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Family Planning Strategies across selected Muslim countries: A review to inform Malaysia's next steps

Prepared by UNU-IIGH for the
LPPKN Technical Working Committee

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Contents

Acronyms

Acronym	Expanded name
ACCRH	Advisory and Coordinating Committee for Reproductive Health
AFR	Adolescent Fertility Rate
AFHCs	Adolescent-friendly Health Centers
ARROW	Asian-Pacific Resource and Research Centre for Women
ASRO	Arab States Regional Office
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CSE	Comprehensive sexuality education
CSO	Civil Society Organisation
DHS	Demographic Health Survey
EU	European Union
FRHAM	Federation of Reproductive Health Associations, Malaysia
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-Based Violence
GDI	Gender Development Index
GII	Gender Inequality Index
GNI	Gross National Income
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV	Human Papilloma Virus
HPF	East and North Africa Health Policy Forum
HPNSP	Health, Population and Nutrition Sector Programme Plan
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
ITGSE	International Technical Guidance on Sexuality Education
IVF	In Vitro fertilization
LAPM	Long acting and permanent methods
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex
LMICs	low-and middle-income countries
LPPKN	Lembaga Penduduk & Pembangunan Keluarga Negara
NCWO	National Council of Women's Organisations Malaysia
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MHAS	Maylasian Healthy Ageing Society
MMR	Maternal Mortality Ratio
MWFCD	Ministry of Women, Family and Community Development
MoE	Ministry of Education
MoH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NAHP	National Adolescent Health Policy
NCIFP	National Composite Index on Family Planning
NFPE	National Family Planning Effort Index
NGO	Nongovernment Organisation
PEKERTI	National Reproductive Health and Social Education Plan of Action
PKK	Pendidkan Kesihatan Keluarga (Family Health Education)
PHC	Primary Health Care
PoA	Plan of Action
QOC	Quality of Care

RH&RHCS	Reproductive Health & Reproductive Health Commodity Security
RTIs	Reproductive Tract Infections
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHE	Sexual and Reproductive Health Education
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
SYPE	Survey of Young People in Egypt
TWC	Technical Working Committee
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YHS	Youth Health Services
YHCs	Youth Health care Centres

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EXECUTIVE SUMMARY

Family planning (FP) is a component of sexual and reproductive health (SRH)[1] and refers to the human right of individuals to regulate the number and spacing of births. FP, particularly modern contraceptive methods, is among the most health-promoting and cost-effective public health interventions, with the potential to improve health outcomes by preventing unintended pregnancies as well as maternal and infant morbidity and mortality. Some methods also prevent sexually transmitted infections (STIs), including HIV/AIDS. Increased contraceptive use is estimated to have prevented 40% of maternal deaths in developing countries over the past 20 years.[2] A further 30% could be prevented by addressing the unmet need for contraception,[3] by removing legal, regulatory, and social barriers to FP and SRH policy and programmes where appropriate.[4]

Several international frameworks, including the International Conference on Population and Development (ICPD) Programme of Action (PoA), the Beijing Platform of Action, and the Sustainable Development Goals (SDGs) Agenda reflect the international evidence-based consensus that universal access to FP is a human right; central to gender equality and women's empowerment, and a key factor in reducing poverty and achieving the SDGs.

LPPKN, a statutory body under the Ministry of Women, Family and Community Development (MWFCD) is leading the review of Malaysia's Family Planning policy environment via a consultative process. The review was guided by a Technical Working Committee (TWC), chaired by LPPKN's Deputy Director-General, with representation from government and non-government stakeholders involved in SRH and FP. This desk review, conducted by the UNU-IIGH, was commissioned by UNFPA at the request of LPPKN. It presents the latest evidence on best practices aligned with international FP guidelines and compares FP policies and practices across selected Sunni Muslim countries: Turkey, Egypt, Morocco, Bangladesh, and Malaysia. A combination of data collection methods was used, including document review, a comparative analysis of FP environments across the selected countries, and stakeholder consultations with LPPKN, UNFPA, and the TWC. This report provides important insights to inform Malaysia's next steps regarding FP policy and programme.

i) Summary of results across selected countries

Reproductive health is a critical public health issue, and the selected countries differ in their commitments to SRH rights and FP principles, adaptations, implementation, and progress measurement. The selected countries, particularly Malaysia, have made remarkable progress in human and economic development. There are legal and policy frameworks for SRH matters, such as the age of marriage, abortion, and gender-based violence. The leading example is Morocco's progressive Family Code or *Moudawana*,[5] praised for addressing women's rights and gender equality in Islamic law. [6]

Following international consensus, all selected countries except Malaysia consider FP a component of a broader SRH plan, encompassing sexuality education (particularly for youth), prevention and treatment

[1] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[2] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[3] Prof. John Cleland MA, Contraception and Health. The Lancet, Volume 380 Issue 9837, July 2012, pp.149-156.
[4] UN Women (1995) The Beijing Declaration and Platform for Action, Fourth World Conference on Women
[5] Center for Public Impact (2020) Reforming Moroccan family law: the Moudawana. Centre for Public Impact (CPI).
[6] Boutayeb W, Lamlili M, Maamri A, et al (2016) Actions on social determinants and interventions in primary health to improve mother and child health and health equity in Morocco. International Journal for Equity in Health

of sexually transmitted diseases and infections (STIs), including HIV/AIDS; and perinatal care,[7] rather than an isolated policy. This approach facilitates the linkages with SRH rights and strengthens the policy or plan. Despite national guidelines, there is a common failure to translate a rights-based SRH framework into practice fully. There are notable policy and programme weaknesses when measured against best practice, such as weak policies for vulnerable populations and exclusion of men's roles and responsibilities within the family unit.

The current national population direction varies across the countries; Malaysia, Turkey, and Morocco earlier contraceptive programme reduced the Total Fertility Rate (TFR) to replacement rate by 2018 (2 births per couple) with populations projected to decrease. Their current population strategies are pronatalist to prevent an economic slowing typical of developed countries, attributed to a shrinking working-age population and an ageing population with a high dependency ratio. In contrast, overpopulated Egypt and Bangladesh are still focusing on containing population growth, which places pressure on their limited resources, commonly seen in developing countries.

The prioritisation of FP and SRH issues within the national agendas is influenced by the wider socio-cultural contexts. Across examined countries, and particularly Malaysia, less controversial SRH services such as perinatal care services seem more likely to get buy-in from key stakeholders, compare with sensitive services such as safe abortion or GBV services, which require specific strategies to transform socio-cultural norms, beliefs and behaviours. [8]

Despite significant progress made, FP implementation remains a challenge across the selected countries. Religion remains a key influence on FP and SRH rights. Most Islamic scholars (particularly in Egypt) permit FP practices as the Quran does not prohibit them. Spacing pregnancies improves the physical health of mothers while reducing the family's economic burden. However, uninformed scholars might view FP as restricting the Islamic world's growth/strength (as in the case in Turkey or Bangladesh), highlighting the need to sensitise and engage religious scholars in broader FP efforts to improve infant and maternal health. [9] Additionally, premarital sexual relationships across the selected countries are forbidden by Islamic Law and unapproved by society. These two factors translate into limited FP/SRH education and services for youth, who face the risk of abuse, STIs, and unwanted pregnancies. Limited FP/SRH education and services disproportionally affect girls and highlight the need for urgent action. In Malaysia and Turkey, the low fertility rate combined with pronatalist policies is likely to present challenges regarding access to — and use of — contraception for all populations, particularly for young people,[10] many of whom are sexually active before marriage.

Domestic politics across selected countries play a crucial role in determining the extent to which a rights-based FP/SRH framework is implemented. [11] Egypt has been particularly successful in engaging religious leaders in FP campaigns — a critical factor for sensitising populations — with renowned Islamic teaching centers issuing fatwas favoring modern contraception and increasing the acceptability of birth

[7] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[8] Lim, S.C. Yap, YC. Barmania, S. Govender, V. Danhoundo, G & Remme, M. (2020) Priority-setting to integrate sexual and reproductive health into universal health coverage: the case of Malaysia, *Sexual and Reproductive Health Matters*
[9] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72
[10] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[11] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033

control within Islam. [12] In contrast, Turkey's conservative political climate since 2010 [13] has restricted FP services for women, impacting policymaking, implementation, and civil society activities related to the promotion of rights-based FP/SRH. [14]

Vulnerable populations such as adolescents, the unmarried, the urban poor, rural communities, sex workers, and people living with HIV often face compounded access barriers and rights violations. These barriers lead to high rates of unintended pregnancy, increased risk of HIV and STIs, limited choice of contraceptive methods, and higher levels of unmet need for FP. These groups require particular attention across the selected countries to ensure their reproductive rights and access to rights-based FP services. [15]

Rational utilisation of existing limited national resources is a significant challenge to improving reproductive health across the countries. Following best practices and with international support, Egypt and Bangladesh have developed FP strategies accompanied by Costed Implementation Plans (CIPs) to ensure FP policies and programmes are fully funded and successfully implemented to achieve the national FP goals.

Examined countries should strengthen their monitoring and evaluation frameworks – crucial in determining and documenting progress, assessing programme effectiveness, and making recommendations for further improvements. [16] FP indicators should align with WHO's reproductive health indicators to enable global monitoring and international comparisons. [17] Each country should also consider the contextual impact of COVID-19 developments on FP and SRH to design an appropriate response. [18]

ii) Specific lessons for Malaysia

Considerable progress has taken place in Malaysia regarding FP. However, the agenda remains unfinished. The *2019 Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) review [19] noted that Malaysian women still experience availability, accessibility, and affordability barriers to high quality services. A religious perspective is frequently adopted, rather than a rights based SRH approach. This perspective is typical for abortion and disproportionally affects vulnerable women and girls (unmarried youth, refugees, indigenous, migrants, transgender, and prisoners).

[12] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

[13] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033

[14] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.

[15] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

[16] The countries included Afghanistan, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen. Six countries did not respond; Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya and the United Arab Emirates.

[17] Measure Evaluation (2020) WHO's short list of reproductive health indicators for global monitoring

[18] Weinberger, M. Hayes, B. White, J. & Skibiak, J. (2020) Doing Things Differently: What It Would Take to Ensure Continued Access to Contraception During COVID-19 Global Health: Science and Practice

[19] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.

Malaysia had the lowest Contraceptive Prevalence Rate (CPR) and the highest unmet need across the selected countries, despite a FP programme integrated into primary health care. The low CPR and high unmet need are slowing the achievement of SDG target 3.7: ensuring universal access to SRH services, including FP, information and education, and the integration of reproductive health into national strategies and programmes by 2030. Addressing the paradoxical relationship of low and stagnant CPR and declining TFR will require developing a strategic and integrated FP policy as a priority within the national agenda that improves the access and quality of FP programmes and services. Special programmes for vulnerable populations (adolescents, refugees, and persons with disabilities) should be streamlined and strengthened.[20]

Malaysia acknowledges the importance of FP policies and programmes on fertility regulation, as reflected in the overall high scores for the 2014 Family Planning Effort Index (FPE)[21] and the 2017 National Composite Index on Family Planning (NCIFP)[22] compared to other countries. The high overall scores are due to the identified areas of strength, which include: service provision for improving maternal and child health, service management and training of service providers, and the collection of data for evaluation (**Appendix 5**). However, the Indexes scores and desk review revealed the following critical gaps in FP policies and services that Malaysia should address as a priority:

1. **Consider FP a component within a broader SRH plan under the existing National Population Policy currently reviewed by LPPKN and the Policy Division with MWFCD rather than an isolated policy**, ensuring a life-course approach to FP and SRH services that encompasses UNFPA's recommended SRH components (**Box 2**).[23] The components include FP services, adolescent sexual and reproductive health, CSE, abortion and management of complications, prevention and treatment of STIs, perinatal care and SRH programmes and services for the elderly.[24] The strategy should be accompanied by a Costed Implementation Plan (CIP) stating the roles and responsibilities of relevant government agencies in its implementation.
2. **Engage in participatory policy formulation by defining FP objectives over a 5-10 year period** with quantitative targets, particularly on reducing unmarried adolescent childbearing as well as maternal and infant mortality, increasing the participatory engagement of key stakeholders (including NGOs, academics and civil society) and strengthening the laws and regulations facilitating contraceptive supplies. Continue strengthening the policies on fertility and age at marriage (ongoing process), import laws and legal regulations and advertising of contraceptives, and ensure favourable statement by political leaders at least 1-2 times per year.
3. **Ensure a rights-based FP policy and programmes** by formulating operational policies to prevent discrimination towards stigmatised groups (unmarried youth, people living with HIV/AIDS, sex workers), providing equitable community-based distribution of contraceptives for hard to reach areas.

[20] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.
[21] FP2020 (2014) Family Planning Effort Index
[22] FP2020 (2017) National Composite Index on Family Planning (NCIFP)
[23] Williams K, Warren C, Askew I (2010) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services
[24] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper

4. **Advocate FP for improving mother and child health across all future FP interventions** among key stakeholders, particularly community and religious leaders, following the lead of Egypt and based on Malaysia's MoH policies and service delivery. Spacing births via contraception is not prohibited by the Quran and enables a logical timeframe for the mother to regain her physical strength and for each child to receive appropriate attention for their nourishing, training, and education.[25]
5. **Strengthen FP service provision by engaging the private sector** to increase community-based distribution, improve administrative structures and the content of mass media campaigns, and identify and leverage incentives and disincentives for FP use.
6. **Implement Comprehensive Sexuality Education (CSE) to prevent unwanted pregnancies among unmarried youth**, as recommended by a previous desk review. [26] Teaching CSE to promote informed choices on safer sex and contraception is primary prevention. CSE has been proven to be more effective than abstinence-only or abstinence plus programmes in delaying sexual initiation and reducing the negative health consequences of unprotected sex. Malaysia's current abstinence-only-until-marriage approach is based on the harmful misconception that CSE might encourage early sexual activity and risk-taking behaviours; it provides very limited information on safer sex and contraception, and should be corrected to align with UNESCO's CSE curriculum guidelines. [27]
7. **Address the needs of vulnerable populations, particularly the unmarried youth** by increasing the accessibility to emergency contraception and safe abortion and providing counselling and contraceptive services for post-abortion women. Reframe abortion services as means to reduce maternal and infant mortality by addressing unsafe practices to the full extent that Malaysia's legal framework allows.
8. **Strengthen the existing accountability mechanisms at national, subnational, and facility levels** to monitor FP information and service availability, accessibility, affordability, acceptability and quality, particularly for vulnerable populations. The 10-yearly Malaysian Population and Family Survey (MPFS) [28] captures national FP data from married women only (overestimating CPR and underestimating unmet needs). More regular and comprehensive FP data including unmarried people and disaggregated by age, sex, economic status and location is required to measure trends and change in knowledge, attitudes and sexual practices (such as safe sex and use of FP methods) to inform FP policy and programmes.
9. **Increase the quality of FP services provided by improving and monitoring Indicators of Quality of Care** (QoC) collated by the public and private sector FP services, strengthening FP logistics and supply system to keep stocks of contraceptive supplies available at all service points, at all times and at all levels (central, provincial, local), strengthening the structures to address QoC (including monitoring, quality improvement activities and training of FP personnel to support informed choices and avoid provider biases). There is a need to identify and address discrimination cases and services denial on non-medical grounds (age, marital status or ability to

[25] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

[26] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.

[27] UNESCO (2018) International Technical Guidance on Sexuality Education

[28] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings

pay), or coercion (inappropriate use of incentives to clients or providers) via regular feedback mechanisms. **Appendix 6** lists online resources to support these activities.

10. **Review the FP related objectives and recommendations from Malaysia's *2010 Population Strategic Plan Study*** [29] (**Appendix 4**) as part of a road map leading to the formulation of a comprehensive FP policy that addresses Malaysia's FP gaps (**Table 14**). The *2010 Plan* advocates for a family-centered approach to FP and proposes establishing a National Institute for Family and Population to study family dynamics changes and their implications as done in other countries.
11. **Consider becoming an active member of – and regular contributor to – the Family Planning 2020 movement**. The movement provides many opportunities to learn lessons across countries and create alliances to strengthen international commitments to designing and implementing evidence-based FP/SRH policies and programme. A range of resources are also available to support the process of policy formulation (see **Appendix 6**).

This desk review provides a comparison in FP policies and programmes across examined countries, and highlights the gaps when measured against international guidelines and best practices, which may be useful for other Islamic countries. Malaysia should address the identified gaps to strengthen FP services that improve maternal and infant health outcomes and achieve its international commitments. A FP plan integrated within a broader rights-based SRH strategy accompanied by a CIP could reinvigorate the FP agenda in Malaysia and ensure a healthy, educated, and productive population. FP integration requires the commitment of relevant government agencies to lead the participatory policy development process. A road map informed by the lessons learned as well as FP guidelines and best practices is provided in **Table 14** to guide the formulation of Malaysia's FP strategy and programmes.

[29] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010

1. BACKGROUND

1.1 Malaysia's Family Planning context

A 1968 report on the FP Programme in Malaysia articulates that on 1 June 1966 the *Population and Development Act* 1966 became national law.[30] The Act established the LPPKN as an autonomous statutory body with seven objectives: (1) the formulation of policies and methods for the promotion of FP knowledge and practice focusing on the health of mothers and children and the welfare of the family, (2) the programming, coordinating and administering of national FP activities, (3) responsibility for the training of all individuals involved in FP activities, (4) responsibility for conducting research on FP medical and biological methods, (5) the promotion of studies and research on the interrelationship across social, cultural, economic and population changes as well as national fertility and maternity, (6) establishing evaluation mechanisms to periodically assess the effectiveness of the programme and progress towards attaining the national objectives and (7) employing officers and assistants as approved by the MWFCD for undertaking the functions and duties of LPPKN. However, there is no national officially endorsed policy for FP in Malaysia.[31]

Although there is no officially endorsed FP policy, a 1996 operational policy statement guides the implementation and coordination of the national FP programming in Malaysia as follows: [32]

- FP services are conducted through a multi-sectoral approach between implementing agencies, where LPPKN acts as coordinator.
- FP service delivery is based on aspects of health and family's health and the practice is voluntary.
- Contraceptive services will be provided through the cafeteria system and delivered by the medical and support staff who are specially trained, with emphasis on medical services and follow-up support.
- Provision of expertise and specialized counselling (genetic counselling, infertility treatment) to improve the quality of FP services in the country.
- FP Education/Population integrated into the formal and non-formal education system.
- Provision of FP in the Social Development Programme is intended to provide an opportunity to improve the lives of family and socio-economic status of women. Improving the quality of education and opportunities for women could indirectly lower the fertility rate.
- Provision of programmes and support activities aimed at improving quality of life. It covers aspects of health, well-being and activities to promote and enhance the status of women.
- Encourage medical, biological, socio-economic and cultural studies related to patterns associated with maternity and fertility health on population growth and their impact on overall socio-economic development.

[30] Dr Ariffin M and Love T (1968) The Family Planning Program

[31] Lembaga Penduduk dan Pembangunan Keluarga Negara and United Nations Population Fund (2020) Family Planning Policy Workshop Meeting Minutes

[32] Lembaga Penduduk and Pembangunan Keluarga Negara website. Retrieved on 28 September 2020.

1.2 The need to develop a Family Planning Policy for Malaysia

The need to review and update the *1966 Family Planning Policy* statement is critical for aligning Malaysia with the latest international FP frameworks and best practices; the family planning field has dramatically progressed since 1966.

To inform this review, LPPKN and the Secretariat to the Advisory and Coordinating Committee for Reproductive Health (ACCRH) conducted the July 2020 Brainstorming Workshop with key stakeholders.[33] The stakeholders included senior government officers from relevant ministries, UNFPA and the principal researcher from UNU-IIGH. The discussion covered whether to develop a sexual and reproductive health policy or keep using the 1966 FP policy statement.

The existing National Population Policy is currently being reviewed by LPPKN and the Policy Division with the MWFCD. During a meeting on 14 October 2020, the TWC identified an opportunity to integrate a comprehensive FP policy within a broader SRH plan under National Population Policy. This approach would first form part of Malaysia's commitment to meet international targets related to SRH indicators, including reducing the maternal and infant mortality rate, addressing unmet need for FP, and increasing the CPR. Secondly, an officially endorsed policy would expedite the allocation of funds for the agreed programmes and activities. Stakeholders also suggested that while awaiting the macro population policy review, Malaysia addresses its commitment to SRH via relevant existing policies such as the *Policy and Action plan for National and Reproductive and Social Health Education* (Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial, also referred as PEKERTI), the *National Policy on Women* and the *National Social Policy*.

[33] Lembaga Penduduk dan Pembangunan Keluarga Negara and United Nations Population Fund (2020) Family Planning Policy Workshop Meeting Minutes

2. CONCEPTUALISING FAMILY PLANNING

FP refers to the basic human right of every individual to freely and responsibly determine when they want to have children and how many they want to have. [34] FP is among the most health-promoting and cost-effective public health interventions (particularly modern contraceptive methods), with the potential to improve health outcomes by preventing unintended pregnancies as well as maternal and infant mortality (about 30% and 10% respectively) and morbidity. Some FP methods also reduce STIs, including HIV/AIDS.[35] FP is a component of SRH, including CSE (particularly for youth), prevention and treatment of STIs (including HIV/AIDS), and perinatal care. [36]

2.1 International Family Planning commitments

Many women's limited power over their sexual and reproductive lives and lack of influence in decision-making are social realities that adversely impact their health. National FP programmes have made significant progress since the 1970s, shifting the focus from narrow policies on population dynamics to a broad sexual and reproductive health and reproductive rights (SRHR) agenda focusing on individual needs, choice and rights of people, particularly women and adolescents. The approach further advocated for the respect of rights and choices, gender equality, and women's empowerment to ensure sustainable development. In the mid-1990s, this agenda was mobilised by two major international forums: the International Conference on Population and Development (ICPD) and the Beijing Platform of Action. The Sustainable Development Goals (SDGs) reiterate the agenda.

Global consensus that FP is a critical component of reproductive health and a human right was secured unanimously in 1994 by 179 countries. The *ICPD Programme of Action* (ICPD PoA) called for all people to have access to comprehensive reproductive health care, including voluntary FP, safe pregnancy and childbirth services, and the prevention and treatment of STIs. It also recognised that reproductive health and women's empowerment are interrelated, and that both are necessary for the advancement of society. The *ICPD Programme of Action* affirms that *all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so* (principle 8).[37] Voluntary, good quality FP services that include counselling and access to contraceptives must be available, accessible and affordable as one of the core elements of a comprehensive sexual and reproductive health services package.[38]

The *Beijing Declaration and the Platform for Action*, adopted unanimously by 189 countries at the Fourth World Conference on Women in 1995, is considered the most comprehensive global policy framework for women's rights.[39] It affirms *the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of FP of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*. ***The promotion of the responsible exercise of these rights for all***

[34] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[35] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.
[36] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[37] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[38] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[39] UN Women (1995) The Beijing Declaration and Platform for Action, Fourth World Conference on Women

people should be the fundamental basis for government-and community-supported policies and programmes in the area of reproductive health, including FP.[40] This includes the commitment to ensuring the promotion of respectful and equitable gender relations and *equal access to and equal treatment of women and men in education and health care* and the enhancement of *women's sexual and reproductive health as well as education*.

The 2015 United Nations General Assembly adopted a global development agenda referred to as the SDGs, consisting of 17 interconnected goals and 169 strategic targets to be achieved by 2030.[41] Achieving the SDGs involves all sectors of society and covers a range of dimensions to drive global financial and human resources allocation and support for nations' policy priorities. Ensuring universal access to SRH and FP services by 2030 is a key target for achieving specific SDGs Goals (**Box 1**). It is one of the most cost-effective SDG targets,[42] as investing in FP provides benefits across portfolios and drives the achievement of the remaining SDGs (

[40] UN Women (1995) The Beijing Declaration and Platform for Action, Fourth World Conference on Women
[41] UN General Assembly (2015) Transforming Our World: The 2030 Agenda for Sustainable Development
[42] Health Policy Plus (2020) Family Planning-Sustainable Development Goals (FP-SDGs) Model

Figure 1).

When couples exercise voluntary FP to space or limit pregnancies, it enables them to allocate limited resources better, thereby increasing household wealth and improving nutrition and health. FP contributes to gender equality by helping girls prevent early pregnancy, extend their education, and make important life choices. It also enhances environmental sustainability and national and international security by alleviating the pressures of rapid population growth and urbanisation on economic and social resources. [43]

All countries face the challenge of meeting the international development commitments (

Figure 2). Addressing the unmet need for FP and providing pregnant women and newborns with the standard quality of care recommended by WHO would, in turn, improve developmental indicators. However, regardless of the well-established FP benefits, many governments in low and middle-income countries gave priority to donors' interests and other areas; only limited investment in FP programmes were made.[44]

[43] Health Policy Plus (2020) Family Planning-Sustainable Development Goals (FP-SDGs) Model
[44] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.

Box 1 Family Planning related targets within the Sustainable Development Goals

FP related targets to be achieved in all countries by 2030 are listed below.

SDG 3: Ensure healthy lives and promote well-being for all and all ages

3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2: End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3: End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
3.7: Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

SDG 5: Achieve gender equality and empower all women and girls

5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
5.4: Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate
5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
5.c: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels

Living up to the commitment of the international community to achieve universal access to reproductive health by 2030 requires the monitoring of key FP indicators.

Source: UN knowledge Platform (2020) Sustainable Development Goals

Figure 1 Family planning benefits shared across portfolios and driving the SDGs [45]

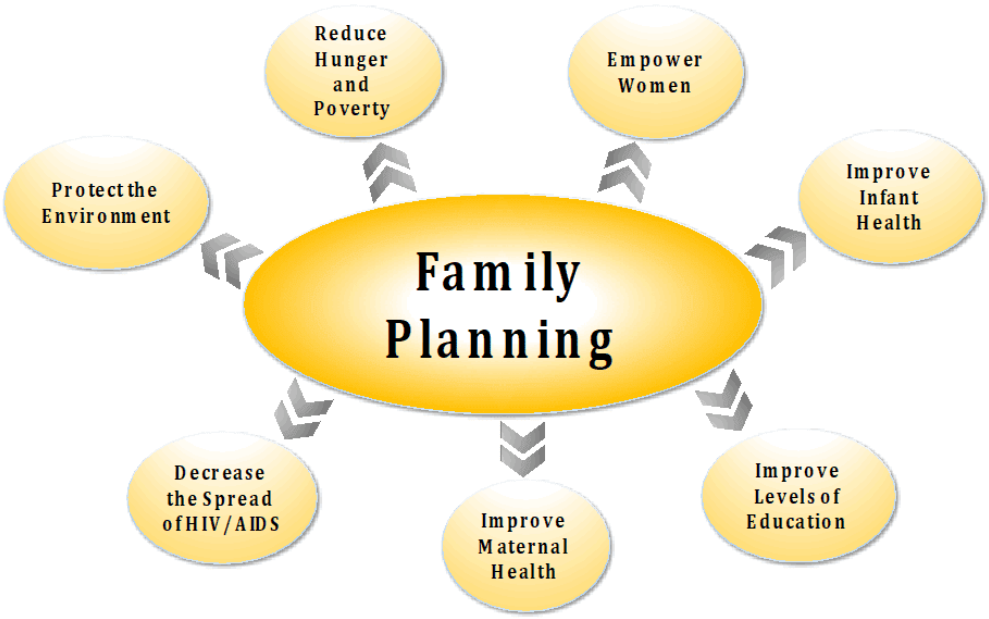
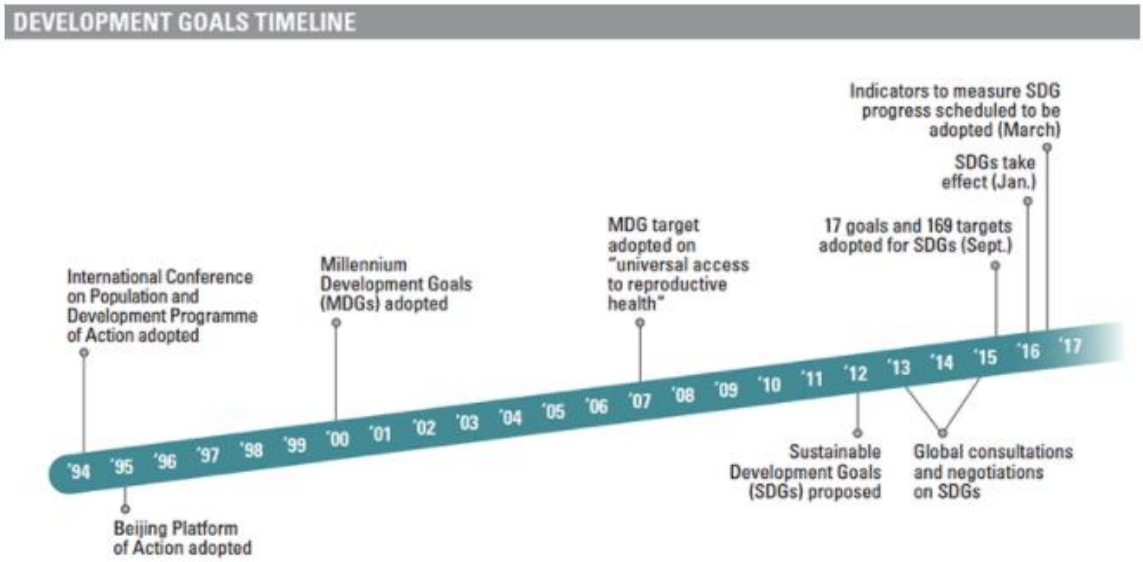


Figure 2 Frameworks for international development commitments [46]



[45] Extracted from: La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper

[46] Extracted from Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals.

3. METHODOLOGY

3.1 Objectives of review

The review aimed to achieve the following objectives:

1) consider the existing international frameworks and guidelines and commitments related to FP practices;
2) review FP strategies across selected Muslim countries with a Sunni majority to inform Malaysia's next steps; and
3) propose recommendations to develop an FP strategy that meets Malaysia's multiracial and multifaith society's needs.

LPPKN and UNFPA requested the UNU-IIGH to produce a desk review to inform the possible development of a FP Strategy to be presented to key stakeholders including the TWC at a meeting in October 2020. The desk review was to be based on a mapping of relevant UNFPA guidelines and related international frameworks as well as related FP policies of selected Muslim countries that align with Malaysia's constitutional and Islamic Sunni faith.

3.2 Selection of comparative Muslim countries

UNU-IIGH based the selection of comparative Muslim countries on objective criteria and input from the TWC. A list of countries that align with Malaysia's Sunni faith was initially proposed by LPPKN, including Egypt, Jordan, Bangladesh, Indonesia and Pakistan. The objective selection criteria were applied to the proposed countries and compared contraceptive prevalence indicators, commitments to key international conventions relevant to SRH rights and the existence of FP strategies. The latter included the level of integration of FP policies into health care programmes, Islamic leaders support and committed public budgets for FP programmes. The selection process identified Bangladesh and Egypt as the best candidates for further country comparisons, with the best contraceptive prevalence progress indicators. The research team presented the selection criteria to the TWC at the inception meeting on 8 July 2020. The TWC suggested incorporating Morocco and Turkey as they are similar to Malaysia's level of human and economic development. Turkey, Morocco, Egypt, Bangladesh and Malaysia were the final agreed comparative countries.

3.3 Data collection

The desk review presents an evidence-based snapshot of the status of key variables supply, enabling environment and demand.[47] Document review and stakeholder consultations were the data collection methods used to meet the study objectives:

- **Document review,** including the following activities:
  - **Review of FP/SRH international guidelines, peer reviewed research publications on FP/SRH best practice (past 5–10 years) and FP/SRH issues for each selected country.** PubMed® and Google Scholar® were used as the main databases for collecting literature.
  - **Review and compilation of relevant FP/SRH country statistics from key sources.** These included the United Nations Development Programme (UNDP) Human Development Index ranking, Service Provision Assessments, Reports from Demographic and Health

[47] Engender Health (2011) The Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming. New York.

Surveys (DHS), UNFPA, U.S. Agency for International Development (USAID), and the World Health Organization (WHO).

- **Review of national policies and guidelines of the selected countries.**
  Country-specific national policies and guidelines and academic literature was reviewed. Country-specific policies and guidelines tend to be published in the country's official language. Where English translation was not available, relevant documents and reports published by reputable agencies were utilised. In the case of Morocco's policy documents, translation from French was required. The review of national policies and guidelines provides a useful summary of key strategic documents, which informs the Desk Review recommendations.
- **Assessment of the current programmatic context in which the national FP programme operates.**
  Selected countries were examined based on the Family Planning Effort Index (FPE) [48] estimating the strength of national family planning programmes and the National Composite Index on Family Planning (NCIFP)[49, 50] measuring the existence of FP policies and programme implementation.

- **Consultative meetings**: UNU-IIGH presented the research proposal with an initial literature review, methodology and workplan (detailing the scope of work, approach, timelines for consultations and deliverables) to LPPKN and UNFPA partners at a pre-inception meeting on 22 June 2020 and to LPPKN's Technical Working Committee at an inception meeting on 8 July 2020. A Workshop with key stakeholders from related government and non-government agencies took place on 10-12 July 2020 to inform the progress of this desk review which was endorsed by the TWC during a meeting on 14 October 2020.

[48] FP2020 (2014) Family Planning Effort Index
[49] FP2020 (2017) National Composite Index on Family Planning (NCIFP)
[50] Weinberger, M. & Ross, J. The National Composite Index for Family Planning (NCIFP), Avenir Health's Track20 Project

3.4 Guiding frameworks for developing a Family Planning Policy

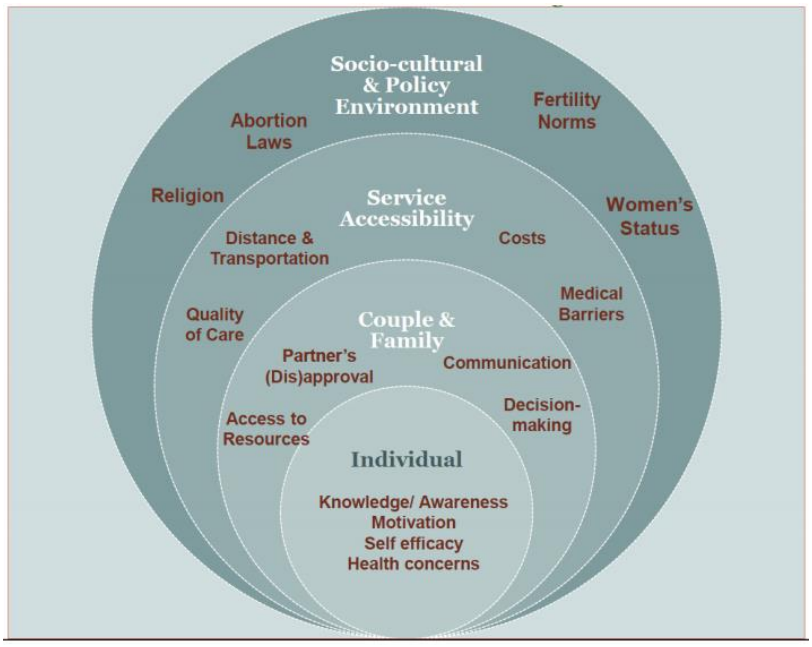
Three frameworks were used to guide this review and comparative analysis: the socioecological framework depicting levels of influence on FP usage*;* UNFPA's *Family Planning Strategy 2012-20* providing a set of guiding principles for FP efforts; and the FP policy development process, further explained below.

3.4.1 Socio-ecological framework

Policies provide the foundation for strong health systems, programmes and services. Supporting national reproductive health policies provides the vision and framework for government action and ensures FP features within the national agenda with the allocation of adequate financial resources. Ministries of Health have a key role in developing health sector policy to improve health system performance and promote population health.[51]

A comprehensive analysis of barriers and facilitators of FP use within a girls and woman's environment, including the relevant stakeholders that influence their decision-making, enables the design of strategies targeted to each level of influence. The approach actively engages influencers to successfully reach these beneficiaries and transform harmful social and gender norms. **Figure 3** shows that comprehensive, multilevel strategies are required to facilitate an enabling environment in which girls' and women's rights are promoted, reinforced and practiced.[52] Adopting a socio-ecological framework commences with the individual and involves family and peers, communities and the wider structural environment.

Figure 3 Socio-ecological framework depicting determinants of Family Planning use [53]



Unmet need for FP refers to the gap between women's reproductive desire to avoid pregnancy and contraceptive behaviour. It is caused by a range of factors, including access (**Figure 4**). It is critical that

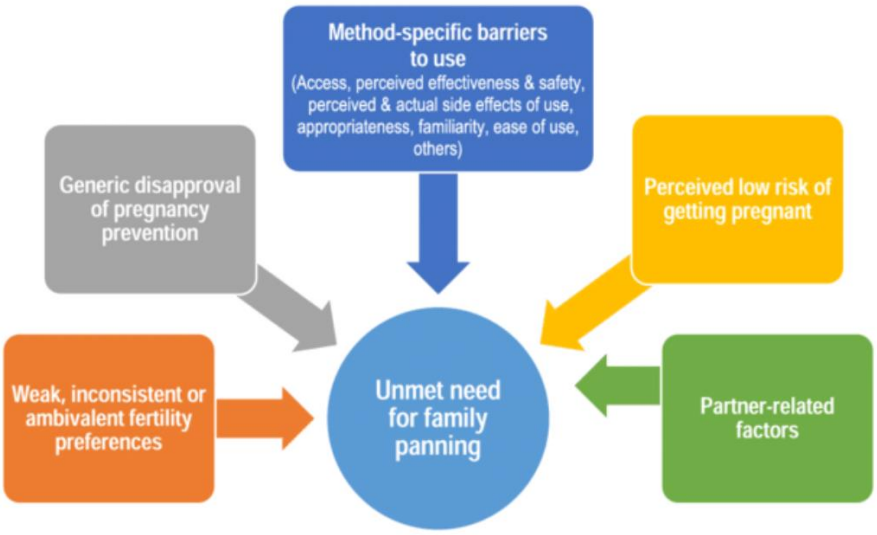
[51] High Impact Practices (2013) Policy: Building the foundation for systems, services, and supplies

[52] Chandra-Mouli V, Plesons M, Hadi S, et al (2018) Building Support for Adolescent Sexuality and Reproductive Health Education and Responding to Resistance in Conservative Contexts: Cases From Pakistan. Glob Health Sci Pract 6:128–136.

[53] Extracted from Cleland, J. Foster, G. Holley, C, Thompson, K (2014) Family Planning Topic Guide

policies comprehensively address the unmet need for FP across different age, ethnic and religious demographics.

Figure 4 Reasons for unmet need for Family Planning [54]



3.4.2 UNFPA Framework

UNFPA is the principal global inter-governmental organization in the UN system with the mandate for FP. Through *Choices not Chance,* UNFPA's *Family Planning Strategy 2012-20*,[55] UNFPA commits to supporting countries accelerate universal access to rights-based FP services via voluntary FP information, services, and supplies that allow individuals and couples to choose whether, when and how many children they have. The Strategy's key indicators include unmet need for FP, CPR, modern methods and the percentage of countries with service delivery points offering at least 3 modern methods of contraception. *Choices not Chance*[56] provides a set of guiding principles for FP efforts (**Table 1Error! Reference source not found.**).

UNFPA also provides general guidelines for national FP Policy development based on the *2030 Agenda for Sustainable Development*. The guidelines include desk review, stakeholder consultations and gap analysis, paying due consideration to contextual needs and practices (**Table 2**). The sustained, secure and timely availability of a wide range of quality contraceptives requires a well-functioning health system. The health system should include logistics to provide equitable access to a range of contraceptives for all populations, including procurement of a mix of contraceptives, supported by national capacity to procure and manage its supply chain. The health system also requires up-to-date information about technological advances and risks. [57] *Choices not Chance* is designed to expand UNFPA's FP capacity while incorporating the health system-strengthening conceptual framework and population-based and development-based perspectives. UNFPA recommends the integration of SRH

[54] Machiyama K, Casterline JB, Mumah JN, et al (2017) Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. Reproductive Health 1:1–11
[55] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[56] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[57] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

services, including FP, into the primary health care system to ensure universal access to the services. The five steps for *Planning and Implementing an Essential Package of SRH Services* [58] include:

- prepare, assess and analyse
- identify facilities
- define and operationalise the Essential SRH Package
- assess initial programme
- phased implementation and plan expansion, and
- maintain commitment, sustain implementation and support nation-wide scale-up.

Other recommendations include supporting data collection for FP resource allocations, having a structured communication plan, and engaging men and boys in planning and delivering interventions.

Table 1 UNFPA's Guiding principles for Family Planning [59]

Principles	Description
Universal human rights	All individuals have the right to health, including SRH; to decide freely and responsibly the number and spacing of their children; to choose whether or not to marry; to access comprehensive sexuality education including FP information; to choose from a broad mix of modern FP methods; to exercise these family-planning related rights independent of identity, race, ethnicity, religion, education, age, income, health or other status.
Non-discrimination	All policies and programmes must guarantee voluntary and confidential access to information, services and participation to everyone including vulnerable and marginalized populations and must uphold the right to make decisions free of coercion or discrimination.
Gender equality and equity	FP information, services and supplies must address gender equity and equality. Empowerment initiatives should ensure the full autonomy of women to decide whether, when and how to practice FP, and to decide which contraceptive method to use. The constructive engagement of men is essential to ensure that they exercise responsibility for their sexual and reproductive behaviour; support their partners' choices; do not either oppose or impose contraception, respecting women's and girls' rights to free, informed and prior consent and to live free from gender-based violence. *A gender perspective examining an FP policy's content and implementation strategy might ask if the strategy: 1.* explicitly accounts for gender-specific ways for women and men to access the FP services they need; and 2. exclude any element of coercion that act to disempower individual men or women (e.g. policies that give husbands control over the reproductive health of women)
Evidence-based, national relevance and sustainability	Reliable data should be collected on a regular basis at country level and deployed for advocacy to facilitate inclusion in national priorities and policies, as appropriate: comprehensive sexuality education and secondary education of girls; access to FP information and services, including through the workplace; multi-sectoral approaches engaging key stakeholders and the private sector to ensure optimal delivery of FP services and supplies; provision of information and services to communities and individuals, especially the marginalized and most vulnerable.
Access for adolescents and young people to comprehensive sexuality education and youth-friendly services	Approaches to service access and provision should correspond to the needs of different age groups including among and between young people and adolescents; ensure linkages to comprehensive sexuality education and promote and secure the right of young people and adolescents to make informed choices about their sexual and reproductive health and exercise due control over all matters related to their sexuality.
Accountability and transparency	Mechanisms must be in place at the country, regional and global levels to ensure FP initiatives meet quality standards, are based in human rights, accountable. for their delivery, demonstrate value for money and report results and outcomes transparently.
Innovation, efficiency, quality and results	Best practices should be identified systematically and where possible scaled up for greater impact; new ideas and new technologies should be trialled to identify innovation to accelerate

[58] Williams K, Warren C, Askew I (2010) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services
[59] Extracted from UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

Principles	Description
	achievement. Providing better quality services attracts more clients, increases FP use, and reduces unintended pregnancy.
Sustainability	National ownership of FP policies and programmes is essential, and governments should be supported to establish approaches that safeguard achievements, extend and improve gains.

Table 2 Processes and indicators - UNFPA's General guidelines for national Family Planning Policy development

Processes	Key indicators / Considerations / Intervention areas
Background information	Key data; indicators to be included: • **government spending on health; government spending on FP;** • market segmentation analysis – who provides most contraceptives – government or private sector? Preferred methods of contraception; • unmet need – status; causes – where and why of inequities; conduct a gap / bottleneck analysis of the existing programme and what needs to be done for improvement.
Obtain Consensus on data	• meeting with government to obtain agreement on national data and indicators.
Convene subnational meetings with ALL stakeholders*****	• understand their needs and expectations and how they can contribute to the programme.
Convene national level meetings with ALL stakeholders *(including religious scholars and members from faith-based organizations)*	• brainstorm on issues from subnational meetings and workshops; • building consensus on causes of inequities and non-utilization of FP and how stakeholders can contribute to the programme.
Identify priorities and action points at different levels	Policy level interventions and actions; • actions at the service delivery level; • actions at the provider level; and • demand creation activities to improve utilization.
At all levels emphasise on FP being a Fundamental Human Right	FP as a fundamental human right committed to by the national government under various international conventions and treaties. Guiding principles will include human rights, reproductive rights and gender equality.
Calculate resource requirements	• human; financial; materials resource requirements for policy implementation.
Identify targets, indicators and timeline and also, how these will be measured and monitored	

** Stakeholder representatives from Ministries of health; education; planning; finance; youth affairs; UN partners; other bilateral and multilateral agencies; INGOs; private sector; manufacturers; representatives from national medical, OB/Gyn, nursing and midwifery associations; academia and research scholars; public health experts; demographers; experts on logistics and supply chain management; representatives from religious and faith based organizations; CSOs and NGOs.*

At the 22 June 2020 pre-inception meeting, LPPKN stakeholders classified UNFPA's *2010 Essential Package of Sexual and Reproductive Health Services* [60] according to the Malaysian context as show in **Box 2**.

Box 2 Malaysia's classification of UNFPA's 2010 Essential Package Components of Sexual and Reproductive Health Services

At the 22 June 2020 pre-inception meeting, LPPKN stakeholders classified UNFPA's *2010 Essential Package of Sexual and Reproductive Health Services* [1] according to the Malaysian context as follows:

- Green – representing the most urgent and doable, and most culturally and religiously acceptable
- Yellow – representing the moderately urgent and doable, and less culturally and religiously acceptable
- Orange – representing the less urgent and doable and most culturally and religiously acceptable
- Red – representing the less urgent and doable, and less culturally and religiously acceptable

UNFPA's recommended SRH services components [1]
1. Family planning/birth spacing services
2. Antenatal care, skilled attendance at delivery, and postnatal care
3. Management of obstetric and neonatal complications and emergencies
4. Abortion and management of complications resulting from unsafe abortion
5. Prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV/AIDS
6. Early diagnosis and treatment for breast and cervical cancer
7. Promotion, education and support for exclusive breast feeding
8. Prevention and appropriate treatment of sub-fertility and infertility
9. Active discouragement of harmful practices such as female genital cutting
10. Adolescent sexual and reproductive health
11. Prevention and management of gender-based violence

[1] *Source: Williams K, Warren C, Askew I (2010) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services*

[60] Williams K. Warren C. & Askew, I. (2020) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services; Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services, Commissioned by UNFPA and the Population Council.

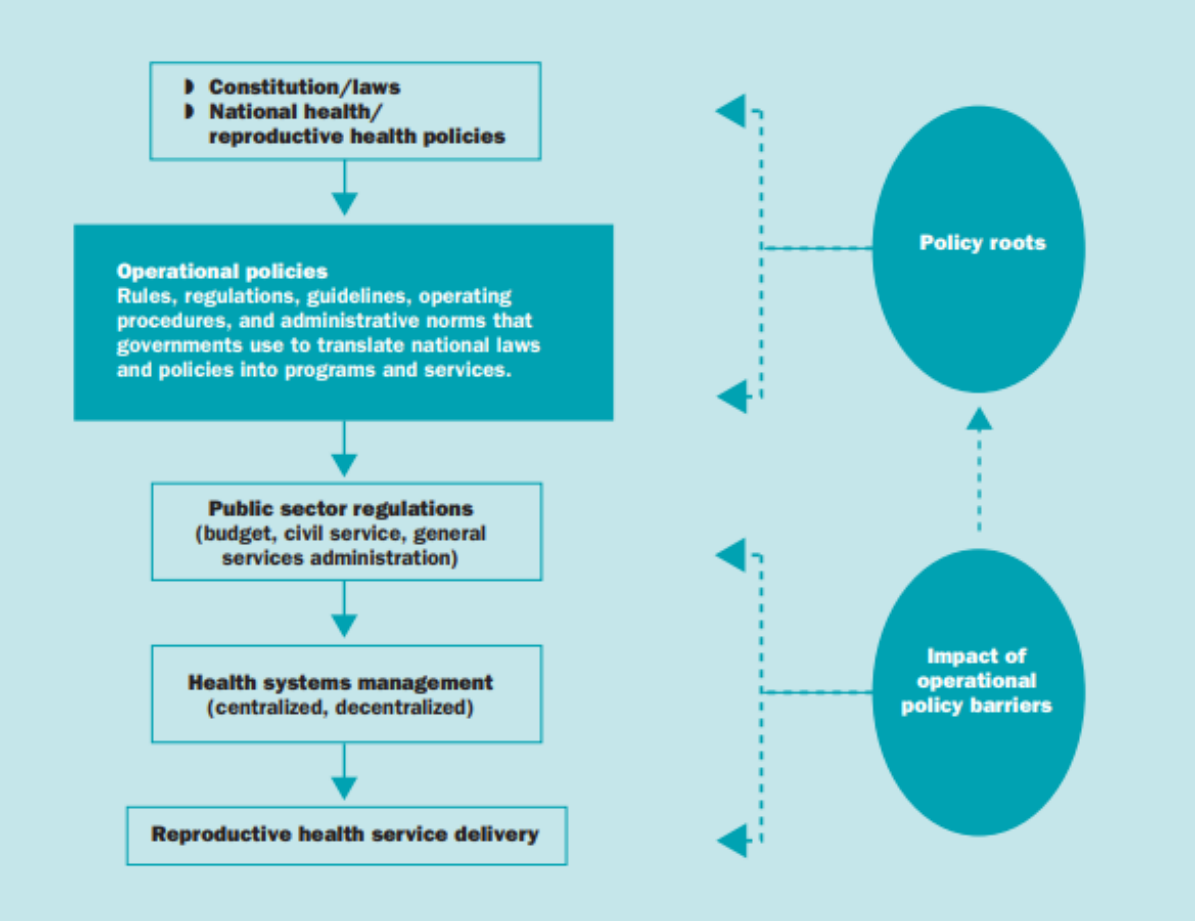
3.4.3 The Family Planning policy development process

The FP policy development process requires several logical steps, starting with its design (which should integrate a right-based approach and consider the characteristics of high impact policy and programmes), and continuing with its implementation, financing, monitoring and evaluation and potential adaptations to the changing environment (currently, the COVID pandemic).

i) Designing effective Family Planning policies

Successful national FP policies are collaboratively developed, implemented and monitored via coordinating mechanisms with representation from a range of multidisciplinary stakeholders (including inter-ministerial officials, NGOs, academics and religious and civil society groups) and are translated into programmes that achieve national level SRH goals. The goals might include reducing maternal mortality or the incidence of HIV/AIDS, or the expansion of access to FP services. Translating national policies to programmes requires the design and implementation of operational policy support systems for delivering services (**Figure 5** and **Table 3**) as well as continuous. [61]

Figure 5 Conceptual framework for FP policies [62]



[61] Cross, H. Hardee, K & Jewell, N (2001) Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs.

[62] Extracted from Cross, H. Hardee, K & Jewell, N (2001) Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs.

Table 3 High Impact Practices Framework for Family Planning policies policy and programming [63]

Policy level	Relevance to family planning programmes
Legal and Regulatory Framework Policy should • protect individual reproductive rights, and they represent political commitment to develop systems that support these rights. • codify and articulate the commitment of countries to respect, protect, and fulfil reproductive rights • set standards for FP financing and for regulation of contraceptive quality and of private-sector providers of FP services.	
Constitution	Overarching legal authority for laws and policies and for guarantees related to right to health, human rights, equity
Laws	Established to protect individuals from outside aggression or harm, to set rules needed for a society to live and work together, to protect the fabric of society as agreed upon by the voice of the people or their representatives, to ensure that justice has been served, and to maintain social order
Financial framework	Size of the total government health budget sets the overall limit on what a government can spend
Regulation of contraceptives	Quality assurance of contraceptives; facilitate import of contraceptives and supplies
Regulation of the private sector	Extent and quality of health services available through the private sector
Macro-Level Sectoral Policy Policies guide the scaling up of evidence-based innovations by integrating new practices into health programmes and services. Addressing the policy dimensions that underlie health systems and services lead to successful scaling up of promising pilot projects and sustaining of health interventions.	
National policies and strategies	Articulate a country's FP goals and priorities, set minimum standards of quality, outline roles and responsibilities, facilitate coordination, guide resource mobilisation, and determine timelines for programme rollout
Decentralisation	Local authorities have political and budgetary autonomy to make certain health service decisions
Operational Level Policy (Plan of Action) National FP clinical guidelines should be regularly reviewed to reflect international standards (WHO's Medical Eligibility Criteria for Contraceptive Use and Selected Practice Recommendations for Contraceptive Use) to promote the delivery of effective, safe, and quality of care of reproductive health services and clarify standards for provision of contraceptives by non-traditional service providers.	
Operational policies linked to the six WHO health systems building blocks [64] [65]	**Governance and Leadership:** involves ensuring strategic policy frameworks exist and are combined with effective oversight consistent with sector goals and system requirements, coalition building, regulation, attention to system-design and accountability, defines priorities for investment, clients' rights and satisfaction, new organisational policies and practices, capacity to assemble and manage resources; optimal allocation and use of limited resources.
	Service Delivery: effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources. It involves guidelines/protocols, client's satisfaction, on-time services, improved treatment and respect to clients, client's indiscrimination.
	Financing: raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial hardship or impoverishment associated with having to pay for them (out-of-pocket expenditures). It provides incentives for providers and users to be efficient It involves the health sector budget and the efficient and effective allocation and management of available financial resources based on identified priority areas within the National Policy.
	Health Workforce: responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. sufficient competent staff, fairly distributed; responsive and productive). In involves health sector regulations and professional association guidelines for task sharing, qualified staff, job satisfaction, motivation, conducive structure, appropriate and timely feedback.
	Medical Products, Vaccines and Technologies: ensures equitable access and assures quality, safety, efficacy and cost-effectiveness and their scientifically sound use. It involves contraceptive methods that programmes are permitted to provide, adequate drugs, medical supplies, medical apparatuses and equipment, up-to-date technologies for patient diagnosis, new organizational practices and policies, networking with the external environment
	Health Information Systems: ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. It involves programme requirements for reporting, monitoring, and evaluation, up-to-date and appropriate guidelines and protocols, appropriate internet access, easy and time-efficient reporting system.

[63] Adapted from FP High Impact Practices (2020) Policy: Building the foundation for systems, services, and supplies
[64] WHO (2007) Strengthening the Health Systems to Improve Health Outcomes: WHO's framework for Action
[65] The six building blocks of WHO's Health Systems Strengthening (HSS) conceptual framework are: 1) governance and leadership; 2) Health Management Information System (HMIS); 3) Human Resources for Health (HRH); 4) service delivery; 5) essential medicines; and 6) financing.

a) Characteristics of high impact Family Planning policies and programmes

Family planning is emerging more prominently in national plans for integrating HIV and SRH and reproductive rights and is increasingly being incorporated into national development plans. However, the extent and scope is limited and varies.[66] Several reviews of FP policies and programmes have been conducted and results are summarised in Error! Reference source not found.. The FP2020 website provides resources to support countries as they strive to strengthen their FP policies and programmes, including a series of High Impact Practices (HIPs) in FP. (Error! Reference source not found.).

Table 4 Summary findings from reviews assessing Family Planning policies and programmes

Study type	Findings
Family planning policies	
A review of 23 case studies of earlier (1950-80) FP programmes[67] from a wide variety of social and economic environments	• There is marked consistency of features improving SRH programme effectiveness for young people despite the wide variation in interventions reviewed. • Strong FP policies with broad popular consensus and consistent programme leadership led to rapid success in contraceptive adoption, with better results found in countries with higher levels of education, higher status of women, and modern transport and communications systems. • Countries where the FP programmes worked outside the Ministry of Health network had little access to facilities, personnel, or research and evaluation resources.
Family planning programmes	
2008 survey of key elements of successful FP programmes identified by 500 FP experts from 98 countries based on experiences, best practices & evidence-based guidance. [68]	• The 10 elements of FP programme success include: 1. Supportive Policies, 2. Evidence-Based Programming 3. Leadership and Management 4. Effective Communication 5. Contraceptive Security 6. Trained Staff 7. Client-Centered Care 8. Easy Access 9. Affordable Services 10. Integrated Services • *Elements of Success in Family Planning Programming* also includes a useful checklist called "Assessing the Elements of Success in Your Programme."
Dramatic increases in contraceptive use in Ethiopia, Malawi, and Rwanda [69] were underpinned by the factors listed on the right.	• Significant political commitment and policy changes beyond the health sector • FP was explicitly recognised as a key contributing factor to national priorities of gender, youth, women's empowerment, rural development, and improved education. • Programmes benefited from champions and collaboration with domestic and international partners. • Ministries of Health led FP Technical Working Groups as collaborative forums with key partners. • Innovative policies on task sharing expanded contraceptive choice at the community level, and public-private partnerships played were key in the success of Ethiopia and Rwanda's FP programmes.
A 2011 systematic review of 63 rigorous evaluations of FP interventions (1995-2008) [70]	• Programmes using approaches to reaching women and couples with FP products and services, providing quality information and service delivery, addressing cultural norms and barriers to contraceptive use, and seeking community support are generally successful in increasing knowledge, attitudes, beliefs, and discussions around FP as well as increasing contraceptive use (particularly development and supply-side interventions). This review provided the following recommendations: • consider the differential impacts of programmes across population subgroups, particularly those most in need of services, such as high-risk subgroups, migrants, and the urban poor. Information on the actual beneficiaries of interventions would support policy that targets scarce resources to those most in need. • understand the cultural backgrounds of the various populations that are being studied, which helps in explaining the different results in unmet need and where these distinct populations are in terms of acceptance and intentions to use FP methods, as well as looking at the socio-demographic characteristics of beneficiaries. • Incorporates M&E activities as part of interventions planning to refine programmes and share lessons learned widely. Rigorous impact evaluations can attribute programme activities to changes in outcomes of interest, which increase accountability, improve programme decision making, and improve maternal and infant health.
A 2009 systematic literature review identifying best practices in FP. [71]	• Most of the literature focused on individual elements of FP programmes, with service delivery models (particularly for clinical services) being the most common. Very few documents addressed FP programmes in their entirety, from a conceptual and holistic perspective.

[66] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

[67] Robinson, W. and Ross, J. (2007) The Global Family Planning Revolution. The World Bank

[68] Richey, C & Salem, R. (2008) Elements of Success in Family Planning Programming

[69] USAID (2013) High Impact Practices in Family Planning (HIP). Family planning policy: Building the foundation for systems, services, and supplies.

[70] Mwaikambo L, Speizer IS, Schurmann A, et al (2011) What works in family planning interventions: A systematic review of the evidence. Stud Fam Plann 42:67–82

[71] EngenderHealth (2011) The Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming. New York.

Table 5 Family Planning Goals: Intervention Definitions and High Impact Practices (HIPs) [72]

Intervention	Sub-Interventions	Definition	Link to HIPs
Public Sector Facilities	n/a	Increase access to a full range of methods within the public sector [by type of facility] and/or increase the number of public sector facilities proving FP services	
Community Health Workers (CHW)	CHW provision of pills and condoms	Provision of FP by lay health workers (CBDs, CHWs) in a community (rather than healthcare facility) setting, limited to pills and condoms (note: must provide FP methods to qualify as CHW)	Proven HIP
	CHW provision of pills, condoms & injectables	Provision of FP by lay health workers (CBDs, CHWs) in a community (rather than healthcare facility) setting; provision includes at least pills, condoms and injectables	
Mobile Outreach	n/a	Provision of a wide range of contraceptives, including long-acting reversible and permanent methods, through Mobile Outreach services	Proven HIP
Social Franchising	n/a	Organization of private providers into branded, quality-assured networks to increase access to provider-dependent contraceptive methods and related services	Promising HIP
Family Planning Vouchers	n/a	Distribution of vouchers for free or subsidized FP services, generally in the interest of providing access to FP for low-income or other underserved populations (e.g., youth)	Emerging HIP
Pharmacies/drug shops	n/a	Provision of contraception through drug shops and pharmacies	Promising HIP
Reduce Stock-outs	n/a	Includes a range of potential interventions to address country specific reasons for stock outs	Enabling Environment HIP
Post-Abortion Family Planning (PAFP)	PAFP Integration	Integration of FP counseling and provision with abortion services or post-abortion care	Proven HIP
Postpartum Family Planning (PPFP)	Facility-Based Integration of PPFP into Antenatal (ANC) and/or Delivery Care	Provision of PPFP counseling during antenatal care in facilities, and/or provision of PPFP counseling and services at the same time and location as facility delivery	Proven HIP
	Facility-Based Integration of PPFP with Postpartum Care	Provision of PPFP counseling and services in a facility during postpartum care (post- delivery)	
	Community-Based/SBC PPFP Promotion	Promotion and provision of PPFP counseling, and sometimes services, outside of facility, generally through community health workers (CHWs)	
	Integration of PPFP with Childhood Immunization services	Provision of FP counseling and services at the same time and location where childhood immunizations are provided	Promising HIP
Youth-Focused Programming	Curriculum-based Sexual and Reproductive Health (SRH) Education	Educational programming for youth focused on improving knowledge, attitudes, and behavior around sexual and reproductive health, including contraceptive use.	HIP Enhancement on Adolescent Friendly Services Adolescents Strategic Planning Guide
	Multi-Component Youth Programming	A combination of demand-side and access-side interventions designed to improve social norms around youth contraceptive use and increase youth knowledge of and access to FP services	
	Multi-Component Youth Programming with Youth-Friendly Service (YFS) Provision	A combination of demand-side and access-side interventions designed to improve social norms around youth contraceptive use and increase youth knowledge of and access to FP services, specifically accompanied by the provision of Youth-Friendly FP service provision	
Social Behavior Change Programming	Comprehensive Community Engagement (CCE)	Promotion of FP (and related topics, e.g., healthy birth spacing) through community engagement and events	Promising HIP
	Community-Based Interpersonal Communication (IPC)	Promotion of FP (and related topics, e.g., healthy birth spacing) through individual or group conversations	
	Mass Media Campaigns	Promotion of FP (and related topics, e.g., healthy birth spacing) through mass media channels including TV, radio, and print materials	Proven HIP

[72] Extracted from: Track20 (2019) FP Goals: Intervention Definitions and Link to FP High Impact Practices (HIPs). Follow the hyperlink for access the HIPs.

b) Integrating a rights-based approach into Family Planning policy and programmes

The 2012 London Summit on Family Planning led to the development of the Family Planning 2020 (FP2020) global movement supporting individuals' sexual and reproductive rights. FP2020 identifies several rights and empowerment principles endorsed by the international community which should guide FP policy and programming to address the reproductive health needs of men and women (**Table 4**). Their consideration should ensure individuals' fundamental right to control their health and body, including sexual and reproductive freedom to decide whether, when, and how many children to have.

Ensuring human rights principles within FP policies is critical for sustainable, equitable and effective FP programmes that result in fewer unintended pregnancies, fewer women and girls dying in pregnancy and childbirth, including from unsafe abortions, and fewer infant deaths. Progressing this agenda requires establishing partnerships across governments, civil society, the private sector and beneficiaries. Key to integrating a rights-based approach into FP policy and programmes is to ensure clients understand and claim their rights and governments address rights violations.[73] The data collection process should capture indicators that reflect the strength of the country's adherence to a rights-based approach to FP (refer to the *Proposed Indicators to Measure Adherence to and Effects of Rights-Based Family Planning*, [74] to assess areas of strength and weakness in a country's FP program).

[73] FP2020 Family Planning 2020: Rights And Empowerment Principles For Family Planning

[74] Wright K. and Hardee K. (2015) Proposed Indicators to Measure Adherence to and Effects of Rights-Based Family Planning Resource Guide

Table 6 Rights and empowerment principles for Family Planning policy and programming[75]

Rights & Principles	Description	Policy & Programming	Measurement	Markets
Transparency and Accountability	Scientifically correct information about contraceptive services should be widely available. These include government data and avenue to redress any issues related to contraceptives.	FP strategy has accountability mechanisms measuring and evaluating contraceptive information, services and supplies with inputs from all stakeholders	Data on awareness, accessibility, availability and quality of contraceptive services.	Accountability and redress mechanism should be created including in private sectors. Data should be used to improve the services.
Voice and Participation	Stakeholders should participate in all steps of contraceptive services. Individuals, particularly beneficiaries, can meaningfully participate in the design, provision, implementation, and evaluation of contraceptive services, programmes and policies.	Ensure meaningful participation of diverse stakeholders (women, adolescents, poor, vulnerable) in policy formulation and design, delivery and oversight of programmes.		Accountability measures for manufacturers and distributors of contraceptives should be identified. They should include the diverse perspectives of the consumers,
Agency and Autonomy	Individuals should have the freedom to decide their contraceptive methods and spacing of their children without any force of coercion and violence.	National FP plans and programmes ensuring access & use of contraceptive methods by eliminating: 1. third-party approval (spousal or parental consent); 2. structural barriers (based on age, ethnicity, marital status) preventing access to contraceptives.	Develop measures on self-determination, and women's awareness & ability to access & use FP. Capture the structural norms and attitudes regarding contraceptives from service providers and the community.	
Availability	Health care services including trained providers should be available for accessing and removing contraceptives.			
Accessibility	Health care services including trained providers should provide access to contraceptives without any discrimination.			
Acceptability	Health care services including trained providers should be respectful of contraceptive choice made and be sensitive to gender and life cycle requirements while maintaining confidentially.	Minimise provider bias (e.g. denial of services or promotion of specific methods to certain subgroups or communities) so that individual choices for contraceptives are respected.	Data gathered to understand issues surrounding accessibility and availability, particularly for vulnerable populations (women, adolescents, ethnic minorities).	Contraceptives should be available at all levels and for all diverse populations, including hard-to-reach and marginalised women and girls
Quality	High quality of contraceptives anchored in empirical evidence should be made available.	Ensuring continuous quality improvement by providing training and tools for delivery of quality counselling.	Capture quality from the provider/facility and client perspectives	Contraceptives should meet the highest standards in quality.
Empowerment	Individuals must be empowered to make decisions about their reproductive rights by having access to the right information, services and items.	National policy that should advocate for empowering individuals to make their own reproductive decisions (e.g. comprehensive sexuality education, girls' education).	Capture changing perceptions of and barriers to women's and girls' ability to access contraceptive services	Marketing strategies should promote awareness about women's and girls' rights to contraception.
Equity and non-discrimination	Individuals should not face discrimination, coercion or violence for accessing contraceptive methods.	Eliminate policies preventing access to contraceptive methods based on age, location, language, ethnicity, disability, HIV status, sexual orientation, marital status or wealth.	Stratified data based on wealth, age, marital status, location and parity to identify and prevent discriminations.	Promote equitable access to contraceptive including ensuring affordable prices for all population segments.
Informed choice	Individuals have access to accurate and clear information about contraceptive methods to make informed decision for contraceptive use.	Programmes prioritise access to information and service provision about the full range of contraceptive methods.	Capture data on indicators of informed choice about a range of contraceptive methods & access to and ability to choose	Keep innovating contraceptives to cover all forms of contraceptive categories including spacing.

[75] Extracted from FP2020 Family Planning 2020: Rights And Empowerment Principles For Family Planning

iii) Financing Family Planning policy and programmes

Domestic public financing is one of several HIPs identified by the Technical Advisory Group (TAG) to the HIP Partnership [76] based on the evidence of what works to support countries in achieving high-quality, voluntary, equitable, and sustainable FP. The TAG comprises FP research experts, policymakers, programme implementers and representatives from donor agencies. [77]

Public investment in FP is value for money. Governments could reduce maternal and newborn health care costs by USD 2.20 for each additional dollar spent on contraceptive services in developing countries.[78]

The success and sustainability of voluntary FP programmes rely on a robust national capacity to implement and manage programmes and mobilise and spend the necessary financial resources for FP commodities, service delivery, demand creation and training.

Countries can increase the value of public expenditure by improving:

- **Budget allocation:** securing sufficient resources in national and sub-national budgets to purchase FP commodities and supplies, service delivery, social and behaviour change activities, and other core components of the FP programme;
- **Budget execution:** ensuring the approved budget is entirely spent in line with stated priorities and within appropriate timelines; and
- **Ensuring efficiency:** using available resources in the most cost-effective way to maximise their impact.

A high impact national FP policy should be accompanied by a Costed Implementation Plan (CIP) – a management tool crucial for governments to determine the financing gaps and mobilising internal resources to address them (**Box 4**).

[76] FP2020 (2020) HIPs on Domestic Public Financing and Supply Chain Management
[77] Family Planning High Impact Practices (2020) https://www.fphighimpactpractices.org/high-impact-practices-in-family-planning-list/
[78] Guttmacher Institute (2017) Adding it up: investing in contraception and maternal and newborn health.

Box 3: Costed Implementation Plans (CIPs) for Family Planning

Countries must be strategic and efficient in investing limited resources to meet the growing demand for FP. The FP CIP is a multi-year actionable roadmap designed under the FP2020 initiative to support governments in transforming FP commitments into concrete programmes and policies by prioritising appropriate interventions, allocating limited resources, unifying stakeholders around one plan, and supporting monitoring and accountability. [a]

CIPs are increasingly used by countries (including Egypt and Bangladesh) and might involve inter-ministerial co-funding arrangements to ensure that policies and programmes are fully funded and successfully implemented. A comprehensive CIP estimates the cost of the resources required for the life of the policy across strategic areas of a FP programme: enabling policy environment (e.g. service providers' capacity building and advocacy); demand creation; service delivery and access; contraceptive logistics and security; financial management, and monitoring and evaluation for accountability. By engaging in the CIP strategic planning process, governments can prioritise FP interventions, detail key activities and outline a roadmap for implementation, estimate the impacts of interventions, forecast costs and make strategic allocation decisions, and mobilise resources to address financial gaps.[b] The steps for developing a CIP are listed below:[c]

1. **Identify the Approach and Purpose of the Plan**: stakeholders build on the national context, identify the process they will follow, and agree on the purpose of the plan.
2. **Determine Focus Areas** conducting a situation analysis and developing projections for the contraceptive prevalence rate goals to lead the key focus areas for the CIP.
3. **Develop Priority Activities and Set Targets**: developing priorities and setting targets to accomplish the goals in each focus area form the basis for the commodities and the human and health system resources needed in the CIP.
4. **Generate Cost Estimates for the Plan**: the costing estimates require detailed descriptions of activities so that the type and magnitude of resources required to support each activity can be determined.
5. **Implement the Plan and Monitor Progress**: while implementation utilises existing structures, monitoring involves developing indicators and a data collection and analysis process to assess progress in resource mobilization, activities, and results.

The Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans provides systematic and practical guidance for articulating the FP goal, results, strategic priorities, and implementation plan at the national, regional or state level. The process, informed by Technical Support Teams in 30 countries that developed CIPs, is highly participatory, involving a range of stakeholders and technical experts. The time to develop a technical strategy can range from 6 to 12 months, depending on the country context (size and diversity) and scope of the CIP (national or subnational). The composition, roles, and responsibilities of different teams and individuals are described in the Team Roles and Responsibilities for CIP Development and Execution document.

Sources:

[a] USAID and Partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh

[b] FP2020 Costed Implementation Plan Resource Kit: Tools And Guidance To Develop And Execute Multi-year Family Planning Plans

[c] FHI 360 Costed Implementation Plans Guidance and Lessons Learned Costed Implementation Plans: Guidance and Lessons Learned

[d] UNFPA, FP2020, USAID (2018) Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans

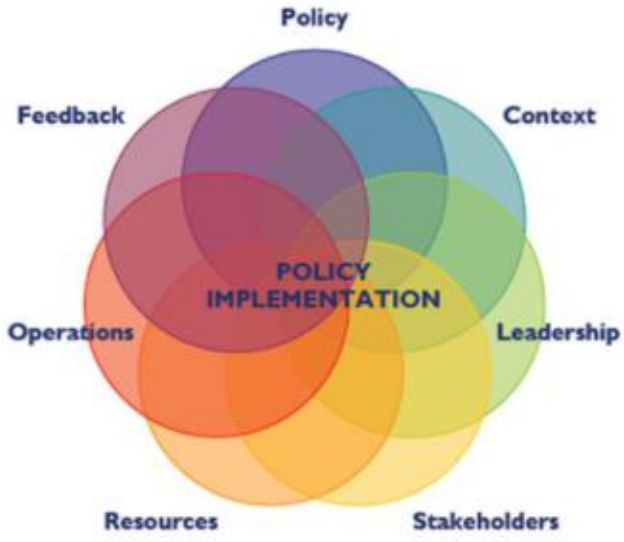
iv) Implementing effective Family Planning policies

USAID notes that policy implementation refers to the mechanisms, resources and relationships that link policy to action. Policy implementation does encounter challenges. USAID developed an implementation assessment tool to assist governments and civil society in monitoring their country's policies. The USAID *Policy Implementation Assessment Tool* [79] identifies seven dimensions that influence policy implementation (**Figure 6**):

1. the policy, its formulation and dissemination
2. the socioeconomic and political context
3. policy implementation leadership
4. stakeholder involvement in policy implementation
5. planning and resource mobilisation
6. operations and services, and
7. feedback on progress and results.

Policy implementation may require creating an implementation plan, guidelines for providing a service, and a budget or a budget line item to finance implementation. The budget line item is required to ensure the policy is implemented as intended by policymakers and that resources (financial, human and material) are available to accomplish the policy objective(s).

Figure 6 Assessing policy implementation[80]



[79] USAID (2010) Taking the Pulse of Policy: The Policy Implementation Assessment Tool

[80] Bhuyan, A., A. Jorgensen, and S. Sharma. 2010. Taking the Pulse of Policy: The Policy Implementation Assessment Tool. Washington, DC: Futures Group, Health Policy Initiative.

v) Monitoring and Evaluating Family Planning policies and programmes

During the 1990s, the international SRH conferences of ICPD and the *Fourth Women's Conference* in Beijing endorsed several global SRH goals and targets. WHO led an interagency technical process to reach consensus among international agencies on a short list of 17 key indicators for national and global monitoring, international comparison, and follow-up to the SRH conferences (**Box 3**). The data collected for reporting the indicators should be useful at the programme management level. [81]

Box 4 WHO's short list of reproductive health indicators for global monitoring

1. **Total Fertility Rate** (TFR): Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life
2. **Contraceptive Prevalence Rate** (CPR): Percent of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method at a particular point in time. The expert group working recommends basing the calculation of contraceptive prevalence on all women of reproductive age, in contrast to the convention used by the DHS and RHS to report it for married women only (or married and unmarried women separately).
3. **Maternal Mortality Ratio** (MMR): Annual number of maternal deaths per 100,000 live births
4. **Antenatal Care Coverage**: Percent of women attended at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants), for reasons relating to pregnancy
5. **Percent of Births Attended by Skilled Health Personnel** (excluding trained or untrained traditional birth attendants)
6. **Availability of Basic Essential Obstetric Care**: Number of facilities with functioning basic essential obstetric care per 500,000 population
7. **Availability of Comprehensive Essential Obstetric Care**: Number of facilities with functioning comprehensive essential obstetric care per 500,000 population
8. **Perinatal Mortality Rate** (PMR): Number of perinatal deaths per 1,000 total births
9. **Low Birth Weight Prevalence:** Percent of live births that weigh less than 2,500g
10. **Positive Syphilis Serology Prevalence in Pregnant Women**: % of pregnant women (15-24) attending antenatal clinics, whose blood has been screened for syphilis, with positive serology for syphilis
11. **Prevalence of Anemia in Women**: Percent of women of reproductive age (15-49) screened for hemoglobin levels with levels 110g/l for pregnant women, and 120g/l for non-pregnant women
12. **Percent of Obstetric and Gynecological Admissions Owing to Abortion**: Percent of all cases admitted to service delivery points providing in-patient obstetric and gynecological services, which are due to abortion (spontaneous and induced, but excluding planned termination of pregnancy)
13. **Reported Prevalence of Women with FGC**: %of women interviewed in a community survey reporting having undergone FGC
14. **Prevalence of Infertility in Women**: % of women of reproductive age (15-49) at risk of pregnancy (not pregnant, sexually active, non-contracepting, and non-lactating) who report trying for a pregnancy for two years or more
15. **Reported Incidence of Urethritis in Men**: % of men aged (15-49) interviewed in a community survey reporting episode of urethritis in the last 12 months
16. **HIV Prevalence among Pregnant Women**: %of pregnant women (15-24) attending antenatal clinics, whose blood has been screened for HIV and who are sero-positive for HIV
17. **Knowledge of HIV-related Prevention Practices**: % of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention

Data Source(s): The DHS or other representative surveys of the intended population can provide certain indicators (1, 2, 4, 5, 8, 11, 13, 14, 15, and 17). Other indicators (6, 7, 10, 12 and 16) require programme-level data: service statistics, facility-based services, or laboratory results on clients. Whereas data are generally available for indicators based on the DHS or RHS, data may be difficult to obtain for certain measures (e.g., percentage of OB-GYN admissions owing to abortion). This set of indicators is not meant to serve as an index; rather, it draws attention to the key measurable areas of RH.

Source: Measure Evaluation (2020) WHO's short list of reproductive health indicators for global monitoring

vi) Adapting the Family Planning policy to the changing environment

COVID-19 is a disruptive phase for essential health services. Its significant impact on FP services is outlined in **Box 5**. Each country's response will vary depending on how the pandemic unfolds and what choices women make about their continued contraceptive use. Using service delivery models that bring services closer to women and girls will be important in light of mobility restrictions. It is critical to review procurement plans and programmes developed before physical distancing to identify any mismatch with current reality and explore ways to meet current needs to minimise the potentially devastating consequences of COVID-19 on women and girls worldwide. Policymakers will need to consider country realities and explore service delivery adaptations to meet these changing needs. Existing data can quantify the potential shift in contraceptive use to help inform decisions. Donors, policymakers, and programme planners may need to revisit supply plans and the use of financing to ensure that contraception is available. An Excel-based tool has been developed for countries to model the Impact of COVID19 on Reproductive Health Options (MICRO) and quantify potential shifts in contraceptive needs that could result from service disruptions and mitigation strategies. [82]

Box 5 COVID-19 Impact on family planning and required adaptations to secure related information and services

The impact of COVID-19 on unmet need for FP is significant. COVID-19 is causing disruptions in meeting the following FP needs:

- Clinical staff occupied with the COVID-19 response may not have time to provide services, or may lack personal protective equipment to provide services safely
- Health facilities in many places are closing or limiting services
- Women are refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions
- Supply chain disruptions are limiting availability of contraceptives in many places, and stock-outs of many contraceptive methods are anticipated within the next 6 months in more than a dozen lowest income countries
- Product shortages and lack of access to trained providers or clinics mean that women may be unable to use their preferred method of contraception, may instead use a less effective short-term method, or may discontinue contraceptive use entirely

In addition, it is estimated that:

- Some 47 million women in 114 low- and middle-income countries are projected to be unable to use modern contraceptives if the average lockdown, or COVID-19-related disruption, continues for 6 months with major disruptions to services
- For every 3 months the lockdown continues, assuming high levels of disruption, up to 2 million additional women may be unable to use modern contraceptives
- If the lockdown continues for 6 months and there are major service disruptions due to COVID-19, an additional 7 million unintended pregnancies are expected to occur
- The number of unintended pregnancies will increase as the lockdown continues and services disruptions are extended

Source: UNFPA (2020) Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage

[81] Measure Evaluation (2020) WHO's short list of reproductive health indicators for global monitoring

[82] Source: Weinberger, M. Hayes, B. White, J. & Skibiak, J. (2020) Doing Things Differently: What It Would Take to Ensure Continued Access to Contraception During COVID-19 Global Health: Science and Practice

4. FINDINGS

This section presents the findings from the literature review across selected countries, covering the Islamic perspective on FP, the contextual differences regarding population and development trends and SRH indicators (with a focus on Malaysia) and the varies FP policy environments and their impact on FP services. A final comparison of FP policies, programme and indicators is also provided using the Family Planning Effort Index (FPE) and the National Composite Index on Family Planning (NCIFP), extracted from the Track20 website. [83]

4.1 The Islamic perspective of Family Planning

Most Islamic countries endorsed the ICPD PoA [84] to enable individuals and couples to choose the number and timing of their children. They also endorsed the SRH related SDGs,[85] albeit with reservations in implementing the recommendations within Islamic Law. The ICPD PoA and other agreements state that individual countries have the sovereign right to contextualise policies and programmes to conform to customary laws, values, and cultures. Still, interventions should uphold individual rights and respond to the complex needs of adolescents and adults. [86]

Modern contraceptives, the restructuring of FP programmes and the international agreements on birth spacing have all progressed FP globally. However, a 2013 review of FP across Islamic countries, including Malaysia, Turkey, Morocco, Egypt and Bangladesh,[87] noted significant social and economic reasons to focus on FP in Muslim countries. Religion remains a central issue regarding FP and contraception despite efforts from FP and birth spacing programmes and NGO advocacy. Most Islamic scholars consider FP practices permissible, as neither the Quran nor the Prophet's (pbuh) tradition (Sunnah) prohibit birth control, spacing pregnancies, or limiting the number of children for couples. Rather, Islam is considerate of FP as spacing pregnancies and reducing pregnancies increases the mothers' physical fitness and reduces the family's economic burden. Religious scholars who view FP as an external western conspiracy aimed at restricting the Islamic world's growth and strength appear uninformed of the historical permissibility of contraception within Islam. They also appear to be unaware of the socio-political and demographic realities in many overpopulated Muslim countries with poor maternal and child health indicators (Egypt, Bangladesh, Pakistan and Indonesia) and high fertility rates, putting pressure on the limited resources and slowing the pace of overall development. The 2013 review concluded that **governments should collaborate with key stakeholders in addressing gaps for advocacy with religious scholars to support FP and birth spacing and improve infant and maternal health**.

The Islamic laws regarding abortion make its legalisation a particularly controversial topic. Islam generally considers abortion to be wrong due to the sanctity of life valued in the Quran. The holy text notes that it is not permissible to abort a child because the parents fear they will be unable to provide

[83] Family Planning 2020 Track20 website
[84] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[85] UN General Assembly (2015) Transforming Our World: The 2030 Agenda for Sustainable Development
[86] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[87] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

for him or her. However, since *Sharia law* encourages Muslims to choose the lesser of two evils, most scholars agree that abortion is permissible if the pregnancy would endanger the mother's life. [88]

4.1.1 Religious context across selected countries and their impact on Family Planning

A 2013 review of FP across Islamic countries [89] provides insights into the religious context across Malaysia, Turkey, Egypt, Morocco and Bangladesh (**Table 7**)

Table 7 Religious context across selected countries[90]

Country	Religious context
Malaysia	Malaysia had policies for balanced, equitable, and sustainable development prior to the ICPD. Reproductive health services, including FP, are integrated with the public and private health care system. The Malaysian Government engages in regular consultations on programme design and implementation with a range of stakeholders, including advocacy groups, the private sector, and community groups, including the clergy. However, the *2019 Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) review [91] noted that Malaysian women still experience availability, accessibility and affordability barriers to high quality services. The services are often provided from a religious perspective, rather than a right-based SRH approach, particularly abortion. The approach is disproportionally affecting vulnerable women and girls (unmarried youth, refugees, indigenous, migrants, transgender and prisoners).
Turkey	The integration of religious leaders in reproductive health programmes and education on FP issues was prioritised to attain desirable fertility rates. Family impositions and religious barriers had been important reasons for the non-use of contraception in Turkey. FP programmes' effectiveness was maximised with the involvement of husbands and religious and other influential leaders in the community. Increases in educational and sociocultural levels and the removal of religion-related misinterpretations have led to a significant decline in the number of pregnancies, number of children, and abortions over time.
Egypt	The country's most authoritative interpreter of Islamic law (the Grand Mufti) issued a religious decree in the mid-1930s permitting contraception, thus allowing birth control clinics in Egyptian cities. He declared that the earliest followers of the Prophet (pbuh) practiced contraception with the knowledge of the Prophet, who did not forbid it. In 1964, Sheikh Hasan Ma'mun encouraged contraception based on the changing needs of the Muslim people. Since 1980, religious leaders have played a significant role in the State Information Service's public education efforts by speaking out on the acceptability of birth control in the eyes of Islam. In the 1990s, the National Population Commission made population issues part of the educational curriculum, including the religious educational curriculum.
Morocco	Women's low use of contraceptives was attributed to religious extremists' barriers who misinterpret Islam regarding FP. However, the working-class community's economic conditions could not be ignored when looking at the complex decision-making process of reproductive health practices. Clergymen were engaged in the national programme to help achieve desired results.
Bangladesh	Husbands' disapproval of FP is still a deterrent to women's regulation of fertility. This phenomenon highlighted the structural influences that explain fertility regulation behaviour. Myths, false beliefs, and rumours about the use of oral contraceptive pills are prevalent in Bangladesh. A lack of consultation with qualified FP workers and the influence of religious norms and folk stories are still key hindrances in the uptake of oral contraceptive use. However, Bangladesh's government has actively engaged Islamic scholars to advocate for maternal and child health, including FP.

[88] Word News (2020) Morocco Liberalizes Abortion Laws, Amends Penal Code

[89] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

[90] Extracted from Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

[91] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.

Malaysian Laws provide an exception to the prohibition of abortion in section 312 of the *Penal Code 1936*.[92] The exception is that a medical practitioner can legally perform abortions if they consider that the pregnancy's continuation would pose a greater risk to the woman's physical and/or psychological health than termination of the pregnancy. Under Syariah Law (Fatwa issued by the *26th Muzakarah of the National Fatwa Committee 1990*), abortion is allowed if the fetus is under 120 days of gestation and the mother's life is under threat or if the fetus is abnormal. Girls under 18 years require parental consent.[93] Countries with restrictive abortion laws tend to manage unwanted pregnancies via primary and tertiary prevention only. Primary prevention is the provision of contraceptives, which may fail and which may not be universally available. Tertiary prevention is concerned with managing the complications of unsafe abortions and other post-abortion care. Secondary prevention, the provision of safe abortion services, is generally not available. Malaysia provides all three levels of prevention. The MoH released the *Guidelines for Termination of Pregnancy* in 2012, which set out the standards for safe abortion services. [94]

In Turkey, the *Population Planning Law 1983* legalises abortion up to 10 weeks' gestation. [95] However, there is political opposition to abortion, resulting in a lack of safe abortion services. In 2012, the government unsuccessfully proposed restricting access to safe abortion services. Nevertheless, women have reported difficulty accessing abortion services across Turkey since 2012. [96] Public health institutions provide only 20% of abortions and more than half in private practices or private hospitals.[97]

Morocco's Penal code was amended to legalise abortion in cases of incest, rape and fetal malformation, and maternal health risks.[98] The Egyptian Penal Code of 1937 (sections 260-264) prohibits abortion under all circumstances.

However, given the stigma associated with abortion, particularly in Muslim countries, many unmarried girls and young women may terminate their pregnancies illegally, underestimating abortion rates where they are collected and reported.

4.1.2 Women's need for Family Planning

UNFPA conducted a review of women's need for FP in Arab countries[99] (including Morocco and Egypt) using national surveys of married women conducted by the Pan Arab Project for Family Health (PAPFAM) and the Demographic and Health Surveys (DHS). The review noted that the expansion of FP services in the Arab region has led to an increase in women's contraceptive use. Nevertheless, a significant proportion of women have *unmet need* for FP risking unintended pregnancies and reduced birth spacing. Decreasing the unmet need helps governments enhance individual rights, slow population

[92] Laws of Malaysia, *Penal Code Act* 1936, revised by *Penal Code 574, amended by Penal Code 1989 Penal Code Amendment A1471 2014*, s312 http://www.agc.gov.my/agcportal/uploads/files/Publications/LOM/EN/Penal%20Code%20%5BAct%20574%5D2.pdf.
[93] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 1-17.
[94] As advised by the MoH representative to the TWC.
[95] Turkey (1983) Law No. 2827 of 1983 Population Planning Law [Turkey], 24 May,
[96] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[97] Mihciokur S, Akin A, Dogan BG, & Ozvaris SB (2014) The unmet need for safe abortion in Turkey: a role for medical abortion and training of medical students, Reproductive Health Matters, 22:sup44, 26-35
[98] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[99] UNFPA (2012) Women's Need for Family Planning in Arab Countries

growth, and achieve their SDGs. The review noted that countries should reduce unmet need by addressing both the demand for and supply of FP services. Governments and nongovernmental organisations can help remove social and economic barriers to using FP, expand coverage of FP services, and improve the quality of information and services by implementing the UNFPA review recommendations:

- Addressing unmet need requires both political and financial commitments to expand and improve FP information and services.
- FP programme planners need to understand the size and major causes of unmet need in their particular countries
- The public and private health sectors need to collaborate to ensure that FP commodities and services are universally available and accessible to those who need them.
- Providers should be trained to give women correct information on contraceptive methods, especially on side effects and how to manage them.
- Interpersonal relations between clients and health providers are an important aspect of quality care.
- FP programmes should also reach out to broader audiences, such as religious and community leaders, and use the media to advocate for FP and responsible parenthood benefits.

4.2 Family Planning policies and services across the Islamic world

Due to unprecedented population global growth, FP and contraception have become a significant priority, particularly in Islamic countries with large populations. Some Islamic countries' maternal and child health indicators are not on track to achieving the SDGs by 2030 (**Box 6**). Therefore, it is paramount that religious leaders, scholars, think tanks and local clergymen disseminate the correct information and actively engage in advocacy for the promotion of birth spacing for the improvement of maternal and child health outcomes. Improving literacy rates through investment in girls' education is another proven strategy to improve reproductive behaviours. [100]

4.2.1 Integrating sexual and reproductive health services into primary health care

Different approaches are used to integrate SRH services at the primary health care (PHC) level, aiming to provide comprehensive services. A 2020 study assessed gaps in the delivery of SRH in PHC services in 11 Arab countries in 2017-18, identifying challenges and proposing action towards universal health coverage. [101] Desk reviews using published programme reports and national statistics were compiled from country reports to present a regional assessment, challenges and recommendations. The assessment found that SRH services are partially integrated into PHC. FP is part of PHC in all countries except Libya, where only counselling is provided. Only Morocco, Tunisia and Oman provide comprehensive HIV services at PHC level. Jordan, Libya and Saudi Arabia rely mainly on referral to other facilities. Most of the integrated FP or HIV services in Sudan, Morocco and Oman are provided within the same facilities. The regional assessment called for action at the policy, organisational, and operational levels, and prioritising services guided by essential SRH care packages. Capacitating the PHC workforce in SRH services and the adoption of the general practice model can ensure proper allocation of resources.

[100] United Nations (2000) The millennium summit. New York

[101] Kabakian-Khasholian T, Quezada-Yamamoto H, Ali A, et al (2020) Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward. Sex Reprod Health Matters 28:1773693

Box 6 WHO's review of essential elements of successful FP programmes in Islamic countries

A review of existing FP policies and programmes across 16 Islamic countries [a] was conducted by WHO in 2009 and 2015 in collaboration with national ministries of health to inform future evidence-based FP strategic policy and planning. The findings shared with all countries in a regional meeting, are summarised in the Table below.

Despite the existence of policies, infrastructure and resources, the vital FP indicators do not provide a positive picture of Islamic countries, likely due to shortcomings in the implementation of national strategies. Implementation barriers among lower middle and low-income countries include lack of infrastructure, stock shortages, lack of trained staff, and cost of contraceptive methods that lead to limited access among vulnerable groups. Islamic religious beliefs and cultural views on family size also plays a role in the acceptance and use of contraception. Despite progress in FP policies and services, selected countries still struggle with weak or nonexistent health information systems. Robust informaton systems are crucial for determining and documenting progress. Documented available best practices in FP suggest a need for close coordination and collaboration among stakeholders in scaling up these best practices, especially in priority countries, to improve maternal and child health in the region.

Table 1 Number of countries implementing FP policies and services according to WHO guidelines

Selected variables	Result in 2015	Result in 2009*
FP safety regulation at Health facility α	16/16 (100%)	16/18 (89%)
FP guidelines and protocols updated β	15/16 (94%)	13/18 (72%)
FP as basic package and delivered at Primary Health Care level	16/16 (100%)	17/18 (94%)
Mix contraceptives in essential drug list	16/16 (100%)	16/18 (89%)
FP counselling and methods in preconception care	6/16 (38%)	NA
FP counselling by nurse	14/16 (88%)	14/18 (78%)
FP effective supply chain management all over the country	13/16 (81%)	12/18 (67%)
FP pre- and in-service training programme in universities	14/15 (93%)	14/18 (78%)
Training guidelines and materials: evidence-based	14/15 (93%)	15/18 (83%)
FP special program for adolescents	8/16 (50%)	6/18 (33%)
FP special program for displaced or refugees	12/13 (92%)	9/18 (50%)
FP special program for poor/disadvantaged	10/15 (67%)	9/18 (50%)
FP promoted through Effective social marketing	10/15 (67%)	12/18 (67%)
FP promoted through community mobilization efforts	12/15 (80%)	11/18 (61%)
HMIS system collects and analyses FP data	15/16 (94%)	13/18 (72%)

**Please note the 2009 data are taken from a previous regional survey on FP (8).*
α: This refers to utilization of WHO MEC standards in prescription of contraceptives to clients.

[a] The countries included Afghanistan, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen. Six countries were excluded due to non-response: Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya and the United Arab Emirates.

Source: Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. Journal of East Mediterranean Health 25:127–133.

4.3 Contextual situation across selected countries

Socioeconomic determinants of health and human development underpin the SRH situation in any country. This section uses selected human development indicators to examine the socioeconomic status of each study country.

4.3.1 Demographic trends and human development indicators

The UN Global Human Development Indicators were used to compare the study countries (**Appendix 2**).[102] In 2018, Malaysia had the smallest population (32.7 million) across the selected Muslim countries, followed by Morocco (36.0 million), Turkey (82.3 million), Egypt (98.4 million) and Bangladesh (161.4 million). It also had the highest life expectancy (76 years). About 75% of Malaysia and Turkey's population live in cities, followed by Morocco, Egypt, and Bangladesh. Malaysia had the highest labour force participation across selected countries and the least percentage of youth (15-24 years) out of school or employment. [103]

In 2018 the TFR was highest for Egypt (3.3 births per woman), followed by Morocco (2.4 births per woman), Turkey (2.1 births per woman), and Malaysia and Bangladesh (both at 2.0 births per woman). Malaysia and Turkey had introduced contraceptive programmes, which reduced the TFR to replacement rate in 2018. Bangladesh had also introduced contraceptive programmes and had decreased the TFR to 2.0 births per woman, reflecting effective FP policy and programmes.

The population pyramids in **Table 8** depict how the population structure is changing regarding fertility rate, life expectancy, and dependency ratio projections (**Box 7**) of the selected countries. Population growth is projected to decrease across all selected countries except Egypt, which is projected to increase. Egypt has an expanding population pyramid reflecting the typical shape of developing nations with high birth rates, shorter life expectancy, young population and rapid growth. Malaysia displays the typical shape of higher development with a contracting population pyramid, declining birth rates, an aging and shrinking population, longer life expectancy, and a projected higher dependency ratio. The population strategy in Malaysia and Turkey shifted in recent years to encourage a higher fertility rate, while Egypt and Bangladesh are focused on controlling population growth (**Appendix 3**).

[102] UN Human Development Programme (2020) Global Human Development Indicators.

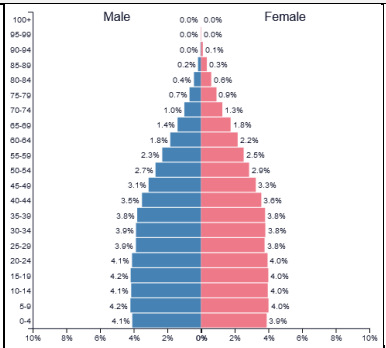
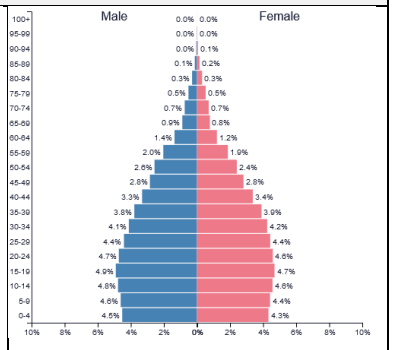
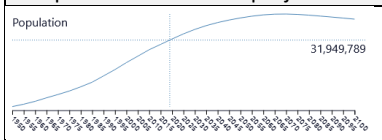
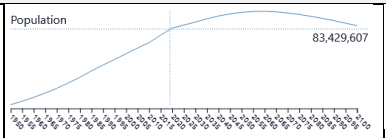
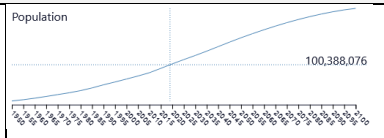
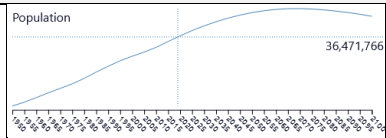
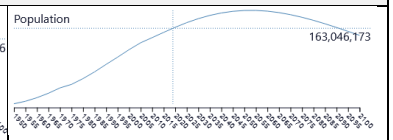
[103] The UN defines youth as those aged 15-24 years, while the Malaysian Youth Policy 2015 (Dasar Belia Malaysia) defines youth as those aged 15-30 years.

Box 7 Interpreting population pyramids and projections

A population pyramid visually displays the age-sex structure of the population which is dependent on the birth, death rates and migration. They reveal information about fertility, mortality and migration or population dynamics. The population size is shown on the x-axis (horizontal) and age-groups on y-axis (vertical), with males on depicted on the left side and females on the right may represent the total population in absolute number or as a percentage. It reveals the last 85 years of a country's or region's demographic history. It indicates the stage of demographic transition (e.g. from high to low fertility) as well as the level of development of a region/country. Its vertical extent indicates the level of life expectancy and share of juvenile, adult and old-age population or dependents and working population or dependency ratio. The broad base of the pyramid means the majority of population lies in the juvenile age group and there is higher dependency ratio of younger population on working population

Source: Saroha, J. (2018) Types and Significance of Population Pyramids, World Wide Journal of Multidisciplinary Research and Development

Table 8 2019 population pyramids and population projections across examines countries [104]

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Population pyramids (%)				
				
Contracting: declining birth rates, longer life expectancy, projected higher dependency ratio. **Negative population growth** with an ageing and shrinking population, typical shape of higher levels of development.	**Contracting:** declining birth rate, lower death rate, slow growth, consistent from age 16 below. **Zero population growth**, typical shape of higher levels of development.	**Expanding:** high birth rate, shorter life expectancy. Young and growing population, typical shape of developing nations, resulting in **rapid population growth**	**Stable:** moderate young population, shorter life expectancy resulting in **slower population growth**	**Expanding:** high birth rate, shorter life expectancy but with recent **contracting trends** attributed to antinatalist population policy, with declining birth rates, resulting in **slower population growth**
Population trends and projections				
				
Overall projected to decrease	Overall projected to decrease	Overall projected to increase	Overall projected to decrease	Overall projected to decrease

[104] Population Statistics (2020) Population Pyramid.net

The *Human Development Index* (HDI) is a summary measure for assessing long-term progress in three basic human development dimensions: a long and healthy life, access to knowledge, and a decent standard of living. Malaysia's HDI value for 2018 was 0.804, ranking 61 out of 189 countries (**Table 9**), second only to Turkey (0.806, ranked 59), followed by Egypt (0.700, ranked 116), Morocco (0.676, ranked 121) and Bangladesh (0.614, ranked 135).[105]

Malaysia has improved its human development indicators remarkably between 1990 and 2018, increasing the HDI 24.9%, from 0.644 to 0.804, the *Gross National Income* (GNI) per capita by about 167.6%, life expectancy by 5.1 years, mean years of schooling by 3.6 years and expected years of schooling by 3.7 years.[106]

Table 9 2018 Human Development Indicators for selected countries [107]

	HDI value			HDI Rank	Life expectancy			Expected years of schooling			Mean years of schooling			Gross National Income (GNI) per capita (2011 PPP USD)		
	All	F	M		All	F	M	All	F	M	All	F	M	All	F	M
Turkey	0.806	0.771	0.834	59	77.4	80.3	74.4	16.4	15.9	16.9	7.7	6.9	8.4	24,905	15,920	34,138
Malaysia	0.804	0.792	0.815	61	76	78.2	74.1	13.5	13.8	13.1	10.2	10	10.3	27,227	20,820	33,279
Egypt	0.700	0.643	0.732	116	71.8	74.2	69.6	13.1	13.1	13.1	7.3	6.7	8.0	10,744	4,364	16,989
Morocco	0.676	0.603	0.724	121	76.5	77.7	75.2	13.1	12.6	13.6	5.5	4.6	6.4	7,480	3,012	12,019
Bangladesh	0.614	0.575	0.642	135	72.3	74.3	70.6	11.2	11.6	10.8	6.1	5.3	6.8	4,057	2,373	5,701

The *Gender Development Index* (GDI) was introduced in 2014 and ranks 166 countries based on the sex disaggregated HDI, defined as a ratio of female to male HDI. GDI measures gender inequalities in achievement in three basic dimensions of human development: health (measured by female and male life expectancy at birth), education (measured by female and male expected years of schooling for children and mean years for adults aged 25 years and older) and in command over economic resources (measured by female and male estimated Gross National Income (GNI) per capita.[108] In 2018, Malaysia had a female HDI value of 0.792 compared with 0.815 for males, resulting in a GDI value of 0.972, positioning it as medium-high gender equality, followed by Turkey (0.924 – medium-low equality). In comparison, GDI values for Egypt (0.878), Morocco (0.833) and Bangladesh (0.833) qualify them as having low gender equality (see **Table 10**).[109]

UNDP introduced the *Gender Inequality Index* (GII) in the 2010 Human Development Report. The GII ranks 162 countries on human development loss due to gender-based inequalities in three dimensions: reproductive health, empowerment, and economic activity, and ranges from 0 (where women and men fare equally) to 1 (where one gender fares poorly in all measured dimensions). The GII measures reproductive health by maternal mortality and adolescent birth rates, empowerment by the share of parliamentary seats held by women and attainment in secondary and higher education by each gender, and economic activity by the labour market participation rate for women and men. [110]

[105] UN Human Development Programme (2020) Global Human Development Indicators.
[106] Human Development report (2019) Malaysian Briefing note
[107] UN Human Development Programme (2020) Global Human Development Indicators.
[108] Standard of living is measured by Gross National Income (GNI) per capita expressed in constant 2011 international dollars converted using purchasing power parity (PPP) conversion rates.
[109] UN Human Development Programme (2019) Human Development Report Technical Notes.
[110] UN Human Development Programme (2019) Human Development Report Technical Notes.

In 2018, Malaysia's GII was 0.274, ranking it 58 out of 162 countries. Women held 15.8% of the parliamentary seats and 79.8% reached the secondary level of education compared to 81.8% of their male counterparts. For every 100,000 live births, 40 women died from pregnancy related causes; and the adolescent birth rate was 13.4 births per 1,000 women aged 15-19 in 2015 (which improved to 9 births per 1,000 women by 2018).[111] Female participation in the labour market was 50.9% compared to 77.4% for men. Malaysia's GII ranking of 58 places it in a better position than the other study countries, with GII values ranking them as Turkey 66, Egypt 102, Morocco 118 and Bangladesh 129 (**Table 10**).[112]

Table 10 2018 Gender Development Index and Gender Inequality Index for selected countries [113]

	GDI value	GII	GII rank	Maternal mortality ratio	Adolescent birth rate	Female seats in parliament	% Population with at least some secondary education		Labour force participation	
							F	M	F	M
Malaysia	0.972	0.274	58	40.0	13.4	15.8	79.8	81.8	50.9	77.4
Turkey	0.924	0.305	66	16.0	26.6	17.4	44.3	66.0	33.5	72.6
Egypt	0.878	0.450	102	33.0	53.8	14.9	59.2	71.2	22.8	73.2
Morocco	0.833	0.432	118	121.0	31.0	18.4	29.0	35.6	21.4	70.4
Bangladesh	0.895	0.536	129	176.0	83.0	20.3	45.3	49.2	36.0	81.3

4.3.2 Sexual and reproductive health indicators

There are well-known and commonly used SRH indicators to monitor progress in achieving the SDGs. This section presents a selection to compare progress with maternal and child health, FP, adolescent fertility rate and STIs, particularly HIV/AIDS.

i) Maternal and child health

Appendix 2 contains maternal and child health indicators. Malaysia and Turkey have the highest antenatal care coverage (97%) with at least one visit, followed by Egypt at 90%, Morocco at 77% and Bangladesh at 64%. Malaysia has the highest percentage of births attended by skilled health personnel at 99.5%, compared with 98% for Turkey, 92% for Egypt, 87% for Morocco and 68% for Bangladesh. Malaysia also has the lowest infant mortality rate at 7.2 per 1,000 live births, compared with 10 for Turkey, 18.8 for Egypt, 20 for Morocco and 2.9 for Bangladesh, and the lowest under 5 mortality rate at 8.8 per 100,000 live births, compared with 11.6 for Turkey, 22.1 for Egypt, 23.3 for Morocco and 32.4 for Bangladesh. Turkey had the lowest maternal mortality ratio of 16 deaths per 100,000 live births, compared with 22 for Malaysia, 33 for Egypt, 121 for Morocco and 176 for Bangladesh.

ii) Family planning

As discussed earlier in this section, Malaysia and Turkey have reduced the TFR to replacement rate. Thus, in recent years, Malaysia and Turkey's population strategy encourages a higher fertility rate, whereas Egypt and Bangladesh focus on controlling population growth (**Appendix 2**). In Malaysia and Turkey, low fertility combined with pronatalist policies likely present challenges regarding access to and the use of contraception for all populations but particularly for young people. [114]

[111] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[112] UN Human Development Programme (2020) Global Human Development Indicators.
[113] UN Human Development Programme (2020) Global Human Development Indicators.
[114] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

The prevalence of premarital sex is used as a proxy to measure shifts in adolescents' attitudes toward sexual activity and inform the provision of SRH education and services. The prevalence of premarital sex among Malaysians aged 12-24 years (measured by local studies and national surveys during 2005-15) ranges from 1.3% to 12.6%, [115] depending on the survey instruments, sample sizes, age groups, study periods and settings. Age at first marriage is another proxy indicator for the initiation of sexual activity. The mean age at first marriage among Malaysian men has increased from 25.6 in 1970 to 28.6 years in 2010. The mean age has also increased for Malaysian women during the same period from 22.1 to 25.7. [116] The increasing gap between age of first sexual intercourse and age of first marriage suggests that *many youths are sexually active before marriage, reflecting a shift from traditional values linked to cultural and religious beliefs towards progressive attitudes to sexual relationships*.

Despite contraception services being available for all youth and women at government clinics in **Malaysia, the country had the lowest contraceptive prevalence rate (any method)** at 52.2% in 2014 (stagnated since 1984) and modern methods at 34.3%.[117] Turkey's contraceptive rale was 73.5%, Morocco 70.8%, Bangladesh 62.3% and Egypt at 58.5%.[118] **Malaysia also had the highest unmet need for FP**,[119] at 19.6% in 2014,[120] down from 25% in 2004.[121] Morocco's unmet need was 13%, followed by Egypt at 12.6%, Bangladesh at 12% and Turkey at 5.9%.[122] Malaysia's low prevalence rate is partly attributed to the fact that SRH services are not actively promoted. Malaysian adolescents may also be afraid to access the services for fear of stigma and discrimination.[123]

The 2014 Malaysian Population and Family Survey revealed that 74.2% of ever-married women aged 15-49 years have ever used FP methods.[124] It is important to consider that FP indicators such as CPR[125] and unmet need for contraception mainly capture married women in predominantly Muslim countries; extramarital sexual activity is forbidden for Muslims under Islamic Law. Since most unmarried women would want to avoid pregnancy, the unmet need is likely to be underestimated.[126]

The Malaysian Government is taking a pronatalist approach to encourage a higher TFR. Hence, the promotion of contraception is unlikely. This approach excludes vulnerable groups with high unmet

[115] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[116] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[117] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[118] UN Human Development Programme (2020) Global Human Development Indicators.
[119] This refers to the number or percent of women currently married or in union who are fertile and desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method. The total number of women with an unmet need for family planning includes those with an unmet need for limiting their number of children and those with an unmet need for spacing (who desire to postpone their next birth by a specified length of time). Source: MEASURE Evaluation (2020) Unmet need for family planning
[120] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[121] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[122] Unmet need: > 25% is considered very high; ≤ 5% is considered very low - Demand satisfied by modern methods: > 75% is considered high; ≤ 50 is considered very low. Source: UN Population Division 2016 World Contraceptive Use (pg. 4)
[123] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[124] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[125] MEASURE Evaluation (2020) Contraceptive prevalence rate (CPR).
[126] Najimudeen M, Sachchithanantham K (2014) An insight into low contraceptive prevalence in Malaysia and its probable consequences. Int J Reprod Contracept Obstet Gynecol 2014; 3(3): 493-496 Volume No.3:493–496.

needs; women of reproductive age who wish to either postpone childbearing or cease childbearing but are not currently using contraception,[127] youth and those exhibiting high risk behaviours.

iii) Adolescent fertility rate and related issues

Out-of-wedlock birthing is strongly disapproved across Muslim countries. **Unwanted adolescent pregnancies limit girls' and young women's educational and economic prospects and slows socio-economic development**. [128]

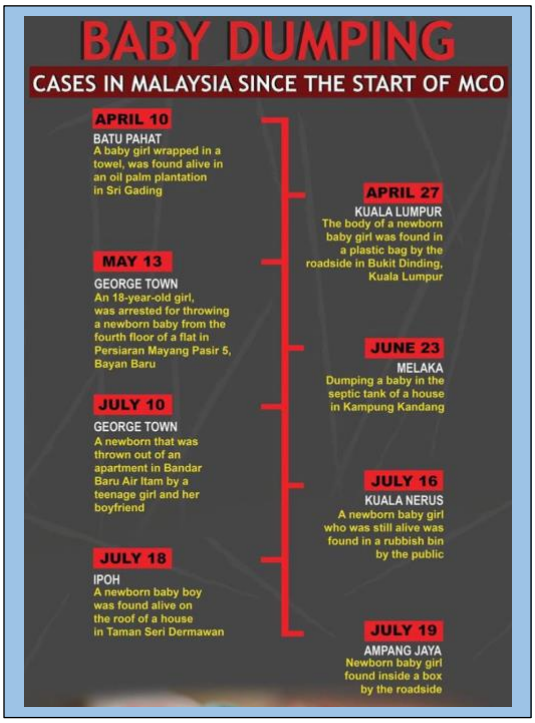
Malaysia had the lowest adolescent fertility rate at 8.5 births per 1,000 women aged 15-19 years in 2018, compared with 26.6 for Turkey, 53.8 for Egypt, 31 for Morocco and 82 for Bangladesh. Adolescent pregnancy remains a significant health and socioeconomic concern in Malaysia, with 13,383 teenage pregnancies recorded in 2015. [129] Births among unmarried adolescents are mostly unintended and lead to serious public health and socioeconomic consequences. Young unmarried pregnant women may spend their pregnancies in sheltered homes to hide their pregnancies.[130] In 2018, 32,087 children aged 0-4 years were registered in childcare centers overseen by the Malaysian Department of Social Welfare.[131] **Unwanted teenage pregnancy bears a heavy economic burden for Malaysia's health and welfare services. Malaysian health and welfare services could easily prevent the economic burden by delivering to Malaysian adolescents a rights-based and gender-sensitive comprehensive sexuality education programme linked to FP services**.

Many unmarried girls and women may terminate their pregnancies. However, given the sensitivities, abortion statistics are not reported. As previously discussed, Section 312 of the Malaysian Penal Code provides an exception to the prohibition of abortion under certain circumstances, as does Syariah Law. Girls under 18 years require parental consent. **The policy and laws requiring parental consent for abortion should be reviewed to facilitate a safe and confidential environment to deliver pregnant adolescents' services.** [132]

The Malaysian MoH released the *2012 Guidelines for Termination of Pregnancy* as part of the strategy to reduce maternal mortality and morbidity. The Guidelines set out the standard for the provision of safe abortion in Malaysia.[133] However, its implementation largely depends on health care professionals. Research indicates that health care professionals are not familiar with the abortion laws, leading to the misconception that abortion is illegal and uniformed advice to continue with the pregnancy.[134] A 2007 study noted that only 57% of the 120 doctors and nurses surveyed knew that abortion is legal in certain circumstances and 38% of the doctors and nurses surveyed considered that raped women should continue the pregnancy instead of terminating it, highlighting their conservative opinions regarding

[127] MEASURE Evaluation (2020) Unmet Need for Family Planning.
[128] Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. In: Guttmacher Institute.
[129] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[130] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[131] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[132] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[133] Ministry of Health Malaysia (2012) Guidelines On Termination Of Pregnancy (TOP) For Hospitals In The Ministry Of Health
[134] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

abortion.[135] **Health care professionals should be adequately briefed on the exceptions for abortion so they can provide accurate information. Also, the collection and reporting of legal abortion statistics can inform the proper allocation of resources to prevent further negative social consequences.**



A tragic outcome resulting from the limited support provided to pregnant teenagers is the common practice of baby dumping. Between 2010 and 2019, 1,010 babies were reported by the Royal Malaysian Police as abandoned. The babies were left in a range of settings, from mosques to waste grounds, bushes, drains and public toilets, although many cases remain unreported.[136]

Limited SRH education, including contraceptive practices, are well known barriers to reducing the adolescent fertility rate.[137] Promoting contraception among high risk groups will likely prevent further socioeconomic costs such as maternal and infant mortality attributed to illegal and unsafe abortions, criminal baby abandonment/dumping practices and child welfare services for abandoned babies.

A previous review also recommends **implementing Comprehensive Sexuality Education (CSE) to prevent unwanted pregnancies among unmarried youth**. [138] Teaching CSE to promote informed choices on safer sex and contraception is more effective than abstinence-only or abstinence plus programmes in delaying sexual initiation and reducing the negative health consequences of unprotected sex. The review found that Malaysia's current abstinence-only-until-marriage approach to sexuality education is based on the harmful misconception that CSE might encourage early sexual activity and risk-taking behaviours and provides very limited information on safer sex and contraception. The teachers' training and support is inadequate; the curriculum is unclear, fragmented and does not align with UNESCO's curriculum guidelines [139]; SRHE programmes are poorly monitored and evaluated, and there is lack of participatory engagement of young people and parents. Community programmes are also limited in their reach, disadvantaging vulnerable out-of-school young people. [140] **Sexuality education in Malaysia should be corrected to align with UNESCO's curriculum guidelines.** [141]

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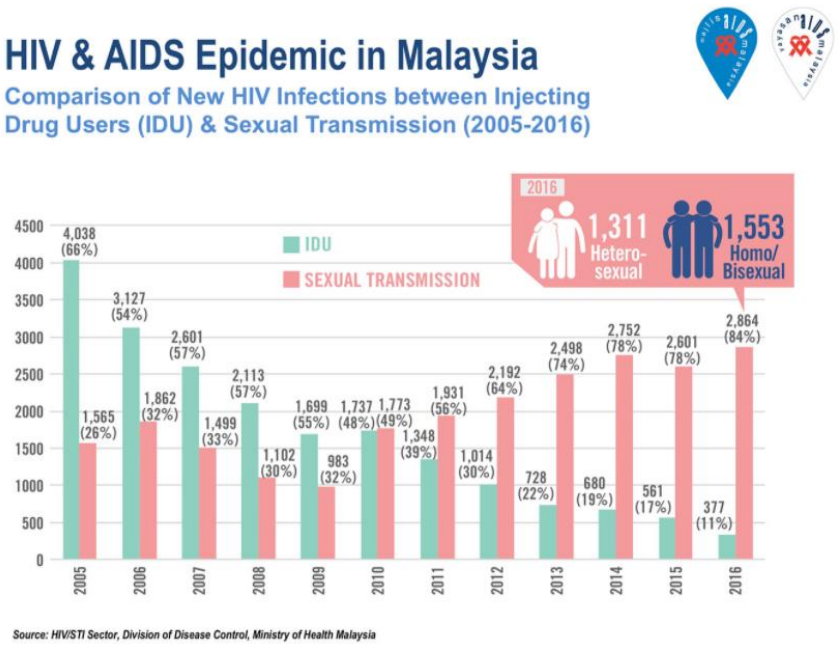
[135] Reproductive Rights Advocacy Alliance Malaysia (2007) Survey Findings of Knowledge and Attitudes of Doctors and Nurses on Abortion by the Reproductive Rights Advocacy Alliance Malaysia (Unpublished)
[136] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[137] Federation of Reproductive Health Associations, Malaysia (2010) ICPD+15 3rd Country Report of Malaysia: NGO Perspectives
[138] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.
[139] Talib J, Mamat M, Ibrahim M & Mohamad Z (2012) Analysis on Sex Education in Schools Across Malaysia. Social and Behavioral Sciences 340–348
[140] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?
[141] UNESCO (2018) International Technical Guidance on Sexuality Education

iv) Sexuality transmissive infections, including HIV/AIDS

Unprotected sexual intercourse is associated with a high risk of STIs, including HIV/AIDS. Malaysia had the highest HIV prevalence rate among adults aged 15-49 years (0.4 compared with 0.1 for Egypt, Morocco and Bangladesh). This could be because Malaysia is actively screening for HIV/AIDS cases. However, HIV/AIDS transmission in Malaysia has shifted from injecting drug users to sexual transmission in recent years(**Figure 7**).[142] There appears to be an upward trend towards highrisk sexual behaviours amongst young people in Malaysia. The 2018 MoH Country Progress Report revealed that 43% of all new HIV infections in Malaysia occurred among people aged 13-29 years (an increase from 40% in 2016), with 90% of youth acquiring HIV infection through unsafe sex (an increase from 84% in 2016).[143] Of the total reported HIV infections between 1986 and 2016, 11% were females and 89% males, 69% were Malay followed by 15% Chinese and 8% Indians.[144] However, these indicators might underestimate the HIV incidence among youth, given the low uptake of STI clinic services by adolescents.[145] This indicates the urgency for implementing SRH education if Malaysia is to reduce HIV prevalence among adults (ages 15-49) as part of achieving the SDG 3.3 target.[146]

Figure 7 HIV/AIDS Epidemic in Malaysia [147]



[142] Malaysian AIDS Council (2016) HIV Statistics
[143] Ministry of Health (2018) Malaysia, Malaysia 2018: Country Progress Report on HIV/AIDS
[144] Malaysian AIDS Council (2020) Overview of the HIV & AIDS Epidemic in Malaysia
[145] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[146] SDG 3.3 target: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. Source: UN development Programme (2019) Human Development Reports: HIV prevalence among adults.
[147] Extracted from Malaysian AIDS Council (2016) HIV Statistics

4.4 Family Planning Policy environment across selected countries

The international consensus is that the primary health care system should deliver SRH information and services linked to a range of sexual and reproductive counselling and services, including contraception, maternal health and GBV services. [148] The ICPD PoA urged governments to make reproductive health services available, accessible, acceptable and affordable to everyone, particularly young people.[149] Addressing women and men's reproductive health needs through existing health facilities, the education system and other social programmes could improve economic prosperity across all sectors and accelerate community development.[150] This section considers the contextual environment for FP policy, the FP policy direction and the programme and services across the study countries. **Appendix 3** contains a summary of the information.

4.4.1 Malaysia

i) Contextual environment

Malaysia is transitioning from an upper-middle-income country to a higher-income country. The population has grown slowly in recent years, from 31.7 million in 2016 to 32.7 million in 2020, of which 90.9% (29.7 million) are citizens and 9.1% (3.0 million) are non-citizens. [151] Malaysia is projected to be an ageing nation by 2030 with a decrease in annual population growth rate from 1.8% in 2010 to 1.5% in 2015 and projected to be 0.8% by 2040. In 2040 the population is projected to be 41.5 million. In 2017, life expectancy at birth was 72.7 years for males and 77.4 years for females.[152] Young people aged 10-24 years account for one-third of Malaysia's population. [153]

Although Islam is Malaysia's official religion, there are no restrictions on practicing other religions. Malaysia's population is largely urban (76% living in urban areas), multi-ethnic (70% Malay; 23% Chinese; 7% Indian) and multi-faith (63% Islam, 19% Buddhism, 10% Christianity, 6% Hinduism).[154,155]

Since independence in 1957, Malaysia has achieved impressive feats in human and social development. Population health outcomes have improved remarkably (increased life expectancy, decreased maternal and child mortality and communicable diseases). The improvement in population health is primarily due to a universal, comprehensive and affordable health care system funded through general taxation.[156]

Malaysia established the *1966 Population and Family Development Act 352*,[157] overseen by LPPKN, to improve maternal and child health and decelerate population growth rate from 3% in 1966 to 2% in 1985. FPs acceptance was increased through its integration into the primary health system and linked with other reproductive health efforts.[158]

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[148] WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
[149] WHO (2017) Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation
[150] UNFPA (2014) Adolescent sexual and reproductive health
[151] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[152] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?
[153] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[154] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[155] Department of Statistics, Malaysia (2020) Population demographics
[156] Ng CW, Mohd Hairi NN, Ng CJ, Kamarulzaman A (2014) Universal health coverage in Malaysia: issues and challenges
[157] Laws Of Malaysia (1966) Malaysia Population and Family Development Act 1966
[158] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia

The TFR in Malaysia has consistently declined for five decades; 4.8 births per woman in 1970 to 3.5 in 1990 to 2.0 in 2018. The 2018 TFR is below the replacement level of 2.1 births per woman.[159] Fertility rates are lower among the sub-groups with higher CPR. These groups include non-Malays and those who have completed higher education.[160] **FP/SRH needs and preferences are diverse. Diversity should be considered across religions and ethnicities when designing policies and programme to ensure *no-one is left behind***.

ii) Family Planning policy direction

Malaysia is committed to implementing the ICPD PoA and the Agenda 2030 for Sustainable Development. Malaysia is drafting a *Sexual Harassment Bill and an Anti-Discrimination Against Women Bill* to address gender equality pursuant to Article 8 of the Federal Constitution. The *National Policy on Reproductive Health and Social Education 2009* will be updated by 2021 to increase further the effectiveness of comprehensive and age-appropriate Sexual and Reproduction Health Education (SRHE) in formal and informal education mechanisms. A national committee will monitor its implementation.[161]

The *2nd Malaysian Population Strategic Plan Study 2010*,[162] a follow-up to the *1st Population Strategic Plan Study 1992*, evaluated the national population programme's implementation. The 2nd Study recommended a strategic plan of action framework to implement future population and development programme. It advocated for a family-centered approach to Malaysian development planning with the overall goal of increasing quality of life via population and development policies and programmes to address poverty and achieve sustainable development, guided by the principles of gender equity, respect for human rights and family values. Labour market policy and FP policy will need to address Malaysia's ageing population and the fertility decline to avoid the workforce's inevitable contraction. Simultaneously, both policies will need to sustain fertility at replacement level, while supporting couples to combine participation in the labour market and their family building. The 2nd Study provided objectives and recommendations, including addressing the fertility decline and long-term population growth objectives, reproductive health, family and gender issues and demographic data issues within a population strategic plan. **Appendix 4** describes the objectives and recommendations.

Malaysia currently aims to reverse the fertility decline by exploring sub-fertility, pro-fertility incentives, and childcare options. LPPKN is the focal point for addressing population, family development and reproductive health issues. LPPKN's *Situational Analysis on Population and Family in Malaysia* [163] reports on the population challenges and proposes several strategies to strengthen future population development programme planning and implementation.[164] The LPPKN Report provides 40 recommendations to meet specific objectives and targets under strategic pillar's each of which is to be implemented by various ministries and agencies during 2018-30. The FP related objectives are as follows:

1. Addressing fertility decline (address subfertility; pro-fertility incentives; childcare options)

[159] Department of Statistics, Malaysia (2020) Population demographics
[160] Ahmad N, Peng T, Zaman K, et al (2010) Status of Family Planning in Malaysia
[161] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.
[162] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010
[163] LPPKN (2018) Situational Analysis on Population and Family in Malaysia

2. Strengthening family institution (promote parental skills, family cohesion and intergenerational support systems)
3. Enhancing population resiliency (raise productivity, increase labour force participation for women, flexible working arrangements, life-course approach to improving health, expand family centric programmes)
4. Mainstreaming policies for active aging (utilising elderly's time and experience, promoting age-friendly environments & community-based care, restructure pension), and
5. Enabling inclusive progress for all (ensure inclusive policy initiatives for disadvantaged communities, promote social entrepreneurship, community cooperation, enhance human development and community outreach programmes via digital technologies).

Malaysia has several strategies related to FP, including the *National Strategy on HIV and AIDS 2011-2015* and the *Revised 2010-15 National Policy for Older Persons*. The MoH developed the *National Adolescent Health Policy* (NAHP) in 2001 and the *2006-2020 National Adolescent Health Plan of Action* (NAHP PoA) in 2007 to empower adolescents (aged 10-19 years) *with the appropriate knowledge and assertive skills to enable them to practice healthy behaviours and lifestyles*.[165] The NAHP PoA operationalises the seven strategies of the NAHP via five priority areas. SRH is one of the five priority areas. Government representatives, academics and NGOs working with adolescents developed a set of activities to address adolescent SRH.[166]

In Malaysia, less controversial SRH services such as perinatal care services seem more likely to get buy-in from key stakeholders. A recent Malaysian study examining the integration of SRH into universal health coverage (UHC) processes identified several strategies triggering this buy-in in the Malaysian context included: generation of public demand and social support; placing SRH issues on the public agenda or linking them with international commitments; engaging with champions within government; and reframing SRH issues to appeal to existing values and beliefs. However, sensitive services like safe abortion or GBV services require strategies to transform socio-cultural norms, believes and behaviours. [167] This was confirmed by the prioritisation of UNFPA's *2010 Essential Package of Sexual and Reproductive Health Services* [168] by LPPKN stakeholders during the pre-inception meeting, as show in **Box 2**.

The delivery of SRHE is currently split between the Ministry of Education (MoE), the MoH, LPPKN and NGOs. The MoE, LPPKN and NGOs provide SRHE to target groups. The MoH provides SRHE at client service centers. Malaysia's *2009-12 National Reproductive Health and Social Education Plan of Action* (referred to as PEKERTI) is being reviewed and updated for 2020-24 through a consultative process led by LPPKN. As such, the delivery of SRHE may change.

[165] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[166] Ministry of Health Malaysia (2015) National Adolescent Health Plan of Action
[167] Lim, S.C. Yap, YC. Barmania, S. Govender, V. Danhoundo, G & Remme, M. (2020) Priority-setting to integrate sexual and reproductive health into universal health coverage: the case of Malaysia, *Sexual and Reproductive Health Matters*
[168] Williams K. Warren C. & Askew, I. (2020) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services; Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services, Commissioned by UNFPA and the Population Council.

iii) Family planning services

MoH mainly provides SRH information and services via clinics offering multidisciplinary services (**Box 8**), in partnership with LPPKN and FRHAM, other agencies such as MoE. NGOs and the private sector also provide these services. These health institutions have their own systems for procuring and delivering SRH information and services (**Table 11**).[169] The 2001 Adolescent Health Policy led to strengthened adolescent SRH services. Public health care facilities provided contraceptive and other SRH services to young people, regardless of their marital status.[170] The 2009-12 PEKERTI Policy directed Malaysia's efforts to increasing access to SRH information and services for young people, stressing positive values and responsible behaviour. [171] In 1996, Malaysia started providing universal access to SRH services for all adolescents in primary, secondary and tertiary health care facilities nationwide. In recent years, the MoH has led initiatives to provide SRH services for both married and unmarried adolescents, as demonstrated by the MoH's *2012 Guidelines for Managing Adolescents Sexual and Reproductive Health problems at Health Clinics*. The 2012 Guidelines are intended to support MoH adolescent friendly health services, although implementation depends on health care providers.

SRH services in Malaysia were historically targeted to married couples. More recently, they have been made available to all groups, generally excluding abortion services.[172] Despite the availability of SRH services, unmet needs for contraceptive methods remain high, as SRH services are not properly

Box 8 Malaysian Ministry of Health's Family Planning related activities

Beneficiaries of MoH's FP services registered at MoH Health Clinics increased from 115,760 in 2017 to 120,698 in 2018. The number of repeat beneficiaries increased from 337,913 in 2017 to 343,811 in 2018. The most widely used methods in 2018 were pills (45.8%), followed by progestogen-only injections (39.2%), male condoms (7.4%) and intrauterine devices (3.5%). The FP programme practices in high-risk women aims to optimise the health among high-risk women before the next pregnancy.

In 2018, MoH related FP activities included the following:

- Updating maternal health services guidelines, including the *Perinatal Care Manual 3rd Edition 2013*, *Guidelines and Checklist for the Colour Coding System for Mother and Newborn Care 4th Edition 2013* and *Mother's Health Record Book*.
- Publishing reference materials by the Family Health Development Division, including the *Handbook for the Management of Maternal Health and Family Planning Services at Health Clinics* and *Prevention and Treatment of Thromboembolism in Pregnancy and Puerperium: a training manual*.
- Conducting training for monitoring among nursing supervisors using the *Handbook for the Management of Maternal Health and Family Planning Services at Health Clinics*, strengthening pre-pregnancy services and revision of *Perinatal Care Manual* and other guidelines. Effective monitoring activities ensure that service delivery meet the standards of care et in the guidelines. The National Training for Safe Motherhood programme was conducted for medical officers in June 2018.

Source: Ministry of Health (2018) Ministry of Health Annual Report 2018

[169] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[170] Ministry of Health Malaysia (2015) National Adolescent Health Plan of Action
[171] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[172] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

promoted, particularly among adolescents and young people. Stigma and discrimination also play a role in the lack of access to SRH services by adolescents and young people.[173] Unmet needs for SRH information and access to contraceptives should be urgently addressed to prevent further STIs and unintended pregnancies. [174] Health care providers should be trained to deliver SRH information and services in a confidential, non-judgmental and non-discriminatory manner.

Although both the Civil and Syariah Laws provide an exception to the prohibition against abortion, a 2019 review of Malaysia's progress regarding CEDAW noted that abortion is stigmatised, costly and government hospitals do not often provide the service. Government hospitals' counselling and information use a religious perspective rather than a reproductive health rights framework.[175] Despite the MoH's 2012 *Guidelines for Termination of Pregnancy* for hospitals, the lack of awareness regarding abortion laws amongst Malaysia's health care providers is likely to lead to illegal and unsafe abortion practices. Unsafe practices will increase the risk of maternal and infant morbidity and mortality. The availability of safe abortion depends not only on permissive legislation but also on political support and health professionals' ability to provide it. **Abortion care, including medical abortion, needs to be included in the medical and nursing school curriculum.** [176]

SRH information and services often neglect older people. Malaysia's life expectancy has increased with health care advancement (74.7 years in 2016 to 76 years in 2018). The number of older people (aged 60 years and above) is projected to increase from 10% in 2017 to 15% in 2030; *aged country* status.[177] The rapid decline in fertility rates has accelerated the country's ageing process, which will be reflected in increased morbidity and disability rates, some of which are related to reproductive health, such as menopause, andropause, breast, cervical, and prostate cancer. A 2016 Malaysian study commissioned by UNFPA to inform evidence-based recommendations for addressing the SRH of older persons noted the lack of an explicit public SRH programme and services for the older population (e.g. sexual and intimacy behaviours, sexual dysfunctions and problems). NGOs dealing with ageing issues such as National Council of Senior Citizens Organisations Malaysia and the Malaysian Healthy Aging Society (MHAS) only focused on advocacy work and educational programme for older population, excluding SRH related services. The lack of public SRH programme and services for older persons might be due to various factors, including limited research and data, inadequate training of health care providers, limited knowledge of sexuality matters among older people, limited knowledge of health issues and risk factors for chronic diseases. Additional barriers could be cultural and religious beliefs, attitudes and stereotypes of SRH and ageing, lack of information and awareness on SRH among the older population, physical or psychological limitations caused by other health or economic problems and loss of independence. T**he SRH needs of older people could be incorporated into SRH programme and services** by building service

[173] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: MalaysiaARROW
[174] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[175] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.
[176] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[177] LPPKN (2018) Situational Analysis on Population and Family in Malaysia

providers' capacity in SRH education, monitoring and evaluation, and allocate financial resources and personnel.[178]

Table 11 Sexual and reproductive health services in the Malaysian health care system [179]

	Ministry of Health (MoH)[1]	Complementary to MoH	
Types of facility	**1. Static facilities: Hospitals, Health Clinics, MCH Clinics, Community Clinics 2. Outreach services: school health team, mobile health team**	**LPPKN: semi-government Kafe@Teen**	**FRHAM: Non-governmental organization**
Service provider	Multidisciplinary team: doctors, nurses, paramedics, allied health personnel Referral to other agencies and specialties as required: e.g. social welfare officer, school counsellor	Teen educators, counselors, nurses, nutrition consultants and medical officers	Peer educators, medical officers
Target group	All ages, including people with disabilities and unmarried	Adolescents and young people aged 13-24 years and their parents	All ages: drug users, sex workers, transsexuals, MSM (men who have sex with men) and disabled youth. The main focus is family planning.
SRH information and treatment	MoH provides SRH education as well as service provision. SRH information, screening for nutrition problems, thalassemia and mental health status, counselling and referral. MCH: family planning services, perinatal services and intrapartum care (including unmarried teen pregnancy), cervical and breast cancer screening, STI and HIV prevention, screening and management, child abuse and domestic violence and HPV vaccination.	SRH information Reproductive clinic Contraception, pregnancy testing, subfertility treatment, Pap smear, andrology services, STI screening and treatment, breast cancer screening, HPV vaccination, general medical check-up, blood tests, counselling	SRH information, contraceptive services including emergency contraception, antenatal services, pre and post counselling for HIV, HIV testing, pre- and post-abortion counselling, referral for abortion.
Available modules	Various modules/manuals/guidelines for each service available. Examples include: • 2012 Live Life, Stay Safe training module on RH for children, adolescent with disabilities • 2013 Perinatal Care Manual 3rd edition • 2009 Module Engaging Adolescent Using HEADSS Framework • 2012 Guidelines for Handling Adolescent Sexual and Reproductive Health Problems at Health Clinics • 2015 HIV/AIDS prevention *Healthy Adolescent*	"I am in control" modules (adolescent and parent versions), RHAM (Reproductive Health of Adolescent module), PEKERTI (teen pregnancy prevention)	• RHAM (in collaboration with NPFDB) • Peer educator programme • Contraception (i.e. choose2protect)
Location and operation time	Schools (scheduled timetable), health clinic (appointment based), Community Health Camps. Specific times and days: 8 am-5 pm every day except weekends Hospital services: 24 hours for emergency cases Health clinics: office hours	Kafe@teen at NPFDB or UTC, residential area, school, LPPKN camp. Kafe@teen: 8 am-5 pm Kafe@teen (UTC): 8 am-10 pm including weekends	Schools, universities, Kafe@teen Varies depending on the sponsor

Source: websites of MoH, NPFDB and FRHAM

[1] Information provided by the MoH representative within the Technical Working Committee (TWC).

[178] Huang Soo Lee M, Lim L (2016) Evidence based approach in addressing the sexual and reproductive health (SRH) of older persons in Malaysia

[179] Table extracted from Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

A 2019 review of Malaysia's progress regarding CEDAW noted that despite some positive changes in law and policy, there had been no significant shift in women's status regarding exercising their reproductive rights regarding the time and spacing of childbearing.[180] Many women experience barriers to accessing high-quality reproductive health services. For example, a husband's consent is required for sterilisation procedures. Despite the Civil and Syariah Laws allowing abortion to protect the physical and mental health of the mother, it is stigmatised and costly, and where government hospitals provide the service, information and counselling is delivered within from a religious perspective, rather than a right-based SRH approach. Access to reproductive healthcare is also limited for some groups of women, including refugee women, indigenous women, migrant women, transgender women, and female prisoners.

4.4.2 Turkey

i) Contextual environment

Turkey is an upper-middle-income country of 82.3 million people in 2018. 75% of the population lives in urban settings. [181] Turkey had accelerated development until the economic crisis of mid-2018. Improved SRH, decreases in infant and maternal mortality and decreases in the TFR (from 2.4 births per woman in 2003 to 2.1 in 2018) and the Adolescent Fertility Rate (AFR) (from 40 per 1,000 women aged 15-19 in 2003 to 26.6 in 2018) are attributed to the introduction of a comprehensive FP programme and an increase in educational attainment. The FP programme was introduced in 1965 and legalised contraceptives. The 1997 nationwide reform of compulsory schooling age extended the basic educational requirement from 5 to 8 years (free of charge in public schools) to align with the standards required to enter the European Union. [182]

ii) Family Planning policy direction

The Turkish Government passed the first population planning law in the 1960s. In 1965, the General Directorate of Maternal and Child Health and Family Planning (MCH–FP), an organ of the MoH, was established. The MCH-FP is responsible for developing policies and strategies and evaluating maternal and child health and FP programme nationally.[183] The MoH, Universities and NGOs in Turkey have a long history of collaboration with international agencies to provide reproductive health programme and services. During 1983-2000, Turkey successfully reduced its population growth rate as contraceptive use among married couples rose to 71%, abortion incidence and maternal deaths from unsafe abortions declined, as did the TFR.[184] Turkey has now shifted to a pronatalist policy to increase fertility to prevent an economic slowdown attributed to an ageing population with a high dependency ratio and a shrinking working-age population. [185]

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[181] UN Human Development Programme (2020) Global Human Development Indicators.
[182] Güneş PM (2016) The Impact of Female Education on Teenage Fertility: Evidence from Turkey. The BE Journal of Economic Analysis & Policy 16:259–288. https://doi.org/10.1515/bejeap-2015-0059
[183] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[184] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[185] Yüceşahin, M. & Adalı, Tuğba & Türkyılmaz, Ahmet. (2016). Population Policies in Turkey and Demographic Changes on a Social Map.

The *Women's Health and Family Planning Advisory Board*, established under MoH in 1993 and chaired by MoH reports to Minister via the MCH–FP.[186] The Board meets twice a year to facilitate inter-sectoral collaboration and monitor implementation of FP policies and programme. Membership includes Ministries of Education, Labour, Media, Religious Affairs, as well as Universities, the Army, NGOs, civil society and other sectors. The Board has successfully motivated all sectors to initiate new approaches and programme based on ICPD PoA recommendations. The programme have included education for adolescents on SRH in schools and education for soldiers to improve male involvement in fertility regulation and FP.

Successive Turkish Governments enacted several laws in the second half of the last century to control its population growth.[187] The first anti-natalist *Population Planning Law*, enacted in 1965, improved women's SRH by legalising the provision of contraception information and clinical services. The *1983 Population Planning Law* legalised induced abortions upon request for up to 10 weeks' gestation and allowed trained nurses and midwives to administer intrauterine devices (IUDs). In 2012, Turkey adopted Law No. 6284 on the *Prevention of Violence against Women and the Protection of the Family*.

During the mid-1990s, the government worked collaboratively with NGOs to develop the *1995 Women's Health and Family Planning Strategic Plan* was collaboratively developed by the government and NGOs. The process was led by MCH–FP with UNFPA's financial support. The Action Plan adapted all ICPD recommendations to the Turkish context. It focused on strengthening inter-sectoral collaboration and the SRH components of primary health care units to reduce regional differences in health indicators, improve services quality, and involve NGOs. The SRH and FP services are co-financed; however, the budget is limited. The MCH-FP pays for FP commodities (contraceptives, equipment and educational materials), while MoH pays for personnel, maintenance and clinic buildings.

The current political environment is pronatalist and antiabortion.[188] In 2012, the government proposed to restrict abortion via a bill that did not pass into law. Nevertheless, women have since reported difficulty accessing abortion services across Turkey. Despite progressive gender equality laws, patriarchal ideology still characterises social structures, influencing women's SRH. Gender differences in education influence health services utilisation by women of reproductive age, including antenatal care, delivery, FP and contact with health personnel.

Turkey issued a *National Strategic Action Plan for SRH 2005-2015*, which incorporated a rights-based approach.[189] However, this approach came to a halt in 2010 when sexual health policy became more conservative and shifted away from the previous commitment to a rights-based approach. While Turkey has made marked progress in FP to date,[190] access to SRH services has become more limited in the last five years due to the conservative political environment. Since 2007 the government's pronatalist

[186] European Committee of the Regions (2020) Turkey Public Health

[188] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[189] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[190] Benezra B (2014) The Institutional History of Family Planning in Turkey. Contemporary Turkey at a Glance

population plan incorporated into the most recent Four-Year Development Plan,[191] encourages women to bear a minimum of three children.

iii) Family planning services

The main weakness of the *MoH Strategic Plan* is absence of promotional SRHR services (including gender issues) for young people.[192] The 2011 health structural reform shifted SRH services delivery to family physicians, many of whom were not capacitated to deliver these. This led to implementation barriers regarding the provision of commodities, STIs management, volunteer counselling and HIV testing. While HIV prevalence is decreasing (0.3% in 2011) Turkey lacks epidemiological data on key populations. [193]

Turkey FP related challenges[194] related to gender inequality and include early marriage and GBV. Approximately 15% of girls are married before the minimum legal age of 18,[195] affecting adolescent SRH with a higher risk of obstetric complications. Data reveals that 35% of partnered women aged ≥ 15 years experienced sexual or physical violence from an intimate partner in 2017.[196]

Perinatal mortality rate remains high at 42 per 1,000 total births, indicating a need to improve maternal health. There are marked differences in regional and rural/urban indicators attributed to gender inequalities in educational levels and access to health care services. Primary health care services, including reproductive health and FP are limited in disadvantaged neighbourhoods. Abortion has been legal and safe in Turkey since 1983, but the unmet need for safe abortion services remains high due to political opposition. Only 20% of abortions have been provided by public health institutions and more than half in private practices or private hospitals.[197] Thus, advocacy to prioritise reproductive health services, and abortion care in particular, in the public health system is needed. [198]

Three main policy documents are currently being drafted: the *2018-23 Women Empowerment Strategy Document and Action Plan*, the *2016-20 Combating Domestic Violence against Women National Action Plan* and the *Early and Forced Marriage Policy*.[199]

4.4.3 Egypt

i) Contextual environment

Egypt is a low-middle-income country with a population of 98.4 million people, most of whom are concentrated around the Nile. Given the pressure of overpopulation on limited food and water

[191] Yüceşahin, M. & Adalı, Tuğba & Türkyılmaz, Ahmet. (2016). Population Policies in Turkey and Demographic Changes on a Social Map.
[192] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[193] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[194] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[195] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[196] Global Burden of Disease Collaborative Network (2017) Global Burden of Disease Study 2016 (GBD 2016) Health-related Sustainable Development Goals (SDG) Indicators 1990-2030. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), quote in (2016) Goal 5: Gender Equality - SDG Tracker. In: Our World in Data.
[197] Mihciokur S, Akin A, Dogan BG, & Ozvaris SB (2014) The unmet need for safe abortion in Turkey: a role for medical abortion and training of medical students, Reproductive Health Matters, 22:sup44, 26-35
[198] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[199] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey

resources and agricultural land, SRH is a priority for the Egyptian Government. Fertility levels decreased to 3.3 births per woman in 2018 and the AFR was 53.8 per 1,000 births in women aged 15-19 years.[200]

Egypt has achieved remarkable progress regarding its national health indicators over the past decades. Availability of basic health services is almost universal and 95% of the population is now living within 5kms of primary health care centers. The Egypt Demographic Household Survey revealed improvements in several key reproductive health indicators in the past 20 years, including reductions in maternal, infant and child mortality due to increased coverage of maternal health services and perinatal care (90% of mothers received antenatal care from a trained provider).

However, there are significant regional disparities in access to and provision of adequate FP services. Poverty and rural settings are associated with high fertility and low contraceptive prevalence.[201] Rural Upper Egypt is particularly disadvantaged regarding maternity care, with 57% antenatal coverage, compared with 80% coverage among urban births.[202] Social, cultural, and religious norms in Egypt have sometimes caused FP to be stigmatised.

ii) Family Planning policy direction

A historical analysis of Egypt's Population Policies noted that Egypt has a comprehensive population policy since 1975 with clearly defined dimensions including population growth, distribution and characteristics, and wide differentials between geographic regions or groups.[203] Significant progress has been achieved in FP from the 1980s, with donor resources benefitting programme at all levels. Progress slowed in the late 90s with reduced donor resources, which were not matched by government resources. High-level political support has varied over time, affecting the level of performance and the national programme's support.

The main objective of all of Egypt's population strategies has been controlling population growth. The *2002-17 National Population Strategy* contained quantitative goals to reduce fertility to replacement level and increase contraceptive utilization. The goals were to change culture and reproductive behaviour to reduce family size to two children per family. These goals were also clearly stated in the *Population and FP Strategy 2007-12*.[204] While the role of education is emphasised in both strategies, full implementation is yet to occur. [205]

The *2015-30 National Population Strategy* contains education goals directed at youth and those of reproductive age. The education topics include FP methods, the value of a smaller family size, SRH and GBV. The intention is to target groups with high fertility and those living in poverty. The education programme will be delivered via NGO door-to-door visits, training religious and community leaders

[200] UNFPA (2020) Egypt Family Planning.
[201] UNFPA Country programme document for Egypt (2018–2022).
[202] UNFPA Egypt (2020) Sexual and reproductive health in Egypt
[203] Hussein A. Egypt's Population Policies And Organizational Framework UNFPA
[204] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[205] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries

(Muslim, Christian) on FP and via sport festivals.[206] Several NGOs in Egypt have pioneered the development of youth SRH programmes, although very few have been scaled up. [207]

Gender inequalities lead to prevalent harmful practices (FGM and early marriage), affect childbearing trends, encourage large families and decrease demand and use of FP services.[208] While Egypt has retained an Islamic interpretation of personal status laws, it has introduced modern reforms such as the criminalisation of FGM and increased the minimum age of marriage to 18 years for boys and girls.[209] However, child marriage still occurs in Egypt, with 1 in 6 girls marrying before her 18th birthday.[210] The Egyptian *Penal Code of 1937* (sections 260-264) prohibits abortion under all circumstances. Egypt is committed to the right to be free from sexual and gender-based violence (GBV). In 2014, an article addressing sexual harassment was introduced into the Penal Code. In 2015 a Presidential Decree was issued withdrawing Egypt's reservation on Article (21) of the Charter on the *16 Rights and Welfare of Child*.[211] However, existing legal, political and institutional frameworks for adolescents SRH rights do not guarantee access to accurate SRH information or education. [212]

Despite Egypt's strategic efforts to reduce population growth rates, a 2019 review of the *National Population Strategy 2015-20* by the National Population Council and UNFPA [213] found significant challenges hampering this effort. These include limited financial resources, varying levels of political support, limited role of regional councils on population, weak follow-up and coordination mechanisms and low participation from non-governmental organizations. The Arab Republic of Egypt United Nations Partnership Development Framework (2018–2022) United for a Sustainable Future supports Egypt's government scaling up FP programme to meet population goals.[214] Assistance from the European Union (EU) and UNFPA through the EU support to Egypt's *National Population Strategy 2018* has the following objectives: [215]

- FP services including contraceptive commodities scaled-up and more accessible (supply-side);
- Youth and population in reproductive age educated on FP, public awareness on the value of smaller family size raised (demand-side);
- Institutional capacities for monitoring and coordination of the implementation of the NPS strengthened (population governance).

The collaboration between the EU and the Government of Egypt initiated the development of a *Family Planning National Costed Implementation Plan 2019-23*. The Plan is a multi-year actionable roadmap

[206] UNFPA (2020) Egypt National Population Strategy 2015-30 progress review - Year 2
[207] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[208] United Nations Population Fund Country programme document for Egypt (2018–2022)
[209] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[210] Population Council (2015) Panel Survey of Young People in Egypt (SYPE) 2014
[211] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[212] Roushdy N (2013) Sexuality Education in Egypt: A Needs Assessment for a Comprehensive Program for Youth
[213] NPC, Embassy of Switzerland in Egypt, and UNFPA (2019) Review of the Executive Plan 2015–2020 In the Context of the National Population and Development Strategy 2015–2020
[214] Arab Republic of Egypt United Nations Partnership Development Framework 2018 to 2022 United for a Sustainable Future
[215] European Union, Egypt Ministry of Health and Population and UNFPA (2019) EU Support to Egypt's National Population Strategy

designed to help the government achieve its FP goals and to ensure integration of services and efforts, including public and private sectors, media institutions and NGOs.[216]

iii) Family planning services

The Egyptian Family Planning Association (EFPA) is a lead Egyptian government partner in the National Population Commission's ongoing initiative to increase contraceptive prevalence. EFPA provides information, education and communication (IEC) programme for the general public, many of which run on a peer-to-peer basis, particularly amongst young people. Emergency intervention to prevent reported early marriage cases is a key priority. [217]

A 2013 Egyptian study assessing youth-friendly clinics noted an improvement in the overall environment for SRH education and service provision in recent years. Pilot government and non-government youth-friendly clinics were established. However, their coverage and use remain limited, with most beneficiaries being married women, highlighting the need to address cultural and religious sensitivities. Government commitment is required to scale up pilot clinics into a national programme to improve youth's welfare. [218]

The Government of Egypt has committed to safeguarding the health of its women and girls and reducing its population growth by expanding its contraceptive programmes and improving the quality of services to attract new users.[219] In 2018, the Government of Egypt pledged to reduce unmet need for FP from 12.6% in 2014 to 10.6% by 2020, the 12-month discontinuation rate from 29% in 2014 to 24% by 2020 and increase the prevalence rate of all contraceptive methods used among married women (CPR) from 58.5% in 2014 to 62.8% by 2020. [220] The Government is integrating FP into all primary health care units and government hospitals to facilitate universal coverage. FP methods and services are offered at low prices and also free of charge in poor villages and mobile clinics.[221]

The FP programme of Egypt is noteworthy because it involves religious leaders in the FP campaigns. Egypt is home to Al-Azhar Mosque and Al-Azhar University, two renowned centers of Islamic teaching. These centers have frequently dispatched fatwas in favour of modern contraception and the Egyptian Government has used them in its FP campaigns. As a consequence, contraceptives are available in Egypt in all government primary health care facilities.[222]

The Egyptian government and UNFPA co-founded a 2-year USD 5.9 million programme under the National Population Strategy. Launched in 2017, the *Two is Enough* inter-ministerial programme is implemented in partnership with local NGOs.[223] The goal is to raise awareness to curb population growth and accelerate social development. The programme includes workshops, conferences, and door-to-door activities to distribute birth control methods to the targeted 1.3 million mothers aged < 35 years to encourage them to have two children at most. These mothers are beneficiaries of an income support

[216] UNFPA (2020) Egypt National Population Strategy 2015-30 progress review - Year 2
[217] IPPF (2016) Egyptian Family Planning Association
[218] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[219] FP2020 Egypt commitment maker since 2017
[220] FP2020 (2018) Egypt FP2020 Commitment Self-Reporting Questionnaire 2018
[221] FP2020 (2018) Egypt FP2020 Commitment Self-Reporting Questionnaire 2018
[222] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72
[223] Wahish, N (2018) Family planning in Egypt: The 'Two is enough' project

programme in 2,257 villages within 119 departments in 10 disadvantaged directorates with highest fertility.

In 2018, the Ministry of Health and Population launched a new FP programme in Egypt in cooperation with USAID to respond to Egypt's rapid population growth. The programme aims to improve citizens' health behaviour and support the quality of FP services and reproductive health. An electronic system will be established to register the programme's beneficiaries, implement a distance learning model, design a FP and reproductive health curriculum in the medical and nursing schools, and involve the private and public sectors in providing the service. USAID will provide technical assistance and training to the Ministry to strengthen its FP and Reproductive Health Programme. Activities will help increase demand for FP services and enhance the quality of services, aiming to improve contraceptive use and reduce fertility over time. The 5-year, $19 million programme will be implemented in nine governorates in Upper Egypt and Cairo and Alexandria.[224]

4.4.4 Morocco

i) Contextual environment

Morocco is a low-middle income country of 36 million people (2018). During the last decades, Morocco has made remarkable progress in reproductive health by increasing access to contraceptives and reducing TFR and infant mortality. However, the reductions are insufficient compared to other developing countries with a similar level of economic development. [225] The age structure is changing, and the country is experiencing a transition at different levels (demographic, geographic, economic, political, and epidemiological). Morocco has large disparities in access to health and social services between urban and rural areas.[226] The country has experienced a consistent decrease in TFR (2.4 births per woman in 2018) and teenage pregnancy (5.5% of the female adolescent population in 2018), and adolescents are considered a vulnerable population.

Women's empowerment remains a challenge in Morocco despite progressive legislation. The 2004 Family Code (*Moudawana*) contained important rights for women, including:

- the right to divorce by mutual consent,
- the right to child custody,
- responsibility for the family to be jointly shared by the husband and the wife, and
- polygamy requires a judge's authorisation and the consent of the man's first wife.[227]

The *2018 Hakkaoui Law* criminalises violence against women. It imposes tougher penalties on perpetrators of violence in the private and public spheres, including sexual harassment, rape, and domestic abuse (online and offline), and bans forced marriage. Morocco is among the first Middle East and North Africa (MENA) countries to repeal the rape in marriage law, which allowed a rapist to evade punishment by marrying his victim. Morocco's Penal code was amended to legalise abortion in cases of incest, rape and fetal malformation, as well as in case of maternal health risks.[228]

[224] FP2020 (2018) Ministry of Health launches family planning program
[225] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health 15
[226] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health 15
[227] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health 15
[228] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries

The Department of Justice and Islamic Affairs and the National Council for Human Rights conducted a study regarding the legal, political, and Islamic implications of liberalising Morocco's abortion laws. The study revealed that most Moroccans supported legalising abortion, but only in cases of rape, incest, and birth defects. As result, the Morrocan Government recently amended the law to allow abortion in cases of incest, rape, and birth defects. The amendment brought the 50-year-old code into alignment with the goals of the 2011 Constitution. Previously, Article 453 of the Penal Code mandated that abortion was only permissible if the health of the mother was in danger.[229]

Nevertheless, substantial legal and gender discrimination persists. Women have fewer rights to economic assets (inheritance), social security benefits and marital property. The law is unequally applied, with public services dedicated to supporting women with legal matters remaining under the influence of social norms.[230]

ii) Family Planning policy direction

FP commitments in Morocco guarantee the rights to reproductive health, to decide the number and spacing of children, to consent to marriage, to be free from sexual and GBV and be equal in marriage.[231] Morocco's *2011-20 National Reproductive Health Strategy* goals included: improving institutional coordination, establishing a central authority regarding SRH, improving access of target populations to SRH services (including adolescents), integrating a SRH monitoring and evaluation system, strengthening SRH communication and partnerships and conducting SRH research. The areas of focus included: family planning, STIs, improve adolescent's knowledge of SRH and contraception, address violence on women and children, and provide perinatal care to reduce maternal and child mortality as well as prevent uterine and breast cancer. Secondary objectives included: promotion of pre-marriage consultations, infertility treatment awareness and improvement and health issues related to menopause. The Moroccan Parliament introduced a 30% gender quota in the 2011 budget for the implementation of the *2011-20 National Reproductive Health Strategy* under Law 130. Despite this framework, it will take time to benefit women. Morocco is training civil servants across several ministries and agencies in gender mainstreaming of programme and monitoring of gender indicators.

The *2020-25 National Reproductive Health Strategy* refers to UNFPA's framework for adolescent SRH for integrating SRH information and services and is yet to be implemented. [232] It has several strategic principles: institutional coordination and evaluation, increasing access to SRH services for targeted populations, integrate a monitoring and evaluation system and strengthening SRH partnerships and research. The focused areas include: adolescents' SRH, physical and mental health Including STIs, family planning, re-designing pre-marital consultation, maternal health and perinatal care, addressing violence towards women and children, uterine, cervical and breast cancer prevention, infertility treatment and health issues related to menopause.

[229] Word News (2020) Morocco Liberalizes Abortion Laws, Amends Penal Code
[230] World Bank Group (2018) Morocco: governing towards efficiency, equity, education and endurance; a systematic country diagnostic.
[231] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[232] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020

iii) Family planning services

The evaluation of the *2011-20 National Reproductive Health Strategy* noted that FP and contraception policies need to reach more women, antenatal and postnatal care should be enhanced, and more skilled medical personnel are needed to assist women during labour, especially for poor women living in rural areas and deprived regions.[233] Generally, SRH in Morocco can be improved by adopting targeted and equitable health strategies to enhance the mean status of the whole population while reducing regional disparities between urban and rural areas and inequalities between rich and poor.[234] Key informants identified the following implementation barriers: limited coordination and integration of the various SRH services, lack of awareness of the strategy by health care professionals, limited and fragmented statistical capacity impacting on monitoring, difficulties in centralising the strategy because of long-standing specialised programme addressing aspects of SRH such as the FP programme, lack of funding to fully implement the strategy and need to collaborate with international organisations to support implementation costs, lack of experienced medical professionals in regions and lack of an action plan before implementing the strategy.[235] **Box 9** contains the recommendations from the evaluation.

Box 9 Evaluation of the Moroccan 2011-20 National Reproductive Health Strategy

The evaluation of the Moroccan *2011-20 National Reproductive Health Strategy* based on interviews with key informants provided the following recommendations

- Form a National Task Force to promote and coordinate activities related to reproductive health education.
- Improve coordination of actors and institutions in the areas of reproductive health
- Educational programmes on various SRH topics have been implemented separately (on STIs, maternal health) but there is a need to integrate the overall SRH educational programme
- Evaluate the level of knowledge of health professionals before designing the educational plan and capacitate health professionals in gender principles and SRH issues (obstetrics, nurses and doctors) and medical students by integrating a SRH module in medicine faculties
- Community engagement in gender and SRH training
- Conduct SRH research: 1) identify barriers to integration of SRH education and services; 2) include all women in reproductive age, not only married women in future surveys; 3) conduct a cost-benefit analysis on implementing SRH education and servicers versus not implementing it 4) identify the impact of improved SRH services on unwanted pregnancies; and 5) identify the savings that investing in women and children's have on productivity, education and the economy
- Increase the effectiveness of SRH communication campaigns (materials and content) targeted to the general public.

Source: Abaacrouche, M & UNFPA's technical support (2020) 2011-20 Evaluation of the National Reproductive Health Strategy

4.4.5 Bangladesh

i) Contextual environment

Bangladesh is a low middle-income country aspiring to become a middle-income country by 2021. The population in 2018 was 161.4 million, with 37% living in urban areas.[236] Bangladesh is one of the most

[233] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
[234] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health 15
[235] Abaacrouche, M & UNFPA's technical support (2020) Evaluation of the National Reproductive Health Strategy 2011-2020
[236] UN Human Development Programme (2020) Global Human Development Indicators.

densely populated countries in the world. [237] The *2014 Bangladesh Demographic Health Survey* noted the population growth rate as 1.37%. [238] Strong growth and rising incomes have enabled Bangladesh to make significant progress against most human development indicators. [239]

FP indicators continue to improve: TFR decreased from 2.3 in 2014 to 2.0 births per women in 2018, the AFR decreased from 113 in 2014 to 82 per 1,000 births in women age 15-19 years and the CPR (all methods) increased to 62%. However, women's low status, the prevalence of child marriage, and high maternal mortality and morbidity rates remain serious concerns. The largest reproductive segment (15-24 years) constitutes a significant proportion of the total population. Bangladesh has low levels of secondary and postsecondary education enrolment. 59% of women (20-24 years) marry before 18 years. These data indicate that SRH education and services are low among the youth.

Despite successes in health indicators, challenges remain in achieving universal access to SRH services, partly because of the persistent unmet need for FP (12%), particularly among unmarried adolescent girls.[240] Annually, nearly one in three pregnancies (1.3 million) are terminated, although abortion is illegal in Bangladesh, except to save a woman's life. [241] Bangladeshi adolescents experience high rates of early marriage, high fertility rates and limited negotiation skills. They have insufficient awareness of and information about reproductive health. [242] Bangladesh has the highest prevalence of child marriage in South Asia, including of girls under 15.[243] Child marriage has begun to decline, but not fast enough to eliminate the practice by 2030 as part of the SDGs.

Bangladeshi society is conservative. There is strong religious sensitivity and socio-cultural taboo attached to sexuality. Although extramarital sex is forbidden, studies reveal diverse sexual practices and behaviours practiced both within and outside marriage, particularly among the youth. Their lack of adequate SRH information and services often leads to risky behaviours. [244] The learning scope from parents, guardians, elders and peers is also very narrow due to conservative views rooted in the culture.[245]

ii) Family Planning policy direction

Bangladesh's commitment and response to FP is based on human rights principles and aligned with the international frameworks on the UN Convention on the Rights of the Child (CRC), [246] ICPD PoA, the Beijing Platform for Action and the SDGs. Post ICPD, Bangladesh formed a National Committee and developed a National PoA for implementation of ICPD PoAform. The National Committee formulated national policies on Population, Maternal Health, HIV/AIDS and STD and Population, Health & SRH and Nutrition.[247]

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[237] UN Human Development Programme (2020) Global Human Development Indicators.
[238] ARROW (2016) Bangladesh Advocacy Brief: Comprehensive Education: the way forward
[239] World Bank data (2020) Bangladesh country update
[240] ARROW (2017) Bangladesh Country Profile on Sexual and Reproductive Rights
[241] ARROW, Country Advocacy Brief (2016): Bangladesh. Comprehensive Sexuality Education: The Way Forward
[242] Ainul S, Bajracharya A, Reichenbach L, Gilles K (2017) Adolescents in Bangladesh: A situation analysis of programmatic approaches to sexual and reproductive health education and services. Population Council
[243] UNFPA-UNICEF 2017 Annual Report Country Profiles: Global Programme to Accelerate Action to End Child Marriage
[244] ARROW, Country Advocacy Brief (2016): Bangladesh. Comprehensive Sexuality Education: The Way Forward
[245] ARROW (2016) Bangladesh Advocacy Brief: Comprehensive Education: the way forward
[246] UN (1989) Convention on the Rights of the Child
[247] UNFPA (2010) The Bangladesh Family Planning Programme: Achievements, Gaps and the Way Forward

The most recent FP related polices include the *4th Health, Population and Nutrition Sector Programme Plan* (4th HPNSP) 2017-22,[248] led by the Ministry of Health and Family Welfare. The 4th HPNSP priortises FP as a path toward achieving the SDGs and is supported by the *National Strategy for Adolescent Health 2017-30.* [249] It also aligns with the Constitution, which guarantees the right to health care and medical treatment for all its citizens, irrespective of age, sex, caste, creed and colour. [250] Several Acts of Parliament guide the 4th HPNSP, including the *Children Act 2013*, *Women and Children Repression Prevention Act 2000* (amended in 2003), *Human Trafficking Prevention and Deterrence Act 2012*, and the *Child Marriage Restraint Act 1929* (amended in 1983).[251]

The *National Plan for Sexual and Reproductive Health* is a costed integrated 5 yearly national plan which prioritises access for key groups aligned with ICPD and SDG objectives to address reproductive health and rights, youth development, and gender equality challenges.[252] Bangladesh prioritised implementing the National Action Plan for Postpartum FP, reducing social and geographical disparity through providing regional FP packages in Sylhet and Chittagong divisions, addressing unmet need among adolescents and youth by operationalising the national adolescent health strategy and ending child marriage.

The Government of Bangladesh will mobilise USD$615 million for the FP programme over 2017-21. This is a 67% increase from the previous programme. Bangladesh has strengthened its efforts to increase trained service providers, including deploying midwives to all sub-district hospitals, improving supervision of FP services by placing clinical teams in all districts and engaging the private sector to address gaps in service provision and supply of commodities.

iii) Costed Implementation Plan for the National Family Planning Programme

The Bangladeshi Government (Programme Management and Monitoring Unit, Ministry of Health and Family Welfare (MOHFW) and the Directorate General of Family Planning) with the support of UNFPA developed the 2020-2022 Costed Implementation Plan (CIP). The development process involved a desk review of international and national evidence, a literature review of high-impact practices, consultation with stakeholders, a review of CIPs of other developing countries, and consultation with international CIP experts.[253] **Table 12** contains a summary of the identified

Specific objectives included: determining the strategies required to achieve both FP2020 and national level goals, estimating the budget required to implement the newly defined and high impact strategies, and estimating the resource-gap especially additional resources required to implement the newly defined and high impact strategies. The key strategies and activities for achieving the FP goals costed for three years (2020-22 of the remaining 4th HPNSP) include:

- Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, and human resources)
- Increasing acceptability of LARC&PMs through skilled human resources and male engagement

[248] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program
[249] Bangladesh Directorate General of Family Planning (2016) National Strategy for Adolescent Health 2017-2030
[250] Bangladesh (1972) Constitution of 1972, Reinstated in 1986, with Amendments through 2014
[251] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program
[252] USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh
[253] USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh

- Promoting interval and post-partum contraception
- Intra- and inter-sectoral collaboration and coordination including NGOs
- Special focus on hard to reach and urban areas, and other low performing areas
- Monitoring, Evaluation and Research
- Targeting adolescents and youth
- Targeting adolescent with special focus on males

Table 12 Bangladesh's Family Planning Programme key challenges [254]

Key Areas	Key issues
Commodity security	○ Private sector data is not properly included in the forecasting and supply planning processes ○ Dependence on development budgets for many FP commodities even though commodities are recurring and essential part of family planning services.
Financing	○ Need to increase overall budgetary allocation ○ Private sector role in FP service delivery and financing not clearly defined
Stewardship, Governance and Partnerships	○ Limited of political goodwill is observed, which is substantiated by lower political attention to national population and other related days ○ Weak supportive supervision mechanisms and structures. including poor accountability ○ Inadequacy of FP coordination and governance mechanisms ○ Lengthy and complicated bureaucratic process in filling vacant posts within minimum time possible
Research, Monitoring and Evaluation	○ Need for more research on FP practices ○ Weak M&E system. Limited systematic use of data in formulation and implementation of national FP program as well as availability and quality of necessary data.
Demand Creation	○ Weak FP services seeking behavior among adolescents ○ Lack of accurate and consistence information among adolescents ○ Myths and misconceptions on side effects
Service Delivery	○ Increasing motivation is challenging due to inadequate number of health care workers which compromises access to and quality of FP services provided by the existing personnel ○ Quality services are not available in many facilities ○ Lack of services in hard-to-reach areas especially in monsoon season ○ Insufficient strategies for provision of high-quality youth friendly services ○ Cultural factors inhibit family planning uptake ○ Men are not targeted since FP is women-centric by design

iv) Family planning services

Despite achieving remarkable progress, several FP related challenges require immediate attention: child marriage, high unmet need for adolescents, underserved urban slums, limited human resources, collaboration across implementing agencies and unequal gender norms. Additionally, new strategies to improve FP indicators to achieve the national level targets need to be implemented.[255]

The Population Council Review of Programmes in Bangladesh,[256] noted that the standard government health facilities SRH information package for adolescents includes: physical and mental changes during puberty, general and menstrual hygiene, early marriage and reproductive health, birth control and violence against adolescent girls and boys. Most health facilities excluding Community Clinics have FP commodities and equipment but only 40% can offer modern FP services. [257] General health care facilities provide youth-friendly services via Adolescent Friendly Health Centers (AFHCs) to reduce stigma and other barriers experienced by unmarried girls when accessing health service. However, usage rates have not improved and there are calls for awareness raising among adolescents' teachers and guardians. Furthermore, the policy environment favours delivering clinical SRH services only to married adolescents.[258]

[254] Extracted from: USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh

[255] USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh

[256] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

[257] ARROW (2016) Bangladesh Advocacy Brief: Comprehensive Education: the way forward

[258] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

4.5 Country comparison of FP policies, programme and indicators

This section compares the FP policies, programme and indicators of the selected countries. The Family Planning Effort Index (FPE),[259] which estimates the strength of National FP Programmes and the National Composite Index on Family Planning (NCIFP),[260] which measures the existence of FP policies and programme implementation, were utilised to undertake the comparison. **Table 13** describes the two published data sources.

Table 13 Indexes for comparing Family Planning policies and programme across countries

Data source	Description
The **Family Planning Effort Index (FPE)** an analysis of national FP programme	• The only data source measuring national FP programmes using a standard set of questions across countries and over time. Equated to "how good a FP programme is" in each country. • Index indicator score quantifies the strength of National FP Programmes as perceived by knowledgeable observers. • It measures level of effort put into nation FP programmes worldwide, and tracks how this changes over time.[261] • Collected via questionnaires administered to 10-15 highly informed respondents per country (ministry of health, IPPF affiliate or NGO; international consultants, and other informed individuals). • Collected 8 times from 1972 to 2014. It revealed that in 1972, a quarter of the world's population lived in countries with very weak or no FP programmes, while in 1999, no country in fell in this category. • Includes 30 measures of effort across four dimensions (policies, services, evaluation, and method access). Researchers convert the responses to these questions to individual scores (ranging from 1-10) for each of the 30 items, using an established set of rules. **The Index serves several important purposes:** • It enables cross-national comparisons of FP programmes across four key components: policies, services, evaluation, and access over time • It traces the evolution of the FP programme in a given country over time; and • It measures FP programme input, independent of outcomes (such as contraceptive prevalence or fertility). • **It attempts to measure the effort (input) that goes into the FP programme, not the results achieved.**
The **National Composite Index on Family Planning (NCIFP)** tool developed to support FP2020's efforts to improve the enabling environment for FP	• Collected in 2017 and 2014, built on the FPE, the data are intended for policy and planning use by each country's FP stakeholders. • Provides new data about key areas important to FP, but have not been well measured in the past. • It measures the existence of policies and guidelines, as well as the extent to which FP programme implementation includes measurable dimensions of quality service provision.[262] • Collected via questionnaires administered to 10-15 highly informed respondents per country (staff of government FP programmes, local NGOs, local academic or research institutions, and international agencies working locally). **Questionnaires consists of 35 items organised under five dimensions:** 1. **Strategy:** What plans are in place? Do they include important elements (e.g. quantified objectives, focus on vulnerable populations, etc)? Is there Government support for FP? 2. **Data:** data collection (service statistics, monitoring sub-groups, etc) to inform decisions. 3. **Quality:** Do services meet WHO standards? Are quality of care indicators monitored? Are there structures in place to support quality services? 4. **Equity:** Focused on issues related to policies and programme related to discrimination, efforts to reach under-served groups, and wide-spread access to FP methods. 5. **Accountability:** Focused on monitoring and addressing issues related to coercion and denial of services and ensuring voluntarism and informed choice. • Total score is average of 35 individual scores for each country. Unweighted average in 2017 across all countries is 65 (out of 100 representing very strong effort), an improvement from 53 in 2014, • Despite differences between countries, there are similarities among the 35 individual scores: they tend to move together, agreeing largely in which rank higher and lower. The scores suggest a commonality in what programmes find more or less difficult to achieve, and is one of many promising avenues for further investigation. • Looking at the five dimensions there is some variability, but less than was seen in 2014. **Strategy continues to score the highest (74), and accountability the lowest (60).** The greatest improvement has been seen in

[259] FP2020 (2014) Family Planning Effort Index
[260] FP2020 (2017) National Composite Index on Family Planning (NCIFP)
[261] Measure Evaluation (2020) Family Planning Program Effort Index
[262] Weinberger, M. & Ross, J. The National Composite Index for Family Planning (NCIFP), Avenir Health's Track20 Project

Data source	Description
	Accountability, up 21 points from 2014. The smallest change was seen in equity, which only increased by 4 points between 2014 and 2017. **• A valuable source of information for the global FP community informing qualitative assessments of FP programmes and as a tool to stimulate and facilitate discussions among stakeholders about the factors that contribute to a strong FP programme, and whether there is agreement on perceptions of quality and equity.**

4.5.1 Findings from the 2014 National Family Planning Effort Index comparison

The overall FPE score measuring efforts into the FP programme (and not the results achieved) across four dimensions (policies, services, evaluation, and method access) was highest for Bangladesh (65.9), closely followed by Malaysia (63.2), Morocco (61.5), Egypt (50.1) and Turkey (38.5) (**Appendix 5**).[263]

The best score for the formulation of ***policies*** was for Bangladesh (72.1), closely followed by Morocco (70.1), Malaysia (59.5), Egypt (53.5) and Turkey (38.6). Among the five countries, Malaysia was second for *policy on fertility* (45.0) after Bangladesh (84.9), with the remaining countries below Malaysia; third for *favourable statement by leaders* (52.0) after Bangladesh (84.9) and Morocco (60.3); fourth *for policy on age at marriage* (62.6) after Morocco (75.4), Egypt (74.6) and Bangladesh (69.8); fourth for *important laws and legal regulations* (59.3) after Morocco (88.9), Bangladesh (83.3) and Turkey (64.6), and fifth or last for *advertising of contraceptives* (46.9). In summary, Malaysia could significantly improve on all FP-related policies when compared to Bangladesh, Morocco and to a certain degree Egypt. Turkey lags behind all compared countries.

The ***policy objectives*** reflect the current population strategies in Malaysia and Turkey (26.3 and 20.7 respectively), which shifted in recent years to encourage higher fertility rate, while Bangladesh (88.1) and Egypt (81.7) are focusing on reducing the population growth. Malaysia is doing well on enhancing economic development, avoiding unwanted births, improving women's health, improving child health, and reducing unmet need for contraceptives compared to the other countries. Malaysia could do better on reducing unmarried adolescent childbearing by implementing CSE and linking it to SRH services as recommended in a previous desk review.[264]

Regarding ***services provision***, both Bangladesh (60.9), Malaysia (60.3) and Morocco (59.6) had the highest scores, with Egypt (49.8) and Turkey (30.3) lagging behind. Malaysia is doing well to involve civil bureaucracy, postpartum programmes, training programme, personnel undertaking assigned tasks, logistics and transportation, and system supervision compared to the other countries. It could improve on involving the private sector agencies and groups, community-based distribution, home visiting workers, administrative structures and mass media campaigns for the distribution of IEC materials on reproductive health, providing incentives and disincentives.

Regarding the ***evaluation***, both Morocco (77.5) and Malaysia (73.3) had the highest scores, with Bangladesh (66.7), Egypt (53.7) and Turkey (53.0) lagging behind. Compared to the other countries, Malaysia is doing well across all the evaluation components, including record-keeping systems, programme evaluation and management's use of evaluation findings.

[263] FP2020 (2014) Family Planning Effort Index

[264] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.

Malaysia is doing well in focusing on certain ***vulnerable populations*** (the poor, rural populations and post-partum women). It could do better addressing the needs of unmarried youth and providing counselling and contraceptives for post-abortion women.

Bangladesh (66.7) and Malaysia (62.2) had the highest scores for ***accessibility***, with Morocco (53.7), Egypt (47.2) and Turkey (43.8) lagging behind.

Malaysia is doing well in the ***accessibility to a range of FP commodities***, including contraceptive pills, injectables, condoms, permanent sterilisation and IUD removal when compared to the other countries. It could improve accessibility to IUDs, male and female sterilisation, implants, emergency contraception, safe abortion and implant removal.

4.5.2 Findings from the 2017 National Composite Index on Family Planning comparison

The overall 2017 NCIFP score [265] builds on the efforts from the 2014 NFPE. It measures the existence of policies and guidelines, as well as the extent to which FP programme implementation includes measurable dimensions of quality service provision (strategy, data, quality, equity and accountability). Bangladesh had the highest score (63.0), closely followed by Egypt (61.6), Morocco (59.5) and Malaysia (58.4). Data for Turkey was not available for this Index (**Appendix 5**).

All compared countries were of a similar rating regarding ***FP Strategy***; Bangladesh (78.0) was the highest, followed by Malaysia (67.7), Egypt (67.6) and Morocco (65.9). Malaysia is doing well in reaching vulnerable populations with quality FP info and services, projecting resource needs (material, human and financial) to implement the FP Strategy, developing a plan to secure the resources, getting high-level FP support from the Director of the National FP programme and reporting to government, when compared to the other countries. It could improve on defining FP objectives over a 5-10-year period, including quantitative targets, ensuring participation of diverse stakeholders and producing regulations to facilitate contraceptive supplies.

Malaysia ranked highest for the ***data*** score (67.1), followed by Egypt (63.2), Morocco (60.1) and Bangladesh (53.6). Malaysia is doing well in collecting data regarding service statistics quality control, the adequateness of clinical record keeping, using data for monitoring (programme statistics, national surveys, and small studies) by programme managers for programme improvement compared to the other countries. It could improve on collecting data from private sector commodities and ensuring FP services access to vulnerable populations.

Both Egypt and Bangladesh had the highest score for ***quality*** (62.9 and 62.6 respectively), followed by Morocco (60.0) and Malaysia (53.7). While Malaysia had high scores for Routine Counseling on Sterilisation Permanence and Access to IUD removal, increasing the quality of the FP services provided should be a priority for Malaysia. It had consistently low scores across most components, particularly in the following areas: producing Indicators of Quality of Care (QOC) collated by both the public and private sector FP services, producing task sharing guidelines for delivery of FP services, establishing structures to address QOC (including participatory monitoring and community/facility quality improvement activities), providing information on informed choice and provider bias collected by government, training for FP personnel to effectively undertake tasks, optimal FP logistics and supply system to keep stocks of contraceptive supplies and related equipment available at all service points, at

[265] FP2020 (2017) National Composite Index on Family Planning (NCIFP)

all times and at all levels (central, provincial, local), optimal supervision system at all levels (regular monitoring visits with corrective or supportive action), and access to implant removal.

Bangladesh had the highest score for ***accountability*** (65), followed by Egypt (62.5), Morocco (57.8) and Malaysia (49.7). Accountability is another priority area for improvement in Malaysia, as it had consistently low scores across all components. The components included monitoring mechanisms at national, subnational, and facility-level to monitor access to voluntary non-discriminatory FP info and services, report denial of services on non-medical grounds (age, marital status, ability to pay), coercion (including inappropriate use of incentives to clients or providers), regular review of violations, and mechanisms for feedback from clients, providers and officials about service availability, accessibility, acceptability and quality.

Both Bangladesh and Malaysia had similar scores for ***equity*** (56.8 and 55.2 respectively), followed by Morocco (51.6) and Egypt (55.2). Malaysia is doing well on addressing provider discrimination and providing access to short-term methods of contraception compared to the other countries. It could improve on policies to prevent discrimination against sub-groups, and providing equitable community-based distribution of contraceptives for hard to reach areas (particularly rural areas) and provide equitable access to long-acting and permanent contraceptive methods (LAPMs).

5. DISCUSSION

The ICPD PoA and the Beijing PoA mobilised he FP agenda and drive most of the Sustainable Development Goals (SDGs).[266] FP's mobilisation reflects the international consensus that universal access to FP is key to ensuring a woman's right to regulate the number and spacing of births, achieving women's empowerment and gender equality, and reducing poverty. FP is also among the most health-promoting and cost-effective public health interventions (particularly modern contraceptive methods), with the potential to improve health outcomes by preventing unintended pregnancies, reduce maternal and infant morbidity and mortality and reduce STIs, including HIV/AIDS. It is estimated that increased contraceptive use has prevented 40% of maternal deaths in developing countries over the past 20 years.[267] A further 30% could be prevented by addressing the unmet need for contraception[268] by removing legal, regulatory and social barriers where appropriate to FP and SRH policy and programme.[269]

FP should be integrated within the SRH policy and programming framework that includes CSE, prevention and treatment of STIs and HIV/AIDS, and perinatal care. [270] SRH information and services should be integrated within primary health care services as there are proven benefits in gender equality, maternal and child health and HIV prevention. [271],[272] Improved access to CSE and modern contraception improves adolescents' chances of achieving higher education levels, delay childbearing and greater ability to engage in income-producing activity. [273] Governments should ensure that FP and SRH services are safe, reliable, convenient, available, accessible, cost-effective/affordable, culturally acceptable and inclusive of all individuals, regardless of gender, marital status, age, sexual orientation or religion.[274],[275] All countries face the challenge of addressing unmet need for FP and providing pregnant women and newborns with the standard quality of care recommended by WHO. This would improve developmental indicators. [276]

This desk review presents the latest evidence on international FP guidelines based on best practices and compares FP policies and practices across selected Sunni Muslim countries –Turkey, Egypt, Morocco, Bangladesh and Malaysia. A combination of data collection methods were used, including a review of relevant documents, a comparative analysis of FP environments across the selected countries and stakeholder consultations with LPPKN, UNFPA and TWC. The desk review provides important insights to inform Malaysia's next steps regarding FP policy and programmes.

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[266] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.
[267] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[268] Prof. John Cleland MA, Contraception and Health. The Lancet, Volume 380 Issue 9837, July 2012, pp.149-156.
[269] UN Women (1995) The Beijing Declaration and Platform for Action, Fourth World Conference on Women
[270] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[271] United Nations, Commission on Population and Development, Forty-Fourth Session, 11-15 April 2011, Report of the Secretary-General entitled Fertility, reproductive health and development. E/CN.9/2011/3.
[272] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[273] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[274] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[275] WHO (2017) Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation
[276] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.

5.1 Family Planning best practices

National reproductive health policies provide the broad vision and framework for government action. The policies should strive for universal access to a wide range of sexuality education and FP/SRH services across the life course.[277] FP is increasingly being incorporated into national development plans as part of SRH and rights, although with limited and variable extent and scope. [278] Countries with the FP policy environments listed in **Box 10** are more likely to reach their set goals. UNFPA's *Family Planning Strategy 2012-20* [279] guides implementing a rights-based FP policy and programme for countries to allow individuals and couples to choose whether, when and how many children they have.

Box 10 Characteristics of best practices in Family Planning policies

- FP policy goal is explicitly featured in the national agenda and aligns with international FP and SRH commitments.
- FP policy is backed up by a strong regulatory framework integrating SRH rights and principles within the national priorities of gender, youth, women's empowerment, improved education, rural development.
- The FP objectives, strategies and activities are designed and operated towards achieving family welfare goals based on a throughout situational analysis and the participatory engagement of a range of stakeholders during the design, the implementation and the evaluation (inter-ministerial officials, service providers, the private sector, religious and community leaders, NGOs, and civil society (youth and women's groups).
- Advocates for comprehensive sexuality education, and integrating universal access to FP/SRH services into primary health care (PHC) provided across the life course (which produces proven benefits in gender equality, maternal and child health and HIV prevention and is a key factor accelerating development).
- It has multisectoral agreements over content and delivery methods and its integration into a government's health care priorities ensures a minimum standard of FP/SRH services that leaves no one behind.
- It uses a multilevel approach addressing individuals, networks and communities at national, regional and local levels to support the implementation and scale up of successful FP/SRH interventions, address conservative opposition, advances international cooperation, and adapts innovation in content, delivery and methodological research.
- It has a long-term agenda (5-10 years) with clearly defined priority areas (e.g. addressing unmet needs of vulnerable groups), which ideally should not be influenced by the internal or external political environment.
- FP policy is translated into operational programmes for delivering services that will achieve the set national goals, contextualised to address specific needs and across the life-span, particularly youth and women's SRH needs.
- Has accountability mechanisms set up prior to implementation; is monitored and evaluated over time at the national, subnational, and facility level to identify and scale-up successful interventions and course-correct or terminate unsuccessful ones for best allocation of limited resources.
- Has strong political leadership and commitment for its implementation and engages religious scholars to support FP and improve infant and maternal health
- Allocates for appropriate human and financial resources via Costed Implementation Plans (CIPs) with clearly defined the roles and responsibilities of each stakeholder towards achieving common goals.

5.2 Family Planning policies and programme across selected countries

The ICPD PoA was endorsed by all the selected countries, albeit with reservations. The ICPD PoA notes that individual countries have the sovereign right to contextualise policies and programme to conform to customary laws, values, and cultures as long as they uphold individual SRH rights and principles and respond to individuals' needs. [280] Expectedly, this review noted that countries differ in their

[277] ARROW (2019) Brief: Universal Health Coverage and Integrating SRHR. Asian-Pacific Resource & Resource Centre or Women
[278] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[279] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[280] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau

commitments to SRH rights and FP principles, adaptations, implementation and progress measurement. Past and current data across the selected countries indicate that reproductive health is a crucial public health issue. These countries, particularly Malaysia, have made remarkable progress in human and economic development. The countries have legal and policy frameworks for SRH for matters such as age of marriage, abortion and gender-based violence. Particularly Morocco, where the 2004 Family Code or *Moudawana* of Maliki Sunni Islamic school, regulates family issues such as marriage, polygamy, divorce, inheritance or child custody. [281] Morocco has been praised for addressing women's rights & gender equality within Islamic law. [282]

The national population goals across countries often direct the FP policy direction, which might encompass certain key aspects of SRH rights, such as access to SRH services or the ability to decide one's health. [283] Following the ICPD and Beijing, all selected countries except Malaysia consider FP a component of a broader SRH plan, which encompasses sexuality education, particularly for youth, prevention and treatment of STISs including HIV/AIDS and perinatal care.[284] Integration in a SRH plan facilitates the linkages with the SRH rights and principles and strengthens the policy or plan overall. However, despite all selected countries having national guidelines, there is a common failure to translate a rights-based SRH framework into practice fully. There are notable policy and programme weaknesses when measured against international guidelines and best practices. Examples include the lack of or weak policies for vulnerable populations and the exclusion of the role and responsibilities within the family unit. The latter example increases the pressure on women as primary carers and decreases their ability to participate in the workforce).

National FP goals vary across countries; Malaysia, Turkey and Morocco introduced contraceptive programmes in the past decades, which reduced the TFR to replacement rate by 2018. The three countries' populations are projected to decrease. The projection has resulted in a shift in their population strategies to encourage higher fertility. The aim is to prevent an economic environment typical of developed nations, an ageing population with a high dependency ratio and a shrinking working-age population. In contrast, overpopulated Egypt and Bangladesh are still focusing on controlling the population growth affecting their limited resources.

The prioritisation of FP and SRH issues within the national agendas is influenced by the wider socio-cultural contexts. Across examined countries, and Malaysia in particular, less controversial SRH services such as perinatal care services seem more likely to get buy-in from key stakeholders, compare with sensitive services such as safe abortion or GBV services, which require specific strategies to transform socio-cultural norms, beliefs and behaviours. [285]

[281] Center for Public Impact (2020) Reforming Moroccan family law: the Moudawana. Centre for Public Impact (CPI).
[282] Boutayeb W, Lamlili M, Maamri A, et al (2016) Actions on social determinants and interventions in primary health to improve mother and child health and health equity in Morocco. International Journal for Equity in Health
[283] Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. In: Guttmacher Institute.
[284] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[285] Lim, S.C. Yap, YC. Barmania, S. Govender, V. Danhoundo, G & Remme, M. (2020) Priority-setting to integrate sexual and reproductive health into universal health coverage: the case of Malaysia, *Sexual and Reproductive Health Matters*

Domestic politics across the selected countries determine whether, how, and to what extent a rights-based approach to SRH and FP framework is implemented.[286] Political contestations over SRH rights continue across the selected countries, despite differences in their overall social attitudes to sexuality and reproductive health. Increasing Islamic division on sexual health issues is echoed in domestic politics; however, the strength and the specific form differ. Egypt has been particularly successful in engaging religious scholars in FP campaigns, a critical factor for sensitising populations. The approach has increased the acceptability of birth control within Islam. The Al-Azhar Mosque and the Al-Azhar University regularly issue fatwas favoring modern contraception with available in all government primary health care facilities. [287] In contrast, Turkey's conservative political turn since early 2010s, [288] has restricted FP services for women .[289] The restrictions are impacting policymaking, implementation, and civil society activities on rights-based sexual health promotion. Turkey has a pronatalist direction within the most recent *Four-Year Development Plan,*[290] which encourages women to bear a minimum of three children. Turkey did not participate in the WHO's Action Plan for Sexual and Reproductive Health on the 2030 Agenda for Sustainable Development in Europe. [291] The country's centralised health governance also makes Turkey's SRH policies vulnerable to abrupt changes.

5.3 Family Planning service delivery across selected countries

Despite significant progress made, FP implementation remains a challenge across the selected countries. Religion remains a critical influence on FP, although its direction (progressive or conservative) varies by country. Misconceptions based on religious precepts significantly contribute to the insufficient progress towards implementing FP services. Islamic religious beliefs and cultural views on family size influence the acceptance and use of contraception. Although most Islamic scholars permit FP practices as the Quran does not prohibit them, uninformed scholars might view FP as restricting the Islamic world's growth/strength. Uninformed views highlight the need to sensitise and engage religious scholars in FP efforts. [292] Additionally, premarital sexual relationships across selected countries are forbidden by Islamic Law and unapproved by society. However, premarital sexual relationships do occur. FP and SRH education and services for youth are required urgently to avoid the risk of STIs and unwanted pregnancies.

FP services are part of the basic health benefits package and are delivered at hospitals, primary health care centers and/or outreach clinics. However, the selected countries face several similar challenges in implementing FP programme. Despite efforts to integrate FP programme into primary health care, access to FP or contraceptive services and equity issues remains a challenge, particularly for vulnerable

[286] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[287] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72
[288] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[289] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[290] Yüceşahin, M. & Adalı, Tuğba & Türkyılmaz, Ahmet. (2016). Population Policies in Turkey and Demographic Changes on a Social Map.
[291] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[292] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

populations. Across Egypt and Bangladesh, the desired result of fertility control was not achieved, especially amongst rural women. Implementation barriers among these low-income countries include lack of infrastructure, stock shortages, lack of trained staff, and cost of contraceptive methods that lead to limited access among vulnerable groups. In Malaysia and Turkey, the low fertility rate combined with pronatalist policies presents challenges regarding access to and use of contraception for all populations, particularly for young people.[293]

The use of modern contraception also varies significantly across and within the selected countries. Common implementation challenges include providing services to hard to reach areas; Turkey, Morocco and Egypt have challenges in addressing geographical disparities in service provision and access. Rural areas are disadvantaged and have worse FP/SRH. Addressing AFR also presents a challenge. Egypt has committed to investing in empowering girls to address this problem. Accessibility barriers to FP services are also linked to conservative religious social attitudes, and contribute to high adolescent pregnancy rates. [294] Since SRH research, education and services are commonly targeted to married couples, unmet need for contraception among young people is underestimated. A 2020 desk review across the same selected countries concluded that implementation of SRH education in schools and the community is poor.[295] Large disparities within countries in CPR and unmet need for FP are associated with poverty, younger age, gender (female), geographical location (urban vs rural) and marital status (unmarried). Approaches to reducing unmet need for FP should be contextually and culturally sensitive. [296] Countries should work on reducing unmet need by addressing both the demand for and supply of FP services. [297]

Other vulnerable populations such as people living with HIV and sex workers often face compounded access barriers and rights violations, leading to high rates of unintended pregnancy, increased risk of HIV and STIs, limited choice of contraceptive methods, and higher levels of unmet need for FP. These groups require particular attention to ensure their reproductive rights and access to rights-based FP services. [298]

Rational utilisation of existing limited national resources is a major challenge to improving reproductive health across countries. Following best practices and with international support, Egypt and Bangladesh have developed SRH strategies accompanied by CIPs. Malaysia would greatly benefit from producing a CIP to accompany an updated FP Strategy. Additionally, since FP benefits are shared across portfolios and drive many SDGs, these costs could be co-shared across ministries.

5.4 Monitoring and Evaluation

Despite progress in FP policies and services, the health information systems across the selected countries vary in the quality and quantity of monitoring and evaluation. Monitoring and evaluation is crucial in determining progress and the quality of implementation of national strategies. Even with existing policies, infrastructure and resources, the key FP indicators could be improved. A well-

[293] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[294] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72
[295] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.
[296] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[297] UNFPA (2012) Women's Need for Family Planning in Arab Countries
[298] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

functioning monitoring and evaluation framework developed before implementation is essential to assess programme effectiveness and make recommendations for further improvements.[299]

Documented best practice in FP suggests the need for close coordination and collaboration among stakeholders in scaling up best practices to improve maternal and child health. [300] Malaysian FP indicators should also align with WHO's reproductive health indicators to enable global monitoring and international comparisons (**Box 3**).[301] Finally, COVID-19 is a disruptive phase for essential health services, significantly impacting on FP services. Each selected country should consider an appropriate response depending on how the pandemic unfolds and what choices women make about their continued contraceptive use. [302]

5.5 Priorities for Family Planning in Malaysia

This desk review highlights the policy and programmatic gaps for Malaysia. It includes recommendations to strengthen FP services to improve maternal and infant health outcomes and meeting Malaysia's international commitments. [303]

While Malaysia has several strategies related to FP, it would greatly benefit from devising a broader right-based SRH plan aligned with the national population policy and other related policies. The alignment of policies will ensure congruence and comprehensiveness of goals and strategies, focusing on addressing the FP and SRH needs of the youth and other vulnerable groups. The *2nd Malaysian Population Strategic Plan Study 2010* [304] advocates for a family-centered approach to Malaysian development planning. While this Plan recommended a strategic framework for implementing future population and development programme guided by the principles of gender equity, respect for human rights and family values, it failed to mention the youth. Nevertheless, the 2010 Plan should be reviewed, as it provides relevant recommendations to address current challenges in Malaysia (such as fertility decline, reproductive health, family and gender issues and demographic trends) within a population strategic framework. LPPKN's 2018 *Situational Analysis on Population and Family in Malaysia* **[305]** also proposes several strategies to reverse the fertility decline by exploring sub-fertility, pro-fertility incentives, childcare options and flexible working arrangements for mothers.

Although considerable progress has been made in Malaysia regarding FP, the agenda remains unfinished. The MoH aims at providing free FP services without discrimination to all regardless of age, religion, ethnicity, marital status, non-citizens must abide to a *Fee Act*. [306] However, the 2019 CEDAW review [307] noted that despite some positive changes in law and policy, there had been no significant shift

[299] The countries included Afghanistan, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Qatar, Pakistan, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Yemen. Six countries did not respond; Bahrain, Djibouti, Islamic Republic of Iran, Kuwait, Libya and the United Arab Emirates.

[300] Kabakian-Khasholian T, Quezada-Yamamoto H, Ali A, et al (2020) Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward. Sex Reprod Health Matters 28:1773693

[301] Measure Evaluation (2020) WHO's short list of reproductive health indicators for global monitoring

[302] Weinberger, M. Hayes, B. White, J. & Skibiak, J. (2020) Doing Things Differently: What It Would Take to Ensure Continued Access to Contraception During COVID-19 Global Health: Science and Practice

[303] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.

[304] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010

[305] LPPKN (2018) Situational Analysis on Population and Family in Malaysia

[306] As advised by the MoH representative to the TWC

[307] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.

in women's status regarding exercising their reproductive rights, including the timing and spacing of childbearing. Malaysian women still experience availability, accessibility and affordability barriers to high quality services, particularly abortion services. The barriers disproportionally affect vulnerable women and girls (unmarried youth, refugees, indigenous, migrants, transgender and prisoners).

Across the examined countries, Malaysia had the lowest CPR and highest unmet need for FP, despite contraception services being integrated into primary health care and made available for all youth and women at government clinics. The low CPR and unmet need is partly attributed to SRH services not being adequately promoted and fear of stigmatisation and discrimination, particularly for adolescents.[308] Malaysia's efforts reduced the adolescent fertility rate from 28 births per 1,000 girls aged 15-19 years in 1991 to 8.5 births in 2018, the lowest across selected countries. However, teenage pregnancy remains a significant health and socioeconomic concern. Despite the exception to the prohibition of abortion in the Malaysian Penal Code, unmarried girls may resort to illegal abortion or baby dumping due to access barriers: the requirement for parental consent for those under 18 years, uninformed advice from health workers. Abortion laws and clinical guidelines should be reviewed to ensure congruence between service availability, affordability and accessibility for high-risk groups.

Additionally, there is limited comprehensive, integrated and up-to-date FP and SRH data to inform planning. The 10-yearly Malaysian Population and Family Survey (MPFS), the most recent dating from 2014, [309] captures national FP data from married women only (overestimating CPR and underestimating unmet needs). More regular and comprehensive FP data including unmarried people and disaggregated by age, sex, economic status and location is required to measure trends and changes in knowledge, attitudes and sexual practices (such as safe sex and use of FP methods) to inform adequate FP policy and programmes. Censuses and other alternating surveys can integrate the collection of attitudes and behaviours regarding FP and SRH at the national and regional levels, and in targeted districts for effective planning, budgeting and monitoring of FP policy implementation and better targeting of disadvantaged groups.

A recent Malaysian study examining the integration of SRH into universal health coverage (UHC) processes identified several strategies triggering buy-in from key stakeholders within the Malaysian context including: generation of public demand and social support; placing SRH issues on the public agenda or linking them with international commitments; engaging with champions within government; and reframing SRH issues to appeal to existing values and beliefs. However, sensitive services such as safe abortion or GBV services require specific strategies to transform socio-cultural norms, believes and behaviours. [310]

Malaysia is taking a proactive approach to improving FP policy and services as demonstrated by this desk review and the related multisectoral consultative process. It provides the opportunity to design, implement and monitor a more inclusive, comprehensive and effective FP policy and programme that meets the needs of Malaysia's multiracial and multifaith society. Such a policy and programme could the

[308] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[309] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[310] Lim, S.C. Yap, YC. Barmania, S. Govender, V. Danhoundo, G & Remme, M. (2020) Priority-setting to integrate sexual and reproductive health into universal health coverage: the case of Malaysia, *Sexual and Reproductive Health Matters*

integration of FP services into primary health care. However, its implementation requires strong leadership and a well-trained workforce (policy makers, academics, health professionals) on SRH rights.

5.6 Limitations of the review

This review faced several challenges, including limited time and resources. The published information on FP policies and programme across the selected countries was limited. Governments might not have published FP related policies and action plans, in which case, secondary data sources referring to these policies were used, including UNFPA country reports. In addition, policies were written in languages other than English. Translation was sourced for official documents from Malaysia and Morocco. Future research in this topic should consider the allocation of time and resources to enable interviews with key informants from agencies providing FP in Malaysia, which would yield more in-depth information.

Despite these limitations, the review provides important insights to inform Malaysia's FP policy and practice to support the achievement of Malaysia's international commitments, particularly the ICPD PoA and SDG Agenda. [311]

[311] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.

6. CONCLUSIONS

SRH rights-based FP planning and programmes are a cost-effective public health measures and development interventions for accelerating the SDGs. National policies and programmes should endorse FP and SRH rights to achieve national targets and meet international commitments.

The selected countries, particularly Malaysia, have made remarkable progress in human and economic development. The SRH legal and policy frameworks have either been drafted or are being drafted. The leading example from Morocco's Family Code or *Moudawana*. However, there is a common failure to translate a rights-based SRH framework into practice fully. Malaysia, Turkey and Morocco are currently encouraging higher fertility rates to prevent a projected economic slowdown, while overpopulated Egypt and Bangladesh are still focusing on controlling the population growth.

Most of the selected countries consider FP a component within a SRH plan, rather than an isolated policy, facilitating the linkages with the SRH rights and principles. However, despite progress in several FP policies and services, the selected countries still face challenges in implementing FP programmes. Domestic politics determines whether, how, and to what extent a SRH rights and FP framework is implemented. Egypt has a more liberal interpretation of FP within the Islamic framework, while Turkey has become more conservative in recent years, which impacts FP/SRH service provision.

Across examined countries, less controversial SRH services such as perinatal care services are more likely to get buy-in from key stakeholders, compare with sensitive services such as safe abortion or GBV services, which require specific strategies to transform socio-cultural norms, beliefs and behaviours. Integration of comprehensive FP and SRH services into national health policies and strategies requires identifying policy windows and enabling conditions to advance specific SRH interventions as well as regular re-prioritisation to ensure *no one is left behind*. [312]

In Malaysia and Turkey, low fertility combined with pronatalist policies presents challenges regarding access to and use of contraception for all populations, particularly for young people. [313] Policy and service gaps were also identified for key vulnerable groups including adolescents, the unmarried, poor, those with disabilities, older people and those living in rural or remote areas. The accessibility barriers are compounded when looking at the intersectionality of these characteristics. Vulnerable groups require particular attention to ensure their reproductive rights and access to rights-based FP services. [314] Following best practice and with international support, Egypt and Bangladesh have developed SRH strategies accompanied by CIPs to ensure the rational utilisation of existing limited national resources. A CIP would also benefit Malaysia.

Malaysia had the lowest CPR and highest unmet need across selected countries, despite a FP programme integrated into primary health care, slowing the achievement of the SDG 3 targets by 2030. Ensuring universal access to SRH services, FP, IEC and the integration of reproductive health into national strategies and programme should be addressed as a priority on the national agenda. Special

[312] Lim, S.C. Yap, YC. Barmania, S. Govender, V. Danhoundo, G & Remme, M. (2020) Priority-setting to integrate sexual and reproductive health into universal health coverage: the case of Malaysia, *Sexual and Reproductive Health Matters*
[313] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[314] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

programmes for vulnerable populations (adolescents, refugees and persons with disabilities) should be streamlined and strengthened. [315]

The desk review proposes the development of a comprehensive FP policy aligned with internationally endorsed FP principles and guidelines. A comprehensive list of recommendations is provided as part of a road map to developing a national FP strategy in **Table 14**.

7. RECOMMENDATIONS

The following recommendations are proposed for consideration regarding Malaysia's FP Policy based on the findings of this desk review.

1. **Consider FP a component within a broader SRH plan under the existing National Population Policy currently reviewed by LPPKN and the Policy Division with MWFCD rather than an isolated policy**, ensuring a life-course approach to FP and SRH services that encompasses UNFPA's recommended SRH components (**Box 2**).[316] The components include FP services, adolescent sexual and reproductive health, CSE, abortion and management of complications, prevention and treatment of STIs, perinatal care and SRH programmes and services for the elderly.[317] The strategy should be accompanied by a CIP stating the roles and responsibilities of relevant government agencies in its implementation.
2. **Ensure a rights-based FP policy and programmes** by formulating operational policies to prevent discrimination towards stigmatised groups (unmarried youth, people living with HIV/AIDS, sex workers), providing equitable community-based distribution of contraceptives for hard to reach areas.
3. **Engage in participatory policy formulation by defining FP objectives over a 5-10 year period** with quantitative targets, particularly on reducing unmarried adolescent childbearing as well as maternal and infant mortality, increasing the participatory engagement of key stakeholders (including NGOs, academics and civil society) and strengthening the laws and regulations facilitating contraceptive supplies. Continue strengthening the policies on fertility and age at marriage (ongoing process), import laws and legal regulations and advertising of contraceptives, and ensure favourable statement by political leaders at least 1-2 times per year.
4. **Advocate FP for improving mother and child health across all future FP interventions** among key stakeholders, particularly community and religious leaders, following the lead of Egypt and based on Malaysia's MoH policies and service delivery. Spacing births via contraception is not prohibited by the Quran and enables a logical timeframe for the mother to regain her physical strength and for each child to receive appropriate attention for their nourishing, training, and education.[318]

[315] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.
[316] Williams K, Warren C, Askew I (2010) Planning and Implementing an Essential Package of Sexual and Reproductive Health Services: Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services
[317] La'o Hamutuk (2018) Inclusive Family Planning takes more than words on paper
[318] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

5. **Strengthen FP service provision by engaging the private sector** to increase community-based distribution, improve administrative structures and the content of mass media campaigns, and identify and leverage incentives and disincentives for FP use.
6. **Implement CSE to prevent unwanted pregnancies among unmarried youth**, as recommended by a previous desk review. [319] Teaching CSE to promote informed choices on safer sex and contraception is primary prevention. CSE has been proven to be more effective than abstinence-only or abstinence plus programmes in delaying sexual initiation and reducing the negative health consequences of unprotected sex. Malaysia's current abstinence-only-until-marriage approach is based on the harmful misconception that CSE might encourage early sexual activity and risk-taking behaviours; it provides very limited information on safer sex and contraception, and should be corrected to align with UNESCO's CSE curriculum guidelines. [320]
7. **Address the needs of vulnerable populations, particularly the unmarried youth** by increasing the accessibility to emergency contraception and safe abortion and providing counselling and contraceptive services for post-abortion women. Reframe abortion services as means to reduce maternal and infant mortality by addressing unsafe practices to the full extent that Malaysia's legal framework allows.
8. **Strengthen the existing accountability mechanisms at national, subnational, and facility levels** to monitor FP information and service availability, accessibility, affordability, acceptability and quality, particularly for vulnerable populations. The 10-yearly Malaysian Population and Family Survey (MPFS) [321] captures national FP data from married women only (overestimating CPR and underestimating unmet needs). More regular and comprehensive FP data including unmarried people and disaggregated by age, sex, economic status and location is required to measure trends and change in knowledge, attitudes and sexual practices (such as safe sex and use of FP methods) to inform FP policy and programmes.
9. **Increase the quality of FP services provided by improving and monitoring Indicators of Quality of Care** (QoC) collated by the public and private sector FP services, strengthening FP logistics and supply system to keep stocks of contraceptive supplies available at all service points, at all times and at all levels (central, provincial, local), strengthening the structures to address QoC (including monitoring, quality improvement activities and training of FP personnel to support informed choices and avoid provider biases). There is a need to identify and address discrimination cases and services denial on non-medical grounds (age, marital status or ability to pay), or coercion (inappropriate use of incentives to clients or providers) via regular feedback mechanisms. **Appendix 6** lists online resources to support these activities.
10. **Review the FP related objectives and recommendations from Malaysia's *2010 Population Strategic Plan Study*** [322] (**Appendix 4**) as part of a road map leading to the formulation of a comprehensive FP policy that addresses Malaysia's FP gaps (**Table 14**). The *2010 Plan* advocates for a family-centered approach to FP and proposes establishing a National Institute for Family and Population to study family dynamics changes and their implications as done in other countries.

[319] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.
[320] UNESCO (2018) International Technical Guidance on Sexuality Education
[321] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[322] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010

11. **Consider becoming an active member of – and regular contributor to – the Family Planning 2020 movement**. The movement provides many opportunities to learn lessons across countries and create alliances to strengthen international commitments to designing and implementing evidence-based FP/SRH policies and programme. A range of resources are also available to support the process of policy formulation (see **Appendix 6**).

A road map informed by the lessons learned as well as FP guidelines and best practices is provided in **Table 14** to guide the formulation of Malaysia's FP strategy and programmes.

8. ROAD MAP FOR FORMULATING AND IMPLEMENTING A FAMILY PLANNING POLICY

Although Malaysia has made considerable progress regarding FP, the agenda remains unfinished. This section presents a road map for developing a comprehensive FP policy for Malaysia based on this review's findings. The roadmap (**Table 14**) may also be useful for other countries. Actioning this road map can be supported by the range of practical resources for FP policy and programmes provided (**Appendix 6**).

Table 14 Road map for developing a comprehensive Family Planning policy [323]

Recommendation	Description/Rationale/Lessons learn across countries
1. Conduct a policy analysis to understand the policy processes and identify key stakeholders as well as barriers and opportunities for policy change to inform strategic planning	• FP policies are the laws, regulations, guidelines, and strategies related to the management and/or delivery of FP goods and services. • Legislation's effects on FP in the context of regulating personal status issues, fertility, and incentives to FP should be considered. [324] • Undertake rigorous situation analysis of current efforts and associated gaps in FP and, on this basis, identify and support opportunities for greater alignment and coordination of all FP efforts under national leadership[325]
2. Engage identified key stakeholders in the process of policy development and clearly define and agree their roles and responsibilities in implementing the policy.	This includes the institutions expected to implement the policy, both at the national and decentralised level. • Strong leadership and commitment are essential to ensure the follow through, resources, and accountability required for implementing policies. • Need for improved institutional coordination between health, nutrition and population services to avoid duplication, training, nursing services, quality assurance, and availability of HR at the facilities. • Develop strategic, more mutually rewarding, long-term partnerships with a wider range of partners, including civil society and private sector and in alignment with FP objectives [326]
3. Establish or strengthen institutional mechanisms for FP	• Establish effective coordination mechanisms among the national partners to address FP comprehensively, encompassing all elements of effective FP programming – supply, demand, access to and quality of care, enabling environments and knowledge management. [327] • An interdisciplinary mechanism for intersectoral collaboration should be established, if not already available to oversee the development of the FP policy based on available evidence and additional targeted research findings. • Revive the Advisory and Coordinating Committee for Reproductive Health (ACCRH) to effectively overseen by LPPKN, to increase the quality of SRH services by improving multisectoral collaboration and coordination (involving governmental, NGO and private partnerships), ensuring participatory planning and effective monitoring and overseeing the implementation. • Turkey established the *Women's Health and Family Planning Advisory Board* in 1993 under MoH[328] which has successfully motivate all sectors to engage in innovative approaches and programme based on ICPD recommendations.
4. Promote strong governance and participatory processes to support policy reform.	• Health governance refers to the capacity of systems and processes to direct resources, performance, and stakeholder participation towards addressing the health needs of individuals in a transparent, accountable, equitable, and responsive manner. It starts with policy formulation, planning and regulation and includes accountability, social participation and system responsiveness. Better alignment and coordination of efforts improves the use of resources and leads to better FP outcomes. [329] • Strengthen strategic, technical, policy and financial capacity in FP and related policy areas and direct them towards achieving the outcomes of country capacity, skills and needs assessments to increase accountability for results delivered. [330] • Actions to support good governance for FP: identify, develop, and/or strengthen accountability systems for FP that foster cooperation among government, the private sector, and civil society;

[323] FP High Impact Practices (2020) Policy: Building the foundation for systems, services, and supplies
[324] Al-dakkak MS (1987) The interaction between the legislative policy and the population problem in Egypt. Popul Bull ESCWA 83–94
[325] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[326] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[327] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[328] European Committee of the Regions (2020) Turkey Public Health
[329] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[330] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

Recommendation	Description/Rationale/Lessons learn across countries
	support voice and accountability programmes for civil society; foster donor collaboration in supporting strong governance for FP; build on existing FP Technical Working Groups to include a focus on governance and accountability; and provide a forum for discourse and exchange of ideas among key stakeholders to facilitate policy implementation and prevent problems in communicating policy ideas –a key barrier to implementing policies.
5. Develop a National FP Policy. Strategic direction to balance population and development via inter-sectorial framework and implementation plan that guides governmental and non-governmental interventions.	• Countries with clear and strong reproductive health policies can better direct the implementation of international agreements as well as get the most benefit from the support of international donors. They need clear national targets, objectives and programme with strong political commitment. [331] • To avoid weakening FP and fertility regulation activities, countries should have a clear, long-term agenda for their health policies and programme, and define and specify their priority areas in reproductive health, which should not be influenced by the political environment, whether internal or external.[332] • A new FP strategy is an opportunity to ensure the optimisation of day-to-day programming via improvements in the coordination of action, resources and leadership on FP at country level. Governments, national stakeholders and external partners bring extensive experience to the table about what needs to be done to achieve universal access to FP. [333] • This document should articulate national FP vision, goals and priorities and development objectives (consider progress outcomes: GBV prevalence, child marriage, adolescent pregnancies, etc), set minimum standards of quality, outline roles and responsibilities, facilitate coordination, guide resource mobilisation, determine timelines for programme rollout and outline reporting requirements including indicators (baseline, midline and endline) to monitor progress and course correct ineffective strategies. • It is strongly recommended to advocate the concept of FP for the betterment of mother's and children's health across all future FP interventions. Spacing children means the practice of contraception to enable a logical timeframe between births for the mother to regain her physical strength and for each child to receive appropriate attention for their nourishing, training, and education.[334] • The comprehensive recommendations of the *2nd Malaysian Population Strategic Plan Study 2010* [335] to address fertility decline, reproductive health, family and gender issues and demographic data issues within a population strategic plan and should be reviewed. • LPPKN's 2018 *Situational Analysis on Population and Family in Malaysia* **[336]** proposed several strategies to reverse the fertility decline trend by exploring sub-fertility, pro-fertility incentives, childcare options and flexible working arrangements for mothers. • If developing a national macro-level population policy to address the balance between population growth and development, design an inter-sectorial framework and implementation plan to guide the governmental and non-governmental interventions covering multiple sub policy areas and ensure the integration of the FP goals and strategies. This framework should support and complement existing policies such as the *National Social Policy*, the *National Policy on Women* and the *National Child Policy*.
Priority areas to be considered	
In line with *leaving no one behind*, it is recommended a strategically focus on vulnerable populations when planning the policy and programme (e.g. women/girls vulnerable to unwanted pregnancies, disadvantaged rural areas).	• A 2019 review of Malaysia's progress regarding CEDAW[337] noted and access to health care is limited for some groups of women, including refugee women, indigenous women, migrant women, transgender women, and female prisoners. • Special programme for adolescents, refugees and persons with disabilities need to be streamlined and strengthened. [338] Programmatic achievements measured by indicators: • A 2010 report noted that National Programme does not provide contraceptive services to the unmarried. [339] In 2012, MoH published national guidelines for health care providers on managing

[331] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127

[332] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127

[333] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020

[334] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72

[335] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010

[336] LPPKN (2018) Situational Analysis on Population and Family in Malaysia

[337] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.

[338] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. East Mediterr Health J 25:127–133.

[339] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia

Recommendation	Description/Rationale/Lessons learn across countries
	SRH and FP services in primary care for adolescents and adults (married, unmarried and disabled). • No special programme is targeted to the women aged 40-49, i.e. those who are at the end of their reproduction. In view of the high unmet need for contraception among these women, special attention needs to be given to them to prevent unwanted births and abortion. [340] • A significant proportion of the population lives in rural and remote areas, far from health services. Even where a facility is located nearby, many clients prefer a more convenient, comfortable, private, and/or confidential setting to receive FP services. [341] • Despite the SRH education efforts by the Malaysian Government and NGOs, the *2014 Malaysian Population and Family Survey*,[342] revealed a lack of reproductive health knowledge among the young people[343]. The knowledge gap be addressed by implementing **CSE to prevent unwanted pregnancies among unmarried youth** and recommended by a previous desk review.[344] The review noted that supporting CSE's informed choices programme on safer sex and contraception is more effective over abstinence-only or abstinence plus programme in delaying sexual initiation and reducing the negative health consequences of unprotected sex. Malaysia's current abstinence-only-until-marriage approach is based on the harmful misconception that CSE might encourage early sexual activity and risk-taking behaviours provides, and provides very limited information on safer sex and contraception, and should be corrected to align with international CSE best practices. The FP-related indicators could be improve (extracted from MoH's Health Facts 2019 [345]): - Maternal mortality ratio (per 100,000 live births): 25 - Perinatal Mortality Rate (per 1,000 births): 8.7 - Neonatal Mortality Rate (per 1,000 live births): 4.4 - Infant Mortality Rate (per 1,000 live births): 6.9 2018 rates per 100,000 population: - HIV Incidence Rate 10.02, Mortality Rate 0.50 - AIDS Incidence Rate 2.80, Mortality Rate 2.48 Despite contraception services being integrated into primary health care and made available for all youth and women at government clinics, the 2014 Population and Family Survey [346] revealed that **Malaysia had the lowest contraceptive prevalence rate (any method)** at 52.2% in 2014 (stagnated since 1984, as was the modern method at 34.3%)[347] **and the highest unmet need for FP** [348] (19.6% in 2014[349], a decrease from 25% in 2004)[350] across selected countries. This is partly attributed to the fact that SRH services are not properly promoted, and adolescents might be afraid to access them for the fear of being stigmatised or discriminated against. [351] Unmet needs for SRH information and access to contraceptives should be urgently addressed to prevent further STIs and unintended pregnancies. [352]
Improve SRH service awareness, delivery, and accessibility to *leave no one behind*.	• Train and engage health care workers, parents, peer educators, NGOs, teachers, community and religious leaders among others in delivering SRH messages and link it with international commitments to achieve the SDGs. • Expand services availability, accessibility and affordability to all children, adolescent, and young people and ensure geographical coverage. • Reframe SRH service delivery for all children, adolescents and young people under *family health* across relevant agencies (following the Ministry of Health's lead) and raise community awareness of SRH to eliminate stigma.

[340] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[341] EngenderHealth (2011) The Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming. New York.
[342] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[343] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[344] Ghani, F. and Awin, N. (2020) *Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action*, United Nations University International Institute for Global Health (UNU-IIGH), commissioned by UNFPA.
[345] Ministry of Health (2019) Health Facts 2019
[346] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[347] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[348] This refers to the number or percent of women currently married or in union who are fertile and desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method. The total number of women with an unmet need for family planning includes those with an unmet need for limiting (who desire no additional children), and those with an unmet need for spacing (who desire to postpone their next birth by a specified length of time). Source: MEASURE Evaluation (2020) Unmet need for family planning
[349] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[350] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[351] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[352] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

Recommendation	Description/Rationale/Lessons learn across countries
	• Review and update MoH's *2012 Guidelines on Managing Adolescents Sexual and Reproductive Health Issues in Health Clinics* to support youth health services. • Reframe termination of pregnancy services as means to reduce maternal and infant mortality by addressing unsafe practices to the full extent that Malaysia's legal framework allows. For instance, Morocco conducted a study regarding the legal, political, and Islamic implications of liberalising Morocco's abortion laws, which revealed that most Moroccans supported legalising abortion, but only in cases of rape, incest, and birth defects. As result, the government recently amended the law to allow abortion in cases of incest, rape, and birth defects to reform the 50-year-old code in alignment with the goals of the 2011 constitution. Previously, Article 453 of the Penal Code mandated that abortion was only permissible if the health of the mother was in danger.[353] • Promote and enforce the guidelines for termination of pregnancy (e.g. eligibility and permissibility based on a health, psychological and counselling assessment, and availability and location of services). • Review the FP policy accounting for the needs of sexually active demographics (both married and unmarried).
A variety of service delivery modalities are needed to ensure access to a range of FP methods.	• Future interventions should provide FP, birth spacing, and general mother and child health services to women and girls to eventually improve their lives. Social marketing has shown successful results in bringing about behaviour change towards the uptake of birth spacing methods. • Approaches to reducing unmet need for FP must we contextually and culturally sensitive in Malaysia's multi ethnic and multi faith society and respond to the individual practices of users who may, for example, discontinue use or switch to another method that they deem more appropriate or that is more reliably available at their local health facility. [354] • Identified barriers to further reductions in adolescent fertility rate includes limited SRH education and contraceptive practices .[355] Promoting contraception along vulnerable demographics will likely prevent further socioeconomic costs such as maternal and infant mortality attributed to illegal and unsafe abortions, criminal baby abandonment/dumping practices and child welfare services for abandoned babies.
Termination of Pregnancy • The policy and laws requiring parental consent for abortion should review to facilitate a safe and confidential environment to deliver services to pregnant adolescents [356] • Include medical abortion care, in the medical school curriculum and as part of ongoing professional training. Health care providers should be trained to deliver SRH information (including abortion exceptions) and services in a confidential and non-judgmental and non-discriminatory manner.	• Although both the Civil and Syariah Laws allow abortion only to protect the physical and mental health of the mother, a 2019 review of Malaysia's progress regarding CEDAW noted that abortion is stigmatised and costly and government hospitals do not often provide the service; information and counselling from government hospitals use a religious perspective, rather than a reproductive health rights framework. [357] • Despite MoH's 2012 *Guidelines for Termination of Pregnancy* for Hospitals, the lack of awareness regarding abortion laws in Malaysia among health care providers is likely to lead to illegal and unsafe abortion practices, increasing the risk of maternal and infant morbidity and mortality. • The availability of safe abortion depends not only on permissive legislation but also political support and the ability of health professionals to provide it. Abortion care, including medical abortion, needs to be included in the medical school curriculum. [358] • During the pre-inception meeting, LPPKN stakeholders classified *prevention of abortion and management of complications resulting from unsafe abortion* as moderately urgent and doable, but less culturally and religiously acceptable (see **Error! Reference source not found.**). However, this is a problem that Malaysia should address to reduce maternal mortality rates. • MoH is finalising the formulation of an alternative pathway to abortion (e.g. parenting or adoption) in partnership with KKM, JKSP and JKM. This pathway is more aligned with the Islamic value system and provides psychological, educational, and economic support network for families via halfway houses.
6. Translate the policy into an operational Plan of Action for policy implementation	• Link it to the six WHO's health systems building blocks: 1) governance and leadership; 2) Health Management Information System; 3) Human Resources for Health; 4) service delivery; 5) essential medicines; and 6) financing.
7. Develop a costed implementation plan (CIP) to allocate resources for policy implementation.	• The FP CIP is a multi-year actionable roadmap designed under the FP2020 initiative to support governments in transforming FP goals into concrete programmes and policies by prioritising

[353] Word News (2020) Morocco Liberalizes Abortion Laws, Amends Penal Code
[354] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[355] Federation of Reproductive Health Associations, Malaysia (2010) ICPD+15 3rd Country Report of Malaysia: NGO Perspectives
[356] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[357] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.
[358] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.

Recommendation	Description/Rationale/Lessons learn across countries
	appropriate interventions, allocating limited resources, unifying stakeholders around one plan, and supporting monitoring and accountability.[359] • CIPs are increasingly used by countries (including Egypt and Bangladesh) and might involve inter-ministerial co-funding arrangements to ensure that policies and programmes are fully funded and successfully implemented. • It estimates the cost of the resources needed for the life of the policy across strategic areas of a FP programme: enabling policy environment (e.g. service providers' capacity building and advocacy); demand creation; service delivery and access; contraceptive logistics and security; financial management, and M&E for accountability. The Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans provides systematic and practical guidance for articulating the FP goal, results, strategic priorities, and implementation plan at the national, reginal or state level. The process, informed by Technical Support Teams in 30 countries that developed CIPs, is highly participatory, involving a range of stakeholders and technical experts. The time to develop a technical strategy can range from 6 to 12 months, depending on the country context (size and diversity) and scope of the CIP (national or subnational). Refer to **Box 4** for more information.
8. Identify and capacitate key implementing groups.	• This involves communication and training of managers, administrators and clinicians and updating the pre-service curriculum for clinical staff. • A competency-based national qualification system certifying health workers to provide quality FP counselling and services would ensure better quality of services. • A prerequisite is the capacity building of Muslim religious leaders. It is crucial that religious leaders and local clergymen possess accurate and appropriate information and skills to help their followers make informed choices on matters related to health and wellbeing, particularly on matters related to FP and birth spacing. There is a need to mobilise and sensitise these stakeholders as social responsibility towards saving women from unwanted pregnancies and improving children's health. [360]
9. Monitor and evaluate policy implementation. Regular data collection, dissemination , and use of feedback are essential for assessing progress and making mid-course corrections. Policy monitoring is a process by which stakeholders follow and assess policies to ensure they are developed, endorsed, enacted, and implemented as intended. Policy monitoring involves (1) appraising the policy environment, (2) gauging the level and quality of stakeholder engagement, (3) documenting the progress of policy development and the legislative endorsement of policy, (4) putting policies into practice through financing and implementation planning, and (5) evaluating outcomes of implementation.[361]	• A well-functioning monitoring and evaluation (M&E) framework is essential to assess programme effectiveness and make recommendations for further improvements. [362] • The 10-yearly Malaysian Population and Family Survey (MPFS) [363] captures national FP data from married women only (overestimating CPR and underestimating unmet needs). More regular and comprehensive FP data including unmarried people and disaggregated by age, sex, economic status and location is required to measure trends and change in knowledge, attitudes and sexual practices (such as safe sex and use of FP methods) to inform FP policy and programmes. • Ensure systematic approaches that maximises use of data, build on evidence, and which effectively monitor and document progress[364] • Establishing a robust M&E mechanism for accountability. New policies should be monitored for unintended consequences using validated methods and by employing social auditing methodology. Evaluation of new policies should include evaluations of decentralised financing, performance-based incentives, removal of user fees, and voucher strategies, among others. • Every effort should be made to use internationally accepted indicators, as not all the WHO indicators on sexual and reproductive health[365] are currently monitored. This would facilitate the evaluation of progress in all components of reproductive health. The FP2020 Core indicators monitor FP progress across countries [366] and cover FP based on a results chain that aims to measure aspects of the enabling environment for FP, the service delivery process the service outputs, expected outcomes and the impact of contraceptive use. While the published data on these indicators is limited across countries (except for Egypt and Bangladesh), it is an entry point for strengthening the collection and reporting of internationally comparable FP indicators (see **Table 17**). • National health authorities should advocate and lead the process of appraisal and prioritisation for scaling up best practices in FP. Evaluation should be a part of pilot studies and a lessons-learnt approach should be used. Ensure coordinated progress and to scale-up what works using integrated innovative approaches based on evidence of success through monitoring and evaluation for measurable results. This applies to the different components of successful FP

[359] USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh
[360] Shaikh BT, Azmat SK, Mazhar A (2013) Family planning and contraception in Islamic countries: a critical review of the literature. J Pak Med Assoc 63:S67-72
[361] USAID (2014) Policy Monitoring resource guide
[362] Shrestha BD, Ali M, Mahaini R, Gholbzouri K (2019) A review of family planning policies and services in WHO Eastern Mediterranean Region Member States. Journal of East Mediterranean Health 25:127–133.
[363] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[364] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[365] Measure Evaluation (2020) WHO's short list of reproductive health indicators for global monitoring
[366] FP2020 Data Dashboard (2019) FP2020's Core Indicators to monitor progress across countries

Recommendation	Description/Rationale/Lessons learn across countries
	strategies: supply, demand, access and quality of care, enabling environment and knowledge management.[367] Malaysia could learn from the M&E recommendation for Egypt regarding building a population related observatory to monitor and evaluate the implementation of the *National Population Strategy 2015-30* to: • Collect and harmonise the available data and indicators and evaluate the strategy; and • Assess and bridge the information gaps by new surveys or innovative research methods such as crowdsourcing and big data methodologies.
10. Improve data sources informing policy, monitoring and evaluating progress, and frequency of collection	• Population data requires quality improvement and further disaggregation by sex, age, economic status and location for effective planning at the local level, budgeting and monitoring at the central level, and better targeting of left-behind population groups • The Malaysian Population & Family Surveys (MPFS), conducted every 10 years are too spaced out to course correct policies unless there are complemented by data from other surveys done in between. • High priority: set strong indicators and monitoring system to regularly assess progress.
11. Identify promising interventions and support scale-up efforts.	• Promote the scaling-up and institutionalising of good practices that include integrated approaches to voluntary, human rights-based FP at country level and do so in collaboration with other development partners [368] • Policy change or adaptation is often needed to support and institutionalise scaleup efforts. Documented available best practices in FP requires close coordination and collaboration among stakeholders in scaling up these best practices, especially in priority states, to improve maternal and child health nationally. [369] The following questions will help guide planning for the scale-up process. Are there any laws or social norms that prohibit aspects of the practice to be scaled up? Is the practice supported by a national policy? Are there any barriers to financing institutionalization of the best practice? Will it fit within country financing guidelines or be part of the recurring budget rather than a development budget funded by donors? Do operational policies, or the rules, regulations, guidelines, operating procedures, and administrative norms that guide implementation, need to be developed or reformed to enhance implementation and scale up of the best practice? Who are the champions who can be engaged to drive the change?
12. Ensure that policies and strategic plans are periodically reviewed and kept up to date.	• Policies should be viewed as *living documents* to be regularly reviewed based on contextual changes and requiring leadership, resources, monitoring, and other inputs dimensions that influence policy implementation to thrive and achieve their goals. [370] • If policies and strategic plans are not sufficiently current, they will not be responsive to societal, cultural, or environmental changes. The strategic plan guiding FP should be adjusted annually based on updated information on health status, services, and the political environment.

[367] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[368] UNFPA Choices not Chance, UNFPA Family Planning Strategy 2012-2020
[369] Chikvaidze P, Madi HH, Mahaini RK (2012) Mapping family planning policy and programme best practices in the WHO Eastern Mediterranean Region: a step towards coordinated scale-up. Journal of East Mediterranean Health 18:911–919.
[370] USAID (2010) Taking the Pulse of Policy: The Policy Implementation Assessment Tool
Bhuyan, A., A. Jorgensen, and S. Sharma. 2010. Taking the Pulse of Policy: The Policy Implementation Assessment Tool. Washington, DC: Futures Group, Health Policy Initiative.

Appendix 1 Technical Working Committee Membership

Technical Working Committee guiding the comparative study of reproductive and social health policies between Malaysia and Muslim countries

1. Chairman:

Deputy Director General (Policy), National Population and Family Development Board (LPPKN)

2. Members:

- Human Reproduction Division, LPPKN
- Population and Family Research Division, LPPKN
- Strategic Planning Division, LPPKN
- Policy and Strategic Planning Division, Ministry of Women, Family and Community Development (KPWKM)
- Ministry of Youth and Sports (KBS)
- Ministry of Health (KKM)
- Ministry of Education Malaysia (KPM)
- Ministry of Higher Education Malaysia (KPT)
- Department of Islamic Development (JAKIM)
- Institute of Higher Learning (IPTA)
- Economic Planning Unit (EPU)
- Legislative Unit, LPPKN
- United Nations Population Fund (UNFPA)
- Federation of Reproductive Health of Malaysia (FRHAM)
- And other related agencies

3. Secretariat

Human Reproduction Division, National Population and Family Development Board (LPPKN).

Appendix 2 Contextual information across selected Muslim countries

Table 15 Commitments to key international conventions/protocols relevant to reproductive rights and the right to sexuality education

International resolutions/frameworks related to family planning	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Universal Declaration of Human Rights, 1948	-	✓	✓	-	-
International Convention on the Elimination of All Forms of Racial Discrimination, 1965	-	✓	✓	✓	✓
International Covenant on Civil and Political Rights, 1966	-	✓	✓	✓	✓
International Covenant on Economic, Social and Cultural Rights, 1966	-	✓	✓	✓	✓
Alma Ata Declaration, 1978	✓	✓	✓	✓	✓
Convention on Elimination of All forms of Discrimination Against Women (CEDAW), 1979	✓	✓	✓	✓	✓
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984	-	✓	✓	✓	✓
Convention on the Rights of the Child, 1989	✓	✓	✓	✓	✓
Cairo Declaration on Human Rights in Islam, 1990	✓	✓	✓	✓	✓
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990	-	✓	✓	✓	✓
International Conference on Population and Development (ICPD), 1994	✓	✓	✓	✓	✓
Beijing Platform for Action (BPfA), 1995	✓	✓	✓	✓	✓
Millennium Development Goals (MDGs), 2000	✓	✓	✓	✓	✓
Convention against Transnational Organized Crime, 2000	✓	✓	✓	✓	✓
Protocol against the Smuggling of Migrants by Land, Sea and Air, 2000	-	✓	✓	-	-
Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, 2000	✓	✓	✓	✓	✓
Convention on the Rights of Persons with Disabilities, 2006	✓	✓	✓	✓	✓
International Convention for the Protection of All Persons from Enforced Disappearance, 2006	-	-	-	✓	-
Declaration on the Rights of Indigenous People, 2007	✓	✓	✓	-	-
2012 CRC-OP-SC - Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography	-	✓	✓	✓	✓
2012 CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	-	✓	✓	✓	✓
Sustainable Development Goals (SDG 3 and SDG 5), 2015	✓	✓	✓	✓	✓

Sources: Centre for Reproductive Rights (www.reproductiverights.org); United Nations (2014). Reproductive rights are human rights: A handbook for national human rights institutions; https://indicators.ohchr.org/ https://www.unodc.org/unodc/en/treaties/CTOC/signatures.html; https://www.refworld.org/docid/3ae6b3822c.html; https://www.ohchr.org/en/issues/ipeoples/pages/declaration.aspx

Table 16 Contextual information across selected countries (2018 data mostly) [371]

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Demography					
Country Income Level[372]	Upper Middle Income	Upper Middle Income	Low Middle Income	Low Middle Income	Low Middle Income
Religions	Secular state [373]: 63% Muslim (Sunni), 19% Buddhism, 10% Christian, 6% Hindu, 2% Other	Secular state: 99.8% Muslim (mostly Sunni), 0.2% Other	Islam state religion post 1980, 90% Muslim (mostly Sunni), 9% Coptic, 1% Other	Islam is state religion, 99% Muslim (Sunni)	Secular state but Islam is state religion. 89% Muslim (mostly Sunni), 11% Hindu, 1% Other
Total population (millions)	31.5 32.7 (2020) [374]	82.3	98.4	36.0	161.4
Total Fertility Rate (2018) [375,376]	2.0 (decreasing)	2.1 (decreasing)	3.3 (decreasing)	2.4 (decreasing)	2.0 (decreasing)
Population strategy	Encourage higher fertility	Encourage higher fertility[377]	Population control	Encourage higher fertility	Population control
Median age (years)	30.3	31.5	24.6	29.5	27.6
Population in millions (< 5 years)	2.6	6.7	13.0	3.4	14.5
Population in millions (ages 15-64 years)	21.9	55.1	60.0	23.7	108.3
Population in millions (≥-65 years)	9.6	7.0	5.1	2.5	8.3
% Urban population	76.0	75.1	42.7	62.5	36.6
Human Development Index (HDI) and rank out of 189 countries	0.804 (61)	0.806 (59)	0.700 (116)	0.676 (121)	0.614 (135)
Human Development Index (HDI), female	0.792	0.771	0.643	0.603	0.575
Human Development Index (HDI), male	0.815	0.834	0.732	0.724	0.642
Economic indicators					
Gross National Income (GNI) per capita (2011 PPP $)	27,227	24,905	10,744	7,480	4,057
Gross Domestic Product (GDP) per capita (2011 PPP S)	28,176	25,287	11,014	7,509	3,879
Income index	0.847	0.833	0.706	0.652	0.559

[371] UN Human Development Programme (2020) Global Human Development Indicators.
[372] World Bank (2019) Country Income Levels.
[373] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[374] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[375] The World Bank (2018) Total Fertility Rate (births per woman).
[376] UN Department of Social Affairs (2020) World Fertility and Family Planning 2020: Highlights
[377] Yucesahin MM, Adali T, Turkyilmaz AS (2016) Population Policies in Turkey and Demographic Changes on a Social Map. Border Crossing 6:240–266
UNFPA (2016) Current overview of Turkey's population

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Work, employment and vulnerability					
Employment to population ratio (% ages 15 and older)	62.4	46.8	42.6	41.3	56.2
Labour force participation rate (% ages 15 and older)	64.6	52.5	48.1	45.4	58.7
Labour force participation rate (% ages 15 and older), male	77.4	72.6	73.2	70.4	81.3
Labour force participation rate (% ages 15 and older), female	50.9 55.2 (2018) [378]	33.5	22.8	21.4	36.0
Unemployment, total (% of labour force)	3.4	10.9	11.4	9.0	4.3
Old-age pension recipients (% of statutory pension age population)	19.8	100.0	n.a.	39.8	33.4
Unemployment, youth (% ages 15–24) [379]	11.2	20.0	32.6	21.9	12.0
Health indicators					
Health expenditure (% of GDP)	3.8	4.3	4.6	5.8	2.4
Life expectancy at birth (years)	76.0	77.4	71.8	76.5	72.3
Life expectancy at birth, males (years)	74.1	74.4	69.6	75.2	70.6
Life expectancy at birth, females (years)	78.2	80.3	74.2	77.7	74.3
HIV prevalence, adult (% ages 15-49)	0.4 ofTotal 4,212 (12% ♀) (2018) [380]	n.a.	0.1	0.1	0.1
Mortality rate, infant (per 1,000 live births)	7.2[381]	10.0	18.8	20.0	26.9
Mortality rate < 5 years (per 100,000 live births)	8.8[382]	11.6	22.1	23.3	32.4
Gender indicators					
Gender development index (GDI)	0.972	0.924	0.878	0.833	0.895
Gender Inequality Index (GII) and rank out of 162 countries	0.274 (58)	0.305 (69)	0.450 (102)	0.492 (118)	0.536 (129)
Adolescent Fertility Rate (births per 1,000 women aged 15-19 years) (2018) [383]	12 (2015) 8.5(2018) [384]	26.6	53.8	31.0	82.0
Maternal mortality ratio (deaths per 100,000 live births)	23.8 (2015) 23.5 (2018) 22 (2019) [385]	16	33	121	176
Antenatal care coverage, at least one visit (%)	97.2	97.0	90.3	77.1	63.9
% of births attended by skilled health personnel	99.5	98.0	91.5	86.6	67.8
Child marriage, women married by age 18 (% of married women ages 20-24)	n.a.	15	17	13	59

[378] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[379] The UN defines youth as those aged 15-24 years, while the Malaysian Youth Policy 2015 (Dasar Belia Malaysia) defines youth as those aged 15-30 years.
[380] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[381] As advised by the MoH representative to the TWC
[382] As advised by the MoH representative to the TWC
[383] The World Bank (2018) Adolescent fertility rate (births per 1,000 women ages 15-19)
[384] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[385] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Contraceptive prevalence, any method (% of married or in-union women ages 15-49)	52.2 (2014) [386]	73.5	58.5	70.8	62.3
Contraceptive prevalence, modern method (% of married or in-union women ages 15-49)	34.3 (2014) [387]	n.a.	n.a.	n.a.	n.a.
Unmet need for family planning (% of married or in-union women ages 15-49 years)	19.6% (2014) [388]	5.9	12.6	13	12.0
Proportion of demand satisfied with modern methods for age group 15-49	58 (2016)[389]	n.a.	n.a.	n.a.	n.a.
Prevalence of female genital mutilation/cutting among girls and women (% of girls and young women ages 15-49)	n.a.	n.a.	87.2	n.a.	n.a.
Violence against women ever experienced, intimate partner (% of female population ages 15 and older)	n.a.	38.0	25.6	n.a.	54.2
SDG Indicator 5.2.1. % of ever-partnered women aged ≥ 15 years experiencing physical or sexual violence from an intimate partner in the previous 12 months [390]	27%	34.5%	39.5%	39.4%	44.5%
Violence against women ever experienced, non-intimate partner (% of female population ages 15 and older)	n.a.	n.a.	n.a.	n.a.	3.0
Education indicators					
Education index	0.713	0.712	0.608	0.547	0.513
Government expenditure on education (% of GDP)	4.7 4.2 (2017) [391]	4.3	n.a.	n.a.	1.5
Expected years of schooling (years)	13.5	16.4	13.1	13.1	11.2
Expected years of schooling, male (years)	13.1	16.9	13.1	13.6	10.8
Expected years of schooling, female (years)	13.8	15.9	13.1	12.6	11.6
Mean years of schooling (years)	10.2	7.7	7.3	5.5	6.1
Mean years of schooling, male (years)	10.3	8.4	8.0	6.4	6.8
Mean years of schooling, female (years)	10.0	6.9	6.7	4.6	5.3
Gross enrolment ratio, pre-primary (% of preschool-age children)	97	30	29	54	40
Gross enrolment ratio, primary (% of preschool-age children)	103	101	105	112	111
Gross enrolment ratio, secondary (% of secondary school-age population)	86	103	86	80	67
Gross enrolment ratio, tertiary (% of tertiary school-age population)	42	104	34	34	18
Literacy rate, adult (% ages 15 and older)	93.7 96.3 (2018) [392]	96.2	71.2	69.4	72.9

[386] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[387] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[388] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[389] ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[390] Global Burden of Disease Collaborative Network (2017) Global Burden of Disease Study 2016 (GBD 2016) Health-related Sustainable Development Goals (SDG) Indicators 1990-2030. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), quote in (2016) Goal 5: Gender Equality - SDG Tracker. In: Our World in Data.
[391] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[392] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
% of primary schools with access to the internet	100 [393]	n.a.	48	79	4
% of secondary schools with access to the internet	100 [394]	n.a.	49	89	82
Population with at least some secondary education (% ages 25 and older)	80.8	53.1	65.3	32.2	46.7
Population with at least some secondary education, male (% ages 25 and older)	81.8	66.0	71.2	35.6	49.2
Population with at least some secondary education, female (% ages 25 and older)	79.8	44.3	59.2	29.0	45.3
Primary school teachers trained to teach (%)	99	n.a.	74	100	50
Primary school dropout rate (% of primary school cohort) [395]	3.6	12.0	3.6	4.9	33.8
Inequality indicators					
Inequality in education (%) [396]	12.1	16.5	38.1	n.a.	37.7
Inequality-adjusted education index [397]	0.627	0.594	0.376	n.a.	0.320
Inequality in income (%)	n.a.	22.6	36.5	21.7	15.7
Inequality in life expectancy (%)	6.1	9.0	11.6	13.0	17.3
Mobility and communication indicators					
Internet users, total (% of population)	81.2	71.0	46.9	64.8	15.0
International student mobility (% of total tertiary enrolment)	2.9	0.6	0.7	-2.8	-1.2
Internet users, female (% of female population)	78.7 (59% ♂; 41% ♀) (2018) [398]	63.9	41.3	61.1	n.a.
Mobile phone subscriptions (per 100 people)	134.5	97.3	95.3	124.2	97.3
% of mobile phone ownership by sex, 2018	(59% ♂; 41% ♀) (2018) [399]	n.a.	n.a.	n.a.	n.a.

[393] United Nations Development Programme (UNDP) 2020 Human Development Indicators. Based on information provided by the MoE representative within the TWC, internet coverage might be limited in schools located in rural and remote areas.
[394] United Nations Development Programme (UNDP) 2020 Human Development Indicators. Based on information provided by the MoE representative within the TWC, internet coverage might be limited in schools located in rural and remote areas.
[395] Refers to the percentage of students from a given cohort who have enrolled in primary school but who drop out before reaching the last grade of primary education. It is calculated as 100 minus the survival rate to the last grade of primary education and assumes that observed flow rates remain unchanged throughout the cohort life and that dropouts do not re-enter school. Source: UNESCO (United Nations Educational, Scientific and Cultural Organization) Institute for Statistics (2019). Data Centre
[396] Refers to inequality in distribution of years of schooling based on data from household surveys estimated using the Atkinson inequality index. Source: Calculated based on data from the Luxembourg Income Study database, Eurostat's European Union Statistics on Income and Living Conditions, the World Bank's International Income Distribution Database, the Center for Distributive, Labor and Social Studies and the World Bank's Socio-Economic Database for Latin America and the Caribbean, ICF Macro Demographic and Health Surveys and United Nations Children's Fund Multiple Indicator Cluster Surveys using the methodology in Technical Note 2.
[397] Refers to the HDI education index value adjusted for inequality in distribution of years of schooling based on data from household surveys listed in Main data sources. Source: Calculated based on inequality in education and the HDI education index.
[398] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[399] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains

FP2020's Core Indicators comparison across selected countries

The FP2020 Core indicators monitor FP progress across countries [400] and cover FP based on a results chain that aims to measure aspects of the enabling environment for FP, the service delivery process the service outputs, expected outcomes and the impact of contraceptive use. While the published data on these indicators is limited (no information was avaiable for Turkey or Morocco), it is an entry point for strengthening the collection and reporting of internationally comparable FP indicators (see **Table 17**).

Table 17 FP2020's Core Indicators 2019 to monitor progress across selected countries [401]

Core FP indicators	Malaysia	Turkey (N/A)	Egypt	Morocco (N/A)	Bangladesh
1. Additional users (all women, millions)	--	--	1.5	--	2.847
2a. Modern contraceptive prevalence rate (mCPR), (% all women)	38.3 (2017) [402]	--	41.5	--	46.3
2b. Modern contraceptive prevalence rate (mCPR), (% married w)	--	--	58.4	--	56.6
3. Unmet need for FP (% married women)	19.6% (2014) [403] 17.6 (2017) [404]	--	14.1	--	18.9
4. Demand satisfied (%)	58 (2016)[405] 54.7 (2017) [406]	--	80.5	--	75
5. Unintended pregnancies (millions)	--	--	1.35	--	4.22
6. Unintended pregnancies averted (millions)	--	--	3.95	--	7.68
7. Unsafe abortions averted (millions)	--	--	1.6	--	3.07
8. Maternal deaths averted (thousands)	--	--	1.3	--	6.7
9. Method Mix (% married population)					
Sterilisation (male)	--	--	0	--	2.2
Sterilisation (male)	--	--	2.1	--	8.5
IUD	--	--	52.9	--	1.1
Implant	--	--	0.9	--	3.2
Injectable	--	--	14.9	--	23
Pill	--	--	28.1	--	50.1
Condom (male)	--	--	0.9	--	11.9
LAM	--	--	0	--	0
Other methods	--	--	0.2	--	0
10. Stock-outs	--	--	n/a	--	n/a
11. Method availability (%)	--	--	n/a	--	n/a
12. Domestic government family planning expenditures (USD)	--	--	n/a	--	218,600,6000
13. Couple-years protection (CYPS)	--	--	n/a	--	n/a
14. Method Information Index (%)	--	--	28.8	--	n/a
15. Family planning counselling	--	--	n/a	--	n/a
16. Family planning decision making (%)	89.2[407]	--	98	--	91.1
17. Adolescent birth rate (ABR, per 1000 women 15–19)	--	--	56	--	113
18. Discontinuation and method switching	--	--	--	--	--

[400] FP2020 Data Dashboard (2019) FP2020's Core Indicators to monitor progress across countries
[401] FP2020 Data Dashboard (2019) FP2020's Core Indicators to monitor progress across countries
[402] United Nations Department of Economic and Social Affairs (2017) World Family Planning
[403] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[404] United Nations Department of Economic and Social Affairs (2017) World Family Planning
[405] ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[406] United Nations Department of Economic and Social Affairs (2017) World Family Planning
[407] Lembaga Penduduk and Pembangunan Keluarga Negara (LPPKN) World Population Day 2018

Appendix 3 Family Planning environments across selected countries

Table 18 Family Planning environments across selected countries

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Population and related Family Planning successes				
• 1st FP policy statement in 1966 coordinated by LPPKN to improve maternal and child health and decelerate population growth rate from an annual 3% in 1966 to 2% in 1985 by increasing FP acceptors. FP was integrated into the primary health system and linked with reproductive health efforts.[408] • Since then, impressive feats in human/social development	Turkey's successes[409]: • Dramatic declines in TFR (from 5 in early 1970s to 2.6 in 1998) and infant mortality rate from 200 per 1,000 live births in 1963 to 35.3 in 2000.	Egypt's successes [410]: • NPS success is attributed to the firm and effective political determination to curb the population increase via multi sectoral engagement (Ministries and NGOs). • Public sympathy is critical to the success of any strategy. The NPS will only succeed if families started to think not only in terms of what is good for them, but also of what is good for their country. • Under the National Strategy, the *Two (children) is Enough* inter-ministerial campaign is raising awareness to curb population growth and accelerate social development among the poorest governorates with highest fertility rates.[411]	Morocco's successes [412] • TFR is 2.04 births per woman in urban areas and 2.8 births per woman in rural areas. • Reproductive health needs projected to increase along with women of reproductive age from 8.5 to 10 million in 2010-25. • Morocco improved reproductive health, although less than other developing countries of similar economic development. [413] • Infant mortality decreased due to immunisation efforts, but maternal mortality remained constant. An efficient primary health care is needed to reach health for all. [414] **Factors in fertility decline**[415] • Due to increases in women's average age at marriage, married women's contraceptive use, desire for smaller families, and increases in girl's educational level.	• Since 1st population policy in 1976, high Government commitment in improving primary health care via community clinics in underserved communities [416] • Achieved several ICPD PoA goals, reducing TFR from 6.3 births in 1975 to 2.3 in 2017, knowledge of FP method is near universal among couples and increased CPR, attributed to strong political commitment and implementation of effective and sustainable FP programmes. [417] • Progressive laws and policies to expand the rights of women and young people.[418]

[408] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[409] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[410] UNFPA (2016) Egypt - Population Situation Analysis
[411] Wahish, N (2018) Family planning in Egypt: The 'Two is enough' project
[412] UNFPA (2011) Final country programme document for Morocco 2012-16
[413] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[414] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[415] Population Reference Bureau (2006) Fertility Decline and Reproductive Health in Morocco: New DHS Figures
[416] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)
[417] UNFPA (2010) The Bangladesh Family Planning Programme: Achievements, Gaps and the Way Forward
[418] UNFPA (2016) Bangladesh - Country programme document for Bangladesh 2017-20

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Demographic and related Family Planning challenges				
Situational analysis on Population and Family in Malaysia reports on the population challenges: [419] • Declines in fertility rates has accelerated Malaysian's ageing process with potential future labour shortages impacting the economy. Thus, high productivity should drive economic growth, with interventions to stop the fertility decline. • Family challenges in ability to have more children: financial constraints (65%); late marriage (late 20s); difficulty to find a spouse (18% ♂; 36% ♀) and 37% subfertility. • Multi-ethnic/multi-faith society with different FP needs makes it challenging to cater for each group.[420] • Malaysia had the lowest CPR and highest unmet need for FP across countries, despite contraception services being integrated into primary health care and made available for all youth and women at government clinics, partly attributed to the fact that SRH services are not properly promoted, and adolescents might be afraid to access them for the fear of being stigmatised or discriminated against.	Turkey challenges[421]: • Early marriage remains an issue and affects adolescent SRH with a higher risk of obstetric complications. • Traditionally, premarital sexual activity for women is stigmatised and condemned. • Perinatal mortality rate is still high at 42 per 1000 total births, indicating a need for improving maternal health. • Marked differences in regional and rural vs urban indicators attributed to gender differences in educational levels: 19% of all women were illiterate in 2000, particularly in rural areas. • Primary health care services, including reproductive health and FP are limited in disadvantaged neighbourhoods.	Egypt's challenges[422]: • Unequal gender power dynamics lead to prevalent harmful practices (FGM and early marriage), affect childbearing trends, encourage large families, and decrease demand and use of FP services. • Major regional disparities in access to -and provision of- adequate FP services. Poverty and rural settings associated with high fertility and low contraceptive prevalence. • High fertility rates since 2006, reaching 3.5 birth per woman in 2014 and decreasing to 3.1 in 2018.[423]	Morocco's challenges[424]: • While infant mortality decreased due to immunisation efforts, maternal mortality remained constant during the last 15 years. An efficient primary health care is needed if countries like Morocco are to reach the goal of health for all. [425] • Health indicators improving but wide spatial disparities persist, particularly in rural areas [426]: Morocco's challenges [427]: • Improving health indicators but SRH inequalities between urban and rural, rich and poor, developed and deprived regions • During the last decades, fertility declined due to different parameters. Infant mortality decreased and should reach the SDG, whereas maternal mortality has remained constant.	Bangladesh challenges[428]: • Growing population size and density • Hight proportion of pop < 15 years • Low female age at marriage • Early childbearing • High neonatal and maternal mortality • Extremely high adolescent fertility Contextual issues:[429] • Reached the lower middle-income country group in 2014, although 23% of population still lives below poverty line. • Differential development across rich/poor, urban/rural districts. • Insufficient allocation of resources for Health System (64% out-of-pocket payments). • Challenging implementation of progressive policies due to inefficiencies in government mechanisms and weak systems and institutions for equity-based planning, budgeting, coordination and monitoring. The 4th HPNSP includes specific indicators to address the challenges.[430]

[419] LPPKN (2018) Situational Analysis on Population and Family in Malaysia
[420] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[421] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[422] United Nations Population Fund Country programme document for Egypt (2018–2022)
[423] UNFPA (2020) Egypt Family Planning.
[424] UNFPA (2011) Final country programme document for Morocco 2012-16
[425] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[426] UNFPA (2011) Final country programme document for Morocco 2012-16
[427] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[428] UNFPA (2010) The Bangladesh Family Planning Programme: Achievements, Gaps and the Way Forward
[429] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)
[430] UNFPA (2016) Bangladesh - Country programme document for Bangladesh 2017-20

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Legal Frameworks (child marriage, abortion, GBV, FGM)				
• *1966 Population and Family Development Act 352*. [431] • Civil laws apply to Muslims and non-Muslims, except for family (Syariah) laws, covering incest, marriage, divorce, children's custody & division of assets Muslims divorces, applied in a religious (Syariah) Court. [432] • Malaysia is a member of the UN Human Rights Council and signatory to the following conventions, albeit with reservations: *Convention on the Rights of the Child* (CRC); *Convention on the Rights of Persons with Disabilities* (CRPD); and *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW). Malaysian reservations to certain CEDAW articles regarding women's rights relating to marriage and family relations, including child marriage.	Turkey's legal framework[433]: • 1st anti-natalist Population Planning Law in 1965, improving women's SRH by legalising contraception information and services. Surgical sterilisation and abortion permitted only on eugenic and medical grounds. Unsafe abortion was unreported problem. • 2nd Population Planning Law of 1983 authorised mid-level providers to insert IUDs, legalised induced abortion on request up to 10 weeks of pregnancy and licensed GPs to terminate pregnancies. • Current political environment is pronatalist and antiabortion[434]: the government proposed in 2012 to restrict abortion via a bill not passed. Women report difficulties accessing abortion. • Progressive gender equality laws, but patriarchal structures. Education influence health services utilisation (antenatal care, FP use, and contact with health personnel).	Three stages of the population policy are identified. [435] • 1st stage from 1962 with a when the Egyptian government adopted a fertility reduction policy • 2nd stage from 1973 with a socioeconomic approach to fertility reduction, considering the socioeconomic standard of the family; education; women's status; mechanization of agriculture; industrialization; infant mortality reduction; social security; information, education, and communication (IEC); and FP services. • 3rd stage from 1975 with a developmental approach to Egypt's population problem (*Strategy of National Development 1978-82)* considering the impact of population size, distribution and characteristics on level of welfare.[436]	• Commits to FP/SRH rights, children number & spacing, marriage equality. [437] • 2004 Moroccan Family Code (*Moudawana*)[438] of Maliki Sunni Islamic school, regulates family (marriage, polygamy, divorce, inheritance, child custody), praised for addressing women's rights & gender equality in Islamic law. [439] • 2011 constitution notes equality in health care access and services & equity in spatial distribution of resources. [440] • Improvements by Moroccan FP programme since 1960s, with legal contraception. CPR increased from 19% in 1980s to 63% in 2003, and 54.8% modern method. [441] • Family law reform, but 50% women required accompanied on medical consultations. [442] • Abortion only legal for mother's health, fetal abnormalities, rape or incest. Estimate 600-800 conducted daily by doctors and 200 illegally. [443]	Contextual issues:[444] • Bangladesh's commitment and response to FP based on human rights principles and aligned with the international frameworks on Child Rights Convention, ICPD PoA, the Beijing Platform for Action and the SDGs. • The Strategy also aligns to the Constitution which guarantees the right to health care and medical treatment for all its citizens, irrespective of age, sex, caste, creed and colour. • The strategy is guided by a number of legislations including the Children Act 2013, Women and Children Repression Prevention Act 2000 (amended in 2003), Human Trafficking Prevention and Deterrence Act 2012, and the Child Marriage Restraint Act 1929 (amended in 1983).

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[440] Boutayeb W, Lamlili M, Maamri A, et al (2016) Actions on social determinants and interventions in primary health to improve mother and child health and health equity in Morocco. International Journal for Equity in Health
[441] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[442] UNFPA (2011) Final country programme document for Morocco 2012-16
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Malaysia	Turkey	Egypt	Morocco	Bangladesh
Related Strategies				
• 2nd Malaysian Population Strategic Plan Study (2010); The National Strategy on HIV and AIDS for 2011-2015; and Revised 2010-15 National Policy for Older Persons. • ***Situational analysis on Population and Family in Malaysia***[445] reports on the population challenges and proposes strategies for population development programmes via 40 recommendations to address objectives and targets under each pillar to be implemented across ministries and agencies during 2018-30.	Turkey issued a ***National Strategic Action Plan for SRH 2005-15***, [446] although the sexual health policy trend is shifting away from its previous commitment to a rights-based approach. While Turkey has made marked progress in FP to date,[447] access to SRH services has become more limited in the last five years due to the conservative political environment. Since 2007, the government's pronatalist population planning within the most recent Four-Year Development Plan[448] encourages women to bear a minimum of three children.	• ***National Population Strategy 2015-30*** (NPS) developed by an inter-ministerial group coordinated by the National Population Council (NPC). [449,450] • Supporting the NPS: Child Strategy, Early Marriage Strategy and Egypt Sustainable Development Strategy (*Egypt's Vision*). [451] • FP from the religious perspective the individual family level involving its social, economic, and health conditions, or society level, while birth control is viewed as a public policy adopted and enforced by the state. The population policy failed to distinguish between these 2 levels. • Population policies were made and approved by the Supreme Council for Population and Family Planning excluding the participation from elected councils. Effectiveness of population policy can be improved by increasing the degree of congruency of policy with religious beliefs, its responsiveness to the needs of the people, and its legitimacy. [452]	Morocco Public health[453] • Launched strategies to improve access to health services and population health outcomes and national strategy to reduce maternal and neonatal mortality. Maternal Mortality Surveillance System indicated 80 % of 2009 maternal deaths avoidable by increasing the standard of care in hospitals. [454] Health outcomes depend on the rate of access to health services & the quality of health care provided. • The *Maternal Mortality Strategy action plan of 2008–12* to reduce the maternal mortality rate (MMR) from 227 to 50 deaths per 100,000 births. Strategies: 1. reduce barriers preventing women from accessing emergency services; 2. enhance health care quality; and 3. improve governance. MoH 2019 data from maternal mortality surveillance system revealed that MMR reduction to 50 not achievable by 2015. Thus, new action plan 2012-16 introduced to target actions for rural and disadvantaged areas.[455]	• ***4th Health, Population and Nutrition Sector Program* (4th HPNSP) 2017-22**[456]**,** led by the Ministry of Health and Family Welfare • *National Plan for Sexual and Reproductive Health*, A costed, integrated national plan which prioritises access for key groups • 5-yearly plans aligned with ICPD and SDG objectives to address reproductive health and rights, youth development, and gender equality challenges. • Supporting the 4th HPNSP: *National Strategy for Adolescent Health 2017-30* [457]

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[453] European Committee of the Regions (2020) Morocco Public Health
[454] Boutayeb W, Lamlili M, Maamri A, et al (2016) Actions on social determinants and interventions in primary health to improve mother and child health and health equity in Morocco. International Journal for Equity in Health
[455] Boutayeb W, Lamlili M, Maamri A, et al (2016) Actions on social determinants and interventions in primary health to improve mother and child health and health equity in Morocco. International Journal for Equity in Health
[456] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)
[457] Bangladesh Directorate General of Family Planning (2016) National Strategy for Adolescent Health 2017-2030

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Institutional mechanisms for family planning				
• The National Population and Family Development Board (LPPKN) established to plan and coordinate all FP activities in the country, beginning with clinical contraceptive services in urban areas and expanding to rural areas via integration of FP with primary health care services of MoH in the early 1970s. [458] • FP services are conducted through a multi-sectoral approach across implementing agencies with LPPKN acts as coordinator; FP service delivery is based on aspects of health and family's health and the practice is voluntary.	Institutional mechanisms[459]: • The General Directorate of Maternal and Child Health and Family Planning (MCH-FP) set up in 1965 within the MoH, develops policies and strategies, implements programmes via FP health centers and evaluates maternal and child health and FP programmes nationally.[460] • The *Women's Health and Family Planning Advisory Board*, established under MoH in 1993 and chaired by MoH reports to Minister via MCH–FP. It meets twice a year to facilitate inter-sectoral collaboration and monitor implementation of FP policies and programmes. Membership includes Ministries of Education, Labour, Media, Religious Affairs, Universities, the Army, NGOs, civil society and other sectors. [461] • The Board has successfully motivate all sectors to initiate new approaches and programmes based on ICPD recommendations (launched education for adolescents on SRH in schools and education for soldiers to improve male involvement in fertility regulation and FP).	• A 2013 National Population and Development Conference resulted in the establishment of an inter-ministerial group coordinated by the National Population Council (NPC) tasked with developing the National Population Strategy 2015-2030. • The NPS has a multi-sectoral approach to ensure integration of services and efforts including government, private sector, public and private media institutions, volunteers and NGOs.[462]	Commits to FP and SRH health [463] • Improved trends. National FP programme since 1966, established a national population commission and local population commissions. Repeal 1967 French Law prohibiting contraceptives. • in 1990s, SRH rights issues gained political attention with advocating NGOs. Ministry for Economic Forecasting and Planning mandate (along with the 16 regional commissions) to ensure integration of population concerns into development planning. • End 1990s, impressive gains in FP, maternal and child health. In 2003, MoH purchase contraceptives without donor contribution. • Narrowed gap in FP service delivery in rural and poor areas to meet rising SRH services & contraception demand. In 2004, >50% married women in rural areas using modern FP method.	• The Population Council is supporting with coordination and accountability:. • Post ICPD, it formed a National Committee and Developed a National PoA for implementation of ICPD PoA and formulated national policies on Population, Maternal Health, HIV/AIDS and STD and Population, Health & SRH and Nutrition. [464]

[458] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
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[460] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
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Family Planning Strategy and Costed Implementation Plans (multi-year actionable roadmap designed to help the government achieve its FP goals)				
No FP Policy endorsed, but 1966 operational policy statement for implementing national FP programme. The earlier aim of Malaysia's FP programme was towards achieving a quality family through spacing 1. Malaysia reduced the TFR to 2.0 births per couple and a further TFR reduction will impact Malaysia's future economic growth. Thus, although it is important to increase the CPR, this should be balanced to avoid a further TFR decline by targeting contraception awareness and services to address unmet needs. 2. Increased awareness of contraception among high risk for STDs to reduce HIV infection rates. 3. Education and awareness among primary care providers regarding contraception for women with unstable medical condition, such as uncontrolled hypertension and diabetes or morbid obesity. For these women, pregnancy is high risk and thus will increase maternal morbidity and mortality rates. Good control of medical conditions prior to pregnancy will lead to safe pregnancy and childbirth.	Turkey's resources[465]: • Turkey is implementing a comprehensive FP programme since 1965 successfully improving of modern contraceptive use. • Turkey issued a ***National Strategic Action Plan for SRH 2005-2015*** [466] • The *1995 Women's Health and Family Planning Strategic Plan* was collaboratively developed by government and NGOs, led by MCH–FP with UNFPA's financial support. The Action Plan adapted all ICPD recommendations to the Turkish context and focused on strengthening inter-sectoral collaboration and the SRH components of primary health care units to reduce regional differences in health indicators, improving quality of services and involving NGOs. *Shared reproductive health and FP services costs (but limited budget):* • MCH-FP pays for FP commodities (contraceptives, equipment and educational materials). • MoH pays for personnel, maintenance and clinic buildings.	• EU[467] is supporting the design of a multisectoral ***FP National Costed Implementation Plan 2019-23*** led by Ministry of Health and Population (MoHP) to identify gaps in programming, agree on interventions and estimate cost. [468] • **UNFPA and Ministry of Health and Population's Family Planning and Reproductive Health Sector 10th Country Programme Action Plan (2018-2022)**[469] to universal access to SRH services by targeting selected governorates with the poorest sexual and reproductive health indicators.	The ***2020-25 National Reproductive Health Strategy*** has several strategic principles noted below. [470]	Costed Implementation Plan (CIP) for ***2020-2022 National Family Planning Program*** *in Bangladesh*[471]*:* identifies key strategies and activities for achieving the goals costed for three years (2020-2022 of current 4th HPNSP) including: • Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, and human resources) • Increasing acceptability of long-acting reversible contraception and permanent methods through skilled human resources and male engagement • Promoting interval and post-partum contraception • Intra- and inter-sectoral collaboration and coordination including NGOs • Special focus on hard to reach and urban areas, and other low performing areas • Monitoring, Evaluation and Research • Targeting adolescents and youth, particularly males

[465] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[466] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[467] European Union, Egypt Ministry of Health and Population and UNFPA (2019) EU Support to Egypt's National Population Strategy
[468] UNFPA (2020) Egypt National Population Strategy 2015-30 progress review - Year 2
[469] United Nations Population Fund Country programme document for Egypt (2018–2022)
[470] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
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Malaysia	Turkey	Egypt	Morocco	Bangladesh
Vision, mission, goals and development objectives				
• Fertility policy shifted from decreasing TFR to no intervention and raising population quality via education and human resource development.[472] • **Current direction:** address fertility decline (subfertility; pro-fertility incentives; childcare options) • ***Situational analysis on Population and Family in Malaysia*** [473] Pillars: 1) *addressing fertility decline* (address subfertility; pro-fertility incentives; childcare options); 2) *strengthening family institution* (promote parental skills, family cohesion and intergenerational support systems) 3) *enhancing population resiliency* (raise productivity, ↑LFP for ♀, flexible working arrangements, life-course approach to improving health, expand family centric programmes) 4) *mainstreaming policies for active aging* (utilising elderly's experience, promoting age-friendly environments & community -based care, restructure pension) 5) *enabling inclusive progress for all* (ensure inclusive policy initiatives	• FP policy trend shifting from previous commitment to a rights-based approach. [474] • Current political environment is pronatalist and antiabortion[475]: Turkey issued a ***National Strategic Action Plan for SRH 2005-2015***, [476] although the sexual health policy trend is shifting away from its previous commitment to a rights-based approach. While Turkey has made marked progress in FP to date,[477] access to SRH services has become more limited in the last five years due to the conservative political environment. Since 2007, the government's pronatalist population planning within the most recent Four-Year Development Plan[478] encourages women to bear a minimum of three children.	• **NPS 2015-30** [479]**:** reduce population growth rates and birth rate from 3.5 births per woman to 2.4 by 2030 and scale up FP programmes (increase CPR from 59% to 72%) to simultaneously address poverty and population growth [480] while targeting disadvantaged governorates and empowering women. • ***National Population Strategy 2015-30*** (NPS) [481]**:** 1) reducing population growth rates, 2) improving population characteristics, 3) redressing imbalances in population distributions and 4) reducing disparities across geographical areas (urban vs. rural, north vs. south, and formal vs. informal urban areas).[482] **Pillars:** improve the population's quality of life via: 1) strengthening access to family planning and reproductive health; 2) foster youth development (health and civic engagement); 3) advance girl's education and women's economic empowerment; and 4) deploy mass media awareness raising campaigns to support all of the above.	The ***2020-25 National Reproductive Health Strategy*** has several strategic principles: institutional coordination and evaluation; increasing access to SRH services for targeted populations; integrate a monitoring and evaluation system; strengthening SRH partnerships and research. The focused areas include: adolescents' SRH, physical and mental health Including STIs; family planning; (re-designing pre-marital consultation), maternal health; perinatal care; addressing violence towards women and children; uterine, cervical and breast cancer prevention; infertility treatment; and health issues related to menopause. [483]	Reduce population growth rates and birth rate • ***4th HPNSP*** [484] **Vision:** to produce healthier, happier and economically productive population and achieve the middle-income country status by 2021. **Mission:** create opportunities to reach and maintain optimal health **Goal:** ensure citizens enjoy health and well-being by expanding access to quality and equitable health care in a healthy environment **Development objective:** increasing access to quality health care and improvement in equity along with achieving UHC.

[472] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[473] LPPKN (2018) Situational Analysis on Population and Family in Malaysia
[474] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
[475] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[476] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033
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[478] Yüceşahin, M. & Adalı, Tuğba & Türkyılmaz, Ahmet. (2016). Population Policies in Turkey and Demographic Changes on a Social Map.
[479] UNFPA (2016) Egypt Population Matters
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[484] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

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for disadvantaged communities, promote social entrepreneurship, community cooperation, enhance human development and community outreach programmes via digital technologies)		**FP objectives under the NPS**: more effective FP and perinatal health services; improved health services to youth; enhancing population characteristics; raising awareness of population problem; women empowerment; and monitoring and assessment efforts.		
Key partners in delivering Family Planning services				
• LPPKN, MoH, the National Population and Family Development Board and Federation of Reproductive Health Association of Malaysia (FRHAM). [485] • The private sector involved in FP commodities needs to be more engaged	The Turkish Family Planning Association, an NGO founded in 1963, the Family Health and Planning Foundation, universities and the MoH have collaborated with the international agencies to provide reproductive health programmes and services.[486]	• The Egyptian Family Planning Association (EFPA) [487] is the government's primary partner in SRH, co-ordinating the delivery of FP services via voluntary organisations. EFPA is a lead partner in the National Population Commission's ongoing initiative to increase contraceptive prevalence across the country. • EFPA provides information, education and communication (IEC) programmes for the general public, many of which (particularly amongst young people) are run on a peer-to-peer basis. Emergency intervention to prevent reported early marriage cases is a key priority.	• The Moroccan Association to combat Clandestine Abortion (AMLAC),	The Population Council

[485] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[486] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[487] IPPF (2016) Egyptian Family Planning Association.

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Integration of FP services into Primary health care (PHC) is essential for equitable access and cost-effective health care and a key factor in the global strategy for universal health coverage (UHC) [488]:				
• The National Programme makes FP services and information available via a network of clinics. MoH integrates FP services with the rural health services, while LPPKN, FRHAM and private sectors provide for FP in urban areas.[489] Private hospitals/clinics and commercial outlets also provide FP services. **FP services** • All government health and Maternal & Child Health clinics provide FP Services. MoH hospitals offer limited FP Services. • In 2019, MoH reported 1,000 Health Clinics and 90 Maternal and Child Health Clinics; 1,791 Community Clinics, 217 Mobile Health Clinics, and 4 Flying Doctor teams with 4 helicopters.[490] • FRHAM delivers a service range via 39 permanent clinics, 356 mobile facilities & 205 community-based distributors/community-based services. [491] • LPPKN's SRH services have been expanded in recent years via 49 clinics across the country delivering contraceptive safe effective, affordable and acceptable choices **Fertility services are limited to:** - 3 fertility clinics (LPPKN 2020) - 135 clinics and 1 hospital with fertility facilities. [492] While all MoH hospitals have fertility clinics, services might not be consistently provided.	No information was found.	Integration FP services into PHC[493]: • 92.1 million population with 28.3 physicians per 10,000 inhabitants. • PHC was established in the early 1940s based on general practice and maternity and child health services by the mid-1990s. • There are approximately 5314 PHC facilities with 14,973 general practitioners and 256 certified FPs. Of these facilities, 61% implemented an FP approach based on formal accreditation. Three types of facilities are in operation: family health units, family health centers, and district hospitals; with a PHC facility within less than 5 km for 95% of the population. This has resulted in nearly 91% children aged 18–29 months fully vaccinated. • The government has created a four-year FP fellowship training programme, while various universities did shape a postgraduate five-year training programme. The main challenges are the high out-of-pocket expenditure on health, low government spending and poor government vision on family practice, resulting in poor public health services that force most of the poorest to use private health care	Integration FP services into PHC[494]: • Lower middle-income country with 34 million people and has 0.68 physicians per 10 000 population. • The public sector, Royal Armed Forces, private sector, and informal sectors provide PHC services. • Public sector is responsible for two levels of delivery: 1. health centers, overseen by a GP and a nurse, provides health promotion, preventive, and curative care; 2. health centers including emergency, oral, and mental health services. • Private sector provides PHC service via *medical practices*, run by individuals or GP group. Has advanced health system to address inequities in services provision. • The advent of mandatory medical coverage has been a real social evolution, obligating the state to implement the regulation of health care providers and control costs in private and public sectors. • Challenges include barriers in services access due to geographical concentration and both qualitative and quantitative deficit in health professionals, as no specialized training for family medicine is available. The two-year master's degree programme in Family and Community Health developed in 2015 is not a substitution for the urgent need to scale up family medicine training.	No information was found.

[488] C van W, F A, T F, et al (2017) Primary health care policy implementation in the Eastern Mediterranean region: Experiences of six countries. Eur J Gen Pract 24:39–44.
[489] UNFPA-ICOMP Regional Consultation (2010) Family Planning in Asia and the Pacific Addressing the Challenges - Malaysia
[490] Ministry of Health (2019) Health Facts 2019 Translated from Malay
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[492] Ministry of Health (2019) Health Facts 2019 Translated from Malay
[493] C van W, F A, T F, et al (2017) Primary health care policy implementation in the Eastern Mediterranean region: Experiences of six countries. Eur J Gen Pract 24:39–44.
[494] N N, R H, Am AD, et al (2019) Primary care health care policy implementation in the Eastern Mediterranean region; experiences of six countries: Part II. Eur J Gen Pract 26:1–6.

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Programmatic achievements (should be measured by indicators)				
• LPPKN collaborates with MoH and FRHAM in providing FP and other reproductive health services to the community.[495] MoH's 2019 Maternal & Child Health Attendances [496] - Antenatal Attendances 6,219 ,159 - Postnatal Attendances 496,640 - Child Attendances 9,938,375	The FP programme has[497]: • Improved quality of care and service utilisation and expanded the range of SRH services in high demand areas. • Reduced unmet need for FP and increased contraceptive choice by introducing implants & injectables. • Distributed *National Service Guidelines on FP* to all primary health care units in 1994 covering reproductive health topics (counselling, sexuality, STIs-HIV/AIDS, abortion, infertility, infection prevention, quality assurance, and recording data on FP services. • Involved men in FP and STI care by Turkish Family Planning Foundation via IEC SRH programmes for young men doing compulsory military service -particularly important in a male-dominated society- which were scaled up. • Launched safe motherhood initiatives in 8 pilot provinces by NGOs with UNFPA & UNICEF. • Improved FP counselling services to ensure informed choice and maintain high continuation rates. • Improved FP in undergraduate medical and nursing–midwifery school curricula in 1992-98 by MoH.	**NPS progress review – year 2**[498] *Outcome 1: FP services incl. contraceptive scaled-up and more accessible (supply-side)* by enhancing the supply chain, building service providers capacity (updating FP training & guidelines) and integrating FP and youth-friendly services into primary health care Centres via cross-sectoral training & integrating FP services into routine immunisation services in postpartum. *Outcome 2: Youth & reproductive age population educated on FP, smaller family value, SRH and GBV* via sport festivals (demand-side), targeting governorates with highest fertility & poverty via NGOs door-to-door visits and training religious /community leaders across religions (Muslim, Christian) on FP. *Outcome 3: Strengthened institutional capacities for monitoring and coordination of NPS* implementation led by the NPC via an intra-ministerial Steering Committee.	Morocco's achievements [499]*:* • Launched in 2008, the national plan for accelerating the reduction of maternal and neonatal mortality has improved access to —and quality of— obstetrical and neonatal care. • Although access to health care and services and health outcomes improved in average during the last decades, socio-economic inequalities and special health inequity are persistent (urban vs rural) [500] Use in Morocco, 1992-1995 changes in the family planning supply environment, in particular increased presence of nurses trained in family planning at public clinics, played a significant role in the increased use of modern contraceptives during the study period. However, programme efforts to broaden the mix of contraceptive methods used by Moroccan women were less successful. [501]	• Of the 131 indicators used, 31 (24%) have been fully achieved and 18 (14%) are partially achieved in the first progress report. • The 4th HPNSP focused on improving the HR capacity via training workshops, seminars and orientations, which has been conducted for 31,682 participants. [502]

[495] Ministry of Women Family and Community Development, Lembaga Penduduk Dan Pembangunan Keluarga Negara
[496] Ministry of Health (2019) Health Facts 2019 Translated from Malay
[497] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[498] UNFPA (2020) Egypt National Population Strategy 2015-30 progress review - Year 2
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[501] Hotchkiss DR (1998) Family Planning Program Effects on Contraceptive
[502] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Key implementation challenges				
• Malaysia had the lowest CPR and highest unmet need for FP across countries, despite contraception services being integrated into primary health care and made available for all youth and women at government clinics, partly attributed to the fact that SRH services are not properly promoted, and adolescents might be afraid to access them for the fear of being stigmatised or discriminated against • Need to expand the country programme core areas of young people's SRHR, empowerment of marginalised women, protection from gender-based violence, ensuring quality of life for the elderly as well as revitalising the national FP programme, and include new and emerging issues such as migrant workers and the feminisation of HIV/AIDS.[503]	Challenges in the provision of reproductive health and FP services[504]: • Poor intersectoral collaboration between MoH units delivering SRH services. MoH should establish a Coordinating Committee on Population and Reproductive Health to plan, coordinate and collaborate on relevant reproductive health and FP activities. • Complex bureaucratic procedures for budget expenditure causing delays in supplies • High turnover among health personnel leading to the need of providing regular training by the MoH • Unbalanced distribution of health personnel across the country (rural and urban and western and eastern regions). • While the MoH, supported by international donors and national NGOs piloted several successful reproductive health programmes, most pilots were not replicated due to lack of political commitment and mismanagement.	*Population Situation Analysis* [505]*:* the NPS review shows that objectives adopted in the planning phases were not achieved due to the lack of resources, weak coordination, discontinuity of institutional framework, centralisation, and the absence of monitoring and evaluation.	Morocco's challenges [506]: • The achievements accomplished in reproductive health remain insufficient. FP and contraception policies need to reach more women; and antenatal and postnatal care should be enhanced especially towards poor women living in rural areas and deprived regions • FP and contraception policies need to reach more women; antenatal and postnatal care should be enhanced, and more skilled medical personnel are needed to assist women during labour, especially for poor women living in rural areas and deprived regions. [507] Morocco's FP [508]: • In 2003, about 10% of women aged 15-49 years had unmet need. Feedback studies indicate the possibility to improve the efficiency of these services, which are available through vertical programmes, by more integrated and comprehensive ones. • The FP programme required quantitative and qualitative improvements regarding % of women using contraception (63%), diversification of contraceptive methods and reduction of unplanned pregnancies especially among young women who are behind the estimated 150 000 illegal abortions performed annually.	From first progress report[509]: • delayed receipt of fund hindered the implementation of planned activities • insufficient fund allocation • unavailability of a robust system of monitoring and supervision • issues with HR, including storage, retention and vacancy in sanctioned position

[503] UNFPA (2013) Country programme document for Malaysia 2013-17
[504] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[505] UNFPA (2016) Egypt - Population Situation Analysis
[506] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[507] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[508] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health
[509] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Issues needing attention				
• The contraceptive prevalence rate increased to 52 % in 1984, the fertility has been declining reaching replacement level, attributed to rising age at marriage and increased contraceptive use. [510]	• Current political environment is pronatalist and antiabortion[511], thus advocacy to prioritise reproductive health services, and abortion care in the public health system are needed • Turkey's centralised health governance makes its sexual health policies vulnerable to abrupt and immediate changes—as demonstrated by the conservative political turn that began in the early 2010s. [512]	*Population Situation Analysis* [513]*:* Though being multi-faceted and comprehensive, the NPS overlooked significant factors: • the Strategy and its plan omitted investment in the large number of young people , representing 1/3 of the population. • despite the large number of political parties in Egypt, the strategy did not involve these parties to any extent. • there is a dire need to more data to monitor the NSP implementation. • Most of the indicators that are related to RH and fertility are driven from surveys conducted with wide time spaces and had sample sizes disallowing the calculation of indicators on small administrative units level.	• SRH in Morocco can be improved by adopting targeted and equitable health strategies that aim to enhance the mean status of the whole population but at the same time to reduce regional disparities between developed and disadvantaged regions; inequalities between rich and poor, and marginalisation of the rural population. [514]	From first progress report • Off-track indicators include MMR, NMR, TFR, unmet need for FP, PNC coverage and IYCF practices that need to be adequately addressed. • Need for improved institutional coordination between health, nutrition and population services to avoid duplication, training, nursing services, quality assurance, and availability of HR at the facilities. [515]

[510] LPPKN (2018) Situational Analysis on Population and Family in Malaysia

[511] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.

[512] Yilmaz V, Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. Societies 10:33. https://doi.org/10.3390/soc10020033

[513] UNFPA (2016) Egypt - Population Situation Analysis

[514] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health

[515] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

Malaysia	Turkey	Egypt	Morocco	Bangladesh
Data sources informing policy, monitoring and evaluating progress, and frequency of collection				
• Malaysian Population and Family Survey (MPFS), conducted every 10 years since 1974 (latest survey was the 2014 5th Malaysian Population and Family Survey (MFFS-5)[516], stratified and representative of the population).	• 5-yearly DHS since 1963 to monitor health trends.	• 2014 Demographic and Health Survey • Egypt Population, Housing, and Establishments Census 2017.[517] • Survey of Young People in Egypt (SYPE), [518] longitudinal nationally representative survey follows up youth in 2009, 2014 and 2016 collecting gender-disaggregated information on SRH, health, schooling and employment. Informs policies and programmes for youth.	• Morocco *National Survey on Population and Family Health 2010-2011*; nationally representative cross-sectional household survey[519]	• 6-yearly Population and Housing Census informs socio-economic development planning and policy formulation at national and subnational levels. • The demographic and health data from the *Bangladesh Demographic and Health Survey* 2017-18 BDHS by the National Institute of Population Research and Training (NIPORT) is essential to monitor progress of the 4th HPNSP 2017-22 [520] • Multiple indicators from other cluster surveys.
Monitoring and Evaluation				
For MoH, a monitoring mechanism is currently in place at national, subnational and facility level. For MoH, public are most welcomed to complaint using the existing web-based platform	Lessons learned: [521] • Turkey has strengthened FP policies and programmes over the years since 1965 with support from international donors, reaching several reproductive health goals. • Although considerable progress has been made, the agenda remains unfinished. ICPD introduced the concept of a comprehensive life-cycle approach, which is well accepted in Turkey. • Involve men in FP programmes	National Population and Development Strategy 2015-30 Review of the Executive Plan 2015-2020[522] *Population Situation Analysis* [523]*:* Limited M&E, suggest **a population observatory to monitor & evaluate NPS implementation**: • Collect and harmonise available data and indicators. • Assess and bridge information gaps by surveys or innovative research (crowdsourcing/big data methodologies). • Improvements to SRH statistics driven by the Egyptian Family Planning Association (EFPA) via service delivery (complementing government services). [524]	• Limited financial resources and the varying levels of political support	The 4th HPNSP progress report highlights implementation challenges to course correct programmes[525] Annual Program Implementation Report (APIR) 2018 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

[516] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[517] Central Agency for Public Mobilization and Statistics (CAPMAS, Egypt) (2017) Egypt Population, Housing, and Establishments Census 2017
[518] Population Council (2014) Survey of Young People in Egypt
[519] Ministry of Public Health (Morocco) (2011) Morocco National Survey on Population and Family Health 2010-2011
http://ghdx.healthdata.org/organizations/ministry-health-morocco
[520] NIPORT (2019) Bangladesh Demographic and Health Survey (BDHS) 2017-18: Key Indicators Report.
[521] Ozvaris SB, Akin L, Akin A (2004) The Role and Influence of Stakeholders and Donors on Reproductive Health Services in Turkey. Reproductive Health Matters 12:116–127
[522] UNFPA (2020) Review of the Executive Plan 2015-2020 in the Context of the National Population and Development Strategy 2015-2030
[523] UNFPA (2016) Egypt - Population Situation Analysis
[524] IPPF (2016) Egyptian Family Planning Association.
[525] PMMU (2017) Program Implementation Report 2017 of the 4th Health, Population and Nutrition Sector Program (4th HPNSP)

Appendix 4 Recommendations from Malaysia's 2010 Population Strategic Plan Study

Table 19 Family planning related objectives and recommendations from Malaysia's 2010 Population Strategic Plan Study [526]

Background	Objectives	Recommendations
FERTILITY DECLINE AND LONG-TERM POPULATION GROWTH OBJECTIVES		
• Need to address fertility decline and avoid workforce contraction and rapid ageing population in *FP policy* and *labour market policy*. • Hight % university educated women remain single in their 30s, and those married have low fertility. High opportunity costs of leaving workforce to raise children: policy to facilitate their *work-life balance.* • Ethnic differentials in fertility (Chinese and Indian populations already below-replacement) shifted population ethnic composition, with Malay population driving fertility rates.	• Sustain fertility at replacement level in the longer term while supporting couples (women and men) to combine participation in the labour market and their family building.	Suggested policies making childbearing more compatible with raising a family include: • Introducing a period of paid paternity leave to make clear the government's support for gender balance in childrearing; • Providing for paid compassionate leave in cases of children's sickness; • Allowing more flexible working hours; • Provision of child-minding facilities at the workplace, and providing government subsidies for childcare costs incurred by working mothers; • Increasing tax concessions for dependent children; • Programmes to encourage husbands to be more fully involved in child-rearing and household activities; • Fully meet the unmet need for contraception especially among disadvantaged groups, as failure to meet their contraceptive needs will place further barriers on their families' socio-economic progress.
REPRODUCTIVE HEALTH		
• Access to FP information and services is a basic right, one to enable couples make their own choices about the births number and spacing. • Unmet need for termination of childbearing in Malaysia is estimated to range from 30-50% if unmet need for spacing is included. • This has significant welfare implications, given unwanted children are unlikely to receive loving care from parents as wanted children. • Infertility is a concern for couples' stability and might cause emotional suffering. • Unmarried sexually active youth risk unwanted pregnancies, unsafe abortion, and contracting STDs, including HIV/AIDS. They require Comprehensive Sexuality Education and access to FP services.	• Reduce the unmet need for FP (as a matter of individual choice); • Improve reproductive health of adolescents and the unmarried; • Reduce resort to abortion, including unsafe abortion; and • Support initiatives to combat the spread of HIV/AIDS and other STDs.	• Programmes to reduce unmet need for FP should focus on: husbands who are apathetic or object to FP; marginalised groups lacking knowledge of and access to FP; users of traditional methods, and those with religious concerns over certain methods; and foreign workers. • Improve SRH of adolescents and older unmarried: provide adolescents information and guidance in SRH matters, including STDs and sexual abuse (via schools); instil a strong moral/religious foundation in children; review and where appropriate, remove legal, regulatory and social barriers to SRH information and services adolescents; identify adolescents' special needs and design programmes to address those needs; develop programmes for prevention and treatment of sexual abuse and incest; provide sexually active adolescents targeted FP information, counselling and services; provide pregnant adolescents with support community support (scaled-up LPPKN's kafe@TEEN programmes); and involve adolescents in the planning, implementation and evaluation of SRH programmes. • Reduce resort to abortion, including unsafe abortion: strengthen FP Information, Education and Communication (IEC) programme; develop clear guidelines and understanding of abortion law and policy; increase access to quality services for abortion complications; and o train doctors in modern abortion techniques (equipped Hospitals/clinics with appropriate equipment and supplies). • Support initiatives to reduce HIV/AIDS and other STDs transmission: conduct studies on the pathways of heterosexual transmission of HIV infection to target programmes and interventions; use a multi-sectoral approach for a coordinated response to the epidemic involving MoH, some NGOs and CBOs; and develop programmes that address SRH youth issues supported by clear and coherent policies concerning SRH rights, such as safer sex promotion and condoms use • Increase availability and affordability of infertility treatment for those requiring such services and study success of infertility treatment.
FAMILY AND GENDER ISSUES		
• Family-centred development is a key aim of the Government.	• Establish a fully caring society and culture, a social system in which the	**Family recommendations**

[526] LPPKN (2010) Second Malaysian Population Strategic Plan Study 2010

Background	Objectives	Recommendations
• Families face multiple challenges in the fast-changing Malaysian society: trends include shrinking family size; three generation households are less common; delayed marriage trends; and increased youth mobility results in diminishing parental roles. • Gender issues require attention to ensure that both women and men contribute to family and society. Harmful attitudes require change (e.g. in Malay and Indian communities, husband's objection is main reason given by women for not working).	welfare of the people will revolve not around the state or individual but around a strong and resilient family system. • Foster a partnership between men and women in family and society based on mutual respect and legally established rights.	• Develop policies and programmes supporting marriage and childbearing to enable men and women combine work with family responsibilities; • Invest in innovative approaches to providing improved childcare facilities: develop community-based childcare centres, workplace-based centres, and enhance private sector role in childcare. Consider childcare subsidy for working mothers; • Develop policies and programmes to support and strengthen vulnerable families (single parents, the poor, disabled); • Build and strengthen informal support networks, partnerships with NGOs and community groups to promote community participation in supporting family members; • Promote more effective household financial planning and budgeting; • Assist families to meet the basic life's necessities, provide assistance to unemployed and retrenched workers; • Develop the concept of families as partners with Government, and sharing responsibility in promoting the wellbeing of Malaysia's population; and • Adopt a National Family Policy and implement the recommended programmes and strategies. **Gender recommendations** • Strengthen existing programmes and implement new programmes to promote women's rights, penalise those violating those rights, and address barriers for women's full participation in labour force, government, politics and decision-making, business and community affairs; • Promote awareness and recognition of women's, and men's, contribution in caring activities and unpaid and voluntary work; • Consider legal reforms and enforcement of existing laws and regulations ensuring women's equal rights and opportunities; • Address gender-based violence via awareness and training education, law enforcement and policy reforms as proposed by the Joint Action Group, improving data collection on violence, and formulating a *National Plan for Prevention of Violence against Women*; • Improve male enrolment and academic performance in secondary and tertiary education and involve schools, parents and the community; • Review school curriculum, recruit more male teachers as role models for boys, and review teaching methods to cater to different needs of boys and girls; and • Devise programmes to address excessive risk-taking by males to reduce male mortality and serious injury.
DEMOGRAPHIC DATA ISSUES		
• Effective planning and development requires accurate and timely data, at the national, state, district and local levels. Monitoring population fertility and migration trends should be a high priority.	• Ensure Malaysia's demographic data is timely, and sufficient in range and quality to meet national and regional and local needs to inform development planning.	• Strengthen the training of those producing and analysing census, vital registration and migration data, and prepare plans for timely and relevant data analysis; • Strengthen civil registration of births and deaths, including Sabah and Sarawak. Conduct studies assessing the extent of under-registration of births and deaths; • Shorten interval between collection and publication of population census data, and birth and death statistics, for each Malaysian States and across ethnic groups; • Strengthen measurement of MDG indicators and ensure consistent reporting of indicators. Publish indicators at lower administrative levels to facilitate programme planning; and • Plan for the conduct of periodic demographic and family surveys.
NEED FOR A NATIONAL INSTITUTE FOR FAMILY AND POPULATION		
• A family-centred approach to development planning requires a research base to study family dynamics changes and their implications.	• Establish a National institute for Family and Population following the lead of countries.	• As research on family change and assessment of policy options requires serious and sustained attention, the establishment of a National Institute for Family and Population is recommended. • Such an Institute could be hosted by a Malaysia's university or government think tank. However, given the role and experience of LPPKN, the logical home for a National Institute of Family and Population would be under the LPPKN.

Appendix 5 Country comparison using Family Planning Effort and National Composite Index on Family Planning

Table 20 Country comparison using the Family Planning Effort[527]

Family Planning indexes	Malaysia	Turkey	Egypt	Morocco	Bangladesh
2014 Family Planning Effort Index (FPE)					
Total score	***63.2***	***38.5***	***50.1***	***61.5***	***65.9***
Policies	**59.5**	**38.6**	**53.5**	**70.1**	**72.7**
Policy on Fertility	45	14.6	44.4	42.1	84.9
Favorable Statement by Leaders (1-2 times per year)	52	1.4	25.4	60.3	67.5
Policy on age at Marriage	62.6	27.4	74.6	75.4	69.8
Import Laws and Legal regulations	59.3	64.6	47.6	88.9	83.3
Advertising of Contraceptives	46.9	51.1	69	78.6	87.3
Objectives (Justifications)					
Reduce Population Growth (pro vs antinatalist FP policies)	26.3	20.7	81.7	36.5	88.1
Enhance Economic Development	69	40	73	72.2	67.5
Avoid Unwanted Births	86.5	75.7	83.3	86.5	84.9
Improve Women's Health	88.9	72.2	84.9	90.5	81.7
Improve Child Health	88.9	63.9	73	88.9	81.7
Reduce Unmarried Adolescent Childbearing	56.7	37.8	14.5	31	48.7
Reduce unmet Need for Contraceptives	83	50	73	88.9	83.3
Services	**60.3**	**30.3**	**49.8**	**59.6**	**60.9**
Involvement of Private Sector Agencies and Groups	64.3	38.2	39.7	65.9	55.6
Involvement of Civil Bureaucracy	67.8	34.7	50.8	79.4	64.3
Community-based distribution	55	23.8	41.9	58.7	84.9
Postpartum Programs	70.8	33.3	56.3	68.3	38.9
Home visiting Workers	48.4	20.1	73	39.7	53.2
Administrative Structure	64.9	32.6	57.3	69	73.8
Training Programme	73.7	60.7	56.3	72.2	61.9
Personnel Undertaking Assigned Tasks	74.3	43.8	54.7	67.5	48.4
Logistics and Transportation	74.3	42.1	59.6	77.8	81
Supervision on System	68.4	38.5	68.5	56.3	40.5
Mass Media for distribution of information, education and counselling (IEC) materials on reproductive health.	42.1	13.2	24.8	44.4	58.7
Incentives and Disincentives	23.5	4.8	12	13.5	50
Evaluation	**73.3**	**53**	**53.7**	**77.5**	**66.7**
Record Keeping Systems	76	72.6	65	77	71.4
Programme Evaluation	72.5	53.2	51.6	76.2	69
Management's Use of Evaluation Findings	71.3	33.3	44.4	79.4	59.5

[527] FP2020 (2014) Family Planning Effort Index

Family Planning indexes	Malaysia	Turkey	Egypt	Morocco	Bangladesh
2014 Family Planning Effort Index (FPE)					
Special populations					
Unmarried Youth	42	23.6	26.2	28.6	12.7
The Poor	82.5	42.2	69	86.5	65.9
Rural Populations	79.6	35.6	71.4	84.1	84.9
Counseling and contraceptive services for post-partum women	83.6	41.7	48.4	76.2	41.3
Counseling and contraceptive services for post-abortion women	60.4	32.5	40.5	66.7	45.2
Accessibility	**66.2**	**43.8**	**47.2**	**53.7**	**66.7**
IUD	66.7	41.5	78.6	74.6	62.7
Contraceptive Pills	86.5	48.9	88.1	92.9	91.3
Injectables	71.9	27.8	83.3	46.8	80.2
Female Sterilisation	62.1	36.1	7.1	54.8	65.8
Male Sterilization	49.4	25	0	1.6	59.5
Condoms	86	60.4	80.2	88.9	88.1
Implants	63.2	13.2	46.2	14.3	61.1
Emergency Contraception	57.4	35.4	23.1	42.1	42.1
Safe Abortion	36.6	37.5	2.4	16.7	55.6
Steterilisation Permanence	77.8	87.5	25.3	80.2	73
IUD Removal	72.6	76.4	77	80.2	62.7
Implant removal	64.8	36.3	55.6	52.1	57.9
Quality of Services	**77.8**	**42.4**	**57.9**	**65.1**	**59.5**

Table 21 Country comparison using the National Composite Index on Family Planning[528]

Family Planning indexes	Malaysia	Turkey	Egypt	Morocco	Bangladesh
2017 National Composite Index on Family Planning (NCIFP)					
Total score	**58.4**	--	**61.6**	**59.5**	**63**
Strategy	**67.7**	--	**67.6**	**65.9**	**78**
Defined FP Objectives over a 5-10 year period, including quantitative targets	63.6	--	100	78.9	94.4
Reaching Vulnerable Populations with quality FP info and services	81.8	--	81.8	85.7	94.4
Resource Needs projected (material, human and financial) to implement the Strategy and a plan to secure the resources	81.8	--	72.7	72.7	88.9
Participation of Diverse stakeholders	60	--	27.3	65	66.7
High Level FP Support from director of the national FP program and whether they report to a high level of government	72.8	--	73.1	30.8	71.9
Regulations Facilitate contraceptive supplies	46.3	--	50.9	62.3	51.9
Data	**67.1**	--	**63.2**	**60.1**	**53.6**
Private Sector Commodities	37.5	--	75	45	55.6
Service Statistics Quality Control	90	--	100	72.7	70.6
Data to Ensure FP services access to Vulnerable Populations	66.7	--	54.5	89.5	64.7
Adequateness of Clinical Record Keeping	77.8	--	66.7	59.1	52
Data Used for Monitoring (program statistics, national surveys, and small studies)	69.1	--	63	53.1	41.4
Data Used by program managers for Program Improvement	68.1	--	44.4	53.1	39.8
Quality	**53.7**	--	**62.9**	**60**	**62.6**
FP Standard Operating Procedures (SoPs) aligned with WHO	70	--	100	78.9	100
Tasksharing of FP services Guidelines	62.5	--	58.3	60	61.1
Indicators of Quality of Care (QOC) collated by Public Sector FP services	50	--	91.7	88.9	94.4
QOC Indicators: Private Sector	16.7	--	25	29.4	43.8
Structures to address QOC (incl. participatory monitoring or community/facility quality improvement activities)	33.3	--	27.3	80	72.2
Information on informed choice and provider bias collected by government	14.3	--	58.3	63.2	50
Training for FP Personnel to effectively undertake tasks	57.8	--	63.9	49.1	55.6
Optimal FP Logistics and Supply System to keep stocks of contraceptive supplies and related equipment available at all service points, at all times and at all levels (central, provincial, local)	57.8	--	68.5	58.3	67.3
Supervision System at all levels is adequate (regular monitoring visits with corrective or supportive action)	65.6	--	72.2	42.1	40.7
Routine Counseling on Sterilisation Permanence	73	--	42.2	59.3	67.9
Access to IUD removal	82.7	--	83.3	63.9	56.1

[528] FP2020 (2017) National Composite Index on Family Planning (NCIFP)

Family Planning indexes	Malaysia	Turkey	Egypt	Morocco	Bangladesh
2017 National Composite Index on Family Planning (NCIFP)					
Accountability	**49.7**	--	**62.9**	**57.8**	**65**
Monitoring for Voluntarism: mechanisms at national, subnational, and facility level to monitor access to voluntary, non-discriminatory FP info and services	55.6	--	75	77.8	94.4
Monitoring for Denial of services: mechanisms to report denial of services on non-medical grounds (age, marital status, ability to pay), or coercion (including inappropriate use of incentives to clients or providers)	33.3	--	72.7	40	47.1
Violations reviewed on a regular basis	33.3	--	41.7	40	41.2
Mechanisms for Client Feedback	62.5	--	50	55	63.2
Dialogue among FP Clients, Providers and Officials s about service availability, accessibility, acceptability and quality	63.6	--	75	76.2	78.9
Equity	**55.2**	--	**47.7**	**51.6**	**56.8**
Policies to Prevent Discrimination towards special sub-groups	31	--	25.2	45.6	49.2
(Lack of) Provider Discrimination	68.9	--	63.8	63.1	60.8
Community-based distribution (CBD) of contraceptives for Hard to Reach Areas (particularly rural areas)	58.9	--	30.6	42.9	50.3
Access to long-acting and permanent methods (LAPMs)	37.5	--	41	32.4	47.1
Access to short-term methods of contraception (STMs)	79.8	--	77.8	73.8	76.8

Appendix 6 Resources for Family Planning policy and programmes

The 2012 London Summit on Family Planning let to the development of the Family Planning 2020 (FP2020) global movement supporting the SRH rights of individuals in partnerships governments, civil society, multilateral organisations, donors, the private sector and researchers support FP worldwide. The FP2020 website provides resources to support countries in strengthening their FP policies and programmes. Some particularly relevant resources are listed below.

- The *Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans* [529] provides systematic and practical guidance for articulating the FP goal, results, strategic priorities, and implementation plan at the national, reginal or state level. The process, informed by Technical Support Teams in 30 countries that developed CIPs, is highly participatory, involving a range of stakeholders and technical experts. The time to develop a technical strategy can range from 6 to 12 months, depending on the country context (size and diversity) and scope of the CIP (national or subnational). The *Team Roles and Responsibilities for CIP Development and Execution* document describes the composition, roles, and responsibilities of different teams and individuals.
- The *Family Planning (FP) Costed Implementation Plan (CIP) Resource Kit*[530] is a critical tool that helps transform FP goals into concrete programmes and policies. The FP CIP process was designed under the FP 2020 initiative to help countries prioritise appropriate interventions, allocate limited resources, unify stakeholders around one plan, and build the base for increased support.[531]
- To strengthen a rights-based approach to FP policy and programmes, refer to the *Proposed Indicators to Measure Adherence to and Effects of Rights-Based Family Planning*, [532]which can assist in collecting data during the situational analysis to demonstrate areas of strength and weakness in a country's FP programme
- High Impact Practices (HIPs) [533] for FP in a range of topics are endorsed by over 30 organisations are HIPs reflect consensus of what works in FP regarding impact on contraceptive use and potential application in a wide range of settings and other outcome measures including unintended pregnancy, fertility, delay of marriage, birth spacing, or breast feeding. Evidence of replicability, scalability, sustainability, and cost effectiveness are also considered. The HIP briefs can be used for advocacy, strategic planning, programme design, exploration of research gaps, to inform policies and guidelines, and to support implementation.
- The *Policy: Building the foundation for systems, services, and supplies* brief describes policy levels, the importance of policies for FP in directing FP programmes, and provides tips on supporting and implementing effective policy change.[534]
- FP2020's Track 20 site [535] provides a range of useful tools for strategic planning and evidence-based decision making as well as for production of annual FP indicators. For instance, the FP Goals tool to improve strategic planning for FP programmes combines demographic data, FP

[529] UNFPA, FP2020, USAID (2018) Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans
[530] FP2020 Costed Implementation Plan Resource Kit: Tools And Guidance To Develop And Execute Multi-year Family Planning Plans
[531] USAID and partners (2020) Policy Brief: Costed Implementation Plan for 2020-2022 National Family Planning Program in Bangladesh
[532] Wright K. and Hardee K. (2015) Proposed Indicators to Measure Adherence to and Effects of Rights-Based Family Planning Resource Guide
[533] USAID (2019) High Impact Practices in Family Planning (HIP).
[534] High Impact Practices in Family Planning (2013) Policy: Building the foundation for systems, services, and supplies
[535] FP2020 (2020) Track 20 Tools

programme information, and evidence of the effectiveness of diverse interventions to help decision-makers set realistic goals and prioritise investments across different FP interventions.

- The *Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming* [536] is a tool for identifying strengths and weaknesses in national FP programmes via programmatic gaps requiring intervention or in-depth assessment. Target audience is high or mid-level FP programme managers in ministries of health, donor agencies, or technical organisations. It proposed several logical steps: 1. methodological desk review; 2. key informant interviews for in-country assessment (to identify outstanding information gaps and triangulate the desk review findings); 3. analysis and write-up of the final report; and 4. discussion of findings with key stakeholders/partners. It considers a holistic view of FP programming grounded in EngenderHealth's SEED Programming Model™ highlighting key components of FP/SRH programmes:
    - **Supply** 1) Health system structure and range of service delivery modalities offering FP 2) Equipment and staffing of health facilities 3) Provider training and skills 4) Management, supervision, and quality assurance and improvement systems 5) Mix of available FP methods 6) Integration of services 7) Referral systems 8) Private-sector involvement with graph showing trends in the source (e.g., private, public) of contraception 9) Youth-friendly services 10) Client-provider interaction/counseling on FP.
    - **Enabling Environment** 11) Leadership and management 12) Supportive laws, policies, and guidelines 13) Human and financial resources for FP 14) Evidence-based decision making 15) Contraceptive security 16) Advocacy efforts 17) Champions for FP 18) Community engagement 19) Efforts to foster positive social norms and transform gender roles.
    - **Demand** 20) Strategies to reduce FP costs to increase demand 21) The FP programme's social and behaviour change communication (SBCC) strategy 22) Commercial and social marketing 23) Mass media with table showing exposure to FP methods via various modes of communication 24) Engaging communities and champions in SBCC 25) Peer education.
- The *Family Planning-Sustainable Development Goals (FP-SDGs) Model*, developed by the Health Policy Plus project, allows users to simulate the effects of FP on a variety of health and non-health SDG indicators. It is an evidence-based advocacy tool that projects medium and long-term effects of three different FP scenarios, capturing the significant impact that contraceptive use has on SDG achievement. Any country can use it to design multiple scenarios to display how investments in FP, education, and the economy can accelerate progress toward the SDGs. By showcasing the benefits of contraceptive use related to health, society, and the economy, the model provides evidence that supports investments in FP at national and subnational levels. Results from country-level applications of the model enable users to make the case for FP financial investments and policy and programmatic improvements and mainstream FP across development sectors.[537]
- The *Policy Implementation Assessment Tool*[538], can be used for assessing policy implementation, and includes two interview guides to cpature the perspectives of policymakers and programme implementers, including community-level health workers, local leaders, and clients. This

[536] EngenderHealth (2011) The Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming. New York.
[537] Health Policy Plus (2020) Family Planning-Sustainable Development Goals (FP-SDGs) Model
[538] USAID (2010) Taking the Pulse of Policy: The Policy Implementation Assessment Tool

document provides guidance to help readers adapt the tool to different policies and contexts in their own countries.

- The *Reality Check Tool* [539] generates data for evidence-based FP advocacy and strategic planning by examining the relation between contraceptive prevalence rate (CPR) and population to estimate the resources required to achieve a future goal and the potential impact of achieving that goal. Reality Check can: quickly test future CPR goal scenarios, including changes in the method mix; compare future scenarios with past performance to determine whether goals are realistic; plan for service expansion to meet goals by estimating resource requirements and estimate the health impact of achieving CPR goals.
- An Excel-based tool has been developed for countries to model the Impact of COVID19 on Reproductive Health Options (MICRO) and quantifying potential shifts in contraceptive needs that could result from different service disruptions and mitigation strategies. [540]
- The Best Practices in Monitoring and Evaluation: Lessons from the USAID Turkey Population Programme contains best practices drawn from the USAID Turkey monitoring and evaluation (M&E) plan[541]. Best practices from this report include: linking M&E to strategic plans and workplans; focusing on efficiency and cost-effectiveness; employing a participatory approach to monitoring progress, utilizing both international and local expertise, disseminative results widely; using data from multiple sources; and facilitating data use for programme improvement. The conclusions emerging from the USAID Turkey M&E experience are that: 1) M&E is a programme asset, not a burden; 2) Local ownership is fundamental to increased utilisation and sustainability; and 3) leadership continuation and commitment is necessary.
- FP2020 High Impact Practices Analysis for Egypt March 2019 is a review supporting discussion on prioritised actions and interventions for the next 18 months using a solution-focused approach. Key country documents reviewed, where available, include the FP2020 Commitment, the Costed Implementation Plan (CIP), and the 2018-2019 Actions for Acceleration. This analysis provides a useful summary of key strategic documents per the three themes of the Focal Point Workshop and the related HIPs: 1) FP Financing (HIPs on Domestic Public Financing and Supply Chain Management); 2) Reaching Youth and Adolescents (HIPs on Adolescents: Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide, Adolescent-Friendly Contraceptive Services, and Engaging Men and Boys in FP: A Strategic Planning Guide); and Faith-based community and faith leaders (no HIPs yet). Included also are Postpartum FP (HIPs on Immediate Postpartum FP, Integration of FP into Immunization Programmes, and Postabortion FP).

[539] EngenderHealth (2020) The Reality Check Tool.
[540] Source: Weinberger, M. Hayes, B. White, J. & Skibiak, J. (2020) Doing Things Differently: What It Would Take to Ensure Continued Access to Contraception During COVID-19 Global Health: Science and Practice
[541] USAID Turkey (2001) Best Practices in Monitoring and Evaluation: Lessons from the USAID Turkey Population Program