MALAYSIA

STAFF APPRAISAL OF A SECOND POPULATION
AND FAMILY HEALTH PROJECT

June 16, 1978

Population Projects Department

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CURRENCY EQUIVALENTS

US$1.00 = M$2.40
M$1.00 = US$0.417
M$1 million = US$416,666

FISCAL YEAR (JANUARY 1 - DECEMBER 31)

ABBREVIATIONS

ASEAN - Association of South East Asian Nations
AVPC  - Audiovisual Material Production Center
CSC   - Community Service Center
FDTC  - Family Development Training Center
FFPA  - Federation of Family Planning Associations
FPA   - Family Planning Association
GOM   - Government of Malaysia
IEC   - Information, Education and Communication
IIDA  - Intensive Input Demonstration Area
IUD   - Intra Uterine Device
MCH/FP- Maternal and Child Health/Family Planning
MCQ   - Midwife Clinic-cum-Quarters
MFFS  - Malaysian Fertility and Family Survey
MOH   - Ministry of Health
NFPB  - National Family Planning Board
PCCU  - Project Construction Coordination Unit
REMS  - Research, Evaluation and Management Information System
UNFPA - United Nations’ Fund for Population Activities
WHO   - World Health Organization
DEFINITIONS

Crude Birth Rate: Number of live births per year per 1,000 of population.

Crude Death Rate: Number of deaths per year per 1,000 of population.

Rate of Natural Increase: Difference between crude birth and crude death rate; usually expressed as a percentage.

Rate of Population Growth: Rate of natural increase adjusted for (net) migration, and expressed as a percentage of the total population of a given year.

General Fertility Rate: Number of live births per year per 1,000 women, aged 15-49 years.

Age-Specific Fertility Rates: Number of live births to women in a given age group per 1,000 women in the same age group, in a given year. It is usually calculated for 5-year age groups.

Total Fertility Rate: The average number of children that would be born per woman if she were to live to the end of her childbearing years, and bear children according to a given set of age-specific fertility rates. The Total Fertility Rate often serves as an estimate of the average number of children per family.

Gross Reproduction Rate: This is the same as the Total Fertility Rate, but refers to the number of daughters a woman would have under prevailing fertility patterns.

Net Reproduction Rate: The number of daughters a woman would have under prevailing fertility and mortality patterns, who would survive to the mean age of childbearing.

Infant Mortality Rate: Annual number of deaths of infants under 1 year per 1,000 live births during the same year.
DEFINITIONS (Cont’d)

Maternal Mortality Rate: Number of maternal deaths per 1,000 births attributable to pregnancy, childbirth, or puerperal complications (i.e., within six weeks following childbirth).

Life Expectancy: Average number of years expected to be lived by children born in the same year if mortality rates for each age/sex group remain the same in the future.

Dependency Ratio: Number of people of 14 years or under, plus people 65 years or over, divided by the population aged 15 to 64 years.
### BASIC DATA

<table>
<thead>
<tr>
<th></th>
<th>1970</th>
<th>1975</th>
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<td>Area in km/².</td>
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<td>Density per km/².</td>
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<td>Population ('000)</td>
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<tr>
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<td>Death Rate.</td>
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<td>6.0/2</td>
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<td>2.4/2</td>
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<tr>
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<td>33.2/1*</td>
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<tr>
<td>Toddler Mortality Rate</td>
<td>4.2/3*</td>
<td>3.1/3*</td>
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<td></td>
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<td>Age Structure (%)</td>
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<td>15-64 Years</td>
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<td>54.4/5</td>
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<td>65 and Over</td>
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<td>Population by Ethnic Group (%)</td>
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<td>Malays</td>
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<tr>
<td>Chinese</td>
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<td>Indians and Others</td>
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<td>Urban Population (%)</td>
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<td>Adult Literacy Rate (%)</td>
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<tr>
<td>Male.</td>
<td>77/4*</td>
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<tr>
<td>Female.</td>
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<tr>
<td>Total.</td>
<td>60.8/4*</td>
<td>76.0/5*</td>
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<tr>
<td>Labor Force ('000).</td>
<td>3,606/5</td>
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<td>Unemployment (%)</td>
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<td>Population per Physician.</td>
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<td>Population per Nurse.</td>
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<td>Population per Midwife.</td>
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<td>Population per Hospital Bed</td>
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<td>Population at Poverty Level (%)</td>
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<td>Family Planning.</td>
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<td>0.11/6</td>
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*Peninsular Malaysia only.

/1 Department of Statistics, Malaysia.  
/2 NFPB, Malaysia.  
/3 Vital Statistics/Economic Report, GOM.  
/4 Malaysia Family and Fertility Survey (1974-75).  
/5 Third Malaysia Plan.  
/6 Population Council.
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This report is based on the findings of the appraisal mission which visited Malaysia in November/December 1977. The mission was composed of Miss I. Z. Husain (Economist), Dr. T. I. Kim (Medical Specialist), Messrs. N. I. Khan (Sociologist), David Mills (Architect) and S. H. Yun (Consultant-Communications). This report was prepared by Miss Husain and Mr. Khan with contributions from the other mission members. A companion Implementation Volume (outlined in Annex 5) containing details of implementation schedules, activities and cost estimates has been prepared.
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IBRD 13445 Peninsular Malaysia
IBRD 13446 East Malaysia

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Population Problem

1.01 Malaysia's population of 12.3 million in 1975 grew at a rate of 3.2% per annum between 1960-70, and doubled in size over the past 20 years. Its natural rate of population growth declined from a level of 3% in 1966 to 2.4% in 1975, in response to both socio-economic development and family planning efforts. At a growth rate of 2.4%, the population will again double in about 29 years. The legacy of the high birth rate, experienced in the 1950s, continues to push a greater proportion of women into the reproductive ages and a larger number of entrants into the labor market, with potential for high rates of population growth and unemployment in the absence of deliberate policies to moderate these trends.

1.02 Despite the decline in fertility during the past decade, the current population growth rate remains a handicap in achieving the objectives of the new economic policy. The twin objectives of this policy, enunciated in 1970, were: (a) eradicating poverty by raising income levels and increasing employment opportunities; and (b) accelerating the process of restructuring the Malaysian society to correct economic imbalances. The development decade (1966-75), which began both with the initiation of a population program and formulation of the development plan, witnessed substantial progress in raising the income levels and reducing the rate of population growth. Evidence towards progress on the second objective, however, remains inconclusive. According to the Third Malaysia Plan, as of 1970, about half (49.3%) of the households ranked below the poverty line, of these were in rural areas; 65% of the Malay households, as compared to 39% Indian and 26% Chinese, were under the poverty line. The incidence of poverty in the Eastern States (Kedah, Kelantan, Perlis and Trengganu) exceeded the national average, with about 50% to 65% of the households falling below the poverty line. Available evidence suggests the existence of notable income disparities within and among ethnic groups and regions.

1.03 The higher fertility level in the poorer section of society is believed to have made the achievement of the second objective, the correction of economic imbalances, more difficult. The larger family size prevalent among poorer sections of society perpetuates the vicious circle of a low standard of living/high fertility leading to inadequate economic opportunities and therefore back to a low standard of living. Notable fertility differentials in Malaysia corresponding to socio-economic inequalities mentioned above reinforce this belief. The Malaysian Post-Census Enumeration

1/ The rate has been adjusted for underenumeration of population estimated in the Post Census Enumeration Survey, 1973.

2/ The poverty line is defined as income below the level necessary "for meeting minimum nutritional and other non-food requirements of each household to sustain a decent standard of living." Government of Malaysia, Third Malaysia Plan, 1976, p. 160.
Survey of 1973 showed that families within the lowest 40% of the income distribution were comparatively larger than those in the upper income group. The same type of inverse relationship between socio-economic status and family size was observed in the Malaysian Fertility and Family Survey (MFFS) and in the national family planning statistics of 1975 described below.

1.04 In 1975, women whose husband’s monthly income averaged more than M$500 had an average of 3.6 children, compared to 4.6 children among those with a monthly income below M$100. On the average, women with 12 years of education had less than two children, women with no education had more than 5 children; rural women had an average of 4.4 children, while their urban counterparts had 4.0. Malay women had an average of 4.8 children, compared with 4.0 for the Indians and 3.7 for the Chinese. The less-developed states of Trengganu and Kelantan had birth rates of about 37 and 36 respectively, compared with about 26 in the more-developed states of Perlis and Penang (Annex 4, Tables 1-3).

1.05 The Third Malaysia Plan has given renewed emphasis to redressing economic and social imbalances. It is now recognized that providing means to poorer sections of society to limit family size is essential for equalizing economic opportunities. The program is taking new directions to help meet these objectives by: (a) intensifying the family planning program in the urban areas to reach an estimated 36% of the population who live in slum areas; (b) extending further the integrated maternal, child health and family planning services to rural areas; and (c) integrating the family planning program with other development activities designed to reach disadvantaged communities and regions. The design of the proposed project is based on these program directions.

Past Demographic Trends, 1966-75

1.06 The decline in the rate of natural increase of the Malaysian population (births minus deaths) since the inception of the family planning program, as shown below, is primarily due to the fall in the birth rate. Further decreases in the rate of natural increase will depend largely upon further decreases in the birth rate. The death rate is already very low and has been stable since the early 1970s. Net migration in Malaysia is insignificant, so that the rate of natural increase is nearly the same as the rate of population growth.

<table>
<thead>
<tr>
<th>Year</th>
<th>Size (millions)</th>
<th>Birth Rate</th>
<th>Death Rate</th>
<th>Rate of Natural Increase</th>
<th>Total Fertility Rate</th>
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<td>1966</td>
<td>9.73</td>
<td>36.5</td>
<td>7.3</td>
<td>3.0</td>
<td>5.2</td>
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<td>1970</td>
<td>10.77</td>
<td>32.6</td>
<td>6.8</td>
<td>2.6</td>
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<td>1975</td>
<td>12.29</td>
<td>30.5</td>
<td>6.0</td>
<td>2.4</td>
<td>4.1</td>
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1.07 The decline in the national birth rate over the period 1967-74 was largely due to a substantial decline in the birth rate in Peninsular Malaysia, where 85% of the population live, and where the official family planning program has been active since 1967. Without a substantial decline in fertility, the birth rate would have risen because of a larger number of women born during the post-war baby boom period entering the reproductive age group. The high birth rate during the post-World War II period contributed to a dramatic increase in the proportion of population under five years of age (19% in 1957). Consequently, 18 years later, in 1975, there were about 1 million females aged 15-24, compared with 0.5 million in 1957. Women in this age group contributed about 39% of the total live births in 1975, and will contribute a still higher proportion of births over the next 10-15 peak years of their reproductive life span. This legacy continues to put pressure on population growth as young women of marriageable age begin to constitute a higher proportion of the population.

1.08 Birth rates in Sarawak remained constant at about 29 per 1,000 during 1967-74, and a slight decline in the birth rate (from 37 to 35.5 per 1,000) was reported for Sabah, although it is still as high as Peninsular Malaysia's rate ten years ago. Demographic trends are described in Annex 4, T-4.

1.09 A comparative analysis of the trends of fertility decline and that of the family planning program performance indicates that family planning practice has made a significant contribution to the decline in fertility during 1967-74. The total fertility rate (average number of children per woman over her childbearing age) declined from 6.1 in 1960 to 4.3 in 1974. Between 1960-67, fertility declined by about 14%. A large part of this decline (over 60%) occurred in the age groups below 25, primarily because of the increased age at marriage associated with the socio-economic development. In contrast, in the subsequent seven-year period (1967-74), fertility declined by about 17% and about three-quarters of this decline occurred in the age groups of 25 years and over, with a corresponding increase in contraceptive practice among these groups (Annex 4, T-5). Of the total program acceptors, over 61% were aged 25 and over.

1.10 This latter fertility trend corresponds with the increase in the level of family planning program performance during 1967-74. The number of program acceptors per year rose from 20,000 in 1967 to 62,000 in 1974. In 1974-75 an estimated 75% of all acceptors received contraceptives from program sources. Over this period (1967-74), the percentage of women within the childbearing ages in Peninsular Malaysia with knowledge of contraception rose from 44 to 92 and the percentage of those who ever used contraception rose from 14 to 45.

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1/ With constant 1966 fertility, the expected birth rate in 1974 would have been about 40 per 1,000 population.
The median age of women at marriage, estimated at about 22 years in 1970, is believed to have gone up further. Given its present high level, it is unlikely that further increase in the median age of women at marriage will have any appreciable impact on fertility. Therefore, a major factor in past fertility decline cannot be counted on for the future. This makes a strong family planning program vital if fertility is to be reduced further.

The well-developed Malaysian health system made great strides in reducing mortality by about 50% during the 1957-67 decade; at present the death rate is about 6 per 1,000. The average expectation of life at birth increased from 56 years in 1970 to 64 in 1975 for males and from 58 to 68 for females. Infant (under 1 year) mortality declined from about 76 per 1,000 in 1970 to 33 in 1975. Infant and toddler (1 to 5 years) mortality rates vary markedly among states and ethnic groups (Annex 4, T-1 and T-6). In spite of the overall decline, these rates are still high in areas with inadequate health facilities. It will be difficult to persuade people in these areas to accept family planning unless mortality rates are reduced. Extension of integrated MCH/nutrition services to areas where health facilities are not available will facilitate this reduction and thus promote acceptance of family planning.

One effect of a sharp fall in mortality while fertility remains high is a rise in the dependency ratio, i.e., the ratio of the population below 15 and over 64 to the population of working ages (15-64). In Peninsular Malaysia, this ratio rose from 82% in 1957 to 87% in 1970 while, for Sarawak and Sabah, it rose from 83% in 1960 to about 92% in 1970. A high dependency ratio means that: (a) a high proportion of household income will be spent for subsistence rather than a better standard of living; and (b) a high proportion of public expenditure must be devoted to health, education and other social services, rather than to economic development.

Future Demographic Prospects (1975-2030)

The Government of Malaysia (GOM) has not yet stated its long-term demographic targets. Its medium-term target for Peninsular Malaysia is a reduction of the birth rate from 30.3 per 1,000 in 1975 to 26 per 1,000 in 1985, and a corresponding population growth rate reduction from 2.4% to 2%. No demographic targets have been set for Sabah and Sarawak, where the approach will be to persuade people to space their children in the interest of maternal and child health.

Attainment of the medium-term target would make it possible to achieve replacement-level fertility in Peninsular Malaysia by 1990. This implies a decline in the natural rate of population growth from the current level of 2.4% to about 1% by the end of this century. Thus Peninsular Malaysia's population may stabilize at about 18 million in the year 2030. Alternatively, if replacement level fertility is reached in the year 2000 instead of 1990, the natural rate of population growth would be about 1.8%, and the population would stabilize at over 20 million in 2040. Under the assumption of replacement level fertility by 1990, the population of Sarawak may stabilize at about 2 million by the year 2030, and Sabah at about 1.6 million by the
year 2045. If reaching the replacement-level fertility is delayed up to the year 2000, the population of Sarawak may stabilize at 2.3 million in 2040, and Sabah at about 2 million in 2050 (Annex 4, T-7). If the tempo of socio-economic development is maintained and the population program's effort is accelerated to cover the presently underserved one third of the urban and about one half of the rural population by 1980, Peninsular Malaysia is likely to succeed in reaching replacement-level fertility by 1990. The family planning program's performance trend in Malaysia, and Singapore's proven success in approaching replacement-level fertility in about a decade, provide reasons to be optimistic about the Malaysian demographic target.

Among the ASEAN countries, the Malaysian family planning program performance stands second only to Singapore—a state with 90% urban population, the world's second highest population density, and an older and stronger family planning program in a more favorable social setting. In 1976, the percentage of women within the reproductive ages who ever used contraception in Peninsular Malaysia (45) was exceeded only by Singapore (77). Corresponding figures for Thailand (32), Philippines (22) and Indonesia (15), were much lower. The Malaysian program has also the distinction of achieving greater demographic impact as it has been recruiting a much larger proportion of younger and low-parity couples compared to other ASEAN countries. In this region, the Malaysian family planning program budget as a percent of the total national budget (0.11%) is the highest (Annex 4, T-8).

Socio-Economic Implications of Future Demographic Trends

Under the assumption of reaching replacement-level fertility by 1990 instead of 2000, the population of Peninsular Malaysia will possibly be about 2.4 million fewer when it stabilizes in 2030. Total fertility would decline from 4.1 in 1975 to 1.9 in 1990 and the dependency burden may fall by about 46 percentage points by the end of the century.

Due to the baby boom of the fifties, the labor force has been growing at a much faster rate (3%) than the population growth rate. The Third Malaysia Plan estimates that the labor force may continue to grow at more than 3% annually during 1980-90. During this period, the working age population (15-64) is likely to increase by about two million, i.e., about four times the number of jobs created under the Second Malaysian Plan when the economic growth rate was more rapid because of favorable export prices. Between 1970-75, 588,000 new jobs were created compared with 618,200 new entrants in the labor force. By 1975, although the rate of unemployment was reduced to 7%, the number of unemployed increased by about 300,000. Absorption of these new entrants into the labor force will require sustained rapid growth of the economy. Further, to achieve the Government target of the ethnic balance in sectoral employment, a heavy burden will be borne by industries to absorb the fast growing Malay labor force.

The impact of the decline in fertility on the working age group is felt with a minimum lag of 15 years. Therefore the need for additional jobs will be less by as much as 75% by the year 2015 if the replacement-level of
fertility is reached by 1990 instead of 2000. Feasibility of achieving this level is enhanced by the proposed improvement in the family planning program through the project.

1.20 Malaysia's education is heavily subsidized by the Government. If fertility reaches replacement level by 1990, the GOM may be able to save as much as M$1,535 million in educational subsidies by 1990, at 1973 constant prices.

1.21 Even at a lower rate of annual increase than the present 5%, the total urban population will increase to three to four times its 1970 level by the year 2000. Without a corresponding increase in urban employment, the migrant and less-skilled workers in the urban job market are likely to experience the highest unemployment rate and consequent social problems. Thus, without a rapid reduction in fertility to reach replacement level by 1990, reducing economic disparities will continue to be difficult. The national population policy and program, described in the following section, are designed to accelerate the pace of this reduction in fertility to complement the Malaysian development goal of reducing economic disparities.

II. NATIONAL POPULATION POLICY AND PROGRAM

Population Policy

2.01 The family planning activities in Peninsular Malaysia were initiated in 1953 by a private organization, the Federation of Family Planning Associations (FFPA). In 1966, the first five-year development plan officially adopted family planning as a means of enhancing family health and welfare and reducing the population growth rate. The target of the plan was to reduce the rate from 3% in 1966 to 2% in 1985, with a corresponding decline in the birth rate from 37 to 26 per 1,000. The National Family Planning Board (NFPB) was set up by an Act of Parliament in 1966 to prepare and implement plans to reach this target.

2.02 In 1967, the family planning activities were initiated in East Malaysia (Sabah and Sarawak) by voluntary family planning associations. The local authorities have been providing the maternal and child health services (MCH). The success of these activities indicates a latent demand for these services, thus efforts are being made by the Ministry of Health (MOH) to provide comprehensive MCH care which will include family planning services. The MOH will thus be responsible for program implementation, while the NFPB will coordinate and evaluate program activities and supply contraceptives.

Program Organization

2.03 NFPB: The Board, which is an interministerial body under the Prime Minister's Department, has been mainly responsible for the program since its inception. The Board consists of a Chairman and 21 members, 10 representing
interested ministries/departments and 11 representing non-governmental sectors. Under the Board are the Director General and the staffs of four technical divisions and of the planning and development units. A Deputy Director General was added as part of the first project. In 1976, the total staff of the NFPB, including field staff, numbered over 600. The organization of the NFPB is shown in Annex 4, C-1.

2.04 The NFPB formulates population and family planning policy, implements the program directly or through other agencies, and coordinates activities. An executive committee, consisting of the NFPB Chairman, Director General and four other Board members, oversees the implementation of the Board’s policies with respect to the family planning program, finance and administration. Routine program management is carried out by the chief executive of the Board, the Director General, with the assistance of the Deputy Director General and the four divisional directors. At the state level, in Peninsular Malaysia, a state family planning officer carries out routine program management responsibility.

2.05 Coordination of population program implementation is achieved through various committees at the central and state levels. Of the nine such committees under the Board, three deal with major aspects of the program while the other six have specialized functions. These three committees are the National Family Planning Committee, Central Coordination Committee and Project Implementation Committee (now renamed Project Steering Committee). The National Family Planning Committee is responsible for overall coordination of the program as well as for formulating program guidelines and implementation strategies for the Board. It has three subcommittees, namely: (i) service and training; (ii) information, education and communication; and (iii) evaluation and research. The Central Coordination Committee is responsible for the coordination of the integrated rural health and family planning program. Inter-agency population activities with respect to the project are coordinated through the Project Steering Committee. The State Family Planning Committees and the State Coordination Committees carry out corresponding functions at the state level. Progress and problems of the interministerial family planning program implementation are also discussed in the monthly meeting of the heads of the government departments chaired by the chief secretary to the Government. The NFPB Director General represents the Board in this meeting (Anex 4, C-2).

2.06 The NFPB budget for 1976 was M$7.75 million (US$3.2 million); this represented a three-fold increase since 1973. The NFPB’s share of the national operating budget increased from 0.08% in 1973 to 0.15% in 1976.

2.07 MOH: In the early 1970s, the MOH began to integrate family planning with its MCH services. As part of the first population project, the administration of the MOH was strengthened by the appointment of an Assistant Director for family planning at the headquarters and one MCH/FP officer in each of the 11 states of Peninsular Malaysia. Also, an additional trained assistant nurse and clerks have been provided at each of the main health centers in the "intensive input demonstration area" (IIDA) program as required under the first project. The organization of the relevant sections of the MOH is shown in Annex 4, C-3.
2.08 The MOH budget in 1976 was M$379 (US$158 million), or about 7% of the total national budget. The corresponding figures for 1973 were M$254 million (US$106 million) and about 7%.

2.09 FFPA: The activities of the FFPA are implemented through its 11 State Family Planning Associations which form the Federation. With the expansion of the official program, FFPA activities have become more varied and the Federation has begun to concentrate in specialized areas such as the treatment of sub-fertility, family life education and marriage counseling.

2.10 In Sabah and Sarawak, the Family Planning Associations, like the FFPA, receive funds directly from the International Planned Parenthood Federation and subventions from the State Governments. These State Associations have not yet joined the FFPA in Peninsular Malaysia, but the possibility is under consideration.

2.11 Ministry of Education: As part of the first project, the Ministry of Education, with United Nations Fund for Population Activities' (UNFPA) support, established a Population Education Unit consisting of eight professional and five general support staff to prepare population education curricula, produce teaching aids and educational materials, and train teachers to introduce population education into the school system.

2.12 Ministry of Agriculture: The Ministry has been training its agricultural extension and community development workers in family planning since 1971. Its Community Development Division has recently begun to promote activities, including family life education, which are designed to raise the socio-economic status of women in rural areas. The Ministry's extension workers (including 5,500 full-time village workers and 105 supervisors) receive brief training from the NFPB in conveying family planning information in their discussions with people in the rural areas. The village workers are responsible for recruiting women for the family development program and giving them vocational training at the village level. The structure of the Community Development Division is shown in Annex 4, C-4.

Program Facilities

2.13 Family planning services are provided through various channels under the NFPB, FFPA and MOH, and by private medical practitioners and traditional midwives. The urban areas and their peripheries are served by 79 static and 373 mobile clinics under the NFPB, and 26 static and 112 mobile clinics under the FFPA. The FFPA also operates 98 clinics on rubber estates and plantations.

2.14 In rural Peninsular Malaysia, the health infrastructure is composed of 1,626 facilities (68 main health centers, 243 health sub-centers and 1,315 midwife clinic-cum-quarters (MCQs) and community health centers). In 1,130 of these facilities (70%) family planning services are already available. In the remainder, family planning services are being integrated as and when the full complement of staff is trained. In addition, services are provided by 170 traditional midwives in rural areas and in about 29 MCH centers in urban areas. These existing service outlets cover a little over one-half of the rural population of Peninsular Malaysia.
2.15 In Sabah and Sarawak, FPAs provide family planning services through state health service outlets, while the NFPB supplements the supplies of contraceptives in Sarawak. The health infrastructure in Sarawak covers 14% of the population adequately, 57% inadequately and 29% of the population not at all; coverage in Sabah is even more inadequate, but specific data are not available.

Program Performance and Trends (1967-77)

2.16 During 1967-77, the program recruited a cumulative total of about 677,000 acceptors, i.e., about 70% of the target. Of these acceptors, 60% were recruited by the NFPB, 23% by the FFPA, 10% by MOH, and the remaining 7% were recruited by other sources (Annex 4, T-9 and T-10). Initially, between 1967-69 the program was confined to providing family planning services through NFPB clinics located mainly in large urban areas. The number of new acceptors increased sharply up through 1969 (averaging more than 70,000 in 1968 and 1969). However, as the reservoir of ready acceptors was exhausted, program performance declined because of the difficulty of recruiting additional acceptors in urban areas and the absence of trained manpower which would be needed to extend the program to rural areas.

2.17 Starting in 1970, the number of new acceptors dropped to 56,000 and remained near that level until 1973. It was during this period that the MOH started to integrate family planning services into its MCH services. Program performance again improved after 1973 and the trend is continuing. The number of new program acceptors exceeded 80,000 in 1977, of which about 36,000 were from integrated rural areas covered by the first Bank-supported population project.

2.18 The program has also been reaching the younger, low-parity, low-income and less-educated groups. During 1967-76, the proportion of total acceptors below age 30 increased from 57% to over 72%; the acceptors with two or less children increased from 30% to 54%; acceptors with primary or no formal education increased from 59% to 74% and acceptors whose husband’s income was below M$300 rose from 46% to over 62% (Annex 4, T-11). Over the period (1970-76), the ethnic composition of acceptors has gradually approximated the composition of the population (Annex 4, T-12).

2.19 During 1967-76, significant changes took place in the levels of knowledge of and attitudes toward family planning. Only 44% of the women of reproductive age (15-44) knew about family planning in 1967; the proportion increased to 92% in 1975. Simultaneously, the proportion of women 15-44 years of age who had ever used contraception increased from 14% to 45% during this time period (Annex 4, T-13).

2.20 The demographic impact of these achievements is reflected in the decline in total fertility from 5.2 to 4.1 during 1967-75 and a decline in the crude birth rate in 1975 to 30.3 (compared to the target of 30). (Details of demographic achievements are described in Annex 4, T-14).
Program Targets, 1978-85

2.21 The NFPB estimates that about 1 million new acceptors need to be recruited in Peninsular Malaysia during the period 1978-85 to reach the crude birth rate target of 26 per 1,000 by 1985. To reach this target decline in fertility, about 44% of Peninsular Malaysian women of reproductive age (15-44 years) will need to practice contraception regularly. In 1974-75, about 35% of the women of reproductive age were reported to be practicing family planning—40% in urban areas and 25% in rural areas. To ensure increased level of contraceptive use, the program must provide more effective contraception to a progressively greater proportion of couples in the reproductive ages and gradually reduce their dependence on less-effective methods and uncertain sources of non-program acceptance. Accordingly, targets of new acceptors to be covered are apportioned between program and non-program sources such that the program contribution increases from 60% to 75% while the non-program contribution decreases from 40% to 25% during the period 1978-85 (Annex 4, T-15). These target rates of contraceptive practice will be feasible if the plans to strengthen the program are carried out. The proposed second project would support a major portion of the improvements needed.

III. THE FIRST POPULATION PROJECT

Design

3.01 The first population project was designed to strengthen the national family planning program by: (a) improving administration and management; (b) extending family planning services to rural areas and demonstrating the effect of intensive inputs in selected rural areas; (c) expediting the family planning training of paramedical personnel; (d) introducing population education into the school system; (e) improving family planning, nutrition and health education programs, particularly for the rural population; and (f) establishing population research programs.

Composition

3.02 The project consisted of: (a) the construction and equipping of MCH/FP administrative centers, urban and rural clinics, a new rural health training center, and extensions to an existing rural health training center and to 365 mid-wifery clinic-cum-quarters (MCQs); (b) equipment for evaluation and research, family planning services/nutrition education, and for the production of IEC materials; (c) 147 four-wheel drive vehicles and 200 scooters; (d) advisory services; (e) funds for training teachers, paramedical staff, and traditional midwives; (f) the preparation of materials for population education and the IEC program; (g) contraceptive supplies; (h) the establishment of a Project Construction Unit; and (i) an external review of the program.
Financing

3.03 Total project cost was estimated at US$14.5 million. It was financed by a UNFPA grant of US$4.3 million, a Bank loan of US$5.0 million, and a GOM contribution of US$5.2 million. The Bank loan financed the total foreign exchange cost, estimated at 49% of the Bank-assisted component of the project, including interest and other charges.

Implementation

3.04 For implementation of the project, the GOM formed a Project Implementation Committee (newly renamed Project Steering Committee). The loan was signed in February 1973, and became effective in June 1973. The UNFPA entered into direct agreement with the GOM to finance a set of separate project components in parallel with the Bank. After initial delays, most of the UNFPA funds have now been spent. The main delay in executing the Bank component of the project has been in the completion of physical facilities. The basic reasons for the delay were:

a. the NFPB Project Secretariat was weak at the outset, while at the MOH no individual was assigned full-time responsibility for project implementation. Because the project was small, the MOH did not establish the Project Construction Unit as required by the Legal Agreement; consequently, there was inadequate coordination of the civil works;

b. the location of buildings and the architects' briefs were frequently changed causing several months' delay in construction; and

c. the sites were not acquired as scheduled, thus preparatory work for construction was delayed.

3.05 To avoid repetition of these situations and to improve implementation, several measures are being introduced into the proposed second project (described in paras. 4.68 and 5.16-5.24). In the meantime, new management at the NFPB has significantly expedited progress of the first project through intensification of management control, field supervision and closer inter-agency coordination.

Progress

3.06 Despite initial delays and difficulties, considerable progress has been made in the following crucial project activities such as: (a) completion of family planning training of 2,700 MOH auxiliary health staff and supervisory personnel; (b) the provision of staff and equipment in the IIDA and the completion of related baseline surveys; (c) appointment of 11 state MCH/FP officers; (d) preparation of 20 IEC training modules and expansion of IEC activities; (e) establishment of a population education unit in the Ministry of Education; (f) installation of a mini-computer for the NFPB;
(g) initiation of a population study program in the University of Malaya; (h) completion of project activities under FFPA; and (i) completion of a management study and an external review of the program.

3.07 Almost all vehicles and special equipment have been either procured or ordered. Most of the advisers have completed their assignments. About 232 buildings out of a total 571 have been completed and the remaining are scheduled for completion during the next 15 months.

Disbursements

3.08 As of the end of May 1978, US$1.3 million (about 26% of the loan) had been disbursed, although the Government had expended sums equivalent to more than 36% of the loan by April 1978; an updated disbursement schedule is given in Annex 4, T-16. In addition to slow project implementation, disbursement delays related to civil works are also caused by the difficulty of obtaining payment vouchers to support applications for withdrawals. The cost of the civil works component of the project has almost doubled, and is now estimated at US$10.6 million (Annex 4, T-17). The GOM has allocated adequate funds in the Third Malaysia Plan to meet these cost overruns. However, if loan disbursements for civil works continue at the agreed rate of 30% of the total cost, the loan will be exhausted by the end of 1979.

Impact

3.09 Preliminary indications suggest that the demographic impact of a number of components already completed and of the covenants in the Legal Agreement complied with is significant. As the project has progressed, the number of acceptors has steadily increased, reaching over 80,000 in 1977. The most striking increase was achieved by the integrated rural health/family planning services, where annual acceptance rose from less than 3,000 in 1971 to about 36,000 in 1977.

External Review

3.10 As provided in the first Loan Agreement, the progress of the program was reviewed in 1977 by an External Review Team. The Team's principal recommendations are: (a) in addition to new acceptors, the family planning target should be expressed in terms of protection rate and reduction of fertility, and not more than 25 to 30% of the target should be left to non-program sources; (b) consideration should be given to the provision of payments to medical practitioners to perform sterilizations and IUD insertions when Government facilities cannot cope with the demand; (c) additional service delivery points should be created in the rural and urban areas in order to provide services for the estimated 730,000 rural and 105,000 urban households classified as "poor"; (d) the NFPB should try to improve the political acceptability of family planning through a "desensitization" campaign; (e) the capacity of NFPB's IEC Division to produce program materials should be strengthened; (f) the number of professionals in the NFPB's Evaluation Division should be increased; (g) a National Research Committee should be set up to encourage research, propose topics and set priorities; (h) a Population Study Center
should be established in the graduate school of the University of Malaya; (i) the NFPB, MOH and FFPA should set up a committee to design standard forms for data collection and performance reports; (j) a cost-effectiveness analysis should be applied to the program, and the NFPB Finance Division should be strengthened for this purpose; and (k) a coordinator should be appointed to supervise the progress of civil works.

Program Requirements and Extension of First Project Activities

3.11 In the light of the External Review Team’s recommendations and new program directions, a number of activities initiated in the first project need to be extended to improve the program, such as: (a) construction of additional urban clinics; (b) extension of the IIDA program; (c) further addition of mobile information units; and (d) strengthening of the management information system initiated in the first project. Other program needs are: (a) reduction in the emphasis on pills and provision of alternative contraceptive methods; (b) provision for treatment of side effects of contraceptive use over a long duration; and (c) broadening of the program base through integration of population education in development programs. The following section describes the component activities which will be undertaken in the second project to meet these program needs.

IV. SECOND PROJECT

A. Design, Objectives, Activities and Composition

Design

4.01 The project is designed to help meet the demographic and development goals of Malaysia as defined in para. 1.05. It will further support the national family planning program by extending the activities begun in the first project and by meeting other priority program needs identified by the GOM, the External Review Team and the Bank. Unlike the first project, the second project will also cover the states of Sabah and Sarawak.

Objectives

4.02 The objectives of the project, which will form the basis of its evaluation, are: (a) to improve the rate of continuation of contraceptive practice, promote the availability of alternative methods, and increase the number of acceptors; (b) to extend services to regions and communities where they are at present inadequate or unavailable; (c) to improve the monitoring and evaluation of the program and promote operational and policy-related research into determinants of demographic changes and their linkages with socio-economic development; and (d) to promote a smaller family norm and demand for family planning services.
Activities

4.03 To these ends the second project, to be implemented over a four-year period, will: (a) establish family planning specialist centers under the NFPB for the provision of specialized health care related to family planning; (b) extend the NFPB service delivery network in urban areas; (c) strengthen the MCH and family planning services of the MOH in 44 districts by replicating the first project's IIDA program; (d) expand and strengthen the capacity of the MOH to give in-service training to its staff in integrated rural health and family planning; (e) strengthen the health education program of the MOH and the information, education and communication (IEC) program of the NFPB; (f) strengthen the NFPB management information system and increase NFPB's research and evaluation capacities; (g) expand the capacity of the Ministry of Agriculture's family development training and promote non-familial roles for women; (h) strengthen the administration of health and family planning services at the MOH and NFPB; (i) improve NFPB's contraceptive storage and distribution system; and (j) make provision for various innovative activities to test new strategies for program improvement.

Project Components

4.04 The project will consist of:

a. Construction, furnishing and equipping of:

NFPB: (i) 1 national and 4 regional FP specialist centers, 36 urban FP clinics of which 15 include MCH clinics, 1 central godown and 1 print shop; MOH: (ii) 6 integrated rural health and family planning training schools; (iii) 73 trainees' quarters--39 at community health centers and 34 at MOQs in Peninsular Malaysia; (iv) 56 trainees' quarters at 32 rural health centers in Sarawak; (v) 25 staff quarters attached to training schools in Sarawak (no equipping for (iii), (iv) and (v) except for 3 hostels included in 56 quarters for Sarawak); (vi) conversion of 34 MOQs into community health centers; (vii) addition of MCH/FP clinics to 12 existing dispensaries; (viii) 1 audiovisual material production center; and (ix) 8 district health offices with MCH/FP service facility; Ministry of Agriculture: (x) 2 family development training centers; (xi) 12 community services centers; and (xii) 1 center for the women's handicraft sales organization;

b. Purchase/lease of land for selected facilities;

c. Purchase of vehicles for:

NFPB: (49 vehicles)--3 minibuses, 14 station wagons, 18 IEC mobile vans, 6 delivery vans, and 8 four-wheel drive, including 6 for the Public Works Department; MOH: (790 vehicles)--223 minibuses, 66 four-wheel drive, 500 scooters, 1 delivery van; and 10 boats and 14 motor boat engines; and Ministry of Agriculture: (8 vehicles)--2 four-wheel drive, and 6 delivery vans;
d. **Purchase of special equipment for:**

**NFPB:** (i) computer software, tape recorders and calculators for the REMIS Division; (ii) audiovisual equipment for 7 IEC mobile vans; (iii) office and accounting equipment for Administrative Division; **MOH:** (iv) equipment for 11 health education mobile vans and one mobile equipment maintenance unit; (v) 77 film-strip projectors for the Health Education Unit; and (vi) immunization and nutrition equipment consisting of 1,100 refrigerators and 2,580 weighing scales;

e. **Technical assistance for:**

**NFPB:** (i) 15.4 man-years of fellowships and 10 man-years of advisory services; **MOH:** (ii) 5.4 man-years of fellowships and 2 man-years of advisory services; **Ministry of Agriculture:** (iii) 4.4 man-years of fellowships; and **Public Works Department:** assisting with professional fees for the design of construction facilities; and

f. **Incremental operating cost for:**

**NFPB:** (i) 1 national family planning specialist center (salaries and allowances, materials, production and research contracts); (ii) 4 regional family planning specialist centers (salaries and allowances, materials); (iii) information, education and communication (procurement and production of films); (iv) evaluation including IEC research (salaries and allowances, production of reports, research contracts); (v) project implementation (salaries and allowances for the Project Secretariat and for PCCU staff and staff added to the 6 state-level Public Works Departments); and (vi) innovative activities; **MOH:** (vii) health education (procurement and production of films and IEC materials, research contracts); and (viii) integrated rural health and family planning training evaluation (research contracts); **Ministry of Agriculture:** (ix) the women's development program (salaries and allowances and research contracts for the women's handicraft sales organization and research contracts for 2 family development training centers).

**B. Project Description**

**Specialized National Family Planning Services**

4.05 Since its inception, the program has relied heavily on pills; nearly 85% of all new acceptors during the last ten years chose this method. The availability of other methods, such as IUD, sterilization and menstrual
regulation, is not adequate. Heavy reliance on pills reduces program effectiveness for two primary reasons: First, as the average age of acceptance declines, the time span over which the acceptor needs protection increases, thus representing possible health risks. Second, as the increasing volume of acceptors makes the incidence of side effects more conspicuous, greater discontinuation may result. (A 1971 survey indicated that pill side effects were the chief reason for discontinuation.)

4.06 About 10% of program acceptors are found to be in need of medical attention. Among married women aged 15-44, 10% are estimated to be sterile or sub-fecund and in need of infertility counseling. About 46,000 women every year give birth to deformed babies and need genetic counseling. It is estimated that at present the hospitals are meeting only 14% of the potential demand for sterilizations (4,000 sterilizations were performed in 1974 in Government hospitals, compared to an estimated demand of 29,000). A recent FPPA survey (Maternal Health and Early Pregnancy Wastage, 1977) noted that 11% of the reported pregnancies resulted in abortions. Seventy percent of the abortees responded that they would have used reliable contraceptive methods if alternatives had been available. Hospital records indicate a high fatality associated with these abortions.

4.07 Present ad hoc efforts to deal with these problems are inadequate. Hospitals and other institutions are too busy to deal with abnormal and complicated family planning cases. Because facilities are not available, less than 2% of women accepting pills are able to obtain Pap smear tests for cancer detection. There is a backlog of two to three months for sterilization cases, partly because of inadequate theater space and partly because few doctors are trained in out-patient sterilization techniques.

4.08 The NFPB lacks the capacity for bio-medical research pertaining to the safety, effectiveness and practicability of family planning methods in the context of bio-medical and cultural characteristics of the Malaysian population. At present this research is conducted to a limited extent by individuals in the Department of Obstetrics and Gynecology at the University of Malaya.

4.09 To meet these needs, the NFPB proposes to establish one national and four regional family planning specialist centers whose functions will be to:

a. provide: (i) the services of specialists for cancer detection; (ii) diagnosis and treatment of complications resulting from oral pills, injectables, and menstrual regulation; (iii) counseling for genetic defects and infertility; and (iv) sterilization, injectables and menstrual regulation on an out-patient basis;

b. train doctors to provide the above services; and

c. conduct and promote program-oriented and country-specific bio-medical research in collaboration with other medical institutions.
The provision of specialized services will help dispel the stigma attached to family planning as a birth reducing effort only; it will improve the program approach to people and thus increase the number of clients. The research facilities will also help to make specialization in family planning more attractive to medical and paramedical personnel.

4.10 The national center will be located in Kuala Lumpur and the regional centers at Kota Bahru (Kelantan), Johore Bahru (Johore), Ipoh (Perak) and Penang. Consideration in the planning of both the national and regional centers has been given to subsequent expansion. Although all five centers will provide services and training and conduct research, the regional centers will concentrate on services, and conduct research and training only as directed by the national center.

4.11 Besides construction and equipping of these centers, the project provides for special equipment, vehicles and technical assistance, including fellowships. Full physical facilities will be required for the national center only. Urban family planning clinic buildings provided under the first project will be enlarged or modified to meet the needs of the four regional centers. Pending completion of the physical facilities, the centers will begin functioning on a small scale in existing premises. The project includes operating expenses for four years for all five centers to cover staff salaries, laboratory operating expenses, research costs, and related maintenance expenses.

4.12 The Director of the national center will report directly to the Director General of the NFPB. The center will have 9 technical sections, staffed by about 12 specialists, 7 technicians and 30 general support staff (see Annex 4, C-5). Each regional center will be headed by a medical officer, and its staff will consist of 2 specialists, 5 technicians, 4 staff nurses and 12 general support staff.

4.13 A Medical and Research Advisory Committee will: (a) determine research priorities; (b) approve research study designs; and (c) ensure coordination of research with other institutions. The Committee will consist of representatives of the NFPB, MOH, the Universities of Malaya and Kebangasaan, and the Institute of Medical Research.

4.14 The NFPB proposes to appoint an adviser for an initial period of six months to: (a) prepare an action plan for the centers; and (b) determine physical space, equipment and manpower requirements. The appointment of the adviser will be a condition of loan effectiveness.

4.15 The capacity of the centers will not be sufficient to meet program requirements. In any case, the innovative nature of their activities limits the rate at which these centers can be expanded. The number of Pap smear tests at these centers will be limited to 90,000 a year, 30,000 at the national center and 15,000 at each of the four regional centers. Although, ideally, the present 600,000 oral pill acceptors and an additional 100,000 acceptors every year should undergo these tests, for at least three years the centers will be able to examine only those already suspected to have complications, or who have taken the pill for three years or more.
4.16 By training existing Government physicians, the national specialist center may be able to increase the number of sterilizations performed in Government hospitals and clinics from 4,000 to 10,400. These, together with the proposed capacity for 2,000 sterilizations at the national center and 1,300 at the four regional centers, will create a total annual capacity of about 14,000 sterilizations. This capacity will meet only 50% of the estimated annual demand of 29,000. It is assumed that private physicians, who also will be trained at the centers, will be able to satisfy part of the unmet demand.

4.17 About 240 doctors (180 Government and 60 private), representing 10% of the total physicians in the country, need to be trained. The corresponding figure for nurses is 420, or 40% of the existing nurses. The centers will train about 100 doctors and 80 nurses a year in sterilization techniques and other modern methods of fertility control. It will take about two and a half years to train 240 physicians and five years to train 420 nurses. Meanwhile, a backlog of 80 new doctors and 200 new nurses will accumulate each year. Annual training capacities are given in Annex 4, T-18.

4.18 The family planning specialist centers' performance will be assessed in terms of quantitative performance indicators specified in Annex 3.

Urban Family Planning Services

4.19 The rapidly growing urban population, estimated at 3.6 million in 1977, is expected to reach 4.5 million by 1982. No data are available, but it is believed that migration from the country to the towns has accelerated. The migrants are concentrated in a few slum areas in which the NFPB is making special efforts to provide family planning services.

4.20 In 1977, there were 113 urban static family planning clinics. Of these, 79 were run by the NFPB and 34 by the FFPA. At the present time each clinic, on an average, reaches a population of more than 26,000. There are also about 440 so-called "mobile clinics" attended on certain days of the week by staff from the static clinics in areas where full-time clinics have not yet been set up, or the demand for family planning does not warrant full-time service. Each mobile clinic, on an average, covers 3,000 population.

4.21 It is estimated that by 1982, 36 additional clinics will be needed to maintain the coverage of population at 30,000 per clinic. The second project includes the construction and equipment of 36 urban clinics. These 36 clinics do not meet the total requirement as only 15 will be additional clinics located in areas where no services are yet available; eight will represent conversions from mobile to static, and 13 will replace inadequate clinics. Out of the total 36 clinics, the 15 clinics in new areas will include space for MCH services to be provided by the MOH, hitherto not available in these areas. The remaining clinics' needs will be met by using MOH facilities and additional mobile units.
4.22 The 15 additional clinics will enable an additional 450,000 people to have ready access to services. Another 200,000 population will be served through conversion of mobile to static clinics. This improved coverage is expected to help in reaching the urban target of contraceptive use—which is 60% of the women within the reproductive age group by 1985. In 1976, about 41% of the total acceptors were served by urban clinics, although only 19% of the total acceptors were urban residents. Thus, about half of the acceptors served by urban clinics were classified as rural residents for that year. (Data are given in Annex 4, T-19.)

4.23 The project also includes 14 station wagons to strengthen supervision and home visiting, and 24 man-months of fellowships for advanced training of the senior staff of the Service Division under the NFPB. The incremental operating cost for the additional clinics will be M$460,000 (US$192,000) per year and will be met from the recurrent budgets of the MOH and NFPB.

4.24 The criteria for evaluating the performance of urban services are specified in Annex 3.

MCH/FP Services in Rural Areas

4.25 The rural population was estimated at 7.3 million in 1977 and is expected to increase to about 9 million by 1985. The present 1,626 MOH health centers and clinics in rural areas cover a little over half of the population, and the more remote areas are served by mobile teams. The MOH proposes to further strengthen the existing MCH/FP services through additional mobile teams, better supervision, frequent home visits and improved health and family planning education.

4.26 The MOH has already introduced family planning services into the MCH program in about 70% of its rural health facilities. To promote this integration and strengthen the MCH services, the first project provided for an IIDA program. Under this program, the project provided additional inputs in 27 out of 70 administrative districts, covering a population of three million, or 25% of the total rural population.

4.27 The additional inputs of the first project consist of: (a) conversion of MCQs into community health centers; (b) training of midwives and assistant nurses in the delivery of family planning services; (c) an increase in the nursing and clerical staff at the health centers; (d) supplying vehicles, including scooters for midwives, and nutrition equipment (weighing scales and cooking equipment); (e) production of IEC materials; and (f) the evaluation of the program. All of the above, except the physical facilities and IEC materials, have been in place for one to two years.

4.28 Pending a complete evaluation scheduled for 1978-79, the NFPB is monitoring performance through service statistics which indicate that, during 1975 and 1976, IIDAs accounted for over 70% of the new acceptors from rural areas, and that in 1976 about 36% of women in IIDAs were practicing family planning, compared to 25% in all rural areas. An ad hoc survey in Trengganu showed that the number of home visits by midwives doubled after they were provided with scooters.
Encouraged by these results, the MOH has decided to extend the program to 44 districts, using similar inputs. The project will contribute to these inputs by providing: (a) 188 mini-buses and 500 scooters; (b) 2,580 infant and adult weighing scales; (c) 1,100 refrigerators for vaccines; and (d) educational and audiovisual materials and equipment.

The first project provided the MOH with 26 mobile teams to cover the more remote areas. The need for further expansion of comprehensive health services in remote areas was emphasized by a 1976 World Health Organization (WHO) study. The second project will, therefore, provide 50 vehicles, 24 of them for new mobile teams, and 26 to replace the vehicles assigned to the existing teams. Each team consists of a medical officer, a hospital assistant, a public health staff nurse, an assistant nurse, one female and one male attendant and a driver. The teams provide a wide range of medical and health services (including antenatal, postnatal, and child health care), immunization, and nutrition, family planning and health education. Each team covers 10,000 to 20,000 people. Thus, the 24 additional teams will cover 240,000 to 480,000 people.

The project will also equip 10 mobile teams for Sarawak with ambulances, long boats and engines and provide fellowships for nine man-months to train MOH officials in planning and management of integrated MCH/FP services and addition of MCH/FP clinics to 12 existing dispensaries including vehicles for these clinics.

The evaluation of the above facilities should be made through the analysis of routine service data and a few special studies administered before and after the new inputs to obtain quantitative measures of performance indicators specified in Annex 3. During negotiations, assurances were obtained from the GOM that the MOH will finalize the establishment of an appropriate transportation maintenance system 1/ not later than August 31, 1979, to ensure proper upkeep of the vehicles to be provided under the project.

Training of Staff for Integrated Rural Health and Family Planning Services

The categories of health staff responsible for rural health and family planning services are: (a) physicians; (b) nurses with three years of training and 12 years of basic education; (c) assistant nurses with two years of training and nine years of basic education; (d) hospital assistants with three years of training and 12 years of basic education; and (e) midwives with two years of training and six years of basic education.

The midwives—the basic peripheral workers—will soon be replaced by community nurses in order to provide a broad range of health services, including family planning, instead of simply MCH care as at present. They will be stationed in MCQs which will be upgraded to community health centers. The MOH is trying to convert a cadre of midwives into a cadre of community

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1/ The MOH, with WHO's assistance, completed a study (1976-77) on the ways of improving the maintenance of MOH's vehicles. A proposal of establishing a new maintenance system is under review by the Government.
nurses by giving them six months’ training. In addition, three new schools are being established to provide a two-year training program for community nurses. Midwives will continue to be stationed in hospitals.

4.35 The basic training of the above categories of nurses (except community nurses) has hitherto included only two hours of instruction in family planning. In-service training in family planning is, therefore, essential. The MOH is now planning to include family planning training in the basic training of nurses and midwives. The training of supervisory staff (both doctors and nurses) in family planning is conducted by the NFPB, which has already trained 90% of them. The NFPB can train 100 personnel annually, and this is adequate for completion of the supervisors’ training.

4.36 The in-service training of assistant nurses, community nurses and midwives is conducted by the MOH, which has trained the present 2,700 assistant nurses and midwives at the five temporary schools set up under the first project. The MOH is now proposing to give these workers three weeks’ retraining in family planning and nutrition. The staff to be retrained in the two above-mentioned categories will exceed 3,500 in 1980, and will increase to 4,400 in 1985 and near 5,000 in 1990. The GOM proposes to retrain all staff every four to five years.

4.37 In Sarawak and Sabah, the Government plans to give all health and medical staff in-service retraining, which will include family planning. The total number of staff to be trained in Sarawak will be over 1,000 in 1980 and will reach about 2,000 in 1990. The corresponding figures for Sabah are 440 and 730. The annual training requirements in both Peninsular and East Malaysia are given in Annex 4, T-20.

4.38 The project includes: (a) the construction and equipment of: (i) six integrated rural health and family planning training schools for various categories of rural health staff--three in Peninsular Malaysia, two in Sarawak and one in Sabah; (ii) field training facilities for community nurses and hospital assistants including trainees’ quarters--73 quarters--39 at community health centers and 34 at MCQs in Peninsular Malaysia, 56 quarters at 32 rural health centers in Sarawak; (iii) 25 staff quarters at training schools in Sarawak; and (iv) conversion of 34 MCQs in Peninsular Malaysia into community health centers; (b) the provision of vehicles, equipment, training materials and manuals; (c) the evaluation of the training program; and (d) 46 man-months of fellowships, (40 man-months to train eight tutors for the Sabah training school and six man-months of study tours for the MOH Training and Manpower Division).

4.39 During negotiations, the GOM agreed that: (a) the MOH will evaluate the functions and training needs of the health staff prior to developing the training curricula; and (b) the curricula and training of trainers of such staff will be completed at least three months before completion of construction of the schools.
Information, Education and Communication (IEC)

4.40 Malaysia has reached a stage of development at which it is becoming more difficult to recruit new family planning acceptors without an effective IEC program. The need for such a program is already obvious in the urban areas, where the number of acceptors has leveled off since 1970. The GOM, therefore, proposes to intensify IEC activities in urban areas, and integrate family planning education with development activities for rural areas (such as health education and the community development program) to sustain an increase in the recruitment level and thus avoid plateauing of performance experienced in urban areas.

4.41 In Malaysia, the family planning IEC program has so far been largely conducted by the NFPB and FFPA. The role of the FFPA, as a voluntary organization, is small, though extremely important. The introduction of population education into the school system by the Ministry of Education and into rural development training program by the Ministry of Agriculture is recent. The NFPB is responsible for coordinating and standardizing all IEC activities and disseminating population and family planning knowledge.

4.42 The IEC program has been handicapped by: (a) political sensitivity to the use of mass media for IEC; (b) the absence of a detailed IEC plan and inadequate coordination of IEC efforts of the various agencies; (c) a weak health education program largely because of the frequent transfers of the central unit staff and shortages of educational materials and software for audiovisual equipment; (d) insufficient research and systematic evaluation; and (e) slow progress of population education activities. The project is designed to overcome some of these limitations.

4.43 During formulation of the first project, the NFPB prepared plans for campaigns directed towards a variety of target audiences. Some of these campaigns had to be curtailed because of increased political sensitivity to family planning. The External Review Team recommended the engagement of a commercial firm of public relations experts to advise ways of reducing public sensitivity to the issue of family planning. Although the NFPB feels that it might not be desirable to use a commercial firm for this purpose at present, it proposes to develop an IEC plan which will include strategies to elicit social and political support for the program. Another way is to include family planning in the development programs of as many ministries as possible. The project, therefore, aims at strengthening health education and community development activities.

4.44 While the NFPB has prepared an outline of IEC activities to be undertaken during the project period, it should also prepare a detailed coordinated IEC plan of action defining the objectives of the IEC program, methods for reaching individual target groups, the role of each of the agencies, the mechanism for coordination and evaluation, and a time schedule. On the basis of this overall plan, the participating agencies should prepare their own sub-plans.
4.45 During negotiations the GOM agreed that the proposed overall IEC plan will be submitted for the Bank's comment not later than January 31, 1979 and the sub-plan for health education not later than April 30, 1979. To monitor the IEC program, the NFPB has established an IEC Subcommittee to the National Family Planning Committee. The composition and terms of reference of the Committee should be included in the IEC plan.

4.46 Group talks have been successfully conducted through NFPB's mobile information units. Altogether, the 11 states in Peninsular Malaysia have 23 mobile vans with audiovisual equipment. Eleven of these vans were supplied under the first project, which also provided for communication research and evaluation. The second project will add to these units and expand the NFPB's capacity for producing printed materials and films and strengthen communication research and evaluation capabilities.

4.47 The MOH has a Health Education Unit with a small central staff and one health education officer in each state which provides health education, including family planning, with the help of six audiovisual vans and a small press for printing pamphlets and posters. In the first project, the Bank provided audiovisual equipment while the UNFPA provided technical assistance and equipment for the production of films and other materials (film strips, slides, charts, etc.,) for use in training health education officers. Not all of the equipment is yet in place. The present project proposes the establishment of an Audiovisual Material Production Center (AVPC) under the MOH's Health Education Unit to enhance the capability to develop and produce audio-visual materials such as film strips, slides, transparencies, posters and printed material. This unit should be able to meet the needs of the MOH and other agencies for these materials.

4.48 The Ministry of Education, with UNFPA support under the first project, is preparing population education curricula for the school system, but has yet to arrange for the requisite training of teachers and to incorporate the subject in textbooks. The first project Loan Agreement required the introduction of population education in the schools by December 31, 1976; this date will be revised. UNFPA funds under the first project are adequate to complete the training program.

4.49 For the Ministry of Agriculture, since 1971 the NFPB has been training agricultural extension workers to spread family health and family planning ideas, and to help the Community Development Division arrange courses in family planning in its four family development training centers (para. 4.55).

4.50 Evaluation of the IEC program to be implemented by all agencies, as well as communication research, is the responsibility of the Research, Evaluation and Management Information System (REMIS) Division of the NFPB. The project provides for a small staff and fellowships to strengthen this capability in the NFPB. The project will thus provide the NFPB with: (a) construction and equipping of a print shop; (b) 18 mobile vans—seven to replace old ones and 11 to add one van per state; (c) funds for the production and purchase of films; (d) fellowships for the training of IEC managers and evaluators (27 man-months); and (e) two officers for evaluation of IEC activities. For the MOH Health Education Unit, the project will provide:
(a) construction and equipping of an AVPC; (b) one three-ton truck for delivery of AVPC supplies; (c) a mobile maintenance unit for audiovisual equipment; (d) 16 mobile vans with audiovisual equipment (five to replace old ones and 11 new ones); (e) funds for the production and purchase of films and other IEC software; (f) 77 film-strip projectors; (g) fellowships (nine man-months) for staff training; (h) advisory services (two man-years) to help establish the AVPC; and (i) funds for health education evaluation studies.

4.51 During negotiations, the GOM agreed to strengthen the Health Education Unit of the MOH with the appointment of a head in an appropriate rank to ensure effective execution of the project, and not later than March 31, 1979, a competent health professional will be appointed to head the AVPC with direct responsibility to the head of the Health Education Unit. The proposed staffing of the Unit is given in Annex 4, C-6.

4.52 The MOH should obtain the services of an adviser for six months to assist in preparing a master plan of action for Health Education and a production plan for the AVPC, and also to determine the space, equipment and manpower requirements of the AVPC. During negotiations, the GOM agreed that the appointment of this adviser, in accordance with the terms of reference to be agreed on between the GOM and the Bank, will be made not later than October 1978. The operational cost of the center will be borne by the GOM.

4.53 The IEC activities of the NFPB and the MOH will be assessed in terms of quantitative performance indicators specified in Annex 3.

Women's Development Programs

4.54 Measures to improve the socio-economic status of women, and thus give them alternatives to child bearing, have proved effective in many countries in creating a demand for family planning services. One of the most convenient channels for reaching women in Malaysia is the Family Development Program under the Community Development Division of the Ministry of Agriculture.

4.55 The Community Development Division has four family development training centers (FDTCs), which offer full-time residential courses for: (a) village community development workers—one in each village; and (b) other women from rural areas wishing to be trained. Already 5,500 village workers and 105 district supervisors have been trained at these four centers. The functions of the village workers are to: (a) organize home economics demonstrations, including vocational training classes; (b) visit rural families to offer advice on home economics topics; (c) organize community projects; and (d) conduct play groups for pre-school aged children. Because of the growing demand for this training, the Ministry of Agriculture is planning three more FDTCs—one is now being established and two are proposed under the present project.
4.56 The four existing and three planned FDTCs will permit about 750 students a year to be trained in various courses of varying duration. The training capacity of the FDTCs is summarized in Annex 4, T-21. The capacity will not be sufficient to cope with the backlog of applications and the need for retraining the 5,500 village workers and 105 district supervisors. Based upon the experience of the experimental community service centers (para. 4.57), the GOM will plan for further extension of the training facilities. The project provides for the construction and equipping (including vehicles) of two FDTCs.

4.57 The GOM proposes to establish 15 experimental community service centers (CSCs) at district levels, one per state and one additional for each of the two priority states. Three of these CSCs will be established under the Bank's fourth education project and 12 under this project. These centers will be a link between the village worker and the village women, inasmuch as they will provide short training courses for the villagers in various vocations, and demonstrations of housekeeping, child care, nutrition and handicrafts. These centers will serve as a focus for social activities and as a development service referral network for the district. Previously trained village women will provide handicraft demonstrations at these centers. Six delivery vans are included in the project to take the goods produced in the CSCs to the FDTCs for grading and pricing and then to the women's handicraft sales organization for marketing.

4.58 Unless the above-described activities result in tangible economic benefits to the village women, they will be self-defeating. To help establish the organizational mechanism necessary to promote these activities, the project includes funds for the purchase of a shop for the women's handicraft sales organization and the payment of staff salaries for four years. Funds are also provided for surveys to determine: (a) types of handicrafts in demand; (b) available skills and resources for production; and (c) the preferences of village women in terms of vocational and home development training. Findings from the comprehensive study of existing non-formal education (funded under the Bank's fourth education project and conducted by the Malaysian Center for Development Studies) to be available in mid-1978, will be used for preparing detailed action plans for the FDTCs and the CSCs. During negotiations, the GOM agreed that the Ministry of Agriculture will prepare and furnish for Bank comments, no later than December 31, 1978, a detailed plan of action which shall: (a) specify the time allotted to family life and MCH/FP topics in the training at the FDTCs and in the activities at the CSCs; and (b) link the training to be carried out in the FDTCs with activities at the CSCs and women's handicraft sales organization.

4.59 The project includes 53 man-months of fellowships to train ten professionals in six areas of specialization. On completing their training, they will staff the two FDTCs, the women's handicraft sales organization and the relevant units within the Community Development Division.

4.60 The Ministry of Agriculture's performance will be assessed in terms of the quantitative performance indicators specified in Annex 3. The findings of the study under the Bank project on the existing status of non-formal
education and family-development activities and those of project-funded market research will be used to establish baseline measures to compare with later measures of project performance.

Research, Evaluation and Management Information System (REMIS)

4.61 The REMIS Division of the NFPB has hitherto concentrated on the production of routine service statistics and on making periodic evaluation studies. Shortage of computer software and professional staff, and lack of interest on the part of local research institutions have restricted the Division’s capacity to analyze routine service statistics for feedback to state and district officers. The first project increased this capacity by providing a mini-computer and advisory services.

4.62 On the recommendation of the External Review Team, the NFPB has established a National Population Research Committee to coordinate research and determine priorities. Assurance was obtained during negotiations that, as recommended by the External Review Team, an evaluation subcommittee representing each of the implementing agencies will be formed by December 31, 1978 in order to: (a) review the existing research system; (b) determine operational data needs; (c) specify the frequency and means of data collection; and (d) design forms and procedures for data collection, processing and feedback.

4.63 Research and evaluation studies to be undertaken by the NFPB during the project period will help to identify the determinants of reproductive behavior and analyze the interaction between demographic and development variables in the Malaysian socio-economic context. Because of the increasing demands on its operational research and evaluation capacity, the NFPB should contract out to universities and other institutions as many research studies as possible. Further, as recommended by the External Review Team, the NFPB should engage graduate students with a view toward their specializing in population research and evaluation. Recognizing the part the universities could play, the first project supported the population study program at the University of Malaya. This program has developed to a stage where a full-fledged Population Study Center could be established, and the GOM is now seeking UNFPA assistance for this purpose.

4.64 Although the MOH is collecting MCH data, it has not yet analyzed these with a view toward the development of a system of feedback. The NFPB will work closely with the MOH in analyzing operationally relevant service statistics.

4.65 To help the REMIS Division to undertake the above activities, the project provides software for the mini-computer, office equipment, vehicles for surveys and funds for six research studies. It also provides for the hiring of university graduates for secondary data analysis and contracting out of indepth analyses of existing data to the universities.

4.66 The External Review Team pointed out that the staff of the REMIS Division is "bottom heavy." To correct this deficiency, the NFPB should fill the vacancies for six professional staff at headquarters (Annex 4, C-7). The
Administration and Management

4.67 The first project included a management study. The principal recommendations of this study, which have been accepted by the NFPB, were: (a) a computer-based management information system should be set up to monitor program inputs and performance; (b) a management information unit should be set up in the Research and Evaluation Division; (c) a Planning and Development Division should be created; (d) the positions of Director General and Deputy Director General of the NFPB should be permanent and full-time, and the Director General should also be Project Administrator; (e) a ministerial circular clarifying NFPB's role in the formulation, review and monitoring of population-related programs, including their funding, be issued; (f) the integration of family planning with rural health and its introduction into the work of other development agencies be accelerated; (g) a manual of project operational procedures should be adopted; and (h) the NFPB should gradually transfer the implementation of the family planning program to other agencies, with a view toward eventually confining its role to that of planning and coordination.

4.68 Action has been taken on all recommendations. The last recommendation is of long-term nature and is being gradually implemented. The Project Secretariat of the NFPB is finalizing an operational manual (referred to in (g) above) which is to be approved by the Project Steering Committee. This manual will consist of: (i) program and project objectives and targets for participating agencies along with quantitative indicators for measuring the attainment of such objectives; (ii) mechanism for collection of required information and analysis; (iii) project implementation schedules; and (iv) project administrative procedures. During negotiations, the GOM agreed that the participating agencies will adopt and adhere to this manual in the implementation of their respective activities.

4.69 To decentralize NFPB administration and promote cooperation between the NFPB and MOH state level administration, the first project helped to construct 11 MCH/FP administrative centers—one in each state. Of the 11, only three are in operation as yet; the remaining eight are in various stages of construction. The MOH is also strengthening its district health administration. At present, the NFPB has no district-level administration.

4.70 The number of health districts has increased from 44 in 1970 to 61 in 1977, and is expected to reach 70 by 1985. The average population coverage of each health district will then be about 180,000. Of the existing 61 district health offices, 28 are in temporary accommodations. The MOH intends to construct 37 permanent office buildings—28 to replace existing temporary accommodations and nine health offices for those yet to be established. Of the 37 new health office buildings, seven are already under construction. The project includes the construction and equipping of eight district health
offices, five of them in areas where there are no accommodations and three to replace inadequate temporary accommodations. Each of these offices will be provided with a vehicle to strengthen field supervision within the health district.

4.71 Both the External Review Team (1977) and the management study made under the first project (1974) recommended the strengthening of the NFPB's cost-accounting and budgetary control system to facilitate cost-benefit and cost-effectiveness analyses. Such analyses will entail the collection of appropriate financial information from other implementing agencies and from different sections within the NFPB. The project includes administrative and accounting equipment to facilitate these undertakings and a fellowship in administration and management.

4.72 The cumulative effects of: (a) the decentralization of program operation; (b) the adoption of the operational manual; and (c) the centralization of financial data processing for cost-benefit and cost-effectiveness analyses will improve program monitoring.

Contraceptive Storage and Distribution

4.73 The NFPB is responsible for supplying contraceptives (mainly pills) to its own and MOH clinics throughout the country. At present, a warehouse, for which the NFPB pays a rent of M$3,000 (US$1,250) a year, serves as a central storehouse for supplies worth about M$1.5 million (US$0.6 million). The size of the warehouse is inadequate, and there is danger of its contents deteriorating. Most of the stock on hand is kept in the central warehouse, which is consequently overburdened with orders. This situation results in delays in the dispatch of supplies, which are sent by mail or commercial carrier and are not always delivered promptly. The NFPB, therefore, proposes to expand central storage capacity and decentralize distribution by establishing storehouses capable of stocking supplies for six months in each state. Also, the present system of supplying contraceptives directly to MOH clinics causes delays. Instead, the NFPB should supply the contraceptives to MOH state offices so that their delivery to the individual clinics could be combined with MOH's well-established drug distribution system.

4.74 The project provides for the construction and equipping of a central warehouse with a space of 17,300 sq. ft. to replace the existing inadequate facilities and provide additional space for central storage of family planning supplies to be procured by the NFPB for all agencies. Based upon the assumption that a six-month supply will be transferred to the proposed state warehouses, the warehouse space provided in the project should be able to meet NFPB's growing requirements. The project also provides six delivery vans, two for the central store, and four to serve the 11 state stores and NFPB urban clinics.

Innovative Activities

4.75 An amount of US$600,000 equivalent is earmarked for funding innovative proposals that may be made during the course of project implementation. These innovative proposals refer to testing of new strategies for program
improvements during the course of project implementation. This provision is intended to add flexibility to the project and encourage local authorities to seek innovations to meet emerging program needs on a continuing basis.

4.76 During negotiations, assurances were obtained from the GOM that the NFPB will form a committee not later than January 31, 1979, to work out the details of various innovative schemes. The committee will consist of the Directors of Services, REMIS and the National Family Planning Specialist Center of NFPB; representatives of the Ministries of Health, Labor and Agriculture; National Union of Plantation Workers, Malaysian Medical Association, Federal Land Development Authority and the FFPA.

4.77 During negotiations, confirmation was obtained that the GOM will seek the Bank's comments on details of the proposals for innovative activities prior to using funds earmarked for this purpose.

4.78 For details on project inputs by functional category, see the Project Activity Matrix, Annex 4, T-22.

V. PROJECT COSTS, FINANCING, IMPLEMENTATION AND EVALUATION

A. Costs and Financing

5.01 The total estimated cost of the project is US$37.7 million equivalent. Of this amount, the proposed loan of US$17.0 million equivalent will finance the foreign exchange component, estimated at about 45% of the total cost. The remaining US$20.7 million in local costs will be financed by the GOM. The total base cost of the project is almost evenly apportioned between civil (50.5%) and non-civil works (49.5%) components of the project. The project costs by expenditure categories are given in Annex 4, T-23, and are summarized in the following table:
5.02 Cost estimates by functional categories, summarized below, show that the combined categories of family planning service delivery account for 45.2% of the total base cost; IEC, women’s development and innovative activities account for 23.3% of the total base cost and the remaining one third of the cost is accounted for by training (16.2%), administration (7.7%), research and evaluation (5.5%) and project implementation (2.1%).
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<td>11.5</td>
</tr>
<tr>
<td>Administration &amp; Management of Health &amp; Population Program</td>
<td>2,851.4</td>
<td>1,188.1</td>
<td>1,277.0 5.6</td>
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<td>Information, Education &amp; Communication</td>
<td>1,383.4</td>
<td>576.4</td>
<td>2,100.8 8.3</td>
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<td>Women's Development Program</td>
<td>6,546.5</td>
<td>2,727.7</td>
<td>4,099.7 13.1</td>
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<tr>
<td>Research &amp; Evaluation</td>
<td>2,572.3</td>
<td>1,071.8</td>
<td>1,732.9 5.5</td>
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<tr>
<td>Innovative Activities</td>
<td>718.8</td>
<td>299.5</td>
<td>599.5 1.9</td>
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<td>Project Implementation</td>
<td>1,417.2</td>
<td>590.5</td>
<td>656.5 2.1</td>
</tr>
<tr>
<td>TOTAL BASE COST</td>
<td>40,201.6</td>
<td>16,750.7</td>
<td>31,263.6 100.0</td>
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<tr>
<td>Contingencies</td>
<td></td>
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<tr>
<td>Physical Contingencies</td>
<td>2,926.1</td>
<td>1,219.2</td>
<td>1,779.6</td>
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<td>Price Contingencies</td>
<td>6,479.8</td>
<td>2,699.9</td>
<td>4,199.7</td>
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<td>TOTAL CONTINGENCIES</td>
<td>9,405.9</td>
<td>3,919.1</td>
<td>12,325.0</td>
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<td>TOTAL ESTIMATED PROJECT COST</td>
<td>49,607.5</td>
<td>20,669.8</td>
<td>37,969.8</td>
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</tbody>
</table>

5.03 Cost estimates are based on salaries and prices prevailing in October 1977 and have been adjusted for price increases in 1978. For civil works, costs are calculated from schedules of accommodation, or type plans where available, and on the basis of unit prices obtained from the Public Works Department. Schedules of accommodation provided by the GOM have been examined to ensure that economic building standards are adopted.

5.04 Estimates for furniture are based on preliminary furniture lists at prices prevailing in October 1977. Estimates for equipment have also been based on preliminary equipment lists, and unit prices were obtained from the latest suppliers' lists.
5.05 The cost of fellowships for officials was based on the amount awarded by the GOM in the recent past--US$25,000 per year. The cost estimates for advisory services vary from US$35,000 to US$60,000 per annum, according to the length of assignment and the skills and expertise needed. 1/ Operating costs include salaries, materials, the cost of production activities, studies and innovative activities. Salaries were based on current scales; for other items NFPB estimates were examined and accepted as reasonable. Local taxes and import duties included in the project cost estimates amount to about US$1 million equivalent.

5.06 The foreign exchange component of civil works and furniture is calculated at 25% of the total cost. Vehicle and equipment costs are treated as 100% foreign, and the operating cost as 100% local, except for materials which are 37% local and for innovative activities which are 50% local.

5.07 The contingency allowance of US$6.5 million includes: (a) physical contingencies for unforeseen factors estimated at 10% of base civil works costs; and (b) price contingencies averaging 15% of base costs and physical contingencies. Contingencies were calculated on the basis of estimated expenditures, and expected annual price increases as follows:

<table>
<thead>
<tr>
<th>Annual Percentage Price Increases</th>
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<tbody>
<tr>
<td>Construction, professional fees,</td>
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<tr>
<td>furniture and land</td>
</tr>
<tr>
<td>Vehicles, equipment</td>
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<tr>
<td>and materials</td>
</tr>
<tr>
<td>Technical assistance and</td>
</tr>
<tr>
<td>fellowships</td>
</tr>
<tr>
<td>Incremental operating costs</td>
</tr>
</tbody>
</table>

B. Procurement

5.08 Buildings are required at 201 locations in Peninsular Malaysia, Sabah and Sarawak. Most buildings will cost between US$10,000 and US$500,000, with a total construction cost of US$13.1 million.

1/ The cost of consultancy services of three months or less duration is estimated as follows: round trip ticket--$1,800; per diem--$50; and fee per day--up to a maximum of $140. Cost of consultancy for more than three months includes: round trip ticket--$1,800; annual family allowance--$600; annual salary--$19,000-33,000 and 1,800 lbs. of freight.
5.09 Malaysia has a well-developed and competent construction industry, and foreign contractors not already established in Malaysia are unlikely to be attracted because of the relatively small contracts and the scattered site locations (see maps: IBRD 13445 and 13446). Contracts for civil works will be awarded on the basis of local competitive bidding in accordance with procurement procedures which are satisfactory to the Bank. Foreign contractors would not be excluded from bidding.

5.10 Government regulations require civil works contractors to be pre-qualified. Contract packages for civil works estimated to cost the equivalent of US$200,000 or more, equipment and furniture estimated to cost the equivalent of US$100,000 or more, and vehicles and materials estimated to cost the equivalent of US$50,000 or more would only be awarded after Bank review.

5.11 Contracts for furniture, equipment and vehicles will be grouped in appropriate bid packages. Except as specified below, these will be awarded after international competitive bidding in accordance with Bank guidelines. In the evaluation of bids, domestic manufacturers will be accorded a preference margin of 15% of the price of competing imports or, if lower, the applicable customs duties. Contracts for equipment and furniture which cannot be reasonably grouped in packages equivalent to at least US$100,000 and contracts for vehicles which cannot be reasonably grouped in packages equivalent to at least US$50,000 will be awarded after local competitive bidding, in accordance with Government procurement procedures acceptable to the Bank, unless Public Works Department's term contracts exist for the procurement of furniture or central Treasury contracts exist for the procurement of equipment and vehicles. Both the Public Works Department and the central Treasury contracts are let in accordance with local competitive bidding procedures and awarded for one year's term. It is estimated that about US$3.6 million worth of equipment and about US$3.7 million worth of vehicles will be procured through ICB. The remaining US$0.7 million worth of equipment and US$0.4 million worth of vehicles will be procured through local competitive bidding or through Treasury contracts where they exist. The total value of furniture to be procured through the Public Works Department's term contracts is estimated to be US$900,000.

5.12 The project includes US$920,000 for the purchase of materials such as materials for the production of films, film strips, transparencies and printed materials. These items are specialized and diverse and cannot be packaged in lots suitable for international competitive bidding. Contracts for these will be awarded on the basis of local competitive bidding, although foreign suppliers will not be excluded. Local tendering procedures are satisfactory to the Bank.

5.13 Notwithstanding the above, however, in order to provide flexibility in the procurement of smaller items, contracts for equipment, furniture, vehicles and materials (where the individual contracts are estimated to cost not more than the equivalent of US$20,000 each) may be procured on a basis of reasonably competitive procedures without resort to local competitive bidding as long as their aggregate will not cost more than the equivalent of US$200,000. It is estimated that about US$45,000 worth of these items will be procured in this manner.
5.14 Consultant services will be procured in accordance with Bank guidelines. Fellowships will be awarded after consultation with the Bank with respect to duration, purpose, place of study and the qualifications of the candidates.

C. Disbursement

5.15 The proposed loan would be disbursed for: (a) 100% of the foreign exchange costs of directly imported equipment, vehicles and materials (clinical, laboratory and audiovisual), 100% of the ex-factory cost of these items when locally manufactured and when awards are won under international competitive bidding and 70% of the cost of other such items when locally-procured; (b) 100% of the total cost of consultants' services, technical assistance, studies and fellowships; (c) 30% of the cost of civil works and furniture; and (d) 50% of the cost of innovative activities (the purpose and amount of the withdrawal requests should conform to the proposals on which the GOM obtained Bank’s approval prior to the use of funds). Disbursements by the Bank are expected to be completed by June 30, 1983. The estimated quarterly disbursement schedule is given in Annex 4, T-24.

D. Implementation

5.16 To avoid repetition of administrative and managerial difficulties encountered with the first project (paras. 3.04-3.05), a number of steps will be taken to ensure effective administration of the second project. The Project Secretariat within the NFPB will be strengthened and upgraded to a full Unit through the appointment of an Assistant Director, an Administrative Officer and a clerk. The project includes salaries for these staff for four years. The Assistant Director of the Unit will also be accountable to the Director General, NFPB, who will be the Project Administrator. The Unit will be responsible for the overall coordination of the project activities. Inter-agency policy coordination for the project will be carried out by the Project Implementation Committee (now renamed as the Project Steering Committee) formed under the first project and chaired by the Economic Planning Unit. Administrative support to this Committee will be provided by the Project Secretariat.

5.17 During negotiations assurances were obtained that by November 30, 1978, each of the participating agencies in the project (the NFPB, MOH, Ministry of Agriculture and the Public Works Department) will designate a project manager to coordinate and expedite the project work within the agency, including the acquisition of land and preparation of architects' briefs. The project manager at the MOH will be full-time. The work of these agencies will be coordinated and monitored by a Project Management Committee, a subcommittee of the Project Steering Committee, which will meet monthly and be chaired by the Assistant Director, Project Secretariat. The Project Steering Committee
will delegate authority to this sub-committee to assume responsibility for routine matters. Annex 4, C-8 shows the organizational structure of the project administration and implementation.

5.18 In order to ensure coordination and steady implementation of civil works, a project construction coordination unit (PCCU) will be set up at the Public Works Department headquarters in Kuala Lumpur. The project provides for salaries and allowances for the PCCU staff. Assurances were obtained during negotiations that the GOM will appoint within the PCCU an architect and two technicians with supporting staff not later than December 31, 1978. Pending these appointments, the assignment of one part-time architect and two part-time technicians with supporting staff to form the PCCU is a condition of loan effectiveness.

5.19 The PCCU will ensure that the responsible agencies take prompt steps to acquire building sites and provide space requirements. The PCCU will also maintain close contact with the Project Secretariat, to whom it will submit monthly progress reports on all project buildings. It will also arrange with the Public Works Department a program for the preparation of designs and contract documents for all buildings in the project so that these can be completed in accordance with the implementation schedule. Funds are provided to support the design of project buildings, either through the use of local architectural consultants for individual buildings or the employment of additional architects by the Public Works Department. Further, support will also be given to both central and state levels of the Public Works Department in the form of transportation for increased civil works supervision.

5.20 In addition to the staff provided for the PCCU at the Central Public Works Department, 10 technicians will be provided in the project to strengthen the Public Works Departments in the states of Johore, Pahang, Perak, Kelantan (combined with Trengganu) and the Federal Territory, which have large construction programs under the project. The allocation of funds by states is given in Annex 4, T-25. Project activities in each state will be coordinated by the State Development Officer; he will particularly assist in the acquisition of land.

5.21 Each ministry will be responsible for procurement of furniture, equipment, vehicles and materials, as well as for the appointment of personnel and initiating the award of fellowships. The NFPB as Project Coordinator will: (a) ensure that the Bank procurement guidelines and agreements are followed; (b) monitor the project implementation schedule of each agency; (c) ensure that changes in the project contents are not made without the Bank's approval; (d) consult the Bank on terms of reference for advisers, training programs for fellowships and qualifications of candidates; (e) submit consolidated quarterly progress reports to the Bank; and (f) consolidate the project accounts and have them audited.

5.22 During the first project, lack of clarity of financial procedures for processing withdrawal applications to the Bank contributed to long lags
between allocation of funds by the Central Public Works Department to the State Public Works Departments and disbursements. Under the proposed second project, these lags will be reduced through: (a) the submission of vouchers by the Public Works Department and all other implementing agencies directly to the Project Administrator at the NFPB, who will be authorized to sign the withdrawal applications on GOM’s behalf, and thus curtail the present five-step voucher countersigning procedures; and (b) routine collection of vouchers and monitoring of civil works by the proposed project management committee.

5.23 As under the first project, payment vouchers, instead of cancelled checks, will be accepted by the Bank as evidence of payment in case of civil works and furniture procured by individual states. Suppliers’ receipts will be furnished for vehicles, furniture, equipment and material procured centrally.

5.24 During negotiations, the GOM has agreed that the acquisition of all sites that will be needed during the first year of the project will be a condition of loan effectiveness. Assurances have been obtained during negotiations that the GOM will acquire all sites that will be needed during the second year of the project life by December 31, 1979 and the balance of the sites needed for the project by December 31, 1980.

5.25 The implementation schedule for civil works is given in Annex 1. At negotiations, the GOM agreed to ensure that the key actions with respect to the project are completed according to the timetable agreed on during negotiations and described in Annex 2 of this report.

E. Project Risks

5.26 In view of the experience with the first project, it would be unrealistic to assume that no difficulties are likely to arise with respect to the second. Some of these could arise if: (a) the Government does not take measures recommended in this report to prevent the recurrence of delays of the kind experienced in the first project; (b) the Government encounters increasing political sensitivity to family planning; (c) the administrative and managerial momentum generated by the present leadership of the NFPB and the Project Secretariat is not sustained; or (d) the personnel and organizational commitments of other agencies, such as the MOH and Ministry of Agriculture, are weakened. However, the increased interest of the Government’s Economic Planning Unit, demonstrated during the proposed project appraisal work, and NFPB’s recent intensification of managerial control over the first project, provide reasons to be optimistic about the success of the proposed project.

F. Project Evaluation

5.27 The project provides for a built-in evaluation system. Immediate progress of the project will be measured against the implementation schedule for each component agreed on by the GOM during negotiations. Intermediate progress of the project will be evaluated on the basis of quantitative indicators specified by the NFPB in consultation with other participating
agencies. A listing of these indicators is given in Annex 3 which will be further refined by the NFPB. Assurances have been obtained during negotiations that a plan of action for project evaluation will be prepared by the NFPB by March 31, 1979. This plan of action will: (a) define measurable objectives of each project component; (b) identify corresponding quantitative indicators; (c) ascertain the availability of baseline values of these indicators from existing data; and (d) determine the future data needs for measuring the progress so that these data are collected through service statistics or future surveys. The project includes 1.9 man-years of technical assistance for project evaluation activities.

VI. PROJECT JUSTIFICATION

6.01 The primary justification of the project lies in its contribution to the planned reduction of the birth rate from 30.3 per 1,000 in 1975 to 26 in 1985 by helping the national family planning program recruit about 800,000 new acceptors over this period. It is difficult to separate the probable contribution of the project from the program's contribution to the achievement of the demographic objective; although NFPB's share of the project budget will constitute about 50% of the NFPB's estimated total budgetary requirements during the next four years. However, possible program improvements resulting from project inputs are described below.

6.02 The establishment of a national and four regional family planning specialist centers will improve the quality of services, provide a wider range of contraceptive methods, with increasing emphasis on more effective and permanent techniques, and offer specialized treatment for complicated cases. Such improvements will inspire greater confidence and thus ensure greater retention of contraceptive use and attract a larger clientele. These centers will increase the potential for sterilizations from 4,000 to 14,000 a year and the number of women undergoing cancer detection tests from 16,000 to 90,000. About 10% of Government physicians, a large number of private physicians and 40% of the nurses in government service will be trained in the latest techniques of sterilization. The treatment of contra-indications associated with contraceptive use is expected to improve through relevant bio-medical research to be conducted at the center. By providing genetic and infertility counseling, both the substantive work and the image of the family planning program will be improved.

6.03 The establishment of additional service points in the fast growing, low-income housing areas in urban centers is expected to increase acceptance among the urban eligible couples from 40% in 1975 to about 60% by 1985.

6.04 The extension of integrated MCH/nutrition/FP services in the rural areas will reduce infant, toddler and maternal mortalities, which in themselves are desirable goals. Further, these reductions will strengthen the motives to plan family size and to take advantage of the easier access to contraceptives. The provision of transportation will widen access of services to the people through mobile teams and improve the quality of services through increased
supervision. The provision of 500 motor scooters for community nurses is expected to nearly double their mobility and facilitate access to hitherto neglected areas. The provision of equipment for immunization and nutrition services, besides strengthening MCH activities, will also help to attract young mothers to the clinics.

6.05 The quality of health and family planning services will improve through continuous in-service training of health staff through six training schools and accommodations for field trainees. Over 1,000 health staff, or about 20% of the total, will receive in-service training annually.

6.06 It is uncertain if the facilities provided in the rural areas will be adequate to increase contraceptive use among the eligible women from 25% in 1975 to 40% by 1985. The present level of health services leaves about half of the rural population to be served only by mobile clinics. Permanent health facilities for these areas will await completion of a survey of the underserved areas being conducted by the MOH to determine the services required in these areas and strategies to be adopted for extension of services. A more comprehensive coverage of underserved areas by health and family planning services should be an important part of a possible third project.

6.07 By integrating population, education and motivational efforts with health education, and family and community development activities, the project will reach the disadvantaged communities more effectively with family planning information and services. Simultaneously, it will improve the health status of the population and create employment for women. These efforts will create conducive conditions for acceptance of a smaller family norm. As the project will help in reaching progressively greater proportions of the population in disadvantaged communities and regions, it will complement Malaysia's development goal of equalizing economic opportunities. Finally, by reducing the overall rate of population growth Malaysia will achieve a better balance of population between those in the productive ages and their dependents, the number of persons entering the labor force after a 15-year time lag will decline, and a larger proportion of investment will be available for raising the standard of living.

VII. AGREEMENTS

7.01 During negotiations, agreements were reached with the GOM on the following points:

a. Establishment of an appropriate transportation maintenance system will be finalized by the MOH not later than August 31, 1979 (para. 4.32);

b. The MOH will: (a) evaluate the functions and training needs of the rural health staff prior to developing the training curricula; and (b) complete the curricula and training of trainers of
such staff at least three months before completion of construction of the schools (para. 4.39); 

c. An overall IEC plan will be submitted for Bank's comment not later than January 31, 1979 and the sub-plan for health education with appropriate emphasis on family health not later than April 30, 1979 (para. 4.45); 

d. The Health Education Unit of the MOH will be strengthened with the appointment of a head in an appropriate rank to ensure effective execution of the project, and not later than March 31, 1979, a competent and suitably qualified health professional will be appointed to head the AVPC with direct responsibility to the head of the Health Education Unit (para. 4.51); 

e. Not later than October 31, 1978, a suitably qualified and competent consultant will be employed by the MOH to prepare plans for health education and the AVPC in accordance with the terms of reference to be agreed between the GOM and the Bank (para. 4.52); 

f. The Ministry of Agriculture will prepare a detailed plan of action to be submitted for Bank comments not later than December 31, 1978 (para. 4.58); 

g. The NFPB will prepare a detailed plan of action for the project evaluation not later than March 31, 1979 (para. 5.27) and will form an evaluation subcommittee (para. 4.62) not later than December 31, 1978; 

h. The operational manual for project administration being finalized by the Project Secretariat will be accepted and adhered to by all participating agencies (para. 4.68); 

i. The NFPB, not later than January 31, 1979, will form a committee to work out details of various innovative schemes and will obtain the Bank's comments on details of such schemes prior to using funds earmarked for innovative activities (paras. 4.76 and 4.77); 

j. Not later than November 30, 1978, the MOH will designate a full-time project manager and the other participating agencies will designate in each such agency a project manager, to coordinate and expedite within such agency work included in the project, including the acquisition of land and the preparation of architects' briefs (para 5.17); 

k. Not later than December 31, 1978, the GOM shall appoint within the project construction coordination unit of the Public Works Department an architect and two technicians with supporting staff (para. 5.18);
1. The GOM will have completed the acquisition of sites required for physical facilities scheduled for design or construction during the second year of the project by December 31, 1979 and the balance by December 31, 1980 (para. 5.24); and

m. The GOM will ensure that the key actions included in the project are completed according to the timetable agreed on at negotiations and described in Annex 2 of this report (para. 5.25);

7.02 As conditions of loan effectiveness:

a. The GOM will complete the acquisition of all sites required for physical facilities scheduled for design or construction prior to the end of the first year of the project (para. 5.24);

b. The appointment of an adviser, for at least six months, to prepare a plan of action for the Family Planning Specialist Centers under the NFPB, and to determine physical space, furniture, equipment and manpower requirements of the centers (para. 4.14); and

c. The assignment of a part-time architect and two part-time technicians with supporting staff to form the project construction coordination unit under the Public Works Department until such staff are appointed on a full-time basis by December 31, 1978 (para. 5.18).

7.03 Subject to the above assurances, the project is suitable for a Bank loan of US$17 million equivalent on standard terms to the Government of Malaysia. The loan would be effective for a period of 17 years, including a grace period of four years.
## ANNEX 1

**MALAYSIA II**

**SUMMARY IMPLEMENTATION SCHEDULE FOR CIVIL WORKS**

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<td>National Family Planning Specialist Centers</td>
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<tr>
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<td>Urban Family Planning Clinics</td>
<td>NFPB</td>
<td>2,668,400</td>
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<td>Central Godown &amp; Printshop</td>
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<td>Project Implementation (Professional Fees)</td>
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<tr>
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<td>Integrated Rural Health and Family Planning Training Schools (Peninsular Malaysia)</td>
<td>MOH</td>
<td>971,300</td>
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<td>X</td>
<td>X</td>
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<td>73</td>
<td>Training Quarters at MCQs (including 34 conversions)</td>
<td>* MOH</td>
<td>895,400</td>
<td>X</td>
<td>X</td>
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<td>56</td>
<td>Quarters for Field Training at 32 Health Units (Sarawak)</td>
<td>* MOH</td>
<td>409,200</td>
<td>X</td>
<td>X</td>
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<td>Addition of MCH/FP Clinics to Existing dispensaries (Sarawak)</td>
<td>MOH</td>
<td>288,000</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>25</td>
<td>Staff Quarters at 12 Existing Training Centers (Sarawak)</td>
<td>* MOH</td>
<td>253,000</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>8</td>
<td>Health Offices with MCH/FP Service Units</td>
<td>* MOH</td>
<td>1,397,000</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Audiovisual Material Production Center</td>
<td>MOH</td>
<td>572,000</td>
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<td>2</td>
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<td>MOA</td>
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<td>12</td>
<td>Community Service Centers</td>
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<td>1</td>
<td>Women's Handicraft Sales Center Purchase of Shophouse</td>
<td>MOA</td>
<td>206,800</td>
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* Existing type design drawings available
### SUMMARY IMPLEMENTATION SCHEDULE FOR KEY PROJECT ACTIVITIES

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<tr>
<th>Action to be completed</th>
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<th>Agency responsible</th>
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<tbody>
<tr>
<td><strong>Civil Works</strong></td>
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<tr>
<td>2. The staffing of the Project Construction Coordinating Unit by the appointment of additional staff to the Public Works Department.</td>
<td>Dec. 31, 1978</td>
<td>PWD/NFPB</td>
</tr>
<tr>
<td>3. The strengthening of the Project Secretariat by the appointment of additional staff at the NFPB.</td>
<td>Jan. 31, 1979</td>
<td>NFPB</td>
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<tr>
<td>4. The acquisition of sites for physical facilities scheduled for design or construction during the second year of project life.</td>
<td>Dec. 31, 1979</td>
<td>NFPB/MOH/ MOA</td>
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<tr>
<td>5. The appointment of additional technical staff at the defined State Public Works Departments.</td>
<td>June 30, 1979</td>
<td>PWD/NFPB</td>
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<tr>
<td>6. The acquisition of sites for the balance of the physical facilities.</td>
<td>Dec. 31, 1980</td>
<td>NFPB/MOH/ MOA</td>
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<tr>
<td><strong>Training</strong></td>
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<tr>
<td>7. Evaluation of the functions and in-service training needs of the paramedical staff.</td>
<td>Dec. 1979</td>
<td>MOH</td>
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<tr>
<td>8. Training of trainers for the Sabah in-service training center.</td>
<td>Mar. 1980</td>
<td>Dept. of Medical and Health Services, Sabah</td>
</tr>
<tr>
<td>a) First group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Second group</td>
<td>March 1981</td>
<td></td>
</tr>
<tr>
<td>Action to be completed</td>
<td>Date of completion</td>
<td>Agency responsible</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td><strong>Family Planning Specialist Centers</strong></td>
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<td></td>
</tr>
<tr>
<td>9. Appointment of an adviser to prepare a plan of action for NFPSC.</td>
<td>Sept. 1978</td>
<td>NFPB</td>
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<tr>
<td>10. Initiation of selected activities of NFPSC at existing facilities.</td>
<td>April 1979</td>
<td>NFPB</td>
</tr>
<tr>
<td>11. Initiation of selected activities of regional family planning specialist centers at existing facilities: a) Ipoh and Penang</td>
<td>Jan. 1980</td>
<td>NFPB</td>
</tr>
<tr>
<td>b) Kota Bahru and Johor Bahru</td>
<td>Jan. 1981</td>
<td>NFPB</td>
</tr>
<tr>
<td><strong>Urban Family Planning Services</strong></td>
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<tr>
<td><strong>MCH/FP Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Arrangement for the improvement of maintenance and repair of vehicles provided under the first and second projects.</td>
<td>Dec. 1979</td>
<td>MOH</td>
</tr>
<tr>
<td><strong>Audiovisual Materials Production (MOH)</strong></td>
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<tr>
<td>15. Appointment of the head of the AVPC.</td>
<td>March 31, 1979</td>
<td>MOH</td>
</tr>
<tr>
<td>17. Finalization of space, equipment and manpower and training requirement of the AVPC.</td>
<td>Dec. 1978</td>
<td>MOH</td>
</tr>
</tbody>
</table>
### SUMMARY IMPLEMENTATION SCHEDULE FOR KEY PROJECT ACTIVITIES (cont.)

<table>
<thead>
<tr>
<th>Action to be completed</th>
<th>Date of completion</th>
<th>Agency responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Development of the production plan.</td>
<td>June 1979</td>
<td>MOH</td>
</tr>
<tr>
<td>Information, Education and Communication (NFPB)</td>
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<tr>
<td>19. Preparation of the master plan for IEC activities.</td>
<td>Dec. 1978</td>
<td>NFPB</td>
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<tr>
<td>Family Development Training Centers and the Community Service Centers</td>
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<td></td>
</tr>
<tr>
<td>20. Development of action plans for the FDTCs and the CSCs.</td>
<td>Dec. 1978</td>
<td>MOA</td>
</tr>
<tr>
<td>21. Hiring of the Project Manager for the Women's Handicraft Sales Organization.</td>
<td>June 1979</td>
<td>MOA</td>
</tr>
<tr>
<td>Research, Evaluation and Management Information</td>
<td></td>
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<tr>
<td>23. Standardization of the formats, collection procedures and processing of the family planning service statistics.</td>
<td>Mar. 1979</td>
<td>NFPB/MOH/MA</td>
</tr>
<tr>
<td>24. Development of the design for project evaluation and measures of quantitative indicators.</td>
<td>Mar. 1979</td>
<td>NFPB</td>
</tr>
</tbody>
</table>

### Additional Abbreviations
- MOA - Ministry of Agriculture.
- NFPSC - National Family Planning Service Center
- PWD - Public Works Department
## ANNEX 3

### MALAYSIA II

**SAMPLE OUTLINE OF QUANTITATIVE MEASURES FOR PROJECT EVALUATION**

<table>
<thead>
<tr>
<th>Project Components</th>
<th>Objectives</th>
<th>Quantitative Indicators</th>
<th>Status and Sources of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Planning Specialist Centers</td>
<td>(1) Improve quality of services; (2) reduce dropout and thus increase continuation rates; (3) promote contraceptive method mix; (4) train doctors in alternative methods; (5) broaden base of acceptance; (6) conduct clinical research; (7) provide specialized infertility services and genetic counseling.</td>
<td>(1) Prevalence of contraceptive side effects; (2) number of acceptors continuing; (3) number receiving alternative methods; (4) number of doctors trained in laproscopy, MR and sterilization; (5) number seeking infertility and genetic counseling; and, (6) number seeking MR.</td>
<td>(1) 1969 defaulter study; (2) MFFS of 1974-75; (3) clinic record cards; (4) hospital records; and, (5) FFPA surveys of 1974 on abortees and sterilized.</td>
</tr>
<tr>
<td>2. Urban Family Planning Clinics</td>
<td>(1) Increase accessibility of FP services to underserved squatters and low income housing areas; (2) increase level of program acceptance among the disadvantaged population; and, (3) provide intensive education and follow-up services.</td>
<td>(1) Per clinic areal coverage; (2) percentage living in low-income housing and squatters' areas; (3) ratio of service units to eligible women in urban areas; (4) number of revisits and new acceptors per FP service units in urban areas; (5) proportion of acceptors and dropouts receiving services from program and non-program sources; and, (6) clinic dropout rates.</td>
<td>(1) NFPB and FFPA service statistics; (2) 1976-77 Family and Health Survey in the Federal Territory; and, (3) MFFS (1974-75).</td>
</tr>
</tbody>
</table>
### SAMPLE OUTLINE OF QUANTITATIVE MEASURES
#### FOR PROJECT EVALUATION (cont.)

<table>
<thead>
<tr>
<th>Project Components</th>
<th>Objectives</th>
<th>Quantitative Indicators</th>
<th>Status and Sources of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Extension of IIDA Program</strong> (Provision of additional vehicles and equipment)</td>
<td>(1) Increase new acceptance; (2) improve post-acceptance follow up and thus continuation of acceptance; (3) ensure appropriate clinic management, replenishing of supplies and client education; (4) increase of delivery attendance by trained staff; and, (5) increase pre- and postnatal care, child vaccination and child growth.</td>
<td>(1) Number of new acceptors; (2) number of revisits and follow up of clients; (3) clinic-wise dropout rate; (4) ratio of staff time to acceptors; (5) number of educational/motivational sessions conducted; (6) areal and population coverage of field visit per unit of transport; (7) number of deliveries attended; (8) number of women receiving pre- and postnatal care; (9) trends of children vaccinated; and, (10) trends in child growth.</td>
<td>(1) Acceptor survey of 1977; (2) clinic records; (3) routine service statistics; (4) IIDA pre- and post surveys; and, (5) vital statistics.</td>
</tr>
<tr>
<td><strong>4. Development of Innovative Scheme, e.g., Incentive Scheme</strong></td>
<td>(1) Promote widespread participation of physicians in providing family planning services; and, (2) extend post-acceptance follow up and treatment of side effects.</td>
<td>(1) Number of non-NFPB physicians providing FP services; (2) proportion of acceptors receiving FP services from non-NFPB physicians; and (3) contraceptive mix and retention rates among non-program acceptors.</td>
<td>(1) Family and Health Survey in the Federal Territory; (2) MFFS survey 1974-75; and, (3) acceptor survey 1977.</td>
</tr>
<tr>
<td><strong>5. Training Centers for Integrated Health and Family Planning</strong></td>
<td>(1) Increase supply of trained health staff for integrated MCH/nutrition and FP services in rural health facilities; and, (2) provide periodic refresher training to auxiliary health staff.</td>
<td>(1) Number of auxiliary staff trained; (2) number of rural health facilities with and without trained staff for FP services; (3) number of rural health units providing FP/MCH and nutrition services; and, (4) ratio of contraceptive acceptors to number of trained staff in MCH/FP clinics compared to that of the NFPB clinics.</td>
<td>(1) IIDA evaluation study 1975-76; (2) MOH service statistics; and, (3) follow-up training evaluation.</td>
</tr>
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</table>
MALAYSIA II

SAMPLE OUTLINE OF QUANTITATIVE MEASURES FOR PROJECT EVALUATION (cont.)

<table>
<thead>
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<th>Project Components</th>
<th>Objectives</th>
<th>Quantitative Indicators</th>
<th>Status and Sources of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Family Development Training Centers</td>
<td>(1) Expand family life education networks; educate young women in better management of home and alternative non-familial activities for planned family and responsible parenthood.</td>
<td>(1) Number of women trained; (2) trainees' level of knowledge and attitude towards non-familial role and responsible parenthood; (3) trainees potential contacts in the community; and, (4) pre- and post-training mobility of the trainees and their participation in non-familial activities.</td>
<td>(1) Pre- and post-training survey of the trainees; (2) trainees' profile in school registers; (3) service statistics from the community service centers; and, (4) handicraft marketing study.</td>
</tr>
<tr>
<td>7. NFPB's IEC and MOH's Health Education Activities</td>
<td>(1) Inform policy workers and opinion leaders; (2) educate youth and newly married; (3) motivate new acceptors; and, (4) reassure old acceptors; and, (5) create strong support and demand for FP services.</td>
<td>(1) Proportion of various target groups reached; (2) proportion of areal coverage; (3) number and types of AV materials produced and distributed; (4) information volume of printing; (5) number of campaigns completed and evaluated; (6) changes in knowledge and attitude among the target groups; and, (7) proportion of clients referred to IEC personnel for services.</td>
<td>(1) Service statistics; (2) pre- and post-campaign survey; and, (3) special studies.</td>
</tr>
<tr>
<td>8. Evaluation, Research and Management Information System</td>
<td>(1) Provide management information thru service statistics; (2) provide operational knowledge about program effectiveness and efficiency; and, (3) promote understanding of population and development linkage.</td>
<td>(1) Volume and frequency of service statistics collected and processed; (2) number of operational studies conducted and findings reported; (3) proportion of findings used in operational decisions; (4) number of basic research conducted, contracted or collaborated with; and, (5) proportion of findings.</td>
<td>(1) Routine monthly, quarterly and annual reports; (2) surveys and evaluative studies; (3) analysis of secondary data; and, (4) basic research contracts.</td>
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MALAYSIA II

SAMPLE OUTLINE OF QUANTITATIVE MEASURES FOR PROJECT EVALUATION (cont.)

<table>
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<th>Project Components</th>
<th>Objectives</th>
<th>Quantitative Indicators (cont.)</th>
<th>Status and Sources of Measures</th>
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<tr>
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<td>used in national policy</td>
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<tr>
<td></td>
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<td>development and other sectoral activities.</td>
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Additional Abbreviations:

AV - Audiovisual
MFFS - Malaysian Family and Fertility Survey
MR - Menstrual Regulation
## MALAYSIA II

### SOCIO-ECONOMIC VARIABLES, VITAL RATES AND FAMILY PLANNING ACCEPTANCE BY STATES

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<th>Total Population (mil.)</th>
<th>% Rural</th>
<th>Per Capita Income</th>
<th>Age Dependency Ratio</th>
<th>Population Growth Rate</th>
<th>Crude Birth Rate</th>
<th>Crude Death Rate</th>
<th>Rate of Natural Increase</th>
<th>Natural Mortality</th>
<th>Infant Mortality</th>
<th>Toddler Mortality</th>
<th>Total Contraceptor Use as % of Eligible Women</th>
<th>% Population Male</th>
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<td>Johore</td>
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<td>79</td>
<td>73.7</td>
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<td>0.82</td>
<td>37.39</td>
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<td>2.3</td>
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/1 The number of deaths per 1,000 children between the ages of 1-5 years.
/2 The difference in the total population size is due to rounding.

Sources:
(1) NFPB.
(2) 1970 Census.
(3) Vital Statistics, Department of Statistics, GOM.
MALAYSIA II

AGE-SPECIFIC FERTILITY BY ETHNIC GROUPS IN PENINSULAR MALAYSIA
(1970 and 1975)

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Additional Abbreviations:
GFR - General Fertility Rate
TFR - Total Fertility Rate

MALAYSIA II

URBAN AND RURAL AGE-SPECIFIC FERTILITY RATES
BY AGE GROUPS OF WOMEN IN PENINSULAR MALAYSIA
(1970 and 1975)

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Additional Abbreviations:

GFR - General Fertility Rate
TFR - Total Fertility Rate

Sources:
(2) Population in 1970 from Age Distribution, Department of Statistics.
(3) Population by strata in 1975 is obtained by applying urban/rural ratio in 1970 to 1975 projected population.
## Annex 4

### Malaysia II


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<th>Year/1</th>
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<th>Birth Rate</th>
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<th>Rate of Natural Increase</th>
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<td>2.5 3.1 2.5 2.5</td>
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### Additional Abbreviations:

Sab. - Sabah
t.m. - Total Malaysia
Sar. - Sarawak
P.M. - Peninsular Malaysia

### Sources:

1. Revised Inter-Censal Population Estimate, Department of Statistics (1960-70) in the case of Sabah and Sarawak.

/1 All population figures are mid-year (June).
ANNEX 4
T-5

MALAYSIA II

TRENDS IN THE DECLINE OF AGE-SPECIFIC AND TOTAL FERTILITY RATES,
FOR SELECTED YEARS IN PENINSULAR MALAYSIA
(1960-75)

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<td>1967</td>
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<td>1970</td>
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<td>1973</td>
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<td>1975</td>
<td>4,145</td>
<td>46</td>
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% Decline
1960-67 14.4 43.2 16.9 10.5 14.0 7.8 20.0
1967-74 17.0 35.2 15.2 15.9 7.7 19.3 30.9
1973-75 6.3 0.0 5.3 2.1 11.5 8.9 2.2

INFANT MORTALITY RATE BY ETHNIC GROUPS IN PENINSULAR MALAYSIA

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<th>Indians</th>
<th>Other</th>
<th>Total</th>
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% Change

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Source: Department of Statistics, Government of Malaysia.
### A. Assuming NRR = 1 by 1990 with the Project

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<th>Female</th>
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<th>Crude Death Rate</th>
<th>Natural Increase</th>
<th>Total Fertility Rate</th>
<th>Women in Reproductive Age (15-49)</th>
<th>Working Age Population (15-64)</th>
<th>Percent Population below Age 15</th>
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### B. Assuming NRR = 1 by 2000 without the Project

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<th>Female</th>
<th>Crude Birth Rate</th>
<th>Crude Death Rate</th>
<th>Natural Increase</th>
<th>Total Fertility Rate</th>
<th>Women in Reproductive Age (15-49)</th>
<th>Working Age Population (15-64)</th>
<th>Percent Population below Age 15</th>
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### MALAYSIA II
### POPULATION PROJECTIONS (cont.)
### SARAWAK (1980-2049)

#### A. Assuming NRR = 1 by 1990 with the Project

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<th>Female (Thousands)</th>
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#### B. Assuming NRR = 1 by 2000 without the Project

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<th>Male (Thousands)</th>
<th>Female (Thousands)</th>
<th>Crude Birth Rate</th>
<th>Crude Death Rate</th>
<th>Natural Increase</th>
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#### Note:
- Bank estimate.

#### Assumptions:
1. No net migration.
2. 1975 mortality rate is held constant, West Model life table is used for this purpose.
3. Expectation of life at birth is assumed to be 63.5 for males and 68.2 for females by 1990.
4. Fertility decline is assumed to be linear throughout.
5. For series "A", fertility is reduced to reach NRR = 1 by 1990; for series "B", fertility is reduced to reach NRR = 1 by 2000.
6. "Future" projection model of U.S. Bureau of Census has been used.
**Malaysia II**

**Socio-Demographic Setting and Comparative Performance of Family Planning Programs in ASEAN Countries (1975)**

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<th>Singapore</th>
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<td>Median Parity of Acceptors</td>
<td>3.1</td>
<td>3.8</td>
<td>3.8</td>
<td>1.6</td>
<td>3.6</td>
</tr>
<tr>
<td>FP Expenditure Percent (US$)</td>
<td>28.5</td>
<td>15.9</td>
<td>58</td>
<td>42</td>
<td>8.8/4</td>
</tr>
<tr>
<td>FP Budget as Percent of Total National Budget (1976)</td>
<td>0.11</td>
<td>0.02</td>
<td>0.04</td>
<td>0.1</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Additional Abbreviations:

GDP - Gross Domestic Product
MWRA - Married Women in Reproductive Ages

/1 Philippines, Malaysia and Singapore rates are 1975 estimates.
/2 Source: World Bank Social Indicators Data Sheets.
/3 Rates are for 1970 excepting Singapore's 1975 estimate.
/4 1975 figure.
# Annex 4

## Malaysia II

### Achievement of Targets of New Acceptors and Birth Rate by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Acceptors (1)</th>
<th>Birth Rate (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Achievement</td>
</tr>
<tr>
<td>1966-70</td>
<td>343,350</td>
<td>273,720 (80%)</td>
</tr>
<tr>
<td>1971</td>
<td>80,000</td>
<td>54,769 (68.5)</td>
</tr>
<tr>
<td>1972</td>
<td>100,000</td>
<td>56,417 (56.4)</td>
</tr>
<tr>
<td>1973</td>
<td>120,000</td>
<td>57,313 (47.8)</td>
</tr>
<tr>
<td>1974</td>
<td>140,000</td>
<td>61,680 (44.1)</td>
</tr>
<tr>
<td>1975</td>
<td>80,000</td>
<td>69,348 (86.7)</td>
</tr>
<tr>
<td>1976</td>
<td>90,000</td>
<td>75,240 (83.6)</td>
</tr>
<tr>
<td>1977</td>
<td>90,000</td>
<td>80,500 (89.0)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,043,350</td>
<td>728,987 (69.9)</td>
</tr>
</tbody>
</table>

**Sources:**

1. National Family Planning Board.
2. Vital Statistics, Department of Statistics, GOM.

*Total includes performance of 1966.*
### NEW ACCEPTORS BY YEAR AND AGENCIES

(1967-77)

<table>
<thead>
<tr>
<th>Year</th>
<th>NPPB</th>
<th>Integration (MOH)</th>
<th>FFPA</th>
<th>Estate</th>
<th>FELDA</th>
<th>Bidan Kompong</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>8,747</td>
<td>10,132</td>
<td>1,795</td>
<td>-</td>
<td>-</td>
<td>552</td>
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<td>20,726</td>
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<tr>
<td>1968</td>
<td>43,058</td>
<td>25,158</td>
<td>2,530</td>
<td>-</td>
<td>-</td>
<td>4,189</td>
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<tr>
<td>1969</td>
<td>48,140</td>
<td>16,695</td>
<td>2,144</td>
<td>-</td>
<td>-</td>
<td>3,596</td>
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<td>70,575</td>
</tr>
<tr>
<td>1970</td>
<td>39,441</td>
<td>13,995</td>
<td>830</td>
<td>147</td>
<td>-</td>
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<td>55,981</td>
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<tr>
<td>1971</td>
<td>36,157</td>
<td>2,963</td>
<td>13,212</td>
<td>642</td>
<td>1,094</td>
<td>701</td>
<td></td>
<td>54,769</td>
</tr>
<tr>
<td>1972</td>
<td>35,015</td>
<td>4,903</td>
<td>12,954</td>
<td>390</td>
<td>1,347</td>
<td>1,001</td>
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<td>56,417</td>
</tr>
<tr>
<td>1973</td>
<td>35,511</td>
<td>4,619</td>
<td>12,007</td>
<td>909</td>
<td>1,585</td>
<td>738</td>
<td>1,944</td>
<td>57,313</td>
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<tr>
<td>1974</td>
<td>36,628</td>
<td>7,422</td>
<td>12,379</td>
<td>413</td>
<td>2,103</td>
<td>2,367</td>
<td>368</td>
<td>61,680</td>
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<tr>
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<td>37,673</td>
<td>14,809</td>
<td>11,389</td>
<td>247</td>
<td>1,720</td>
<td>2,805</td>
<td>255</td>
<td>69,348</td>
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<td>1976</td>
<td>36,050</td>
<td>22,894</td>
<td>11,515</td>
<td>112</td>
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<td>2,871</td>
<td>132</td>
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<td>TOTAL</td>
<td>355,920</td>
<td>57,610</td>
<td>139,886</td>
<td>10,012</td>
<td>9,632</td>
<td>10,988</td>
<td>12,906</td>
<td>596,954</td>
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<tr>
<td>%</td>
<td>59.6</td>
<td>9.7</td>
<td>23.4</td>
<td>1.7</td>
<td>1.6</td>
<td>1.8</td>
<td>2.2</td>
<td>1.00</td>
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<td>1977</td>
<td>44,639</td>
<td>35,861</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>80,500</td>
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<td>TOTAL</td>
<td>400,559</td>
<td>93,471</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>677,454</td>
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</tbody>
</table>

**Source:** National Family Planning Board.
MALAYSIA II

PERCENTAGE OF FAMILY PLANNING ACCEPTORS
BY SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS
(1967-76)

<table>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptor age &lt; 30</td>
<td>57.0</td>
<td>61.7</td>
<td>64.0</td>
<td>66.4</td>
<td>68.9</td>
<td>71.3</td>
<td>72.1</td>
</tr>
<tr>
<td>Acceptors age 30+</td>
<td>43.0</td>
<td>38.3</td>
<td>36.0</td>
<td>33.6</td>
<td>31.1</td>
<td>28.7</td>
<td>27.9</td>
</tr>
<tr>
<td>Acceptor parity (0-2)</td>
<td>30.0</td>
<td>37.7</td>
<td>40.7</td>
<td>43.9</td>
<td>47.5</td>
<td>50.5</td>
<td>53.5</td>
</tr>
<tr>
<td>Acceptor parity (3-4)</td>
<td>27.4</td>
<td>26.8</td>
<td>26.7</td>
<td>26.1</td>
<td>25.6</td>
<td>24.8</td>
<td>24.2</td>
</tr>
<tr>
<td>Acceptor parity (5+)</td>
<td>42.6</td>
<td>35.5</td>
<td>32.6</td>
<td>30.0</td>
<td>26.9</td>
<td>24.7</td>
<td>22.3</td>
</tr>
<tr>
<td>Acceptor's education (O - Primary)</td>
<td>58.9</td>
<td>75.9</td>
<td>74.8</td>
<td>73.9</td>
<td>74.2</td>
<td>73.8</td>
<td>73.6</td>
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<tr>
<td>Acceptor's education (secondary and higher)</td>
<td>41.1</td>
<td>24.1</td>
<td>25.2</td>
<td>26.1</td>
<td>25.8</td>
<td>26.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Acceptor's monthly income (1-299)/l</td>
<td>45.7</td>
<td>59.1</td>
<td>60.6</td>
<td>60.0</td>
<td>59.1</td>
<td>60.8</td>
<td>62.3</td>
</tr>
<tr>
<td>Acceptor's monthly income (300-699)/l</td>
<td>5.17</td>
<td>7.4</td>
<td>8.2</td>
<td>9.6</td>
<td>12.7</td>
<td>13.9</td>
<td>16.0</td>
</tr>
<tr>
<td>Acceptor's monthly income (700+)/l</td>
<td>0.63</td>
<td>1.3</td>
<td>1.4</td>
<td>1.5</td>
<td>1.8</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Acceptors wanting additional children</td>
<td>43.7</td>
<td>53.5</td>
<td>56.5</td>
<td>58.9</td>
<td>62.7</td>
<td>65.9</td>
<td>68.2</td>
</tr>
<tr>
<td>Acceptors with prior use of FP</td>
<td>26.6</td>
<td>23.8</td>
<td>35.8</td>
<td>36.2</td>
<td>38.1</td>
<td>39.6</td>
<td>40.5</td>
</tr>
<tr>
<td>Acceptors who never used FP before</td>
<td>72.9</td>
<td>76.2</td>
<td>64.2</td>
<td>63.8</td>
<td>61.9</td>
<td>60.4</td>
<td>59.5</td>
</tr>
</tbody>
</table>

\[1\] Acceptor's monthly income refers to husband's income—in Malaysian dollars.

Source: Annual Report (1976), National Family Planning Board.
MALAYSIA II

NEW ACCEPTORS BY ETHNIC GROUPS IN PENINSULAR MALAYSIA

<table>
<thead>
<tr>
<th>Year</th>
<th>Malay</th>
<th>Chinese</th>
<th>Indians</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January-December 1970</td>
<td>26,862</td>
<td>22,921</td>
<td>5,606</td>
<td>566</td>
<td>55,955</td>
</tr>
<tr>
<td>(Percentage)</td>
<td>48.0</td>
<td>41.0</td>
<td>10.0</td>
<td>1.0</td>
<td>100.0</td>
</tr>
<tr>
<td>January-December 1975</td>
<td>42,179</td>
<td>20,724</td>
<td>6,055</td>
<td>390</td>
<td>69,348</td>
</tr>
<tr>
<td>(Percentage)</td>
<td>60.8</td>
<td>29.9</td>
<td>8.7</td>
<td>0.6</td>
<td>100.0</td>
</tr>
<tr>
<td>January-December 1976</td>
<td>43,990</td>
<td>23,424</td>
<td>7,092</td>
<td>704</td>
<td>75,210</td>
</tr>
<tr>
<td>(Percentage)</td>
<td>58.5</td>
<td>31.1</td>
<td>9.4</td>
<td>0.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: National Family Planning Board.
MALAYSIA II

CHANGES IN KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) OF FAMILY PLANNING (currently married women in Peninsular Malaysia) (1966-67, 1970, 1974-75)

<table>
<thead>
<tr>
<th>Percentage of Currently Married Women</th>
<th>WMFS (1) 1966-67</th>
<th>PES (2) 1970</th>
<th>MFFS (3) 1974-75 (Estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved family planning</td>
<td>70</td>
<td>78</td>
<td>-</td>
</tr>
<tr>
<td>With knowledge of family planning</td>
<td>44</td>
<td>85</td>
<td>92</td>
</tr>
<tr>
<td>Ever used contraception</td>
<td>14</td>
<td>27</td>
<td>45</td>
</tr>
<tr>
<td>Currently using contraception</td>
<td>8</td>
<td>16</td>
<td>35</td>
</tr>
</tbody>
</table>

Sources: (1) WMFS - West Malaysia Family Survey.  
(2) PES - Post Enumeration Survey.  
(3) MFFS - Malaysian Family and Fertility Survey.
MALAYSIA II

DEMOGRAPHIC ACHIEVEMENTS OF THE NATIONAL FAMILY PLANNING PROGRAM (1970-1975)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expected Births/1</td>
<td>339,916</td>
<td>354,067</td>
<td>369,126</td>
<td>385,248</td>
<td>402,099</td>
<td>419,703</td>
</tr>
<tr>
<td>Actual Births</td>
<td>297,358</td>
<td>309,378</td>
<td>308,347</td>
<td>302,867</td>
<td>312,740</td>
<td>313,741</td>
</tr>
<tr>
<td>Total Births Averted</td>
<td>41,108</td>
<td>44,689</td>
<td>60,779</td>
<td>82,381</td>
<td>89,359</td>
<td>105,962</td>
</tr>
<tr>
<td>Births Averted by Program/2</td>
<td>37,327</td>
<td>40,616</td>
<td>42,957</td>
<td>44,918</td>
<td>46,985</td>
<td>50,025</td>
</tr>
<tr>
<td>Births Averted by Program(%)</td>
<td>87.7</td>
<td>90.9</td>
<td>70.7</td>
<td>54.5</td>
<td>52.6</td>
<td>47.2</td>
</tr>
<tr>
<td>Contraceptive Prevalence in a Year /3</td>
<td>93,317</td>
<td>101,539</td>
<td>107,393</td>
<td>112,295</td>
<td>117,746</td>
<td>125,063</td>
</tr>
</tbody>
</table>

Source: National Family Planning Board.

/1 Assuming 1966 age-specific fertility rate holds constant from 1970-1975.
/2 (Prevalence in year) x (acceptor's fertility rate at acceptance) = births averted by program.
/3 Contraceptive prevalence rate has been estimated on the basis of continuation rate obtained in 1969 acceptor survey. This rate is based on an initial loss of 10% of users, followed by a monthly reduction of 2% of those remaining at the beginning of each month. This gives a 12 month continuation rate of 76.6%.
/4 Actual births figures need further checking as these appear to be under-reported.
### TARGETS OF NEW ACCEPTORS, CONTINUING USERS AND PERCENTAGE OF MARRIED WOMEN IN REPRODUCTIVE AGES BY PROGRAM AND NON-PROGRAM SOURCES IN PENINSULAR MALAYSIA (1978-1985)

<table>
<thead>
<tr>
<th>Year</th>
<th>Program New Acceptors</th>
<th>Program Continuing Users</th>
<th>Non-Program New Acceptors</th>
<th>Non-Program Continuing Users</th>
<th>Total New Acceptors</th>
<th>Total Continuing Users</th>
<th>Percentage of Coverage of Married Women of Reproductive Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90,000</td>
<td>60,000</td>
<td>150,000</td>
<td>60,000</td>
<td>1978</td>
<td>90,000</td>
<td>92,700</td>
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<td>60.0</td>
<td>60.0</td>
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<td>92,700</td>
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<td>62.4</td>
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<td>62.4</td>
<td>62.4</td>
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<td>95,400</td>
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<td>64.3</td>
<td>64.3</td>
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<td>103,500</td>
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<tr>
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<td>66.4</td>
<td>66.4</td>
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<td>103,500</td>
<td>106,200</td>
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<tr>
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<td>68.6</td>
<td>68.6</td>
<td>68.6</td>
<td>1983</td>
<td>106,200</td>
<td>108,900</td>
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<td>70.7</td>
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<td>70.7</td>
<td>70.7</td>
<td>1984</td>
<td>108,900</td>
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<td>106,200</td>
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</tr>
<tr>
<td></td>
<td>150,000</td>
<td>148,560</td>
<td>148,370</td>
<td>147,740</td>
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<td>37.6</td>
<td>35.7</td>
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<tr>
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<td>31.4</td>
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<tr>
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<td>33.6</td>
<td>31.4</td>
<td>29.3</td>
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</tr>
<tr>
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<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

/1 Acceptor—male/female in the reproductive age receiving any method of contraception with the intention of use.
/2 Continuing User—acceptor of any contraception continuing on contraception.
MALAYSIA II

UPDATED SCHEDULE OF DISBURSEMENTS UNDER THE FIRST PROJECT (FY1978-80) (US$000)

<table>
<thead>
<tr>
<th>IBRD Fiscal Year and Quarter</th>
<th>Amount in Quarter</th>
<th>Cumulative</th>
<th>Percent Disbursed</th>
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<tr>
<td>FY 1978</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 31, 1978</td>
<td>141.2</td>
<td>1,078.5</td>
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</tr>
<tr>
<td>June 30, 1978</td>
<td>500.0</td>
<td>1,578.5</td>
<td>31.6</td>
</tr>
<tr>
<td>FY 1979</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>September 30, 1978</td>
<td>600.0</td>
<td>2,178.5</td>
<td>43.6</td>
</tr>
<tr>
<td>December 31, 1978</td>
<td>700.0</td>
<td>2,878.5</td>
<td>57.6</td>
</tr>
<tr>
<td>March 31, 1979</td>
<td>800.0</td>
<td>3,678.5</td>
<td>73.6</td>
</tr>
<tr>
<td>June 30, 1979</td>
<td>700.0</td>
<td>4,378.5</td>
<td>87.6</td>
</tr>
<tr>
<td>FY 1980</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>September 30, 1979</td>
<td>500.0</td>
<td>4,878.5</td>
<td>97.6</td>
</tr>
<tr>
<td>December 31, 1979</td>
<td>121.5</td>
<td>5,000.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
MALAYSIA II

REVISED COST ESTIMATE AND EXPENDITURE UNDER THE FIRST PROJECT (US$)

<table>
<thead>
<tr>
<th>Component</th>
<th>Appraisal Report Estimate</th>
<th>Revised Estimate February 1978</th>
<th>Expenditure</th>
<th>Disbursement IBRD Loan</th>
<th>Percent to be Disbursed</th>
</tr>
</thead>
</table>

I. Civil Works

| 1. State Administrative Blocks | 762,963 | 600,000 | 300,000 | - | 30 |
| 2. Urban Clinics | 301,451 | 877,300 | 59,000 | - | 30 |
| 3. Rural Clinics | 2,075,000 | 2,673,000 | 1,526,000 | - | 30 |
| 4. MCQs | 1,259,027 | 3,650,000 | 1,750,000 | - | 30 |
| 5. Training Centers | 342,000 | 1,062,500 | - | - | - |

Total Construction 4,740,441 8,922,800 3,635,000* 469,443

| 6. Furniture and Equipment | 928,850 | 1,625,000 | - | - | 68 |
| 7. Professional Fees | 249,955 | - | - | - | 30 |

Total Civil Works 5,919,246 10,547,800 3,635,000* 469,443

II. Non-Civil Works

| 1. Management Studies | 90,000 | 21,223 | 21,223 | 21,223 | 100 |
| 2. Senior Research Adviser | 135,000 | 69,541 | 39,477 | 34,166 | 100 |
| 3. Junior Research Adviser | 50,000 | 33,936 | - | - | 100 |
| 4. Vehicles | 298,000 | 248,000 | 203,200 | 100,743 | 100 |
| 5. Computer & Auxiliary Equipment | 80,000 | 207,000 | 51,541 | 5,816 | 100 |
| 6. Baseline Survey | 50,000 | 50,000 | 64,754 | - | 0 |
| 7. External Review | 25,000 | 25,000 | 23,341 | - | 0 |
| 8. IEC Equipment | 222,000 | 222,000 | 101,396 | 50,000 | 100 |
| 9. Training Activities | 222,000 | 222,000 | 162,000 | - | 0 |
| 10. Project Construction Unit | 105,000 | - | - | - | 0 |
| 11. Staff Evaluation Division, NFPB | 40,000 | 40,000 | 40,000 | - | 0 |

Total Non-Civil Works 1,317,000 1,138,700 706,932** 211,948

Unallocated 1,902,948
Interest & Commitment 1,995,600 1,075,000 255,897*** 255,897

TOTAL PROJECT COST 10,234,794 12,761,500 4,597,829 937,288

* as of December 31, 1977
** as of September 30, 1977
*** as of February 28, 1978
### MALAYSIA II

**ANNUAL TRAINING CAPACITY OF THE NATIONAL FAMILY PLANNING SPECIALIST CENTER**

<table>
<thead>
<tr>
<th></th>
<th>Existing Number to be Trained</th>
<th>Duration (weeks)</th>
<th>Number in Each Class</th>
<th>Number of Classes in a Year</th>
<th>Total Trained in a Year</th>
<th>Total Weeks of Training in a Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Doctors</strong></td>
<td>240/1</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td>420/2</td>
<td>3</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>24</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>660</td>
<td>5</td>
<td>20</td>
<td>18</td>
<td>180</td>
<td>44</td>
</tr>
</tbody>
</table>

/1 Two per each of 60 government hospitals, one per each of 60 health districts and about 60 private practitioners.

/2 Two per each of 62 main health centers and one per each of 295 health sub-centers.
MALAYSIA II

PERCENTAGE DISTRIBUTION OF ACCEPTORS
BY LOCATION OF CLINICS AND RESIDENCE OF ACCEPTORS
(1968, 1974-76)

<table>
<thead>
<tr>
<th>Year</th>
<th>Clinic</th>
<th>Location</th>
<th>Residence of Acceptors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>1968</td>
<td>70.0</td>
<td>30.0</td>
<td>Not Reported</td>
</tr>
<tr>
<td>1974</td>
<td>43.5</td>
<td>56.5</td>
<td>19.7</td>
</tr>
<tr>
<td>1975</td>
<td>39.4</td>
<td>60.6</td>
<td>17.9</td>
</tr>
<tr>
<td>1976</td>
<td>41.1</td>
<td>58.9</td>
<td>19.4</td>
</tr>
</tbody>
</table>

Source: National Family Planning Board.
## ANNEX 4

MALAYSIA II

ANNUAL TRAINING REQUIREMENTS AND CAPACITIES AT THE PROPOSED INTEGRATED RURAL HEALTH AND FAMILY PLANNING TRAINING SCHOOLS

<table>
<thead>
<tr>
<th>Locality</th>
<th>Type of Training</th>
<th>Category</th>
<th>Duration</th>
<th>No. of Trained in a Group</th>
<th>No. of Groups</th>
<th>No. of Centers</th>
<th>Total Training Capacity</th>
<th>Annual Training Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nutrition, basic and FP refresher/2</td>
<td>&quot;</td>
<td>3 weeks</td>
<td>20</td>
<td>10</td>
<td>13</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Field training</td>
<td>Student Public Health Nurses</td>
<td>2 weeks</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Field training</td>
<td>Student Public Health Inspectors</td>
<td>44 weeks</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sarawak</td>
<td>Refresher of midwives as community nurses/3</td>
<td>&quot;</td>
<td>6 months</td>
<td>30</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Refresher for integrated health services/2</td>
<td>Hospital Assistants</td>
<td>5 months</td>
<td>30</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Refresher training in MCH/FP/Nutrition</td>
<td>Community Nurses, Assistant Health Services</td>
<td>3 weeks</td>
<td>30</td>
<td>-</td>
<td>7</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sabah</td>
<td>Refresher/3</td>
<td>&quot;</td>
<td>12 weeks</td>
<td>50</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>for integrated health services</td>
<td>Hospital Assistants, Assistant Health Services, Assistant Public Health Inspectors</td>
<td>&quot;</td>
<td>3 weeks</td>
<td>50</td>
<td>-</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Refresher training MCH/FP/Nutrition</td>
<td>&quot;</td>
<td>3 weeks</td>
<td>50</td>
<td>-</td>
<td>5</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

1/ Basic training in family planning will be reduced by 1985 due to the recruitment of community nurses who will have received family planning training during the two years' basic training program.

2/ Refresher training will be given to the staff every five years in Peninsular Malaysia and every four years in Sarawak and Sabah.

3/ The refresher program will be completed before 1985; from 1985 onward, the centers will conduct the refresher training program.

Source: Ministry of Health.
**MALAYSIA II**

**THE TRAINING CAPACITY OF THE FAMILY DEVELOPMENT TRAINING CENTERS**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Intake</th>
<th>Courses Given Each Year</th>
<th>Number Trained Each Year</th>
<th>Total to Be Trained in All Schools</th>
<th>Average Weeks of Use of Each School</th>
</tr>
</thead>
<tbody>
<tr>
<td>New FDTCs (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic course/1</td>
<td>3 months</td>
<td>60</td>
<td>3</td>
<td>180</td>
<td>360</td>
</tr>
<tr>
<td>Special course/2</td>
<td>6 months</td>
<td>60</td>
<td>2</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>300</td>
<td>480</td>
</tr>
<tr>
<td>Existing FDTCs (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic course/1</td>
<td>3 months</td>
<td>30</td>
<td>3</td>
<td>90</td>
<td>180</td>
</tr>
<tr>
<td>Special course/2</td>
<td>6 months</td>
<td>30</td>
<td>2</td>
<td>60</td>
<td>120</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>150</td>
<td>300</td>
</tr>
</tbody>
</table>

/1 Home Economics including vocational training.  
/2 Child Development or play group.

**Source:** Community Development Division, Ministry of Agriculture.
<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Land Facilities</th>
<th>Construction Facilities</th>
<th>Professional Services</th>
<th>Other Services</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized Personal Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Rural Health and Family Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Health Services Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion and Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research &amp; Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovative Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Details:**

- **Specialized Personal Health Services**: 3 National FP Specialist Centers, 6 Regional FP Specialist Centers.
- **Integrated Rural Health and Family Health Services**: 36 Urban FP Clinics, 36 Rural FP Clinics.
- **Health Promotion and Education**: 67 Health Offices.
- **Research & Evaluation**: 7 National Health Institutes.
- **Innovative Activities**: 7 National Health Institutes.
- **Project Implementation**: 7 National Health Institutes.
<table>
<thead>
<tr>
<th>Functional Category</th>
<th>Devisement</th>
<th>Cost</th>
<th>Cost</th>
<th>Incremental Operating Cost</th>
<th>Reasonable Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning</strong></td>
<td><strong>National FP Specialist Ctr.</strong></td>
<td>122.2</td>
<td>24.2</td>
<td>14.5</td>
<td>National FP Specialist Ctr.</td>
</tr>
<tr>
<td></td>
<td><strong>Regional FP Specialist Ctr.</strong></td>
<td>89.1</td>
<td>17.8</td>
<td>2.5</td>
<td>Regional FP Specialist Ctr.</td>
</tr>
<tr>
<td><strong>Urban Family Planning Services</strong></td>
<td><strong>Urban FP Clinics</strong></td>
<td>320.2</td>
<td>64.0</td>
<td>9.0</td>
<td>Urban FP Clinics</td>
</tr>
<tr>
<td><strong>Storage &amp; Distribution of Contraceptives</strong></td>
<td><strong>MFP Central Goods</strong></td>
<td>55.4</td>
<td>11.1</td>
<td>1.8</td>
<td>MFP Central Goods</td>
</tr>
<tr>
<td><strong>Strengthening of MNP &amp; Prevention in Rural Areas</strong></td>
<td><strong>MNP/FP Clinic Additions</strong></td>
<td>27.3</td>
<td>5.5</td>
<td>0.8</td>
<td>MNP/FP Clinic Additions</td>
</tr>
<tr>
<td><strong>Urbanization &amp; Management of Health and Population Program</strong></td>
<td><strong>Office Facilities</strong></td>
<td>59.6</td>
<td>11.9</td>
<td>1.8</td>
<td>Office Facilities</td>
</tr>
<tr>
<td></td>
<td><strong>Health Offices</strong></td>
<td>56.5</td>
<td>11.3</td>
<td>1.8</td>
<td>Health Offices</td>
</tr>
<tr>
<td><strong>Information, Education &amp; Communication</strong></td>
<td><strong>Weekly &amp; Goodwill</strong></td>
<td>107.8</td>
<td>21.5</td>
<td>3.4</td>
<td>Weekly &amp; Goodwill</td>
</tr>
<tr>
<td></td>
<td><strong>Mobile Units (7)</strong></td>
<td>25.2</td>
<td>5.0</td>
<td>0.8</td>
<td>Mobile Units (7)</td>
</tr>
<tr>
<td></td>
<td><strong>DNA for Maintenance</strong></td>
<td>2.3</td>
<td>0.5</td>
<td>0.1</td>
<td>DNA for Maintenance</td>
</tr>
<tr>
<td></td>
<td><strong>Pack. (AFC)</strong></td>
<td>176.0</td>
<td>35.6</td>
<td>5.5</td>
<td>Pack. (AFC)</td>
</tr>
<tr>
<td></td>
<td><strong>18L Filmstrip Projectors</strong></td>
<td>26.7</td>
<td>5.3</td>
<td>1.0</td>
<td>18L Filmstrip Projectors</td>
</tr>
<tr>
<td></td>
<td><strong>Mobile Health M. (11 units)</strong></td>
<td>11.7</td>
<td>2.3</td>
<td>0.4</td>
<td>Mobile Health M. (11 units)</td>
</tr>
<tr>
<td><strong>Women's Development Program</strong></td>
<td><strong>Community Service Ctr.</strong></td>
<td>46.0</td>
<td>9.2</td>
<td>1.5</td>
<td>Community Service Ctr.</td>
</tr>
<tr>
<td></td>
<td><strong>Family Dev. Trg. Ctr.</strong></td>
<td>28.4</td>
<td>5.7</td>
<td>1.0</td>
<td>Family Dev. Trg. Ctr.</td>
</tr>
<tr>
<td></td>
<td><strong>Medical Sales Org.</strong></td>
<td>5.3</td>
<td>1.1</td>
<td>0.2</td>
<td>Medical Sales Org.</td>
</tr>
<tr>
<td><strong>Research &amp; Evaluation</strong></td>
<td><strong>Computer Software (Dev. Dev.)</strong></td>
<td>195.6</td>
<td>39.1</td>
<td>7.0</td>
<td>Computer Software (Dev. Dev.)</td>
</tr>
<tr>
<td></td>
<td><strong>Calculators &amp; Tape Recorders (Dev. Dev.)</strong></td>
<td>8.9</td>
<td>1.8</td>
<td>0.3</td>
<td>Calculators &amp; Tape Recorders (Dev. Dev.)</td>
</tr>
<tr>
<td></td>
<td><strong>Software Application</strong></td>
<td>14.5</td>
<td>2.9</td>
<td>0.5</td>
<td>Software Application</td>
</tr>
<tr>
<td></td>
<td><strong>Operating Research</strong></td>
<td>44.0</td>
<td>8.8</td>
<td>1.5</td>
<td>Operating Research</td>
</tr>
<tr>
<td></td>
<td><strong>Project Evaluation</strong></td>
<td>33.0</td>
<td>6.6</td>
<td>1.1</td>
<td>Project Evaluation</td>
</tr>
<tr>
<td><strong>Project Implementation</strong></td>
<td><strong>Additional Observations</strong></td>
<td>199.5</td>
<td>39.9</td>
<td>7.0</td>
<td>Additional Observations</td>
</tr>
</tbody>
</table>

**Salaries & Allowances**

- 42.0
- 84.0
- 167.2

- 394.9
- 789.8
- 1572.3

- 394.9
- 789.8
- 1572.3
## Wahlbiel II

**Second Population and Family Reunion Project: Detailed Unit Estimates (E3000)**

### 1. Civil Works

<table>
<thead>
<tr>
<th>Description</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. Furniture

<table>
<thead>
<tr>
<th>Description</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total LT

| | | | |
| | | | |

---

**Notes:**

- The table represents detailed unit estimates for the Wahlbiel II project.
- Each row indicates the responsible agency and the estimated units for different years (1979, 1980, 1981).
- The table provides a comprehensive overview of the project's progress and planned expenditures.

---

**References:**

- Detailed data on population and family reunion projects in the Wahlbiel II area.
- Specific units estimated for various civil works and furniture projects.

---

**Total LT:**

| | | | |
| | | | |
**MALAYSIA II**

SECOND POPULATION AND FAMILY HEALTH PROJECT: DETAILED COST ESTIMATES (cont.)

(USD$000)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Local</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Urban FP Clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 General Hospital and Dispensaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Integrated Rural Health &amp; FP Fitzr., P. Malaysia</td>
<td>60.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Training Courses at MOH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Integrated Rural Health &amp; FP Typ. Sch., Sabah</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6 Health Offices with MOH/FPS Service Units</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.7 Community Service Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 3.2</td>
<td>225.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 4. Professional Services | | | | |
| | | | | |
| Total Civil Works | 390.0 | | | |

II. Non-Civil Works

| 1. Vehicles | | | | |
| 1.1 Motorcycles - Mat. Fr. Spec. Ctr. | 25 | | | |
| | | | | |
| 1.3 Motorcycle - SEZ | 100.0 | | | |
| | | | | |
| 1.4 Vehicle Taxis - Central Government | | | | |
| | | | | |
| 1.6 Long Wheel Base 4WD - MOH Supervision | 60.0 | | | |
| | | | | |
| 1.8 Motorcycle - Home Visit & MOH Services | 22.0 | | | |
| | | | | |
| 1.9 Scooters - Home Visiting | 500 | | | |
| | | | | |
| 1.11 Motorcycles - Mobile Health Education Units | | | | |
| | | | | |
| 1.12 Motorcycles - Health Officers | | | | |
| | | | | |
| 1.14 Motorcycles - Integrated Mobile Health and FP | | | | |
| | | | | |
| Total 1.2 | | | | |

Total 11.1 | 703.0 | | | |

| (%) | | | | |

| (100%) | | | | |

| Total Local | 353.0 | | | |

| | | | | |

- **3.1 FEAc**
- **91.5 68.7**
- **60.7**
- **60.7**
- **50.0**
- **206.3**
- **190.0**
- **190.0**

- **3.3**
- **91.5**
- **91.5**

- **3.4**
- **91.5**
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- **3.6**
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## DETAILED COST ESTIMATES (Contd.)

**MALAYSIA II**

**SECOND POPULATION AND FAMILY HEALTH PROJECT**

### 7. Equipment

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**Total 7.2** |

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**Total 8.2** |

### 9. TOTAL

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**Total 9.2**
## Malaysia II

### Second Population and Family Health Project

#### Detailed Cost Estimates (cont.)

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### 111. Continuance

#### 1. Civil Works

- **Medical Continuance**
  - Price Continuance
  - Total Continuance (Civil Works)

#### 2. Non-Civil Works

- Price Continuance
- Total Continuance

### 112. Total Estimated Project Cost

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<td>240.2</td>
<td>243.5</td>
<td>299.2</td>
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</table>

**50% of foreign expenditure.

**Additional Abbreviations:**
- AT - Authoritative
- MHC - Maternal and Child Health Centers
- M4U - Ministry of Agriculture
- MNS - Ministry of National Security
- MD - Ministry of Development
- MOP - Ministry of Public Works
- MOE - Ministry of Education
- MOF - Ministry of Finance
- MORDI - Ministry of Rural Development
- MRC - Ministry of Rural Development
- MUNA - Ministry of National Education
- MNES - Ministry of National Education
- MNS - Ministry of National Security
- MOP - Ministry of Public Works
- MRRD - Ministry of Rural Development
- MRT - Ministry of Rural Development
- MURR - Ministry of Rural Development
- MÜSP - Ministry of Urban Development
- MÜR - Ministry of Urban Development
- MÜS - Ministry of Urban Development
- MÜT - Ministry of Urban Development
- MÜV - Ministry of Urban Development
- MÜW - Ministry of Urban Development
- MÜX - Ministry of Urban Development
- MÜY - Ministry of Urban Development
- MÜZ - Ministry of Urban Development
- MÜA - Ministry of Urban Development
- MÜB - Ministry of Urban Development
- MÜC - Ministry of Urban Development
- MÜD - Ministry of Urban Development
- MÜE - Ministry of Urban Development
- MÜF - Ministry of Urban Development
- MÜG - Ministry of Urban Development
- MÜH - Ministry of Urban Development
- MÜI - Ministry of Urban Development
- MÜJ - Ministry of Urban Development
- MÜK - Ministry of Urban Development
- MÜL - Ministry of Urban Development
- MÜM - Ministry of Urban Development
- MÜN - Ministry of Urban Development
- MÜO - Ministry of Urban Development
- MÜP - Ministry of Urban Development
- MÜQ - Ministry of Urban Development
- MÜR - Ministry of Urban Development
- MÜS - Ministry of Urban Development
- MÜT - Ministry of Urban Development
- MÜV - Ministry of Urban Development
- MÜW - Ministry of Urban Development
- MÜX - Ministry of Urban Development
- MÜY - Ministry of Urban Development
- MÜZ - Ministry of Urban Development

(Cont.)
MALAYSIA II

SECOND POPULATION AND FAMILY HEALTH PROJECT:
ESTIMATED SCHEDULE OF DISBURSEMENTS (FY1980-83)
(US$000)

<table>
<thead>
<tr>
<th>Fiscal Year and Quarter</th>
<th>Disbursement during Quarter</th>
<th>Cumulative Disbursement</th>
<th>Percentage of Loan Disbursed (cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1980</td>
<td></td>
<td></td>
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<tr>
<td>September 30, 1979</td>
<td>658.8</td>
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<td>June 30, 1981</td>
<td>1,597.8</td>
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<td>FY 1982</td>
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<td>September 30, 1981</td>
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<td>September 30, 1982</td>
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<td>June 30, 1983</td>
<td>185.9</td>
<td>17,000.0</td>
<td>100.0</td>
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<td>TOTAL</td>
<td>17,000.0</td>
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SECOND MALAYSIA POPULATION AND FAMILY HEALTH PROJECT:

PROJECT COST ESTIMATES BY STATES
(US$000)

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<tr>
<th>Status</th>
<th>Basic Project Cost</th>
<th>Construction Cost</th>
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<td>Federal Territory</td>
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<td>1,990</td>
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<td>Johore</td>
<td>1,751</td>
<td>550</td>
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<tr>
<td>Kedah</td>
<td>907</td>
<td>275</td>
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<tr>
<td>Kelantan</td>
<td>1,970</td>
<td>864</td>
</tr>
<tr>
<td>Malacca</td>
<td>469</td>
<td>79</td>
</tr>
<tr>
<td>North Sembilan</td>
<td>782</td>
<td>288</td>
</tr>
<tr>
<td>Pahang</td>
<td>1,594</td>
<td>707</td>
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<tr>
<td>Penang</td>
<td>2,751</td>
<td>1,414</td>
</tr>
<tr>
<td>Perak</td>
<td>4,314</td>
<td>2,252</td>
</tr>
<tr>
<td>Perlis</td>
<td>313</td>
<td>39</td>
</tr>
<tr>
<td>Selangor</td>
<td>2,032</td>
<td>930</td>
</tr>
<tr>
<td>Trengganu</td>
<td>1,188</td>
<td>524</td>
</tr>
<tr>
<td><strong>Total Peninsular Malaysia</strong></td>
<td><strong>26,919</strong></td>
<td><strong>9,912</strong></td>
</tr>
<tr>
<td>Sabah</td>
<td>1,000</td>
<td>720</td>
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<tr>
<td>Sarawak</td>
<td>3,345</td>
<td>2,461</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>31,264</strong></td>
<td><strong>13,093</strong></td>
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MALAYSIA II
COORDINATION OF THE NATIONAL FAMILY PLANNING PROGRAM

The Treasury
- Ministry of Health
- Ministry of Agriculture
- Ministry of Information
- Ministry of Education
- Ministry of Local Government and Federal Territories
- Ministry of Welfare Services
- Ministry of Labour
- Economic Planning Unit
- Public Reimbursements from Social Welfare Services, Commerce and Institutions

Chairman, NFPB
Director General, NFPB
Director General EPB
Representative, MCA
Director AFS, NFPB
Secretary

Director Health, MHC, Chair
Director General, NFPB, Co-Chair
Deputy, Community Development, MDA
Executive Director, FPA

Directors, TEC, PEMS, Services & Training Planning & Government, NFPB
Director, Public Health, MOH
Assistant Director, MOH
Assistant Director, Family Planning, MOH
Assistant Director, Health Education, MOH

Director General, NFPB
Executive Director EPB
Director AFS, NFPB
Secretary

State Director, Medical & Health Services, MOH, Chair
State Medical Officer, NFPB, Secretary
State Community Development Officer, MOA
Representative, Public

State Coordinating Committee
State Family Planning Committee
Public Reimbursements from Social Welfare Services, Commerce and Institutions

Central Coordination Committee
Medical Advisory Council
National Family Planning Committee
Establishment and Budget Committee
National Family Planning Research Committee
Reproduction and Family Planning Committee
NFPB/EPB Training and Service Committee
National Joint Research Committee
Project Steering Committee

Representatives from the Structure incorporated in the NFPB
Subcommittee Service and Training
Subcommittee Research and Evaluation
Subcommittee Service and Training
Subcommittee Research and Evaluation

Representative from the State Planning Unit
Representative from the State Government

Additional Abbreviations:
AFS - Administration, Finance and Supplies
EPB - Economic Planning Unit
MOF - Ministry of Finance
MOH - Ministry of Health
MOP - Ministry of Agriculture
MOP - Public Works Department

World Bank - A863
MALAYSIA II
ORGANIZATIONAL STRUCTURE: MINISTRY OF AGRICULTURE

Minister's Office

Secretary General's Office

Division
Division
Community Development Division
Division
Division

Planning and Evaluation Unit
Community Education Unit
Administration and Finance Unit
Training Units
Family Development Unit

Rural Institute*
Regional Family Development Training Institutions*
Women's Handicraft Sales Organization

State Director Community Development

Mobile Demonstration Unit
Community Services Centers

*Presently directly under Community Development Division

Line of administrative control
Line of coordination and technical support

Proposed additions under the project

State Level

District Level

National Level
ANNEX 4

ORGANIZATION AND STAFFING OF THE NATIONAL FAMILY PLANNING SPECIALIST CENTER

Additional Abbreviation:

IMR - Institute of Medical Research
MALAYSIA II
ORGANIZATION AND STAFFING OF THE HEALTH EDUCATION UNIT

- Audiovisual Production Centre
- Service Provision Section
- Research & Development Section
- Administration Section

<table>
<thead>
<tr>
<th>Positions</th>
<th>Existing</th>
<th>To-be-filled</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>Production supervisor</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Editor</td>
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<td>1</td>
</tr>
<tr>
<td>Translator</td>
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<td>0</td>
</tr>
<tr>
<td>Scriptwriter</td>
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<tr>
<td>Photographer</td>
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<tr>
<td>Graphic artist</td>
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<td>1</td>
</tr>
<tr>
<td>Artist</td>
<td>1</td>
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</tr>
<tr>
<td>Machine Operator</td>
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<td>2</td>
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<tr>
<td>IMG laborer</td>
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<td>2</td>
</tr>
<tr>
<td>Clerk</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Composing typeset</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Typist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Office boy</td>
<td>0</td>
<td>1</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Positions</th>
<th>Existing</th>
<th>To-be-filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education officer</td>
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<table>
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</thead>
<tbody>
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</tr>
<tr>
<td>Clerk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Junior clerk</td>
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<td>1</td>
</tr>
<tr>
<td>Typist</td>
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<tr>
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<tr>
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<td>Stenographer</td>
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<tr>
<td>Maintenance technician</td>
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<tr>
<td>Carpenter</td>
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<tr>
<td>Driver</td>
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<td>Office boy</td>
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ORGANIZATION AND STAFFING OF THE RESEARCH, EVALUATION AND MANAGEMENT INFORMATION SYSTEM DIVISION (REMIS)

Electronic Data Processing (Computer) Section

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<tr>
<td>Computer Programmer</td>
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<tr>
<td>Console Operator</td>
<td>-</td>
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<td>Data Processing Staff</td>
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Service Statistics/Reports Publication Section

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<tr>
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<td>-</td>
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<tr>
<td>Staff</td>
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Field Survey-cum-Research

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<tr>
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Demographic Analysis/Special Studies

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<tr>
<td>Field Interviewer</td>
<td>Perma-</td>
<td>Tent.</td>
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<tr>
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<td>nent 8</td>
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State level of Evaluation Assistant

<table>
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</table>

*Data processing of Electronic Data Processing Section renders services to the Service Statistics/Reports Publication Section when required.*
Additional Abbreviations:

EPU - Economic Planning Unit
MOA - Ministry of Agriculture
PWD - Public Works Department
MALAYSIA
LOCATION OF PHYSICAL FACILITIES
SUPPORTED UNDER SECOND POPULATION
AND FAMILY HEALTH PROJECT
WEST MALAYSIA

(A) National Family Planning Board Facilities
   • National Family Planning Specialist Center
   • Regional Family Planning Specialist Centers
   • Urban Family Planning Clinics ("Type C" & MCHC)
   • Urban Family Planning Clinics Special Type
   • Central N.FPB Godown and Print Shop

(B) Ministry of Health Facilities
   • Integrated Rural Health and Family Planning Training Schools
   • Training Quarters at MPCs
   • Audio Visual Material Production Center
   • Health Offices with MCH/FP Service Units

(C) Ministry of Agricultural Facilities
   • Family Development Training Centers
   • Community Service Centers
   • Women's Handicraft Sales Organization

Population Density per Sq Km.
By State (1975)
- A 0 - 50
- B 51 - 100
- C 101 - 200
- D 201 - 300
- E 301 - Over

[Map showing locations of physical facilities in West Malaysia]
LOCATION OF PHYSICAL FACILITIES SUPPORTED UNDER SECOND POPULATION AND FAMILY HEALTH PROJECT
EAST MALAYSIA (Sabah and Sarawak)

Ministry of Agriculture Facilities
- Family Development Training Centre

Ministry of Health Facilities
- Integrated Rural Health & Family Planning Training School
- Quarters for Field Training at Health Units
- Addition of MCH/FP Clinic to Existing Dispensaries
- Staff Quarters at Existing Training Centers

Note: Population Densities for Sabah and Sarawak are 10 and 9 respectively, per Square Kilometer.
ANNEX 5

MALAYSIA II

RELATED DOCUMENTS AND DATA AVAILABLE IN THE PROJECT FILE

A. General Reports and Studies Related to Population/Family Planning


A-6 Vital Rates by Various Socio-Economic Characteristics.

A-7 Some Case Studies on Poverty in Malaysia; Mokhzani and Mun.

A-8 Squatter Settlements in Kuala Lumpur; Peter Piri and Students (August 1976).


A-12 Report of Evaluation Subcommittee to CentralCoordination Committee; NFPB (February 1977).


B. General Reports and Studies Related to the Project

B-1 Implementation Volume

Summary Action Plans for All Components
Implementation Schedules for All Components
Schedules for Construction and Procurement
List of Facilities, Equipment, Furniture, Vehicles and Personnel
Implementation Volume (cont.)

List and Terms of Reference of Fellowships and Advisers
Program Targets
Composition and Functions of the PCCU, Project Secretariat
and Committees under the Project

B-2 The National Family Planning Board's Request for the Second
IBRD Loan (September 1977).

B-3 Ministry of Health Proposal for Assistance from IBRD under
Population Project II (September 1977).

B-4 Proposed Population Project II (Requests); Community Development
Division, Ministry of Agriculture (September 1977).

B-5 Proposal from Research, Evaluation and Management Information
System Division; NFPB (July 1977).

B-6 Policy and Operational Program (Urban Program); NFPB (March 1977).

B-7 Working Paper--Taking Over from UNFPA Recurrent Expenditure for
Three Family Planning Regional Training Centers; NFPB (May 1977).

B-8 The Up-to-Date Report on the Population Project I.

B-9 Proposed Population Project II Preparation: Establishment of an
Institute of Health for Integrating Training Programme in Sabah
(Malaysia); State Directorate of Health, Sabah (August 1977).

B-10 Proposals for IBRD's Assistance (Sarawak); State Health Directorate
of Sarawak (July 1977).

B-11 Research Contribution to Population Studies: Input-Output
Relationships in Family Planning; Tan Boon Ann et al, NFPB;
(December 1975).


B-13 Population and Family Health Project: List of Equipment and
Furniture.

C. Selected Working Papers and Prepared Documents

C-1 Consultant's Report on the National and Regional Fertility Services
and Research Center; Prof. Brenner (September 1977).

C-2 Consultant's Draft Report on Nutrition and MCH Components under
the Project; Prof. Wadsworth (September 1977).