EVIDENCE-BASED STRATEGIES FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES IN MALAYSIA

United Nations Population Fund
2011

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STUDY TEAM

Linking HIV and SRH

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… to strengthen and scaling up the SRH and HIV linkages in Malaysia

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ACKNOWLEDGEMENT

This project would not have been possible without the support of many people. The Project Team would like to express gratitude and gratefully acknowledge the many agencies and individuals for their invaluable assistance and support in the production of this report:

- Dr Ang Eng Suan, Consultant, UNFPA Malaysia for her continuing advice and guidance

- All agencies who have given invaluable inputs to complete the documentation:

    - National Population and Family Development Board (NPFDB)
    - Federation of Reproductive Health Associations, Malaysia (FRHAM)
    - Women's Institute of Management (WIM)
    - PT Foundation (PTF)
    - Women and Health Association of Kuala Lumpur (WAKE)
    - Safe Clinic

- Mr Azrul Mohd Khalid for his review of the report

- and UNFPA staff for their logistic support throughout the production of the report

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral therapy
CPAP	Country Programme Action Plan
FFPAM	Federation of Family Planning Associations, Malaysia
FHDA	Penang Family Health Development Association
FP	Family Planning
FPA	Family Planning Association
FRHAM	Federation of Reproductive Health Associations, Malaysia
GBV	Gender based violence
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
ICPD POA	International Conference on Population and Development programme of action
IDU	Injecting drug user
IEC	Information, education and communication
INTAN Lifezone Johor	*Pertubuhan Kebajikan Intan Zon Kehidupan Johor Bahru*
IPPF	International Planned Parenthood Federation
IUCD	Interuterine Contraceptive Device
JTF	Japan Trust Fund
KAPs	Key affected populations
MA	Member- associations (of FRHAM at state level)
MAC	Malaysian AIDS Council
MDG	Millennium Development Goal
MOH	Ministry of Health
MSM	Men having sex with men
NGO	Non-governmental Organization
NPFDB	National Population and Family Development Board
NSEP	Needle and Syringe Exchange Program
NSP	National Strategic Plan
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PPTCT	Prevention of parent to child transmission
PO	Partner Organization (of Malaysian AIDS Council)
PTF	PT Foundation
RH	Reproductive health
RHAM	Reproductive Health Adolescent Module
SALIN	The Dutch Ministry of Foreign Affairs' Strategic Alliance with

	International NGOs
S&FT FREHA	Selangor & FT Family Reproductive Health Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and right
STB	*Sekolah Tunas Bakti*
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
TSP	*Taman Seri Putri*
UBW	Unified and Budget Work Plan
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WAKE	*Pertubuhan Wanita dan Kesihatan, Kuala Lumpur*
WIM	Women's Institute of Management
WHO	World Health Organization

EXECUTIVE SUMMARY

The study on "Evidence-based Strategies for Sexual and Reproductive Health Linkages and HIV in Malaysia" was funded by UNFPA under the 2011 Unified and Budget Work Plan (UBW) as part of their continuing efforts to strengthen the country's strategic response on HIV prevention education and delivery of linked SRH and HIV services with dedicated integration of the gender perspective among most-at-risk population groups especially young people and sex workers. It was designed to complement the WHO/UNFPA funded study on Strengthening HIV and SRH linkages in Malaysia in 2010 that focused on the "supply" components of linked HIV/SRH services. In fact the study was aimed to evaluate the "demand" aspects, namely programme efficiency and effectiveness through a desk review and the responses from the recipients of such services.

It was carried out within a four month period from August to November 2011 and comprised of two components; a desk review on the organizations which included certain components of HIV and SRH linkages in their programmes and services and a rapid assessment with service providers, key affected populations, clients and beneficiaries of the programmes or services. It assessed and documented the linkages of SRH and HIV Programmes in the country and provided evidence-based strategies and service models for advocacy, policies and operational plans to strengthen and scaling up the SRH and HIV linkages.

The desk review was carried out at five organisations, namely the Federation of Reproductive Health Associations, Malaysia (FRHAM), the National Population and Family Development Board (NPFDB), Women's Institute of Management (WIM), PT Foundation (PTF) and the Safe Clinic. The findings from the desk review showed that most of the SRH and HIV programmes in Malaysia were still managed separately and running vertically and the bi-directional linkages in the SRH and HIV programmes and services were limited. However, there was growing awareness and support for linkages; coordination mechanism and joint planning have indeed started among the civil society, community and government agencies. The most commonly HIV services which were integrated in RH facilities/clinics of FRHAM and NPFDB were HIV prevention information and condom provision. Other HIV services such as HIV counselling and testing, psychosocial support for PLHIV and HIV prevention information for key affected

populations were also available in certain service delivery points of FRHAM and the Safe Clinic. Most of these SRH and HIV integrated services were provided at the same facility, on the same day and by the same provider or referred to other service delivery points for follow up. None of the SRH organizations provided home-based care for PLHIV but ARV treatment was available in the Safe Clinic. For HIV organisations, only STIs prevention and management were integrated into the HIV prevention programmes as part of a "HIV prevention" approach to reduce the risks of key affected populations' susceptibility to HIV. The HIV organizations were least likely to provide other SRH services at their facilities but referrals for SRH services were available upon request. The desk review found that the Safe Clinic appeared to be a model clinic that provided comprehensive linked HIV and SRH services, including HIV treatment in a friendly, confidential and non stigmatising environment. However, the high cost of providing free services has forced them to impose a minimal charge for services and this has in fact turned away clients from the key affected populations.

A total of 109 clients from the SRH or HIV programme such as young people, RH/FP clients, women living with HIV, female sex workers and indigenous women participated in the second part of the study, the rapid assessment. Through the rapid assessment, it was found that almost all service users favoured receiving SRH and HIV linked services at the same site. Most of them viewed it as a good opportunity to receive additional services, reduced the number of trips to facilities, transportation cost and time. However, the sex workers, women living with HIV and young people from the juvenile homes, were concerned about possible stigma and discrimination and the confidentiality of services and they hoped that these issues would be addressed in the provision of in linked services. For most the service providers from RH facilities and outreach worker from HIV organisations, most of them accepted the concept of SRH and HIV linkages. However, issues such as policy environment, stakeholder's commitment, client, human resources and programme logistics need to be strengthened in order to increase the feasibility of linked services. Furthermore, they also pointed out that resources, especially financial and human resources, technical assistance and capacity building as well as partnership with other agencies were urgently needed.

Through the desk review and rapid assessment, some key challenges in implementing and strengthening SRH and HIV linkages were identified. They include:

a. Policy on SRH and HIV linked services

Malaysia does not have a policy to provide SRH and HIV linked services. The Ministry of Health, the main provider of health in the country in fact view SRH and HIV as two very different entities and the resolution made at the Roundtable Discussion on WHO/UNFPA Study on Strengthening HIV and SRH Linkages in Malaysia in 2010 to use the National Strategic Plan on HIV/AIDS to define actions to enhance the synergistic effects of an integrated and linked response on HIV/AIDS and the SRHR in the country will definitely take time to be translated into programs. The importance of having a policy is reflected in the work of FRHAM where changes started with a policy reflected in the strategic plan. Without a clear policy HIV and SRH programmes will continue to run vertically. In the long run the SRH needs and rights of key affected population will continue to be sidelined.

b. Technical support and capacity building

Technical support to build a common understanding of SRH and HIV linkages programs as well as joint planning and coordination among the SRH organisations and HIV agencies is limited. Standard operational guidelines, training materials and training of master trainers in linkages were not available. As such, basic awareness of the value of the linkages was still poor among many health workers and outreach workers from both SRH and HIV organizations.

c. Harmonization of budgets

There is no specific budget devoted to just putting SRH and HIV linkages into action. Any linked programme and services in this area is covered under limited budget traditionally provided for under the each organisation normal annual work program and budget for the year and mainly depend on the organisations' own initiatives. Furthermore, the implementation and the sustainability of SRH and HIV linked programmes services for the marginalised key affected populations such as youths, sex workers, IDUs and PLHIVs depended on the availability of funding from donors, and only targeted certain groups (i.e. only for sex workers) rather than providing a package of support for those who were in need.

d. Community involvement to reduce stigma associated with HIV/STIs, risky behaviours, and acceptance of HIV care in RH settings

There is a lack of involvement of the key affected populations and PLHIV in planning and implementing HIV and SRH linked programmes among the SRH organisations in Malaysia. The RH and FP services were mainly provided by health care professionals including doctors and nurses using the "health" approach but not "right-based" approach. The lack of understanding and sensitivity to the needs of key affected populations is a barrier for the community to access the services.

e. Monitoring and evaluation

Instituting a common/linked monitoring and evaluation system is the largest constraint in linking SRH and HIV programmes and services. Both SRH and HIV organizations in Malaysia have their own monitoring and evaluation structure and different reporting systems for different donors. Therefore, it is difficult to capture the result of HIV and SRH linkages even though some linked services are available at certain service delivery points.

In order to overcome these challenges the following are recommended:

- **Review of existing policies** - the Ministry of Health, SRH and HIV organisations should review their existing policies and if need be come up with a policy on linked RH and HIV policy. The National Strategic Plan on HIV must include plans to address the SRH needs of key affected population as well as that of their spouses and partners.

- **Advocacy, Coordination and Collaboration** – To develop an appropriate institutional mechanisms, coordination and collaboration through advocacy. The main agencies such MOH, MAC, NPFDB and FRHAM to come together to ensure coordination between SRH and HIV efforts at the highest level and provide the foundations and justification for other HIV agencies to increase their commitment to linkages and help 'make it happen'.

- **Capacity building of health care providers and outreach workers –** To train both healthcare providers and outreach workers to have a common understanding of the components of a minimum package of SRH & HIV linkages. The capacity building/training programmes also need to ensure that they not only cover only clinical aspects of SRH & HIV, but issues such as confidentiality, stigma and human rights.

- **Financial support and harmonization of budgets** - Financial support or adequate funding for SRH and HIV linkages is needed to conduct training and provide linked services. Donors need to demonstrate their commitment to SRH and HIV linkages by explicitly welcoming the approach in funding criteria, channelling the funding to integrated interventions and providing a package of support. For the organisations that received funding, accountability should be ensured through effective monitoring and evaluation systems; providing regular reporting and feedback to stakeholders; and having transparent systems for financial management.

- **Monitoring and evaluation** - The government agencies, SRH and HIV organisations in Malaysia need to collaborate and discuss the adaption of its systems for monitoring, evaluation and reporting including the careful selection of indicators and targets that measure the extent and success of linkages are needed.

SRH and HIV linkages in programs have already begun in Malaysia. Today we see more HIV programs including SRH services (directly or indirectly) and SRH programs including HIV services but Malaysia has a long way to go. In order to move forward staff of SRH as well as HIV programs in the country must come together and devise a coordinating mechanism to take their cause to a higher level.

1. Introduction

This report on "Evidence-based Strategies for Sexual and Reproductive Health Linkages and HIV in Malaysia" was funded by UNFPA under the 2011 Unified and Budget Work Plan (UBW). The UBW was intended to strengthen the capacity of the UNFPA country office to coordinate the annual activities of the RH and HIV Programmes defined under the Country Programme Action Plan (CPAP) 2008 -2012. The CPAP, which was supported jointly by UNFPA and the Government of Malaysia focused on strengthening the country's strategic response on HIV prevention education and delivery of linked SRH and HIV services with dedicated integration of the gender perspective among most-at-risk population groups especially young people and sex workers.

The study was aimed at assessing and documenting the linkages of SRH and HIV Programmes in the country and provide evidence-based strategies and service models to continually contribute towards achieving the goals and objectives of the national programmes on SRH and HIV in line with the Millennium Development Goals (MDGs) and the International Conference on Population and Development plan of action (ICPD POA).

The study was carried out within a four month period from August to November 2011 and comprised of two components; a desk review on the organizations which participated in the UNFPA CPAP RH and HIV Programme and a rapid assessment with service providers, key affected populations, clients and beneficiaries of the programmes or services. The desk review was carried out at the Federation of Reproductive Health Associations, Malaysia (FRHAM), the National Population and Family Development Board (NPFDB), Women's Institute of Management (WIM), PT Foundation (PTF) and the Safe Clinic to capture the most recent innovative linkage initiatives in Malaysia, while the rapid assessment was conducted with the purpose of assessing HIV and SRH bi-directional linkages at programmes and service-delivery levels by using two modified questionnaires based on the Rapid Assessment Tool for SRH and HIV Linkages, 2009.

It also served to complement the WHO/UNFPA funded study on Strengthening HIV and SRH linkages in Malaysia in 2010. In view of the fact that the WHO/UNFPA study only focused on the "supply" components of linked HIV/SRH services, this study was designed to evaluate "demand" aspects, namely programme efficiency and

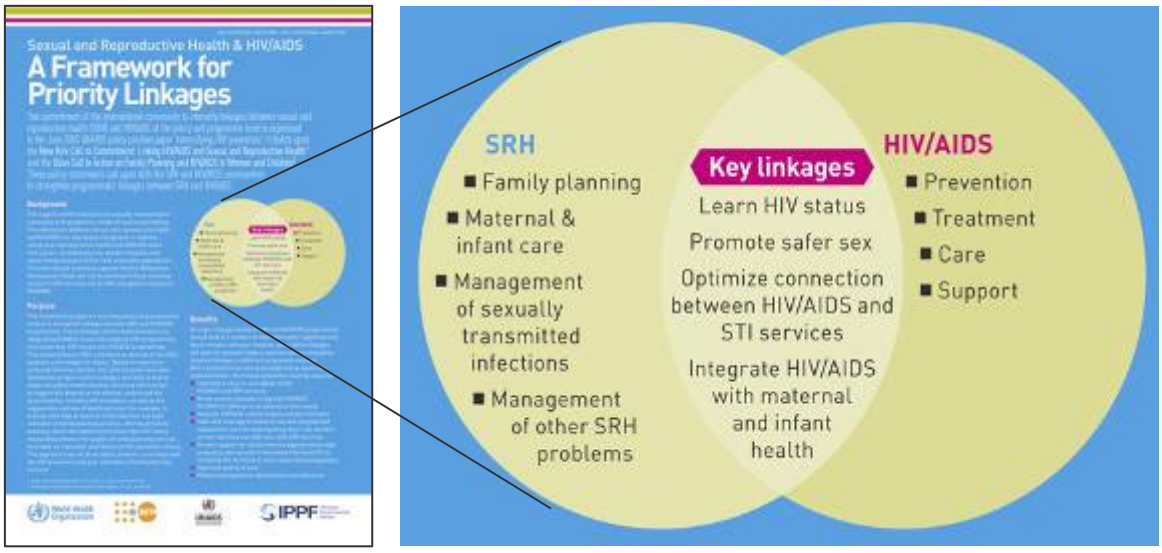
effectiveness through the desk review and the responses from the recipients of such services. The outcome of the study would be proposed for evidence-based advocacy, policies and operational plans to strengthen and scaling up the SRH and HIV linkages.

2. Linking Sexual and Reproductive Health and HIV/AIDS

2.1 International Overview - Commitment and Progress

The importance of linkages between sexual and reproductive health (SRH) and infection by the Human Immunodeficiency Virus (HIV) is widely recognized. The international community in fact pointed out that the Millennium Development Goals (MDGs) and Programme of Action (PoA) of the International Conference on Population and Development (ICPD) will not be achieved without ensuring universal access to SRH and HIV prevention, treatment, care and support.[1&2]

A conceptual framework for linkages that was developed by WHO, UNFPA, UNAIDS and IPPF in 2005 identified priority areas for linkages, key actions on advocacy and policy dialogues and services which could lead to significant public health benefits and improve the efficient use of resources[3]. The framework also emphasized fulfilling the sexual and reproductive rights and needs of the communities most at risk to address HIV infection and unintended pregnancies.



[1] UNAIDS,UNFPA and FHI (2004). *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health.*

[2] WHO and UNFPA (2004). *The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, 3-5 May 2004.*

[3] WHO, UNFPA, IPPF and UNAIDS (2005). *Sexual and Reproductive Health and HIV/AIDS: A framework for priority linkages.*

Furthermore, studies also showed that bi-directional linkages between SRH and HIV-related policies and programmes can lead to a number of important public health, socio-economic, and individual benefits. The evidence reviewed in 2008 revealed that the linkages provide opportunities to improve access to and uptake of key HIV and SRH services, better access of people living with HIV to SRH services tailored to their needs, reduction in HIV-related stigma and discrimination, improve coverage of the underserved/vulnerable/key populations, greater support for dual protection, improve quality of care, reduce duplication of efforts and competition for scarce resources, better understanding and protection of individuals' rights, mutually reinforcing complementarities in legal and policy frameworks, enhance programme effectiveness and efficiency and better utilization of scarce human resources for health[4].

In order to build a common understanding among the SRH and HIV communities of linked SRH and HIV responses and to ensure that it is underpinned by a human rights approach, key principles and working definition for selected terms has also been identified in 2009 through a rapid assessment tool[5]. The principles of linking include the following:

- Address structural determinants
- Focus on human rights and gender
- Promote a coordinated and coherent response
- Meaningful involvement of PLHIV
- Foster community participation
- Reduce stigma and discrimination
- Recognise the centrality of sexuality

At the same time , the Rapid Assessment Tool for SRH and HIV linkages was developed as a tool that can be used both regionally and nationally to assess the bi-directional linkages between HIV and sexual and reproductive health at the policy, systems and service-delivery levels. A total of 19 countries which included Bangladesh, Pakistan, Vietnam, Morocco, Russian Federation, Belize, Benin, Botwasna, Cote d'Ivoire, Lebanon, Kyrgyzstan, Burkina Faso, Tunisia, Central African Republic, Malawi, Swaziland, Tanzania, Uganda and Zimbabwe participated in assessing SRH and HIV linkages using the tool

[4] IPPF, UCSF, UNAIDS, UNFPA & WHO (2008). *Linkages: Evidence Review and Recommendations*
[5] IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW & Young Positives, (2009). *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide.*

between 2008 to 2011 and summary reports that highlighted their experiences, results and further actions, has been produced[6].

The key findings of the assessment showed that only a few countries had strong political will, strategies and partnership for SRH & HIV linkages. Most countries lacked national strategies, legislation, policies and coordination mechanisms for SRH and HIV linkages. In addition, the integration of SRH and HIV services was also found predominantly among selected services and/or through specific entry points and tended to discontinue due to shortages of human resources, training, standard operational guidelines and financial support. Based on the outcomes from the rapid assessments, a consultation was held from 1-3 December 2010 to discuss country implementation of the Rapid Assessment Tool for SRH and HIV Linkages. Participants included those from 16 countries which had implemented the tool, nine countries that planned to implement it, and regional as well as international partners. Six priority areas were identified during the consultation. They included: strengthening national coordination and leadership of SRH & HIV linkages work; agreeing on a minimum national package for linkages; developing training materials and capacity building on linkages; strengthening linkages among referral services organisations, logistics and commodities distribution systems; positioning attention to linkages within the broader dialogue on national health systems; and using the involvement of key populations to advocate for SRH rights[7]. All countries involved in the consultation workshop recognized and agreed that more effort and increased commitment and resources were needed in order to strengthen the SRH and HIV linkages at the national level.

[6] IAWG for SRH & HIV Linkages. (2011). Implementation of the Rapid Assessment Tool. *http://www.srhhivlinkages.org/uploads/docs/articles/ratimplementation_2011_en.pdf*

[7] IPPF, UNFPA, WHO, UNAIDS. (2010). Consultation to Discuss Country Implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages. *http://www.srhhivlinkages.org/uploads/docs/articles/ratconsultation_2010_en.pdf*

2.2 Country Overview - Commitment and Progress

The Malaysian Government has reiterated that it is committed to the full implementation of the ICPD POA and the MDGs.[8] In addition, Malaysia has actively involved itself in international forums and workshops on SRH and HIV linkages since 2006.

In the Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services, and the 6th UN Asia-Pacific Prevention of Mother-to-Child Transmission of HIV (PMTCT) Task Force Meeting in 2006, Malaysia reported that HIV and SRH linked services had been initiated in stages into the Maternal Child Health (MCH) services since the early 1980s [Malaria, tuberculosis (TB) and STIs]; comprehensively from the 1990s (Family planning since the early 1990s, PMTCT since 1998). At this forum, Malaysia was one of the 20 Asia and Pacific participating countries who agreed to undertake broader national level consultation, to strengthen the comprehensive approach to PMTCT and to expand access to treatment and care for HIV positive pregnant girls, women, their partners and their children[9].

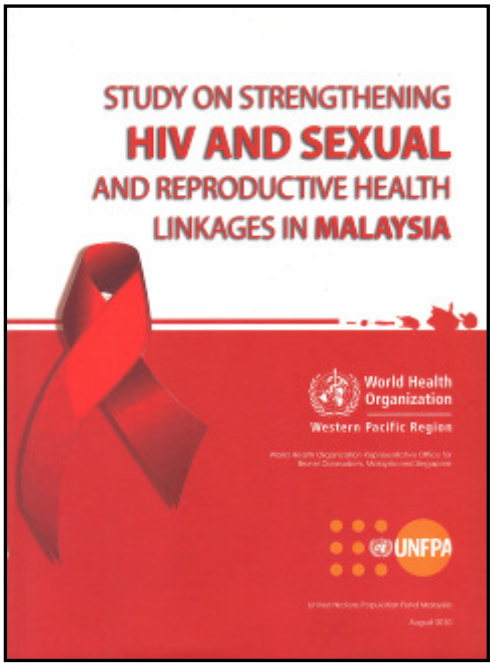
In 2009, Malaysia also participated in the Workshop on Expanding Linkages between HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services and identified priorities and potential next steps for the country programmes to improve or expand the linked response[10]. The priority areas identified by representatives from both Family Health Division and AIDS/STD Section, Ministry of Health Malaysia to strengthen the SRH and HIV services in primary health care services, included up scaling human resources, capacity building, building smart partnerships with NGOs and strengthening the monitoring and evaluation system through improving data collection system and joint meeting with relevant stakeholders.

[8] Y. B. Dato' Sri Shahrizat Abdul Jalil, Minster of Women, Family and Community Development (2009), *Keynote Address: Population and Development Conference 2009: Harnessing the Resources*, (Conference was held on 10 August 2009, at the Matrade Exhibition and Conference Centre, Kuala Lumpur)

[9] UNAIDS, UNICEF, UNFPA & WHO (2006). *Report on the Joint Forum Incorporating the Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services and the 6th UN Asia-Pacific Prevention of Mother-to-Child Transmission of HIV (PMTCT) Task Force Meeting*, Kuala Lumpur, 6th – 10th November 2006.

[10] WPRO and UNICEF (2009). *Meeting Report of Workshop On Expanding Linkages Between HIV/STI Services With Reproductive, Adolescent, Maternal, Newborn And Child Health Services.*

A WHO/UNFPA funded study on HIV and SRH linkages in Malaysia in 2010 showed that there is no explicitly promulgated HIV, SRH or HIV and SRH linked Policy in Malaysia, but most of the key agencies in the health sector such as Ministry of Health (MOH), National Population and Family Development Board (NPFDB), Malaysian AIDS Council (MAC) and the Federation of Reproductive Health Associations, Malaysia (FRHAM), have well publicised instruments such as strategy plan, framework or guidelines defining actions on HIV and SRH that seem to reflect policy. However, none of these documents addressed on SRH and HIV linkages directly[11].



Despite not having linked HIV and SRH Policy, the study found that various types of programmes and services currently implemented by these organizations in Malaysia were already HIV and SRH linked to some extent. Nonetheless, there has neither been an organised documentation nor systematic review of the current practices in order to identify gaps to up scale or strengthen the linkages between HIV and SRH.

The study was followed by a National Roundtable Discussion on Strengthening HIV and SRH Linkages in Malaysia on 4 August 2010. Through the roundtable discussion, most of the agencies in Malaysia indicated that they accepted the concept of strengthening the linkages between HIV and SRH but indicated that they needed more support, ranging from a more supportive policy environment, increased stakeholder commitment, technical assistance to improve linked programming, financial and human resources as well as capacity training. Furthermore, the representatives from the key agencies such as MOH, MAC, NPFDB, FRHAM, PT Foundation, etc also collectively agreed to include SRH and HIV linkages into the National Strategic Plan on HIV and AIDS in 2011 – 2015 and use the same policy instrument to define actions to enhance the synergistic effects of an integrated and linked response on HIV/AIDS and SRH and rights in the country[12].

[11] WPRO and UNFPA Malaysia (2010). *Study on HIV and Sexual and Reproductive Health Linkages in Malaysia.*
[12] Ibid 11.

3. Evidence-based Strategies for SRH and HIV Linkages in Malaysia

The UNFPA Unified and Budget Work Plan (UBW) Project on "Evidence-based Strategies for Sexual and Reproductive Health Linkages and HIV in Malaysia" was implemented with the following goal and objectives:

3.1 Goal:

To assess and document the linkages of SRH and HIV Programmes in the country and provide evidence-based strategies and service models to continually contribute towards achieving the goals and objectives of the national programmes on SRH and HIV in line with the Millennium Development Goals (MDGs) and the International Conference on Population and Development plan of action (ICPD POA).

3.2 Objectives:

1. To gain a clearer understanding of the effectiveness, optimal circumstances, and best practices for strengthening SRH and HIV linkages through systematic review of the literature, programme and services, with a focus on most-at-risk groups (young people and vulnerable women in difficult circumstances).

2. To identify the gaps and major challenges experienced by the organisations such as FRHAM, NPFDB, WIM, PT Foundation and the Safe Clinic in implementing the HIV and SRH linked programme and services

3. To identify the special features of organizations that make them uniquely appropriate vehicles for promoting HIV and SRH linkages and explore how they can best be supported in this work and

4. To propose steps for expansion and scaling up a well as other strategies for UNFPA to consider in taking this initiative forward.

3.3 Methodology

The study focused on the organizations that participated in the UNFPA Country Programme Action Plan (CPAP) RH and HIV Programme 2008 – 2012 [Federation of Reproductive Health Associations, Malaysia (FRHAM), the National Population and Family Development Board (NPFDB) and Women's Institute of Management (WIM)], and PT Foundation, a community AIDS organization that works directly with marginalized communities as well as the Safe Clinic which is a newly formed organization to offer HIV and SRH linked programmes.

The study was divided to two parts, which included a desk review and a rapid assessment. The desk review was aimed at capturing the most recent innovative linkage initiatives that exist between sexual and reproductive health services and/or HIV prevention, and AIDS treatment as well as care and support at each agency. On the other hand, the rapid assessment was conducted with various service providers and clients who benefited from the training or service delivery programme in order to gather their points of view on the linked programmes and services to supplement the gaps of service delivery. In order to facilitate consistent understanding in this study, the following definitions were used:

Linkages: The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to broader human rights based approach, of which service integration is a subset.[13]

Integration: Different kinds of sexual and reproductive health and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another as an example. It is based on the need to offer comprehensive and integrated services[14].

Bi-directionality: Both the SRH and the HIV communities address relevant aspects of each others' agendas. For example: linking sexual and reproductive health (SRH) with HIV-related policies and programmes and linking HIV with SRH-related policies and programmes[15]

[13] Ibid 5.
[14] Ibid 5.
[15] Ibid 5.

3.3.1 Desk Review

The desk review started with approaching the identified five organizations in order to gather in-depth information and assess their HIV and SRH bi-directional linkages at the programmess and service-delivery levels. The documents required for desk review not only covered the published studies and rigorous evaluation studies that are related to HIV and SRH linkages, but also included "promising practices" such as 'Grey' literature (non-published studies), reported evaluation of projects, preliminary or situational analysis study, existing training curriculum/materials and standard operational guidelines for service delivery or protocols for delivery of services, etc. In addition, 'intangible' policies/practices such as attitudes of agencies/organizations towards key populations, sexuality, and reproduction, etc were reviewed through observation.

These documents were collected, analyzed and tabulated accordingly into a template that covered 5 approaches as follows (Appendix 1):

- Approach 1: Capacity Building/Training Programme on SRH, HIV and STI
- Approach 2: Educational Programme on SRH, HIV and STI
- Approach 3: Linked SRH/HIV/STI and PPTCT Programme
- Approach 4: Linked SRH/STI/HIV Counseling and Testing Programme
- Approach 5: Linked SRH/STI/HIV Prevention, Treatment, Care and Support Programme by and for PLHIV

3.3.2 Rapid Assessment of the Training and Service Delivery Programmes

A cross-sectional rapid assessment was carried out in order to assess HIV and SRH bi-directional linkages in the training and service-delivery programmes utilising the two questionnaires (one for service providers/outreach workers and another for clients/beneficiaries) modified from the Rapid Assessment Tool for SRH and HIV Linkages, 2009.

The questionnaire for service providers/outreach workers was designed to identify the gaps and challenges in delivering the SRH and HIV linked services. It focused on the current SRH and HIV linked services provided, mode of delivery, constraints, impact and support needed in delivering the SRH and HIV linked services.

For the questionnaire targeting clients/beneficiaries of linked programmes or services, questions suggested by the Rapid Assessment Tool such as types of linked services received by clients, reasons for not able to access the linked services, preference on how services should be deliver, advantages and disadvantages of linked services were included. In addition, there were questions on SRH and HIV linked information made available to them. Both questionnaires were prepared in English and translated into the Malay language. (Appendix 2a, 2b, 3a and 3b)

The study was conducted through self-administration (mainly among the service providers) and face-to-face interviews with young people and various participants of training programs, as well as clients of the service delivery section of FRHAM, NPFDB, WIM, PTF, WAKE and the Safe Clinic .
The targeted respondents included the following:

- Youths (aged 14 – 24 years old)
- Family planning/reproductive health clients
- Female Sex Workers
- Indigenous women
- Women living with HIV
- Service Providers from FP/RH clinics
- Outreach workers from HIV organisations

3.4 Expected Output

Production of an analytical report of the CPAP activity outputs from 2008 to 2010 as an advocacy document for evidence-based strategies and service models to further strengthen the linkages between SRH and HIV especially among marginalized and vulnerable populations.

4. Desk Review of SRH and HIV/AIDS Linkages

4.1 A Case study of the Federation of Reproductive Health Associations, Malaysia (FRHAM)

4.1.1 Providing HIV-related information and services in a sexual and reproductive health setting: Transition from traditional to pioneering role

The Federation of Reproductive Health Associations, Malaysia (FRHAM), formerly known as the Federation of Family Planning Associations, Malaysia (FFPAM), is a federation of 13 State Member Associations (MAs) which are independently registered with the Registrar of Societies. In 1963 the various state MAs together formed the Federation of Family Planning Associations (FFPAM). In 2009 FFPAM was renamed the Federation of Reproductive Health Associations (FRHAM) to better reflect the change in role and service over time. FRHAM is a Member Association of the International Planned Parenthood Federation (IPPF) since 1963, and the second largest supplier of contraceptives in the country after the Government.

A Member Association of

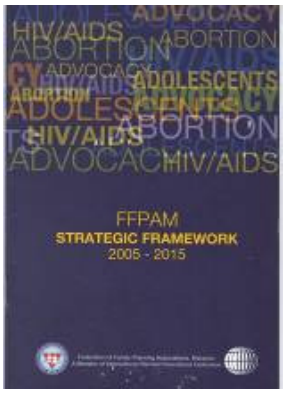
FRHAM today is a not for profit non government organization that aims to educate Malaysians about family planning and responsible parenthood, promote and provide effective family planning and sexual and reproductive health services. Clinical services are offered by state MAs but planning, training, monitoring and evaluation are responsibilities of FRHAM. FRHAM has 38 clinics and 353 re-supply points across the country providing SRH services to more than 100,000 clients (male, female and young people). [16]These programmes and services provided have evolved from just basic family planning services to more comprehensive sexual and reproductive health services, including maternal and child health care, STI prevention and management, prevention

[16] FRHAM (2010). *FRHAM Annual Report 2009.*

of unsafe abortions, referral for safe abortion services, post abortion care services and other SRH services such as Pap smear, breast examination (for early detection of cancer) and menopausal services.

FRHAM has played a pivotal role in implementing HIV/AIDS related programmes since the emergence of HIV epidemic in Malaysia in 1986 by providing HIV prevention information to the general population, including men, women and young people. In 1992, FRHAM was one of the NGOs which initiated and facilitated the formation of the Malaysian AIDS Council (MAC), an umbrella and coordinating body of multisectoral NGOs involved in HIV/AIDS activities. HIV/AIDS has also been identified by FRHAM as one of the core programmes in the *FFPAM Strategic Framework 2005 – 2015.* The programme strategies identified under the framework included of the following:

1. Reduction of social, religious, cultural including gender, economic, legal and political barriers that make people vulnerable to HIV/AIDS
2. **Increased access to interventions programs for the prevention of HIV/AIDS/STIs through integrated, gender-sensitive SRH and Rights programmes**
3. Increased access to care, support and treatment for people infected and support for those affected by HIV/AIDS



Furthermore, a Minimum Service Package on SRH-HIV linked services was adopted by the National Council of FRHAM in April 2010 to be integrated into the state member associations' existing programmes.

FRHAM - Minimum Service Package on SRH-HIV linked services

1. Voluntary Counseling and Testing (VCT)
2. Psycho-social support
3. Prevention for and by people living with HIV
4. HIV prevention information and services for the general population
5. Condom provision
6. PMTCT
   - Prevention of HIV among women of childbearing age and their partners
   - Prevention of unintended pregnancies in HIV + women
   - Care & support for HIV + mothers and their family
7. Specific HIV information and services for key affected populations (IDUs, MSM

In view of the fact that certain policies and trainings on HIV and SRH linkages had been in place and provided for by FRHAM, the 13 state member associations began to examine where traditional sexual and reproductive health services and HIV/AIDS services overlapped and then made decisions based on the capacity and resources of each association to identify the types of HIV/AIDS services they could provide. Thus a number of state MAs began to include HIV-related services such as voluntary counseling and testing (VCT) and psychosocial support for PLHIV and their families in their programmes (as listed in Table 1). They also began to reach out to specific key affected populations such as sex workers, IDUs, refugees and marginalized youths. State MAs that were not ready to provide HIV-related services, focused mainly on the provision of HIV prevention information and condom for their RH clients. Currently, these include:

- five of the 13 state MAs provide voluntary counseling and testing for HIV
- two state MAs offer psychosocial support for PLHIV
- two state MAs work closely with the Needle and Syringe Exchange Program (NSEP) sites to prevent HIV transmissions among spouses/partners of IDUs

HIV-related treatments such as the provision of antiretroviral therapy (ARV) was not included as part of clinic services as PLHIV in Malaysia are able to access free treatment at government hospitals. However, FRHAM and state MAs have partnered with the Ministry of Health at the national and state levels for referral of clients who tested positive for follow-up treatment.

Table 1: List of SRH and HIV Linked Services by FRHAM and its state MAs

HIV/SRH	Family planning	Maternal & child health care	STI prevention & management	Prevention of unsafe abortion & management	Other SRH services
NSEP/ MMT	2 state MAs (Johor, Kelantan)	2 state MAs (Johor, Kelantan)	2 state MAs (Johor, Kelantan)	2 state MAs (Johor, Kelantan)	2 state MAs (Johor, Kelantan)
HIV prevention, education & condoms	13 state MAs	7 state MAs (Johor, Melaka, Pahang, Kelantan, Selangor, Sabah, Sarawak)	13 state MAs	13 state MAs	13 state MAs
HIV counseling & testing	5 State MAs (Kelantan, Penang, Selangor, Melaka, Sarawak)	5 State MAs (Kelantan, Penang, Selangor, Melaka, Sarawak)	5 State MAs (Kelantan, Penang, Selangor, Melaka, Sarawak)	5 State MAs (Kelantan, Penang, Selangor, Melaka, Sarawak)	5 State MAs (Kelantan, Penang, Selangor, Melaka, Sarawak)
***PMTCT -** Prong 1: Prevention of HIV among women of childbearing age and partners	13 state MAs	7 state MAs (Johor, Melaka, Pahang, Kelantan, Selangor, Sabah, Sarawak)	13 state MAs	13 state MAs	13 state MAs
Psychosocial & other services for PLHIV	2 state MAs (Penang and Sarawak)		2 state MAs (Penang and Sarawak)		2 state MAs (Penang and Sarawak)

* *There are four prongs of PMTCT services as identified in the Rapid Assessment Tool:*

- *Prong 1: Prevention of HIV among women of childbearing age and partners*
- *Prong 2: Prevention of unintended pregnancies in HIV+ women*
- *Prong 3: Prevention of HIV transmission from an HIV + woman to her child*
- *Prong 4: Care & support for the HIV + mother and her family*

Although the FRHAM's Minimum Service Package on SRH-HIV linked services recommended state MAs to provide services as listed in Prong 1, 2 and 4, all state MAs only included Prong 1 in their current services.

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4.1.2 Information and Services for young people: A pressing need

Adolescent sexual and reproductive health is one of the key programmes of FRHAM. In view of the fact that young people are vulnerable to STIs including HIV/AIDS and unintended pregnancy, FRHAM as the key NGO in the field of reproductive health has always advocated for all adolescents and young people to be made aware of their sexual and reproductive rights so that they are empowered to make informed choices and act on them. Various information, education and communication (IEC) materials and training modules on adolescent sexual and reproductive health including HIV have been developed and campaigns and training workshops, especially training workshops for peer educators have also been conducted regularly. In addition to that, youth-friendly services are available in state MAs' clinics.

The emphasis on the need to focus on the changing reproductive and sexual health needs of young people prompted the FRHAM to develop the "Reproductive Health Adolescent Module (RHAM)" in 2000 to promote healthy practices and life-enhancing values, self-esteem, gender equality and family relationships. Information on sexual and reproductive health and rights and life-skills including education on condom use as well as other contraception were included in the module. The module has been utilized by state MAs of FRHAM, Ministry of Education, Ministry of Women, Family and Community Development and some schools as a tool to advocate and promote HIV/AIDS and sexual health among young people.

In order to reach out to disadvantaged youths in juvenile homes run by the Department of Social Welfare [Sekolah Tunas Bakti (STB) for boys and Taman Seri Putri (TSP) for girls], FRHAM with funding from UNFPA adapted the RHAM module and produced the "Perjalanan Kehidupan" (Lives Journey) incorporating more elements of HIV and responsibilities in sexual relationship, including safer sex, condom use, risk behaviours, gender, stigma and discrimination.

Using the Life's Journey module, training and peer education programmes were conducted in 13 juvenile homes throughout Malaysia and as a result of these programmes, the number of young people who requested for SRH or HIV-related services also increased. These youths would be referred to the state MAs equipped with clinics through an arrangement with the caretakers of the homes' and the Department of Social Welfare under the Ministry of Women, Family and Community Development. Some state MAs like Terengganu on the other hand were allowed to bring the services directly to the juvenile homes.

Quote from Participants:

"Saya sudah kurangkan merokok, dulu saya tidak pandai pakai kondom. Sekarang saya sudah pandai pakai kondom secara betul, saya tidak akan lepak dengan kawan-kawan saya lagi" [I have reduced my smoking. Before I did not know how to wear a condom, now I knowhow to do it correctly. I will also not mix with my previous friends again]

16 years old boy, STB Kuching

"Saya telah mempelajari tentang jangkitan penyakit kelamin dan HIV/AIDS, memahami tubuh badan and fungsi-fungsi organ, cara-cara menggunakan kondom dengan betul" [I have learned about sexually transmitted infections, and HIV/AIDS, understand development of my body, functions of my organs, correct method of wearing the condom]

16 years old boy, STB Kuching

In addition to the positive impact on the youths themselves, the project, through the sensitization workshops, also increased the commitment of the stakeholders including the officers from the Department of Social Welfare, the caretakers from the juvenile homes in fulfilling the SRH needs, including HIV and STIs prevention, and rights of those under their care. In general most of the caretakers recognised the RH needs of the young people in the homes and upon request, assisted them by sending them to state MAs for services.

On the other hand, youth friendly centres and clinics were available at the state levels for young people to access SRH and HIV information, para-counseling, SRHR education and services. In 2009, the youth friendly services were further strengthened through an IPPF project funded by The Dutch Ministry of Foreign Affairs' Strategic Alliance with International NGOs (SALIN) Plus funds.

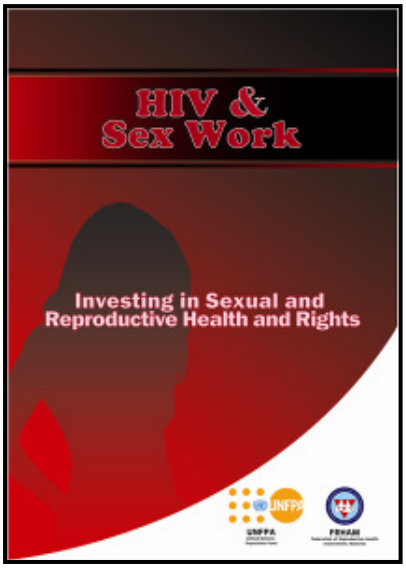
The objective of the project was to provide youth friendly information and services to young people and increase the quality of services through inclusion of youth as service providers as well as policy makers. At the MA level youth committees were set up to plan and execute youth friendly services through peer education. Trained "youth educators" shared SRH and HIV information with young people from diverse backgrounds and sexual orientations through outreach activities and used a variety of strategies to communicate their message. In addition, young people also assisted in the youth-friendly clinics to make the new comers feel more comfortable when seeking RH services. Services included counseling on safer sex and sexuality, contraceptives services, HIV prevention information, condom and VCT, screening and management for STIs and referral for safe abortion services.

Through this project FRHAM managed to reach out to a total of 11,366 youth clients. Young people from marginalized communities such as young drug users, sex workers, transsexuals, MSM and youth with disabilities were served under the project and many were more aware of their SRHR and have greater access to comprehensive youth-friendly SRH services including HIV and AIDS.

4.1.3 Reaching out to key affected populations

4.1.3.1 Sex Workers

In Malaysia, the key affected populations such as sex workers, IDUs, MSM and refugees have been targeted for HIV prevention efforts as is evident in the National Strategic plan on HIV/AIDS 2006 to 2010[17]. Unfortunately little attention has been given to SRH-related care for them. In order to bring the key affected populations into the focus for SRH-HIV convergence the UNFPA funded project entitled "HIV and Sex Work Programme, 2008-2012" was initiated in 2008. The project started with a comprehensive situational analysis of sex work in Malaysia and the

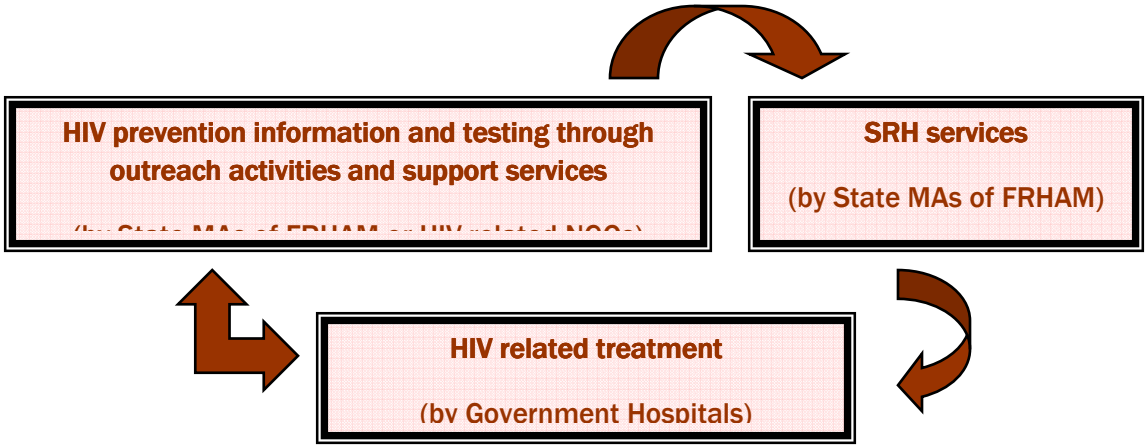


[17] Ministry of Health, Malaysia (2006). *Malaysia National Strategic Plan on HIV/AIDS 2006 – 2010.*

report was published in 2010 which revealed that most of the sex workers were not only at risk of HIV infection but also of other sexual and reproductive health problems including STIs, unintended pregnancies and unsafe abortion[18]. The study clearly showed that there was a need for Malaysia to adopt a comprehensive Plan of Action on HIV and Sex Work that linked HIV and SRH services in order to address sex workers' sexual and reproductive needs, provide them with comprehensive care and not just treat them as "target" populations for HIV prevention efforts.

As a result of the study some MAs were identified and recruited as project sites where the SRH including HIV/AIDS needs of sex workers were addressed, either at the MA's premises or through mobile clinics at places identified by HIV NGOS. Sex workers were also encouraged to seek for SRH and HIV-related services including contraception, STIs screening and treatment, Pap smear, breast examination, and general health screening at state MAs' clinics. Sex workers who tested HIV positive were referred to government hospitals for HIV treatment and follow-up.

Figure 1: Coordination and Referral Mechanism for SRH and HIV linked Services for Sex Workers



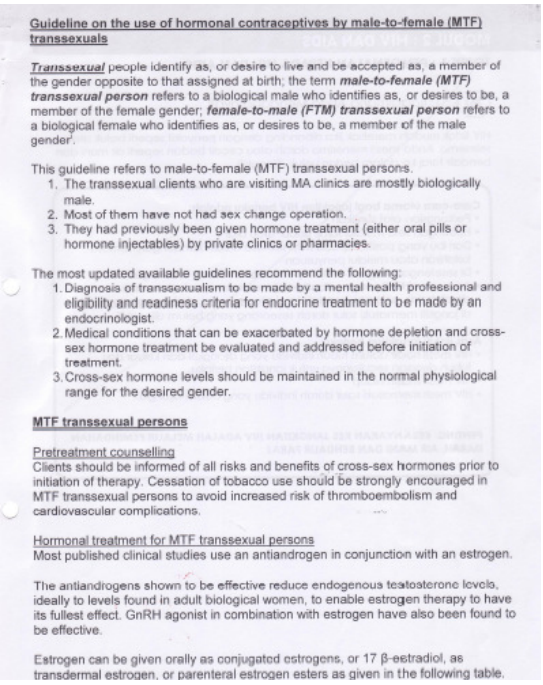
[18] FRHAM and UNFPA Malaysia (2010). *HIV and Sex Work: Investing in Sexual and Reproductive and Rights.*

It should be noted that although SRH services were available in all state MAs clinics, the uptake of SRH services, especially contraception services among the sex workers was slow. Most of the sex workers were unaware of their SRH needs, had a lot of misconceptions about contraception and were not aware that condoms could be used for "dual protection" against HIV/STIs as well as unintended pregnancies.

Quote from outreach worker in Melaka :

Female sex workers believe that they do not need to be on oral contraceptive pills as the pills will make them fat, they will straight go for "cuci perut" procedure (generally assumed as abortion) every 6 months. They believe that this can keep them safe from contracting any diseases including HIV/AIDS and also pregnancy. Many of the sex workers (those who are drug users) are scared to go for VCT because they are afraid that the presence of drug in their blood will be detected.

Many sex workers in Melaka and Kelantan who came to clinics for services were transsexuals. Most of them requested hormonal contraceptives to transform their body shape. In view of that, the Medical Committee of FRHAM developed the "Guideline on the use of hormonal contraceptives by male-to-female transsexuals" which provides operational guidelines for the provision of contraceptives to transsexuals.



Guideline on the use of hormonal contraceptives by male-to-female (MTF) transsexuals

Transsexual people identify as, or desire to live and be accepted as, a member of the gender opposite to that assigned at birth; the term ***male-to-female (MTF) transsexual person*** refers to a biological male who identifies as, or desires to be, a member of the female gender; ***female-to-male (FTM) transsexual person*** refers to a biological female who identifies as, or desires to be, a member of the male gender[1].

This guideline refers to male-to-female (MTF) transsexual persons.

1. The transsexual clients who are visiting MA clinics are mostly biologically male.
2. Most of them have not had sex change operation.
3. They had previously been given hormone treatment (either oral pills or hormone injectables) by private clinics or pharmacies.

The most updated available guidelines recommend the following:

1. Diagnosis of transsexualism to be made by a mental health professional and eligibility and readiness criteria for endocrine treatment to be made by an endocrinologist.
2. Medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed before initiation of treatment.
3. Cross-sex hormone levels should be maintained in the normal physiological range for the desired gender.

MTF transsexual persons

Pretreatment counselling

Clients should be informed of all risks and benefits of cross-sex hormones prior to initiation of therapy. Cessation of tobacco use should be strongly encouraged in MTF transsexual persons to avoid increased risk of thromboembolism and cardiovascular complications.

Hormonal treatment for MTF transsexual persons

Most published clinical studies use an antiandrogen in conjunction with an estrogen.

The antiandrogens shown to be effective reduce endogenous testosterone levels, ideally to levels found in adult biological women, to enable estrogen therapy to have its fullest effect. GnRH agonist in combination with estrogen have also been found to be effective.

Estrogen can be given orally as conjugated estrogens, or 17 β-estradiol, as transdermal estrogen, or parenteral estrogen esters as given in the following table.

Since the project started in 2009, FRHAM and state MAs have been working closely with most of the HIV-related organizations (e.g. PT Foundation, WAKE and Intan Life Zone Johor) and government agencies such as the Ministry of Health, Ministry of Women, Family and Community Development, religious departments and law enforcement at national and state levels. The supports from government agencies provide an enabling environment for people involved in sex work to seek SRH and HIV information and service. In addition to that, the collaboration with other HIV-related agencies avoided duplication of efforts and maximized the use of limited resources.

4.1.3.2 Refugees

The SRH and HIV needs of the refugee communities are often neglected due to the economics, language, distance and legality of their presence in Malaysia. In view of that, FRHAM spearheaded a two-year project (2009 – 2011) funded by the Japan Trust Fund (JTF) through IPPF aimed at improving the SRH and rights of refugee communities by providing accessibility to SRH and HIV services.

The project started by engaging outreach and healthcare workers from among the refugee communities and providing them with training on SRH and HIV. The outreach workers were expected to disseminate the SRH and HIV information to their communities and encouraged the refugees to come for services. At the same time healthcare providers from the refugee community were recruited and stationed in the clinics to facilitate the delivery of services.

At the end of the project, a total of 13,900 refugees were provided with SRH and HIV prevention information through outreach activities and over 2,000 clients from the refugee communities were able to access SRH and HIV-related services through the three family planning clinics in Kuala Lumpur and Selangor. Refugees now make up 43% of the total clients served by the Selangor and Federal Territory MA. The clinics also have VCT services available for refugee clients. In addition, the uptake of VCT services among the refugee population is also increasing. Effective referral mechanism have also been developed for all refugee clients found to be HIV positive to be referred to UNHCR and henceforth to government hospitals for treatment and related services.

Some Quotes:

"*Before we had nowhere to go for women's health services. If the clinic closes, we will [again] have nowhere to go for [SRH] services.*" **Refugee client**

"Health staff are very open- they do not ask about marital status" **Refugee client**

"*Before I had heard about modern family planning methods, but did not know how to use them. It's easy to talk about SRH issues for me now. I can explain the advantages of good SRH to the community*" **Outreach Workers from the Refugee Communities**

4.1.3.3 Spouses/partners of IDUs

The concern over the increase of women infected by their spouse or partner who were also drug users prompted the initiation of the project "Reducing HIV vulnerability among Injecting Drug Users' (IDUs) spouses/partners via provision of comprehensive SRH information and services including STI and HIV" funded by the Ministry of Health through the Malaysian AIDS Council (MAC) in 2009. The project was aimed at reducing HIV transmission through the provision of condom, STI treatment, information and education on HIV and SRH, VCT, and referrals for HIV-related treatment through FRHAM clinics in Johor and Kelantan.

The state MAs were expected to work closely with the Needle and Syringe Exchange Programmes (NSEP) sites to reach out to spouses or partners of IDUs and services were brought to the "door-steps" of the beneficiaries. Appropriate referrals to hospitals, Department of Social Welfare and others for services such as complicated STI treatment, HIV treatment, care and support are also made on a case-to-case basis.

Through the project, staff and volunteers were exposed to the needs of marginalized groups and developed more positive attitudes in serving them. The spouses were also more aware of the SRH needs provided by the clinics and shared the information with their peers. However, the project discontinued after a year as the uptake of the services among the clients was low. One of the reasons cited for the low uptake was of the limited manpower at the NSEP sites. The shortage of human resources at these sites resulted in the HIV prevention programme among IDUs being placed at the forefront. As such, they were no longer able to assist in this project.

4.1.4 Linking SRH/ STI/HIV Prevention, treatment, care and support: Responding to the Sexual and Reproductive Needs of PLHIV

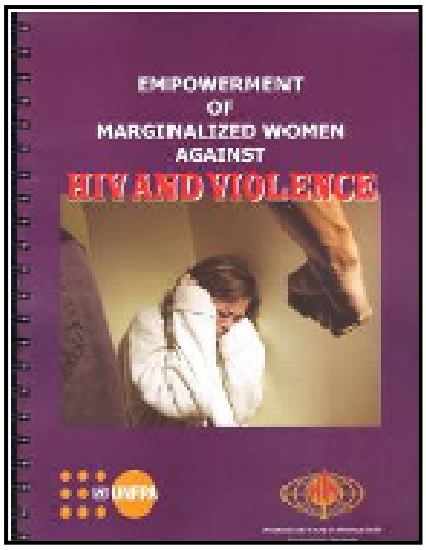
One of the programme strategies under FRHAM's Strategic Framework 2005 - 2015 is to increase access to care, support and treatment for people infected and as well as address SRH needs of HIV+ women. These support programmes were implemented by state MAs of Penang and Sarawak. Penang FHDA's MAY CARE Centre has provided PLHIVs a drop-in centre to rest, meet with their peers, obtain support, as well as to receive counseling and information about treatment. In addition to that, condoms and supplements are distributed and SRH talks, sharing sessions and skill building workshops

are held from time to time. Sarawak FPA's "Spread a Smile" project focuses on adoption of families affected by HIV, while "Breaking the Silence" care and support group mainly support families of people living with HIV.

4.2 A Case study of the Women's Institute of Management (WIM)

4.2.1 Linking Gender-Based Violence and HIV prevention and education – Reaching those most vulnerable to HIV

The WIM's training programme on HIV and violence was meant to supplement their existing entrepreneurial programme for marginalized women (pre-release women prisoners, aboriginal women, estate women, and single mothers). It was also intended to protect women from HIV by addressing poverty, economic and gender inequalities.



An interactive training module "Empowerment of marginalized women against HIV and Violence" was produced in two languages, English and Bahasa Malaysia under this programme to cater for marginalized women who are generally not well educated.

Empowerment workshops were conducted based on the training module for marginalised women including indigenous women, estate women, single mothers and women living with HIV. The workshops provided a platform for the women to examine their beliefs, myths, values and attitudes by giving them sufficient information on HIV and violence in order to empower them to make informed choices in protecting themselves from HIV and improving their sexual and reproductive health and rights (SRHR). Most of the women were able to understand violence inflicted by their intimate partners is not a "norm" but a violation of their rights and that they could take proper steps to negotiate with their partners or to seek for help in order to protect themselves and their children. The pre and post tests' results of the workshops showed that there was an increased of HIV knowledge (especially on HIV transmission) and understanding of the issue of violence and the linkages between HIV and violence

among marginalized women. In addition, stigma and discriminations towards PLHIV were also reduced.

In addition to this, the training was also an entry point for the marginalized women to recognize their SRH needs as the training also provide other basic SRH information such as cervical cancer and breast cancer when requested. For example, HIV positive women from WAKE were more aware of their risks to gynaecological cancers and they started to request for Pap smear and breast examination services in the hospitals where they received their HIV-related treatments.

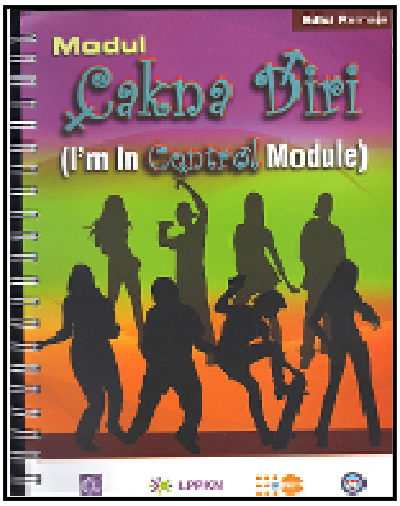
"My husband had previously read to me news of HIV/AIDS in the papers as I'm unable to read myself. But in this village, no one has ever talked about the disease and we really do not know what the virus is, how it is transmitted or where it comes from. I will share with my husband whatever I learned in the workshop." **Indigenous women, 31 years old.**

"I had previous misconceptions that we cannot mix with people living with the disease. But this workshop taught me to not discriminate now that I know how the virus is transmitted." **Indigenous women, 45 years old.**

4.3 A Case study of the National Population and Family Development Board (NPFDB)

4.3.1 I'm in Control: An entry point for sexuality education for young people

The "I'm in Control" module was developed by NPFDB under the UNFPA funded project "Up scaling Kafe@Teen Programme, 2008 – 2012", to provide knowledge and skills to adolescents and young people to prevent or reduce sexual risk-taking behaviors that can lead to unintended pregnancy, HIV & STI. The module is made up of three components, which include information on reproductive health such as sexuality, responsibilities, unintended pregnancies, HIV and STIs, abortion and abandoned babies, techniques/skills to avoid pre-marital sex and information on safe sex.



More than 300 Form Four students from five urban and rural schools in Kuala Lumpur, Selangor, Penang, Kelantan and Pahang have gone through the training programme over the past few years and there was a significant increase in awareness as well as knowledge and improvement in attitude among the participating students. In addition, the training programme also reached out to poor and marginalized young people and empowered them to say 'NO' to pre-marital sex and high-risk activities through the partnership with the NGOs such as the "MY Kasih Foundation".

Some Quotes from MY Kasih Foundation's participants:

"*Now I have more information of HIV and AIDS*"

"Always be aware and think very carefully before engaging in sexual activities"

"This is an important issue for teenagers"

"Girls are more empowered to say 'NO' to sex"

"Session is a great platform for teenagers to voice out issues"

The module and trainings are designed to suit the Malaysian societal values (cultural and religious), advocating abstinence only and to educate young people in the absence of sexuality education in schools. Furthermore, it provides a platform for young people to be aware of their SRH needs and to address the increasing number of young people accessing adolescent reproductive health information and counseling at NPFDB's Kafe@Teen facilities.

Kafe@Teen is a youth centre that offers counseling, reproductive health and HIV information and services for menstruation problem, pimples and skin problems, vaginal discharge, etc for young people. In addition, it provides a space for young people to discuss sexuality and social issues with the doctors, nurses or counselors through "Teen Talk" or "Teen Chat" sessions. Currently, there is a total of

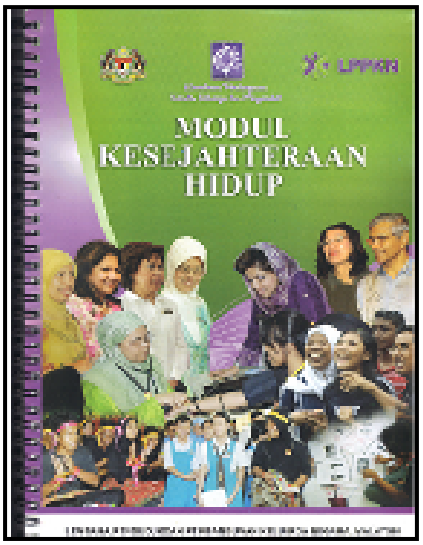
6 Kafe@Teen located in different states throughout the country. Training activities have also been conducted by using "I'm Control" or "*Wellness in Life" (Modul Kesejahteraan Hidup)* modules from NPFDB, "Reproductive Health Adolescent Module (RHAM)" and "Life Journey" modules from FRHAM during the "Teen Chat" sessions. From 2006 to 2010, 80,128 young people were provided with SRH and HIV information, while 6,312 teenagers obtained clinical services from Kafe@Teen. However, it should be noted that teaching of life-skills such as the use of condoms and other contraceptive use was not available at the sessions conducted at Kafe@Teen. Furthermore, condoms were also not available at Kafe@Teen. Therefore it can be assumed that it is more of a counseling and information facility that is culturally acceptable (because of the unavailability of contraception services) and the National Family Programme does not provide contraceptive services to the unmarried[19].

Nevertheless, the "I'm in Control" module has been an entry point to advocate for SRH education to be included in school co-curriculum. A parents' guide was developed to provide knowledge, information and awareness of adolescent reproductive health and sexuality issues among parents and teachers. Support from parents and leaders have also been obtained through sensitization workshops. The module has since been recommended for integration into the co-curriculum in all secondary schools.

"When we get the outcome of this pilot project, we hope we can get the approval of the government to implement it as part of the co-curriculum. We have already prepared a cabinet paper, which the minister will present to the cabinet, to make this module part of the co-curriculum in all schools."

YBhg. Dato' Aminah Bt Abdul Rahman, Director General NPFDB
New Straits Times, 25 July 2010

[19] Tey Nai Peng, Norliza Ahmad et al. (2010). *Status of Family Planning in Malaysia, 2010: Sustaining Lower Fertility*. Paper presented at UNFPA and ICOMP Regional Consultation on Family Planning in Asia and the Pacific, 8-10 December 2010, Bangkok, Thailand.



Specific elements of the I'm in Control Module were also extracted and included into the training module for young people who participated in the National Services programmes.[20] The training module was officially launched by the Minister of Women, Welfare and Community Development earlier in the year and it served as introductory activities that would expose national services trainees to sex education or reproductive and social health education and enlighten them on family life and positive relationship between the genders such as mutual respect between male and female. Training of trainers for staff of the training camps was also conducted in preparation for implementing the curriculum at the camps that cater for as many as 30,000 National Service trainees in 82 camps each year.

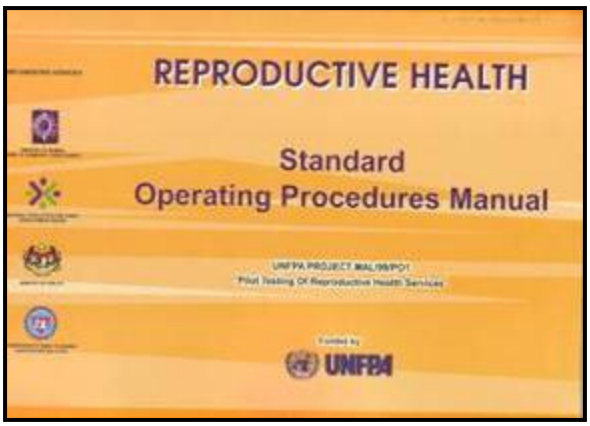
4.3.2 Raising awareness of HIV and SRH: Taking the message to where the people are

In an effort to bring their services to the most in need populations the NPFDB uses mobile clinics *(Pusat Keluarga Bergerak LPPKN 1Malaysia) that travels to* low-income communities in remote rural areas as well as to persons with disabilities (PWDs). Working together with the department of Social Welfare, the "*Nur@Rumah"* as it is called provides SRH information and services to low income families who were receiving financial assistance from the Department of Social Welfare and reached through home visits.

[20] National Population and Family Development Board. (2010). *Wellness in Life or Modul Kesejahteraan Hidup*

This service provides SRH services which include family counselling, family planning, breast examination, Pap smear, blood pressure, blood tests and registration of subsidized mammograms through the mobile clinics and home visits. In addition to that, information and education on HIV is also made available to enable the low-income communities to make informed choices regarding their reproductive health and protect themselves from HIV infection. Clients who need HIV testing and other HIV-related services are referred to government hospitals.

4.3.3 Linking SRH and HIV: Challenges in implementing convergence

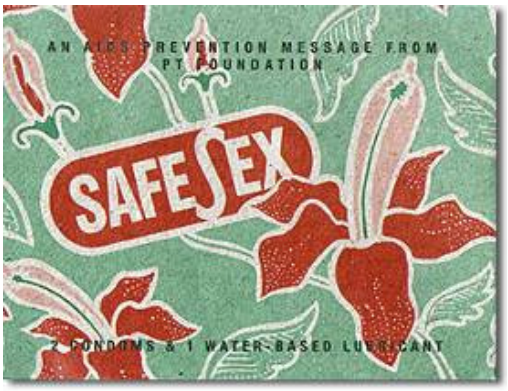


A Standard Operating Procedures Manual on Reproductive Health was developed by NPFDB in 2004 under the UNFPA Funded Project "Pilot Testing of Integrated Comprehensive Reproductive Health Services within the Primary Health Care System". The manual serves as a systematic and standardised tool to guide all reproductive health care providers of the Ministry of Health, NPFDB and FRHAM. Management of HIV/AIDS such as screening of high risk groups and antenatal mothers for HIV, treatment and care of PLHIV and prevention of the of HIV transmission were also included in the guidelines as part of primary health care services. However, information on HIV was only provided in 56 NPFDB's reproductive health clinics *(Nur Clinics)* upon request by the FP/SRH clients. Testing of HIV was offered to the RH clients as part of the blood screening package but pre and post counselling is not provided. This is due to the limited available manpower and lack of training for the service providers. Clients who tested positive are referred to MOH for follow up and treatment. However, they were welcome to come back to NPFDB for RH and FP services.

4.4 A Case study of the PT Foundation

Founded in 1987, PT Foundation (previously known as Pink Triangle Sdn Bhd), is a community-based, voluntary non-profit organization providing HIV/AIDS education, prevention, care and support programmes. They are known for their sexuality awareness and empowerment programmes for key affected populations, mainly drug users, sex workers, transsexuals, men who have sex with men (MSM), and people living with HIV/AIDS (PLHIV).

PT Foundation (PTF) runs 5 drop-in centres which offer food, shelter, care and support to over 200 clients each day. Through the programs and the drop-in centres, PTF serves, educates and supports over 50,000 people who are most at risk of HIV in Malaysia every year.[21]



PTF's programmes have emphasized on practice of safer sex by addressing STIs and HIV prevention and condoms use, and since 2006, anonymous HIV screening with pre-test and post-test counselling was initiated for key affected populations. However, it should be noted that the STIs prevention and education programme in PTF have always been structured as part of a "HIV prevention" approach. It is used as an intervention to reduce the risks of key affected populations' susceptibility to HIV but not considered as part of sexual and reproductive health.

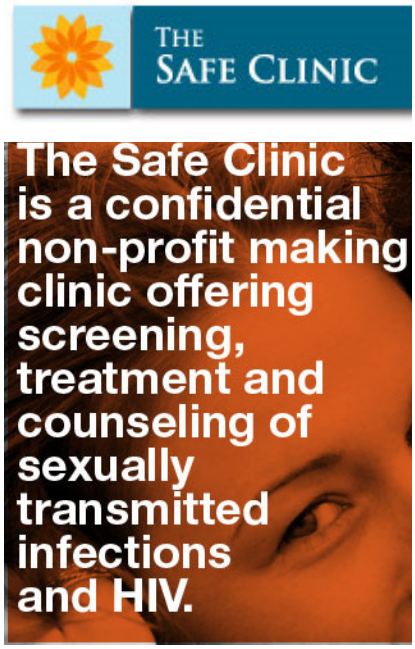
In 2009, the sex worker programmes under PTF began to work with other agencies such as FRHAM, government clinics and Hospital Kuala Lumpur to provide SRH information and RH services to the sex workers. Staff of Selangor & FT Family Reproductive Health Association (S&FT FREHA), a MA of FRHAM goes to PTF periodically to provide SRH information on family planning, breast cancer, cervical cancer and menopause to sex

[21] PT Foundation. *http://www.ptfmalaysia.org/index.php*

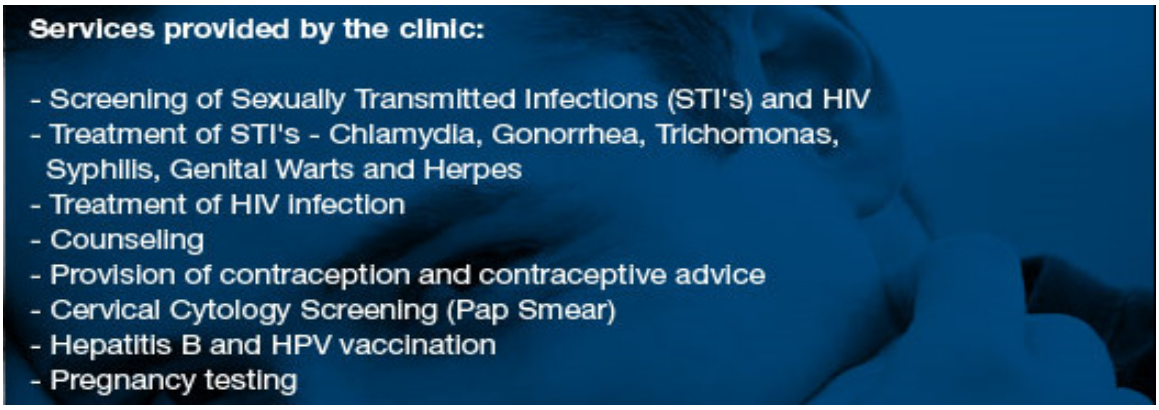
workers. In addition, SRH services such as family planning, Pap smear, screening for STIs and breast examinations are also provided. Sex workers who are pregnant are referred by PTF to the maternal and child health clinics under the Ministry of Health for ante-natal care. Sex workers, who face gender-based violence, are sent to the one-stop crisis centre or referred to women shelters. The outreach workers also assist the sex workers to make police report or refer them to legal aid where appropriate. Some sex workers were also referred to the Safe Clinic for comprehensive SRH and HIV linked services when services were available without charge in 2010.

The SRH and HIV linked programme or services in PTF for the other key affected populations such as IDUs, MSM, TS and PLHIV are still limited and mainly focused on STIs prevention. However, most of the clients from these communities are referred to the Safe Clinic or the General Hospital in Kuala Lumpur.

4.5 A Case study of the Safe Clinic



Established in 2010, the Safe Clinic is a non-profit community clinic in Kuala Lumpur which offers HIV and sexual and reproductive health linked services, especially for key affected populations. SRH services offered by the Safe Clinic include family planning, prevention and management of STIs, emergency contraception, referral for gender-based violence and abortion services, sexuality counseling and gynecological cancer screening. HIV related services include HIV counseling and testing, prophylaxis and treatment for PLHIV (ARV), prevention information and services for the general population inclusive of women of childbearing age and their partners a well as key affected populations such as IDUs, MSM, SWs, refugees, transsexuals, clients of sex workers, positive women and migrants. Condoms are freely available for prevention of STIs including HIV and unintended pregnancies to all clients in need.



More than 700 clients have sought the services of the Safe Clinic since its inception in August 2010. About 70% of their clients are male and 30% are females or transsexuals. Of the male clients, the majority of them are MSM who come for HIV and STI testing and sexuality counseling, followed by clients of sex workers. Women who come to the Safe Clinic include, sex workers, foreign students or workers, female partners of MSM, women who are having sex with women and refugees. PLHIVs also come to the Safe Clinic for SRH and HIV services and some also obtain their ARV treatment from the clinic. However, there has been a drop in the number of clients especially those from the key affected populations as the clinic now charges fees for its services which were previously available at no cost.

The HIV-SRH linked services in the Safe Clinic are provided either by the same or different provider on the same day and certain services such GBV, abortion and support services for PLHIV are referred to other related facilities or organizations. However, nurses continue to follow-up on referred clients in order to ensure that they have been attended to. The volunteer doctors and nurses find that the linked services in the Safe Clinic especially in linking family planning and STI services with HIV prevention education and testing are very effective. Nevertheless, they also recognized that the uptake of services among the women is still slow and greater effort is needed to reach out to women.

With regards to the constraints in offering the SRH and HIV linked services, the doctors stated that shortage of equipment; staff time and training are the main constraints and it is also difficult to recruit volunteer doctors to serve the community. In addition, they

said that the costs of services to their organization, workload for providers, time spent per client and the need for equipment, supplies and drugs has escalated.

In order to strengthen the HIV and SRH services, the doctors and nurses from the Safe Clinic felt that they need a supportive policy environment, stakeholder commitment, human resources and planning, health provider training, client education and involvement, quality of services, a SOP on SRH and HIV linked services, infrastructure, supply management, monitoring and evaluation systems. In addition, they also need continuous and sustained financial and human resources, technical assistance, capacity building and partnership with other agencies.

If the resources are made available in the future, the service providers wished to include home-based care for PLHIV, methadone, gender-based violence and abortion services at the Safe Clinic.

SRH and HIV should be closely linked as it is an entity and by addressing both issues at the same time, management of disease and problems in community is more holistic.

Volunteer doctor from the Safe Clinic, female, 31 years old.

Involvement of stakeholders (government agencies and community based organizations) is crucial for linking SRH and HIV service. Advocacy needs to be top down and bottom up. From our experiences, it is easier for a SRH organization to start HIV services than the other way round.

Volunteer doctor from the Safe Clinic, male, 30 years old.

From the observation from the researcher, the clinic appeared to be model clinic that provides comprehensive SRH and HIV services, especially for the key affected populations. Condoms and lubricants are freely available at the facility and the privacy of the clients is ensured both in the physical set up as well with the service providers. The volunteer doctors and nurses are friendly and sensitive to the needs of the communities and spent time to build relationship with the clients using the human rights approach. The success of the clinic is mainly dependent on the dedication of the doctors and service providers. However, the founders and the volunteer doctors of the safe clinic are also in a dilemma about reaching out the key affected populations (KAPs) who often cannot pay for services (except for the MSM community as most of them are

better educated and hold high positions) and sustaining the clinic. They recognize that it was too costly to sustain the clinic if they were to provide free services to meet the needs of the KAPs.

Thus it is evident from the desk review that SRH and HIV link services are mainly provided by FRHAM through its many outlets run by the state MAs. Even though FRHAM at the highest decision making level (Council) supports and promotes linked services the operationalisation of the policy is left to the MAs and this explains the different approaches as well as the differing target population each MA serves. Nonetheless it must be recognized as an important step towards providing linked services. The National Population and Family Development Board, (despite being an RH agency), being a government supported organization are in some way constrained by rules set out by the government. For example the provision of contraception to married couples only policy thus depriving young people of their right to family planning. Although they do not explicitly spell out the fact they provide RH services to the marginalized, they also do not turn away women irrespective of why they are there or what they do as long as they are married. HIV organizations are involving all HIV/AIDS related programs and work very closely key affected populations but are rather slow in the uptake of RH services. In all these organization any shift in program approach takes time and training. Perhaps the reason why Safe Clinic is seen as an exemplary RH and HIV linked service provider is the fact that it is new and is set up by a group of volunteers who were already convinced of the need for such an approach and they were able to then employ likeminded staff who have shared vision.

5. Findings of Rapid Assessment on SRH and HIV linkages

5.1 Clients views on linkages:

5.1.1 Youths

The rapid assessment on SRH and HIV linkages was conducted among 32 youths who had participated in the FRHAM's state MAs (Kelantan and Sarawak) and NPFDB's training programmes. Out of the 32 youths, 4 of them were youth volunteers of state MAs of FRHAM between 16 and 25 years, 19 (11 male and 8 female youths between 14 and 21 years) were from Kafe@Teen of the NPFDB, while the other 9 boys (between 14 and 17 years) were youths from juvenile homes.

Majority of the youths from FRHAM (both youth volunteers and youths from juvenile homes) stated that they received certain linked SRH information such as contraception, STIs, safe pregnancy and childbirth, gender based violence, prevention of unsafe abortion, cervical cancer and breast cancer and HIV prevention information including VCT and condom use under the training and peer education programmes of state MAs. In addition, they also cited that they preferred to obtain SRH and HIV linked information from the same facility and the same person as they felt more comfortable to talk to the same person whom they could trust.

The youths from Kafe@Teen who were below 18 years old said that they had received certain information on menstruation, on physical changes related to being a teenager, on the risk of teenage pregnancy and HIV from school and talks conducted at Kafe@Teen. For the youths aged 18 years and older, most of them said that they heard about contraception, STIs, gender based violence (GBV) and HIV from their friends, television, newspapers, peer educators and internet. Most of young people from Kafe@Teen, regardless their age, were unsure of the additional information they wished to have as they were not of aware of the information and felt uncomfortable to ask for it. However, some of them also mentioned that they wished to have in depth information on HIV prevention, STIs, family planning methods including natural methods and condom use.

With regards to the SRH and HIV services, all youth volunteers from FRHAM and youths from Kafe@Teen said that they had never received any of the services. They either felt that they did not need it and/or did not know where/how to look for it. However, some of them, especially girls, said they wish to receive HPV injections or condoms from the youth centres in order to protect themselves. For the boys from the juvenile homes, the majority of them did not receive any of the SRH and HIV services as they were either not aware of it or they did not know where/how to look for it. Only one of the boys said that he was recommended by the service providers for HIV testing. Three said that they had received condoms for HIV prevention.

Nevertheless, all youths preferred to have SRH and HIV services together at the same facility as it reduced the number of trips to the facility, reduced transportation costs and was a good opportunity to access additional services. However, they were also worried that the service providers would be too busy and that they would be forced to wait longer. Youths from juvenile homes, were more concern with the confidentiality of the services provided as well as possible discrimination due to stigma at the service delivery points.

5.1.2 Clients from Reproductive Health Clinics

A total of 29 responses were received from family planning acceptors/reproductive health clients of state MAs' clinics of FRHAM in Sarawak and Selangor/FT and NPFDB's clinics (*Nur Sejahtera* Clinic and Sub fertility in Kuala Lumpur). All of the respondents were female and the majority of them were between 20 to 40 years old with 5 respondents aged over 40.

Most of the respondents stated that they had received some information on SRH and HIV through various channels such as television, newspaper, school, friends, internet, pamphlets/leaflets and healthcare providers. However, almost all of them stated they had never received any HIV and SRH linked information from the same facility or same service providers and only two of them said that they received information on HIV prevention and testing from the state MAs' clinics. Ignorance, lack of awareness and discomfort with the SRH or HIV information were the main reasons that they did not able to receive all the information they wanted. In view of the fact that most of the women were in their reproductive age, they said they wished to have more information

on prevention of HIV among women and prevention of HIV transmission from mother to child.

In addition to not receiving any SRH and HIV linked information most of the RH clients also said that they had never received linked services. It should also be noted that of the women who were Muslims and had to undergo mandatory premarital HIV testing, almost all of them stated that they did not receive any pre and post test counselling or any information related to safe sex and condom use. Most of them said that they were not aware of the importance of the testing but did it anyway as they were required to do so to get married. The interviews also found that a number of women thought that they were not at risk of HIV as they were married.

Nevertheless, the rapid assessment with RH clients revealed that nearly all preferred to have SRH and HIV information and services from the same service providers/health care facility at one time as it was viewed as a dependable, trustworthy and reliable source of information. It would also reduce the number of trips to a health facility and therefore save money spent on transportation. However, most of the women also raised concerns about confidentiality and quality of the linked services as providers might be too busy and increase time spent waiting. Some of women also said that they felt embarrassed to talk about HIV issues with the providers.

Women who came for sub fertility services, prefer not to link HIV with the sub fertility services as they wanted the service providers to focus on providing the sub fertility services they came for. However, most of them also stated that they had no objection with linking HIV with other SRH services such as family planning and they thought it was a good opportunity for them to access additional services.

5.1.3 Indigenous Women (*Orang Asli* women)

Ten indigenous women from *Kampung Kacau Baru settlement*, Semenyih participated in the study. Out of 10 respondents, 8 of them were between 24 to 30 years old, and had 2 to 6 children, while 1 respondent was 37 years old with 4 children and another, 48 years with 7 children.

All respondents said that they were aware of family planning and safe pregnancy and childbirth and all of them had their pregnancies attended to at ante-natal clinics run by

the Ministry of Health. Although they had been advised by the nurses to practise some form of family planning, only four of them said they actually used modern contraceptive methods such as oral pills or injections. For the SRH services such as Pap smear and breast examination, six women reported that they were aware of it and had been checked.

Majority of the indigenous women were not aware of STIs, abortion and GBV. In addition, most of them were also not aware of HIV although all of them had the HIV test during their ante-natal check-ups. They said that they were only informed by the doctors or nurses that they would be tested for HIV. There was no pre and post counselling nor any information on condom use. However, the 4 women who had participated in the Women's Institute of Management's training on HIV and GBV said that they understood what HIV is, how it is transmitted, the use of condom, gender-based violence and how to protect themselves from HIV and GBV. Other indigenous women who had previously not participated in the training, said that they did not have time due to work had to take care of their young children as the reason. The indigenous women said they wished to have the information but they couldn't afford to spend two to three full days for the workshop. As such, they suggested that the training to be broken up into shorter sessions (2 to 3 hours per session) in the afternoons.

On the other hand, most women stated that they wished to have more information on STIs because they had experienced symptoms, e.g.: itchiness, sores, discharge, abdominal pain and painful urination but were unsure as to the cause. Most of them had not seen a doctor about it as they did not know how or what to ask or did not feel comfortable to ask about it. Instead, they bought the medicine as recommended by their friends from the pharmacy.

Nevertheless, all respondents in this study cited that they preferred to receive SRH and HIV services at the same facility or by the same provider that they were comfortable with. They said that it would a good opportunity for them to access additional information and services so that they are protected. Furthermore, it would also reduce the number of trips for them to the healthcare facility and reduce their transportation costs. With regards to the disadvantages of SRH and HIV linked services, all the indigenous women said that they could not think of any disadvantage.

5.1.4 Women living with HIV

Ten women living with HIV from the home run by WAKE and the Drop in Centre of PT Foundation participated in the interview. The five HIV positive women from WAKE were between 39 to 59 years, while the other five from PTF were in their reproductive age (28 to 45 years).

The interviews with the respondents from WAKE revealed that they had received some SRH and HIV information but mostly not at the same time and at the same facility. However, they obtained some information on HIV prevention, violence, cervical cancer and breast cancer from a workshop on HIV and violence conducted by the Women's Management of Institute in 2010. Although the women were more aware of their SRH needs after the WIM's training, they were still unable to receive SRH services such as Pap smear and breast examination in one common location or hospital. A referral letter is usually issued by the hospital referring them to government polyclinics for the relevant services. As a result, most of the HIV-positive women at WAKE home tended to forgo their regular gynaecological check-ups as it was inconvenient for them to travel to another clinic by public transport and they were also unsure about the attitude of the healthcare providers.

The rapid assessment conducted in PTF showed that they received STIs and HIV prevention information from the outreach workers and the drop-in centre of PTF. All of the respondents from PTF were in their reproductive age and had husbands or partners. Most of them have heard about family planning methods such as oral pills, Interuterine Contraceptive Device (IUCD) and injections but many were using condom as a dual protection to protect themselves from unintended pregnancies as well as HIV. Two respondents said that they have had tubal ligations while a few HIV-positive women from PTF said that they wished to have another child. In general they wished to have more information on maternal and child health, especially information related to positive couples. For the SRH and HIV linked services, the majority of the HIV-positive women from PTF had similar experiences as the women living with HIV from the WAKE home. Most of them had never received linked services from the same service points. They were either being referred by the hospital where they receive their HIV-related treatment to another department in the same hospital or to other government clinics.

Generally, the study showed that all HIV-positive women preferred to have more information on SRH and to be served by the same provider and within the same

healthcare facility, from where they received their HIV-related treatment in order to would reduce the transportation costs and the inconvenience of travel. Furthermore, access to SRH linked services would keep them healthy and protect themselves from other diseases. However, they were also unsure of the attitude of the RH staff (towards PLHIV), confidentiality and fees for the services.

5.1.5 Sex workers

A rapid assessment was conducted among 28 female sex workers in Kuala Lumpur, Klang, Melaka and Sarawak. The sex workers in Kuala Lumpur were aged between 40 to 54 years old and they were the clients of PT Foundation. Majority of the female sex workers from Klang were aged between 22 to 35 years and they were clients of the outreach workers from WAKE; while the sex workers from Sarawak (aged 24 to 27 years) and Melaka (40 years old and above) were served by the state MAs of FRHAM.

Most of sex workers served by WAKE received condoms, HIV and STIs prevention information from the outreach workers. They were also referred to and in most instances accompanied to the Ministry of Health HIV/STI clinic in Klang for HIV and STI testing. However, they indicated that they had never received SRH information from the outreach workers. They were aware of the risk of unintended pregnancies as they received information from their peers and most of them went to the private general practitioner clinics for hormonal injectables every three months.

In Melaka and Sarawak, most of the sex workers who are clients of state MAs of FRHAM have heard about and received SRH and HIV information and services such as contraception, STIs, prevention of unsafe abortion, cervical cancer, breast cancer, HIV prevention information and HIV testing from outreach workers and service providers of family planning clinics.

The majority of sex workers from PT Foundation said that they received HIV prevention information and HIV testing from PTF and SRH information and services such as contraception, breast cancer, cervical cancer, STIs and menopause from the Selangor & FT Family Reproductive Health Association (S&FT FREHA) at the drop-in centre of PTF. Although contraception services were also offered by S&FT FREHA, almost all of them did not access them due to the misconceptions about contraception. For example, some of them believed that family planning was only for couples who were married, some of

them were worried about the possible perceived side effects (e.g. weight gain) of the hormonal methods such as oral pills. In view of the fact that they were not on any contraceptive method and were also not using the condom consistently, especially with their regular partners or when clients willing to pay more, when questioned, a number of them said that they had gone for *"cuci perut"* (abortion) and some have had repeated abortions.

All female sex workers in this study said that they preferred to receive information and services on SRH and HIV at the same facility provided that issues of stigma and discrimination and confidentiality were addressed.

5.2 Outreach workers and service providers' views on linkages

5.2.1 Service providers from reproductive health clinics

A total of 26 individual who are service providers from reproductive health clinics provided their feedback on HIV and SRH linkages. All of the service providers were female, between 28 and 55 years and 12 of them were recruited from the state MAs (Kelantan, Melaka, Sarawak and Selangor/FT) of FRHAM, while 14 respondents were recruited from NPFDB.

The responses from the service providers of FRHAM confirmed that SRH and HIV linkages occurred at their service delivery points. HIV prevention, education and condom provision, HIV counselling and testing, and HIV information and services for key populations such as sex workers, IDUs, refugees and transsexuals were integrated into reproductive health clinics. The linked services were located in the same service site with the same provider. However, for HIV-related treatment; clients would be referred to government hospital at the state level. Phone calls were also made to ensure that clients had gone for their follow-up. Majority of the service providers stated that linking the RH services and HIV prevention information was a more effective programme compared to the other HIV services such as VCT, psychosocial support for PLHIV and reaching out to the key affected populations. However, they faced a lot of constraints in linking the services, especially shortage of time, training and inappropriate/insufficient staff supervision. They also stated that their workload, time spent with clients and the need for equipment, supplies and drugs had increased. In order to strengthen the linked services, all the service providers cited that a supportive policy environment, health

provider training, standard operational guidelines, supply management and monitoring and evaluation systems were needed. In addition, finance and human resources, technical assistance, capacity building and partnership with other agencies were the most urgently needed. Nevertheless, most of the service providers felt that additional HIV-related services such as psycho-social support for PLHIV and PMTCT should also be included in the existing RH clinics.

The service providers from NPFDB's clinics stated that their clinics focused in providing SRH services such as family planning and screening for gynaecological cancers (breast cancer and cervical cancer). For HIV related services, HIV leaflets and pamphlets were made available in the clinics. HIV testing was included in the blood screening package and basic information on HIV would be provided upon request. It should be noted that pre and post counselling was not available in the clinic and clients who tested positive through the blood screening package would be referred to the government hospital. In addition, the provision of condoms in NPFDB's clinics was mainly for family planning purposes. The reason for not providing HIV related services including pre and post counselling for HIV testing was due to the lack of capacity and available training in this area. As such, most service providers stated that they were not confident to provide in depth information on HIV to the clients. Most of the service providers from NPFDB felt that the shortage of staff time and lack of training on HIV were the main constraints they would face in linking the SRH and HIV services. Furthermore, they also feared that their workload and the time spent with clients would increase. Nevertheless, they recognised that HIV prevention information and HIV testing were important to be provided for their clients and their opinions on the support and the resources that were needed to strengthen the SRH and HIV linkages in their clinics were similar to that of the service providers from FRHAM.

5.2.2 Outreach workers and caretakers from HIV-related organisations

The programme manager, 2 outreach workers and 2 caretakers from WAKE and 5 outreach workers under the positive living and sex workers programmes from PT Foundation participated in the rapid assessment.

The programme manager from WAKE indicated that there was no linked service provided by WAKE to their clients at the time of the study. Although information on STIs was provided during the outreach activities it was focused on the HIV approach. He said

that he was aware of the benefits of SRH and HIV linkages and he wished to work closely with FRHAM in order to link the services. However, the collaboration with FRHAM is yet to materialise due to human resource constraints. In addition, the outreach workers and caretakers from WAKE also stated that they were not trained in any SRH related information and they also feared that linkages would increase their workload and time spent per client as well as costs. Most of them indicated that they acknowledged the importance of SRH services as they have witnessed some of the RH problems, such as unwanted pregnancies and abortion but assisted their clients on a case to case basis through referral to relevant agencies.

Outreach workers from PTF under the sex workers programmes, they referred their clients to the Safe Clinic, FRHAM's clinics or government hospital for SRH services. Most of their clients had their Pap smear, breast examination, HIV testing and STIs screening regularly and they found that these programmes were effective. However, they were not able to persuade their clients to take up contraceptive methods. The outreach workers who provided support services for women living with HIV, focused on providing psycho-social support, HIV prevention information among couples, condom and prevention of unintended pregnancies in HIV positive women. In addition, they would provide STI information and other basic SRH information such as family planning, breast cancer and cervical cancer for the HIV-positive women and referred them to government clinics upon request. However, they could not provide in-depth SRH information due to shortage of time with clients and lack of training on the issue.

Nevertheless, all outreach workers and caretakers stated that clearer policies, operational guidelines, staffing and capacity building and support such as technical assistance and commodity supply from the Malaysian AIDS Council (MAC) were needed in order to deliver the HIV and SRH linked services. In addition, finance and human resources as well as partnership with other agencies were very important to kick start or strengthen the SRH and HIV linked services.

6. Discussions

The initial findings of the study showed that the bi-directional linkages in the SRH and HIV programmes and services were still limited but there was a growing awareness and support for linkages among the civil society, community and government agencies. The study revealed that the SRH organisation such as FRHAM and HIV organisation have started to work together to link their programmes and services. Sensitization workshops and capacity building on HIV and SRH linkages have been carried out by FRHAM for its state MAs and the stakeholders to build a stronger foundation for linked response to reproductive health and HIV/AIDS and to facilitate the partnership on linkages. In addition, coordination and referral mechanism among the HIV NGOs, FRHAM and government hospitals have also been established at various levels. However, continuous awareness raising and institutional capacity building are needed at all levels as basic awareness of the value of the SRH and HIV linkages is still low among many health workers, programme managers and outreach workers and the collaboration is limited within certain groups of stakeholders. Furthermore, the shortage and high turn over of management and programme staff, health service providers and outreach workers in the NGO sector are among the main factors which contribute to the NGOs' inconsistency in the partnership and putting linkages into action.

The desk review and the rapid assessment in this study have confirmed that definite functional linkages of SRH and HIV services have occurred at the training and educational programmes. HIV and SRH linked information have been disseminated by FRHAM, WIM and NPFDB to the general population, including men, women and young people. Moreover, a number of state MAs of FRHAM have also disseminated SRH and HIV linked information to the key affected populations such as sex workers, refugees, and spouse/ partners of IDUs. For HIV organisations, the outreach programmes for key affected populations are still mainly focused on HIV-related information and STI information due to limited human resources and lack of capacity on SRH but SRH organisations have been invited from time to time to talk on SRH issues for the marginalised communities.

The study revealed that the SRH and HIV linked services predominantly take place among selected services and/or through specific entry points. For example, HIV prevention information, testing, condom provision and support services are linked with the SRH services in FRHAM's clinics at certain states. For NPFDB's clinics, HIV

information is offered upon request and HIV testing is included in the blood screening package but counselling is not available. Although the linked services are available at some of FRHAM's clinics, it should be noted that the uptakes of VCT services is still low, in particular among the routine clients (women in reproductive age) as the service providers perceived them as "low risk" groups and the VCT service is only offered upon request. Furthermore, the promotion of condom use among these women is low and it is mainly positioned as a family planning method, especially in NPFDB's clinics. In addition to that, the initial findings from the rapid assessment on the family planning/RH clients showed that most of them were generally uncomfortable and reluctant to seek SRH and HIV information and services because of embarrassment and the sensitivity of the SRH and HIV issues. In addition, a number of women who had been through compulsory pre-marital HIV testing considered themselves not at risk as they trusted their husbands. As such, the lack of VCT at FRHAM's and NPFDB's RH clinics as one of the commonest and earliest contact points women and youth of reproductive age group have with the health care system may be a missed opportunity to protect women from HIV infection in view of the fact that HIV infection is increasing among the "low risk" women in Malaysia. Therefore, service providers need to be proactive, sensitive to the clients needs and use their own initiative to reach potential clients.

With regards to the SRH and HIV linked services for key affected populations, the study showed that the uptake of a comprehensive package of SRH/HIV services among sex workers and spouses/partners of IDUs, especially for contraception, maternal and child health care and abortion related services is also low. Most of the key affected populations lack SRH information and were not aware of their SRH needs. This was mainly due to the fact that most of the outreach workers concentrated on providing HIV prevention information and promoting condom use among the key affected populations. As a result, their needs for SRH services tended to be neglected. Most of the HIV organisations and the outreach workers assume condom as "dual protection" against HIV and STIs and did not include unintended pregnancies as an added value to the use of the condom. The dismal use of condom by sex workers when having sex with their regular partners or spouses shows that more work needs to be done and innovative strategies are needed to ensure that the dual-protection approach is routinely featured in family planning and HIV/AIDS prevention programmes.

This study revealed that reaching out to female partners of MSM and clients of sex workers by NGOs is almost non existent and a comprehensive package of SRH/HIV services for HIV positive women was also limited. The rapid assessment with HIV-

positive women in this study showed that most of them had never received any SRH information including family planning from the current healthcare setting from where they received HIV-related services and they tended to forgo their regular gynecological check-ups as they either did not have the extra time to go or it was inconvenient for them to get transport to another healthcare service centre to request for it. In view of the fact that most of the support groups in Malaysia focused on provision of psychosocial supports for PLHIV to cope with the disease, their SRH needs including family planning have not been a priority, thus missing an important opportunity to respond to the HIV-infected women's needs.

Nevertheless, nearly all respondents in this study acknowledge the benefits of linking SRH and HIV services regardless their background. They prefer to have a 'one stop shop' for SRH and HIV, especially to be served by the same provider for SRH and HIV and within the same facility. However, key affected populations raised concerns regarding possible discrimination and lack of confidentiality of services. From the service providers and outreach workers' view on linkages, they required clear directions and instruction from the management as well as clinical standards or operational guidelines and training in order to deliver the services. In addition, they were also concerned and feared that linkages would increase their workload and decrease the amount of time spent for each client.

7. Conclusion and Recommendations

7.1 Conclusion

This study on "Evidence-based Strategies for Sexual and Reproductive Health Linkages and HIV in Malaysia" is a follow up to the 2010 WHO/UNFPA funded study on strengthening HIV and SRH linkages in Malaysia. The latter was mainly conducted among the policy makers and programme managers of SRH and HIV organizations as an introductory activity and provided a general overview of sexual and reproductive health and HIV linkages at policy, system and service levels in Malaysia. It mainly focused on the "supply" components of linked HIV/SRH services. This study in 2011 was aimed at gaining a clearer understanding of the scope, depth and best practices of the SRH and HIV linkages programmes in the country as well as to identify the gaps and major challenges as experienced by the respective organisations and most importantly the beneficiaries of the current services. It consisted of a desk review of five organisations, namely FRHAM, NPFDB, WIM, PT Foundation and the Safe Clinic and a rapid assessment of the service providers, outreach workers and clients or beneficiaries of the SRH and HIV programmes to identify their needs and their views on SRH and HIV linked programmes.

The findings from the desk review showed that most of the SRH and HIV programmes were still managed separately and running vertically. The national SRH programmes in Malaysia are mainly structured under the "health" system and provided by the Family Health Division of the Ministry of Health, NPFDB and FRHAM. HIV and STIs programmes was mostly offered by HIV organisations such as PT Foundation, WAKE, DIC Pahang, Intan Life Zone, etc, coordinated by Malaysian AIDS Council and monitored by AIDS/ STD Section, Disease Control Division under the Ministry of Health as part of the "disease control" system. The Ministry of Health have their own STI and HIV services. Although the desk review found that the bi-directional linkages in the SRH and HIV programmes and services in Malaysia were still limited, there was a growing awareness and support for linkages; coordination mechanism and joint planning have indeed started among the civil society, community and government agencies. For example, FRHAM started to provide HIV testing in their clinics and reach out to key affected populations through networking with HIV organisations such as PTF and Intan Life Zone, while PTF has begun to refer their clients to FRHAM clinics or government clinics for SRH services.

The desk review also revealed that the HIV services most commonly provided by RH facilities/clinics of FRHAM and NPFDB were HIV prevention information and condom provision. Meanwhile a few FRHAM's clinics also provide specific information/ services including counselling and testing and psychosocial support for key affected populations. Most of these SRH and HIV integrated services were provided at the same facility, on the same day and by the same provider or referred to other service delivery points for follow up. However, none of the SRH organizations provided home-based care or treatment for PLHIV. For HIV organisations such as PT Foundation and WAKE, only STIs prevention and management were integrated into the HIV prevention programmes for the key affected populations. Overall, HIV organizations were least likely to provide SRH services such as family planning, gender-based violence, maternal and child health and screening for gynaecological cancers and prevention of unsafe abortion/provision or post-abortion care. However, referrals for these SRH services were available upon request.

The Safe Clinic appeared to be a model clinic for linked HIV and SRH services with their comprehensive range of services for both components, including HIV treatment. In addition, the sensitivity of service providers in providing the services in a friendly environment without stigma and discrimination ensured clients that confidentiality was maintained at all times. However, the high cost of providing free services has forced them to impose a minimal charge for services. This has in fact turned away clients from the KAPs leaving only those clients who are able to pay.

The second part of the study was a rapid assessment with clients or beneficiaries, services providers and outreach workers. A total of 109 clients from the SRH or HIV programme such as young people, RH/FP clients, women living with HIV, female sex workers and indigenous women participated in the assessment. Most of the women at SRH services centers were primarily seeking family planning and screening for gynaecological cancers, while most at HIV services were seeking HIV counselling and testing, treatment and care. Some of the women had received some SRH and HIV linked information and services at specific service delivery points, such as FRHAM's clinics and the Safe Clinic However, most of them had not received any linked information and services. Almost all service users favoured receiving services at the same site as they viewed it as a good opportunity to receive additional services, reduced the number of trips to facilities and therefore transportation cost and time. Women living with HIV and young people from the juvenile homes, however were concerned about possible stigma

and discrimination and the confidentiality of services. They hoped that these issues would be addressed in the provision of in linked services.

From the service providers and outreach workers' perspectives, the needs for SRH and HIV linked services among their clients were increasing but the linkages were limited due to constraints. At both types of facilities, the most common constraint cited were the shortage of staff and lack of relevant training. When asked to assess the likely impact of having linked services, most service providers and outreach workers were most concern with increase workload and time spent per client, followed by the need for space, and privacy as well as equipment, supplies and drugs. All service providers and outreach workers cited that issues such as policy environment, stakeholder's commitment, client, human resources and programme logistics need to be strengthened in order to increase the feasibility of linked services. Furthermore, resources, especially financial and human resources, technical assistance and capacity building and partnership with other agencies were urgently needed.

Some key challenges in implementing and strengthening SRH and HIV linkages were identified through the desk review and rapid assessment. These key challenges include:

a. Policy on SRH and HIV linked services

The WHO and UNFPA funded Study on Strengthening HIV and SRH Linkages in Malaysia in 2010 showed that there was no national SRH and HIV linked policy, strategies or guidelines. For the SRH agencies such as the National Population and Family Development Board and the Family Health Development Division, MOH, SRH policy was also not available but their family planning programme mainly refer to the Family Planning Policy that was developed by the NPFDB. HIV agencies mainly referred to the National Strategic Plan on HIV/AIDS and Malaysian AIDS Council (MAC) Strategic Plan. The Federation of Reproductive Health Associations, Malaysia (FRHAM), appeared to the only organization which adopted the concept of SRH and HIV linkages and this reflected in their Strategic Framework and the "Guidelines on Minimum Service Package on SRH-HIV linked services". Having such a policy has compelled member associations to provide linked services at all their service points and this is also reflected in all the projects initiated at the Federation level.

Although a resolution was made at the Roundtable Discussion on WHO/UNFPA Study on Strengthening HIV and SRH Linkages in Malaysia in 2010 to use the

National Strategic Plan on HIV/AIDS to define actions to enhance the synergistic effects of an integrated and linked response on HIV/AIDS and the SRHR in the country, it has taken time to be translated into programs. The lack of a SRH and HIV linked policy; the inadequacy of existing SRH and HIV policies and the practice barriers has particular implications for SRH and HIV linked programme and services. Most of the time, HIV and SRH programmes still run vertically as there is no clear direction and instruction from the policy level to link SRH to HIV or vice verse. Furthermore, the National Family Programme usually does not provide contraceptive services to the unmarried[22] and the needs of key affected populations (such as SWs, IDUs, MSM and TS) were only address in the HIV policies and programmes. The young people and key affected populations were underserved as they are only targeted for HIV prevention and no mention is made of their SRH needs and rights. In addition, HIV policy and programme that focused solely on key affected population alone can bring more stigma and discrimination and develop a false sense of security among the general population, especially among the women.

b. Technical support and capacity building

In Malaysia, although most of the government agencies and NGOs at the National Roundtable Discussion on Strengthening HIV and SRH Linkages in Malaysia on 4 August 2010, indicated that they accepted and were committed to strengthening the linkages between HIV and SRH, technical assistance to improve linked programming as well as capacity building of field workers and service providers is still limited. Technical support to build a common understanding of SRH and HIV linkages programs as well as joint planning and coordination among the SRH organisations and HIV agencies is limited to those initiated by FRHAM. Standard operational guidelines, training materials and training of master trainers in linkages were limited and this limitation is exacerbated by wider, on-going crises in human resources. Therefore, basic awareness of the value of the linkages is still poor among many health workers and outreach workers from both SRH and HIV organizations.

[22] Tey Nai Peng, Norliza Ahmad et al. (2010). *Status of Family Planning in Malaysia, 2010: Sustaining Lower Fertility*. Paper presented at UNFPA and ICOMP Regional Consultation on Family Planning in Asia and the Pacific, 8-10 December 2010, Bangkok, Thailand.

c. Harmonization of budgets

The SRH and HIV organisations in Malaysia have always experienced inadequate funding for SRH and HIV programmes. Therefore, it is not surprising that there is no specific budget devoted to just putting SRH and HIV linkages into action. Any linked programme and services in this area is covered under limited budget traditionally provided for under the each organisation's normal annual work program and budget for the year and mainly depend on the organisations' own initiatives. On the other hand, the implementation and the sustainability of SRH and HIV linked programmes services for the marginalised key affected populations such as youths, sex workers, IDUs and PLHIVs were depended on the availability of funding from donors. For example: FRHAM could not continue to reach out to the female spouses or partners of IDUs due to the fact that the project had ended. There was also a drop in the number of clients who access SRH and HIV linked services at the Safe Clinic once they started to charge minimal fees. In addition, there is not one coordinating mechanism in the country. The Malaysian AIDS Council to some extent influences how HIV/AIDS money is spent but unfortunately does not see coordination as their role since they are made up of mostly HIV organisations. Furthermore they are being monitored by the Infectious Division of the Ministry of Health and SRH in MOH comes under the Family Health Division.

Most of the time, the funding and resources for SRH and HIV linkages is allocated specifically to certain target groups and rather than being channelled to integrated interventions and providing a package of support for those who were in need. For example, although FRHAM provides free SRH and HIV services at PT Foundation for sex workers under their "Sex Worker" project, the services were not extended to the other marginalised groups in PTF such as women living with HIV (despite the fact that the programs were all housed in the same building but on different floors) as the funding for the services were specifically for sex worker related services.

d. Community involvement to reduce stigma associated with HIV/STIs, risky behaviours, and acceptance of HIV care in RH settings

There is a lack of involvement of the key affected populations and PLHIV in planning and implementing HIV and SRH linked programmes among the SRH organisations in Malaysia. The RH and FP services were mainly provided by health care professionals including doctors and nurses using the "health" approach but not "right-based"

approach. The lack of understanding and sensitivity to the needs of key affected populations is a barrier for the community to access the services. FRHAM provides training on the rights based approach but training can be expensive for a large organisation such as FRHAM.

On the other hand, HIV organisations in Malaysia are mainly run by the community people for their community. In most instances staff are selected based on the fact they are from the community and not necessary based on educational background. It would be safe to say that staff of HIV organisations are very motivated in their work but because of the lack of basic education training on RH will take a longer time and require more resource, something the NGOs are sorely short off. However training on RH for HIV staff is a worthwhile investment.

e. Monitoring and evaluation

Instituting a common/linked monitoring and evaluation system is the largest constraint in linking SRH and HIV programmes and services. Both SRH and HIV organizations in Malaysia have their own monitoring and evaluation structure and different reporting systems for different donors. Therefore, it is difficult to capture the result of HIV and SRH linkages even though some linked services are available at certain service delivery points.

SRH and HIV have common causes. The HIV epidemic as it is in Malaysia today calls for attention to be paid to the needs of marginalized communities who are affected by the epidemic directly of indirectly. SRH programs have slowly evolved over the years from just merely contraception focus to a more comprehensive range of services. The advent of HIV and its effect on women in particular has forced SRH staff who traditionally have been serving women of reproductive age to look beyond their comfort zones and adapt to serving the needs of marginalized communities, or key affected populations. They may have the technical knowledge and skills but that is not enough. To effectively serve marginalized populations requires passion, something HIV staffs have plenty of. In order to have effective linked programs marrying passion with knowledge is very important and this is seen very clearly in the Safe Clinic. Staff, doctors, nurses and counselors are working at the clinic driven by passion but unlike other NGOs in the field they bring with them the relevant skills to provide a service.

SRH and HIV linkages in programs have already begun in Malaysia. Today we see more HIV programs including SRH services (directly or indirectly) and SRH programs including HIV services but Malaysia has a long way to go. In order to move forward staff of SRH as well as HIV programs in the country must come together and devise a coordinating mechanism to take their cause to a higher level.

7.2 Recommendations

7.2.1 Policy on SRH and HIV linked services

The success of SRH and HIV Linkages at programmes and services delivery level can only be achieved through the removal of barriers at the policy level. These barriers include isolated and separated processes in decision-making, planning, implementation, procurement, and monitoring and evaluation at national level and the barriers and restrictions imposed by donors. Key policy makers such as parliamentarians, policy-makers, civil society, legal bodies, faith-based organisations, human rights groups and members of key populations should be engaged in the discourse on linkages including reviewing and developing supportive laws and policies. An explicit SRH and HIV linked policy is not necessary but both the SRH and the HIV communities must address relevant aspects of each others' policies. Such policies must build upon the key principles that are identified in the Rapid Assessment Tool[23,] which included the following:

- Address structural determinants
- Focus on human rights and gender
- Promote a coordinated and coherent response
- Meaningful involvement of PLHIV
- Foster community participation
- Reduce stigma and discrimination
- Recognise the centrality of sexuality

Such strategies would provide necessary support to make available comprehensive reproductive health and HIV/AIDS services to people, drive better resource allocation and strengthen health delivery systems.

[23] Ibid 5.

7.2.2 Advocacy, Coordination and Collaboration

It should be recognised that HIV/AIDS and SRH share common root causes such as poverty, gender and generational inequality, and the marginalisation of key affected populations (sex workers, IDU, MSM and refugees). Therefore, successful SRH and HIV linkages can only be achieved, if it is supported by the commitment from all SRH and HIV agencies beginning with the development of appropriate institutional mechanisms, coordination and collaboration.

More advocacy work needs to be done in order to ensure that a coordination body that can bring together SRH and HIV stakeholders to plan coordinated strategies in the key areas (such as decision-making processes and roles and responsibilities). It is critical to convince and engage the main agencies such MOH, MAC, NPFDB and FRHAM to come together to ensure coordination between SRH and HIV efforts at the highest level. FRHAM, NPFDB, MOH and MAC, being umbrella organisations to support and coordinate the efforts of organisations working on HIV/AIDS issues in Malaysia, must take the lead and bring together other agencies and to coordinate and ensure different thematic areas of SRH & HIV linkages work are covered. If clear guidance and direction on SRH and HIV linkages is set, it will provide the foundations and justification for coordination efforts for other HIV agencies which are the Partner Organisations/Line agencies of MAC to increase their commitment to linkages and help 'make it happen'. It should be noted that as far back as 2006 and again in 2009 (pg. 7) the MOH has already acknowledged the importance of offering linked SRH and HIV services but it would seem that it was about integrating the services within the Ministry rather than with the NGOs.

Alternatively the National Coordinating Committee on AIDS Intervention (NCCAI) chaired by the Minister of Health can assume this role of coordination. If the National Coordinating Committee endorses and promotes SRH and HIV linked programs funding could possibly be made available. Otherwise, left to NGOs, funding and therefore sustainability of will at best be a start (when funding is available) and stop (when finding ends) effort. MOH, the biggest provider of free (and therefore available to all marginalised communities) RH and HIV services must be convinced that linked programs work better and is more cost effective. Without higher level intervention MOH will continue their vertical RH and HIV approach in their provision of services.

7.2.3 Capacity building of health care providers and outreach workers

The study showed that there is high demand amongst the service providers and outreach workers for support for capacity building programs to enable them to provide more comprehensive and higher quality HIV/AIDS and SRHR information, counselling and services. Unfortunately capacity building is expensive considering the big number of staff who will have to be trained. Therefore financial commitments and resources should be secured.

Both healthcare providers and outreach workers must be trained to have a common understanding of the components of a minimum package of SRH & HIV linkages. Furthermore, the capacity building/training programmes also need to ensure that they not only cover only clinical aspects of SRH & HIV, but issues such as confidentiality, stigma and human rights. Health care providers need to be sensitive to the needs and issues of key populations, while outreach workers who work with key affected populations need to be trained on SRH information and the importance of promoting SRH information. The training programme can be done by adapting existing resources with the support from SRH and HIV organisations. For example, outreach workers can share their experiences of working with key affected populations with the healthcare providers whereas healthcare providers can share basic information on SRH with the outreach workers. Nevertheless, appropriate and sufficient staff supervision and motivation are also essential to protect service providers and outreach workers from "burnout" syndrome and prevent high turn over of staff.

7.2.4 Financial support and harmonization of budgets

Financial support or adequate funding for SRH and HIV linkages is needed to conduct training and provide linked services especially for the marginalized communities who cannot afford to pay for medication and related tests. International agencies such as IPPF and UNFPA and government agencies such as Ministry of Health and Ministry of Women, Family and Community Development, Malaysian AIDS Council need to demonstrate their commitment to SRH and HIV linkages by explicitly welcoming the approach in funding criteria, channelling the funding to integrated interventions and providing a package of support. For the organisations that received funding, accountability should be ensured through effective monitoring and evaluation systems;

providing regular reporting and feedback to stakeholders; and having transparent systems for financial management.

7.2.5 Monitoring and evaluation

With increasing work linking SRH and HIV, the government agencies, SRH and HIV organisations in Malaysia need to collaborate and discuss the adaption of its systems for monitoring, evaluation and reporting. Systematic monitoring and evaluation of processes and outcomes of SRH and HIV interventions including the careful selection of indicators and targets that measure the extent and success of linkages are needed. In addition, the monitoring and evaluation systems and tools should also expand its measurement of impact beyond HIV outcomes to sexual and reproductive health outcomes.

Operational research on SRH/HIV linkages is also recommended to be conducted periodically in order to identify the gaps, major challenges in implementing the HIV and SRH linked programmes and possibilities of up scaling the programmes.

Appendix 1

Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
Approach 1: Capacity Building/Training Programme on SRH, HIV and STI 1.1 Training for staff and volunteer on SRH and HIV linkages 1.2 Empower women and girls/PLHIV/youth/key populations (SW, IDU, MSM, refugees, etc) to negotiate safer sex and to access RH and HIV/AIDS services				
Approach 2: Educational Programme on SRH, HIV and STI 2.1 Promotion of safer sex/condom use for dual protection 2.2 Behaviour change communication (BCC)/Outreach/peer education programme on SRH, HIV and STI for women and girls/PLHIV/youth/key populations (IDU, MSM, SW, etc) 2.3 IEC/BCC programme to avoid stigma and discrimination towards PLHIV and key population				
Approach 3: Linked SRH/HIV/STI and PMTCT Programme 3.1 Prong 1: Prevention of HIV among women of childbearing age and partners 3.2 Prong 2: Prevention of unintended pregnancies in HIV + women 3.3 Prong 3: Prevention of HIV transmission from an HIV + woman to her child 3.4 Prong 4: Care & support for the HIV + mother and her family				
Approach 4: Linked SRH/STI/HIV counselling and testing Programme				
Approach 5: Linked SRH/ STI/HIV Prevention, treatment, care and support Programme by and for PLHIV				

RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES – CLIENTS AND BENEFICIARIES

	A.) Background
1.	**Facility/Service Delivery Point/NGO: _____**
2.	**Age: _____**
3.	**Gender:** ☐ Male ☐ Female
4.	**Category:** ☐ Youth ☐ Disadvantage Youth ☐ Sex worker ☐ PLHIV ☐ Clients from National Family Planning Programme ☐ Marginalised women (Single mother/estate women/indigenous people, etc)
	B.) HIV and SRH Linked Information
5.	**Have you ever received any of the following information? (*You can select more than 1 answer)*** **<u>A. Sexual and Reproductive Health Information</u>** ☐ Contraception, eg: oral pills, IUCD, injections, etc ☐ Sexually Transmitted Infections, eg: Syphilis, Chlamydia, Herpes Simplex, etc ☐ Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc ☐ Gender-based violence, eg: rape, sexual harassment, physical or mental abuse ☐ Prevention of unsafe abortion/Termination of pregnancy ☐ Others, eg: Pap smear, Breast Examination, etc ☐ None **<u>B. HIV Information</u>** ☐ HIV prevention and education, eg: What is HIV? How is HIV Transmitted? ,etc ☐ Condom as dual protection ☐ HIV counselling and testing (VCT) ☐ How to prevent HIV transmission from PLHIVs to their children ☐ How to prevent HIV transmission among PLHIVs ☐ HIV Treatment (ARV or HAART) ☐ Support services for PLHIV ☐ Other HIV information (specify): _____ ☐ None

6. **Where did you get the information from? (*You can select more than 1 answer)***

- ☐ Television
- ☐ Newspapers
- ☐ School
- ☐ Parents
- ☐ Friends
- ☐ Peer educators
- ☐ Outreach workers
- ☐ Healthcare providers/Healthcare facilities
- ☐ NGOs/Drop in centres
- ☐ Internet
- ☐ Telephone helpline
- ☐ Pamphlets/Leaflets
- ☐ Others, please specify _____

7. **Did you get all of the information you want?**

- ☐ Yes
- ☐ No
- ☐ Unsure

8. **Why did you not receive all the information you wanted? (*You can select more than 1 answer)***

- ☐ Do not know about the information
- ☐ Do not where/how to look for the information
- ☐ Not available at your place
- ☐ Do not have time
- ☐ Do not feel comfortable requesting the information
- ☐ Do not feel is important
- ☐ Other (specify): _____

9. **What other information would you have liked to get? (*You can select more than 1 answer)***

<u>A. Sexual and Reproductive Health Information</u>

- ☐ Contraception, eg: oral pills, IUCD, injections, etc
- ☐ Sexually Transmitted Infections, eg: Syphilis, Chlamydia, Herpes Simplex, etc
- ☐ Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc
- ☐ Gender-based violence, eg: rape, sexual harassment, physical or mental abuse
- ☐ Prevention of unsafe abortion/Termination of pregnancy
- ☐ Others, eg: Pap smear, Breast Examination, etc
- ☐ None

B. HIV Information

- ☐ HIV prevention and education, eg: What is HIV? How is HIV Transmitted? ,etc
- ☐ Condom as dual protection
- ☐ HIV counselling and testing (VCT)
- ☐ How to prevent HIV transmission from PLHIVs to their children
- ☐ How to prevent HIV transmission among PLHIVs
- ☐ HIV Treatment (ARV or HAART)
- ☐ Support services for PLHIV
- ☐ Other HIV information (specify): _____
- ☐ None

10. **Have you ever received any of the HIV and SRH information at the same facilities/from the same person (such as peer educator/outreach worker) at one time?**

- ☐ Yes, please specify from who/where _____ (Please go to question 11)
- ☐ No (Please skip question 11 and go to question 12)

11. **Please specify the linked HIV and SRH information that you had received before. Please tick (√) at the column that applies.**

SRH/HIV	HIV prevention, education & condoms	HIV counselling & testing (VCT)	Prevention of HIV from parents to children	HIV Treatment (ARV or HAART)	Support services for PLHIV
Contraception, eg: oral pills, IUCD, injections, etc					
STIs, eg: Syphilis, Chlamydia, Herpes Simplex					
Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc					
GBV, eg: rape, sexual harassment, physical or mental abuse					
Prevention of unsafe abortion/Termination of pregnancy					
Other SRH services, eg: Pap smear, Breast Examination, etc					

12. **Do you prefer sexual and reproductive health and HIV information at the same facilities/from the same person (such as peer educator/outreach worker) at one time?**

☐ Yes, please specify why?
_____?

☐ No, please specify why?
_____ _____

C.) HIV and SRH Linked Services

13. **Have you ever received any of the following services? (*You can select more than 1 answer)***

A. Sexual and Reproductive Health Services

☐ Contraception, eg: oral pills, IUCD, injections, etc
☐ Sexually Transmitted Infections, eg: Syphilis, Chlamydia, Herpes Simplex, etc
☐ Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc
☐ Gender-based violence, eg: rape, sexual harassment, physical or mental abuse
☐ Prevention of unsafe abortion/Termination of pregnancy
☐ Others, eg: Pap smear, Breast Examination, etc
☐ None

HIV Services:

☐ HIV counselling and testing (If yes)
  ☐ VCT
  ☐ Recommended by doctors/nurses
☐ Treatment for PLHIV (HAART/ARV/other treatments for TB, rashes, etc)
☐ Home-based care
☐ Support groups
☐ Prevention of HIV among PLHIVs
☐ HIV prevention information and services for general population
☐ Condom provision
☐ PMTCT (four prongs)
  ☐ Prong 1: Prevention of HIV among women of childbearing age and partners
  ☐ Prong 2: Prevention of unintended pregnancies in HIV + women
  ☐ Prong 3: Prevention of HIV transmission from an HIV + woman to her child
  ☐ Prong 4: Care & support for the HIV + mother and her family
☐ Other services (specify): _____
☐ None

14. **Did you get all of the services you want?**

- ☐ Yes
- ☐ No
- ☐ Unsure

15. **Why did you not receive all the services you wanted? (*You can select more than 1 answer)***

- ☐ Cost
- ☐ Not aware of the services
- ☐ Do not where/how to look for the services
- ☐ Not available at your place
- ☐ Do not have time
- ☐ Do not feel comfortable requesting the services
- ☐ Do not feel is important
- ☐ Other (specify): _____

16. **Have you ever being referred for the services that you would like to get?**

- ☐ Yes
- ☐ No

17. **What other services would you have liked to get? (*You can select more than 1 answer)***

A. Sexual and Reproductive Health Services

- ☐ Contraception, eg: oral pills, IUCD, injections, etc
- ☐ Sexually Transmitted Infections, eg: Syphilis, Chlamydia, Herpes Simplex, etc
- ☐ Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc
- ☐ Gender-based violence, eg: rape, sexual harassment, physical or mental abuse
- ☐ Prevention of unsafe abortion/Termination of pregnancy
- ☐ Others, eg: Pap smear, Breast Examination, etc
- ☐ None

HIV Services:

- ☐ HIV counselling and testing (If yes)
  - ☐ VCT
  - ☐ Recommended by doctors/nurses
- ☐ Treatment for PLHIV (HAART/ARV/other treatments for TB, rashes, etc)
- ☐ Home-based care
- ☐ Support groups
- ☐ Prevention of HIV among PLHIVs
- ☐ HIV prevention information and services for general population

- ☐ Condom provision
- ☐ PMTCT (four prongs)
  - ☐ Prong 1: Prevention of HIV among women of childbearing age and partners
  - ☐ Prong 2: Prevention of unintended pregnancies in HIV + women
  - ☐ Prong 3: Prevention of HIV transmission from an HIV + woman to her child
  - ☐ Prong 4: Care & support for the HIV + mother and her family
- ☐ Other services (specify): _____
- ☐ None

18. **Have you ever received any of the HIV and SRH services as mentioned earlier at the same facilities at one time?**

- ☐ Yes
- ☐ No (If no, please skip question 19 and go to question 20)

19. **Please specify the linked HIV and SRH services that you had received before. Please tick (√) at the column that applicable.**

SRH/HIV	HIV prevention, education & condoms	HIV counselling & testing (VCT)	Prevention of HIV from parents to children	HIV Treatment (ARV or HAART)	Support services for PLHIV
Contraception, eg: oral pills, IUCD, injections, etc					
STIs, eg: Syphilis, Chlamydia, Herpes Simplex					
Safe pregnancy and childbirth, eg: check-up before and after delivery, injection for newborn baby, etc					
GBV, eg: rape, sexual harassment, physical or mental abuse					
Prevention of unsafe abortion/Termination of pregnancy					
Other SRH services, eg: Pap smear, Breast Examination, etc					

20. **Do you prefer sexual and reproductive health and HIV services at the same facility, or do you prefer different facilities?**

- ☐ Prefer same facility/site
- ☐ Prefer a different facility/site
- ☐ No preference
- ☐ Don't know
- ☐ Other, please specify

_____

21. **What do you think may be some of the possible benefits of receiving all these services from the same facility at one time? (*You can select more than 1 answer)***

- ☐ Reduce number of trips to facility
- ☐ Improve efficiency of services
- ☐ Reduce transportation costs
- ☐ Reduce fees
- ☐ Reduce waiting time
- ☐ Good opportunity to access additional services
- ☐ Reduce stigma for HIV
- ☐ Don't know

22. **What do you think may be some of the possible disadvantages of receiving all these services from the same facility at one time? (*You can select more than 1 answer)***

- ☐ Fear of stigma and discrimination
- ☐ Fear of less confidentiality
- ☐ Embarrassment to talk about HIV with provider of same village/ neighbourhood
- ☐ Increase client waiting time
- ☐ Provider will be too busy
- ☐ Decrease quality of services
- ☐ Don't know
- ☐ Other (specify): _____

23. **Do you have any suggestions about the integration of sexual and reproductive health and HIV services?**

_____
_____
_____
_____
_____
_____
_____

	B.) Latar Belakang
1.	**Organisasi: _____**
2.	**Umur: _____**
3.	**Jantina:** ☐ Lelaki ☐ Perempuan
4.	**Kategori:** ☐ Pemuda ☐ Pekerja Seks ☐ Orang yang hidup dengan HIV ☐ Klien/Penerima Perkhidmatan Perancangan Keluarga ☐ Ibu Tunggal/Wanita dari estate/Orang Asli
	B.) Maklumat tentang HIV dan Kesihatan Seksual dan Reproduktif
5.	**Pernahkah anda menerima maklumat berikut? (Anda boleh memilih lebih daripada satu jawapan)** **<u>A. Maklumat tentang Seksual dan Reproduktif</u>** ☐ Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD ☐ Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex ☐ Kehamilan dan kelahiran anak yang selamat, cth: pemeriksaan sebelum dan selepas melahirkan anak, suntikan untuk bayi yang baru lahir ☐ Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental ☐ Pencegahan keguguran yang tidak selamat ☐ Lain-lain, cth: Pap smear, pemeriksaan payudara ☐ Tiada sebarang di atas **<u>B. Maklumat HIV</u>** ☐ Pendidikan pencegahan HIV, cth: Apa itu HIV? Bagaimanakah ia dijangkiti? ☐ Kondom sebagai cara pelindungan HIV and kahamilan ☐ Kaunseling dan ujian HIV ☐ Bagaimanakah mencegah jangkitan HIV daripada ibubapa kepada anak-anak ☐ Bagaimanakah mencegah jangkitan HIV di kalangan orang yang hidup dengan HIV ☐ Perubatan untuk HIV (ARV atau HAART) ☐ Perkhidmatan sokongan untuk orang yang hidup dengan HIV ☐ Maklumat HIV yang lain : _____ ☐ Tiada sebarang di atas

6. **Siapakah/Dari manakah anda menerima maklumat tersebut? (Anda boleh memilih lebih daripada satu jawapan)**

- ☐ Ibu bapa
- ☐ Kawan
- ☐ Pendidik rakan sebaya (*Peer educators)*
- ☐ Pekerja *outreach*
- ☐ Doktor/jururawat/hospital
- ☐ Televisyen
- ☐ Suratkhabar
- ☐ Sekolah
- ☐ Pertubuhan Bukan Kerajaan / *Drop in centres*
- ☐ Internet
- ☐ Talian bantuan telefon
- ☐ Risalah
- ☐ Lain-lain, sila nyatakan _____

7. **Adakah anda mendapat semua maklumat yang anda ingin tahu?**

- ☐ Ya
- ☐ Tidak
- ☐ Tidak Pasti

8. **Mengapakah anda tidak mendapat semua maklumat yang anda ingin tahu? (Anda boleh memilih lebih daripada satu jawapan)**

- ☐ Tidak tahu tentang maklumat tersebut
- ☐ Tidak tahu dimanakah/bagaimanakah untuk mendapat maklumat tersebut
- ☐ Maklumat tersebut tidak disediakan di tempat anda
- ☐ Tiada masa
- ☐ Tidak selesa/malu untuk bertanya tentang maklumat tersebut
- ☐ Tidak berasa maklumat itu penting
- ☐ Sebab-sebab lain, sila nyatakan: _____

9. **Apakah maklumat lain yang anda ingin dapatkan? (Anda boleh memilih lebih daripada satu jawapan)**

<u>A. Maklumat tentang Seksual dan Reproduktif</u>

- ☐ Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD
- ☐ Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex
- ☐ Cara kehamilan dan kelahiran anak yang selamat, cth: pemeriksaan sebelum dan selepas melahirkan anak, suntikan untuk bayi yang baru lahir
- ☐ Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental
- ☐ Pencegahan keguguran yang tidak selamat
- ☐ Lain-lain, cth: Pap smear, pemeriksaan payudara
- ☐ Tiada sebarang di atas

B. Maklumat HIV

- ☐ Pendidikan pencegahan HIV, cth: Apa itu HIV? Bagaimanakah ia dijangkiti?
- ☐ Kondom sebagai cara pelindungan HIV and kahamilan
- ☐ Kaunseling dan ujian HIV
- ☐ Bagaimanakah mencegah jangkitan HIV daripada ibubapa kepada anak-anak
- ☐ Bagaimanakah mencegah jangkitan HIV di kalangan orang yang hidup dengan HIV
- ☐ Perubatan untuk HIV (ARV atau HAART)
- ☐ Perkhidmatan sokongan untuk orang yang hidup dengan HIV
- ☐ Maklumat HIV yang lain : _____
- ☐ Tiada sebarang di atas

10. **Pernahkah anda menerima sebarang gabunagn maklumat tentang HIV dan kesihatan seksual dan reproduktif pada masa yang sama dan dari tempat/orang *(peer educator/outreach worker)* yang sama?**

- ☐ Ya, sila nyatakan dari mana/siapa _____ (Sila jawap soalan 11)
- ☐ Tidak (Sila skip soalan 11 dan terus jawap 12)

11. **Sila tandakan (√) dalam kotak yang sesuai untuk menunjukkan maklumat HIV dan kesihatan seksual dan reproduktif yang pernah anda terima pada masa/tempat yang sama**

Gabungan maklumat tentang kesihatan Seksual dan Reproduktif/HIV	**Pendidikan HIV & Kondom**	**Kaunseling dan ujian HIV**	**Pencengahan HIV daripada ibubapa kepada anak**	**Perubatan HIV (ARV or HAART)**	**Sokongan untuk orang hidup dengan PLHIV**
Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD					
Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex					
Cara kehamilan dan kelahiran anak yang selamat					
Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental					
Pencegahan keguguran yang tidak selamat					
Lain-lain, cth: Pap smear, pemeriksaan payudara					

12. **Adakah anda lebih suka menerima maklumat HIV dan kesihatan seksual dan reproduktif pada masa yang sama dan dari tempat/orang yang sama (peer educator/outreach worker) atau tidak?**

☐ Ya, sila nyatakan sebabnya _____
☐ Tidak, sila nyatakan sebabnya _____ _____

C.) Perkhidmatan HIV dan Kesihatan Seksual dan Reproduktif

13. **Pernahkah anda menerima perkhidmatan berikut? (Anda boleh memilih lebih daripada satu jawapan)**

A. Perkhidmatan tentang Seksual dan Reproduktif

☐ Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD
☐ Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex
☐ Cara kehamilan dan kelahiran anak yang selamat, cth: pemeriksaan sebelum dan selepas melahirkan anak, suntikan untuk bayi yang baru lahir
☐ Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental
☐ Pencegahan keguguran yang tidak selamat
☐ Lain-lain, cth: Pap smear, pemeriksaan payudara
☐ Tiada sebarang di atas

B. Perkhidmatan HIV:

☐ Kaunseling dan ujian HIV (Jika ya, sila nyatakan jenis ujian yang anda terima)
  ☐ Kaunseling dan ujian HIV secara sukarela
  ☐ Ujian HIV dicadangkan oleh doctor/jururawat
☐ Perubatan/rawatan HIV(HAART/ARV/ rawatan untuk TB, ruam)
☐ Penjagaan di rumah *(Home-based care)*
☐ Sokongan kumpulan *(Support groups)*
☐ Pencegahan jangkitan HIV dikalangan orang yang hidup dengan HIV
☐ Pencegahan jangkitan HIV dikalangan orang/penduduk umum
☐ Pembekalan kondom
☐ Pencegahan jangkitan HIV daripada ibubapa kepada anak
  ☐ Jenis 1: Pencegahan jangkitan HIV dikalangan wanita dalam lingkungan usia reproduktif (tahun 15 – 49) dan pasangannya
  ☐ Jenis 2: Pencegahan kehamilan yang tidak sengaja dikalangan wanita HIV+
  ☐ Jenis 3: Pencegahan jangkitan HIV daripada wanita HIV+ kepada anaknya
  ☐ Jenis 4: Pemberian penjagaan dan sokongan kepada ibu HIV+ dan keluarganya
☐ Perkhidmatan lain (nyatakan):_____
☐ Tiada sebarang di atas

14. **Adakah anda mendapat semua perkhidmatan yang anda ingin tahu?**

- ☐ Ya
- ☐ Tidak
- ☐ Tidak Pasti

15. **Mengapakah anda tidak mendapat semua perkhidmatan yang anda ingin dapat? (Anda boleh memilih lebih daripada satu jawapan)**

- ☐ Tidak tahu tentang perkhidmatan tersebut
- ☐ Tidak tahu dimanakah/bagaimanakah untuk mendapat perkhidmatan tersebut
- ☐ Perkhidmatan tersebut tidak disediakan di tempat anda
- ☐ Tiada masa
- ☐ Tidak selesa/malu untuk bertanya tentang perkhidmatan tersebut
- ☐ Tidak berasa perkhidmatan itu penting
- ☐ Sebab-sebab lain, sila nyatakan: _____

16. **Pernahkah anda dirujuk ke mana-mana supaya mendapatkan perkhidmatan yang anda ingin dapatkan?**

- ☐ Ya
- ☐ Tidak

17. **Apakah perkhidmatan lain yang anda ingin dapatkan? (Anda boleh memilih lebih daripada satu jawapan)**

A. Perkhidmatan tentang Seksual dan Reproduktif

- ☐ Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD
- ☐ Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex
- ☐ Cara kehamilan dan kelahiran anak yang selamat, cth: pemeriksaan sebelum dan selepas melahirkan anak, suntikan untuk bayi yang baru lahir
- ☐ Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental
- ☐ Pencegahan keguguran yang tidak selamat
- ☐ Lain-lain, cth: Pap smear, pemeriksaan payudara
- ☐ Tiada sebarang di atas

B. Perkhidmatan HIV:

- ☐ Kaunseling dan ujian HIV (Jika ya, sila nyatakan jenis ujian yang anda terima)
  - ☐ Kaunseling dan ujian HIV secara sukarela
  - ☐ Ujian HIV dicadangkan oleh doctor/jururawat
- ☐ Perubatan/rawatan HIV(HAART/ARV/ rawatan untuk TB, ruam)
- ☐ Penjagaan di rumah *(Home-based care)*
- ☐ Sokongan kumpulan *(Support groups)*

- ☐ Pencegahan jangkitan HIV dikalangan orang yang hidup dengan HIV
- ☐ Pencegahan jangkitan HIV dikalangan orang/penduduk umum
- ☐ Pembekalan kondom
- ☐ Pencegahan jangkitan HIV daripada ibubapa kepada anak
  - ☐ Jenis 1: Pencegahan jangkitan HIV dikalangan wanita dalam lingkungan usia reproduktif (tahun 15 – 49) dan pasangannya
  - ☐ Jenis 2: Pencegahan kehamilan yang tidak sengaja dikalangan wanita HIV+
  - ☐ Jenis 3: Pencegahan jangkitan HIV daripada wanita HIV+ kepada anaknya
  - ☐ Jenis 4: Pemberian penjagaan dan sokongan kepada ibu HIV+ dan keluarganya
- ☐ Perkhidmatan lain (nyatakan):_____
- ☐ Tiada sebarang di atas

18. **Pernahkah anda mendapat apa-apa perkhidmatan HIV and kesihatan seksual dan reproduktif serentak di tempat yang sama dan pada masa yang sama?**

- ☐ Ya
- ☐ Tidak (Jika tidak, sila skip soalan 19 dan terus jawap soalan 20)

19. **Sila tandakan (V) dalam kotak yang sesuai untuk menunjukkan jenis gabungan perkhidmatan HIV dan kesihatan seksual dan reproduktif yang pernah anda terima pada masa/tempat yang sama**

Gabungan Perkhidmatan kesihatan Seksual dan Reproduktif/HIV	**Pendidikan HIV & Kondom**	**Kaunseling dan ujian HIV**	**Pencengahan HIV daripada ibubapa kepada anak**	**Perubatan HIV (ARV or HAART)**	**Sokongan untuk orang hidup dengan PLHIV**
Kontraseptif atau perancangan keluarga , cth: pil, kondom, suntikan & IUCD					
Penyakit Kelamin, cth: Sifilis, klamidia, Herpes Simplex					
Cara kehamilan dan kelahiran anak yang selamat					
Keganasan berasaskan jantina, cth: rogol, gangguan seksual, penderaan fizikal atau mental					
Pencegahan keguguran yang tidak selamat					
Lain-lain, cth: Pap smear, pemeriksaan payudara					

20. **Adakah anda lebih suka menerima perkhidmatan HIV dan kesihatan seksual dan reproduktif yang digabungkan di tempat yang sama atau tempat yang berlainan?**

- ☐ Lebih suka di tempat yang sama
- ☐ Lebih suka di tempat yang berlainan
- ☐ Tiada keutamaan/kesukaan
- ☐ Tidak tahu
- ☐ Lain-lain, sila nyatakan_____

21. **Pada pendapat anda, apakah kebaikan untuk menerima perkhidmatan HIV dan kesihatan seksual dan reproduktif di tempat yang sama atau pada masa yang sama? (Anda boleh memilih lebih daripada satu jawapan)**

- ☐ Kurangkan kekerapan ke tempat perkhidmatan
- ☐ Meningkatkan kecekapan perkhidmatan
- ☐ Kurangkan kos perjalanan/pengangkutan
- ☐ Kurangkan kos perkhidmatan
- ☐ Kurangkan masa menunggu
- ☐ Peluang yang baik untuk mendapat perkhidmatan yang berlebihan
- ☐ Kurangkan stigma terhadap HIV
- ☐ Tidak tahu
- ☐ Lain-lain (nyataka): _____

22. **Pada pendapat anda, apakah keburukan untuk menerima perkhidmatan HIV dan kesihatan seksual dan reproduktif di tempat yang sama atau pada masa yang sama? (Anda boleh memilih lebih daripada satu jawapan)**

- ☐ Takut stigma dan diskriminasi
- ☐ Kekurangan kesulitan (cth: mungkin status HIV akan ditahui oleh orang ramai)
- ☐ Rasa malu untuk membincangkan HIV dengan doctor/jururawat yang tinggal di kampong/tempat yang sama
- ☐ Masa menunggu dipanjangkan
- ☐ Doktor/Jururawat menjadi terlalu sibuk
- ☐ Kualiti perkhidmatan diturukan
- ☐ Tidak tahu
- ☐ Lain-lain (nyataka): _____

23. **Apakah cadangan lain anda tentang gabungan program HIV dan kesihatan seksual dan reproduktif ?**

_____
_____
_____
_____
_____
_____

	A.) Background
1.	**Facility/Service Delivery Point/NGO: _____**
2.	**Age (no. of years): _____**
3.	**Gender:** ☐ Male ☐ Female
4.	**Category:** ☐ Service Providers who provide family planning and SRH services ☐ Service Providers who provide HIV related services ☐ Outreach workers
	B.) Linked SRH and HIV Services
5.	**Which of the following services in SRH or HIV were offered first in your clinic/organisation before integration of either the HIV or SRH services? (i.e. before integration)** *[Select either A or B. Read all options. Tick all as appropriate]* **<u>A. HIV Services</u>** ☐ HIV counselling and testing (If yes) ☐ VCT (clients come to request HIV counselling and testing) ☐ Provider-initiated testing and counselling (clients are routinely offered HIV testing and counselling) ☐ Prophylaxis and treatment for PLHIV (ARV/HAART) ☐ Home-based care ☐ Psycho-social support (Support groups) ☐ Prevention for and by people living with HIV ☐ HIV prevention information and services for general population ☐ Condom provision ☐ PMTCT (four prongs) ☐ Prong 1: Prevention of HIV among women of childbearing age and partners ☐ Prong 2: Prevention of unintended pregnancies in HIV + women ☐ Prong 3: Prevention of HIV transmission from an HIV + woman to her child ☐ Prong 4: Care & support for the HIV + mother and her family ☐ Specific HIV information and services for key populations ☐ IDUs ☐ MSM ☐ SWs ☐ Other key populations (specify) : _____ ☐ Other HIV services (specify): _____ ☐ None

B.SRH Services

☐ Family planning, eg: oral pills, IUCD, injections, etc
☐ Prevention and management of Sexually Transmitted Infections (STIs)
☐ Maternal and newborn care, eg: check-up before and after delivery, injection for newborn baby, etc
☐ Prevention, management or referral of gender-based violence, eg: rape, sexual harassment, physical or mental abuse
☐ Prevention of unsafe abortion, management of post-abortion care or referral
☐ Other SRH services (specify): _____
☐ None

6. Which of the following SRH or HIV services are linked with your existing HIV/SRH services?
[Select either A or B. Read all options. Tick all as appropriate]

A. SRH Services with integration of following HIV Services:

☐ HIV counselling and testing (If yes)
  ☐ VCT (clients come to request HIV counselling and testing)
  ☐ Provider-initiated testing and counselling (clients are routinely offered HIV testing and counselling)
☐ Prophylaxis and treatment for PLHIV (ARV/HAART)
☐ Home-based care
☐ Psycho-social support (Support groups)
☐ Prevention for and by people living with HIV
☐ HIV prevention information and services for general population
☐ Condom provision
☐ PMTCT (four prongs)
  ☐ Prong 1: Prevention of HIV among women of childbearing age and partners
  ☐ Prong 2: Prevention of unintended pregnancies in HIV + women
  ☐ Prong 3: Prevention of HIV transmission from an HIV + woman to her child
  ☐ Prong 4: Care & support for the HIV + mother and her family
☐ Specific HIV information and services for key populations
  ☐ IDUs ☐ MSM ☐ SWs ☐ Other key populations (specify) : _____
☐ Other HIV services (specify): _____
☐ None

B. HIV Services with integration of following SRH Services:

☐ Family planning, eg: oral pills, IUCD, injections, etc
☐ Prevention and management of Sexually Transmitted Infections (STIs)
☐ Maternal and newborn care, eg: check-up before and after delivery, injection for newborn baby, etc
☐ Prevention, management or referral of gender-based violence, eg: rape, sexual harassment, physical or mental abuse
☐ Prevention of unsafe abortion, management of post-abortion care or referral
☐ Other SRH services (specify): _____
☐ None

7. How does your organization/institution offer HIV-SRH linked services within your existing services? *[Read all options. Tick all as appropriate]*

- ☐ Located in the same service site with the same provider
  - ☐ Offered on the same day?
- ☐ Located within the same service site with different provider
  - ☐ Offered on the same day?
- ☐ Referred to different service site within the organization
  - ☐ Offered on the same day?
- ☐ Referred to another facility/organization
- ☐ Other (specify): _____

8. Is there any follow-up to see whether clients act on referrals?

- ☐ Yes
- ☐ No (please specify why not?)
  - ☐ Too busy
  - ☐ Not necessary
  - ☐ Clients usually return on their own
  - ☐ Don't know
  - ☐ Other (specify): _____

9. Please rate each of the following as to how effective it is to offering linked SRH and HIV services in your organization. *[For each cell, indicate response between 1 to 5]*
(1) not effective (2) somewhat effective (3) effective
(4) very effective (5) don't know

SRH/HIV	HIV prevention, education & condoms	HIV counselling & testing	PMTCT	Clinical care For PLHIV	Psychosocial & other services for PLHIV
Family planning					
Maternal & child health care					
GBV prevention & management					
STI prevention & management					
Prevention of unsafe abortion and management					
Other SRH services					

10. Please rate each of the following as to how large a constraint it is to offer linked SRH and HIV services in your organization. *[For each cell, indicate response between 1 to 5]*

(1) Not a constraint (2) Small constraint (3) Medium constraint
(4) Large constraint (5) Unsure, don't know

	Level of constraint
Shortage of equipment for offering integrated services	
Shortage of space for offering private and confidential services	
Shortage of staff time	
Shortage of staff training	
Inappropriate/insufficient staff supervision	
Low staff motivation	
Some other constraint? (specify): _____	

11. What do you think is or will be the likely impact of linking SRH and HIV services on the following service dimensions. Will they decrease, increase or not change?
[*Please answer all statements below*]

	Decrease	No change	Increase	Unsure, don't know
Costs of services of your organization				
Cost of services to client				
Efficiency of services				
Stigmatization of HIV clients				
Stigmatization of SRH clients				
Workload for providers				
Time spent per client				
Space and privacy				
Need for equipment, supplies, and drugs				
Other, specify: _____				

12. How could the HIV and SRH linked services be strengthened in your clinic/organization?
[Read all options. *Tick all as appropriate*]

- ☐ Supportive policy environment
- ☐ Stakeholder commitment
- ☐ Human resources and planning
- ☐ Health provider training
- ☐ Client education involvement
- ☐ Quality of services
- ☐ Standard Operational Guidelines on SRH and HIV linked services
- ☐ Infrastructure
- ☐ Supply management (including commodity security)
- ☐ Monitoring and Evaluation system
- ☐ Other (specify): _____
- ☐ Unsure, don't know

13. What is the most urgent resource required to strengthen the HIV and SRH linked services in your clinic/organization? *[Read all options. Tick all as appropriate]*

- ☐ Finance resources
- ☐ Human resources
- ☐ Technical assistance
- ☐ Capacity building including sensitization workshop
- ☐ Infrastructure
- ☐ Commodity Supply
- ☐ Partnership with other agencies (government and non-government)
- ☐ Other (specify): _____
- ☐ Unsure, don't know

14. Which of the following SRH or HIV services that you think should be integrated within your existing services in the future? *[Select either A or B. Read all options. Tick all as appropriate]*

A. SRH Services with integration of following HIV Services:

- ☐ HIV counselling and testing (If yes)
  - ☐ VCT (clients come to request HIV counselling and testing)
  - ☐ Provider-initiated testing and counselling (clients are routinely offered HIV testing and counselling)
- ☐ Prophylaxis and treatment for PLHIV (ARV/HAART)
- ☐ Home-based care
- ☐ Psycho-social support (Support groups)
- ☐ Prevention for and by people living with HIV
- ☐ HIV prevention information and services for general population
- ☐ Condom provision
- ☐ PMTCT (four prongs)
  - ☐ Prong 1: Prevention of HIV among women of childbearing age and partners
  - ☐ Prong 2: Prevention of unintended pregnancies in HIV + women
  - ☐ Prong 3: Prevention of HIV transmission from an HIV + woman to her child
  - ☐ Prong 4: Care & support for the HIV + mother and her family
- ☐ Specific HIV information and services for key populations
  - ☐ IDUs ☐ MSM ☐ SWs ☐ Other key populations (specify) : _____
- ☐ Other HIV services (specify): _____
- ☐ None

B. HIV Services with integration of following SRH Services:

- ☐ Family planning, eg: oral pills, IUCD, injections, etc
- ☐ Prevention and management of Sexually Transmitted Infections (STIs)
- ☐ Maternal and newborn care, eg: check-up before and after delivery, injection for newborn baby, etc
- ☐ Prevention, management or referral of gender-based violence, eg: rape, sexual harassment, physical or mental abuse
- ☐ Prevention of unsafe abortion, management of post-abortion care or referral
- ☐ Other SRH services (specify): _____
- ☐ None

	A.) Latar Belakang
1.	**Organisasi/NGO: _____**
2.	**Umur: _____**
3.	**Jantina:** ☐ Lelaki ☐ Perempuan ☐ Transeksual
4.	**Kategori:** ☐ Pembekal perkhidmatan kesihatan yang berkaitan dengan perancangan keluarga dan kesihatan seksual dan reproduktif ☐ Pembekal perkhidmatan kesihatan yang berkaitan dengan HIV ☐ Pekerja *Outreach*
	B.) Gabungan Perkhidmatan HIV dan Kesihatan Seksual dan Reproduktif
5.	**Apakah perkhidmatan yang berkaitan dengan <u>HIV</u> atau <u>Kesihatan Seksual dan Reproduktif (SRH)</u> yang tersenarai seperti berikut ditawarkan oleh organisasi anda sebelum integrasi? [Pilih sama ada A atau B dan tandakan semua jawapan yang berkaitan]** **<u>A. HIV Services</u>** ☐ Kaunseling dan Ujian HIV (jika ya) ☐ Perkhidmatan ujian dan kaunseling sukarela *(VCT)* ☐ Kaunseling dan ujian HIV yang dimulakan oleh pemberi khidmat seperti doktor atau jururawat *(PITC)* ☐ Penjagaaan berasaskan rumah untuk orang yang hidup dengan HIV *(PLHIV)* ☐ Sokongan psiko-social ☐ Pencegahan yang dijalankan untuk dan oleh Orang Yang Hidup Dengan HIV *(PLHIV)* ☐ Maklumat/Informasi tentang pencegahan HIV untuk penduduk umum ☐ Pembekalan Kondom ☐ Program Pencegahan Jangkitan HIV dari Ibu ke Anak *(PMTCT)* ☐ Jenis 1: Pencegahan jangkitan HIV dikalangan wanita dalam lingkungan usia reproduktif (tahun 15 – 49) dan pasangannya ☐ Jenis 2: Pencegahan kehamilan yang tidak sengaja dikalangan wanita HIV+ ☐ Jenis 3: Pencegahan jangkitan HIV daripada wanita HIV+ kepada anaknya ☐ Jenis 4: Pemberian penjagaan dan sokongan kepada ibu HIV+ dan keluarganya ☐ Maklumat/Informasi dan perkhidmatan HIV yang khusus kepada golongan masyarakat yang penting ☐ Pengguna dadah suntikan *(IDUs)* ☐ Lelaki yang melakukan seks dengan lelaki *(MSM)* ☐ Pekerja Seks *(SWs)* ☐ Golongan masyarakat penting yang lain (senaraikan): _____ ☐ Perkhidmatan lain yang berkaitan dengan HIV (senaraikan): _____ ☐ Tiada perkhidmatan yang berkaitan dengan HIV

B. Perkhidmatan Kesihatan Seksual dan Reproduktif

- ☐ Perancangan Keluarga
- ☐ Pencegahan dan pengurusan penyakit kelamin/seksual *(STIs)*
- ☐ Penjagaan ibu dan bayi yang baru dilahirkan
- ☐ Pencegahan dan pengurusan keganasan berasaskan jantina *(gender-based violence)*
- ☐ Pencegahan pengguguran yang tidak selamat dan penjagaan selepas pengguguran
- ☐ Perkhidmatan Kesihatan Seksual dan Reproduktif yang lain (senaraikan): _____
- ☐ Tiada Perkhidmatan yang berkaitan dengan Kesihatan Seksual dan Reproduktif

6. Apakah perkhidmatan yang berkaitan dengan HIV atau Kesihatan Seksual dan Reproduktif (SRH) yang tersenarai seperti berikut telah diintegrasikan ke dalm perkhidmatan yang ditawarkan oleh organisasi anda sekarang? [Pilih sama ada A atau B dan tandakan semua jawapan yang berkaitan]

A. Perkhidmatan SRH yang mengitegrasikan perkhidmatan HIV berikut:

- ☐ Kaunseling dan Ujian HIV (jika ya)
  - ☐ Perkhidmatan ujian dan kaunseling sukarela *(VCT)*
  - ☐ Kaunseling dan ujian HIV yang dimulakan oleh pemberi khidmat seperti doktor atau jururawat *(PITC)*
- ☐ Penjagaaan berasaskan rumah untuk orang yang hidup dengan HIV *(PLHIV)*
- ☐ Sokongan psiko-social
- ☐ Pencegahan yang dijalankan untuk dan oleh Orang Yang Hidup Dengan HIV *(PLHIV)*
- ☐ Maklumat/Informasi tentang pencegahan HIV untuk penduduk umum
- ☐ Pembekalan Kondom
- ☐ Program Pencegahan Jangkitan HIV dari Ibu ke Anak *(PMTCT)*
  - ☐ Jenis 1: Pencegahan jangkitan HIV dikalangan wanita dalam lingkungan usia reproduktif (tahun 15 – 49) dan pasangannya
  - ☐ Jenis 2: Pencegahan kehamilan yang tidak sengaja dikalangan wanita HIV+
  - ☐ Jenis 3: Pencegahan jangkitan HIV daripada wanita HIV+ kepada anaknya
  - ☐ Jenis 4: Pemberian penjagaan dan sokongan kepada ibu HIV+ dan keluarganya
- ☐ Maklumat/Informasi dan perkhidmatan HIV yang khusus kepada golongan masyarakat yang penting
  - ☐ Pengguna dadah suntikan *(IDUs)*
  - ☐ Lelaki yang melakukan seks dengan lelaki *(MSM)*
  - ☐ Pekerja Seks *(SWs)*
  - ☐ Golongan masyarakat penting yang lain (senaraikan): _____
- ☐ Perkhidmatan lain yang berkaitan dengan HIV (senaraikan): _____
- ☐ Tiada perkhidmatan yang berkaitan dengan HIV

B. Perkhidmatan HIV yang mengitegrasikan perkhidmatan SRH berikut:

- ☐ Perancangan Keluarga
- ☐ Pencegahan dan pengurusan penyakit kelamin/seksual *(STIs)*
- ☐ Penjagaan ibu dan bayi yang baru dilahirkan
- ☐ Pencegahan dan pengurusan keganasan berasaskan jantina *(gender-based violence)*
- ☐ Pencegahan pengguguran yang tidak selamat dan penjagaan selepas pengguguran
- ☐ Perkhidmatan Kesihatan Seksual dan Reproduktif yang lain (senaraikan):
  _____
- ☐ Tiada Perkhidmatan yang berkaitan dengan Kesihatan Seksual dan Reproduktif

7. Bagaimanakah organisasi anda membekalkan perkhidmatan yang mengintegrasikan HIV/SRH dalam perkhidmatan yang tersedia ada di organisasi anda? *[Baca semua pilihan dan pilih mana-mana yang sesuai]*

- ☐ Di tempat/fasiliti yang sama dan dibekalkan oleh pemberi khidmat seperti doktor atau jururawat/pekerja *outreach* yang sama
  - ☐ Ditawarkan pada hari yang sama?
- ☐ Di tempat/fasiliti perkhidmatan yang sama dan dibekalkan oleh pemberi khidmat seperti doktor atau jururawat/pekerja *outreach* yang berlainan
  - ☐ Ditawarkan pada hari yang sama?
- ☐ Merujuk pelanggan kepada tempat/fasiliti yang berlainan tetapi masih dalam organisasi anda untuk perkhidmatan yang berlainan
  - ☐ Ditawarkan pada hari yang sama?
- ☐ Merujuk pelanggan kepada organisasi lain untuk perkhidmatan yang berlainan
- ☐ Lain-lain (senaraikan): _____

8. Adakah langkah tindak lanjut diambil untuk memastikan pelanggan bertindak atas rujukkan kepada organisasi yang lain?

- ☐ Ya
- ☐ Tidak (sila senaraikan mengapa tiada langkah tindak lanjut diambil?)
  - ☐ Terlalu sibuk
  - ☐ Tidak diperlukan
  - ☐ Pelanggan biasanya akan kembali sendiri
  - ☐ Tidak tahu
  - ☐ Lain-lain (senaraikan): _____

9. Sila nilaikan keberkesanan perkhidmatan yang ditawarkan oleh organisasi anda selepas HIV dan Kesihatan Seksual dan Reproduktif diintegrasikan bersama.

Sebagai contoh, jika perkhidmatan NSEP menjadi sangat berkesan selepas membekalkan program perancangan keluarga, anda haruslah mengiri "4" seperti berikut:

KSR/HIV	Perancangan Keluarga	Penjagaan ibu dan bayi yang baru dilahirkan	Pencegahan dan pengurusan keganasan berasaskan jantina (GBV)	Pencegahan dan pengurusan penyakit kelamin (STIs)	Perkhidmatan yang berkaitan dengan penggguran	Perkhidmatan KSR yang lain
Pendidikan, Pencegahan jangkitan HIV dan pembekalan kondom	**4**					

Untuk setiap kotak, sila tunjukkan maklum balas anda dengan memilihkan 1 hingga 5
(1) Tidak berkesan (2) Agak berkesan (3) Berkesan
(4) Sangat berkesan (5) Tidak tahu

KSR/HIV	**Perancangan Keluarga**	**Penjagaan ibu dan bayi yang baru dilahirkan**	**Pencegahan dan pengurusan keganasan berasaskan jantina (GBV)**	**Pencegahan dan pengurusan penyakit kelamin (STIs)**	**Perkhidmatan yang berkaitan dengan penggguran**	**Perkhidmatan KSR yang lain**
Pendidikan, Pencegahan jangkitan HIV dan pembekalan kondom						
Kaunseling dan Ujian HIV						
Program Pencegahan Jangkitan HIV dari Ibu ke Anak (PMTCT)						
Rawatan Klinikal untuk PLHIV						
Psikososial & dan perkhidmatan lain untuk PLHIV						

10. **Sila nilaikan masalah/halangan yang tersenarai seperti berikut yang anda fikirkan akan dihadapi jika anda ingin mengintegrasikan perkhidmatan Kesihatan Seksual dan Reproduktif ke dalam perkhidmatan HIV yang ditawarkan oleh organisasi anda.** *[Untuk setiap kotak, sila tunjukkan maklum balas anda dengan memilihkan 1 hingga 5]*

(2) Tiada halangan/masalah *(2) Sedikit halangan/masalah*
(3) Halangan/Masalah medium *(4) Halangan/Masalah besar*
(5) Tidak pasti/tidak tahu

	Tingkat Halangan
Kekurangan alatan untuk menginterasikan perkhidmatan HIV dan SRH	
Kekurangan ruangan/kawasan untuk membekalkan perkhidmatan peribadi dan sulit	
Kekurangan masa dikalangan kakitangan/pekerja	
Kekurangan latihan untuk kakitangan/pekerja	
Kekurangan/Tiada penyeliaan/pemantauan untuk kakitangan/pekerja	
Kekurangan motivasi dikalangan kakitangan/pekerja	
Halangan/Masalah lain? (senaraikan): _____	

11. **Apakah kesan (kebaikan/keburukan) terhadap perkhidmatan yang anda fikirkan jika perkhidmatan KSR diintegrasikan ke dalam perkhidmatan HIV. Adakah aspect yang tersenarai di kenyataan berikut akan ditingkatkan, dikurangkan atau tiada perubahan?**
[*Sila berikan jawapan untuk semua kenyataan di bawah*]

Kenyataan	**Berkurang**	**Tiada perubahan**	**Meningkat**	**Tidak pasti/Tidak tahu**
Kos untuk membiayai organisasi anda				
Kos perkhidmatan kepada Pelanggan/dibayar oleh pelanggan				
Efisiensi/Keberkesanan perkhidmatan				
Stigma terhadap pelanggan yang hidup dengan HIV				
Kebebanan kerja untuk pemberi khidmat seperti doktor atau jururawat/pekerja *outreach*				
Masa yang digunakan untuk setiap pelanggan				
Ruangan dan privasi/peribadi				
Keperluan untuk peralatan, pembekalan dan ubat-ubatan				
Lain-lain (senaraikan): _____				

12. Bagaimanakan perkhidmatan integrasi HIV dan Kesihatan Seksual dan Reproduktif dapat ditambah baik di organisasi anda? *[Baca semua pilihan dan pilih mana-mana yang sesuai]*

- ☐ Mempunyai Dasar/Polisi yang menyokong integrasi
- ☐ Komitmen daripada pemegang kepentingan (stakeholder)
- ☐ Sumber manusia dan perancangan
- ☐ Latihan untuk pemberi khidmat dan pekerja *Outreach*
- ☐ Penglibatan pelanggan dalam program dan memberikan pendidikan kepada mereka
- ☐ Perkhidmatan yang berkualiti
- ☐ Garis pandun operasi yang seragam untuk mengintegrasikan perkhidmatan HIV dan KSR
- ☐ Infrastruktur/Kemudahan
- ☐ Pengurusan pembekalan komoditi
- ☐ Sistem Pemantauan dan penyeliaan
- ☐ Lain-lain (senaraikan): _____
- ☐ Tidak pasti/tidak tahu

13. Apakah jenis sumber yang paling desak diperlukan oleh organisasi anda untuk mengintegrasikan perkhidmatan HIV dan Kesihatan Seksual dan Reproduktif ? *[Baca semua pilihan dan pilih mana-mana yang sesuai]*

- ☐ Sumber kewangan
- ☐ Sumber manusia
- ☐ Bantuan teknikal
- ☐ Pembangunan kapasiti termasuk latihan untuk pekerja
- ☐ Infrastruktur/Kemudahan
- ☐ Pembekalan komoditi
- ☐ Kerjasama dengan lembaga/agensi lain (kerajaan dan bukan kerajaan)
- ☐ Lain-lain (senaraikan): _____
- ☐ Tidak pasti/tidak tahu

14. Apakah perkhidmatan yang berkaitan dengan HIV atau Kesihatan Seksual dan Reproduktif (SRH) yang tersenarai seperti berikut yand anda rasa perlu diintegrasikan ke dalm perkhidmatan yang ditawarkan oleh organisasi anda? [Pilih sama ada A atau B dan tandakan semua jawapan yang berkaitan]

A. Perkhidmatan HIV yang mengitegrasikan perkhidmatan SRH berikut:

- ☐ Perancangan Keluarga
- ☐ Pencegahan dan pengurusan penyakit kelamin/seksual *(STIs)*
- ☐ Penjagaan ibu dan bayi yang baru dilahirkan
- ☐ Pencegahan dan pengurusan keganasan berasaskan jantina *(gender-based violence)*
- ☐ Pencegahan pengguguran yang tidak selamat dan penjagaan selepas pengguguran
- ☐ Perkhidmatan Kesihatan Seksual dan Reproduktif yang lain (senaraikan): _____
- ☐ Tiada Perkhidmatan yang berkaitan dengan Kesihatan Seksual dan Reproduktif

B.Perkhidmatan SRH yang mengitegrasikan perkhidmatan HIV berikut:

- ☐ Kaunseling dan Ujian HIV (jika ya)
  - ☐ Perkhidmatan ujian dan kaunseling sukarela *(VCT)*
  - ☐ Kaunseling dan ujian HIV yang dimulakan oleh pemberi khidmat seperti doktor atau jururawat *(PITC)*
- ☐ Penjagaaan berasaskan rumah untuk orang yang hidup dengan HIV *(PLHIV)*
- ☐ Sokongan psiko-social
- ☐ Pencegahan yang dijalankan untuk dan oleh Orang Yang Hidup Dengan HIV *(PLHIV)*
- ☐ Maklumat/Informasi tentang pencegahan HIV untuk penduduk umum
- ☐ Pembekalan Kondom
- ☐ Program Pencegahan Jangkitan HIV dari Ibu ke Anak *(PMTCT)*
  - ☐ Jenis 1: Pencegahan jangkitan HIV dikalangan wanita dalam lingkungan usia reproduktif (tahun 15 – 49) dan pasangannya
  - ☐ Jenis 2: Pencegahan kehamilan yang tidak sengaja dikalangan wanita HIV+
  - ☐ Jenis 3: Pencegahan jangkitan HIV daripada wanita HIV+ kepada anaknya
  - ☐ Jenis 4: Pemberian penjagaan dan sokongan kepada ibu HIV+ dan keluarganya
- ☐ Maklumat/Informasi dan perkhidmatan HIV yang khusus kepada golongan masyarakat yang penting
  - ☐ Pengguna dadah suntikan *(IDUs)*
  - ☐ Lelaki yang melakukan seks dengan lelaki *(MSM)*
  - ☐ Pekerja Seks *(SWs)*
  - ☐ Golongan masyarakat penting yang lain (senaraikan): _____
- ☐ Perkhidmatan lain yang berkaitan dengan HIV (senaraikan): _____
- ☐ Tiada perkhidmatan yang berkaitan dengan HIV