

# W MENAND GIRLS Confronting HIV and AIDS in Malaysia







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Cover photo: UNICEF/Malaysia/2007/Palani Mohan

Photo caption: Faloziyah Binti Mohd Uri (20), her mother-in-law Sahrela Binti Putri (47) and her daughter Siti Nurshamimi Shahril at their flats in Sungai Petani, Kedah. Sahrela is a member of Prostanita, a women's peer-to-peer programme to ensure that women and girls from lower-income groups are equipped with skills and knowledge that will sustain and support them and their children from the harm of HIV and AIDS. The programme was initiated by the Ministry of Health and UNICEF in 2006.

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# FOREWORD MINISTER OF HEALTH, MALAYSIA





Malaysia has experienced escalating rates of HIV from its first case in 1986 but since 2003, the rate has been continuously declining. However, the number of new HIV infection among women has increased from 5.02% of total HIV cases in 1997 to 16.3% in 2007.

As part of the government's continued commitment towards overcoming the HIV challenges, the National Strategic Plan on HIV/AIDS 2006-2010 (NSP) was developed to provide a framework for Malaysia's response on HIV and AIDS. The NSP addresses the issue of women and AIDS as outline in its fourth strategy of reducing HIV vulnerability among women, young people and children.

This report grows out of the shared belief by the government and UNICEF that there must be a response to the impending HIV crisis confronting women and girls in Malaysia. Strong political commitment, leadership at the highest level and a multi-sectoral framework are required to address the complex issues affecting women's ability to control and make decisions regarding sexual and reproductive health.

The government is fully committed to putting women and children on the national agenda for HIV, as this is in line with the country's goal of minimising the impact of the epidemic on the individual, family, community and nation.

DATO' LIOW TIONG LAI



# FOREWORD UNICEF REPRESENTATIVE, MALAYSIA



The Government of Malaysia has made remarkable achievements in addressing HIV and AIDS through prevention, control and treatment programmes, tackling even the most controversial issues with great courage.

However, the scale of the country's response is becoming increasingly dwarfed by the size and complexity of the epidemic, as HIV appears to be taking on a young, feminine face. The four-fold increase in new reported HIV cases amongst women in the last 10 years is cause for enormous concern. Women and girls play unique roles in the family and community as mothers and caregivers. When they are infected with HIV, it directly affects the lives of their children, those born with the virus as well as those who will be prematurely orphaned.

The UNICEF and UNAIDS global campaign, "Unite for Children, Unite against AIDS", provides a framework that complements the fourth strategy of the Government's National Strategic Plan on HIV/AIDS 2006 - 2010, which aims to reduce HIV vulnerability among women, young people and children. The four objectives of the campaign – to prevent mother-to-child HIV transmission; to provide paediatric treatment; to prevent infection among adolescents and young people; and to protect and support children affected by HIV and AIDS – can make a real difference in the lives of children affected by HIV and AIDS, and help take Malaysia one step closer to achieving the Sixth Millennium Development Goal (MDG).

This report demonstrates that the vulnerability of women and girls to HIV requires a gendered response that addresses social and cultural factors. UNICEF stands by the Government in keeping the lens on women and children to ensure that all the other achievements of the nation are not derailed by this epidemic, and that we unite to build an AIDS-free generation.

YOUSSOUF OOMAR

FOREWORD	4
TABLE OF CONTENTS	7
LIST OF TABLES	8
LIST OF FIGURES	8
ACRONYMS	9
EXECUTIVE SUMMARY	11

### CHAPTER 1:

THE FACE OF HIV AND AIDS:	
INCREASINGLY YOUNG AND FEMALE	15

Global Overview South and Southeast Asia The Malaysia HIV epidemic

### CHAPTER 2:

### THE FEMALE EPIDEMIC IN MALAYSIA ...... 29

Feminisation of the Malaysian HIV epidemic From injecting drug use to heterosexual transmission

### CHAPTER 3:

WOMEN AND GIRLS IN MALAYSIA	
EXPERIENCING HIV AND AIDS	41

As drug users As housewives and heads of households As pregnant mothers As sex workers As HIV-positive women As young people As migrant workers As refugees

### As victims of human trafficking

# TABLE OF CONTENTS

### 

Biological Social and cultural Sexual reproductive health knowledge and attitudes Sexual behaviour and practices Intergenerational sex Sexual violence Economic Lack of economic power

### CHAPTER 5:

WHAT IS NEEDED		85
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# TABLE OF TABLES FIGURES **& FIGURES**

### **TABLES**

8

1	Overview of the epidemic	23
2	Routine HIV Testing	25
3	No. of new HIV and AIDS cases Per Year in Malaysia, 1986 – 2007	31
4	Main modes of HIV transmission according to states, as of Dec 2006	35
5	Antenatal HIV Screening in Malaysia, 1998 – 2006	49
6	HIV screening of migrant workers in Malaysia 1998 – 2004	59
7	Percentage of respondents with correct responses to specific questions on SRH and HIV and AIDS	73
8	Results from the Durex Sex Survey 2003 – Malaysia	76
9	Relationship of rape survivor and perpetrator, 2000 – v2002	80

1	Percentage of female HIV cases in six countries in 2002 & 2006	19
2	Total HIV and AIDS cases in Malaysia, 1986 – 2007	21
3	Women with HIV by states, Dec 2006	23
4	Reported HIV Infection, 2007	24
5	The Malaysian HIV epidemic, 1986 – 2007	31
6	New HIV and AIDS cases, AIDS related deaths – Women, 1986 – 2007	33
7	Percentage of new HIV cases – men & women, 1996 – 2007	33
8	Reported new HIV infections among women in 2002 & 2007	37
9	Comparison of HIV transmission cases between heterosexual & IDU categories, 1996-2006	37
10	Transmission factors – pregnant women with HIV, 2002	37
11	Breakdown of reported HIV infections among women for 2002	38
12	Sexual relationships between populations at risk	42
13	Gender profile of drug users in Malaysia, 2004 – 2006	43
14	New HIV and AIDS cases amongst housewives, 1996 – 2007	47
15	New HIV cases amongst pregnant women, 1996-2006	49
16	New HIV and AIDS cases – female sex workers, 1996 – 2007	51
17	Percentage of yearly HIV, AIDS cases and AIDS related deaths – Women, 1996 – 2007	53
18	New HIV and AIDS cases amongst youth, 13 – 29 yrs	57
19	Proportion of HIV and AIDS cases according to age group, Dec 2006	57
20	Perception of adolescents on HIV and AIDS information	74

# **ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
DIC	Drop-In Centre
FFPAM	Federation of Family Planning Associations of Malaysia
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use/User
ILO	International Labour Organisation
MAC	Malaysian AIDS Council
MDGs	Millennium Development Goals
МОН	Ministry of Health
МТСТ	Mother-to-child transmission
NADA	National Anti Drug Agency
NGO	Non-Government Organisation
NPFDB	National Population and Family Development Board
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan on HIV and AIDS
PLHIV	People Living With HIV
PROSTAR	Program Sihat Tanpa AIDS Remaja
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
тв	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

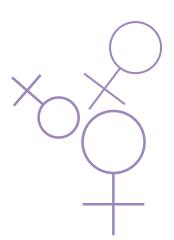


# **EXECUTIVE SUMMARY**

Globally, young women and girls are more vulnerable to HIV infection, which causes AIDS, with studies showing females being 2.5 times more likely to be infected with HIV as their male counterparts. Of the 33 million people estimated to be currently living with HIV around the world as of 2007, half are female. Of the estimated 5 million people living with HIV in Asia, around 29% or a third are women.

In Malaysia, as of December 2007, less than 10% of the overall 80 938 reported HIV cases were women and girls. However, over the past decade, there remains a worrying trend of new HIV infections occurring amongst women from 1.2% of total new cases in 1990, 9.0% in 2002, 10.8% in 2004 to 15% in 2006. The latest data from the Ministry of Health as of December 2007 indicates that this proportion is now 16%. Most HIV infections among women and girls in Malaysia have occurred through heterosexual sex, a large number of whom are housewives. In 2006, 27.4% of new male and female reported HIV cases were attributed to heterosexual intercourse. In 2007, it was 28.7%.

Marriage has been far from being a guarantee of safety from HIV for women with examples from surrounding countries such as Cambodia, Indonesia and Thailand increasingly indicating that husbands were the primary source of infection for women. Alarmingly, this is a trend which is gradually dominating the number of cases reported amongst women in several states of Malaysia.



These women and girls, having acquired HIV, could become discriminated and marginalised from their communities. Fear of such marginalisation could result in women not seeking information and undergoing screening for HIV. It would also prevent them from disclosing their status and obtaining appropriate counselling and treatment. With increasing numbers of affected families whose parents become infected with HIV, the number of children infected or orphaned will also rise.

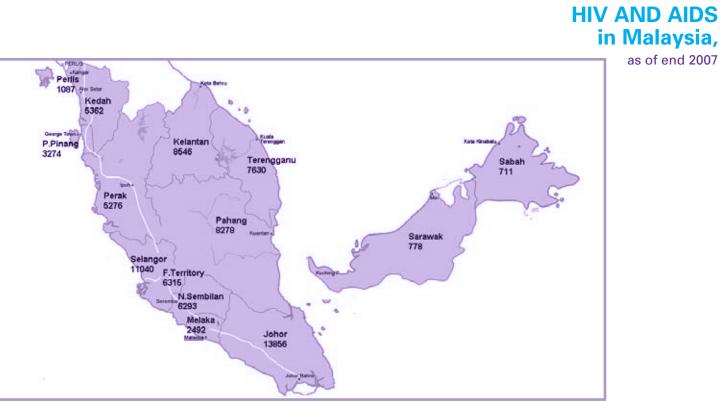
However, the main mode of male HIV transmission observed in the country continues to be via injecting drug use where nine out of ten infections are men. Infection numbers amongst women continue to be low compared to the larger total number of cases as a result of injecting drug use, which are predominantly composed of men.

This report grows out of the shared belief that there must be a response to the impeding HIV crisis confronting women and girls in Malaysia. The increasingly feminised nature of the HIV epidemic in the country has been linked to issues affecting women's ability to control and decide issues relating to sex. Whether as injecting drug users, housewives, migrant workers, professionals, refugees or sex workers, women and girls experience HIV and AIDS differently compared to men and boys. Their risks and vulnerabilities to HIV require a gendered response. As such, gender disaggregated surveillance data on HIV infections and behaviours must be made available.

Women and girls deserve a separate strategy because of the increasing and disproportionate numbers becoming infected. This concern is currently reflected under Strategy 4 of the National Strategic Plan on HIV and AIDS 2006 – 2010. The limitations lie elsewhere, as we are not short of resources that can be committed to women and women's issues neither is there the lack of political will to respond and to commit. However, the national HIV and AIDS responses are still concentrated mainly in the Ministry of Health. The multifaceted nature of women and HIV requires the involvement of wider networks of multi-sectoral collaboration.

This approach is needed to take action to increase women and girls' knowledge of the disease, expand access to sexual reproductive health education and testing, increase their ability to protect themselves from HIV as well as fight gender discrimination and violence.

The increasingly feminised nature of the HIV epidemic in the country has been linked to issues affecting women's ability to control and decide issues relating to sex.



Geographical distribution of HIV cases in Malaysia

People infected with HIV in Malaysia (1986-2007)	TOTAL	80 938
	> 13 years	80 174
	Women	6 834
	Children < 13 years	764
People newly infected with HIV in Malaysia in 2007	TOTAL	4 549
	> 13 years	4 491
	Women	745
	Children < 13 years	58
AIDS deaths in Malaysia in 2007	TOTAL	1 179
	Men	1 048
	Women	131



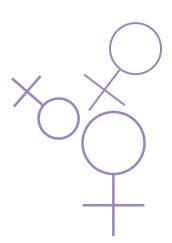
## **INTRODUCTION**

# THE FACE OF HIV AND AIDS: INCREASINGLY YOUNG AND FEMALE

Gender roles and their subsequent interactions have had a significant influence on the past, present and future course and impact of the HIV and AIDS epidemic in every region and country of the world.

In order to better respond and effectively address the many current challenges brought forth by the epidemic, it is necessary and critical to understand the influence these gender roles and interactions have on individuals' knowledge and practices in the context of HIV. Studies have shown that a woman experiences and responds differently to the epidemic compared to a man.

It is therefore necessary to adopt an approach to HIV and AIDS that recognises gender does not only determine an individual's vulnerability to infection; but can also shape the issues faced by those living with HIV, as well as influence the response of the community.



Young people (aged 15 – 24 years) are the fastest growing group of newly infected persons with approximately 6 000 individuals infected each day.

Girls in this age group are increasingly more likely to be infected than boys.

# **Global Overview**

During the early years of the AIDS pandemic, men vastly outnumbered women amongst people infected with HIV. It took some time and a great deal of scientific evidence before it moved away from a mindset of a male only epidemic to one that accepted the fact that HIV was also a threat to women. The proportion of women infected by HIV worldwide has steadily grown since then with current statistics from 2007 showing that half of all people living with HIV globally are female.

In December 2002, United Nations Secretary General Kofi Annan announced that for the first time, women represented half of those living with HIV worldwide, and more than half in sub-Saharan Africa<sup>1</sup>, where women make up almost 59% of all people infected with HIV<sup>2</sup>. Young women between the ages of 15 and 24 are most at risk as they constitute 76% of young people living with HIV in the region. The highest female infection rates in Asia can now be seen in countries such as Cambodia and Thailand experiencing generalised epidemics and where transmission is primarily heterosexual<sup>3</sup>.

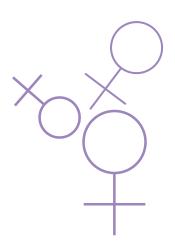
In 2006, 17.7 million women were estimated living with HIV, an increase of over one million when compared with statistics from 2004. More adult women than ever before are now living with HIV<sup>4</sup>.

The age of the individual has always been a factor in the spread of the epidemic, but never has it been more apparent as current studies show that young women are several times more likely than young men to contract the disease through heterosexual contact<sup>5</sup>. Young people (aged 15 – 24 years) are the fastest growing group of newly infected persons with approximately 6 000 individuals infected each day. Girls in this age group are increasingly more likely to be infected than boys. Worldwide, 62% of young people living with HIV are adolescent girls<sup>6</sup>. In many societies, present in both the developed and the developing world, young girls are often marginalised by social and economic norms, and are vulnerable to infection through sexual relationships with older and more experienced men, early onset of sexual activity, and early age at marriage.

REGIONAL HIV AND AIDS STATISTICS, 2007						
	Adults & children         Adults & children newly         Adults (15-49)         Adults           living with HIV         infected with HIV         prevalence (%)         deaths deaths deaths					
Sub-Saharan Africa	22 million	1.9 million	5	1.5 million		
Oceania	74 000	13 000	0.4	1 000		
South and South East Asia	4.2 million	330 000	0.3	340 000		
East Asia	740 000	52 000	0.1	40 000		
Latin America	1.7 million	140 000	0.5	63 000		
Caribbean	230 000	20 000	1.1	14 000		
Eastern Europe & Central Asia	1.5 million	110 000	0.8	58 000		
Western & Central Europe	730 000	27 000	0.3	8 000		
North America	1.2 million	54 000	0.6	23 000		
Middle East & North Africa	380 000	40 000	0.3	27 000		
TOTAL	33 million	2.7 million	0.8	2 million		
	Source: UNAIDS. Global AIDS Epidemic Update, August 2008					

REGIONAL HIV AND AIDS STATISTIC FOR WOMEN, 2004 AND 2006						
	Number of wome	n (15-49) living with HIV	% of Adults (15-49) living with HIV who are women			
	2004	2006	2004	2006		
Sub-Saharan Africa	12.7 million	13.3 million	59	59		
Oceania	180 000	200 000	49	48		
South and South East Asia	2 million	2.2 million	29	29		
East Asia	160 000	210 000 27		29		
Latin America	450 000	510 000	30	31		
Caribbean	110 000	120 000	50	50		
Eastern Europe & Central Asia	410 000	510 000	30	30		
Western & Central Europe	190 000	210 000	28	28		
North America	300 000	350 000	26	26		
Oceania	32 000	36 000	47	47		
TOTAL	16.5 million	16.5 million 17.7 million 48				

Source: UNAIDS. Global AIDS Epidemic Update, December 2006



More than 100 million women and girls are estimated to be affected as widows, caregivers, sisters, heads of households, mothers, grandmothers and many other roles and with different responsibilities, as a result of family members infected with the disease. The epidemic has also forced vast numbers of affected young women and girls who have lost parents and family members into precarious and vulnerable circumstances, resulting in exposure to exploitation, sexual and physical abuse, and the risk of becoming infected with HIV. With 70% of the world's poor being women, they have few economic options and are far more vulnerable to the threat of absolute poverty<sup>7</sup>. They may be forced to engage in transactional sex to pay for food, school fees and other necessities for the family. Forced sex, gender based violence and the inability to negotiate condom use in these conditions becomes even more likely.

Women and girls find themselves shouldered with the burden of caring for those infected in the family. They may be ill themselves or living with the disease which could result in the loss of employment as a result of stigma and discrimination. The resulting poverty coupled with HIV reduces the woman's ability to provide for her family.

More than 100 million women and girls are estimated to be affected as widows, caregivers, sisters, heads of households, mothers, grandmothers and many other roles and with different responsibilities, as a result of family members infected with the disease<sup>8</sup>.

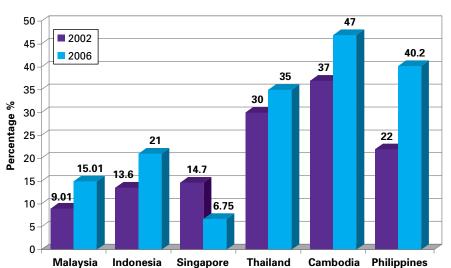
## South and Southeast Asia

By the 1990s, the HIV pandemic was well established across the Asia region whereupon UNAIDS estimated that in 2007, more than 380 000 people were newly infected with HIV<sup>9</sup>. As can be seen from the regional UNAIDS statistics, the majority of these cases were in South and Southeast Asia, bringing the total number of people living with HIV in this region to 5 million<sup>10</sup>. 29% or 2.2 million of this number in 2006 were women. In the same year, approximately 700 000 people died from AIDS-related illnesses.

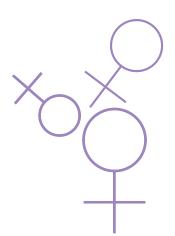
An increasing proportion of people living with HIV in this region are women and girls. Overall in Southeast Asia, women currently represent 29% of adults living with HIV<sup>11</sup>. Feminisation of the HIV epidemic in this region is rapidly occurring and is reflected in the fact that almost 40% of new HIV cases are among women. This development is strongly linked to the increase in heterosexually transmitted HIV cases seen across the countries in the region.

In countries such as Malaysia and Vietnam where the spread of the virus has been predominantly through injecting drug use, there are now signs of a rapidly spreading heterosexually transmitted HIV epidemic. On the other hand, in countries such as Indonesia, Cambodia and Thailand, where transmission is primarily through unprotected heterosexual sex, cases of infection through injecting drug use are steadily on the increase.

With the exception of Singapore, a comparison of six countries in the Southeast Asia region, indicates an overall trend of increasing numbers of women newly infected with HIV. As women represent only a small proportion of drug users (estimated to be 10% in Asia), many of these infections are attributed through heterosexual transmission.



**Figure 1:** Percentage of female HIV cases in six countries in 2002 and 2006 Sources: Various sources<sup>12</sup>



A disturbing key factor driving the Asian epidemic, particularly in the Southeast Asian region, is the overlap of the two main risk behaviours, namely injecting drug use and sex work. China, India, Vietnam, Indonesia and Thailand, are increasingly seeing this trend in their respective epidemics.<sup>13</sup> In these countries, the selling of sex to procure drugs and the high number of IDUs buying sex were common and on the rise. This overlap between injecting drug use and sex work is considered to be an alarming development which is particularly conducive to the rapid spread of HIV in Asia, particularly among women.

Of the 10 million young people living with HIV worldwide, 21% live in the Asia and the Pacific region.

Globally, young people (ages 15-24) represent half of all new HIV cases and a quarter of all people living with HIV under the age of 25.<sup>14</sup> Sixty per cent (60%) of all new infections or an estimated 6 000 young people are infected every day which translates to 1 person every 14 minutes. The majority of these new cases are among women and girls. In South and Southeast Asia, 40% of all young people living with HIV are young women.<sup>15</sup> The rate of HIV infection among girls is rapidly outstripping the rate among boys.

Key factors cited as being responsible for this increase in vulnerability to HIV have included harmful social practices such as gender bias and discrimination, preference for sons, early marriage, female genital mutilation, sexual violence and human trafficking<sup>16</sup>. Women in Asia are also found to know less than men about how HIV is transmitted and how to prevent infection.

Often what they do know is frequently rendered useless by the discrimination and violence they face.

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# **The Malaysian HIV Epidemic**

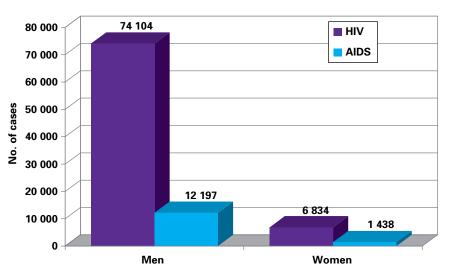
As of December 2007, after more than 20 years into the HIV epidemic in Malaysia, the country has recorded a total of 80 938 persons with HIV since the first reported case in 1986.

Most reported infections occur among young Malay males, and about 75% of HIV and AIDS cases are among injecting drug users. Although HIV prevalence is less than 1% among the Malaysian adult population, it is above 19% among injecting drug users.<sup>17</sup>

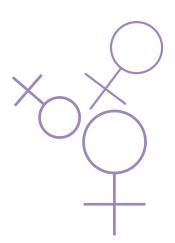
Men represent the majority (92%) of cumulative HIV cases while women and girls account for less than 10% of this total. Currently, cumulative reported cases of HIV transmission has been predominantly through injecting drug use (72.7%), followed by heterosexual intercourse (15.3%) and homosexual or bisexual contact (1.7%)<sup>18</sup>.

The Malaysian epidemic has since 1986 been predominantly male and spread through the sharing of injecting equipment among injectors.

Although the annual new cases of HIV have averaged 5 640 for the past 10 years, the reported number of men newly infected has decreased steadily during this period. Women, on the other hand, have seen a steep increase in the number of new HIV cases. By 2006, women and girls made up almost one fifth of newly infected persons nationwide.



**Figure 2** : Total HIV and AIDS Cases in Malaysia, 1986 – 2007 Source: Ministry of Health



Based on reported available data from the Ministry of Health, most HIV infections among women in Malaysia have occurred through heterosexual intercourse (63.9% in 2002), a large number of who were housewives.

On the other hand, the main mode of male HIV transmission continues to be via injecting drug use where nine out of ten infections are men. Alarmingly, 27.4% of total new reported HIV cases in 2006 as compared to 10.2% ten years ago, were found to be transmitted via the heterosexual route. In 2007, it was 28.9%.

This significant amplification coincides with the rapid incline of new female HIV cases and represents a dynamic which is slowly being seen in the Malaysian epidemic: men continue to get infected with HIV through injecting drug use while women are increasingly contracting the disease through heterosexual intercourse.

Such a significant development requires a comprehensive examination to determine whether the response to the epidemic thus far has taken into consideration the gender dynamics which are present and influencing the spread of HIV. Given the increases in the number of women infected with HIV, there is a special need to address the operational factors which can contribute to women's vulnerability and risk in the Malaysian context.

A review of the reported Ministry of Health surveillance data as of December 2007 was conducted in preparation for this report.

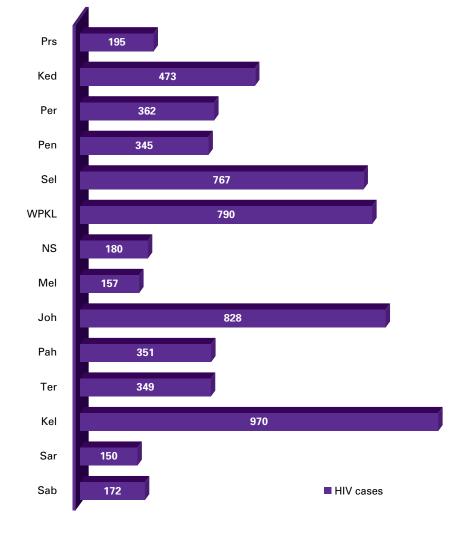
It revealed that in addition to there being an epidemic requiring gender specific interventions which take into consideration the IDU-heterosexual framework, the national response needs to recognise the fact that the Malaysian Peninsular situation is entirely different to that experienced by the East Malaysia states of Sabah and Sarawak.

In the two latter states, it is heterosexual transmission (81.7% and 65.1% of all HIV cases in Sabah and Sarawak respectively) and not injecting drug use which dominates the spread of the epidemic<sup>19</sup>. Interestingly, women represent around a third of all HIV cases in those two states.

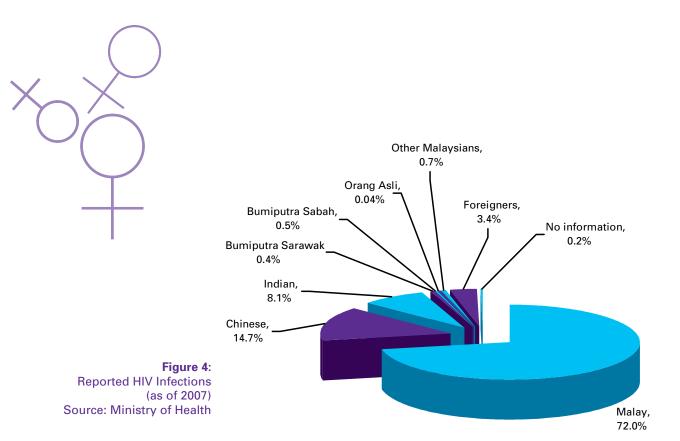
Given the increases in the number of women infected with HIV, there is a special need to address the operational factors which can contribute to women's vulnerability and risk in the Malaysian context.

Cumulative number of HIV infections since 1986	80 938
Cumulative number of AIDS related deaths since 1986	9 487
Women with HIV as of Dec 2007	6 834
Children under 13 with HIV as of Dec 2007	764
New HIV infections detected in 2007	4 549
AIDS related deaths in 2007	1 048
Estimated adult (aged 15-49 years) HIV prevalence	0.4%





**Figure 3:** Women with HIV, 2006 (by states) Source: Ministry of Health



It is necessary to emphasise the need for gender to be mainstreamed into any analysis of the epidemic to better understand how and why HIV affects women and men differently. By ethnicity, the majority of cases comprise Malay men aged 20 to 39 (around 70%). HIV acquired through injecting drug use seems predominant amongst those of Malay and Indian ethnicity.

Chinese Malaysians, on the other hand, appear to be contracting HIV through heterosexual transmission. These three ethnicities form the bulk of people who have contracted the disease thus far.

However, it should be noted that the epidemic has spread into Orang Asli and the indigenous population in East Malaysia (Figure 4). The dynamics of the epidemic in these communities are possibly different and require a better understanding of the risk and vulnerability issues affecting them.

Youth in the age group of 13 to 29 years represent 35.9% of all HIV cases reported in Malaysia thus far. The majority of those in this category are male and injecting drug users. There has been a marked consistent decrease in the number and proportion of persons in this age group reported annually to be newly infected with HIV.

Screening for HIV is widely available both through Government and private facilities and is conducted throughout the country. Data gathered through the Government screening services has resulted in improvements in the overall understanding of the HIV epidemic in Malaysia. Table 2 indicates the routine testing conducted on selected groups of the population through Government healthcare facilities, forming the bulk of the HIV and AIDS statistics reported to the Ministry of Health. As HIV cases are confined primarily amongst certain sub-populations (e.g. injecting drug users) with prevalence being higher than 5% and the general prevalence being less than 1%, Malaysia is termed by the World Health Organisation (WHO) as experiencing a concentrated epidemic.<sup>20</sup>

Gender disaggregated data and analysis is needed to examine the epidemic in Malaysia, particularly when understanding women and girls' vulnerability to HIV. The responses, experiences and the burden of disease are different for men and women. Therefore it is necessary to emphasise the need for gender to be mainstreamed into any analysis of the epidemic to better understand how and why HIV affects women and men differently.

- Women receiving antenatal care in Government facilities
- Blood donors
- Inmates of drug rehabilitation centres
- High-risk prison inmates (drug users, drug dealers and sex workers)
- Confirmed tuberculosis cases
- STD cases
- Patients with suspected clinical symptoms
- Traced contacts of confirmed infected persons

Table 2:Routine HIV testingSource: Ministry of Health, 2007

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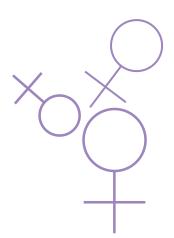


# OVERVIEW: THE FEMALE HIV EPIDEMIC IN MALAYSIA

# FEMINISATION OF THE MALAYSIAN HIV EPIDEMIC

Women remain one of the fastest growing populations being infected with HIV in Malaysia. Although the proportion of women and girls reported to have been infected with HIV remains less than 10 percent as of December 2007, the past five years have seen dramatic increases in the number of new cases documented amongst women. From the first reported case of HIV in 1986, the face of the Malaysian epidemic has been predominantly male and intimately related to the risk behaviours associated with drug use, especially among those utilising injecting equipment.

Different variations and interpretations of the above figure have been used to describe the HIV and AIDS epidemic in Malaysia. However, what are less common are figures and analysis conducted and interpreted from a gender perspective. When done so, it can be seen that undoubtedly the Malaysian HIV epidemic is evolving and that the profile of those newly infected and affected is slowly changing.



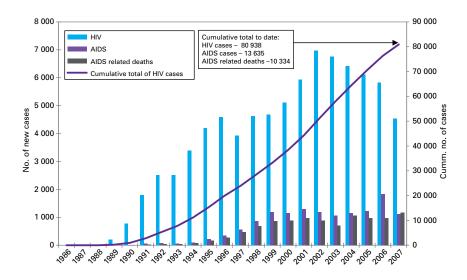
Since 2002, the epidemic has in fact seen a gradual decrease in new annual HIV cases as shown in Figure 5. Though an average yearly decrease of 4.35% has been observed in the reported numbers for the past five years, the incidence profile has slowly shifted from male to increasingly becoming female in nature. This change is reflected in the alarming development observed in the composition of new HIV cases: the number of women and girls newly infected with HIV increased by 39% from 629 cases in 2002 to 875 in 2006 which in itself represents a jump of 344% from the 197 new cases seen in 1997. Meanwhile, the number of reported AIDS cases amongst women also increased by 78% within the 2002 – 2006 period.

By December 2007, a total of 6 834 women were reported to have been infected with HIV compared to 74 104 men, while 1 438 cases of AIDS and 847 AIDS related deaths were also seen amongst women and girls. The trend of increasing numbers of women and girls newly infected with HIV can be clearly seen in Figure 6 which indicates that this movement is increasingly rapid and rising steeply.

After 20 years of the HIV epidemic in Malaysia, the female side of the equation remains unclear and often subjected to interpretations which confuse the predominantly male-IDU driven scenario with the epidemic as experienced by women. This has led to generalised statements such as 'women are only a small percentage of HIV and AIDS cases' and 'sexual transmission account for a small proportion of HIV-positive cases'. Although statistically true, such statements would undermine the response to address the epidemic amongst women on account of the narrow and non-gender specific focus.

It can also be observed that beginning from 2001, the proportion of new HIV cases reported amongst men began to steadily decrease while those amongst women rose (Figure 7).

After 20 years of the HIV epidermic in Malaysia, the female side of the equation remains unclear.

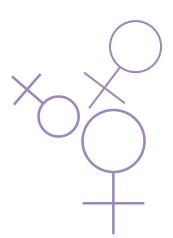




Year	HIV Infection			AIDS Cases		
Tear	Male	Female	Total	Male	Female	Total
1986	3	0	3	1	0	1
1987	2	0	2	0	0	0
1988	7	2	9	2	0	2
1989	197	3	200	2	0	2
1990	769	9	778	18	0	18
1991	1 7 4 1	53	1 794	58	2	60
1992	2 443	69	2 512	70	3	73
1993	2 441	66	2 507	64	7	71
1994	3 289	104	3 393	98	7	105
1995	4 037	161	4 198	218	15	233
1996	4 406	191	4 597	327	20	347
1997	3 727	197	3 924	538	30	568
1998	4 327	297	4 624	818	57	875
1999	4 312	380	4 692	1 114	86	1 200
2000	4 626	481	5 107	1 071	97	1 168
2001	5 472	466	5 938	1 188	114	1 302
2002	6 349	629	6 978	1 068	125	1 193
2003	6 083	673	6 756	939	137	1 076
2004	5 731	696	6 427	1 002	146	1 148
2005	5 383	737	6 120	1 044	177	1 221
2006	4 955	875	5 830	1 620	222	1 842
2007	3 804	745	4 549	937	193	1 130
TOTAL	74 104	6 834	80 938	12 197	1 438	13 635

Table 3:

No. of New HIV and AIDS Cases Per Year in Malaysia, 1986 –2007 Source: Ministry of Health



The proportion of reported new HIV cases attributed to women can be seen to have steadily increased each year.

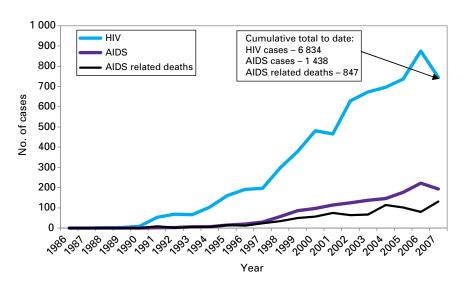
Only ten years ago, men accounted for more than 96% of new HIV cases. However, as can be observed from the incline depicted in Figure 7, from 4.15% of all female HIV cases reported in 1996 to 15.01% in 2006, this increase of 262% represents an alarming trend in new infections occurring each year which is strongly linked to women. In 2007, it was 16.4%. By the end of 2006, the Ministry of Health recorded the highest numbers of reported incidences of new infections with 875 HIV and 222 AIDS cases among adolescent and adult women in Malaysia.

Based on these official statistics from the Ministry of Health, in the past 10 years alone, women have moved from those least affected by HIV to those in whom the disease is spreading fastest.

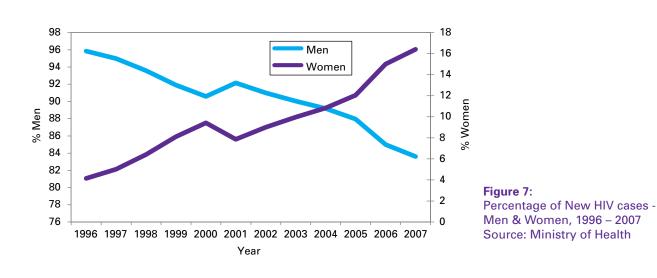
Eight out of the 13 states in Malaysia have reported increases between 7.5% (Kedah) and 205% (Pahang) in the number of new reported cases among women. On the other hand, Perlis, Penang, Johor and the Federal Territory of Kuala Lumpur recorded decreases between the year 2002 and 2006. However, Kelantan, Kuala Lumpur and Selangor remain the top three regions where HIV amongst women is highest compared to the other states recorded in 2006. Kelantan, with a cumulative total of 970 reported female cases of HIV, is the state with the highest number of women found to be infected since 1986.

When segregated according to occupation, a Ministry of Health HIV and AIDS report for 2002 indicated that the majority of women detected with HIV in that year were found to be housewives (26.3%), followed by industrial workers (4.1%), sex workers (2.8%), private sector workers (2.0%), government servants (1.8%) and students (1.0%)<sup>21</sup>. In some states, HIV was found to have been mainly acquired by those previously thought to be least likely to be infected, namely housewives. In states such as Johor, this group of women form the majority of female cases seen in this state.

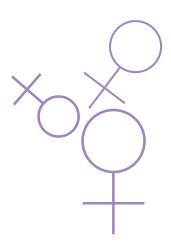
In the past 10 years alone, women have moved from those least affected by HIV to those in whom the disease is spreading fastest. There have been cases of women with HIV and AIDS reported from all states and territories in Malaysia. Out of the 6 834 women in Malaysia who have acquired HIV since 1988, 59% were reported between 2002 and 2006. The same period also saw 65% of all reported female AIDS cases and 59% of AIDS-related deaths amongst women and girls. A reduction in the ratio of infected males to infected females can also be observed from the reported data: from 10:1 in 2002 to 5:1 in 2006.







33



Women in Malaysia infected with HIV (as of Dec 2007):	6 834
No. of women who developed AIDS:	1 438
No. of women who have died due to AIDS related complications:	847
No. of women newly infected with HIV each day	2

Based on reported figures from the Ministry of Health

# From injecting drug use to heterosexual transmission

Worldwide, heterosexual intercourse is the most common mode of HIV transmission. In South and Southeast Asia, injecting drug use and heterosexual contact are the main transmission routes seen.<sup>22</sup> Based on the reported Ministry of Health data, there are two main modes of transmission which can be observed to be prevalent in Malaysia, namely:

- · Injecting drug use
- · Heterosexual intercourse

There is no doubt that, for the moment, injecting drug use remains the predominant mode of HIV transmission in Malaysia. The majority of reported HIV cases are among individuals whose infection has been attributed to the use and sharing of contaminated needles in injecting drugs.

Nevertheless, there are clear indications that transmission through sex is becoming a major factor in the present and future evolution of the country's epidemic. Figure 9, demonstrates a clear trend from 2001 when fewer annual cases attributed to the IDU route were detected. However, the proportion of heterosexually acquired cases can be observed to have steadily and consistently increased.

Heterosexual transmission now accounts for nearly a third of newly reported HIV cases in Malaysia.

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As of December 2007, HIV transmission attributed to heterosexual intercourse constitutes 16.1% of overall cases of the disease. However, this same year saw the significant increase of newly infected cases acquired through heterosexual contact from 17.5% in 2002 to 27.4% in 2006 and 28.9% in 2007. Heterosexual transmission now accounts for nearly a third of newly reported HIV cases in Malaysia.

An examination of the HIV and AIDS data from each state in Table 4 reveals that there are two main trends of HIV infection occurring in Malaysia. The majority of states have IDU driven epidemics but a number have heterosexual transmissions either equally contributing or leading HIV infection. States like Sabah and Sarawak have reported 76.1% and 87.8% of their HIV cases respectively being transmitted through this route in 2006.

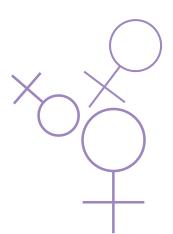


A Ministry of Health report in 2003, reported that for 2002, 63.9% of cases seen amongst women for that year were acquired through heterosexual intercourse.<sup>23</sup>

State	Adults & children with HIV and AIDS	Newly infected (2006)	Cumulative Female %	Main modes of transmission	Hetero % (2006)
Perlis	1 033	53	18.9	IDU, Hetero	43.3
Kedah	4 956	508	9.5	IDU, Hetero	19.5
Perak	5 032	308	7.2	IDU, Hetero	29.9
Penang	3 016	228	11.4	IDU, Hetero	53.5
Selangor	10 317	866	7.4	IDU, Hetero	19.2
WP KL	5 970	921	13.2	IDU, Hetero	16.0
N. Sembilan	6 152	109	2.9	IDU, Hetero	30.3
Melaka	2 356	94	6.7	IDU	6.4
Johor	13 251	594	6.2	IDU, Hetero	17.0
Pahang	7 878	549	4.5	IDU	13.5
Terengganu	7 308	374	4.8	IDU	9.6
Kelantan	7 876	998	12.3	IDU, Hetero	15.1
Sarawak	665	113	22.6	Hetero	76.1
Sabah	579	115	29.7	Hetero	87.8
TOTAL	76 389	5 830	8.0	-	15.3

Table 4:

Main modes of HIV transmission according to states, Dec 2006 Source: Ministry of Health



Three out of every five cases of women found to be with HIV contracted it through this form of sexual contact, while injecting drug use was 20% and other risk factors were 16%. The same report indicated a dynamic of the female scenario seen in Malaysia when viewed from an ethnic perspective – showing that the majority of cases were among Malay women (54.8%) who acquired HIV mainly through heterosexual contact (56%). For each of the two other main ethnic groups in the country, namely Chinese and Indians, this mode of transmission was responsible for the majority of female cases seen in their respective communities.

The proportion of female cases for 2002 via heterosexual contact and through injecting drug use were found to have both increased significantly from the previous year.

As part of the prevention of mother-to-child-transmission (PMTCT) programme in 2002, antenatal screening conducted with almost 360 000 pregnant women detected 141 individuals with HIV, 86% of whom were found to have acquired HIV through heterosexual contact.

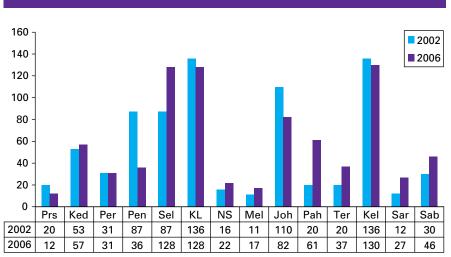
The overlap between the two main risk behaviours, injecting drug use and sex work, first mentioned in the earlier section is certainly occurring in the country.

Anecdotal information from community-based organisations, clinicians and studies conducted in the field are indicating that injecting drug users are engaging in sex or providing sexual services. To what extent and scale it is occurring is currently unclear.

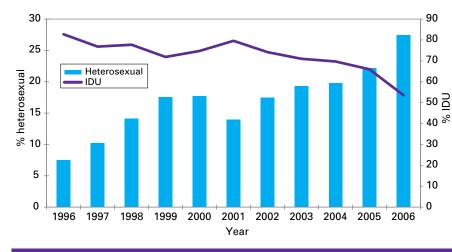
There is currently a dearth of studies aimed at identifying the behaviour of the vast majority of injectors, particularly data to indicate whether drug users are sexually active. As a result, a common belief is prevalent amongst a number of Government agencies, law enforcement and non-government organisations engaged in the rehabilitation of drug users, that a drug user is thought to be less likely to engage in sexual activities.

However, a study conducted in 2007 amongst female sex workers, which is discussed in a later section of this report, indicated that drug use and the practice of sharing needles were prevalent in this population.<sup>24</sup> Female injectors were also found to be selling sex to finance their drug use.

Female injectors were also found to be selling sex to finance their drug use.

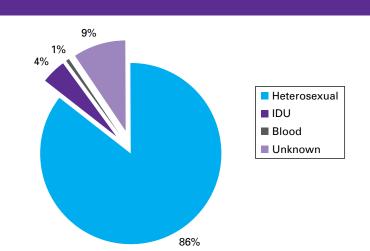




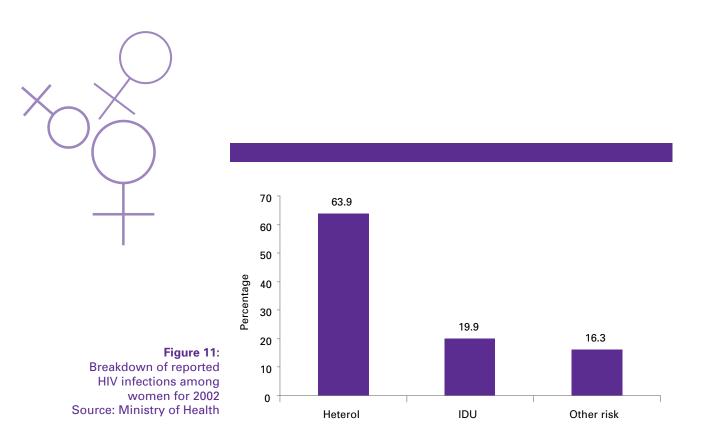


#### Figure 9:

Comparision of HIV transmission cases between heterosexual & IDU categories, 1996 – 2006 Source: Ministry of Health



**Figure 10:** Transmission factors - pregnant women with HIV, 2002



These observed trends reflect an alarming rate of HIV infection amongst women via heterosexual transmission which differs from that of the men. The main mode of male transmission is via intravenous drug use.<sup>25</sup> Although, more men are currently infected than women, this masks the fact that the proportion of women, who are predominantly acquiring HIV through heterosexual intercourse, continues to grow rapidly and consistently each year.

- 21. Ministry of Health (2003). *Report to the Director General AIDS/ STI Unit.*
- 22. UNAIDS (2006). op. cit. (see reference 2)
- 23. Ministry of Health (2003). *Report to the Director General AIDS/ STI Unit.*
- 24. Khartini Slamah (2007). *Report on HIV/AIDS and Female Sex Workers in Malaysia.* May 2007
- 25. World Health Organisation (2004). Consensus Report on STI, HIV and AIDS Epidemiology – Malaysia

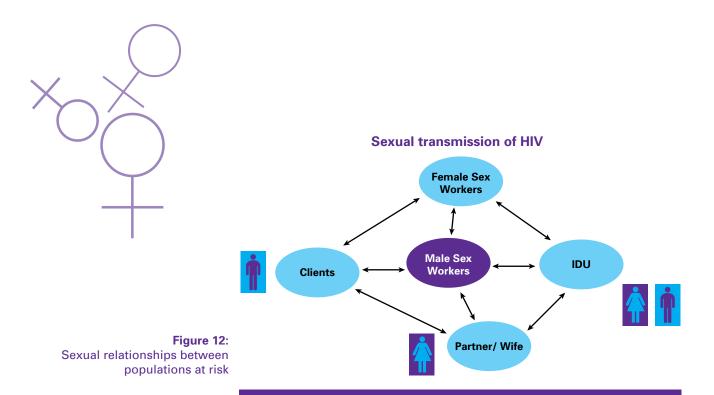




## WOMEN AND GIRLS IN MALAYSIA EXPERIENCING HIV AND AIDS

In Malaysia, though the general picture of the epidemic is largely concentrated around specific populations groups such as drug users, women experience HIV and AIDS in many different circumstances and environments other than as injectors.

Together with biological factors which render women 2-4 times more at risk than men of HIV infection through unprotected sexual intercourse and vulnerabilities brought about by socioeconomic circumstances, both must also contend with circumstances which have complicated the overall understanding and response to the HIV epidemic.<sup>26</sup>



A male IDU has unprotected sexual intercourse with his wife while purchasing sex elsewhere with drugs or money. There is an overall low level of reported condom use in each of these interactions. These circumstances can be seen as increasingly complex and intertwined relationships with different populations at risk interacting and possibly, infecting each other. In the development and implementation of HIV and AIDS interventions, it is no longer possible to address specific populations individually without consideration of intervening factors such as the overlapping of risk behaviours involving injecting drug use and sex work amongst the groups, which is of major concern in Asia.<sup>27</sup> Figure 12 illustrates a dynamic increasingly observed in several sites in the Klang Valley as well as Northern and East Coast states. Male and female drug users have been reported selling sex for money and to procure drugs.<sup>28</sup> They also share injecting equipment with other male and female injectors. A male injecting drug user (IDU) has unprotected sexual intercourse with his wife while purchasing sex elsewhere with drugs or money. There is an overall low level of reported condom use in each of these interactions. Studies have shown that these populations are vulnerable to each other through risk behaviour such as unprotected sexual intercourse and the sharing of injecting equipment.

Future interventions must anticipate and take into account these different levels of complexity and to respond accordingly. One such example would be that a needle and syringe exchange programme with injectors would also need to distribute and make condoms widely and easily accessible to its constituents to address the issue of unprotected sexual intercourse with injectors.

### As drug users

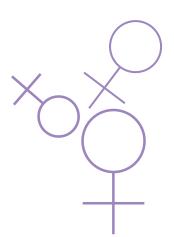
Injecting drug use has long been seen as being responsible for the spread and in some countries, the dramatic exacerbation, of the HIV epidemic in Asia. Coupled with the fact that 25% of the estimated 13 million injectors worldwide live in this part of the world, there is an urgent need to further understand how women and girls fit into this predominantly male population where 10% are female.<sup>29</sup> Although women represent a small segment of the Malaysian profile of drug users (around 2%), they remain an unknown quantity.

In 2006, 3 127 new cases of HIV amongst IDUs were detected, bringing a reported cumulative total of 52 407 persons from this community with this disease. In that same year, 13 058 drug users were newly detected by the National Anti-Drug Agency. Around 2% or 300 were female. However, due to the lack of available gender desegregated data, it is not known how many of those IDUs found to be with HIV were women. The cumulative number of IDUs infected with HIV who are female is also not known. The last relevant report containing this information was in 2002 where 64% of women reported with HIV were attributed to injecting drug use.<sup>30</sup>



692 (2%) 667 (2%) 300 (2%) 37 980 (98%) 2004 2005 2006 Men Women

Figure 13: Gender profile of drug users in Malaysia, 2004 - 2006 Source: Drug Report 2006, NADA 2006



According to the National Anti Drugs Agency in 2007, there were 654 inmates living with HIV in its drug rehabilitation centres (DRC) nationwide.<sup>31</sup> However, official data indicating the number of women who are infected with HIV and in these DRCs is unavailable.

A study conducted in 1996 by the Science University of Malaysia (USM) amongst 172 female inmates of a DRC found 14% to have acquired HIV, while 83% of them were found to be infected through injecting drug use.<sup>32</sup>

From anecdotal information, male injectors have been found to share injecting drug equipment to establish or strengthen existing relationships with their female partners. Needles are also shared between sex workers and clients who pay for sexual services with drugs. In these conditions, needles and syringes are commonly shared multiple times while condom use is low and infrequent.

The overall situation and status of the wives and sexual partners of injecting drug users found to be with HIV is also unknown.

There is currently a dearth of studies aimed at clarifying the behaviour of the vast majority of injectors, particularly data to indicate whether drug users are sexually active. A common belief is prevalent amongst a number of Government agencies, law enforcement and non-government organisations engaged in the rehabilitation of drug users, that a drug user is thought to be less likely to engage in sexual activities. However, a report by the Cabinet Subcommittee for the Treatment and Rehabilitation of Drug Users of a study conducted in 1998, stated that 77.6% of IDUs at drug rehabilitation centres were sexually active.<sup>34</sup> This study which involved 6 326 inmates of these centres also indicated that only 18.7% used a condom during sex.

A Behavioural Surveillance Survey (BSS) conducted with 100 IDUs in Kuantan, Pahang indicated that 37% of respondents had had sex in the last month; 15% had bought or sold sex in the last month; and 12% of the men had purchased or sold sex.<sup>35</sup> All of the female respondents involved in the survey had bought or sold sex.

Female drug users often lack personal power and skills, experience a lack of community support and access to health care and social services.<sup>33</sup>

44

A recent study in 2007 conducted amongst female sex workers also indicated that drug use and in particular, the sharing of needles was prevalent in this population<sup>36</sup>. Almost 20% of female respondents of the BSS conducted by the Ministry of Health amongst commercial sex workers in 2004 reported using drugs in one form or another, 16% of whom indicated that they had injected. Despite these results, no specific comprehensive study has yet been conducted to gauge the scale and degree of interaction between sex workers and injecting drug use, as well as drug users being involved in paid sex as clients or service providers.

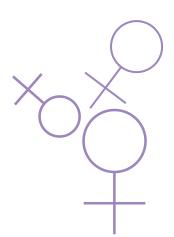
It is possible for there to be further female cases of HIV yet unseen as many female IDUs stay secluded and rely on the male partner to source for drugs. Women and girls as drug users face tremendous social stigma, discrimination and shame which are worsened by occurrences of sexual violence and mistreatment, domestic violence and spousal abuse, human trafficking and lower social status.<sup>37</sup> These circumstances make it less likely for them to seek information, education, and healthcare services, which increase their risk and exposure to HIV infection.



The number of reported HIV and AIDS cases amongst women categorised in the Ministry of Health's database as housewives, consistently increase each year.

Though only 5.6% of newly infected cases of HIV seen in 2006 were housewives, the past five years have seen an average of almost 300 new cases each year in this category. The end of December 2007, saw this proportion increase to 7.3%. Statistics from 2004 indicated that 44% of all women reported with HIV were housewives.<sup>38</sup> As of December 2007, 70% of the total 2 438 women from this category were reported having acquired HIV within the past five years, while an average of 28 new cases were reported each month in 2007.





many of these new infections were in married monogamous women. It is likely that infection occurred via their sposues. More often than not, they are housewives who are unaware that they are at risk of being exposed to HIV. When the number of those infected from this group is compared to that of sex workers, a population considered being at risk and more vulnerable to infection, it can be seen that almost five times the number of housewives were acquiring HIV as compared to that of sex workers during the past five years. The increase in HIV cases through heterosexual transmission in several states have been seen as warning signs indicating that more housewives could be at higher risk of acquiring the virus from their husbands.

It is commonly thought that housewives are at low risk of infection. However,

Sabah and Sarawak, whose epidemics are predominantly driven by heterosexual transmission, saw it necessary to raise public attention to this issue given the nature of the epidemic being different from that of Peninsular Malaysia.<sup>39</sup> Studies conducted with the wives of fishermen in three villages in Terengganu also found them to be extremely vulnerable to infection.<sup>40</sup>

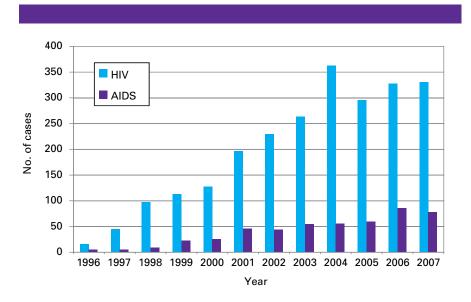
HIV numbers among housewives are seen highest in the states of Kedah, Terengganu and Kelantan, where each has recorded more than 200 cases thus far.<sup>41</sup> As of December 2007, Kelantan reported 379 cases detected amongst housewives, making it the highest recorded in Malaysia. In Johor, it is estimated that 90% of HIV cases detected amongst women and young girls in that state are Malay housewives.

A 2006 study conducted among 130 respondents to understand the impact of HIV on People Living with HIV (PLHIV) and their families found that women who acquired their infection from their husbands were badly affected economically.<sup>42</sup> The loss of the sole income earner in the family, usually the husband, due to death or incapacitation related to AIDS, resulted in housewives having to assume the head of household, breadwinner, single parent and possibly carrying the burden of caring for sick family members. This situation becomes increasingly distressed when the women are themselves sick and are unable to continue to work or care for the family.

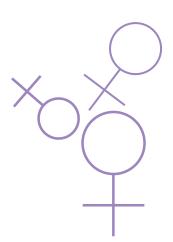
The increase in HIV cases through heterosexual transmission in several states have been seen as warning signs indicating that more housewives could be at higher risk of acquiring the virus from their husbands. A trend observed occurring amongst rural populations is the increase in the number of households headed by women.<sup>43</sup> The 8th Malaysian Plan reported almost 20% of such rural households being in poverty which makes them more vulnerable to risks and circumstances associated with HIV infection such as sex work.<sup>44</sup>

Although there has been much progress in the empowerment of women in Malaysia (high literacy rate, access to education, labour participation in most industries, etc), women generally continue to face the challenge of protecting themselves and their families from HIV due to their subservient roles in relationships. This dynamic, together with the lack of awareness and knowledge of HIV and AIDS, create immense vulnerabilities. In many ways, female sex workers are able to better protect themselves compared to housewives as they are better positioned and have the opportunity to negotiate the use of condoms during sexual intercourse.





**Figure 14**: New HIV and AIDS cases amongst housewives, 1996 – 2007 Source: Ministry of Health



Screening results from the antenatal HIV testing programme suggest that an increasingly large proportion of married women are being infected by husbands who are practicing risky behaviour which exposes them to possible infection.

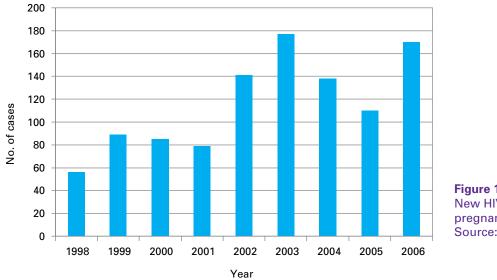
### As pregnant mothers

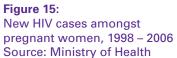
Piloted in 1997 and later deployed nationally in 1998, antenatal HIV testing programmes were established by the Ministry of Health targeting at the screening and treatment of pregnant mothers with HIV to prevent mother-to-child transmission (MTCT). Pregnant women who visit Government antenatal clinics are tested for infection (voluntary as an "op-out" option) and those found HIV-positive are offered counselling and anti-retroviral (ARV) treatment. More than 70% of antenatal mothers are estimated to seek medical care at Government clinics.<sup>45</sup> Mothers who participate in the programme receive this treatment for free throughout their pregnancy (antenatal and intra-partum) and for life. Their newborn babies are also put on treatment and given regular tests for HIV.

As of December 2006, this nationwide programme has detected 1 045 cases of HIV out of almost 3 million women screened (0.035%). With almost all pregnant women attending antenatal clinics being screened for HIV, it can be observed from Table 5 that HIV prevalence within this population remains around 0.04. However, it is disturbing to note that this figure has increased since 2000. Table 5 seems to indicate that more pregnant women have been detected with HIV since the inception of the programme, which could mean that the programme has achieved better and improved coverage or that more women in Malaysia are becoming infected with HIV.

Heterosexual transmission was the main reported cause of infection amongst HIV infected pregnant mothers with 86% of cases being attributed to this route in 2002. Data from this year also indicated that most of these women were of Malay ethnicity, between 20 – 29 years old, pregnant for the first time (primigravida) and contracted HIV through heterosexual intercourse.<sup>46</sup> A third of the men whose partners or wives attributed their infection to sex refused to be tested for HIV. Unfortunately, screening results from the antenatal HIV testing programme suggest that an increasingly large proportion of married women are being infected by husbands who are practicing risky behaviour which exposes them to possible infection.

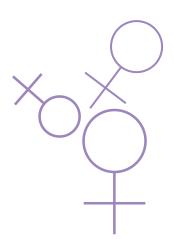
Three elements constitute an effective prevention of MTCT: preventing infection in women of reproductive age; preventing unwanted pregnancies in women with HIV; and offering MTCT prevention interventions to women who are both with HIV and pregnant.<sup>47</sup>





	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total no. of pregnant women attending government antenatal clinics	323 902	416 400	347 979	392 139	387 208	374 386	386 037	375 785	385 976
No. of pregnant women screened for HIV	161 087	276 000	286 390	343 030	359 411	361 152	377 016	373 048	384 027
Percentage	49.7	66.2	82.3	87.5	92.8	96.5	97.7	99.3	99.5
No. of pregnant women detected with HIV	56	89	85	79	141	177	138	110	170
Percentage	0.035	0.032	0.029	0.023	0.039	0.049	0.037	0.029	0.044

Table 5:Antenatal HIV Screening inMalaysia, 1998 – 2006Source: Summary of HIV andAIDS Cases, Ministry of Health



In the prevention of mother-to-child transmission, this programme has been considered a resounding success with less than 5% of infants born to mothers with HIV becoming infected. The commonly used protocol in this intervention involves the administration of AZT (Zidovudine) throughout the 2nd trimester and followed by elective Caesarean section performed on the mothers to prevent transmission during labour.<sup>48</sup> The infant is later given AZT for six weeks.

The first two elements remain significant challenges which are not currently addressed through the MTCT programme in its existing form. The current focus of the interventions is on preventing infection being transmitted to the infant.

A number of cases have been cited where widows or women divorced by their husbands had to resort to commercial sex as a result of the loss of rights such as the right of inheritance to their husbands' property.

#### As sex workers

As of December 2007, 482 women working as sex workers were detected with HIV, representing 0.6% of the cumulative total of 80 938 persons with the disease. Only 25 out of 4 549 cases (0.5%) were detected to be in this category for the whole of 2007.

Very little is known of the Malaysian sex industry and the scenario shown in Figure 16 relies on HIV screenings conducted in detention institutions or police raids.<sup>49</sup> This limitation severely restricts the ability to respond and provide services such as testing and medical treatment for HIV.

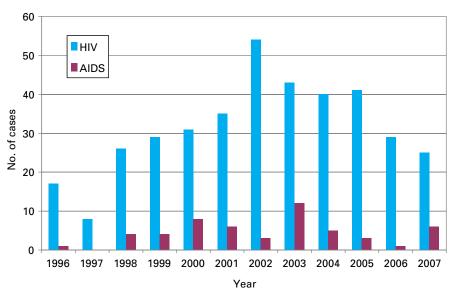
An ILO report published in 1998 estimated that Malaysia has a sex industry which comprises up to 150 000 individuals.<sup>50</sup> The majority are sex workers who sell sex and are mostly women. Male, transgender and child sex workers are also present in the industry.

The other components of the sex industry are the owners, managers, pimps and other employees of the sex establishments, as well as various components related to the entertainment and tourism industry. Indirect sex workers, individuals who do not operate as sex workers in a brothel, may provide sexual services in settings such as hair salons, karaoke lounges, nightclubs, hotels, bars and massage parlours.<sup>51</sup>

Entry into sex work by local women appears to be mostly a voluntary decision.<sup>52</sup> However, half the respondents of a discussion with 12 sex workers cited difficult economic circumstances and options which were limited by their educational background and family status.<sup>53</sup> A number of cases have been cited where widows or women divorced by their husbands had to resort to commercial sex as a result of the loss of rights such as the right of inheritance to their husbands' property. In the case of already marginalised women such as undocumented migrants, sex work for money or favours becomes a way to survive.

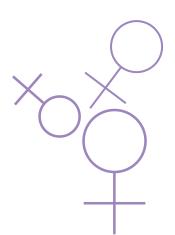


A survey among 2 000 sex workers conducted by the Ministry of Health in 1996 identified HIV prevalence of 6.3% for this population. However, a HIV prevalence survey conducted later in 2000 indicated that the rate observed that year was 11.5%.<sup>54</sup> However, female sex workers were found to not infect one another with HIV unless they were also IDUs and sharing needles.



**Figure 16:** New HIV and AIDS cases female sex workers, 1996 – 2007 Source: Ministry of Health

51



The Behavioural Surveillance Survey (BSS) conducted by the Ministry of Health in 2004, indicated that though almost 20% of female sex workers had used drugs, only 2.9% had injected drugs.<sup>55</sup> It is their clients or partners who are more likely to infect them with HIV through unprotected sexual intercourse. Once infected, they are likely to pass the infection on to other clients who do not use or incorrectly use condoms.

Despite surveys indicating high levels of HIV and AIDS knowledge and awareness amongst female sex workers, it is not enough because a change in attitude and behaviour still needs to happen. There are some sex workers and many clients of sex workers who refuse to wear condoms. More than 40% of respondents in the BSS with female sex workers indicated infrequent (once in a while, seldom and never) use of condoms during sexual intercourse.<sup>56</sup> However, the client's refusal to wear a condom was cited as the predominant reason for the absence of protective measures being used. Some sex workers also appear to not be asking clients to use condoms, expecting them to refuse or fearing the loss of the client.<sup>57</sup> Insistence on condoms could lead to sexual violence or abuse by the client.

Any intervention working to prevent HIV infection in the sex sector must acknowledge and address this dynamic. Merely focusing on female sex workers as the supply side of sex work is insufficient as the unequal power relations and lack of bargaining power obstructs any intervention (i.e. condoms) which requires the client's participation. Women and girls in this industry are unprotected from HIV infection unless they are aware of the repercussions and, at the same time, their clients agree to using condoms. The clients of sex workers must be included in any intervention.

There have been many cases of foreign women and girls being involved in sex work in Malaysia. A significant number of these women were victims of human trafficking syndicates.<sup>58</sup> Many are deceived into coming into the country with promises of lucrative jobs; upon arrival, their travel documents, passports and personal documentation are confiscated by syndicate operators. Very few HIV interventions reach them and their situation is unknown.

Some sex workers also appear to not be asking clients to use condoms, expecting them to refuse or fearing the loss of the client. Insistence on condoms could lead to sexual violence or abuse by the client.

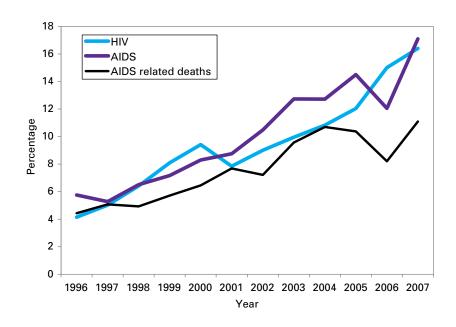
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### As HIV-positive women

At the start of 2008, Ministry of Health data indicated that 6 834 women and girls were reported to have acquired HIV since 1986 and that there were 1 438 AIDS cases. What can clearly be seen from the available reported data is that the number of women and girls becoming HIV-positive is increasing on a yearly basis and are gaining a greater share of the HIV population in the country.

Due to the lack of research conducted in this area, not much is known of these women, their issues and how the disease affects their families. Understanding how women living with HIV in Malaysia experience this disease is still limited to newspaper articles and anecdotes from patients to attending physicians. However, recent studies done to evaluate the impact of HIV and AIDS on people and communities in Malaysia living with the disease have underlined key issues which are no different to those experienced by women and their families elsewhere around the world, in parts of Asia such as Cambodia and Thailand, as well as in Africa.

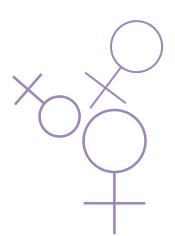
Generally, studies involving people living with HIV (PLHIV) including positive women, report having good access to regular and either fully or partially subsidised healthcare services and medical care from Government hospitals.<sup>59</sup>





53

**Figure 17:** Percentage of Yearly HIV, AIDS Cases and AIDS Related Deaths -Women, 1996 – 2007 Source: Ministry of Health



Though occasionally faced with episodes of discriminatory practices (e.g. admonishment from nurses for getting pregnant with a HIV infected husband or doctors avoiding physical contact) from healthcare personnel, the broad view is that accessing and obtaining relevant and quality healthcare and treatment is less of a problem for women living with HIV in Malaysia.

However, the question of treatment affordability, though much reduced as compared to as recently as three years ago (currently between RM 350 to RM 2 000 monthly according to treatment protocol), remains a daunting one especially with issues such as the loss of employment affecting the ability to afford treatment.

Though real obstacles remain such as the need to travel considerable distances to access these services in Government hospitals located in urban centres and far from rural areas, high quality HIV treatment and counselling are available and accessible for much less than what it would cost in developed countries. In a number of cases, the facility and availability of counselling at Government hospitals have made major contributions to enabling families to understand and to accept their individual situations and so stay together.

PLHIV, especially women and girls, are more likely to continue to shy away from relationships and disclosure of their HIV status, fearing rejection from families and friends. Women may be blamed for bringing AIDS into the house. Those known or thought to have HIV may be evicted, ostracised, dismissed from work, beaten or even killed. This often results in them going 'underground' or suffering alone.<sup>60</sup> Abandonment of PLHIV by family members or being left to face death alone has been a commonly reported occurrence which has spurred the initiation and development of individual support groups and related non-government organisations (NGOs).

There are currently more than 15 NGOs in the country (mostly urban-based) offering information and counselling, basic medical treatment, shelter care and support for people living with HIV. Organisations such as Persatuan Perantaraan Pesakit-Pesakit Kelantan (SAHABAT) and Intan Drop-In Society often see a large percentage of their clientele being women and girls living with HIV. Several NGOs also offer a secure environment for affected women to support each other and share experiences.<sup>61</sup>

PLHIV, especially women and girls, are more likely to continue to shy away from relationships and disclosure of their HIV status, fearing rejection from families and friends. Women may be blamed for bringing AIDS into the house. In states such as Kelantan where women and girls are heavily affected by the epidemic, establishment of support groups have led to large numbers of women living with HIV working to support each other.<sup>62</sup> Organisations such as Rumah Solehah have successfully provided medical, emotional and social support to single mothers and their children living with HIV who have been shunned by their families. Success stories abound with many of these women being reunited with their families and communities, becoming self sufficient and independent.

The effects of stigma and discrimination are particularly significant with the death of the male partner leaving women solely responsible for households infected and affected by HIV and AIDS. The ability to maintain the integrity and stability of the family becomes dependent on being able to obtain and retain a source of income. Many PLHIV face issues of stigma and discrimination as a result of disclosure of their status in places of employment, such as being forced to resign and unable to secure a job as few employers would hire a person with HIV.

The loss of income as a result of this practice of discrimination deprives the person with HIV of the ability to support the family, afford treatment or even be healthy. This causes a vicious cycle which results in the deterioration in the health of the individual, depriving him or her of the capacity to seek work.<sup>63</sup> Women and girls living with HIV who are also single parents or heads of households are particularly vulnerable in such circumstances often leading to their involvement in sex work to provide income for the family.

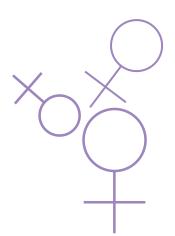
There is a need to further acknowledge and strengthen the concerns of women and girls living with HIV in Malaysia in advocacy agendas, programmes and research.

#### As young people

Globally, 6 000 young people aged 16 to 24 years are newly infected with HIV each day.<sup>64</sup> These individuals account for half of all new HIV infections, two-thirds of which are female.



55



Girls and young women are highly vulnerable to HIV infection and STI due to biological, economic and cultural factors.<sup>65</sup> Their reproductive organs are immature and more likely to tear during intercourse. The high social value placed on virginity in unmarried young women and girls often ensures that they are kept ignorant about sexual matters.<sup>66</sup> Girls are expected to be naive and "innocent" to maintain a virginal façade. As a result they often lack basic information and services to protect themselves.

It may be seen as immoral or promiscuous to inquire as to the subject of sex. Due to their low status in society by both gender and age, young women and girls continue to lack negotiating power which puts them at risk of sexual exploitation and violence.

Young women and girls in Malaysia are not exempted from such circumstances and often face similar situations in everyday life which makes them vulnerable to HIV infection.

Most HIV infections in Malaysia are reported to occur among young Malay heterosexuals, and about 75% of HIV and AIDS cases are among injecting drug users. A total of 29 859 persons below the age of 29 years constitute 36.9% of the cumulative total of all persons reported with HIV. They represent the younger and most productive section of the country's population. Around 50% of Malaysia's population is below the age of 24 years.<sup>67</sup>

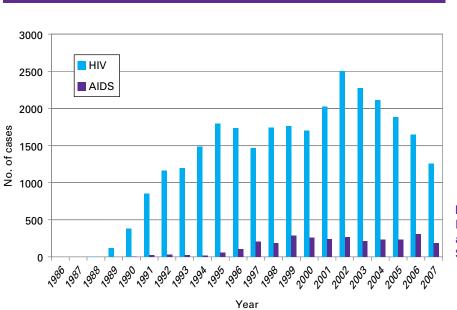
The proportion of newly infected HIV cases each year amongst youth aged below 29 years has consistently been around 30 – 35%. However, the past five years have seen a consistent drop in the number of HIV cases in the 13 to 29 years age group as seen in Figure 18. This closely coincides with the drop in reported IDU related HIV transmission during the same period as the profile of drug users in Malaysia indicates that 70.4% of them are of this age group and 97.7% are male.<sup>68</sup> Currently unknown is the status of young women in this category as the available data is currently not gender disaggregated.

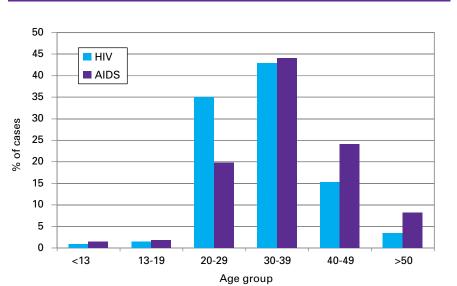
As mentioned earlier in this document, women and girls in this country are predominantly infected through heterosexual transmission and thus not necessarily reflected in this decline of HIV cases affecting this age group. What is known is that there is an increase seen in the number of heterosexual transmission cases and that more women and girls than men and boys are newly infected through this route each year.

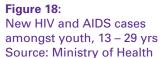
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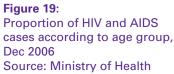
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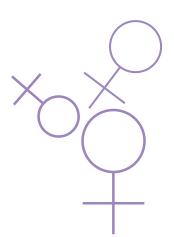
No gender desegregated data was available to ascertain the HIV and AIDS situation amongst young women and girls below the age of 29. It is possible that due to the likely possibility that most young women and girls would not usually fall under any of the categories of people routinely tested (refer Table 2) and thus not being screened, the development of the epidemic in this age group will remain unclear and possibly underrepresented.











However, looking at the incidence of sexually transmitted infections such as gonorrhea and syphilis, it is possible to ascertain the level of vulnerability and possible infection occurring amongst young women and girls in Malaysia. In 2004, 2 631 STI related cases were reported in the Government health clinics, of which the majority were female (83%) and only 18% were male.

Two thirds of these cases were between the ages of 20 and 39. Of the reported STI cases, 57.7% were of Malay ethnicity, followed by Chinese at 13.7%. It is also possible that young women are more likely to proactively seek medical treatment for reproductive health related problems. The presence of an STI increases the risk of becoming infected with HIV by two to nine times.<sup>69</sup>

With sexual health studies such as the Durex Sex Survey and the National Population and Family Development Board's Adolescent Sexual Reproductive Health 2003 reporting increased numbers of young people engaging in sexual intercourse before the age of 18, it is certainly necessary to ascertain the level of unsafe sexual behaviour and practice in order to obtain a better understanding of how HIV and AIDS is affecting young women and girls in the country.

#### As migrant workers

An estimated 1.8 million registered immigrant workers and 500 000 illegal workers currently reside in Malaysia.<sup>70</sup> Due to the Government's concern over the potential health risks posed by these foreign workers, also termed as migrant workers, to Malaysians, a policy was constituted whereupon foreign workers currently undergo three mandatory medical screenings in the first two years of their arrival.

The HIV situation amongst migrant populations in Malaysia is currently unclear as screening is done for the purpose of detecting migrant workers who are considered medically unfit or pregnant and therefore qualify for deportation back to their countries of origin. This policy requires foreign workers to prove that they are healthy and free from infectious disease and various non-communicable diseases in order to qualify for a work permit. This is done through a full medical screening which includes testing for HIV. First introduced in 2003, the policy now involves compulsory screening within the first month of arrival and at the end of the first and second year.<sup>71</sup> The HIV situation amongst these populations in Malaysia is currently unclear as screening is done for the purpose of ensuring that migrant workers entering Malaysia are healthy and fit to work.

Under this regulation, female migrant workers need to be screened for more than 15 infectious diseases and conditions including HIV, STDs, tuberculosis, malaria and pregnancy.<sup>72</sup>

The Foreign Workers Medical Examination Agency (FOMEMA), a centralised agency in charge of these medical screenings, communicates the results to the Immigration Department which then notifies the employer of the employee's medical status. Should they be found to have tested positive for any of these diseases or be pregnant, they are subject to deportation without treatment, medical assistance or post-test counselling.<sup>73</sup>

Women make up the majority of unskilled and semi-skilled migrants who undergo the screening. Professionals and expatriates are exempted and do not undergo any sort of medical testing or screening.

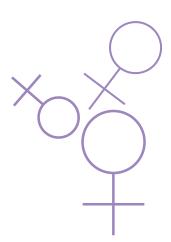
Year	No. of persons	HIV			
	screened	+ ve	%		
1998	565 737	178	0.0315		
1999	545 222	80	0.0146		
2000	525 681	98	0.0186		
2001	500 133	91	0.0182		
2002	402 831	122	0.0303		
2003	716 157	286	0.0399		
2004	909 273	337	0.0317		
TOTAL	4 158 034	1 192	0.0287		



59

Table 6:HIV Screening of MigrantWorkers in Malaysia, 1998 – 2

Workers in Malaysia, 1998 – 2004 Source: Ministry of Health



#### As refugees

The Office of the United Nations High Commissioner for Refugees (UNHCR) in Malaysia registered 37 938 persons of concern by October 2007.<sup>74</sup> This population includes 12 880 Rohingya Muslim refugees from Myanmar, 19 314 other persons of concern from Myanmar, and 5 744 individuals from other countries. 7 003 or 18.5 % of this population are women and 9 408 are children (25%). As monitored by UNHCR and other health NGOs working with the refugee community, the population of refugees living with HIV and AIDS is 138 persons (as of October 2007).<sup>75</sup>

Forming the front line of addressing the HIV epidemic amongst the refugee population, UNHCR and several Malaysian health NGOs (e.g. Malaysian Care, A Call To Serve (ACTS) Malaysia and Catholic Welfare Services) provide HIV related prevention and response programmes through visits to detention centres and mobile clinics in jungle and urban settlements.<sup>76</sup> This includes a voluntary counselling and testing (VCT) campaign among the refugees in 2008 to raise AIDS awareness and to provide testing services as well as psychosocial counselling for those living with HIV. Of those reached in this campaign, 23% were women.

In an arrangement between the Government of Malaysia and UNHCR, refugees registered and provided with relevant UNHCR documentation are able to receive medical services at Government hospitals at half the cost usually charged to foreigners. In addition, refugees and asylum seekers with HIV are able to benefit from related and appropriate medical treatment for free from the Government's public health service.<sup>77</sup>

Despite being identified as a marginalised and vulnerable population under the National Strategic Plan on HIV/AIDS 2006-2010, data on incidence rates amongst refugees are not yet captured through the existing HIV surveillance system.<sup>78</sup> Nevertheless, the circumstances faced daily by women and girls in this community make them vulnerable to HIV infection. Cramped living conditions with males and females together in close proximity, the threat of sexual violence, the need to conduct transactional sex for money and favours and the loss of male family members to disease, police and immigration raids, and many other situations combine to create conditions of vulnerability which increases the likelihood of contracting HIV and spreading it.

Trafficking is a health problem, as trafficked women and children are most at risk from HIV infection. It is a gender problem, as unequal power relations reinforce women's secondary status in society.

### As victims of human trafficking

"Trafficking is a complex development issue. It is an economic problem, as the vast majority of women seeking to escape poverty are lured into trafficking by the false promise of economic gain. Trafficking is a health problem, as trafficked women and children are most at risk from HIV infection. It is a gender problem, as unequal power relations reinforce women's secondary status in society. Lastly, it is a legal problem, as its victims are stripped of their human rights and lack any access to redress for the crimes committed against them."<sup>79</sup>

Women and girls as victims of human trafficking remain a hidden dimension of the HIV epidemic in Malaysia.<sup>80</sup> Though the trafficking of men from Malaysia to other countries also exists, the country has increasingly seen itself as becoming a destination for sex trafficking for women and girls from Indonesia, Thailand, Taiwan, South Asia, the Philippines, Cambodia, Myanmar and China.<sup>81</sup> Can we relate human trafficking to HIV vulnerability?

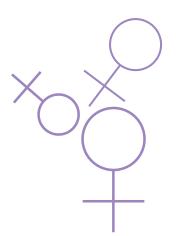
A common methodology used by traffickers to dupe their victims into being trafficked is the lure and promise of available lucrative jobs in Malaysia. Once in the country, the use and burden of incurred debt is utilised to keep these women and girls in subjugation. They are then compelled and forced to work until the debt is repaid. The United Nations Protocol on Trafficking in Persons identifies 'bonded labour' or 'debt bondage' as a form of human trafficking.<sup>82</sup>

Though in most cases of human trafficking in Malaysia, these women and girls are not originally victims of abduction from their countries of origin, they become trapped in an ever growing burden of debt. To pay off such debts and with their passports confiscated by the traffickers, the women are often forced to work as sex workers in entertainment centres, hair salons or massage parlours.<sup>83</sup> These locations often have hidden partitions which serve as rooms where women and girls are made and often forced to entertain clients.<sup>84</sup> Compliance is enforced through the threat or acts of physical violence including rape.

No data is available to indicate HIV incidence rates amongst women and girls who are victims of human trafficking. However, such conditions produce situations of extreme vulnerability which make it extremely hard, if not impossible, for the women to insist on safe sexual behaviour and for any sort of HIV intervention to be carried out.



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A recent positive development has occurred in this area where Malaysia has gazetted a tough and comprehensive new anti-human trafficking act which punishes traffickers with up to 20 years in prison, heavy fines and whipping, if convicted.<sup>85</sup>

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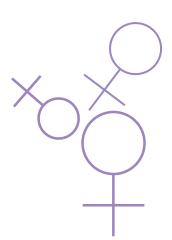


### **VULNERABLE AND AT RISK OF HIV**

Vulnerability to HIV infection amongst women and girls is often linked and determined by factors which affects and commonly prevents women from actively making choices and decisions about their lives.<sup>86</sup>

Risks refer to the probability that a person will acquire a HIV infection. HIV risk reduction strategies are designed to address the immediate risk-taking action while HIV vulnerability reduction strategies are aimed at addressing the underlying and causal factors to risk.<sup>87</sup>

How women and men obtain, understand and use information concerning gender roles and responsibilities, sexual reproduction and sexuality influences their risk and vulnerability to HIV infection.



### **Biological vulnerability**

Specific biological factors place women at an inherently greater risk of contracting HIV than men. Compared to males, females have a larger genital mucosa surface (lining of the vagina and cervix) area exposed during sexual intercourse. This soft tissue in the woman's reproductive tract is able to tear and absorb fluids easily. Fluids such as semen have a higher concentration of HIV compared to those secreted by the female during sex.<sup>88</sup> Together, not only does this provide a transmission route for the virus, it also makes male-to-female transmission more efficient than female-to-male. Having reproductive tracts which have not yet fully matured place young women and girls at even greater risk to HIV infection.<sup>89</sup>

Tearing and bleeding of the tissues of the genitalia during intercourse, whether as a result of sexual violence, physical abuse or female genital mutilation, multiplies the risk of HIV infection. In circumstances where there is forced sex, often the vagina is not lubricated. The tissues of the vagina then tear more easily resulting in an increased risk of exposure to HIV infection.

When the risk of HIV transmission from male to female and vice versa are compared, it is generally estimated that women's risk of acquiring HIV is between 2 to 4 times higher than that of men's.

Through a number of conversations with students from secondary schools in Kuala Lumpur, unprotected anal intercourse appears to be increasingly preferred by both young women and men during sexual activity as it preserves virginity and avoids the risk of pregnancy.<sup>90</sup> However, tears in anal tissue increases the risk of HIV transmission during anal sex.

Having a pre-existing sexually transmitted infection (STI) will also be a risk factor in acquiring HIV which could increase the risk of transmission up to 10 times. Women are more likely than men to have untreated STIs as the symptoms are absent or harder to see.<sup>91</sup> The perceived associated shame or fear could also prevent them from seeking testing and treatment for the STI. More often than not, women who are monogamous do not consider themselves at risk and hence perceive themselves to be uninfected.

When the risk of HIV transmission from male to female and vice versa are compared, it is generally estimated that women's risk of acquiring HIV is between 2 to 4 times higher than that of men's. Studies have estimated that women between 25 and 49 years have slightly higher levels of vulnerability to HIV infection compared to men. However, between the ages of 20 and 24, they become three times more vulnerable. The most vulnerable period in females is between the ages of 15 and 19 when they are about 6 times more vulnerable than males.<sup>92</sup> Though women are more likely to contract HIV from unprotected sex, they continue to be dependent on male cooperation to protect themselves from HIV.

### Social and cultural vulnerability

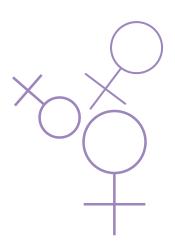
#### Sexual reproductive health knowledge and attitudes

A 2006 nationwide survey which examined the issue of HIV and AIDS knowledge, attitudes and risk behaviour in Malaysia found that there were reasonably high levels of basic information about the disease among the general population.<sup>93</sup> Almost all of those surveyed had heard of HIV and AIDS, understood the nature of the disease and knew the common routes of HIV transmission. However, how such basic information is translated into behaviour change and safe practices remains a formidable challenge which is often confounded by social, cultural and religious expectations and norms.

Although there have been decades of successful nationwide programmes delivering reproductive health services to women at all levels of society in Malaysia, sometimes a culture of silence across ethnic lines continues to dictate and expect that women and girls remain ignorant about sex and their sexuality. Though this expectation has been rapidly rendered practically obsolete by the availability of increasingly varied and comprehensive information from alternative sources such as the Internet, it continues to be perpetrated from one generation of men and women to the next.<sup>94</sup> This culture of silence, often arguably continued by men and sustained by women, continues to obstruct the ability of women and girls to protect themselves through information and practice.

Worldwide, many cultures expect women and girls to be totally ignorant of sex, it expects that young men be "all-knowing" and to be the guide for his female partner in all things sexual. Men are expected to be more knowledgeable and experienced about sex. This expectation puts men, particularly young men, at risk of infection because it prevents them from seeking information and admitting to their lack of sexual reproductive health (SRH) knowledge.





It encourages experimentation in sexual acts such as vaginal or anal intercourse which are usually unsafe and unprotected. It also implies that there is a need to prove their entry into manhood through sex.<sup>95</sup>

Restricting the access and availability of sexual reproductive health information to young women and girls to keep them ignorant about issues of sex is seen as a sign of purity and of high social value.<sup>96</sup> To enquire of the subject of sex and sexuality, is to be perceived as immoral, morally suspect, or worse, of easy virtue and sexually promiscuous.<sup>97</sup>

Through the use of knowledge, attitude and practice (KAP) surveys and other similar research instruments to ascertain the level of information and awareness of HIV and AIDS over the past decade, it is possible to surmise that amongst specific populations such as young people between the ages of 13 and 29, the situation of vulnerability and risk has not improved. The available literature indicates varying degrees of knowledge and understanding of sexual reproductive health amongst young people. Young women and men are alarmingly more vulnerable to HIV than ever before with increasing levels of unsafe sexual behaviour and low levels of behaviour change. Despite increasing awareness of HIV and AIDS among the general population, there have been unequal and often dangerously low levels of SRH awareness, knowledge and understanding.

A 1986 study of sexual activities conducted amongst 1 200 single adolescents aged 15 and 21 years old also evaluated levels of knowledge of virginity, pregnancy, contraception and access to information.<sup>98</sup> It reported that though 70% of male respondents knew that virginity could be lost through sexual intercourse, only 30% of females could claim the same.

The 1994 National Study on Reproductive Health of Adolescents which involved 1 379 adolescents between the ages of 13 and 19 reported that there was a general lack of knowledge, misinformation and misunderstanding about reproduction among adolescents. The study's report revealed that only a quarter of respondents had adequate anatomical knowledge of their respective reproductive organs; 86% knew that sexual intercourse could lead to pregnancy; and that girls had a better knowledge and understanding of their reproductive system compared to that of boys.<sup>99</sup>

Young women and men are alarmingly more vulnerable to HIV than ever before with increasing levels of unsafe sexual behaviour and low levels of behaviour change. However, both girls and boys had a poor understanding of the whole reproductive process. Table 7 indicates that the majority of respondents had heard of HIV and AIDS, and had knowledge of possible transmission routes. However, the low levels of SRH knowledge and understanding could contribute to their not understanding or practicing safer behaviour.

A study was conducted by the Malaysian AIDS Council (MAC) in 1999/2000 to examine knowledge, attitude and practices/behaviour associated with HIV and AIDS among female and male adolescents in Malaysia.<sup>100</sup> Involving 7 045 respondents comprising in-school and out-of-school adolescents as well as those in drug rehabilitation centres and tertiary institutions of higher learning, the study revealed that knowledge of HIV and AIDS was generally high and felt to be sufficient. Almost 40% felt that the information was insufficient and wanted more. It is interesting to note that a third were of the view that though they had enough information, they were still confused.



Young women and young men were found to be familiar with the causes and effects of the disease. There was also a fair knowledge of HIV transmission routes amongst the respondents of the study. However, the gap between knowledge and practice was clearly demonstrated in the findings. One such example could be seen in the use of the condom.

Knowledge	Boys	Girls
Female reproductive anatomy	25.3	23.3
Male reproductive anatomy	20.9	10.6
Pregnancy – through sexual intercourse	85.3	
Contraception – condoms	67.7	63.3
Contraception – pills	57.1	66.7
Have ever heard of STI	65.3	
Have ever heard of AIDS	98.1	
HIV can be transmitted through random sex	95.6	
HIV can be transmitted through sharing of needles	96.5	

#### Table 7:

Percentage of respondents with correct responses to specific questions on SRH and HIV and AIDS Source: National Population and Family Development Board, 1998 73

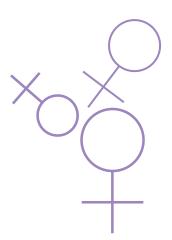
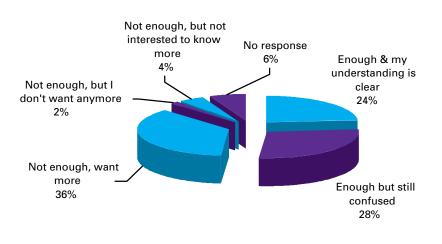


Figure 20: Perception of Adolescents on HIV and AIDS Information Source: Malaysian AIDS Council, 2003



Young people are increasingly sexually active, it is therefore necessary to question whether today's young women and young men are sufficiently equipped with adequate available information, education and understanding of sexual reproductive health, relevant guidance and services. The most recent picture of HIV and AIDS knowledge, attitudes and risk behaviour in Malaysia among the general population comes from the 2006 nationwide survey mentioned earlier in this section. As noted before, there were reasonably overall high levels of basic information about the disease among Malaysians. Almost everyone had heard of HIV and AIDS, and understood the nature of the disease. Most were knowledgeable about the common routes of HIV infection and could identify HIV prevention methods such as not sharing needles and syringes, and having sex with only one faithful and uninfected partner. However, many also maintained that infection could also occur through kissing, sharing meals, usage of public toilets and casual contact.<sup>101</sup>

With mounting evidence and the reality that young people are increasingly sexually active, it is therefore necessary to question whether today's young women and young men are sufficiently equipped with adequate available information, education and understanding of sexual reproductive health, relevant guidance and services.<sup>102</sup>

#### **Sexual behaviour and practices**

There are currently two major factors affecting the onset and pattern of sexual behaviour amongst young women and men in Malaysia. Firstly, the age of sexual maturity or puberty amongst girls is currently indicated as 12.6 years (onset of menarche) and boys at 13.8 years (having wet dreams).<sup>103</sup> However, the age of sexual maturity appears to be reducing with incidences of sexual experiences recorded with girls and boys as young as 9 years old.<sup>104</sup>

Secondly, there has been a rise in the age at first marriage. In 1984, the mean age at first marriage was 26.9 years for men and 24.5 years for women. Later on in 1994, it increased to 28 years for men and 24.9 years for women.<sup>105</sup> These figures also differed significantly higher in urban areas as compared to those in rural regions. The delay in marriage by young people, especially young women and girls are clear indications of improved socioeconomic and educational opportunities as well as better health conditions.<sup>106</sup>

However, these two factors combine to produce a growing age gap between puberty and marriage which has led to an increase in the number of sexually active, unmarried young people. The 1994 National Study on Reproductive Health of Adolescents revealed that 40% of respondents were dating at 13 years old. By the age of 18, 35% had started kissing while 16% had experienced petting. Almost half of the female respondents had kissed their partners. A comparison between the household and media surveys of this study indicated that only 1% from the former was sexually active. The latter recorded 27% of who were sexually active. Conversely, the Second National Health and Morbidity Survey conducted in 1996 stated that only 2% of 30 000 secondary school students were sexually active and had engaged in sexual intercourse.

The 1999/2000 Malaysian AIDS Council study indicated that a quarter of outof-school respondents had had sexual intercourse while slightly more than 1% of their in-school counterparts had similar experiences. More than 25% of all respondents in this study who had penetrative sex also had anal sex.<sup>107</sup>

An examination of existing studies on adolescent sexual reproductive health in Malaysia indicates that the age at first sexual intercourse or sexual debut ranges between 9 to 24 years old.<sup>108</sup> The average accepted range for sexual debut currently found in existing literature is 17 to 18 years. In the majority of these studies, more boys and young men than girls and young women reported having had sexual intercourse.



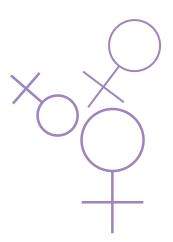


Table 8:Results from the Durex Sex<br/>Survey 2003 - MalaysiaSource: Durex Sex Survey, 2003

Actions by respondents (Malaysia)	Percentage
Did not use condoms during sex	35
Continued to have sex despite refusal of partner to wear condom	45
Least likely to reveal having an sexually transmitted infection (STI)	90

Young men have been found to resort to purchasing sex for their first sexual experience. A survey documented that about 15% of in-school males and almost 27% of out-of-school males had their first sexual encounter with a sex worker.<sup>109</sup> This lends credence to the premise stated earlier that the culture of silence creates the environment where there is less pressure for boys and young men to remain sexually inexperienced.

As a result of gender norms and expectations, the lack of information and awareness of sexual reproductive health has led to women, especially young women, being exposed to HIV infection. Young people are having premarital sex, and in most cases practicing unsafe behaviour which does not allow them to protect themselves from HIV infection. <sup>110</sup>

Despite available studies which indicate an increasingly early age of sexual activity and exposure, high risk and unprotected sexual intercourse is being practiced. Such a picture was captured in the Durex Sex Survey in 2003 as illustrated in Table 8.

This survey conducted globally by condom manufacturer Durex found that 45% of Malaysians who participated in the study continued to have sex despite the refusal of their partner to wear a condom.<sup>111</sup> Even more alarming was the finding that 90% of respondents would not reveal having a pre-existing sexually transmitted infection to their sexual partner. The incidence of STIs and teenage pregnancies are also indicative of unprotected and unsafe sexual behaviour. In a similar survey Durex conducted in 2005, it found that 7% of young women between the ages of 17 and 18 had experienced an unplanned pregnancy,<sup>112</sup> and 15% of respondents over 19 years had similar experiences.

76

As a result of gender norms and expectations, the lack of information and awareness of sexual reproductive health has led to women, especially young women, being exposed to HIV infection. A number of anecdotal reports have emerged indicating unsafe sexual practices linked to the premium of virginity. Young women have begun to practice anal sex as an alternative to vaginal penetration, to preserve their virginity. The Malaysian AIDS Council study indicated that more than 25% of those who had conducted penetrative sex had engaged in anal sex.<sup>113</sup> The practice of anal sex places them at increased risk of HIV infection.

Overall, women and men in Malaysia are having their first sexual experiences at a much earlier age compared to when their parents had theirs. Women and girls are made vulnerable by circumstances which encourage ignorance and feelings of shame.

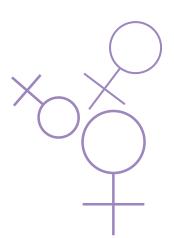


#### Intergenerational sex

A key factor driving HIV infection amongst girls and young women in several Asian countries is intergenerational sex (IGS).<sup>114</sup> IGS is defined as any behaviour between a minor and someone at least 5 years older that is perceived by either participant or by society as sexually stimulating or intended to be sexually stimulating. The decrease in the age of sexual maturity could have significant ramifications for girls and young women in Malaysia. Such changes will result in increased vulnerability to HIV as their debut of sexual experience becomes earlier and younger. Possible risks of IGS relationships would include acquiring sexually transmitted diseases such as HIV as well as the occurrence of unplanned pregnancies.

Though there is limited available research in this area, it can be observed that younger women often date and marry older men because of their greater wealth and status. Within this context, young women tend to have sexual partners who are 5 to 10 years older than them. Older men are seen to be more financially and socially secure as well as representing a better indicator for the future.<sup>115</sup> However, older men are also more likely to be exposed to sexually transmitted diseases than their younger counterparts because they have been sexually active for longer periods of time.

There are reports of a "sugar daddy" phenomena being perpetuated amongst secondary school girls and young women in Malaysia, particularly those living in urban areas.



often wealthier men. Being able to profit materially from such a relationship is the main motivator for girls to accept a "sugar daddy".<sup>116</sup> However, many girls have a boyfriend, of similar age, and a 'sugar daddy' at the same time. This new phenomenon in the country, needs to be explored further.

This situation refers to sexual relations between young women and older and,

On the other hand, older men are seeking out younger girls in the belief that, as virgins or less sexually experienced, they are free from HIV and disease. These men may offer them money or gifts in exchange for favours which may or may not be sexual in nature. These favours could range from dating or being a companion for dinner, to masturbation, oral sex, as well as penetrative sex. Such a relationship could even lead to marriage.

The preoccupation with female virginity, represented by girls and young women, could lead them to being infected with HIV from their more experienced male partners or husbands who experience no social pressure to remain celibate until marriage.<sup>117</sup>

Though very little has been documented of intergenerational sex in Malaysia, it does exist. This is a trend that has been observed in other developing as well as developed countries.<sup>118</sup> This form of sexual relationship exposes women to infection, as a group more likely to have HIV (older men) transmits the virus to a group with low or no risk of infection (girls and young women).

#### Sexual violence

Within the context of gender and the HIV epidemic, sexual violence is complex. The nature of sexual violence often reflects social, cultural, economic and religious disparities which are prevalent and exist between women and men.

The relationship between the perpetrators and survivors commonly mirrors the dynamics of gender and the relationship of power between the two sexes, particularly within the context of husband and wives, older men and girls or boys and sex workers and their clients. The perpetrators of sexual violence are often men.

The preoccupation with female virginity, represented by girls and young women, could lead them to being infected with HIV from their more experienced male partners or husbands who experience no social pressure to remain celibate until marriage. In addition to the psychological and emotional trauma of sexual violence, survivors experience physical injury and the threat of unwanted pregnancy and infection of STDs such as HIV. Rape is commonly conducted without the use of a condom and could involve penetration of either or both the vagina and anus. The risk of HIV transmission may be greatly exacerbated by physical damage in the form of tearing and bleeding in the genital area.

Sexual violence against women and girls, especially rape, is a risk factor for HIV that is currently inadequately recognised or addressed as there is currently very little local data or research available on the subject. However, this form of crime has become an increasingly unfortunate feature in the lives of girls and women in Malaysia.

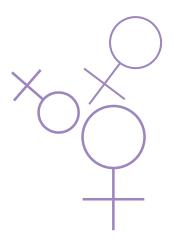
In 2006, 2 435 rape cases were reported throughout Malaysia representing 7 women being raped everyday in that year.<sup>129</sup> The perpetrators in these cases were often older men while the survivors, young women or girls. This trend exposes these young women to HIV infection as the men are often sexually experienced.

Among married couples the risk of HIV transmission is negligible when both partners are uninfected at the time of marriage, engage in sex exclusively with each other and do not practice risk behaviours, it is becoming frequently the case that male spouses often have been exposed to a risk of infection in one form or another. This can take on the form of injecting drug use, purchasing and having unprotected sex.

Women in these relationships often are unable to insist on fidelity, refuse sex with their partner, or demand the use of condoms. Even when they know or suspect that their partners have acquired HIV or some other STD, they are often unable to negotiate safer behaviour. Though no available national study has examined sexual violence in the context of HIV prevention, anecdotal information from community based organisations working on these issues indicate that there is a high level of abuse by men whose wives dare ask them to wear a condom during sex.



79



Relationship/ Year	2000	2001	2002
Friend	457	541	572
Boyfriend	239	272	252
Stranger	207	201	215
Father	67	77	77
Stepfather	38	52	40
Uncle	34	42	65
Brother-in-law	30	23	21
Grandfather	4	5	13
Neighbour	65	86	45
TOTAL	1 141	1 299	1 300

Table 9:Relationship of rape survivorand perpetrator, 2000 – 2002Source: Royal MalaysianPolice, 2003

Young women and girls may also contract HIV from forced sex. The high number of sexual abuse cases occurring with close family acquaintances, such as family members or friends, is alarming. Young women and girls may also contract HIV from forced sex. The high number of sexual abuse cases occurring with close family acquaintances, such as family members or friends, is alarming.<sup>120</sup>

The girls and young women involved are often unable to come forward to expose the crime for fear of stigmatisation and accusations of immorality, while mothers often know that their children are being abused, yet are afraid to speak out. As a result of this silence, incidences which occur within this category are hidden and could continue to be so for a long time.

The consequences of such abovementioned circumstances are many, not the least, acquiring HIV. Adolescent girls who go through such experiences often suffer a collapse in self-esteem. They may feel extremely ashamed and dirty which may lead to self destructive conduct.<sup>121</sup> This could lead to adopting risky behaviour and practices such as unprotected sex, sexual relations with multiple partners, sex work, and drug use, any of which could result in HIV infection.

Malaysian studies show that girls who had been sexually abused resulted in high risk sexual behaviour such as having sex at an early age or trading sex for money or drugs.<sup>122</sup>

#### **Economic vulnerability**

#### Lack of economic power

The lack of economic power has been mentioned several times during the course of this document to highlight the disparity women and girls face in dealing with HIV and AIDS. Their lower social status and economic dependence on men and other family members prevent women from removing themselves from relationships which carry major risks of HIV infection.

This also causes women and girls, particularly those who are married, to be unable to negotiate safer sex as this implies lack of trust and possible accusations of infidelity (usually aimed at the women). The fear that their husbands may abandon or divorce them makes it difficult for many women to negotiate for safer sex. It is also not uncommon for this to result in violence in an effort to impose authority.

In Malaysia, very little research has been conducted to examine this issue. As a country whose population is experiencing the benefits of development, Malaysia is also facing increases in the costs of living affecting both rural and urban areas but predominantly the latter. Relative poverty or pressure to provide an income for themselves or their families can also encourage such risks as enduring an abusive relationship or engaging in unsafe transactional sex in exchange for money, housing, food or education. All of which could expose a person to HIV.

Some women enter into sex work by economic necessity. In many cases, sex work becomes the only means of support for separated, divorced or unmarried women, particularly if they have a limited educational background and thus fewer employment opportunities.

Due to such an economic imbalance, men have considerable power over women. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favours; that they are less likely to succeed in negotiating protection in preventing HIV infection; and that they are less likely to leave a risky relationship.<sup>123</sup>



81

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(Courtesy Charlie Liddal)

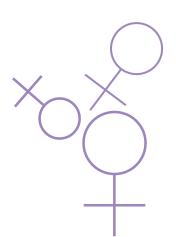
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## WHAT IS NEEDED?

HIV programmes which have succeeded in preventing the spread of HIV and providing appropriate care, treatment and support to those living or affected with the disease are those which are based on hard and practical social realities rather than social ideals.

HIV prevention efforts must not ignore the social, political, cultural and religious contexts which push people into risk behaviour and make it difficult for them to adopt safer behaviour.

Programmes that have tackled these underlying issues around risk behaviour which causes people to be vulnerable to HIV have been more successful than programmes which have avoided these issues.



The increasing spread of HIV among women and girls in Malaysia is more than just an issue of preventing or controlling the spread of a disease. It is an issue of understanding and responding to vulnerabilities and risks related to gender discrimination and inequality, cultural and religious norms and expectations, and economics.

The Monitoring the AIDS Pandemic (MAP) Network have identified that Asia's HIV prevention successes have the following three features in common:<sup>124</sup>

 The specific behaviours which cause the most infections are addressed and specific relevant services are provided to reduce the risks associated with those behaviours.

Such examples include the implementation of programmes to encourage men to practice risk avoidance, including abstinence, mutual fidelity and partner reduction, or to use easily available condoms during the purchase of sex. They also include increasing access to systematic STI screening and treatment services for female, male and transgender sex workers. These services can be accessed through nondescript facilities made available in identified zones such as Chow Kit and Bukit Bintang. Examples of such installations include the DSC Clinic in Singapore managed by the Ministry of Health.<sup>125</sup>

Access to information and to services is provided on a scale large enough to make an impact on HIV transmission.

Small pilot or demonstration projects benefit only those in the vicinity or coverage of the programmes which is often limited. Active documentation of projects which prove successful must be codified and shared so that their methods can be replicated in different locations and scale. Up scaling successful interventions to the national level will demonstrate applicability and ensure that the results can be duplicated broadly across the country

 The establishment of an enabling environment is necessary to obtain support for the provision of appropriate HIV prevention services for populations at higher risk of HIV exposure.

People will forgo or avoid using prevention services if using those services place them at risk of other threats, for example, of being arrested which jeopardises their livelihoods. Successfully implemented HIV prevention programmes such as the Needle and Syringe Exchange Programme (NSEP) have worked when law enforcement bodies, social services, and religious authorities come together to ensure that those in need of these services are supported to protect themselves and others from HIV. Arguments put forward in the previous sections have shown that the need to address the escalating numbers of women and girls getting infected with HIV is fairly clear and urgent. However, prevention programmes involving this significant part of the population continues to be complicated by a number of issues including:

- Insufficient disaggregated data and analysis, particularly from a gender perspective.
- Institutional and social denial that sexual behaviour between young men and young women actually takes place outside of marriage.
- Sensitivities surrounding the introduction of sexual reproductive health education in schools.
- The difficulty of reaching many of those vulnerable to HIV infection (e.g. housewives) and marginalised populations (e.g. sex workers).

Based on the observations contained within this report and to address the increasing number of women and girls becoming infected with HIV in Malaysia, the following key areas need to be addressed:

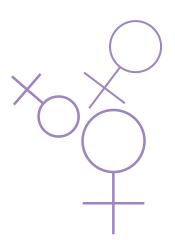
## Recognition of the multifaceted nature of the problem

Decision makers need to further strengthen the acknowledgement of women as a vulnerable group requiring specific interventions. Though the Government has expressed strong political support and has committed significant financial resources (RM 500 million or USD 151 million under the 9th Malaysian Plan) to address the issue of HIV and AIDS in the country, a separate distinction must be made to highlight the issue of women and HIV.<sup>130</sup> Political attention, support and commitment of resources from all Government ministries concerned are necessary. Though women have been identified as being a population of concern under Strategy 4 of the National Strategic Plan on HIV/AIDS 2006-2010, a much more concerted and stronger effort and response is needed from other Ministries.

As highlighted in this report, the increasing spread of HIV among women and girls in Malaysia is more than just an issue of preventing or controlling the spread of a disease. It is an issue of understanding and responding to vulnerabilities and risks related to gender discrimination and inequality, cultural and religious norms and expectations, and economics.



87



Issues such as the gap between high levels of HIV and AIDS awareness and actual sexual practices and behaviour can be addressed through programmes which involve young women and men in schools and universities. The social issues require a response that is multi-faceted in nature. A multisectoral approach is necessary to halt and reverse HIV among women and girls in Malaysia. Thus far, the national response has obtained the involvement and commitment of ministries such as the Ministry of Youth and Sports; Ministry of Home Affairs and Ministry of Human Resources. Coordination of such a response has been critical in ensuring that the gains and progress made are able to be sustained. To further strengthen this effort, the following recommendations are proposed:

- Establishment and strengthening of a Women, Girls and HIV Desk It is proposed that an officer within the existing National AIDS Secretariat be given the mandate, responsibility and funding to monitor and advise on the national HIV and AIDS work affecting women and girls.<sup>127</sup>
- Enhance the availability and capacity of technical expertise at the National AIDS Secretariat

The number of available technical staff at the National AIDS Secretariat should be increased. This is in response to the increasing demand for the development and implementation of more HIV and AIDS programmes in support of the Givernment's commitment to the National Strategic Plan.

#### More research and surveillance

Increase the availability of gender disaggregated data and analysis Gender disaggregated data must be recorded in a standardised manner and routinely published and made available to researchers and individuals involved in the development, implementation and evaluation of HIV programmes and interventions. Gender disaggregated analysis should be incorporated on past, existing and future related health data. Such analysis will be useful to demonstrate how and why diseases affect women differently, the issue of the burden of disease, and the levels of access to women and men.

Evidence gathered through examination of gender disaggregated data will be critical to assess and monitor the appropriateness of current responses and identify causal factors of discrimination and stigma. A better understanding of these issues are crucial to develop a more tailored and effective approach to the provision of HIV prevention, care and support in women and men.

More social science research to examine HIV related vulnerabilities and risk
More social science research is necessary to understand the decisions
and choices concerning vulnerabilities and risk. Research in this area will
allow for evidence-based interventions which respond to strengths and
weaknesses in existing HIV prevention, care and treatment programmes.
Findings from such research can be used to ascertain and respond
to gaps and barriers such as sexual discrimination in the delivery of
services, particularly in the area of HIV prevention.



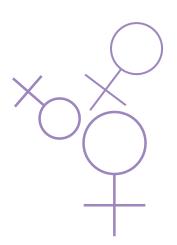
Many gaps continue to exist in our understanding of the dynamics of the HIV epidemic in Malaysia, particularly those concerning heterosexual transmission, women of marginalised communities and the effectiveness of existing interventions.

## Greater access to prevention and treatment services

Identify and implement specific programmes which address issues of HIV vulnerability for women

Appropriate programmes which identify and address vulnerability to HIV infection amongst women in Malaysia must be developed and implemented. These programmes, which should comprise of targeted and nationwide interventions, would be more effective if developed and conducted in partnership with relevant non-governmental organisations.

Issues such as the gap between high levels of HIV and AIDS awareness and actual sexual practices and behaviour can be addressed through programmes which involve young women and men in schools and universities. Young men and boys can be mobilised through discussions within and outside the classroom which address personal attitudes, cultural and religious norms and expectations, as well as sexual behaviour. Addressing issues such as the risks of intergenerational sex can be conducted through sexual reproductive health education.



Successful promotion for men and women to go for voluntary HIV counselling and testing, particularly those within the range of 20-39 years and practicing unsafe or risky behaviour, could result in behaviour change and contribute to reductions in HIV incidence. Existing policies and legislation should be revised within the context of women and their vulnerability to HIV, with a focus on social protection. This would include:

- o Ensure programmes and policies are in place to protect women against violence within and outside the household.
- Highlight the need to invest in strategies for policy makers, law enforcement, members of the judiciary, social service providers and civil servants regarding the social, cultural and economic factors which put women and girls at risk of HIV
- Encourage women to go for voluntary HIV counselling and testing (VCT) Successful promotion for men and women to go for voluntary HIV counselling and testing, particularly those within the range of 20 – 39 years and practicing unsafe or risky behaviour, could result in behaviour change and contribute to reductions in HIV incidence. Studies have shown that the availability and active promotion of VCT can contribute to more people choosing abstinence, decreases in unprotected sexual intercourse and the number of multiple partners and increases in condom use.<sup>128</sup> In terms of treatment, the VCT becomes the point of entry for HIV treatment. The majority of people living with HIV do not know their status. Many women and men at risk have not been tested. As such, the screening would seek to assist those with HIV to obtain treatment options as well as obtain appropriate counselling.
- Encourage couples to go far premarital HIV screening and counselling
   Couples planning for marriage should be encouraged to attend HIV
   premarital counselling and to voluntarily undergo a test to screen for
   HIV as well as other sexually transmitted diseases. This premarital
   health examination would provide an opportunity for the diagnosis of
   untreated diseases and for health education. Better communication
   materials as well as information dissemination sessions and discussions
   should be conducted and made available as part of premarital courses.
   Such voluntary sessions should be aimed at evaluating risk behaviour
   of participants and emphasising the need to know one's status prior to
   marriage. The content should also be aimed at preventing persons from
   acquiring HIV though risk reduction and transmitting infection after marriage.

The implementation of voluntary testing should also include discussions on the benefits of early detection and how to prevent oneself from HIV infection within marriage.

#### • Strengthen sexual reproductive health education and youth initiatives

Despite higher levels of HIV and AIDS awareness, young people continue to express a need for more sexual and reproductive health knowledge. There were also those who feel they have had enough information but remained uncertain or confused. Improving and scaling up existing sexual reproductive health education should be done to address the needs of young people in school. Though awareness continues to be high, it remains worrisome that safe practices and behaviour are low. Such gaps should be addressed through the teaching of life skills. However, the existing as well as future proposed content for sexual reproductive health education should be evaluated against the capacity of educators to deliver the syllabus.

The issue of out-of-school youths who remain outside the school system and are often marginalised should be highlighted. The existing PROSTAR (*Program Sihat Tanpa AIDS Remaja*) programme, with its nationwide coverage and institutional support, can be utilised to address this concern. A HIV prevention health programme for young people, PROSTAR was developed in 1996 to engage those 13-25 years of age to be more aware of HIV and AIDS and adopt healthy lifestyle practices. The programme is targeted at secondary school children, factory workers, university and college students, youth associations and clubs. PROSTAR activities are implemented at district, state and national levels with the involvement of State AIDS officers, Health Education Officers and Health Inspectors.<sup>129</sup> By the end of 2003. It is estimated that 600 000 young people have been in contact with PROSTAR, a programme which has enormous potential to be a change agent for young people, particularly those in schools.



91

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#### Bahan Tanaman Guthrie ...hasi kal yang Bertanusan

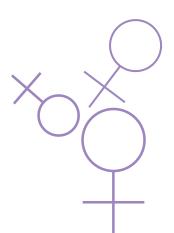
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### CONCLUSION

As this report shows, the developing scenario of HIV and AIDS among women and girls in Malaysia is alarming. A concerted effort at all levels is required to address the needs, vulnerabilities and risks of women and girls as well as the gender inequalities which fuel the epidemic.

The involvement and engagement of men and boys are necessary for any sort of HIV intervention or initiative with women to succeed. This is particularly critical in addressing issues of risk and vulnerability to HIV infection. Programmes targeting women must embrace men as partners in order to support and develop the necessary structures and enabling environment which are more supportive to women. However, such an undertaking will require a greater recognition of the often subordinate relationship of women's economic, social status and HIV transmission.



It is crucial that the Malaysian national HIV and AIDS programme ensure that reported data are disaggregated by sex and made widely available as this will enable a clearer understanding of gender relations in the context of the epidemic within the country. It will also highlight the complexity needed to develop appropriate and relevant programmes to reduce vulnerability to HIV.

It is clear from this report that there is a dearth of studies examining the multifaceted issue of women and HIV and AIDS. In order to evaluate the effectiveness of existing interventions, evidence and analysis collected through research would enable improvements to be made as well strengths and gaps to be recognised. A more comprehensive response is possible by ensuring that interventions are based on evidence and better research.

Strategies to reverse the HIV epidemic cannot succeed unless continued political leadership is embraced and women and girls are empowered. The Government must utilise resources to address the needs and realities of women and girls. These resources must be made available where they are most needed, in programmes for women and girls affected by HIV and AIDS. There should be more gender specific HIV programmes and interventions which take into account the dual nature of the epidemic in Malaysia, whereupon currently women are getting infected through heterosexual transmission while men acquire HIV through injecting drug use.

The multifaceted nature of women and HIV requires the deeper involvement of other Ministries and the establishing of wider networks of multi-sectoral collaboration. Without recognition of this urgency, leadership, political will and commitment, the situation for women and girls will continue to deteriorate and the female proportion of the Malaysian epidemic will increase.

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