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Co-financed by the Connecting Europe Facility of the European Union

ENGLISH

THE SRHR TOOLKIT

ON RIGHTS-BASED CONTRACEPTION AND DIRECTORY ON SRHR INFORMATION AND SERVICES FOR WOMEN, GIRLS, AND YOUNG PEOPLE IN MALAYSIA

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2025

ISBN: 978-967-0339-55-9

PUBLISHED BY

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About ARROW

ARROW is a regional non-profit women's organisation based in Kuala Lumpur, Malaysia. It has consultative status with the Economic and Social Council (UN ECOSOC) of the United Nations. ARROW strives to enable women to be equal citizens in all aspects of their life by ensuring their sexual and reproductive health and rights (SRHR) are achieved. Contact them at: arrow@arrow.org.my

About the Gender Equality Initiative (GEI) in Malaysia

The Gender Equality Initiative (GEI) aims to contribute to an enabling environment for women, girls, LGBTIQ persons and young people in all their diversity to participate in national development and democratic processes that are gender responsive and inclusive and contribute to the acceleration of 2030 Agenda for sustainable development.

We are grateful to the European Union for their funding of the initiative and this toolkit.

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ACKNOWLEDGEMENTS

This Toolkit owes its inception and development to *"An Advocate's Guide Integrating Human Rights in Universal Access to Contraception"* published in 2016. This pioneering effort provided the critical groundwork necessary for adapting and contextualising this resource to the Malaysian setting.

The development and dissemination of this Toolkit have been made possible through the generous support of the European Union (EU) as part of its funded project titled 'Strengthening Capacities Towards Inclusive Development Pathways: A Crucial Pivot to Development in Malaysia.

Our heartfelt thanks to the ARROW team for their leadership, overall coordination and review of the Toolkit at various stages. Their commitment in sexual and reproductive health and rights (SRHR) work, especially in ensuring rights-based SRHR information and services in Malaysia are well appreciated and applauded.

We extend our sincere gratitude to the representatives and experts from various organizations who generously contributed their time and expertise to pilot test the toolkit. Their invaluable feedback has been instrumental in refining and enhancing the Toolkit.

We would like to thank the following individuals and organisations for their contribution during two of the pilot tests conducted:

- Ameena Siddiqi (SIS)
- Andi Suraidah (Legal Diginity)
- Dhanya Sakar (WAO)
- Fara Rom, For Youth Initiative Kuala Lumpur (FYIKL)
- Hafsah Nizar (FRHAM)
- Jayamalar Samuel (FRHAM)
- Jeremy Selvarajah (FRHAM)
- Nurul Khalida Binti Mazlan
- Prof Dr Sharon Bong (Monash University)
- Sharmilah Rajendran (FRHAM)
- Tengku Nur Fadzilah Tengku Hassan (ReHAK)

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We acknowledge the commitment and support of all those involved in this project and hope that this Toolkit will serve as a valuable resource for healthcare providers, policymakers, CSOs and advocates working to improve sexual and reproductive health care services and information in Malaysia.

GLOSSARY

ACCEPTABILITY OF CONTRACEPTIVE INFORMATION AND SERVICES

Health care institutions and providers must be respectful of medical ethics. They should respect the dignity of all clients, provide culturally appropriate care, be responsive to needs based on gender, age, culture (including religion, belief, values, norms, and language), and physical abilities.[1]

ACCESSIBILITY OF CONTRACEPTIVE INFORMATION AND SERVICES

All health care must be accessible to all without discrimination. No one shall be denied preventive, promotive or curative health care including contraceptive services and allied sexual and reproductive health services that s/he needs. Accessibility has three overlapping dimensions: Physical accessibility; economic accessibility or affordability; and access to information.[2]

ACCOUNTABILITY

Governments and public agencies must be held accountable and answerable for their acts or omissions in relation to their duties related to protecting the right to health care, including right to contraceptive information and services, through enforceable standards, regulations, and independent compliance-monitoring bodies. Governments are also accountable for regulating the actions of private entities such as private health care providers, insurance companies and pharmaceuticals so that their actions do not violate citizens' right to health.[3]

AVAILABILITY OF CONTRACEPTIVE INFORMATION AND SERVICES

Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals); goods (e.g. contraceptives, other drugs, equipment); basic amenities such as potable drinking water and sanitation; information and services on sexual and reproductive health including contraception; must be available in sufficient quantity within the state, and distributed equitably across geographical areas and communities.[4]

BODILY AUTONOMY AND INTEGRITY

Refers to the individual right to have control over their own bodies, including the freedom to make choices without external interferences. This is essential for personal dignity, agency and gender equality.[5] Bodily integrity is the inviolability of the physical body and emphasizes the importance of personal autonomy and the self-determination of human beings over their own bodies.[6]

COMPREHENSIVE CONTRACEPTIVE INFORMATION AND SERVICES

Refers to the provision of information and services for all methods of contraception without imposing programme-based or provider-based restrictions of specific contraceptive methods.[7]

COMPREHENSIVE SEXUALITY EDUCATION (CSE)

Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.[8]

INFORMED CONSENT

Refers to a process of giving patients/individuals sufficient and relevant information to enable them to make decisions for themselves on their health. People should never be pressured, forced, coerced or in any other way persuaded to undergo treatment or interventions against their will.[9]

CONTRACEPTION

A way to prevent pregnancies. There are many different types of contraceptives. Methods such as condoms provide dual protection against sexually transmitted infections (STIs) and pregnancy.[10]

FAMILY PLANNING

Provides information and methods for individuals to decide if and when to have children. It includes various contraceptives, fertility treatments, and education about pregnancy and infertility.[11]

GENDER

Gender refers to the socially constructed roles, behaviours, and attributes that a society believes are appropriate for individuals based on the sex assigned at birth. Gender is hierarchical and can lead to inequalities.

GENDER EQUALITY AND EQUITY

Gender equality refers to the equal rights, responsibilities, and opportunities of all individuals, regardless of gender. It acknowledges that individuals have unique needs and face different disadvantages that often intersect. It aims to level the playing field by providing support and opportunities tailored to these needs, ensuring everyone can achieve the same outcomes.[12]

Gender equity recognizes that women, men, intersex and transgender individuals have different needs and historical and social disadvantages that hinder them from otherwise operating on a level playing field. Thus, it recognises that to achieve gender equality, some people may need more or different support or opportunities than others to achieve the same outcomes. Thus, efforts to create gender equity contribute to gender equality.[13]

GENDER TRANSFORMATIVE APPROACHES

An approach on how to sustainably transform unequal power dynamics and relations to achieve gender equality.

HEALTHCARE PROVIDER

Any person or organisation that offers healthcare services.

HUMAN RIGHTS

Refer to 'Understanding human rights'.

HUMAN RIGHTS-BASED APPROACH (HRBA)

An approach that positions access to education, healthcare, and other basic necessities as obligatory responsibilities of governments, not optional acts of goodwill, as a result of their agreement to international and regional human rights treaties. It integrates human rights standards and principles into planning and policy-making, viewing individuals as rights-holders and governments as duty-bearers required to fulfil specific obligations.[14]

IEC MATERIALS OR SBCC MATERIALS

Information, education and communication (IEC) materials, such as flyers, booklets or social media posts, that are used to share public health messaging. Social and Behavioural Change Communication (SBCC) are various communication techniques to help people change their behaviour for the better.

INFORMED DECISION MAKING

A choice that individuals make once they have all the information related to an issue.

INTERSECTIONALITY

Acknowledges that individuals' multiple identities such as age, race, class, gender, nationality, language, religion, marital status, disability, culture, and employment influence the way one experiences themselves and the world and how they are viewed by the society.

INTIMATE PARTNER VIOLENCE (IPV)

A behaviour within an intimate relationship that causes physical, sexual, or psychological harm. It includes physical aggression, sexual coercion, psychological abuse, and controlling behaviours. It can occur in current or former spouses and partners.[15]

MARGINALISED AND EXCLUDED GROUPS

Refers to groups or communities that are systematically excluded and side-lined in society due to various factors such as age, race, ethnicity, gender, sexual orientation, disability, geographic location, or economic status. These groups often have limited or no access to resources, rights, and opportunities, and face barriers to participation in social, economic, and political life.

MATERNAL MORTALITY RATIO

Number of maternal deaths during a given time period per 100,000 live births during the same time period.[16]

MEDICAL ABORTION

Abortion with pills (Mifepristone and Misoprostol). It is 95% effective and extremely safe. According to WHO, safe abortion requires only accurate information, quality medications, and mutual respect and trust. Routine blood tests, ultrasound and follow up are usually not needed.[17]

MOBILE CONTRACEPTIVE SERVICES

The use of mobile clinics to provide contraceptive services, usually too difficult-to-reach areas or marginalised populations.

NON-DISCRIMINATION IN THE PROVISION OF CONTRACEPTIVE INFORMATION AND SERVICES

Contraceptive services information and services must be accessible and provided without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status. The design of programmes should take account of the fact that vulnerable groups may face special barriers.[18]

PARTICIPATION

Individuals and communities must be able to play an active, free and meaningful part in the design and implementation of contraceptive services policies and programmes. Policies and programmes are therefore required to create structures and mechanisms that will allow and enable such participation by all stakeholders, especially traditionally excluded and marginalised groups.[19]

PRIVACY AND CONFIDENTIALITY

Respect for client's privacy, confidentiality and dignity is a fundamental tenet of medical ethics. Upholding the client's privacy and maintaining confidentiality is important in all areas of health care. It is especially critical when providing contraceptive information and services, failing which several negative consequences can arise. For example, the service loses the client's trust, and the client may not return for a service or follow up.[20]

POSITIVE REFRAMING

A problem-solving and communication strategy that focuses on shared values, including national values, to connect differing perspectives. It inspires change through common virtues, such as kindness, to collectively inspire positive change. This reframing method encourages optimistic and collaborative approach to problem-solving and discussions.[21]

QUALITY

All health care, including contraceptive information and services must be medically appropriate and guided by technical quality standards and control mechanisms. More importantly they should be characterized by positive attitudes on the part of providers, informed decision-making on the part of the client and provided in a timely and safe manner, and to the client's satisfaction.[22]

SAFE ABORTION CARE

Abortion or termination of pregnancy is carried out using a method recommended by WHO, appropriate to the pregnancy duration and by someone with the necessary skills. These include medical abortion or surgical procedures (for later pregnancy stages). It can be done safely in many settings and by different health workers, and in early pregnancy, a woman can do it herself.

SERVICE DELIVERY POINTS (SDPs)

In this toolkit, SDPs are government clinics, mobile clinics or hospitals that provides SRH services.

SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

Gender-based violence, broader in scope, includes harmful acts targeting individuals based on their gender, such as domestic violence, forced/child marriage, and female genital mutilation.

Sexual violence, a form of gender-based violence, involves any coerced sexual act, attempt, or harassment, regardless of the victim's relationship with the perpetrator, such as rape, forced pregnancy, and trafficking.

SEXUAL AND REPRODUCTIVE HEALTH (SRH)

Good SRH means being physically, mentally, and socially healthy when it comes to our body's reproductive system. It's about being able to enjoy sex safely, decide if and when to have children, and get the right care and information to make these choices.[23]

SOGIESC

Short for 'sexual orientation, gender identity, gender expression and sex characteristics', it is an umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories.[24]

THIRD-PARTY AUTHORISATION

A requirement by laws/policies indicating that someone else, like a parent, partner, or doctor, must give permission before a health service is given. This is required even when the woman, girl, or pregnant person has already met all other legal conditions.

TRANSITION-RELATED HEALTHCARE (TRH)

Health care services, such as hormone therapy and gender-affirming surgery that are medically needed by trans or gender-diverse communities.

INTRODUCTION

For centuries, the management of sexual and reproductive health (SRH) issues, especially pregnancy and abortion or termination of pregnancy, have been integral to the life cycles of women, as well as trans and gender diverse persons. From ancestral and traditional knowledge to adopting self-care methods and through the advancements of modern medicine and healthcare systems, a consistent theme has persisted in preventing pregnancy or managing unintended pregnancies: the right to decide over one's own body and life, also known as bodily autonomy.

This concept, deeply rooted in the history of humankind, is not only a fundamental human right, but also a critical component of sexual and reproductive health and rights (SRHR). Gender equality can only be achieved when women and girls in all their diversities have the power to make choices and exercise control over their bodies. Bodily autonomy highlights the importance of individual choice and control, regardless of the era.

WHAT IS THIS TOOLKIT?

This toolkit was developed as part of the Asian-Pacific Resource & Research Centre For Women initiative titled 'Strengthening Capacities towards Inclusive Development Pathways: A Crucial Pivot to Development in Malaysia'. It is an adaptation of ARROW's 2016 Advocate Guide: Integrating Human Rights in Universal Access to Contraception, which uses the recommendations by the 2014 World Health Organization guide, 'Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations'.

The toolkit aims to support health service providers, government bodies and civil society organisations (CSOs) working on and advocating for SRHR to assess national and state-level health systems in delivering human rights-based access to contraception. It is also specifically designed and tailored to cater for the Malaysian context.

BOX 1: WHAT DOES SRHR LOOK LIKE?[25]

- Bodily autonomy and integrity
- Defining one's own sexual orientation, gender identity and expression
- Deciding whether and when to be sexually active, and where and how
- Choosing partners
- Experiencing safe and pleasurable sex
- Making decisions about marriage
- Deciding whether and when to have children, including child spacing
- Lifetime access to quality and accurate information and services
- Access to SRH services based on the latest scientific progress
- Access to age-appropriate comprehensive sexuality education (CSE)
- Privacy and confidentiality
- Free from discrimination, coercion, exploitation and violence
- Holistic SRH perspective: Physical, emotional, psychological and mental health aspects

WHO IS THIS TOOLKIT FOR?

This toolkit is designed for relevant stakeholders, including health service providers, government bodies and CSOs working on and advocating for SRHR outlined in Box 2. When implementing this toolkit, it is also crucial to engage with community-based organisations (CBOs) working with marginalised and excluded groups. Their inclusion is vital to ensure the voices and experiences of these groups are heard, which would enrich the assessment.

The toolkit offers dual functionalities:

1. For governments, it serves as a self-assessment exercise to periodically evaluate whether contraceptive services and information are provided in a manner that fulfil human rights.
2. For CSOs and advocates, it acts as a resource to inform their advocacy work on SRHR in regards to public health care systems in providing contraceptive services and information.

The dual approach ensures that both government and advocates have a comprehensive resource to support their work in fulfilling, protecting and upholding SRHR.

BOX 2: COMPREHENSIVE SRH SERVICES[26]

- Comprehensive sexuality education (CSE)
- Information, counselling and access to modern contraceptive methods
- Information, counselling and services for managing menstrual abnormalities (including Genitourinary Syndrome of Menopause, Pre, Peri, Post-menopausal conditions)[27]
- Information, counselling and services for managing subfertility and infertility
- Information, counselling and services for sexual health and well-being
- Preconception, antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
- Prevention and treatment of HIV and other sexually transmitted infections (STIs)
- Prevention and treatment of reproductive tract infections (RTIs)
- Prevention, detection and management of reproductive cancers, especially cervical and breast cancers
- Prevention, detection, immediate services and referrals for cases of gender-based violence (GBV), including sexual and gender-based violence (SGBV)
- Safe abortion services and treatment of complications of unsafe abortion
- Transition-related health care services

Box 2 lists a summary of comprehensive SRH services from a life course perspective. This approach encourages stakeholders to provide holistic and rights-based SRH care, including contraception, tailored to the diverse needs of individuals at all life stages. It is essential for creating inclusive and effective SRH services that enhance health outcomes and ensure dignity for everyone.

WHY THIS TOOLKIT?

This toolkit aims to support you to critically assess and analyse how the national and state-levels health systems is upholding human rights standards in the delivery of contraceptive information and services. It provides information on nine (9) human rights that are linked to contraceptive information and services, curated checklists for analysis, and a step-by-step action plan development guide. The goal is to strengthen capacities, expand knowledge with clear action plans and create positive legal, policy and norms changes, keeping in mind the diverse experiences of women, girls, and gender diverse individuals.

HOW DO YOU USE THIS TOOLKIT?

The toolkit can be read from end-to-end to help build your background knowledge and gather insights on the various aspects covered. If time is short, we recommend reading the 'Roadmap' chapter, skimming through the introduction of Chapter 2, and then directly proceeding to the section on the specific human rights that are your primary focus. If you are exploring this toolkit, feel free to jump right to any specific chapter aligned to your needs.

There are tools and templates within the chapter or in Annexes that will be useful in operationalising your learnings.

SPECIAL FEATURES OF THIS SRHR TOOLKIT

- **Policy language:** We understand that policy language can be overwhelming and difficult-to-understand. The checklist items have been simplified as much as possible in hope that you will find it easy-to-use.
- **Expanded use of contraception:** The use of contraception extends beyond its traditional roles in pregnancy prevention, spacing, and limitation. This updated checklist includes the broader uses of contraception, particularly in the context of transition-related healthcare for trans and gender diverse persons.
- **Living document:** This document is intended as a living tool to be regularly updated. A simple and concise format facilitates easy tracking of progress and review. You are encouraged to adapt and creatively edit the templates as needed. We hope that you will inject vibrancy and creativity into what is often a lengthy and challenging process.

METHODOLOGY

The toolkit adopts a well-defined methodology that includes a multi-step process designed to ensure that it is participatory, reliable, feasible, practical, and forward looking. It aims to identify and prioritise areas where human rights may be lacking and recommends actionable steps for improvement.

DESK REVIEW: Our initial step involved an extensive desk review of materials, information, and studies available online. Notably, the toolkit draws extensively from two highly credible sources: ARROW's 2016 Advocate Guide: Integrating Human Rights in Universal Access to Contraception, and the World Health Organization's 2014 guide, 'Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations', we achieve the point of the toolkit being reliable as ARROW and WHO are two credible sources.

The reliability was further strengthened by a comprehensive literature review for better understanding the SRHR landscape in Malaysia.

OUTLINE DEVELOPMENT AND REVIEW: The toolkit's outline was collaboratively developed by the external consultants and ARROW team, ensuring a participatory approach. Additionally, the toolkit underwent a rigorous review process, involving the ARROW team and an external reviewer who is an SRH expert.

LOCALISATION EFFORTS: Capitalizing on the experience in community-based, national, and regional SRH work, and incorporating insights from the ARROW team, this toolkit has been carefully tailored to reflect on the healthcare systems in Malaysia. Care is taken to ensure this toolkit is accessible by using straightforward and user-friendly language.

PILOT TESTING: To enhance the toolkit's user experience, feasibility and practicality, we conducted two pilot tests of the checklist items and user guide. These tests took place during the 'CSO Dialogue on Malaysia's Progress on the SDGs and Access to SRHR Services' and 'Strategising Workshop for the Gender Equality Initiative in Malaysia' attended by members of SRH and non-SRH NGOs/CBOs in 2023. Feedback and comments received from the participants were thoughtfully incorporated into the toolkit.

ACTIONABLE AND FORWARD LOOKING: The toolkit's core element, the checklist is designed not only to identify areas for improvements but also to prompt users to be forward thinking. It encourages users to craft actionable and practical solutions that can contribute to positive changes.

LIMITATIONS

While the methodology has been vigorous and thoughtful, we acknowledge certain limitations in our toolkit's development.

OFFLINE INFORMATION: The development of the toolkit relied on the desk review of materials, information, and studies available online. There might be extensive offline information that was not included within the scope of the toolkit. On-the-ground realities based on online sources might not fully represent the true realities of diverse groups in Malaysia.

EVOLUTION OF SRHR: In this toolkit, a total of nine standards related to SRHR[28] are included. Considering the post-COVID advancements in telemedicine and self-care interventions, we acknowledge the potential for including additional human rights standards. Nevertheless, this version adheres to the original framework, with the inclusion of provider's rights under Standard 9: Accountability.

CONTINUOUS USER INVOLVEMENT: Given these considerations, the toolkit serves as a guidance. We recommended that users integrate their own knowledge and experience and relevant information when using the toolkit. There is immense value in each of us, our experiences, and lived realities.

SELF-CARE

And some self-care notes before we begin.[29, 30]

- **Do no harm:** In your assessment, you may find sensitive and confidential personal identifiable information. Ensure that robust data protection measures are in place, and that you exercise due diligence and seek consent before sharing this information. Also, establish mechanisms where individuals can withdraw consent at any time.
- **Exercise good judgement:** Start with what you know while being critical with it. One way is to get multiple perspectives on a question or situation, especially from the marginalised and excluded groups. Assess what you currently know while recognising the absence of information, this will help you in understanding the bigger picture.
- **Embrace 'No' as an opportunity:** A 'No' is not a failure; it signifies areas for improvement and actions. Reflect on each 'No' to identify learning opportunities and alternative strategies.
- **Positive reframing:** Positive reframing builds a growth mindset, foster positive relationships and promote well-being. This approach encourages us to think of our findings with a balanced view. It may even allow us to explore creative solutions from a different light.
- **Celebrate every step:** Remember to celebrate successes, no matter how it looks. Embrace setbacks as they too are progress to our goals.
- **Supportive peer network:** Build a shared space for exchanging experiences, emotional support and coping strategies. Regular interactions with fellow advocates foster solidarity and resilience, essential for sustaining the rigours of this challenging field.
- Most importantly, remember that you and your wellbeing matter. **Practise self-care and take care of each other. We are in this for a long run, and we will get there!**

FRAMING THE TOOLKIT

This chapter will give you a look into Malaysia's SRH history and an analysis of the current situation. You'll also learn briefly about the human rights framework and how it relates to universal access to SRH services and information.

NAVIGATING MALAYSIA'S SEXUAL AND REPRODUCTIVE HEALTH (SRH) HISTORY

Let's start by exploring Malaysia's SRH history and landscape from pre-colonisation to present day. By learning about this history, we hope that you will grasp the nuances of today's SRH challenges and opportunities in Malaysia, which will better help inform the work we do.

As noted in the introduction, for centuries, the management of pregnancy and abortion has been part of the life cycles of women, girls, as well as trans and gender diverse persons. This goes beyond just lived experiences. Historically, women are also known to be healers—unlicensed doctors, anatomists, abortionists, nurses, and counsellors, providing treatment to others and oftentimes, sharing vital information through secrecy and word of mouth.[31] In various cultures, they were revered as 'wise women', and labelled as witches too.[32]

In Malaysia, before the introduction of modern healthcare system in prior to colonialisation, people relied on traditional healers, such as *dukun* or *sinseh* (medical practitioners), *pawang* (healers with supernatural power), *bidan* (midwives) for health-related issues, including pregnancy and abortion.[33] Nonetheless, despite the initial rejection and undervaluation by colonial systems, the significant role of traditional medicine is now well-recognised, illustrating an important part of the country's rich traditional medicine heritage.

The Shift to Modern Medicine

Colonisation and the adoption of western medicine led to significant change in the healthcare landscape, especially in SRH issues. This period marked the medicalisation of healthcare, including pregnancy and abortion, as well as the introduction of restrictive laws on abortion. Medicalisation is "the process by which non-medical (or social) problems become defined and treated as medical problems, usually as illnesses or disorders".[34] This may extend social control by prioritising medical intervention over personal agency.[35] Next, Malaysia's health laws unveil a historical foundation influenced by colonial legislation. The Malaysian abortion law originally came from the British Empire's Indian Penal Code 1871, prohibiting abortion on all grounds.[36] Further, the 1956 Medicines Advertisement and Sale Act, also prohibited the publication of abortion[37] and contraceptive-related advertisements.[38]

Emergence of the Family Planning Movement in Malaysia

In the 1950s, the family planning movement began in Malaysia. The first Family Planning Association (FPA) was registered in Selangor in 1953, and by 1958, the Federation of Family Planning Associations, Malaysia (FFPAM) was formed,[39] and subsequently family planning associations were established in each state.

Sexual and Reproductive Health-Related Policies

We will now briefly showcase some of Malaysia's policies on sexual and reproductive health and family planning. As you become familiar with the key developments in the policy history outlined in Table 1, we hope that it will help you in critically assessing how well our policies and programmes uphold human rights standards.

TABLE 1: SEXUAL AND REPRODUCTIVE HEALTH-RELATED, INCLUDING FAMILY PLANNING POLICIES

YEAR	EVENT
1966	**The Start of Public Family Planning Initiatives by the Government**[40] High fertility post-war had prompted the set-up of the Population and Family Development Act (National Family Planning Act No. 42) and the National Family Planning Board. It was assumed then that high population growth would slow down the economic growth of the country. The National Family Planning board was a government agency responsible for implementing the national family planning program and to reduce the fertility rate by 1985.
1971	**First Step to Legalising Abortion in Malaysia**[41] Section 312 (Penal Code)[42] was amended from total prohibition to allowing abortion if it was necessary to save a woman's life.
1982	**Transition-related Health Care** The National Fatwa Council issued a fatwa banning sex reassignment surgeries (now known as transition-related healthcare) for transgender individuals.[43] Doctors stopped performing these surgeries even though the ban did not carry legal authority.
1984	**Population Growth Policy** The Malaysian government introduced the 70 million Population Policy by 2100 as a larger population is beneficial in achieving national development goals. It also renamed the Family Planning Board to the National Population and Family Development Board (NPFDB) (*Lembaga Penduduk dan Pembangunan Keluarga* or *LPPKN)*.
1989	**Legalising Abortion** Section 312 (Penal Code) was amended again in to permit abortion to safeguard a woman's mental and physical health further expanding abortion, instrumental to legalising abortion. **Introduction of Sexuality Education**[44] Sexuality education was first introduced in Malaysia as Family Health Education by the Ministry of Education in secondary schools. **Women's Development** The National Womens Policy and Women Development Action Plan ensured that women have the same opportunities as men in areas like the economy, law, health, education, and more, aiming to improve life for women in all these ways. They are aligned with the non-discrimination principle as enshrined in the Federal Constitution, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of Child (CRC), Beijing Declaration and Platform for Action, Millennium Development Goals (MDGs).[45]

TABLE 1_2: SEXUAL AND REPRODUCTIVE HEALTH-RELATED, INCLUDING FAMILY PLANNING POLICIES

1992	**A Shift to Population and Family Development Programmes**[46] The NPFDB commissioned Strategic Plan Study for the Implementation of the National Population Policy and found that due to the decline in fertility rates, it was not possible to reach a 70 million population by 2100. It has since recommended to focus on having a quality population and strong family institutions rather than a quantitative target.
1994	**International Conference of Population Development (ICPD) and Malaysia's SRH Policies** The ICPD shifted the perspective in reproductive health and is considered to be the birth of the modern SRHR movement. A Program of Action (PoA) was developed by the end of the ICPD and was approved and adopted by 179 countries.[47] Malaysia decided on a 20-year plan in managing population issues based on its participation in the ICPD.
1996	**Family Planning Policy Statement** From a population growth policy, the government has taken a position to develop a high quality population and strong families. As a result, the Policy statement guiding the implementation of family planning (FP) program was introduced. It focused on providing comprehensive and voluntary FP services. **One Stop Crisis Centre (OSCC)** The One Stop Crisis Centre (OSCC) was established, marking a critical step towards addressing and responding to sexual and gender-based violence (SGBV).[48]
2000	**Millennium Development Goals (MDGs** Malaysia committed to achieve MDGs by 2015 which included SRHR related goals (under Goals 3, 4, and 5, 16 and 17).
2001	**Introduction of Child Act 2001** The Child Act 2001 is a law in Malaysia that helps protect and care for children. It outlines measures to protect children from harm, such as violence and abuse, and laws that specifically make incest illegal and safeguard children from family violence.
2007	**Improving Access to Contraceptive and Safe Abortion Services** The Reproductive Rights Advocacy Alliance Malaysia (RRAAM), a coalition of 12 organisations was formed to increase access to legal, safe and affordable contraceptive and safe abortion services.
2009	**Introduction of National Child Policy and Child Protection Policy** The National Child Policy *(Dasar dan Pelan Tindakan Kanak-kanak Negara)* and Child Protection Policy were formed, aligned with the Convention on the Right of the Child (CRC). It addresses child-related issues, such as child abuse, sexual abuse, violence against children and child pornography.

TABLE 1_3: SEXUAL AND REPRODUCTIVE HEALTH-RELATED, INCLUDING FAMILY PLANNING POLICIES

2009-2019	**Reproductive and Social Health Education** The National Reproductive and Social Health Education Policy *(Dasar Pendidikan Kesihatan Reproduktif dan Sosial Kebangsaan)* or PKRS policy was introduced to systematically provide sexuality education, including to young people. The PKRS Policy was renamed PEKERTI Policy or Policy and Action Plan for National Reproductive and Social Health Education *(Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial* or *PEKERTI)* in 2012.
2011	**The 'Family' Agenda in National Development** The National Family Policy laid a foundation in prioritising the family perspective in socio-economic development. The government stated its commitment to develop prosperous, healthy, and resilient families.
2012	**Termination of Pregnancy Guideline (TOP) for Ministry of Health Hospitals** The TOP guideline marks a significant step in providing safe, accessible, acceptable, timely and stigma-free abortion in health facilities.
2015	**Sustainable Development Goals (SDGs)** When the MDGs and ICPD PoA phased out in 2015, SRHR were folded into the Sustainable Development Goals (SDGs).
2016-2030	**National Strategic Plan on Ending AIDS** This strategic plan adopts the vision for Malaysia in getting to the "Three Zeros: Zero new infection, Zero discrimination and Zero AIDS related deaths", and places testing and treatment at the heart of the national response in ending AIDS.
2020	**National Strategy Plan in Handling the Causes of Child Marriage** This strategic plan is a collaborative governmental effort to address child marriage. One of its strategies is to address the lack of access to sexual and reproductive health education and parenting skill.
2022-2025	**A Continuous and Expanded Effort in Providing Reproductive and Social Health Education** The Policy and Action plan for National and Reproductive and Social Health Education *(Polisi dan Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial* or *PEKERTI)* has been updated and enhanced to provide sexuality education for all Malaysians. It outlines the goal of fostering a healthy population characterised by high moral values and responsible behaviours.
2022	**Anti-Sexual Harassment Act 2022** This act marked a significant step in addressing sexual harassment in Malaysia and provides rights of redress for any person who has been sexually harassed.[49]

EVOLUTION OF POPULATION POLICY IN MALAYSIA

An analysis by the Malaysian Population Research Hub under the National Population and Family Development Board (NPFDB) shows that in the history of family planning and sexual and reproductive health (SRH) in Malaysia, the country's policies evolved from aiming for a substantial quantitative population increase to a shift to ensuring population quality and building strong family institutions.[50]

While the national agenda includes families, it's important to consider evolving structures of 'family' or living arrangements in the SRHR context. These include those who are separated, divorced, or widowed,[51] as well as unmarried couples who live together, who might not fit the traditional idea of a family. Given the evolving nature of family structures, it is important to consider these changes to effectively meet everyone's SRH needs.

This comprehensive policy landscape highlights a focused effort on fostering strong family units; however, it's equally important to acknowledge and address the needs of individuals and communities that may not fall within traditional family definitions when completing the checklists.

BEGINNING AND EVOLUTION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

Sexual and reproductive health and rights (SRHR) have been an integral part of the human rights discussion. The concept was first coined during the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, marking a paradigm shift from a focus on population control to prioritising human rights, women's rights and gender equality.[52] Subsequent years saw further advancements. The Beijing Declaration and Platform for Action in 1995 reinforced women's rights to control their own sexuality without coercion, discrimination, or violence.

Subsequent International treaties and agreements, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Sustainable Development Goals (SDGs), have reinforced the critical role of SRHR within the human rights framework. In summary, these developments reflect a growing global consensus that SRHR is important to achieving broader health, gender equality, and development goals.

UNDERSTANDING HUMAN RIGHTS

Imagine a world where everyone regardless of who they are and their backgrounds, is treated with respect and dignity. A world where everyone can access resources and make choices about their lives regardless of their age, gender, race, national or ethnic origin, colour, religion, language, marital status, disability, culture, employment and other aspects. The human rights are our pathway to creating that dream world.[53] Box 3 visualises an overview of the 30 basic human rights.[54]

BOX 3: 30 BASIC HUMAN RIGHTS

Free and equal	Freedom from discrimination	Right to life
Freedom from slavery	Freedom from torture	Right to recognition before the law
Right to equality before the law	Access to justice	Freedom from arbitrary detention
Right to fair trial	Presumption of innocence	Right to privacy
Freedom of movement	Right to asylum	Right to nationality
Right to marriage and to found a family	Right to own property	Freedom of religion and belief
Freedom of expression	Freedom of assembly	Right to partake in public affairs
Right to social security	Right to work	Right to leisure and rest
Right to adequate standard of living	Right to education	Right to cultural, artistic and scientific life
Right to a free and fair world	Duty to your community	Rights are inalienable

Government Upholding Human Rights and National Core Values

Human rights are universal rights that every person holds. Within this framework, every person is a right-holder, and the government assumes the crucial role as duty-bearers to respect, protect, and fulfil these rights.

This commitment includes delivering access to quality contraceptive information and services aligned to the latest scientific developments and guidelines. It is a responsibility beyond privileges, charity or good will, and one that aligns with the nation's core values to promote the well-being of the people, as well as the government's international commitments to human rights through the ratification of related treaties.

Threefold Obligations: To Respect, Protect, and Fulfil

Governments' obligations to human rights include three distinct aspects:

1. **Respect:** This means states respect and commit to the enjoyment of rights. For instance, a state should enact laws or policies that enable provision of SRH services for certain groups, such as unmarried young persons or transwomen.
2. **Protect:** This involves preventing rights violations and providing safe mechanisms if violations occur. For example, states should ensure service providers do not discriminate against clients based on gender identities.
3. **Fulfil:** The state must take all appropriate actions, including legislative, administrative, budgetary, and legal measures, to enable individuals to enjoy their rights. Even in low-resource settings, states are expected to progressively increase resources to meet the public health needs of their population.

Access to Contraception as a Human Right

Based on these human rights, WHO released a guidance document with recommendations of how human rights should be integrated within the context of SRH, especially contraceptive information and service provision. These recommendations are summarised in Figure 1. There are nine key human rights standards connected to the delivery of SRH, particularly in relation to contraceptive information and services. Additionally, this toolkit includes a supplementary checklist focused on the rights of healthcare providers, ensuring a comprehensive approach to SRH service provision.

FIGURE 1: 9 KEY HUMAN RIGHTS STANDARDS

Figure 1: There are nine (9) key human rights standards connected to the delivery of SRH, particularly in relation to contraceptive information and services. Additionally, this toolkit includes a supplementary checklist focused on the rights of healthcare providers, ensuring a comprehensive approach to SRH service provision.

A COMPREHENSIVE FRAMING OF CONTRACEPTIVE INFORMATION AND SERVICES PROVISION

We recommend a broader perspective on contraceptive information and service provision which extend beyond the traditional focus on pregnancy planning.

It should encompass:

1. **Prevention and Management of Sexually Transmitted Infections (STIs):** Recognising the integral role of contraceptive services in preventing and managing STIs.
2. **Management of Unintended Pregnancies:** Including the provision of safe abortion services for failed and non-use of contraceptives.
3. **Support for transgender individuals:** Addressing the specific needs of transgender individuals by including hormonal contraceptive usage as part of the gender transition process.
4. **Inclusivity for diverse SOGIESC:** Recognising that individuals across the spectrum of sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC) may require access to contraceptives for various reasons, not limited to pregnancy prevention.

For detailed explanations of what each of these mean, we recommend you refer to WHO's Guide "Ensuring human rights in the provision of contraceptive information and services" and ARROW's Advocate Guides. We hope by gaining more insights into these human rights, you can better facilitate a self-assessment of the public healthcare system's SRH delivery, and also better assess, plan and advocate for effective and inclusive SRH law, policies, guidelines, and norms.

Note: The WHO's last comprehensive recommendation on this topic was published in 2014. Given, the rapid scientific progress, and evolving societal norms there is a pressing need for an updated guideline that reflects current knowledge and practices.

NOTES

ROADMAP

FIGURE 2: SIMPLIFIED ILLUSTRATION OF THE TOOLKIT ROADMAP

This Chapter is written to guide you through a step-by-step process to use this toolkit.

Figure 2 is a simplified illustration of the roadmap to use this toolkit. We value your work and experiences and acknowledge the on-ground reality. As you work through this toolkit, maintain a creative and open-minded approach, ensuring that all relevant perspectives are thoughtfully integrated!

INFORMAL DISCUSSION: WHERE YOU START MATTERS LESS THAN THAT YOU DO!

To kickstart the use of this toolkit, consider starting with an informal discussion within your ministry, agency or organisation. You could also invite other agencies or organisations that collaborate closely with you or are part of your network to introduce and discuss the human rights approach in SRHR brought by the this toolkit.

This step is optional, as more structured conversations are detailed in the upcoming chapters, but beginning with a familiar approach can be beneficial.

EXERCISING YOUR BEST JUDGEMENT

What are the SRHR opportunities for improvement?

For example, consider looking into why the teenage maternal mortality ratio is increasing; how we can improve the level of support provided to rape survivors; or looking into unintended pregnancies and baby dumping.

Start with your personal experiences and observations in the SRHR field. You may also use Boxes 1 and 2 from the previous chapter as conversation starters. This approach will assist you in identifying and listing key issues of concern.

IMAGINATION EXERCISE

We invite you to use this space for a creative exercise:

OPTION 1: For self-assessing the public health care system
The Government is on a journey to conceptualise an ideal environment where the sexual and reproductive health rights of every individual are fully upheld on a special island.
What will this island look like to you? How does it feel to be on this island?

OPTION 2: For assessing the public health care system as a stakeholder
The Government has decided to invite you and your team to design an island where everyone has the fullest right to their sexual and reproductive health!
What will this island look like to you? How does it feel to be on this island?

THE SRHR TOOLKIT

The toolkit is crafted to accelerate your understanding of human rights, enabling you to identify and streamline SRHR issues from a human rights perspective, particularly those involving fulfilling human rights.

As mentioned at the beginning of the chapter, it has dual functionalities:

1. For governments, it serves as a self-assessment exercise to periodically evaluate whether contraceptive services and information are provided in a manner that fulfil human rights.
2. For CSOs and advocates, it acts as a resource to inform their advocacy work on SRHR in regards to public health care systems in providing contraceptive services and information.

- Chapter 1 involves overall structured planning to help you and your team to prepare.
- Chapter 2 entails conducting a rapid assessment using a set of proposed SRHR indicators.
- Chapter 3, the document's core, contains the human right standards that are important to know when assessing provision of SRHR, including contraceptive information and services.

We recommend reading the summary of each human right linked to SRHR, the corresponding WHO recommendations, and a summary of key assessment categories for each checklist item. This will enhance your understanding of the relevant human rights aspects before you start completing the checklist items at **Annex 4: The Assessment**, more efficiently.

BOX 4: CHECKLIST "MENU"

How Do I Decide Which Human Rights Standards and Checklist(s) to Pick?

It is normal to feel overwhelmed initially when selecting the checklist(s). Here are two strategies that you can use:

1. If it's your first time:
We recommend that you complete the whole checklist in batches.

2. If this is a regular assessment:
Select according to your chosen human rights standard(s)
> Once you've chosen one or more human rights standards, proceed to complete all corresponding checklists.

Select Checklists across different human rights standard(s)
> Skim through the list of checklists and mix and match these checklists as needed.

We recommend against splitting/combining individual checklist items, as they are purposefully grouped to provide a coherent interpretation of the WHO recommendations.

- Chapter 4 guides you in formulating an action plan, including conducting a SWOT analysis before moving into the planning phase.
- Chapter 5 involves setting up a monitoring, evaluation and follow-up mechanism to track your progress. The checklist completed in Chapter 3 is intended to be a dynamic document, and the monitoring framework will assist in its regular updating.
- The concluding chapter offers completed examples of tools and checklists for reference.

BOX 5: TIPS & TRICKS

1. Chapters 1: Preparing for the Assessment and Chapter 2: Rapid Assessment are interchangeable.
You have the option to complete Chapter 1 followed by Chapter 2, or vice versa.

2. Skimming the 9 Human Rights (Chapter 3):
It's beneficial to briefly review all 9 human rights standards and align the relevant ones with your identified issues of concern.

3. Drawing from Experience vs Data (or vice versa):
The rapid assessment in Chapter 2 aids in collecting data to support your on-the-ground observations. Conversely, it can also highlight SRHR gaps through the data, backing up experiential insights.

4. Insufficient SRHR data: If you find yourself short on data, here are several data collection methods:
> **Review Existing Documents:** Look at government documents, policies, and reports related to SRH. Check out legal documents and demographic data too.
> **Interviews and Group Discussions:** Talk to clients, health workers, policymakers, and others involved in SRH services. Focus groups can also help understand experiences of marginalised communities.
> **Visit Health Facilities:** See how SRH services are being provided in different service delivery points (SDPs). This can show you how friendly and efficient these services are, especially for young people.
> **Client Surveys**: Conduct surveys with people who use contraceptive services to get their perspectives and experiences.
> **Use Online Sources:** Collect information from the internet, like news articles and social media posts about SRH and contraception.
> **Get Real-Time Feedback:** Set up a digital platform where clients can give feedback about their experiences with SRH services.
> **Work with Government Officials or Cross-Ministerial/ Agency Collaboration:** Work with other relevant ministries or agencies, at the national or state levels, to ensure a comprehensive coverage of this assessment. Engage with people in the Ministry of Health and supportive parliamentarians to get SRH-related data, like budget information and service availability.
> **Collaborate with Academics:** Partner with researchers and students to conduct studies/research.

NOTES

CHAPTER 1: Preparing for the Assessment

This Chapter will help you prepare for a systematic and thorough assessment. Proper preparation is key to ensuring clarity and efficiency throughout the assessment process. It will also be helpful to set each assessor's expectation right.

1. CLARIFY THE PURPOSE

It is important to understand why you are doing the assessment. Determine whether it is for advocacy efforts, a routine review, or as part of an international human rights monitoring mechanism such as the Universal Periodic Review (UPR). This will shape the aspects such as the timeline, scope and who will be involved in the assessment.

2. GET THE BUY-IN

Identify who needs to be involved in the assessment, decision-making and who will influence the planning of the next steps.

3. BUILD YOUR TEAM

- Assign clear roles and responsibilities to team members. This can include roles such a project lead, assessors, facilitator and note-taker.
- If the assessment will involve multiple teams/ agencies/ organisations, ensure that there is a good representation of team members and be cognizant of power imbalances. For example, having a youth representative in a group of majority adults will need a unique discussion technique that provides the space for meaningful participation.
- Consider integrating efforts with existing working groups in your context.

4. CREATE A BUDGET:

Determine the cost for the coordination, meeting etc., so that you can get it sourced in advance.

5. DEVELOP A TIMELINE:

The timeline depends on the assessment scope and the team's capacity. If the assessment is for a particular event, this will also affect the timeline. A tentative timeline may look like this:

- Preparation: 1-2 months in advance
- Rapid assessment: 1 day
- Assessment: each standard can take ½ to 3 days to complete
- Action plan and next steps: 1 day
- Implementation, monitoring, evaluation and follow up: on-going.

6. REVIEW PAST ASSESSMENTS:

Analyse any previous assessment reports, UPR submissions, and recommendations to build on past work and identify areas for further exploration.

7. GUIDING PRINCIPLES

- **Do no harm:**[55] Prioritise the confidentiality and safety all, including participants and subject of assessment.
- **Data protection:**[56] Highlight the importance of data privacy and protection, especially when dealing with personally identifiable or sensitive information.
- **Continue refining:** Cultivate the practice of continuous improvement. The assessment should be seen as a starting point rather than a one-off exercise.
- **Pilot testing:** Consider conducting a pilot test of the assessment process in a small team and use the learnings to enhance the actual assessment.

A template to help facilitate a structured preparation is provided in **Annex 1: Assessment Preparation Template**. This template is a guide for documenting all the important information in the preparation phase and can be customised based on your own needs and context. Note: this can also be completed after completing Chapter 2: Rapid Assessment.

Once you complete these steps, you will now hopefully be equipped to begin the assessment. With clarity, commitment and a solid plan, you are ready to start.

Let's go!

CHAPTER 2: Rapid Assessment

In this Chapter, you will conduct a rapid assessment to help you prepare for the full assessment. A rapid assessment provides a quick, yet insightful, overview of the current status and can help guide where detailed investigations are needed. This will be a valuable step to be informed of the environment you are working in, so it is crucial that you undertake the rapid assessment before moving to the checklist. However, be realistic about expectations. You are dedicating a brief focused time to this exercise; it is fine if the results are incomplete or imperfect. You may find more information when completing the checklist and this can be updated.

WHAT WILL YOU ASSESS?

Your assessment will involve multiple dimensions. Here's a breakdown of key aspects you should consider:

1. **POLICY AND LAWS**
   a. What are the laws regarding contraceptive information and services? Does it involve any criminalisation/ penalties?
   b. What are the policies regarding contraceptive information and services? Any gaps or areas that does not align with actual needs?

2. **HEALTH SYSTEM LANDSCAPE**
   a. What are the contraceptive services available in the country? Do also refer too Box 2 for a list of comprehensive SRH services.
   b. Where are they available? Examine the distribution of healthcare facilities offering contraceptive information and services.
   c. Who provides these services? Consider the number, and level of healthcare providers providing contraceptive information and services.
   d. What constitutes accessible contraceptive information and service provision and how is it currently measured?

3. **RECENT DEVELOPMENTS**
   a. What are the new developments, technologies, or methods related to contraception globally? Are these available locally or are there any steps to integrate them locally?
   b. Are there any new studies or findings on contraception locally?

4. **NORMS AND PERCEPTION**
   a. What are the common attitudes and beliefs about contraception, including the norms and taboos?
   b. How is the public engaged in contraceptive issues and programmes?

5. **FUNDING**
   a. What is the national and external donors' budget and resource allocation for contraceptive information and services?
   b. Does this align with actual needs?

6. **DATA**
   a. Are quality and reliable data on contraceptive information and services available? See **Annex 2: Rapid Assessment Indicators** for a list of indicators that are important to track.
   b. Are these data used for decision making?

7. **STAKEHOLDER ANALYSIS**
   a. Who are the key stakeholders, including government bodies, CSOs/NGOs, services providers etc?
   b. Are there any active working groups on contraceptive information and services?

8. **CHALLENGES**
   a. What are the barriers to accessing contraceptive information and services?

9. **BEST PRACTICES**
   a. Are there any successful programmes on contraceptive information and services? Assess why they are successful.

ANALYSING RAPID ASSESSMENT DATA

Reflect on all the information you just gathered. You can then discuss this in your group based on the following questions:

- Which areas require immediate attention?
- What surprises or most valuable findings emerged from the rapid assessment?
- What are the potential areas for collaboration among different stakeholders?
- What are some of the enabling factors that contributed to the success of certain policies or service delivery work. Explore how these factors can be adapted and applied to other areas or services?

IDENTIFYING THE MARGINALISED AND EXCLUDED GROUPS

Now that you have completed the rapid assessment, the next step is to identify the list of marginalised and excluded groups.

This is one of the most important steps in this process. Your checklist findings and next step will rely significantly on this information. Therefore, you need to ensure a detailed assessment of the population and understand who may not have been adequately included or consistently been excluded by current sexual and reproductive health policy and services, especially contraceptive information and service provision.

You are encouraged to consider the intersectionality of this population. Look for how different aspects of their lives, like being poor, facing discrimination because of gender, race, or having a disability, can overlap and affect people in complex ways. This means understanding that someone might experience not just one, but several types of challenges at the same time.

Consider these general questions to help you in your brainstorming:

- Are the populations of concern: poor, marginalised, socially-excluded and/or under-served?
- What are their intersectionalities?
- What are the unmet needs in contraceptive SRH services and information for this group?
- What are the key barriers that are preventing this group from accessing SRH services and information?

BOX 6: DEFINITIONS OF POOR, MARGINALISED, SOCIALLY-EXCLUDED AND UNDER-SERVED GROUPS[57]

Poor: people living below Malaysia's average poverty line income on less than RM2,589[58] per month per household.

Marginalised: people who for reasons of poverty, geographical inaccessibility, culture, language, religions, gender, disability, migrant status or other disadvantage, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unmet.

Socially-excluded: people who wholly or partially excluded from full participation in the society in which they live.

Under-served: people who are not normally or well-served by established sexual and reproductive health delivery programme due to a lack of capacity and/or political will; for example, people living in rural/remote areas, young people, people with a low socio-economic status, people living with disabilities, unmarried people, etc.

This exercise will be completed in the template provided in **Annex 3: Marginalised and Excluded Groups**.

NEXT STEP

With the rapid assessment and identification of the marginalised and excluded completed, you are well positioned to move to the next step which is a more detailed assessment. This approach ensures that every step of the assessment is conducted with an awareness of the diverse needs within the community. You will now move on to the next step, good luck!

CHAPTER 3: The Assessment

In this chapter, we will guide you through the human right standards that are important to know when assessing provision of SRHR, including contraceptive information and services. This chapter is the heart of the toolkit and is designed to help you in assessing compliance and understanding the depth of their implementations. The aim is to equip you with the knowledge and resources to take the steps to meaningful improvements.

HOW TO NAVIGATE THROUGH THIS CHAPTER?

This chapter is structured into nine (9) human rights standards comprising 24 recommendations in line with WHO's guidance and recommendations for Ensuring Human Rights in the Provision of Contraceptive Information and Service.

Each standard includes:

1. **What does this mean:** Explains the significance of the standard and how it applies to our context.
2. **What will you assess:** An overview of what you can expect in completing this standard.
3. **Key assessment categories:** A list of areas that you need to consider in your assessment.
4. **Useful reference materials:** Readings and resources to increase your knowledge and understanding of each standard.
5. **Useful documents for verification:** Documents that serve as evidence for your findings.
6. **Checklist in Annex:** At the end of each standard, you will be directed to a detailed checklist in the **Annex 4: The Assessment**.

USING THE CHECKLIST

We recommend approaching the checklist thoroughly via various lenses such as:

1. **Human rights lens:**[59] Recognising that everyone is entitled to fundamental human rights, like the rights to SRH services, and the Government is obliged to fulfil these rights.
2. **Critical lens:** Examine each item critically to understand the real situation. For instance, if there have been no reports of contraceptive shortages which might seem positive, consider if this is a genuine progress or the result of lack of documentation and field visits.
3. **Intersectionality lens**: Recognise the interconnectedness of various identities such as age, gender, nationality, religion, ethnicity which can create an overlapping or independent system of discrimination. For instance, how an unmarried, pregnant, Malay Muslim adolescent may experience services differently as compared to a married, pregnant, Malay Muslim adolescent.
4. **Gender lens:** Understand how different genders (women, men, transgender and non-binary) are uniquely affected. For example, a transgender male may face significant barriers and stigma in accessing safe abortion care due to his gender identity as compared to a cis woman.
5. **Localised knowledge:** Apply your understanding of local context and knowledge to inform the assessment. For example, consider the diverse cultural and religious background of the Malaysian population and how it influences knowledge, attitude and practices related to SRH.

We understand that it can be overwhelming to complete all of the checklist at once. Therefore, we encourage you to approach this process strategically:

- **Select:** Choose which standard is most relevant or critical for your current assessment.
- **Prioritise:** Based on your objectives and resources pre-determined in the previous chapter, decide which checklist is useful to tackle first.
- **Consult:** Each one of us has our own unique knowledge and experience, include diverse assessors from diverse social identities to ensure a comprehensive assessment.
- **Trust:** The checklist items are designed to be flexible, allowing you to exercise your own judgement in completing the assessment. ***Remember, there is no right or wrong answer!***

COMPLETING THE CHECKLIST: A STEP-BY-STEP GUIDE

The checklist is divided into two parts. The first part gathers information about the assessment context. The second part, which is the core part of the toolkit, contains a set of questions or statements, referred to as the checklist items.

We recommend completing the checklist on a computer or laptop for ease of editing. You can upload the toolkit onto the cloud where multiple assessors can complete it at the same time. Alternatively, you can appoint a note-taker who will do this for you. If preferred, hard copies can be used for discussion. If you prefer to use the hard copy, we recommend that you print it out to take notes and later complete the digital copy. Digital copies are easier for storage purposes as well.

Here's how to complete the checklist.

PART 1: ASSESSMENT INFORMATION	
NAME OF ORGANIZATION:	Name of the organisation or agency completing the assessment.
COUNTRY/STATE:	The country or state in which the assessment is being carried out.
NAME OF ASSESSORS:	Names and titles of individuals performing the assessment.
DATE:	The current date when the assessment is started.
DATE OF PREVIOUS ASSESSMENT:	If applicable, the date of previous similar assessment.
PROJECT LEAD:	The main contact person overseeing the assessment who is responsible for follow-up and coordination.
PART 2: CHECKLIST	
CHECKLIST ITEM:	Each checklist comprises one or more WHO recommendations that are broken down into checklist items.
CHECKLIST STATUS:	Mark the progress of each checklist item as Not started, In progress, Delayed or Completed.
FINDINGS:	Write your findings for each item, including any observations and references to relevant policies or guidelines.
NEXT STEPS:	Write your findings for each item, including any observations and references to relevant policies or guidelines.
PRIORITY:	Prioritise each next steps as Critical (issues that need immediate action), High (action is required soon), Medium (can be addressed in 3-5 months), Low (can be addressed in 6-12 months).
BY WHOM:	Assign a person responsible for this action.
BY WHEN:	Set a deadline for each section for the Project Lead to oversee follow-ups.
BUDGET:	If applicable, indicate the budget needed to undertake these actions.
KEY STAKEHOLDERS:	Identify any key stakeholders related to the checklist item who is key in contributing to the next steps.
ANY NOTES:	Use this space for additional notes or comments that are useful for the assessment.

Before going into the details, we have summarised all nine human rights standards with their respective checklists and key assessment categories. This compilation provides an overview for you in selecting the relevant HR standards and corresponding checklists.

TABLE 2: NINE HUMAN RIGHTS STANDARDS WITH THEIR RESPECTIVE CHECKLISTS

HUMAN RIGHTS STANDARD	CHECKLIST	KEY ASSESSMENT CATEGORIES
STANDARD 1: Non-discrimination in Provision of Contraceptive Information and Services	**1.1: SRH coercion and incentives** **1.2: Marginalised populations**	> Policy and guidelines > Service accessibility and integration > Equity and non-discrimination > Data utilisation for service improvement > Accountability and ethical practices
STANDARD 2: Availability of Contraceptive Information and Services	**2.1: Contraceptive commodities, supply, equipment and method range**	> Essential drug list > Supply chain reliability > Government investment in SRH > Service delivery availability > Provider availability and responsiveness
STANDARD 3: Accessibility of Contraceptive Information and Services	**3.1: Comprehensive Sexuality Education in and out of school** **3.2: Affordable SRH services, including contraceptives for all** **3.3: SRH info and service for the difficult-to-reach** **3.4: SRH info and services during emergency or humanitarian settings** **3.5: SRH info and services and HIV care** **3.6: Contraceptive info and services within Antenatal, Postnatal and Post-Abortion care** **3.7: Self-Autonomy vs Third Party Authorizations**	> Comprehensive sexuality education (CSE) > Financial barriers > Safe abortion > Coverage of services > Services in diverse context > Law and policies
STANDARD 4: Acceptability of Contraceptive Information and Services	**4.1: Gender transformative SRH service delivery** **4.2: Management of side effects**	> Gender Equality policy and guidelines > Gender-transformative care > Management of side-effects > Provider training > Resources for acceptability
STANDARD 5: Quality of Contraceptive Information and Services	**5.1: Quality assurance**	> Policy and guidelines > Service quality > Provider competency > Client feedback utilisation > Timeliness

TABLE 2_2: NINE HUMAN RIGHTS STANDARDS WITH THEIR RESPECTIVE CHECKLISTS

STANDARD 6: Informed Decision Making	**6.1: Comprehensive info, education and counselling for informed decision making**	> Informed consent > Provider Training > Implementation > Job aid
STANDARD 7: Privacy and Confidentiality	**7.1: Protecting personal privacy and confidentiality of medical records**	> Policy and guidelines > Provider Training > Infrastructure preparedness > Client feedback mechanism
STANDARD 8: Participation	**8.1: Meaningful engagement in SRH program and policy design**	> Policy and guidelines > Representation > Meaningful Engagement
STANDARD 9: Accountability	**9.1: Effective accountability mechanisms at all levels, i.e., international, national and individual levels** **9.2 Providers' rights** **9.2.1: Non-discrimination and representation in health care provider recruitment** **9.2.2: Human rights-based work environment** **9.2.3: Capacity building on human rights approaches** **9.2.4: Community health workers (CHW)**	> Reporting and accountability > Human rights recommendations implementation > Law integration > Grievance Mechanisms > Data utilisation > Recruitment > Work environment and safety > Capacity sharing > Community health worker (CHW) inclusion

Now, let us move to the next section to explore each standard in detail.

STANDARD 1: Non-discrimination in Provision of Contraceptive Information and Services

WHO Recommendation

1.1 Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice).

1.2 Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalised populations in their access to these services.

WHAT DOES THIS MEAN?

This standard advocates for equitable access to contraceptive information and services, ensuring that no individual faces discrimination, coercion, or violence in their health choices. It emphasises the importance of inclusive policies and practices that cater to all segments of the population, especially the marginalised groups.

WHAT WILL YOU ASSESS?

You will assess how inclusive policies and practices related to contraceptive services are. This involves looking at the broader policy and guidelines, programme implementation, service delivery, and the mechanisms in place for feedback and accountability. The focus is on ensuring that every individual's rights and choices are respected and that services are customised to meet the diverse needs of the population.

KEY ASSESSMENT CATEGORIES:

- **Policy and guidelines:** Evaluate the inclusivity and supportiveness of policies and guidelines.
- **Service accessibility and integration:** Look at how contraceptive services are integrated within the broader health system and their accessibility to all.
- **Equity and non-discrimination:** Consider the specific needs and barriers of different groups, including the marginalised groups.
- **Data utilisation for service improvement:** Assess how data is used to inform and enhance services.
- **Accountability and ethical practices:** Review mechanisms for reporting, incentives, and provider accountability to ensure they uphold non-discrimination.

USEFUL REFERENCE MATERIALS

- *Garis Panduan Perancang Keluarga Kebangsaan*
- *Buku Panduan Ibu dan Perancang Keluarga di Klinik Kesihatan*
- *Garis Panduan Pengendalian Masalah Kesihatan Seksual dan Reproduktif Remaja di Klinik Kesihatan*
- General Hospital Operational Policy (2013)
- Performance-based funding mechanism

USEFUL DOCUMENTS FOR VERIFICATION

- Quality of Care assessment report
- Field visit report
- Health setting assessment report

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 1**.

STANDARD 2: Availability of Contraceptive Information and Services

WHO Recommendation

2.1 Recommend integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability.

WHAT DOES THIS MEAN?

This standard focuses on ensuring a consistent availability of contraceptive information and services, including safe abortion care. This is not limited to just the listing of contraceptives as essential drugs but also ensuring they are consistently available to the public, backed by supportive and delivered through a network of well-equipped and well-staffed service delivery points.

WHAT WILL YOU ASSESS?

You will assess the availability and continuity of contraceptive services, including the readiness of service delivery points and human resources. The assessment includes reviewing how the healthcare system responds to supply and poorly equipped service delivery issues. It also includes government investment in health and ability to provide innovative service delivery models addressing various clients' needs.

KEY ASSESSMENT CATEGORIES:

- **Essential drug list:** Verify whether a complete range of contraceptive options are officially recognised as essential and consistently available.
- **Supply chain reliability:** Assess cases and management of stock-outs and the reliability of the contraceptive supply chain.
- **Government investment in SRH:** Examine government spending trends on SRH and its adequacy in meeting needs.
- **Service delivery availability:** Determine the distribution and readiness of service delivery points to provide contraceptives services in line with population size and need.
- **Provider availability and responsiveness:** Evaluate the availability of skilled and well-equipped healthcare providers and the responsiveness of services to client feedback and complaints.

USEFUL REFERENCE MATERIALS

- WHO Model List of Essential Medicines
- National Essential Medicines List (NEML)
- Guidelines on Termination of Pregnancy
- General Hospital Operational Policy (2013)

USEFUL DOCUMENTS FOR VERIFICATION

- Commodity inventory report
- Stock out reports
- Service statistics – for report of contraceptive discontinuation
- Feedback and complaint reports

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 2**.

STANDARD 3: Accessibility of Contraceptive Information and Services

WHO Recommendation

3.1 Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition.

3.2 Recommend eliminating financial barriers to contraceptive use by marginalized populations including adolescents and the poor and make contraceptives affordable to all.

3.3 Recommend interventions to improve access to comprehensive contraceptive information and services for users and potential users with difficulties in accessing services (e.g. rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO Abortion care guidelines, 2022. (Note: this guidelines updates and replaces the previous WHO guidelines)

3.4 Recommend special efforts be made to provide comprehensive contraceptive information and services to displaced populations, those in crisis settings, and survivors of sexual violence, who particularly need access to emergency contraception.

3.5 Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health-care setting.

3.6 Recommend that comprehensive contraceptive information and services be provided during antenatal and postpartum care.

3.7 Recommend that comprehensive contraceptive information and services be routinely integrated with abortion and post-abortion care.

3.8 Recommend that mobile outreach services be used to improve access to contraceptive information and services for populations who face geographical barriers to access.

3.9 Recommend elimination of third-party authorization requirements, including spousal authorization for individuals/women accessing contraceptive and related information and services.

3.10 Recommend provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, to meet the educational and service needs of adolescents.

WHAT DOES THIS MEAN?

This standard contains a total of 10. recommendations. They cover a breadth of areas essential for guaranteeing access to contraceptive information and services and other sexual and reproductive health related services. These services are not just about being listed as essential but also about being available, accessible and affordable when people need them.

WHAT WILL YOU ASSESS?

You will assess the implementation information provision through comprehensive sexuality education, whether services are affordable, how services are delivered during emergencies, the integration of services, and elimination of unnecessary barriers. Particular attention should be given to the inclusivity and comprehensiveness of these services, ensuring they reach and meet the needs of every person.

KEY ASSESSMENT CATEGORIES:

- **Comprehensive sexuality education (CSE):** Assess the inclusion, funding, and implementation of CSE in policy and practice.
- **Financial barriers:** Evaluate the cost of services and the availability of financial support mechanisms especially for the marginalised groups.
- **Safe abortion:** Determine if policies and practices related to abortion are based on global recommendations.
- **Coverage of service:** Determine the comprehensiveness and integration of contraceptive services within other sexual and reproductive health related services such as HIV, antenatal and postpartum care and during emergency.
- **Services in diverse context:** Examine the reach and effectiveness of service delivery in stable, emergency, and mobile outreach settings.
- **Law and policies:** Review the laws and policies to ensure it supports access to sexual and reproductive health services without the need for approval from any other individuals, bodies, or institution.

USEFUL REFERENCE MATERIALS

- Abortion Care Guidelines, 2022
- Towards a Supportive Law and Policy Environment for Quality Abortion Care: Evidence Brief, 2022
- *Dasar dan Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial Kebangsaan (PEKERTI)*
- International Technical Guidance on Sexuality Education: An Evidence-informed Approach
- Minimum Initial Service Package (MISP) for SRH in Crisis Situations
- One Stop Crisis Centre (Policy and Guidelines for Hospitals, Ministry of Health Malaysia)
- UPR – A Review of Malaysia UPR 2018-2023
- Minimum Initial Service Package for SRH in Crisis Situations
- General Hospital Operational Policy (2013)
- Qualitative Assessment of Sexual and Reproductive Health and Rights and Access to Health Care Services among Women Living with HIV within the context of Mother-to-Child Transmission of HIV in Malaysia (2022)

USEFUL DOCUMENTS FOR VERIFICATION

- National HIV policy
- Antenatal and postpartum care guidelines
- Gender-based violence guide
- National budget and expenditure

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 3**.

STANDARD 4: Acceptability of Contraceptive Information and Services

WHO Recommendation

4.1 Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that include skills building (i.e. communications and negotiations), and that are tailored to meet communities' and individuals' specific needs.

Note: The original recommendation was for a 'gender-sensitive' approach, which acknowledges the different roles individuals play but does not necessarily address them. Recent evidence suggests that a 'gender-transformative' approach, which works to positively change harmful norms and promote equality, might be more effective.

4.2 Recommend that follow-up services for management of contraceptive side-effects be prioritized as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and available.

WHAT DOES THIS MEAN?

This standard highlights the importance of providing contraceptive information and services that are acceptable to all individuals, respecting their unique needs. It calls for gender-transformative approaches that not only recognises but also aim to positively transform harmful gender norms and promote equality. Additionally, it emphasises the need for effective management of contraceptive side-effects and reliable referral systems.

WHAT WILL YOU ASSESS?

You will explore the integration of gender equality in policies and service delivery, the responsiveness of services to gender-based violence and transition-related healthcare needs, and the mechanisms for handling contraceptive side-effects. You will also assess trainings of healthcare providers to ensure gender-transformative care and the resources available to clients for a supportive service.

KEY ASSESSMENT CATEGORIES:

- **Gender Equality policy and guidelines:** Evaluate the integration of gender equality laws/ policies and their impact on service delivery.
- **Gender-transformative care:** Review gender-transformative practices within sexual and reproductive health services.
- **Management of side-effects:** Assess the guidelines for managing contraceptive side-effects, including referrals for relevant services.
- **Provider training:** Look at the extent of provider training for gender-transformative care and the presence of supportive environments for discussions on reproductive coercion or gender-based violence.
- **Resources for acceptability:** Examine the availability of additional resources (personnel, space and information materials) to increase the acceptability services.

USEFUL REFERENCE MATERIALS

- Family Planning – A Global Handbook for Providers
- Family Planning and Comprehensive Abortion Care Toolkit for the Primary Health Care Workforce: Volume 1
- RESPECT Women: Preventing Violence Against Women
- Gender Integration Continuum

USEFUL DOCUMENTS FOR VERIFICATION

- National gender equality law/policy
- Gender assessment findings
- Service delivery guidelines
- Training records
- Client feedback/complaint

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 4**.

STANDARD 5: Quality of Contraceptive Information and Services

WHO Recommendation

5.1 Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes.

5.2 Recommend that provision of long-acting reversible contraception (LARC) methods should include insertion and removal services, and counselling on side-effects, in the same locality.

5.3 Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.

WHAT DOES THIS MEAN?

This standard emphasises the need for quality contraceptive information and services that is centred around clients' needs and preferences. It underscores the importance of having quality of care (QoC) processes in place, services that are coupled with LARCS and routine training of service providers to maintain a quality service.

WHAT WILL YOU ASSESS?

You will assess the QoC processes within contraceptive information service provision, the comprehensiveness of LARC related services, training of service providers and client feedback mechanism.

KEY ASSESSMENT CATEGORIES:

- **Policy and guidelines:** Examine whether the quality of care (QoC) guidelines aligned with WHO recommendations and their implementation status.
- **Service quality:** Assess whether the quality of contraceptive services, including LARC, is consistently monitored and assessed.
- **Provider competency:** Verify if the service provider training meets WHO core competencies for SRH care.
- **Client feedback utilisation:** Review the client feedback mechanism and if feedbacks are systematically collected and used to enhance service quality.
- **Timeliness:** Evaluate if guidelines and practices ensure reduces harmful delay and provide timely care.

USEFUL REFERENCE MATERIALS

- Sexual and Reproductive Health: Core Competencies in Primary Care
- General Hospital Operational Policy (2013)
- General Surgical Services Operational Policy (2018)

USEFUL DOCUMENTS FOR VERIFICATION

- Service delivery guidelines
- Training records
- Client feedback/complaint
- Compliance certifications

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 5**.

STANDARD 6: Informed Decision-making

WHO Recommendation

6.1 Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.

6.2 Recommend every individual is ensured the opportunity to make an informed choice for their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination.

WHAT DOES THIS MEAN?

This standard emphasises the right of individuals to make well-informed choices about contraception. It states that all individuals, especially those marginalised, have access to complete and evidence-based information and that they receive it in an environment that supports their decision-making autonomy.

WHAT WILL YOU ASSESS?

You will check if services are following the correct steps to make sure clients understand their options and are able to provide informed consent. You will also assess if the service providers are adequately trained to facilitate all clients' decision-making process, including those who are marginalised. Additionally, the assessment will cover the availability and updating of resources and tools that assist clients in understanding their contraceptive options.

KEY ASSESSMENT CATEGORIES:

- **Informed consent:** Verify that guidelines are in place for obtaining informed consent and facilitating informed decision-making.
- **Provider Training:** Assess the training providers receive to ensure they can support clients, particularly marginalised groups, in making informed decisions.
- **Implementation:** Evaluate if providers in practice are enabling informed decision-making, with special attention to marginalised groups and adolescents.
- **Job aid:** Check if there are updated resources and tools to support clients in making informed choices about contraception.

USEFUL REFERENCE MATERIALS

- Malaysian Medical Council (MMC) Guidelines: Consent for Treatment of Patients by Registered Medical Practitioners
- General Hospital Operational Policy (2013)
- General Surgical Services Operational Policy (2018)

USEFUL DOCUMENTS FOR VERIFICATION

- Patient informed consent forms (adults and minors), patient information sheet, medical history form
- SRH IEC materials
- Client feedback/complaint

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 6**.

STANDARD 7: Privacy and Confidentiality

WHO Recommendation

7.1 Recommend that privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information.

WHAT DOES THIS MEAN?

This standard highlights the right to privacy and confidentiality as important components of contraceptive services. It requires that individuals' interactions with service providers remain private, and their personal data is protected throughout the service provision.

WHAT WILL YOU ASSESS?

You will evaluate the availability and effectiveness of privacy and confidentiality guidelines, the adequacy of service provider training, the service delivery points' ability to support privacy, and the mechanisms for client feedback on privacy concerns.

KEY ASSESSMENT CATEGORIES:

- **Policy and guidelines:** Confirm that guidelines align with WHO recommendations and check for their promotion, funding, and mandated implementation.
- **Provider Training:** Assess whether training on privacy and confidentiality is included for providers and if it is monitored.
- **Infrastructure preparedness:** Evaluate the setup of service areas to ensure client conversations and care are private.
- **Client feedback mechanism:** Review the mechanisms in place for reporting privacy violations and ensuring feedback is addressed without compromising client safety.

USEFUL REFERENCE MATERIALS

- *Pekeliling Ketua Pengarah Kesihatan Bil 17/2010*
- Confidentiality of Medical Records Information
- General Hospital Operational Policy (2013)
- Personal Data Protection Act (2010)

USEFUL DOCUMENTS FOR VERIFICATION

- Patient informed consent forms
- Privacy and data protection policies (physical and digital data)
- Non-disclosure agreements by healthcare providers
- Incident report
- Client feedback/complaint

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 7**.

STANDARD 8: Participation

WHO Recommendation

8.1 Recommend that communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring.

WHAT DOES THIS MEAN?

This standard recognises the important role of community involvement, especially from those directly impacted by contraceptive programmes. Meaningful participation ensures that services are tailored to meet the actual needs and circumstances of the community and that policies are shaped by the voices of those they affect.

WHAT WILL YOU ASSESS?

You will focus on the availability and effectiveness of policies that encourage community participation. You will also examine the representation within these participatory mechanisms, ensuring diverse and marginalised groups have a voice.

KEY ASSESSMENT CATEGORIES:

- **Policy and guidelines:** Check if there are guidelines that facilitate regular community consultation and if these are actively implemented and supported.
- **Representation:** Analyse the composition of participatory groups to ensure diversity, including women, youth, and marginalised groups, and identify any consistently unrepresented- groups and the reasons for their absence.
- **Meaningful Engagement:** Evaluate the process of community engagement, including consultation on meeting logistics, the regularity of meetings, record-keeping of minutes, and follow-up on actions, with an eye towards whose perspectives are most and least represented.

USEFUL REFERENCE MATERIALS

- General Hospital Operational Policy (2013)
- Medical Social Worker (MSW) in Community Work

USEFUL DOCUMENTS FOR VERIFICATION

- Meeting minutes and attendance sheets
- Survey/research findings
- Feedback from Hospital Board of Visitors

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 8**.

STANDARD 9: Accountability

WHO Recommendation

9.1 Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.

9.2 Recommended that evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur.

Recommend that, in settings where performance-based financing (PBF) occurs, a system of checks and balances should be in place, including assurance of non-coercion and protection of human rights. If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability.

WHAT DOES THIS MEAN?

This standard calls for a comprehensive accountability mechanism that upholds high-quality service and protection of human rights. This includes regular monitoring and evaluation, as well as the availability of grievance mechanisms. The standard also underscores the importance of assessing the impact of performance-based funding (PBF) on the sexual and reproductive health services.

WHAT WILL YOU ASSESS?

You will examine the reporting mechanisms to human rights bodies, the implementation of human rights recommendations, the integration of international rights into national laws, the effectiveness of grievance mechanisms, and the impact of performance-based funding on services.

KEY ASSESSMENT CATEGORIES:

- **Reporting and accountability:** Determine the consistency and frequency of government reporting on SRH rights to human rights committees.
- **Human rights recommendations implementation:** Evaluate whether the government acts upon international human rights recommendations.
- **Law integration:** Verify the integration of international treaty rights into national laws and identify any conflicting domestic laws.
- **Grievance Mechanisms:** Assess the existence and efficacy of grievance mechanisms and their accessibility to the public.
- **Data utilisation:** Examine how data on SRH is used for decision-making and the regularity of its review and update.

USEFUL REFERENCE MATERIALS

- General Hospital Operational Policy (2013)
- United Nations Human Rights Treaty Bodies: Malaysia

USEFUL DOCUMENTS FOR VERIFICATION

- Monitoring and evaluation reports
- Feedback from Hospital Board of Visitors
- Audit reports
- Compliance certifications

For detailed guidance on conducting the assessment, refer to the checklist in **ANNEX 4: STANDARD 9**.

ADDITIONAL CHECKLIST: Providers' Rights

Additional Recommendation

Rights-based contraceptive information and services depend on the extent to which providers and the service delivery team as a whole are equipped and supported by the health system to do so. We therefore outline some essential dimensions of upholding the rights of contraceptive service providers, although recommendations contained in the WHO Guidance document do not address this issue explicitly.

9.2.1 Non-discrimination and representation in health care provider recruitment
9.2.2 Human rights-based work environment
9.2.3 Capacity sharing on human right approaches
9.2.4 Community health workers.

WHAT DOES THIS MEAN?

While this Standard is not explicitly mentioned in the WHO guidance, the rights of service providers are crucial to the delivery of rights-based contraceptive information and services. This standard highlights the need for a health system that respects and protects the rights of service providers including community healthcare workers. This includes fair recruitment, a supportive work environment, and access to ongoing training, which are all essential for the provision of quality services.

WHAT WILL YOU ASSESS?

You will assess the systems that are in place to uphold provider rights, ensuring they have the necessary tools, resources and environment to perform their duties effectively.

KEY ASSESSMENT CATEGORIES:

- **Recruitment:** Evaluate the recruitment policies and the diversity they promote within the healthcare workforce.
- **Work environment and safety:** Assess the health system's commitment to a safe and rights-based work environment.
- **Capacity strengthening:** Review the extent and effectiveness of human rights and gender-transformative training programs.
- **Community health worker (CHW) inclusion:** Ensure CHWs are supported by policies that guarantee fair representation, safety, and adequate training.

USEFUL REFERENCE MATERIALS

- General Hospital Operational Policy (2013)
- Medical Social Worker (MSW) in Community Work
- General Surgical Services Operational Policy (2018)
- Medical and Health Care Services (booklet by MIDA)
- Medical Act (Act 50)
- Nurses Act (Act 14)

USEFUL DOCUMENTS FOR VERIFICATION

- Recruitment policies and records
- Work environment policies
- Training curriculum, records or manual
- Employee satisfaction surveys
- Workplace incident reports

For detailed guidance on conducting the assessment, refer to the checklist in **Annex 4: Standard 9**.

CHAPTER 4: Turning Findings Into an Action Plan

A MOMENT OF APPRECIATION

Congratulations on completing the assessment! Take a moment to reflect on the journey you've just completed with your team. It is a significant milestone! Therefore, take this moment to celebrate the hard work. Well done!

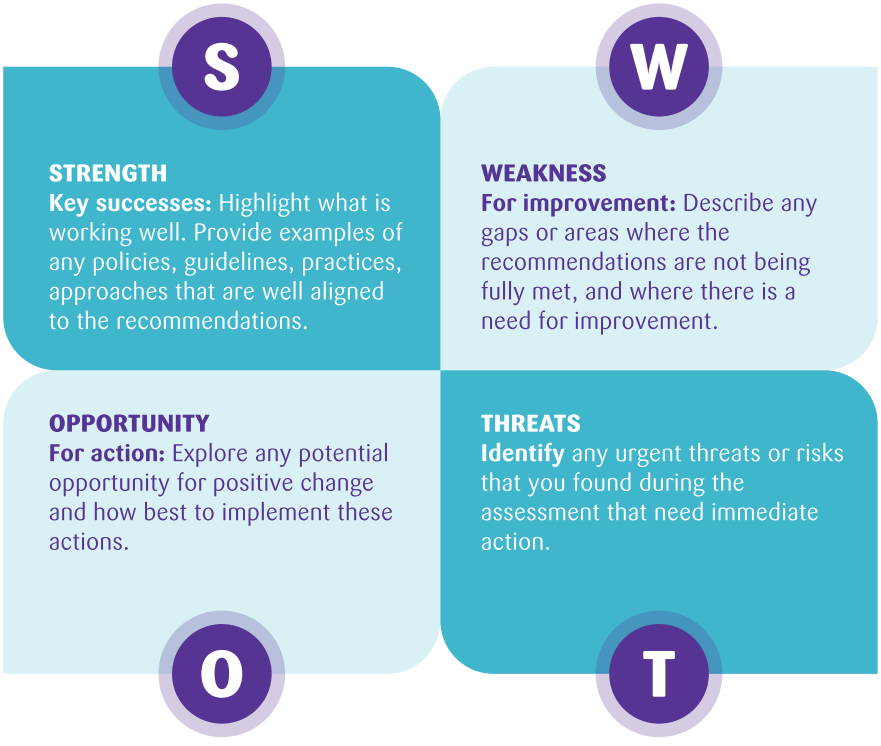
At this point, you may experience a whole spectrum of emotions. You may feel a sense of achievement when you observed that the country is performing well in certain areas. There may also be a sense of realisation that there are still some improvements needed in certain areas. Or you may even feel dejected by the amount of work ahead. Whatever it is that you are feeling, recognise that each emotion is a valid response to the effort you have invested in this process. If you feel the need to take a break to process these emotions and regroup, do so. When you are ready, we will be here to take the next steps together.

ANALYSING YOUR FINDINGS

After completing the assessment, the next step is to analyse your findings. The analysis will be conducted by each standard using the SWOT analysis approach. You are also welcome to use other approaches that you think are useful. In the SWOT analysis approach, you will dissect the findings into four distinct categories: successes, threats, weaknesses and opportunities. This approach will provide a comprehensive understanding of each standard and inform the development of an action plan.

A template of the SWOT analysis is available in **Annex 5: SWOT Analysis**.

FIGURE 3: **SWOT ANALYSIS: A BRIEF OVERVIEW OF FINDINGS**



SYNTHESISING ANALYSIS

Next you will synthesise the analysis to see the broader picture and in terms of your ministry/ department/ organisation's strategy plan. Look for any patterns across the standards.

Some patterns that you may encounter:

- **Awareness-raising needs:** Are there gaps in knowledge that can be addressed through an awareness raising campaign?
- **Community mobilisation:** Is there a need for collective action to support changes in policies or service delivery?
- **Norms change:** Does it require a need to positively shift harmful norms?
- **Advocacy:** Are there specific policies or practices that need to be changed that involves decision-makers and influential people?

By recognising these patterns, you can strategically tailor your action plan to be as effective as possible by using resources wisely too. Prioritisation is key too as some actions will require immediate intervention, while others can be part of a longer-term strategy. Additionally, some actions may require budgets and this may influence prioritisation.

As you synthesise your data and findings, be mindful that when data is limited or non-existent, it is important to champion the call for more comprehensive data collection and research. On the other hand, when needs are met according to existing data, the focus should shift towards identifying strategies for improvement, ensuring the sustainability of successful outcomes, and scaling effective practices.

MOVING TO ACTION PLANNING

Next, you will move into the action planning phase. This phase involves the creation of a detailed plan. Remember, the work you have done so far is valuable. Acknowledge your dedication that has brought you to this point. We are proud of you!

TABLE 3: STEP-BY-STEP GUIDE ON DEVELOPING YOUR ACTION PLAN:

STEP 1 **DEFINE THE ACTIONS:** For each opportunity identified in your SWOT analysis, define specific actions that need to be taken. These should be specific, measurable, achievable, realistic and time-bound, also known as SMART.
STEP 2 **ASSIGN RESPONSIBILITIES:** Identify who will be responsible for each action. This could be individuals, or teams, within your ministry/department/organisation, or external partners and stakeholders.
STEP 3 **SET REALISTIC TIMELINES:** Establish deadlines for each action. Some actions may be short-term, while others may be part of a longer-term strategy. Ensure that timelines are realistic and allow for flexibility where necessary.
STEP 4 **INCLUDE BUDGET:** Determine the budget required for each action. Consider all potential costs and explore sources of funding if necessary.
STEP 5 **MONITORING, EVALUATION AND FOLLOW UP:** Establish a process for monitoring progress and evaluating the impact of each action. This will help you to measure success and make adjustments as needed. See Chapter 5 for more information.

A template for the action plan is available in **Annex 6: Action Plan**.

FINAL STEPS IN ACTION PLANNING

Communication: Communicate your action plan to all relevant stakeholders. Transparency and clarity are key to ensuring everyone understands their roles and responsibilities. Flexibility: Be prepared to adapt your plan as circumstances change. Flexibility is crucial in responding to new challenges and opportunities.

Collaboration: Engage with partners, stakeholders, and communities. Collaborative efforts often yield better results and ensure broader support for your actions.

Documentation: Keep detailed records of your actions, progress, and any changes made to your plan. This documentation will be valuable for future assessments and reports.

Remember, the action plan is a living document. It should evolve as you make progress and as new information becomes available. Your commitment to turning findings into action is commendable. It's through these actions that real change is achieved!

NOTES

CHAPTER 5: Monitoring, Evaluation, and Follow up

Great job on creating your action plan! It is natural to feel overwhelmed by the process given the many important advocacy initiatives at hand. But we're proud of you for taking this significant step in streamlining your core advocacy initiatives and efforts.

Remember, it's perfectly fine if not every issue has been addressed right away, at one go. Since this toolkit is crafted as a dynamic document, we will guide you on how to effectively use it to incorporate the progress or challenges, as well as emerging issues in the pipeline.

After establishing your action plan as detailed in the previous chapter, your next step is to develop a monitoring and follow-up framework. We recommend that the leading agency for the assessment take the lead and conduct this monitoring and evaluation process.

The included framework for monitoring, evaluation and follow up will be useful in tracking your progress. It will also support you and your team in making informed decisions related to your advocacy work. Keep up the excellent work!

WHAT IS MONITORING?

Think of monitoring as a 'health' check-up for your action plan. It is a process that will help you see how well your plans are working, if there are any issues that need attention, and if they need any improvements to be more effective.

- **Following the plan:** To make sure that we are doing all the activities we planned.
- **Keeping to the schedule:** To check if our work is following the timeline we set.
- **Finding strengths and weaknesses:** To find out what's working well and what areas need more work.
- **Making adjustments:** To decide if a change of strategy is needed to make sure that our plan is more effective.
- **Budget check:** To look at our budget and spending to ensure the activities are sustainably funded.

WHAT IS EVALUATION?

Evaluation is like taking a step back to look at the progress of your action plan, usually after a longer period of time. A recommended time frame would ideally be every six months or at minimum annually, with a final evaluation at the end of the implementation of the action plan. You would check what went well, what didn't go as planned, and what you could do better next time. This process helps us understand if we achieved what we wanted, how we can improve, and what we learned from the whole experience.

MOVING TO MONITORING AND FOLLOW UP

The monitoring process comprises two parts: the Master List and the Itemised List.

- **Master List:** This encompasses a compilation of primary actions, each linked with its corresponding human rights issue, relevant policy, and a checklist. This integration facilitates streamlined tracking and oversight.
- **Itemised List:** This list offers a detailed breakdown of activities derived from each main action. It includes various components that assist in effectively tracking and assessing the progress of these activities.

A template for the monitoring and follow up framework is available in **Annex 7: Monitoring and Evaluation Framework**. The key elements of a monitoring and follow-up framework, emphasising actionable steps, designated responsibilities, and consistent progress evaluation, are detailed in Table 4.

TABLE 4: **MONITORING MASTER LIST**

Timeline	Refers to the specific time period for implementing the action plan.
Human Rights Focus	Specifies the particular human rights principle that the action aims to address.
Checklist	Indicates the specific checklist (referenced in **Annex 4: The Assessment**) that is relevant to the action plan.
Policy to Change	Identifies the specific policy/guideline that needs modification or improvement.
What to Change? (Action Point)	Describes the specific changes or interventions required in the policy.
Monitoring Frequency	How often the monitoring activities will be conducted to track progress.
Date of Monitoring	The specific date when the next monitoring activity is planned.
Date of Next Evaluation	The specific date when the next evaluation is planned.
Total Budget	Specifies the total funds for this specific action plan item.

ITEMISED LIST

Human Rights Focus	Specifies the particular human rights principle that the action aims to address.
Checklist	Indicates the specific checklist (referenced in **Annex 4: The Assessment**) that is relevant to the action plan.
Policy to Change	Identifies the specific policy/guideline that needs modification or improvement.
What to Change? (Action Point)	Describes the specific changes or interventions required in the policy.
How Can We Do It? (Activities)	Outlines the activities or steps to be taken to implement the change.
Indicator	Used to measure progress or success of the activities, which may be quantitative or qualitative in nature.
Target	The specific outcomes that the activities aim to achieve or key population groups.
Data Source	The source from where indicator/data will be obtained.
Frequency	How often data will be collected or activities will be performed.
Who is Responsible for Collecting This Data?	Identifies the person or team responsible for data collection.
Where will it be reported?	Specifies where or to whom the data and progress reports will be submitted.
Next Activity Follow-Up Date	The scheduled date for the next activity date.
Progress Notes	Key observations or remarks documenting the progress of activities, essential for tracking and assessing their development. We recommend listing the latest meeting at the first line, followed by notes from previous meetings
Challenges	Any difficulties or obstacles encountered that may impact the implementation or success of the action plan.
Budget	Specifies the funds for this specific activity.

MOVING TO EVALUATION

Here are four aspects of an evaluation[60] that you may consider in setting up your evaluation plan.

- **Utility:** How will the evaluation results be used? For example, further grant from the Ministry of Economics, evidence for the relevant ministries or to inform the UPR processes
- **Feasibility:** Are the evaluation procedures practical, given the time, resources, and expertise available?
- **Propriety:** Is the evaluation being conducted in a fair and ethical way?
- **Accuracy:** Are approaches at each step accurate, given stakeholder needs and evaluation purpose?

Feel free to put together your evaluation plan. Here, we've broken it down into three simple steps for you.

EVALUATION PLAN: 3 Simple Steps

STEP 1:
IDENTIFY STAKEHOLDERS AND USERS OF THE EVALUATION PLAN
Identify stakeholders, including those involved in the action plan; target population; and users of the evaluation.

STEP 2:
GATHER REQUIRED DATA
Collect monitoring data (i.e., quantitative and qualitative data), conduct interviews or focus group discussions to assess the action plan.

STEP 3:
CRITICALLY ANALYSE FINDINGS AND FORMULATE RECOMMENDATIONS
Evaluate the data to identify strengths, weaknesses, and areas for improvement in the action plan.

NOTES

PUTTING IT ALL TOGETHER

This section contains examples of templates for your reference and learning. In Step 1, we have provided two versions in the preparation of the assessment, Example A is an assessment done by civil society organisations (CSOs), while Example B is an example of how the Government can use this process as a self-assessment. Do note that the following Steps 2 to 7 are based on Example A, but they may overlap as well.

NOTE: All names used in these tables are fictional and used for illustrative purposes only.

Take note that you are free to edit and improve on the templates based on your assessment goals and objectives, and work processes.

STEP 1: PREPARING FOR THE ASSESSMENT

EXAMPLE A: Preparation for the Universal Periodic Review (UPR) by a team of civil society organisations (CSOs) on the government's progress in providing rights based contraceptive information and services.

EXAMPLE A_1: PREPARATION FOR THE UNIVERSAL PERIODIC REVIEW (UPR)

DATE	**18 November 2023**
PURPOSE OF ASSESSMENT	During its 2nd universal periodic review (UPR), the Malaysian government received three recommendations on the right to health, namely: 1. Ensuring universal access to health care and addressing out-of-pocket expenditures for healthcare services. 2. Ensuring that non-citizens do not have to pay a deposit for admission to public hospitals and that they are not charged higher fees compared to Malaysian citizens. 3. Ensuring access to SRH services, in particular for women and girls and adequate sexuality education and information. As the next step, the government through the Ministry of Health (MOH), Ministry of Education (MOE), Ministry of Women, Family and Community Development (MWFCD) and the National Population and Family Development Board (NPFDB) is seeking inputs from civil society organisations (CSOs). The purpose of the assessment is to gather insights of the gaps and recommend improvements.
SCOPE OF ASSESSMENT	☒ **Standard 1:** Non-discrimination ☒ **Standard 2:** Availability ☒ **Standard 3:** Accessibility ☒ **Standard 4:** Acceptability ☐ **Standard 5:** Quality ☐ **Standard 6:** Informed decision-making ☐ **Standard 7:** Privacy and confidentiality ☐ **Standard 8:** Participation ☐ **Standard 9:** Accountability

EXAMPLE A_2: PREPARATION FOR THE UNIVERSAL PERIODIC REVIEW (UPR)

WHO WILL BE INVOLVED	1. **Project lead:** Name, position in the organisation, organisation name 2. **Service delivery team from Organization X**: Name(s) 3. **Migrant group coalition:** Name(s) 4. **Sexuality education collation:** Name(s) 5. **National women doctor organisation:** Name(s)
ROLES AND RESPONSIBILITIES Include name of team member, their role and responsibilities.	1. **Ratna Seri:** overall coordination, facilitation, and liaison with the relevant ministries. Additional responsibilities: overseeing the entire process, ensuring collaborations among different groups and reporting progress to all involved parties in a transparent and timely manner. 2. **Service delivery team from Organization X:** lead the assessment of current service delivery models' availability, accessibility, acceptability and quality. 3. **Migrant group coalition**: Representing migrant perspectives, focusing on accessibility and barriers. Responsible for collecting feedback from migrant communities. 4. **Sexuality education collation:** Assessing gaps and recommendations to improve current sexuality education curriculum. Outreach to in and out of school young people to gather feedback on current sexuality education. 5. **National women doctor organisation:** Researching best practices and international standards. Providing a medical perspective on SRH services, with a focus on women's and girls' health needs.
BUDGET	**RM200,000** Source: Government of Malaysia and Swedish International Development Cooperation Agency (Sida)
TIMELINE	**Preparation and planning** : Dec 2023 – Jan 2024 **Assessment** : Feb – Apr 2024 **Analysis and initial findings** : May – June 2024 **Report preparation** : July 2024 **Stakeholder review and feedback** : August 2024 **Final report submission** : September 2024 **Monitoring** : Monthly **Evaluation** : Every 6 months
PAST ASSESSMENTS TO CONSIDER	• 2nd UPR recommendations document • Latest report on the analysis of comprehensive sexuality education (CSE) • National Health and Morbidity Survey • Quality of care reports
ADDITIONAL NOTES	• Enquire if any participants need an introductory session to SRHR. • Decide on methods of communications and how frequent the team should meet.

EXAMPLE B: Self-assessment by the Government (e.g. Ministry of Health or LPPKN)

EXAMPLE B_1: SELF-ASSESSMENT BY THE GOVERNMENT

DATE	**18 November 2023**
PURPOSE OF ASSESSMENT	During its 2nd universal periodic review (UPR), the Malaysian government received three recommendations on the right to health, namely: 1. Ensuring universal access to health care and addressing out-of-pocket expenditures for healthcare services. 2. Ensuring that non-citizens do not have to pay a deposit for admission to public hospitals and that they are not charged higher fees compared to Malaysian citizens. 3. Ensuring access to SRH services, in particular for women and girls and adequate sexuality education and information. As the next step, the government through the Ministry of Health (MOH), Ministry of Education (MOE), Ministry of Women, Family and Community Development (MWFCD) and the National Family Planning Board (NFPB) is seeking inputs from civil society organisations (CSOs). The purpose of the assessment is to gather insights of the gaps and recommend improvements.
SCOPE OF ASSESSMENT	☒ **Standard 1:** Non-discrimination ☒ **Standard 2:** Availability ☒ **Standard 3:** Accessibility ☒ **Standard 4:** Acceptability ☐ **Standard 5:** Quality ☐ **Standard 6:** Informed decision-making ☐ **Standard 7:** Privacy and confidentiality ☐ **Standard 8:** Participation ☐ **Standard 9:** Accountability
WHO WILL BE INVOLVED	1. **Project lead:** Dr Rafidah Mazlan, Ministry of Health 2. **Head of Family Health Development Division:** Dr Syahrina Yaacob 3. **Head of Pharmaceutical Division:** Dr Shiromie Kaur 4. **Institute of Health and Behavioural Research:** Dr Malik Abdullah 5. **Ministry of Education representative:** Pn Salawati Shamsudin
ROLES AND RESPONSIBILITIES Include name of team member, their role and responsibilities.	1. **Dr Rafidah:** overall coordination, facilitation, and liaison with the relevant department and ministries. Additional responsibilities: overseeing the entire process, ensuring collaborations among different groups and reporting progress to all involved parties in a transparent and timely manner. 2. **Head of Family Health Development Division:** lead the assessment of current service delivery models' availability, accessibility, acceptability and quality. 3. **Institute of Health and Behavioural Research:** Provide research findings on SRH services done by the MOH and plan relevant research to collect data. Responsible In conducting monitoring and evaluation. 4. **Ministry of Education:** Assessing gaps and recommendations to improve current sexuality education curriculum. Outreach to in and out of school young people to gather feedback on current sexuality education.

EXAMPLE B_2: SELF-ASSESSMENT BY THE GOVERNMENT

BUDGET	**RM50,000** Source: Government of Malaysia
TIMELINE	**Preparation and planning** : Dec 2023 – Jan 2024 **Assessment** : Feb – Apr 2024 **Analysis and initial findings** : May – June 2024 **Report preparation** : July 2024 **Stakeholder review and feedback** : August 2024 **Final report submission** : September 2024 **Monitoring** : Monthly **Evaluation** : Every 6 months
PAST ASSESSMENTS TO CONSIDER	• 2nd UPR recommendations document • Latest report on the analysis of comprehensive sexuality education (CSE) • National Health and Morbidity Survey • Quality of care reports
ADDITIONAL NOTES	• Enquire if any participants need an introductory session to SRHR. • Decide on methods of communications and how frequent the team should meet.

STEP 2: RAPID ASSESSMENT

The objective of this rapid assessment is to quickly update the team and prepare for a more comprehensive assessment. This initial assessment offers a quick and insightful overview of the current situation, highlighting areas that require in-depth investigation.

- In Part 1, the team will engage in a discussion centred around a series of questions.
- In Part 2, the focus will shift to compiling relevant quantitative data.

For Part 1, two (2) questions were selected for the purpose of this exercise.

PART 1: HEALTH SYSTEM LANDSCAPE

a. What are the contraceptive services available in the country? Do also refer too Box 2 for a list of comprehensive SRH services.

In Malaysia, maternal and child health (including antenatal, childbirth and postnatal care) and contraceptive services are widely available for married women.

While the public health care system provides contraceptive services, there are reports that unmarried girls below 18 years old and unmarried young women and women found it difficult to access these services. Some married women also face difficulty accessing safe abortion services.

b. Where are they available? Examine the distribution of healthcare facilities offering contraceptive information and services.

Contraceptive services are provided by government clinics and hospitals. We have a strong public health care network.

Other options:

- People can also access them through private health care but they are usually very costly. Some pharmacies sell contraceptives over-the-counter and online (i.e., the pill and condom).
- NGO clinics also provide contraceptive services.

PART 2: NORMS AND PERCEPTIONS

What are the common attitudes and beliefs about contraception, including the norms and taboos?

While we have a strong public health care network and empathetic healthcare providers, there are reports that underage girls and unmarried women find it hard to gain access to contraception based on their age and marital status.

Due to stigma and their personal beliefs, healthcare providers refuse SRH services to unmarried, sexually active women and girls.

Some women also reported that they are turned down from getting long-acting reversible contraception because they have not given birth to their first child, and are instead recommended to take short-acting methods, even though they reported having psychiatric issues that makes taking consistent daily medicine a challenge.

For Part 2, here are the indicators selected for the purpose of this exercise.

1. **Contraceptive prevalence rates (CPR)**
   a. Overall: 55%
   b. Modern methods: 32%

2. **Unmet need for family planning/contraception:** 25%

3. **Total fertility rates**
   a. Overall: 1.6 children aged 15 to 49 years old
   b. Adolescent fertility rate

4. **Data on safe and unsafe abortion**
   a. From a local abortion hotline survey:
      i. 38% who needed abortion were 19 – 24 years old (majority)
      ii. 80% were in the first trimester (less than 12 weeks)
      iii. 45% preferred medical abortion and 47% surgical

5. **Data on baby dumping**
   a. On average, 1 baby is abandoned every 3 days in Malaysia
   b. PDRM reported:
      i. 128 cases (2018)
      ii. 125 cases (2019)
      iii. 104 cases (2020)
      iv. 86 cases (2021)
   c. Survival rate
      i. Alive: 149 cases (34%)
      ii. Dead: 294 cases (66%)

6. **Data on HIV and STIs**
   a. STI cases among teenagers (reported by Minister of Education on 30 October 2023)
      i. 913 cases (2018 – 2022) aged 13 to 17 years old
      ii. Type of STIs: Syphilis, gonorrhoea, chancroid and HIV

STEP 3: MARGINALISED AND EXCLUDED GROUPS

Please see **link** here under Tab: Marginalised and Excluded, or scan the QR code.

MARGINALISED AND EXCLUDED GROUPS	
GROUP	Unmarried young girls/women
CATEGORY Can be more than one	Poor/Marginalized/Socially-excluded/Under-served
UNMET NEEDS	• Barriers in obtaining contraceptives due to legal age restrictions, societal stigma, or lack of information; • Lack of access to confidential and non-judgemental adolescent-friendly health services; • Lack of access to accurate, age-appropriate comprehensive sexuality education; • Young girls/women may be at risk of sexual coercion, exploitation, and violence, so they need access to services that offer protection, legal support, and counselling.
KEY BARRIERS	Adolescent-friendly SRH services is not widely available in practice
INTERSECTIONALITIES	Identify the overlapping forms of discrimination and disadvantage characterised by multiple interconnected factors such as socioeconomic status, gender, race, and disability. 1. **Gender:** Female face challenges in accessing contraceptive services often due to cultural norms and gender based discrimination in healthcare systems. 2. **Age:** Young girls face significant barriers to request for health services with a trusted adult. 3. **Marital status:** Unmarried girl/women are expected not to be having sex and wait till they are married to do so. 4. **Race/Religion:** Muslim or Christian girls from religious background may not be condoned to get contraceptive services.

STEP 4: THE ASSESSMENT

Please see **link** here under Tab: Standard 1 for the expanded table, or scan the QR code.

STANDARD 1: NON-DISCRIMINATION IN PROVISION OF CONTRACEPTIVE INFORMATION AND SERVICES →

RECOMMENDATIONS 1.1 Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice).	CHECKLIST	FINDINGS	NEXT STEPS
CHECKLIST 1.1			
1.1.1 Policy/guidelines promoting sexual and reproductive health (SRH) services for all Are there policies/guidelines in place to ensure that individuals from all backgrounds receive the contraceptive information and services that they want?	Completed	The government has a family planning policy statement that states its commitment in providing comprehensive and voluntary FP services.	To identify if this is the case on the ground.
1.1.2 Policy/guidelines on forced contraception Are there policies/guidelines ensuring that no one is forced to use a contraception method they don't want?	Not started	We could not find an online version of this policy.	To contact Ministry of Health to enquire of such policy is available, and to look for data/cases of forced coercion.
1.1.3 Policy/guidelines on transition-related healthcare Are there policies/guidelines ensuring that individuals, particularly transgender persons receive appropriate contraceptive services (e.g. hormonal injections/pills) for transition-related healthcare?	Not started	We could not find an online version of this policy.	
1.1.4 Feedback mechanism Is there a mechanism in place (e.g., safe reporting, spot-checks, feedback form) to protect individuals, including marginalised groups, from coerced contraception? Does the mechanism ensure the anonymity and safety of the person reporting?	In progress	There is a government-initiated feedback mechanism.	To investigate if it is user-friendly, how many cases are reported and the nature of the cases.
1.1.5 Incentives for contraceptive use Are clients given any financial or non-financial rewards for using contraception?	Not started		
1.1.6 Conditional services/benefits for users Is it a requirement to use contraception in order to receive other services or benefits?	In progress	There are no such policy in practice. But there are reports from our members that clients with more than five children are coerced to use contraception. The perceived 'benefit' is a positive perception from the medical team, especially the doctor.	To run a qualitative study to identify the usual 'reasons' for contraceptive use and whether family planning nurses persuade certain women to take up contraceptives while turning others away.
1.1.7 Provider performance rewards Are there any rewards for service providers or service delivery points for achieving specific "targets" in the number of contraceptive users?	Not started		
1.1.8 Provider non-performance Are there any penalties for service providers or service delivery points (SDPs) for not achieving specific "targets" in the number of contraceptive users?	In progress		To interview service providers to find out if they need to achieve certain targets of contraceptive users.
RECOMMENDATIONS 1.2 **Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalized populations in their access to these services.**	**CHECKLIST**	**FINDINGS**	**NEXT STEPS**
CHECKLIST 1.2			
1.2.1 Programme labelling Is the programme referred to as a "family planning" programme and is it integrated with maternal and child health services?			
1.2.2 Gender equality Does the programme aim to achieve gender equality? If so, does it identify and positively transform harmful gender norms related to contraceptive information and services?			
1.2.3 Legal/policy restrictions Are there any laws/policies that prevent people from receiving contraceptive information and services? If so, please specify the law/policy, the groups affected, and the reasons for the restriction.			
1.2.4 Data collection and research Is data collection and analysis regarding the access to contraceptive information and services by women, men, and individuals with diverse sexual orientations, gender identities, expressions, and sexual characteristics (SOGIESC) conducted? How is this data used in programme planning and resource allocation?			
1.2.5 Needs - Women Does the programme address the contraceptive needs and barriers faced by women? If so, are there specific services with consideration for location, timing, infrastructure and human resources?			
1.2.6 Needs - Men Does the programme address the contraceptive needs and barriers faced by men? If so, are there specific services with consideration for location, timing, infrastructure and human resources?			
1.2.7 Needs - Diverse sexual orientations, gender identities, expressions and sexual characteristics (SOGIESC) Does the programme address contraceptive needs and barriers faced by individuals with diverse SOGIESC? If so, are there specific services with consideration for location, timing, infrastructure and human resources?			
1.2.8 Needs - Young people Does the programme address contraceptive needs and barriers faced by young people? Are various groups considered (e.g., in-school and out-of-school, girls and boys, married and single?) If so, are there specific services with consideration for location, timing, infrastructure and human resources?			
1.2.9 Needs - Marginalised Groups Does the programme address contraceptive needs and barriers faced by marginalised groups? (Please refer to the pre-checklist on marginalised and excluded groups) If so, are there specific services with consideration for location, timing, infrastructure and human resources?			

CONTINUATION OF THE STANDARD 1 TABLE

PRIORITY	BY WHOM	BY WHEN	BUDGET	KEY STAKEHOLDERS	ANY NOTES
Critical	Service delivery team from Organisation X	11/15/2023	RM500	Family medicine specialist from KK XYZ	
					Definition: Health care services, such as hormone therapy and gender-affirming surgery that are medically needed by trans or gender-diverse communities.
Medium	Service delivery team from Organisation X		11/15/2023	Ministry of Health – record department	
High	National women doctor organisation	11/15/2023	RM500	FMS and nurses	
	National women doctor organisation				
	National women doctor organisation	11/15/2023		FMS and nurses	

PRIORITY	BY WHOM	BY WHEN	BUDGET	KEY STAKEHOLDERS	ANY NOTES

STEP 5: SWOT ANALYSIS

KEY SUCCESSES

Highlight what is working well. Provide examples of any policies, guidelines, practices, approaches that are well aligned to the recommendations.

- **Wide Availability of Maternal and Child Health Services:** Services like antenatal, childbirth, and postnatal care are widely accessible, especially for married women.
- **Strong Public Healthcare Network:** Government clinics and hospitals provide a robust network for delivering SRH services.
- **Contraceptive Availability:** Contraceptives are available through public healthcare, private healthcare, pharmacies, and NGOs.
- **Data Availability:** There is accessible data on contraceptive prevalence rates, fertility rates, abortion, baby dumping, and STIs, aiding in understanding and addressing SRH issues.

IMMEDIATE THREATS

Identify any urgent threats or risk that you found during the assessment that need immediate action.

- **Stigma and Cultural Barriers:** Social stigma and cultural norms that restrict open discussion and access to SRH services.
- **Non-evidence Based Online SRH Information:** Young people rely on unverified online information, including pornography as their source of SRH information.
- **High Unmet Need for Family Planning:** A significant percentage of unmet needs could lead to unwanted pregnancies and related issues.
- **Increasing Cases of Baby Dumping and STIs Among Teenagers:** Rising trends in these areas highlight gaps in current SRH education and services.

WEAKNESSES FOR IMPROVEMENT

Describe any gaps or areas where the recommendations are not being fully met, where there is a need for improvement.

- **Restricted Access for Unmarried and Young Women:** Unmarried girls below 18 and unmarried young women face challenges in accessing contraceptive services and safe abortion.
- **Barriers in Accessing Long-Acting Contraception:** Some women, particularly those without children, face difficulties in accessing long-acting contraception
- **Healthcare Providers Refusal to Provide Service:** Doctors and nurses sometimes refuse to provide service due to stigma and their personal beliefs.

OPPORTUNITY FOR ACTION

Explore any potential opportunity for positive hange and how best to implement these actions.

- **Improving Access for Unmarried and Young Women**: Addressing the current restrictions to make SRH services more inclusive.
- **Education and Training for Healthcare Providers:** Enhancing understanding and reducing the impact of personal beliefs on service delivery.
- **Leveraging Data for Better Services:** Using existing data to improve and tailor SRH services, especially for vulnerable groups.

STEP 6: ACTION PLAN

Note that from Step 4: The Assessment, example for checklist item 1.1.1, the finding is that "The government has a family planning policy statement that states its commitment in providing comprehensive and voluntary FP services", while the follow up action is to "identify if comprehensive and voluntary FP services are provided on the ground".

STEP-BY-STEP ACTION PLAN	
STEP 1: DEFINE THE ACTIONS	• Hold a meeting with the Family Medicine Specialist (FMS) of Klinik Kesihatan XYZ to share the findings and set up a technical working committee to study the issue of unmarried women/girls unable to access contraception. • The objective of this committee is to build a women-friendly image of this clinic among unmarried women/girls in this area and design a safe space for them to get contraceptive information and counselling.
STEP 2: ASSIGN RESPONSIBILITIES	• The National Sexual and Reproductive Health Coalition will be responsible for coordinating meetings with Klinik Kesihatan XYZ.
STEP 3: SET REALISTIC TIMELINES	Timeline: November 2023 – March 2024
STEP 4: INCLUDE BUDGET	The grand total budget is RM 200,000. • The first phase will incur a cost of RM 5,000.
STEP 5: MONITORING AND EVALUATION	The first phase of activities will be done from November 2023 to the first quarter of 2024. • Monitoring will be done monthly • Evaluation of the project will be done in March 2023.

STEP 7: MONITORING, EVALUATION AND FOLLOW UP

MONITORING: MASTER LIST

TIMELINE	HUMAN RIGHTS FOCUS	CHECKLIST	POLICY TO CHANGE	WHAT TO CHANGE? (Action Point)	MONITORING FREQUENCY	DATE OF NEXT MONITORING	DATE OF NEXT EVALUATION	TOTAL BUDGET	NOTES
Nov. to Dec. 2023	Non-Discrimination	1.1	Policy on providing contraception	Sexually active unmarried women/ girls can receive contraception	Monthly	15 Dec. 2023	15 Jan. 2024 (every 6 months)	RM500	
Jan. to Mar. 2024	Acceptability	4.2	Gender-transformative SRH service delivery	Provider to receive training to provide gender-transformative service delivery	Monthly	15 Feb. 2024	15 Mar. 2024	RM4,500	

MONITORING: ITEMISED LIST

HUMAN RIGHTS FOCUS: Non-Discrimination

CHECKLIST: Checklist 1.1

TOTAL NUMBER OF MEETINGS: 1 Meeting

POLICY TO CHANGE	WHAT TO CHANGE? (Action Point)	HOW CAN WE DO IT? (Activities)	INDICATOR	TARGET	DATA SOURCE	MONITORING FREQUENCY	WHO IS RESPONSIBLE FOR COLLECTING THIS DATA	WHERE WILL IT BE REPORTED?	NEXT ACTIVITY FOLLOW UP DATE
Policy on providing contraception	Sexually active unmarried women/ girls can receive contraception	Meeting with Klinik Kesihatan XYZ	Formation of technical working committee to study the issue of unmarried women/girls unable to access contraception	1. Family medicine specialist 2. Family planning nurses 3. Key population	Meeting minutes	Monthly	Organization X	HR+SRH working	15 Jan. 2024

PROGRESS NOTES:	15 Dec. 2023	An informal visit was made to meet Dr XXX, the FMS of Klinik Kesihatan (KK) XYZ to brief her about the SRHR toolkit and share the plan to study the issue of unmarried women/girls unable to access contraception.
	1 Nov. 2023	An invitation email was sent to Dr XXX, the FMS of Klinik Kesihatan XYZ to arrange for a meeting.
CHALLENGES:	We note that the clinic was very busy and small. It makes it difficult to provide counselling in a safe space.	
BUDGET:	• RM150 to purchase afternoon tea for this meeting. • Transportation cost from workplace to Klinik Kesihatan: RM 50 x 3 transports (RM150) • Staff cost: 0.1FTE (RM 200)	

EVALUATION

This is an example evaluation for an action item from Checklist Item 1.1 extracted from the previous page.

DATE:	15 FEBRUARY 2024
STEP 1: IDENTIFY STAKEHOLDERS AND USERS OF THE EVALUATION PLAN	**Identify stakeholders, including those involved in the action plan; target population; and users of the evaluation.** The stakeholders are: • Members of the Human rights and SRH working group (set up for the purpose of the assessment using this toolkit) for the purpose of identify the overall progress of advancing human rights in the context of contraceptive services and information through the public health care system. • Representatives from the ministry/department/agency related to health, education and women/family development.
STEP 2: GATHER REQUIRED DATA	**Collect monitoring data (i.e., quantitative and qualitative data), conduct interviews or focus group discussions to assess the action plan.** The data available are from: • Monitoring reports and meeting notes recorded • Conduct a confidential focus group discussion with target group (unmarried young women) who access services at the designed safe space at Klinik XYZ for their feedback.
STEP 3: CRITICALLY ANALYSE FINDINGS AND FORMULATE RECOMMENDATIONS	**Evaluate the data to identify strengths, weaknesses, and areas for improvement in the action plan.** What we did well? • We have a built strong trust with the team at Klinik XYZ and this networking mechanism can be duplicated with other government clinics by having the FMS as a spokesperson. • We identified strategies to complement national values with human rights principles for the betterment of the nation and this was well accepted. What can be improved? • We lack the man power and capacity to roll this out to other clinics for the moment. Our CSO team members are engaged with their daily tasks and do not have much time for this initiative. • We lack a team of religious spokesperson to assist in discussing about religious and personal values against providing health care for the under-served and for those in need. Strategies Identified 1. Harmonising human rights and national development plans and values 2. Building trustworthy stakeholder relationship through open conversations.

NOTES

ANNEXES

ANNEX 1

DATE	Project date
PURPOSE OF ASSESSMENT	Define the objectives of the assessment
SCOPE OF ASSESSMENT	☐ **Standard 1:** Non-discrimination ☐ **Standard 2:** Availability ☐ **Standard 3:** Accessibility ☐ **Standard 4:** Acceptability ☐ **Standard 5:** Quality ☐ **Standard 6:** Informed decision-making ☐ **Standard 7:** Privacy and confidentiality ☐ **Standard 8:** Participation ☐ **Standard 9:** Accountability
WHO WILL BE INVOLVED	List down team members and stakeholders who will be involved
ROLES AND RESPONSIBILITIES	Include name of team members, their roles and responsibilities Team Member 1: XXX, YYY, ZZZ Team Member 2: XXX, YYY, ZZZ Team Member 3: XXX, YYY, ZZZ
BUDGET	Detail the estimated cost and funding source or currently available budget.
TIMELINE	Outline the timeline for each stage of the assessment, specify the start and end dates, and include pertinent notes for each phase.
PAST ASSESSMENTS TO CONSIDER	List past relevant assessments, including details on what each assessment covered, the year it was conducted and its relevance to the current assessment.
ADDITIONAL NOTES	Any other relevant information for the assessment.

ANNEX 2

RAPID ASSESSMENT INDICATORS

Use this list of indicators to monitor the status of SRH data in Malaysia. This is not an exhaustive list, feel free to expand it with relevant indicators as needed. You are also encouraged to refer to **ARROW's Advocate Guide: Strategic Indicators for Universal Access to SRHR**.

1. **Contraceptive prevalence rates (CPR)**
   a. Overall
   b. Modern methods
   c. Ever used vs. current use
   d. Proportion of women living with HIV using contraception
   e. Proportion of unmarried sexually active women/girls using contraception

2. **Unmet need for family planning/contraception**

3. **Total fertility rates**
   a. Overall
   b. Adolescent fertility rate

4. **Maternal mortality ratio/rate**
   a. Overall
   b. Adolescent-specific maternal mortality ratio/rate

5. **Perinatal and infant mortality ratio/rate**

6. **Age of marriage**
   a. Overall
   b. Among young people and adolescents
   c. Legal age of marriage and sexual consent

7. **Data on safe and unsafe abortion**

8. **Data on transition-related health care**
   a. Transgender individuals accessing hormone therapy (breakdown by age, location and other categories)
   b. Transgender individuals who had undergone sex reassignment surgeries (in and out of Malaysia)
   c. Transgender individuals accessing mental health services related to transition

9. **Comprehensive sexuality education**
   a. Young people receiving CSE (in and out-of-school)
   b. Proportion of young people with basic knowledge about SRHR (breakdown by age, sex and other categories)

10. **Gender-based violence (breakdown by age, sex and other categories)**
    a. Rape cases
    b. Incest

11. **Data on baby dumping**
    a. Overall
    b. Survival rates

12. **Data on unintended/unplanned pregnancies**
    a. Overall
    b. Teenage pregnancies

13. **Data on HIV and STIs**
    a. Prevalence and Incidence rates among key populations, including young people and adolescents
    b. Treatment coverage

14. **Data on reproductive cancers**
    a. Breast, cervical, uterus, ovarian cancers etc.
    b. Human Papillomavirus (HPV) vaccination

15. **Out-of-pocket expenditure as proportion of total health expenditure**

ANNEX 3

LIST OF MARGINALISED AND EXCLUDED GROUPS

WHO	DEFINITION
POOR	Unmarried young girls/women
MARGINALISED	People who for reasons of poverty, geographical inaccessibility, culture, language, religions, gender, disability, migrant status or other disadvantage, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unsatisfied.
SOCIALLY-EXCLUDED	People who wholly or partially excluded from full participation in the society in which they live.
UNDER-SERVED	People who are not normally or well-served by established sexual and reproductive health delivery programme due to a lack of capacity and/or political will; for example, people living in rural/remote areas, young people, people with a low socio-economic status, people living with disabilities, unmarried people, etc.
DISCUSSION QUESTIONS	• Are the populations of concern: poor, marginalised, socially-excluded and/or under-served? • What are the intersectionalities? • What are the unmet needs in SRH services and information for this group? • What are the key barriers that are preventing this group from accessing SRH services and information?
GROUP	
CATEGORY	Poor/Marginalised/Socially-excluded/Under-served
UNMET NEEDS	
KEY BARRIERS	
INTERSECTIONALITIES	Identify the overlapping forms of discrimination and disadvantage characterised by multiple interconnected factors such as socioeconomic status, gender, race, and disability.

ANNEX 4

Here's a **link to an online Excel document** you can copy for your assessment. You may also scan the QR code.

RAPID ASSESSMENT	
DATE	
PURPOSE OF ASSESSMENT	
SCOPE OF ASSESSMENT	
WHO WILL BE INVOLVED?	
ROLES AND RESPONSIBILITIES	
BUDGET	
TIMELINE	
PAST ASSESSMENT TO CONSIDER	
ADDITIONAL NOTES	

PART 1: ASSESSMENT INFORMATION	
NAME OF ORGANIZATION	Name of the organization or agency completing the assessment.
COUNTRY/STATE	The country or state in which the assessment is being carried out.
NAME OF ASSESSORS	Name of assessors.
DATE	The current date when the assessment is started.
DATE OF PREVIOUS ASSESSMENT	If applicable, the date of previous similar assessment.
PROJECT LEAD	The main contact person overseeing the assessment and is responsible for follow-up and coordination.

PART 2: ASSESSMENT INFORMATION	
CHECKLIST ITEM	Each checklist comprises one or more WHO recommendations that are broken down into checklist items.
CHECKLIST STATUS	Mark the progress of each checklist item as Not started, In progress, Delayed or Completed.
FINDINGS	Write your findings for each item, include any observations and references to relevant policies or guidelines.
NEXT STEPS	List any immediate actions to improve compliance.
PRIORITY	Prioritise each next steps as Critical (issues that need immediate action), High (action is required soon), Medium (can be addressed in 3-5 months), Low (can be addressed in 6-12 months).
BY WHOM	Assign a person responsible for this action.
BY WHEN	Set a deadline for each section for the Project Lead to oversee follow-ups.
BUDGET	If applicable, indicate the budget needed to undertake this actions.
KEY STAKEHOLDERS	Identify any key stakeholders related to the checklist item who is key and contribute to the next steps.
ANY NOTES	Use this space for additional notes or comments that is useful for the assessment.

ANNEX 5

STANDARD NO.: Title
FINDINGS SUMMARY: Provide a brief overview of the standard and its level of compliance.

S

KEY SUCCESSES
Highlight what is working well. Provide examples of any policies, guidelines, practices, approaches that are well aligned to the recommendations.

W

WEAKNESSES FOR IMPROVEMENT
Describe any gaps or areas where the recommendations are not being fully met, where there is a need for improvement.

OPPORTUNITY FOR ACTION
Explore any potential opportunity for positive change and how best to implement these actions.

O

IMMEDIATE THREATS
Identify any urgent threats or risk that you found during the assessment that need immediate action.

T

ANNEX 6

STEP-BY-STEP ACTION PLAN	
STEP 1: DEFINE THE ACTIONS	For each opportunity identified in your SWOT analysis, define specific actions that need to be taken. These should be specific, measurable, achievable, realistic and time-bound, also known as SMART.
STEP 2: ASSIGN RESPONSIBILITIES	Identify who will be responsible for each action. This could be individuals, or teams, within your organisation, or external partners and stakeholders.
STEP 3: SET REALISTIC TIMELINES	Establish deadlines for each action. Some actions may be short-term, while others may be part of a longer-term strategy. Ensure that timelines are realistic and allow for flexibility where necessary.
STEP 4: INCLUDE BUDGET	Determine the budget required for each action. Consider all potential costs and explore sources of funding if necessary.
STEP 5: MONITORING AND EVALUATION	Establish a process for monitoring progress and evaluating the impact of each action. This will help you to measure success and make adjustments as needed. See Chapter 4 for more information.

ANNEX 7

Here is a monitoring framework tailored for this toolkit, specifically designed to track progress in settings with limited resources. Use this document as a reference to periodically review your activities and to stay informed about upcoming planned activities within the set timeframe. Please feel free to modify it as needed to better suit your requirements! We also suggest organising this material in a way that facilitates easy review and reference in the future.

MONITORING: MASTER LIST

TIMELINE	HUMAN RIGHTS FOCUS	CHECKLIST	POLICY TO CHANGE	WHAT TO CHANGE? (Action Point)	MONITORING FREQUENCY	DATE OF NEXT MONITORING	DATE OF NEXT EVALUATION	TOTAL BUDGET	NOTES
Refers to the specific time period for implementing the action plan.	Specifies the particular human rights principle that the action aims to address.	Indicates the specific checklist (referenced in Annex 4: The Assessment) that is relevant to the action plan.	Identifies the specific policy/ guideline that needs modification or improvement.	Describes the specific changes or interventions required in the policy.	How often the monitoring activities will be conducted to track progress.	The specific date when the next monitoring activity is planned .	The specific date when the next evaluation is planned.	Specifies the total funds for this specific action plan item.	Include your notes here.

MONITORING: ITEMISED LIST

HUMAN RIGHTS FOCUS: Specifies the particular human rights principle that the action aims to address.

CHECKLIST: Indicates the specific checklist (referenced in **Annex 4: The Assessment**) that is relevant to the action plan.

TOTAL NUMBER OF MEETINGS: Specify number

POLICY TO CHANGE	WHAT TO CHANGE? (Action Point)	HOW CAN WE DO IT? (Activities)	INDICATOR	TARGET	DATA SOURCE	MONITORING FREQUENCY	WHO IS RESPONSIBLE FOR COLLECTING THIS DATA	WHERE WILL IT BE REPORTED?	NEXT ACTIVITY FOLLOW UP DATE
Identifies the specific policy/ guideline that needs modification or improvement.	Describes the specific changes or interventions required in the policy.	Outlines the activities or steps to be taken to implement the change.	Used to measure progress or success of the activities, which may be quantitative or qualitative in nature.	The specific outcomes that the activities aim to achieve or key population groups.	The source from where indicator/data will be obtained or verified.	How often data will be collected, or activities will be performed.	Identifies the person or team responsible for data collection.	Specifies where or to whom the data and progress reports will be submitted.	The scheduled date for the next activity date.
			Add additional lines for additional indicator(s).	Add additional lines for additional target(s).	Add the source for the corresponding indicator and target here.		Include person/team responsible here (if different team is handling this).		

PROGRESS NOTES:	Date	Include the latest meeting notes here. Key observations or remarks documenting the progress of activities, essential for tracking and assessing their development. We recommend listing the latest meeting at the first line, followed by notes from previous meetings.
	Date	Include older meeting notes here.
	Date	
CHALLENGES:	Any difficulties or obstacles encountered that may impact the implementation or success of the action plan.	
BUDGET:	Specifies the funds for this specific activity.	

EVALUATION

This is an example evaluation for an action item from Checklist Item 1.1 extracted from the previous page.

DATE:	
STEP 1: IDENTIFY STAKEHOLDERS AND USERS OF THE EVALUATION PLAN	Identify stakeholders, including those involved in the action plan; target population; and users of the evaluation.
STEP 2: GATHER REQUIRED DATA	Collect monitoring data (i.e., quantitative and qualitative data), conduct interviews or focus group discussions to assess the action plan
STEP 3: CRITICALLY ANALYSE FINDINGS AND FORMULATE RECOMMENDATIONS	Evaluate the data to identify strengths, weaknesses, and areas for improvement in the action plan • What we did well? • What can be improved? • Strategies Identified

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ISBN 978-967-0339-55-9

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