Review Article

Leaving No Child Behind: Equity in the First 1,000 Days

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ABSTRACT

Background: The first 1,000 days of life, from conception to a child's second birthday, lay the base for later health, learning and economic well-being. Malaysia's national averages obscure a deepening equity gap: marginalised communities record stunting, maternal anaemia, and preventable under-five mortality multiples higher than the national average.

Aims: This review identifies the marginalised child populations in Malaysia, quantifies the disparity between those populations and the national average for first-1,000-days outcomes, and analyses the systemic determinants that produce and perpetuate the gap.

Review Result: Six populations are identified: children living in absolute and relative poverty, including the interior-Sabah and urban poor; indigenous communities (Orang Asli and Penan); refugee and stateless children; children in prison or immigration detention; looked-after children; and children with disabilities. For each, the review names the mechanism of harm in the first 1,000 days: obstructed antenatal access, unregistered birth, interrupted neonatal follow-up, malnutrition in pregnancy and infancy, and delayed detection of developmental disability. Preconception nutrition and maternal mental health are treated as part of the window, not preparatory to it.

Conclusion: Persistent inequity in the first 1,000 days in Malaysia is a consequence of policy choice. The recommendations issued to Malaysia in January 2026 by the UN Committee on the Rights of the Child offer a roadmap that matches the equity gap documented here.

Clinical Significance: Paediatricians and primary-care practitioners have the authority and the data to advocate for child-rights-based budgeting, disaggregated data, universal birth registration, and withdrawal of Malaysia's outstanding reservations under the Convention on the Rights of the Child (CRC).

Keywords: first 1,000 days; child health equity; Malaysia; marginalised children; social determinants of health; stunting; birth registration; child rights; perinatal health.

INTRODUCTION

The period from conception to a child's second birthday, about 1,000 days, is when the base for lifelong health and wellbeing is built. It is recognised as one of the most crucial periods for physical growth and brain development in children[1,2]. For healthcare professionals, this period offers the most significant opportunity to influence long-term health, cognitive development, and socioeconomic outcomes.

However, for many children in marginalised communities, this window is obstructed by systemic inequities. The majority of children in marginalised communities continue to face higher rates of stunting and preventable mortality/morbidity despite national progress for the 'mainstream' communities. The benefits of modern child health are not distributed equally.

This paper examines: (i) who the marginalised child populations in Malaysia are; (ii) the magnitude of the gap between those populations and mainstream communities for first-1,000-days outcomes; (iii) the systemic obstacles that sustain that gap; and (iv) what can be done to overcome them. To address these questions, we draw on data from national surveys, the Department of Statistics Malaysia, international health organisations, and peer-reviewed publications and grey literature published between 2008 and 2026.

Note that this is a narrative rather than systematic review and some comparisons rely on older data and grey literature because newer disaggregated data are not in the public domain. Climate-related determinants are excluded by scope. The paper draws on a single jurisdiction and is not intended as a cross-country comparison.

Who are the Marginalised Communities in Malaysia?

Population estimates for 2025 show 9.03 million children aged below 18, or 26.4% of the total population (Table 1)[3].

Table 1. Population Data on Children in Malaysia, 2025[3]

Age (years)	All Children (Numbers in 1,000s)	% of Total Population
0-4	2,306.6	6.7
5-6	987.1	2.9
7-12	3,069.3	9.0
13-17	2,663.3	7.8
Population of Children (Sub-Total)	9,026.3	26.4
Total (all ages including adults)	34,231.7	100

Children and their families that are marginalised in Malaysia form a significant proportion of the population (Table 2). The groups described below are each marginalised in different ways, but this paper is concerned with a single, specific window of harm: the 1,000 days from conception to the second birthday. For each group, we attempt to identify the mechanisms by which marginalisation obstructs the first 1,000 days - antenatal access, safe delivery, birth registration at birth, neonatal follow-up, immunisation, breastfeeding, nutrition of the pregnant mother and infant, and early detection and intervention for developmental delay. Outside this window, the harms are real and well documented; inside this window, they are developmentally irreversible. That is the argument of this paper.

Children Living in Poverty

The 2024 poverty statistics of the Department of Statistics Malaysia (DOSM)[4] put the mean Poverty Line Income (PLI) at RM2,705, with 5.1% of households in absolute poverty and 0.09% in hardcore poverty. The estimated number of households living in absolute poverty would be ~416,000 (based on data from DOSM[4,5]). It is estimated

that approximately 1.0-1.2 million children live in absolute poverty (note that low-income groups would have a typically higher than the national average household size and more children). Absolute poverty was higher in rural households (9.9%) than in urban households (3.7%), and by state it was highest in Sabah (17.7%) and Kelantan (11.5%).

Relative poverty was 16.7%, measured as household income below half the national median (RM3,509 in 2024). The number of children living in relative poverty would be 3.2-3.5 million (estimated 1.44 million households).

Indigenous Children

The government probably holds counts of indigenous (Orang Asli) children in Peninsular Malaysia, but these are not shown in national data publications. Often, they are included under a 'Bumiputera' or 'Other-Bumiputera' category (with East Malaysians). The Orang Asli of Peninsular Malaysia comprise 18 sub-groups across three major groupings (Negrito, Senoi, and Proto-Malay). In a special report on the demographic of Orang Asli[6] it was reported that the population of Orang Asli in 2025 was 227,900. The same report showed that one-third (33.3%) of Orang Asli were aged 0–14 years in 2020. From these figures, a reasonable estimate of the population of Orang Asli children in 2025 would be in the range of 85,000-100,000. In East Malaysia, the indigenous peoples include the Kadazan-Dusun, Murut and Bajau in Sabah, and the Iban, Bidayuh, Melanau and Penan in Sarawak. This paper gives particular attention to the Penan. Data on the Penan population in Sarawak is also weak. It was estimated at 11,000 in 2008[7] but other informal estimates say current numbers are up to 16,000 (various, unverified estimates). No national figure exists for Penan children, although they probably make up 30–40% of the community.

Migrant, Refugee and Stateless Children

Data on migrant, refugee and stateless children in Malaysia is poor. UNHCR Malaysia had 211,360 registered refugees and asylum-seekers at the end of October 2025[8]. About 90% (189,760) were from Myanmar, with most of the remainder from Pakistan, Yemen, Somalia, Afghanistan, Syria, Sri Lanka, Palestine and Iraq; 64,801 were under 18. In 2019 the UNHCR estimated 450,000 stateless persons in Sabah[9]. However, in March 2022 the Sabah Chief Minister put the number of non-citizen residents at 810,443, or 23.7% of the state's population, most of them Bajau Laut[9]. Welfare Department figures for 2019 recorded 1,933 stateless children (1,098 boys, 835 girls) living in welfare homes across the country[10]. Population data for 2025 shows that 703,100 children (aged 0-19 years) are non-citizens (excluding data on persons in Malaysia of other citizenship) and comprise 7% of the childhood population[11]. Most of these children would probably be stateless children.

The first 1000-days mechanism of harm for this group is access: to antenatal care, safe delivery, birth registration at birth, neonatal follow-up, and infant immunisation. Each of these is obstructed by immigration-enforcement concerns and by the higher cost of public-facility care for non-citizens.

Children in Prison/Detention

Women make up 7-9% of the total Malaysian prison population[12,13]. Under Regulation 13 of the Prisons Regulations 2000, a mother in prison may keep her child with her until the age of three, often so that she can continue breastfeeding. There is a lack of proper nursery or dedicated facilities in most prisons that house women. No figures have been published on the number of young children living with their mothers in prison. A separate issue involves children, including infants, being held in immigration detention centres without suitable facilities, sometimes separated from parents or kept with them in inappropriate conditions. The Home Minister announced that as of 31 August 2025, 2,196 children were detained (11% of the 20,143 undocumented migrants) at 18 immigration depots and two temporary facilities[14]. The majority of these children (66%) are unaccompanied and separated from their families[15].

The first 1000-days mechanism of harm here is not imprisonment itself but its developmental correlates: maternal stress and trauma during pregnancy, childbirth under detention protocols, disrupted or absent breastfeeding, infection exposure in crowded facilities, and interruption of routine infant care and surveillance.

Looked After Children (Institutions or Residential Care)

Malaysia has no complete count of looked-after children. The 'Children Statistics Malaysia 2025'[3] cites two different figures. Firstly, the number of inmates in government children's institutions for 2024 was 2,078. Secondly, the number of 'inmates' of childcare centres for 2024 was 38,955 (possibly including those run by private and civil society organisations). Some homes are unregistered, making the exact number difficult to track. OrphanCare Foundation Malaysia estimated that there were ~64,000 children living under institutional care in Malaysia in 2021[16].

For the first 1000-days window, institutional placement of infants and very young children has specific developmental consequences: relational deprivation, inconsistent caregiving, constrained language exposure, variable nutrition quality, and increased infection risk. These are not aggregated into the national discussion because the national discussion treats alternative care as a child-protection issue rather than a developmental one.

Children with Disabilities

Malaysia's data on childhood disability are inadequate. Data of the Welfare Department (JKM) up to February 2026 show 219,564 children aged 18 years or younger registered persons with disabilities[17]; there is gross under-representation of girls registered. The absence of anti-discriminatory protection exposes children with disabilities to discrimination, especially in the right to mainstream education, access to insurance coverage and future employment. Hence, many families hesitate to register with JKM. UNICEF[18] estimates that about one child in ten worldwide, close to 240 million children in all, has a disability. Using the 2025 population of children[3], the registered children with disabilities amounts to 2.43% of all children, far below the expected 10% from international data. However, the 2022 National Health and Morbidity Survey (NHMS) on maternal and child

health found developmental delay in 7.4% of children aged 6–59 months[19]. Note that the NHMS disability rates do not include childhood disability due to psychosocial (mental health) issues. Hence, it would be reasonable to accept the UNICEF rate and assume that approximately 10% of all children in Malaysia have a disability.

Table 2. Population of Marginalised & Potentially Marginalised Children in Malaysia

Category	Number	% of Total Children
All Children	9,026.3	100.0
Children Living in Poverty		
Absolute Poverty	1,000,000-1,200,000@	11.1 – 13.3
Relative Poverty	3,200,000-3,500,000@	35.5 – 38.8
Indigenous Children (Orang Asli & Penan)	~100,000@	1.1
Non-citizens - Migrant, Refugee and Stateless Children	703,100@	7.0
Children in immigration detention	2,196	-
Looked After Children (Institutions or Residential Care)	>60,000@	0.7
Children with Disabilities	~900,000*	10.0

@Using estimates from DOSM data and other reports, see text
*Using NHMS data and UNICEF estimates, see text
#Ages 0-19, as published by DOSM
No figures are published for children living with their mothers in prison

What are the Problems Faced by Children in Marginalised Communities?

Here the focus will be on the first 1,000 days and not on inequalities faced in later years in life like school education, employment, etc. The key impacts on children and pregnant mothers for marginalised communities are summarised below. The key problems are poverty-related barriers and inadequate access to healthcare.

Poor Maternal Nutrition/Health & Teenage Pregnancies

Poor maternal nutrition slows the baby's growth in the womb and leads to low birth weight, especially the symmetrical small-for-gestational-age (SGA) baby. These babies are at higher risk of death before the age of five and of developmental delay[20]. National data from 2019 found anaemia in 29.9% of Malaysian women of reproductive age. Anaemia points to poor nutrition and raises the risk that the baby is born small and later becomes stunted[21].

The first 1,000 days begin biologically before pregnancy is confirmed. The primordial follicle takes months to mature before ovulation, and the mother's metabolic state shapes the intrauterine environment from conception forward. That state includes her nutrition, her micronutrient status (folic acid, vitamin D, iodine, iron) and her psychosocial wellbeing. For first-1,000-days policy, this means preconception nutrition and maternal mental health are not preparatory; they are part of the window. An impoverished woman who becomes pregnant without antenatal preparation enters the first 1,000 days at a disadvantage that no amount of neonatal care can fully recover. Hence, we need to work with families before the mother becomes pregnant, at least 6 months (180 days) before conception.

Findings from National Obstetric Registry[22] and NHMS 2024[23] suggest that 40-50% of women in pregnancy are

overweight or obese, often linked to poverty. Obesity is associated with gestational diabetes mellitus (GDM prevalence 27.1%) and with more complications in pregnancy and delivery[19].

Ministry of Health (MoH) facilities recorded 41,842 pregnancies among girls aged 19 years or younger over 2020–2024[24]. Of these 16,951 involved unmarried girls. Note that the data is only from MoH health facilities and the problem is probably much larger if we had national data. Teenage pregnancies have a strong correlation with poverty, lack of education, nutritional deficiencies, high rates of adverse birth outcomes and perinatal mortality, with significant psychosocial impact[25].

Perinatal Psychosocial Health

Perinatal psychosocial health - encompassing depression, anxiety, and psychosis during pregnancy and the first year after birth - is one of the most consequential yet often neglected determinants of child outcomes in the first 1,000 days. Maternal psychosocial illness directly impairs infant attachment, breastfeeding initiation and duration, cognitive stimulation, and early brain development in the child, with effects that can persist across the child's lifetime. For marginalised mothers in Malaysia, this burden is both amplified and invisible.

A 2018 review of postnatal depression across cultures reported rates in Malaysia ranging from 6.8% to 27.3%[26]. The relationship between poverty and perinatal depression in Malaysia is well established and a local study showed that postpartum mothers from low incomes households were two to three times as likely as middle- and high-income mothers to report postpartum depressive symptoms[27].

Perinatal mental health services have improved, but a large treatment gap remains[28]. For refugee, stateless, and undocumented mothers, the barriers are even greater, making perinatal psychosocial illness in these communities almost entirely unaddressed. Undetected and untreated perinatal depression in marginalised mothers directly impairs the neurological, nutritional, and emotional development of the child in the first 1,000 days.

Stunting in Children & Breastfeeding

Nationally, 21% of children under five were stunted in 2022[19]. Locally, childhood stunting is higher in households with low income (B40)[29], remote rural communities (Pahang 28%, Sabah 25%)[19] and indigenous children under two years of age (41%)[30]. Families often rely on calorie-dense but nutrient-poor options with resultant micronutrient deficiencies in iron, zinc, and Vitamin A. Stunting has lifelong consequences. A stunted child is unlikely to reach full adult height. Stunting is also linked to smaller brain growth, possibly poorer cognitive development and lower productivity in adult life, and so to a lifetime poverty trap[31]. Evidence also links stunting to later adult obesity, more childhood infections, premature death and a higher likelihood that the following generation will also be stunted[32]. Stunting in children is also well associated with an increased under-five mortality[33].

The World Health Organization (WHO) regards exclusive breastfeeding for the first six months as one of the

most effective ways to lower child mortality and promote healthy development[34]. There is limited national data on exclusive breastfeeding but 50.6% of mothers continue breastfeeding children aged 12–23 months[19]. Generally, lower-income groups and rural populations tend to have higher exclusive breastfeeding rates than higher-income and urban groups[19]. But the milk composition and quality in malnourished mothers needs more evaluation.

Under-5 Mortality

Malaysia has met the SDG 3.2 targets for neonatal and under-five mortality at national level, but a national average can hide large gaps. Mortality data are not routinely broken down by region, income or ethnicity, so the communities that have not reached the target remain unseen[35]. Under-five deaths in 2016 show how large these gaps are. Compared with the major ethnic groups, the age-specific mortality rate ratio was 11.0 for Orang Asli children in Peninsular Malaysia, 1.7 for the indigenous groups of Sabah and Sarawak, and 25.0 for children of Indonesian and Myanmar residents[35,36,37].

Access to Healthcare

There is considerable research to show that poverty is a major barrier to accessing health care and health information[38,39]. Half the specialist human resources in the country are in the private sector but the private health services are out of the reach of the majority of poor families. Following advocacy with the Minister of Health in 2008–2009, responsibility for Orang Asli health care was moved from JAKOA, the Orang Asli development agency, to the Ministry of Health. However, access to health remains inconsistent for Orang Asli children[40] and depends on interest from local health authorities. There is also mistrust of the health services by some Orang Asli communities. Health access for remote rural communities in Sabah remains a challenge[40]. Migrant, refugee and stateless parents are deterred from seeking care for their children by fear of arrest and deportation, cost, frequent relocation for work, language barriers and, at times, disrespectful treatment by health staff. Government-run public healthcare facilities are accessible but at a much higher cost compared to Malaysian citizens; often out of the reach of most migrant, refugee and stateless families[40]. Much of the current healthcare provision is ad hoc by civil society organisations (CSOs).

Early Childhood Development and Care

With 1 in 10 children having a developmental delay or disability[18] it is critical that all children have access to routine developmental surveillance and screening to identify problems early, have prompt access to diagnostic services, and receive timely early intervention and good-quality early childhood care. All these are lacking or non-existent in marginalised children with most missing the prime window for therapy[40]. The majority of early intervention services are run by CSOs (with a waiting list and with very limited governmental support) or accessible at costly private centres/therapists[41]. The 'disability-associated cost' often pushes families deeper into poverty.

For children with disabilities specifically, routine developmental surveillance in the first 1,000 days is not a general good; it is a rights-based imperative. The United Nations Committee on the Rights of the Child urged Malaysia to

"organize the collection of data on children with disabilities and develop an efficient system for diagnosing disability" and to "take immediate measures to ensure that children with disabilities have access to healthcare, including early detection and intervention programmes"[42].

Birth Registration as a First 1000-Days Equity Determinant

Birth registration at birth is the single most consequential administrative event in the first 1,000 days. Without a birth certificate, a child has no stable pathway into subsidised healthcare, routine immunisation records, national childhood surveillance systems, school enrolment, or social assistance[42]. For the first 1000-days initiative, the operational implication is that universal birth registration at birth is a precondition, not a deliverable.

How Big is the Gap Between Marginalised and 'Mainstream' Communities?

Much of our data nationally is aggregated. Although household income data is collected this is rarely shown by social class in relation to health or nutrition. Hence, it is difficult to see the gross disparity between pregnant mother and children in marginalised communities vs those in non-marginalised communities for the first 1,000 days. Table 3 is a limited attempt to show some disparities using available data. The disparities are huge and the gap possibly ever widening.

Table 3. Estimates of Disparity Between Marginalised and 'Mainstream' Communities*

Indicator	Non-marginalised (national / major ethnic groups)	Marginalised (Orang Asli, interior Sabah, non-citizen)
Under-5 mortality (2016 age-specific, per ethnic group)	Baseline (major ethnic groups, Peninsular Malaysia)	Rate ratio: Orang Asli 11.0; Sabah and Sarawak indigenous groups 1.7; children of Indonesian and Myanmar residents 25.0 [35,36,37]
Childhood stunting (HAZ < –2SD)	National stunting prevalence 21% (NHMS 2022)	Orang Asli under 2 years 41%; Sabah 25%, rural Pahang 28% (under 5 years) [19,30]
Maternal anaemia (reproductive-age women)	National 29.9%	Higher among B40 and rural communities (narrative evidence; disaggregated data not published) [21]
Registered childhood disability prevalence	Non-marginalised column: Registered 2.43% of children (JKM, 2026); developmental delay 7.4% (ages 6–59 months, NHMS 2022) [17,18,19]	No figures published by group; under-registration particularly for girls [17]
Healthcare access for non-citizen children	Subsidised public-facility care	Public facilities accessible only at much higher cost; deterrent effect of immigration-enforcement concerns [40,42]

* Data from international sources on the wide gap for marginalised children for under-5 mortality, stunting and access to healthcare support this data[43,44]

What Hinders the Marginalised Communities from Achieving Equity in the First 1,000 Days?

Malaysia's National Children's Policy and Action Plan[45] is framed around inclusion, equity and non-discrimination, and states that it covers every child in the country, consistent with the Convention on the Rights of the Child

(CRC) and the Child Act 2001. Its non-discrimination clause, however, makes that coverage subject to the laws and regulations already in force[45]. This qualifier materially weakens the force of the policy's promise of universality, because it leaves intact the very legal and administrative barriers and existing discriminatory policies that exclude certain groups from health, education, registration, and protection; most notably for stateless, refugee and migrant children, those held in detention, and those with disabilities.

Malaysia has no comprehensive anti-discrimination law that satisfies CRC standards. The existing safeguards, namely Article 8 of the Federal Constitution, the Child Act 2001, the Persons with Disabilities Act 2008 and the Mental Health Act 2001, do not address the structural barriers these communities face. Five CRC reservations remain in place, covering non-discrimination (Art. 2), name and nationality (Art. 7), freedom of thought, conscience and religion (Art. 14), free and compulsory primary education (Art. 28(1)(a)), and torture and deprivation of liberty (Art. 37). As such we have national-governmental-systemic-barriers and policies that create profound inequalities for vulnerable and marginalised children in Malaysia.

The Committee's January 2026 Concluding Observations make the same point[42]. Malaysia has not yet achieved "full compliance with the Convention and the Optional Protocols" and continues to exhibit "structural discrimination against indigenous children, including Orang Asli children, children with disabilities, children living in poverty, lesbian, gay, bisexual, transgender and intersex children and asylum-seeking, refugee, migrant, undocumented and stateless children" (paragraph 26)[42]. Malaysia has made progress, including meeting the national SDG 3.2 targets for child mortality[35]. The Committee's concern is with the children that this progress has not yet reached.

But we must ask why certain populations of Malaysian pregnant mothers and young children - including indigenous communities, interior Sabah and the urban poor - continue to face much higher rates of poverty and preventable mortality/morbidity despite national progress. The main reason is the social determinants of health. Households that are poor, excluded or affected by disability have the weakest access to health services, early childhood education and basic infrastructure; it is their infants who die or fall ill most often, and their mothers who carry the greatest burden of illness in pregnancy. There are inadequate financial and human resources allocated or targeted to alleviate poverty and provide healthcare in marginalised communities. The present model of our healthcare is curative, tending to focus on disease and not health; it is centred on doctors and illness, costly, fragmented and hospital-based[46]. The commercialisation of healthcare services has worsened our maternal and child health services, creating a private-public divide, inaccessible to poorer communities.

The persistence of inequality and disparity in the first 1,000 days in Malaysia is primarily a failure of policy choice and implementation. A middle-income country that possesses the data, the institutions, and the fiscal instruments to reduce child poverty and health inequity carries the responsibility for the gap between what its systems can deliver and what they currently deliver. The condition is neither natural nor inevitable. In the first 1,000 days, the consequence of that failure is a cohort of Malaysian children - Orang Asli, interior Sabah, non-citizen, urban poor,

in detention, or looked-after - whose developmental trajectories are being set below their genetic potential by the decisions of a state that is otherwise capable of protecting them.

What can we Do to Overcome these Systemic Inequities?

Bridging the equity gap, so that every child, regardless of birth circumstances, receives a fair start, is the urgent priority. The mechanism by which poverty, legal status, and geographic isolation create the biological embedding of adversity, leading to lifelong disparities, requires further examination. Addressing the social determinants of health that create disparate outcomes is the next step.

Civil society organisations cannot meet the task of ending inequality in all children in Malaysia – they can elevate small groups of mothers and children but even there often face national policy hindrances. A change and reform in government policy and action is required. The key action that healthcare professionals and civil society can do is to be child advocates and activists to petition for change in government policy. The following are key recommendations of change required and key institutional and policy reform that we should advocate for, adapted and updated from our earlier published recommendations[47]:

Collect Granular Disaggregated Data

The lack of disaggregated data hides the impact of social determinants of health and the size of the problem in marginalised communities. Advocacy is required for mandated, full disclosure and linked access to data – health indices with socio-economic status by geographical region and ethnicity.

Report SDG targets by Marginalised Groups

SDG achievements should be reported by individual marginalised community rather than by national aggregate. Under-five mortality rates are required by social class and by marginalised group.

End Poverty for All Children Through Child-Rights-Based Budgeting

Child poverty that persists in a country with Malaysia's resources is a national failing. The United Nations Committee on the Rights of the Child urged that Malaysia adopt a "child-rights-based approach in the elaboration of the State budget, by implementing a tracking system for the allocation and the use of resources for children throughout the budget" and that budget lines for children in disadvantaged or vulnerable situations be "protected even in situations of economic crisis" (paragraph 14)[42]. This, rather than generic safety-net language, is the budgetary reform Malaysia needs. It requires: (a) mapping all families at risk; (b) defining protected, disaggregated budget lines for indigenous, stateless, refugee, looked-after, and disabled children; (c) tracking expenditure against those lines publicly; and (d) ensuring that social assistance reaches children regardless of their parents' employment status or immigration status (Committee paragraph 60(b))[42]. Government should plan and deliver this with the civil society organisations that already work with these families.

Ensure Universal Healthcare & Education Access

Enact a law that gives every child and pregnant woman in Malaysia the right to health care, whatever their legal status, in line with Article 24 of the CRC and the Child Act 2001 and ensure that every birth is registered. No child should be refused basic immunisation or necessary care. Remove the high fees charged to migrant, refugee and stateless children, and ensure that families are not arrested or detained when they attend a hospital, clinic or community learning centre. Introduce and enforce a policy that gives every child access to education, including early childhood education, regardless of status.

Reform National Policy and Withdrawal of CRC Reservations[42]

1. Withdraw every remaining CRC reservation.
2. Bring all domestic law and policy into line with the CRC, including a comprehensive revision of the Child Act.
3. Accede to the 1951 Refugee Convention and its 1967 Protocol.
4. Accede to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).

Conclusion

While the policy reforms set out above are medium- and long-term, paediatricians and primary care health professionals can be advocates and take the following action.

1. We can use our professional authority. Paediatricians in Malaysia are trusted voices on child rights; that trust is a professional asset that can be deployed in advocacy.
2. Consider extending our work and commitments into the community[46].
3. Partner with civil society organisations that work with marginalised communities.
4. Document situations in which a child is denied care, delayed care, or receives inadequate care because of legal status, cost, or geography. Unpublished documentation becomes the evidence for the advocacy set out in the recommendations.
5. Focus our research on marginalised children and use that data to advocate for change.

Healthcare professionals are challenged to reconsider our role, not only as clinicians but as systemic advocates of social justice and health equity. Rights-based solutions must be implemented: poverty reduction programmes, with universal access to nutrition, health and early intervention. Dismantling barriers within healthcare delivery, improving support for vulnerable families, and using data-driven advocacy to influence national policy must be done collectively. The healthcare workforce must be deployed more effectively to underserved areas. All laws,

policies and institutions must be examined for discriminatory effect, and active steps taken to rectify it.

This is a call to action to move from a position of passive observation to actively safeguarding every child's rights, beginning with those most at risk. "Leaving No Child Behind" must not be a catch phrase but a policy reality with measurable, enforceable commitments.

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