

ROUND 9 – HIV

3. PROPOSAL SUMMARY

3.1. Duration of Proposal	Planned Start Date	To
Month and year: <i>(up to 5 years)</i>	January 2010	December 2014

3.2. Consolidation of grants		<input type="checkbox"/> Yes <i>(go first to (b) below)</i>
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 9 HIV proposal?		<input checked="" type="checkbox"/> No <i>(go to s.3.3. below)</i>
<p>'Consolidation' refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 9 proposal.</p> <p>→ <i>More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at:</i> http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FAQ_GrantConsolidation_en.pdf</p>		
(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval? <i>(List the relevant grant number(s))</i>	N/A	

3.3. Alignment of planning and fiscal cycles

Describe how the start date:
(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or
(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.
<p>As this proposal has only an NGO PR, government funding cycles are of limited concern here. The national Government of Malaysia budget is prepared on a two-yearly basis. Budget planning commences in the first quarter of the year. Government agencies are required to conduct a needs assessment and submit their proposals to the treasury by the end of the first quarter. Treasury evaluates the proposals and a consolidated national budget is tabled to Parliament by September. Approved funds are disbursed by early January of the following year to Heads of Departments.</p> <p>Once approved by the cabinet, the National Strategic Plan for HIV/AIDS budget is managed solely by the AIDS/STD Unit at the Ministry of Health. The funds are distributed to other government agencies and CSOs requiring funding for HIV/AIDS programming. The AIDS/STD unit reports directly to the Director General of Health. Internal and external audits are conducted regularly.</p> <p>To date, the CSO Grant Cycle for MOH Grants has been managed by the Project Implementation Unit of the Malaysian AIDS Council (MAC): this PIU has now been transferred to the Malaysian AIDS Foundation (PR).</p> <p>To date, the CSO Grant funding cycle process has commenced in June annually. There is a clear delineation of activities in the funding cycle summarized below:</p> <ol style="list-style-type: none"> 1. Project Management Workshop for the MAC and all its partner organizations (June) 2. Project proposal submission (end August) 3. Internal Review by MAC's key officers, i.e. Heads of Departments (September) 4. External (independent) Review by Proposal Working Group (October) 5. Presentation of proposed activities to the Ministry of Health (December) 6. Issuance of contracts and letters of approval for Long Term Projects/Non Contentious Activities (January)

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- 7. Submission of project listing to State Health Departments for Endorsement (January)
- 8. Disbursement of advance payment to successful project implementers by late January

Alignment to the GFATM Grant Disbursement

As this proposal is designed to begin in January 2010, it will be in alignment with the government funding processes for 2010 (which are being developed in 2009). This means that the GF project will be able to take advantage of government decisions for HIV prevention, care and treatment, and ensure there is no duplication between GoM and GF activities. The alignment of the CSO grant funding cycle with the GF grant funding cycle will be carried out in the first quarter of the grant period.

3.4. Program-based approach for HIV

3.4.1. Does planning and funding for the country's response to HIV occur through a program-based approach?	<input type="checkbox"/>	Yes. Answer s.3.4.2
	x	No. → Go to s.3.5.
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	<input type="checkbox"/>	Yes → <i>Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.</i>
	<input type="checkbox"/>	No. Do not complete s.5.5

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3.5. Summary of Round 9 HIV Proposal

Provide a summary of the HIV proposal described in detail in section 4.

This proposal reflects an unusual situation in Asia, perhaps globally. The Government of Malaysia (GoM) has fully accepted its responsibility to provide treatments and services for people living with HIV and AIDS, has organized national awareness and education efforts on HIV for the general population, and has supported very strongly (with both financial and public/ media support) efforts by non-government organizations to try to reach populations most-at-risk of HIV infection including injecting drug users, sex workers, transgendered people, gay and other men who have sex with men and prisoners. These efforts have seen the following results by 2009:

- 1.8 million needles and syringes distributed annually in 8 states
- 75 methadone centres (including 4 in prisons) with 7,065 clients registered
- Government STI service delivery points for sex workers in 3 states; drop-in centres in several cities for sex workers, MSM and transgendered people
- Anonymous VCT available in 1,099 health facilities
- PMTCT offered to 3m women (2000-2008)
- 8,187 PLHIV on ART of the 14,918 PLHIV estimated to be in need of ART: ART is available from 192 sites, 100% of which use CD4 monitoring
- Hospital PLHIV Peer Support Programmes now being implemented in 6 states

The private sector in Malaysia has, until late 2008, begun to contribute in significant ways to addressing HIV, including the creation of Living with HIV Champions at institutions such as the Standard Chartered Bank. NGOs in Malaysia have piloted a range of activities and strategies to reach most-at-risk populations and have been successful at a small scale.

However, with Asian financial crisis in the 1990s, followed by the Global Economic Crisis of today, Malaysia is unable to increase the government, private and NGO resources to scale up all the prevention efforts needed to reach and provide a full range of appropriate services to those most at risk of HIV infection. As Malaysia is an Upper Middle Income Country, with the GoM committed to spending at least 22.5m Eu per year from 2010-14 on HIV/AIDS medical and health needs of most-at-risk populations, this proposal seeks 54,937,995 Eu over 5 years to scale up NGO programs to reach on a regular basis a substantial number of those most at risk of HIV by 2014: i.e., 90,000 IDUs; 40,000 sex workers; 100,000 MSM; 18,000 transgendered people; 25,000 prisoners and 50,000 refugees, migrants and mobile populations.

Malaysia has a concentrated epidemic, with injecting drug use the main transmission mode. Although HIV prevalence has been less than 1 per cent amongst the general population, there are indications that infections are moving out of the IDU population (in which HIV prevalence has been consistently higher than 5 per cent for several years) into other sectors of the population. High HIV prevalence is also found amongst other vulnerable populations in various cities and states. Gender inequity, stigma, discrimination, silence, denial, and ignorance are widespread and help to fuel the epidemic. Therefore this proposal has the following goal, objectives and activities:

Goal: To reduce HIV transmission and reduce morbidity and mortality among most at risk populations in Malaysia.

Objective 1: To build a more supportive environment to ensure that the Malaysian HIV/AIDS response reaches those most at risk of HIV infection through

- Improved coordination of NGO services with an NGO PR and 19 experienced NGO SRs already identified and willing to massively scale up their services: specific staff and strategies to manage scale-up have been factored into budgets for these organisations
- Strengthening these NGOs to ensure they can build programs to reach the ambitious targets, especially concentrating on financial management, MIS, human resource development (especially in those organizations largely comprising MSM, IDUs or ex-IDUs, sex workers, transgendered people and ex-prisoners), organizational development and specialist technical capacity building to ensure that scale-up is based on evidence of effectiveness
- Improved coordination of NGO activities funded through this proposal with government-funded health system and NGO activities to achieve synergies where possible and avoid duplication
- Substantial advocacy training and other capacity-building to ensure that communities, faith-based organizations and fellowships and government agencies understand and work with NGOs on national scale-up of services to MARPs
- Community mobilization and stakeholder sensitization by the PR and all SRs, with a particular aim of raising awareness of the need to work with MARPs and reducing stigma and discrimination experienced by MARPs, including within the health system
- Operational research including mapping, population size estimation and health facility surveys as well as

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specific issues affecting project implementation such as barriers to service access by MARPs and models that ensure increased access to government health services

- Functional and integrated M&E systems in NGOs, integrated with the National HIV/AIDS M&E system for planning and monitoring scale up both in terms of regular reach and quality of services

Objective 2: To reduce the number of new infections among most-at-risk populations in Malaysia through:

- Building on the lessons learned by Malaysian NGOs in the past 15 years of successful strategies for reaching and attracting to services each of the most-at-risk populations (MARPs) covered by this proposal: IDUs, sex workers, transgendered people, gay and other men who have sex with men, prisoners, refugees, migrants and mobile populations
- Capacity building through trainer of trainers and ongoing and refresher capacity building and mentoring to ensure that scale-up proceeds as quickly as possible
- Reaching MARPs with BCC materials and strategies that are grounded in international expertise and local culture, outreach, drop-in centres and shelters in strategic locations; with the addition of a scaled-up needle-syringe program for IDUs and pre- and post-release programs for prisoners
- Increasing the linkages between NGO programs that reach MARPs and provide education and the means of prevention, and government and other health services providing VCT, STI, HIV and TB services, and (if needed) drug treatment (including methadone treatment)

Objective 3: To reduce morbidity and mortality related to HIV/AIDS through:

- In addition to current government-funded efforts, 10 PLHIV support groups and programs providing psychosocial support and advocacy for PLHIV and their families
- Establishment of 10 new drop-in centre/ shelters in strategic locations to provide accommodation and a range of services including psychosocial support, recreation facilities, nutrition, information services, and linkages to HIV, STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including methadone treatment).
- Expansion of the hospital peer support program with 500 PLHIV trained as Peer Support Workers
- Expansion of home and community-based care through BCC materials and strategies grounded in international expertise and local culture, and capacity building through trainer of trainers and ongoing and refresher capacity building and mentoring to ensure speedy scale-up.

The development and submission of the Country Proposal to the Global Fund is part of that continuing political and financial commitment to ensure that the national response to HIV is better equipped with the necessary tools and more comprehensive, particularly in communities which are not able to be reached by existing government healthcare services. This proposal will substantially help Malaysia realise MDG 6 related to the reversal of the HIV epidemic, which has spurred the Government into accepting the argument that extraordinary measures needed to be undertaken to effectively address the situation.

The activities in this proposal, combined with ongoing government-funded activities will lead to a substantial reduction in the number of people being infected with HIV each year in Malaysia. With the concentration on advocacy and community mobilization as well as large-scale prevention activities focused carefully on those most at risk of infection, it is planned that these activities will leverage increased community, private and government support over the period of the grant, leading to comprehensive HIV treatment, care and support in Malaysia by 2014. It should be noted that the only procurement in the attached budget is for needles and syringes, condoms, and equipment/ supplies for outreach, drop-in centres, offices and shelters. For this reason, the percentage of the budget required for some costs such as human resources are higher than they would be if procurement of ARVs and other medications were to be included. The Government of Malaysia has a highly functional procurement system for all medical supplies and equipment and is committed to providing from its own budget ART to all PLHIV in need of treatment.

4. PROGRAM DESCRIPTION

4.1. National prevention, treatment, care, and support strategies

(a) Briefly summarize:

- the current HIV national prevention, treatment, and care and support strategies;
- how these strategies respond comprehensively to current epidemiological situation in the country; and
- the improved HIV outcomes expected from implementation of these strategies.

The Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2) is based upon the recognition of the threat posed by HIV/AIDS as one of the high priority issues impacting upon the health care, economic and social development, and overall human security of Malaysia. The Strategic Plan aims to prevent the transmission of HIV, reduce morbidity and mortality related to HIV/AIDS, and minimise the impact of HIV/AIDS on the individual, family,

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community and nation.

The Strategic Plan – the fourth such National Strategic Plan on HIV/AIDS in Malaysia – has its foundations in the provisions of the Malaysian Constitution and current legislation related to HIV/AIDS, in addition to international treaties and obligations. The Strategic Plan was developed via a multi-sectoral consultative process, and takes into consideration Malaysia's social and economic development level, and its cultural and historical traditions. It also builds upon lessons learned from international experience. The Strategic Plan is complementary to the 9th Malaysian Plan (Annex 1) and the National Drug Strategy (Annex 6), and provides the basis for coordinating the work of all partners with a view to successfully achieving United Nations General Assembly Special Session on HIV/AIDS (UNGASS) targets and Millennium Development Goals (MDGs) on HIV/AIDS.

The core guiding principles of the Strategic Plan reflect the 'Three Ones' (i.e. one agreed national HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and one agreed national monitoring and evaluation system) in order to ensure an effective national response to HIV/AIDS. The Strategic Plan addresses HIV/AIDS as a development issue, not just a health issue.

The Strategic Plan acts as the master plan for the basis of coordinating the HIV/AIDS activities of all national stakeholders. It adopts an integrated approach to HIV/AIDS prevention, treatment, care, and support, consisting of six priority strategy areas including: strengthening leadership and advocacy; training and capacity enhancement; reducing HIV vulnerability among injecting drug users (IDUs) and their partners; reducing HIV vulnerability among women, young people and children; reducing HIV vulnerability among marginalised and vulnerable populations; and improving access to treatment, care and support. The Strategic Plan provides a framework for the provision of an appropriate balance between prevention, treatment, care, and support.

Close to 80 per cent of reported HIV cases in Malaysia occur among those aged 20 – 39 years, the younger and potentially more productive segment of the population. Malaysia has a concentrated epidemic, with injecting drug use the main transmission mode. Although HIV prevalence has been less than 1 per cent amongst the general population, there are indications that infections are moving out of the injecting drug user population (in which HIV prevalence has been consistently higher than 5 per cent for several years) into the general population. High HIV prevalence is also found amongst vulnerable populations in certain regions. For example, in 2000, the HIV prevalence rate among cohorts of sex workers in different parts of Kuala Lumpur was greater than 10 per cent (Annex 17). The escalation in the rate of HIV transmission amongst most at-risk young people, and the growing impact of HIV on women and girls, is of concern: by 2006, women and girls made up almost one-fifth of newly infected persons (Annex 16). While the main mode of transmission continues to be via injecting drug use, 27.4% of total new reported cases in 2006 as compared to 10.2% in 1996 were via heterosexual route; in 2007, it was 28.9% (Annex 18). Gender inequity, stigma, discrimination, silence, denial, and ignorance are widespread and help to fuel the epidemic.

ART: At end of 2008, cumulative figure of 8,187 PLHIV on ART, 14,918 PLHIV in need of ART according to NSP M&E report 2008 (Annex 57). Adequate supply of first line ART in government facilities: have not experienced stock out in the last 12 months.

CD4 Lab facilities: 100% facilities offering ART use CD4 monitoring; 16 healthcare facilities offer CD4 monitoring onsite and 164 via referrals

MMT: At end of 2008, there were 75 methadone centres in Malaysia, (59 government facilities, 9 private clinics, 3 post rehabilitation centres and 4 prisons): 7,065 patients registered, 5,024 retained.

SRH/STI clinics: There are 3 government service delivery points for sex workers where STI services are provided in the States of Pahang, Sabah and Sarawak.

PMTCT: The programme has successfully addressed the incidence of MTCT among 65% of all antenatal mothers (UNGASS Progress Report: Annex 14).

Hospital Peer Support Programmes: now being implemented in 6 states (major hospitals), PLHIV support in Infectious Diseases clinics for ease of referrals and continued treatment

Anonymous VCT available in 1099 health facilities (17% of public health facilities)

Prevention in healthcare settings: 100% use of new, disposable, single use injection equipment in healthcare facilities.

Improved HIV related outcomes anticipated as a result of the implementation of the six priority strategies detailed within the Strategic Plan include: the reduction of the number of new infections among young people aged 15–24; reduction in the number of new infections among adults aged 25–49; reduction in the number of new infections among injecting drug users and other most-at-risk populations (sex workers, the transgendered, and gay men and other who have sex with men); reduction in the number of HIV infected infants born to mothers infected with HIV; and increased survival of, and improved quality of life among, people living with HIV/AIDS.

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(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal (or, *identify the specific Annex number from a Round 7 or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
<input type="checkbox"/> National Health Sector Development/Strategic Plan		
9 th Malaysia Plan 2006 – 2010	Annex 1	Page 426
<input checked="" type="checkbox"/> National HIV Control Strategy or Plan		
Malaysia National Strategic Plan on HIV/AIDS 2006 – 2010	Annex 2	Executive Summary
Malaysian AIDS Council Strategic Plan 2008-2010	Annex 3	Executive Summary
<input checked="" type="checkbox"/> Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)		
Universal Precautions	Annex 4	
Voluntary HIV Testing	Annex 5	
Harm Reduction Programme	Annex 6	
Dangerous Drugs Act of 1952, Parliament of Malaysia (1952)	Annex 7	
<input checked="" type="checkbox"/> National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need of services		
Prevention and Control of Infectious Diseases Act of 1988 (Act 342)	Annex 8	
Guidelines for the management of Adults and Adolescents with HIV Infection with Antiretroviral Therapy, Ministry of Health (2006)	Annex 9	
Antiretroviral Treatment Manual for HIV Patients in Drug Rehabilitation Institutions, Ministry of Health (2005)	Annex 10	
Code of Medical Ethics, Malaysian Medical Council	Annex 11	
Code of Practice on the Prevention and Management of HIV/AIDS – HIV in the Workplace, Ministry of Human Resource (2001)	Annex 12	
<input checked="" type="checkbox"/> Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal		
Monitoring & Evaluation of the Malaysian National Strategic Plan on HIV/AIDS Report, 2008	Annex 13	Executive Summary
UNGASS Country Progress Report (Malaysia), 2008	Annex 14	Status at a Glance (pg 4 – 10)
4 th WHO/MOH National Consensus on HIV/AIDS in Malaysia (2006)	Annex 15	Key recommendations (pg 25 – 26)

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Women and Girls Confronting HIV/AIDS in Malaysia, Ministry of Health and UNICEF, 2008	Annex 16	Chapter 1
Summary Findings of Behavioural Surveillance Surveys (BSS) in Malaysia. AIDS/STD Section, Ministry of Health & WHO Western Pacific Region (2006).	Annex 17	Executive Summary Programmatic Implications (pg 53)
Report of Behavioural Surveillance Survey in Malaysia – Injecting Drug Users (First Round 2003 - 2004), Ministry of Health (2005).	Annex 18	Executive Summary Findings (pg. 3)
Study on the Impact of HIV on People Living with HIV, their Families and Community in Malaysia. United Nations Country Team on HIV/AIDS Malaysia (2006)	Annex 19	
Human Rights Report, Undocumented migrants and refugees in Malaysia: Raids, Detention and Discrimination, FIDH & SUARAM (2008)	Annex 20	Chapter 23 (pg. 23-28)
State of Health of Migrants, CARAM Asia (2005)	Annex 21	Malaysia Country Report (pg. 135-144)
Achieving the Millennium Development Goals. Success and Challenges. The UN Country Team Malaysia and the Economic Planning Unit, Government of Malaysia (2005)	Annex 22	Chapter 6
x <i>National Monitoring and Evaluation Plan (health sector, disease specific or other)</i>		
National HIV and AIDS Statistics, AIDS/STD Section, Ministry of Health (Dec 2008)	Annex 23	Entire Document
Country review – Malaysia. HIV and AIDS Data Hub for Asia and the Pacific (2008)	Annex 24	Overview

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4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal		
(a) Do the activities target:		
x Whole country	<input type="checkbox"/> Specific Region(s) <i>**If so, insert a map to show where</i>	<input type="checkbox"/> Specific population groups <i>**If so, insert a map to show where these groups are if they are in a specific area of the country</i>

**** Paste map here if relevant**

(a) Size of population group(s) <i>(If national data is disaggregated differently then type over the categories proposed)</i>			
Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	26,572,000	Epidemiological Fact Sheet on HIV and AIDS, Core data on epidemiology and response, Malaysia, 2008 Update (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance) (Annex 25)	2007
Population 15 – 49 years	14,362,000	Epidemiological Fact Sheet on HIV and AIDS, Core data on epidemiology and response, Malaysia, 2008 Update (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance) (Annex 25)	2007
Women > 25 years	6,634,100	Department of Statistics, Malaysia (Annex 26)	2007
Women 19 – 24 years	1,209,600	Department of Statistics, Malaysia (Annex 26)	2007
Women 15 – 18 years	1,258,700	Department of Statistics, Malaysia (Annex 26)	2007
Women 15 – 24 years	2,491,000	Epidemiological Fact Sheet on HIV and AIDS, Core data on epidemiology and response, Malaysia, 2008 Update (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance) (Annex 25)	2007
Women 15 – 24 years (2)	2,468,300	Department of Statistics, Malaysia	2007

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(a) Size of population group(s) <i>(If national data is disaggregated differently then type over the categories proposed)</i>			
Population Groups	Population Size	Source of Data	Year of Estimate
Men > 25 years	6,751,600	Department of Statistics, Malaysia (Annex 26)	2007
Men 19 – 24 years	1,248,800	Department of Statistics, Malaysia (Annex 26)	2007
Men 15 – 18 years	1,321,100	Department of Statistics, Malaysia (Annex 26)	2007
Girls 0 – 14 years	4,237,400	Department of Statistics, Malaysia (Annex 26)	2007
Boys 0 – 14 years	4,511,200	Department of Statistics, Malaysia (Annex 26)	2007
Injecting drug users	120,000	Estimation of Drug Users and Injecting Drug Users in Malaysia, Ministry of Health, University Utara Malaysia, WHO (2003) (Annex 27)	Data collection in 2002, report published in 2003
	Estimates: 104,486-135,506;		
	117,000 - 240,000	Cited in Rapid Situation Assessment of Malaysia, 2004 by Gary Reid, Adeeba Kamarulzaman and Sangeeta Kaur Sran (Annex 28)	2004
	120,000	PSE, MAC Strategic Plan 2008-2010 (Annex 29)	2008
Sex workers	50,000	In Country Consensus, WHO & MOH (Annex 15)	2006
	Estimates: 40,000-60,000		
	50,000	PSE, MAC Strategic Plan 2008-2010 (Annex 29)	2008
Men who have sex with men	330,000		
	Estimates: 177,377-443,443	In Country Consensus, WHO & MOH (Annex 15)	2006
	350,000	PSE, MAC Strategic Plan 2008-2010 (Annex 29)	2008

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(a) Size of population group(s) <i>(If national data is disaggregated differently then type over the categories proposed)</i>			
Population Groups	Population Size	Source of Data	Year of Estimate
Transgender	20,000	Exploring HIV Related Needs For Safety Among Transsexuals or Mak Nyah, Teh Yik Koon (Annex 30)	2006
Prisoners	72,615	Annual Report and Annual Statistic (Prison Department) (Annex 31)	2006
Most at-risk adolescents	125,000	5% of total youth aged 15-18 Department of Statistics, Malaysia (Annex 26)	2007
Mobile (migrant and refugee) populations – documented	Migrants : 1.8 million Refugees : 46,358 Total : 1,846,358	Cited in “Undocumented migrants and refugees in Malaysia: Raids, Detention and Discrimination”, International Federation of Human Rights and Suara Rakyat Malaysia (SUARAM) (Annex 20)	2008
Indigenous people (orang asli)	147000	Reducing HIV Vulnerability Among Indigenous Community (Orang Asli) in Peninsular Malaysia (Annex 32)	2008

4.2.2. HIV epidemiology of target population(s) <i>(If national data is disaggregated differently then type other the categories suggested)</i>			
Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV (all ages)	85,000	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Women living with HIV > 29 years	5000	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Women living with HIV 20-29 years	2300	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Women living with HIV 13-19 years	100	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Pregnant women living with HIV	N/A		
Men living with HIV > 29 years	48,000	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008

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4.2.2. HIV epidemiology of target population(s) <i>(If national data is disaggregated differently then type other the categories suggested)</i>			
Population Groups	Estimated Number	Source of Data	Year of Estimate
Men living with HIV 20-29 years	25000	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Men living with HIV 13-19 years	1100	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Girls (0 – 142years) living with HIV	80	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Boys (0 – 12 years) living with HIV	900	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
AIDS related deaths per year	10,783 (cumulative) 490/yr (average over 22yrs)	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Injecting drug users living with HIV	60,248	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Prisoners living with HIV	4,357	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Sex workers living with HIV	543	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Men who have sex with men living with HIV	1,585	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Transgender living with HIV	N/A		
Most at-risk adolescents living with HIV	1,200 (age 13 – 19)	Epidemiological Fact Sheet on HIV and AIDS, 2008 Update, Ministry of Health (Annex 25)	2008
Mobile (migrant and refugee) populations living with HIV	224 (refugees)	Brief Background for Refugee Inclusion GFATM Submission for HIV (UNHCR) (Annex 33)	2009
Indigenous people living with HIV	39	HIV/AIDS Update, MOH (Annex 56)	2009
Number of people in need of ARVs	14,918	Monitoring & Evaluation of the Malaysian National Strategic Plan on HIV/AIDS Report (Annex 13)	2008
Number of women and men separately > 14 years in need of	N/A		

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4.2.2. HIV epidemiology of target population(s) <i>(If national data is disaggregated differently then type other the categories suggested)</i>			
Population Groups	Estimated Number	Source of Data	Year of Estimate
ARVs			
Number of women and men separately > 14 years receiving ARVs	N/A		
Number of children 0 – 14 receiving ARVs	N/A		
Number of injecting (or other) drug users receiving ARVs	N/A		
Number of people in need of treatment for opportunistic infections	N/A		

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4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations¹ who may have disproportionately low access to HIV prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. HIV program

Describe:

- the main weaknesses in the implementation of current HIV strategies;
- how these weaknesses affect achievement of planned national HIV outcomes; and
- existing gaps in the delivery of services to target populations.

Implementation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2) has achieved substantial results in providing general access to HIV prevention, treatment, care, and support. However, as part of the Year 2007 Report on the Monitoring and Evaluation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 13), it was recommended that improvements be made to address weaknesses in the implementation of National Strategic Plan activities, including the following:

- With most Malaysian non-government organisations heavily reliant upon government grants for National Strategic Plan activities, any delay in the release of government grant monies adversely affects the implementation of such activities by the non-government organisations
- Location of HIV voluntary counselling and testing (VCT) centres / one-stop drop-in centres for marginalised population groups has been concentrated in urban areas. The resultant low service utilisation must be rectified in order to reduce the vulnerability of marginalised populations
- Detailed information regarding the actual injecting, sexual and other risk behaviours of injecting drug users is lacking. Regular behavioural surveillance surveys (BSS) should be conducted across Malaysia, as a supplement to existing monitoring and evaluation systems;
- Expansion of the methadone programme is required to ensure increased accessibility and coverage for those injecting drug users in need of this opioid substitution treatment modality.
- Expansion of harm reduction in incarcerated settings has been limited by lack of human resources and infrastructure
- Substantial ARV treatment coverage levels have been observed among people living with HIV/AIDS, and pregnant women with HIV/AIDS. Such coverage has not been realised members of marginalised population groups living with HIV/AIDS due to accessibility issues;
- ART coverage to IDUs is challenging due to lack of awareness of treatment, distance needed to travel, stigma and discrimination.
- Needle exchange programs are currently only carried out by NGOs which are limited in capacity and geographic coverage, and have not yet reached out to rural areas
- Improved coordination among all government and non-government organisations involved in the implementation of the National Strategic Plan is required. In particular, the leadership contribution of State Health Departments and District Health Offices should increase
- Insufficient programmes reaching out to MAPRs due to lack of capacity of civil society organizations (CSOs)

¹ Please refer back to the definition in s.2 and found in the [Round 9 Guidelines](#).

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4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect HIV outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and HIV outcomes (e.g.: PMTCT services), but perhaps not also malaria and tuberculosis programming and service delivery.*

Also from the Year 2007 Report on the Monitoring and Evaluation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2), overall health system issues included:

- The Malaysian health care delivery system would benefit from the increased development of health education materials, modules and activities regarding HIV/AIDS. Integrated into current programmes within the health care delivery system, such materials and modules will help to address widespread stigmatisation, discrimination and subsequent marginalisation of people living with HIV/AIDS;
- The number of appropriately trained managers across all Malaysian government agencies involved with HIV/AIDS prevention programmes needs to be increased. In addition, the low percentage of transnational companies with workplace HIV policies, poor implementation of planned health promotion activities, and low coverage of prison inmates receiving HIV voluntary counselling and testing (VCT) reflect the lack of stakeholder commitment, particularly among other government agencies. These activity areas should be scaled up, in order to ensure the success of National Strategic Plan strategies. Awareness raising and capacity building with regards HIV/AIDS is essential for the key personnel of all government agencies involved with HIV/AIDS prevention programmes;
- The secretariat of the national monitoring and evaluation process needs to have its own team of epidemiology, behavioural research, behavioural science, and biomedical statistics experts, in order to reduce its reliance upon monitoring and evaluation expertise from international agencies. Clear indicators and targets for HIV/AIDS programmes and activities, comparable with established international data sets, should be developed and integrated into the current monitoring and evaluation system.
- STI services are currently not available (or have very poor coverage) for most MARPs – SW, TG, MSM, spouses of IDUs, refugees, migrants. There is a nationwide burden of providing SRH/STI services to MARPs as it is currently shouldered by private practitioners and NGOs such as the Federation of Reproductive Health Associations Malaysia. This results in it being a financial burden for MARPs to get treated for STIs or obtain SRH services.
- A review of the PMTCT programme in 2007 (Annex 14) suggested that the programme is only reaching more highly motivated mothers as well as those at lower risk of acquiring HIV infection. Coverage also appears to not extend to MARPs such as IDUs and their partners. The majority of children with HIV have been identified and referred for care and treatment from outside the PMTCT programme.
- 6% of the prison population are HIV infected and an equally significant percentage of HIV infected IDU are in drug rehabilitation centres. Access to healthcare in both these institutions is limited. (Annex 31)
- At present TB services and HIV are not integrated which represents a problem to those with co infection.

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect HIV outcomes.

The results of the Year 2007 Report on the Monitoring and Evaluation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2) have been taken into account in planning changes to government services in 2009.

These changes include:

- Increased joint action and cooperation between the government and private health sector with community based organizations and other NGOs
- Policies developed on:
 - o Screening For HIV
 - o Notification of HIV/AIDS / Death due to HIV/AIDS
 - o Partner Notification
 - o Contact Tracing
 - o Provision of Medical Care And Counselling Services
 - o Treatment For HIV/AIDS
 - o Universal Precautions
 - o Health Education
 - o Voluntary HIV Testing

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- Strategic information and surveillance being improved through
 - o Mapping and PSE activities
 - o BSS and national WHO/MOH consensus every two years
 - o IBBS (first one) to be implemented in 2009 for IDU, SW & TS
 - o VDTS (venue day time survey) to be implemented in 2009

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4.4. Round 9 Priorities

Complete the tables below on a program coverage basis (and not financial data) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current HIV epidemiology and identified weaknesses and gaps from s.4.2.2 and s.4.3.

Note: All health systems strengthening needs that are most effectively responded to on an HIV disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No:	1	Historical		Current		Country targets			
Indicator name	Number of MARP reached through outreach programs	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target (from annual plans where these exist)				370,000	370,000	370,000	370,000	370,000	370,000
B: Extent of need already planned to be met under other programs			18,000	21,000	21,000	21,000	21,000	21,000	21,000
C: Expected annual gap in achieving plans				349,000	349,000	349,000	349,000	349,000	349,000
D: Round 9 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			24,000	51,000	116,000	229,000	323,000

Priority No:	2	Historical		Current		Country targets			
Indicator name	Number of Syringes Distributed	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target (from annual plans where these exist)		12m	12m	12m	12m	13m	14m	15m	16m
B: Extent of need already planned to be met under other programs		1.5m	1.8m	1.8m	2m	2m	2m	2m	2m
C: Expected annual gap in achieving plans		10.5m	10.2m	10.2m	10m	11m	12m	13m	14m
D: Round 9 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			0.8m	1.8m	3m	8m	14m

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Priority No:	3	Historical		Current		Country targets			
Indicator name	Number of PLHIV and their families reached by trained Outreach Workers	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target (from annual plans where these exist)		40,000	45,000	50,000	55,000	60,000	70,000	80,000	90,000
B: Extent of need already planned to be met under other programs		8000	12,000	14,000	16,000	18,000	20,000	22,000	24,000
C: Expected annual gap in achieving plans				36,000	39,000	42,000	50,000	58,000	66,000
D: Round 9 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			1200	3000	10,000	25,000	50,000

→ If there are six priority areas, copy the table above once more.

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4.5. Implementation strategy

4.5.1. Round 9 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA), activities and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*

Where there are planned activities that benefit the health system that can easily be included in the HIV program description (because they predominantly contribute to HIV outcomes), include them in this section only of the Round 9 proposal.

Note: *If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B in one disease proposal in Round 9. The applicant will need to decide which disease to include s.4B (but only once). → Refer to the [Round 9 Guidelines](#) (s.4.5.1.) for information on this choice.*

Goal of this proposal: To reduce HIV transmission and reduce morbidity and mortality among most at risk populations in Malaysia.

Objective One: To build a more supportive environment to ensure that the Malaysian HIV/AIDS response reaches those most at risk of HIV infection

SDA 1.1: Coordination

1.1.1. Program Coordination

Implementing Partners: MAF, MAC, SRs, MARP Representatives, Program Partners

1.1.1.1. MAF Coordination and Management

Support will be provided to strengthen the overall capacity of the Malaysian AIDS Foundation to perform its functions as Principal Recipient.

1.1.1.2. MAC Coordination and Management

Support will be provided to strengthen the overall capacity of the Malaysian AIDS Council to perform its functions in coordinating the work of the other SRs, ensuring geographical coverage based on epidemiology and preventing duplication.

1.1.1.3 Six Monthly Coordination Meetings

To review ongoing progress of the program, stakeholders will meet every six months to review the progress made to date, strengths and weaknesses of program implementation and undertake planning for the following six months to ensure coordination. A total of up to 100 participants will be involved including MAF, MAC, SRs, MARP and PLHIV representatives, academic institutions, Government, and bilateral/multi-lateral partners.

1.1.1.4 Procurement of commodities for MARPs

Injecting kits, condoms and lubricant will be centrally procured by MAC to achieve the lowest prices (as MAC has been procuring these items for all HIV NGOs in Malaysia to date) and MAC's experienced supply management team will ensure sufficient supplies to all organizations working with most-at-risk populations. No procurement of medical equipment or supplies is envisaged in this proposal as procurement for these items is already carried out by the MoH in Malaysia.

1.1.2 Advocacy

Implementing Partners: MAF, MAC, AARG, CERIA, ACTS, DIC Pahang, FHDA, FRHA, Harapan Komuniti, Harvest Center, HEI, ILZ, Kenosis, MTAAG, SAHABAT, PT Foundation, PKI, SACS, Sahabat, Tenaganita

1.1.2.1 Advocacy Toolkit Development

Technical assistance will be recruited in Q2 of the Program to adapt existing global and regional advocacy resources into a Malaysian HIV and MARP Advocacy Toolkit, including TOT program development and advocacy guides. A total of 500 toolkits will be developed and the program will be reviewed and revised in Year 3 of the program.

1.1.2.2 Advocacy TOT

Two participants representing each MARP from each SR and MAF will be trained in TOT to provide

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training in advocacy to their staff, volunteers and program partners. In Q3 of Year 1, two training programs will be facilitated by MAF with 70 TOT trained. By the conclusion of the five day training, each organisation will have developed an advocacy strategy and plan which will guide the rollout of advocacy forums and activities. A follow up TOT including refresher training will be held in Year 3 of the Program.

1.1.2.3 Advocacy Forums and Activities (20 Organisations)

The Malaysian AIDS Council and proposed Sub recipients will be supported to roll out Advocacy forums and activities based upon their organisational plans. Where multiple CSOs are operational in similar geographical areas these will be coordinated and prepared jointly where appropriate.

SDA 1.2: Strategic Information

1.2.1. Operational Research among MARPs

Implementing Partners: MAF, MAC, SRs, Academic Institutions, Technical Assistance

1.2.1.1. Operational Research

To build stronger baseline data, support ongoing outcome monitoring and assist in guiding the rollout of the response, a package of operational research will be undertaken in **years 1 and 3** of the program. Operational research will include mapping, KAPB surveys, population size estimation and health facility surveys as well as specific issues affecting project implementation such as barriers to service access by MARPs and models that ensure increased access to government health services.

SDA 1.3: Monitoring and Evaluation of MARPS activities

1.3.1. Monitoring and Evaluation

Implementing Partners: MAC, MAF, AARG, CERIA, ACTS, DIC Pahang, FHDA, FRHA, Harapan Komuniti, Harvest Center, HEI, ILZ, Kenosis, MTAAG, SAHABAT, PT Foundation, PKI, SACS, Sahabat, Tenaganita, Technical Assistance

1.3.1.1. M&E Strategy and Plan Development

In Q1 of the program, technical assistance will be recruited to work with partners to develop a detailed M&E strategy and plan, training materials and monitoring tools. The M&E strategy will be reviewed and revised in Year 3 of the Program.

1.3.1.2. M&E Training

Utilising the training and M&E tools developed in 1.3.1.1, two five-day M&E training programs will be provided to program partners annually. From year 2 training will include training for new program personnel and refresher training to previously trained program personnel.

1.3.1.3. M&E Exposure Visits

Key program M&E personnel will be provided opportunities to participate in a regional exposure visit to experience and review regional approaches to program monitoring. 20 personnel from MAF, MAC and key Sub recipients will participate. Two visits will be undertaken in Q2 and Q6 of the program.

SDA 1.4: Institutional and Technical Capacity Building

1.4.1. Civil Society Strengthening

Implementing Partners: MAF, MAC, AARG, CERIA, ACTS, DIC Pahang, FHDA, FRHA, Harapan Komuniti, Harvest Center, HEI, ILZ, Kenosis, MTAAG, SAHABAT, PT Foundation, PKI, SACS, Sahabat, Tenaganita, Technical Assistance

1.4.1.1. Financial Management Capacity Building

MAF will undertake an analysis of the current capacities of program partners in Financial Management in Q1, and tools and training will be provided to partners to strengthen financial management systems.

1.4.1.2. CSO Development Strategy and Tools

Technical assistance will be recruited in Q2 of the Program to adapt existing global and regional CSO Institutional and Technical Capacity Building programs and resources into a Malaysian CSO Capacity Building Toolkit, including TOT program development, CSO tools and resources.

1.4.1.3. MIS Strengthening

Linked to activity 1.3., systems to support management information and data collection at sub recipient level will be strengthened with IT, training and support.

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1.4.1.4. Human Resource Development

Human resource management and program skills will be developed with sub recipient partners. Training will be provided in program management. Training will be provided in Q3 in years 1, 2 and 3.

1.4.1.5. Specialist Technical Capacity Building

A package of training programs will be made available to sub recipients. Programs will include HIV Prevention Education, Drug Prevention Education, Harm Reduction, Social Marketing, Counselling, Psycho-social Support, Outreach Programming, Facilitation Skills etc. Each year 12 training packages will be provided, with 20 participants per workshop.

1.4.1.6. CSO Mentoring

A total of six Mentors will be recruited and located in MAF and MAC to provide ongoing support to sub recipients and partner organisations in institutional and technical support and capacity building.

1.4.1.7. SR Intuitional Capacity Building

Funds will be made available to support the institutional capacity building of SRs to support the rollout of the implementation of the program.

1.4.2. Community Mobilisation

Implementing Partners: MAF, MAC, AARG, CERIA, ACTS, DIC Pahang, FHDA, FRHA, Harapan Komuniti, Harvest Center, HEI, ILZ, Kenosis, MTAAG, SAHABAT, PT Foundation, PKI, SACS, Sahabat, Tenaganita, Technical Assistance

1.4.2.1. Community Mobilisation Strategy and Tools

Technical assistance will be recruited in Q3 of the Program to develop community mobilisation resources and tools for use by all sub recipients.

1.4.2.2. Stakeholder Sensitisation and Advocacy

Each Sub Recipient will be required to undertake stakeholder sensitisation and advocacy initiatives through community mobilisation efforts with a particular aim of raising awareness of the need to work with MARPs and reducing stigma and discrimination experienced by MARPs

1.4.2.3. Stakeholder Consultation

To support each phase of the program, each Sub Recipient will undertake a range of stakeholder consultations in years 1 and 3 of the program to engage and advocate for the needs of MARPs in program planning, implementation and evaluation.

1.4.2.4. Community Mobilisation Activities

Each Sub Recipient will undertake to sensitise health care workers to attract and retain MARPs in health services, concentrating on stigma reduction, confidentiality and cross-referral/ linkage between government and NGO services

Objective Two: To reduce the number of new HIV infections among most-at-risk populations in Malaysia

SDA 2.1: MARP Vulnerability Reduction

2.1.1. Injecting Drug User Programs

Implementing Partners: Intan Life Zone, Sahabat, PKI, Kenosis, DIC Pahang, FPA Penang, AARG, Cahaya Harapan, PTF, MAC

2.1.1.1. IDU BCC Strategy

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3. This strategy will comprise a systematic approach to build trust with each MARP through attraction to NGO activities, accompanied referral to related testing, diagnosis, treatments, ensuring appropriate pre- and post-test counseling and accompanied referral to relevant services.

2.1.1.2. IDU Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

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2.1.1.3. IDU Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.1.4. Peer Education and Outreach TOT

Taking into account the mobility of MARPs, annual TOT and training programs will be held to train and provide refresher training to SR and MARP Peer Education and Outreach staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 240 trainers will be trained.

2.1.1.5. Peer Education and Outreach Training

Trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provide ongoing refresher training and resource kits to support their work.

2.1.1.6. Outreach Programs

Based on the results of the operational research, 20 outreach programs will be established and linked to the Drop In Centres (DICs). Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including DST). By end of program (EOP) 90,000 IDUs will be reached on a regular basis through outreach and/ or DIC/ shelters, both utilizing needle-syringe programs among a range of services.

2.1.1.7. Drop In Centres, Shelters and Livelihood Programs

Over the program 15 DICs will be established in high traffic areas to provide a range of services including Psycho-social support, recreation facilities, nutrition, referral and information services, with at least 1 DIC in each State where injecting is known to occur. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub. Linked to the DICs, 8 shelters will be established to provide crisis accommodation and support and lead to improved referrals and to DIC and other community services for prevention, diagnosis, treatment, and support

2.1.2. Sex Workers Programs

Implementing Partners: PKI, Kenosis, DIC Pahang, FPA Penang, Cahaya Harapan, FRHAM, MAC, PTF, SACS

2.1.2.1. SW Behaviour Change Communication Program

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3.

2.1.2.2. SW Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

2.1.2.3. SW Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.2.4. Peer Education and Outreach TOT

Taking into account the mobility of MARPs, annual TOT and training programs will be held to train and provide refresher training to SR and MARP Peer Education and Outreach staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 240 trainers will be trained.

2.1.2.5. Peer Education and Outreach Training

Trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provide ongoing refresher training and resource kits to support their work.

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2.1.2.6. Outreach Programs

Based on the results of the operational research, 15 outreach programs will be established and linked to the Drop In Centres. Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about MARP and HIV programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including OST). By EOP, 40,000 sex workers will be reached on a regular basis through outreach and/ or DIC/ shelters.

2.1.2.7. Drop In Centres, Shelters and Livelihood Programs

Over the program 10 Drop In Centres will be established in high traffic areas to provide a range of services including Psycho-social support, recreation facilities, nutrition, referral and information services, with at least 1 DIC in each State where injecting is known to occur. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub. Linked to the DICs, six shelters will be established to provide crisis accommodation and support and lead to improved referrals and to the DIC and other community services for prevention, diagnosis, treatment, and support.

2.1.3. Gay Men and Other MSM Programs

Implementing Partners: PKI, FPA Penang, Cahaya Harapan, MAC, PTF

2.1.3.1. MSM Behaviour Change Communication Program

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3.

2.1.3.2. MSM Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

2.1.3.3. MSM Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.3.4. Peer Education and Outreach TOT

Taking into account the mobility of MARPs, annual TOT and training programs will be held to train and provide refresher training to SR and MARP Peer Education and Outreach staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 200 trainers will be trained.

2.1.3.5. Peer Education and Outreach Training

Trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provide ongoing refresher training and resource kits to support their work.

2.1.3.6. Outreach Programs

Based on the results of the operational research, 5 outreach programs will be established and linked to the Drop In Centres. Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about MARP and HIV programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including OST). By EOP, 100,000 MSM will be reached on a regular basis through outreach and/ or DICs.

2.1.3.7. Drop In Centres

Over the program 5 Drop In Centres will be established in high traffic areas to provide a range of services including Psycho-social support, recreation facilities, nutrition, referral and information services. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub.

2.1.4. Transgendered Programs

Implementing Partners: PKI, DIC Pahang, FPA Penang, Cahaya Harapan, MAC, PTF, SACS

2.1.4.1. Transgendered Behaviour Change Communication Program

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to

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guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3.

2.1.4.2. Transgendered Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

2.1.4.3. Transgendered Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.4.4. Peer Education and Outreach TOT

Taking into account the mobility of MARPs, annual TOT and training programs will be held to train and provide refresher training to SR and MARP Peer Education and Outreach staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 200 trainers will be trained.

2.1.4.5. Peer Education and Outreach Training

Working through four organisations, trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provided ongoing refresher training and resource kits to support their work.

2.1.4.6. Outreach Programs

Based on the results of the operational research, 6 outreach programs will be established and linked to the Drop In Centres. Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about MARP and HIV programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including OST). By EOP, 18,000 transgendered people will be reached on a regular basis through outreach and/ or DIC/ shelters.

2.1.4.7. Drop In Centres, Shelters and Livelihood Programs

Over the program 6 Drop In Centres will be established in high traffic areas to provide a range of services including Psycho-social support, recreation facilities, nutrition, referral and information services. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub. Linked to the DICs four shelters will be established to provide crisis accommodation and support and lead to improved referrals and to the DIC and other community services for prevention, diagnosis, treatment, and support.

2.1.5. Prisoner and Custodial Setting Programs

Implementing Partners: Sahabat, Kenosis, DIC Pahang, FPA Penang, AARG, Cahaya Harapan, FRHAM, CERIA

2.1.5.1. Prisoner Behaviour Change Communication Program

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3.

2.1.5.2. Prisoner Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

2.1.5.3. Prisoner Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.5.4. Peer Education and Outreach TOT

Annual TOT and training programs will be held to train and provide refresher training to SR and prisoner Peer Education and DIC staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 160 trainers will be trained.

2.1.5.5. Peer Education and Outreach Training

Trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with

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SRs and prisoners and ex-prisoners and the trained peer educators will be supported by the DICs. Peer educators will be provided ongoing refresher training and resource kits to support their work. Education and training will also be provided to prison officers.

2.1.5.6. Pre and Post Release Programs and Livelihood Programs

8 pre- and post-release programs and 8 DICs will be established to support pre and post release programs for prisoners and support services to their families. Psycho-social support, referrals, information, outreach, condom promotion and distribution, nutrition support etc will be provided. Linked to the DICs 4 shelters will be established to provide crisis accommodation and support and lead to improved referrals and to the DIC and other community services for prevention, diagnosis, treatment, and support. By EOP, 25,000 prisoners will be reached on a regular basis through outreach, pre- or post-release and/ or DIC/ shelters.

2.1.6. Migrants, Refugees and Mobile Populations

Implementing Partners: HEI, PKI, FRHAM, MAC, ACTS, Harvest, SACS

2.1.6.1. Migrants, Refugees and Mobile Populations BCC Strategy

Technical assistance will be recruited in Q1 of the Program to develop a National BCC strategy to guide the development and implementation of MARP programs. This will be linked and coordinated with other MARP BCC strategy development. A review will be undertaken in Year 3.

2.1.6.2. Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve MARP involvement in project planning, implementation and evaluation.

2.1.6.3. Communication Materials

Based upon the BCC strategy development and focus group discussions, a package of communication materials will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

2.1.6.4. Peer Education and Outreach TOT

Taking into account the mobility of MARPs, annual TOT and training programs will be held to train and provide refresher training to SR and MARP Peer Education and Outreach staff. These TOTs will then be supported to rollout training and peer education and outreach activities. By the end of year 5 a total of 200 trainers will be trained.

2.1.6.5. Peer Education and Outreach Training

Trainers after TOT will implement 5 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provided ongoing refresher training and resource kits to support their work.

2.1.6.6. Outreach Programs

Based on the results of the operational research, 8 outreach programs will be established and linked to the Drop In Centres. Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about MARP and HIV programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including OST). By EOP, 25,000 50,000 refugees, migrants and people from mobile populations will be reached on a regular basis through outreach, and/ or DIC/ shelters.

2.1.6.7. Drop In Centres, Shelters and Livelihood Programs

8 Drop In Centres will be established in appropriate locations to provide a range of services including psycho-social support, recreation facilities, nutrition, referral and information services. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub. Linked to the DICs, 4 shelters will be established to provide crisis accommodation and support and lead to improved referrals and to the DIC and other community services for prevention, diagnosis, treatment, and support.

Objective Three: To reduce morbidity and mortality related to HIV/AIDS

SDA 3.1: Psycho-social Care and Support

3.1.1. Hospital Peer Support Program

Implementing Partners: HEI, PKI, MTAAG, PTF

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3.1.1.1. Hospital Peer Support Programs

500 PLHIV and their families will be trained as Peer Support Workers to provide outreach to PLHIV and their families who are hospitalized or in hospice residential care.

3.1.2. Home and Community Based Care

Implementing Partners: HEI, Sahabat, PKI, Kenosis, DIC Pahang, FPA Penang, AARG, Cahaya Harapan, MTAAG, MAC, PTF, Harapan Komuniti, SACS

3.1.2.1. Focus Groups

Annual focus groups will be undertaken by MAF through implementing partners to improve PLHIV involvement in project planning, implementation and evaluation.

3.1.2.2. Communication Materials

A package of communication materials for PLHIV and their families will be developed, tested, and distributed through all activities in the program. Sub Recipients will be provided communication materials based on their program needs.

3.1.2.3. Peer Education and Outreach TOT

Taking into account the mobility and well being issues of PLHIVs, annual TOTs and training programs will be held to train and provide refresher training to sub recipient and PLHIV and their families Peer Education and Outreach TOTs. Annually 32 PLHIV trainers will be trained.

3.1.2.4. Peer Education and Outreach Training

Trainers after TOT will implement 6 Peer Education and Outreach training workshops each year with partners and MARP representatives and the trained peer educators will be supported by the DIC and Outreach programs. Peer educators will be provided ongoing refresher training and resource kits to support their work. A total of 100 PLHIV and their families will be trained annually.

3.1.2.5. Home Based Care Outreach Programs

Based on the results of operational research, 10 outreach programs will be established and linked to Drop In Centres. Peer educators and volunteers will undertake outreach activities including group and one on one contact, provide referrals, information about programs, and linkages to STI, health and TB services, and (if needed) needle - syringe programmes and drug treatment (including OST).

3.1.2.6. Drop In Centres

10 Drop In Centres will be established in high traffic areas to provide a range of services including Psycho-social support, recreation facilities, nutrition, referral and information services. Drop In Centres will be supported by outreach and peer education programs with the DIC operating as a hub with stronger links to MARP and HIV programs and services.

3.1.2.7. PLHIV Support Networks and Programs

A total of 10 PLHIV support groups and 10 programs will be established to provide psycho-social support and advocacy for PLHIV and their families through the life of the program.

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

Not applicable

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

The following achievements have been taken into account when designing the strategic activities and targets for this proposal. For many years, Malaysia has worked through NGOs to pilot many different activities to reach MARPs with a range of NGO and government services:

1. **Provision of ART** - First line ART is available for free from government hospitals and clinics. Under the existing NSP (2006-2010), the government aim to achieve 10,000 patients on ART by 2010. The government's pilot ART for PLHIV in drug rehabilitation centres is recognised as a best practice in the Asia

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Pacific region.

- 2. Needle and Syringe Exchange Programme (NSEP)** – the NSEP programme was introduced in 2006, with a target to provide NSEP services to 15,000 by 2010. As at end of 2008, NSEP is being implemented in 8 states, with 12,230 registered clients.
- 3. Methadone Maintenance Therapy Programme** - The MMT programme was introduced in 2005, with a target to support 25,000 DUs by 2010. As at end of 2008, 75 MMT centres have been set up. 7,065 DUs have registered to date with 5,024 active clients retained.
- 4. Prevention of Mother to Child Transmission (PMTCT)** – The PMTCT programme was initiated in 1998 and is implemented nationwide through public healthcare facilities. HIV positive mothers accessing ANC services from public healthcare services receive lifetime treatment for free. Their babies are tested regularly and also receive lifetime treatment for free should they be tested HIV positive. To date 3,237,080 women have participated in the PMTCT programme.

During this process, the following challenges have been identified in program implementation and management:

1. Inadequate program coverage for MARPs identified in this proposal. There is a critical need to build the capacity of CSOs which are the primary implementers of programmes for MARPs. This will complement the government and public health sector in reaching the MARPs and ensure they are able to access prevention, treatment, care and support services
2. Quality assurance of programmes to minimise client drop-outs due to their mobility, thus compromising on follow up services such as referrals and psycho-social support. This is also relevant for ART programme, particularly for MARPs. Treatment adherence and positive prevention can be further improved by strengthening Government and CSO partnership.
3. Stigma and discrimination towards MARPs impedes public health programming as the communities move further underground and are difficult to access.
4. Lack of capacity and resources of CSOs affects the outcome of HIV interventions. This includes inadequate numbers of trained project staff and poor administrative and financial systems.
5. Insufficient baseline data on MARPS to guide programme planning
6. National monitoring and evaluation of government and CSO programmes for MARPs are not yet congruent, thus limiting the impact analysis of targeted interventions for MARPs.

The lessons learned have been addressed in this proposal. In order to achieve rapid up scaling of existing programmes and initiating new ones, the first two years of the grant implementation will focus on civil society strengthening, evidence building via systematic needs assessment and surveillance while improving the quality of care and support for PLHIV, and beginning to expand services to MARPs. Sufficient allowance has been allotted for Technical Assistance support (for management; financial systems; M&E and governance) for capacity building to ensure sustainability of present and future interventions. In Years 3-5, this investment will deliver substantially higher reach and quality to all MARPs programs, resulting in sufficient coverage to reduce HIV incidence in each of the most-at-risk populations.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available HIV prevention, treatment and/or care and support services.

(If certain population groups face barriers to access, such as women and girls, adolescents, sexual minorities and other key affected populations, ensure that your explanation disaggregates the response between these key population groups).

The Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2) addresses HIV/AIDS not just as a health issue, but also as a development issue. As the master plan for the basis of coordinating the HIV/AIDS activities of all national stakeholders, the Strategic Plan provides a framework for the provision of an appropriate balance between prevention, treatment, care, and support. Both the achievements and shortcomings of the Strategic Plan and its implementation across Malaysia have informed this proposal and the planned interventions and activities detailed herein. With the goal of reducing HIV transmission, along with morbidity and mortality among the most at-risk populations in Malaysia, the proposal will focus on addressing the needs of the key affected population groups, specifically injecting drug users; sex workers; gay men and other men who have sex with men; transgendered people; prisoners and others in custodial settings; and migrants, refugees and mobile populations.

One of the key driving forces in the HIV epidemic in Malaysia (as in many countries with concentrated HIV epidemics) is marginalization and inequality. Who gets HIV and why, and who gets effective HIV treatment care and support and why, is determined to some extent by a set of cultural norms that alienate particular groups from the information, commodities, services and personal power they need in order to protect themselves from HIV or to secure the services and support they need if they are diagnosed with HIV. Women in sex work are in an environment in which the attitudes and behaviours of men (clients, brothel owners, policemen) have a significant impact on their ability to choose safer behaviours. Transgendered people are discriminated against in employment and forced into informal

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employment areas like sex work and face discrimination in accessing HIV prevention, STI and other health services.. Men who have sex with men also face discrimination in health services that affect their ability to access HIV prevention and care.

By building a more supportive environment to ensure that the Malaysian HIV response reaches those most at risk of HIV infection, and by increasing coverage and enhancing access to an essential suite of comprehensive services, the activities in this proposal will not only reduce the number of new HIV infections among most-at-risk populations in the country, but will act to increase the overall level of social equality. Targeted advocacy efforts, emphasising the importance of working with the most at-risk populations, will be undertaken with stakeholders at national, state and district levels, including politicians, religious leaders, and senior health and law enforcement staff, among others. The focus of much of this advocacy will be upon the reduction of the stigmatisation and discrimination of the most vulnerable population groups in Malaysia, in addition to catalysing the review of relevant plans and strategies and facilitating resultant amendments to these as needed.

Reducing the vulnerability of most at-risk populations will also address specific issues of marginalization of these populations within Malaysia. Safe spaces (i.e. drop-in centres), peer-based outreach, information provision and education, condom distribution, and socio-legal support will all assist in bringing these populations in contact with the knowledge and equipment they need to prevent HIV infection. Because the programs are largely to be provided by organisations comprising or with longstanding relationships with these populations, these activities will also reduce individual population members' sense of marginalization. In addition to the core interventions, IDUs, sex workers, gay men and other men who have sex with men, the transgendered, and migrants, refugees and mobile populations will also benefit from assisted structured referral to primary and specialist health care, tuberculosis (TB) and HIV services and, if required, needle and syringe programmes (NSP) and drug treatment (including opioid substitution treatment / OST). Prisoners and others in custodial settings will not only receive peer-based education and information materials, but also will have the opportunity to participate in structured pre-release programmes (linked to post-release programmes). Blood-borne virus counselling and testing, sexually transmitted infection (STI) diagnosis and treatment, and the prevention of mother-to-child transmission of HIV (PMTCT) activity areas will work towards reducing stigmatisation and discrimination by sensitising health workers and clinical staff in order to attract and retain most at-risk population group members in services, and will stress the importance of confidentiality and cross-referral / linkages between government and non-government services.

A systematic approach to building rapport and trust with the most at-risk populations, utilising counselling by non-government organisation (NGO) staff and accompanied prioritised referral to testing and treatment services, is a core element of activities detailed within this proposal. Psycho-social care and support, in the form of a hospital peer support programme, and home and community-based care programmes, will also strengthen social equality for the most vulnerable population groups in Malaysia. This linkage of peer-based programmes to the wider health system is the strongest way in which these activities will reduce social and gender equity. Together with sensitization of health staff and advocacy among opinion leaders, the core prevention activities in this proposal will foster an enabling environment which ensures that marginalized groups are able to access the services they need, when and where they need them.

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

The factors considered when deciding to proceed with a HIV-specific proposal were that those populations most at risk of HIV infection are specific to this one disease category and are not necessarily the same populations at risk for TB and malaria. Although the activities in this proposal are designed to provide a disease-specific response, it is not expected that there will be any unintended consequences on the Malaysian health system. Essentially, the activities in this proposal will bring most at risk populations into greater contact with already existing and generally highly functional health facilities and staff. There will be a need for some health and medical staff for some of the activities provided by subrecipients (NGOs), but it is expected that these staff will generally be hired on an hourly or daily basis, and will not draw staff in significant numbers away from the health system. The GoM has committed to continuing to fund HIV activities within the government health system for the period of the grant, so no potentially disruptive effects should occur to any parts of the government health system through the implementation of this proposal.

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4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. (e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 or Round 8 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

Not Applicable

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (summarizing the main achievements planned from that funding over the same term as this proposal).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

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The GoM commitment to the national HIV/AIDS response under the National Strategic Plan on HIV/AIDS (2006 – 2010) is approximately EU22.5 million/year. This represents 0.35% of the total operational budget for the Ministry of Health (MoH).

This GoM commitment is used for the following activities:

- Management and coordination of HIV/AIDS activities
- Infection control in health settings
- VCT
- PMTCT
- ART and OI treatment
- Clinical treatment and hospitalization of people with HIV/AIDS
- Support to NGOs to address some needs of most at risk populations
- Multisectoral HIV activities, such as through the Ministry of Justice (prisons programs)

Funding allocated for HIV and AIDS programming in Malaysia from multilateral agencies including UNDP, UNICEF, UNFPA, UNHCR and WHO for the years 2006 – 2010 is approximately EU2.6million. The Malaysian UN Theme Group (UNTG) on HIV provides coordinated support to all key stakeholders working on HIV/AIDS in the country.

The UN system is represented on the CCM through the UN Theme Group on HIV and which works towards coordinating its activities to avoid no activities in this proposal duplicate its existing projects or planned activities.

UNDP continues to monitor the impact of HIV and AIDS through strategic discourse in providing evidence for support of multi-sectoral policy changes such as engagement with religious leaders.

UNICEF has been involved in the support of the national harm reduction programme since the inception of the needle syringe exchange initiative. UNICEF works closely with the Ministry of Health (MoH) and Ministry of Education to support a substantial portion of programmes targeting children.

WHO is working closely with the MoH in building the national capacity and development of national surveillance, prevention and control of HIV and STI. It also provides technical support for the up scaling of the overall harm reduction programme.

UNFPA, through the Federation of Reproductive Health Association Malaysia (FRHAM) and provides support for programme implementation on sexual reproductive health and HIV and AIDS interventions targeting women and youth. One of its programmes involves the provision of SRH services to sex workers through FRHAM service facilities.

UNHCR provides limited support to persons of concern infected and affected by HIV and AIDS, prioritizing its funding allocation to cater for the cost of ART and shelter for persons of concern living with HIV.

The Malaysian Round 9 Global Fund proposal is targeted to increase CSOs capacity to upscale HIV/AIDS intervention for MARPs, without intending to duplicate or replace other available sources of funding. It is well accepted that CSOs are the main implementers of targeted intervention for MARPs. However, the coverage of these interventions are extremely inadequate and funding for MARP programming remains a challenge due to stigma, discrimination and the lack of an enabling environment for these interventions to take place.

4.6.3. Partnerships with the private sector

- (a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the [Round 9 Guidelines](#) for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

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Private sector funding is at a very early stage in Malaysia. One new scheme is the pledge by Standard Chartered Bank Malaysia Berhad of RM1.2 million (EU253,000) to the Standard Chartered Pediatric HIV/AIDS programme to support children infected or affected by HIV/AIDS in Malaysia. The programme was set up in collaboration with Malaysian AIDS Foundation (MAF) to support 330 children from families with financial challenges to provide basic needs such as food, education and medical treatment. In addition, last year (2007) 243 children were supported through the MAF Paediatric AIDS Fund through generous donations from the public.

These children do not form part of the beneficiaries of this proposal.

Mercedes-Benz, L'Oreal and MAC cosmetics also provide small grants to Malaysian AIDS Council (EU20,000 – 30,000) for Red Ribbon campaigns general HIV education and support for shelter homes

- (b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment
(All or part, and which part, of proposal's targeted population group(s)?) →

Contribution Value (in USD or EURO)
Refer to the [Round 9 Guidelines](#) for examples

Organization Name	Contribution Description (in words)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
							0
<i>[use "Tab" key to add extra rows if needed]</i>							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved HIV outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach prevention, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes. → *Refer to country evaluation reviews, if available.*

This proposal includes a number of activities which, once implemented, will notably strengthen and further develop the capacity of community organisations and systems aimed at enabling improving access to HIV prevention, treatment, care, and support services, and subsequent health and social outcomes for the most at-risk populations in Malaysia. Larger numbers of people from most at-risk populations will be covered by quality services, as a result of the capacity building of community organisations and the subsequent maximised utilisation of a significantly upskilled workforce.

The core capacity building of NGO programme managers and staff will revolve around reducing the vulnerability of the most at-risk populations (i.e. injecting drug users; sex workers; gay men and other men who have sex with men; the transgendered; prisoners and others in custodial settings; and migrants, refugees and mobile populations). Technical assistance will be sought to ensure that international evidence-based practices are utilized with each population.

Workforce development will not only build technical capacity with regards key interventions such as safe spaces (i.e. drop-in centres), peer-based outreach, information provision and education, condom distribution, socio-legal support

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(i.e. shelters and livelihood programmes), and sub-population-specific services such as needle and syringe programmes and assisted structured referral / prioritised access to drug treatment including opioid substitution treatment (injecting drug users), structured pre-release programmes linked to post-release programmes (prisoners and others in custodial settings), and assisted structured referral to primary and specialist health care, tuberculosis (TB) and HIV services (all six identified most at-risk populations), but will also enhance national NGO capacity related to financial management, human resource management and management information systems (MIS) strengthening.

A civil society organisational development plan, addressing essential components of both organisational systems development and physical infrastructure development, will feature prominently among efforts to strengthen civil society. This civil society organisational development plan will be complemented by a community mobilisation strategy with related tools, including a comprehensive and broadly relevant advocacy guide / resource including separate tailored sections aimed at specific audiences (such as politicians, religious leaders, senior health and law enforcement staff, the media).

Coordination will be improved, duplication avoided, service delivery coverage maximised, and impact enhanced by the building of a more supportive environment (via targeted advocacy efforts at national, state and district levels, emphasising the importance of working with the most at-risk populations), and systematic partnerships built as a result of a national civil society organisation HIV conference. A biannual coordination meeting will also help to ensure that the activities detailed within this proposal are adequately coordinated between all stakeholders.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

The realisation in 2005 that MDG 6 related to the reversal of the HIV epidemic would not be fulfilled, spurred the Government into accepting the argument that extraordinary measures needed to be undertaken to effectively address the situation. As quoted in the Economic Planning Unit's 2005 landmark MDG report, "achieving the 2010 UNGASS targets and attaining the last remaining MDG in Malaysia will require an innovative and expanded effort" (Annex 22). The Government has provided full support at the highest level to introduce new initiatives which respond to the HIV epidemic utilising a more aggressive and effective approach i.e. the Needle Syringe Exchange Programme (NSEP) and scale up of the existing methadone maintenance therapy (MMT) programme. The development and submission of the Country Proposal to the Global Fund is part of that continuing political and financial commitment to ensure that the national response to HIV is better equipped with the necessary tools and more comprehensive, particularly in communities which are not able to be reached by existing government healthcare services.

This proposal will work with Malaysia's efforts to meet its Millennium Development Goals in the following ways:

- The strategies described in the Country Proposal depend on and are guided by the National Strategic Plan on HIV/AIDS 2006 – 2010 (Annex 2). The current NSP identifies the necessary framework for Malaysia's response to HIV and AIDS over a period of five years and provides the basis for coordinating the work of all partners with a view to successfully achieving UNGASS targets and MDGs on HIV. The NSP provides the necessary supporting goals, fundamental principles, broad strategies, and the institutional framework for implementation of the proposed interventions contained within this proposal.
- Though the NSP envisaged a massive surge in programmes addressing populations vulnerable to HIV, the response to most-at-risk populations (i.e. sex workers, transgendered, MSM, etc) has been limited due to human and financial capacity problems experienced by most of the non-governmental organisations working on HIV related issues.
- The strategies and interventions of the Country Proposal will see continuity of support in the next NSP which is currently being developed and planned for the period of 2011 – 2015. The financial commitment of the NSP 2006 – 2010 of approximately EU115 million which is also embodied in the 9th Malaysian Plan, will also be repeated for the next NSP and 10th Malaysian Plan.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national HIV outcomes and measuring impact.

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Where one exists, refer to a recent national or external evaluation of the IMS in your description.

The national HIV/AIDS monitoring and evaluation system is outlined in the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2). The secretariat of the national monitoring and evaluation (M&E) process is located within the AIDS/STD Section of the Disease Control Division within the Department of Public Health of the Ministry of Health. In addition to the M&E of the HIV/AIDS situation in Malaysia, the Disease Control Division is responsible for HIV/AIDS programme activities and coordination, policy making and analysis, and advocacy. In consultation with the National Advisory Committee on AIDS (NACA) and the Technical Committee on AIDS (TCA), the AIDS/STD Section of the Disease Control Division provides an annual report to the Inter-Ministerial Committee on AIDS (IMCA) on the progress against the National Strategic Plan, annual work plans and budgets. Within the Disease Control Division, the national HIV/AIDS M&E secretariat is responsible for building and maintaining linkages with state and district authorities, NGOs and civil society, and for facilitating the sharing of information among the various stakeholders, including the Cabinet Committee on AIDS (CCA – chaired by the Deputy Prime Minister); NACA, chaired by the Minister of Health; and the TCA, chaired by the Director of Health Malaysia, Ministry of Health.

At national level, the AIDS/STD Section of the Disease Control Division has established a formal Monitoring and Evaluation Unit, responsible for the bulk of the surveillance programmes and activities related to HIV/AIDS. M&E of activities detailed within the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 are integrated into the various programmes implemented by the AIDS/STD Section of the Disease Control Division, which consists of approximately 20 public health and medical specialists who together plan, implement and monitor all national activities related to HIV/AIDS and STD. Data is collected from stakeholders on a monthly basis on both the progress of activities and HIV/AIDS surveillance, and regular technical meetings are held in order to obtain stakeholder feedback. Data collected mainly relates to the number of activities completed, with increased focus needing to be placed upon the establishment of clear indicators for HIV/AIDS programmes and activities, and the subsequent collection of related data.

At state level, M&E activities are coordinated by the AIDS/STD Units of the Public Health Programmes of the State Health Departments. Such a unit usually consists of a public health physician (referred to as a State AIDS Officer) assisted by one or two technical staff. The AIDS/STD Units of the Public Health Programmes receive data from sources such as hospitals, clinics, government and private health facilities and institutions, and NGOs. Data is collated and entered into specific computer applications (i.e. the Communicable Diseases Information System or CDCIS) before being submitted to the Disease Control Division within the Department of Public Health of the Ministry of Health. Meetings with key HIV/AIDS stakeholders and the State Health Departments, reflective of similar national level dialogues, also form an integral part of the state level M&E approaches. At district level, the Communicable Diseases Units (CDC) of the District Health Offices bear the responsibility of HIV/AIDS M&E. Related activities are usually performed by a health inspector as part of district communicable disease surveillance, under the coordination of the district medical officer. Data is collected and returned to the AIDS/STD Units of the respective State Health Departments on a monthly basis.

Results of the M&E system are used to measure the impact of various strategies on HIV risk behaviours among most-at-risk populations. However, behavioural surveillance studies do not at present examine risk behaviours of all populations on a regular basis. With the involvement of NGOs working directly with most-at-risk populations, this proposal will ensure that more rigorous and regular behavioural surveillance studies are put in place to measure trends over time and to assist in project and MoH decision-making and resource allocation.

In addition, little is known about health-seeking behaviour among most at risk populations and their current usage of health facilities. Through the activities in this proposal, obstacles to engaging with the GoM health system will be identified and strategies put in place to enhance both acceptances of these populations by health facilities, and engagement with these facilities by most at risk populations.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal (*at the PR, Sub-Recipient, and community implementation levels*) use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

The project M&E plan is congruent with the national HIV/AIDS M&E system outlined in the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2). The project M&E plan was elaborated subsequent to the consolidation of the revision of the list of national indicators. Programme M&E of grant implementation will be performed in accordance with the GFATM M&E guidelines. M&E will be conducted at various levels.

The expected outcomes will be evaluated by means of indicators oriented both to the process and, importantly, the results and outcomes of HIV/AIDS programme activities. M&E of activities will be performed under the joint leadership of the Project Implementation Unit established by the Principal Recipient and the secretariat of the national HIV/AIDS M&E system, located within the AIDS/STD Section of the Disease Control Division within the Department of Public Health of the Ministry of Health. The CCM, chaired by the Deputy Minister of Health, will be responsible for

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ensuring appropriate linkages between the project's M&E processes and the national M&E system for integration into a single M&E system. To ensure consistency and integrity of M&E processes, a detailed M&E framework will be developed by the PIU, which has prior experience in developing M&E frameworks for work with MARPs. The M&E framework will comprise a description of the data collection procedure, methods of calculation of indicators, standard reporting templates, scheme of reporting and data dissemination, in addition to defining responsibilities at each stage.

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

→ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

As part of the 2007 Report on the Monitoring and Evaluation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2), it was recommended that the following improvements be made to address shortcomings in the existing national M&E systems:

- Capacity enhancement and upgrading of human resource capabilities in the field of HIV/AIDS (and, specifically, HIV/AIDS M&E), particularly within the secretariat of the national M&E process within the AIDS/STD Section of the Disease Control Division within the Department of Public Health of the Ministry of Health. In order to reduce reliance upon expertise from international agencies, the AIDS/STD Section of the Disease Control Division needs to have its own team of epidemiology, behavioural research, behavioural science, and biomedical statistics experts: MoH is planning this ;
- Development of clear indicators and targets for HIV/AIDS programmes and activities by the AIDS/STD Section of the Disease Control Division. Indicators and targets should relate to significantly more than mere activity progress and completion, and need to be broadened to measure the achievement of HIV/AIDS prevention activities. Such indicators must be comparable with established international data sets and should not unnecessarily burden focal points;
- Behavioural Surveillance Surveys among most at-risk populations (i.e. injecting drug users, sex workers, men who have sex with men, the transgendered) need to be conducted regularly in order to monitor behavioural changes over time. As a low HIV prevalence country, Malaysia must focus its attention upon the behaviour of these most at-risk populations.

This proposal will assist in addressing these issues by:

- Funding advocacy to the MoH to implement the recommendation on the composition of the MoH HIV/AIDS M&E team, and by providing capacity building activities to those NGO staff and academic staff working with NGOs (a common practice in Malaysia) to develop a trained pool of M&E practitioners the MoH can call on for specific advice and assistance;
- Development of clear indicators and targets for this proposal has been carried out in collaboration with the AIDS/STD Section of the Disease Control Division, assisting the national M&E team to harmonise datasets and reduce the burden on both governmental and NGO focal points;
- With the involvement of NGOs working directly with most-at-risk populations, this proposal will ensure that more rigorous and regular behavioural surveillance studies are put in place to measure trends over time and to assist in project and MoH decision-making and resource allocation.

4% of the total budget of the proposal is allocated specifically for the strengthening of M&E systems in Malaysia.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) other than 'Global Fund Grant Performance Reports'. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.

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	Malaysia
<p>The Malaysian AIDS Foundation (MAF) is a legally constituted entity under the laws of Malaysia, with demonstrated successful prior experience in implementing or providing grants to implement relevant programmes for a range of populations most-at-risk of HIV infection in Malaysia. MAF is governed by a board of trustees adherent to the Trustees (Incorporation) Act 1952 and Trustees (Incorporation) (Amendment) Act 2004.</p> <p>MAF possesses a Program Implementation Unit (PIU) with the range of skills required to implement programmes and provide technical support to its implementing partners. It's established organisational level monitoring and evaluation (M&E) systems enable programmatic data to be captured and maintained, and for reports to be generated according to standard and agreed formats, at predetermined frequencies and to known deadlines.</p> <p>The PIU at MAF has financial procedures and administrative and control policies (encompassing cheque and cash transactions, petty cash and cash advances, and payments to project partners) with clear delegation of authority for approvals. It utilises the computerised accounting system UBS Accounting to track all transactions according to the approved budget with proper supporting documents. The UBS Accounting system is multi-lingual and allows MAF to collate information for newly acquired assets, maintain the organisation assets historical records, compute the depreciation of assets, and determine the gain or loss on disposal of assets. MAF is also equipped with an onward granting system which ensures the strategic and transparent selection and mobilisation of implementing partners. MAF has a record of promptly submitting annual returns and tax payments to the government authorities.</p> <p>MAF implements organisational processes that increase gender equality and empower women, men and sexual minorities. There are currently six male and eight female staff at MAF, with an additional six male and eight female staff anticipated following restructuring. MAF has a transparent, non-discriminatory and equal opportunity recruitment system, which includes internal and external advertising, and actively encourages the recruitment of appropriately qualified HIV-positive staff and volunteers (including representatives of most at-risk populations) in its governance and organisational structures.</p> <p>The MAF management and staff have relevant qualifications and practical experience for the implementation of large-scale externally funded projects. With such personnel and its defined organisational structure (including appropriate supervision arrangements and internal reporting requirements), MAF is well placed to supervise disbursements in accordance with this proposal's financial management arrangements, and comply with national legislation. MAF will also ensure that effective arrangements are made with regards to procurement and supply management, and all necessary programmatic and financial monitoring and evaluation requirements.</p> <p>Given the increasing scope of activities and commensurate workload entailed with this proposal, MAF capacity will be further strengthened by relevant technical assistance and operational support, sought in this proposal.</p>	

→ Copy and paste tables above if more than three Principal Recipients

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	<input checked="" type="checkbox"/> Yes
	<input type="checkbox"/> No
(b) If no , why not?	
(c) If yes , how many sub-recipients will be involved?	<input type="checkbox"/> 1 – 6
	<input type="checkbox"/> 7 – 20
	x <input type="checkbox"/> 21 – 50
	<input type="checkbox"/> more than 50

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<p>(d) Are the sub-recipients already identified? <i>(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)</i></p>	<p><input checked="" type="checkbox"/> Yes <i>[Insert Annex Number for list]</i></p> <hr/> <p><input type="checkbox"/> No Answer s.4.9.4. to explain</p>
<p>(e) If yes, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.</p>	
<p>The Country Coordinating Mechanism (CCM) of Malaysia identified and approved 19 sub-recipients to implement activities detailed within this proposal, based upon submitted expressions of interest (EOIs) to meet published selection criteria (Annex 37), at its meeting on 21 April 2009 (Annex 42). The overwhelming majority of the 19 pre-approved sub-recipients are registered as non-government organisations, with one faith-based organisation and two academic / educational institutions (see s. 4.9.3.).</p>	

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

The Country Coordinating Mechanism (CCM) of Malaysia identified and approved 19 sub-recipients to implement activities detailed within this proposal, based upon submitted expressions of interest (EOIs), at its meeting on 21 April 2009 (Annex 42). Descriptions of the past implementation experience of each of these sub-recipients follow.

1) Malaysian AIDS Council: MAC is an initiative of the Ministry of Health. Formed in 1992, MAC brings HIV-related NGOs under one umbrella in order to maximise their efforts and to ensure that limited resources are used as efficiently as possible. The organisation is prominently involved in advocacy and public policy reform, programme development and management, prevention and education programmes, outreach and peer-based education programmes, care and support services including support networks, the development of information/education/communication (IEC) materials, public awareness campaigns and exhibitions, and training workshops, seminars and forums. The organization also provides a resource centre and library.

2) Centre of Excellence Research in AIDS: CERIA has carried out HIV/AIDS research and piloted a harm reduction project in Pengkalen Chepa Prison. This project involved psychosocial counselling, methadone treatment and post-release case management for prisoners with a history of injecting drug use. CERIA continues to monitor and research prisoners included in this pilot programme whom have been released back into society. It is a centre under the administration of the University of Malaya. Grants to the CERIA are strictly governed by the Institute of Research Management and Consultancy (IPPP), and the expenditure of such grants complies with Malaysian government guidelines

3) Drugs Intervention Community Pahang: DIC Pahang is a community-based organisation providing comprehensive services to the drug user community in the state of Pahang. Formed in 2000, the organisation implements targeted intervention programmes to prevent the transmission of HIV and other blood borne viruses via a drop-in centre, needle and syringe programme (NSEP), condom distribution, referrals to methadone maintenance therapy (MMT), a social reintegration programme, and voluntary counselling and testing (VCT). In addition, the organisation provides a shelter for women and children, a burial assistance team, and a 24 hour telephone helpline to provide information on drugs and HIV, and service referrals. The organisation is also actively involved in providing HIV awareness education to schools, colleges, universities and the general public.

4) Federation of Reproductive Health Associations Malaysia: FRHAM (previously known as the Federation of Family Planning Associations Malaysia) was formed in 1958 with the objective to be the leading voluntary family planning/reproductive health organisation in Malaysia. It is a non-governmental and non-political organisation and is a Federation of 13 member associations from all states of Malaysia. FRHAM aims to educate people on the importance of their reproductive health needs, mainstreaming HIV for the promotion of the optimal health of women, men, adolescents, and youth. The emphasis of its service provision and advice are targeted towards marginalised and vulnerable groups of the community. During 2007 and 2008, FRHAM has implemented programmes for women and youth including: a programme empowering young rural teenage girls with life skills to prevent HIV and STI infection in Kelantan; a gender-sensitive HIV education and community programme in Sabah; a project to strengthen the capability and capacity of young people in HIV and STI prevention in Penang, Kelantan, Melaka and Kedah, Pulau Langkawi; a project reaching out to most-at-risk youth in addressing sexual and reproductive health needs and HIV prevention through peer education, sexual and reproductive health and HIV awareness talks in Selangor/WP,

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Pahang, Sabah, Kelantan, Terengganu, Melaka, Perak; sexual and a youth empowerment project to halt HIV infection in Kota Baru, Kelantan. FRHAM has implemented the following programmes for sex workers: a national project to increase knowledge and to change attitudes and behaviour regarding sexual and reproductive health and HIV prevention among those involved in sex work; a condoms promotion programme in Sarawak; and a project to raise awareness of sexual and reproductive health and HIV prevention among sex workers in Penang.

5) Harapan Komuniti Berhad: HKB is a registered not-for-profit organisation operating since 2004. The organisation is focused on community-based holistic development, and is staffed mainly by volunteers and part-time helpers. Operating in Kuala Lumpur, Selangor, Kota Kuala Muda, Kedah, Johor Bahru, and Johor, HKB works to bring love, hope and peace to the poor, needy and marginalised through training and education, health, counselling, disaster relief and food sharing programmes. The organisation has provided disaster relief to tsunami-hit families at Kampung Paya, Kota Kuala Muda, and Kedah, as well as relief for families affected by the double flood in Muar, Johor. It has initiated a HIV IEC centre with outreach to PLHIV (including youth and women).

6) Harvest Centre Bhd.: HCB is a non-profit private company limited by guarantee established to address various issues in the development of urban poor communities such as those of Sentul, Kuala Lumpur. The organisation has been involved in community work since 1998, bringing medical and health care, home improvement and food provision to underprivileged families. Since 2002, the organisation has been focusing on providing educational programs for urban poor children which address the learning difficulties and challenges that they face. The organisation specialises in developing curricula for pre-school, primary and secondary school students, building and implementing community learning centres, teaching children and youth, teacher training, and developing sports education programmes. It is the only organisation in Malaysia operating full secondary school education programs for refugee children. The organisation has been involved in training teachers from various refugee communities on behalf of United Nations High Commission for Refugees (UNHCR), and has trained teachers and helped develop the primary education within the Rohingya communities in the Klang Valley. The organisation has also started a pre-school project with the orang asli (indigenous) communities throughout Malaysia, and has helped to initiate and support the formation of the Malaysian Refugee Teachers' Association.

7) Health Equity Initiatives Sdn Bhd.: HEI is a community-based organisation in Kuala Lumpur that was established in December 2007. The organisation works to promote the right to health of marginalised communities by developing community-based health interventions that increase their agency and promote their health. HEI supports community-based groups and organisations to realise their right to health and uses evidence-based and participatory approaches to demonstrate links between social marginalisation and health to promote equity in health, and to advocate for the development of just, fair and inclusive policies that enable less advantaged communities to gain control over their health. Additionally, the organisation engages in national, regional and global partnerships that foster equity and justice in health. Since its inception, the organisation has implemented community based health interventions and community health education, campaigns and medical camps, and has trained community health workers and students of medicine and psychology. The organisation has also delivered counseling, psychological and psychiatric services, conducted research and evidence based advocacy, and developed tools and manuals for community health interventions.

8) Kenosis Home: Kenosis Home is a faith-based non-profit drug rehabilitation center in Kuala Lumpur. Kenosis Home is set up to provide rehabilitation that instills Christian values in its residents. It offers a caring supportive and disciplined environment for the residents to empower themselves to live a purposeful and drug-free life.

9) Kumpulan A.C.T.S. Berhad: During 2007 and 2008 Kumpulan A.C.T.S. Berhad has implemented primary health care services through static and mobile clinics for migrants, refugees and mobile populations (including asylum seekers). The organisation has also delivered mental health services via counsellors and psychologists, voluntary counselling and testing services, and operated a shelter home for migrants, refugees and mobile populations (including those living with HIV) and two convalescence homes for migrants, refugees and mobile populations (including asylum seekers).

10) AIDS Action & Research Group: AARG was established in 1994 and is based in the School of Social Sciences at the Universiti Sains Malaysia. AARG consists of academic and non-academic staff dedicated to preventing the spread of HIV and to helping those infected with and affected by HIV. The organisation has expertise in social work, sociology, psychology, counselling, public health, mass communications, accounting, demography, economics, law, criminology, drug research and rehabilitation, management, languages, medicine, nursing, and industrial relations. The organisation has engaged in various researches, education, training, and community action activities related to HIV/AIDS. It also provides a HIV telephone counselling service.

11) MTAAG PLUS BHD: MTAAG PLUS BHD is involved in national advocacy and information sharing efforts, particularly with regards to antiretroviral treatment access and literacy (including among illiterate people living in rural areas) and towards developing a Malaysian network of PLHIV. Partners with whom the organisation has implemented programmes with during the past two years include the Australia Federation of AIDS Organisations (AFAO), Malaysian AIDS Council, Third World Network (TWN), TIDE Foundation, ITPC, GNP+, ICW, UNAIDS, IPPF,

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Health and Development Networks (HDN) and local partner organisations.

12) Penang Family Health Development Association: PFHDA (formerly Penang Family Planning Association) was established in 1961. It is a member of the Federation of Reproductive Health Associations Malaysia (FRHAM). During 2007 and 2008 the organization has implemented a drop-in centre and clinic for PLHIV, transgender, IDUs and MSM, and outreach to sex workers, the transgendered, MSM, and most at-risk youth. The organisation has also facilitated a support group for PLHIV families (including antiretroviral treatment adherence), a youth drama programme, a post-release programme for former drug user prisoners (and their spouses) during probation, and the HALT HIV programme for recovering drug users at Pusat Serenti. The organisation's sexual and reproductive health activities include the provision of clinical services and information/referral for pre- and post-abortion services, adoption services and unwed mothers' shelters. .

13) Persatuan Cahaya Harapan Negeri Kedah: During 2007 and 2008 PCHNK has implemented predominantly harm reduction programmes aimed at injecting drug users, MSM, PLHIV, sex workers, and families of affected people. Such programmes have included needle and syringe exchange programmes (NSEP), condom distribution, peer-based outreach and information provision, group and individual drug use counseling and support groups, voluntary counselling and testing services, and referrals to primary and specialist health care services. The organisation has also undertaken advocacy efforts targeted at police, the anti drug agency (AADK), prisons, religious organisations, community leaders, university and school students, and the general public. .

14) Persatuan Perantaraan Pesakit-Pesakit Kelantan: SAHABAT, a non profit organisation set up to serve people with special needs, was established in 1999 after consultation with the doctors from Hospital Kota Bharu, Prof Dr Azhar Mohd Zain, Dean Fakulti Perubatan Universiti Putra Malaysia, Dato' Dr Abdul Razak Hj Kechik then Chief Medical and Health Officer Perak, Individuals, IDUs, government agencies and NGOs. The mission of the organization is to provide harm reduction for PLHIV, counseling post-rehabilitation, aftercare, care and support for PLHIV, assistance to recovering drug users (particularly those who are HIV-positive) for re-integration to society.

15) Pertubuhan Kebajikan Intan Zon Kehidupan (Intan Life Zone Welfare Society): Intan Life Zone Welfare Society is a fully registered welfare society formed in 2004. It is governed by a committee of local members of the community and has a staff of more than 20 full time workers including programme managers, outreach workers, qualified medical staff, and case workers. Many of the organisation's personnel are former drug users and HIV positive individuals who were previously service receivers. Based in Johor Bahru, the organisation implements three separate programs, including a needle and syringe programme (NSEP) with drop-in centre and outreach teams; a drug recovery house which caters for the rehabilitation of disowned and homeless drug users via counselling and motivational activities aimed at social reintegration; and dignity homes (for both men and women) which provide a fully residential programme for those infected and affected by HIV, with emphasis placed on restoring dignity and self-assurance, and achieving social reintegration.

16) Pertubuhan Komuniti Intan: PKI was founded in 2003 to assist marginalised groups, particularly PLHIV in the Lower Perak District. It provides home visits to PLHIV, seeking their needs and responding with appropriate assistance where possible; hospital peer support and drop-in centre for PLHIV; PLHIV support groups; outreach to the transgendered and to sex workers; and HIV awareness programs in villages, estates and schools.

17) PT Foundation: PT Foundation (previously known as Pink Triangle Sdn Bhd.) is a community-based, voluntary non-profit organisation providing HIV education, prevention, care, and support programmes, and sexuality awareness and empowerment programmes for vulnerable communities in Malaysia. The organisation works with drug users, sex workers, maknyah (transgendered people), gay men, and people living with HIV. The organisation was registered in 1987 and gradually expanded its services to include drop-in centres, support groups, and outreach work. The organisation has successfully delivered HIV programmes that were funded by the Australian Federation of AIDS Organisations (AFAO), the Dutch HIV/AIDS Fund (HIVOS) and the European Commission (EU). Such programmes have included a comprehensive MSM outreach programme with condom distribution and a community-based free and anonymous rapid HIV screening and counselling services; an outreach programme to sex workers in Chow Kit, Melaka, Kuantan, Ipoh, and Kelantan; the Ikhlas Programme for injecting drug users, featuring peer-based outreach, drop-in centre, and needle and syringe programme (NSEP); a hospital-based peer support outreach service for marginalised communities; support groups for single mothers, sex workers, maknyah and MSM; and telephone counseling via a HIV and Sexuality Hotline. The organisation practices professional, accountable and transparent governance and management, and has been internationally recognised via numerous humanitarian awards.

18) Sarawak AIDS Concern Society: Sarawak AIDS Concern Society was registered in 1998 as an initiative of the Sarawak AIDS Network (SAN). The organisation implements advocacy, education and information sharing programmes related to HIV, and aims to promote and protect the rights of PLHIV. Based in the capital city, Kuching, the organisation has been actively expanding its areas of operation over the past few years to include the rest of Sarawak. The organisation works to build and strengthen its capacity in order to reach out to more people, particularly peer-based outreach and support programmes for sex workers, the transgendered and PLHIV in rural areas.

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19) Tenaganita Sdn Bhd.: Tenaganita Sdn Bhd. is a women and migrant workers organisation working to promote and protect the rights of all women and migrant workers within a globalised world. Formed in 1991, the organisation features eight major programs to empower, organise and consolidate migrant and women workers within Malaysia and regionally. During 2007 and 2008 Tenaganita Sdn Bhd. has implemented the programmes for refugees including the following: establishment of drop-in centers serving as focal points for training, outreach, incident reporting, counselling, and case management; establishment of support groups / networks; and delivery of peer education and community awareness raising training, including on HIV/AIDS. In the same period the organisation has implemented the programmes for migrants, refugees and mobile populations: peer-based education training workshops and outreach programmes; condom and IEC materials distribution; case management; rescues and crisis shelter; and advocacy.

According to the procedures of the Malaysian AIDS Foundation (MAF) which has been appointed by the Country Coordinating Mechanism (CCM) of Malaysia as the Principal Recipient, all prospective sub-recipients of Global Fund Round 9 proposal funds will undergo organisational capacity assessment prior to the signing of cooperation agreements. Such capacity assessment will include the assessment of managerial and personnel capacities, financial management, administrative and procurement systems, and monitoring and evaluation mechanisms, and will identify priority areas for technical assistance and capacity building for each sub-recipient. Technical assistance has been sought within this proposal to address the most pressing needs of SRs, which mainly relate to scaling up from high-quality, small-scale activities to a much larger scale without sacrificing quality.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

The Country Coordinating Mechanism (CCM) of Malaysia identified and approved 19 sub-recipients to implement activities detailed within this proposal, based upon submitted expressions of interest (EOIs), at its meeting on 21 April 2009 (Annex 42).

In the course of developing the proposal, it became clear that additional technical assistance will be required for civil society strengthening and for ensuring that the large numbers of pre-identified SRs carry out international, evidence-based activities of a high quality across Malaysia. It is envisaged that further SRs may need to be identified to carry out some of these TA and other activities.

If additional sub-recipients are required, the established Malaysian AIDS Foundation (MAF) procedures for the fair and transparent assessment and selection of sub-recipients (in which terms of reference are developed and published, advertising is carried out online and in national media and an independent reference group is appointed to review and decide on appropriate SRs) will be followed.

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** (e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems); and
- **The extent to which partners will support program implementation** (e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant).

Members of the Country Coordinating Mechanism (CCM) of Malaysia unanimously endorsed the Malaysian AIDS Foundation (MAF) as the sole principal recipient at its meeting on 21 April 2009 (Annex 42). For the purposes of this proposal, dual track financing will not be implemented. The Malaysian AIDS Foundation (MAF) will employ systematic coordination mechanisms for sub-recipients revolving around the biannual disbursement of funds, quarterly financial performance reporting and monthly programmatic performance monitoring. Established internal operating procedures for sub-recipients, in the form of a sub-recipient's management manual which includes implementation guidelines and operational procedures, will contribute to appropriate coordination.

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It should be noted that prior to the finalisation of sub-recipient agreements, the organisational capacity of each sub-recipient will be evaluated and capacity building priority areas identified. A broader civil society organisational development plan, addressing essential components of both organisational systems development and physical infrastructure development, will also feature prominently among efforts to both strengthen and coordinate sub-recipients. A national civil society organisation HIV conference, and a biannual coordination meeting, will also help to ensure that the activities detailed within this proposal are adequately coordinated between all stakeholders. Such gatherings will also help to establish and maintain essential systematic partnerships.

The Malaysian AIDS Foundation (MAF) will collaborate with the secretariat of the national monitoring and evaluation process within the AIDS/STD Section of the Disease Control Division within the Department of Public Health of the Ministry of Health, the AIDS/STD Units of the Public Health Programmes of the State Health Departments, the Communicable Diseases Units (CDC) of the District Health Offices, and sub-recipients to develop a M&E plan which consolidates indicators and clearly determines targets for HIV/AIDS programmes and activities, and features strategies and training components which enhance human resource capabilities in the field of HIV/AIDS M&E in Malaysia.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

- (a) the assistance that is planned;**
- (b) the process used to identify needs within the various sectors;
- (c) how the assistance will be obtained on competitive, transparent terms; and
- (d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

ROUND 9 – HIV

Implementation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 has achieved satisfactory results in providing access to HIV prevention, treatment, care, and support services. Sustaining and building upon these achievements to ensure that more people from the most at-risk population groups will be covered by quality services will require the strengthening and further development of the capacity of HIV related public and community organisations and systems throughout Malaysia.

As noted earlier (see s. 4.3.1.), the Year 2007 Report on the Monitoring and Evaluation of the Malaysia National Strategic Plan on HIV/AIDS 2006-2010 (Annex 2) recommended that numerous improvements be made to address weaknesses in the implementation of activities towards the prevention of HIV in Malaysia. The process of selecting sub-recipients and developing this proposal has also highlighted key areas requiring technical and management assistance, and capacity building.

Given Malaysia's HIV epidemiological context, and subsequent prioritisation of responses, the implementation capacity of sub-recipients will be strengthened via the capacity building of programme managers and staff with regards to reducing the vulnerability of the most at-risk populations (i.e. injecting drug users; sex workers; gay men and other men who have sex with men; the transgendered; prisoners and others in custodial settings; and migrants, refugees and mobile populations). This core element of HIV workforce development will build technical capacity related to key interventions such as:

- safe spaces (i.e. drop-in centres);
- peer-based outreach;
- information provision and education;
- condom distribution; and
- socio-legal support (i.e. shelters and livelihood programmes).

Technical assistance and capacity building for HIV programme managers and staff will also focus upon sub-population-specific services such as needle and syringe programmes (NSP) and assisted structured referral / prioritised access to drug treatment (including opioid substitution treatment / OST) for injecting drug users; structured pre-release programmes (linked to post-release programmes) for prisoners and others in custodial settings; and assisted structured referral to primary and specialist health care, tuberculosis (TB) and HIV services for all six identified most at-risk populations. The building of workforce capacity in these areas will utilise both training of trainers (TOT) and peer-based education approaches.

In addition to strengthening the capacity of sub-recipient programme managers and staff with regards to reducing the vulnerability of the most at-risk populations, the technical and management assistance and capacity building activities detailed within this proposal will also enhance national capacity related to financial management, human resource development, management information systems (MIS) strengthening, and relevant monitoring and evaluation (M&E) systems.

The overall capacity (both implementation and otherwise) of the principal recipient – the Malaysian AIDS Foundation (MAF) – will also be strengthened as a result of the aforementioned technical assistance and capacity building activities.

Relevant provisions for technical and management assistance, and capacity building, have been included in the component budget of this proposal.

Technical and management assistance and capacity building services will be provided by suitable providers capable of demonstrating prior expertise in the effective management of comprehensive HIV prevention, treatment, care, and support programmes for most at-risk and vulnerable populations. Such service providers will be identified via a transparent and competitive tender process, and will be engaged to develop the in-country workforce expertise towards sustainable high quality HIV related service implementation across Malaysia.

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4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	<input type="checkbox"/> No → Go to s.4B if relevant, or direct to s.5.
	<input checked="" type="checkbox"/> Yes → Continue on to answer s.4.10.2.

4.10.2. Table of roles and responsibilities –			
Provide as complete details as possible. (e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.			
Activity	Which organizations and/or departments are responsible for this function? (Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)	In this proposal what is the role of the organization responsible for this function? (Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	MAC	SR	No
Intellectual property rights	N/A		n/a
Management and coordination <i>More details required in s.4.10.3.</i>	MAC	SR	Yes
Product selection	MAC		Yes
Management Information Systems (MIS)	MAC	SR	Yes
Forecasting	MAC	SR	Yes
Procurement and planning	MAC	SR	Yes
Storage and inventory management <i>More details required in s.4.10.4</i>	MAC	SR	Yes
Ensuring rational use and patient safety (pharmacovigilance)	MAC	SR	Yes

4.10.3. Past management experience		
What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?		
Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year (Same currency as on cover of proposal)
MAC	SR	

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<i>[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]</i>		

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

Only health products to be procured are condoms, lubricant, and injecting sets for IDUs comprising 3 x needles and syringes.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	<input type="checkbox"/>	National medical stores or equivalent
	<input type="checkbox"/>	Sub-contracted national organization(s) <i>(specify)</i>
	<input type="checkbox"/>	Sub-contracted international organization(s) <i>(specify)</i>
	<input checked="" type="checkbox"/>	Other: MAC warehouse <i>(specify)</i>

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Warehouse will be leased as part of proposal implementation.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Distribution will be carried out by SR NGOs which have been distributing commodities under GoM MoH grants for more than 5 years. There will be an increase in commodity distribution through this proposal and technical assistance will be provided by MAF and MAC to ensure that each SR's capacity to distribute is enhanced (through additional staff, vehicles, appropriate storage and planning sections in the SR management manual, etc)

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-HIV' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-HIV' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

ATTACHMENT B

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4.10.7. Multi-drug-resistant tuberculosis	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?	<input type="checkbox"/> Yes <i>In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.</i>
	<input checked="" type="checkbox"/> No <i>Do not include these costs</i>

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the tuberculosis or malaria proposal*

Read the [Round 9 Guidelines](#) to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website [here](#) if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

NOT APPLICABLE

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5. FUNDING REQUEST

5.1. Financial gap analysis – HIV

→ Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.

Financial gap analysis (same currency as identified on proposal coversheet)								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A → Provide annual amounts	36m	37.5m	39.1m	42m	44.5m	47.2m	50.3m	54m
Line A.1 → Total need over length of Round 9 Funding Request						<i>(combined total need over Round 9 proposal term)</i>		350.6m
Current and future resources to meet financial need								
Domestic source B1 : Loans and debt relief (<i>provide name of source</i>)	0	0	0	0	0	0	0	0
Domestic source B2 National funding resources	22.5m	22.5m	22.5m	22.5m	22.5m	22.5m	22.5m	22.5m
Domestic source B3 Private Sector contributions (national)				>300,000	>300,000	>300,000	>300,000	>300,000
Total of Line B entries → Total current & planned DOMESTIC (including debt relief) resources:	22.5m	22.5m	22.5m	22.8m	22.8m	22.8m	22.8m	22.8m

ROUND 9 – HIV

Financial gap analysis <i>(same currency as identified on proposal coversheet)</i>								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
External source C 1 <i>(provide source name)</i> Malaysian UN Theme Group	730,000	885,000	1.075m	670,000	0	0	0	0
External source C2 <i>(provide source name)</i>								
External source C3 Private Sector contributions (International)								
Total of Line C entries → Total current & planned EXTERNAL (non-Global Fund grant) resources:	730,000	885,000	1.075m	670,000	0	0	0	0
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	0	0	0	0	0	0	0	0
Line E → Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	23.2m	23.4m	23.5m	23.2m	22.8m	22.8m	22.8m	22.8m
Calculation of gap in financial resources and summary of total funding requested in Round 9 (to be supported by detailed budget)								
Line F → Total funding gap (i.e. Line F = Line A – Line E)	12.8m	14.1m	15.6m	18.8m	21.7m	24.4m	27.5m	31.2m

ROUND 9 – HIV

Financial gap analysis <i>(same currency as identified on proposal coversheet)</i>								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Line G = Round 9 HIV funding request <i>(same amount as requested in table 5.3 for this disease)</i>				8,992,465	7,561,121	12,815,580	12,504,464	13,064,364

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 9, the total maximum funding request for HIV in Line G is:

- (a) For Lower-Middle income countries, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*
- (b) For Upper-Middle income countries, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*

Line H → Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

Cost sharing = $\frac{\text{(Total of Line D entries over 2010-2014 period + Line G Total)} \times 100}{\text{Line A.1}}$

15.7% = $(0+54,937,995) \times 100 / 350600000$

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5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed (e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis); and
- budgeted in a way that ensures that government, non-government and community needs were included to ensure fully implementation of country's HIV program strategies.

Since the 8th Malaysia Plan, the Ministry of Health Malaysia and the Economic Planning Unit (EPU) have renewed their efforts to develop a national health care financing mechanism. The need for such a mechanism was further emphasized in the 9th Malaysia Plan 2006-2010 (Annex 1). In early 2005, engagement of a national health financing mechanism (NHFM) consultancy service was approved by the EPU. This consultancy service was funded by the United Nations Development Programme (UNDP) and a consultancy consortium was officially engaged in March 2006. The NHFM project team is continuing to work on development of the NHFM design, including institutional development (Annex 55).

In the absence of an NHFM, the HIV/AIDS budget is prepared as part of the national budget every two years. Domestic resources for AIDS programs are obtained from the Treasury, channelled through the Ministry of Health for national, state and district level activities. The Government of Malaysia made a three-fold increase in the allocation to HIV/AIDS for the five years of the current National Strategic Plan (2006-2010) over the allocation for the previous NSP. The GoM is expected to commit to expend at least as much on HIV/AIDS in 2010-2014 as it has committed to the current NSP (total: 112.5m EU).

Despite this increased allocation, the funding from government alone is deemed to be insufficient to prevent and control the spread of HIV in Malaysia. The financial needs in 5.1 were estimates from the government, NGO and academic members of the CCM of the country's real needs to reduce HIV incidence among most at risk populations in Malaysia, based on advice from international technical experts. The increase over time represents additional needs for treatment of HIV positive members of most at risk populations.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

- prioritize domestic financial contributions to the national HIV program (including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget); and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

The Government has undertaken several measures to curb the growth of HIV epidemic in the country, among which include the following:

1. Support for programs by NGOs to reach most at risk populations in some cities
2. Formation of structures to manage, coordinate and implement national policies on HIV & AIDS with participation of various ministries, non-government organizations and other key stakeholders: National AIDS Task Force (1985); Inter-Ministerial Cabinet Committee on AIDS (1992); Malaysian AIDS Council (1993); Malaysian AIDS Foundation (2000); Harm Reduction Working Group (2003); National Advisory Committee on AIDS (2006)
3. Formulation and adoption of National Strategic Plans on HIV/AIDS (1st in 1988; 2nd in 2000; 3rd in 2004; 4th in 2006)
4. Development, implementation and monitoring of national HIV/AIDS programmes (PMTCT Programme in 1988; Healthy Lifestyle Campaign (1993); Code of Practice for the Prevention of HIV/AIDS in the Work-Place (2001); PROSTAR – Programme for Healthy Youths without AIDS – via peer to peer youth clubs (2004); Methadone maintenance therapy and Needle Syringe Exchange Program (2005), among others
5. Membership and participation in international and regional bodies on HIV/AIDS: ASEAN Task Force on HIV/AIDS (1993); Adoption of 2001 UNGASS Declaration of Commitment on HIV/AIDS
6. Sentinel surveillance and routine screening of various groups in government clinics/health centres: Surveillance programme (1988); surveillance of antenatal mothers (1994) and TB and STD patients (1996-1998); voluntary, anonymous and free HIV screening services through health clinics piloted in one state (Johor) in 2001 and expanded nationwide since 2002; 1st and 2nd Behavioural Surveillance Survey on high-risk groups (2003 and 2006); Three rounds of consensus on HIV epidemiology with technical and financial assistance from the WHO were undertaken to estimate the number of people

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living with HIV in Malaysia (1998, 2000 and 2003).

7. Convening of international/regional/national conferences/forums on HIV/AIDS

Advocacy activities, which form an important part of the activities in this proposal, will encourage greater GoM commitment to HIV/AIDS among most at risk populations during the next five years so that government allocations should rise above the levels already committed to by the GoM until 2014. Even with the current level of commitment, the funds sought from GF for this proposal (should it be funded) would represent well under 35% of the total expenditure on HIV/AIDS among these populations from 2010-2014.

5.1.3. External funding *excluding Global Fund – 'LINE C' entries in table 5.1*

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time*). Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

UN agencies' planned HIV budgets for the period 2011-2015 would remain limited and in line with their core mandates. Budgeting for UN activities is unlikely to affect budgets for the activities in this proposal.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget in Microsoft Excel format as a clearly numbered annex.** Wherever possible, use the same numbering for budget line items as the program description.
 - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** (*or to use a template if there is no existing in-country detailed budgeting framework*) **refer to the budget information available at the following link:** <http://www.theglobalfund.org/en/rounds/9/single/#budget>
2. Ensure the detailed budget is consistent with the detailed workplan of program activities.
3. From that detailed budget, **prepare a 'Summary by Objective and Service Delivery Area'** (s.5.3.)
4. From the same detailed budget, **prepare a 'Summary by Cost Category'** (s.5.4.)
5. Do not include any CCM or Sub-CCM operating costs in Round 9. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: <http://www.theglobalfund.org/en/ccm/>

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5.3. Summary of detailed budget by objective and service delivery area -

Objective Number	Service delivery area <i>(Use the same numbering as in program description in s.4.5.1.)</i>	Year 1	Year 2	Year 3	Year 4	Year 5	Total
SDA 1.1	Coordination	1,062,472	1,070,896	1,643,672	2,292,136	3,022,136	9,091,312
SDA 1.2	Strategic Information	305,600	0	0	305,600	0	611,200
SDA 1.3.	M&E of MARP Interventions	310,382	179,482	173,582	42,682	42,682	748,808
SDA 1.4.	Institutional and Technical Capacity Building	2,046,691	1,702,843	2,344,659	2,077,257	2,077,257	10,248,706
SDA 2.1.1.	IDU Programs	1,702,420	1,453,610	2,370,293	2,218,984	2,218,984	9,964,291
SDA 2.1.2	Sex Worker Programs	725,601	594,368	1,424,868	1,263,636	1,263,636	5,272,108
SDA 2.1.3.	Gay Men and Other MSM	490,920	423,274	652,316	600,709	600,709	2,767,928
SDA 2.1.4.	Transgendered	492,171	412,688	835,477	745,993	745,993	3,232,322
SDA 2.1.5.	Prisoners	566,747	486,223	900,338	809,814	809,814	3,572,937
SDA 2.1.6.	Migrants Refugees	682,180	576,656	1,104,187	998,663	998,663	4,360,350
SDA 3.1.	Psycho-Social Care and Support	873,582	755,881	1,402,189	1,284,489	1,284,489	5,600,631
Round 9 HIV funding request:		9,258,766	7,655,921	12,851,581	12,639,963	13,064,363	55,470,595

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5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

Avoid using the "other" category unless necessary – read the [Round 9 Guidelines](#).

	<i>(same currency as on cover sheet of Proposal Form)</i>					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	2,662,650	2,634,650	4,542,562	4,514,562	4,514,562	18,868,985
Technical and Management Assistance	214,385	48,195	214,385	45,432	45,432	567,829
Training	654,010	484,217	654,009	415,555	415,555	2,623,347
Health products and health equipment	317,500	500,000	1,000,000	1,730,000	2,460,000	6,007,500
Pharmaceutical products (medicines)	0	0	0	0	0	0
Procurement and supply management costs	0	0	0	0	0	0
Infrastructure and other equipment	658,751	163,291	733,896	301,976	301,976	2,159,890
Communication Materials	780,100	742,600	870,100	862,600	862,600	4,118,000
Monitoring & Evaluation	1,144,026	645,726	788,306	947,406	641,806	4,167,268
Living Support to Clients/Target Populations	945,510	785,510	1,345,250	1,185,250	1,185,250	5,446,772
Planning and administration	976,310	793,750	1,467,290	1,401,400	1,401,400	6,040,150
Overheads	506,203	506,203	899,003	899,003	899,003	3,709,414
Other: <i>(Use to meet national budget planning categories, if required)</i>	399,320	351,780	336,780	336,780	336,780	1,761,440
Round 9 HIV funding request <i>(Should be the same annual totals as table 5.2)</i>	9,258,765	7,655,921	12,851,580	12,639,964	13,064,364	55,470,595

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5.4.1. Overall budget context

Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

Human Resources: 34% of the overall budget is for human resources, which a doubling of human resources from phase 1 to phase 2 to allow scale up of reach and build the institutional capacity of sub recipient organisations (Civil Society Organisations) to implement the proposed activities.

Commodities: To ensure universal access as the program scales up from phase 1 to phase 2, the demand for condoms, lubricant and syringe kits will grow.

Technical Assistance: The majority of technical assistance is built in year one and year three to address the technical and institutional capacity needs of civil society organisations and key program partners. Year three will include capacity building and technical assistance to support new CSOs and partners being engaged through the response and provide refresher training opportunities for existing trained personnel.

Monitoring and Evaluation: The bulk of monitoring and evaluation is allocated in year one to improve baseline information and strategic information as well as strengthen M&E capacity of partners.

5.4.2. Human resources

In cases where 'human resources' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

→ Attach supporting information as a clearly named and numbered annex

In this proposal, the human resource (HR) costs are approximately 34% of the budget. The HR budget will support the cost of hiring administrative and project staff; including targeted capacity building programmes for NGO workers. The aim to accomplish rapid capacity enhancement of NGOs capacity in order to expand geographical coverage and number of MARPs reached via this proposal.

1. Basis of budget calculation – a consensus was achieved on maximum (or ceiling) values for a salary scheme specifically developed for the Round 9 Global Fund proposal at the Budget Consultation Workshop which was attended by the 20 pre-identified Sub Recipients. Critical assumptions for the budget development were derived from two main sources:
 - a. Malaysia Salary Handbook 2008/2009 published by Kelly Services is a documentation of salary ranges for various positions across the industries in Malaysia through a compilation of salaries and job titles. The salary ranges are indicative of actual transactions between employers and employees and represent a reflection of the marketplace (Annex 58).
 - b. Government Rates were also used as reference. Government rates have been utilised in past years annual budgeting process by NGOs in carrying out activities under the Malaysian National Strategic Plan (Annex 59).
2. Calculation method for first 2 years, then 3 – 5 years
 - a. Human resource variations from phase 1 to phase 2 relate to the doubling of project activities and programs and reach.
3. Rationale
 - a. The 19 pre-identified SRs in this proposal provide social services such as health, capacity building, care and support for MARPs. Human resource development for civil society is critical in ensuring the sustainability and effectiveness of NGO programme implementation. Talent retention is a major challenge for NGOs. High staff turnover rates are common as most Malaysian NGOs are unable to offer competitive compensation packages. Government funding is specifically allocated for programme execution and discourages support towards organizational operational expenditure (OPEX). The Malaysian corporate sector though its Corporate Social Responsibility (CSR) programming is averse to supporting human capital development, especially for programmes targeted to MARPs and HIV/AIDS.

NGOs are responsible for building capacities of their members and beneficiaries thus ensuring that skills of NGO

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personnel are developed and consequently the communities they serve. In order to upscale current activities and implement new initiatives under the Global Fund, human resource development and capacity building are critical components for a successful and impact driven HIV/AIDS programming in Malaysia.

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national HIV program.

→ *Attach supporting information as a clearly named and numbered annex*

Besides Human Resource costs all other category costs are below 11%.

5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism

Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

→ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*

NOT APPLICABLE

5.5.2. Measuring performance

How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.

NOT APPLICABLE

5.5.3. Additionality of Global Fund request

Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism.

If the focus of the common fund is broader than the HIV program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on HIV outcomes during the proposal term.

NOT APPLICABLE

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5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 9

SECTION 5B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.

Read the [Round 9 Guidelines](#) to consider including HSS cross-cutting interventions

Download 'Section 5B' from the Global Fund website [here](#) if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') in Round 9 and has completed section 4B and included that section in the HIV proposal sections.

NOT APPLICABLE

Proposal checklist – Section 3 to 5 HIV

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	Annex 2
4.2.1	Map if proposal targets specific region/population group	Annex 56
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	n/a
4.4	Document(s) that explain basis for coverage targets	Annexus 15, 17, 18, 20, 21, 25
4.5.1	A completed 'Performance Framework' by disease Refer to the M&E Toolkit for help in completing this table.	Attachment A
4.5.1	A detailed component Work Plan (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	Work plan
4.5.2	A copy of the Technical Review Panel (TRP) Review Form for unapproved Round 7 or Round 8 proposals (only if relevant).	n/a
4.8.1	A recent evaluation of the 'Impact Measurement Systems' as relevant to the proposal (if one exists)	n/a
4.9.1	A recent assessment of the Principal Recipient capacities (other than Global Fund Grant Performance Report).	n/a
4.9.1 <i>(for non-CCM applicants)</i>	Document describing the organization such as: official registration papers, summary of recent history of organization, management team information	n/a
4.9.2	List of sub-recipients already identified (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	Reference : Section 4.9.3 of the proposal
4.10.6	A completed 'List of Pharmaceutical and Health Products' by disease (if applicable).	Attachment B
Section 4B: HSS Cross-cutting (once only in whole country proposal)		List Annex Name and Number
4B.2	A completed separate HSS cross-cutting 'Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted) Refer to the M&E Toolkit for help in completing this table.	Attachment A
4B.2	A detailed separate HSS cross-cutting Work Plan (or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted) (quarterly information for the first two years and annual information for years 3, 4 and 5).	Work plan

Proposal checklist – Section 3 to 5 HIV

Section 5: Financial Information		List Annex Name and Number
5.2	A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)	Detailed Budget
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	n/a
5.4.3	Information on basis of costing for 'large cost category' items	n/a
5.5.1 <i>(if common funding mechanism)</i>	Documentation describing the functioning of the common funding mechanism	n/a
5.5.2 <i>(if common funding mechanism)</i>	Most recent assessment of the performance of the common funding mechanism	n/a
Section 5B: HSS Cross-cutting financial information		List Annex Name and Number
5B.1	A separate HSS cross-cutting 'detailed budget' (or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted). Quarterly information for the first two years, and annual information for years 3, 4 and 5).	Detailed Budget
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	n/a
5B.4.3	Information on basis of costing for 'large cost category' items	n/a
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		List Annex Name and Number