Health in All Policies:
The Primary Health Care Approach in Malaysia

50-years experience in addressing social determinants of health through Intersectoral Action for Health

Kamaliah Mohamad Noh
Safurah Jaafar
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Executive Summary

At Independence in 1957, Malaysia inherited a rural urban divide and racial identification of specific economic functions. Thus, the government’s welfarist policy was on growth with equity. This entailed the formulation of national social policies to reduce poverty and at the same time to restructure society by addressing economic imbalances and eventually eliminating racial identification of specific economic functions.

The poverty reduction approaches placed a strong emphasis on rural socio-economic development addressing the social determinants of health. This approach has served Malaysia well over the decades but since the 1990s Malaysia has been caught in a middle income trap. Realising that achieving a high income nation status by 2020 is not possible at the present economic trajectory, Malaysia has now embarked on a national transformation agenda based on the four pillars of inculcating the cultural and societal values under the 1Malaysia Concept and the twin commitments of people first in all policies & projects and performance now; a government transformation programme (GTP); macroeconomic policies under the economic transformation programme (ETP); and the operationalisation of these policies through the 10th Malaysia Plan.

The highest political commitment is given to the implementation of these national policies by the various agencies, orchestrated and coordinated by a central planning process which cascades down to the state and district administrative levels of the government machinery. The health policies follow these national policies and the thrust of the Malaysian health care system is primary health care, supported by an inclusive referral system to decentralized secondary care and regionalized tertiary care. This model of comprehensive public primary health care delivers promotive, preventive, curative and rehabilitative care across the life course. The network of static health facilities is organized into a two-tier system which includes outreach services for remote areas. Community participation is encouraged through village health promoters, health volunteers and advisory panels. The primary health care approach has delivered increased access to health care at a relatively low-cost. This has translated into health gains for the Malaysian population comparable with countries of similar economic development.

As Malaysia moves towards a high income nation status, as demographic and epidemiological transitions continue, and as new health technology develops, the demand for health care by the
population will continue to rise with increasing expectations for more care of even higher quality, and at ever increasing cost. This is especially challenging as Malaysia’s open economy is yet to recover fully from the Asian financial crisis of 1997. The government transformation programme, with its focus on a whole-of-government approach, is a natural progression for the primary health care approach to addressing the social determinants of health as a vehicle for social justice to reduce health inequalities.

**Problem**

Equity has taken centre stage in the strategic plans of the Malaysian government. The impetus was brought about following, a short-lived riot in 1969, in the capital city of Kuala Lumpur which led to a state of emergency being declared nationwide. The emergency, which ended in 1971, underscored the need to place greater racial balance in economic participation, opportunities and employment. The economic stresses of poverty were believed to be the main contributor to the ethnic tensions.

**Space**

At Independence almost 90% of the population were poor and the urban-rural income inequity ratio in 1970 was 1:2.14. Inequities persist among ethnic groups and by geographic location. For example, 77.2% of the bottom 40% of the population are among the *bumiputras* and many are located in the states of Sabah and Sarawak. In the early 70s, people’s awareness of the importance of secondary education was low, especially in the rural areas and in 1971, only 39.3% of Malaysians aged between 12 to 16 years old continued their secondary education.

**Context**

Malaysia is a federation of states and a parliamentary democracy, with the Prime Minister the head of government and the constitutional monarch elected by the sultans. Malaysia is a multicultural society and a secular state with Islam the official religion. The population reached 28.4 million in 2010 and has an annual population growth rate of 1.3%. The Chinese, Indians, Thais, Indonesians Arabs, and later Europeans, mainly Portuguese, Dutch and British have contributed to the multi-ethnic population of Malaysia. They mixed along with the indigenous population namely the Malays, Orang Asli and natives in Sabah and Sarawak, amongst others the Iban, Bidayuh, Melanau, Penan, Kadazan, Bajau and Murut. The indigenous groups later termed *Bumiputras*, have important significance in the planning and redistribution of resources for equity. As of 2010, the population
distribution in Malaysia stands at 60.5% Bumiputras, 22.8% Chinese, 6.8% Indians and 1.3% others (Department of Statistics, Malaysia).

The society and economy were transformed by rapid economic growth in the latter half of the 20th century, although growth has slowed somewhat over the last decade. Classified by the World Bank as a high middle-income country, per capita income in 2008 was PPP US$14,215.

Malaysia is located in South East Asia, between latitudes 2° and 7° North of the Equator and longitudes 100° and 119° East. The South China Sea separates Peninsular Malaysia from East Malaysia on the island of Borneo, a distance of 540 kilometers. Her neighbours are Thailand in the north, Sumatra Indonesia to the west and Singapore to the south. East Malaysia is bordered by Kalimantan Indonesia, the Sultanate of Brunei Darussalam and the Philippines (Figure 1).

The total land area of the country is 329,960 sq. km, with Peninsular Malaysia occupying an area of 131,805 km², Sabah including the Federal Territory of Labuan 73,997 km² and Sarawak 124,450 km². The country is undergoing urbanization attributed largely to migration from rural to urban areas for economic reasons, with the urban population comprising 70% in 2008 compared to only 27% in 1970. The capital city, Kuala Lumpur, has a population of approximately three million. Malaysia is a tropical country with an equatorial climate, hot and humid throughout the year, the climate being influenced by the monsoon seasons, with average temperatures ranging between 21° C to 32° C, and an annual rainfall of 2000mm to 2500mm.

At Independence in 1957, then Malaya inherited a rural-urban divide and racial identification of specific economic functions leading to socio-economic disparities within the country, mainly along ethnic lines. The indigenous population were residing mainly in the economically deprived rural areas as farmers and fishermen while the Chinese were in the urban areas involved in tin mining, commerce and trade. The Indians were working in the rubber estates and in the railways.

The focus of the development plans in the post-Independence era (1957 – 1970) was on rural development. The Malaysian National Policies were also influenced by the welfarist values of the recently-departed colonial government. These policies are also in congruence with global initiatives, for example, the Alma Ata Declaration of 1978, with its focus on the primary health care approach for health development by multi-sectoral partners. To ease the ethnic tensions caused by economic
inequities and to foster national unity, the New Economic Policy (1970-1990) was initiated for economic growth in national development and concurrently social restructuring given the ethnic configurations of Malaysia’s patterns of economic occupations and wealth ownership at that point in time.

The poverty reduction approaches placed a strong emphasis on rural socio-economic development addressing the social determinants of health. This approach has served Malaysia well over the decades but since the 1990s Malaysia has been caught in a middle income trap. Realising that achieving a high income nation status by 2020 is not possible at the present economic trajectory, Malaysia has now embarked on a national transformation agenda. The Government Transformation Programme is one of the four pillars of this transformation. Its focus on a whole-of-government approach is a natural progression from the primary health care approach to addressing the social determinants of health as a vehicle for social justice to reduce health inequalities. The other national pillars to transform the direction of the nation’s development include inculcating the cultural and societal values under the 1Malaysia Concept (with its values of unity in diversity & inclusiveness; social justice; basic human, moral and aspirational values of culture of excellence, perseverance, acceptance, education, integrity, wisdom, humility and loyalty; and the twin commitments of people first in all policies & projects and performance now to ensure delivery of big results fast & positive outcomes for the people) and macroeconomic policies under the economic transformation programme (ETP) and the operationalisation of these policies through the 10th Malaysia Plan.

**Planning**

The social policy formulation process involved political, administrative, legal and parliamentary components. Malaysia follows a systematic planning process whereby five-year plans are set within longer Outline Perspective Plans (OPPs), and systematic reviews are conducted at mid-point of these five-year plans. Annual plans are vehicles for fine-tuning and adjusting the five-year plans to adapt to changing circumstances. The institutions that participate in the social policy formulation process include individual members of the public; interest groups and NGOs; mass media; political parties; federal public service entities, including those at sub-federal levels; the Cabinet; the Parliament (House of Representatives and Senate) and the Paramount Ruler or King. On matters that may affect the Islamic religion and Malay culture, the Council of Rulers is also consulted.
The evolution of the country’s economy was initiated through the New Economic Plan (NEP) which bears a two-pronged strategy:

1) To reduce and eventually eradicate absolute poverty by raising income levels,
2) To restructure society by correcting economic imbalances by reducing and eventually eliminating racial identification of specific economic function.

The poverty reducing approaches emphasised agricultural and rural development to raise income of poor farmers; labour-intensive export industrialization to absorb workers; and public investment in education, health and infrastructure especially in rural areas to raise levels of poor. Many of the essential elements of Social Determinants for Health are highly correlated with poverty eradication programmes. By 1990, Malaysia had become a newly industrialised country (NIC) with 30% of exports constituting manufactured goods.

The National Development Policy (1991-2000) succeeded the NEP and was introduced to retain the main elements of the NEP but moving towards capital-intensive and technology sophisticated industries, with several new thrusts to strike a more balanced development. These initiatives served to emphasis the non-materialistic aspects of national development, especially the strengthening of social and spiritual values, as well as the protection of the ecology. However, private investments (both domestic and foreign) have never recovered the levels prior to the 1997 economic crisis.

Subsequently, the National Vision Policy (2001-2010) was introduced in the first decade of the new millennium to guide Malaysia through the impending challenges of the 21st century, especially in the face of global competition. In essence, the National Vision Policy represents the consolidation of all past development efforts, aimed at establishing a united, progressive and prosperous Malaysia that lives in harmony and engages its citizenry in full and fair partnership. Again the emphasis is also given to the building of a resilient and competitive nation as well as an equitable healthy society, unity and social stability. The economic focus was on identifying and developing new sources of growth, particularly the services sector.

With the national transformation programme, the New Economic Model (2011-2020) has been formulated to achieve sustainable and inclusive economic growth through creating a competitive investment environment. In common with previous national plans, inclusiveness as a key element in the NEM, reiterates the government’s commitment to narrow disparities to enable all communities to
benefit from the country’s wealth. Of note is the leveraging of women’s talents to raise productivity and the focus on uplifting the bottom 40%, irrespective of race, through social assistance programmes and education to break the poverty cycle.

Implementation

From the post-Independence era (1957-1970) with its focus on infrastructural rural development to the New Economic Policy (2011-2020) with its sustainable and inclusive economic growth, the Malaysian national policies have been implemented through Malaysia's legal, policy and institutional framework of the federal system of governance and administration. The implementing ministries are structured to have at least three levels of organization, viz., federal, state and district. In addition, there are also the sub-district, mukim and village levels for each district. Ministry of Health and Ministry of Education, ranked among the larger ministries, have service delivery points, i.e., schools and clinics, even at village levels. There are also mobile clinics to provide the remotest areas with adequate healthcare.

Central Policy Body

The implementation of Healthy Public Policies in Malaysia, which emphasizes the role of intersectoral activity at the central governmental level, has been significantly enhanced since the late 1970s. The early driver to health equities was the NEP’s focus on reducing urban-rural differentials.

The coordinating agency at the central level is led by the National Development Council made up of selected ministers and is chaired by the Prime Minister. It resolves coordinating issues in the implementation of various development projects, giving particular attention to projects on poverty reduction and those targeted at improving the socio-economic position of the poor and underserved. In the New Economic Model, the National Development Planning Committee (NDPC) as the premier body for policy development, coordination and consultation before policy is presented to Cabinet, is being revived.

Decentralised Intersectoral Action for Health

The national public policies in Malaysia are explicitly inter-sectoral from the outset. The key steps in getting vertically organised and centrally administered programmes to translate horizontally into comprehensive, community-based programmes structured around common health problems,
inevitably requires management capacity of the district personnel, whether health personnel or other government agencies. District level staffs are continuously guided to be able to support decentralised development of comprehensive programmes with clear roles, goals and procedures.

The policies are usually developed through participation of the staff from the implementation level initially through conducting the situational analyses to prioritise health problems at a district or local level. The magnitude of the problem, its distribution of the problem, its causes and contributing factors as well as the identification of potential resources, including community capacities and strengths, which can be mobilised and actions which can be undertaken to address the problem, are identified. Proposals are then formulated for example, Safe Motherhood Initiative, the Integrated Management of Childhood Illness, DOTS, Harm Reduction, National Strategic Plans and technical guidelines for the management of non-communicable and communicable diseases after a process of meetings and feedback across all levels through the District Health Officer, the State Health Directors and the Health Ministry. The Ministry will filter the most appropriate to the Central Agencies for approval, namely the Treasury and Public Services to secure the necessary mandate and resources. This is important to ensure success in policy implementation. There is an advantage in standardising and replicating these core activities in health facilities at different levels so that reinforcement of practice throughout the health system can be assured, and goals achievements accelerated.

Facilitating organisational change and encouraging (particularly government) staff to be more flexible, innovative and responsive to local communities are key actions in achieving success. In the past, many of the initiatives to promote community participation in health have concentrated on inviting members of the community to participate in activities established (and largely controlled) by the health services. However, over the last three decades, a wide range of community groups or organisations play substantial roles in promoting health. Community traditions of mutual support and cooperation and a long history of community action have contributed to improving health, albeit at different levels of activity for different groups. They include, in addition to representative health councils, women's groups, youth groups, social clubs, cooperative societies, mutual aid societies and sporting clubs. Settings-based health promotion initiatives offer a mechanism of extending health services towards a more intersectoral and developmental role.
Evaluation

As in the cases of social policy formulation and implementation, monitoring and coordination (M&C) are joint efforts by many government agencies at the various implementation levels of government and administration. The same institutions conduct evaluation on the implementation of social policies in Malaysia. The data generated from the implementation levels of the organisation forms an important set of inputs of the coordination function. Centrally, the Department of Statistics coordinates the collection and analysis of data from the various agencies as well as conducting their own census and household surveys. With the government transformation programme, the evaluation has been strengthened and become more transparent with an independent evaluation board collecting data from the government agencies to give feedback to the highest level of decision makers and is published in the public domain (Figure 2).

Malaysia is well on track to reach the targets of the Millennium Development Goals and overall aggregate social indicators approach levels similar to those of developed countries. The national averages of morbidity and mortality rates have shown a marked reduction from the 1970s but in the last decade, the rates have stagnated as shown in Table 1.

However, disaggregated data show remaining inequities by geographical region and ethnicity. For example, as shown in Figure 3, the national life expectancy at birth has been steadily increasing for both men and women such that it is 71.6 years and 76.4 years, respectively, in 2009 as compared to 55.8 and 58.2 at Independence in 1957. The life expectancy at birth by ethnicity show differences with the Chinese showing the longest life expectancy followed by the Bumiputras and the Indians consistent across the sexes, as shown in Figures 4 & 5.

The maternal mortality ratio has decreased from a high 530 per 100,000 livebirths in 1950 to 28 in 2009 but has stagnated since 2000, as shown in Figure 6. The same pattern is observed for the infant mortality rate as shown in Figure 7 and under-5 mortality ratio in Figure 9. Males have a higher IMR and under-5 mortality ratio as compared to females but the gap has not changed in a decade as shown in Figures 8 and 10, respectively.

Poverty has reduced from 50% in 1970 to 3.6% in 2007. The gap between rural and urban poverty has reduced and in 2009 rural poverty was 8.4% as compared to 1.7% urban poverty, as shown in...
Figure 11. The gap between the main ethnic groups has reduced and the *Bumiputras* have the highest poverty rate followed by the Indians, as shown in Figure 12.

Primary and secondary school participation rates have increased to above 90% and 80%, respectively, in 2007, as shown in Figure 13. However, inequities remain and in 2008, 36% of *Orang Asli* (aborigines) students who completed primary education did not enrol for secondary education. The trend of adult literacy rate (15 years and above) has shown a gradual increase from 84.3% in 1989 to reach 92.8% in 2008, as shown in Figure 14. However, the rate is higher in the urban areas, at more than 95%, as compared to less than 90% in the rural areas. The gap between the urban and rural areas is narrowing since 2003, between 6% to 8%.

**Conclusion**

The existence of a stable and supportive political environment *for a lengthy and continuous period*, which allowed the orderly and incremental development of social policies, is a distinguishing feature of Malaysia’s development. Not many developing countries had the benefit of such an environment. Successive strong governments under the Alliance and the National Front held large majorities in Parliament and the State Assemblies. This political strength contributed to uninterrupted development and implementation of the social services thereby contributing towards improvements to the quality of life of the people. With sustained economic growth, the country could invest in universal benefits including education and healthcare services.

Malaysia has the institutional framework for a whole-of-government approach to achieve social equity through economic growth. The central planning at the highest level gives political commitment and drives the coordination and implementation at the district level in a concerted inter-sectoral action. In tandem, the health care system has given emphasis to the primary health care approach in the delivery of comprehensive health care reaching a wide coverage of the population. Malaysia’s success has depended upon each agency performing well in the delivery of social services but intersectoral action at all levels of the government machinery which has resulted in synergising these efforts to deliver an outcome which has reduced health inequities whether geographical or ethnic.
With Malaysia still recovering from the global financial crises and with the economy contracting by 3% in 2009, the government is prioritising targeted social services to benefit the bottom 40% of low income households. In addition, to ensure cost effectiveness of government interventions, planning & coordination is now strengthened with the setting up of an independent performance management and delivery unit which not only brings a to planning for national policies, but also brings in more private sector and civil society participation in the process. The transparent evaluation of the government’s performance improves governance. This includes an independent evaluation of government policies utilising objective indicators at all levels of implementation, including the monitoring of key performance indicators (KPIs), including Ministerial KPIs.

In addressing the social determinants of health, Malaysia has drawn upon its values of social justice and equity to foster national unity. These are enshrined in the Constitution and supported by a legal and policy framework. However, more needs to be done in civil society engagement and shared responsibility with the government in adopting accountable and transparent frameworks.
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Figure 1: Map of Malaysia

MAP SHOWING BOUNDARIES OF STATES AND ADMINISTRATIVE DISTRICTS, MALAYSIA, 2010

Source: Department of Statistic Malaysia
Figure 2: Evaluation of Implementation of National Policies

- GOVERNMENT AGENCIES
  - PRIME MINISTER
    - Implementation Actions
  - MINISTRIES
    - Delivery Management Office
    - Implementation of policies and actions
  - PEMANDU
    - Monitoring & Tracking Delivery
    - Economic Delivery Unit
    - SRs NKEAs

- INDEPENDENT BODY
  - INDEPENDENT EVALUATION BOARD
    - Provides independent assessment of achievements of NEP objectives as embedded in the ETP, 10MP and later 11MP.
    - Evaluates implementation and impact of SRs and other related policies underlying ETP.
    - Makes recommendations for policy corrections to sustain economic transformation.
    - IEB only constituted every two years and its report will be disseminated publicly.
    - IEB comprised of eminent persons from business and academical locality and from abroad.
Table 1: Summary health indicators

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<tbody>
<tr>
<td>Life expectancy at birth, female (years)</td>
<td>65.6</td>
<td>70.5</td>
<td>73.5</td>
<td>74.7</td>
<td>76.4</td>
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<tr>
<td>Life expectancy at birth, male (years)</td>
<td>61.6</td>
<td>66.4</td>
<td>68.9</td>
<td>70.0</td>
<td>71.6</td>
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<td>Mortality rate, infant under one year (/1000 LB)</td>
<td>39.4</td>
<td>23.8</td>
<td>13.1</td>
<td>6.5</td>
<td>7.0</td>
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<tr>
<td>Mortality rate, toddler (/1000 children 1-4 years)</td>
<td>4.2</td>
<td>2.1</td>
<td>0.9</td>
<td>0.6</td>
<td>0.87</td>
</tr>
<tr>
<td>Maternal mortality (/1000 LB)</td>
<td>1.4</td>
<td>0.6</td>
<td>0.2</td>
<td>0.3</td>
<td>0.28</td>
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Figure 3: Life expectancy at birth, Malaysia, by sex, 1957-2009

Source: Department of Statistic Malaysia
Figure 4: Life expectancy at birth of Malaysian males by ethnicity, 1970-2009

Source: Department of Statistic Malaysia

Figure 5: Life expectancy at birth of Malaysian females by ethnicity, 1970-2009

Source: Department of Statistic Malaysia
Figure 6: Maternal Mortality Ratio (per 100,000 livebirths), Malaysia, 1950 - 2009

![Graph showing Maternal Mortality Ratio over time](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>MMR</th>
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<tbody>
<tr>
<td>1950</td>
<td>510</td>
</tr>
<tr>
<td>1965</td>
<td>220</td>
</tr>
<tr>
<td>1970</td>
<td>195</td>
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<tr>
<td>1977</td>
<td>160</td>
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<td>1991</td>
<td>44</td>
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<tr>
<td>1995</td>
<td>46.9</td>
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<td>2000</td>
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<tr>
<td>2005</td>
<td>27.9</td>
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<td>2009</td>
<td>28</td>
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Source: Department of Statistic Malaysia

Figure 7: Infant Mortality Rate (per 1,000 livebirths), Malaysia, 1957 - 2008

![Graph showing Infant Mortality Rate over time](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>IMR</th>
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<tbody>
<tr>
<td>1957</td>
<td>75.5</td>
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<tr>
<td>1960</td>
<td>68.9</td>
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<td>1970</td>
<td>59.4</td>
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<tr>
<td>1980</td>
<td>23.8</td>
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<tr>
<td>1991</td>
<td>12.5</td>
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<td>2000</td>
<td>6.5</td>
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<tr>
<td>2001</td>
<td>5.7</td>
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<td>2002</td>
<td>6.5</td>
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<td>2003</td>
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<td>2004</td>
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<td>2005</td>
<td>6.5</td>
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<tr>
<td>2006</td>
<td>6.2</td>
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<td>2007</td>
<td>6.2</td>
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<tr>
<td>2008</td>
<td>6.2</td>
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<td>2009</td>
<td>7</td>
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Source: Department of Statistic Malaysia
Figure 8: Infant Mortality Rate (per 1,000 livebirths) by Sex, Malaysia, 1991-2008

![Graph showing Infant Mortality Rate (per 1,000 livebirths) by Sex, Malaysia, 1991-2008](image)

Source: Department of Statistic Malaysia

Figure 9: Under-5 Mortality Ratio, Malaysia, 1990-2009

![Graph showing Under-5 Mortality Ratio, Malaysia, 1990-2009](image)

Source: Department of Statistic Malaysia
Figure 10: Under-5 Mortality Ratio (per 1,000 livebirths) by Sex, Malaysia, 2000-2008

![Figure 10: Under-5 Mortality Ratio (per 1,000 livebirths) by Sex, Malaysia, 2000-2008](image)

Source: Department of Statistic Malaysia

Figure 11: Poverty in Rural and Urban Areas as a Percentage of total households, Malaysia 1970 – 2009

![Figure 11: Poverty in Rural and Urban Areas as a Percentage of total households, Malaysia 1970 – 2009](image)
Figure 12: Incidence of Poverty by Ethnic Group, Malaysia, 1990 - 2009

![Graph showing the incidence of poverty by ethnic group in Malaysia from 1990 to 2009.](image)

Source: Economic Planning Unit, Malaysia_ (1) Household Income Surveys, (2) Statistical compilations_1990-2009

Figure 13: Student participation rates in schools, Malaysia, 1971 - 2007

![Graph showing student participation rates in primary and secondary levels in Malaysia from 1971 to 2007.](image)

Source: Ministry of Education Malaysia; Department of Statistics Malaysia
Figure 14: Adult literacy and illiteracy rates Malaysia 1989 - 2008

Source: Ministry of Education Malaysia; Department of Statistics Malaysia