The Health of Children and Youth in Malaysia

Evergreen Needs, Changing Needs

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Resources

- 1. Why Children Need South East Asia to Achieve SDG 3 Goals-Final-Amar.pdf
- 2. Children's Access to Healthcare-V8-Share-Amar.pdf
- 3. White Paper on Health-4-Amar.pdf
- 4. Developing Care in the Community-Amar-8-final.pdf
- 5. Current Challenges in Child Health-Amar-2019-v7.pdf
- 6. Dead children - the true state of our child health services.pdf
- 7. COVID-19 and its impact to the future generations-9-Amar.pdf
- 8. Disability and the COVID-19 Pandemic-June 2022.pdf
- 9. What True Keluarga Malaysia Means and Looks Like for Our Children-2021-Final.pdf
- 10. OA Childhood Mortality and Morbidity-Amar-6-1.pdf

https://drive.google.com/drive/folders/1ezWOn7wyjjBmEGwuuJwfMFblDM3xsYgS?usp=sharing

Data & Reality based
Focus on Social Determinants of Health

Population Data on Children in Malaysia, 2020

Age (years)	Numbers in 1,000s			% of Total Population
	Male	Female	Total	
0-4	1,313.2	1,229.0	2,542.2	7.8%
5-9	1,321.7	1,232.3	2,554.0	7.8%
10-14	1,288.8	1,215.3	2,504.1	7.7%
15-19	1,468.3	1,367.4	2,835.7	8.7%
Population of Children (Sub-Total)	**5,392.0**	**5,044.0**	**10,436.0**	**32.0%**
Total (all ages including adults)	16,805.6	15,851.7	32,657.3	100%

Source: Department of Statistics, Malaysia 2021

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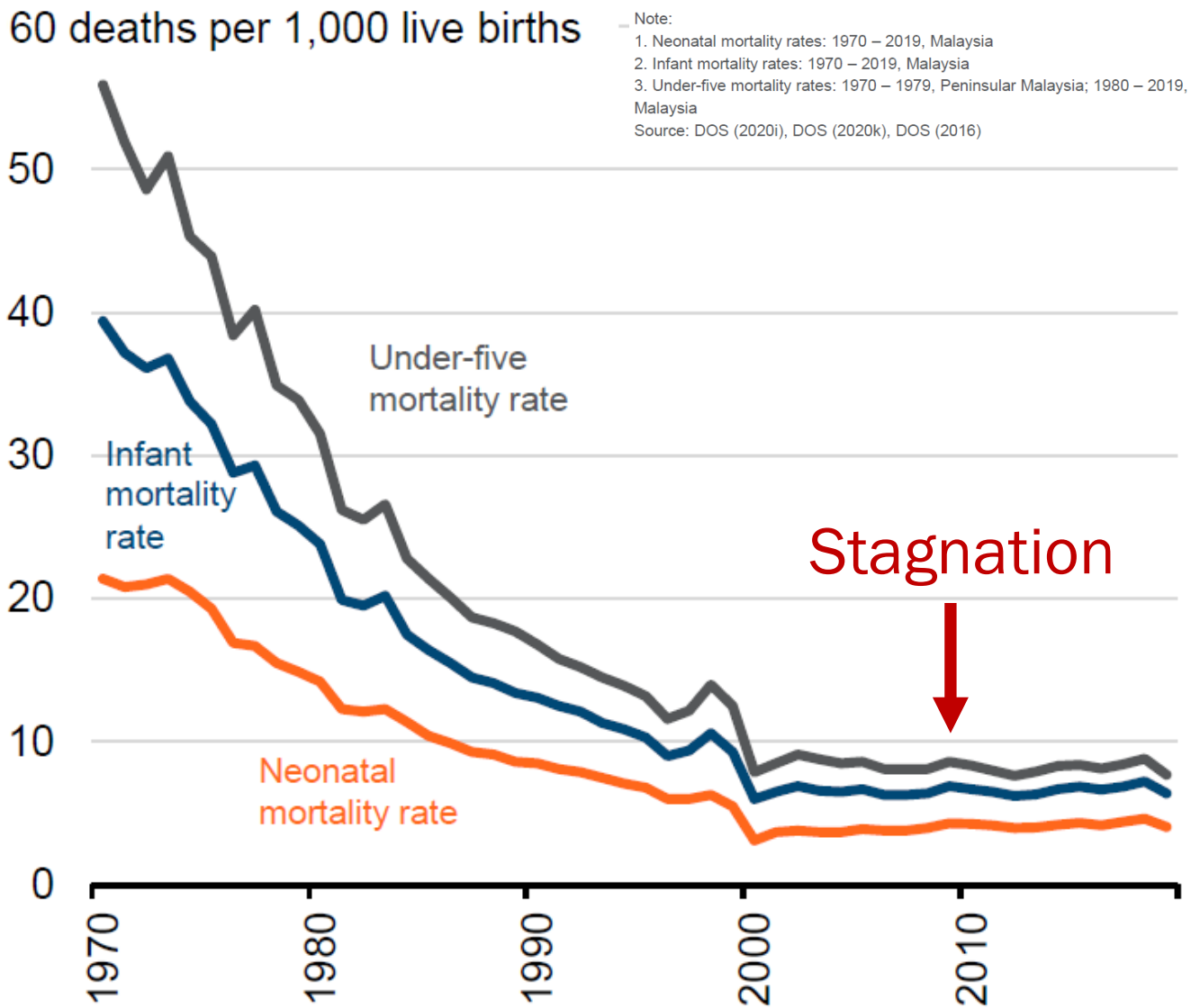
Child mortality rates, 1970 – 2019

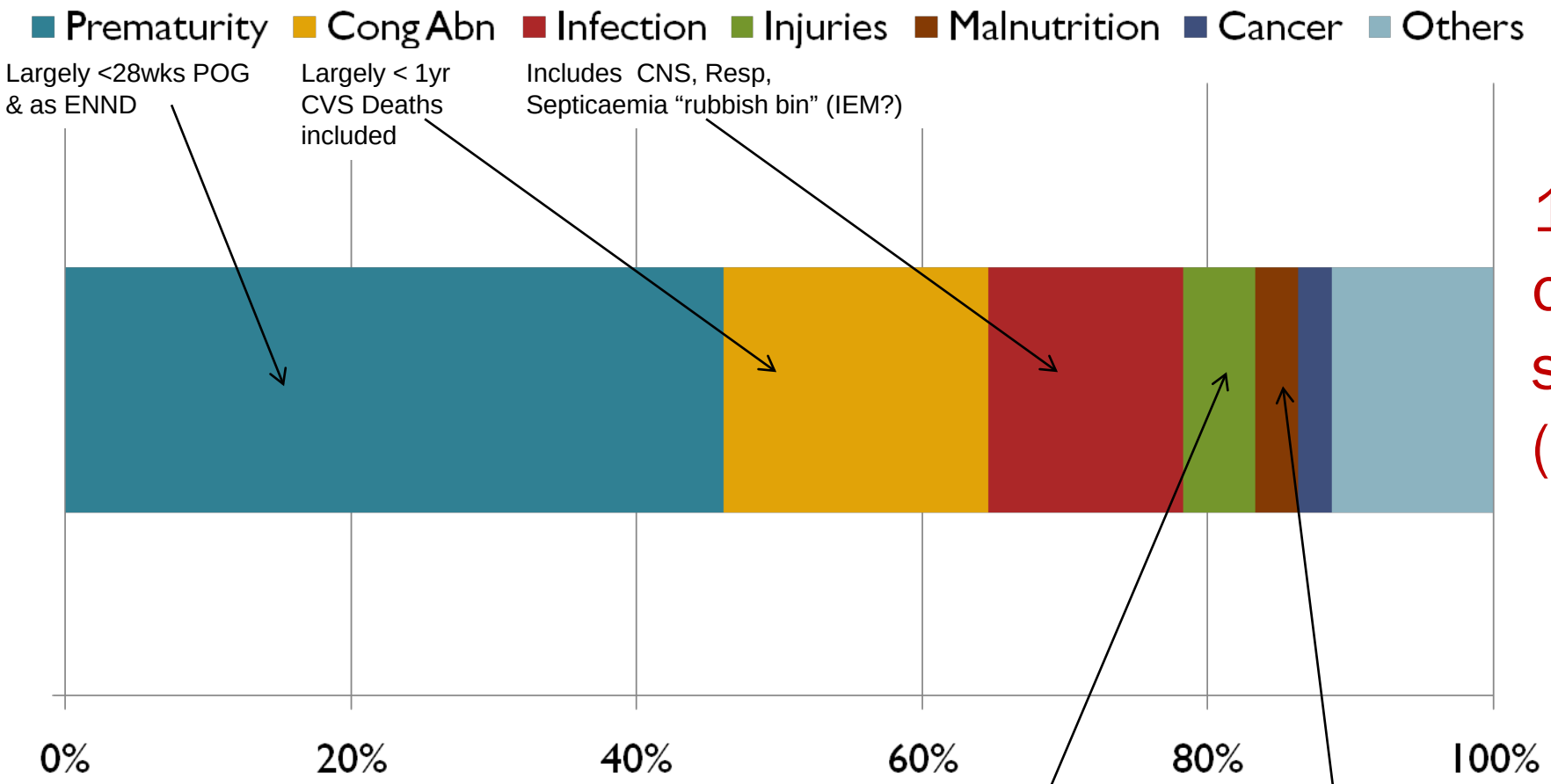


1. Poor development of critical children services (**NICU/PICU**)

- Services for children not on par with services for adults
- Adult curative specialty & ICU services grown by leaps/bounds
- Services for children only grown incrementally – PICU & NICU grossly inadequate
- Every single day struggling to find a bed
- Stagnation of mortality rates for ~20 years

Significantly grow PICU & NICU beds to meet acceptable norms
Paediatric Nursing workforce crisis
Urgent need to accelerate development of tertiary specialty services for children

Cause of Under 5 Deaths



1. Poor development of critical children services (**NICU/PICU**)

Source: Composite Data from:
Wong et al, National under 5 mortality study
Health Informatics Center, MOH
Krishan & Amar HSS, Drowning & injury Data

Injuries 1-4 yrs
Drowning, RTA, Fire, Poisoning

Malnutrition
Mainly OA kids, 1-4 yrs

MOH overdue in recognizing those aged 12-17 years are children

- Usually admitted to adult wards
- Traumatically placed next to ill/dying 50-70 yr adults
- Seen in adult-based clinics by staff lacking adequate training
- Development of appropriate services for adolescent limited (~15% pop)

2. Limited appropriate in-patients services for Adolescents

MOH policy must change definition of a child

Adolescents need to be placed/seen in appropriate child-friendly health facilities

- Adolescent wards and clinics
- Staff trained in their care

" a child means < age of 18 years unless, under the law applicable to the child, majority is attained earlier" Article 1, Convention on the Rights of the Child 1989 (UNCRC)

"child means a person under the age of 18 years" Part I Section 2(1), Child Act 2001

1

We require
A Life Course Perspective on Health

Acknowledging that health status reflects cumulative life conditions.
Interventions should be tailored to specific developmental stages.
Take into account the impact of cumulative social and environmental exposures.

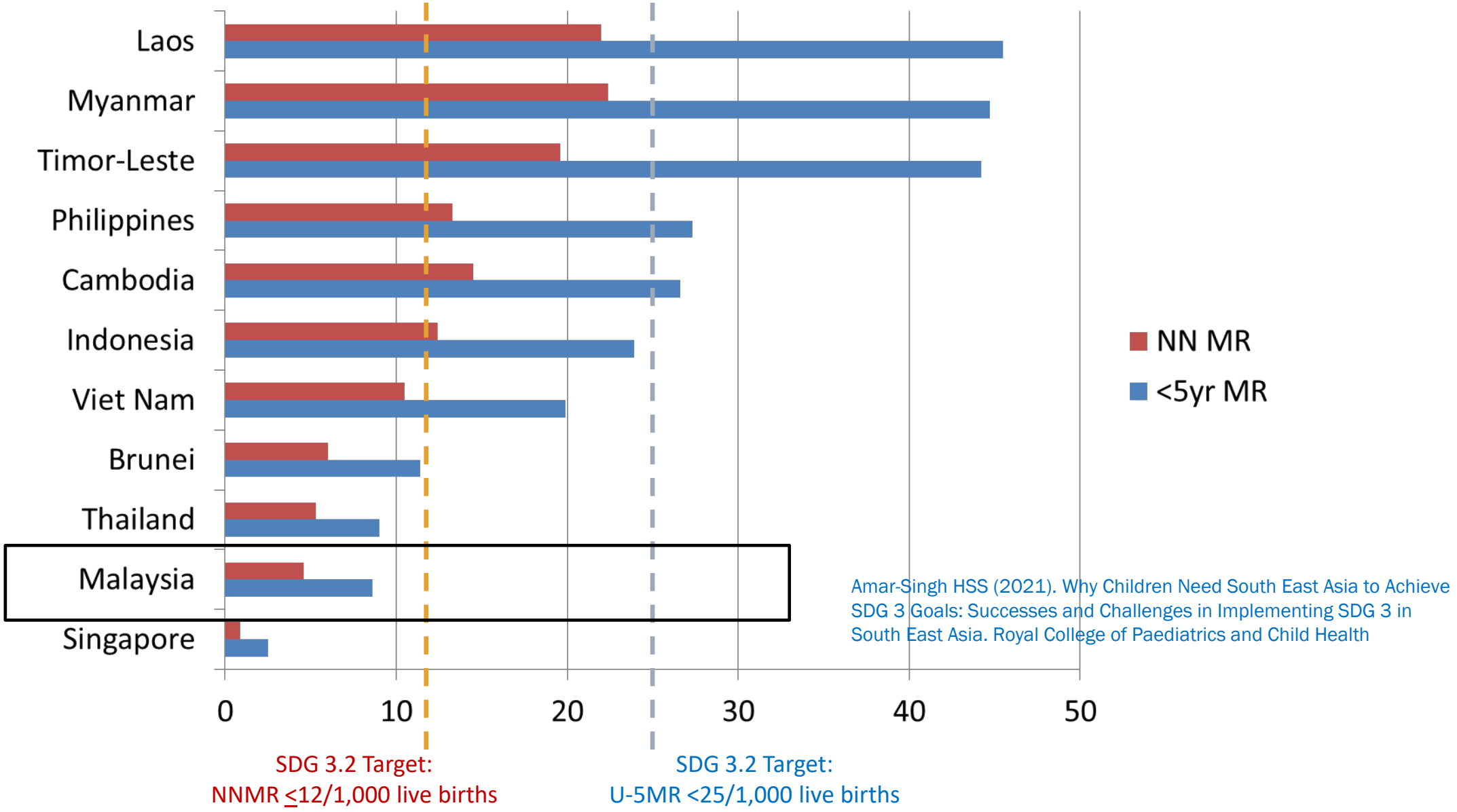
Antenatal, Neonatal, Childhood, Adolescent, Adult, Elderly

3. Developing services for Indigenous children (Orang Asli & Penans)

Orang Asli health status has not changed significantly unlike the general population

- Poverty rate remains high at 80%
- Childhood malnutrition high (60-70% are malnourished by 5-7 years of age)
- Malnutrition rates are increasing
  - Recent study on all OA children aged ≤2 years in Perak, >40% were malnourished by 2 years of age
- Some health staff looked down on the community
- Under 5 mortality rates for Orang Asli children **11x** major ethnic groups
- Mistrust of the health services by some
- Poor schooling perpetuates the cycle of poverty & limited health access
- Environmental destruction (logging, river pollution) worsen malnutrition

Neonatal and Under 5 Achievements, 2019

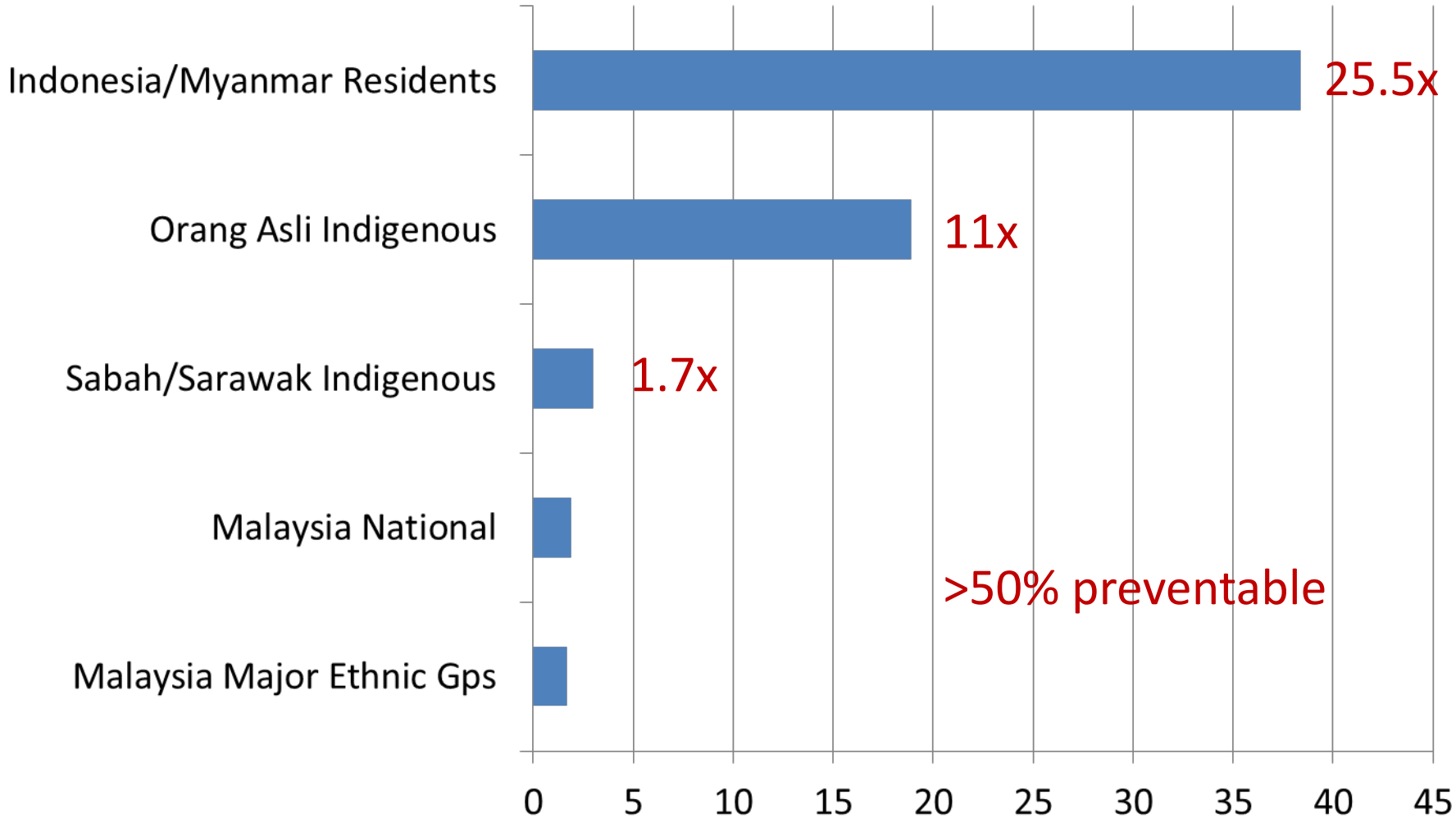


Amar-Singh HSS (2021). Why Children Need South East Asia to Achieve SDG 3 Goals: Successes and Challenges in Implementing SDG 3 in South East Asia. Royal College of Paediatrics and Child Health

Disaggregated Data

Under-5 Age-Specific MR **by Ethnic group**, 2016

Source: Hung, Mariana 2020; Amar-Singh HSS June 2019, Amar-Singh HSS, June 2021



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3. Developing services for Indigenous children (Orang Asli & Penans)

Need culturally acceptable & sensitive health strategies

Develop community resilience in health via **paid village health teams**

Need to strengthen Orang Asli Mobile Teams & Flying Doctor Services

Bring every pregnant woman out, with family, at 34-36 week POG

- Await delivery in hospital
- Keep postnatal period with the child for 2 weeks
- Critical to reducing perinatal and maternal mortality

Establish community re-feeding centres in villages

- one protein rich meal to all children under 5 years of age daily
- most successful upstream effort to reduce child mortality
- requires consistent funding and support

4. Supporting Children Who Live in Poverty

Focus on Inner City Poor and Sabah

Revised poverty line income (PLI) (RM2,208) -

- ~405,400 households (~1.2 million children) living in poverty
- Merdeka Centre: Covid-19 pushed 8-10% of pop into poverty
- **Conservative estimates: 3-4 million children live in poverty in Malaysia**

Problem of poverty compounded by increases in urban pop

- 75-80% in 2020 live in urban environments

Poverty major barrier to accessing health care & health information

Poverty undermines health through nutrition and poor living conditions

Limited focus on the poor in their health service strategies or policies

Private health services are out of the reach to most poor families

- Half specialist human resources in the private sector

Disproportionate distribution of specialists

Located at major cities & west coast of Peninsular Malaysia - Sabah poorly served outside major cities

4. Supporting Children Who Live in Poverty

Focus on Inner City Poor and Sabah

Require disaggregated data, broken down by detailed sub-categories (indigenous, marginalised groups, level of income, gender)

Need to **map communities** with high child mortality rates and focus sufficient resources on those with high rates

Need **compulsory death registration and mandated medical certification of deaths** by law

Need **decentralisation** of services and manpower

Working on health alone will not result in the dramatic change in child mortality, morbidity or access to health care - Need to end child poverty (SDG 1) and child hunger (SDG 2)

2

We need to Reverse the ‘Inverse Care Law’

(those who need health care the most are the ones least likely to get it)

and target marginalized communities

Disaggregated Data is critical

We need to achieve health goals for ALL children regardless of their status
Not as an average or for a portion of the community
We must not leave behind marginalised communities

5. Routine Healthcare for Migrant, Refugee and Stateless Children

- "**child detainees in Malaysia are detained in unacceptable fetid conditions and are often placed in adult facilities by gender**" United Nations Human Rights Office of High Commissioner, Universal Periodic Review March 2018
- Immigration laws do not appear to distinguish between children & adults
- Some detained without their parents or guardians present

- **Limited access to hospitalization/specialist care** for ill migrant, refugee and stateless children
  - High fees for hospitalisation, procedures and medications
  - Children denied discharge until parents can settle the bill (even if dies)
  - At discharge children with chronic problems given 5 days medication with no follow up
- **Limited access to primary / basic healthcare** for migrant, refugee and stateless children

Despite being a legal requirement under the Child Act (and UNCRC) that covers all children in Malaysia

5. Routine Healthcare for Migrant, Refugee and Stateless Children

- Require legislation that guarantees all children living in Malaysia a right to health care, regardless of their legal status
- Migrant, refugee and stateless children/families need to be protected against arrest and detention when they seek healthcare at hospitals and clinics
- **Universal access to health services**
  - Including hospitalization, treatment of illness & rehabilitation
  - Prohibitive and expensive fees/charges should be removed
  - Free primary health care and immunization to all children in Malaysia, regardless of their status
  - All children with chronic illnesses should be given appropriate health care and medication
- Need to move all children out of detention centres into safe shelters with their families
- All children should have access to education

3

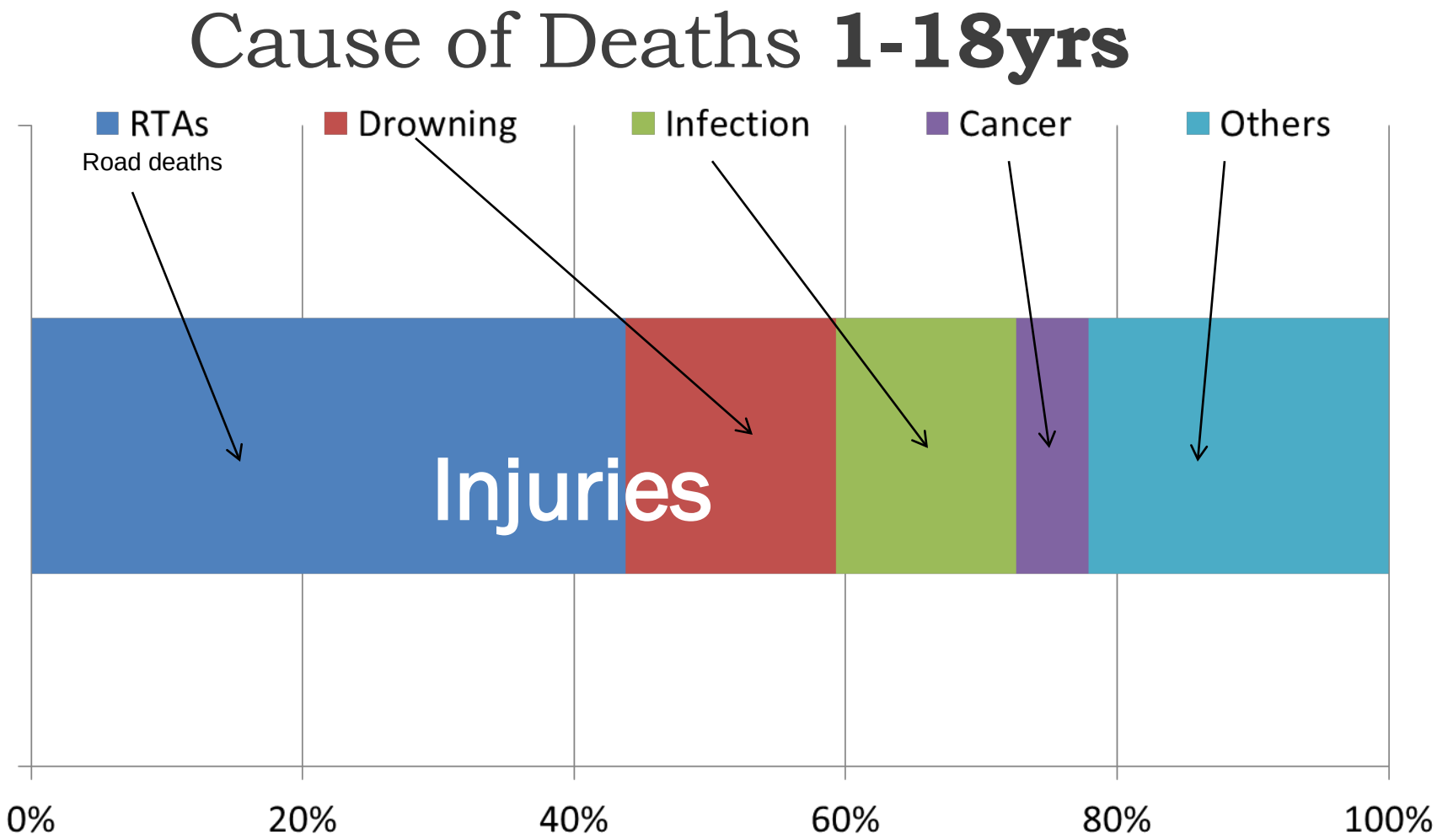
To ensure **universal access** to **health**
for **All** children in Malaysia
we require a **rights-based approach**
as outlined in the UNCRC

If we neglect some children, we fail all children

6. Abuse, Injury, Disability burdens

Abuse	Disability	Injury
1:10 sexually abused **1:4 physically abused** (community prevalence studies)	**15% of children** 40-50% of specialist clinic visits	**> 1,500 deaths per year esp, road and drowning** **4x as many disabled**
Current services very weak Doctors poorly trained Often fail to use Child Act to protect children No prevention programmes	Screening limited Doctors poorly trained (university) Assessment & rehabilitation services very limited Rural communities access poor	Neglected by HCPs and MOH Hardly any emphasis or funding
Child Act needs to be implemented fully in the health system HCPs must not fail their child protection role HCPs need to be trained in child protection management	MOH need to plan, organize and budget in line with 15% disabled Medical universities to dramatically improve the curriculum on children with disabilities Outreach services for all rural, indigenous, poor urban communities	Many evidence based initiatives that work – need to be promoted by HCP and MOH

6. Abuse, Injury, Disability burdens



Source: Composite Data from:
Health Informatics Center, MOH
Krishan & Amar HSS, Drowning & injury Data

6. Abuse, Injury, Disability burdens

No disease kills our children
like RTI & Drowning

For every
1 child that dies of dengue
30 will die on the road
10 will die of drowning

MOH spending or focus on prevention?

4

We need an **Evidence and Data–based Approach** to child health needs

Areas with large health burdens must not be neglected

7. Psychosocial & Lifestyle-related adult illnesses with onset in childhood

Mental Health, Obesity, Smoking, Screen addiction, Sexual behaviour, Drug use, etc

Adolescents 10-17 years (NHMS 2017, 2015)

- 1:10 currently use alcohol
- 1:5 of boys smoke (5% of girls)
- 3-4% currently on drugs
- 7-10% had sex
- 1:5 depressed, 1:10 have had suicidal ideation
- 1:2.5 internet addiction
- 1:5 obesity or overweight

Life Style Illnesses Explosion
An Unhealthy Population
(Adults, Malaysia, Today)

1:3 obese or overweight
1:3 Hypertension
1:3 Diabetes
1:5 Asthma/Chronic respiratory illness
1:5 Coronary artery disease
1:3 Allergies
1:4 will get the Big C

8. Impact of Covid-19 & Climate Change

Covid-19

Great distractor, siphoned off resources, energy, focus

Downward Poverty Spiral - Worsening Childhood Malnutrition

Interrupted Education

A Generational Scar/Gap

Potential Mass Disability Event

Climate Emergency

Estimated that 25% of childhood deaths and disease burden could be prevented by reduction of environmental risks (air pollution, unsafe water, sanitation, chemicals)
Prüss-Ustün et al 2016

Growing problem & threatens to engulf and reverse all health gains

7. Psychosocial & Lifestyle-related adult illnesses with onset in childhood

8. Climate Change

Not much evidence that health education campaigns effective

Need environmental and city-wide changes WHO 2011, Cohen 2014, Cavoli 2015, WHO 2016, Khreis 2017

Investment in mobility: cheap and efficient Electrical Bus Rapid Transit (eBRT) public transport, walking & cycling with severe restriction in cars

Promoting safe green spaces & recreational areas in all urban areas that comprise 30% of total land area

A national campaign to move adults away from screens, so as to support children - promote screen free days weekly for families

Routine obesity screening programme at 2 yrs of age

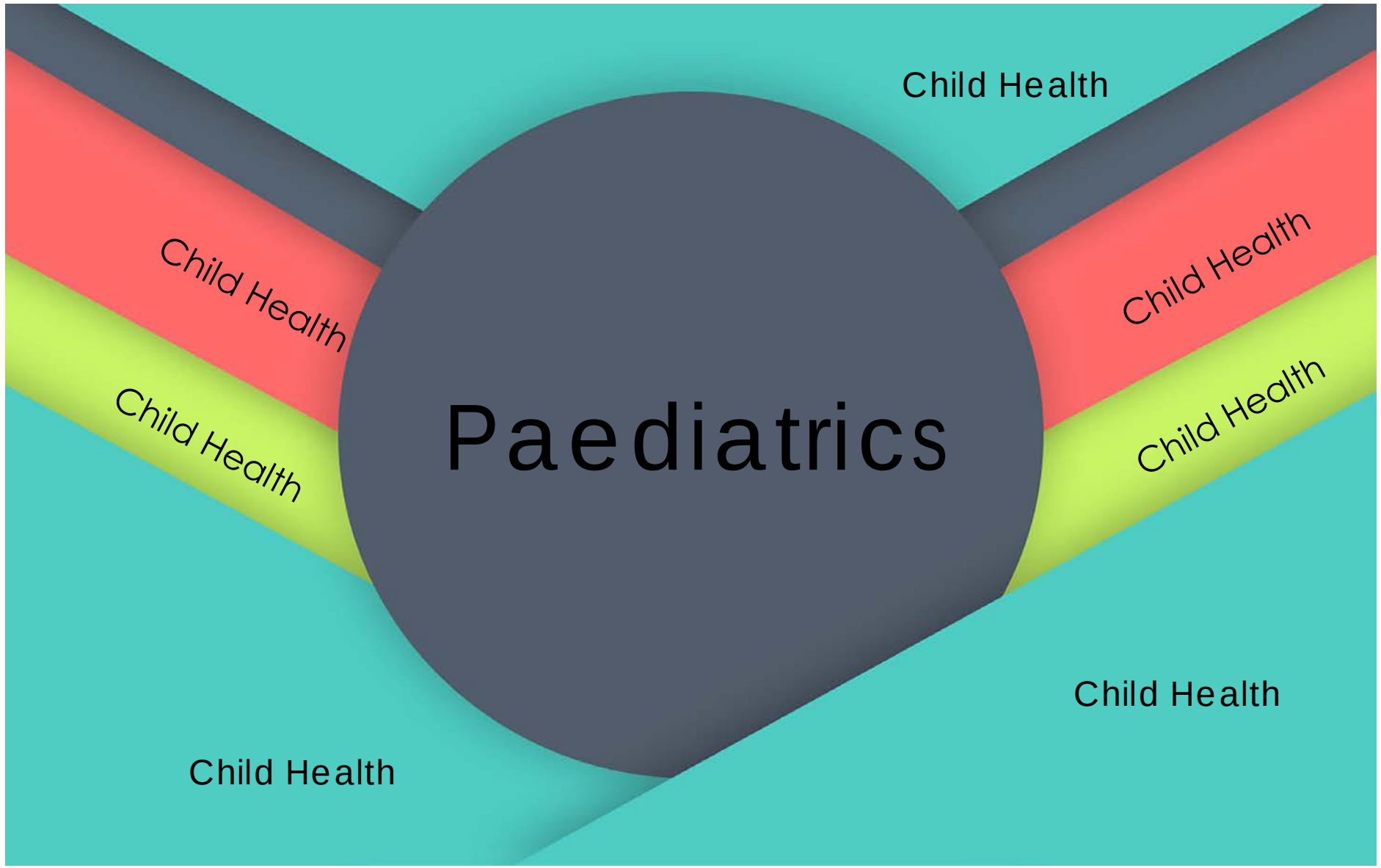
5

Health is not possible in Isolation

We **need significant change in the environment and mobility** to impact long term health

Developing Healthy Environments is Crucial

Paediatrics vs Child Health



Addiction to a curative, Specialist and drug based illness system

6

Child Health vs Paediatrics

Retrain HCPs

Focus on health not illness

Need to move our specialist resources out of institutions in the community to impact prevention

6

6

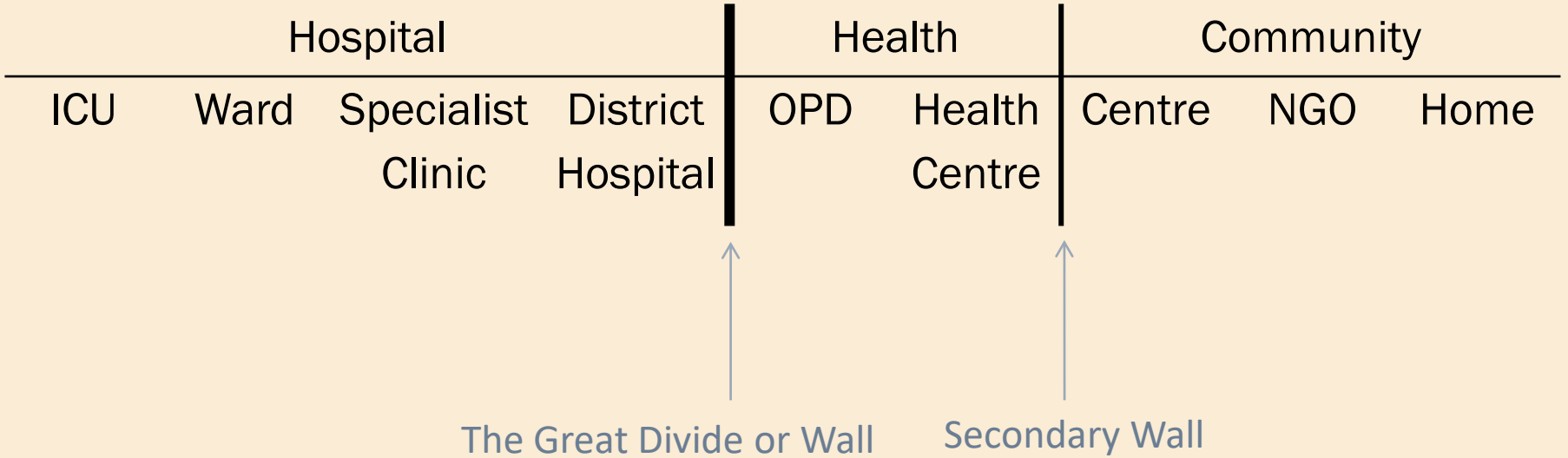
Need to promote mobile,
not building-base,
services for health delivery

6

Community Self Care is the Key

Need to **empower** the community for self-care using trans-disciplinary community health care workers

Health Happens Here



We need to move away from a mind-set of delivery of healthcare to the community and work towards the development of capability within the community for self-care

7

Key Directions Moving from:

1. a disease-centred care to a person-centred care
2. a focus on intermittent, episodic illness to a focus of continuous life-long health
3. limited consultation to one of enduring personal relationships & integrated care
4. the community as consumers of healthcare to one where the community are partners in managing their own health

We hope to return to a person-centred integrated care system, where the person & community are viewed as their own healer. And healthcare professionals are embedded in and integrated with the community.

0

the river

Health
Promotion
Selfcare

Mountain
of Health

Primary Care
Risk Reduction & some Prevention

Help, help!

Tertiary/Hospital
Based Care
Illness care

A

Secondary Care
Minimise handicap

Dato' Dr Amar-Singh HSS
1991

In all actions concerning children....

the **best interests of the child**

shall be a primary consideration

UNCRC