COUNTRY REPORT

MALAYSIA

The 6th ASEAN & Japan High Level Officials Meeting on Caring Societies: "Healthy Next Generation: Strengthening Joint Collaboration Between Health and Social Welfare"

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1. INTRODUCTION

1.1 General Information

Malaysia is an independent nation with a parliamentary constitutional monarchy and federal government structure. The country lies in the heart of Southeast Asia and comprises of thirteen states spread across two major regions separated by the South China Sea (Peninsular Malaysia and East Malaysia on the Borneo island), and three Federal Territories. The country has a total area of approximately 329,758 sq. km.

1.2 Important Figures and Statistics

Malaysia's population increased from 23.5 million in 2000 to 27.2 million in 2007, with non-citizens accounting for 2.4 million. It is estimated that the population will increase at an average annual rate of 2.0 % to reach 28.9 million in 2010. The composition of the total population comprises of about 8.79 million (32.2%) below the age of 15 years, 17.26 million (63.4%) in the economically-productive age group of 15-64 years and 1.20 million (4.4%) elderly people aged 65 years and above. Average annual population growth rates will continue to slow down with the declining fertility rate and delayed in marriageable age. The overall population density for Malaysia in 2007 is 82 persons per sq. km. Meanwhile, the proportion of the population residing in the urban areas increased from 62.0% in 2000 to 63.4% in 2007. This trend towards greater urbanisation of the population is indicative of the growing economic opportunities and better social amenities in the urban areas.

Since 2000, mortality rates have declined but marginally. The crude birth rate reduced from 22.6 per thousand population in 2000 to 17.5 in 2007. Meanwhile the crude death rate increased from 4.4 per thousand in 2000 to 4.5 per thousand in 2007. The infant mortality rate has reached single digit (level prevailing in highly developed countries), and has been declining from 7.9 per 1,000 live births in 2000 to 6.3 in 2007. Similarly, under-5 mortality rate declined from 8.6 in 2000 to 8.5 per 1000 live births in 2006. The maternal mortality ratio appeared to plateau at 30 per 100,000 live births since 2000. Life expectancy at birth for both men and women continue to increase each year from 70.2 years (men) and 75.0 years (women) in 2000 to 71.9 years (men) and 76.4 (women) in 2007 respectively. The successive improvements in these vital statistics are evident of an increasingly health conscious community, a political administration committed to better health care and the burgeoning economic wealth of the nation.

Besides these vital statistics, looking at the socio-economic development of the country, Malaysia's Per capita Gross National Income (GNI) at current price was RM 13,418 in year 2000 and has increased to RM23,115 in 2007. The poverty rate has reduced from 8.5 in 1999 to 3.6 in 2007. Poverty rate is four fold higher in the rural as compared to urban areas. The percentage of literacy rate among the 15 years and above age group increased from 88.7% in 2000 to 92.3% in 2007. The primary school enrolment ratio male to female is currently 1.05:1. As for the safe water supply, in the year 2000, 85.0% of household in the rural areas and 97.0% in urban areas had access to safe water supply. These figures increased to 97.9% in the year 2007 in the urban and 92.6% in rural areas in the year 2007. **(The details of the statistics as shown in Appendix 1 – Table 1.1 and 1.2)**

1.3 **Maternal and Child Health in Malaysia**

Brief Overview of Maternal and Child Health Program in Malaysia

Health Programmes for maternal and child health in Malaysia began as far back as 1923, with the introduction of legislation for the control of practice of midwifery and the training of midwives in the Straits Settlements and subsequently in the other states of the Malay Peninsular.

Upon independence in 1957, Maternal and Child Health (MCH) services came to fore as an essential component of the National Rural Health Development Programme. Since then, extensive development of health infrastructure facilities was initiated under the Rural Health Services Scheme. Rural Health Units to serve a population of 50,000 each were organised on a three-tier system of referral for MCH Care. Dental and outpatient care were also offered at these main health centres and health sub-centres (1:10,000 population) as well as domiciliary delivery from Midwife Clinics (1:2,000 population).

The earlier 3-tier system was later modified during the mid-term review of the 2nd Malaysia Plan (1971-1975) to a 2-tier system with a Health Clinic (1:20,000 population) and the community clinic (Klinik Desa) (1:4,000 population) following a World Health Organisation (WHO) assisted Operations Research study on local health services in 1973.

The 1970s was the era where testing of the concept of an integrated multi-agency approach was put to practice through projects such as the applied food and nutrition programme, school health program, and integration of family planning into MCH services. These initiatives were

subsequently integrated into rural health and rural development programmes.

The establishment of the MCH and Health Education Unit of the Ministry of Health Malaysia in 1971, with maternal and child nutrition as one of the major service components, facilitated the implementation of programmes to reduce childhood malnutrition. It was also recognised that improving nutrition status and correcting anaemia in pregnancy improved infant survival and prevented the birth of low birth weight babies.

The organisation of MCH services give emphasis on the child growth monitoring, regularising the immunisation schedules for children, and providing nutrition education in clinics and villages contributed to reducing child mortality. The first advocacy campaign for breastfeeding in 1976 was another factor which improved infant survival.

1.3.1 **Improve Maternal Health**

Various specific strategies under the maternal and child health programmes have been used at all levels of health care to the better management of mothers and infants at risk.

The strategic approaches used in improving maternal health include health advocacy to empower women to have early antenatal check up and close monitoring of high risk cases for safe deliveries. Other activities are Home Based Maternal Health card for antenatal mothers so as to give better quality of care in terms of continuity and linkage to the whole health care system. Nutritional management of pregnant women include nutritional assessment, monitoring as well as provision of

supplements (full cream milk and haematinics). Community health education on healthy eating through ‘cooking demonstration’ is being conducted at health clinics. Other strategies to improve maternal health are the application of the colour coding system for all pregnant women, auditing of all maternal deaths in Malaysia and the Quality Assurance Programme where indicators such as the rate of incidences of eclampsia, puerperal sepsis, neonatal tetanus, severe neonatal jaundice and immunisation coverage are used to measure the quality of care.

Strategies developed in obstetrics and perinatal services in hospitals include day care services, birthing centres, high dependency wards, obstetric Red Alert System and combined clinics to manage cases with medical problems. The introduction of teleconferencing between specialists and medical officers at district hospitals without specialist in the management of emergency cases has been implemented in some hospitals. Health clinics are also equipped with appropriate technology such as daptone, colorimeter, ultrasound, glucometer and resuscitation equipment.

Malaysian’s experience in reducing maternal mortality reflects a comprehensive strategic approach to improve maternal health. The six key elements of this approach are as follows:

i. Improve access to, and quality of care of maternal health services, including family planning, by expanding health care facilities in rural and urban areas;
ii. Invest in upgrading of essential obstetric care in district hospitals, with a focus on emergency obstetric care services;

iii. Streamline and improve the efficiency of referral and feedback systems to prevent delay in service delivery;
iv. Increase in the professional skills of trained delivery attendants to manage pregnancy and delivery complication;
v. Implement a monitoring system with periodic reviews of the system investigation, including reporting of maternal deaths through a confidential enquiry system; and
vi. Work closely with communities to remove social and cultural constraints and improve acceptability of modern maternal health services.

Indicators for monitoring maternal health

Two recommended indicators for monitoring progress towards achieving the Millennium Development Goals (MDGs) between 1990 and 2015 are maternal mortality ratio (MMR) and the proportion of birth attended by skilled health personnel.

Trends in maternal mortality

The reported MMR had halved between 1957 and 1970, when it fell from around 280 to 141 per 100,000 live births. Whereas in 1991 the ratio appeared to plateau at 30 per 100,000 live births and the ratio has maintained up to the present year. The leading causes of maternal death currently are obstetric pulmonary embolism, hypertensive disorders in pregnancy, associated medical complications mainly due to heart diseases in pregnancy and postpartum haemorrhage. **(The statistics of leading causes of maternal deaths as shown in Appendix 2 – Table 1.3.1)**.

Birth attended by skilled health personnel

In Malaysia, the proportion of births attended by trained health personnel had increased markedly and in 2006, 98.3% of the deliveries conducted by trained health personnel. This is related to the rapid development and upgrading of health care services over the past decades, including the establishment of nursing and midwifery schools, led to both an increase in the number of trained health personnel and improved midwifery and obstetric skills including family planning through postgraduate and in-service training. The training of traditional birth attendants (TBAs) as partners in health care with government-trained midwives, and the utilisation of TBAs to promote the use of health facilities to women for antenatal care, delivery and post natal care, was another factor that led to an increase in the proportion of deliveries attended by trained personnel. Malaysian women were encouraged to deliver in hospitals, especially those with high risk of pregnancy complication (assigned red and yellow colour codes) during prenatal assessment. There is a shift to institutional deliveries, and currently the proportion of births delivered in hospitals, maternity homes and clinics have risen sharply that in 2006, the figure stands above 95.0%. The quality of nursing and midwifery curriculum, training and practice is regularly reviewed and governed by the Board of Nurses and Board of Midwives. Nurses and midwives have been utilised as the main providers of the maternal and child health program, with regulatory standards and practices ensuring quality maternal care. Expected mothers were advised about the importance of skilled attendance for delivery and discouraged from the traditional custom of delivering at home with the support of TBAs. **(The details on Pregnancy and Delivery as shown in Appendix 3 – Table 1.3.2)**.

Family planning and maternal health

Increasing access to family planning services and information has been an important factor in improving maternal health. It is a factor in lowering pregnancy among women known to have relatively higher risks of maternal morbidity and mortality such as those with high parity, medical conditions, childbearing ages and others. Family planning services in Malaysia are mainly provided through the Ministry of Health's facilities, National Population and Family Development Board (NPFDB) facilities, Federation of Family Planning Associations Malaysia (FFPAM) clinics and private general practitioners of private hospitals.

1.3.2 **Reduce Child Mortality**

The improvement of child health and the reduction of child mortality have been in national development goals ever since the First Malaysia Plan (1956 – 1960), and the policy vision of good health has been supported by a range of programmatic interventions. Medical advances, including vaccines and oral rehydration for the treatment of diarrhoea, have been made widely accessible through the country's primary health care system.

Malaysia's Under-5 mortality rate declined from 57 per 1000 live births in 1970 to 17 in 1990, and to 8.5 in 2006. Similarly, the infant mortality rate has been declining from 13.1 in 1990 to 6.6 per 1000 lives births in 2006. Overall, the 5 most common causes of infant deaths in 2006, were (i) conditions originating in the perinatal period (56.0%); (ii) the congenital malformations, deformations and chromosomal abnormalities (20.5%); (iii) certain infectious and parasitic diseases (9.4%); (iv) diseases of the respiratory system (4.3%); and (v) diseases of the nervous system (3.0%). Meanwhile the causes of under-5 deaths were (i) the congenital

malformations, deformations and chromosomal abnormalities (25.1%); followed by (ii) certain infectious and parasitic diseases (18.8%); (iii) diseases of the respiratory system (13.0%); (iv) diseases of the nervous system (8.2%); and (v) injuries, poisoning and external causes (7.5%). **(The statistics of leading causes of infant deaths as shown in Appendix 4 – Table 1.3.3 & 1.3.4)**.

Indicators for monitoring infant and child mortality

The under-5 mortality rate and the infant mortality rate are sensitive outcome indicators of the development process. These indicators not only reflect the health conditions, but also as an indicator of the social, economic, and environmental condition in which children live. The third indicator is the proportion of 1-year-old children immunised against measles which provides a measure of the coverage and the quality of the child health care system. In essence, immunisation is the crucial component for reducing child mortality.

Immunisation

Immunisation activities are part of the MCH services. Recognising that despite a very strong MCH programme, immunisation coverage had not achieved satisfactory levels. In 1989, an in-depth review and development of a three year plan was conducted to achieve “Universal Child Immunisation” with the support from United Nations Children’s Fund (UNICEF) and a consultant from WHO. The strategies for the plan include:

- setting realistic immunisation targets for each districts and health facility;

- mapping of operational areas for better provision of services and supervision, so that every square metre within a district is allocated to a health facility, and there are no ‘no man’s land’;
- inter agency approaches for community mobilisation such as estate management, Orang Asli Department, labour offices, private doctors and non-governmental organisation (NGO);
- extension of immunisation services to the outpatient department in hospitals and paediatric wards; and
- health education and promotion – production of immunisation manual with improvements made in the chapters on cold chain, contraindications and techniques in immunisation and media campaign.

With the implementation of the various strategies for Universal Child Immunisation there has been tremendous improvement in the coverage of all immunisation programmes.

Along with this, there was a decline in the reported incidence of some of the childhood immunisable diseases. In 2006, there were no poliomyelitis cases reported. Thus, Malaysia remains polio free since 2000. The incidence of whooping cough, neonatal tetanus and diphtheria were maintained at less than 1 per 100,000 population. Since the introduction of measles immunisation in 1982, the number of measles cases have declined among children below 2 years of age. The incidence rate of measles had decreased from 29.15 per 100,000 population in 1986 to 2.27 in 2006. A similar trend was observed in Hepatitis B, where the incidence rate has decreased from 12.8 per 100,000 population to 4.68 in 2006. (**The**

Percentage of Immunisation Coverage as shown in Appendix 5 – Table 1.3.5).

Maternal and child nutrition

Strategies for the improvement of maternal and child nutrition begin with plans for adequate nutrients for children from infancy to adolescence, during pregnancy and puerperium. Nutritional management of pregnant women includes nutritional assessment, monitoring as well as provision of supplements such as full cream milk and hematinics.

In improving the nutritional status of infants, specific strategies such as the Code of Ethics for infant formula (implemented in June 1979), all health and hospital personnel are actively promoting breast feeding to mothers. Activities under the Code of ethics for Infant Formula Products were, (i) vetting of informational and educational materials on infant formula products; and (ii) monitoring of code violations. Baby Friendly Hospital Initiative was one of the most ingenious measures to support breastfeeding practices through participation and commitment from both the government and private hospitals. MOH continuously provide intensive health education programmes, conducting lactation management courses for health workers and counsellors. Malaysia is the first country in Western Pacific Region and third in the world to have achieved 100% Baby-friendly Hospitals at Government facilities. **(The details on Conditions Related to Child Health and Welfare as shown in Appendix 6 – Table 1.3.6)**

Newborn screening

Newborn screening for Glucose-6-phosphate dehydrogenase deficiency (G6PD) was started in 1981. Initially it was implemented in general

hospitals and selected district hospitals but currently has been extended to health clinics. In 2006, a total of 301,025 newborns were screened for G6PD and 2 % were detected to be G6PD deficient. Neonates with G6PD deficient are at risk of severe hyperbilirubinemia (neonatal jaundice) with subsequent complications of kernicterus, and that exposure of G6PD deficient individuals to oxidative stress may result in hemolytic anemia.

Screening for congenital hypothyroidism was initiated in 1998. By 2006, about 70 hospitals conducted the screening programme and about 307 cases of congenital hypothyroidism were detected and early treatment instituted to prevent mental retardation and improved quality of life of the affected child.

1.4 **Overview of the Social Welfare**

The Department of Social Welfare was established in the year 1946 and the Department had undergone several structural changes since then. On 27 March 2004, the Department was put under the purview of the Ministry of Women, Family and Community Development, Malaysia. On 1 April 2005, the Department has restructured its organisation as well as its roles and functions according to its various target groups.

For instance, the welfare services for mothers is incorporated in few of its divisions namely the Older Persons and Family Division; and the Socio Economy and Assistance Division. With regards to the Division of Older Persons and Family, it manages cases of Domestic Violence which is stipulated under the Domestic Violence Act 1994. Women as being mothers are the vulnerables and reported cases of domestic

violence shows that women are the highest victims of domestic violence. The division being guided by the Domestic Violence Act 1994 provides various services including protection to the victims of domestic violence.

Whereas, the Socio Economy and Assistance Division provides financial assistance to enhance the quality of life of families in need especially single mothers. As for unmarried mothers who are below 18 years of age, the division is guided by the Child Act 2001 (Act 611) in providing assistance and protection.

Besides the Department of Social Welfare, the government has assigned many other government agencies to provide aids and assistance to women especially mothers namely the Department of Women's Development under the Ministry of Women, Family and Community Development, the Department of Health under the Ministry of Health, hospitals, religious departments, and related NGOs.

As for the Department of Social Welfare, one of the most important target group under the purview of the Department is the family, hence this will be inclusive of the mothers. Therefore as we discuss about the child in one way or another it will be related to the mother. Which means, helping the child will also help the mother and vice versa.

Child Abuse and Neglect

Under the Penal Code [Act 574], provisions which cover offences affecting the human body apply equally to adults and children as victims of such acts. In addition the provision of the Domestic Violence Act 1994 [Act 521] is also aimed at protecting a child against any form of abuse committed within the household.

The Child Act 2001 [Act 611] provides extra protection for children, in which it stipulates for offences regarding ill-treatment, neglect, abandonment or exposure of children to moral danger, children used as prostitutes and beggars, children left without reasonable supervision, and unlawful transfer of possession, custody or control of children.

Under the Act 611, the Court for Children is also empowered to order the child in need of care, protection and rehabilitation to be placed in a place of safety, place of refuge, custody and control of a foster parent or in the care of a person who is willing and whom the Court for Children considers to be fit and proper to undertake the care of such child. The provisions under Part V Chapter 2 and Part VI Chapter 1 provide for the identification, reporting, referral, investigation, treatment and follow-up of the child who is in need of care, protection and rehabilitation. Before issuing the order, the Court for Children is obliged to place paramount consideration to the best interests of the child. An opportunity will also be given to the parents or guardian to be heard before the order is made. 1,800 child abuse cases in 2005 and 2,279 cases in 2007 were reported to the Department of Social Welfare which include neglect, physical, sexual and emotional abuse. **(The statistics of abuse cases as shown in Appendix 7 – Table 1.4.1)**.

The Department of Social Welfare has developed seven Training Modules on Handling Child Abuse Cases through the funding of UNICEF. These modules guide Social Welfare Officers, members of the Child Protection Teams, Health Department, police and the prison personnel in handling child abuse cases professionally.

2. LEGISLATION & INSTITUTIONAL FRAMEWORK FOR MATERNAL AND CHILD HEALTH AND WELFARE

The health sector is guided in its planning process by the long term and short term government policies with relevance to the health context.

2.1 The National Development Policy

The National Development Policy stresses the need for balanced development and emphasises growth with equity which enables all Malaysians to participate in the mainstream of economic activities thereby ensuring political stability and national unity. There is reference made to equity, inequalities, human resource development, science and technology development and protection of the environment.

2.2 Vision 2020

Malaysia is to be fully developed country in our own mould. The nine strategic challenges of Vision 2020 that need to be addressed are:

- Strengthening national unity;
- Attitude formation;
- Fostering a mature democracy;
- Spiritual enhancement;
- Creation of a tolerant and liberal atmosphere;
- Developing a scientific and progressive society;
- Infusing a caring society;
- Proceeding towards a more equitable society; and
- Achieving prosperity.

2.3 Guidelines on Preparation of Five Year Plans e.g. 9TH Malaysia Plan (2006-2010)

The guidelines from the Economic Planning Unit based on the Circular 4/49 "Penyediaan Rancangan Malaysia Kesembilan 2006-2010" (Preparation Guidelines for the 9th Malaysia Plan) authorised by the National Development Planning Committee for the National Seventh Malaysia Plan are relevant. These highlighted:

- The Malaysia Incorporated policy
  The co-operation between the government and the public sector for the mutual benefit of both and ultimately the country;
- The government shall continue to uplift the quality of life of the people while at the same time maintaining the principles of equity and access; and
- Emphasis is to be given towards poverty reduction and assistance to the poor to enable them lead a productive and quality life.

2.4 The National Policy on Women

The National Policy on Women [NPW] was formally adopted by the Malaysian Government at the end of year 1989. The NPW provides the necessary framework for the various arms of government to address women's concerns within their sectoral areas of responsibility and highlights various areas for immediate action.

The Primary objectives of the policy are:

- To ensure equality in obtaining resources, information, opportunities in participation and development for both men and women. Objectives in equality and equity must be based on development policies that are people-oriented so that women could contribute and achieve their highest potential.

- To integrate women in all sectors of national development in line with the ability and needs of women to improve the quality of life, eradicate poverty, abolish ignorance, illiteracy and to achieve a peaceful, prosperous and happy nation.

  The national machinery to spearhead the development process comprises of government and non-government agencies at various levels. They are:

  - The National Advisory Council for the Integration of Women in Development [NACIWID];
  - The Women's Affairs Division of the Ministry of National Unity and Social Development, popularly known as HAWA;
  - The Committee of Liaison Officers [Los};
  - The Consultative Committees on Women in Development at the State and District levels; and
  - Federal and state level departments.

These government agencies work closely with non-governmental agencies directly and through the National Council of Women's Organisations [NCWO]. Many government agencies have programmes focused on women as their target groups. Most programmes emphasise women and the family while some promote income-generating activities. For example, the programmes by the National Population and Family Development Board promote family development, while the Ministry of Health focuses on the well-being of women and children. Income generating programmes are organised by the Ministry of Rural Development, the Ministry of Agriculture and the Ministry of Land and Regional Development.

2.5 Ministry of Health Policies

The MOH policies have been formulated in relation to the situational analysis and health problems identified from the changing patterns of diseases associated with changes in the environment, population characteristics and medical progress.

Family Health Programme

The Family Health Development Division has a role in moulding the national policy for the health care and development of individuals in the family unit, covering from the new-born to the geriatric age group (womb to tomb approach)

2.6 Laws & Regulations

i. Midwifery Act 1966 (revised 1990);
ii. Family Planning Act 1966 (revised 1984);
iii. Married Women And Children Maintainance Laws;

- Married Women And Children (Maintainance) Act 1950 (Act 263);
- Married Women Act 1957 (Act 450);
- Married Women And Children (Enforcement Of Maintainance) Act 1968 (Act 356);
- Legitimacy Act 1961 (Act 60);

iv. Islamic Family Law (Federal Territories) Act 1984 (Act 303);

v. Domestic Violence Act 1994 (Act 521);

vi. Prevention and Control of Infectious Disease Act 1988 ;

vii. Employment Act 1955 (Act 265) and Regulations;

viii. Child Act 2001 (Act 611);

ix. Care Centres Act 1993 (Act 506);

x. Child Care Centre Act 1984 (Act 308);

xi. Adoption Act 1952 (Act 257);

xii. Registration of Adoption Act (Act 253);

xiii. Guardianship of Infants Act 1961 (Amendment 1999); and

xiv. Evidence of Child Witness Act 2007 (Act 676).

3. RELATED PROGRAMMES (GOOD PRACTICES)

The introduction of health information system, Quality Assurance Programme, perinatal surveillance, and action plan for HIV/AIDS, Malaysia is well placed for further reduction of maternal and child morbidity and mortality.

3.1 **MCH Quality Assurance Programme**

Malaysia gives special attention to the issue of quality in health and since the early 1990's, continuous quality improvement or CQI became a high-priority programme in the Ministry of Health. Quality Assurance Programme is the major activities among the CQI initiatives, and it began to be introduced into maternal and child health care in 1991. Indicators selected to measure the quality of maternal care are incidence rate of Eclampsia and Puerperal Sepsis and for child health are Neonatal Tetanus, Severe Neonatal jaundice and immunisation coverage. The basic concept is to analyse why an achievable benefit was not achieved, and the intention is to identify causes and institute remedial measures, using a formal and standardised methodology.

3.2 **Home-based maternal and child health record**

The home-based maternal and child health record has been introduced by WHO to Malaysia since 1996. An effort has been made to provide a concise record which can be retained by the women herself and her newborn. All information about her pregnancies, the births of her children and her health between pregnancies is recorded. For every newborn, they will be provided with a home-based child health record. A pre-eminent consideration in its design is that it should be useful to the individual to whom it refers, rather than exclusively to health professionals. It was also seen as essential that the record should be adaptable for use in societies with widely differing health needs, treatment facilities and levels of literacy. By 1st July 1997 this card has been implemented nation-wide.

3.3 **Preventing mother-to child transmission of HIV/AIDS**

AIDS was unknown in Malaysia until the first case of AIDS was detected in December 1986. By 2006, the reported cumulative number of HIV cases was 76,389. Of these, 12,506 (16.4%) cases were AIDS and a total of 9155 death was reported within the same period. About 80 per cent of reported HIV/AIDS cases occur among those aged 20-39, the younger and potentially more productive segment of the nation's population.

HIV screening program among antenatal mothers called Prevention of Mother -To-Child-Transmission (MTCT) was implemented in 1998. HIV testing was available to all pregnant women attending government facilities for early diagnosis and intervention with AZT when indicated.

In 2006, the coverage of HIV screening among antenatal mother attending government clinics was 99.5% (384,027) with 0.04% detected HIV positive. Among the HIV positive mothers, 7 babies (3.7%) were diagnosed HIV positive. All HIV positive antenatal mothers and their newborn were provided with free AZT treatment and formula milk. The objective for the program is to reduce the risk of HIV transmission from infected mother and their new-born.

In response to the United Nations General Assembly Special session on HIV/AIDS (UNGASS), Ministry of Health has formulated the HIV/AIDS National Strategy Plan (NSP) 2006-2010 which consist of 6 main strategies. The objective of the NSP are to achieve the principles of UNGASS and the MDGs targets and also to complement approaches outlined in the national drug strategy as follows:

- To reduce the number of young people aged 15 – 24 who are HIV-infected
- To reduce the number of adults aged 25-49 who are HIV-infected
- To reduce the number of HIV infections in injecting drug users
- To reduce the number of HIV-infected infants born to HIV-infected mothers annually
- To reduce marginalised population (sex workers, transsexual and men who have sex with men) who are HIV-infected
- To increase the survival and quality of life among people living with HIV/AIDS

3.4 **Confidential Enquiry into Maternal Deaths (CEMD)**

The Confidential Enquiry into Maternal Deaths is another strategy in improving maternal health. It was conseptualised in 1987, based on the England and Wales system, and was introduced in 1991. This review/audit process identifies avoidable and unavoidable factors that contributed to each and every reported maternal death, using the “road to death” model. Some of the principles in CEMD are (i) confidentiality is essential, the case/death, personnel involved in the management and the place the event occurred are not known to the “auditors”, (b) comprehensive, (c) allows cross reference among all parties involved, (d) close rapport between various levels of care and between the providers (public and private) of care (e) it is not a fault-finding exercise, with no punitive intention, and the main aim is to identify the final cause of death and remediable and non-remediable factors that contributed to

the maternal death. Remedial actions at each level are suggested. Recommendations made are circulated to those involved in providing obstetric care for implementation in an effort to further reduce maternal mortality.

3.5 **Community Based Rehabilitation Centres**

Community Based Rehabilitation (CBR) centres were established throughout the country by the Department of Social Welfare. A CBR centre is a one-stop centre for persons with disabilities (PWD), including children. This centre provides services such as diagnosis, rehabilitation, treatment and special education. It also provides vocational training to prepare the PWDs for employment. The CBR centres are run by members of the community, volunteers and representatives from the relevant government agencies, namely the Ministry of Health, Ministry of Education and the Ministry of Human Resources. Presently, there are 382 CBR centres with 12,212 PWDs, including children throughout the country. The Ministry of Women, Family and Community Development plans to open at least 10 new CBR centres every year. **(The statistics of CBR as shown in Appendix 8 – Table 3.5.1)**.

The Ministry provides yearly monetary grants to the CBR centres for their operational expenses, programmes and activities. PWDs who participate under the CBR receive a monthly allowance of RM 25.00 per month and free meals from the Ministry. This allowance will be increased to RM50.00 per month beginning from January 2007. In early 2008, the allocations for CBR centres has been increased by the Government. Among the increment are RM3,000 per month allocated for rental, RM1,000 per month allocated for utilities, RM50,000 (one-off) allocated for tools and equipment and RM30,000 per year for programmes &

activities. In addition, the monthly allowance for CBR volunteer also been increased by the Government which are RM800 per month for volunteer, RM1,200 per month for supervisor and RM150 per month for PWDs who joins CBR. These allocations are made for the improvement on the operational of the centre and to support and encourage more PWDs as well as volunteers to join the centre.

The CBR centres organise several activities for the benefit of the disabled children. Among them are:

(a) **Therapy**

There are three kinds of therapies offered, namely physiology therapy, occupational therapy and speech therapy. This training is done under close supervision of selected specialists. Physiology therapy focuses on the rehabilitation of the human body which involves activities concerning basic motion skills such as crawling, walking, running, jumping and kicking. The occupational therapy teaches the PWDs on various occupational skills to help them with their jobs. Lastly, the speech therapy focuses on verbal communications skills, designed with advanced techniques to help PWDs with speech impediments to learn to speak better.

(b) **Language and Social Development**

The PWDs are taught to express themselves verbally, through writing and inscriptions. This allows them to communicate properly and for others to understand them better. Under this activity, PWDs are also taught interaction skills, such as sign language and other methods.

(c) **Basic Daily Life Skills**

This activity provides basic activities on how a person takes care of oneself. It includes food and water intakes, bathing, toilet training, grooming, wheel chair handling as well as getting in and out of bed and vehicles.

(d) **Reading, Writing and Arithmetic (3R)**

The PWDs, especially the children are taught basic skills in reading, writing and arithmetic. In addition, they are trained to handle writing tools and materials.

(e) **Recreational Therapy**

In this activity, PWDs are encouraged to explore their talents through games, making handicrafts and playing musical instruments. Often, outdoor excursions to various places are made to further enhance their self esteem and sense of accomplishment.

(f) **Independent Living Training**

This is a treatment that focuses on helping PWDs to achieve independence in all aspects of their lives. It can provide children with various needs with positive as well as fun activities to improve their cognitive, physical and motor skills. Several ‘hostels’ are set up where four to five PWDs could learn to live together on their own under the supervision of a coordinator.

The CBR training thus benefits the PWDs, their families and the community. Adequate training and suitable rehabilitation services are provided to cater for the different needs and types of disabilities. This will

allow the PWDs to be integrated into the society and not left discriminated. It will also instil the value of independence and positive attitude among PWDs. The National Council for Community Based Rehabilitation (NCCBR) was established by the Government to assist in the rehabilitation programmes. In essence, CBR has raised the awareness level among family members on the importance of early prevention as well as to participate actively and contribute to the development of the disabled children.

The ratio of carers to children with disabilities in CBR centres was reduced from 1:10 to 1:5 in 2003. This allowed the carers to give more attention to the disabled. A Training Manual was developed in 2003 to train carers, parents, families and the community members on various rehabilitation and vocational modules to improve the quality of care for children with disabilities in the community.

In addition, the Department of Social Welfare has developed a portal known as CBR Net (www.pdknet.com.my) in 2003. Through this portal, CBR programmes and activities are readily available online. Parents can access and obtain relevant information for the benefit of their children.

3.6 One Stop Crisis Centre in the Management of Battered Women, Child Abuse and Rape

In 1993 the Accident and Emergency Department of Hospital Kuala Lumpur conducted a study for four months of 186 cases of battered women. The study revealed that the women's needs went beyond medical treatment. The study was presented at the International Seminar held in Kuala Lumpur, accordingly the A & E Department, Kuala Lumpur Hospital established a One Stop Crisis Centre for battered Women in

1994. At this centre, the women not only get medical treatment but have access to a counsellor and to other agencies if she requests.

The project involved multisectoral agencies comprising of governmental and non-governmental agencies managing cases of domestic violence in a comprehensive manner. Thus making it a Model of Client Focus and Patient Centered Medicine where all the officers from various agencies will go to the centre and the case being seen and managed accordingly.

Agencies involved include department of Obstetric and Gynaecology, Department of Forensic, Department of Psychiatry, Department of Social Medicine, Department of Social Welfare, Police Department and Legal Aid Bureau as well as non-governmental organisations.

Objectives of the centre:

- For confirmation of diagnosis and giving therapeutic management
- Place where counselling and emotional support can be carried out
- a multi-sectoral approach of crisis management
- provision of temporary shelter
- medical report

The aim of this centre is not only to manage the individual case admitted, but also to become a place where information and documentation on the domestic violence can be captured. It is expected that with the implementation of this crisis centre nationwide, we will be able to assess and monitor the severity of this issue i.e. on domestic violence in the country. Therefore an organised plan of action can be undertaken to

prevent the occurrence of domestic violence. OSCC had been expended to all general hospitals nationwide.

Case	2000	Latest
Child abuse[3]	934	1800

3.7 **Welfare Assistance for Children and Family**

In providing welfare assistance as well as medical facilities for children and family, the Department of Social Welfare is working hand in hand with the Ministry of Health especially in providing medical treatment for all children. The medical services provided in all government hospitals and clinics are free of charge.

On the other hand, In term of financial aids for children, Department of Social Welfare had provided School Financial Aids which is to prevent school dropout among the orphan, poor and also disabled children. As we know, these aids are also to help those parents with low income, suffering from an illness which hindered them from earning income, disabled or imprisoned. As a guideline, the family with average household income of not more than RM500 per month is eligible for these aids. However, those with higher household income could be considered depending on their situation.

The package of School Financial Aids include school fees, examination fees, school workbook and textbook, transportation fees and school uniform. This aid is given annually in lump sum to the respective head of family. As for the school uniform it is divided into 2 types, which are:-

i. RM180 per year for Primary School pupil
ii. RM220 per year for Secondary School pupil

However, Department of Social Welfare is not only providing aids to children, it is also given to all citizens who qualified and need attention from the department. This included the disabled citizens, the poor, senior citizens and of course for the children welfare as well.

Department of Social Welfare also gives special financial aids to the disabled children whose family is having difficulties in providing them with the special care needed by the disabled children such as special kind of milk, diaper and various kinds of supporting apparatus to enhance the children's quality of life. To ensure the poor family and single mother can continue to raise their disabled children in the family, the department provided the disabled children with financial aids of RM100 per person and in maximum of RM450 per family if there are more the 4 disabled children in one family.

Following which, Department of Social Welfare will register them. Being registered, the disabled child is entitled to get free health and medical care for life. Department of Social Welfare will provide the disabled child with the necessary help apparatus as recommended by the specialist doctor and they will be treated by doctors regarding their health and medical predicament. They will then be categorized by the specialist into certain category of disability.

For the disabled children of school going age, they will be channeled by the Department of Social Welfare to the Division of Special Education under the Ministry of Education for their schooling purpose.

Besides that, with effect from 1 January 2006, the financial assistance by the Department of Social Welfare for needy children was increased from a minimum rate of RM80.00 to RM 100.00 per month per children, and the maximum was increased from RM380.00 to RM 450.00 per month per family. This monetary assistance is aimed to ease the burden of poor families in bringing up their children.

The Department of Social Welfare also provides financial assistance known as School Financial Aids for the purchase of school uniforms, transportation, examination fees and spectacles for needy school going children. This reduces the burden of poor families that have school going children. The Department of Social Welfare has introduced fostering allowances to encourage the participation of the public in caring for the orphan. The foster family is given RM250.00 for each child. 104 children was fostered out in 2004 and 121 children in 2005, with RM236, 894 and RM347,450 spent for the fostering programmes for these corresponding years. **(The details of this financial assistance given is as shown in Appendix 9 – 3.7.1).**

On the whole, the reason the government is emphasising on the family to raise their own children is to adhere to the philosophy that the best place for a child is in the family and institutional care is the last resort.

3.8 Nutrition Rehabilitation Programme for Malnourished Children

The government's pro-poor policies in the 1980s contributed to further reducing infant and child mortality equity gaps. The nutrition rehabilitation programme for malnourished children was developed based on the findings of the National Nutrition Surveillance system 1982-1986. The rehabilitation programme was implemented in 1988 to

improve the overall nutrition status of young children. A monthly food basket containing food supplements distributed to malnourished children monthly. These children were selected based on weight and family income. In 2006, a total of 8,623 children received food basket, and currently, the criteria on income of family had been reviewed and in 2008, a total of RM10.3 million had been allocated for purchasing of food basket, training activities including cooking demonstration to mothers with underweight or malnourished children.

3.9 **Child Protection Teams**

One of the provisions of the Child Act 2001 (Act 611) is the establishment of Child Protection Teams to co-ordinate support services at the community level for children in need of care and protection and family crisis. According to Act 611, the Child Protector functions as the Chairman while other members of the team include a medical officer, a police officer and community members interested in child welfare. The Child Protection Teams are encouraged to carry out preventive and rehabilitative programmes such as the establishment of Child Activity Centres and Crisis Intervention Centres for children and families in high risk areas. Other activities include educating the local community in advocating a safe environment for the young child. As of 2008, 131 Child Protection Team have been established throughout Malaysia. These Child Protection Teams have been given training and exposure through conventions, seminars and courses on issues pertaining to child welfare with special focus on working with abused children, affected families and the perpetrators.

3.10 **Coordinating Council for the Protection of Children**

A Coordinating Council for the Protection of Children was established under Child Act 2001 [Act 611]. The Council is responsible for advising the Minister of Women, Family and Community Development on all aspects of child protection as well as coordinating the resources of various Government departments involved in child protection. It also renders advice on the management and operations of the Child Protection Teams throughout the country. This Council is chaired by the Director General of the Department of Social Welfare and represented by the relevant Government departments, child experts as well as the NGOs.

4. **CHALLENGES**

The experiences of Malaysia in the maternal and child care are very encouraging, however there are hurdles to cross and these may be quite specific to Malaysia. Some of the challenges are:

The "Law of diminishing returns", the need to focus on morbidity

This is a real challenge, it is not only has effect on motivation level, it also implies a lot more resources are needed, especially facilities for emergency obstetric care, communication and transportation, and more higher level special services at secondary and tertiary level of health care. Mortality is becoming a rare event, while morbidity is a commoner event, and it occurrence and measurement is more easily appreciated. Some of the morbid conditions associated with pregnancy and childbirth have long lasting and even lifelong consequences, compromising the health and quality of life of women, their partners and families.

Gaps in knowledge, uncertainties in maternal and child health care

New understanding is needed for many risks and causal factors to maternal and child death. These are not only from the biological perspective, but also the social and economic perspective.

Towards an integrated health care

Integration of the maternal and child health care and welfare is a challenge currently and in the future whereby the integration can be looked as

(i) Vertical integration within the same system, such as the referral system between primary to secondary to tertiary levels of care within the Ministry of Health system.

(ii) The horizontal integration with other related agencies, although efforts are being made to alleviate this such as the OSCC, CEMD, nutrition rehabilitation program for the malnourished children and community based rehabilitave centres.

(iii) Malaysia is also moving towards “integrative medicine” in which optimal use is to be made of traditional and complementary medicine, the experience with TBA’s is only a small component in the wide range of T/CM being practiced in Malaysia, and many uncertainties exist.

5. Conclusion

Malaysia is one developing country in the South East Asia that has achieved some degree of success in reducing maternal and child mortality. This success occurred through very serious efforts beginning with a strong political will and commitment. Socio-economic development and availability of resources make reduction of maternal

and child mortality easier. The country has several constraints, and there are newer challenges that if not managed well, may have compromised the past achievements. Towards achieving healthy next generation and the Millennium Development Goals, strengthening collaboration between health care and social welfare services for mothers and children is essential for child survival and development.

APPENDIX 1

Table 1.1: General Information

	2000	2004	2007
Per capita Gross National Income at current prices	RM13,418	RM16,616	RM23,115
Poverty rate (%)	(1999)		
Total	8.5	5.7	3.6
Urban	3.3	2.5	2.0
Rural	14.8	11.9	7.1
Adult Literacy rate:			
age 10 and above	93.8	95.1	NA
age 15 and above	88.7	91.5	92.3
Primary school enrolment ratio			
Male	1,507,988	1,603,500	1,628,388
Female	1,425,889	1,517,386	1,539,387
Total	2,933,877	3,120,886	3,167,775
% Female (over total)	48.6	48.6	48.6
Net primary school attendance (by sex)	NA	NA	NA
Access to safe water	92.0	94.0	95.4
Urban areas	97.0	97.0	97.9
Rural areas	85.0	87.0	92.6

Source: *Department of Statistics Malaysia*

Table 1.2: Vital Statistics in Malaysia 2000– 2007

	2000	2001	2002	2003	2004	2005	2006	2007
Total population (million)	23.3	23.8	24.5	25.1	25.6	26.1	25.6	27.2
Under 15 years(%)	33.3	33.3	33.5	33.2	32.9	32.6	32.4	32.2
15-64 years (%)	62.8	62.8	62.5	62.7	62.9	63.1	63.3	63.4
65 years and above (%)	3.9	3.9	4.0	4.1	4.2	4.3	4.3	4.4
Urban population (%)	62.0	59.6	62.4	62.6	62.8	63.0	63.2	63.4
Rural population (%)	38.0	40.4	37.6	37.4	37.2	37.0	36.8	36.6
Annual Population Growth Rate (%)	2.5	2.2	2.1	2.1	2.1	2.1	1.9	2.0
Sex ratio (per 100 female)								
All ages	104	104	104	104	103	103	103	104
0-14	106	106	106	106	106	106	106	106
15-64	104	104	104	103	103	103	103	104
65+	88	88	88	88	88	88	89	87
Total Fertility Rate (per female aged 15-49 years)	2.9	2.8	2.6	2.5	2.4	2.3	2.4	NA
Crude Birth Rate (per 1000 population)	22.6	22.2	21.7	20.6	19.1	18.4	18.0	17.5
Crude Death Rate (per 1000 population)	4.4	4.4	4.6	4.7	4.5	4.5	4.5	4.5
Life expectancy at birth (Age in Years)								
Male	70.2	70.3	70.4	70.3	71.1	71.5	71.8	71.9
Female	75.0	75.2	75.3	75.9	75.9	76.2	76.3	76.4
Infant Mortality Rate (per 1000 LB)	7.9	5.7	6.5	6.6	6.5	6.7	6.6	6.3
Under 5 Mortality Rate (per 1000 LB)	8.6	8.6	8.8	8.7	8.5	8.6	8.5	NA
Maternal Mortality Rate (per 100,000 LB)	30	30	30	30	30	30	30	30

Source: Department of Statistics Malaysia

APPENDIX 2

Table 1.3.1: Leading Causes Of Maternal Deaths, 2000 & 2005

Causes	2000		2005	
	n	%	n	%
1. Obstetric Pulmonary Embolism	23	15.8	25	20
2. Hypertensive Disorders in Pregnancy	13	8.9	20	16
3. Associated Medical complications	22	15.1	17	13.6
4. Post Partum Haemorrhage	31	21.2	17	13.6
5. Obstetric Trauma	12	8.2	11	8.8
6. Abortion	2	1.4	9	7.2
7. Puerperal sepsis	6	4.1	5	4
8. Ante Partum Haemorrhage	5	3.4	4	3.2

Source: Division of Family Health Development, MOH
CEMD, MOH 2000 & 2005

***n – numbers of maternal deaths**

APPENDIX 3

Table 1.3.2: Pregnancy and Delivery 2000 and 2006

Year	2000	2004	2006
Mean age at first marriage			
Male	28.6	28.9	
Female	25.1	25.3	
Skilled birth attendant	96.8%		98.3%
Place of Delivery			
Government hospitals	73.5%		80.6%
Private hospitals/ maternity homes	18.2%		14.5%

Source: IDS, Ministry of Health Malaysia

Source: 2000 – Population Census, Dept. Of Statistics Malaysia, 2004- NPFDB Malaysia, Malaysian Population and Family Survey

APPENDIX 4

Table 1.3.3: Leading Causes of Infant Deaths 2006

Causes	2006
3 certain condition originating in the perinatal period Disorders related to pregnancy Respiratory, intrauterine hypoxia and birth asphyxia Infection specific to the perinatal period	56.0%
2. Congenital malformations, deformations and chromosomal abnormalities Chromosomal abnormalities Anenchephaly and similar malformation Other congenital malformation	20.5%
3. Infectious and parasitic diseases Septicaemia – 248 deaths diarrhoea and gastroenteritis – 10 deaths tetanus – 7 deaths HIV – 3 deaths	9.4%
4. Diseases of the respiratory system Pneumonia other lung infections	4.3%
5. Diseases of the nervous system Bacterial meningitis Encephalitis, myelitis	3.0%

Source: IDS, MOH Malaysia

Table 1.3.4: Leading Causes of Under-Five Deaths 2006

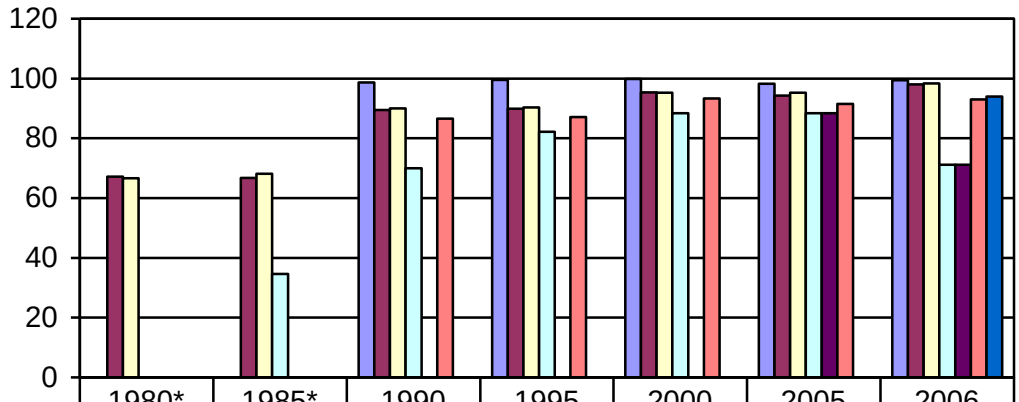
Causes	2006
Congenital malformations, deformations and chromosomal abnormalities Congenital heart disease (39.7%) Syndromes (24.6%) Gastrointestinal system malformations (12.0%) Central nervous system malformations (10.6%)	25.1%

Causes	2006
Infectious and parasitic diseases Acute diarrhoel diseases (25.9%) HIV – 19 deaths Dengue infection – 7 Tuberculosis – 5 Measles -3 Malaria – 2 Tetanus (Sabah) – 4 Hand foot and mouth disease (Sarawak) – 12	18.8%
Diseases of the respiratory system Pneumonia (70.8%) Asthma – 4 cases	13.0%
Diseases of the nervous system	8.2%
Injuries, poisoning and external causes Drowning (25.0%) Motor vehicle accident (21.1%) Burns (11.7%) Poisoning (8.6%)	7.5%

Source: IDS, MOH Malaysia

APPENDIX 5

Table 1.3.5: Percentage of Immunisation Coverage, 1980 – 2006



	1980*	1985*	1990	1995	2000	2005	2006
BCG	NAD	NAD	98.7	99.5	99.9	98.3	99.4
Polio (3rd dose)	67.2	66.7	89.5	89.9	95.4	94.3	98
DPT (3rd dose)	66.6	68.1	90	90.3	95.3	95.3	98.4
Measles		34.6	70	82.2	88.4	88.4	71.1
MMR						88.4	71.1
Hep B (3rd dose)			86.6	87.1	93.3	91.5	93

note: * - Peninsular Malaysia

Source: Ministry of Health Malaysia

APPENDIX 6

TABLE 1.3.6.: Conditions Related to Child Health and Welfare

	2000	2006
Malnutrition[1]		
Severe	1%	0.6%
moderate	13.0%	7.1%
Underweight births (live birth < 2.5 kg)[2]	9%	10.1%
Child abuse[3]	934	1,999

Source: 1 – Ministry of Health Malaysia, Annual report
2- Department of Statistics, Malaysia
3 – Department of Social Welfare, Malaysia

APPENDIX 7

Table 1.4.1: Number of Abuse Cases in 2005 to 2008

Year	**2005**	**2006**	**2007**	**2008 (until Mei)**
Total	1,800	1,999	2,279	1,017

APPENDIX 8

Table 3.5.1: Community Based Rehabilitation (CBR) Centres, 2000 to 2007

Year	No. of CBR Centres	No. of PWDs
2000	229	7,210
2001	243	7,400
2002	259	7,620
2003	274	7,870
2004	293	8,193
2005	313	8,453
2006	364	9,500
2007	382	12,212

Source: Department of Social Welfare

*** PWDs – People With Disabilities**

APPENDIX 9

3.7.1 Table: Types of Aids for Children and Family

TYPES OF AIDS	RATE	PURPOSE OF THE AIDS GIVEN	REQUIREMENTS TO OBTAIN AIDS
Children Financial Aids	RM100 a month per person Maximum RM450 a month for family with more than 4 children	To ensure poor families and single mothers continue to raise their children in their own family structure.	i. Families with children who needs financial aids to raise them; ii. Families having children below 18 years old; iii. Children in the schooling age, who need to continue their studies; iv. Orphans; and v. Families/guardians with children who are unable to work because of sickness, disabilities or suffering with illnesses.
Fostering Financial Aids	RM250 a month per child. Maximum of RM500 per month for a family with two or more children.	Helping those children who are unfortunate and orphans who do not have any relative to stay in the community with the foster family.	i. Children below 18 years old; ii. Orphans; iii. Children who live with a foster family; iv. Children who are not adopted

TYPES OF AIDS	RATE	PURPOSE OF THE AIDS GIVEN	REQUIREMENTS TO OBTAIN AIDS
		To help the foster family who are willing accept and care for these children.	through the Adoption Act 1952 (Act 257) Adoption or Registration of Act (Act 253);and v. Children taken under the Fostering Programme by Department of Social Welfare.
Launching Grant	RM2,700 one off	To help client of Department of Social Welfare who have the interest and potential to empower them to start a small entrepreneurship, agricultural activities or a business. To enable the clients to be more productive and move towards independent living.	i. Client who received monthly aid from Department of Social Welfare such as single mothers or their children who are able to manage a project; ii. People with disabilities and iii. Ex-trainees from Welfare Institutions
General Financial Aids	RM80 a month per person or RM350 a month per family (maximum). Aids for House Repairing maximum RM2500 once	Provide daily expenditure to people in need. This include people in poverty, disabled people, families with problems, old	Families with household income below RM400 a month.

TYPES OF AIDS	RATE	PURPOSE OF THE AIDS GIVEN	REQUIREMENTS TO OBTAIN AIDS
		aged people, etc. Provide Emergency Aids to those in need.	
School Financial Aids	Actual Rate : • School fee; • Examination fee; • School workbook/ text book; • Transportation fee; • School uniform RM180 per person a year (Primary School); or • RM220 per person a year (Secondary School).	To prevent school dropout among the orphans, poor and disabled children. To help the parents with low income.	i. Poor children, orphans, disabled children. ii. Children whose parents with low income, suffering from illnesses, disable or imprisoned. iii. Families with income not more than RM500 a month.

APPENDIX 10

THE DISTRIBUTION OF HEALTH FACILITIES IN MALAYSIA, 1998

STATE	D.H.O	R.H.O	Health Office			H. C	C.H.C	MCH	MC
			Distr	Port	A. P				
Perlis	0	0	1	0	0	9	29	1	0
Kedah	0	0	11	0	0	54	224	9	10
P.Pinang	0	0	5	1	1	27	61	7	0
Perak	0	0	9	0	0	83	254	7	20
Selangor	0	0	9	1	1	58	136	12	4
W. P	0	0	0	0	0	14	0	0	0
N. Sembilan	0	0	5	0	0	39	105	5	4
Melaka	0	0	3	0	0	27	63	1	1
Johor	0	0	8	0	0	87	271	7	5
Pahang	0	0	11	0	0	65	228	8	23
Terengganu	0	0	7	0	0	41	132	2	1
Kelantan	0	0	10	0	0	59	202	3	9
Peninsular Malaysia	**0**	**0**	**79**	**2**	**2**	**563**	**1705**	**62**	**77**
Sabah	0	10	11	0	0	90	190	19	8
Sarawak	9	0	15	0	0	119	97	26	123
MALAYSIA	**9**	**10**	**105**	**2**	**2**	**772**	**1992**	**107**	**208**

Note:

D.H.O : Division Health Office
R.H.O : Regional Health Office
Distr : District
A. Port : Airport
H.C : Health Clinic
C.H.C : Community Health Clinic
M.C.H : Maternal and Child Health Clinic
M.C : Mobile Clinic

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