



**HEALTH
EQUITY
MATTERS**

HIV. LGBTIQ+. COMMUNITIES.

REGIONAL LEARNING EXCHANGE AND PORTFOLIO REVIEW

PROGRAM REPORT

**GRAND MILLENIUM HOTEL
KUALA LUMPUR
06-08 OCTOBER 2026**

Programme overview

The SKPA2 Regional Learning and Exchange Portfolio Review took place in Kuala Lumpur, Malaysia, from 6 to 8 October 2026. It brought together government and community representatives from Bhutan, Fiji, Sri Lanka and Malaysia, alongside Health Equity Matters and partner organisations, to examine harm reduction practice and identify actions that participating countries could adapt to their own settings.

The programme combined presentations on national experience, government and community forums, practical service discussions, two site visits and facilitated country planning. Day 1 established the policy and epidemiological context. Day 2 examined how services operate and how clients move between community support and clinical care. Day 3 translated the learning into proposed country actions over the following 12 months.

Across the programme, participants returned to a common concern: services can be available yet remain inaccessible when people fear stigma, disclosure or legal consequences. Malaysia's experience illustrated how sustained government engagement, paid community workers, peer navigation and practical referral arrangements can help address these barriers. Country discussions also showed that service models must respond to local patterns of drug use, institutional capacity and the legal environment.

Main results of the exchange

The exchange clarified several practical features of Malaysia's response. These included collaboration between the Ministry of Health and community organisations, training and accreditation for community HIV screening, distribution of harm reduction supplies, integration of pre-exposure prophylaxis (PrEP) into clinical services, and the use of peer workers to support linkage and retention. Visits to Klinik Kesihatan Kuala Lumpur and PT Foundation demonstrated how these arrangements operate in government and community settings.

Bhutan, Fiji and Sri Lanka each developed a proposed country action plan. Bhutan prioritised evidence on chemsex and its integration into existing outreach and monitoring. Fiji focused on governance, standard operating procedures and the establishment of needle and syringe services. Sri Lanka proposed a broader programme of evidence generation, advocacy, workforce development and service expansion. Technical support, financing and cross-sector cooperation were identified as requirements across all three plans. These were proposed next steps rather than completed interventions or new funding commitments.

Programme sequence

Day	Focus	Main activities
Day 1 6 October 2026	National context and partnerships	Malaysia's harm reduction history; country presentations from Fiji, Bhutan and Sri Lanka; government and community dialogue; government leadership forum
Day 2 7 October 2026	Service delivery and practice	COMRED and Malaysia's chemsex response; needle and syringe programming; visits to Klinik Kesihatan Kuala Lumpur and PT Foundation
Day 3 8 October 2026	Reflection and country planning	Post-it wall exercise; country discussions and presentations; development and review of proposed country action plans

Attendance is consolidated in one section at the end of this report.

Day 1: National experience and partnerships

6 October 2026 / Millennium Room VI, Level 2, Grand Millennium Hotel, Kuala Lumpur

Day 1 examined the development of harm reduction in Malaysia and the different challenges facing Fiji, Bhutan and Sri Lanka. The country presentations provided a basis for two forums on how governments, enforcement agencies and community organisations can work together.

Harm reduction in Malaysia

Dr Palaniappan Narayanan traced Malaysia's experience from early needle and syringe work associated with Program Ikhlas during the 1990s to the development of a national harm reduction response. He described the collaboration between the Ministry of Health Malaysia and the Malaysian AIDS Council (MAC) from 2005, including task-force arrangements, needs assessments, population size estimation, coverage analysis and programme costing. Early implementation in Penang, Kuala Lumpur and Johor Bahru was supported by policy engagement and efforts to improve understanding through the media.



Palani presenting Malaysia's harm reduction experience on Day 1.

The presentation identified persistent barriers, including misunderstanding of harm reduction, the expectation that abstinence should be the only measure of success, and uncertainty over financing. It also described the need to adapt services as drug use and HIV transmission patterns changed. Stimulant-related harm and chemsex required engagement with populations whose needs were not fully addressed by earlier services, including young people, women, sex workers, men who have sex with men (MSM) and transgender people. Chemsex services faced overlapping stigma related to drug use and same-sex behaviour. Responses described included education, HIV and sexually transmitted infection (STI) testing, harm reduction supplies and online outreach.

The discussion distinguished the earlier epidemic among people injecting heroin from the later increase in HIV diagnoses among MSM. Participants explored differences in how generations perceive HIV, including the influence of earlier experiences of AIDS-related deaths and the availability of effective treatment today. Speakers also reflected on the shift from outreach at physical venues, such as parks and saunas, towards greater reliance on digital platforms. These observations highlighted the importance of adapting engagement methods while maintaining personal contact and community trust.

Monitoring was presented as central to defending and improving the response. Early systems tracked people reached, equipment distributed and returned, referrals and HIV-related indicators. Baseline information and six-monthly analyses supported reporting to government and the national task force. Dedicated staff and collaboration with researchers helped turn programme records into evidence for continued support. The session connected Malaysia's experience to the wider task facing participating countries: establishing credible services and documenting their contribution from an early stage.

Chemsex and harm reduction in Fiji

Fiji's presentation described an urgent response to HIV and changing drug use patterns. The country was discussed both as a transit point in the regional drug trade and as an emerging market. Methamphetamine and cocaine injection were highlighted, alongside group injecting and frequent use. The presentation reported that approximately half of those described began drug use by injecting, and cited a national HIV emergency declaration on 9 September 2026. These were figures and developments reported during the country session.



Dr Sailosi presenting chemsex and harm reduction in Fiji.

Chemsex evidence was still limited. Information was emerging from clinical services, peer outreach and community accounts, and a community-led exploratory study with an Australian institution was being developed. Delegates described preparations involving commodities and facility readiness, but noted that a comprehensive harm reduction service platform, including a needle and syringe programme, had yet to be established. Peer networks, international support, government engagement and police sensitisation were helping to create the conditions for implementation.

Discussion focused on stigma and the durability of political support. Awareness sessions and media campaigns had not yet overcome fear and negative attitudes towards people who use drugs and other key populations. Engagement with faith-based communities remained difficult. Delegates also described uncertainty around political continuity and the need to formalise commitments while support was available. Calls from some groups for mandatory testing illustrated the tension between an emergency response and maintaining community confidence. The discussion pointed to the importance of a formal framework, consistent public communication and sustained cooperation with affected communities.

Chemsex and harm reduction in Bhutan

Bhutan's presentation described increasing methamphetamine use and a response that linked national programme leadership with community delivery. The Ministry of Health and the National HIV/AIDS and STI Control Programme (NACP) were described as responsible for policy, clinical guidance, logistics and health-system integration. Community organisations contributed substance use outreach, rehabilitation, engagement with key populations, stigma reduction and advocacy for people living with HIV.



Deki presenting chemsex and harm reduction in Bhutan.

Activities discussed included the expansion of voluntary HIV and STI screening, HIV self-testing and tailored information in prisons and detention settings, alongside peer distribution of condoms and lubricants. Collaboration with the Royal Bhutan Police and narcotics authorities was framed as part of a public health response to drug use. Delegates identified three constraints: incomplete clinical and surveillance information, insufficient skills and tools, and confidentiality concerns that discouraged disclosure and service use.

Participants asked how Bhutan was updating assessments of community drug use. The response highlighted population size estimation already being undertaken to inform planning. A discussion of the proposed move from daily to on-demand PrEP clarified that this programme approach concerned MSM, while sex workers continued to use daily PrEP. The exchange reinforced the need to define the intended population and intervention clearly, and to base future chemsex work on better information about community needs.

Chemsex and harm reduction in Sri Lanka

Sri Lanka's presentation described continued heroin use alongside growing concern about methamphetamine and chemsex. Delegates reported that a new round of integrated biological and behavioural surveillance was underway in 2026, following the previous round in 2018. Figures cited during the presentation included a 113% increase in HIV cases between 2021 and 2026, chemsex reported in approximately 5.3% of new HIV cases, and an increase in hepatitis C

prevalence among people who inject drugs from 6.2% in 2018 to 62.8% in 2026. These figures were presented as part of the national account; the discussion did not establish common denominators for comparison with other countries.



Dr Janitha presenting chemsex and harm reduction in Sri Lanka.

The presentation described evidence of methamphetamine injection among MSM and substantial gaps in knowledge about adolescents, women and people using multiple substances. Delegates also discussed opposition to mainstream harm reduction interventions and concerns about rehabilitation services that did not sufficiently assess clients' psychosocial circumstances. Research, community engagement and service planning needed to reflect changes in substance use rather than rely on older assumptions.

The discussion examined how to advance chemsex services and needle and syringe programming in a culturally sensitive environment. Delegates described the need for Ministry of Health guidance, stronger national coordination, targeted peer outreach, links to primary care and regular HIV testing. PrEP expansion, including possible future introduction of injectable PrEP, was proposed as part of prevention planning. These were areas for development, rather than announcements of implemented services.

Participants also considered engagement with religious leaders, civil society and universities. Objections to needle and syringe programmes were described as a continuing obstacle. Speakers stressed clear explanations of harm reduction and collaboration with non-governmental organisations (NGOs) to address the perception that services encourage drug use. Digital media offered opportunities to reach communities but also created risks of misunderstanding and public backlash. The discussion supported communication adapted to the local context, with consistent messages and continued advocacy across institutions.

Government and community partnership

The government and community forum examined what would be required to move from separate institutional efforts towards practical partnership. Sri Lankan delegates highlighted legal restrictions and HIV-related stigma, noting that free healthcare did not automatically translate into willingness to seek HIV services. Fiji described gaps in governance and difficulty recruiting clients within the existing framework. Bhutan identified mutual distrust, including different assumptions about the government's capacity to meet community needs.

Malaysia's experience emphasised the importance of giving communities a meaningful role in programme design and delivery. Locally based organisations were able to adapt services to different settings, while recognising community workers as paid staff supported continuity. Speakers also discussed corporate engagement and financing. Political will, participation, policy change and perseverance were presented as recurring requirements for a sustained response.

The dialogue addressed the distinction between sexual behaviour and sexual orientation. Yusral explained that MSM is a behavioural category and does not necessarily indicate a gay or bisexual identity. Tashi noted that stigma and legal concerns can affect self-reported information about HIV transmission. Participants supported listening to communities when selecting service language and interpreting data. Malaysia's use of the term "women at risk" was offered as an example of language chosen for service engagement. No revised reporting classification was formally adopted.

Closing reflections identified different practical priorities. Malaysia called for a roadmap with milestones; Sri Lanka for an action plan developed with stakeholders; and Fiji for an end to work in silos. Bhutan proposed a regular forum in which communities and service providers could question assumptions, make decisions and follow through. Together, these reflections gave the later country planning exercise a clear emphasis on responsibilities and working arrangements.



Government and community representatives discussing partnership during Day 1.

Government leadership and coordination

The government leadership forum examined how Malaysia connects HIV policy, primary care, enforcement agencies and community organisations. Dr Natalia binti Che Ishak's presentation introduced the partnership model. The forum covered methadone and needle and syringe services, community screening accreditation, PrEP, referral pathways, programme oversight and financing. Questions focused on how these arrangements might be adapted in other countries.



Dr Natalia presenting the government leadership and partnership for harm reduction in Malaysia.

Access to prevention and testing

Speakers described PrEP as an entry point to HIV testing, STI screening and continuing contact with healthcare services. Implementation had required repeated engagement with healthcare workers, communities and religious leaders, alongside a public health explanation of the intervention. MAC described demand generation and peer navigation, with navigation arrangements subsequently decentralised to state implementing partners. Increased detection of STIs through PrEP services was discussed as a consequence of more frequent screening. The exchange did not establish that PrEP itself caused antimicrobial resistance.

Digital approaches discussed included TestNow HIV self-test ordering, promotion through MySejahtera, the ProtectNow service directory and collaboration with content creators. Participants also emphasised personal rapport and referrals between community members. In response to concerns about anonymity in smaller communities, speakers highlighted trust in NGOs, although a specific model for small-country settings was not developed.

Community HIV screening was described as subject to Ministry of Health training and individual accreditation, renewed every two years. Reactive screening results required confirmation at a health facility. NGOs followed up referrals, state AIDS officers checked linkage, and peer navigators helped clients attend clinics. Commercial self-test purchases were distinguished

from the free kits available through TestNow. Results from commercial purchases were not automatically reported; the discussion did not establish the precise regulatory reporting requirement.

Treatment pathways and client engagement

The National Anti-Drugs Agency (NADA) described institutional and community treatment pathways, HIV screening within its services and referral to the Ministry of Health. Speakers distinguished these arrangements from police enforcement that could result in imprisonment. The coexistence of treatment and criminal justice approaches remained a challenge, and the specific procedure for a chemsex-related arrest was not fully clarified.

A reported institutional rehabilitation success rate of 75% prompted discussion about how success is defined and how long clients are followed. Speakers described a biopsychosocial and spiritual approach, access to psychological support and referrals to psychiatry. Community treatment and One Stop Centre for Addiction services were discussed as complementary approaches. Voluntary engagement, motivation and support with social needs were favoured in the discussion of drug dependence and relapse.

The forum also considered clients who were reluctant to attend HIV treatment. Speakers mentioned occasional use of disease-control powers and police assistance in tracing clients. Participants cautioned that coercion could weaken trust and discourage future testing or engagement. These were reported practices and concerns, rather than a consensus endorsing compulsory HIV treatment. The importance of sustained clinician-client relationships and peer support remained central to the discussion.

Supplies and practical support

NGOs described preparing and distributing harm reduction supplies, recording quantities issued and returned, and providing disposal education and sharps collection under government monitoring. A clarification established that new supplies continued to be provided even when used needles were not returned. The discussion therefore emphasised access to sterile equipment alongside safer disposal, rather than making access conditional on returns.

Practical assistance included NGO transport support and corporate-supported temporary accommodation for people travelling long distances, particularly in Sabah and Sarawak. Speakers described free first-line HIV treatment for Malaysians and treatment within the programme to prevent mother-to-child transmission. MAC explained that routine cash payments simply for attending services were not its approach, because of concerns about long-term sustainability.

Financing and accountability

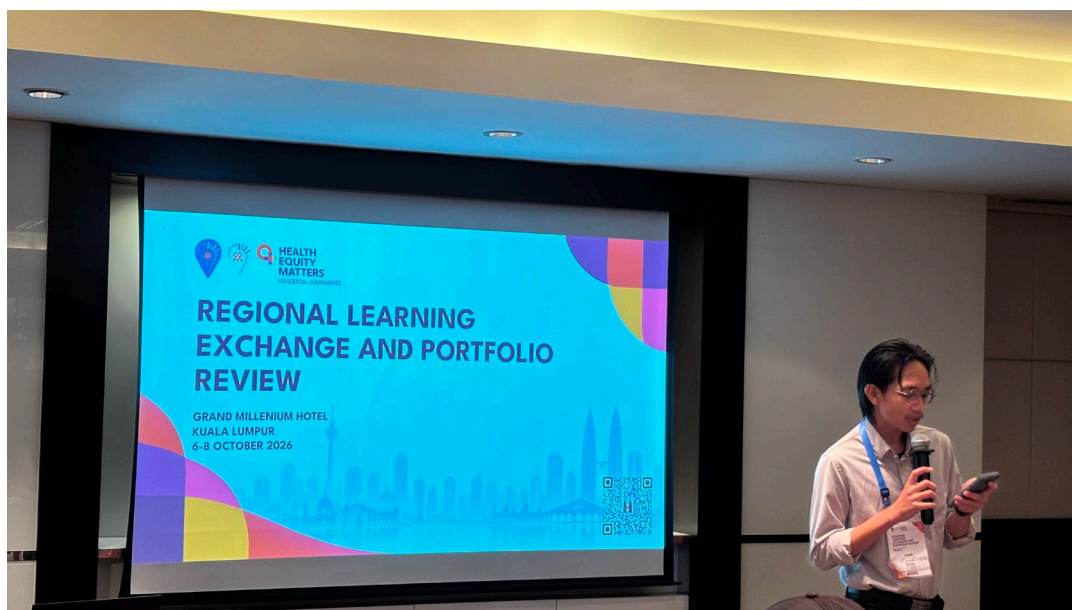
The Ministry of Health described RM8 million in support for NGO activities and an annual technical review against programme indicators. MAC coordinated implementing partners, with performance influencing allocations. Participants discussed the need to sustain community workers and services through domestic financing and corporate support as Global Fund support transitions.

The forum recommended that governments and NGOs jointly prepare costed proposals specifying service sites, staffing, commodities and monitoring requirements, and present these proactively to decision makers. No new financing commitment or detailed formula for paying community workers was agreed. The discussion established a practical planning task: translating service needs and evidence of delivery into proposals that can be assessed and funded.

Day 2: Service delivery and site visits

7 October 2026 / Millennium Room X, Level 3, Grand Millennium Hotel, and service sites in Kuala Lumpur

Day 2 moved from national policy to the practical organisation of services. Presentations examined community responses to chemsex, the expansion of Malaysia's programme and needle and syringe delivery. Visits to a government clinic and a community organisation then allowed delegates to explore referral arrangements, integrated care and support beyond clinical treatment.



Adam is doing the Day 1 reflection.

Community responses to chemsex through COMRED

The session recorded as Chemuse introduced COMRED's community-led approach to chemsex-related harm reduction. It began with reasons people may engage in chemsex, including social connection, confidence, sexual exploration and enhanced or prolonged sexual experiences. These motivations were considered alongside possible sexual health, mental health and physical harms. Substance use was discussed across a spectrum, recognising that people have different patterns of use, needs and readiness for change.

COMRED described confidential, person-centred support spanning HIV and STI screening, treatment linkage, mental health screening, peer facilitation and support groups. Mental health assessment tools included the Patient Health Questionnaire 4 and further anxiety screening where needed. Community workers and volunteers were trained to provide support, guidance and advocacy. The model connected chemsex engagement with opportunities to support PrEP use and HIV treatment continuity.

Outreach combined physical venues and online information, including engagement through Grindr. More than 1,000 people had reportedly been reached online. However, online reach was distinguished from virtual intervention: clients were asked to attend the office to complete

consent procedures and obtain harm reduction packs. Educational materials were developed in Malay and English using non-judgemental language. Psychoeducation and support groups drew on the SMART Recovery framework, with reported attendance growing from one participant to an average of five to seven per session over six months.

Community consultation shaped the contents, functionality and discreet packaging of harm reduction packs. The name was changed from "party pack" to "harm reduction pack". This illustrated how community input affected both the practical product and its public health framing. Discussion of supplies included affordability and access to suitable lubricants, with silicone-based products described as more expensive than water-based alternatives.

Questions about cost clarified that services delivered directly by COMRED were free, while professional services could involve subsidised fees. The first session with the in-house psychologist was free, followed by discounted second and third sessions and a community rate thereafter. The discussion also distinguished clients' broad goals of stopping drug use from reported progress in stopping specific substances, particularly methamphetamine.

Participants explored whether written information was accessible and well understood. The programme had prioritised written materials and psychoeducation, but information on reading habits and comprehension was limited. This identified a need to assess how clients use educational content and how peer facilitators can be supported with the workload involved. Questions about blocked social media accounts also highlighted the fragility of relying on commercial platforms for continuing contact. Speakers described moving communication to direct contact channels once clients had engaged.

Legal and worker-safety arrangements were still being developed. COMRED described a preference for office-based appointments, proposed procedures for outreach away from the office and review by a technical advisory board that included legal expertise. Plans for pre-intervention and post-intervention data collection were intended to assess client benefit. The session demonstrated the value of community-led design while identifying areas where protocols and evaluation required further development.

Expanding the chemsex response in Malaysia

Palani and Yusral explained that Malaysia's programme had developed through central training of trainers and a wider network of peer navigators. Approximately 20 community health workers formed a chemsex core team, connected to networks of people who engage in chemsex. Training covered mental health first aid, counselling and the legal context, alongside HIV prevention and service navigation.

The discussion attributed progress partly to relationships established through earlier needle and syringe work. Those connections helped position chemsex services within an existing harm reduction response and supported engagement with authorities. Harm reduction packs were developed with the Ministry of Health; speakers described the inclusion of pipes within an approach intended to reduce injecting-related harm. This was presented as a feature of the Malaysian programme, rather than a package to adopt without local assessment.

Speakers reported improved community recognition of substances, knowledge of PrEP and willingness to approach services. They also stressed that overlapping criminalisation and stigma continued to make outreach difficult. The main lesson for participating countries was the need to combine workforce development with stakeholder relationships and continuing contact with the communities services aim to reach.

Injecting drug use and needle and syringe programming

Insaf Murni's presentation explained its work in HIV prevention, research and support for people experiencing drug dependence. It distinguished demand reduction, supply reduction and harm reduction by their respective focus on use, availability and harmful consequences. Malaysia's core harm reduction interventions were described as methadone maintenance treatment and the Needle and Syringe Exchange Programme (NSEP).

The service model extended beyond distributing equipment. It included prevention information, counselling, HIV screening, referral and follow-up, supported by mapping and dialogue with the Ministry of Health and NADA. Peer involvement, accurate information and trust were presented as requirements for effective prevention. Workers used brief conversations, repeated engagement and local languages to support changes such as moving away from sharing injecting equipment.

The supplies demonstrated included needles in two sizes, 1 ml syringes, alcohol swabs, cotton and a cooker. Condoms were distributed according to demand, and sharps containers of different sizes supported collection. The package was provided through MAC's programme arrangements. Water for injection was not part of the official package described, although workers reported responding to unmet client needs on an informal basis. The discussion identified a gap in the supplied package, rather than establishing an endorsed alternative procedure.

Delegates asked about transporting sharps containers discreetly. Workers described placing them in a black bag, while acknowledging that clients could still recognise the equipment. The exchange illustrated that confidentiality depends on day-to-day logistics as well as formal policies. Offline outreach was complemented by online engagement through platforms such as WeChat, Grindr and Twitter.

Insaf Murni also described clinic-linked and district activities, including Projek Kasih at Klinik Kesihatan Pandamaran, psychosocial work in Sepang and collaboration with health and academic partners. For Projek Kasih, staff were to rotate over six months to support a clinic serving approximately 150 patients. These examples showed how community organisations contribute staff time and follow-up within wider local services.

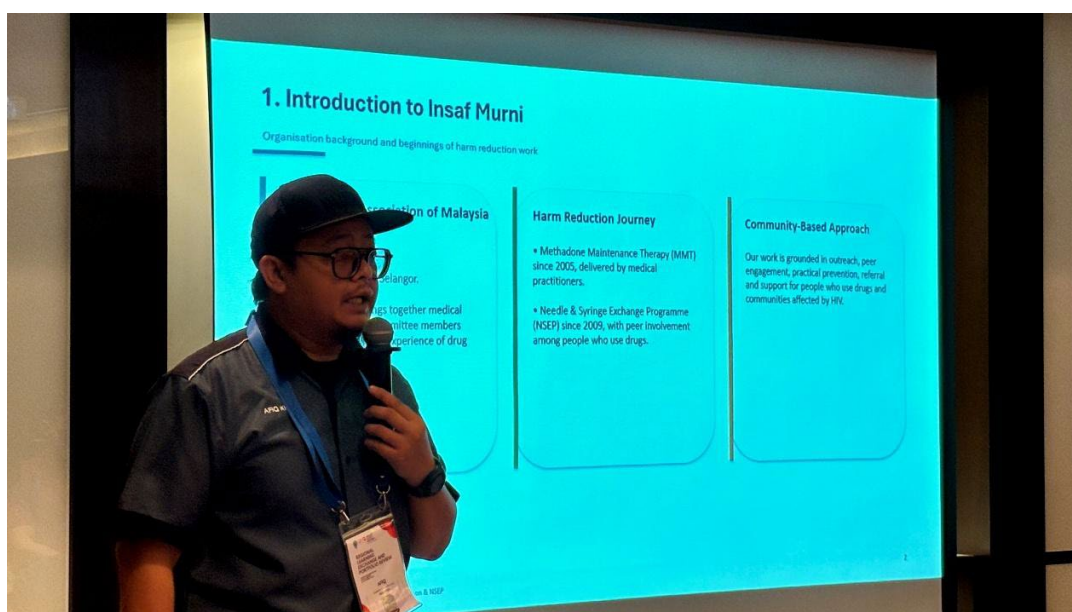
Programme governance and allocation of funds

The discussion clarified that Insaf Murni operated outside government and received Ministry of Health funding through MAC. Similar organisations provided services across different states. MAC described national HIV planning as a stakeholder process involving relevant ministries,

agencies and communities, with strategies translated into indicators, budgets and programme targets.

Funding decisions considered population needs, geographical mapping, population size estimates and the number of people that a community health worker could realistically reach. Speakers estimated that current outreach covered approximately 20% to 30% of key populations, indicating a continuing gap between service resources and need. Better estimates and mapping were therefore important both for allocating existing funds and for demonstrating the need for increased coverage.

Annual technical review involved clinical, public health, Ministry of Health and community perspectives. Performance informed recommendations to continue, adjust or discontinue activities, while detailed expenditure and output records supported accountability. The Malaysian AIDS Foundation (MAF) was described as mobilising resources, including corporate contributions, to support HIV-related work implemented through MAC and partners. The discussion reinforced the distinction between raising resources, coordinating programmes and delivering services locally.



Insaf Murni presenting its needle and syringe programme and community outreach work.

Site visit to Klinik Kesihatan Kuala Lumpur

Delegates visited Klinik Kesihatan Kuala Lumpur (KKKL), where Dr Safuan delivered the welcome and Dr Satya introduced the Communicable Disease Unit. The briefing described an integrated service model encompassing health promotion, screening, diagnosis, treatment, rehabilitation and supportive care. Staff emphasised welcoming clients at the first visit and building trust within a dedicated HIV and STI service environment.



Dr Sathya explaining the available services at KK Kuala Lumpur.

Community organisations contributed at several points in the care pathway. Before clinic attendance, they provided screening, referral, appointment reminders and peer navigation. During continuing care, they supported treatment literacy, counselling, adherence and mental health needs. Follow-up included retention support, contact with clients who missed appointments, social welfare referrals and support groups. These functions showed how community workers complement clinical services by addressing practical and social barriers.

The visit introduced Fast-PrEP, rapid initiation of antiretroviral treatment, HIV and tuberculosis services, methadone treatment and One Stop Centre for Addiction support. Delegates were shown the steps involved in a PrEP appointment and the work of peer navigators and HIV counsellors. Questions about adherence during periods of chemsex prompted discussion of continuing reminders and support to take medication as prescribed. Eligibility was described in broad terms during the exchange; individual clinical assessment remained part of accessing services.

The tour included the X-ray unit, methadone services, infection treatment facilities, Hope Cabin, counselling space and the fever screening and triage area. Hope Cabin operated during office hours and provided a setting for harm reduction discussion, information about methadone and connection with support groups. Staff explained that tests at fever triage were selected according to symptoms and the suspected condition.

Participants explored how workers respond to agitated clients. The discussion emphasised empathy, active listening, communication and the contribution of workers with community experience. Long-term methadone care was discussed in relation to individual needs and circumstances. Stigma reduction was addressed through staff sensitisation and workshops using Ministry of Health modules, with participation across staff levels and opportunities for NGO involvement.

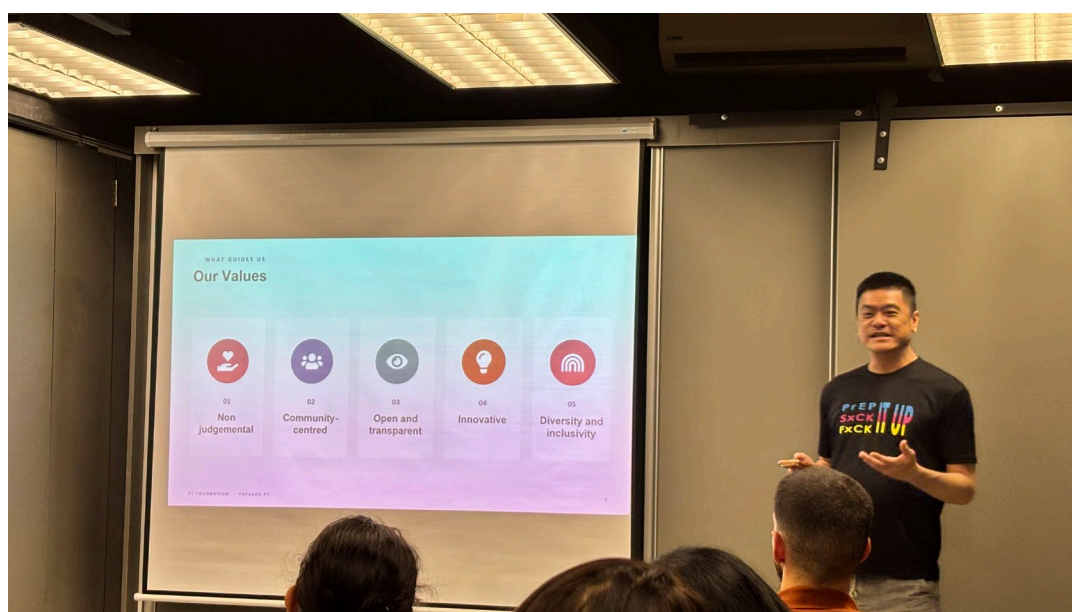
The visit demonstrated how government facilities and community partners can share responsibility for engagement, clinical care and continuing support. It also made visible the operational details that influence client experience, including navigation, privacy, appointment processes and the availability of supportive spaces.



Delegates being introduced to services at Klinik Kesihatan Kuala Lumpur.

Site visit to COMRED and PT Foundation

The second visit took place at PT Foundation's Community Health Care Clinic. The briefing introduced the organisation's wider HIV and STI work, including testing, prevention, treatment access, adherence and care. Outreach through WhatsApp, Facebook, Instagram, TikTok, Twitter, Telegram and Threads supported contact with communities who might not approach mainstream services directly.



Delegates being introduced with the PTF values.

Delegates were introduced to the DHSKP programme, JomTest and the One Stop Centre. Staff described challenges involving dependence on donor funding, workforce capacity, stigma and data systems. Support for people living with HIV combined empowerment, treatment literacy, psychosocial care and peer engagement. The Positive Living programme was presented as a private setting in which clients could obtain information, support and links to services.

The KAMI programme focused on HIV education and prevention among students in higher education. It used a tailored sexual and reproductive health intervention while addressing barriers involving limited knowledge, confidentiality concerns, stigma, cultural and religious sensitivities, and the legal and policy environment. This showed how community organisations adapt their work for younger people and institutional settings.

The P-HERO support group was described as a six-month programme with meetings every two weeks. Topics included HIV stigma, mental health screening and wider issues affecting daily life. INAP PT, a transitional residential programme, provided structured support and reintegration assistance to help maintain HIV treatment and care. In response to questions about length of stay, staff explained that many clients completed six months, with the duration and possible extensions guided by individual needs, including additional psychiatric support.

The presentation also discussed public health work through the Shariah principles of alleviating hardship and preserving life. This offered an example of framing services in terms that could support understanding within the local context. Delegates compared services and barriers in their own countries, drawing connections between clinical access, housing, emotional support and continuity of care.

The visit extended the day's learning beyond individual interventions. It illustrated how a community organisation can connect prevention and treatment with peer support, youth engagement and practical assistance, while managing the constraints of financing and staff capacity.



Regional delegates discussing community HIV services at PT Foundation.

Day 3: Reflection and country action planning

8 October 2026 / Millennium Room X, Level 3, Grand Millennium Hotel, Kuala Lumpur

Day 3 focused on what participants could take forward at home. A post-it wall exercise gathered initial reflections, after which country teams considered feasibility, institutional responsibilities, barriers and support needs. Teams then developed and presented proposed action plans for the following 12 months.

Consolidating learning through the post it wall

Sri Lankan delegates highlighted the professionalism of community organisations, their relationship with government and the need to strengthen staff skills. They identified PrEP expansion, information and education materials, and mental health first aid as areas to develop. Bhutan emphasised intentional cooperation across the health system, with clear roles for each organisation and individual. Fiji identified harm reduction assessment, sterile equipment, mental health screening and brief counselling as practical priorities, alongside stronger links to care.

Facilitated discussion asked teams to consider what would need to change for these ideas to work locally. Participants examined lessons from Malaysia's earlier development, including the need to support existing NGOs and obtain government backing before national expansion. The exercise encouraged teams to define specific changes, rather than reproduce Malaysia's model without considering local circumstances.



Participants reviewing the country post-it walls during the reflection exercise.

Sri Lanka proposed greater government attention to chemsex and harm reduction, with cooperation between health services, community organisations and police. Bhutan identified a rapid assessment, stronger monitoring, healthcare worker sensitisation and, subject to funding, a combination of online and in-person outreach supported by standard operating

procedures. Fiji highlighted the need for a formally documented Ministry of Health direction and a national framework.

The discussion of operational standards clarified that organisational development included staff understanding of harm reduction concepts and the ability to communicate with communities and government counterparts. Sri Lankan delegates identified potential engagement with social services, probation, education and narcotics police. Sensitisation was considered necessary for these relationships to support service access.

Bhutan's discussion examined how organisations could move beyond familiar networks and challenge assumptions about one another. Participants considered joint discussion a way to combine community knowledge with institutional expertise and identify actual service needs. The exchange favoured shared public health objectives and regular dialogue to reduce competition and distrust where resources were limited.

Country action planning

Each country translated its reflections into a proposed plan using the template provided. The presentations identified priorities, leads, partners, barriers and requested support. Milestones were more detailed for some activities than others. The plans below reflect the actions and timing presented during the workshop; implementation remained dependent on national processes and available resources.

Bhutan

Bhutan proposed building evidence on chemsex and incorporating the findings into existing HIV outreach. The NACP within the Ministry of Health was identified as the lead. The three priorities were a rapid assessment, revised outreach procedures and a stronger monitoring, evaluation, accountability and learning system.

The rapid assessment would establish a baseline on chemsex and sexualised drug use. Revised procedures would cover these issues alongside PrEP and support a combined online and in-person outreach model. Monitoring would capture relevant needs, referral outcomes and community feedback, with improved data validation. Integrating the work into routine services was intended to avoid creating a separate programme without a clear delivery structure.

Milestone	Proposed result
By month 3	Assessment tools prepared and ethical clearance obtained
By month 6	Rapid assessment completed
By month 9	Outreach workers trained on revised procedures
By month 12	Baseline evidence available; chemsex monitoring integrated into routine outreach; data validation strengthened

Key partners identified included Save the Children, QVoB, Pride Bhutan, Lhak-Sam, other community organisations, the Royal Bhutan Police and BFDA. Limited technical expertise and funding were identified as the principal constraints. The team requested technical oversight and resources for the planned activities.

Feedback encouraged Bhutan to use community consultation and focus groups as a proportionate first step where the extent of chemsex was not yet established. This would help clarify patterns of drug use and service needs before committing to a more extensive assessment or intervention.

Fiji



Dr Sailosi Soqo and Asaeli in discussion with Joe.

Fiji proposed establishing the governance and operational foundations for a national harm reduction response, led by the Ministry of Health. The plan centred on reactivating the Harm Reduction Sub-Committee under the National Counter-Narcotics Committee, revising its terms of reference and conducting at least ten coordination meetings. An endorsed action plan would provide a basis for joint implementation.

The team also proposed a complete set of harm reduction standard operating procedures and a phased launch of a needle and syringe programme. Initial delivery would use Ministry of Health sexual and reproductive health clinics and civil society organisations, followed by wider

coverage. Training for health workers and community staff was included in the proposed national rollout.

Milestone	Proposed result
By month 3	Needle and syringe services introduced at one of three Ministry of Health sexual and reproductive health clinics and through civil society organisations in the Central Division
By month 6	Services extended to all three clinics and civil society partners nationwide
By month 12	Sub-committee operating with an endorsed action plan; procedures finalised and reviewed; national programme operating with trained health and community staff

Partners identified included relevant ministries, civil society, faith-based organisations, police, town councils and the Pharmacy Society. The plan linked specific barriers to practical responses: clearer terms of reference and regular meetings for weak coordination; joint consultations for slow endorsement; public communication for community resistance; and sensitisation for law enforcement concerns.

Support requested included technical assistance for procedures, agreements and memoranda of understanding; workforce development; advocacy champions; and financing for needle and syringe commodities. The presentation made clear that establishing governance and securing the conditions for delivery were essential parts of service rollout.

Sri Lanka



Sri Lankan delegates.

Sri Lanka proposed a programme combining evidence generation, cross-sector advocacy and expansion of harm reduction services. SKPA and the National STD/AIDS Control Programme (NSACP) were identified as leads, with the College of Psychiatrists leading the service

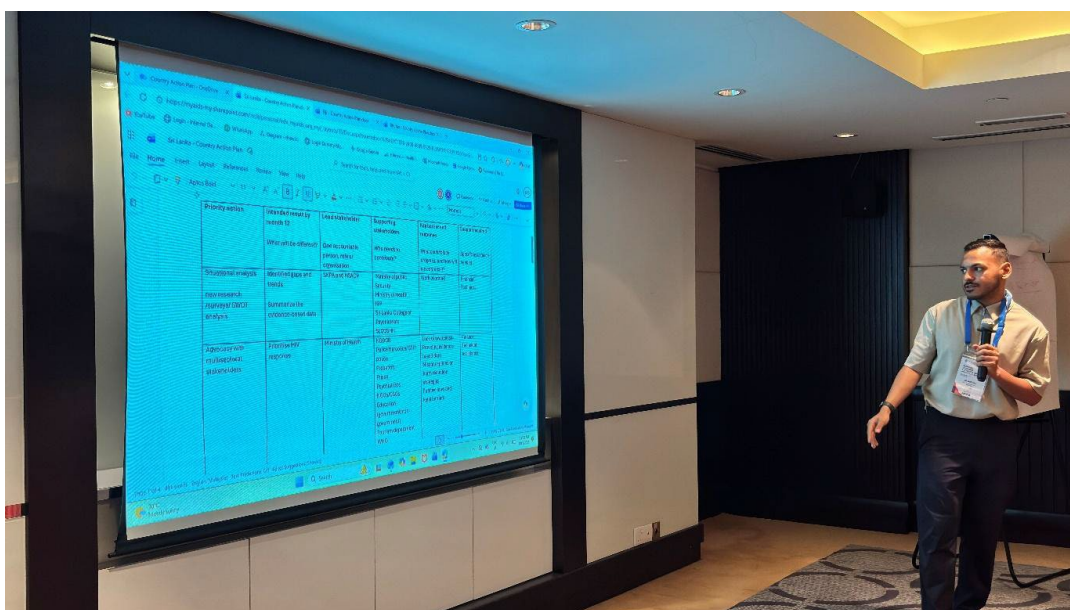
component. The plan sought to connect policy development with community capacity and practical delivery.

A situational analysis would combine research, surveys and a review of strengths, weaknesses, opportunities and threats, with findings presented to a technical working group by month 12. Advocacy would involve health, justice, law enforcement, education, tourism, NGOs and WHO partners. The team proposed establishing a chemsex and harm reduction technical working group and bringing NSACP into the National Task Force.

Workforce development included training of trainers in mental health first aid, information and education materials, and cascade training for community organisations and health staff. Legal and policy preparation would include an audit, standard operating procedures and memoranda of understanding between the Ministries of Health, Justice and Public Security. These activities were intended to create a more supportive environment for implementation.

The proposed 12-month results included establishing chemsex and harm reduction services, expanding needle and syringe programmes and PrEP access, and introducing opioid agonist therapy. Punitive laws, misconceptions, stigma towards community organisations, weak government-community relationships and limited funding were identified as barriers. Technical and financial support were requested across the plan.

Discussion questioned how the proposed opioid treatment component related to reported growth in stimulant use and the constraints on available resources. The response referred to treatment choice and relapse concerns. Further feedback encouraged the team to determine which services should take priority, particularly needle and syringe programming and PrEP. The exchange did not resolve a final sequencing or financing decision for the full package.



Sri Lankan delegates presenting their proposed country action plan.

Shared priorities and follow up

The country plans differed in emphasis but shared a need to connect national leadership with community delivery. Bhutan's proposed starting point was evidence and integration into existing outreach. Fiji prioritised a governance framework and operational procedures for new services. Sri Lanka combined advocacy and policy preparation with a broader service expansion proposal. Each plan required further national coordination and technical or financial support.

The programme produced three concrete forms of learning. Country comparisons clarified how drug use patterns, stigma and institutional arrangements affect service design. The Malaysian presentations and site visits illustrated practical mechanisms for screening, navigation, referral and community support. The final planning exercise converted these observations into country-specific proposals and milestones.

Several implications recurred across the discussions. Community workers need training, supervision and sustainable remuneration if services are to continue. Digital outreach can extend reach, but continuing contact depends on trust and reliable referral arrangements. Service information needs to reflect local language, community understanding and confidentiality concerns. Monitoring must show who is reached and whether people obtain care, rather than record activities alone.

The proposed country plans provide a basis for follow-up between national programmes, community organisations and technical partners. Review can focus on the assessment and governance milestones already identified, the feasibility of proposed service expansion and the support needed to address barriers. The workshop did not record new financing commitments or confirm delivery of the proposed 12-month results. Its immediate contribution was a clearer set of priorities and working relationships through which those results could be pursued.

Consolidated attendance

Participation across the three days included government, community, clinical and technical partners. The roster below combines the session and site-visit attendance lists; participation varied by activity. Names are presented as recorded, using fuller forms where these appear elsewhere in the attendance records.

Organisation or delegation	Participants
Ministry of Health Malaysia	Noordalilah binti Mohd Noor; Natalia binti Che Ishak
National Anti-Drugs Agency	Abduh Munauwar; Erwandi bin Masran
Royal Malaysia Police	S. Robert A/L Santhanam
Malaysian AIDS Council and Malaysian AIDS Foundation	Riffu; Edx; Adam; Ishak; Wei Hong; Yuwana Podin; Yusralhakim; Pat; Palani
Health Equity Matters	Matthew Kusen; Olivia McDonald; Joe Elias; Philips Loh; Dash
Technical contributor	Dr Palaniappan Narayanan, also recorded as Palani
SEED	Jane Kasim
PT Foundation	Justin; Wan Mohd Ridwan bin W Mohd Yusoff
Insaf Murni	Mohd Afiq bin Mohamad Khairi
KLASS	Ahmad Tarmizi
CCM and Persatuan Cahaya Harapan Negeri Kedah/Perlis	Mohamad Fitri bin Abdul Halim
Sri Lanka	Tennekoon; Vino Sujeewa Dharmakulasinghe; Mihitha Basnayake; Herath; Indunil Dissanayaka; Jayanthi Kuru-Utumpala
Bhutan	Namgay Choden; Deki Phuntsho; Tashi Tsheten
Fiji	Sailosi Soqo; Asaeli Sinusetaki
International Planned Parenthood Federation	Natassha Kaur; Gessen Rocas
Klinik Kesihatan Kuala Lumpur	Dr Safuan; Dr Satya

COMPENDIUM

BHUTAN - COUNTRY ACTION PLAN

Priority action	Intended result by month 12 <i>What will be different?</i>	Lead stakeholder <i>One accountable person, role or organisation</i>	Supporting stakeholders <i>Who needs to contribute?</i>	Key barrier and response <i>What could block progress, and how will we address it?</i>	Support required <i>Specific assistance needed</i>
Conduct a rapid assessment to understand current chemsex situation in Bhutan	- Baseline information on chemsex in Bhutan established. - Action plan including chemsex monitoring framework and other action documents based on the assessment report developed.	Mr. Deki Phuntsho, NACP, MoH	Save the Children, Queer Voices of Bhutan (QVoB), Pride Bhutan, Red Purse Network, Lhak-Sam, Chithuen Phendhey Association, The PEMA Secretariat, Royal Bhutan Police, Bhutan Food & Drug Authority (BFDA),	- Technical competence in the area for oversight on chemsex rapid assessment - Financial Support	- Technical Oversight Support - Funded activities
Review the SOP for Outreach workers to include chem sex and	Outreach strategy and SOPs in place.	Mr. Deki Phuntsho, NACP, MoH	Save the Children, Outreach workers.	Technical competence for oversight	Technical Oversight Support

sexualised drug-use component	2. Outreach workers trained on hybrid outreach model. 3. Outline outreach is initiated.			2. Financial Support	2. Funded activities
Strengthen MEAL system to capture sexualised drug-use needs, outreach quality, referral outcomes and community feedback.	1. Data collection on chemsex initiated as a part of overall outreach data collection 2. Monitoring data validation strengthened	Mr. Deki Phuntsho, NACP, MoH	Save the Children, NACP, HISCs and Outreach workers	1. Technical competence and financial support 2. Funded activities	1. Technical Oversight Support 2. Funded activities
Regular community consultations	3.			4.	5.

PROGRESS TRACKER

Priority action	Month 3	Month 6	Month 9	Month 12
	<i>First concrete deliverable</i>	<i>Implementation progress</i>	<i>Review and adjustment</i>	<i>Result and next decision</i>
Conduct a rapid assessment to understand current chemsex situation in Bhutan	Rapid assessment methodology, stakeholder consultations, ethical clearances, and data collection tools finalized.	Rapid assessment completed. Action plan based on report developed.	1. Action plan operationalized. 2. Chemsex monitoring mechanism integrated into existing outreach program.	Chemsex monitoring integrated through regular outreach work initiated.
Reviewing the SOP for Outreach workers to include chem sex and sexualised drug-use component	Existing outreach SOP reviewed; gaps regarding sexualized drug use identified.	Revised draft SOP for hybrid/online outreach developed (ChemSex & PrEP included).	SOP reviewed; ORWs trained.	Operationalised Online and outreach activities.
Strengthen MEAL system to capture sexualised drug-use needs, outreach quality, referral outcomes and community feedback.	Reviewed existing tools and set indicators	Train and pilot the revised tools	1) Develop data collection tool for chemsex to be used by outreach workers. 2) Outreach workers trained on data collection methods and tools.	Monitoring data validation strengthened.

FIJI COUNTRY ACTION PLAN

Priority action	Intended result by month 12 <i>What will be different?</i>	Lead stakeholder <i>One accountable person, role or organisation</i>	Supporting stakeholders <i>Who needs to contribute?</i>	Key barrier and response <i>What could block progress, and how will we address it?</i>	Support required <i>Specific assistance needed</i>
Reactivate and strengthen the Harm Reductions Sub-Committee under the National Counter-Narcotics Committee to coordinate a multi-sectoral evidence-based harm reduction response.	HR Subcommittee operational with at least ten formal coordination meetings conducted =, agreed priorities established and an endorsed action plan developed.	Ministry of Health	Min of Justice, Min of Women, Min of Policing, Min of Youth, Min of Environment, CSOs, Pharmacy Society	1. Limited contingency coordination and agreement on harm reduction priorities. Response: Establish clear TOR, defined responsibilities and regular coordination mechanisms 2. Delays in Developing and endorsing operational frameworks. Response: Facilitate joint	Technical Assistance to strengthen coordination and develop governance and operational framework, facilitate stakeholder consultations and support implementation.

				consultations to develop and approve SOPs, MOAs and MOUs.	
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THE COUNTER NARCOTICS FRAMEWORK

FIJI LAWS

- Illicit Drugs Control Act
- Pesticides Act 1871
- Revised Customs Act 1986
- Food Safety Act 1986
- Medicinal Products Act 1986
- Pharmacy Profession Act 2011
- Substance Advisory Council Act 1998
- Biosecurity Act 2008
- Fiji Corrections Act 2006
- Biosecurity Act 2008
- Fiji Corrections Service Act 2006
- Crimes Act 2009
- Mental Health Act 2010
- Customs Prohibited and Restricted Act 1986
- I Taukei Affairs Act 1944
- Criminal Procedure Act
- Sanitary Act
- Media Industry Development Act 2010
- Sentencing and Penalties Act 2009
- Maritime and Safety Act

NATIONAL SECURITY &
DEFENCE COUNCIL

NSDC

Cabinet

Permanent Secretaries

Coordination &
Steering
Committee

PS MOHAI Chair

- Policies
- Strategic Direction
- Resources
- Oversee Establishment

Senior Officials

Counter Narcotics
Committee

Counter Narcotics Committee

- Formulate Policies
- Analysis of Data
- Advice to Task Force on trends
- Secretariat to Task Force

(Sub-committees of the CNC)

HARM REDUCTION
(Treatment and High-risk Behaviors)

- Led By: Ministry of Health and Medical Services – St Giles medical superintendent and **Head of Wellness Unit**
- Ministry of Women, Children and social protection - child rehabilitation unit
 - Fiji Corrections Services
 - Counselling and treatment NGO's
 - Faith-Based Organizations
 - Academia (tertiary institutions)

DEMAND REDUCTION
(Prevention and Awareness)

- Led by: NSAAC (MoE), Ministry Women, Children and Social Protection
- Ministry of Youth and Sport
 - Ministry of i-Taukei Affairs
 - Youth focused Advocacy and community-based NGO's and CSO's
 - Private Sector youth organisations
 - Faith Based Organizations
 - Media
 - Academia (Universities and training colleges)

SUPPLY REDUCTION
(Law Enforcement and National Security)

- Led by: Ministry of Home Affairs and Immigration (Counter Narcotics Bureau)
- Ministry of Agriculture (Crop Sub)
 - Fiji Police Force
 - Fiji Corrections Services
 - Fiji Immigration Department
 - Biosecurity Authority of Fiji
 - Fiji Revenue & Customs Services
 - Financial Intelligence Unit
 - Republic of Fiji Military Forces – Naval Squadron
 - Maritime & Safety Authority of Fiji (AIS use regulated)
 - Fiji Airports Ltd
 - Joint Agencies – Interpol

LEGAL REFORM
(Prosecution and Drug Court)

- Led by: Director of Public Prosecutions
- Fiji Police Prosecution
 - Ministry of i-Taukei Affairs
 - Mental Health Specialists (Substance use treatment and recovery)
 - Social Work and social welfare services
 - Government Analyst



Harm Reduction SOP's	SOP's developed	Harm Reduction Sub-Committee (MOH Lead)	CSO, FBO, Ethnic Affairs, MOWCSP, MOE, Corrections	1. Poorly written SOP Response: Technical Review 2. Deviation from the SOP Response: Strengthen SOP Review process	1. Technical Support – Consultant needed
Implement Needle Syringe Program	Needle Syringe Program up and running	CSO + MOH	Police, Town Councils, Environmental Unit, MOWCSP, Pharmacy Society, Private Healthcare Providers	1. Pushback from Public and FBO Response: Awareness 2. Disposal – Detractors. Response: Awareness 3. Law enforcement Response: Sensitization	1. Technical support. 2. MOU/A's with stakeholders. 3. Capacity Building. 4. Public awareness 5. Advocacy – Champion 6. Financial support for commodities.

PROGRESS TRACKER (MONITORING, EVALUATION, & LEARNING)

Priority action	Month 3	Month 6	Month 9	Month 12
	<i>First concrete deliverable</i>	<i>Implementation progress</i>	Review and adjustment	Result and next decision
HR SC	1. Meeting minutes + attendance. 2. Membership confirmed 3. TOR revised and finalized 4. HR Framework/Policy Developed	1. Monthly meeting minutes 2. Action Plans 6 months Evaluation	None	1. Action Plans 12 months Evaluation 2. Annual Report
HR SOP	1. List of SOP's Finalized 2. 100% SOPs Drafted 3. 100% SOPs Finalized	1. 100% Finalized SOP's Reviewed	None	1. 100% Finalized SOP's Reviewed
NSP	1. Running at MOH SRH Clinics 1/3 2. Running at CSOs x Central Division 3. HR Capacity Building HCW + CSO 4. Surveillance Reports generated	1. Running at MOH SRH Clinics 3/3 2. Running at CSOs x nationally 3. 6 months NSP review	None	1. HR Refresher Capacity Building HCW + CSO

SRI LANKA - COUNTRY ACTION PLAN

Priority action	Intended result by month 12 <i>What will be different?</i>	Lead stakeholder <i>One accountable person, role or organisation</i>	Supporting stakeholders <i>Who needs to contribute?</i>	Key barrier and response <i>What could block progress, and how will we address it?</i>	Support required <i>Specific assistance needed</i>
Situational analysis new research /surveys/ SWOT analysis	Identified gaps and trends Summarize the evidence-based data	SKPA and NSACP	Ministry of public Security Ministry of Health IGP Sri Lanka College of Psychiatrists SLCOSH	Work overload	Financial Technical
Advocacy with multisectoral stakeholders	Prioritise HIV response	Ministry of Health	NDDCB Police Narcotics/ STF/ police Probation Prison Psychiatrists NGOs/CSOs Education (government/non-government) Tourism department WHO	Lack of awareness- Providing evidence-based data Misconceptions on harm reduction strategies Punitive laws and legal barriers-	Finance Technical assistance

Capacity building of Community Organizations and Health Sector TOT for mental health first-aid Development of IEC materials	Strengthened Capacity of Community Organizations and Health Sector	SKPA and NSACP	NGO Secretariat	Weak collaboration between government and CBOs Financial sustainability of CBOs Stigma attached to CBOs High requirements/standards of NGO Secretariat	Technical and financial assistance
Scale-up NSEP Scale-up PrEP services Implementation of Opioid agonist therapy	Established chemsex and Harm reduction services	NSACP and College of Psychiatrists	Ministry of Health Ministry of public security College of Psychiatrists SLCOSH HH	Punitive laws Financial and technical constrains	Technical and financial

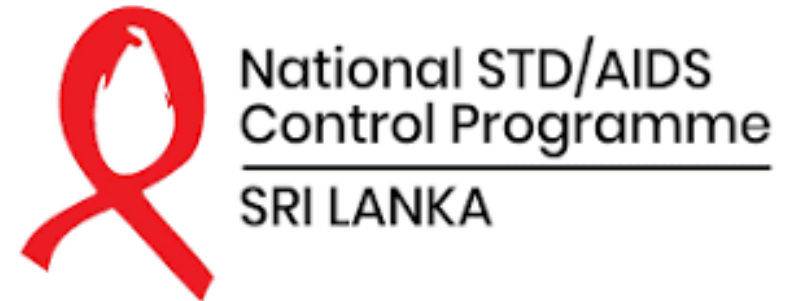
PROGRESS TRACKER

Priority action	Month 3	Month 6	Month 9	Month 12
	<i>First concrete deliverable</i>	<i>Implementation progress</i>	Review and adjustment	Result and next decision
Situational analysis new research /surveys/ SWOT/assessment (Qualitative and quantativw)analysis	Concept note and research questions	Conduct data collection and desk review	Prioritize strategies	Present data to the Chemsex and harm reduction technical working group
Advocacy with multisectoral stakeholders	Identified gaps and trends Summarize the evidence- based data	Established technical working group on chemsex harm reduction NSACP part of the National Task Force Strengthened Capacity of Community Organizations and Health Sector	Monitoring and evaluation	Advocacy with multisectoral stakeholders
Strengthened Capacity of Community Organizations and Health Sector	TOT – Community Leaders Capacity development of CBOs Capacity development of healthcare staff	Continue cascade training, M&E	Monitoring and evaluation	Strengthened Capacity of Community Organizations and Health Sector

Establish/Ensure harm reduction services for chemsex	SWOT analysis Legal Audit	SOPs/Guidelines/Policies MoUs between Ministries of Health, Justice and Public Security M &E	Monitoring and evaluation	Established chemsex and Harm reduction services for chemsex and harm reduction - Scaled up NSP program - scale up of PrEP access/availability
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Chemsex and harm reduction in Sri Lanka: Current Context and Emerging Public Health Concerns

Dr.Vino Dharmakulasinghe,
Consultant Venereologist and
IEC, Advocacy and condom promotion
coordinator, NSACP.



Objectives

- Sri Lankan situation in relation to chemsex and harm reduction
- The main harm reduction issues, priorities, or challenges currently being addressed
- Existing services, policies, or initiatives that are relevant to the response
- Key gaps, barriers, and opportunities for further development
- What Sri Lanka is hoping to learn from Malaysia and from the experiences of other participating countries

Where Sri Lanka is starting from in relation to chemsex and harm reduction



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Analyze the epidemic of substance use pattern in Sri Lanka

Exhibit I - Drug Related Arrests 2020 - 2024

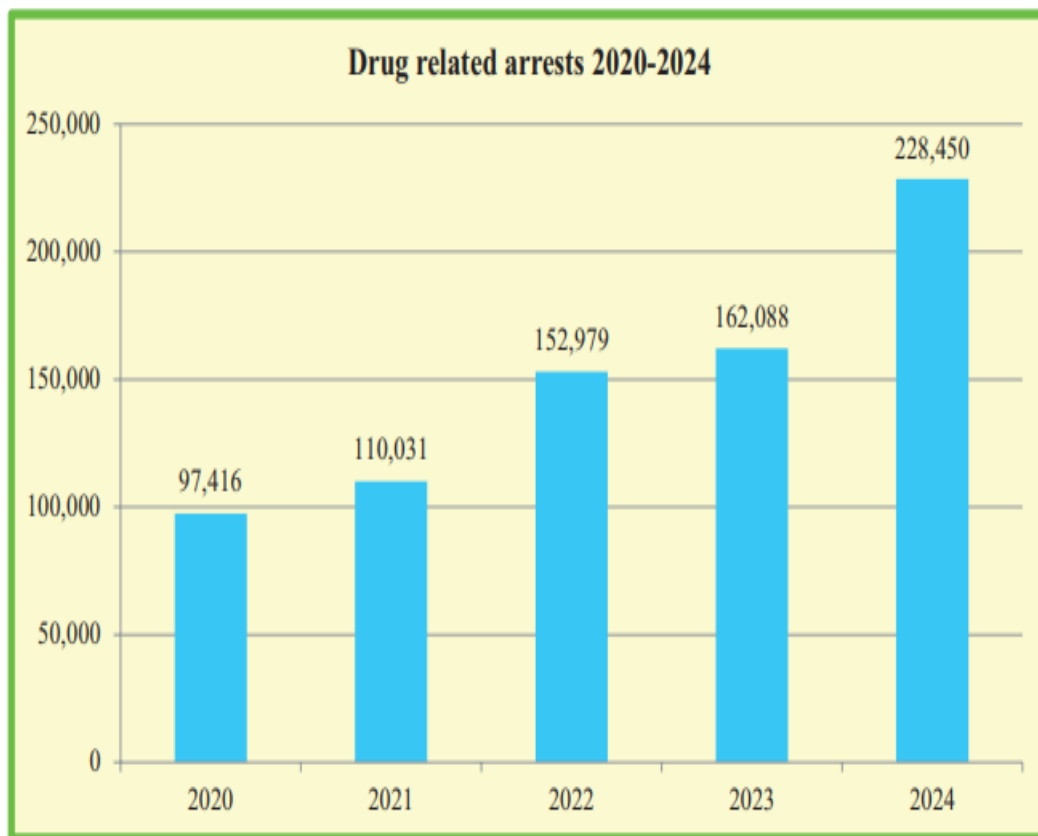
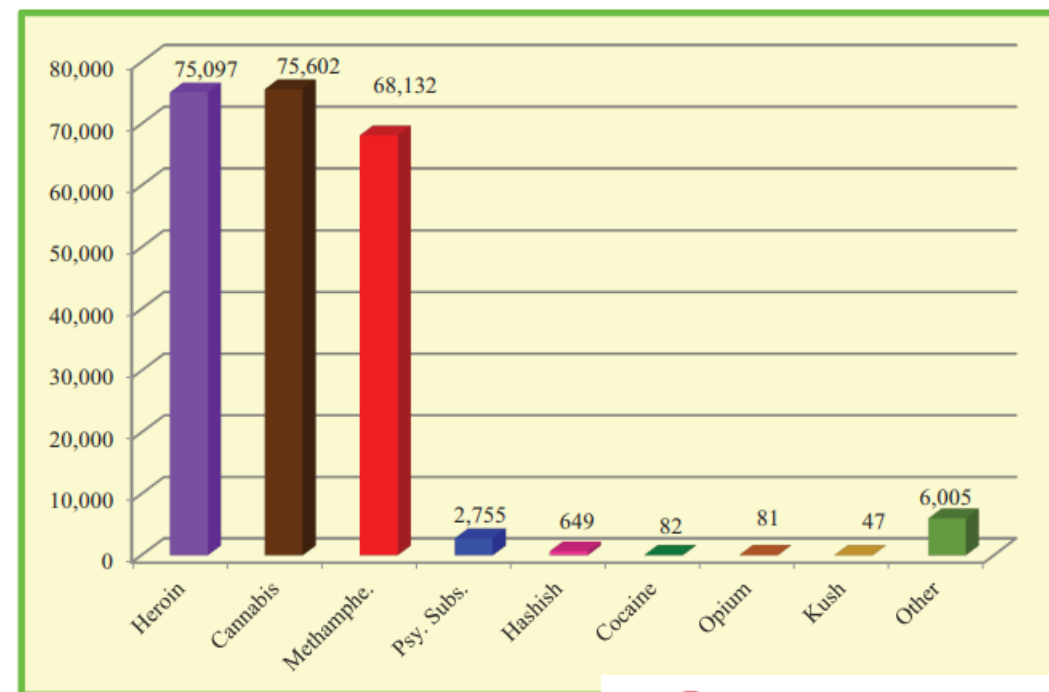


Exhibit II - Drug Related Arrests by Drugs 2024



Analyze the HIV, hepatitis B and C risk in relation to substance abuse in Sri Lanka

IBSS data (Awaiting results in 2026)

Local research data

Community clinic data; According to H2H organization data(NGO/CBO working with MSMs in Colombo district) data-from January to August 2025

- Number reported chemsex among reached MSMs;121/1127 (10.7%)
- Number reported chemsex among HIV positive; 16/25(2%)

STD clinic data from the year 2025

- Number of STD clinic attendees reported chemsex; 380/88,013 =0.4%
- Number reported chemsex among HIV positive; 45/874=5.3%
- Number reported chemsex among Hepatitis B positive; 0/61=0%
- Number reported chemsex positive among hepatitis C positive;08/137=5.8%



Chemsex was identified as emerging threat for rising HIV, hepatitis B and C in **majority of advocacy meetings**. Majority of MSMs who involved in chemsex are **injecting crystal meth.**

STD clinic quarterly returns

Global HIV epidemic

Global HIV Epidemic Incidence and Mortality

2024
Globally

40.8 million

People living with HIV



1.3 million
People newly infected

- 40%

New infections/year
relative to 2010

0.63 million
HIV-related deaths

- 54%

Deaths/year
relative to 2010

Source: UNAIDS/WHO and HIV.gov

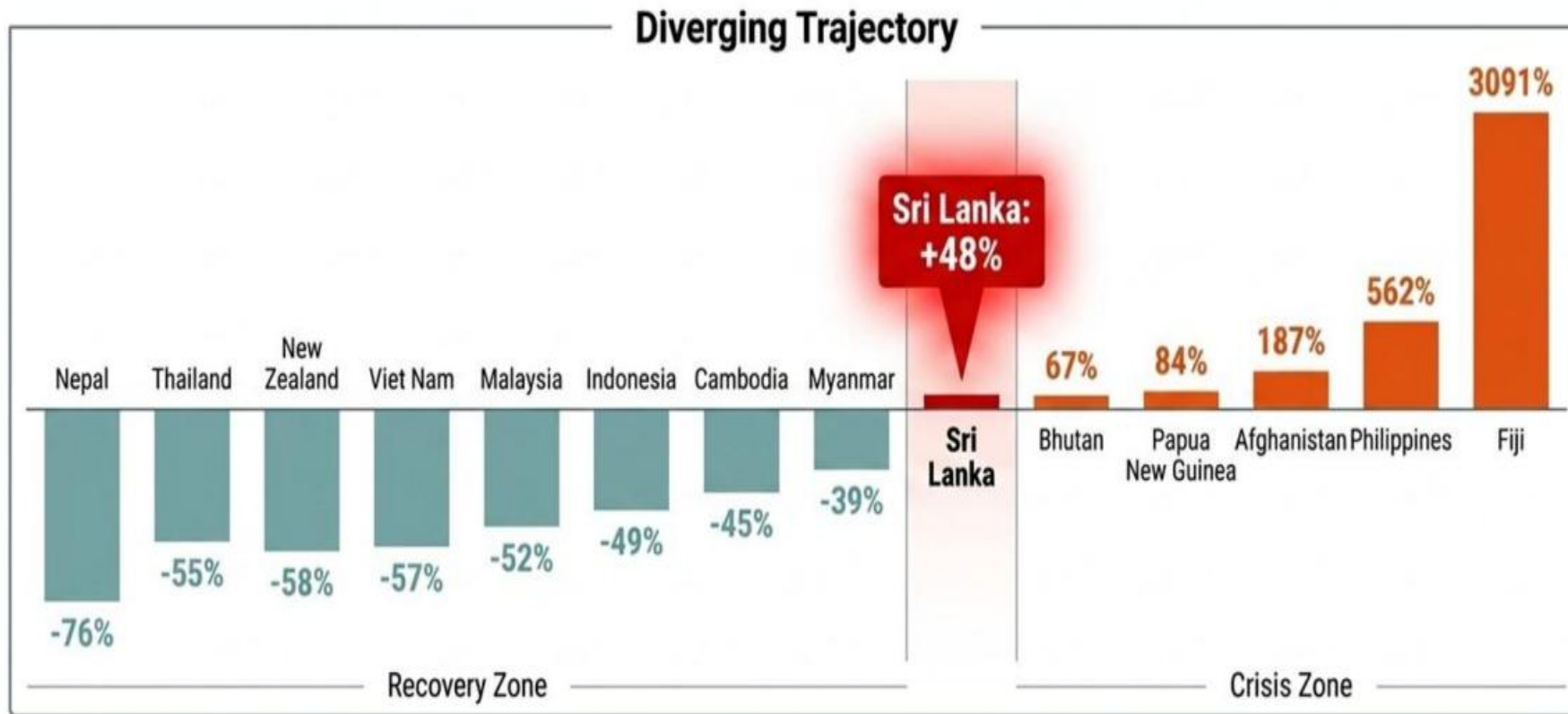


World Health
Organization



National STD/AIDS
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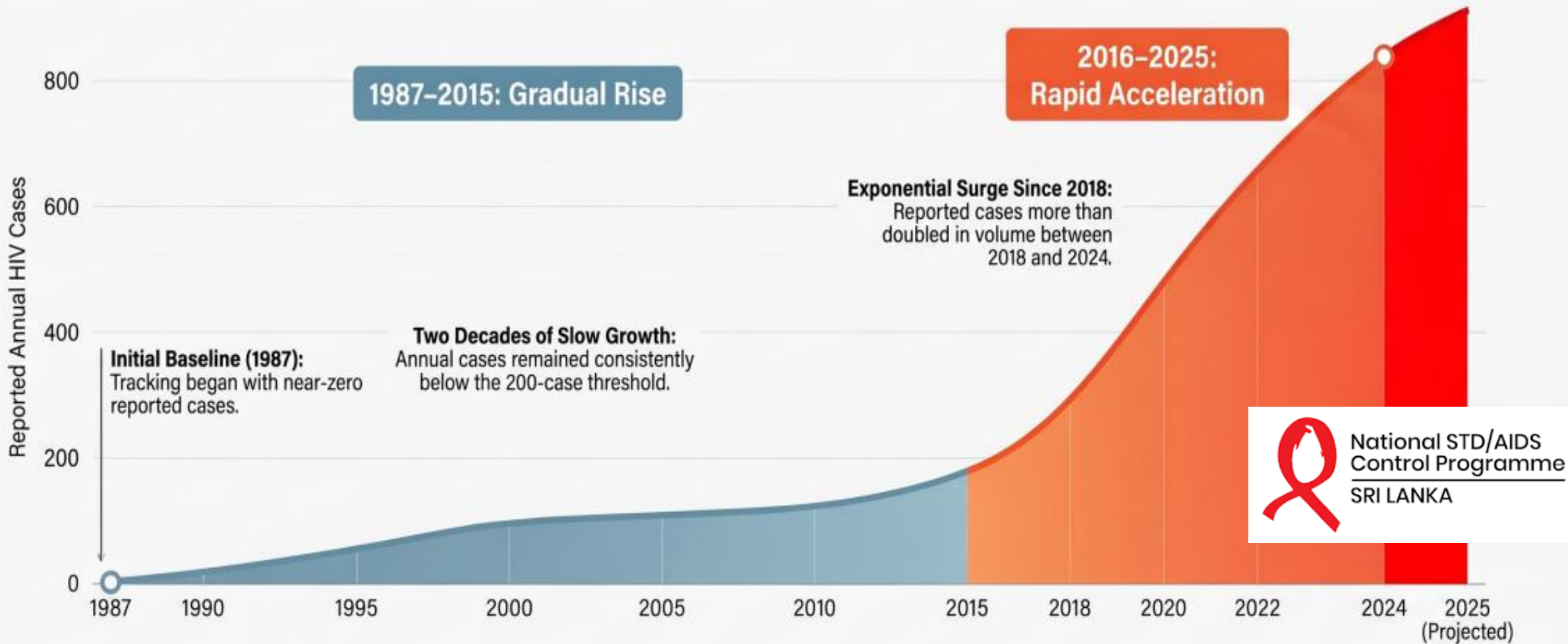
Asia and the Pacific face a growing HIV prevention crisis! New infections are now rising in nine countries.

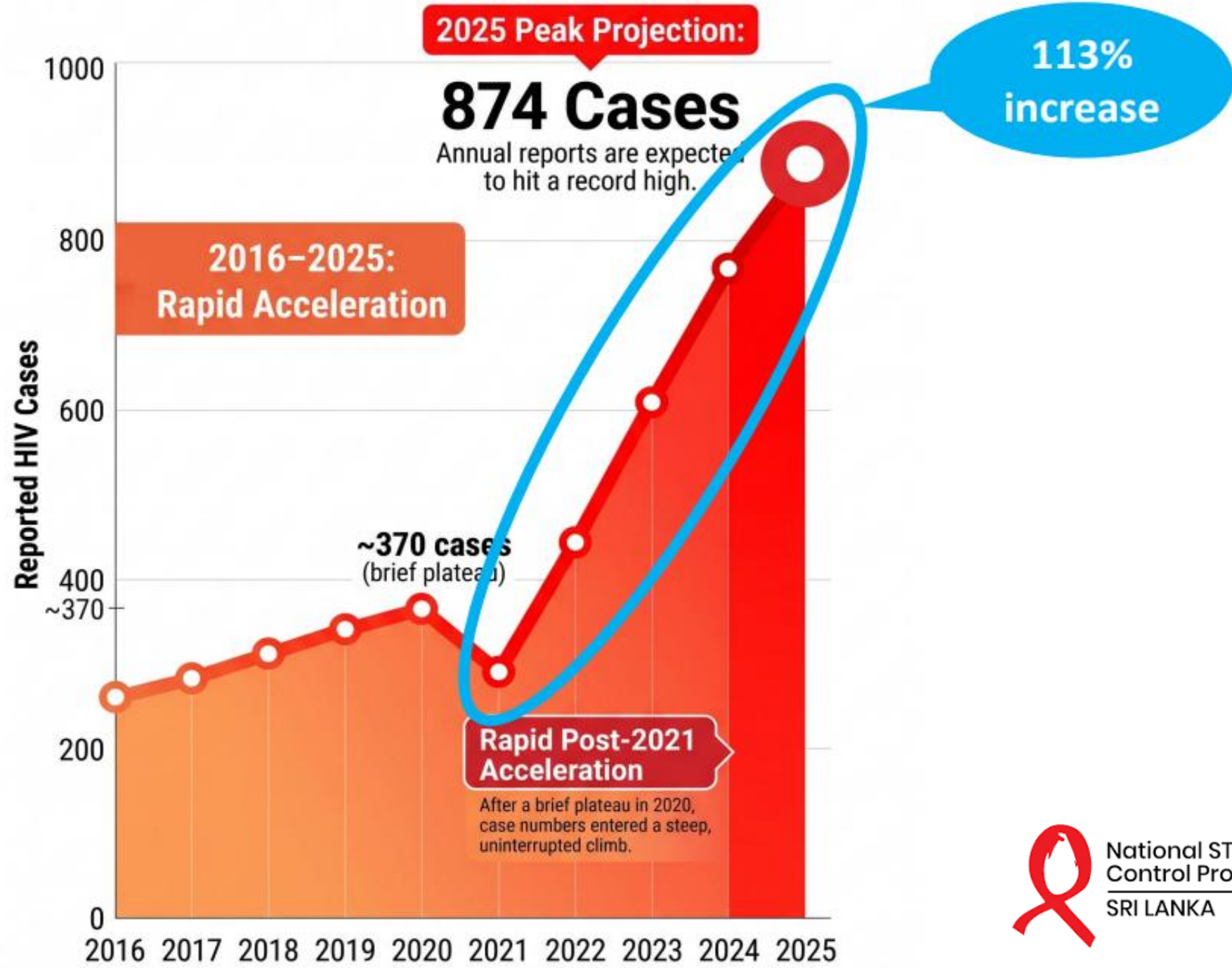


Percentage change in new HIV by country 2010 – 2024 : Source UNAIDS

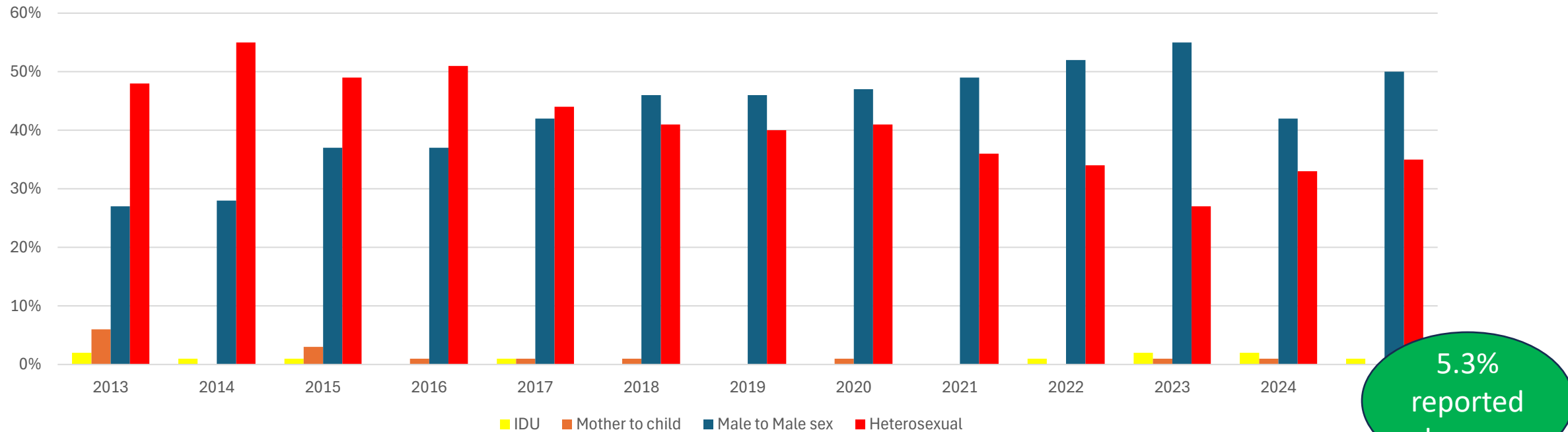
HIV Trends: The Escalating Surge (1987–2025)

This infographic tracks the annual reporting of HIV cases from the start of data collection in 1987 through projected figures for 2025. The data reveals a shift from low, stable numbers to a period of exponential growth beginning in the mid-2010s.



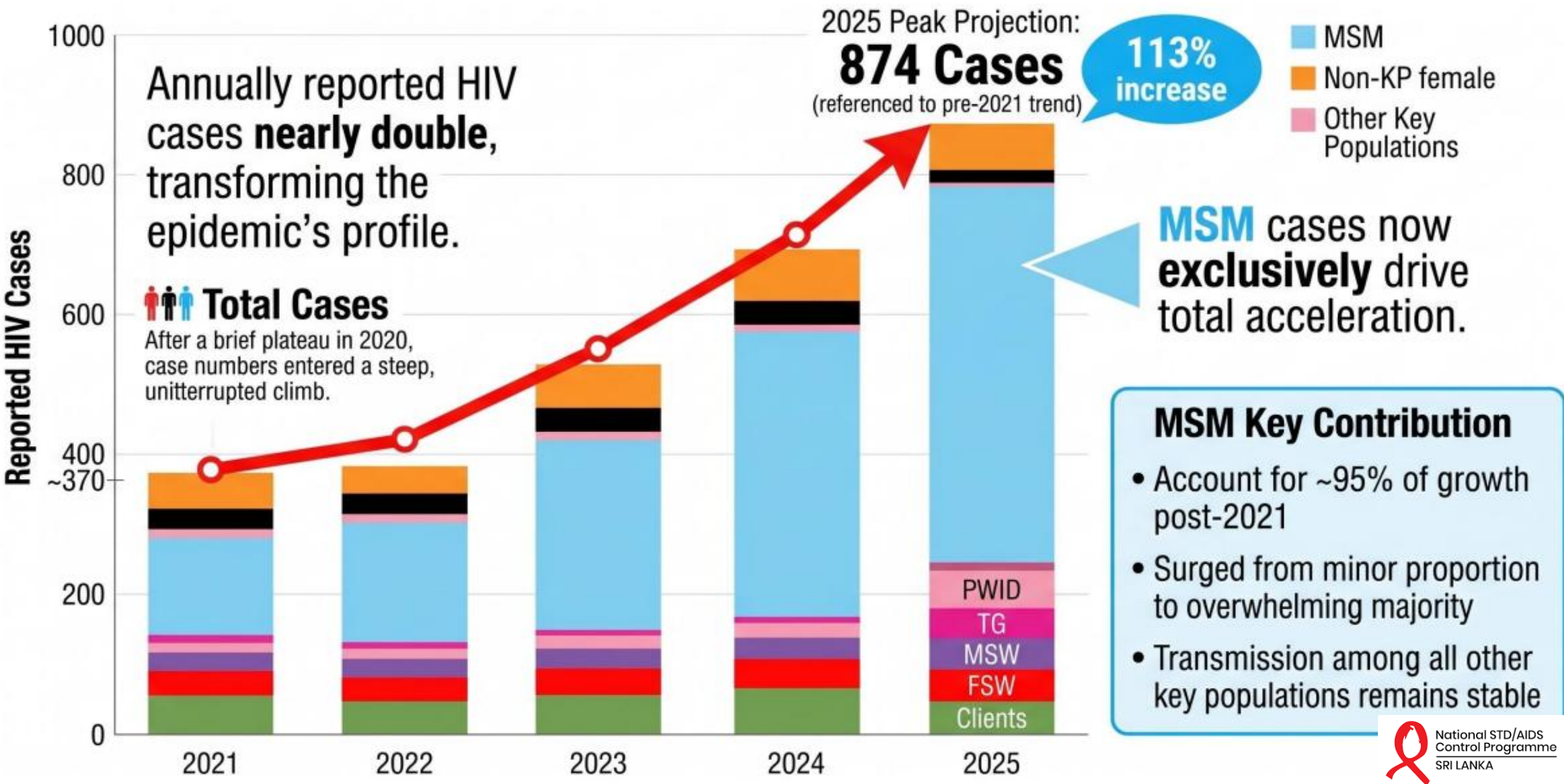


Probable mode of HIV transmission-Sri Lanka



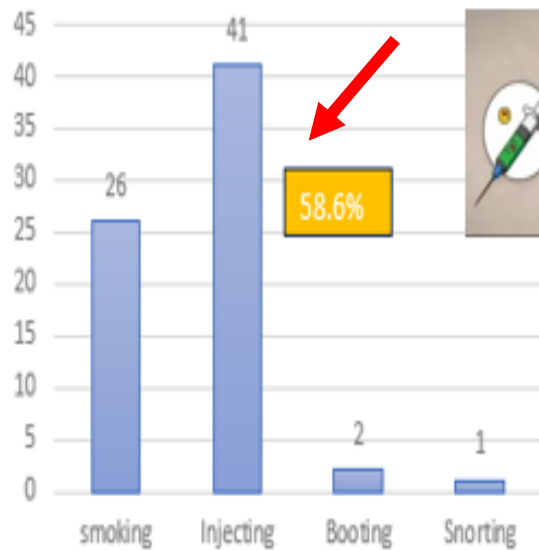
5.3%
reported
chemsex

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
IDU	2%	1%	1%	0%	1%	0%	0%	0%	0%	1%	2%	1%	0.5%
Mother to child	6%	0	3%	1%	1%	1%	0%	1%	0%	0%	1%	1%	0%
MSM	27%	28%	37%	37%	42%	46%	46%	47%	49%	52%	55%	53%	50%
Heterosexual	48%	55%	49%	51%	44%	41%	40%	41%	36%	34%	27%	45%	35%



A local study in Sri Lanka found that injecting crystal methamphetamine was the predominant method of drug use among MSM who engaged in chemsex

Common routes of administration of drugs used in chemsex

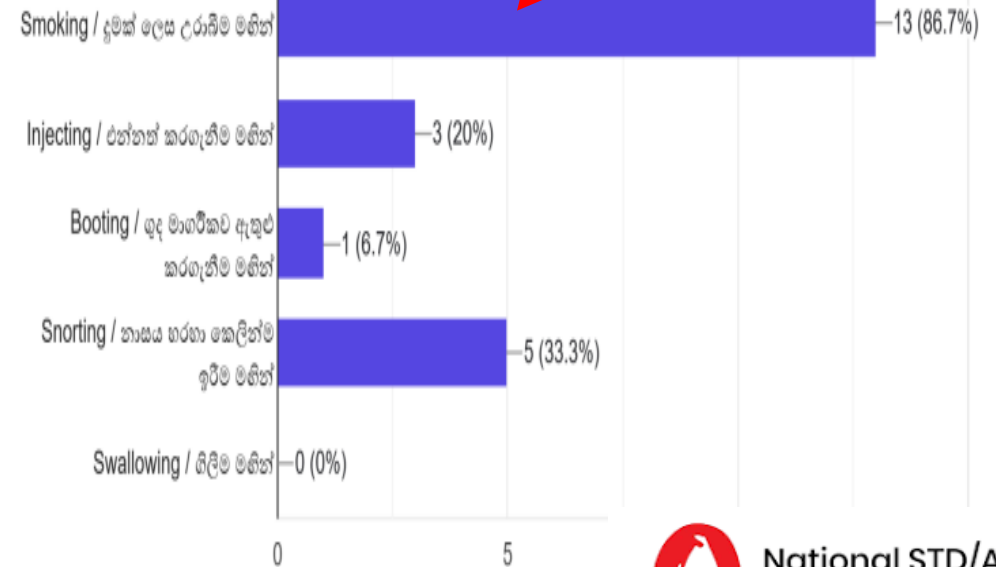


MSM



9. Methamphetamine use method / මෙතමෙටමින් (දයිස්) භාවිත කළේ නම්, භාවිත කළ ආකාරය.

15 responses



TGW



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Hepatitis B and C situation

- Globally 1.1 million HBV-related deaths and 240 000 HCV related deaths.
- Globally in 2024, there were an estimated 240 million people living with a chronic HBV infection and 47 million with a viremic HCV.
- According to the IMMR of Sri Lanka in 2024 28 diagnosed with acute hepatitis B and 218 diagnosed with chronic hepatitis B. No data on deaths in related to hepatitis.
- According to the NSACP annual report -2025, there **were 65 hepatitis B cases and 137 hepatitis C cases** diagnosed among STD clinic attendees across the country.

5.8%
chemsex

% PWID who are found Positive for hepatitis C virus
2018=6.2%
% PWID who are found positive for Hepatitis C in
2026=61.85%



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Community led interventions for hepatitis C treatment through community clinic

Table 10.2: **Community Led services reported in 2025**

Indicators	MSM	FSW	TG	PWID	BB
Number of condoms distributed	360840	766691	46644	4488	16378
Number of PrEP tablets distributed	16176	1754	743	0	0
Number of people treated for Hepatitis C	0	0	0	97	0
Number of people cured of Hepatitis C	0	0	0	35	0
Number of needles and syringes distributed	0	0	0	3429	0

Source: Prevention Information Management System (PIMS), NSACP Service Package CT Report and Service CT Report

Rapid assessment of chemsex and substance use situation in Sri Lanka

- Data from sexual health clinics
- Quantitative study component; questionnaire filled from 200 chemsex participants
- Qualitative study component;
 - Two focus group discussions with chemsex participants in Colombo and Gampaha
 - Focus group discussion with National Dangerous drug Control Board, Sri Lanka College of Psychiatrists, Prison authorities, Legal personals, Health ministry officials etc
- National Workshop on Chemsex Harm Reduction – 18 & 19 June 2026, held on 18 and 19 June 2026 at the Emerald Hall, Courtyard by Marriott Colombo.



The main harm reduction issues, priorities, or challenges



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Emerging Priorities: Chemsex and poly-substance users on the dangers of mixing drugs

Exhibit III - Heroin Related Arrests 2020 - 2024

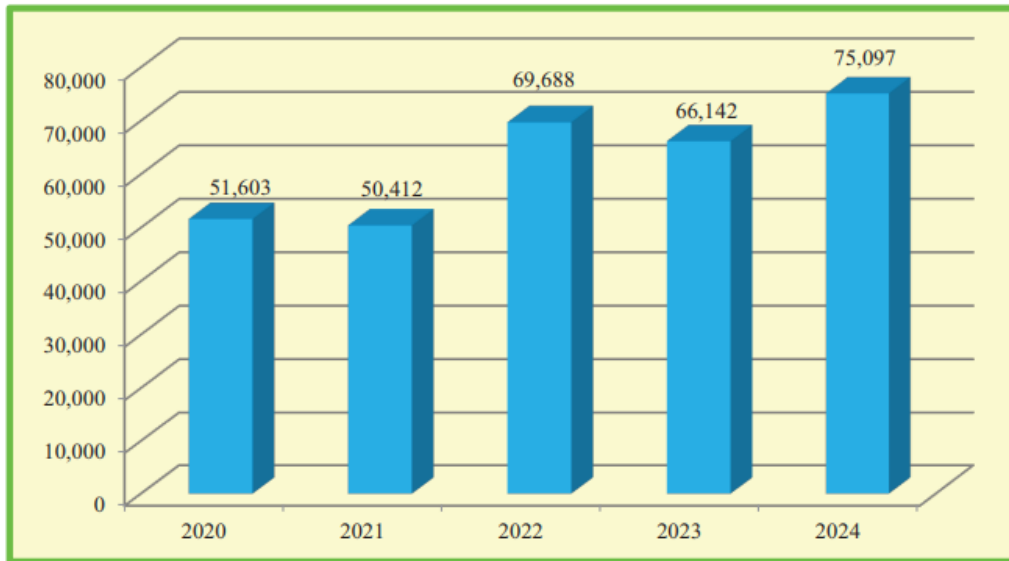
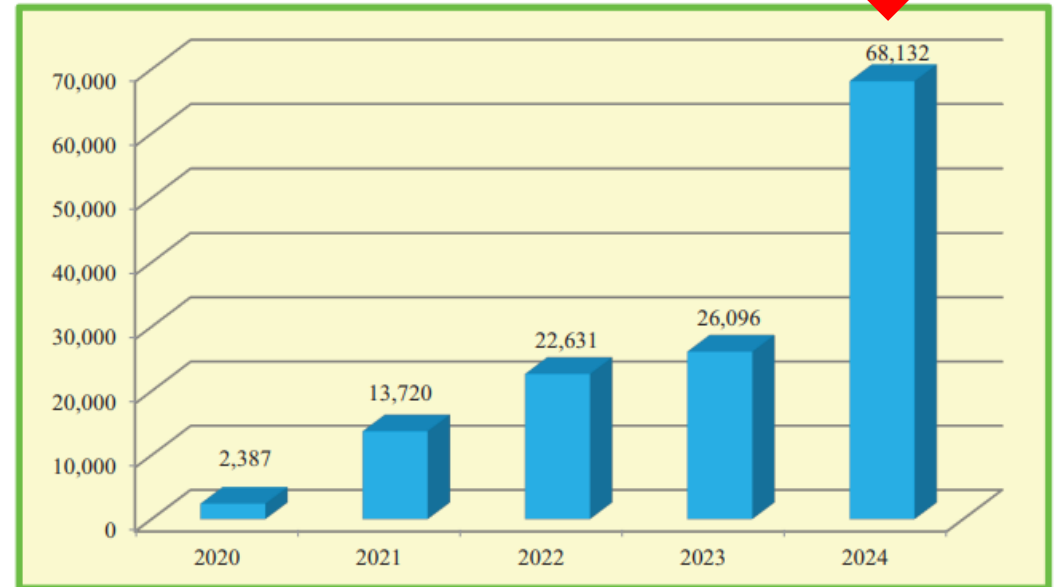
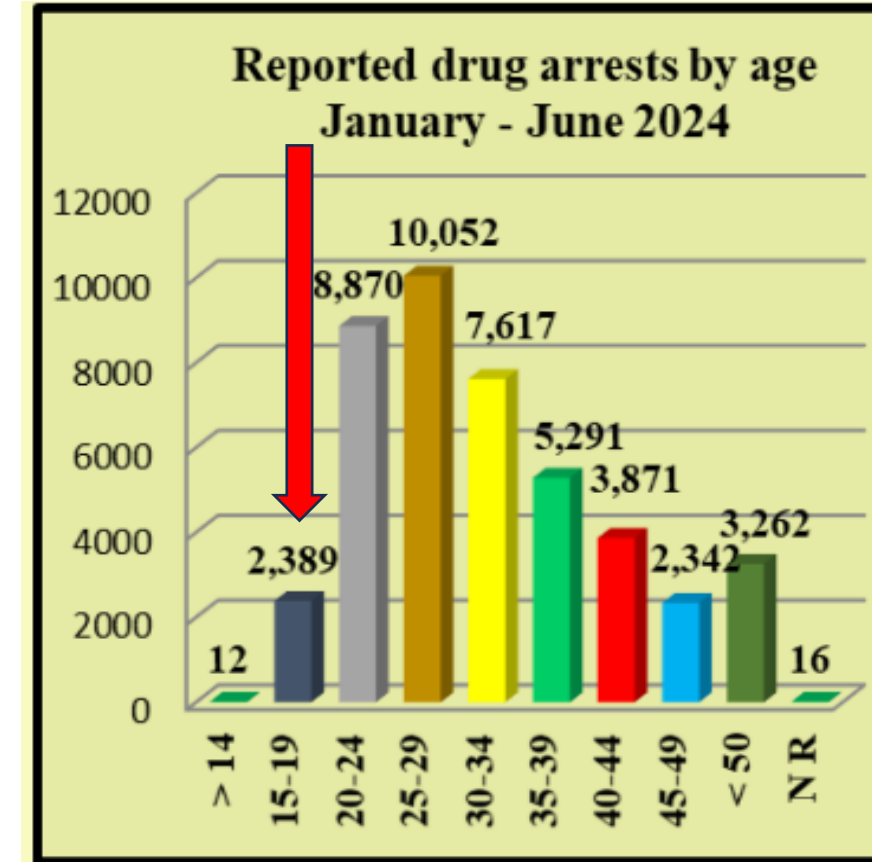
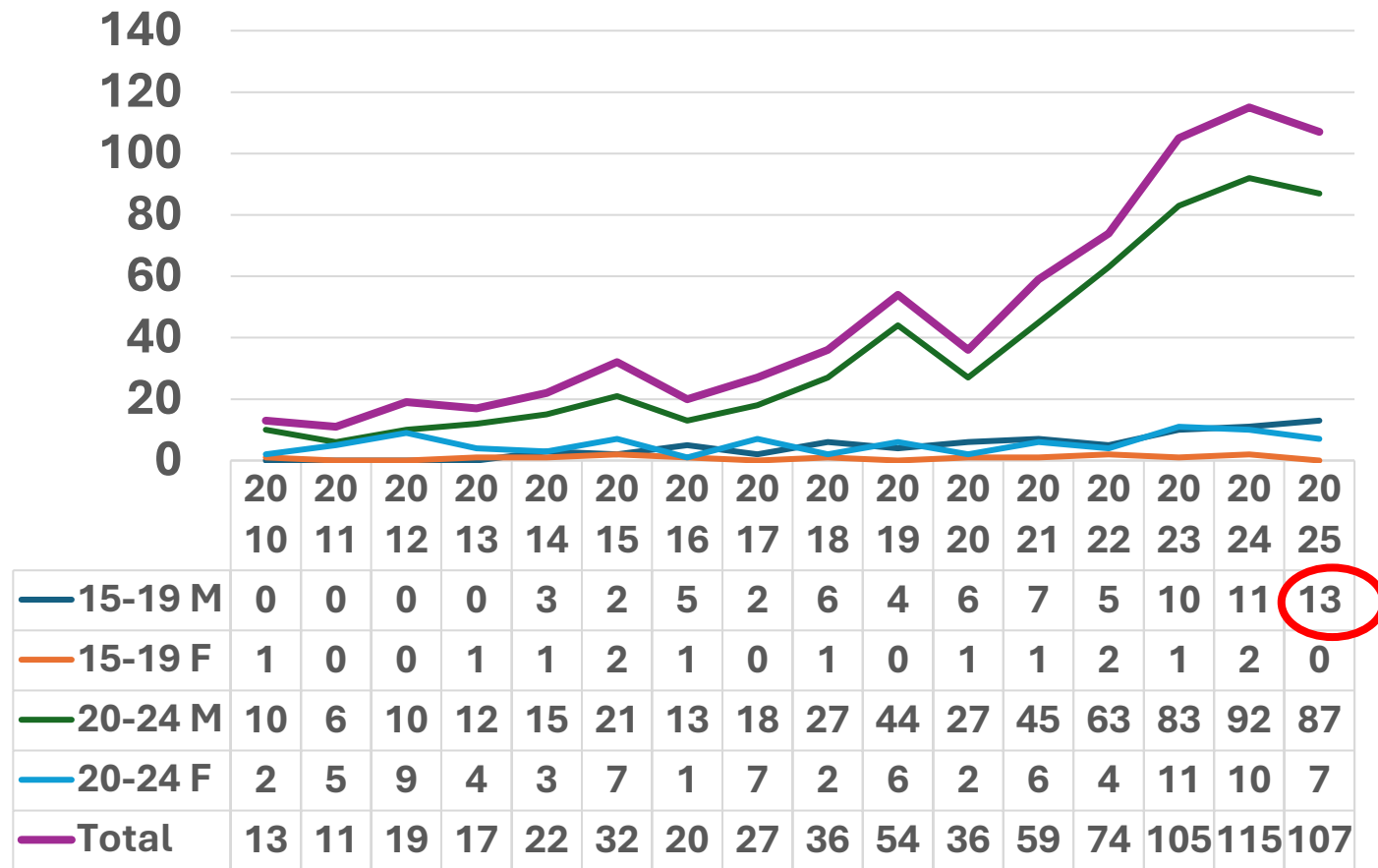


Exhibit V - Methamphetamine Related Arrests 2020 - 2024



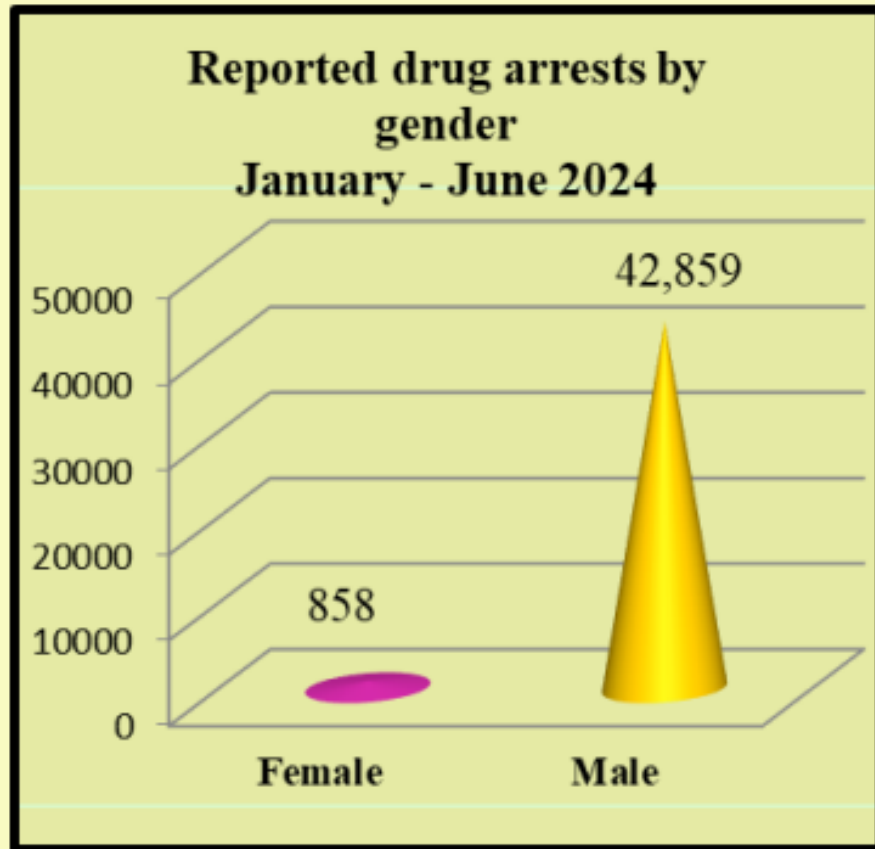
Emerging Priorities: Drug use among adolescence



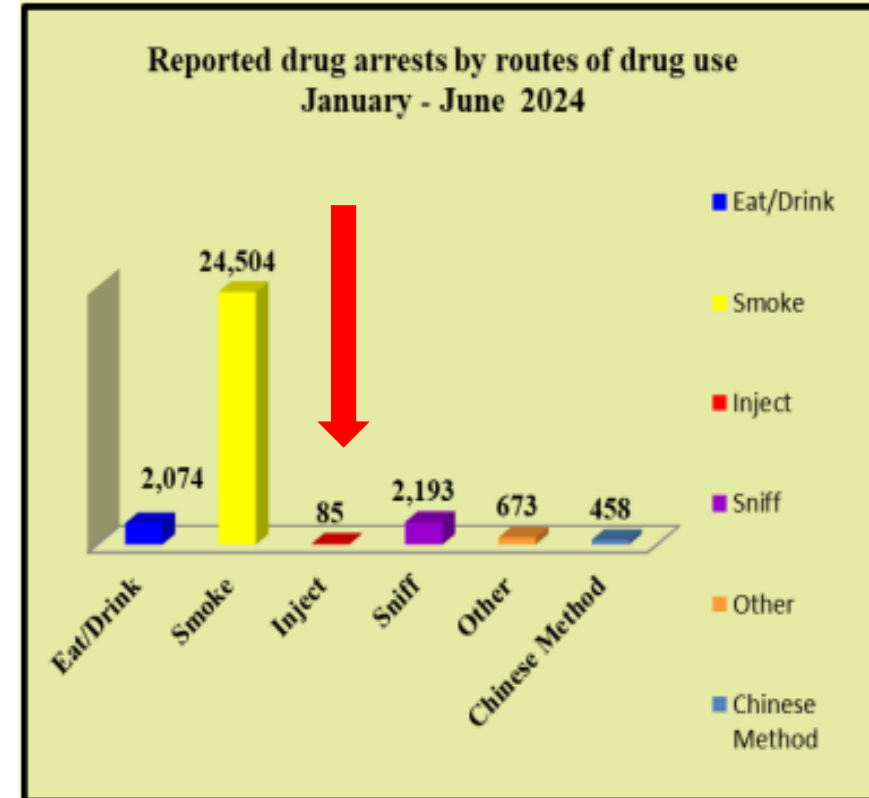
Source:- Drug Abuse Monitoring System - 2024

There is a Rising Trend of HIV Among 15 to 24 Age Group

Lack of data regarding drug use behavior among females and Injecting users ?underestimating



Source:- Drug Abuse Monitoring System - 2024



Source:- Drug Abuse Monitoring System - 2024

The main harm reduction issues

- **Absence of Mainstream Harm Reduction Services:** Fundamental global harm reduction strategies—such as **Needle and Syringe Exchange Programs (NSEP)**, **Opioid Substitution Therapy (OST)** (e.g., methadone or buprenorphine), and public Naloxone distribution—are nearly non-existent, Naloxone is available only Emergency department of the hospitals.
- **Issues related to state rehabilitation programs** rely heavily on a highly rigid, military-style or abstinence-only approach. These environments generally lack psychosocial profiling, leading to high relapse rates post-release
- **Shortage of updated, localized research** tracking substance use trends, psychosocial impact on multiple substance use, and the specific needs of marginalized sub-populations, such as adolescents or incarcerated mothers

Punitive laws



- **The Poisons Opium and Dangerous Drugs Ordinance (PODD) 1936**, is the primary statute governing drug-related offences and penalties. The Ordinance, however, is vastly outdated and does not meet the needs of the current context.
- **The Drug Dependent Persons (Treatment and Rehabilitation) Act, No. 54 of 2007** is a core piece of legislation in Sri Lanka that shifts the focus from purely punitive measures to treatment, care, and rehabilitation for individual's dependent on drugs.
- **Aiding and Abetting: Section 54B** states that any person **who aids, abets, counsels, or procures the commission of an offence under Section 54A** is guilty of an offence against the Ordinance. Punishment: The law treats accomplices exactly the same as primary offenders. If a person is convicted by the High Court of aiding and abetting the trafficking of minimum specified amounts of hard drugs, they are liable to the penalty of death or life imprisonment.

Existing services, policies, or initiatives that are relevant to the response

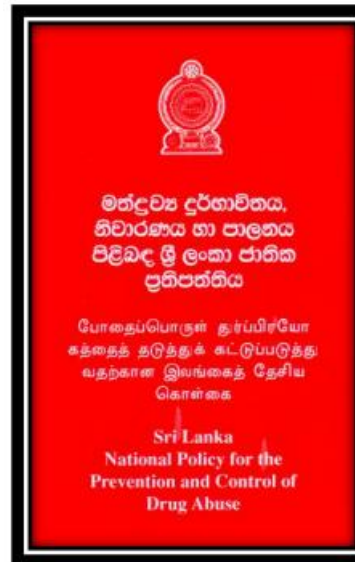
Where to Find Dedicated Substance Management in Sri Lanka

- Basic psychological support, counseling, and preliminary psychiatric evaluations can be accessed at general outpatient mental health clinics across the country, formal medical detoxification, specialized addiction psychiatry, and structured rehabilitation are concentrated within specific, designated facilities
- **Specialized Addiction Clinics:** Certain tertiary government institutions have designated addiction psychiatry units. Ex;NIMH
- **Designated Severe Addiction Hospitals:** The government has officially designated 10 specific state hospitals across the country equipped to manage severe drug addiction treatments and clinical detoxification.
- **National Dangerous Drugs Control Board (NDDCB):** The NDDCB is the principal government body managing formal substance rehabilitation. They run regional residential treatment and detox centers in Colombo (Talangama), Kandy, Galle, and Nittambuwa

Policies in Sri Lanka

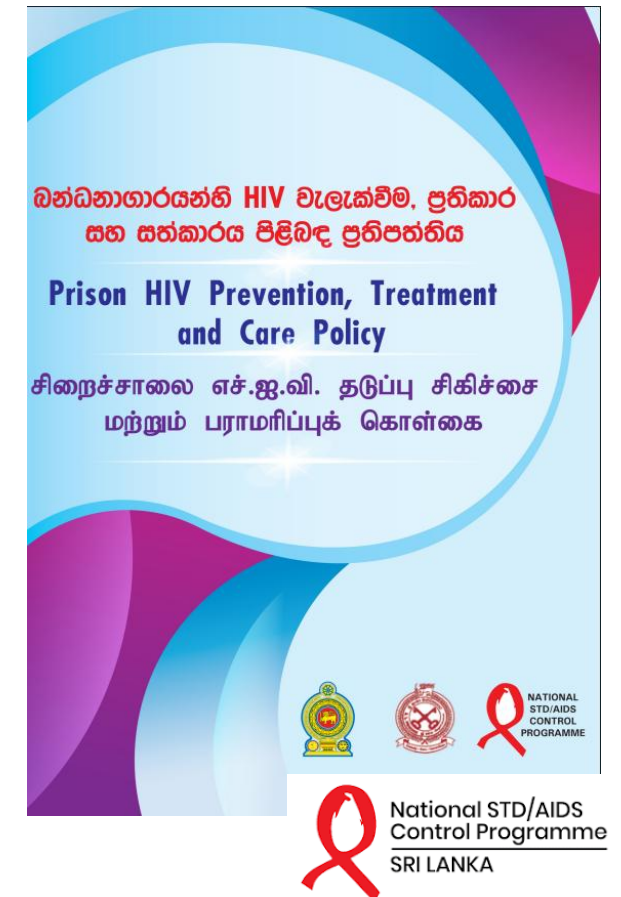
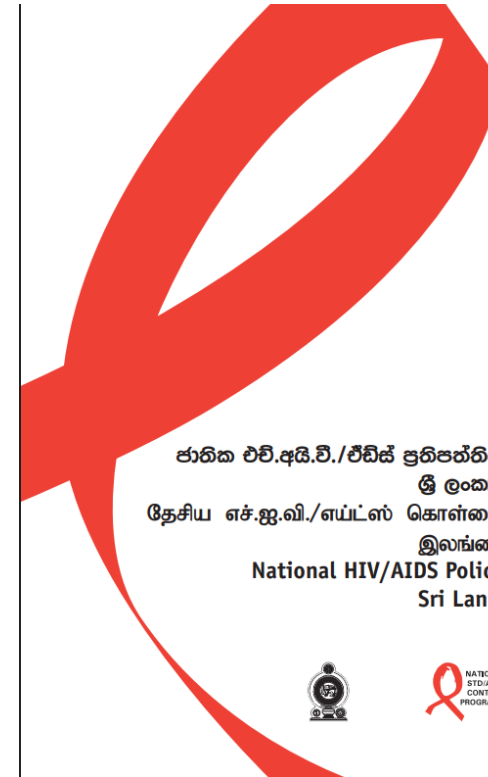
Policy

SRI LANKA NATIONAL POLICY FOR THE PREVENTION AND CONTROL OF DRUG ABUSE-2010



Policies

National AIDS policy-2011, Prison policy-2017



Laws and regulations

Laws

- NATIONAL DANGEROUS DRUGS CONTROL BOARD ACT No. 11 of 1984
- DRUG DEPENDANT PERSONS (TREATMENT AND REHABILITATION) ACT, No.54 OF 2007
- POISONS, OPIUM AND DANGEROUS DRUGS (AMENDMENT) ACT, No. 13 OF 1984
- NATIONAL AUTHORITY ON TOBACCO AND ALCOHOL ACT, No 27 OF 2006
- POISONS, OPIUM AND DANGEROUS DRUGS (AMENDMENT) ACT, No. 41 OF 2022

Regulation

- DRUG DEPENDANT PERSONS (TREATMENT AND REHABILITATION) ACT, No.54 OF 2007
- 6-CONVENTIONS AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT, No.01 OF 2008

Health Ministry circular no DMH/E/01/2021 dated 03/07/2023 Guideline for the management of patients presenting with opioid, cannabis, methamphetamine or polysubstance withdrawal at primary health care settings



Initiatives relevant to the national response

- The Presidential Task Force to Study the Implementation of **“One Country, One Law”** was established in Sri Lanka by former President Gotabaya Rajapaksa via an extraordinary gazette in October 2021.
- The **“Ratama Ekata – National Operation”** is a comprehensive national initiative launched in Sri Lanka under the leadership of President Anura Kumara Dissanayake to eradicate the drug menace, dismantle organized crime, and rehabilitate addicts. The program focuses on breaking down illicit drug trafficking networks, offering robust rehabilitation pathways for those struggling with addiction, driving nation-wide public education campaigns, and securing multi-sector participation (including security forces, intelligence, and community organizations).



Key gaps, barriers, and opportunities for further development



Key gaps

- Sri Lanka's approach to substance use is primarily anchored in demand reduction, prevention, and abstinence-based treatment rather than **full-scale clinical harm reduction** (such as needle-exchange programs or opioid substitution therapy), which remain largely limited or absent.
- Punitive Legal Frameworks
- Sociocultural Stigma
- Institutional bias
- Lack of integration
- Severe resource and economic constraints

Opportunities

- **National policies, regulations, health ministry circulars and guidelines** for substance abuse in Sri Lanka
- Sri Lanka possesses a highly competent, **decentralized primary healthcare network**.
- **Targeted Peer Outreach:** Non-government organizations like the FPASL and SKPA with collaboration of NSACP have started specialized peer-educator programs addressing emerging issues like chemsex and sexualized drug use among key populations.
- Strong political commitment to reduce substance abuse in Sri Lanka.



Sri Lanka launches the WHO
SAFER technical package and its
first alcohol investment case:
turning evidence into action

Opportunities to prevent STI and HIV in related to chemsex and harm reduction

Awareness of STI/HIV Prevention through STD clinic health care workers and outreach workers from NGO/CBOs

Condom use

Pre-Exposure Prophylaxis (PrEP) **(preferred preventive option)**

Plans to introduction of injectable Lenacapavir

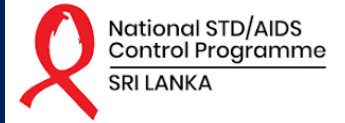
Post-Exposure Prophylaxis (PEP/PEPSE)

Importance of regular HIV/STI testing



What Sri Lanka is hoping to learn from Malaysia
and from the experiences of other participating
countries

What Sri Lanka is hoping to learn from Malaysia and from the experiences of other participating countries



- By looking to Malaysia and other international models, Sri Lanka hopes to learn how to successfully transition toward **an evidence-based, community-led, and public health-oriented harm reduction model**
- **Navigating the Transition from Punitive Policy to Public Health.** Both Sri Lanka and Malaysia share a history of deeply entrenched punitive laws regarding illicit drug use. Sri Lanka is eager to understand how Malaysia shifted its national mindset to successfully implement progressive harm reduction initiatives.
- Implementing **Scalable Opiate Substitution and Needle Programs.** Under the Malaysian AIDS Council (MAC) and Ministry of Health, Malaysia established highly successful models for **Methadone Maintenance Therapy (MMT) and Needle and Syringe Exchange Programs (NSEP)**. Sri Lanka hopes to adopt these exact clinical interventions to effectively lower the risk of HIV and Hepatitis C transmission among people who inject drugs (PWID), replacing cost-inefficient incarceration with cost-effective clinical care.
- **Scaling Community-Led Responses and Peer Networks.** Through joint regional programs, NGO/CBOs in Sri Lanka are learning to leverage peer-led education to deliver trauma-informed care. Sri Lanka is observing how Malaysia's initiative trains community healthcare workers and peer navigators (many with lived experiences) to link marginalized populations directly to HIV testing, PrEP, and mental health services.

Thank you



National STD/AIDS
Control Programme

SRI LANKA



**MINISTRY OF HEALTH
& MEDICAL SERVICES**

Chemsex & Harm Reduction in Fiji

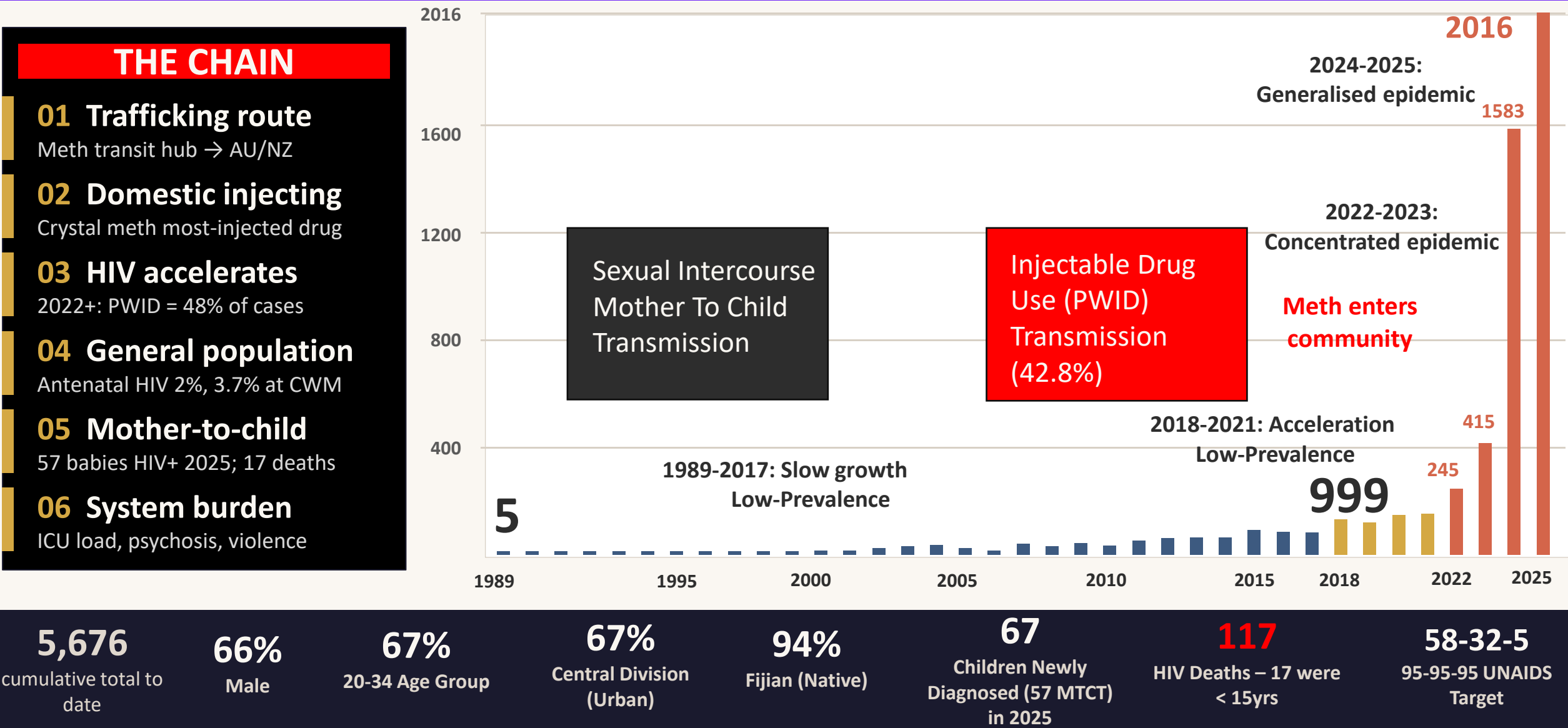
Dr. Sailosi Soqo

Harm Reduction and Drug User Health Lead,
Sexual and Reproductive Health and HIV Unit,
Ministry of Health and Medical Services

October 2026

FIJI - Low HIV Prevalence to National HIV Emergency

Fiji HIV Epidemic Timeline • 1989 to 2025 • Source: MOHMS HIV Surveillance Report 2025



The current drug use situation in Fiji

- **Fiji** has one of the **fastest-growing HIV epidemics in the world**
 - Declared National HIV **Outbreak** in Jan 2025 (routine response) –
 - SRH & HIV Unit Formed
 - Declared National HIV **Emergency** 9 September 2026 (better response)
 - Injecting Drug Use **main driver** + new risk
- Key Population :
 - Ethnic, Males, 20-34 years age range, Urban Centers
 - SW, MSM, TG, Preg Moms
- **Methamphetamine** is the most common injecting drug
 - Injecting as **initial mode** of use (50%)
 - Most inject **daily** plus in **groups**
 - **Sharing injection** equipment (needle, syringe, and mixing apparatus) – Cultural practice
 - 100% shared with someone at least once
 - Some share with multiple people in one event
 - Koda (common) vs Bluetoothing (uncommon)
 - **Drug Progression** – Glue TO Green TO White
 - **High Functioning** IDU + CHEMSEX

The current chemsex situation in Fiji

- **Where we are starting from** – we have signals, not data
 - Clinical, peer-outreach and community **sources report drug use in sexual settings** among gay, bisexual and other MSM and among sex workers – scale, drugs, practices and risks unknown
 - **Last behavioral study of MSM was Secret Lives, Other Voices (2010–11)** – before methamphetamine; no chemsex question in any survey or clinical screen since
 - PrEP, HIV/STI testing (and NSP) are delivered as separate offers; nobody asks about sexualized drug use
- **What is starting: a community-led exploratory study with the Kirby Institute** (convened September 2026)
 - Two-phase qualitative design: stakeholder interviews first, then community interviews (online and in person, trained local interviewers)
 - Broad 'MSM plus' scope under consideration – sexual and gender minorities, sex workers, people who inject drugs; final eligibility set after stakeholder phase
 - Main urban centers PLUS tourism-linked and selected rural settings; documenting Fiji-specific practices and local terminology rather than importing definitions
 - Partners: MHMS SRH and HIV Unit (three technical leads), Kirby Institute funding the exploratory phase, Fiji National University as preferred academic and ethics partner; community organizations to be engaged
- **Scope covers HIV prevention** and broader harm reduction – mental health and supports for dependence – not only HIV prevention

The harm reduction and related services that currently exist in Fiji

- **Harm Reduction Strategy (2023 – 2028)**
 - Cabinet endorsed, Heavy on Rehabilitation, Psychiatric Hospital put as lead
 - SRH & HIV Unit formed in Aug 2025
 - Cabinet Sub-Committee formed [Recent]
 - Legal Framework GAP – HIV Act (2011) Amendment Done Vs Conflicting Laws
- **Harm Reduction Service currently**
 - None
 - Sensitization - Fiji Police with GLEPHA (2026), Cabinet, FBO, CBO, MOH, Community Leaders, Teachers
- **No National Needle and Syringe Programme (NSP) [*]**
 - Facility Readiness Assessment Done (3X), Commodities Ready
 - Implementation Plan Done Dec 2025
 - MOH Facility distribution Vs Community Distribution Vs Outreach
 - Secondary Distribution via CSO's + PWID Peer distributors
- **What is working:**
 - Peer-led network, international support, government support, police sensitization, unit leadership.

Key gaps and barriers in Fiji

- **Legal, policy and policing** – no explicit harm reduction provision in law or a national harm reduction policy; possession of equipment can still expose clients and staff (Illicit Drugs Control Act 2004); an informal police–health agreement is in place for NSP sites and peer distributors, but it is not yet written down or backed by law
- **Stimulants without a treatment anchor** – no drug treatment pathway, and the epidemic is stimulant-driven, so the evidence-based response for methamphetamine – injected and sexualised – is the harder question
- **Chemsex is invisible in services** – no screening for sexualised drug use in PrEP, STI or HIV clinics; no MSM- or sex-worker-specific harm reduction offer; stigma layered twice; no data since 2010–11
- **Evidence, monitoring and disposal** – CSO distribution reporting inconsistent; no PWID size estimate; no unique client tracking; sharps disposal dropped from 2025 procurement and unresolved
- **Reach, workforce and financing** – services concentrated in Suva while the West and North are under-served; peer workers, hub staff and NSP managers are a thin, unsalaried layer; commodities are funded but outreach needs a sustainable domestic line

Desired learning outcomes from the workshop

- **Law and policing** – how harm reduction was reconciled with drug law; how an informal police–health understanding becomes a written agreement, and what those agreements looked like; protecting clients and peer workers (service providers)
- **Chemsex services** – how Malaysia and others built chemsex-aware testing, PrEP and support for MSM; community-led models; what to ask, and how, without driving people away
- **Peer workforce** – framework, recruiting, training, paying, supervising and retaining peer outreach workers; career pathways for people with lived experience
- **Stimulants without OAT** – responses for methamphetamine where opioid agonist therapy is not the anchor service; contingency management and psychosocial models
- **Data, disposal and secondary distribution** – unique client identifiers, coverage estimates, size estimation and IBBS design; secondary distribution and disposal models; reporting without deterring clients
- **Sustainability** – moving from donor-funded commodities to domestic budget lines; integrating harm reduction and chemsex into primary care and national HIV guidelines
 - Malaysia has twenty years of NSEP and MMT experience – Fiji has sixteen months. We are here to learn what to keep and what to avoid.

VINAKA



Chemsex & Harm Reduction in Bhutan

A Country Context Presentation
(10-15 minutes per country)
Presenter: Deki Phuntsho

October 2026



Overview of
presentation

Presentation Outline

 Epidemiology & Drug Use
Landscapes

 Current Landscape

 Governance &
Partnership Models

 Structural & Information
Gaps

 Emerging Dynamics

 Regional Exchange
Objectives

1,845

National PSE (PWUID)

Bio-behavioral synthesis

97%

Pharmaceutical Opioids

Spasmo-Proxyvon, Tramadol

>2,000

High-Risk Screenings

Screened for HIV/STIs in 2025

↳ Geographic Hubs & Emerging Risk Dynamics

- Commercial & Border Corridors: Concentrated heavily in Thimphu (347), Sarpang/Gelephu (196), and Chukha/Phuntsholing (147).
- Synthetic Stimulant Surge: Rapid increase in crystalline methamphetamine and amphetamine-type stimulants (ATS) within urban youth networks.
- Key Population Intersections: Convergence between synthetic stimulant use and condomless sex among high-risk groups.

Health Info & Service Centers (HISCs)

Dedicated primary care hubs providing accessible, confidential HIV/STI screening, clinical treatment, and specialized harm reduction interventions.

Targeted Peer Outreach

Peer-led distribution of specialized condoms and lubricants, scaling HIV Self-Testing (HIVST) for low-threshold testing, and basic psychosocial first aid.

Correctional Facility Expansion

Systemic expansion of voluntary HIV/STI screening, self-testing kits, and tailored awareness programs into prison settings and detention facilities.

Differentiated Clinical Models

Transitioning from daily oral PrEP to Event-Driven PrEP (ED-PrEP) under revised national clinical guidelines across 7 regional hub districts.

Governance & Partnership Models

MULTI-SECTORAL ALIGNMENT

Sector / Lead	Key Organizations	Core Functions & Strategic Foc
Government Lead Policy & Direction Policy & Direction	Ministry of Health / NACP	Policy direction, national clinical guidelines development, logistics management, and digital health system integration.
CSO Delivery Partners Community Outreach Community Outreach	- Chithuen Phendhey Assoc. (CPA) / Happiness Home / Jurwa - Pride Bhutan & Red Purse Network - Lhak-Sam	Peer-led substance use outreach, harm reduction & rehab, key population network engagement, stigma reduction, and PLHIV advocacy.
Law Enforcement & Healthcare Alignment Public Health Approach Public Health Approach	Royal Bhutan Police & Narcotics Control Authorities	Re-framing drug use as a public health priority rather than punitive matter. Strategic top-up allocations for GC8, TAG policy reviews, and JDWNR Hospital clinician deployment to Thimphu HISC.

Clinical & Surveillance Registration Gaps

The National Electronic Patient Information System (ePIS) lacks standardized variables to systematically capture chemsex behaviors or specific drug-use modalities during routine medical visits.

Capacity & Tooling Deficits

Absence of specialized, culturally adapted Chemsex Peer Training Modules and non-stigmatizing IEC materials. Peer workers currently lack formal training in low-intensity psychological first aid for acute stimulant toxicity and psychosis.

Confidentiality & Stigma Barriers

Pervasive fear of public disclosure in small, close-knit communities where anonymity is difficult to maintain, preventing key populations from seeking timely health interventions.

Micro-Network Hyper-Vulnerability

In small populations, sexual and drug networks tightly overlap. A minor influx of synthetic stimulants rapidly accelerates STI/HIV transmission across an entire micro-network.

Digitalization of Risk & Outreach

Rapid migration of drug acquisition and chemsex party coordination to encrypted digital platforms and social media applications requires modern digital health approaches.

Mental Health Integration

Chemsex and substance reliance are deeply rooted in minority stress and trauma. Mental wellness screenings must be embedded directly into routine STI consultations.

Regional Exchange Objectives

MALAYSIA LEARNING EXCHANGE

1 Operational Chemsex Team Models

Studying the organizational structure, training curricula, and peer deployment workflows of Malaysia's specialized Chemsex response teams.

2 Harm Reduction Tools & Distribution

Evaluating localized 'Party Pack' assembly, distribution logistics, and targeted non-stigmatizing harm reduction informational materials.

3 Digital Outreach & Low-Threshold Portals

Examining safe digital tools, online risk screening portals, and encrypted appointment booking platforms for hard-to-reach groups.

4 Policy & Environment Navigation

Learning strategies for advocating, implementing, and sustaining harm reduction services within culturally conservative and legally complex environments.

Thank You

Deki Phuntsho



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The Architecture of Trust

How Malaysia Built a National Harm Reduction Ecosystem

A blueprint for GO-NGO smart partnerships, law enforcement collaboration, and **community-led health** in criminalized settings.

DR NATALIA BINTI CHE ISHAK

PUBLIC HEALTH MEDICINE SPECIALIST
HIV/STI/HEP C SECTOR, DISEASE CONTROL DIVISION
MINISTRY OF HEALTH MALAYSIA

A Three-Decade Roadmap of National and Global Commitments

Global Initiatives

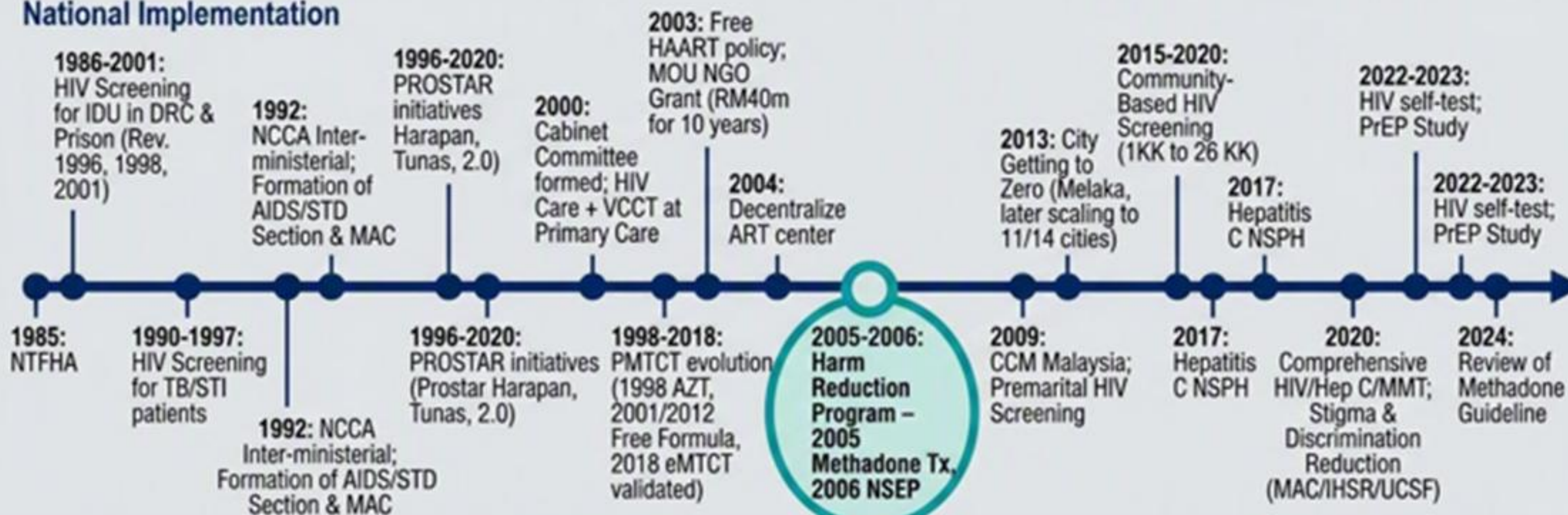
2000: MDG

2001: UNGASS Declaration

2011: Political Declaration

2016: Ending AIDS Declaration / SDG

National Implementation



The Epidemiological Crisis



Historically, Malaysia's HIV epidemic was heavily driven by **People Who Inject Drugs (PWID)** via **shared, unsterile needles**. With transmission rates skyrocketing, public health demanded an immediate, pragmatic intervention.

The Reality Check

The Challenge: Overcoming immense initial political and societal resistance to the concept of 'giving needles to addicts' by relentlessly framing it as disease control, not drug tolerance.

The Authority

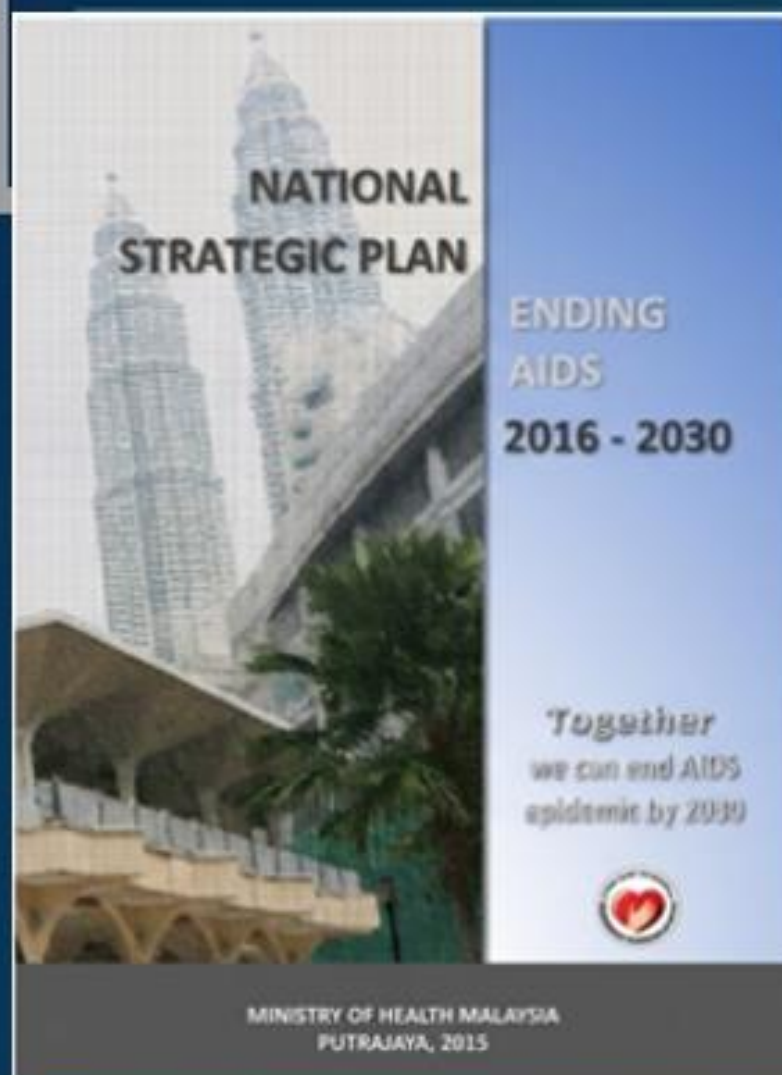


13 Jan 2005: The National Drug Action Council (chaired by the Deputy Prime Minister) approves a pilot for methadone substitution therapy.

12 April 2006: Cabinet Approval (chaired by the Prime Minister) greenlights the Needle and Syringe Exchange Program (NSEP).

Global Mandate: Sustainable Development Goals (SDG) – Ending AIDS

National Policy: National Strategic Plan on Ending AIDS (NSPEA 2016-2030)



Strategy 1: Screening and Treatment to End AIDS.

Strategy 2: Improving the Quality and Coverage of Prevention Programs among Key Populations.

2.1: Prevention of HIV Transmission through Injecting Drug Use.

2.2: Prevention of Sexual Transmission.

2.3: Elimination of Mother-to-Child Infection.

2.4: HIV Prevention among key population youth.

Strategy 3: Reduction of stigma and discrimination.

Strategy 4: Ensuring the Quality of Strategic Information and its Use by Policymakers and Planners through Monitoring, Evaluation, and Research.

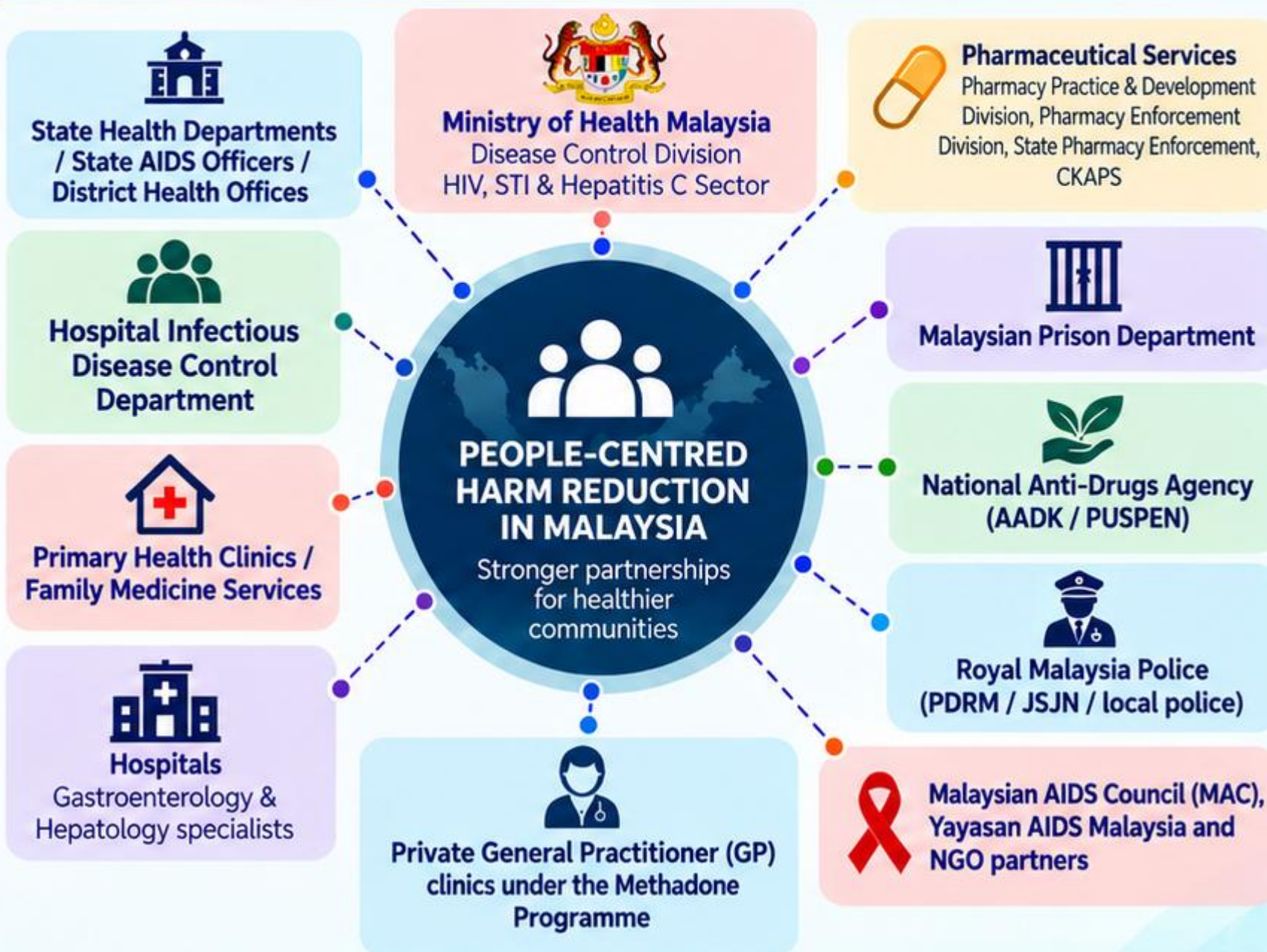
Inter-Agency Engagement in Malaysia's Harm Reduction Programme

A stronger, coordinated response for HIV prevention, Methadone treatment and Hepatitis C care

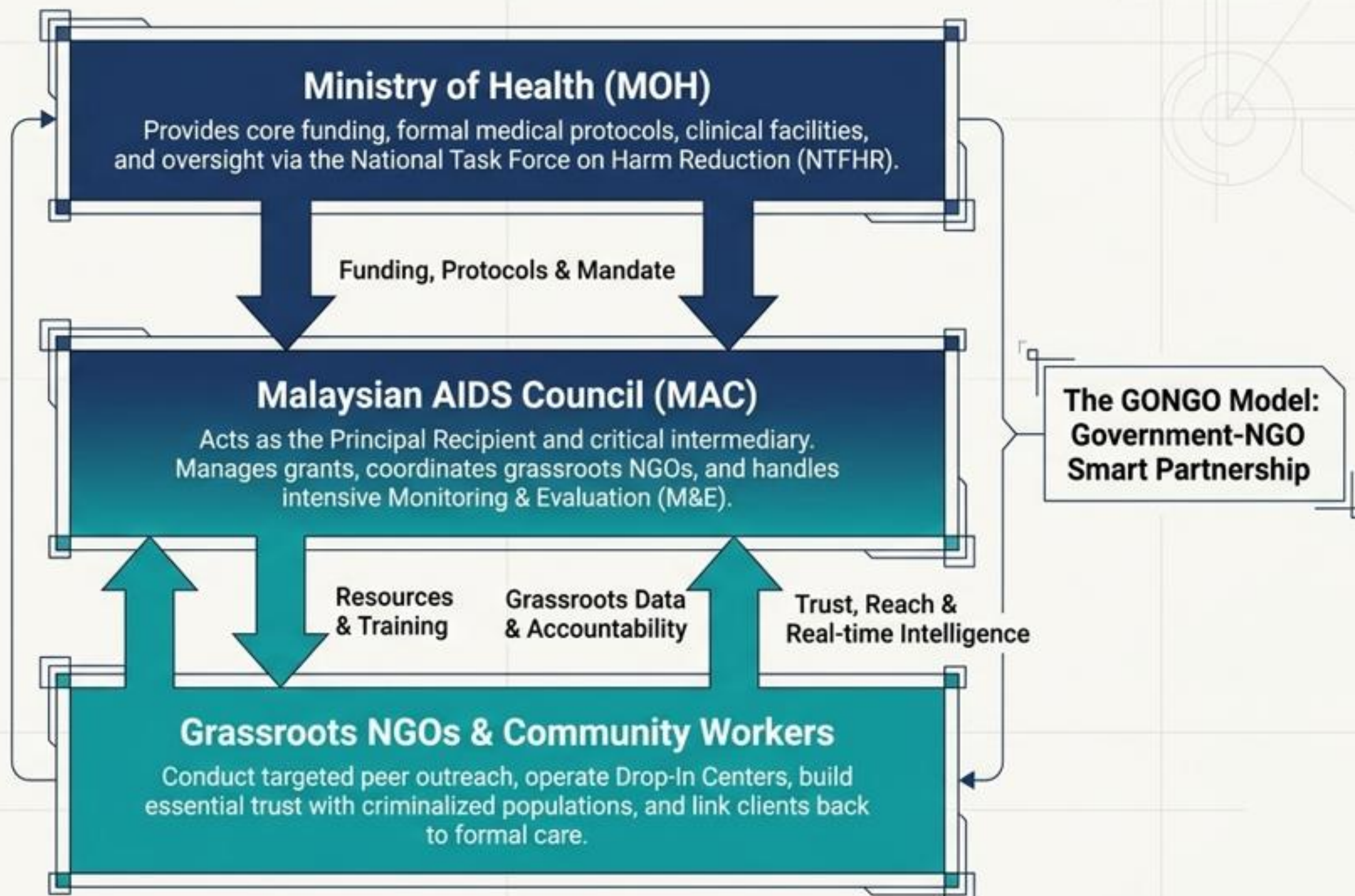
Why inter-agency engagement is important

- **1 Coordinated public health response**
Aligns prevention, treatment, rehabilitation and enforcement efforts for people who inject drugs (PWID) and other key populations.
- **2 Continuity of care**
Reduces treatment interruption for Methadone, HIV and Hepatitis C during arrest, detention, imprisonment, rehabilitation and release.
- **3 Safer outreach and referrals**
Supports safer outreach activities, early identification and notification to relevant authorities and smoother referral pathways.
- **4 Stronger governance and compliance**
Improves SOP implementation, audits, regulatory compliance, medicine supply and safe dispensing.
- **5 Better data and programme monitoring**
Strengthens reporting, surveillance and follow-up across facilities and agencies.

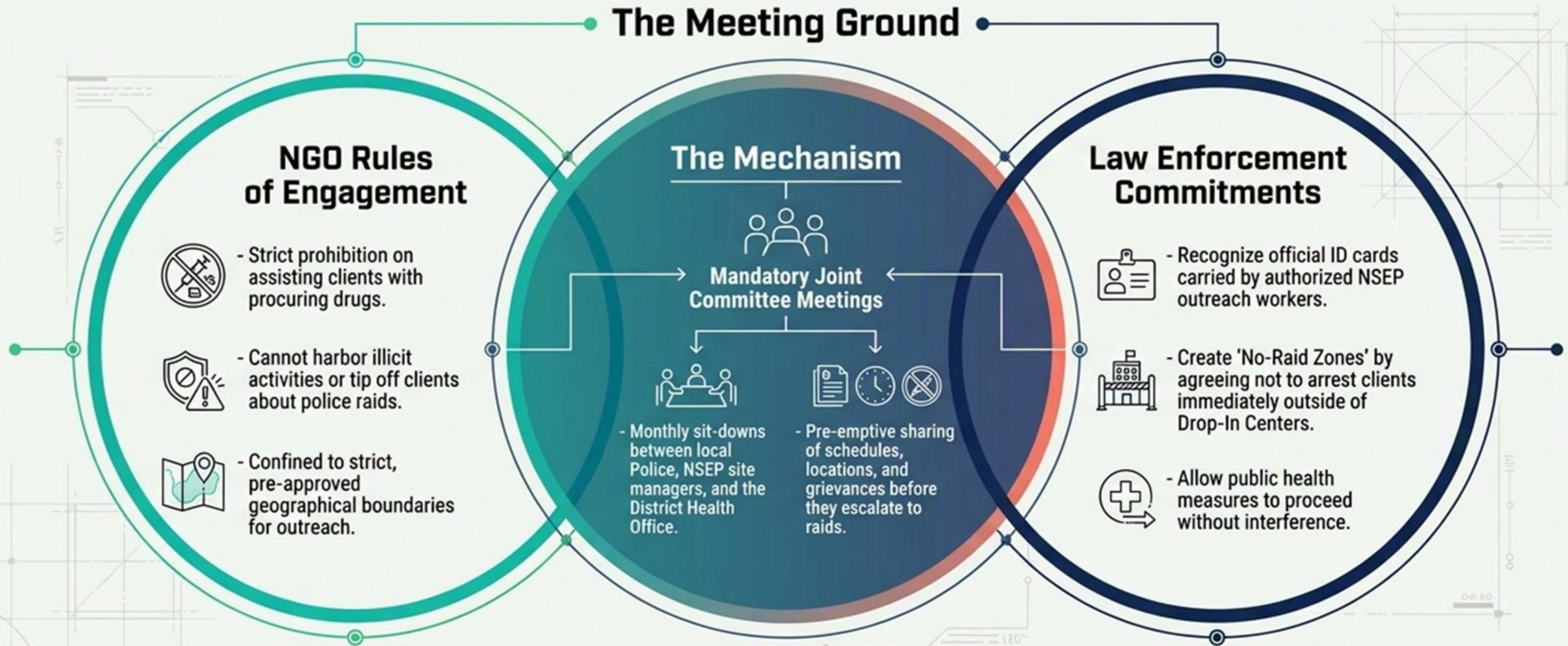
Key agencies involved



The Architecture of Collaboration: Building the GONGO Engine



De-escalation & Diplomacy: Operationalizing Police SOPs



Harm reduction in a criminalized context is fundamentally an exercise in multi-agency diplomacy.

National Guideline for Police on NSEP: The Formal Truce



Police Commitments



Do not target NSEP zones (Drop-In Centres) for arbitrary raids.



Recognize and respect official ID cards carried by authorized NGO outreach workers.



Allow safe passage for clients carrying used needles for exchange.



NGO Commitments



Never interfere with active police operations.



Zero tolerance for illicit drug dealing or facilitating crime.



Proactively share specific operational locations, outreach hours, and staff lists with local precinct chiefs.



The Challenge: Ensuring these rules cascade down from police headquarters to the actual officers on the street, requiring constant re-education and localized relationship building.

Operating in the Shadows: Built-in Systemic Resilience



Crisis:
Police raid a
Drop-In Centre?

- **Protocol:** Clients are informed upfront that NSEP cannot protect them from illegal acts committed on-site. NGO manager coordinates directly with precinct leadership.



Crisis:
A needle-stick
injury occurs?

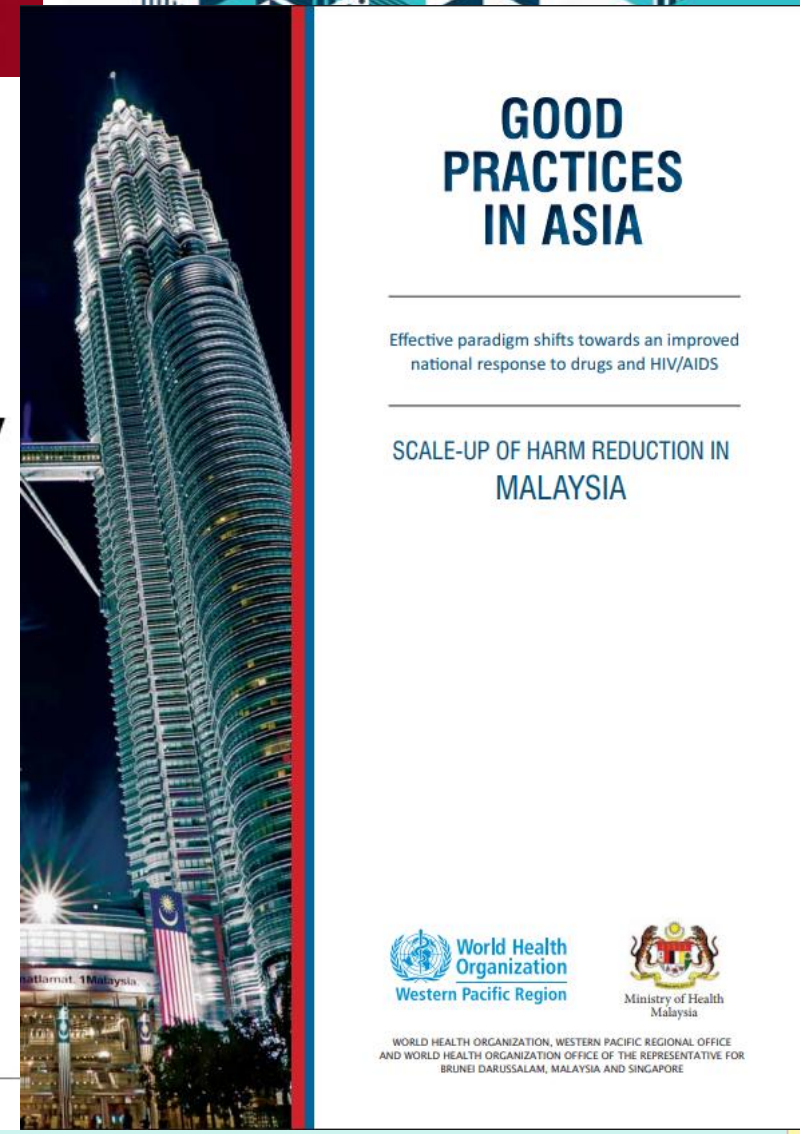
- **Protocol:** Flush area, do not force bleeding, immediately utilize established fast-track links to infectious disease clinics at local hospitals (e.g., HKL) for PEP.



Crisis:
Neighbors
complain about
DIC activity?

- **Protocol:** NGO managers are required to engage in preemptive community dialogues with local village chiefs (JKKK), religious leaders, and politicians to explain the public health cost-savings.





The Harm Reduction Evolution Matrix

	2006 Pilot Era	2024 Comprehensive Era
Primary Target	 People Who Inject Drugs (PWID) exclusively.	 All Key Populations (PWID, MSM, TG, FSW, WAR).
Setting	 Isolated NGO Drop-in Centers and street outreach. 	 Formalized Government Clinics ("Model KK") and sophisticated Digital Portals. 
Service Focus	 Needle & Syringe Exchange (NSEP) and Methadone (MMT). 	 Differentiated HIV Services, PrEP, HCV treatment, and Chemsex interventions.
Workforce	 Volunteer peer outreach workers.	 Certified, recognized Community Health Workers (PKK) operating within clinical settings.

From isolated intervention to mainstreamed primary care ecosystem.

Penetrating the Underground: Community-Based Testing (CBT)

Reaching criminalized populations (MSM, FSW, TG) navigating chemsex and profound legal vulnerability.

1. Trust & Infiltration

Using peer networks to enter closed chemsex environments where government clinics cannot legally or practically go.

2. The Safety Buffer

NGOs provide a crucial shield of anonymity, actively distributing safe sex kits and condoms without judgment.

3. Syndromic Interventions

Moving beyond HIV to physically screen for Hepatitis C and STIs (Modified Syndromic Approach) directly where the people are.

Formalizing the Informal:
Only NGO outreach workers **fully trained and accredited** by the **Ministry of Health** may conduct rapid medical screening in the field



The Reality Check

The Challenge: Managing the dual stigma of drug use and same-sex activity; requiring outreach workers to navigate intense legal and social landmines without compromising client safety.

The Comprehensive Harm Reduction Service Package (DHSKP)

Differentiated HIV Service Delivery for Key Populations

Medication-Assisted Therapy (MAT)

Specifically Methadone treatment.



NSEP

Needle and Syringe Exchange Programmes.



HIV Care

Screening, treatment, and comprehensive care.



STI Care

Screening, treatment, and care for sexually transmitted infections.



Hepatitis Care

Screening, treatment, and care.



Prevention

Condom distribution.



Education

Health education and promotion.



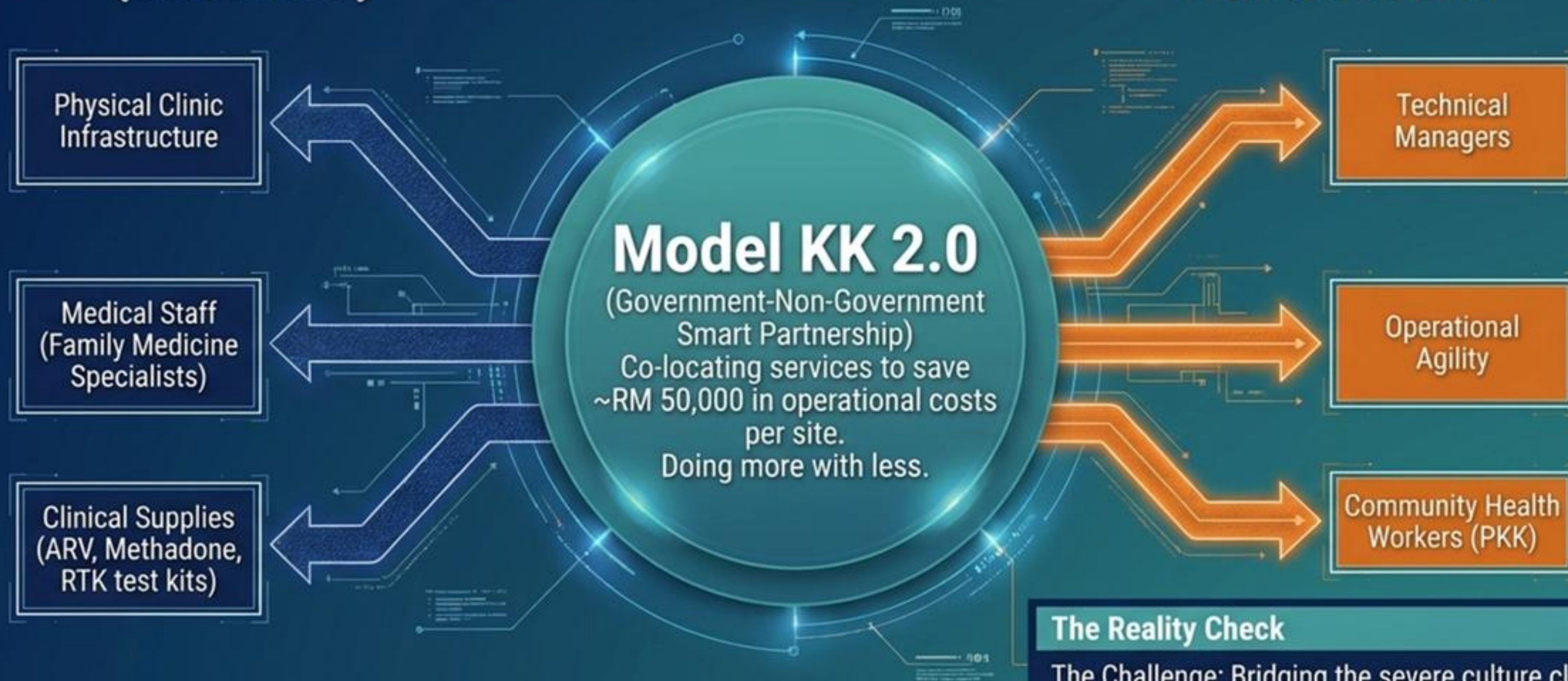
Psychosocial Support

Counseling and Referrals (e.g., mental health, welfare, employment).



Ministry of Health (Government)

Malaysian AIDS Council & NGOs



The Reality Check

The Challenge: Bridging the severe culture clash between the rigid, formal clinical setting of government healthcare and the informal, grassroots agility of NGO outreach workers, requiring active stigma reduction among medical staff.

Medication – Assisted Therapy via Methadone (MMT)

Program Mechanics

Utilizes methadone in syrup form as an Opiate Substitution Therapy (OST).

Historical Milestone

Pilot initiated in October 2005 across 10 facilities.

Implementation Network

- ✓ Government Hospitals
- ✓ Government Health Clinics (Klinik Kesihatan)
- ✓ Private Clinics
- ✓ Facilities under AADK (National Anti-Drug Agency)
- ✓ Prison Departments



Harm Reduction Program (NSEP & MMT)

OST - Opiate Substitution Therapy (Inception : Oct 2005)

Table 1 : Number of OST Treatment Center and Patient at Government Setting, Malaysia 2018 – June 2026									
	2018	2019	2020	2021	2022	2023	2024	2025	June 2026
Treatment centre	511	504	515	515	499	456	466	465	465
New Patient	2,426	2,084	1,681	971	1,338	1,314	1,100	1,120	570
Cumulative Patient	46,239	49,456	51,137	51,137	52,050	51,131	52,162	55,430	52,756
No. Active Patient	19,419	19,358	18,174	16,681	16,780	15,800	15,150	14,558	13,380
Source : Programmatic Data Program, MoH Malaysia									

Table 2 : Number of GP with OST* Services and Number of Patient, Malaysia 2018 – 2025								
	2018	2019	2020	2021	2022	2023	2024	2025
No. of GP	278	259	257	233	234	234	236	321
Cumulative Patient	53,276	59,374	51,223	55,524	68,096	92,410	114,772	44,274
Active Patient				38,866	51,412	50,826	35, 695	34,091
Note : * OST include using Methadone, Suboxone, Buprenorphine								
Source : mySPIKE, Pharmaceutical Service Pogram, MoH Malaysia								

The Needle and Syringe Exchange Program (NSEP)

- 3 June 2005** — Ministry of Health announces the implementation of the NSEP and condom distribution program to curb HIV infection among PWID.
- February 2006** — Pilot project officially implemented by NGOs.
- 2008** — NSEP initiated in government health clinics.

Financial & Operational Backbone

Financial assistance and backing provided by: MOH (KKM), The Global Fund (2011-2014), Malaysian AIDS Council (MAC), and Malaysian AIDS Foundation (MAF).



Scaling & Evolution: Launching the Controversial NSEP Pilot (2006)

Operational Mechanics



Damage Control Measures



Total Media Blackout



To prevent moral panic and public backlash from derailing the fragile pilot, strict information control was enforced.

- Staff were strictly forbidden from engaging the media.
- All external communication was routed exclusively through the National Task Force on Harm Reduction (NTFHR).
- Focus was kept on silent, rigorous execution to build undeniable epidemiological proof.

Harm Reduction Program (NSEP & MMT)

Needle & Syringe Exchange Program (inception : Feb 2006)

Table 3 : Needle Syringe Exchange Program (NSEP) , Malaysia 2018 – June 2026

	2018	2019	2020	2021	2022	2023	2024	2025	June 2026
Total Needle Distributed	1,349,604	1,174,881	863,744	780,841	652,701	233,555	201,674	274,078	88,976
Total Syringe Distributed	1,339,194	1,172,384	863,401	728,276	654,717	231,757	198,279	271,767	88,521

Source : M&E, Malaysia AIDS Council

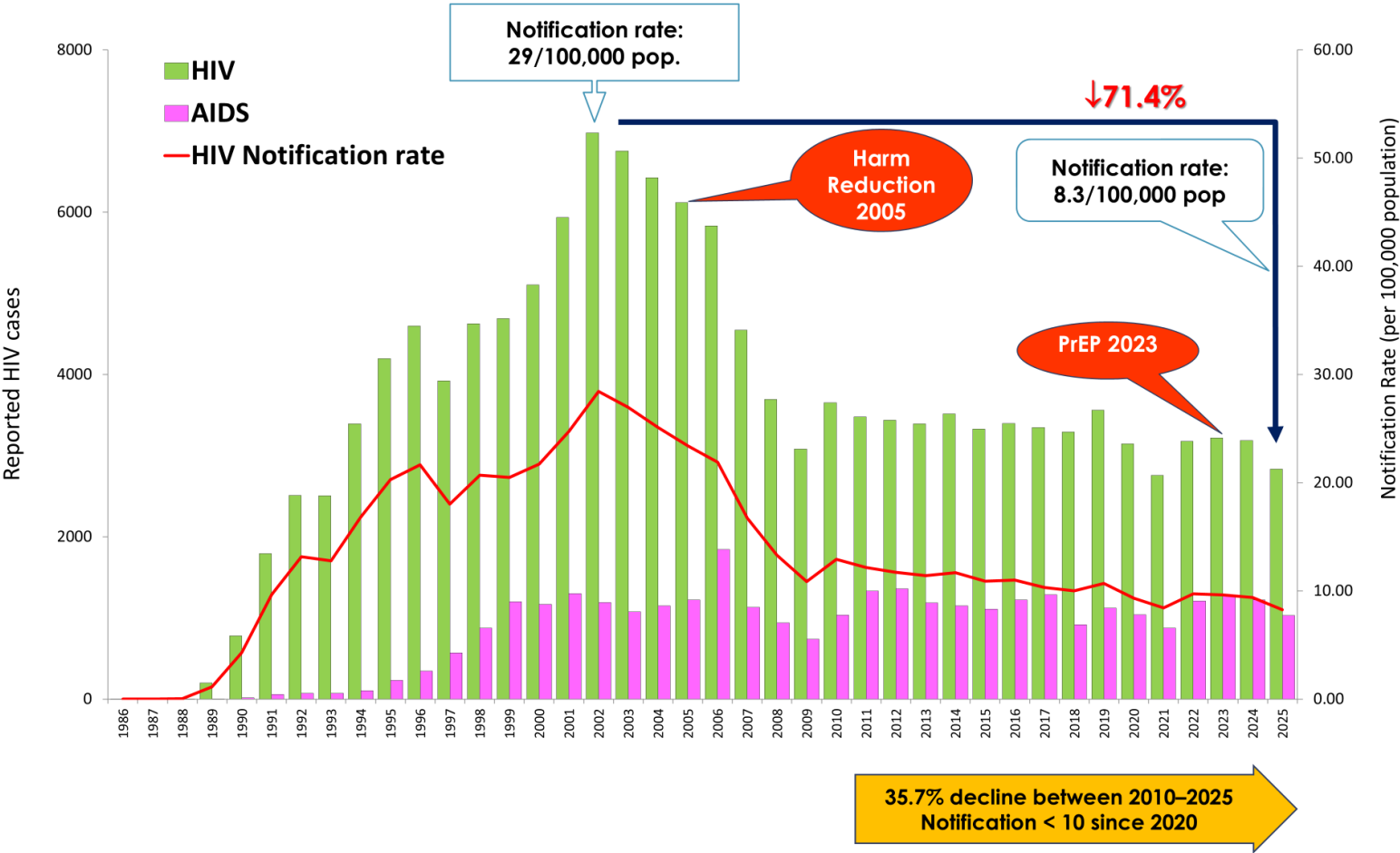
Proven Success Demands Continued Inter-Agency Commitment

Harm Reduction has been definitively proven successful in reducing HIV transmission through injection needle use and significantly reducing opiate dependency.

The continued survival and efficacy of this public health milestone rely entirely on the sustained commitment and cooperation of multiple cross-functional agencies.

The epidemiological shift from 61% IVDU transmission in 1990 down to just 2% in 2025 is the direct result of these targeted interventions.

Reported HIV and AIDS, Malaysia 1986 – 2025



Navigating Current Challenges in Harm Reduction Efficacy

1. Changing Drug Landscapes

An increase in users of Amphetamine-Type Stimulants (ATS) and polydrug users, complicating traditional opiate-focused therapies.

2. Resource Constraints

Ongoing human resource limitations for program delivery and management.

3. Social Stigma

Lingering negative public and patient perceptions regarding Methadone treatment.

4. Regulatory Hurdles

Constraints and friction from a legal and law enforcement perspective.



WORLD BANK



UNIVERSITY
OF MALAYA

Return on Investment and
Cost-Effectiveness of Harm
Reduction Programme in Malaysia

Herlianna Naning
Cliff Kerr
Adeeba Kamarulzaman
Sutayut Osomprasop
Maznah Dahlui
Chiu-Wan Ng
David P Wilson

BILIK RAWATAN
METHADONE



Harm Reduction is not about
condoning the behavior.
It is about preserving the human life.

The true success of Malaysia's architecture of trust is the systemic journey of reclassifying marginalized individuals—from treating them as criminals to treating them as patients deserving of care.

Injecting Drug Use and Needle/Syringe Exchange Programme

@ Insaf Murni

Mohd Afiq Bin Mohamad Khairi

Manager

Insaf Murni Association of Malaysia



1. Introduction to Insaf Murni

Organisation background and beginnings of harm reduction work

Insaf Murni Association of Malaysia

Established in 2006.

Head office: Kajang, Selangor.

The association brings together medical doctors, executive committee members and people with lived experience of drug use.

Harm Reduction Journey

- Methadone Maintenance Therapy (MMT) since 2005, delivered by medical practitioners.
- Needle & Syringe Exchange Programme (NSEP) since 2009, with peer involvement among people who use drugs.

Community-Based Approach

Our work is grounded in outreach, peer engagement, practical prevention, referral and support for people who use drugs and communities affected by HIV.

2. Objectives of the Association

- Promote research activities in the field of drug dependence and substance use.
- Provide treatment, medical care and psychosocial rehabilitation, while increasing awareness of the harms associated with drug use.
- Support individuals experiencing drug dependence and substance use problems.
- Promote activities related to HIV/AIDS prevention and response.
- Provide counselling and psychosocial support services for communities in need.
- Mobilise financial resources through economic activities, work programmes, research, employment opportunities and external contributions.



3. Three Approaches to Addressing Drug-Related Problems

Demand reduction, supply reduction and harm reduction address different parts of the problem

DEMAND REDUCTION

Reduce the desire or need to use drugs.

Examples:

- Education
- Rehabilitation
- Treatment and support

Works for people who are ready and able to change their drug use.

SUPPLY REDUCTION

Reduce the availability of drugs.

Examples:

- Disrupt drug production
- Destroy processing facilities
- Arrest traffickers

Even where supply is disrupted, drugs may remain available and patterns of use may change.

HARM REDUCTION

Reduce the health and social harms associated with drug use.

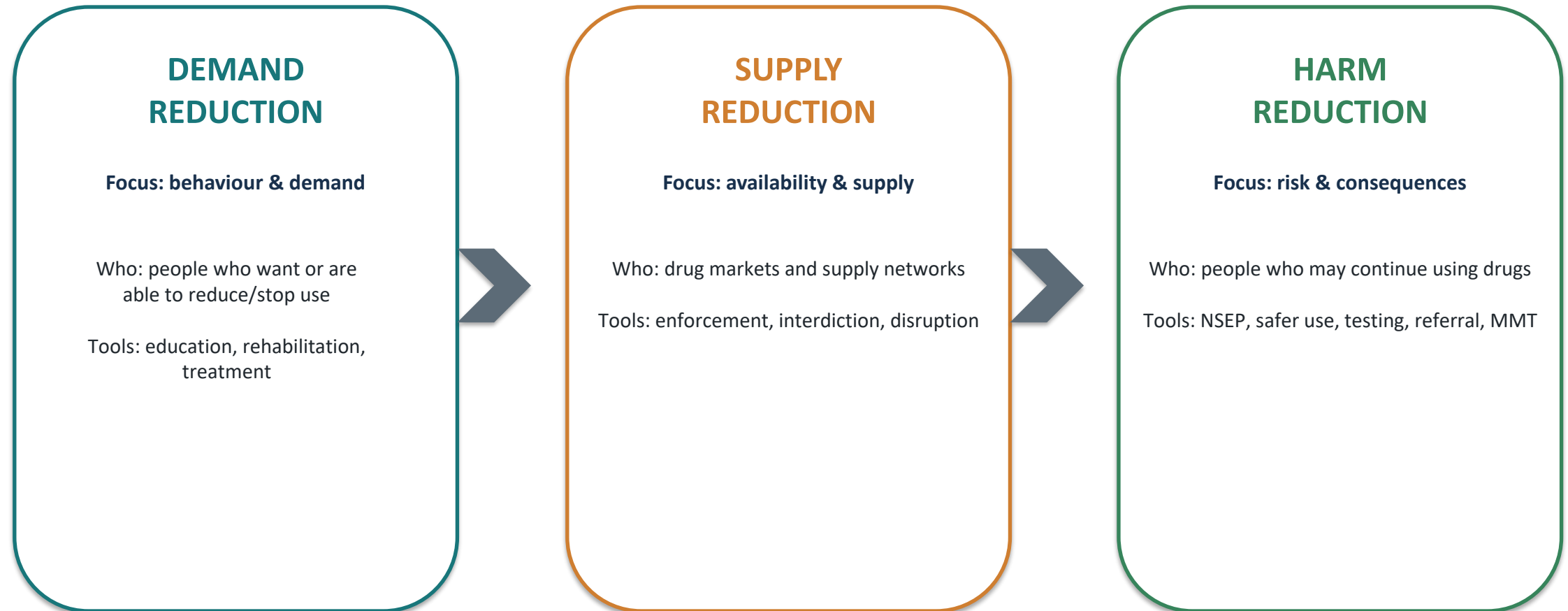
Examples:

- NSEP
- Safer injecting information
- HIV/STI testing and referral
- MMT

Meets people where they are, including those who continue to use drugs.

4. How the Three Approaches Differ

A complementary framework rather than mutually exclusive approaches



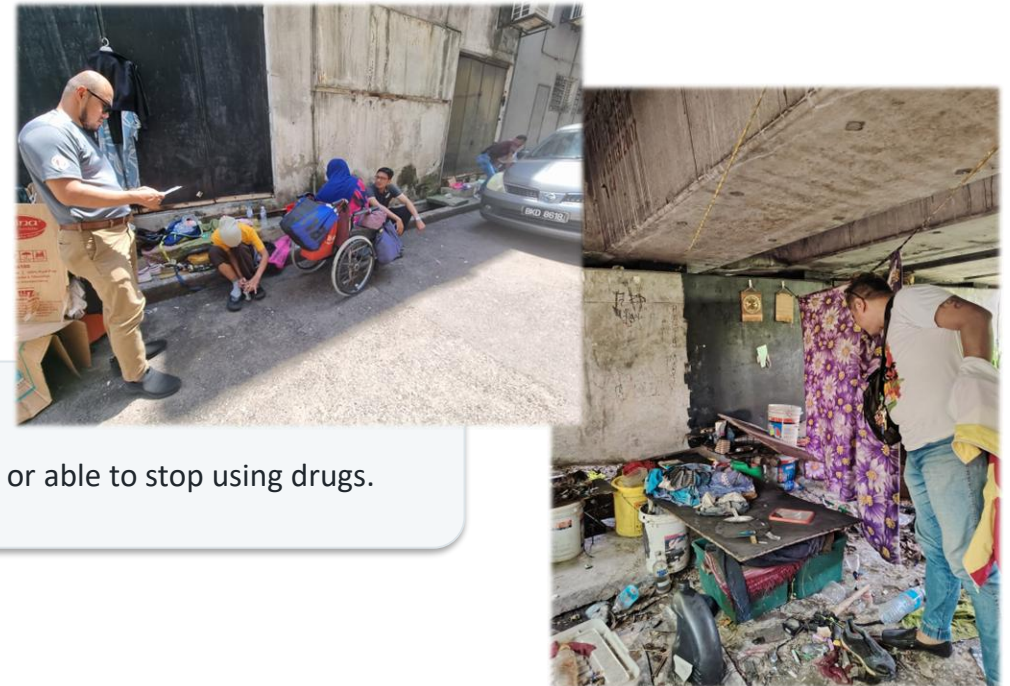
4. Harm Reduction in Malaysia

A practical, evidence-informed public health response

- Focuses on practical, evidence-based strategies to minimise the negative health and social consequences of high-risk behaviours, particularly substance use and infectious disease transmission.
- Malaysia's formal harm reduction journey began in the mid-2000s, in response to an escalating HIV epidemic strongly associated with people who inject drugs (PWID).
- The approach combines prevention, treatment access, community outreach, risk reduction, testing, referral and ongoing support.

Core principle

People who use drugs can be reached with health services even when they are not yet ready or able to stop using drugs.



5. Why Is Harm Reduction Needed?

Protecting individuals, partners, families and the wider community

- Earlier projections warned that, without effective prevention, Malaysia could face a substantial HIV burden by 2015.
- Harm reduction was developed as a targeted response to prevent HIV transmission among people who inject drugs and their sexual partners.
- Undiagnosed or untreated HIV among people who inject drugs can contribute to onward transmission to sexual partners and, in some circumstances, to children.
- Harm reduction creates opportunities for people who use drugs to access HIV testing, treatment, care, psychosocial support and other health services.
- Evidence from multiple settings has shown that harm reduction can reduce HIV transmission and is cost-effective, without evidence that it increases initiation of drug use.



6. Core Harm Reduction Programmes in Malaysia

Methadone Maintenance Therapy (MMT)

- Provides a daily oral medication as a substitute for illicit opioids such as heroin or morphine.
- Helps stabilise clients, reduce illicit opioid use and reduce risks associated with injecting.
- Can support reductions in HIV transmission risk, criminal activity and relapse.
- For eligible clients aged 18+, take-home doses of up to 3 days may be available under stable compliance, subject to programme requirements.

Needle & Syringe Exchange Programme (NSEP)

- Delivered through government and NGO outreach services.
- Provides sterile injecting equipment and facilitates safe disposal of used equipment.
- Reduces sharing of injecting equipment and associated blood-borne infection risks, including HIV and viral hepatitis.
- Creates a practical entry point to counselling, testing, treatment and referral services.

7. NSEP & People Who Inject Drugs (PWID) in Malaysia

NSEP as Harm Reduction

NSEP is a core component of harm reduction.

Its purpose is not to promote drug use, but to reduce the health consequences associated with injecting and equipment sharing.

Why Prevention Matters

There is no single intervention that works for every person who uses drugs.

For people who continue to inject, preventing HIV and other blood-borne infections is a critical public health measure.

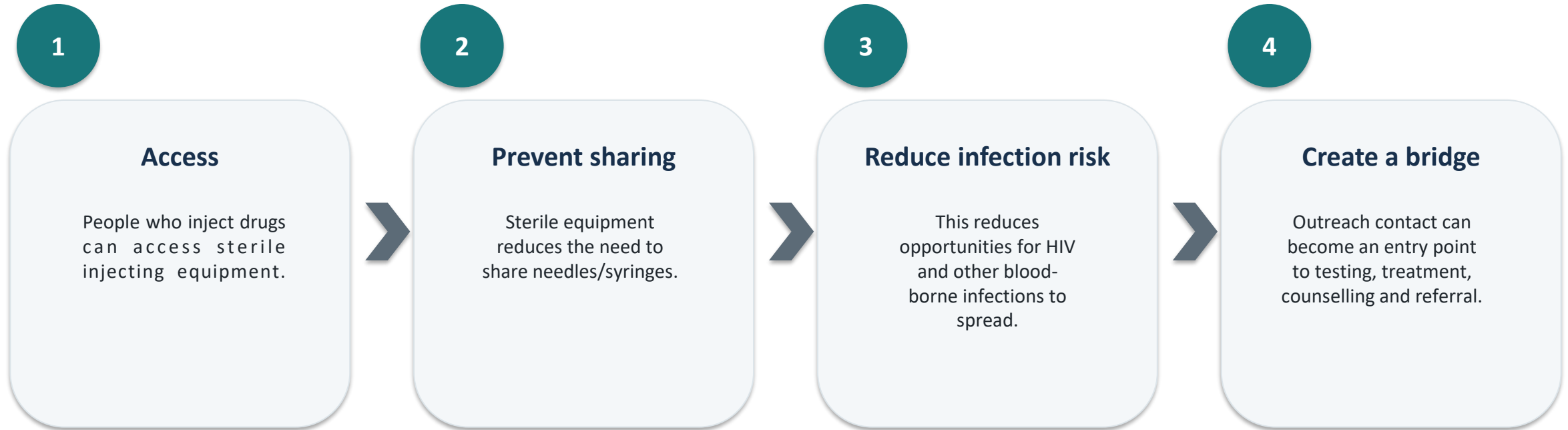
Historical HIV Context

74% of reported HIV infections in Malaysia from 1986–2004 were attributed to injecting drug use.

This historical burden was a major driver for the development of harm reduction responses.

8. What Is NSEP?

Needle & Syringe Exchange Programme



Key message

A person may not know when or how they acquired HIV — but reducing equipment sharing helps prevent onward transmission.

10. Comprehensive NSEP Components

NSEP works best as a package of prevention, education, screening and referral

PREVENTION

- Sterile injecting equipment / NSEP kits
- Condoms
- Safer injecting information
- Safe disposal of used equipment

EDUCATION & SUPPORT

- Safer injecting practices
- Information, Education & Communication (IEC)
- Counselling
- Peer support / outreach
- Overdose awareness and response

SCREENING & REFERRAL

- HIV / STI screening
- Counselling and testing services
- MMT referral
- Community-based treatment / rehabilitation (CBT)
- Other health and social services

NSEP ACTIVITIES

- ✓ Dialogue with stakeholders.(MoH, Police, Religious Body, NADA)
- ✓ Advocacy with Police Department. (meeting and dialogue)
- ✓ Training and development.(in house training and workshop)
- ✓ Mapping.
- ✓ Focus group meeting and discussion before HR program.
- ✓ Outreach – NSEP kits, condom, pamphlet, IEC etc.
- ✓ Information, knowledges and awareness.
- ✓ Referral
 - Methadone Program.
 - Screening – HIV, HCV, TB, STI etc.
 - Treatment
 - Welfare
 - Job placement
- ✓ Counseling
- ✓ Support Group/Peer Support.
- ✓ Community Based Testing (CBT) – HIV testing

NSEP ACTIVITIES

- Provision of sterile needles and syringes
- Safe disposal of used injecting equipment
- Provision of leaflets on health and drug issues
- Referral to drug, health and welfare agencies
 - includes drug and HIV treatment centers and Community Based Testing (CBT)
 - at client request

✓What's in NSEP kits?

- I. 4 needles sized 25G & 26G
- II. 4 syringes 1 ml
- III. 8 pcs alcohol swab
- IV. 1 cotton rolls
- V. 1 cooker

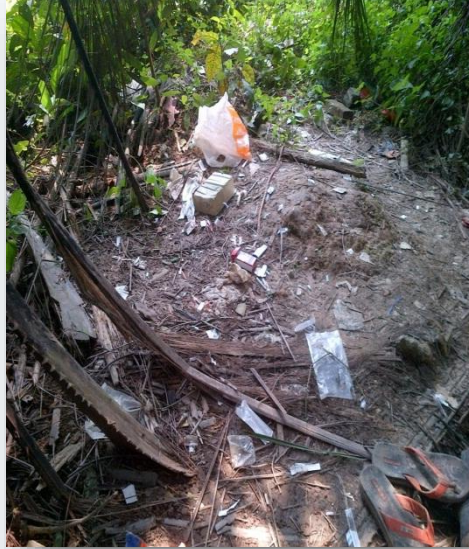
- ✓ Condom distributed separately based on demand.
- ✓ Sharp Bin – 3 different sizes sharp bin has been uses to collect used needles and syringes.



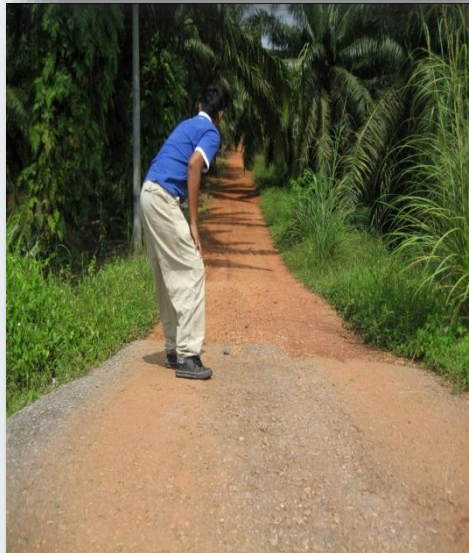
NSEP KITS



Mapping



- To gain information about :
 - Key population size
 - Demographic
 - Drug usage trend
 - Port
 - Peak Time
 - Risk



OUTREACH



Focus Group Discussion (FGD)



- ✓ To assess client needs & issues related to program.
- ✓ Program improvement.
- ✓ Develop planning and activities based on client needs.



11. Elements of Effective Prevention

Reaching people consistently, respectfully and with practical services

- Meaningful engagement and peer involvement — outreach is more effective when people with lived experience help build trust and access.
- Trust and accurate information — messages must be credible, understandable and non-judgemental.
- Improved access to sterile needles and injecting equipment — services must be available where and when people need them.
- Access to testing and treatment — prevention should connect clients to HIV/STI testing, treatment and care.
- Access to recovery and substitution treatment — including MMT and other appropriate psychosocial and rehabilitation services.

12. The Effectiveness of Education

Education is not a one-off activity — it is integrated into outreach

Behaviour Change

Education can help people who inject drugs recognise risk and consider changes towards safer behaviour.

Multiple Methods

Use different communication methods: brief conversations, IEC materials, demonstrations, counselling and peer-led messaging.

Trust & Local Language

Messages are more likely to be heard when they are repeated during outreach, delivered in familiar language and grounded in trust.

13. Importance of Screening & Referral

NSEP is a gateway to broader health, treatment and support services

HIV / STI Screening

- Knowing one's status is an early step in preventing HIV/STI transmission.
- Helps clients understand their health status and make informed decisions.
- Enables earlier access to appropriate treatment and care.
- Generates information that can support national planning, projections and strategic responses.

MMT Referral

- Reduces risks of HIV and blood-borne infections among PWID and their partners.
- Can reduce frequency of injecting and illicit opioid use.
- Supports relapse prevention and continuity of care.
- Can be integrated with HIV treatment, healthcare and psychosocial support.
- Supports physical and mental wellbeing and can reduce involvement in criminal activity.

Models of NSEP Operation

- Fixed Sites or “Shop Front” Model
 - NSEP will be conducted within Drop In Centers
 - stand-alone premises
 - provide NSEP and other services



- Outreach Services
 - a mix of strategies needed to effectively target IDUs
 - may be an out-of-hours service
 - increased access for IDUs



INSAF MURNI BRANCHES

Insaf Murni has two additional branches located in Pandamaran, Klang and Kuala Lumpur.

Both cabins are situated within Ministry of Health (MOH) health clinic facilities—specifically within the premises of Pandamaran Health Clinic (Heart To Heart Cabin) and Kuala Lumpur Health Clinic (Harapan Cabin).



KABIN HARAPAN PROJECT



PROJEK KABIN HEART TO HEART (H2H)

OUR ROLES



OUTREACH

- Harm Reduction Activities
- Identifying new cases and lost-to-follow-up cases
 - Assessing clients' needs
 - Conducting screening tests



REFERRAL

- Referral to treatment for new cases, follow-ups, or re-referrals
 - Ensuring adherence to treatment
 - Collaboration with health authorities



FOLLOW UP

- Ensuring a high level of treatment adherence
 - Conducting follow-ups and discussions for drop-out cases
 - Peer support groups

PHYSICAL OUTREACH

- Similar to the key population PWUD, there are still physical outreach efforts conducted for Transgender (TG) and Women at Risk (WAR) populations
- Outreach for PWUD is carried out in the field (known as “ports”) such as forests, bushes, landfill sites, cemeteries, and similar secluded areas
- TG and WAR are usually reached at brothels and alleyways
- Distribution of NSEP kits, prevention packages (condoms & lubricants), and IEC materials
- Delivering information, knowledge, and awareness on topics such as safe practices and behavior change
- Outreach Workers (PKK) also gather important data during outreach for purposes such as incident reporting, mapping, and other documentation needs



ONLINE OUTREACH

- Typically, MSM, TG, and WAR are the key populations using social and dating apps for outreach purposes
- Online outreach is conducted through social media platforms
- Information shared includes:
 - Awareness on HIV/AIDS and STIs
 - Education on sexual health, drug use, women’s issues, and general health
- Main medium to encourage key populations (KP) to undergo HIV and Syphilis screening



Chat, explore, meet and more...



COMMUNITY BASED TESTING (CBT)

All Insaf Murni staff have been accredited by the Ministry of Health (MOH) to conduct community-based screening tests. Outreach Workers (PKK) carry out screening tests in the field, during events, or at community gatherings.



SUPPORT GROUP



A peer support group is a group of individuals or organizations that provide emotional, psychosocial, and practical support to those in recovery from drug addiction.



Peer support is important because it provides emotional support, boosts motivation, helps prevent relapse, teaches healthy coping skills, and builds positive social connections. All of these factors increase the chances of success in the recovery process and reduce the risk of returning to drug use.

AADK TESTING



- Collaboration with AADK for Community-Based Testing (CBT)
- Collaboration with AADK to conduct community-based testing (CBT) at PUSPEN, community halls, district AADK branches, and other locations
- All Outreach Workers (PKK) accredited with CBT certification are involved in this monthly program
- The program also includes peer support groups and counseling services
- District AADK offices collaborating with Insaf Murni (IM) include:
 - AADK Sepang
 - AADK Hulu Langat
 - AADK Klang
 - AADK Petaling
 - AADK Cheras
 - AADK Sentul
 - AADK Gombak
 - AADK Kuala Selangor



PROJEK KASIH



PROJEK KASIH



Warga emas / oku
Anda memerlukan wheelchair dan
pembantu sukarela?
Jika ya, kami sedia membantu anda.
Sila ke kaunter wheelchair

Dengan kerjasama
Klinik Kesihatan Pandamaran &
Persatuan Insaf Murni Malaysia



This project is implemented at
KK Pandamaran through the
collaborative efforts of
various stakeholders,
including the health sector,
NGOs, clients, private sector,
individuals, and the local
community committee.

PROJEK KASIH

- Psychosocial Project for MMT Clients and PLHIV at KK Pandamaran
- Psychosocial activities are conducted for MMT clients and PLHIV at Pandamaran Health Clinic (KK Pandamaran)
- Clients assist persons with disabilities (OKU) and elderly patients by pushing their wheelchairs to access treatment at the clinic
- Helps reduce stigma and discrimination towards the community
- Fosters closer connection between clients and the wider society



PSYCHOSOCIAL PROGRAM – SEPANG DISTRICT

This program involves the health authorities, Insaf Murni, and methadone and STI clients.

The program is in the form of a teambuilding activity, attended by 60 participants.

PSYCHOSOCIAL PROGRAM – SEPANG DISTRICT



IMPACT

- Ensuring there is no stigma and discrimination
- Creating a healthy environment physically and emotionally
- Supporting treatment retention



COLLABORATION WITH HULU
LANGAT DISTRICT HEALTH DEPT
& UKM.



Puisidra



Life Art



Sharing

- Reducing Stigma : Eliminating stigma against people who use drugs by emphasizing their right to access treatment and support, rather than being punished or imprisoned.
- Improving Access to Treatment : Ensuring that people who use drugs have access to effective treatment and support services, instead of facing imprisonment, which does not address the root causes of addiction.
- Policy Reform : Advocating for changes in global drug policies by promoting a public health approach rather than a criminal justice approach.



WORLD AIDS DAY

The annual celebration on December 1st marks the culmination of all the work that has been carried out throughout the year.

Each year, Insaf Murni seizes the opportunity to successfully organize this event in collaboration with various partners.



Persatuan INSAF MURNI Malaysia

PERSATUAN INSAF MURNI MALAYSIA

ABOUT US

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 Phone: +603-87398250
 Email: insaf.murni@nsep.org.my

No 8-1 Jalan Ria 3,
 Kawasan Perindustrian Ria,
 Jalan Semenyih, 43000 Kajang, Selangor
 0901-06-SEL

Persatuan INSAF MURNI Malaysia

PERSATUAN INSAF MURNI MALAYSIA

TEMUSERU
 NEEDLE & SYRINGE EXCHANGE PROGRAM (NSEP)
 UJIAN SARINGAN HIV

RUJUKAN RAWATAN (HMT, HIV, HEP C, STD)
 BIMBINGAN DAN KAUNSELING
 KUMPULAN SOKONG BANTU

PENDIDIKAN DAN PENCEGAHAN JANGKITAN MELALUI HUBUNGAN SEKSUAL
 PEMBIMBING RAKAN SEBAYA

U = U
 Undetectable Means Untransmittable

Facebook: persatuan insaf murni malaysia
 Phone: +603-87398250
 Email: insaf.murni@nsep.org.my

FREE HIV & SYPHILIS TEST

Wednesday, 26th July 2023, 5pm - 11pm
 Empire Damansara Studio 26, Petaling Jaya
 Persatuan insaf murni malaysia

Ujian saringan dan Rawatan Hepatitis C

Tahukah anda?
 Lebih kurang **500,000** orang dijangkiti Hepatitis C di Malaysia tetapi tidak mengetahui status.

10X ganda mudah berjangkit berbanding HIV

Hep C boleh dirawat dan disembuhkan

Poster ini merupakan kolaborasi di antara Fakulti Farmasi, Tentera dan Animal & Persatuan Insaf Murni Malaysia (PIMM)

TREATMENT AS PREVENTION

HAART treatment can prevent the potential of new infections through the concept of

U = U
 Undetectable Untransmittable

Poster ini merupakan kolaborasi di antara Fakulti Farmasi, Tentera dan Animal & Persatuan Insaf Murni Malaysia (PIMM)

ADDICTION

PERSATUAN INSAF MURNI MALAYSIA BERKOLABORASI DENGAN BERJASAMA POLIKLINIK KHAJAZ (KAJANG), MENJALANKAN PERKHIDMATAN:

RAWATAN KETAGIHAN DADAH
 KAUNSELING
 SOKONG BANTU (SUPPORT GROUP)

Poster ini merupakan kolaborasi di antara Fakulti Farmasi, Tentera dan Animal & Persatuan Insaf Murni Malaysia (PIMM)

PENGEHAHAN KEMUDARATAN

Sebelum : Berkongsi jarum suntikan
 Selepas : Tidak kongsi jarum suntikan

Sebelum : Penggunaan darah suntikan
 Selepas : Rawatan Methadone

Sebelum : Tidak menggunakan kondom
 Selepas : Penggunaan kondom

Poster ini merupakan kolaborasi di antara Fakulti Farmasi, Tentera dan Animal & Persatuan Insaf Murni Malaysia (PIMM)

Borak-borak kosong! PWUD dan Keluarga

PWUD (People Who Use Drugs)

24 Jun 2023
 8.30 - 9.30 malam
 Platform @INSAFMURNI

Q&A Moderator: DYTA FLY POK Insaf Murni
 ABILAN Syarikat Syarikat UN
 SYAHIDATI POK Insaf Murni

Apa realiti kat luar sana?
 Impak dadah kepada keluarga?
 Apa polisi yang ada untuk support PWUD dan keluarga?

BORAK-BORAK KOSONG 2.0

PWUD DULU & SEKARANG

Moderator: Titi Team INSPIRE, Mula Team INSPIRE

18 Ogos 2023
 Facebook: Persatuan Insaf Murni Malaysia
 0930min - 1100min

Sertai Kami!

Bagaimanakah perkhidmatan rawatan berbeza dulu dan sekarang?
 Apa beza scene dadah dulu dan sekarang?

THEATER INTERNAL CASTING

Jika anda mempunyai bakat atau ingin mencuba pengalaman baru dalam bidang pentas

SERTAI KAMI

18 OGOS 2023, 11 pagi - 5 petang
 PEJABAT INSAF MURNI KAJANG
 Syarikat 010-8015422
 Dr Khairul 016-5624408

Sekatan: Bebas Tense/Strip. Akan diberikan pada hari tersebut.
 UNTUK MAKI UMAT LANJUT, HUBUNGI

08.30
 Thursday, 07 September 2023

THURSDAY TRAINING

EXPLORE TRAINING CENTRE, KAJANG

- Hep C training for PKK knowledge.
- Ethics training by Masters of Health Research Ethics (MHRE), UM.
- Food & Tea
- Interactive session
- Bonding session

insafmurni | insafmurni | insafmurni | insafmurni

POSTER



2022

ANUGERAH RIBEN MERAH KEBANGSAAN

2023





THANKS FOR
LISTENING

Comred, PT Foundation



What is Chemsex

CHEM + SEX

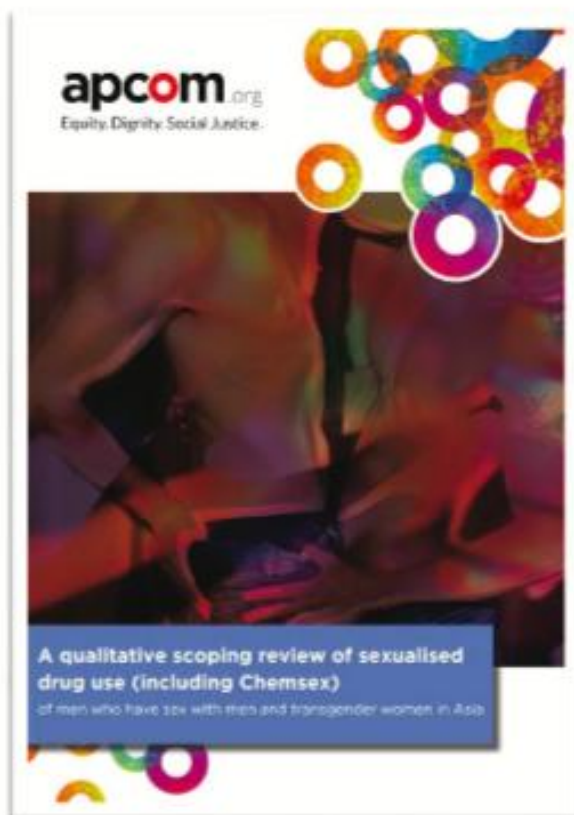
- Methamphetamine
- Gamma-hydroxybutyrate (GHB/GBL)
- Mephedrone
- MDMA/Ecstasy
- Alkyl nitrites
- Sildenafil/Tadalafil

Sexual Intercourse

- MSM
- Transgender
- Sex worker

Intentional use of substances before or during sexual intercourse (*Giorgetti et al., 2017*)

Why People Engage In Chemsex?



Why do MSM and TGW in Asia engage in sexualized drug use?

Enhanced and extended sexual gratification and pleasure

Freedom and confidence to explore sexual fantasies

Pride and empowerment

Beauty and social power

Social and sexual lubricant

Community identity and culture

Coping mechanism

Newland, J., and A. Kelly-Hanku. "A qualitative scoping review of sexualised drug use (including Chemsex) of men who have sex with men and transgender women in Asia." Retrieved from <https://www.aidsdatahub.org/sites/default/files/resource/apcom-qualitative-scoping-review-sexualised-drug-use-including-chemsex-2021.pdf> (2021).

Chemsex Is Already Present In Malaysia

- The intersection of sexualized drug use (SDU) or chemsex, key populations, and HIV presents a critical public health challenge in Malaysia.
 - Prevalence around 7 to 13% past 6 months among MSM (Lim SH et al. 2015; Lim SH et al. 2017; Maviglia F et al. 2023) and 32.3% for ATS use among FSW for past 30 days (Pederson CJ et al. 2022)
 - Individuals engaging in chemsex are at higher risk of HIV acquisition and face significant barriers to accessing prevention, care, and treatment services.
 - Currently, services for those engaging in SDU/chemsex in Malaysia remain limited
- Community workers are the main key players in Malaysian response in ending HIV

Chemsex Concerns

Sexual health

- HIV
- Viral hepatitis
- STIs
- Sexual pleasures and sober sex
- Unconsented sex

Mental health

- Paranoia, psychosis, hallucination
- Trauma
- Anxiety
- Depression
- Suicidal
- ADHD

Other physical health

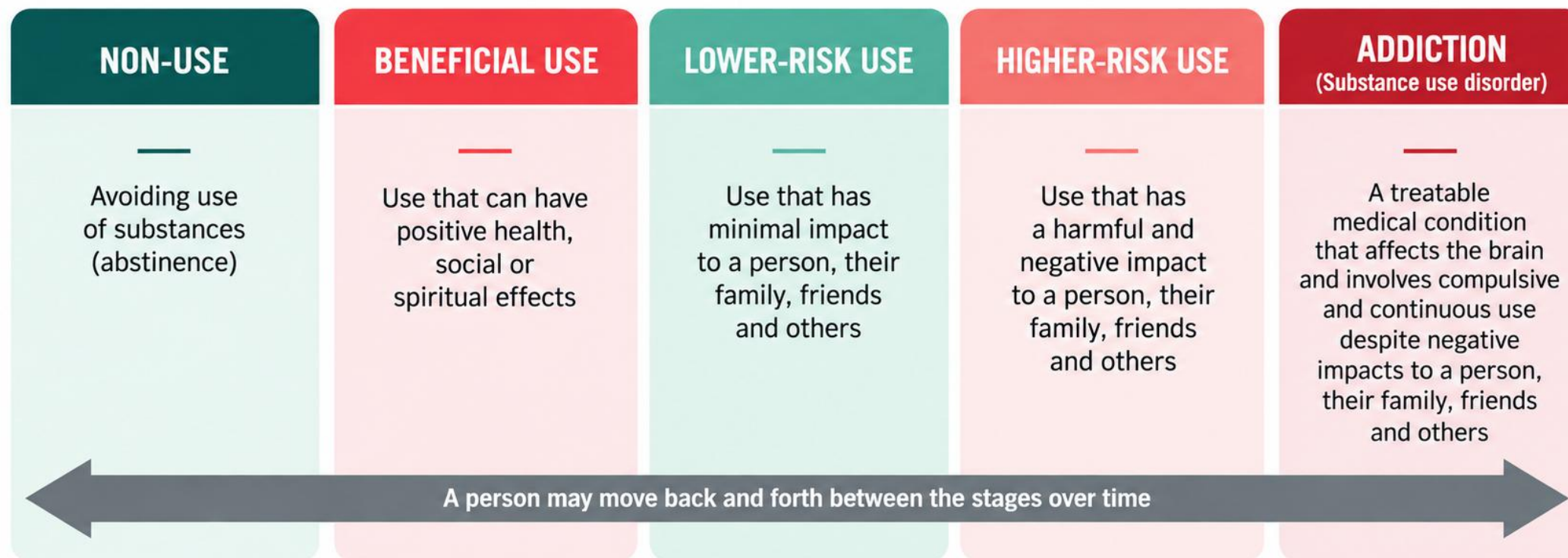
- Injection related complications
- Compliance to medications and drug-drug interaction
- Drug related harm e.g. overdose
- Physical harms
- Cardiovascular
- Malnutrition

Psychosocial, spiritual health

- Relationship
- Financial
- Work/ study performance
- Lost control

Substance Use Spectrum

People use substances, such as controlled and illegal drugs, cannabis, tobacco/nicotine and alcohol for different reasons, including medical purposes; religious or ceremonial purposes; personal enjoyment; or to cope with stress, trauma or pain. Substance use is different for everyone and can be viewed on a spectrum with varying stages of benefits and harms.



What We Get To Know

People engaging in chemsex may face multiple, overlapping needs

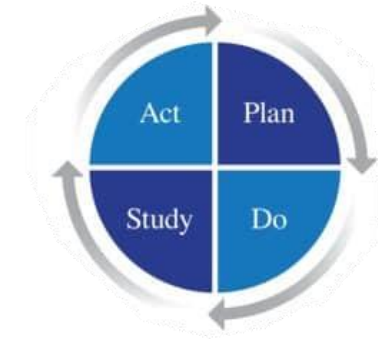
- **HIV/STIs**
 - **Substance use**
 - **Mental health**
 - **Sexual health**
 - **Physical wellbeing**
 - **Access to care**
-
- A 2026 study similarly identifies stigma, criminalisation and limited service availability as barriers to accessing harm-reduction services (Gautam et. al, 2026)
 - Yet tailored services for people engaging in chemsex remain limited in Malaysia.
 - Are our existing services designed to respond to all of these needs?

Comred (Community-led Harm Reduction)

- Globally, harm-reduction interventions, such as needle and syringe programs, peer-led outreach, and overdose prevention education, have proven effective in reducing adverse outcomes among people who use drugs, including MSM who engage in chemsex
- However, such behavioral interventions remain limited or inaccessible in Malaysia
- Comred reach and deliver tailored, confidential, and person-centered support for chemsex-related harm reduction, an area not yet explored in Malaysia

Comred (cont)

Implementation project



Objectives

- to develop and implement an integrated community-led harm reduction and mental health services, complementary program, tailored to the local need in Indonesia SDU/chemsex
- Capacity building and knowledge sharing



COMRED implementation



HIV/STI

- Free HIV & STI screening
- Linkage to HIV PrEP and treatment
- Peer-facilitator support:
 - Adherence to ART and PrEP
 - Monitor outcomes: PrEP uptake, HIV/STI status
- In house referral to physician

Mental health

- Screening with PHQ-4
- Further evaluation with PHQ-9 /GAD if needed
- In-house psychologist referral or referral to specialist care
- Peer-facilitator support

Chemsex

- ASSIST
- Community-led intervention (Peer-facilitator)
 - Setting action plan
 - Brief intervention: motivational interview, cognitive behavioural therapy
 - WHO self-help toolkits/ SMART recovery
- Support group
- Paraphernalia kits

Peer Facilitators and Training

PEOPLE
COMMUNITIES
BRIGHTER TOMORROWS

Who?

- Community workers or volunteer with lived or past-experience with chemsex.
- provide essential support, guidance, and advocacy

- No proper training; mainly from self-experience and friends
- Training needed: Chemsex and substances, screening and harm reduction, support during crisis, basic counselling skills, professionalism and **setting boundaries**
- Support needed: **Continuous supervision** and mentorship, **access for mental health support** for PFs

- Understanding substance use, chemsex and addiction, recovery and treatment, mental health, psychological first aid, HIV, viral hepatitis and STIs, Implementation considerations (tools, care plan, motivational interviewing), legal workshop etc
- 2 weekly group supervision, individual supervision, mental health support

- Feedback on training and compile into formal training modules
- Collaboration for scalability



Outreach

Online

Reach
>1000
individual

Offline

Awareness Activities

SUPPORTED BY VIIV POSITIVE ACTION


PT FOUNDATION
"TAHAPAN 77"
COMMUNITY-LED HARM REDUCTION

DEMYSTIFYING THE LANGUAGE OF CHEMSEX:

Documenting Slang to Bridge Communication Gaps in Harm Reduction

Justin Tien Wei Long^{1,2}, Chew Han Hoong^{1,2,10}, Mohammad Shahril Bin Zaini^{1,2}, Saiful Haszrul Bin Hakim^{1,2}, Tong Ming Yun^{1,2,4}, Muhammad Nasyirudin Bin Mohamad^{1,2,5}, Mohamad Zahiran Bin Ahmad^{1,2,6}, Kishen Kunalan^{1,2,7}, Tai Fook Then^{1,2,11}, Ashwin Thind^{1,2,5}, Szalizi Bin Basri^{1,2,3,4}

Affiliations

¹PT Foundation, ²Project COMRED, ³Infectious Disease Unit, Department of Medicine, Universiti Malaya Medical Centre, ⁴Centre of Excellence for Research in Infectious Diseases and AIDS (CERIA), ⁵Department of Social and Preventive Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia, ⁶Jejaka, ⁷Queer Malaysian Indians, ⁸Kuala Lumpur AIDS Support Services Society (KLASS), ⁹Persatuan Insaf Murni Malaysia, ¹⁰Positive Living ¹¹Community Health Care Clinic (CHCC)

BACKGROUND

- Chemsex communities form distinct subcultures with unique practices.
- Slang, abbreviations, and emojis are widely used to describe substances and experiences.
- These coded terms strengthen in-group communication and discretion.
- However, they create barriers for healthcare and outreach workers to interpret accurately.
- In Malaysia, such language has never been systematically documented.
- This gap limits culturally responsive and effective harm reduction efforts.

METHODS

- Peer-to-peer approach engaging nine (9) chemsex participants from diverse subcultures.
- Participants shared commonly used slang, abbreviations, and emojis related to substances and practices.
- Responses were compiled into a preliminary glossary to guide the development of culturally competent information, education and communication (IEC) materials under Project COMRED.

CONCLUSION

- Chemsex slang is fluid, multilingual, and locally adapted.
- Understanding this language improves communication and harm reduction practice.
- Continuous local updates and training are vital to strengthen community engagement.

Contact Us

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SCAN
HERE

RESULTS

Methamphetamine-related Terms

Words: Ice, Tina, Batu, Syabu, Crystal, Wawa, Bepong, Ice-Cream, Cream, Diamond, Snow, Kayu, Puff

Emojis: ❄️, 💎, 🌨️, 🪄, 🧊, 🍷, 🍹, 🍸, 🍺, 🍻, 🍾, 🍷, 🍹, 🍸, 🍺, 🍻, 🍾

Notes: Often associated with "Chemfun", "HiFun", "Fly", "Cloud", "PnP" and "party".

MDMA / Ecstasy-related Terms

Words: E, Ecstasy, MDMA, Molly, Candy, Pill Kuda, Pop, Gula

Emojis: 🍬, 🍭, 🍡, 🍷, 🍹, 🍸, 🍺, 🍻, 🍾

Notes: Commonly associated with music or "party" settings (PnP, PP, Hompar, ES)

GHB/GBL-related Terms

Words: G, G-water, Gina, Geebs, BDO, Liquid E, Liquid Ecstasy, Liquid X, Liquid Gold, Juice

Notes: G, G-water and Gina are the commonly used terms

Localized Terms

Words: Yaba (amphetamine tablet), Smack (heroin), Soap (polydrug), Gula (coded word for drugs in general).

Practice and Contextual Terms

Words: CF, ES, ChemFun, Chill, HiFun, ChillFun, PnP (Party and Play), PP (Private Party), SF (Slam Fun), Hompar (Home Party), Booty Bump (rectal), SI ⚡ (injecting), Puff (smoking), Cloud, Fly

Emojis: 🚬 (high/flying), 🧠 (cloudy/head high), ⚡ (injecting).

Meaning: Refers to chemsex settings, methods of administration, and experience levels

Emoji-Based Codes

Display as a small infographic cluster:

❄️ 💎 🌨️ 🪄 🧊 🍷 🍹 🍸 🍺 🍻 🍾

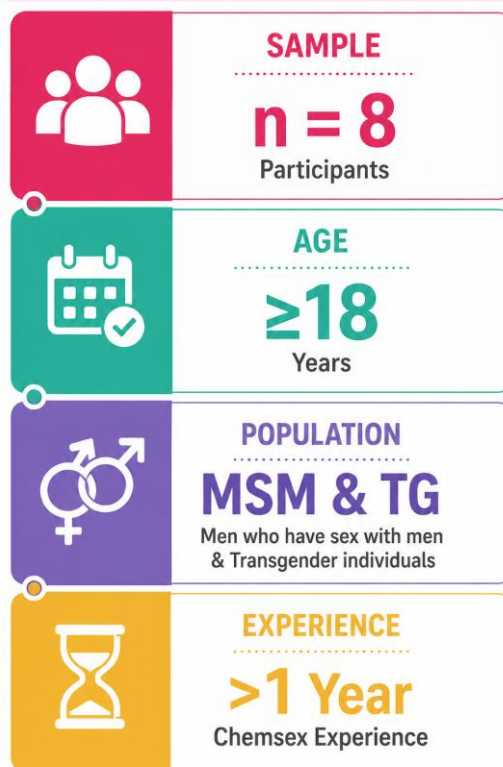
Represent discreet shorthand for drugs or chemsex activities used on dating apps to avoid detection or censorship.

Psychoeducation and support group

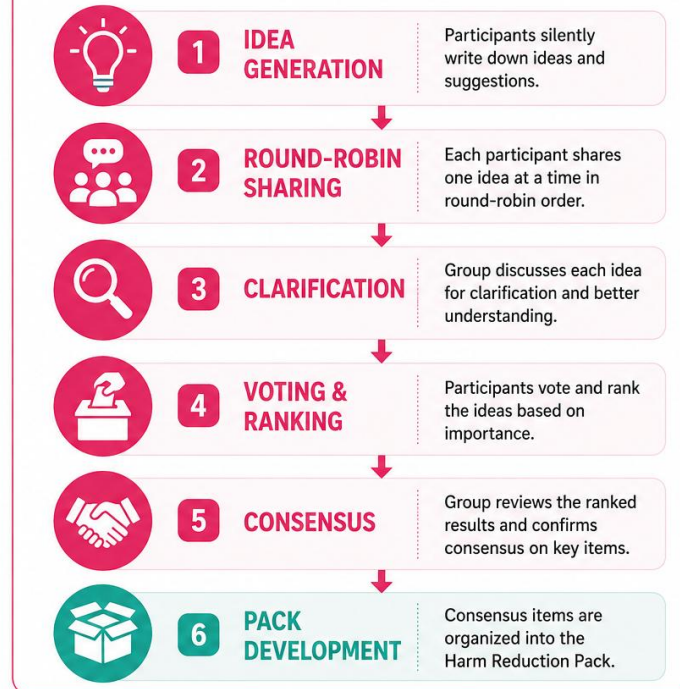
- **SMART Recovery** framework
- delivered **bilingually** (English and Bahasa Melayu) with standardized handouts.
- Participation increased from one to an average of 5–7 individuals per session within six months.
- **Lessons learned**
 - Structured frameworks improve focus and safety.
 - Peer-led facilitation with co-facilitators enhances emotional support.
 - Flexible attendance reduces shame and supports re-engagement.
 - Minimal cultural tailoring (bilingual delivery, contextual examples) maintains fidelity while increasing accessibility.

Harm Reduction Pack

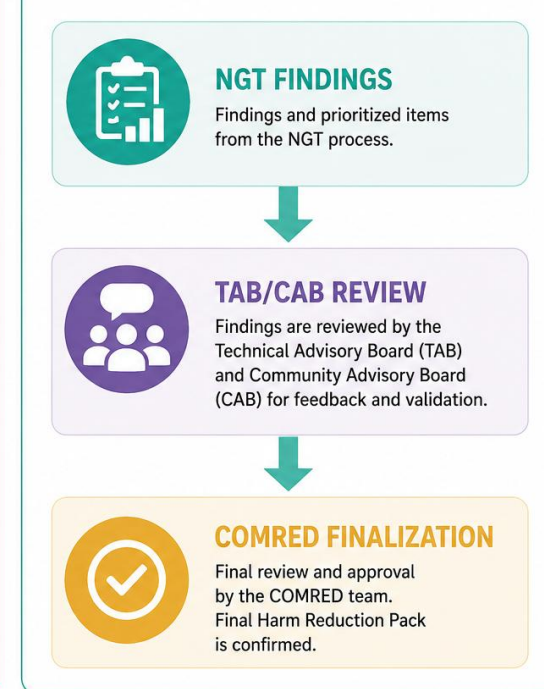
PARTICIPANT CHARACTERISTICS



NGT PROCESS



ADVISORY REVIEW



The NGT ensured meaningful participation of MSM and transgender individuals with lived experience of chemsex, resulting in a culturally appropriate and community-informed Harm Reduction Pack.

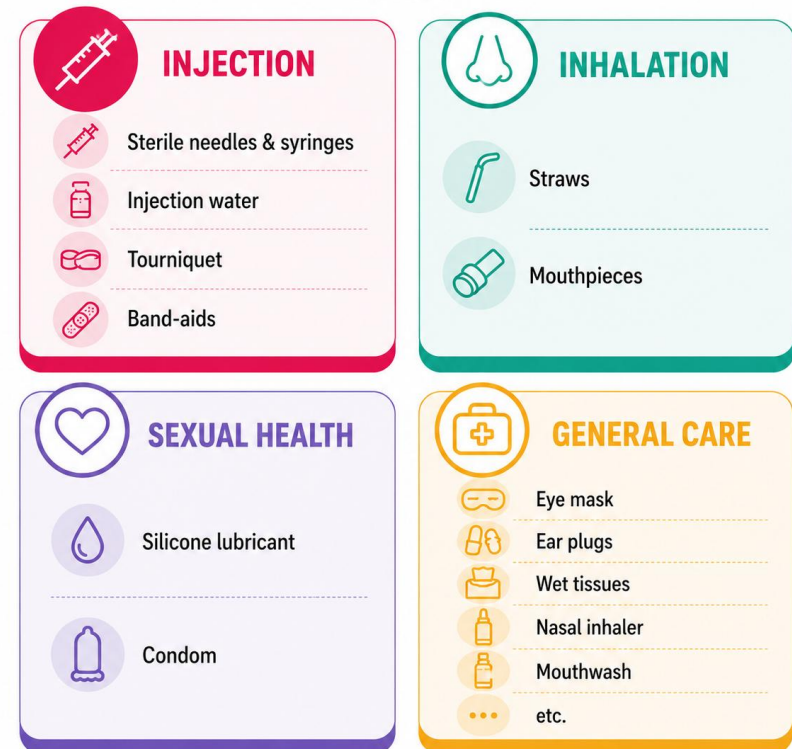
Harm Reduction Pack

Designed to provide practical harm-reduction within the chemsex context

Community input shaped:

- Pack contents → functionality and feasibility
- Pack Layout
- Format and packaging → Discreet
- Naming: “Party Pack” → “Harm Reduction Pack”

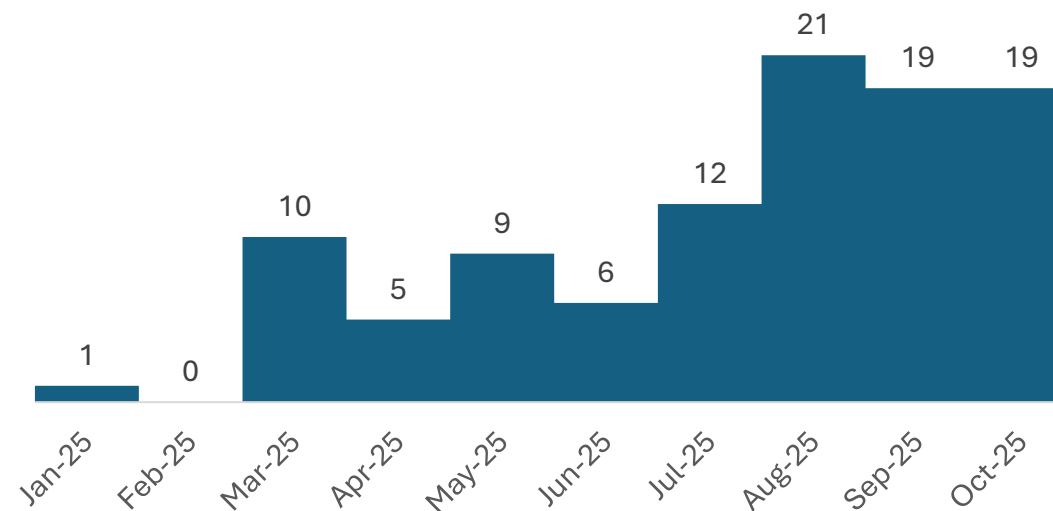
FOUR CONSENSUS THEMES



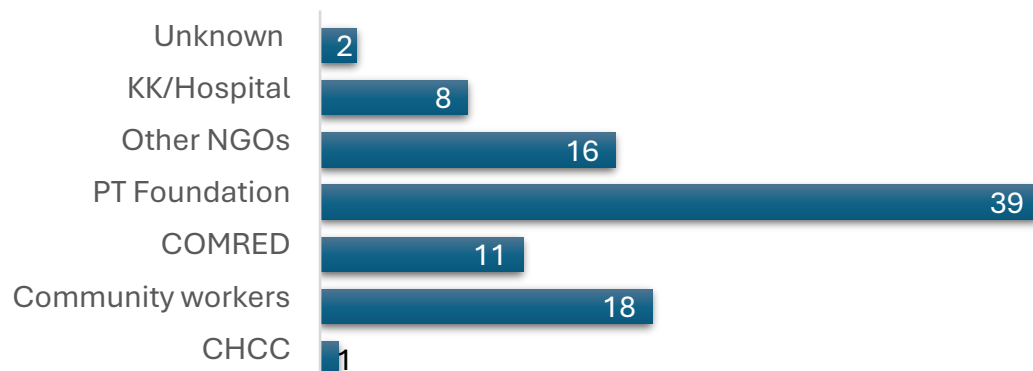
Implementation Findings

Median age: 32 (IQR 28 – 36)	
Gender and sexual orientation	
Male	90 (94.7%)
MSM	84 (93.3%)
Bisexual	4 (4.4%)
Prefer not to mention	2 (2.2%)
Transgender	1 (1.1%)
Non-binary	3 (3.2%)
Prefer not to mention	1 (1.1%)

No. of new recruitments (n=102)



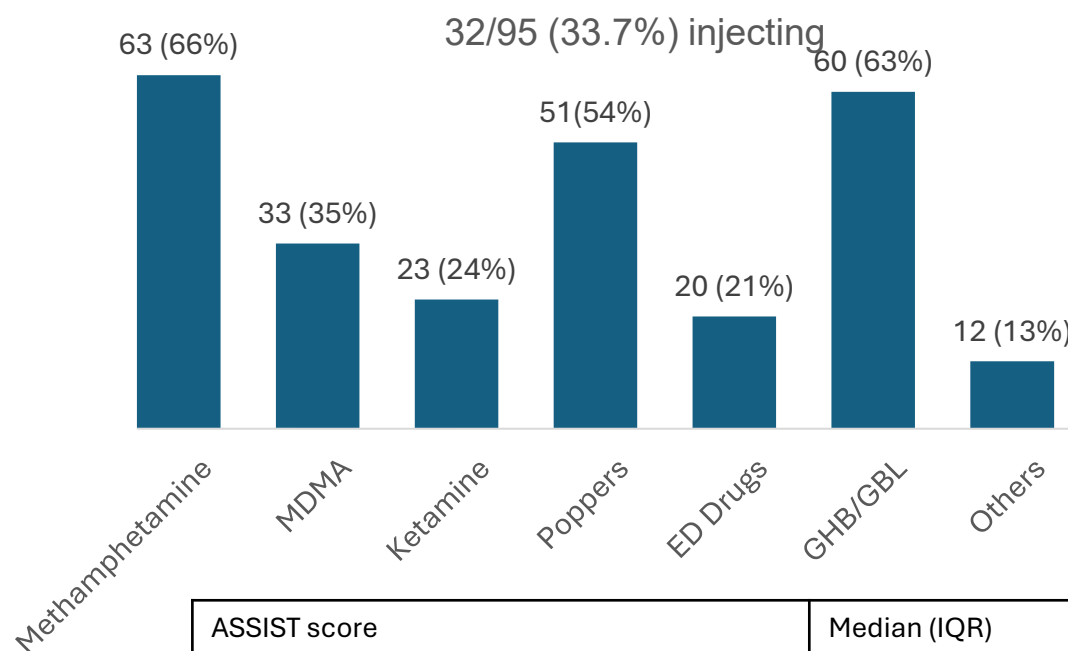
Source of Referral (n=95)



Follow-up rates	N (%)
Month-1	23/82 (28%)
Month-2	16/64 (28%)
Month-3	23/43 (53%)

SBIRTH : CHEMSEX

Substance use for chemsex in the past 3 months



ASSIST score	Median (IQR)
Amphetamine-type stimulants (Meth, MDMA, Mephedrone, Amphetamine)	21 (12 – 27)
Inhalants (Poppers)	7 (3 – 12.5)
Others (GHB/GBL)	8 (5 – 18)

23/95 (24%) screed as high risk	
Referred for further assessment	9 (39%)
Already under treatment/care	3 (13%)
Brief intervention	9 (39%)
Refusal for referral	2 (9%)
Goals (n=95)	
Undecided	2 (2.1%)
No changes	5 (5.3%)
Continue as current usage with harm reduction	23 (24.2%)
Reduce usage with harm reduction	44 (46.3%)
Complete abstinence and harm reduction	21 (22.1%)

SBIRT: Chemsex

ASSIST-LITE Stimulant risk, n=81

In the past 3 months	Yes	No
4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?		
4a. Did you use a stimulant at least once each week or more often?		
4b. Has anyone expressed concern about your use of a stimulant?		

Risk category:

0 = Low

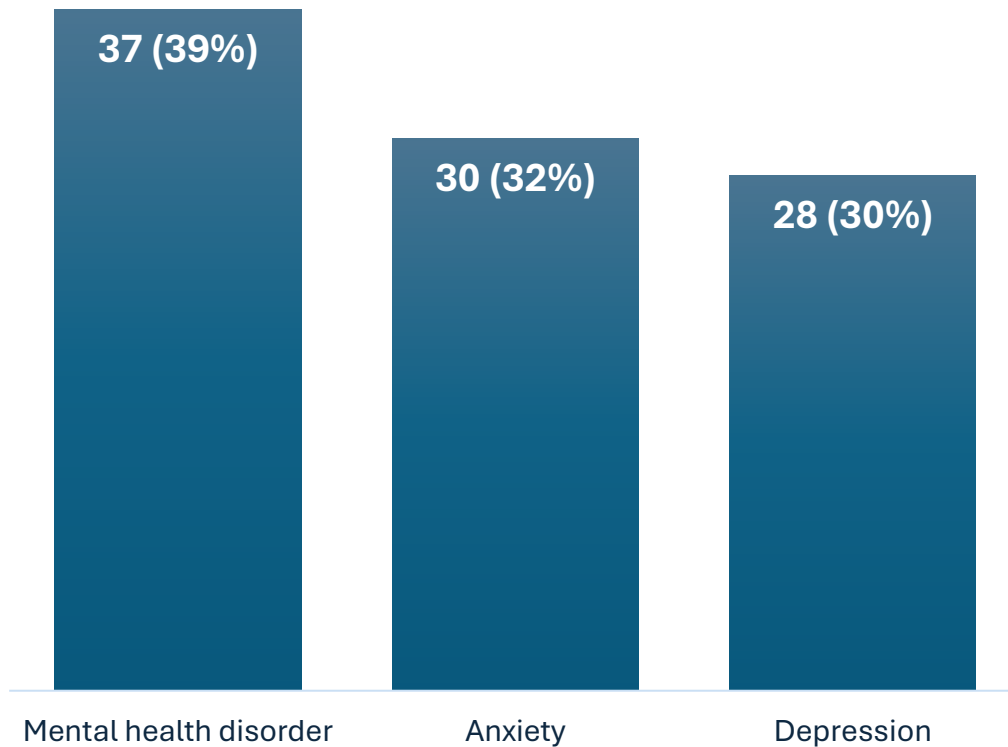
1-2 = Moderate

3 = High

	Baseline		Month-3	
Low	29	35.8%	48	59.3%
Moderate	36	44.4%	28	34.6%
High	16	19.8%	5	6.2%
Changes				
Improvement		28	34.6%	
No changes		50	61.7%	
Worsening		3	3.7%	
Wilcoxon signed-rank test: Z = −3.67, p < 0.0001; effect size r = 0.41.				

SBIRTH : Mental Health

PHQ-4 screening (n=95) Med 4 (IQR 3-4)



PHQ-4

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Outcomes (n=37)

Referred	14 (37.8%)
Already on treatment/ under care	4 (10.8%)
Refusal for referral	13 (35.1%)
No documentation	6 (16.2%)

SBIRT: HIV, Viral Hepatitis and Syphilis

HIV	
Known PWH	37 (39%); all on HAART
Not screened	1 (1%)
HIV Ag/Ab NR	57 (60%)
Already on PrEP	31 (54%)
Referred for PrEP	13 (23%)
Not keen for PrEP	1 (2%)
No documentation	12 (21%)
Hepatitis C	
Non-reactive	77 (81%)
Under care/treated	1 (1%)
Not screened	7 (18%)

Hepatitis B	
Non-reactive	55 (58%)
Reactive	1 (1%), referred
Under care/treatment	1 (1%)
Not screened	38 (40%)
Syphilis	
Non-reactive	60 (53%), 1 on doxyPEP
Reactive	5 (5%); all referred
History of syphilis	16 (17%)
Not screened	14 (15%)

Lesson Learnt

1. Community engagement is essential

- Lived experience informs **relevant, acceptable and person-centred interventions**
- Community co-design strengthens **context-specific harm-reduction approaches**
- Community workers with lived experience **bridge gaps in formal health services and connect clients to appropriate care**

2. Harm reduction meets clients where they are

- Clients have different **levels of readiness for change**
- Harm reduction can support clients **regardless of whether their goal is reduction or abstinence**
- With continued support, most clients maintained or improved their level of stimulant-related risk
- Flexible, structured approaches can accommodate **changing needs and readiness**

Lesson Learnt

3. Chemsex services can strengthen HIV prevention and treatment

- Provides a **new entry point to reach a hard-to-reach community**
- Creates opportunities to integrate **HIV prevention and treatment with chemsex support by linkage, adherence and continuity of care**
- Can support clients to maintain **PrEP and HIV treatment**

4. Sustainability requires an integrated health-system response

- Chemsex involves overlapping **HIV, substance-use, mental-health and psychosocial needs**
- Cross-learning between **NGOs, healthcare providers, peers and community leaders** strengthens implementation
- Long-term scale-up requires **policy support, community leadership and sustainable financing**

Thank You & Acknowledgements

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- Ano Tong
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- Kishen Kunalen
- Mohamad Zahiran bin Ahmad Toee

- **Technical & Community Advisory Member**

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