The Policy and Legal Environments Related to HIV Services in Malaysia

REVIEW AND CONSULTATION

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REVIEW AND CONSULTATION

Acknowledgements

The main objective of the report on the *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia* is to identify the current status of policy and legal environment in Malaysia that safeguard the universal human rights of the key affected populations with regard to the HIV prevention, care and treatment. The review and consultation establishes a baseline on the current enabling environment (policies and laws) in relation to safeguarding the human rights of the key populations and second, and it provides a set of recommendations to input into any reforms to promote an enabling environment where the human rights of the key populations are protected.

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Foreword

The law can have a profound impact on the lives of people – especially those who are vulnerable and marginalized. The true test of an inclusive and caring society is reflected in its commitment to protect the rights of minorities.

In Malaysia, the HIV epidemic continues to be concentrated among key populations, who often represent highly ostracized and stigmatized segments within all societies. Members of these communities are not only rejected socially, but further marginalized through legal frameworks that cast them as criminals. Criminal laws and discriminatory practices based on moral judgment, superstition, ancient beliefs, fear and misinformation, punish instead of protect. They drive at-risk communities underground, preventing them from accessing lifesaving treatment and prevention information and services, heightening their risk for HIV.

The Global Commission on HIV and the Law (2010-2012), a high-level initiative launched in 2010 by UNDP Administrator, Helen Clark, examined how law and practices can transform the global AIDS response. The Commission's findings and recommendations reveal that evidence-based laws and practices firmly grounded in human rights are powerful instruments for challenging discrimination, promoting public health, and protecting human rights. The benefits are felt beyond HIV responses to encompass health and development outcomes more broadly.

Furthermore, United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) Resolutions 66/10 and 67/9 recommended that punitive laws and policies targeting key populations be abolished to reduce levels of social stigma, discrimination, violence and broader human rights violations.

Now, more than ever, it is time for the country to ensure a policy and legal environment that can support an effective national AIDS response to mitigate the impact of HIV and promote and protect the human rights of people living with HIV and AIDS and those most vulnerable to HIV.

I welcome the *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia*. This review of HIV-related laws and policies identifies legal barriers to accessing health and HIV services for key populations and presents a set of recommendations that can save lives, save money and help end the AIDS epidemic in Malaysia.

I hope that individuals and civil society organizations will use this resource to claim their rights, and also that policy and lawmakers, officials responsible for criminal justice, law enforcement officers, national AIDS programme officials, and donors will use it to inform the development and implementation of an enabling legal environment for effective HIV and heath responses.

Ms. Michelle Gyles-McDonnough,
UN Resident Coordinator, Malaysia

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List of Abbreviations/Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
CBOs	Community based organisations
CEDAW	Committee on the Elimination of Discrimination against Women
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organisations
EPF	Employees Provident Fund
ESCAP	Economic and Social Commission for Asia and the Pacific
EU FTA	European Union Free Trade Agreement
HIV	Human Immunodeficiency Virus
ISEAN-HIVOS	Insular Southeast Asian Network on MSM, TG, and HIV - Humanist Institute for Co-operation with Developing Countries
JAWI	Federal Territory Islamic Affairs Department
MDG	Millennium Development Goal
MITI	Ministry of International Trade and Industry
MMT	Methadone Maintenance Treatment
MDTCA	Ministry of Domestic Trade and Consumer Affairs
MSM	Men who have sex with men
NGOs	Non-government Organisations
NSEP	Needle and Syringe Exchange Program
PTF	PT Foundation
PTSC	Project Technical Steering Committee
PUSPENs	Narcotics Addiction Rehabilitation Centres
PWUD	Persons who use drugs
SOCSO	Social Security Organisation
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
SUHAKAM	Human Rights Commission Malaysian
TPPA	Trans-Pacific Partnership Agreement
TRIPs	Trade-Related Intellectual Property Rights
UN	United Nations
VCT	Voluntary Counselling and Testing

PART ONE

Introduction and overview

This report on the *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia* (the Review) was commissioned by the United Nations HIV/AIDS Theme Group in Malaysia; the period of review is 2007-2013. A multi-sectoral Project Technical Steering Committee comprising government, civil society, UN and the Human Rights Commission of Malaysia was established by the Theme Group to oversee the implementation of the project (see Appendix 5 for list of the steering committee members and terms of reference).

Globally, governments in their commitment to the *2011 Political Declaration: Intensifying our Efforts to Eliminate HIV/AIDS* agreed to review laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment and care and support programmes to people living with and affected by HIV.

At the Asia Pacific regional level, governments signed on to the Economic and Social Commission for Asia and the Pacific (ESCAP) Roadmap to 2015, a framework for the implementation of the 2011 Political Declaration. Specifically, the ESCAP Resolutions 66/10 and 67/9 pertaining to the removal of legal and political barriers to universal access and the review of national laws, policies and practices to eliminate all forms of HIV related discrimination, the outcome of the Asia Pacific High Level Inter-governmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals led to the undertaking of this review and consultation.

The review and consultation process adopted the guidance document for Asia and the Pacific Region – *Creating Enabling Legal Environments: Conducting National Reviews and Multi-Sector Consultations on Legal and Policy Barriers to HIV Services* (Ad-Hoc UN Regional Interagency Team on AIDS on Enabling Legal Environments, 2013).

There are two main components to this Review:

i. Analysis on the policy and legal environments in the context of access to and delivery of HIV services.
ii. Multi-stakeholder consultation to discuss the preliminary findings of the study and propose policy and legal reforms to strengthen access to and delivery of HIV services to the Malaysian government.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (ISEAN-HIVOS regional initiative) provided funds for this project.

Methodology

For this study a qualitative approach was deemed suitable to collect data as respondents' experiences in law and policy making and enforcement were sought. Semi-structured interviews were conducted with representatives from select entities from the governmental and non-governmental sectors. These organisations were selected by the Project Technical Steering Group Committee as they were directly involved in HIV and AIDS initiatives and engaged in dialogue on related laws and policies. The respondents included the Ministry of Health, Federal Territory Islamic Affairs Department (JAWI), Human Rights Commission Malaysian (SUHAKAM), Kuala Lumpur Legal Aid Centre, Malaysian AIDS Council and PT Foundation (PTF). The Attorney-General's Chambers was unavailable for an interview.

In addition, data was obtained from the proceedings of the national *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia*, specifically the recommendations that were produced by participants.

A literature review was undertaken on laws, policies and practices that affect key populations or most-at-risk populations such as persons who use drugs (PWUD), men who have sex with men (MSM), transgenders and sex workers and their access to HIV services. Sources of literature were peer-reviewed articles (e.g. social sciences and health sciences); articles specific to Malaysia were limited indicating a dearth in HIV and AIDS research. Document analysis also included primary sources such as strategic plans, articles of law (Constitutional and Sharia law), as well as other documents such as local, regional and international reports on law, health and HIV and AIDS.

Outline of report

This report comprises four sections:

- Part 1: Introduction and overview (this section)
- Part 2: Literature review
- Part 3: Report on the *Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia*
- Part 4: Propositions and recommendations

PART TWO

Literature review and analysis

The first section of this review entailed identifying sources of information on national level laws that may relate to HIV in Malaysia. Resources that were of relevance to this topic were also used to provide a broader perspective on legal aspects that effected HIV interventions and the implications for public health. The literature encompassed peer reviewed articles, government reports, non-governmental documents and findings from studies and reviews by other agencies, including the Global Commission on HIV and the Law.

The consequences of laws and their enforcement and HIV are well documented in many countries and settings. In particular, the key populations or most-at-risk populations of sex workers, men who have sex with men, transgender and injecting drug users affected by the epidemic are also the populations most effected by laws primarily due to their engagement in illicit behaviour and are criminalised[1]. In addition, there are HIV-specific legislations to prosecute intentional HIV exposure, nondisclosure and transmission cases. Conversely, there are also Acts and Statutes, such as on anti-discrimination, enacted to protect those infected and affected by the epidemic, namely people living with HIV[2].

Stigma and discrimination associated with the epidemic is widespread. Key affected populations, including those living with HIV, face tremendous challenges in their everyday living, whether at the workplace, healthcare setting or home environment. Their vulnerable and marginalised status places them at increased risk of HIV transmission, and criminalisation heightens these risks and reinforces stigma and discrimination. The immediate effect of illegality is these populations retreat into spaces that are difficult to access by service providers, i.e. underground, with dire ramifications for public health interventions. Outreach to these populations to deliver education on HIV are hampered as is their access to prevention initiatives (including harm minimisation programmes, e.g. syringe and needle exchange, medication-assisted treatment for opioid dependence and condom distribution), healthcare services (e.g. voluntary testing and counselling services) and antiretroviral therapy.

In the report "Redefining AIDS in Asia: Crafting an Effective Response" by the Commission on AIDS in Asia [3], it was emphasised that the need for 'an enabling environment' was critical in minimising the impediments to prevention and care initiatives and the delivery of services. An enabling environment that relates to the law and HIV entails that "laws and policies against discrimination on the basis of HIV status, risk behaviour, occupation, and gender are in place are monitored and enforced" [4]. Structural level intervention is a key strategy in facilitating an environment conducive for individual and programmatic approaches and initiatives to mitigate HIV transmission.

Malaysia – HIV, laws, regulations and policies

Status of the epidemic

The HIV situation in Malaysia is characterised as a concentrated epidemic with most cases reported among injecting drug users, MSM, transgenders and sex workers. Injecting drug users represent between 70-80 per cent of the total reported HIV cases, with 65,032 as of end 2011 [5]. While HIV transmission through injecting drug use remains significant, since 2011 HIV infection through sexual transmission, including among young people, transgender persons and men who have sex with men, accounted for more of the new cases than through injecting drug use [5].

In response to the current and projected HIV situation, stated in the National Strategic Plan on HIV and AIDS 2011-2015[6], is the key strategy of "improving the quality and coverage of prevention programmes among most at risk and vulnerable populations" (p.19). To facilitate the implementation of this strategy is the tandem strategy of "maintaining and improving an enabling environment for HIV prevention, treatment, care and support" (p.19). However, it is difficult to identify tangible programmes that directly address the increasing sexual transmission rates among key affected populations. Furthermore, it is unclear how the MoH allocates resources (funds and technical support) to implement such programmes.

Law and regulations

The legal system instituted in Malaysia is that of common law, which was inherited from the country's last colonial power, the British. Similar to most countries, Malaysia has laws that reflect its unique circumstances and, as in this case, this has manifested in a dual justice system. Sharia law applies to people who adhere to the Islamic faith and is parallel to the other spectrum of law under the Constitution; it deals with all conducts of Muslims in the country specifically in the matters related to family law and religious administration. A number of laws from both systems can be applied to the HIV sector relating to prevention interventions, care and treatment services, and the most-at-risks and their activities.

In addition to national laws, Malaysia is party to various international treaties and signatory to United Nations and regional (i.e. Association of Southeast Asian Nations [ASEAN]) political declarations on HIV and AIDS. Relevant to this report are the following:

i) HIV and AIDS

- United Nations General Assembly Special Session on HIV and AIDS 2001 (Declaration of Commitment on HIV/AIDS)

- Political Declaration on HIV/AIDS 2006
- Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS 2011
- ASEAN Commitments on HIV and AIDS 2007
- ASEAN Declaration of Commitment: Getting to Zero New Infections, Zero Discrimination, Zero AIDS-related Deaths 2011
- Millennium Development Goal 6: Combat HIV/AIDS, Malaria and other diseases (MDG 6)

ii) International human rights conventions:

- Universal Declaration of Human Rights 1948
- Convention on the Elimination of Discrimination against Women (CEDAW) 1979
- Convention on the Rights of the Child (CRC) 1989
- Convention on the Prevention and Punishment of the Crime of Genocide 1948
- Convention on the Rights of Persons with Disabilities 2008

iii) Human trafficking:

- Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime 2000
- Article 6 of CEDAW: Trafficking and prostitution - Governments

The Malaysian government's leadership to fulfil its commitment to the above have been commendable on some issues, e.g. the implementation of harm reduction measures among injecting drug users. Conversely, there are significant gaps pertaining to action required to reduce the vulnerability to HIV infection (particularly among key affected populations and young people) and to advance human rights to reduce stigma, discrimination and violence related to HIV. These are key elements in the Declaration of Commitment on HIV/AIDS and subsequent Political Declarations on HIV/AIDS (i.e. 2006 and 2011). As will be evident in the analysis that follows the requisite enabling environments to facilitate development of policies and implementation of effective programmes, have not for the most part been established.

Most-at-risk populations or key affected populations

Injecting drug users or people who inject drugs

Malaysia has a punitive approach to "dadah" or illicit drugs – zero tolerance and drug free –and have wide-ranging policies and laws related to prevention, treatment and rehabilitations (e.g. drug use, possession and trafficking).

Alarmed by the rapid increase in illicit drug use in the 1970s, particularly among males in the workforce, the government took a hard-line stance and declared the drug problem as a threat to national security[7]. The prevailing response spearheaded by the United States of America and the United Nations during that period was the strict control of drugs, from its cultivation to use[8]. The government adopted this approach, setting the goal of becoming a drug free nation; punitive laws and harsh, compulsory detention and rehabilitation programmes for drug users convicted of drug offences were instituted. The criminalisation of drugs was further justified to curb the emerging HIV epidemic among injecting drug users.

Numerous studies have shown that laws and enforcement practices of laws which criminalise drug use lead to an environment that increases the HIV vulnerability of drug users [9, 10]. Injecting drug

users face constant harassment and threat of arrest by police and law enforcement officers for the possession of injecting equipment (including sterile paraphernalia). They are reluctant to carry needles and syringes, thus, increasing the likelihood of sharing injecting equipment and exposure to HIV infection. In order to avoid run-ins with the police or raids, injecting drug users would hurriedly inject drugs and if they are sharing paraphernalia they are unlikely to be using clean equipment. As well, needles and syringes would be disposed of unsafely, e.g. dropped in the alleyways, and other users may pick up these unsterile equipment and reuse them. Aggressive law enforcement practices can lead to injecting drug user populations being driven underground or to become more hidden, inducing them to engage in riskier behaviour. For example, they may use the services of 'professional' injectors located in concealed locations who will administer the drugs to multiple injecting drug users, often using the same injecting equipment.

Provision and access to HIV services

Although harsh laws are the mainstay to the drug use problem there has been a major transformation in drug policy that has clear effect whereby HIV transmission rates have reportedly decreased among injecting drug users[11]. In the mid-2000s the pilot methadone maintenance treatment (MMT) and needle and syringe exchange program (NSEP) initiatives were approved by the government for implementation and subsequently resulted in positive outcomes[12, 13]. The MMT is administered through government healthcare centres and by private medical practitioners, and the NSEP is mainly delivered by NGOs[14].

A further discernible shift is the move away from addressing drug use as a purely criminal justice matter towards incorporating health and wellbeing strategies and requiring an inter-sectoral partnership approach [14]. As such, health sector entities, AIDS technical and policy committees and law enforcement agencies are now together endeavouring to deal with the prevention and treatment aspects of drug use. In 2010 the trajectory towards a client centred, voluntary, non-criminal approach to drug treatment and rehabilitation manifested in the establishment of the Cure and Care Clinics by the National Anti-Drugs Agency[15]. These clinics are slated to replace the approximately 28 PUSPENs (narcotics addiction rehabilitation centres) which are viewed as an unsuccessful programme with reported high relapse rates of between 70 and 90 per cent among those who underwent rehabilitation [16].

These substantial efforts in the past five years to curb the rapid increase in HIV among injecting drug users has seen a decrease in the rate of HIV transmissions through the sharing of needles and in 2011, reported cases of HIV infection through sexual transmission exceeded infection through injecting drug use [5]. As well, the government's undertaking of harm minimisation or reduction programmes to accelerate the response to HIV has contributed to, a) a fall in the number of drug users detained in PUSPENs, thus, lessening exposure to other communicable diseases; b) injecting drug users receiving MMT reportedly being more likely to adhere to antiretroviral therapy; c) a change to safer injecting behaviour; and d) the increased capacity of injecting drug users on opiate substitution treatment to retain employment [13, 14, 17]. Furthermore, this shift in drug policy towards a focus on health and wellbeing of the individual signals a change in how drug users are viewed that may lead to decreasing stigma. In turn, this may encourage drug users to access healthcare services and treatment.

The new approach and transition to harm reduction strategies has unsurprisingly not been without barriers. Although the Ministry of Health and the Royal Malaysian Police have made cooperative efforts to enable the implementation of the NSEP and MMT (i.e. the National Needle and Syringe Exchange Program: Police Standard Operating Procedure)[18],the fundamental "clash" between punitive drug policies and harm minimisation strategies has impeded the carrying out of these programmes. Illustrative of this conflict is the law on the possession of injecting equipment - Section

37 of the Dangerous Drugs Act 1952 –which is contrary to the key component of the NSEP of providing sterile paraphernalia. It has been reported that injecting drug users accessing the needle syringe exchange and methadone provision sites continue to face harassment and arrest by law enforcement personnel around the vicinity [14].

As stated above, law enforcement practices often lead to the dispersal of drug users and their retreat to hidden locations. HIV services are interrupted when NGO workers are unable to locate the injecting drug users to deliver harm minimization information and materials, and they are unlikely to attend the drop-in facilities that provide services, including basic medical attention, counselling and respite care.

The entrenched view that the appropriate recourse to illicit drugs and drug taking behavior is a prohibitionist approach deepens the stigma attached to drug users and discrimination towards them in many settings, including at health care facilities. Medical practitioners have been known to be hesitant in prescribing anti-retroviral therapy to HIV positive injecting drug users due to concerns regarding poor adherence [14]. As well, injecting drug users are unlikely to seek treatment and health services if they perceive they will be discriminated against.

Laws and enforcement practices – enablers or impediments to HIV services

In Malaysia, there are six main statutes pertaining to drug offences. These are the i) Dangerous Drugs Act 1852, ii) Poisons Act 1952, iii) Drug Dependants (Treatment and Rehabilitation) Act 1983, iv) Dangerous Drugs (Special Preventive Measures) Act 1985, v) Dangerous Drugs (Forfeiture of Property) Act 1988 and; vi) National Anti-Drug Agency Act 2004. The agencies responsible for the implementation and enforcement of the laws are the Internal Security Ministry and National Anti-Drugs Agency. The details of these laws are presented in Table 1.

Table 1

Laws	Details
Dangerous Drugs Act 1952 (revised 1980):	
• Section 9	Possession of prepared opium is an offence
• Section 10 (2)	Criminalisation of possession of utensils used to prepare opium
• Section 15	Self-administering a dangerous drug is an offence
Drug Dependants (Treatment & Rehabilitation) Act 1983	Mandatory to detain and rehabilitate a person with drug dependency
National Anti Drug Agency Act 2004	Mandate: main agency responsible for policy formulation on drug use prevention, treatment, rehabilitation and enforcement

The main approaches to addressing laws and policies that are barriers to addressing HIV and AIDS and injecting drug use that should be considered are: a) decriminalising or depenalising individual drug use and possession, and b) integrating harm reduction into law enforcement and drug control

policy[19]. Evidence demonstrates that such approaches have not increased drug dependency or the prevalence of drug use[19].

Depenalising is a less punitive approach that would include practical diversionary methods to redirect the offender from the criminal justice system to non-punitive interventions such as community-based treatment and voluntary rehabilitation. This would reduce incarceration and the pressure on the prisons system and allow for access to a range of health and social services.

Although the Ministry of Health and the Royal Malaysian Police have made efforts to cooperate on the implementation of the NSEP and MMT, the full integration of harm reduction strategies into law enforcement policies and practices is required. For on-the-ground policing to reflect incorporation of the strategies, comprehensive education and training of law enforcement officers are required; a significant gap exists of police personnel knowledge (at various levels) on harm reduction and its link to curbing the spread of HIV [18].

The above two approaches should be applied in tandem, as a single approach is unlikely to achieve the goals of reducing drug use and its potential harm to the individual and wider community, and mitigate the transmission of HIV. A combination of approaches has a number of benefits including, improved attendance at voluntary programmes to manage drug dependence and decreased drug-related crime. In addition, law enforcement efforts can be re-focused on drug trafficking and securing public safety.

Sex work and sex workers

A study by Lim, Ang and Teh [20] reported there are an estimated 60,000 sex workers in the country, of whom 40,000 are female and 20,000 are transgender persons (mostly female transgenders); estimates of male sex workers is unavailable. An Integrated Bio-Behavioral Surveillance study conducted in 2012 reported a HIV prevalence of 4.2 per cent among female sex workers[11]. In the sex work industry many sex workers are based in venues such as brothels and entertainment outlets, while others do not work at specific locations and are street based.

The Malaysian public's impression of sex workers and sex work is shaped largely through the media where police raids on brothels, massage parlours or karaoke outlets are reported to create sensational news[21]; or the tagging of 'red light' areas identified with sex workers and brothels. The negative and illicit image is compounded by the close association of sex workers and sexual transmission of HIV, and combined with the overlay of criminalisation of sex work, pose serious challenges to HIV policies and programmes. The illegality of sex work exposes the vulnerable position of sex workers to HIV, which impact on their access to HIV programmes. Sukhtantar [22] posits there are several factors that contribute to their vulnerability - the work, violence and limited access to healthcare services.

The conditions surrounding sex work such as concealment of sexual relations and threat of exposure lead to inconsistent safe sex practices. The threat of and actual harm to and victimisation of sex workers by perpetrators (e.g. clients and law enforcement personnel) place sex workers at higher risk of being infected [23]. The inadequate access to prevention and treatment services, often due to stigmatisation and discrimination by healthcare and welfare providers, limit sex workers' capacity to protect against infection and obtain antiretroviral therapy and sexually transmitted infections screening and treatment[24].

The criminalisation and harsh law enforcement practices targeting sex workers in Malaysia has raised multiple layers of issues [25-27], including:

- harassment by personnel from the many law enforcement bodies (i.e. police vice squad, immigration department, anti-drugs agency and the religious police), and allegations of extensive corruption;
- the threat of detention for engaging in sex work by law enforcement officers if sex workers are found to possess condoms (exceeding three); used condoms taken and used as evidence of sex work activity, thus, countering HIV prevention interventions, i.e. condom promotion and safe sex behaviour;
- pervasive abuse against sex workers (e.g. by pimps, clients, partners and law enforcement personnel); and
- disempowerment of sex workers as there are impediments to complaints and recourse against violations by law enforcement personnel (both civil and religious).

Provision and access to HIV services

The context of sex work (i.e. illegality, invisibility and social marginalisation) poses many challenges to delivering HIV services to sex workers and their clients in Malaysia. The few service providers are mostly community-based organisations who are best skilled and experienced to work with the community. Provision of services include outreach work (e.g. to brothels), peer-to-peer education and drop-in centres which provide education on HIV and sexually transmitted infections and safe sex practices, commodities (e.g. condoms and lubricants), and information on voluntary testing and counselling.

A legal environment that facilitates and empowers is a pre-requisite for prevention and treatment programmes to be effectively carried out. Critically, how these laws are interpreted by enforcement officers is a key factor to ensuring programmes are not challenged and sex workers have unimpeded access to health promotion and social services. For example, an essential prevention strategy is education on safe sex practices and the appropriate use of and distribution of condoms and lubricants. Yet, a common enforcement practice is to cite possession of condoms as evidence of sex work (see above) which undoes prevention efforts and also damages working relations (i.e. trust is fractured) between field/outreach workers and sex workers, jeopardising future service provision. The threat of raids conducted by law enforcement agencies (i.e. the police, religious authorities and immigration department) produces a hazardous climate for sex work as transactions are often carried out hurriedly (reducing the opportunity to negotiate safe sex) and/or in circumstances where safety and freedom from violence cannot be ensured, further increasing the risk of HIV infection.

Criminalisation and the negative representation of sex work (i.e. through the media and public campaigns) reinforce judgemental social attitudes towards sex workers and are also reflected among many health care workers. For example, sex workers are reported to have avoided seeking treatment for sexually transmitted infections and reproductive health services at most public health care clinics [28] as they encounter staff that have not been appropriately trained to administer to sex workers and their specific needs, instead disregarding sex workers as individuals with rights to health and health care.

Adverse consequences also directly affect the staff of organisations which provide HIV services. Outreach workers report experiences of intimidation as they carry out their tasks as often they would have in their possession condoms and lubricants and educational material (e.g. with graphic illustrations) for distribution to sex workers. At drop-in centres a perceivable decrease in sex workers accessing the facilities is noted when raids conducted by law enforcement authorities to expose "illegal" activities have been conducted in the vicinity, as sex workers would retreat underground. Also, law enforcement officers have been reported to harass sex workers as they access facilities that dispense HIV related services.

Laws and enforcement practices – enablers or impediments to HIV services

The laws that criminalise sex work and sex workers in many countries are often:

- criminal offences pertaining to adult sex work and the sex industry;
- public order, vagrancy and other offences selectively enforced against sex workers;
- trafficking laws that are enforced against sex workers, rather than traffickers.

In Malaysia, the types of laws and offences applied to sex work and sex workers are consistent with the above categories. Sex work conducted in private is not illegal, however, the act of soliciting and operating a brothel are both illegal. The Penal Code (Act 574) and Minor Offences Act 1955 are laws that directly relate to sex work and sex workers. In addition, Sharia law is applied to Muslims who engage in sex work – the acts of 'zina' and 'khalwat'. In Table 2, the details of the laws are provided.

While the intent of the law is to penalise all elements related to the sex industry, strategies must be identified and applied to minimise the adverse consequences of criminalisation that compromise the national HIV response and to uphold the basic human right to health. A step-by-step approach to repealing laws and converting punitive law enforcement practices to collaborative initiatives among key stakeholder, within the government and non-governmental partners is required. Existing collaboration between the two sectors, albeit on a modest scale to curtail disruption of HIV services by law enforcement practices should be strengthened. These include developing standard operating procedures that accommodate HIV interventions, continued training for relevant government agencies on their role in contributing to a response that is health based (e.g. not presenting used condoms as evidence of sex work), intensifying the dialogues and negotiations at policy and operational levels to actualise practical agreements and actions (e.g. deterring abuse and violations of sex workers), and joint field expeditions to study successful measures applied by countries with similar situations (these approaches can also be applied to the drug use setting).

A necessary step is a legal review of laws and criminal penalties pertaining to sex work, specifically the Minor Offences Act and the Penal Code (Act 574) (see Table 2), in conjunction with an examination of regulatory frameworks that have been applied to sex work venues (including brothels and entertainment outlets) and harm reduction programmes (i.e. condom promotion) in neighbouring countries that may be plausible and practical alternatives. It is important for the state to a) affirm the basic rights of sex workers in equality under the law and to access legal services and non-discriminatory health services, and b) sanction protection of sex workers from all forms of violence and exploitation. In addition, mechanisms for sex workers to report abuse by law enforcement officers should be established and penalties applied.

Men who have sex with men

The number of men who have sex with men in Malaysia was estimated to be 173,000 in 2008 [9]. As of end 2011 there were 2,406 reported cases of HIV among this population, or 2.5 per cent of the total reported cumulative cases of HIV[5]; incidence rates of HIV infection within this community is unknown. Compared with the HIV epidemic among injecting drug users, the reported cases of HIV among men who have sex with men is relatively low. However, HIV infection through sexual transmission is on the increase and has surpassed injecting drug use in the last two years [9]. The men who have sex with men population is facing a rapid increase of HIV infections, in which MSM are disproportionately affected by the epidemic; men who have sex with men are 18.7 times more likely to be infected than in the general population[29]. Two studies on risk behavior and knowledge of transmission methods among men who have sex with men in specific settings have reported HIV prevalence at 3.9% and 9.2% among study cohorts [30, 31].

Table 2

LAWS	DETAILS
Child Act 2001	
Section 43	Conviction for prostitution and trafficking of a minor (for the purposes of prostitution)
Minor Offences Act 1955:	
• Section 18	Disorderly conduct in hotels, boarding-houses
• Section 21	Arrest for indecent behaviour
• Section 27	Arrest for indecent or disorderly behaviour in or near public road or resort
Penal Code (Act 574):	
• Section 372 (1):	Exploiting any person for purposes of prostitution
• Section 372A	Persons living on or trading in prostitution
• Section 372B	Soliciting for purpose of prostitution
• Section 373	Suppression of brothels
• Section 377D (gross indecency)	Outrages on decency
• Immigration Act 1959 Section 8	Sex worker would fall within the category of "Prohibited Immigrants"
• Anti-trafficking Persons Act 2007	All forms of exploitation - sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude, any illegal activity or the removal of human organs
Syariah Criminal Offence 1997 (Federated Territories) Act 1997	
• Section 21 (1) – prostitution	Any woman who prostitutes herself shall be guilty of an offence
• Section 21 (2)	Any person who— (a) prostitutes his wife or a female child under his care; or (b) causes or allows his wife or a female child under his care to prostitute herselfshall be guilty of an offence
• Section 27 – *khalwat*	a) man who is found together with one or more women, not being his wife or mahram; or (b) woman who is found together with one or more men, not being her husband or mahram, in any secluded place or in a house or room under circumstances which may give rise to suspicion that they were engaged in immoral acts shall be guilty of an offence
• Sharia Criminal Offences	Differ from the above; state by state regulation

In the mid-80s when the first cases of HIV were reported [32], the early prevention and care and support initiatives for men who have sex with men were at the community level [33], albeit at a low scale. Until now, community-based programmes continue to be the primary response with minimal support (i.e. funding) from the government. This community is largely hidden as homosexuality is

highly stigmatised, more so with laws (civil and Sharia) which prohibit sexual relations between men, as shown in Table 3.Punitive laws generate an environment of fear and intimidation, and men who have sex with men have faced abuses by the police[34]. The existence of sodomy laws allows law enforcement officers to intimidate and harass men who have sex with men. For example, the police conduct periodic raids of venues frequented by men who have sex with men for the purpose of detecting drug use or other illicit behaviour. These activities are usually sensationalised by the media in their reporting, reinforcing the association of vice with same-sex behaviour [35].

These threats extend to owners of the establishment patronised by men who have sex with men, particularly if safe sex education and prevention materials (e.g. condoms) provided for the patrons are found on the premises as these could be viewed by the police as breaching laws, specifically Section 292 of the Penal Code (see below) [30].

Provision and access to HIV services

Evidence shows that criminalisation and illegality of sex between men, which exacerbates the social stigma of homosexuality, can negatively affect HIV prevention and treatment programmes [36, 37]. Detrimental consequences include, i) impeding HIV interventions (e.g. police may disrupt targeted HIV education at men who have sex as men, as it may be deemed to be promoting or condoning

Table 3

LAW	DETAILS
Minor Offences Act 1955:	
• Section 18	Possession of prepared opium is an offence
• Section 10(2)	Arrest for indecent behaviour
Penal Code (Act 574):	
• Section 377A	Wilful Intercourse against the order of nature by penile penetration to the anus or mouth of the recipient
• Section 377B	20 years imprisonment and whipping for an offence under Section 377A
• Section 377C	Forceful Intercourse against the order of nature by penile penetration to the anus or mouth of the recipient
• Section 377D	Outrages on decency
• Section 292	Circulation of "obscene" material is an offence
Penal Code (Act 574):	
• Section 25 - *liwat*	Any male person who commits liwat shall be guilty of an offence
• Sharia Criminal Offences	Differ from the above; state by state regulation

same sex activities); ii) discouraging health seeking behaviour (e.g. men who have sex with men fear their sexual orientation may be found out and their confidentiality breached), iii) reluctance of the government to provide resources for HIV services and behavioural and epidemiological research required for development of effective and targeted interventions; iv) lowered self-esteem and increased risk behaviour due to social marginalisation, and v) discrimination by health care practitioners as criminalisation reinforces prejudiced social views [34].

Of the few studies conducted in Malaysia on the prevalence of men who have sex with men behaviour and their knowledge on HIV, it was found that high risk behaviour was occurring within this population and they had low knowledge of HIV transmission methods [30, 31, 38]. This suggests that HIV information and education may not be reaching this population or communicated effectively, which could be due to the following:

- The repressive legal environment disallows public messaging related to HIV prevention for men who have sex with men, and HIV education occurs during discreet outreach activities, including at saunas, massage parlours and clubs;
- Programme coverage is limited. For example, outreach work is confined to a few major cities, e.g. Kuala Lumpur and Penang, due to resource limitations;
- HIV transmission information and condoms have to be packaged carefully to avoid being labelled as pornographic or obscene and seized by law enforcement authorities (i.e. Penal Code (Act 574) Section 292);
- One community-based organisation, the PT Foundation, implements prevention and care and support activities for the men who have sex with men community. Due to resource constrains, most initiatives run on a project basis, i.e. short funding cycle, thus, uncertainty of funding and interruptions to interventions are impediments for sustained and comprehensive programmes;
- Registration of organisations. The strict conditions of the Societies Act constrains registration of civil society groups, and the Registrar of Societies would unlikely allow the formal establishment of a group linked to men who have sex with men. This impedes mobilisation and organising at the community level to respond to the epidemic;
- Inadequate resources. Funding for men who have sex with men programmes have been sourced from external donors, however, this has ceased as funders have prioritised support to lower income countries. Limited funding by the government has constrained the expansion of community-based programmes.

The repressive legal environment has also affected the access to HIV treatment services by men who have sex with men. HIV testing is avoided for fear of confidentiality breaches, thus, jeopardising opportunities for prevention interventions and enrolment in antiretroviral treatment that can reduce HIV transmission. The government heavily subsidises anti-retroviral treatments and associated medical treatments in public healthcare centres, e.g. hospitals, but from anecdotal testimonies of some HIV positive men who have sex with men, they prefer to seek treatment in neighbouring countries. The reasons cited are fear of exposure of their identity, discrimination by healthcare workers and preservation of anonymity when abroad.

***Laws and enforcement practices – enablers or impediments to HIV servic*es**

It is evident that criminalisation and high levels of stigma has had adverse consequences on the delivery of HIV services. To minimise repressive conditions and law enforcement practices which violate the rights of men who have sex with men and jeopardises their access to prevention and treatment interventions, the following should be considered:

- decriminalising same sex orientation and behaviour (i.e. adult consensual sex in private) - Penal Code Sections 377A, 377B, 377D; and

- depenalising offences related to possession of HIV prevention materials, including targeted educational resources and commodities (i.e. condoms and lubricants)

Female transgenders or mak nyahs

One of the communities most vulnerable to HIV infection is the female transgender sub-population. A bio-behavioural study conducted in 2009 [6] revealed HIV prevalence to be at 9.7 per cent among mak nyahs. The minimal data available about HIV risk of transgender women, globally, is reflected in Malaysia where few studies have been conducted to ascertain the extent of their vulnerability to HIV and risk behaviours. In Malaysia, many of the transgenders engage in sex work and their low knowledge of HIV and use of condoms lead to higher risk to HIV infection [39].

Globally, studies show that transgenders' risks to HIV are disproportionate and are compounded by several factors, notably social stigma leading to discrimination and human rights violations. The social exclusion and continued marginalisation permeates most aspects of their lives, from attaining legal employment and accommodation to educational opportunities, leaving them with little recourse but to turn to sex work for a livelihood and to secure funds for hormonal treatments and sex re-assignment and related surgery surgeries[40]. The urgency to gain an income often increases risk-taking behaviours, such as acquiescing to clients' demand to abstain from the use of condoms.

Locally, the sex work environment for mak nyahs is similar to that of female sex workers. Transgender sex workers are confronted with similar hazards in their work – exploitation, harassment and violence – and face an added dimension of vulnerability to violence and threats by clients when their transgender identity is found out[40]. Clients may assault them or refuse to pay for the service; transgenders are disinclined to lodge reports with the police regarding these transgressions for fear of reprisal from clients or threat of arrest (i.e. engagement in sex work) by the enforcement authorities.

Criminal charges related to sex work have been brought against transgender sex workers who have also been penalised for cross-dressing and indecent behaviour. If they are detained by law enforcement officers, they face an intimidating situation while in custody. These include procedural arrangements that place them in cells with men which jeopardises their safety, degrading and humiliating treatment (some transgenders have disclosed anecdotally that they have been forced to expose their genitalia), and persecution based on their gender orientation[27]. If they are incarcerated for a longer period (e.g. prison) they are likely to be targeted by other inmates and experience various forms of violence, including sexual abuse which increases risk of sexually transmitted infections (STI) and HIV[41]. Furthermore, access to medical care (i.e. sexual reproductive health [SRH] services) may be denied.

Provision and access to HIV services

The increased visibility of mak nyahs, in part, is attributed to their inclusion as one of the populations most-at-risk within the context of the HIV epidemic as many are engaged in sex work. Interventions to educate on HIV and AIDS, prevention methods and facilitating peer support have been carried out at the grassroots level by a few community-based groups. Cognizant of the high levels of stigma and discrimination against transgenders, the underlying approach of the programmes conducted by some community-based organisations (e.g. PTF) is to empower the individual and community which are manifested in modalities including development of the self and human rights. The HIV related aspects are interventions or programmatic areas that range from peer outreach to drop-in centres that incorporate safe sex education, counselling, peer support, basic health services and

training related to legal rights. HIV services are concentrated in Kuala Lumpur, and transgenders located away from the capital city have scant options.

While HIV prevention and treatment interventions are vital, another health related necessity for transgenders is sexual and reproductive health information and medical services. Specialised SRH services for transgenders is scarce and only provided by few providers, including private medical practitioners and NGOs (e.g. Family Health Development Association). The lack of services to an extent has led to a common practice among transgenders to share information and seek advice through their peer networks on SRH matters and hormone treatments. Often, this leads to inaccurate information and self-prescribed administration of medicines and hormone therapy.

Few female transgenders are likely to view the public health sector as being able to meet their specific reproductive health needs, not least because of the discrimination they face but also few medical practitioners are trained and have the expertise to manage mak nyahs' complex health requirements and HIV related treatment. The judgemental attitudes of many health care workers and their poor comprehension of the multiple socio-economic and legal issues affecting transgenders create an unreceptive environment that deters their use of these facilities.

The repressive environment and adversities experienced by transgenders often result in their low self-esteem and contribute to mental health issues. Drug use is not uncommon among transgenders which adds yet another layer of complexity to the health issues faced by them.

Laws, policies and enforcement practices – enablers or impediments to HIV services

As discussed in the above section on legislation and sex work, a punitive approach has adverse consequences for mitigating the impact of HIV on the sex worker population. For the many transgenders engaged in the sex industry, the ramifications are compounded by the unique set of circumstances related to their gender orientation and identity.

Underlying their vulnerability to HIV is the absence of formal recourse to establishing a legal identity that records their self-identified gender and not the gender assigned at birth. In Malaysia, the legal framework does not recognise or allow for a change in sex . Without official identity documents mak nyahs encounter overwhelming barriers in conducting their day-to-day affairs, be it seeking employment or accessing public facilities. For example, most workplace regulations require employees to abide by a dress-code that reflects the employee's gender which creates a barrier for most transgenders to comply, thus narrowing their options of employment. In health care settings, transgenders have been known to have been turned away or treated discourteously which have resulted in non-access to medical treatment or deterring them from seeking health care services.

The laws which apply to transgender sex workers are the same as for other sex workers, and these are the Penal Code and Minor Offences Acts under civil law, and Muslim adherents are subject to Sharia law on sex work and in addition, to a specific law on "male posing as a woman" (Section 28), as presented in Table 4. The modus operandi of law enforcement authorities as discussed in the previous section on sex workers applies to enforcement practices with transgender sex workers, e.g. confiscation of condoms and use of condoms as evidence of illegal sex work activity. Harassment and persecution of transgender sex workers are heightened indicating that law enforcement authorities may be specifically targeting this segment of the sex worker community. The consequences of punitive law enforcement vis-à-vis HIV services for transgender sex workers are no different from other marginalised populations; this population will attempt to remain hidden, resort to strategies that result in increased HIV risk behaviour and avoid accessing services if law enforcement authorities are perceived to be "staking-out" service provision sites.

Table 4

LAW	DETAILS
Minor Offences Act 1955:	
• Section 18	Disorderly conduct in hotels, boarding-houses
• Section 21	Prostitute behaving in disorderly or indecent manner in public or near public road
• Section 27	Arrest for indecent or disorderly behaviour by a sex worker in or near public road or resort
Penal Code (Act 574):	
• Section 372 (1):	Exploiting any person for purposes of prostitution
• Section 372A	Persons living on or trading in prostitution
• Section 372B	Soliciting for purpose of prostitution
• Section 373	Suppression of brothels
• Section 377D (gross indecency)	Outrages on decency
Syariah Criminal Offence 1997 (Federated Territories) Act 1997	
• Section 21 - prostitution	Any woman who prostitutes herself shall be guilty of an offence
• Section 27 - *khalwat*	Any – (a) man who is found together with one or more women, notbeing his wife or mahram; or (b) woman who is found together with one or more men, notbeing her husband or mahram, in any secluded place or in a house or room under circumstances which may give rise to suspicion that they were engaged in immoral acts shall be guilty of an offence
• Section 28 – male posing as woman	Any male person who, in any public place, wears a woman's attire and poses as a woman for immoral purposes shall be guilty of an offence
• Section 29 - Indecent acts in public place	Any person contrary to Islamic law, acts or behaves in an indecent manner in any public place
• Sharia Criminal Offences	Differ from the above; state by state regulation

Operations or raids are mounted periodically by Islamic religious agencies to arrest and prosecute Muslim transgenders contravening cross-dressing and indecent public behaviour laws. These arrests are often reported by the media in sensational terms and accompanied by inappropriate images of those arrested; it appears the intended aim is to cause deep embarrassment and shame. Public statements by Muslim religious leaders and senior government officers of religious affairs department such as those denouncing transgenders and issuing recommendation that are not evidence based to 'rehabilitate' transgenders further magnifies already prevalent stigma associated with mak nyahs [42].Such pronouncements do not aid the Department of Islamic Development in their strategy to reach out to the may nyah community offering pathways to employment, self-development and HIV education [43].

There is compelling evidence that that criminalisation and punitive approaches to transgenders, particularly mak nyah sex workers, undermine the provision of HIV prevention and treatment services. There are two major aspects in the legislative framework that should be considered for legal review, namely laws pertaining to sex work and the sex industry (i.e. the Minor Offences Act and the Penal Code Section 574), and legal gender change. A legal review of the laws regarding sex work and sex workers as presented above (pg 10-11) namely decriminalisation and depenalisation, apply to transgender sex workers and are highly vital as they are disproportionately at higher risk of HIV infection. Law enforcement practices, in particular, are cause for concern as it appears the authorities are allowed to carry out their duties that transgress ethical codes of conduct when dealing with mak nyahs. Standard operating procedures which integrate non-discriminatory regulations should be established and adhered to, and a mechanism established that enables transgenders to lodge reports of violations and abuses without exposing themselves to recrimination.

A key barrier to mak nyahs from being able to meet their basic needs (e.g. securing employment, housing, use of public amenities and access to health care) is official legal identity certification which reflects their gender identity. For non-Muslim transgenders who have undergone sex reassignment surgery, there have been cases whereby attempts have been made to legally change their sex on identity documents but these have been unsuccessful. This option is unavailable to Muslim mak nyahs and they are 'trapped' in the binary of male/female gender identity. It would be instructive to study other Islamic countries, in particular Iran, which has taken a stance to allow sex reassignment medical procedures and for transgenders to change their gender on legal documentation, including national identity card, birth certificate and passport.

Young key affected population (YKAP)

Malaysia has a relatively young population with almost half comprising of children (0-14 years at 29.4%) and young people (15-24 years at 17.2%), as of 2010[44]. Of the total number of HIV cases, 35% are among young people aged between 13-29 years; the majority are heterosexual males who acquired HIV through injecting drug use[5]. The number of HIV cases for children below 13 years of age account for approximately 1% of total cases; most infections are attributed to vertical transmission [5]. However, the prevention of the vertical transmission programme has been relatively successful in stemming the rates of infection from mother to infant [11]. The lowered rate of new infections from mother-to-child transmission is not reflected in infection among older children or adolescents. The rate of infection for girls and women appear to be rising in the past 10 years, accounting for 20% of new reported infections in 2010 [5]. For this report, the focus will be on adolescents (i.e. less than 18 years) affected and infected by HIV, or young key affected people.

There are many layers of complexity when responding to children in relation to HIV. As a starting point, children are not a homogenous population but are markedly different according to their

stage of biological, psychological and behavioural development (i.e. at different ages); the evolving capacity of the child to make independent decisions is a vital consideration vis-à-vis interventions that directly affect them - Article 5, CRC [45]. In addition, there are inequalities that directly affect the status of the child or adolescent, including gender and socio-economic position, which contribute to their vulnerability and risk taking behaviour, particularly among young girls. Studies have shown that globally many adolescent girls experience sexual violence and forced sexual intercourse at an early age which places them at increased risk of HIV infection. The varying levels of vulnerability and degrees of risk requires specific interventions for distinct groups of young people, such as adolescents who are marginalised and more vulnerable, adolescent girls and adolescents living with HIV [46].

There has been limited research on HIV knowledge and sexual behaviour among young key affected people in Malaysia. However, available information indicates that many respondents have low knowledge of HIV and prevention methods, are engaged in at-risk behaviour (e.g. unsafe sex and injecting drug use), and begin sexual activity before 18 years of age [47, 48]. This suggests a gap in accessibility to and provision of HIV prevention education and services.

Provision and access to HIV services

Much of the HIV initiatives for adolescents focuses on general information on HIV and AIDS and are designed for delivery in institutional settings. The avenues of information on HIV for adolescents are mostly public campaigns, school curriculum (but it is unclear if its delivery is consistent), government peer education programme among youths, school-based outreach by NGOs and youth drop-in centres that incorporate HIV education.

Much of the education and distribution of information are targeted at the general adolescent population and limited to the larger cities, and few programmes address the segment of adolescents most vulnerable and at-risk of infection. Of particular concern is the segment of young key affected people who engage in injecting drug use, same sex sexual activity and sex work, exposing them to a higher risk of HIV infection. Knowledge on prevention in relation to these high risk activities that is specific for young key affected people is minimal and their (irregular, and if any) access to harm reduction information and technologies may only be through NGO outreach activities specific to adult most-at-risk populations. Similarly, health care services related to STI and SRH that is specific to the needs of adolescents is minimal and difficult for young key affected people to access. Adolescents, particularly the most-at-risk, would be averse to seeking services that in their views would breach their confidentiality and their identity would be disclosed to law enforcement officers and their parents or guardians. Also, they would be discouraged by the perceived stigma that is attached to involvement in illicit activities.

As will be discussed in the section below, the provision of and accessibility to the prevention, treatment, and care and support package is determined to an extent by the legal framework which establishes the parameters that 'permit' the delivery of HIV and health related services to adolescents.

Laws and policies – enablers or impediments to HIV services

Malaysian law provides for a protective environment for the child, and it has ratified the CRC (1995) which, in part, led to the Child Act 2001. Further to the CRC, the UN Committee on the Rights of the Child, General Comment No 3, sets out legal approaches for dealing with children and HIV and AIDS that include laws, policies, programmes which are non-discriminatory, facilitate children's access to HIV services, allow for their participation to shape responses, and prioritises the needs and best interest of the child. Subsequent to the Child Act 2001, the government developed the

National Policy on Children and the National Child Protection Policy (2009) which focus on the rights of the child to survival, protection, development and participation, in alignment with the principles of the CRC.As well, the policies emphasise the protection of children from all forms of harm and strengthening social and welfare support services to address the specific issues of children in need. It is unclear whether strategies for the provision of practical and accessible HIV prevention, treatment and care services have been incorporated into the policies.

The primary concerns in relation to HIV and young people include the various forms of stigma and discrimination they face (e.g. living with HIV, having a family member with HIV, gender and sexual orientation), access to STI and SRH services (e.g. medical care, prevention technologies, voluntary HIV testing and counselling), HIV treatment and care, and voluntary rehabilitation services. The accessibility of these services by young key affected people is bound by the national legislative framework which also has implications on service providers and the support they can offer. It should be noted that the mandate of the laws is to be protective of minors.

A recent study on 'Addressing Barriers and Improving Access to Comprehensive HIV Health Services in Malaysia for Young Key Affected Population' [47] identified laws which impede young key affected people'saccess to HIV prevention and treatment. These laws pertain to the legal determination of the age of a child, the age of criminal responsibility, and the age of legal capacity, illegal and illicit behaviour (i.e. same sex sexual activity, drug use and sex work) parental consent, legal age of marriage and consent to sex and the rights to confidentiality. In Table 5, an overview of these laws and the implications on access to HIV, STI and SRH prevention and treatment are presented.

It is recognised there are multiple perspectives on the matter of the law, HIV and children. The priority is to ensure policies and strategies are in place to minimise the risk of young people, particular those most-at-risk, from HIV infection.

Different approaches are required to address the challenges that arise from the legislative framework and policies which impede young people's access to HIV and related health care services, particularly within the context of the increasing rate of HIV infection through sexual transmission. One approach is to be cognizant of laws which are not harmonised, thus, contributing to contradictory translation of regulations among those involved in the care, support and protections of young people, including government social, welfare and health agencies, NGOs and parents/guardians. For example, service providers have the view that they are not permitted to make available SRH educational resources and clinical services to young people who have not reached the age of majority (18 years), without parental permission, or they can only be provided for "special cases" (e.g. young person living with HIV). However, the age of consent to sex at 16 years allows older adolescents to be legally sexually active.

A coherent and systematic approach is required to ensure that legislation and policies reflect the current national situation of children affected by HIV, are based on evidence and have considered models for service provision. The evolving capacity of young person's capacity to make informed and independent decisions have to be recognised, and their participation encouraged in order to actualise their right to health and health care.

People living with HIV

The number of people living with HIV in Malaysia continues to rise. As of end 2011, the cumulative number of people living with HIV is reported at 79,855 [5]. Most would have contracted HIV through the sharing of unclean injecting equipment, however, since 2011 reports indicate that more people are likely to contact HIV through sexual transmission than injecting drug use[11].

Table 5

LAWS	IMPLICATIONS FOR PROVISION AND ACCESS TO HIV, STI AND SRH SERVICES
Act 611: Child ACT 2001 (children under 18 years)	It is unclear for children under 18 years of age what services they can independently access. This would cause confusion among service providers such as health care workers on who they can deliver services to and the type of services they can offer. They may be reluctant to address the needs of young people who engage in at-risk behaviour (e.g. unprotected sexual activity), which leaves this group few options of prevention and treatment facilities.
Age of criminal responsibility: • Penal Code (Act 374) – section 82 Penal Code (Act 574) pertaining to carnal intercourse and sex work (including solicitation and exploitation) and similar legislation under Syaria law	Strict laws prohibit same sex relations (i.e. men who have sex with men), sex work and drug use. Persons involved in these activities, including young people, take steps to avoid detection or arrest by law enforcement officers. This poses challenges to locating, educating and providing services to this most-at-risk segment of young people. The criminalisation of these behaviours and activities reinforces the stigma attached to people who engage in illicit and illegal behaviour.
Age of legal capacity: • Age of Majority Act 1971	Requires minors to be accompanied by a parent or legal guardian when seeking medical/clinical services. While the broad intent of the law is to protect minors, it restricts and deters minors (i.e. older adolescents) from services such as voluntary HIV testing and counselling and treatment for STIs.
Age of marriage (civil law) • 21 for men and 18 years women Age of marriage (Sharia law) • 18 years for men and 16 years for women Consent to sex • 16 years for men and women	Unmarried Muslim adolescents who are sexually active would be averse to approaching facilities for educational and prevention materials (e.g. condoms) for fear that they would be reported to religious authorities. As well, service providers may be compelled to only produce educational materials for married persons. Limited SRH services (e.g. contraceptives) are provided to unmarried persons (i.e. adolescents), persons living with HIV and at-risk individuals at public health facilities and NGO centres (e.g. Family Planning Association).

The role of stigma and discrimination continues to be pivotal as impediments to HIV prevention, care, support and treatment, and undermines effective responses to the epidemic. The fear of HIV and its negative association to certain socially unacceptable behaviours (e.g. drug use) and communities (e.g. most-at-risk populations) discourages people from testing, accessing prevention information and seeking treatment. Critically, their invisibility creates a gap in the necessary involvement of people living with HIV in comprehensive HIV and AIDS policy and strategy development, and participation in prevention interventions [3].

Most people living with HIV in Malaysia would be doubly stigmatised as the public perceives individuals infected with HIV as having been involved in immoral and illegal behaviour. Malaysian PLHIV have reported experiencing stigma and discrimination in various settings including, at the workplace, religious sites, household and healthcare facilities [49]. Discriminatory actions against them include, dismissal from employment, forced HIV testing, isolation from others in institutional settings (e.g. drug rehabilitation centres), refusal of medical care and treatment, and ineligibility for health insurance.

A few countries in this region have established anti-discrimination laws protecting people living with HIV. Malaysia does not have such a legal framework to protect the rights of people living with HIV, nor clearly identified rights to HIV prevention (e.g. commodities such as condoms and education). Godwin [50] notes the Persons with Disabilities Act 2008 institutes rights for persons with disabilities to access a range of public facilities, education and livelihood opportunities. The implications of this law for a person living with HIV is unclear, e.g. would being infected with HIV be viewed as a disability. Likewise the overarching Constitution of Malaysia provides for the rights to education and employment irrespective of sex, religion, race, descent and so forth, but articulation on prohibition of discrimination based on HIV is absent. Other laws which affect people living with HIV are shown in Table 6.

Table 6

LAW	DETAILS
Prevention and Control of Infectious Diseases Act 1988	
• Section 12	Knowingly infects another person with HIV – an offence
Immigration Act 1959/1963, 8 (3) c	Entry will not be granted to those who refuse to perform a required medical exam
Immigration Act 1959/1963, 8 (3) b	(HIV testing is mandatory for incoming prospective migrant workers and for the annual renewal of work permits under the Policy of Mandatory Testing)
Sharia law (state specific)	Entry to Malaysia can be denied to people with mental diseases as well as to people with infectious diseases whose presence could be harmful to the Malaysian society

Various states have instated a Sharia requirement of mandatory HIV testing for pre-marital couples. Studies on pre-marital screening in faith-based settings have found that mandatory testing could generate social stigma and infringe on the fundamental human rights of infected individuals[51] and lead to avoidance of testing [52]; mandatory testing is not cost-effective in low prevalence settings [53],nor is there evidence to show that mandatory testing protects either partner (usually the woman) from HIV infection. It is recommended that mandatory screening is replaced with voluntary confidential HIV testing with pre- and post-test counselling. Also, concerns have been raised that support (e.g. counselling) for discordant couples were inadequate and often they were discouraged from proceeding with marriage[54]. As well, confidentially of the sero-status of infected partners will be breached as family members are informed of their HIV status.

PART THREE

Consultation on Policy & Legal Environments Related to HIV and AIDS Services in Malaysia

As part of the Review a two-day consultation was conducted. The Consultation was a platform to ascertain developments in the policy and legal arena and the implications on HIV and AIDS services, and to generate recommendations to strengthen enabling aspects as well as to address the impediments to programmes and initiatives. Participants comprised of representatives from key government ministries and departments, civil society organisations (CSOs), academia, clinicians and UN agencies (Appendix 1 – Participants list).

Day One

The first day of the Consultation was allocated for CSOs, particularly those working with key affected populations, to confer on the ramifications of legislation and policies on the implementation of interventions at the community level. This was to provide CSOs the opportunity to raise their concerns and consolidate recommendations to mitigate the negative consequences of laws and policies.

To facilitate the participants' discussions, they were provided with an overview of key policy and legal issues pertaining to the access and utilization of HIV and AIDS services in Malaysia, as well as the practices of enforcement personnel in applying the related laws, by the project consultant. Following this, CSOs deliberated in separate groups, one focused on the drug user population and associated risk behaviours and the other centred on sex workers, men who have sex with men, people living with HIV, and young key affected population and children.

The results of the CSO deliberations was captured in the "Civil Society's Consensus Statement of the Policy and Legal Environments Related to HIV and AIDS Services in Malaysia" (Appendix 2), to be brought forward to the following day's consultation. The premise of the statement was that health is a fundamental human right with an emphasis on an anti-discriminatory approach towards people living with HIV and affected communities at all levels and settings.

Day Two

The second day of the Consultation brought together representatives from different government bodies, the UN, academia and the SUHAKAM, a broader group of stakeholders, in addition to the CSOs. The first part of the morning was focused on setting the frame and context for the day's deliberations. The latter half of the day was set aside for group discussion with the aim of identifying strategies and recommendations to address challenges and barriers to access and delivery of HIV services.

The Consultation commenced with a welcome by the Chair of the Malaysia UN Theme Group, followed by the keynote address of the Vice-Chairman of the SUHAKAM (Appendix 4). The keynote speaker set the tone for the day's proceedings by emphasising that "equality and non-discrimination is the pillar on which all other human rights are based", as instated in the country's Federal Constitution. The status of the epidemic and context of the national response to HIV was presented by the Senior Principal Assistant Director (HIV/STI) of the Ministry of Health The speaker highlighted notable developments in addressing the epidemic, including the decline in the HIV notification rate, the relative success of the harm reduction programme and the likelihood of the country reaching the MDG6 target. It was reported that a shift has occurred in the major transmission method from injecting drug use to sexual transmission, and the Ministry of Health has developed strategies to address this transition. It was noted that the reported HIV infection rate is increasing among the key affected populations, including men who have sex with men and transgender people (but to a lesser extent among injecting drug users).

As a follow-on of the Day One civil society session, the consensus statement was presented by a CSO representative which provided participants with tangible proposals to consider as they re-assembled into designated groups to identify the policy and legal barriers and propose strategies to counter the impediments in relation to i) harm reduction interventions, ii) key affected populations and iii) testing, treatment, care and support.

The full transcript of the groups' analyses and proposals from the three groups are presented in Appendix 2.

The complete recommendations from the two day Consultation are integrated within the recommendations section in Part Four of this report.

PART FOUR

Propositions and recommendations

This section of the report encapsulates the major recommendations from the two-day Consultation, interviews with key stakeholders and findings from studies related to policies and legislation vis-à-vis HIV and AIDS. As well, limitations to this review and suggestions for further research to augment understanding on this issue are forwarded.

"Health is a basic human right, inherent to all peoples irrespective of their civil, political, economic, social and cultural background" - SUHAKAM

The rights-based approach to health is recognised as fundamental for the Malaysian population's well-being. The government's investment in healthcare for its people has produced a relatively low cost health care systems with universal and comprehensive services that has resulted in considerable health gains[55]; the government strives to ensure health care is affordable and accessible to those in need.

In relation to HIV and AIDS, first line antiretroviral medication to people living with HIV is provided by the government through the public health care system at no cost to people living with HIV (for those eligible for treatment) while second line antiretroviral medication is heavily subsidised. Also, to prevent mother-to-child transmission, antiretroviral prophylaxis is provided to pregnant women and mothers at public hospitals and health care centres. More recently, antiretroviral therapy has been made available to inmates in incarcerated settings, ie prisons and drug rehabilitation centres (in selected sites).

The initiative to roll-out the NSEP and MMT is a milestone in instating a national policy centred on halting transmission using a harm reduction approach in relation to injecting drug use. These programmes have been relatively successful as HIV infection rates are decreasing within the injecting drug users sub-population. To maintain the gains and turnaround the epidemic operational, collaborative and human resource issues have to be addressed, specifically, operational matters such as the inconsistent adherence to standard operating procedures (i.e. between the Ministry of Health and the Royal Malaysian Police).

The noticeable increase in the HIV infection rate through sexual transmission since 2011 was addressed during the mid-term review of the current National Strategic Plan on HIV/AIDS 2011-2015. Stated in the National Strategic Plan is, Strategy 1: Improving the quality and coverage of prevention programmes among most-at-risk and vulnerable populations[11, pg 23]which includes an emphasis on the prevention of HIV infection through unprotected sex. A range of interventions were identified including harm reduction strategies (e.g. condom promotion), provision of health services (e.g. SRH), and voluntary testing and counselling facilities.

A number of recommendations for the implementation of the interventions were proposed in the Mid-term Review Report, including the provision of prevention packages at premises or locations where key affected populations work or frequent, health and treatment related services (e.g. for SRH, voluntary counselling and testing (VCT), STI, and antiretroviral treatment at public (e.g. primary care centres) and private (e.g. family planning clinics) facilities, and the expansion of outreach services. It should be noted that much effort has been made to implement many of these HIV services which have been stymied by considerable challenges, namely a repressive legal and law enforcement environment (see Part Two).

Social and cultural beliefs and preconceptions are powerful influences in shaping views of risk behaviours associated with HIV transmission, particularly behaviour linked to illicit and illegal activities, in turn leading to stigma of and prejudiced actions against persons involved in these activities. Often, structural frameworks, such as laws and policies, are perceived as endorsement of these negative perceptions as they prescribe punitive actions against those involved in these activities. Legislation and policies are critical elements in facilitating or impeding an environment conducive for the development and implementation of effective HIV programmes. The Commission on AIDS in Asia report [3]states, "legal provisions should not hamper or disrupt efforts to control or treat HIV" and recommends governments to put in place legislative and administrative directives to relevant bodies, including enforcement agencies (e.g. police) and correctional sites to expedite the provision of services to key affected populations[3, pg 12]. Enabling environments are pre-requisites for the administering and sustainability of HIV related services, as well as the scale up of programmes to a national scale to achieve the required coverage at population level. The government's policies on the NSEP and MMT are examples of structural interventions to creating an enabling setting.

Therefore, a similar directive to that for the NSEP and MMT is necessary to curb the rise of HIV through sexual transmission. A preliminary step to policy development would be to expedite the establishment of a National Task Force on Mitigation of Sexual Transmission of HIV/AIDS, which is a recommendation from the Mid-term Review. A key mandate of the Task Force should be the study of evidence-based interventions and investigation of model legal frameworks and policies that facilitate an enabling environment for the development and provision of HIV services. Also, a priority should be the examination of existing local harm reduction strategies and health care initiatives to prevent sexual transmission that include education, promotion and distribution of condoms and lubricants, VCT, community care, STI and SRH services that are being implemented as these present opportunities for scale-up.

The HIV epidemic can be reversed through strong political leadership which takes action to eliminate impediments to comprehensive prevention and treatment, namely structural barriers such as legislations which hamper HIV services. An effective response will facilitate socio-economic development and contribute towards the government's goal of achieving developed country status by 2020.

Recommendations

The two-day consultation and interviews with key informants generated recommendations that are based on the frontline experiences of these stakeholders who attest to how laws and policies were being enforced and applied, and if they were barriers or enablers to an enabling environment. At many levels, these recommendations mirror the findings of operational research and reports from specialised thematic bodies, such as the Global Commission on HIV and the Law which have held regional dialogues on laws and practices relating to criminalisation of people living with HIV and populations vulnerable to HIV.

The recommendations are varied as some proposals focus on the repeal of specific laws and others reflect concerns regarding the practice or enforcement of laws and policies that directly impact on the delivery of services to populations most-at-risk. Furthermore, recommendations were assigned for action according to short to long-term time frames. For example, the period for a structural level intervention such as the introduction of a HIV anti-discriminatory act would be expected to be a medium-term (and onwards) project. As well, cross-cutting themes (e.g. stigma and discrimination) are identifiable which may indicate the extent and pervasiveness of particular regulations or policies affecting service provision.

It should be noted that many of the recommendations are aligned and iterations of strategies articulated in the NSP 2011-2015 and the Mid-Term Review of the NSP. The government is committed to implementing the activities outlined to achieve set targets to reduce HIV infection (particularly among the key affected populations) and to increase treatment for people living with HIV. To do so, it will have to address the structural barriers to creating enabling environments for the delivery of HIV services.

The recommendations are presented according to the categories of i) prevention, and ii) treatment, care and support services

Prevention services: This pertains to the interventions with key affected populations, and includes outreach, peer-to-peer education and support, drop-in centres, venue-based education, the NSEP and MMT.

It is necessary to reiterate that often the use of the law as a threat to arrest by (some) enforcement personnel causes considerable disconcertment among NGO workers and most-at-risk populations. As well, the existence of punitive laws will drive the most-at-risk populations undergrown or into hiding.

A. Policies

- Strengthen and expand coverage of the NSEP and MMT
    - To address gaps in inter-sectoral collaboration (e.g. among Ministry of Health, National Anti-Drugs Agency and NGOs) through conduct of operational research on impediments to effective implementation of harm reduction interventions (e.g. effect of counter-productive law enforcement practices), and multi-stakeholder consultations to review relevant standard operating procedures.
    - To expand the NSEP and MMT to incarcerated settings (e.g. prisons); this will facilitate treatment initiatives for inmates.

- Review of law enforcement practices
    - Examine standard operating procedures which counteract prevention efforts with key affected populations (e.g. possession of three condoms on sex workers and obtaining used condoms as evidence of sex work), reinforce negative perceptions and heighten stigma.

- Prevention services to young key affected population
  - Young people between 12 to 17 years of age are able to access prevention information and commodities, VCT, SRH services, including HIV and STI testing and treatment without parental consent (based on their evolving capacity to make independent decisions that affect their health and well-being)
  - Remove requirement of HIV test for admissions applications to tertiary education institutions (e.g. universities). Replace with HIV prevention information and services package for students.

REVIEW AND AMEND LEGISLATION:	FOR CONSIDERATION:
Sex workers & sex industry • Minor Offences Act 1955 – Sections 18, 21 and 27 • Penal Code Act 574 – Sections 372 (1), 372A, 372B, 373, & 377D • Sharia laws	• Examine models of regulatory frameworks vis-à-vis sex work venues and harm minimisation programmes in neighbouring countries. • Affirm basic rights of sex workers in equality under the law • Sanction protection of sex workers from all forms of violence and exploitation • Establish mechanisms for sex workers to report abuses by law enforcement officers (Details on page 11)
Men who have sex with men • Penal Code Act 574 - Sections 377A, 377B, 377D, & 292 • Minor Offences Act 1955 – Sections 18, 21 and 27 • Sharia laws	• To create an enabling environment punitive laws that generate an environment of fear and intimidation have to be addressed. • Criminalisation allows for unethical practices among law enforcers against marginalised populations, e.g. harassment and extortion (Details on page 13)
Transgender people or mak nyah • Minor Offences Act 1955 – Sections 18, 21 and 27 • Penal Code Act 574 – Sections 372 (1), 372A, 372B, 373, & 377D • Reinforcement of Regulation 16(c) of the National Registration Regulations 1990	• Legal identity documentation that reflects transgenders gender identity is vital to enabling them to conduct their daily affairs and access public facilities, including health care. Legal recourse is required to facilitate the change of gender on official documents. • Reinforcement of Regulation 16(c) of the National Registration Regulations 1990Sex work: see above considerations (Details on pages 15-16)

B. Laws

- Review and reform of laws (i.e. decriminalising and depenalising) which impede prevention strategies (i.e. for most-at-risk populations) and contravene public health principles.
- Review and amend state and federal Sharia law that requires mandatory pre-marital testing for Muslim couples. To replace with voluntary testing that ensures:

  i. Pre and post-test counselling
  ii. Confidentiality of HIV status confined to couples
  iii. HIV discordant couples retain the right to marriage

- Dangerous Drugs Act 1952 Reform Parliamentary Roundtable:

    - Continued government support of Roundtable process to align polices regarding harm reduction with components of the Dangerous Drugs Act

- Review of laws that affect the operations of NGOs' service delivery:

    - Societies Act: The Act states strict conditions for the registering of an organisation with implications for community-based groups who work with key affected populations. An inability for such groups to obtain legal status curbs their ability to obtain funding (e.g. most funders require recipients to have legal standing) and they may run afoul of law enforcement agencies when providing services.
    - Printing and Publications Act 1984 and Penal Code Act 574 Section 292s: Education materials have to be adapted to specific audiences and CSOs must be allowed to develop resources that are effective in delivering the required information regarding prevention. These materials should not be classified as obscene and are allowed to be distributed.

Treatment, care and support services: This encompasses services provided by the public and private (including non-governmental) sectors, including antiretroviral therapy, the NSEP, the MMT, drop-in centres, halfway houses and shelters. The policies on making available heavily subsidised antiretroviral therapy and related medical support at public hospitals are steps to provide people living with HIV with clinical assistance to ensure they maintain a good quality of life.

The polices on the NSEP, MMT and Cure and Care Centres are intended to improve the health of the injecting drug users, and are testament of the utility of structural interventions in mitigating the epidemic. To an extent, this shift in approach signals the move towards less punitive tactics and may lessen the stigma attached to key affected populations. This revised approach should apply to all policies and laws that inadvertently reinforce stigma and discrimination drive vulnerable populations underground and deter individuals from seeking timely medical and social support services.

A. Policies

- Antiretroviral therapy – accessibility to antiretroviral medicines

    - Second line antiretroviral medicines to be subsidised and available in all public hospitals;
    - Ministry of Health to study and consider WHO recommended antiretroviral therapy guidelines (CD4 500) for adoption;
    - Ministry of Health to revise the eligibility of HIV positive injecting drug users (who are not on MMT) to access antiretroviral medicines.

- Antiretroviral medicines – trade related procurement agreements and intellectual property rights

    - Close inter-sectoral collaboration (i.e. Ministry of Health, MITI & MDTCA) to review implications of, i) TPPA and EU FTA on generic ARV competition, ii) Intellectual Property chapter related to TPPA, and iii) maintainTrade-Related Intellectual Property Rights (TRIPs) flexibility and public health care protection under the WTO Doha Declaration.

- Incarcerated settings (i.e. prisons and government drug rehabilitation centres)

    - Development of standard operating procedures for provision of medical services, including provision of antiretroviral medicines to people living with HIV in lock-up settings;

- Expand availability of the MMT (e.g. for entire duration of incarceration) and antiretroviral therapy in the prisons systems; seamless transition to community run MMT programmes post-release of prisoners.

- Accelerate the phasing out of compulsory drug rehabilitation at PUSPEN centres and continue the conversion of PUSPENs into sites that facilitate expansion of care and cure clinics.

- Review procurement policies for medicines for co-infections, e.g. Hepatitis C, to ensure availability and accessibility at major public hospitals.

- Standardisation of guidelines among Ministry of Health, EPF and SOCSO for withdrawal of funds (e.g. for medical treatment).

- Malaysian Medical Association Charter: review to enhance measurements on confidentiality such as public boards and posters on the duty of confidentiality at all places and enforcement of monetary indemnity to patients in the event of breach

B. Laws

- Prevention and Control of Infectious Diseases Act 1988: Review the efficacy of this Act in curbing HIV transmission and consider adverse consequences of its application

- Introduce a HIV anti-discrimination bill: prohibits discrimination against PLHIV (in all areas) and affected persons (including migrants), mandatory HIV testing and breach of confidentiality, termination of employment based on HIV diagnosis.

- Section 377A and B of the Penal Code: review interpretation of contents as drafting includes consensual participants from all background, married or gay

- Reinforcement of existing laws that protect and uphold rights for affected people such as Regulation 16(c) of the National Registration Regulations 1990 (amendment of gender expression on identification documents), and Section 12 of the Employment Act 1955 (statutory termination notice).

Limitations to the Review

A period of three to six months for a national review and consultation on the policy and legal environments related to HIV services was suggested in the review and Guidance Document for Asia and the Pacific Region (2013) for 'Conducting National Reviews and Multi-Sector Consultations on Legal and Policy Barriers to HIV services'[56]. For this review and consultation in Malaysia, a shorter timeframe was only available to carry out this project.

A drawback to this Review was not being able to secure interviews with all intended stakeholders, in particular with representatives from the Attorney-General's Chambers. A few of the respondents had limited time to be interviewed, as such restricted the data that could be obtained. Furthermore, all respondents were located in Kuala Lumpur and perspectives from stakeholders beyond the capital city were not gathered. Similarly, the two-day national consultation lacked the wider representation.

The brevity of the consultation only allowed for an abbreviated agenda, and the forum would have benefitted from a more comprehensive presentation of expert assessment on the legal framework vis-à-vis the epidemic and deliberation on practical inter-sectoral collaboration. Although many of the key stakeholders were present, there was a gap in the representation from the law enforcement sector, namely, the National Anti-Drugs Agency, Police and Immigration Ministry.

Nonetheless, this project provided an opportunity for stakeholders to take-stock of the legal and policy situation, assess impediments and identify steps to collaborate towards generating an environment conducive for mitigating the spread of HIV.

Conclusion

The HIV epidemic in Malaysia has changed its course in the last five years mainly due to the government's policy on the NSEP and MMT which has resulted in the decrease of infection rates among intravenous drug users. The investment in the harm reduction programme must not be jeopardised by laws, policies and law enforcement practices that have been counterproductive and are barriers to infected and affected people accessing HIV prevention, treatment, care and support services. Resources are finite and if detrimental processes and actions are allowed to continue there will surely be ramifications for the scale up of the harm reduction programme for intravenous drug user, as well as for other key affected populations particularly those who are most at risk of HIV through unsafe sexual behaviour. The increasing rate of cases through sexual transmissions must be addressed decisively and urgently to avoid a situation akin to HIV among injecting drug users.

There is no doubt that the gains made in the last few years to curb the epidemic must be built on and the momentum maintained. The premise of health and equitable access to health as every individual's fundamental right must underpin the determination of the laws, policies and law enforcement practices that directly impact on the realities of the population at ground level. The government, which has seen the rewards of its policy on harm reduction, must persevere and demonstrate continued leadership to play its part in the global community's commitment of "Getting to Zero: Zero New HIV Infections, Zero Discrimination, and Zero AIDS-Related Deaths (2011-2015)".

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APPENDIX ONE

Review and Consultation of the Policy and Legal Environments Related to HIV Services in Malaysia
(28-29 October 2013)

PROGRAMME

28 OCTOBER 2013

08.30 a.m.	Registration
09.00 a.m.	**Welcome and Introduction of Participants** Ms Fifa Rahman, Policy Manager, European Union Asia Action and CAHR Projects, Malaysian AIDS Council
09.30 a.m.	**Key Legal Issues Raised in the Review Report: Negative and Positive Health/Legal Impacts** Dr Susan Chong, Lecturer, La Trobe University
10.00 a.m.	Discussions
10.30 a.m.	Tea Break
11.00 a.m.	**Group Discussion 1: Validating Key legal Issues found in the Review Report**
12:30 p.m.	Lunch
02.00 p.m.	**Group Discussion 2: Identifying Key Priority Issues to be Raised at Consultation**

03.30 p.m.	**Plenary Presentation of Group Work and Building Consensus Statement for the Consultation**
04.30 p.m.	**Closing Remarks**

29 OCTOBER 2013

08.30 a.m.	Registration
09.10 a.m.	**Welcoming Remarks** Dr Graham Harrison, Chair, UN HIV/AIDS Theme Group
09.15 a.m.	**Community Voice**
09.30 a.m.	**The Nexus between HIV, Policies and Legal Environments** Datuk Dr Khaw Lake Tee, Vice Chairperson, National Human Rights Commission of Malaysia (SUHAKAM)
10.00 a.m.	Tea Break
10.30 a.m.	**National Epidemiology and Socio-Cultural Vulnerabilities** Dr Sha'ari Ngadiman, Deputy Director Disease Control Division and Head, HIV/AIDS Sector, Ministry of Health, Malaysia
10.50 a.m.	**Global Commission on HIV and Law Risks, Rights & Health** Edmund Settle, Policy Advisor, HIV, Health and Development, Asia-Pacific Regional Centre, United Nations Development Programme
11:10 p.m.	**Review of the Policy and Legal Environments Related to HIV Services in Malaysia** Dr Susan Chong, Lecturer, La Trobe University
11.30 a.m.	Discussions
12.00 p.m.	Group Work – Identification of Priority Policy and Legal Environments Related to Access to and Delivery of HIV services
01.00 p.m.	Lunch
02.00 p.m.	**Group Work – Identification of Strategies/Recommendations to Address Challenges/Barriers to Access to and Delivery of HIV services**
03.30 p.m.	**Plenary Presentation of Group Work**
04.30 p.m.	**Follow up and monitoring mechanism**
05.00 p.m.	**Closing Remarks**

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19. Genevieve Tan, Community Legal Aid Clinic of the Kuala Lumpur Legal Aid Centre
20. Hairudin Masnin, UNAIDS
21. Hisham Rahman, Malaysian AIDS Council
22. James George, UNDP
23. Juanita Lourdes Joseph, UNDP
24. Khartini, APSNW
25. Linda Tham, UNDP
26. Manohara, Malaysian AIDS Council
27. Mitch Yusmar, PT Foundation
28. Moi Lee Liow, APCASO
29. N. Sasidharan, Prisons, Anti-drugs &Civil Defence Division, Ministry of Home Affairs
30. Nisha Ayub, PT Foundation
31. Noel Ponniah, PT Foundation
32. Norlela Mokhtar, Pewahim
33. Oliver Sison, PT Foundation
34. Prof Teh Yik Koon, Universiti Pertahanan Nasional
35. Raymond Tai, PT Foundation
36. Shamala Chandrasekaran, Malaysian AIDS Council
37. Sulastri Ariffin, PT Foundation

APPENDIX TWO

Review and Consultation of the Policy and Legal Environments Related to HIV Services in Malaysia

(28-29 October 2013)

Civil Society's Consensus Statement of the Policy and Legal Environments Related to HIV & AIDS Services in Malaysia

"Health is a basic human right, inherent to all peoples irrespective of their civil, political, economic, social and cultural background" - SUHAKAM

Constitution of WHO affirms that:

- the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, and economic or social condition.

United Nations (UN) Universal Declaration of Human Rights (UDHR) Article 25 (1):

- everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

United Nations Economic and Social Council, General Comment on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) on the Right to the highest attainable standard of health states:

- (right) to health is access to healthcare services.
- Prohibits discrimination on any grounds;
- Emphasises equality and the special obligation of States to provide to those who do not have sufficient means with the necessary health insurance and healthcare facilities.

Stigma and discrimination associated with the epidemic is widespread. Key affected populations, including those living with HIV, face tremendous challenges in their everyday living, whether at the workplace, healthcare setting or home environment. Their vulnerable and marginalised status places them at increased risk of HIV transmission and criminalisation heightens these risks, and reinforces stigma and discrimination.

Civil society stakeholders at the "Meeting on Policy and Legal Environments Related to HIV and AIDS Services in Malaysia",

on 28 October 2013, propose:

(i) Consideration of a HIV anti-discrimination law that prohibits discrimination against PLHIV (in all areas), mandatory HIV testing and breach of confidentiality.
(ii) A review of laws which impede HIV and AIDS prevention strategies and contravene public health interventions.
(iii) Review criminal penalties for sex work and soliciting. Consider approaches that support safe and healthy behaviours in sex work settings.
(iv) Standard protocol for law enforcement agencies to recognise the implementation of NSEP and MMT (ie possession of needles and syringes, and self-administration of drugs). Expansion of harm reduction programmes in prisons (eg condom provision and needle syringe programme)
(v) Prevention and response to punitive practices by enforcement personnel towards MSM, transgender people, sex workers and people who use drugs.
(vi) Review of SoP regarding the confiscation of syringes and condoms, or use of syringes or condoms as evidence for prosecution or as a basis of arrest.
(vii) Voluntary HIV testing must include pre and post test counselling; confidentiality of HIV status confined to couples; HIV discordant couples retain the right to marriage
(viii) Removal of requirement for HIV in the workplace and admission into tertiary education institutions.
(ix) Transgender people are granted identity rights. Appropriate SRH and HIV services are accessible.
(x) Young people under 18 years of age are able to access prevention information and condoms, SRH services, including HIV and STI testing and treatment without parental consent (caveat re maturity).
(xi) Expansion of legal aid services and legal empowerment programmes (including legal education) for people living with HIV and key populations.

APPENDIX THREE

Review and Consultation of the Policy and Legal Environments Related to HIV Services in Malaysia

(28-29 October 2013)

GROUP PRESENTATIONS

I. Group One – harm reduction (specific to IDUs)

Issue: Discriminatory practises that may be a result of policies and laws

Recommendations:

a) SUHAKAM and Bar Council to follow up on recommendation No: ix of the SUHAKAM report, "Public Forum on The Right to Health: Achieving MDGs"
b) [create] laws to prohibit discrimination against people living with HIV/AIDS.

Issue: [Policies to address] lack of health services (including continuity of methadone) and HIV prevention in lockup, 14 day remand.

Recommendations:

a) [Malaysian AIDS Council (MAC)] to draft a proposal for pilot project for provision of health services in one lockup site. MAC will report to UNAIDS on progress and feasibility for implementation.
b) UNAIDS to conduct a comparative survey/study of benefits of medical services in lockup.

Issue: Medicines procurement policies affecting co-infections, in particular Hepatitis C

Recommendations:

a) Consultation among NGOS, Biro Farmaseutikal Kebangsaan and Bar Council regarding best practices in Hepatitis C medicines procurement policies based on a rights approach; UNAIDS to provide technical support.

Issue: Dangerous Drugs Act 1952

Recommendations:

a) Dangerous Drugs Act 1952 Reform Parliamentary Roundtable will be held on 3rd December 2013, MAC will forward proposals to amend laws that deter IDUs from seeking treatment and to scale up the harm reduction program and expand it to non-IDUs.
b) MAC to secure funding for Year 2 Drug Law Reform meeting. Call upon UNAIDS to follow up with the government on the concerns raised at the Parliamentary Roundtable.

Issue: SoP for NSEP and MMT implementation for law enforcement agencies.

Recommendations:

a) Operational research on law enforcement practices, consultations with police and multi-stakeholders to review SoP. MAC to lead the process.

Issue: Policy and procedures to commence MMT

Recommendations:

a) Review of the procedures regarding the start of MMT for IDUs and the take home doses, e.g. currently it is three days maximum.

In addition to the above proposals, this group produced recommendations for the Project Technical Steering Group, as follows:

1. Steering Group to ensure Bar Council and SUHAKAM follow up and participate with government in regard to law reform and review on discriminatory practices
2. Steering Group to require monitoring of advocacy of pilot project of medical services in a police lockup. To ensure sufficient support from medical sector.
3. Steering Group to require follow-up to Drug Law Reform Parliamentary Roundtable, and facilitate publicity of positive results of roundtable.

II. Group Two – key affected populations

Issue: Anti-discriminatory HIV laws and policies

Recommendations:

a) Consideration of HIV anti-discrimination law, policy and SoPsthat prohibit discrimination against people living with HIV (in all areas) and affected persons (including migrants), mandatory HIV testing and breach of confidentiality. In particular, the following should be considered:

i. Voluntary HIV testing must include pre- and post-test counselling;
ii. Confidentiality of HIV status confined to couples;
iii. HIV discordant couples retain the right to marriage
iv. Removal of requirement to declare HIV status for employment purposes and admission into tertiary education institutions.
v. Review health and life insurance policies to provide coverage for people living with HIV

Issue: Civil and Sharia laws and policies which impede HIV and AIDS prevention, care and treatment strategies that contravene public health interventions.

Recommendations:

a) A review of laws pertaining to:

   i. Sex Workers
   ii. Solicitation (sex work)
   iii. Cross dressing
   iv. Penal Code 377A andB
   v. Anti-Trafficking

Issue: S for law enforcement agencies

Recommendations:

a) Strengthen or establish a process for law enforcement agencies, CSOs and relevant government departments to:

   i. develop SoPs to implement a comprehensive National Sexual Transmission strategy
   ii. facilitate the implementation of the NSEP and MMT (ie permit possession of needles and syringes, and self-administration of drugs)
   iii. review enforcement methods that impede HIV prevention work such as punitive practices towards key affected populations, including men who have sex with men MSM, transgender people, sex workers, migrants and people who use drug (eg use of syringes or condoms as evidence for prosecution or as a basis of arrest).

Issue: Policies related to prevention interventions and services

Recommendations:

a) Scaling up of harm reduction programmes to include incarcerated settings (eg condom provision and needle syringe programme)
b) Transgender people to be legally recognized, and appropriate SRH and HIV services to be made accessible to them.
c) Young people between 12 to 17 years of age are able to access prevention information and commodities, voluntary counselling testing, sexual reproductive health services, including HIV and STI testing and treatment without parental consent (caveat re maturity)

Group Two strongly recommended that in order for the above recommendations to actualize in a transparent and accountable manner, a national statutory body (akin to the National AIDS Control Organisations in India and Indonesia) to bring together key stakeholders including government agencies, academia, CSOs, faith based organizations and the private sector is established.

III. Group Three - testing, treatment, care and support

LEVEL	TESTING	TREATMENT	CARE	SUPPORT
Structural	MoH and Department of Islamic Development (JAKIM) (national and state) discuss, develop and implement policies to ensure the movement from mandatory to voluntary testing for Malaysian Muslim couples	Ministry of Home Affairs to develop, implement and monitor SoP on lock ups to ensure adherence to treatment of people living with HIV MoH to ensure second line ARVs to be subsidized across the country MoH, Ministry International Trade and Industry (MITI), Ministry of Domestic Trade and Consumer Affairs (MoDTCA) to ensure that the Trans-Pacific Partnership Agreement and the European Union Free Trade Agreement (TPPA) should not interfere with the provisions of generic antiretroviral (ARV) medicines competition MoH, MITI, MoDTCA to discuss and take out the IP chapter from the trade negotiations related to TPPA Sustain Trade-Related Intellectual Property Rights (TRIPs) flexibility and public health care protection under World Trade Organization's Doha Declaration MOH to improve procurement policy for generic medicine MoH to adopt new WHO recommended ARV guidelines (CD4 500) for national ARV treatment	Employee Provident Fund and Social Security Oganisation to standardize/align criteria with MoH guidelines	
National	United Nations Development Programme (UNDP) to push MoH to require pre and post HIV and STI test counselling in hospitals and clinics and sensitize theMalaysian Medical Association and Association of Private Hospitals	MoH to revise/extend the eligibility (not too rigid) of ARV to HIV positive injecting drug users	MoH to ensure that positive women's right to reproductive health choices are respected and supported	UNDP to work closely with MoH in ensuring hospitals and clinics in key cities have people living with HIV support groups
Programmatic	SoP on HIV test and confidentiality in hospitals and clinics must be followed			
Grassroots		CSOs to work with local police in ensuring clients in remand adhere to their ARV treatment regimen		CSOs to work together in building and training peer support groups

APPENDIX FOUR

Consultation on policy and legal environment related to HIV/AIDS services in Malaysia

Keynote Address by Datuk Dr Khaw Lake Tee

Human Rights

Equality and non-discrimination, inviolable in every key international human rights agreement, are the pillars on which all other human rights rest.

In Malaysia, these fundamental principles are reflected in Article 8 of the Federal Constitution, which guarantees equality before the law and equal protection of the law. Thus, although there is no law in Malaysia expressly prohibiting discrimination on the basis of HIV status, these key principles should guide and support the contention that HIV status should not be used as the basis for any form of discrimination.

Central to the concept of human rights and freedom are the protection of human dignity. To quote Kofi A. Annan, the former Secretary General of the United Nations

"Human rights are the foundation of human existence and co-existence; that human rights are universal, indivisible and interdependent; and that human rights lie at the heart of all that the United Nations aspires to achieve in peace and development. Human rights are what made us human. They are the principles by which we create the sacred home for human dignity"

The Human Rights Commission of Malaysia (SUHAKAM) is a firm advocate of the human rights approach in dealing with the issue of HIV/AIDS.

We recognise that discrimination, marginalization, stigmatization and a lack of respect for the human rights and dignity of individuals and groups have heightened their vulnerability to becoming exposed

to HIV/AIDS. SUHAKAM's vision is a world where HIV/AIDs would be recognised and more effectively responded to, through a combined, largely expanded health, social and economic development strategy, firmly grounded in human rights.

Today's consultation on the policy and legal environment would greatly propel us in that direction.

HIV and Law

The laws in any country are an expression of a country's policies, and they are based on various cultural, religious, ethical and other norms that the local society considers important, reflecting what that society considers acceptable, or not, at any given period of time. Societal cultural and ethical norms are not fixed – they can and do change over time.

Policy and law can be a human good that makes a material difference in people's lives. It is therefore not surprising that policy and law has the power to bridge the gap between vulnerability and resilience to HIV.

Laws can protect the dignity of all people living with HIV, especially those most at risk such as injecting drug users (IDUs), sex workers, transgender people, men having sex with men, prisoners and migrants.

At the same time, law can have a negative impact on the lives of people living with HIV or those in at-risk populations. Laws can prohibit or permit specific individual or group behaviours and actions.

For instance, in many countries criminal law has been used as a regulatory tool to enforce moral values. Such laws may have the consequence of driving certain behaviours underground resulting in the unintended victimization and further discrimination of individuals. Evidence has shown that widespread use of criminal law to regulate sexual behaviour and drug use has had a profoundly negative impact on the epidemic and the social well-being of these sections of society, and consequently has impacted negatively on society as a whole.

For health-related issues, particularly where a disease may have been contracted through practices that are illegal or considered unacceptable or unusual, this may prove to be problematic, as it can easily prevent provision of prevention advice, services or support. And this is particularly relevant to HIV – this is a virus often contracted through practices which many societies around the world would sooner not admit occur in their society, and around topics that many individuals find difficult to discuss openly – such as injecting drug use, sexual activity, sexual identity and so forth.

In short, laws have proven to be discriminatory of persons with HIV status in many instances.

Through HIV, many lessons have been learnt – one of which is, that despite the sensitive nature of these issues, it is important that they are discussed in society, and that the lessons learnt, not only within our own country but also internationally, are examined to identify what evidence there is on the effectiveness and the unintended consequences of existing laws and policies.

And this is not a one-off discussion; it is an ongoing discussion to ensure that our laws reflect current society's perspectives on its cultural and ethical norms, and that the mechanisms available under the laws do actually achieve the intended results and minimize any unintended consequences.

Stigma and Discrimination

Key affected populations, such as injecting drug users (IDUs), men who have sex with men (MSM), transgender persons and sex workers are very frequently marginalized, stigmatized and discriminated against. This places them at significantly higher risk of becoming HIV infected.

Stigma and discrimination against IDUs, MSM, transgender persons and sex workers erodes their access to and utilization of HIV services.

IDUs, MSM, transgender persons and sex workers can face harassment and arrest from law enforcement agencies. Sex workers face harassment and violence, and this has a tendency to push sex work underground, where it is harder to negotiate for safer conditions and consistent condom use. Sex workers fear that carrying condoms can be used as evidence against them. Stigmatized and criminalized sex workers are unable to access programmes of HIV prevention and care. They may also be less likely to even get tested, with the result that there is a risk of further HIV transmission to other people.

The Yogjakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, provides recommendations on how, consistent with human rights principles, existing laws should be applied in specific situations relevant to sexual minorities. For instance, the Principles recommend that the medical records of sexual minorities be 'treated with confidentiality' and that states 'ensure that all health service providers treat clients and their partners with non-discrimination on the basis of sexual orientation or gender identity".

It should not be forgotten that there are also people who may be infected by HIV not through any practices deemed unusual or unacceptable by others in society.

Consider a child born to an HIV-infected mother who has not been able to access services that could have prevented the transmission of HIV to her child. Perhaps that mother had no idea of her HIV status, and perhaps she had contracted HIV from her husband or partner who had contracted HIV through earlier sexual contact with an HIV positive partner.

Consider too a person who received a life-saving blood transfusion that was not adequately tested for HIV.

Should the stigma, discrimination and fear in society, occurring because of the assumptions about sexual and drug practices which many consider are not 'the norm' or have no place in their society, also visit upon those who are innocent of any such practices?

All people with HIV deserve our non-judgmental support if we are to be able to successfully combat HIV in our society.

Gender and HIV/AIDS

Women are biologically more vulnerable to HIV, but gender inequality and discrimination that are enshrined in customs and traditions rob women of their power to negotiate for safer sex.

Sexual violence deprives women of their ability to control their lives and thereby protect their health, making them vulnerable to HIV.

Disclosure of positive HIV status also puts women at risk and in fear of violence.

While the HIV infection among males in Malaysia is showing a significant decline beginning in 2003, the female infection rate is showing the opposite trend. Women and girls are increasingly getting infected with HIV and constitute around 21% of newly infected persons nationwide in 2011 compared to barely 5% ten years ago.

Children and Young People

Global experience has shown that young people tend to take risks, and that they are not aware of the level of risk that they may be taking – this is true whether it is driving at high speed, smoking tobacco, drinking alcohol or trying other drugs, and sexual activity. Sexually active young people are particularly vulnerable to HIV. They are vulnerable to pressure from peers or boyfriends to engage in risky behaviours. There is therefore a need for them to be able to access appropriate prevention information, and for good quality, comprehensive sexual and reproductive health services to be available to young people.

There is also a need to provide and strengthen sex education among the young to prevent the spread of HIV. Indeed in 2006, SUHAKAM had recommended that compulsory HIV/AIDS education be made part of the secondary school curriculum.

Young people living with HIV, who may become infected either by birth to HIV-positive mothers or through sex or drug injection, have particularly complex needs.

Healthcare providers may deny young people's health services without parental consent. The proponent of such laws say that they protect children (a broad category including everyone from birth to 18), but in reality, fear of the disapproval and rage of their parents leads young people to avoid accessing reproductive health and HIV-related services.

Age-appropriate comprehensive sexual and life skills education, including information on HIV prevention, serves the health of young people.

Conclusion

Today, we come together as a group of individuals from diverse backgrounds and experiences to share our perspectives on the role of policy and law in order to facilitate an effective and efficient response to HIV. What we share is our abiding commitment to public health and social justice.

Many would say that the law can be complex and challenging and is best left alone. However, experiences from other countries around the world have shown us a very different perspective. Constructive dialogue on controversial issues can lead to better enforcement of existing law enforcement or sometimes progressive law reform.

SUHAKAM looks forward to a day where there is a law to prohibit discriminatory practices toward people living with HIV/AIDS so as to enable them to live with dignity and without shame and stigma.

APPENDIX FIVE

Review and Consultation on Policy and Legal Environments Related to HIV Services in Malaysia

List of Project Technical Steering Committee Members

1. YBhg Datuk Dr Khaw Lake Tee
   Vice Chair, Human Rights Commission of Malaysia (SUHAKAM)
2. Dr. Christopher Lee
   Department of Medicine, Hospital Sungai Buloh
3. Mr. Puravelan
   Malaysian Bar Council
4. Professor Adeeba Kamarulzaman
   Center of Excellence for Research in AIDS (CERiA)
5. YBhg Datuk Dr Raj Abdul Karim
   President, Malaysian AIDS Council
6. Ms Fifa Rahman
   Policy Manager, Malaysian Aids Council
7. Ms Zaki Arzmi
   Manager, Media and Communications Department, Malaysian Aids Council
8. Ms. Fatimah Abdullah @ Selvi,
   Pertubuhan Advokasi Masyarakat Terpinggir
9. Mr. Raymond Tai
   Acting Executive Director and ISEAN-Hivos National Programme Director, PT Foundation
10. Mr. Francis Oliver P. Sison
    PT Foundation
11. Mr. Chang Kai Peng
    Malaysian AIDS Council
12. Mr. Andrew Tan
    Kuala Lumpur AIDS Services Society
13. Dr Harrison Graham
    WHO Representative to Malaysia, Singapore and Brunei Darusalam and,
    Chair, UN HIV/AIDS Theme Group
14. Mr James George Chacko
    Assistant Resident Representative, UNDP
15. Mr Hairudin Masnin
    UNAIDS Country Manager
16. Ms Juanita Lourdes Joseph
    UN Coordination Specialist

APPENDIX SIX

Review and Consultation on Policy and Legal Environments Related to HIV Services in Malaysia

Terms of Reference for Project Technical Steering Committee

1. Background

The UN Economic and Social Commission for Asia and the Pacific (UNESCAP) Resolution 66/10 of May 2010, calls for the removal of legal and political barriers to universal access, in particular with regard to key affected populations. In addition, in March 2011, the UNESCAP Member States adopted Resolution 67/9, undertaking to initiate a review of national laws, policies and practices with a view to eliminating all forms of discrimination against people at risk of infection or living with HIV, in particular key affected populations. In February 2012, the Asia-Pacific High Level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and Millennium Development Goals was convened, in order to assess regional progress against the Resolution 66/10 and commitments in the Political Declaration on HIV and AIDS and Millennium Development Goals (MDG).

In Asia and the Pacific, key legal and policy challenges in relation to HIV include:

- Some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status;
- HIV-related stigma and discrimination in employment, healthcare and education settings;
- Compulsory detention centres for people who use drugs and sex workers; the death penalty for drug-related offences;
- Criminalizing sex work and sex between consenting adults;

- Restrictions on access to confidential HIV testing and other services on a range of grounds including age, marital status; nationality/migration status and for those in closed settings;
- Public security and police harassment, violence and selective enforcement of sex work, obscenity, vagrancy and other public order offences targeting MSM and transgender people9;
- International agreements and laws that hinder access to affordable ARVs.

The ESCAP Roadmap to 2015 includes the following key actions:

- a review of national laws, policies and practices to enable full achievement of universal access to with a view to eliminating all forms of discrimination against people at risk of infection or living with HIV, in particular key affected populations. (ESCAP Resolution 67/9, 2011);
- organize national multi-sectoral consultations, as appropriate, on policy and legal environment affecting universal access, in accordance with ESCAP resolution 67/9 (Regional Framework to Support the Implementation of International and Region-specific Commitments, E/ESCAP/HIV/IGM.1/3/ Rev.1, 2012)
- a regional overview of progress in meeting the commitments in the Political Declaration and ESCAP Resolutions 66/10 and 67/9 (early 2014)

2. HIV and the Law

In June 2010, UNAIDS Programme Coordinating Board (PCB) called for an establishment of an independent Global Commission on HIV and the Law, to conduct an 18-month research programme to examine existing evidence and generate new evidence on rights and the law in the context of HIV, and to develop recommendations. This Commission is led by UNDP and comprises international leaders from different sectors and public health experts.

Some of the key messages from the Commission were:

- Good laws and practices that protect human rights and build on public health evidence already exist – they strengthen the global AIDS response and they must be replicated or brought to scale urgently;
- Some laws have an adverse impact on human rights and could fuelling the spread of HIV, and limit effectiveness and efficiency of HIV and health investments;
- Structural drivers such as law have a vital role to play in ending HIV epidemic.

There is an urgent need to examine HIV-specific laws, broader laws that influence HIV, as well as policies and programmes that create enabling environments where laws cannot be changed.

3. Review and Consultation on Legal and Policy Environments Related to HIV Services

The United Nations Theme Group on HIV/AIDS in Malaysia has received some funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (ISEAN-HIVOS regional initiative) for a review and consultation on the Legal and Policy Environments Related to HIV Services in Malaysia. This is part of a regional initiative that will also take place in Indonesia, Philippines and Timor-Letse.

The regional initiative is designed to build upon the above noted UNESCAP Resolutions as well as the Asia-Pacific High Level Intergovernmental Meeting by undertaking an assessment on the legal and policy environments relating to HIV services. The initiative proposed to be undertaken in Malaysia by the United Nations Theme Group on HIV/AIDS in Malaysia has two primary activities:

a) Analysis/ study on the legal and policy environment in the context of HIV services in Malaysia;
b) Multi-stakeholder consultations to discuss the findings of the study and propose areas for further improvement of HIV services in Malaysia and submitted to the Government of Malaysia for consideration.

3.1 Country-level Review Stage

A review involves the analysis of the legal environment in the context of HIV services. The review may be conducted in various ways and may include:

- A consolidation of previous reviews and recommendations, with further research to fill any gaps.
- A desk review of relevant international and regional commitments, national laws, regulations and policies as well as research reports, submissions and case studies relevant to the HIV services in Malaysia.
- Interviews, surveys, questionnaires, site visits and/or focus group discussions with key stakeholders from executive, legislative and judicial branches of government, civil society, key population groups, traditional authorities, religious organisations, the private sector and international organisations, amongst others.
- The output is the report on the Status on Legal and Policy Environments Related to HIV Services in Malaysia

3.2 Consultation Stage

The primary purpose of the consultation is to provide a broad range of stakeholders with the opportunity to discuss and (where appropriate, validate or refine) recommendations for appreciation of law or other programme initiatives intended to increase access to rights-respecting HIV services by eliminating real or perceived impediments to delivery of equitable health services to all individuals and communities, particularly key populations at higher risk.

3.3 Steering Committee

To move the initiative forward, the United Nations Theme Group on HIV/AIDS will set-up a Project Technical Steering Committee (PTSC) to guide and provide feedback to the 2 activities above to ensure a multi-stakeholder perspective in the design and implementation of the activities. The expected role of the Project Technical Steering Committee, among others, is to:

- Provide oversight and technical guidance on the structure and substantive content of the studyand multi-stakeholder consultations;
- Review the findings or the study and feedback/ recommendations from the multi-stakeholder consultations;
- Provide feedback on identifying appropriate platforms to share, disseminate and support further strengthening of the legal and policy environment for HIV services in Malaysia.

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