WHO COUNTRY COOPERATION STRATEGY

MALAYSIA

2006-2008

WHO Representative Office in Malaysia

Section 1 Introduction

The 8th Malaysia Plan (2001-2005) has been successfully implemented and the 9th Malaysia Plan will provide the future directions for the health sector for the next five years. In collaboration with the Ministry of Health, WHO has finalized and begun to implement its country programme budget for 2006-2007. Therefore it is now timely for WHO to review its country cooperation and update and revise the WHO Country Cooperation Strategy (CCS) that was prepared in 2002.

The first CCS defined the broad framework for WHO's cooperation with Malaysia for 2002-2005, and articulated a coherent vision and selected priorities for WHO to work with the Ministry of Health. This revised CCS is based on a systematic assessment of Malaysia's new health challenges and changing needs, and its ability to assist other countries and WHO, to take a leading role in specific areas of public health concern in ASEAN and other countries. The revised CCS has identified WHO's strategic agenda and the principal components of cooperation over the next 3-5 years: development and strengthening of health system; prevention, control and management of noncommunicable diseases and major risk factors and promotion of healthy lifestyles; and communicable disease control, as well as the new strategic approaches based on the challenges and needs for the country collaboration in Malaysia.

Section 2 Government and People: Health and Development Challenges

2.1 Economic and social situation

Malaysia is composed of Peninsular Malaysia and the states of Sabah and Sarawak on the island of Borneo. The total land area is 330 252 square kilometres. Malaysia, a constitutional monarchy with a non-elected upper house and an elected lower house, is composed of 13 states and three federal territories. The paramount ruler is elected by and from the hereditary rulers of nine of the states for five-year terms. The head of government is the Honourable Prime Minister Dato' Seri Abdullah bin Ahmad Badawi (since 31 October 2003).

Socioeconomic development, including health in Malaysia, is planned using three types of planning horizons. One is the five-year socio-economic development plan where currently Malaysia has just completed the Eighth Malaysia Planning Cycle (2001-2005). Another is the medium-term plan that is known as the Outline Perspective Plan (OPP). The Third OPP (2000-2010) is known as the National Vision Policy and has the objective of achieving national unity and solidarity, using ICT and

the knowledge-based economy (K-economy) to improve the overall economy of the country. Finally, Malaysia's long-term development strategy (30-year planning horizon), Vision 2020 is designed to achieve developed nation status by 2020. Malaysia must be fully developed in terms of all dimensions of national life: national unity and social cohesion, the economy, social justice, political stability, system of government, quality of life, social and spiritual values, and national pride and confidence. In moving towards these goals, emphasis has been placed on the importance of human resource development, increasing the country's competitiveness in high value-added export goods and services (notably information technology) and industrial diversification, private/public sector partnerships, furthering open trade, enhancing the financial sector and sharing the benefits of growth equitably among the population.

The Malaysian economy accelerated its growth momentum in 2004 with GDP growth of 6.5%. Growth has become broader based with all sectors registering positive growth. Domestic demand has continued to sustain growth for five consecutive years. Better export earnings and inflow of foreign funds increased the international reserves to USD54.4 billion as of 14 August 2004. Inflation remains low at 1.5%. The unemployment rate remains low at 3.5%. With stronger growth in the economy, per capita national income is expected to increase to RM16 098 (USD4270) while purchasing power parity (PPP) is higher at USD10 163 in 2004.

In 2004, Malaysia has a population of 25.6 million, more than 60% of whom live in urban areas. The population group of 0 to 14 year old accounts for 32.9%, the 15 to 64 years age group accounts for 62.9%, while the population over 65 years comprises 4.2% of the total population. The population grew at an average of 2.5% per year between 1991 and 2003. Its ethnically diverse people is comprised of 65% Bumiputera, 26.1% Chinese, and 7.6% Indian. Life expectancy at birth for both genders has increased over the years. In 1990, the life expectancy for males and females were 68.8 years and 73.5 years, respectively. The life expectancy for males and females in 2004 had improved further to 70.4 years and 76.2 years, respectively. Improving the social and economic condition of the Malay people and some small ethnic minorities, all known collectively as Bumiputera, is one of the aims of national development policy.

The Human Development Index of Malaysia is ranked 59th out of 177 countries by the United Nations in 2004. The literacy rate was 94% of the population in 2004. Malaysia had essentially achieved the goal of universal primary education in 1990 with 97% of primary school children completing primary school education. The

gender disparity had largely disappeared at the primary level since 1970. In most recent years, girls outnumber boys both in secondary school enrolment (in all states) and more conspicuously at the tertiary level. The female labor force participation rates had remained unchanged over the past quarter century at around 47%. In the political picture, women's share of appointed seats in the Senate has risen substantially. However, the numbers of women as elected members in Parliament, and especially in state legislatures are relatively small.

Poverty eradication is a key goal among the Millennium Development Goals (MDGs). Just below half of all households were classified as poor in 1970. This proportion was halved over 15 years, and halved again in the subsequent 15 years. By 2004, the overall poverty incidence was 5.1% of households, 2% in urban areas, and 11.4% in rural areas. Poverty varies considerably by state and ethnic groups. The highest incidences are in Sabah (16%) and Kelantan (12%). In 2002, the poverty incidence was 7.3% for Bumiputera, 1.5% for Chinese, and 1.9% for Indians. The Government is committed to further reduce poverty and aims to eliminate hard core poverty by 2010.

The favourable position that Malaysia now occupies in economic and social development owes much to the innovative policies and strategies for development implemented through the national five-year plans. Many of the issues that have since emerged internationally on the MDGs and their related targets were identified and acted upon in early official policies, giving better achievement performances as the country monitors MDGs. However, Malaysia faces a huge challenge in achieving the goal for halting and reversing the spread of HIV/AIDS (MDG-6).

2.2 Health status overview

Malaysians enjoy a relatively high overall standard of health. The Infant Mortality Rate (IMR) had shown an improvement from 10.4 per 1000 live births in 1995 to 8.1/1000 live births in 2000 and 5.9/ 1000 live births in 2004. The Maternal Mortality Ratio (MMR) had increased slightly from 0.2 per 1000 live births in 1995 to 0.3 per 1000 live births in 2004. Both communicable and noncommunicable diseases remain a burden to Malaysia. The country has begun experiencing a changing pattern of both diseases. The five leading disease burden based on disability-adjusted life years (DALYs) in Malaysia for males were ischaemic heart disease, road traffic accidents, cerebrovascular diseases, septicaemia, and acute low respiratory tract infections. For females the disease burden were ischaemic heart disease, cerebrovascular disease, unipolar major depression, septicaemia and diabetes,

which are almost similar to the disease burdens of developed nations. With the demographic increase in the number of adolescents and young adults, the rise in high-risk behaviour among young people is a great concern.

There is still persistent incidence of a few key communicable diseases. As of March 2005, an estimated 75 075 people were living with HIV/AIDS and 73% of these individuals were infected through injecting drug use (IDU). The current pattern is one of a concentrated epidemic among IDUs. The number of drug users continues to grow rapidly and progression to injecting drug use was occurring earlier. There are indications that infections are moving out of the initial drug user group into the general population. HIV/AIDS prevention and care pose a major challenge to the government and civil society. Comprehensive and integrated national responses are required with emphasis on political commitment, multisectoral approach, harm reduction programmes and intensification of HIV prevention and treatment programmes.

Emerging diseases have posed threats over the last few years. The novel Nipah virus outbreak killed 104 people during 1998 to 1999 and devastated the country's pig industry. The Severe Acute Respiratory Syndrome (SARS) outbreak in the Region in 2003, avian influenza and potential influenza pandemics have highlighted the need to strengthen disease surveillance and early warning systems, to develop effective rapid response mechanisms and pandemic preparedness, and to strengthen international, regional collaboration (including ASEAN). There continues to be challenges with Tuberculosis (TB) including TB-HIV co-infection and vectorborne diseases such as dengue. Malaria remains a challenge in more remote parts of the country. Filariasis has yet to be eliminated. Some pockets of communicable disease problems still persist, especially in rural areas.

Rapid industrialization, socioeconomic changes, and urban migration have resulted in certain segments of the population, such as the urban poor and displaced people, people living with HIV/AIDS, injecting drug users and sex workers becoming marginalized. These communities might have reduced access to existent health services. There are a large number of foreign workers, some of whom are illegal, in the country and there are concerns that they may bring in communicable diseases endemic in their country of origin.

2.3 Health sector overview

The established Vision for Health provides a common goal and direction in all health and health related concerns. The Vision for Health is to develop a nation of healthy individuals, families and communities supported by a health care system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer friendly, with emphasis on quality, innovation and health promotion, and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life.

Health care in Malaysia is provided by the public and private sectors and nongovernmental organizations (NGOs). The major provider and financier of health services is the Ministry of Health. Primary health care has been well developed. Basic health care, through static health facilities, is currently available to and accessible (within 5 km) for more than 93% of the population of Peninsular Malaysia, 76% in Sabah and 61% in Sarawak[1]. This coverage will be higher if the non-static health facilities, e.g. flying doctor squad and mobile health teams, are included. Secondary and tertiary care services are widely available in government and private hospitals across the country. Health is administered centrally from the Ministry of Health albeit with decentralized management. Health and medical care are decentralized to the regions, states and districts to increase efficiency. A national referral system has been established to provide highly specialized care to augment the basic care provided in health clinics. Other government agencies such as the Ministry of Education, Ministry of Defense, Ministry of Local Government and the Ministry of Human Resources complement and supplement the roles of the Ministry of Health. In 2004, there were 2877 primary health care clinics and 125 public hospitals (including institutions) under the Ministry of Health and 9410 doctors working in public hospitals.

Over the past few decades, there has been an increasing role of the private sector in the provision of health care for the country. However, there is inadequate integration between public and private health services. There were 218 private hospitals in 2004 compared with 50 hospitals in 1980, mostly located in urban areas. Doctor to population ratios in 2004 ranged from 1 doctor per 1268 population in Peninsular Malaysia to 1 doctor per 2765 population in Sabah and 1 doctor per 2115 population in Sarawak. In 2004, there were 8836 doctors in private hospitals accounting for 48% of the total number of medical practitioners, but private hospitals only accounted for

[1] Institute of Public Health, Ministry of Health, National Health and Morbidity Survey 1996: Volume 3 on Recent Illness/Injury, Health Seeking Behaviour and Out-of-pocket Health care Expenditure, 1997.

21% of the total hospital beds in the country. Access to private hospitals is limited to people who can afford to pay. The growth of the private health care sector has triggered the steady migration of senior doctors, specialists and experienced allied health professionals from the public sector to the private sector. There is insufficient information on the quality of services in the private sector. Enforcing regulations under the Private Health Care Facilities and Services Act 1998 will help to monitor the quality and control the distribution of private providers. Other providers of health care include the traditional and complementary medicine (TCM) practitioners and NGOs.

Malaysia spent an estimated 3.8% of the Gross Domestic Product (GDP) on health in 2002. Per capita spending was estimated at RM257 (USD68) in 2002. In 2003, the government allocated 6.9% of the national budget to health. Health care services are provided in government hospitals across the country at nil or nominal cost to the user. Health services provided in the public sector is highly subsidized by the Government. In 2003, the revenue collected from providing medical, dental and health services in government hospitals accounted for about 2.8% of the Ministry of Health's total operating budget. For 2003, the Ministry of Health's operating budget has been increased by 332% as compared to 1990. Over-dependence on public hospitals is also an issue, particularly for inpatient care, maternity care and the care for chronic illness. Eighty percent (80%) of hospitalization occurs in public hospitals. A national survey, conducted by the Public Health Institute, estimated out-of-pocket expenditure to be RM180 per capita (USD40) or 4.8% of per capita income in 1996[1]. There is an increasing trend of private health care expenditure, including out-of-pocket expenditure that is one of the least efficient and most inequitable means of financing of health care.

Research is given a high priority in the Ministry of Health. The National Institute of Health (NIH) was established in the 7th Malaysia Plan. Presently, there are seven institutes under the NIH. The 106 year old Institute for Medical Research (IMR) is the most established biomedical research institution with two WHO collaborating centres in tropical diseases. It also provides training in various tropical diseases fields for health workers around the Asia-Pacific Region. IMR is also a WHO national influenza centre and a reference public health laboratory. The Institute for Health Systems Research (IHSR) is one of the active WHO collaborating centres with expertise in the areas of health systems, research methodology, and quality assurance. The other institutes under the NIH are the Institute for Public Health, the Institute for Health Management, the Institute for Health Promotion, the Network of Clinical Research

Centre and the National Institute for Natural Products, Vaccines and Biologicals. These institutes have developed their capacity to provide institutional support to the Ministry of Health and the health sector in various areas.

A major effort to develop Malaysia's human capital has created a relatively strong education and research capacity in the health sector. Educators and researchers have been trained in universities, local and abroad in large numbers; many have returned to practice, teach and undertake research in Malaysian institutions. There are ten medical schools, six public and four private. A number of joint ventures have been established with universities abroad that enabled students in a variety of disciplines to receive degrees in Malaysia from universities outside the country.

There are a large number of national NGOs in health and many of them are professional associations. Some examples include the Malaysian Academy of Medicine, the Malaysian Medical Association, the Malaysian AIDS Council, the Malaysian Association of Prevention of Tuberculosis, the Malaysia Tobacco Control Council, the National Breast Feeding Association and others. The NGOs work closely with the Ministry of Health and have provided assistance at various levels of capacity.

2.4 National health goals, priorities and challenges

The new thrust in the Ninth Malaysia Plan (2006-2010) is "towards achieving better health through consolidation of services". The emphasis is on sustainability and not on reducing the current health services. There is also a focus on wellness, upgrading and maintenance of existing facilities and equipment, and the quality of health care. The development of primary health care facilities in underserved areas in both urban and rural areas will remain a national priority.

In the Ninth Malaysia Plan, two primary and four supporting health goals are set to ensure more efficient and equitable health are being provided. National health priorities are set to target a few selected diseases and risk factors.

Primary goals:

- Prevent and reduce disease burden
- Enhance health care delivery system

Supporting goals:

- Optimize resources
- Enhance research and development

- Manage crisis and disasters effectively
- Strengthen health information management system

Beyond ensuring what have been carried out in the Eight Malaysia Plan will be maintained, the Ninth Malaysia Plan shall also give more emphasis in reducing the prevalence of the following top disease priorities and the related risk factors:

- Ischaemic heart diseases
- Mental illness
- Cerebrovascular diseases and stroke
- Road traffic injuries
- Cancers
- Asthma and chronic obstructive pulmonary diseases
- Diabetes mellitus
- Infectious diseases of major public health problems such as dengue, HIV/AIDS and others

The risk factors that shall be given more emphasis are:

- Tobacco
- Blood pressure
- Overweight
- Cholesterol
- Physical inactivity
- Stress
- Alcohol
- Other factors which influence the infectious diseases of major public health concern

In achieving the Vision for Health and the mission of the Ministry of Health, the activities carried out by the health sector shall be in line with the eight goals of the health services namely the wellness focus, the person focus, the informed person, self-help, care provided at home or closer to home, seamless continuous care, services tailored to individual or group needs and finally effective, efficient and affordable services. The Vision for Health empowers individuals, families and communities, emphasizes wellness and care as well as achieving an enhanced quality of life. Maintaining wellness has been identified as the way forward for the Malaysian health system and the wellness paradigm is the foundation in the design and planning of health care in the country.

The health sector and the Ministry of Health will face a wider set of challenges in the future, including:

- Health care financing mechanism
- Restructuring the health care delivery system and changing roles of the government
- Human resource development
- Quality of health care
- Globalization
- Information and communication technology

2.5 Health care financing mechanism

Changing of disease patterns, new technologies and medicines, the growing expectations of consumers for high quality of care and the expansion of the private sector have led to the decision to establish a new national health financing mechanism, which emphasizes equity, efficiency, acceptability, accessibility, affordability and comprehensive coverage. It is proposed that the main source of revenue collection shall be from the National Health Insurance system. Those who can afford to pay will have to contribute, while the government will contribute for disadvantaged groups such as the poor, the elderly and the disabled.

It is proposed that the National Health Financing Authority (NHFA) under the Ministry of Health, be established as a not-for-profit entity to manage the National Health Insurance. The new scheme shall be based on cost and risk sharing and made compulsory for everyone who can afford to pay the premiums. The scheme should be able to create greater integration of health services at primary, secondary and tertiary levels and also within the public sector and between the public and private sector. Any private health insurance must complement and not compete with the national health-financing scheme. The preparatory work of the national health-financing scheme has been initiated. WHO has been an active partner in the planning for the National Health Care Financing Mechanism.

2.6 Restructuring of health delivery services and changing roles of the government

Restructuring of the health service delivery system aims to increase further efficiency and quality of the delivery of health services, provide more flexibility and autonomy in the provision of health services and to reduce the brain–drain of health professionals from the public sector to the private sector by providing a more conducive working

environment, reducing the heavy workload and bureaucracy and providing better remuneration. However, restructured entities of the Ministry of Health should not be privatized and should maintain their social obligations in providing health care services to the community. Some preparatory work has been initiated while the strategy, plan and options for restructuring have to be further debated and studied.

The role of government in health care has started to change. The future role of the Government would include a focus on regulation, enforcement, policy-making, monitoring and financing and provision of certain health services. The Government will continue to run selected public health programmes categorized as public goods.

2.7 Human resource development

Having made substantial investment in physical infrastructure and advanced technology, Malaysia has given higher priority to addressing serious challenges in human resources. The Malaysian health system serves a growing population with an increasing elderly component. The disease pattern is changing from communicable diseases to noncommunicable diseases. This raises demand for health services and shifts the nature of services required. The high economic growth is increasing consumers' demand for high quality services, technological developments, and different types of specialist services. The rapid growth of the private sector has further increased demand. Thus, the rate of growth in demand for staff, as well as the composition of the skilled workforce has been changing over time. The acute shortage and misdistribution of key groups of personnel, including nurses and doctors, pose a real threat. Shortages have been exacerbated by the exodus of staff from the public sector to the domestic private sector and overseas. While consideration is being given to improving remuneration, working conditions and career prospects in the public sector, it is very important to strengthen human resource strategic and operational planning and resource coordination at the Ministry of Health level.

2.8 Quality of health care

The Government is committed to providing quality services. Many quality improvement initiatives have been introduced in government agencies, such as the ISO 9000/2000, Client Charter, Key Performance Indicators and others. To provide a broad direction on quality improvement, a Strategic Plan for Quality in Health was published in 1998.

The Ministry of Health has formalized the Quality Assurance Programme (QAP) in 1985. Under the QAP, two approaches have been adopted, the National Indicator Approach (NIA) and the Hospital/District Specific Approach (HSA/DSA). Within the Ministry of Health, the programmes for QA have been established in the following services: Patient Care, Public Health, Pharmaceutical, Oral Health, Laboratory and Engineering services as well as the Training Programmes for Allied Health. The QAP is guided by a National Quality Assurance Steering Committee, chaired by the Director-General of Health. A Technical QA Committee assisted the technical development and implementation of QA programmes. A National Secretariat for QA located at the IHSR supports the Steering Committee and coordination of programmes. In order to continuously build a critical mass of personnel competent in undertaking QA initiatives, QA training modules, and databases of QA projects and trained personnel have been developed. Regular training programmes are carried out at national and state levels. Formal and informal forum for sharing experiences are regularly organized, including the biannual National QA Convention.

Patient safety is another important agenda. A National Patient Safety Council was established to advise the Ministry of Health on the priority areas and national strategies for patient safety in health care. Besides QAP and patient safety, the hospitals and health centres carry out many other quality improvement initiatives. Some of these include, ISO 9000/2000, hospital infection control, clinical practice guidelines, mortality reviews, risk management, client satisfaction surveys and others. The public and private hospitals also subscribe to the Hospital Accreditation Programme, managed by the Malaysian Society for Quality in Health.

2.9 Globalization

The Malaysian economy’s integration with the global economy has created opportunities and prosperity but globalization also brings risks and challenges for health. Cross-border transmission of diseases, such as SARS and avian influenza, through international travel pose serious threats to health, political and economical stability and development. The marketing of harmful products and unhealthy behaviours such as tobacco use has contributed to the shift to a predominant noncommunicable burden of disease. Increasing urbanization has resulted in stressful working styles, increasing pollution, poorer sanitation and housing. All the issues are challenging the country to develop systematic strategies and approaches for timely response.

At the global level, food safety will continue to be given a greater emphasis in enhancing the protection of public health against food hazards. The ability to effectively and promptly assess, communicate and manage food hazards will be given focus by strengthening the monitoring and surveillance programme and establishing networks internationally and regionally. Food safety is now addressed with a “Farm to Table Approach”, a comprehensive integrated multidisciplinary approach to food safety that addresses problems at the source. Risk-based approaches are being adopted in the formulation of food safety strategies. New threats emerge from innovations in food science and new processing technologies such as novel foods, food irradiation, organic foods, etc. There are also emerging and re-emerging diseases such as E-coli 0157:H7, viruses and Bovine Spongiform Encephalopathy (BSE). Intensive agricultural practices and new farming methods have also given rise to new threats such as pesticide abuses and veterinary drug abuses in animal husbandry. Food safety also needs to cater to changing consumer demands, habits, choices, affluence, lifestyle and culture. As such, some reorientation of the food safety programmes required to keep up with advances in science and technology; trends and developments locally and internationally; legislative developments and other emerging food safety problems. Capacity-building in the areas of risk analysis, laboratory’s capabilities and building scientific alliances will be given the needed attention.

The Government is concerned with the issue of access to affordable medicine. Since 2004, by use of the Trade-Related Aspect of Intellectual Property Rights (TRIPs) and the Doha Agreement, the Ministry of Health has issued a compulsory licence to import cheaper anti-retroviral drug for HIV/AIDS from India. Health tourism has been seen as the catalyst for economic development. Under the General Agreement on Trade in Services (GATS), medical, dental and hospital services have been identified as important for trade. The negotiation process is ongoing. However, to assess and handle the impact of liberalization will require consideration of the domestic market competition, quality of health care, affordability, equity and efficiency, apart from the non-discriminatory privilege of foreign specialists practising in Malaysia. The impact of the ASEAN Free Trade Agreement on tobacco products, international and regional collaborative mechanisms and networking for the control of cross-border transmission of infectious diseases, and food safety require integrated and multisectoral responses, including a comprehensive country assessment, strategy development, and intensified coordination. While integrating into the global economy, the wise utilization of the World Trade Organization trade agreement to address the

health needs of the people and to take advantage of new medicines and health technologies will be a major challenge.

2.9.1 Information and communication technology (ICT)

An ICT plan has been implemented by the Ministry of Health to enhance evidence-based medicine and evidence-based planning and decision-making, and to support hospital management, health and medical research, disease surveillance and crisis and disaster management. Under the 7th Plan, there was substantial investment in information technology and a large public building programme for health facilities, in order to increase access for the low-income population, particularly in rural areas. The Ministry of Health has good telemedicine and telehealth capacity with a Telemedicine Act enacted in 1997. During the 7th Malaysia Plan (1996-2000), a fully computerized Total Hospital Information System (THIS) was completed and operationalized in two hospitals. THIS was further expanded in the 8th Malaysia Plan (2001-2005). The application of five telehealth projects, namely the Lifetime Health Plan (LHP), the Lifetime Health Records (LTR), Continuing Medical Education (CME), Mass Customized Personalized Health Information and Education (MCPHIE) and teleconsultation will be expanded nationwide.

The health information in the country will be further strengthened through the development of a national approach for the health information management in the country. This includes the development of a mechanism for national coordination and partnership, ensuring the building blocks such as health informatics standards, data protection and infrastructure readiness. Towards this end the current Information Documentation unit will be upgraded to Health Informatics Centre (HIC). A National Health Information Framework will be developed to identify the key deliverables and role of all stakeholders. In the 9th Malaysia Plan, among the major outcomes would be the development of electronic reporting system for the generation of health information management system statistics and reports and the establishment of the National Health data warehouse to contain all domain repositories and registries.

Section 3 Development and partnerships

3.1 A policy of national self-reliance

National self-reliance for Malaysia is a key platform of the Vision 2020. Malaysia does not actively seek outside financial assistance from donors or international financial institutions. The country is able to pay for advice or develop its own expertise in many areas. Because of Malaysia’s comparatively advanced state of

development, with relatively sufficient capacity and resources for health, development partners, United Nations (UN) agencies and bilateral agencies focus on selective interests and areas in development. An example is the USD1 million contributed by Japan in 2003-2004 for food safety programmes and facilities in Malaysia.

Official development assistance (ODA) was USD86 million in 2002, USD107 million in 2003, and USD290 million in 2004. The top five donors of gross ODA (2003-2004 average) were Japan (USD306 million), Denmark (USD14 million), Germany (USD7 million), France (USD4 million), and Spain (USD3 million). The World Bank provided Malaysia with a social sector loan in 1997, which was used to improve the public health laboratory and upgrade health facilities. Since then, Malaysia has not requested loans from the World Bank, International Monetary Fund or Asian Development Bank but continues to seek technical advice from them. In general, aid levels have been relatively low given the size of the economy.

Receipts	2002	2003	2004
Net ODA (USD million)	86	107	290
Bilateral share (gross ODA)	99%	98%	99%
Net ODA / GNI	0.1%	0.1%	0.2%
Net Private flows (USD million)	3 133	806	825

For reference	2002	2003	2004
Population (million)	24.3	24.8	25.2
GNI per capita (Atlas USD)	3 550	3 880	4 650

Top Ten Donors of gross ODA (2003-04 average)		(USD m)
1	Japan	306
2	Denmark	14
3	Germany	7
4	France	4
5	Spain	3
6	United States	2
7	Australia	2
8	MONTREAL PROTOCOL	1
9	UNTA	1
10	Norway	1

3.2 UN agencies retain some limited health sector activity

The five UN agencies present in Malaysia are the United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations High Commission for Refugees (UNHCR) and WHO. The UN Country Team works closely in preparing MDG reports for Malaysia and in the area of HIV/AIDS. A UN HIV/AIDS Theme Group comprised of the five UN agencies, chaired on a rotation basis by the respective agencies has, provided support to the government, civil society and NGOs in strengthening HIV/AIDS prevention and care. After the Common Country Assessment/United Nations Development Assistance Framework was developed in 2002, the preparation of Malaysia MDGs report and the control of HIV/AIDS are the only activities that have brought together all UN agencies.

Malaysia has reached the UNICEF criteria for full graduation for UNICEF support (Gross National Income is USD2350 or higher per person; with the under five years child mortality rate of less than 35/1000 live birth and below). However, with the objective of establishing strong and wide partnerships between UNICEF and Malaysia before Malaysia' full graduation in 2007, UNICEF has strengthened its country collaboration and country office capacity since 2004. The three main "programme pillars" which have been identified by the Government and UNICEF are fight against HIV/AIDS, child protection, and prevention of child injury and accident with a budget of USD3 million in 2005-2007. Of this USD3 million dollar budget, UNICEF Malaysia has secured USD1.5 million from its Regular Resource Budget. UNICEF Malaysia has recently been identified as a new model country office for responding to new types of challenges, such as child injury and accidents, and child abuse and neglect. The Malaysia Country Programme is the forerunner to formulate and develop new UNICEF strategies and it is planned that the Malaysian models will be replicated in many other countries in the future.

UNDP provides support in human development, energy and the environment, and South-to-South Cooperation and has been in involved National Health Accounts and HIV/AIDS with a budget of USD6 500 000 in 2004-2005. In response to a request for support by the Economic Planning Unit of the Prime Minister's Office, Malaysia, UNDP and the Government of Malaysia have jointly funded the National Health Care Financing in Malaysia with a total budget of USD550 000 (USD150 000 from UNDP and USD400 000 from the Government of Malaysia for cost-sharing). The main objective of this project is to develop a proposal on development of the national health care financing mechanism for the country, and the plan of action for implementation.

UNFPA began providing assistance to Malaysia in 1973. Its assistance has been directed towards selected interventions, particularly in the area of reproductive health and HIV/AIDS and Sexually Transmitted Infections (STIs) since 1997. In July 2003, the Government of Malaysia agreed to cost-share the UNFPA programme for an initial period of five years. The Government and UNFPA each contributed USD200 000 per year, making a total of USD400 000 for 2004-2007. This budget includes the programme support costs of UNFPA country office in the amount of USD100 000 annually.

UNHCR had a programme of USD760 000 in 2005 for project activities in assistance of living, medical services, education, etc. for refugees, mainly from neighboring states and the Philippines.

3.3 ASEAN

Malaysia is placing more emphasis on regional health development cooperation than ever before, particularly as a member of the Association of South East Asian Nations (ASEAN). ASEAN Health Ministers and senior health officials meet every two years to exchange information and experience, establish consensus on common concerned regional issues and challenges, and set up task forces to coordinate important activities. The issues of SARS, avian influenza, pandemic influenza preparedness, refugee/illegal immigrant have received a very high profile related to disease prevention and surveillance, and health systems issues. Other common issues, especially those with cross-border implications such as HIV, TB, trade related health services and goods, and food and drugs have been on the agenda for united action. Malaysia has been playing leadership roles in development of ASEAN public health laboratory network, improvement of early warning system for disease outbreak, avian influenza surveillance, assessment of the impact of ASEAN Free Trade Agreement (AFTA) on tobacco trade and expansion of the AFTA exemption to include tobacco and tobacco products. ASEAN plus three and the newly launched East Asia Summit have further added weight to the leadership role being played by Malaysia.

3.4 Organization of Islamic countries

Malaysia is Chairman of the Organization of Islamic Countries (OIC) and has been active in providing support and leadership for other Islamic countries by use of Malaysian successful development experiences, and promotion of Islam Hadhari approach. After facilitating the adoption of a historic resolution aimed at eradicating polio from all OIC Member States in the Summit Conference of the Organization of the Islamic Conference in Malaysia in October 2003, the Malaysian Government made a landmark contribution of USD1 million to WHO for mass polio immunization campaigns in 22 countries across west and central Africa. Malaysia has implemented successfully the Malaysian Technical Collaboration Programme (MTCP) in ASEAN countries and further extended it to 140 South countries to share experiences in human resources development and to strengthen partnerships. With the Malaysian experience being appreciated and received in more Islamic countries, Malaysia has been increasingly influential in political, social and economic development in the world.

Section 4 The current WHO cooperation in Malaysia

4.1 Past WHO activity

WHO has been active in Malaysia since the time of Malaysian independence in 1957. WHO country programmes since 1996 have mainly been based on fellowships and other training opportunities covering a wide range of areas, including oral care, family medicine, perinatal surveillance, food safety, environmental health, tuberculosis, vectorborne disease and cancer control. During the biennium 2004-2005, WHO has also assisted with technical advice in areas such as health reform with emphasis on health financing strategy development, integration of public and private services, various approaches for human resources development, support for strengthening surveillance and early warning system, disaster management, the environmental health risk assessment and indicators development.

WHO works with the Ministry of Health and has generally not worked with other ministries or central agencies and NGOs on policy matters related to health. Although multisectoral collaboration and partnership have been highlighted in the WHO strategies, active pursuit of those approaches has been restricted.

4.2 WHO's country programme: 2004-2005 and 2006-2007

WHO Country Programme Budget for Malaysia was USD850 000 in 2004-2005 and USD949 000 in 2006-2007. An additional USD107 000 has been allocated from WPRO and HQ to support country activities for 2004-2005. The WHO country office operating budget, including the costs for long-term posts, was USD857 000 in 2004-2005. A similar amount is expected in 2006-2007. The office budget is allocated separately from the country budget.

WHO Collaborative Programme Budget for Malaysia (USD)

	2004-2005	2006-2007
Regular budget	850,000	949,000
Extra budget	137,000	?
WHO Office Operating Budget	857,000	857,000
Total	1,844,000	1,806,000

Distribution of the Country Programme Budget (USD)

	2004-2005	2006-2007
WHO budget	987,000	949,000
STC	37.2%	37%
LC	6%	14%
FEL/OV	46%	46%
APW	2%	1%
SE	0	1%
Other	9%	0

Within the WHO country budget, resources have mainly been allocated to fellowships and study tours (46% in 2004-2005 and 2006-2007). Other major programme components include short-term consultants (37% in 2004-2005 and 2006-2007), technical services provided through contracts (APWs, 2% in 2004-2005, 1% in 2006-2007) and local costs to support workshops (6% in 2004-2005, 14% in 2006-2007).

There were about 100 Malaysian WHO fellows and study tours from 2002 to 2005. Most of them headed for countries such as the UK, USA and Australia. WHO

fellowships were used mainly for short-term, specialized individual learning rather than for a wider institutional development.

There have been active WHO intercountry activities funded from extrabudgetary sources and managed by WHO's Western Pacific Regional Office (WPRO) and WHO Headquarters. These include work on emerging diseases surveillance and outbreak response including early warning system, national strategy development and harm reduction on HIV/AIDS, TB control, tobacco control, environment health, health promotion and blindness prevention and health surveys. Technical and financial support was also provided for capacity-building of the Malaysian Health Foundation, and National Poison Centre. With funding support from WHO Headquarters and WPRO intercountry resources, 64 Malaysians were invited and participated in 42 WHO regional and 9 global meetings and workshops in 2004; 71 Malaysians in 48 WHO regional and 10 global meetings and workshops in 2005, which were held outside Malaysia.

WHO also makes great use of Malaysia as a venue for training and regional and international meetings because of its low cost, convenient location and experienced resource persons and local counterparts. These events usually involve the Malaysia WHO office in their planning and logistics preparation. In 2002-2003, there were 35 WHO-funded or co-sponsored global and regional conferences on a wide variety of topics. In 2004-2005 there were 24 such conferences. The activities were not designed specifically for Malaysia but, as the host country, Malaysia has benefited from them.

From 2002 to 2005 there were about 285 visiting WHO fellows to Malaysia, mostly from China, Mongolia and Viet Nam. These visiting fellows were financed by WHO programmes in their countries of origin, but they required preceptors to provide 'on-the-job' training and support. Malaysia has demonstrated a significant commitment to this effort.

4.3 WHO collaborating centres

There are seven WHO collaborating centres in Malaysia, pursuing agreed programmes of work that benefit both the nation and the region. They are:

- WHO Collaborating Centre for Health Systems Research and Quality Improvement at the Institute for Health Systems Research, Ministry of Health

- WHO Collaborating Centre for Regulatory Control of Pharmaceuticals at the National Pharmaceutical Control Bureau, Ministry of Health

- WHO Collaborating Centre for Drug Information in the National Poison Centre at the Universiti Sains Malaysia

- WHO Collaborating Centre for Arbovirus Reference and Research (Dengue and Dengue Haemorrhagic Fever) in the Department of Microbiology at the University of Malaya

- WHO Collaborating Centre for Ecology, Taxonomy and Control of Vectors of Malaria, Filariasis and Dengue in the Division of Medical Entomology at the Institute for Medical Research, Ministry of Health

- WHO Collaborating Centre for Taxonomy, Immunology and Chemotherapy of Brugian Filariasis in the Division of Parasitology, also at the Institute for Medical Research, Ministry of Health

- WHO Collaborating Centre for Evidence-based Health Care Practice in Health Technology Assessment Unit, Ministry of Health

Collaborating Centres have played important roles in strengthening the knowledge base in specialized areas and in extending WHO's reach, providing technical support and advice in development of national policies and strategies in various areas, and conducting training. Their work programmes are supported and monitored by the technical programmes and units in WHO HQ and Regional Office, with annual performance assessments and quadrennial reviews of designation. A challenge for WHO is how to support and utilize resources and expertise in the Centres for national health development and strengthen collaboration in the Region.

4.4 The WHO country office

The WHO country office in Malaysia is small; the WHO Representative (WR) is the only professional officer and signatory for financial transactions. A new WR was appointed in 2004. The roles of the WR include active advocacy in health policy and strategies, global and regional health priorities and concerns, providing advice and important health information from WHO and international community. Apart from traditional support for development and implementation of the WHO country programme and the intercountry programme (ICP) activities, and making a substantial contribution to various national meetings and technical committees, the

WR is also responsible for coordinating and contributing to international and regional meetings held in the country, facilitating dialogue between stakeholders

With threats being posed by emerging diseases such as SARS and avian influenza, and the potential influenza pandemic, and challenges from rapid increase in HIV/ AIDS prevalence, greater demands have been made on the country office in recent years.

The WHO Representative for Malaysia also covers Brunei Darussalam and Singapore, which takes up one-third of his time. After the Regional SARS outbreak in 2003, Singapore and Brunei Darussalam have shown substantially increase in their interest and expectations of the WHO collaboration. Singapore has strengthened its participation in the WHO Regional Committee Meeting, World Health Assembly and Executive Board. They are also more actively involved in WHO regional initiatives in emerging disease surveillance and response, including avian influenza, and pandemic influenza preparedness. The Singapore Ministry of Health has organized jointly with WHO several meetings in priority areas in Singapore. In recent years, the Ministry of Health of Brunei Darussalam has also increased its interest in collaboration with WHO in priority areas and capacity-building.

Because of the recent interests, the WR and staff of the country office are required to keep closer communication with the health ministries in Singapore and Brunei in disease surveillance and response, participate in more dialogue at the level of ministers of health and director generals of health on the concerns and interests of the health ministries, and coordinate and participate in more joint activities in those two countries.

Section 5 WHO corporate policy framework: global and regional

Directions

The WHO Director-General stressed in his inaugural speech the "need to do the right things, in the right places and in the right way". The real centre of the work of WHO is countries and countries have to be placed "at the heart of WHO's work". The targets identified by the Director-General include management and expenditure of 70% of overall WHO resources in countries and regions for the 2004-2005 biennium and 75% for the 2006-2007 biennium.

Majority of countries in WPRO with WHO presence have either completed or in the process of developing their Country Cooperation Strategy (CCS), reflecting a

medium term vision of WHO for its cooperation with a country and defining a strategic framework for working with a country. The CCS clarifies WHO's proposed roles and functions in supporting national health plans and other national health and development frameworks. The CCS is an organization-wide reference for country work, guiding planning, budgeting, and resource allocation. It is the basis for developing "WHO one country plan and budget" and is used for mobilizing human and financial resources for strengthening WHO support to countries, in order to contribute optimally to national health development. In a two way process, it feeds into, and takes into consideration, both the General Programme of Work and the Programme Budget.

In developing its programme budget the WHO is guided by the principles of results-based management; priority setting from Member States, with priority areas identified based on recent World Health Assembly (WHA) resolutions, as well as global and regional collective mandates, such as the MDGs and promotion of decentralization, moving resources to regions and countries. Priorities expressed in the recent WHA resolutions include the need to enhance global health security, accelerate progress towards achieving the MDGs, responding to the burden of noncommunicable diseases, promoting equity in health and ensuring accountability.

Under the 2006-2007-programme budget the following areas have been identified for greater emphasis:

- Epidemic alert and response
- Making pregnancy safer
- Child and adolescent health
- Surveillance, prevention and management of chronic noncommunicable diseases
- Tobacco
- Planning, resource coordination and oversight

The Fiftieth Session of the Regional Committee for the Western Pacific endorsed the document “WHO in the Western Pacific Region: A Framework for Action” as a set of guiding principles for WHO’s work in the Region. The Regional Committee requested the Member States to work with WHO to implement the Organization’s programme of technical cooperation in line with the approaches described in the Framework for Action. The Regional Director was asked to implement the approaches outlined in the Framework for Action, with particular attention to the least developed countries.

The Framework for Action identified four main challenges for WHO and the tasks associated with them:

- improve our understanding of the changing needs of Member States;
- reform WHO;
- strengthen partnerships; and
- achieve more with fewer resources.

In order to meet these challenges, the Regional Director identified the four major themes listed below, each of which has action- and outcome-oriented strategic focuses:

- Combating communicable diseases;
- Building healthy communities and populations;
- Health sector development; and
- Reaching out.

In line with the Regional Director's desire for WHO to become more focused on priority problems at the country level, dialogue with the Member States and other international partners has increased and their involvement in policy-making and evaluation of WHO's performance has grown. In addition, WHO has undergone a process of reform and restructuring as outlined in the Framework for Action. This process has included cultural and orientation reforms, changes in the management framework and organizational structure, strengthening of country presence and operations and reforms in personnel management and staff development.

Achieving better health for all by promoting the development and implementation of appropriate pro-poor health policies and interventions is therefore central to WHO's work. However, the capacity of key ministries of Member States to address poverty in health remains weak. Therefore, a major objective of the WHO's support to countries and areas is the strengthening of both the capacity and commitment to develop and implement pro-poor health policies and interventions across a range of sectors, in the context of recent global initiatives. Strengthened commitment and capacity will catalyze action and contribute significantly to the development and implementation of appropriate pro-poor health policies and interventions in Member States.

The MDGs have focused the efforts of the world community on achieving significant, measurable improvements in people's lives, with the elimination of poverty as the overarching priority. Targeting health interventions will promote progress towards the MDGs, particularly among the least developed countries in the Region. WHO

supports Member States to create an enabling environment for poverty alleviation and to strengthen health systems, as prerequisites for ensuring equitable access to efficient and good quality health services for all. If the number of people in extreme poverty is to be halved by 2015 (the target of the MDG on poverty), health policy development and systems implementation must be more effective in achieving greater equality of health outcomes and greater equity in health financing.

As well as supporting Member States in the implementation of activities to achieve the MDGs, the future support of WHO will focus on: conducting advocacy and strengthening awareness; building national capacity for MDG monitoring and reporting; providing guidance on standard definitions, means of verification, data sources, and methods of estimation; and assessing the extent to which progress is pro-poor and equitable.

Many developing countries in the Region face common challenges in developing and implementing policies to address poverty, health and equity, and in incorporating them into their national agendas for socioeconomic development. There is a growing awareness that the achievement of national goals depends to a large extent on health improvements among the poor and disadvantaged. If these are to be achieved, investments in health to strengthen health systems, particularly those providing essential health services, need to be increased, and the financial burden associated with health care needs to be reduced. In addition, there is a need to integrate technical and financial resources to strengthen the sustainable development of health systems. The regional and country offices will intensify their effort to work closely with governments to support their national efforts to address these concerns.

WHO provides technical assistance to support pro-poor health policies in many areas. This includes work to promote universal access to essential drugs; improve social protection, especially against catastrophic health expenditures, through pro-poor health care financing mechanisms; strengthen knowledge and evidence through national health accounts, cost-effectiveness analysis and other operational research; and make services accessible to all, including the poor and marginalized.

Section 6 The strategic agenda for WHO cooperation with Malaysia

6.1 The approach to the strategic agenda

Malaysia is looking to WHO for specific advice, international advocacy and a more intensive support in dealing with new and emerging health challenges due to

changing disease patterns, globalization and urbanization. Therefore, collaboration with WHO as a global health agency has been regarded as very important by the Ministry of Health and to the health sector. The direction, strategy and approach and priorities of WHO collaboration need to be consistently reviewed and adjusted to meet these needs.

In view of above, the WHO's new strategic agenda is designed to:

- Provide selective WHO support to Malaysia with an emphasis on new health challenges and emerging health issues where WHO is best placed to assist because of its technical strengths and global orientation. Applying the principle of selectivity, this strategic agenda proposes three principal components of cooperation over the next 3-5 years: development and strengthening of health system, prevention and control of noncommunicable diseases and promotion of healthy lifestyles, mental health, and communicable disease control.

- Support Malaysia in providing assistance to WHO and other member countries with WHO acting as the facilitator and broker in these partnerships. The Ministry of Health has affirmed its commitment consistently to make such contribution in recognition of the benefits Malaysia has derived as a recipient of assistance from WHO.

- Support key Malaysian institutions and the Ministry of Health to play a leading role at regional and international levels in some technical areas.

The details will come with planning, which should be sufficiently flexible to allow the inevitable adjustments as country's needs and WHO's specific contribution are clarified for each piece of work.

6.2 Future WHO support to Malaysia

Component 1:

Development and strengthening of health system

- Health care financing mechanism

  WHO support was initiated in 2005 for the development of an essential health care package with emphasis on the component of preventive care. For the period 2006-2007, WHO will further play its roles as technical broker and advisor in collaboration with the UNDP/EPU in developing the new national health financing

mechanism, the National Health Insurance and the proposed National Health Financing Authority (NHFA) under the Ministry of Health.

- Restructuring of health services delivery system and strengthening strategic health planning

  After providing substantial support for health planning and evaluation for the 7th and 8th Malaysia Plans, WHO will further assess needs and possibilities to support the restructuring of health services delivery system and the changing roles of the government. WHO's support will be provided for strategic health planning and development of an integrated health risk screening tools and procedures. In response to increasing needs in prevention, treatment and research for cancer, a model and scope of a National Cancer Institute will be studied.

- Human resource development

  The current WHO country programme is based predominantly on a fellowship programme. This level of investment in fellowships crowds out opportunities for WHO to work more strategically with Malaysia. The fellowships should be used only in the capacity-building that is critical and urgent for the introduction of essential health technology and skills, and new developments that will greatly contribute to improvement of efficiency and effectiveness of the health system where the Government lacks sufficient funding for training in those areas. While WHO will continue to provide fellowships, the percentage of fellowships in the total WHO country budget should be reduced to 20% or less by 2010, given that Malaysia's level of development and its ability to train own workforce. Meanwhile, WHO will collaborate with the Ministry of Health to strengthen human resource strategic and operational planning and resource coordination and develop norms for different types of health specialties.

- Quality of health care

  In support to the Government's efforts to pursue a strong national quality programme throughout the country, WHO's main focus will be to further develop the quality assurance programme through hospital quality care indicators system; control of hospital infection; and development, revision and updating of evidence-based clinical practice guidelines. Following adoption of World Health Assembly resolution on patient safety, the Ministry of Health has progressed significantly in their pursuit on patient safety. WHO will collaborate with Ministry of

Health in the partnership of WHO Global Alliance on Patient Safety, including the signing of country's pledge on 'Clean Care is Safer Care'.

- Health information and health research

Support for critical health systems research, epidemiological and clinical research will be further provided to produce important impact on policy and decision-making, and improve effectiveness and efficiency of health system. Translation of research results into action, clinical research methodology and ethics, Malaysia burden of diseases and development of population health information system through the use of Tele-primary health care will be the main areas for collaboration. WHO could facilitate collaboration in vaccine research and herb medicine research identified as national health priorities by the Ministry of Health.

WHO will continue to cooperate with the present development of Health Informatics Centre. Cooperation will focus on Health Informatics standards, ICD-10 diagnostic and procedure coding and other related issues in health information.

Component 2:

Prevention, control of noncommunicable diseases and major risk factors, and promotion of healthy lifestyles and mental health

- Noncommunicable diseases (NCD) prevention and control, promotion of healthy lifestyles and mental health

A main challenge is to further improve effectiveness of and increase the coverage of the integrated NCD prevention and control programmes at district and primary health care levels. WHO could assist in evaluation of impact and effectiveness of NCD interventions, exchange of information and experiences on best practices for prevention and control of diabetes and hypertension, and training in effective NCD risk factor interventions. WHO's NCD risk factor STEPS survey provides well-developed protocols for collaboration in future NCD risk factor surveys and strengthening of a national NCD surveillance system. Development of the national cancer control programme and strengthening of national cancer registry will be included in the collaboration programme. WHO could collaborate in mental health with emphasis on potential action areas such as development of evidence-based policy and

strategy and community mental health, epidemiological research and surveillance, and suicide prevention.

- Tobacco

  WHO will assist in implementation of the Framework Convention on Tobacco Control (FCTC), revision of a blueprint for national policy on tobacco control, and drafting of the Tobacco Control Act. Tobacco Products Regulations and content measurement will also be assisted. Malaysia has been playing a leading role in addressing the impact of ASEAN Free Trade Agreement on tobacco tax. WHO will further support the Ministry of Health to address specific tobacco control issues in the Region particularly in ASEAN setting. WHO will further assist the Malaysian Health Promotion Foundation (MHPF) in supporting its strategy development and capacity-building as well as its operations in a wide range of health programmes, including tobacco control.

Component 3:

Communicable disease control

- Disease surveillance and outbreak response, and disaster preparedness

  Avian influenza is endemic in several Asian countries and continues to spread. The world is now in the gravest possible danger of a pandemic. WHO's support is required in strengthening national surveillance capacity and early warning system. Other challenges are to improve the capacity to implementing the international and national health regulations, and prevent cross-border transfer of diseases of national and international public health importance at international entry points. WHO will support national planning for pandemic influenza preparedness and more integrated disaster preparedness. The development of a national strategy and programme for zoonosis prevention and control, and improvement of animal husbandry practices will be priority areas for collaboration between health and agriculture sectors.

- HIV/AIDS

  The prevalence rate of HIV/AIDS has been increasing continuously. A multisectoral and integrated national strategy is required for a strong country response to HIV/AIDS. A partnership approach, involving a broad range of key stakeholders and participatory processes, should be adopted. The Government made a dramatic policy change in June 2005 to address the development of a

comprehensive harm reduction approach involving needle and syringe exchange programmes (NSEP) and methadone maintenance treatment (MMT). WHO will further support develoipment of the broad range of effective approaches for HIV prevention, treatment and care through Universal Access Initiative, finalization of the Behaviour Surveillance Survey Report, and conduct of and dissemination of results of a WHO study on sex workers in Malaysia, strengthening continuous epidemiological surveillance and monitoring of HIV/AIDS and risk factors, and training and evaluation of the harm reduction programme.

- Tuberculosis

  Malaysia has achieved 80% case detection and 100% directly observed treatment, short-course coverage. The treatment success rate (2002 cohort) stands at 76% and it is likely that the 85% target could be achieved by 2005. However, the quality of smears is below the accepted quality standard in some states. The problem of TB-HIV is increasing. Not all HIV-infected persons are screened for TB and logistic problems prevent the routine TB screening of HIV-infected inmates in Drug Rehabilitation Centres and prisons. Up to 10% of TB cases notified nationally are among migrant workers. WHO assistance is needed to address quality control for microscopy services, strengthen the surveillance and management of TB-HIV co-infection, and develop effective mechanisms to manage TB-HIV co-infection among prisoners and IDUs. Collaboration between the public and private sector should be promoted.

6.3 Future Malaysia support to other WHO member countries, and WHO support to key Malaysian institutions and Ministry of Health to play a leading role at regional and international levels

A key element of cooperation between WHO and Malaysia has been to support key Malaysian institutions and the Ministry of Health to play a leading role at regional and international levels. In the past years, WHO has supported capacity-building in the Ministry of Health and several national institutions. For example:

- The Institute for Health Systems Research as a WHO Collaborating Centre for Health Systems Research and Quality Improvement has been active in conducting research and providing support in training in the areas of quality assurance, health systems research and national health surveys.

- The National Poison Centre at the Universiti Sains Malaysia as a WHO Collaborating Centre on Drug Information has been playing a leading role in tobacco control as the national clearing house for tobacco control, drug information development and distribution.

- The National Environmental Health Research Centre, initially established with financial and technical assistance from WHO for five years, serves as a national information clearing house for environmental health research, and ultimately will become a ‘regional centre of excellence’.

- The Institute for Medical Research as a WHO National Influenza Reference Centre and national reference laboratory for laboratory diagnosis and surveillance of communicable diseases and influenza viruses.

- The WHO Regional Centre for Research and Training in Tropical Diseases, based in the Institute for Medical Research has been active in providing technical support and training to meet regional and domestic needs.

- The Institute for Health Management has been a key training institution to provide regular courses in health management for the Ministry of Health staff. It has the potential to be a regional training centre due to its excellent training facilities and matured teaching personnel. With WHO assistance, the Institute has conducted a national survey on needs and issues in human resource for health, and a national seminar for review and development of recommendations on policy and strategy.

The Ministry of Health and these institutions will be able to contribute to the international and regional health programmes without significant financial assistance from WHO. They can offer further assistance to, and cooperation with other WHO member countries in WPRO and ASEAN countries. The assistance includes:

- Providing technical consultancies for WHO and other member states.

- Receiving WHO foreign fellows. Malaysia has consistently attracted a large number of WHO fellows.

- Hosting international and regional meetings and events. In recent years, Malaysia has become a regional hot spot for WHO regional and global meetings.

- Conduct training programmes in selected areas.

A key strategic task for the WHO Representative in Malaysia and WPRO will be to strengthen its coordinating capacity at the country level. This is to fully utilize the strengths and enthusiasm of the Ministry of Health and the key institutions in important areas, and realize this potential for mutual benefits. The important areas with such strengths and rich experiences are primary health care, maternal and child health, nutrition, food quality and safety, pharmaceutical regulation control, quality assurance, blood safety, health systems research, community health surveys, healthy city initiative and others.

Section 7 Implementing the strategic agenda: implications for WHO Secretariat

7.1 Strategic changes of WHO country office's ways of work

WHO CCS for Malaysia has provided an opportunity for WHO to review its country collaboration in Malaysia and reassess its roles, functions and methods of working in the country.

Based on the challenges and needs for the country collaboration in Malaysia, the following strategic approaches are required.

- A shift from support for the routine operations of technical programmes in the Ministry of Health to a focus on health advocacy, national health policy and strategy development, and selective priority programme development.
- Strengthen support for communicable disease surveillance, early warning and response mechanisms in disease outbreaks, implementation of the new International Health Regulations and risk communication for emerging diseases and potential pandemic influenza, and integrated disaster preparedness.
- Facilitating coordination with WPRO and other WHO country offices to encourage and assist Malaysia in playing a leading role with neighboring countries, ASEAN and the OIC, in regional and international health development.
- Maintaining an active dialogue at the higher level with the Ministry of Health and Government for the work of the governing bodies of WHO on priority health issues at national and international levels.

- Strengthening information exchange and networking through WHO country office

7.2 Minimum requirements for the core capacity of the WHO Country Office

In order to meet the challenges and demands for the current level of collaboration, fulfill the strategic approaches of WHO‘s work, and taking into consideration the coverage of three member states, there should be appropriate capacity within the country office:

The technical team of the country office is composed of the WHO Representative (WR) and a Technical Officer. The WR has overall responsibility for WHO's collaborative programmes in the country. The Technical Officer would cover communicable diseases programmes with focus on surveillance and outbreak response, advocacy and risk communication. The Technical Officer should also provide support for programme management related issues. Given the good capacity existing in Malaysia, a post of National Professional Officer should be funded from the country budget from 2007 onwards. The WR and the Technical Officer should be supported by an adequate administrative support team.

7.3 Future direction for WHO country presence

It is foreseen that in the next four years the WHO country presence in Malaysia will be important to strengthen national health development, intensify regional and international collaboration in priority health areas, improve disease surveillance and outbreak response, and to maintain effective communication between WHO and the respective governments. Due to strong and stable economic, social and health development in Malaysia, WHO country presence and ways of WHO collaboration in the country should be assessed and adjusted every 2-3 years to ensure maximum mutual benefits.

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