KEMENTERIAN PEMBANGUNAN WANITA,
KELUARGA DAN MASYARAKAT

LPPKN
LEMBAGA PENDUDUK DAN PEMBANGUNAN KELUARGA NEGARA

LAPORAN KAJIAN

AMALAN PERANCANG KELUARGA DI MALAYSIA

Report on the Study of Family Planning Practices in Malaysia



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Report on the Study of
Family Planning Practices in Malaysia



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KATA PENGANTAR

Dato' Sri Hajah Nancy Shukri

MENTERI
PEMBANGUNAN WANITA, KELUARGA DAN MASYARAKAT

Penubuhan Lembaga Perancang Keluarga Negara pada tahun 1966 menjadi titik awal perkembangan pendekatan negara terhadap perancangan keluarga. Pindaan Akta dan pertukaran nama kepada Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN) pada tahun 1984 seterusnya memperluas mandat organisasi daripada tumpuan terhadap perkhidmatan kontraseptif kepada skop yang lebih menyeluruh, meliputi kependudukan, pembangunan keluarga dan reproduksi manusia. Seiring dengan peluasan mandat ini, pendekatan perancangan keluarga turut berkembang dengan memberi penekanan kepada kesihatan reproduktif, pendidikan, kesedaran dan sokongan kepada keluarga. Pendekatan ini memberi ruang kepada pasangan untuk merancang bilangan dan jarak kelahiran anak secara terancang dan bertanggungjawab, sekali gus menyokong pembentukan keluarga yang sejahtera.

"Penubuhan Lembaga Perancang Keluarga Negara pada tahun 1966 menjadi titik awal perkembangan pendekatan negara terhadap perancangan keluarga."

Kajian Amalan Perancang Keluarga di Malaysia merupakan inisiatif penting dalam menilai keberkesanan dasar tersebut, di samping memberikan gambaran tentang tahap kesedaran, penerimaan serta cabaran semasa masyarakat. Dapatan kajian ini diharapkan dapat dimanfaatkan oleh pembuat dasar, penyedia perkhidmatan, ahli akademik dan rakan strategik dalam memperkukuh dasar serta pelaksanaan program perancang keluarga negara. Penghargaan turut dirakamkan kepada semua warga kerja LPPKN yang telah menyumbang kepada penerbitan laporan ini.



KATA PENGANTAR

Datuk Dr. Maziah Che Yusoff

KETUA SETIAUSAHA

KEMENTERIAN PEMBANGUNAN WANITA, KELUARGA DAN MASYARAKAT

Kajian Amalan Perancang Keluarga di Malaysia merupakan satu inisiatif penting dalam menilai keberkesanan dasar yang telah digariskan oleh kerajaan melalui Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN). Kajian ini menyediakan data dan maklumat yang komprehensif mengenai tahap kesedaran, penerimaan serta amalan masyarakat terhadap perancangan keluarga, sekali gus menjadi asas kukuh dalam merangka strategi yang lebih berkesan dan responsif terhadap perubahan demografi serta sosioekonomi negara.

Setinggi-tinggi penghargaan dirakamkan kepada LPPKN, para perunding dan semua pihak yang terlibat dalam menjayakan kajian ini. Sumbangan yang diberikan telah memastikan penerbitan laporan yang berkualiti dan bermanfaat kepada pembuat dasar, pengamal, penyelidik dan rakan strategik dalam memperkukuh sistem perancang keluarga dan kesihatan reproduktif negara. Diharapkan dapatan serta saranan kajian dapat secara optimum demi kesejahteraan wanita, keluarga dan masyarakat di negara ini.

"Kajian Amalan Perancang Keluarga di Malaysia merupakan satu inisiatif penting dalam menilai keberkesanan dasar yang telah digariskan oleh kerajaan."

KATA PENGANTAR

Dato Sri Rohani Abdul Karim

PENGERUSI

LEMBAGA PENDUDUK DAN PEMBANGUNAN KELUARGA NEGARA



Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN) sentiasa komited dalam memperkasakan kesejahteraan demografi serta institusi keluarga di negara ini. Pelaksanaan Kajian Amalan Perancang Keluarga di Malaysia bertujuan untuk meningkatkan pemahaman berkaitan isu dan cabaran utama berkaitan penggunaan kontraseptif dan rawatan subfertiliti, di samping meneliti amalan serta keperluan semasa bagi menyokong perancangan dan penambahbaikan program perancang keluarga di Malaysia.

Dapatan kajian ini menyediakan asas strategik untuk memandu penggubalan dasar dan intervensi kesihatan reproduktif yang lebih efektif. Maklumat berasaskan bukti (*evidence-based*) ini penting dalam memastikan program perancang keluarga disasarkan secara inklusif demi memenuhi keperluan segenap lapisan masyarakat.

"Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN) sentiasa komited dalam memperkasakan kesejahteraan demografi serta institusi keluarga di negara ini."

Setinggi-tinggi penghargaan dirakamkan kepada Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM), United Nations Population Fund (UNFPA) in Malaysia, UPUM Sdn. Bhd., serta seluruh warga kerja LPPKN atas komitmen menjayakan penerbitan laporan ini. Diharapkan dapatan kajian ini dapat dimanfaatkan sepenuhnya demi memperkukuh kesejahteraan keluarga dan mendokong pembangunan sosioekonomi negara.



KATA PENGANTAR

Dato' Abdul Shukur Abdullah

KETUA PENGARAH
LEMBAGA PENDUDUK DAN PEMBANGUNAN KELUARGA NEGARA

Trend perancang keluarga di Malaysia menunjukkan kadar penggunaan kontraseptif yang masih sederhana dan mendatar, meskipun negara berdepan penurunan kadar kesuburan yang ketara. Perubahan ini dipengaruhi oleh pelbagai faktor seperti peningkatan umur perkahwinan, perubahan sosioekonomi dan struktur masyarakat, serta membawa kepada cabaran baharu termasuk isu subfertiliti dalam kalangan pasangan yang menginginkan anak.

Sehubungan itu, Kajian Amalan Perancang Keluarga di Malaysia dilaksanakan sebagai usaha komprehensif untuk meneliti trend semasa, mengenal pasti faktor yang mempengaruhi penggunaan kontraseptif, serta memahami isu berkaitan subfertiliti bagi menyokong penambahbaikan dasar dan program perancang keluarga negara. Kajian ini menggunakan pendekatan campuran yang menggabungkan kaedah kuantitatif dan kualitatif bagi memberikan gambaran yang menyeluruh dan mendalam tentang amalan perancang keluarga dalam kalangan masyarakat.

"Trend perancang keluarga di Malaysia menunjukkan kadar penggunaan kontraseptif yang masih sederhana dan mendatar, meskipun negara berdepan penurunan kadar kesuburan yang ketara."

Penghargaan turut dirakamkan kepada United Nations Population Fund (UNFPA) Malaysia atas sokongan dan peruntukan yang diberikan, serta kepada UPUM Sdn. Bhd. sebagai perunding kajian. Diharapkan dapatan kajian ini dapat dimanfaatkan dalam merangka strategi yang lebih berkesan demi kesejahteraan keluarga dan pembangunan negara.

KATA PENGANTAR



Dr. Julitta Onabanjo

PERWAKILAN
UNITED NATIONS POPULATION FUND

> "Perancangan keluarga pada asasnya ialah tentang pilihan yang berteraskan hak asasi manusia, keputusan secara sukarela dan hak setiap individu untuk menentukan tubuh serta kehidupan reproduktif mereka sendiri."

Perancangan keluarga pada asasnya ialah tentang pilihan yang berteraskan hak asasi manusia, keputusan secara sukarela dan hak setiap individu untuk menentukan tubuh serta kehidupan reproduktif mereka sendiri. Setiap individu dan pasangan perlu mempunyai maklumat, perkhidmatan dan sokongan yang mencukupi untuk membuat keputusan secara bebas dan bertanggungjawab tentang sama ada, bila dan berapa ramai anak yang ingin dimiliki. Ketika Malaysia melalui perubahan demografi yang ketara — termasuk penurunan kadar kesuburan, usia perkahwinan dan kelahiran anak yang semakin lewat, serta perubahan dalam realiti sosioekonomi — usaha untuk memastikan kesihatan dan hak seksual dan reproduktif dihormati dan dipenuhi sepanjang hayat menjadi semakin penting agar setiap individu dapat merealisasikan hasrat reproduktif mereka. Kajian Amalan Perancangan Keluarga di Malaysia amat bertepatan pada masanya kerana memberi gambaran tentang pelbagai faktor yang mempengaruhi keputusan berkaitan perancangan keluarga, termasuk pengetahuan, akses, kemampuan, dinamika pasangan dan keupayaan membuat keputusan sendiri.

UNFPA menegaskan bahawa kesihatan dan hak seksual dan reproduktif merupakan hak asasi manusia. Dengan meletakkan perancangan keluarga dalam pendekatan kitaran hayat yang menyeluruh, masyarakat dapat memperkukuh autonomi individu, menyokong mereka dalam merealisasikan hasrat reproduktif masing-masing, serta membina masyarakat yang lebih inklusif, saksama dan berdaya tahan.

UNFPA berbesar hati dapat menyokong kajian ini dan merakamkan penghargaan kepada Kementerian Pembangunan Wanita, Keluarga dan Masyarakat, LPPKN dan pasukan penyelidik. Kami berharap dapatan kajian ini dapat menjadi rujukan dalam usaha memperkukuh dasar serta perkhidmatan kesihatan reproduktif yang lebih responsif terhadap keperluan individu dan keluarga.

PENGHARGAAN

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JAWATANKUASA TEKNIKAL DAN KERJA KAPKM

Kementerian / Jabatan

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Federation of Reproductive Health Association Malaysia
Academy of Family Physicians of Malaysia

LPPKN

Bahagian Perancangan Strategik
Bahagian Reproduksi Manusia
Bahagian Penyelidikan Kependudukan dan Keluarga
Pusat Kepakaran Subfertiliti

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Bahagian Penyelidikan Kependudukan dan Keluarga LPPKN


My FAMILY
DAD
Daddy
Me

Ringkasan Eksekutif



Foto : pavel danilyuk / Pexels

Perancang keluarga merupakan komponen asas kesihatan seksual dan reproduktif yang penting dalam meningkatkan kesejahteraan ibu, anak dan keluarga. Ia merangkumi maklumat, perkhidmatan dan kaedah yang membolehkan wanita dan pasangan membuat keputusan mengenai bilangan anak, masa dan jarak kehamilan, serta rawatan subfertiliti. Di Malaysia, perkhidmatan ini disediakan oleh Kementerian Kesihatan Malaysia (KKM), Lembaga Penduduk dan Pembangunan Keluarga Negara, (LPPKN) sektor swasta dan Badan Bukan Kerajaan (NGO). Walaupun pelbagai program telah dilaksanakan, kadar penggunaan kontraseptif kekal sederhana dan mendatar, di samping wujud cabaran seperti keperluan kontraseptif yang tidak dipenuhi, akses kepada rawatan subfertiliti, serta penurunan kadar fertiliti akibat perubahan sosiodemografi seperti peningkatan umur perkahwinan dan penyertaan wanita dalam pendidikan serta tenaga kerja.

Sehubungan itu, kajian ini dijalankan untuk mengenal pasti isu dan cabaran berkaitan pengetahuan, sikap dan amalan kontraseptif termasuk rawatan subfertiliti; menilai keberkesanan pelaksanaan program perancang keluarga dalam konteks dasar sedia ada; dan mencadangkan penambahbaikan program pada masa akan datang. Reka bentuk kajian menggunakan pendekatan gabungan yang merangkumi kajian pustaka, analisis situasi serta kaedah kuantitatif dan kualitatif. Komponen kuantitatif dilaksanakan melalui tinjauan dalam talian menggunakan soal selidik berstruktur melibatkan wanita berumur 15 hingga 49 tahun, manakala komponen kualitatif melibatkan temubual mendalam secara interpretatif dengan pelbagai kumpulan termasuk wanita berisiko tinggi, wanita berkahwin yang mengalami subfertiliti, wanita belum berkahwin serta pembekal perkhidmatan perancang keluarga dari sektor awam dan swasta.

Dapatan menunjukkan tahap pengetahuan terhadap kaedah kontraseptif moden adalah tinggi, namun pengetahuan terhadap kaedah tertentu seperti gegelang vagina dan tubaligasi masih rendah. Sikap terhadap penggunaan kontraseptif secara umumnya positif, walaupun masih terdapat kebimbangan berkaitan kesan terhadap kesuburan jangka panjang. Dari segi amalan, majoriti responden menunjukkan penerimaan yang baik terhadap perancang keluarga. Dalam kalangan wanita pernah berkahwin, sebahagian besar pernah menggunakan kontraseptif dan kira-kira separuh wanita yang masih berkahwin sedang menggunakannya, dengan kondom sebagai kaedah paling lazim. Kebanyakan responden menggunakan satu kaedah sahaja dan membuat keputusan bersama pasangan, terutamanya dalam memulakan atau menghentikan penggunaan bagi tujuan mendapatkan anak. Faktor utama tidak menggunakan kontraseptif termasuk keinginan untuk hamil, kurang minat dan kebimbangan terhadap kesan sampingan.

Dalam konteks subfertiliti, majoriti responden menerima rawatan moden sebagai wajar, namun akses dan penggunaan rawatan masih dipengaruhi oleh faktor kos, masa, pengetahuan serta stigma. Sebahagian yang menjalani rawatan melebihi dua tahun berjaya hamil, dengan kebanyakan mendapatkan rawatan di fasiliti swasta. Dapatan

kualitatif menonjolkan pelbagai tema utama termasuk cabaran kesihatan, pengaruh pasangan dan keluarga, kekangan kewangan, tekanan emosi, serta norma sosiobudaya yang mempengaruhi keputusan berkaitan kontraseptif dan rawatan subfertiliti. Wanita yang mengalami subfertiliti turut berhadapan tekanan sosial dan kekurangan sokongan, manakala golongan belum berkahwin menunjukkan perubahan nilai terhadap perkahwinan dan keibubapaan yang semakin dipengaruhi oleh faktor ekonomi dan kesiapsiagaan diri.

Dari sudut sistem penyampaian, beberapa isu dikenal pasti termasuk kekangan kewangan dan sumber, kekurangan kepakaran, serta cabaran operasi dalam penyampaian perkhidmatan. Sehubungan itu, kajian ini mencadangkan lima (5) hala tuju utama yang memberi penekanan kepada pendekatan yang lebih menyeluruh dan bersepadu dalam memperkukuh perkhidmatan perancang keluarga negara.

Pertama, pendidikan kesihatan seksual dan reproduktif perlu diperkasa melalui program pendidikan komprehensif yang bersesuaian mengikut kumpulan sasaran, dengan penggunaan bahan pembelajaran interaktif dan pendekatan yang responsif kepada perubahan semasa. Penekanan juga perlu diberikan kepada peningkatan literasi reproduktif, termasuk pemahaman tentang kontraseptif, kesuburan dan perancangan keluarga secara berinformasi.

Kedua, pemanfaatan teknologi dilihat sebagai pemangkin utama dalam memperluas capaian maklumat dan perkhidmatan. Pengintegrasian platform digital seperti aplikasi mudah alih dan media sosial boleh membantu menyampaikan maklumat yang tepat dan mudah diakses, termasuk melalui kolaborasi dengan pempengaruh dan pencipta kandungan yang berwibawa bagi meningkatkan kesedaran dan mengurangkan stigma berkaitan kesihatan reproduktif.

Ketiga, aspek perkhidmatan menumpukan kepada peningkatan akses dan kualiti penyampaian perkhidmatan perancang keluarga. Ini termasuk memperluas liputan perkhidmatan, memperkukuh kapasiti tenaga pakar, memastikan bekalan kontraseptif mencukupi, serta menyediakan sokongan yang lebih menyeluruh bagi rawatan subfertiliti. Usaha ini bertujuan meningkatkan penggunaan kontraseptif moden dan mengurangkan keperluan yang tidak dipenuhi dalam kalangan masyarakat.

Keempat, tadbir urus perlu diperkukuh melalui penyelarasan yang lebih berkesan antara agensi, khususnya antara KKM dan LPPKN. Ini termasuk pembangunan pelan strategik yang jelas, mekanisme pemantauan yang sistematik, serta pengukuhan kerjasama rentas sektor bagi memastikan pelaksanaan program yang lebih cekap dan berimpak tinggi. Kelima, pengukuhan data menjadi asas penting dalam menyokong perancangan dasar berasaskan bukti. Cadangan termasuk pewujudan Hab Data Kesihatan Seksual dan Reproduktif Nasional, pelaksanaan tinjauan perancang keluarga secara berkala (contohnya setiap lima tahun), serta kajian tematik tahunan. Pendekatan ini akan

memastikan data yang komprehensif, terkini dan relevan sentiasa tersedia untuk menyokong pembuatan keputusan dan penambahbaikan dasar secara berterusan.

Secara keseluruhannya, kajian ini menegaskan bahawa perancang keluarga kekal sebagai agenda penting dalam memastikan kesejahteraan keluarga dan pembangunan negara yang mampan. Walaupun tahap pengetahuan dan sikap masyarakat terhadap kontraseptif adalah positif, cabaran dari segi amalan, akses perkhidmatan, serta isu subfertiliti masih memerlukan perhatian yang berterusan. Pendekatan bersepadu melalui pengukuhan pendidikan, pemanfaatan teknologi, penambahbaikan perkhidmatan, tadbir urus yang efektif serta sistem data yang mantap adalah penting bagi memastikan dasar dan program yang dilaksanakan lebih responsif dan berimpak tinggi. Seiring dengan perubahan keperluan masyarakat, perancang keluarga kini telah berevolusi daripada fokus asal terhadap pengawalan bilangan anak kepada pendekatan yang lebih menyeluruh, termasuk sokongan terhadap rawatan subfertiliti, sekali gus memperkukuh peranannya sebagai sistem sokongan yang inklusif, berdaya tahan dan berasaskan bukti demi kesejahteraan rakyat.

Pengenalan



Foto : Kaushal Amrutiya / Pexels

Definisi Perancang Keluarga

Definisi operasi yang digunakan oleh Bahagian Kesihatan Reproduktif dan Penyelidikan Pertubuhan Kesihatan Sedunia (WHO):

> ***"Keupayaan individu dan pasangan untuk merancang serta mencapai bilangan anak yang diinginkan termasuk penjarakan dan masa kelahiran. Ia dicapai melalui penggunaan kaedah kontraseptif serta rawatan ketidaksuburan"***
>
> ***Pertubuhan Kesihatan Sedunia (WHO), 2008***

Latar Belakang Program Perancang Keluarga

Program perancang keluarga di negara ini diterajui oleh dua (2) institusi utama iaitu Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN) dan Kementerian Kesihatan Malaysia (KKM). LPPKN memainkan peranan penting dalam membentuk Garis Panduan Perancang Keluarga Kebangsaan yang bertindak sebagai pelan induk bagi inisiatif program perancang keluarga di negara ini. Garis panduan ini memastikan bahawa perkhidmatan perancang keluarga disepadukan dengan perkhidmatan kesihatan ibu dan anak, menjadinya mudah diakses melalui kemudahan kesihatan awam (Lorenzoni et al., 2022).

Selain daripada membangunkan garis panduan di peringkat nasional, LPPKN turut memberikan perkhidmatan perancang keluarga termasuk program pendidikan dan juga kempen kesedaran untuk mendidik masyarakat awam mengenai kepentingan perancang keluarga, sama ada penggunaan kontraseptif atau rawatan subfertiliti. Salah satu inisiatif strategik yang diperkenalkan adalah penubuhan rangkaian 50 Klinik Nur Sejahtera LPPKN di seluruh negara bagi menyediakan pelbagai perkhidmatan perancang keluarga termasuk saringan kesihatan dan sesi kaunseling untuk menyokong individu dan keluarga dalam membuat keputusan yang berinformasi mengenai kesihatan reproduktif mereka.

KKM turut menyediakan perkhidmatan perancang keluarga melalui klinik kesihatan dan hospital kerajaan di seluruh negara. Perkhidmatan KKM turut merangkumi kaunseling, pendidikan dan pengedaran pelbagai kaedah kontraseptif. Selain daripada sektor kerajaan, sektor swasta turut memainkan peranan penting dalam kesejahteraan kesihatan reproduktif terutamanya melalui rawatan subfertiliti. Terdapat pelbagai hospital dan klinik swasta yang menawarkan perkhidmatan rawatan subfertiliti, antaranya seperti TMC Fertility Centre, Alpha Fertility Centre dan Sunway Fertility Centre.

Program dan perkhidmatan berkaitan perancang keluarga di negara ini telah berkembang sejak penggubalan Akta Penduduk dan Pembangunan Keluarga Negara 1966 (APPK 1966, Akta 352). Akta ini bertujuan untuk mengawal dan mempromosikan kesihatan reproduktif dengan memastikan bahawa perkhidmatan perancang keluarga dapat diakses oleh semua rakyat. APPK 1966 mengiktiraf kepentingan kesihatan reproduktif dalam pembangunan negara yang memberi penekanan kepada kesihatan ibu dan anak, pertumbuhan dan pembangunan penduduk serta memperkasa setiap individu untuk membuat pilihan tepat mengenai kehidupan kekeluargaan (Mohd Nor et al., 2022).

Latar Belakang Kajian

Bagi mendapatkan gambaran yang lebih menyeluruh mengenai isu dan cabaran berkaitan amalan perancangan keluarga di negara ini, Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM) melalui LPPKN telah melantik UPUM Sdn. Bhd. (Kumpulan Perunding Universiti Malaya) untuk menjalankan Kajian Amalan Perancang Keluarga di Malaysia bermula dari 1 Ogos 2024 sehingga 31 Oktober 2025. Pelaksanaan kajian ini telah dibiayai oleh United Nations Population Fund (UNFPA) melalui peruntukan Country Programme of Action (CPAP), 2021 – 2025.

Objektif utama kajian adalah untuk:

01

Mengenal pasti isu dan cabaran dalam aspek perancang keluarga, termasuk penggunaan kontraseptif dan rawatan subfertiliti.

02

Menilai keberkesanan pelaksanaan program perancang keluarga, yang meliputi perkhidmatan kontraseptif dan rawatan subfertiliti dalam konteks dasar-dasar kerajaan sedia ada.

03

Mencadangkan penambahbaikan terhadap program perancang keluarga negara pada masa hadapan agar lebih responsif, inklusif dan selaras dengan keperluan pasangan serta keluarga di Malaysia.

METODOLOGI

Skop Kajian

Bagi mengenal pasti isu dan cabaran berkaitan perancang keluarga secara menyeluruh, kajian ini telah menggabungkan perspektif pengguna perancang keluarga dalam kalangan wanita serta perspektif penyedia perkhidmatan sama ada premis kerajaan atau swasta yang terlibat dalam pelaksanaan program atau perkhidmatan perancang keluarga.

Reka Bentuk Kajian

Kajian ini menggunakan reka bentuk kajian campuran (*mixed method*) yang merangkumi pendekatan kuantitatif dan kualitatif. Pendekatan ini dipilih bagi memberikan gambaran yang lebih komprehensif dan holistik terhadap isu serta cabaran yang dikaji.

Saiz Sampel

Sampel kajian ini terdiri daripada: (i) wanita berkahwin berumur 15 hingga 49 tahun; (ii) wanita tidak pernah berkahwin; dan (iii) penyedia perkhidmatan kesihatan berkaitan perancang keluarga serta rawatan subfertiliti.

Berikut adalah saiz sampel kajian berdasarkan kepada kaedah pengumpulan data yang digunakan:

Tinjauan dalam talian *(online survey)*: 1,029 orang responden

Temubual mendalam *(in-depth interview)*

i. Wanita berkahwin 15-49 tahun: 39 orang responden
ii. Wanita tidak pernah berkahwin (berumur kurang daripada 30 tahun): 22 orang responden
iii. Penyedia perkhidmatan kesihatan: 15 orang responden

Responden tinjauan dalam talian direkrut melalui beberapa platform media sosial seperti Facebook dan WhatsApp.

Responden temubual mendalam dikenalpasti melalui senarai responden yang telah melengkapkan tinjauan dalam talian dan juga dengan menggunakan teknik *snowballing sampling.*

Profil Responden Bagi Tinjauan Dalam Talian

	Bilangan	Peratusan
Tempat Kediaman		
Bandar	866	84.2
Luar Bandar	163	15.8
Kumpulan Umur		
15 hingga 19 tahun	15	1.5
20 hingga 24 tahun	202	19.6
25 hingga 29 tahun	154	15.0
30 hingga 34 tahun	183	17.8
35 hingga 39 tahun	195	19.0
40 hingga 44 tahun	180	17.5
45 hingga 49 tahun	100	9.7
Status Perkahwinan		
Masih Berkahwin	604	58.7
Bercerai / Berpisah / Balu	42	4.1
Tidak Pernah Berkahwin	383	37.2
Etnik		
Melayu	797	77.5
Cina	150	14.6
India	48	4.7
Lain-lain	34	3.3
Tahap Pendidikan Tertinggi		
Diploma / Sijil dan ke bawah	374	36.3
Sarjana Muda dan ke atas	655	63.7
Status Pekerjaan		
Kerajaan	433	42.1
Swasta	256	24.9
Bekerja Sendiri	56	5.4
Tidak Bekerja	284	27.6
Pendapatan Isi Rumah		
Kurang daripada RM2,500	246	23.9
RM2,500 hingga RM4,849	292	28.4
RM4,850 hingga RM10,959	328	31.9
RM10,960 dan lebih	163	15.8
JUMLAH	**1,029**	**100.0**

Profil Responden Bagi Temubual Mendalam

	Bilangan	Peratusan
Tempat Kediaman		
Bandar	47	77.1
Luar Bandar	14	22.9
Kumpulan Umur		
15 hingga 29 tahun	30	49.2
30 hingga 39 tahun	11	18.0
40 hingga 49 tahun	20	32.8
Etnik		
Melayu	44	72.1
Cina	7	11.5
India	5	8.2
Lain-lain	5	8.2
Status Perkahwinan		
Berkahwin	37	60.7
Bercerai / Berpisah / Balu	2	3.3
Tidak Pernah Berkahwin	22	36.1
Status Pekerjaan		
Bekerja	33	54.1
Tidak Bekerja	28	45.9
Kategori Perancangan Keluarga		
Mempunyai masalah subfertiliti	12	19.7
Pengguna kaedah kontraseptif	29	47.5
Bukan pengguna kaedah kontraseptif	20	32.8
Status Kesihatan		
Mempunyai masalah kesihatan	10	16.4
Tiada masalah Kesihatan	51	83.6
Status Orang Kurang Upaya (OKU)		
OKU	5	8.2
Bukan OKU	56	91.8
JUMLAH	**61**	**100.0**

Kaedah Pengumpulan Data

Bagi kajian kuantitatif, data dikumpulkan dengan menggunakan borang soalan selidik yang ditadbir sendiri oleh responden secara dalam talian. Responden direkrut melalui pelbagai platform media sosial seperti *Facebook, WhatsApp* dan juga e-mel. Terdapat empat (4) bahagian utama borang soalan selidik seperti berikut: (i) latar belakang responden & perihal perkahwinan; (ii) kesihatan seksual dan reproduktif, kehamilan, dan fertiliti; (iii) amalan perancang keluarga; dan (iv) pengguguran / keguguran.

Bagi kajian kualitatif, data dikumpulkan melalui sesi temubual mendalam (*in-depth interview*) dengan menggunakan borang soalan selidik separa berstruktur. Pendekatan ini bertujuan untuk mengumpulkan maklumat yang lebih terperinci dan mendalam tentang pengalaman wanita berkaitan amalan perancang keluarga dan rawatan subfertiliti, termasuk pengalaman daripada penyedia perkhidmatan yang terpilih.

Analisis Data

Data Kuantitatif

Analisis deskriptif digunakan untuk menjana profil tahap pengetahuan (*knowledge*), sikap (*attitude*) dan amalan (*practice*) atau singkatannya KAP berkaitan perancang keluarga mengikut latar belakang sosiodemografi responden dan strata, menjana profil tahap KAP berkaitan subfertiliti mengikut latar belakang sosiodemografi responden dan strata, melihat ciri-ciri responden dalam amalan penggunaan kontraseptif (moden dan tradisional) dan pembuat keputusan dalam penggunaan kaedah kontraseptif.

Analisis inferensi digunakan untuk melihat skor pengetahuan tentang kaedah perancang keluarga serta amalan mengikut latar belakang sosiodemografi responden dan strata, faktor-faktor yang mempengaruhi tahap pengetahuan dan penggunaan kontraseptif.

Data Kualitatif

Analisis data kualitatif dilaksanakan melalui pendekatan analisis tematik berasaskan kerangka yang dicadangkan oleh Paul Colaizzi (1978), bagi menstrukturkan dan mentafsir makna pengalaman responden secara sistematik. Seterusnya, dapatan tersebut diperkukuh menerusi pendekatan Define, Design, Refine (DDR) yang dilaksanakan secara berfasa, meliputi: (i) Fasa 1 – analisis fenomenologi untuk mengenal pasti tema utama; (ii) Fasa 2 – reka bentuk kerangka fenomenologi berasaskan dapatan; dan (iii) Fasa 3 – penilaian dan pemurnian dapatan daripada Fasa 1 dan Fasa 2.

Limitasi Kajian

Adalah penting untuk dinyatakan bahawa dapatan kajian ini tidak bertujuan untuk mewakili keseluruhan penduduk negara secara statistik. Memandangkan komponen kuantitatif kajian dilaksanakan melalui tinjauan dalam talian yang dilengkapkan sendiri oleh responden (*self-administered online survey*), responden yang terlibat adalah terdiri daripada individu yang mempunyai akses kepada internet dan bersedia untuk menyertai kajian sahaja.

Seperti yang dilaporkan secara meluas dalam literatur berkaitan tinjauan dalam talian, pendekatan ini berpotensi menghasilkan keterwakilan yang lebih tinggi dalam kalangan individu yang tinggal di kawasan bandar, mempunyai tahap pendidikan yang lebih tinggi serta mempunyai akses yang lebih baik kepada teknologi dan internet.

Oleh itu, dapatan kajian ini hendaklah ditafsirkan sebagai mencerminkan pandangan, pengalaman dan amalan responden yang terlibat dalam kajian, dan bukannya sebagai anggaran yang mewakili keseluruhan penduduk Malaysia. Justeru, penemuan kajian tidak boleh digeneralisasikan kepada populasi negara, dan perhatian sewajarnya perlu diberikan semasa mentafsir dapatan bagi subkumpulan responden yang mempunyai saiz sampel yang kecil.

Sorotan Literatur



Foto : cottonbro studio / Pexels

Faktor-faktor Yang Mempengaruhi Amalan Penggunaan Kontraseptif Dan Rawatan Subfertiliti

Faktor Individu

- Wanita yang mempunyai tahap pendidikan yang lebih tinggi di negara ini lebih cenderung untuk menggunakan kontraseptif moden dan menangguhkan kelahiran anak (Hoo & Lai, 2023; Samat et al., 2022; Abdullah et al., 2021).

- Prevalens keperluan kontraseptif yang tidak dipenuhi adalah lebih tinggi dalam kalangan wanita berumur 36 tahun ke atas (Awaluddin et al. 2025).

- Umur perkahwinan mempengaruhi pola kesuburan sepanjang hayat (Tey Nai Peng, 2020).

- Pendapatan yang lebih tinggi dan terlibat dalam pekerjaan bergaji dikaitakan dengan pembuatan keputusan secara bersama (suami dan isteri) dalam penggunaan kontraseptif dan akses yang lebih besar kepada kontraseptif moden (Awaluddin et al., 2025; Lai et al., 2020; Damtew & Fantaye, 2024; Gemmill, 2018).

- Wanita yang tinggal di bandar melaporkan penggunaan kontraseptif moden yang lebih tinggi berbanding wanita yang tinggal di luar bandar (Hoo & Lai, 2023; Tey Nai Peng, 2020).

- Tempoh perkahwinan yang lebih lama mengubah pemilihan kaedah dan autonomi keputusan (Suriyani Muhammad et al., 2019).

- Tahap pengetahuan kontraseptif yang lebih tinggi berkait rapat dengan sikap yang positif dan kebarangkalian penggunaan yang lebih tinggi (Shafei et al., 2012; Najafi et al., 2011).

- Kekurangan pengetahuan sering menimbulkan kebimbangan terhadap kesan sampingan yang merupakan sebab utama wanita tidak atau berhenti menggunakan kontraseptif moden di Malaysia (Wong, 2012; Wong et al., 2014).

- Jurang pengetahuan tentang kontraseptif kecemasan menimbulkan kekeliruan mengenai cara penggunaan yang betul (Malaysian Journal of Pharmacy, 2019).

- Penghentian penggunaan secara kerap menunjukkan cabaran dalam akses kepada perkhidmatan dan keyakinan terhadap kaedah kontraseptif (Shafei et al., 2012; Najafi et al., 2011).

- Pengetahuan dan kemahiran pembekal perkhidmatan turut menjadi penentu kepada kaedah kontraseptif yang ditawarkan (Abdullah et al., 2017).

- Norma seksual yang konservatif dan nilai agama dalam kalangan wanita Melayu Islam dikaitkan dengan literasi kesihatan reproduktif yang rendah serta penerimaan terhad terhadap kaedah moden (Wong, 2012; Strathclyde University, 2018).

- Kebimbangan terhadap tanggapan penggunaan kontraseptif boleh menjejaskan kesuburan pada masa hadapan (Wong, 2012).

Faktor Keluarga dan Komuniti

- Pasangan dan keluarga merupakan pengaruh utama terhadap tingkah laku penggunaan kontraseptif dan proses pembuatan keputusan berkaitan kontraseptif (Kassa et al., 2022; Najafi-Sharjabad et al., 2014).

- Wanita yang mempunyai lebih daripada 4 orang anak di negara ini berkemungkinan hampir 3 kali ganda untuk menggunakan kontraseptif (Mansor & Lim Abdullah, 2015).

- Suami sering berperanan sebagai pembuat keputusan utama mengenai niat kesuburan dan penggunaan kontraseptif (Kassa et al., 2022; Kabagenyi et al., 2014).

- Subfertiliti dalam kalangan golongan lelaki mengancam identiti sosial dan maskuliniti, mendorong kepada penyembunyian dan penglibatan rendah dalam rawatan subfertiliti (Liyanage et al., 2024; Iwelumor et al., 2019).

- Tekanan keluarga khususnya mentua mengukuhkan jangkaan kesuburan dan mengehadkan autonomi dalam keputusan kontraseptif dan rawatan subfertiliti (Lawrenz et al., 2019; Iwelumor et al., 2019; Pradhan & Mondal, 2023).

- Peningkatan komunikasi suami-isteri meningkatkan kebarangkalian penggunaan kaedah moden (Najafi-Sharjabad et al., 2014).

- Walaupun wanita sering memulakaan penggunaan kontraseptif, lelaki lebih kerap membuat keputusan muktamad terhadap pemilihan kaedah dan kesinambungan penggunaannya di negara ini (Tong et al, 2014; Low et al, 2026).

- Jangkaan tradisional bahawa keibuan menandakan kebahagiaan rumah tangga turut menjadikan persetujuan lelaki sebagai pra-syarat penggunaan kontraseptif (Wong et al., 2009).

- Ketakutan berterusan terhadap kesan sampingan dan persepsi risiko subfertiliti akibat kontraseptif terus mengekang penggunaan terutama dalam rumah tangga yang mengekalkan dominasi lelaki dan keputusan reproduktif (Wong et al., 2009; Mansor & Lim Abdullah, 2015).

- Kadar penggunaan kontraseptif adalah lebih tinggi serta pilihan kaedah yang pelbagai dalam kalangan wanita bandar (Samat et al., 2021; Tey & Abdurahman, 1981).

- Jarak bertindak sebagai penghalang utama di mana wanita yang tinggal lebih 60 kilometer daripada pusat rawatan kesuburan mencatatkan kadar penggunaan yang jauh lebih rendah (Lazzari et al., 2022).

- Komuniti luar bandar sering berhadapan dengan kos pengangkutan yang lebih tinggi, kesinambungan penjagaan yang terganggu, serta akses terhad kepada pilihan kontraseptif (Freitas et al., 2024; Goncalves et al., 2025).

- Perkhidmatan reproduktif khusus seperti rawatan kesuburan tertumpu di hospital tertiari di kawasan bandar utama, lalu mewujudkan jurang akses yang lebih ketara bagi penduduk di kawasan kurang membangun (Ali et al., 2024).

- Faktor yang menghalang penggunaan termasuk kebimbangan terhadap kesan sampingan, kaunseling yang tidak mencukupi dan kurang penglibatan pasangan (Lee et al., 2019; Hafizah et al., 2020).

Faktor Sosiobudaya

- Kepercayaan agama khususnya nilai Islam konservatif mempengaruhi persepsi terhadap seksualiti pra-perkahwinan, saiz keluarga dan tahap penerimaan terhadap kaedah kontraseptif moden (Wong, 2012a; Alomair et al., 2020).

- Identiti etnik menyumbang kepada variasi dalam pengetahuan kesihatan reproduktif dan autonomi dengan wanita Melayu Islam berdepan stigma negatif berbanding wanita Cina dan India (Wong, 2012b; Najafi-Sharjabad et al., 2014).

- Walaupun terdapat kepelbagaian tafsiran dan sebahagian wanita Islam menerima kontraseptif bagi tujuan penjarakan anak, usaha mengehadkan bilangan anak sering dinilai secara negatif (Abdi et al., 2020).

- Kekangan sistemik mengehadkan akses kepada perkhidmatan, pilihan kontraseptif dan kaunseling reproduktif kepada wanita berisiko (Sukeri et al., 2023).

- Kebolehcapaian terjejas apabila komuniti luar bandar berdepan dengan kekurangan kemudahan, keupayaan perkhidmatan dan kos kewangan yang tinggi (Cheong et al., 2021; Loganathan et al., 2020; Sawadogo et al., 2023).

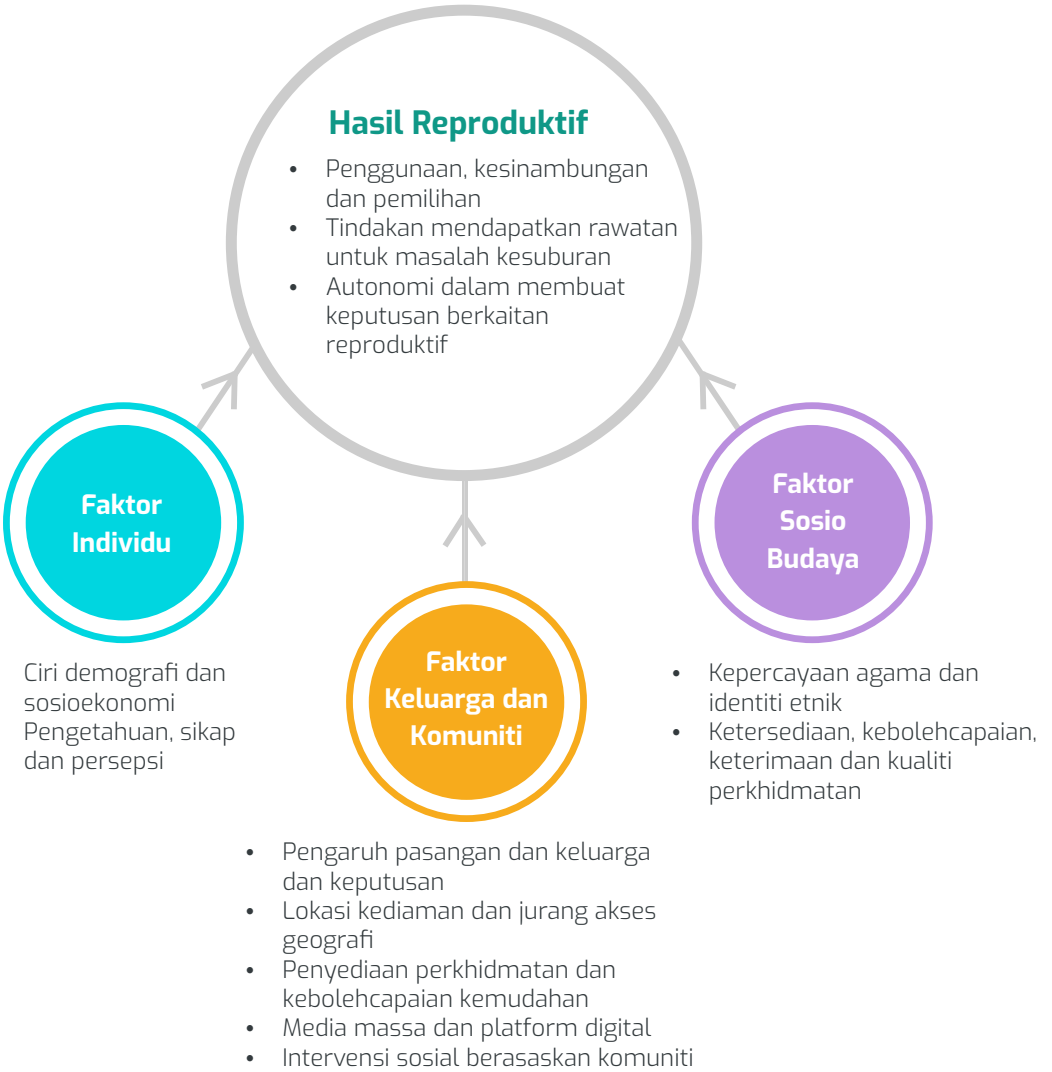
- Ketersediaan masih terhad akibat kekurangan dan agihan tidak sekata dari aspek tenaga kerja dan bekalan kontraseptif (Homer et al., 2018).

- Halangan bahasa, ketidakselarasan budaya dan diskriminasi membebankan penduduk terpinggir secara tidak seimbang (Quayson et al., 2018).

- Kebolehcapaian terjejas apabila komuniti luar bandar berdepan dengan kekurangan kemudahan, keupayaan perkhidmatan dan kos kewangan yang tinggi (Cheong et al., 2021; Loganathan et al., 2020; Sawadogo et al., 2023).

- Stigma subfertiliti mencetus tekanan psikologi dalam komuniti (Hussain et al., 2020).

Faktor-faktor Yang Mempengaruhi Amalan Penggunaan Kontraseptif Dan Rawatan Subfertiliti



Kerangka Konsep - Faktor yang Mempengaruhi Amalan Perancang Keluarga di Malaysia

Pelaksanaan Program Perancang Keluarga

Filipina

CPR 58% 2022

TFR 1.9 2023

UMN 12% 2022



Filipina melaksanakan dasar perancang keluarga bagi menangani pertumbuhan penduduk yang pesat dan kadar kesuburan yang tinggi, dengan penekanan kepada peningkatan kesejahteraan keluarga serta kesihatan ibu dan anak. Dasar ini berteraskan prinsip *responsible parenthood*, iaitu keupayaan keluarga membuat keputusan reproduktif secara bijaksana mengikut kapasiti sosioekonomi.

Program perancang keluarga di Filipina mula dilaksanakan secara rasmi pada akhir 1960-an, khususnya dengan pengenalan dasar nasional pada tahun 1969 serta pelancaran Philippine Population Program pada tahun 1970 melalui Executive Order No. 233. Pelaksanaan program ini diperkukuh lagi pada awal 1970-an melalui penubuhan Commission on Population (POPCOM) sebagai badan penyelaras utama di peringkat nasional. Usaha jangka panjang dasar ini bertujuan mencapai pertumbuhan penduduk yang seimbang serta memperkukuh pembangunan modal insan melalui pembentukan keluarga berkualiti.

Kerangka perundangan perancang keluarga Filipina diperkukuh melalui penggubalan Responsible Parenthood and Reproductive Health Act (RA 10354, 2012) yang menjamin akses menyeluruh kepada perkhidmatan kesihatan reproduktif, termasuk kontraseptif dan penjagaan ibu dan anak. Pelaksanaan dasar disokong oleh integrasi perkhidmatan dalam sistem kesihatan awam, pendidikan kesihatan reproduktif di sekolah, penyediaan subsidi kontraseptif, serta kolaborasi antara agensi kerajaan, pihak berkuasa tempatan dan NGO. Pendekatan ini memperluas capaian perkhidmatan khususnya kepada komuniti kurang berkemampuan dan kawasan terpencil.

Program perancang keluarga Filipina menunjukkan kemajuan ketara apabila kadar kesuburan telah menurun kepada sekitar 1.9 anak per wanita, iaitu di bawah paras penggantian, manakala penggunaan kaedah kontraseptif moden terus meningkat dalam kalangan wanita usia reproduktif. Selain itu, lebih daripada sembilan juta rakyat Filipina kini menggunakan kaedah perancang keluarga, yang menyumbang kepada penurunan kadar pertumbuhan penduduk kepada sekitar 0.8% bagi tempoh 2020 hingga 2024.

Walau bagaimanapun, cabaran masih wujud termasuk ketidaksamaan akses antara wilayah, keperluan perancang keluarga yang belum dipenuhi serta peningkatan isu kehamilan remaja yang memerlukan intervensi lebih bersasar.

Singapura

CPR 62% 1997

TFR 1.0 2023

UMN 10% 2023



Dasar perancang keluarga di Singapura bermula sebagai usaha mengawal pertumbuhan penduduk yang tinggi pada era 1960-an bagi melindungi kestabilan ekonomi dan sumber negara. Melalui penyediaan akses kontraseptif serta perkhidmatan kesihatan ibu dan anak, dasar ini berjaya menurunkan kadar kesuburan dengan ketara. Kerangka institusi seperti Singapore Family Planning Association (SFPA) dan Singapore Family Planning and Population Board (SFPPB), bersama dasar perundangan seperti Two-Child Policy serta Akta Penamatan Kehamilan dan Pensterilan (1974), menjadi asas utama kejayaan kawalan kelahiran negara tersebut.

Namun, kejayaan ini membawa kepada penurunan kadar kesuburan di bawah paras penggantian penduduk, menyebabkan Singapura beralih kepada dasar pronatalis bermula akhir 1980-an. Kerajaan memperkenalkan pelbagai sokongan mesra keluarga seperti Marriage and Parenthood Package, insentif kewangan, subsidi penjagaan anak, cuti ibu bapa, serta pembiayaan rawatan kesuburan melalui skim ART. Singapura berdepan cabaran serius apabila kadar kesuburan negara jatuh ke paras sangat rendah sekitar 0.87 pada tahun 2025 - yang merupakan rekod terendah negara - sekali gus menunjukkan bahawa langkah pronatalis sedia ada masih belum mencukupi untuk meningkatkan kadar kelahiran. Situasi ini mendorong kerajaan untuk terus menilai semula dasar sokongan keluarga dan memperkenalkan pendekatan baharu bagi menangani perubahan sikap terhadap perkahwinan dan keibubapaan serta isu kos sara hidup yang semakin meningkat.

Thailand

CPR 73% 2022

TFR 1.2 2023

UMN 9% 2022



Thailand merupakan antara negara ASEAN yang paling berjaya melaksanakan program perancang keluarga secara menyeluruh sejak awal 1970-an melalui National Family Planning Program (NFPP). Objektif utama dasar ini ialah mengurangkan kadar pertumbuhan penduduk dengan mempromosikan penggunaan kontraseptif secara meluas, khususnya melalui pendekatan berasaskan komuniti. Kejayaan NFPP dipacu oleh strategi inovatif seperti penglibatan sukarelawan kesihatan komuniti dan integrasi perkhidmatan perancang keluarga ke dalam sistem kesihatan primer, sekali gus memastikan akses yang meluas tanpa mengira lokasi geografi atau latar belakang sosioekonomi.

Seiring perubahan cabaran kesihatan awam, Thailand memperkenalkan Dasar Kesihatan Reproduktif Nasional 2010–2020 yang memberi penekanan kepada akses kesihatan reproduktif secara inklusif, khususnya bagi golongan terpinggir seperti remaja dan wanita muda. Dasar ini menekankan pendidikan kesihatan seksual dan reproduktif, kaunseling serta kepelbagaian kaedah kontraseptif bagi mengurangkan keperluan tidak dipenuhi (*unmet need*).

Thailand mencatat kadar penggunaan kontraseptif yang tinggi dalam kalangan wanita berkahwin, iaitu sekitar 70% menggunakan sekurang-kurangnya satu kaedah, mencerminkan keberkesanan program jangka panjang negara ini. Namun, kadar kesuburan negara telah menurun dengan ketara kepada sekitar 1.2–1.5 anak per wanita, jauh di bawah paras penggantian, menjadikan Thailand sebuah masyarakat menua dan berdepan penyusutan penduduk. Situasi ini menunjukkan bahawa fokus dasar kini semakin beralih daripada kawalan kelahiran kepada pengurusan impak demografi seperti penuaan penduduk dan kekurangan tenaga kerja.

Jepun

CPR 58% — 2021

TFR 1.2 — 2023

UMN 15% — 2023



Dasar perancang keluarga di Jepun dibangunkan dengan penekanan kepada integrasi perkhidmatan perancang keluarga bersama penjagaan kesihatan ibu dan anak, di samping menangani cabaran kadar kelahiran yang semakin menurun. Pendekatan ini mula berkembang sejak era pasca Perang Dunia Kedua, khususnya sekitar awal 1950-an apabila gerakan perancang keluarga diperkenalkan secara meluas melalui penubuhan Japan Family Planning Association pada tahun 1954. Objektif utama dasar ini bukan sahaja memastikan akses kepada kontraseptif dan kaunseling kesihatan

reproduktif, tetapi juga membentuk persekitaran sosial yang menyokong kesejahteraan keluarga. Pendekatan ini melihat perancang keluarga sebagai sebahagian daripada sistem sokongan menyeluruh bagi membolehkan individu dan pasangan mengimbangi tanggungjawab pekerjaan serta kehidupan berkeluarga.

Kerangka perundangan Jepun diperkukuh melalui Undang-Undang Kesihatan Ibu dan Anak 1965 serta Basic Law on Measures for Society with Decreasing Birthrate 2003. Undang-undang ini mengintegrasikan perkhidmatan perancang keluarga dengan penjagaan pra dan pasca kelahiran serta memperkenalkan langkah mesra keluarga seperti cuti ibu bapa, keseimbangan kerja-kehidupan dan kesinambungan akses kontraseptif. Pelaksanaan dasar ini berdepan cabaran berterusan apabila kadar kesuburan Jepun kekal sangat rendah, sekitar 1.15 pada tahun 2024, sekali gus mencerminkan kegagalan relatif dasar dalam meningkatkan kelahiran walaupun pelbagai intervensi telah diperkenalkan. Situasi ini menunjukkan bahawa pendekatan perancang keluarga di Jepun telah beralih daripada kawalan penduduk kepada usaha menyokong peningkatan kadar kelahiran dalam konteks masyarakat menua dan penurunan saiz penduduk.

Belanda





Dasar perancang keluarga di Belanda berteraskan pendekatan progresif yang menekankan hak reproduktif, autonomi individu dan akses sejagat kepada perkhidmatan kesihatan reproduktif. Perkhidmatan perancang keluarga tidak dilaksanakan secara terasing, sebaliknya diintegrasikan sepenuhnya dalam sistem kesihatan awam nasional berasaskan prinsip perlindungan kesihatan sejagat. Pendekatan ini memastikan setiap individu, tanpa mengira jantina, umur atau latar belakang sosioekonomi, mempunyai akses kepada maklumat, pendidikan dan kaedah kontraseptif yang diperlukan bagi membuat keputusan reproduktif secara bermaklumat.

Walaupun Belanda tidak mempunyai undang-undang khusus berkaitan perancang keluarga, perlindungan melalui sistem insurans kesihatan nasional serta kerjasama erat dengan NGO seperti Program Rutgers memperkukuh pelaksanaan dasar ini. Strategi utama merangkumi pendidikan seks komprehensif di sekolah, akses meluas kepada kontraseptif moden termasuk kaedah jangka panjang (LARC), serta sokongan pembiayaan rawatan kesuburan seperti IVF dan ICSI.

Indonesia

CPR 53% 2023

TFR 2.1 2023

UMN 11% 2017



Dasar perancang keluarga di Indonesia dilaksanakan melalui Program Perancang Keluarga Nasional dengan objektif utama mengurangkan kadar kesuburan, memperbaiki kesihatan reproduktif dan mewujudkan keseimbangan pembangunan kependudukan. Program ini mula dilaksanakan secara rasmi pada tahun 1970 melalui penubuhan Badan Kependudukan dan Keluarga Berencana Nasional (BKKBN) sebagai agensi utama penyelaras dasar perancang keluarga di peringkat nasional. Program ini dibangunkan bagi menangani pertumbuhan penduduk yang pesat yang berpotensi menjejaskan pembangunan sosioekonomi negara. Pendekatan dasar turut memberi penekanan kepada peluasan capaian perkhidmatan kesihatan reproduktif agar dapat dinikmati oleh semua lapisan masyarakat, khususnya golongan luar bandar dan komuniti sukar dicapai.

Kerangka perundangan dan institusi perancang keluarga Indonesia diperkukuh melalui penubuhan BKKBN serta penggubalan Undang-Undang Pembangunan Kependudukan dan Keluarga No. 52/2009. Pelaksanaan dasar disokong oleh strategi berasaskan komuniti melalui peranan kader kesihatan, kempen media berskala besar, penyediaan pelbagai kaedah kontraseptif termasuk kaedah jangka panjang, serta usaha meningkatkan penglibatan lelaki dalam perancang keluarga. Struktur institusi ini turut mengalami penstrukturan semula apabila BKKBN diperluas fungsinya dan digabungkan di bawah Kementerian Kependudukan dan Pembangunan Keluarga (Kemendukbangga) pada tahun 2024 bagi memperkukuh penyelarasan dasar kependudukan dan pembangunan keluarga secara lebih holistik.

Turkiye

CPR 70% 2018

TFR 1.5 2023

UMN 12% 2018

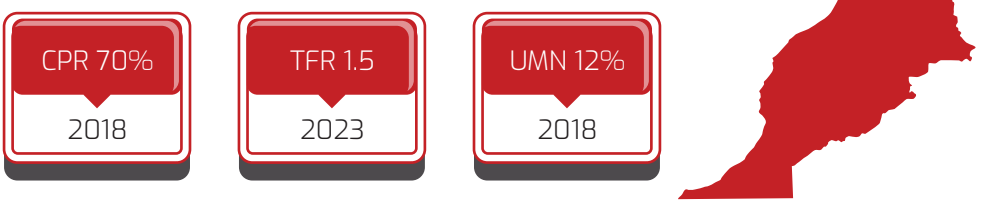


Dasar perancang keluarga di Turkiye bermula dengan penggubalan Undang-Undang Perancangan Populasi No. 557 pada tahun 1965, yang mengiktiraf kesan negatif pertumbuhan penduduk yang pesat terhadap pembangunan ekonomi serta kesihatan ibu dan anak. Dasar ini menandakan perubahan penting apabila penggunaan kontraseptif dibenarkan secara rasmi dan perancang keluarga dijadikan sebahagian

daripada agenda pembangunan negara sejajar dengan proses pemodenan. Pendekatan ini menekankan bahawa pengurusan kesuburan bukan sekadar isu peribadi, tetapi berkait rapat dengan kesejahteraan nasional dan kemajuan kesihatan awam.

Dari segi pelaksanaan, perancang keluarga diintegrasikan ke dalam sistem kesihatan nasional dengan sokongan kuat Kementerian Kesihatan, disertai strategi komunikasi awam yang konsisten dan persuasif. Kempen melalui media, poster dan pendekatan bersemuka digunakan bagi membentuk kesedaran serta mengubah norma budaya terhadap saiz keluarga. Kadar penggunaan kontraseptif moden di Turkiye masih sederhana dengan hanya sekitar satu pertiga hingga separuh wanita berkahwin menggunakan kaedah moden, dan terdapat keperluan yang tidak dipenuhi yang ketara, sementara negara menghadapi kadar kesuburan yang rendah dan terus menurun jauh di bawah paras penggantian, menunjukkan bahawa cabaran akses, norma budaya, dan keperluan belum dipenuhi masih wujud meskipun program telah bertahan beberapa dekad.

Maghribi



Dasar perancang keluarga di Maghribi bermula pada era 1960-an sebagai respons kepada pertumbuhan penduduk yang pesat dan kadar kesuburan yang sangat tinggi. Objektif awal dasar ini adalah untuk memperlahankan pertumbuhan penduduk dengan mengurangkan kadar kesuburan serta meningkatkan kesihatan ibu dan anak, selaras dengan keperluan pembangunan ekonomi negara. Seiring masa, perancang keluarga di Maghribi berkembang menjadi strategi pembangunan sosial yang lebih menyeluruh, dengan penekanan kepada kesejahteraan keluarga serta pemerkasaan wanita melalui pendidikan dan penyertaan dalam tenaga kerja.

Dari segi pelaksanaan, perancang keluarga diintegrasikan ke dalam sistem kesihatan awam tanpa sokongan perundangan khusus pada peringkat awal, namun diperkukuh melalui peranan aktif Kementerian Kesihatan serta sokongan rakan antarabangsa. Strategi utama merangkumi penyediaan kontraseptif secara percuma di fasiliti kesihatan awam, kempen kesedaran melalui media dan pemimpin komuniti, serta penglibatan pasangan dalam membuat keputusan reproduktif. Kadar penggunaan kontraseptif moden di Maghribi adalah tinggi di kalangan wanita yang sudah berkahwin, dengan lebih 70% menggunakan sesuatu bentuk kontraseptif dan kebanyakan memilih pil sebagai kaedah utama, manakala kadar kesuburan negara telah menurun ketara kepada sekitar 2.1 hingga 2.4 orang anak bagi setiap wanita, menunjukkan kejayaan

agenda perancangan keluarga sambil menangani jurang akses di kawasan luar bandar dan persepsi budaya terhadap kaedah tertentu.

Mesir

CPR 59% 2014

TFR 2.8 2023

UMN 13% 2014



Dasar perancang keluarga di Mesir bermula secara tidak formal pada tahun 1950-an melalui klinik sukarela sektor swasta sebelum berkembang menjadi dasar nasional apabila pertumbuhan penduduk yang pesat mula dilihat sebagai ancaman terhadap pembangunan ekonomi negara. Titik perubahan utama berlaku pada tahun 1962 apabila kerajaan secara rasmi menyokong perancang keluarga sebagai agenda nasional. Sejak itu, dasar ini memberi tumpuan kepada pengurangan kadar kelahiran melalui penyediaan perkhidmatan kesihatan reproduktif, dengan penekanan bahawa isu kependudukan berkait rapat dengan kemajuan ekonomi dan kesejahteraan sosial.

Kerangka institusi Mesir diperkukuh melalui penubuhan Majlis Tertinggi Penduduk dan Perancang Keluarga pada 1965 yang kemudiannya berkembang menjadi National Population Council (NPC), berperanan menyelaras dasar dan pelaksanaan antara pelbagai kementerian serta rakan antarabangsa. Strategi pelaksanaan merangkumi integrasi perancang keluarga dalam sistem kesihatan awam, penyediaan kontraseptif pada kos rendah atau percuma, latihan intensif petugas kesihatan serta kempen komunikasi awam berskala besar melalui media massa. Program perancang keluarga Mesir terus beroperasi sebagai komponen utama dasar kependudukan, dengan kadar penggunaan kontraseptif yang meningkat secara beransur-ansur dan usaha untuk mengurangkan jurang akses di kawasan luar bandar, namun kadar fertiliti domestik masih sekitar 3.1 hingga 3.5 anak per wanita dan keperluan belum dipenuhi kekal tinggi di kalangan sesetengah kumpulan, terutamanya golongan remaja dan kawasan kurang berkemampuan.

Bangladesh

CPR 64% 2022

TFR 2.2 2023

UMN 10% 2022



Bangladesh melaksanakan dasar perancang keluarga secara agresif sejak 1970-an bagi mengekang pertumbuhan penduduk yang sangat tinggi serta meningkatkan kesihatan ibu dan anak. Pelaburan besar dalam program perancang keluarga berasaskan komuniti terbukti berjaya menurunkan kadar kesuburan secara konsisten, daripada sekitar enam kelahiran bagi setiap wanita pada 1970-an kepada hampir paras penggantian dalam dekad kebelakangan ini. Kejayaan ini dikaitkan dengan peluasan akses kontraseptif moden, strategi komunikasi komuniti yang berkesan serta integrasi perancang keluarga dalam agenda pembangunan negara.

Kadar penggunaan kontraseptif moden di Bangladesh kekal tinggi dengan lebih 60% wanita berkahwin menggunakan sesuatu bentuk kontraseptif, namun terdapat variasi serantau dan keperluan belum dipenuhi terutama dalam kalangan remaja dan kawasan luar bandar, di mana kadar penggunaan masih rendah dan program baru seperti National Family Planning Strategy 2025–2030 dilancarkan untuk menangani isu ini. Dari segi institusi, pelaksanaan dasar diselaraskan oleh Kementerian Kesihatan dan Kebajikan Keluarga dengan sokongan kuat rangkaian pekerja komuniti wanita yang dikenali sebagai Family Welfare Assistants (FWA). Strategi utama seperti *doorstep delivery* membolehkan perkhidmatan kaunseling dan kontraseptif disampaikan terus ke rumah, sekali gus mengatasi halangan budaya dan akses, khususnya di kawasan luar bandar.

Australia





Dasar perancang keluarga di Australia menekankan akses saksama kepada perkhidmatan kesihatan reproduktif sebagai sebahagian daripada sistem kesihatan sejagat. Objektif utama dasar ini ialah memastikan semua lapisan masyarakat, khususnya komuniti terpencil serta masyarakat Aboriginal dan Torres Strait Islander, mendapat akses kepada kaedah kontraseptif yang selamat, berkesan dan mampu milik. Pergerakan dan dasar perancang keluarga moden di Australia berkembang sejak awal abad ke-20 melalui pertubuhan badan seperti Family Planning Australia (ditubuhkan 1926) dan pada 1970-an apabila kaedah kontraseptif moden, termasuk pil, mula diperluaskan kepada semua wanita tanpa syarat perkahwinan, membantu mengukuhkan akses perancangan keluarga secara formal. Australia mengiktiraf kepelbagaian keperluan reproduktif berdasarkan konteks geografi dan budaya, dan komited untuk mengurangkan jurang ketidaksamaan kesihatan antara komuniti *indigenous* dan populasi umum.

Kerangka perundangan Australia disokong melalui Pharmaceutical Benefits Scheme (PBS) yang menyediakan subsidi kontraseptif, serta program khusus seperti Remote Area Aboriginal Health Services (RAAHS) dan Closing the Gap PBS Co-payment bagi meningkatkan akses dalam kalangan komuniti *indigenous*. Dari segi pelaksanaan, strategi utama merangkumi penggunaan perkhidmatan kesihatan mudah alih, teleperubatan, klinik satelit di kawasan terpencil serta peluasan peranan farmasi komuniti. Usaha perancang keluarga terus diperkukuh dengan inisiatif untuk menjadikan kontraseptif lebih mampu milik melalui PBS serta kempen kesihatan reproduktif yang disasarkan, sambil Australia turut menghadapi cabaran demografi seperti kadar kesuburan rendah dan keperluan meningkatkan kesedaran serta capaian di kalangan komuniti terpinggir.

Mexico





Dasar perancang keluarga di Mexico dilaksanakan melalui pendekatan komprehensif dengan matlamat utama meningkatkan kesihatan reproduktif, memperluas akses kepada kontraseptif khususnya dalam kalangan golongan berpendapatan rendah, serta menangani isu kehamilan remaja. Program perancangan keluarga negara mula dibangunkan pada awal 1970-an apabila kerajaan mengubah dasar populasi, termasuk pindaan Perlembagaan pada 1974 yang menjamin hak setiap pasangan untuk membuat keputusan reproduktif, dan pelancaran Programa Nacional de Planificación Familiar pada 1977 sebagai program nasional rasmi.

Kerangka perundangan Mexico diperkukuh melalui Program Nasional Kependudukan, Undang-Undang Kesihatan Am 1984 yang mewajibkan integrasi perancang keluarga dalam penjagaan kesihatan primer, serta Strategi Nasional Pencegahan Kehamilan Remaja (ENAPEA). Pelaksanaan dasar menekankan jangkauan komuniti, pendidikan kesihatan seksual dan reproduktif, serta pengagihan kontraseptif secara percuma kepada golongan sasar. Kadar penggunaan kontraseptif moden di Mexico adalah relatif tinggi dan kadar kesuburan telah menurun kepada hampir paras penggantian, namun terdapat jurang akses antara kawasan bandar dan luar bandar serta dalam komuniti peribumi, dan usaha pendidikan serta perluasan perkhidmatan terus menjadi fokus dasar demi menangani isu kehamilan remaja dan ketidaksamaan kesihatan reproduktif di beberapa kawasan.

Jerman

CPR 68%
2023

TFR 1.4
2023

UMN 9%
2023

Dasar perancang keluarga di Jerman merupakan sebahagian daripada sistem penjagaan kesihatan universal yang menekankan hak reproduktif dan autonomi individu. Pendekatan ini berkembang secara formal sejak pertengahan abad ke-20, dengan pendidikan seks dan informasi kontraseptif disokong secara undang-undang melalui Akta Pendidikan Seksual pada 1995, sementara akses kontraseptif moden dan kaunseling terus berkembang sejak 1970-an dan 1980-an sebagai sebahagian daripada dasar kesihatan awam dan hak reproduktif. Objektif utama dasar ini ialah memastikan akses saksama kepada kontraseptif, khususnya dalam kalangan golongan muda, di samping memperkukuh pendidikan kesihatan seksual dan reproduktif yang komprehensif. Pendekatan ini bertujuan membolehkan individu membuat keputusan reproduktif yang bermaklumat, bebas stigma dan berasaskan maklumat sahih sejak usia muda.

Kerangka perundangan Jerman diperkukuh melalui skim insurans kesihatan wajib yang menyediakan perlindungan kontraseptif berasaskan umur, serta perkhidmatan kaunseling kesihatan seksual dan reproduktif secara percuma dan tanpa pendedahan identiti seperti yang diperuntukkan di bawah SchKG. Strategi pelaksanaan melibatkan pendidikan seksual yang sistematik di sekolah, rangkaian kaunseling awam dan NGO seperti Pro Familia, serta ketersediaan pelbagai kaedah kontraseptif termasuk pil kecemasan tanpa preskripsi.

Penggunaan kontraseptif di Jerman adalah tinggi dengan sekitar 76% orang dewasa yang aktif secara seksual melaporkan menggunakan kontraseptif – paras tertinggi sejak lebih sepuluh tahun – dan hampir 87% remaja dan dewasa muda menggunakan kaedah semasa hubungan seksual; ini mencerminkan keberkesanan pendidikan seks dan akses serviks, meskipun pilihan kaedah berubah (contoh: pil sedikit menurun sementara penggunaan kondom kekal dominan).

Perancis

CPR 78% 2023

TFR 1.7 2023

UMN 4% 2023



Kerangka perundangan dan institusi Perancis menyokong penyediaan kontraseptif percuma secara meluas, termasuk pil kecemasan tanpa preskripsi untuk semua wanita serta kondom percuma bagi individu di bawah umur 26 tahun. Pelaksanaan dasar diperkukuh melalui skim Jaminan Sosial Perancis (Assurance Maladie) dengan pembiayaan penuh bagi golongan muda, penyediaan perkhidmatan di pusat perancang keluarga serta kempen kesedaran awam yang komprehensif. Perancis terus memperluas akses, termasuk memperkenalkan kontraseptif percuma untuk wanita sehingga umur 25 tahun melalui dasar baru sejak 2022, sebagai langkah menangani halangan kewangan terhadap penggunaan kontraseptif oleh golongan muda sambil mengekalkan tahap penggunaan kaedah moden yang tinggi, walaupun jurang akses masih berlaku dalam sesetengah komuniti.

United Kingdom

CPR 76% 2023

TFR 1.6 2023

UMN 7% 2023



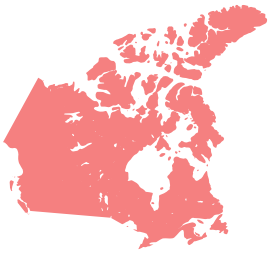
Dasar perancang keluarga di United Kingdom dilaksanakan melalui penyediaan akses percuma dan universal kepada kontraseptif di bawah National Health Service (NHS). Dasar akses perancang keluarga NHS ini bermula secara formal dengan penggubalan National Health Service (Family Planning) Act pada tahun 1967, yang memperluas perkhidmatan kontraseptif melalui NHS kepada semua, termasuk golongan muda dan bukan hanya mereka yang berisiko. Objektif utama dasar ini ialah memastikan semua penduduk, termasuk golongan muda dan remaja di bawah umur 16 tahun, mempunyai akses kepada perkhidmatan kontraseptif tanpa diskriminasi dan tanpa pendedahan identiti. Pendekatan ini menegaskan bahawa kesihatan reproduktif merupakan hak asas yang perlu dilindungi oleh sistem kesihatan awam, tanpa mengira umur, status sosial atau lokasi geografi.

Kerangka perundangan dan institusi UK memastikan semua kaedah kontraseptif, termasuk pil kontraseptif kecemasan, dibekalkan secara percuma melalui fasiliti NHS, klinik perancang keluarga dan farmasi komuniti. Pelaksanaan dasar diperkukuh

melalui NHS Pharmacy Contraception Service (PCS) serta inovasi perkhidmatan seperti teleperubatan dan konsultasi atas talian, khususnya semasa pandemik COVID-19. Akses kepada perkhidmatan kontraseptif tetap percuma melalui NHS dengan pelbagai saluran (GP, klinik seksual & reproduktif, farmasi), dan usaha peningkatan akses seperti pengedaran pil kecemasan secara percuma di hampir 10,000 farmasi telah dilaksanakan untuk mengurangkan jurang perkhidmatan, walaupun beberapa kajian menunjukkan masih wujud halangan praktikal seperti masa menunggu dan variasi capaian di peringkat tempatan.

Kanada





Dasar perancang keluarga di Kanada berteraskan komitmen kepada akses universal kontraseptif sebagai sebahagian daripada sistem kesihatan awam dan hak kesihatan reproduktif. Objektif utama dasar ini ialah memastikan semua rakyat Kanada, tanpa mengira lokasi geografi atau status sosioekonomi, mempunyai akses kepada kaedah kontraseptif yang selamat, berkesan dan mampu milik. Kanada mengiktiraf bahawa akses kepada kontraseptif bukan sahaja isu kesihatan awam, tetapi juga hak asasi manusia yang penting dalam menyokong kesejahteraan individu dan perancangan kehidupan keluarga.

Kerangka perundangan Kanada diperkukuh melalui pengenalan Bill C-64 (Pharmacare Nasional) yang memberi keutamaan kepada perkhidmatan kontraseptif dan bertujuan menyediakan akses universal, serta pelaksanaan peringkat wilayah seperti di British Columbia yang menyediakan kontraseptif percuma dan melindungi prosedur sterilisasi di bawah insurans kesihatan. Strategi pelaksanaan menekankan kerjasama antara kerajaan persekutuan dan wilayah, penyediaan akses tanpa pendedahan identiti khususnya bagi golongan muda, serta pendekatan berasaskan bukti yang menunjukkan pulangan pelaburan positif melalui pengurangan kos berkaitan kehamilan tidak diingini.

Dengan penggubalan Pharmacare Act dan perjanjian antara kerajaan persekutuan dan beberapa wilayah untuk perlindungan kontraseptif secara universal, Kanada sedang bergerak ke arah akses kontraseptif percuma bagi rakyatnya, meskipun pelaksanaan penuh masih bergantung kepada rundingan dan kerjasama dengan wilayah lain serta kekal terdapat jurang akses di sesetengah kawasan.



Penemuan Kajian



Foto : Mikhail Maslov / Pexels

Isu Dan Cabaran Berkaitan Amalan Perancang Keluarga

Isu dan Cabaran #1:

Pengetahuan Kontraseptif Asas Tinggi, Namun Belum Menyeluruh Bagi Kaedah Kurang Lazim

Lebih 80% responden mengetahui kaedah kontraseptif asas seperti pil, suntikan, implan dan azal. Namun, pengetahuan terhadap kaedah yang kurang lazim digunakan seperti tampalan hormon, ligasi tiub dan gegelang vagina masih terhad kepada sekitar separuh responden wanita berkahwin. Secara keseluruhan, hampir dua pertiga responden wanita berkahwin mempunyai pengetahuan yang tidak mencukupi mengenai penggunaan kontraseptif.

Dapatan kualitatif turut menunjukkan bahawa sumber maklumat kontraseptif banyak diperoleh secara tidak formal, terutamanya melalui internet, media sosial, pengalaman orang lain dan carian Google, selain petugas kesihatan. Kebergantungan kepada sumber digital dan rakan sebaya, serta kekeliruan pada peringkat awal perkahwinan, menyumbang kepada kelewatan membuat keputusan perancangan keluarga dan berlakunya kehamilan yang tidak dirancang.

Penemuan Kajian Kuantitatif

- Lebih daripada 80% responden wanita berkahwin yang mengetahui tentang kaedah kontraseptif utama seperti kondom (95.0%), pil (85.1%), suntikan (86.8%), implan (85.1%) dan azal (89.7%).

- Namun, hanya sekitar separuh responden wanita berkahwin yang mengetahui tentang kaedah kontraseptif seperti tampalan hormon (58.6%), ligasi tiub (55.6%) dan gegelang vagina (55.1%).

- Hampir dua pertiga responden wanita berkahwin tidak mempunyai pengetahuan yang mencukupi tentang penggunaan kaedah kontraseptif (pengetahuan rendah: 26.0%; pengetahuan sederhana: 36.3%).

Penemuan Kajian Kualitatif

"Semua maklumat saya tahu dari nurse dan Google" (Informan 15, 45 tahun, OKU penglihatan).

"Sumber saya seperti internet atau online platform, forum, TV/radio, Youtube/akaun rasmi kerajaan dan juga hospital. Selalu tengok IG, FB, TikTok tapi saya lebih pilih yang official dan doktor berdaftar" (Informan 18, 35 tahun).

"Biasanya internet ja.. Tengok pengalaman orang.. Tanya kawan-kawan" (Informan 24, 45 tahun).

"Maklumat utama dari [fasiliti kesihatan awam], buku pink, kalau tak jelas, tanya Google" (Informan 22, 38 tahun).

"Masa tu tak reti. Untuk awal kan tak boleh.. Lepas tu tak sempat rancang, dah mengandung" (Informan 23, 47 tahun).

Peratusan Wanita Yang Mengetahui Tentang Kaedah Kontraseptif Mengikut Status Perkahwinan

	Masih Berkahwin	Bercerai / Berpisah / Balu	Tidak Pernah Berkahwin	Jumlah
Kondom	95.0	92.9	87.2	92.0
Pil kontraseptif	85.1	83.3	70.5	80.9
Alat Dalam Rahim	89.1	90.5	66.8	79.6
Suntikan	86.8	85.7	60.1	76.8
Implan	85.1	83.3	56.1	74.2
Vasektomi	73.0	69.0	61.6	68.8
Pil Kontraseptif Kecemasan	70.0	78.6	59.8	66.6
Tampalan Hormon	58.6	64.3	39.9	51.9
Gegelang Vagina	55.1	66.7	44.6	51.7
Ligasi Tiub	55.6	66.7	44.6	52.0
Cara Waktu Selamat	92.9	90.5	80.2	88.0
Azal	89.7	88.1	54.8	76.7
Menyusu Badan	75.7	78.6	41.0	62.9

Soalan: Adakah anda tahu mengenai kaedah kontraseptif berikut?

Peratusan Wanita Mengikut Tahap Pengetahuan Mengenai Kaedah Kontraseptif Dan Ciri-Ciri Sosiodemografi

	Rendah	Sederhana	Tinggi	Jumlah
Tempat Kediaman				
Bandar	39.8	30.9	29.2	100.0
Luar Bandar	38.7	32.5	28.8	100.0
Status Perkahwinan				
Masih Berkahwin	26.0	36.3	37.7	100.0
Berpisah / Bercerai / Balu	23.8	45.2	31.0	100.0
Tidak Pernah Berkahwin	62.9	21.7	15.4	100.0
Etnik				
Melayu	37.4	32.0	30.6	100.0
Cina	54.0	25.3	20.7	100.0
India	37.5	33.3	29.2	100.0
Bumiputera Sabah	28.6	50.0	21.4	100.0
Bumiputera Sarawak	35.0	25.0	40.0	100.0
Pendapatan Isi Rumah				
Kurang Daripada RM2,500	62.6	23.2	14.2	100.0
RM2,500 – RM4,899	41.1	30.5	28.4	100.0
RM4,850 – RM10,959	29.6	34.5	36.0	100.0
RM10,960 dan Lebih	22.7	38.0	39.3	100.0
Keseluruhan	**39.7**	**31.2**	**29.2**	**100.0**

Nota: Tahap pengetahuan responden diukur berdasarkan sembilan (9) pernyataan. Skor antara 0-5 dikategorikan sebagai "rendah", skor 6-7 dikategorikan sebagai "sederhana", dan skor 8-9 dikategorikan sebagai "tinggi".

Soalan: Berdasarkan kenyataan yang berikut, sila tandakan Ya / Tidak / Tidak Pasti: (i) Kondom tidak boleh melewati tarikh luput; (ii) Alat dalam rahim (IUCD) tidak boleh digunakan oleh wanitanulliparous (wanita yang belum melahirkan bayi); (iii) vasektomi lelaki (prosedur pembedahan untuk pemandulan) dan penstrilan wanita (prosedur kekal untuk mencegah kehamilan) adalah kaedah kawalan kelahiran yang paling berkesan; (iv) Pil kontraseptif kecemasan diambil sejurus selepas mengadakan hubungan seks; (v) Wanita mesti mengambil pil perancang setiap hari bagi mengelakkan kehamilan; (vi) Suntikan kontraseptif diambil setiap 2 atau 3 bulan; (vii) Sepasang suami isteri boleh mengelakkan hubungan seks pada hari-hari subur di mana kehamilan berkemungkinan besar berlaku; (viii) Penggunaan kaedah kontraseptif adalah untuk mengurangkan bilangan anak; (ix) Penggunaan kaedah kontraseptif adalah untuk menjarakkan kehamilan.

Isu dan Cabaran #2:

Salah Tanggapan Terhadap Penggunaan Kontraseptif

Penemuan tinjauan menunjukkan bahawa salah tanggapan terhadap penggunaan kontraseptif masih meluas dalam kalangan wanita berkahwin. Sebahagian responden berpendapat penggunaan kondom mengurangkan keseronokan seksual dan kontraseptif boleh menjejaskan kesuburan, manakala hampir satu pertiga percaya bahawa perbincangan mengenai kontraseptif dengan golongan muda akan menggalakkan pergaulan bebas.

Dapatan kualitatif mengukuhkan penemuan kuantitatif, menunjukkan kebimbangan terhadap kesan hormon, pengalaman kesan sampingan, serta pengaruh pasangan sebagai faktor utama penolakan kontraseptif moden. Akibatnya, sebahagian wanita memilih kaedah tradisional atau mengelakkan penggunaan kontraseptif sama sekali, sekali gus menjejaskan keberkesanan perancangan keluarga dan meningkatkan risiko kehamilan tidak dirancang.

Penemuan Kajian Kuantitatif

- Lebih satu perempat (28.0%) responden wanita berkahwin berpendapat bahawa penggunaan kondom mengurangkan keseronokan dalam hubungan seks.

- Satu perlima (20.9%) responden wanita berkahwin berpendapat bahawa penggunaan kontraseptif boleh menjejaskan kesuburan.

- Lebih satu pertiga (35.3%) responden wanita berkahwin berpendapat bahawa perbincangan dengan golongan muda mengenai penggunaan kontraseptif akan menggalakkan pergaulan bebas.

Penemuan Kajian Kualitatif

"Saya tak percayakan diri sendiri kalau makan ubat.. Dari segi cucuk memang saya tak boleh. Suami pun tak galakkan ambil ubat" (Informan 22, 38 tahun).

"Sebab saya takut dia kacau dengan hormon.. Jadi saya tak ambil, saya guna kaedah tradisional" (Informan 33, 26 tahun).

"Dah pakai implan, cucuk pun kena. Lepas tu makan banyak. Period tak teratur tu biasa la kan" (Informan 25, 47 tahun).

Peratusan Wanita Berkahwin Yang Bersetuju Dengan Pernyataan Terpilih

	Peratusan
Penggunaan kontraseptif adalah bertentangan dengan kepercayaan agama dan nilai budaya.	6.5
Kontraseptif hanya penting untuk golongan wanita sahaja.	5.6
Penggunaan kondom mengurangkan keseronokan dalam hubungan intim.	21.4
Penggunaan kontraseptif boleh menjejaskan kesuburan pada masa hadapan.	21.4
Membincangkan kaedah kontraseptif seperti penggunaan kondom dengan golongan muda akan menggalakkan pergaulan bebas.	31.4
Penggunaan kontraseptif adalah penting untuk mengelakkan kehamilan yang tidak dirancang.	73.3
Jarak pendek antara kehamilan memberi kesan buruk kepada kesihatan ibu.	78.6

Soalan: Sejauh manakah anda bersetuju dengan pernyataan berikut? Sila tandakan Sangat Tidak Setuju / Tidak Setuju / Neutral / Setuju / Sangat Setuju.

Peratusan Wanita Mengikut Kategori Sikap Terhadap Kaedah Kontraseptif Dan Ciri-Ciri Sosiodemografi

	Negatif	Neutral	Positif	Jumlah
Tempat Kediaman				
Bandar	27.5	61.5	11.0	100.0
Luar Bandar	32.5	60.1	7.4	100.0
Status Perkahwinan				
Masih Berkahwin	26.3	63.7	9.9	100.0
Berpisah / Bercerai / Balu	31.0	59.5	9.5	100.0
Tidak Pernah Berkahwin	31.1	57.7	11.2	100.0
Etnik				
Melayu	29.5	62.0	8.5	100.0
Cina	22.0	61.3	16.7	100.0
India	16.7	60.4	22.9	100.0
Bumiputera Sabah	50.0	50.0	0.0	100.0
Bumiputera Sarawak	35.7	42.9	21.4	100.0
Pendapatan Isi Rumah				
Kurang Daripada RM2,500	43.1	50.4	6.5	100.0
RM2,500 – RM4,899	30.5	63.0	6.5	100.0
RM4,850 – RM10,959	21.3	66.2	12.5	100.0
RM10,960 dan Lebih	16.0	65.0	19.0	100.0
Keseluruhan	**28.3**	**61.3**	**10.4**	**100.0**

Nota: Kategori sikap responden diukur berdasarkan tujuh (7) pernyataan menggunakan skala Likert lima mata, daripada 1 (sangat tidak setuju) hingga 5 (sangat setuju). Kategori sikap ditentukan berdasarkan skor komposit yang diperoleh daripada kesemua pernyataan tersebut.

Soalan: Berdasarkan Soalan: Apakah pandangan anda mengenai amalan penggunaan kontraseptif? Sila tandakan Sangat Tidak Setuju / Tidak Setuju / Neutral / Setuju / Sangat Setuju: (i) Penggunaan kontraseptif adalah bertentangan dengan kepercayaan agama dan nilai budaya; (ii) Kontraseptif hanya penting untuk golongan wanita sahaja; (iii) Penggunaan kondom mengurangkan keseronokan dalam hubungan intim; (iv) Penggunaan kontraseptif boleh menjejaskan kesuburan pada masa hadapan; (v) Membincangkan kaedah kontraseptif seperti penggunaan kondom dengan golongan muda akan menggalakkan pergaulan bebas; (vi) Penggunaan kontraseptif adalah penting untuk mengelakkan kehamilan yang tidak dirancang; (vii) Jarak pendek antara kehamilan memberi kesan buruk kepada kesihatan ibu.

Isu dan Cabaran #3:

Amalan Penggunaan Kontraseptif Yang Rendah

Penemuan tinjauan menunjukkan bahawa amalan penggunaan kontraseptif dalam kalangan wanita berkahwin masih rendah dan tidak konsisten. Walaupun sebahagian besar pernah menggunakan kontraseptif, kurang separuh sedang menggunakannya, dan dalam kalangan pengguna semasa, kaedah bukan moden lebih dominan berbanding kaedah moden. Kondom dan IUCD merupakan kaedah moden paling kerap digunakan, manakala azal dan kaedah waktu selamat mendominasi kaedah bukan moden. Bagi wanita yang tidak menggunakan kontraseptif pada masa ini, alasan utama ialah keinginan untuk hamil, diikuti pengalaman atau kebimbangan terhadap kesan sampingan. Keputusan berkaitan penggunaan kontraseptif lazimnya dibuat bersama pasangan, namun hanya sebahagian kecil merancang untuk menggunakan kontraseptif pada masa hadapan.

Dapatan kualitatif menonjolkan peranan dinamik pasangan, tuntutan kerjaya, pengalaman kesihatan berisiko, akses subsidi, serta kepercayaan terhadap kaedah tradisional dalam membentuk corak penggunaan kontraseptif, sekali gus mencerminkan cabaran berlapis dalam menggalakkan amalan perancang keluarga yang berkesan.

Penemuan Kajian Kuantitatif

- Hanya 66.2% responden wanita berkahwin yang pernah menggunakan kontraseptif.
- Kurang separuh (45.4%) responden wanita berkahwin yang sedang menggunakan kontraseptif.
- Sebanyak 38.2% responden wanita berkahwin mereka menggunakan kaedah moden sementara baki 7.1% menggunakan kaedah bukan moden.
- Kondom dan alat dalam rahim (IUCD) adalah kaedah kontraseptif moden yang paling banyak digunakan oleh responden wanita berkahwin dengan masing-masing 12.3% dan 7.0%.
- Sementara itu, azal dan cara waktu selamat adalah kaedah kontraseptif bukan moden yang paling banyak digunakan dengan masing-masing 3.0% dan 3.8%.
- Dalam kalangan responden wanita berkahwin yang tidak menggunakan kontraseptif sekarang (tetapi pernah menggunakannya sebelum ini):
  - lebih 40% mereka memberikan alasan “ingin hamil” menyebabkan mereka tidak menggunakan kontraseptif semasa tinjauan dijalankan;
  - “pernah mengalami kesan sampingan” dan “berasa takut dengan kemungkinan berlaku kesan sampingan” turut merupakan sebab utama mereka tidak menggunakan kontraseptif dengan masing-masing 9.0% dan 8.2%

- hampir 60% mereka membuat keputusan tersebut (tidak menggunakan kontraseptif semasa tinjauan dijalankan) secara bersama dengan pasangan dan;
- hanya 32.5% sahaja mereka yang merancang untuk menggunakan kontraseptif pada masa akan datang.

Penemuan Kajian Kualitatif

"Saya dapat subsidi dari kerajaan, jadi tak perlu bayar implan" (Informan 16, 44 tahun, OKU fizikal).

"Saya buat keputusan sendiri, dengan nasihat doktor dan bincang dengan suami" (Informan 15, 45 tahun, OKU penglihatan).

"Saya dan suami tinggal berjauhan kerana kerja. Susah kalau ada lagi baby.. Tiada siapa bantu.. Career demand lagi" (Informan 14, 41 tahun)

"Suami tak bagi pakai kontraseptif.. Saya ikut saja.. Malas gaduh" (Informan 7, 45 tahun).

"Makan ubat. Makan jamu lah.. Apa lah.. Petua orang dulu-dulu" (Informan 25, 47 tahun, OKU fizikal).

"Last pregnancy tu.. Tekanan darah tinggi dah detect.. Lepas postnatal pun masih tinggi. Doktor memang start bagi ubat.. Saya high risk, jadi hospital kerajaan memang bagi pilihan nak pasang apa, tapi implan dia tak bagi.. Sebab saya kecil-kecil" (Informan 22, 38 tahun).

Peratusan Wanita Berkahwin Mengikut Kaedah Kontraseptif

	Peratusan
Kondom	12.3
Alat Dalam Rahim	7.0
Pil Kontraseptif	5.3
Implan	5.1
Ligasi Tiub	4.8
Suntikan	3.0
Pil Kontraseptif Kecemasan	0.5
Vasektomi	0.3
Tampalan Hormon	-
Gegelang Vagina	-
Azal	3.0
Cara Waktu Selamat	3.8
Menyusu Badan	0.3

Soalan: Apakah kaedah kontraseptif yang anda atau pasangan anda gunakan sekarang?

Sebab-Sebab Wanita Berkahwin Tidak Pernah Menggunakan Kaedah Kontraseptif

	Peratusan
Ingin hamil	44.1
Tidak berminat / tidak berhasrat	25.2
Takut kemungkinan menghadapi kesan sampingan	20.8
Tidak mengetahui tentang kaedah kontraseptif	6.4
Pasangan tidak benarkan	2.0
Nasihat pengamal perubatan	1.5

Soalan: Mengapakah anda atau pasangan / bekas pasangan anda tidak pernah menggunakan sebarang kaedah kontraseptif?

Peratusan Wanita Berkahwin Yang Menggunakan Kaedah Kontraseptif Mengikut Ciri-Ciri Sosiodemografi

		Moden	Bukan Moden
Strata	Bandar	36.5	7.5
	Luar Bandar	48.8	4.8
Etnik	Melayu	39.0	6.5
	Cina	43.9	14.6
	India	14.3	4.8
	Bumiputera Sabah	20.0	20.0
	Bumiputera Sarawak	42.9	0.0
Pendapatan Isi Rumah	Kurang daripada RM2,500	16.2	2.7
	RM2,500 – RM4,849	31.1	8.1
	RM4,850 – RM10,959	43.2	6.8
	RM10,960 dan lebih	50.4	8.9
	Jumlah	**38.2**	**7.1**

Isu dan Cabaran #4:

Pasangan Lelaki Berperanan Secara Pasif Dalam Proses Pembuatan Keputusan Berkaitan Penggunaan Kontraseptif

Penemuan tinjauan menunjukkan bahawa penglibatan pasangan lelaki dalam pembuatan keputusan berkaitan penggunaan kontraseptif masih terhad dan bersifat pasif. Sebahagian responden wanita berkahwin membuat keputusan berkaitan penggunaan, tidak menggunakan, atau berhenti menggunakan kontraseptif tanpa

penglibatan aktif pasangan, dengan peratusan tertinggi dicatatkan dalam keputusan untuk berhenti menggunakan kontraseptif.

Dapatan kualitatif memperlihatkan bahawa walaupun perbincangan dengan pasangan berlaku, tanggungjawab dan implikasi penggunaan kontraseptif lebih banyak dipikul oleh wanita, manakala pasangan lelaki cenderung bersetuju atau "mengikut" keputusan tanpa penglibatan substantif. Corak ini mencerminkan keperluan untuk pendekatan perancang keluarga yang lebih inklusif terhadap lelaki bagi menggalakkan perkongsian tanggungjawab dan keputusan yang lebih seimbang.

Penemuan Kajian Kuantitatif

- Secara keseluruhannya, lebih 70% responden wanita berkahwin membuat keputusan secara bersama dengan pasangan untuk menggunakan kontraseptif.
- Walau bagaimanapun, terdapat responden wanita berkahwin yang tidak melibatkan pasangan dalam proses pembuatan keputusan berkaitan penggunaan kontraseptif seperti berikut:
  - 18.9% daripada mereka yang mengambil keputusan untuk menggunakan kontraseptif.
  - 19.4% daripada mereka yang mengambil keputusan untuk tidak (pernah) menggunakan kontraseptif.
  - 33.3% daripada mereka yang mengambil keputusan untuk berhenti daripada menggunakan kontraseptif.

Penemuan Kajian Kualitatif

"Selalunya akak yang buat keputusan.. Suami ikut je. Sebab kita yang tanggung semua" (Informan 23, 47 tahun).

"Keputusan tu biasanya saya buat.. Tapi saya tetap bincang dengan suami. Dia follow je" (Informan 22, 38 tahun).

"Suami selalunya ada teman pergi klinik, tapi semua kesan.. Saya yang kena tanggung" (Informan 9, 35 tahun).

Peratusan Wanita Berkahwin Mengikut Pembuatan Keputusan Dalam Penggunaan Kontraseptif

	Peratusan
Sendiri	19.0
Pasangan	3.0
Bersama dengan pasangan	76.0
Lain-lain	2.0

Soalan: Siapakah yang membuat Keputusan untuk menggunakan kaedah kontraseptif?

Peratusan Wanita Berkahwin Mengikut Pembuatan Keputusan Dalam Penggunaan Kontraseptif

	Sendiri	Pasangan	Bersama Dengan Pasangan	Lain-lain	Jumlah
Tempat Kediaman					
Bandar	18.6	3.6	75.9	1.8	100.0
Luar Bandar	20.5	4.5	72.7	2.3	100.0
Etnik					
Melayu	20.9	2.6	74.8	1.7	100.0
Cina	4.2	12.5	83.3	0.0	100.0
Lain-lain	10.0	10.0	70.0	10.0	100.0
Pendapatan Isi Rumah					
Kurang Daripada RM2,500	7.1	0.0	85.7	7.1	100.0
RM2,500 – RM4,899	31.1	4.9	63.9	0.0	100.0
RM4,850 – RM10,959	18.9	5.4	73.0	2.7	100.0
RM10,960 dan Lebih	11.5	1.3	85.9	1.3	100.0
Keseluruhan	**18.9**	**3.8**	**75.4**	**1.9**	**100.0**

Nota: Kategori "lain-lain" termasuk etnik India, Bumiputera Sabah dan Bumiptera Sarawak berikutan saiz sampel yang kecil.

Isu dan Cabaran #5:

Kos Kaedah Perancang Keluarga Dan Rawatan Subfertiliti Yang Tinggi

Penemuan tinjauan menunjukkan bahawa kos yang tinggi merupakan halangan utama kepada akses perkhidmatan perancang keluarga dan rawatan subfertiliti. Sebahagian responden wanita berkahwin yang menghadapi masalah subfertiliti tidak mendapatkan rawatan perubatan moden disebabkan kekangan kewangan, termasuk kos rawatan yang tinggi, ketiadaan jaminan kejayaan, serta perbelanjaan sampingan seperti kos perjalanan dan masa.

Dapatan kualitatif menegaskan bahawa kos rawatan subfertiliti (termasuk IUI dan IVF) yang tinggi, keperluan kitaran rawatan berulang, dan ketiadaan subsidi yang mencukupi menjejaskan kemampuan kewangan pasangan untuk mendapatkan rawatan. Selain itu, kos kaedah perancang keluarga tertentu seperti implan turut dianggap mahal oleh sebahagian responden, sekali gus menonjolkan keperluan kepada mekanisme subsidi, perlindungan kewangan, dan peluasan akses perkhidmatan bagi mengurangkan beban kos dan meningkatkan akses rawatan.

Penemuan Kajian Kuantitatif

- Sebanyak 21.2% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana mempunyai kekangan kewangan untuk berbuat demikian.

Penemuan Kajian Kualitatif

".. kurangkan harga implan.. Hanya implan je yang berkesan untuk perancang keluarga 100%.. Subsidi ataupun pengurangan harga" (Informan 25, 47 tahun).

"Kos rawatan (subfertiliti) ni mahal.. Rasa tak cukup nak tanggung semua tu" (Informan 9, 35 tahun).

"Saya kerja di Penang.. Jauh berulang-alik buat rawatan di Shah Alam. Kos.. Masa.. Semuanya mencabar" (Informan 12, 29 tahun).

"Itu salah satu faktor kenapa kami tidak.. Buat IVF atau IUI.. Memikirkan kos" (Informan 18, 37 tahun).

"Satu cycle.. 50-60k.. No guarantee" (Informan 28, 38 tahun).

"So saya rasa kalau RM10,000 pun rasa lebih lah.. RM15,000 kot.. Saya ada je simpan semua-semua daripada saya buat tu kan" (Informan 39, 26 tahun).

"Kos kerajaan (fasiliti kesihatan awam) sekitar RM10,000-RM14,000.. Bayar ansur-ansur ikut langkah prosedur. Proses smooth tapi tetap membebankan" (Informan 26, 37 tahun).

Peratusan Wanita Berkahwin Mengikut Sebab Tidak Mendapatkan Rawatan Subfertiliti

	Peratusan
Tidak mengetahui cara untuk mendapatkan rawatan	21.2
Pasangan tidak bersetuju untuk mendapatkan rawatan	11.5
Menghadapi masalah kewangan	21.2
Menghadapi masalah logistik (seperti tiada pengangkutan, jauh dari kediaman dan lain-lain)	3.8
Tiada mempunyai masa yang sesuai	30.8
Berasa takut	19.2
Berasa malu	15.4
Tidak menganggap diri mempunyai sebarang masalah	44.2
Tidak kisah sekiranya tidak mempunyai anak	25.0
Mempunyai masalah kesihatan	1.9

Soalan: Mengapa anda / pasangan / bekas pasangan tidak mendapatkan nasihat atau rawatan perubatan moden bagi mengatasi masalah kesukaran untuk hamil?

Isu dan Cabaran #6

Akses Kepada Rawatan Subfertiliti Yang Terhad

Penemuan tinjauan menunjukkan bahawa akses kepada rawatan subfertiliti masih terhad, terutamanya disebabkan oleh kekangan masa dan logistik. Sebahagian responden wanita berkahwin tidak mendapatkan rawatan perubatan moden kerana kesukaran mengurus masa, jarak perjalanan, serta halangan mobiliti, di samping prosedur perkhidmatan yang memerlukan tempoh menunggu yang panjang.

Dapatan kualitatif menonjolkan perbezaan ketara antara sektor awam dan swasta, di mana hospital kerajaan menawarkan kos lebih rendah tetapi berdepan isu masa menunggu dan proses yang perlahan, manakala rawatan swasta lebih pantas namun mahal. Walaupun terdapat pengalaman positif terhadap perkhidmatan LPPKN yang dianggap lebih lancar dan mesra klien, kos dan keperluan pematuhan prosedur masih menjadi cabaran, sekali gus menunjukkan keperluan untuk meningkatkan kecekapan sistem, mengurangkan masa menunggu, dan memperkukuh akses perkhidmatan subfertiliti yang mampu milik.

Penemuan Kajian Kuantitatif

- Hampir 4% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden disebabkan oleh masalah logistik.

- Hampir satu pertiga (30.8%) responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana tidak mempunyai masa yang sesuai untuk berbuat demikian.

Penemuan Kajian Kualitatif

"Hospital kerajaan ada, tapi kena tunggu giliran lama. Nak cepat, kena pergi swasta. Tapi mahal sangat" (Informan 3, 32 tahun).

"Kalau daripada segi government pula.. Prosedur dia lambat sangat.. Appoinment ke appoinment sebulan dua bulan makan masa.. Gap dia terlampau lama" (Informan 39, 26 tahun).

".. akses dan mobiliti di (fasiliti kesihatan awam).. Banyak checkpoint" (Informan 18, 37 tahun).

"(Fasiliti kesihatan awam).. Prosedur smooth.. Staf dan doktor sangat understanding" (Informan 26, 37 tahun).

"Hospital kerajaan kena tunggu lama. Kalau pergi swasta tapi mahal sangat" (Informan 2, 38 tahun).

Isu dan Cabaran #7:

Stigma Sosial Terhadap Wanita Yang Mengalami Masalah Subfertiliti

Penemuan tinjauan menunjukkan bahawa stigma sosial masih menjadi halangan penting kepada wanita yang mengalami masalah subfertiliti untuk mendapatkan rawatan perubatan moden. Sebahagian responden tidak mendapatkan rawatan kerana ketiadaan persetujuan pasangan, manakala hampir satu perlima menangguhkan rawatan akibat perasaan takut dan malu yang berpunca daripada persepsi negatif masyarakat.

Dapatan kualitatif menggambarkan bahawa salah faham, tekanan sosial dan norma budaya yang mengaitkan keupayaan mempunyai anak sebagai kewajipan perkahwinan memberi kesan psikososial yang mendalam kepada wanita. Stigma ini bukan sahaja menjejaskan kesejahteraan emosi, malah mendorong sesetengah wanita untuk menyembunyikan keadaan mereka dan mengelakkan rawatan, sekali gus menekankan keperluan kepada pendekatan advokasi, pendidikan komuniti dan sokongan psikososial yang lebih menyeluruh.

Penemuan Kajian Kuantitatif

- Sebanyak 11.5% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana tidak mendapat persetujuan daripada pasangan untuk berbuat demikian.

- Hampir satu perlima responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana mempunyai perasaan takut (19.2%) dan malu (15.4%).

Penemuan Kajian Kualitatif

"Kalau kita buat IUI dan IVF ni kadang-kadang orang salah fikir.. Dulu kan dia panggil baby tabung.. Orang-orang tua tu, kawan-kawan kerja.. Macam-macam cakap" (Informan 39, 26 tahun).

"Kalau saya ketengahkan masalah ni dekat komuniti.. Saya banyak luka hati.. Tak dipanggil ke majlis orang mengandung, katanya bad blood boleh affect baby.. Deepavali orang kecam bila you nak mengandung.. Saya sampai avoid event" (Informan 26, 37 tahun).

"Orang luar kadang-kadang salah faham menganggap tidak mahu berusaha.. Budaya masyarakat memandang mempunyai anak sebagai satu kewajipan perkahwinan" (Informan 20, 41 tahun).

"Kadang-kadang ada tekanan secara halus. Soalan sensitif.. Tidak ramai yang faham" (Informan 17, 40 tahun).

Isu dan Cabaran #8:

Pengetahuan Mengenai Perihal Subfertiliti (Simptom Dan Rawatan) Yang Rendah

Penemuan tinjauan menunjukkan bahawa tahap pengetahuan mengenai subfertiliti masih rendah, khususnya berkaitan simptom awal, tempoh subur dan laluan mendapatkan rawatan. Sebahagian responden wanita berkahwin tidak mendapatkan rawatan perubatan moden kerana tidak mengetahui cara atau saluran untuk mendapatkan rawatan, manakala sebahagian besar lagi menganggap diri mereka tidak mempunyai masalah subfertiliti, walaupun mengalami tanda-tanda yang berkaitan.

Dapatan kualitatif menunjukkan bahawa kekurangan literasi kesihatan reproduktif menyebabkan kelewatan pengesanan dan rawatan awal, serta menimbulkan kesan psikologi seperti rasa bersalah, rendah diri dan kekeliruan terhadap keadaan kesihatan sendiri.

Situasi ini menekankan keperluan kepada pendidikan kesihatan reproduktif yang lebih menyeluruh, saringan awal dan kaunseling proaktif bagi meningkatkan kesedaran serta mendorong intervensi yang lebih awal dan berkesan.

Penemuan Kajian Kuantitatif

- Sebanyak 21.2% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana tidak mengetahui cara untuk mendapatkannya.

- Sebanyak 44.2% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana menganggap mereka tidak mempunyai sebarang masalah.

Penemuan Kajian Kualitatif

"Kalau dari awal saya tahu, mungkin kami boleh rancang dan mula rawatan lebih awal" (Informan 3, 32 tahun).

".. dulu-dulu saya tak tahu pun kira waktu subur.. Kitaran haid" (Informan 2, 38 tahun).

"Saya rasa macam tak sempurna.. Orang lain senang je dapat anak. Saya dah cuba.. Kadang-kadang saya salahkan diri sendiri" (Informan 9, 35 tahun).

"Jadi ada masalah.. Ovum kecil dan susah nak dapat anak.. Sekarang ni saya fikir dengan tiroid lagi.. Yang mungkin lagi susah (nak hamil)" (Informan 3, 32 tahun).

Isu dan Cabaran #9:

Masalah Kesihatan Mengganggu Wanita Untuk Mendapatkan Rawatan Subfertiliti

Penemuan tinjauan menunjukkan bahawa masalah kesihatan sedia ada merupakan antara faktor yang menghalang sebahagian kecil wanita daripada mendapatkan rawatan subfertiliti. Walaupun peratusannya relatif rendah, isu kesihatan seperti gangguan hormon, PCOS, fibroid, masalah tiroid, keguguran berulang serta pengalaman kegagalan rawatan sebelum ini memberi kesan langsung terhadap kesesuaian klinikal dan kesediaan wanita untuk meneruskan rawatan.

Dapatan kualitatif menggambarkan bahawa sejarah kesihatan yang kompleks dan pengalaman rawatan yang menyakitkan atau gagal bukan sahaja membataskan pilihan rawatan, malah memberi kesan emosi yang mendalam seperti keletihan fizikal dan psikologi.

Keadaan ini menekankan keperluan kepada pendekatan rawatan yang lebih bersepadu, berperingkat dan berpusatkan klien, termasuk pemantauan kesihatan menyeluruh, kaunseling berterusan dan sokongan emosi dalam pengurusan subfertiliti.

Penemuan Kajian Kuantitatif

- Hampir 2% responden wanita berkahwin yang mempunyai masalah subfertiliti tidak mendapatkan rawatan perubatan moden kerana mempunyai masalah kesihatan.

Penemuan Kajian Kualitatif

"Sebelum ni doktor kata saya dah tak boleh. Tapi saya dapat anak. Bersedia.. Bersedia.. Nak-nak masa tu fibroid kecil juga" (Informan 16, 44 tahun).

"12 tahun. IVF dua kali.. Semua gagal" (Informan 17, 40 tahun).

".. banyak kali miscarriage.. Bila saya stimulate dengan ubat.. Ada masalah lain.. Painful" (Informan 28, 38 tahun).

"Nombor satu sebab weight gain je sebenarnya.. Berat badan sebab saya naik mendadak lepas kahwin tu.. PCOS satu, lepas tu tiroid juga.. Hyper-tiroid" (Informan 39, 26 tahun).

Keberkesanan Prestasi Pelaksanaan Program Perancang Keluarga

Pencapaian Dasar Dan Program Berkaitan Perancangan Keluarga

Contraception Policy Atlas Asia and the Pacific telah dilancarkan oleh The European Parliamentary Forum for Sexual and Reproductive Rights (EPF), Family Planning 2030 (FP2030) dan International Planned Parenthood Federation (IPPF) pada 16 November 2023 di Bangkok, Thailand. Atlas ini menyediakan maklumat penting tentang landskap perancang keluarga dan status kontraseptif berdasarkan kepada penilaian yang dilakukan terhadap 43 buah negara di rantau Asia Pasifik, yang melibatkan tiga (3) komponen utama iaitu kerangka perundangan, akses dan peruntukan kewangan.

Berdasarkan Contraception Policy Atlas Asia-Pacific 2023, pengiktirafan hak reproduktif dalam undang-undang atau akta, termasuk hak untuk menentukan bilangan, masa dan jarak kelahiran, merupakan komponen penting dalam mewujudkan persekitaran yang menyokong amalan perancang keluarga. Namun, perbandingan antara negara Asia Pasifik menunjukkan bahawa pengiktirafan hak tersebut tidak semestinya diterjemahkan kepada kadar penggunaan kontraseptif (CPR) yang lebih tinggi. Negara seperti Hong Kong (67%), Indonesia (64%) dan Kemboja (62%) mencatat CPR yang tinggi seiring dengan pengiktirafan hak reproduktif, manakala Filipina (58%), Nepal (57%), Malaysia (52%) dan Pakistan (34%) masih merekodkan CPR yang sederhana atau rendah walaupun mempunyai pengiktirafan yang sama.

Perbandingan Pengiktirafan Hak Reproduktif Dalam Undang-Undang / Akta Di Negara Asia Pasifik Mengikut Kadar Penggunaan Kontraseptif (CPR)

Negara Yang Mempunyai Pengiktirafan	
CPR Rendah	**CPR Tinggi**
Filipina (58%)	Hong Kong (67%)
Nepal (57%)	Indonesia (64%)
Malaysia (52%)	Kemboja (62%)
Pakistan (34%)	
Negara Yang Tidak Mempunyai Pengiktirafan	
CPR Rendah	**CPR Tinggi**
Myanmar (52%)	China (85%)
Jepun (40%)	Thailand (73%)
	Vietnam (73%)
	Bangladesh (64%)

Sumber: Contraception Policy Atlas Asia-Pacific 2023.
Nota: Angka dalam kurungan () menunjukkan nilai CPR (%).

Sebaliknya, beberapa negara yang tidak mengiktiraf hak reproduktif secara jelas dalam undang-undang turut mencatat CPR yang tinggi, antaranya China (85%), Thailand (73%), Vietnam (73%) dan Bangladesh (64%). Dapatan ini menunjukkan bahawa selain komitmen dasar dan perundangan, faktor seperti akses kepada perkhidmatan kesihatan reproduktif, ketersediaan bekalan kontraseptif, kepelbagaian pilihan kaedah, literasi kesihatan dan keberkesanan pelaksanaan program turut mempengaruhi penggunaan kontraseptif.

Didapati majoriti negara yang dikaji mempunyai pelan atau strategi nasional berkaitan kontraseptif serta komitmen antarabangsa seperti Every Woman Every Child (EWEC), Nairobi Summit dan FP2030. Sembilan negara termasuk Malaysia, Indonesia, Filipina, Thailand dan Bangladesh mempunyai kedua-dua komponen ini, dan kebanyakannya mencatat CPR yang sederhana hingga tinggi.

Walau bagaimanapun, kewujudan pelan nasional dan komitmen antarabangsa tidak semestinya menentukan tahap CPR. Hong Kong (67%) dan Korea Selatan (82%) tetap mencatat CPR yang tinggi walaupun tidak mempunyai pelan atau komitmen yang dinilai dalam atlas tersebut. Dapatan ini menunjukkan bahawa selain dasar dan komitmen formal, faktor seperti pembangunan sosioekonomi, akses kepada perkhidmatan kesihatan, literasi kesihatan reproduktif, autonomi individu dan ketersediaan kontraseptif turut mempengaruhi penggunaan kontraseptif.

Negara Asia Pasifik Terpilih Yang Mempunyai Pelan / Strategi Nasional Berkaitan Kontraseptif Dan Komitmen Dalam Inisiatif Global

Negara	Pelan / Strategi Nasional	Komitmen Antarabangsa
Malaysia	Ya	Ya
Indonesia	Ya	Ya
Filipina	Ya	Ya
Thailand	Ya	Ya
Kemboja	Ya	Ya
Pakistan	Ya	Ya
Nepal	Ya	Ya
Bangladesh	Ya	Ya
Sri Lanka	Ya	Ya
Hong Kong	Tidak	Tidak
Macao	Tidak	Tidak
Korea Selatan	Tidak	Tidak

Sumber: Contraception Policy Atlas Asia-Pacific 2023.

Berdasarkan Contraception Policy Atlas Asia-Pacific 2023, liputan kaedah kontraseptif moden dalam National Essential Medicines List (NEML) merupakan salah satu instrumen yang menyokong ketersediaan dan akses kepada kontraseptif. Negara seperti Kemboja, Bangladesh, Sri Lanka dan Myanmar yang mempunyai liputan enam hingga sepuluh kaedah moden dalam NEML mencatat CPR antara 52% hingga 65%, manakala Malaysia dan Indonesia yang mempunyai liputan lebih terhad masih merekodkan CPR masing-masing sebanyak 52% dan 64%.

Walau bagaimanapun, bilangan kaedah yang disenaraikan dalam NEML tidak semestinya menentukan tahap penggunaan kontraseptif. Korea Selatan (82%) dan Vietnam (73%) mencatat CPR yang tinggi walaupun tiada kaedah moden disenaraikan dalam NEML yang dinilai, manakala Jepun hanya merekodkan CPR sebanyak 40%. Dapatan ini menunjukkan bahawa selain NEML, faktor seperti kekuatan sistem kesihatan, akses kepada perkhidmatan perancang keluarga, pembiayaan kesihatan, literasi kesihatan reproduktif dan penerimaan masyarakat turut mempengaruhi penggunaan kontraseptif.

Perbandingan Kadar Penggunaan Kontraseptif (CPR) Mengikut Tahap Liputan Kaedah Kontraseptif Moden Dalam Senarai Ubat-Ubatan Penting Kebangsaan (NEML) Di Negara Asia Pasifik Terpilih

Liputan Kaedah Kontraseptif Moden dalam Senarai Ubat-Ubatan Penting Kebangsaan (NEML)		
Antara 6 hingga 10 Kaedah	**Antara 1 hingga 5 Kaedah**	**Tiada Liputan**
Kemboja (62%) Bangladesh (64%) Sri Lanka (65%) Myanmar (52%)	Malaysia (52%) Indonesia (64%)	Jepun (40%) Vietnam (73%) Korea Selatan (82%)

Sumber: Contraception Policy Atlas Asia-Pacific 2023.
Nota: Angka dalam kurungan () menunjukkan nilai CPR (%).

Berkenaan dengan kerangka pendidikan kesihatan seksual dan reproduktif (SRHE), didapati tujuh (7) negara yang mempunyai kerangka SRHE, termasuk China, Vietnam, India, Hong Kong, Indonesia, Filipina dan Malaysia, secara umumnya mencatat PR yang sederhana hingga tinggi. Walau bagaimanapun, kewujudan kerangka SRHE bukan satu-satunya faktor yang mempengaruhi penggunaan kontraseptif. Thailand dan Sri Lanka turut mencatat CPR yang tinggi walaupun tidak mempunyai kerangka SRHE yang dikenal pasti dalam penilaian ini.

Dapatan ini menunjukkan bahawa selain pendidikan SRHE, faktor seperti akses kepada perkhidmatan kesihatan reproduktif, ketersediaan kontraseptif, sokongan dasar kerajaan, pembangunan sosioekonomi dan penerimaan masyarakat turut memainkan peranan penting dalam mempengaruhi penggunaan kontraseptif. Namun begitu, kerangka SRHE

kekal penting dalam memperkukuh literasi kesihatan reproduktif dan menyokong pembuatan keputusan yang lebih bermaklumat.

Perbandingan Kadar Penggunaan Kontraseptif (CPR) Mengikut Kewujudan Kerangka Pendidikan Kesihatan Seksual Dan Reproduktif (SRHE) Di Negara Asia Pasifik Terpilih

Ada Kerangka SRHE	Tiada Kerangka SRHE
China (85%)	Thailand (73%)
Vietnam (73%)	Sri Lanka (82%)
India (67%)	
Hong Kong (67%)	
Indonesia (64%)	
Filipina (58%)	
Malaysia (52%)	

Sumber: Contraception Policy Atlas Asia-Pacific 2023.
Nota: Angka dalam kurungan () menunjukkan nilai CPR (%).

Pengumpulan data kesihatan seksual dan reproduktif (SRH) secara berkala penting untuk memantau trend penggunaan kontraseptif, menilai keberkesanan program dan menyokong perancangan berasaskan bukti. Negara seperti China, India, Hong Kong dan Indonesia yang mengumpul data SRH dalam tempoh kurang daripada lima tahun mencatat kadar CPR yang sederhana hingga tinggi.

Walau bagaimanapun, kekerapan pengumpulan data sahaja tidak menjamin CPR yang lebih tinggi. Korea Selatan, Thailand dan Vietnam turut mencatat CPR yang tinggi walaupun mengumpul data SRH pada selang masa melebihi lima tahun. Dapatan ini menunjukkan bahawa selain data yang berkala, faktor seperti akses kepada perkhidmatan kesihatan reproduktif, ketersediaan kontraseptif, sokongan dasar, pembangunan sosioekonomi dan penerimaan masyarakat turut mempengaruhi penggunaan kontraseptif.

Perbandingan Kadar Penggunaan Kontraseptif (CPR) Mengikut Kekerapan Pengumpulan Data Kesihatan Seksual Dan Reproduktif (SRH) Di Negara Asia Pasifik Terpilih

Kerap (kurang daripada 5 tahun)	Jarang (lebih daripada 5 tahun)
China (85%)	Korea Selatan (82%)
India (67%)	Thailand (73%)
Hong Kong (67%)	Vietnam (73%)
Indonesia (64%)	Malaysia (52%)

Sumber: Contraception Policy Atlas Asia-Pacific 2023.
Nota: Angka dalam kurungan () menunjukkan nilai CPR (%).

Berdasarkan Contraception Policy Atlas Asia-Pacific 2023, didapati negara seperti Thailand (73%), Vietnam (73%), Kemboja (62%), Indonesia (64%), Bangladesh (64%) dan Filipina (58%) yang mempunyai jawatankuasa khusus ini mencatat CPR yang sederhana hingga tinggi. Walau bagaimanapun, kewujudan jawatankuasa nasional bukan satu-satunya faktor yang mempengaruhi penggunaan kontraseptif. China (85%), Korea Selatan (82%) dan Hong Kong (67%) turut mencatat CPR yang tinggi walaupun tidak mempunyai mekanisme tersebut, manakala Malaysia dan Jepun yang juga tidak mempunyai jawatankuasa khusus merekodkan CPR yang lebih rendah.

Dapatan ini menunjukkan bahawa selain tadbir urus bekalan, faktor seperti kekuatan sistem kesihatan, pembangunan sosioekonomi, akses kepada perkhidmatan kesihatan reproduktif dan penerimaan masyarakat turut memainkan peranan penting. Namun demikian, penubuhan jawatankuasa khusus kekal relevan sebagai platform untuk memperkukuh perancangan dan kesinambungan bekalan kontraseptif di peringkat nasional.

Perbandingan Kadar Penggunaan Kontraseptif (CPR) Mengikut Jawatankuasa Nasional Pengurusan Bekalan Kontraseptif Di Negara Asia Pasifik Terpilih

Negara Yang Mempunyai Jawatankuasa	Negara Yang Tidak Mempunyai Jawatankuasa
Thailand (73%)	China (85%)
Vietnam (73%)	Korea Selatan (82%)
Kemboja(62%)	Hong Kong (67%)
Indonesia (64%)	Malaysia (52%)
Bangladesh (64%)	Jepun (40%)
Filipina (58%)	

Sumber: Contraception Policy Atlas Asia-Pacific 2023.
Nota: Angka dalam kurungan () menunjukkan nilai CPR (%).

Pencapaian Indikator Berkaitan Perancang Keluarga

Dari segi prestasi indikator perancang keluarga, Malaysia menunjukkan pencapaian yang sederhana berbanding negara lain dalam rantau Asia. Walaupun lebih separuh wanita berkahwin pernah menggunakan sebarang kaedah perancang keluarga, kadar penggunaan kontraseptif moden di negara ini masih relatif rendah, iaitu sekitar 34%, berbanding Thailand yang melebihi 70% dan Vietnam sekitar 60%. Perbandingan antara negara mendapati bahawa kesan perbelanjaan kesihatan terhadap pencapaian indikator perancang keluarga adalah tidak bergantung kepada orientasi perbelanjaan tersebut. Indeks Liputan Penjagaan Kesihatan (*Health Care Coverage Index*) turut mempengaruhi sejauh mana perkhidmatan perancang keluarga dapat diakses dan dimanfaatkan oleh penduduk. Malaysia mencatatkan skor indeks yang relatif baik (sekitar 76), setanding atau lebih tinggi berbanding beberapa negara Asia Tenggara lain. Namun, perbandingan

dengan Thailand (sekitar 82) dan Jepun (sekitar 83) menunjukkan bahawa liputan kesihatan yang tinggi tidak secara automatik menjamin penggunaan kontraseptif moden yang tinggi, terutamanya dalam konteks negara yang telah mencapai kadar kesuburan rendah seperti Malaysia (1.6) dan Jepun (1.2).

Penggunaan kontraseptif moden lazimnya mempunyai hubungan songsang dengan kadar kesuburan (*Total Fertility Rate*, TFR), di mana negara yang mencatat penggunaan kontraseptif yang lebih tinggi cenderung mempunyai kadar kesuburan yang lebih rendah. Corak ini dapat dilihat di Thailand yang merekodkan penggunaan kontraseptif moden sekitar 71% dengan TFR sebanyak 1.0 anak, berbanding Pakistan yang mempunyai penggunaan kontraseptif sekitar 23% dan TFR yang jauh lebih tinggi iaitu 3.6 anak.

Namun demikian, Malaysia menunjukkan pola yang agak berbeza apabila mencatat penggunaan kontraseptif moden yang masih sederhana, sekitar 34%, tetapi telah mencapai TFR yang rendah iaitu 1.6 anak bagi setiap wanita. Keadaan ini menunjukkan bahawa hubungan antara penggunaan kontraseptif dan kesuburan tidak semestinya bersifat linear, khususnya bagi negara yang telah mencapai peringkat akhir transisi demografi.

Perbandingan Indikator Perancang Keluarga Dan Sistem Kesihatan Di Negara Asia Terpilih

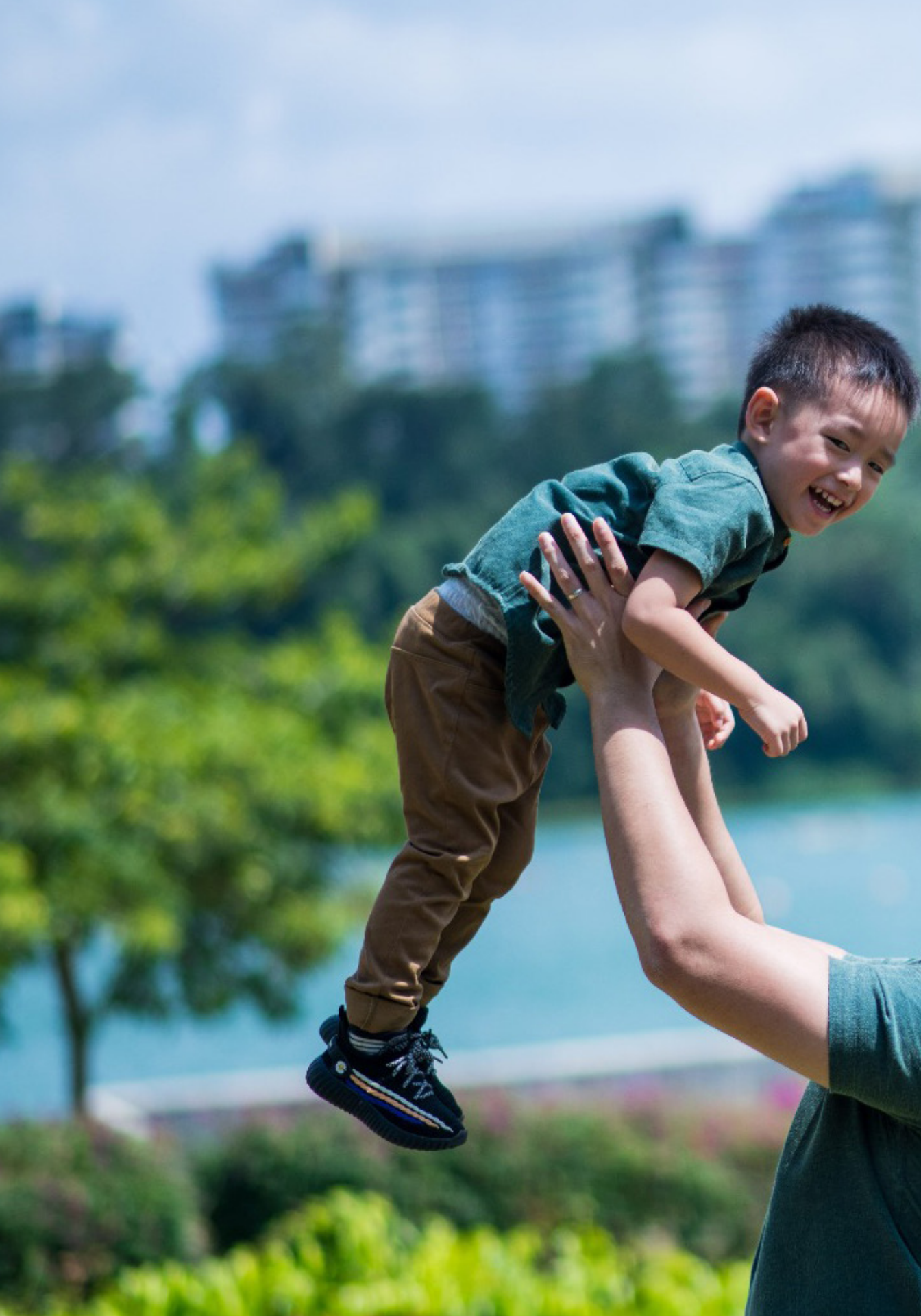
		Perancangan Keluarga Dalam Kalangan Wanita Berkahwin			Perbelanjaan Kesihatan per Kapita (US$)	
Negara	**Kadar Kesuburan Jumlah**	**Gunakan Semua Kaedah (%)**	**Gunakan Kaedah Moden (%)**	**Indeks Liputan Perkhidmatan Kesihatan Sejagat**	**Jumlah Perbelanjaan Kesihatan 2020/2022**	**Perbelanjaan Khusus Penjagaan Kesihatan Primer (PHC) 2018/2022**
Brunei	1.8	-	-	78	693	-
Kemboja	2.7	62	45	58	122	71
Indonesia	2.2	64	57	55	161	-
Laos	2.5	53	-	52	69	47
Malaysia	1.6	52	34	76	487	233
Myanmar	2	52	51	52	65	41
Filipina	1.9	58	42	58	178	-
Singapura	1	-	-	89	3,970	-
Thailand	1	73	71	82	364	160
Timor-Leste	3.6	26	24	52	135	-
Vietnam	2	73	60	68	173	-
China	1	85	81	81	671	-
Hong Kong	0.8	67	65	-	-	-
Macau	0.6	-	-	-	-	-
Jepan	1.2	40	33	83	4,347	-
Korea Selatan	0.7	82	-	89	3,124	-
Taiwan	0.9	75	66	-	-	-
Bangladesh	2.2	64	55	52	58	34
India	2	67	56	63	74	28
Nepal	2.1	57	43	54	65	44
Pakistan	3.6	34	23	45	43	25

Sumber: Population Reference Bureau (PRB) 2024 World Population Data Sheet.

Dalam konteks fasa transisi demografi, negara kini berada dalam kategori pasca-transisi, iaitu fasa yang dicirikan oleh kadar kesuburan dan pertumbuhan penduduk yang rendah. Corak yang hampir serupa turut dapat diperhatikan di Jepun, yang mencatat penggunaan kontraseptif moden sekitar 33% di mana hampir menyamai Malaysia (34%). Namun, negara tersebut mempunyai kadar kesuburan yang lebih rendah, sekitar 1.2 hingga 1.3 anak bagi setiap wanita.

Keadaan ini menunjukkan bahawa apabila sesebuah negara mencapai tahap pembangunan demografi yang lebih maju, faktor selain penggunaan kontraseptif menjadi semakin dominan dalam mempengaruhi keputusan untuk mempunyai anak. Antaranya termasuk peningkatan umur perkahwinan, tahap pendidikan wanita yang lebih tinggi, penyertaan wanita dalam pasaran kerja, peningkatan kos sara hidup serta perubahan nilai dan aspirasi keluarga moden.

Justeru, walaupun penggunaan kontraseptif kekal sebagai komponen penting dalam perancangan keluarga, corak kesuburan semasa di negara ini semakin dipengaruhi oleh faktor sosial, ekonomi dan demografi yang lebih luas. Dapatan ini menunjukkan bahawa usaha memahami penurunan kesuburan atau merangka dasar berkaitan fertiliti memerlukan pendekatan yang lebih menyeluruh dan tidak hanya tertumpu kepada aspek penggunaan kontraseptif semata-mata.



Cadangan Hala Tuju Program Perancang Keluarga



Foto : shiau tung su / Pexels

Hala Tuju 1 Pendidikan Kesihatan Seksual Dan Reproduktif

Objektif Hala Tuju

Bertujuan untuk meningkatkan pengetahuan dan kesedaran tentang kesihatan seksual dan reproduktif, meningkatkan pengetahuan tentang pilihan kaedah kontraseptif yang ditawarkan oleh pembekal perkhidmatan, dan meningkatkan pengetahuan dan kesedaran mengenai kesuburan di peringkat individu.

Aktiviti Utama Hala Tuju

(i) Program Kesedaran Tentang Kesihatan Seksual dan Reproduktif
Pembangunan program perlu berfokus kepada mempergiat program kesedaran di peringkat sekolah dan institusi pengajian tinggi melalui kerjasama strategik pelbagai agensi seperti LPPKN, KKM, KPM, KPT dan NGO.

(ii) Pengetahuan Pilihan Kaedah Kontraseptif dan Kesedaran Kesuburan
Bengkel atau kaunseling yang dilaksanakan oleh anggota klinikal LPPKN dengan kerjasama hospital kerajaan dan swasta bagi penyampaian maklumat yang lebih komprehensif dan inklusif. Pelaksanaan program ini disyorkan secara bersasar mengikut peringkat umur dan tahap kesihatan pasangan.

Hasil Yang Dijangka

(i) Mengelakkan stigma dan prejudis terhadap peranan perancang keluarga serta memastikan setiap individu mendapat akses kepada maklumat yang sahih.

(ii) Membantu pasangan untuk membuat keputusan bermaklumat dalam merancang kehamilan.

Hala Tuju 2 Akses Dan Teknologi: Hebahan Melalui Media Digital

Objektif Hala Tuju

Bertujuan untuk memperluaskan capaian maklumat kesuburan dan kesihatan reproduktif melalui pengguna platform digital yang inklusif dan mudah diakses (seperti TikTok, YouTube, Facebook dan lain-lain).

Aktiviti Utama Hala Tuju

(i) Kolaborasi Dengan Professional *Content Creator*
Kerjasama strategik ini akan menghasilkan kandungan program yang lebih kreatif, menarik dan selari dengan perkembangan semasa, sekaligus berupaya

memperluaskan capaian maklumat melalui peningkatan jumlah tontonan dan perkongsian.

(ii) Memperkasa Komunikasi Melalui Platform Media Digital dan Sosial
Memanfaatkan penggunaan platform media digital dan sosial dengan berkerjasama dengan pempengaruh (*influencer*) yang mempunyai ramai pengikut (*follower*) untuk hebahan maklumat yang lebih meluas.

Hasil Yang Dijangka

(i) Penyampaian maklumat yang lebih menarik, mudah diakses dan mudah difahami.

(ii) Meningkatkan capaian terutama kepada golongan muda, yang menjadi pengguna utama media digital.

(iii) Mewujudkan ruang komuniti interaktif untuk perbincangan yang lebih terbuka.

(iv) Menangani cabaran ketidaktepatan maklumat melalui kerjasama antara pakar teknikal dan pengamal media digital seperti pencipta kandungan dan pempengaruh.

Hala Tuju 3 Penyampaian Perkhidmatan Perancang Keluarga

Objektif Hala Tuju

Bertujuan untuk menambahbaik penyampaian perkhidmatan perancang keluarga, meliputi penggunaan kontraseptif dan rawatan subfertiliti.

Aktiviti Utama Hala Tuju

(i) Memperkukuh Kerjasama Strategik LPPKN dan KKM
Memperkukuh kerjasama rentas agensi melalui penyelarasan peranan, perkongsian data dan integrasi perkhidmatan bagi memastikan penyampaian perkhidmatan perancang keluarga yang lebih komprehensif, cekap dan bersepadu di semua peringkat.

(ii) Menggalakkan Penglibatan Syarikat Insurans Kesihatan
Mewujudkan rangka kerja sokongan termasuk insentif, garis panduan dan skim galakan yang bersesuaian bagi menggalakkan syarikat swasta termasuk syarikat perlindungan insurans kesihatan bersedia menanggung sebahagian atau keseluruhan kos perkhidmatan perancang keluarga dan rawatan subfertiliti.

Hasil Yang Dijangka

(i) Penyampaian perkhidmatan perancang keluarga yang lebih bersepadu dan efisien.

(ii) Peningkatan akses dan liputan perkhidmatan kepada kumpulan sasaran.

(iii) Pengurangan beban kos rawatan melalui sokongan perlindungan insurans.

(iv) Peningkatan kualiti dan keberkesanan perkhidmatan kesihatan reproduktif.

(v) Pengukuhan kerjasama strategik antara sektor awam dan swasta.

Hala Tuju 4 Tadbir Urus Membangun Pelan Strategik Mesra Keluarga

Objektif Hala Tuju

Bertujuan untuk menggerakkan faktor pemudah cara iaitu sokongan infrastruktur fizikal dan strategi kerja fleksibel bagi menambahbaik mekanisme pelaksanaan program yang menyokong pembangunan pelan strategik mesra keluarga.

Aktiviti Utama Hala Tuju

(i) Sokongan Infrastruktur Fizikal

Pemerkasaan penyediaan kemudahan mesra keluarga di tempat kerja seperti pusat jagaan kanak-kanak, bilik penyusuan serta sudut informasi kesihatan reproduktif. Kemudahan ini membantu mengurangkan kebimbangan terhadap penjagaan anak dan kesinambungan kerjaya, sekali gus mewujudkan persekitaran yang kondusif bagi wanita dan pasangan untuk mempertimbangkan perancangan kehamilan serta mendapatkan rawatan subfertiliti.

(ii) Dasar Kerja Fleksibel

Menggalakkan pelaksanaan dasar kerja fleksibel bagi memberi ruang kepada wanita dan pasangan mengurus komitmen keluarga di mana fleksibiliti ini turut menyokong kesinambungan rawatan dan pematuhan kepada intervensi yang diperlukan.

Hasil Yang Dijangka

(i) Wanita dan pasangan berasa lebih yakin untuk merancang kehamilan tanpa menjejaskan kerjaya.

(ii) Peningkatan kecenderungan untuk mendapatkan rawatan subfertiliti dalam kalangan pasangan yang memerlukan.

(iii) Pengurangan penangguhan kehamilan atas faktor kerjaya dan kekangan penjagaan anak.

Hala Tuju 5 Hab Data Kesihatan Seksual Dan Reproduktif Nasional

Objektif Hala Tuju

Bertujuan untuk mengumpulkan data daripada pelbagai sumber seperti perkhidmatan perancang keluarga dan saringan kesihatan reproduktif untuk membangun hab data secara berpusat. Penyelarasan data memastikan ketepatan dan keseragaman, selari dengan inisiatif data terbuka nasional.

Aktiviti Utama Hala Tuju

(i) Tinjauan Tahunan Perancang Keluarga

Mengumpulkan data rutin tahunan daripada Klinik Nur Sejahtera LPPKN di mana antara data yang disyorkan adalah seperti jenis dan bilangan perkhidmatan / pemeriksaan yang dibekalkan / ditawarkan kepada pasangan.

(ii) Survei Perancang Keluarga (setiap 5 tahun)

Survei ini akan menyokong data kajian nasional berskala besar LPPKN yang dikumpulkan setiap 10 tahun. Survei ini akan menggunakan sampel yang berupaya mewakili keseluruhan populasi bagi menghasilkan beberapa indikator utama seperti kadar penggunaan kontraseptif (*contraceptive*), kadar keperluan kontraseptif yang tidak dipenuhi (*unmet need for contraceptive*) dan lain-lain.

Hasil Yang Dijangka

(i) Pengumpulan data berpusat dalam memastikan data kesihatan seksual dan reproduktif digunakan secara efisien.

(ii) Meningkatkan penyelarasan, pemantauan berterusan, penilaian keputusan perkhidmatan yang konsisten dan analisa berasaskan bukti.



Rujukan



Foto : Mikhail Nilov / Pexels

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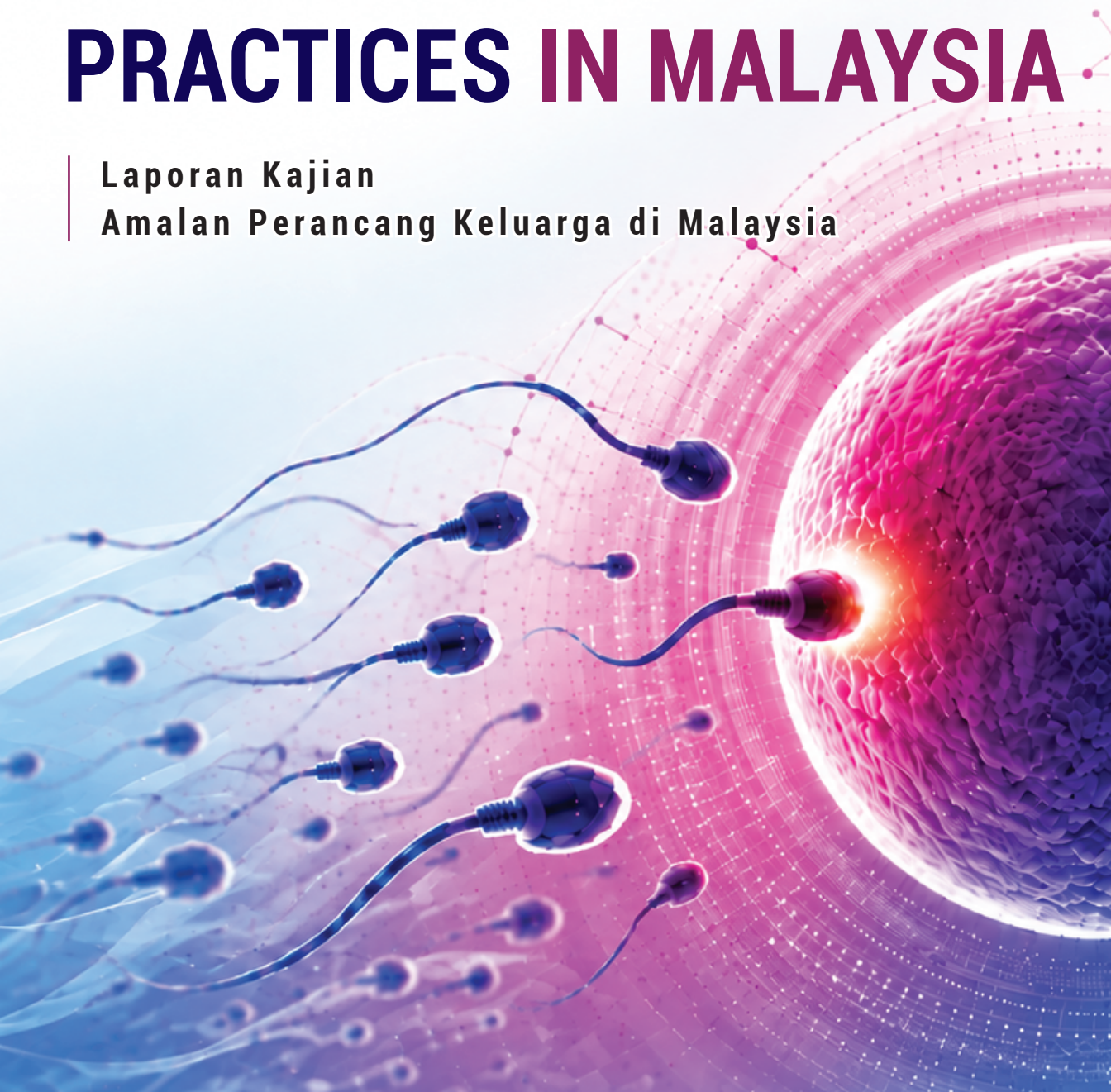
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REPORT ON THE STUDY OF

FAMILY PLANNING PRACTICES IN MALAYSIA

Laporan Kajian
Amalan Perancang Keluarga di Malaysia



LPPKN
LEMBAGA PENDUDUK DAN PEMBANGUNAN KELUARGA NEGARA



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FOREWORD

Dato' Sri Hajah Nancy Shukri

MINISTER

WOMEN, FAMILY AND COMMUNITY DEVELOPMENT

The establishment of the National Family Planning Board in 1966 marked the beginning of the evolution of Malaysia's approach to family planning. Amendments to the Act and the subsequent change of name to the National Population and Family Development Board (LPPKN) in 1984 further expanded the organisation's mandate beyond a primary focus on contraceptive services to encompass population, family development and human reproduction. In line with this expanded mandate, the approach to family planning also evolved to place greater emphasis on reproductive health, education, awareness and support for families. This approach enables couples to plan the number and spacing of their children in an informed and responsible manner, while supporting the development of strong and resilient families.

"The establishment of the National Family Planning Board in 1966 marked the beginning of the evolution of Malaysia's approach to family planning."

The Study of Family Planning Practices in Malaysia is an important initiative to assess the policy's effectiveness and provide an overview of current levels of awareness and acceptance, as well as the challenges faced by society. Policymakers, service providers, academics, and strategic partners are expected to use the study's findings to strengthen the national family planning policy and programme implementation. Appreciation is also extended to all LPPKN staff who have contributed to the publication of this report.



FOREWORD

Datuk Dr. Maziah Che Yusoff

SECRETARY GENERAL

MINISTRY OF WOMEN, FAMILY AND COMMUNITY DEVELOPMENT

The Study of Family Planning Practices in Malaysia is an important initiative for assessing the effectiveness of government policies implemented by the National Population and Family Development Board (LPPKN). This study provides comprehensive data on the community's awareness, acceptance, and family planning practices, forming a solid foundation for developing more effective and responsive strategies in response to the country's demographic and socioeconomic changes.

The highest appreciation is extended to LPPKN, the consultants, and all parties involved in the successful conduct of this study. Their contributions ensured the publication of a high-quality, beneficial report for policymakers, practitioners, researchers, and strategic partners to strengthen the country's family planning and reproductive health system. It is hoped that the study's findings and recommendations can be optimally utilised for the well-being of women, families, and society in this country.

"The Study of Family Planning Practices in Malaysia is an important initiative for assessing the effectiveness of government policies."



FOREWORD

Dato Sri Rohani Abdul Karim

CHAIRMAN

NATIONAL POPULATION AND FAMILY DEVELOPMENT BOARD

The National Population and Family Development Board (LPPKN) remains committed to strengthening demographic well-being and family institutions in the country. Through the Study on Family Planning Practices in Malaysia, LPPKN seeks to understand the key issues and challenges related to contraceptive use and subfertility treatment, while examining current practices and needs to support the planning and improvement of family planning programmes in Malaysia.

The findings of this study provide a strategic foundation to guide policy formulation and more effective reproductive health interventions. This evidence-based information is essential to ensure family planning programmes are inclusively targeted to meet the needs of all segments of society.

> "The National Population and Family Development Board (LPPKN) remains committed to strengthening demographic well-being and family institutions in the country."

Highest appreciation is extended to the Ministry of Women, Family and Community Development (KPWKM), the United Nations Population Fund (UNFPA) in Malaysia, UPUM Sdn. Bhd., and all LPPKN staff for their commitment to completing this publication. It is hoped that the study's findings will be fully utilised to strengthen family well-being and support the nation's socioeconomic development.



FOREWORD

Dato' Abdul Shukur Abdullah

DIRECTOR GENERAL

NATIONAL POPULATION AND FAMILY DEVELOPMENT BOARD

The family planning trend in Malaysia shows a moderate and stable rate of contraceptive use, despite the country facing a significant decline in fertility rates. These changes are influenced by various factors such as the increase in the age of marriage, socioeconomic changes, and societal structure, and have led to new challenges, including issues of subfertility among couples who desire children.

In this regard, the Study of Family Planning Practices in Malaysia was conducted as a comprehensive effort to examine current trends, identify factors influencing contraceptive use, and understand issues related to subfertility to support improvements in national family planning policies and programmes.

This study employs a mixed-methods approach, combining quantitative and qualitative methods to provide a comprehensive, in-depth picture of family planning practices within the community. Appreciation is also extended to the United Nations Population Fund (UNFPA) Malaysia for its support and funding, as well as to UPUM Sdn. Bhd. as the research consultant. It is hoped that the findings of this study can be utilised to formulate more effective strategies for the welfare of families and the nation's development.

"The family planning trend in Malaysia shows a moderate and stable rate of contraceptive use, despite the country facing a significant decline in fertility rates."

FOREWORD



Dr. Julitta Onabanjo

REPRESENTATIVE

UNITED NATIONS POPULATION FUND

Family planning is fundamentally about choice grounded in human rights, voluntary decision-making and bodily autonomy: ensuring that individuals and couples have the information, services and support they need to decide freely and responsibly whether, when and how many children to have. As Malaysia undergoes demographic shifts - marked by declining fertility, delayed marriage and childbearing, and evolving socioeconomic dynamics - safeguarding bodily autonomy and fulfilling sexual and reproductive health and rights across every stage of the lifecycle become essential to enabling all individuals to realize their reproductive aspirations. The Study of Family Planning Practices in Malaysia is therefore timely in highlighting the factors that shape these decisions, including knowledge, access, affordability, partner dynamics and autonomy.

"Family planning is fundamentally about choice grounded in human rights, voluntary decision-making and bodily autonomy: ensuring that individuals and couples have the information, services and support they need to decide freely and responsibly whether, when and how many children to have."

UNFPA affirms that sexual and reproductive health and rights are fundamental human rights. By embedding family planning within a holistic lifecycle approach, societies uphold bodily autonomy, enable people to realize their reproductive intentions, and foster resilient, equitable populations.

UNFPA is pleased to have supported this study and extends its sincere appreciation to the Ministry of Women, Family and Community Development, National Population and Family Development Board (LPPKN) and the research team. We hope the findings will help inform future efforts to strengthen reproductive health policies and services that are responsive to the needs of individuals and families.

ACKNOWLEDGEMENTS

The National Population and Family Development Board (LPPKN) wishes to express its sincere appreciation and gratitude to the ministries, agencies and departments that contributed to the implementation in the Study of Family Planning Practices in Malaysia (KAPKM).

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Ministry of Higher Education
Departments of Social Welfare (JKM)
Malaysian Social Institute (ISM)

Non-Governmental / International Organisations

United Nations Population Fund (UNFPA) in Malaysia
Federation of Reproductive Health Association (FRHAM) Malaysia
Academy of Family Physicians of Malaysia

National Population and Family Development Board (LPPKN)

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Secretariat

Evaluation Research Unit
Population and Family Research Division


My FAMILY
DAD
Daddy
Me

Executive Summary



Photo : pavel danilyuk / Pexels

Family planning is a fundamental component of sexual and reproductive health, essential to the well-being of mothers, children, and families. It encompasses information, services, and methods that enable women and couples to decide on the number of children and the timing and spacing of pregnancies, as well as access to subfertility treatments. In Malaysia, the Ministry of Health Malaysia (KKM), the National Population and Family Development Board (LPPKN), the private sector, and NGOs provide these services. Despite various programmes, the contraceptive use rate remains moderate and stagnant, alongside challenges such as unmet contraceptive needs, limited access to subfertility treatments, and declining fertility rates driven by sociodemographic changes, including later marriage ages and increased women's participation in education and the workforce.

Accordingly, this study aimed to identify issues and challenges related to knowledge, attitudes, and contraceptive practices, including subfertility treatment; assess the effectiveness of implementing family planning programmes within existing policies; and propose programme improvements. The study design employs a mixed-methods approach, including a literature review, situational analysis, and both quantitative and qualitative methods. The quantitative component used an online survey with a structured questionnaire administered to women aged 15 to 49 years, while the qualitative component involved in-depth interviews with various groups, including high-risk women, married women experiencing subfertility, unmarried women, and family planning service providers from both the public and private sectors.

The findings indicate that overall knowledge of modern contraceptive methods is high, but knowledge of specific methods, such as the vaginal ring and tubal ligation, remains low. Attitudes towards contraceptive use are generally positive, although concerns about long-term effects on fertility persist. In practice, most respondents accept family planning. Among married women, most have used contraceptives at some point, and about half of currently married women are using them, with condoms the most common method. Most respondents use only one method and make decisions together with their partners, especially when starting or stopping use to have children. The main reasons for not using contraception include the desire to conceive, lack of interest, and concerns about side effects.

In the context of subfertility, the majority of respondents accept modern treatment as appropriate, but access to and use of treatment are still influenced by factors such as cost, time, knowledge, and stigma. Some who underwent treatment for more than two years successfully achieved pregnancy, with the majority receiving treatment at private facilities. Qualitative findings highlight various key themes, including health challenges, the influence of partners and family, financial constraints, emotional distress, and sociocultural norms that affect decisions related to contraception and subfertility treatment. Women experiencing subfertility also face social pressure and a lack of support, while unmarried individuals show changing values toward marriage and

parenthood, increasingly influenced by economic factors and personal readiness.

From the delivery system's perspective, several issues have been identified, including financial and resource constraints, a lack of expertise, and operational challenges in service delivery. In this regard, this study proposes five (5) main directions that emphasise a more comprehensive and integrated approach to strengthening national family planning services. First, sexual and reproductive health education needs to be strengthened through comprehensive educational programmes tailored to target groups, using interactive learning materials and approaches that are responsive to current changes. Emphasis should also be placed on improving reproductive literacy, including understanding contraception, fertility, and informed family planning.

Second, technology is a key catalyst for expanding the reach of information and services. Integrating digital platforms, such as mobile applications and social media, can deliver accurate, easily accessible information, including by collaborating with credible influencers and content creators to raise awareness and reduce stigma related to reproductive health.

Thirdly, the service-related aspect focuses on improving access to and the quality of family planning services. This includes expanding service coverage, strengthening the capacity of expert personnel, ensuring sufficient contraceptive supplies, and providing more comprehensive support for subfertility treatment. These efforts aim to increase the use of modern contraceptives and reduce unmet needs in the community.

Fourth, governance needs stronger inter-agency coordination, particularly between the KKM and LPPKN. This includes developing a clear strategic plan, establishing systematic monitoring mechanisms, and strengthening cross-sector collaboration to implement more efficient, high-impact programmes.

Fifth, strengthening data is an important foundation for evidence-based policy planning. The proposal includes establishing a National Sexual and Reproductive Health Data Hub, implementing periodic family planning surveys (for example, every five years), and conducting annual thematic studies. This approach will ensure that comprehensive, up-to-date, and relevant data is always available to support decision-making and continuous policy improvement.

Overall, this study emphasises that family planning remains an important agenda for ensuring family welfare and sustainable national development. Although the community's knowledge and attitudes towards contraceptives are positive, challenges in practice, access to services, and subfertility still require continuous attention.

An integrated approach, through strengthening education, utilising technology, improving services, effective governance, and a robust data system, is essential to ensure that the policies and programmes implemented are more responsive and impactful. In line with society's changing needs, family planning has evolved from its original focus on controlling the number of children to a more comprehensive approach, including support for subfertility treatments, thereby strengthening its role as an inclusive, resilient, and evidence-based support system for people's well-being.

Introduction



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Definition of Family Planning

Working definition used by the Department of Reproductive Health and Research, World Health Organization (WHO):

> ***"the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility"***
>
> ***World Health Organization (WHO), 2008***

Background of the Family Planning Programme

The family planning programme in this country is led by two main institutions, namely the National Population and Family Development Board (LPPKN) and the Ministry of Health Malaysia (KKM). LPPKN plays an important role in shaping the National Family Planning Guidelines, which serve as the master plan for family planning programme initiatives in the country. These guidelines ensure that family planning services are integrated with maternal and child health services, making them easily accessible through public health facilities (Lorenzoni et al., 2022).

In addition to developing national guidelines, LPPKN provides family planning services, including educational programmes and awareness campaigns that inform the public about the importance of family planning, whether through contraceptive use or subfertility treatments. One strategic initiative is establishing a network of 50 LPPKN Nur Sejahtera Clinics nationwide to provide a range of family planning services, including health screenings and counselling sessions, to support individuals and families in making informed decisions about their reproductive health.

KKM also provides family planning services through health clinics and government hospitals nationwide. KKM's services also include counselling, education, and the distribution of various contraceptive methods. In addition to the government sector, the private sector plays an important role in reproductive health, especially through subfertility treatments. Various private hospitals and clinics offer subfertility treatment services, including TMC Fertility Centre, Alpha Fertility Centre, and Sunway Fertility Centre.

Family planning programmes and services in this country have evolved since the enactment of the National Population and Family Development Act 1966 (APPK 1966, Act 352). The Act aims to regulate and promote reproductive health by ensuring that family planning services are accessible to all citizens. The 1966 Family Planning Act recognises the importance of reproductive health in national development, emphasising maternal and child health, population growth and development, and empowering individuals to make informed choices about family life (Mohd Nor et al., 2022).

Background of the Study

To obtain a more comprehensive picture of the issues and challenges related to family planning practices in this country, the Ministry of Women, Family and Community Development (KPWKM), through LPPKN, has appointed UPUM Sdn. Bhd. (University of Malaya Consulting Group) to conduct the Study of Family Planning Practices in Malaysia from 1st August 2024 to 31st October 2025. The United Nations Population Fund (UNFPA) funds the study through the Country Programme Action Plan (CPAP), 2021-2025.

The main objectives of the study are to:

01

Identify issues and challenges in family planning, including the use of contraceptives and subfertility treatments.

02

Evaluate the effectiveness of implementing family planning programmes, which include contraceptive services and subfertility treatments, within the context of existing government policies.

03

Recommend future improvements to the national family planning programme to make it more responsive, inclusive, and aligned with the needs of couples and families in Malaysia.

METHODOLOGY

Scope of Study

To comprehensively identify issues and challenges related to family planning, this study incorporates the perspectives of family planning users among women, as well as service providers from government or private premises involved in implementing family planning programmes or services.

Study Design

This study uses a mixed-methods design that combines quantitative and qualitative approaches. This approach was chosen to provide a more comprehensive and holistic picture of the issues and challenges under investigation.

Sample Size

The sample of this study comprises: (i) married women aged 15 to 49 years; (ii) unmarried women; and (iii) healthcare providers involved in family planning and subfertility treatment.

Here is the sample size for the study, based on the data collection method used:

Online survey
Women aged 15-49: 1,029 respondents

In-depth interview (IDI)
i. Married women aged 15-49: 39 respondents
ii. Unmarried women (aged less than 30 years): 22 respondents
iii. Healthcare service providers: 15 respondents

Online survey respondents were recruited through social media platform, including Facebook and WhatsApp

In-depth interview informants were identified from a list of respondents who completed the online survey and through snowball sampling.

Respondent Profile for Online Survey

	Number	Percentage
Place of Residence		
Urban	866	84.2
Rural	163	15.8
Age Group		
15 to 19 Years Old	15	1.5
20 to 24 Years Old	202	19.6
25 to 29 Years Old	154	15.0
30 to 34 Years Old	183	17.8
35 to 39 Years Old	195	19.0
40 to 44 Years Old	180	17.5
45 to 49 Years Old	100	9.7
Marital Status		
Currently Married	604	58.7
Divorced / Separated / Widowed	42	4.1
Never Married	383	37.2
Ethnicity		
Malay	797	77.5
Chinese	150	14.6
Indian	48	4.7
Others	34	3.3
Highest Level of Education		
Diploma / Certificate and Below	374	36.3
Bachelor's Degree and Above	655	63.7
Employment Status		
Government	433	42.1
Private Sector	256	24.9
Self-Employed	56	5.4
Not Employed	284	27.6
Household Income		
Less Than RM2,500	246	23.9
RM2,500 to RM4,849	292	28.4
RM4,850 to RM10,959	328	31.9
RM10,960 and Above	163	15.8
TOTAL	**1,029**	**100.0**

Respondent Profile for In-Depth Interview

	Number	Percentage
Place of Residence		
Urban	47	77.1
Rural	14	22.9
Age Group		
15 to 29 Years Old	30	49.2
30 to 9 Years Old	11	18.0
40 to 49 Years Old	20	32.8
Ethnicity		
Malay	44	72.1
Chinese	7	11.5
Indian	5	8.2
Others	5	8.2
Marital Status		
Currently Married	37	60.7
Divorced / Separated / Widowed	2	3.3
Never Married	22	36.1
Employment Status		
Working	33	54.1
Not Working	28	45.9
Family Planning Category		
Has Subfertility Problems	12	19.7
Contraceptive Method User	29	47.5
Non-User of Contraceptive Methods	20	32.8
Health Status		
With Health Problems	10	16.4
Without Health Problems	51	83.6
Disability Status		
Person with Disabilities (PWD)	5	8.2
Person without Disabilities (Non-PWD)	56	91.8
TOTAL	**61**	**100.0**

Data Collection Methods

For the quantitative study, data were collected online via a self-administered questionnaire. Respondents were recruited through various social media platforms, including Facebook and WhatsApp, as well as email. The questionnaire comprised four (4) main sections: (i) respondent background and marital status; (ii) sexual and reproductive health, pregnancy, and fertility; (iii) family planning practices; and (iv) abortion/miscarriage.

For the qualitative study, data were collected through in-depth interview sessions using semi-structured questionnaires. This approach aims to gather more detailed information about women's experiences with family planning practices and subfertility treatments, including experiences from selected service providers.

Data Analysis

Quantitative Data

Descriptive analysis is used to generate profiles of knowledge, attitude, and practice (KAP) levels related to family planning and subfertility, according to the respondents' sociodemographic background and strata; to examine the characteristics of respondents in the practice of contraceptive use (modern and traditional); and to examine the characteristics of decision-makers in the use of contraceptive methods.

Inferential analysis is used to examine knowledge scores on family planning methods and practices by respondents' sociodemographic background and strata, as well as the factors influencing knowledge levels and contraceptive use.

Qualitative Data

Qualitative data analysis is conducted through a thematic analysis approach based on the framework proposed by Paul Colaizzi (1978), to systematically structure and interpret the meaning of respondents' experiences. Next, the findings are reinforced through the application of the Define, Design, Refine (DDR) method, implemented in phases, including: (i) Phase 1 – phenomenological analysis to identify the main themes; (ii) Phase 2 – design of the phenomenological framework based on the findings; and (iii) Phase 3 – evaluation and refinement of the findings from Phases 1 and 2.

Study Limitation

The findings of this study are not intended to be statistically representative of the entire country's population. Because the quantitative component of the study used a self-administered online survey, respondents were limited to individuals with internet access who were willing to participate.

As widely reported in the literature on online surveys, this approach may overrepresent individuals living in urban areas, those with higher levels of education, and those with better access to technology and the internet.

Therefore, the findings should be interpreted as reflecting only the views, experiences, and practices of study respondents, rather than as estimates representative of the Malaysian population as a whole. They should not be generalised to the national population, and caution is needed when interpreting results for respondent subgroups with small sample sizes.

Literature Review



Photo : cottonbro studio / Pexels

Factors Influencing the Practice of Contraceptive Use and Subfertility Treatment

Individual Factor

- Women with higher levels of education in this country are more likely to use modern contraception and to delay childbirth (Hoo & Lai, 2023; Samat et al., 2022; Abdullah et al., 2021).
- The prevalence of unmet contraceptive needs is higher among women aged 36 and above (Awaluddin et al., 2025).
- The age at marriage affects lifelong fertility patterns (Tey Nai Peng, 2020).
- Higher income and involvement in paid employment are associated with joint decision-making (husband and wife) on contraceptive use and with greater access to modern contraceptives (Awaluddin et al., 2025; Lai et al., 2020; Damtew & Fantaye, 2024; Gemmill, 2018).
- Women living in urban areas report higher use of modern contraceptives than those in rural areas (Hoo & Lai, 2023; Tey Nai Peng, 2020).
- A longer duration of marriage influences the choice of methods and decision-making autonomy (Suriyani Muhammad et al., 2019).
- A higher level of contraceptive knowledge is closely associated with a positive attitude and a greater likelihood of use (Shafei et al., 2012; Najafi et al., 2011).
- Lack of knowledge often raises concerns about side effects, which is the main reason women in Malaysia do not use or stop using modern contraceptives (Wong, 2012; Wong et al., 2014).
- The knowledge gap regarding emergency contraceptives creates confusion about their proper use (Malaysian Journal of Pharmacy, 2019).
- Frequent discontinuation of use indicates challenges with access to services and with confidence in contraceptive methods (Shafei et al., 2012; Najafi et al., 2011).
- The knowledge and skills of service providers also determine which contraceptive methods are offered (Abdullah et al., 2017).

- Conservative sexual norms and religious values among Malay Muslim women are linked to low reproductive health literacy and limited acceptance of modern methods (Wong, 2012; Strathclyde University, 2018).

- Concerns about the perception that contraceptive use may affect future fertility (Wong, 2012).

Family and Community Factor

- Partners and family are the primary influences on contraceptive use and the decision-making process related to contraception (Kassa et al., 2022; Najafi-Sharjabad et al., 2014).

- Women with more than 4 children in this country are almost three times more likely to use contraception (Mansor & Lim Abdullah, 2015).

- Husbands often play the role of primary decision-makers regarding fertility intentions and contraceptive use (Kassa et al., 2022; Kabagenyi et al., 2014).

- Subfertility among men threatens social identity and masculinity, leading to concealment and low engagement with subfertility treatment (Liyanage et al., 2024; Iwelumor et al., 2019).

- Family pressure, particularly from in-laws, reinforces fertility expectations and constrains autonomy in contraceptive decisions and subfertility treatments (Lawrenz et al., 2019; Iwelumor et al., 2019; Pradhan & Mondal, 2023).

- Effective communication between husband and wife increases the likelihood of using modern methods (Najafi-Sharjabad et al., 2014).

- Although women often initiate the use of contraception, men more frequently make the final decisions about the choice of method and its continued use in this country (Tong et al., 2014; Low et al., 2006).

- The traditional expectation that motherhood signifies household happiness also makes male consent a prerequisite for using contraception (Wong et al., 2009).

- Ongoing fears of side effects and perceptions of subfertility risk associated with contraceptives continue to hinder use, particularly in households where male dominance and reproductive decision-making prevail (Wong et al., 2009; Mansor & Lim Abdullah, 2015).

- The rate of contraceptive use is higher, and the range of methods is broader among urban women (Samat et al., 2021; Tey & Abdurahman, 1981).

- Distance is a major barrier, as women living more than 60 kilometres from fertility treatment centres record significantly lower usage rates (Lazzari et al., 2022).

- Rural communities often face higher transport costs, disrupted continuity of care, and limited access to contraceptive options (Freitas et al., 2024; Goncalves et al., 2025).

- Specialised reproductive services, such as fertility treatments, are concentrated in tertiary hospitals in major urban areas, creating a wider access gap for residents in underdeveloped areas (Ali et al., 2024).

- Factors hindering use include concerns about side effects, inadequate counselling, and lack of partner involvement (Lee et al., 2019; Hafizah et al., 2020).

Sociocultural Factor

- Religious beliefs, particularly conservative Islamic values, shape perceptions of premarital sexuality, family size, and the acceptance of modern contraceptive methods (Wong, 2012a; Alomair et al., 2020).

- Ethnic identity contributes to variations in reproductive health knowledge and autonomy, with Malay Muslim women facing stigma compared with Chinese and Indian women (Wong, 2012b; Najafi-Sharjabad et al., 2014).

- Although there are various interpretations and some Muslim women accept contraception for child spacing, efforts to limit the number of children are often viewed negatively (Abdi et al., 2020).

- Systemic constraints limit at-risk women's access to services, contraceptive options, and reproductive counselling (Sukeri et al., 2023).

- Accessibility is compromised when rural communities face a lack of facilities and service capacity, as well as high financial costs (Cheong et al., 2021; Loganathan et al., 2020; Sawadogo et al., 2023).

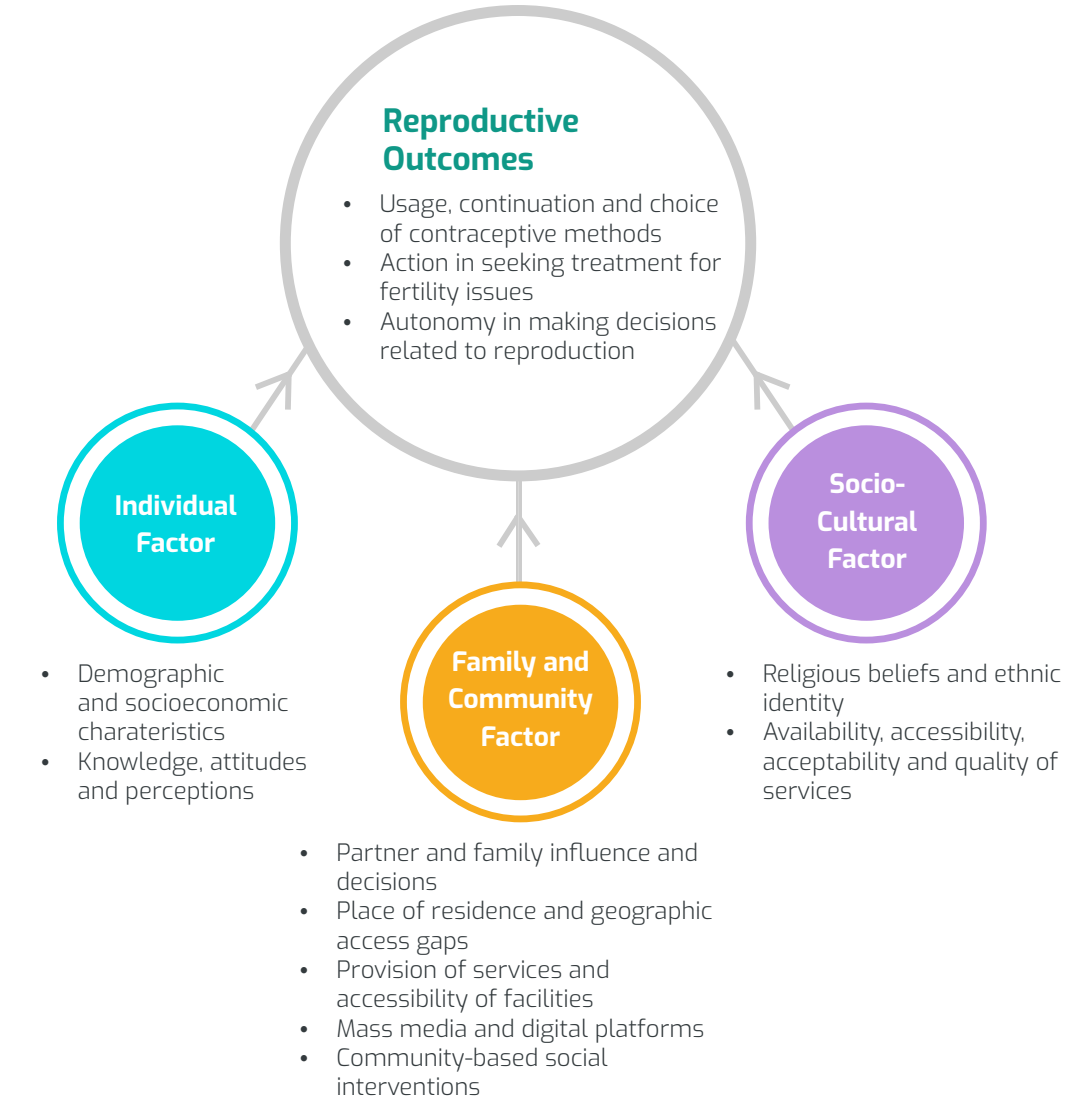
- Availability remains limited due to shortages and uneven distribution of workforce and contraceptive supplies (Homer et al., 2018).

- Language barriers, cultural dissonance, and discrimination disproportionately burden marginalised populations (Quayson et al., 2018).

- Accessibility is compromised when rural communities face a lack of facilities and service capacity, as well as high financial costs (Cheong et al., 2021; Loganathan et al., 2020; Sawadogo et al., 2023).

- The stigma associated with subfertility triggers psychological stress in the community (Hussain et al., 2020).

Factors Influencing the Practice of Contraceptive Use and Subfertility Treatment



Conceptual Framework - Factors Influencing Family Planning Practices in Malaysia

Implementation of the Family Planning Programme

Philippines

CPR 58%
2022

TFR 1.9
2023

UMN 12%
2022



The Philippines implements family planning policies to address rapid population growth and high fertility rates, emphasising improved family welfare and maternal and child health. This policy is based on the principle of responsible parenthood: families' ability to make reproductive decisions wisely, according to their socioeconomic capacity.

The family planning programme in the Philippines was officially implemented in the late 1960s, particularly with the introduction of the national policy in 1969 and the launch of the Philippine Population Programme in 1970 through Executive Order No. 233. The programme's implementation was further strengthened in the early 1970s with the establishment of the Commission on Population (POPCOM) as the main national coordinating body. This policy aims to achieve balanced population growth and strengthen human capital development by forming quality families.

The legal framework for family planning in the Philippines is strengthened through the enactment of the Responsible Parenthood and Reproductive Health Act (RA 10354, 2012), which guarantees comprehensive access to reproductive health services, including contraceptives and maternal and child care. The policy's implementation is supported by integrating services within the public health system, providing reproductive health education in schools, offering contraceptive subsidies, and fostering collaboration among government agencies, local authorities, and NGOs. This approach expands access to services, particularly for underprivileged communities and remote areas.

The Philippine family planning programme has made significant progress, with the fertility rate falling to around 1.9 children per woman, below the replacement level, while the use of modern contraceptive methods continues to rise among women of reproductive age. Additionally, more than nine million Filipinos now use family planning methods, contributing to a reduction in the population growth rate to around 0.8% from 2020 to 2024. However, challenges remain, including unequal access between regions, unmet family planning needs, and the rising issue of teenage pregnancies, which require more targeted interventions.

Singapore

CPR 62% 1997

TFR 1.0 2023

UMN 10% 2023



Singapore's family planning policy began in the 1960s to control rapid population growth and protect economic stability and national resources. Through the provision of access to contraceptives and maternal and child health services, this policy significantly reduced the fertility rate. Institutional frameworks such as the Singapore Family Planning Association (SFPA) and the Singapore Family Planning and Population Board (SFPPB), along with legislative policies like the Two-Child Policy and the Termination of Pregnancy and Sterilisation Act (1974), form the main foundation of the country's success in birth control.

However, this success drove the fertility rate below replacement level, prompting Singapore to shift to a pronatalist policy from the late 1980s. The government introduced various family-friendly measures, such as the Marriage and Parenthood Package, financial incentives, childcare subsidies, parental leave, and funding for fertility treatments through the ART scheme. Singapore faces a serious challenge as the total fertility rate (TFR) fell to around 0.87 in 2025—the country's lowest on record—suggesting that existing pronatalist measures remain insufficient to raise the birth rate. This situation has prompted the government to continually reassess family support policies and introduce new approaches to address changing attitudes towards marriage and parenthood, as well as the rising cost of living.

Thailand

CPR 73% 2022

TFR 1.2 2023

UMN 9% 2022



Thailand is one of the most successful ASEAN countries in implementing a comprehensive family planning programme since the early 1970s through the National Family Planning Programme (NFPP). The main objective of this policy is to reduce the population growth rate by promoting the widespread use of contraceptives, particularly through a community-based approach. The NFPP's success is driven by innovative strategies such as involving community health volunteers and integrating family

planning services into the primary healthcare system, ensuring widespread access regardless of location or socioeconomic background.

In response to evolving public health challenges, Thailand introduced the National Reproductive Health Policy 2010–2020, which emphasises inclusive access to reproductive health, particularly for marginalised groups such as adolescents and young women. The policy emphasises sexual and reproductive health education, counselling, and a range of contraceptive methods to reduce unmet need.

Thailand records a high rate of contraceptive use among married women, with around 70% using at least one method, reflecting the effectiveness of the country's long-term programmes. However, the country's fertility rate has fallen significantly to around 1.2–1.5 children per woman, far below the replacement level, making Thailand an ageing society facing population decline. This situation indicates that policy focus is increasingly shifting from birth control to managing demographic impacts, such as an ageing population and labour shortages.

Japan





Japan's family planning policy was developed to integrate family planning services with maternal and child healthcare while also addressing the declining birth rate. This approach began to take shape in the post-World War II era, particularly in the early 1950s, when the family planning movement gained wider traction with the establishment of the Japan Family Planning Association in 1954. The main objective of this policy is not only to ensure access to contraceptives and reproductive health counselling but also to create a social environment that supports family well-being. This approach views family planning as part of a comprehensive support system that enables individuals and couples to balance work responsibilities and family life.

Japan's legal framework is strengthened by the Maternal and Child Health Law of 1965 and the Basic Law on Measures for Society with Decreasing Birthrate of 2003. This law integrates family planning services with prenatal and postnatal care and introduces family-friendly measures such as parental leave, work-life balance, and continued access to contraception. Implementing this policy faces ongoing challenges, as Japan's fertility rate remains very low, around 1.15 in 2024, reflecting the policy's limited success in increasing births despite various interventions. This suggests Japan's family planning

approach has shifted from population control to efforts to support higher birth rates amid an ageing society and population decline.

Netherlands

CPR 73% 2013

TFR 1.4 2023

UMN 7% 2023



Family planning policy in the Netherlands is grounded in a progressive approach that emphasises reproductive rights, individual autonomy, and universal access to reproductive health services. Family planning services are not delivered in isolation; instead, they are fully integrated into the national public health system, which is based on the principle of universal health coverage. This approach ensures that every individual, regardless of gender, age, or socioeconomic background, has access to the information, education, and contraceptive methods needed to make informed reproductive decisions.

Although the Netherlands has no specific family planning laws, the national health insurance system and close cooperation with NGOs such as the Rutgers Programme strengthen the implementation of this policy. The main strategies include comprehensive sex education in schools, widespread access to modern contraceptives, including long-acting reversible contraception (LARC), and financial support for fertility treatments such as IVF and ICSI.

Indonesia

CPR 53% 2023

TFR 2.1 2023

UMN 11% 2017



Indonesia implements its family planning policy through the National Family Planning Program, with the main objectives of reducing the fertility rate, improving reproductive health, and balancing population growth. The program was officially launched in 1970 through the establishment of the National Family Planning Coordinating Board (BKKBN) as the main agency coordinating family planning policies at the national level. It was developed to address rapid population growth, which could undermine the country's

socioeconomic development. The policy approach also emphasises expanding access to reproductive health services so all segments of society can benefit, particularly rural populations and hard-to-reach communities.

Indonesia strengthened its legislative framework and family planning institutions by establishing the National Population and Family Planning Board (BKKBN) and enacting the Population and Family Development Law No. 52/2009. The policy's implementation is supported by community-based strategies, including the role of health cadres, large-scale media campaigns, the provision of various contraceptive methods, including long-term methods, and efforts to increase male involvement in family planning. The institution also underwent restructuring when BKKBN expanded its functions and was merged under the Ministry of Population and Family Development (Kemendukbangga) in 2024 to strengthen coordination of population and family development policies more holistically.

Turkey



Turkey's family planning policy began with the enactment of the Population Planning Law No. 557 in 1965, which recognised the negative impact of rapid population growth on economic development and maternal and child health. This policy marked an important change by officially permitting the use of contraceptives and making family planning part of the national development agenda in line with the modernisation process. This approach emphasises that fertility management is not just a personal issue but is closely linked to national welfare and public health advancement.

Family planning is integrated into the national health system, with strong support from the Ministry of Health and consistent, persuasive public communication strategies. Media campaigns, posters, and face-to-face approaches raise awareness and shift cultural norms around family size. The rate of modern family planning method use in Turkey remains moderate, with only about one-third to half of married women using modern methods. There is a significant unmet need, and the country faces a low and continuously declining fertility rate far below the replacement level – indicating that challenges of access, cultural norms, and unmet needs persist despite the programme having lasted several decades.

Morocco

CPR 70% 2018

TFR 1.5 2023

UMN 12% 2018



Morocco's family planning policy began in the 1960s in response to rapid population growth and very high fertility rates. The initial objective was to slow population growth by reducing fertility rates and improving maternal and child health, in line with the country's economic development needs. Over time, family planning in Morocco evolved into a broader social development strategy, emphasising family welfare and women's empowerment through education and workforce participation.

In terms of implementation, family planning was integrated into the public health system without specific legal support at the outset, but the Ministry of Health strengthened it through active leadership and support from international partners. The main strategies include providing contraceptives free of charge at public health facilities, awareness campaigns through the media and community leaders, and involving partners in reproductive decision-making. The rate of modern contraceptive use in Morocco is high among married women, with over 70% using some form of contraception and most choosing the pill as the primary method. The national fertility rate has significantly decreased to around 2.1–2.4 children per woman, indicating the success of the family planning agenda, while access gaps in rural areas and cultural perceptions towards certain methods remain to be addressed.

Eygpt

CPR 59% 2014

TFR 2.8 2023

UMN 13% 2014



Family planning policy in Egypt began informally in the 1950s through voluntary private-sector clinics, before evolving into a national policy as rapid population growth was seen as a threat to the country's economic development. The main turning point came in 1962, when the government officially supported family planning as part of the national agenda. Since then, the policy has focused on reducing birth rates by providing reproductive health services, emphasising that population issues are closely linked to economic progress and social welfare.

Egypt strengthened its institutional framework by establishing the Supreme Council for Population and Family Planning in 1965, which later evolved into the National Population Council (NPC), which coordinates policies and implementation across various ministries and international partners. Implementation strategies include integrating family planning into the public health system, providing low-cost or free contraceptives, providing intensive training for health workers, and running large-scale public communication campaigns through mass media. The Egyptian family planning programme continues to be a key component of population policy, with a gradually increasing contraceptive use rate and efforts to reduce access gaps in rural areas. However, the domestic fertility rate remains around 3.1–3.5 children per woman, and unmet needs remain high among certain groups, particularly adolescents and in low-income areas.

Bangladesh





Bangladesh has aggressively implemented family planning policies since the 1970s to curb very high population growth and improve maternal and child health. Significant investment in community-based family planning programmes has consistently reduced the fertility rate, from around six births per woman in the 1970s to nearly replacement level in recent decades. This success is attributed to expanded access to modern contraceptives, effective community communication strategies, and the integration of family planning into the national development agenda.

The use of modern family planning methods in Bangladesh remains high, with over 60% of married women using some form of contraception. However, regional variations and unmet needs persist, particularly among adolescents and in rural areas, where use remains low. New programmes, such as the National Family Planning Strategy 2025–2030, have been launched to address these issues. At the institutional level, the Ministry of Health and Family Welfare coordinates policy implementation, with strong support from a network of women community workers known as Family Welfare Assistants (FWA). Key strategies, such as doorstep delivery, enable counselling and contraceptive services to be provided directly at home, thereby overcoming cultural and access barriers, especially in rural areas.

Australia

CPR 65% 2016

TFR 1.5 2023

UMN 10% 2023



Australia's family planning policy emphasises equitable access to reproductive health services as part of the universal health system. The main objective of this policy is to ensure that all layers of society, particularly remote communities and Aboriginal and Torres Strait Islander communities, have access to safe, effective, and affordable contraceptive methods. The modern family planning movement and policy in Australia have developed since the early 20th century, through the establishment of organisations such as Family Planning Australia (founded in 1926), and in the 1970s, when modern contraceptive methods, including the pill, began to be extended to all women without the condition of marriage, helping to formalise access to family planning. Australia recognises the diversity of reproductive needs based on geographical and cultural contexts and is committed to reducing the health inequality gap between indigenous communities and the general population.

Australia's legislative framework is supported by the Pharmaceutical Benefits Scheme (PBS), which provides contraceptive subsidies, as well as specific programmes such as the Remote Area Aboriginal Health Services (RAAHS) and the Closing the Gap PBS Co-payment to improve access among Indigenous communities. Implementation strategies include mobile health services, telemedicine, satellite clinics in remote areas, and expanding the role of community pharmacies. Family planning efforts continue to be strengthened through initiatives to make contraceptives more affordable via the PBS and targeted reproductive health campaigns. Australia also faces demographic challenges, including low fertility rates and the need to increase awareness and access among marginalised communities.

Mexico

CPR 69% 2023

TFR 1.9 2023

UMN 11% 2018



The family planning policy in Mexico is implemented through a comprehensive approach with the main goals of improving reproductive health, expanding access to contraceptives, particularly among low-income groups, and addressing teenage

pregnancy. The national family planning programme began developing in the early 1970s, when the government changed population policies, including the 1974 constitutional amendment guaranteeing every couple the right to make reproductive decisions and the launch of the Programa Nacional de Planificación Familiar in 1977 as the official national programme.

Mexico's legal framework is strengthened by the National Population Program, the General Health Law of 1984, which mandates integrating family planning into primary healthcare, and the National Strategy for the Prevention of Adolescent Pregnancy (ENAPEA). Policy implementation emphasises community outreach, sexual and reproductive health education, and the free distribution of contraceptives to target groups. The rate of modern family planning method use in Mexico is relatively high, and the fertility rate has decreased to nearly replacement level. However, an access gap remains between urban and rural areas, as well as within indigenous communities. Efforts in education and service expansion continue to be the focus of policies to address teenage pregnancy and reproductive health inequalities in some areas.

Germany

CPR 68% 2023

TFR 1.4 2023

UMN 9% 2023

Family planning policy in Germany is part of the universal healthcare system, which emphasises reproductive rights and individual autonomy. This approach has developed formally since the mid-20th century, with sex education and contraceptive information legally supported through the Sexual Education Act in 1995. Access to modern contraceptives and counselling has continued to evolve since the 1970s and 1980s as part of public health policy and reproductive rights. The main objective of this policy is to ensure equitable access to contraceptives, particularly among young people, while strengthening comprehensive sexual and reproductive health education. This approach aims to help individuals make informed, stigma-free, evidence-based reproductive decisions from a young age.

The German legal framework is strengthened by a mandatory health insurance scheme that provides age-based contraceptive coverage, as well as free and anonymous sexual and reproductive health counselling services, as stipulated under the SchKG. The implementation strategy involves systematic sexual education in schools, a network of public counselling and NGOs such as Pro Familia, and the availability of various contraceptive methods, including emergency pills without a prescription. Contraceptive use in Germany is high, with around 76% of sexually active adults

reporting use – the highest level in over a decade – and nearly 87% of teenagers and young adults using methods during sexual intercourse. This reflects the effectiveness of sex education and cervical access, although method choices are changing (for example, pill use has slightly decreased while condom use remains dominant).

France



CPR 78% 2023

TFR 1.7 2023

UMN 4% 2023

The French legal and institutional framework supports the widespread provision of free contraceptives, including emergency pills without a prescription for all women and free condoms for individuals under 26 years old. The French Social Security scheme (Assurance Maladie) supports implementation by fully funding young people, supporting services at family planning centres, and running comprehensive public awareness campaigns. France continues to expand access, including the introduction of free contraceptives for women up to the age of 25 through a new policy since 2022, as a measure to address financial barriers to contraceptive use among young people while maintaining a high level of use of modern methods, although access gaps still occur in some communities.

United Kingdom



CPR 76% 2023

TFR 1.6 2023

UMN 7% 2023

The family planning policy in the United Kingdom is implemented by providing free, universal access to contraceptives through the National Health Service (NHS). The NHS family planning access policy formally began with the enactment of the National Health Service (Family Planning) Act in 1967, which extended contraceptive services through the NHS to everyone, including young people, not just those at risk. The main objective of this policy is to ensure that all residents, including young people and teenagers under the age of 16, have access to contraceptive services without discrimination and without exposing their identities. This approach emphasises that reproductive health is a fundamental right that the public health system must protect, regardless of age, social status, or geographic location.

The UK legal and institutional framework ensures that all contraceptive methods, including emergency contraceptive pills, are provided free of charge through NHS facilities, family planning clinics, and community pharmacies. The NHS Pharmacy Contraception Service (PCS) and innovations such as telemedicine and online consultations reinforce policy implementation, especially during the COVID-19 pandemic. Access to contraceptive services remains free through the NHS via various channels (GPs, sexual and reproductive health clinics, pharmacies), and efforts to improve access, such as distributing emergency contraceptive pills free of charge at nearly 10,000 pharmacies, have been implemented to reduce service gaps. However, some studies indicate that practical barriers, such as waiting times and variations in local access, still exist.

Canada





The family planning policy in Canada is grounded in a commitment to universal access to contraception within the public health system and to reproductive health rights. The policy's main objective is to ensure that all Canadians, regardless of geographical location or socioeconomic status, have access to safe, effective, and affordable contraceptive methods. Canada recognises that access to contraception is not only a public health issue but also an important human right that supports individual well-being and family planning.

The Canadian legislative framework is strengthened by the introduction of Bill C-64 (National Pharmacare), which prioritises contraceptive services and aims to provide universal access, as well as by regional implementations such as in British Columbia, which offers free contraceptives and covers sterilisation procedures under health insurance. The implementation strategy emphasises cooperation between the federal and provincial governments, access without identity disclosure, especially for young people, and an evidence-based approach that demonstrates a positive return on investment through the reduction of costs related to unwanted pregnancies. With the enactment of the Pharmacare Act and agreements between the federal government and several provinces for universal contraceptive coverage, Canada is moving towards free contraceptive access for millions of its citizens, although full implementation still depends on negotiations and cooperation with other provinces, and access gaps remain in certain areas.

Study Findings



Photo : Mikhail Maslov / Pexels

Issues and Challenges Related to Family Planning Practices

Issue and Challenge #1:

High Knowledge of Basic Contraceptive Methods, But Gaps Remain For Less Common Methods

More than 80% of respondents were aware of basic methods such as pills, injections, implants, and the withdrawal method. However, awareness of less commonly known methods, including hormonal patches, tubal ligation, and vaginal rings, was reported by only about half of married women respondents. Overall, nearly two-thirds of married women respondents had insufficient knowledge about the use of contraceptives.

The qualitative findings further suggest that information on contraception is often obtained through a combination of formal and informal sources. In addition to healthcare providers, respondents frequently relied on the internet, social media, Google searches, peers, and the experiences of others. Reliance on these sources, coupled with limited knowledge during the early stages of marriage, may contribute to delays in informed family planning decision-making and, in some cases, unintended pregnancies.

Findings of the Quantitative Study

- More than 80% of married women respondents were aware of basic contraceptive methods, including the condom (95.0%), pill (85.1%), injection (86.8%), implant (85.1%), and withdrawal method (89.7%).

- Only about half of married women respondents were aware of less common contraceptive methods, including hormonal patches (58.6%), tubal ligation (55.6%), and vaginal rings (55.1%).

- Almost two-thirds of married women respondents lack sufficient knowledge of contraceptive methods (low knowledge: 26.0%; moderate knowledge: 36.3%).

Findings of the Qualitative Study

"Everything I know comes from the nurse and Google" (Informant 15, 45 years old, visually impaired).

"I get my information from the internet or online platforms, forums, TV and radio, YouTube, official government accounts, and hospitals. I often check Instagram, Facebook and TikTok, but I prefer official sources and registered doctors" (Informant 18, 35 years old).

"Usually, just the internet.. I look at other people's experiences.. ask my friends" (Informant 24, 45 years old).

"The main source of information is (public health facility) and the pink book. If something isn't clear, I Google it" (Informant 22, 38 years old).

"At that time, I didn't really know. At the beginning, I couldn't.. Then, I didn't have time to plan, and I was already pregnant" (Informant 23, 47 years old).

Proportion of Women with Knowledge of Contraceptive Methods by Marital Status

	Currently Married	Divorced / Separated / Widow	Never Married	Total
Condom	95.0	92.9	87.2	92.0
Contraceptive pill	85.1	83.3	70.5	80.9
Intrauterine Device	89.1	90.5	66.8	79.6
Injection	86.8	85.7	60.1	76.8
Implant	85.1	83.3	56.1	74.2
Vasectomy	73.0	69.0	61.6	68.8
Emergency Contraceptive Pill	70.0	78.6	59.8	66.6
Hormonal Patch	58.6	64.3	39.9	51.9
Vaginal Ring	55.1	66.7	44.6	51.7
Tubal Ligation	55.6	66.7	44.6	52.0
Calendar-based Method	92.9	90.5	80.2	88.0
Withdrawal Method	89.7	88.1	54.8	76.7
Breastfeeding	75.7	78.6	41.0	62.9

Percentage of Women by Level of Knowledge on Contraceptive Methods and Sociodemographic Characteristic

	Low	Moderate	High	Total
Place of Residence				
Urban	39.8	30.9	29.2	100.0
Rural	38.7	32.5	28.8	100.0
Marital Status				
Currently Married	26.0	36.3	37.7	100.0
Separated / Divorced / Widowed	23.8	45.2	31.0	100.0
Never Married	62.9	21.7	15.4	100.0
Ethnicity				
Malay	37.4	32.0	30.6	100.0
Chinese	54.0	25.3	20.7	100.0
Indian	37.5	33.3	29.2	100.0
Sabah Bumiputera	28.6	50.0	21.4	100.0
Sarawak Bumiputera	35.0	25.0	40.0	100.0
Household Income				
Less than RM2,500	62.6	23.2	14.2	100.0
RM2,500 – RM4,899	41.1	30.5	28.4	100.0
RM4,850 – RM10,959	29.6	34.5	36.0	100.0
RM10,960 and above	22.7	38.0	39.3	100.0
Overall	**39.7**	**31.2**	**29.2**	**100.0**

Note: Respondents level of knowledge was measured based on nine (9) statements. Scores ranging from 0-5 were categorised as "low", scores of 6-7 as "moderate", and scores of 8-9 as "high".

Question: Based on the following statements, please indicate Yes / No / Not Sure:
(i) Condoms should not be used beyond their expiry date;
(ii) An intrauterine contraceptive device (IUCD) cannot be used by nulliparous women (women who have never given birth);
(iii) Male vasectomy (a surgical procedure for sterilisation) and female sterilisation (a permanent procedure to prevent pregnancy) are the most effective methods of birth control;
(iv) Emergency contraceptive pills are taken immediately after sexual intercourse;
(v) Women must take contraceptive pills every day to prevent pregnancy;
(vi) Contraceptive injections are administered every two or three months;
(vii) A married couple can avoid sexual intercourse during the fertile days when pregnancy is most likely to occur;
(viii) Contraceptive methods are used to limit the number of children; and
(ix) Contraceptive methods are used to space pregnancies.

Issue and Challenge #2:

Misconceptions Concerning the Utilisation of Contraceptive Methods

Survey findings indicate that misconceptions about contraception remain prevalent among married women. Some respondents believe that using condoms reduces sexual pleasure and that contraceptive use can affect fertility, while more than one-third believe that discussing contraception with young people may encourage inappropriate social behaviour.

Qualitative findings further support the quantitative findings, highlighting concerns about hormonal effects and side effects, as well as partner influence, as important factors contributing to the non-use of modern contraceptive methods. Consequently, some women opt for traditional methods or refrain from using contraception altogether, potentially limiting effective family planning and increasing the risk of unintended pregnancies.

Findings of the Quantitative Study

- More than one-quarter (28.0%) of married women respondents believed that condom use reduces sexual pleasure.
- One-fifth (20.9%) of married women respondents believed that contraceptive use could affect fertility.
- More than one-third (35.3%) of married women respondents believed that discussing contraceptive use with young people would encourage inappropriate social behaviour.

Findings of the Qualitative Study

"I don't trust myself when it comes to taking pills.. As for injections, I really can't do that. My husband doesn't encourage me to take the pills either" (Informant 22, 38 years old).

"I'm afraid it might interfere with my hormones.. So, I don't use it, I use traditional methods instead" (Informant 33, 26 years old).

"I've used the implant and had the injections too. After that, I ate a lot. Having irregular periods is normal, right?" (Informant 25, 47 years old).

Proportion of Married Women Who Agreed with Selected Statements

	Percentage
The use of contraceptives is against religious beliefs and cultural values.	6.5
Contraceptives are only important for women (not men).	5.6
Condom use reduces pleasure in sexual intercouse.	21.4
Contraceptive use can affect fertility in the future.	21.4
Discussing contraceptive methods with young people will encourage promiscuity.	31.4
Contraceptive use is important to prevent unintended pregnancy.	73.3

Question: To what extent do you agree with the following statements? Please indicate Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree.

Percentage of Women by Attitude Category Towards Contraceptive Methods and Sociodemographic Characteristics

	Negative	Neutral	Positive	Total
Place of Residence				
Urban	27.5	61.5	11.0	100.0
Rural	32.5	60.1	7.4	100.0
Marital Status				
Currently Married	26.3	63.7	9.9	100.0
Separated / Divorced / Widowed	31.0	59.5	9.5	100.0
Never Married	31.1	57.7	11.2	100.0
Ethnicity				
Malay	29.5	62.0	8.5	100.0
Chinese	22.0	61.3	16.7	100.0
Indian	16.7	60.4	22.9	100.0
Sabah Bumiputera	50.0	50.0	0.0	100.0
Sarawak Bumiputera	35.7	42.9	21.4	100.0
Household Income				
Less than RM2,500	43.1	50.4	6.5	100.0
RM2,500 – RM4,899	30.5	63.0	6.5	100.0
RM4,850 – RM10,959	21.3	66.2	12.5	100.0
RM10,960 and above	16.0	65.0	19.0	100.0
Overall	**28.3**	**61.3**	**10.4**	**100.0**

Note: Respondents' level of attitude was measured based on seven (7) statements using a 5-point Likert scale: 1 (strongly disagree), 2 (disagree), 3 (neutral), 4 (agree), and 5 (strongly agree). Attitude category was determined based on the composite score obtained.

Question: What are your views on contraceptive use? Please indicate Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree for each of the following statements:
(i) Contraceptive use is contrary to religious beliefs and cultural values;
(ii) Contraceptives are only important for women;
(iii) Condom use reduces pleasure during sexual intercourse;
(iv) Contraceptive use can affect future fertility;
(v) Discussing contraceptive methods, such as condom use, with young people will encourage sexual promiscuity;
(vi) Contraceptive use is important for preventing unintended pregnancies; and
(vii) Short intervals between pregnancies can adversely affect maternal health.

Issue and Challenge #3:

Low Contraceptive Use

Survey findings indicate that contraceptive use among married women remains relatively low and inconsistent. Although the majority have ever used contraception, fewer than half were currently using any contraceptive method. Among modern methods, condoms and IUCDs were the most commonly used, while withdrawal and calendar-based methods were the predominant non-modern methods.

Among women who were not currently using contraception, the most commonly reported reason was the desire to become pregnant, followed by previous experience of or concerns about side effects. Decisions regarding contraceptive use were generally made jointly with a partner. However, only a small proportion of women who were not currently using contraception expressed an intention to use a contraceptive method in the future.

The qualitative findings provide further insight into the factors shaping contraceptive practices. Partner dynamics, career demands, health-related considerations, access to subsidies, and reliance on traditional methods were among the factors influencing women's contraceptive decisions. These findings highlight the multiple and interrelated factors that may influence contraceptive uptake and the adoption of effective family planning practices.

Findings of the Quantitative Study

- Only 66.2% of married women respondents have ever used contraception.
- Fewer than half (45.4%) of married women respondents are currently using contraception.
- 38.2% of married women respondent are using modern methods, while the remaining 7.1% are using non-modern methods;
- Condoms and intrauterine devices (IUDs) are the most commonly used modern contraceptive methods, at 12.3% and 7.0%, respectively. Meanwhile, withdrawal and calendar-based methods are the most commonly used non-modern contraceptive methods, at 3.0% and 3.8%, respectively.
- Among married women respondents who are not currently using contraception but have used it before:
  - more than 40% of them gave the reason "want to get pregnant", which led them not to use contraceptives at the time of the survey;

- "had experienced side effects" and "being afraid of the possibility of side effects" are also the main reasons they do not use contraceptives, with 9.0% and 8.2% respectively;
- almost 60% of them made that decision (not using contraception at the time of the survey) together with their partner; and
- only 32.5% of them plan to use contraception in future.

Findings of the Qualitative Study

"I received a government subsidy, so I didn't have to pay for the implant" (Informant 16, 44 years old, physically disabled).

"I made the decision myself, with advice from the doctor and after discussing it with my husband" (Informant 15, 45 years old, visually impaired).

"My husband and I live apart because of work. It would be difficult if we had another baby.. There's no one to help.. My career is demanding too" (Informant 14, 41 years old).

"My husband wouldn't let me use contraceptives.. I just went along with it.. I didn't want to argue" (Informant 7, 45 years old).

"Taking medicine. Taking jamu (traditional herbal remedies).. Things like that.. Traditional remedies passed down from the older generation" (Informant 25, 47 years old, physically disabled).

"During my last pregnancy.. they detected that I had high blood pressure.. even after giving birth, it was still high. The doctor started me on medication.. I was high risk, so the (public health facility) gave me options on what I could use, but they didn't offer me the implant because I'm small in size" (Informant 22, 38 years old).

Proportion of Married Women by Contraceptive Method Used

	Percentage
Condom	12.3
Intrauterine Contraceptive Device	7.0
Contraceptive Pill	5.3
Implant	5.1
Tubal Ligation	4.8
Injection	3.0
Emergency Contraceptive Pill	0.5
Vasectomy	0.3
Hormonal Patch	-
Vaginal Ring	-
Withdrawal Method	3.0
Calendar-based Method	3.8
Breastfeeding	0.3

Question: What contraceptive method are you or your partner currently using?

Reasons for Never Using Contraceptive Methods among Married Women

	Percentage
Desire to become pregnant	44.1
Lack of interest / intention to use contraception	25.2
Fear of potential side effects	20.8
Lack of awareness of contraceptive methods	6.4
Partner's disapproval	2.0
Advise from healthcare providers	1.5

Question: Why have you or your partner/former partner never used any contraceptive method?

Proportion of Married Women Using Contraceptive Methods by Sociodemographic Characteristics

		Modern	Non-Modern
Place of Residence	Urban	36.5	7.5
	Rural	48.8	4.8
Ethnicity	Malay	39.0	6.5
	Chinese	43.9	14.6
	Indian	14.3	4.8
	Sabah Bumiputera	20.0	20.0
	Sarawak Bumiputera	42.9	0.0
Household Income	Less than RM2,500	16.2	2.7
	RM2,500 – RM4,849	31.1	8.1
	RM4,850 – RM10,959	43.2	6.8
	RM10,960 and above	50.4	8.9
	Total	**38.2**	**7.1**

Issue and challenge #4:

Male Partners Tend to Adopt a Passive Role in Contraceptive Decision-Making

Survey findings indicate that male partners' involvement in contraceptive decision-making remains relatively limited and passive. Some married women respondents reported making decisions regarding the use, non-use, or discontinuation of contraception without their partners' active involvement, with the highest proportion observed in decisions to discontinue contraceptive use.

The qualitative findings further suggest that, although discussions between partners do take place, women often bear greater responsibility for contraceptive use and its associated effects, while male partners tend to support or go along with decisions without substantial involvement in the decision-making process. These findings highlight the need for a more inclusive approach to family planning that actively engages men and promotes greater shared responsibility and joint decision-making between partners.

Findings of the Quantitative Study

- More than 70% of married women respondents jointly decide with their partners on contraceptive use.

- However, there are married women respondents who do not involve their partners in the decision-making process regarding contraceptive use, as follows:
  - 18.9% of those who decided to use contraception;
  - 19.4% of those who decided not to (ever) use contraception; and
  - 33.3% of those who decided to stop using contraception.

Findings of the Qualitative Study

"Most of the time, I'm the one who makes the decision.. My husband just goes along with it. Because I'm the one who has to go through it all" (Informant 23, 47 years old).

"Usually, I'm the one who makes the decision.. But I still discuss it with my husband. He just goes along with it" (Informant 22, 38 years old).

"My husband usually comes with me to the clinic, but when it comes to all the effects.. I'm the one who has to deal with them" (Informant 9, 35 years old).

Percentage of Married Women by Contraceptive Use Decision-Making

	Percentage
Respondent	19.0
Husband	3.0
Jointly / Together	76.0
Others	2.0

Question: Who makes the decision to use contraceptive methods?

Percentage of Married Women by Decision-Making Regarding Contraceptive Use

	Self	Partner	Jointly with Partner	Others	Total
Place of Residence					
Urban	18.6	3.6	75.9	1.8	100.0
Rural	20.5	4.5	72.7	2.3	100.0
Ethnicity					
Malay	20.9	2.6	74.8	1.7	100.0
Chinese	4.2	12.5	83.3	0.0	100.0
Others	10.0	10.0	70.0	10.0	100.0
Household Income					
Less than RM2,500	7.1	0.0	85.7	7.1	100.0
RM2,500 – RM4,899	31.1	4.9	63.9	0.0	100.0
RM4,850 – RM10,959	18.9	5.4	73.0	2.7	100.0
RM10,960 and above	11.5	1.3	85.9	1.3	100.0
Overall	**18.9**	**3.8**	**75.4**	**1.9**	**100.0**

Note: The "others" category includes Indian, Sabah Bumiputera, Sarawak Bumiputera ethnics group due to their small sample sizes.

Issue and challenge #5:

High Cost of Family Planning and Subfertility Treatments

Survey findings indicate that high costs represent a major barrier to accessing family planning services and subfertility treatment. Some married women respondents experiencing subfertility reported not seeking modern medical treatment due to financial constraints, including the high cost of treatment, uncertainty regarding treatment success, and additional expenses associated with travel and time.

The qualitative findings further highlight the financial burden associated with subfertility treatment, particularly IUI and IVF, which may require multiple treatment cycles without any guarantee of success. Limited financial assistance or subsidies may further constrain couples' ability to pursue treatment. Some respondents also perceived certain contraceptive methods, such as implants, as costly. These findings underscore the importance of strengthening subsidy mechanisms, financial support, and access to affordable services to reduce financial barriers to family planning and subfertility care.

Findings of the Quantitative Study

- 21.2% of married women respondents with subfertility do not seek modern medical treatment due to financial constraints.

Findings of the Qualitative Study

".. reduce the price of the implant.. The implant is the only method that is 100% effective for family planning.. Maybe provide a subsidy or reduce the price" (Informant 25, 47 years old).

"The cost of subfertility treatment is expensive.. I don't think I can afford all of it" (Informant 9, 35 years old).

"I work in Penang.. It's a long way to travel back and forth for treatment in Shah Alam. The cost.. The time.. Everything is challenging" (Informant 12, 29 years old).

"That's one of the reasons why we didn't... Go for IVF or IUI.. Because of the cost " (Informant 18, 37 years old).

"One cycle.. RM50,000-RM60,000.. No guarantee" (Informant 28, 38 years old).

"So I feel that even RM10,000 is already a lot.. Maybe around RM15,000.. I did have some savings set aside for all of this" (Informant 39, 26 years old).

"The cost at a government [public health facility] is around RM10,000–RM14,000... You pay gradually at each stage of the procedure. The process is smooth, but it's still a financial burden" (Informant 26, 37 years old).

Reasons for Not Receiving Subfertility Treatment among Married Women

	Percentage
Lack of knowledge on how to seek treatment	21.2
Partner's unwillingness to seek treatment	11.5
Financial constraints	21.2
Logistical barriers	3.8
Time constraints	30.8
Fear of treatment	19.2
Embarrassment	15.4
Perception of not having a subfertility problem	44.2
Not having children yet / recently married	25.0
Health-related reason	1.9

Question: Why did you, your partner, or former partner not seek medical advice or modern medical treatment for difficulties in getting pregnant?

Issue and challenge #6:

Limited Access to Subfertility Treatments

Survey findings indicate that access to subfertility treatment remains constrained by time, logistical, and service-related barriers. Some married women respondents experiencing subfertility reported not seeking modern medical treatment due to difficulties related to time commitments, travel distance, mobility, and lengthy waiting periods associated with service procedures.

The qualitative findings further highlight differences in access between public and private healthcare services. Public healthcare facilities are generally perceived as more affordable but may involve longer waiting times and slower processes, whereas private services offer faster access but at substantially higher costs. Some public health facilities were viewed positively for smoother procedures and supportive healthcare providers, although costs and procedural requirements remained concerns for some respondents. These findings underscore the need to improve service efficiency, reduce waiting times, and strengthen access to affordable and accessible subfertility care.

Findings of the Quantitative study

- Almost 4% of married women respondents with subfertility do not seek modern medical treatment due to logistical problems.

- Almost a third (30.8%) of married women respondents with subfertility issues did not seek modern medical treatment because they lacked the time to do so.

Findings of the Qualitative Study

"Government hospitals are available, but you have to wait a long time for your turn. If you want it faster, you have to go to private hospital. But it's very expensive" (Informant 3, 32 years old).

"When it comes to government healthcare.. The process is very slow.. It can take one or two months from one appointment to the next.. The gap is just too long" (Informant 39, 26 years old).

".. access and mobility at [public health facility].. There are many checkpoints" (Informant 18, 37 years old).

"At [public health facility].. The process was smooth.. The staff and doctors were very understanding" (Informant 26, 37 years old).

"At a government hospital, you have to wait a long time. You can go to a private hospital, but it's very expensive" (Informant 2, 38 years old).

Issue and challenge #7:

Social Stigma Confronting Women with Subfertility Issues

Survey findings indicate that social stigma remains an important barrier to seeking modern medical treatment among women experiencing subfertility. Some respondents reported not seeking treatment due to a lack of spousal support or approval, while nearly one-fifth delayed seeking treatment because of fear and embarrassment associated with negative societal perceptions.

The qualitative findings further highlight the psychosocial challenges associated with subfertility, including misconceptions, social pressure, and cultural expectations that regard having children as an important part of marriage. Such experiences may affect women's emotional well-being and contribute to reluctance to disclose their condition, participate in social activities, or seek treatment. These findings underscore the need for comprehensive advocacy, community education, and psychosocial support to reduce stigma and foster a more supportive environment for individuals and couples experiencing subfertility.

Findings of the Quantitative Study

- 11.5% of married women respondents with subfertility issues do not seek modern medical treatment because they do not have their partner's approval.

- Almost one-fifth of married women respondents with subfertility issues do not seek modern medical treatment due to fear (19.2%) and shame (15.4%).

Findings of the Qualitative Study

"When we go for IUI or IVF, sometimes people get the wrong idea.. Back then, they used to call it a "test-tube baby". Older people, colleagues.. They would say all sorts of things " (Informant 39, 26 years old).

"When I bring up this issue in the community.. I've been hurt many times.. I wasn't invited to events for pregnant women because they said "bad blood" could affect the baby.. During Deepavali, people would criticise me about when I was going to get pregnant.. I ended up avoiding events" (Informant 26, 37 years old).

"Sometimes, people outside misunderstand and think that we're not trying.. In our society, having children is seen as an obligation in marriage" (Informant 20, 41 years old).

"Sometimes, there's subtle pressure.. Sensitive questions.. Not many people understand" (Informant 17, 40 years old).

Issue and challenge #8:

Limited Awareness Regarding Subfertility (Symptoms and Treatments)

Survey findings indicate that knowledge of subfertility remains limited, particularly in relation to early signs, fertile periods, and pathways to accessing appropriate treatment. Some married women respondents reported not seeking modern medical treatment because they did not know how or where to obtain it, while others did not perceive themselves as experiencing subfertility despite reporting related concerns or symptoms.

The qualitative findings further suggest that limited reproductive health literacy may contribute to delays in recognising potential fertility problems and seeking timely medical advice or treatment. Respondents also described psychological and emotional challenges, including self-blame, feelings of inadequacy, and uncertainty about their reproductive health conditions.

These findings underscore the importance of strengthening reproductive health education, promoting early screening and timely help-seeking, and providing proactive counselling to improve awareness and facilitate earlier access to appropriate assessment and intervention.

Findings of the Quantitative Study

- 21.2% of married women respondents with subfertility issues do not seek modern medical treatment because they do not know how to access it.

- 44.2% of married women respondents with subfertility issues do not seek modern medical treatment because they believe they have no problems.

Findings of the Qualitative Study

"If I had known earlier, maybe we could have planned and started treatment earlier" (Informant 3, 32 years).

".. back then, I didn't even know how to work out my fertile period.. Or understand my menstrual cycle " (Informant 2, 38 years old).

"I feel like I'm not complete.. Other people seem to have children so easily. I've tried.. Sometimes, I blame myself" (Informant 9, 35 years old).

"So, there was a problem.. The ovum was small, and it was difficult to get pregnant.. Now, I'm also thinking about my thyroid... Which might make it even more difficult (to get pregnant)" (Informant 3, 32 years old).

Issue and challenge #9:

Health Issues Hindering Women's Access to Subfertility Treatments

Survey findings indicate that existing health conditions are among the factors that may prevent a small proportion of women from seeking subfertility treatment. Although the proportion is relatively low, conditions such as hormonal disorders, PCOS, fibroids, and thyroid problems, as well as recurrent miscarriages and previous unsuccessful treatment attempts, may influence women's treatment options and their willingness to pursue or continue treatment.

The qualitative findings further highlight the challenges faced by women with complex health histories, particularly those who have experienced painful procedures, recurrent pregnancy loss, or unsuccessful treatment. These experiences may affect not only their treatment journey but also their physical and emotional well-being, contributing to fatigue, distress, and uncertainty about continuing treatment.

These findings underscore the importance of a more integrated, staged, and client-centred approach to subfertility care, supported by comprehensive health assessment and monitoring, ongoing counselling, and appropriate psychosocial support throughout the treatment journey.

Findings of the Quantitative Study

- Almost 2% of married women respondents with subfertility do not seek modern medical treatment due to health problems.

Findings of the Qualitative Study

"Previously, the doctor said I couldn't (get pregnant) anymore. But I did have a child. Be prepared.. Be prepared.. Especially since I also had a small fibroid at the time" (Informant 16, 44 years old).

"12 years. I went through IVF twice.. Both attempts failed" (Informant 17, 40 years old).

".. I had several miscarriages.. When I was stimulated with medication.. There were other problems.. It was painful" (Informant 28, 38 years old).

"The main reason was actually weight gain.. My weight increased quite suddenly after I got married.. PCOS was one issue, and then there was also my thyroid.. Hyperthyroid" (Informant 39, 26 years old).

Effectiveness of Family Planning Programme Implementation

Achievements of Policies and Programmes Related to Family Planning

The Contraception Policy Atlas Asia and the Pacific was launched by the European Parliamentary Forum for Sexual and Reproductive Rights (EPF), Family Planning 2030 (FP2030) and the International Planned Parenthood Federation (IPPF) on 16 November 2023 in Bangkok, Thailand. This atlas provides important information on the family planning landscape and contraceptive status, based on an assessment of 43 countries in the Asia-Pacific region. It comprises three (3) main components: the legal framework, access, and financial allocation.

According to the Contraception Policy Atlas Asia-Pacific 2023, recognition of reproductive rights in law or in an act, including the right to determine the number, timing and spacing of births, is an important component of creating an environment that supports family planning. However, comparisons across Asia-Pacific countries show that such recognition does not necessarily translate into higher contraceptive prevalence rates (CPR). Countries such as Hong Kong (67%), Indonesia (64%) and Cambodia (62%) recorded high CPR in line with recognition of reproductive rights, while the Philippines (58%), Nepal (57%), Malaysia (52%) and Pakistan (34%) still recorded moderate or low CPR despite similar recognition.

Comparison of the Recognition of Reproductive Rights in Laws and Acts Across Asia-Pacific Countries by Contraceptive Prevalence Rate (CPR)

Countries With Recognition	
Low CPR	**High CPR**
Philippines (58%)	Hong Kong (67%)
Nepal (57%)	Indonesia (64%)
Malaysia (52%)	Cambodia (62%)
Pakistan (34%)	
Countries Without Recognition	
Low CPR	**High CPR**
Myanmar (52%)	China (85%)
Japan (40%)	Thailand (73%)
	Vietnam (73%)

Source: Contraception Policy Atlas Asia-Pacific 2023.
Note: Figures in parentheses () indicate the CPR (%).

On the other hand, several countries that do not explicitly recognise reproductive rights in law also recorded high CPR, including China (85%), Thailand (73%), Vietnam (73%) and Bangladesh (64%). These findings indicate that, in addition to policy and legal commitments, factors such as access to reproductive health services, availability of contraceptive supplies, variety of method choices, health literacy and the effectiveness of programme implementation also influence contraceptive use.

The majority of countries studied have national plans or strategies related to contraception, as well as international commitments such as Every Woman Every Child (EWEC), the Nairobi Summit, and FP2030. Nine countries, including Malaysia, Indonesia, the Philippines, Thailand and Bangladesh, have both components, and most of them record moderate to high CPR.

However, a national plan and international commitment do not necessarily determine CPR levels. Hong Kong (67%) and South Korea (82%) still recorded high CPR despite lacking a plan or commitment, as assessed in the atlas. These findings suggest that, in addition to formal policies and commitments, factors such as socioeconomic development, access to health services, reproductive health literacy, individual autonomy and contraceptive availability also influence contraceptive use.

National Plans / Strategies on Contraception and Global Commitments in Selected Asia-Pacific Countries

Country	National Plan / Strategy	International Commitment
Malaysia	Yes	Yes
Indonesia	Yes	Yes
Philippines	Yes	Yes
Thailand	Yes	Yes
Cambodia	Yes	Yes
Pakistan	Yes	Yes
Nepal	Yes	Yes
Bangladesh	Yes	Yes
Sri Lanka	Yes	Yes
Hong Kong	No	No
Macao	No	No
South Korea	No	No

Source: Contraception Policy Atlas Asia-Pacific 2023.

According to the Contraception Policy Atlas Asia-Pacific 2023, coverage of modern contraceptive methods in the National Essential Medicines List (NEML) is one instrument that supports contraceptive availability and access. Countries such as Cambodia, Bangladesh, Sri Lanka and Myanmar, which have coverage of six to ten modern methods in the NEML, recorded CPR between 52% and 65%, while Malaysia and Indonesia, which have more limited coverage, still recorded CPR of 52% and 64%, respectively.

However, the number of methods listed in the NEML does not necessarily determine the level of contraceptive use. South Korea (82%) and Vietnam (73%) recorded high CPR despite no modern methods being listed in the NEMLs assessed, whereas Japan recorded a CPR of only 40%. These findings suggest that, in addition to the NEML, factors such as the strength of the health system, access to family planning services, health financing, reproductive health literacy and societal acceptance also influence contraceptive use.

Contraceptive Prevalence Rate (CPR) by Modern Contraceptive Method Coverage in National Essential Medicines Lists (NEML) in Selected Asia-Pacific Countries

Coverage of Modern Contraceptive Methods in The National Essential Medicines Lists (NEML)		
Between 6 to 10 Methods	**Between 1 to 5 Methods**	**No Coverage**
Cambodia (62%)	Malaysia (52%)	Japan (40%)
Bangladesh (64%)	Indonesia (64%)	Vietnam (73%)
Sri Lanka (65%)		South Korea (82%)
Myanmar (52%)		

Source: Contraception Policy Atlas Asia-Pacific 2023.
Note: Figures in parentheses () indicate the CPR (%).

Regarding sexual and reproductive health education (SRHE) frameworks, seven (7) countries with SRHE frameworks, including China, Vietnam, India, Hong Kong, Indonesia, the Philippines and Malaysia, generally recorded moderate to high CPR. However, the presence of an SRHE framework is not the only factor influencing contraceptive use. Thailand and Sri Lanka also recorded high CPR despite not having an SRHE framework identified in this assessment.

These findings suggest that, in addition to SRHE education, factors such as access to reproductive health services, contraceptive availability, government policy support, socioeconomic development, and community acceptance also play important roles in shaping contraceptive use. Nevertheless, the SRHE framework remains important for strengthening reproductive health literacy and supporting more informed decision-making.

Comparison of Contraceptive Prevalence Rates (CPR) by the Presence of a Sexual and Reproductive Health and Rights Education (SRHE) Framework in Selected Asia-Pacific Countries

With SRHE Framework	Without SRHE Framework
China (85%)	Thailand (73%)
Vietnam (73%)	Sri Lanka (82%)
India (67%)	
Hong Kong (67%)	
Indonesia (64%)	
Philippines (58%)	
Malaysia (52%)	

Source: Contraception Policy Atlas Asia-Pacific 2023.
Note: Figures in parentheses () indicate the CPR (%).

Regular collection of sexual and reproductive health (SRH) data is essential for monitoring trends in contraceptive use, assessing programme effectiveness, and supporting evidence-based planning. Countries such as China, India, Hong Kong, and Indonesia, which have collected SRH data for less than five years, have reported moderate to high CPR.

However, data collection frequency alone does not guarantee higher CPR. South Korea, Thailand and Vietnam also recorded high CPR despite collecting SRH data at intervals of more than five years. These findings suggest that, in addition to periodic data, factors such as access to reproductive health services, contraceptive availability, policy support, socioeconomic development and societal acceptance also influence contraceptive use.

Comparison of Contraceptive Prevalence Rates (CPR) by the Frequency of Sexual and Reproductive Health and Rights (SRH) Data Collection in Selected Asia-Pacific Countries

Frequent (less than 5 years)	Infrequent (more than 5 years)
China (85%)	South Korea (82%)
India (67%)	Thailand (73%)
Hong Kong (67%)	Vietnam (73%)
Indonesia (64%)	Malaysia (52%)

Source: Contraception Policy Atlas Asia-Pacific 2023.
Note: Figures in parentheses () indicate the CPR (%).

According to the Contraception Policy Atlas Asia-Pacific 2023, countries with dedicated committees, such as Thailand (73%), Vietnam (73%), Cambodia (62%), Indonesia (64%), Bangladesh (64%) and the Philippines (58%), recorded moderate to high CPR. However, the presence of a national committee is not the only factor influencing contraceptive use. China (85%), South Korea (82%) and Hong Kong (67%) also recorded high CPR despite lacking such a mechanism, while Malaysia and Japan, which also lack dedicated committees, recorded lower CPR.

These findings indicate that, in addition to supply governance, factors such as health system strength, socioeconomic development, access to reproductive health services and community acceptance also play an important role. However, establishing a dedicated committee remains relevant as a platform for strengthening planning and the sustainability of contraceptive supply at the national level.

Comparison of Contraceptive Prevalence Rates (CPR) by the Presence of a National Contraceptive Supply Management Committee in Selected Asia-Pacific Countries

Countries With a Committee	Countries Without a Committee
Thailand (73%)	China (85%)
Vietnam (73%)	South Korea (82%)
Cambodia (62%)	Hong Kong (67%)
Indonesia (64%)	Malaysia (52%)
Bangladesh (64%)	Japan (40%)
Philippines (58%)	

Source: Contraception Policy Atlas Asia-Pacific 2023.
Note: Figures in parentheses () indicate the CPR (%).

Achievement of Indicators Related to Family Planning

According to the Population Reference Bureau (PRB) 2024 World Population Data Sheet Malaysia demonstrates moderate performance in family planning indicators compared with other countries in the Asian region. Although more than half of married women have used some form of family planning method, the rate of modern contraceptive use in this country is still relatively low, at around 34%, compared with Thailand, which is over 70%, and Vietnam, around 60%. Comparisons between countries found that the impact of health expenditure on family planning indicators is independent of the expenditure's orientation.

The Health Care Coverage Index also affects how accessible and used family planning services are. Malaysia recorded a relatively high index score (around 76), comparable to or higher than that of several other Southeast Asian countries. However, comparisons with Thailand (around 82) and Japan (around 83) show that high health coverage does not automatically translate into high modern contraceptive use, especially in countries that have achieved low TFR, such as Malaysia (1.6) and Japan (1.2).

Comparison of Family Planning and Health System Indicators in Selected Asian Countries

		Family Planning Among Married Women			Health Spending per Capita (US$)	
Countries	**Total Fertility Rate**	**Using All Methods (%)**	**Using Modern Methods (%)**	**Universal Health Care Service Coverage Index**	**Total Health Spending 2020/2022**	**PHC-Specific Spending 2018/2022**
Brunei	1.8	-	-	78	693	-
Cambodia	2.7	62	45	58	122	71
Indonesia	2.2	64	57	55	161	-
Laos	2.5	53	-	52	69	47
Malaysia	1.6	52	34	76	487	233
Myanmar	2	52	51	52	65	41
Philippines	1.9	58	42	58	178	-
Singapore	1	-	-	89	3,970	-
Thailand	1	73	71	82	364	160
Timor-Leste	3.6	26	24	52	135	-
Vietnam	2	73	60	68	173	-
China	1	85	81	81	671	-
Hong Kong	0.8	67	65	-	-	-
Macao	0.6	-	-	-	-	-
Japan	1.2	40	33	83	4,347	-
South Korea	0.7	82	-	89	3,124	-
Taiwan	0.9	75	66	-	-	-
Bangladesh	2.2	64	55	52	58	34
India	2	67	56	63	74	28
Nepal	2.1	57	43	54	65	44
Pakistan	3.6	34	23	45	43	25

Source: Population Reference Bureau (PRB) 2024 World Population Data Sheet.

Modern contraceptive use is generally inversely related to TFR, with countries that have higher contraceptive use tending to have lower fertility rates. This pattern is evident in Thailand, which has a modern contraceptive use rate of around 71% and a TFR of 1.0 children, compared with Pakistan, which has a contraceptive use rate of around 23% and a much higher TFR of 3.6 children.

However, Malaysia shows a somewhat different pattern, with modest use of modern contraceptives at around 34%, yet it has achieved a low fertility rate of 1.6 children per woman. This situation shows that the relationship between contraceptive use and fertility is not necessarily linear, especially for countries that have reached the final stages of demographic transition.

Within the demographic transition, Malaysia is currently in the post-transition category, a phase characterised by low fertility rates and population growth. A similar pattern can be observed in Japan, which has a modern contraceptive use rate of around 33%, almost comparable to Malaysia (34%), but a lower fertility rate, around 1.2 to 1.3 children per woman.

This situation shows that as a country reaches a more advanced stage of demographic development, factors other than contraceptive use become increasingly dominant in shaping decisions about having children. These include later age at marriage, higher levels of women's education, greater women's participation in the labour market, rising cost of living, and changing values and aspirations of the modern family.

Thus, although contraceptive use remains an important component of family planning, current fertility patterns in the country are increasingly shaped by broader social, economic and demographic factors. These findings suggest that efforts to understand fertility decline or to formulate fertility-related policies require a more comprehensive approach, rather than focusing solely on contraceptive use.

Proposed Directions for Strengthening Family Planning Programmes



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Direction 1 Sexual and Reproductive Health Education

Objective

Aims to enhance knowledge and awareness about sexual and reproductive health, improve knowledge about the contraceptive methods offered by service providers, and increase knowledge and awareness regarding fertility at the individual level.

Main Activities

(i) Sexual and Reproductive Health Awareness Programme
The programme should focus on enhancing awareness programmes at the school and higher education levels through strategic collaboration with agencies such as LPPKN, KKM, KPM, KPT, and NGOs.

(ii) Knowledge of Contraceptive Methods and Fertility Awareness
LPPKN clinical members conduct workshops or counselling sessions, in collaboration with government and private hospitals, to deliver more comprehensive and inclusive information. This programme should be tailored to the couple's age and health status.

Expected Results

(i) Avoiding stigma and prejudice toward the role of family planning and ensuring that every individual has access to reliable and precise data.

(ii) Helping married couples make informed decisions in planning a pregnancy.

Direction 2 Access and Technology: Dissemination Through Digital Media

Objective

Aims to expand access to fertility and reproductive health information through the use of inclusive and easily accessible digital platforms (such as TikTok, YouTube, Facebook, and others).

Main Activities

(i) Collaboration with Professional Content Creator
This strategic collaboration will produce programme content that is more creative, engaging, and aligned with current developments, while also expanding the reach of information by increasing views and shares.

(ii) Empowering Communication Through Digital and Social Media Platforms
Utilising digital and social media platforms by collaborating with influencers who have a large number of followers to achieve wider dissemination of information.

Expected Results

(i) The delivery of information that is more engaging, easily accessible, and easy to understand.

(ii) Enhancing access, especially for young people, who are the main users of digital media.

(iii) Creating an interactive community space for more open discussions.

(iv) Addressing the challenge of information inaccuracy through collaboration between technical experts and digital media practitioners, such as content creators and influencers.pempengaruh.

Direction 3 Family Planning Service Delivery

Objective

Aims to improve the delivery of family planning services, covering contraceptive use and subfertility treatment.

Main Activities

(i) Strengthening the Strategic Cooperation of LPPKN and KKM
Strengthen inter-agency collaboration through role coordination, data sharing and service integration to ensure the delivery of more comprehensive, efficient and integrated family planning services at all levels.

(ii) Encouraging Involvement of Health Insurance Companies
Create a support framework, including guidelines and appropriate incentive schemes, to encourage private companies, including health insurance providers, to cover part or all of the costs of family planning services and subfertility treatment.

Expected Results

(i) Delivery of more integrated and efficient family planning services.

(ii) Increasing access and service coverage to the target group.

(iii) Reduction of treatment cost burden through insurance coverage support.

(iv) Improving the quality and effectiveness of reproductive health services.

(v) Strengthening strategic cooperation between the public and private sectors.

Direction 4 Governance for Developing a Family-Friendly Strategic Plan

Objective

Aims to mobilise enablers, including physical infrastructure support and flexible work strategies, to improve program implementation mechanisms that support the development of a family-friendly strategic plan.

Main Activities

(i) Support for Physical Infrastructure

Empowering the provision of family-friendly facilities in the workplace, such as child care centres, breastfeeding rooms and reproductive health information corners. These facilities help reduce concerns about childcare and career continuity, thus creating a conducive environment for women and couples to consider pregnancy planning and seek subfertility treatment.

(ii) Flexible Work Policy

Encouraging the implementation of flexible work policies to give space to women and couples to manage family commitments, where this flexibility also supports continuity of treatment and adherence to necessary interventions.

Expected Results

(i) Women and couples feel more confident in planning a pregnancy without affecting their careers.

(ii) Increasing the tendency to seek subfertility treatment among couples in need.

(iii) Reduction in delaying pregnancy due to career factors and childcare constraints.

Direction 5 National Sexual and Reproductive Health Data Hub

Objective

Aims to collect data from various sources, such as family planning services and reproductive health screenings, to develop a centralised data hub. Data coordination ensures accuracy and consistency, in line with the national open data initiative.

Main Activities

(i) Annual Evaluation of Family Planning

Collecting annual routine data from Nur Sejahtera LPPKN Clinic, where among the recommended data is the type and number of services / examinations provided / offered to couples.

(ii) Family Planning Survey (every 5 years)

This survey will support LPPKN's large-scale national study, which is conducted every 10 years. This survey will use a sample that can represent the entire population to produce key indicators, such as the contraceptive use rate, the unmet need for contraceptives and others.

Expected Outcome

(i) Centralised data collection to ensure sexual and reproductive health data is used efficiently.

(ii) Improve coordination, continuous monitoring, consistent evaluation of service results and evidence-based analysis.



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GLOSARI / GLOSSARY

SINGKATAN / ABBREVATION

ART	:	Assisted Reproductive Technology
ART	:	Assisted Reproductive Technology
APPK 1996	:	Akta Penduduk dan Pembangunan Keluarga Negara 1996
ASEAN	:	The Association of Southeast Asian Nations
BKKBN	:	Badan Kependudukan dan Keluarga Berencana Nasional
CPAP	:	Country Programme Action Plan
CPR	:	Contraceptive Prevalence Rate
DDR	:	Define, Design, Refine
ENAPEA	:	Strategi Nasional Pencegahan Kehamilan Remaja
EPF	:	The European Parliamentary Forum for Sexual and Reproductive Rights
EWEC	:	Every Woman Every Child
FP2030	:	Family Planning 2030
FWA	:	Family Welfare Assistants
GP	:	Pengamal Perubatan Am
ICSI	:	Intra-Cytoplasmic Sperm Injection
IPPF	:	International Planned Parenthood Federation
IUCD/IUD	:	Intrauterine Contraceptive Device
IUI	:	Intrauterine Insemination
IVF	:	In-Vitro Fertilization
JKM	:	Jabatan Kebajikan Masyarakat
KAP	:	Knowledge, Attitude, Practice
KAPKM	:	Kajian Amalan Perancang Keluarga di Malaysia
Kemendukbangga / BKKBN	:	Kementerian Kependudukan dan Pembangunan Keluarga/ Badan Kependudukan dan Keluarga Berencana Nasional
KKM	:	Kementerian Kesihatan Malaysia
KPT	:	Kementerian Pendidikan Tinggi
KPWKM	:	Kementerian Pembangunan Wanita, Keluarga dan Masyarakat
LARC	:	Long-Acting Reversible Contraception
LPPKN	:	Lembaga Penduduk dan Pembangunan Keluarga Negara
NEML	:	National Essential Medicines List
NFPP	:	National Family Planning Programme
NGO	:	Non-Governmental Organization

NHS	:	National Health Service
NPC	:	National Population Council
OKU	:	Orang Kurang Upaya
PBS	:	Pharmaceutical Benefits Scheme
PCS	:	Pharmacy Contraception Service
PCOS	:	Polycystic Ovary Syndrome
POPCOM	:	Commission on Population
PPUM	:	Pusat Perubatan Universiti Malaya
PRB	:	Population Reference Bureau
RAAHS	:	Remote Area Aboriginal Health Services
SchKG	:	Act on Assistance to Avoid and Cope with Conflicts in Pregnancy
SFPA	:	Singapore Family Planning Association
SFPPB	:	Singapore Family Planning and Population Board
SRHR	:	Sexual and Reproductive Health and Rights
SWOT	:	Strengths, Weaknesses, Opportunities & Threats
TFR	:	Total Fertility Rate
UMN	:	Unmet Need for Family Panning
UNFPA	:	United Nations Population Fund
UPUM	:	Kumpulan Perunding Universiti Malaya
WHO	:	World Health Organization

LPPKN

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