Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Burmese Refugees and the Status of Family Planning Services in UNHCR's Operation in Kuala Lumpur, Malaysia

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This report is one of a series of five reports documenting baseline findings and recommendations to improve family planning programming for refugees in Djibouti, Jordan, Kenya, Malaysia and Uganda. The reports have similar objectives, literature reviews, methodology and limitations sections. The studies can be found at http://www.womensrefugeecommission.org/reports.

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ACRONYMS AND ABBREVIATIONS

ACR	Alliance of Chin Refugees
CDC	Centers for Disease Control and Prevention
CDU	Community development unit
CHW	Community health worker
CRC	Chin Refugee Committee
CPR	Contraceptive prevalence rate
EC	Emergency contraception
FGD	Focus group discussions
FRHAM	Federation of Reproductive Health Associations of Malaysia
FP	Family planning
IAD	Individual Assistance Department
IUD	Intrauterine device
JTF	Japan Trust Fund
MCH	Maternal and child health
MOH	Ministry of Health
NPFDB	National Population and Family Development Board
OCP	Oral contraceptive pills
RELA	Ikatan Relawan Rakyat Malaysia
RSM	Rohingya Society of Malaysia
SGBV	Sexual and gender-based violence
S&WP FPA	Selangor & Wilayah Persekutuan Family Planning Association
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation
WRA	Women of reproductive age

EXECUTIVE SUMMARY

This report summarises a family planning (FP) study undertaken in June-July 2011 by the United Nations High Commissioner for Refugees (UNHCR), the Women's Refugee Commission (WRC) and the Centers for Disease Control and Prevention (CDC) to document knowledge, beliefs, perceptions and practices of Burmese refugees living in Kuala Lumpur, Malaysia, as well as the quality of services provided in order to improve programming and subsequently increase uptake of FP services among the refugee population.

UNHCR's Kuala Lumpur site was chosen to participate in this study after taking into consideration its previous exposure to FP interventions, its existing FP programmes for refugees, the supposed cultural barriers among the Burmese refugees and a lack of FP-related survey data.

The baseline study utilised a multi-pronged approach that included a literature review of FP-related information, data and available services among the refugee population living in Kuala Lumpur; in-depth interviews with community leaders to learn about the challenges and barriers to increasing contraceptive uptake among the refugee community; a household survey using the adapted CDC reproductive health assessment toolkit to gather FP-related knowledge, attitudes and behaviour among women of reproductive age; focus group discussions (FGDs) with women, men and adolescent boys and girls to gather qualitative data on attitudes and barriers; and facility assessments to examine FP service availability, quality of services and provider opinions.

KEY FINDINGS

The baseline assessment revealed a strong desire by the refugee community to both space and limit births, particularly in light of the difficult living conditions in Malaysia. Despite this, the study revealed a dearth of accurate FP information, including information on how and where to access services, the range of methods available and proper use. The household survey revealed a contraceptive prevalence rate (CPR) of 34.2% for modern methods and 42.2% for any method. The study also revealed a reliance on an informal network of community leaders, community health care workers and peers for FP and reproductive health information. To date there has been inadequate training and supervision of this network to ensure that the FP messages delivered are accurate and consistent. Existing government and NGO FP facilities are good, but are inadequate to service the entire refugee population in need, in particular those communities whose location outside of central Kuala Lumpur make access to these facilities extremely difficult.

KEY RECOMMENDATIONS

The following recommendations are based on the quantitative and qualitative findings of this study.

IMMEDIATE RECOMMENDATIONS

1. **UNHCR should collaborate with the Ministry of Health (MOH) and the Federation of Reproductive Health Associations (FRHAM) to conduct a series of trainings on sexual and reproductive health with a focus on FP for community health workers (CHWs), community health coordinators of the various ethnic community organisations and adult and adolescent peer educators.** FGDs and key informant interviews revealed CHWs, community leaders and peers were the most popular source for FP information; however, interviews with key informants suggest that the current FP knowledge of this network is not sufficient. UNHCR has held several FP trainings for health workers and community leaders, but the feedback was that

they were too brief. Similarly, feedback from a recent sexual and reproductive health training for adolescent peer-educators conducted by FRHAM and UNHCR indicated that the participants felt that the five-day training was not sufficient to thoroughly cover the broad range of topics.

2. **UNHCR, MOH and FRHAM should collaborate to develop a monitoring and evaluation plan for CHWs, peer educators and community leaders who undergo FP training.** UNHCR has indicated that the absence of staff and funding makes supervision of their network of CHWs difficult. Sharing this supervisory role with FRHAM and MOH may help ease the burden on UNHCR staff. Periodic refresher courses, tests on knowledge and skills and individual meetings with feedback from clinic providers may help increase the motivation of the existing network of CHWs.

3. **UNHCR and its implementing partners should integrate education on emergency contraception (EC) into all FP and sexual and gender-based violence (SGBV) training and counselling.** Only 4.3% of women surveyed had heard of EC. None of the focus group participants and only one of the refugee community leaders was familiar with EC, and none of the health facilities assessed were currently providing EC.

4. **UNHCR should develop a contraceptive choices chart and brochure in the Burmese language that includes information on where each method is available.** FGDs and interviews revealed a lack of knowledge on which FP choices were available where. UNHCR is currently using a brochure that lists clinics with their hours, locations and available services in English. Adapting the brochure specifically for FP facilities that lists the methods clinics offer, clinic hours and locations, as well as a brief description of each method, in Burmese may help to alleviate confusion over where to access services.

5. **UNHCR should work with partner nongovernmental organisation (NGO) and MOH clinics to increase coordination between clinics, and in particular to develop an effective referral scheme.** Improved partnerships between the NGO clinics and the development of formal mechanisms for following up on referrals made to partner organisations may help to improve the seemingly *ad hoc* nature of referrals between clinics.

6. **In the absence of funding for new clinics or more mobile clinics for refugees in less accessible neighbourhoods, UNHCR and its implementing partners should seek innovative solutions for decreasing barriers for this population.** One suggestion would be to tap into the network of existing private and National Population and Development Board (NPDB) clinics in these neighbourhoods, in particular the Ampang and Selayang neighbourhoods, and persuading them to offer free or discounted services to refugees, to be reimbursed by UNHCR or another funder for every refugee they served, in a scheme similar to the FRHAM/Japan Trust Fund (JTF)/ International Planned Parenthood Federation (IPPF) project.[1]

LONG-TERM RECOMMENDATIONS

7. **UNHCR should continue lobbying for increased funding so that it can improve its capacity to register refugees in a timely manner.** Registration increases access to services exponentially. It affords refugees the confidence to leave their homes and seek services, as well as a reduction in cost for services. Wait times for registration remain unacceptably long.

[1] IPPF ESEAOR Annual Report 2009. Retrieved from http://www.ippfeseaor.org/en/Resources/Publications/Annual+Report+2009.htm.

8. **UNHCR and its implementing partners should continue to lobby donors and the Malaysian government for increased funding to ensure that they can continue providing free and low-cost FP services, including through its network of CHWs and translators, to the refugee population.** Funding from UNHCR and other donors allows clinics to provide free or low-cost FP services that refugees may not be able to afford otherwise. In addition, UNHCR translators and CHWs provide an invaluable service to refugees in select health facilities as language and culture represents a significant barrier for the Burmese refugee community.

9. **UNHCR should work with its implementing partners and the Malaysian government to encourage the government to revise its policy on sexual and reproductive health counselling and services for adolescents and unmarried persons**. Currently, the National Program does not provide FP services to unmarried clients, and adolescent fertility has become a major concern as lack of reproductive health knowledge and access to FP information and services is believed to be a major factor behind an increase in adolescent pregnancy and abandoned babies.[2]

INTRODUCTION

Malaysia hosts a large number of refugees and asylum-seekers, the vast majority of whom are from Myanmar (Burma). Refugees from Myanmar flee systematic discrimination, forced labour and violence that result from the decades-long conflict between the repressive ruling military regime, political opposition and various ethnic minorities.

As of July 2011, 94,775 persons of concern were registered with UNHCR in Malaysia, made up of 83,919 registered refugees and 10,856 asylum-seekers. Eighty-four percent of registered refugees and 8% of asylum-seekers were from Myanmar, including 34,000 ethnic Chin, 20,368 ethnic Rohingya and 9,300 ethnic Myanmar Muslim.[3] Seventy percent of these refugees and asylum-seekers are men and 30% are female. Among the Burmese refugees there are 15,245 households with females between the ages of 18 and 59. There are approximately 17,400 registered refugees below the age of 18, including 1,797 girls between the ages of 12 and 17.[4] A large number of persons of concern also remain unregistered with UNHCR. The refugee communities estimate this number to be around 10,000.[5]

Malaysia is not party to the 1951 *Convention Relating to the Status of Refugees*, so there is no distinction under Malaysian law between refugees and other undocumented persons, including illegal migrant workers. This leaves refugees vulnerable to detention, corporal punishment and deportation. Malaysia has no formal mechanism for granting asylum or registering refugee populations, so UNHCR is responsible for all refugee status determinations and issuing cards to recognized refugees. Refugees' and asylum-seekers' freedom of movement depends on the acceptance of their documents by Malaysian authorities. Those with UNHCR refugee cards enjoy some freedom of movement and residence—although they are usually safe from arrest by the police, they can still be detained by Ikatan Relawan Rakyat Malaysia (RELA), a paramilitary civilian corps formed by the Malaysia government, and immigration officials.[6] Police still arrest asylum-seekers occasionally, as they do not always recognize the "under consideration" letters UNHCR issues to asylum-seekers.

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[2] Ahmad, N et al. (2010). *Status of Family Planning in Malaysia*. United Nations Population Fund. Unpublished report. Retrieved from http://www.icomp.org.my/new/uploads/fpconsultation/Malaysia.pdf.
[3] United Nations High Commissioner for Refugees-Malaysia. *Overall Monthly Statistical Report for July 2011*. Unpublished raw data.
[4] Ibid.
[5] United National High Commissioner for Refugees-Malaysia (March 2011), *Refugees in Malaysia Factsheet*.
[6] Kaur, A. (2007). *Refugees and Refugee Policy in Malaysia*. UNEAC Asia Papers, No 18.

The various refugee communities are scattered throughout Malaysia, but the vast majority live in and around Kuala Lumpur. There are no refugee camps in Malaysia; instead, refugees share low-cost housing often in groups of up to 40 people or more.[7] They have no access to legal employment and so they tend to work in jobs that are dirty, dangerous and difficult. Their illegal status also makes them vulnerable to exploitation and abuse by employers who often pay low wages or withhold wages altogether. Refugee children do not have access to formal education. In the 2009 "Refugee Rights Report Card" issued by the U.S. Committee for Refugees and Immigrants, Malaysia received the lowest possible score.[8]

With no change to the political situation in Myanmar in the foreseeable future and significant wait times for resettlement to a third country, it is crucial to address the dire conditions facing Burmese refugees who currently call Malaysia home.

Access to FP services is a human right[9] and access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. Effective FP also provides women and girls the autonomy to determine the number and spacing of their children, access to educational and livelihoods opportunities and possibilities for families to manage scarce resources more effectively.

UNHCR has focused on emergency obstetric care, SGBV and HIV/AIDS in the past several years, while FP activities have not been given sufficient attention. In 2010, UNHCR programmes in several countries reported an increase in uptake in contraceptive methods that could be linked with changes in service provision. With this in mind, UNHCR intended to document knowledge, beliefs, perceptions and practices of refugees, as well as the quality of services provided in order to improve programming and subsequently increase uptake of FP services among the refugee population. The study is one of several conducted for a global overview of baseline findings.

UNHCR's Kuala Lumpur site was chosen to participate in this study after taking into consideration its previous exposure to FP interventions, its existing FP programmes for refugees, the supposed cultural barriers among the Burmese refugees and a lack of FP-related survey data.

[7] United National High Commissioner for Refugees-Malaysia (March 2011). *Refugees in Malaysia Factsheet*.
[8] U.S. Committee for Refugees and Immigrants. *World Refugee Survey 2009: Malaysia*. Retrieved from http://www.refugees.org/resources/refugee-warehousing/archived-world-refugee-surveys/2009-world-refugee-survey.html .
[9] Under international law, universal access to family planning is a human right. According to Article 16(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all individuals and couples have the "right to decide on the number, spacing and timing of children". The Programme of Action from the 1994 International Conference on Population and Development also notes the right of couples and individuals "to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so" (Article 7.3). Moreover, General Comment No. 14, para. 12 of the Committee on Economic, Social and Cultural Rights states that the right to the highest attainable standard of health includes the "right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning".

OBJECTIVES

Goal
To document knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision in the select UNHCR operation to improve programming and subsequently increase uptake of FP services among women, men and adolescents.

Objectives
- To increase baseline information to guide policy and planning.
- To improve quality of services through training and guiding health and community providers, and improving infrastructure as required.
- To adapt programmes according to barriers, beliefs, fears and perceptions, in terms of information, education and communication efforts, and service delivery.
- To expand access through a broader choice of contraceptive methods, community-based distribution and linkages with national programmes or other in-country initiatives as appropriate.

Study Question
This study aimed to answer the primary question: What are the barriers and challenges at the community and health facility levels that hinder increased uptake of contraceptives among the select refugee communities, and what are the practical ways that the challenges can be addressed?

LITERATURE REVIEW

Under Malaysia's National [FP] Program, FP services and information are available through a network of clinics under the MOH, the National Population and Family Development Board (NPFDB) and the FRHAM. A network of private hospitals and clinics also provides FP services.

Notably, the National Program does not provide FP services to unmarried clients and adolescent fertility has become a major concern as lack of reproductive health knowledge and access to FP information and services is believed to be a major factor behind an increase in teen pregnancy and abandoned babies.[10]

The MOH has recently introduced guidelines based on the World Health Organisation's (WHO) *Medical Eligibility Criteria for Contraceptive Use and Selected Practice Recommendations for Contraceptive Use* and training workshops were conducted at all levels of care to train all government health care providers on the use of the guidelines.[11] Under the MOH, FP services are already integrated with other services, such as maternal and child health (MCH) care services and outpatient care, including HIV and sexually transmitted infections (STIs).[12]

The CPR for the Malaysian host population has remained around 50% for the past three decades. Modern methods have increased slightly from 30.2% in 1994 to 34.4% in 2004, with the pill being the most popular method. There has also been a decrease in the use of non-modern methods from 24.6% in

[10] Ahmad, N et al. (2010). *Status of Family Planning in Malaysia*. United Nations Population Fund. Unpublished report. Retrieved from http://www.icomp.org.my/new/uploads/fpconsultation/Malaysia.pdf.
[11] Ibid.
[12] Ibid.

1994 to 17.5% in 2004.[13] The unmet need for modern contraception for the purpose of limiting births had increased from 25% in 1988 to 36% in 2004.[14]

FP services are available to refugees under the National Program. Through partnerships with UNHCR, several FRHAM and MOH clinics offer Burmese translators and reduced costs for registered refugees. Registered refugees are also able to access the network of private hospitals and clinics and NPFDB clinics, but in reality, cost and language barriers often prohibit this option. Unregistered refugees and asylum-seekers, however, have a much more difficult time accessing these services. They are not able to receive the discounts offered to registered refugees and are often denied services altogether without an official form of identification.

In 2009, FRHAM began a two-year project to "improve the sexual and reproductive health and rights of refugee communities via increased utilization of sexual and reproductive health services including family planning and provision of information on HIV and STI prevention".[15] In collaboration with the refugee community, orientation programmes, capacity-building sessions and sensitisation workshops were provided to outreach and health care workers, as well as to the service providers from the Selangor & Wilayah Persekutuan Family Planning Association (S&WP FPA) to increase their sensitivity, commitment, knowledge and skills on sexual and reproductive health, HIV and AIDS. Since June 2009, to fulfil the unmet needs of the community, three clinics operated under S&WP FPA have provided such services to refugees. Information, education and communication (IEC) materials translated into Burmese were also distributed to the refugee communities.[16]

The endline assessment of this project found that there was a general improvement in the knowledge and exposure to reproductive health, contraception, HIV/AIDS and STI information in the refugee community from the 2009 baseline assessment, based on a pre- and post-test questionnaire and FGDs conducted in spring and summer 2010. It also found that service providers were well equipped with knowledge with regard to sexual and reproductive health, HIV/AIDS and STIs. Lastly, the assessment found that education through outreach activities is important to educate the community on FP and HIV/AIDS, including the availability of such services.[17] One of the greatest challenges identified during the project was the issue of security of both the outreach and health care workers. Despite the support of MOH and the Ministry of Women and Family and Community Development, the police and RELA continue to harass and arrest outreach and health care workers.[18] Although this project, funded by the IPPF and JFT, ended in 2011, UNHCR is in negotiations to continue funding FP services to refugees via the S&WP FPA clinics.

Refugees are also able access FP services at several NGO clinics, including the Tzu Chi Buddhist clinic and the ACTS clinic, which offer services free of charge. None of the health facilities currently use community-based distribution approaches to reach refugee populations for which access is a barrier. Malaysian law prohibits lay people from distributing hormonal methods—only doctors can prescribe and distribute them. In some situations, nurses are allowed to provide them to ensure continued supply, but a doctor must first write a prescription. [19]

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[13] Ibid.
[14] Ibid.
[15] IPPF ESEAOR Annual Report 2009. Retrieved from http://www.ippfeseaor.org/en/Resources/Publications/Annual+Report+2009.htm.
[16] Ibid.
[17] IPPF/Japan Trust Fund Funded Project on Increasing Sexual and Reproductive Health Services and Rights to the Refugee Communities in the Klang Valley 2009-2011-End Line Assessment. Unpublished Report.
[18] IPPF ESEAOR Annual Report 2009. Retrieved from http://www.ippfeseaor.org/en/Resources/Publications/Annual+Report+2009.htm.
[19] Dr. Susheela Balasundaram, UNHCR, personal correspondence, September 6, 2011.

METHODOLOGY

Household Survey Methodology
The household survey tool, an adapted version of the CDC's *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, was designed to gather FP-related knowledge, attitudes and behaviour among women of reproductive age (15-49 years).

Survey participants were randomly selected from a list of households generated using UNHCR's ProGres database of registered refugees. Households were filtered to include only Burmese refugees living in Kuala Lumpur and surrounding Selangor state with at least one woman of reproductive age (WRA) living in the household. Because refugees living in Kuala Lumpur are very mobile and UNHCR had very few accurate addresses on file, it was necessary to call every selected household to verify their current address. The locator process, whereby one WRA from each household is randomly selected for participation in the study was also done over the phone. In order to reach as many participants as possible, the households on the list were called at a variety of times, including in the evenings and on weekends. For the purpose of this study, a household was defined as members of the same extended family living together, since in Kuala Lumpur many refugees live in multi-family apartments or rooms.

The study team included six female Burmese CHW employed by UNHCR. They worked on the study full time from June 13 through July 20, putting their usual CHW job responsibilities on hold. There was also one male study team member who acted as an interpreter during the training and assisted in communication throughout the study, as the English skills of the study team were very limited. The team received a four-day training on the study methodologies, interviewer techniques and the informed consent process. The training was also used to verify the Burmese translation of the survey tool, locator and consent forms. One day was dedicated to piloting the locator form and survey tool.

The team reached 480 households over the phone, which resulted in 422 completed household interviews, for a response rate of 88%. This number does not factor in wrong numbers, participants who could not speak Burmese or participants that the study team was not able to reach via phone after seven attempts. If these households are factored, then the response rate was 53%. Study participants were informed of the interview and consent processes prior to their interview. Study team members were asked to emphasise that the interview was not connected in any way to the participants' refugee status, resettlement or financial assistance. Participants' names, phone numbers and addresses which were necessary to record on the locator forms were kept locked for the duration of the study and shredded at the conclusion of the study.

Facility Assessment Methodology
UNHCR and the WRC, together with an FP expert consultant, adapted UNHCR's existing health facilities assessment tool. Two tools were developed; one for the staff in charge and another for other staff and consultation observations. The Individual Assistance Department (IAD) at UNHCR-Malaysia identified both the facilities and providers. The facilities were chosen to represent both government- and NGO-run clinics that service large numbers of refugees. The facility assessments and provider interviews were conducted in English. All of the participants were read the informed consent prior to their interview.

In-depth Interview Methodology
Refugee community leaders were identified with the help of UNHCR's Community Development Unit (CDU). Due to time constraints, it was not possible to interview all of the community leaders so data on certain ethnic groups was prioritised based on input from the Public Health/HIV focal point at the regional and country level. The Chin community was chosen as it represents the largest Burmese ethnic group living in Malaysia. Rohingya and Myanmar Muslim groups, the second and third largest ethnic groups respectively, were chosen because there is a particular interest in the FP knowledge, attitudes and beliefs of Muslim refugees living in Kuala Lumpur, and furthermore, focus groups on FP conducted by UNHCR-Malaysia in 2009 did not include Rohingya or Myanmar Muslim participants.[20] A community leader from the Mon Women's Refugee Organisation was also interviewed. Interviews were conducted in English with the Mon and Chin leaders and via a Burmese interpreter for the Rohingya and Myanmar Muslim interviews. All participants were read the informed consent prior to their interview.

Focus Group Discussion Methodology
Community leaders, identified by the IAD and the CDU, were asked to gather study participants from their community. Convenience sampling was used and study participants were chosen based on their ability to speak Burmese and their willingness to participate in a discussion on women's health. Four discussions were held for each ethnicity at community centres, with the exception of the Rohingya community, for which a woman's discussion was not feasible. Participants were grouped by age and gender (women, men, adolescent girls and adolescent boys, age 15-19). Community leaders were asked to identify six to eight participants per group. There were no identifiable risks to participation in the FGDs and there was no compensation for participation. Discussions lasted between 30 minutes to a little over an hour and took place at community centres in the refugee communities.

The Chin FGDs consisted of eight boys, eight girls, four men and five women. The Myanmar Muslim FGDs consisted of five boys and seven girls, six men, and six women. The Rohingya FGDs consisted of three boys, six girls and six men. Several women sat in on the Rohingya girls' discussion group, but left after they asked several questions about registration and financial assistance.

Discussions were conducted in Burmese by a male and female CHW who could speak both Burmese and English. All discussions were recorded and the audio files were transcribed by a volunteer, with the exception of Rohingya men's discussion, which was conducted in a local dialect and later transcribed by the researcher and moderator and the Rohingya girls' discussion (the recording was inaudible and so the discussion was analysed using only the moderator's notes).

The FGD discussion guide was developed by UNHCR and WRC. The questions were translated into Burmese and reviewed by the FGD moderators during the five-day training. The two moderators received an additional half-day of FGD training, which involved going over the questions in the discussion guide, reviewing any unfamiliar terms or concepts and role-playing with a focus on how FGDs differ from individual interviews.

Discussion participants were informed of the purpose of the study. They were guided to speak about their community in general and told that there were no right or wrong answers, and that the knowledge gained from these discussions would help improve access to health care for their community. They were also informed that the information they shared would be kept confidential so they could feel free to

[20] Baroang, C. (August 2009). *Missing Pieces: Family Planning, HIV/AIDS, and STI Knowledge among Refugees from Myanmar. Kuala Lumpur, Malaysia*: United Nations High Commissioner for Refugees. Unpublished report.

speak honestly. The moderator informed the FGD participants that they did not have to participate and could stop the interview at any time.

Ethical Considerations
The data collection team was trained on the ethical issues that relate to working with refugee populations. Informed consent was obtained from participants of all activities. All participants were also informed about the procedures and the voluntary nature of their participation; assured confidentiality; and informed that no adverse consequences would arise if they declined to participate. No identifying markers were listed on any of the collected data. The data were stored securely by the UNHCR country office and will be destroyed after five years if no further analysis is required.

PRESENTATION OF FINDINGS

Household Survey
Of the women surveyed, 68.4% were Christian, 19.4% were Muslim and 10.3% where Buddhist. The largest ethnic group represented was the Chin (43.8%), followed by Kachin (24.7%), Myanmar Muslim (12.8%), Rohingya (6%), among several other smaller ethnicities. Of the women surveyed, 79.2% were married and the vast majority of women had between one and three children.

Oral contraceptive pills (OPCs), male condoms and injectables are the three methods that survey participants were most familiar with. Among the women surveyed, 80.7% had heard of the pill, but of those women, only 38.8% had been instructed how to use it. Likewise, 82.4% of survey participants had heard of the condom but only 42.2% had been instructed how to use it, and 74.9% had heard of injectables but only 48.4% had been instructed how to use them, perhaps indicating a need for increased education and outreach efforts. There is very low awareness of both female condoms and EC, at 11.4% and 4.3%, respectively. There was also relatively low awareness of long-acting methods, such as intrauterine devices (IUDs) and implants. Of the women interviewed, 29.4% had heard of the IUD and 37.6% had heard of the implant.

Among current users of FP, 37% were using OCP, 19.6% the male condom, 17.4% injectables, 24.7% withdrawal, 9.1% rhythm/calendar method, 5.5% tubal ligation and 2.3% IUD.

The CPR for modern methods is 34.2%, and the CPR for any method is 42.2%. This is on par with the 2010 CPR for modern methods and any method in Myanmar, 33% and 37% respectively.[21]

FP-6: Family Planning Method Being Used Among Women Who Are Currently Using Any Family Planning Method, Kuala Lumpur, Malaysia 2011 {N =170}	
Method	**% (n) women***
Pill	37% (60)
IUD	2.3% (5)
Male condom	19.6% (38)
Female condom	0% (0)

[21] United Nations Population Fund. (2010). *State of World Population 2010: From Conflict and Crisis to Renewal: Generations of Change*. Barbara Crossette, New York, NY. .

Implants	0% (0)
Injectables	17.4% (34)
Emergency contraception	0% (0)
Tubal ligation	5.5 % (3)
Vasectomy	0% (0)
Lactational amenorrhea	0% (0)
Rhythm/calendar/counting days	9.1% (18)
Withdrawal	24.7% (45)
Periodic abstinence	0% (0)

There is a noticeable contrast between the CPR for Muslim women (36.4% for modern methods and 32.7% for all methods) and Christian women (62.5% for modern methods and 65.9% for all methods). Of Muslim women who are currently using any FP method, the majority of women were using OCPs (69.4%), 16.7% injectables and only 1.4% the male condom. The majority of Muslim women were familiar with OCPs (84.9%), male condom (65.9%), injectables (88.1%) and tubal ligation (58.7%). Consistent with the other religions sampled, very few Muslim women are familiar with EC (9.5%) or female condoms (2.4%). The majority of Muslim women were obtaining their FP methods at NGO health centres, with the exception of OCPs, which the majority of Muslim women were obtaining from pharmacies (63.6%).

Facility Assessments

The overall quality of the services available to the refugee community is good, based on the facility assessment indicators; however, they are not sufficient to meet the current demand for FP services, particularly for those refugee communities living in neighbourhoods far from the city centre, where the majority of facilities are located.

The S&WP FPA clinics, which are administered by FRHAM, have a very good method mix. They are able to offer services to refugees at a low cost. Contraceptive methods are free; however, there is a five Malaysian Ringgit (RM) ($1.66) registration fee. The services for refugees were previously funded through JTF, but that funding has ended and UNHCR will take over funding for services to refugees. The clinic is operating on a shoestring budget and a lack of funding is their biggest concern. In addition, FRHAM may have difficulty maintaining its supplies as IPPF, the main source of funding for contraceptives, is imposing a gradual decrease in contributed supplies of 30% each year starting in 2010.[22] The facility itself is very crowded and there is a complete lack of privacy and confidentiality. Consultations and FP counselling take place in the waiting room. A Burmese health care worker, provided by UNHCR, administers these consultations. The doctor, who is in on Tuesdays and Thursdays from 9-11:30 am, only sees complicated cases and IUDs. There has been no in-house FP training for the staff administering consultations despite the fact that they are often times the only person a client sees. Although stock-outs are infrequent, on the day that the facility assessment was conducted, the clinic had run out of injectables, and instead of referring clients to another facility, it was switching women to OCPs.

The refugee communities interviewed appeared to favour the Tzu-Chi clinic, an NGO-run clinic where all services are completely free. The staff were perceived as friendly and warm and the refugees seemed

[22] United Nations Population Fund. (2010) *Status of Family Planning in Malaysia*. Ahmad, N et al. Unpublished Report.

very satisfied with the services. Unfortunately, the clinic only provides three FP methods, injectables, OCPs and male condoms, and does not offer any long-lasting, reversible methods. Despite this fact, they have no formal referral system for the methods they do not provide. Depending on the provider, he or she will refer to other NGO clinics for temporary methods and to the hospital for permanent methods. Tzu-Chi clinic also does not provide contraceptives to unmarried clients. The clinic manager, doctor and nurse all said that staff was well-trained and sufficient; however, there have been no trainings on FP in the last year and they use, like the other clinics providing services to refugees, a network of Burmese health workers who had received health training in Myanmar and are now providing counselling despite their lack of sufficient training or refresher courses for their skills. There is also inconsistency across providers for crucial concerns, such as whether or not dual method use is promoted, whether or not to counsel adolescents on FP, and whether or not a client could refill her OCP prescription at Tzu-Chi or if she would only be provided her first month of pills and instructed to refill elsewhere.

The MOH MCH clinic in Hang Tuah estimates that 60% of its clients are registered refugees and of those 60%, 80% are Burmese. Currently, the refugee population is overwhelming the staff. Refugees are asked to go to the clinic that is closest to where they live, but the word has spread that the MCH clinic in Hang Tuah has Burmese translators (UNHCR health workers) and the service is good, so clients are coming from far away, burdening the staff and significantly increasing wait times for the local community. The staff also have complaints about the size and flow of the existing facility. The waiting room is too small and the building does not allow for privacy. The staff are very well trained and the clinic has a good method mix, but it is short-staffed and refugees must pay for services—with their UN card, registered refugees pay 7.5 RM ($2.50) which is inclusive of their consultation, any necessary tests and supplies and all prescriptions. Unregistered refugees pay the full "foreigner's rate," which is 15 RM ($5).

The MCH clinic's referral system is also very good—it refers clients to the parent clinic for IUDs and the hospital for complicated cases and permanent methods, both of which are within 5 Km of the MCH clinic. Staff also accompany clients that they refer, follow up on referrals and conduct home visits. Registered refugees receive a 50% discount at the government hospitals. The cost of seeing a specialist is 60 RM ($19.90); subsequent visits with the specialist are 5 RM ($1.66) for registered refugees and 60 RM for unregistered refugees.

Qualitative Findings

Number of Children and Spacing. The most common desired number of children across all groups was three to four children, although several participants mentioned the desire for five, six or seven children, with several women mentioning they would take as many as God gives. A desire to space between two and three years was most commonly mentioned. Most groups seem very aware of the benefits of spacing births, including the health of the mother, the economics of raising many children and the desire to delay having children in light of their living situation in Malaysia. "We have to consider time and condition—we would be in trouble if we took every time we got."[23] A notable exception was the Rohingya men's group, which did not believe there to be any benefit to spacing births.

Family Planning Decision-Making. The Mon and Myanmar Muslim leaders indicated that the men would have more say in FP decisions, whereas the Chin and Rohingya leaders said that couples would make FP decisions together. It is interesting to note that the Mon and Myanmar Muslim community leaders were both women and the Rohingya and Chin community leaders were men.

[23] Myanmar Muslim Women 20 July 2011, Selayang, Kuala Lumpur, Malaysia.

Most FGD participants said that they would decide together, with a few notable exceptions, for example, one Rohingya man who said, "Discussed or not, I will have two children."[24]

Knowledge of Family Planning. All of the adult participants in the FGDs had heard of FP. The most common methods noted were OCPs and injectables. None of the participants were familiar with EC. The other methods mentioned were the male condom, withdrawal and abortion. The Chin men's and women's groups mentioned the calendar method, but they were not sure how to use it.

The discussions revealed a large amount of misinformation around FP methods and side effects. In the Chin men's group, several participants mentioned having the woman take exercise after sex, bathing after sex and teasing and frightening the woman after sex as ways of avoiding pregnancy. Many of the participants, in particular the Rohingya men's group, were very concerned about the side effects of using contraception; in particular, it was thought that taking OCPs and injectables can cause birth defects in future children and infertility in woman after they stop taking it. Several groups also mentioned that taking contraceptives when women are young is worse. One woman from the Chin group mentioned that a girl should be over 20 before taking OCP because taking it at a young age can cause skin disease and tuberculosis. Several women mentioned that they had received OCPs from both a clinic and a pharmacy but had not been instructed how to use it.[25]

All of the participants had a superficial knowledge of the main FP methods used in the community—condoms, injectables and OCPs—but no in-depth knowledge on side effects or proper use. This is consistent with the community leaders' knowledge.

Practice of Family Planning. All of the community leaders said that the women in their communities were very interested in FP and open to it because of how difficult it is to support children. "Here, to have a baby is very different. Malaysian government doesn't provide school, health care, so they have to think about family planning and space more."[26]

Every group said that a lot of people were practicing FP in the community, with the exception of the Rohingya men's group, which did not think that many people were practicing FP. It should be noted that the Rohingya women's group, on the other hand, did think that a lot of people in the community were practicing FP.

Sources of Family Planning and Barriers to Access. Most participants mentioned that clinics, especially government and NGO clinics, were the best places to access services. A majority of participants also mentioned that CHWs and their respective community organisations were the best sources for FP information. Although many participants mentioned that NGO and government clinics were the best places, in reality many of them were purchasing contraceptives, especially OCPs, in pharmacies and illegally from Burmese shops in Kuala Lumpur.

There were many inconsistencies and confusion over where refugees could access services and what services were available where. All of the leaders mentioned a lack of services available or conveniently located in their communities, and most leaders mentioned that women would come to the community centres for advice, but having said this, they were not sure where to refer them for certain services. The community centres and leaders are able to refer women to the appropriate places and can also

[24] Rohingya men's FGD participant, RSM office, Ampang, 17 July 2011.
[25] Chin women's FGD, ACR office, Pudu, 30 July 2011.
[26] Interview with Rohingya Society of Malaysia leader, Ampang, 5 July 2011.

accompany them to the facilities and assist with language barriers, but they were concerned that refugees who live far from the community centres are probably not getting the guidance and support that they need.

Barriers to FP services and information include cost, particularly for those without a UNHCR card, not knowing where to go or who to call, difficulty in transportation, language barriers and the fact that people will gossip if they know a woman is seeking FP, even if she is married.

The Role of Religion in Family Planning Decision-Making. All of the groups mentioned that their religions, Islam in the case of the Rohingyas and the Myanmar Muslims and Christianity in the case of the Chin, prohibited the use of FP. The Rohingya community leader noted that Islam does not support the use of FP, but mentions that if pregnancy endangers the woman's life it is permissible for her to use OCPs and injectables. Also, one community leader thought that in reality, men may be using religion as an excuse for their own preferences; the leader believed that men were more tolerant of injectables and OCPs than condoms because they did not interfere with their sex lives. This view is also consistent with a finding from a 2009 report by UNHCR on the assistance needs of Rohingyas.[27] A common finding was that very few women were not taking contraceptives for purely religious reasons. "Yes, religious leaders says not to use, but we do whatever we wish. We'll use because it's necessary and not use if it's not needed. This is not the time that they can control seriously. If they controlled, people hid and did it. They cannot control."[28] The Rohingya's men's group, on the other hand, was adamantly opposed to FP, mentioning several times their belief that they would go to hell if they used it.

Community Suggestions for Improving Access to Services. Suggestions included a FP clinic in the Selayang and Ampang neighbourhoods where there are currently no low-cost services available. The participants mentioned that UNHCR, CHWs and religious leaders could help to educate and encourage people to access FP services. The Chin community leaders specifically mentioned using the Chin Christian fellowships to help spread FP messages because "everyone goes and if religious leaders are talking about family planning, then people will listen."[29]

Several community leaders mentioned the need for more trainings on FP material, including specific information on how each method works, correct usage and side effects. There have been several trainings to date, but they were relatively short and provided more of an overview of the topic than in-depth training. Community leaders want more detailed information so that they can help spread accurate messages. They also mentioned that it would be best for women to obtain FP information from other women since culturally it may not be acceptable to talk to men about FP, even to a male doctor.

Adolescents. All of the adolescent participants agreed that it is difficult for boys and girls to meet in their respective communities, but they also acknowledged that boys and girls are having sex. Without exception, all of the adult FGD participants disapproved of sexual relationships outside of marriage and agreed that if such a relationship was discovered, a marriage would be arranged.

Adolescent participants' FP knowledge comes from older community members, parents, friends and UNHCR CHWs. They have heard of OCPs, injectables and condoms. None had heard of EC and very few

[27] United Nations High Commissioner for Refugees-Malaysia. (August 2009). *Assistance Needs of the Rohingyas*. Kuala Lumpur, Malaysia. Unpublished report.
[28] Myanmar Muslim women's FGD, Selayang, 20 July2011.
[29] Interview with CRC community leader, Pudu, 6 July 2011.

had heard of female condoms. Their knowledge of these methods was also very superficial; they were unsure of side effects or proper use. Their perception was that even though it was not approved of by their respective religions and communities, adolescents were still using contraceptives.

The adolescents that participated did not know where to get accurate information on FP. They were familiar with several of the NGO clinics but did not know what services were offered. The main barrier mentioned was that they were too shy to seek out information and they did not know where to go. They expressed a clear interest in knowing more. One adolescent boy mentioned, "We will experience and so we need to know. One day, it will happen. Or we can't say that it won't come. We need to know."[30] Another noted, "We should learn them because we should have known them. It doesn't matter we use or don't use. When there is in the event, we can explain. Even if I don't use, I can tell friends."[31]

DISCUSSION

The FGDs, interviews with community leaders and previous FGDs from 2009 reveal both a desire to limit the number of children and to space births; largely, it would seem, as a result of the difficult living situation in Malaysia.

A common finding is a reliance on a network of CHWs and medical assistants, some of whom have had health training in Myanmar. They assume much of the responsibility for counselling, but they have had informal or no training at all since beginning work in the clinics. The refugee community also relies on CHWs, community leaders and peers for FP information. To date, there is very little supervision over this network and serious misinformation may spread if unchecked. More in-depth knowledge on FP is needed and trainings for CHWs; health workers and community leaders may be the first step in addressing this misinformation. Information on where to access services is also lacking; most participants and community leaders were not sure where they could access various FP methods, including long-lasting methods. Increased coordination between NGO and government clinics and an effective referral system would be helpful.

Access is also a significant problem. Many women are getting pills at pharmacies or illegally at Burmese shops in Kuala Lumpur, where they are not always instructed on how to use them correctly. This finding is consistent with FGDs in 2009, which revealed that the pharmacy was the most common place to get pills.[32] It is also consistent with a 2009 report on the Rohingya ethnic group, which revealed that the Rohingya will go to a private clinic despite higher costs, indicating that the money they spend on public transportation to the government and NGOs clinics is equivalent to seeking care in a private clinic.[33]

Many of the communities, in particular the Myanmar Muslim and Rohingya communities in Selayang and Ampang neighbourhoods, have difficulty accessing services. They are also afraid to travel to access services for fear of being detained if they are unregistered. Furthermore, if they are unregistered they cannot access discounted services. Language, transportation and cost are all significant barriers. Without funding for more clinics or increasing the number and frequency of mobile clinics, it may be

[30] Chin boys group, 30 July 2011, ACR office, Pudu, Kuala Lumpur Malaysia.
[31] Myanmar Muslim Boys Group,24 July 2011, Selayang, Kuala Lumpur, Malaysia.
[32] United Nations High Commissioner for Refugees. (August 2009). *Missing Pieces: Family Planning, HIV/AIDS, and STI Knowledge among Refugees from Myanmar*. Kuala Lumpur, Malaysia: Catherine Baroang. Unpublished report.
[33] United Nations High Commissioner for Refugees-Malaysia. (August 2009) *Assistance Needs of the Rohingyas*. Kuala Lumpur, Malaysia. Unpublished report.

necessary to tap into existing private clinics or NPDB clinics that are already in their neighbourhoods and working with them to develop discounts or reimbursement plans for services provided to refugees.

Religion was perceived to be a barrier to accessing FP services prior to this study; however, with the exception of the men's Rohingya group, it seems that religious Muslim and Christian communities still desire access to FP services in light of their living situation. Even the Rohingya men's group acknowledged that their religion allowed for FP if it was for the health of the mother. Raising awareness of how too many children and not enough spacing affects the health of the mother may help increase acceptance of FP in this community. Continued outreach to community and religious leaders may also be helpful in this regard.

LIMITATIONS

An ongoing challenge during the study was managing participants' expectations in regard to their registration, status determination, resettlement applications and financial assistance. The study team was instructed to specifically mention that participation in the study would have no effect, positively or negatively, on their respective applications. Even so, being affiliated with UNHCR caused issues throughout the survey, interviews and FGDs, including one FGD having to be cancelled due to a lack of interest in the actual topic for participants. Registration issues were first and foremost on refugees' minds. UNHCR previously gave registration priority to pregnant women, but in 2009 they stopped because they thought that unregistered individuals were getting married and becoming pregnant so that they could register more quickly. This serves to illustrate the gravity of the concern for refugees.

The primary limitation for the FGDs was a lack of time to reach saturation. There was only enough time to conduct one focus group for each age/gender sub-group per ethnic community. In addition, participants were chosen by the community leaders and all lived close to the community centre where the FGDs took place, implying that these participants may have better access to information and services. Combined with FGDs conducted in 2009, however, these discussions can help form a preliminary picture of the FP knowledge, attitudes and beliefs and barriers to information and services.

There was also a lack of privacy for the FGDs. Although private rooms were requested, the community centres were very busy and community members were coming in and out during several of the discussions. The community centres were seen as preferable despite this lack of privacy, because the UNHCR office is inconvenient for most refugees and it would have served to contribute to concerns about status, financial assistance and resettlement.

Lastly, the quality of the FGD translations was a notable limitation. Because the moderators were also CHWs with other job responsibilities, they were not able to spend time after the FGDs to transcribe the recordings. Instead, the recordings were sent to a volunteer to be transcribed. Portions of the transcriptions the researcher received were extremely difficult to understand, making analysis difficult.

Sources of bias in the household survey stemmed from the need to have accurate phone numbers in order to verify participant's addresses. Presumably those without accurate phone numbers on file were the most out of touch with UNHCR services. Due to logistical restraints the team was only able to conduct the survey in Burmese. Fifteen of the households that the team contacted did not speak Burmese, but rather an ethnic dialect, and thus were not interviewed. This would also bias the results as language difficulties represent a major barrier to accessing services.

APPENDICES

APPENDIX I: HOUSEHOLD SURVEY DATA TABLES

AWARENESS, EVER USE AND PROBLEMS WITH FAMILY PLANNING METHODS

TABLE FP-1: Awareness of Family Planning Methods among Women of Reproductive Age, Kuala Lumpur, Malaysia 2011 {N = Total Surveyed}

Method	% (n) women*
Pill	80.7% (321)
IUD	29.4% (152)
Male condom	82.4% (332)
Female condom	11.4% (65)
Implants	37.6% (104)
Injectables	74.9% (301)
Emergency contraception	4.3% (18)
Tubal ligation	43.5% (194)
Rhythm/calendar/counting days	46.1% (145)
Withdrawal	34.4% (177)

**Percentages may add up to more than 100% as respondent may give more than 1 response.*

Key Indicator FP-A: Proportion of Women Who Have Ever Used Any Family Planning Method Among Women of Reproductive Age, Kuala Lumpur, Malaysia 2011 {N = 422}

Indicator	% (n) women
Ever used family planning method	49.6% (243)

TABLE FP-2: Proportion of Women Who Have Been Instructed How to Use or Have Ever Used Family Planning Methods among Women of Reproductive Age,* Kuala Lumpur, Malaysia 2011. {N = 422}

Method	Instructed how to use method % (n) women	Ever used % (n) women
Pill	38.8% (194)	27.1% (124)
IUD	8.9% (44)	2.0 % (10)
Male condom	42.2% (219)	15.4% (80)
Female condom	2.8% (15)	11.1% (64)
Implants	4.9% (20)	0.2 % (1)
Injectables	48.4% (172)	19.6% (97)
Emergency contraception	1.4% (7)	0.2 % (1)
Tubal ligation	9.4% (31)	2.2% (5)
Rhythm/calendar/counting days	18% (89)	12.2% (59)
Withdrawal	22.8% (121)	17.6% (94)

**Percentages may add up to more than 100% as respondent may give more than 1 response.*

TABLE FP–3: Knowledge of Where to Get Modern* Family Planning Methods among Women of Reproductive Age,† Kuala Lumpur, Malaysia 2011 {N = 422}

Method	Health Center % (n) women	Private clinic % (n) women	Market % (n) women	Friends/ relatives % (n) women	Pharmacy % (n) women	Don't Know % (n) women
Pill	16.0% (74)	2.1% (10)	5% (20)	0% (0)	36.8% (136)	38.4% (74)
IUD	52.9% (81)	2.1% (1)	0% (0)	0% (0)	0.5% (1)	38.7% (61)
Male condom	58.1% (160)	0.4% (2)	8.4% (39)	0% (0)	15.3% (56)	15.9% (67)
Female condom	23.0% (15)	1.4% (1)	4.1% (2)	0% (0)	29.9% (20)	37.8% (25)
Implants	25.0% (50)	2.0% (2)	0% (0)	0% (0)	0% (0)	67.2% (42)
Injectables	68.5% (193)	8.0% (29)	0% (0)	0% (0)	2.3% (6)	17.8% (63)
Emergency contraception	28.6% (5)	14.3% (1)	3.6% (2)	0% (0)	25% (4)	21.4% (6)
Tubal ligation	79.6% (145)	0% (0)	0% (0)	0% (0)	0.3% (1)	15.7% (35)

**Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy.*

†Percentages may add up to more than 100% as respondent may give more than 1 response.

TABLE FP–4: Main Problem Reported with Using Specific Family Planning Methods among Women Who Have Ever Heard of that Method, Kuala Lumpur, Malaysia 2011 {N = 422}

Method	Lack of access % (n) women	Opposition to use % (n) women	Method-related % (n) women	No problem % (n) women
Pill	0.2% (1)	0% (0)	7.3% (29)	25.6% (91)
IUD	0% (0)	0% (0)	7.9% (11)	8.4% (13)
Male condom	0% (0)	1.3% (7)	0.8% (4)	26.9% (119)
Implants	0% (0)	0% (0)	0% (0)	4.5% (8)
Injectables	0.2% (1)	0% (0)	11.1% (42)	15.4% (56)
Emergency contraception	0% (0)	0% (0)	3.6% (1)	10.7% (1)
Tubal ligation	0% (1)	0% (0)	1.4% (4)	7.2% (16)
Rhythm/calendar/counting days	0% (0)	2.01% (6)	2.0% (5)	20.4% (50)
Withdrawal	0% (0)	7.17% (16)	2.2% (4)	46.2% (85)

CURRENT USE OF FAMILY PLANNING

Key Indicator FP-B): Proportion of Women Who Are Currently Using a Modern* Family Planning Method among Ever Married Women of Reproductive Age, Kuala Lumpur, Malaysia 2011 {N=326†}	
Indicator	**% (n) women**
Contraceptive prevalence (modern methods)	34.2% (137)

**Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy.*
†The denominator may include women who are not at risk for pregnancy because they are currently pregnant, infecund, or have had a hysterectomy.

Key Indicator FP-C): Proportion of Women Who Are Currently Using Any Family Planning Method among Ever Married Women of Reproductive Age, Kuala Lumpur, Malaysia 2011 {N = 326*}	
Indicator	**% (n) women**
Contraceptive prevalence (any method)	42.2% (168)

**The denominator may include women who are not at risk for pregnancy because they are currently pregnant, infecund, or have had a hysterectomy.*

TABLE FP-5: Demographic Characteristics of Women Who Are Currently Using Any Family Planning Method, Kuala Lumpur, Malaysia 2011 {N = 170}	
Characteristic	**% (n) women**
Age	
15-24	13.5% (23)
25-34	59.5% (106)
35-49	26.1% (35)
Relationship Status	
Living with a husband/partner	99.1% (165)
Not living with husband/partner	0.9% (2)
Total pregnancies	
0	14.4% (30)
1-2	45.6% (77)
3-4	22.3% (38)
>4	17.7% (21)
Sexually active in last 30 days	
Yes	87.9% (157)
No	9.8% (6)

FP-6: Family Planning Method Being Used among Women Who Are Currently Using Any Family Planning Method, Kuala Lumpur, Malaysia 2011 {N =170 }	
Method	**% (n) women***
Pill	37% (60)
IUD	2.3% (5)
Male condom	19.6% (38)
Female condom	0% (0)
Implants	0% (0)
Injectables	17.4 %(34)
Emergency contraception	0% (0)
Tubal ligation	5.5 %(3)
Vasectomy	0% (0)
Lactational amenorrhea	0% (0)
Rhythm/calendar/counting days	9.1 %(18)
Withdrawal	24.7 %(45)
Periodic abstinence	0% (0)

**Percentages may add up to more than 100% as respondent may give more than 1 response.*

TABLE FP–7: Location Where Family Planning Method Was Last Obtained among Women Who Are Currently Using a Modern* Family Planning Method, Kuala Lumpur, Malaysia 2011 {N = 136}	
Method	**% (n) women**
Health Center	54.5% (74)
Hospital	5.1% (7)
Supermarket/Market	13.2% (18)
Pharmacy	25% (34)

**Modern methods include the pill, IUD, female and male condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy.*

BARRIERS TO FAMILY PLANNING

Key Indicator FP-D: Proportion of Women Who Are at Risk for Pregnancy,* Desire to Stop or Delay Childbearing, and Are Not Using Family Planning among Women of Reproductive Age, Kuala Lumpur, Malaysia 2011 {N = 422}	
Indicator	**% (n) women**
Unmet need*	5.4% (29)

**Women who are at risk for pregnancy are women who report being fecund, sexually, active, NOT pregnant and NOT postpartum.*

FP-8: Barriers to Family Planning among Women Who Are At Risk for Pregnancy, Desire to Stop or Delay Childbearing and Are Not Using Family Planning, Kuala Lumpur, Malaysia 2011 {N= 29}	
Barriers to family planning	**% (n) women***
Fertility-related reasons	51.4% (13)
Opposition to use	2.9% (1)
Lack of knowledge	5.7% (2)
Method-related reasons	8.6% (3)
Other	8.6% (3)

**Percentages may add up to more than 100% as respondent may give more than 1 response.*

TABLE FP-9: Demographic Characteristics of Women Who Reported Barriers to Family Planning among Women Who Are at Risk for Pregnancy, Desire to Stop or Delay Childbearing and Are Not Using Family Planning, Kuala Lumpur, Malaysia 2011 {N= 29}					
Characteristic	**Fertility-related % (n) women**	**Opposition to use % (n) women**	**Lack of knowledge % (n) women**	**Method related % (n) women**	**Lack of access % (n) women**
Age					
15-24	11.1% (2)	100% (1)	50% (1)	33.3% (1)	0% (0)
25-34	55.6% (8)	0% (0)	0% (0)	33.3% (1)	0% (0)
35-49	33.3% (3)	0% (0)	50% (1)	33.3% (1)	0% (0)
Relationship Status					
Living with a husband/partner	100% (13)	100% (1)	100% (2)	100% (3)	0% (0)
Not living with a husband/partner	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Total pregnancies					
0	5.6% (1)	0% (0)	50% (1)	33.3% (1)	0% (0)
1-2	55.6% (8)	100% (1)	0% (0)	0% (0)	0% (0)
3-4	33.3% (3)	0% (0)	0% (0)	66.7% (2)	0% (0)
>4	5.6% (1)	0% (0)	50% (1)	0% (0)	0% (0)
Sexually active in last 30 days					
Yes	100% (13)	100% (1)	100% (2)	100% (3)	0% (0)
No	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)

INTENT TO USE A FAMILY PLANNING METHOD IN THE NEXT 12 MONTHS

KEY INDICATOR FP-E: Proportion of Women Who Are Not Currently Using a Family Planning Method, but Plan To in the Next 12 Months, Kuala Lumpur, Malaysia 2011 {N=422}	
Indicator	**% (n) women**
Future intent to use family planning in next 12 months	7.3 %(25)

APPENDIX II: HEALTH FACILITY ASSESSMENT SUMMARY

Topic	Indicator	Tzu-Chi Buddhist	MCH	S&WP FPA
Staffing	# of doctors or clinical officers providing any FP method	2	1	1
	# of midwives, nurse-midwives or nurses providing any FP method	5	13	1
Training	Proportion of doctors or clinical officers trained in FP among all doctors and clinical officers providing FP	100%	100%	100%
	Proportion of midwives, nurse-midwives or nurses trained in FP among all midwives, nurse-midwives or nurses providing FP	0	100%	0
Method Mix	# of temporary methods available	3	5	5
	# of long-acting methods available	0	0	1
	# of permanent methods available	0	0	1
	# of traditional methods promoted	0	2	2
	Is EC available?	No	No	No
Relative Score of Quality Measure	Score (Out of 15)	9	11	10
Capacity to meet infection prevention standards	Score (Out of 15)	15	15	15