

THE STATE OF CHILDREN IN MALAYSIA

**An Attempt to have a Comprehensive and Ongoing Repository of Data
on the Well-Being of All Children in Malaysia with an Analysis / Review
of Issues and Recommendations**

Dedicated to Every Child in Malaysia who are our Treasure.

With an Aim to Leave No Child Behind.



Important Note on Updates: This is a living document, continually updated in line with new data, contributions and revisions. The latest version can be found at (QR Code):

https://drive.google.com/drive/folders/1auypO-Ybdyh3Mu5WE1_CRGbh6fkmqPaw?usp=sharing

Please note that this is a work in progress. Some sections require a major revision with updated data. Other sections need to be expanded and some sub-sections need to be grown into full sections.



Updated September 2026

Dedication

We would like to acknowledge and thank the many children and families whose courage in the face of adversity and difficulties have given a voice to the needs of All Children in Malaysia. Many Civil Society Organisations and individuals have advocated for children and we hope our work bears fruit. It is only by working together, and making the rights of children a major agenda of society and of the authorities, can we meet the needs of all in Malaysia.

Citation

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This document is an open-source resource but appropriate credit and acknowledgment should be given if used. We hope the data, information and analysis in this document can be used to advance the rights and services of children in Malaysia. Front cover image of Orang Asli children credit: Dato' Dr Amar-Singh HSS; it cannot be reused without permission.

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Foreword

Children are often spoken of as the 'future' of every nation, and yet they remain among the most vulnerable. In Malaysia, we have made remarkable strides in health, education, and economic development over the past five decades. Our infant mortality rates have fallen dramatically, immunisation coverage has remained above 95%, and access to primary healthcare is available to the majority. These are achievements we should be proud of. But they should not blind us to a deeper and more troubling reality.

Beneath the averages and the national statistics lies a disturbing landscape of inequality. The benefits of Malaysia's development have not reached all children equally. Indigenous Orang Asli children experience under-5 mortality rates very much higher than that of the national average. Refugee and stateless children grow up without legal identity, without access to basic health and education, and without the security of a home. Children in relative poverty - and there are three to four million of them - live in conditions that permanently harm their physical growth, their cognitive development, and their life trajectory. Children with disabilities are often excluded from education, healthcare, and society. Our adolescents are experiencing a psycho-social (mental health) crisis that is deepening year by year.

This document is an attempt to tell the full story - not the version that appears in glossy national reports, but the version that every civil society organisation, paediatrician, social worker, teacher, and community health worker encounters daily. It draws on decades of on-the-ground-work, research, advocacy, and published data. It is aimed to be comprehensive and honest. A child who is stunted, abused, trafficked, or excluded from school is not a statistic. They are a person whose future has already been shaped and diminished by failures that are systemic and preventable; often a failure of governance.

We have attempted to outline each issue, defining the problem, quantifying it, identifying who is most at risk, examining what we are doing, and asking what more must be done. Each section of this document follows that discipline. Every claim is sourced. Where data are absent, that absence is itself named as a failure.

This document is offered as a reference for civil society advocates, policy makers, healthcare professionals, researchers, and anyone who believes that 'leaving no child behind' must be not a slogan, but a measurable and enforceable commitment. The children of Malaysia are watching us. The question is whether we are watching them.

Children are not just our future, they are our present treasure. We must work to improve their situation and change their outcomes today.

Child Rights Index

This scorecard brings together key child-rights indicators reported in this document. It is a dashboard of indicators, not a composite score. Each value is taken from the section shown in the last column, where the source and definition are given.

Table i: Child Rights Index: key indicators, latest value, trend and data confidence

Domain	Indicator	Latest value (year)	Trend	Data confidence	Section
Survival	Infant mortality rate	7.2 per 1,000 live births (2024)	Worsening (5.9 in 2020; 6.8 in 2022)	High	2
Survival	Under-5 mortality rate	8.7 per 1,000 live births (2024)	Worsening (7.3 in 2020)	High	2
Survival	Maternal mortality ratio	24.3 per 100,000 live births (2024)	Stagnant (26.0 in 2022)	High	3
Health	Measles-mumps-rubella (MMR) vaccine coverage	93.2% (2024)	Worsening (declined from 2023; below the 95% herd-immunity threshold)	High	7
Nutrition	Stunting in under 5 children	21.8% (2019)	Worsening (as reported in Section 4)	Medium	4
Nutrition	Exclusive breastfeeding, infants under 6 months	47.3% (2016)	Unclear (no recent survey; WHO target 50%)	Medium	3
Mental health	Adolescent suicidal ideation	13.1% (2022)	Worsening (7.9% in 2012; 10.0% in 2017)	High	11
Mental health	Adolescents with depression	25% (2022)	Worsening (MOH target was a fall from 18% to 10% by 2025)	High	11
Adolescent health	Vaping among teens aged 13–17	14.9% (2022)	Worsening (9.8% in 2017)	High	18
Protection	Children in registered child protection centres	38,955 children in 1,517 centres (2024)	Unclear	Medium	9
Protection	Child marriage	About 15,000 cases recorded, 2007–2017	Unclear (sources conflict on recent trend)	Low	8, 10
Education	Upper secondary students proceeding to post-secondary education	18% (2024)	Unclear	Medium	13
Education	Preschool enrolment	Approximately 90%	Unclear	Medium	12
Disability	Registered persons with disabilities (all ages)	772,090 (30 April 2025), about 13% of the estimated total	Unclear (registration is voluntary)	Low	14
Poverty	Absolute household poverty	5.1% (2024); rural 9.9%, urban 3.7%	Improving (6.2% in 2022)	High	15
Equity	Orang Asli under-5 mortality relative to major ethnic groups	11 times higher (2016)	Unclear (no recent data)	Low	2, 16
Equity	Stunting in Orang Asli under 5 children	43.8% (2022)	Unclear	Medium	16
Migrant children	Refugee and asylum-seeker children registered with UNHCR	64,801 (October 2025)	Unclear	Medium	17
Migrant children	Children in immigration detention	About 2,200 (estimate, July 2025)	Unclear	Low	17
Legal framework	UNCRC articles subject to reservations	5 (Articles 2, 7, 14, 28(1)(a), 37)	No change reported	High	22

How to read this page. Trend compares the latest value with the earlier values reported in the section cited: Improving, Worsening, Stagnant or Unclear (no comparable earlier data, or sources conflict). Data confidence is a suggested rating: High = recent national survey or official statistics; Medium = official or peer-reviewed data that are older, partial or from a subset of children; Low = estimates, administrative undercounts, single studies or conflicting sources. Trend and confidence labels are the editor's suggestions.

Section 1: Socio-Demographics of Children in Malaysia

26.4% or 9.03 million children under the age of 18 yrs (5–5.5 million adolescents).

Live births in Malaysia have been declining for the past decade.

~7% (700,000) of children are non-citizen, migrant, refugee, stateless.

1.1 Definition of a Child

A 'child' is defined as any person under 18 years of age under Section 2(1) of the Child Act 2001 (revised 2016), and under Article 1 of the United Nations Convention on the Rights of the Child (UNCRC) 1989. The World Health Organisation (WHO) has expanded its definition of adolescence to encompass those aged 10 to 24 years, recognising the extended developmental period in contemporary contexts. Malaysia's legal and policy landscape reflects some inconsistency in the definition of a child across various legislation, including variations under civil and Syariah law - an issue that remains unresolved and one that the UN Committee on the Rights of the Child has repeatedly called on Malaysia to address.

1.2 Total Child Population based on National Data

According to the Department of Statistics Malaysia (DOSM) Children Statistics 2025, Malaysia is home to 9.03 million children under the age of 18, representing 26.4% of the total population of 34.23 million. This reflects a continuing demographic transition, with the proportion of children in the population declining from 33.1% in 2017 to 26.4% in 2025, driven by falling birth rates and a growing elderly population. Boys outnumber girls: 4.66 million boys and 4.37 million girls. Children under 5 years of age total 2.31 million - 1.19 million boys and 1.12 million girls.

Table 1.1: Population of Children in Malaysia by Age and Sex, 2025 (estimated). Source: DOSM Children Statistics 2025.

Age Group	Male (000s)	Female (000s)	Total (000s)	% of Total Population
0–4	1,215	1,139	2,354	6.9%
5–9	1,230	1,153	2,383	7.0%
10–14	1,266	1,185	2,451	7.2%
15–17	951	892	1,843	5.4%
Sub-Total (0–17)	4,662	4,369	9,031	26.4%
Total population (all ages)	17,879	16,350	34,229	100%

Selangor has the highest absolute number of children under 18 at 1.81 million, followed by Johor and Sabah. Putrajaya has the highest proportion of children as a percentage of its total population (39.9%), followed by Kelantan (33.5%) and Terengganu (32.9%). These figures reflect the higher fertility rates in the rural east coast states, as well as Sabah, where populations are younger and birth rates remain elevated.

1.3 Adolescent Population

There are approximately 5.0–5.5 million adolescents (aged 10–19 years) in Malaysia, representing a significant portion of the population. The WHO extended definition of adolescence (10–24 years) would encompass an even larger group, approaching 8–9 million young people. Adolescents occupy a unique and often neglected space in our health and social services - too old for paediatric services, too young for adult ones; physically capable but emotionally and cognitively still developing; facing health risks

that are distinct from both children and adults. Adolescent health data can be derived primarily from the National Health and Morbidity Surveys (NHMS) Adolescent Health Surveys, which have been conducted in 2012, 2017, and 2022.

1.4 Birth Trends and Crude Birth Rate

Live births in Malaysia have been declining in the past decade and this was accelerated during the height of the COVID-19 pandemic (Table 1.2, Figure 1.1). There was a rise in 2023 followed by a sharp decline of 9% in 2024 from 2023 figures (DOSM Children Statistics 2025). Of the 414,918 births in 2024, 213,919 were boys and 200,999 were girls. The Crude Birth Rate (CBR) for 2024 was 12.2 per 1,000 population, down from 13.6 in 2023 (MOH Health Facts 2025). This downward trend in births has significant implications for future social services, workforce planning, and the dependency ratio. Malaysia is on a demographic trajectory towards an 'aged society' by 2044, when more than 14% of the population will be aged above 65.

Table 1.2: Live Births Malaysia 2012-2024. Source: DOSM Children Statistics 2025.

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Live Births	496313	491239	511594	526012	503914	528612	521136	508203	508685	501945	489863	471504	439744	423124	455761	414918

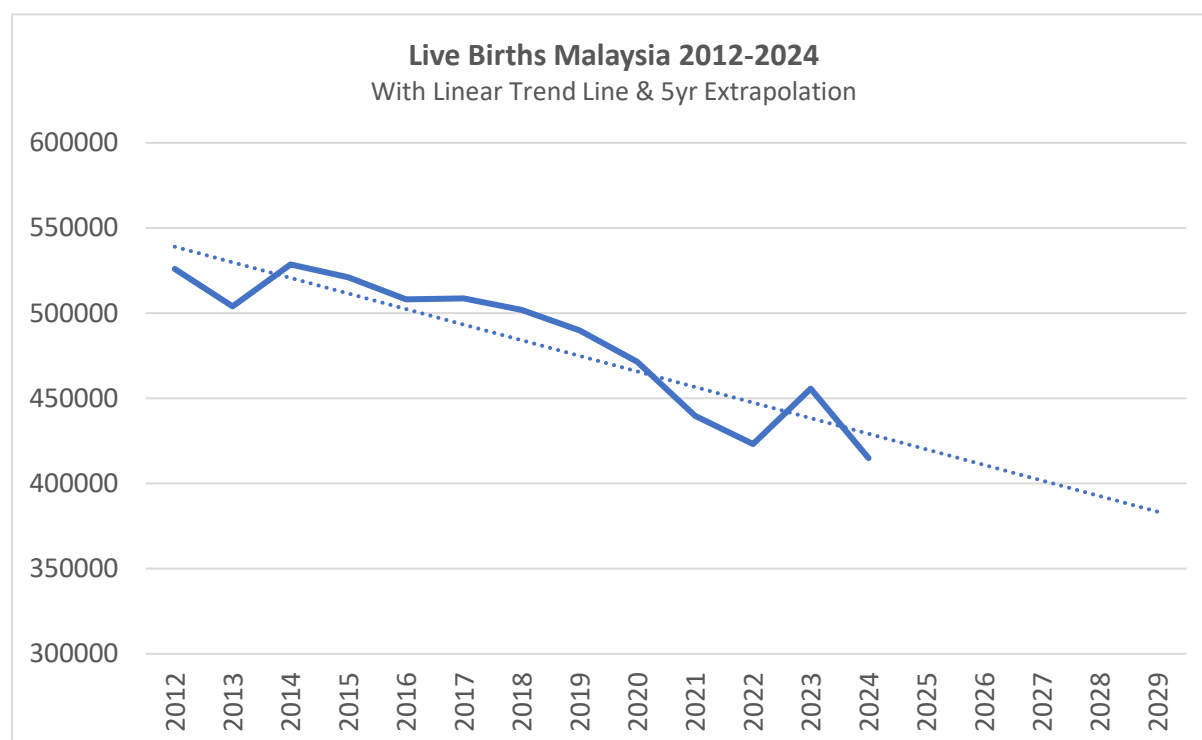


Figure 1.1: Live Births Malaysia 2012-2024. Source: DOSM Children Statistics 2025

1.5 Non-Citizen Children

Data on the population of non-citizen children, especially migrant, refugee and stateless children, is poor. These children are often excluded from the national data and this renders them invisible - and this invisibility carries profound consequences for their health, development, and survival.

Some available data:

Population data for 2025 shows that 703,100 children (aged 0-19 years) are non-citizens (excluding data on persons in Malaysia of other citizenship) and comprise 7% of the childhood population (DOSM 2026). Most of these children would probably be stateless children.

As of end October 2025, there were 211,360 refugees and asylum-seekers registered with UNHCR in Malaysia (UNHCR Malaysia 2026). Of these 189,760 were from Myanmar, 5,797 Pakistanis, 3,121 Yemenis, 2,898 Somalis, 2,751 Afghans, 2,509 Syrians, 1,061 Sri Lankans, 502 Palestinians, 438 Iraqis, and others. Of this number there were 64,801 children below the age of 18 years.

In 2019 the UNHCR estimated 450,000 stateless persons in Sabah (CSO UNCRC Submission 2025). However, the Chief Minister of Sabah announced in March 2022 that 810,443 residents of Sabah were non-citizens (23.7% of Sabah's population), comprising mostly the Bajau Laut community (CSO UNCRC Submission 2025).

One data from the Welfare Department showed 1,933 stateless children under the age of 18 years in homes nationwide in 2019 (1,098 boys and 835 girls) (FMT Reporters 2020).

End-of-Section References

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Section 2: Mortality and Morbidity Indices

3,602 children under 5yrs died in 2024, half of which were preventable.

Injury related deaths (transport & drowning) are not addressed.

Lack of disaggregated data conceal significant disparities between communities.

Health services for children are chronically underfunded & social determinants of health unaddressed.

2.1 Introduction

Childhood mortality rates are among the most sensitive indicators of a nation's socio-economic development and health system quality. They reflect not only the state of medical care, but also poverty levels, nutrition, environmental quality, maternal health, and equity of access to services. Malaysia has made significant progress since independence, reducing its infant mortality rate from over 70 per 1,000 live births in the 1950s to 7.2 per 1,000 live births in 2024 (Table 2.1).

2.2 National Mortality Trends

Table 2.1: Trends in Childhood and Maternal Mortality Rates, Malaysia. Sources: MOH Health Facts 2025 and United Nations Inter-agency Group for Child Mortality Estimation.

Mortality Rate	1965	1970	1980	1990	2000	2010	2020	2022	2024
Perinatal MR (per 1,000 births)	26.5		26.7	12.4	7.3	7.7	8.0	8.2	7.9
Stillbirth Rate (per 1,000 births)	22.0		15.5	9.0	3.8	4.5	5.1	5.0	4.5
Neonatal MR (per 1,000 live births)	39.3	22.9	14.8	8.4	4.5	4.3	3.9	4.2	4.5
Infant MR (per 1,000 live births)	48.5	39.4	24.9	13.1	6.5	6.7	5.9	6.8	7.2
Toddler MR (per 1,000 aged 1–4)	—	—	—	—	—	—	—	0.4	0.3
Under-5 MR (per 1,000 live births)	70.2	55.9	30.4	16.8	8.9	8.4	7.3	8.6	8.7
Maternal Mortality Ratio (per 100,000 live births)	—	—	—	—	—	—	—	26.0	24.3

Total deaths among children under 5 years in 2024 numbered 3,602, including 2,974 infant deaths (1,863 were neonatal) and 628 deaths among children aged 1–4 years (DOSM Children Statistics 2025). This represents over 10 deaths per day in this age group, half of which were preventable (Amar-Singh HSS, et al. 2017).

The national aggregate mortality rates conceal profound and widening disparities between communities. Without disaggregated data by social class, ethnicity, legal status, this national average masks communities where the true rate may be many times higher (see under various relevant sections).

State-level data from the Petunjuk Kesihatan 2025 (MOH Health Indicators) show that infant mortality rates in 2024 ranged from 4.9 per 1,000 live births in W.P. Kuala Lumpur to 16.0 per 1,000 live births in W.P. Labuan and 9.6 in Sabah - more than three times the capital's rate. Neonatal mortality similarly varies from 2.9 in Kuala Lumpur to 11.5 in W.P. Labuan. These are not random variations - they suggest poverty, health access, and the concentration of indigenous, rural, migrant and undocumented populations. These persistent geographic inequity - not the national average - must drive resource allocation decisions for child health services.

Table 2.2: Infant Mortality Rate by State, Malaysia, 2023–2024. Source: Ministry of Health Malaysia, Petunjuk Kesihatan 2025 (Health Indicators 2025). Rates per 1,000 live births.

State	Infant Deaths 2024	Infant MR 2024	Infant Deaths 2023	Infant MR 2023	Change in MR 2023→2024
Johor	360	7.1	341	6.1	+1.0
Kedah	225	7.3	200	5.9	+1.4
Kelantan	202	6.3	251	7.0	-0.7
Melaka	103	8.2	90	6.6	+1.6
Negeri Sembilan	138	9.4	115	6.9	+2.5
Pahang	138	6.4	198	8.2	-1.8
Perak	210	7.6	220	7.2	+0.4
Perlis	31	8.7	24	6.2	+2.5
Pulau Pinang	111	6.1	110	5.6	+0.5
Sabah	405	9.6	382	8.2	+1.4
Sarawak	221	7.3	217	6.4	+0.9
Selangor	519	6.2	558	6.2	0.0
Terengganu	170	7.2	202	7.7	-0.5
W.P. Kuala Lumpur	104	4.9	112	5.2	-0.3
W.P. Labuan	21	16.0	10	7.1	+8.9
W.P. Putrajaya	16	10.3	24	14.0	-3.7
MALAYSIA	2,974	7.2	3,054	6.7	+0.5

Note however, that under-5 year mortality indicators have plateaued and stagnated since around 2000-2005 (Figure 2.1). This partly due to the chronic under funding of health services for children (Table 2.3) and the grossly unaddressed social determinants of health.

While the overall health budget has increased the, amount we actually allocate to paediatric care in MOH hospitals is very tiny and has, relatively to total health budget, been decreasing (Table 2.3). One continual reality is the desperate shortage of intensive care and high dependency beds for children all over the country (Amar-Singh HSS 2019). Every day most paediatric departments will be scrambling to try and find a bed for an ill baby or child.

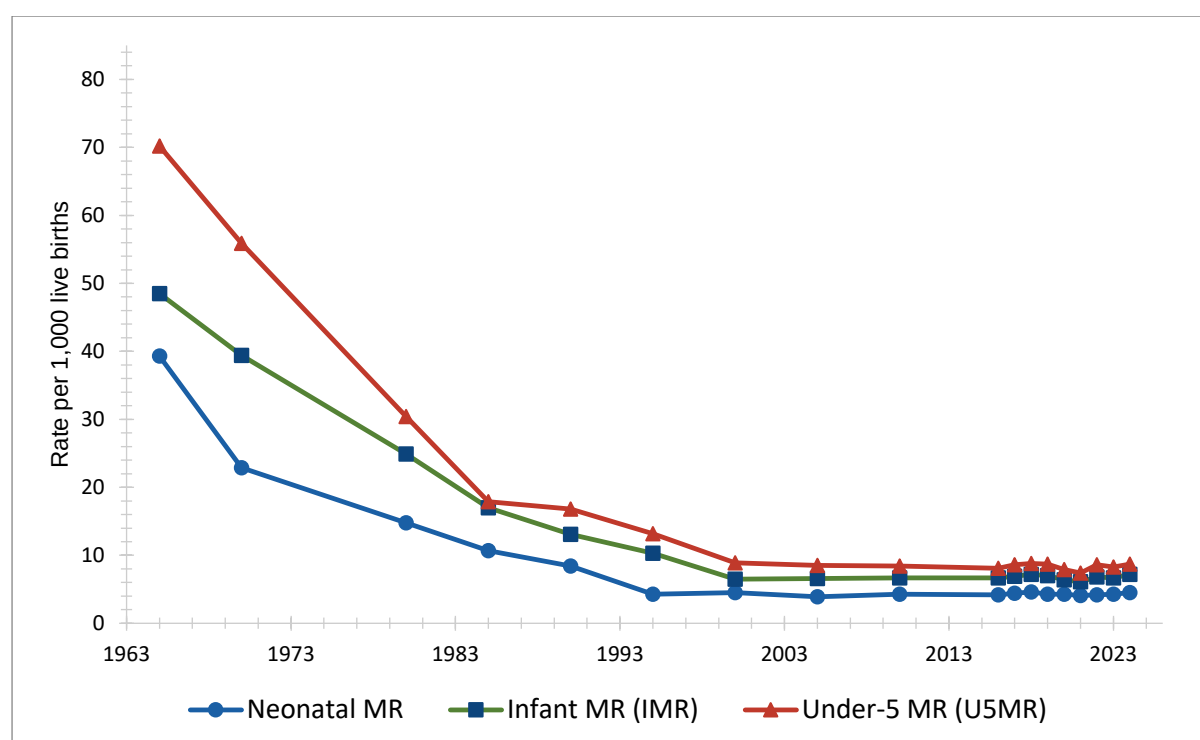


Figure 2.1: Under-5, infant and neonatal mortality rates 1965 to 2024, Malaysia. Sources: DOSM & MOH and United Nations Inter-agency Group for Child Mortality Estimation.

Table 2.3: Paediatric Budget compared to Total Health Budget, MOH. Source: Annual budget reports, MOF, Malaysia.

Year	Paediatric Budget	Total Health Budget	Percentage of Total
2024	620,892,300	41,217,816,500	1.5%
2023	610,506,300	36,327,355,900	1.7%
2022	591,088,200	32,409,629,800	1.8%
2021	578,878,900	31,941,504,300	1.8%
2020	660,210,700	30,602,080,900	2.2%
2019	630,411,000	28,678,743,500	2.2%
2013	384,920,300	19,227,189,500	2.0%

Overall, we spend far too little on health (Table 2.4).

Table 2.4: Proportion of Gross National Income for Health, Malaysia, 2020-2024.

Indicator	2020	2021	2022	2023	2024
Gross National Income (GNI) at Current Prices (Million)	RM1,415,688	RM1,474,621	RM1,731,944	RM1,769,983	RM1,866,181
Health Budget (Operating and Development) (Million)	RM30,602	RM31,942	RM32,410	RM36,140	RM41,218
Percentage of GNI for Health	2.16%	2.17%	1.87%	2.04%	2.21%

2.3 SDG 3.2 Target Achievement

SDG Goal 3.2 targets a neonatal mortality rate of at most 12 per 1,000 live births, and an under-5 mortality rate of at most 25 per 1,000 live births by 2030. On paper, Malaysia has achieved both targets. However, these aggregate national figures obscure profound inequities (Hung & Mariana 2016; Amar-Singh HSS 2023):

Orang Asli (Peninsular Malaysia indigenous) children had an under-5 age-specific mortality rate 11 times that of major ethnic groups in 2016.

Indigenous ethnic groups in Sabah and Sarawak had mortality rates 1.7 times that of major ethnic groups.

Children of Indonesian and Myanmar residents in Malaysia had under-5 age-specific mortality rates 25.5 times higher than the national average.

Urban poor children, especially inner-city slum communities, have mortality rates 2–5 times the national average.

The lack of mandatory disaggregated data by income, ethnicity, and geographic location means that these disparities are not systematically captured in national reporting. This is a fundamental failure of data governance that enables governments to claim SDG achievement while communities of children continue to die at rates reminiscent of the pre-development era.

2.4 Causes of Under-5 Death

The three leading categories of under-5 deaths in Malaysia (DOSM Statistics on Causes of Death 2025) are:

- Prematurity and related neonatal conditions
- Congenital abnormalities
- Infections, septicaemia and pneumonia
- Injuries (drowning and transport related)

A national study of under-5 deaths in Malaysia for 2015 found that at least 48.7% were preventable, often due to family factors (delay in seeking treatment) and quality of medical care issues (failure to escalate care, limited human resources) (Amar-Singh HSS, et al. 2017). This rate was higher than the self-reported (by health professionals) preventable rate of 27.2%. A second audit in 2016 showed that the preventable death percentage remain high at 46.7% (Aina Mariana Abdul Manaf et al. Under-5 Mortality Review 2016: Looking into The Preventable Deaths MOH/K/ASA/119.22(RR)) compared to the self-reported data of 30.52% (Hung Liang Choo, Aina Mariana Abdul Manaf. A Study on Under-5 Deaths in Malaysia in the Year 2016. Putrajaya 2020. MOH/K/ASA/113.20(TR)-e).

For 2023, 39.3% of deaths (adult and child combined) were not medically certified (DOSM Statistics on Causes of Death 2024 & 2025). The true burden of child mortality from injuries, malnutrition, and infectious disease therefore remains significantly underestimated.

Injuries, particularly road traffic and drowning, are underrepresented in official cause-of-death data for children, largely because injury deaths are often not certified by medical practitioners, are under-reported, particularly in rural communities and in Sabah, and occur especially in older children (see section under Injuries).

2.5 Deaths Among Older Children (5–18 Years)

Although the SDG focus rests on the under 5 group, deaths among older children are not insignificant. Approximately 20% of all childhood deaths occur in the 5–18 year age group (Amar-Singh HSS 2023). The leading causes in this age group are injuries (road traffic injuries and drowning). Suicide is also an increasingly significant cause of adolescent death (see relevant section).

2.6 The 'New Morbidities' — Current Healthcare Challenges

Beyond traditional mortality metrics, Malaysia's child health system now faces a spectrum of 'new morbidities', chronic, complex, and psycho-social in nature, that the current health system was not designed to address:

Table 2.5: Current Child Health Challenges — New Morbidities (Amar-Singh HSS 2023).

Challenge	Scale of the Problem	Key Actions Required
Malnutrition (stunting)	21.2% of under 5 children were stunted (NHMS 2022) with the highest prevalence in Pahang state at 28.2%. Stunting is >60% in Orang Asli. International datasets like WHO/UNICEF Joint Estimates estimate stunting at 23- 24.0%.	Poverty reduction, universal school breakfast, targeted nutrition
Child mental health	1 in 6 children aged 5–15 with mental health problems (NHMS 2023); 1 in 4 adolescents with depression (NHMS 2022)	Expanded psychosocial services, school-based support, de-stigmatisation
Childhood obesity	Rising — 9.2% overweight + 8.8% obese in school-age children (SEANUTS II 2023)	Food environment regulation, sugar taxation, active living
Children with disabilities	7.4% developmental delay (NHMS 2022 MCH); 15–17% estimated overall	ECI funding, inclusive education, rights-based legislation
Road traffic injuries	850–900 deaths/year, 28,500 admissions/year among under-18s	Mandatory helmets, speed control, pedestrian safety
Drowning	250–350 deaths/year (2nd commonest cause of child injury death)	Water safety education, pool regulations, swimming skills
Child abuse/neglect	9,624 cases in need of care and protection (2024, DOSM)	Mandatory reporting, child protection team strengthening

Psycho-Social issues > 30% Significant Mental Health problems 20% Substance abuse (including Vaping) 20% Obesity or Overweight 30% Internet/Screen Addiction 40-50%	Injuries (Road & Drowning)	Impact of Climate Change & AI on Health
Significant Poverty > 20% Indigenous Inner city families Stateless, Refugees, Migrants		
Disability (including learning disorders) 15%		
Serious Abuse (Sexual) > 10%		

Figure 2.2: A summary of child health needs in Malaysia.

2.7 Key Recommendations

1. The lack of granular disaggregated data hides the impact of social determinants of health and the size of the problem in marginalised communities. We government mandated, full disclosure and access to data that is linked – health indices with socio-economic status by geographical region and ethnicity.
2. We need to stop looking at SDGs achievements on a national basis but by individual marginalised communities. We require under-5 mortality rates by social class and for marginalised groups.
3. We need a child-rights-based approach to the allocation of the government budget. The Paediatric Budget in the Ministry of Health must be significantly revised to reflect the pressing needs and services for children. Services for children in the Ministry of Health, especially the

Neonatal and Paediatric intensive care units (NICU & PICU) must be funded and provided human resources on par with the adult ICUs.

4. We need to ensure universal healthcare and education access by enacting legal provisions that guarantee all children and pregnant mothers living in Malaysia the right to healthcare, regardless of their legal status, with formal birth registration.

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Section 3: Maternal Health and the First 1,000 Days

First 1,000-Days: Period from conception to 2yrs is vital for brain & physical growth.
30% of women of reproductive age are anaemic - a sign of nutrition deficiency & risk factor for stunting in the newborn.
Exclusive breastfeeding rates remain low.
Teenage pregnancy rates remains high.

3.1 Why the First 1,000 Days Matter

The first 1,000 days of life, from conception to two years of age, represent the most critical and time-sensitive window for physical growth, brain development, and the formation of lifelong health and social trajectories (Aguayo & Britto 2024; UNICEF 2020). This period offers the most significant opportunity to influence long-term health, cognitive development, and socioeconomic outcomes. The biological effects of what happens during these 1,000 days are not merely physical, they are inscribed into the architecture of the developing brain. The concept of 'biological embedding of adversity' describes the mechanism by which poverty, poor nutrition, and social exclusion during this window become inscribed in a child's physiology, with consequences that persist across a lifetime and across generations (Amar-Singh HSS & Srividhya Ganapathy 2026).

Yet in Malaysia, the gains achieved in national health averages obscure a deepening equity crisis: the benefits of modern child health are not reaching those who need them most.

3.2 Maternal Health Before and During Pregnancy

The first 1,000 days do not begin at birth, they before conception, and optimal outcomes require that mothers enter pregnancy in good nutritional health. The evidence increasingly shows that periconceptional maternal nutrition, in the six months before conception, is as consequential as care during pregnancy itself (Amar-Singh HSS & Srividhya Ganapathy 2026).

Anaemia in pregnancy remains a significant problem. The NHMS 2019 data showed that 29.9% of women of reproductive age were anaemic (IPH NHMS 2019) - a sign of nutrition deficiency and a major risk factor for low birth weight and stunting in the newborn. Low birth weight (<2.5 kg) affects 13.3% of live births in Malaysia (2024 data) (MOH Health Facts 2025).

Teenage pregnancy remains a concern. New antenatal cases among adolescents registered in MOH primary healthcare facilities declined from 13,831 (2015) to 10,349 (2019), but the rate remains high (IPH NHMS 2019). Of these adolescent pregnancies, 40.2% were to unmarried women and 80.2% were to those no longer in school - underscoring the relationship between early pregnancy, educational dropout, and poverty.

Maternal Mortality Ratio: 24.3 per 100,000 live births (2024) (Amar-Singh HSS & Srividhya Ganapathy 2026). This is significantly higher than regional peers such as Singapore (8.1) and South Korea (11.0), and has remained largely stagnant over the past decade.

3.3 Breastfeeding

Optimal breastfeeding practice - exclusive breastfeeding for the first 6 months, followed by continued breastfeeding with appropriate complementary foods to two years - is the cornerstone of infant nutrition and immune protection. Breast milk provides uniquely matched nutrition and bioactive compounds that cannot be replicated by any formula product.

In Malaysia, exclusive breastfeeding rates remain disappointingly low. The 2016 NHMS estimated that only 47.3% of infants under 6 months were exclusively breastfed, far below the WHO target of 50%. Commercial marketing of breast milk substitutes, insufficient maternity leave, a lack of workplace support for breastfeeding mothers, and inadequate training of healthcare professionals in breastfeeding support all contribute to this low rate.

Rates are even lower among marginalised communities, including the urban poor and migrant workers, where formula feeding is often perceived as a marker of modernity, and where the true costs of formula and its risks in conditions of poverty and poor water quality are not adequately communicated.

3.4 Complementary Feeding and Childhood Nutrition

Inappropriate complementary feeding - both in timing and content - contributes significantly to childhood malnutrition in Malaysia. The NHMS 2017 found that 10% of children come to school without breakfast and another 60% have irregular breakfast. Among the youngest children, a heavy reliance on rice porridge, sweetened beverages, and processed snacks - with insufficient protein, iron, and micronutrients - drives both stunting and the simultaneous rise in overweight and obesity.

3.5 Equity in the First 1,000 Days

The stark reality is that not all children in Malaysia enter the world with the same chance. For children born in marginalised communities, the first 1,000 days are already compromised before they begin:

- Orang Asli children: Malnutrition rates of 40–70% by 2 years of age; perinatal mortality rates more than 3 times the national average (Amar-Singh HSS 2008).
- Children in poverty: Approximately 3–4 million children live in poverty in Malaysia, with rates sharply worsened by the COVID-19 pandemic (Amar-Singh HSS 2022). The revised Poverty Line Income of RM 2,280 revealed ~400,000 households - approximately 1.2 million children - living below the poverty line (Amar-Singh HSS & Srividhya Ganapathy 2026).
- Children in Sabah: Interior communities in Sabah have some of the worst maternal and child health indices in the country, with limited access to antenatal care, skilled birth attendants, and primary health services.
- Refugee and stateless children: Without birth registration, these children are invisible to health systems from the moment of birth. They receive no routine immunisation, no growth monitoring, and no nutritional support through public health channels.

These are not accidents of circumstance. They are the product of deliberate policy choices: inadequate disaggregated data collection that renders marginalised communities invisible, insufficient investment in community health workers, the absence of universal early childhood nutrition programmes, and a healthcare system that remains hospital-centric, curative, and inaccessible to the poor.

3.6 Key Recommendations

1. Institute a Universal School Breakfast Programme (Sarapan Pagi) for all primary school children, regardless of income - not merely for those below the poverty line. Access to daily protein-rich nutrition in school is the most cost-effective intervention to address stunting in school-age children.
2. Mandatorily identify and support mothers with malnutrition during pregnancy, including financial support for food security.
3. Formally incorporate pre-conceptional care into the maternal health programme, with nutritional assessment and supplementation commencing six months before planned conception.
4. Strengthen and fund community re-feeding centres in Orang Asli and rural Sabah communities; ensuring continuity of funding.

5. Increase exclusive breastfeeding rates through strengthening the Baby Friendly Hospital Initiative, expanding maternity leave to 6 months, and prohibiting unethical breast milk substitute marketing in healthcare settings.
6. Commit to mandatory data disaggregation by income, ethnicity, and geographic location for all child nutrition and mortality indicators.

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Section 4: Malnutrition – Stunting and Obesity

**Stunting in Malaysia is high & worsening: 1 in every 5 children under-5 is stunted.
Orang Asli Children have stunting rates of >40%.
18% of children are overweight or obese.**

4.1 Introduction

Malaysia faces a 'triple burden of malnutrition': undernutrition (stunting, wasting, underweight), micronutrient deficiencies, and overnutrition (overweight and obesity) - often within the same household and the same community (Poh et al. 2023). This paradox is not unique to Malaysia but is particularly acute given our middle-income status and the expectation that development would have resolved undernutrition by now. Instead, we are worsening.

4.2 Stunting - The Silent Crisis

Stunting is defined as height-for-age below minus 2 standard deviations of the WHO growth reference median. It is the most sensitive indicator of chronic malnutrition and represents a permanent effect on a child's physical and cognitive development (Amar-Singh HSS 2023). Once stunted, a child cannot recover their potential height. More critically, stunting implies smaller brains, poorer cognitive development, reduced adult productivity, and a lifetime poverty trap. There is also evidence linking childhood stunting to increased risk of adult obesity, childhood infections, premature death, and intergenerational stunting (Amar-Singh HSS 2023).

The trajectory of stunting in Malaysia is alarming and worsening:

- 6.6% in 2011 (NHMS 2011)
- 17.7% in 2015 (NHMS 2015)
- 21.8% in 2019 (NHMS 2019) - 1 in every 5 children under-5 is stunted

Stunting in children aged 5-17 years was 12.7% in 2019 - 1 in every 6 teenagers is stunted (Amar-Singh HSS 2023). Compared to regional peers, these rates are deeply concerning: Singapore has 4% and Thailand 11% stunting rates respectively (Amar-Singh HSS 2023). Malaysian teenagers are 6–7 cm shorter than the WHO standard for their age - not because of genetics, but because of poverty and inadequate nutrition. While stunting rates globally are declining, Malaysia's rates are increasing, trending towards rates seen in poorer developing nations.

The causes of stunting are not primarily medical. They are social and economic. Pathological causes (chronic illness) account for only a minority. The majority of cases are driven by food insecurity - inadequate nutrition during pregnancy and childhood - rooted in poverty. The NHMS 2019 data shows that among women of reproductive age, 29.9% were anaemic, a signal of pre-existing nutritional deficiency that sets the stage for low birth weight and stunting (IPH NHMS 2019).

Stunting disproportionately affects (IPH NHMS 2019):

- Rural vs urban communities: 17.1% vs 11.3% in teenagers
- Sarawak natives (16.4%) and Sabah natives (14.4%)
- Those with household incomes below RM 1,000 per month (18.0%)
- Orang Asli children: Stunting rates of 60–70% by 5–7 years of age. A 2022 audit of Orang Asli children under 2 years in Perak showed that more than 40% were malnourished, most received inappropriate care, and another 40% had incomplete growth monitoring (Chew et al. 2022).

The situation among the Orang Asli is a national emergency. Their stunting rates, if treated as a separate country, would place them among the most malnourished populations in the world. Yet this data is systematically hidden by the aggregation of national statistics.

4.3 Underweight and Wasting

The NHMS 2019 found a 14.1% underweight rate among under-5 children - up from 11.6% in 2011. The SEANUTS II Malaysia study (Poh et al. 2023) found stunting in 13.8% and wasting in 6.2% of under-5 children, with 8.9% of children 0.5–12.9 years stunted and 6.7% thin. These rates confirm the sustained and severe magnitude of undernutrition in young Malaysian children.

4.4 Overweight and Obesity

At the same time, overweight and obesity are rising rapidly among Malaysian children, creating a simultaneous double burden. The SEANUTS II Malaysia study (Poh et al. 2023) found 9.2% overweight and 8.8% obese among children aged 0.5–12.9 years. Among adolescents, the picture is similarly concerning, with national surveys showing rising rates of overweight and obesity driven by ultra-processed food consumption, sugary beverages, inadequate physical activity, and long screen time.

The NHMS 2023 noted that the prevalence of overweight and obesity among adults increased by almost 10% from 2011 to 2023. These trends begin in childhood. Malaysia has one of the highest childhood obesity risks in Southeast Asia, scoring 7.5 out of 11 on the World Obesity Federation's Childhood Obesity Risk Index.

Drivers of childhood overweight and obesity include:

- Aggressive marketing of ultra-processed foods and sugary drinks to children
- School canteens that predominantly sell nutritionally poor foods
- Insufficient physical education and active play
- Heavy screen time and sedentary behaviour: 49.9% of adults have sedentary behaviour (NHMS 2023); trends are worse among children
- The paradoxical link with poverty: cheap, calorie-dense, nutritionally poor food is the most accessible for low-income families

4.5 Programmes and Gaps

The School-based Supplementary Food Programme (Rancangan Makanan Tambahan, RMT) aims to provide 1/3 to 1/4 of primary school children's daily nutritional requirements. However, only 600,000–800,000 children benefit due to strict eligibility criteria (household income below the national poverty line, or being Orang Asli, Penan, or disabled) (Amar-Singh HSS 2023). This leaves the vast majority of food-insecure children unserved.

Proposed national strategic plans - including the '2022-2030 National Strategic Plan to Combat the Double Burden of Malnutrition Among Children' - represent a positive step. However, their effectiveness depends on political will, adequate funding, and genuine commitment at the highest levels of government.

4.6 Recommendations

1. Institute a Universal School Breakfast Programme for all children - not just those below the poverty line. Nutrition advice to the poor without addressing purchasing power has no impact.
2. Commit to ending child poverty and malnutrition through structural reforms aligned with SDG Goals 1 and 2. Especially target indigenous children, rural Sabah, inner-city poor, stateless, and refugee children.
3. Require comprehensive, disaggregated nutritional data - by income, location, ethnicity, and citizenship status - to identify communities with inequities and target support.

4. Regulate the marketing of breast milk substitutes and ultra-processed foods to children, consistent with the International Code of Marketing of Breast-milk Substitutes.
5. Establish a bipartisan, multi-stakeholder National Committee on Child Stunting chaired at the Prime Minister level.

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Section 5: Children's Access to Healthcare

Despite progress in health services, there are children who remain underserved.
 Neonatal / Paediatric ICU services are languishing resulting in preventable deaths.
 MOH policy does not recognise adolescents as children or provide appropriate facilities for their needs.
 Orang Asli services continue to be weak and inadequate.
 Migrant, refugee and stateless children do not have their basic rights to healthcare.

5.1 The Right to Health

Article 24 of the UNCRC clearly states the '*right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.*' It further requires governments to 'strive to ensure that no child is deprived of his or her right of access to such healthcare services.' The Child Act 2001 Section 17 reinforces this: '*A child is in need of care and protection if the child needs to be examined, investigated or treated for the purpose of restoring or preserving his health.*' To ensure universal access to health for all children in Malaysia, we require a rights-based approach as outlined in the UNCRC.

In general, Malaysia has a robust public health system that is accessible to the majority of communities with minimal or no payment. However, despite extensive progress in health / medical care, there are children who remain fragile and underserved - 'pockets' of children who lack adequate access to health services. The 'inverse care law' - those who need healthcare the most are the ones least likely to get it - has worsened especially with extensive urbanisation (Amar-Singh HSS 2022).

5.2 Summary of MOH Child Health Services

As of 2024, MOH provides the following services for maternal and child health (MOH Health Facts 2025):

- 5,431,917 antenatal attendances
- 470,581 postnatal attendances
- 9,672,504 child attendances to maternal and child health clinics

Primary childhood immunisation coverage for 2024 remained high overall, though declining slightly from recent peaks:

- BCG: 98.36%
- DTaP-IPV-HIB (3rd dose): 101.61% (issues with denominator)
- PCV (2nd dose): 100.29% (issues with denominator)
- MMR (1st dose, children aged 1–<2 years): 93.15%
- Hepatitis B (4th/completed dose): 101.61% (issues with denominator)

However, the DOSM Children Statistics 2025 noted a decline in immunisation coverage in 2024 across all five major vaccines - a concerning trend that warrants urgent investigation. These figures are also unlikely to include migrant, refugee, and stateless children.

Malaysia's health system has grown significantly over the past decade. The Ministry of Health (MOH) 2025 allocation was RM45.27 billion - 10.70% of the national budget - with RM38.53 billion for operations and RM6.74 billion for development. Total national health expenditure in 2023 was RM84.2 billion (4.62% of GDP) (Amar-Singh HSS 2022). Despite this investment, per capita allocations remain below comparator countries and the distribution is heavily urban-centred.

Table 5.1: MOH and Private Healthcare Facilities, Malaysia, 2024. Source: Ministry of Health Malaysia, Health Facts 2025.

Facility Type	Government (MOH) 2024	Private 2024
Hospitals (licensed)	139 MOH + 11 special medical institutions	214 private hospitals
Official beds	41,209 (MOH) + 5,646 (special)	19,920 (private hospitals)
Health Clinics (Klinik Kesihatan)	1,131	11,067 medical clinics
Rural Clinics (Klinik Desa)	1,656	—
Community Clinics	205	—
Pharmacies	—	4,320 community pharmacies
Haemodialysis Centres	—	812 (9,384 chairs)

Table 5.2: Health Human Resources, Malaysia, 2024. Source: Health Facts 2025, MOH Malaysia.

Health Professional	Total (all sectors)	Doctor: Population Ratio	MOH employed
Doctors	74,517	1:403 (vs 1:281 nurses)	45,697
Registered Nurses	121,361	1:281	70,234
Dental Practitioners	14,641	1:2,326	7,456
Pharmacists	21,070	1:1,538	12,701
Allied Health (Physio, OT, SLT, etc.)	Limited data	—	—

Malaysia has 74,517 doctors (1 per 403 population) and 121,361 registered nurses. Yet the allied health workforce - physiotherapists, speech therapists, occupational therapists - critical for childhood disability rehabilitation, remains critically understaffed and underfunded.

Table 5.3: Selected MOH Child and Maternal Health Service Volumes, 2024. Source: Health Facts 2025, MOH Malaysia.

MOH Child Health Service	2024 Data
Child attendance at government facilities	9,672,504
Antenatal attendances	5,431,917
Postnatal attendances	470,581
Total MOH hospital admissions	2,579,373
Outpatient attendance (Public health facilities)	46,277,333
Medical Rehabilitation – Physiotherapy sessions	2,640,690
Medical Rehabilitation – Occupational Therapy	1,274,877
Medical Rehabilitation – Speech therapy	129,303
Medical Social attendances	148,455

5.3 Recognition of Adolescents as Children

A critical structural failure in the Malaysian health system is the persistent non-recognition of adolescents (aged 12-17 years) as children in health service delivery. The MOH routinely admits adolescents to adult wards - placing teenagers next to seriously ill elderly adults. They are seen in adult-based clinics by clinicians who may lack training in adolescent health. Services for this ~15% of the population have grown only incrementally.

ICU services for children remain grossly inadequate (Amar-Singh HSS 2022). Some premature infants may not be offered care when NICU beds are full - a situation that occurs most days of the year in most MOH hospitals. The growth of adult curative specialty services has far outpaced the development of paediatric services.

5.4 Children in Poverty and Urban Settings

Private health services are out of the reach of the majority of poor families. Half the specialist human resources in the country are in the private sector, serving less than one third the health work burden - effectively privatising expertise away from the communities that need it most. There is also a disproportionate concentration of specialists in major cities and on the west coast of Peninsular Malaysia, leaving Sabah, rural Sarawak, and remote peninsular communities severely underserved (Amar-Singh HSS 2022).

With 3-4 million children living in relative poverty and 75-80% of the population now urban, the inner-city poor are a particularly vulnerable community - living in close quarters, with limited access to quality healthcare, and often falling between the gaps of rural-targeted health programmes and urban-based services that cater primarily to those with means.

5.5 Healthcare for Indigenous Children (Orang Asli)

Despite considerable improvement in the health status of the general population over the past 50 years, Orang Asli health has not changed significantly and in many respects has deteriorated (Amar-Singh HSS 2022). The poverty rate for the Orang Asli remains at approximately 80%; malnutrition rates in their children remain at 60–70% by 5–7 years of age. The under-5 mortality rate for Orang Asli children was 11 times that of major ethnic groups in 2019.

National advocacy in 2008-2009 succeeded in transferring health services from the national Orang Asli government agency (JAKOA) to the Ministry of Health, allowing improved health access (Amar-Singh HSS 2022). However, access remains inconsistent and depends heavily on the interest of local health authorities. Significant challenges persist:

- The Orang Asli Mobile Team achieved 66.2% of four-weekly planned village visits in 2019 (limited by damaged roads, extreme weather, and vehicle damage).
- The Flying Doctor Service based at Kinta, Perak achieved only 41.6% of 173 planned flights to remote Orang Asli villages for 2019.
- Some Orang Asli children have never been to school; more than 50% drop out of primary school. Without education, health literacy is severely compromised.

More than a decade after the formal transfer of health responsibility, health services for Orang Asli communities remain fragile, dependent on individual champions, and inadequately funded. (see Section on Indigenous Children).

5.6 Healthcare for Children with Disabilities

Data from international studies suggest that 10% of all children have developmental problems in the preschool period, and that by school age, the rate of detected disability rises to 15–17%. The NHMS 2022 MCH Survey found a 7.4% prevalence of developmental delay among children aged 6–59 months. Yet current health services for children with disabilities are better at assessment than intervention. Rural communities have very limited access; vulnerable children in remote rural communities have almost none.

University medical student training on learning disabilities is almost non-existent. Most doctors have very limited knowledge and skills to evaluate children with disabilities. Medical rehabilitation manpower has grown but remains institutionally based, adult-focused, and physically disability-oriented. Children with rare diseases are chronically underserved (see Section on Disability).

5.7 Routine Healthcare for Migrant, Refugee and Stateless Children

The basic rights to healthcare for migrant, refugee and stateless children, as enshrined in the UNCRC and Child Act, have not been upheld by the Malaysian government. These children do not receive

routine primary immunisation, as well as growth and developmental monitoring, and health advice/education (Amar-Singh HSS 2022). Provision of primary immunisation to these children protects not only them but all Malaysian children (herd immunity).

There exist many barriers to these families accessing healthcare for their children, which include: fear of being deported, poverty, work mobility, language and the lack of respect and treatment received from health staff. Government-run public healthcare facilities are accessible to 'foreigners', but at a much higher cost compared to Malaysian citizens; often out of the reach of most migrant, refugee and stateless families. Much of the current provision is ad hoc by CSOs or by government agencies when an outbreak occurs.

Healthcare for ill children who require hospitalisation or to see a specialist is even worse. While admission is possible for life threatening illnesses, guardians still have to pay high fees for hospitalisation, procedures and medications; putting such healthcare out of the reach of many (admission deposits range from RM 500-1,200 depending on category of illness). Some who are admitted are denied a discharge until they can settle the bill. Currently various funding mechanisms are used to support these children, including CSO funding, ethnic/country based NGOs raising funds, public fund raising or collections by MOH staff. At discharge these children, even with chronic problems, are only given five days' worth of medication with no follow up. MOH guidelines require health staff to report all undocumented foreigners to the Immigration Department or Police (this happens even at the time of birth of a child). (see Section on Migrant, Refugee and Stateless Children).

5.8 Recommendations

1. MOH policy must urgently recognise that adolescents aged 12-17 are children and must be placed and seen in appropriate child-friendly facilities with clinicians trained for their needs.
2. All hospitals must urgently expand PICU and NICU capacity to meet acceptable norms - the current deficit results in preventable deaths.
3. The government must adequately fund and strengthen Orang Asli Mobile Teams, Flying Doctor Services, and community re-feeding centres, with ring-fenced budgets and accountability mechanisms.
4. A rights-based approach that guarantees all children in Malaysia - regardless of legal status - access to free primary healthcare, immunisation, and essential hospital care must be legislated. Migrant, refugee and stateless children/families need to be protected against arrest and detention when they seek healthcare at hospitals and clinics.
5. Medical school curricula must significantly improve training on child disability recognition, assessment, and rehabilitation.

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Section 6: Unintentional Injuries

Road traffic injuries are the leading cause of death (900/yr) & disability among children aged 1-18 years.

Drowning is a common cause of death & disability (500 drown, 300 died yearly) among children aged 1-18 years.

Childhood home injuries cause morbidity among children but are not systematically addressed (especially poisoning).

Unintentional injuries are the leading cause of death and disability among children aged 1–18 years in Malaysia. They are not accidents - they are injuries with predictable, patterned events with well-understood risk factors and evidence-based prevention strategies. This section covers the three principal categories: road traffic injuries, drowning, and home injuries. Together, they account for over 1,500 child deaths per year, tens of thousands of hospital admissions and are an important cause of disability. All are largely preventable.

6.1 Road Traffic Injuries (Road Traffic Injuries Fact Sheet, Amar-Singh HSS 2022)

6.1.1 Introduction

Childhood injury is a major health problem contributing to considerable mortality and morbidity among children. Road traffic injuries (RTIs) are the leading cause of death among children aged 1-18 years in Malaysia. Yet road injuries remain a 'neglected epidemic' - preventable deaths and disabilities that receive insufficient attention in both policy and public discourse. Children use roads as pedestrians, cyclists, motorcyclists, and vehicle occupants. They play near roads, live adjacent to them, and use them for travel. The road network is frequently designed without consideration for children.

6.1.2 Size of the Problem

- Deaths: 850–900 children each year (20–23% of all road traffic injury deaths in the country) (Sharon-Linus Lojikip et al. 2012)
- Average death rate: 8 per 100,000 children per year - among the highest in the region
- Hospital admissions (MOH): 28,500–29,000 per year
- For each death, there are 32 hospital admissions (South-East Asian data: 1 death: 254 hospital treatments: 4 permanent disabilities)
- Permanent disability rate: estimated 20 per 100,000 children (South-East Asian data)

6.1.3 Profile by Injury Type

Table 6.1: Malaysia Child RTI Death Rate vs Regional Comparison. Source: Road Traffic Injuries Fact Sheet, Amar-Singh HSS 2022.

Country/Region	Malaysia	Global (WHO)	SE Asia (LMIC)	Europe (HIC)	W. Pacific (HIC)
Child RTI Death Rate (per 100,000)	8.0	10.7	7.4	5.2	4.2

6.1.4 Risk Profile by Injury Type and Demographics

- Children aged 12–18 years are disproportionately affected: RTI death rates by age group are 0–1yr (1.61), 2–4yr (2.24), 5–11yr (2.80), 12–18yr (16.78 per 100,000)
- Boys are 4.5 times more likely to die than girls: Male RTI death rate 12.91 vs female 2.86 per 100,000 children

- Motorcycle deaths dominate: Deaths are highest for motorcycle riders, followed by pillion riders, pedestrians, and car occupants
- Most at-risk road users by admissions 2002–2010: Motorcycle rider (12–19yr): 40,971 admissions
- Rural areas and Sabah have higher rates due to poor road infrastructure and longer travel distances
- Inadequate road design that ignores children as users - no dedicated pedestrian paths or safe crossings near schools in many areas
- Very high rates of motorcycle use - motorcycles are the vehicle of the poor and constitute 50–60% of the vehicle fleet
- Non-use of helmets, particularly among adolescents, and non-provision of appropriate child helmets
- Absence of child restraint seats: Malaysia's legislated car child seat use remains poorly enforced
- Driving under the influence of alcohol and fatigue
- Smartphones and distracted driving
- Children on motorcycles as pillion riders from infancy - a normalised but extremely dangerous practice

Several committees exist to address RTIs, including the Cabinet Committee on Road Safety and the National Road Safety Council. Key regulations include mandatory helmet use (though enforcement for children is weak) and the Road Safety Education in schools. However:

- There is no legislated minimum age for motorcycle riding as a pillion passenger
- Car child seat legislation exists but enforcement is inconsistent and penalties inadequate
- Road safety education in schools is not sufficiently practical or behaviour-changing
- There is no systematic surveillance of RTI disability rates in children

6.2 Drowning (Drowning Fact Sheet, Amar-Singh HSS 2022)

6.2.1 Introduction

Children look at water differently from adults - for them it implies fun and play. Drowning is an injury that displays epidemiological patterns that change according to age group, body of water, and activity. A young child can drown in a very small amount of water, in a pail at home or a drain nearby. Older children die in ponds, lakes, rivers, the sea, and often at recreational areas. Drowning is the second commonest cause of injury death among children aged 1-18 years in Malaysia, and represents a significant but preventable toll.

Drowning is defined as 'the process of experiencing respiratory impairment from submersion or immersion in liquid.' Outcomes are divided into three categories: Death, Morbidity (including serious brain damage), and No morbidity.

6.2.2 Size of the Problem

- Deaths: 250–350 children each year - 45–50% of all drowning deaths in the country
- Average child drowning death rate: 3.05 per 100,000 children per year
- Hospital admissions (MOH): 200–250 children per year - morbidity outcomes uncertain, but many are brain-damaged
- Total drowning events (death and non-death): more than 500 per year (5 per 100,000 children)

6.2.3 Profile by Injury Type

Table 6.2: Child Drowning Death Rate per 100,000 - Regional Comparison. Source: Drowning Fact Sheet, Amar-Singh HSS 2022.

Country/Region	Malaysia	Global (WHO)	Vietnam	Thailand	Korea	WP (LMIC)
Child Drowning Rate (per 100,000)	5.0	7.2	10.98	10.84	0.67	13.9

6.2.4 Risk Profile by Injury Type and Demographics

- Sabah has the highest drowning rates in Malaysia; east coast regions have high rates, especially during the annual monsoon season
- Boys drown 3.5 times more often than girls; children aged 5–14 years are most at risk, primarily due to recreational activities
- Half of drowning admissions to MOH hospitals are in the 1–4 year age group - toddlers drowning in small amounts of water at home
- Most prevalent sites: seas and rivers (recreational areas); however significant numbers drown in swimming pools and theme parks
- Hotel swimming pools, assumed to be safe recreational areas, were found to have a high volume of drowning events - not recognised until the drowning registry was established
- Data from narrative accounts suggests deaths are increased by children attempting to save other children - secondary drowning victims

Current regulations are limited:

- Local ferry services are required to have lifejacket facilities
- Hotels are required to have lifeguards if the swimming pool is of a certain depth
- SIRIM has produced local standards for life jackets
- Outdoor school activities involving water must be under the supervision of a certified lifesaver

However, significant regulatory gaps exist:

- No requirement for compulsory swimming lessons in schools
- No mandatory fencing around residential ponds and drains
- No mandatory life jacket use for children in recreational water activities
- No mandatory pool safety barriers for hotel and residential swimming pools
- No comprehensive national drowning prevention programme for children

6.3 Home Injuries (Home Injuries Fact Sheet, Amar-Singh HSS 2022)

6.3.1 Introduction

Childhood home injuries contribute to considerable morbidity among children. They include falls, poisoning, fires/burns, suffocation, and foreign body injuries. Children are naturally curious and will explore any and all environments accessible to them. Unfortunately, the average home environment can be hazardous to children, with the potential for falls, poisoning, burns, and suffocation.

6.3.2 Size of the Problem

- 8.2% (approximately 100,000) of children aged below 7 years experience a home injury (NHMS 2011). The rate is highest for children aged 0–4 years
- MOH admissions data (2003–2007) shows 18,000–23,500 children admitted annually for home injuries
- Falls constitute approximately half of all home injury admissions

- Significant volumes of poisoning, fires/burns, and suffocation admissions are also recorded annually

6.3.3 Profile by Injury Type

Table 6.3: Children admitted to MOH hospitals for Home Injuries by type, 2003–2007. Source: HMIS, Ministry of Health, Malaysia; Home Injuries Fact Sheet, Amar-Singh HSS 2022.

Injury Type	2003	2004	2005	2006	2007
Falls	12,838	13,061	13,596	10,048	9,923
Poisoning	2,005	2,106	2,190	2,488	2,455
Fires & Burns	3,576	3,854	3,770	2,623	2,462
Suffocation	2,316	2,351	2,520	1,578	2,549
Foreign body	1,386	1,415	1,456	1,693	1,614
TOTAL	22,121	22,787	23,532	18,430	19,003

6.3.4 Risk Profile by Injury Type and Demographics

- Falls: More common in adolescent boys (M:F ratio 2.3:1); peak in children aged 5–11 and 12–19 years
- Poisoning: Predominantly in adolescent girls (M:F ratio 1:4.1) and primarily intentional/suicidal in nature — a critical child mental health and child protection issue masquerading as an injury statistic
- Fires/Burns: Twice as likely in boys, especially aged 5–11 years
- Suffocation and foreign bodies: Predominantly in children under 5 years — the most dangerous period for these injuries

The finding that most adolescent poisoning admissions are intentional/suicidal among girls deserves special emphasis. This is not merely an injury statistic — it is a mental health crisis signal. Adolescent girls in Malaysia are experiencing significant psychological distress, and home medicines and chemicals provide a readily accessible means for self-harm. This linkage between home injury data and mental health need is explored further in other sections.

6.4 Recommendations

1. Establish a national childhood RTI registry to track disability, long-term outcomes, and prevention effectiveness.
2. Legislate and enforce a minimum age for children riding as pillion passengers on motorcycles.
3. Make child car seat use mandatory from birth, with government subsidy programmes for low-income families.
4. Redesign roads near schools and residential areas to systematically include safe pedestrian paths, speed humps, and school zones with enforced speed limits.
5. Establish a National Drowning Prevention Programme with dedicated funding, a national drowning registry, and community-based water safety education.
6. Implement a national compulsory swimming programme in all primary schools, beginning in Year 1, as part of the physical education curriculum.
7. Mandate safety barriers (fencing) around all open water bodies near residential areas, including drains that can accumulate water after rain.
8. Require hotel swimming pools and water theme parks to have trained lifeguards during all operational hours, regardless of pool depth.

9. Mandate life jacket use for children in all recreational water activities, including river crossing, boat rides, and sea activities.
10. Implement mandatory child-safe packaging for all household medications, cleaning products, and toxic substances.
11. National home safety education programme targeting parents of young children, covering falls prevention, safe storage of poisons, burn prevention, and choking hazards.
12. Mandate safety features in new residential building codes: window guards, non-climbable balcony barriers, and stair gates.

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Section 7: Communicable Diseases and Immunisation

Communicable diseases remain a significant cause of morbidity and mortality among Malaysian children

Childhood vaccines rates show some decline in coverage especially MMR

Migrant, refugee & stateless children do not have routine access to primary immunisation

7.1 Introduction

Communicable diseases remain a significant cause of morbidity and mortality among Malaysian children, even as the overall burden of non-communicable diseases rises. Vector-borne diseases - especially dengue and hand-foot-mouth disease (HFMD) - are endemic and affect children disproportionately. Tuberculosis continues to be a major public health concern. Meanwhile, declining immunisation coverage across all major vaccines in 2024 raises the concern of resurgent vaccine-preventable diseases, especially measles.

7.2 Communicable Disease Burden, 2024

Health Facts 2025 (reference data for 2024) documents the current communicable disease burden in Malaysia. The data show dengue remaining at epidemic levels, HFMD continuing as a major childhood illness, and tuberculosis representing a serious ongoing public health threat.

Table 7.1: Incidence and Mortality Rates of Key Communicable Diseases, Malaysia, 2024. Source: MOH, Health Facts 2025. Rates per 100,000 population.

Communicable Disease	Incidence Rate (/100,000)	Mortality Rate (/100,000)	Notes
Dengue Fever (incl. DHF)	359.45	0.34	Endemic; >1.2 million cases est. 2024; children affected
Hand, Foot & Mouth Disease (HFMD)	237.72	0.00	Primarily affects children <5 years; causes of death include EV71
COVID-19	300.97	0.17	2024 data; ongoing community transmission
Tuberculosis (TB)	76.88	7.58	High case burden; BCG coverage 98.4% but TB persists
Hepatitis B	24.60	0.30	Childhood immunisation programme reduces perinatal transmission
Hepatitis C	13.48	0.20	No childhood vaccination; concern for PWID-linked vertical transmission
Syphilis	16.45	0.06	Rising STI rates; congenital syphilis a risk for neonates
Measles	11.13	0.01	Rate rising; declining immunisation coverage a key driver
HIV (notification rate)	9.35	0.84	New infections; perinatal transmission prevention critical
Leptospirosis	7.12	0.13	Outdoor/flooding exposure; affects rural and outdoor-active children
Malaria	7.00	0.01	Highest in Sabah with children at risk
Food Poisoning	73.14	0.02	School settings are of concern
Pertussis (Whooping Cough)	1.41	0.03	Resurgence risk as immunisation rates fall

7.3 Immunisation Coverage

Malaysia's National Immunisation Programme provides free vaccination for all Malaysian children through government health facilities. Health Facts 2025 reports overall coverage rates for 2024, while the DOSM Children Statistics 2025 documents a concerning decline across all vaccines compared to 2023. Coverage figures above 100% reflect immunisation of children born in previous years or denominators based on live births.

Major childhood vaccines rates show some decline in coverage in 2024 compared to 2023. MMR coverage dropped to 93.2%, well below the 95% threshold required for measles herd immunity. Combined with a measles incidence rate of 11.13 per 100,000, this signals a growing risk of measles outbreaks. The reasons behind this decline require urgent investigation and corrective action. There are studies to suggest growing vaccine hesitancy in the community.

Table 7.2: Childhood Immunisation Coverage, Malaysia, 2022–2024. Sources: Ministry of Health Malaysia, Health Facts 2025; DOSM Children Statistics 2025.

Vaccine	2022	2023	2024	Target group
BCG (Tuberculosis)	98.9%	98.7%	98.4%	At birth
DTsP-IPV-HIB (3rd dose)	107.5%	107.7%	101.6%	Birth - 5 months
Hepatitis B (4th dose)	107.5%	107.7%	101.6%	Birth - 12 months
PCV (Pneumococcal) (2nd dose)			100.3%	Birth - 5 months
MMR (Mumps/Measles/Rubella)	95.8%	95.1%	93.2%	9-12 months
HPV completion dose (girls 13 yrs)	93.3%	91.9%	92.6%	School-based programme, Standard 2

Note: Rates above 100% are issues with the denominator

These figures are also unlikely to include migrant, refugee, and stateless children. The recently completed statewide Sabah Child Wellbeing Index (UNICEF 2026) that sampled more 2,000 household showed that basic vaccinations coverage by age 23 months was only 73.6%. This suggest, as many civil society organisations know, that the vast majority of undocumented children are not vaccinated. Provision of primary immunisation to these children protects not only them but all Malaysian children (herd immunity).

7.4 Recommendations

1. All children in Malaysia, regardless of legal status, require access to free primary healthcare which includes immunisation. We need to mandate this by law.
2. Conduct an urgent national audit of vaccine hesitancy in different community and work to stem the declining MMR immunisation coverage and prevent measles outbreak. Catch-up vaccination campaigns for children may be required.

End-of-Section References

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Section 8: Child Protection, Violence, and Maltreatment

Official reports capture only a fraction of the true abuse burden

Community-based prevalence studies suggest 1 in 10 children in Malaysian are sexually abused, and 1 in 4 physically abused

More than 40% of Malaysian parents use physical punishment or violent discipline in children under 5 years of age

Child marriage remains an unresolved crisis in the country

8.1 Introduction

Despite many advances in society, children remain fragile and open to abuse and violence. In Malaysia, like many countries, we have an endemic maltreatment of children. Data on violence against children is incomplete due to underreporting, fragmented data collection between agencies, and a cultural reluctance to report child maltreatment. What we do see in the official data is therefore the tip of a very large iceberg.

8.2 Child Abuse and Neglect

The number of children in need of care and protection recorded by the Department of Social Welfare (JKM) has been rising sharply (DOSM Children Statistics 2025):

- 2022: 6,770 children
- 2023: 8,536 children — a 26.1% increase
- 2024: 9,624 children — a further 12.7% increase

Girls accounted for 62.7% of the total in 2024. These figures include children facing or at risk of abuse, neglect, abandonment, and cases where parents or guardians are unfit or unable to provide proper care.

Official sexual abuse statistics in Malaysia are fragmented because child sexual abuse is classified differently across agencies and age groups, and rape is used as an umbrella term that obscures child-specific data. Approximately 30-40% of all children under 18 years who are identified as sexually abused are often classified as 'rape' and may not be referred to the Welfare Department or paediatricians and only reported to the police (seen by obstetricians). Sexual offences involving children reported to the Royal Malaysia Police (PDRM) have been rising (DOSM Children Statistics 2024):

- 2022: 1,239 cases
- 2023: 1,567 cases - a 26.5% increase

The breakdown in 2023 was: physical sexual assault on a child (1,389), non-physical sexual assault on a child (91), and child pornography (67).

Classifying child and adolescent sexual abuse under the general category of rape confuses the issue and limits appropriate support and data collection.

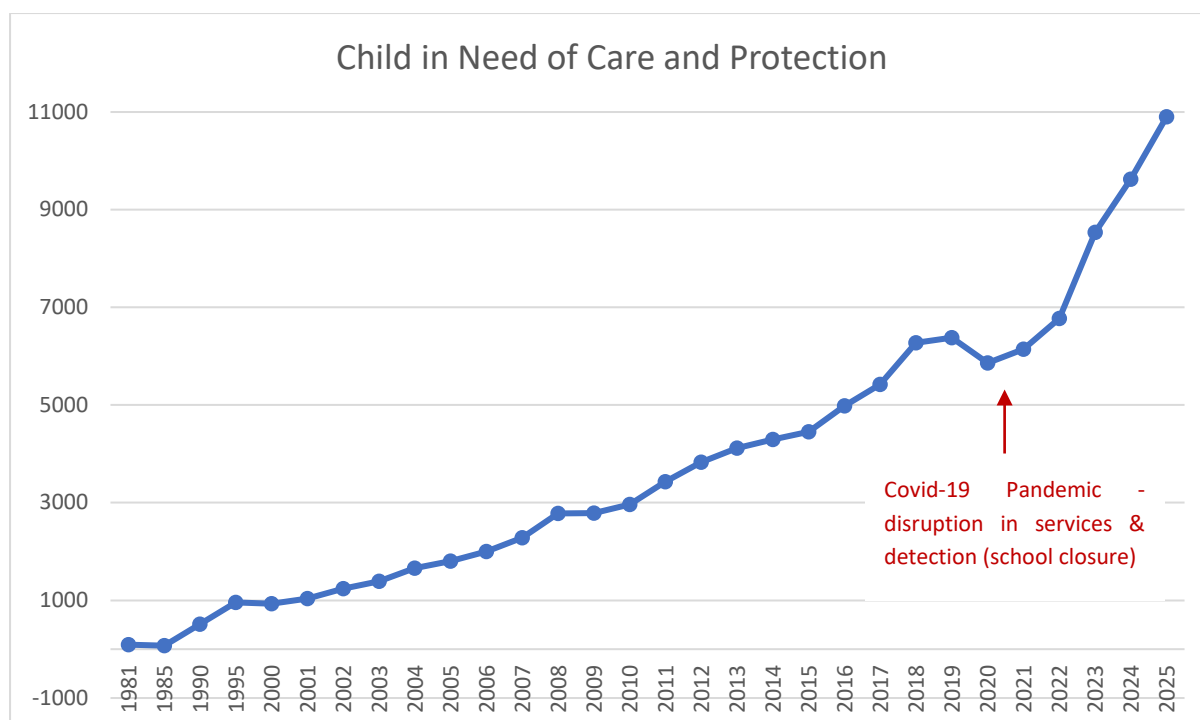


Figure 8.1: Children in Need of Care and Protection 1981-2024 Malaysia. DOSM 2024 & 2025 & Department of Social Welfare annual reports.

8.2.1 The True Scale of Child Sexual Abuse

Reported figures grossly underrepresent the true prevalence. Community prevalence studies reveal a far greater burden than official reports suggest. Three local community prevalence studies on abuse show sexual abuse rates of 8–26% and physical abuse rates of 19–53% of all children. Data from community studies on maltreatment of 15–17 year olds (2006) and 10–12 year olds (2011) showed that at least half had experienced some form of physical or emotional abuse and lived in uncertain home environments (Table 8.1). The majority of child sexual abuse occurs within families or by known persons and is never reported.

Table 8.1: Community Prevalence Studies on Child Maltreatment in Malaysia. Sources: Choo et al. (2011); Ahmed et al. (2015 PLoS ONE); Amar-Singh HSS (1996, 2023), Kamaruddin (2000).

Study	Population	Key Findings
Choo et al., 2011 Soc. for Adolescent Health & Medicine	1,870 students aged 15–17 Selangor	45% experienced at least one form of maltreatment: Physical 19%, Neglect 21%, Emotional 20%, Sexual 22%. Domestic violence in home: 10%.
Ahmed et al., 2015 PLoS ONE	3,509 students aged 10–12 Selangor	67% experienced at least one form of maltreatment: Physical 53%, Neglect 37%, Emotional 21%, Abuse by teachers: 29%.
Amar-Singh HSS, 1996; Kamaruddin, 2000; Choo, 2011	Community prevalence studies (3 studies combined)	Sexual abuse rates: 8–26% of all children. Physical abuse rates: 19–53% of all children.

Malaysia has seen a significant increase in online child sexual exploitation and abuse (CSEA), facilitated by the widespread use of smartphones and social media. Perpetrators groom children online, often over extended periods before physical contact or image-based abuse occurs.

There are reports of abuse from childcare centres, institutions and tahfiz schools (SUHAKAM 2020). There is no clear idea of the number of unregistered tahfiz schools but media reports suggest hundreds just in the Klang valley alone (Bernama 2025). Abuse may be covered up in religious centres and institutions.

Table 8.2 show children in need of care and protection by state with rates. States with rates far below the national average should be viewed with suspect as poorly reporting or detecting regions – this includes Kelantan, Sarawak, Terengganu, Pahang and Selangor.

Table 8.2: Children in Need of Care and Protection by State (Child Abuse) and rate of per 1,000 Children Aged 0–17 years by state. Sources: Population data: Department of Statistics Malaysia (DOSM) 2025. Child protection data: Department of Social Welfare annual report 2024.

State / Territory	Population Aged 0–17 Years (2024) ('000)	Children in Need of Care & Protection (2024)	Rate per 1,000 Children (0–17 years)
Johor	1,108.4	1,037	0.94
Kedah	637.3	640	1.00
Kelantan	641.2	408	0.64
Melaka	273.5	516	1.89
Negeri Sembilan	349.2	407	1.17
Pahang	487.3	376	0.77
Perak	662.0	705	1.06
Perlis	68.8	211	3.07
Pulau Pinang	405.7	578	1.42
Sabah	1,120.9	1,181	1.05
Sarawak	627.1	470	0.75
Selangor	1,826.6	1,563	0.86
Terengganu	409.0	307	0.75
W.P. Kuala Lumpur	445.4	1,105	2.48
W.P. Labuan	30.7	55	1.79
W.P. Putrajaya	48.7	65	1.33
Malaysia (National)	9,141.8	9,624	1.05

The ethnic and sex of children identified in need of care and protection suggests that some groups are over represented (Table 8.3). This needs a detailed analysis by as to underreporting in others or increased risk factors in some. Population rates of abuse by ethnic groups may be required

Table 8.3: Children in Need of Care and Protection by Ethnic Group and Sex, 2024. Source: Department of Social Welfare annual report 2024.

Ethnic Group	Sex			Proportion of Total
	Male	Female	Total	
Malay	2,598	3,989	6,587	68.4%
Chinese	249	355	604	6.3%
Indian	283	349	632	6.6%
Peninsular Natives	19	74	93	1.0%
Sabah Natives	165	641	806	8.4%
Sarawak Natives	54	186	240	2.5%
Others	58	137	195	2.0%
Non-citizens	167	300	467	4.9%
Total	3,593	6,031	9,624	100%

Table 8.4 shows the breakdown of reported abuse by category/type. As mentioned earlier, the numbers for sexual abuse are lower as some teenagers are classified under rape.

Table 8.4: Child Abuse Reports by Type, Malaysia, 2001–2024. Source: Annual reports of the Department of Social Welfare, Malaysia.

Type of Abuse	2001	2010	2015	2019	2022	2023	2024	2025
Abandonment	70	54	104	168		59		86
Neglect	303	804	1,039	2,153		3,247		4,024
Physical abuse	287	438	673	1,571		2,008		2,599
Sexual abuse	251	871	921	1,856		2,630		3,228
Emotional abuse	56	49	78	120		120		191
Need Treatment						204		309
Others	69	22	45	514		268		467
TOTAL	1,036	3,257	4,453	6,382	6,770	8,536	9,624	10,904

Note: 2020–2021 data considered unreliable due to COVID-19 disruption to reporting services.

8.2.2 Profile of Abuse and Abusers

Data from official reports and community studies reveal a consistent profile. The abuser is known to the child in 90–95% of cases - challenging the myth of the ‘stranger danger’ narrative. Physical abuse is most commonly perpetrated by parents (mother or father). Sexual abuse is most commonly perpetrated by fathers, stepfathers, uncles, neighbours, teachers, or religious teachers. Among reported cases (JKM 2024 data):

- Girls account for 62.7% (6,031 out of 9,624) reported abuse victims.
- Community studies do not show significant ethnic differences in abuse rates.

8.3 Corporal Punishment, Parental Discipline & Physical Punishment

The 2022 National Health and Morbidity Survey (NHMS) 45.0% of Malaysian parents believe physical punishment is needed to bring up, raise or educate a young child properly. Among children 1 to 5 years of age the prevalence of use of violent discipline was 66.6%, physical punishment 40.6% and psychological aggression 58.1%. This normalisation of violence in the home is both a form of abuse in itself and a key risk factor for escalation to more severe physical abuse. Malaysia has not yet enacted a comprehensive prohibition of all forms of corporal punishment in the home.

Malaysia permits judicial corporal punishment (caning/whipping) of child offenders - a practice inconsistent with the UNCRC Article 37 prohibition on torture and cruel, inhuman, or degrading treatment or punishment. Despite the UNCRC Committee's repeated calls for Malaysia to abolish this practice, it remains in use. The Child Act 2001 retains the option of corporal punishment for child offenders in its original provisions.

Corporal punishment in schools is also legally permitted and widely practised, particularly caning of male students. This normalises violence against children and is at odds with modern evidence-based approaches to child discipline.

8.4 Children Exposed to Domestic Violence

Domestic violence is a significant risk factor for child abuse and a form of child maltreatment in its own right. The Women, Family and Community Development Minister reported in the media that 5,507 domestic violence cases were recorded in 2023, rising to 7,116 in 2024 and 7,391 in 2025 (Abdul Latif 2026). She also noted that the actual number could be higher as some go unreported. Children who witness domestic violence experience profound psychological harm, including anxiety, post-traumatic

stress disorder, and impaired development. The true incidence of children exposed to domestic violence is unknown because Malaysia does not systematically collect this data.

8.5 Teenage Pregnancy

Teenage pregnancy is both a consequence of child marriage and sexual violence, and a standalone indicator of inadequate sexual and reproductive health education and services for adolescents. A review showed more than 19,000 births to teenage mothers (aged 10–19) recorded each year between 2009 and 2011 (Mohd Suan et al. 2015). Overall, the percentage of teen births out of total national deliveries has dropped over the decades - decreasing from 10% in 1964, to 4.7% in 1984, and hovering around 3.7% to 3.9% between 2009 and 2011 (Mohd Suan et al. 2015). But there are regional disparities with a higher proportion of teenage pregnancies than the national average (teen births accounted for 9.2% of total births in Sarawak and 7.5% in Sabah (Mohd Suan et al. 2015).

Between 2020 and 2024, government healthcare facilities in Malaysia recorded 41,842 pregnancies among teenagers aged 19 and under, with roughly 40% (16,951) involving unmarried girls (New Straits Times 2025). Approximately 50% of total teenage pregnancy cases involve Malay teens, followed by 11% Iban, 9% Orang Asli in Peninsular Malaysia, 5% Chinese, and 3% Indian, with the remainder from various other ethnicities. According to the Ministry of Health Malaysia, Sarawak consistently reports the highest number of teenage pregnancy cases nationwide, followed closely by Sabah and Pahang (New Straits Times 2025). School dropout is common problem with teenage pregnancy.

Abandoned babies are often a tragic indicator of teenage pregnancy, child sexual abuse, and social crisis. Approximately babies are 100 abandoned yearly (Baqutayan et al. 2022; OrphanCare Foundation 2021). Sadly, many of these babies are found dead. These are almost exclusively infants of teenage mothers, many the result of sexual abuse. The consistent annual toll reflects a systemic failure in sexual and reproductive health education and support services for adolescents.

8.6 Missing, Runaway and Trafficked Children

Reported cases of missing children under 18 have increased annually. Figure 8.2 shows the rising trend. According to the Royal Malaysia Police (PDRM), approximately 71.8% of cases are voluntary runaways. Other causes include leaving school (3.36%), guardian abductions (1.14%), and accidents (3%). Females account for ~75% of reported missing children and the highest concentration of disappearances occur among teenagers aged 13 to 18. Authorities report a highly successful resolution rate, with 96% to 99% of missing children ultimately being located or returning home safely (New Straits Times 2026b).

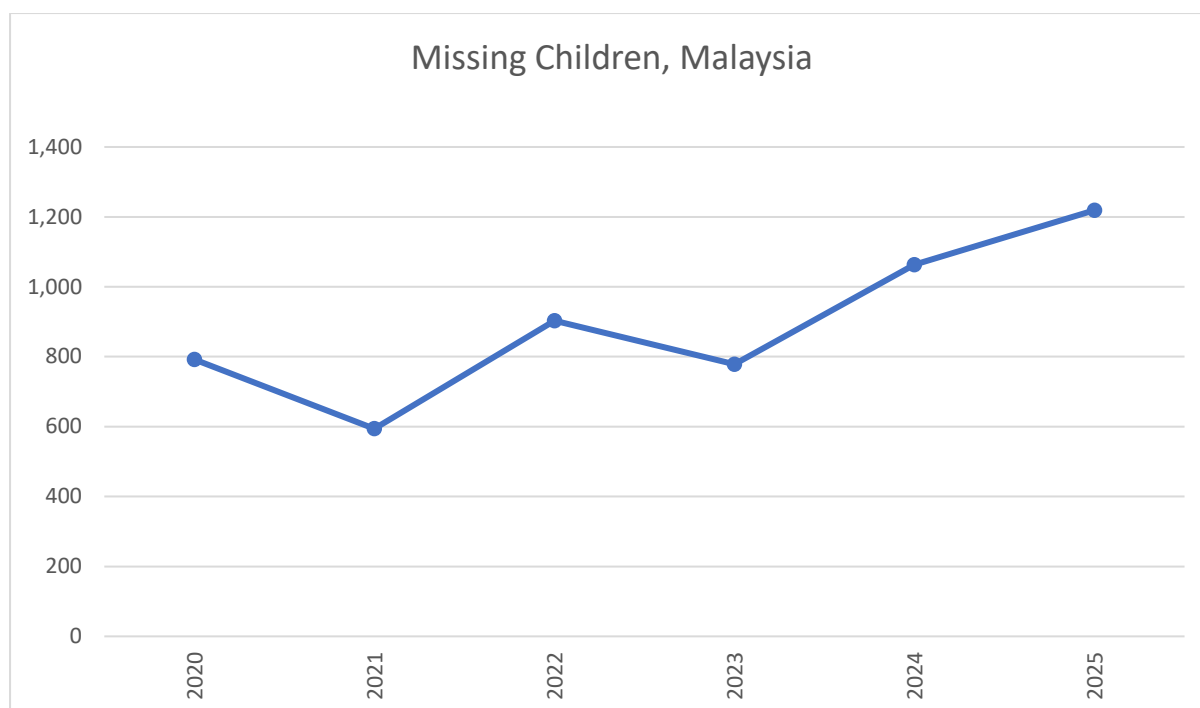


Figure 8.2: Missing Children 2020-2025 Malaysia. Source: media reports (New Straits Times 2026b).

Official, disaggregated statistics for purely trafficked children in Malaysia are difficult to isolate due to the secretive nature of the crime. However, human trafficking remains a significant issue (ECPAT Malaysia 2008). Malaysia is considered a source, transit, and destination country for women and girls trafficked for the purpose of sexual exploitation. According to the '2024 Trafficking in Persons Report', Malaysia, law enforcement initiated 157 total trafficking investigations and prosecuted 117 alleged traffickers across various exploitation types (U.S. Department of State 2024). Girls and vulnerable migrant children are at the highest risk for both labour and sexual exploitation, with many cases previously uncouned because victims are treated as immigration violators rather than survivors. The Anti-Trafficking in Persons Act 2008 provides a legal framework, but victim identification, survivor support, and reintegration services remain critically underdeveloped.

8.7 Children in Conflict with the Law

The number of children involved in crime decreased by 4.2% in 2024 to 2,627 cases (DOSM 2025). Bumiputera children made up 82.2% of this total, followed by Chinese (9.0%), Indians (4.9%), and others (4.1%) (DOSM 2025). Boys account for over 90% of cases. Assault and other crimes against the person rose sharply, from 486 cases in 2021 to 773 in 2023, even as drug and traffic offences fell. School-based disciplinary cases with criminal elements numbered 3,570 in 2024 - 3,113 among secondary students (153 per 100,000) and 457 among primary students (17 per 100,000) (Parliamentary replies by the Education Minister).

Children involved in crime are often themselves victims - of poverty, family dysfunction, lack of educational opportunity, and community violence. The current system remains insufficiently focused on rehabilitation and the underlying social determinants of juvenile delinquency. Malaysia still relies overwhelmingly on formal prosecution rather than diversion. A national diversion taskforce was set up in 2016 and piloted in only three districts from late 2019; it has not been rolled out nationally. Children found 'beyond control', a status category covering running away, truancy and defiance rather than a criminal offence, can still be institutionalised under the Child Act 2001.

Historic figures on children held in adult prison infrastructure, cited in earlier civil society reporting at 2,964 in 2004 and 9,000 in 2008, have not been updated in recent official statistics; current figures

should be sought directly from the Prisons Department and JKM as a priority data gap. The use of adult prison infrastructure for child offenders is inconsistent with the UNCRC and the Child Act 2001.

8.8 Bullying and School-Based Violence

Data suggest that bullying is pervasive in Malaysian schools. The Global Youth Online Behaviour Survey (Microsoft Corporation, 2012) found that 84% of Malaysian students (aged 8–17 years, n=7,600) had experienced bullying - making Malaysia one of the highest-ranking countries in this survey. The UNICEF World Children's Day survey in 2017 reported that 7 in 10 children in Malaysia (aged 9-18 years) worry a lot about bullying (CF: 3:10 Japan, 4:10 UK).

Official school records from MOE data substantially undercount this and showed 3,887 students found to be involved in bullying in 2022, 5,891 in 2023 and 5,703 in 2024(Oct) (Students Discipline System, Sistem Sahsiah Diri Murid, SSDM MOE 2025).

The National Health and Morbidity Survey 2022 (data affected by Covid-19 pandemic) showed that 8.6% of 13-17 year students reported been bullied in the past 30 days. In addition, 7.5% reported physical abuse at home and 43.2% reported verbal abuse at home. The same survey showed that 18.3% of teens reported they had been involved in cyberbullying activities (22.7% boys, 13.9% girls).

Table 8.5: Data Sheet on Bullying in Children & Adolescents in Malaysia

Malaysian Data	Year	Sample Size	Source & Notes
Children in Schools & Institutions			
Students found to be involved in bullying: 5,703 in 2024(Oct), 5,891 in 2023, 3,887 in 2022	2025	-	Students Discipline System (Sistem Sahsiah Diri Murid, SSDM), MOE
8.6% reported been bullied 7.5% reported physical abuse at home 43.2% reported verbal abuse at home	2022 (data affected by Covid-19 pandemic)	33,523 239 schools 13-17yrs Data for past 30 days	National Health and Morbidity Survey 2022
3 in 4 reported being bullied, especially humiliating name calling 83% subjected to bullying in the classroom 64% admitted been involved acts of bullying	2018	1,001 in school 1,010 online <18yrs	Children4Change survey, Kindness Project by UNICEF, social enterprise WOMEN & Ministry of Education
16.2% (1:6) reported been bullied (18.7% in boys, 13.7% in girls) - Rates 23% Form 1, 19% F2, 15% F3, 13% F4, 10% F5 - Most common forms of bullying: body/face shaming or sexual comments 11.8% reported physical abuse at home 41.0% reported verbal abuse at home	2017	27,497 212 schools 13-17yrs Data for past 30 days	National Health and Morbidity Survey 2017
Adolescents who experienced bullying were at a 4x higher risk of suicide attempts (aOR 4.8, 95% CI: 4.4, 5.6)	2107	Using NHMS 2017 data set	Liew et al, BMC Public Health 2023
CyberBullying			
13% cyberbullied 57.3% know someone cyberbullied	Published 2024	534 aged 15- 26yrs, using online Google Forms	Kee et al, Computers in Human Behaviour, 2024

Malaysian Data	Year	Sample Size	Source & Notes
18.3% reported they had been involved in cyberbullying activities (22.7% boys, 13.9% girls) - Common forms: rude comments, spread rumours	2022 (data affected by Covid-19 pandemic)	33,523 239 schools 13-17yrs Data for past year	National Health and Morbidity Survey 2022
28% young people say they have been a victim of online bullying especially via social media apps & online games. - Only 2 in 7 knew of a helpline to turn to if they are a victim of cyber bullying. 1 in 5 young people globally reported having skipped school due to cyberbullying	2019	6,953 13-24yrs	U-Report, UNICEF
1 in 4 parents say their child has experienced cyberbullying - Commonest cyberbully is a classmate 53%	2018	20,000+	Ipsos
40% cyber-bullied - Only 47% seek parents' advice when in difficulties 40% addicted to online peer pressure	2016	1,896 students 12-18yrs	Telenor Group
84% bullied (33% online, 69% offline)	2012	7,600 8-17yrs	Global Youth Online Behaviour Survey, Microsoft Corp.
General Data			
7 in 10 children in Malaysia worry a lot about bullying (CF: 3:10 Japan, 4:10 UK)	2017	11,000 9-18yrs	World Children's Day survey in 14 countries, UNICEF
16.5% (1:6) experienced mental health problems (prevalence doubled since 2019) 46% have peer problems (no good friends, bullied by other children, not liked by other children, etc) 25% have conduct problems (scared often, have tantrums, often disobey instruction, often lie, often fight with other children, etc)	2023	2,400 5-15yrs	National Health and Morbidity Survey 2023
66.6% (2:3) of children received some form of violent disciplinary method (58.1% psychological aggression, 40.6% physical punishment) 45.0% of parents believed that physical punishment is necessary to raise a child	2022	13,832 households 25,413 parents of children 1-5yrs	National Health and Morbidity Survey 2022: Maternal and Child Health
Data from community study on Adolescent Maltreatment 10-12yr olds: 67% at least one maltreatment (Physical 53%, Neglect 37%, Emotional 21%, Teacher 29%)	2011	3509 students Selangor	Ahmed et al 2015 PLoS ONE 56% urban, 99.5% living at home, unemployed fathers 4.7%, parental conflict 13.5%, parental drug abuse 1.7%
Data from community study on Adolescent Maltreatment 15-17yr olds: 45% at least one maltreatment (Physical 19%, Neglect 21%, Emotional 20%, Sexual 22%)	2006	1,870 Students Selangor	Choo et al, 2011 Society for Adolescent Health and Medicine Domestic violence 10%, parental mental illness 2%, parental drug use 2%
Children Involved in Crime: 3,457 in 2021, 3,013 in 2022, 2,743 in 2023	2024	Police reports	Children Statistics Malaysia 2024, Department Of Statistics Malaysia

8.9 Recommendations

1. Enhance mandatory reporting (legislation) requiring all teachers, those who work with children and the general public to report suspected child abuse and neglect.
2. Raise the minimum age of marriage to 18 years across all legal systems (civil and Syariah), with no exceptions. Implement this uniformly across all states.
3. Abolish corporal punishment in all settings - schools, homes, justice system - in line with UNCRC Article 37 obligations.
4. Substantially expand investment in child protection teams, social workers, and community-based child protection at the district level.
5. Develop a national online child safety strategy, including digital literacy education in schools, platform accountability mechanisms, and a rapid-response system for online CSEA reporting.
6. Urgently reform the residential care system with independent inspection, minimum standards, and genuine prioritisation of family-based alternatives.

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Section 9: Alternative Care, Foster Care and Adoption (Looked After Children & Residential Care)

1,517 registered child protection centres housed 38,955 children in 2024.

Only around 4,000 children were placed in family environments between 2019 and 2024.

There is no dedicated Foster Care or Adoption Act: both rely on thin provisions in the Child Act 2001 and two older adoption statutes.

The 2024 exposure of abuse in institutions underscored a systemic failure requiring urgent structural reform.

In Malaysia, looked-after children are children who are placed under alternative care when they cannot safely remain with their biological parents or usual caregivers. Child protection and residential care are governed mainly by the Child Act 2001 (Act 611), with the Department of Social Welfare Malaysia (JKM) playing a key role in child protection and welfare services. Children may be placed in residential care because of neglect, abuse, abandonment, family problems or the absence of a suitable caregiver. JKM operates residential institutions including Rumah Kanak-Kanak (RKK), which provide accommodation, food, clothing, education, healthcare, protection and supervision. Under the Child Act, the court may make protection and care orders for children who require care and protection. Malaysia's alternative-care framework also recognises family-based care, foster care and placement with relatives (kinship/relative care) as possible care arrangements. Therefore, residential care is one part of Malaysia's wider child-protection system and is intended to provide children with safety and basic care while appropriate longer-term arrangements are considered.

There were 1,517 registered child protection centres nationwide housing 38,955 children in 2024 (DOSM 2025). Of roughly 33,000 institutions registered with the Department of Social Welfare, only about 3,000 are welfare-related, and many of these care for children under 5, the age group least suited to institutional life.

Malaysia prioritises family-based care, placing only around 4,000 children in family environments between 2019 and 2024 (UN Committee on the Rights of the Child 2026). However, kinship care, foster care, and guardianship options remain underdeveloped, underfunded, and inadequately monitored.

Malaysia's alternative care system faces serious structural challenges. In 2024, a widespread exposure of abuse of children in institutions underscored a serious systemic failure requiring urgent structural reform (UN Committee on the Rights of the Child 2026). Some children experience chronic institutional abuse - including physical, sexual, and emotional mistreatment - within the very facilities meant to protect them.

There is no dedicated Foster Care or Adoption Act. Both are governed by thin provisions inside the Child Act 2001 and two separate, older adoption statutes, and the Department of Social Welfare remains the only authorised body to arrange foster placements.

Adoption under Malaysia's civil registration route does not legally extinguish a child's biological parentage, and Islamic adoption does not change lineage (nasab) or confer automatic inheritance rights, leaving many adopted children with an unsettled legal identity.

9.1 Foster Care: A System Without an Agency Sector

The Department of Social Welfare is the sole legal authority for arranging foster placements. There is no independent network of licensed foster care agencies of the kind found in many comparator countries; the one significant exception is the non-governmental organisation OrphanCare, which works alongside the Department to place infants, including babies surrendered through baby hatches, with

foster and prospective adoptive families. Academic reviews of the legal framework describe it as thin: the Child Act 2001 provides for foster care in principle but leaves the practical detail of standards, training, monitoring and support to departmental policy rather than binding law. Applicants apply directly to the Department, undergo interviews and training, and the process is not integrated with the wider architecture of the Act.

9.2 Adoption: Two Systems, Neither Fully Secure

Non-Muslim adoption in Peninsular Malaysia can proceed either as a de facto registration through the National Registration Department under the Registration of Adoptions Act 1952, or as a formal court order under the Adoption Act 1952; Sabah and Sarawak require a court order in every case. A child must ordinarily be fostered for at least two years before adoption can be finalised. Critically, registration under the 1952 Act does not sever the child's legal tie to their biological parents; it is described in the legal literature as an acknowledgment of custody rather than a full transfer of parentage. For Muslim children, adoption (anak angkat) under Islamic law does not change a child's nasab (lineage) or automatically confer inheritance rights, which can leave an adopted Muslim child without the surname, identity documentation consistency, or inheritance security that adoptive families often assume they are providing. These are not technicalities; they surface later in a child's life around school enrolment, marriage, and family disputes.

9.3 Institutional Oversight: The 2024 Wake-Up Call

This report already notes that a widespread exposure of institutional abuse in 2024 underscored serious systemic failure. That finding deserves to anchor a wider reform push. Malaysia has no independent inspection body for residential childcare institutions comparable to an ombudsman or inspectorate with statutory powers to enter, inspect and publish findings. Registration with the Department of Social Welfare is not the same as active, independent, published quality oversight.

9.4 Recommendations

1. Enact a dedicated Foster Care and Adoption Act, separate from the Child Act 2001, that sets binding national standards for recruitment, training, monitoring, and financial support of foster and kinship carers.
2. Set a national deinstitutionalisation target and timeline, with a specific, earlier target for children under 3 years of age, who should not be placed in institutional care except as a genuine short-term emergency measure pending a family-based placement.
3. License and fund a small number of accredited, independent fostering and adoption agencies to work alongside the Department of Social Welfare, ending its position as sole gatekeeper.
4. Establish an independent inspectorate for all registered childcare institutions, with statutory powers of entry and a legal duty to publish findings, in direct response to the 2024 institutional abuse revelations.
5. Reform the legal status of adoption, for both civil and Islamic adoption routes, to give adopted children clearer, more secure identity, inheritance and family status, closing the gap between what adoptive families believe they are securing and what the law actually provides.
6. Fund and expand kinship care and legal guardianship as a first option ahead of both institutional and stranger foster placement, recognising that many children needing alternative care already have extended family willing to care for them if given financial and practical support.

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Section 10: Child Marriage

About 15,000 child marriages were recorded in Malaysia between 2007 and 2017.

Married girls carry the greater risk of: early pregnancy, domestic violence, educational dropout and lifetime poverty.

Islamic family law sets the minimum age at 18 for boys and 16 for girls, but exceptions below these ages remain possible.

As of 2026, only Selangor and Kedah have raised the minimum marriage age to 18 for Muslims and non-Muslims without exceptions.

Child marriage remains a practice in some communities in Malaysia. Both boys and girls are affected, but the impact on girls is greater given the risks of early pregnancy, domestic violence, educational dropout, and lifetime poverty. Between 2007 and 2017, approximately 15,000 cases were recorded in Malaysia (UNICEF Malaysia 2021). There was drop in civil marriages during the height of the Covid-19 Pandemic and the implementation of the 'National Strategy Plan to Overcome the Cause of Child Marriage' by (KPWKM), but data suggests it is rising again (Figure 10.1).

The legal age for civil marriage for non-Muslims is 18 (with exceptions), while Islamic family laws set the minimum age at 18 for boys and 16 for girls. However, Syariah courts and state Chief Ministers retain the authority to approve exceptions below these ages. As of 2026, Selangor and Kedah are the only states that have fully amended their laws to raise the minimum legal marriage age to 18 for both Muslims and non-Muslims without exceptions.

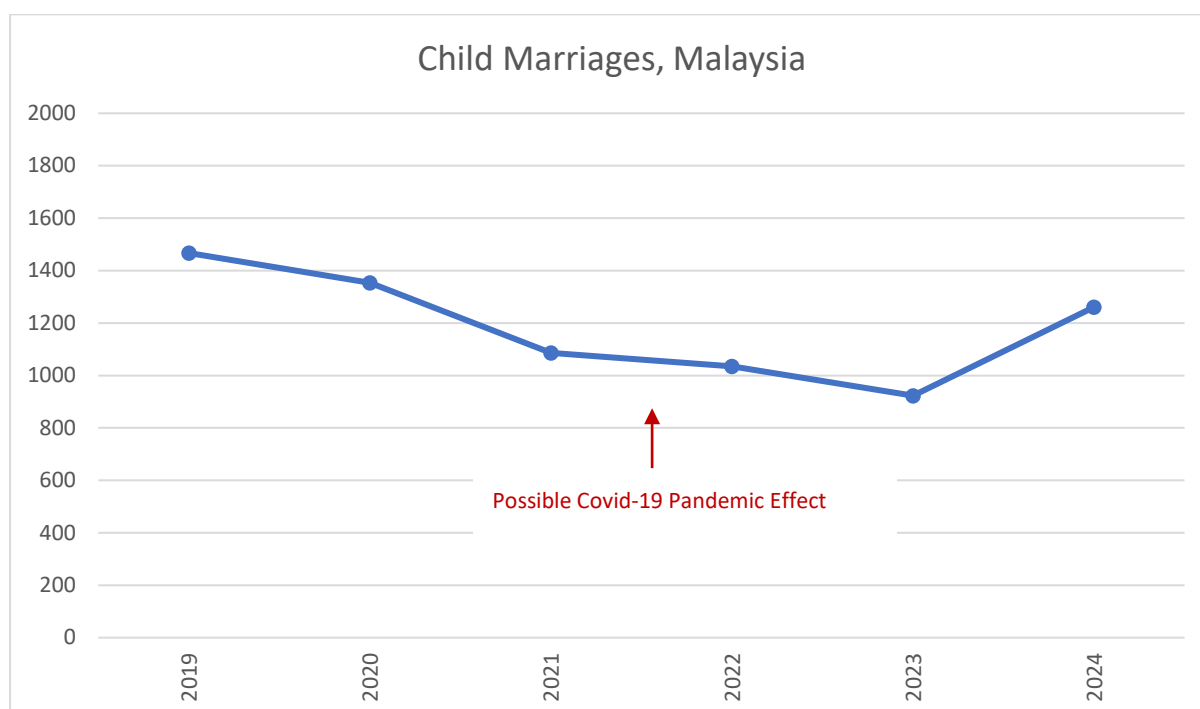


Figure 10.1: Child Marriages 2019-2024 Malaysia. Source: media reports (FMT 2025; New Straits Times 2026a).

10.1 The Unregistered Marriage Blind Spot

The state-by-state legal patchwork is itself only part of the picture. Even where a state has not closed the age loophole, the officially recorded marriages in Figure 10.1 capture only unions registered through the Syariah court or civil system. Unregistered religious marriages, sometimes referred to as *nikah tidak sah* or *nikah gantung*, are not counted anywhere in national marriage statistics, yet they are widely reported by civil society organisations working with at-risk adolescents as a route used specifically to

sidestep the minimum age requirement altogether. This means the declining or rising trend visible in official child marriage figures may not reflect the true trend in the underlying practice, only the trend in what is formally registered.

10.2 Marriage as a Shadow Child Protection Failure

A pattern that deserves explicit naming in this report is the use of marriage as an informal family or community resolution to a case of premarital pregnancy or, more seriously, sexual abuse. Where a girl becomes pregnant, whether through a consensual teenage relationship or through abuse by a known adult, one commonly reported resolution is for the family to arrange her marriage to the man involved, rather than to report the matter to the Welfare Department or the police. This has the effect of converting what should be a child protection or criminal case into a private family matter, permanently removing the girl from the very systems that exist to protect her. She is not counted as an abuse survivor. She is counted, if at all, only as a bride.

10.3 Recommendations

1. Require every state, not only Selangor and Kedah, to remove the exception clause permitting marriage below 18 under both civil and Syariah law, with no route for court or ministerial discretion to lower the age.
2. Mandate that any marriage application involving a party under 18, at the point it reaches a Syariah court, a Chief Minister's office, or a religious official, automatically triggers a child protection screening and referral to the Welfare Department to rule out coerced marriage, sexual abuse or trafficking, independent of whether the marriage itself is subsequently approved.
3. Criminalise and actively enforce against the solemnisation of unregistered religious marriages involving a minor, closing the loophole that currently allows the age limit to be sidestepped entirely outside the formal system.
4. Publish disaggregated annual data, by state and by stated reason for the application, on all marriage applications involving a minor, whether approved or refused, so that policy can respond to the real pattern rather than only the registered fraction of it.

End-of-Section References

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Section 11: Mental Health and Psychosocial Well-Being

Malaysia is facing a child and adolescent psychosocial (mental) health emergency
1 in 6 children aged 5–15 yrs has a psychosocial (mental) health problem
Vaping with substance abuse is fast becoming an adolescent crisis

11.1 Introduction

Malaysia is facing a child and adolescent psychosocial (mental) health crisis. The evidence shows that the trajectory is worsening, however the response remains inadequate. Every data point from each successive National Health and Morbidity Surveys - 2012, 2017, 2022 - shows a consistent and alarming escalation in mental health problems, suicidal ideation, depression, and anxiety among our children and young people. The COVID-19 pandemic significantly accelerated these trends. We can no longer treat this as a secondary or optional health concern - it is a public health emergency.

11.2 Psychosocial (Mental) Health in Children and Adolescents

The rate of children having a psychosocial (mental) problem rose from 7.9% in 2019 to 16.5% in 2022 - a doubling in just a few years (Institute for Public Health 2022). Table 11.1 compares data from NHMS 2012, 2017 and 2022 (Institute for Public Health 2022). Suicidal ideation has risen from 7.9% in 2012 to 10.0% in 2017 and 13.1% in 2022. While suicide attempt rates rose from 6.9% in 2017 to 9.5% in 2022. Loneliness and anxiety rates have doubled since 2012.

Table 11.1: Comparison of selected psychosocial (mental) problem from NHMS 2012, 2017 and 2022. Source: Institute for Public Health 2022.

Indicator	NHMS 2012	NHMS 2017	NHMS 2022
Loneliness	8.1	9.3	16.2
Inability to sleep due to worry	5.4	7.1	12.9
Suicidal ideation	7.9	10.0	13.1
Suicidal plan	6.4	7.3	10.0
Suicidal attempt	6.8	6.9	9.5
Not having any close friend	3.1	3.6	4.2

Suicide (intentional self-harm) is the fourth leading causes of death young people aged 15-40 years and the suicide mortality rate has increased from 2.0 in 2020 to 3.3 in 2024 per 100,000 population (Department of Statistics Malaysia 2025). Note that the World Health Organization (2020) quotes higher rates of suicide for Malaysia and lists suicide as the third top cause of adolescent fatalities globally (World Health Organization 2020); as can be seen from NHMS data.

The official number of recorded adolescent suicide deaths is widely acknowledged by public health experts to be an underestimation. Data collection for suicide, particularly in the adolescent demographic, suffers from systemic blind spots that obscure the true scale of the crisis. The National Suicide Registry Malaysia (NSRM), established in 2007, published its last comprehensive report in 2009 (Malaysia Mental Health Guide 2026). A replacement system - the National Suicide and Fatal Injury Registry Malaysia (NSFIRM) - has been under development since 2020. Comprehensive data from this system has not yet been released publicly. This data gap is in itself a policy failure - we cannot effectively address a crisis we do not properly count.

The Section 309 of the Penal Code, which criminalised attempted suicide, was repealed in May 2023 - a landmark development. However, this legislative change must be accompanied by investment in

services if it is to result in young people seeking help rather than simply facing fewer legal consequences (Malaysia Mental Health Guide 2026).

The Malaysian Youth Mental Health Index 2023 (Institute for Youth Research Malaysia & UNICEF 2024), covering 6,000 participants, gave an overall rating of 71.9 - indicating 'moderate risk.' The worst scoring areas were Surrounding Environment Domain (65.5), Social Support Domain (68.3), and Healthy Mind Domain (66.1). This data suggests that youths find their environments not very supportive (especially physical environments and social expectations), are receiving inadequate support from family, significant others, and experts, and many have some degree of anxiety and depression.

11.3 Adolescent Risk Behaviours

Table 11.2 compares data from NHMS 2012, 2017 and 2022 of selected adolescent risk behaviours (Institute for Public Health 2022). Of serious concern is the problem of vaping. NHMS 2022 showed that for school students aged 13-17 years, 14.9% were e-cig/vape users (23.3% male and 6.2% female). This would mean that of the approximately 2.7 million children (2022 data) aged 13-17 years, about 300,000+ are vaping. Today that number would easily have reached 4-500,000 and is growing rapidly.

The access and promotion of vape products to young children and teenagers is widespread, often found just outside school premises. Many primary school students are interested in vaping. Most youth think it is 'cool' to vape and probably harm-less as the government has chosen not to ban vaping. Vaping allows for the easy addition of many substances, often harmful or addictive (Deputy IGP Ayob Khan recently disclosed, 65% of confiscated vape devices contained synthetic drugs such as methamphetamine and fentanyl). Vaping has resulted in a crisis in our youth, with an enormous health and social burden that we are generating for the near future.

Table 11.2: Comparison of selected adolescent risk behaviours from NHMS 2012, 2017 and 2022. Source: Institute for Public Health 2022.

Risk Behaviour Indicator (%)	NHMS 2012	NHMS 2017	NHMS 2022
Current Smoking (Cigarettes)	11.5	13.8	6.2
Current E-Cigarette / Vape Use	N/A	9.8	14.9
Current Alcohol Consumption	8.9	10.2	7.4
Current Drug / Substance Abuse	1.5	3.4	1.4
Ever Had Sexual Intercourse	8.3	7.3	5.9
Involved in Physical Fights (Past 12 Months)	18.3	14.1	13.2

11.4 Contributing Factors

To plan any meaningful and real action plans, we need to understand the reasons behind this global growing 'psychosocial' pandemic. The reasons are complex and include the loss of social community especially extended families, massive growth of impersonal cities, the addiction and dependence on screens and social media by both adolescents and adults, the loss of green lungs with an environmental/climate crisis, the enormous academic pressure and the loss of a future/hope for our children.

Hence the action plan needs to call for long term prevention via a transformation of our cities and social life. We require meaningful connections and relationships that are not screen based. We require numerous city-based green lungs for families to hang out and find each other. We require clean air (worsening air pollution is linked to suicides). We need to change the focus of society on what constitutes success - relationships - and not achievements, acquisition, ability or fame.

While we work on prevention, we also have to identify youth currently struggling with psychosocial issues. Parents need to invest more time in listening to their children. Teachers must be aware that it is happening to the children they are teaching in class. The government needs to invest in the expansion of psychosocial services for adolescents nationwide and this requires targeted federal funding.

11.5 Gaps in Services

The MOH National Strategic Plan for Mental Health 2020–2025 targeted reduction of adolescent depression from 18% to 10% by 2025 (Ministry of Health Malaysia 2020). Given the 2022 NHMS data showing 25% of adolescents with depression, this target has not been achieved. Despite the scale of the crisis, Malaysia's mental health service infrastructure for children and adolescents is woefully inadequate (Malaysia Mental Health Guide 2026). Community-based mental health services for children and adolescents are almost non-existent outside major urban hospitals. School-based counsellors are present but trained in academic guidance rather than clinical mental health support. Adolescent psychiatric and psychological services have long waiting lists in most government hospitals. There are no dedicated adolescent health inpatient facilities in most states. Access for poor urban communities, rural communities, indigenous children, and migrant/refugee children is essentially nil

11.6 Recommendations

1. Declare child and adolescent psychosocial (mental) health a national emergency, with dedicated federal funding allocation separate from the general mental health budget.
2. Develop school-based mental health support programmes in all government schools, staffed by trained counsellors and psychosocial workers - not repurposed academic counsellors.
3. Establish dedicated adolescent mental health drop-in centres, accessible without parental consent, sited in locations accessible to young people (community centres, near schools, online).
4. Invest in community-based psychosocial services for rural, indigenous, poor urban, and non-citizen communities.
5. Fully implement and resource the National Suicide Registry with publicly accessible annual data.
6. Address the social determinants of adolescent mental health - particularly academic pressure, online harms, and family poverty - through cross-sectoral policy action.

End-of-Section References

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Section 12: Early Childhood Care and Education (ECCE)

(Current Landscape, Government Policies, Challenges & Strategic Directions for the ECCE Sector)

Preschool enrolment has reached approximately 90%, but reform must pursue access and quality together.

About 2.31 million children are under 5, yet only 62,870 are enrolled in registered TASKA.

Fragmented governance across several ministries is the central structural problem of the ECCE sector.

RMK13 (2026–2030) proposes compulsory preschool at age five.

12.1 Executive Overview

Early Childhood Care and Education (ECCE) is the foundation for lifelong learning, health, well-being, social-emotional development, identity and participation. Birth to six is not merely preparation for formal schooling, it is a critical period requiring care, protection, nutrition, responsive relationships and high-quality learning.

Malaysia broadly operates two interconnected streams: Taman Asuhan Kanak Kanak (TASKA) for children below four, and Taman Didikan (TADIK/TABIK) preschool programmes for children ages four to six. Although administratively separated, they form one developmental continuum. The ecosystem includes the Ministry of Women Family and Community Development (MWFC), Ministry of Education (MOE), Community Development Department Ministry of Rural Development (KEMAS), Department of National Unity and Integration Ministry of National Unity (JPNIN), Department of Labour, Ministry of Human Resource (JTK) State Religious Authorities, Local Authorities, employers, NGOs, communities and private providers.

TASKA are principally regulated by MWFC through the Department of Social Welfare (DSW) under the Child Care Centre Act 1984 [Act 308] and Child Care Centre Regulations 2012. The system covers registration, inspection and enforcement and includes institutional, workplace, community and home-based TASKA. The Kursus Asuhan PERMATA (KAP) Certification applies as the only compulsory qualification for operators, managers, supervisors and care providers. Recent measures include childcare fee subsidies for eligible families, tax relief for fees paid to registered TASKA/TADIK, strengthened enforcement, and since January 2025 registration plaques with QR codes so parents can verify TASKA registration. Licensing remains a key challenge with only 3,592 childcare centres registered. Licensing for thousands of homebased TASKA/ Care providers and community-based TASKA is almost nonexistent due to unresponsive and outdated legislation and regulations. Hence, we see the rapid increase in the number of illegal childcare centres and new forms of informal childcare including playgroups, toy libraries, early intervention centres, activity centres and even on call childcare services which meet the needs of working parents

TADIK /TABIK come under the purview of the Ministry of Education (MOE) RMK13 (2026–2030) proposes compulsory preschool at age five. MOE has also introduced Kurikulum Prasekolah 2026 and Kurikulum Prasekolah 2026 (Pendidikan Khas) as the current National Preschool Curriculum across preschools/kindergartens in the National Education System. While enrolment rate has reached approximately 90%, reform must pursue access and quality together: affordability, inclusion, safeguarding, workforce status, ratios, curriculum, assessment, infrastructure, nutrition, family engagement and monitoring .

The central structural problem is fragmented governance: registration, regulation, financing, workforce development, curriculum, monitoring and quality assurance sit across different institutions. From the child's perspective, however, care, education, health, nutrition, protection and social-emotional

development are inseparable. The administrative split must not be mistaken for a developmental split: physical development, health/nutrition, attachment, language, cognition, social-emotional development, identity, protection, play and early learning develop within a seamless continuum

12.2 Overall Structure of Malaysia's ECCE Sector

Malaysia's ECCE Sector is regulated through various Ministries and Agencies :-

- **MWFC/DSW:** TASKA registration, regulation, monitoring and enforcement of TASKA under Act 308 and the 2012 Regulations; quality includes responsive caregiving, secure relationships, health/nutrition, protection, developmentally appropriate learning, inclusion and family partnership.
- **MOE:** National preschool policy/curriculum plus direct provision in government primary schools and other MOE institutions; Kurikulum Prasekolah 2026 strengthens common expectations, while RMK13 provides financing for expansion to the most marginalised
- **KEMAS** under Ministry of Rural and Regional Development (KKDW): major community- based provider, especially in rural, semi-urban and lower-income communities. TASKA

KEMAS serves children ages 2–4 while TABIKA KEMAS serves ages 4–6. Both are highly subsidised and support social inclusion.

- **JPNIN** under the Ministry of National Unity: TASKA Perpaduan generally serves ages 2–4; TABIKA Perpaduan (TP) serves ages 4–6 and adds unity, patriotism, Rukun Negara, respect for diversity and positive values. Its 2021–2030 plan addresses curriculum, professionalism, governance, partnerships, monitoring and evaluation. A 2026 JPNIN review reported no increase in additional TASKA/TABIKA since 2013 despite demand, and uneven distribution across states/residential areas.
- **JTK/MOHR:** primarily regulatory rather than an ECCE provider. Estate employers must provide a childcare/creche facility where at least five dependents aged four and below reside, linking childcare with labour, welfare and women's employment.
- **Jabatan Agama Islam Negeri (JAIN) / Majlis Agama Islam Negeri (MAIN)** and related Islamic institutions: operate or support Tadika Islam/Agama and, in some jurisdictions, childcare. Provision integrates mainstream ECCE with Quranic learning, doa, akhlak, adab, religious knowledge and Muslim identity. Governance varies by state. MAIWP provides a continuum through TASKA Permata Junior MAIWP, TADIKA Permata MAIWP and MAIWP Kids.
- **Private and employer-based:** Provided through NGO, charitable, faith-based, community, home-based, cooperative (MARA, ANGKASA) and state-foundation services further diversify provision. Diversity is a strength only if common minimum expectations protect safety, competency, inclusion, health/nutrition, infrastructure, curriculum, monitoring and quality.

12.3 Legislative and Policy Framework

Malaysia has substantial ECCE legislation but no single comprehensive birth-to-six ECCE law. Childcare below four is mainly governed through the TASKA framework; preschool ages four to six principally through the Education Act 1996 [Act 550] and national preschool framework. Other government agencies operate under their own legislation as well Hence the fragmentation of governance over the ECCE Sector

12.3.1 Act 308 and TASKA

Act 308 establishes registration, regulation, inspection and enforcement of TASKA. Registration may require compliance with PBT, BOMBA, health authorities and other technical/land authorities.

The Child Care Centre Regulations 2012 address premises suitability/safety, minimum space, sanitation/hygiene, caregiver-child ratios, personnel qualifications/training,

health/safety/nutrition/menus, routines/activities, furniture/equipment/materials, records, emergency procedures and other security/monitoring requirements. The Child Care Centre (Compounding Offences) Regulations 2011 specify compoundable offences and procedures.

Kursus Asuhan dan Didikan Awal Kanak-Kanak PERMATA (KAP) is the core compulsory professional competency route for relevant childcare personnel. It covers and integrates holistic child growth/development, responsive care and stimulation, health, nutrition, safety, protection, learning environments, observation, developmental support, parent and family partnerships.

12.3.2 Act 550 - Education Act 1996

Act 550 formally places preschool/kindergartens in the National Education System. It covers establishment, operation and registration of kindergartens, use of the National Preschool Curriculum and ministerial authority. Private TADIKA registration supports minimum expectations for governance, premises, health/safety, personnel, curriculum, records, learning environments and technical-authority compliance. KPM issued updated guidelines for establishment, registration and operation of private educational institutions in January 2026.

Kurikulum Prasekolah 2026 and its Pendidikan Khas counterpart, implemented through SPI KPM Bil. 1/2026, replace the previous framework for relevant institutions and strengthen consistency across KPM, public agencies and private providers. SKPK/SKPK 2.0 adds quality assessment covering teachers/assistants, governance, curriculum, engagement/interaction, health, nutrition and safety.

12.3.3 Act 751 Rukun Tetangga Act 2012: Provides the Rukun Tetangga/community framework supporting JPNIN structures. JPNIN operational guidelines govern TASKA/TABIKA Perpaduan alongside applicable ECCE law.

12.3.4 Act 446 (the Workers' Minimum Standards of Housing, Accommodations and Amenities Act 1990) and Regulations: Addresses childcare in plantations requiring plantation owners to establish creches within their plantations

12.3.5 State Enactments/Rules cover Islamic TASKA and TADIKA.

Each State has its own Enactment or Rules For example in Selangor this includes the 2003 Administration of Islam Enactment and 1988 Control of Islamic Religious Schools Enactment.

JAKIM's SIMPENI (Islamic Education Information System) run under the Department of Islamic Development Malaysia (JAKIM) is a national information/coordination platform, not the principal state regulatory law. It verifies Islamic educational institutions, manages data and provides public access to these institutions

12.4 Malaysia's ECCE Data Landscape: Childcare for 0-4 Years

12.4.1 Data on Children under 5 and Registered TASKA

Registered TASKA statistics describe only the formal system. They do not capture care by parents, grandparents, relatives, domestic caregivers, babysitters or informal home-based carers

Table 12.1: TASKA Data 2023 -2025

Indicator	Figure	Year
Children under 5	2.31 million	2025
Registered TASKA	3,198	2024
Registered TASKA	3,155	2023
Children enrolled in registered TASKA	62,870	2024
Registered TASKA enrolment	60,785	2023
Growth in registered TASKA	+1.4%	2023 - 2024
Growth in registered enrolment	+3.4%	2023 - 2024

The contrast between 2.31 million children below five and 62,870 children enrolled in registered TASKA is striking, but it must not be presented as a precise 2.7% childcare-access rate because the age definitions and reference years differ and many children are cared for outside registered TASKA. It does show that formally registered TASKA represents only a very small part of the childcare ecosystem. A fundamental question that needs to be addressed is where, by whom and under what conditions are the remaining young children cared for?

12.4.2 State distribution, 2024

Adequacy cannot be judged from centre counts alone; population size, age structure, parental employment, urbanisation, centre capacity, affordability and geography matter. The data summary below indicates that Selangor has the highest provision, Johor has a 29.4% rise in registered centres, but KL/Putrajaya are facing operator decline alongside enrolment growth. Perak is experiencing strong enrolment pressure.

Table 12.2: TASKA data by States

State/Territory	Registered TASKA	Children enrolled
Selangor	945	14,032
Johor	361	5,397
Sabah	225	3,267
Perak	194	5,608
W.P. Kuala Lumpur	193	6,319
Kelantan	175	4,796
Pahang	149	3,126
Pulau Pinang	146	2,778
Negeri Sembilan	144	2,446
Terengganu	140	2,823
Sarawak	138	3,150
Kedah	132	2,673
Perlis	43	721
W.P. Labuan	20	360

12.4.3 Childcare Gaps, Informal Care and Demand Pressure

Formal–informal gap

Malaysia's care continuum runs **from parents → grandparents/relatives → domestic caregivers → babysitters → informal home-based care → registered TASKA**. National planning therefore needs data on parental/family care, informal paid care, unregistered home-based childcare, workplace childcare, demand, affordability, geographic accessibility, family preferences and unmet need.

Workforce data gap

JKM requires recognised KAAK/KAP training and age-specific caregiver-child ratios. It is noted that a nationally consolidated current figure for active registered TASKA childcare providers who have completed KAP is available through the National Child Development Research Centre (NCDRC). The data substantiates the fact that Malaysia needs a comprehensive workforce information system tracking numbers, qualifications, training, employment status, turnover, remuneration and CPD to be able to work on a roadmap for career pathways that enables childcare providers to be recognised as professionals

While Malaysia's overall female labour force participation rate stands at **56.6%**, women's participation varies heavily across specific sectors, industries, and job types. Women make up the dominant majority in household /care work with 92% involved in household work with 68.7% in health and social work and

65.4% in education. The World Bank Report -Breaking Barriers 2019 recommended expanding the availability, quality and affordability of childcare services as part of a comprehensive policy approach to enabling participation of women in the workforce

Estimated supply gap

The NCDRC data describes a substantial formal childcare access gap with barely 62,000 children enrolled. As Malaysia moves towards enabling participation of women in the workforce. With an estimated 2.3 million children aged four and below it was suggested that a structural requirement of 20,000–30,000 registered centres against the current 3,592 licensed centres, implying a deficit above 80%. These estimates are not equivalent to official national counts, and illustrate the need for a verified demand/capacity model for

Planning should link: Population → Demand → Registered Capacity → Workforce → Affordability → Location → Quality → Unmet Needs.

Urban and rural differences

Urban areas face high rent, salaries, compliance costs and waiting lists; rural/remote areas face distance, dispersed populations, transport, infrastructure and workforce shortages. Low-density communities may not sustain conventional centres, increasing the importance of registered home-based and community models.

- Selangor is the largest formal market;
- Johor is identified as a fast-growing market (+29.4% in the report's trend analysis).
- KL/Putrajaya are described as an urban paradox: high rents/safety compliance with an 8–10% operator decline, while enrolment rose 8% in KL and 10% in Putrajaya.
- Perak is described as having a 33% increase in enrolment demand;

The policy objective is not merely to have more centres, but safe, affordable, accessible and developmentally appropriate childcare for every family that needs it.

12.5 The Preschool Sector: Children Aged 4–6

12.5.1 Preschool Data

Malaysia has a large, diverse preschool sector delivered by government, public agencies, private, religious, NGO and community providers. Unlike registered TASKA, preschool participation is substantially higher, especially near primary-school entry.

Table 12.3: Preschool Data 2023

Key indicator	Malaysia 2023
Preschool institutions	24,828
Preschool teachers	67,013
Children enrolled	788,950
Government/public preschool institutions	More than 16,700

These figures, drawn in the report from Malaysia Educational Statistics 2023 and the World Bank Malaysia Economic Monitor 2024, shows that preschool is a major national social and educational service. MOE statistics separately record KEMAS, Perpaduan, JAIN, ABIM and private kindergartens. Government provision is central to affordability and equity while private providers add substantial capacity and workforce.

Table 12.4: Overall enrolment in preschools / kindergartens

Age cohort	2021	2023
4+	68.45%	77.95%

Age cohort	2021	2023
5+	83.65%	90.67%

Malaysia is approaching very high participation among five-year-olds, but gaps remain, especially for younger preschool-aged children. MOE opened 119 additional preschool classes in 2023 to increase participation. But in remote areas in Sabah, Sarawak, Kelantan, Pahang, Johore and Perak where indigenous children live preschool education remains hard to access

12.5.2 Access is not the same as quality

Almost 789,000 enrolments and a large provider network gives Malaysia a strong platform for universal participation. However, quality can still be weakened by insufficiently qualified or supported educators, staff turnover, limited play/learning resources, constrained environments, insufficient support for disability/additional needs, inconsistent pedagogy, affordability geographical barriers and weak continuity between TASKA and preschool.

The strategic question is therefore no longer only “How many preschool places does Malaysia have?” but whether every child can access a preschool that is affordable, inclusive, safe and consistently high quality. This becomes more urgent with RMK13’s proposed compulsory preschool at age five. Universal participation and universal quality must advance together, with government and non-government providers included. The World Bank’s 2024 Malaysia Economic Monitor, Bending Bamboo Shoots reinforces the importance of early education and foundational skills for long-term human-capital development.

12.6 Challenges in the ECCE Sector

12.6.1 The Central Challenge: Fragmented Governance Across 0 -6 years

Malaysia has no single authority responsible for the complete birth-to-six continuum. Different agencies hold different functions. Fragmentation does not necessarily require moving every function into one ministry; specialised responsibilities can remain if national coordination is stronger. Fragmentation currently produces differences in licensing, funding, curriculum, workforce qualifications, remuneration, professional development, inspection, data collection, inclusion, infrastructure and parent support.

12.6.2 Childcare-sector pressures

Care gap: only a small share of children under four are in registered TASKA; many rely on family or unregistered home-based care.

- **Urban/rural shrinkage:** high overheads and staffing deficits can reduce registered provision despite demand.
- **Mandatory staff requirements:** accredited-centre caregivers require government-approved training such as KAP.
- **Low Level Compulsory Qualification:** Since 1984 when the Childcare Centres Act was implemented the minimum qualification is still at Certificate level. There is no requirement for minimum Diploma for childcare providers.
- **High turnover:** trained workers leave for higher-paying sectors, reducing returns on operator training.
- **Financial constraints:** limited budgets restrict high-quality training and external expertise.
- **Coverage shortages:** substitute educators are difficult to find during training.
- Paid training time increases payroll costs.
- Staff educational backgrounds vary widely, making one-size-fits-all training ineffective.
- Evolving licensing/regulatory requirements add administrative burden.

- Burnout and low morale reduce engagement with mandatory training.

12.6.3 Access, Affordability and TASKA Sustainability

Quality childcare has unavoidable costs: qualified staff, legal ratios, rent/utilities, food, insurance, maintenance, learning resources, safety equipment, professional training and administrative compliance. Yet families may be unable to absorb higher fees. The core tension is: affordable fees for parents + sustainable income for providers + high-quality care for children.

The existing Subsidi Yuran Pengasuhan supports eligible children in registered TASKA, however this is limited. It is recommended that any subsidy policy should evolve to balance family affordability and provider viability. In 2025, KPWK publically acknowledged childcare-cost and TASKA-sustainability concerns and considered the future of subsidies alongside stronger caregiver professionalism and structured training.

12.6.4 Challenges for Corporate/Workplace Childcare

As of 2024, there are 265 registered workplace nurseries across the country, with 221 in the public sector and 44 in the private sector. Workplace childcare potentially improves staff retention, decreases absenteeism and increases productivity. Operational ROI figures include turnover reductions of up to 50%, absenteeism reductions of 20–30%, and about 23% of working parents reportedly declining competitive job offers to retain childcare access.

There are corporate tax deductions for childcare allowances; Industrial Building Allowance, described as typically 10% annually for qualifying capital expenditure; tax-exempt childcare perquisites up to specified thresholds such as RM3,000 per year in Malaysia; and, in some regions, additional deductions for extended paid caregiving leave. Yet the uptake by the corporate sector remains very low.

Why workplace childcare up- take remains low

- High capital cost for compliant premises, furniture, safety modifications and maintenance.
- Permanent staffing overheads to maintain legal ratios and qualified personnel.
- Multi-agency compliance and perceived civil liability for children's safety.
- SMEs often lack capital, headcount and space.
- Industrial sites/high-rises may be poorly suited or zoned for young children.
- Hybrid/remote work can shift preference towards childcare near home rather than at the office.

12.6.5 Human Resources Challenges: The Most Important Quality Factor

There is a national ECCE workforce crisis driven by low wages, qualification deficits and fragmented oversight. Raising quality is difficult if qualified personnel cannot be recruited and retained.

- Current professional-development pathway
 - **KAP:** recognised JKM training for relevant TASKA personnel.
 - **MOHR/JPK:** SKM Level 3 in Early Childhood Care and Development through structured workplace learning/National Dual Training System (SLDN).
 - **Recognition of Prior Achievement (PPT):** experienced carers may obtain SKM certification through assessment of prior workplace experience and competence against NOSS.
 - **HRD Corp:** levy-claimable courses can include toddler/classroom management, inclusive learning, lesson planning and Occupational Safety and Health in childcare.
 - **Jabatan Tenaga Kerja Semenanjung Malaysia(JTKSM):** briefings on employment rights, minimum wage, statutory hours and relevant employment law; the report also notes child-labour /workplace-safety induction initiatives.

- **Preschool professional pathways:** Diploma in Early Childhood Education and degree/postgraduate ECCE programmes; the report links these to the policy expectation for preschool teachers to hold at least a Diploma.

Major manpower challenges

- **Qualification gap:** the report states roughly half of the workforce still does not meet the Diploma standard, with up to 73% of private preschool teachers lacking the required qualification; childcare personnel have a different minimum training/certificate route.
- Severe wage deprivation encourages qualified educators to leave for better-paid sectors.
- **Affordability paradox:** operators cannot substantially raise wages without increasing parent fees because provision relies heavily on parental fees.
- High attrition/burnout arises from ratios, non-teaching workload and long operating hours.
- Fragmented regulation consumes management time.
- Low social status and flat career structures reinforce the perception of ECCE workers as ‘babysitters’ rather than skilled professionals.

Table 12.5: Workforce Challenges

National challenge	Consequence	Long-term threat
Low public funding	Centres absorb operating costs	Growth of risky/unregistered care
Mandatory Diploma policies	Unqualified staff displaced	Local staffing shortages
Enrolment capping	Insufficient staff for ratios	Parents lose care options/workforce participation

12.6.6 Recommendations: Financial and Workforce Interventions

The Khazanah Research Institute reports that Malaysia's childcare ecosystem relies heavily on private providers, which often leads to high costs and a lack of standardisation. There is a critical need to address the issue of affordability as even the M40 group cannot afford the cost of childcare for their children. Below are some recommendations to finance the cost of childcare:-

Professionalisation with subsidised upskilling

National qualification mandates should be paired with grants/subsidised pathways such as KAP and CPD so existing staff are not simply displaced. The aim is to raise competency without worsening shortages.

Supply-side institutional support

Direct grants, per-capita support, infrastructure upgrades and establishment incentives can reduce rent, food and safety-compliance pressure, freeing centre resources for wages and substitute staff. A limitation is that grants do not automatically guarantee that savings are passed on to staff salaries.

Conditional fee subsidies and formalisation

JKM's Subsidi Yuran Pengasuhan at RM180 per month per eligible child in a registered centre is limited. Linking support to registration can encourage formalisation, bringing staff into regulated workforce systems and associated wage/social-security requirements.

Expansion of public employment ecosystems

Expansion of KEMAS TABIKA and government-aided preschool can establish structured salary, benefits and career benchmarks and elevate ECCE's status from temporary care work to a viable profession.

Fiscal integration and workplace incentives

Currently RM3,000 childcare tax relief and corporate tax deductions for employers establishing on-site childcare is available but not attractive enough for employers. Corporate-backed centres may have

stronger budgets, HR systems and administrative support, although benefits may be concentrated in urban formal employment.

Table 12.6: Financial and Workforce Interventions

Policy instrument	Immediate benefit	Structural blind spot
Upskilling mandates & grants	Standardises quality	Trained staff may migrate to better-paid sectors
Direct institutional grants	Frees funds for payroll	No guaranteed surplus goes to wages
Workplace/on-site subsidies	Create stronger corporate ECCE jobs	May leave rural educators behind

National ECCE Workforce Framework and Strategy

A national ECCE workforce strategy should align qualification levels, competency standards, salaries, CPD, supervision, career progression, retention and workforce data. The report's long-term aspiration is to transform ECCE from a low-paid care occupation into a recognised professional career

12.7 Curriculum and Safeguarding

12.7.1 National Curriculum Frameworks

Malaysia already has curriculum/developmental foundations: PERMATA for birth to four integrates care, health, nutrition, safety and physical, language, cognitive, socio-emotional and spiritual development. The Kurikulum Prasekolah 2026 and its Pendidikan Khas curriculum provide the current national preschool direction for ages four to six across MOE, public agencies and private agencies. The preschool framework emphasises communication, positive self-concept/confidence, physical health/safety, values, creativity, social development, critical/creative thinking and readiness for subsequent learning. The next challenge is implementation quality, not another curriculum.

12.7.2 Child Protection Policy and Safeguarding

In 2026 KPM introduced Garis Panduan Pengurusan Sekolah Selamat and Polisi Perlindungan Murid through SPI Bil. 3 and Bil. 4/2026. For TASKAs there is no compulsory requirement for TASKAs to have a Child Protection Policy. Safeguarding must be a core ECCE quality dimension, especially because very young children may be unable to recognise, communicate or report unsafe behaviour.

- Safer recruitment and staff screening.
- Codes of conduct and appropriate adult-child boundaries.
- Child-safe environments and prevention of abuse/neglect.
- Reporting/referral procedures, staff training and supervision.
- Incident management.
- Developmentally appropriate mechanisms for children's voices.

12.7.3 From curriculum compliance to child experience

Two centres may use the same curriculum but provide very different experiences. Quality depends on *educator competence* → *adult-child interaction* → *learning environment* → *play opportunities* → *inclusion* → *leadership* → *safeguarding* → *family engagement*.

Quality assurance should therefore ask not only whether the prescribed curriculum is implemented, but what the child experiences each day. This shifts the system from curriculum compliance to quality implementation.

12.8 Quality Improvement and Accreditation

12.8.1 National ECCE Quality Framework

A National ECCE Coordination and Quality Framework should link KPWK/JKM + KPM + KEMAS + JPNIN + State religious authorities + local authorities + private providers + employers + civil society. It should establish common child outcomes while preserving institutional identities. The long-term goal is one birth-to-six system rather than two disconnected childcare and preschool systems.

12.8.2 Continuous improvement, not inspection alone

Common principles should apply from birth to six while indicators remain age-appropriate;

practice for a six-month-old cannot be identical to practice for a five-year-old. The proposed cycle changes quality assurance from '*Find faults → Issue instructions → Pass/Fail*' to '*Assess → Understand → Support → Improve → Monitor → Sustain Quality*'.

A fuller cycle is *Registration → Self-assessment → External assessment → Improvement plan → Professional support → Reassessment*.

Table 12.7: Quality Dimensions

Quality dimensions	What should be assessed
1. Safety & safeguarding	Recruitment, supervision, conduct, protection, reporting, safe environments
2. Educator–child interaction	Warm, respectful, responsive, developmentally appropriate relationships
3. Curriculum implementation	PERMATA/ Kurikulum Prasekolah translated into daily experience
4. Learning through play	Exploration, creativity, movement, imagination, child-initiated learning
5. Language & communication	Conversation, storytelling, early literacy and communication
6. Social-emotional development	Regulation, confidence, empathy, resilience, belonging
7. Inclusion	Participation/support for disability and additional needs
8. Health & nutrition	Nutrition, hygiene, activity, rest, monitoring, healthy routines
9. Physical environment	Safe, accessible, stimulating indoor/outdoor spaces
10. Family engagement	Partnership, communication and participation
11. Leadership & management	Governance, supervision, ethics, planning, quality management
12. Continuous professional development	Qualifications, coaching, mentoring, reflection, learning

A tiered system could inform parents, guide provider improvement and target government support, but should not become punitive bureaucracy. Improvement needs resources, mentoring, CPD and realistic time. The proposed birth-to-six quality continuum covers responsive care/attachment, health, nutrition and safety, play/exploration, language/communication, social-emotional development, early learning; inclusion/participation, and school transition.

Table 12.8: Tiered Quality System

Level	Quality status	Focus
1	Minimum Standard	Legally compliant, safe, registered
2	Developing Quality	Core quality practices established
3	Good Quality	Consistent developmental/pedagogical practice
4	High Quality	Strong leadership, inclusion, workforce, family engagement
5	Centre of Excellence	Excellence, innovation, mentoring, sector leadership

12.9 Inclusion and Children with Disabilities/Additional Needs

Inclusive ECCE should be a core national policy, not a specialist add-on. Developmental delays, disabilities and additional learning needs should be identified and supported before primary school. Early support can strengthen communication, mobility, social-emotional development, participation, independence and learning while helping families respond to children's needs.

12.9.1 Existing foundations

- Kurikulum Prasekolah 2026 (Pendidikan Khas)

This provides a national preschool curriculum for special educational needs. For younger children, JKM recognises differentiated caregiver-child ratios.

Table 12.9: Childcare provider: Child Ratios

Age	Typical children	Children with special needs
Birth–1 year	1:3	2:3
1–3 years	1:5	2:5
3–4 years	1:10	3:10

TASKA OKU: Early Intervention and Participation

TASKA OKU under the purview of DSW is an important, specialised component of the journey towards inclusivity and access. Currently there are six focus categories:

Table 12.10: Categories of TASKA OKU

Category	Focus
Down Syndrome	Care, development and appropriate early support
Autism	Structured care, developmental/intervention support
Visual disability	Learning adapted to visual needs
Hearing disability	Communication and developmental support
Physical disability	Accessible care and physical-development support
Learning disability	Individualised developmental/early-learning support

There are currently 11 TASKA OKU nationwide, highlighting the importance of specialised provision but also the scale and access is a major challenge due to budget constraints

12.9.2 Recommendations for Continuum of Provision for Inclusion

Key recommendations to move towards Inclusion in the ECCE Sector :-

- Mainstream ECCE with universal inclusive practice.
- Mainstream ECCE with additional support.
- Targeted early intervention.
- Specialised support/services.
- TASKA OKU or specialised ECCE were required.

12.9.3 Placement should reflect the child's best interests, developmental needs and participation in partnership with the family, using the least restrictive and most developmentally appropriate environment while recognising that some children benefit from specialised provision.

12.9.4 Inclusion must be measured as a quality outcome. Inclusivity includes: -

- Early identification: build educator/caregiver capacity to recognise developmental concerns.
- Developmental screening: establish appropriate screening/referral pathways. Early intervention: connect children promptly to health, rehabilitation, therapy and developmental services.

- Individualised support: plan around strengths, needs and developmental goals.
- Reasonable accommodation: adapt routines, activities, teaching and environments.
- Accessible and sensory-friendly indoor/outdoor environments.
- Assistive technology for communication, mobility and learning.
- Educator competency in disability, observation, adaptation and differentiated teaching.
- Family partnership in assessment, planning and intervention.
- Multidisciplinary collaboration across health, rehabilitation, psychology, social welfare and education.
- Transition planning from TASKA to preschool and preschool to primary school.
- Communication support: speech, language, sign, visual and alternative communication

12.9.5 Mainstream TASKA/TADIKa need trained educators, manageable groups, extra personnel where required, adaptive materials, flexible routines and specialist advice. A practical pathway is:

Child enters ECCE → Educator observes → Concern discussed with family → Screening/referral → Support plan → Environment / Programme adapted → Specialist support if needed → Progress reviewed.

12.9.6 Families are central partners and may need help navigating health, JKM, education, rehabilitation, early intervention and disability services. Malaysia should build an integrated early-intervention network, so families do not have to coordinate multiple systems alone.

12.9.7 Quality assessment should test whether centres welcome different abilities, identify concerns, provide reasonable accommodation, train staff, adapt activities, work with families/specialists and prevent stigma/discrimination. The strategic goal is meaningful participation: every child should belong, participate, communicate, play, learn and develop with the support required.

12.10 Rural, Low-Income and Underserved Communities

Geography, income, transport, disability, employment patterns and provider viability shape ECCE access. Kelantan and Terengganu have high proportions of children in their populations: children under 18 represent 33.5% of Kelantan and 32.9% of Terengganu, second and third only to Putrajaya according to the DOSM data.

12.10.1 Different communities, Different barriers

One of the greatest challenges in delivering quality ECCE is enabling equity for all children as set out in the table below:-

Table 12.11: Barriers and Policy Response

Community	Potential barrier	Policy response
Rural	Distance, transport, small catchments	Community centres, mobile/outreach, transport support
Remote Sabah/Sarawak	Distance, dispersed settlements, infrastructure /workforce	Locally adapted models, community educators, targeted investment
Low-income urban/PPR	Fees, transport, limited places, working hours	Subsidised care, community TASKA, extended hours
Plantations	Isolation, few alternatives	Enforce/strengthen employer childcare
Orang Asli/Indigenous	Distance, language, culture, accessibility	Community-designed, culturally responsive ECCE
Children with disabilities	Accessible facilities/specialists unavailable	Inclusive mainstream, TASKA OKU, early intervention / mobile specialists

Community	Potential barrier	Policy response
Shift Working Families	Standard hours mis match	Flexible/ Extended hours / Workplace childcare
Low Density Areas	Conventional Centres financially weak	Small scale home / community models
Refugee, Stateless	No access to any form of quality ECCE	Small scale home / community models by NGOs

12.10.2 National ECCE Map: From population mapping to ECCE needs mapping

Malaysia should identify 'ECCE deserts' by combining population, income, disability, employment, transport, provider capacity and enrolment data. A national ECCE Needs Map would direct investment to greatest unmet need rather than relying on provider applications or existing demand.

12.10.3 Affordability is part of accessibility: a place that exists but cannot be afforded is not meaningful access. Nor should every community receive the same delivery model. The report supports centre-based TASKA, community TASKA, workplace TASKA, registered home-based care, mobile/outreach services and integrated community hubs, provided each meets standards for safeguarding, caregiver competency, health, nutrition, child development and quality.

The strategic shift is from equal provision to equitable provision: not 'Where can another centre be opened?' but ***'Where are children with least access, and what model best fits their families and communities?'***

12.11 International Comparison and Lessons for Malaysia

12.11.1 Singapore

Singapore's ECDA integrates regulation, quality assurance, affordability, professional development and sector development from infant care through childcare and preschool. Features highlighted include integrated coordination, family subsidies, operator support for infrastructure/rental/teaching resources, professional development, national information/professional registration and SPARK quality assurance. SPARK 2.0 emphasises child-centred quality, provider ownership and reflective continuous improvement.

12.11.2 Australia

Australia's National Quality Framework combines national legislation/regulations, approved learning frameworks, qualification requirements, the National Quality Standard and formal assessment/rating. The seven NQS Quality Areas are educational programme/practice; children's health/safety; physical environment; staffing; relationships; family/community partnerships; governance/leadership. Ratings range from Significant Improvement Required through Working Towards, Meeting, Exceeding and, where applicable, Excellent. Quality Improvement Plans link assessment to improvement. Belonging, Being and Becoming covers birth to five.

12.11.3 Organization for Economic Co-operation and Development (OECD)

2025 Education figures cited in the OECD Report show an average enrolment of about 79% for three-year-olds and 90% for four-year-olds. For five-year-olds, 86% are in ECCE and 97% when those already in primary school are included. In more than half of OECD countries with available data, participation among ages three to five is at least 90%. Government sources provide most pre-primary funding on average; expenditure for ages three to five averaged about 0.59% of GDP in 2022.

Table 12.12: Malaysia :The Way Forward

Dimensions	International lessons	Potential Malaysia Direction
Governance	Central/National coordination	Stronger cross-ministerial coordination
Birth–6	Coherent early-years systems	Integrated birth-to-six framework
Quality	SPARK/NQS and ratings	National ECCE quality framework
Assessment	Continuous improvement	Beyond licensing/compliance
Workforce	Professionalisation	Qualifications, careers, CPD
Affordability	Means-tested support	Review subsidy mechanisms
Provider sustainability	Mixed grants/support	Operating/rental/quality support
Equity	Targeted support	Prioritise underserved groups
Improvement	Mentoring and plans	Link inspection, CPD and improvement

Central lesson: Malaysia does not primarily need another curriculum or layer of regulation. It needs to connect existing legislation, TASKA registration, PERMATA, Kurikulum Prasekolah 2026, government provision and private capacity into a coherent system. Do not simply regulate ECCE—finance it, professionalise its workforce, measure quality, support improvement and ensure participation.

12.12 Rancangan Malaysia Ke-13 (RMK13) 2026–2030

12.12.1 RMK13 positions education reform as part of social mobility and stronger outcomes and specifically proposes compulsory preschool at age five to optimise early cognitive development. This shifts preschool from an optional service toward a core national education pathway. If participation becomes compulsory, capacity, affordability, quality and inclusion must rise together. What is needed for a child centred ECCE services: -

- Sufficient preschool places
- Adequate teachers
- Infrastructure
- Inclusive provision
- Transport where necessary
- Family support
- Sustainable public financing
- Quality assurance

12.12.2 There is an important policy gap: RMK13 explicitly advances preschool reform and compulsory preschool at five but does not substantially mainstream the childcare sector through universal fee subsidy and one coordinated agency while existing laws remain with respective ministries.

The childcare sector remains not included in the mainstream budget planning, has fractured governance structure (due to the many parties involved in providing services), has no clear cohesive long-term vision and framework to develop the sector as an essential service to support families. It is a critical sector in enabling the increased participation of women in the workforce, to halt the declining birthrates and enabling the economy to grow while ensuring that the youngest of our children receive the nurturing care that provides them with the foundations for life long health, nutrition and participation as future workforce and citizens

12.13 ECCE Sector SWOT: Strengths, Weaknesses, Threats, Opportunities

Table 12.13: ECCE Sector SWOT Analysis

Strengths	Weaknesses
Established TASKA/preschool law /regulations	Fragmented governance
Compulsory Basic Childcare Certification (KAP)	Uneven implementation / monitoring
TASKA and TADIKa registration system	Uneven quality
Kurikulum Prasekolah 2026	Qualified workforce shortages
Strong KEMAS rural/underserved network	Low pay, weak career progression, turnover
Urban Poor ECCE through JPNIN	Weak 0–4 / 4–6 integration
Diverse Childcare and Preschool Provider base	Poor Safeguarding Governance
High 5+ preschool participation	Geographic / socioeconomic inequality
Growing national priority	Limited TASKA capacity
Extensive public provision of preschools	Fragmented workforce/quality/data systems
Opportunities	Threats
RMK13 reform window	Rising rent, salary, food, utility/compliance costs
Universal/compulsory preschool	TASKA closures / weak sustainability
Integrated birth-to-six framework	Educator / caregiver attrition
National data/digital systems	Urban–rural / regional inequality
Public-private partnerships	Limited affordable infant care
Workplace childcare	Specialist-support demand exceeds personnel
Inclusive ECCE	Financial / staff pressure may reduce quality
National quality framework	Access expansion without quality
Workforce professionalisation	Continued informal / unregistered care
Integrated health / nutrition / safeguarding	Unequal standards across jurisdictions

Overall interpretation: Malaysia does not lack an ECCE system; it lacks coherence and consistency. The opportunity is one national vision; common minimum quality standards and shared child-development outcomes delivered through diverse providers.

12.14 Vision and Key Policy Recommendations

12.14.1 Malaysia should adopt a child-centred ECCE vision aligned with the **UN Convention on the Rights of the Child 1989**: every child receives equitable, affordable, inclusive, safe and high-quality ECCE from birth to six and enters school healthy, confident, resilient and ready to learn. ECCE should be understood not simply as childcare for working parents plus preschool preparation, but as developmental, educational, social-protection and human-capital investment. The reform opportunity is created by Kurikulum Prasekolah 2026, RMK13, PERMATA, JKM regulation and current attention to childcare affordability as part of the Care Economy. The aim is not only to have more TASKA/TADIKa, but better services where children are safe, respected, included, stimulated, listened to and learn through relationships and play.

12.14.2 Workforce Framework Direction

As a key success factor, it is recommended that an ECCE Workforce Framework capable of transforming ECCE from low-paid care work into a recognised profession be implemented. This should connect entry training, KAP/SKM and academic qualifications, competency recognition, CPD, supervision/mentoring, career ladders, remuneration, retention and workforce data. Public and private reforms must avoid qualification mandates that raise standards while unintentionally creating shortages

12.14.3 Short Term Recommendations: 2026–2028

- Create a formal National ECCE Coordination Agency linking all major agencies.
- Targeted subsidies for lower-income households and graduated subsidies for middle-income working families.
- Enhanced mother prenatal/postnatal support as well as infant-care support.
- Employer-supported childcare and incentives for workplace TASKA.
- Capital grants in underserved communities and operating support for strategically located community TASKA.
- Incentives for inclusive childcare and special support for rural/remote providers.
- Protect TASKA sustainability by reviewing subsidy mechanisms against current operating costs, especially infant care.
- Develop a national workforce strategy covering qualifications, salaries, CPD, career progression and retention.
- Strengthen identification/monitoring of unregistered childcare while helping operators meet registration requirements.
- Provide targeted grants for reasonable accommodation and inclusive services.
- Support effective Kurikulum Prasekolah 2026 implementation, especially in private/community provision.

12.14.4 Medium Term Recommendations: 2028–2030

- Establish a National ECCE Quality Framework with common TASKA/TADIKa standards and appropriate age requirements.
- Introduce transparent quality rating and improvement based on assessment, support and continuous improvement.
- Use national mapping to expand childcare/preschool in underserved areas.
- Develop a national competency framework and recognised career levels.
- Integrate early identification/intervention by linking TASKA/TADIKa with health, child-development and special-education services.

12.14.5 Long-Term Recommendations: 2030 and Beyond

- One National Vision: Every child has the right to quality ECCE.
- Common child outcomes: appropriate physical, cognitive, language, social-emotional and self-help competencies.
- Common quality expectations: all providers meet clear minimum and quality standards.
- Professional workforce: recognised qualifications, career pathways and appropriate remuneration.
- Sustainable financing: government, families and employers share responsibility.
- Strong family partnerships: parents are partners, not merely childcare consumers.
- Data-driven planning: government knows where children and services are and where gaps remain.

The Guiding principle is that public funding should follow the child, while quality funding must also sustain the provider. Integration does not require one Ministry to operate every service. It requires shared national architecture:

12.15 The Way Forward for ECCE: Integrated Birth-to-Six ECCE System

The way forward for ECCE in Malaysia can be summarised under 5 Strategi Pillars :-

Table 12.14: Five strategic pillars

Pillar	Direction
1. Governance Reform	Coordinate KPM, KPWK/JKM, KEMAS, JPNIN, state religious authorities, local authorities and private providers.
2. Universal & Equitable Access	Ensure access for low-income, rural, remote and underserved children.
3. Quality Improvement	Move from minimum compliance to assessment, professional support and continuous improvement.
4. Professional Workforce	Build a respected, adequately remunerated and professionally recognised workforce.
5. Sustainable Financing	Protect both family affordability and provider sustainability.

12.15.1 Overall ECCE System Logic Framework

The overarching direction is to retain Malaysia's provider diversity while ensuring that a child's safety, developmental opportunity and quality do not depend on which ministry, community, religious authority, employer or private organisation operates the service.

Governance → Sustainable Public Financing → Affordable Access → Professional Workforce → Common Quality Standards → Assessment & Continuous Improvement → Inclusive and Equitable Provision.

12.16 Conclusions

Malaysia already has the essential building blocks of an ECCE system: legislation, TASKA registration, public infrastructure, national developmental/curriculum frameworks, government investment, diverse public/private/community/religious provision and high preschool participation near school entry. Its main challenge is not absence of provision but fragmentation, uneven quality, affordability pressure, workforce instability, incomplete childcare data, limited formal TASKA capacity, inclusion gaps and geographic inequality.

The next reform phase should connect care and education from birth to six, finance affordability and provider viability together, professionalise the workforce, strengthen safeguarding and inclusion, measure service quality rather than registration alone, map unmet needs, formalise safe home/community options where appropriate, and link ECCE with health, nutrition, early intervention, family support and school transition.

The central policy test is whether every child—regardless of income, disability, ethnicity, geography or provider—can access safe, affordable, inclusive and high-quality ECCE. Expansion without quality is insufficient. Regulation without financing and professional support is also insufficient.

12.16.1 Towards One National Vision for early Childhood care and Education in Malaysia

Every child in Malaysia, from birth to six years, should have equitable access to affordable, inclusive, safe and high-quality ECCE regardless of family income, disability, ethnicity, geographical location or provider. Malaysia should progressively move from a multi-provider landscape to an integrated birth-to-six system that places ***The Child—Not Institutional Boundaries—At the Centre.***

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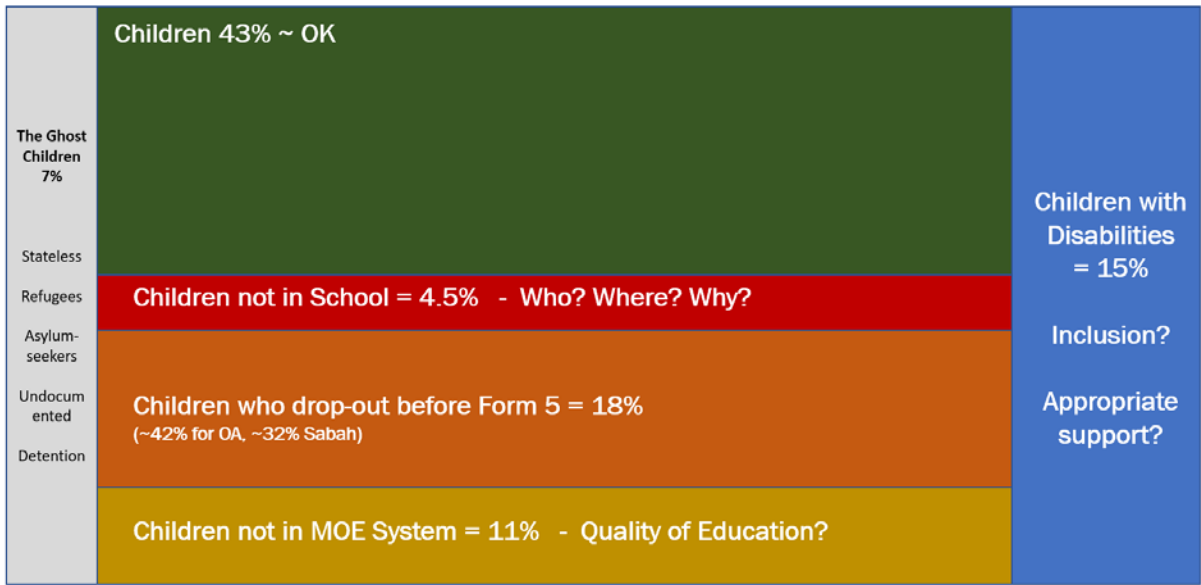
Section 13: Education – Access, Quality and Exclusion

Only 18% of upper secondary students proceed to post-secondary education.

Government school enrolment fell by 0.2% in 2024, with a 3.0% drop at upper secondary level.

The official dropout rate of about 2% hides the loss of children who fail to move from Year 6 to Form 1.

In PISA 2022, Malaysia ranked 55th of 81 countries in mathematics and 46th in both reading and science.



13.1 Introduction

Education is a fundamental right enshrined in UNCRC Article 28, which obligates Malaysia to make primary education compulsory and free for all children, and to make secondary and higher education accessible. Education is also the most powerful instrument we have for breaking the cycle of poverty and creating the conditions for lifelong health. A child who does not complete secondary education is significantly more likely to live in poverty, experience poor health, and see their own children suffer the same fate. The Education Act 1996 and the National Education Policy provide the legislative and policy framework for schooling in Malaysia, but significant gaps exist in reach, quality, and equity.

13.2 School Enrolment Data

Government and government-aided school enrolment in 2024 was 4.97 million students — a decline of 0.2% from the previous year, with a 3.0% drop at the upper secondary level. Private school enrolment also declined by 0.3% to 441,371 students. The number of registered childcare centres (Taska) increased slightly by 1.4% to 3,198 in 2024.

Critically, only 18% of upper secondary students proceed to post-secondary education. This dramatic drop-off between upper secondary and post-secondary represents a massive loss of human potential — and a structural failure that disproportionately affects children from lower-income families.

13.3 Key Educational Challenges

13.3.1 School Dropout and Transitions

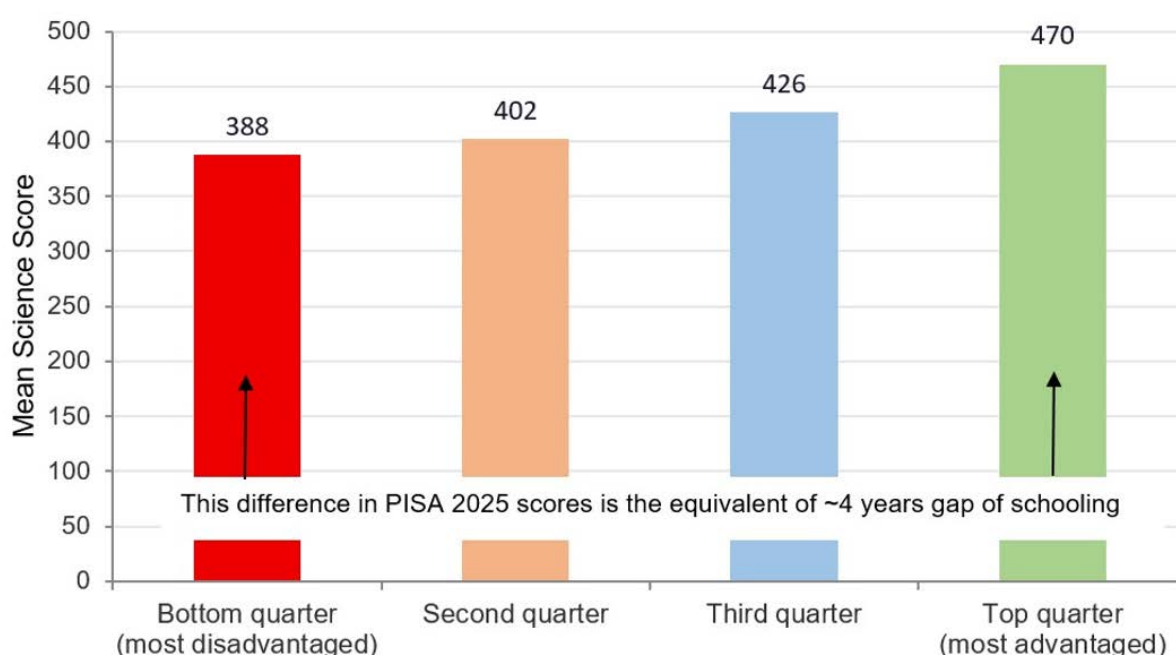
While Malaysia's official secondary school dropout rate appears low at approximately 2%, this figure does not capture the largest loss — children who fail to make the transition from Year 6 (primary) to Form 1 (secondary). When this transition loss is included, the effective dropout rate is significantly higher. The Education Ministry's 'Zero Reject Policy' is a stated principle, but its implementation in practice is uneven, particularly for children with disabilities, children in poverty, and non-citizen children.

13.3.2 Quality of Education and Learning Outcomes

The COVID-19 pandemic caused Malaysia's worst learning loss in the region, with extended school closures that disproportionately affected children from low-income families who lacked devices, internet connectivity, and parental support for home learning.

Malaysia continues to perform below its economic level in international learning assessments. In PISA 2025, Malaysian students scored 397 in mathematics (an 11-point drop from 2022), 393 in reading (a 5-point increase), and 419 in science (a 3-point increase) across 91 participating countries and economies. While performance in science and reading showed slight recovery, the significant drop in mathematics highlights ongoing educational challenges, keeping student achievement consistent with middle-income peers rather than a nation aspiring to high-income status.

The PISA 2025 data confirms that a student's family background remains one of the strongest predictors of academic performance in Malaysia. Socio-economically advantaged 15-year-olds, the top 25% by family wealth, parental education and home resources, outscored their disadvantaged peers (the bottom 25%) by 82 points in science (see Figure 31.1).



Source: OECD (2026), PISA 2025 Results, Table I.B1.2b.2.

Figure 13.1: Science Performance by National Socio-Economic Quarter, PISA 2025, Malaysia

What this means in the real-world terms is of extreme concern because, in standard OECD PISA methodology, 20 score points roughly represent one year of schooling. Consequently, an 82-point difference corresponds to approximately 4 years of formal education. This means that our 15-year-olds in the bottom 25% socio-economic group are 4 schooling years behind the top 25%. This is a gap we cannot afford to ignore. This is the 'inverse care law of education' or the 'social determinants of

education' – children who need the most support, resources, and high-quality teaching to succeed are the ones least likely to receive them.

The data also shows that nearly two-thirds (63%) of Malaysia's most disadvantaged students failed to reach even baseline science proficiency (Level 2) in 2025.

13.3.3 Exclusion of Non-Citizen Children

Refugee children are currently denied basic education in Ministry of Education schools. Malaysia's 'Zero Reject Policy' is technically applicable to all children but is not applied to non-citizens. UNHCR-run community learning centres provide some education for refugee children, but the quality, resources, and coverage are severely limited. Children of undocumented migrants in Sabah — potentially the largest excluded group — have access only to informal schools that operate without consistent curriculum or accreditation.

Access to education is further restricted by: lack of documentation (no birth certificate, no MyKid), language barriers, poverty, and fear of arrest when seeking registration.

13.3.4 Orang Asli Educational Exclusion

MOE highlighted the transition rate of Orang Asli children from Standard 6 to Form 1 increased to 94.02% in 2025 compared to 89% in 2023 attributed to K9 and K11 Comprehensive Special Model School (Berita RTM, 2026). However, this transition rate alone is not adequate to reflect the reality and persistent gap of drop-out of Orang Asli students as the past and available public-view dataset on the number of Orang Asli children completing Standard 6 reduced significantly from 4,705 in 2012 to 3,812 in 2019 (Kementerian Kemajuan Desa and Wilayah, 2021), suggesting the increase of past transition rate (%) against the reduced number of primary school students.

42.29% of Orang Asli students failed to complete their education till Form 5 in 2021 (Kamarudin & Mohd Said, 2023). There is a need for data on how many Orang Asli children never enrolled in school and the illiteracy rate among young adults.

13.3.5 Inclusive Education for Children with Disabilities

Inclusive education for children with disabilities remains aspirational in Malaysia. While some special education schools and integration programmes exist, the majority of children with learning disabilities in mainstream schools do not receive the support they require. Resources and special education teachers are insufficient and often inadequately trained. Children with more severe disabilities are typically placed in separate special education schools, often distant from their communities.

13.3.6 Tahfiz and Home Schools

The MOH school health programme does not fully reach children in unregistered tahfiz (Islamic religious) schools and home schools. The 2021 fire at the Darul Quran Ittifaqiyah tahfiz school in Kuala Lumpur that killed 23 students drew attention to the poor regulation, safety conditions, and health oversight of these institutions. An estimated hundreds of thousands of children attend tahfiz schools with varying degrees of oversight and health service access.

13.4 The Vaping and Substance Use Crisis in Schools

The NHMS Adolescent Health Survey 2022 documented a deeply alarming trend in vaping among teenagers:

- E-cigarette and vape use among teens aged 13–17 rose from 9.8% in 2017 to 14.9% in 2022
- Teen vaping prevalence: 23.3% in males and 6.2% in females
- 166,000 adolescents had used drugs; 60,000 were currently using drugs at time of survey
- Alcohol use: 1 in 10 adolescents currently uses alcohol

These are substances being used in and around school environments. The school system's response — largely punitive — has not been effective at preventing uptake or supporting cessation.

13.5 Recommendations

1. Implement the 'Zero Reject Policy' genuinely for all children in Malaysia, including refugee and stateless children, with documentation barriers removed as a condition of school enrolment.
2. Mandate free, quality, inclusive primary and secondary education for all children regardless of citizenship status, funded by the federal government.
3. Address the COVID-19 learning loss through a structured national learning recovery programme, with targeted support for children from low-income families.
4. Invest significantly in special education teacher training, resource rooms, and support systems for children with disabilities in mainstream schools.
5. Regulate tahfiz and home schools to ensure minimum standards of education quality, safety, and health service access.
6. Implement evidence-based substance use prevention programmes in schools, replacing punitive approaches with health-promoting and resilience-building approaches.

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Section 14: Children with Disabilities

As of 30 April 2025, 772,090 persons with disabilities were registered, only an estimated 13% of the true number.

An estimated 15% of school-age children have some form of disability or developmental problem.

The NHMS 2022 found developmental delay in 7.4% of children aged 6–59 months, almost certainly an underestimate.

Females account for only 34.2% of registered persons with disabilities.

14.1 Introduction

Children with disabilities represent one of the most systematically marginalised groups in Malaysia. They face barriers to healthcare, education, community participation, and legal protection at every turn. They are disproportionately concentrated in poverty. Their families bear enormous economic, emotional, and social burdens — often without adequate support from public services. And yet, in the national policy and health planning landscape, children with disabilities remain an afterthought.

Internationally, approximately 15% of the global population has some form of disability. Among children, the WHO and World Bank estimate 10% in preschool and 15–17% by school age. The NHMS 2022 MCH Survey found a 7.4% prevalence of developmental delay among children aged 6–59 months in Malaysia — almost certainly an underestimate given the limited systematic screening infrastructure.

14.2 Size of the Problem

- Estimated 15% of all school-age children have some form of disability or developmental problem
- 7.4% prevalence of developmental delay in children 6–59 months (NHMS 2022 MCH)
- JKM voluntary registration severely undercounts the true disability burden. As of 30 April 2025, 772,090 persons with disabilities (PwDs) were registered — only an estimated 13% of the true PwD population in Malaysia. Girls and women are grossly underrepresented: males account for 507,799 (65.8%) of registrations versus only 264,291 females (34.2%). Registration is further deterred by the absence of anti-discrimination protections — registration exposes PwDs to discrimination in education, employment, and insurance without any legal recourse.
- The largest registered category is learning disability (304,834), followed by physical disability (257,959), visual (64,550), mental (60,214), hearing (48,192), various/mixed (32,296), and speech (4,045) — JKM, 30 April 2025
- NHMS 2023 (adults): 8.2% disability prevalence; 21.7% of adults living with functional limitations — including 11.1% with difficulty seeing, 10.2% walking, 6.9% remembering, 3.2% hearing, 1.8% communicating, and 1.5% in self-care
- Children with disabilities in Orang Asli communities, interior Sabah, and refugee/stateless populations have virtually no access to diagnostic or rehabilitation services

If 15% of all children in Malaysia have a disability, that represents approximately 1.35 million children. Only 772,090 persons with disabilities of all ages are registered – and current government services are designed for a fraction even of that number.

The National Council for Persons with Disabilities (MKBOKU), the peak policymaking body under the PwD Act, included only 2 PwDs among its 10 appointed members in the 2023–2025 Council. All MKBOKU members are bound to silence by the Official Secrets Act, meaning the outcomes of its work over more than 16 years remain largely unknown to the disability community. This governance deficit

has profound implications for children with disabilities, whose interests are inadequately represented at the highest policy levels.

14.3 Current Services and Gaps

14.3.1 Diagnostic Services

Current health services are better at assessment than at intervention or education support. Developmental screening is conducted during MOH well-child visits, but the coverage and quality are inconsistent, particularly in urban settings. There is no population-based newborn hearing screening programme in the public sector (though some hospitals conduct it). Autism diagnosis is often delayed by 2–3 years beyond the recommended age of 18–24 months, due to insufficient trained specialists and long waiting lists.

14.3.2 Early Childhood Intervention (ECI)

ECI — therapy and educational support in the first 6 years — provides the greatest returns on investment for children with developmental disabilities. The first two to three years of a disabled child's life significantly impact developmental trajectories, making early identification and support critical for improving care outcomes.

In Malaysia, ECI services are fragmented between MOH (some assessment and therapy), Ministry of Education (Special Education), and Civil Society Organisations (most of the actual community-based intervention). Government-initiated ECI centres — including Genius Kurnia, Taska OKU, and Pusat Perkhidmatan Pendidikan Khas (3PK) — are fully funded but located only in some urban areas. JKM community-based rehabilitation (CBR) centres and other qualified CSOs receive partial funding of varied amounts. Government ECI is largely urban-based, institution-focused, and physically disability-centred. Children with learning disabilities such as autism, intellectual disability, and developmental language disorders — which form the largest registered group — are poorly served.

Urban-based CSOs provide most ECI services but have long waiting lists. Children with disabilities from rural communities — especially in interior Sabah and Sarawak — have limited or no access; the nearest ECI or CBR centre is at least six hours away, with high travel costs that are prohibitive for B40 families. Remote telepractice ECI is hampered by unstable internet connectivity, particularly in Sabah and Sarawak. Non-profit CSO services are beyond the financial reach of most families, and children with disabilities from B40 families in urban poor areas and rural east coast communities cannot afford them.

A significant and underappreciated inequity exists in ECI access by gender. Data from 14 Malaysian ECI CSOs show that boys make up 72.6% of children receiving ECI, and girls only 27.4%. This disparity is not a reflection of true prevalence — it reflects international evidence of referral and diagnostic bias against girls with autism and ADHD, resulting in systematic underidentification and underservice of girls with disabilities.

ECI service quality varies greatly, with no standard-based monitoring; very few services are disability-affirming and family-centred. Training for ECI practitioners is limited and unstructured, with insufficient government funding. The expanding privatisation of professional services has created a rich-poor chasm in service access, worsening outcome inequities. COVID-19 exposed the fragility of the current model: most parents reported significant regression in their disabled children's skills during pandemic school closures.

A national review of ECI services has identified four key movements needed for transformation. First, mainstreaming: transitioning from NGO/CSO-led services to government-funded mainstream provision, reaching rural, indigenous, and poor urban communities universally. Second, a family-centred and disability-led approach: shifting from provider-led services to meaningful family participation, with disability-led insights shaping service design. Third, inclusion as the organising principle: moving away from segregation toward Universal Design for Learning across all service delivery. Fourth, an evidence

and outcomes-based orientation: replacing ad-hoc therapy practices with structured, transdisciplinary training and systematic outcome monitoring.

14.3.3 Education for Children with Disabilities

Three main educational pathways exist: Special Education Schools (SJK/SMK Khas), Special Education Integration Programmes in mainstream schools, and private special education centres. However, the data reveal a system that falls far short of its stated ambitions.

The Malaysia Education Blueprint 2013–2025 set a target of 75% inclusion by 2025. Although the MoE 2023 Annual Report states an inclusion rate of 89.9%, the MoE 2023 Quick Facts reveals a very different picture: full inclusion stands at only 19.0%, with partial inclusion at 77.2%. Partial inclusion covers students with disabilities who attend mainstream classes only for co-academic or co-curricular activities — not full academic integration. This statistical sleight of hand obscures the reality that genuine inclusive education for most children with disabilities remains unrealised.

Only 93,407 children are identified with a disability in MoE schools — meaning more than 300,000 children with disabilities are unrecognised in schools, in other education settings, or entirely out of school. In Sabah, one child in every two registered as disabled was out of school. Many parents struggle to have their disabled children included in regular government schools, with some resorting to costly private services. Common reasons cited include lack of individualised support, inaccessible environments, bullying, and hostile social environments.

The exclusion continues into higher education. Data from 2022 show that a mere 0.55% — only 792 of 144,579 students — enrolled in public universities were persons with disabilities. Community colleges enrolled 1.03% PwDs (157 of 15,239) and polytechnics 0.21% (167 of 77,816). The 240-page Malaysia Education Blueprint 2015–2025 (Higher Education) mentions “persons with disabilities” only twice, with no mention of “inclusion,” “reasonable accommodation,” or “barrier-free environments.”

- Many children with disabilities never make it into any educational pathway due to lack of diagnosis, inaccessibility of services, or parental poverty
- The quality of special education varies enormously across states and between rural and urban settings
- Children with more complex or multiple disabilities are often excluded even from special education settings
- COVID-19 severely disrupted services for children with disabilities, with most parents reporting significant regression in skills

14.3.4 Rural, Indigenous, and Marginalised Children

Vulnerable children in remote rural communities — Orang Asli, Penan, interior Sabah — have virtually no access to disability services. For these communities, a child with a disability may never receive a diagnosis, let alone therapy or educational support. The Community-Based Rehabilitation Services (CBRS) programme of the Department of Social Welfare has limited functionality and reach.

14.3.5 Children with Rare Diseases

Children with rare diseases face a particularly severe access crisis in Malaysia. They are chronically underdiagnosed, underserved, and unable to access available therapeutic modalities internationally. Unlike adult chronic disease programmes (e.g. chronic renal disease, HIV) which have substantial locked-in funding, rare disease programmes for children lack sustainable, ring-fenced funding. Families are often left to fend for themselves — raising funds publicly, importing medications illegally, or simply watching their children deteriorate. The MOH has yet to officially define rare diseases or adopt a national rare disease policy.

14.3.6 Social Support, Long-term Care, and Families

Financial support for families of disabled children is critically inadequate. JKM provides a monthly allowance of RM500 for registered PwDs who are bedbound and RM300 for those unable to work — amounts that barely cover the cost of living, let alone the additional costs of disability-related care and assistive devices. The 2019 NHMS national household survey found that 5.3% of the population was providing informal care to persons with long-term illness, disability, or old age, with women disproportionately represented. Informal care averaged 5.3 years of commitment at 24.5 hours per week on average, and 16% of informal care partners reported that care responsibilities had affected their own physical and/or mental health.

Mothers of disabled children frequently leave employment to provide full-time care and learning support, a sacrifice that often extends beyond primary school as children struggle to access appropriate accommodation. Malaysia lacks a formal assisted living programme with stable government financing, including payment for care partners and personal assistants. JKM operates only seven Taman Sinar Harapan residential institutions for PwDs with high support needs nationwide — none of which are located in East Malaysia — and all are of limited quality. Private residential care is expensive and largely inaccessible to lower-income families. Malaysia has no comprehensive national policy on long-term care financing for persons with disabilities.

14.3.7 Gender, Abuse Risk, and Cultural Barriers

Children with disabilities face a dramatically elevated risk of abuse and violence. Globally, persons with disabilities are three times more likely to experience sexual assault; children with psychosocial or intellectual disabilities are nearly five times more at risk than non-disabled peers. In Malaysia, support for abuse survivors with disabilities lacks a disability-affirming approach, and most first responders cannot communicate in Malaysian Sign Language (BIM) with Deaf survivors. This compounds systemic barriers that prevent justice access for children with intellectual disabilities.

Girls with disabilities are particularly vulnerable. They are underdiagnosed due to gender bias in diagnostic tools and practitioners' limited understanding of gender-disability intersectionality. Mothers of children with disabilities also experience stigmatisation due to cultural beliefs attributing disabilities to failures in observing traditional taboos, sometimes driving families toward harmful practices such as exorcism to “treat” the disability. Poor understanding of intersectionality — across gender, ethnicity, socioeconomic status, and disability — can result in the disproportionate or late identification of disability in minority groups such as the Orang Asli/Asal and stateless children.

14.4 Legislative Framework

The Persons with Disabilities Act 2008 (Act 685) provides the primary legal framework for disability rights in Malaysia. It is, however, fundamentally deficient: it contains no anti-discrimination provision, offers no recourse for redress when PwDs experience discrimination, and lacks rights-based enforcement mechanisms. The Education Act 1996 provides for special education, but there is no legal mandate for inclusion in mainstream settings. Critically, the Federal Constitution itself does not explicitly prohibit disability-based discrimination — Articles 8(2) and 12(1) require amendment to do so.

Malaysia ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2010, but its implementation across government ministries remains fragmented and insufficiently monitored. Having delayed harmonisation for over 13 years following CRPD ratification, Malaysia lags significantly behind regional neighbours. Countries such as India, South Korea, Thailand, and Indonesia have considerably stronger disability legislation, including comprehensive definitions of discrimination, independent disability commissions, and meaningful grievance redress mechanisms — none of which exist in Malaysia's current framework.

Employment data underscore the cumulative effect of these systemic failures. The government has maintained a 1% employment target for PwDs in the civil service since 1988; yet as of 2022, only 0.3%

of civil servants were PwDs, and in 2024, of 21,814 newly appointed civil servants, only 74 (0.34%) were PwDs. In the broader workforce, only 10,766 PwDs are actively employed — a mere 0.06% of Malaysia's total workforce of 17.34 million (2024). Between 1990 and 2018, only 14,252 PwDs were employed in the private sector over nearly three decades.

14.5 Recommendations

1. MOH and all government agencies must formally acknowledge that 15% of children have a disability and plan, organise, and budget accordingly — not for a fraction of the actual need.
2. Develop a national ECI policy with ring-fenced funding, covering all children aged 0–6 with developmental concerns, delivered in community and home settings.
3. MOH must adopt an official National Rare Disease Policy, including a rare disease registry, funding mechanism, and patient support framework.
4. Decentralise disability assessment and rehabilitation services so that rural, indigenous, and marginalised communities have access — through mobile outreach teams and telemedicine support.
5. Medical school curricula must be radically improved to provide all doctors with competency in identifying, assessing, and managing childhood developmental disabilities.
6. Develop trans-disciplinary therapy workers — individuals trained across speech, physiotherapy, occupational therapy, and educational support — specifically for deployment in community settings.
7. Amend the Federal Constitution Articles 8(2) and 12(1) to expressly prohibit discrimination on the ground of disability, including in education; and amend the Persons with Disabilities Act 2008 to include comprehensive definitions of discrimination, effective grievance redress mechanisms, and gender equality-disability intersectionality.
8. Mainstream and fund all accredited ECI services with a fee schedule that caps charges by private services and clinicians; upgrade CBR services to a professional standard on par with CSO provision; and embed the four transformation movements for ECI — mainstreaming, family-centred care, inclusion, and evidence-based practice — into a new National ECI Policy.
9. Overhaul Malaysia's education system from preschool to tertiary to genuinely prioritise inclusive education: transform the MoE Special Education Unit into an Inclusive Education Unit; amend the Education Act 1996 to mandate inclusion; adopt Universal Design for Learning across all levels; and refocus KPIs from achievement to inclusion outcomes.
10. Address gender diagnostic bias systematically: require all ECI and developmental services to monitor and report gender breakdown of children served, with corrective action where boys significantly outnumber girls; ensure diagnostic tools are reviewed for gender bias.
11. Introduce a long-term care financing framework: institute a state-funded allowance for informal care partners; expand Taman Sinar Harapan facilities to East Malaysia; establish residential care standards and oversight; and create a national personal assistance programme for PwDs with high support needs.

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Section 15: Poverty and Social Determinants of Child Health

Absolute household poverty fell from 6.2% in 2022 to 5.1% in 2024, but the gains are unequal.

In 2024, 9.9% of rural households were in absolute poverty compared with 3.7% of urban households.

Sabah has the highest state poverty incidence at 17.7%, followed by Kelantan at 11.5%.

Child poverty is multidimensional: income, food security, housing, education, disability, legal identity and access to services.

15.1 Introduction

Malaysia has made substantial progress in economic development, poverty reduction and healthcare provision. Nevertheless, national progress has not benefited all children equally. Socioeconomic, geographical and social inequalities continue to influence the circumstances in which children are born, grow, learn and access healthcare.

The national incidence of absolute poverty declined from 6.2% of households in 2022 to 5.1% in 2024. However, marked disparities remain. In 2024, absolute poverty affected 9.9% of rural households compared with 3.7% of urban households, while Sabah recorded the highest state poverty incidence at 17.7%, followed by Kelantan at 11.5%. These differences are particularly important when considering child health because household income influences not only material living conditions but also access to nutrition, education, transport, healthcare and opportunities for development.

Income alone, however, provides an incomplete account of poverty as experienced by children. Malaysia's Multidimensional Poverty Index (MPI) incorporates dimensions of education, health and living standards and therefore provides a broader assessment of deprivation. Although the national MPI improved from 0.0037 in 2022 to 0.0025 in 2024, the rural MPI remained substantially higher than the urban index, at 0.0109 compared with 0.0001. The health component includes access to health services and clean water, while living-standard indicators include housing conditions, overcrowding, sanitation, transport and basic communication facilities.

Child poverty should therefore be understood as multidimensional deprivation, arising from the interaction of household income with food security, housing, education, parental employment, geography, disability, legal identity, social protection and access to essential services. The central challenge for Malaysia is consequently not only to reduce aggregate poverty, but to identify which children are being left behind, why they remain disadvantaged and how these disadvantages affect their health and development.

15.2 Poverty as a Social Determinant of Child Health

The relationship between poverty and child health is cumulative and interconnected rather than attributable to a single pathway:

Poverty → material deprivation → adverse living conditions → reduced access to essential services → poorer child health and development

Financial insecurity may simultaneously affect a family's ability to purchase nutritious food, maintain suitable housing, afford transport, support children's education and attend healthcare appointments. Parental stress and insecure employment may further influence the home environment and the capacity to respond to a child's health and developmental needs.

The consequences are particularly important during childhood because biological growth, brain development, learning and social development are occurring concurrently. Disadvantage experienced during these critical periods may therefore have effects extending beyond the immediate episode of poverty and into adult health, education and economic productivity.

15.2.1 Nutrition and food security

Nutrition represents one of the most direct pathways through which socioeconomic disadvantage affects children. Rising food costs may compel low-income households to compromise not only the quantity of food consumed but also its nutritional quality. Consequently, poverty may contribute simultaneously to undernutrition, micronutrient deficiency and increased reliance on inexpensive energy-dense foods.

Malaysia continues to face this double burden of malnutrition, in which undernutrition coexists with overweight and obesity. Socioeconomic disadvantage therefore cannot be equated simply with insufficient caloric intake; food insecurity may also manifest as poor dietary quality and unhealthy dietary patterns.

The experience of low-income families in Kuala Lumpur illustrates this relationship. UNICEF's Living on the Edge study of 755 low-income households in 16 public-housing communities found that 41% were living in absolute poverty. Eight in ten households reported insufficient income to meet basic needs, 90% were affected by rising food prices and approximately half of the children were reportedly eating fewer than three meals each day. Children in households headed by women or persons with disabilities experienced particularly pronounced socioeconomic vulnerability.

These findings demonstrate why nutritional interventions cannot rely solely on educating parents about healthy food choices. Families require the economic means to act on such advice. The RM5 million Cash Plus initiative introduced by Kuala Lumpur City Hall and UNICEF under Budget 2025 represents one attempt to address this interaction by combining financial assistance with child-focused nutrition and parenting support for low-income families with young children.

15.2.2 Housing, environment and geography

Housing and place of residence also influence child health. Overcrowding, inadequate ventilation and poor environmental conditions may increase exposure to communicable diseases, environmental hazards and psychological stress.

Urbanisation does not necessarily protect children from poverty-related health risks. Families may live geographically close to hospitals, schools and other public services while remaining unable to benefit fully from them because of transport costs, insecure employment, insufficient household income or competing caregiving responsibilities.

Conversely, rural and remote communities may experience the combined effects of socioeconomic and geographical disadvantage. The persistence of a substantial urban-rural difference in both absolute and multidimensional poverty indicates that place of residence remains an important determinant of opportunity in Malaysia.

Geographical inequity is particularly apparent in Sabah. The Sabah Child Wellbeing Index, published in 2026, examined child well-being across health, nutrition, learning, play and rest, safety and protection, and participation. It identified significant inequalities and deliberately included groups frequently missed by conventional surveys, including undocumented and stateless children and children with disabilities. Almost one in four children surveyed was not fully immunised, and children with disabilities and undocumented or stateless children experienced some of the greatest barriers to well-being.

15.3 Socioeconomic Status and Access to Healthcare

Malaysia has an extensive public healthcare system, and strengthening equitable access remains a central component of national health reform. However, the availability of healthcare should not be equated with accessibility.

For families experiencing poverty, the financial burden of seeking healthcare extends beyond registration or consultation fees. Transport, loss of daily wages when a caregiver accompanies a child, medication and investigation costs, meals while travelling, care arrangements for siblings and repeated follow-up appointments may collectively become substantial.

These barriers are particularly relevant to children requiring chronic disease management, rehabilitation, developmental services or repeated specialist review. A family may therefore fail to attend appointments despite recognising their importance because healthcare competes with the immediate need to maintain household income.

This distinction has implications for clinical practice. Behaviour interpreted as "non-compliance" or "poor adherence" may sometimes represent an inability rather than an unwillingness to engage with recommended care. Understanding the child's socioeconomic context enables clinicians to ask not only why a family did not attend, but also what prevented them from doing so.

Malaysia's Health White Paper provides an important policy framework for addressing these inequities. Its reform agenda prioritises primary healthcare and equity in healthcare delivery, health promotion and disease prevention, sustainable and equitable health financing, and stronger health-system governance. The White Paper explicitly seeks a health system that is equitable, accessible, affordable and sustainable.

Reducing socioeconomic inequalities in child health is therefore integral to Malaysia's existing health-system reform rather than an additional or competing objective.

15.4 Children at Greater Risk of Being Left Behind

Socioeconomic disadvantage is not uniformly distributed among Malaysian children. Children living in rural and remote areas, Sabah and Sarawak, Orang Asli and other Indigenous communities, low-income urban households, families affected by disability, and migrant, refugee, undocumented and stateless populations may experience disproportionate barriers.

The UNICEF Malaysia Country Programme for 2026–2030 similarly identifies persistent inequality despite national development and notes that poverty is higher among households with children and among households headed by women and persons with disabilities. It also highlights continuing gaps in social-protection coverage and adequacy.

An important feature of disadvantage is that vulnerabilities frequently intersect. A child living in poverty in a remote community may experience both financial and geographical barriers to healthcare. A child with a disability may require more frequent healthcare while the family simultaneously faces additional caregiving and transport expenses. An undocumented child living in poverty may experience material deprivation compounded by legal and administrative barriers.

The children at greatest risk may consequently be those experiencing several disadvantages simultaneously rather than those affected by a single socioeconomic factor.

15.5 Legal Identity as a Social Determinant of Health

Legal identity warrants particular attention in discussions of health equity in Malaysia. For refugee, asylum-seeking, undocumented and stateless children, socioeconomic disadvantage may intersect with immigration or documentation status in ways that directly influence access to healthcare.

UNHCR-registered refugees and asylum seekers currently access Malaysian government healthcare facilities at 50% of the fee charged to foreigners, while individuals without UNHCR documentation are charged the full foreigners' rate. Hospital admission may additionally require substantial deposits; current UNHCR guidance indicates estimated deposits of RM700–RM1,400 for UNHCR-registered refugees requiring inpatient treatment, with subsequent treatment charges potentially exceeding the deposit.

For families already living with financial insecurity, such charges may represent a significant barrier to timely healthcare.

Legal status may also affect whether families feel safe approaching healthcare institutions. The UN Committee on the Rights of the Child expressed particular concern in its 2026 review of Malaysia about barriers affecting asylum-seeking, refugee, migrant, undocumented and stateless children. It recommended ensuring their access to public health and other basic services and called for removal of regulations requiring healthcare personnel to report undocumented persons, together with the establishment of a firewall between service providers and immigration authorities.

Legal identity therefore extends beyond an administrative classification. Where it determines the cost, accessibility or perceived safety of seeking healthcare, it becomes a structural social determinant of child health.

This is especially significant for preventive services. Missed immunisation, growth monitoring or developmental surveillance may initially be invisible, but their consequences may emerge later as preventable disease, delayed diagnosis or missed opportunities for early intervention.

15.6 The Impact of Poverty on the Child

Poverty rarely appears on a child's medical problem list. Clinicians instead encounter its downstream consequences: inadequate nutrition, growth faltering, obesity, recurrent infection, incomplete immunisation, delayed healthcare-seeking, missed appointments, difficulties sustaining treatment, delayed developmental intervention, educational difficulties and psychosocial stress.

These pathways can reinforce one another:

poor nutrition → recurrent illness → delayed healthcare-seeking → missed preventive care → difficulties maintaining treatment → developmental and educational disadvantage → psychosocial stress → poorer long-term health

Such associations should not be interpreted as inevitable consequences of poverty or as evidence of inadequate parenting. Families make decisions within the resources and constraints available to them. A parent who misses a hospital appointment because attendance requires sacrificing a day's income is confronting a structural constraint rather than necessarily demonstrating disregard for the child's healthcare.

The effects may also accumulate across the life course. Poor childhood health can interfere with schooling; disrupted education may reduce subsequent employment opportunities; and reduced economic opportunity may perpetuate poverty in the next generation.

Reducing child poverty should consequently be recognised as a health intervention as well as a social and economic priority.

15.7 From Health Inequality to Children's Rights

Socioeconomic disparities in child health are not solely questions of service efficiency or distributive policy. They are also questions of children's rights.

Article 24 of the United Nations Convention on the Rights of the Child (CRC) recognises the right of the child to the highest attainable standard of health and requires States Parties to strive to ensure that no

child is deprived of access to healthcare services. Malaysia ratified the CRC in 1995 and does not maintain a reservation to Article 24. It does, however, retain reservations to Articles 2, 7, 14, 28(1)(a) and 37.

The distinction is important. Children do not determine household income, parental employment, disability, geographical location or documentation status. When such circumstances systematically influence access to nutrition, healthcare, education and social protection, socioeconomic inequality becomes a question of fairness, social justice and children's rights.

The Committee on the Rights of the Child's concluding observations of February 2026 are especially relevant. While acknowledging Malaysia's progress in reducing poverty, the Committee remained concerned about children living in poverty and extreme poverty, particularly in Sabah, Kelantan and Sarawak, and about barriers to accessing social security and social assistance. It recommended that children and families living in poverty receive adequate financial support and free and accessible services without discrimination.

The Committee also identified structural discrimination affecting children in poverty, Indigenous children, children with disabilities, and asylum-seeking, refugee, migrant, undocumented and stateless children. In relation to nutrition, it called for systematic collection of child food-security and nutrition data, adequate implementation and monitoring of national nutrition policies, improved access to healthy food for poor households and stronger action on childhood obesity.

These recommendations shift the policy question from whether disadvantaged children should receive additional assistance to what structural changes are required to ensure that all children can realise their rights.

The major socioeconomic determinants affecting Malaysian children, their potential health consequences and corresponding policy responses are summarised below.

Table 15.1: Key Socioeconomic Determinants of Child Health in Malaysia and Potential Policy Responses

Determinant	Impact on child	Malaysian evidence / current context	Recommended response
Household poverty and low income	Reduced ability to meet nutritional, educational, healthcare and other basic needs; increased family stress; cumulative disadvantage across childhood.	Absolute household poverty was 5.1% nationally in 2024, but remained higher in rural areas (9.9%) and particularly in Sabah (17.7%) and Kelantan (11.5%).	Strengthen child-sensitive social protection; adjust assistance according to household size, disability and local living costs; monitor child-specific outcomes rather than household income alone.
Multidimensional deprivation	Simultaneous disadvantages in health, education, housing, sanitation, transport and communication may compound developmental and health risks.	Malaysia's MPI improved to 0.0025 in 2024, but substantial urban-rural disparities persisted.	Develop a child-specific multidimensional deprivation framework and disaggregate data by geography, disability, socioeconomic status, Indigenous status, nationality and documentation status.
Food insecurity and poor dietary quality	Stunting, wasting, micronutrient deficiency, impaired development and immunity; simultaneously increased risk of overweight and obesity.	Among low-income Kuala Lumpur households studied by UNICEF, 90% reported being affected by rising food prices, and approximately half of children reportedly consumed fewer than three meals daily.	Combine nutrition programmes with income and food-security interventions; improve affordability of healthy foods; evaluate and scale effective Cash Plus approaches.
Inadequate housing and overcrowding	Greater exposure to communicable disease, environmental hazards, poor sleep and psychosocial stress.	Multidimensional poverty measures include housing conditions, overcrowding, sanitation and access to basic services.	Integrate child-health policy with housing and local-government policy; improve housing quality, sanitation and safe environments in deprived communities.

Determinant	Impact on child	Malaysian evidence / current context	Recommended response
Rural and remote residence	Delayed access to preventive and curative care; fewer specialist and developmental services; transport costs; educational and digital disadvantage.	Rural absolute poverty was 9.9% in 2024; the Sabah Child Wellbeing Index demonstrates continuing geographical inequalities.	Allocate healthcare resources according to need and deprivation; strengthen rural primary care, mobile/outreach services, transport assistance, telehealth and workforce distribution.
Indirect costs of healthcare	Delayed presentation, missed follow-up, interrupted chronic disease treatment and reduced access to rehabilitation or developmental care.	Malaysia's Health White Paper recognises affordability and equitable access as health-system priorities.	Measure healthcare affordability from the family's perspective, including indirect costs; decentralise follow-up where possible; strengthen community and primary-care services.
Limited access to preventive healthcare	Incomplete immunisation, missed growth and developmental surveillance, delayed recognition of disease and preventable morbidity.	In the 2026 Sabah Child Wellbeing Index, almost one in four children surveyed was not fully immunised.	Protect universal access to immunisation, growth monitoring, developmental surveillance and essential preventive services, with targeted outreach to underserved populations.
Disability	Increased healthcare and rehabilitation needs; greater caregiving and financial burden; possible exclusion from education and services.	UNICEF identifies children with disabilities and households affected by disability among groups experiencing disproportionate disadvantage.	Provide disability-sensitive social protection, accessible health and rehabilitation services, inclusive education, transport support and systematic disaggregated monitoring.
Undocumented or stateless status	Financial and administrative barriers to healthcare; incomplete immunisation; reduced access to education and social protection; fear or reluctance to seek services.	UNICEF reports continuing gaps affecting undocumented and stateless children; the CRC Committee raised concerns regarding access to essential services.	Ensure essential preventive and primary healthcare based on child need; reduce administrative barriers; improve birth registration and consider separation between essential service provision and immigration enforcement.
Refugee and asylum-seeking status	Delayed healthcare because of cost, documentation requirements or fear; particularly serious consequences for preventive and chronic care.	UNHCR-registered refugees and asylum seekers pay 50% of the foreigners' rate at government facilities; inpatient deposits may create additional barriers.	Improve financial protection for essential child healthcare; provide clear information regarding entitlements; ensure preventive services remain accessible.
Educational disadvantage and digital exclusion	Poor school readiness and educational attainment; reduced future employment opportunities; perpetuation of intergenerational poverty.	Education and access to basic communication are included within Malaysia's multidimensional assessment of deprivation.	Strengthen early-childhood development, educational inclusion and digital access; integrate education indicators into child-poverty monitoring.
Inadequate social protection	Food insecurity, inability to absorb economic shocks, treatment interruption and heightened family stress.	UNICEF's Malaysia programme identifies persistent gaps in coverage and adequacy of social protection.	Develop a coherent child-sensitive social-protection floor; simplify access; prioritise early childhood and households facing multiple vulnerabilities.
Fragmented policy response	Children's needs may fall between health, welfare, education, housing and immigration systems.	Malaysia has relevant frameworks, but determinants of child health span several ministries and agencies.	Establish a whole-of-government child-health-equity approach, with common indicators, accountability and coordinated planning.

Determinant	Impact on child	Malaysian evidence / current context	Recommended response
Limited visibility of vulnerable children in national data	Inequalities may remain hidden, resulting in resources being distributed according to averages rather than need.	The CRC Committee has called for stronger disaggregated data, particularly concerning stateless, undocumented, refugee and Indigenous children and children with disabilities.	Strengthen disaggregated child data and child-responsive budgeting; routinely assess whether resources reach children experiencing the greatest deprivation.
Limited participation of children and families	Policies may overlook practical barriers and lived experiences, particularly among marginalised groups.	The CRC emphasises children's right to express views on matters affecting them; the 2026 Committee recommendations reinforce meaningful child participation.	Include children, adolescents and caregivers, including those from marginalised groups, in programme design, monitoring and evaluation.

Abbreviations: CRC, Convention on the Rights of the Child; MPI, Multidimensional Poverty Index; UNICEF, United Nations Children's Fund; UNHCR, United Nations High Commissioner for Refugees.

These determinants should not be viewed in isolation. Their effects are frequently cumulative, with children experiencing poverty alongside disability, geographical disadvantage or insecure legal status facing the greatest risk of exclusion.

15.8 Conclusion

Malaysia's achievements in reducing poverty and establishing an extensive healthcare system provide a strong foundation for improving child health. The next challenge is one of equity: ensuring that children who have benefited least from national progress are not left behind. For a child, poverty is more than household income falling below a statistical threshold. It may mean inadequate nutrition, overcrowded housing, limited educational resources, long journeys to obtain healthcare, a parent losing wages to attend hospital, missed preventive services, insecure legal identity or growing up in a community where opportunities are systematically constrained. These disadvantages may accumulate and become embedded in a child's physical health, development, education and future socioeconomic opportunities.

Addressing them therefore requires more than healthcare reform or poverty reduction in isolation. It requires a coordinated, rights-based approach to the social determinants of health, supported by child-sensitive data, effective social protection, equitable healthcare financing, strong primary and preventive services, and policies that specifically reach children experiencing multiple vulnerabilities.

Malaysia already possesses many of the necessary policy foundations. The Health White Paper provides the architecture for a more equitable and sustainable healthcare system, while the National Child Policy and Action Plan 2026–2030 establish a contemporary framework for children's well-being. The Committee on the Rights of the Child's 2026 concluding observations provide an additional benchmark against which remaining gaps can be assessed. The task now is to connect these commitments and translate them into measurable improvements in children's lives.

Reducing childhood poverty should be regarded as a child-health intervention, just as improving access to healthcare should form part of the response to childhood poverty. Ultimately, Malaysia's progress should be judged not only by national income, overall poverty reduction or average health indicators, but also by the circumstances of children who have benefited least from that progress. A child's opportunity to survive, develop and attain the highest possible standard of health should not be determined by household income, geographical location, disability or documentation status. Ensuring that opportunity is both an investment in Malaysia's future and a fundamental commitment to its children.

15.9 Recommendations

Malaysia has strong foundations on which to build a more equitable approach to child health. The Health White Paper provides a framework for health-system reform, while the National Child Policy and its Action Plan 2026–2030 provide an overarching child-policy framework. The 2026 CRC concluding observations identify important remaining gaps. The priority should therefore be to align existing policies around measurable improvements in child well-being.

1. Measure child poverty through a multidimensional lens

National poverty monitoring should continue to include household income while developing more child-sensitive measures of deprivation. These should encompass health, nutrition, education, housing, sanitation, disability, digital access, protection and legal identity. Data should be disaggregated by age, sex, disability, geographical location, socioeconomic background, Indigenous or ethnic background, nationality, migration status and statelessness. The CRC Committee specifically recommended addressing major gaps in data relating to stateless, undocumented, refugee and Indigenous children and children with disabilities.

2. Introduce child-responsive budgeting

Reducing inequity requires resources that can be identified, monitored and protected. Malaysia should progressively implement child-responsive budgeting that tracks expenditure benefiting children and evaluates its distribution across socioeconomic and geographical groups. The CRC Committee expressed concern in 2026 about the absence of child-focused budgeting and recommended budget tracking, adequate allocations for children's rights and protected budget lines for children in vulnerable circumstances.

3. Strengthen child-sensitive social protection

Social assistance should account for household size, disability, nutritional vulnerability, geographical differences in living costs and other factors that increase the cost of raising children. The Cash Plus model provides a useful opportunity to evaluate whether combining income support with nutrition and parenting interventions produces better child outcomes than financial assistance alone. Where effective, such interventions could inform broader child-sensitive social-protection strategies.

4. Make healthcare financially accessible from the family's perspective

Healthcare affordability should not be measured solely by consultation charges. Assessment of financial barriers should include transport, repeated appointments, loss of caregiver income, medications and other indirect expenses. Greater use of community outreach, mobile services, strengthened primary healthcare and appropriately designed telehealth may reduce the burden experienced by families requiring repeated care. This approach is directly aligned with the Health White Paper's commitments to equitable healthcare delivery, stronger primary healthcare and affordable comprehensive services.

5. Protect access to essential preventive child healthcare

Preventive services provide some of the greatest opportunities to reduce socioeconomic health inequities. Immunisation, growth and developmental surveillance, maternal and child health services, nutritional assessment and other core preventive interventions should be accessible to every child. Particular attention is required where poverty, geography, disability or documentation status creates barriers. Preventing avoidable disease is both clinically more effective and economically more sustainable than managing complications arising from delayed access to healthcare.

6. Reduce legal and administrative barriers affecting undocumented and stateless children

Essential child healthcare should be guided primarily by health need and the best interests of the child. Malaysia should carefully consider the CRC Committee's recommendation to ensure

access to public healthcare for refugee, asylum-seeking, migrant, undocumented and stateless children and to establish separation between essential service provision and immigration enforcement. Parallel efforts to improve birth registration and prevent childhood statelessness remain important because legal identity affects access to multiple determinants of well-being, including health, education and social protection.

7. Allocate resources according to need

National averages should not obscure substantial geographical disparities. The persistence of markedly higher poverty in Sabah and rural Malaysia supports targeted allocation of healthcare professionals, nutrition programmes, outreach services, transport support and other resources according to local deprivation and child need rather than population size alone. The Sabah Child Wellbeing Index provides an example of how locally disaggregated, multidimensional data can guide more equitable investment.

8. Make nutrition policy poverty-sensitive

Healthy eating advice has limited practical value when families cannot afford nutritious food. Nutrition policy should therefore be integrated with food affordability, social protection, breastfeeding support and measures addressing unhealthy food environments. The CRC Committee's recommendation to ensure poor households can access healthy food while simultaneously addressing childhood obesity provides a useful policy direction.

9. Adopt a whole-of-government approach

Many of the most important determinants of child health lie outside healthcare institutions. Health, education, welfare, housing, finance, civil registration, transport, digital infrastructure and local government policies all shape the conditions in which children develop. Addressing childhood poverty therefore requires coordinated accountability across sectors rather than isolated interventions. Child-health equity should become an explicit outcome against which relevant national and state policies are assessed.

10. Include children and families in decisions affecting them

Children and families experiencing poverty possess knowledge that administrative datasets cannot capture. Their participation can reveal practical barriers to services and identify interventions that are realistic, acceptable and responsive to lived experience. Particular effort should be made to include children whose voices are least frequently represented, including Indigenous children, children with disabilities, undocumented and stateless children, and children living in remote communities. Meaningful participation is not simply good programme design; it reflects the CRC principle that children should have opportunities to express their views on matters affecting them.

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Section 16: Indigenous Children – The Orang Asli and Beyond

The Orang Asli population is about 227,900 (2025), roughly 0.8% of the population of Peninsular Malaysia.

Under-5 mortality among Orang Asli children was 11 times that of the major ethnic groups in 2016.

Among Orang Asli children below 5 years, 43.8% are stunted, 12.3% wasted and 6.7% overweight (IPH 2022).

These realities are hidden behind the national average.

16.1 Introduction

No group of Malaysian children is more marginalised, more invisible, and more profoundly failed by the state than indigenous children. The Orang Asli, termed as aborigine under the Aboriginal Peoples Act 1954 (Act 134), is defined based on spoken aboriginal language, follow the aboriginal way of life, customs and beliefs, and blood relations or lineage (Government of Malaysia, 1954). The Orang Asli, the Indigenous Peoples, the First Nation peoples of Peninsular Malaysia, continue to face health, educational, and social indices observed in socio-economic disadvantaged nations. At the same time, Orang Asli children remain 'left behind' and their situation is not improving. In many respects, it is worsening.

The fact that these realities are not visible in Malaysia's national health statistics, because they are hidden behind the national average, is itself a profound injustice. We can only address what we are willing to see. And for too long, Malaysia has chosen not to see.

16.2 Orang Asli Population

The Orang Asli population comprises approximately 227,900 people in 2025 (Department of Statistics Malaysia [DOSM], 2025), representing around 0.8% of the population of Peninsular Malaysia. This accounts for an average annual growth rate of 1.2% when compared to 213,461 Orang Asli population in 2020 (DOSM, 2025). They are 3 main ethnic groups, namely the Senoi, Negrito and Proto-Malay, that are further divided into 18 sub ethnic-groups. The Department of Orang Asli Development (JAKOA) officially recognised 853 villages and classified their settlements as towns (0.7%), fringes of suburbs (63.2%) and interior (36.1%). They are concentrated in Pahang (36.8%), Perak (32.3%), Selangor (9.6%), and Kelantan (7.2%). More than 55% of the Orang Asli population is below 20 years of age - a young population with enormous need and enormous potential, chronically underserved.

16.3 Mortality and Morbidity — A Silent Catastrophe

Under-5 mortality rate: 11 times that of major ethnic groups (Malay/Chinese/Indian) in 2016. The three leading causes of death are infections (septicaemia, pneumonia, neonatal sepsis) - all malnutrition-related.

The nutrition status among Orang Asli children below 5 years old remained concern, with 43.8% stunting, 12.3% wasting, and 6.7% overweight (Institute for Public Health, 2022).

Survey findings based on 324 Orang Asli children aged 12 to 23 months found only 60.7% had verified complete primary immunisation; this prevalence was considerably lower than the prevalence in general population; and Orang Asli children, particularly from the Negrito tribe from remote area recorded the lowest rate of receiving completed primary immunisation at 36.5% (Institute for Public Health, 2022). All the mentioned immunisation rate was below the national's target of 95% immunisation coverage.

Orang Asli below 5 years old were found with low birth weight (24.4%) and underweight (32.9%) (Institute for Public Health, 2022).

Although the national prevalence of children under the age of 5 having anaemia is 46.5% (NHMS 2022), a systematic review reported that Orang Asli children experience significant pooled prevalence of anaemia of 61.6% (Ab Aziz et al., 2024).

A cross-sectional survey involving 1,142 Orang Asli school-going children reported that 70.1% of them were infected with at least one of the soil-transmitted helminth (STH) species, surpassing the World Health Organization (WHO)'s threshold of 20% for policy intervention (Nasr et al, 2020).

16.4 Poverty and Education

The overall poverty rate is 89.4% with a hardcore poverty rate of 33.0% (IWGIA, COAC, JAKOA).

MOE highlighted the transition rate of Orang Asli children from Standard 6 to Form 1 increased to 94.02% in 2025 compared to 89% in 2023 attributed to K9 and K11 Comprehensive Special Model School (Berita RTM, 2026). However, this transition rate alone is not adequate to reflect the reality and persistent gap of drop-out of Orang Asli students as the past and available public-view dataset on the number of Orang Asli children completing Standard 6 reduced significantly from 4,705 in 2012 to 3,812 in 2019 (Kementerian Kemajuan Desa and Wilayah, 2021), suggesting the increase of past transition rate (%) against the reduced number of primary school students.

42.29% of Orang Asli students failed to complete their education till Form 5 in 2021 (Kamarudin & Mohd Said, 2023)

There is a need for data on how many Orang Asli children never enrolled in school and the illiteracy rate among young adults.

16.5 Health Service Access

MOH health services targeting four weekly visits to Orang Asli communities achieved only 66.2% of planned visits in 2019 due to logistical challenges. The Flying Doctor Service from Kinta, Perak achieved only 41.6% of planned flights. Immunisation rates in some communities are as low as 15–40%.

One recent study of 61 Orang Asli children admitted to Hospital Gua Musang showed that 85.2% were not fully vaccinated. In 2007, a 2022 audit of all Orang Asli children under 2 years in Perak found more than 40% malnourished, with most receiving inappropriate nutritional care.

A particular challenge is the RPS (Resettlement Scheme) — where communities are moved from forest areas to agricultural settlements. Observation over many years suggests the RPS worsens Orang Asli health and nutrition, as relocated communities lose access to traditional food sources and struggle to adapt to agricultural activities.

16.6 Sabah and Sarawak Indigenous Communities

Indigenous ethnic groups in Sabah and Sarawak had under-5 mortality rates 1.7 times that of major ethnic groups in 2016. Interior communities in Sabah — including Kadazan-Dusun, Murut, and Bajau Laut communities — face challenges very similar to Orang Asli in Peninsular Malaysia: geographic isolation, limited health access, high malnutrition rates, and poor educational outcomes. The Bajau Laut sea-nomad children of eastern Sabah are among the most marginalised children in Malaysia, with minimal documentation and no regular access to any government services.

16.7 Recommendations

1. Make Orang Asli and Sabah/Sarawak indigenous child mortality and malnutrition rates national health indicators, with explicit targets and accountability at the Health Minister level.

2. Provide consistent, ring-fenced funding for community re-feeding centres in all Orang Asli and interior Sabah communities, providing at least one protein-rich meal daily to all under 5 children.
3. Strengthen and fully fund the Orang Asli Mobile Health Teams and Flying Doctor Services, with dedicated vehicles, aircraft, and staff.
4. Bring all pregnant Orang Asli women to hospital at 34–36 weeks for delivery, with culturally appropriate family accommodation, and retain mother and child for 1–2 weeks post-delivery.
5. Develop culturally acceptable, community-based health workers in Orang Asli villages — paid, trained, and supported by MOH — to provide first-line health monitoring, early identification of malnutrition, and referral.
6. Revamp the food basket programme (KZM), which has been consistently shown to have poor delivery and effectiveness, with a direct nutrition support model.

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Section 17: Migrant, Refugee, and Stateless Children

Malaysia hosts thousands of non-citizen children, which some estimate to be about 7% of the national child population, alongside 211,360 UNHCR-registered refugees and asylum-seekers as of October 2025, of whom 64,801 are children under 18.

As of July 2025, Malaysia was holding an estimated 22,000 people in immigration detention without judicial oversight. The Home Minister told Parliament that 10% of detainees were children, meaning roughly 2,200 children were in detention at that point.

The Child Act 2001's own Preamble already promises protection to every child 'without regard to distinction of any kind', and a Malaysian court confirmed in 2023 that this includes stateless children. But the Education Act 1996 and Ministry of Health circulars, the actual laws and rules that control a child's access to school and healthcare, carry no equivalent non-discrimination guarantee.

17.1 Introduction

Malaysia hosts a large population of refugees, asylum-seekers, stateless persons and undocumented migrants. The children in these communities face significant deprivations. They lack legal status, documentation, access to education, and routine healthcare. They live in fear of arrest, detention, and deportation. And yet they are children, equally deserving of the protections guaranteed by the UNCRC, which Malaysia has ratified. The gap between legal obligation and lived reality for these children is among the most serious human rights failures in contemporary Malaysia, and, as this update sets out, that gap is not primarily a gap in the law protecting children. It is a gap between one law that already says the right thing and several others that do not.

17.2 Scale of the Population

Registered refugees and asylum-seekers (UNHCR, end October 2025): 211,360, including 64,801 children under 18. This is a substantial increase from the 183,790 registered in January 2023 (46,170 children), an approximately 40% rise in the registered child population in under three years.

Of the October 2025 total, 189,760 were from Myanmar; the remainder came from more than 50 other countries, including Pakistan (5,797), Yemen (3,121), Somalia (2,898), Afghanistan (2,751), Syria (2,509), Sri Lanka (1,061), Palestine (502) and Iraq (438).

Non-citizen children overall (DOSM, 2025-26): 703,100 children aged 0-19, representing 7% of Malaysia's child population. Most of these children are presumed stateless or without settled legal status.

Stateless population: UNHCR's most recent published country total, end 2023, records 117,070 stateless people in Malaysia, the third largest reported stateless population in Southeast Asia. This sits alongside the older, frequently cited Home Minister figure of 290,000 (2016) and UNHCR's own registered stateless caseload of 108,332 plus roughly 55,000 'of concern'. The range between these figures is itself evidence of how poorly this population is counted.

Undocumented economic migrants: estimated at 1 to 3 million across Malaysia, concentrated in Sabah, with many children born in Malaysia to these families.

Sabah's non-citizen population was put at 810,443 by the Chief Minister in 2022, 23.7% of the state's population, nearly double UNHCR's own 2019 estimate of 450,000 stateless persons in Sabah. This gap between two official-source estimates, taken only three years apart, underlines how uncouned this population remains.

Indonesian and Myanmar residents' children in Malaysia had an under-5 mortality rate 25.5 times the national average in 2016. No more recent disaggregated mortality figure for this population appears to be publicly available, a data gap that should be treated as a priority for update.

17.3 Legal Framework, Critical Gaps

Malaysia is not a signatory to the 1951 UN Refugee Convention or its 1967 Protocol, and has not ratified the 1961 Convention on the Reduction of Statelessness. Refugees are treated as undocumented migrants under domestic immigration law. There is no legal framework for refugee protection, no legal status that distinguishes a refugee from an irregular migrant, and no pathway to permanent residency or citizenship for most.

Immigration law does not conform to the Child Act or the UNCRC and does not distinguish between children and adults for most operational purposes. Children can be, and are, detained in immigration detention centres as 'illegal immigrants', with the consequences for health, education and psychological development set out later in this section.

In 2025, the Federal Constitution was amended to grant citizenship to children born abroad to Malaysian mothers, a genuine and positive development. It does not, however, touch two further gaps that continue to manufacture statelessness inside Malaysia itself: a Malaysian mother still cannot automatically transfer citizenship to a child born in Malaysia out of wedlock, and a Malaysian father cannot transfer citizenship to a child born outside a marriage recognised by the state. Birth registration remains available in principle to all children born in Malaysia regardless of parental documentation status, but accessing that registration in practice faces numerous barriers, and this is examined in full in Section 17.10 below.

A significant and very recent development is the launch, on 1 January 2026, of a new national refugee registration scheme, the Dokumen Pendaftaran Pelarian (DPP), run by the Home Affairs Ministry. It is intended to replace UNHCR's own registration process and is being piloted first among refugees already held in immigration detention centres. At the time of writing this scheme is too new for its effect on children's legal status and protection to be assessed, and it should be tracked closely in the next update of this report, since it represents the most consequential change to how Malaysia identifies and registers this population in over a decade.

17.4 One Law That Covers All Children, and Two That Do Not

This is the single most important legal point in this section, and it deserves to be stated plainly rather than left implicit. The Child Act 2001 already, on its own terms, protects every child in Malaysia. Its Preamble recognises that every child is entitled to protection and assistance in all circumstances, without regard to distinction of any kind. This is not a matter of interpretation. In 2023, the High Court ruled directly on it, finding that the Immigration Department had acted unlawfully in arresting and detaining three stateless, Selangor-born children for 28 days without bringing them before a Court for Children within 24 hours, as the Child Act requires for every child, citizen or not. The presiding judge stated that the Act protects every child, even those without Malaysian citizenship, and that the Preamble's guarantee of protection without distinction admits no exception for citizenship status. Malaysia's own government repeated this position to the UN Committee on the Rights of the Child in January 2026, telling the Committee that non-citizen children were accorded protection through the Child Act 2001.

Taken at face value, this should resolve most of the concerns in this section. It does not, and the reason why is the central finding of this update. The Child Act 2001 is a child protection statute. It governs abuse, neglect, care and protection proceedings, and the treatment of children who come into contact with welfare and justice systems. It does not, and was never designed to, govern a child's right to enrol in a government school or to be treated at a public clinic without prohibitive cost. Those two domains sit inside entirely separate legislation and administrative practice: the Education Act 1996 for schooling,

and Ministry of Health circulars, including Circular 10/2001, for healthcare. Neither carries the Child Act's non-discrimination language. Neither has ever been tested in court the way the Child Act was in the 2023 case above. The result is a two-tier legal reality: a child who is abused or neglected is, in principle and increasingly in practice, protected by the same law regardless of citizenship, while the same child, seeking a school place or a vaccination, is governed by rules that were never written with a non-discrimination guarantee at all, and that continue to exclude them as a matter of routine administrative practice.

This is not a new observation. The Committee on the Rights of the Child raised it as far back as Malaysia's 2010 Universal Periodic Review, noting with concern that non-citizen children had to pay a school fee and were accepted into government schools only if they held adequate documentation and if places were available. Sixteen years on refugee children remain denied access to Ministry of Education schools altogether, and Section 17.9 below confirms that the fee structure governing healthcare access has, if anything, become more elaborate rather than simpler. The technicality has outlived multiple election cycles, multiple reform announcements, and, evidently, direct judicial correction of the underlying legal principle in an entirely different domain.

17.4.1 Why This Matters for Every Other Recommendation in This Section

We have recommended specific fixes to specific sectoral problems: remove the MOH reporting requirement, extend legal aid, allow school enrolment without documentation. Each of those recommendations remains necessary and is repeated below. But the 2023 court case and the government's own January 2026 statement to the CRC Committee show precisely why sector-by-sector fixes alone will not close this gap permanently. The Child Act's protection is real, and it can be enforced, as the 2023 ruling shows, but only within the domain the Act actually covers. A future MOH circular, a future Ministry of Education enrolment policy, or a future immigration directive can each recreate a citizenship-based exclusion in its own domain without ever conflicting with the Child Act, because the Child Act's non-discrimination guarantee simply does not reach into education or health legislation as currently drafted. The only fix that closes this permanently is to write the same non-discrimination guarantee, in equivalent terms, directly into the Education Act 1996 and into the statutory or regulatory framework governing MOH's fee and reporting practices, so that a child's access to school and healthcare rests on the same explicit legal footing as their protection from abuse already does.

17.5 Refugee and Migrant Children in Detention

Children of refugees, asylum-seekers and undocumented migrants continue to be detained in Malaysia's immigration detention centres, some without a parent or guardian, separated from family members. As of July 2025, Malaysia was holding an estimated 18,000 migrants, refugees and asylum-seekers in detention without judicial oversight; the Home Minister told Parliament that 10% of detainees were children, meaning roughly 1,800 children were in detention at that point. This follows a sharp escalation in enforcement activity: between January and May 2025 alone, authorities arrested an estimated 34,000 individuals in immigration raids. Earlier point-in-time counts show the same pattern over several years: 1,179 children detained as of January 2023, 1,030 children across 19 detention centres as of April 2023, and 12,435 people of all ages in detention as of December 2023.

In 2022, 153 people died in immigration detention, including 25 women and seven children. Conditions have repeatedly driven detainees to attempt escape: 528 people, including 137 children, escaped from the Sungai Bakap detention centre in April 2022, and 131 people, mostly Rohingya refugees, escaped from the Bidor Temporary Immigration Depot in February 2024. UNHCR has been denied access to all immigration detention centres since August 2019, now more than six years, meaning no independent international body is able to monitor conditions or assist with refugee status determination for anyone detained during this period.

In 2023, the government launched Baitul Mahabbah, intended as a dedicated facility for children aged 10 and under, moving them out of standard detention depots. As of September 2024, roughly 170

children, some unaccompanied, were held in these centres. Human Rights Watch, which has monitored the initiative, describes it as failing to provide a genuine alternative to detention, since children remain in a closed, institutional setting rather than in the community-based alternatives recommended by the UNCRC.

17.6 Access to Healthcare

The basic right to healthcare for migrant, refugee and stateless children, guaranteed under UNCRC Article 24, has not been upheld. These children do not receive routine primary immunisation, growth or developmental monitoring, or health education as a matter of course. The 2019 polio outbreak in Sabah, the first in Malaysia in 27 years, was directly linked to the absence of routine immunisation among migrant children, and it remains the clearest demonstration that excluding this population from healthcare does not only harm them, it endangers herd immunity for every child in Malaysia.

Healthcare in Malaysia operates on a three-tier fee structure for this population. Citizens receive free or heavily subsidised care. UNHCR-registered refugees and asylum-seekers are entitled to a 50% discount off the standard foreigner rate at government facilities. Everyone else, including undocumented migrant children and many stateless children without UNHCR documentation, pays the full foreigner rate with no discount at all. In practice this still prices most families out: a normal delivery at the foreigner rate costs roughly RM4,000 to RM5,000, and a single antenatal or postnatal screening at a private clinic costs RM100 to RM500. Hospital admission requires a deposit of roughly RM500 to RM1,400 depending on the facility and category of illness, and some families are denied discharge until the bill is settled. At discharge, only five days of medication is typically provided, with no follow-up arranged, even for children with chronic conditions.

Multiple barriers compound the cost problem. Chief among them is the requirement, under MOH Circular 10/2001, for health staff to report undocumented foreigners to the Immigration Department or police, a duty that this report's Section 17.4 has already shown carries no equivalent non-discrimination override anywhere in health legislation. This reporting duty applies even at the point of a child's birth. Families also report language barriers and a documented lack of respectful treatment by health staff, and the basic economics of informal work, where missing a day of work to queue at a clinic can cost a family more than the visit itself. Civil society organisations, including Médecins Sans Frontières and the network of NGO clinics listed at the end of this section, fill a meaningful part of the primary care gap, but they are generally not equipped for hospitalisation, surgery or specialist paediatric care, which pushes a seriously ill child straight back into the fee structure described above.

17.7 Maternal Healthcare for Refugee, Stateless and Non-Citizen Women

A 2019 UNHCR study estimated maternal mortality among refugees in Malaysia at 62 deaths per 100,000 live births, against a national maternal mortality ratio that was around 36 at the time. That gap, refugee mothers dying at roughly twice the rate of the general population, has not been re-measured since. No comparable, updated study has been published in over six years, even as the registered refugee population, and specifically the number of refugee children, has grown by roughly 40% over the same period, as this section's Section 17.2 sets out. Humanitarian organisations working directly in refugee clinics state that they have no reason to believe maternal outcomes have improved, and state equally plainly that no data exists to confirm or refute that.

The drivers are the same cost and fear barriers documented throughout this section: antenatal and postnatal screening priced at RM100 to RM500 a visit even at the discounted rate, delivery costs of RM4,000 to RM5,000 at the full foreigner rate, and the same MOH Circular 10/2001 reporting duty that discourages any undocumented woman from presenting for antenatal care at all until a crisis forces the issue. A small number of NGO clinics, including Klinik Amal Muhajir, offer maternal and child healthcare

at a nominal cost, but their capacity does not come close to matching the scale of the population documented in this section.

17.8 Access to Education

Refugee children remain denied access to Ministry of Education schools. This is not a new finding. As far back as Malaysia's 2010 Universal Periodic Review, the Committee on the Rights of the Child noted with concern that non-citizen children had to pay a school fee and were accepted only if they held adequate documents and if places were available. Sixteen years later, this remains an accurate description of practice: UNHCR-supported community learning centres (CLCs) serve some refugee children, but coverage is limited, quality is inconsistent, and credentials are not nationally recognised outside the CLC network. An estimated 120,000 to 150,000 refugee children remain out of school in Malaysia.

Children of undocumented migrants, particularly in Sabah, have access only to informal schools operating without accreditation. These children face a future without any formal educational qualification at all, entrenching the multi-generational poverty this report documents throughout its treatment of Sabah's non-citizen population.

17.9 Legal Aid and Access to Justice

Malaysia's two statutory legal aid channels, the National Legal Aid Foundation (NLAF) for Peninsular Malaysia and Yayasan Bantuan Guaman Kebangsaan (YBGK) for Sabah, Sarawak and Labuan, are built around citizen access. Non-citizen children and families fall outside their routine coverage. The main channel of free legal help for refugees is the Bar Council and UNHCR's Refugee and Asylum-Seeker Legal Aid Scheme (RALAS), running since 2019, which has reached over 3,000 individuals through Legal Aid Centres in Kuala Lumpur, Penang and Kelantan. It is a valuable partnership, but it is a partnership, not a statutory entitlement, and its geographic footprint does not match where Malaysia's non-citizen population actually lives in the greatest numbers, particularly Sabah.

The consequences of this gap run through nearly every issue in this section. A child in immigration detention, as Section 17.5 documents, has no guaranteed independent legal representation to challenge that detention. A stateless child's citizenship application, examined in Section 17.10 below, is far more likely to succeed with legal representation than without it, yet that representation is not guaranteed. An undocumented family that experiences or reports child abuse faces the same fear of immigration referral in the justice system that this section documents in the healthcare system, discouraging them from ever approaching the police or the Welfare Department.

17.10 Statelessness: How It Is Manufactured, Not Only Inherited

Section 17.2 above sets out the scale of Malaysia's stateless child population. What deserves further emphasis is that a meaningful share of this population is not the children of foreign nationals at all, but children with a genuine claim to Malaysian citizenship who are denied it by gaps in the law itself. Two gender-discriminatory provisions do most of the damage: a Malaysian mother cannot automatically pass citizenship to a child born in Malaysia out of wedlock, and a Malaysian father cannot pass citizenship to a child born outside a marriage recognised by the state. Both situations are common, not exceptional, particularly among poorer families and in Sabah, where informal unions are widespread. The 2025 constitutional amendment noted in Section 17.3 above, allowing citizenship for children born abroad to Malaysian mothers, is a genuine step forward, but it does not touch either of these two domestic gaps.

A further, distinct category is what legal researchers term homegrown statelessness: children of two Malaysian citizen parents who are nonetheless refused citizenship because a birth in an earlier generation was never registered, or because of a documentation gap. The National Registration

Department's discretionary nationality-by-registration process, the route most affected families must use, can take years to resolve, if it resolves at all. A child can spend the whole of childhood, and in some documented cases longer, waiting on an application for a citizenship they are legally entitled to.

17.11 CSOs and NGOs that Support Refugees, Stateless and Migrant Children

This list is not exhaustive and is arranged in alphabetical order. Preserved from the original directory and retained here as a working resource alongside the updated data above.

Table 17.1: Directory of civil society organisations and NGOs supporting refugee, stateless and migrant children in Malaysia

Organisation	Contact	Services
Al-Ikhlash Hope Society (alikhlahshopesociety.org)	alikhlahshopesoc@gmail.com	Fundraises and manages Al-Ikhlash School's operations; centre for 300+ Rohingya families for community gathering and donation distribution.
Asylum Access Malaysia (asylumaccess.org)	+603-22015438; malaysia@asylumaccess.org; legal.aam@asylumaccess.org	Legal protection and rights awareness for refugees; practical training on education, work and healthcare.
Johor Outreach and Community Centre / Cahaya Surya Bakti (johorocc.org)	07-5629800; info@johorocc.org	Platform for refugee community development and protection; connects to UNHCR services, health, food aid, case management and education.
Dignity for Children Foundation (dignityforchildren.org)	011-63873364 (Eng/Malay); 011-69969436 (Burmese/Urdu)	Formal education (preschool to tertiary), case management, mental health and psychosocial support.
Elom Initiatives	010-2100093; elominitiatives@gmail.com	Primary, secondary and informal education for refugees.
ElShaddai Centre (ecb.org.my)	03-33186386; info@ecb.org.my	Education (preschool to tertiary), social work, vocational training and healthcare for refugees, asylum-seekers and stateless people.
Health Equity Initiatives (healthequityinitiatives.com)	03-2272 4957/3255	Public and mental health programmes; capacity-building on refugee mental health and trauma-informed care; specialist psychiatric and counselling services.
HOST International (hostint.org/malaysia)	017-6897827; malaysia@hostinternational.org.au	Community-based child protection and alternatives to detention through case management.
Human Aid Selangor (hass.life)	011-11483414	Humanitarian services for the Rohingya community; runs the Rainbow of Love Learning Centre.
Klinik Amal Muhajir (muhajirclinic.com)	03-89385511	Medical care for RM5 covering communicable and non-communicable disease, maternal and child health.
Médecins Sans Frontières (msf.org/malaysia)	penang-pc-assist@oca.msf.org	Emergency medical and mental health aid, mainly northern Peninsular Malaysia.
OrphanCare Foundation (orphancare.org.my)	see website	Baby hatch and infant fostering/adoption pathway, working with JKM.
Refuge for the Refugees (rftr.super.site)	hello@rftr.my; foodaid@rftr.my	Policy and advocacy, case management, emergency relief; supports 10 refugee schools in Malaysia and 25 in Myanmar.
TENAGANITA (tenaganita.net)	03-77703671/3691	Legal aid and community support for migrants, refugees and trafficked women and children.
Tzu-Chi Education Centres (tzuchi.my)	see website	Alternative learning centres and health support, working with UNHCR.

Organisation	Contact	Services
Yayasan Chow Kit (yck.org.my)	03-26020892; admin@yck.org.my	Drop-in centres and a safe home for children needing temporary guardianship in and around Chow Kit.

A fuller directory, including additional organisations such as Hilla Community Centre, Jaringan Rohingya Education Centre, Kachin Learning Centre, Malaysian Social Research Institute, Myanmar Ethnic Women Refugee Organisation, PichaEats, Refugee Emergency Fund, Refugee Network Centre Malaysia, Rohingya Women Development Network, Somali Women's Association Malaysia and The Peace Education Centre, is retained from the original document and available on request.

17.12 Recommendations

Legal & Constitutional Reform

1. Amend the Federal Constitution to give Malaysian mothers and fathers equal, automatic rights to transfer citizenship to children born in Malaysia, regardless of the parents' marital status.
2. Amend the Child Act 2001 to make explicit that its non-discrimination guarantee covers every child in Malaysia, and mirror that same explicit guarantee in the Education Act 1996 and in the statutory basis for the Ministry of Health's (MOH) fee and reporting practices.
3. Task the Attorney General's Chambers with a formal legislative harmonisation review to identify and close every point where sectoral law falls short of the Child Act 2001 non-discrimination standard.
4. Direct the Immigration Department, via a binding inter-ministerial protocol, to treat the 2023 High Court ruling as the governing standard for all children encountered in enforcement action, including the requirement to bring any detained child before a Court for Children within 24 hours regardless of citizenship.
5. Set a statutory maximum processing time (e.g., six to twelve months) for nationality-by-registration applications for children with a credible claim to citizenship.

International Treaties & Obligations

6. Withdraw Malaysia's outstanding reservation to UNCRC Article 2 (non-discrimination).
7. Ratify the 1951 Refugee Convention and its 1967 Protocol, developing a domestic legal framework for refugee protection with a clear legal pathway for children.
8. Ratify the 1961 Convention on the Reduction of Statelessness.

Immigration, Detention, & Protection

9. End the immigration detention of children entirely and replace it with community-based case management.
10. Restore UNHCR and independent civil society access to all immigration detention centres.
11. Publish child detention statistics on a regular, standing basis (age, sex, accompaniment status, and length of detention).
12. Independently evaluate the new DPP registration scheme launched in January 2026 for its effect on children's access to legal status and protection.

Healthcare & Maternal Care

13. Suspend the application of MOH Circular 10/2001 to health-seeking encounters, establishing a clear firewall between healthcare access and immigration enforcement.
14. Place MOH's fee structure and reporting obligations on a statutory footing with explicit non-discrimination guarantees, rather than relying on administrative circulars.

15. Provide free primary immunisation and essential healthcare to all children regardless of legal status.
16. Remove financial barriers to healthcare and maternal care for all children and pregnant women regardless of legal status.
17. Standardise a specific, capped rate for non-citizen children (lower than the adult foreigner rate) and extend reduced rates/discounts to unregistered stateless and undocumented children.
18. Formalise referral pathways and cost-sharing agreements between MOH hospitals and the NGO clinic network for primary and hospital-level care, including dedicated funded pathways for maternal care.

Education

19. Amend the Education Act 1996 to insert a non-discrimination clause guaranteeing every child access to enrolment regardless of citizenship, immigration status, or documentation.
20. Allow all children to register for government schools without requiring citizenship documentation.
21. Formally recognise Community Learning Centre (CLC) credentials within the national education framework.
22. Fund and regulate informal schools serving undocumented migrant children in Sabah to minimum quality and safety standards as an interim step.

Legal Aid & Advocacy

23. Formally extend National Legal Aid Foundation (NLAF/YBGK) eligibility to non-citizen children and their guardians for matters affecting welfare, protection, custody, citizenship, and immigration proceedings.
24. Scale RALAS-style legal aid partnerships nationwide, with priority given to Sabah.
25. Guarantee independent legal representation for every unaccompanied or separated non-citizen child in court or immigration proceedings.
26. Fund a dedicated legal aid stream for statelessness determination and nationality-by-registration applications.

Data & Research

27. Commission updated data across state indicators, including refugee and stateless maternal mortality/morbidity studies and non-citizen under-5 mortality.
28. Commission an independent, dedicated Sabah statelessness census, conducted separately from immigration enforcement, to establish an accurate baseline population.

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Section 18: Adolescent Health – Gender, Sexuality, and Identity

There are approximately 5.0–5.5 million adolescents aged 10–19 years in Malaysia.

Vaping among teens aged 13–17 rose from 9.8% in 2017 to 14.9% in 2022, while cigarette smoking fell from 13.8% to 6.2%.

10,349 new adolescent pregnancies were registered in 2019: 40.2% were unmarried and 80.2% were no longer in school.

18.1 Introduction

There are approximately 5.0–5.5 million adolescents aged 10–19 years in Malaysia. They are a demographically significant, health-complex, and frequently neglected group. The NHMS 2022 Adolescent Health Survey reveals a generation under enormous and escalating stress — carrying academic burdens, navigating complex social media environments, experiencing health risk-taking behaviour, and increasingly presenting with serious mental health problems. Their specific health needs — both physical and psychosocial — require dedicated attention, non-judgmental services, and a rights-based approach.

18.2 Health Risk Behaviours

- Alcohol use: 1 in 10 adolescents currently drinks alcohol
- Tobacco smoking: 1 in 5 boys smokes (5% of girls); but cigarette rates in teens dropped from 13.8% to 6.2% (2017–2022)
- Vaping: E-cigarette/vape use among teens 13–17 rose from 9.8% (2017) to 14.9% (2022); 23.3% prevalence in male teens
- Drug use: 1 in 25 adolescents has used drugs; 3–4% are currently using drugs; 166,000 had ever used drugs; 60,000 currently using
- Sexual activity: 7–10% of adolescents report having had sex
- Teenage pregnancy: 10,349 new adolescent antenatal cases registered in MOH in 2019 — 40.2% unmarried, 80.2% no longer in school

18.3 Sexual and Reproductive Health

SDG 3.7 calls for universal access to sexual and reproductive healthcare services, including family planning, information, and education. This is not available to all adolescents in Malaysia, and particularly not to unmarried adolescents.

In principle, MOH has a good National Adolescent Health Policy that empowers adolescents to take responsibility for their health, focusing on mental and sexual health and risk-taking behaviours. However, in practice, staff on the ground often respond to adolescents from religious or cultural perspectives that can be judgmental and limiting, especially regarding:

- Contraceptive access for unmarried adolescents — effectively denied in most MOH settings
- Sexuality-related concerns — responses are often moralising rather than health-promoting
- Transgender health concerns — frequently dismissed or pathologised

The right of adolescents to access healthcare related to their own bodies — including contraception — without requiring parental consent is not recognised in Malaysian law. This is a fundamental gap in adolescent rights that results in unwanted pregnancies, unsafe abortions, and sexually transmitted infections that could have been prevented.

18.4 LGBTQ+ Adolescents

LGBTQ+ adolescents in Malaysia face a uniquely hostile environment. Same-sex relationships are criminalised under both civil law (Section 377 of the Penal Code) and Syariah law in all states. Schools, religious institutions, and some healthcare providers actively engage in efforts to change sexual orientation or gender identity — practices that are classified as harmful by every major mental health professional body internationally.

There are no safe, confidential, affirming health or counselling services for LGBTQ+ young people in the public health system. The consequences are predictable: higher rates of mental health problems, self-harm, suicidal ideation, and social isolation. Research consistently shows that LGBTQ+ young people who have accepting families and communities have mental health outcomes equivalent to their non-LGBTQ+ peers. The harm is caused by rejection and discrimination — not by identity.

The silence on this issue in national health and education policy is itself harmful. Adolescents who are struggling with their identity deserve health services that recognise their humanity, not criminalise it.

18.5 Adolescent Rights as Patients

Adolescents' basic rights as patients in decision-making are not supported in Malaysia. They are viewed as minors under the care of parents or guardians, with no independent right to consent to their own medical treatment. This is particularly problematic in sensitive areas including sexual health, mental health, and substance use — where an adolescent's ability to seek confidential care is critical. Clinicians who wish to provide confidential adolescent-centred care currently do so in a legal grey area without the explicit backing of legislation.

18.6 Recommendations

1. Implement the SDG 3.7 commitment — universal access to sexual and reproductive healthcare services — for all adolescents, including unmarried adolescents, without requiring parental consent.
2. Develop non-judgmental, rights-based training for all healthcare staff who work with adolescents — particularly on sexual health, gender identity, and mental health.
3. Legislate adolescent healthcare rights, including a defined age of consent for medical treatment (suggested 16 years) and the right to confidential care for sensitive health issues.
4. End criminalisation of and discrimination against LGBTQ+ young people in healthcare settings. Ensure that affirming, non-harmful mental health and psychosocial support is available.
5. Establish drop-in adolescent health centres in accessible community locations — not hospital clinics — where young people can seek confidential support without fear.

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Section 19: Climate Change and Environmental Risks

The December 2021 floods affected 4 million people across 10 states.

Children are more vulnerable than adults to heat, air pollution, vector-borne disease and water contamination.

Transboundary haze recurs annually, with particularly severe episodes in 2015, 2019 and 2026.

19.1 Introduction

Climate change is not a distant future threat for children — it is an immediate and accelerating present-day reality. Children are the most vulnerable population to climate change impacts: their physiological characteristics (higher respiratory rates, greater surface area to body mass ratio, immature immune systems, and developing neurological systems) make them more susceptible to heat, air pollution, vector-borne diseases, and water contamination. Younger children and fetuses are particularly vulnerable. The children alive today will bear the consequences of the climate decisions — or failures — of previous generations for their entire lives.

Malaysia is already experiencing the consequences of climate change: more intense floods (the December 2021 Klang Valley mega-flood was unprecedented in modern memory), increasingly severe heatwaves, worsening air quality from transboundary haze, and rising sea levels threatening coastal communities. Each of these has direct and measurable impacts on child health.

19.2 Specific Climate-Related Health Risks for Children

19.2.1 Floods

Malaysia experienced catastrophic floods in December 2021 — the worst in the Klang Valley in decades — affecting 4 million people across 10 states. Children in affected communities faced immediate risks of drowning (flood deaths are one of the leading child injury risks), waterborne disease (diarrhoeal disease, leptospirosis), mental health trauma, and educational disruption. Food security and access to healthcare were also severely compromised for weeks to months. Climate projections indicate that such extreme flood events will become more frequent and more severe.

19.2.2 Haze and Air Pollution

Transboundary haze — primarily from forest and peatland fires in Indonesia — is a recurring annual event in Malaysia, with particularly severe episodes in 2015, 2019, and intermittently in subsequent years. Fine particulate matter (PM_{2.5}) at the levels recorded during severe haze events causes acute respiratory illness, aggravates asthma and other chronic lung conditions, and affects fetal growth and development when mothers are exposed during pregnancy. Children in haze-exposed communities have higher hospital admission rates, higher rates of respiratory illness, and evidence of impaired lung development. Research from other countries (South Korea, Sri Lanka) has also linked air pollution exposure to higher suicide rates.

19.2.3 Heat

Rising temperatures in Malaysia increase the risk of heat-related illness in children — particularly during outdoor physical activity, sports events, and in poorly ventilated school classrooms. Children are physiologically more vulnerable to heat than adults. Infants and young children left in enclosed spaces (including cars) are at risk of rapid, fatal hyperthermia. Schools without adequate air conditioning or

natural ventilation are becoming increasingly unsuitable learning environments as ambient temperatures rise.

19.2.4 Vector-Borne Disease

Climate change alters the geographic distribution and seasonal patterns of vector-borne diseases. Dengue — already a significant child health burden in Malaysia — is expanding in distribution as *Aedes* mosquito habitats extend with warming temperatures and altered rainfall patterns. Dengue deaths in children remain a recurrent and preventable problem.

19.2.5 Food and Water Security

Climate-related disruptions to agricultural systems and water supplies disproportionately affect poor communities — the communities already experiencing the worst child nutrition outcomes. Flooding of agricultural land, saltwater intrusion into coastal freshwater supplies, and drought in Sabah/Sarawak during El Niño events all threaten food security for the most vulnerable children.

19.3 Malaysia's Response — Gaps

Malaysia has committed to various climate agreements, including NDCs under the Paris Agreement. However:

- There is no child-specific climate and health action plan
- Adaptation planning inadequately considers the specific vulnerabilities of children
- Air quality monitoring is insufficient, particularly in schools and residential areas
- Mental health support for children affected by climate-related disasters is minimal
- The most climate-vulnerable communities — the indigenous and the poor — are largely absent from national climate planning discussions

19.4 Recommendations

1. Develop a Child-Specific Climate Health Action Plan that explicitly addresses the heightened vulnerability of children to climate impacts across all relevant sectors.
2. Mandate minimum air quality standards for school environments, including contingency plans for haze events (indoor air purifiers, school closures below Air Pollutant Index thresholds protective for children).
3. Integrate climate change health impacts — including mental health effects of climate disasters — into the school health and community health curriculum.
4. Ensure that children and young people have genuine representation and participation in Malaysia's climate policy decision-making processes.
5. Prioritise climate adaptation investment in the most vulnerable communities — indigenous, coastal, and poor urban — whose children face the greatest climate health risks.

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Section 20: AI, Online Safety, and Screen Risks

WHO recommends no screen time for children under 2 and no more than 1 hour a day at ages 2–4; these limits are widely violated in Malaysia.

School-age children spent 6–8 hours a day on devices during pandemic home learning.

There are limited national programmes to guide parents on healthy screen use for young children.

20.1 Introduction

The digital revolution has fundamentally transformed childhood. Children in Malaysia — including very young children — spend substantial time on digital devices, consuming social media content, playing online games, and increasingly interacting with AI-powered platforms and tools. This digital immersion carries both benefits and serious risks. The risks — cyberbullying, online sexual exploitation, exposure to harmful content, addictive technology design, sleep disruption, and the emerging challenges of AI-generated content — demand urgent policy attention and practical action. Malaysia has been slow to develop and implement a coherent child digital safety framework.

20.2 Screen Time and Young Children

WHO guidelines recommend no screen time for children under 2, and no more than 1 hour per day for children aged 2–4. These guidelines are widely violated in Malaysia, particularly in urban settings where screens are used as primary child pacifiers and entertainment tools from infancy. Excessive early screen time is associated with delayed language development, impaired social skills, sleep disturbance, reduced parent-child interaction quality, and — in older children — attention and executive function difficulties.

The COVID-19 pandemic dramatically increased children's screen time, with school-age children spending 6–8 hours daily on devices during the home-learning period. The normalisation of this level of screen exposure has persisted post-pandemic. There is no national programme in Malaysia to guide parents on healthy screen use for young children, and paediatric healthcare providers are not systematically screening for or addressing problematic screen use.

20.3 Social Media and Adolescent Mental Health

The relationship between social media use and adolescent mental health — particularly for girls — is now strongly supported by research evidence. Heavy social media use is associated with:

- Increased rates of depression, anxiety, loneliness, and low self-esteem — particularly in adolescent girls
- Cyberbullying: Malaysia's Microsoft Global Youth Online Behaviour Survey has consistently shown Malaysia among the highest globally for online bullying exposure
- Social comparison — constant exposure to curated, idealised images contributing to body image problems, eating disorders, and social anxiety
- Sleep disruption — evening screen use suppresses melatonin, delays sleep onset, and reduces sleep duration, with well-documented consequences for cognitive development and mental health
- Exposure to harmful content — including self-harm content, eating disorder promotion, extremism, and pornography — often served by algorithmic recommendation systems designed for engagement rather than safety

The NHMS 2022 adolescent data showing that suicidal ideation, loneliness, and anxiety rates have doubled since 2012 is occurring concurrently with the rapid expansion of smartphone and social media use among Malaysian teenagers. While this correlation does not prove causation in isolation, the international research evidence strongly implicates social media as a significant contributing factor.

20.4 Online Child Sexual Exploitation and Abuse (OCSEA)

Online child sexual exploitation and abuse (OCSEA) has grown substantially in Malaysia, facilitated by widespread smartphone ownership, messaging apps, and gaming platforms. Forms include:

- Online grooming — adults building trust with children online before requesting sexual images or arranging physical meetings
- Child Sexual Abuse Material (CSAM) — creation, sharing, and viewing of images and videos
- Sextortion — coercion of children through threatening to share sexual images
- Live-streaming sexual abuse — children exploited in real-time for paying audiences

The number of child pornography cases reported to the PDRM rose to 67 in 2023. This is almost certainly a severe underestimate of the true burden, as most cases go unreported due to shame, fear, lack of awareness, and victim blaming.

Malaysia does not yet have a specialised, adequately funded national centre for reporting and responding to OCSEA — equivalent to the INHOPE network's Hotline programmes in Europe.

20.5 Artificial Intelligence — Emerging Risks and Opportunities

The rapid proliferation of AI tools — including large language models, image generators, and AI-powered recommendation systems — presents new dimensions of risk for children:

- AI-generated CSAM — AI image generation tools are being used to create synthetic child sexual abuse material, complicating legal frameworks and law enforcement responses
- Deepfakes — AI-generated non-consensual images or videos depicting real children in sexual or humiliating situations
- Misinformation and manipulation — AI tools that can generate convincing false information at scale, potentially radicalising young people or exposing them to harmful ideologies
- Addiction-by-design — AI-powered engagement optimisation in social media and gaming is deliberately designed to maximise time on platform, at the expense of child well-being
- AI in education — while AI tools can support learning, their uncritical adoption without safeguards can undermine critical thinking, academic integrity, and the development of foundational cognitive skills

Conversely, AI holds genuine potential to improve child health outcomes — through early identification of developmental disorders, mental health screening tools, accessible health information, and personalised learning. The challenge is to harness these benefits while protecting children from the harms.

20.6 Current Regulatory Gaps

- No minimum age for social media use is legally mandated in Malaysia (though some platforms nominally set 13 years)
- No legal requirement for social media platforms to protect children from harmful content or addictive design
- No national OCSEA reporting hotline or specialised law enforcement unit with adequate resources

- No national digital literacy curriculum that addresses online safety, critical media literacy, and AI literacy
- No legal framework addressing AI-generated CSAM or deepfakes involving minors

Table 20.1: Studies on Electronic Screen Time in Children in Malaysia

Study Year	Study Design	Sample Size	Time Spent on Electronic Screen	Reference
2016	Cross-sectional, community-based	382 children 2yrs or younger (Ipoh, Perak)	Mean screen time 5.9 hours	Suria Junus, Amar-Singh HSS, et al
2016	National cross-sectional survey	Children below 5 years (national sample)	52.2% exceeded the 2 h/day screen-time limit; 74% of those aged below 2 years were exposed to screens.	National Health & Morbidity Survey 2016 (Maternal & Child Health)
2017	National cross-sectional survey	School-going adolescents aged 10–17 years (national)	48.2% watched TV / used computer / played video games for no more than 2 h/day (i.e. ~51.8% exceeded 2 h/day).	NHMS: Adolescent Nutrition Survey 2017
2020	Cross-sectional	284 children aged 4–6 years (kindergartens, urban & rural Kuantan, Pahang)	Almost 90% used electronic gadgets; 89.8% recorded more than 2 h/day of total screen-viewing duration.	Ghazali J, et al. Malays J Public Health Med.
2022	National cross-sectional survey	Online Safety for Kids and Families, n = 4,500	75% of children spend 1-6 hrs a day online	Google Malaysia
2022	Cross-sectional	489 parent–child dyads; children below 5 years (Petaling district, Selangor)	Median total screen time 3.00 h/day (IQR 1.36–5.04); 91.4% exceeded the WHO limit. Devices: television 66%, handheld 30%, computer 4%.	Raj D, et al. Int J Environ Res Public Health.
2022	Cross-sectional (online survey)	Parents of preschoolers aged 18–60 months (recruited via parenting Facebook groups)	77% of children spent more than 1 h/day of screen time. Older age (≥ 2 y), male gender and gadget ownership were associated with excessive use.	Musa H, et al. Malays J Paediatr Child Health.
2023	Cross-sectional (online)	372 adolescents aged 13–17 years (Klang Valley)	99.4% had more than 4 h/day of screen time; 38.5% had more than three devices at home.	Saat NZM, et al. Healthcare (Basel)
2026	Cross-sectional	254 children aged 18 months (parents recruited at 4 primary health clinics)	66.1% had less than 1 h/day; about one-third (~33.9%) had more than 1 h/day (defined as excessive). Children in mixed-care environments were 3.10× more likely to have excessive screen time.	Musa H, et al. BMJ Paediatr Open

Table 20.2: Studies on Internet addiction in Children in Malaysia

Study Year	Study Design	Sample Size	Addiction Rates	Reference (online link)
2017	Nationwide cross-sectional school-based survey	27,497 school-going adolescents aged 13–17 years, from 212 randomly selected secondary schools (national)	Internet addiction prevalence 29.0% (Malay Version of the Internet Addiction Test, MVIAT).	Chan et al. Int J Environ Res Public Health. 2021
2018	Cross-sectional	199 adolescents from 6 secondary schools in the Klang Valley	49.2% were classified as addicted to the internet (MVIAT).	Abdul Aziz et al. Int Med J Malaysia. 2018
2021	Cross-sectional online survey	420 adolescents aged 13–17 years (secondary schools, Melaka)	45.5% were classified as internet-addicted users (MVIAT).	Md Bukhori AB et al. 2024

Study Year	Study Design	Sample Size	Addiction Rates	Reference (online link)
2021	Cross-sectional online survey	535 early adolescents (lower-secondary students, Kota Bharu, Kelantan)	Internet addiction prevalence 48.6% (MVIAT).	Sangaran LN et al. Malays Fam Physician. 2024
2022	Cross-sectional (SmartPLS mediation modelling)	500 adolescents aged 13–19 years, from 7 secondary schools	Internet addiction prevalence 29.6% (Internet Addiction Test, IAT).	Fu SC et al. Children (Basel). 2022
2024	Cross-sectional (convenience sampling)	174 adolescents aged 13–17 years (Puncak Alam, Selangor)	36.8% exhibited a mild level of internet addiction (IAT). (Study reported severity levels rather than single “addicted” cut-off.)	Mohd Azhari AF et al. JUMMEC. 2024
2024	Cross-sectional (convenience sampling)	376 students aged 16-17 from urban and rural districts in Kedah	26.9% of participants met the criteria for IA, with 14.1 at risk	Hamed et al. J. of Inform. System & Techn. Management, 2024
2024	Cross-sectional (convenience sampling)	384 adolescents aged 13–21 in Johor & Sarawak	72.0% high levels of social media addiction	Victor et al. Int J Adolesc Youth 2024

20.7 Recommendations

1. Mandate social media and gaming platform operators to implement age-appropriate design standards that protect children from addictive features, harmful content recommendation, and inadequate privacy settings.
2. Establish a national OCSEA reporting centre, a Hotline, with dedicated law enforcement support, victim services, and intelligence functions.
3. Introduce a mandatory, age-appropriate digital literacy and online safety curriculum in all schools from Year 1, covering cyberbullying, healthy screen use, critical media literacy, OCSEA awareness, and AI literacy.
4. Urgently develop a legal framework addressing AI-generated CSAM and deepfakes involving minors, with specific criminal penalties.
5. Engage healthcare providers to systematically screen for problematic screen use in children at well-child visits, with guidance for parents and referral pathways.

End-of-Section References

- Amar-Singh, H. S. S. (2024, April). Facts and figures on Malaysian youth mental health. *CodeBlue*. <https://codeblue.galencentre.org/2024/04/facts-and-figures-on-malaysian-youth-mental-health-dr-amar-singh-hss/>
- Department of Statistics Malaysia. (2024). *Children statistics, Malaysia, 2024*. <https://www.dosm.gov.my/portal-main/release-content/children-statistics-malaysia-20244>
- Microsoft Corporation. (n.d.). *Global youth online behaviour survey* (various years). <https://www.microsoft.com/en-us/digital-skills/online-safety>

Section 21: Laws Relating to Children in Malaysia

Malaysia has no single comprehensive code on childhood: law is spread across the Federal Constitution, federal statutes, State Islamic family laws and Sabah and Sarawak legislation.

The Child Act 2001 is the central federal statute and defines a child as a person under eighteen years.

Citizenship, education, marriage, employment, criminal liability, evidence and adoption are governed by separate laws.

21.1 Introduction and Scope

Relevant UNCRC provisions for comparison: Articles 1 (definition of a child), 2 (non-discrimination), 3 (best interests) and 4 (implementation of rights).

Methodological note: Cross-references identify potentially relevant treaty provisions only. They do not, by themselves, establish Malaysian compliance; reservations, implementation, enforcement and outcomes require separate assessment in the UNCRC Compliance section.

Malaysia does not have a single, comprehensive code governing every aspect of childhood. The domestic legal framework is distributed across the Federal Constitution, federal statutes, subsidiary legislation, State Islamic family laws and, in Sabah and Sarawak, legislation that may differ from the law applicable in Peninsular Malaysia. This section describes the principal Malaysian laws affecting children. Assessment of Malaysia's compliance with the United Nations Convention on the Rights of the Child (UNCRC), including treaty reservations and concluding observations, is addressed separately.

The Child Act 2001 is the central federal statute on the care, protection and rehabilitation of children. It defines a child as a person under eighteen years and consolidates the former Juvenile Courts Act 1947, Women and Girls Protection Act 1973 and Child Protection Act 1991. The Act must nevertheless be read together with other laws because questions such as citizenship, education, marriage, employment, criminal liability, evidence and adoption are governed by separate legal regimes.

21.2 Constitutional and Jurisdictional Framework

Relevant UNCRC provisions for comparison: Articles 2 (non-discrimination), 3 (best interests), 4 (implementation), 7 (birth registration, name and nationality), 8 (preservation of identity), 14 (freedom of thought, conscience and religion) and 30 (minority culture, religion and language).

The Federal Constitution is the supreme law. Its guarantees of liberty, equality and non-discrimination, freedom of religion and rights in respect of education form part of the legal setting in which child-related legislation operates. Citizenship is governed principally by Part III and the Second Schedule. The constitutional rules are technical and may turn on place of birth, the citizenship and marital status of a parent, registration requirements and the law in force on the date of birth.

Parliament passed reforms intended to place Malaysian mothers and fathers on an equal footing in transmitting citizenship to children born abroad. The Constitution (Amendment) Act 2025 (Act A1752) was gazetted, but its operation depended on a commencement notification. As at 3 August 2026, the safest verified formulation is that implementation had been publicly announced for mid-2026; the precise operative date and the amended Citizenship Rules should therefore be checked against the Gazette before publication. For children born before commencement, the existing registration routes and transitional arrangements remain legally important.

Legislative competence is also divided. Civil law statutes apply federally subject to their express territorial reach, while Islamic family law, including Muslim marriage, is principally a State matter. This produces differences between civil and Syariah rules and between the States. Any national account should therefore avoid presenting a single State enactment as the law for all Malaysia.

21.3 Principal Child-Related Legislation

Relevant UNCRC provisions for comparison: Articles 3 (*best interests*), 4 (*legislative and administrative implementation*) and 41 (*application of higher domestic standards*).

Table 21.1: Principal Malaysian legislation affecting children: subject matter and scope

Legislation	Principal subject matter	Scope / note
Child Act 2001 [Act 611]	Care, protection and rehabilitation; children in need of care and protection; Court for Children; family-based care, institutions and offences against children.	Federal
Sexual Offences against Children Act 2017 [Act 792]	Specific offences involving child sexual abuse material, grooming, sexual assault and abuse of a relationship of trust; procedural and sentencing provisions. Amendments in 2023 and 2024 expanded the framework.	Federal
Evidence of Child Witness Act 2007 [Act 676]	Special measures for child witnesses, including screens, live link, video recording, intermediaries and accompanying adults. Amendments raised the statutory age to under eighteen and strengthened competency and questioning rules.	Federal
Domestic Violence Act 1994 [Act 521]	Protective orders and other protection for victims of domestic violence, including children who fall within the statutory definition of family member.	Federal
Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007 [Act 670]	Offences, enforcement powers and protection measures concerning trafficking, including child victims.	Federal
Education Act 1996 [Act 550]	National education system, compulsory primary education under section 29A, and special education. Access rules and administrative practice are especially significant for children who are not citizens.	Federal
Persons with Disabilities Act 2008 [Act 685]	Recognition of access to education, health, habilitation, rehabilitation and participation for persons with disabilities, including children; enforcement is mainly administrative rather than a general civil damages regime.	Federal
Children and Young Persons (Employment) Act 1966 [Act 350]	Regulates permitted work, hours and hazardous work. It defines a child as under fifteen and a young person as aged fifteen but under eighteen. Its express territorial application is Peninsular Malaysia.	Peninsular Malaysia
Law Reform (Marriage and Divorce) Act 1976 [Act 164]	Civil marriage, divorce, custody and maintenance for non-Muslims. Section 10 generally sets eighteen as the minimum age, but permits a female aged sixteen or above to marry with a licence from the Chief Minister.	Non-Muslims
Adoption Act 1952 [Act 257] and Registration of Adoptions Act 1952 [Act 253]	Alternative statutory routes relevant to adoption in Peninsular Malaysia; their scope, legal effects and application to Muslims differ.	Primarily Peninsular Malaysia
Births and Deaths Registration Act 1957 [Act 299]	Registration of births and deaths in Peninsular Malaysia. Sabah and Sarawak have separate registration ordinances.	Territorially differentiated

21.4 The Child Act 2001: Protection, Care and the Court for Children

Relevant UNCRC provisions for comparison: Articles 3 (*best interests*), 9 (*separation from parents*), 12 (*right to be heard*), 18 (*parental responsibilities*), 19 (*protection from violence, abuse and neglect*), 20 (*alternative care*), 25 (*periodic review of placement*), 37 (*deprivation of liberty*), 39 (*recovery and reintegration*) and 40 (*child justice*).

The Child Act is the organising statute for child protection. It identifies circumstances in which a child is in need of care and protection, including physical or emotional injury, sexual abuse, neglect, abandonment, exposure and situations in which a parent or guardian is unable or unwilling to provide adequate protection. It authorises Protectors and police officers to take temporary protective action and enables the Court for Children to make orders suited to the child's circumstances.

The Child (Amendment) Act 2016 introduced important institutional and family-support changes, including the National Council for Children, Child Protection Teams, family-based care and community service. The Act also contains duties to notify suspected abuse. The duty is not confined to doctors: sections 27, 28 and 29 respectively address medical officers or registered medical practitioners, members of the family, and childcare providers. It is therefore inaccurate to state without qualification that Malaysia has no mandatory child-abuse reporting law. The more precise concern is that the statutory categories are limited and do not impose an express universal duty on every professional who works with children.

Proceedings involving a child charged with an offence are generally heard by a Court for Children, subject to statutory exceptions. The Act restricts publication of identifying particulars and provides child-specific procedures and orders. Section 97 prohibits a sentence of death against a person who was a child when the offence was committed, substituting detention at the pleasure of the Yang di-Pertuan Agong or the Ruler or Yang di-Pertua Negeri, as applicable.

21.5 Protection from Sexual Offences and Child-Sensitive Evidence

Relevant UNCRC provisions for comparison: *Articles 12 (right to be heard), 16 (privacy), 19 (protection from violence), 34 (protection from sexual exploitation and abuse), 35 (prevention of abduction, sale and trafficking), 36 (protection from other exploitation) and 39 (recovery and reintegration).*

The Sexual Offences against Children Act 2017 supplements offences found in the Penal Code. It creates a specialist framework addressing child sexual abuse material, grooming, physical and non-physical sexual assault, and abuse of positions of trust. The 2023 amendments replaced outdated terminology, added offences directed at online sexual activity and strengthened compensation-related provisions; further amendments in 2024 must be read with their commencement notification.

The Evidence of Child Witness Act 2007 provides measures intended to reduce the burden of participation in court, including evidence behind a screen, live-link evidence, video-recorded evidence, special hearings, intermediaries and an accompanying adult. The 2023 and 2024 reforms increased the relevant age from under sixteen to under eighteen and introduced a presumption of competency, rules on evidence on oath and controls against improper questioning. The amended statute reportedly came into force on 3 March 2025.

21.6 Family Law, Marriage, Custody and Adoption

Relevant UNCRC provisions for comparison: *Articles 3 (best interests), 5 (evolving capacities and family guidance), 9 (separation and contact with parents), 12 (child's views), 18 (common parental responsibilities), 20 (alternative care), 21 (adoption) and 27 (adequate standard of living).*

For non-Muslims, the Law Reform (Marriage and Divorce) Act 1976 governs civil marriage, divorce, custody and maintenance. In custody matters, the welfare of the child is the paramount consideration under section 88, while the court may consider the wishes of a parent and, where the child is of an age to express an independent opinion, the child's wishes.

Minimum-age rules are not uniform. Under the civil statute, a marriage is generally void where either party is under eighteen, subject to the statutory exception permitting a female who has completed sixteen years to marry under a Chief Minister's licence. For Muslims, minimum ages and judicial

exceptions are set by the respective State Islamic family-law enactments; a commonly used model sets eighteen for males and sixteen for females, with written permission of a Syariah Judge for marriage below those ages. Because Islamic family law is State law, a national report should identify this as a general pattern rather than an identical rule in every State.

Adoption is likewise plural. The Adoption Act 1952 and Registration of Adoptions Act 1952 provide different routes and legal consequences, and their territorial and religious application must be distinguished. Child placement may also engage the Child Act, particularly where a child requires care and protection.

21.7 Education, Disability and Child Employment

Relevant UNCRC provisions for comparison: *Articles 2 (non-discrimination), 23 (children with disabilities), 24 (health), 28 (right to education), 29 (aims of education), 31 (rest, play and culture) and 32 (protection from economic exploitation and hazardous work).*

Section 29A of the Education Act 1996 makes primary education compulsory for Malaysian-citizen children of the prescribed age, subject to exemptions. The statutory wording is important: it does not create an equivalent unconditional entitlement to free compulsory primary education for every non-citizen child. Special education is provided for within the national education framework, while the Persons with Disabilities Act 2008 recognises access to education on an equal basis and requires reasonable accommodation in appropriate circumstances.

Child employment is regulated, not absolutely prohibited. In Peninsular Malaysia, Act 350 generally prohibits hazardous work and limits the kinds of work in which children and young persons may be engaged. The Act uses age categories that differ from the Child Act: 'child' means under fifteen, while 'young person' means fifteen to under eighteen. Sabah and Sarawak have separate labour legislation, illustrating why the under-eighteen definition in the Child Act does not automatically supply a uniform definition for every statutory purpose.

21.8 Trafficking, Domestic Violence and Related Criminal Law

Relevant UNCRC provisions for comparison: *Articles 19 (protection from violence, abuse and neglect), 33 (protection from illicit drugs), 34 (sexual exploitation and abuse), 35 (abduction, sale and trafficking), 36 (other exploitation), 37 (detention and treatment), 39 (recovery and reintegration) and 40 (child justice).*

The Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007 criminalises trafficking and supplies protection mechanisms for trafficked persons. Where the victim is a child, consent is not treated in the same way as in an adult case and protective placement may be ordered. The Domestic Violence Act 1994 operates alongside Penal Code offences and provides protective remedies rather than replacing the criminal law.

The Penal Code remains relevant to homicide, hurt, assault, sexual offences, kidnapping, abduction, abandonment and cruelty. It should not, however, be described as though section 377 in general merely 'criminalises same-sex relationships': the group of provisions beginning at section 377 covers several distinct offences, and any analysis of their application to children requires provision-specific treatment.

21.9 Independent Oversight and Recent Institutional Reform

Relevant UNCRC provisions for comparison: *Articles 4 (implementation of rights), 12 (participation and the child's views), 42 (making the Convention widely known) and 44 (State reporting).*

The Human Rights Commission of Malaysia Act 1999 was amended by Act A1714, in force from 10 July 2024. The amendment provides for a Chief Children Commissioner and two Children Commissioners within SUHAKAM and strengthens the statutory structure for dealing with human-rights matters relating to children. The office is institutionally located within SUHAKAM; it is not a separate Commission of Children established by Act A1712. Act A1712 is the Environmental Quality (Amendment) Act 2024.

21.10 Labour Law Relating to Children

Relevant UNCRC provisions for comparison: *Articles 24 (health), 28 (education), 31 (rest and leisure), 32 (protection from economic exploitation and hazardous work) and 36 (protection from other exploitation).*

Malaysian law does not prohibit every form of work undertaken by persons below eighteen. It distinguishes legitimate, age-appropriate employment from exploitative, prohibited or hazardous child labour.

In Peninsular Malaysia, the principal legislation is the Children and Young Persons (Employment) Act 1966 [Act 350], substantially amended in 2019. The Act defines a child as a person under fifteen and a young person as a person aged fifteen but under eighteen.

A child must generally be at least thirteen to undertake permitted light work. Children may only engage in limited categories of employment, including suitable light work in a family undertaking, licensed public entertainment, approved government-sponsored work or training, and an approved apprenticeship.

Young persons may undertake a broader range of suitable employment. However, no child or young person may be employed in work prohibited under the Fifth Schedule or in hazardous work listed in the Fourth Schedule. A young person may undertake hazardous work only as part of an apprenticeship or vocational training and under personal supervision.

The Act also limits working days and hours. Neither a child nor a young person may work more than six days in seven consecutive days. A child ordinarily cannot work between 8.00 pm and 7.00 am, for more than three consecutive hours without a thirty-minute break, or for more than six hours daily. Where the child attends school, schooling and work together cannot exceed seven hours. A young person ordinarily cannot work between 8.00 pm and 6.00 am, for more than four consecutive hours without a thirty-minute break, or for more than seven hours daily. Where the young person attends school, schooling and work together cannot exceed eight hours.

Limited statutory exceptions apply, including certain work in public entertainment, agriculture and supervised training. These exceptions should be interpreted consistently with the child's education, health, safety and welfare.

Section 13 gives a child or young person statutory capacity to enter into a contract of service under Act 350. This is a specific exception to the ordinary rule that a person below eighteen lacks general contractual capacity. It does not give the child unrestricted capacity to enter every type of commercial contract.

Act 350 must be read with the Employment Act 1955, occupational safety and health legislation, minimum-wage requirements, the Child Act 2001 and anti-trafficking laws. Employment involving exploitation, forced labour, trafficking, commercial sexual exploitation, unlawful activity, or work prejudicial to a child's health, safety, morals or education may attract liability under more than one statute.

Act 350 applies principally to Peninsular Malaysia and has been extended to Labuan by subsidiary legislation. Sabah and Sarawak operate under their respective Labour Ordinances, which contain specific protections for children and young persons. A national report should therefore not present Act 350 as the sole law applicable throughout Malaysia.

The principal legal question is not merely whether a child performs work. The relevant questions are whether the child has attained the permitted age, whether the work falls within an authorised category, whether it is safe and age-appropriate, whether the working-time restrictions are observed, and whether the employment interferes with education or exposes the child to exploitation.

21.11 Structural Issues Requiring Continued Legal Attention

Relevant UNCRC provisions for comparison: *Articles 1 (definition of a child), 2 (non-discrimination), 3 (best interests), 4 (implementation), 7 (nationality), 12 (child's views), 19 (protection), 28 (education), 32 (child labour), 37 (detention) and 40 (child justice).*

Definitions and age thresholds differ across statutes. The Child Act uses under eighteen, Act 350 separates children from young persons at fifteen, and marriage laws employ different thresholds and exceptions.

The division between federal civil law and State Islamic family law produces non-uniform rules, particularly in relation to marriage.

Territorial differences remain material. Several statutes cited in national discussions apply expressly to Peninsular Malaysia, while Sabah and Sarawak have separate laws.

Legal protection is dispersed across welfare, criminal, family, education, labour, immigration, citizenship and disability regimes. Effective protection therefore depends on coordination among courts, police, welfare authorities, health services, schools and labour agencies.

The Child Act contains mandatory notification duties, but Parliament may consider whether the range of mandated reporters, safeguards, referral pathways and consequences for non-reporting remain adequate.

Commencement dates must be checked separately from the date a Bill is passed or an amending Act is gazetted. This is particularly important for recent constitutional and child-witness reforms.

21.12 Conclusion

Relevant UNCRC provisions for comparison: *Articles 2, 3, 4 and 41, reflecting non-discrimination, best interests, implementation and the preservation of any stronger domestic protection.*

Malaysia has a substantial body of legislation relating to children, anchored by the Child Act 2001 but extending far beyond it. The central legal challenge is not simply the absence of legislation; it is the coexistence of multiple definitions, jurisdictions, territorial rules, institutional mandates and commencement arrangements. A reliable account must therefore distinguish enacted law from policy, a passed Bill from an operative amendment, and federal rules from State-specific laws.

End-of-Section References

Adoption Act 1952 (Act 257) (Malaysia), ss 1(2), 3 and 9.

Age of Majority Act 1971 (Act 21) (Malaysia), s 2.

Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007 (Act 670) (Malaysia), ss 2 and 12–15; Parts III, V and VA.

Attorney General's Chambers of Malaysia. (n.d.). *Laws of Malaysia: Updated federal legislation collection*. <https://lom.agc.gov.my/>

Births and Deaths Registration Act 1957 (Act 299) (Malaysia), ss 1(2) and 7–13.

Births and Deaths Registration Ordinance 1951 (Sabah Cap 123).

Births and Deaths Registration Ordinance 1951 (Sarawak Cap 10).

Child (Amendment) Act 2016 (Act A1511) (Malaysia).

- Child Act 2001* (Act 611) (Malaysia), ss 2, 3–7, 11, 15, 17–19, 27–30, 40–46, 46B–46C, 83, 91, 97 and 134; Parts V, VI, VII, X and XI; long title.
- Children and Young Persons (Employment) Act 1966* (Act 350) (Malaysia), ss 1, 1(2), 1A, 2, 2(1A), 2(1B), 2(2), 2(2A), 2(2B), 4–7, 13 and 16; Fourth and Fifth Schedules. Official text: Department of Labour Peninsular Malaysia. https://jtksm.mohr.gov.my/sites/default/files/2023-03/5.%20Children%20and%20Young%20Persons%20%28Employment%29%20Act%201966_0.pdf
- Constitution (Amendment) Act 2025* (Act A1752) (Malaysia).
- Contracts Act 1950* (Act 136) (Malaysia), s 11.
- Domestic Violence Act 1994* (Act 521) (Malaysia), ss 2–6.
- Education Act 1996* (Act 550) (Malaysia), ss 29A and 40–41.
- Environmental Quality (Amendment) Act 2024* (Act A1712) (Malaysia).
- Evidence of Child Witness Act 2007* (Act 676) (Malaysia), ss 2A, 2B and 3–10; *Evidence of Child Witness (Amendment) Act 2023*; *Evidence of Child Witness (Amendment) Act 2024* (Act A1731).
- Federal Constitution* (Malaysia), arts 4(1), 5, 8, 11, 12 and Part III.
- Federal Territory of Labuan (Extension of Children and Young Persons (Employment) Act) Order 2000* (PU(A) 401/2000).
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- Human Rights Commission of Malaysia Act 1999* (Act 597) (Malaysia), s 6A; *Human Rights Commission of Malaysia (Amendment) Act 2024* (Act A1714), ss 3–5, commenced 10 July 2024 by PU(B) 247/2024. Amended Act 597: SUHAKAM. <https://suhakam.org.my/wp-content/uploads/2026/01/Human-Rights-Commission-of-Malaysia-Act-1999-ACT-597.pdf>
- Islamic Family Law (Federal Territories) Act 1984* (Act 303) (Malaysia), s 8. State enactments must be checked individually.
- Labour Ordinance of Sabah* (Sabah Cap 67).
- Labour Ordinance of Sarawak* (Sarawak Cap 76), as amended, including the *Labour Ordinance of Sarawak (Amendment) Act 2025* (Act A1754).
- Law Reform (Marriage and Divorce) Act 1976* (Act 164) (Malaysia), ss 10, 88 and 92.
- Malaysian CARE. (2025, March 3). *Amended Child Witness Act 2024 now in effect*. <https://malaysiancare.org/amended-child-witness-act-2024-now-in-effect/>
- Office of the Children's Commissioner, SUHAKAM. (2026, January 10). *Media statement no 01-2026*. <https://suhakam.org.my/2026/01/media-statement-no-01-occ-childrens-commissioner-welcomes-implementation-of-law-granting-automatic-citizenship-to-children-born-overseas-to-malaysian-mothers-in-mid-2026/>
- Persons with Disabilities Act 2008* (Act 685) (Malaysia), ss 28–33.
- Registration of Adoptions Act 1952* (Act 253) (Malaysia), ss 1(2), 6 and 9.
- Sexual Offences against Children Act 2017* (Act 792) (Malaysia), ss 4–18; Parts II–IV; *Sexual Offences against Children (Amendment) Act 2023*; *Sexual Offences against Children (Amendment) Act 2024* (Act A1734).
- United Nations. (1989). *Convention on the Rights of the Child* (1577 UNTS 3). Article titles used in the cross-references follow the Convention text; see UNICEF, *Convention on the Rights of the Child: Children's version*. <https://www.unicef.org/reports/convention-rights-child-children-version>

Section 22: UNCRC Compliance

Malaysia acceded to the UNCRC in 1995.

Reservations remain on Articles 2, 7, 14, 28(1)(a) and 37.

In early 2026 the UNCRC Committee commended progress on maternal and child healthcare, primary healthcare and infant mortality.

However, the UNCRC Committee expressed concerns about the longstanding remaining UNCRC reservations, the lack of legal harmonization and age of criminal responsibility, protection of refugee, migrant, and undocumented children, de-institutionalisation and social work professionalisation, child justice and participation.

22.1 Introduction

Malaysia acceded to the United Nations Convention on the Rights of the Child (UNCRC) in 1995, establishing a foundational legal obligation to protect and fulfill the rights of every child within its jurisdiction. Over the past three decades, the country has introduced notable legislative frameworks – such as the Child Act 2001, Sexual Offences Against Children Act (SOACA) 2017, National Child Policy and Plan of Action 2026–2030 and of recent, the Online Safety Act 2025 and Social Work Profession Bill 2026.

During its 100th session review in early 2026, the UNCRC Committee commended Malaysia's progress in improving maternal and child healthcare, expanding primary healthcare infrastructure (including mobile, riverboat, and bus clinics for rural populations) and lowering infant mortality. However, the Committee's Concluding Observations (CRC/C/MYS/CO/2-4), the UNCRC Civil Society Organisation (CSO) Alternative Report (2024), submissions from the Social Workers Alliance Malaysia (SWAM), and ECPAT Malaysia / OCSEA Working Group's position paper to the Malaysian Communications and Multimedia Commission (MCMC) reveals persistent structural gaps across all key sectors.

In its 2026 Concluding Observations, the UNCRC Committee explicitly urged Malaysia to ensure child rights realisation throughout its implementation of the 2030 Agenda, emphasising that sustainable national progress requires active participation of children. Core UNCRC compliance priorities directly mirror key Sustainable Development Goal (SDG) targets: removing barriers to universal birth registration and legal identity advances SDG 16.9; guaranteeing quality, non-discriminatory primary and secondary education for all children – including stateless and refugee minors – drives SDG 4; eradicating child marriage and female genital mutilation/cutting fulfills SDG 5.3; and reforming child protection, social work, and juvenile justice systems underpins social inclusion and institutional integrity under SDG 10 and SDG 16. By aligning national child policy reforms, budget allocations, and legislative overhauls with the SDGs, Malaysia can operationalise a human-rights-based framework that leaves no child behind.

22.2 General Measures of Implementation and Legal Harmonisation

22.2.1 Reservations and Legislative Fragmentation

Malaysia continues to maintain reservations on key UNCRC provisions: Articles 2 (Non-discrimination), 7 (Birth registration and nationality), 14 (Freedom of thought, conscience, and religion), 28(1)(a) (Free and compulsory primary education), and 37 (Torture, degrading treatment, and deprivation of liberty). These reservations entrench discriminatory practices and prevent equal realisation of rights across civil, Sharia, and customary (*adat*) legal systems. A core structural barrier is legal fragmentation:

- **Legal Harmonisation:** The Child Act 2001 requires a comprehensive reform to fully align with UNCRC standards. Contradictions between Sharia law, civil law, and customary law persist regarding the definition of a child and legal capacity.
- **Institutional Oversight:** The establishment of the Office of the Children's Commissioner under SUHAKAM is a positive milestone, yet it remains under-resourced and lacks full autonomy. While the National Council for Children acts as an advisory body, it lacks a dedicated mandate and cross-sectoral authority to coordinate UNCRC implementation.
- **Data Disaggregation:** The launch of MaNIS represents a positive step, but integrated, disaggregated data regarding stateless, undocumented, refugee, Indigenous, and disabled children remains missing. (MaNIS: <https://manis.kpwkm.gov.my/public/article/tentang-manis-2.0>)

22.3 Civil Rights, Identity, and Nationality

22.3.1 Birth Registration Barriers

Administrative challenges, strict registration requirements, geographical isolation in Sabah and Sarawak, and fear of arrest, detention and deportation leave thousands of migrant, stateless, refugee, and Indigenous (e.g., Bajau Laut) children unregistered. This lack of legal documentation deprives them of foundational identity documents, preventing them from schooling, healthcare, protection and social welfare.

22.3.2 Nationality and Legal Amendments

The Constitution (Amendment) Act 2025 allowed Malaysian mothers to confer citizenship on children born abroad on equal terms with Malaysian fathers. However, the amendment was not applied retroactively, leaving past cases unresolved and requiring parents to navigate lengthy discretionary registration processes under Article 15(2). Furthermore, regressive constitutional amendments have heightened concerns surrounding intergenerational statelessness:

- **Removal of Automatic Citizenship for Permanent Residents' Children:** The amendment removed "permanent resident" from Section 1(a) of Part II of the Second Schedule, stripping automatic citizenship by operation of law for children born in Malaysia to permanent residents (which includes long-term stateless populations) and forcing them into discretionary application pathways.
- **Lowering Application Age Limits:** The amendment reduced the maximum age limit for discretionary citizenship applications under Article 15A from 21 years down to 18 years. Shortening this window by three years creates a tighter deadline for stateless youths navigating administrative hurdles.

22.4 Healthcare Access and Sexual and Reproductive Health Rights (SRHR)

While primary healthcare infrastructure has expanded significantly for citizens, non-citizen; refugee, stateless and undocumented children face major structural, financial, and legal obstacles:

- **Institutional Barriers to Care:** Public healthcare fees for non-citizens remain exorbitant. The Ministry of Health Circular 10/2001 mandates that healthcare personnel report undocumented individuals to immigration enforcement authorities. This policy actively deters families from seeking timely healthcare and emergency medical treatment due to fear of arrest, detention, and deportation. CSOs reported that children and women including pregnant women are not excluded and many have been exposed to harsh detention conditions.
- **Adolescent Health & SRHR Deficits:** SRHR remain severely restricted by abstinence-based PEERS curricula, socio-cultural gender norms and restricted legal access to safe reproductive care. This lack of age-appropriate Comprehensive Sexuality Education (CSE) leaves

adolescence vulnerable to unplanned pregnancies, sexually transmitted infections, and sexual exploitation offline and online. Adolescent mental health is deteriorating, with elevated rates of depression, anxiety, and suicidal ideation.

22.5 Protection Against Harmful Practices (Child Marriage and FGM/C)

Harmful traditional and religious practices continue to undermine children's cognitive, social-emotional, physical and psychological behaviour and functions.

- **Child Marriage:** Under civil law, the minimum legal age of marriage is set at 18, but exceptions persist under Sharia law and customary systems. Apart from Selangor and Kedah, legal gaps and lack of political will across other states allow child marriages to continue. The UNCRC Committee and CSOs have strongly urged Malaysia to unify the legal age of marriage at 18 across civil, Sharia, and customary law without any legal exceptions.
- **Female Genital Mutilation/Cutting (FGM/C):** FGM/C remains widely practiced and medicalised among Muslim communities in Malaysia, supported by a religious fatwa and performed by licensed healthcare practitioners despite a lack of scientific justification. The Committee explicitly recommended prohibiting FGM/C in civil, Sharia, and customary law, alongside public awareness campaigns to shift cultural norms.

22.6 Corporal Punishment

Corporal punishment remains a lawful, culturally accepted, and pervasive form of discipline across multiple environments where children live, learn and play in Malaysia.

- **Legal and Institutional Prevalences:** Physical punishment remains legally permitted in homes, public and religious schools (including *Tahfiz* institutions), alternative care settings, and juvenile penal institutions. Provisions in the Penal Code, Criminal Procedure Code, Prison Act 1995, and Education Act 1996 continue to authorise corporal discipline.
- **International Non-Compliance:** Recalling General Comment No. 8 (2006), the UNCRC Committee urged Malaysia to explicitly repeal all legislation, policies and social, cultural and religious norms allowing corporal punishment and promote positive, non-violent, participatory forms of child-rearing and school discipline.

22.7 Alternative Care and Deinstitutionalisation

The alternative care framework for children deprived of a family environment suffers from poverty, poor parenting, weak enforcement, poor oversight, and an over-reliance on residential institutions.

- **Weak Implementation of Family-Based Care:** Although the Family-Based Care Regulations 2017 were introduced, further efforts are needed to align this Regulation with the UN Guidelines on Alternative Care and stronger enforcement due to a shortage of qualified competent social workers, a lack of standardised procedures, lack of information on where children are placed.
- **Institutional Care Gaps:** An estimated 64,000 children reside in residential care facilities (RCFs), most with living parents. The Department of Social Welfare (JKM) lacks the operational capacity to register, inspect, and monitor both registered and unregistered facilities. The Global Ikhwan Services and Business (GISB) care centres case highlight severe systemic oversight failures.
- **Call for Deinstitutionalisation:** The UNCRC Committee recommended that Malaysia establish a clear strategy for deinstitutionalisation, implement evidence based parenting and family strengthening programmes to hinder separation, conduct a comprehensive mapping of care

facilities, enforce minimum quality standards, and expand family-based care including kinship and foster care.

22.8 Inclusion of Refugee, Migrant, Asylum-Seeking, and Stateless Children

Non-citizen and undocumented children represent one of the most marginalised populations in Malaysia due to the lack of legal status and documentation.

- **Exclusion from Child Protection System:** Malaysia is not a party to the 1951 Refugee Convention or the 1954/1961 Statelessness Conventions. Stateless, refugee and asylum-seeking children are treated under the Immigration Act, subjecting them to systemic exclusion from protection, education, social welfare and subsidised healthcare, exposing them to child labour, human trafficking, and exploitation.
- **Immigration Detention of Minors:** Malaysia continues to arrest and detain asylum-seeking, refugee, and undocumented children in immigration detention facilities. While alternative facilities like *Baitul Mahabbah* were established, human rights monitoring bodies emphasise that these centres do not meet UNCRC standards. The UNCRC Committee reiterated that Malaysia must end the immigration detention of children entirely and roll out Alternatives to Detention focusing on family- and community-based care.

22.9 Child Protection, Access to Justice, and Social Work Reforms

22.9.1 Juvenile Justice

- **Minimum Age of Criminal Responsibility (MACR):** Under Section 82 of the Penal Code, the MACR remains low at 10 years old. The UNCRC Committee urged raising the MACR to at least 14 years old.
- **Indefinite Detention:** Section 97 of the Child Act 2001 permits detaining children convicted of capital offences "during the pleasure" of the Ruler, leading to possible indefinite detention, which is opposed by UNCRC.
- **Interagency Child Protection Case Management (CPCM) & Rehabilitation:** The UNCRC committee called for Malaysia to review and improve its interagency CPCM mechanism with the inputs of diverse children in order for the protection and support services rendered to be child friendly and the best interests of each child survivor is systematically considered. Diversion pathways and rehabilitation for high-risk children and convicted children do not adequately meet UNCRC standards, with limited options and mainly underutilised and access to legal representation for children held under security legislation (e.g., SOSMA) is inconsistent.

22.9.2 The Social Work Profession Bill

While intended to professionalise the workforce, the Act contains fundamental defects that contradict UNCRC recommendations and international social work standards set by the International Federation of Social Workers.

- **Exclusion of the Public Sector Workforce:** The Bill excludes public sector social workers within JKM, Ministry of Health (KKM), and MAPO—from statutory registration and practicing certificate requirements. Public sector officers are the *only* practitioners invested with mandatory legal powers under the Child Act 2001, SOACA 2017 and [Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007](#) (ATIPSOM) to intervene in child abuse, exploitation and trafficking cases, remove children from harmful and risky situations and placing them in a safe and suitable alternative care, which presently are mostly institutional care facilities. Excluding government officers means these officers with statutory authority are not held accountable to

mandatory professional standards or code of ethics. UNCRC Committee specifically called for the public sector to be included.

- **Lack of Independence:** Unlike professional acts governing lawyers or medical doctors, the Social Work Profession Council is entirely appointed by the Minister. Professional practitioners and educators are not elected by their peers, undermining self-regulation and unbiased autonomy. There is no guaranteed seat for established bodies i.e. Malaysian Association of Social Workers (MASW) as a core member of the Council.
- **Effect on Civil Society:** The Bill imposes oppressive secrecy obligations on practitioners and trainees, penalising information disclosures with fines up to RM50,000, imprisonment up to three years, or both. This provision conflates ethical confidentiality with the Official Secrets Act, deterring whistleblowers in cases of institutional abuse.

22.10 Digital Rights Contraventions: The Under-16 Social Media Ban and Age Verification

In 2026, MCMC enforced the Social Media Ban and mandated age verification (eKYC) against government-issued records (MyKad, passport, MyDigital ID for children below 16 years old. They established the Child Protection Code (CPC) and Risk Mitigation Code (RMC) under the Online Safety Act (ONSA) 2025 for tech platforms, however these codes need to be strengthened with inputs from children below age 16 and made mandatory for all tech platforms.

This ban and eKYC does not align with UNCRC General Comment No. 25 on children's rights in the digital environment and the UNCRC Committee's 2026 Concluding Observations.

22.10.1 Contravention of Articles 12, 13, 15, and 17 (Digital Rights & Expression)

- **Digital Exclusion:** Licensed services under ONSA encompass platforms used for communication, education, streaming, and gaming. Blanket account bans strip children under 16 of access to online educational platforms, digital literacy tools, creative expression, and connecting with friends and families.
- **Isolation of Marginalised and Remote Children:** For refugee, stateless, undocumented, disabled, and rural children, the internet is a lifeline for education, family reunification, and social support. The ban isolates marginalised groups and penalises children for the failures of tech platforms to ensure platform safety.
- **Digital Competency Skills:** Denying children access to digital spaces undermines Malaysia's own educational goals designed to build 21st-century coding and digital competency skills.

22.10.2 Privacy Risks via Government-ID Verification

- **Violation of Data Minimisation:** Mandating identity verification against government databases (MyKad, passport) violates UNCRC data sharing and confidentiality principles and creates severe privacy risks.
- **Exclusion of Undocumented Children:** Stateless, refugee, and unregistered children lacking official government identification are automatically excluded digital spaces, regardless of age.
- **Dark Web & Unregulated Spaces:** With 94% of Malaysian adolescents active internet users, an enforced ban drives children toward Virtual Private Networks (VPNs), unmonitored dark web platforms, and account-sharing with unverified adults, increasing exposure to grooming, sexual exploitation, sexual extortion, and production, sale and distribution and live-streaming of Child Abuse Sexual Material (CSAM).

22.10.3 Lack of Child Rights Impact Assessments (CRIAs) and Alternative Safeguards

- **Shift of Burden:** MCMC's policy shifts the burden of online safety onto children and parents rather than enforcing mandatory Safety-by-Design on tech platforms.
- **CRIA & Safety by Design:** MCMC must mandate Child Rights Impact Assessments (CRIAs), algorithm-level protections, default maximum privacy settings, disabling addictive design features and zero data tracking for commercial profiling. Furthermore, diverse children require accessible, child friendly 24/7 toll-free hotlines in multiple languages operated by qualified, professional social workers with a solid evidence-based child protection information management system.

22.11 Urgent UNCRC Action Areas Highlighted by UNCRC Committee

In concluding the 2026 state review, Country Taskforce Coordinator Dr. Rinchen Chopel praised Malaysia's progress and highlighted six critical areas requiring immediate intervention.

Table 22.1: Urgent UNCRC action areas and the compliance steps required

Priority Area	UNCRC Compliance
Withdrawal of Reservations	Set a clear timeline to withdraw remaining reservations to Articles 2, 7, 14, 28(1)(a), and 37.
Legislative Alignment	Harmonise civil, Sharia, and customary laws; amend ATIPSOM, Social Work Profession Bill, Education Act, ONSA to reflect UNCRC standards
Protection & Digital Rights	Repeal blanket under-16 digital bans, enforce Safety-by-Design and CRIAs under ONSA 2025, raise MACR to 14, repeal Section 97 indefinite detention, and expand diversion.
Inclusion of Marginalised Groups	Grant refugees, stateless and undocumented children universal access to healthcare, social welfare and education, repeal Circular 10/2001, end child immigration detention via ATDs, and prevent statelessness.
Fiscal Investment in Children	Conduct child-rights budgeting under General Comment No. 19, track allocations, and protect specific funding lines for B40, disabled, and marginalised children
Human Rights Reporting Obligations	Submit overdue state reports under the Optional Protocols on the Sale of Children (OPSC) and Armed Conflict (OPAC), pending since May 2014.

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Section 23: Community Health Services for Children

The healthcare system is structurally biased towards hospital-based, curative, specialist care.

Community care services are severely underdeveloped.

The school health programme reaches most government school children in Years 1, 6 and Form 3, but not tahfiz, homeschool or refugee community schools.

23.1 Introduction

The Malaysian healthcare system is structurally biased towards hospital-based, curative, specialist care. Community care services — services delivered in homes, communities, and local service centres — are severely underdeveloped. This structural imbalance means that the healthcare system is most accessible to those least in need (those able to reach hospitals in major cities), while those with the greatest need (the poor, the rural, the indigenous, the disabled) are the least served. Ivan Illich's insight from 1975 remains as true today: 'Effective healthcare depends on self-care; this fact is currently heralded as if it were a discovery.'

Community care is not an optional add-on to a health system. It is its foundation — and in Malaysia, that foundation is crumbling.

23.2 Current State of Community Child Health Services

The MOH primary care community child health services include:

- Well-child clinics at health centres: covering immunisation, growth monitoring, developmental surveillance — good urban coverage, but very weak in inner-city slum communities
- Antenatal and postnatal home visits: Well established in rural areas; very weak in urban settings; quality has deteriorated
- School health programme: Reaches most government school children in Years 1, 6, and Form 3; does not reach tahfiz, homeschool, or refugee community schools
- School dental services: Extensive mobile dental service reaching most government school children; poor coverage of tahfiz and private schools
- Orang Asli Mobile Teams and Flying Doctor Services: Chronically underfunded, achieving well below target coverage (66.2% and 41.6% respectively in 2019)

23.3 The Workforce Gap

Malaysia has a critical shortage of community health workers:

Table 23.1: Global Health Workforce Statistics — Malaysia vs Regional Comparators. Source: WHO/OECD, supplemented by country data; Amar-Singh HSS, *Addressing Community Health Challenges*, MJPCCH 2025.

Category (per 10,000 population)	Malaysia	Singapore	South Korea
Community health workers	4.0 (2010)	5.0 (2016)	4.0 (2009)
Hospital beds	20.1 (2021)	25.2 (2021)	127.5 (2021)
Nurses (per 10,000)	33.9 (2019)	61.8 (2017)	80.9 (2019)
Doctors	23.2 (2021)	26.0 (2021)	25.2 (2021)

The minimum requirement for adequate community health services is estimated at: five community health workers per 1,000 population; five trans-disciplinary workers (child, disability and elderly based);

two to three counsellors/psychology-trained persons for adolescent and mental health; and one to two specialised mobile rapid response teams per 1,000 population. Malaysia is nowhere near these targets.

We currently have 3–4 times more hospital beds and doctors per 10,000 population than community health workers. We have half the nursing workforce of Singapore and one third that of South Korea. We are investing in the wrong end of the health system.

23.4 Moving from Institution to Community

The transformation needed is fundamental — not cosmetic. The key shifts required are:

- From disease-centred care to person-centred care
- From intermittent, episodic illness management to continuous lifelong health
- From limited consultation to enduring personal relationships and integrated care
- From the community as healthcare consumers to the community as partners in managing their own health

This transformation requires mobile services (buses/vehicles with examination areas and basic investigations), decentralisation of specialist expertise from Klang Valley to regions, and fundamental change in how we train healthcare professionals — so that doctors, nurses, and therapists are trained to prevent and empower, not merely to diagnose and prescribe.

23.5 Civil Society Organisations (CSOs) as Partners

CSOs are better at working in communities and have fewer bureaucratic obstacles. In many areas — disability, refugee health, community mental health, palliative care — CSOs provide the majority of effective community services. The government should formally recognise this role and invest adequately in funding community-based CSOs, rather than viewing them as supplementary to an inadequate government system.

End-of-Section References

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Section 24: Conclusion: A Call for Transformative Action

24.1 The Reality Behind the Averages

Malaysia has made impressive progress in child health, education, and welfare over the past 60 years. Our infant mortality rate has fallen from over 70 to 7 per 1,000 live births. Immunisation coverage exceeds 95%. Access to primary education is near-universal for citizens. These are genuine achievements and should be acknowledged.

But they are not enough. And they are not the whole story.

The 'averages' that populate our national health reports conceal a reality that no Malaysian should be comfortable with: Orang Asli children dying at many times the national rate. Three to four million children in poverty. One in five children under 5 stunted. One in four adolescents battling depression. Thousands of refugee children denied education, healthcare, and legal identity. Children in residential care institutions experiencing abuse. Girls being married off at 15 or 16. Tens of thousands of undocumented children who have never existed in any government system.

These are not marginal failures of an otherwise effective system. They are systematic, predictable, and preventable outcomes of policy choices – choices about who deserves to be seen, who deserves protection, and who deserves investment.

24.2 The Principles That Must Guide Transformation

Any meaningful transformation of child health and well-being in Malaysia must be grounded in:

- **Rights** – Children have rights, not needs that governments may or may not choose to meet. Every child, regardless of race, religion, citizenship, or disability, has the same right to health, education, protection, and a childhood.
- **Equity** – 'Leaving no child behind' must be operationalised as a commitment to the bottom 20%, not as a slogan applied to national averages. Resources must flow disproportionately to those with the greatest need.
- **Evidence** – Every programme, every investment, every claim of success must be accountable to data. We must collect disaggregated data by income, ethnicity, location, and citizenship. We must audit outcomes honestly.
- **Partnership** – The government cannot do this alone, and civil society cannot do it alone. We need authentic partnerships between government, CSOs, communities, healthcare professionals, educators, families and children. The community must be its own healer.
- **Prevention** – We must shift investment decisively upstream – to the first 1,000 days, to school-based health programmes, to community mental health, to injury prevention – rather than spending disproportionately on curative hospital care for the consequences of avoidable deprivation.

24.3 Summary of Priority Recommendations

Across the preceding 20+ sections, over 100 specific recommendations have been made. Below is a consolidated list of the highest-priority actions, organised by urgency and potential impact:

24.3.1 Immediate – Within 12 Months

- Declare child and adolescent mental health a national emergency, with dedicated federal funding and a national action plan.

- Remove the MOH requirement for health staff to report undocumented foreigners at the point of healthcare – no child should be deterred from seeking care by fear of detention.
- Institute a universal school breakfast programme for all primary school children, not just those below the poverty line.
- Move all children out of immigration detention centres into safe shelters.
- Commit to full birth registration for all children born in Malaysia, regardless of parental documentation status.

24.3.2 Medium Term – Within 3 Years

- Withdraw Malaysia's remaining UNCRC reservations – particularly Article 2 (non-discrimination), Article 7 (birth registration/nationality), Article 37 (freedom from torture and arbitrary detention).
- Set a universal minimum age of marriage at 18, across both civil and Syariah law, with no exceptions.
- Legislate mandatory reporting of child abuse and neglect for all professionals working with children.
- Abolish corporal punishment in all school settings.
- Legislate free primary education for all children in Malaysia regardless of citizenship.
- Develop a Child-Specific Climate Health Action Plan.
- Establish a National OCSEA Reporting and Response Centre.

24.3.3 Structural – Within 5 Years

- Transform the healthcare system from hospital-centric to community-centred – investing in community health workers, mobile outreach, and trans-disciplinary therapists.
- Commit to ending child poverty through a universal child benefit and genuine SDG 1 and SDG 2 targets.
- Institute mandatory disaggregated data collection for all child health, education, and welfare indicators.
- Develop a National ECI (Early Childhood Intervention) Policy with ring-fenced funding for all children with developmental disabilities.
- Ratify the 1951 UN Refugee Convention and develop a domestic legal framework for refugee children.

24.4 A Final Word

In a sense, we need to return to our roots. Policy makers and professionals were once embedded in and integrated with communities. They recognised the strengths of individuals to maintain and improve their well-being. With time, this relationship became fragmented and divorced; we moved to a them-and-us model. The focus must now return to a person-centred integrated care system, where the person and community are viewed as their own healers.

But for children who are orphaned, stateless, malnourished, abused, or living in a forest without clean water, the community cannot heal itself without structural support. The government must lead. Civil society must be funded and empowered. Professionals must move from passive observation to active guardianship. We need to become systemic advocates of social justice and health equity.

The children of Malaysia are watching us. The question is whether we are truly watching them – all of them, not just the ones who are easy to see.