which have been attributed with increased sites and clients over the last few years have made this one of the programmes which has managed to get worldwide attention. A number of innovative strategies have been introduced lately i.e. the introduction of the

MMT at National Anti Drug Agency service centres and incarcerated settings specifically prisons. More than 40,000 injecting drug users have been beneficiaries of this programme so far.

2.2.5 PMTCT programme

The prevention of mother-to-child transmission (PMTCT) (prevention of vertical transmission) programme in Malaysia introduced in 1998 is based strongly around ARV prophylaxis for the child, safer delivery and infant feeding practices. It is also depended on detection of HIV infection during the mother's antenatal period. The programme is implemented nationwide since 1998 at government health clinics and hospitals, and incorporates HIV screening utilising an opt-out approach. Although it covers only women receiving antenatal care at these government facilities, it is estimated that over 70% of total antenatal mothers nationwide utilise public antenatal facilities. Antenatal HIV cases from the private sector are also referred to the government medical system.

2.2.6 Mobilisation 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 National Coordinating Committee on AIDS Intervention and the Country Coordinating Mechanism. In the former, civil society is represented by the Malaysian AIDS Council while in the later several representatives (e.g. sex workers, PLHIV and transgender) have been elected onto the CCM by their respective communities.

2.2.7 Engagement with religious leaders

The engagement with and involvement of religious leaders, especially Muslim religious leaders has increased significantly over the past few years. A lot of advocacy and investment in programming was done to mobilise and harness the support of Islamic religious leaders for HIV prevention and the provision of care and support.

Muslim religious leaders have been actively involved in the implementation of HIV awareness programmes and also proactively established care and support facilities from financial and welfare assistance to shelters for Muslim PLHIV. The past 2 years in particular have seen the remarkable development of programmes by the Department of Islamic Development which involve a number of religious bodies engaging most-at-risk populations such as female sex workers and transgender persons through the availability of religious classes.

2.2.8 Increased availability and improvement of quality strategic information

Much progress has been made in understanding the Malaysian HIV epidemic and most at risk populations (MARPs), particularly vulnerability to HIV and STI infection and the need for specific essential services. Much improvement has been achieved in the reporting of UNGASS country progress indicator data as a result of a number of surveys and research studies conducted in the past two years by a number of NGOs working with the Ministry of Health, such as the Malaysian AIDS Council (MAC), PT Foundation (PTF) and Federation of Reproductive Health Associations Malaysia (FRHAM) as well as the involvement of research bodies such as the Centre for Excellence on Research

in AIDS (CERIA). The involvements of these NGOs have complemented the efforts made by the government bodies to produce quality data.

Detailed gender disaggregated data has also recently become available as a result of a revision of the national HIV reporting system and the National AIDS Registry by the Ministry of Health. Analysis of this data is critical to ensure a better understanding of how men and women are vulnerable to HIV infection in Malaysia.

2.3 Key challenges

As a result of the progress made in the NSP, expectations on both Government and civil society have become significantly higher. Much of the challenges are related to sustaining the results of existing HIV prevention, treatment, care and support programmes both financially and programmatically.

2.3.1 The rise in sexual transmission

The rise in sexual transmission would require a further strengthening of commitment from the Government to undertake and improve upon programmes which specifically address the issue of sexual reproductive health, especially among young people. Policy-makers will need to be better informed about the importance of adolescent health and sexual reproductive health, particularly within the context of HIV.

As issues relating to sexuality and young people are often contentious and linked to public morality, thus, making it more essential to further consult and engage religious leaders and other community leaders. The upholding of social and religious values and rulings should take into consideration the realities of an epidemic which is increasingly spread through sexual transmission.

2.3.2 Sustainability of human, financial and infrastructure resources

Concern has been expressed as to whether many of the achievements made in the past few years are financially sustainable due to the sole reliance on public funding. Reaching out to these populations also remains a significant challenge. Over the last decade, the vast majority of prevention programmes involving MARPs by CBOs and NGOs have been heavily funded by the government. As a result, interventions programmes are sometimes confined to certain geographical locations and communities to get the maximum coverage and impact.

Sustainability of funding, and human capacity enhancement in HIV/AIDS prevention programmes especially among the civil society therefore is one of the major concerns for Malaysia and NSP 2011-2015.

2.3.3 Financial cost of providing increased ARV treatment coverage

Revised needs and coverage estimates based on the 2009 adoption of WHO's recommended criteria of CD4<350 for ARV treatment initiation, indicate an increased burden in the provision of ART. This revision of treatment protocol has significantly increased the number of persons estimated to be in

need of treatment. Of major concern for the Government on this issue, is the large financial cost of providing this increased coverage which is expected to cost an estimated RM 60 million annually.

2.3.4 Engaging religious leaders

The engagement of religious leaders from all faiths is expected to play a continued, expanding and critical role over the years in providing complementary care and support services for PLHIV and those affected as well as prevention of sexual HIV transmission. The Government is currently making an effort to expand this engagement to those from non-Muslim faiths. Some of the religious departments e.g. Selangor and Pahang have provision in their enactment to provide deserving PLHIVs *zakat* (tithes). The next few years will probably see more shelter homes being built by the religious departments.

2.3.5 Mobilising MARPs and vulnerable populations to access public HIV healthcare services

Mobilising MARPs, vulnerable populations and related civil society organisations to access and utilise the many available public HIV related healthcare facilities and service points remains an ongoing challenge. Perceived as well as actual occurrences of stigma and discrimination by these communities may act as deterrents and obstacles for them to utilise these facilities. There is also a need for NGOs to be able to work with these public facilities to provide services for vulnerable populations such as former prisoners and drug rehabilitation centres inmates who have been released from such institutions. One of the greatest challenges to date would definitely have to be adhering to ARV treatment.

2.3.6 Stigma and discrimination

Stigma and discrimination continues to be an issue, however it has lessen now. Nevertheless, it not only affects PLHIV but to those around them, and also affect the progress and successful implementation of HIV prevention, treatment, care and support programmes. Vulnerable populations and MARPs may encounter incidences of discriminatory practices in public and private workspaces as well as during the implementation of HIV programmes, which inevitably might complicate the outcomes of impact of such programmes.

2.3.7 Structural challenges

The Ministry of Health and its civil society partners face many challenges in responding to AIDS in the country, some of which are structural in nature. These may affect the implementation of the harm reduction programme as well as interventions with sex workers, transgender persons and MSM programmes. However, in dealing with these issues, government officials and their civil society counterparts have been encouraged to work together. Frequent dialogues and discussions have been held either at the local or national levels to address some of these challenges. A lot more needs to be done to overcome some of these challenges.

2.3.8 More research and studies needed

Strategic information such as behavioural data necessary to plan and implement a comprehensive response to HIV was previously quite limited. Data for these populations on HIV prevalence, profiles of risk behaviour and vulnerabilities were often anecdotal, limited or simply not available. The availability of relevant strategic information has improved tremendously since 2009.

Though there continues to be limited research concerning most-at-risk populations and HIV, the past few years have seen the implementation of a number of behavioural studies and research with these communities. These are still limited in certain geographical locations and must be further expanded to other parts of Malaysia.

CHAPTER 3
The National Strategic Plan on HIV and AIDS 2011 - 2015

The National Strategic Plan on HIV and AIDS 2011 – 2015 runs parallel and is harmonised with the aims and objectives of the 10th Malaysian Plan (10MP) for 2011 – 2015 which guides the development of Malaysia for the next five years as well as the policies outlined under the 1Malaysia initiative related to healthcare.

3.1 Guiding Principles for the National Strategic Plan on HIV and AIDS 2011 – 2015

Malaysia's national multisectoral response to HIV and AIDS is built and guided by the following guiding principles:

3.1.1 The spread of HIV is a challenge to the national development of Malaysia and is a concern to be addressed under the 10th Malaysian Plan and the 1Malaysia initiative.

3.1.2 The HIV and AIDS response will be based on evidence and prioritise interventions among most at risk populations (MARPs) and will also include other populations made vulnerable to HIV infection due to risk behaviours and environment.

3.1.3 The HIV and AIDS response will be comprehensive and focus on promoting healthy practices, disease prevention, as well as treatment, care and support for People Living with HIV and people affected by HIV and AIDS.

3.1.4 The response to HIV and AIDS should take into consideration cultural, religious and societal values.

3.1.5 Government, civil society and private sector stakeholders will work together in multisectoral partnership to respond to the spread of HIV and AIDS in the country. Working in consultation and collaboration with relevant stakeholders, the Government will provide policy direction, HIV treatment for those in need, and financial resources in support of this effort. Civil society, including non-government organisations, community groups, People Living With HIV and those affected by HIV and AIDS, will support and complement the Government in the prevention of HIV, as well as care and support for those living with HIV and those affected.

3.1.6 All stakeholders will work together to create a conducive and enabling environment to ensure the effectiveness of interventions under the HIV response which respect human dignity, gender and sexuality.

3.1.7 Active and meaningful participation of key populations including most at risk communities, People Living with HIV and those affected will be integral to the development, implementation, monitoring and evaluation of all interventions.

3.2 Goal and Specific Objectives

3.2.1 Goal

The National Strategic Plan on HIV and AIDS 2011 – 2015 aims to prevent and reduce the risk and spread of HIV infection, improve the quality of life of People Living with HIV, and reduce the social and economic impact resulting from HIV and AIDS on the individual, family and society.

3.2.2 Specific Objectives

a) To further reduce by 50% the number of new HIV infections (i.e. notification rate of HIV) 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 individual, 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 behaviour for at risk and vulnerable populations.

These objectives can only be meaningfully achieved and sustained under the commitments to Universal Access and the Millennium Development Goals after programmes have achieved 80% service coverage among MARPs where 60% of those covered practice safe behaviours.

3.3 Strategic Targets

It is aimed that by the end of 2015, a 50% reduction of new infections able to be prevented and averted is achieved. Malaysia is currently able to provide Universal Access coverage on a number of limited services related to treatment of HIV and AIDS. However, the National Strategic Plan on HIV and AIDS 2011 – 2015 strives to sustain the progress and achievements made over the past National Strategic Plans on HIV and AIDS. To do so, this National Strategic Plan on HIV and AIDS targets to achieve the following:

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.

3.4 Strategies

The National Strategic Plan on HIV and AIDS 2011 – 2015 is both a continuation and is as a result of the efforts of the previous National Strategic Plan 2006 – 2010. It is a response to the improved understanding and increase in behavioural and surveillance data availability amongst most at risk populations. This National Strategic Plan on HIV and AIDS is also a response to the increasing challenges and issues faced in the Malaysian HIV epidemic. It is intended to be a component within the 1Malaysia framework related to healthcare.

There will be 5 main strategies to be undertaken under this plan, namely:

a) Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations

b) Improving the quality and coverage of testing and treatment

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

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

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

The key stakeholders of the National Strategic Plan will continue to support the government, policy makes and the Ministry of Health in advocating the multisectoral approach on HIV and AIDS issues. For the execution and fulfilment of the strategies to be implemented fully, the commitment and partnership of government, civil society and private sector stakeholders working together in the spirit of consultation and collaboration are crucial.

3.4.1 Strategy 1: Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations

HIV prevention efforts in 2011 – 2015 will 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 most at risk and vulnerable populations and advocacy amongst the most-at-risk youth populations

Strategy 1.1: Prevention of HIV transmission through the sharing of needles and syringes

The primary mode of transmission in Malaysia continues to be through injecting drug use. Sustaining and scaling up of existing comprehensive prevention interventions which includes the harm reduction (needle syringe exchange and methadone maintenance therapy) programme continues to be needed and their coverage increased to include other identified populations.

Key Activities:

a. Build an enabling environment for HIV prevention with IDUs and their partners by mobilizing key stakeholders, including, health care providers, community networks, NGOs, local authorities, and law enforcement.

b. Develop other innovative strategies to address challenges for the delivery of HIV prevention with IDUs.
c. Implement targeted behaviour change approaches for male and female IDUs which emphasize risk reduction and promote safer sexual and risk reduction behaviours.
d. Implement national scale up of HIV prevention with IDUs and their partners including needle and syringe exchange programmes and opioid substitution therapy.
e. Strengthen mechanisms to manage HIV prevention among drug users in prisons and other detention facilities and drug rehabilitation centres.

Strategy 1.2: Prevention of HIV transmission through unprotected sex

Under this strategy addressing sexual transmission of HIV, coverage of interventions is improved upon to encourage barrier methods (e.g. condom use) among MARPs and vulnerable populations; provision of sexual reproductive health (SRH) education and other essential SRH services; encourage behavioural change among MARPs towards safer sexual practices; implementation of programmes which address intimate partner transmission of HIV; encouraging HIV testing through voluntary testing and counselling; and promotion of information and awareness of HIV and STIs through media.

Key Activities:

a. Review existing strategies including awareness programmes and activities to encourage and facilitate behavioural change among MARPs.
b. Build an enabling environment for behavioural change through economic, welfare and religious aid.
c. Raise awareness and build knowledge and awareness on HIV and other diseases (e.g. TB and STIs), among MARPs, married and unmarried couples, and members of most at risk youth and their sexual partners.
d. Improve and strengthen VCT, STI and SRH services to all MARPs, including counselling for married and unmarried couples.
e. Raise awareness and understanding of HIV and STIs, support and promote the appropriate use of condoms and lubricants when engaged in sexual activities, particularly among MARPs, their partners and/or clients.
f. Develop and scale up services on sexual reproductive health, counselling and treatment related to STIs, HIV and AIDS to ensure universal coverage.
g. Expand and scale up HIV prevention programming incorporating a comprehensive package of services for men who have sex with men (MSM) and transgender persons.
h. Strengthen the participation of national and local partners in the provision of HIV prevention programmes targeting migrant workers and refugees.
i. Implement targeted behaviour change communication interventions to promote safer sexual behaviour, address negative gender values, and promote male responsibility for positive health.
j. Develop strategies to address barriers and challenges which prevent the efficient and effective delivery of HIV prevention services to MARPs especially MSM, SW and TGs

Strategy 1.3: Prevention of mother to child transmission

The Prevention of Mother To Child Transmission (PMTCT) programme in government healthcare facilities should be continued including screening, providing treatment, care and support for pregnant women with HIV and their partners/ spouses. More pregnant women will be screened for HIV through integration of PMTCT in antenatal services at public and private health facilities with improved linkages between existing SRH and HIV programmes. The goal would be to eliminate vertical transmission by 2015.

Key Activities:

a. Maintain the provision of quality, comprehensive national PPTCT services, in line with the WHO recommended four pronged strategy, to reach pregnant women, their partners and their infants, including most at risk populations.
b. Strengthen community awareness of HIV to increase enrolment in the PMTCT programme and other related antenatal, family planning, sexual and reproductive health, voluntary confidential counselling and testing services, particularly among most at risk populations.
c. Ensure all HIV-infected pregnant women and their HIV-exposed infants under the PMTCT programme receive ARV treatment/ prophylaxis and breastfeeding education to reduce mother-to-child transmission of HIV.
d. Ensure the availability of PMTCT in all ANC facilities including private health care facilities

3.4.2 Strategy 2: Improving the quality and coverage of testing and treatment

The Government continues to support a decentralised 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 already provides and is committed to affordable access to clinical care through the public health system, including free or subsidized access to ART.

People Living with HIV (PLHIV) in closed settings and those living outside the major cities are of particularly concern and will need to be covered under existing programmes. Stronger linkages and referral systems between HIV and related services such as VCT, tuberculosis (TB), opportunistic infections (OIs), SRH, opioid substitution therapy (OST) and PMTCT will be encouraged. There is also a need to ensure and maintain the quality and sustainability of treatment, care and support services for PLHIV. Positive prevention should also be promoted among those living with HIV.

Key Activities:

a. Ensure adequate number and training of healthcare workers to deliver VCT and ARV and related services.
b. Strengthen priority health services through increased integration of HIV service delivery.
c. Improve coverage and early access to and quality of HIV testing, care and treatment, sexual reproductive health and STI services for most at risk populations and their partners.
d. Increase access and quality of HIV testing and counselling services in the public and private sectors to identify those in need of HIV treatment.
e. Strengthen capacity of VCT related staff.

f. Improve adherence to treatment and detection of treatment failure.

g. Expand routine PICT for pregnant women, TB and STI patients and strengthen linkages from prevention to care and treatment.

h. Develop and scale up care and treatment with anti-retroviral drugs and TB treatment for drug users in prisons and other detention centres.

3.4.3 Strategy 3: Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.

Increasing access and availability of care and support programmes for People Living with HIV (PLHIV) and those affected which address physical, mental, social, spiritual, religious and economical aspects.

Key Activities:

a. Improve coordination, linkages and referral among social, health and community based services at the community level.

b. Strengthen the quality and impact of PLHIV and MARPs support groups and networks.

c. Link PLHIV and their families to existing social support programmes to ensure access to essential services.

d. Increase visibility and meaningful participation and decision making of PLHIV and MARPs in impact mitigation programmes.

e. Provide quality emotional, religious and spiritual support to PLHIV and their families.

3.4.5 Strategy 4: 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 necessary 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.

Key Activities:

a. Ensure HIV issues are mainstreamed into national social development plans and the necessary financial and technical resources are mobilised to support development and implementation of HIV and AIDS plans and programmes.

b. Strengthen capacity of key ministries and other government and civil society stakeholders at the national and local levels to develop and implement targeted evidence-based interventions.

c. Engage law enforcement, healthcare service providers, relevant public officials and civil society stakeholders, to assess and mitigate complications to the national HIV response.

d. Improve the representation, involvement and capacity of civil society, community based organizations and affected population networks in dialogue and decision-making, towards achieving Universal Access and strengthening the national response.

e. Strengthen the work of the private sector among local businesses to promote corporate social responsibility and to establish workplace-based HIV prevention programmes and to address stigma and discrimination in the private sector.

f. Intensify public understanding and awareness of HIV and AIDS through focused communications and integration into community-based HIV education messages.

3.4.6 Strategy 5: Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.

There is a continuous need to improve upon the availability of research, surveillance and bio-behavioural data, and analysis of monitoring and evaluation of HIV programmes to guide and determine policy and programme frameworks for prevention, treatment, care and support.

Key Activities:

a. Develop and strengthen partnerships to plan, coordinate and manage the national monitoring and evaluation, research and surveillance systems.

b. Produce and disseminate timely and high quality data from research, integrated biological behavioural surveillance (IBBS), population size estimations and other studies.

c. Promote the production, dissemination and effective use of strategic information to inform and guide programme and policy decision making.

d. Consolidate and streamline mechanism for data collection from both private and public HC facilities for future planning

CHAPTER 4
Coordination and Implementation

It is necessary to ensure that the implementation of the National Strategic Plan on HIV and AIDS is structured and managed accordingly to facilitate the participation and involvement of relevant stakeholders from government, civil society, the private sector and development partners, and to ensure output of the intended results from the many interventions. Strong governance and coordination of the National AIDS Programme by the Ministry of Health will ensure harmonisation and alignment of all stakeholders involved in the Malaysian AIDS response.

The overarching principle in management of the National Strategic Plan is the *Three Ones Principle* of one national multisectoral strategy, one national coordination platform with a multisectoral mandate and one monitoring and evaluation framework.

4.1 Coordination

NCCAI and NATCA

In 2009, the HIV policy and decision making structure was revised with the intention of streamlining the functions of the different entities involved in HIV policy development.

Under this new revision, the Cabinet Committee on AIDS was restructured and is now known as the *National Coordinating Committee on AIDS Intervention (NCCAI)* chaired by the Minister of Health. The NCCAI functions as the highest decision-making body on HIV and AIDS related policies. Its membership includes all the Secretary Generals of the relevant ministries and agencies listed in the NSP as well as civil society representatives, including the Malaysian AIDS Council.

Figure 4: National HIV and AIDS Policy Framework

Source: Ministry of Health (2009)

The *National Advisory and Technical Committee on AIDS (NATCA)*, is actually a merging of the two bodies present in the previous framework namely, the National Advisory Committee on AIDS and the Technical Committee on AIDS. This committee, which is chaired by the Director General of Health, acts as a high level advisory body to the NCCAI. It provides a forum for discussion of policy issues relevant to increasing the success of Malaysia's response to the HIV epidemic as well as to review progress against the annual work plans and budgets.

The membership of the NATCA is made up of key Ministry officials, subject matter experts, NGO and community representatives and the Director Generals and HIV Focal Points of the Ministries. It meets and reports to the NCCAI.

National AIDS Programme Secretariat

The responsibility for the overall coordination of Malaysia's HIV and AIDS responses is currently tasked to the AIDS/STI Sector of the Disease Control Division, Ministry of Health located in Putrajaya, the Federal Administrative capital of Malaysia. The AIDS/STI Sector is currently functioning as the National AIDS Programme (NAP) Secretariat. 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.

The NAP Secretariat will be strengthened with sufficient resources and capacity to the implementation of the National Strategy on HIV and AIDS 2011 – 2015. It will be responsible for overall coordination, monitoring, evaluation and reporting. This secretariat will continue to strengthen and maintain linkages with state and district authorities through the respective State AIDS Officers build capacity of ministerial AIDS focal points and facilitate information sharing among the different national level committees.

The work of the National AIDS Programme Secretariat is supported by the State AIDS Officers whose tasks are to plan, coordinate, implement and evaluate HIV interventions. The AIDS Officers and the NAP Secretariat are also instrumental and critical in ensuring that HIV prevention, care and support programmes carried out by NGOs, who are recipients of public funds, are harmonised and in line with the identified priorities under the National Strategy on HIV and AIDS.

Country Coordinating Mechanism (CCM)

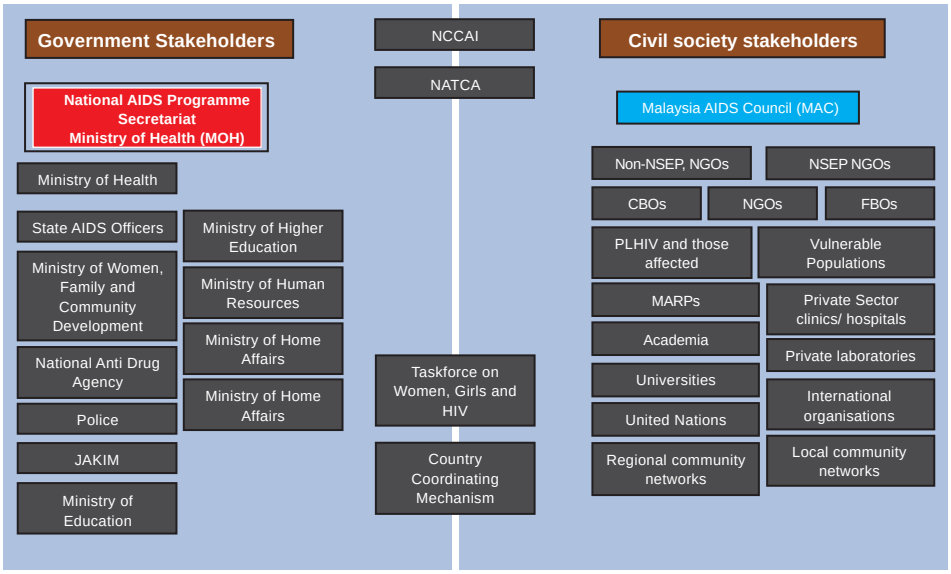
The Country Coordinating Mechanism, chaired by the Deputy Minister of Health, provides governance for all programmes and activities related to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) in Malaysia. This mechanism operates concurrently and complements the work of the NATCA.

Taskforce on Women, Girls and HIV/AIDS

The Government established the Taskforce on Women, Girls and HIV/AIDS as a response to the increase in the number of female HIV cases and in incidences of sexual HIV transmission. This taskforce is spearheaded by the Ministry of Women, Family and Community Development and is tasked to guide the actions of the Government in its response to

addressing the abovementioned situation as well as the behavioural and socioeconomic factors behind the sexual transmission of HIV.

Figure 5: Stakeholders in the Malaysian HIV response



Civil society

The Malaysian AIDS Council (MAC) was initially established in 1992 by the Ministry of Health and serves as an umbrella organisation to support and coordinate the efforts of partner organisations working on HIV and AIDS issues in Malaysia. In partnership with government agencies, private sectors and international organisations, MAC works towards ensuring a committed and effective response by NGOs working on HIV and AIDS issues. Most of the public funds for use by non-governmental organisations working on HIV and AIDS projects are channelled through and coordinated by the MAC.

The MAC facilitates the collaboration with civil society organisations in the implementation of the National Strategy on HIV and AIDS. Consultative mechanisms such as CSO stakeholder meetings at the national level will be established in an effort to seek a wide variety of viewpoints from the different at risk and vulnerable communities which would help streamline Malaysia's response to HIV and provide input towards the implementation and evaluation of the National Strategy on HIV and AIDS.

4.2 Implementing the National Strategic Plan

Priority Setting

Priority setting is a key task in the management of the National Strategy on HIV and AIDS and will be guided by further improvements in the availability and use of strategic information. The priorities set in the National Strategy on HIV and AIDS will be reviewed regularly, as part of the monitoring and evaluation arrangements described in Chapter 6.

Effective resource tracking system will be put in place to provide information and feedback concerning the alignment of resource allocations to agreed priorities. The collection, storage and sharing of strategic information and the need for a resource tracking system is addressed under Strategy 5.

Development of the 2011 – 2012 and 2013 – 2015 workplans

Two set of workplans based on clear and evidence driven national priorities will be developed to guide the implementation of the National Action Plan on HIV and AIDS 2011 – 2015 and will cover the periods of 2011 – 2012 and 2013 – 2015. These workplans will be used to detail the activities to be conducted and to guide decision making in resource allocation of public funds. These activities must be clear, action and results oriented, and targeted which will translate strategic priorities to operational realities. The development of the 2013 – 2015 workplan will also be guided by the outputs from the mid-term review of the NSP. The workplans of other individual stakeholders involved in the HIV response will be complementary to those mentioned above.

Given its role in monitoring and evaluation as well as resource tracking, the National AIDS Programme Secretariat will play a central role in priority setting and the development of the workplans. The Secretariat will facilitate this process through the supporting of relevant partnership and stakeholder forums and technical working groups. It will collect, analyse and provide the strategic programmatic and financial information that is needed to inform the priority setting process.

For specific components of the National Action Plan on HIV and AIDS, relevant Ministries and organisations will collaborate through technical working groups established for specific issues and population groups. The work of the individual Ministries and organisations will contribute towards the implementation of components of the National Strategic Plan and towards the achievement of agreed expected results and targets.

CHAPTER 5
Resource Mobilisation

Over the next five years, it will be important to advocate for sustained domestic commitment to fund the national response to HIV and AIDS. Resource allocations will need to be aligned to the priority areas and programmes identified in the National Strategic Plan on HIV and AIDS and National Action Plan on HIV and AIDS.

The National AIDS Programme Secretariat will track the variety and amount of resources allocated to the National Strategy which will provide crucial information on whether the existing allocation of funding is aligned with agreed national priorities. Such a system will highlight areas where insufficient resources are being allocated and experiencing gaps in funding.

The provision of necessary and adequate resources and technical assistance will be needed for the next five years to further strengthen organisational and human capacity for HIV programmes to be sustained and to build upon the progress and results obtained from the previous National Strategic Plan.

5.1 Estimating the resources needed

The resources required to achieve the NSP coverage and impact goals needs to be calculated 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. Coverage 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.

A number of assumptions have been made, which the cost estimates are based on i.e.:-

a) Population sizes: The population sizes are estimated based on size estimation studies. Particular populations such as MSM and clients of sex workers are extremely difficult to reach and therefore to estimate their sizes.

b) Target setting: Targets to be reached are based on perceived implementation capacity which varies according to the different implementing partners.

c) Unit costs: these are the main assumptions for calculation of total costs; As the same programme and interventions might have several unit costs depending on the geographical location, the unit costs indicated are the average value.

d) Overhead and management costs: these costs are not fully represented in the unit costs as they differ according to the programmes and activities involved.

5.2 Sources of funding

A bulk of the allocation from the previous NSPs was spent on the provision of HIV treatment and involved funding of HIV NGO prevention programmes which were small scale and with limited coverage. A three-fold increase in this allocation, now totalling RM 100 million (approximately USD 32 million) per annum, was made available to both government agencies and civil society organisations for the past five years (2006 – 2010) in support of implementation of the NSP. With an annual budget of RM 100 million allocated to it, the allocation provided by the Government utilising public funds to the national HIV programme currently translates to approximately RM 3.1 (USD 1) per capita.

In 2008, total AIDS expenditure was approximately RM 86.6 million, 96.95% was financed by Government funding and 3.05% by the private sector and international sources. In 2009, expenditure increased by RM 8.6 million.

Regarding sources of financing for HIV programmes, as indicated in the table below, in 2008 and 2009, the domestic public funding from the Government shouldered most of the AIDS related expenditure, whereas international and private sector contributions resources contributed to less than 3%.

Table 4: Source of approximate AIDS expenditure 2008 – 2009

Source of Funding	Year 2008 (RM)	%	Year 2009 (RM)	%
Domestic Public	83 993 000	96.95	92 661 000	96.71
Domestic Private	1 619 000	1.87	1 629 000	1.70
International	1 020 000	1.18	1 520 000	1.59
Total	**86 632 000**	**100.0**	**95 810 000**	**100.0**

Source: UNGASS Country Progress Report (Malaysia) 2008 & 2010

Government funding is channelled from the Ministry of Finance to the Ministry of Health which disburses the funds to other government ministries and departments. The other Ministries are also able to provide funding for their own HIV related programmes utilising their individual budgets. The government is committed to subsidise ARV for PLHIV either in institutionalised settings or otherwise, HIV screening programmes and activities either at the Primary Care Levels (VCT, PPCT, pre-marital HIV screening, STI patients) or secondary levels.

In the case of NGO related programmes, the MOH uses the Malaysian AIDS Council as a conduit for channelling the necessary public funds to the individual NGOs. Currently, a lot of HIV prevention and control programmes and activities are channelled to MAC namely the NSEP for IDUs and intervention programmes for MARPs (sex workers, MSM, transgender).

CHAPTER 6
Monitoring and Evaluation

In line with the *Three Ones Principle*, implementation of the National Strategic Plan will be monitored and evaluated through the national HIV monitoring and evaluation framework, which is coordinated by the National AIDS Programme Secretariat.

Information gathered from national monitoring and evaluation of HIV and AIDS programmes will be used to:

a) Ensure HIV and AIDS prevention programmes achieve high levels of accountability and efficiency

b) Inform and help determine whether programme up scaling or expansion is required

c) Allow corrective or remedial action to be taken

d) Provide information and data which is beneficial for the implementation of the programme and serve as input for the design of future programmes.

e) For the purpose of reporting on international commitments such as UNGASS reporting, Universal Access and the MDGs.

Partners involved in the implementation of the National Strategic Plan will continue to operate their own systems for programme monitoring and evaluation. The national monitoring and evaluation framework system (M&E), as outlined by the NSP 2011-2015 will consolidate information that is generated by the government and other key stakeholders. Expected results and targets will be monitored and evaluated periodically.

6.1 Programme Coverage

It is aimed that by 2015, coverage of programmes reaching out to most at risk populations will be at 80%. To achieve the targets of Universal Access by that year, as shown in Table 5, the programme coverage targets are determined accordingly to ensure that MARPs and PLHIVs are able to access prevention, treatment, care and support services needed.

Therefore, in general by 2015, it is aimed that 80% of injecting drug users are able to be reached by the harm reduction programme (MMT and NSEP) of which 60% of them would consistently not be sharing needles; 60% of key most at risk populations would consistently be using condoms; 60% of all PLHIV in need of and eligible for treatment are able to access ARV.

Table 5: Programme coverage targets (2010 & 2015)

Population	Est. no. (as of 2010)	Baseline 2010		2011		2012		2013		2014		2015	
		Actual	%	No.	%	No.	%	No.	%	No.	%	No.	%
IDU	170 000[1]	21 559	13%	34 000	20%	51 000	30%	85 000	50%	119 000	70%	136 000	80%
Female sex workers	60 000[2]	18 000	30%	25 200	40%	31 500	50%	37 800	60%	44 100	70%	50 400	80%
Transgender persons	5 000[3]	1 500	30%	2100	40%	2 625	50%	3 150	60%	3 675	70%	4 200	80%
MSM	173 000[4]	6 000	3.5%	36 330	20%	54 495	30%	90 825	50%	127 155	70%	145 320	80%
Clients of sex workers	845 000[5]	-	-	17 745	2%	44 363	5%	88 725	10%	133 088	15%	177 450	20%
Intimate partners of at risk populations*	Data not available. To be estimated	-	-	TBD	5%	TBD	10%	TBD	15%	TBD	20%	TBD	30%
Mothers needing PMTCT	410[6]	171	42%	450	100%	450	100%	460	100%	470	100%	490	100%
PLHIV (Eligible: CD4 <350)	26 722[7]	9 962	37%	15 567	50%	21 794	70%	24 907	80%	28 021	90%	31 134	100%

*Estimation exercise to be conducted

6.2 Monitoring and Evaluation Process

Monitoring and evaluation will be utilising a process which is able to capture and evaluate various levels of programme implementation, from input, activities, output to impact. All stakeholders involved in the response to HIV in Malaysia are contributors to the various indicators and are equally responsible to ensure that they are regularly monitored and utilised to measure progress.

The National AIDS Programme Secretariat is given the responsibility to monitor and evaluate the overall HIV/AIDS framework. The NAP Secretariat is also empowered to ensure that all relevant stakeholders report to the Secretariat on specific indicators as necessary.

[1] Malaysian AIDS Council (2010) *Integrated Bio-Behavioural Surveillance (IBBS) survey with IDUs, SW, TG*. Powerpoint presentation. Presented on 11 March 2010

[2] Lim Hock Eam, Ang Chooi Leng and Teh Yik Koon (2010). *Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work.* UNFPA Project

[3] Malaysian AIDS Council (2010) *Integrated Bio-Behavioural Surveillance (IBBS) survey with IDUs, SW, TG*. Powerpoint presentation. Presented on 11 March 2010

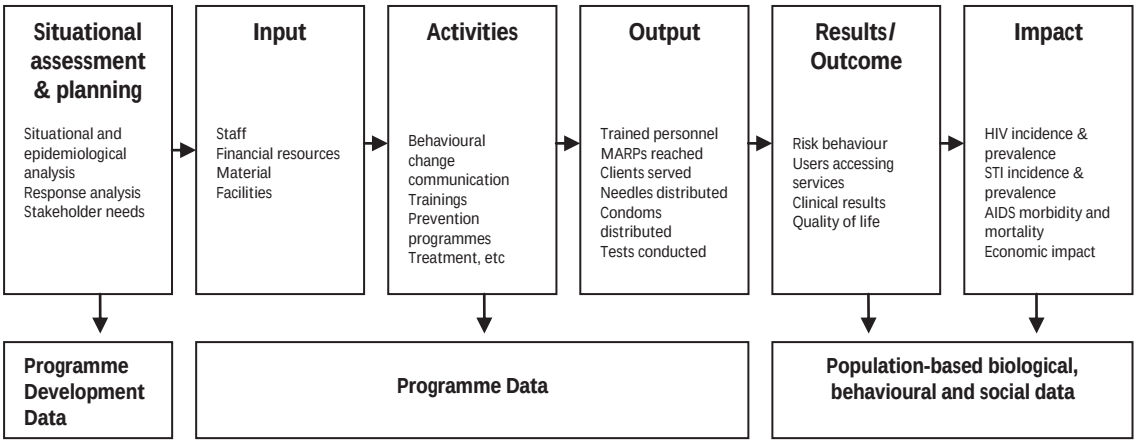
[4] Kanter J, Koh C, Kiew R, Tai R, Izenberg J, Razali K and Kamarulzaman A (2009). Abstract: *Risk Behaviour and HIV Prevalence among MSM in a Predominantly Muslim and Multi-Ethnic Society: A Venue-Based Study in Kuala Lumpur, Malaysia*.

[5] Ministry of Health and World Health Organisation (2009). National Consensus Workshop on Estimation and Projection of the Malaysian HIV Epidemic. Revised version 20th March 2011.

[6] Ibid

[7] Ibid

Figure 7: Monitoring and Evaluation Process



Adapted from 'Rugg et al (2004). Global advances in HIV/AIDS monitoring and evaluation. New directions for Evaluation. Referenced within 'UNAIDS (2007). A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations. ', page 13

The overall monitoring and evaluation framework for the National Strategic Plan on HIV and AIDS can be found in Annex 3, and provides a detailed account of the various indicators, method of measurement and the stakeholder responsible for each individual indicator.

This process of information and data gathering for monitoring and evaluation is best illustrated in Figure 7 above.

6.3 Data Collection

The NAP Secretariat will work with Ministries in the Government and civil society organisations to conduct national monitoring and evaluation. Utilising strategic information gained from the framework, the NAP Secretariat will be able to evaluate the existing response as well as determine areas needing improvement or change.

6.3.1 *Surveillance*

The responsibility of HIV surveillance is with the AIDS/STI Sector of the Ministry of Health. A number of surveillance related activities will be needed, namely:

(a) HIV sentinel surveillance

The Ministry of Health conducts ongoing sentinel surveillance covering different populations including injecting drug users, sex workers, pregnant women, and many others.

(b) National AIDS Registry

The Ministry of Health established the National AIDS Registry (NAR) in 2009. Intended to replace the existing surveillance system, the Internet-based registry is designed to function as a more streamlined and effective national HIV programme monitoring mechanism able to capture detailed disaggregated data systematically. The Registry captures data on each HIV

patient relating to their socioeconomic background, status of HIV treatment and background information

(c) Integrated bio-behavioural surveillance (IBBS)
Periodic IBBS will be conducted with most at risk populations in different states as needed.

(d) Other strategic information needed
Other strategic information needed and currently being developed are the ARV resistance surveillance, estimation of MARPs, PLHIVs, etc. Such information will to be developed with the universities, institutions and international agencies to have a more meaningful data collection and future projections.

Other data sources:

- Mapping of Most-At-Risk Populations
- Monitoring of programme coverage
- Monitoring of prevention services
- Monitoring of behavioural change communication programmes
- Monitoring of treatment services
- Monitoring of impact mitigation services
- Various researches, especially operational research needed to increase the effectiveness of prevention, treatment, care and support programmes.

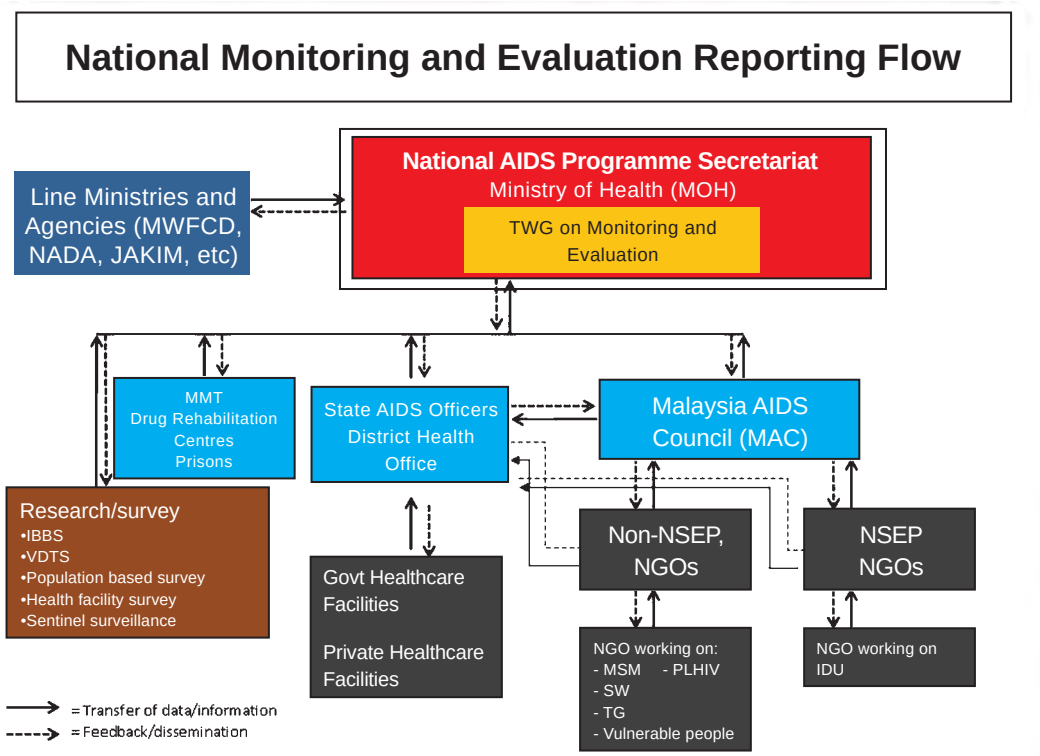
6.4 Monitoring and Reporting Structure

Horizontal working relationships between government and non-government agencies at the state level are critical to ensure that there is appropriate programme monitoring at both operational programme and national levels.

The National HIV and AIDS Monitoring, Evaluation and Reporting Guidelines that will be produced and used as the basis for monitoring and evaluation in respect of the implementation of the National Strategic Plan on HIV and AIDS 2011 – 2015. These guidelines will kept as simple and practical as possible so as to allow monitoring, evaluation and reporting to be properly carried out. The dissemination of these guidelines, and the provision of training on how they should be used, will be initiated so that monitoring, evaluation and reporting will be optimized at all levels.

A Technical Working Group on Monitoring and Evaluation (TWG-M&E) chaired by the Monitoring and Evaluation Unit of the National AIDS Programme Secretariat is proposed to lead on the HIV programme performance reviews conducted at the National level. This provides an opportunity for a strengthening of the Secretariat's own technical capacity as well as those of the relevant and involved ministries and civil society organisations.

Figure 8: Monitoring and Evaluation Reporting Structure



6.5 Progress Monitoring and Evaluation

Progress monitoring and evaluation are conducted utilising a joint government and civil society periodic performance review which should be conducted at both state and national levels. The intention of the performance reviews is to evaluate progress based on coverage, effectiveness and sustainability of programmes.

6.5.1 *HIV programme performance review (State level)*

The frequency of the state level HIV programme review should be every 4 months with the State AIDS Officers and the State Health Department taking the lead. The review will be conducted with government and civil society organisations responding to HIV at the state level.

6.5.2 *Annual Progress Report*

The National AIDS Programme Secretariat will coordinate and facilitate the preparation of annual progress reports and the Work Plans through the national HIV programme performance review, which will be discussed and finalised as part of the annual joint stakeholder meeting held in October. The inputs of the annual progress reports will also be based on the HIV programme performance review conducted at the State level.

The annual progress report will provide information on the progress made in implementing the Work Plan. Based on programme monitoring data that is routinely collected by the National AIDS Programme Secretariat and the Malaysian AIDS Council, an assessment is made whether planned activities have been implemented and whether planned outputs and expected results have been achieved.

The annual progress report will also be based on the indicators and targets agreed in the M&E framework, which includes core indicators (see Annex 3). Based on data collected by the National AIDS Programme Secretariat and the Malaysian AIDS Council, and stored in a centralised database, an analysis will be made concerning the progress made in achieving the agreed targets for these core indicators.

Finally, the annual progress report will include an analysis of most recent surveillance data as well as data from other recent surveys in order to assess changing and emerging epidemiological trends.

Based on the results and findings of the assessments presented in the annual progress report, the National AIDS Programme Secretariat, in close consultation with its partners, will prepare or revise the Work Plan for the coming years.

6.5.3 *Mid Term Review*

A mid-term review of the implementation of the National Strategic Plan is planned to take place in 2013. It will review progress made in the first two years of the NSP. The review will be discussed in a joint stakeholder meeting, with the aim of reaching consensus on:

(a) Progress made in the implementation of the national response as agreed in the current National Strategic Plan

(b) The direction and scope of future implementation of the response to HIV and AIDS.

6.5.4 *Final Review and Impact Evaluation*

A final evaluation of the National Strategic Plan will take place in the second half of 2015. The final evaluation will assess whether expected results and targets have been achieved, through the analysis of available data to measure outcome and impact and a comparison with baselines values for these core indicators.

The final evaluation will not only assess effectiveness of individual programmes and of the overall national response, but will also take into consideration the quality and efficiency of programmes and interventions.

6.5.5 *HIV and AIDS Research*

Monitoring and evaluation of the National Strategic Plan will also require data collected through research, including regular surveys. Research, as indicated in Strategy 5 of the National Strategic Plan on HIV and AIDS, compliments monitoring and evaluation by building a knowledge base which will guide the national response. Thematic research will be needed in order to better understand

underlying causes, dynamics and impacts of the epidemic, such as epidemiological trends, new and emerging areas of concern and a better understanding of vulnerability and long-term consequences of the epidemic.

It is therefore envisaged that:

(a) Appropriate research is conducted which is clear and current to support the broader picture of AIDS alleviation, amongst the various MARPs and vulnerable populations.

(b) There is better access to and resource mobilisation of funding for research.

(c) There is a systematic management and sharing of research data put into place to ensure that findings are used to improve the response to the HIV epidemic.

Annex 1:

Framework for the National Strategic Plan on HIV and AIDS 2011 – 2015

Strategies	Target Populations	Rationale	Key Activity
Strategy 1: **Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations**	Most at risk and vulnerable populations	HIV prevention efforts in 2011 – 2015 will focus on two primary prongs of HIV transmission: • Sharing of needles and syringes through injecting drug use • Unprotected sexual intercourse	
1.1 Prevention of HIV transmission through the sharing of needles and syringes	IDUs	Primary mode of transmission in Malaysia continues to be through injecting drug use. Sustaining and scaling up of a more comprehensive programme covering the harm reduction (needle syringe exchange and methadone maintenance therapy) programme continues to be needed. Increased coverage to include: • Fishermen and other mobile populations • Populations in closed settings • At risk youth • Women and transgender persons	• Build an enabling environment for HIV prevention with IDUs and their partners by mobilizing key stakeholders, including, health care providers, community networks, NGOs, local authorities, and law enforcement • Develop strategies to address barriers and challenges which prevent the efficient and effective delivery of HIV prevention with IDUs. • Implement targeted behaviour change approaches for male and female IDUs which emphasize risk reduction and promote safer sexual and risk reduction behaviours. • Implement national scale up of HIV prevention with IDUs and their partners including needle and syringe exchange programmes and opioid substitution therapy. • Strengthen mechanisms to manage HIV prevention among drug users in prisons and other detention centres.

Strategies	Target Populations	Rationale	Key Activity
1.2 Prevention of HIV transmission through unprotected sex	Sex workers, at risk youth, men who have sex with men, migrants, refugees, sexual partners of IDUs, female sexual partners of MSM, clients of sex workers, transgender persons Sexual partners of MARPs	Improving coverage of interventions which: • Encourage behavioural change among MARPs • encourage condom use among MARPs • provide sexual reproductive health education and other SRH services • address intimate partner transmission of HIV • encourage HIV testing through VCT • promote information and awareness of HIV and STI through media and means which are accessible and friendly to most at risk populations. By 2015, achieved 80% service coverage among most at risk populations where 60% of those covered practice safe behaviours.	• Review existing strategies including awareness programmes and activities to encourage and facilitate behavioural change among MARPs. • Build an enabling environment for behavioural change through economic, welfare and religious aid. • Raise awareness and build knowledge and awareness on HIV and other diseases (e.g. TB and STIs), among MARPs, married and unmarried couples, and members of most at risk youth and their sexual partners. • Improve and strengthen VCT, STI and SRH services to all MARPs, including counselling for married and unmarried couples. • Raise awareness and understanding of HIV and STIs, support and promote the appropriate use of condoms and lubricants when engaged in sexual activities, particularly among MARPs, their partners and/ or their clients. • Develop and scale up services on sexual reproductive health, counselling and treatment related to STIs, HIV and AIDS to ensure universal coverage. • Expand and scale up HIV prevention programming incorporating a comprehensive package of services for men who have sex with men (MSM) and transgender persons. • Strengthen the participation of national and local partners in the provision of HIV prevention programmes targeting foreign migrant workers and refugees. • Implement targeted behaviour change communication interventions to promote safer

Strategies	Target Populations	Rationale	Key Activity
			sexual behaviour, address negative gender values, and promote male responsibility for positive health. • Review existing policies and develop strategies to address barriers and challenges which prevent the efficient and effective delivery of HIV prevention services to MARPs especially MSM, SW and TGs.
1.3 Prevention of parent to child transmission (PPTCT)	Married and unmarried pregnant mothers, women of reproductive age	The PPTCT programme in government healthcare facilities continues to be needed to screen and provide treatment, care and support for pregnant women with HIV and their partners/ spouses. More pregnant women will be screened for HIV through integration of PPTCT in antenatal services at public and private health facilities with improved linkages between existing SRH and HIV programmes. The goal would be to eliminate incidences of vertical transmission by 2015.	• Maintain the provision of quality, comprehensive national PPTCT services, in line with the WHO recommended four pronged strategy, to reach pregnant women, their partners and their infants, including most at risk populations. • Strengthen community awareness of HIV to increase enrolment in the PPTCT programme and other related antenatal, family planning, sexual and reproductive health, voluntary confidential counselling and testing services, particularly among most at risk populations. • Ensure all HIV-infected pregnant women and their HIV-exposed infants under the PPTCT programme receive ARV treatment/ prophylaxis and breastfeeding education to reduce mother-to-child transmission of HIV. • Ensure the availability of PPTCT in all ANC facilities including private health care facilities
Strategy 2: **Improving the quality and coverage of testing and treatment.**	PLHIV (adults and children) and those affected	The Government continues to support a decentralised approach to health services which includes community-based and primary health care through to hospital-based care. It provides psychosocial support including VCT, nutritional support and treatment for common	• Ensure adequate number and training of healthcare workers to deliver VCT and ARV and related services • Strengthen priority health services through increased integration of HIV service delivery. • Improve coverage and early access to and quality of

Strategies	Target Populations	Rationale	Key Activity
		opportunistic infections. Malaysia already provides and is committed to affordable access to clinical care through the public health system, including free or subsidized access to ART. People Living with HIV in closed settings and those living outside the major cities are of particularly concern. Stronger linkages and referral systems between HIV and related services such as VCT, TB, OI, SRH, OST and PPTCT will be needed. There is also a need to ensure and maintain the quality and sustainability of treatment, care and support services for PLHIV. Positive prevention should also be promoted among those living with HIV Service coverage is aimed to be 80% of those estimated to be eligible for treatment.	HIV testing, care and treatment, sexual reproductive health and STI services for most at risk populations and their partners. • Increase access and quality of HIV testing and counselling services in the public and private sectors to identify those in need of HIV treatment • Strengthen capacity of VCT related staff. • Improve adherence to treatment and detection of line treatment failure • Expand routine PICT for pregnant women, TB and STI patients and strengthen linkages from prevention to care and treatment. • Develop and scale up care and treatment with anti-retroviral drugs and TB treatment for drug users in prisons and other detention centres.
Strategy 3: **Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.**	PLHIV (adults and children) and those affected	Increasing access and availability of care and support programmes for People Living with HIV and those affected which address physical, mental, social, spiritual, religious and economical aspects.	• Improve coordination, linkages and referral among social, health and community based services at the community level. • Strengthen the quality and impact of PLHIV and MARPs support groups and networks. • Link PLHIV and their families to existing social protection programmes to ensure access to essential services. • Increase visibility and meaningful participation and decision making of PLHIV and MARPs in impact mitigation programmes.

Strategies	Target Populations	Rationale	Key Activity
			• Provide quality emotional, religious and spiritual support to PLHIV and their families. • Strengthen the role of community and home based care to support positive prevention and linkages to TB and SRH services.
Strategy 4: **Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.**	All	Prevention and treatment programmes are more effective when operating in an enabling environment that does not stigmatise and discriminate against those most at risk and those affected. Creating and maintaining a better understanding of HIV to reduce stigma and discrimination. Establish and maintain an enabling public policy and legal environment that will help to reduce HIV stigma and discrimination and is supportive to HIV programmes and interventions respecting human dignity, gender and sexuality	• Ensure HIV issues are mainstreamed into national social development plans and the necessary financial and technical resources are mobilised to support development and implementation of HIV and AIDS plans and programmes. • Strengthen capacity of key ministries and other government and civil society stakeholders at the national and local levels to develop and implement targeted evidence-based interventions. • Engage law enforcement, healthcare service providers, relevant public officials and civil society stakeholders, to assess and mitigate complications to the national HIV response. • Improve the representation, involvement and capacity of civil society, community based organizations and affected population networks in dialogue and decision-making, towards achieving Universal Access and strengthening the national response. • Strengthen the work of the private sector among local businesses to promote corporate social responsibility and to establish workplace-based HIV prevention programmes and to address stigma and discrimination in the private sector. • Intensify public understanding and awareness of HIV and AIDS through focused communications and

Strategies	Target Populations	Rationale	Key Activity
			integration into community-based HIV education messages.
Strategy 5: **Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.**	All	The availability of research, surveillance and bio-behavioural data, and analysis of monitoring and evaluation of HIV programmes is improved upon and used to guide and determine policy and programme frameworks for prevention, treatment, care and support.	• Develop and strengthen partnerships to plan, coordinate and manage the national monitoring and evaluation, research and surveillance systems. • Produce and disseminate timely and high quality data from research, integrated biological behavioural surveillance (IBBS), population size estimations and other studies. • Promote the production, dissemination and effective use of strategic information to inform and guide programme and policy decision making. • Consolidate and streamline mechanisms for data collection from both private and public HC facilities for future planning

Annex 2:

National Action Plan on HIV and AIDS 2011 – 2015

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
Strategy 1: Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations			
1.1 Prevention of HIV transmission through the sharing of needles and syringes			
• Build an enabling environment for HIV prevention with IDUs and their partners by mobilizing key stakeholders, including, health care providers, community networks, NGOs, local authorities, and law enforcement	PDRM, AADK, MOH, JAKIM, MAC,	• All districts which implement harm reduction programmes will have harm reduction committees involving law enforcement officers.	• Sustain ongoing advocacy with government bodies and civil society organisations at state and national levels • Engagement with print and electronic mass media on IDU issues.
• Develop strategies to address barriers and challenges which prevent the efficient and effective delivery of HIV prevention with IDUs.	PDRM, AADK, MOH, JAKIM, MAC	• Identified barriers and challenges have been significantly reduced or removed.	• Engage decision and policy makers, community groups and media on IDU related issues including needle syringe exchange, treatment, rehabilitation and community support.
• Implement targeted behaviour change approaches for male and female IDUs which emphasize risk reduction and promote safer sexual and risk reduction behaviours.	AADK, District Health Offices, Religious Department	• 60% of male and female IDUs report not sharing injecting equipment. • 60% of sexually active male and female IDUs adopt safer sex behaviour (i.e. using condoms)	• Upscale coverage of existing IDU and SRH programmes to achieve improvement in HIV knowledge and understanding, risk assessment and ability to access services such as NSEP, MMT, condoms and lubricants as well as information for HIV prevention of IDUs and their partners.
• Implement national scale up of HIV prevention with IDUs and their partners including needle and syringe exchange programmes and opioid substitution therapy.	MOH, AADK, MAC, Private Drug Rehab Centres	• Each district government health clinic is able to provide harm reduction services. • Increase in the number of NGOs able to provide NSEP services.	• Upscale coverage of existing NSEP and MMT programmes with government healthcare clinics and NGOs. • Increase the number of access points for MMT with private healthcare services..

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
		• Waiting list should not be more than one month.	
• Strengthen mechanisms to manage HIV prevention among drug users in prisons and other detention centres.	PUSPEN, Prisons Department, PDRM	• MMT is available in 18 prisons and 24 drug rehabilitation centres (PUSPEN).	• Upscale existing MMT programme covering incarcerated settings. • Linkage of former detainees with post-release services (counselling, MMT, treatment and support groups)
1.2 Prevention of HIV transmission through unprotected sex			
• Review existing strategies including awareness programmes and activities to encourage and facilitate behavioural change among MARPs.	MOH, relevant Ministries, MAC, NGOs	• Review and reforms of HIV programmes and other relevant interventions have been conducted.	• Establish national multi stakeholder Working Group with a mandate to review existing HIV programmes and provide recommendations for reform. • Identify and integrate best practices for HIV prevention programmes with sex workers, their partners and clients.
• Build an enabling environment for behavioural change through economic, welfare and religious assistance.	KPWKM, JAKIM, KKLW, MAC	• Programmes are available to address vulnerabilities linked to socioeconomic factors and gender (e.g. poverty and single mothers)	• Establish livelihood, life skills and welfare community programmes to address poverty and the needs of low income populations. • Establish partnership with government and civil society stakeholders on the issues of socioeconomic disparity, gender and HIV.
• Raise awareness and build knowledge of HIV and other diseases (e.g TB and STIs), among MARPs, married and unmarried couples, and members of most at risk youth and their sexual partners.	MOH, KPWKM, MAC, NGOs, Media	• Mapping, size estimate and sociobehavioural studies for each MARPs have been done at least once.	• Conduct mapping, size estimation and IBBS exercises with each MARPs and identified vulnerable populations. • Disseminate findings from HIV studies to relevant government and civil society stakeholders to assist

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
			in addressing issues of socioeconomic disparity, gender based violence and HIV vulnerability.
• Improve and strengthen VCT, STI and SRH services to all MARPs, including counselling for married and unmarried couples.	MOH, KPWKM, MAC, NGOs, JAKIM	• 50% of public healthcare facilities have a person trained in post basic counselling. • 100 facilitators trained in VCT are available across the country • 15 Family Health Clinics (FHC) able to provide comprehensive VCT, STI and SRH services which are MARP friendly. • Community run facilities based on the PBKS model are established in 3 states with the highest incidence of HIV.	• Conduct training of VCT facilitators and other service providers from NGOs and government healthcare facilities to be equipped to integrate HIV into SRH services and to provide VCT and SRH services based on the 3C principles (counselling, consent and confidential). • Identify and engage, at least one FHC in each state to collaborate with a qualified NGO to provide comprehensive MARP friendly VCT, STI and SRH services. • Maintain existing NGO run VCT facilities to complement the Government's network of healthcare facilities providing similar services.
• Raise awareness and understanding of HIV and STIs, support and promote the appropriate use of condoms and lubricants when engaged in sexual activities, particularly among MARPs, their partners and/ or clients..	MOH, KPWKM, MAC, NGOs	• 80% of MARPs are reached by a comprehensive HIV programme. • 60% of MARPs , their partners or clients of sex workers use a condom during sexual intercourse. • NGOs are capable of designing and conducting evidenced based outreach programmes covering Peninsular and East Malaysia.	• Promote HIV prevention and behaviour change, such as safer condom use through antenatal clinics, other health services and NGO facilities such as the *Pusat Bantuan Khidmat Sosial* (PBKS) which are most often used by most at risk populations • Identify and develop the capacity of relevant NGOs to design and conduct evidenced based outreach programmes which include risk assessment, safer sex kits and targeted IEC materials.
• Develop and scale up services on sexual reproductive health, counselling and treatment related to STIs, HIV and AIDS	MOH, MAC, NGOs	• A comprehensive minimum package of services for MARPs has been developed and deployed.	• Upscale coverage of existing HIV and SRH services and programmes in government healthcare centres and NGOs.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
• Strengthen the participation of national and local partners in the provision of HIV prevention programmes for refugees.	UNHCR, MOH	• HIV prevention programmes are available for refugees. • 80% of refugees reached by HIV prevention programmes and 60% practice safer sex behaviour.	• Develop a minimum standard package of HIV prevention services for refugees. • Initiate and strengthen existing HIV programmes for refugees utilising the minimum standard package of HIV prevention services.
• Strengthen the participation of national and local partners in the provision of HIV prevention programmes for refugees.	UNHCR, MOH	• HIV prevention programmes are available for refugees. • 80% of refugees reached by HIV prevention programmes and 60% practice safer sex behaviour.	• Develop a minimum standard package of HIV prevention services for refugees. • Initiate and strengthen existing HIV programmes for refugees utilising the minimum standard package of HIV prevention services.
• Strengthen the participation of national and local partners in the provision of HIV prevention programmes for refugees.	UNHCR, MOH	• HIV prevention programmes are available for refugees. • 80% of refugees reached by HIV prevention programmes and 60% practice safer sex behaviour.	• Develop a minimum standard package of HIV prevention services for refugees. • Initiate and strengthen existing HIV programmes for refugees utilising the minimum standard package of HIV prevention services.
• Strengthen the participation of national and local partners in the provision of HIV prevention programmes for refugees.	UNHCR, MOH	• HIV prevention programmes are available for refugees. • 80% of refugees reached by HIV prevention programmes and 60% practice safer sex behaviour.	• Develop a minimum standard package of HIV prevention services for refugees. • Initiate and strengthen existing HIV programmes for refugees utilising the minimum standard package of HIV prevention services.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
efficient and effective delivery of HIV prevention services to MARPs especially MSM, SW and TGs		conducted.	address barriers and challenges and provide recommendations for reform. • Develop standard operating procedures on HIV prevention services for most-at-risk young people (18 – 24 years old) and on the testing and treatment for minors.
1.3 Prevention of parent to child transmission (PPTCT)			
• Maintain the provision of quality, comprehensive national PPTCT services, in line with the WHO recommended four pronged strategy to reach pregnant women, their partners and their infants, including most at risk populations.	MOH, Association of Private Hospital/ Federation of General Practitioners of Malaysia , Women 's NGO, WABA, LPPKN KPWKM	• 0% of babies will be born with HIV by mothers living with HIV	• Initiate new PPTCT programmes and strengthen existing PPTCT interventions in the private sector. • Improve pre-pregnancy and post natal care by identifying those who are at risk
• Strengthen community awareness of HIV to increase enrolment in the PPTCT programme and other related antenatal, family planning, sexual and reproductive health, voluntary confidential counselling and testing services, particularly among most at risk populations.	MOH, Association of Private Hospital/ Federation of General Practitioners of Malaysia , Women 's NGO, WABA, LPPKN KPWKM	• 80% coverage of reproductive age group (15-49 years)	• Work with pharmaceutical companies, other corporate sector actors, NGOs and faith based organisations to create awareness and IEC materials which are used in road shows, health camps/campaigns and campaigns using social media, web sites and the mass media.. • Conduct community outreach programs which provide information and referral to antenatal, family planning, SRH, and VCT services.
• Ensure all HIV-infected pregnant women and their HIV-exposed infants under the PPTCT programme receive ARV treatment/ prophylaxis and breastfeeding education to reduce mother-to-child transmission of HIV.	MOH, MOE, MOHE, NGOs	• 100 % mothers with HIV and their newborn receive ARV treatment • 100% of ANC personnel in government and private healthcare facilities are trained in PPTCT	• Conduct close monitoring and supervision on drug adherence • Conduct capacity building through continuous training of ANC personnel in government healthcare facilities.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
• Ensure the availability of PPTCT in all ANC facilities including private health care facilities.	Public and Private sectors	• 0% vertical transmission reported	• Initiate and sustain PPTCT programmes and strengthen existing PPTCT interventions including in the private sector.
Strategy 2: Improving the quality and coverage of testing and treatment.			
• Ensure adequate number and training of healthcare workers to deliver ARV and related services	MOH, MAC, Private Medical Practitioners, civil society	• Increased number of referrals of ARV/STI/ PLHIV from private healthcare practitioners.	• Further develop, revise and ensure implementation of treatment related policies, strategies and guidelines • Train additional staff and further strengthen capacity of staff involved in facility based care
• Strengthen priority health services through increased integration of HIV service delivery.	MOH, MAC, civil society	• Comprehensive and CSO integrated HIV service support model deployed in one designated clinic per state	• Develop comprehensive and CSO integrated HIV related support services model
• Improve coverage and early access to and quality of HIV testing, care and treatment, sexual reproductive health and STI services for most at risk populations and their partners.	MOH, MAC, civil society	• 60% of MARPs reached by current programmes report knowledge of or accessing a SRH/STI/HIV service. • 80% of those eligible for treatment receive ARV	• Strengthen linkages and referral between facility based private and government services (VCT, OI/ART, PPTCT, TB, STI, and SRH) and NGO services. • Maintain the availability of ART for adult and paediatric patients in all major government healthcare facilities.
• Increase access and quality of HIV testing and counselling services in the public and private sectors to identify those in need of HIV treatment	MOH, MAC, civil society	• 60% of MARPs reached by current programmes report knowledge of or accessing a SRH/STI/HIV service.	• Update and revision of Standard Operating Procedures (SOP) for testing. • Deployment of revised SOP through training of government, private and NGO healthcare workers.
• Strengthen capacity of VCT related staff.	MOH, MAC, civil society	• 80% of government healthcare workers and NGOs involved in the provision of VCT have undergone HIV testing related training	• Provide HIV testing related training for government, private and NGO healthcare workers.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
• Improve adherence to treatment and detection of treatment failure	MOH, MAC, civil society	• 50% reduction in the number of cases of 1st line treatment failure	• Increase capacity and availability of trained relevant counsellors and peer support services, and of relevant healthcare practitioners in the area of resistance testing. • Provide simpler options for first line treatment regimen (3 in 1)
• Expand routine PICT for pregnant women, TB and STI patients and strengthen linkages from prevention to care and treatment.	MOH, MAC, private healthcare facilities, civil society	• 80% of government and private healthcare facilities are able to provide PICT to pregnant women, TB and STI patients	• Provide PICT related training for relevant government, private and NGO healthcare workers.
• Develop and scale up care and treatment with anti-retroviral drugs and TB treatment for drug users in prisons and other detention centres.	MOH, Ministry of Home Affairs, Prisons Department, NADA, MAC, civil society	• 90% of all eligible persons in closed settings have access to ART and/or TB treatment.	• Provide ART and TB treatment to eligible persons in prisons and drug rehabilitation centres.
Strategy 3: Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.			
• Improve coordination, linkages and referral among social, health and community based services at the community level.	MOH, KPWKM, MAC, civil society	• Each designated infectious disease clinic per state will have an accredited peer support group. • All peer support personnel in these groups are trained in referral and linkages of HIV related services and relevant social support programmes.	• Establish an accreditation system for HIV peer support groups which is standardized throughout the country • Brief peer educators and hospital counsellors on available government and NGO welfare and social support programmes.
• Strengthen the quality and impact of PLHIV and MARPs support groups and networks.	MOH, MAC, KPWKM	• A PLHIV support group in each state and linked to a national network. • A MARPs support groups in designated states.	• Training of PLHIV facilitators • Establish PLHIV support groups in each state and strengthen an existing national PLHIV network.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
• Link PLHIV and their families to existing social protection programmes to ensure access to essential services.	MOH, MAC, KPWKM, Task force on Woman, Girls and HIV, JAKIM	• A third of all PLHIV support group facilitators (state and national) are women. • Increased referral cases by support groups to social protection (e.g. welfare services, Baitulmal, etc)	• Training of PLHIV women facilitators • Brief PLHIV facilitators on available government and NGO social protection programmes linked to gender based violence, single mothers as well as welfare and social support issues.
• Increase visibility and meaningful participation and decision making of PLHIV and MARPs in impact mitigation programmes.	MOH, PLHIV organizations/ networks, related govt organizations	• PLHIV and MARPS are involved in the decision making process of 80% of programmes which involve them.	• Increase capacity and coverage of impact mitigation programmes to cover all PLHIV • Increase opportunity for PLHIV and MARPS to be involved in the planning, implementation and evaluation of impact mitigation programmes i.e. treatment, care and support programmes
• Provide quality emotional, religious and spiritual support to PLHIV and their families.	Government and NGO religious bodies, FBOs, JAKIM, MAC, PLHIV organizations/networks	• Availability of HIV related pastoral support by individual religious beliefs in all states and with all religions.	• Involve and build capacity of faith-based organizations in programmes involving PLHIV/MARPs
• Strengthen the role of community and home based care to support positive prevention and linkages to TB and SRH services	MOH, MAC, KPWKM, JAKIM, civil society	• One home-based care programme established and present in each state • Established referral system for PLHIV/MARPS to TB and SRH services. • One shelter home for PLHIV established and operating in each state.	• Develop SOP and provide training for home-based care and shelter home providers • Ensure that home-based care and shelter home providers are knowledgeable in TB and SRH referrals
Strategy 4: Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.			
• Ensure HIV issues are mainstreamed into national social development plans and the necessary financial and technical resources are mobilised to support	NCCAI, NATCA, EPU, MOH, MAC, NGOs	• Inclusion of HIV into the 5 year Malaysian Plan. • The 5 year National Strategy on HIV and AIDS	• Strengthen the management and capacity of the National AIDS Programme secretariat (AIDS/STI Sector and the Malaysian AIDS Council) to improve coordination and management of the national

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
development and implementation of HIV and AIDS plans and programmes.		is funded and supported by key stakeholders.	response. • Conduct review and streamlining of existing policies and strategies.
• Strengthen capacity and plans of key ministries, other government stakeholders and civil society organisations at the national and local levels to improve and strengthen targeted evidence-based interventions.	NCCAI, NATCA, MOH, relevant ministries, MAC	• The National Strategy on HIV and AIDS 2011 – 2015 is able to be effectively implemented, monitored and evaluated for impact.	• Engage key ministries in the work and decision-making processes of the National Coordinating Committee on AIDS Intervention (NCCAI) and National Advisory and Technical Committee on AIDS (NATCA). • Build capacity of participants who routinely attend Federal, State and District level HIV programme meetings.
• Sensitise and engage law enforcement, healthcare service providers, relevant public officials and civil society stakeholders, to assess, prevent and mitigate any negative consequences of laws and policies to the national HIV response	MOH, Members of Parliament, law enforcement bodies, MAC, NGOs.	• Increased capacity of government and civil stakeholders to address issues of stigma and discrimination	• Build capacity of parliamentarians, law enforcement officials, and key policy and decision makers on HIV related issues.
• Improve the representation, involvement and capacity of civil society, community based organizations and affected population networks in policy dialogue and decision-making, towards achieving Universal Access and strengthening the national response.	MAC, NGOs, civil society networks	• Increased capacity of civil society representatives in consultative bodies (e.g. Country Coordinating Mechanism) and policy discussions.	• Build capacity of civil society representatives to enable them to participate and contribute in policy dialogue and decision making.
• Strengthen the work of the private sector among local businesses to promote corporate social responsibility and to	Ministry of Human Resource, MAC, NGOs, private sector bodies and companies	• 30 private sector companies have adopted either the MOHR's *HIV in the Workplace Policy*, the *Malaysian AIDS Charter* or	• Promote the *HIV in the Workplace Policy* (MOHR) and the *Malaysian AIDS Charter* to private sector companies and organisations.

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
establish workplace-based HIV prevention programmes and to address stigma and discrimination in the private sector.		established some form of AIDS in the workplace policy.	
• Intensify public understanding and awareness of HIV and AIDS through focused communications and integration into community-based HIV education messages.	MOH, MAC, NGOs, KPWKM, MOE, MOHE, Ministry of Information, Communication and Culture, NGOs, Media	• 60% of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	• Promote comprehensive sexual reproductive health and life skills based education and HIV awareness programmes among young people aged 15-24.
Strategy 5: Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.			
• Develop and strengthen partnerships to plan, coordinate and manage the national monitoring and evaluation, research and surveillance systems.	MOH, MAC, Civil society, related government agencies, research institutions	• An integrated M&E unit has been established at the national level and coordinated by the HIV/STI sector.	• Strengthen the existing surveillance system by developing a comprehensive national M&E framework
• Produce and disseminate timely and high quality data from research, integrated biological behavioural surveillance (IBBS), population size estimations and other studies.	MOH, MAC, MARPs, research institutions, regional & international organisations	• Minimum of 1 research per MARP and other vulnerable populations is produced and disseminated within 6 months of research • All HIV related research is compiled in a research directory. • A national M&E Framework and manual is developed and disseminated to all stakeholders	• Conduct size estimation and social research on MARPS/ other determined vulnerable populations with individual researchers, institutions and NGOs. at national and state level • Produce comprehensive and high quality routine programme monitoring data by harmonizing and standardising M&E efforts including alignment of measureable indicators which reflect actual programme achievement, indicator definitions, data collection tools, data management and reporting procedures.
• Promote the production, dissemination and effective use of strategic information to inform and guide programme and	MOH, relevant govt agencies, civil society, media	• A minimum of 1 update session conducted during NATCA.	• Train experts in writing evidence based policy briefs, risk communication material and to conduct media training

Key Activities	Key Stakeholders	Planned Target Achievements by end of 2015	Priority Programmes
policy decision making.		• 60% of news coverage on HIV is based on reliable data and facts.	• Develop smart partnership and sensitisation programmes with media practitioners on HIV related issues.
• Develop mechanism for data collection from both private and public healthcare facilities for future planning	MOH, private health practitioners, civil society	• Family Health Division and HIV/STI establish an integrated and consolidated database	• Establish an agreement between different stakeholders (Govt, private and BGO) to systematically and consistently contribute related HIV data • Assess and upgrade existing HIV data collection systems to enable improved data analysis and accessible to MOH and NGOs.

Annex 3:

Proposed target for NSEP under NSP 2011 – 2015

STATE	TARGET OF NEW CLIENT FOR NSEP				
	2011	2012	2013	2014	2015
Perlis	248	392	494	530	587
Kedah	1,762	2,779	3,502	3,763	4,168
P. Pinang	2,786	4,394	5,538	5,949	6,590
Perak	1,583	2,497	3,147	3,381	3,745
W.P. KL	3,690	5,820	7,336	7,882	8,730
Selangor	3,141	4,953	6,243	6,708	7,430
N. Sembilan	1,102	1,738	2,190	2,354	2,607
Melaka	603	950	1,199	1,288	1,426
Johor	2,550	4,022	5,070	5,447	6,033
Kelantan	2,117	3,339	4,208	4,520	5,008
Terengganu	2,208	3,482	4,389	4,716	5,223
Pahang	1,919	3,027	3,815	4,099	4,540
Sarawak	722	1,139	1,436	1,543	1,709
Sabah	1,438	2,268	2,859	3,072	3,403
TOTAL	**25,869**	**40,800**	**51,425**	**55,250**	**61,200**

Proposed target for MMT under NSP 2011 – 2015

STATE	TARGET OF NEW CLIENT FOR MMT				
	2011	2012	2013	2014	2015
Perlis	202	270	438	548	742
Kedah	1,436	1,915	2,963	3,891	5,267
P. Pinang	2,271	3,028	4,685	6,151	8,328
Perak	1,291	1,721	2,662	3,495	4,744
W.P. KL	3,009	3,926	6,206	8,149	11,033
Selangor	2,561	3,417	5,282	6,935	9,390
N. Sembilan	901	1,198	1,854	2,534	3,300
Melaka	492	655	1,035	1,381	1,814
Johor	2,078	2,772	4,289	5,632	7,625
Kelantan	1,726	2,301	3,560	4,678	6,329
Terengganu	1,800	2,400	3,725	4,876	6,329
Pahang	1,565	2,086	3,227	4,238	5,738
Sarawak	570	759	1,175	1,543	2,089
Sabah	500	750	975	1,200	1,800
TOTAL	**20,400**	**27,200**	**42,075**	**55,250**	**74,800**

Proposed target for Reagent and ARV under NSP 2011 – 2015

STATE	TARGET OF NEW PATIENT ON ARV				
	2011	2012	2013	2014	2015
Perlis	124	140	157	174	190
Kedah	544	618	691	763	836
P. Pinang	1,426	1,616	1,806	1,997	2,187
Perak	894	1,013	1,132	1,251	1,370
W.P. KL	16	18	20	23	25
Selangor	4,141	4,693	5,244	5,797	6,348
N. Sembilan	1,002	1,136	1,269	1,403	1,536
Melaka	278	315	352	389	426
Johor	3,122	3,538	3,954	4,370	4,787
Kelantan	1,258	1,426	1,593	1,761	1,929
Terengganu	373	423	472	522	572
Pahang	444	503	563	622	681
Sarawak	391	443	496	548	600
Sabah	728	825	922	1,019	1,116
WPLabuan	3	4	4	5	6
HKL	255	290	324	358	392
TOTAL	**15,000**	**17,000**	**19,000**	**21,000**	**23,000**

Annex 4:

Performance Indicators for the National Strategic Plan on HIV and AIDS 2011 – 2015

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
GENERAL INDICATORS (IMPACT)						
1	HIV prevalence among population aged 15-49 years	MOH-Projection of the Malaysia HIV epidemic	Every 2 years	0.50%		NSP
2	Percentage of young women and men aged 15–24 who are HIV infected.	Programme Monitoring (PPTCT Programme)	Every 2 years	0.05%		UNGASS 22, MDG
3	Percentage of most at- risk populations who are HIV infected	IDU – IBBS	Every 2 years	22.06% (2009)	17%	UNGASS 23
		SW – IBBS	Every 2 years	10.53% (2009)	7%	
		TG – IBBS	Every 2 years	9.7% (2009)	6%	
		MSM – VDTS	Every 2 years	3.87% (2009)	2%	
4	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	National ART Programme Monitoring	Every year	86.9% (2009)	90%	UNGASS 24, UA
5	Percentage of infants born to HIV-infected mothers who are infected	PMTCT program monitoring	Every year	2.67% (2009)	0%	UNGASS 25

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
Strategy 1: Improving the quality and coverage of prevention programmes among most at risk and vulnerable populations.						
OUTCOME INDICATORS						
6	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IBBS	Every 2 years	22.6% (2008)	50%	UNGASS 13, UA
7	Percentage of most at- risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IDU – IBBS (2009)	Every 2 years	DU : 49.68%	60%	UNGASS 14
		SW – IBBS (2009)	Every 2 years	SW : 38.48%	60%	
		TG – IBBS (2009)	Every 2 years	TG: 37%	60%	
		MSM – N/A	Every 2 years	MSM : N/A	60%	
8	Percentage of young women and men who have had sexual intercourse before the age of 15	Cross sectional Malaysian school survey	Every 2 years	5.38% (2006)	4%	UNGASS 15, UA
9	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Population based survey	Every 3-5 years	N/A		UNGASS 16
10	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.	Population based survey	Every 3-5 years	N/A		UNGASS 17
11	Percentage of female and male sex workers reporting the use of a condom with their most recent client	IBBS	Every 2 years	61.34% (2009-Female only)	80%	UNGASS 18
12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	MAC Programme Monitoring		21% (2008)	60%	UNGASS 19
13	Percentage of injecting drug users who report the use of a condom at last sexual intercourse	IDU – IBBS	Every 2 years	27.8% (2009)	60%	UNGASS 20

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
14	Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	IDU – IBBS	Every 2 years	83.49%	95%	UNGASS 21
OUTPUT INDICATOR						
15	Percentage of most at- risk populations reached with HIV prevention programmes disaggregated by types of MARPs.	IDU – IBBS	Every 2 years	27% (2009)	50%	UNGASS 9
		SW – IBBS	Every 2 years	12% (2009)	80%	
		TB – IBBS	Every 2 years	65% (2009)	80%	
		MSM – N/A	Every 2 years	N/A	80%	
16	Number of district government health clinic providing NSEP services	MOH	Every year	73	800	NSP
17	Number of NGOs providing NSEP service	MOH	Every year	18	66	NSP
18	Percentage of targeted clients receiving NSEP kits at NSEP site	Program monitoring (MAC)	Every year	N/A	100%	NSP
19	Number of MMT service available disaggregated by type of centre.	MOH				NSP
	• Prison		Every year	18 (2010)	32	
	• National Anti-Drug Agency facilities		Every year	25 (2010)	24	
	• Government healthcare facility		Every year	174 (2010)	800	
20	Number of comprehensive minimum package of services for MARPs developed and deployed.	MAC	Every year	N/A	5	NSP
21	Number of TWG for MARPs to monitor comprehensive minimum package of services established	MAC	Every year	N/A	1	

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
Strategy 2: Improving the quality and coverage of testing and treatment.						
OUTCOME INDICATORS						
22	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	(HIV Programme Monitoring)	Every year	98%	98%	UNGASS 7, UA
23	Percentage of MARPs (Most at- risk populations) that have received an HIV test in the last 12 months and who know the results.	IDU – IBBS	Every 2 years	IDU : 33.0% (2009)	60%	UNGASS 8,
		SW – IBBS	Every 2 years	SW : 19.96% (2009)	90%	
		TG – IBBS	Every 2 years	TG: 19% (2009)	90%	
		MSM – N/A	Every 2 years	MSM : N/A	60%	
OUTPUT IDICATORS						
24	Percentage of adults and children with advanced HIV infection (CD4 <350 or showing signs of AIDS) receiving antiretroviral therapy	National AIDS Registry	Every year	37.3%; 9,962 (2009)	95%	UNGASS 4, MDG, UA
25	Percentage of health care worker trained in HIV related service delivery disaggregated by type of healthcare workers:	MOH / MAC				NSP
	• Government healthcare worker		Every 2 years	N/A	85%	
	• Private healthcare worker		Every 2 years	N/A	85%	
26	Number of designated clinic deployed comprehensive and CSO integrated HIV service support model	MOH / MAC				NSP
	• Government clinic		Every year	N/A	14	
	• Private clinic		Every year	N/A	14	
27	Percentage of people in enclosed settings who eligible accessing to ART and/or TB treatment.	MOH	Every year	N/A	90%	NSP

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
28	Percentage of MARPs reached by current programmes report accessing a SRH/STI/HIV services.	MAC	Every 2 years	IDU : N/A	60%	NSP
			Every 2 years	SW : N/A	60%	
			Every 2 years	MSM : N/A	60%	
			Every 2 years	TG: N/A	60%	
29	Percentage of health care facilities providing PICT to pregnant women, TB and STI patients disaggregated by types of health care facilities.	MOH				NSP
	• Government health facility		Every year	N/A	100%	
	• Private health facility		Every year	N/A	100%	
Strategy 3: Increasing the access and availability of care, support and social impact mitigation programmes for People Living with HIV and those affected.						
OUTCOME INDICATORS						
30	Percentage of pregnant women who received an HIV test who know the results	Program monitoring (PPTCT)	Every year	N/A	100%	NSP
31	Percentage of male partners of positive pregnant women attending ANC who know their HIV status	Program monitoring (PPTCT)	Every year	N/A	100%	NSP
33	Percentage of positive male partners of pregnant women use condom to protect PPTCT.	Program monitoring (PPTCT)	Every year	N/A	100%	NSP
OUTPUT IDICATORS						
33	Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	Programme monitoring (PPTCT)	Every year	100% of 347 women received ART over the past two years	100%	UNGASS 5, UA
34	% of infants born to HIV – Infected women receiving any ARV prophylaxis for PPTCT	Programme monitoring (PPTCT)	Every year	N/A	100%	NSP

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
35	Number of designated clinic/hospital have an accredited peer support group	Programme monitoring (MAC)	Every year	5	14	NSP
36	Number of PLHIV support group established linked to a national network	Programme monitoring (MAC)	Every year	N/A	18	NSP
37	Number of home-based care programme for PLHIV established and present	Programme monitoring (MAC)	Every year	1	18	NSP
38	Number of shelter home for PLHIV established and operating	Programme monitoring (MAC)	Every year	N/A	18	NSP
Strategy 4: Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.						
OUTCOME INDICATORS						
39	**National Composite Policy Index (NCPI)**					UNGASS
	1. Strategic Plan	UNGASS	Every 2 years	8 (2009) (A)	8	
	2. Political support	UNGASS	Every 2 years	9 (2009) (A)	9	
	3. Human rights					
	• Promote and protect human rights	UNGASS	Every 2 years	5 (2009) (B)	6	
	• Law enforcement	UNGASS	Every 2 years	7 (2009) (B)	7	
	4. Civil society participation	UNGASS	Every 2 years	8 (2009) (B)	8	
	5. Prevention	UNGASS	Every 2 years	7 (A); 5 (B)	7	
	6. Treatment care and support program	UNGASS	Every 2 years	7 (A); 6 (B)	7	
	7. Effort to meet HIV-related need of OVC	UNGASS	Every 2 years	5 (A); 1 (B)	1	
	8. Monitoring and evaluation	UNGASS	Every 2 years	5 (2009) (A)	5	

No	Indicators	Data Source	Frequency	Baseline Value & Year	Target 2015	Indicator reference
Strategy 5: Increasing the availability and quality of strategic information and its use by policy makers and programme planners through monitoring, evaluation and research.						
OUTCOME INDICATORS						
40	Progress made in strengthening the M&E system (assessed through the M and E System Strengthening tool)					
	1. An integrated M&E Unit has been established at the national level coordinated by HIV/STI sector	MOH	Once	N/A	Established	
	2. All HIV related research is compiled in a research directory	MOH	Every 2 years	N/A	Completed	
	3. Minimum of research per MARP and other vulnerable populations is conducted and its report is disseminated within 6	MOH	Every 2 years	4 (2009)	Completed	
	4. Routine HIV programme monitoring	MOH	Every year	N/A	Completed	
	5. 60% of news coverage on HIV is based on reliable data and facts.	MOH	Every 2 years	N/A	60%	
	6. Family Health Division and HIV/STI establish an integrated and consolidated database	MOH	Once	N/A	Completed	

Annex 5:

Technical Team

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