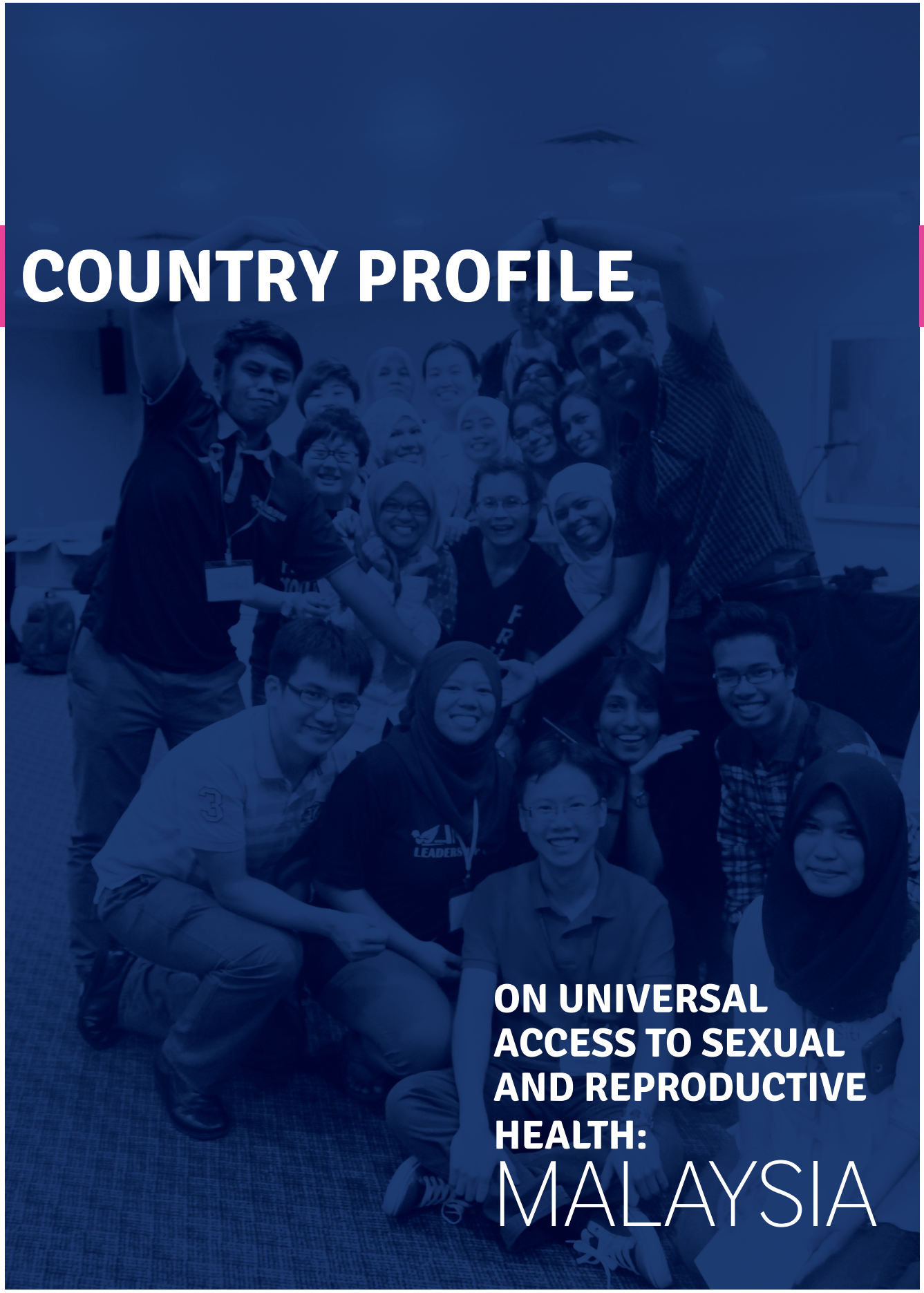
COUNTRY PROFILE



ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

MALAYSIA

This project is funded by the European Union

1. Introduction

Malaysia, a middle income country is a federation of 13 states and three federal territories. The country is one of the vibrant south-east Asian economy, with a diverse, multi-ethnic, multi-religious, and multi-cultural society. The Malays are the major ethnic group (67.4%), followed by the Chinese (24.6%), Indian (7.3%) and others (0.7%) (Ministry of Women, Family and Community Development, no year). Malaysia's population stands at 29.3 million in 2012 (Department of Statistics [DoS] Malaysia, 2012a). The average annual population growth rate has declined markedly during 1980-1981 to 1991-2000, from 2.7% to 2.1%. It is projected that population will increase to 32.4 million in 2020 (DoS Malaysia, 2012b).

In 2012, the female population comprised 14.2 million (51.5%) and the male population comprised 15.1 million (51.5%) (Ministry of Women, Family and Community Development, 2013). Life expectancy at birth for men and women in 2012 was measured at 72.3 and 77.2 years old, respectively (DoS Malaysia, 2012a). In 2012, the young population constituted about 26.4% of the total population and this is expected to decline to 24% in 2020 (DoS Malaysia, 2012a). For the aging population, it will increase from 5.3% in 2012 to 6.8% in 2020 (DoS Malaysia, 2012a). The proportion of working age population (15-64 years old) is increasing steadily from 63.3% in 2006 to 68.3% in 2012, indicating that Malaysia is still benefiting from the demographic dividend (DoS Malaysia, 2012a).

In terms of health financing, government expenditure in health as a percentage of overall health expenditure has been around 54-59% range between 1995 to 2011 (Table 1).

During the same time period, the trend for out-of-pocket expenditure as percentage of the total health expenditure fluctuated between 32%-36% range. However, in recent years, even though public health care is available at minimal cost, many are opting for private health services, including the poor, because they needed immediate treatment (Tan, Arman, and Vijaindren, 2013). The National Health and Morbidity Survey II in 1996 reported that 79% of respondents paid from out-of-pocket for private health care services (Institute for Public Health of Malaysia, 1996). This percentage would have increased by 2014. Increasing out-of-pocket expenditure for health care services will add burden to the population, especially the marginalised, including women and young people and the poor. Moreover, the total health expenditure as percentage of the Gross Domestic Product (GDP) is between 3-4% for the same time period (Table 1). This indicates that the Malaysian government has for many years allocated less than the ideal percentage for total health expenditure compared to the minimum of 5% of the GDP recommended by the World Health Organization (World Health Organization [WHO], 2011).

Table 1. Expenditure on Health (%)

	1995	2000	2007	2009	2010	2011
General government expenditure on health as % of total health expenditure	57	56	54	59	57	55
Out of pocket expenditure as % of the total health expenditure	33	34	36	32	33	35
Total health expenditure as % of the GDP	3	3	4	4	4	4

Source: WHO, 2011.

Malaysia is a member of the UN Human Rights Council and a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD). For CEDAW, though the Malaysian government has adopted the Optional Protocol to the CEDAW, there are reservations on five CEDAW articles: 9(2)[1], 16(1)(a)[2], 16(1)(c)[3], 16(1)(f)[4] and 16(1)(g)[5] (Women's AID Organization [WAO], 2012; Office of the High Commissioner for Human Rights, [OHCHR], 2013).

The reservations are related to: 1) "transmission of citizenship to children from Malaysian mothers to children born overseas," 2) polygamy, 3) child marriage, 4) guardianship and custody, and the religious conversion of the children when a spouse converts to Islam (WAO, 2012). As for CRC, Malaysia has adopted the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography; and the Optional Protocol to the CRC on the involvement of Children in Armed Conflict (OHCHR, 2013).

Malaysia has yet to ratify the International Covenant on Civil and Political Rights (CCPR); the International Covenant on Economic, Social and Cultural Rights (CESCR); the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW); the International Convention on the Elimination of All Forms of Racial Discrimination (CERD); and the 1951 Refugee Convention (OHCHR, 2014; United Nations High Commissioner for Refugees, 2014).

Malaysia implements the Programme of Action of the International Conference on Population and Development (ICPD PoA) 1994 and the Platform for Action of the Fourth World Conference on Women 1995. Two reviews have been conducted on Malaysia's performance towards achieving the Millennium Development Goals (MDGs).

2. The status of sexual and reproductive health in Malaysia

Sexual and reproductive health (SRH) connotes that "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so...[as well as for] the enhancement of life and personal relations" (United Nations Population Fund [UNFPA], 2004). In the ICPD PoA, it is anticipated that "by 2015 all primary health care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods,...to prevent infection" (UNFPA, 2004). The section below will provide a snapshot of the status of SRH in Malaysia. The topics covered include contraception, maternal health, adolescent and young people's SRH, HIV and AIDS, and availability of SRH services at different levels of care.

Contraception

The ICPD PoA urged Member States to respect the rights of all persons to "chose the number, spacing and timing of the birth of their children;" and "make quality family planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality;" and "increase the participation and sharing of responsibility of men in the actual practice of family planning" (UNFPA, 2004a).

Further to this, the Key Actions for the Further Implementation of the ICPD PoA stated that it is the "basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children" (UNFPA, 2004b).

[1] CEDAW Article 9(2): State Parties shall grant women equal rights with men with respect to the nationality of their children (United Nations [UN] Women, no year).
[2] CEDAW Article 16(1)(a): State Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: the same right to enter into marriage (United Nations [UN] Women, no year).
[3] CEDAW Article 16(1)(c): State Parties shall take ...on a basis of equality of men and women: the same rights and responsibilities during marriage and at its dissolution (United Nations [UN] Women, no year).
[4] CEDAW Article 16(1)(f): State Parties shall take...on a basis of equality of men and women: the same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exists in national legislation; in all cases the interest of the children shall be paramount (United Nations [UN] Women, no year).
[5] CEDAW Article 16(1)(g): State Parties shall take...on a basis of equality of men and women: the same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation (United Nations [UN] Women, no year).

Hence, "where there is a gap[6] between contraceptive use and the proportion of individuals expressing a desire to space or limit their families" it is essential that access to information, counselling and services are made available by governments (UNFPA, 2004b).

In this section, the total fertility rate (TFR) will be discussed as it is "an indirect indicator of good or poor reproductive health, since a high total fertility rate (>5 births) represents a high risk of reproductive ill health" along with contraceptive prevalence rate (CPR), which is an indicator that "serves as a proxy measure to access reproductive health services, assuming that there is no coercion for acceptance of birth control through government policy," and unmet need for family planning, which is an indicator that "gives the gap between women's reproductive intentions and actual contraceptive behaviour" (Asian-Pacific Resource and Research Centre for Women [ARROW], 2013).

Total Fertility Rate (TFR)

The TFR in Malaysia has declined gradually throughout the years as shown in Table 2. Malaysia has reached the replacement fertility rate of 2.1 in 2010. The TFR has plateaued since 2010. In 2011, the TFR for Malays is 2.7, Chinese is 1.5 and Indians is 1.6 (Tey and Siti Norlasiah, 2014). The decline in TFR is mainly due to more Malaysian women delaying marriage and having fewer children to pursue higher education and career advancement (Satia, Zaman and Lim, 2009). This is evident through the increasing number of female participation in the labour force, which has increased from 46.1% in 2007 to 49.5% in 2012 (DoS Malaysia, 2013a).

Contraceptive Prevalence Rate (CPR)

The CPR was 52% in 1984 and has been stagnant since then (Norliza et al., 2012). Tey and Siti Norlasiah suggested the stalling of contraceptive usage may be due to several factors, namely, (i) the shift in national programme thrust from family planning to family development, (ii) structural barriers such as non-functioning of State Reproductive Health Committees as well as lack of "coordinated planning and evaluation of implementing agencies at the State level to address barrier and improve performance," (iii) social cultural barriers and personal reasons that hinder individuals from using contraception, and (iv) induced abortion (Tey and Siti Norlasiah, 2014).

For Peninsular Malaysia, the CPR remained stagnant with contraceptive prevalence for any method at 51.9% and any modern method at 34.3% in 2004 as shown in Table 3. The CPR for the Chinese and Indians are higher than the Malays (Table 3).

For Sabah and Sarawak, the CPR for any method was at 50.4% and 53% respectively in 2004, similar to the levels in Peninsular Malaysia (Table 4). For any modern method, during the same time period, Sabah and Sarawak reported 37.4% and 42.3% respectively.

Common modern methods used in Peninsular Malaysia are oral pill followed by female sterilisation and condom as shown in Table 5. The trend for IUD and injectable usage show a slight increase from 1974 to 2004. Rhythm method is the preferred method under the traditional method.

Table 2. Total Fertility Rate

Year	1995	2000	2005	2009	2010	2011	2012
TFR	3.3	3	2.4	2.3	2.1	2.1	2.1

Source: Ministry of Women, Family and Community Development, 2013.

Table 3. CPR for Peninsular Malaysia and by Major Ethnic Group

	Any method			Modern method		
	1988	1994	2004	1988	1994	2004
Peninsular Malaysia	49.8	54.8	51.9	33.5	30.2	34.3
Malays	39.8	45.9	43.0	24.8	22.4	28.2
Chinese	67.2	72.8	67.0	49.6	47.0	45.6
Indians	57.7	64.1	54.7	39.0	33.2	32.2

Source: National Population and Family Development Board (NPFDB), 1994 and 2004.

[6]This gap is known as unmet need for family planning.

While usage of modern contraceptive remained low and constant, the unmet need in Malaysia has risen over time. The unmet need for Peninsular Malaysia for contraception shows an increase from 16.0% in 1988 to 24.7% in 2004 for any method, and from 25% in 1998 to 36.2% in 2004 for modern method (Table 6). Moreover, the unmet need for the Indians is the highest compared to the other ethnic groups for any method and modern method. According to Norliza et. al., unmet need is mainly influenced by the women's educational level, age and number of parity instead of urban/rural locality (Norliza et al., 2012). Generally, unmet needs are higher among women who are older, with lower education and with more children.

The unmet need for Sabah and Sarawak indicate a similar pattern. The unmet need is highest among the Chinese for modern method both in Sabah (47.6%) and Sarawak (44.2%). Similar key reasons were given by women for not using any contraceptives in the 1994 and 2004 Malaysian Population and Family Surveys (see Table 7). The four key reasons are: want to have more children, fear of side-effect, husband's objection, and medical and health reason. A matter of concern is that a higher percentage of women in the 2004 survey compared to the 1994 survey were concerned about the side-effects of contraceptives (10.3% in 1994 vs. 26.4% in 2004). There is also an increase in the percentage of women reporting husband's objection, which is from 8.0% in 1994 to 12.6% in 2004.

Table 4. CPR for Sabah and Sarawak

	Any method		Modern method	
	1989	2004	1989	2004
Sabah	50.1	50.4	30.1	37.4
Sarawak	57.8	53.0	44.4	42.3

Source: NPFDB, 1994 and 2004.

Table 5. CPR for Methods in Peninsular Malaysia

	1974	1984	1994	2004
Modern methods				
Pill	18.0	11.9	13.3	13.0
Female sterilisation	3.8	7.6	6.9	6.1
Condom	3.2	7.7	5.4	6.9
IUD	0.8	2.2	3.9	4.2
Injectable	0.2	0.5	0.6	1.2
Traditional methods				
Rhythm	3.8	7.0	8.8	8.6
Withdrawal	2.0	4.0	6.9	3.8

Source: NPFDB, 1974, 1984, 1994 and 2004.

Table 6. Unmeet Need for Contraception by Ethnic Groups

	Peninsular Malaysia				Sabah		Sarawak	
	Any Method		Modern Method		Any Method	Modern Method	Any Method	Modern Method
	1988	2004	1988	2004	2004		2004	
Overall	16.0	24.7	25.0	36.2	23.8	31.3	24.0	30.0
Ethnic Groups								
Malays/Bumiputra	17.0	25.9	23.0	33.6	22.5	29.6	21.6	25.3
Chinese	13.0	22.2	25.0	39.8	35.0	47.6	31.6	44.2
Indians	21.0	26.6	32.0	44.7	-	-	-	-
Others	-	-	-	-	25.2	30.1	6.3	18.9

Source: NPFDB, 1994 and 2004.

Reasons given by women for stopping contraceptive usage are also similar to the reasons given by them for not using contraceptives as shown in Table 8. About 36.4% of women in the 2004 survey compared to 31.1% women in the 1994 survey cited contraceptive related reasons (for example, side-effects of contraceptive, method failure and discomfort caused by method) for their discontinuation. The problems can be redressed with proper contraceptive information and counselling as well as quality service.

Maternal Health

Safe motherhood is very important as maternal morbidity and mortality will have "very serious consequences within the family, given the crucial role of the mother for her children's health and welfare" and "the death of the mother increases the risk to the survival of her young children" (UNFPA, 2004).

In this section, indicators discussed are maternal mortality ratio (MMR) as it is a "reflection of how safe child delivery is for the woman;" perinatal mortality rate (PMR) and infant mortality rate (IMR) as they are "a good indicator of both the status of maternal health and nutrition, and of the quality of obstetric care; "basic emergency obstetric care and comprehensive emergency obstetric care as they are indicators "assessing the needs for health system strengthening to ensure availability of emergency obstetric care at the national and sub-national levels;" and antenatal care coverage as it is indicator for "women's access to health care service" (ARROW, 2013).

Maternal Mortality Ratio (MMR)

MMR has reduced markedly since 1991 and is not a major concern in Malaysia. However, we have yet to achieve the MDG 5a target (11 per 100,000 live births). Malaysia is still about halfway to achieving the target (Table 9).

In terms of breakdown by citizenship as shown in Table 10, Malaysian women contributed to about three-fourths of maternal deaths and this occurred mainly in Johor and Selangor. Non-citizen documented women made up about 10% of maternal deaths. Non-citizen undocumented women also made up about 10% of maternal deaths and this occurred mostly in Sabah (Ministry of Health [MOH] Malaysia, 2012a).

The three main direct causes of maternal deaths are haemorrhage, hypertension and obstetric embolism as shown in Table 11. Death due to abortion comprised about 0.5%. Women do have problem "getting accurate information on available safe abortion services and at affordable fees" and this is compounded by "judgmental attitude amongst providers to these clients"(Low, Tong and Gunasegaran, 2013). About 60-75% of maternal deaths occurred during the postpartum stage (MOH Malaysia, 2008).

For the proportion of births attended by skilled birth attendants, the baseline is 74.2% in 1990. The proportion has increased to 98.6% in 2011 (DoS Malaysia, 2010a). Hospital delivery has always been encouraged.

Table 7. Reason for Not Using Any Contraceptive Methods in Peninsular Malaysia

	1994	2004
Want more children	53.0	39.3
Fear of side-effects	10.3	26.4
Husband's objection	8.0	12.6
Medical and health reason	3.4	5.4

Source: NPFDB, 1994 and 2004.

Table 8. Reason for Stopping Contraceptive Use in Peninsular Malaysia

	1994	2004
Want more children	38.4	27.4
Side-effects	22.4	26.5
Advised by medical professional	7.7	10.6
Method failure	4.7	3.1
Discomfort caused by method	4.0	6.8
Husband's objection	2.4	3.9

Source: NPFDB, 1994 and 2004.

Basic emergency obstetric care and comprehensive emergency obstetric care are available. Pregnant women are referred to maternal and child health clinics for antenatal check-ups. If there is complication during antenatal or prior to delivery, they will be referred to secondary or tertiary health care facilities (MOH Malaysia, 2010). This is also applicable for the coverage of post partum/ post-natal care within 48 hours of delivery by a skilled health provider (MOH Malaysia, 2010). Antenatal care coverage has improved since the onset of the MDG in 1990. Antenatal visit (first visit) has increased from 78.1% (baseline) in 1990 to 94.0% in 2011 (DoS Malaysia, 2010a).

Perinatal Mortality Rate (PMR) has reduced slightly from 7.2 per 1,000 live births in 2005 to 7.6 per 1,000 live births in 2011 (Ministry of Women, Family and Community Development, 2013). The baseline Infant Mortality Rate (IMR) in 1990 at the onset of the MDG in 1990 was 13.1 per 1,000 live births (DoS Malaysia, 2010a). In 2010, it has dropped to 6.7 per 1,000 live births and plateaued from 2011 onwards at 6.6 per 1,000 live births (DoS Malaysia, 2010a). Despite the significant decrease, Malaysia might not be able to achieve the MDG 4a target of 4.4 in 2015.

Adolescent and Young People's Sexual and Reproductive Health

The ICPD PoA highlighted the need to address adolescent SRH issues, including "unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV and AIDS through the promotion of responsible and healthy reproductive and sexual behaviour" (UNFPA, 2004). It is essential that they have access to SRH information, education and services that will enable them to make informed choice and responsible decision for their lives.

In this section, indicators discussed are adolescent birth rate as it is "an important indicator of adolescent reproductive health and rights," and availability and range of adolescent SRH services as it is an indicator on "access to health care for adolescents irrespective of marital status" (ARROW, 2013).

Adolescent Birth Rate

In Malaysia, the adolescent birth rate for girls aged 15-19 has decline markedly from 28 in 1991 to 13 in 2012 as shown in Table 12.

Table 9. MMR Trend in Malaysia

1991	2009	2010	2011
44 (Baseline)	28.0	26.1	25.5

Source: DoS Malaysia, 2010a and 2011.

Table 10. Percentage of Maternal Deaths by Citizenship

	2009	2010	2011	2012
Malaysians	74.1	77.7	77.7	77.3
Non-citizen documented	10.8	11.4	16.6	9.9
Non-citizen undocumented	15.0	10.8	5.7	12.8

Source: MOH Malaysia, 2012a.

Table 11. Direct Causes of Maternal Deaths (%)

	2011	2012
Haemorrhage	25.3	18
Hypertension	14.3	12.4
Embolism	12.1	17.4
Sepsis	3.8	12.4
Abortion	0.5	0.6

Source: MOH, 2012a.

However, MMR among adolescent aged 15-19 years old has nearly doubled within five years from 2007 to 2011 (see Table 13). The number of teenage pregnancies has also increased within the same time period as indicated by the number of live births among adolescent mothers aged 15-19 years old (Table 13). This is a matter of concern and viewed by the government as a serious issue.

Access to SRH Information and Services for Adolescents and Young People

The MOH developed the National Adolescent Health Policy in 2001 and the National Adolescent Health, Plan of Action, 2006-2020 in 2007 (MOH Malaysia, 2001 and 2007). Public health care facilities normally do not provide contraceptive services to unmarried young people. However, in recent years, the MOH has been taking initiatives in advocating for the provision of SRH services for adolescents regardless of their marital status. The Guidelines on Managing Adolescents Sexual and Reproductive Health Issues in Health Clinics was developed in 2012 (MOH Malaysia, 2012b). The guidelines provide health care providers the standard operating procedures on how to treat adolescents, especially young girls, for pregnancy and abortion; sexually transmitted infections (STIs), including HIV/AIDS; sexual violence; and contraceptives (MOH Malaysia, 2012b). Despite the guidelines which underscored youth-friendly services, the quality of service depends very much on how sensitised the health care providers are towards universal access to SRH for all, including the adolescents.

In 2012, Malaysia began to provide universal access to health care services, including sexual and reproductive services, to all adolescents in all primary, secondary and tertiary health care facilities nationwide (United Nations, 2012). If a service is unavailable at the primary health care, adolescents will be referred to either secondary or tertiary health care facilities. Though SRH services, including contraceptives, are available in all government hospitals and clinics, information on the availability of the services was not made known to the adolescents. This is a case of where the services are available but the adolescents are unaware of it, hence, they continue to have unmet need.

> Many young girls and boys in the juvenile homes under the Department of Social Welfare we found to have poor knowledge about sexual and reproductive health, and were involved in unprotected sex at very young age—some as young as 9-10 years old--and becoming pregnant.
>
> *Associate Professor Dr Tey Nai Peng. Excerpt from the Final Project Evaluation Report on UNFPA Project on Reaching Out to Disadvantaged Youths to Address SRH Needs and HIV Prevention through Peer Education, 2008-2012 implemented by FRHAM.*

For termination of pregnancy, young girls irrespective of their marital status have access to this service at government health facilities, including the health clinics and community clinics. Again, most adolescents are unaware of this service. However, for girls below 18 years old, parental or guardian consent is needed as they are still considered a child[8]. Also, sexual intercourse with a girl aged below 16 years old whether with her consent or against her will is considered statutory rape (MOH Malaysia, 2012b).

Table 12. Adolescent Birth Rate

Year	1991	1995	2000	2005	2009	2012
Adolescent Birth Rate	28	23	17	13	15	13

Source: DoS Malaysia, no year, 2011 and 2013b.

Table 13. MMR and Live Births among Adolescent Girls

	2007	2008	2009	2010	2011
MMR adolescent	18.5	16.9	21.1	31.5	33.3
Live births	16207	17698	18911	19018	18040*

*Preliminary data live births, DoS in 2011.

Source: MOH Malaysia, 2013.

[7]This is also known as age-specific fertility rate for young girls aged 15-19 years old.
[8]The Malaysian Child Act 2001 defines anyone below 18 years old as a child.

HIV and AIDS

It is underscored in the ICPD PoA the importance to "prevent, reduce the spread of and minimise the impact of HIV infection;...at the individual, community and national levels" and to "ensure that HIV infected individuals have adequate medical care and not discriminated against" (UNFPA, 2004).

The indicators discussed in this section are HIV prevalence and burden as they are indicators on the prevalence of "HIV among different population sub-groups and of the numbers of persons in the population living with HIV or AIDS," and availability of services for HIV and AIDS, which assess the "availability of prevention and treatment for HIV for different sub-groups of the population" (ARROW, 2013).

The HIV epidemic in Malaysia is a concentrated epidemic, particularly among the most-at-risk populations (MARPs), for example, the injecting drug users, sex workers, men who have sex with men, transgender persons, and their intimate partners (MOH Malaysia, 2011a). The HIV prevalence trend among general population tends to be less than 1% (MOH Malaysia, 2005 and 2011a). The HIV prevalence among the MARPs ranges between 3-20% (MOH Malaysia, 2011a).

The percentage of young people between 15-24 living with HIV is 0.1% in 2012 (UNAIDS, 2013). In Malaysia, young people between 13-29 years old comprised 26% of reported infections (MOH Malaysia, 2012c).

The number of HIV cases reported from 2000 to 2012 among male has decreased to about half, however, the opposite is observed among women (see Table 14). HIV cases among women has increased from 480 in 2000 to 734 in 2012. Hence, the term "feminisation of HIV" is of concern to the government and those involved in HIV related work.

For AIDS cases reported, the number of cases among men fluctuates between 900 to 1100 cases during the period of 2000-2012 as shown in Table 14. However, the cases have more than doubled among the women during the same period, that is from 97 in 2000 to 215 in 2012.

There is a decrease in percentage of sex workers living with HIV, that is from 10.5% in 2009 to 4.2% in 2012 (UNAIDS, 2013). With the increase in outreach programmes for sex workers from 7 in 2010 to 21 in 2011, this resulted in 81% increase in number of sex workers reached, that is from 2889 in 2010 to 5243 in 2011 (MOH Malaysia, 2012c).

However, the percentage of men having sex with men living with HIV has increased from 3.9% in 2009 to 12.6% in 2012 (UNAIDS, 2013). The "People Like You Sexual Health" (PUSH) Project found that condom use by men having sex with men is very low, which is about 38% (MOH Malaysia, 2012c). This issue has been highlighted in various meetings and workshops by MOH and Malaysian AIDS Council.

> Some male sex workers do not use condoms when they masturbate their clients. Reasons why some do not use condom during anal sex with their clients were because either their clients refuses to use condoms as they are not nice, the clients pay more or they are regular clients. Some also do not use condom with their partners and / or non-paying clients.
>
> *Interviews with male sex workers. Excerpt from HIV and Sex Work. Investing in Sexual and Reproductive Health and Rights, FRHAM and UNFPA, 2010.*

In Malaysia, 89.4% of 342 HIV positive pregnant mothers received antiretroviral treatment to reduce the risk of mother-to-child transmission in 2012 (UNAIDS, 2013). In 2011, 228 infants borne by HIV positive women were given antiretroviral treatment, thus resulting in the prevention of 225 mother-to-child transmission of HIV infections (MOH Malaysia, 2012c).

Table 14. Number of Reported HIV and AIDS Cases

	2000	2002	2003	2005	2010	2011	2012
Reported HIV cases							
Male	4626	6349	6083	5383	2984	2744	2704
Female	481	629	673	737	668	735	734
Reported AIDS cases							
Male	1071	1068	939	1004	868	1131	1146
Female	97	125	137	177	167	203	215

Source: Ministry of Women, Family and Community Development, 2013.

HIV counselling and testing and general outpatient care is being carried out by NGOs like PT Foundation and FRHAM. Currently, all government health facilities are providing free HIV screening (MOH Malaysia, 2012c). There is a degree of HIV linkages with SRH in government health care facilities and the clinics under FRHAM.

The government of Malaysia provides fully subsidised first-line highly active antiretroviral therapy (HAART) for all Malaysians, and partially subsidise second-line treatments (MOH Malaysia, 2011b). Since 1998, Malaysian AIDS Foundation created the PAL Scheme (Medical Assistance Scheme) to provide "poor Malaysians living with HIV/AIDS the opportunity to undergo HAART" (Malaysian AIDS Foundation [MAF], 1998). Antiretroviral treatment is available for infant as well. This is part of safer delivery and infant feeding practices in the prevention of mother-to-child transmission (MOH Malaysia, 2012c). Even though Malaysia did not sign the 1951 Refugee Convention and its 1967 Protocol, there was a circular by MOH in 2006 "permitting [documented] refugees to access public health services, including antiretroviral therapy (ART) as part of the national HIV treatment and programme," in which first-line HAART is fully subsidised for refugees (Mendelsohn et al., 2014). UNHCR would pay for the more expansive first-line treatments, second-line treatments, and virological monitoring for refugees (Mendelsohn et al., 2014).

Since May 2006, Malaysia started manufacturing its own combination of 3-in-1 antiretroviral drugs (MOH Malaysia, 2012c). Malaysia has increased CD4 eligibility from 250 to 350 cells/mm3 to include more people living with HIV who are eligible for ART treatment (MAF, 1998). In 2009, the guidelines were revised to include rapid tests, (HAART) and Polymerase Chain Reaction (PCR) tests for babies, as well as tracing of spouses and partners as part of a comprehensive package of HIV treatment, care and support services for a new HIV positive case (MOH Malaysia, 2012c). ART used to be available only at hospital, however, since 2006 it is available at primary health care facilities (MOH Malaysia, 2012c). The efforts mentioned above have contributed to the decline in the number of AIDS-related deaths.

Availability of Sexual and Reproductive Health Services at Different Levels of Care

The ICPD PoA pointed out that governments should "ensure that comprehensive and factual information and a full range of [sexual and] reproductive health care services, including family planning, are accessible, affordable, acceptable and convenient to all users," and particularly it is "accessible through the primary health care system" (UNFPA, 2004).

In this section, the indicators discussed are related to the availability of SRH services at different levels of care, which assess the "broad-based availability of a comprehensive set of SRH services" (ARROW, 2013).

SRH is not a priority issue for the Malaysian government, though the unmet need shows an increasing trend. In Malaysia, family planning services and programmes are mainly provided by three core organisations, namely: the Ministry of Health (MOH), the National Population and Family Development Board (NPFDB), which is under the Ministry of Women, Family and Community Development, and the Federation of Reproductive Health Associations, Malaysia (FRHAM).

At the government health care facilities, SRH services are available at primary, secondary and tertiary health care facilities under the MOH. Primary health care facilities are managed by the Family Health Development Division. The health care services are categorized under maternal health; perinatal, neonatal and child health; adolescent health; adult health; geriatric health; and health care for persons with disabilities (MOH Malaysia, 2014). Contraception, gynaecological services, antenatal and post-natal services, cervical and breast cancer screening, HIV prevention and treatment, including preventing mother-to-child transmission (PMTCT), are available at primary health care facilities such as maternal and child health clinics.

Clients could access the primary health care services as walk-in patients. However, for secondary and tertiary health care facilities, normally a referral from a doctor in the primary health care facilities or a private practitioner is needed before a client could seek treatment from a specialist. Abortion service is available starting from the primary health care facilities such as community clinics and health clinics and also at secondary and tertiary health care facilities such as public hospitals.

NPFDB and FRHAM's clinics throughout the country are also core providers of SRH services at primary level for women, men and adolescents. The services provided by NPFDB's clinics are contraception, pregnancy test, subfertility treatment, pap smear, andrology services, screening and treatment for STI, breast cancer screening, HPV vaccination, general medical check-up and blood test, and counselling (NPFDB, 2012). FRHAM's clinics provide similar services as well as emergency contraceptive, antenatal services, pre- and post-counselling for HIV, HIV testing, pre-and post-abortion counselling, and referral for abortion.

3. Recommendations

The recommendations to strengthen the SRH services in Malaysia are:

- We call upon the government, NGOs and private sectors to strengthen provision of comprehensive SRH information (e.g., promote usage of modern contraceptives, promote a broad range of method-mix contraceptives, addressing the side-effects and discontinued usage of contraceptives, and availability of termination of pregnancy services) and services (e.g., counseling for contraception, and HIV and AIDS prevention, treatment, care and support) at government, non-government and private health facilities to young people, women and men; especially to the marginalised, poor, migrant workers and refugees.
- We call upon the government and medical universities to strengthen capacity and skills of health care service providers in terms of their awareness on the laws and policies pertaining to SRH, including termination of pregnancy; and deliver quality service to all without discrimination and stigmatisation, regardless of age, marital status, citizenship, disability, sexual orientation and gender identities.
- Young people are not aware that they have full access to SRH services though it is available to them. We call upon the government and NGOs to increase efforts to promote the available SRH services, including contraceptives and termination of pregnancy, at all levels of government health facilities in the urban and rural areas.
- We call upon the public and private health care providers to ensure the confidentiality of all young people who seek SRH services, especially at government health facilities. This would encourage the young people to access the services without feeling stigmatised and discriminated by adults.
- We call upon the government to mainstream SRH services, including HIV and AIDS as part of outpatient care.
- We call upon the government to strengthen management and follow-up of sexually transmitted infections to reduce transmission of HIV.
- We call upon the government to strengthen initiatives on universal access to voluntary HIV counseling and testing particularly for individuals involved with high risk behaviour, for example, sex workers, men who have sex with men, refugees, and migrants.
- Only 30% of eligible people living with HIV are receiving antiretroviral treatment. We call upon the government to upscale antiretroviral treatment to a larger population, especially the MARPS, migrants and refugees, to reduce the community viral load.

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About FRHAM

The Federation of Reproductive Health Associations, Malaysia (FRHAM), formerly known as the Federation of Family Planning Associations, Malaysia (FFPAM). Established in 1958 is a federated organization of 13 State Member Associations. It is the leading non-profit NGO in Malaysia advocating and promoting sexual and reproductive health, including family planning, and reproductive rights of women, men and young people. In the provision of information and services to our target beneficiaries, we do not discriminate on the basis of sex, politics, race, religion or status. Services are based on informed choice and no coercion will be used in the promotion of any services. FRHAM is an accredited member of the International Planned Parenthood Federation (IPPF).

In 2012, FRHAM was awarded the United Nations Population Award due to our works and services on population and SRH related concerns, including making specific efforts to the marginalised communities (e.g., rural communities, sex workers, people living with HIV, refugees and young people).

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About the Country Profile

This country profile is developed by the Federation of Reproductive Health Associations, Malaysia (FRHAM), as part of the initiative, "Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asia-Pacific Network for SRHR," with the assistance of the European Union. This project is being implemented in Malaysia by FRHAM, in partnership with the Asian-Pacific Resource and Research Centre for Women (ARROW). Countries covered by the initiative are Bangladesh, Cambodia, China, India, Indonesia, Lao PDR, Maldives, Malaysia, Mongolia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Vietnam. The contents of this publication are the sole responsibility of FRHAM and can in no way be taken to reflect the views of the European Union. Electronic copies are available at www.frham.org.my, www.arrow.org.my and www.srhrforallnow.org

This project is funded by the European Union