Rapid Assessment of HIV and STI Programme for Female and Mak Nyah Sex Workers in Malaysia

Prepared for

Malaysian AIDS Council

By AIDS Projects Management Group (APMG)

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Table of Contents

ABBREVIATIONS 3

EXECUTIVE SUMMARY 4

1 BACKGROUND 8

2 OBJECTIVES OF THE ASSESSMENT 11

3 METHODOLOGY 12

4 LIMITATIONS OF THE STUDY 14

5 FINDINGS 15

5.1 Situational Analysis – The Complexity of Sex Work Environment and Gender Differences 15

5.2 Expanding Reach and Coverage 18

5.3 The Program Structure 20

5.3.1 Supporting Evidence Based Planning and Management: Program Management Structure at National, PR and SR Levels 20

5.3.2 Using Data for Evidence Based Planning: Project Reporting, Monitoring and Evaluation 23

5.4 The Service Package 25

5.4.1 Creating an Enabling Environment: Sensitisation of Stakeholders 25

5.4.2 Reaching out to Clients with Integrated and Relevant Services: Outreach Workers 26

5.4.3 Promoting Health Seeking Behaviour 29

5.4.4 Strengthening Access and Utilization of Condoms: Condom Social Marketing 31

5.4.5 Moving from Information Education and Communication (IEC) to a Behaviour Change Communication (BCC) Approach 36

5.4.6 Supporting Human Rights of MARPs: Legal Training and Support 38

5.4.7 Strengthening Capacity Building of SRs through In-house Training 39

6 STRATEGIC RECOMENDATIONS 40

Strengthen Governance of SW Intervention through National Coordination 40

Evidence-based Programming 40

Develop Stronger Partnerships to Strengthen the Enabling Environment and Support a Holistic Integrated Service Package. 41

Scale-up Reach by Expanding Coverage Area and Adopting New Programming Approaches. 41

Strengthen the Health Service Package 42

Improve Standards and Strengthen SR Capacity 42

Community Mobilisation in Support of Self-Determination and Improved Human Rights for SWs 42

Sustainability of Project Outcomes 43

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
DU	Drug User
GF	Global Fund
FGD	Focus group discussion
FP	Family Planning
FSWs	Female Sex Worker
HIV	Human Immunodeficiency Virus
IEC	Information Communication and Education
IBBS	Integrated bio-behavioural survey
ICT	Information and Communication Technology
IDU	Intravenous drug user
KPIs	Key performance indicators
MoH	Ministry of Health
NSP	National Strategic Plan on HIV and AIDS 2011-2015
ORW	Outreach Worker
PLWHA	People living with HIV/AIDS
PM	Project Manager
STI	Sexually Transmitted Infections
SR	Sub recipient
SW	Sex Worker
TOR	Terms of Reference
Mak Nyah SW	Transgender Sex Worker
VCCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

AIDS Projects Management Group (APMG) was commissioned to undertake a rapid assessment of SW intervention programme in Malaysia to provide strategic recommendations to support Malaysia's Global Fund Phase II renewal application and the mid-term review of NSP 2010-2015

The main finding from this assessment is that the Global Fund programme has contributed towards significant coverage of the population and has provided an opportunity for Malaysian NGOs to design and work towards delivering a comprehensive package of services for the sex worker population in the last one and half years. In all the sites visited, there was strong evidence of the impact of the intervention in the SW community, the high commitment of the SRs to the project, and evidence of greater community understanding and acceptance of the importance of HIV prevention in the project sites.

Evidence of a strong working relationship between NGO and government service providers was observed. Strong referral systems, willingness of government service providers to extend on-site services, and sex worker friendly staff have contributed substantially to uptake of VCCT and STI services provided by the government. In one site, a local family medicine specialist working at a general hospital provided a private entrance to the clinic for sex workers and has been successful in establishing the trust of the community. At this site, both female and mak nyah sex workers confirmed that public healthcare was their choice of health service provider.

The complexity around the SW environment relating to law and religious enforcement, violence, stigma and discrimination and illegal residency (migrant) status requires flexibility in project implementation so as to respond to changing situations and harness opportunities as they arise. Despite all the challenges and complexities mentioned, in all the sites visited the SRs had made significant and successful strides into reaching both Mak Nyah SW and FSW communities. This was made possible through the sensitisation efforts with various relevant stakeholders, which was part of the GF programme strategy. It is recommended that repeated, ongoing and frequent contact and sensitisation was necessary due to the high staff turnover of agencies and gaps in disseminating information from high to low ranks.

ORWs were observed to have a good understanding of the project and have strong rapport with clients, were interested and open to learning new skills, and were highly motivated. They wanted more technical support and guidance on how to more effectively reach FSWs, knowledge about the multitude of needs of their clients and wanted more information on issues like: womens health, substance abuse, income generation, social welfare, legal knowledge, immigration laws, and crisis management. Safety and security of ORWs was a major concern that was mentioned repeatedly in all the sites visited. There were several positive initiatives reported on this issue: for instance safety was reported to have been included in the MAC ORW training and was included to varying degrees in the SR in-house training and support of ORWs. But they highlighted that they need more support in terms of tools and equipment to maximise their security such as: pepper spray, a whistle, and a project bag that helps to identify ORWs as NGO project workers.

It was also evident that the programme has had much more success in reaching Mak Nyah SWs than FSWs who were reported to be much more diverse and hidden. To reach the underserved population, a Peer Education model could be adopted. The value of the issuance of an ID card as a measure of project reach should be reviewed, as this may be excluding SWs from participating in the intervention and may be reducing the flexibility of ORWs to work with a range of gatekeepers/entry points in the community. Consideration should be given to defining 'reach' based on an unique individual identifier which is being adopted increasingly in other parts of the region, thus doing away with the ID card completely.

Those respondents reached by the intervention reported a willingness to access STI and VCCT in 'client friendly facilities' defined to be: confidential, private, friendly and welcoming attitude, convenient location and opening hours, short waiting time, quality diagnosis and treatment, integrated health services (ie not just STI/VCCT specific), and affordable. Most respondents stated that these characteristics were most likely found in the private sector and therefore prefer to go to private clinics. Some SRs reported having success in attracting clients to the public facilities if there was a special day/hours allocated only to SWs: eg first Monday evening of the month. SWs felt that this was less stigmatising because they would not be seen by the general public and would have more privacy.

Overall the assessment team concluded that the condoms distributed were of very high quality and well accepted by SWs. However, SWs reported standardised packaging of condoms in packs of 36 in transparent plastic was problematic. The packaging of condoms needs to be more discreet (to foster greater willingness to carry condoms) and flexible in quantity (as SWs demand are unique in different sites). There were strong recommendations from respondents that lubricants should be included in the kit. Many of the older FSWs reported dryness and Mak Nyah SW reported injury due to anal sex and thus requested that lubricants be included in the kit to reduce possibility for lesions and tears that heighten the risk of transmission of HIV.

In the sites visited there was an impressive evidence-base of reported behavioural change occurring amongst SWs reached by the intervention. Most respondents said they liked the current IEC materials but they could be improved to be more relevant and convenient to SWs: recommendations included easier-to-understand language, range of sizes of materials, inclusion of women health (family planning, pap smears and breast checks) and the opportunity of linking HIV/STI prevention with broader issues of reproductive health.

Legal and human rights components of the Project were reported by all SRs as a vital component of the intervention. SWs valued the legal training they had attended which helped them understand citizens' rights and how to respond in case of an arrest. Some SRs however were disappointed with the low turnout to legal training and suggested that training should be delivered in a more relevant way in the future so as to improve attendance, for instance linking legal training to other SW interests like a joint workshop on subjects which interest sex workers; for example beauty for transgender sex workers and economic empowerment for female sex workers.

There was good evidence of efforts to conduct in-house capacity building within SRs. In order to enhance the effectiveness of programme staff in responding to varied needs from their clients, PMs and ORWs requested further capacity building initiatives to include topics on leadership, evidence based

advocacy, behavioural modification, community mobilisation, law relating to migrant workers, sexual reproductive health, other chronic illnesses, administrative and management skills.

The findings of the rapid assessment fall under the following 4 themes:

- Situational analysis which gives a general overview of the observations of the assessment team in relation to the SW community, their behaviours, priorities, and situation in the context of the wider community.
- Expanding reach and coverage which assesses the current coverage of the interventions and the capacity and feasibility of SRs to scale-up interventions into new sites and populations.
- The program structure which looks at programmatic successes and how these can be built on to further strengthen the program.
- The service package which examines each of the elements of the package of services including: sensitising stakeholders, outreach workers, health education and promoting of health services and condoms, legal training and support, and project team capacity building

High Level Recommendations

1. Strengthen Governance of SW intervention through National Coordination – initiate a joint annual national planning process between MoH, MAC and SRs.
2. Evidence-based Programming – utilise the local and national evidence to inform all aspects of programming and strengthen sharing of experiences across the SRs. Conduct operational research to fill knowledge gaps and strengthen M&E indicators in line with evidence based programming and determine the feasibility of harmonizing GF M&E with the NSP M&E.
3. Develop Stronger Partnerships to Strengthen the Enabling Environment and Support a Holistic Integrated Service Package. – Build on existing partnerships and develop new partnerships with relevant government, NGO, and private sector agencies; particularly the department of legal aid. Support SRs to develop a *Local Service Directory* of partner agencies to strengthen referral to quality services in the community.
4. Scale-up Reach by Expanding Coverage Area and Adopting New Programming Approaches – expand into new hotspots and explore the possibility of using new approaches such as peer education to reach into hard to reach FSW settings. Also explore the feasibility of integrating other stakeholders into the project design and providing them with a service package such as: (i) gatekeepers (pimps and mamisan), (ii) customers (through work-based interventions), and (iii) male sex workers (including men who sell sex to men and men who sell sex to women). Review M&E indicators to determine how these activities could be measured.
5. Strengthen the Health Service Package – Review health information materials for relevance to SW, explore the feasibility of using ICT for health education, and consider the development of a campaign 'brand and logo'. To strengthen condom distribution review condom packaging and include lubricants as part of the condom kit. Identify SW friendly health services and determine the feasibility of running government run outreach services or SW only services at specific times in

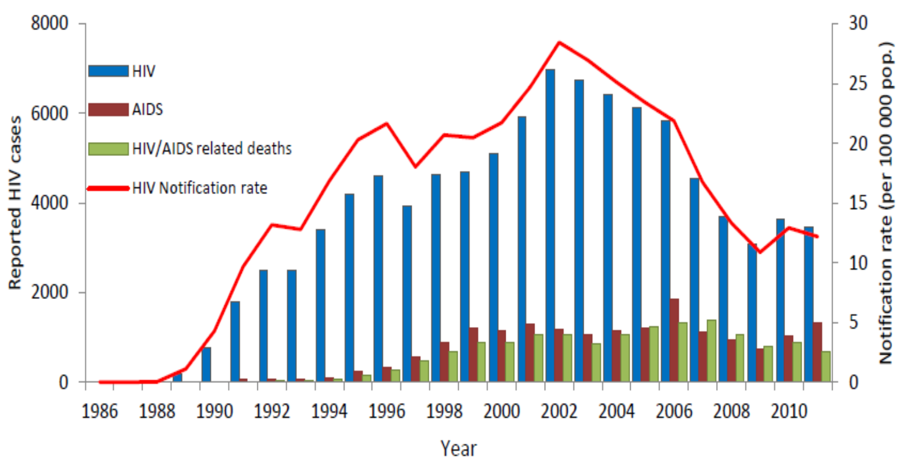
fixed sites. A health service referral slips/voucher should be explored for improved referral and tracking of health seeking behaviour.

6. Improve Standards and Strengthen SR Capacity – Review SOP to strengthen safety and security of SRs and provide safety kit to ORWs (whistle, pepper spray, and bag). Issue a letter of endorsement from MoH/MAC to all ORWs to further support their safety and security. Also review TORs/job descriptions of PMs/ORWs in light of any changes to their scope of work expected in Phase II. Develop an in-house training plan utilising experts in the community to build capacity of SR teams.
7. Community Mobilization in Support of Self-Determination and Improved Human Rights for SWs - Develop a rapid community crisis response plan that will strengthen the capacity of the SW community together with SRs to respond rapidly to crisis. Also provide safe spaces and support SW community to mobilise including supporting them to link with relevant community opportunities (eg income generation activities and small loan facilities).
8. Sustainability of Project Outcomes - Develop an exit strategy to ensure sustainability of project activities post GF Round 10 grant. The feasibility of moving to a subsidised condom promotion project using a private/NGO partner should be explored if free condom distribution is discontinued.

1 BACKGROUND

HIV Epidemic in Malaysia

In 2011, the Ministry of Health (MOH) of Malaysia reported that more than 14,000 people have died related to HIV/AIDS and 94,841 people living with HIV. Since the first case detected in 1986, the highest number of new cases was reported in 2002 at 6,978 and has since declined to 3,479 new cases in 2011. The notification rate has also continues to decline from 23.4 cases per 100,000 in 2005 to 12.2 cases per 100,000 in 2011.



The country has a concentrated epidemic since the adult prevalence rate among the general population was estimated to be less than 1% but much higher among high risk populations. The majority of the infected cases are male, constituting 90% of people living with HIV. However, over the last 20 years, there is a clear shift in gender ratio from 1 female for 99 males in 1990 to 1 female for 10 males in 2000 to 1 female for 4 males in 2010. A similar change is observed in risk of transmission. In the early years, the majority of the cases are attributed to injecting drug users (IDUs) but slowly shifted from 1 sexual transmission for every 9 IDU in 1990 to 2 sexual transmissions for every 8 IDU in 2000 and 5 sexual transmission for every 5 IDU in 2010[1]. The yearly increases in the number of reported HIV cases from heterosexual transmission - which currently accounts for almost a third of all new infections - is a strong indicator of a new trend linked to heterosexual spread of HIV in the local context.

Sex Workers

A size estimation study conducted in 2009 showed that there are approximately 60,000 SWs in Malaysia, comprised of 40,000 female sex workers (FSW) and 20,000 Mak Nyah[2]. The recent statistics from the Ministry of Health Malaysia show that while only 0.6% of new cases were sex workers (21 of 3479), this figure is taken as underreporting as sex workers will not necessarily identify themselves and may not

[1] Global AIDS Response 2012. Country Progress report January 2010 – December 2011.

[2] Eam, L.H., Leng, A. C., Koon, T.Y., (2010*). Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work*

come forward for treatment. A range of socio-cultural and legal issues, stigma, discrimination, and social exclusion increase the risk and vulnerability of sex workers, be it female or Mak Nyah, to HIV and other sexually transmitted infections (STI).

The preliminary results of the Integrated Bio-Behavioural Surveillance Survey (IBBS) in 2012 reported HIV prevalence of FSW and Mak Nyah is 4.2% and 5.3% respectively[3]: If these averages are applied across the population size estimates above, this would equal to 1,680 FSW and 1,060 HIV-positive Mak Nyah sex workers. However prevalence varies from one to another state where some states such Pahang, Kelantan and Selangor reported HIV prevalence among FSW as high as 9% to 18%. Mak Nyah's HIV prevalence was reported between 1.4% and 7.5% except for Pahang state which reported HIV prevalence among Mak Nyah to be 18%. The first round of IBBS was conducted in 2009 around Klang Valley vicinity and may not be comparable with the recent IBBS 2012. HIV prevalence of FSW and Mak Nyah was reported as 10.5% and 9.7% respectively[4].

The IBBS 2012 study found that half of FSWs were above 40 years old and only 48% attained primary education. The Mak Nyah community were mostly young people (20 to 30 years old) and about half had at least completed upper secondary school. These findings were found to be consistent with a study conducted by United Nations Population Fund (UNFPA) and Federation of Reproductive Health Associations (FRHAM) in 2010, PAMT rapid assessment in 2011 and IBBS study in 2009[5,6].

According to UNFPA/FRHAM study, most of the FSWs are brothels or street-based. Similar findings were learned through PAMT rapid assessment conducted in 2011 but phone-based sex work was also identified as an emerging trend in contacting clients.

Condom use among sex workers with commercial partners was reported to be generally good in all the four studies. In comparison to FSW, condom use was found to be higher among Mak Nyah. Over 90% of Mak Nyah reported condom use with recent clients as opposed to 61% of FSW surveyed in IBBS 2009. But these findings were not supported with the recent IBBS 2012 as high condom use was reported for both FSW and Mak Nyah population. Nonetheless, condom use with intimate (non-commercial) partners was very poor in all reports.

All four studies found that a relatively small percentage of respondents are injecting drug users. The IBBS studies for both rounds reported over 2% having injected drugs in the last year; the UNFPA/FRHAM study and PAMT rapid assessment found that injecting drug users were 8% and 3% respectively. This population has higher risk exposure to HIV infection as reported in the UNFPA/FRHAM study that sex workers who were taking drugs were reportedly more willingly to practice unsafe sex for a higher price.

[3] IBBS 2012 Preliminary Results Powerpoint Presentation. February 2013. Ministry of Health
[4] Malaysia 2010 UNGASS Country Progress Report: Reporting period: January 2008 – December 2009. (2010). Ministry of Health Malaysia
[5] Federation of Reproductive Health Associations Malaysia, United Nations Population Fund (2009) Report On HIV/AIDS and Sex Work In Malaysia: Female Sex Workers. UNFPA
[6] PAMT (2012) A Rapid Assessment on Sex Work and HIV in Malaysia

National Strategic Plan 2011-2015

Objectives:

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

NSP Strategies

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

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

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

Strategy 4: Maintaining and improving an enabling environment for HIV prevention, treatment, care and support.

Strategy 5: Increasing the availability and quality of strategic information and its use by policy makers

The majority of sex workers were aware of HIV but have limited awareness on STIs. Over one third of IBBS 2009 respondents experienced STI symptoms of whom 40% were self-treated and over 10% did not seek treatment. The study by UNFPA/FRHAM reported that, of those who did not do anything for these symptoms, most said that they did not know what to do or that these symptoms were common among women.

National Response

Malaysia has for many years, responded to a national concentrated HIV epidemic amongst Most at Risk Populations (MARPs). Support for the HIV response in the country is predominantly by the Government of Malaysia through the MoH. MoH, as the coordinator of national response for HIV, has been providing funding to non-government organisations via MAC, to implement prevention activities among female sex workers and Mak Nyah sex workers for fifteen years, beginning in 1998.

The evolution of MARPs-targeted interventions began with the Malaysia National Strategic Plan (NSP) on HIV/AIDS 2006-2010. The NSP had as its first aim to prevent the transmission of HIV among injecting drug users, sex workers, mak nyah and men who have sex with men. The NSP was a product of multi-sectoral collaboration, with input from both governmental and non governmental agencies. NGOs continued to receive support from the government, implementing activities which support the goals and strategies of the NSP.

Subsequently in 2011, MoH developed the National Strategic Plan (NSP) on HIV/AIDS 2011 – 2015[7], which aimed to provide a common ground and emphasis on integrated and comprehensive approaches addressing the needs of prevention, treatment, care and support. Increased levels and additional sources of funding, combined with inter-agency structural support have made it possible to expand or upscale HIV and AIDS interventions in the region, giving Malaysia avenues to accelerate the national response to the epidemic.

The NSP plan has specifically spelt out provisions for prevention programmes for high risk groups in Strategy 1. These provisions are

DS 2011-2015. (2011). Ministry of Health Malaysia

needle-syringe exchange program (NSEP) to reduce the sharing of unsterile needles-syringe among IDUs, methadone maintenance therapy (MMT) to help IDUs in opiate addiction management and provision of condoms, VCCT and other related services in prevention of transmission through unprotected sex among sex workers.

The Global Fund Round 10 proposal included activities addressing injecting drug users (IDU), female and mak nyah sex workers. The IDU population remains a key population for the HIV response with evidence to show that this population has the highest HIV prevalence and injecting drug use with nonsterile injecting equipment is the prime driver of the epidemic in the country.

Female and mak nyah sex workers were chosen as these populations have the second highest HIV prevalence. The Global Fund grant is solely aimed at increasing coverage of a core set of prevention activities by local nongovernmental organisations from 6% to 15% of female and mak nyah sex workers. It was understood at the point of writing the GF proposal that it would not be possible to achieve saturation coverage of female and mak nyah populations nor reverse the trend of HIV within the lifetime of the grant and limited funds. It does however provide a sharp increase to the existing national response by accelerating expansion of current programmes targeting injecting drug users and sex workers.

At the point of writing the Round 10 Global Fund Proposal, the national programme targeting sex workers had reached 3,107 out of a total community-based estimate of 60,000 female and mak nyah sex workers. Funding for this population was irregular, the package of services was not standardised or evidence-based, and there were few organisations dedicated to the health of sex workers.

The Global Fund goal is to contribute to the ongoing achievement of the first goal of the Malaysia National Strategic Plan on HIV/AIDS 2006 – 2010; which was to prevent transmission of HIV. No care, support, and treatment or impact mitigation activities were proposed. There are two objectives to the GF grant: the first objective is to increase coverage of a package of services for injecting drug users and the second objective is to increase coverage of a package of services for female sex workers and mak nyah sex workers. The service delivery package is based on the differing needs of members of each key population.

2 OBJECTIVES OF THE ASSESSMENT

The overall objective is to carry out an assessment of existing HIV/AIDS and STI prevention programmes for female and Mak Nyah sex workers provided by non-government organisations in Malaysia with the view to support the development of Malaysia's Global Fund Phase II renewal application and the mid-term review of NSP 2010-2015.

Specific objectives include:

- To describe the current status of the sex workers programme activities at non-government and informal settings

- To identify the conditions (geographic, economic, social and administrative) that facilitate or hinder programme implementation
- To identify sex worker community's priorities and the most pressing needs for improving their state of health, quality of life and involvement in NGO programme activities
- To determine accessibility, availability and quality of condoms, lubricants and other health commodities
- To provide recommendations on the best options for management of the programmes

3 METHODOLOGY

APMG's approach to the rapid assessment of the sex workers programme in Malaysia used an adaptation of the Appreciative Inquiry methodology. This methodology combines a rigorous examination of data with an approach that is designed to assess the strengths of programs and institutions, and to determine ways to build on those strengths for increased effectiveness.

This approach is attractive because it:

- Focuses on positive elements of the programs being evaluated, while noting areas of improvements in less successful programme elements.
- Complements and strengthens other evaluation practices previously performed
- Increases use of evaluation results and learning
- Reframes evaluation tools to strengthen qualitative data collection

At the core of this approach is an examination of what has worked, drawing out the successes and progresses that implementing partners and beneficiaries can identify. It is not a substitute for an objective and rigorous examination of progress and process, but complements this by setting an assessment environment that is constructive and participatory. Within the theoretical framework of appreciative inquiry, the assessment team employed a range of qualitative methodologies including focus group discussions and in depth interviews with staff and clients, key informant interviews and observations. Client feedback was received in private without program staff present in order to facilitate full disclosure.

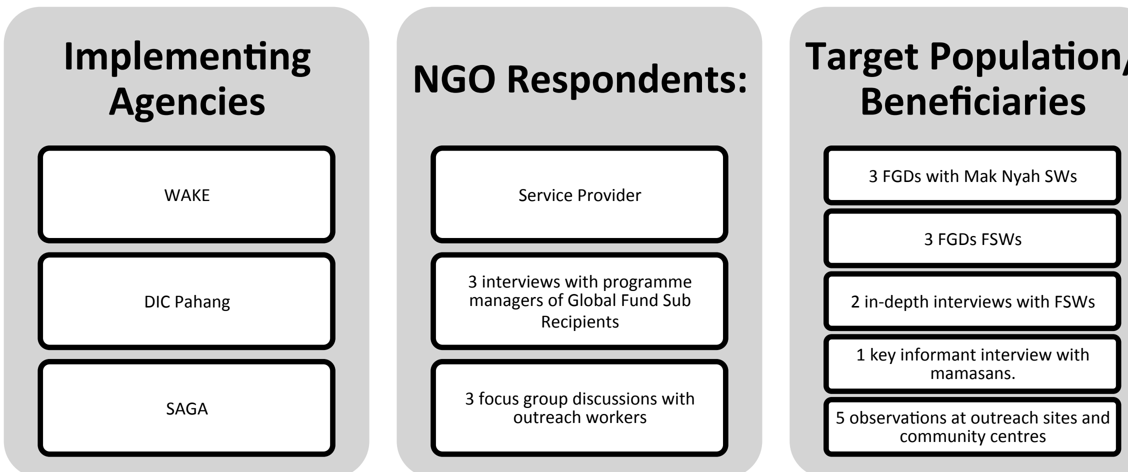
Phase 1 – Desk-Review and Development of Focus Group Discussion Guide (FGD)

1. **Desk review:** desk review of all available documents related to the project, including progress reports of the GF project implemented by the MAC, noting data and questions from management letters issued by the Global Fund Secretariat.
2. **Focus Group Discussion (FGD):** the FGD guide was developed using a participative approach. Consultations with MAC programme staff and a pre-test of the guide was conducted with a group of male, female and Mak Nyah sex workers. An outreach worker demonstrating good communication skills was identified in the course of testing the guide and consequently recruited and trained as a co-facilitator to support APMG's consultants for data collection purposes. Focus group guides used in the site visits can be found in Annex 8.4

3. **Selection of respondent**: The selection of respondent groups and assessment sites were agreed upon with MAC programme team. Respondent groups included programme managers, outreach workers, female and Mak Nyah sex workers, mamasans, pimps and owners of entertainment venues (where possible).
4. **Site selection**: The criteria for site selection included the following considerations:
   - areas where there is high concentration of female and Mak Nyah sex workers
   - areas where there is currently low access to HIV and STI prevention services due to minimal linkages between NGO and government services
   - inadequate information regarding mobility and power dynamics (between sex workers and gatekeepers)
   - areas requiring greater investment in community mobilisation and empowerment to establish longer term and sustainable HIV and STI prevention, treatment, care and support activities

Phase 2 – In-Country Implementation

1. **Data Collection**
   - Client feedback was received in private without program staff present in order to facilitate full disclosure
   - Interviews were conducted in Malay and where possible, in English.
   - Respondents were informed that their responses would be anonymous. Some FGDs were recorded (for data verification) with permission
   - Respondents were compensated for their time, with light refreshments provide



The assessment team also attempted to conduct FGDs with SWs who were not participating in the program but were unsuccessful in organising these. However the team had several informal discussions on the streets with this population to try to gauge why they do not want to participate. A detailed schedule of interviews and visits is attached as Annex 8.2.

Phase 3 – Presentation of Preliminary Findings and Preparation of Draft Assessment Report

Preliminary findings were presented to MAC, SRs and MOH officers from national and state levels on the 22nd of February at the GF Phase II reprogramming meeting and the assessment team took the

opportunity to further verify the findings across the entire Program including sites that were not visited, to share success stories across the Program, and to provide critical feedback to all relevant stakeholders for the purpose of discussion regarding service coverage and considerations for reprogramming, programme design, performance indicators, and future projection of health commodities planning and programme coverage.

A second presentation of the draft assessment report was conducted on the 4th of March to the team of Grant Management Solutions (GMS) consultants, the Global Fund Technical Coordinator from the Office of the Global AIDS Coordinator (OGAC) and the Director of Multilateral Diplomacy at the Office of the US Global AIDS Coordinator. A final report was prepared by the assessment team and was then shared with key stakeholders to further verify the findings.

4 LIMITATIONS OF THE STUDY

Time and budget constraint. Study was limited to three Sub Recipients of the Global Fund project and therefore the results reflect limited sampling of sex workers programme implementers and target community. However, careful attention was paid in the selection of the sites to ensure the assessment team saw a wide range of programs at different levels of success, and the validating processes mentioned above also strengthen the reliability of our findings.

Non-government organisation's perspective only. Due to the urgency of the assessment for the purpose of GF Phase II programming, the assessment team was unable to conduct data collection from the government counterpart as there was insufficient time to submit the assessment protocol to the Malaysian National Research Registry, which is necessary in order to conduct studies involving government agencies.

Language barrier. In addition, most interviews and focus groups were conducted in the local language, Malay. Where possible, simultaneous direct translation to English was provided for the non-Malay speaking consultant.

Difficulties to reach Female Sex Workers. The team agreed that for future assessments, it may be more effective to conduct more in-depth interviews with female sex workers in addition to FGDs. The team observed that in two FGDs, female sex workers were generally shy and averse to sharing personal and private knowledge of the sex work environment they work in and that in-depth interviews conducted with carefully selected peer leaders might be much more informative. The team also found that it was very effective to involve a MARPs representative as a co-facilitators of the FGDs. The presence of a community representative allowed the group to open up more freely and helped the non-MARPs facilitators understand how to phrase the questions in the local language.

5 FINDINGS

5.1 Situational Analysis – The Complexity of Sex Work Environment and Gender Differences

Overall the Assessment Team found that the Project had made excellent progress in a very short time of project implementation, ie. less than 2 years. In all the sites visited there was strong evidence of the impact of the intervention in the SW community, the high commitment of the SRs to the project, and evidence of greater community understanding and acceptance of the importance of HIV prevention in the project sites. MoH, MAC and the SRs are to be highly congratulated for their strong leadership and commitment to Project implementation in an area of interventions that is new and challenging throughout the world.

The assessment team found that each of the sites visited were highly diverse with a wide range of characteristics in terms of:

1. structure and capacity of SRs (discussed further in Section 5.3.1 of this report),
2. characteristics of the sex work environment and
3. degree of tolerance and community acceptance in support of an enabling environment for the intervention.

This confirms that the sites visited were well selected providing a full spectrum of characteristics likely to be occurring across the program.

Supply, demand and the environment in which sex work occurs varied widely from site to site. In some sites observed there were rows of female and mak nyah SWs soliciting customers, with constant streams of vehicles cruising the area. Whilst in others there were many SWs and no customers to be seen. Mak Nyah sex workers were observed to be more able to respond to threatening situations. Female SWs however work in dynamic and complex environments, are less seen on the streets and are in constant fear of arrests. All sites reported frequent raids which contributed to a constantly changing environment and closures of entertainment sites and opening of new sites.

The severity and frequency of violence, stigma and discrimination was also observed to be different from site to site. For instance, whilst the assessment team was visiting one site there was a reported hit and run assault on a Mak Nyah SW. This type of assault and other street violence by the local community was reported to be a nightly occurrence at this site. However at another site visited there was no evidence of harassment of SWs and an apparent harmonious relationship between the local community and the SW community. This is evidence of successful advocacy activities conducted by the implementing NGO working in that area with no obvious signs of corrupt practices by local gangsters. Sex workers working in that particular site are mostly independent, ie. not controlled by pimps, mamasans or syndicates.

Picture 1: Hygiene pack, prevention messages and clean working environment for Mak Nyah SWs, managed by older Mak Nyahs

Police raids were reported to occur frequently in Kuala Lumpur, and less frequently in Kuantan and Sandakan. The assessment team witnessed rapid closure of entertainment sites and frantic dispersion of sex workers on the rumour of a police raid while conducting group interviews. In contrast, at another site, two police cars without slowing down drove straight past the assessment team who were handing out condoms and talking to a large group of SWs.

Most noteworthy were the differences observed during the fieldwork between the two SW populations targeted by the intervention; Mak Nyah SWs and Female SWs, and these findings were also found to be consistent with the findings of the literature review undertaken at the outset of the assessment (refer to Section 1 for details of the literature reviewed).

For instance, Mak Nyah SWs tended to be less mobile and more likely to come from local or nearby communities. They were more visible and concentrated, working mostly on the streets. They were observed to be a very tight knit community, well networked, active, wanting to participate and learn, and longing for family, and community acceptance. The Mak Nyah SWs met were mostly in their 20s and 30s with a few still in their teens.

On one occasion, the assessment team met a 68 year old Mak Nyah, though no longer active in sex work, supporting younger Mak Nyah sex workers by ensuring a safe and hygienic environment for sex work to take place (Picture 1).

Most of the Mak Nyah SW respondents were technologically savvy, using various modes of social networking to both source clients and provide online sexual services including the use of mobile phones, facebook, tweeting and active in specialized websites (both national and global). They also reported actively seeking out information, had good knowledge of the importance of STIs and HIV and reported a strong commitment to using a condom and stated that they had confidence to negotiate this with their customers.

They tend to have fewer customers per night by comparison to FSWs, averaging about 1-2 clients per night. Many Mak Nyah SWs respondents reported that they also had part-time jobs doing make-up, hairdressing and working in restaurants; and saw sex work income as supplementary. Mak Nyah SWs expressed a lot of interest in getting support to develop new skills and technical assistance to make their part-time employment a more viable business enterprise that they could survive on. It was observed that all these attributes made it much easier to reach and enlist Mak Nyah SWs into the intervention.

On the other hand, FSWs were observed to be a much a more complex community and thus harder to reach. They operate out of a wide range of locations including: street, home, brothels, clubs/bars, karaoke and massage parlours. In stark contrast to Mak Nyah SW, FSWs tended to be secretive, closed, shy, suspicious, fearful, less well networked, have less free time, less willingness to participate in outside activities, less active in information seeking and less confident in negotiating with their customers. A majority of those met were single mothers with between 3 to 4 children, and a few reported having much larger families of 7 to 9 children. The spectrum of ages of FSWs was observed to be large from those in their late teens and early 20s up to those well into their 50s. There is also a well-defined hierarchy of low to high-end sex workers that don't interact with each other. FSWs were more dependent and desperate for the income generated through sex work because they did not have other sources of income and many had heavy financial burdens of: children, chronically ill husbands or other family financial debt or responsibilities. FSWs tended to be a highly mobile community, fragmented, and comprising mostly of either internal migrants or cross border illegal undocumented migrants who speak a variety of different languages, many unable to speak Malay. It was also observed that some of the FSWs are illiterate or have low literacy skills, consistent with recent findings from IBBS 2012.

Table 1: Example of Female Sex Workers Profile Interviewed

	Respondent 1	**Respondent 2**	**Respondent 3**	**Respondent 4**	**Respondent 5**
Origin	Terengganu, Malaysia	Terengganu, Malaysia	Kelantan, Malaysia	Medan, Indonesian	Terengganu, Malaysia
Age	49	57	53	47	43
Marital Status	Widow, 9 children	Widow, 3 children	Widow, 8 children	Single mother, 3 children	Widow, 4 children
HIV Status	Unknown	Unknown	Unknown	Unknown	PLHIV
Other Information	-	12 years in sex work	• Sold by husband in Singapore (1981) • husband died of AIDS	• 2 years in Malaysia • 2 children in University • Wishes to stop sex work by June 2014 when children complete university	• 12 years in sex work • husband died of AIDS

The illegal status of the migrant FSWs contributes to them being extremely vulnerable to law enforcement and violence. Some FSWs are known to be human trafficked and held as virtual prisoners; others are operating out of facilities run by syndicates and criminal gangs, both virtually impossible and dangerous for ORWs to penetrate. Like Mak Nyah SW, FSWs are also operating through social media (mobile phone and internet) but are not as active in this medium as Mak Nyah SW. FSWs have many more clients per night than Mak Nyah SW, with some FSWs reporting having more than 5 clients a night.

These characteristics contribute to the complexity of working with FSWs and point to the need for a different approach to working with FSWs than TGSW which is more focused on peer-to-peer education to be discussed further in Section 5 of this report.

> *Importantly, amongst both FSWs and Mak Nyah SW the issues of STIs and HIV/AIDS were not top-of-the-mind for either group with the exception of older female sex workers interviewed in Pahang. When asked what both these communities cared and worried about they mostly talked about money and family, especially their children in the case of FSWs.*

Few mentioned health, and even when prompted directly about health issues, Mak Nyah SW were more worried about hormone treatment and beauty therapy whilst FSWs were more likely to mention issues like their general health and chronic diseases like diabetes and hypertension. This emphasizes that in order to achieve better results there is a need for the project to better link HIV prevention messages with issues that resonate with the SW populations such as: family, money, general health, drug treatment, womens health in the case of FSWs, and chronic diseases.

Finally, both FSWs and Mak Nyah SW reported alcohol and drug use both within the SW community and also amongst their customers including use of ice, ecstasy, methamphetamines, cocaine, marijuana and less frequently intravenous drugs such as heroin. Many customers are reported to like to bring drugs and want to use drugs during sex. Most SWs reported that they didn't like to consume drugs with their customers (or let their customers use drugs) because their customers were: more likely to get violent, unable to get an erection or had an extended duration erection, were less likely to use a condom, and in the case of intravenous drug use there were further risks due to needle sharing. Despite their unwillingness to consume drugs, many SWs reported that they were pressured and had no other choice. Again, the program has an opportunity here to better link drug and alcohol education with project messages.

The highly complex and changing context outlined above requires flexibility in project implementation so as to respond to changing situations and harness opportunities as they arise.

5.2 Expanding Reach and Coverage

Despite all the challenges and complexities mentioned above, in all the sites visited the SRs had made significant and successful strides into reaching both Mak Nyah SW and FSW communities. However, it was also evident for reasons stated in the previous section, that the programme has had much more success in reaching Mak Nyah SWs than FSWs. This unbalanced reach was also reflected in the Program monitoring data which shows that despite FSWs being a much bigger population (total population estimates of FSWs 40,000[8] to Mak Nyah SW 20,000); Mak Nyah SW were almost twice as likely to be reached by the Project (Table 1).

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[8] This estimate is only based on Malaysian FSWs and does not include migrant FSWs. In the sites visited it was observed that the migrant FSWs population could be equally as big as the Malaysian FSW population.

The MAC monitoring data indicates that a total of 2,129 Mak Nyah SW have been reached by the GF project versus 1,287 FSWs; 25,036 kits of condoms have been distributed to Mak Nyah SWs by comparison to only 16,021 having been distributed to FSWs. The fact that there is a trend towards higher heterosexual transmission of HIV/AIDS in Malaysia and that the IBBS 2012 indicates comparable high prevalence rates of HIV/AIDS in both Mak Nyah SW (5.7%) and FSWs (4.2%[9]) is adequate evidence to warrant at least having a goal of equal reach for both FSWs and Mak Nyah SW, if not more focus on FSWs given the bigger population size.

In total, 4,362 SWs were reached as of December 2012 through the GF, MoH and MAF programmes. However, there is a high possibility that the number of SWs reached reported through the MOH programme in 2012 is underestimated due to limitations of previous monitoring system which was unable to detect double counts (of individuals) or repeat clients, hence it was impossible to report coverage. Data from 2009 and 2010 showed that more than 2,000 SWs were reached from 46 intervention sites funded by the MoH. The Syrex system was introduced in 2012 and since then, all interventions sites are able to report cumulative numbers of MARPs reached. The SW coverage reported under MAF funded programme started only in June 2012 implemented by two NGOs.

Table 2: Tabulation of Programme Coverage for Female and Mak Nyah Sex Workers to date

	Size Estimates [1]	GF [2]	MOH [3]	MAF [4]	**Total Coverage**	**% of Coverage**
Mak Nyah	20,000	2,129	275	416	2,820	14%
FSW	40,000	1,287	207	48	1,542	4%
Total	**60,000**	**3,416**	**482**	**464**	4,362	7%

[1] *Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work*. Eam, L.H., Leng, A. C., Koon, T.Y., (2010*).*
[2] Coverage of SWs reported through Global Fund funded programme
[3] Coverage of SWs since 2012 through MOH funding
[4] Coverage of SWs reported through MAF funded **1 year** programme.

Based on the tabulation of programme coverage in Table 2, the SW programme coverage is at 7% of which, 65% of cumulative coverage comprise of Mak Nyah SWs. Among the Mak Nyah population, the coverage is 14% of the 20,000 population size estimated; whereas the coverage of FSWs is only 4% of the 40,000 population size estimated FSWs (likely to be a significantly underestimate[10]).

The reach varies significantly from State to State, for instance Terengganu and Perlis have no interventions and therefore report 0% reach and Selangor has a low 5% reach despite having a reported HIV prevalence rate of 10% in the SW population. On the other hand, Melaka has far exceeded the other states having achieved a reach of 54% of the SW population.

[9] This could be an underestimate because it excludes FSWs who are illegal undocumented migrants.
[10] This total population estimate only includes Malaysian FSWs and does not include migrant FSWs. Since most of the project sites also reach migrant FSWs a more accurate % of reach should include both Malaysian FSWs and migrant FSWs.

It was observed that the sites visited had mostly reached the easiest to reach SW population and scaling-up will require:

1. expanding into new sites through community mapping
2. adopting new approaches to scaling up that facilitate greater reach whilst ensuring maintenance of behaviour change in existing hotspots.

It will be impossible for the program to scale-up significantly with the same amount of resources using the existing model of intense frequency of ORW contact with SWs. Global experience shows that reaching the harder to reach populations often costs more in terms of time and money thus pushing up the unit cost of the intervention. However, by adopting different models and approaches as recommended in more detail in sections 5 and 6 of this report, further scale-up can be facilitated with nominal additional resources by reducing the intensity and frequency of contact whilst not compromising on the impact for behaviour change.

With respect to reach and coverage, SRs visited also raised the issue that they are not currently reaching into male sex workers (ie men who sell sex to men and men who sell sex to women), and reported that there is very little known about the size, behaviour, location, and HIV/AIDS prevalence of this population. The Project should consider gaining a better understanding of the size and risk of this population to guide SRs for future programming. A SR led community-based operational research study could help to determine if this is also an important population to reach with interventions.

5.3 The Program Structure

5.3.1 Supporting Evidence Based Planning and Management: Program Management Structure at National, PR and SR Levels

Programme Planning and Management at the National Level

The government of Malaysia in partnership with NGOs had started working on HIV/AIDS interventions for MARPs including SWs as early as 1998. The initial priority was mostly focussed on treatment especially for PLWHA. Due to limited resources and know-how community-based preventative interventions had only been implemented sporadically and at a small-scale. A lack of an evidence base resulted in these interventions being more reactive than proactive with little capacity to assess performance and measure impact and outcomes.

The NSP is administered through an annual planning cycle. NGOs are requested to submit proposals to MAC according to thematic areas of programmatic priorities stated in the NSP. The MAC coordinates NGO proposal submission, implementation and reporting to the MOH.

The introduction of the Global Fund (GF) MARPs Funding Stream which became available in 2009 provided an opportunity to strengthen SW interventions and scale up coverage of HIV prevention for SWs in Malaysia. Guided by a population size estimate of SWs conducted by Eam LH, Ang CL, Teh YK[11] in

[11] Size Estimation for Local Responses in Malaysia for HIV Prevention in Sex Work, 2010. Eam LH, Ang CL, Teh YK

2010 and Kuala Lumpur based IBBS data; a scale up plan for SW programme was formulated. A new model of programme management and governance were established with the introduction of the Global Fund mechanism in Malaysia.

To respond to the different reporting requirements and needs of MoH and GF, two teams were set up to administer program implementation within MAC. Whilst this structure had several advantages for the purposes of accountability of funding sources and programming, the downside has been vertical programming and little coordination between the two teams, ie. MAC GF Project Management Unit and MAC MoH Programme Management Department.

There were various challenges at the initial stages of designing the Global Fund project. Given the limited evidence base, low-capacity of sub-recipients, and lack of experience in Malaysia of implementing a Global Fund grant inevitably the initial design of the Project was somewhat "top-down" and generic. This was necessary to accelerate the proposal development process and to ensure sufficient allocations were made to achieve significant coverage of FSWs and Mak Nyah SW throughout the country. Sub recipients were identified where possible and allocations were made for new sites notwithstanding the presence of existing NGOs working with SWs in those areas. Identification of new SRs in new sites proved to be a big challenge for MAC in the first phase of GF implementation. The main contributing factors were limitation in choices of NGOs working in those areas and the lack of willingness and confidence on the part of NGOs to take on sex workers intervention due to the hidden nature of sex workers and the lack of enabling environment to support safe and efficient implementation of the programme.

As a result, MAC had to abort plans to set up a new site in Miri and expand its programme in Sarawak (East Malaysia). In addition, an existing site managed by PT Foundation in Kuala Lumpur was later terminated due to failure in meeting targets. Targets for those sites were re-allocated to performing SRs and a new site was identified in Negeri Sembilan, which was later taken up by a new SR.

These challenges caused delays in project implementation and affected overall targets achieved.

RECOMMENDATION FOR STRENGTHENING PROGRAMME PLANNING
1. Civil society plays a critical role in the planning, implementation and reporting of HIV/AIDS prevention programmes. Greater coordination of SW programme management and funding cycle can be achieved at the national level with joint planning by NGOs and government at the state level. 2. It is recommended that NGOs participating in HIV interventions are included in the coordination of annual HIV/AIDS planning at the state level; ie. prior to submission of annual budgets to the MOH at the National level. The level of effort and investment in each state for the target group should be based on mapping of population size, IBBS data, local budget to reflect cost of living in each state and a scan of other factors which may influence the effectiveness of programme implementation. **3.** This structure will be relevant beyond the lifespan of any external funding contribution to HIV response in the country. It is essential that the structure is robust, with clear delegation of responsibilities, and that it embrace a multi-sectoral approach. This structure will enhance health systems and community systems strengthening.

Programme Planning and Management at the SR Level

It was observed that each SR interviewed for the purpose of this assessment had different programme management structures, each with unique strengths contributing to the success of the programme. All SRs are MARPs centric organisations with a mix of community and non community staff members at both management and operational levels.

The dynamic and composition of outreach worker teams also contributed to the extent of reach and quality of service provision. This is described in greater detail in section 5.4.2. It was noted that Mak Nyah SW were actively involved in management and implementation of all programs however; FSWs were less involved in both management and employment of programme staff.

It was observed that programme managers with previous experience working on SW interventions are better skilled and equipped to respond to crisis situations, identify potential partners/stakeholders and successful in fulfilling the potential of less experienced outreach workers.

In addition the capacity of SRs in programme implementation was affected by the levels of:

- Leadership
- Maturity of the SR
- Duration of experience working with FSWs
- Various historical characteristics of the SR and their subsequent standing in the community and ability to influence authorities and decision makers.

Program Managers reported limited technical capacity to adapt programs to the realities at the grassroot level due to GF structural constraints and targets, for example:

- changing the number of condoms distributed would impact on GF targets
- changing the number of participants attending workshops would affect the GF budget
- expanding the reach of the program would affect the travel budget

Evidence from the program was rarely reported to be used for evidence based planning. The perceived lack of flexibility of the GF project and the focus on KPIs was seen as a constraint to more evidence based planning and quality improvement to the program.

Cost Structure of SR Programmes

Standard cost structure for SW programme was applied to new sites identified in the GF proposal. While this was initially useful to attract NGOs to conduct activities targeting SWs, this cost structure needs to be reviewed to better reflect local implementation costs. Urban vs rural cost of living considerations with input from local government will ensure cost efficiencies and circumvent operational cost inequities.

RECOMMENDATION FOR STRENGTHENING SR PROGRAMME STRUCTURE
1. Active participation of SR programme staff in Phase II reprogramming to reflect local realities. 2. MAC to provide more strategic technical assistance in support of programme development. This may require additional skills development within MAC and help programmes respond to evidence whilst meeting minimum GF requirements. 3. Capacity building needs: a. Community mapping to identify the number of SWs at each site to justify cost of outreach b. Evidence-based planning and decision making techniques using programme data, ie. M&E, finance and programme review c. Development of SR Advocacy Strategy to support inter-agency partnerships in the locality to achieve integrated/holistic service delivery and an enabling environment. d. Budget needs to reflect cost of living in each state and point to point travel estimates 4. Develop a "How to Run a Sex Worker Programme" toolkit to support PMs and ORWs to implement good practice interventions (including case studies, tools, resources etc). 5. Review operational cost – consider strategic location of SR office and more efficient use of office space. Offices located close to hot spots are more likely to be frequented by SW clients and to create conducive environments for clients to seek assistance, participate in programmes and volunteer. 6. Cost efficiency considerations - better planning of outreach activities based on real need rather than a top-down prescriptive approach would allow programs to have a broader reach and greater impact.

5.3.2 Using Data for Evidence Based Planning: Project Reporting, Monitoring and Evaluation

PM and ORWs displayed sufficient capacity and knowledge in performing data collection, utilising templates provided by MAC and understand the reporting processes. The program implements an ID card system which contains a unique identifier code to avoid duplication in reporting. A typical data collection is defined as recording the number of condom kits given out to SW and their unique identifier code. However, several Mak Nyah SWs mentioned that the unique identifier code requires clients' mother's initials which are culturally sensitive among the community. Data collected by ORW is recorded in a logbook indicated in Figure 3 below.

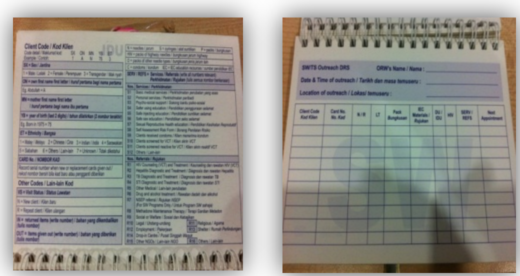

Figure 1 : Outreach Worker Logbook

SRs use a standard database system known as SyrEx as the reporting tool for GF program. The system which was adopted from Alliance Ukraine, however has several limitations. The system can be installed in one computer per NGO and therefore can only be operated by one person at a time. At present,

programme managers reported that they have not yet encountered any difficulties but it is foreseen that as the amount of data entry increases, this may result in inefficient time allocation for data entry.

Our assessment indicates that the GF reporting is focused on upward dissemination of quantitative data to MAC/GF and this may not necessarily reflect behavioural change. A client is reported 'reached' when an ID card is issued while the behaviour change communication model requires a repeat one-to-one intervention which is not the focus of the existing monitoring and evaluation reporting system.

It was outside the scope of the assessment to verify and validate the data (ie. duplication, validity, quality of data, and tracking of loss to follow-up). It was noted that programme managers expressed data collection challenges; eg. target found to be unrealistic due to lack of evidence in the early proposal stage. The complexity around the SW environment poses barriers in delivering effective services and this affects service delivery performance. For example, increased police raids inevitably influence the number of customers and visibility of sex workers in a particular site, hence affecting the number of kits distributed or clients reached.

Capacity building programmes conducted by MAC on outreach, monitoring and evaluation (SyrEx), financial management systems and project reporting received positive feedback from SR programme staff. Regular monitoring visits to programme sites provide an opportunity for SRs to share their successes and challenges and to receive practical support from MAC.

RECOMMENDATIONS FOR EVIDENCE BASED PLANNING AND REPROGRAMMING
1. **Evidence-based programming and advocacy -** current reporting structure should be reviewed to meet (a) external GF reporting requirements and (b) to collect knowledge for internal program improvement for MAC and SR. Incorporating a small section for justification for under-achieving targets would provide an avenue for SRs to highlight challenges faced in service delivery or for sharing experiences and learning. An evidence-based program is vital for future programming decisions as well as a powerful tool for advocacy work. 2. **Performance-based funding framework –** the performance-based funding system could be strengthened by developing more meaningful indicators. For example, re-defining 'reached' client to emphasise the behaviour change communication model. This may also include introducing additional variables such as counselling, VCT, and referral to STI diagnosis and treatment, income generating schemes, etc. It is highly recommended that this exercise involves collaboration between community and the local health department in ensuring the target is realistic to the best of available knowledge. 3. **Capacity in interpreting and using monitoring data for decision-making, advocacy, and program improvement** - capacity building in interpreting and using monitoring data at MAC level is critical to intensify the utilisation of monitoring data at both SR and MAC level. In an environment where funding is scarce, data analysis and application skill are necessity in communicating evidence-based findings to stakeholders. 4. **Operational Research** – there is a need for further operational research studies in key areas to better understand risk factors and to support evidence-based programme prioritising and planning in the following areas: a. Level of risk of FSWs in different settings, behaviours, and demographics (eg ethnicity, age, drug taking behaviour, etc) b. TGs in different age group especially at-school TGs

c. Male sex workers and MSM
d. ICT utilisation and opportunities to use this as a channel for access unreached populations and for disseminating information and services/products (eg condoms)
e. Analysis of IEC materials to determine if they are appropriate for the client group and if messages are understood.

5.4 The Service Package

5.4.1 Creating an Enabling Environment: Sensitisation of Stakeholders

All the sites visited had undertaken sensitisation efforts with a wide range of stakeholders (eg police, religious authorities, local government, health providers, drug authorities, welfare agencies, legal aid, and other community businessmen/women and gatekeepers). This was mostly undertaken by PMs, visiting agency by agency to brief them about planned interventions. The importance of sensitising authorities was seen as a key success factor for the intervention but there was no formula for guaranteed success.

All SRs visited stated that the strategy for sensitisation depended on the local situation and had various levels of success depending on their:

1. ability to negotiate with the authorities and reach mutual respect
2. SRs history and standing in the community
3. capacity and networks of the SR and
4. other external factors outside the control of the SR (eg local laws, local political priorities etc).

For instance one SR reported that they had successfully negotiated with law enforcement agencies and consequently had minimal disturbances during outreach activities; but another SR said that their best efforts had resulted in law enforcement agencies using their outreach schedules to plan raids creating mistrust amongst their clients and an unwillingness to participate in the project. A closer partnership was especially identified to be needed with legal aid which is discussed further in section 5.4.6 of this report.

One of the major challenges of sensitisation efforts was identified as the need for repeated, ongoing and frequent contact and sensitisation with agencies due to the high staff turnover at agencies. Also there was no guarantee that information provided to agency leaders was disseminated through the ranks of the organisation leading to potential misunderstandings and at times contradictory and conflicting messages in the field.

There was evidence of strong relationships having been built between SRs and MoH and, where these had been built, they were observed to have helped intervention implementation significantly. In other sites visited it was observed that there was an opportunity to work more closely with district health authorities to provide technical support to the intervention, facilitate and mediate sensitisation of different agencies in the community. In line with the NSP, health authorities and SRs have common

goals in the prevention of HIV in MARPs and a close partnership would maximise competitive advantages of each stakeholder to support the best possible outcomes for the intervention.

RECOMMENDATIONS FOR STRENGTHENING THE CREATION OF AN ENABLING ENVIRONMENT
Continued and sustained national and local advocacy: There is still considerable effort needed in sensitising authorities to the importance of the Project's approach to reducing the spread of HIV. Malaysia has developed global recognition for its commitment and innovation in harm reduction for IDUs and this success needs to be harnessed to create an equally supportive environment for interventions with other MARPs. Advocacy needs to occur at all levels; national, state and district. To support this advocacy SRs need capacity building in negotiation skills, management of conflict, advocacy, and communication skills.

5.4.2 Reaching out to Clients with Integrated and Relevant Services: Outreach Workers

ORWs were observed to have a good understanding of: the project goals and targets, the project components, and their terms of reference. They have strong rapport with clients, good communication skills, interested and open to learning new skills and are highly motivated.

Many of the ORWs were also observed to go beyond their TOR in supporting SWs (eg responding to crisis situations, welfare assistance, care and support); and trying to innovate with new approaches (eg one site had adopted a buddy system). They however, reported their frustrations with the enormity of their task and their inability to respond adequately to the broad and complex needs of their clients. In general they felt that their efforts to reach Mak Nyah SW were very successful, however they wanted more technical support and guidance on how to more effectively reach FSWs who were reported to be much more diverse and hidden.

They also felt they had numerous gaps in knowledge about the multitude of needs of their clients and wanted more information on issues like: womens health, drug support, income generation, social welfare, legal knowledge, immigration laws, and crisis management. In some sites visited there were also concerns about the long and inflexible working hours of ORWs. Since ORWs work late into the night (often until 3-4am in the morning), they felt that their day/office hours should be considerate of this and thus be more flexible.

Safety and security of ORWs was a major concern that was mentioned repeatedly in all the sites visited. There were several positive initiatives reported on this issue, for instance safety was reported to have been included in the MAC ORW training and was included to varying degrees in the SR in-house training and support of ORWs. One program visited reported that they have regular safety talks and conduct routine post-outreach briefings which allow the project team to problem-solve on related issues. However, ORWs reported that they need more support on this along with tools and equipment to maximise their security such as: pepper spray, a whistle, and a project bag that helps to identify ORWs as NGO project workers.

"I am not from the SW community, I wear a hijab and I am female. But the Mak Nyah sex workers are comfortable with me, to a point they sometimes show me their private parts when they are concerned about STIs and other health matters. I wish I knew more about sexual reproductive health for transgenders so that I can at least provide some comfort or refer them to the right people" – Case Worker, DIC Pahang

One of the tasks of ORWs is to enlist SWs into the project if they meet the criteria and thus issue them with an ID card. SWs who participated in the project reported that the ID card allowed them to receive free condoms which were highly valued. However, they also hoped that the ID cards could have other benefits such as to protect them from being arrested or give them a greater sense of personal security.

There was some evidence that the ID card was seen to be stigmatising and associated a person with sex work; and so some FSWs opted out of accepting the ID card because they didn't want to be identified as a SW or were in denial of being a SW. It was reported to be more difficult for the project to serve these non-identifying FSWs (or potential FSWs) who were reported to be mostly equally at risk of HIV as their participating friends.

Picture 2: Outreach workers observed to carry backpacks suitable for camping to accommodate large condom kits

Many of the ORWs employed in the sites visited are from the Mak Nyah community, a few were non-MARPs community-based workers, and 1-2 were from the female SW community. This is likely to be a key contributing factor to the high success of the intervention reaching into Mak Nyah SW, and the challenges for ORWs in trying to engage FSWs into the programme.

Most of the SRs stated recruitment of FSWs as ORWs is a challenge due to: (i) difficulty of finding FSWs with capacity and desire to be an ORW, (ii) difficulty to offer a competitive salary that is comparable with FSW income, (iii) FSWs who were hired in the past did not stay for long due to high level of mobility or other factors (eg had a baby), and (iv) the challenges of hiring FSWs who are migrant undocumented workers because they do not have a Malaysian ID card. For the project to better engage with FSWs it was recommended by SRs that the project adopt a different model and try to engage with part-time Peer Leaders who live and work directly in the FSW community commonly referred to as a Peer Education model discussed further in the recommendations below.

There were some good examples reported of PMs and ORWs who had made breakthroughs with developing partnerships with other SW gatekeepers and entry points such as mamasans, pimps, owners of entertainment facilities, and syndicate leaders. This experience needs to be more widely shared across the Program because other sites visited (which were less successful in this aspect), wanted to

know more about how to work with these gatekeepers that they had identified as key entry points to reaching SWs. Some sites found it virtually impossible to penetrate gatekeepers because they felt they didn't have the skills, authority, and confidence to negotiate with these gatekeepers and more notably they were worried for their safety if they were to get involved with such persons, many of whom are underground characters and gangsters.

It was also observed that there were many other important potential gatekeepers and entry points that were not being reached by the intervention that could be important channels for education, condom promotion and normalisation, and health service referral points, for instance taxi drivers, hairdressers and street vendors operating in hot spots.

RECOMMENDATIONS FOR STRENGTHENING AND SCALING UP THE IMPACT OF OUTREACH

1. **Strengthen Working Conditions and Security and Safety of ORWS.** The project should consider the following:
   - Supply ORWs with safety equipment such as pepper spray, whistle and bag.
   - Review TORs of ORWs (including working hours) to reflect their full scope of work which is reflected in the TORs
   - Review training programs to ensure that essential core competencies for ORW work are being developed. In particular review occupational health and safety aspects of the TOR and training.
   - Develop guidelines and tools for ensuring safety and security of ORWs (eg Tips on Do's and Don'ts for safety and security of ORWs, an official letter from the MoH/MAC that endorses the ORW as a representative of the Project, and emergency procedure guidelines).
2. **Strengthening ORWs' provision of integrated support services through strengthening the referral system:**
   - Work with other agencies in the community that can support the work of ORWs and reduce the burden and stress associated with case management
   - Strengthen sensitisation and networking with stakeholders thus strengthening ORWs role as referral agents to various government, non-government and private agencies
   - Develop ***Local Service Directory*** for ORWs to support consistent and quality referral for clients. The Directory should include information on a range of agencies in the locality including: health services, legal aid, welfare services, micro-finance opportunities, counselling hotlines, employment services, immigration services, drug treatment, training schools, adult education opportunities, child care services, crisis shelters, and mental health services. The Directory should include the name of the agency, services provided, contact name, contact address, phone number, opening hours, and cost.
3. **Scaling up the coverage to FSWs through a Peer Education Model.**
   - A Peer Education model will help the project to work in a more relevant way with FSWs and scale up the intervention dramatically. For a small incentive, one Peer Leader could be responsible for a number of sites comprising of 20 to 50 FSWs who they educate and provide condoms to on a part-time basis as part of their routine daily activities. This model will address many of the challenges of employing ORWs from the FSW community mentioned above and should achieve the same, or better results. The important considerations for this model to succeed will be: (i) careful selection of Peer Leaders, (ii) capacity building of Peer Leaders, (iii) management and support of Peer Leaders and (iv) ongoing motivation of Peer Leaders.

- A strategy will have to be developed for the inevitable high turnover of Peer Leaders. Therefore it is recommended to recruit and train new Peer Leaders every 3 months so that the project is able to replace Peer Leaders as necessary. Sustaining motivation of Peer Leaders is another important factor for success, an award of excellence and/or other benefits such as additional training opportunities or access to small loans may help the Peer Leaders to feel more valued and gain more personal benefit from doing this important work. Depending on capacity and resources of the SR another tier of Peer Educators could be recruited to work under Peer Leaders and potentially be promoted in the future (if they have capacity and if a Peer Leader position becomes vacant). From experience in other countries in the region one ORW can manage up to 20 Peer Leaders and one Peer Leader can reach up to 20 to 50 FSWs. With 4 ORWs managing a network of Peer Leaders the potential reach could be up 4000 FSWs.

4. **Review the value of defining reach by the issuance of an ID card.** The value of the issuance of an ID card as a measure of project reach should be reviewed, as this may be excluding SWs from participating in the intervention and may be reducing the flexibility of ORWs to work with a range of gatekeepers/entry points in the community. Consideration should be given to defining 'reach' based on an unique individual identifier which is being adopted increasingly in other parts of the region, thus doing away with the ID card completely.
5. **Broaden the scope of reach of ORWs:** The project should continue to try to work with gatekeepers such as pimps and mamasans; however SRs should also consider broadening the scope of ORWs' reach into new gatekeepers and community networks that might be less threatening and dangerous such as: taxi drivers, hairdressers, beauty salons, street vendors and local restaurants where SWs are known to frequent. These agents can also be important educators and condom distributors. Some of these gatekeepers may be willing to do this work gratis as part of their routine daily interaction with their customers, but a small incentive such as the ability to sell condoms for a set minimum amount may be an additional motivation for them.

5.4.3 Promoting Health Seeking Behaviour

Respondents reached by the intervention reported a willingness to access STI and VCCT services in 'client friendly facilities' defined to be: confidential, private, friendly and welcoming attitude, convenient location and opening hours, short waiting time, quality diagnosis and treatment, integrated health services (ie not just STI/VCCT specific), and affordable. Some Mak Nyah SW also mentioned that the gender of the provider was important and that they preferred to see a male doctor rather than female. Most respondents stated that these characteristics were most likely found in the private sector and therefore prefer to go to private clinics; however in one site visited a well-respected doctor in a public facility with a discreet back door, short waiting times, and free services (including for those that are migrant undocumented workers) was the preferred option for both Mak Nyah SW and FSWs. For most respondents private facilities were considered affordable at between RM20 to RM60 per visit.

Although health facilities were usually identified through friend-to-friend referral, ORWs were also reported by SWs to be an important referral point for health services. Most ORWs only knew of the government facilities offering STIs, VCCT and ART and felt unable to refer SWs with confidence to private providers or for other health interconnected issues such as TB, hepatitis, family planning, or abortion. The complexity of SWs' health needs and their interconnectedness requires ORWs to take a broader

perspective on their role as a health service referral point. For instance, the relationship between abortion and safe sex is closely linked and when an FSW is referred for a safe abortion she can easily be provided with an STI or VCCT service, but if she is not referred to a safe abortion service this opportunity may be lost and, in the worst case scenario, the FSW may die of an unsafe abortion.

An assessment of the clinical quality of preferred private clinics was beyond the scope of this rapid assessment but respondents' strong preference towards private clinics indicates that it would be less effort for SRs to work with MoH in ensuring quality of care and certification in preferred private clinics than trying to make public facilities more acceptable to SWs. Furthermore, the successful experiences in some of the intervention sites of partnership with the Family Planning Association should also be explored for potential scale up as this more holistic integrated womens health approach is likely to be more acceptable to FSWs.

It was observed that substantial efforts had been made to try to provide health services at a time, place, and location that are convenient to SWs. For instance, it was reported that partnerships between SRs and district health authorities to provide outreach clinical services for STIs/VCCT were highly appreciated by SWs (eg drop in centres, SW's home, entertainment facility etc). However some SRs said outreach clinics had mixed results in that the cost outweighed the benefit because attendance was often low. In one site assessed, regular fortnightly/monthly outreach in a fixed community site was reported to be more successful than one-off mobile outreach in that the reliability and regularity of these services tended to attract more clients. Some SRs reported having success in attracting clients to the public facilities if there are special days/hours allocated only to SWs eg first Monday evening of the month. SWs felt that this was less stigmatising because they would not be seen by the general public and would have more privacy.

Other allied health services such as pharmacies and traditional health services were also widely used by SWs for specific health issues especially; (i) traditional healers providing beauty treatments for TGSW, (ii) pharmacies providing hormone treatment for TGSW, and (iii) pharmacies providing contraception and medical abortion for FSWs. Partnering with these allied health services that are frequently used by SWs may also help to strengthen the referral system by building the capacity of these services to also be referral points.

The perceived emphasis of the Project on VCCT was mentioned by several respondents as a deterrent to some SWs participating in the intervention, particularly FSWs. The non-participating SWs were reported to not yet be ready to know their HIV status and felt that the project promoted VCCT too actively and therefore they opted-out of project participation. This is a lost opportunity for the project because for many, acceptance of VCCT is a complex and long journey, and the many benefits in terms of prevention and improved health seeking behaviour of participating in the intervention out-weighs non-participation even if the end point of acceptance of VCCT is not realised within the life of the project. Therefore it is recommended that the SRs try to focus on maximising participation of SWs in the intervention whilst continuing to promote VCCT but not at the expense of excluding those that are not yet ready to accept VCCT.

Another challenge for the project sites visited was acceptance of VCCT for the illegal and undocumented FSWs which, based on the assessment findings, is likely to be a significant component of the total FSW population in Malaysia. The significant size of the migrant undocumented population of FSWs was evident during the site visits when the assessment team met with an equal (if not greater) number of migrant undocumented FSWs as Malaysian FSWs. In the FGDs these migrant undocumented FSWs stated that they were unwilling to accept VCCT because they didn't feel that there was anything for them if they were diagnosed positive.

For instance, they would not be eligible for free ART (or other free health services) from the Malaysian Ministry of Health and so they didn't have motivation to know their HIV status. Although the Malaysian government does not have official jurisdiction over this population of FSWs (and therefore no responsibility) nevertheless it was reported that these FSWs frequently have transactional sex with Malaysian men and therefore it is in the interests of the Malaysian government to ensure that HIV prevention efforts reach this population of migrant undocumented FSWs.

RECOMMENDATIONS FOR STRENGTHENING THE HEALTH SEEKING BEHAVIOUR
1. **Strengthen the quality and referral system to improve health seeking behaviour outcomes:** o SRs to work with District Health authorities to conduct a community mapping of available health services in hotspots taking into consideration SWs' preferences. Facilities to be assessed should include public, private clinics, NGO facilities (eg Family Planning Association), traditional services, and pharmacies. o A selection of 5-8 recommended quality health facilities can be added to the ***Local Service Directory*** mentioned above (refer to 5.4.2) to help ORWs consistently and more confidently refer clients to quality health services. o A referral slip/voucher for ORWs to use for referrals could also be considered so as to better track health seeking behaviour at service delivery points partnered with the intervention. Since health seeking behaviour is an important indicator of the impact of the intervention a voucher would help to attribute health seeking behaviour with the intervention. 2. **Engage MARPs in Service Delivery:** o One way that government based health facilities in the region have had success in attracting SWs to their facility has been to hire someone from the MARPs community as a service provider in the facility (eg administration, counselling, customer relations etc). This strategy has helped the facility to gain more trust in the SW community as they feel that they are being served by their own community. 3. **Creating an enabling environment for illegal and undocumented FSWs to seek VCCT services:** o SRs need more support and guidance from MoH and MAC about how to overcome the barriers to VCCT given the lack of availability of free ART treatment for HIV+ migrant FSWs whom are illegal and undocumented.

5.4.4 Strengthening Access and Utilization of Condoms: Condom Social Marketing

The importance of condom distribution as a pivotal part of the intervention was observed in all the sites assessed. The valuing of free condom distribution and acceptance of the importance of condom use in all the SW FGDs is a credit to the hard work of SRs. Most impressively, there were no reports of stock-outs of condom kits and the PMs and ORWs clearly understood their condom kit KPIs. In all the sites

observed, the ORWs distributed, in accordance with the project design, a standardised kit of 36 condoms packaged in a plastic bag 2 times a month to each client based on the provision of a project ID card. It was observed that condoms were distributed to all those holding ID cards equally whether they were Malaysians or foreign undocumented workers.

The feedback about the quality of condoms was very positive: most felt that these condoms were much better than what they could purchase in the pharmacy, though as can be expected there were rare reports of breakage and leakage, mostly due to incorrect use. Also there were occasional reports of over or under sized, bad taste, dryness, and bad texture of condoms due to the variety of condom brands which had been distributed in the past. However, overall the assessment team concluded that the current condoms distributed (supplied by the MoH) were considered to be of very high quality and well accepted by SWs.

Programs were observed to have varying levels of flexibility with respect to the provision of condoms to those who were not able to present their ID card (ie one SW said that their ID card was with a friend). Some programs had loose condoms that they provided under these circumstances and others denied condoms to those without ID cards on the basis that they were not to be trusted and were possibly trying to "cheat" the project. Further guidance needs to be given to ORWs about how to manage these situations so as to ensure that there is no risk of unsafe sexual practice as a result of being denied condoms.

As stated in Section 5.4.2 there was good evidence of PMs and ORWs partnering with gatekeepers (eg mamasans and pimps) for onward condom distribution to the harder to reach sex workers, especially FSWs and these successes should be celebrated and shared. However, the project KPIs and focus on distribution of kits directly to SWs was observed to challenge accounting and administration of these more innovative approaches. Furthermore the focus on KPIs of distributing a fixed kit of 36 pieces per client each fortnight did not allow ORWs flexibility to innovate and respond to local demand and explore new channels of distribution.

There were also some successes reported and observed of ORWs distributing condoms to customers of SWs, eg the naval-base and directly to men in the local community that are known to buy sex. SRs reported that they see the importance of distributing condoms to both those that sell and buy sex but they perceived that this work was not directly within the scope of the Project and wanted more guidance on how to report on this and they also wanted more know-how on how to reach these at-risk populations.

Although the condom distribution was highly valued by SWs, the standardised packaging of condoms in packs of 36 in transparent plastic was reported by respondents to be problematic for two reasons. Firstly, in some sites the 36 piece pack was not enough for the SWs' demand and in other sites it was too much for demand. It was generally agreed that condoms should be distributed more flexibly according to the local situation and individual needs, since there was likely to be considerable wastage for those who were oversupplied and the possibility of risk behaviour for those who were undersupplied. Those who were oversupplied mostly reported stockpiling the condoms which were likely to expire, although

some reported onward distribution to other sex workers, or returning them to the SR. Those who were undersupplied reported trying to get condoms from friends, not using a condom, trying to convince the customer to buy a condom, and in some cases buying condoms themselves.

Respondents recommended that the program take a more flexible approach to the distribution of condoms with a variety of sized packs to cater for different individual needs, such as a mix of distribution by:

1. single pieces (easy to use in facilities such as brothels and massage parlours)
2. 3 or 5 piece pack for convenient carrying in a small purse, and
3. 10 piece pack for clients with greater demand.

Thus it was proposed that the project distribute multiples of these packs based on individual client or gatekeeper needs on a fortnightly or even monthly basis (in areas where the intervention is more mature and does not require high frequency of exposure to maintain behaviour change).

The second concern raised in relation to the packaging of condoms was the need for more discreet packaging to foster greater willingness to carry condoms. For instance, respondents requested that the plastic transparent packaging be changed to non-transparent obscure packaging. For instance respondents recommended a small attractive purse sized pack with the look of a make-up container,

> *"When we work like this, we know of diseases. We are scared... will the condom break? We need lubricant. We are much older now. I am 47 (years old) and my water (vaginal fluid) is less. If I use my saliva, the condom will break. Some customers take a long time. Lubricant helps" – Female Sex Worker*
>
> *"Do you have lubricants (the first question she asked the interviewer)? I had a sex change not too long ago. I often bleed after serving a customer. When are you going to give us lubricants?" – Mak Nyah Sex Worker*

chewing gum/candy pack, or matchbox.

It is recommended that any changes to the quantity and look of the package should be informed by more research with SWs because the assessment team was unable to conclude definitively the optimum size and look of the packaging in the short time available for the assessment.

There were strong recommendations from respondents that lubricants should be included in the kit. Many of the older FSWs reported dryness and Mak Nyah SW reported injury due to anal sex and thus requested that lubricants be included in the kit to reduce possibility for lesions and tears that heighten the risk of transmission of HIV. One of the sites visited was distributing residual lubricant stock with Project condoms and the quality of this was reported to be very high. However this site reported near stock out and no resources to procure additional stock.

Availability of condoms for sale in the vicinity of hotspots is reported to be high. Most convenience stores, pharmacies and other outlets stock a full range of condoms. A pack of 3 pieces of condoms was reported to be between RM3 to RM18 (the more expensive were top end coloured and flavoured condoms). These condoms were seen to be expensive but affordable when in need. The quality of cheaper condoms was not considered to be as good as the Project-distributed condoms; even Durex condoms were thought to be inferior in quality to those distributed by the Project. When probed further about how much SWs were willing to pay for a condom in the instance that free condom distribution was discontinued, most thought they could afford to pay between 30 to 50 cents per piece.

The contribution that condom distribution has played as a stimulant to normalising condom carrying and usage was evident in numerous "pre and post" stories provided by respondents. For instance, many respondents reported that before this intervention they would never carry a condom because they were scared of arrest by police or religious authorities and that the condom would be used as evidence of engagement in sex work. These stories were backed up by numerous accounts of how SWs in the past had been arrested for carrying a condom and spent up to 2 weeks in remand, paid RM4,000 for release from remand, and in some cases provided sexual favours to law enforcement agents in return for dropping sex work charges. This behaviour change towards normalisation of condoms in the intervention sites observed demonstrates the success of the project sensitisation efforts having created a more enabling environment and mutual respect between SRs, SWs, and law enforcement authorities. Nevertheless it is worth noting that even in these somewhat supportive environments, there were isolated recent reports of law enforcement authority raids, arrests, and harassment.

Not all intervention sites visited, despite the SRs best efforts, were able to achieve a more enabling environment for the normalisation of condom carrying. In one site visit, respondents in both the TGSW and FSW FGD were not carrying condoms at the time of the FGD and reported that they do not carry condoms because they still fear arrest and that condoms would be used as evidence of engagement in sex work. When asked what they do with the condoms distributed to them by the Project some reported that they keep them in secret hiding places near where they see their customers.

However, the resilience and negotiation capacity of SWs even in non-enabling sites was impressive: one ORW gave an account of a SW who was caught by the police carrying a Project condom kit and she quickly responded to the police that the condoms were obtained from an NGO for her personal use. Apparently she was immediately left alone by the authorities and even distributed condoms to the law enforcement officer upon his request.

The assessment found that there was a high level of reported condom usage amongst both FSWs and Mak Nyah SW. For instance respondents said *'we always use a condom'* and *'no condom no sex'*. Mak Nyah SW were more adamant and confident in their ability to negotiate a condom and were not as desperate for money since they had other sources of income to supplement their sex work. FSW tended to be less confident in negotiating condom use due to factors such as: desperation for money, unequal power relations and, in the cases of migrant workers, increased vulnerability due to illegal status. However, there were also reports of non-use and incorrect use of condoms. For instance several respondents stated that they would have sex without a condom if the customer offered significantly

more money especially if they needed the money because business was slow or they needed a fix of drugs. Incorrect use of condoms was also reported by several respondents, including doubling of condoms, baby oil, Vaseline, and saliva in place of lubricants.

In addition, non-use of condoms with intimate partners was reported to be common by both Mak Nyah SWs and FSWs, consistent with recent IBBS 2012 preliminary findings. Many of the respondents reported to have numerous intimate partners concurrently and also reported that their partners were DU/IDU and some reported having intimate relationships with PLWHA, all factors contributing to significantly increased risk in the case of unsafe sex practices.

In addition in all the sites visited, rates of STIs and unplanned pregnancies were reported to be high by a number of respondents further indicating the likelihood of non-use or incorrect use of condoms. SWs reported that customers very rarely bring condoms of their own accord and they felt that the project should also help to educate their customers about safe sex because this would help the SW to negotiate better with the customers. Promoting consistent and correct use of condoms will continue to be a focal point of the intervention and the establishment of a new social norm of routine condom usage in sex work in the hotspots will be a long process.

As stated in the Situational Analysis of this report, the assessment team also found that some FSW respondents expressed more concern about their general health than STIs and HIV/AIDS, particularly concerns about family planning and preventing unplanned pregnancies. There is an opportunity for the project to link dual messaging for FSWs to make condoms more relevant and acceptable to this population *ie a condom will prevent you from getting pregnant and from getting STIs/HIVs*. Ideally these messages should also promote dual method messaging ie Condom+ another method of family planning to allow SWs to confidentially prevent unplanned pregnancy and HIV/STIs (in the case of condom breakage or misused).

Finally, as stated previously the high usage of ICT by both Mak Nyah SW and FSWs offers an opportunity to educate about and promote condoms through mobile phones and local internet sites (facebook, websites etc). In other countries in the region condoms have been sold and promoted on line or via SMS messaging and this could be explored for the Malaysian context. At least, efforts could be made to use these channels for reinforcing educational messages about the correct and consistent use of condoms.

RECOMMENDATIONS FOR STRENGTHENING THE CONDOM DISTRIBUTION
1. **Creating an enabling environment for condom usage:** Strengthen sensitisation of law enforcement agencies to the importance of creating an enabling environment for condom carrying in the interests of public health and harm minimisation. A partnership with district health authorities to lead and facilitate this dialogue may result in better outcomes for the intervention as these health authorities are better positioned to negotiate with law enforcement authorities than NGOs. 2. **Strengthen condom promotion communication messages and materials:** Strengthen capacity of ORWs in educating SWs on negotiation skills for consistent and correct use of condoms with both clients and long-term partners. Develop condom promotion materials for FSWs that better link condom usage with prevention of unplanned pregnancies as well as prevention of HIV/STIs. Also explore ways of reinforcing correct and consistent use and promotion of condoms through ICT.

RECOMMENDATIONS FOR STRENGTHENING THE CONDOM DISTRIBUTION

3. **Repackaging of condom kit:** Review the condom distribution quantities, method of distribution, and packaging of condoms to: (i) better reflect individual needs, (ii) be more flexible to respond to SW demand, and (iii) promote more discreet carrying of condoms. Also include lubricants in the condom kit.
4. **Broaden the definition of 'at risk population' in the hotspot and review the KPIs accordingly:** The project needs more flexibility of condom distribution to ensure all 'at risk populations' and key gatekeepers can access condoms. As stated in Section 5.4.2, for the purpose of condom distribution the project should consider adopting a unique individual identifier that can capture reach but will not alienate SWs that do not want to identify as a SW, and thus do away with the ID card. The project should also look at ways to support the SRs distributing condoms to a wider group of gatekeepers (eg mamisan, pimps, taxi drivers, and beauty shops) and 'at risk populations' (eg customers and taxi drivers) and consider ways this broader reach could be captured in monitoring and evaluation indicators.

5. **Subsidised condom promotion program:** Based on regional experience of free condom distribution being discontinued by donors/governments with little notice due to other health priorities, consideration should be given in this Project to the sustainability of free condom supply by MoH and an exit strategy should be considered in the later part of Phase II of the GF Project introducing a highly subsidised condom promotion project that can continue to be distributed through existing distribution channels. This could be managed through a private partner. There is substantial global evidence that the purchase of a condom (for no matter how little) is highly correlated with its use and that free distribution of condoms do not necessarily correlate to usage because they are not valued by the consumer in the same way that a product that is purchased. More research would be required to ensure the success of a subsidised condom promoting project including better understanding of what is affordable, promotion, distribution channels, positioning, packaging, and product.

5.4.5 Moving from Information Education and Communication (IEC) to a Behaviour Change Communication (BCC) Approach

In the sites visited there was an impressive evidence-base of reported behavioural change occurring amongst SWs reached by the intervention. This is a great achievement given that the intervention has been in the field for less than 2 years. Reported behaviour change included: increased willingness to carry and use condoms and improved health seeking behaviour.

SWs reported that they had received IEC materials from the project, and they had good recall of IEC material content and messages. Most respondents said they liked the graphic final stage STI pictorials because they used them to "scare" their clients into wearing a condom: others stated that the materials were irrelevant to them because they had never seen infections like these and therefore their clients (and themselves) were 'clean'. Many SWs said they used the IEC materials to educate their clients. For this purpose, some FSWs felt the look and feel of the IEC materials could be improved to be more relevant and convenient to SWs; for instance the size of the materials were seen to be too big to slip into a pocket and the quality of the paper was not strong enough to endure repeated use.

Consideration should also be given to language barriers for migrant FSWs. Ideally each ORW should have IEC materials in the main languages of migrant workers within the hotspot: this could be achieved by:

1. procuring language specific materials through regional networks,
2. designing multiple languages in one brochure, or
3. alternatively translating communication materials into different languages.

The assessment also found evidence of illiteracy and low-literacy especially amongst FSWs, so as far as possible materials should be pictorially based and visual with as little writing as possible.

As stated previously, the increased use of ICT by both FSWs and Mak Nyah SW is an exciting opportunity for new ways of communicating with hard to reach SW populations with health messages and promotion of services and products. Regionally there are many examples of the use of hotlines, SMS messaging, facebook, and specialised websites for disseminating health messages to MARPs populations and these could be explored for their feasibility and relevance in the Malaysian context.

PMs and ORWs met by the assessment team had little understanding of basic behaviour change theories that would help them to better prioritise, plan, monitor, and evaluate the impact of their work. As a result they were observed to at times feel frustrated and lack motivation. Some basic knowledge of the complexity of behaviour change in the context of the individual and the broader enabling environment for the project teams would help interventions be more strategic, evidence based and able to scale-up, and prevent burnout among ORWs.

The high level of mobility of SWs between intervention sites (and beyond) offers an excellent opportunity to 'brand' the intervention sites into a single BCC 'brand'. This will help reinforce messages across the SR hotspots and amplify the impact of the intervention through viral/word-of-mouth communication. In other countries in the region brands like *Smart Girl* (Cambodia), *Think of Life* (Papua New Guinea), and *More Safety* (China) have successfully helped to pull together MARPs focussed interventions in multiple hotspots into a single intervention creating stronger impact and recognition.

RECOMMENDATIONS FOR MOVING FROM IEC TO BCC APPRACHES
1. **Review communication materials:** Conduct further research with FSWs and Mak Nyah SW to possibly redesign the communication materials to better reflect their desires and needs so they can better accept and adopt communication messages including consideration of: relevance of the messages to SWs, the look and feel of the materials, the size of materials, quality of the paper, language, and literacy. Ensure SWs are involved in the formative research, design and pre-testing to ensure maximum relevance and acceptance of the materials. 2. **Explore opportunities to better utilise ICT:** Conduct further research into the feasibility of using ICT channels to reinforce health messages and promote health products and services. 3. **Develop skills in Behaviour Change Communication:** Introduce basic BCC concepts to PMs and ORWs so that they can more strategically and effectively communicate with SWs. 4. **Develop a 'brand' to strengthen the impact of the intervention:** In partnership with SWs develop a relevant, positive, and impactful brand and logo for the intervention that can be used in all SR sites for all communications efforts which will more effectively pull the intervention together across SR hotspots and thus amplify the impact of the intervention to a highly mobile

population.

5.4.6 Supporting Human Rights of MARPs: Legal Training and Support

The legal component of the Project was reported by all SRs as a vital component of the intervention. SRs had conducted training for SWs as outlined in the project design two times per year for approximately 2 hours per session. SWs reported that the legal training that they attended helped them to understand their human rights and what to do in the case of an arrest. Some SRs however were disappointed with the low turnout to legal training and suggested that training should be delivered in a more relevant way in the future so as to improve attendance, for instance linking training to other SW interests like a joint workshop on Beauty and Legal Tips.

In the hotspots ORWs are faced on a daily-basis with responding to a plethora of legal issues including: sexual harassment, domestic violence, rape, assault, immigration issues, and arrests. ORWs showed strong commitment to helping their friends/clients by mobilising their available resources to the best of their ability in support of human rights of SWs. There were many success stories reported, of PMs and ORWs negotiating legal issues on behalf of the SW community. In this respect the legal training and partnership with legal aid has paid off in creating a more just environment for SWs. However, it was also observed that the crisis management and legal support provided by ORWs was sometimes based on the goodwill of ORWs and thus reactionary rather than being a well-planned community crisis management response.

All SRs had developed working relationships with legal aid to support legal issues in the community though the success of these partnerships varied. Most experiences partnering with legal aid were reported to be positive but one SR reported that their relationship with a legal aid officer was so detrimental to the project that it resulted in a significant number of SWs refusing to participate in the program.

There are extremely encouraging signs of community mobilisation of the SW community themselves, with the first SW owned and operated NGO of Malaysia being engaged as one of the SRs on the GF project. This NGO is currently expanding its reach into States. The experience of this SR needs to be shared across the program to foster more community mobilisation by SW groups themselves to actively stand-up for their human rights and voice their opinions on issues that concern them. In other countries in the region social and political change in favour of improved choices and human rights for marginalised communities such as SWs have only come about through greater SW community led action.

RECOMMENDATIONS FOR STRENGTHENING LEGAL AID TRAINING AND CRISIS RESPONSE
1. **Strengthen the relationship between MAC/SRs and Legal Aid:** The project needs a strong relationship with Legal Aid to ensure that legal issues in the SW community are responded to rapidly, efficiently and effectively. The Project should consider contracting directly with Legal Aid Department as a SR to support a national mobilisation of legal aid support. Each SR should have a pool of legal aid officers who are sensitised, sympathetic, and knowledgeable on the types of legal issues facing SWs, and that are able to respond quickly and willingly when called upon. 2. **Develop a Community Crisis Response strategy:** SRs to work with ORWs and other stakeholders (eg legal aid) to develop a plan of action in the case of a legal situation. For instance who should take

the lead, who should be contacted etc.

3. **Strengthen legal training for ORWs and SWs:** Further develop the skills and capacities of ORWs and SWs in the areas of human rights, civil and sharia law, and how to respond to legal crises. Provide training in a flexible way that maximises participation and the interest of participants.
4. **Create a supportive environment for SWs to stand up for their human rights:** Provide SWs with safe spaces and encourage and support them to organise on behalf of their own human rights in support of greater self-determination.

5.4.7 Strengthening Capacity Building of SRs through In-house Training

There was good evidence of efforts to do in-house capacity building and training within SRs: for instance one SR reported that a doctor comes there to do regular health education training for ORWs and, in another SR, ORWs reported that they use life-sized body maps to do sex education with SWs. However some SRs did not know what to do with the in-house capacity building budget-line with is verified by the under-spend in this budget-line across the Program. The assessment team was not able to gauge whether this was because of: lack of in-house training capacity, lack of understanding of training needs, lack of motivation, or other factors. This needs further exploration by MAC. However, during the assessment, PMs and ORWs pointed to a number of areas where they would like further capacity building including:

- Leadership and advocacy skills
- Communication skills including negotiation skills, behaviour change communication, and counselling skills.
- Techniques for community mobilisation
- Legal skills and conflict resolution
- Health knowledge including: womens health (FP), other health issues (eg TB, diabetes, hepatitis), drug and alcohol addiction, etc
- Management skills especially if ORWs will be required to manage Peer Leaders.
- Administrative and computer skills
- Stress management skills

SWs also identified additional areas where they would like to develop their capacities and skills such as: cooking, makeup and beauty, hairdressing, clothes design, and running a small business. They also would like the project to help them source micro-finance and small loans so they can diversify into other income generating activities. Although these areas of capacity building are outside the scope of the project, strategic partnerships by SRs with other government and non-government agencies would help to link this population to other training and business development opportunities available in the local community.

RECOMMENDATIONS FOR IN-HOUSE CAPACITY BUILDING FOR PROGRAMME STAFF

1. **Support the SRs to develop an in-house training plan for project teams**. MAC should work with the SRs to develop an in-house training plan utilising experts in the community to build capacity of PMs/ORWs: for instance a respected social worker in the community could be invited to give a lunch time talk about counselling.
2. **Develop partnerships with income generating activities and skills in the local community**: Partner

with agencies in the community that could help SWs with income generating activities and skills. The District Health Authorities could help with sourcing and negotiating these partnerships in the interests of providing more choices for SWs.

6 STRATEGIC RECOMENDATIONS

As indicated above, to date the Project has made tremendous strides forward in a relatively short timeframe. To support even further success in the coming 3 years of Phase II of Project implementation the assessment team has provided detailed recommendations above which were: (i) identified by respondents who participated in the assessment, (ii) drawn from relevant regional experience, and (iii) sourced from the collective broad experience of the Assessment Team. This section of the report summarises these recommendations into 8 strategic recommendations as follows:

1. Strengthen Governance of SW Intervention through National Coordination
2. Evidence-based Programming
3. Develop Stronger Partnerships to Strengthen the Enabling Environment and Support a Holistic Integrated Service Package
4. Scale-up Reach by Expanding Coverage Area and Adopting New Programming Approaches.
5. Strengthen the Health Service Package
6. Improve Standards and Strengthen SR Capacity
7. Community Mobilisation in Support of Self-Determination and Improved Human rights for SWs
8. Sustainability of Outcomes

Strengthen Governance of SW Intervention through National Coordination

MAC to initiate joint annual planning process between MoH, MAC, and SRs at national and state level to assist in: strengthened coordination between SRs and government authorities, improved understanding of real costs associated with implementing the intervention, and support more sustainability of the program which will facilitate improved outcomes for HIV prevention efforts in the SW community.

Evidence-based Programming

MAC together with MoH, SRs and GF to review monitoring and evaluation indicators and targets in light of Phase II strategy and assess the feasibility of harmonising these with NSP national monitoring and evaluation framework.

1. For Immediate Programmatic Response
    a. SRs: Conduct community based mapping to identify local priorities, targeted coverage and reach, and costing of the intervention and feed this into the Phase II planning process.
    b. MAC: Build in flexibility to programming to allow for changing local context and innovation.
2. For Short-term Programmatic Response
    a. MOH: Collectively invest in critical operational research and conduct further secondary analysis of existing research that can fill gaps in knowledge and help prioritise

programing based on the evidence. The priority of operational research as identified by the assessment team is to determine the relative risk of different cohorts of the FSW population (eg demographic, drug-taking behaviour, location etc) to help guide SRs for prioritising FSW interventions.

3. For Long-term Considerations
    a. MAC: Provide further technical assistance to SRs and facilitate cross-SR sharing through: study tours, mentoring, and documentation of case-studies. To consider developing a *How to Run a Sex Worker Program* toolkit that guides PMs and ORWs through the process of: community assessment and mapping, project design, implementation, and monitoring and evaluation including case studies, tools and resources to support quality SW interventions.

Develop Stronger Partnerships to Strengthen the Enabling Environment and Support a Holistic Integrated Service Package.

MAC together with MOH and SRs to strengthen existing partnerships (and build new partnerships) with a range of stakeholders at national and local level (See Annex 7 for Global Best Practice)

1. For Immediate Programmatic Response
    a. MAC: Develop a template for *Local Service Directory*, which can be adapted by each implementing agency to support quality and consistent referral by ORWs to other agencies as necessary
        i. government agencies (eg law enforcement authorities, legal aid, local government agencies, health authorities, drug authorities, employment training agencies, income generation support agencies, and welfare agencies),
        ii. NGOs (eg crisis shelters and FPA clinics), and
        iii. Private sector (including private clinics, and local entertainment businessmen/women).

1. For Short-term Programmatic Response
    a. MAC: Develop stronger partnership with legal-aid at national level and assess the feasibility of engaging the department of legal aid as a GF SR so that they can better mobilise their local network in support of improved legal aid support in the SRs and hotspots.

Scale-up Reach by Expanding Coverage Area and Adopting New Programming Approaches.

1. For Immediate Programmatic Response
    a. SR: Scale up reach by expanding into new hotspots and explore the possibility of using peer education to expand into new FSW settings.
    b. MAC: Together with SRs to review the minimum service package provided by ORWs (ie frequency of contact etc) in light of increasing reach, coverage and the introduction of new approaches (eg Peer Education, See Annex 7 for Global Best Practice).
    c. MAC/MOH: Together with SR to review the feasibility and value of the continued issuance of an ID card to SWs if the project scales up significantly and consider abolishing the ID card in favour of a simpler measure of reach based on individual unique identifier; this will be easier to administer as the project expands its coverage.

   d. MAC: To explore the feasibility of integrating other stakeholders into the project design and providing them with a service package such as: (i) gatekeepers (pimps and mamisan), (ii) customers (through work-based interventions), and (iii) male sex workers (including men who sell sex to men and men who sell sex to women).

Strengthen the Health Service Package

1. For Immediate Programmatic Response
   a. MAC: Together with SRs and MoH to review: (i) the quantity of condoms per kit, (ii) the packaging of condoms to make them more discreet, and (iii) the inclusion of lubricant as part of the condom kit.
   b. SR: partnership with district health authorities to map and assess quality of SWs' preferred health services and select 'quality SW friendly' health services (including public, private, NGO (eg FPA) and pharmacies) and include in *Local Service Directory* and assess the feasibility of providing regular outreach clinical services or special allocated times for SWs at fixed sites
2. For Long-term Considerations
   a. MAC: together with SRs to explore the feasibility of using service vouchers/referral slips for ORWs and Peer Leaders to strengthen the health service referral system and better track health service seeking behaviour attributable to the intervention. To get technical assistance from MoH on strategies that will promote undocumented migrant FSWs to test for VCCT.
   b. MAC: together with SRs to review existing communication materials for: look, quality, content, and language and literacy barriers; and explore the feasibility of disseminating health information through popular SW ICT channels and consider development of a campaign 'brand and logo' that can tie the project together across SRs into a single intervention and thereby amplify national impact.

Improve Standards and Strengthen SR Capacity

1. For Immediate Programmatic Response
   a. MAC/MOH: together with the SRs to look at the Standard Operating Procedures to ensure they maximise the safety and security of all project staff and provide safety kit (eg a whistle, pepper spray, and bag). A letter of endorsement from MoH/MAC may also help to ensure ORW safety.
   b. MAC: To review and update TORs of PMs/ORWs in light of any changes to their scope of work in Phase II. To work with the SRs to develop an in-house training plan utilising experts in the community to build capacity of PMs/ORWs.

Community Mobilisation in Support of Self-Determination and Improved Human Rights for SWs

1. For Immediate Programmatic Response
   a. SR: to work with SW community to develop a community crisis response plan that will strengthen the capacity of the community to respond rapidly to legal crisis See Annex 7 for Global Best Practice)
2. For Short-term Programmatic Response

a. MAC/MOH: To provide safe spaces and support SW community to mobilise including supporting them to link with relevant community opportunities (eg income generation activities and small loan facilities).

Sustainability of Project Outcomes

1. For Long-term Considerations
    a. MOH: together with MAC, SRs and district authorities to develop an exit strategy to ensure sustainability of project activities post GF Round 10 grant. The feasibility of moving to a subsidised condom promotion project using a private/NGO partner should be explored if free condom distribution is discontinued.