

FINAL DRAFT
30 Aug 2007

MALAYSIA

PRIMARY HEALTH CARE KEY TO INTERSECTORAL ACTION FOR HEALTH AND EQUITY

Dr. Safurah Hj Jaafar
Dr. Mohd Raili Hj Suhaili
Dr. Kamaliah Mohd Noh
Dr. Fauziah Zainal Ehsan
Dr. Lee Fuei Siong

ACKNOWLEDGEMENTS

We would like to place on record our appreciation and sincere thanks to Dato' Dr. Mohd. Nasir bin Mohd Ashraf, Secretary General, Ministry of Health and Tan Sri Datuk Dr. Ismail Merican, Director General of Health Malaysia for their endorsement and support to conduct this case study.

Our sincere thanks to Dato' Dr. Hj. Ramlee Hj. Rahmat, Deputy Director General of Health and Dr Maimunah Abd. Hamid, Head of the Health System Research Management Institute, for their encouragements and facilitation in setting up the network.

The team is indebted to the following key-informants from the various ministries, departments and professional bodies who provided us with Invaluable information, contents and materials.

Ms. Daisy Rajoo, Economic Planning Unit
Mr. Gan Thye Heng - Treasury
Mr. Shamsul Shamdin – National Audit Department
Dr. Samsuddeen Abd Aziz – Ministry of Education
Lt. Kol. (Dr) Khairuddin Husain – Ministry of Defense
Mr. Fadzil Ismail – Ministry of Local Government
Mr. Azman Abdul Manaf – Ministry of Works
Ms. Siti Hafizah Bt Abd Mutalep – Orang Asli Affairs Department
Mr. Abd Kadir Bin Hussin – Immigration Department
Mr. Md Ziki Bin A. Rahman – Registration Department
Mr. Sri Ram a/l Letchimanan - Kementerian Penerangan
Ms. Sharonkumari a/p Sandanasany – Ministry of Women's, Family and Community Development
Mrs. Kamarul Farida Kamarul Zaman – National Family Planning and Population Development Board
Mrs. Liah Pariuk – Welfare Department
Dr. Sudhananthan - Academy of Family Practitioners Malaysia
Ms. Zainab Tambi – Family Health Development Division
Dr. Noraini Mohd Yusoff - Family Health Development Division
Dr. Mariam Jamaluddin – Family Health Development Division
Dr. Alias Abdul Aziz – Disease Control Division
Dr. Izzuna Mudla Mohamed Ghazali – Medical Development Division
Dr. Lokman Rejali – Food Safety and Quality Division
Dr. Mahrusah Jamaudin – Dental Division
Mr. Abdul Manan Bin Mat Dahan – Health Education and Communication Centre
Staff of Family Health Development Division
Ms. Simren Kaur and Mohammad Hafiz Abdul Rahim who helped with the editorial

Special Mention to the Economic Planning Unit and The United Nation Country Team (UNCT) Malaysia whose various reports have been very valuable in preparing this case study

The Research Team is most grateful to the Public Health Agency of Canada and The World Health Organisation for inviting us to participate and partially funding, without which, this study would not have materialised.

CONTENTS

Summary	4
I. Scope and Study Objectives	5
II. Study Methodology	5
III. Working Definitions	5
A. Introduction	6
B. Contextual factors	8
C. Public policy of Malaysia	9
I. Origins of policy	9
II. Key characteristics of policy environment	9
III. Policy formulation	10
IV. Policy implementation	10
V. Policy evaluation	10
D. Intersectoral action for Equity and Health – Mechanism	10
I. The Central Policy Body	10
II. Decentralising Intersectoral Activities for Health	11
E. Intersectoral action in health – The impact	12
I. The rural health services	12
II. Equity and Health	13
i. Reducing poverty through better health	13
ii. Incorporating “Primary Health Care – 1978”	14
iii. Reduce the poverty, reduce the mortality	15
a) Infant mortality	16
b) Maternal mortality	16
c) Nutrition	17
d) Education	18
e) Employment	20
f) Environment	21
g) Infrastructure	22
h) Selected Diseases	23
i. Immunisable diseases	24
ii. Malaria	24
iii. Tuberculosis	25
iv. HIV/AIDS and TB	25
F. PHC Malaysia in the new millennium	26
G. Special groups	28
I. The poor	28
II. Orang asli	29
III. Women	30
IV. Youths	30
H. Opportunities, Challenges and Insight	31
I. The Political environment	31
II. Administrative Competence and Technical Expertise	32
III. Globalisation	33
I. Conclusion	34
Appendix 1 - Policy Formulation Institutional Framework	35
Appendix 2 – Implementation Coordination Mechanism	36
Appendix 3 – Projects Examples – Intersectoral Action for Health	37
Appendix 4 – Intersectoral Action Players	38
References	39

INTERSECTORAL ACTION FOR HEALTH AND EQUITY MALAYSIA

Summary

Malaysia has attained commendable health achievements for the socioeconomic status in which she records. This has much to do with the policies laid and strategies taken since independence on Rural Health Service (RHS) which was later changed to Primary Health Care (PHC). The concept of RHS and also similarly expounded by PHC, codified in the Alma Ata Declaration explicitly outlined a strategy, which would respond more equitably, appropriately and effectively to basic health care needs and also address the underlying social, economic and political causes of poor health. Principles underpin the PHC approach, namely, universal accessibility and coverage on the basis of need; comprehensive care with an emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; inter-sectoral action for health; and appropriate technology and cost-effectiveness in relation to available resources were the thrust taken then and till today.

PHC concept here is based on the understanding that health improvement results from a reduction in both the effects of disease (morbidity and mortality) and its incidence as well as from a general increase in social well-being. The effects of disease may be modified by successful treatment and rehabilitation and its incidence may be reduced by preventive measures while, well-being is promoted by improved social environments created by the harnessing of political will and effective intersectoral action.

The approach of comprehensive health systems in Malaysia includes, therefore, curative and rehabilitative components to address the effects of health problems, a preventive component to address the immediate and underlying causative factors which operate at the level of the individual, and a promotive component which addresses the more basic (intersectoral) causes which operate usually at the level of society.

The main driver of change for Intersectoral Action at the Central and Decentralised Level is the 'poverty eradication programme' by the Government that has created ripples of almost orchestrated activities by the various governmental and others institutions. Improving poverty improves income, education, food availability, health, and shelter.

This paper described the various process of how '**intersectoral**' policies at the central governmental level are developed in addressing health equities. It attempts to make some analysis of how the appropriate roles for various governmental, non-governmental and private-sector agencies in the **intersectoral mix** work together for specific health issues. It also examines the case of implementing PHC in Malaysia through **intersectoral division** of effort at the decentralised level.

Strategies for comprehensively tackling health problems can be grouped essentially under two complementary headings: 1) promoting healthy policies and plans and 2) implementing comprehensive and decentralised health systems. Success of these strategies depends upon the creation of a facilitating environment both at the central level government level which provides the mandate, resources, financing and legislation in order to ensure cost-effectiveness and sustainability, while at the decentralized level it allows for ease of communication and encourage innovativeness through such actions as advocacy, community mobilisation, capacity-building, and organisational change.

I. Scope and Study Objectives

The objective of this study is to relate the experiences of Malaysia in addressing the various social determinants of health and implementing intersectoral action as part of a mix of strategies to improve health equity, using Primary Health Care as the focal point.

II. Study Methodology

The scope of the study is guided by answering the following questions that has been prepared by the CSDH secretariat WHO.

What was the mandate and nature of the policy challenge?

What contextual factors were most significant?

What were the mechanisms used to support IA and what did work and did not work?

What roles did the various actors play?

What health and broader social outcomes were achieved?

What lessons learned?

What is needed to support more effective IA in the future?

This paper examines experiences both through focus group discussions and those documented by policy-makers, practitioners, academics within and without the country related to social determinants of health, equity, intersectoral action and health. Documents retrieved dated as far back in 1960's, to date.

Firstly a brainstorming session was held by the authors to outline the framework of the intersectoral action for health in the country and the contributing players. As the major contributors were not only from the Ministry of Health but includes other government agencies, it was decided that their representatives would be gathered for a discussion on their strategies and activities contributing to health of the country.

Two multidisciplinary and participatory workshops were conducted with important stakeholders from government, non-government and community organizations, national institutes and academic institutions. 27 representatives from the various organizations attended the workshop. In Workshop 1, participants prioritized the main health and health-related problems in the Malaysia and from their perspective what have Malaysia health achieved.

In Workshop 2, following presentations of the above, participants from the respective departments and organizations listed and describe their roles on strategic or policy contributions to health of the nation. They were also requested to share whether intersectoral action for health was an approach that their organization embraced. They worked in groups facilitated by the authors. Each group's discussion was then summarized by the authors to contribute to the final interpretation of the country's efforts in intersectoral action for the social determinants of health.

The output of both workshops gave the authors a new framework to write the article and attempt to substantiate all policies and actions from information provided in the workshop. Where information were inadequate, the respective organizations were consulted to assist furnish additional information. The article describe on the Primary Health Care approach taken by the country and how it is key to the resulting intersectoral actions to reduce health equities at the national level.

III. Working Definitions

As this study covers 3 aspects below, each has been defined below:

- Social Determinants of Health
- Intersectoral Action for Health
- Primary Health Care

Social Determinants of Health

The Ottawa Charter on Health Promotion identified eight key determinants ("prerequisites") of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require coordinated action among different government departments, as well as among non-governmental and voluntary organizations, the private sector and the media.

Intersectoral Action for Health

"a recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone." (WHO International Conference on Intersectoral Action for Health 1997, p.3).

Primary Health Care

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process

A. Introduction

Come August 31st 2007, Malaysia will be marking its 50 years as a sovereign nation. By now, the multiracial population would have exceeded the last census that placed it at 26.12 million people (yr 2005), with more than 50 % concentrated in urban areas. This historical make-up of its population dates as far back as the 1800s, when the Malacca Straits' trading routes brought in traders, settlers and colonizers. The Chinese, Indians, Thais, Indonesians, Arabs, and later Europeans, mainly Portuguese, Dutch and British have contributed to the multi-ethnic population of Malaysia. They mixed along with the indigenous namely the Malays, Orang Asli and natives in Sabah and Sarawak, amongst others the Iban, Bidayuh, Melanau, Penan, Kadazan, Bajau and Murut. The indigenous groups later called Bumiputras, have important significance in the planning and redistribution of resources for equity. As of 2005 the population distribution in Malaysia stands at 61.1% Bumiputras, 23.5% Chinese, 7.02% Indians and 1.19% others. (Department of Statistics, Malaysia)

By this time, significant strides had been made in the field of healthcare. The life expectancy at birth for the average Malaysian man rose from 55.8 years in 1957 to 73 in 2005, while infant mortality also dropped from 80 deaths per every 1,000 infants to 5 per 1,000 infants for the same period.

Concurrent improvements have also been made in the field of education. If there was a time that an entire '*kampung*' or village would celebrate the rare university acceptance, the novelty now is just customary with more young adults gaining access to tertiary education. The percentage has increased from a mere 3% in 1980 to 29% in 2005 for the relevant cohort. Progress is being made to achieve a target of a 40% tertiary educated population by the year 2020.

Continuous efforts are being made so that more and more Malaysians escape the clutches of poverty and enjoy improved standards of living. Back in 1970s, the incidence of poverty

amongst Malaysian was at an alarming 49.3%. The various interventions and strategies have made quantum progress in reducing the rate to 5.7 per cent in 2005.

Using the Human Development Index (HDI) indicator has allowed Malaysia to compare its overall standing on an international platform. Developed by the UNDP it not only measure economic progress, but also the environment in which people can develop their full potential and lead productive, creative lives. Table 1 shows how Malaysia fairs, with the HDI rising steadily over the years. By 2002, Malaysia was ranked 59th in the world.

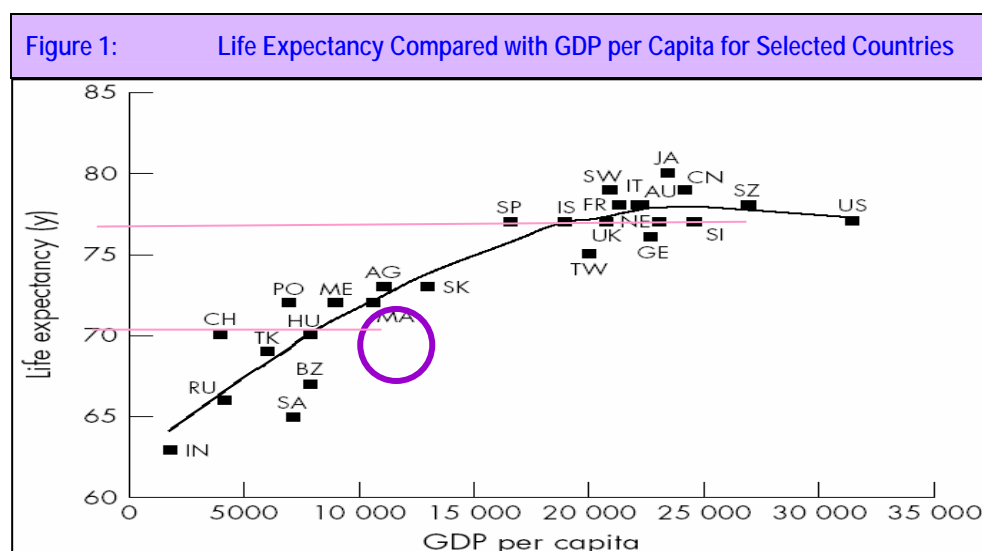
Year	1975	1980	1985	1990	1995	2000	2002
Human Development Index	0.614	0.657	0.693	0.720	0.759	0.789	0.793

Source : United Nation Development Plan : Ref: <http://hdr.undp.org/hd/>

Countries	% GDP	Life Expectancy		Infant Mortality	Countries	% GDP	Life Expectancy		Infant Mortality
	2004	2004	2004	2005		2004	2004	2004	2005
Indonesia	3.1	65	68	28	China	5.6	70	74	23
Philippines	3.2	65	72	25	Korea	5.6	73	80	5
Thailand	3.3	67	73	18	U.K	8	76	81	5
MALAYSIA	3.8	69	74	5	Canada	9.9	78	83	5
Singapore	4.5	77	82	3	Switzerland	11.1	78	83	4
India	4.8	61	63	56	USA	15.2	75	80	6

Source : World Health Report, 2006 and UNICEF 2007

Although Malaysia spends with a smaller percentage of GDP in 2004 the life expectancy and the infant mortality rates have been reduced dramatically almost to that of achievements in Korea or the UK, see Table 2.

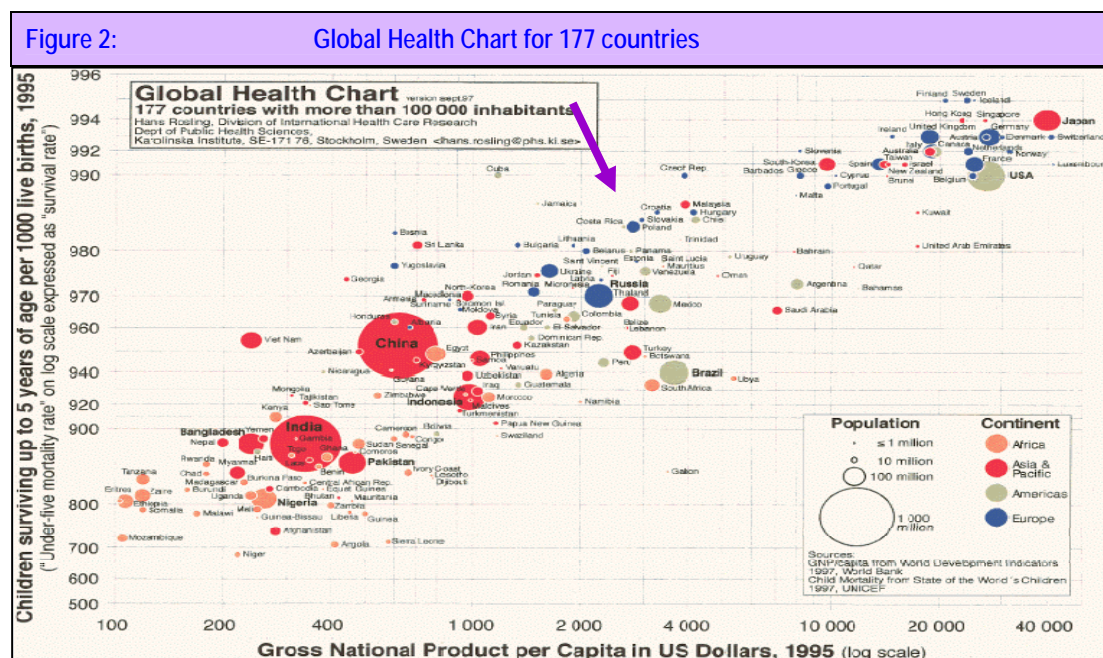


Country codes:
 AG=Argentina AU=Australia BZ=Brazil CH=China CN=Canada FR=France
 GE=Germany HU=Hungary IN=India IS=Israel IT=Italy JA=Japan
 MA=Malaysia ME=Mexico NE=Netherlands PO=Poland RU=Russia
 SA=South Africa SI=Singapore SK=South Korea SP=Spain SW=Sweden
 SZ=Switzerland TK=Turkey TW=Taiwan UK=Utd Kingdom US=United States

Source: Economist Intelligence Unit. Healthcare International. 4th quarter 1999. London, UK: Economist Intelligence Unit, 1999.

Figure 1, illustrate Malaysia’s position in relation to other countries with respect to its GDP per capita of US\$10,318 in 2005¹ and the life expectancy.

Figure 2, illustrates Malaysia’s standing amongst 176 countries with respect to children surviving up to 5 years of age per 1000 live births in 1995.



Source: Karolinska Institute: www.whc.ki.se/index.php.

Among the countries with similar GNP, Malaysia spends more of public funds on the poorest 20% of the population and this has resulted in a higher child survival as compared to those countries who may have not done so for a greater share of the government expenditure. The survival rate of children up till 5 years of age in Malaysia is much higher as compared to other countries with similar GNP per capita.

Table 3: Share of Public Spending on Health among Countries with Similar GNP per Capita But Very Disparate Child Survival (to Age 5) Rates, 1995				
High child survival		Low child survival		Additional children lost per 1000
Sri Lanka	1.1	Ivory Coast	0.3	150
Malaysia	2.6	Brazil	0.4	45
Costa Rica	2.1	South Africa	0.9	55
Jamaica	3.3	Ecuador	0.2	25
Nicaragua	1.0	India	0.3	50
Egypt	0.6	Ivory Coast	0.3	100

Sources: Calculated from Karolinska Institute, Global health chart, www.whc.ki.se/index.php. Victora et al, *Lancet* 2003; 362:233-241. Castro-Leal et al, *Bull World Health Organ* 2000; 78:66-74. Carr. *Improving the Health of the World's Poorest People*. Population Health Bureau, 2004.

NB: Ratio*: percent of expenditures for health from the government to poorest 20% vs. richest 20% of population
Ratios** of one or more signify a greater share of government expenditures to poorest segment of population.

¹ Ninth Malaysia Plan 2006-2010, Economic Planning Unit, Prime Minister’s Department, 2006.

B. Contextual Factors

Poverty is the main underlying cause of ill health in many rural and peri-urban communities in Malaysia. Evidence to date clearly establishes the links between poverty and personal, community and system-based shortcomings in health, nutrition and education domains. It was therefore essential to target those vulnerable populations living in communities of extreme poverty as they suffer disproportionately from a wide-range of adverse outcomes. Due to the high levels of poverty, difficulties in access to care, and local beliefs and customs, many in this population do not seek conventional medical services until late in an illness and do not attend health centres during a pregnancy or at delivery. This has also led to increasing transmission and complications of prevalent illnesses.

Based on situational analysis conducted for the second Malaysia Plan 1961-1965, the priority social problems, as well as their associated causes and effects, fit into five general categories: 1) health; 2) nutrition; 3) education; 4) environment; and 5) social development. Poverty was an underlying cause as well as a common effect of each problem. This is consistent with the cyclical nature of poverty as both a cause and effect of adverse health, nutrition and education outcomes. In addition, it was clear from the problem trees that many of the problems were interrelated with one another and were multiaetiological.

Concurrently during the same period the nation's population was growing at about 3% per year, a rate at which the population would double in less than 25 years. Such an extreme rapid rate of population would imperil efforts to raise per capita income levels. If economic growth was not rapid enough to provide income to families, frustrations and discontentment would set-in too precarious for a multiethnic country as Malaysia.

For a stable government 3 strategic poverty-reducing approachesⁱ were instituted with emphasis on:

- i) Agricultural and rural development to raise income of poor farmers
- ii) Labour-intensive export industrialization to absorb workers
- iii) Public investment in education, health and infrastructure especially in rural areas to raise levels of poor.

Many of the essential elements of Social Determinants for Health are highly correlated with poverty eradication programmes, which can be identified in the National Policies that have produced tangible improvements.

From the early years of the 1970s, Malaysia has pronounced its policy focus on Growth with Equity. Introduced through the New Economic Plan (NEP) it bears a two-pronged strategy:

- 1) To reduce and eventually eradicate absolute poverty by raising income levels
- 2) To increase employment opportunities for all Malaysians.

These policies were intended to restructure society by correcting economic imbalances by reducing and eventually eliminating racial identification of specific economic functions. The successful poverty reduction approach placed a strong emphasis on basic human requirements such as agriculture, education, health and infrastructure in rural development.

The NEP initiated the evolution of the country's economy. Upon its completion, the National Development Policy (1991-2000) was introduced to retain the main elements of the NEP, with several new thrusts to strike a more balanced development. These initiatives served to emphasize the non-materialistic aspects of national development, especially the strengthening of social and spiritual values, as well as the protection of the ecology.

Subsequently, the National Vision Policy (2001-2010) was introduced in the first decade of the new millennium to guide Malaysia through the impending challenges of the 21st century. In essence, the National Vision Policy represents the consolidation of all past

development efforts, aimed at establishing a united, progressive and prosperous Malaysia that lives in harmony and engages its citizenry in full and fair partnership. Again the emphasis is also given to the building of a resilient and competitive nation as well as an equitable healthy society, unity and social stability.

Intersectoral Action culminates when there is a shared objectives, shared rewards and facilitating environment: With a stable political environment and consistent unfaltering message on 'equity' over the last 40 years, the various organizations has come to rank within people-centred and pro-social development of the country. The interministerial and interorganisational relationships are further galvanized by strong mandate by the highest body of the government. See Appendix I and IV.

Across the 3 National Policies, NEP, NDP, NVP, the Malaysian Social Policies have incorporated objectives and strategies that address social concerns and problems that include health, education, training, housing, unemployment, poverty and income disparities, crime, drug addiction, ethnic and community relations, and family violence. The paramount goal of these policies is to improve the welfare or well being of the people or vulnerable groups, such as women, youths, children, the aged, the disabled, ethnic groups and other minorities. The cumulative positive results over the years bear testament of the Malaysia's commitments and approaches.

C. Public Policies in Malaysia

I. Origins of Policy

Equity has taken centre stage in the strategic plans of the Malaysian government. The impetus was brought about following, a short-lived riot in 1969, in the capital city of Kuala Lumpur which led to a state of emergency being declared nationwide. The emergency, which ended in 1971, underscored the need to place greater racial balance in economic participation, opportunities and employment. Thus the New Economic Policy was initiated, predicated upon the firm belief that economic growth alone was not enough and should not be an end in national development, given the ethnic configurations of Malaysia's patterns of economic occupations and wealth ownership at that point in time.

The ultimate goal was and still is national unity, i.e. a multi-ethnic and multi-religious nation whose citizens live in peace and harmony. To achieve unity, it was paramount that the fruits of economic growth be equitably shared among the major ethnic and economical groups.

II. Key characteristics of social policies

There were two features of the evolution of social policies in Malaysia that can be considered as distinguishing it from those of other countries. Firstly, there was the existence of a stable and supportive political environment *for a lengthy and continuous period*, which allowed the orderly and incremental development of social policies. Not many developing countries had the benefit of such an environment. In this regard, while the absence of major natural disasters can be attributed to the favourable geographical location of Malaysia, the other elements of stability and harmony had much to do with the pragmatic and sensible nature of Malaysians.

Secondly, there was a real will and commitment on the part of the government and public sector to improve the well being of the people. Successive strong governments under the Alliance and the National Front held large majorities in Parliament and the State Assemblies. Evidently, this political strength was well complemented with a real willingness and commitment to develop the social services and the country as a whole, thereby contributing towards improvements to the quality of life of the people.

III. Policy Formulation

The social policy formulation process involved political, administrative, legal and parliamentary components, while its decision-making is circumscribed by the main principles of the equitable growth philosophy. Malaysia follows a systematic planning process whereby five-year plans are set within longer Outline Perspective Plans (OPPs), and systematic reviews are conducted at mid-point of these five-year plans. Annual plans are vehicles for fine-tuning and adjusting the five-year plans to adapt to changing circumstances. The institutions that participate in the social policy formulation process include individual members of the public; interest groups and NGOs; mass media; political parties; federal public service entities, including those at sub-federal levels; the Cabinet; the Parliament (House of Representatives and Senate) and the Paramount Ruler or King. On matters that may affect the Islamic religion and Malay culture, the Council of Rulers is also consulted.

IV. Policy Implementation; Ministerial, State and District/Community

In view of Malaysia's federal system of governance and administration, the implementing ministries are structured to have at least three levels of organization, viz., federal, state and district. In addition, there are also the sub-district, *mukim* and village levels for each district. Ministry of Health and Ministry of Education, ranked among the larger ministries, have service delivery points, i.e., schools and clinics, even at village levels. There are also mobile clinics to provide the remotest areas with adequate healthcare.

V. Policy Evaluation

The same institutions conduct evaluation on the implementation of social policies in Malaysia. The data generated by the monitoring process forms an important set of inputs of the coordination function. As in the cases of social policy formulation and implementation, monitoring and coordination (M&C) are joint efforts by many public services organizations at many levels of government and administration the bulk are done at the community level where the impact is felt most.

D. Intersectoral Action for Equity and Health – Mechanism

I. The Central Policy Body

The implementation of Healthy Public Policies in Malaysia, which emphasizes the role of intersectoral activity at the central governmental level, has been significantly enhanced since the late 1970s as discussed in Para C. Initiated by the National Economic Policies focusing on reducing urban-rural differentials, were the early drivers to health equities.

The coordinating agency at the central level is lead by the National Development Council made up of selected

Financing and Budgeting

The Treasury a central agency is under the Prime Minister's Department. Central agencies are authorized by law and administrative procedures to consider and approve requests for projects and funds from implementing ministries.

The Treasury, under delegated authority from Parliament, manages public finance. It prepares the annual budget that is presented to Parliament for approval and then to the King for assent. In preparing the budget, the practice in the last decade or so, has been to conduct a series of dialogues with representatives of the relevant private sector bodies and NGOs so as to obtain their inputs. They are also attended by representatives of other central agencies and relevant ministries. The dialogues are in addition to the long-standing practice of budget negotiations or discussions between each ministry, including ministries implementing social policies, and the Treasury to determine its annual budget allocation. The allocation itself is divided into two sub-allocations, viz., for operating and capital or development expenditures.

Health budget is both bottoms-up and top down. Yearly budget from each of the ministry including MOH, is put-up to the treasury based on collective requests from various stakeholders. This not only funds the operational and development funds but also include grants for community work and NGOs.

ministers and is chaired by the Prime Minister. It resolves serious issues in coordinating implementation of various development projects. In this regard, it gives particular attention to projects on poverty reduction and those targeted at improving the socio-economic position of the poor and underserved. See Appendices I, II and III.

Apart from the above-mentioned committees and institutions, there are several other mechanisms that are in practice and which are also utilized by ministers and administrators to monitor and coordinate social policy implementation. The Post-Cabinet Meeting in each ministry, every Wednesday afternoon, is one of them. At each meeting, the minister will inform his deputy minister(s), parliamentary secretary (ies), senior ministry officers and department heads about decisions or observations made by the Cabinet in its meeting that morning. In many cases, they pertain to the progress and problems of project implementation. Hence close monitoring of projects and goals or finding solutions are the common agenda.

II. Decentralising Intersectoral Activities for Health

The Public Policies in Malaysia outlines the principles of implementation of comprehensive and decentralized health systems, explicitly inter-sectoral from the outset. The key steps in getting vertically organised and centrally administered programmes to translate horizontally into comprehensive, community-based programmes structured around common health problems, inevitably requires transformation of both management systems and practice. Making the transition from a centralised bureaucratic system often much required, to a decentralised, client-oriented organisational culture calls for a significant investment in developing both management systems and structures and the management capacity of health personnel. District level staffs are continuously guided to be able to support decentralised development of comprehensive programmes with clear roles, goals and procedures.

The policies are usually developed through participation of the staff from the community level on a continuous process. Staffs at the community level, are delegated to conduct situational analysis and isolate priority health problems in a district or local level. This should identify the prevalence and distribution of the problem, its causes, and potential resources, including community capacities and strengths, which can be mobilised and actions which can be undertaken to address the problem. Various subsequent proposals for example, Safe Motherhood Initiative, the Integrated Management of Childhood Illness, DOTS, Harm Reduction, technical guidelines for the management of non-communicable or communicable diseases, often culminated through various meetings and feedback. It will be relayed through the District Health Officer, the State Health Directors before it be taken up by the Health Ministry. Even then, the Ministry having scanned various proposals, usually thousands of such, will filter the most appropriate to the Central Agencies for approval, namely the Treasury and Public Services to secure the necessary mandate and resources. This is important to ensure Policy implementation right through both vertically and horizontally at all levels. There is an advantage in standardising and replicating these core activities in health facilities at different levels so that reinforcement of practice throughout the health system can be assured, and goals achievements accelerated.

Facilitating organisational change and encouraging (particularly government) staff to be more flexible, innovative and responsive to local communities are key actions in achieving success. In the past many of the initiatives to promote community participation in health have concentrated on inviting community people to participate in activities established (and largely controlled) by the health services. However over the last 3 decades, a wide range of community groups or organisations play substantial role in promoting health. They owe their origins to age-old community traditions of mutual support and cooperation and have a long history of community action. They include, in addition to representative health councils, women's groups, youth groups, social clubs, cooperative societies, mutual aid

societies and sporting clubs. There are many roles, often invisible, played by such groups that contribute to improving health.

Although the numbers of such efforts and commitment has grown, more could be achieved if systematic partnership with the health sector can be further exploited. Settings-based health promotion initiatives offer a perspective and mechanism for this kind of relationship. The concept of health promoting districts holds much promise and should be developed as a means of extending health services towards a more intersectoral and developmental role.

E. Intersectoral action in health – The Impact

Table 4: Federal Government Development Expenditure by Sector, Malaysia 1970 – 2005 (% of Total Development Expenditure)					
SECTORS	1970	1980	1990	2000	2005
1.Security	23.7	16.4	9.9	15.3	11.6
2.Social Services	11.2	15.9	24.5	39.6	39.5
a.Education	6.1	7.5	15.3	25.4	23.0
b.Health	2.8	1.1	4.3	4.6	5.3
c.Housing	-	4.0	0.4	4.3	5.2
d.Others	-	-	4.5	5.4	10.9
4.Economic services	62.2	64.8	62.7	41.7	41.4
a. Agriculture & Rural development	27.3	15.2	12.1	4.2	5.4
b. Public utilities	2.8	8.9	7.5	5.4	9.9
c. Trade and industry	13.8	20.8	25.5	13.1	9.2
d. Transport	11.0	13.8	17.3	17.4	14.8
e. Communication	7.3	5.7	0.0	0.8	0.2
f. Others	-	-	0.3	0.6	2.1
5.General administration	2.9	3.0	2.9	10.4	7.5

Sources : Ministry of Finance, Economic Report, various years

The development of the health sector has been and will always be viewed as one of the many contributors to national development. As such, investments in health are a central part of the overall developmental strategy. An improved health status is seen not just as an outcome of economic development, but also as a means of achieving it. Education and health rank among the major recipients of investments in the social sector. See Table 4. Specifically, health accounted for 5.3% of the total social sector development expenditure in 2005.

I. Rural Health Services (1960-1970)

The Ministry of Health inherited a fairly sound medical and health services from the British when Malaysia attained independence in 1957. However, it was a system that was very much urban based that failed to meet the health needs of the rural population. Consequently, there was a major restructuring of the health service system, with the highest priority assigned to rural health services. Taking on a population based approach and focussing on the economically disadvantaged. .

The Rural Health Service was developed in 1966 and was initially delivered through a three-tier rural health unit with the main health centre (MHC) serving a population of 50,000. Each MHC had within its periphery, 4 health sub centres (HSC) to serve roughly 10,000 people each. Below, the MHC and each HSC, were 4 midwife clinics cum quarters (MCQ) intended to serve 2,000 people each and were located within the centres' operational areas. See Table 5.

In 1969, a study of the local health services was completed together with WHO's assistance, and under the Mid Term Review of the Second Malaysia Plan (1971-1975) a two-tier delivery system was recommended. It did away with the health sub centre and introduced a community nurse clinic in place of the midwife clinic cum quarters. The facility/population ratio changed so that health centres now covered between 15,000 to 20,000 population and rural clinics 2,000 to 4,000 population. This historical move upgraded the level of care provided by rural health services. Concurrently, the referral network between these health clinics with both the district and state hospitals were established with common policies and operating procedures to facilitate speedier and more efficient management of referred cases.

Structure	Level of Service	Staff	Services
Three-tier system (1956-70)	Main health centre (1:50,000 population)	Doctor and dental officer	Priority outpatient care and dental care
	Health sub-centre (1:10,000)	Medical assistants and staff nurses	Outpatient screening and MCH care
	Midwife clinics (1:2,000)	Midwife	Home delivery and home visiting
Two-tier system (1970-present)	Health centre (1:20,00)	Doctor, dental officer, medical assistants, and public health nurses	Outpatient, MCH care, environment health, food quality demonstration, health education, family planning and dispensary
	Community clinics (1:4,000)	Community nurse, midwife, and midwives	MCH care, home delivery, home-visiting, minor ailments, family planning

Today, the number of health facilities has increased in line with continuously improving healthcare accessibility and equity to the poor and underserved. See Table 6. In the latter part of the last century, the rural-urban migration created a new class of poor urbanites who had poor access to free public clinics. This aspect had to be taken into consideration during the infrastructure development period of 2000-2005 and 2005-2010.

Facilities	1957*	1970**	1980**	1996**
Midwife cum clinic and Community Clinics	0	943	1509	1987
Health Clinics all types (PHC)	7	224	725	897
Hospitals	60	72	88	118

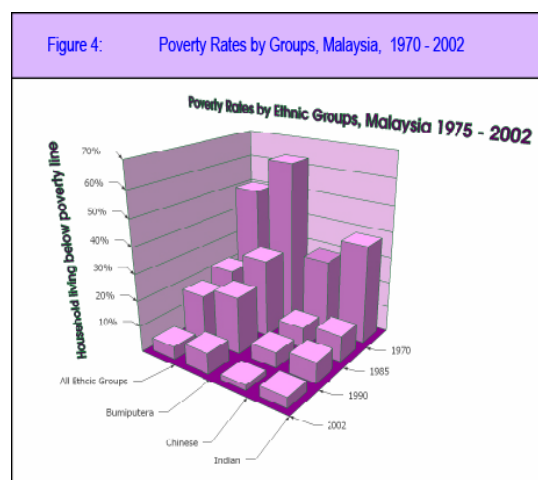
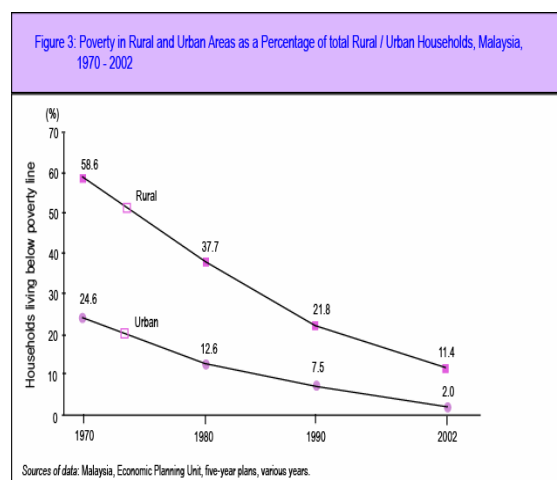
Source : Ministry of Health, Health Management and Information System
 * - Malaya
 ** - Malaysia

II. Equity and Health

1. Reducing poverty through better health

The prevalence of poverty was high among the rural population of the early 1970s, with 49.3%, living below the poverty line. Overall, they accounted for 60% of the nation's poor. See Figure 3. Among the various races, the Bumiputras had amongst the highest incidence of poverty, with more than two-thirds living below the poverty line. See (Figure 10).

With such high prevalence and increasing sensitivities among the population, there was an immediate call for strategies to address the poverty gap. Alleviation of hunger and improving nutritional status were deemed the most appropriate strategies for immediate implementation.



To overcome the nutritional diseases and deficiencies, especially prevalent in the rural areas, the government through the Department of Agriculture, in collaboration with the Ministry of Local Government, Health and Education initiated a long-term poverty-reducing project known as the Applied Food and Nutrition Programme (AFNP) in 1972. The project was aimed at increasing local production of nutritious foods, improving nutritional education, health and basic education and promoting supplementary feeding of pregnant and lactating mothers, toddlers and school-going children.

Therefore, it was as early as the 1970s that the era of **integrated multi-agency intersectoral approaches** was put in to practice with the launch of the Applied Food and Nutrition Programme, the School Health Programme, and integration of Family Planning into Maternal and Child Health (MCH) services projects. These initiatives were among the higher profile projects in the rural health and rural development programmes.

2. Incorporating “Primary Health Care – 1978”

The birth of Primary Health Care came just as Malaysia was strengthening its foundations in elements that were similarly expounded by the Alma-Ata Declaration. See Box.1, an extraction of the PHC proclamation, item IV. As a signatory to the declaration, the Malaysian Rural Health Service was revamped to uphold the principles of the Declaration

BOX 1 : PHC : Item IV

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process

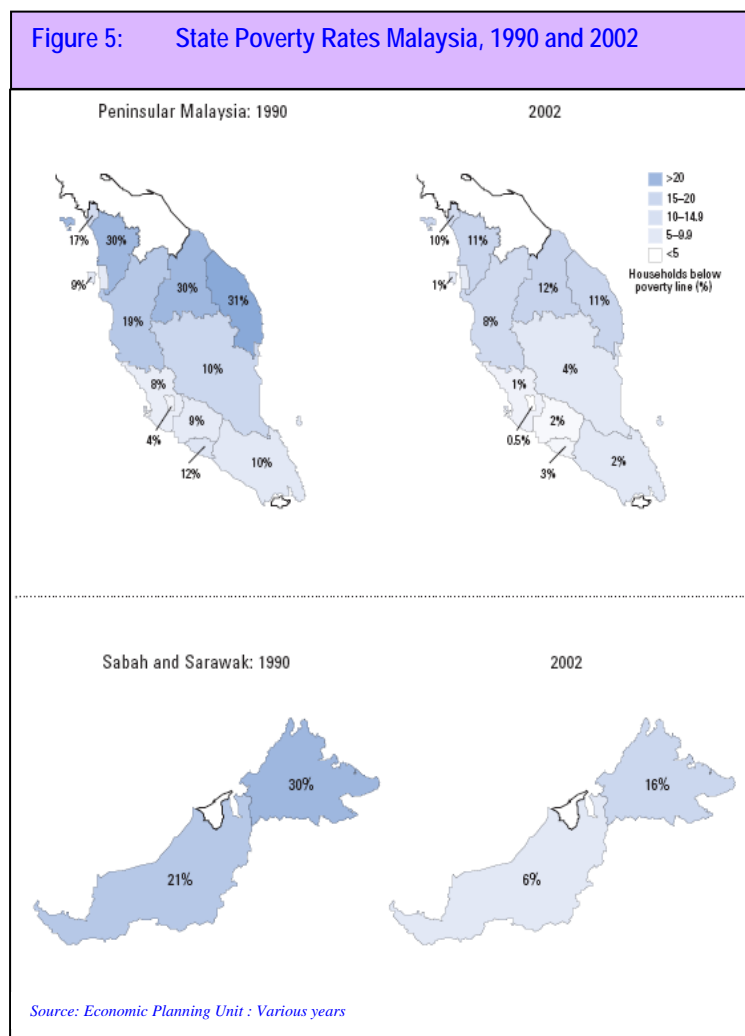
affirming that health as a fundamental human right and called for a transformation of conventional health care systems and for broad intersectoral collaboration and community

organizing. Various intersectoral strategies that were already in place were reviewed incorporating tested-technology or consensus on new approaches to ensure speedier progress.

3. Reduce the poverty, reduce the mortality

With the establishment of the Maternal and Child Health and Health Education Unit in the Ministry of Health in 1971, PHC package was easily implemented and monitored. Infant and Maternal mortality data which correspond with the poverty levels of the various states (refer Figures 5, 6 and 7) facilitated and allowed greater justification for a more equitable division of resources. These 'rural states' in the early 70 and 80s such as Sabah, Sarawak, Kelantan, Terengganu, Kedah, Pahang and Perlis were given particular emphasis, with greater provision of clinics, hospitals and human resource. Similar initiatives were also made by in the areas of education, agriculture and housing, transport, information infrastructure development to synergize rural development in order to gradually reduce and overcome poverty, which has resulted with improved social economic status of the rural community.

Figure 5: State Poverty Rates Malaysia, 1990 and 2002



However, acceptance to various health delivery services in those early years was lukewarm. Some communities even resisted proffered services. As a result, there was low coverage for antenatal /child health visits and activities and outcomes were poor.

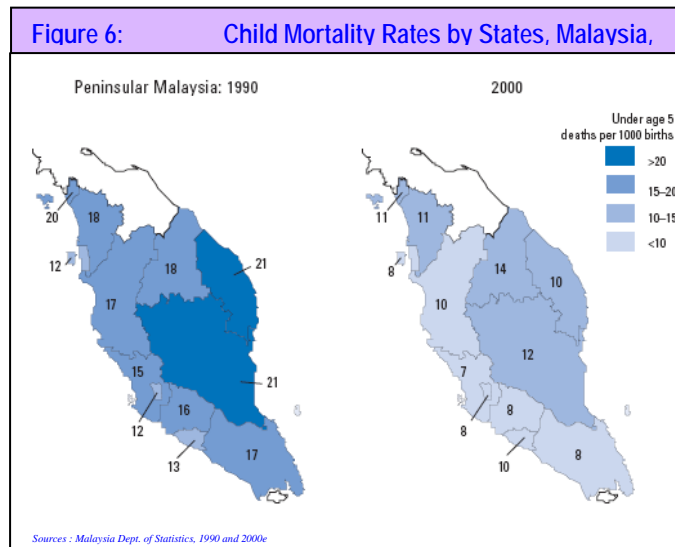
The underutilization of PHC facilities however, was later overcome by removing traditional, social and cultural barriers, personal beliefs and preferences of the communities through extensive health education initiatives via community clinics, at homes, in villages and among influential persons in the community to improve acceptability.

Even to this day, pregnancy and delivery is affected by traditional and sociocultural practices beliefs and taboo. Studies on preferences for place of

delivery provided data for improvements on in-service training and on managerial and organizational aspects of services. The District Specific Approach, Safe Motherhood Strategies, Risk Approach Projects, Child Health and Expanded Programme on Immunisation to name a few were implemented. The result: reduced waiting time,

improved patient flow, timely referrals and appropriate management of pregnant women and high-risk children with complications, as well as a more friendly, client oriented service. Community education and advocacy are also strong elements utilised in all the above approaches as pregnancy, delivery and infant care are very closely linked to the socio-cultural and traditional environment of the family and community. The need to use village head, religious figures, influential village women or village health workers whom the community trusts has to be optimized.

a. Infant Mortality

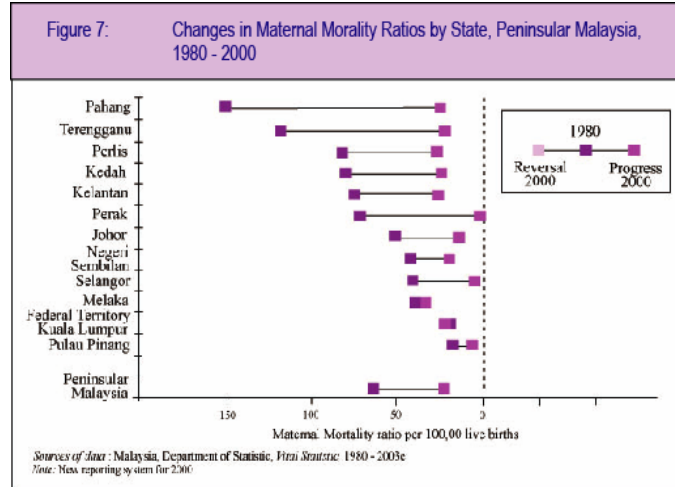


Corresponding high infant mortalities noted in the same states in 1970, showed marked reductions by the year 2000. See Figure 6. These illustrate the high correlation between poverty and mortality rates, in this context the infant mortality rates.

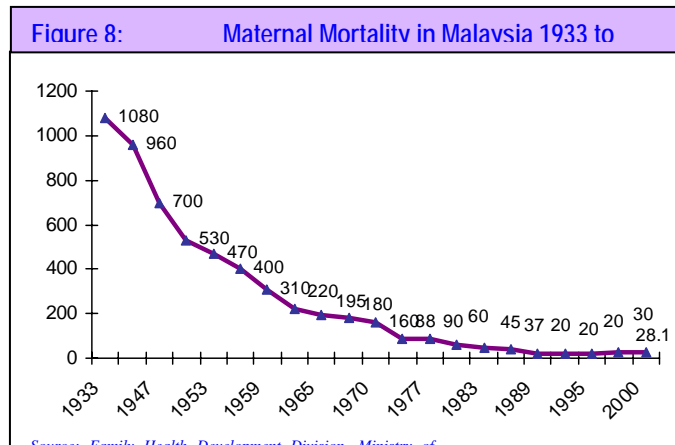
b. Maternal Mortality

The states also recorded among the highest maternal mortality in the '70s and '80s.

Within a short period over the last two decades, the improvements have been significant whereby these lagging states began catching up with the rest of the country. Pahang and Terengganu, see Figure 7, each state fell from an initial 151 and 118 per 100,000 live births to just 24 and 21 per 100,000 live births in 2000.



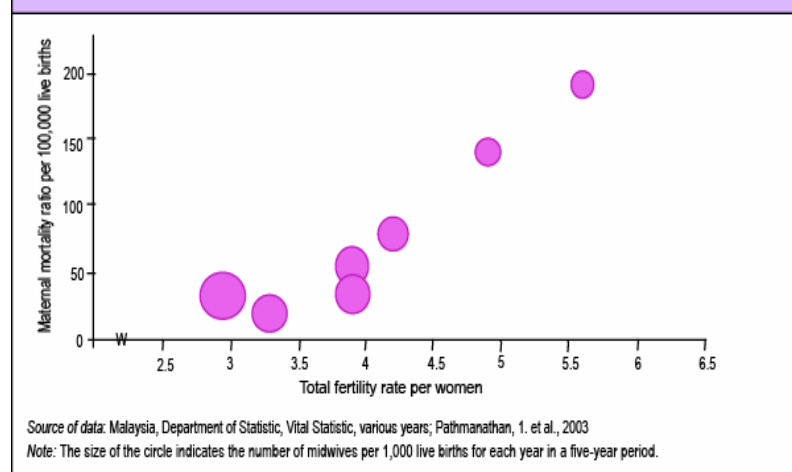
These substantial reductions were mainly due to the overall socio-economic development through improvements made in infrastructure, education, water



and sanitation, nutrition and access to healthcare services. The spread of the 3-tier and 2-tier systems and the outreach services brought basic maternal and child health services to remote locations and thus, spared them from the considerable damage of poverty inflicts on health. These strategies were the result of concerted efforts and commitments made by various ministries backed by a sustained mandate from the government.

The increase in manpower, particularly in the number of midwives serving the rural community, further accelerated the reduction seen in maternal mortality rates. Health education and improved socio-economic conditions together with family planning approaches have also reduced fertility rates which correspondingly, reduced maternal mortality.

Figure 9: As Total Fertility Rates Decrease and the Number of Midwives per 1,000 Live Births Rises, the Maternal Mortality Ratios Decline, Peninsular Malaysia, 1965-2000



Empowerment of women has made it possible for them to join in the decision making regarding pregnancy, delivery and family size, which otherwise remained the domain of the husband or the male head of the family. Figure 9 shows that smaller family size and decreasing fertility rates over the period from 1965 to 2000 is also strongly associated with the dip in maternal mortality.

c. Nutrition

Table 7: Nutritional Status of Children Aged Less Than 5 Years, Malaysia
 Nutritional Status of Children (weight-for-age)

Year	Moderate underweight malnourished (%)	Severe underweight malnourished (%)
1990	24.5	0.5
1991	25.6	0.5
1992	25.1	0.5
1993	22.8	0.5
1994	22.0	0.4
1995	20.0	0.6
1996	19.4	0.8
1997	17.7	1.0
1998	17.3	1.1
1999	14.7	1.0
2000	13.0	1.0
2001	11.5	0.9
2002	11.1	0.9

Source : Malaysia, Ministry of Health, 1991 and 2001

The government’s pro-poor policies that were started in the ‘70s contributed to further reduction of infant and child mortality gaps. The “Development Program for the Hardcore Poor” which among others, includes the nutritional rehabilitation programme specifically undertaken for the treatment of malnourished children under age 5. The trend has also shown a decline of underweight children by 50% associated with both moderate and severe malnutrition (see table 7). This was yet another catalyst to improve the overall nutritional status of the socio-economically disadvantaged young. Health staffs that are trained made

concerted efforts to reach children in the underserved and isolated areas. It intensified coverage and further ensured equitable improvements to reduce the disparities.

The Department of Agriculture ensures **Food security** through the production of *padi* and the target is to meet a 90% self-sufficiency level by 2010 (see table 8).The ‘Green Book Programme’ that is similar to the earlier Applied Food and Nutrition Project, was reactivated to promote the cultivation of food crops at the community level. Fruit production was up-scaled to meet export demands while vegetable production was focused on high value varieties for both local consumption and selected export markets.

Commodity	2000	2005	2010
Rice	70	72	90
Fruits	94	117	138
Vegetables	95	74	108
Fisheries	86	91	104
Beef	15	23	28
Mutton	6	8	10
Poultry	113	121	122
Eggs	116	113	115
Pork	100	107	132
Milk	3	5	5

Source : Ministry of Agriculture and Agro-Based Industry

For school going children, the Ministry of Agriculture ran a programme to supply milk to schools, especially rural schools. In 1983, this initiative was taken up by the Ministry of Education together with local milk manufacturers in the form of the ‘School Milk Programme’. This programme complemented the Supplementary Food Programme, initiated when school children were noted to be attending school without breakfast. This program was well received by the rural children, reflected by the improved attendance and nutritional gain. The Ministry of Health is responsible for monitoring nutritional content and food safety on a regular basis.

The school health programme was introduced as early as 1967. In 1999 the Health Promoting School programme was introduced with an integrated approach to a) Health school policy b) Safe and healthy physical environment c) Safe and healthy social school environment d) Community participation e) Personal skills development and f) School health services. Greater integration between the various ministries became imperative towards achieving healthier and more wholesome school children.

d. Education

The focus on education started in the First Malaysia Plan 1966-1970, which stated that ‘unless the educational system is geared to meet the development needs of the country, there will be a misallocation of an important economic resource, which will slow down the rate of economic and social advance’. Using national unity as the basis, investments were made to improve access to education within all strata of the population. In 1970, 30% of the population above the age of 6 did not attend school. But by 2005, the percentage of school-going children jumped to 96%. The national education participation rate improved with significant increases made at all levels from the pre-school and tertiary levels. Figure 10 & 11, show the inverse relationship between poverty levels with literacy rate, with age and family size.

Figure 10: Relationship Between Poverty and Literacy Rates, Malaysia, 1991 - 2000

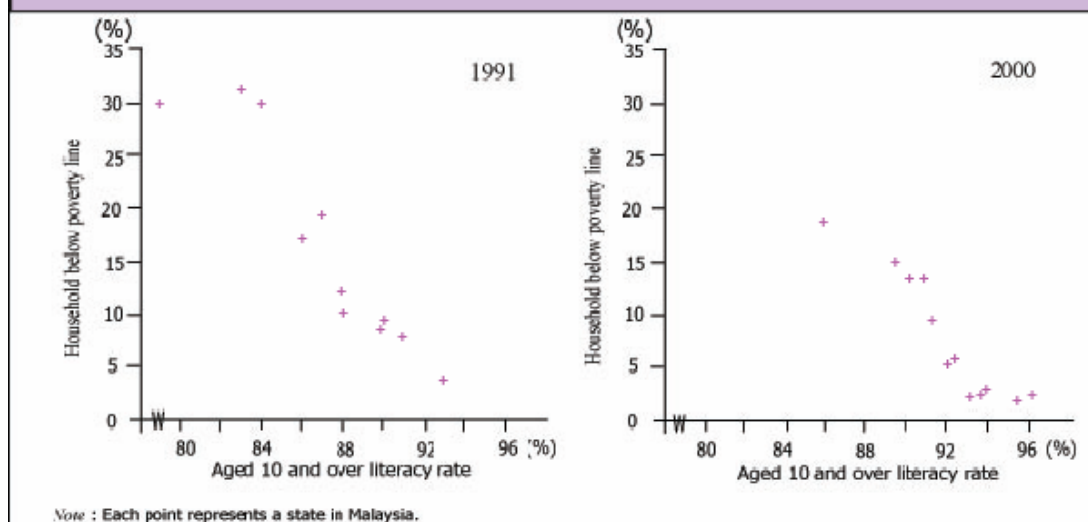
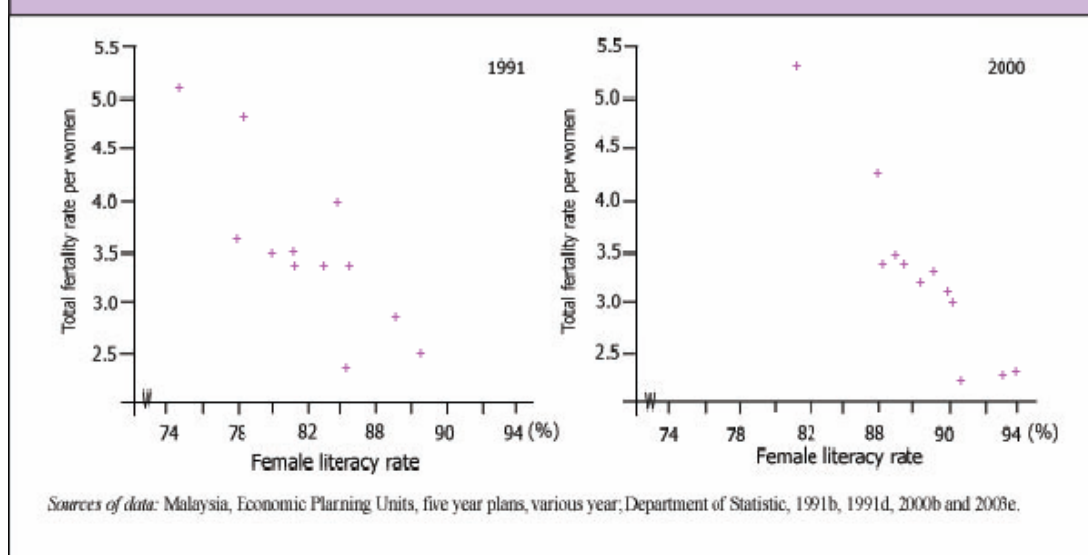


Figure 11: Relationship Between Female Literacy Rate and Family Size, Malaysia, 1991 - 2000



The literacy rate (aged 10 and above) has increased from 93.8% in 2000 to 95.1% in 2005. Females made up 49%, 50% and 66% of the enrolment in primary, secondary and post secondary schools respectively, and have remained so, from 2000 till 2005. But the enrolment of females in colleges and universities has increased significantly from 47% to 50% and 56% to 61% respectively from 2000 till 2005.

Table 9: Access to education, 1990 – 2005

Participation rate (%)	1990	2005
Pre-school (4-6 years old)	33.1	60.0
Primary	93.2	96.0
Secondary	68.0	85.0
Tertiary (17-23 years old)	16.9	29.9

Source: Ministry of Education

Malaysia’s success in achieving universal primary education is attributable to many factors. These include the government’s investment in early education to ensure all children are accorded equal educational opportunities within a conducive environment. It is evident that with rising literacy rates, poverty rates have declined particularly with the strong relationship between female literacy and family size.

Table 10: Literacy Rates of 15-19 Year Olds by Ethnic Group, Malaysia, 1970 – 2000 (%)

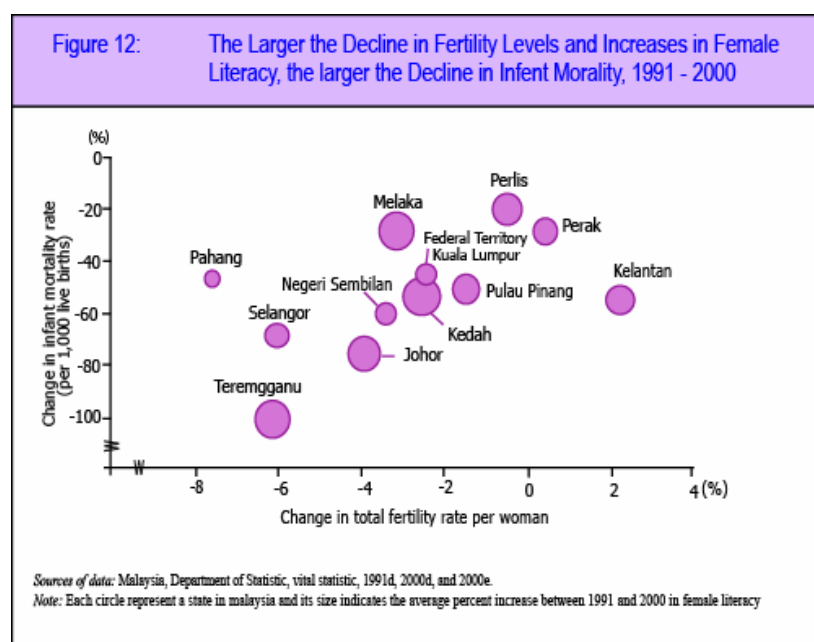
Year	Bumiputera	Chinese	Indians
1970*	91.0	94.0	87.0
1980*	96.0	97.0	92.0
1991	96.9	98.4	96.9
2000	96.3	99.6	98.7

Source : Malaysia, Department of Statistics, 1980, 1991, 2000.
* Relates to Peninsula Malaysia

Over the past 30 years, the literacy rate among youths aged between the 15-19 years increased in all 3 ethnic groups despite a later start by the Bumiputras and the Indians.

Education, female literacy and infant mortality

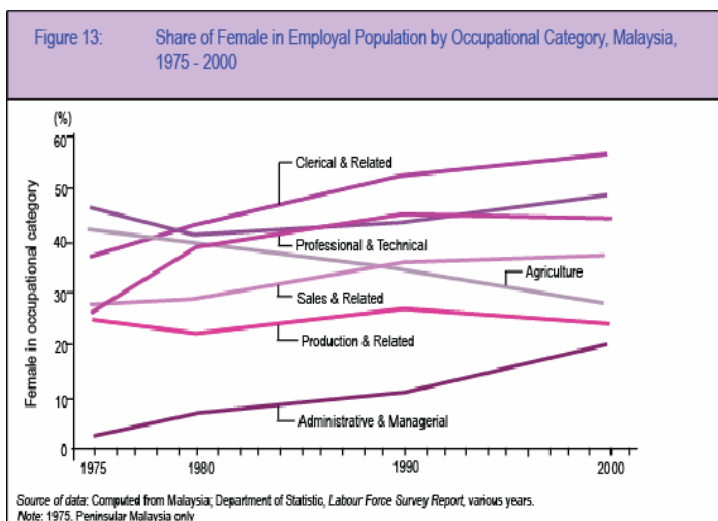
By ensuring universal primary health care coverage together with the enrolment of all girls and boys in school with targeted nutritional programmes for the poor, infant and child mortalities have been greatly reduced. Investment in maternal education have affected family nutritional status and led to the full use of the available health care services. The trend has been reinforced by better educated mothers, who typically take care of the health and nutrition of their children, now having



greater awareness of the importance of health care services and correspondingly, making more demands for them.

e. Employment

Employment opportunities for women have improved. The share of women employed has also more than doubled in professional and the clerical groups in 2000 in comparison to the 1980s. Their participation in agriculture has however reduced.



Although the participation at various levels of education for female is commendable, it does not commensurate with the female labour force participation rate. In 2004, only an estimated 10,856 persons were within the working age population of 15-64 years. The total number of economically active male (as percentage of males in the working age population) was 88.1%. However the total number of economically active female (as percentage of total number of females in

the working age population) was 46.4%. It is also noted that the average women's earnings were only 47.2% that of men's income in Malaysiaⁱⁱ.

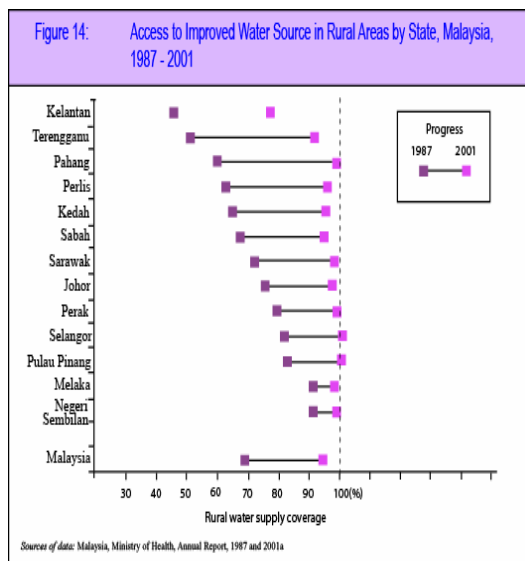
TABLE 11: Distribution of Employed Females and Males of Total Female and Male Labour Force by Occupational Category, Malaysia, 1980 and 2000 (%)

Occupational Category	1980		2000	
	Females	Males	Females	Males
Professional, Technical & Related Workers	7.7	6.2	13.5	8.9
Administrative & Managerial Workers	0.4	2.6	2.2	4.7
Clerical & Related Workers	10.7	7.2	17.5	7.1
Sales & Related Workers	8.4	10.4	12.1	11.1
Service Workers	11.1	8.1	17.4	9.5
Agriculture Workers	42.5	32.4	14.8	20.4
Production & Related Workers	19.2	33.2	22.6	38.4
All categories	100	100	100	100

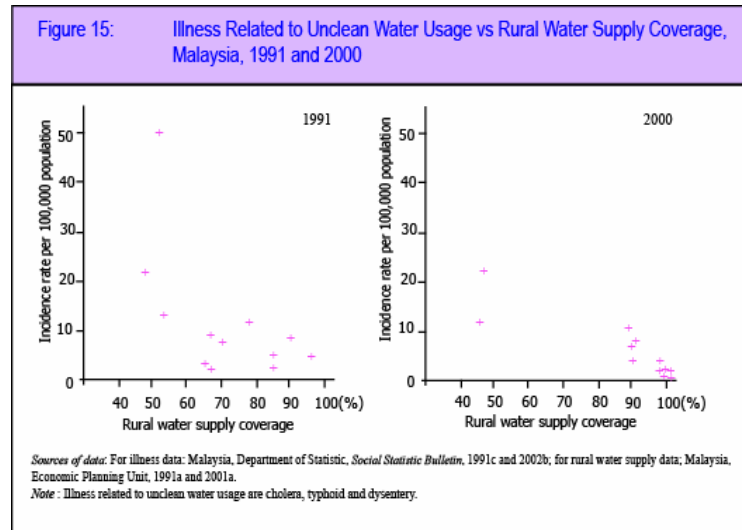
Source of data : Computed from Malaysia, Department of Statistic, Labour Force Survey Report, various years.

f. Environmental

In Malaysia, the provision of environmental sanitation and safe water supply is truly a model of inter-sectoral collaboration with multiple agencies involved in delivering related services in a coordinated manner. The provision in the towns is under the purview of the Local Councils or Authorities under the Ministry of Housing and Local Government while the rural areas are covered by the Ministry of Health and the Ministry of Rural Development.

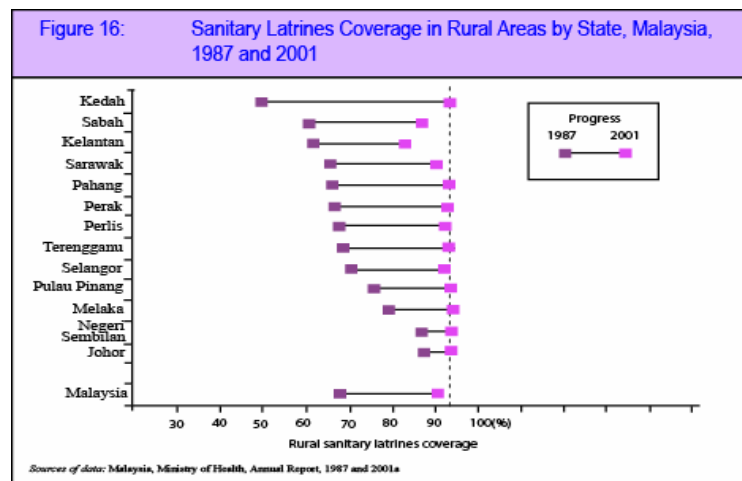


National **water supply** coverage increased from 80% of the total population in 1990 to 95% in 2005. Urban coverage remained consistently high while rural coverage rose significantly from 67% in 1990 to 92% in 2005. See figure 14. Figure 15 shows the incidence of illnesses and its strong relationship with the usage of unclean water.



Since 1973, the active promotion of environmental sanitation has improved the health of the population, with coverage reaching almost 100% for all states with the exception of Kelantan and Sabah (2000). Food and water borne diseases has declined and recent floods in 2007 that occurred in southern states of Malaysia did not set-off any typhoid or cholera outbreak which was common sequelae in the past.

g. Infrastructure



The **National electricity coverage** has expanded from 80% in 1990 to 93% in 2005. Rural electricity coverage rose significantly from 67% in 1990 to 92% in 2005.

Access to adequate, affordable and **quality housing** improved as well, as indicated by the increase in the household to house ratio from 1: 1.14 in 1991 to 1: 1.18 in 2005.

Information and Communication Technology, ICT is transforming the global economy by providing a new engine for development that is changing its fundamental dynamics. The Multimedia super-corridor was an impetus to look into investments in ICT as not only as a means of socioeconomic ascendancy but also as a tool for poverty eradication. The huge digital divide between the urban and poor is being narrowed by the ‘Universal provider project’ that is bringing communication access to the most remote of communities. For the exception of cellular telephone however, the penetration rate is below 20% for other communication media. These targets are continuing revised in their efforts to increase penetration.

Indicator	2000	2005	2010*
Fixed Telephone Lines In Operation			
-Number of Lines(million)	4.6	4.4	-
-Penetration rate (%) ²	19.7	16.6	-
Cellular Phone Subscriptions			
-Number of subscriptions (million)	5.0	19.5	24.4
-Penetration Rate (%) ²	21.8	74.1	85.0
Personal Computers Installed			
-Number of units Installed (million)	2.2	5.7	11.5
-Penetration Rate (%) ²	9.4	21.8 ²	40.0 ²
Internet Dial-up Subscriptions			
-Number of subscriptions (million)	1.7	3.7	10.0
-Penetration Rate (%) ²	7.1	13.9	35.0
Internet Broadband Subscriptions			
-Number of subscriptions (million)	-	90,630	3,733,000
-Penetration Rate (%) ²	-	1.9	13.0

Source : Malaysian Communications and Multimedia Commission and Economic Planning Unit

h. Selected Diseases

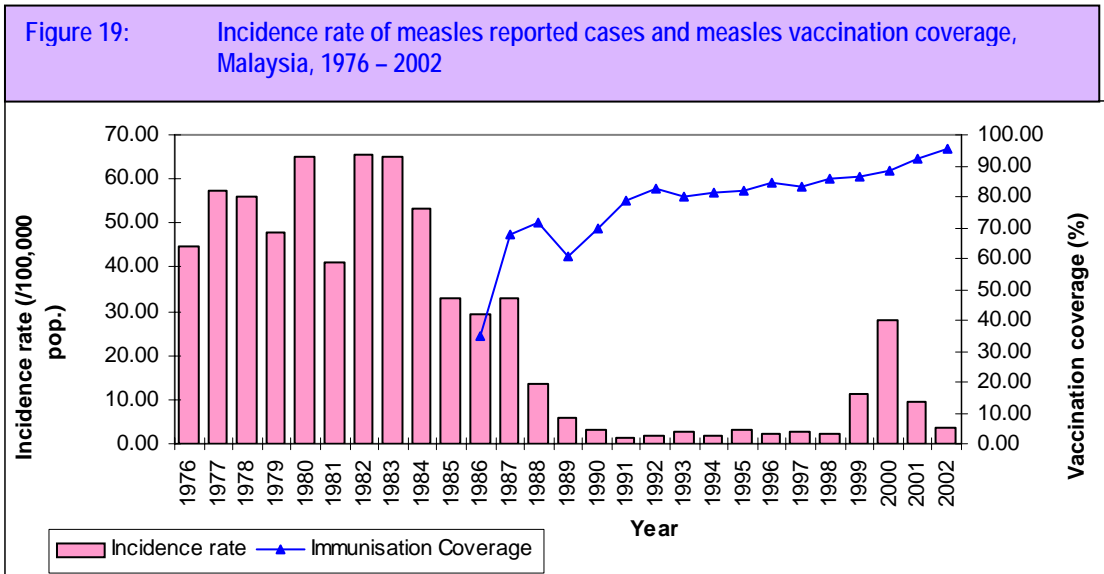
i. Immunisable Diseases

The Primary Health Care approach has also seen significant improvements in the reduction of several targeted diseases. Immunization against relevant diseases has reduced such cases dramatically with the introduction of the “Expanded Programme of Immunization”. The programme which was started in 1960s with DPT and BCG, saw further addition of polio vaccines in 1974, measles in 1982, rubella for school children in 1987, hep B in 1989 and finally, the recently Hib B in 2005.

Around 70% of all immunizations is administered by the PHC health clinics and the rest by the private general practitioners. Few paediatrics clinics in the hospitals are also offering catching up immunizations for miss-opportunities strategies. These diseases, such as diphtheria, whooping cough and tetanus, have not been reported in the country in the last five years.

Immunisation was initially received with lots of sceptism from the community with numerous objections in the form of religious and intellectual arguments along with plain disbelief in vaccination. To achieve success, the project needed the participation of the various Universities, NGOs, religious bodies and local authorities to not only counter these arguments but to participate in buying-in, implementing and rolling-out massive campaigns.

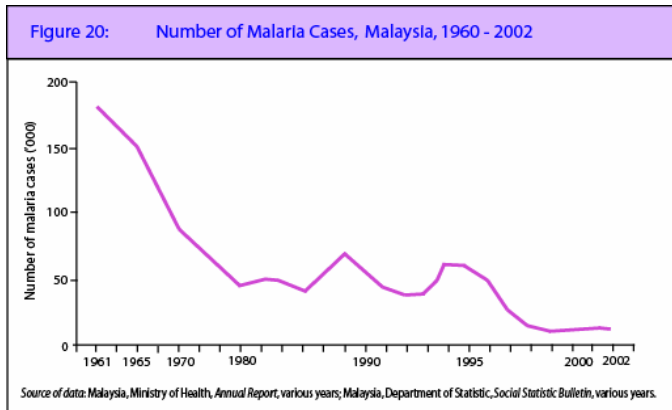
Measles immunization which was introduced later in 1982, subsequently took a 3 years mopping up period. By 1985, the immunization coverage with single dose of live attenuated vaccine at 9 months of age improved rapidly from 34.6% in 1986 to more than 85% in the late 1990s. After 1987, the incidence of measles declined rapidly, falling from 33/100,000 population in 1987 to 2/100,000 population in 1998. However although by in the late 1990s, the immunization coverage was more than 85%, the incidence of measles was on a rise, prompting a review of the single dose immunization policy to the 2-dose immunization with MMR, as part of the revised measles elimination programme, implemented in 2002.



Source: Surveillance Unit, Disease Control Division, Ministry of Health Malaysia

ii. Malaria

In addition to environmental assessment and control of vectors, RHS staff assisted in both passive and active case detection. Every patient presenting at the clinic with fever has screened for malaria. And from 1980, such efforts have produced a steep decline in the number of reported cases of malaria.



The incidence then levelled off until the late 1990s when another drop in incidence occurred,

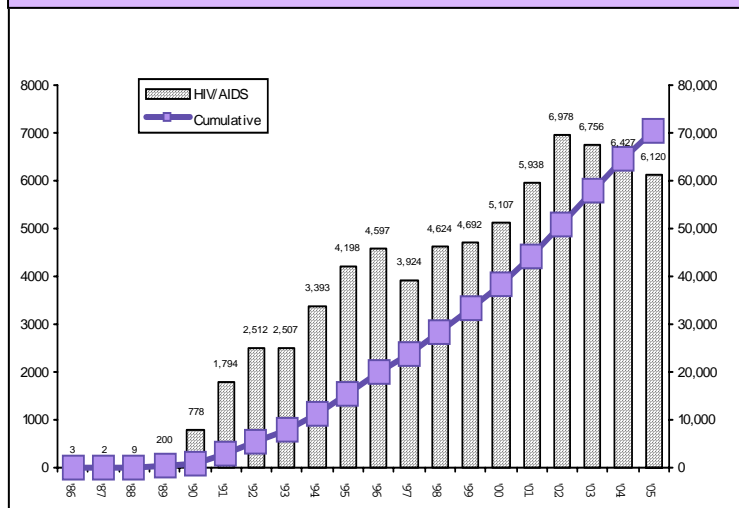
driven by a sharp reduction in Sabah, the one state that has contributed majority of the cases in Malaysia. Since 2000, the incidence has stabilized at the incidence rate of between 26 to 55/100,000 population. The success relied on an understanding of malaria’s location-specific epidemiology throughout the country and the subsequent adoption of multiple strategies targeted at the host, parasite, mosquito and environment. Once again, the good collaboration between key players and the formulation of policies played key roles in achieving success.

iii. Tuberculosis

In the early 1940s and 1950s, tuberculosis (TB) was the number one cause of death in Malaysia. Patients with TB were admitted to the many sanatoria in various parts of the country and were often managed by surgical means. TB chemotherapy only became available in the late 1950s. At this time, TB was firmly entrenched as a major cause of morbidity and mortality. Realizing its seriousness, the Malaysian government launched its National TB Control Programme (NTP) in 1961.

The incidence of tuberculosis have not decreased instead a gradual increased has been reported from 58 in 1995 slowly rising to 65.9 in the year 2000. Even states with low rates such as Selangor notified 1,459 causes (I.R. 43.1/100,000) as compared to 31.2/100,000 in 1995, while the highest is Sabah with an incidence rate of 120/100,000. This increase has call for more vigorous intervention firstly, those with HIV/AIDS infection, who are particularly vulnerable to turn infection with *M. tuberculosis* into active TB.

Figure 21: Reported HIV/AIDS, Malaysia, 1986-2005

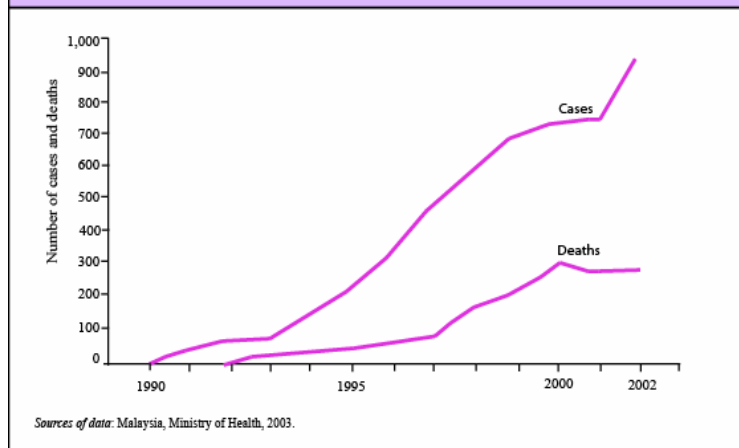


iv. HIV/AIDS and TB

The increasing prevalence of HIV in Malaysia has yet to abate since the first reported cases in 1986. The adult prevalence of HIV in Malaysia is presently at 0.5%. There was three virtual peaks in 1992, 1996 and 2002, denoting that the source of transmissions is localized and continual. Around 79% of HIV cases and 65.4% of AIDS cases in Malaysia are within the age group of 20 – 39 years.

STD/AIDS Unit, Disease Control Division, Ministry of Health Malaysia

Figure 23: Number of TB with HIV Cases and Number of Deaths, Malaysia 1990 - 2002



In 1990, there were only 6 cases of TB co-infection with HIV cases reported among the 10,873 TB cases, but in 2002, the number had escalated to 933 cases or 6.5% of the total number of 14,389. There is a sudden and shocking increase of 187 cases (25%) when compared to the 2001 report, but with better and improved management of HIV cases, death due to TB/HIV remains static.

TB and HIV continue to be serious infections in Malaysia. The key strategies in reducing these disease lies on the current multisectoral strategies of both the social and medical approaches, namely :

- 1) increasing public awareness of the disease
- 2) reducing poverty and optimizing access to medical facilities
- 3) ensuring all identified TB cases are incorporated to the DOTs programme
- 4) achieving more effective follow-up strategies of patients defaulting on treatment
- 5) curbing the accelerating occurrence of co-infection with HIV and
- 6) pre-empting and dealing with the rise of multi-drug resistance.

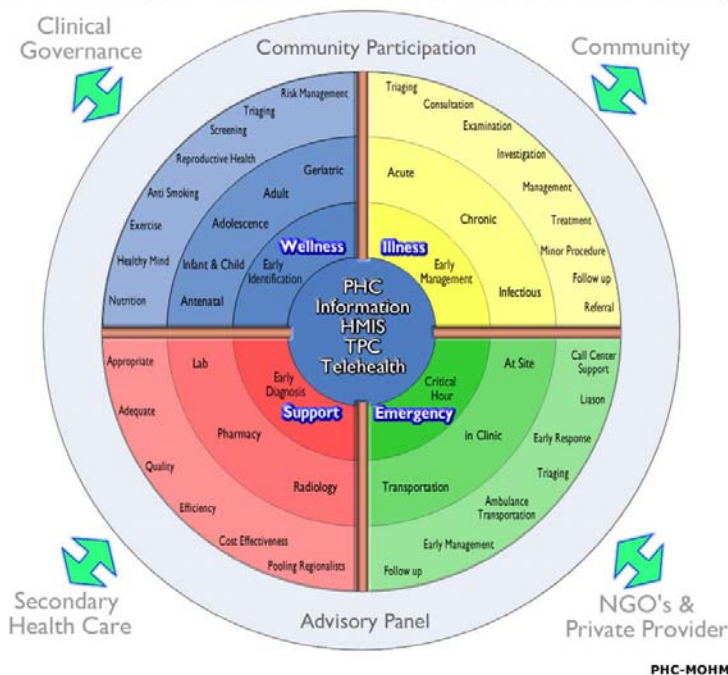
E. Primary Health Care in the new Millennium

From the onset of the 7th Malaysia Plan, the Rural Health Service of the 1960's have been changed to be called as Primary Health Care Services run by the Ministry of Health. The poor and underserved in the rural and urban are given better access to health services in these various levels of PHC clinics.

Since independence, Malaysia's public sector has consistently maintained as the largest integrated health services from primary, secondary and tertiary levels of care. This not only ensures the economies of scale in the provision of care, but also ensures a seamless and borderless system. Additionally, it allows better sharing of resources and better management of patients and clients through an integrated health and clinical management protocols.

An important component indicative of the quality of the health care services is the population's access to health care, both in the terms of geography and costs. The policy towards bringing health care to the people live has resulted in 88.5 % of the population having access to a health facility within 5 km to where they live (National Health Morbidity Survey II, 1996). However, these static facilities can only provide coverage to people living within 10 km radius. The remote populations are better served through the mobile health teams via land, water and air. These teams are charged with providing maternal and child health and outpatient services, environmental sanitation and organize health education talks when they visit these remote areas.

Reviewed Approach of Primary Health Care Clinics (REAP)



Under the 9th Malaysia Plan, The Reviewed Approach (REAP) has been introduced. The focus is on the integration of various services that looks at comprehensiveness of the delivery of care at first point of contact, and working with the various stakeholders in the external environment . The acronym WISE has been given to represent **W**ellness, **I**llness, **S**upport (clinical), **E**mergency and **I**nformation. The various components of the services are illustrated in the figure in here.

The primary health care service providers are hence multidisciplinary with a range of competencies to manage clients at the first point of contact. And due to the perpetual insufficient numbers, the ever expanding scope of primary health care services, and the increasing demands and expectations of the consumers, staffs are being further trained in multiple skills.

However, the need for specialized health care providers is undeniable with the rising pressures on the system. Accordingly over the years, more categories of staff were established, such as the Family Medicine Specialists (FMS), physiotherapist and occupational therapist. The FMS was first introduced in1997 and are currently 120 of them who distributed all over the country.

Malaysia has a dual health system of public and private practices. The Government is the main provider of primary care facilities. The private practices however only began in the late 1950s and since then the main stay of their services were almost entirely confined to medical and curative. It is only recently that some elements of preventive care are being provided. Referral from private to public has been an ongoing process. Another player in the provision of primary health care in Malaysia is the traditional and complementary medicine (T/CM) practitioners. T/CM has long been in existent but is now emerging in its acceptance as an option to health care. Hence the Ministry of Health is in the processes of regulating T/CM so as to make it a safe alternative for the people.

Community participation in primary health care has been an essential factor in the success of health promotion and disease prevention activities. The willingness of the rural community particularly, to work alongside the clinic health staff has given birth to several successful endeavours such as the Health Clinic Advisory Panel, Village Health Promoter (VHP) programme in Sarawak, and the PHC Volunteer of Sabah. There are currently 800 health clinic advisory panels and 1,600 VHPs.

The status of people’s health stems from the environment and the way we live. Recognizing this, public health in Malaysia has focused on health promotion. It is also recognizes that patient education is insufficient to bring about behavioural change and that environmental and social barriers has to be confronted e.g., the formulation of anti-tobacco laws by the government through increased taxation on tobacco and its products in an effort to control of cancer. And for the promotion of breastfeeding, the establishment of the Malaysian Code of Ethics for Infant Formula Products has been able to control the marketing, distribution and information on all infant formula products, thereby reducing easy accessibility and availability of such products to potential clients.

Table 13: FACILITIES PROVIDED BY MINISTRY OF HEALTH, 2000 AND 2005

Type of Facility	Number		Ratio of Facility to Population	
	2000	2005	2000	2005
Rural Health Facilities				
Community Clinics	1,924	1,900	1:4,640	1:5,085
Health Clinics	474	495	1:17,506	1:19,520
Mobile Units	204	200	1:43,764	1:48,312
Mobile Dental Clinics	8	30		
Urban Health Facilities				
Health Clinics	473	462	1:30,797	1:35,638

Source : Ministry of Health, Health and Management Information System for the years

The role of the primary health providers in addressing disasters and major crises is jointly worked with secondary care. A disaster preparedness plan has been drawn up following several critical natural disasters that had hit both country and the world. The plan spelt out the roles of each health care level in the event of such a crisis, and actions that need to be taken. The plan is but part of a larger nation wide plan involving relevant agencies. At the primary health care level, the most crucial input is early detection and immediate notification, together with early, rapid mobilization of resources (being the first responder).

Another turn in the way primary health care is delivered in the country is through the use of appropriate technology. ICT is seen as a potential method of enhancing delivery of primary health care. In the long term, it may be the way to manage the persistent problem of human resource scarcity and to address the diverse concerns of all the stakeholders in health care. Malaysia has developed its own clinic health information system that is currently in use in several project sites. Through this system, the seamless link between

primary and secondary care is established and maintained, and this can potentially link the public and private systems as well once there is general acceptance of this system.

F. SPECIAL GROUPS

I. The Poor

Malaysia's economic policy in 1970 was directed at eradicating poverty in the long-term and reducing it in the short and intermediate-terms. In 1989, the primary focus was shifted from reducing poverty to reducing hardcore or extreme poverty. The major strategies or programmes had four aspects. First, the promotion of rapid economic growth to create greater employment and business opportunities especially targeted to poor households. Second, the provision of greater access to better education and training facilities to members of these poor households so that they may obtain gainful employment in better paying positions or operate their own micro or small businesses. Third, the provision of increased access to social amenities and facilities to upgrade the poor's welfare and quality of life. These provisions include better housing, access to piped or potable water, electricity, sanitation, health and medical services, schools, rural hostels, roads and transportation services. And finally, the provision of monetary assistance members of poor households incapable of earning an income due to old age or some form of physical disability.

		1999			2004		
		Malaysia	Urban	Rural	Malaysia	Urban	Rural
Hardcore Poverty							
Incidence hardcore poverty	(%)	1.9	0.5	3.6	1.2	0.4	2.9
No of Hardcore Poor Household	('000)	91.7	11.9	79.8	67.3	14.1	53.2
Poverty Gap	(%)	0.4	0.1	0.8	0.2	0.1	0.6
Overall Poverty							
Incidence hardcore poverty	(%)	8.5	3.3	14.8	5.7	2.5	11.9
No of Hardcore Poor Household	('000)	409.3	86.1	323.3	311.3	91.6	219.7
Poverty Gap	(%)	2.3	0.8	4.0	1.4	0.6	3.0
Total Households	('000)	4,800.0	2,612.5	2,187.5	5,459.4	3,605.9	1,853.5

Source : Economic Planning Unit and Department of Statistics, Household income surveys 1999 and 2004

The government is committed in continuously addressing socio-economic imbalances which may have negative implications of national growth, threaten national unity and affect societal stability. Hardcore poverty eradication and overall poverty reduction is the key priority particularly among the inter- and intra-ethnic inequalities, the rural-urban and regional gaps as well as existing disparities in employment, income and wealth. Special groups such as the elderly, disabled, single mothers and orphans will continue to receive support and attention.

Poverty eradication in the recent 5 year plan is targeted at halving the incidence of overall poverty to 2.8% and to completely eliminate the incidence of hardcore poverty by 2010. To reach these objectives, programmes targeted at specific impoverished groups like the pockets of urban and rural poor will be pursued. Existing programmes and projects under the Integrated Development Programme for urban community and various capacity building programmes is being enhanced to ensure its effectiveness in lifting households out of poverty.

Table 15 : Overview of Anti-Poverty Developments, Malaysia, 1960-2010			
1960-70	1971-90	1991-2000	2001-10
Pre-NEP	New Economic Policy (NEP) OPP1	National Development Policy (NDP) OPP1	National Vision Policy (NVP) OPP3
First Malaysia Plan (1966-70)	Second Malaysia Plan (1971-5) Third Malaysia Plan (1976-80) Fourth Malaysia Plan (1981-5) Fifth Malaysia Plan (1986-90)	Sixth Malaysia Plan (1991-5) Seventh Malaysia (1996-2000)	Eight Malaysia Plan (2001-5)
Economic Objectives and Strategies Related to Poverty			
Diversification of the economy from primary products to manufacturing and nation building through education. Increasing per capita income and consumption of the rural population. Providing adequate Infrastructure to the poor.	Two-prong approach of -Poverty eradication -Society restructuring	Eradication of hard-core poverty and reducing relative poverty. Focus on the rapid development of an active BCIC. Boosting productivity via enhanced human resource development strategies and through the promotion of science and technology to accelerate the process of eradicating poverty.	Raising the quality of development and generating high sustainable growth. National unity is the overriding objective. Promoting economic growth alongside continued poverty eradication and society restructuring.
Major Poverty Eradication Programmes			
Land consolidation and rehabilitation -FELDA (1956) -MARA (1966) -FELCRA (1966) -MARDEC (1966) -JANGKA -KETENGAH	Continued focus on the agriculture and rural development. Creation of -MADA (1970) -RISDA (1971) -LKIM (1971) To modernize the rural and agricultural sector. IADP programmes launched (1983) AIM established (1987) Micro-credit schemes (1986) Creation of a BCIC. Settlement schemes for the <i>Orang Asli</i> . Text book on loan schemes. Scholarship for low income families.	Development programme for the hard-core poor (PPRT). Continued focus on programmes launched in the previous long term plans (i.e. land consolidation and rehabilitation, commercialization of farms and expansion of education and training). Participation of the private sector in poverty alleviation programmes.	Target groups better identified. Cabinet committee on urban poverty created (2001). Launching of special HIS on <i>Bumiputera</i> minorities in Sabah and Sarawak(2002). Targeting urban poverty-mapping urban poverty & better monitoring of poverty programmes (2003). Continued focus on enhancing the skills and education of the vulnerable groups.

This creates a new role for social protection: helping individuals better manage their income – in the possibility of unemployment, disability, sickness, and other shocks –through labour market policies and educational training, pension systems and disability insurance. Malaysia has a productivity-linked wage system that provides flexibility in the labour market, retrenchment benefits, and a pension system to cover all employees in the formal sector, army and civil service. The currency crisis has shown that, to a large extent, Malaysia’s economic fundamentals provide a safety net that is resilient to such shocks.

II. The Orang Asli

The indigenous group (Orang Asli) in Peninsula Malaysia makes up 0.6% of the total population. The Department of Orang Asli Affairs has been entrusted with eradicating poverty, reducing the divide in education, health and providing these people access to basic facilities. To reinforce this, the National Development Council on August 21, 1999 stated that “where appropriate, the indigenous group is to be made a shared agenda” by Department of Orang Asli Affairs and the other implementation agencies.

A special programme for the aboriginal people or Orang Asli of Malaysia, whose households experience poverty at an incidence of almost 51.0 per cent, was also introduced. Steps are ongoing to assist them out of poverty, includes getting these people involved in income-generating activities, such as participating in land development schemes, vegetable farming, livestock-rearing, retail business and cottage industries. They are also participants in the National Equity Trust Scheme for the hardcore poor.

Special Health Unit has been developed to look after more than 300,000 Orang Asli who are either located near the villages of in the very remote interior through land, water or air mobile units. Their health improvements has been showing very gradual improvements.

Around October 2003, a special education programme was implemented to assist Orang Asli students in primary schools. Under this programme, school uniforms, fees, books, writing materials, and transportation to school were provided. Qualified Orang Asli individuals were encouraged to join the teaching profession, as a strategy to increase the attendance of the Orang Asli students.

III. Women

The health of women has been given high priority. Two main approaches have been adopted. The first involves improving the general health of the family and this includes maternal and child health, immunization, family planning, nutrition and early detection of serious diseases. The second involves conducting health education and awareness programmes for women to ensure that they remain healthy, well into their old age.

Recognizing that the feminization of poverty is a worldwide phenomenon, special attention is being given to poor households headed by women. This was done because the incidence of poverty among female-headed households was about 16.0 per cent in 1999, more than doubled the national average of 7.5 percent. The main strategy being adopted is to provide them with the necessary assistance and to venture into micro-businesses. To further improve the status and well being of women, steps continue to be explored under the review of existing and formulation of new legislation. This includes amendments to the Employment Act, 1955, that enables more women to join the labour force through the introduction of flexible working hours. In addition, the provision of equal pay for full and part-time employment is aimed at encouraging more housewives to join the labour force as part-time employees.

Steps are also being taken to ensure greater uniformity in the judgements passed down by syariah courts (which are state, not federal institutions) on matters pertaining to Islamic family law. To further ensure that the interests of women are safeguarded, perhaps the most important step taken in recent times, was the creation of the Ministry of Women and Family Development in 2001. The existence of the Ministry now permits for greater coordination and integration in the implementation of poverty eradication programmes and strategies for women.

IV. Youths

Youth development is also being given serious attention. Various programmes are developed to mould and develop resilience among the youth so that they may contribute positively towards nation building. Working towards this end, 6 strategies have been adopted, viz., broadening the knowledge base of youths; instilling in them positive values and attitudes; increasing their vocational and technical skills; facilitating and promoting social interaction among them; promoting the importance of a healthy lifestyle for them; and developing within youths the spirit of cooperation and partnership that is necessary among government agencies, private sectors and NGOs.

In consonance with the objectives and strategies of the youth policy, programmes on leadership training, skills training, entrepreneurial development, healthy lifestyle, sports, arts and culture, among others have been made available to youths. The Government, mainly through the Ministry of Youth and Sports, implemented all the aforementioned programmes with the complementing efforts of youth organizations, other NGOs and the private sector. Government efforts have also been directed towards dealing with problem youths. These included the rehabilitation of youths involved in unhealthy activities such as substance abuse and criminal activities. The programmes were implemented in collaboration with the National Association for the Prevention of *Dadah* (drug addiction) as well as the Malaysian Crime Prevention Foundation. Federal Government development expenditure in this area, as provided for through the Ministry of Youth and Sports, amounts to almost RM1.4 billion. In total, the amount represents 1.4 per cent of the total development expenditure for the 1996-2000 period.

G. OPPORTUNITIES, CHALLENGES, INSIGHT

Malaysia's success in its overall social development efforts and social policy process that contributes to address the various social determinants for health, can be attributed to three factors. They are the positive political environment; the administrative competence and technical expertise available for the process; and non-domestic or global factors.

I. The political environment

The political environment, within which the social policy process has taken place, has been conducive in many ways. It had at least four positive features, namely, strongly elected governments, governments committed to equitable growth, an open social policy formulation process and a preference for moderation and consensus in resolving political issues.

Firstly, strongly elected governments have been a constant feature in the Malaysian landscape. The people of Malaysia have given the successive governments not only the right but also the confidence to govern in ways that best meets the needs of its supporters and the nation as a whole. The coalitions that formed the successive Governments were made up of ethnic-based parties² which gave added confidence in the capabilities of the governments to work in the best interest of all groups.

Malaysia has been fortunate to produce leaders who have accepted the wisdom of inter-ethnic cooperation in politics. The situation could have been different. It could have been a series of revolving door governments weakened by the lack of political will, total national support and inter-ethnic conflicts and violence. And this would have resulted in wasted resources that could have benefited social and economic development.

Secondly, the commitment of the Government towards equitable growth has been made apparent through its pro-poor policy and for real, broad-based improvements to the social services, public amenities and the quality of life of all Malaysians. Budget allocations and subsequently, actual expenditure for education, health, other social services and rural development, as well as the existence of special ministries for the development of education, health, women, youth, social welfare and rural areas are clear evidence of this support. The emplacement of the NEP, NDP and NVP as the paramount national

² Coalition governments in Malaysia differed from those commonly formed in other countries in that it has been a largely permanent coalition and in existence before elections. It has not been formed after elections to enable several parties to get a majority in the legislative assembly and form a government.

development policies over successive time periods is yet another clear testimony on the joint emphasis given to social and economic development.

Thirdly, the social policy process has been transparent and open on the formulation of social development programmes and projects. Ordinary citizens, NGOs and interest groups are free to access three different channels of communication to express their views to decision-makers, i.e. political parties, public service and mass media. This process has been structured to allow for constructive criticisms and suggestions within the accepted boundaries of the law.

And finally, the preference for moderation and consensus in resolving political issues, including those pertaining to social policies, has borne fruit. Given the plurality of the population, and as a result of the over-riding objective of national unity and social harmony, Malaysians have accepted the value of mutual tolerance and respect for each other. The preferred mode in addressing contentious issues is for involved parties to reach a consensus and adopt a moderate stand.

II. Administrative competence and technical expertise

The operationalization of social policies formulated by decision-makers and planners into implementable programmes has contributed towards improving the coverage and quality of social services provided. These efforts have resulted in the overall improvement of the people's quality of life of the people, ie:

- 1) Availability of clear guidelines like the NEP, NDP and NVP, the long- and medium-term national development plans and annual budgets. Specific legislation and policies on particular social areas of concern on clear implementation guidelines also exist; alongside a well-trained public service, adequate financial resources, nominal fees, inclusion of the private
- 2) Well-trained service workers that are highly-qualified and very experienced in their areas of specialization.
- 3) Availability of financial resources to implement social policies. The resources were partly sourced from multilateral organizations; the bulk which comes from domestic sources.

III. Globalization

Malaysia has always been an active participant in the world economy. Its open economy experienced rapid growth under the driving force of its exports. Direct foreign investments, imported technologies, foreign managements and technical expertise have been permanent features in the development of the economy's various sectors like manufacturing. In spite of this, however, Malaysia views with caution the call for unfettered globalization and cross-border trade, in particular, if they are to be effected at a rate determined by the developed world and huge multinationals.

The argument for globalization and trade liberalization, though coupled with arguments on the potential social benefits to be derived, is in reality blind to the actual detrimental social effects brought on by of certain facets of the free economy. In particular, the free and rapid movements of capital from one country to another, which is permitted under free economy regulations, in search of better returns, will have disastrous economic and social effects on the economy experiencing the outflow of resources. It will cause, among others, unemployment, a rise in the incidence of poverty and place undue strain on the government's social services and social welfare budgets. The experience of Indonesia, Thailand, South Korea, and Malaysia, in the wake of the 1997 currency crisis bears testimony to this reality.

In view of these shortcomings, Malaysia has, along with many other developing nations, adopted the position that globalization and trade liberalization should be introduced in phases. This is to enable itself the time to prepare and strengthen its economy and institutions to face the competition of the open market. With this regard, Malaysia's primary aim is to ensure that it retains controls over its own economy and at the same time, benefits fully from globalization and free trade. This is necessary to give Malaysia the freedom and independence to determine its own ways to achieve economic growth, social development and national unity.

Although many strategies are in place and conducive for Intersectoral Actions in Health for Equity with the existence of legislation, strong official policy and a good organizational structure stronger efforts are still needed to turn health promotion into general practice. National, regional and local bodies as well as non-governmental and private organizations although are showing an increasing interest, there are many more areas that needs to be exploited. Some new concern areas includes Disaster Management, Environmental Protection, Wellness, Self help and Self Care .

H. Conclusions

Political stability, alongside the continuous social development agenda and adherence to the long term, medium term and short term development plans, and through changes in political leaders, played a major factor in the success of inter-sectoral action in health in Malaysia. As a country, we are internally driven to achieve our mission of addressing persistent socioeconomic inequities to improve and sustain the citizenry's quality of life. At the same time, the federal government is sensitive to international pressure, and takes pride in its image in the global arena. "*Malaysia Boleh*" or "*Malaysia can do it*" is the rallying cry in the face of challenges, which ingrained in the Malaysian psyche, expresses a new-found confidence in our own capabilities and capacity to progress.

Why has inter-sectoral action in health been so readily embraced in Malaysia? The main agenda of the government has always that of the nation's citizens, and this is the shared vision of the government agencies. It is no wonder then that there is a sustained commitment to inter-sectoral action as there is a sense of ownership of these policies by the various agencies, which are inherently compatible with each other. This vertical integration produces a sense of shared responsibility, leading to *esprit de corps*. The various agencies discovered that by pooling resources it became the most effective way of achieving their organisations' objectives more quickly.

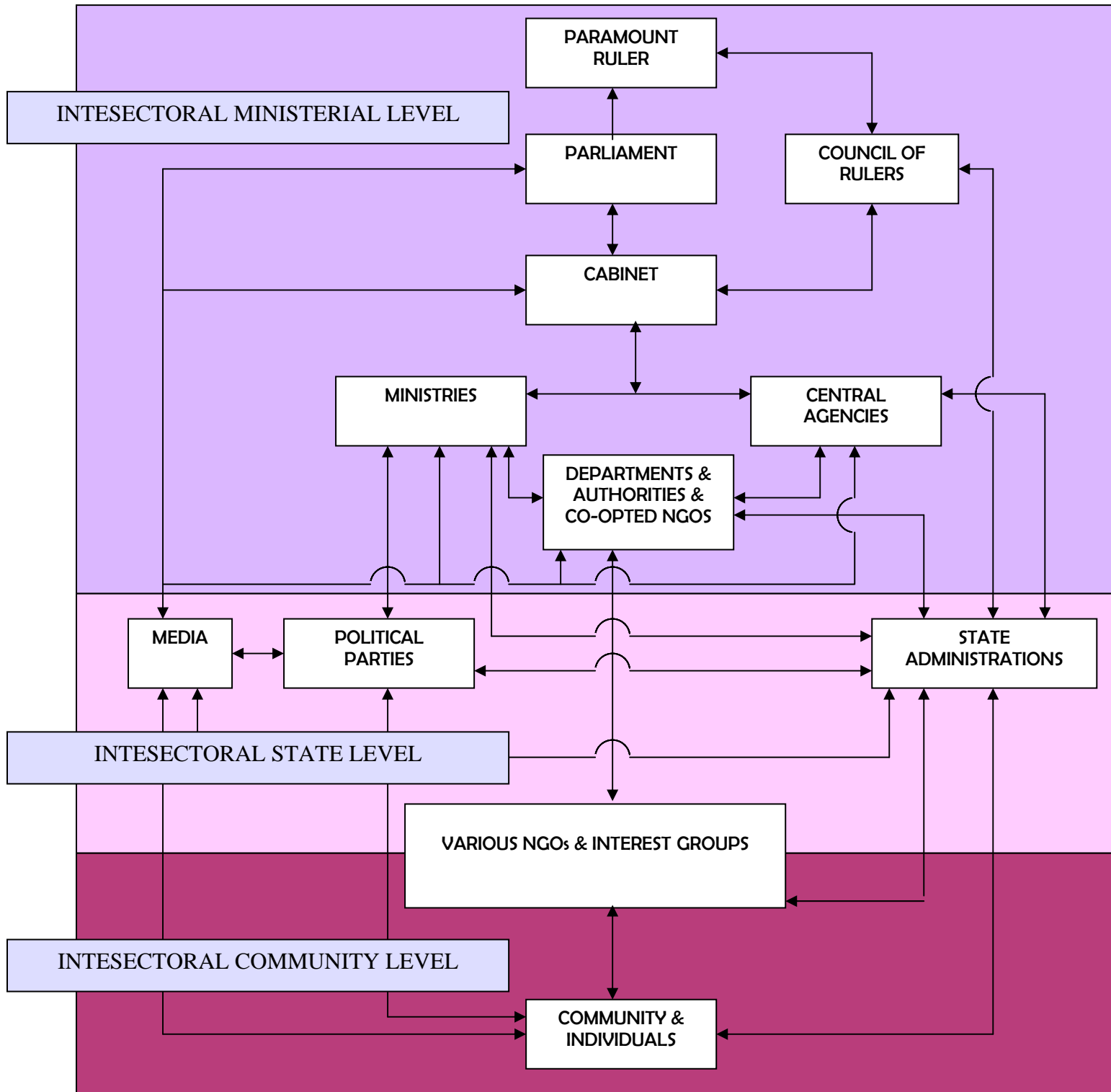
When the outcome of the inter-sectoral action impacts the larger section of society, it galvanizes various stakeholders to work together and triggers concrete action. This is particularly true for issues that capture the public's interest, as reflected in the media spotlight on those issues.

And when the affected group is perceived as an especially vulnerable one, for example children and the elderly, various sectors of the community will advocate inter-sectoral action. For instance, during disease with nationwide implications, as experienced with the SARS and Nipah virus outbreaks, existing inter-sectoral committees rapidly went into action that resulted in a rapid and integrated response up to implementation levels. It helped that the structure had been tested before under the challenged by previous outbreaks.

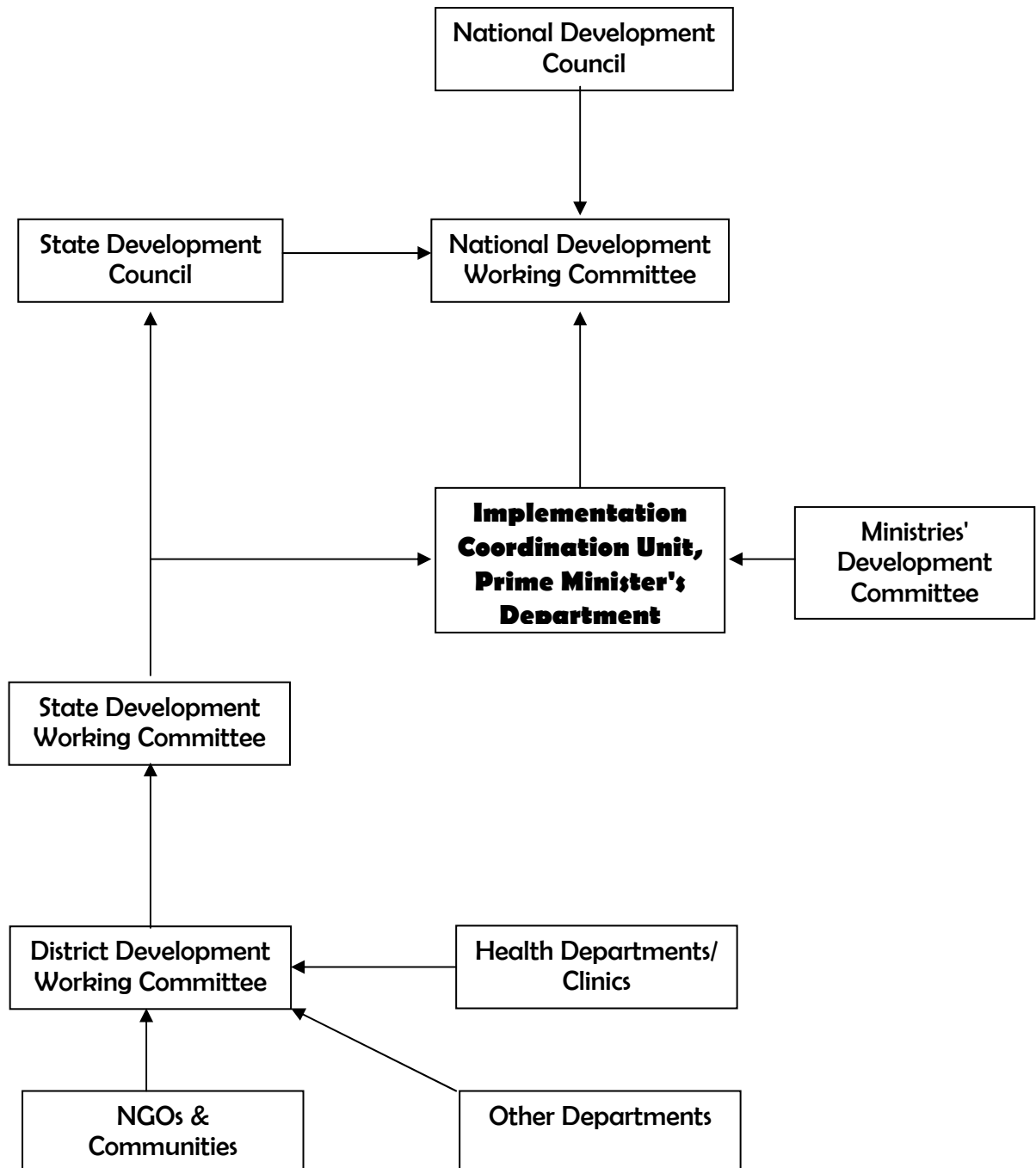
The underlying philosophy of Malaysia's development initiatives is that growth should not to be pursued as an end in itself. Growth has always been accompanied by equitable distribution in all segments of society. Malaysia has thus undertaken to achieve rapid and sustainable economic development because this will provide a larger volume of resources for social development.

The Government believes that economic growth alone cannot guarantee social harmony, more so in a plural society like Malaysia. It requires placing the right people at the centre of development and directing economic resources to meet human needs effectively. As such, social development, which is aimed at building a better life and enhancing its quality, has and will continue to be a significant part of the overall development agenda, as indicated by the allocations provided under the various five-year development plans. Thus, the universalization of social services, not only improved the standard of living of the population, but also promoted health equity.

**POLICY FORMULATION INSTITUTIONAL FRAMEWORK
(INTERSECTORAL MODEL)**



IMPLEMENTATION COORDINATION MECHANISM FOR NATIONAL VISION POLICY



Intersectoral Actions for health, examples at 4 levels:

Ministerial Level

Action: Extreme poverty reduction (PPRT)

Lead Agency: Prime Ministers Department to State Secretary to District Officer

Level: National, State, District

Objective: Eradication of Poverty (including health status as one objective)

When Started: 1985

Impact: Reduction of poverty from 25% to 5%,

Sustainability: Sustained to date due to highest level commitment and translated down to the community.

Ministerial Level

Action: “Prostar” (Health without AIDs)

Lead Agency: Ministry of Education

Level : State and District

Objective: AIDS free for Adolescence

When Started : 1990

Impact : More than 50,000 youth have been involved since inception and more than 90% have improved knowledge on AIDs and its prevention.

Sustainability: Sustained to date, partially funded by federal government and NGOs.

State Level

Action: Kuching Healthy City Initiative

Lead Agency: State Planning Unit under the State Secretary's office of the Sarawak State Govt

Level: State

Objective: Create a healthy city and has extended to alliance for healthy cities internationally

When started: 1994

Impact: Able to look at multicausal problems and using a multisectoral approach in working out the solutions

Sustainability: Sustainable because it has the support of the highest level of the state govt, has a core team, has mentors and champions.

State & Community level

Action: Village health promoter

Lead agency: Sarawak Health Dept

Level: State

Objective: ‘Health For All’ for underserved population in Sarawak - mainly determined by inaccessibility

When started: 1983

Impact: Every Village in Sarawak has a VHP. Community participation in primary health care, extension of health care delivery to inaccessible areas, community development

Sustainability: sustainable because of community participation, has mentors and champions, enjoys support of highest level of Sarawak Health Department.

INTERSECTORAL ACTION PLAYERS

VISION	POLICIES	CONTRIBUTORS	COLLABORATORS	IMPACT
<p>NATIONAL VISION</p> <ul style="list-style-type: none"> • NEP • NDP • NVP 	<ul style="list-style-type: none"> • National unity • Mobility of labor • National/Malaysian identity • Integrated • Political stability • Economic development & prosperity • Learning organization • Human dev capital agenda • Knowledge economy & enterprise • Frontier of change • National capability • Voluntarism • Urban-Rural differentials 	<ul style="list-style-type: none"> • Health • Agriculture • Education • Social welfare • Loc Govt. & Housing • Women affairs • Aborigines Dept • Treasury • Economic Planning Unit • Defence • Immigration • Religious Affairs • Communication • Public Works • National Law • Audit • Malaysian Med Assc • Acad Fam Physic • Urban Rural Dvp 	<ul style="list-style-type: none"> • Health Status • Morbidity • Mortality • Literacy • Women's rights • Children • Youth • Elderly • Marginalized gp • Sanitation • Housing • Transport • Communication • Occupational health 	<ul style="list-style-type: none"> • Decreased Poverty • Decrease Morbidity • Decrease mortality • Increase coverage • Improved GDP on health outcome

ⁱ Richard Leete, UNDP, Eradicating Poverty in Malaysia – A human rights perspective, January 2005, Kuala Lumpur

ⁱⁱ Human Development Report, UNDP, 2005,

SELECTED REFERENCES

Abbas, Fadil Azim. 1997. *Poverty Reduction in Malaysia, 1970-1995*. Paper presented to the Special Event on Poverty Eradication, Annual Session of the Executive Board, United Nations Development Programmed, New York, May 20, 1997.

Abbas, Fadil A. and Haridas, P. 1988. *The Monitoring and Evaluation of Development Projects in Malaysia*. Paper presented to East Asian Regional Seminar on Monitoring and Evaluation, Kuala Lumpur, December 1988.

Action on the social determinants of health: Learning from previous experiences
World health organization, Secretariat of the commission on social determinants of health
[Http://www.who.int/social_determinants/en/](http://www.who.int/social_determinants/en/)

Bank Negara Malaysia (2004), Bank Negara Annual Report, 2003, Kuala Lumpur.

David A. Tejada de Rivero, Alma-Ata Revisited Perspectives in Health Magazine
The Magazine of the Pan American Health Organization
Volume 8, Number 2, 2003

Fatimah m. A, mad n. Rosli s. Food security in Malaysia, 1996 , University Pertanian Malaysia

Hamid, Ahmad Sarji Abdul. 1993. *Malaysia's Vision 2020: Understanding the Concept, Implications and Challenges*, Kuala Lumpur, Pelandok Publications.

Khan, M. Adil. 1991. *Initiatives in Efficiency: Experience of Malaysia in Monitoring and Evaluation*. A report Commissioned by the Central Evaluation Office, UNDP, May 1991.

F.H.K. Wong. 1977. " History, Structure and Objectives", *Reading in Malaysian Education*, F.H.K.

Malaysia, Ministry of Education (1991), Malaysian Educational Statistics, 1991, Kuala Lumpur: Educational Planning and Research Division.

Malaysian dream of the New Economic Policy <http://www.themalaysiandream.net/about/>

Mohd. Najib Abdul Razak, Globalising Malaysia, Towards Building a Developed Nation,, 2006, MPH Printing

Government of Malaysia. 1966. *First Malaysia Plan, 1966-1970*, Kuala Lumpur, *Jabatan Cetak Kerajaan*.

Government of Malaysia. 1973. *Mid-Term Review of the Second Malaysia Plan, 1971-1975*, Kuala Lumpur, Government Press.

Government of Malaysia. 1991. *Second Outline Perspective Plan, 1991-2000*, Kuala Lumpur, *Percetakan Nasional Malaysia Berhad*.

Government of Malaysia. 1996. *Seventh Malaysia Plan, 1996-2000*, Kuala Lumpur, Percetakan Nasional Malaysia Berhad.

Government of Malaysia. 2001. *English Malaysia Plan 2001-2005*, Kuala Lumpur, Percetakan Nasional Malaysia Berhad.

Government of Malaysia. 1995. *Malaysia: National Report: World Summit for social Development: Poverty Reduction, Expansion of Productive Employment and Social Integration in Malaysia, 1971-1994*, Kuala Lumpur, Percetakan Nasional Malaysia Berhad.

Government of Malaysia. 1998. *National Economic Recovery Plan: Agenda for Action*, Kuala Lumpur, Percetakan Nasional Berhad.

ILO. 1996. *Malaysia; Report to the Government on the development of social protection policy and strategy*, Geneva, ILO.

Jomo, K. S. and Wee, C. H. (2004), *Affirmative Action and Exclusion in Malaysia: Ethnic and Regional Inequalities in a Multicultural Society*, Background Paper for the Human Development Report 2004.

Leete, R. (1996), *Malaysia's Demographic Transition: Rapid Development, Culture, and Politics*, South-East Asian Social Sciences Monographs, Kuala Lumpur: Oxford University Press.

Malaysia, Economic Planning Unit (1971), *Second Malaysia Plan, 1971-1975*, Kuala Lumpur

----- (1976), *Third Malaysia Plan, 1975-1980*, Kuala Lumpur

----- (1981), *Fourth Malaysia Plan, 1981-1985*, Kuala Lumpur

----- (1984), *Mid-Term Review of the Fourth Malaysia Plan, 1981-1985*, Kuala Lumpur

----- (1986), *Fifth Malaysia Plan, 1986-1990*, Kuala Lumpur

----- (1991a), *Sixth Malaysia Plan, 1991-1995*, Kuala Lumpur

----- (1991b), *The Second Outline Perspective Plan, 1991-2000*, Kuala Lumpur

----- (1996), *Seventh Malaysia Plan, 1996-2000*, Kuala Lumpur

----- (1999), *Mid-Term Review of the Seventh Malaysia Plan, 1996-2000*, Kuala Lumpur

----- (2001a), *Eight Malaysia Plan, 2001-2005*, Kuala Lumpur

----- (2001b), *The Third Outline Perspective Plan, 2001-2010*, Kuala Lumpur

----- (20002), *Malaysia Quality of Life Index, 2002*, Kuala Lumpur

----- (2003), *Mid-Term Review of the Eight Malaysia Plan, 2001-2005*, Kuala Lumpur

Social Contract Malaysia

http://en.wikipedia.org/w/index.php?title=Social_contract_%28Malaysia%29&action=history

Wong, Kuala Lumpur, *Penerbit Universiti Malaya*. pp. 1-27.

World Bank. 1997. *Malaysia: Enterprise Training, Technology and Productivity*, Washington, D.C.