Malaysia

Country Cooperation Strategy

World Health Organization
Section 1  Introduction

Malaysia is developing at an unprecedented pace. Most traditional development agencies have concluded or greatly limited their activity in Malaysia as the country manages its own development, in close cooperation with its neighbours. The 6th Malaysia Plan has just been released, charting Malaysia's path for the next 5 years, including identifying priority areas for the health sector. All this makes it timely for WHO to review its country cooperation and ensure that it adds maximum value.

This WHO Country Cooperation Strategy (CCS) defines the broad framework for WHO's cooperation in, and with, Malaysia for the next 3-5 years. It articulates a coherent vision and selective priorities for the entire WHO secretariat.

The CCS is based on a systematic assessment of Malaysia's development challenges and health needs, its potential for assisting other countries and the Government of Malaysia's policies and expectations. While a clear aim is to ensure greater responsiveness to the country's needs, the CCS also reflects WHO's own values, principles and corporate and regional strategies. Important elements include WHO's intention to be more selective in its range of activities and to foster strategic thinking, emphasising the Organization's increasingly important role as policy advisor and broker.

Section 2  Government and People: Health and Development Challenges

2.1 Economic and social situation

Malaysia has an outward-looking approach allied to a strong sense of national self-reliance. Its long term development strategy, Vision 2020, is designed to achieve developed nation status by 2020. Key aims include increasing the country's competitiveness in high value-added export goods and services (notably information technology), furthering open trade, enhancing its financial sector and sharing the benefits of growth equitably among the population.

The country had an excellent record of economic performance and social progress in the late twentieth century. Steady growth between 1980 and 1997 resulted in a doubling of real per capita GNP and a 1997 per capita income of US$4,377. Then the South Asian financial crisis of that year led to a significant set back, with per capita income dropping to US$3,093 in 1998. The impact was felt most among the lower socio-economic groups, particularly in rural areas. Nonetheless, Malaysia's well developed infrastructure has helped it weather the crisis, with per capita GNP rebounding to US$3,515 in year 2000 and an unemployment rate of only 3%. GDP, which contracted by 7.4% in 1998, has shown a recovery with growth of 8.5% in 2000. External reserves increased from US$20 billion in 1997 to US$27 billion in 2001.

Malaysia has a population of 22.9 million, half of whom live in urban areas. Population grew at an average of 2.4% per year between 1995 and 2000. Its ethnically diverse people is comprised of 56% Malay, 25% Chinese, 7% Indian, with the remaining 10% consisting of a variety of ethnicities, among them the indigenous Orang Asli people. Improving the social and economic condition of the Malay and some small ethnic minorities, all known collectively as Bumiputera, is one of the aims of national development policy. Social problems arise mostly from the rural-urban
shift, an undercurrent of racial sensitivities and the presence of as many as 1 million illegal immigrants.

The overall incidence of poverty mirrors the country's economic performance, decreasing sharply from 32.1% in 1980 to 6.6% in 1997 but turning upwards again to 7.6% in 1998. During this period, the distribution of income to households tended to become more equal. Social policy and poverty reduction strategies are closely coordinated by the Prime Minister's Department. Emphasis will continue to be given to income distribution and restructurings of ownership to reflect the ethnic composition of the population, by implementing programmes to increase and sustain Bumiputera share capital ownership and control of corporations. An integrated package of anti-poverty measures is aimed at reducing the incidence of absolute poverty by 0.5% by 2005.

Malaysia is ranked 81st out of 174 countries in the 2000 UN Human Development Index. The population is well educated with a 1998 literacy rate of 93.7%, an indication that the status of women is relatively high in Malaysian society. Education at primary and secondary levels, and social services in general, are universal and free (or near free) to the user. Malaysia has sought to balance economic development with a sustainable environmental policy.

2.2 Health status overview

Malaysians enjoy a relatively high overall standard of health. In 2000, infant mortality was 7.9 per 1,000 live births and maternal mortality 0.2 per 1000 live births. Life expectancy for men stood at 69.9 years and women at 74.9 years. The gender difference is believed to be a result of the shift to a predominantly non-communicable burden of disease in which men suffer disproportionately from the leading causes of death, namely heart disease, cerebrovascular disease, and cancer. In addition, there is increasing morbidity and mortality from road crashes and diabetes, with the latter now prevalent in 5-10% of the population. Current non-communicable mortality patterns are approaching those of high-income countries. With the demographic increase in the number of adolescents and young adults, the rise in high risk behaviour among young people is a great concern.

At the same time, some pockets of communicable disease problems still persist, especially in rural areas, imposing substantial social and economic costs. TB, cholera, and hand, foot and mouth disease are re-emerging and there continue to be problems with vector borne diseases such as dengue. Malaria remains a challenge in more remote parts of the country. Filariasis has yet to be eliminated. New infectious diseases are appearing, such as the Nipah virus which in 1998-9 killed 69 people and devastated the country's pig industry. The Nipah outbreak also highlighted the need to strengthen disease surveillance and rapid response mechanisms. Sexually transmitted diseases are on the rise. With an estimated 38,000 people living with HIV/AIDS at the end of 2000 (74% spread through intravenous drug use), HIV/AIDS prevention and care pose a major challenge to the government.

2.3 Health sector overview

Malaysia spent an estimated 3.9% of GNP on health in 1996. Per capita spending was estimated at US$263 in 1995. In 2000, the government allocated 7.7% of the national budget to health, up from 7.4% in 1999. During the South Asian financial crisis, the health budget
was increased by more than had been planned, to assist with the health consequences of the economic downturn.

Health is regarded as an integral part of the development process and instrumental to socioeconomic advancement. With poverty reduction as the main thrust of Malaysia development plans since 1970, the health sector has contributed mainly with nutrition programmes, sanitation, home visits and exemption from any user charges for essential services at government primary healthcare facilities.

While Malaysia is a federal state, health is administered centrally from the Ministry of Health albeit with decentralised management. The Ministry recently took over certain local authority functions to put some areas of service provision on a viable scale. Secondary and tertiary care services are now widely available in government hospitals across the country at no, or nominal, cost to the user. Both out-patient and in-patient services are free to those who cannot afford to pay, and are highly subsidised to others. A modest fee is charged to those wishing to upgrade their accommodation. Fees collected as user charges in government hospitals account for about 3.5% of the Ministry of Health's budget. In 2000, there were 27 million outpatient visits and 1.5 million in-patients discharged from public facilities.

Nonetheless, the government remains concerned about issues of equity, access and affordability. At present, public expenditure accounts for only about 43% of total health spending. With some funding from UNDP and technical support from WHO, work is planned on national health accounts to map total health expenditure sources and usage.

A national survey estimated out-of-pocket expenditure to be RM$ 180 per capita (US$ 40) or 4.8% of per capita income in 1996. Most of this was spent on private primary care even though the public system is regarded as good quality and reasonably accessible to all. An estimated half-million people have private health insurance. Between 1995 and 1999, the private health sector expanded from 197 to 225 hospitals, mostly located in urban areas. By 1999, 43% of medical practitioners worked in the private sector; definitive information about utilisation must await completion of the national accounts.

A policy of corporatisation public health providers set out in the recently ended 7th Malaysia Plan (1995-2000) encountered a number of implementation problems and, to date, has been effected only in the national cardio-thoracic hospital. Publicly-owned health providers are now seen as providing a stronger basis for achieving public health objectives than corporatisation. However, a number of non-core ancillary services such as laundry and waste disposal have been privatised.

Under the 7th Plan, there was substantial investment in information technology and a large public building programme for health facilities, in order to increase access for the low income population, particularly in rural areas. The health sector is part of Malaysia's 'multimedia super-corridor' project designed to position the country as a global leader in the application of information technology. One of the results has been a well-developed telemedicine and telehealth capacity. A Telemecicine Act was enacted in 1997 and two IT-based hospitals were commissioned in 2000.

A major effort to develop Malaysia's human capital has created a relatively strong education and research capacity in the health sector. Educators and researchers have been trained in
universities around the world in large numbers; many have returned to practise, teach and research in Malaysian institutions. There are ten medical schools, six public and four private. Joint ventures now enable students in a variety of disciplines to receive degrees in Malaysia from universities in the UK and Australia.

There are five institutes of the National Institutes of Health. The 100 year old Institute of Medical Research is the most established and provides training in various specialised fields for health workers around the Asia-Pacific Region and from as far away as Africa. Now under the National Institutes of Health umbrella, the Institute plans to give further emphasis to biomedical research. The Institute of Public Health has expanded its training programmes and is the national focal point, and a WHO collaborating centre, for health systems research. The three other Institutes - the Institute of Health Management, the Institute of Health Promotion and Network of Clinical Research Centres – are newly formed and not yet fully operational.

While there is a large number of national NGOs in the health and social sector, very few possess a membership or resource base of any significance. This may be due to the strength of the Ministry and a cultural preference for individual responsibility and self-reliance. Many of the NGOs are professional associations. Notable among the NGOs that do exist is the Malaysian AIDS Council which enjoys wide support and is able to address issues that can be too contentious for government to address directly.

2.4 Challenges

The 8th Malaysia Plan (2001-2005) seeks to consolidate gains from the 7th Plan. Its main thrust is to sustain growth and competitiveness in the face of growing globalisation and also to enhance the quality of life through provision of better social services. The priority given to the health sector under social sector development is evidenced by a 47.3% increase in its allocation over the 7th Plan's health sector budget. While the latter focused on expanding the range of health facilities, the 8th Plan will concentrate on improving the quality of public health and curative services. Making a reality of this vision will be demanding, particularly in the face of a wider set of challenges including:

- health care financing reform
- integration of healthcare provision
- quality of services
- human resource development
- globalisation and industrialisation

Health care financing reform

By running a substantial publicly funded health service with accessible services for all, the government is in essence the main insurer. Rising costs, growing public expectations and the size and performance of the private sector - generating high out of pocket payments - have led to consideration of new means of financing health care to ensure appropriate cost-sharing. Such a reform might also serve as an entree to better regulation of the private sector. No decision has yet been taken on the two alternative sources of financing examined, the medical savings account and social health insurance. Core funding from the preferred scheme is likely to be supplemented by sin taxes on products like tobacco and alcohol. The government recognises that such a major reform of the health care system would face social and political resistance.
Integration of provision and regulation of the private sector

On the provider side, the government is developing proposals for the integration of health services across public, private and NGO boundaries, with referral systems which ensure access to appropriate levels of care based on need.

Insufficient is known about the quality of services in the private sector. The government will enforce regulations under the Private Health Care Facilities and Services Act 1998, and utilise credentialing and certificates of need, to improve quality and control the distribution of private providers. To date, such providers have favoured urban areas with the result that doctor to population ratios in 1999 ranged from 1 practitioner per 1485 people in Kuala Lumpur to 1 practitioner per 4120 people in Sabah.

The appropriate and cost-effective use of expensive technology is another challenge arising from the uncontrolled growth of the private sector.

Quality of services

Having secured reasonably good measures on quantity of life, the Malaysian public is now looking to the government for improvements in the quality of life and care. Increased public expectations of better standards, as well as a trend towards litigation in medical practice, have led government to pursue a strong national quality assurance programme throughout the country.

The government’s efforts to regulate and integrate the private sector, and its commitment to the application of IT in health care management, are part of this larger desire to improve the quality of services in Malaysia. Proposals to provide patients with smart cards possessing a comprehensive lifetime medical record are currently being tested by public servants. The national telemedicine programme is seen as key to re-engineering quality processes and systems rather than simply the exploitation of high technology. Better linkages with the welfare sector are needed to improve the quality of continuing care and rehabilitation.

Human resource development

Against the background of this investment in physical infrastructure and advanced technology, Malaysia now has to tackle serious problems in the human resource base to plan and deliver services.

Malaysia is developing a battery of strengthened human resources policies, including a sizeable investment in education and the development of continuous professional development and continuous medical education. An important component of the workforce plan is the deployment of family medicine specialists who will boost the gate-keeping role of primary care practitioners and coordinate access to the rest of the system. Multi-skilling is leading to an extended role for allied health professionals. But the acute shortage and misdistribution of key groups of personnel, including nurses and doctors, pose a real threat. Shortages resulting from increasing demand and training mismatches have been exacerbated by the exodus of staff from the public sector to the domestic private sector and overseas. Consideration is being given to improving remuneration, working conditions and career prospects in the public sector in an effort to retain
staff. WHO, with the active participation of Malaysia, has already begun a study to identify options for structuring the functions of an operationally-based public health workforce.

**Globalisation and Industrialisation**

The Malaysian economy’s integration with the global economy has created opportunities and prosperity but brings with it challenges - including public health risks in areas such as tobacco, food and pharmaceuticals. These products from a variety of international sources are advertised, traded and distributed relatively freely. Globalisation has had an adverse impact on traditional lifestyles. For example, changing diet and tobacco use have contributed to the shift to a predominantly non-communicable burden of disease. One quarter of people over 18 years old were reported as tobacco smokers in 1996. The Ministry of Health is proposing new regulations to ban tobacco advertising, require cigarette packets to carry warning labels, and establish smokefree areas. Obesity now affects 1 in 18 high school students, up dramatically from 1 in 136 a decade ago. These tobacco and obesity risk factors have serious implications for future morbidity and mortality from heart disease, cancer and diabetes.

At the same time, domestic industrialisation is leading to more injuries and occupationally related diseases, as well as increased environmental risks to health. More generally, industrialisation and urbanisation will have an effect on the lifestyle and mental health of the population. Favourable socio-economic conditions in Malaysia have attracted a large number of foreign workers whose healthcare needs have placed an additional burden on the country.

**Section 3 Development and Partnerships**

**3.1 A policy of national self-reliance**

The extent of Malaysia’s economic and social development means that it does not generally seek outside financial assistance from donors or international financial institutions. National self-reliance for Malaysia is a key platform of the Vision 2020 policy which aspires to a “society with faith and confidence in itself, justifiably proud of what it has accomplished, robust enough to face all manner of adversity...distinguished by the pursuit of excellence, fully aware of all its potentials, psychologically subservient to none and respected by the peoples of the world.” Malaysia draws on international technical assistance in much the same way as established high income countries. The country is able to pay for advice or develop its own expertise in many cases, so is not dependent on development agencies.

Until 1998, Japan, Denmark and Germany were the major donors, active mostly in human resource development, natural resources, industry, agriculture, forestry and fisheries. Official development assistance in 1998 was US$ 55.1 million and total bilateral aid was US$ 48.5 million. The World Bank provided Malaysia with a social sector loan in 1997, which was used to improve the public health laboratory and upgrade health facilities. Since then, Malaysia has not requested loans from the World Bank, International Monetary Fund or Asian Development Bank but continues to seek technical advice from them. In general, Malaysia opted to weather the South Asian financial crisis under its own management. Aid levels have been relatively low, given the size of the economy, and are believed to have reduced rapidly since 1998. In 2000, there was no direct aid to the health sector.
3.2 UN agencies retain some limited health sector activity

UN agency programmes in Malaysia have become smaller in recent decades. UNDP is involved in HIV/AIDS and environment programmes and invested US$ 1,318,000 in 1999. UNICEF runs a fellowship/training programme (US$ 713,000 in 1999) and plans to discontinue its conventional country operations in Malaysia after its 2002-2005 programme. It is seeking ways to engage at a macro-policy level and to develop NGO capacity. UNICEF hopes that Malaysia will become a donor country in the near future. The UN Population Fund (UNFPA) had a US$ 200,000 programme in 1999 to top up and seed areas of priority. The Fund believes that it is best able to assist in areas that can be sensitive for the government, such as sexuality education. UNHCR had a small programme of US$ 212,000 in 1999 for about 5,000 refugees, mainly from neighbouring states and the Philippines. WHO chairs, on a rotating basis, an HIV/AIDS Theme Group comprising of UN, national agencies and NGOs. The control of HIV/AIDS is the only activity that brings together all of the UN. The next step for the UN agencies is to embark on a Common Country Assessment.

3.3 Regional development groupings come to the fore

Malaysia is placing much greater emphasis on regional health development cooperation than ever before, particularly as a member of the Association of South East Asian Nations (ASEAN), the border state grouping of Brunei, Indonesia, Singapore and Thailand, and SEAMIC involving eight countries. ASEAN health ministers are meeting more frequently to compare experience and good practice and coordinate some activities. Senior health officials of the border states also come together to address common issues, especially those with cross-border implications such as HIV, TB, refugees/illegal migration, food and drugs. The refugee/illegal immigrant issue has received a higher profile related to the spread of disease and the costs of their health care.

Section 4 The WHO Current Country Programme in Malaysia

4.1 Past WHO activity

WHO has been active in Malaysia since the time of Malaysian independence in 1957. In the early years, WHO's cooperation focused on communicable disease control. Malaysia considers that it has closely applied a Health-for-All-Strategy and established a primary care led health system based on the Alma Ata Declaration.

WHO country programmes since 1996 have mainly been based on fellowships and other training opportunities in a wide range of areas including dental care, family medicine, perinatal surveillance, food safety, environmental health, tuberculosis, vector borne disease and cancer control. During these biennia, WHO has also assisted with technical advice in areas such as leprosy control, quality of care and regulation of health professions, and specialist support for disease outbreaks and other emergent and previously unknown problems such as the environmental haze caused by massive forest fires in nearby Indonesia in 1998.
WHO has focused on the Ministry of Health and has generally not worked with sister ministries or central agencies on policy matters with a bearing on health.

4.2 WHO's current country programme: 2000-2001

WHO's direct programme budget for Malaysia in 2000-2001 is US$ 973,000, with an additional US$ 66,000 supporting the WHO country office. The pie chart below shows the distribution of the programme budget.

Within these areas of work, resources have mainly been allocated to fellowships (75%), with lesser amounts used for short term consultants (14%) and local costs to support workshops (9%).

There are 80 out-going WHO fellows for 2000-2001; typically most head for high income countries such as the USA and Australia. WHO fellowships have been used mainly for short term, specialised individual learning rather than for wider institutional development. While fellowships of this kind have been useful in the past, they are now of questionable value in the light of the government's ability and willingness to invest in human resource development.

At the same time, more than 200 incoming WHO fellows are expected in 2000-2001, mostly from Southeast Asian countries. Incoming fellows are financed by WHO programmes in their country of origin, but they require preceptors to provide 'on-the-job' training and support. This therefore represents a significant commitment of effort by Malaysia.

Malaysia also benefits from inter-country activities, often funded from extra-budgetary sources and managed by WHO's Western Pacific Regional Office or headquarters. These include work on health field projects and support for the Environmental Health Research Centre and the Regional Centre for Research and Training in Tropical Diseases and Nutrition at the Institute of Medical Research.
In addition, WHO makes great use of Malaysia as a venue for training and large meetings because of its convenient location and experienced resource people. These events usually involve the Malaysia WHO office in planning and logistics. In 2000-2001 there have been, or are plans for, ten WHO funded or co-sponsored global and regional conferences on a wide variety of topics, such as evidence-based health policy, diabetes, and accreditation of medical programmes. These activities are not designed solely for Malaysia but, as the host country, Malaysia tends to benefit disproportionately.

4.3 The WHO country office

The WHO country office in Malaysia is small; the WHO Representative is the only professional officer and signatory for financial transactions. With the appointment in 2000 of a new permanent representative after a gap, the postholder is now very active in advocacy work, providing rapid advice and information, contributing to various national and international meetings held in the country, facilitating dialogue between stakeholders and making a substantial contribution to Ministry of Health technical committees (for example, on HIV and health sector performance).

The WHO Representative for Malaysia also covers Brunei and Singapore, which take up one-third of his time. The advantage of this combined post is that it facilitates networking and inter-country work.

Section 5 WHO Corporate Policy Framework: Global and Regional Directions

5.1 WHO Policy Framework

A WHO Country Cooperation Strategy must reflect the Organization's corporate policy framework and its regional strategies. WHO's mission, as set out in its constitution, remains the attainment for all people of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill-health; more complex health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership.

WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health. This policy framework continues to reflect the values and principles articulated in the Global Health for All policy, which was re-affirmed by the World Health Assembly in 1998 with new emphases on:

- adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction
- playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise
- triggering more effective action to improve health and to decrease inequalities in health outcomes by carefully negotiating partnership and catalysing action on the part of others
5.2 WHO's goals and priorities

WHO's goals are to build healthy populations and communities and to combat ill health. To attain these goals, it has adopted the following four interrelated strategic directions:

- reducing excess mortality, morbidity and disability, especially in poor and marginalised populations
- promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair
- developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.3 Regional Emphasis

Within the WHO's corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework around four outcome-oriented themes: combating communicable diseases, building healthy communities and populations, developing a stronger health sector, and reaching out (which encompasses information technology, external relations and public information).

The 1999 Regional Committee made TB a special regional project, in recognition of the fact that one quarter of all TB victims (some 2 million people) live in the region. Three-quarters of them are in the prime of their productive and reproductive lives, and the majority bear a double burden of disease and poverty.

Section 6 The Strategic Agenda for WHO Cooperation with Malaysia

6.1 The approach to the strategic agenda

Having considered the health and development challenges in Malaysia, the role of development partners and WHO global and regional priorities, the picture that emerges is one of increasingly reciprocal cooperation between WHO and Malaysia.

The country has good aggregate health indicators and a system that is primary care led and generally accessible. Because of Malaysia's comparatively advanced state of development, bilateral agencies are no longer active in health and UN agencies have been scaling back operations, given the need to be more selective. As Malaysia's Human Development Index rating continues to increase, WHO's own programme will inevitably be refocused.

The current WHO country programme is relatively small and based predominantly on a fellowship programme of diminishing value, given Malaysia's level of development and ability to train its own workforce. This level of investment in fellowships crowds out opportunities for WHO to work more
strategically with Malaysia. WHO will continue to help build capacity in critical areas, such as health care financing and management. But in future, while there will remain need for some fellowships, greater priority will be given to strengthening institutional development.

Discussions with the Ministry of Health indicate that, in the main, Malaysia is now looking for exchange of information and advice on best practice, with more intensive support from WHO in a few targeted areas during this period of rapid, but perhaps still somewhat fragile, development. Malaysia also looks to WHO for international advocacy and advice on emerging health issues such as tobacco use.

In the light of this, WHO’s new strategic agenda is designed to:

- **provide selective WHO support to Malaysia** during a period of transition, with an emphasis on unresolved health issues where WHO is best placed to assist because of its technical expertise and global orientation. Applying the principle of selectivity, this strategic agenda proposes four principal components of cooperation over the next 3-5 years: improving health sector performance, development of resource institutions, health promotion and protection, and communicable disease control including HIV/AIDS.

- **develop Malaysia’s role in providing assistance to other member countries**, with WHO acting as the facilitator and broker in these partnerships.

Further details are given below.

This strategic agenda indicates direction. Details will come with planning which must be sufficiently flexible to allow the inevitable adjustments as country needs and WHO’s specific contribution are clarified for each piece of work.

### 6.2 Future WHO support to Malaysia

#### Component 1

**Improving health sector performance**

The 8th Malaysia Plan identifies a number of objectives for the health sector over the next five years, and strategies to achieve them. These objectives include improved levels of population health and reduced inequalities, and more efficient use of resources.

The Ministry of Health has expressed interest in using the new WHO performance assessment framework to review the overall performance of the health system in Malaysia. The new information will serve as a baseline from which to monitor the impact of future health sector changes. It can also be used to inform the strategies for improved performance that are currently being developed by the Ministry of Health. The Ministry wishes to build national skills in the assessment methods as quickly as possible, and to contribute to the further refinement of the methods themselves.

This joint WHO / MOH work on performance assessment and improvement is being organised under the umbrella of the *Enhancing Health System Performance Initiative*, which includes countries from all WHO Regions.
WHO's support to Malaysia will primarily focus on:

- helping to develop the range of skills needed to conduct the assessment activities (of outcomes initially, but also of functions), through joint analysis or through workshops
- contributing to discussion of the policy implications of this assessment, by discussing ways to interpret and present findings
- fostering informal exchange of information and debate on health system performance between countries, through a range of regional networks of individuals and institutions
- facilitating more structured analysis and comparison of health system performance through inter-country meetings, and through supporting publication.

In addition, WHO will encourage:

- Malaysia's contribution to the further development of the approach so that it can be used more routinely
- Malaysia's role in helping develop national skills for performance assessment in other countries, which it has indicated it would be willing to support.

Component 2
Development of resource institutions

A key element of cooperation between WHO and Malaysia has been the development of resource institutions in the health sector.

On some fronts, WHO's past investment in institutional development is now mature. For example, the National Environmental Health Research Centre, initially established with financial and technical assistance from WHO for 5 years, is emerging as a national information clearing house for environmental health research, and will ultimately become a 'regional centre of excellence'. In the development of this Centre, WHO provided support in the form of strategic planning and human resource development and brokered a partnership between the Centre and the WHO collaborating centre in the University of Western Sydney, Australia. From 2001 the Environmental Health Research Centre will be funded by the Ministry of Health. Similarly, WPRO has been active in previous biennia in providing technical and financial support for the Regional Centre for Research and Training in Tropical Diseases, based in the Institute of Medical Research. These activities no longer need significant assistance from WHO but both collaborations demonstrate a model for effective future work of this kind.

As part of its strategic agenda for the next 3-5 years, WHO will therefore support the Institute of Health Management - one of the new institutes comprising the National Institutes of Health - on similar lines, through human resource development in management training and research, and the facilitation of networking with other health management institutes in the region.

Under the 8th Malaysia Plan, the Institute of Medical Research will be reorganised into six research centres, namely infectious diseases, herbal medicine, cancer, allergy and immunology, CVD, diabetes and nutrition and environmental health research. While all these centres will be able to draw on selective assistance from WHO, the Organization is keen to cooperate specifically on herbal medicines research, catalysing and facilitating a network of similar centres in the region.
There are six WHO Collaborating Centres in Malaysia. Collaboration has been particularly intensive with three: the Health Systems Research division of the Institute of Public Health, the National Pharmaceutical Control Bureau in the Ministry of Health and the National Poison Centre at the University of Science. Collaboration with the other three centres — namely the centre for arbor virus reference and research in the Department of Microbiology at the University of Malaya, and two centres at the Institute of Medical Research (the centre for vector control for malaria, dengue and filariasis in the Division of Medical Entomology and the centre for brugia filariasis in the division of Parasitology) — is also active though their involvement has been limited due to the specific nature of their work.

Susantha provided this redraft in his email of 25 June: (NB 1st sentence and opening of second sentence amended by Katja who is pursuing content/location urgently with Richard/Susantha.

Component 3
Health promotion and protection

WHO's cooperation in relation to health promotion and protection will encompass three key areas:

- **non-communicable disease control, with a focus on diabetes**
  The burden of disease in Malaysia has shifted to non-communicable diseases. The Ministry of Health has asked WHO to assist with models of best practice on issues such as diabetes control, where statistics point to a major epidemic and WHO has well-developed experience. More broadly, WHO's development of a global risk factor surveillance protocol also presents opportunities for collaboration. Given Malaysia's particular emphasis on health promotion and wellness, WHO will provide support in developing models and skills for community mobilisation, behaviour modification and social marketing strategies.

- **environmental health**
  Malaysia has done much on this front which could contribute advantageously to the work of WHO. Healthy cities projects in Johor Bahru and Kuching have benefited from significant WHO leadership and support since 1994 and now serve as regional models. There is scope for Malaysia to provide consultants, training and fellowship opportunities (as appropriate) on its Healthy Cities programme and on water supply, sanitation, and solid and healthcare waste management issues. At the same time WHO will continue to provide advice to Malaysia on issues like developing and implementing a national environmental health impact assessment system, and a national environmental health action plan involving relevant government agencies, academia, NGOs, industry and business.

- **tobacco**
  Given the steady rise in smoking rates, WHO will assist in the practical development of a national action plan on tobacco control. WHO has already planned a WHO-CDC collaboration on tobacco control in Malaysia, Viet Nam and Laos. Since Malaysia is one of the countries involved in the Rockefeller Foundation's Asia project on tobacco control, WHO will explore the possibility of working in partnership under one banner on a WHO-CDC-Rockefeller Foundation-Malaysia initiative against tobacco.

Component 4
Communicable disease control

Three priorities have been identified under communicable disease control:

- **disease surveillance and outbreak management**
  From time to time there are disease outbreaks where Malaysia lacks the experience and detailed understanding of the disease that is necessary for control. Recent incidents have highlighted the need for more effective surveillance and response mechanisms. WHO will help on both fronts, including providing models for outbreak management. To be effective, WHO will need to ensure that timeliness standards are met.

- **HIV/AIDS**
  Ideally this should be an area of reciprocal activity. Malaysia’s expertise in diagnosis of sexually transmitted infections and AIDS care could be used advantageously within the Western Pacific Region. Equally WHO is well-placed to support the development of policies within Malaysia in relation to the complex range of issues surrounding pharmaceuticals, in particular the new antiretrovirals, and to effective interventions to reduce HIV transmission among injecting drug users. Because of its neutral position and recognised expertise, WHO will also have a role to play in national analysis of epidemiological data on a regular basis as well as behavioural (second generation) HIV surveillance.

- **tuberculosis**
  Reducing TB rates is a global and regional priority for WHO. Given the recent increase of tuberculosis in Malaysia along with a growth in HIV-TB infection, new efforts to control the disease are needed. WHO will assist in undertaking a prevalence study and in developing a standardised information system to inform management of Malaysia’s TB control programme.

6.3 Future Government of Malaysia support to other WHO member countries

As reflected earlier in this section, Malaysia has developed sufficient capability in specific areas to offer assistance to, and cooperation with, other WHO member countries (especially in the Western Pacific region), with WHO acting as the facilitator and broker of these partnerships. During discussion of this country cooperation strategy, the Ministry of Health affirmed its commitment to make such a contribution, in recognition of the benefit Malaysia has derived as a recipient of assistance from WHO, either directly or from other member countries. It outlined possible areas of opportunity, including amongst others education and research, health planning, implementing primary health care, making pregnancy safer, AIDS care, healthy cities and lifestyles, health engineering, pharmacy, and optimising information technology in health. The point was made in relation to infectious disease control that other countries may be able to learn from the full range of Malaysia’s experiences, with their share of successes, uncertainties and failures. A key strategic task for WHO’s Representative in Malaysia and its Western Pacific Regional Office will be to work with the Ministry to realise this potential to mutual benefit.

Section 7 Implications for Implementation

7.1 Implications for WHO’s functions and methods of work
WHO's Country Cooperation Strategy for Malaysia has substantial implications for the roles, functions and methods of work of WHO as a whole.

This new strategic approach requires WHO to maintain regular and close contact with the Ministry of Health so that the Organization can be up to date and able to advise on issues inclusively at short notice. It requires a significant shift from the more administrative function of managing a fellowship programme to an operation that maintains a broad strategic overview of national health policy and challenges, then draws quickly and selectively on the rest of WHO for policy and advocacy support in the areas identified above.

As the WHO country office in Malaysia consists only of the WHO Representative and general support staff, successful implementation of this strategy will require the active engagement of region and headquarters offices in providing high quality inputs. Timely support will be essential to meet the short response times that are a reality of life for the Malaysian Ministry of Health. It will be a prime task of the WHO representative to draw down and coordinate these inputs from within WHO and externally.

At the same time, the strategy also puts considerable emphasis on WHO's brokerage and facilitator roles, drawing strength from WHO's neutrality and global health leadership profile. Improved coordination with neighbouring WHO country offices in different regions will be important, since Malaysia is increasingly working with border states and ASEAN on regional development.

7.2 Conclusion

This Country Cooperation Strategy signals a new era of cooperation and growing reciprocity between WHO and Malaysia. It is a strategy that recognises Malaysia's strong capacities and selective interest in utilising WHO's expertise in areas of comparative advantage consistent with WHO policy. The key components cover capacity-building and information exchange on improving health sector performance, the development of selected resource institutions, targeted support for health promotion and protection, and models of best practice for non-communicable diseases. The strategy also recognises the potential for Malaysia to share its expertise more widely with other member countries, with WHO acting as the facilitator. The fellowship programme that has been the basis of recent WHO cooperation will be reduced to make way for these new activities.
Malaysia Country Cooperation Strategy: Sources of information


CONFIDENTIAL MEMO

The Future Programme and Country Presence

This 2001 WHO country cooperation strategy makes clear Malaysia's growing self-reliance in the health sector. While the country's need for support is likely to justify a WHO programme of cooperation for the next two biennia (2002-3 and 2004-5), it is inevitable that the country cooperation programme and budget will decrease as the country's HDI continues to increase.

This raises the issue of the continued justification for a WHO country presence in Malaysia. The CCS team's conclusion is that it is at present strategically useful to WHO to maintain a country presence in order to utilise resources within Malaysia and, critically, to develop Malaysia's role in providing support to other countries. As outlined in the CCS, Malaysia has developed sufficient capability in specific areas to offer assistance to and cooperation with other member countries, with WHO acting as the facilitator and broker of these partnerships. During discussions on the CCS, the Ministry of Health affirmed its commitment to make such contributions (especially in the Western Pacific Region), and outlined some possible areas of opportunity. A key strategic task for the WR and WPRO will be to work with the Ministry to effect this development.

Over the longer term, there may be scope for Malaysia to take on greater responsibility for maintaining a country presence of some form, as WHO reviews its position.

Implications for WHO as a whole

The key changes necessary to support effective implementation of the strategic agenda are:

- regular high-level contact between the WHO representative and senior Ministry of Health officials (DG and DDGs), (plus selected programme managers of areas where WHO is active), to ensure that WHO is able to stay abreast of policy issues and contribute when requested or as programmed. This requires proactive engagement. When the Ministry of Health moves to the new administrative capital of Putrajaya in 2 years time, the WHO office should ideally be colocated in the same building.

- agreement at all levels of WHO to support the Malaysia country office in providing high quality human resources. There are no professional staff in Malaysia other than the WHO Representative. A key role of the WHO representative is to draw down and coordinate the resource inputs from within WHO or externally.

- agreement to provide the Malaysia country office with timely support when it is necessary to draw down assistance at short notice. If WHO is not able to meet the short response times that are a reality for the Malaysian Ministry of Health, WHO will find it has missed opportunities and that Malaysia will look elsewhere for assistance.

- affording the WHO Representative authority to adjust plans. There are times when the WHO Representative will need to make quick decisions in order to be relevant and influential in working with a fast-paced government. The expected results of the Programme Budget will need to be drawn fairly broadly to allow flexibility to meet specific needs.
improved coordination with neighbouring WHO country offices in different WHO regions. This is important because Malaysia is increasingly working with border states and ASEAN on regional development. Unless WHO has a parallel process, it will not be able to keep pace with global and regional issues that influence the health sector. Beyond this localised imperative, there would be general advantage in developing mechanisms to share countries experience and expertise more widely around the world.