**INPUT SUBMISSION FOR HUMAN RIGHTS COUNCIL (HRC) RESOLUTION 44/2 FROM MINISTRY OF HEALTH (MOH) MALAYSIA**

**1.0 Introduction**

The COVID-19 crisis is a brutal reminder of the importance of ensuring lasting progress with respect to social rights enjoyment, particularly through the development of universal public health services. As Governments of Malaysia face formidable challenges in protecting the people from COVID-19 pandemic, Ministry of Health (MOH) Malaysia had also engineered our work processes to ensure universal, timely, equitable and unhindered access to safe, affordable, effective and quality health care. While ensuring that, the system is also working hard to ensure a perfect balance on the right to the safe and healthy working environment for its healthcare workforce (HCWs).

**2.0 Challenges**

It is known that the overwhelmed health facilities will reduce the standard of care, hence worsen the health outcome (Emanuel et al., 2020), in which patients whose critically ill with COVID-19 might fare particularly poorly. In the early phase of pandemic, MOH was challenged by the unpredictability of novel infection and lack of data, causing inadequate hospital capacity especially intensive care facilities and access to mechanical ventilation supports as well as inadequate molecular diagnostic capacity to cope with the surge of cases.

Other than that, various issues pertaining to supply of medical equipment and critical consumables such as PPE to the Ministry of Health Malaysia. Main issue of increase demand of medical equipment such as ventilators, PAPR, patient monitors and PPE in short notice especially during the second wave was made worse with limited supply available for these equipment and consumables in the both domestic and international market. This is due to export bans by countries manufacturing the above products, competition from nations securing critical supply of equipment and consumable as well restricted international transportation due to covid-19 has made procurement of critical medical equipment and consumables both difficult to secure and costly.

This overwhelming burden of COVID-19 infection had taken a toll on COVID-19 and non COVID-19 patients alike. In addition, the third wave of COVID-19 infection in Malaysia was exacerbated by the cluster of infection at many construction sites, mainly inhabited by non-citizen in very crowded living quarters. The high numbers of infection among non-citizen not only impose additional burden on MOH facilities but also spawn issues such as communication, cultural barriers and security. As the COVID-19 pandemic expands in Malaysia, a central focus of MOH effort will be limiting fatalities while keeping the case burden of patients with COVID-19 within the treatment capacity of our healthcare system. Patients without COVID-19 who require care for other conditions will also affected by the health system’s inability to meet their needs.

The COVID-19 pandemic also created a huge workload burden for MOH HCWs, which lead to exhaustion and mental distress because of factors such as sleep disturbance, increased and lengthy working hours, debilitating fatigue, and the fear of becoming infected and exposing their family members to this potentially lethal infection.

**3.0 Measures taken as part of health responses**

MOH had innovated some initiatives to enhance capacity and preparedness of MOH hospitals so that both COVID-19 and non COVID-19 patients irrespective of citizenship will receive an appropriate level of care during pandemic. Among the initiatives were;

1. Dedicated COVID-19 hospital

* *Hospital Sungai Buloh* served as full national COVID-19 hospital that provides their services only for the COVID-19 cases.
* 35 hospitals with intensive care capacity including repurposed of incentive care unit, 20 laboratory for diagnostic PCR testing, services reprioritisation and modular units to facilitate screening. This was done with the means of emergency procurement.

1. Diversion of new admission or decanting of non COVID-19 patients to other MOH hospitals, university hospitals and military hospitals
2. Establishment of Low risk COVID-19 Quarantine and Treatment Centre (PKRC) for both citizen and non-citizen as step down care recovering from hospitals and quarantine centre for category 1 and 2 COVID-19 patients.
3. Cooperation with Army Forces to establish Army Field Hospitals and Makeshift Hospital to manage the non COVID-19 cases.
4. Outsourcing of urgent and semi-urgent surgeries and procedures for non-COVID cases to private hospitals so that government hospitals can be maximized to treat COVID-19 patient.
5. Central stockpiling of critical medical equipment and PPE received via donations by NGO, Multinational Companies and other nations such as Saudi Arabia, China and Singapore were carried out with CSR help by Local GLC concessionaires Pharmaniaga Sdn. Bhd. These equipments are later distributed by the company to designated treatment centres in view of number of COVID-19 cases and severity. As of in March 2021, the Ministry of Health have distributed 1213 ventilators via central/hospital procurement and donation to most designated COVID-19 hospitals.
6. Central Emergency Pooled procurement program to allow faster procurement process with larger volume with reduced cost to be obtained for the public hospitals designated as Full or Hybrid COVID-19 treatment centres. The Medical Programme along with the Procurement Division devised strategies to counter these issues mainly through Central Emergency Pooled Procurement worth RM 188,380,264 to secure critical medical equipment such as:
7. Ventilators,
8. ICU beds
9. Patient Monitor
10. Fluid Management System
11. PAPR
12. Isopods.

Besides medical equipment, Personal Protective Equipment (PPE) worth RM 117,030,793 was also done to secure PPE’s such as:

1. 3 ply Face Mask
2. N95 respirator
3. Jump suit Coverall
4. Isolation Gown
5. Central procurement via central tenders worth RM 163,553,895 and RM 55,450,000 (leasing) were conducted to supply critical medical equipment for other major services such as:
6. Acute coronary diseases (Cardiology) – 3 Intensive Cardiac Laboratory(ICL)
7. Cancer treatment and screening (oncology and Radiology): - 2 Linear accelerator devices, 1 Brachytherapy, 3 Fully Digital Mammogram
8. Radiology Diagnostic Services – 4 MRI 1.5 tesla, 3 Ct Scan 64 detector,
9. Radiology Diagnostic Services (Leasing) – 8 MRI 1.5 tesla.

Meanwhile, in response to the right to safe and healthy environment, few countermeasures had been implemented including;

* Coordinated HCWs mobilisation at national level to match healthcare facilities and the HCWs mix.
* Procurement of enough personal protective equipment (PPEs) through emergency procurement to ensure HCWs safety.
* Development of Sequence of Donning and Doffing of PPE of COVID-19 pandemic Guideline to give clear guide on managing the spread of infection among HCWs.
* Establishment of COVID-10 Mental Health Kit in Healthcare Setting and Quarantine Centre
* Creation of Post-MCO Plan & Return to Work policy to protect the HCWs by hazard identification and new norm infection control measures.
* Production up to 40 management guidelines and standard operating procedures that cover all aspect of COVID-19 management to reduce the introduction and spread of COVID-19 to patients, visitors and importantly to HCWs.

**4.0 Conclusion**

MOH Malaysia is always inspired to make its healthcare services available to everyone without discrimination, including the most vulnerable and marginalized. MOH Malaysia also believed that respect for human rights across the spectrum, including economic, social, cultural, and civil and political rights, will be fundamental to the success of the public health response and recovery from the pandemic, hence will undertake all the necessary collaborative actions to achieve the objectives.

Reference

Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., . . . Phillips, J. P. (2020). Fair allocation of scarce medical resources in the time of Covid-19. In: Mass Medical Soc.

**Additional input on human rights challenges experienced in responding to the COVID-19 pandemic, including in relation to the measures taken as part of the health response**

* From Independence in 1957, Malaysia had strongly invested in progressively developing the health care system. This ensured availability of good quality health services which are financed mainly through general taxation[[1]](#footnote-1), not just rural populations but marginalised population too. Thus, Malaysia achieved Universal Health Coverage or UHC in the 1980s[[2]](#footnote-2) through general tax-funding.
* Public health services are integrated almost seamlessly with personal healthcare services in MOH facilities, especially during this COVID-19 pandemic. The centralized system of MOH makes it much easier to efficiently share and distribute resources across activities, levels, and regions.
* Malaysia’s systematic investments in Essential Public Health functions ensured that every district in the country has an effective District Health Office, conducting surveillance and disease control at ground level. This is supported by public health laboratories in all regions of the country for disease testing.
* Past experiences of facing several infectious disease outbreaks, such as leptospirosis, Nipah encephalitis, SARS, and MERSCoV have also increased our capability and strength in active case detection, patient isolation, and contact tracing for disease control. These experiences have collectively paved the way to strengthen our resilience in handling infectious diseases. Malaysia had institutionalized strategies such as public health security systems for Public Health Emergency Preparedness to respond to outbreaks, in line with directives under the country’s National Security Council Policy and Mechanism of National Disaster Management and Relief.
* Because MOH services are highly centralized under the jurisdiction, governance and legal framework of the federal government, it was relatively easy and quick to integrate and activate Disaster Management plans. This federalized nature facilitates cooperation and coordination with other central government agencies, such as the army, police and immigration who also play major roles in the country’s COVID-19 outbreak response and movement control efforts. All work closely together under the umbrella of Act 342, which is the Prevention and Control of Infectious Diseases Act 1988, ensuring a Whole of Government approach.
* In order to anticipate the need for more hospitalization, investments were made to increase bed capacity of existing hospitals. For example, our national referral center for infectious diseases is one of the dedicated hospitals for COVID-19 treatment. Like other countries, semi-dedicated hospitals were also identified to cater for additional COVID-19 patients where necessary. Other facilities like exhibition centers, hotels and hostels were also modified to cater for either mild cases or as quarantine centers for those who were exposed or returning from overseas.
* Given the need to optimize the resources, personnel were redeployed and equipment such as PPEs, ventilators, test kits, medication and others were efficiently purchased and distributed to hospitals as well as primary care and community screening facilities, through close and careful monitoring of local supply levels.
* With regards to expanding testing capacity, other agencies under the Ministry of Higher Education, Ministry of Science, Technology, and Innovation, Ministry of Defence, as well as private laboratories were also mobilised. This quickly increased Malaysia’s diagnostics capacity for COVID-19, from an initial 6 laboratories to 68 laboratories as off now.
* The pandemic has also provided opportunities to increase the relevance of IT and digital health such as virtual consultations and telehealth, as well as the development of applications for outbreak management. Applications and websites like “MySejahtera”, “e-covid19” and others facilitate contact tracing, empowers the community to conduct self-evaluation of health risk status, allows self-management of health profiles, as well as updates the public with the latest facts to combat fake news.
* Fees in the public health system are highly subsidized. So, residents enjoy financial risk protection against catastrophic spending for health care.
* Under the Prevention and Control of Infectious Diseases Act 1988, public sector screening, treatment and hospitalization of patients for infectious diseases, including COVID-19, is completely free for everyone including immigrants.
* The Temporary Measures Act for Reducing the Effects of Coronavirus Disease 2019 (COVID-19) 2020 was established to provide an exemption or relief to assist the B40 and M40 as well.

**Additional input on any technical support needed to address the challenges identified, including the socio-economic impacts of COVID-19 and response measures**

1. Malaysia has been an advocate for access of healthcare to the entire population, regardless of citizenship and with no discrimination. This is in the spirit of Leaving No One Behind and Universal Health Coverage. As Dr Tedros, the Director-General of WHO says, until everyone is safe, nobody is. With reference to the Resolution adopted by the Human Rights Council on 16 July 2020, Malaysia is pleased to support and endorse this.
2. During this COVID-19 pandemic, globally countries experienced challenges and this is where gaps in the system were clearly apparent. This gave an opportunity for governments around the world to focus on human rights, as there had been a dire need to protect the entire population from COVID-19.
3. Malaysia also had our unique set of challenges in this regard. Throughout the pandemic, our government leaders have always openly invited migrants (including undocumented migrants) to come forward for free testing for COVID-19 at designated venues throughout the country. These migrants were then treated completely free, as they are treated equal to the citizens.
4. With reference to Para 4 of the A/HRC/RES/44/2 Resolution, whereby there is a need for States to collaborate with all relevant stakeholders, to take collection action in response to pandemics and health emergencies, Malaysia has also collaborated with the local and international NGOs and CSOs to assist and reach out to the vulnerable populations.
5. We are also very grateful to many NGOs in Malaysia who have all joined forces and worked together with the government of Malaysia in reaching out to the vulnerable population. During this pandemic, we saw the best of humanity as many generous donors from the public came forward to donate towards helping the vulnerable population, especially with basic needs such as food and shelter.
6. During the course of this pandemic, evidently there were many clusters identified and some of these clusters originated from workplaces. The government of Malaysia implemented strict punitive measures on employers who housed their foreign migrant workers in crowded confined spaces. This was done via the enforcement of the Workers’ Minimum Standards of Housing and Amenities Act 1990.
7. For all the foreigners (documented and undocumented) who had tested positive for COVID-19, they had been given free treatment at the healthcare facilities in Malaysia. Quarantine centres were also open to foreigners whereby their accommodation, food and medical treatment had been fully absorbed by the government of Malaysia.
8. There has been a considerable economic crisis following the pandemic and countries around the world have been combating this. Evidently the vulnerable population would be affected by this as they do not have any savings or financial back up during these financial struggles. Therefore, one of the measures implemented by the government of Malaysia is to boost the domestic tourism within the country. As of 10th March 2021, travel for tourism will be allowed under the targeted bubble travel between states in Malaysia under the recovery control order (RMCO) and will be subjected to strict conditions. Those who want to travel for domestic tourism can only do so by using tour agency vehicles whereby the operator would have to seek police permission before making the journey. This is anticipated to boost up the domestic tourism economy as many livelihoods have been hit hard by the pandemic.
9. Ultimately, the government of Malaysia has ensured that healthcare access is available to everyone on its soil. We wish to reiterate Dr Tedros, Director-General of WHO’s quote, “health is not a luxury item for those who can afford it; it’s a human right”. Truly, Malaysia agrees to the fundamental principle that by adopting a human rights-based approach in the COVID-19 response and recovery, we can minimize sickness and death, especially among the most disadvantaged people.

**Additional input on any good or promising practices in these areas, including examples of international cooperation**

We welcome cooperation from high income countries in assisting developing country like Malaysia, in term of knowledge, experience and technical support in the response to the COVID-19 pandemic.

Currently, the Government of Japan is offering technical cooperation to Malaysia through Japan International Cooperation Agency (JICA). We are in the process of submitting application to JICA to provide storage equipment for Malaysia's National Covid-19 Immunization Programme which will be rolled out in three phases starting 23 February ?021.

We were also offered by JICA to join COVID-19 Webinar Series -Sharing of Japanese Experiences titled “COVID-19 Case Management In Japan” which took place on Wednesday, 3 March, 2021.

It is an honour for advanced country like Japan to assist Malaysia in coping with the pandemic by giving support to our vaccination programme which commence in February 2021.

1. Ng Chiu Wan, Noran Naqiah Mohd Hairi, Ng Chirk Jenn, Adeeba Kamarulzaman (2014)*Universal Health Coverage In Malaysia: Issues And Challenges* [↑](#footnote-ref-1)
2. Savedoff, William & Smith, Amy. (2011). *Achieving Universal Health Coverage: Learning from Chile, Japan, Malaysia and Sweden*. [↑](#footnote-ref-2)