

Universal health coverage for sexual and reproductive health in Malaysia

Evidence brief

Evidence and policy implications



Key messages

- ▶ Malaysia has made considerable progress towards universal health coverage (UHC). An extensive public health care system provides near-free health care, including a range of essential sexual and reproductive health (SRH) services.
- ▶ There are, however, gaps in prioritization, resource allocation and access for different SRH services. This brief highlights evidence regarding pregnancy and delivery, gender-based violence (GBV), and safe abortion/post-abortion care.
- ▶ In Malaysia, pregnancy and delivery services are considered essential and high-priority. Maternal health care is sufficiently integrated into the country's UHC due to need, strong political prioritization and accountability, and a well-funded health system.
- ▶ If GBV is to be made a higher public health priority, services for the prevention and treatment of GBV require greater involvement from civil society, as well a multisectoral approach, to advocate policy change.
- ▶ Meanwhile, prioritization of, and access to safe abortion and post-abortion care is challenged by weak data, poor political will and wider contextual factors.
- ▶ Key policy imperatives include ensuring the full participation of relevant stakeholders in policy-making. This should strengthen the evidence base for services of lower priority, as well as monitoring the provision, population coverage and financial protection of SRH services, especially for people who are marginalized or vulnerable.

Introduction

UHC means that “all people have access to the health services they need, when and where they need them, without financial hardship” (1). This includes universal access to a comprehensive range of SRH services under the mandate of the Sustainable Development Goals.

The Malaysian Government has made several commitments to strengthen the public health care system to achieve UHC (2). Citizens can access health

care through a two-tier system, which comprises a subsidized and tax-funded public system, delivered through federal government, and the private system, which they access predominantly through out-of-pocket expenditures(3). The majority of the population has access to free, or almost free health care services, from preventive care to treatment (4). These investments are evident in the country's improving health indicators, notably the maternal mortality rate, which has fallen substantially (5). However, while

pregnancy and maternal care have been consistently prioritized as essential services and integrated in the public health system, other SRH services have received less attention.

About this evidence brief

There are several studies pertaining to various aspects of SRH in Malaysia (5,6), and UHC independently (7). There is, however, little research on integration of SRH in UHC-related policies and programmes. This brief highlights evidence from a case study of Malaysia that critically examines the national measures that have been taken to progress towards universal access to selected SRH services. The case study focused on three tracer interventions: pregnancy and safe delivery, services for the prevention and treatment of GBV, and safe abortion (and post-abortion care). It was based on a combination of an iterative literature review, policy analysis and primary data from interviews with 20 key informants who represent the relevant stakeholder perspectives, from policy-makers, non-governmental organizations (NGOs) and United Nations agency representatives, to religious leaders. The framework for analysis was adapted from the “Health Policy Triangle” (8,9).

Key findings

Importance of context and values

In Malaysia, issues surrounding sex and sexuality are sensitive, posing constraints and challenges in the integration of SRH services. While it may be relatively easy to justify and integrate pregnancy and delivery care into the public health care system for married couples, extending those services to unmarried couples and adolescents is more challenging.

The Malaysian Government has used various strategies to navigate contentious issues surrounding SRH, given the cultural and religious context. Reframing is one such strategy that has been particularly successful. A good example of this is GBV, which has been reframed as a health issue by SRH organizations and women-led NGOs to leverage greater buy-in from stakeholders (6).

Well-funded and established health systems, and use of existing services

Malaysia has a well-funded, established health system (10,11), in which services are delivered through the federal government and via the private health care system (3). Large investments in the public health

system have been made, including extending and improving the health care infrastructure in rural areas, training and deploying more health care personnel to increase geographical health care coverage, and improving access to and the quality of services overall.

The successful integration and implementation of SRH services in Malaysia is heavily reliant on investments in the health system. Pregnancy and delivery services have been implemented successfully, due to early and sustained prioritization and investment in rural health services since the 1960s (12). This investment is central to the primary health care system, and continues to be ring-fenced in the health budget today.

Although married Malaysian women are able to access most of the free or subsidized SRH services, it should be noted that accessing the full range of SRH services, including maternal care, can be more challenging for:

- unmarried women
- young people
- lesbian, gay, bisexual, transgender and intersex (LGBTI+) people
- migrant workers
- indigenous people.

This is due to sociocultural, religious, legal and financial barriers (13–15). In 2014, it was announced that medical fees for non-Malaysians, including migrant workers, would be increased (16). The announcement stated that, starting in 2017, non-Malaysians would be required to pay the full cost of medical fees at public health care settings. Refugees with an Office of the United Nations High Commissioner for Refugees (UNHCR) card could receive a 50% discount. This fee increase has become a significant barrier for many migrants and refugees to access pregnancy care and safe delivery services (17).

The expanded health system in Malaysia has enabled additional SRH services to be established. For example, one-stop crisis centres (OSCCs) use accident and emergency departments in hospitals as an entry point to accessing GBV services. OSCCs were piloted in 1994, using a multisectoral approach and existing resources within the hospital, and they were implemented with relative ease due to the health system already in place (6).

Civil society and champions

The catalyst for the OSCCs was legislative change and the tabling of the Domestic Violence Act 1994 (under the purview of the Ministry of Women, Family and

Community). Previously perceived as a private matter (18), GBV has been brought into the light through the persistent efforts of a network of women-led NGOs with grassroots experience, advocating services for the people affected. Prominent political champions have also lobbied for GBV to be written into policy, capitalizing on the burgeoning international women's rights movement. Key champions used networks of lawyers, politicians and health workers to advocate change, leading to legal reform. As a result, the Domestic Violence Act was passed under the Penal Law in 1994. This provided an important opportunity for women-led NGOs to work with health experts (6).

Political prioritization and accountability

In a few decades, Malaysia has successfully reduced the country's high maternal mortality rate from 140.8 per 100 000 live births in 1970 to 23.5 in 2018 (19,20). This has been due to a number of interconnecting and enabling factors – including economic development, investment in health infrastructure and human resources – all of which have been driven predominantly by political will.

There is substantial political and performance responsibility for services related to maternal care, with most indicators being actively monitored and data collected through a comprehensive Confidential Enquiry into Maternal Deaths. In comparison, there is limited accountability for GBV services (that is, OSCCs), with little performance data being collected to monitor uptake and quality (6). There are also gaps in access for migrants, refugees and transgender people due to a lack of trust in the police and the immigration department (21).

Data on abortion are difficult to obtain, despite an estimated 4% of all pregnancies ending in abortion in Peninsular Malaysia (22). There is a policy on the termination of pregnancy (23), but it has limited eligibility criteria, and there is a great deal of accountability placed on health care providers by criminal law and the medical licensing bodies.

Across all tracers, there are also significant gaps in access to SRH services for non-citizens (migrants and refugees), young adults, unmarried women and people from within the LGBTI+ community (13,24,25).

Policy implications

Create and leverage political momentum with data and accountability

High-level political prioritization and action is a prerequisite for successful integration of SRH into UHC. Data on and awareness of maternal mortality rates are

important factors in prioritizing maternal health and pregnancy services and securing resources to support the implementation of strategic plans and access to services. Similar evidence-based approaches are required to strengthen political commitment to address GBV and provide access to safe abortion services.

Reframing a contested SRH intervention as a public good is effective but can raise certain issues within the political agenda. The limitations also include the medicalization of OSCCs and the availability of less comprehensive services and options.

Strengthen the role of civil society and champions as drivers of change

Women-led NGOs and champions are instrumental in advocating legislative change, lobbying policy-makers and capitalizing on windows of opportunity (26). The wider participation of all critical stakeholders in health planning and prioritization processes, especially those who may be marginalized, is needed to ensure that SRH needs are met.

Monitor the level of financial protection and population coverage of SRH services, especially for marginalized groups

Concerted attention should be placed on monitoring groups who pay for services out of their own pockets (such as migrants and young adolescents) and determining why they do so. This is critical for addressing gaps in UHC and ensuring that SRH services are available and accessible to everyone who needs them, and that no one is left behind.

Conclusion

While Malaysia has made significant efforts and progress in ensuring financial protection and access to a wider range of SRH services at various strata of the public health care system, there is variation in degrees of integration, coverage and prioritization of different SRH services. Even when policies or guidelines are in place, financial commitments and implementation on the ground differ, and are dependent on prioritization in the public health system. Efforts to integrate SRH services in UHC processes therefore need to be cognizant of the overall context and values, but also driven by improved evidence and local partnerships to ensure that the rights of vulnerable and marginalized groups are not left behind.

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