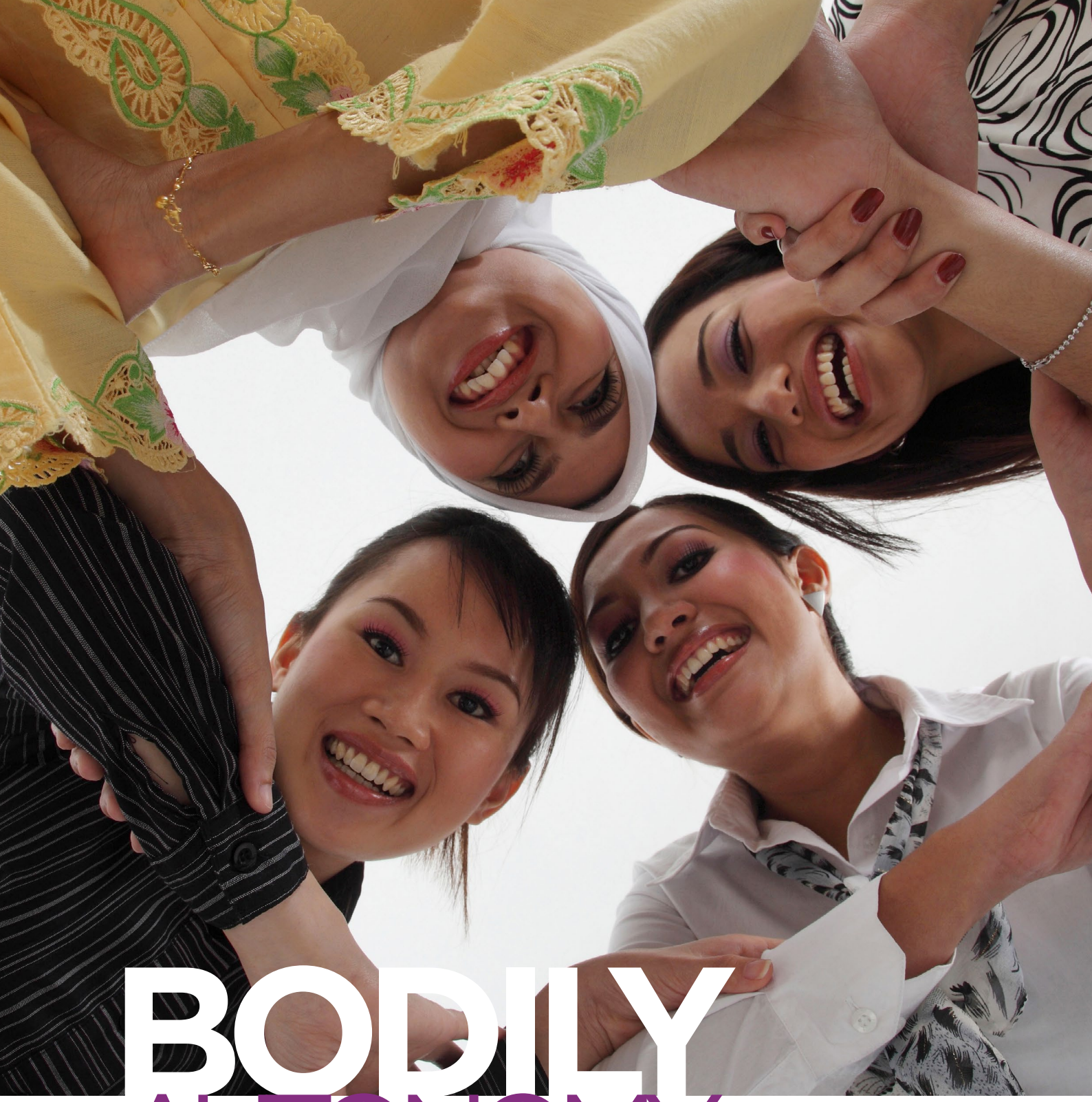

BODILY AUTONOMY IN MALAYSIA

PERCEPTIONS AND EXPERIENCES ACROSS WOMEN'S LIFE STAGES (18-65+)

This project is funded by the European Union

A Report on Malaysia's Progress and Commitment to Bodily Autonomy.

Bodily Autonomy in Malaysia: Perceptions and Experiences Across Women's Life Stages (18-65+)

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EXECUTIVE SUMMARY

About This Study

This report presents findings from the first nationally distributed, mixed-methods study on women's bodily autonomy and gender equality in Malaysia, commissioned by SIS Forum in 2025. Bodily autonomy — the right to make informed, free, and independent decisions about one's own body — sits at the heart of gender equality. This study examines the extent to which women in Malaysia are able to exercise this right, and the social, structural, institutional, and legal barriers that constrain it.

The study combined a nationally distributed quantitative survey of 1,004 women and 92 men, conducted between September and October 2025, with qualitative research — comprising focus group discussions, in-depth interviews, and key informant interviews — with specific population groups including young women, Indigenous communities, women with disabilities, and civil society representatives.

In parallel, a complementary study explored bodily autonomy among 142 LGBTIQA and gender-diverse participants, supplemented by in-depth interviews with seven key informants. Findings from this complementary research are integrated in this report.

The study is organised around five interconnected dimensions of bodily autonomy: healthcare and reproductive decision-making; relationships and marriage; freedom from gender-based violence; bodily appearance and gender expression; and access to education and information. Together, these dimensions provide a multi-layered picture of women's bodily autonomy across different age cohorts, ethnicities, income levels, and geographies in Malaysia. It is the first study of its kind in the country.

Key Findings

Healthcare and Reproductive Health

A majority of women (68%) report having access to healthcare when needed. However, a substantial minority (32%) experience limited access, with inequalities shaped consistently by income, education, age, and geography. Women in Sabah (50%) and Sarawak (44%) face the greatest barriers, along with those who are from the youngest age group (18-24 years old), lower income brackets or with secondary education and below. LGBTIQA persons face additional barriers rooted in fear of discrimination, a trust deficit, and the near-absence of gender-affirming services. Whether or not currently affordable healthcare services can be sustained remains to be seen given that the system is overextended, along with rising medical costs, particularly in private hospitals and clinics.

Utilisation of reproductive healthcare remains inadequate, particularly for preventive services, and is most limited among students, unemployed women, and those in lower-income brackets.

It is also very low among women in the youngest (18-24) and oldest (55 and above) age groups. Contraception is similarly underutilised (44%) and responsibility for its usage falls disproportionately on women — 59% bear primary responsibility, while only 11% report that their spouse or partner takes this role. Christian women are more than twice as likely as Muslim women to report that their spouse or partner takes primary responsibility for contraception; 19% versus 8%.

Awareness of abortion law is low. Fewer than half of women (45%) know that therapeutic abortion is legal in Malaysia under certain circumstances, and one in five (21%) believe it to be entirely illegal. A further 24% believe it is completely outlawed for Muslim women — rising to 31% among Malay and Muslim women, and 42% in Kelantan. Only one in three women (34%) knows how to access information on abortion services.

Relationships, Marriage, and Sexual Autonomy

A large majority of women's (78%) decision to marry was largely their own, with autonomy increasing consistently with income, education, and employment. However, financial dependence significantly limits this freedom — women who are students, homemakers or caregivers, or low-income earners are considerably more likely to report that parents or family members played the primary role in their marriage decision. Among women earning under RM1,000 per month, 21% say their parents primarily decided on their marriage.

Sexual autonomy within marriage is the most constrained dimension of bodily autonomy in this study. Only 52% of women report being able to refuse sex with their spouse or partner, and a further 37% can do so only sometimes. Malay and Muslim women report the least sexual autonomy — only 44% report being able to refuse sex, compared with around three-quarters of Chinese and Indian women.

The most commonly cited reasons for not refusing are the belief that sex is a marital duty (68%), religious beliefs (59%), and fear of partner anger (14%).

Benchmarked against the UN SDG indicator 5.6.1, Malaysia's composite bodily autonomy score of 45% falls below both the global average (55%) and the East and Southeast Asia regional average (76%). Women in Malaysia perform comparably to regional peers on contraception (93%) and healthcare decisions (92%), but lag significantly on sexual autonomy: only 51% report being able to refuse sex with a spouse or partner, compared to 86% regionally. This single dimension is the primary driver of Malaysia's low composite score, placing it just above the lowest-performing regions in the world.

Gender-Based Violence

Sexual violence against women is widespread, with younger women most affected. While 53% report no such experience, 43% have experienced at least one form of violation. The most commonly reported forms are inappropriate touching (24%) and unwanted sexual comments or gestures (21%). Younger women — particularly those aged 18-34 — report higher levels of harassment across all forms. Among LGBTIQA respondents, a large majority (78%) reported experiencing some form of GBV.

Most incidents go unreported. Among those who experienced GBV in the past 12 months, only 36% reported it to any authority. The main barriers are the perception that the incident was not serious enough (35%), fear of not being believed (33%), and shame or stigma (32%). Only 5% of LGBTIQA survivors reported incidents, reflecting acute mistrust of formal institutions. Confidence in legal protection is also limited: while 51% of women believe existing laws offer adequate protection, 40% do not.

Online GBV is widespread and growing. A substantial minority (41%) reported experiencing at least one form of online violence — including unwanted sexual messages or images (33%), cyberstalking (13%), non-consensual use of images (9%), doxing (8%), and threats of violence (7%).

Among LGBTIQA respondents, nearly three quarters (73%) reported experiencing online GBV. Beyond direct experience, 63% of women avoid sharing photos of themselves online due to fear of harassment — a pervasive form of self-censorship that limits women's public participation.

Qualitative findings reveal that many women do not initially recognise GBV due to its normalisation, and that recognition often comes through peer discussion and targeted awareness-raising. Indigenous women face compounded barriers — structural gaps in rural service provision, lack of inter-agency coordination, and a near-total absence of shelters or support mechanisms leave Orang Asal women disproportionately exposed and underserved. Women with disabilities face distinct but equally significant barriers, including inaccessible reporting mechanisms, communication gaps in healthcare and support settings, and the absence of disability-inclusive GBV services thus leaving them among the least likely to receive help when they need it most.

Bodily Appearance and Gender Expression

While 78% of respondents agree that women and men should be free to choose how they dress, only 54% of women report always being able to dress as they wish without fear of judgment or restriction. Younger women and students are most constrained — only 30% of students report full freedom of dress. Religious expectations are the most commonly cited source of restriction (51% overall, peaking at 79% in Terengganu and 66% in Kelantan). Roughly one in three women (31%) has experienced criticism, punishment, or restriction because of her clothing.

Among LGBTIQA respondents, a large majority (81%) reported having been criticised, punished, or restricted because of their gender expression. A third (34%) experienced pressure to change their sexual orientation or gender identity, and 12% reported being forcibly subjected to therapy or institutionalisation without consent — four times the rate recorded among the general women's sample (3%).

Education and Knowledge About Bodily Autonomy

The formal education system has largely failed to deliver comprehensive sexuality education. A notable minority of women (40%) report that their school provided no CSE at all. Qualitative interviews further revealed that where sexuality education was delivered, content focused predominantly on biology and moral guidance, with minimal attention to consent, relationships, or rights. One in four women (23%) reports period checks conducted by teachers — rising to 31-36% among women aged 18-34 — indicating these are recent practices. Trust in schools as safe environments remains low: only 42% of respondents believe schools reliably protect girls' bodily autonomy, and 41% feel the same for boys — suggesting this is not a gendered failing so much as a systemic one, pointing to a broader institutional gap in how schools uphold the bodily autonomy of all children.

Despite or perhaps because of these shortcomings, support for CSE is near-universal: 88% of women and 85% of men support its implementation in Malaysian schools — one of the strongest consensus findings in the study.

The internet has become the primary source of information on bodily autonomy and reproductive health, cited by 63% of women, ahead of the media (49%), parents (41%), and the school syllabus (40%). Reliance on digital platforms is highest among younger women, with 70% of those aged 18-24 and 72% of those aged 25-34 turning to the internet as their main source. While the dominance of informal and online sources raises concerns about accuracy, relevance, and the absence of culturally grounded guidance, schools remain an important space. Notably, 49% of men cited the school syllabus as a source of information, suggesting that formal education continues to reach younger generations and has significant potential as a channel for delivering rights-based information on bodily autonomy and reproductive health.

Cross Cutting Findings

Several patterns cut across all five dimensions of the study. Inequality is consistent and cumulative — the same groups of women face greater constraints across almost every domain examined: older women, rural women, Indigenous women, women with disabilities, LGBTIQA, and those with lower incomes and less formal education. Younger women face similar restrictions in certain domains, for example, access to reproductive healthcare.

Greater autonomy across all dimensions — from healthcare decision-making to marriage choices to freedom of dress — is shaped by a complex interplay of factors, including economic independence, political empowerment, and patriarchal structures and belief systems that limit women's power to negotiate within households, communities and institutions. Yet these individual factors — economic, political, social — are themselves products of deeper structural failings: systems and institutions that were not built with women's full participation in mind, and that continue to reproduce inequality through policy gaps, enforcement failures, and entrenched patriarchal norms. Nowhere are these failings more starkly visible than in the experiences of LGBTIQA and gender-diverse people, whose barriers to bodily autonomy are compounded by criminalisation, stigma, and near-total exclusion from mainstream healthcare and support systems.

Conclusion

What the data reveals is a society in which formal commitments to gender equality coexist with persistent and deeply embedded inequalities in women's lived realities. The gap between Malaysia's legal and policy commitments and everyday experience is not incidental — it is produced by gender norms that treat women's bodies as objects of family and community regulation, institutional cultures that dismiss or reproduce violations, and structural inequalities that determine how much real choice women are able to exercise in both private and public life.

There are, nonetheless, reasons for cautious optimism. Public attitudes in Malaysia are in many respects ahead of institutional practice — the breadth of support for comprehensive sexuality education, women's reproductive rights, and freedom of dress signals that the social impetus for change exists. The challenge lies in closing the gap between stated values and daily reality. What is needed now is a response equal to the evidence — one that draws on government, civil society, religious institutions, healthcare providers, educators, media, and communities working in concert rather than in isolation.

Summary of Recommendations

The study identifies ten interconnected recommendations, addressed to the government of Malaysia, healthcare bodies, law enforcement agencies, schools, civil society organisations, religious institutions, and media producers:

1

Engage key sources of social influence to shift gender norms — Engage religious leaders, media producers, content creators, and civil society organisations to challenge stigma, promote respectful representations of womanhood, and reinforce women's right to make informed choices about their bodies and relationships.

2

Transform how children and young people are educated about their bodies and rights — Implement a standardised, evidence-based CSE curriculum from primary school onwards. Ensure accessible and inclusive delivery. Invest in teacher training. Build partnerships with civil society organisations delivering community-based CSE.

3

Empower youth as agents of change — Support youth-led campaigns on bodily autonomy and GBV. Mainstream gender-transformative content in secondary and university curricula. Invest in youth leadership for young women from underserved communities.

4

Empower girls and women through education, economic independence, and political participation — Invest in economic and political empowerment programmes. Advocate for family-friendly workplace policies. Strengthen protections against child marriage. Increase women's representation in political and decision-making bodies.

5

Engage men and boys as partners — Develop gender-transformative programmes for men and boys. Engage men in reproductive health services. Promote men's equal involvement in caregiving. Build on evidence-based approaches to engaging men in GBV prevention.

6

Break cycles of gender-based violence — Scale up community-based GBV prevention. Establish accessible and anonymous reporting mechanisms. Develop dedicated legislation on online GBV. Strengthen holistic survivor support services. Review GBV guidelines to include protocols for LGBTIQA cases.

7

Enhance access to quality healthcare for underserved groups — Increase healthcare resources in Sabah, Sarawak, and Kelantan. Expand mobile and outreach services. Mandate disability-inclusive provision. Introduce targeted subsidies for low-income women. Expand gender-affirming and HIV- and STI-related services.

8

Transform institutions to uphold, not undermine, women's bodily autonomy — Enforce informed consent protocols in healthcare. Mandate training in respectful care. Clarify inter-agency coordination in GBV response. Prohibit period checks in schools. Update health guidelines to reflect international standards on LGBTIQA wellbeing.

9

Close the gap between law and practice and strengthen legal frameworks —Invest in legal literacy campaigns. Establish a monitoring and evaluation framework to track the implementation and efficacy of GBV-related legislation. Mandate gender-awareness training for law enforcement. Review and strengthen provisions on marital rape, child marriage, online GBV, and female genital cutting. Withdraw all remaining reservations to CEDAW. Repeal laws criminalising LGBTIQA people.

10

Generate better data and sustain accountability — Commission regular disaggregated data collection on bodily autonomy. Expand research on men and masculinities. Strengthen health data collection for marginalised communities. Leverage CEDAW, SDG, and ASEAN commitments as accountability mechanisms

List of Figures

Acronym	Full Terms
ASEAN	Association of Southeast Asian Nations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DKKN	Dasar Kasih Sayang Keluarga Negara (National Family Compassion Policy)
DOSM	Department of Statistics Malaysia
DVA	Domestic Violence Act 1994
FGD	Focus Group Discussion
GBV	Gender-Based Violence
IDI	In-Depth Interview
JAKIM	Jabatan Kemajuan Islam Malaysia (Department of Islamic Development Malaysia)
JAKOA	Jabatan Kemajuan Orang Asli (Department of Orang Asli Development)
JKM	Jabatan Kebajikan Masyarakat (Department of Social Welfare)
KII	Key Informant Interview
LGBTIQA	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
LPPKN	Lembaga Penduduk dan Pembangunan Keluarga Negara (National Population and Family Development Board Malaysia)
NGO	Non-Governmental Organisation
OSCC	One Stop Crisis Centre
PEERS	Reproductive Health and Social Education (Pendidikan Kesihatan Reproduktif dan Sosial)
PEKERTI	National Policy on Reproductive Health and Social Education
ReHAK	Reproductive Health Association of Kelantan
RM	Ringgit Malaysia
SDG	Sustainable Development Goal
SIS	SIS Forum (formerly known as Sisters in Islam)
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UNFPA	United Nations Population Fund
WCC	Women's Centre for Change
WHO	World Health Organization

Glossary of Key Terms

The following key terms are used throughout this report. Definitions are provided to support consistent understanding of concepts central to the study.

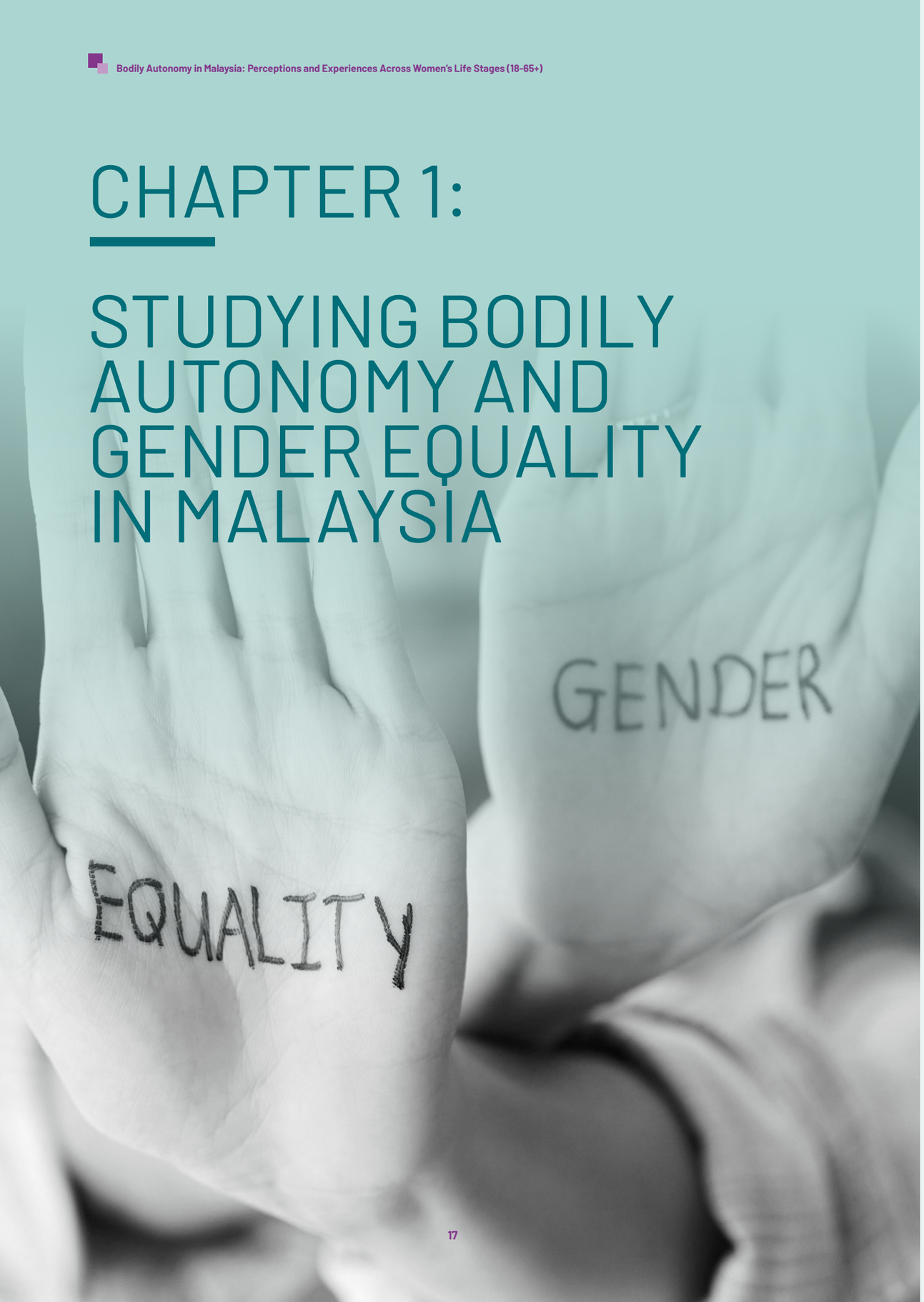
Terms	Definition
Bodily Autonomy	The right to make informed, free, and independent decisions about one's own body, encompassing choices about healthcare and reproduction, freedom from violence and coercion, the ability to determine one's own sexuality and gender expression, and access to the education and information needed to exercise these rights meaningfully.
Child Marriage / Early Marriage	Marriage in which at least one party is below 18 years of age. In Malaysia, the minimum age of marriage is 18 under civil law (with exceptions under syariah provisions in most states), and 16 for girls under syariah law with further exceptions permissible with court consent.
Comprehensive Sexuality Education (CSE)	A curriculum-based approach to teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality, aimed at equipping children and young people with knowledge, skills, attitudes, and values to protect their health, develop respectful relationships, and make informed decisions.
Contraceptive Prevalence Rate	The proportion of women of reproductive age who are using, or whose partner is using, a contraceptive method.
Cyberstalking	The use of electronic communication to repeatedly harass, intimidate, or threaten an individual, often involving monitoring of the victim's online activity.
Disaggregated Data	Data that is broken down by specific characteristics such as age, sex, ethnicity, income, or geographic location to reveal disparities that may be hidden in aggregate figures.
Doxing	The practice of researching and publicly exposing personal or private information about an individual online without their consent, typically with malicious intent.
Dual Legal System	Malaysia's system in which Muslims are subject to both civil law and syariah (Islamic) law, particularly in matters of personal status such as marriage, divorce, inheritance, and certain moral offences, administered by state-level syariah courts and religious authorities.
Female Circumcision / Female Genital Cutting (FGC)	Procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Classified by the World Health Organization as a human rights violation. In Malaysia, declared obligatory under Islamic law by the 2009 National Fatwa Council ruling, a position contested by many Islamic scholars.
Fiqh	The human body of Islamic jurisprudence — historically developed scholarly legal reasoning and rulings — as distinguished from Shariah. Fiqh is considered contingent, contextual, and open to reinterpretation, whereas Shariah refers to the immutable divine path.

Terms	Definition
Gender-Based Violence (GBV)	Violence directed against a person because of their gender or that disproportionately affects persons of a particular gender, including physical, sexual, psychological, and economic violence.
Gender Expression	The external presentation of one's gender through behaviour, clothing, hairstyle, and other factors, which may or may not correspond to socially defined norms of masculinity or femininity.
Gender Norms	Socially constructed rules and expectations about how people of different genders should behave, dress, and participate in society. These norms are learned, reinforced through social institutions, and can be a source of constraint on bodily autonomy.
Indigenous Communities / Orang Asal	The collective term for the indigenous peoples of Malaysia, comprising the Orang Asli of Peninsular Malaysia and the indigenous ethnic groups of Sabah and Sarawak. Used interchangeably with 'Orang Asal' in this report.
Informed Consent	Agreement to a procedure or decision made voluntarily, based on full and accurate information about the nature, risks, benefits, and alternatives involved, and without coercion or undue pressure.
Intersectionality	An analytical framework that recognises how overlapping social identities — such as gender, race, class, disability, religion, and age — interact to create compounding and distinct forms of discrimination and disadvantage.
Intimate Partner Violence (IPV)	Physical, sexual, or psychological harm perpetrated by a current or former intimate partner or spouse. Includes domestic violence and marital coercion.
Marital Rape	Non-consensual sexual intercourse between spouses. Not comprehensively criminalised in Malaysia; existing legal provisions remain subject to contestation.
Maternal Mortality Ratio	The number of maternal deaths per 100,000 live births in a given period, used as an indicator of the quality of reproductive and maternal healthcare.
Mixed-Methods Study	A research design that combines quantitative and qualitative methods to provide a more complete picture of a phenomenon. This study used an online survey alongside focus group discussions and in-depth interviews.
Non-Consensual Sharing of Intimate Images	The distribution of sexual or intimate images or videos of a person without their consent, sometimes referred to as 'revenge porn'. A form of online gender-based violence.
Nusyuz	An Islamic jurisprudential concept referring to a wife's disobedience or refusal of marital duties. Under syariah provisions in Malaysia, a wife's refusal of sex may be framed as nusyuz, conditioning certain spousal rights on her compliance.
Online Gender-Based Violence (OGBV)	Forms of gender-based violence that occur through digital platforms and technologies, including cyberstalking, doxing, non-consensual sharing of intimate images, online harassment, and threats of violence.

Terms	Definition
Orang Asal	The collective term for the indigenous peoples of Malaysia, comprising the Orang Asli of Peninsular Malaysia and the indigenous ethnic groups of Sabah and Sarawak, including Kadazan-Dusun, Iban, Bidayuh, and other groups. The term, meaning 'original people,' is increasingly used in policy and advocacy contexts to affirm the distinct rights, identities, and cultural heritage of Malaysia's indigenous communities. Used interchangeably with 'Indigenous Communities' in this report.
Orang Asli	The indigenous peoples of Peninsular Malaysia, comprising diverse ethnic groups with distinct languages, cultures, and traditions. A subset of the broader category of Orang Asal or Indigenous peoples.
Period Checks	The practice — reported in Malaysian schools — of teachers inspecting female students to verify whether they are menstruating, typically in relation to religious observance. Described by participants as a violation of bodily privacy and dignity.
Purposive Sampling	A non-probability sampling technique in which participants are selected deliberately based on specific characteristics relevant to the research, used in this study to ensure inclusion of underrepresented groups such as indigenous women, women with disabilities, and GBV survivors.
Reproductive Autonomy	The ability of a person to make free and informed decisions about their reproductive health and life, including decisions about contraception, pregnancy, and family formation, without coercion or undue restriction.
Sexual and Reproductive Health (SRH)	A state of complete physical, mental, and social wellbeing in all matters relating to the reproductive system, encompassing access to safe, effective, affordable, and acceptable methods of family planning, as well as access to appropriate healthcare services, information, and education.
Social Desirability Bias	The tendency of survey respondents to answer questions in a way that presents them favourably or conforms to perceived social norms, potentially leading to under-reporting of stigmatised experiences such as gender-based violence.
Shariah / Syariah	Islamic law as derived from the Quran and the Sunnah (the practices and sayings of the Prophet Muhammad). In Malaysia, syariah courts administer personal status law for Muslims in each state, covering matters such as marriage, divorce, inheritance, and certain moral offences.
Syariah Criminal Enactments	State-level legislation in Malaysia that establishes offences and punishments under Islamic criminal law applicable to Muslims. Provisions vary by state and may include penalties for 'indecent' dress, cross-dressing, and other moral offences.
Therapeutic Abortion	Termination of a pregnancy on medical or health grounds. Under Malaysian law, abortion is legal where continuation of the pregnancy would pose a risk to the physical or mental health of the pregnant woman. This provision is widely unknown among Malaysian women.
Unmet Need for Family Planning	The proportion of women of reproductive age who want to stop or delay childbearing but are not using any method of contraception.

CHAPTER 1:

STUDYING BODILY AUTONOMY AND GENDER EQUALITY IN MALAYSIA



1.1 Introduction

Women's bodily autonomy, the right to make informed, free, and independent decisions about one's own body, sits at the heart of gender equality. It encompasses choices about healthcare and reproduction, freedom from violence and coercion, the ability to determine one's own sexuality and gender expression, and access to the education and information needed to exercise these rights meaningfully. Where bodily autonomy is constrained, so too are women's broader social, economic, and political opportunities and participation.

Despite significant progress in women's educational attainment, workforce participation and political representation over recent decades, gaps in bodily autonomy persist across many societies, including those with relatively strong development indicators. These gaps are often invisible in aggregate data, masked by national averages that obscure the experiences of women, particularly those older, poorer, less educated, with disabilities, living in rural or remote areas, or from marginalised communities. Understanding the full picture requires research that is disaggregated, intersectional, and grounded in women's lived experiences.

This report presents findings from a mixed-methods study on bodily autonomy and gender equality among women in Malaysia commissioned by SIS Forum (SIS) in 2025. The SIS Bodily Autonomy Study (from here on, 'the study') was undertaken to comprehend the extent to which women in Malaysia are able to exercise meaningful autonomy over their bodies, the barriers that constrain this autonomy, and the socio-cultural, political, institutional, and structural factors that shape their experiences. Its findings are intended to inform policy, strengthen advocacy, and support efforts by government, civil society, and international partners to advance gender equality in Malaysia.

The study was commissioned against a backdrop of growing national and regional interest in gender equality, reproductive rights, and the prevention of gender-based violence. While Malaysia has committed to these goals through its ratification of United Nations (UN) international human rights conventions and adoption of related UN declarations and action plans, alongside the development of domestic legal and policy frameworks, implementation has been uneven, and significant gaps remain between formal commitments and women's everyday realities.

At the same time, there is a clear need for more meaningful and disaggregated evidence on women's bodily autonomy in Malaysia. Existing data including national health surveys, administrative data, and periodic reports to international bodies, provide valuable foundations, but tend to focus on measurable outcomes such as contraceptive prevalence rates, maternal mortality, and reported rates of GBV, without fully capturing the social, cultural, and institutional dynamics that shape these outcomes. The experiences of the most marginalised groups also remain underrepresented in national datasets, pointing to the need for more inclusive and nuanced data collection going forward.

The study addressed these gaps by combining a nationally distributed quantitative survey with qualitative research conducted with specific groups, including young women, Indigenous communities, women with disabilities, and civil society representatives, whose experiences are often absent from mainstream data. A complementary study on the experiences of LGBTIQA and gender-diverse communities was conducted in parallel, recognising that their relationship to bodily autonomy is shaped by a distinct and compounded set of barriers that a nationally representative survey alone cannot adequately capture. Together, these components provide a multi-layered picture of bodily autonomy across women of different ages and backgrounds in Malaysia, one that captures both the prevalence of specific experiences and the contextual realities that give them meaning. It is the first study of its kind in the country, and gives empirical grounding to concerns about women's bodily autonomy.

The findings of the study presented in this report are intended to serve as an evidence base for policymakers, civil society organisations, healthcare providers, educators, and others working to advance women's rights and gender equality in Malaysia. They are also intended to contribute to regional and global conversations about bodily autonomy, recognising that the challenges documented here — while shaped by Malaysia's specific social and institutional context — reflect dynamics that are shared across many societies.

1.2 Bodily Autonomy and Gender Equality

Bodily autonomy is recognised worldwide as a fundamental human right and a prerequisite for gender equality. It refers to the power and agency to make choices about one's body without fear of violence or coercion. It is closely linked to a range of other rights, including the right to health, the right to be free from violence and discrimination, the right to education, and the right to full and equal participation in public and private life.

The relationship between bodily autonomy and gender equality is reciprocal. When women are able to make free and informed decisions about their reproductive health, their relationships, and their physical expression, they are better positioned to participate fully in economic and public life. Conversely, whether through social norms, legal restrictions, institutional barriers, or interpersonal violence, constraints on bodily autonomy reinforce and entrench broader gender inequalities. The State of World Population reports produced annually by the United Nations Population Fund (UNFPA) have consistently demonstrated that countries with higher levels of women's bodily autonomy also tend to have better outcomes on a wide range of gender equality and development indicators.

Bodily autonomy is not a single, discrete concept but a multidimensional one. It encompasses at least five interconnected domains: the ability to make decisions about one's own healthcare and reproductive health; freedom from sexual violence, harassment, and coercion; autonomy over bodily appearance and gender expression; access to accurate and comprehensive information about one's body and rights; and the ability to make decisions within relationships, including about sex, marriage, and family formation. The study conducted in 2025 was organised around these domains, recognising that constraints in any one area are rarely isolated from constraints in others.

Critically, bodily autonomy must be understood as more than the absence of direct coercion. Even where formal legal protections exist, women may be unable to exercise meaningful autonomy if they lack access to information, services, economic resources, or social support; if they face stigma or judgment for the choices they make; or if the institutions they interact with — healthcare providers, schools, law enforcement — are not equipped or inclined to uphold their rights. This study therefore examines not only the prevalence of direct violations but also the social and structural conditions that enable or constrain women's ability to act on their own choices.

1.3 Bodily Autonomy and Women's Power to Decide

The UNFPA framework on bodily autonomy identifies three core components of women's power to decide: the ability to make decisions about one's own sexual and reproductive health and rights; freedom from violence and coercion; and access to the information and services needed to exercise informed choice.[1] These components are deeply interdependent. A woman who lacks access to accurate information about contraception, for example, cannot make a truly informed decision about family planning — even if no one is directly preventing her from doing so. A woman who fears violence or social judgment for her choices cannot act freely, even in the technical absence of legal restriction.

UNFPA's global data highlights the scale of the challenge. Worldwide, only around 55% of women are able to make their own decisions about sexual and reproductive health, including whether to use contraception, whether to seek healthcare and whether to say no to sex with their partner.[2] Access to information is similarly constrained: a substantial share of women in low- and middle-income countries report receiving no education about sexuality, reproduction, or bodily rights at any point in their lives.

These patterns are not confined to lower-income countries. Even in middle- and upper-income settings, women from marginalised groups — including those with disabilities, lower incomes or education, come from Indigenous or minority communities, or are older, migrant workers, refugees, asylum seekers or stateless — consistently report lower levels of bodily autonomy than their more advantaged counterparts. This underscores that bodily autonomy is fundamentally shaped by power relations whether this is within households, communities, or institutions, and that achieving it requires action at all of these levels.

The UNFPA framework was adopted as the analytical foundation for this study for several reasons. First, it is grounded in international human rights norms and has been applied across diverse national contexts, making it well-suited to situating Malaysia's experience within a broader global picture. Second, its multidimensional structure, spanning healthcare decision-making, freedom from violence, and access to information, reflects the full range of domains in which bodily autonomy is exercised or constrained. Third, it recognises that autonomy is shaped by structural conditions and power relations, not only by individual choice or formal legal rights. This orientation is particularly important in a context like Malaysia, where legal frameworks are relatively developed but implementation and social norms present significant barriers. Fourth, the framework is directly linked to the Sustainable Development Goals, particularly SDG 5 on gender equality and SDG 3 on good health and well-being. UNFPA positions bodily autonomy as both a goal in its own right and an enabler of progress across multiple SDGs. This includes education, poverty reduction, and economic participation. The framework connects individual women's experiences to the broader development agenda to which Malaysia has committed. Finally, the framework's emphasis on disaggregation, and its focus on understanding how autonomy varies across different groups of women, aligns with the intersectional approach that this study sought to apply.

1 United Nations Population Fund (UNFPA) (2025). Guidelines on Collecting Data for SDG Indicator 5.6.1 on Women's Sexual and Reproductive Health and Rights Decision-Making in National Household Surveys. Apr. United Nations Population Fund. https://www.unfpa.org/publications/guidelines-collecting-data-sdg-indicator-561-women%E2%80%99s-sexual-and-reproductive-health

2 UNFPA (2021). State of World Population 2021: My body is my own — claiming the right to autonomy and self-determination. https://www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_EN_web.3.21_0.pdf

1.4 The Malaysian Context

1.4.1 Gender Equality In Malaysia: Progress and Persistent Challenges

Malaysia is an upper-middle-income country with a strong record of economic growth and public expenditure in education and healthcare. Its Global Gender Gap Index, which has grown steadily over the past 20 years, reflects this with the country's good standing in both these spheres. Women's educational attainment has risen substantially over recent decades: women now outnumber men in university enrolment, and female literacy rates are on par with those of men. The maternal mortality ratio today has declined drastically since the 1960s, and women are also outliving men.[3]

Despite these advances, significant gender inequalities persist. Malaysia's 2025 Global Gender Gap Index has risen over the last two decades, but slowly and outpaced by most of its neighbours.[4] This is due to faring poorly on economic participation and political empowerment, despite performing relatively well on educational attainment and health outcomes. In 2025, the female labour force participation rate stands at around 56.5%, but is still far below that of men (83%).[5] They are also significantly underrepresented in senior leadership roles in both the public and private sectors, and the gender pay gap continues across most industries.

Unpaid care work falls disproportionately on women, constraining their economic and political participation and limiting their autonomy within households.[6]

These aggregate indicators, while useful, do not fully capture the diversity of women's experiences within Malaysia. The country's multiethnic and multireligious composition means that women's experiences of gender norms, legal frameworks, and social expectations vary considerably depending on their background and location. For instance, women in rural and remote areas, particularly in Sabah and Sarawak, face compounded disadvantages in access to healthcare, education, and economic opportunity. Women from Indigenous communities navigate additional layers of marginalisation, including geographic isolation, limited institutional presence, and the erosion of traditional knowledge and support structures. Women with disabilities face a distinct set of barriers, including healthcare and education systems that are largely not designed for them, reliance on intermediaries to access services and information, and social stigma that compounds their exclusion from public and economic life.

3 Malaysia. Gender Data Portal. World Bank. https://genderdata.worldbank.org/en/economies/malaysia; Ritchie, Hannah (2026). "Malaysia Country Profile: Health". *Our World in Data*. https://ourworldindata.org/profile/health/malaysia.

4 "Interactive: Malaysia's score improves for gender equality but we are still worst in Asean". *The Star*. 6 Mar 2026. https://www.thestar.com.my/news/nation/2026/03/06/interactive-malaysias-score-improves-for-gender-equality-but-we-are-still-worst-in-asean

5 Department of Statistics Malaysia (DOSM) (2025). Statistics on Women Empowerment and Malaysia Gender Gap Index, 2025. https://www.dosm.gov.my/portal-main/release-content/statistics-on-women-empowerment-and-malaysia-gender-gap-index-

6 Choong, Christopher Weng Wai, Adam Manaf Mohamed Firouz, Alyssa Farha Jasmin, Nazihah Muhamad Noor, and Rachel Gong (2019). Time to Care: Gender inequality, unpaid care work and time use survey. Kuala Lumpur: Khazanah Research Institute.

1.4.2 The Socio-Cultural and Political Context

Gender norms in Malaysia are shaped by a complex interplay of socio-cultural and political influences over time. Malaysia's ethnic and religious diversity gives rise to a plurality of gender norms, with communities each drawing on distinct cultural and religious traditions in shaping expectations of women's roles and conduct.

For Malaysia's Muslim majority, Islamic principles and interpretations play a central role in shaping expectations around women's sexuality, roles, and family life. Religious institutions, including JAKIM (the Department of Islamic Development Malaysia) and state-level religious authorities, exercise considerable influence over family law, moral regulation, and public discourse on gender, particularly in more conservative states.[7]

At the same time, Malaysia's diverse communities across Peninsular Malaysia, Sabah, and Sarawak each bring distinct gender norms rooted in their own religious, cultural, and customary traditions — with social structures and practices that in some cases offer women greater agency and in others impose specific constraints. Across communities, however, expectations around a 'good' woman — one who defers to male authority, is married, has children, and exercises sexual propriety — continue to shape women's lives, often operating alongside, and sometimes in tension with, formal legal rights and progressive social values.

The intersection of these cultural and religious influences with rapid urbanisation, digital connectivity, and exposure to global gender equality norms creates a complex and often contradictory landscape. One would expect that many women in Malaysia, particularly younger and more urban ones, hold views that are more egalitarian than those of previous generations, and are increasingly willing to challenge traditional gender norms.

However, they, like other women, also have to contend with conservative social movements that have grown in influence, bolstered by state-led politicised ethnicity and religion since the late-20th century.[8] This phenomenon peaked in the first decade of the new millennium and has contributed to the demonisation of women, but especially those younger, who do not conform to acceptable norms of femininity. Similarly painted as outcasts are those who do not fit the heteronormative model, in particular, lesbian, gay, bisexual, transgender, intersex and queer persons.[9]

Moral panics around such social 'deviants' women, focused on their 'immoral' dressing and 'unnatural' behaviour, have punctuated the nation's history and are an important reminder of how bodies of women as well as sexual and gender marginals are sites of contestation and resistance.[10] They have also generated a public discourse on gender and sexuality that is frequently narrow and contentious. The result is a society in which formal support for gender equality coexists with persistent structural and attitudinal barriers to women's bodily autonomy in practice.[11]

7 Maznah Mohamad. (2020). *The Divine Bureaucracy and Disenchantment of Social Life: A study of bureaucratic Islam in Malaysia*. Palgrave Macmillan. https://doi.org/10.1007/978-981-15-2093-8

8 Norani Othman, Mavis Puthucheary and Clive Kessler (eds.) (2008). *Sharing the Nation: Faith, difference, power and the state 50 years after Merdeka*. Petaling Jaya: Strategic Information and Research Development Centre (SIRD).

9 Cheah, E (2020). Monitoring Report: LGBTIQ+ rights in Malaysia. Kuala Lumpur: ARROW, Justice for Sisters, Gender Equality Initiative in Malaysia. https://arrow.org.my/wp-content/uploads/2021/01/LGBTIQ-Rights-in-Malaysia-.pdf

10 Shanon Shah (2022). *The Making of a "Moral" Public Sphere: Islam, media and social change in Malaysia*. Palgrave Macmillan; Ng, Cecilia, Maznah Mohamad, and tan beng hui (2006). *Feminism and the Women's Movement in Malaysia: An unsung (r)evolution*. London and New York: Routledge.

11 Women's Aid Organisation (WAO) (2021). A Study on Malaysian Public Attitudes and Perceptions Towards Violence Against Women (VAW): A summary of initial findings and recommendations. Petaling Jaya: WAO. https://wao.org.my/wp-content/uploads/2021/11/PRINT-WAO_VAW-Public-Attitudes-and-Perceptions-Report-2021_19-NOV_FINAL.pdf

1.4.3 Legal and Policy Frameworks

Malaysia has developed a substantial body of legislation and policy relevant to gender equality and women's rights, though implementation remains uneven and significant gaps persist.

The Federal Constitution guarantees equality before the law and prohibits discrimination on the basis of gender in certain contexts. However, constitutional protections for gender equality are qualified by provisions that permit discrimination under personal and customary law, and by the absence of a comprehensive anti-discrimination framework covering all public and private spheres. The constitutionally enshrined dual legal system, under which Muslims are subject to syariah law in addition to civil law, creates particular complexity for women's rights, as syariah provisions on family, marriage, and morality can in some cases conflict with civil law protections.

Key legislation relevant to the bodily autonomy of women and girls includes reforms to the rape provisions of the Penal Code (amended 1989, 2014), the Domestic Violence Act 1994 (amended 2017), which criminalises physical, emotional, and psychological abuse within marriage and family relationships; and the Sexual Harassment Act 2022, which governs harassment in the workplace.

Additionally for girls, there is the Child Act 2001, which sets out protections for children, including provisions relevant to child marriage; and the Sexual Offences Against Children Act 2017 [Act 792]. Besides rape and stalking, the Penal Code contains provisions criminalising sexual assault, and various forms of violence. The Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2007 addresses human trafficking, including for sexual exploitation.

Despite these laws, several marked disparities and challenges remain. Child marriage continues to be legally permissible under both civil and Syariah law in Malaysia. Under civil law, the minimum age of marriage is 18, but girls aged 16 may marry with the permission of the State Chief Minister. Under syariah law, the minimum age is 16 for girls and 18 for boys, with syariah courts empowered to grant permission for marriage below these ages in certain circumstances. In Sabah and Sarawak, separate ordinances and native customary laws further complicate the legal landscape. [12]

12 Sisters in Islam (2023). Child Marriage in Malaysia. https://sistersinislam.org/wp-content/uploads/2021/10/SIS_childmarriage_Final_2023.pdf

Marital rape is not comprehensively criminalised, with existing provisions subject to ongoing legal contestation;[13] the DVA excludes unmarried women in intimate partnerships from protection. Comprehensive legislation specifically addressing online gender-based violence remains underdeveloped, despite the rapid growth and seriousness of digital harassment. There are syariah provisions to punish Muslims who dress 'indecently' or 'pose' as members of the opposite gender. Along with the Penal Code, these also criminalise sexual acts that are consensual but deemed to be "against the order of nature".[14]

At the policy level, the government has adopted successive national policy frameworks on gender equality, including the National Policy on Women 2021-2025, and most recently the National Policy on Women 2025-2030 and the National Action Plan on Women, Peace and Security 2025-2030.

Malaysia's 12th Malaysia Plan (2021-2025) includes explicit commitments to improving gender equality outcomes across health, education, and economic participation.

Recognising the shortcomings in the current provision of healthcare, the Malaysian Parliament adopted the Health White Paper in 2023, which focuses on expanding accessibility, promoting a patient-centric model, and ensuring long-term sustainability.

13 Women's Aid Organisation (WAO) (2018). Marriage is Not a License to Rape: Policy brief on marital rape. WAO. https://wao.org.my/wp-content/uploads/2018/11/WAO-Policy-Brief-2018-1-Marital-Rape.pdf

14 Joint Action Group for Gender Equality (JAG), Women's Aid Organisation (WAO), and coalition partners. (2024). Joint NGO Report for the Malaysian Government's Review by the CEDAW Committee at the 88th CEDAW Session, May. https://wao.org.my/wp-content/uploads/2024/05/88th-CEDAW-Session_Malaysia-Joint-NGO-Report_April-2024.pdf

1.4.4 Islam, Gender Norms, and Bodily Autonomy

Approximately 63.5% of the Malaysian population identifies as Muslim[15]. Under Article 3 of the Federal Constitution, Islam is the religion of the Federation, while other religions may be practised in peace and harmony in any part of the Federation. For the Malay Muslim majority, Islamic teachings, institutions, and interpretive authorities exert significant influence over how questions of marriage, sexuality, reproduction, dress, and women's roles in family and society are framed and adjudicated — both through formal syariah jurisdiction over Muslims in matters of personal status, and through the broader social and moral discourse shaped by religious institutions, scholars, and community norms.

Several features of Malaysia's religious landscape are particularly consequential for women's bodily autonomy. The dual legal system is among the most significant. Muslims are subject to syariah law in addition to civil law, particularly in matters of marriage, divorce, inheritance, custody, and certain moral offences. Each of Malaysia's 13 states and the federal territories has its own Islamic Family Law Enactment and its own syariah criminal provisions, administered by state-level religious authorities and syariah courts. This produces significant variation across jurisdictions, but also a number of shared features that bear directly on bodily autonomy. While the 2018 amendment to the Law Reform (Marriage and Divorce) Act raised the civil law minimum age to 18 — with an exception allowing girls aged 16 to marry with the Chief Minister's permission — syariah enactments in most states continue to permit marriage from the age of 16 for girls, with courts empowered to grant permission below this age in certain circumstances.[16] Polygamy is permitted, subject to procedural conditions whose enforcement is uneven.

Provisions on nusyuz (wifely disobedience) condition certain spousal rights on a wife's compliance with marital duties and have been used to frame a wife's refusal of sex as a religious as well as marital infraction. These provisions reflect what Muslim feminist scholars have characterised as the classical fiqh construction of marriage as a contract of exchange patterned on the contract of sale (bay'), in which the husband's obligation to maintain his wife (nafaqah) is set against the wife's corresponding obligation of obedience and sexual availability (tamkin) — a structure sometimes referred to as the 'maintenance-obedience formula' or the 'gender contract'.[17] As noted elsewhere in this report, syariah criminal enactments in most states also penalise women for 'indecent' dress and for cross-dressing.

Equally consequential is the institutional weight of religious authorities over public discourse on gender. JAKIM, state religious departments, the National Fatwa Council, and state mufti offices issue rulings, guidelines, and educational materials that shape how Muslims and, through them, the broader public understand questions of sexuality, family, and women's roles. Friday sermons, religious television programming, and school-based Islamic Education form a substantial part of the cultural environment in which Muslim women come to understand their bodies and rights. The dominant institutional positions are not the only Islamic positions available, but they are the ones that carry the weight of state endorsement and institutional reach.

15 Department of Statistics Malaysia (DOSM) (2025). Kawasanku Dashboard. Population and Housing Census of Malaysia 2020 (MyCensus 2020). Last updated: 31 October 2025. https://open.dosm.gov.my/dashboard/kawasanku

16 UNICEF Malaysia (2020). Towards Ending Child Marriage in Malaysia. Advocacy Brief. UNICEF Malaysia. https://www.unicef.org/malaysia/media/1781/file/Advocacy%20brief:%20Towards%20ending%20child%20marriage%20in%20Malaysia.pdf

17 Mir-Hosseini, Ziba, Al-Sharmani, Mulki, and Rumminger, Jana (eds.) (2015). *Men in Charge? Rethinking authority in Muslim legal tradition*. Oneworld.

A further dimension is the regular mobilisation of religious arguments against legal and policy reforms that would advance women's bodily autonomy. Proposals to raise the minimum age of marriage to 18 across both legal systems, to comprehensively criminalise marital rape, and to reform specific provisions of Muslim family law have repeatedly encountered opposition framed in religious terms, particularly from state religious authorities and political actors positioning themselves as defenders of Islamic law. Malaysia's continuing reservations to Article 16 of CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women), which concerns equality in marriage and family life, are justified on the basis of conflict with syariah principles — a position the CEDAW Committee has repeatedly recommended Malaysia reconsider, and which a government working committee was still evaluating as recently as 2024.[18]

Taken together, these features produce a landscape in which the dominant interpretations of Islam are not simply one influence among many, but are embedded in the legal, institutional, and discursive structures that shape Muslim women's lives. They should not be read as indicating that Islam itself constrains women's autonomy, but rather that a particular set of interpretations has been institutionalised in Malaysia. As the comparative examples in Box 1 illustrate, these interpretations are contestable and changeable as seen in other Muslim-majority countries that have pursued meaningful reform from within their own Islamic legal traditions..

18 Committee on the Elimination of Discrimination against Women. (2024). Concluding Observations on the Sixth Periodic Report of Malaysia. CEDAW/C/MYS/CO/6. United Nations. https://www.ohchr.org/en/documents/concluding-observations/cedawcmysco6-concluding-observations-sixth-periodic-report

Box 1. Gender Equality and Justice in Islam

The constraints on Muslim women's bodily autonomy described in this section should not be read as the fixed or inevitable expression of Islamic teaching. A substantial body of scholarship and activism within Malaysia and globally has long argued that the dominant interpretations are neither the only nor the most defensible readings of the tradition. The central methodological distinction in this work is between shariah (the divine path, understood as immutable) and fiqh (the historical body of human juristic understanding, which is contingent, contextual, and open to reinterpretation). The laws and institutional positions that shape Muslim women's lives in Malaysia are fiqh — historically specific juristic constructions, not divine mandates — and can therefore be reformed from within the tradition.

On marriage and sexual autonomy

Progressive Muslim scholars have argued that the Qur'anic conception of marriage is grounded in mutuality *(mu'asharah bil-ma'ruf),* tranquillity *(sakinah),* and mercy *(rahmah),* as reflected in Qur'an 30:21 and 2:187. These framings are inconsistent with conceptions of marriage that treat a wife's body as perpetually available to her husband. Consent is foundational in Islamic ethics, and the concept of *nusyuz* has been read historically in ways that ignore parallel obligations on husbands and misrepresent the underlying ethical framework. On this reading, the comprehensive criminalisation of marital rape is not in conflict with Islamic principles but consistent with them.[19]

On child marriage

The protections of childhood, the requirement of full consent, and the Islamic principle of preventing harm *(lā darar wa lā dirār)* all weigh against permitting marriage below 18. Muslim-majority countries including Morocco and Indonesia have raised the minimum age of marriage on grounds explicitly rooted in Islamic ethics. Indonesia's Law No. 16 of 2019 raised the minimum age to 19 for both men and women, grounded in the principle of *maslahah* (public welfare and benefit). Morocco's 2004 Family Code *(Mudawwanah)* is a further landmark: it replaced the gender-specific maintenance-obedience framework with a single provision on the mutual rights and duties of spouses, grounded in Islamic legal tradition rather than departing from it.[20]

19 Mir-Hosseini, Ziba, Al-Sharmani, Mulki, and Rumminger, Jana (eds.) (2015). *Men in Charge? Rethinking authority in Muslim legal tradition.* Oneworld.

20 Musawah. (2020). Ending child marriage in Muslim family laws (Policy Brief No. 2). https://www.musawah.org/wp-content/uploads/2020/11/Policy-Brief-2-Ending-Child-Marriage-in-Muslim-Family-Laws.pdf

On reproductive autonomy

Classical Islamic jurisprudence contains substantial provisions permitting contraception and, under certain conditions, the termination of pregnancy.[21] Malaysia's existing legal provisions on therapeutic abortion are consistent with mainstream Sunni jurisprudence, yet the dominant public framing of abortion as religiously prohibited has obscured this from many women who would most benefit from accurate information. The framing of family planning as a private rather than religiously sanctioned matter also sits uneasily with classical jurisprudence, in which both spouses share responsibility for reproductive decisions.

On dress and bodily expression

What Islamic teachings require of Muslim women with respect to dress is the subject of substantial scholarly disagreement among classical and contemporary scholars.[22] The mobilisation of state and syariah enforcement around women's dress in Malaysia reflects one interpretation that has been institutionalised but does not represent a unanimous or settled position within the tradition.

On female circumcision

Leading Islamic scholars and institutions in many parts of the world have stated that the practice has no clear foundation in the Qur'an, is not required by the prophetic tradition as authoritatively understood, and constitutes harm rather than religious obligation. The framing of the practice as religiously obligatory in Malaysia, reinforced by the National Fatwa Council's 2009 ruling, reflects a localised interpretation contested both within Malaysia and internationally,[23] and one that stands in contrast to the World Health Organization's classification of all forms of female genital cutting as a human rights violation.[24]

21 Sisters in Islam. (2021). Islam and family planning. https://sistersinislam.org/wp-content/uploads/2021/10/booklet-islam-family-planning.pdf

22 El Fadl, Khaled Abou (2001). *Speaking in God's Name: Islamic law, authority and women.* Oneworld

23 Orchid Project (2024). Country Profile: FGC in Malaysia. Version 2. June. FGM/C Research Initiative. https://www.fgmcri.org/media/uploads/Country%20Research%20and%20Resources/Malaysia/malaysia_country_profile_v2_(june_2024).pdf; Pillai, Stephanie Shamila, Kaur, Surinderpal, Nik Nur Ainin Soffiya Nik Mat, and Syazwani Izzati Azhar (2021). A Discourse Analysis of Media Representations of Female Circumcision in Malaysia. Sisters in Islam and Universiti Malaya. https://sistersinislam.org/wp-content/uploads/2021/04/A-Discourse-Analysis-of-Media-Representatios-of-Female-Circumcision-in-Malaysia-January-2021.pdf

24 World Health Organization (2023). Female Genital Mutilation. Fact sheet. WHO. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

1.4.5 Health Programmes and Initiatives

Accessible healthcare services remain fundamental for the enjoyment of a high standard of sexual and reproductive health (SRH). Malaysia has a well-established primary care system, which is part of a widespread and highly subsidised public healthcare sector. The scope of services has expanded significantly since the early postcolonial period when healthcare policy focused mainly on rural wellbeing.[25] As of August 2024, the Ministry of Health operated 148 hospitals across the country, alongside numerous health clinics, rural health clinics, community-based health clinics, and maternal and child health clinics.[26] It also operates a One Stop Crisis Centre at emergency rooms of government hospitals, where survivors of gender-based violence can have easier access to support (e.g., medical aid, counselling, lodging police reports).

The Ministry of Women, Family and Community Development serves as the primary government body responsible for gender policy, and a network of government-linked agencies — including Jabatan Kebajikan Masyarakat (JKM) and Pusat Khidmat Masyarakat — that provides social protection services relevant to survivors of GBV.

Positively, its response to Malaysia's unmet family planning rate, among the highest in Southeast Asia, has been to prioritise ensuring that "every woman and family has access to accurate information, appropriate support, and the ability to make informed decisions about family planning". It is also seeking to get men to step up to share responsibility in this.[27]

The government's response to health and SRH concerning LGBTIQA persons revolves around HIV and STI services. As part of its efforts to end AIDS by 2030, it introduced community-friendly clinics to provide stigma-free HIV and STI services for key affected populations in 2022.[28] While representing a step in the right direction, there are a number of gaps to do with their scope and reach. Overall there is also a deep sense of mistrust in such government-run facilities, a direct result of LGBTIQA people's experiences with state-led discrimination. In fact, the demonisation, pathologisation and criminalisation of LGBTIQA persons are crucial social determinants of their health, impacting on their access to healthcare services.

25 Ministry of Health Malaysia (2019). Malaysian Healthcare System: Towards enhancing universal coverage.The 13th Meeting of the Comcec Poverty Alleviation Workshop Group. 4 Apr. https://www.comcec.org/wp-content/uploads/2021/07/8-malaysia-Turki-ppt-edited-4-april.pdf

26 Universal Health Coverage: Malaysia's progress. 22nd Asean and Japan High-Level Officials Meeting on Caring Society. 25-27 Nov 2024. https://www.mhlw.go.jp/content/10500000/001463117.pdf

27 "Men should share responsibility in family planning". *The Star*. 26 Mar 2026. https://www.thestar.com.my/news/nation/2026/03/26/menshould-share-responsibility-in-family-planning

28 Ministry of Health Malaysia (2015). National Strategic Plan for Ending AIDS (2016-2030). Putrajaya. https://www.moh.gov.my/images/04-penerbitan/pelan-strategik/58510b70ca319_compressed.pdf

1.4.6 Comprehensive Sexuality Education

Comprehensive sexuality education (CSE) refers to a curriculum-based approach to teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with the knowledge, skills, attitudes, and values necessary to protect their health, develop respectful relationships, and make informed and responsible decisions throughout their lives.

In Malaysia, sexuality education is not explicitly framed as CSE within the school system. Instead, elements of it have been incorporated into the national curriculum since 1989 through Health Education and were later formalised as Reproductive Health and Social Education (PEERS) in 2006. PEERS is taught from Year 1 to Form 5 and is integrated across subjects such as science, biology, physical education, and religious or moral studies, rather than delivered as a standalone subject. It remains the primary institutional mechanism through which students are introduced to reproductive health and social issues.[29]

At the policy level, Malaysia has developed multiple initiatives to improve adolescent access to sexual and reproductive health information and services. In 2009, the government introduced the National Policy on Reproductive Health and Social Education (PEKERTI), implemented by the National Population and Family Development Board Malaysia (LPPKN), with the aim of strengthening young people's access to SRH education, information, and services. The most recent policy document covers 2022-2025.[30] This included initiatives such as KafeTEEN centres, school-based programmes, and the integration of reproductive health modules into youth training platforms. There are currently 18 KafeTEEN youth centres nationwide and 143 KafeTEEN clubs in secondary schools.[31] The Ministry of Health has complemented these efforts through broader adolescent health policies and guidelines introduced in 2012 to promote youth-friendly SRH services in healthcare settings. However, implementation across both education and health sectors has been uneven, often depending on institutional capacity and individual providers.

29 Federation of Reproductive Health Associations Malaysia (FRHAM) and Asian-Pacific Resource and Research Centre for Women (ARROW) (2019). Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come? National Report on the State of the Region Report on Sexual and Reproductive Health and Rights: ICPD+25. FRHAM and ARROW. https://arrow.org.my/wp-content/uploads/2019/04/FRHAM-ICPD-25-Final-Report-proofread-and-formatted-Jeremy-Final.pdf

30 Lembaga Penduduk dan Pembangunan Keluarga Negara (LPPKN) (n.d.). Dasar dan Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial Kebangsaan (PEKERTI) [National Policy and Action Plan on Reproductive and Social Health Education]. https://www.lppkn.gov.my/lppkngateway/frontend/web/index.php?r=portal/article&menu=3&id=SnlwSyt2Z1R2aUJZQ25lc1BWb3l3Zz09

31 "Nearly 17,000 unmarried teenagers pregnant in Malaysia over four years." New Straits Times. 20 Nov 2020. https://www.nst.com.my/news/nation/2025/11/1318994/nearly-17000-unmarried-teenagers-pregnant-malaysia-over-four-years

Within schools, existing research suggests that the delivery of sexuality education under PEERS is inconsistent and limited in scope.[32] Teaching tends to focus heavily on biological aspects such as anatomy and disease prevention while offering minimal engagement with topics such as relationships, consent, communication, and decision-making skills. The curriculum adopts a largely abstinence-oriented approach, reflecting dominant social and religious norms, with contraception addressed only briefly within the context of marriage, and topics such as abortion generally not discussed. As a result, many students report limited exposure to meaningful or practical sexuality education, with the quality of learning often dependent on individual teachers' comfort and willingness to engage with sensitive topics. The new guidelines for PEERS introduced in November 2024 appear to signal a shift in this direction, placing greater emphasis on content more closely aligned with comprehensive sexuality education. A 2025 directive by the Minister of Education calls for the increase of PEERS module teaching time allocation starting in the 2027 curriculum.[33]

More recently, the government has introduced the National Family Compassion Policy (DKKN) 2026-2030 and the National Action Plan on Children (2026-2030), signalling continued commitment to family wellbeing and child protection. While these policies play an important role in strengthening support systems for children and families, their focus is largely framed around protection, moral development, and social cohesion. It remains to be seen to what extent these frameworks will incorporate rights-based, comprehensive sexuality education and meaningful attention to adolescents' sexual and reproductive health and bodily autonomy.

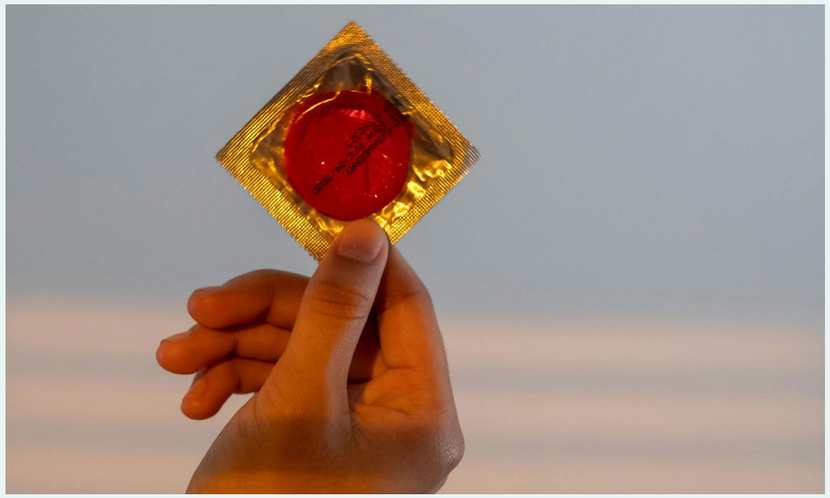
32 ARROW (2019). *Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?*

33 "MOE to increase PEERS module periods in 2027 to combat sexual harassment". *Bernama.* 13 Jun 2025

Box 2. Adolescent Sexual and Reproductive Health in Malaysia

National health data points to notable gaps in adolescent sexual and reproductive health knowledge and behaviour. The National Health and Morbidity Survey 2022: Adolescent Health Survey found that 7.6% of Malaysian adolescents aged 13-17 reported having had sexual intercourse, with higher prevalence among boys (9.2%) than girls (6.0%). Among those who were sexually active, nearly one in three (32.8%) reported sexual debut before the age of 14, and only 11.8% reported using condoms during their last sexual encounter. Knowledge of sexual health remains critically low, with only 1.3% of adolescents demonstrating adequate knowledge of HIV prevention.[34]

The consequences of these gaps are reflected in pregnancy data. Between 2020 and 2024, a total of 16,951 unmarried teenagers aged 19 and below were recorded as pregnant at government healthcare facilities. When married adolescents are included, the total number of teenage pregnancies during this period reached 41,842.[35] Together, these figures underscore the urgent need for accessible, inclusive, and effective sexuality education and reproductive health services for young people in Malaysia.



34 Institute for Public Health (2022). Technical Report: National Health and Morbidity Survey (NHMS) 2022: Adolescent Health Survey, Malaysia. National Institute of Health, Ministry of Health Malaysia. https://iku.nih.gov.my/images/nhms-2022/Report_Malaysia_nhms_ahs_2022.pdf

35 "Nearly 17,000 unmarried teenagers pregnant in Malaysia over four years." *New Straits Times*. 20 Nov 2020. https://www.nst.com.my/news/nation/2025/11/1318994/nearly-17000-unmarried-teenagers-pregnant-malaysia-over-four-years

1.4.7 Malaysia's Commitment Under International Human Rights Law

Malaysia ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995, committing itself to eliminating discrimination against women in all its forms and to taking active measures to promote substantive gender equality. CEDAW requires state parties to ensure women's equal access to healthcare, education, and economic opportunity; to address gender-based violence; and to reform laws and practices that discriminate against women, including in the areas of marriage and family life.

However, Malaysia ratified CEDAW with reservations on several key provisions still remaining, including articles 9 (2), 16 (1) (a), (c), (f), and (g), which relate to nationality, marriage, and family rights.[36] These reservations, which reflect the perceived incompatibility of certain CEDAW provisions with Islamic law and customary practice, have been a longstanding subject of concern in Malaysia's periodic reviews before the CEDAW Committee.

Malaysia has been repeatedly urged to withdraw its reservations and to bring its domestic legal framework — including provisions on child marriage, marital rape, and syariah-civil law conflicts — into full compliance with the Convention. Malaysia ratified the Convention on the Rights of the Child (CRC) in 1995, committing to protect children from discrimination, abuse, and exploitation, and to ensure their right to health, education, and participation in decisions that affect them.

In the context of this study, the CRC is particularly relevant to findings on child and early marriage, bodily autonomy violations in school settings, and the adequacy of sexuality education — areas where children's rights to protection, information, and dignity intersect directly with the issues examined here.

In 2010, Malaysia ratified the Convention on the Rights of Persons with Disabilities (CRPD), obligating the state to ensure that persons with disabilities enjoy equal access to healthcare, education, and legal protection, and are free from exploitation, violence, and abuse. The findings of the SIS Bodily Autonomy Study indicate that women with disabilities continue to face significant barriers to realising these rights in practice, including in healthcare settings, educational institutions, and access to information.

Malaysia has also adopted the Beijing Platform for Action, the Sustainable Development Goals (that includes SDG 5 on gender equality and SDG 3 on good health and well-being), and the ASEAN Declaration on the Elimination of Violence Against Women and Violence Against Children. These provide an important framework for assessing progress and identifying areas where national law and practice fall short of international standards.

36 While Malaysia's reservation to article 9(2) remains for now, a 2024 constitutional amendment and subsequent court settlement in 2025 have significantly addressed discrimination against Malaysian mothers seeking to confer citizenship to their overseas-born children. This has brought practice closer to CEDAW requirements, even as the formal reservation remains in place.

CHAPTER 2:

METHODOLOGY

The SIS study employed a mixed-methods approach designed to capture both the breadth and depth of women's experiences of bodily autonomy in Malaysia. A nationwide quantitative survey formed the primary data source, supplemented by qualitative fieldwork comprising focus group discussions, in-depth interviews, and key informant interviews. A smaller male comparator sample was also included to provide contextual insight into broader societal attitudes toward gender roles and bodily autonomy.

A complementary study on the experiences of LGBTIQA and gender-diverse communities was conducted in parallel. Together, these components provide a multi-layered picture of bodily autonomy in Malaysia, in particular for women across diverse populations, life stages, and social contexts.

2.1 Nationwide Study

2.1.1 Quantitative Survey

A nationwide quantitative survey was administered online to a representative sample of women aged 18 and above across Malaysia, with an estimated completion time of 15-20 minutes. A male comparator sample was also included, drawn from the same survey instrument, to capture men's experiences of and attitudes toward bodily autonomy. This provided both a contextual lens on broader social norms and insight into how bodily autonomy is understood and experienced across genders. The primary focus of this study, however, remained women's lived experiences of bodily autonomy in Malaysia

The questionnaire covered several thematic areas: key decision-making factors influencing bodily autonomy; cultural, family, and religious influences; awareness of and access to reproductive health information; challenges in exercising autonomy in contexts such as at home, sexual relations, school and workplace; perceptions of legal and policy frameworks; expectations of and gaps in support systems; preferred sources of information and support; and the influence of media and peer networks on gender norms.

For the male sample, additional questions explored men's perspectives on bodily autonomy, family planning, and shared household decision-making.

Respondents were recruited through online survey panels between September and October 2025. Participation was voluntary and responses were collected anonymously. Data quality checks were implemented throughout, including the removal of incomplete responses and verification of response consistency.

2.1.1.1 Sampling Approach

The study achieved a total sample of 1,100 respondents, comprising 1,004 women, 92 men, and 4 non-binary or gender-undeclared respondents. Respondents were recruited across Malaysia to ensure representation across major ethnic groups as well as urban and rural populations across both Peninsular and East Malaysia, in line with Department of Statistics Malaysia (DOSM) classifications. The target profile encompassed women across different life stages and age cohorts, enabling the study to capture a broad range of experiences and perspectives.

2.1.1.2 Achieved Sampling Distribution

Among female respondents (n=1,004), the age distribution was as follows: 18-24 years (204), 25-34 years (262), 35-44 years (231), 45-54 years (185), 55-64 years (93), and 65 years and above (29). This ensured representation across early adulthood, mid-life, and later adulthood.

For the male sample (n=92), the distribution was: 18-24 years (16), 25-34 years (25), 35-44 years (27), 45-54 years (18), 55-64 years (2), and 65 years and above (4). The male sample was included primarily to provide contextual insights into societal attitudes toward bodily autonomy, rather than as a statistically representative population sample.

2.1.1.3 A Note on Reporting Conventions

Throughout this report, quantitative findings are described using standardised language to ensure consistency and avoid overstating or understating results. The following thresholds apply:

Term	Threshold
Almost all / Nearly all	90% and above
A large majority	75-89%
A majority / Most	51-74%
Around half	45-55%
A substantial minority	30-44%
A notable minority	15-29%
A small proportion	5-14%
A very small proportion	Under 5%

Percentages are always provided alongside descriptive language. The term 'significant' is used in its everyday rather than statistical sense throughout this report and has been largely replaced with more precise descriptors — 'notable', 'substantial', or 'meaningful' — to avoid ambiguity. Where findings are described as 'prevalent', this refers to experiences reported by at least 30% of the relevant group.

2.1.2 Qualitative Component: Focus Group Discussions, In-Depth Interviews, Key Informant Interviews

The qualitative component comprised Focus Group Discussions (FGDs), In-Depth Interviews (IDIs), and Key Informant Interviews (KIIs), conducted between September 2025 and January 2026. Sessions typically lasted 60-120 minutes, held virtually or in person. Together they enabled the study to capture collective social norms through FGDs and individual, nuanced perspectives through IDIs and KIIs — particularly important for sensitive topics such as reproductive health, relationships, and gender-based violence.

2.1.2.1 Focus Group Discussions

Six FGDs were conducted with specific population segments to capture group-level dynamics, social norms, and shared narratives. Participant groups included young women aged 18-35; Orang Asal from Peninsular Malaysia and Sabah and Sarawak; CSE educators; persons with disabilities, including members of the Deaf community with a sign language interpreter; and men aged 40 and below. Sessions were conducted primarily via virtual platforms.

2.1.2.2 In-Depth Interviews

Twelve IDIs were conducted with a diverse range of participants, including women across different age groups and life stages; men from urban and semi-urban settings; individuals from diverse ethnic and religious backgrounds; civil society representatives and women's rights advocates; survivors of gender-based violence (where ethically appropriate); persons with disabilities; and academics, health practitioners, and community leaders with expertise in gender and policy. IDIs were held virtually or in person according to participant preference and accessibility needs.

2.1.2.3 Key Informant Interviews

Ten KIIs were conducted with individuals whose professional roles, specialist knowledge, or lived experience gave them particular insights into the study's themes. Key informants included experts in sexual and reproductive health and rights; specialists in comprehensive sexuality education; medical practitioners in reproductive and maternal healthcare; representatives of organisations working on women's rights and gender-based violence; and disability advocates. A flexible interview guide allowed conversations to follow each informant's area of expertise while remaining anchored to the study's core questions on bodily autonomy policy and practice in Malaysia.

Together, the FGDs, IDIs and KIIs enabled deeper exploration of personal experiences related to bodily autonomy and decision-making; barriers in accessing healthcare, information, and support; cultural, religious, and societal influences on individual agency; and sensitive topics including relationships, consent, and gender-based violence.

2.2 Complementary Research

In parallel to this national study, SIS commissioned a dedicated research project exploring bodily autonomy within the LGBTIQA and gender-diverse community in Malaysia. This complementary study was undertaken in recognition that these individuals face a distinct and compounded set of barriers to bodily autonomy — navigating not only the systemic challenges experienced by women broadly, but also the additional layers of legal criminalisation, social stigma, and institutional exclusion that disproportionately affect this community. Their experiences, while connected to the broader landscape of bodily autonomy in Malaysia, require specific and focused inquiry that a nationally representative survey alone cannot adequately capture.

The complementary research also employed a mixed-methods approach. An online survey was conducted between 2 November and 2 December 2025, gathering responses from 142 LGBTIQA participants across a range of gender identities and sexual orientations. This was supplemented by in-depth interviews with seven key informants from LGBTIQA communities and service providers, conducted between 14 and 19 January 2026. The key findings of this study have been incorporated into this report to better reflect the full spectrum of bodily autonomy experiences in Malaysia, including those of its most marginalised communities.

2.3 Ethical Considerations

Given the sensitive nature of the subject matter, encompassing gender-based violence, reproductive health, bodily autonomy, and personal experiences of discrimination, ethical considerations were central to the design and implementation of this study.

Informed consent was obtained from all participants prior to involvement. Survey respondents were informed of the study's purpose, the voluntary nature of participation, and their right to withdraw at any point. For qualitative participants, consent was obtained verbally and in writing, with care taken to explain how data would be used and stored. Confidentiality was maintained throughout: survey responses were collected anonymously, qualitative participants were assigned pseudonyms, and any identifying details were removed from transcripts and reporting.

Questionnaire items and discussion guides were reviewed to ensure sensitivity and avoid risk of trauma, and facilitators received training to respond appropriately to sensitive disclosures. Information on relevant support services and hotlines was made available to all participants.

Accessibility and inclusion were treated as core ethical obligations. FGDs with Deaf participants were conducted with the support of sign language interpreters, and materials were adapted where necessary to ensure that participants with disabilities were able to engage fully.

All data was stored securely in accordance with applicable data protection standards, with access restricted to the core research team. Qualitative recordings and transcripts were retained only for the duration required for analysis and handled in line with established protocols for sensitive research data.

The research instruments were reviewed and verified by an external panel consisting of subject experts.

2.4 Limitations

While this study provides valuable insights into women's bodily autonomy and related experiences in Malaysia, a number of limitations should be noted when interpreting the findings.

Sampling constraints. The quantitative survey was conducted using an online panel, which may have introduced selection bias toward respondents with internet access, higher digital literacy, and greater familiarity with online platforms. This may have resulted in the underrepresentation of older women, those in rural or remote areas, and individuals from lower-income backgrounds or with less digital familiarity — groups that are also likely to face greater constraints on bodily autonomy. Findings should therefore be interpreted as indicative rather than fully representative of the national population.

Self-reporting bias. As with all self-reported data, responses may be influenced by social desirability, particularly on sensitive topics such as gender-based violence, sexual experiences, and reproductive decision-making. Respondents may have underreported experiences that carry social stigma or legal risk, or may have provided responses that they perceived to be more socially acceptable. This is likely to result in an underestimation of the prevalence of certain experiences, including harassment, coercion, and constrained autonomy.

Underrepresentation of marginalised groups. Despite efforts to include diverse population segments, certain groups remain difficult to reach through standard recruitment methods. Women without stable internet access, those in deeply rural or Indigenous settings, undocumented individuals, and those in highly restrictive domestic environments are less likely to have participated. The qualitative component partially addresses this through purposive sampling of Indigenous and women with disabilities communities, but the overall study should not be taken as fully capturing the experiences of these groups. While the quantitative survey allowed respondents to self-identify their gender — not sexuality — this assumed a certain level of comfort to do so. Implicit also were questions to capture experiences of sexual and gender marginals but only as a collective category, not individual identities.

Male sample size. As noted, the male sample (n=92) is relatively small and was not designed to be statistically representative. Findings from the male sample provide useful contextual insights but should not be interpreted as generalisable to men in Malaysia more broadly.

Qualitative scope and transferability. The qualitative component, while rich in depth, was conducted with a limited number of participants across specific population groups. Findings from FGDs and IDIs reflect the perspectives of those participants and are not intended to be representative of all women in those groups. They are best understood as illustrative of particular experiences and social dynamics, offering context for the quantitative findings rather than standing as independent evidence of prevalence.

Intersectionality. While the study captures variation across key demographic variables such as age, ethnicity, income, and location, it was not designed to undertake a fully intersectional analysis. The compounding effects of multiple overlapping identities and structural disadvantages — for example, being an older, low-income, rural, Indigenous woman — may not be fully captured in the analysis and warrant further dedicated research.

CHAPTER 3:

WHAT THE DATA REVEALS

Key Findings

1. **Most women can access healthcare, but inequalities persist**

   Sixty-eight percent of women report having access to healthcare when needed. However, a substantial minority (32%) experience limited access, including 11% who report no access at all. Access is particularly challenging for women who are poor, have only up to secondary-level education, and are outside the 25-44 year old bracket, i.e., older women and younger women. State-wise, women in Sabah (50%) and Sarawak (44%) have the most limited access, but Terengganu has the highest percentage of women with no access at all (21%).

2. **Affordability and the quality of healthcare remain important concerns**

   Public hospitals and clinics are the most preferred healthcare choice for 44% of the respondents; another 34% used a combination of public and private facilities. The most common challenges to access are cost, along with transportation and distance issues. Inadequate quality of services are especially significant for vulnerable populations including Indigenous women and women with disabilities. For LGBTIQA persons, poor access is also attributed to a lack of appropriate services, fear of discrimination and a trust deficit.

3. **Reproductive healthcare services are critically underutilised**

   Only 47% of women surveyed have previously needed reproductive healthcare services (excluding contraception). Utilisation is lowest among students (86%), unemployed (69%), and those living in Kelantan (67%). Among Indian (66%) and Chinese women (63%), usage is also very low (Malay women, 50%). The same pattern is seen with contraceptive uptake: only 44% of women reported having needed contraception before.

4. **Women bear disproportionate responsibility for contraception, but decision-making is shaped by income, education and religion**

   The burden of contraceptive decision-making is borne by women — 58% report being primarily responsible for decisions about its usage, 27% share decision-making with their spouse or partner. Responsibility for actual contraceptive usage is highest among women who are primary income earners (78%), have full-time employment (65%), and are university-educated (62%). Among Muslim women, only 8% report that their spouse or partner takes primary responsibility for contraception compared with 19% of Christian women.

5. **Most women do not know what the law on abortion allows**

   Therapeutic abortion is legal in Malaysia under certain circumstances, yet fewer than half of women (45%) are aware of this. One in five (21%) believes abortion is entirely illegal. A further 24% believe it is completely outlawed for Muslim women — rising to 31% among Malay and Muslim women, and 42% in Kelantan. Only one in three women (34%) knows how to find information about abortion services. Groups that tend to face greater barriers to health information are the same ones who show the least knowledge: women with low incomes and formal education, full-time homemakers or caregivers, unemployed, and from Sabah – which has the lowest rate of awareness across all states (25%).

6. Most women report agency over marriage decisions, but financial dependence significantly limits this

A substantial majority of women believe the decision to marry (78%), when to marry (67%), and whom to marry (70%), was largely their own. However, those who are students, caregivers or homemakers, or earning under RM1,000 per month are considerably more likely to report that parents or family members made these decisions for them. Among women earning under RM1,000, 21% say their parents primarily decided their marriage.

7. Sexual autonomy within marriage or an intimate relationship is the most constrained domain in the study

Only 52% of women currently married or in a sexual relationship report being able to refuse sex with their spouse or partner. A further 37% can do so only sometimes, and 6% cannot refuse at all. Malay and Muslim women (44%) are least able to refuse sex next to roughly three-quarters of Chinese and Indian women. Educational attainment and income also influence this outcome. For instance, an even smaller proportion of women with secondary education (37%) are able to say no to sex (versus 60% of tertiary educated women). The three most common reasons for not refusing sex are the belief that sex is a marital duty (68%), religious beliefs (59%), and fear of partner anger (14%).

8. Malaysia's overall bodily autonomy score falls well below regional peers, driven primarily by women's limited power to refuse sex.

Benchmarked against UN SDG indicator 5.6.1 — which measures the proportion of women able to make their own informed decisions across three dimensions of sexual and reproductive health: healthcare, contraception, and the ability to refuse sex — Malaysia's composite bodily autonomy score of 45% falls below both the global average (55%) and the East and Southeast Asia (ESEA) regional average (76%). Women in Malaysia perform comparably to regional peers on decisions about contraception (93%, vs. 94% regionally) and healthcare (92%, vs. 92% regionally), but lag considerably on sexual autonomy: only 51% report being able to say no to sex with a spouse or partner, compared to 86% regionally and 75% globally.

9. Sexual violence against women is widespread, younger women most affected

While 53% report no such experience, 43% have experienced at least one form of violation (4% prefer not to say). The most commonly reported forms are inappropriate touching (24%) and unwanted sexual comments or gestures (21%), followed by online sexual harassment (17%), physical stalking (9%), and coerced or forced sex (6%). Younger women are most affected: unwanted sexual comments are most prevalent among women aged 18-24 (29%), and inappropriate touching peaks among those aged 25-34 (30%). Among LGBTIQA respondents, a large majority (78%) reported experiencing some form of GBV.

10. Most sexual violence incidents go unreported

Among those who experienced sexual harassment or violence in the last 12 months, only 36% reported it to any authority. The main barriers are the perception that the incident was not serious enough (35%), fear of not being believed (33%), shame or stigma (32%), and lack of trust in authorities or past negative experiences (30%). Only 5% of LGBTIQA survivors reported incidents due to an acute mistrust of formal institutions.

11. Confidence in Malaysia's legal framework for addressing GBV is limited

While 51% of women believe existing laws offer adequate protection, 40% do not — suggesting that for a significant proportion of women, the law is not perceived as a reliable safeguard. Male respondents expressed greater confidence at 62%, though nearly a third (32%) remained unconvinced. These findings suggest that legal reform alone is insufficient; stronger enforcement, more accessible redress mechanisms, and broader public awareness of legal protections are all needed to close this gap.

12. Online gender-based violence is widespread and growing, particularly among younger women

A substantial minority (41%) reported experiencing at least one form of online GBV — including unwanted sexual messages or images (33%), cyberstalking (13%), non-consensual use of images (9%), doxing (8%), and threats of violence (7%). Among LGBTIQA respondents, nearly three-quarters (73%) reported experiencing online GBV. Approximately one in two women aged 18-24 has received unwanted sexual content online. Beyond direct experience, 63% of women avoid sharing photos of themselves online due to fear of harassment — a pervasive form of self-censorship that limits women's public participation.

13. Female circumcision is widely viewed as religiously obligatory, despite contested evidence

A majority of respondents (57%) view female circumcision as religiously obligatory, while 21% consider it harmless and 14% view it as cultural. Opposition is limited: only 9% describe the practice as harmful and 11% support its legal prohibition. These findings reflect the significant influence of institutional religious framing on public attitudes — and point to the need for more accurate, accessible, and evidence-based public information on the practice.

14. Most women support freedom of dress in principle, but many cannot exercise it in practice

Nearly four out of five (78%) women respondents agree that women and men should be free to choose how they dress. Only 54%, however, report always being able to dress as they wish without fear of judgment or restriction. Younger women and students are the most constrained — only 30% of students and 40% of women aged 18–24 report full freedom of dress.

15. One in three women has faced adverse reactions for what she wears

Thirty-one percent of women have experienced criticism, punishment, or restriction because of their clothing — from their family, community, employer, school, or the authorities. This is more pronounced among students (49%), younger women (45%), and those living with parents (44%). Religious expectations are identified as the most restrictive influence by 51% of women overall, rising to 79% in Terengganu and 66% in Kelantan. Among LGBTIQA respondents, a large majority (81%) reported having experienced such discrimination because of their gender expression.

16. A notable proportion of LGBTIQA respondents have been subjected to forced conversion or therapy

A third (34%) of LGBTIQA respondents experienced pressure to change their sexual orientation or gender identity, and 12% reported being forcibly subjected to therapy or institutionalisation without consent. Among the general women's sample, only 3% reported being pressured to undergo psychological therapy or committed to a medical facility without their consent — four times lower than the LGBTIQA rate.

17. School-based bodily autonomy violations are recent and widespread

One in four women (23%) reports period checks conducted by teachers — rising to 31%-36% among women aged 18-34, indicating these are recent rather than historical practices. Fourteen percent report pressure to wear the hijab in school, and 9% report sexual harassment within school settings. Only 41% of respondents believe schools reliably provide safe environments that respect students' bodily autonomy.

18. There is near-universal support for comprehensive sexuality education in schools

Despite — or because of — these gaps in provision, 88% of women and 85% of men support the implementation of comprehensive sexuality education in Malaysian schools. Support was highest among women aged 35-44 (93%) and those aged 25-34 (89%) — age groups that broadly correspond to those most likely to have school-going children. This is among the strongest consensus findings in the study.

19. The internet has become the primary source of information about bodily autonomy and reproductive health, though schools remain an important space

The internet is the most commonly cited source among women respondents (63%), ahead of media (49%), parents or caregivers (41%), and the school syllabus (40%). Reliance on the internet was particularly high among younger women — 70% of those aged 18-24 and 72% of those aged 25-34. Among men, 49% cited the school syllabus as a source — notably higher than among women — suggesting that schools continue to reach younger generations and remain an important, if underutilised, space for delivering information on bodily autonomy and reproductive health.

3.1 Healthcare and Reproductive Healthcare Services

Access to healthcare — and the ability to make informed, independent decisions within healthcare settings — is a foundational dimension of bodily autonomy. For women, this encompasses not only general health services but the full range of sexual and reproductive healthcare including contraception, maternal care, menopause-related therapy, preventive screening, and access to safe and legal abortion. Whether a woman can access these services, whether she is treated with respect when she does, and whether she is given the information needed to make her own decisions – these are not merely questions of healthcare access and quality, they are a matter of rights. This section examines how women in Malaysia experience healthcare access and decision-making across general, reproductive, and maternal health, and what the findings reveal about the gap between formal provision and women's ability to exercise meaningful autonomy over their own health.

3.1.1 Affordability Shapes Healthcare Choices

The survey findings show that government hospitals and clinics are the preferred source of healthcare with 44% of women respondents solely relying on this, while a further 34% used a combination of both public and private service providers.

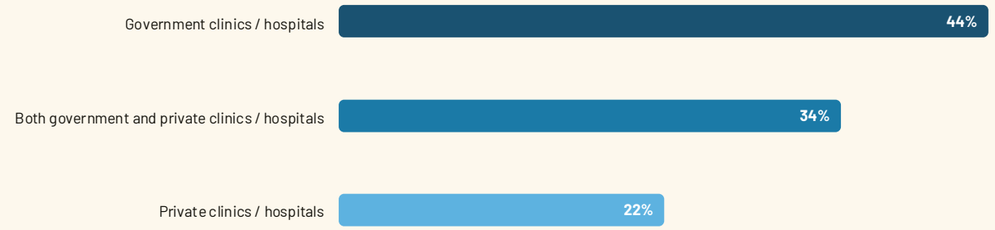
Malaysia's two-tiered healthcare system helps explain this result. Public healthcare services — largely financed by federal government tax revenue — offers basic healthcare at minimal cost, with secondary and tertiary services requiring only nominal fees.[37]

In contrast, around one-fifth (22%) of the women respondents surveyed relied primarily on private hospitals and clinics, where services are financed through out-of-pocket payments or private health insurance.

The most frequent users of private healthcare tend to be among women with a monthly salary of RM5,000 or more (34%), or have university education (29%). For those living in Kuala Lumpur, reliance on private services (39%) far exceeded that of public hospitals and clinics (23%). This may reflect the greater concentration of private providers in the capital, and higher income levels among some of its residents.

Main Sources of Healthcare Services Used by Women

Figure 1: Women respondents by type of healthcare facility (%)



Question: B1.3: Which of the following is your main source of healthcare services? (Single Answer)

Base: Women (n=1,004)

37 Siaw, Timothy and Hon, Yee Neng (n.d.). "Healthcare Financing and Reimbursement: A global review of major topics and trends". IBA Healthcare and Life Sciences Law Committee. Healthcare Financing and Reimbursement Survey — Malaysia. https://www.ibanet.org/document?id=Healthcare-Survey-2025-Malaysia

While healthcare currently remains affordable for many women in Malaysia, sustaining this is pending the government's ability to address a number of existing and emerging challenges (Box 3).

Box 3. The Future of Women's Wellbeing in Malaysia

Malaysia's Universal Health Coverage (UHC) index has steadily improved, reaching 80 in 2023, above the global average of 71.[38] Despite this progress, long-term underfunding in the public healthcare sector has created persistent challenges, including staff shortages, heavy workloads, and infrastructure gaps.[39]

This may explain why although a majority of survey respondents rated the quality of healthcare services they used most as 'good'; around one-third regarded this as only 'adequate'.

Cost remains a key barrier. In his report on Malaysia a decade ago, the United Nations Special Rapporteur on Health cautioned that "affordability has become a key challenge in ensuring universal access to quality health care".[40] Nearly ten years later, the 2023 National Health and Morbidity Survey reported that 12.9% of individuals with unmet healthcare needs cited affordability as the main reason.[41] The survey findings mirror this trend.

More worrying, long-term government underspending in public healthcare, rising rates of non-communicable diseases, an ageing population, and high medical inflation are placing tremendous pressure on the sustainability of Malaysia's healthcare system today.[42]

Without greater investment in universal healthcare and sexual and reproductive health services, some groups like older women may be disproportionately affected and face worsening health outcomes. Although women tend to live longer than men, they often do so with fewer financial resources due to longstanding gender inequality (e.g., gender wage gap, burden of unpaid care work, etc.).[43] Consequently, they risk experiencing poorer health while requiring more healthcare services in later life.

38 UHC Service Coverage Index. WHO Data. https://data.who.int/indicators/i/3805B1E/9A706FD

39 Ilyana Mukhriz, Teoh Ai Ni, and Puteri Marjan Megat Muzafar (2022). "Increase financing to strrengthen Malaysia's public healthcare system". Khazanah Research Institute. 10 Nov. https://www.krinstitute.org/publications/increase-financing-to-strengthen-malaysias-public-healthcare-system

40 Human Rights Council (2015). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, Addendum, Visit to Malaysia (19 November–2 December 2014). 1 May, A/HRC/29/33/Add.1, https://docs.un.org/en/A/HRC/29/33/Add.1

41 Institute for Public Health (2024). National Health and Morbidity Survey (NHMS) 2023: Non-Communicable Diseases and Healthcare Demand - Key Findings. Shah Alam: Institute for Public Health. MOH/S/IKU 221.24(IL)-e. https://iku.nih.gov.my/images/nhms2023/key-findings-nhms-2023.pdf

42 "13MP Vision For Health Simply Not Bold Enough". *Code Blue*. 1 August 2025. https://codeblue.galencentre.org/2025/08/13mp-vision-for-health-simply-not-bold-enough/; Mohd Arshil Moideen, Wan Nadiah Wan Mohd Abdullah Yaakob, and Khasnur Abd Malek (2025). "Towards a Sustainable Healthcare System: A concept paper for a national hybrid financing model for Malaysia". *International Journal of Health Policy and Management. 14 Sept:9223.* doi: 10.34172/ijhpm.9223.

43 Pfordten, Diyana (2025). "The growing gender gap among Malaysia's older workers. *The Star*. 22 Sept.

3.1.2 Relatively Accessible and Good Healthcare, but Inequalities Persist

> *"There are many cases of death because emergency treatment could not be administered in the clinic. This is the reality for villagers in the interior of Sabah because of a lack of infrastructure.*
> *[Orang Asal participant, FGD]*
>
> *Government healthcare is frustrating because staff often do not provide explanations, I feel clueless. Additionally, the crowded environment and emphasis on moving patients quickly make the experience even more challenging.*
> *[Deaf participant, FGD]*
>
> *It is difficult. Depending on where you stay, KKM staff... they don't have disability awareness.*
> *[Blind researcher and disability advocate, KII]*

Healthcare services are generally accessible and widely perceived as being of satisfactory standard. The majority of women surveyed (68%) believed that they have had access to healthcare when needed, and only 1% rated the quality of these services as 'poor'. Even so, it should be noted that roughly one in three women (32%) believed their quality to be just 'adequate', and only 13% rated this as 'excellent'. In short, there is still room for improvement.

Unequal Access Across Social Groups

More importantly, despite generally high levels of healthcare access, the survey revealed notable inequalities.

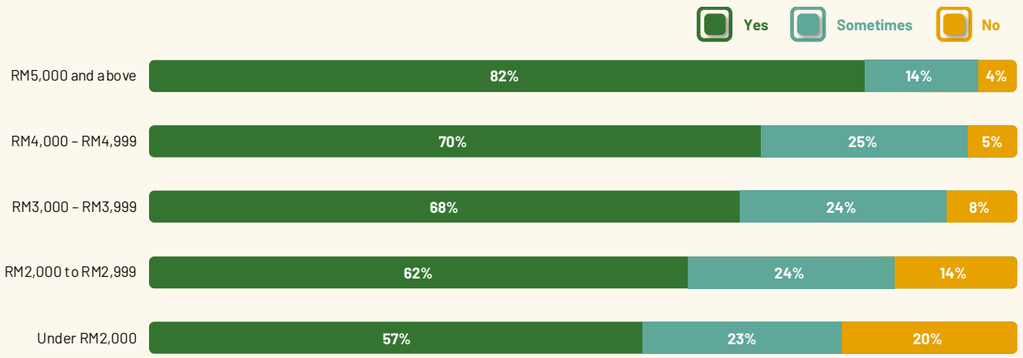
Around one-third of women respondents (32%) experience limited access to healthcare services, 21% had access only 'sometimes' while 11% reported having had no access at all.

Access varied by income, formal education, age, and geographical location. Women who earned more, had university degrees, fell within the 25-44 age bracket, or lived in Peninsular Malaysia, were more likely to report reliable access to healthcare providers.

For example, 82% of women with higher incomes (earning RM5,000 and above per month) found healthcare accessible next to 57% of women earning less than RM2,000 per month. Among those who are employed, a smaller percentage reported having difficulties accessing healthcare services, compared with 29% of unemployed respondents and 21% of homemakers or caregivers.

Access to Healthcare Services

Figure 2: Women respondents who reported having access to healthcare services by income (%)



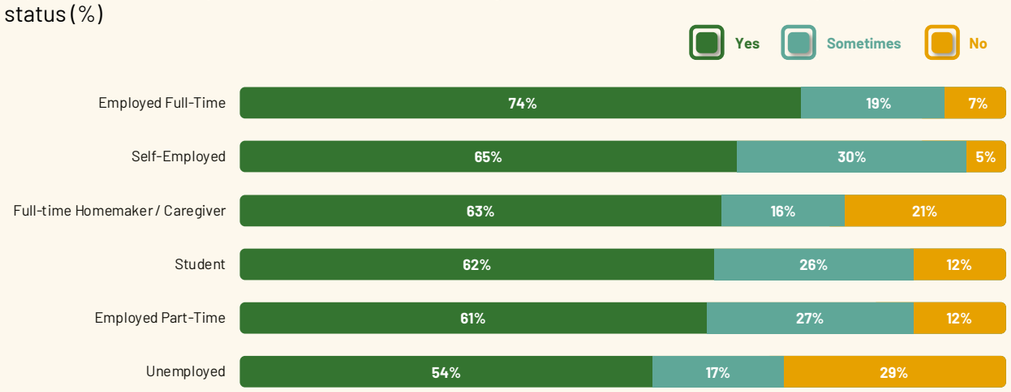
Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

Base: Women (n=1,004)

Notes:
- Earning RM5,000 and above (n=289) includes income groups RM5,000–RM6,999 (n=111), RM7,000–RM8,999 (n=81), RM9,000–RM10,999 (n=49), RM11,000–RM14,999 (n=18), and RM15,000 and above (n=26)
- Earning below RM2,000 (n=279) includes income groups less than RM1,000 (n=137) and RM1,000–RM1,999 (n=142)

Access to Healthcare Services

Figure 3: Women respondents who reported having access to healthcare services by employment status (%)



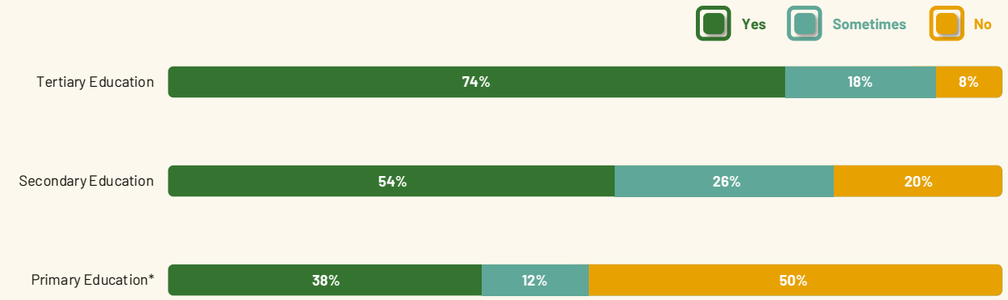
Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

Base: Women (n=1,004)

Similarly, education levels show a clear gradient. Respondents with tertiary qualifications (74%) reported no issues with access, compared to 54% of secondary school leavers. Notably, 20% of secondary school leavers reported having no access at all, almost double the overall rate of 11%.

Access to Healthcare Services

Figure 4: Women respondents who reported having access to healthcare services by formal education (%)



Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

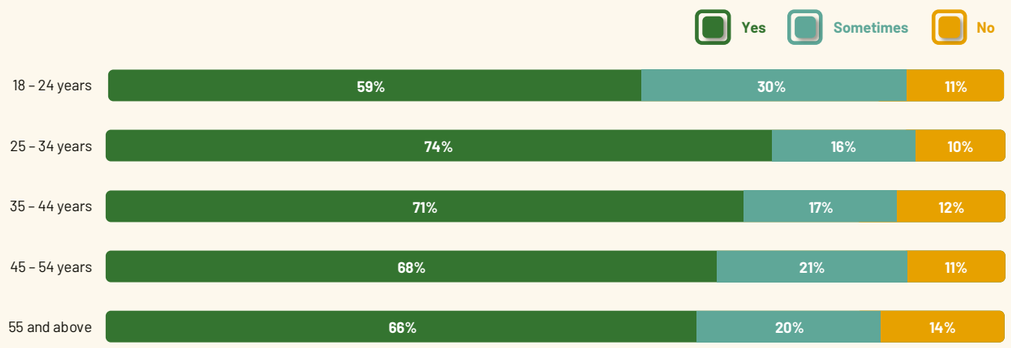
Base: Women (n=1,004)

Notes:
- Secondary Education (n=266) includes Secondary school (no SPM) (n=43), and SPM or equivalent (n=223)
- Tertiary Education (n= 728) includes Malaysian Skills Certificate (n=28), Diploma (n=205), Bachelor's degree (n=445), and Postgraduate degree (n=50).
- * Primary Education sub-group has a small sample size (n=8) and results should be interpreted with caution.

Age and geographical disparities are also evident. Respondents aged 18-24 (40%) and those from Sabah (50%) and Sarawak (44%) reported the most limited healthcare access (i.e. those who responded 'sometimes' or 'no'). However, the highest proportion of 'no access' was reported for Terengganu (21%), Sabah (19%) and Kelantan (18%).

Access to Healthcare Services

Figure 5: Women respondents who reported having access to healthcare services by age (%)



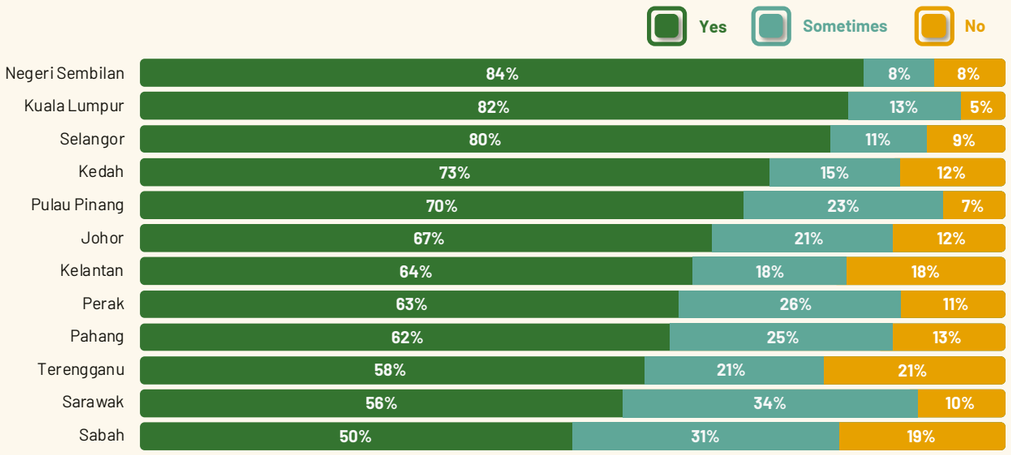
Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

Base: Women (n=1,004)

Note:
- 55 years and above (n=122) consists of age groups 55–64 years (n=93) and 65 years and above (n=29)

Access to Healthcare Services

Figure 6: Women respondents who reported having access to healthcare services by geographical location (%)



Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

Base: Women (n=1,004)

Note:
- Data for Perlis, Malacca, W.P. Putrajaya, and Labuan have been omitted due to small sample sizes

While general healthcare services were relatively accessible for LGBTIQA and gender diverse persons, this also depended on the types of services sought. LGBTIQA-specific healthcare services (e.g., gender-affirming care, pre-exposure prophylaxis (PrEP)) were the least accessible, even though many of those surveyed from these communities had identified this need. Fear of discrimination, trust deficit and lack of knowledge on how to access support services were most commonly reported barriers to accessing services and redress.

Differing Levels of Satisfaction

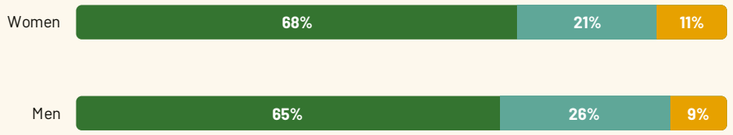
The same pattern with access to healthcare is seen in contentment levels with these services. While the majority found the quality healthcare services acceptable, views vary across different demographics. Older women, for example, expressed much higher dissatisfaction rates — 45-54 years old (2%) and 55-64 years old (3%) — i.e., 2-3 times the overall figure of 1%. Likewise, with Indian (5%) and Chinese (3%) women survey respondents, and those living in the state of Selangor (3%).

Qualitative data obtained from the FGD with the Orang Asal women gave further insights into the challenges around accessing healthcare services. Despite the existence of community, health or maternity clinics in the vicinity of a village, these can be extremely poorly equipped to the point of not being able to cope with anything beyond a pedestrian ailment. For the more complex cases, women still need to walk for hours to obtain medical help.

Even though proportionately slightly less male (65%, n=92) than female respondents (68%) said they had access to healthcare, these men reported a higher satisfaction rate with the quality of services they received. Sixty-four percent rated this as 'good' (64%), whereas with women, it was only 54%.

Access to Healthcare Services

Figure 7: Women and men respondents who reported having access to healthcare services (%)



Question: B1.1: Do you have access to healthcare services when you need it? (Single Answer)

Base: Women (n=1,004); Men (n=92)

Note:
The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.

The LGBTIQA survey respondents reported an inconsistent quality of care, likely due to gaps in cultural competence, including the limited integration of gender-affirming practices within the general healthcare system.

In another FGD with the Deaf community, several participants said they preferred private healthcare services because the staff there were more patient and provided enough information for them to make informed decisions. This was unlike their experience with government hospitals where staff often derogatorily referred to them as mute, did not provide any explanation about the prescribed medication yet expecting them to simply accept this. The absence of informed consent extended beyond information — a blind researcher and disability advocate consulted for this study described being physically guided, touched, and moved by healthcare staff without being asked or warned: "They just grab us, touch us, guide us — without asking. They don't ask for consent." [Blind researcher and disability advocate, KII].

An Orang Asli community organiser echoed this sentiment in the Orang Asal FGD, "The information on the medicines is not always clear. Mothers in villages in the interior areas do not know about the side effects. Then when the nurses come, they chastise the women for being fat, body shaming *pulak*." [Orang Asli participant, FGD]. When the information is not there, it makes it more difficult for the village women to trust government services.

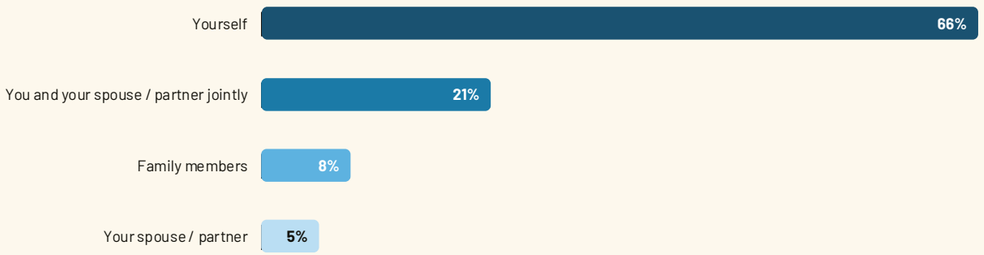
3.1.3 Economic Independence and Healthcare Decisions

Two-thirds (66%) of women surveyed reported that they make independent decisions regarding their general healthcare. This result stands out for those aged 25-34 (72%) and those who are the primary income providers for their households (85%). A further 21% reported making healthcare decisions jointly with their spouse or partner.

> *They assume we know nothing. Because we are blind, they think we cannot understand, cannot decide.*
> *[Blind researcher and disability advocate, KII]*

Decision-making on Healthcare

Figure 8: Women respondents by who usually makes decisions about their healthcare (%)



Question: B2: Who usually makes decisions about your healthcare (e.g., when to seek treatment, what kind of care to receive)? (Single Answer)

Base: Women (n=1,004)

Women with less formal education (secondary school, 14%), are full-time homemakers or caregivers (9%), and have lower incomes (under RM2,000 per month, 6%), were more likely to rely on their spouse or partner to make healthcare decisions. On the whole, however, this represented a small percentage of those surveyed (5%).

Likewise, only 8% reported that their family members took charge of their healthcare decisions, but younger women showed greater dependence on them. Among those aged 18-24, 29% reported deferring healthcare decisions to their parents or other family members. Women respondents who were unemployed but looking for work (40%), living with their parents (39%) or earning under RM1,000 per month (27%) were also more likely to rely on family members for healthcare decisions.

3.1.4 Despite Availability, Utilisation of Non-Contraceptive Reproductive Healthcare is Low

Only 47% of women surveyed reported ever needing reproductive healthcare services (excluding contraception) such as pap smears, fertility treatments, prenatal/postnatal care, abortions, hormone therapy, menopause-related treatments. This relatively low demand is worrying and raises important public health concerns (see Box 4).

Need for Reproductive Healthcare Services

Figure 9: Women respondents who reported needing reproductive healthcare services (excluding contraception) (%)

Question: B3.1: Have you ever needed reproductive healthcare services not including contraception (e.g., pap smear, fertility treatment, prenatal/ postnatal care, abortion, hormone therapy, menopause-related treatment)? (Single Answer)

Base: Women (n=1,004)

Box 4. SRH and the Impact of Poor Understanding

Breast cancer is the fourth leading cause of death among women in Malaysia and the second leading cause among women aged 30-44.[44]

Preventive screening and early detection play a critical role in identifying these diseases. National data, however, indicates low uptake of these services. The 2023 National Health and Morbidity Survey (NHMS) reported that 71% of women aged over 40 had never had a mammogram, 65% had not had a Pap smear within the last three years.[45]

Recent epidemiological trends indicate that HIV transmission in Malaysia has shifted from needle-sharing to sexual transmission. Young adults also accounted for 75% of newly reported HIV cases in 2024. Although men still represent the majority of cases, the proportion of women living with HIV has increased significantly—from 1% in the 1990s to around 10% today.[46]

Low utilisation of SRH services may also have adverse consequences not only on the prevention and treatment of HIV, but also other sexually transmitted infections (STIs).

This is especially critical given the growing sexual activity among young people. According to the 2022 NHMS, 75% of adolescents surveyed had engaged in sexual activity recently, with many reporting their first sexual experience before the age of 14. Moreover, between 2018 and 2022, 913 teenagers tested positive for STIs, and in 2022 nearly one-quarter of reported gonorrhoea cases involved individuals under the age of 21.[47]

44 Department of Statistics (2025). Statistics on Causes of Death Malaysia, 2025. https://www.dosm.gov.my/uploads/release-content/file_20260316130953.pdf; Ministry of Health Malaysia (2019). Malaysian Burden of Disease and Injury Study 2019. MOH/S/IKU/247.24(RR)-e. https://iku.nih.gov.my/images/teknikal-report/malaysian-burden-of-disease-and-injury-study-2019.pdf

45 Institute for Public Health (2024). National Health and Morbidity Survey (NHMS) 2023: Non-Communicable Diseases and Healthcare Demand - Key Findings. Shah Alam: Institute for Public Health. MOH/S/IKU 221.24(IL)-e. https://iku.nih.gov.my/images/nhms2023/key-findings-nhms-2023.pdf

46 "Young adults majority of new HIV cases in Malaysia", *The Star*. 7 Aug 2025, https://www.thestar.com.my/news/nation/2025/08/07/young-adults-majority-of-new-hiv-cases-in-malaysia

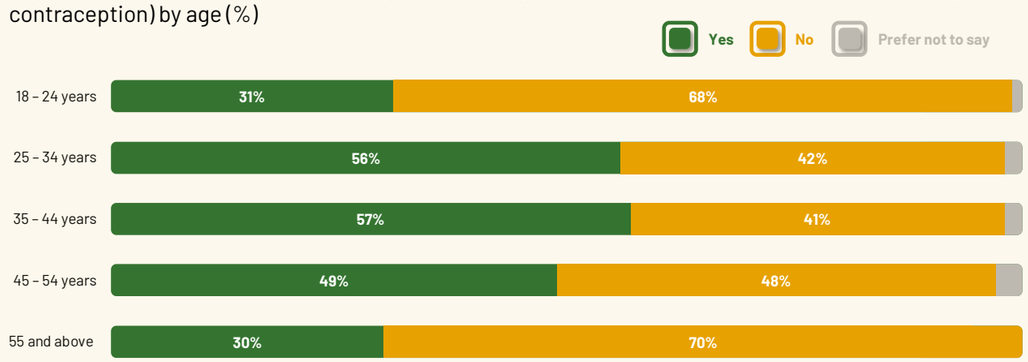
47 "Over 900 teens in Malaysia tested positive for STDs from 2018 to 2022", *Straits Times*. 30 Oct 2023, https://www.straitstimes.com/asia/se-asia/almost-1000-teens-in-malaysia-tested-positive-for-stds-from-2018-to-2022; "Youths Below 21 Comprised 22% Of Gonorrhoea Cases In 2022 In Malaysia", *Code Blue*. 30 Jun 2023, https://codeblue.galencentre.org/2023/06/youths-below-21-comprised-22-of-gonorrhoea-cases-in-2022-in-malaysia/

No real pattern is discernible across different education levels. Instead, age, income and employment status appear to influence this outcome.

Both the youngest (68%, 18-24) and oldest (70%, 55 and above) age groups were the most likely never to have utilised reproductive healthcare services before. This suggests that more needs to be done to raise awareness of both age cohorts, on the importance of sexual and reproductive healthcare.

Need for Reproductive Healthcare Services (excluding contraception)

Figure 10: Women respondents who reported needing reproductive healthcare services (excluding contraception) by age (%)



Question: B3.1: Have you ever needed reproductive healthcare services not including contraception (e.g., pap smear, fertility treatment, prenatal/postnatal care, abortion, hormone therapy, menopause-related treatment)? (Single Answer)

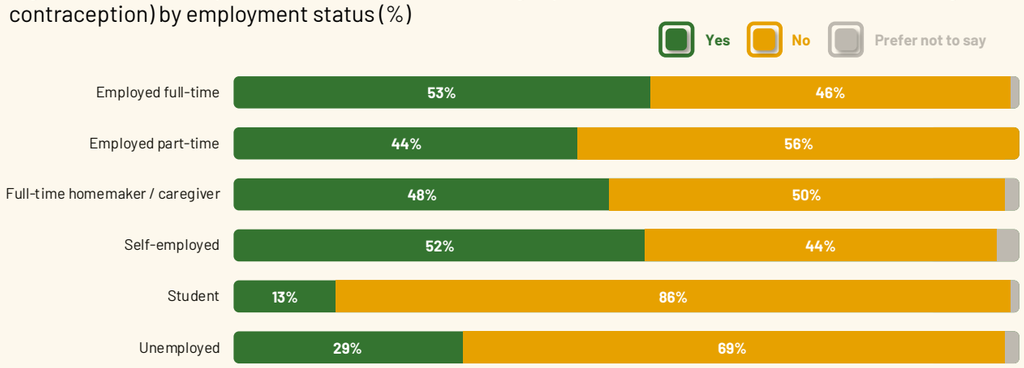
Base: Women (n=1,004)

Note:
- 55 years and above (n=122) consists of age groups 55–64 years (n=93) and 65 years and above (n=29)

The underutilisation of such healthcare services was most common among student respondents (86%), those unemployed (69%), and those making under RM4,000 per month (57%). In contrast, only 46% of women with full-time jobs and 36% of those earning RM7,000 or more per month, said the same.

Need for Reproductive Healthcare Services (excluding contraception)

Figure 11: Women respondents who reported needing reproductive healthcare services (excluding contraception) by employment status (%)



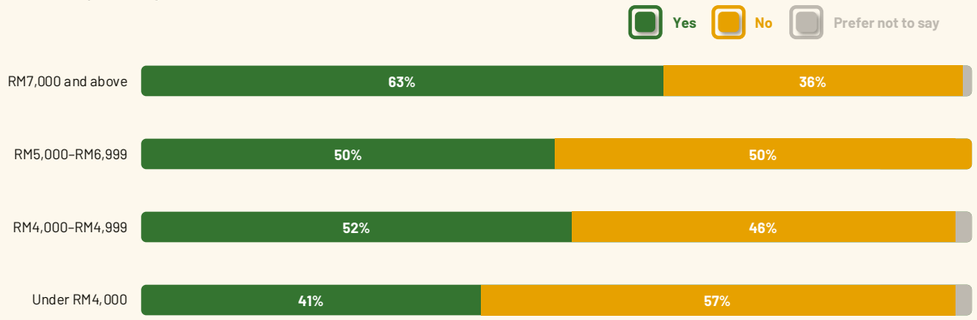
Question: B3.1: Have you ever needed reproductive healthcare services not including contraception (e.g., pap smear, fertility treatment, prenatal/postnatal care, abortion, hormone therapy, menopause-related treatment)? (Single Answer)

Base: Women (n=1,004)

Note:
Unemployed (n=58) comprises respondents who are unemployed and actively seeking work (n=35) as well as those who are unemployed and not seeking work (n=23).

Need for Reproductive Healthcare Services (excluding contraception)

Figure 12: Women respondents who reported needing reproductive healthcare services excluding contraception by income (%)



Question: B3.1: Have you ever needed reproductive healthcare services not including contraception (e.g., pap smear, fertility treatment, prenatal/postnatal care, abortion, hormone therapy, menopause-related treatment)? (Single Answer)

Base: Women (n=1,004)

Note:
- Earning under RM4,000 (n=590) includes income groups less than RM1,000 (n=137), RM1,000–RM1,999 (n=142), RM2,000–RM2,999 (n=157), and RM3,000–RM3,999 (n=154)
- Earning RM7,000 and above (n=174) includes income groups RM7,000–RM8,999 (n=81), RM9,000–RM10,999 (n=49), RM11,000–RM14,999 (n=18), and RM15,000 and above (n=26).

Ethnic differences were also observed. A higher proportion of Indian (66%) and Chinese (63%) women reported not having any need for reproductive healthcare services compared with Malay women (50%).

Sharing on women's poor utilisation of reproductive healthcare services, a long-time women's rights activist said that some from marginalised communities like the Orang Asli avoid going to the hospital because *"ramai orang* [many people]" or the perception that "doctors [are] no good" [Women's rights activist, KII]. In one case, a pregnant Orang Asli woman opted for a traditional village healer and ended up having a miscarriage before passing away. This, the activist said, was the result of women not having "basic knowledge" about their bodies.

According to a former sex worker key informant, low levels of SRH awareness among women in the sex industry are compounded by the criminalisation of sex work, which forces them underground and significantly limits the ability of NGOs to conduct health outreach and education. The above-mentioned women's rights activist concurred, noting that these women often resort to improvised and unsafe practices in the absence of accessible and non-judgmental health information and services. Their poor knowledge, however, is not a reflection of individual behaviour but a consequence of structural exclusion: without safe and accessible channels for health information, women in this community are left without the means to protect themselves.

3.1.5 High but Unequal Access to Respectful Reproductive Healthcare Services

Of those who reported needing non-contraceptive reproductive healthcare (n=489), 93% said they could access the services they needed; 5% said they could not.

Access was highest among women with university qualifications (96%) and those aged 18-24 (95%), and lowest among homemakers or caregivers (11% reported no access) and those who earned under RM3,000 per month (9%). It is worth noting that access for LGBTIQA respondents was lower (72%), reflecting challenges unique to them.

Almost all (96%) of those who were able to access reproductive healthcare services (n=464) reported feeling comfortable and treated with respect, albeit with some divergence based on income and ethnicity. For example, the level of satisfaction was lower among women who earned under RM1,000 per month (91%) compared to higher-income groups (RM7,000 and above, 99%), and among Chinese women (88%) next to Malay women (98%).

Barriers to Accessing Reproductive Health Services

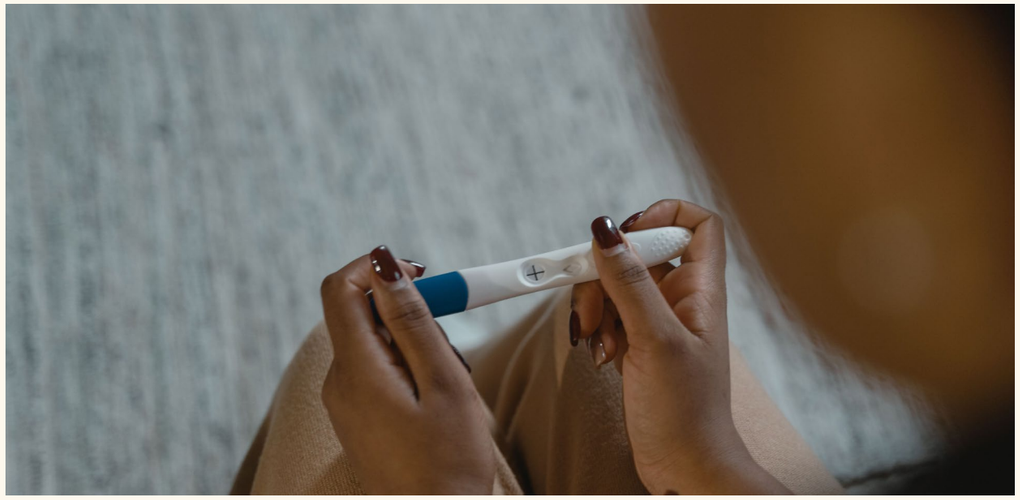
Although only a small number of respondents in the women's survey (n=34) reported being unable to access reproductive healthcare (excluding contraception) when needed, their responses highlight important barriers.

Cost was the most frequently cited barrier (56%), particularly for rural women (80%) and those aged 55-64 (75%). This was notable for the LGBTIQA respondents largely because services like gender-affirming care remain poorly developed, and are primarily available — though unevenly — in the private sector.

Other challenges included distance and transportation (26%), and limited availability of facilities (21%). Compared to those in rural areas, urban women respondents found both these to be more challenging. Fear of judgement or discrimination was reported as a major barrier to SRHR across all LGBTIQA groups, regardless of whether participants were able to access SRH. Among those wanting to start a family, half — mostly cisgender and transgender women — were uncomfortable with discussing fertility plans with healthcare providers.

These findings are also supported by data from the qualitative interviews. The Orang Asli FGD highlighted additional access challenges those living in remote areas faced with regards to reproductive health services. In the event they needed to deliver their baby at the nearest hospital in town, they would have to find temporary accommodation there some time before delivery. This increased their expenses or involved dependence on the generosity of a family member or friend or incurred additional costs to cover lodging and transport.

Another key informant shared the case of a woman who delayed seeking hospital care out of fear of being reported to the police for drug use. As a result, she did not know that she had experienced an intrauterine fetal death until much later [Women's rights activist, KII].



3.1.6 Pressure in Reproductive Health Decision-Making

> *I attended a government meeting where I heard how they are worried about Malaysia's low fertility rate. I was surprised because in our [Orang Asal] village, we are always told to stop having more children. Banyak sudah anak kau ini. Berhentilah beranak. [You have had more than enough children. Stop giving birth].*
> *[Orang Asal participant from Sabah, FGD]*

While most respondents did not report experiencing pressure in making reproductive health decisions, a notable minority (around 10%, n=125) indicated feeling pressured or forced by a family member, institution, or partner or spouse.

Family members (parents, older relatives) were the most commonly cited source (23%), followed by government authorities (e.g., healthcare providers) (18%) and partners or spouses (16%).

A smaller proportion (3%) reported pressure related to psychological or medical interventions.

Qualitative findings provide further context. Indigenous participants described instances where women felt pressured into contraception or sterilisation without fully understanding the procedures or being able to provide informed consent. These accounts suggest not only potential gaps in communication, access to information, and safeguards within healthcare interactions, but also the practice of double-standards and discriminatory positions towards certain segments of society such as the Orang Asal.

3.1.7 Low Uptake of Contraception Despite Availability

Only 44% of women surveyed said that they had previously needed contraception (birth control pills, condoms, IUD, implants). This reflects Malaysia's traditionally long-standing pattern of a low Contraceptive Prevalence Rate (CPR) (see Box 5).

Box 5. Contraception Usage in Malaysia

Malaysia has traditionally recorded a relatively low Contraceptive Prevalence Rate (CPR), defined as the percentage of women of reproductive age (15-49 years) who use any form of contraception. In 2022, its CPR stood at 42.8% of married women — unmarried women are excluded from this national statistic, which means that the actual prevalence across the broader population may be even lower.

Use of modern contraceptive methods — including injectables, hormonal implants, oral contraceptive pills, condoms, and intra-uterine devices — remains low. In 2022, the prevalence rate for modern methods was 34.5%, falling below the global average of 45%.[48]

The low usage of contraception among young women, as seen in this survey, is noteworthy given the rising incidence of teen pregnancies in Malaysia. Between 2019 and 2024, just over 21,000 teenage pregnancies were recorded at government health facilities.[49]

48 United Nations (2022). World Family Planning 2022: Meeting the changing needs for family planning — contraceptive usage by age and method. New York. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2023/Feb/undesa_pd_2022_world-family-planning.pdf; "Making Sense Of Malaysia's Contraceptive Prevalence Rate — Dr John Teo", *Code Blue*. 11 Dec 2020, https://codeblue.galencentre.org/2020/12/making-sense-of-malaysias-contraceptive-prevalence-rate-dr-john-teo/

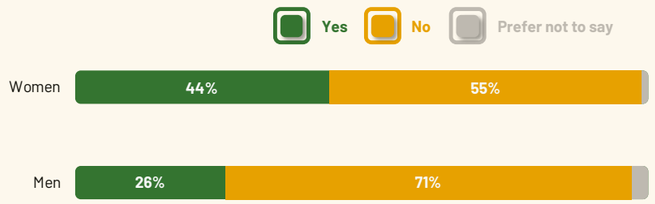
49 "Over 21,000 out-of-wedlock teen pregnancies recorded from 2019 to 2024, Malaysia's Parliament told", *The Straits Times*. 11 Feb 2026, https://www.straitstimes.com/asia/se-asia/over-21000-out-of-wedlock-teen-pregnancies-recorded-from-2019-to-2024-malaysias-parliament-told

Contraceptive needs also varied considerably across demographic groups. It was highest among women with incomes of RM7,000 and above per month (61%), married (60%), and aged 25-44 years (55%).

Conversely, it was lowest for single women (14%), those 18-24 (25%), and women whose monthly incomes were under RM2,000 (37%).

Need for Contraception

Figure 13: Women and men respondents who reported ever needing contraceptive services (%)



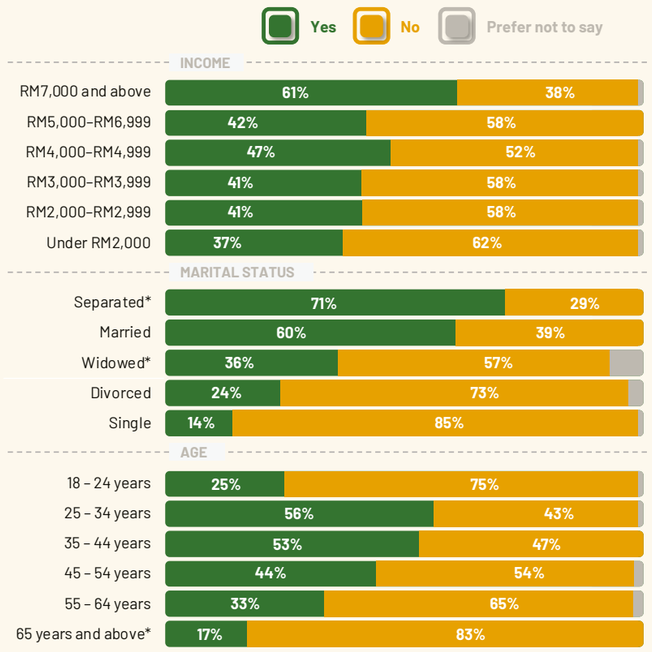
Question: B3.5: Have you ever needed contraception (e.g., pills, IUD, condoms, implants)? (Single Answer)

Base: Women (n=1,004); Men (n=92)

Note:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.

Need for Contraception

Figure 14: Women respondents who reported ever needing contraceptive services by income, marital status, and age (%)



Question: B3.5: Have you ever needed contraception (e.g., pills, IUD, condoms, implants)? (Single Answer)

Base: Women (n=1,004)

Notes:

Income
- Below RM2,000 category (n=279) comprises less than RM1,000 (n=137) and RM1,000–RM1,999 (n=142);
- RM7,000 and above category (n=174) comprises RM7,000–RM8,999 (n=81), RM9,000–RM10,999 (n=49), RM11,000–RM14,999 (n=18), and RM15,000 and above (n=26).

Marital Status
- Findings for the Separated (n=7) and Widowed (n=14) subgroups should be interpreted with caution due to the small sample sizes.

Age
- Findings for respondents aged 65 years and above (n=29) should be interpreted with caution due to the small sample size.

Two additional findings are noteworthy. First, Indian (20%) and Chinese (35%) women reported substantially lower levels of contraceptive need compared with Kadazan-Dusun (51%) and Malay women (48%). Further research is needed to better understand these differences. Second, an equally low usage was seen among male respondents. Only 26% reported ever needing contraceptive services.

For women who have needed contraception, almost all (95%) have been able to access these services. Of the 4% who had no access, a very small number (n=22) provided insights into the barriers they encountered. The top three reasons were cost (27%), fear of judgment (18%), and partner restrictions (14%).

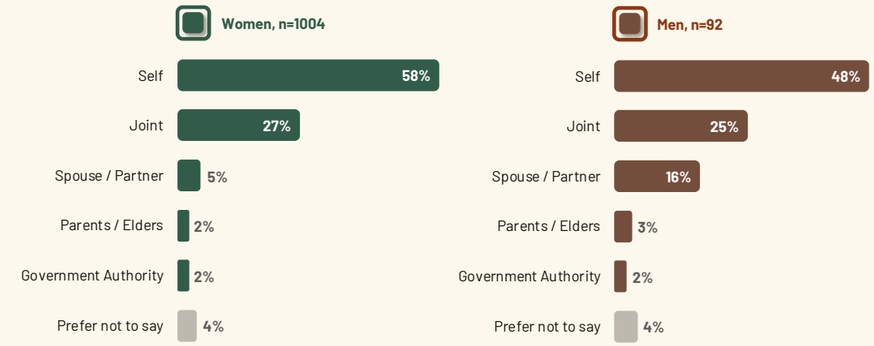
The fact that many more teenagers are now engaging in sexual relations and yet know so little about safeguards against unwanted pregnancies was raised by several key informants. One who said that pregnancies among 13-14 year olds was now "very common" shared how some of them have told her how *"tak pe, minum air panas, tak boleh* pregnant [it is ok, drink hot water, won't get pregnant]; jump up and down, won't get pregnant" [SRHR advocate, KII]. These misconceptions stem from the lack of comprehensive and age-appropriate sex education in schools, leaving children to seek such information on their own (see also Section 3.5).

3.1.8 Women Primarily Responsible for Contraceptive Decisions

Fifty-eight percent of women surveyed reported independently deciding whether or not to use contraception; 27% did so jointly with their spouse or partner.

Decision-Making on Contraception

Figure 15: Women and men respondents by who usually makes decisions about using contraception (%)



Question: B3.8: Who usually makes the decision on whether or not you should use contraception? (Single Answer)

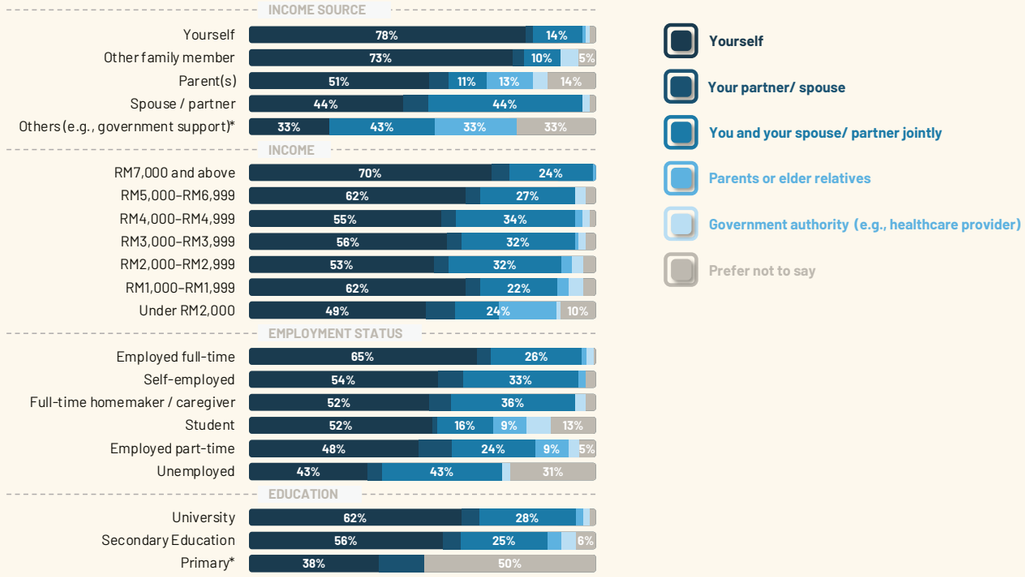
Base: Women (n=1,004); Men (n=92)

Notes:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.
- Others (Women: n=16; Men: n=1) not shown due to insufficient sample size.

Contraceptive autonomy was highest among women who were the primary providers for their households (78%), had a minimum monthly income of RM7,000 (70%), were employed full-time (65%), or with university degrees (62%).

Decision-Making on Contraception by Demographic Group

Figure 16: Women respondents who reported deciding on contraceptive usage by main household provider, income, employment status, and formal education (%)



Question: B3.8: Who usually makes the decision on whether or not you should use contraception? (Single Answer)

Base: Women (n=1,004)

Notes:

Income Source
- ***Others (n=10)** comprises respondents receiving Government Support (n=3) and those classified as Other (n=7). Findings for this category should be interpreted with caution due to the small sample size.

Income
- **Earning RM7,000 and above (n=174)** comprises respondents with monthly incomes of RM7,000–RM8,999 (n=81), RM9,000–RM10,999 (n=49), RM11,000–RM14,999 (n=18), and RM15,000 and above (n=26).
- **Earning under RM2,000** (n=279) comprises respondents with monthly incomes of RM1,000 – RM1,999 (n=142) and Less than RM1,000 (n=137).

Employment Status
- **Unemployed** (n=58) comprises respondents who are unemployed and actively seeking work (n=35) as well as those who are unemployed and not seeking work (n=23).

Education
- **University degree** (n=495) comprises respondents with a Bachelor's degree (n=445) and a postgraduate qualification (n=50).
- **Primary Education** (n=8) has a small sample size; findings should be interpreted with caution.

Half of the married women respondents (50%) reported making these decisions independently, while 39% made them jointly with their partner. Joint contraceptive decisions were also more common in households where the spouse or partner was the primary income provider (44%) and among Malay women (30%) compared to 16% Indian and 22% Chinese women.

The majority of women not only decided on contraception, they were also chiefly responsible for ensuring its usage (59%). Another 22% shared the responsibility for using contraception with their spouse or partner. Only 11% said that their spouse or partner solely took charge of this.

A very significant proportion of women living in Kuala Lumpur (73%) were responsible for using contraception in their relationships. Ethnic and religious divergences were also evident. Chinese (19%) and Indian (18%) women were more likely than Malay women (9%) to report that their spouse or partner took primary responsibility for contraception usage, while one in five (19%) Christian women versus 8% of Muslim women said the same.

Among the men surveyed,16% reported deferring contraception decisions to their spouse or partner. Only 5% of women said this. Proportionately, slightly fewer men took responsibility for using contraception during sex (51% versus 59% women).

These findings reflect a wider pattern where in sexual relationships, responsibility for contraceptive decisions and usage often fall on the shoulders of women. Female agency and control over their bodies — including making decisions about contraception — is important. However, it can absolve men from taking joint responsibility for something both partners need to be involved with. Contraceptive decision-making, like many aspects in a functioning and meaningful relationship, needs to be through an embedded process of negotiation. Failing this, women will continue to bear the brunt of reproductive care.

3.1.9 Generally High Satisfaction with Maternal Healthcare, but Gaps Remain

In the context of maternal healthcare, informed consent is a fundamental right. Of the women respondents who had experienced pregnancy or childbirth, 86% considered the information they received from healthcare providers to have been sufficient for making informed decisions. Married women reported considerably higher satisfaction (87%) than single women (58%). Younger women (18-24, 78%) and older women (55-64, 75%) similarly indicated lower levels of satisfaction with the information they received.

Three in four women (74%) reported being able to accept or refuse medical procedures offered during pregnancy or childbirth, such as caesarean sections, induced labour, or pain medication. However, 9% reported being unable to do so.

Those most affected were Kadazan-Dusun women (18%), those earning under RM1,000 per month (16%), SPM-level qualifications (14%), and full-time homemakers or caregivers (13%).

Out of 641 women who have been pregnant or given birth, 392 (61%) have reported at least one barrier to accessing adequate maternal healthcare. Cost was the most commonly cited barrier to accessing adequate maternal healthcare (64%). Transport or distance was also a notable impediment (34%) — particularly in Sabah, where 59% of women respondents identified this as a challenge. Lack of medical facilities (29%) and discrimination or poor treatment by healthcare providers (28%) were also prominent concerns. Notwithstanding the small sample size (n=21), over half the single women respondents identified lack of medical facilities as a barrier (57%).

Box 6. Measuring Women's Bodily Autonomy in Malaysia

The UN SDG indicator 5.6.1 measures the proportion of women aged 15-49 years (married or in union), who make their own decisions about their healthcare, contraceptive usage and whether or not to engage in sexual intercourse with their husband or partner. Only a woman who can decide on all three components is considered to have autonomy in sexual and reproductive health decision making, and to be empowered to exercise these rights.[50]

In line with this indicator, the SIS survey included the same SDG indicator 5.6.1 questions to better understand how Malaysian women experience bodily autonomy.

1. Who usually makes decisions about your healthcare (e.g. when to seek treatment, what kind of care to receive)?

2. Who usually makes the decision on whether or not you should use contraception?

3. Can you say no to your spouse/partner if you do not want to have sexual activity?

The SIS survey results for these questions were filtered to include only women aged 18-54 years old — the closest approximate possible — who were married or in a sexual relationship (n=571). It should also be noted that where the global SDG database uses 'depends' as a response option for the question on refusing sex, the SIS survey used 'sometimes'; both capture the same underlying construct, that a woman's ability to refuse sex is conditional rather than consistent, and are treated equivalently here, with only 'yes' responses counted toward full bodily autonomy.

The smaller sample size and slightly larger age bracket means that the results are not directly comparable to those generated by the global database used by UNFPA, the custodian agency of SDG 5.6.1. Nonetheless, they still provide valuable insights into the decision-making power women in Malaysia have over their sexual and reproductive health across different stages of life and serves as an approximation of how Malaysia fares against other nations.

	World	East & South East Asia	Malaysia
All three dimensions of indicator 5.6.1	55%	76%	45%
Power to say no to sex	75%	86%	51%
Power to decide on contraception	91%	94%	93%
Power to decide on healthcare	75%	92%	92%

The findings show that women in Malaysia have greatest decision-making powers in relation to contraception (93%) and healthcare (92%). However, they fare very poorly when it comes to refusing sex with their spouse/partner (51%). Their overall bodily autonomy indicator — reflecting the proportion of women who have the ability to decide on all three dimensions — is even lower at 45%, a figure that puts Malaysia just above the poorest faring countries in the world; Middle Africa (36%) and Western Africa (38%) as well as Central and Southern Asia (43%).

50 UNFPA (2024). Guidelines on Collecting Data for SDG Indicator 5.6.1 on Women's Sexual and Reproductive Health and Reproductive Rights Decision-making in National Household Surveys. June. New York; UNFPA (2021). State of World Population 2021.

3.1.10 Low Awareness about Abortion Law and Services

Qualified Support for the Right to Abortion

Almost two-thirds of women respondents (63%) supported the right to abortion, but only under specific circumstances such as rape or serious health risk. Unconditional support was higher among women who were Chinese (36%), Buddhist (36%), Kuala Lumpur residents (27%), primary household income earners (25%), and single (21%).

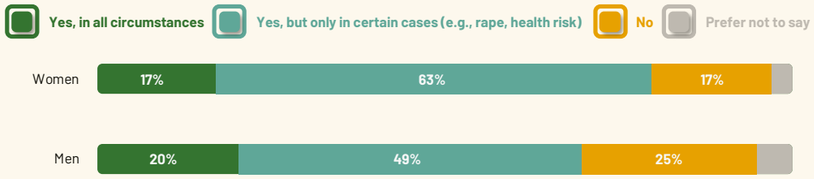
In response to the question about supporting a woman's right to abortion, 17% said 'Yes, in all circumstances'; the same proportion as those who said 'No'.

Opposition to abortion was more prevalent among women with secondary education (37% versus 12% tertiary education), Kadazan-Dusun women (28% versus 11% Chinese), Christians (25% versus 17% Muslim), women aged 55 and above (25% versus 14% 18-24 year olds), full-time homemakers or caregivers (23% versus 6% students), rural respondents (22% versus 16% urban), and those earning under RM2,000 per month (21% versus 7% RM7,00 and above).

Among male respondents, 20% supported abortion without conditions, compared to 17% of female respondents, while 25% opposed it outright, compared to 17% of women. Conditional support — accepting abortion only in certain circumstances — was lower among men (49%) than among women (63%).

Views on Right to Abortion

Figure 17: Women and men respondents by view on right to abortion (%)



Question: B5.1 Do you believe every individual should have the right to abortion? (Single Answer)

Base: Women (n=1,004); Men (n=92)

Note:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.

Inadequate Legal Awareness and Knowledge about Services

Less than half of women respondents (45%) correctly understood that abortion was legal under certain circumstances in Malaysia, while 21% believed it to be entirely illegal. The corresponding figures for men were 41% and 16%.

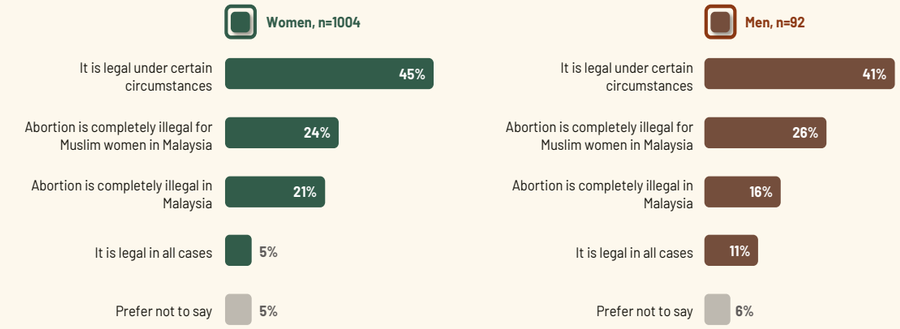
Among women, gaps in legal knowledge were most pronounced among non-Malay ethnic groups — Kadazan-Dusun (40%), Indian (36%), and Chinese (26%) women were more likely than Malay women (15%) to believe that abortion is entirely illegal. Non-Muslim women followed a similar pattern: Christians (42%), Hindus (33%), and Buddhists (23%) compared with Muslim women (16%). Legal awareness was also lower among women with fewer years of formal education and lower incomes — groups that tend to face greater structural barriers to accessing health and legal information — with 35% of women with SPM qualifications or less, and 30% of those earning under RM1,000 per month, believing abortion to be entirely illegal. A higher proportion of women surveyed in Sarawak (39%) and Sabah (37%) also held this view.

A separate finding shows that 24% of women believed abortion was completely illegal for Muslim women specifically (26% of men held the same view). This belief was most prevalent among Malay and Muslim women (31% each), and was particularly concentrated in Kelantan, where 42% of women respondents held this view — nearly double the national rate.

Only one in three women (34%) knew how to access information about abortion services. Awareness was lowest among overlapping groups most likely to face broader information barriers: women earning under RM2,000 per month (25%), those with up to secondary school education (25%), full-time homemakers or caregivers (24%), and unemployed women (23%).

Views on Abortion Law

Figure 18: Women and men respondents by view on abortion law (%)



Question: B5.3 Which of the following best reflects your understanding of abortion laws in Malaysia? (Single Answer)

Base: Women (n=1,004); Men (n=92)

Note:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.

Box 7. Abortion Regulations in Malaysia

In Malaysia, medical or therapeutic abortion is legal under certain circumstances. Section 312 of the Penal Code (Act 574, as amended in 1971 and 1989) permits a registered medical practitioner to terminate a pregnancy where, in their good faith opinion, continuing the pregnancy would involve greater risk to the life of the pregnant woman, or injury to her mental or physical health, than if the pregnancy were terminated. Outside of these grounds, inducing an abortion remains a criminal offence, carrying penalties of up to three years imprisonment and a fine, or up to seven years in jail if the pregnancy has advanced beyond the first trimester.

The decision to perform the procedure rests entirely with the doctor rather than the woman herself, meaning women have no independent legal right to request or refuse termination. A 2007 survey by the Reproductive Rights Advocacy Alliance Malaysia (RRAAM) found that only 57% of 120 doctors and nurses surveyed knew that abortion is legal in certain circumstances – a significant gap in clinical awareness that has direct implications for the services women are able to access.

The government's Ministry of Health 2012 Guidelines on the Termination of Pregnancy explicitly confirms the availability of therapeutic abortion services in public hospitals, and sets out the clinical and procedural standards for its delivery. However, the phrase "injury to mental or physical health" leaves considerable room for interpretation and healthcare providers may decline to provide the service based on differing views of what meets this threshold. Grounds such as rape, incest, or foetal impairment are not explicitly state in the law, though some legal interpretations hold that they may fall within the health risk provisions.

Despite this legal framework, awareness remains critically low, both among the general public and healthcare practitioners, leaving many women without the knowledge or the means to access services they are legally entitled to.[50]

50 Ministry of Health Malaysia (2012). Guideline on Termination of Pregnancy (TOP) for Hospitals in the Ministry of Health Malaysia. Ministry of Health Malaysia. https://www.moh.gov.my/images/04-penerbitan/penerbitan-klinikal/perkhidmatan-OG-dan-pediatrik/3._Guideline_On_TOP_for_Hospitals_in_MOH_.pdf; Reproductive Rights Advocacy Alliance Malaysia (RRAAM) (2007). Frequently Asked Questions: Abortion. https://www.rraam.org/faqs/

3.1.11 Conclusions

The findings in this section indicate that while Malaysia's healthcare system is generally accessible and of satisfactory quality, access is not experienced equally across all groups. Age, education, employment, income levels, and geographic location continue to shape who is able to access quality healthcare services consistently and without difficulty.

Women in Sabah, Sarawak and rural locations, along with those with lower incomes and less formal education, face the most severe and compounded disadvantages across almost every dimension examined. While public healthcare provides an important foundation, pressures on the system — including staff shortages, infrastructure gaps, and rising costs in the private sector — present ongoing challenges that risk widening these inequalities further.

Accessible, inclusive, and high-quality reproductive healthcare services are essential for achieving the highest standards of sexual and reproductive health. Women's utilisation of reproductive healthcare services in Malaysia, however, remains relatively low, particularly for preventive care. Both the youngest and oldest age groups are the most likely never to have used these services, and underutilisation is most pronounced among students, unemployed women, and those earning under RM4,000 per month. That access to these services is reported to be high among those who do use them suggests that barriers extend beyond availability to include cost, awareness, stigma, and social norms.

For marginalised groups — including Orang Asal women in remote areas, women in sex work, and those with disabilities — poor health literacy and structural exclusion create additional risks that the mainstream healthcare system is not adequately equipped to address.

For LGBTIQA and gender-diverse people, fear of discrimination and the near-absence of gender affirming services present distinct and compounding barriers.

Contraceptive use remains limited despite accessibility, pointing to the influence of cultural expectations, knowledge gaps, and gender dynamics. Responsibility for contraceptive decisions and usage continues to fall disproportionately on women, with only 11% reporting that their spouse or partner takes primary responsibility. This pattern varies by ethnicity, with Chinese and Indian men more likely to share or assume this responsibility compared to Malay men, reflecting the role of cultural and religious norms in shaping contraceptive dynamics within relationships.

Most women who have experienced pregnancy or childbirth report satisfaction with the maternal healthcare they received, yet single, younger, and older women — as well as those with lower incomes and less education — are notably less positive. The ability to make informed decisions about medical procedures during pregnancy and childbirth, while broadly reported, remains constrained for the most economically and socially marginalised women.

On abortion, the gap between legal rights and public awareness is stark. Despite the legal permissibility of therapeutic abortion in Malaysia, fewer than half of women know what the law allows, and one in five believe it to be entirely illegal. This knowledge gap is sharpest among non-Malay, non-Muslim women, as well as those with lower formal education, and lower-income groups — all of whom already face greater barriers to health information more broadly. Without awareness of their legal rights, women cannot exercise them.

Finally, while many women report making independent decisions about their healthcare, this autonomy is not universal. Decision-making is shaped by economic independence, social roles, and cultural beliefs — particularly in relation to contraception, sexual relations, and pregnancy. Younger women, homemakers, students, and those earning the least are consistently the most likely to defer decisions to spouses, partners, or family members.

Taken together, these findings highlight that improving healthcare outcomes for women in Malaysia requires not only maintaining access, but also addressing underlying inequalities, strengthening legal and health literacy, and supporting women's ability to exercise informed and independent choices at every stage of their reproductive lives.

3.2 Relationships and Marriage

The freedom to choose if, when, and whom to marry — and to exercise agency within intimate relationships, including the right to refuse unwanted sex — are fundamental to women's dignity, health, and life outcomes. In Malaysia, these decisions are shaped by a complex interplay of economic dependence, family expectations, religious teachings, and deeply embedded gender norms that frame marriage as both a social obligation and a site of male authority.

This section examines the extent to which women in Malaysia report meaningful agency over marriage decisions and sexual autonomy, and the social and structural factors that expand or constrain this agency.

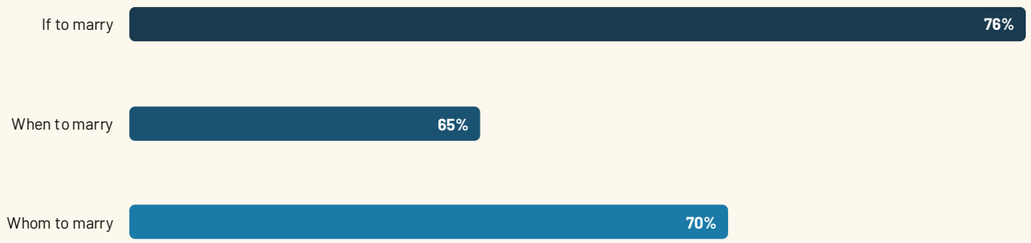
3.2.1 Varied Assertions of Women's Agency in Relation to Marriage

> *The system has failed them [the youth]. Who has taught them about their body and rights? No one.*
> *[Women's rights activist, KII]*

A large majority of women believe that it is or was largely their own decision to marry (76%). This was especially so for those who are the main providers of their household (85%), earning a monthly income of at least RM4,000 (84%), have university degrees (bachelor's 82%, PhD 98%), and are engaged in full-time employment (81%).

Freedom to Decide on Marriage

Figure 19: Women respondents who reported having full freedom to decide if, when, and whom to marry (%)



Question: C2.2 Did you have full freedom to decide the following? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%.

Parents or immediate family members are the main influence over marriage decisions of women living with their parents (25%), still studying (22%), earning under RM1,000 every month (21%), or are younger, i.e., 18-24 years old (19%).

Slightly fewer enjoy the freedom to determine when they marry. Only two out of three women (65%) feel they have full control over the timing of when they marry. Those with monthly incomes of above RM5,000 (87%), and tertiary qualifications (77%) enjoy greater freedom to decide in this regard.

Women seem to be largely deciding for themselves, whom they marry (70%). Those drawing a monthly salary of above RM5,000 and above (79%), possess a university degree (81%), or have full-time work (75%), appear better placed to choose their own spouse.

The female respondents typically marry for the first time between the ages of 25-34 years (42%), followed by 18-24 years (26%). Early or child marriage is not common but still occurs. A small proportion (1%) reported marrying before the age of 18. Although they comprise a very small fraction of respondents, the findings shed additional profile insights on these women. Their education levels are lower, they are largely unemployed or homemakers or caregivers, and more are found in lower income brackets. The highest prevalence is observed in Sabah (3%).

A long-time women's rights activist linked the persistence of child marriage here to the absence of comprehensive sexuality education in schools, a gap that cuts across communities but whose consequences fall hardest on those with the least access to alternative sources of information and support. She described cases in which young people, without adequate knowledge of their bodies or rights, engage in sex and are then pressured into marriage by their communities rather than offered support. This, in her opinion, was not their fault but the failure of the system.

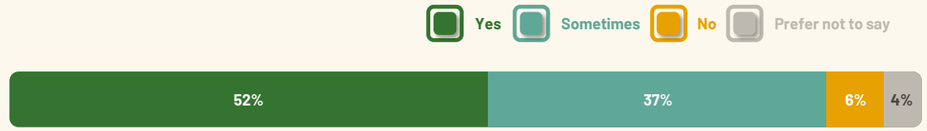
3.2.2 Restricted Autonomy to Refuse Unwanted Sex

> *It is still awkward to say no to a partner... many people still believe that once you are in a relationship... you owe something to your partner.*
> *[Young woman participant, FGD]*

Slightly over half of the women surveyed (52%) reported that they could refuse sex with their spouse or partner. A further 37% said they could do so only 'sometimes', while 6% reported that they could not refuse at all.

Autonomy to Refuse Sexual Activity with Spouse or Partner

Figure 20: Women respondents who reported being able to refuse sexual activity with their spouse or partner (%)



Question: C1.3 Can you say 'no' to your spouse / partner if you do not want to have sexual activity? (Single Answer)

Base: Women who are currently married / in a sexual relationship (n=682)

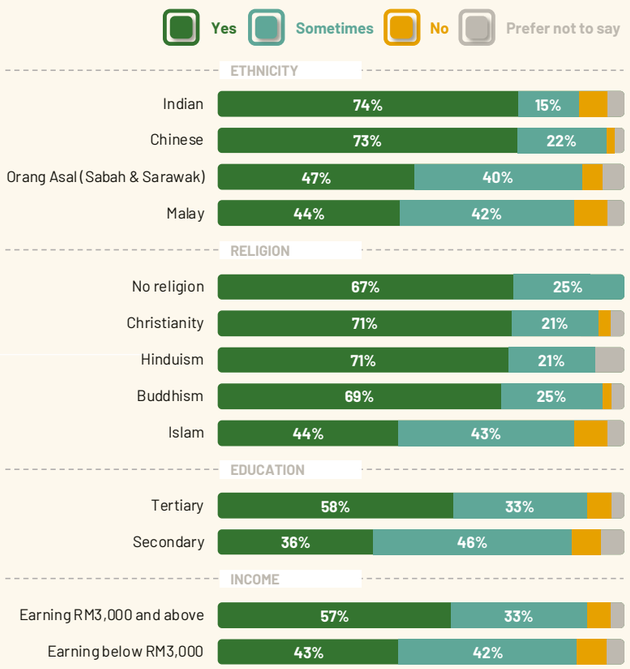
Differences across demographic groups were pronounced

Malay and Muslim women reported the least ability to refuse sex. While around three-quarters of Indian and Chinese women, 71% of Christian women, and 69% of Buddhist women said they could refuse sex, only 44% of Malay and Muslim women reported the same level of autonomy.

Educational attainment and income also appear to influence this dynamic. Among women with tertiary education, 58% reported being able to refuse sex, compared with only 36% of women with secondary education. Similarly, 57% of women earning RM3,000 or more per month reported being able to refuse sex, compared with 43% of women earning less than RM3,000.

Autonomy to Refuse Sexual Activity

Figure 21: Women respondents who reported being able to refuse sexual activity with their spouse or partner by ethnicity, religion, formal education, and income (%)



Question: C1.3 Can you say 'no' to your spouse / partner if you do not want to have sexual activity? (Single Answer)

Base: Women who are currently married / in a sexual relationship (n=682)

Notes:

Ethnicity
- **Orang Asal category** (n=73) comprises Kadazan-Dusun (n=35), Bajau (n=8), Murut (n=1), Other Orang Asal Sabah (n=5), Iban (n=15), Bidayuh (n=5), Melanau (n=3), and Other Orang Asal Sarawak (n=0).

Religion
- Findings for respondents reporting **no religion** (n=12) and **Hinduism** (n=14) should be interpreted with caution due to the small sample sizes.
- Results for **"Others"** (n=2) and **"Prefer Not to Say"** (n=1) are not shown due to insufficient sample sizes.

Education:
- **Secondary Education** (n=181) comprises Secondary School (No SPM) (n=26) and SPM or equivalent (n=155).
- **Tertiary Education** (n=497) comprises Malaysian Skills Certificate (n=15), Diploma (n=134), Bachelor's Degree (n=312), and Postgraduate Degree (n=36). Findings for the Primary Education subgroup (n=3) was not shown due to insufficient sample size.

Income
- **RM3,000 and above category** (n=400) comprises RM3,000–RM3,999 (n=106), RM4,000–RM4,999 (n=65), RM5,000–RM6,999 (n=84), RM7,000–RM8,999 (n=67), RM9,000–RM10,999 (n=40), RM11,000–RM14,999 (n=14), and RM15,000 and above (n=24).
- **Below RM3,000 category** (n=260) comprises less than RM1,000 (n=76), RM1,000–RM1,999 (n=77), and RM2,000–RM2,999 (n=107).

The three most commonly cited reasons for not refusing sex were the belief that sexual activity constitutes a marital duty, religious beliefs, and fear of partner anger.

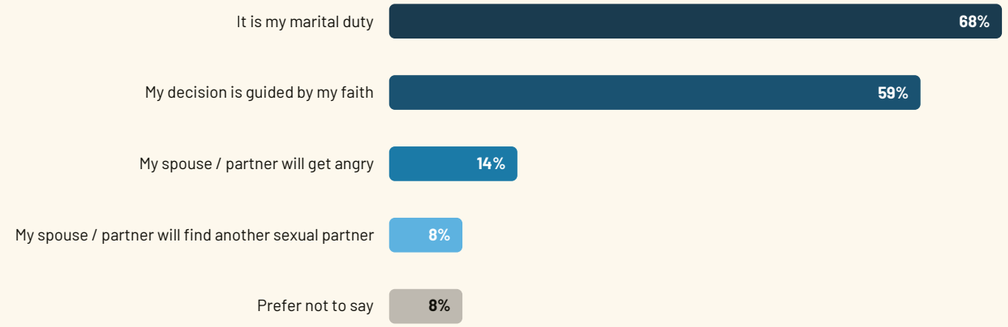
Sixty-eight percent of women overall said it was their marital duty to have sex with their spouse or partner. The same reasoning was held by even higher proportions among rural (81%), 25-34 years old (77%), Malay (73%), and Muslim (72%) women.

Around 59% of women reported that their decision regarding sexual relations was guided by religious beliefs, while approximately one-quarter of Chinese (26%) and Indian (25%) women respondents said they feared incurring the wrath of their spouse or partner (versus 12% of Malay women).

Male respondents reported similar attitudes. Approximately 67% stated that they could not refuse sex because they considered it a marital duty, 59% said their decisions were guided by faith, and 27% cited fear of making their spouse or partner angry.

Reasons for Inability to Refuse Sexual Activity

Figure 22: Women respondents citing main reasons for being unable to refuse sexual activity with their spouse or partner (%)



Question: C1.4 What are the main reasons you feel unable to refuse sexual activity with your spouse / partner? (Multiple Answer)

Base: Women who are currently married / in a sexual relationship and chosed to answer this question (n=517)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

3.2.3 Conclusion

Most women in Malaysia believe that they exercise a meaningful degree of agency over marriage decisions. The majority report that the choice of if, when, and whom to marry is largely their own. This finding may reflect both rising formal educational attainment and greater economic independence among women.

However, the right to decide if, when, and whom to marry is not equally enjoyed. Women who are financially dependent — whether as students, homemakers or caregivers, or low-income earners — are considerably more likely to report that parents or family members play the primary role in such decisions. The gradient is consistent: autonomy over marriage decision-making increases with income, education, and employment status.

While child and early marriage affects only a small proportion of respondents, its endurance warrants attention. Those who married before the age of 18 are disproportionately concentrated among women with lower education and limited economic participation, and are most prevalent in Sabah, reflecting the compounding disadvantages that make younger girls particularly vulnerable. That this practice continues, even at low levels, points to gaps in legal protection, enforcement, and comprehensive sexuality education that remain to be addressed.

Sexual autonomy within marriage and intimate relationships tells a more troubling story. Only around half of women report being able to refuse sex with their spouse or partner, and a further 37% can do so only sometimes. The belief that sex is a marital duty — held by over two-thirds of women — is the most commonly cited reason for not refusing, alongside religious beliefs and fear of partner anger. These patterns are most pronounced among Malay and Muslim women, rural women, and those with lower incomes and less formal education.

Taken together, these findings suggest that progress on marriage autonomy is real but uneven, and that autonomy within marriage — particularly around sexual relations — remains significantly constrained. Sustaining and extending progress requires continued investment in breaking gender stereotypes, alongside broader efforts to shift the social and religious norms that frame sexual compliance as a marital obligation rather than a matter of individual choice.

These findings take on additional significance when benchmarked against the UN SDG indicator 5.6.1. Malaysia's composite bodily autonomy score of 45% — reflecting the share of women who exercise meaningful decision-making power across all three dimensions of healthcare, contraception, and the ability to refuse sex — falls well below the global average (55%) and the East and Southeast Asia regional average (76%). Women in Malaysia perform on par with regional peers on healthcare and contraception decisions, but the country's score on sexual autonomy (51%) is dramatically lower than the regional benchmark (86%), pulling the overall composite down sharply. This places Malaysia just above the lowest-performing regions in the world and underscores that closing the gap in women's bodily autonomy requires targeted action on sexual autonomy within intimate relationships — including the norms, legal frameworks, and institutional practices that currently constrain it.

3.3 Gender-Based Violence

Gender-based violence is both a cause and a consequence of unequal power relations between women and men. It occurs across all settings — homes, public spaces, workplaces, schools, and increasingly online — and takes many forms, from physical and sexual violence to psychological coercion, economic control, and digital harassment. In Malaysia, as in many societies, GBV is shaped by gender norms that normalise male authority, frame women's bodies as objects of family and community regulation, and place the burden of protection on women rather than on the systems and institutions meant to uphold their rights.

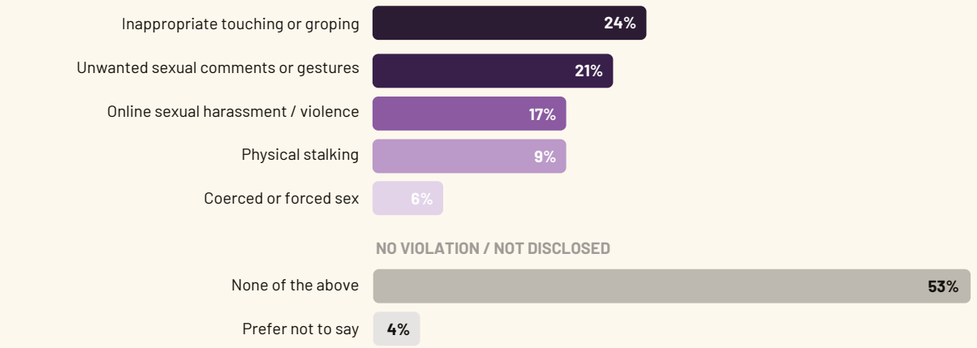
This section examines the prevalence of sexual violence (including sexual harassment) among women in Malaysia, the barriers that prevent survivors from seeking help or formal redress, the growing challenge of online GBV, and the specific experiences of female circumcision and bodily autonomy violations targeting LGBTIQA and gender-diverse people.

3.3.1 High Incidence of Sexual Violence (including Sexual Harassment)

> *I don't know a single woman [who] has not faced any sort of sexual aggression before. It's always some type of harassment... from microaggressions up to really extreme violence.*
> *[Young woman participant, FGD]*
>
> *Harassment is super common among my age and the problem is women still get blamed when something happens to them. People always ask what you were wearing, why you were out so late.*
> *[Young woman participant, FGD]*

Survey findings indicate that a substantial minority of women respondents have experienced some form of sexual violence or harassment. While a majority (53%) reported no such incidents and a very small proportion (4%) preferred not to respond, a notable minority (43%) reported at least one form of violation. The most commonly reported forms were inappropriate touching (24%) and unwanted sexual comments or gestures (21%), followed by online sexual harassment (17%), physical stalking (9%), and coerced or forced sex (6%).

Types of Sexual Violence Experienced
Figure 23: Women respondents reporting by each type of sexual violence (%)



Question: D1.1 The following question relates to experiences that may involve sexual harassment or sexual violence. Have you encountered any of the behaviours below? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

Clear age-related patterns emerge from the data. Younger women, particularly those aged 18-34, report higher levels of harassment across multiple forms. Unwanted sexual comments and gestures are most prevalent among women aged 18-24 (29%), while inappropriate touching is highest among those aged 25-34 (30%).

Online sexual harassment is also more common among younger cohorts, affecting 27% of those aged 18-24 and 26% of those aged 25-34. Overall, while sexual violence occurs across the life course, younger women report higher levels of both physical and online forms of violation.

Types of Sexual Violence Experienced
Figure 24: Women respondents reporting by each type of sexual violence, by age (%)

	18 – 24 years	25 – 34 years	35 – 44 years	45 – 54 years	55 years and above
Inappropriate touching or groping	25%	30%	22%	24%	16%
Unwanted sexual comments or gestures	29%	24%	18%	18%	13%
Online sexual harassment / violence	27%	26%	12%	6%	4%
Physical stalking	9%	12%	9%	8%	6%
Coerced or forced sex	4%	6%	6%	6%	7%
	Highest Frequency				Lowest Frequency
NO VIOLATION / NOT DISCLOSED					
None of the above	45%	47%	55%	59%	67%
Prefer not to say	4%	3%	5%	5%	5%

Question: D1.1 The following question relates to experiences that may involve sexual harassment or sexual violence. Have you encountered any of the behaviours below? (Multiple Answer)

Base: Women (n=1,004)

Notes:
- Multiple responses allowed; percentages may sum to more than 100%
- 55 years and above (n=122) consists of age groups 55-64 years (n=93) and 65 years and above (n=29).

Among the women surveyed who experienced sexual harassment or violence, 16% reported that such incidents occurred within the past 12 months. Incidents most commonly took place online (40%) and in public spaces (38%), followed by workplaces (21%), homes (11%), and educational institutions (7%).

The complementary study findings point to an even higher burden among LGBTIQA and gender-diverse individuals. Over three-quarters (78.2%) of LGBTIQA respondents reported having experienced some form of GBV, with higher rates among cisgender queer women and transgender participants. Among those who experienced harassment or violence, 28.2% reported incidents within the past 12 months — nearly double the rate recorded among the general women's sample — indicating that these experiences are both more prevalent.

Qualitative findings from in-depth interviews and focus group discussions align with the survey results, suggesting that experiences of gender-based violence are relatively common across different social contexts. Participants frequently described encountering various forms of harassment and sexual aggression, while also noting that certain behaviours are not always immediately recognised as abusive because it has become so normalised. As one participant observed, "I feel like most women don't realise that it's violence or harassment until someone points it out... it's wired to their brain that this is the culture" [Young woman participant, FGD]. Recognition often occurs through peer discussions, suggesting that awareness of GBV is shaped through shared experiences and social validation. Young women rated gender-based violence as acutely prevalent among their cohort — when asked to score its prevalence on a scale of 1 to 10, every respondent gave a score of 10.

3.3.2 Underreporting of Sexual Violence (including Sexual Harassment)

> *Even when a woman wants to report they will worry about not being believed and also being ashamed... some police reports get brushed off... that makes survivors scared to come forward.*
> *[Young woman participant, FGD]*
>
> *My friend who is deaf also thought these behaviors were normal because they were in a relationship. This often happens due to a lack of information and limited access to guidance, leaving many people unsure of what is right or wrong.*
> *[Deaf participant, FGD]*

Findings indicate that a substantial proportion of incidents of sexual violence are not reported to authorities. Among respondents who experienced sexual violence in the past 12 months (n=94), only 36% reported them, while 49% did not and 15% preferred not to disclose. Among LGBTIQA respondents, the reporting rate was significantly lower, at just 5%.

Several barriers to reporting were identified. The most commonly cited reason was the perception that the incident was not serious enough (35%), followed by fear of not being believed (33%) and shame or stigma (32%). Lack of trust in authorities or previous negative experiences was also reported (30%), alongside uncertainty about where to report (12%) and fear of retaliation (10%). For LGBTIQA respondents, trust deficit in public institutions was the most common barrier to reporting.

Interview participants highlighted the role of social norms in shaping responses to GBV. Victim-blaming was described as a recurring concern, particularly in public and online discourse, where attention is often directed toward women's behaviour or appearance rather than the actions of perpetrators. Such dynamics contribute to feelings of shame and discourage reporting or help-seeking.

Many participants expressed limited confidence in formal reporting mechanisms, including law enforcement, preferring instead to rely on informal support networks such as friends, peer groups, or counselling.

Findings from discussions with Deaf women suggest that communication barriers compound these challenges. Participants reported that healthcare providers, schools, and public services do not always adequately accommodate the needs of Deaf individuals, limiting access to information and support. The absence of sign language interpreters in healthcare and support settings was highlighted as a particularly significant barrier. A blind researcher consulted for this study reported similar vulnerabilities within the blind community. These findings, while not nationally representative of women with disabilities, are consistent with global evidence and point to the need for dedicated attention to this group in Malaysia's policy and programmatic responses.

Focus group discussions with Orang Asal participants highlight how social norms, stigma, and structural constraints in rural settings shape both the experience and reporting of GBV. Participants described instances of physical violence that were often treated as private or domestic matters, and noted that incidents were not always taken seriously by local authorities unless they involved severe harm. Concerns around stigma and the cultural notion of "*bukak aib* (exposing private matters)" were highlighted as factors discouraging reporting, with some participants noting that coming forward could result in negative social consequences. Early and underage marriage was also raised as a concern, with social media identified as a facilitating factor. Limited access to education on bodily autonomy was noted, with many young people relying on informal or online sources that may not provide adequate guidance or protection.

One Orang Asal leader shared that it was only after attending a GBV workshop that she came to recognise how prevalent GBV was within her own community — illustrating how critical awareness-building is in enabling recognition. An Orang Asli community organiser further noted that even when women do come forward, the absence of shelters and support mechanisms in rural areas leaves them without meaningful recourse. The lack of coordination among agencies was also raised as a concern — she recounted a case in which a woman seeking assistance was redirected between agencies, none of which had a clear mandate or adequate capacity to help. These structural gaps leave Orang Asal women disproportionately exposed and underserved.

These findings point to the need for systemic reforms that address both institutional barriers to reporting and the social norms that normalise GBV and discourage survivors from coming forward.

3.3.3 Perceptions of Legal Protection

The findings reveal a substantial confidence deficit in Malaysia's legal protections against GBV. Only around half of women respondents (51%) believe existing laws offer adequate protection, while 40% do not — suggesting that for a significant proportion of women, the law is not perceived as a reliable safeguard.

Male respondents were more confident at 62%, though nearly a third (32%) remained unconvinced. This gap between legal provision and perceived effectiveness points to the need for stronger implementation, enforcement, and public communication around GBV-related legislation.

3.3.4 The Emerging Challenge of Online Gender-Based Violence

Survey findings indicate that online gender-based violence is a widespread and multifaceted experience. While a majority (56%) reported not encountering such behaviours, a substantial minority (41%) reported experiencing at least one form of online GBV (3% prefer not to say).

The most commonly reported form was unwanted sexual messages or images (33%), followed by cyberstalking (13%), non-consensual use of images (9%), doxing (8%), and threats of violence (7%). The proportion was considerably higher among LGBTIQA respondents, nearly three quarters (73%) of whom reported experiencing online gender-based violence.

Types of Online Gender-Based Violence Experienced

Figure 25: Women respondents reporting by each type of online gender-based violence experienced (%)

Question: D2.1 The following question relates to experiences that may involve online gender-based violence. Have you encountered any of the behaviours below? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

Younger women are particularly affected, reinforcing the role of digital spaces in shaping contemporary experiences of GBV. Approximately one in two women aged 18–24 reported receiving unwanted sexual messages or images. Similarly, one in five women aged 25–34 reported experiencing cyberstalking. Young women in the focus group discussion confirmed the prevalence of receiving unsolicited sexual images via social media.

Types of Online Gender-Based Violence Experienced

Figure 26: Women respondents reporting by each type of online gender-based violence experienced by age (%)

	18 – 24 years	25 – 34 years	35 – 44 years	45 – 54 years	55 years and above
Unwanted sexual messages or images	46%	42%	29%	21%	14%
Cyberstalking	15%	21%	9%	9%	5%
Non-consensual use of your photos (e.g. deepfakes, doctored images)	11%	13%	8%	3%	5%
Doxing (release of private information)	9%	9%	10%	5%	4%
Threats of violence	12%	8%	5%	5%	2%
	Highest Frequency				Lowest Frequency
NO VIOLATION / NOT DISCLOSED					
None of the above	39%	46%	60%	69%	82%
Prefer not to say	5%	3%	1%	4%	2%
	Highest Frequency				Lowest Frequency

Question: D2.1 The following question relates to experiences that may involve online gender-based violence. Have you encountered any of the behaviours below? (Multiple Answer)

Base: Women (n=1,004)

Notes:
- Multiple responses allowed; percentages may sum to more than 100%
- 55 years and above (n=122) consists of age groups 55–64 years (n=93) and 65 years and above (n=29).

Beyond direct experiences, online GBV also shapes behaviour. A majority of respondents (63%) reported avoiding sharing photos of themselves online due to fear of harassment or judgment, indicating a form of self-censorship linked to perceived risks.

When asked whether photos or videos of them had ever been shared online without their consent, the majority of women respondents (88%) said no. However, 11% reported that this had happened to them — a figure that, while seemingly small, represents a significant number of women when projected across the population, and is likely an underestimate given the stigma and shame associated with this form of violation.

Reporting of online GBV remains limited. While 25% reported incidents to an authority, 22% did not. Among those who reported, the police were the most common authority (87%), followed by social media platforms (27%) and employers or educational institutions (19%).

Barriers to reporting mirror those observed offline. The most common reasons include perceptions that incidents were not serious (49%), shame or stigma (41%), and fear of not being believed (40%). Additional barriers include lack of knowledge on reporting mechanisms (30%), distrust in authorities (28%), and fear of retaliation (26%). While 51% reported having access to clear information on how to respond to online GBV, 44% did not.

Of particular concern are emerging cases involving the sexual exploitation of minors through online platforms. One SRHR advocate and service provider recounted the case of a 13-year-old girl who was brought by her mother to seek abortion services after becoming pregnant as a result of sexual exploitation facilitated through an online messaging platform. In a separate case reported in the media, a 15-year-old girl from Kelantan, herself a survivor of sexual violence, was found to have been offering sexual services through an online messaging platform; the situation came to light only after her mother filed a police report. Kelantan police confirmed the girl had been placed under the care of the Social Welfare Department, noting that the case required a comprehensive rehabilitation approach rather than a purely criminal response.[51] A CSE practitioner in Sabah similarly reported encountering cases of the same nature among schoolgirls in the area.

While such cases are likely underreported, key informants noted a worrying trend of young girls using online platforms to exchange sex for money — suggesting that visible incidents may reflect a broader pattern that warrants urgent attention. These cases illustrate the compounding vulnerabilities facing young girls at the intersection of digital exploitation, economic precarity, and limited access to comprehensive sexuality education — and the critical role of frontline health providers and families in identifying and responding to such cases.

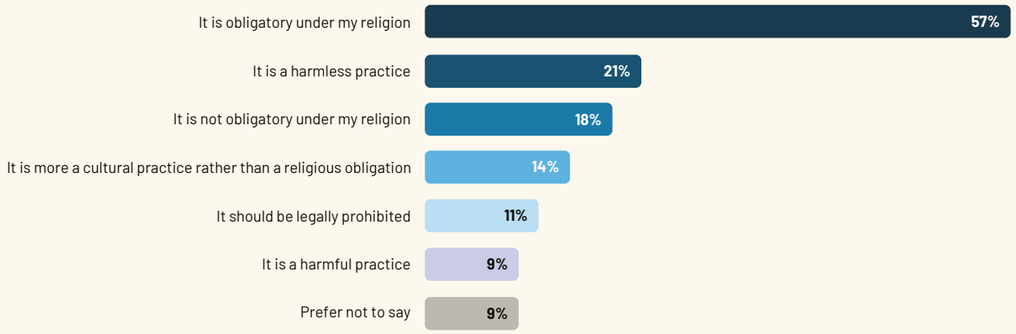
51 "Kelantan police: Teen girl found offering sex on Telegram now under Social Welfare care". *Malay Mail*. 29 Sept 2025. https://www.malaymail.com/news/malaysia/2025/09/29/kelantan-police-teen-girl-found-offering-sex-on-telegram-now-under-social-welfare-care/192820

3.3.5 Female Circumcision is Widely Viewed Through Religious and Cultural Lenses

Survey findings indicate that attitudes toward female circumcision are largely shaped by religious and cultural perspectives. The majority of respondents (57%) view the practice as religiously obligatory, while 21% consider it harmless and 14% view it as cultural rather than religious.

Views on Female Circumcision (Sunat Perempuan)

Figure 27: Women respondents by view on female circumcision group (%)



Question: D3.3 Which of the following statements best reflect your view on female circumcision (sunat perempuan)? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

Younger respondents were more likely to view the practice as religiously obligatory, peaking at 69% among those aged 25-34, compared to 43% among those aged 45-54, 38% among those aged 55-64, and 21% among those aged 65 and above. This belief was also more widely held among respondents in Terengganu (82%), Kelantan (80%), and Kedah (72%), as well as those in rural areas (62%).

At the same time, 18% of respondents do not consider the practice religiously obligatory, indicating some divergence in interpretation. Opposition remains limited, with 9% viewing the practice as harmful and 11% supporting legal prohibition — positions most strongly held among women aged 55-64 (harmful 19%; should be legally prohibited 22%).

3.3.6 Bodily Autonomy Violations Targeting Gender Identity and Sexual Orientation

While a very small proportion of women respondents (3%) indicated having been pressured to undergo psychological therapy or been committed to a medical facility without their consent, four times as many LGBTIQA respondents (12%) said they had been forcibly subjected to the same due to their sexual orientation, gender identity and expression, and sex characteristics (SOGIESC). Another 33.8% experienced pressure to change their sexual orientation, gender identity and expression.

3.3.7 Conclusion

Gender-based violence remains a significant and pervasive issue in Malaysia, with nearly half of women respondents reporting at least one form of sexual harassment or violence. These experiences occur across online, public, and private spaces, and are not confined to any particular demographic — though younger women, women with disabilities, Indigenous women, and LGBTIQA and gender-diverse people face disproportionately higher exposure and compounded barriers to seeking help.

Underreporting is the norm rather than the exception. Only 36% of women who experienced GBV in the past 12 months reported it to any authority — and among LGBTIQA respondents, this fell to just 5%. The barriers are both attitudinal and structural: shame and stigma, fear of not being believed, victim-blaming in public discourse, limited trust in law enforcement, and the absence of accessible and inclusive support services all contribute to a landscape in which survivors are more likely to turn to informal networks than formal institutions. For Deaf women, women with visual impairments, and Orang Asal women in rural areas, these barriers are compounded further by communication gaps, geographic isolation, and the near-total absence of shelters and coordinated support.

Online GBV has emerged as a significant and growing dimension of this problem, affecting a substantial minority of women and a large majority of LGBTIQA respondents. The normalisation of digital harassment — including unsolicited sexual images, cyberstalking, and non-consensual sharing of intimate content — is shaping women's behaviour in ways that extend beyond direct harm, with a majority of women avoiding sharing photos of themselves online due to fear of harassment. The sexual exploitation of minors through online platforms is an emerging concern that requires urgent attention.

Confidence in legal protection is limited. Only around half of women believe existing laws offer adequate protection against GBV, pointing to a significant gap between legal provision and perceived effectiveness. Female circumcision, meanwhile, continues to be viewed by a majority as religiously obligatory — a position that reflects institutional influence rather than settled scholarly consensus, and one that sits in direct contrast to the World Health Organization's classification of all forms of female genital cutting as a human rights violation.

Taken together, these findings make clear that legal frameworks alone are insufficient. Closing the gap between law and lived experience requires sustained investment in awareness-building and legal literacy, reform of institutional practices that discourage reporting, accessible and inclusive support services for all survivors, and a serious reckoning with the social norms that continue to normalise violence, silence survivors, and place the burden of protection on women rather than on the systems designed to protect them.

Box 8. Disability and the Right to Bodily Autonomy — Global Context

For women and girls with disabilities, bodily autonomy is not simply constrained — it is frequently denied across multiple domains simultaneously. Globally, five interconnected rights are routinely violated: the right to make informed decisions about one's own body and health; the right to live free from violence; the right to access sexual and reproductive health information and services; the right to live without discrimination; and the right to protection during crises.

Reproductive decision-making is a particular area of concern. Women with disabilities — especially those with intellectual disabilities — are disproportionately subjected to sterilisation, abortion, and contraception imposed by others without their knowledge or agreement, on the grounds that others know what is best for them. This is a violation of both reproductive rights and legal capacity. Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD) is unambiguous: persons with disabilities hold legal capacity on an equal basis with all others, and must have access to the support they need to exercise it.

Violence experienced by women with disabilities extends well beyond physical and sexual harm. It includes the deliberate withholding of medication and assistive devices, the removal of mobility aids, controlling or restricting communication, and sustained psychological manipulation. These disability-specific forms of abuse are often invisible in mainstream GBV data and poorly addressed in existing response systems. Research indicates that women with disabilities may be up to ten times more likely to experience sexual violence than women without disabilities — yet they remain far less likely to have access to adequate prevention or support services.

Exclusion from sexuality education compounds these vulnerabilities. The widespread assumption that women and girls with disabilities are asexual or do not require reproductive health information leaves them less equipped to recognise abuse, understand their rights, or seek help. The consequences are significant: a substantial proportion of women with disabilities have never accessed any form of sexual or reproductive health service.

At the root of these violations are deeply embedded social and gender norms that cast women with disabilities as dependent, incapable of autonomous decision-making, or outside the scope of reproductive life. Challenging these norms — through law, policy, service delivery, and community engagement — is essential to realising the bodily autonomy of women with disabilities on equal terms with all others.[52]

52 UNFPA (2022). Disability and the Right to Bodily Autonomy. United Nations Population Fund.

3.4 Bodily Appearance and Gender Expression

Bodily appearance and gender expression — how people choose to dress, present, and move through the world — are among the most visible and contested dimensions of bodily autonomy. In Malaysia, decisions about clothing and gender presentation are shaped by a complex interplay of religious expectations, cultural norms, family pressure, institutional rules, and in some cases, legal sanction.

This section examines the extent to which women in Malaysia are able to exercise meaningful autonomy over their bodily appearance and gender expression, the sources of constraint they encounter, and the gap between the values women espouse and the freedoms they are able to exercise in practice.

3.4.1 Mixed Support for Women's Freedom to Decide What to Wear

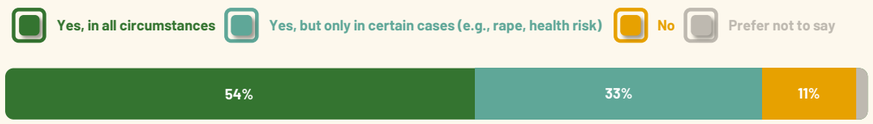
Only 54% of respondents felt they could always dress how they want without fear of judgment or restriction. Forty-three percent reported there were limits to their ability to do this, with 33% saying 'sometimes' and 11% feeling they could not at all.

The pressure to conform to gender norms of an 'ideal' woman was felt most by younger and/or single women. Only 40% of those in the 18-24 year bracket said 'yes', compared to 60% for 45-54 year olds. Likewise, single women (40%) reported lower freedom than married women (62%), while only one in three students (30%) felt able to dress without fearing negative consequences.

Because of what they wore, roughly one in three women respondents (31%) had suffered from criticism, punishment or restrictions from their family, community, employer, school or the authorities. This was more pronounced among students (49%), younger women (45%), those living at home (44%), and single women (39%). Higher proportions were also observed in Kelantan (36%), Kuala Lumpur (35%), and Johor (35%).

Freedom to Choose Dressing

Figure 28: Women respondents reporting ability to dress how they want without negative repercussions (%)



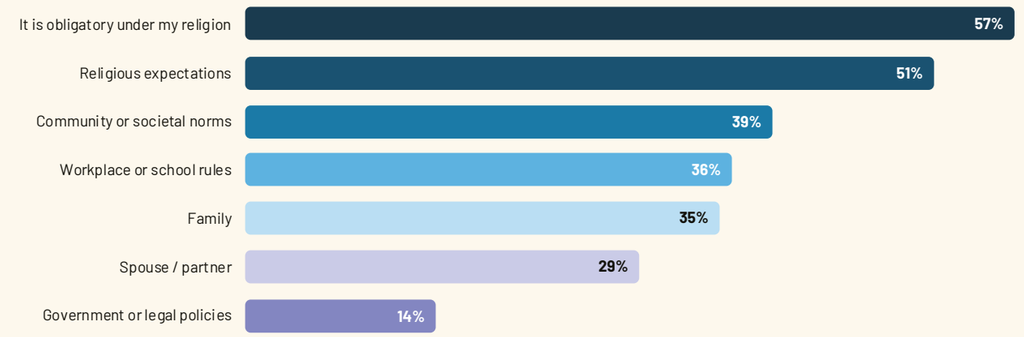
Question: E1.1 Can you dress the way you want to without fear of judgment or restriction from family, community, or authorities? (Single Answer)

Base: Women (n=1,004)

Just over half the women respondents (51%) identified religious expectations as the most restrictive influence on their choice of clothing, with women from Terengganu (79%) and Kelantan (67%) feeling this pressure the most.

Reasons for Inability to Dress Freely

Figure 29: Women respondents citing reason for being unable to dress freely (%)



Question: E1.3 If you feel you are restricted in your choice of clothing, what are the main sources of that pressure? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

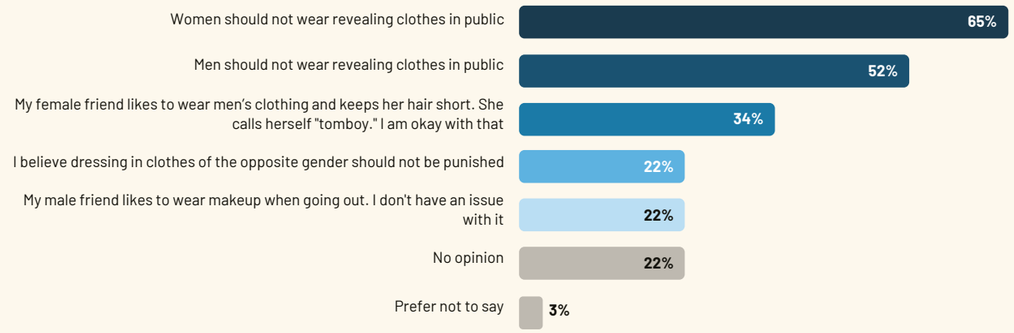
Other sources included community or social norms (39%), workplace or school rules (36%), and family pressure (35%). Spouses or partners were cited by 29% of the respondents, while 14% identified government legislation and policies.

Nearly four out of five women surveyed (78%) agreed that women and men should have the freedom to choose how they dress. However, a small percentage did not share this view for women (15%) nor for men (16%).

At the same time, 65% believed that women should not wear revealing clothes in public, and 52% felt the same about men. These views varied considerably by ethnicity and geography, with higher levels of restriction observed in states such as Terengganu (91%) and Kelantan (84%).

Views on 'appropriate' dressing for women and men in public

Figure 30: Women respondents by views on women's and men's choice of dressing or appearance (%)



Question: E1.6 Which of the following statements do you agree with? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

3.4.2 Gender Expression Remains Constrained and a Site of Discrimination

Among women respondents, there was a greater acceptance of women appearing masculine (34%) than men appearing feminine (22%). Overall, only 22% believed that dressing in clothes of the opposite gender should not be punished, but in Kuala Lumpur, acceptance levels were higher with 40% of the respondents identifying with this statement.

A notable minority (22%) expressed indifference ("I don't really care"), with higher proportions among older women (27%) and female respondents in Sarawak (33%) and Sabah (31%).

A small but notable proportion of women respondents (20%) had experienced discrimination for displaying masculine traits (12%), wearing male clothes (9%), or having very short hair (8%).

A much higher proportion of LGBTIQA respondents reported having been criticised, punished or restricted because of their gender expression (81%). Another 34% experienced pressure to change their SOGIE, while 12% reported being forcibly subjected to therapy or institutionalisation in healthcare settings without their consent due to their SOGIESC.

These experiences were more common among younger women and students. Male respondents reported similar patterns, with slightly higher levels of discrimination for wearing women's clothes (14%) or appearing feminine (16%).

Experience of discrimination based on dressing or appearance
Figure 31: Women respondents by type of discrimination (%)

Question: E1.7 Have you ever faced discrimination.. on the following? (Multiple Answer)

Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%

3.4.3 Conclusion

The findings from this section reveal a significant gap between expressed values and lived experience when it comes to bodily appearance and gender expression. While a large majority of women agree in principle that people should be free to choose how they dress, just over half report being able to exercise this freedom in practice — and roughly one in three has faced criticism, punishment, or restriction because of their clothing choices.

Religious expectations are the dominant source of constraint, particularly in states such as Terengganu and Kelantan, but family pressure, community norms, workplace rules, and government legislation all play a role. The burden of conformity falls most heavily on younger women, students, and single women — those who are often the most economically dependent and least able to resist social pressure without consequence.

Gender expression beyond dress is even more constrained. Acceptance of gender non-conformity remains limited across the general women's sample, and a notable minority have experienced direct discrimination for displaying traits associated with the opposite gender. For LGBTIQA and gender-diverse people, these constraints are far more severe — a large majority have faced criticism or restriction because of their gender expression, more than a third have experienced pressure to change their sexual orientation or gender identity, and a small but significant proportion have been forcibly subjected to therapy or institutionalisation without their consent. These are not merely social pressures but violations of bodily autonomy in the most direct sense.

Taken together, these findings underscore that freedom of dress and gender expression cannot be separated from broader questions of autonomy, dignity, and safety. For many women — and especially for LGBTIQA and gender-diverse people — the body remains a site of regulation, judgment, and punishment rather than self-determination.

3.5 Education and Knowledge About Bodily Autonomy

Education is foundational to bodily autonomy. Without accurate, accessible, and rights-based information about their bodies, health, and relationships, women and young people cannot make truly informed decisions — regardless of what the law permits or what services are available. Schools are the primary institutional space through which this information should be delivered, and the values and practices within them shape how young people come to understand their bodies, their rights, and what they are entitled to expect from others.

This section examines how Malaysian schools are performing against this standard — whether they are experienced as safe environments that respect students' bodily autonomy, whether they are delivering comprehensive sexuality education, and where young people are turning when formal education falls short.

3.5.1 Schools Are Not Always Perceived as Safe Spaces That Respect Students' Bodily Autonomy

Survey findings reveal mixed perceptions of whether schools in Malaysia provide safe environments and respect students' bodily autonomy. While 41% of women respondents believed that schools provide a safe and respectful environment for boys, a majority were less certain: 39% felt this occurs only sometimes, and 15% believed that schools do not provide such an environment. These findings suggest that confidence in schools as safe environments for bodily autonomy is limited.

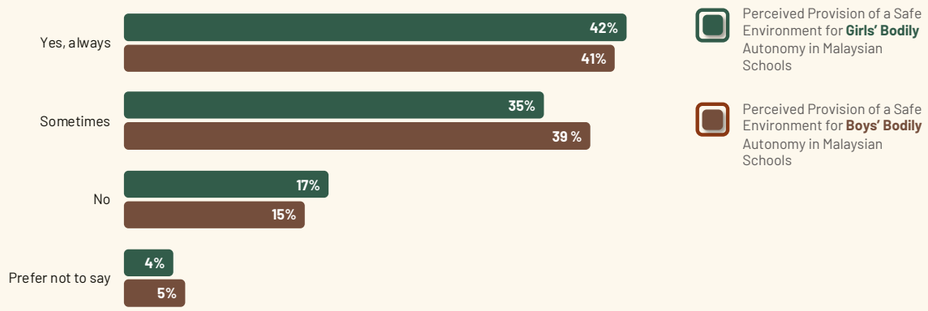
Perceptions were broadly similar with regard to girls. Forty-two percent of respondents believed that schools provide a safe environment and respect girls' bodily autonomy, while 35% felt this occurs only sometimes and 17% believed that schools do not.

This indicates that concerns about safety and respect are not limited to one gender but reflect broader uncertainty about how consistently schools uphold students' bodily autonomy.

Disaggregated findings suggest some variation by location, with slightly higher levels of confidence reported among rural respondents compared to urban respondents. However, across all groups, a substantial proportion of respondents expressed only partial or no confidence in schools as safe environments. This pattern points to systemic concerns rather than isolated perceptions.

Perceptions of School Safety and Respect for Bodily Autonomy

Figure 32: Women respondents by level of confidence in Malaysian schools as safe environments for girls and for boys (%)



Question:
- F1.2 Do you think schools in Malaysia provide a safe environment and respect the bodily autonomy of boys? (Single Answer)
- F1.3 Do you think schools in Malaysia provide a safe environment and respect the bodily autonomy of girls? (Single Answer)

Base: Women (n=1,004)

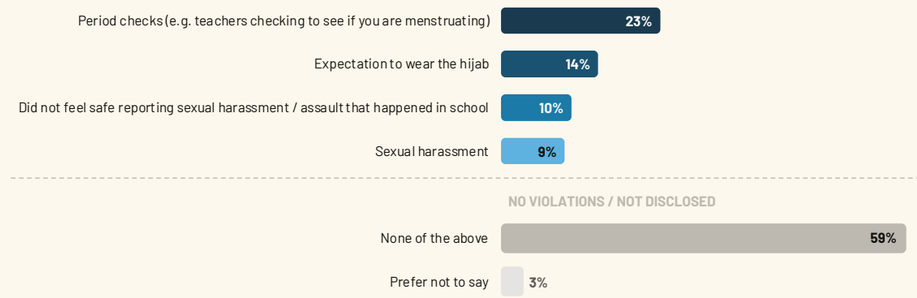
3.5.2 Bodily Autonomy Violations Occur Within School Settings

> *When I was young, I thought that period checks were a normal procedure in school.*
> *[Young woman participant, FGD]*

Beyond perceptions of safety, survey findings indicate that a notable proportion of respondents experienced practices in school that may undermine bodily autonomy. The most commonly reported was period checks conducted by teachers (23%), followed by pressure to wear the hijab (14%), sexual harassment (9%), and feeling unsafe reporting sexual harassment or assault (10%).

Bodily Autonomy Violations in School Settings

Figure 33: Women respondents reporting each type of bodily autonomy violation experienced in school (%)



Question: F1.4 Have you experienced the following in school? (Multiple Answer)

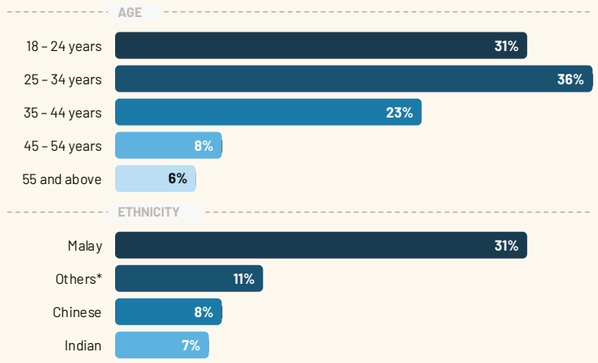
Base: Women (n=1,004)

Note:
- Multiple responses allowed; percentages may sum to more than 100%.

Age-disaggregated data indicates that such experiences are more commonly reported among younger respondents, particularly those aged 18-34. Period checks were most frequently reported among women aged 25-34 (36%) and 18-24 (31%), suggesting either greater prevalence in more recent schooling experiences or increased awareness of such practices as violations of bodily autonomy. Differences are also observed across ethnic groups, with higher reporting among Malay respondents compared to other groups.

Period Checks in School

Figure 34: Women respondents who experienced period check by age and ethnicity (%)



Question: F1.4 Have you experienced the following in school? (Multiple Answer)

Base: Women respondent who experience period checks (n=230).

Notes:
- Multiple responses allowed; percentages may sum to more than 100%.
- Findings for respondents aged 65 years and above (n=29) should be interpreted with caution due to the small sample size
- * Others includes: Kadazan-Dusun (n=50), Bajau (n=17*), Iban (n=17*), Bidayuh (n=7*), Melanau (n=4*), Other Orang Asal Sarawak (n=2*), Other Orang Asal Sabah (n=7*), Murut (n=3*), Semai (n=1*), Mixed ethnicity (n=2*), Other (n=10*), Prefer not to say (n=4*) = n=124. Many constituent groups are small samples — treat with caution

Other forms of violations were also reported across age groups. Sexual harassment in school was reported by 9% of respondents overall, rising to 13% among women aged 18-34. Ten percent of women reported not feeling safe reporting incidents of harassment or assault. This figure rose to one in three among LGBTIQA survey participants, pointing to significant barriers to redress for this community. Pressure to wear the hijab was reported by 14% of respondents, with higher rates among women aged 25-34 (19%) and Muslim women (19%).

Qualitative insights provide further context. Some participants described period checks as routine school practice at the time, noting that while they felt discomfort, they did not initially recognise these experiences as violations. Awareness often developed later, suggesting that normalisation within school settings may shape how such practices are perceived and reported.

3.5.3 Strong Support for Comprehensive Sexuality Education Despite Gaps in Delivery

> *They do not teach how to understand your body in depth... they just focus on 'don't do this, don't touch that'... many girls grow up confused and afraid to talk about our health.*
> *[Young woman participant, FGD]*

> *The materials are not accessible. Even information about menstruation — we cannot access it properly.*
> *[Blind researcher and disability advocate, KII]*

> *During primary school, we had limited exposure to sex education, as the curriculum focused more on religious teachings, and sexual topics were considered taboo.*
> *[Deaf participant, FGD]*

Despite gaps in provision, respondents expressed strong support for comprehensive sexuality education (CSE). Around half of women respondents (51%) reported that Malaysian schools provide some form of CSE, while 40% reported that they do not — pointing to uneven and inconsistent implementation across the education system.

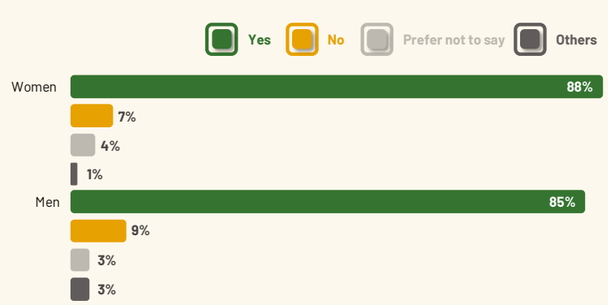
Qualitative findings shed further light on these gaps. Participants described sexuality education as limited in scope and often introduced only at later stages of secondary school, with little to no structured content at the primary level. Discussions around sexuality were frequently treated as sensitive or taboo, and where information was provided, it tended to focus on biological concepts or moral guidance, with limited attention to consent, relationships, or bodily autonomy. As a result, many participants reported turning to peer discussions and the internet to fill these gaps.

As one participant noted, "I don't remember or recall any of these topics being taught in schools... most of the information... I had to research on my own" [Young woman participant, FGD].

Accessibility emerged as an additional barrier for some groups. Participants from the Deaf community noted that sexuality education was rarely delivered in accessible formats, limiting their ability to engage with the content and leading many to rely on informal or community-based sources instead. A blind researcher and disability advocate consulted for this study reported similar experiences within the blind community.

Support for Comprehensive Sexuality Education in Malaysian Schools

Figure 35: Women and men respondents who agreed that Malaysian schools should provide comprehensive sexuality education (%)



Question: F1.5 Do you think Malaysian schools should provide comprehensive sexuality education (which includes information on sexual and reproductive health, rights and bodily autonomy) to students? (Single Answer)

Base: Women (n=1,004); Men (n=92)

Notes:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.
- The "Other" option is included to capture responses that do not align directly with the fixed categories (e.g., "Yes," "No," or "Prefer not to say"), particularly where respondents may interpret the question differently, or indicate perspectives that cannot be accurately classified within the predefined response set.

Key informants further challenged the characterisation of current provision as truly comprehensive, describing it as fragmented, neither rights-based nor inclusive, and heavily skewed toward content about women and girls, with boys largely absent from the curriculum. Implementation was identified as a persistent barrier — teachers frequently avoid or inadequately deliver the material, a pattern that informants noted has endured for at least a decade alongside resistance from parents. Of particular concern is the question of age-appropriateness: key informants argued that rights-based consent education needs to begin earlier than current practice, with one suggesting that concepts such as negotiating consent should be introduced at age nine rather than twelve.

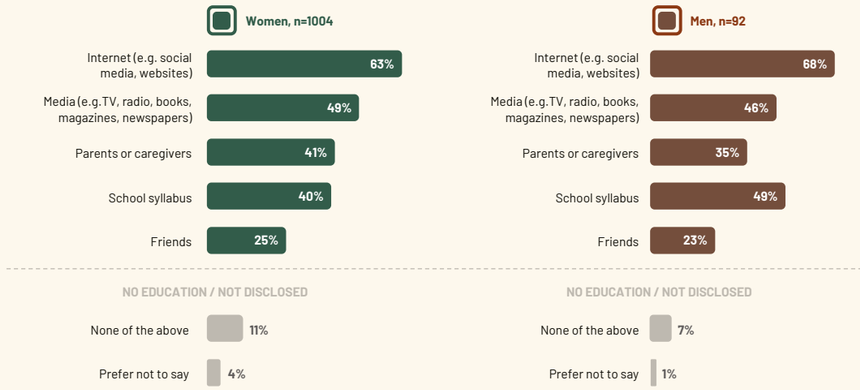
Despite these gaps — or perhaps because of them — there is broad consensus on the importance of CSE. An overwhelming 88% of women respondents and 85% of men agreed that comprehensive sexuality education should be implemented in Malaysian schools, making this one of the strongest consensus findings in the study.

3.5.4 Internet and Informal Networks as Key Sources of Information

> *Most of the information is self-discovery... I searched on the internet how to take care of my body.*
> *[Young woman participant, FGD]*
>
> *There's no proper education in school... I learned from my mom... and now from social media like TikTok.*
> *[Young woman participant, FGD]*

Survey findings indicate that individuals rely on a range of sources to obtain information about bodily autonomy and reproductive health, with informal and digital sources playing an important role. Among women respondents, the internet was the most cited source (63%), followed by media (49%), parents or caregivers (41%), and the school syllabus (40%). Friends were cited by 25% of respondents, while 11% reported not receiving any such information. Reliance on the internet was particularly high among younger women — 70% of those aged 18-24 and 72% of those aged 25-34 — suggesting that digital platforms have become the primary channel through which younger generations access information on bodily autonomy and reproductive health.

Sources of Information About Bodily Autonomy and Reproductive Health - Women
Figure 36: Women and men respondents by source of information about bodily autonomy and reproductive health (%)



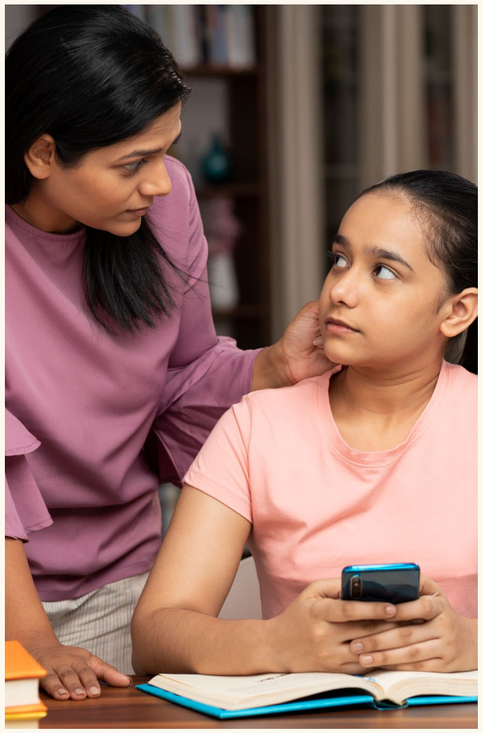
Question: F1.6 What are your sources of information about bodily autonomy.. body (e.g. healthcare, contraception, abortion, sexual consent, reproductive health)? (Multiple Answer)

Base: Women (n=1,004); Men (n=92)

Notes:
- The male subgroup has a relatively small sample size; therefore, subgroup comparisons should be interpreted with caution.
- Multiple responses allowed; percentages may sum to more than 100%.

The school syllabus was cited more frequently among women aged 18-44 (ranging from 45-51%) than among those aged 45 and above (30% and below), suggesting that curriculum coverage of these topics has increased over time, or that older women were less likely to have received it. Across ethnic groups, Malay women were most likely to cite the internet (66%), followed by Chinese women (60%) and Indian women (48%). That Indian women report the lowest internet reliance of the three major ethnic groups points to possible differences in access, language, or community-based information channels that warrant further investigation.

Among male respondents, the internet was similarly the most cited source of information on bodily autonomy and reproductive health (68%), followed by the school syllabus (49%), media (46%), and parents or caregivers (35%). Friends were cited by 23%, while 7% reported not receiving any such information. Notably, male respondents were more likely than women to cite the school syllabus as a source (49% versus 40%).



Qualitative findings further illustrate these patterns. Participants, particularly younger women, described using digital platforms, including social media and artificial intelligence tools, to seek information about sexuality and reproductive health. While these platforms provide accessible and immediate information, participants expressed concerns about accuracy, relevance, and the dominance of Western perspectives that may not reflect local contexts.

Participants also highlighted that Muslim women may face additional challenges in accessing and interpreting information, particularly when navigating the boundaries between religious teachings and cultural practices. Findings from discussions with women with disabilities reinforce the role of informal and digital sources, with participants describing relying on peers, online content, and community networks due to limited access to accessible school-based education.

3.5.5 Conclusion

The findings from this section reveal a school system that is falling short of its potential as a space for supporting young people's bodily autonomy — both in terms of safety and in terms of education.

Confidence in schools as safe environments that respect students' bodily autonomy is limited and uneven. A notable proportion of respondents reported experiencing practices within school settings that directly undermine this — most prominently period checks, which were reported by nearly one in four women overall and by nearly a third of those aged 18-34, indicating that these are recent rather than historical practices. Sexual harassment, pressure to wear the hijab, and barriers to reporting violations were also reported, with LGBTIQA students facing particular difficulty in accessing redress. That many participants did not initially recognise these experiences as violations points to how deeply normalised such practices have become within school cultures.

Comprehensive sexuality education, where it exists, is widely described as fragmented, inaccessible, and inadequate. It arrives too late, covers too little, excludes boys, and is frequently delivered poorly or not at all due to teacher discomfort and parental resistance. For Deaf students, students with visual impairments, and other young people with disabilities, the problem is compounded by materials and delivery methods that were not designed with their needs in mind. The result is that many young people — particularly younger women and those from marginalised communities — turn to the internet, peers, and social media to fill gaps that schools should be addressing. While these sources provide accessible and immediate information, concerns about accuracy, cultural relevance, and the absence of rights-based framing are well-founded.

Against this backdrop, the near-universal support for comprehensive sexuality education — 88% of women and 85% of men — is one of the most striking findings in the study. It signals not only recognition of the current gaps, but a clear public mandate for change. Translating this consensus into practice will require sustained investment in teacher training, curriculum reform that is rights-based, age-appropriate, and inclusive from primary school onwards, and a commitment to making schools genuinely safe spaces for all students — regardless of gender, disability, ethnicity, or sexual orientation.

CHAPTER 4:

THE WAY FORWARD

This study set out to examine the extent to which women in Malaysia are able to exercise meaningful autonomy over their bodies, and the barriers — social, structural, institutional, and legal — that constrain this autonomy. What the data reveals is a society in which formal commitments to gender equality coexist with persistent and deeply embedded inequalities in women's lived realities.

Across every dimension examined — healthcare, reproductive decision-making, sexual autonomy, gender-based violence, bodily expression, and education — the findings point to a consistent pattern: women's ability to make free and informed decisions about their own bodies is shaped not only by individual circumstance, but by the intersecting effects of income, education, ethnicity, religion, age, location, sexuality, and disability status.

The women who face the greatest constraints are older women, rural women, Indigenous women, women with disabilities, and those with lower incomes and less formal education. They are the women most likely to be invisible in aggregate data, and most likely to be underserved by systems that were not designed with them in mind.

What explains the gap between formal progress and lived experience? The answer this study points to is not primarily one of law — though legal gaps remain significant — but of gender norms, institutional culture, and structural inequality. Gender norms that treat women's bodies as objects of family and community regulation rather than individual agency. Institutional cultures in healthcare, law enforcement, and schools that dismiss, minimise, or reproduce violations rather than redressing them. And structural inequalities in income, education, and economic dependence that determine, more consistently than any other factor, how much real choice women are able to exercise.

Critically, these constraints are not experienced as isolated incidents but as accumulated across a lifetime and interconnected across dimensions. Girls who grow up in environments where their autonomy over dress, movement, and relationships is routinely curtailed learn to experience that curtailment as normal. Women who have never been told that marital coercion is a violation of their rights cannot recognise it as one. Young people who receive no comprehensive sexuality education navigate their bodies and relationships without the information needed to make genuinely informed choices. Changing this requires more than legislation. It requires sustained, coordinated action across the institutions, communities, and relationships through which norms are formed, challenged, and passed on. This points to the importance of understanding bodily autonomy not as a series discrete right, but as a continuum that must be understood and responded to across the full arc of women's lives.

There are, nonetheless, reasons for cautious optimism. Public attitudes in Malaysia are, in many respects, ahead of institutional practice. The near-universal support for comprehensive sexuality education, the majority view that women should be free to choose how they dress, the widespread belief that healthcare decisions should belong to women themselves — these are not trivial findings. They suggest that the social impetus for change exists, and that efforts to advance bodily autonomy can draw on genuine public support if they are directed at the right levers: the institutions, services, and accountability mechanisms that translate stated values into daily reality.

The challenge ahead lies in closing this gap — between law and enforcement, between public support and institutional practice, between the autonomy that most Malaysians say they believe in and the autonomy that women are actually able to exercise in their lives. The evidence presented in this report is intended to support that effort — to make visible what has too long remained hidden, and to ground the advocacy and policy work ahead in the realities of women's lives.

Several findings deserve particular emphasis. Sexual autonomy within marriage remains the most constrained dimension of bodily autonomy in this study — with fewer than half of Malay and Muslim women reporting the ability to refuse sex with their spouse or partner, a finding that reflects the weight of religious framing, social norms, and the uneven distribution of power within intimate relationships. Gender-based violence is widespread, underreported, and normalised to a degree that many women do not immediately recognise their own experiences as abuse. The formal education system has largely failed to equip women — or men — with the knowledge, language, or confidence to understand and assert their rights. And legal awareness remains critically low: the majority of women do not know what the law permits on abortion, leaving those most in need of accurate information the least likely to have it.

These findings are further contextualised by Malaysia's standing on the UN SDG indicator 5.6.1, which measures the proportion of women able to make their own informed decisions across healthcare, contraception, and the ability to refuse sex.

Malaysia's composite score of 45% falls below the global average (55%) and well below the East and Southeast Asia regional average (76%). While women in Malaysia compare favourably with regional peers on healthcare and contraception decisions, the country's score on sexual autonomy — at just 51% — is dramatically below the regional benchmark of 86%, dragging the overall composite sharply downwards and placing Malaysia just above the lowest-performing regions in the world. This single gap — the limited ability of women to refuse sex with a spouse or partner — is not merely a personal or cultural matter. It is a measurable structural failing, one that this evidence demands be addressed as a priority.

These are not isolated failures. They reflect structural conditions in law, in institutional practice, in resource allocation, and in the dominant social and religious discourses that shape how women understand their bodies and their rights. The gap between Malaysia's formal legal and policy commitments and the everyday realities documented in this study is the product of uneven implementation, inadequate resourcing, and the persistent influence of norms that subordinate women's autonomy.

The complementary research conducted with LGBTIQA and gender-diverse communities underscores that these structural failings fall most heavily on those already marginalised by law and society. For these individuals, barriers to bodily autonomy are compounded by criminalisation, stigma, and near-total exclusion from mainstream healthcare and support systems. Their experiences are not peripheral to the broader picture of bodily autonomy in Malaysia; they are its sharpest expression.

At the same time, the findings offer grounds for cautious optimism. There is near-universal support among both women and men for comprehensive sexuality education in schools. Majorities support women's right to make their own reproductive decisions. Awareness is growing, particularly among younger and more urban women, and peer networks and digital access are increasingly serving as alternative channels for information and solidarity where formal systems have failed. They point to a public that is, in many respects, ahead of the institutions and policies that are meant to serve it.

What is needed now is a response equal to the evidence — one that draws on government, civil society, religious institutions, healthcare providers, educators, media, and communities working in concert rather than in isolation.

Closing the gap between commitment and lived reality requires political will to enact and enforce the reforms this evidence demands; investment in services, data, and accountability mechanisms that are equitable across geography, identity, and circumstance; meaningful partnership with the civil society organisations and communities closest to the women whose lives are at stake; and a sustained reckoning with the gender norms, institutional cultures, and structural inequalities that continue to limit what women in Malaysia are able to decide about their own bodies and lives. The evidence presented in this report is intended to support that effort — to centre the experiences of women whose realities have too often been overlooked.

CHAPTER 5:

RECOMMENDATIONS

Effecting change in social norms, in individual attitudes, in household and institutional power dynamics, and in women's ability to exercise genuine autonomy over their bodies requires an integrated, multi-sectoral approach. The findings of this study point to ten interconnected recommendations for action that take into account a holistic model of change and a life-course approach. These recommendations are addressed to the government of Malaysia, healthcare bodies, law enforcement agencies, schools, civil society organisations, religious institutions, and media producers.

1. Engage key sources of social influence to shift gender norms that constrain women's bodily autonomy

Women's ability to exercise autonomy over their bodies is not primarily constrained by law, but by gender norms — norms that facilitate control over women's appearance, behaviours, and reproductive choices by families, communities, partners, and institutions. Changing these norms requires more than individual awareness-raising. It requires sustained engagement with religious community, and media institutions through which gender norms are often produced and reproduced. This is particularly important in Malaysia, where religious authorities, community leaders, and vernacular media exercise significant influence over public discourse on women's roles and bodies.

Actions

a. Engage progressive religious leaders and institutions to adopt a gender equality framework in interpretations of religious teachings on marital duty, bodily autonomy, and women's rights, and to actively challenge norms that enable gender-based violence, restrict women's choices, or limit their reproductive decision-making.

b. Partner with media producers, social media influencers, broadcasters, content creators, advertising agencies, health communicators, and civil society organisations to develop and amplify content that is inclusive, accurate, and non-judgmental. This content should actively challenge stigma, taboos, and victim-blaming narratives; promote diverse and respectful representations of womanhood and lived experience; normalise open conversations about sexual and reproductive health and rights and bodily autonomy; and reinforce the right of women and young people to make informed choices about their bodies, relationships, and futures.

c. Build on existing cultural expressions, literature, and community-based advocacy that already advance positive messages about women's agency — including women-led theatre and arts organisations, feminist writers and poets, vernacular-language podcasts and digital content creators, and civil society organisations that produce accessible public communications on women's rights — and support their reach and visibility across different communities and platforms.

d. Engage men and boys as active allies in changing norms — not only as targets of behaviour-change programmes, but as advocates within their own families, communities, and workplaces. Build on and amplify existing initiatives that are already doing this work effectively.[53]

53 See for example, the bystander intervention campaign "Weh, Bro!" by Women's Aid Organisation (WAO) that equips members of the public — with a particular focus on men — to respond safely when they witness harassment or abuse in public spaces.

2. Change the way children and young people are educated about their bodies, rights, and relationships

Most young Malaysians receive inadequate or no comprehensive sexuality education. The vacuum left by formal education is filled by digital platforms, peer networks, and informal sources of uncertain accuracy.

At the same time, violations of bodily autonomy within schools — period checks, hijab pressure, harassment — are reported at significant rates and frequently left unquestioned.

Actions

a. Accelerate the implementation of a standardised, evidence-based comprehensive sexuality education curriculum across all Malaysian schools, covering bodily autonomy, consent, healthy relationships, reproductive health, and the recognition of abuse — introduced at an age-appropriate level from primary school onwards.

b. Ensure CSE is accessible to all students through adapted materials and inclusive delivery, including sign language interpretation, large print and audio formats, simplified content for learners with disabilities, culturally appropriate materials for Indigenous and rural communities, and inclusive and non-stigmatising language.

c. Prioritise investment in training for teachers, counsellors, and school administrators on CSE content and delivery, SRHR, SOGIE, and human rights — with emphasis on creating safe, non-judgmental learning environments, building capacity to recognise and respond to disclosures of abuse, and ensuring non-discrimination and the protection of all students' rights in line with the Convention on the Rights of the Child.

d. Allocate protected curriculum time, train specialist facilitators or school counsellors to lead delivery, and build partnerships with civil society organisations and health professionals who can co-deliver sessions — rather than placing additional responsibilities on already overburdened teachers.

e. Engage parents, community leaders, and religious figures in dialogues about the importance of age-appropriate CSE, building broader social support for its implementation.

f. Extend education on bodily autonomy and rights to out-of-school settings, including through community programmes, NGO-led initiatives, and youth organisations, to reach young people not in formal education.

g. Support, fund, and build partnerships with civil society organisations and NGOs delivering innovative, community-based CSE and bodily autonomy education, recognising that their community reach, expertise, and trust are essential complements to what formal education systems can provide.

h. Review school policies, guidelines, and circulars to ensure non-discrimination and the protection of all students' rights, strengthen the accessibility and inclusivity of complaint mechanisms and counselling services so that all students have safe and confidential avenues to seek support.

3. Empower youth as agents of change for gender equality

Younger women in Malaysia hold more egalitarian attitudes than older women, and are more likely to recognise violations of bodily autonomy as violations.

At the same time, younger women face the highest rates of harassment, the greatest constraints on dress and self-expression, and the most significant barriers to reproductive decision-making.

Actions

a. Support the creation and expansion of youth-led campaigns and platforms on bodily autonomy, gender equality, and safe reporting of GBV, building on the digital fluency and social networks of younger women and men.

b. Mainstream gender-transformative content in secondary school and university curricula, supporting students' ability to think critically about gender norms, bodily autonomy, and consent.

c. Invest in youth leadership opportunities for young women, particularly those from marginalised and underserved communities, through internships, mentoring, and formal recognition of youth advocacy on gender rights.

d. Engage young men as active allies in advancing bodily autonomy, recognising that change in gender norms requires the participation of those who currently benefit from unequal arrangements.

4. Empower girls and women through education, economic independence, and political empowerment

Economic independence, educational attainment, and political participation are the factors most consistently associated with women's ability to exercise bodily autonomy. Women who are economically dependent report significantly lower levels of autonomy in healthcare decisions, marriage choices, sexual relations, and freedom of dress. Investing in girls' education and women's economic and political empowerment is therefore not only a development goal — it is a precondition for bodily autonomy.

Actions

a. Invest in economic empowerment programmes for women, including vocational training, financial literacy, access to credit, and pathways into formal employment, with particular attention to women in rural areas, Indigenous communities, and lower-income brackets.

b. Advocate for family-friendly workplace policies, including maternity and paternity leave, flexible working arrangements, and subsidised childcare, that support women's sustained participation in the workforce.

c. Strengthen legal protections against child and early marriage, and ensure that girls' continued education is actively supported and protected at the community, institutional, and policy level.

d. Address the disproportionate burden of unpaid care work borne by women, including by promoting men's engagement in caregiving and domestic responsibilities.

e. Increase women's representation in political and decision-making bodies at all levels including parliament, local government, the judiciary, and senior public service roles, if necessary through the adoption of temporary special measures such as quotas or targets.

f. Promote women's civic participation and leadership at the community level, including by supporting civil society organisations led by and for women, and by building capacity and creating more spaces for women — particularly those from underserved communities — to engage in public advocacy and decision-making processes.

5. Engage men and boys as partners in advancing bodily autonomy and gender equality

The findings of this study make clear that women's bodily autonomy is shaped not only by structural conditions and institutional failures, but by the attitudes, expectations, and behaviours of the men and boys in their lives.

At the same time, boys and men are not exempt from bodily autonomy constraints of their own — including pressure to conform to masculine norms, stigma around help-seeking, and silence around sexual violence experienced by men.

Actions

a. Develop and implement gender-transformative programmes for men and boys that address attitudes toward women's autonomy, consent, sexual relations, and shared responsibility for reproductive health and family planning.

b. Engage men as active participants in reproductive health services, including through couples-based counselling, male-friendly family planning services, and paternity support programmes that promote shared decision-making.

c. Promote men's active and equal involvement in parenting and caregiving, including through family-friendly workplace policies, commensurate paternity leave, and community programmes that support fathers' engagement in early childhood development and household decision-making.

d. Build on existing evidence-based approaches to engaging men in GBV prevention, including bystander intervention programmes, community-based norm change initiatives, and workplace programmes addressing harassment and respectful relationships.

e. Support further research on men and masculinities in Malaysia to better understand how gender norms shape men's attitudes and behaviours, and to inform the design of more effective interventions.

f. Recognise that boys and men also experience constraints on their bodily autonomy — including social pressure to conform to dominant masculine norms, limited ability to seek help for mental and physical health concerns, stigma around male sexual violence, and restricted emotional expression — while maintaining a clear focus on the disproportionate impact that bodily autonomy violations have on women and girls.

6. Break cycles of gender-based violence through prevention, accountability, and support

Gender-based violence is widespread, largely unreported, and inadequately addressed by existing institutional responses. Nearly half of women surveyed have experienced some form of sexual harassment or violence.

Most incidents go unreported, and many of those who do report face further harm or dismissal. Online GBV is a growing and poorly addressed dimension of this problem, affecting younger women in particular.

Actions

a. Scale up community-based interventions that change violence-supportive norms, and engage community and religious leaders in preventing GBV and holding perpetrators accountable.

b. Establish safe, accessible, and anonymous reporting mechanisms for gender-based violence — both offline and online — and invest in public campaigns that communicate what GBV is, what the law provides, and how to access support.

c. Implement and scale up GBV prevention curricula in schools and workplaces, addressing both physical and online forms of violence, with particular attention to the normalisation of harassment.

d. Strengthen regulatory frameworks governing online platforms to ensure accountability for addressing reports of online GBV, and develop accessible guidance for survivors on how to report digital harassment.

e. Provide adequate and holistic support services for GBV survivors, encompassing psychosocial care, economic assistance, and safe shelter, that are accessible outside major urban areas, available in multiple languages and formats, and designed to be inclusive of all survivors, including those facing additional barriers to accessing help.

f. Strengthen the capacity of the Tribunal for Anti-Sexual Harassment and provide training for GBV responders (e.g., counsellors, welfare officers, police officers, OSCC service providers) in trauma-informed, survivor-centred approaches that are responsive to the diverse needs and circumstances of all survivors, including those who face additional barriers to accessing help.

g. Review and expand existing GBV guidelines — including the Guidelines for Managing Domestic Violence Cases and the OSCC policy and guidelines — to include specific protocols for responding to cases involving LGBTIQA and gender-diverse people, developed in collaboration with LGBTIQA civil society organisations.

7. Enhance access to quality and respectful healthcare and reproductive services for underserved groups

Access to healthcare — general, reproductive, and maternal — is not experienced equally across all groups. The same women who face the greatest barriers to access are also the least likely to be reached by awareness campaigns, the most likely to be underrepresented in national datasets, and the least likely to know their legal rights. Equality in healthcare cannot be achieved through universal approaches alone.

Actions

a. Increase the allocation of healthcare resources — personnel, facilities, and equipment — to underserved states, particularly Sabah, Sarawak, and Kelantan, where access gaps are most pronounced.

b. Expand mobile and outreach health services for rural, Indigenous, and geographically isolated communities, with consistent scheduling and follow-through of planned visits.

c. Mandate disability-inclusive healthcare provision across all public facilities, including accessible physical infrastructure, sign language interpretation, easy-read materials, alternative formats for the visually impaired, and care protocols that address patients directly rather than through companions or caregivers.

d. Introduce targeted subsidies and expanded coverage for low-income women, homemakers, and the unemployed, and continue efforts to address the burden of rising private insurance premiums that are pushing healthcare out of reach for many.

e. Promote awareness of reproductive health services and preventive care — including mammograms and pap smears — particularly among older women and lower-income groups, where utilisation is lowest despite availability.

f. Expand and integrate LGBTIQA-affirming services and HIV-related interventions into the national healthcare system, with particular attention to the needs of trans men and transmasculine persons, who face comparatively lower access to HIV-related services and information.

8. Transform institutions to uphold, not undermine, women's bodily autonomy

There are consistent institutional gaps across healthcare, law enforcement, schools, and social protection agencies. Healthcare providers fail to obtain informed consent or provide adequate information for patients to make independent decisions about their own care. Police dismiss GBV complaints as a private matter. Schools conduct intrusive body checks and fail to deliver adequate sexuality education. These failures are not solely a matter of individual conduct — they reflect systemic gaps in training, accountability, and institutional culture.

Actions

a. Introduce and enforce clear protocols for informed consent across all reproductive and maternal healthcare interactions, with explicit requirements to explain available options, associated risks, and the voluntary nature of all procedures.

b. Mandate training for healthcare providers in respectful, patient-centred care, with specific attention to marginalised patients including Indigenous women, women with disabilities, LGBTIQA, and those with lower health literacy or income.

c. Establish accessible, confidential patient feedback mechanisms within healthcare facilities to identify and address cases of coercive or disrespectful care.

d. Clarify inter-agency coordination (such as between, KKM, JKM, JAKOA and other relevant bodies) to eliminate jurisdictional gaps in GBV response, particularly in rural, Indigenous, and communities in Sabah and Sarawak.

e. Expand access to One-Stop Crisis Centres and survivor protection shelters beyond major urban centres, with priority given to Sabah and Sarawak and other remote areas in Peninsular Malaysia, where access to support services remains challenging.

f. Prohibit the practice of period checks in schools, develop and implement school-level policies on student dignity and bodily autonomy, and establish safe and confidential reporting mechanisms for students who experience harassment or violations in school settings.

g. Review and update medical and health guidelines to reflect current evidence and international human rights standards on the wellbeing of LGBTIQA and gender-diverse people, with particular attention to ensuring that clinical practices do not cause harm.

9. Close the gap between law and practice and strengthen legal frameworks

Many women in this study expressed support for legal protections on paper, while doubting whether those protections function in practice. There are numerous gaps: only half believed that existing laws adequately protect them from gender-based violence; most were unaware of what the law on abortion actually allows; marital rape is not comprehensively criminalised; child marriage remains legally permissible under state syariah provisions and native customary law; and online gender-based violence is not adequately addressed by existing legislation. This combination of legal gaps and low legal literacy represents a significant barrier to bodily autonomy.

Actions

a. Invest in sustained public information campaigns on women's rights within marriage, and protections against gender-based violence, the legal status of therapeutic abortion, ensuring these reach those who face the greatest barriers to accessing legal information — including rural women, those with lower formal education, and older women.

b. Establish a systematic monitoring and evaluation framework to assess the implementation and efficacy of GBV-related legislation, including the Domestic Violence Act, the Sexual Harassment Act, and provisions under the Penal Code — tracking prosecution rates, case outcomes, survivor satisfaction, and barriers to reporting — and publish findings regularly to support evidence-based law reform and public accountability.

c. Carry out mandatory, standardised gender-awareness training for law enforcement personnel, including police, prosecutors, and judges, that covers the full spectrum of gender-based violence, emphasises survivor-centred approaches, and addresses the normalisation of intimate partner violence and marital coercion.

d. Review and strengthen legal provisions on marital rape, child and early marriage, online gender-based violence, and female genital cutting to bring domestic law into full compliance with Malaysia's obligations under CEDAW and international human rights standards. As a first step, withdraw all remaining reservations to CEDAW without further delay.

e. Harmonise the minimum age of marriage across civil and syariah jurisdictions to ensure consistent protection for girls regardless of religious affiliation.

f. Develop dedicated legislation on online gender-based violence, including cyberstalking, non-consensual sharing of intimate images, and doxing, commensurate with the scale and seriousness of digital harassment documented in this study

g. Repeal all laws and policies that criminalise and discriminate against LGBTIQA people, and review legislation that restricts access to services and legal safeguards.

10. Generate better data and sustain accountability for progress

This is the first nationally distributed, mixed-methods study on women's bodily autonomy in Malaysia. Sustaining progress requires sustained investment in evidence.

Actions

a. Commission regular, disaggregated data collection on women's bodily autonomy, tracking outcomes across social groups, geographic settings, and life stages, with particular attention to groups underrepresented in national datasets including Indigenous women, women with disabilities, undocumented individuals, LGBTIQA people, and those in rural areas.

b. Build research capacity within Malaysian institutions on bodily autonomy, gender-based violence, and reproductive rights, including through partnerships with civil society, universities, and international research networks.

c. Expand the evidence base to include research on men and masculinities, examining how gender norms, power relations, and social expectations shape men's attitudes and behaviours related to bodily autonomy, gender equality, and gender-based violence.

d. Leverage Malaysia's commitments under CEDAW, the SDGs, and the ASEAN regional framework as accountability mechanisms, and ensure that the findings of this study are submitted and considered in Malaysia's periodic reporting processes.

e. Actively disseminate the findings and recommendations of this study to policymakers, healthcare providers, educators, community leaders, and civil society organisations, and advocate for these to be considered in relevant national policy reviews and government action plans.

A CALL FOR COMMITMENT AND ACTION

The recommendations above span multiple sectors, institutions, and levels of government, and cannot be achieved by any single actor alone. Their realisation will require sustained political will, coordinated action across ministries and agencies, meaningful partnership with civil society, and accountability to the women whose lives and rights are at stake. Many of the issues documented in this study are not new as they have been raised in previous research, and in advocacy by women's organisations, including in Malaysia's periodic reviews before the UN CEDAW Committee. What has been lacking is not recognition of the problems, but consistent commitment to addressing them. This study offers nationally distributed evidence on women's bodily autonomy across the life course in Malaysia, and its findings provide a clear and evidence-based foundation for the policy, institutional, and social change that is needed.

SIS Forum (Malaysia) (SIS) is a civil society organisation which believes that Islam upholds Equality, Justice, Freedom, and Dignity. SIS is made up of Muslim women and men working on women's rights within the frameworks of Islam and universal human rights, taking into account the lived realities of women on the ground. Since its establishment in 1987, SIS has successfully created a public voice and a public space that enable Muslims to engage with their faith in the struggle for justice, human rights, and democracy in the 21st century.

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