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Introduction and Objectives

Introduction

Advocacy for family planning education and services in Malaysia began with the pioneering work of concerned individuals and medical practitioners in the early 1950s. The first Family Planning Association (FPA) was registered in 1953 in the state of Selangor and in 1958, four state FPAs formed the Federation of Family Planning Associations, Malaysia (FFPAM). Today the FFPAM with member-associations in all 13 states in the country is the leading non-government organisation advocating and promoting family planning, family life education and responsible parenthood.

The Malaysian Government introduced a national programme in family planning in 1966 with the passage of the National Family Planning Act (Act of Parliament No. 42 of 1966) and established the National Family Planning Board (NFPB) as a statutory inter-ministerial body to set the groundwork for achievement of the economic, demographic and social objectives of the country's First 20-Year Development Plan, 1966-1985. Specifically, the demographic goal is to reduce the annual rate of natural increase from three percent to two percent over the 20-year period. The Board established its own network beginning 1967 but due to resource and logistical constraints, set up an alliance with the Ministry of Health (MOH) to integrate family planning into the maternal and child health (MCH) component of the Rural Health Services in 1970. A Central Coordinating Committee (CCC) was then set up to ensure proper planning, development, monitoring and evaluation of the programme by the three major implementing agencies, i.e. NFPB, MOH and FFPAM.

The implementation of the family planning programme and the integration of population factors for national and sectoral development were strengthened when the New Population Policy was introduced during the Mid-term Review of the Fourth Malaysia Plan (1984). In 1998, the Malaysian Parliament approved a name change of the Family Planning Act to the National Population and Family Development Act, legitimising the broadening of the scope of the national programme beyond the focus on contraception.

In the early years, the NFPB functioned relatively autonomously, guided by its 21-member Board of Directors and reporting annually to the Parliament through the Prime Minister's Department. As part of a regularisation exercise affecting all statutory bodies in the mid and late eighties, the Board was placed under the Ministry of National Unity and Social Development in 1990, together with four other departments, namely National Unity, Welfare, Aboriginal Affairs and Women's affairs.

At the International Conference on Population and Development (ICPD) in Cairo in 1994, the Malaysian delegation was led by the Minister of National Unity and Social Development. The coordination of the implementation of the Programme of Action (PoA) was entrusted to the NPFDB, to be carried out by building upon and strengthening existing population and development policies and programmes within the total national development efforts. The development and issuance of the Outline Perspective and Five-Year Plans is the responsibility of the Economic Planning Unit, Prime Minister's Department, engaging central and sectoral agencies through the Inter-Agency Planning Groups (IAPG) as well as Technical Working Groups (TWG)

Since the ICPD, programme strategies and designs of the inter-sectoral agencies have further expanded to ensure the provision of a broad package of reproductive health services, including menopause services; they have introduced special service delivery models to reach marginalised groups; increased access of adolescents to reproductive health information and selected services and maintained a continuing emphasis on the prevention of unsafe abortions and their complications, as well as their management.

Programmes on gender equality and women's empowerment, that had been prioritised by NGOs like the NCWO and the FFPAM even before the ICPD and the Fourth World Conference on Women, were further strengthened through the national women's development strategy. The Government of Malaysia however maintains its position, stance and reservations with regard to the concept of the (traditional) family and not providing contraceptives to unmarried people, especially adolescents as made known during the ICPD in 1994 and re-iterated at the ICPD+5 in 1999 as well as at the 5th Asia and Pacific Population Conference in 2002. It would therefore be safe to say that while a wide range of Reproductive Health Services have been made accessible, sexual health as well as rights to all areas of sexual and reproductive health, have been treated with some caution.

In the other areas of social development, the 'Education For All' and 'Health For All' strategies continue to address relevant ICPD goals with regard to education for both girls and boys and further reductions in the levels of infant, child and maternal mortality. Alleviation of poverty has also been a top priority of development programmes when the country acquired sovereignty status and has remained an integral component and thrust of major policies. The Malaysian Government has further committed itself at the United Nations Millennium Summit (2000) to eliminate poverty and ensure social justice and economic development. It is expected that the measures taken to achieve ICPD and related UN conference goals on children, women, HIV/AIDS and environment will contribute to and facilitate the total national efforts to achieve the Millennium Development Goals (MDGs).

In the NGO sector, the FFPAM, the leading NGO in family planning, sexual and reproductive health in the country takes a primary role in advocating a broader approach that encompasses the sexual and reproductive health and rights perspective, and gender equality and equity, while testing new modalities for the delivery of services to vulnerable and disadvantaged populations. Further advocacy and dissemination efforts are carried out through the Malaysian NGO Coordinating Committee for Reproductive Health (MNCCRH), which establishes the mechanisms to strengthen linkages and highlight the roles and contributions of member agencies, especially the National Council of Women's Organisations (NCWO), Malaysian AIDS Council. The Human Rights Commission of Malaysia (*Suruhanjaya Hak Asasi Manusia or SUHAKAM*) established in 1999 maintains a watch on human rights development in the country. Private medical clinics/centres continue to provide a range of clinical services in family planning, sexual and reproductive health, while pharmacies located mainly in urban areas offer a range of medical drugs and related supplies for the promotion of health and well-being of the Malaysian people.

In consonance with its primary role advocating a continuing focus on population, family planning, sexual and reproductive health and rights in the country, the FFPAM acted as the country focal point for the NGO sector for the ICPD+5 review in 1999. Since then the Federation has continued to play a leading role through the Malaysian NGO Coordinating Committee for Reproductive Health (MNCCRH) in closely monitoring and promoting the full implementation of the ICPD PoA in the

country. For the ten-year anniversary of the ICPD, the FFPAM, working alongside and in partnership with the Malaysian Government, is again actively involved in the multi-level assessment exercises, encompassing issues and solutions most pertinent at country level and regional and international situations.

Study Objectives

The objectives of this study are as follows:

1 To assess progress in policies, laws, programmes and services at the local and national levels over the last ten years, in understanding, accepting and implementing the critical ICPD gender equality and SRHR objectives
2 To assess outcomes of these changes on women's health, women's status and women's lives
3 To identify and analyse the main ICPD implementation barriers and facilitating factors for change perceived by NGOs and government in relation to:
   a. The political, economic and social context (country and global)
   b. Institutional factors (government lack of action/ inertia, regulation, enforcement)
   c. Effectiveness of NGOs and civil society participation and advocacy
   d. Presence of ICPD adversaries (threats or enemies)
   e. Impact of health sector reform (e.g. decentralisation, financing, community participation, accountability) World Bank, IMF, ADB and other donor policies
4 To analyse the differences in the government's assessment of ICPD progress in the government country reports to the 5th Asian and Pacific Population Conference (APPC) and UNFPA Field Inquiry 2003 Reports compared to the country study assessment, and why
5 To recommend critical actions to be taken by government, NGOs and donors at local, national and regional levels.

A Planning Meeting convened by ARROW on June 29–July 1, 2003 to discuss the implementation of the project had decided on the indicator frameworks for advocacy and monitoring in three broad ICPD areas listed below; with young people's right of access to information and services as a cross-cutting issue for all three sets of indicators, and the impact of health sector reform on access to SRHR applying to the second and third sets of indicators only:

I. Gender equality, social equality and equity,
II. Reducing maternal mortality and promoting safe motherhood and safe abortion,
III. Promoting and protecting sexual health and rights, safe contraception, preventing and treating HIV/AIDS and reproductive cancers.

Methodology and Country Team

Methodology of Study

The Country Report took into consideration the key areas of concern identified at the international level, e.g. United Nations Population Fund (UNFPA) and ICPD at Ten NGO International Steering Committee as well as local situations and have specific reference to the contents of the ICPD+5 exercise, especially the NGO Country Report for Malaysia produced by the Malaysian Steering Committee in 1999. Two broad methodological approaches were utilised:

- Data were collected and analysed to measure progress guided by indicator frameworks on three broad ICPD areas and the two cross-cutting issues.

- The Malaysian Government report on ICPD implementation progress was compared to the findings of this country study.

Various sources were used for the secondary data analysis. National data were used whenever available and the most up-to-date data (either quantitative or qualitative) were obtained from various research studies, surveys or service statistics but findings from smaller micro studies were used for some indicators. Generally, the data were found to be credible, reliable and up-to-date. Some key sources of secondary data were:

- Government Outline Perspective and Five-Year Development Plans
- National Surveys – Population Census, Population and Family/Fertility
- Annual Economic Reports, Ministry of Finance
- Annual Reports of the Department of Statistics, Ministry of Health and Ministry of Women and Family Development, and the FFPAM
- Government: ICPD and Beijing five and 10-year reviews and country report to 5th Asian and Pacific Population Conference 2002 (APPC)
- UNFPA Country Field Inquiry Questionnaire (FIQ) - 2003
- UNDP Human Development Report 2003

Further inputs for the Country Study included a 'Key Informants Survey' through a postal questionnaire involving a total of eight key agencies in the government and NGO sectors:

- Personnel who can give national policy perspectives – National Population and Family Development Board, Ministry of Health and Ministry of Education
- Programme managers in states/provinces/service providers at grassroots level – Family Planning Associations of Kedah, Perak and Melaka
- The Malaysian Chapter of the ASEAN Parliamentarian Forum on Population and Development (APFPD)

Country Study Team

The team comprised the following three members:

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Country Context

Government Commitment

In Malaysia the implementation of the ICPD Programme of Action is charged to the Ministry of National Unity and Social Development, with the National Population and Family Development Board designated as the coordinating agency. At the ICPD in Cairo in 1994, the Minister of National Unity and Social Development was the head of the Malaysian Government Delegation, with members from key agencies involved in population and development, i.e. Economic Planning Unit (Prime Minister's Department), NPFDB, Ministry of Health and the FFPAM as the NGO representative, with an almost similar composition for the ICPD+5 Review meeting. The NPFDB, through the Ministry is entrusted with the responsibility of ensuring the integration of the ICPD PoA in the national development plan.

Since being involved in the critical tasks in the negotiation process to finalise the twenty year Programme of Action at Cairo in 1994, Malaysia continues to participate actively in ICPD-related events especially in the period leading to and inclusive of the ICPD+5 review; as a member of the UN Commission on Population and Development for a period of four years from 1997 and as Chair of the 31st Session of the same Commission from February 1998 to March 1999. In both instances the director-general of the National Population and Family Development Board (NPFDB) represented Malaysia.

The creation of the Ministry of Women and Family Development in February 2001 gave a much needed impetus to the planning, implementation and evaluation of programmes, with higher resource allocations for the population, family development and women's development programmes in the country. This is partly attributed to the fact that in the early years, the Board enjoyed a relatively independent role as a semi-autonomous body reporting to Parliament through the Prime Minister's Department. From 1990, however, as part of a regularisation exercise affecting all statutory bodies, the Board was placed within the Ministry of National Unity and Social Development, which had altogether five portfolios (National Unity, Welfare, Aboriginal Affairs, Population and Family Development and Women's Affairs), and it began to function almost like a regular government department. The creation of the Ministry of Women and Family Development in February 2001 encompassing only the Department for Women's Development and the National Population and Family Development Board, the two Departments tasked with the implementation of the critical elements of the ICPD PoA, provides a more visible and tangible profile, better programme focus and higher resource allocations for the population, family development and women's development programmes in the country, especially as the Ministry is led by a woman minister who is dynamic and forward-looking. Regional and international collaboration and networking are also facilitated as there is now a separate ministry dedicated to the affairs of women and family. Following the country's 11th General Election in March 2004, and a re-structuring of the portfolio of Cabinet ministers, the Ministry was renamed the Ministry of Women, Family and Community Development.

At the 5th Asia and Pacific Population Conference on Population held in Bangkok in December 2002, the Malaysian Government delegation again played an active role, in agreement with the delegations of all but three participating countries to reiterate its commitment and promise made in Cairo in 1994. Malaysia's Minister of Women and Family Development – Honorable Dato Seri' Sharizat Abdul Jalil, ably chaired the plenary session amidst attempts to re-write the language and commitments of the PoA; especially those clauses pertaining to sexual and reproductive health and rights, adolescent sexual and reproductive health and HIV/AIDS.

Malaysia also completed the United Nations Population Fund (UNFPA) Field Inquiry Questionnaire (FIQ) in 2003 in contribution to the global report of national experiences that was released at the annual session of the UNDP/UNFPA Executive Board in June 2004, in Geneva. The Malaysian FIQ report is a consolidation of the inputs of several related government agencies and the Federation of Family Planning Associations, Malaysia, a move prompted by the UNFPA Office in Kuala Lumpur. Further the National Population and Family Development Board convened a consultative meeting involving again these key agencies in early March 2004 to discuss Malaysia's inputs in preparation for the 37th Session of the UN Commission on Population and Development, 22-26 March 2004 in New York and to prepare a Country Report to commemorate the ICPD at Ten.

Key agencies, both government and NGO, continue to be regularly consulted through the NPFDB's Board of Directors (ten members representing government agencies and ten members appointed from civil society and meets four times a year) and the annual NGO dialogues of the Ministry. These processes help to highlight issues relating to population, family development, family planning, sexual and reproductive health and their inclusion into the official documents. In 2004, the Board convened its inaugural NPFDB NGO dialogue to obtain more direct feedback from its partner agencies in preparation for the Annual Budget Dialogue towards the presentation of the Annual Budget in Parliament scheduled in October 2004.

Civil Society Initiatives

In Malaysia, the NGO sector is recognised for its pioneering efforts and supported by the Malaysian Government in terms of its contributory and complementary roles in welfare and social development, with various schemes for financial and in-kind support and a combination of fixed and project-related grants. For both the ICPD and FWCW, and several other UN Conferences in the recent decade, many NGOs are involved in prior discussions between government representatives and the civil society sector at the country level. Representatives from the FFPAM and NCWO were nominated to the official delegations for the ICPD and FWCW respectively.

The Federation of Family Planning Associations, Malaysia (FFPAM) is acknowledged as the leading NGO in the field of population, family planning, sexual and reproductive health, and receives technical, financial and other in-kind support from the government. The FFPAM has continued to serve as an appointed member on the NPFDB Board of Directors since its inception in 1966. The FFPAM Chairman was a fully sponsored member of the Government Delegation to both the ICPD and ICPD+5 Conferences. At the 5th Asia and Pacific Population Conference, the FFPAM Chairman and Executive Director were accepted as members of the Government's team although not government-sponsored, and the latter was co-opted into the Drafting Committee during the Bangkok meeting.

Government funding for NGOs to carry out women and family development activities increased from about RM 4 million in 2001 to RM 10 million in 2003. The FFPAM was able to access a higher amount of government funding following the change in the manner of disbursement of government grants to NGOs in 1997. In the transition period from fixed non-restricted funds to project-related grants, the fixed subsidy of RM 200,000 per year since 1962 remained till 2000, but increased to RM 140,000 in 2001 to almost RM 600,000 annually for the 2002-2003 periods.

For the five year review of the ICPD Programme of Action, the FFPAM acting as the focal country point set up the Malaysian Steering Committee (MSC) comprising umbrella organisations representing grass root communities involved in the reproductive health agenda. The 'ICPD+5 Country Report of Malaysia: NGO Perspectives' (January 1999) was acknowledged as a critical output and reference for the ICPD+5 review process. The FFPAM continues to chair the Malaysian NGO Coordinating Committee for Reproductive Health (MNCCRH) that took over the task from the Malaysian Steering Committee, to continually monitor the implementation of the ICPD Programme of Action in Malaysia and to promote the participation of civil society partners towards the achievement of ICPD goals. The partner members representing umbrella NGOs in welfare and social development (National Council of Welfare and Social Development), women (National Council

of Women's Organisation), youth (Malaysian Association of Youth Clubs) and HIV/AIDS (Malaysian AIDS Council) work closely to advocate key stakeholders. The advocacy and dissemination efforts included the organisation of three national seminars, i.e. the Malaysian NGO National Seminar on Reproductive Health, 2000; the National Youth Seminar on Youth-friendly Sexual and Reproductive Health Programme, 2002 and the Seminar on Men as Partners in Sexual and Reproductive Health, 2003. Consultations with single-purpose or dedicated NGOs like the Women's Aid Organisation and All Women's Action Society were held based on the issues being addressed.

For the ICPD at Ten exercise, the FFPAM and the MNCCRH are leading the country-level NGO sector, contributing to and participating in activities at regional and international levels under the 'Countdown 2015' initiative coordinated by Family Care International, the International Planned Parenthood Federation and Population Action International. In addition to the ARROW project, the FFPAM will prepare a country report as a member-association of IPPF and play an active role in NGO-led activities at the regional (East, South-East Asia and Oceania Region) and international levels as well as participating in relevant government contributions to the process. The FFPAM in consultation with the MNCCRH partner agencies proposed a Policy Dialogue to involve national level decision-makers from relevant government agencies and key stakeholders from the community. It also planned a national seminar on the outcomes and recommendations of the country, regional and international level review exercises for dissemination and coalition building among civil society players towards a more effective sector-wide approach to the full implementation of the ICPD PoA in the remaining years till 2015.

Several initiatives are also being taken by NGOs whose mission and goals relate to specific issues of the ICPD, especially the National Council of Women's Organisations (NCWO) on issues affecting the status and lives of women. The NCWO is an umbrella organisation of nearly 100 women NGOs whose mission is 'to advocate and work with single-minded determination to eliminate the disadvantages and inequalities affecting women, especially those at the grassroots communities.' The NCWO was responsible for coordinating civil society action for the Fourth World Conference on Women (Beijing, 1995), the Beijing+5 review and was involved in providing succinct inputs for the Government Report for the Convention for the Elimination of Discrimination Against Women (CEDAW) as well as producing an NGO report. Both reports have yet to be submitted to the CEDAW Review Committee.

The Malaysian AIDS Council (MAC), which was established in 1993 and has 36 member-affiliates to-date including the FFPAM as one of the founding members, has grown in terms of sector involvement and geographical coverage in the three programme areas on prevention, support and treatment. Beginning 2003, the Government provided a ten-year grant of RM 4 million annually to strengthen the depth and outreach of MAC work. The MAC, with the support of the Ministry of Women, Family and Community Development, selected the theme 'Women and HIV/AIDS' to commemorate the 2004 International AIDS Memorial Day to draw attention to the increasing burden of HIV/AIDS on women in Malaysia.

Being aware of the need to gain the support of Muslim religious leaders and mindful of their attitude towards sensitive issues associated with how the virus is contracted as well as towards some of the 'best practices' that have been seen to be effective in other parts of the world, MAC organised a study tour for Malaysian religious leaders to Uganda where in addition to visiting Islamic HIV/AIDS programmes they attended the First Muslims Leaders' Consultation on HIV/AIDS. Subsequent to this visit, the Malaysian AIDS Council together with the

Religious Department co-organised the second International Muslim Consultation in 2002 to explore Islamic approaches to the epidemic. Recommendations made by participants attending the conference have now been studied by a group of religious leaders.

Concerned that Muslim women are more 'hindered in their quest for claiming rights over their own bodies and their sexuality' than their non-Muslim counterparts, and keeping in mind the need to respect cultural relativity in the ICPD PoA, the religion-based NGO Sisters-in-Islam organised a Southeast Asian Workshop on Islam, Reproductive Health and Women's Rights in 1998 in Kuala Lumpur which included participants from Indonesia, Malaysia, the Philippines and Singapore. A publication 'Islam and Family Planning' was produced to document Malaysian perspectives (this was based on a paper, 'Contraception, Abortion and Reproductive Issues in the Legacy of Islam,' by the late Dr Abdel Rahim Omran who was the Chief Population Advisor to Al-Azhar University in Cairo).

Recently, in 2004, the Human Rights Commission (*SUHAKAM*) has also taken up the issues of trafficking of women and children in the context of rights and is considering more affirmative action on this matter.

International/Regional Cooperation

The Malaysian programme in population, family planning, sexual and reproductive health has benefitted from the close cooperation and assistance of four key international agencies, namely the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation (IPPF) through its East, South-east Asia and Oceania Regional Office (ESEAOR), the Asian-Pacific Research and Resource Centre for Women (ARROW) and the International Council on Management of Population Programmes (ICOMP). This has been facilitated in part by the fact that the regional offices of the latter three agencies are located in Kuala Lumpur, Malaysia.

Under the UNFPA 5th Cycle Assistance, the UNFPA Kuala Lumpur Office, working through the Economic Planning Unit, Prime Minister's Department and the UNFPA Asia Pacific Regional Office in Bangkok, Thailand, assisted to secure three projects directed at integrating and expanding the elements of reproductive health into the national programme. Two projects are being implemented by the NPFDB, the first (MAL/99/P01) 'Pilot Testing of Reproductive Health Services' involves the introduction/integration of the ten elements of reproductive health into the clinical services of eight clinics (Kelantan, Penang and Perak) of the Board, MOH and FPA 'as a follow up to the ICPD … to undertake a comprehensive and integrated approach to provide reproductive health care within the primary health care system … and determine the future strategies for a broader service approach and viable inter-linkages between different existing delivery systems.' The second project (MAL/03/P04) 'South-South Cooperation in Reproductive Health in Malaysia' was launched in May 2004 and will develop and promote a series of training packages on reproductive health (RH) among planners/managers and service providers of RH Programmes in Malaysia and the ASEAN region. The FFPAM's project (MAL/98/P02) 'Promoting Adolescent Reproductive Health and Responsible Living' resulted in the launch of the 'Reproductive Health of Adolescents Module' (RHAM) in 2000, followed by training of educators, including youth volunteers, from various agencies in Malaysia and also other ASEAN countries. This project, together with the outputs of several others on service delivery modalities (IPPF-sponsored) has helped in establishing FFPAM's position as the leading advocate and service provider of ASRH. The FFPAM also successfully acquired a Malaysian Government grant to transform the RHAM into an internet-based courseware – the e-RHAM project (DAGS, 2002).

The FFPAM, as a member-association of the IPPF, receives technical and financial support to develop country specific activities in the context of the ICPD PoA and to learn and share experiences in implementing national-level activities through the regular annual meetings involving volunteers and staff of member-associations. Furthermore, the IPPF ESEAOR in effecting the IPPF Strategic Plan 2000 as well as the more recent focus on the 5As – Abortion, Access, Adolescents, Advocacy and AIDS - provides FFPAM several opportunities to further enhance its advocacy role. Through participation in the three projects – Inform, Innovate and Initiate - the FFPAM was able to develop specific mechanisms on information and dissemination strategies (IPPF i3-Inform, 2000), introduce youth-friendly services (IPPF i3-Innovate, 2000) and initiate rights-based programmes to benefit marginalised populations (IPPF i3-Initiate/Ford Foundation, 2001) to continually be at the forefront of issues and be relevant to the needs of the community. Another project (Price Foundation, 2002) provided an even broader platform to empower women and other members (men and adolescents) of an agricultural community to consider integration of reproductive health with income generation and environmental sustainability initiatives.

In addition to the i3 projects on ASRH, the FFPAM also tested two different modalities, 'Strategies for SRH of Adolescents and Youth' to introduce related services at in-school and out-of-school (factory-based) settings (JOICFP RAS/00/P05, 2001) and 'Educating Young people About Sexual and Reproductive Health Rights in Malaysia' (IPPF/German Federal Ministry of Economic Cooperation and Development, 2002) to adapt strategies and outputs of current ASRH programmes for Muslim youths. The lessons learnt from both these projects are now being utilised in more FPAs to ensure culture-specific and youth-friendly services.

Through the MNCCRH, ARROW has helped to provide guidance for the NGO initiatives for the implementation of the ICPD PoA since the ICPD+5 review in 1999 as well as directly inviting local agencies including the University of Malaya (Health Research Development Unit) and FFPAM to participate in ARROW regional meetings and projects for the monitoring of the implementation of the ICPD PoA – 'Taking up the Cairo Challenge – Country Studies in Asia-Pacific' and the current 'ICPD 10 years On'.

The ICOMP Project 'Strengthening the Leadership Capacity of Adolescent RH Programme Managers and Youth Leaders in Asia' (1999) involved representatives of both NPFDB and FFPAM in learning and experience-sharing workshops followed by an opportunity to develop and improve youth-friendly services within the individual agency programme.

Assessing Progress in achieving ICPD Goals and Objectives

Gender Equality, Social Equality and Equity

Status of Women

Rapid socio-economic development in a favourable political and democratic environment has facilitated significant changes in the social structure and the narrowing of gender disparities, although specific norms and practices of the multi-ethnic and multi-cultural community, family and work environment place some restrictions as equal partners between the two sexes. The human development index of Malaysia has increased from 0.658 in 1980 to 0.721 in 1990, 0.782 in 2000 and 0.79 in 2001. The Malaysian HDI was ranked 56th in the world, but the gender empowerment measure (GEM) of 0.503 was ranked 37th. In comparison, the GEM for most developed countries is between 0.7 and 0.82. The Malaysian GEM is comparable to Singapore's 0.509, although the latter is ranked 26th in HDI.

The relative absence of women in the political arena appears to be the weakest link in the relations of power. Despite comprising almost 50 percent of the population and hence potential voters in the country as provided for by the Federal Constitution, only three women leaders were elected to full Ministerial posts from a total of 31 in the 11th General Election (March 2004). A more positive trend is the increasing number of women in top executive posts in the Malaysian Civil Service, with the key posts of Auditor-General and National Bank (Bank Negara) being held by women. The Ministry of Women, Family and Community Development has highlighted the need for women to 'break the glass ceiling' at a seminar convened to celebrate 'Women's Day' in 2003.

The ICPD goal relating to the empowerment of women to achieve equality and equity based on harmonious partnerships between men and women, and to enable women to realise their potential is expected to be fully achieved with the amendment to the Federal Constitution in 2001 to include 'gender' in the Article 8.2 on 'discrimination'. Consequently women will now be able to play out critical roles as active decision makers, participants and beneficiaries as envisaged in the National Policy on Women (1989) benefitting equally from all economic and social sector opportunities.

Equal Opportunities in Education for Males and Females

Males and females have equal access to educational opportunities in Malaysia. Free education for six years was already the practice in the pre-ICPD era with almost universal enrolment for primary education, achieving a high rate of 99.8 percent by 1990. In 2003, primary school education (six to eleven years old) was made compulsory, thus mandating equal opportunities to girls and boys for access to basic education, and better employment opportunities. The enrolment rate for secondary education (12-18 years) remains relatively high, at almost 60 percent throughout the nineties. The ratio of primary to secondary school enrolment is almost 70 percent at present. Over-crowding in urban schools, due to an increasingly urbanised population, and a higher ratio of female to male teachers, has affected the quality of teaching and is a cause for concern to educators and parents alike.

The proliferation of institutions of higher learning has resulted in a marked improvement in the educational level of the population. There is now a tendency for females to outnumber males in institutions of higher learning. In 1998, the number of female students in government assisted post-secondary schools more than doubled that of male students (44,201 as compared to 21,439). The gender gap in government-assisted technical schools traditionally dominated by males also appears to be narrowing (14,201 females as against 21,332 males). More females were pursuing civil engineering as compared to males (6,516 as against 4,708). In this present situation and increasing participation of women in the modern sector economy, the status of women has been and is expected to increase steadily.

Table 1: Education Indicators, 1990 – 2001

	1990	1994	2001
School enrolment			
Primary, female (percent gross)	93.615	102.55	98.872
Primary, male (percent gross)	93.801	101.8	98.614
Secondary, female (percent gross)	58.16	58.686	73.991
Secondary, male (percent gross)	54.549	53.764	66.862
Illiteracy rate			
Adult female (percent of females ages 15 and above)	25.621	21.793	15.984
Adult male (percent of males ages 15 and above)	13.132	11.172	8.3092

Between 1991 and 2000, the proportion of females aged 25-29 years with tertiary education almost doubled from 7.2 percent to 14.1 percent, while that of the males had increased from 8.8 percent to 13.5 percent. The number of female students in institutions of higher learning increased from 131,728 in 1997 to 211,147 in 2001, while the male intake increased from 117,538 to 165,841 during the same period. More and more females are pursuing courses, such as engineering and medicine, which used to be male domains. The number of female medical students more than doubled that of males in 2001 (4,926 as compared to 2,144), and the gender gap in engineering courses at the degree level is also narrowing. Between 1997 and 2001, the number of female engineering students in local universities increased from 4,594 to 10,020 compared to the males, from 12,996 to 19,545.

Women at the Workplace

The female labour force participation rate has been increasing steadily from 31 percent in 1970 to about 50 percent by the mid-1990s. Rapid industrial development has continued to draw large numbers of young, unmarried Malay women from the rural areas into urban-located factories. The labour force participation of women aged 20-29 years was about 60 percent in 2000, indicating that younger women are more likely to be economically active, on account of higher educational achievement.

With a shift away from traditional occupations, the proportion of women who worked as unpaid family workers has been falling, from about 40 percent in 1970 to about ten percent in 2000. More than three quarters of the women workers are now working as employees. Of the economically active women, about 56 percent are now engaged in sales and services, 27 percent are in manufacturing and 12 percent are in agriculture. In 1980, women made up 38 percent of the professional/

technical workers and 8.3 percent of the administrative and managerial workers, and this increased to about 45 percent and 20.2 percent respectively in 2000. Between 1991 and 2000, the proportion of economically active women working as professional and technical personnel increased from nine percent to 13.6 percent, and the proportion working as managers and administrators increased from 0.6 percent to 2.3 percent. On the other hand, the proportion of women workers engaged in the agricultural sector had decreased from 28.1 percent to 13.9 percent.

With the increase of women in labour force participation, particularly in the modern sector of the economy, women's work and their role in the family have posed new problems relating to childcare. Alternative arrangements become necessary to ensure that work and family life does not become incompatible. Towards this end, the Government has urged employers to provide crèche facilities, beginning with the issuing of a circular to government departments (1987). More flexible working hours and the option for women to take leave and return to work later, without sacrificing seniority have yet to be seriously considered as women-sensitive approaches for more equal female labour force participation.

Despite efforts made by the Government, few employers (government agencies included) provide childcare facilities and fewer still are willing today to retain positions for women who take leave in excess of their entitlement, let alone ensuring that their seniority is ensured.

There is, however, increasing acceptance for women to work from home, especially when the ICT can be used effectively to run a business. The 'Working @ Home' project started by the 'Mom4Mom' in 2000 has expanded to provide an option of teleworking to Malaysians (women) belonging to disadvantaged and special groups the opportunity to work from home.

Women's Health Status

General Health, Mortality and Life Expectancy

The changing status of women can be seen from their health conditions, which have improved tremendously since the country gained Independence in 1957. Access to health care, including reproductive health, is a basic right under CEDAW. Article 12 requires states to eliminate discrimination in access to health services throughout the lifecycle, particularly in the areas of family planning, pregnancy and confinement, and the postnatal period. Women have lower mortality rates and higher life expectancy as compared to males.

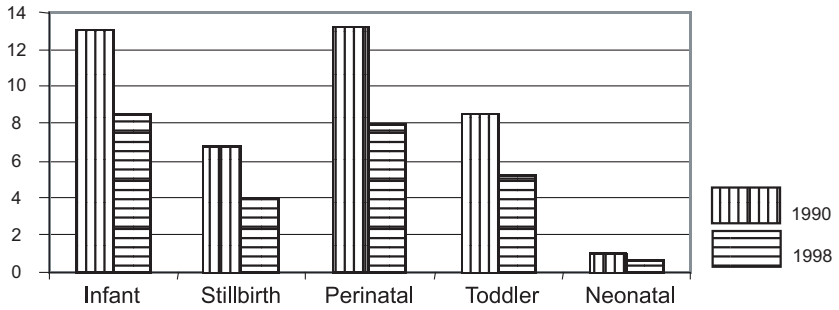
Table 2: Health Indicators, 1990 – 2003

Health Indicators	1990		1994		2003	
	Male	Female	Male	Female	Male	Female
Life expectancy at birth (Peninsular Malaysia)	69.2	73.4	69.3	74.4	70.6	75.5
Crude death rate	5.2	3.9	5.2	3.9	5.2	3.9

Source: Vital Statistics Report (Various Years), Department of Statistics, Malaysia

Malaysia has achieved a high standard of health and its relatively low mortality rates across all segments of the population is proof of this. The crude death rate had fallen from 6.7 in 1970 (7.5 for males and 5.8 for females) to 4.6 per thousand (population) (5.2 for males and 3.9 for females) by 1986 and has been sustained at about that figure since then. Other measures of mortality have also declined remarkably during the 1990s. Between 1990 and 1998, the infant mortality rate declined from 13.1 per thousand births (13.1 for males and 14.5 for females) to 8.5 (9.3 for males and 7.7 for females); the still birth rate from 6.8 per thousand births to 3.9; the perinatal mortality rate fell from 13.2 per thousand births to 7.9; the neonatal mortality rate fell from 8.5 per thousand births (9.4 for males and 7.4 for females) to 5.2 (5.9 for males and 4.6 for females); the toddler mortality rate from 0.9 to 0.7. In 1998, the infant mortality rate of the Chinese (5.7 per thousand births for males and 4.5 per thousand births for females) was still considerably lower than that of the Malays (10.3 for males and 8.3 for females), and the Indians (7.3 for males and 6.9 for females).

Fig.1: Trend of Infant and Childhood Mortality ('000 LB), Malaysia 1990-1998



Consequent upon mortality declines, life expectancy continues to improve between 1990 and 1998, from 69.2 years to 69.7 years for males; and from 73.4 years to 74.7 years for females. The life expectancy of Malaysian women, currently at 75.5 years, is at par with developed countries and is second only to Singapore in the South-east Asian region. Differentials in life expectancy however, can still be observed. For instance, the female life expectancy in 1998 was considerably higher among the Chinese (77.7 years) as compared to that of the Malays (73.1 years) and Indians (73.6 years). However, such differentials have narrowed over the years.

Women's reproductive health status has also improved tremendously alongside, albeit differentially along geographical, educational and ethnic lines. The most significant improvements are in neonatal and infant mortality of the girl child and in maternal mortality as preventive health care has effectively reduced deaths due to most communicable and preventable diseases while addressing somewhat the other genetic and degenerative diseases. However, the issue of reproductive cancers in women remains a public health and medical challenge. (See sections below.)

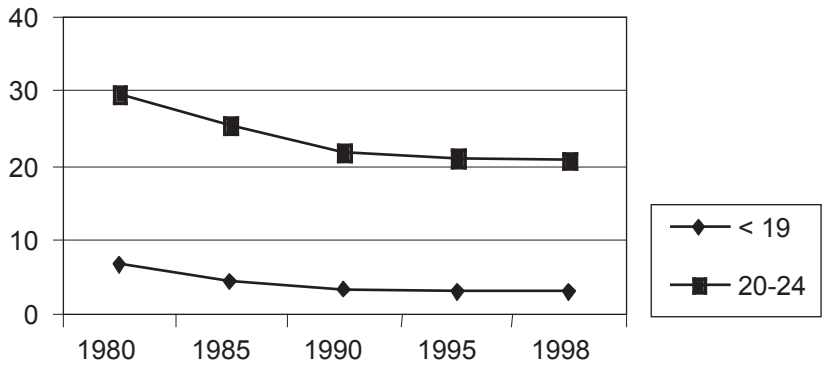
Childbearing and Fertility Levels

As fertility declines, women enjoy a better state of health, with lower morbidity and mortality associated with frequent childbearing. The crude birth rate has been falling from 36.7 per thousand population at the inception of the National Family Planning Programme in 1966 to 27.9 in 1990 and 21.3 in 2003. The total fertility rate in Peninsular Malaysia declined correspondingly from 5.7 to 3.3 and

3.0. The benefits accrued are uneven, as wide differentials in the fertility rate can be observed across socio-economic groups. For instance, the total fertility for the Malays (3.8) was significantly higher than that of the Chinese (2.2) and Indians (2.6). The 1994 Malaysian Population and Family Survey showed that women aged 40 and over in the east coast of Peninsular Malaysia had almost two children more than those from other regions; and older women with tertiary education had 2.3 fewer children than those with no schooling.

Further the gains benefitted young women more as the decline in the total fertility rate was brought about mainly by lower fertility among the younger women resulting from postponement of marriage, particularly among the more educated women. Teenage marriage and births to teenage mothers have been falling rapidly. The proportion of females aged 15-19 who have ever married fell from 7.6 per cent in 1991 to 4.9 per cent in 2000. The singulate mean age at first marriage among Malaysian women has increased from 24.8 years in 1991 to 25.1 years in 2000, and the corresponding figures for males are 27.8 and 28.6 respectively. The proportion of first live births born to mothers below 20 years of age had declined from ten percent in 1990 to 7.5 percent in 2000; and the proportion of births born to mothers below 15 years of age has become very negligible, falling from 0.1 percent to 0.09 percent during the same period. According to the 1994 Malaysian Population and Family Survey, 14.6 percent of girls were bearing children before 18 years of age.

Fig.2: Percentage of Births to Mothers, Peninsular Malaysia, By Age of Mother, 1980-1998



With regard to the total number of births to adolescent mothers (19 years and below) in Peninsular Malaysia, the analysis showed that the decreasing fertility in these young women had started earlier, as shown in the monotonical decrease from 23,113 births in 1980 to 12,320 births in 1998. This was in contrast to births by mothers in the 20-24 age group, which decreased from a high of about 101,685 (births) in 1980 for a period of about 10 years but stabilised at about 86,000 annual births in the last ten years. (See also Table 3)

Table 3: Total Number of Births (and Percentages) by Age of Mother, Peninsular Malaysia, 1980 – 1998

Age Group	1980	1990	1995	1998
<15 years	165 (0.05)	133 (0.03)	164 (0.04)	132 (0.03)
15-19 years	22,948 (6.61)	13,433 (3.40)	13,110 (3.08)	12,188 (2.87
20-24 years	101,685 (29.30)	84,810 (21.45)	88,627 (20.80)	86,517 (20.40)
> 25 years	221,926 (63.95)	296,526 (75.01)	323,496 (75.95)	323,112 (76.18)
Unknown	291 (0.08)	419 (0.11)	542 (0.13)	2208 (0.52)
Total	347,015 (100.0)	395,321 (100.0)	425,939 (100.0)	424,157 (100.0)

Source: Vital Statistics Report (Various Years), Department of Statistics, Malaysia

Nutritional Status of Women

Nutrition levels are measured in many ways. In the larger picture they are generally measured in terms of food security, which is defined 'as access to sufficient, safe and nutritious food by all people at all times to meet their dietary needs and food preferences for an active and healthy life' (Khor, 2003). At the national level, food availability in terms of per person per year was already quite high in 1995 and between then and 2001 it has continued to increase with people having greater access to meat and fish as well as vegetables and fruit. Interestingly the consumption of sugar by Malaysians is among the highest in South-East Asia.

In terms of calorie availability per capita per day, between 1970 and 2000 Malaysia experienced an increase from 2,000 to almost 3,000 bringing it to the level of the developed countries of Australia and New Zealand and in fact higher than that of Japan. This therefore puts Malaysia at the level of a country in transition and experiencing under as well as over-nutrition depending on the sub-population groups that are being referred to.

Around the time of the ICPD, one large study undertaken by Chee et al. (1997) between 1992 and 1993 of 409 adults aged eighteen to sixty found that rural male respondents had lower energy intake than their urban counterparts, while among women there was no significant difference in energy intake. At the same time rural respondents' intake of vitamins and minerals was lower than the urbanites and the diet of rural males was deficient at less than two thirds of the recommended dietary allowance (RDA) in calcium, riboflavin and niacin. Calcium and iron intakes of rural as well as the urban women were also less than two thirds of their RDA. In addition to the above, rural women's diets were also deficient in Vitamins A and niacin.

A study of pregnant mothers attending antenatal clinics in rural Kelantan revealed that almost half (47.5 percent) of them were anaemic by WHO criteria (Hb < 11.0 g/dl) on their first visit for antenatal care and at the same time 6 percent of the children born weighed less than 2.5kg. Meanwhile Tee et al. (1998) also found that the prevalence of anaemia was 25 percent among female adults living in rural villages and estates in Peninsular Malaysia, with the highest (50 percent) among fishing populations.

Nutritional studies among indigenous Orang Asli women showed them to have an even less satisfactory nutritional status. Lim and Chee (1997) in their study of 34 Orang Asli women found that more than a third (35.7 percent) suffered from chronic energy deficiency and that only 42.9 percent had normal weights. With the exception of vitamin C their mean intakes of other nutrients was also deficient. Diets of the elderly were also found to be deficient all round with the highest deficits in calcium and niacin as well as vitamin A among elderly women (Suriah, 1996).

More recent studies on the nutritional status of women have found that anaemia is still a perennial problem among female adults (20-25 per cent depending on the study) but prevalence declined between 1995 and the present. There is also a decrease in iodine deficiency disorder in Sarawak and Sabah. However nutritionists cautioned that contrary to the past there is a growing problem of excess weight and obesity not only in urban but rural areas as well (Khor, 2003).

Between 1995 and 2000 the incidence of premature (less than 2.5 kg.) births in Malaysia also declined from 9.1 percent of total births to 7.2 percent in 2000 (vital statistics for the respective years), indicating an improvement in the nutritional and health status of childbearing women.

Violence against Women / Sexual Abuse of Women

According to the MPEN II report, the number of reported violent crimes increased from 9,383 in 1990 to 21,259 in 1999, and the number of murders increased from 313 to 588 during the same period. In 1999, a total of 6,538 juveniles were arrested for various crimes including murder (19 cases), rape (124 cases), inflicting injury (263 cases) and for theft and house break-in.

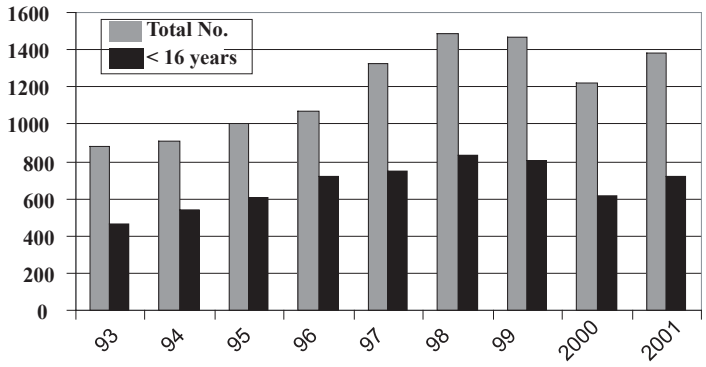
Mass media reports on a number of rape-cum-murder cases have helped to raise public awareness and concern. However, only a small number of these are actually reported. One reason for this could be that the majority of the perpetrators are relatives or acquaintances of the victims and many victims may see such violence as normal. Others may hesitate to report such violence out of fear. The incidence is, however, widespread. Existing laws are inadequate to deal with gender violence; in recognition of this the Prime Minister has ordered tougher measures to be taken to address such crimes.

In a Malaysian study of 616 paramedic students it was reported that eight percent of the women and two percent of the men had reported sexual abuse, interpreted here to mean 'vaginal or anal penetration, or unsolicited sexual contact, witnessing exhibitionism before the age of 18' (Population Report, 1999). In another study of the reproductive health of 214 female dental nursing students (mean age was 20.96 years) by Umi Kalsom (2001) three (1.4 percent) of the respondents reported that they had been raped between five and six years of age. Data such as these only go to show that perhaps sexual abuse is far more rampant than what is reported in the press.

The number of reported cases of rape has also increased over time (Figure 3). According to the Rape Report on Malaysia, in 1993 there were 879 such cases giving it 2.4 cases per day (Lai et al., 2002) and this increased to 1,539 in 1998 resulting in 4.2 cases per day. In 2002 statistics from the Royal Police Department showed that 1,418 cases were reported to them. It must be borne in mind that that these statistics are only of those cases that have been reported. Conservative estimates put it that for each case that is reported, another ten go unreported.

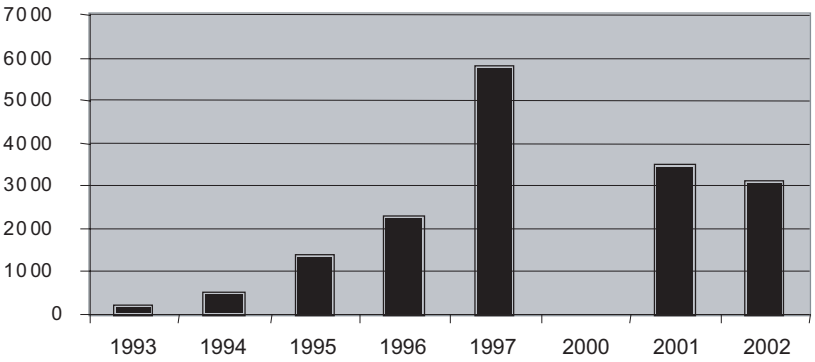
More than half (55.8 percent) of the victims or survivors were under 16 years. Contrary to belief, only 20 percent of rapes took place in isolated places and 67 percent took place in the home or some buildings (not hotels) or places generally regarded as safe by women. Analysis of the relationship of the perpetrator with the survivor using 1998 data revealed that only 16 percent were strangers and another eight percent were new acquaintances. The rest were actually known to the survivors of rape, 35 percent being colleagues or people from the same village, 19 percent boyfriends, 13 percent were cases of incest, seven percent by family members, and another eight percent were employers, teachers or the *Bomoh* (traditional medicine man) (Lai et al. 2002).

Fig. 4: Number of Rape Cases Reported by Year



Domestic violence has also attracted considerable attention. Basically domestic violence includes physical battery, incest, rape, sexual abuse and psychological bullying and exploitation. In the early part of the nineties the number of cases reported to the police was around five hundred or less. With the passage of the Domestic Violence Act in 1994 and its implementation in 1996, victims were better empowered to make the relevant reports. This accounts for the increase in the number of reported cases in 1997. Data for 2001 and 2002 showed that the number reported each year was around 3,000. Nonetheless only a fraction of spousal violence is reported. In fact one study conducted by the Women's Aid Organisation in 1990 estimated that 39 percent of Malaysian women aged 15 years and above suffered from spousal abuse (Wong, 1999).

Fig. 5: Number of Domestic Violence Cases Reported to Police



Reducing Maternal Mortality and Promoting Safe Motherhood and Safe Abortion

Maternal and Child Health

Maternal and child health services are available through the extensive outlets of government clinics and private centres. BCG coverage is almost universal, with the exception of Sabah and Sarawak. Even then, in 1999, the BCG coverage in Sabah and Sarawak was 96.7 percent and 98.3 percent respectively. As at 1999, polio immunisation coverage of infants, booster doses for standard one pupils, DPT and booster dose double antigen for standard one pupils were estimated at 93 to 96 percent. However, measles immunisation coverage for infants was relatively lower, at 86.6 percent.

The reduction in births to very young mothers and older mothers has resulted in the decrease in high-risk births. In Peninsular Malaysia and Sarawak, the proportion of high-risk births has been declining from 15 percent in 1985 to seven percent in 1990 and three percent in 2001. The proportion of high-risk births in Sabah was relatively higher at 19 percent in 2001, although it had also been declining from 28 percent in 1985 and 26 percent in 1990. It is worth noting that the proportion of newborns weighing below 2.5 kg has increased from 7.8 percent in 1991 to 9.2 percent in 1999; and the proportion of children under five who are underweight was estimated at about 18 percent (Interactive World Map).

Data from the 1996 Second Health and Morbidity Survey show that 88.6 percent of babies were breast-fed, a slight increase from 85 percent reported in the 1988 Malaysian Family Life Survey-II. The mean and median duration of breast-feeding was estimated at 28 weeks and 18 weeks respectively. Compared to a median duration of about 26 weeks reported in the 1988 survey, the breastfeeding duration seemed to have decreased. It must also be mentioned that only 29 percent of the babies were breastfed without supplementary food.

In 1999, coverage of antenatal mothers (1st visit) and tetanus toxoid by the public sector stood at 74.3 percent and 85.6 percent respectively. However, a sizable proportion of pregnant mothers went to private hospitals and clinics for antenatal checks, as shown by the very low coverage among mothers in the Federal Territory of Kuala Lumpur of around 30 to 33 percent, compared to at least 80 percent in all other states. Incidentally, Kuala Lumpur also registered a very low polio immunisation and DPT coverage for infants at about 40 percent.

The postnatal care coverage has improved considerably from 50.3 percent in 1985 to 67 percent in 1990 and 77.7 percent in 2001. Postnatal care coverage by Government facilities in Sabah and Sarawak improved much more rapidly from 65.9 percent and 85.3 percent in 1990 to 92.4 percent and 96.3 respectively in 2001, as compared to a more gradual increase in Peninsular Malaysia, from 64.9 to 73.3 percent during the same period. The observed differentials can be attributed to the fact that women in Peninsular Malaysia are more likely to seek postnatal care from private hospitals or clinics.

Maternal Mortality and Morbidity

In Malaysia, the number of maternal deaths decreased from 702 in 1963 to 496 in 1970, 240 in 1980, 94 in 1990 and 85 in 1996. Surprisingly, the number of maternal deaths had increased to 91 in 1997 and 146 in 1998, the higher number attributed to the inclusion of all deaths among pregnant women, irrespective of the cause of death and comprising cases of undocumented workers in the state of Sabah.

In tandem with the reduction in the number of deaths, the maternal mortality rate has declined very rapidly from 148 per 100,000 live births in 1970 to 63 in 1980, and further to 20 in 1990 before increasing to 30 in 1998 due to the definition of maternal mortality being made all inclusive.

In 1998, out of the 146 maternal deaths, 118 were medically certified and inspected while the remaining 28 were uncertified. Of the certified deaths, 94 were due to direct obstetric causes, 22 were due to abortion and two were due to indirect obstetric causes. Of the direct obstetric causes, haemorrhage of pregnancy and childbirth was by far the most common (39 deaths); followed by complications of the puerperium (28 deaths); and hypertension complicating pregnancy, childbirth and the puerperium, excessive vomiting in pregnancy (16 deaths). The causes of maternal deaths were about the same in 1991 and 1998.

In Peninsular Malaysia, the proportion of births delivered in hospitals or clinics as an indicator of an improved assurance for maternal protection and survival, has been increasing very sharply from 53.6 percent in 1985 to about 98 percent in 2000 and 2001. In 1985, about 87 percent of the births in Peninsular Malaysia were attended by trained personnel, but this has increased to about 96 percent in 1990 and 99.2 percent in 2001 (79.5 percent by government personnel and the remaining by private doctors and nurses). In Sarawak, about 93.4 percent of the deliveries in 1999 were attended by trained staff (88.5 percent by government personnel); but a much lower proportion of deliveries in Sabah were attended by trained personnel (78.6 percent) and most of these were by government personnel. In Sabah, the proportion of institutional deliveries has been increasing from 53.8 percent in 1985 to 61.6 percent in 1990 and 75.5 percent in 2001. A tremendous increase in institutional deliveries has been achieved between 1985 and 1990, from 67.1 percent to 90.3 percent, and this increased further to 97.9 percent in 2001. In terms of birth attendants, the proportion of births in Sabah attended by trained personnel increased from 74.2 percent in 1990 to 81.2 percent in 2000, while the corresponding increase in Sarawak was from 90.9 percent to 98.0 percent.

Abortion

The Penal Code (Amendment) Act 1989 (Act 727) provides for legal abortion to be carried out safely; only a medical practitioner registered under the Medical Act 1971 can undertake the procedure, with the proviso that 'such practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated'. The penalties for contravening the Act are accordingly provided as for all other criminal offences.

Perhaps because of the law and probably more due to the 'sensitive' nature of the procedure, there is a paucity of data on abortion in the country, especially for the unmarried and adolescent population groups. The 1966 West Malaysia Family Survey revealed that at least one percent of the respondents aged between 15 and 44 years admitted to having one induced abortion during their reproductive life. The youngest cohort of respondents – wives (15-24 years old) - reportedly never ever used abortion as a family planning practice. The rate of abortion increased to 2.5 percent in the 1974 Malaysian Fertility and Family Survey. In a more focussed study on Maternal Health and Early Pregnancy Wastage in Peninsular Malaysia carried out in 1974, the rate was 10.7 percent (FFPAM, 1977). From the 1984 MPFS Survey involving 3,866 ever-married women, 16.3 percent had experienced at least one spontaneous abortion and 5.8 percent had at least one induced abortion. There is still public and professional (including

the Malaysian Medical Association) opinion that a good number of women have sought recourse to terminations of their pregnancies, for various reasons, and that a proportion of them would have been under unsafe conditions.

In 2002, the Ministry of Health convened a number of meetings to review the Penal Code on Termination of Pregnancy to discuss amendments to decriminalise the procedure and reduce restrictions on access to it. The initiative, led by the Malaysian Medical Association and with the involvement of NGOs like the FFPAM and the Obstetrical and Gynaecological Society of Malaysia, proposed that there should be no punishment when no consent of the woman is available/ possible, that if 'where the pregnant woman is mentally, emotionally or physically incapable of giving consent, or is below the legal age of valid consent, the opinion of two medical practitioners registered under the Medical Act 1971, based on considerations as provided for in the exceptions stated in Section 312, and acting in good faith, shall be accepted as consent in lieu.' Further, there should be an addition to the provision on the mother's situation, 'if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, or the pregnancy is alleged to have been caused by rape or incest.' The proposed amendments are currently being reviewed by the Attorney General's office.

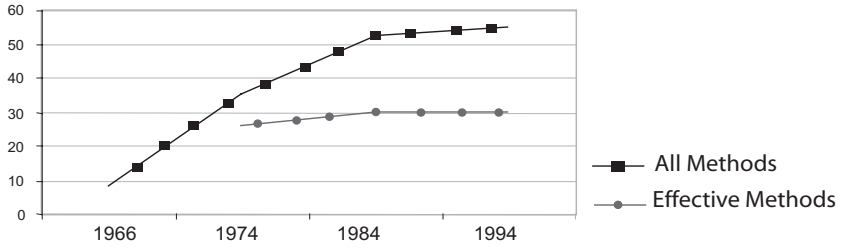
Meanwhile, the focus of government, private sector and NGO programmes has been to maintain a continuing emphasis on the prevention of unsafe abortions and their complications as well as the management of such complications. Most activities concentrate on providing information and education for planned parenthood and clinical services for contraceptive use to make 'every pregnancy a wanted pregnancy' and counselling to deter use of unskilled personnel to carry out termination procedures. An appropriate set of standard operating procedures apply for the clinical management of the complications of septic abortions including an emphasis on counselling and the provision of contraceptives before discharge from the hospital.

Promoting and Protecting Sexual Health and Rights: Safe Contraception, Preventing and Treating HIV/AIDS and Reproductive Cancers

Contraceptive Use

To a lesser extent, fertility decline among Malaysian women was brought about by contraceptive use, as reflected by the longer birth intervals and the termination of childbearing at younger ages. Contraceptive prevalence rate (CPR) among married women at the first ever survey in 1966 registered only eight percent. This rate increased to 35.5 percent in 1974 and then rose to 52.2 percent in 1984 but increased only slightly to 54.8 percent in 1994. The contraceptive prevalence rate for modern methods is even lower, increasing from 25.8 percent in 1974 and remained at just about 30 percent in 1984 and 1994.

Fig. 6: Contraceptive Prevalence Rate



The Malaysian CPR is much lower than that of many developing countries, such as Indonesia (CPR of 57.4 percent for any method and 54.7 percent for modern methods), Thailand (CPR of 72.2 percent for any method and 69.8 percent for modern methods) and Vietnam (CPR of 78.5 percent for any method and 56.7 percent for modern methods). It should be noted that the survey populations are ever-married women, in line with the national policy of providing contraceptives only to married couples. The relatively low contraceptive prevalence rate, particularly the modern methods, may also be partly attributed to the lack of information, education and communication (IEC) programmes for family planning especially following the propounding of the '70 Million Population' scenario in 1982, and partly because women are marrying much later. Owing to the lack of information on induced abortion and breastfeeding, the fertility inhibiting effects of these two variables cannot be ascertained.

In more recent statements on the Population Policy, the National Population and Family Development Board stated that the main aim of the future population policy is to sustain population growth that is in balance with resources and sustainable development. This is in accordance with Government's efforts to create Malaysia as an industrialised nation but at the same time maintaining a quality population founded on a healthy, resilient and stable family system. This will necessarily demand, at the macro level, better integration of population factors within the overall development planning processes, and at the micro-level, strengthening of the family as a building block towards the development of a quality population. Contraceptive practice is treated more as an option, rather than a means to family development.

The CPR varies widely by socio-economic groups. For instance, the three east coastal states in Peninsular Malaysia (Kelantan, Terengganu and Pahang) registered a CPR of only 24 percent in 1994 as compared to about two third in all other states. The urban and rural Malays had a CPR of about 50 percent as compared to about three quarters among Chinese (both urban and rural), and rural Indians. More anthropological as well as ethnocentric studies would be helpful to ascertain if empowering Muslim women 'to have control over their own bodies' is a possible strategy to improve the CPR. However, it is interesting to note the close correspondence between that the level of CPR (56 percent) in the squatter areas in five major urban centres and the general population, indicating that family planning services are also widely available in the squatter areas and the squatter populations are receptive to them.

Wide discrepancies in the CPR among various population groups prevail despite the availability of contraceptive services through the numerous health centres operated by the Ministry of Health. This is so despite efforts made over the years to make services user-friendly. For instance, since ICPD but more specifically in the last two years, efforts have been made to reduce the number of trips women needed to make to the health centres in order to avail the different services (previously different maternal and child health services were only available on different days).

There is a strong possibility that religious beliefs impact on CPR among Muslim women, and to address this, Sisters in Islam convened a meeting on Islam and Family Planning in 1998. However to what extent individual Muslim women have translated the message into decisions remains an open question. Some groups (especially Muslims clerics) regard Sisters in Islam as a 'westernised' group and accuse them of not being Islamic. At the same time Islam also encourages women to breastfeed and many Muslim women think that breastfeeding is a form of contraception. While the CPR is low, the use of unreliable traditional methods

is conversely high. 'Jamu' or traditional herbs are now packed into capsules and are easily available. Although the efficacy of these is questionable, ease of access, familiarity and the fact that manufacturers often sell their products as contraceptives that can also preserve those attributes in women which are pleasing to their husbands, helps to make them popular. It also does not help that very often information on the side effects of oral contraceptives is widely circulated in the local press prompting women to seek 'safer methods'. The use of male methods of contraception, like the condom, in Malaysia is also very low and the fact that it is associated with sex workers and extramarital affairs does not augur well.

From the survey findings, another significant feature was that the modern male methods are used by only a small segment of the population, leaving women to assume the major responsibilities for the practice of family planning. The oral pill remained the most popular method. About seven percent of married women underwent tubal ligation. However, vasectomy remains negligible. There was, in fact, a slight decline in the proportion using condoms, from eight percent to 5.4 percent. A rather sizable proportion of married couples rely on natural family planning methods. Between 1984 and 1994, the proportion using the rhythm method and withdrawal increased from seven percent and 4.1 percent to 8.8 percent and 6.9 percent respectively. However, the proportion using other traditional methods had decreased from 9.3 percent to 6.7 percent. About 22.4 percent of the couples are using mostly natural family planning methods, that involve male participation, and this was about the same level as in 1984.

Interestingly, the 1994 Population and Family Survey did not ask a question on whether or not women wanted additional children, and hence the data do not allow an estimation of unmet need for contraception. A WHO-funded survey in the rural areas in 1996 by the Faculty of Economics and Administration provided an estimate on unmet need.

Table 7: Contraceptive Prevalence Rate and Unmet Needs

Ethnic Group	Any method			Modern methods		
	For limiting	For spacing	Total	For limiting	For spacing	Total
Malays	15.9	15.0	30.9	21.5	20.6	42.1
Chinese	9.1	5.4	14.5	20.4	6.8	27.2
Indians	24.7	6.7	31.4	28.1	9.0	37.1

The fertility level is declining gradually in keeping with the demographic target of the new population policy (decelerating the rate of fertility decline). The Government does not see the need for interventions to influence fertility. With a population of about 24 million, resource-rich Malaysia is still relatively under-populated, and rapid industrialisation and economic growth have resulted in labour shortages; this need has been met by foreign workers in the 1990s. Development policies have emphasised that it is the quality rather than the quantity of the population that matters. An educated population can make its own choices about family formation and family size.

FFPAM is complementing and supplementing the Government's efforts in the provision of reproductive health services such as counselling as well as contraceptive information and methods so that an informed choice can be made,

particularly by high risk and underprivileged groups. Some groups are slow in getting reproductive health information due to socio-cultural influences and end up with a larger family size (as in the case of East coast states). However, a survey in the squatter areas in five major towns in Peninsular Malaysia found that the contraceptive prevalence rate of women from these areas is at par with the national average, and close to half of the women had had a Pap smear taken (a level which is much higher than the national figure).

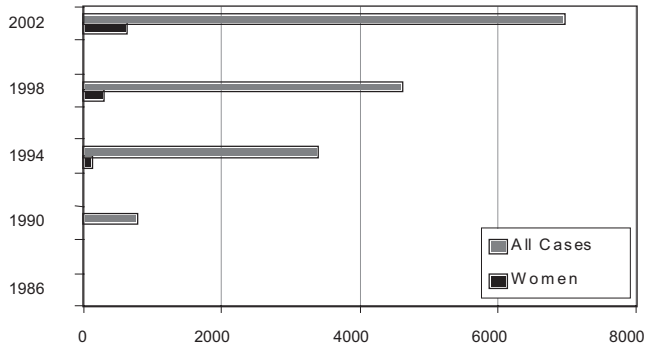
The data that show contraceptive prevalence remaining more or less unchanged since the mid 1980s, and marital fertility also remaining relatively high at about seven children per married woman, would mean that the rising age at marriage and the proportion remaining single have been important factors in fertility decline in recent years. Some sub-groups of the population have already achieved replacement level fertility. As the age at marriage and non-marriage are expected to increase further with improvements in education, the fertility level will continue to decline. However, it is important to note that the economically disadvantaged groups

However, it is important to note that the economically disadvantaged groups tend to have higher fertility, and this may accentuate the economic imbalance. There is, therefore, a need to step up IEC activities to educate the disadvantaged segments of the population to enable them to make informed decisions on the number and timing of births.

The 5th Population and Family Survey 2004 will provide updated data on trends in fertility, childbearing and service delivery. In particular it will confirm if indeed the plateau in the CPR between 1984 and 1994 will continue.

HIV/AIDS

Fig. 8: HIV Infections

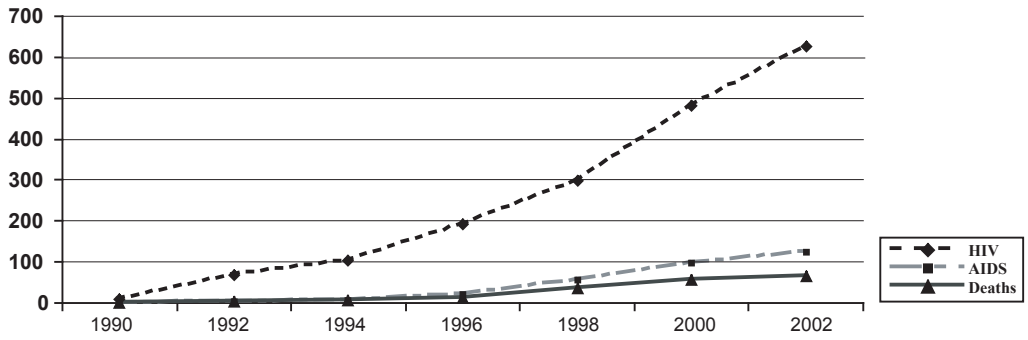


Perhaps of all the indicators of reproductive health, HIV/AIDS is the latecomer. At the ICPD in 1994, HIV/AIDS was not a major concern for Asia and the potential for widespread epidemics was not fully appreciated. For Malaysia, data from the Ministry of Health (HIV/AIDS Unit) show that in fact by the end of 1994 there was only 3,390 cases of HIV, 105 cases of AIDS and of these, women only made up 3.05 percent and 6.67 percent of total HIV and AIDS cases in Malaysia, respectively. However as we entered into this millennium the scenario started to change, fast. In 2001, the HIV prevalence was estimated at 0.7 for males and 0.12 for females. Although the prevalence of HIV/AIDS is still relatively low in Malaysia, there is a growing concern over the spread of the disease. The Ministry of Health and the Malaysian AIDS Council along with other NGOS are making concerted efforts to control the spread of this pandemic through educational campaigns as the

incidence of new infections continues unabated despite the national programme being introduced in 1986.

As the epidemic permeates into the population heterosexual modes of transmission are increasing from year to year. Not only are total infections in the country increasing, the percentage of the infected that are women is also increasing. Translated into numbers, the total women infected with HIV quadrupled from 104 cases in 1994 to 481 in 2000 and in fact multiplied six times to 629 in 2002. Between 1986 and 2001 HIV infected women made up 5.59 percent of the total infected population, but in 2002 alone, HIV infected women made up 8.95 percent of the total. Part of the increase in the number of infected women is due to the fact that the Ministry of Health introduced antenatal testing at all Government run antenatal clinics throughout the country in stages, beginning in 1998. However even when the 141 cases identified through these clinics were removed from the total, women still made up 7.1 percent of the total HIV cases detected in 2002.

Fig. 9: Number of Women Infected by HIV/AIDS



From seven women who were diagnosed with AIDS in 1994 the figure multiplied sixteen times to 97 in 2000 and in 2002 a total of 125 women were diagnosed with AIDS. The same was true of deaths from AIDS with an increase from six cases in 1994 to 57 in 2000 and in 2002 the number of women who died from AIDS was 64. It can therefore be concluded that from the overall data especially the component on the number of women diagnosed with HIV, AIDS, and deaths showing an increase from year to year, there does not seem to be any indication that the epidemic can be quickly stopped and reversed, as targetted in the MDG goal on HIV/AIDS.

The Malaysian AIDS Council is taking the initiative to increase awareness and take affirmative action to halt the trend of increasing incidence of HIV among women. The Council obtained the cooperation and collaboration of the Ministry of Women, Family and Community Development to commemorate the International AIDS Memorial Day 2004 with the theme 'Women and HIV/AIDS' as the forerunner of a future and continuing emphasis on the special position of women with regards to this scourge.

Reproductive Cancers

The Ministry of Health's First Report of the National Cancer Registry (2002) indicated that a Malaysian woman has a one in 19 chance of getting breast cancer in her lifetime. Breast cancer is the commonest cancer in all ethnic groups and from all age groups in females from the age of 20 years with an age-standardised incidence rate (ASR) of 52.8 per 100,000 population, accounting for 30.4 percent

of newly diagnosed cancer cases. The cumulative lifetime risk of developing breast cancer is highest among Malay women (1:24) whereas the figure is only 14 for Chinese women. Cancer of the cervix uteri is the second most common cancer among women with an ASR of 21.5 per 100,000 women, comprising 12.0 percent of total female cancers and Chinese women have the highest ASR (33.6 per 100,000 population) with a lifetime risk of 1:28. The cases were also diagnosed in the late stages, with those in stages three and four comprising 29 percent of all cases reported.

The high incidence of reproductive cancers affecting the breast and cervix uteri in Malaysian women has continued unabated despite the recognition of the problem and the availability of tools and resources for screening and early diagnosis to reduce the morbidity and mortality associated with these conditions. Primary level screening through clinical breast examinations and Pap smear tests was first carried out for women attending family planning clinics, initially at the FPA clinics and then at all government clinics. Since the mid-1980s these services were extended to all eligible women, both through opportunistic screening as well as special campaigns. Beginning in the early 1990s, the Ministry of Health set up dedicated breast cancer clinics (Klinik Payu Dara) at all major hospitals to improve the management of breast disease in Malaysian women.

Data from the Second Health and Morbidity Survey (1996) show that only 26 percent of the women in the target group had ever had a Pap smear examination. Higher screening rates were reported from urban women, Chinese women and those with higher education. This prompted the setting up of a National Technical Committee for Cervical Cancer Screening with annual targets and a plan for sufficient resources for training of medical and nursing personnel, clinical and outreach services and laboratory support services. Yet the uptake of the Pap smear service averaging 350,000 to 395,000 annually between 1996 and 2001 remained dismally low with less than 40 percent of the total eligible women covered.

Comparison with Government Reports

The above write-up on the overall achievements in implementing the ICPD goals and objectives in both the UNFPA Field Inquiry Questionnaire and this study has many similarities. The FFPAM was invited to participate in this questionnaire, and to complement the reports of the various government agencies. The FFPAM's role was also to fill the gaps in the Government's report pertaining to 'sensitive areas' such as sexuality education and services in adolescent sexual and reproductive health as well as 'innovative' strategies on rights-based approaches and programmes that a government agency would be more reticent in implementing or publicly acknowledging as a 'correct' strategy.

The similarities are due to the fact that all parties draw upon published reports and statistics by the relevant government ministries. The Department of Statistics publishes reliable, comprehensive and regular reports, especially for the population censuses and vital statistics affecting the total population, and differentiated by variables such as age groups, sex, geographical locations, ethnic groups (not for all variables) etc. Gender-disaggregated data however is generally insufficient for detailed gender studies. The relevant ministries and other bodies also produce their annual reports, although access to these reports may be more restricted (e.g. MOH Annual Reports) or delayed (NPFDB Annual Reports are available usually two years late, available only after presentation to the Parliament). Nevertheless, the reports are frequently made available due to

inter-agency trust and cooperation and also because NGO inputs are generally solicited for official status reports as for the ICPD reviews.

Nevertheless, the FIQ 2003 contains mainly position statements, with most answers being in the affirmative to queries about whether specific policies and programmes exist or have been introduced since the ICPD. A minor point is that the FIQ was completed at the end of 2003, and therefore did not contain the latest developments, for example the changes in political and administrative arrangements especially affecting the Ministry of Women and Family Development following the 11th General Elections.

On the other hand, the statement pertaining to 'not providing contraceptives to unmarried people' remains without further elaboration, as in all previous ICPD-related documents, despite including the inputs of the FFPAM, which highlighted the need for, and the availability of feasible service delivery modalities for SRH education and selected sexual health services for young people.

Main Implementation Barriers and Facilitating Factors

Political Commitment

Malaysia has an enabling environment with a favourable political, economic and social framework with the relevant policies, strategies and necessary legislations that facilitate the achievements of the ICPD goals and objectives. The country's development plans have consistently stressed national unity, equity in the fulfilment of basic needs and quality of life for the Malaysian people. A continuing thrust on human development is further embodied in the country's Vision 2020, an ultimate goal of achieving fully industrialised nation status by the year 2020. The Seventh Malaysia Plan, 1996-2000 and Eighth Malaysia Plan, 2001-2005, have been formulated to focus on a better quality of life, with poverty eradication being the main thrust and 'better packages' for social, education and health services that are in consonance with the goals and objectives of the ICPD.

The Government of Malaysia has further demonstrated its commitment to improve the status of women with the establishment of the Ministry of Women and Family Development in 2001. The Ministry is expected to strengthen the implementation of the National Policy on Women (1989) in successive development plans since 1991 (Sixth Malaysia Plan, 1991-1995) in order to: (i) involve more women in decision-making; (ii) safeguard their rights to health, education, and social well-being; (iii) remove legal obstacles and discriminatory practices; and (iv) ensure access to and benefits of development particularly in science and technology. The Seventh Malaysia Plan (1996-2000) and the Eighth Malaysia Plan (2001-2005) reiterated women's concerns and provide the appropriate enabling environment for women to participate more effectively as partners in social and economic development, as well as allowing them to continue to play a significant role in the development of their families. Towards this end, the Government, working closely with NGOs and the private sector has implemented many gender-sensitive programmes, including changes in the legal and institutional framework, which further facilitated their involvement in socio-economic development.

Favourable Socio-economic Situation

In the past decade political and economic conditions throughout the region have not been conducive to change. This is due to the Asian financial crisis in mid-1977, the global impact of the Middle-East crisis and Iraq War and the

Severe Acute Respiratory Syndrome (SARS) epidemic in 2003. Nevertheless Malaysia has continued to benefit from the progress in economic growth as well as meeting social objectives. The Malaysian economy which had experienced remarkable growth from the 1970s and achieved a GDP of 8.7 percent per annum under the Sixth Malaysia Plan period, 1991-1995 was able to sustain the pace of development at about 4.7 percent per annum during the period of the Seventh Malaysia Plan, 1996-2000. The negative growth registered in 1998 was quickly reversed and the sluggish growth rebounded strongly attaining a rate of 4.1 percent in 2002 and registering 4.5 percent in 2003, with plans for continual gain in the momentum of growth of 7.5 percent per year during the Eighth Malaysia Plan, 2001-2005.

The overall socio-economic development in the country has remained at a satisfactory level and has generally facilitated the achievement of the ICPD goals and objectives as well as the MDG and related goals of the individual social sector. The introductory chapter of the Eighth Malaysia Plan, 2001-2005, explained how the country experienced satisfactory growth despite the Asian economic crisis, by pursuing sound macroeconomic management, maintaining prudent fiscal and monetary policies and enhancing efforts to develop a knowledge-based economy with continuing emphasis on human resource development towards ensuring poverty eradication and restructuring society. The per capita income (GNI at market prices) which reached RM 13,485 by Year 2000 continued to rise to RM 14,098 by 2003 while the labour force participation achieved about 65 percent and the unemployment rate well below four percent in this period.

Enhancing the quality of life through provision of and access to social services enabled people to live with dignity and participate fully in society as the Government made good its commitment for financial support to NGOs and other community organisations following the initial cutback immediately after the Asian financial crisis. In recent years, through the Ministry of Women and Family Development, there was an added emphasis on addressing social issues to combat the effects of globalisation that threatened the integrity of the family structure and traditional communities as well as influenced cultural values and norms in social integration and nation-building. The budget allocated for the Ministry in 2004 has been raised to RM 110 million, from RM 99 million the year before (under the Ministry of Women and Family Development, without the Community Development component which is being adjusted following the expansion in March 2004).

Legislative and Structural Provisions

An important facilitating factor was that following the ICPD the implementation of the PoA was carried out through the integration of the ICPD goals, objectives and elements within the policy objectives, framework and programmes of the country's development plans, the relevant plans being the Seventh Malaysia Plan (1996-2000) and Eighth Malaysia Plan (2001-2005). Hence this action greatly facilitated its uptake and inclusion into the plans and programmes of the sectoral agencies through the regular inter-agency planning groups (IAPG) and the Technical Working Groups (TWG) for each of the Development Plans with the Economic Planning Unit of the Prime Minister's Department playing a central role in the planning and monitoring of the UN Conferences. The inter-linkages of the programmes under the World Summit on Children (1990) and the Fourth World Conference on Women (1995) are therefore firm and sustainable. At the same time, this arrangement created a situation whereby there was too much inter-agency dependence for a particular programme to be implemented and the energy and creativity for innovations slow in coming or unduly delayed due to bureaucratic procedures.

As well, there were some constraints. The tasks for the on-the-ground monitoring and evaluation of ICPD-related activities under the purview of the National Population and Family Development Board did not enjoy a high level of priority as the Board is a statutory organisation and not a full-fledged government agency. It was reporting to two different ministries in the short time span of ten years until its placement under the newly established Ministry of Women and Family Development in 2001. Family planning in terms of contraceptive services is still mainly promoted for the health of the mother and child and therefore the welfare of the family. The scope of family planning however is progressively widened with elements of family development, sexual and reproductive health, especially after the Act was amended to become the National Population and Family Development Act in 1988. The vision re-stated as 'To strengthen families towards the realisation of a caring society, quality population and progressive Malaysian nation' had a broader programme focus on Population, Family Development and Parenting and Human Reproduction but more diffuse strategies and activities. While this is an important development to note, there is some concern that women's reproductive health and rights (presumably subsumed under Family Development) could be overlooked and not given the priority they deserve.

The immediate activities following the ICPD in 1994 were the organisation of several workshops to further discuss and facilitate the integration of population and family development factors in the programmes of related agencies, involving both central agencies like the Economic Planning Unit, Prime Minister's Department and the sectoral Ministries of Health, Education, Youth & Sports, Rural Development and Social Welfare. These Plans of Action were not widely circulated to continually guide sectoral planning or be used as a reference by NGOs. However beyond these 'information sharing' meetings little or no effort has been made to collectively coordinate or plan activities with a view to achieving the ICPD PoA. In fact five years after ICPD in 2000, it was still observed that sex-disaggregated data were not easily obtained from government agencies.

No major forums were held for the monitoring, evaluation and further planning and implementation of the PoA until the ICPD+5 review. Then, the Board held two roundtables, on 'Linkages between Population and Sustainable Development' and 'Reproductive Health, Reproductive Rights and Religious and Ethical Issues' and issued a publication: 'Initiatives in Population and Development: Malaysia's Development'. This document elaborates on the changes in policies, programmes, institutional and organisational framework to support the ICPD PoA.

To further implement the concept of reproductive health expounded in the ICPD PoA, the Board set up an Advisory and Coordinating Committee on Reproductive Health (ACCRH) in 2001, replacing the Central Coordinating Committee (CCC) and the State Coordinating Committees (SCC). The ACCRH membership is expanded to include more government agencies, i.e. Ministries of Health, Education, Human Resources, Youth and Sports and Department for Islamic Development (*JAKIM*) and NGOs (FFPAM, Malaysian AIDS Council). Since its inception, the ACCRH however has not met regularly as scheduled (twice a year) while not all states have convened the annual meetings as required. Hence the government's, or more precisely the NPFDB's efforts to improve the mechanism and process of planning and coordination of a more effective national programme in reproductive health have been slow to bear results.

The Department of Women's Affairs, which comes under the same ministries as the NPFDB is tasked with the implementation of the ICPD strategy on empowering women and promoting gender equality. The Department gained a higher status as a full department under the Ministry of Women and Family Development, with

strengthening of the programmes to improve the well-being of women consistent with existing legal provisions and the National Policy for Women (1989), and in consonance with the Platform for Action of the Fourth World Conference on Women (Beijing, 1995). A Plan of Action for the Advancement of Women was formulated in 1997 to further guide national planning and programming. In August 2001, Article 8(2) of the Federal Constitution was amended to include the word 'gender', thus prohibiting laws and policies from discrimination against women, and men. This amendment cannot be taken as an explicit action to promote gender equality, but rather a means to facilitate women's development. The grassroots implementation is rather slow and not well coordinated as it was left to the State Women Development Councils for follow-through.

The social agenda as an issue is recognised as a national priority to address emerging issues including that of adolescent health and development. The Cabinet Committee on Social Issues was set-up in 1997 and implemented through a Social Action Plan (*PINTAS*) with appropriate budgetary allocations under the Ministry of National Unity and Social Development. It was only in 2003 that a National Social Policy was elaborated, and this is yet to be used widely to guide programme development and planning in various sectors.

On the other hand, the Policy for Older Persons approved in 1999, which emphasises the dignity, self-reliance, participation and care and protection of older persons aged 60 years and above as respected and productive members of the family and society has a more concrete Plan of Action. This Plan, finalised in September 1999, contains provisions for education, employment, community participation, recreation, transport, housing, family support systems, health, social security, media and research and development.

Human resource development remains a principal thrust of the nation's Development Plans. The education sector provides for primary, secondary and tertiary education and vocational skills training for Malaysia's young population, in preparation for a strong human resource base for long-term economic growth and global competition, with emphasis on a knowledgeable population. Primary education (years one to six) which had been provided free in the country and achieved almost universal registration for Year One pupils was nevertheless made compulsory as of the year 2003, with a record three million children enrolled for primary education in 2003. Hence with no disparity on gender for basic education, the focus is on ensuring quality education to prepare the country's future work force, with an emphasis on matching academic qualifications and training to the needs of the labour market. The Ministries of Youth and Sports and Entrepreneurial Development further equip the young population on individual development in culture and arts, etc., as well as entrepreneurship and economic independence.

With the expected increase in the young population (15-24 years) from 4.03 million in 1995 to 4.98 million in 2005, youth development is further emphasised with the objective of moulding and developing a resilient youth community able to contribute positively towards nation building. Measures include greater accessibility to education and training with specific programmes for leadership training, entrepreneurial development and healthy lifestyles. There is also a strong focus on life-long education, facilitated by the extensive resources made available for the ICT sector through the Multi-media Superior Corridor (MSC) initiative. This strategy targets young people as the promoters, motivators, and end-users of electronic and internet-based learning tools.

The strategy for 'Health For All' is followed through in both the Seventh and Eighth Malaysia Plan periods (1996-2000 and 2001-2005 respectively) after the ICPD. The scope of the family health programme under the Ministry of Health, which aims to promote and maintain the optimal health status for the individual, family and community, comprise new groups of beneficiaries, i.e. older persons and adolescents, with inclusions of the relevant elements of reproductive health such as menopause services and adolescent health. Public health facilities and coverage is expected to continue to improve, in particular rural health facilities for the promotion and provision of health services as well as appropriate health services for those with special needs.

Government expenditure on health has increased from Ringgit Malaysia (RM) 1.777 billion in 1990 to RM 2.327 billion in 1994 and RM 6.655 billion in 2002. Expenditure on health services made up about five percent of the total government expenditure in 1990 and 1994 respectively, and this increased to 6.4 percent in 2002 (Asian Development Bank). In terms of development expenditure, the government allocated RM 3.725 billion to the health sector under the 7th Malaysia Plan (1996-2000), and RM 5.500 billion or 5 percent of the social sector development budget for the Eighth Malaysia Plan period.

In specific terms, the traditional 'Maternal and Child Health' (MCH) approach has been re-organised with separate emphasis on child health and women's health, the latter including services for family planning, menopause and screening for gynaecological cancers, that is a strategic emphasis on 'well women'. The Cancer Registry which has entered into the implementation phase in 2003 after a successful pilot testing period is a critical tool as the two most important cancers affecting women are diseases of the reproductive system i.e. breast and cervical cancers. A programme for men's health is currently being developed. The adoption of a National Adolescent Health Policy in 2001 paves the way for more focussed and structured programming for young people, beginning with the priority action on prevention of substance abuse and balanced nutrition towards a healthy lifestyle.

HIV/AIDS is recognised as a national issue since 1986 and the National HIV/AIDS Programme is coordinated by an inter-ministerial committee chaired by the Minister of Health and spearheaded by an especially established unit under the Division for Disease Control. The national programme provides free services for anonymous HIV testing and treatment for the antenatal mother and children affected through maternal-child transmission. The prevention programme on HIV/AIDS in the country relies heavily on prevention education especially among young people (*PROSTAR* programme) while offering limited services in harm reduction.

With regard to poverty alleviation, the economic objective of the First Twenty-Year Plan 1966-1985 aimed for overall economic development through an increase of the Gross Domestic Product but the promulgation of the New Economic Policy driving the First Outline Perspective Plan, 1971-1990, specified the twin objectives of eradicating poverty and eliminating the identification of race with economic function, with an over-riding objective to achieve national unity. The Seventh Malaysia Plan, 1996-2000, which covers the second phase of the Second Outline Perspective Plan (OPP2), 1991-2000 and driven by the National Development Policy, emphasised the concept of balanced development, with strategies to further reduce poverty, especially relative and hardcore poverty as well as restructure society so as to achieve equitable distribution in the context of a healthy and sustained economic growth. Poverty eradication was stated as a main thrust of the Eighth Malaysia Plan, 2001-2005, to bring down the nation's hardcore poverty level to 0.5 percent by 2005. In this Plan, the poverty eradication

programmes are more target-specific to address pockets of poverty in rural and urban areas in implementing the distributional strategies for an equitable society.

Despite the availability of funds and a strong commitment to improve the health status of all Malaysians, the inability of the government to undertake programmes seen as 'controversial' by religious groups is obvious. For example the adolescent health programme of the Ministry of Health touches on areas of nutrition and body image and little on premarital sex except to emphasise that it not prohibited by all religions. Healthy lifestyle programmes emphasise exercise, nutrition, freedom from drugs and alcohol but say nothing on abstinence and fidelity and do not go into harm reduction (condom or needles exchange). In fact the National Drug Agency, entrusted with the responsibility of rehabilitating drug users does not teach inmates (except those married and HIV positive) about the condom let alone about the cleaning of needles. More than 81 percent of PLWHAs are in the age-range of 20 to 39, and the ever increasing social problem of unplanned teenage pregnancies has not convinced the leaders of the need to provide sex education in schools. The standard answer is that all elements of sex education have been incorporated into Science, Physical Education, Moral studies and Religious education. This has prompted an activitist Dr S.P. Choong, former Chairman of the FFPAM and Community AIDS Programme in Penang to urge politicians to face arguments from "traditional and conservative" organisations, that oppose sex education (often mistaken to be educating children to have sex). He also says that politicians "who duck the problem involving human sexuality often give the excuse that the people are not quite ready. But, if leaders are not ready to face these issues, when will the people be?"

Civil Society Initiatives

The FFPAM, registered in 1958 and with member-associations from all 13 states in the country has remained in the forefront advancing from its role as an advocate on family planning to issues on sexual and reproductive health and rights. The FFPAM also keeps abreast of national, regional and international issues through active networking, collaboration and participation, and has been a member of the International Planned Parenthood (IPPF) since 1961. To meet the challenges of the 1990s, the FFPAM governing body approved the 'FFPAM Strategic Plan Towards Vision 2020' in 1992. The Plan, published in 1994 contained goals and strategies on five programme areas relating to Family Planning, Sexual and Reproductive Health, Advocacy and IEC, Family Life Education (for Youth) and Women's Development that were considered highly relevant and hence continued to be used to guide programme planning, implementation and evaluation in the Federation to address the ICPD and related issues.

Since the ICPD, the FFPAM has implemented more focussed activities on educational and service delivery modalities including piloting the rights-based approach on sexual and reproductive health and rights. The rights-based framework was adopted to ensure access to services, promoting informed choice, involving men in reproductive health and satisfying unmet needs for contraception, especially involving adolescents and marginalised communities such as women workers in the agricultural sector. Both the Ford Foundation/IPPF project on 'Empowerment of Young Women from Underserved Communities in Reproductive Rights and Reproductive Health' (2001-2002) and Price Foundation/IPPF project on 'Empowering Women in the Agricultural Sector through Income Generation and Integration of Reproductive Health and Environmental Developmental Activities' (2002-2003) provided very useful learning experiences for FFPAM to define the multi-sectoral service delivery modalities to these under-served populations.

The lessons learnt have also been shared with member-associations of the IPPF East, South-east Asia and Oceania region (ESEAOR) to develop their own programmes.

The FFPAM's Family Life Education programme for young people produced its signature Reproductive Health of Adolescents Module (RHAM®) in 2000, under the UNFPA project: 'Promoting Adolescent Reproductive Health and Healthy Living' (MAL/98/P02). The module is widely recognised locally and in the region as a highly relevant and effective training tool on providing knowledge and responsible living skills to young people, both in and out-of-schools. The RHAM is available in the local language (*MKRR®* as a dual-language edition, 2002) and also transformed into an internet-based courseware edition with Islamic perspectives, e-RHAM® and e-RHAM IP®, the latter through a grant provided by the Malaysian Government under the Demonstrator Application Grant Scheme (2002/2004). The Ministry of Education has endorsed the use of the RHAM as reference material for the Family Health Education curriculum for secondary schools.

The updated Strategic Plan in 2003 encompasses 13 strategic challenges focussing on goals and corresponding strategies on Advocacy, Programme Management and Governance and Management that will enable FFPAM to be a more effective, caring and self-reliant NGO in the field of population, family planning and sexual and reproductive health. The programme areas are currently being re-oriented in consonance with the IPPF Strategic Plan (2002), to focus on advocacy, access, abortion, adolescents, and HIV/AIDS (5As) with support strategies on governance, capacity building, knowledge management and resource mobilisation.

NGOs directly involved in sexual and reproductive health and rights continue to advocate for services for various populations which otherwise would have been left out of government programmes. For example in the area of adolescent reproductive health FFPAM facilitated a meeting of young people and more recently men to discuss their right to reproductive health. Considerable efforts were made to make their voices heard by the political leaders. So far the response from non-health agencies (Ministry of Youth for example) has been lukewarm. The Ministry of Health, on the other hand provided non controversial health services like nutrition and prevention of drug abuse but steered clear of direct reproductive health services for young people except to advise against premarital sex, all keeping well within the law of no contraceptives for unmarried individuals. This does not deprive the economically better-off or urban adolescents because they can seek alternative services from the numerous general practitioners in urban areas but it deprives the poor, uneducated and rural and marginalised populations of their right to reproductive health services.

At the same time because NGOs receive some funding from the Government, it can be misconstrued by the Government that even when they are not involved in "controversial services" (as in reproductive health services for adolescents) they have nonetheless provided the NGOs with the funds to do so. Therefore failure to address the particular reproductive and sexual health problem rests solely with the NGOs. It must be remembered that NGO programmes and services have limited reach. Unlike the Government, the services they provide are in urban areas and even when they make special efforts to reach the rural population financial sustenance is a problem.

Geopolitical developments

Malaysia continues to be the receiving country in the South East Asia region and beyond for citizens of less developed countries to find better employment and a higher standard of living. While the flow of documented workers for professional services is systematically controlled and monitored, workers for the agricultural, construction, domestic and service industries are subject to frequent regulatory changes, with regard to application criteria, fees and charges and length of stay. This is compounded by the large flows of undocumented workers for the latter group of services reacting to and suffering from the impact of irregular supply and demand situation. The problem of the large numbers of illegal migrants from neighbouring countries especially Indonesia persists, and along with this influx, the attendant social and health issues.

For the scheduled migrant workers, a "clean bill of health" is an entry requirement and many do not recognise the rights and responsibilities of maintaining a continuum of good health status. Undocumented workers have limited access to comprehensive health care for fear of being detected and deported. In relation to reproductive health, many women are ignorant of their rights, and as many of the reproductive health care elements are preventive in nature the women themselves do not see the need and the extra effort required to avail themselves of the services. In fact the data on maternal morbidity and mortality statistics in the state of Sabah have been disproportionately skewed by the higher incidence in these population groups. Women employees for the domestic sector are still subject to the "no-pregnancy" clause. The ruling on family (non-) reunification remains.

Elements of Reproductive Health

The reproductive health elements, as defined under the ICPD PoA, were implemented at various levels based on the priorities and resource availability and capabilities of the implementing agencies, with family planning, safe motherhood and HIV/AIDS enjoying the most attention. The NPFDB directs the national family development programme (includes family planning and infertility services) as provided for under the Act of Parliament (Act No 42 of 1966, amended 1988), and which was relatively effectively moderated through the Central Coordinating Committee for Family Planning (1970-2000), the Advisory and Coordinating Committee for Reproductive Health (from 2001) has not been as effective. The project to integrate the ten elements of reproductive health remains at a pilot testing stage, while the Ministry of Health continues to focus more on services for safe motherhood, management of complications of abortion and HIV/AIDS and the FFPAM promotes other RH services for older persons (including menopause) and sexual and reproductive health services for young people.

Contraceptive supplies remain at a very affordable level, especially as the Ministry of Health continues to provide them free to all its clients; the NPFDB charges a very low rate, all brands of oral pills being dispensed at only RM 1.50 per cycle, and the intra-uterine device costing only RM 25 per piece. On the other hand, the Federation of Family Planning Associations, Malaysia (FFPAM) being the pioneer and dominant NGO providing family planning, sexual and reproductive health services, continues to remain in the forefront as a dependable and reliable source of affordable, convenient and quality health care. Their contraceptive stocks, provided as a commodity grant by the IPPF, are available at nominal rates just slightly higher than those provided by the NPFDB. Several types of contraceptive services and commodities are also available from the private sector network located mainly in the urban and suburban areas, at rates between two to three times those of the NPFDB and FFPAM.

On the problem relating to the backlog of reading of the Pap smear slides at the Ministry of Health level, the Ministry began in March 2004 to discuss the need to introduce a new category of laboratory personnel in the form of "Cyto-screener" in an attempt to deal with the workload and at the same time maintain a high quality for the reading of the Pap smear slides.

Additional Concerns in Support of ICPD

Services for Adolescent Sexual and Reproductive Health

Young people under the age of 25 make up about a third of the country's population. In all major reports cited on adolescent sexual behaviour, there was a clear trend towards increasing sexual activity among young people with no adequate protection with the concern that unplanned pregnancy and sexually transmitted infections may be unchecked. Sexual activity is initiated at very early ages, the average age being 13-15 years although in some studies it is 17-18 years. The proportion of adolescents and unmarried youths who have experienced sexual intercourse is most likely to be in the range of 10-20 per cent, with increasing incidence with age, residence and schooling status. Boys are also more likely to be sexually experienced. In all cases, the recommendations emphasise the need for adequate and comprehensive sexual education for young people.

Due to the increasing trend of social ills reported among young populations and the pioneering work of the NGOs, the curriculum for sexuality education for adolescents boys and girls has received more attention from the authorities, especially the Ministry of Education, to promote family and cultural values on healthy and responsible living, including the virtues of sexual abstinence before marriage and the importance of gender equality. However, comprehensive, youth-friendly and affordable services to reduce unhealthy behaviour (in the form of prevention of teenage pregnancies and the consequent problems of abortion, abandoned babies and the like, and sexually transmitted infections, especially HIV/AIDS) have not been recognised/accepted. Even at the NGO clinics, only limited preventive services are available.

In the current context, the teaching of sexuality education, must be taken seriously as a primary responsibility of the family, to be supplemented and complemented by other institution-based programmes, both in the school and by community organisations with the commitment, dedication and expertise to provide such services. A review and re-statement of the current policy to reaffirm the main principles for the proper upbringing of children towards very specific goals or responsible living and complete with the infrastructure and resources is urgently required.

Young people, including adolescents, know about family planning, yet many of them do not access such services, partly because they feel they are unprepared for them. Service policies that affect the provision of family planning services in the country can sometimes also act as a barrier. Currently, it can be said that there is almost universal (economic and physical) access to family planning services in the country as such services first became available in the 1950s through individual efforts and as a result of the efforts of community organisations like the Family Planning Associations. Since the mid-1960s public sector sources such as the National Family Planning Board/National Population and Family Development Board (1966/1988) and Ministry of Health, the latter through the introduction of the Integration Programme of Maternal and Child Health and Family Planning in 1970, have also contributed to this. The private sector also played a significant role, serving about 25 per cent current users

in 1974 to some 40 per cent in 1984 (NPFDB, 1988) and 45 per cent by 1988 (NPFDB, 1999).

Generally, family planning is promoted for health reasons with an emphasis on spacing and avoidance of risk pregnancies, and clinical services in the public sector are mostly targeted at married couples. Those who are not married usually obtain services from private sector sources and FPA clinics, while supplies of hormonal pills can be obtained from pharmacies and condoms from general goods outlets. The FFPAM and other non-government organisations are increasingly advocating the promotion of sexual and reproductive health of adolescents, primarily through prevention education but also the provision of selected clinical services (FFPAM Annual Reports, 1980 - 2001).

The Ageing Population

Consequent upon fertility decline and extension of life expectancy, the population of Malaysia is ageing gradually. The female population aged 55 and older had increased from 770,070 in 1991 to 1,017,925 in 2000, and now constitutes about 9.3 per cent of the total female population. In the 20-year period from 1995 to 2015, the proportion of persons aged 60 years and above is expected to rise from six per cent to nine per cent, due to a higher rate of growth for this population group, increasing from 3.6 per cent to 4.4 per cent while the population growth rate is expected to decline from 2.7 per cent to 1.8 per cent.

While the maternal and child health programme has contributed towards a remarkable improvement in maternal mortality and morbidity among women in the childbearing age groups, there is a need to improve the reproductive health programme for older women, particularly with respect to management of menopause, cancer screening and other health problems.

Single Mothers

The number of single mothers has also increased to 620,389 in 2000 from 538,924 in 1991. About two thirds of these were aged 55 and over. Many single mothers are in need of financial assistance and other forms of assistance to support themselves and their dependents. The Government has implemented poverty eradication programmes, with single mothers as one of the main target groups. However, a large number of single mothers may not be aware of such programmes and do not receive the necessary assistance. It is proposed that more information and assistance be provided to these women.

Crimes and Violence against Women

In spite of commendable social development in Malaysia and the establishment of a Crime Prevention Foundation, there is now a growing concern about rising crimes and violence, particularly against children and women.

HIV/AIDS

Despite the recognition of the problem of HIV/AIDS and the corresponding budgetary allocation as well as a nationwide programme to address the challenge, there is concern that the epidemic may not be contained. The causes for it are multiple but it would be safe to say that like other countries in Asia, gender and

poverty number among the main ones. Because of the manner in which Malaysia collects data on HIV/AIDS (all prisoners along with suspected drug users - who are rounded up by the police - are tested) from the beginning of the epidemic there seems to have been a certain amount of complacency on the part of the general population who are not drug-users to think that they are therefore not vulnerable. In general most of the data show that almost three quarters of the infected each year were drug-users who contracted the virus through sharing of needles. The World Health Organisation (WHO, 2003) pointed out that a study of intravenous drug-users conducted in 1998 showed that 81 percent shared needles and 21 percent shared more than one per day. The National Drug Agency estimated that there were more than 400,000 drug users in the country. Coupled with the fact that rehabilitation centres are under-staffed and that rehabilitation is almost ineffective, the potential threat from this marginalised community would be almost explosive because drug-users also have sex and sometimes the need for money to buy drugs forces them into sex work. At the same time some of them are married and it is very likely that they could pass on the virus to their wives. We already have evidence of infected women and children abandoned or widowed or orphaned by infected drug-user fathers.

Even when counselling has been given to partners of confirmed HIV/AIDS positive individuals there is no guarantee that the (spouse) women will be protected from infection by their partners. In a study of 128 positive (at least one partner was positive) couples that were counselled on safe sex only 49.2 percent were using the condom (59.2 percent among the Chinese, 50 percent Indians and only 34 percent of the Malay couples). It would also be wrong to fault the men because it is sometimes the women themselves who do not insist on the use of the condom due to the fact that it has been ingrained in them that their role is to please the husband (including during sex). Furthermore the condom is often associated with the prevention of pregnancy rather than a protection against STD including HIV/AIDS.

Testimonies by positive women also shed some light on how gender roles increase their vulnerability. Some women were “coerced” into marriage by parents because to have an unmarried old daughter is seen as a disgrace to the family. As women grow older (and culturally a husband is expected to be older than the wife) the availability of potential suitors is limited. Under such circumstances parents unknowingly marry off their daughters to drug users (who may be positive) thus infecting both the daughters and young children.

In 1998 the Ministry of Health embarked on a programme to test all antenatal mothers who attended the antenatal clinics run by the Government. With this programme, 161,087 mothers (representing 49.7 percent of all antenatal mothers) were screened that year. The percentage screened increased from year to year so that by 2002, 92.8 percent of all antenatal mothers had been screened. While the act by the Ministry of Health is noble, one questions the implications of embarking on such an enormous programme from the standpoint of pre and post-test counselling. In a system where antenatal clinics tend to be crowded, it would be inconceivable that each mother be adequately counselled before and after testing. At the same time administering AZT to mothers (to prevent MTCT) at a time when she does not need the medication yet could lead to resistance. With pressure from the Malaysian AIDS Council and concerned women’s groups, the policy of the Ministry of Health is now to provide free of charge, lifelong medication, including antiretroviral medication to all women and children detected as HIV positive or with AIDS during antenatal screening.

Challenges and Recommendations

Advocacy

In the present context of a strong political commitment to the ICPD PoA and other related UN agreements and treaties, explicit policies and necessary instruments including the systems, infrastructure, human and other resource allocations, coupled with the highly competitive private sector enterprise and a willing and dedicated NGO presence, the critical challenges to the countdown to 2015 are to ensure sustainability of previous and current initiatives and to avoid complacency and competing challenges.

Malaysia has embarked on its own unique mode of addressing population, family and individual concerns in the context of the overall national goals of ensuring poverty eradication, restructuring society and national unity. Firstly, continuing advocacy at the government level is still necessary – from parliamentarians and key agency staff to programme implementers - to ensure that the systematic and regularised five-year reviews of the Malaysia Development Plans could be more effectively utilised to provide a comprehensive and sector-wide evaluation of policies, programmes and to identify key areas for future action.

Advocacy to the other group of stakeholders representing the recipients or beneficiaries is equally important; it must focus on ensuring proper understanding of basic human rights, pertain to the promotion and protection of the sexual and reproductive rights, especially of women and adolescents, and the necessary actions thereof to be keepers of their own health. Specifically this is to ensure they derive maximum benefit from the policies, strategic plans and the implementation of sexual and reproductive health services to respect all human rights, including the right to development, and that such services meet lifelong health needs, including the needs of adolescents, address inequities and inequalities due to poverty, gender and other factors and ensure equity of access to information and services.

Access for Vulnerable and Marginalised Populations

A main outcome of the focussed advocacy efforts is to ensure access to the full benefits of good reproductive health services for vulnerable and marginalised population groups. Priority programmes for equitable access are required for young people, older persons, men, indigenous community and migrant workers. The inputs must be tailored to their expressed needs in the context of a full recognition of their sexual and reproductive rights. This includes women in special circumstances such as single mothers and undocumented workers.

Specific attention is also necessary to combat the threat of HIV/AIDS and its potential to affect women in increasing proportions due to a lack of understanding and action on gender concerns.

Alliance Building

Achieving the ICPD goals and objectives satisfactorily will be facilitated by effective networking and collaboration between all major parties interested and committed to the reproductive health agenda. The Malaysian NGO Coordinating Committee for Reproductive Health (MNCCRH), with the FFPAM in the chair, has demonstrated its commitment to this task and is prepared to play an even more critical role as the liaison between the Government and civil society and

the further spread of programmes to the grassroots level. The process of alliance building with hitherto unlinked community groups and other social organisations can be stepped up with a formalisation of its role and the necessary institutional support.

Meanwhile the governance and knowledge management issues must be considered seriously and effectively instituted by all partner agencies with confidence, trust and meaningful sharing to further accelerate the full implementation of the ICPD PoA and to benefit those in need and deserving attention.

Financing and Resource Mobilisation

The civil society partners committed to the full implementation of the ICPD PoA must ensure the maintenance of an adequate resource base to carry out and sustain the activities relating to advocacy, information and education, capacity building, pilot testing of service delivery modalities and service delivery to the target population. The beneficiary communities for education and service delivery activities comprise mainly the vulnerable and marginalised populations.

Conclusion

In conjunction with the tenth anniversary of the ICPD, the UNFPA has reaffirmed the Programme of Action of the ICPD as a progressive agenda for human development synergistically supporting and reinforcing the actions of other sectoral concerns that should culminate in the global action to eradicate poverty and achieve social justice and economic development for all humankind. The Programme represents a radical approach that respects human rights and promotes the autonomy of individuals yet requires a common vision and aim through effective partnerships, inter-sectoral collaboration and mutual accountability. It is imperative therefore that member states stay firm to the pledge retaining the language and commitments made in 1994 and work towards its full implementation by 2015.

The appraisal of the country-level implementation in the past ten years shows considerable progress in the policies, laws and programmes for the promotion and implementation of the ICPD PoA and a satisfactory level in the understanding, accepting and implementing of the critical ICPD gender equality and SRHR objectives. Malaysian women enjoy many benefits from the country's rapid socio-economic advancement in terms of improved health status, education and employment opportunities.

The main constraints relate to equitable access and utilisation of resources and services for sexual and reproductive rights and health by selected marginalised groups who are hindered from joining mainstream development, possibly due to a need to adhere to traditional/cultural norms, societal pressures, language barriers, ignorance and apathy. In particular indigenous population groups, resident communities of the estate sector and migrant workers deserve urgent attention.

The NGO sector needs to be better recognised and given higher opportunities in the alliance creation process to build on the gains achieved since their pioneering efforts in the early decades following the country's independence. At the same time they need to build the necessary capabilities to deliver quality services appropriate to the needs of the community.

In conclusion, the Government of Malaysia and its people are deeply committed to the implementation of the PoA with significant levels of achievement for all the major goals and objectives of the ICPD PoA; on universal access to family planning by 2015, providing basic education equitably to boys and girls and further reductions in infant, child and maternal mortality. All these goals are practically achievable as the country has a head start under the Vision 2020 initiative and enjoys political stability and economic sustainability with a promise to abide by previous commitments following the recently concluded 11th General Election when the ruling party of Barisan Nasional was returned with overwhelming majority and a strong mandate for the next five years.

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Abbreviations / Acronyms

ACCRH	Advisory and Coordinating Committee on Reproductive Health
AIDS	Acquired Immunodeficiency Syndrome
APPC	Asian and Pacific Population Conference
ARROW	Asian-Pacific Resource and Research Centre for Women
APFPD	ASEAN Parliamentarian Forum on Population and Development
ASEAN	Association of South East Asian Nations
ASR	Age-standardised Incidence Rate
ASRH	Adolescent Sexual and Reproductive Health
AWAM	All Women's Action Society, Malaysia
AZT	Azidothymidine
BCG	Bacille Calmette-Guerin
CEDAW	Convention for the Elimination of Discrimination Against Women
CCC	Central Coordinating Committee
CPR	Contraceptive Prevalence Rate
DAGS	Demonstration Application Grants Scheme
DPT	Diphtheria, Pertussis and Tetanus
ESEAOR	East and South East Asia and Oceania Region
FFPAM	Federation of Family Planning Associations, Malaysia
FIQ	Field Enquiry Questionnaire
FPA	Family Planning Association
FWCW	Fourth World Conference on Women
GDP	Gross Domestic Product
GNI	Gross Net Income
GEM	Gender Empowerment Measure
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IAPG	Inter-agency Planning Groups
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
JAKIM	*Jabatan Kemajuan Islam Malaysia* (Department for Islamic Development, Malaysia)
JOICFP	Japan Organisation for International Cooperation in Family Planning

MAC	Malaysian AIDS Council
MCH	Maternal and Child Health
IMF	International Monetary Fund
MDG	Millennium Development Goals
MNCCRH	Malaysian NGO Coordinating Committee for Reproductive Health
MOH	Ministry of Health
MPEN	*Majlis Perundingan Ekonomi Negara* (National Economic Action Council)
MSC	Multi-media Super Corridor
MSC	Malaysian Steering Committee
MTCT	Mother to Child Transmission
NCWO	National Council of Women's Organisations
NFPB	National Family Planning Board
NFPDB	National Family Planning and Development Board
NGO	Non Government Organisation
PINTAS	*Pelan Induk Tindakan Sosial* (National Social Action Plan)
PLWHAs	People Living with HIV/AIDS
PoA	Programme of Action
PROSTAR	*Programme Sihat Tanpa AIDS untuk Remaja* (Staying Healthy Without AIDS Programme for Adolescents)
RDA	Recommended Dietary Allowance
RHAM	Reproductive Health for Adolescents Module
SARS	Severe Acute Respiratory Syndrome
SCC	State Coordinating Committee
SRHR	Sexual and Reproductive Health and Rights
SUHAKAM	*Suruhanjaya Hak Asasi Manusia* (Human Rights Commission of Malaysia)
TWG	Technical Working Group
UNFPA	United Nations Population Fund
WHO	World Health Organisation