Part 7

ADDRESSING THE UNMET NEED FOR FAMILY PLANNING AMONG THE YOUNG PEOPLE IN MALAYSIA

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National Overview

Malaysia, comprising of 11 states in Peninsular Malaysia and two more Sabah and Sarawak in East Malaysia, has a population of 28.3 million. Since Independence in 1957, the Malaysian people have enjoyed an increasingly better quality of life with the country’s continuing socio-economic advancements. It is classified by World Bank as an upper-middle-income South-East Asian country, with the Gross Domestic Product (GDP) growth of 5 to 5.5%. The gross national income per capita was RM 26,175 in 2010 but it was estimated that 3.8% of the population (or 228,000 households) live below the national poverty line.

In view of the economic progress that has been achieved over the past twenty years, the changes in the demographic profile for the period has also progressed favorably with significant declines in mortality and fertility and longer life expectancy (Table 1). Although most areas of the health sector have showed great improvements, more recent reviews, including the 2010 MDG Report and the ICPD Third Country Report of Malaysia: NGO Perspectives, noted that the progress in maternal health, morbidity and mortality as well as contraceptive prevalence rates has either slowed down or stagnated since the nineties. The maternal mortality ratio in 1997 was 44 maternal deaths per 100,000 live births and the rate fell substantially in the mid-1990s to reach 29.1 by 1997. Since then the progress has been slow, and the rate registered at 27.3 in 2010 (Table 1). The contraceptive prevalence rate has stagnated at about 50% over the Malaysian Population and Family Surveys of 1984, 1994 and 2004. Unmet need for family planning, especially for women with less education remains high and is increasing, resulting in unplanned pregnancies and unwanted births.

On the other hand, the emergence of the HIV and AIDS epidemic that lead to high morbidity and mortality remain a “critical pervasive threat” to the country. While Malaysia is classified as a country with a concentrated epidemic among the most at risk population such as injecting drug users (IDUs), men who have sex with men (MSM) and female sex workers (FSW), transgender (TG), HIV positive women who were infected through sexual transmission and unprotected sexual contact is increasing. In addition, young people between the ages 13-29 years old represented 35.9% of cumulative HIV infections from 1986 to December 2009.

Overall Status of Young People in Malaysia

Demographic Profile of Young People

According to the World Health Organization, 1.75 billion people in the world today are young people between 10 to 24 years old, and 85% of them live in developing countries where they make up almost a third to a half of the total population. In Malaysia, there were 8.4 million young people in the age group of 10 to 24 years in 2010, which constituted about 30% of the total population as shown in Table 2. Although population 24 years or younger make up almost one third of the Malaysia’s population for the past 20 years, their contribution as percentage of the population is already at its peak. It was estimated that the proportion of young people would be getting smaller and only constituting of one quarter by 2020 due to the decline in total fertility rate in Malaysia.

Youth Literacy Rate

Young people in Malaysia are healthier and better educated than those of earlier generations. The literacy rate among young people aged 15 to 24 years old has increased from 75% in 1970 to 97% in year 2000 (Figure 1). The female literacy rate was slightly higher than the male literacy rate. UNESCO projected that Malaysia will have more young men than young women who are illiterate (Figure 2) by 2015. In fact, the MDG Progress Report 2010 also showed that girls outnumber boys, in both secondary schools and universities. More boys tended to dropout from school after they completed their primary education.

Youth Employment

Although there was an increase of youth literacy rate, it has not translated into jobs needed. The Economic and Social Commission for Asia and the Pacific (ESCAP)’s data shows that the youth unemployment rate (15 – 24 years) is increasing in Malaysia, with the unemployment rate in 2008 being 10.3% for males, while for female it was 11.8% (Figure 3). On the other hand, the unemployment rate among Malaysian graduates is also increasing, from 65,500 in 2010 to 71,600 in first quarter 2011. The
reasons why young people who despite graduating from university are not able to enter the labor force is partly due to their education and skill mismatch. Apparently young people do not seem to have the skills required by the labor market and lack proficiency in English. In view of the fact that youths must play an important role in transforming Malaysia from middle-income to high-income country and that the unemployment or underemployment may increase their vulnerability and involvement with risky behavior and therefore increase the burden and responsibilities for the society, various programs such as internship, soft-skill training and job placement initiatives have been designed for unemployed graduates under the Tenth Malaysia Plan.

Age of first marriage

Age at first marriage is usually used as a measure of entry into sexual activity for both men and women and entry into marriage also marks the beginning of exposure to childbearing. Early entry into marriage exposes women to the risk of early childbearing and can also impede improvements in their educational, economic, and social status. Furthermore, if young girls marry older men, it may have undesirable implications on their health and fertility.

According to the 2010 census report, the mean age at first marriage has increased. In 1970, it was 25.6 years for men and 22.1 years for women, increasing to 28 years for men and 25.1 years for women in 2010 as shown in Figure 4. In Malaysia, young women and men are marrying later and having fewer children due to improved education and availability of employment. In addition, female independence and participation in the labor force, and increasing freedom in the choice of a marriage partner may be the other factors that contribute to the rising age at marriage.

While the mean age at first marriage in Malaysia is increasing, there are still a big number of young women who marry early (defined as marriage of children and adolescents below the age of 18). The 2010 Population and Housing Census revealed that 84,261 girls and 74,071 boys between the ages of 15 to 19 were married. The 2004 Malaysian Population and Family Survey (MPFS) also showed that, out of 3,693 married women in Peninsular Malaysia in the study, 2.6% of them married before age of 15 and 20.1% of them married between the ages of 15 and 19.

<table>
<thead>
<tr>
<th>Table 1 Country Context – Social Demographic Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size of population (million)</strong></td>
</tr>
<tr>
<td><strong>Population Growth (%)</strong></td>
</tr>
<tr>
<td><strong>Ethnic groups</strong></td>
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<tr>
<td><strong>Religions</strong></td>
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<tr>
<td><strong>Languages</strong></td>
</tr>
<tr>
<td><strong>Population living below the national poverty line (%)</strong></td>
</tr>
<tr>
<td><strong>Crude birth rate (per 1000 population)</strong></td>
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<tr>
<td><strong>Crude death rate (per 1000 population)</strong></td>
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<tr>
<td><strong>Life expectancy at birth (years)</strong></td>
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<tr>
<td><strong>Total Fertility rate</strong></td>
</tr>
<tr>
<td><strong>Contraceptive prevalence rate for women (ages 15–49)</strong></td>
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<tr>
<td><strong>Maternal mortality ratio</strong></td>
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<td><strong>Infant mortality rate</strong></td>
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<tr>
<td><strong>HIV prevalence rate (15–49)</strong></td>
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<tr>
<td><strong>HIV prevalence in vulnerable groups</strong></td>
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</tbody>
</table>
### Table 2: Demographic profile of adolescents in Malaysia, 2010

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 10-24 (millions)</td>
<td>8.4</td>
<td>8.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Population aged 10-14 (thousands)</td>
<td>2,733</td>
<td>3,040</td>
<td>3,357</td>
</tr>
<tr>
<td>Population aged 15-19 (thousands)</td>
<td>2,836</td>
<td>3,143</td>
<td>3,450</td>
</tr>
<tr>
<td>Population aged 20-24 (thousands)</td>
<td>2,853</td>
<td>3,160</td>
<td>3,467</td>
</tr>
</tbody>
</table>

### Figure 1: Youth (15 – 24 years old) Literacy Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>75</td>
<td>83</td>
<td>68</td>
</tr>
<tr>
<td>1980</td>
<td>91.9</td>
<td>94</td>
<td>89.9</td>
</tr>
<tr>
<td>1990</td>
<td>95.6</td>
<td>95.9</td>
<td>95.3</td>
</tr>
<tr>
<td>2000</td>
<td>97.2</td>
<td>97.2</td>
<td>97.3</td>
</tr>
</tbody>
</table>

### Figure 2: Total Numbers ('000) of Youth (aged 15 – 24) who illiterate

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985-1994</td>
<td>155</td>
<td>72.8</td>
<td>82.2</td>
</tr>
<tr>
<td>2000-2007</td>
<td>86</td>
<td>45.6</td>
<td>40.4</td>
</tr>
<tr>
<td>Projected 2015</td>
<td>51</td>
<td>29.1</td>
<td>21.9</td>
</tr>
</tbody>
</table>
3 Youth (aged 15 – 24) Unemployment Rates Between 2000 And 2008

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>8.3</td>
<td>10.9</td>
</tr>
<tr>
<td>Male</td>
<td>8.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Female</td>
<td>8.3</td>
<td>11.8</td>
</tr>
</tbody>
</table>

4 Mean Age at First Marriage by Gender, 1970 - 2010

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>25.6</td>
<td>26.6</td>
<td>28.2</td>
<td>28.6</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>22.1</td>
<td>23.5</td>
<td>24.7</td>
<td>25.1</td>
<td>25.7</td>
</tr>
</tbody>
</table>

5 Adolescent Fertility Rate, 1991 - 2009

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</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>28</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>13</td>
<td>15</td>
</tr>
</tbody>
</table>
and 19. On the other hand, for the 1,656 women from Sabah who participated in the same study, the proportion of women who married before 19 years was much higher (7.1% of them married under the age of 15 and 37.7% married between ages 15 and 19).

The UNGASS progress report 2010 reported that 32 young Muslim girls under the age of ten, 445 girls between the ages of 10 to 14 and 6,815 girls between the ages of 15 to 19 went for HIV pre-marital testing in 2009 in order to get married. Compared to young girls, only two boys under the age of 14 and 1,911 boys between the ages of 15 and 19 went for the same test in the same period. Therefore, some of these girl children were obviously being married off to older men. Furthermore, the MPFS study also showed that women who married early tended to have more children. The mean number of children in their life time for women who married before age of 17 was 5.1 and for those who married between ages 17 to 18 was 4.2 while women who married at ages 25 to 29 had an average of only 2.4 children.

### Adolescent fertility rate

The adolescent fertility rate is defined as the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk of childbearing among adolescent women 15 to 19 years of age. It is also

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### Table 3

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Peninsular Malaysia</td>
<td>Sabah</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Reproductive Organ</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
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<th></th>
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<tr>
<td></td>
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<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Reproductive Organ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Place where the fetus grows | 66.8 | 55.9 | 61.5 | 64.0 | 55.4 | 59.7 |
| Channel where the baby is born | 48.8 | 45.0 | 47.0 | 39.9 | 37.7 | 38.8 |

### Family Planning Method

| Have heard of family planning | 53.7 | 39.1 | 46.3 | 60.2 | 44.3 | 52.1 |
| Pill | 82.9 | 70.1 | 77.4 | 52.1 | 34.1 | 42.9 |
| Condom | 45.6 | 67.4 | 54.9 | 27.7 | 28.6 | 28.2 |
| IUCD | 10.6 | 7.3 | 9.2 | 6.7 | 2.8 | 4.7 |
| Injectables | 9.5 | 5.8 | 7.9 | 10.7 | 3.2 | 6.9 |
| Tuba ligation | 4.5 | 1.7 | 3.3 | 3.4 | 1.3 | 2.3 |
| Vasectomy | 3.4 | 2.3 | 3.0 | 1.1 | 0.6 | 0.9 |
| Rhythm | 5.0 | 3.5 | 4.3 | 1.6 | 0.2 | 0.9 |
| Abstinence | 2.8 | 2.3 | 2.6 | 0.9 | 0.9 | 0.9 |

### HIV/AIDS and STIs

| AIDS – Have heard of AIDS | 95.9 | 95.0 | 95.5 | 92.4 | 89.8 | 91.0 |
| STIs – Have heard of STIs | 68.5 | 59.8 | 64.1 | 73.6 | 65.5 | 69.4 |
| HIV/AIDS can be transmitted through sexual intercourse | 48.3 | 71.0 | 80.9 |
| HIV prevention method – Correct Usage of Condom | 14.8 | 29.6 | 39.2 |
referred to as the age-specific fertility rate for women aged 15-19.

Adolescent fertility rate declined from 28 in 1991 to only 15 by 1997 but has stagnated at 15 up to 2007, declining slightly to 13 by 2009. Thus it would be safe to say that adolescent fertility has indeed stagnated at around 15 per 1000 women ages 15 to 19 (Figure 5). Although the adolescent birth rates in Malaysia is relatively low compared to many other countries in the world, teenage fertility remain a major concern in view of the rising problems of abandoned babies, and pregnancy before marriage. In addition, teenage mothers and their children are also at high risk of reproductive morbidity and mortality.

**Reproductive Health Status of young people**

**Knowledge and Source of Information**

The Malaysian Population and Family Survey, (2004), revealed that around half of the young people (13 to 24) interview knew about the reproductive organs and reproductive process such as the place where fetus grow and the channel where the baby is born (Table 3), with those from Peninsular Malaysia having slightly better knowledge than those from Sabah. Comparison by gender basically show that males had slightly higher knowledge of their own organs and it was the same with the females but it was disappointing that more girls also knew about where the fetus develop and the organ through which the fetus is born.

Rahman et al., in a study of 1,034 secondary school students (13 to 18 years) in a conservative state like Kelantan also reported similar findings (Table 3). Two third of the respondents (62.3%) in the Rahman et al.’s study did not know that the vagina is the organ for sexual intercourse. Majority of them (69.6%) were not aware that girls can get pregnant with a single act of sexual intercourse and 83% of them thought that washing the vagina after sexual intercourse can prevent pregnancy. Another study of 860 students aged 13 to 18 from Penang Island, Klang Valley and Johor Bahru (all relatively urban areas) also found that knowledge on sexual and reproductive health was low. The students from these three sites were asked about the function of sexual reproduction organs, puberty, pregnancy, contraception, STIs and abortion through a self-administered questionnaire. In this study the average score was only 16.15 out of 34. About half of the respondents (47.6%) obtained sexual knowledge scores below the average. Older students scored higher than younger students but both male and female respondents had similar levels of sexual knowledge.

With regards to the family planning methods, only about half (Peninsular Malaysia - 46.3% and Sabah - 52.1%) of the unmarried young people interviewed in the 2004 Malaysian Population and Family Survey reported that they had heard of family planning and generally more girls knew about it than boys (Table 3). When these young people were asked about the types of methods that they heard about, the pill was the most commonly cited method, follow by condom, IUCD and injectables. On the other hand, only 4.3% of the young people from Peninsular Malaysia knew about the rhythm method.

Compared to the topics of reproductive organ and family planning, almost all of the young people (95.5% of those from Peninsular Malaysia and 91% of those from Sabah); both male and female had heard of AIDS (Table 3). Two thirds of them said that they received the information through television or radio, followed by newspapers and through the teacher or school (Table 4).

Although nine out of ten youths in Malaysia cited that they were aware of HIV and AIDS, a study conducted...
by the Ministry of Health with 6,000 National Service trainees (aged 17-19 years old) as quoted by the 2010 UNGASS Progress Report, found that only 22.6 % of them could correctly identify ways of preventing the sexual transmission of HIV and who could reject major misconceptions about HIV transmission48. According to the 3rd National Health and Morbidity Survey, only 33.4 to 56 % of the young people knew that HIV/AIDS can be transmitted through sexual intercourse and majority of them did not know the correct way of using the condom49. Another study conducted by Wong et al., in Penang, Selangor, Johor, Kelantan, Sabah and Sarawak among 1,075 young adult respondents aged 15 to 24 also reported that most of the young people were not well equipped with the HIV prevention information50. The study found that although most of them were aware that they should avoid taking drugs, should not share injecting needles and syringes, and to have sex with only one faithful uninfected partner in order to protect themselves from HIV , only 79.5 % of them knew that HIV/AIDS could be prevented by using condoms, while 41.9 % of them believed that washing the genital area with soap after sexual intercourse could prevent HIV infection and 36.1 % believed that avoiding touching HIV positive people could also protected them from HIV infection.

The MPFS (2004) showed that knowledge on STI was even poorer with only about two thirds of the youths having heard of it51. The 3rd National Health and Morbidity Survey reported that most of the young people aged 20-24 (80.9 %) had heard of STIs compared to those young people in the younger age groups52 (Table 3). Most of the young people also cited television or radio as their main sources of information of STIs (Table 4).

In view of the fact that sex education is not an independent subject in school, and the fact that topics related to anatomy, reproduction, contraception and sexually transmitted disease are integrated in science subjects for lower secondary level students, it is not surprising that the knowledge on sexual and reproductive health among the young people has not improved over time. The findings from the literature review are similar with the 2005 WHO report 53, which concluded that sexual and reproductive health knowledge among adolescents was low. About half of the young people were still not familiar with reproductive organs, reproductive process and family planning methods even though “reproduction” is being taught as one of the topics in Science at the lower secondary school (Form 3 – ages between 15 to 16). On the other hand, although majority of the young people had heard about HIV/AIDS, they did not understand HIV transmission well and were not equipped with the skills to protect themselves from HIV/AIDS and STIs. The other fact is that most of the young people did not get accurate and in depth information from reliable sources and some of them (8 to 10.1% for Peninsular Malaysia and 6.3% to 22.3% for Sabah) even claimed that they have been exposed to pornographic magazines, photos or video (Table 5). The information from these sources that portray sex as a pleasure without responsibility can be misleading to young people.
Dating and Sexual Experience

Dating Experience

The 2004 Malaysia Population and Family Survey reported that slightly more than two thirds of adolescents had some dating experience\(^5\). About 65.5% of adolescents from Peninsular Malaysia and 73.3% from Sabah admitted that they had held hands (Table 6). About a quarter of them (26.2% from Peninsular Malaysia and 20.4% from Sabah) said they had kissed. In addition, 11.8% (Sabah) to 16% of them said that they had engaged in “petting”. In this study, a higher percentage of males than females reported that they had some dating experience and the percentage of young people who had some dating experience also increased by age. Such findings did not vary much with that of the 1994-1995 National Study on Reproductive Health of Adolescents as quoted in the WHO report 2005\(^5\).

Sexual Experience

According to the 3\(^{rd}\) National Health and Morbidity Survey in 2006, the mean age at first sexual intercourse for males (n = 6,007) was 24.8 years old and for females (n = 6,977) was 22.8 years\(^6\). Although the study showed that most Malaysians had their first sex at a much later age, others reported that a number of young people aged 15 to 24 were indeed sexually active and the percentage young people who were sexually active has increased over the years. The Malaysia Population and Family Health Survey conducted by National Population and Family Development Board throughout the country showed that the prevalence of sexual intercourse among youths had risen from less than 1% in 1994 to about 2% (2.1% for Sabah and 2.2% for Peninsular Malaysia) in 2004\(^5\).

While the findings from MPFS (2004) still showed that the percentage of youths who had ever engaged in sexual activities was only about 2%, other studies found that the percentage of young people who were sexually active was much higher, ranging from 5.4% to 13% (Table 7). For example, a cross-sectional school survey conducted among 4,500 school students in Negeri Sembilan in 2001 reported that 5.4% had ever had sex and the mean age at first sexual intercourse was 15 years\(^5\). A similar study conducted in the schools in Penang in recent years reported that 12.6% of school students had claimed to have sexual experience\(^6\). Majority of these students in Penang (75.7%) had their sexual debut at aged 15-19 years and about one third of them (38.2%) said that they had had more than 3 partners. In a paper published in 2000 by Zulkifli and Low, it also reported that the proportion of unmarried youth who had experienced sexual intercourse was about 13\(^6\). Another nationwide cross sectional study that was conducted among 22,750 youth by using secondary data from Adolescent Health Screening Forms showed that 7% of youths reported having had premarital sex\(^6\).

Generally young males were more likely to be sexually active than young females. However, a study among young women aged 15 to 24 in 9 states in Peninsular Malaysia by University Malaysia and Ministry of Women, Family and Community Development in 2009 reported that women who had ever had premarital sex had increased\(^7\). A total of 5.9 % of the young women who participated in this study admitted that they had ever engaged in sexual intercourse and some of their sexual debut took place as early as 14 years old. In this study however, majority of the young

### Table 7: Prevalence of premarital sex according to selected studies by gender

<table>
<thead>
<tr>
<th>Site</th>
<th>Sample Size</th>
<th>Age Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysia(^6)</td>
<td>N = 468</td>
<td>13-24</td>
<td>18.2</td>
</tr>
<tr>
<td>Peninsular Malaysia(^5)</td>
<td>N = 1,762 (M= 892, F = 870)</td>
<td>13-24</td>
<td>3.8</td>
</tr>
<tr>
<td>Sabah(^6)</td>
<td>N = 916 (M= 469, F = 447)</td>
<td>13-24</td>
<td>2.8</td>
</tr>
<tr>
<td>Negeri Sembilan(^7)</td>
<td>N = 4500 (M=2,089, F = 2,411)</td>
<td>12-19</td>
<td>8.3</td>
</tr>
<tr>
<td>9 states in North, South, East and Central Zones(^8)</td>
<td>F = 2,005</td>
<td>15-24</td>
<td>5.9</td>
</tr>
<tr>
<td>Penang(^9)</td>
<td>N = 1,139 (M = 474, F = 665)</td>
<td>15-20</td>
<td>17.5</td>
</tr>
<tr>
<td>Malaysia secondary data from Adolescent Health Screening Forms(^7)</td>
<td>N=22,750</td>
<td>Mean Age = 19.0</td>
<td>7</td>
</tr>
</tbody>
</table>
women (over 80%) claimed that it was important to keep their virginity before marriage, while 11% of them thought that premarital sex was acceptable\textsuperscript{72}.

All these studies revealed that the sexual experiences among adolescents were associated with socio-economic factors (age and employment) and the living arrangement (staying or living away from parents). The secondary data from Adolescent Health Screening Forms also found that adolescents with no history of substance abuse, no anti-social behavior, no risky behavior and adhered to their religious practices were less likely to engage in sexual intercourse\textsuperscript{73}.

**Contraceptive use and unmet need**

The unmet need on contraception among young and unmarried people remain unclear as the MPFS (2004) only studied the contraceptive use among married women and the Ministry of Health and NPFDB do not provide contraceptive services to the unmarried\textsuperscript{74}. However, a study conducted in among 468 unmarried youths by Zulkifli and Low revealed that 72% among those youth who were sexually active did not use any contraception\textsuperscript{75}. Meanwhile an online survey by Bayer Schering Pharma among 100 Malaysian youths (aged 18 – 21) in 2009 showed that over 50% of the young people were not familiar with or confused about the different contraception methods and nearly 60% of them either did not talk about contraception or found it difficult to talk about it with their partners before the first time they had sex\textsuperscript{76}. More than 20% of the young women in the Bayer’s online study did not use contraception as they did not like it and over 20% of them were not using it due to partners’ objection. In addition, 24% of the young men did not use contraception because they felt that they were not at risk of pregnancy.

Contraceptive Prevalence Rate (CPR) for all methods has stagnated at about 50% according to the Malaysian Population and Family Surveys of 1984, 1994 and 2004. The rate was not increased over the last three decades and contraceptive use among young married women aged 15 to 24 was even lower. As shown in Table 8, the percentage of women who have ever used any contraceptive method was only about 50 percent among women aged 20 to 24. Contraceptive use reported by women aged 15 to 19 was much lower than that reported by women aged 20 to 24, i.e. about 30%.

The latest MPFS study in 2004 also reported that 33.3 to 47.1% of women in Peninsular Malaysia and 40.6 to 51.6% of married women from Sabah were using contraception at the time of the study. However, the proportion of women who were using modern method was far lower. Only about 30 to 40% of the married young women used modern methods (Table 9). Among those women (aged 20 to 24) in Peninsular Malaysia who were using modern contraceptive methods, most of them were from rural areas (36.2%), poorer educated (100% of the women who never been to school and 56.3% of the women who only completed primary education in this age group reported that they were using modern methods) and were working. The findings from the study on women in Sabah also showed a similar pattern.

Among all the modern methods, the pill was the most commonly used method for married women aged 20 to 24 both from Peninsular Malaysia and Sabah (48.2 % and 70.8 % respectively) (Table 9). The male condom was the second preferred method for women from Peninsular Malaysia, followed by IUCD and Injectables. Meanwhile in Sabah, except for the pill, most married young women preferred to use injectables, followed by male condom and IUCD. The MPFS 2004 showed that younger women (age 15-19) were less likely to be using contraception than

<table>
<thead>
<tr>
<th>Survey</th>
<th>Ever used contraception (all methods)</th>
<th>Currently using contraception (all methods)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>15-19 yr</td>
</tr>
<tr>
<td>MPFS 1984/85</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Sabah PFS 1989</td>
<td>72</td>
<td>41.3</td>
</tr>
<tr>
<td>Sarawak PFS 1989</td>
<td>77.7</td>
<td>52.6</td>
</tr>
<tr>
<td>MPFS 1994</td>
<td>Na</td>
<td>Na</td>
</tr>
<tr>
<td>MPFS 2004 – Peninsular Malaysia</td>
<td>69.1</td>
<td>38.1</td>
</tr>
<tr>
<td>MPFS 2004 – Sabah</td>
<td>70.3</td>
<td>34.2</td>
</tr>
</tbody>
</table>
women aged 20 to 24. The pill and male condom were the most popular among women aged 15 to 19.

Traditional methods were less commonly used among young married women. In Peninsular Malaysia, none of the married women aged 15 to 19 used any of the traditional methods. For the women aged 20 to 24, about 15% of them stated that they were using traditional methods to plan for their families and the rhythm method was most commonly used (18.8%), followed by withdrawal (7.1%) and abstinence (2.4%). In Sabah, less than 10% of the young married women claimed that they had used traditional methods for family planning. The Rhythm method was the most common method. For the Sabah women aged 20 to 24, a number of them also chose withdrawal (6.2%) and abstinence (1.5%) as their family planning methods.

Table 10 shows the distribution of currently married nonusers who do not use family planning by reason for not using contraception, according to age. The majority of women (63.2% to 72%) who were not using a contraceptive method cited that they were planning for a pregnancy. The next most often cited was the fear of side effects of method (7.1% to 22.2%). In addition, the objection from husband was another reason that women did not practice any family planning method. The situation of “husband opposed to use” was more commonly cited as a reason by the women from Peninsular Malaysia (about 7 to 8%) than women from Sabah (about 2 to 4%). It should be noted that the proportion who mentioned husband’s objection does not vary much across the ethnic groups and no respondent had specifically mentioned religion as posing a barrier to contraceptive use. However, the percentage of Malay women who cited husband’s objection as a reason was slightly higher compared to the other ethnic groups. In view of the fact that all the Malay women are Muslims, it was not surprising that most of them felt that they should let their husbands make decisions on issues such as the number of children, family planning and the use of contraception because in Islam the man is the head of the family and the wife should be obedient and submissive to her husband.

About one fifth (21.4%) of the young women aged 20 to 24 from Peninsular Malaysia said they did not want a pregnancy but were not using any contraception (construed in the study to be an unmet need for family planning). Most of these women were from urban areas, had only lower secondary education and were not working. On the other hand, none of the women in the same age group from Sabah stated they had any unmet need for family planning.

The family planning needs and use among young people remain a major concern, especially among unmarried youth as studies have shown that the number of youths who were sexually active and the age of marriage is increasing, and yet, most of them were not aware of the importance of contraception and cannot access contraceptive services from the government facilities (where it is available free of charge). The lack of awareness and inaccessibility of contraceptives among youths has created unintended pregnancies, unsafe abortion and abandoned babies. Most of the young unmarried girls who have unintended pregnancies are forced to drop out from school and get married, while some choose to go to temporary shelters.
and give then up their babies for adoption or taken back by parents to be brought up as a sibling. Some have been known to abandoned their babies in garbage dumps, bushes or public toilets. According to the Star’s report on 21 June 2011, from 2008 to April 2011, a total of 539 teenage girls were pregnant and sheltered at the welfare institutions. In addition, 472 babies were abandoned throughout the country from 2005 to August 2010, of whom, 258 were dead and 214 were still alive according to police report as quoted by the Malaysian Insider.

On the other hand, although married women faced less obstacles in accessing family planning services, their unmet needs for contraception and the reasons of not using contraception such as "fear of side effects" and "husband's objection" should also be given more attention.

### Pregnancy and Child Birth

#### Live births

The vital statistics of 2010 reported that the mean age at first live birth among Malaysia women was 26.9 years in 2009. However, many mothers in Malaysia give birth before 19 years despite the fact that they are not ready to start a family, from both a biological as well as a social perspective.

In 2009, the number of live births to adolescent mothers (aged 19 and below) was 19,125, accounting for 4 % of the total live births (Table 11). Out of these 214 (1.1%) were to mothers below 15 years. Most of the adolescent mothers who delivered below 15 years old were classified as “Bumiputera” (33.6%) and include indigenous peoples from Peninsular Malaysia and natives of Sabah and Sarawak, followed by Malays (30.4%) and others including non-Malaysian (10.1%). On the other hand, births to mothers in the 20-24 year were reported at 85,650, which was 17.3 % of the total live births. More than half of the mothers who had a live birth in this age group were Malays (54.7%), followed by other Bumiputera (19.3%) and Chinese only represented 12.9%.

Many studies have shown that pregnancy and childbirth are high-risk events for young women as they are not physiologically or psychologically mature. It was therefore not surprising that more underweight babies (less than 2.5 kg) were born to mothers who were below 19 years (22 % of mother under aged 15 and 20.8 % of the mothers aged 15 to 19).

Compared to young women, fewer young men aged below 19 years old (0.5 %) and aged 20 to 24 years (6.7 %) were reported to have fathered children. However, it should be noted that there were a total of 25,588 live births (5.1 %) without the record of the fathers’ names in their birth certificates (Table 11). The high number of registered births without the name of the father may be due in part to the practice of the National Registration Department to not record the father’s name if the child was born less than six months after their marriage. In fact up to February 2012, 234,000 children have “no-information” written in the space provided for their fathers’ names in their birth certificate. Basically many of these children were conceived before marriage (a result of unplanned premarital sex).

#### Abortion

In Malaysia, abortion is permitted under The Penal Code Amendment Act (Section 312, 1989) if the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental and physical health of the pregnant woman. Although abortion is permitted under certain conditions in Malaysia, most people, including the healthcare professionals are uninformed of the legal...
framework of abortion and have conservative opinions on this issue. In Kamaluddin’s study (2008) among abortion clients, she had found that 41% of respondents did not know the legal conditions of abortion. In addition, a survey of 120 doctors and nurses found that only 57% correctly knew the law and 38% of them said that women who were being raped should also continue the pregnancy instead of having an abortion.

Although abortion services are available in both public and private healthcare facilities in Malaysia, most people are not aware of it and most of the healthcare providers tend to neglect the need of women to access safe abortion services due to fear that addressing it might be construed as promoting abortion. As such, it is not surprising that there is no official published source of data on abortion for Malaysia. However, the 2008 WHO report on Health in Asia and Pacific reported that “38 out of every 1,000 women aged between 15 and 49 years had been for abortion in Malaysia.”

According to Kamaluddin, S. F. (2010) in her follow-up study of 28,605 women seeking pregnancy terminations at a private clinic in Penang between 1998 and 2005, there was a growing trend of young single teenage and young adult working women who sought abortion services. More than half of the women (54%) who came for abortion services were in their late twenties (mean age = 29 years), had a monthly household income of less than RM2,000 (100%) and had used contraception in the past (85%). Seven to 8% were in the age group of 15 to 19 years but the number of young women in this age group who had abortion had increased from 110 in 1999 to 140 per year in 2004/2005 (Table 12). Majority of the women aged 15 to 19 (59%) had their abortion when they were 6 to 9 weeks pregnant, followed 22% at 10 to 12 weeks of their pregnancy. It should be noted that they are data from a private clinic from where women could sought abortion services. The economic background would reflect the fact that these women could afford to seek the service from the private clinic. Attempts have been made in the past by the Federation of Reproductive Health Associations, Malaysia (FRHAM), an NGO involved in reproductive health to conduct a more comprehensive study of the clinics (and there are indeed many) providing similar services but there was not cooperation from any for fear of being raided (this is despite the fact that the abortion law is clear on those eligible to have an abortion).

### Law and Policy

#### Law and Legislation

**Marriage and sexual relations**

In Malaysia, the minimum age at first marriage for both women and men is 18 years of age under the Civil Marriages law, while under the Malaysian Syariah law (for Muslims), the minimum age for marriage for women is 16 years and for men it is 18 years except where the Syariah Judge has granted his permission in writing in certain circumstances. The requirement of consent in this situation is provided in section 13 which provides that a marriage shall not be recognized and shall not be registered under this Act unless both parties to the marriage have consented thereto, and (a) the wali (representative) of the woman has consented.
thereto in accordance with *Hukum Syarak* (*a type of Syariah law*).

Under the Syariah law, two unmarried Muslims who are found together or alone in any secluded place or in a house or room under circumstances which may give rise to suspicion that they engaged in immoral acts will be charged as *Khalwat* under Act 559 - Syariah Criminal Offences, section 27, with the fine not exceeding three thousand ringgit or to imprisonment for a term not exceeding two years or to both.\(^91\)

**Abortion**

In Malaysia, abortion is permitted under The Penal Code Amendment Act (Section 312, 1989) with certain conditions. It allows a registered medical practitioner to "terminate the pregnancy of a woman if such medical 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 and physical health of the pregnant woman greater than if the pregnancy were terminated."\(^92\)

With regards to the provision on abortion under Syariah laws and according to the fatwa (*a ruling on a point of Islamic law given by a recognized authority*), the Department of Islamic Development Malaysia’s website points out that abortion is *makruh* (*not encouraged*) for up to 40 days, *harus* (*permissible*) for up to 120 days if there is fetal impairment or is a threat to the woman’s life and *haram* (*forbidden*) beyond 120 days except to save the life of the mother.\(^93\)

**Policy**

**National Adolescent Health Policy (2001)**

The National Adolescent Health Policy was launched in 2001 to encourage and ensure the development of adolescents in realizing their own responsibilities for health.

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**Table 12**  
Age Group of Abortion Clients From a Clinic in Penang, 1998 - 2005\(^90\)

<table>
<thead>
<tr>
<th>Year</th>
<th>1998 (%)</th>
<th>1999 (%)</th>
<th>2000 (%)</th>
<th>2001 (%)</th>
<th>2002 (%)</th>
<th>2003 (%)</th>
<th>2004 (%)</th>
<th>2005 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 19 yr</td>
<td>74 (11)</td>
<td>110 (8)</td>
<td>110 (7)</td>
<td>103 (7)</td>
<td>119 (8)</td>
<td>118 (8)</td>
<td>140 (8)</td>
<td>136 (7)</td>
</tr>
<tr>
<td>20 – 29 yr</td>
<td>317 (47)</td>
<td>751 (52)</td>
<td>776 (53)</td>
<td>851 (57)</td>
<td>846 (55)</td>
<td>889 (58)</td>
<td>1002 (56)</td>
<td>1094 (56)</td>
</tr>
<tr>
<td>30 – 44 yr</td>
<td>288 (42)</td>
<td>596 (41)</td>
<td>592 (40)</td>
<td>549 (37)</td>
<td>568 (37)</td>
<td>539 (35)</td>
<td>634 (36)</td>
<td>726 (38)</td>
</tr>
<tr>
<td>Total</td>
<td>679 (100)</td>
<td>1457 (100)</td>
<td>1478 (100)</td>
<td>1503 (100)</td>
<td>1533 (100)</td>
<td>1546 (100)</td>
<td>1776 (100)</td>
<td>1956 (100)</td>
</tr>
</tbody>
</table>

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The policy also aimed at empowering adolescents with the appropriate knowledge and assertive skills to enable them to practice health-promoting behavior through their active participation. The objectives of the policy included the following: a) to support the development of resilient adolescents through promotion of health and responsible living, b) to prevent the health consequences of risky behavior through promotion of wellness and provision of appropriate health care services and c) to promote active adolescent participation in health promotion and preventive activities. However, the policy made no mention of sexual and reproductive health needs among adolescents directly.

**The National Adolescent Health, Plan of Action, 2006-2020**

The Ministry of Health has developed a national plan of action for adolescent health for the period 2006-2020, with the following objectives: \(^94\):

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• Promoting the development of resilient adolescents through promotion of health and responsible living;
• Preventing the health consequences of risk behaviors through promotion of wellness and provision of health care services;
• Promoting active adolescent participation in health promotion and preventive activities.

There are seven strategies and five priority areas. The strategies cover the following areas: health promotion, access to appropriate health services, human resource development, adolescent health information system, research and development, strategic alliances and legislation. The priorities are: nutritional health, sexual and reproductive health (SRH), mental health, high-risk behaviors and physical health.

National Policy on Reproductive Health and Social Education (2011)

The National Policy on Reproductive Health and Social Education was developed in 2011 aimed at increasing the knowledge on sexual and reproductive health among Malaysians and encourage them to have a positive attitude towards reproductive health and social services. According to the statement made by the Secretary General, Ministry of Women, Family and Community Development at the 44th Session of the Commission on Population and Development in April 2011 the policy will “further pave the way for more accessible reproductive, sexual and social health information and services for in-school, out-of-school and most at risk youths. Information and skills on adolescent sexual and reproductive health (ASRH) would also be integrated into the National Service Program curriculum which covers more than 100,000 school leavers each year”.

National Family Planning Policy

The National Population and Family Development Board (NPFDB) was established under the Population and Family Development Act of 1966 (revised 1988) “to formulate policies (and methods) relating to family planning.” Since then, a clinical service guideline on based on Family Planning Policy has been developed by NPFDB to guide their health personnel. The policy aims to ensure that delivering of family planning services is done voluntarily to benefit the health and welfare of families. The Family Health Development Division, Ministry of Health adopted the policy from the time when the family planning/maternal health services were integrated in the MOH’s health clinics in 1973. The policy does not specify the target group for family planning services. However, all government clinics including those run by the NPFDB’s clinics and government clinics only provide family planning services to married couples.

Programs and Services

Sex Education

In Malaysia, school-based sexual and reproductive health education has been implemented as Family and Health Education (FHE) and has been taught to secondary school students since 1989 and to primary school students since 1994. The FHE curriculum has been incorporated into the examinable subjects such as biology, science, moral and religion and non-examinable subjects such as physical education. The approach to integration of FHE is mostly content based by providing information and life skills education is not included and it has always emphasized moral values.

In 2011, the FHE curriculum was revised and renamed as “Reproductive Health and Social Education” (or PEERS - Pendidikan Kesihatan Reproduktif dan Social). The new curriculum includes topics ranging from personal hygiene, sexuality education to life skills such as self-respect and negotiation skills. It is suppose to be taught for 30 minutes a week in primary schools and 40 minutes twice a month in secondary schools. Only teachers who have undergone training sessions were eligible to teach this subject in order to ensure the effectiveness of the teaching and learning process. However, the implementation and effectiveness of the PEERS program still remained unclear a year after the announcement. The feedbacks from the schools and teachers showed that most teachers feel uncomfortable to teach the subject due to the shortcomings in training, support, school leadership and commitment.

Information and education programs by other agencies

In Malaysia, there are a number of agencies, both government and non-government organizations which have educational programmes to address adolescent sexual and reproductive health. Various information, education and communication (IEC) materials and training modules on adolescent sexual and reproductive health including family planning and HIV have been developed by these agencies, which include the National Population and Family Development Board, Malaysian AIDS Council and the Federation of Reproductive Health Associations, Malaysia (previously known as Federation of Family Planning Associations, Malaysia).

Under the NPFDB’s youth programme, a module called “I Am in Control” provides information on reproductive health such as sexuality, responsibilities, unintended
pregnancies, HIV and STIs, abortion and abandoned babies, techniques/skills to avoid pre-marital sex and information on safe sex has been developed and used over the past four years as part of the secondary school co-curriculum activities. Specific elements of the I’m in Control Module were also extracted and included into the training module for young people who participated in the National Services Programs. The module and training are designed to suit the Malaysian societal values (culture and religion), advocating abstinence only and to educate young people in the absence of sexuality education in schools. It should be noted that teaching of life-skills such as the use of condoms and other contraceptive use are not included.

There has been other initiatives by the National and Population and Family Development Board to get vital SRH information out to in-school children. Working with the Ministry of Education a specially designed module has been designed to enable teachers to implement the programs in schools after the year six students have sat for their Ujian Pendidikan Sekolah Rendah (Primary School Examination). An equivalent program has also been planned for the junior high school students upon completion of their Lower Secondary School Examination. At the time of the writing of this report “Training of Teachers” have been being conducted to prepare teachers to pilot test the module in more than 30 schools.

On the other hand, as a key NGO in the field of reproductive health, FRHAM has always advocated for all adolescents and young people to be made aware of their sexual and reproductive health needs and rights so that they are empowered to make informed choices and act on them. By using peer to peer approach, where young peer educators are trained to empower their peers, FRHAM believes that young people will be equipped with responsible behaviors and avoid health damaging activities. More innovative approaches have also been designed for education on sexual and reproductive health by FRHAM such as the electronic version of the Reproductive Health of Adolescents Module (e-RHAM). In addition, the organisation also reached out to disadvantaged youths in juvenile homes run by the Department of Social Welfare to provide them with SRH and HIV prevention information through peer education. The added advantage of FRHAM’s program is that it is implemented by all 13 member associations throughout the country.

Adolescent Reproductive Health Services

Adolescent Health Services by Ministry of Health

The Adolescent Health Unit was established as an expanded scope of the Maternal and Child Health Program by the Ministry of Health, Malaysia in 1996. The services provided include health promotion, screening for health-risk behaviors including behaviors that contribute to injuries and violence; alcohol or other drug use; tobacco use; sexual and reproductive health; unhealthy dietary behaviors; and physical inactivity, counseling, and referred to hospitals or other agencies for further management.

In 2011, there were 642 health clinics of the Ministry of Health providing adolescent health care. Sexual and reproductive health problems are included as part of the services of the clinics but it remains a challenge as not many adolescents are aware of it and most of them are also reluctant to reveal their problems even if they knew about the services. In addition, most of the health professionals who serve young people are often confronted with policies, regulations and guidelines with which they have to weigh against issues surrounding rights of their clients, religious views, and their own personal beliefs about a very sensitive issue like sexual matters. Those who lack the skills to deal with sexuality issues, may indeed be ineffective and inappropriate to care for young people. To this end the Ministry of Health has over the years conducted training programs for their personnel to enable them to be “Youth-friendly” in view of the fact that young clients are often afraid of meeting “moral gatekeepers” when they sought help on sexuality matters. The Ministry of Health as the main provider of family services in the country usually does not provide contraceptive services to unmarried young people although there is no specific policy and guidelines with regards to this.

Kafe@Teen by National Population and Family Development Board

The first two Kafe@Teen centers were set up by the National Population and Family Development Board in Kuala Lumpur and Butterworth, Penang in 2005. It was established as a youth centre that offer counseling, reproductive health and HIV information and services for young people. Currently, there are a total of 6 Kafe@Teen located in different states throughout the country, i.e. Kuala Lumpur (2 centers), Penang (2 centers), Negeri Sembilan and Kelantan. From 2006 to 2010, 80,128 young people
were provided with SRH and HIV information, while 6,312 teenagers obtained clinical services for menstruation problem, pimples and skin problems, vaginal discharge, etc from Kafe@Teen. Although information on contraception is available in Kafe@Teen, provision of family planning services including condom were also not available at Kafe@Teen. However if a doctor after examining a client feels that some form of contraceptive is needed to protect the health of a young client it can be dispensed albeit on a case by case basis.

**Youth Friendly Services by the Federation of Reproductive Health Associations, Malaysia**

Compared to the government agencies which are not able to provide family services to young people, FRHAM is a nongovernmental organization that provides family planning and reproductive health services to everyone, including young people through the clinics run by its 13 State Member Associations.

Furthermore, youth friendly centers and clinics are set up at 11 states (except Johor and Pahang), specifically for young people to access SRH and HIV information, education and services. Through the youth centers, youth friendly sexuality education coupled with life skills are imparted to young people. In addition, services such as counseling on safer sex and sexuality, contraceptives services, HIV prevention information, condom and VCT (VCT was available in 5 state MAs), screening and management for STIs and referral for safe abortion services are also available for clients including young people. On the other hand, FRHAM and its state Member Associations also reach out to young people from marginalized communities such as young drug users, sex workers, transsexuals, MSM and youth with disabilities and provide them with comprehensive youth-friendly SRH services including HIV and AIDS.

**Gaps and Barriers**

**National data on Youth Sexuality, Sexual and Reproductive Health and Family Planning Needs**

Although numerous small-scale studies have been carried out in Malaysia to determine the knowledge, attitudes, and behavior of young people with respect to health, human reproductive systems, and exposure to information on these subjects, they vary in geographical coverage, focus, and age range of subjects. Furthermore, there are no periodic national surveys carried out in Malaysia to provide concrete evidence on changes in knowledge attitudes, and practices regarding young people’s sexuality and reproductive health. The National Study on Reproductive Health and Sexuality of Adolescents in Malaysia began in 1994 by the National Population and Family Development Board and is conducted every ten years, the latest of which was in 2004). However limited data were collected in these surveys. This survey does not include information about young people’s sexual development such as age of menarche, wet dreams, young people’s attitudes, and sexual activities such as practice of safe sex and use of family planning methods etc. Without concrete data it is difficult to have policies, programs and services to meet the sexual and reproductive health needs of young people in the country. At best, policies and programs are formulated as a reaction to problems that surface in the news.

**Policy**

Several policies have been formulated at the national level in the recent past to meet the health needs of adolescents and young people. However, with the exception of the recent National Adolescent Health, Plan of Action, 2006-2020, most policies have overlooked the sexual and reproductive health needs including the need for family planning among young people. In addition, policies such as National Family Planning Policy and National Policy on Reproductive Health and Social Education has never specified whether it is advocating the SRH information and services for young people and remains ambiguous about the extent to which information and services will be made available to the unmarried. Furthermore, most of the policies and strategic plans in Malaysia treat young people as “target” populations in reducing their risky behaviors and do not recognize their need for sexual and reproductive health services but instead talk about providing them with comprehensive health care.

On the other hand, even though the MOH's national plan of action for adolescent health, 2006-2020, identified that SRH as one of their priority areas, the plan is mainly known to MOH's clinics and hospitals and not widely circulated to other relevant agencies and stakeholders. Therefore, it is not surprising that the plan was not adopted by other agencies in view of the lack of a coordination and joint planning mechanism among the key agencies.

**Program**

The promotion of comprehensive sexuality education in schools has been controversial due to the cultural and religious beliefs. Many have feared that it might encourage sexual activity among young people who are not sexually active, and increase levels of risk-taking among those who are sexually experienced. Moreover, for many adults, including parents and teachers, it is perhaps convenient
not to have to talk with young people about sexual matters. In view of the sensitivity of the issues, it is understandable why the term “family health” or “reproductive health” is usually used to frame sexuality education programs. For example, it was implemented within the context of Family Health Education since the early nineties and then as the term “Reproductive Health and Social Education” beginning 2010.

While the curriculum documents outlining the content of sexual and reproductive health has been developed by the Curriculum Development Center of the Ministry of Education and the sexual and reproductive health education was to have been implemented in school, guidelines for the schools and teachers such as lesson plans, who are responsible to teach the subject, how the subject is to be incorporated into the current timetable, the mode of delivery, for example, or whether the subject should be addressed via knowledge-based models or via interactive and skills-based modes of learning, etc still remained unclear. It is unsure whether sex or reproductive health education is taught in school because the current curricula is already crowded and the subject is not an examination subject. In general non examination subjects are not a priority because schools are judged and rewarded based on major public examination scores of students. No reward is being awarded to schools which have the best SRH educated students. There is also no detail feedback from schools and teachers who taught the subject and students who attended the classes. This is most unfortunate because our focus group discussions with youths revealed that young people are hungry for SRH knowledge but are unable to get it from school. In fact many of the young people feel that they would rather SRH be taught by teachers than parents.

The impact of the training and educational programs conducted by the National Population and Family Development Board for the young people in the schools and national service trainees has not been systematically evaluated in terms of quality or effectiveness, as the programs are new. However it has been reported that feedback from students who attended the program was generally positive and the opportunity to explore sexual matters in a safe space is appreciated by both girls and boys. It might be important to have in place an evaluation and monitoring mechanism from the start. At the same time it was evident that youths were receiving more explicit information rather than learning more life skills. On the other hand, the coverage of the training programs for the young people that are conducted by NGOs such as FRHAM, may be limited due to constrains of resources, both manpower and funding.

The needs of the out-of-school youths are in general, poorly met. Currently, only FRHAM provides some SRH and HIV information for the youths in juvenile homes and even this hinges on availability of funds from funding agencies like UNFPA. For those youths marginalized by different sexual orientation, there is no specific program to meet their SRH needs except for PT Foundation and Safe Clinic whose coverage is only in the Klang valley and they provide mainly HIV related information.

Services

Despite the Ministry of Health’s commitment to addressing the sexual and reproductive health service needs of youth through their adolescent clinics, there remains ambiguity in service delivery. First of all, most of the young people are not aware of the services due to lack of publicity. It is generally assumed that the government does not provide contraceptive services to the unmarried young people. However, all pregnant women irrespective of whether they are married or not do access prenatal services and deliver in health facilities.

Through the interviews with MOH, it was reported that a total of 124 trainings sessions on adolescent health care and counseling were conducted in 2009 at national, state and district levels involving 1,520 healthcare providers (doctors and paramedics). As such, MOH believes that most of their service providers had been trained to be sensitive to the needs of young people and they were able to deliver the services in a non-judgmental manner. Service providers have been asked to treat the young person professionally and to meet their health needs including reproductive health. In our focus group discussion with young people, one of them reported that his friend was able to obtain contraceptives from a government clinic. While there is no publicized evidence of effort to evaluate these services, the MOH is beginning to collect data on young people who avail their services.

With other agencies who work closely with young people, the NPFDB’s Kafe@Teen and their family planning clinics do not provide family planning services including condom to the young people although information on SRH and HIV are available. On the other hand, FRHAM appears to be the only NGO providing SRH and family planning services through its youth friendly centers at the state level. The youth friendly centers of FRHAM were set up through the funding from the international donor and they provided free services during the project period in 2009 to 2011. However, the clinics impose a minimal charge for services after the project was over in order to sustain the program. This might turned away some youth clients, especially those from marginalized communities, leaving only those clients who are able to pay.
The Way Forward

Advocacy

More structured advocacy work needs to be done in order to ensure that a coordinating body be established to bring together relevant stakeholders to plan coordinated strategies in the key areas (such as decision-making processes and roles and responsibilities). It is critical to convince and engage the main agencies and individuals such as Ministry of Education, Ministry of Health, Ministry of Youth, Ministry of Women, Family and Community Development, National Population and Family Development Board, the Federation of Reproductive Health Associations, Malaysia, religious leaders and community leaders to come together for more effective coordination in order to meet the unmet Sexual and Reproductive Health needs of young people. If clear guidance and direction on provision of comprehensive sexuality education, SRH programs and services for young people are in place, it will provide the foundation and justification for coordination efforts for the schools, teachers, service providers and other program personnel at the grass root level to increase their commitment and help ‘make it happen’. The setting up of a national coordinating committee at the highest level similar to the National Coordinating Committee on AIDS Intervention (NCCAI) can assume this role of coordination.

Nevertheless, the national coordinating committee must recognize that young people are at risk of unsafe sex that puts them at risk to unwanted pregnancies, unsafe abortion and STI including HIV and be convinced that provision of sexual health education and SRH services for young people is meant to increase young people’s exposure to positive and constructive relationships and activities that promote healthy, responsible and compassionate choices in order to enable them realize their fullest potential. In addition, young people should also be included as part of the committee. Their voices should be heard and they should be given a platform to raise their concerns about sexuality and suggest programs and services that address their needs. Through the committee, it can also facilitate dialogue between young people and adults.

On the other hand, there is a need for media advocacy. The results and outcomes of evidence-based research, programs and services on sexual and reproductive health for young people should be widely disseminated through the media. Besides that, a more pro-active stance is needed by those involved in policy and provision of sexuality education to engage with the media in conveying the need for, and the positive impact of, sexuality education for the well-being and health of young people. Furthermore, this can create greater public awareness, desensitize the issue and more open discussions on sexuality education/services can take place.

Greater synergy and ‘joint action’

The interagency partnership, coordination and collaboration are crucial in meeting the SRH needs of young people. In view of the fact that some schools have been unable to carry out sexual and reproductive health education because of a shortage of trained teachers, NGOs can be involved and brought into schools to train the teachers.

On the other hand, the key stakeholders such as MOE, MOH, MWFCDS, NPFDB and NGOs should meet regularly and share their expertise, experiences, lessons learned in implementing SRH programs and services for young people through a task force consisting of representatives from concerned partners. The National Adolescent Health, Plan of Action, 2006-2020 by Ministry of Health should be circulated and adopted by relevant stakeholders.

An effective referral system should also be developed in order to ensure that young people who need SRH services or other treatment, care and support are referred respectively to hospitals, clinics and Department of Social Welfare.

Up-Scaling Sexuality Education Programs

According to UNESCO, introduction of comprehensive sexuality education into the school curriculum is the most effective, cost-effective and cost-saving strategy to reduce the adverse health events among young people, including HIV infections, other STIs and unintended pregnancies.

While the Ministry of Education is committed to implement comprehensive sexuality education in the school curriculum, policy guidance and the detail plans of implementation must be clearly outlined. A well-developed national policy on sexuality education that is explicitly linked to education sector plans, as well as to other national strategic plan and policy framework on youth reproductive health should be developed and circulated to the schools in order to provide an institutional basis for the implementation of sexuality education programs; address sensitivities concerning the implementation of sexuality education programs; and protect and support teachers responsible for delivery of sexuality education. In addition, the availability of the plans of implementation such as how to select and train teachers who are responsible to teach the subject, lesson plans, number of hours, how the subject is to be incorporated into the current timetable, the mode of delivery, provision of resources (including materials), etc. are extremely important in order to increase the schools’ commitment, develop the teachers’ skills and build their comfort and confidence in delivering sexuality education.
Delivery of Youth Friendly Services

In order to provide SRH including family planning services which young people trust and feel is there for them and their needs, the following youth friendly characteristics are essential for effective services according to the IPPF’s guidelines:

- Providers should be trained to work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs
- Services must be confidential, non-judgmental and private
- Clinic opening hours should be convenient for adolescents and young people: such times include late afternoons (after school), evenings and weekends
- Services should be accessible to all adolescents and young people irrespective of their age, marital status, sexual orientation or ability to pay
- An effective referral system should be in place
- Opportunities should be made available for adolescents and young people to be involved in designing, implementing and evaluating the program
- Services should seek to involve and gain the support of those important in the lives of young people and in the local community, such as partners, parents/guardians and schools

To strengthen the youth services in Malaysia, first of all, a self-assessment on the existing standard of the services, service providers’ needs, management such as effective and efficiency of the services and clients’ satisfaction of the services need to be conducted by relevant agencies such as MOH, NPFDB and FRHAM respectively. The self-assessment should be conducted as a team exercise within the agencies with the participation of managers, service providers and young people in order to identify the obstacles to providing youth friendly services and find ways to overcome them together.

Furthermore, a national standard, implementation guide and standard operational guidelines for youth friendly services must be developed in order to provide clearer guidance for service providers and ensure the quality of the services. These standard guidelines can also be used as the monitoring and evaluation tool for YFS clinics.

Nevertheless, there is also a need to improve publicity of clinics in the community. In order to increase youth awareness about the services, there needs to be an emphasis placed on increasing community, especially parental, support for reproductive services for young people. Alternatively, the government clinics should work more closely with the NGOs or youth peer educators in promoting their services. NGOs can refer their youth clients for the services and youth peer educators can spread the news about the availability of the services among their peers.

On the other hand, to address the SRH needs for those young people with different sexual orientation, all the relevant agencies may need to learn from the Safe Clinic, a non-profit community clinic in Kuala Lumpur which offers HIV and sexual and reproductive health linked services, especially for key affected populations. The success of the clinic is mainly dependent on the dedication of the doctors and service providers. The volunteer doctors and nurses are friendly and sensitive to the needs of the communities and spent time to build relationship with the clients using the human rights approach.

Research and Study

It is proposed that a nationwide study similar to the Indonesian Young Adult Reproductive Health Survey or the Philippines Young Adult Fertility and Sexuality Study be conducted periodically in Malaysia to provide more comprehensive trend analysis and evidenced-based data on knowledge, attitudes, and behavior of young adults about human reproduction, relationships, HIV/AIDS and other sexually transmitted infections.

In addition, other research activities, especially quality in-depth studies should also be conducted for a better understanding of the situation for more focused interventions. However, it is recommended that all the research should be coordinated in order to ensure that important areas are covered and duplication avoided. Furthermore there must be a mechanism to share findings of research either through periodic conference or publication of a journal on reproductive health.

Monitoring and Evaluation

There is a need to monitor program implementation and service provision for young people among the key agencies, such as Ministry of Health, National Population and Family Development Board and FRHAM, focusing on progress made and identification of facilitating factors, gaps and constraints, as well as emerging issues that require attention. Findings from these would help to strengthen the current programs and services. Furthermore, client exit interview and assessment on the capacity of service providers in delivering the services are needed and should be conducted regularly to assess the effectiveness and efficacy of the programs and services. It is also recommended that, the monitoring and evaluation system among the key agencies be improved and standardized for more reliable and useful information.
Conclusion

Malaysia is on the verge of being declared a developed country. Achievements in all areas of development are evident in improvements in quality of life of the people. Unlike neighbors like Indonesia and The Philippines who will still be benefitting from the demographic dividend Malaysia's benefit may be over soon. Declining fertility has already resulted in a declining young population whose health is of utmost importance to the future of the country. Young people today face many risks arising from not just improvements in nutrition (and therefore earlier menarche), education (and therefore more years in school resulting in late marriage), mobility (away from protection of the family from a very young age) but also from exposure to the internet which if not used appropriately can have more harm than good. It has become almost impossible to shield the young from influence that comes in various forms. The only way to protect them is to provide them with the knowledge to make sound decisions and grow up into adults contributing to develop Malaysia. The young today were born into a world that advocates rights and indeed they have the right to sexual and reproductive health knowledge and service. To deprive them of this right can lead to increase resources to take care of social consequences that may arise. There is no waiting anymore, the data is staring at us in the face. Our young need SRH knowledge, information and services to protect themselves and the many more generations to come.

Malaysia is a country with enough resources to address the SRH needs of the young. There is no short of modules on SRH. The challenge is in the delivery as well as decisions on how and which messages should be included. Very often the safest methods need not be the most effective methods. Young people should not be treated as fragile and in need of special treatment. There are not the problem. They may face some problems growing up but why they have the problems may not necessary be their fault. Young people should be treated as the solution. We must accept the fact that they face many challenges in this borderless world and that they need information in order to make wise decisions that will not jeopardize their future. Depriving them of the information for fear that they do not make good use of the information is to mistrust them. Young people have the right to information in order to make good decisions. If we do not give them the information they may seek it from places or people who may not be responsible. To this end the media has a role to play. Very often social problems arising from irresponsible behavior of young people are
highlighted but the media should also point out the causes. Has the families or community failed them by not ensuring that they are well equip to make the decisions? Sexual and reproductive health of the young people is part of a continuum of health in their lifetime. Meeting their needs for SRH knowledge and services will save the country from having to deal with many more problems not just now but even more in the future.

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Reproduktif, Kesihatan Seksual Dan Reproduktif Wanita Di Malaysia (National Study on Reproductive Rights, Sexual and Reproductive Health of Women In Malaysia)


