COUNTRY REPORT

Malaysia

The 9th ASEAN & Japan High Level Officials Meeting on Caring Societies: Human Resource Development in the sectors of Welfare and Health – with a focus on capacity building of service providers and employability promotion of vulnerable people

25 October - 28 October 2011

Tokyo, Japan

SECTION 1

FOLLOW UP ON THE RECOMMENDATIONS OF THE 8TH HIGH LEVEL OFFICIALS MEETING – "POVERTY ALLEVIATION WITH A FOCUS ON VULNERABLE PEOPLE IN MALAYSIA."

1.1 The 8th High Level Officials Meeting adopted the following recommendations to be implemented both at the regional and national level by the participating countries:

Regional Level

a. to promote regional information sharing and dissemination of good practices in poverty reduction;

b. to encourage discussion on social protection concepts and components including development of a framework on poverty reduction in line with the MDGs platform;

c. to enhance capacity building on monitoring and evaluation on poverty reduction for relevant officials to meet local needs;

National Level

a. to encourage an appropriate budget for reduction programs with a focus on vulnerable groups;

b. to encourage a holistic approach to policy planning and review/evaluation, involving senior-level officials from respective ministries and local government;

c. to promote suitable coverage of social protection schemes, particularly for vulnerable group;

d. to strengthen community-based poverty reduction programmes and capacity building to officials, service providers, health and social workers at different levels;

e. to strengthen the systematic collection of data to facilitate policy and service planning programme implementation as well as monitoring and evaluation;

f. to advocate health issues in poverty agenda and poverty issues in health agenda.

1.2 Under the concept of 1Malaysia, People First, Performance Now introduced by the Government of Malaysia in April 2009, raising living standards of low-income households was given the utmost priority. Hence, under the Government Transformation Programme, the National Key Results Area-Low-Income Households or LIH NKRA was introduced in July 2009. LIH NKRA calls for the raising standards of low-income households in a sustainable manner, to ensure aid reaches to the needy quickly and efficiently, and to create opportunities for the low-income households to earn income independently.

1.3 In addressing the issue of poverty under the LIH NKRA, three key areas were identified:

a. To standardise the definition of low-income groups

Standardisation of the definition of low-income households is crucial to ensure supports are targeted to the right people. In this regard, the Government had successfully identified the categories of low-income households based on monthly income. In Peninsular Malaysia, extreme poor households are those who earn monthly income of RM440 and below; poor households whose income is RM750. In Sabah, extreme poor is defined as households whose income is RM540 and below, and RM960 and below as poor households. Meanwhile, in Sarawak, households whose earn monthly income of RM520 and below are defined as extreme poor and RM830 and below as poor households. The national definition of low-income households is households whose monthly income is RM2,000 and below.

b. To implement quick, high impact initiatives immediately and lay the ground work for longer-term actions

These initiatives were aimed to improve immediate welfare as well as build income-earning potentials to ensure sustainability. Several measures were identified, including welfare assistance programmes, housing support and the 1AZAM (end the poverty era) programme. 1AZAM is a specific initiative that sets out to lift low-income households out of poverty through means of employment, entrepreneurship, agricultural activities and services. (Please refer to details in 1AZAM programme).

c. To put enabler in place to ensure the poverty eradication programme are both effective and efficient

To ensure the effectiveness of the poverty eradication programme, the eKasih database (a central registry of low-income households) has been designated as the sole database for low-income households and the Implementation Coordination Unit of the Prime Minister's Department as the sole manager for this database.

1AZAM Programme

1.4 To equip the poor and extreme poor with the means to increase their income, programmes were intensified to build up the capabilities of these groups and create jobs for them. Efforts undertaken included 1AZAM programme to create jobs through a mixture of employment and entrepreneurship (social enterprise and productive welfare). Four initiatives under 1AZAM programme were identified as follow:

a. AZAM Tani (to provide economic resources to enable the poor to venture into agricultural and agro-based activities);

b. AZAM Niaga (opportunities provided to the poor to start up small business);

c. AZAM Khidmat (opportunities provided to the poor to venture into service sector or self-employed); and

d. AZAM Kerja (offers employment opportunities to the poor through job matching or job placement).

1.5 Under 1AZAM programme, women from low-income households were also given due attention and to be trained and developed to become entrepreneurs. In this regard, the Ministry of Women, Family and Community Development with the cooperation of Amanah Ikhtiar Malaysia had trained and developed women entrepreneurs by the end of 2010. Women entrepreneurs are defined as those with a net income of RM3,500 (USD1,087) per month or more (for a consecutive period of 3 months).

Collaborative Efforts

1.6 Executing programmes under the LIH NKRA, the Ministry of Women, Family and Community Development is the designated Lead Ministry and coordinator for the LIH NKRA. The Ministry works in close collaboration with several other ministries and agencies. For instance, the Ministry of Agriculture is responsible for AZAM Tani initiative; the Ministry of Human Resources for AZAM Kerja; Amanah Ikhtiar Malaysia (a private trustee body with the objective to reduce poverty) for AZAM Niaga and AZAM Khidmat; the Ministry of Health for the nutrition programme for children from the low-income households; and the Ministry of Education for the dilapidated schools project. The LIH NKRA also received ancillary support from the State Government of Sabah and Sarawak. The state agencies assist in identification of participants for 1AZAM programme and the implementation of LIH NKRA initiatives.

Community-based poverty reduction programme

1.7 Various community-based programmes and projects were implemented by various organisations as part of LIH NKRA initiatives. For instance, the National

Welfare Foundation carried out community programmes such as Mindset Change Programme, Gempur NKRA and insurance initiative. Through the Gempur NKRA programme in November 2010, 91 extreme poor and poor households received food basket. In addition, PETRONAS (the national petroleum company) provided subsidies for essential goods to poor households via their convenient stores.

Budget

1.8 An amount of RM1,166,500 million (USD362,143 million) was spent in 2010 to implement programmes of raising living standards of low-income households under the LIH NKRA. Out of the amount, RM415.66 million (USD129.5 million) was spent for operating expenditure and RM750.84 million (USD233.8 million) for development expenditure. For 2011, an amount of RM198,336 million (USD61,574 million) is allocated to undertake programmes and projects under the LIH NKRA, with RM84.436 million (USD26.2 million) for operating expenditure and RM113.3 million (USD35.2 million) for development expenditure.

Achievements and successes of poverty eradication programme under the LIH NKRA

1.9 The following were some of major wins of NKRA LIH in 2010:

a. The goal to reduce 44,643 extreme poor households to zero per cent by the end of 2010 was achieved. The Government is confident of sustaining the zero extreme poverty figure via the 1AZAM programme.

b. 15,868 or 34% of 46,000 poor households were removed from the poor category.

c. 2,000 women were trained and developed as entrepreneurs. 580 women have successfully become entrepreneurs.

d. 35,095 (80%) units of the Projek Perumahan Rakyat and Perumahan Awam (housing project for the poor) under the Kuala Lumpur City Hall offered for sale to current tenants;

eKasih Database of the poor and vulnerable

1.10 A centralised and integrated data base, known as e-Kasih, was designed as database of poor and vulnerable groups and individuals. This database was developed in 2008 and will be eventually designated as the sole database for the low income households that will contain centralised information on the actual and potential recipients of government's social safety net programmes. It serves as follows:

a. Integrate data on household profile and also programme participation;

b. Provide base for planning poverty eradication programmes;

c. Identify qualifying criteria for programmes; and

d. Assist in monitoring and evaluation.

1.11 1AZAM initiative was offered to extreme and poor households registered in the eKasih database. This close monitoring of registered households was a key element in ensuring the implementation of LIH NKRA proceeded smoothly. All households registered in the eKasih database underwent verification by the Implementation Coordination Unit of the Prime Minister's Department.

The National Delivery Task Force

1.12 To ensure the poverty reduction programme is implemented in a holistic manner, a coordinating mechanism known as Delivery Task Force (DTF) was established under the Chairmanship of the Deputy Prime Minister. The DTF comprises representative of various ministries and agencies, including the Ministry of Rural and Regional Development, Ministry of Federal Territories and Urban Wellbeing, the Ministry of Agriculture, Ministry of Human Resources, the State Government of Sabah, the State Government of Sarawak as well as the Amanah Ikhtiar Malaysia.

1.13 Preceding the DTF meeting, a Pre-Delivery Task Force Meeting chaired by the Secretary General of the Ministry of Women, Family and Community Development is held. The main objective of the meeting is to discuss the progress made by the relevant ministries and agencies as champions of LIH NKRA initiatives. Policies relating to poverty eradication and outcome of the programmes will also be discussed at length in the meeting. The Pre-DTF meeting also serves as an avenue for problem solving in implementing LIH NKRA.

Social Protection Scheme

1.14 Various social protection schemes are provided to the poor who include social safety net, social insurance and housing. Through the social safety net, welfare assistance is provided to the needy and poor. This includes monthly financial assistance to older persons, to the children, to persons with disabilities who are unable to work and incentive allowance for disabled workers. These schemes are under the DSW. For 2010, RM1.2 billion (USD0.37 billion) was spent for welfare assistance.

1.15 In 2010, the Government offered to sell 35,095 Kuala Lumpur City Hall low cost units to current tenants at a price of between RM21,500 (USD6,674) to RM35,000 (USD10,866) per unit – up to 75% less than the market value.

Health Issues in Poverty Agenda and Poverty Issues In Health Agenda

1.16 The poverty reduction approaches placed a strong emphasis on rural socio-economic development addressing the social determinants of health. This approach has served Malaysia well over the decades but since the 1990s Malaysia has been caught in a middle income trap. Realising that achieving a high income nation status by 2020 is not possible at the present economic trajectory, Malaysia has now embarked on a national transformation agenda based on the four pillars of inculcating the cultural and societal values under the 1Malaysia Concept and the twin commitments of *people first* in all policies & projects and *performance now*; a government transformation programme (GTP); macroeconomic policies under the economic transformation programme (ETP); and the operationalisation of these policies through the 10th Malaysia Plan.

1.17 The highest political commitment is given to the implementation of these national policies by the various agencies, orchestrated and coordinated by a central planning process which cascades down to the state and district administrative levels of the government machinery. The health policies follow these national policies and the thrust of the Malaysian health care system is primary health care, supported by an inclusive referral system to decentralized secondary care and regionalized tertiary care. This model of comprehensive public primary health care delivers promotion, preventive, curative and rehabilitative care across the life course.

1.18 The government transformation programme, with its focus on a whole-of-government approach, is a natural progression for the primary health care approach to addressing the social determinants of health as a vehicle for social justice to reduce health inequalities.

1.19 In view of this, the formulation of health policies in the country has always been aligned and supportive towards the national policies especially with regard to social.

SECTION 2

CURRENT SITUATION ON HUMAN RESOURCE DEVELOPMENT IN HEALTH AND WELFARE SERVICES

Background Information of Malaysia

General information

2.1 Malaysia is an upper-middle income South-East Asian country, comprising 11 states in Peninsular Malaysia, Sabah and Sarawak. Peninsular Malaysia accounts for almost 79.9 per cent of the population, Sabah 1.3 per cent and Sarawak 8.8 per cent. Malaysia is a country of diversity given its multi-ethnic,

multi-cultural and multi-linguistic population. The population comprises of Malays (49%), Chinese (23%), Indians (7%), other Bumiputera (11%), and others, including non-citizens (10%). More than two thirds of the population lives in urban conurbations, with urbanisation by state ranging from 35 per cent to 90 per cent.

2.2 Malaysia's Gross National Income (GNI) per capita was USD4,163 in 2003. It had increased to USD5,008 in 2005 and USD8,256 in 2010.

2.3 The proportion of households living below the food poverty line income (extreme poor) had decreased from 3.7 per cent in 1990 to 0.80 per cent in 2009. The Government had achieved the goal to reduce extreme poor households to zero per cent at the end of 2010.

2.4 The literacy rate for the 15 years and above increased from 88.7% in 2000 to 93.1% in 2010. The primary school enrolment for the year 2010 is 94.2 per cent and lower and upper secondary school is 86.8 and 77.2 per cent respectively.

Important Figures and Statistics

2.5 The rate of natural increase of population of Malaysia was 14.9 per cent in 2003, decreased to 13.9 percent in 2005.

2.6 The total population of Malaysia in the year 2000 was 23.3 million as compared to 28.33 million in 2010. This gives an average annual population growth of 2.0 per cent for the period. However, 91.8 per cent of the total population are citizens of Malaysia, whereas, the remaining 8.2 per cent are non-citizens.

2.7 The proportion of the population of Malaysia below the age of 15 decreased to 27.6 per cent (2010) compared to 33.3 per cent in the year 2000. In contrast, the proportion of working age population, aged 15 to 64 years, increased to 67.3 per cent from 62.8 during the same period. Similarly, the proportion of population aged 65 years and over has recorded an increase, that is, 5.1 per cent as compared to 3.9 per cent in the year 2000. Consequently, the median age increased from 23.6 years in the 2000 to 26.2 years in 2010, while dependency ratio dropped from 59.2 per cent to 48.5 per cent during the same period. The trend of these indicators reflects the transition of age structure towards an ageing population in the country.

2.8 The crude birth rate reduced from 22.6 per thousand populations in the year 2000 to 18.8 in 2010. Meanwhile the crude death rate recorded 4.9 per thousand in 2010. The infant mortality rate has declined from 6.3 per 1,000 live births (2000) to 6.3 in the year 2010. In general, life expectancy at birth has increased over the years. In 2010, life expectancy for women and men is 76.6 years and 71.7 years respectively as compared to 75 years and 70.2 years respectively in 2000. The successive improvement in these vital statistics are evident of an increasingly health conscious society and a commitment to a better health care by the government of Malaysia.

Labour force population by industry and age

2.9 The total labour force age in Malaysia recorded an increase of 8.69 per cent compared to the total in the year 2003. The total population of working age is 18.37 million, which is 64.84 per cent. However, out of this total, the total labour force in the country for the year 2010 is 11.52 million compared to the total of 10.24 million in the year 2003.

Health and Welfare Services

2.10 In Malaysia's public sector, health and welfare services are provided by two different ministries. Hence, the information on health and welfare services is reported separately.

Welfare Services

2.11 Welfare services in Malaysia are provided by the Department of Social Welfare (DSW). The DSW has undergone several structural changes since its establishment in 1946. Currently the DSW is under the Ministry of Women, Family and Community Development. The main target groups of the DSW are the needy and the vulnerable namely, poor families, persons with disabilities, older persons, high risk children and victims of disaster. Due to current challenges and the increased awareness of human rights, the welfare services in Malaysia has transformed from merely welfare-based approach to rights-based approach. Welfare services are delivered to target groups through its 15 offices at the state level and 104 offices at the district level, apart from the head office.

2.12 The DSW is headed by a Director General and assisted by two Deputy Director General. There are 10 divisions under the DSW namely, Planning and Development, Coordination of International Affairs, Legal and Advocacy, Counseling and Psychology, Administration and Management, Children, Community Services Order, Older Persons and Family, Community Development, Socio-Economy and Assistance, and a department of Persons With Disabilities. Each division is headed by a director.

2.13 The DSW offers welfare services to the target groups via its five core thrusts i.e. prevention, protection, rehabilitation, development and integration. Recognising that welfare services cover a wide range of target groups and the capacity of the officers is limited, the DSW works in close collaboration with other relevant government agencies, NGOs and community-based organisations in meeting the needs of the target groups particularly the vulnerable groups such as the bed-ridden persons, the older persons and the children.

2.14 Today, the DSW is the biggest arm of the Ministry of Women, Family and Community Development which is responsible for 63 welfare institutions and has an allocation of RM1.4 billion per year with 500,000 clients.

Regulations and Policy Related to Human Resource Development

2.15 Generally, the social welfare officers discharge their responsibilities in accordance with the provision of various legislation namely, the Destitute Persons Act 1977, Child Care Centre Act 1984, Care Centers Act 1993, Domestic Violence Act 1994, Child Act 2001 and Persons With Disabilities Act 2008. These Acts requires certain competency and professional level of the officers. In addition, the welfare officers need to enhance their capacity in order to achieve the goal of the National Social Welfare Policy, 1990 to promote social stability, harmony, self-reliance and equal opportunities of the target groups. The policy also calls for the strengthening and enhancing of the family unit and social cohesion, and fostering a caring society.

2.16 As such, social workers of the DSW need to enhance their competency to enable them to assess psycho-social needs of individuals, families and communities, and deliver services in response to those needs. This is to ensure officers involved in social work have appropriate knowledge, values and skills, as well as ensuring efficient and effective welfare services delivery.

2.17 As government officers, social welfare officers are also required to undergo training for at least seven days in one year as stipulated in the service circular issued by the Public Service Department.

Information on each professional and workers

2.18 Currently, there are 6,527 personnel employed by the DSW comprising various categories/schemes as below:

Table 1: Personnel Employed by DSW according to Category

Category	No. of Personnel	Remarks
Social Welfare Officer (Degree holders)	635	75% are having social work or human science related qualification. Others are from various background such as finance, management, IT and so forth.
Assistant Social Welfare Officer (Diploma holders)	4,327	65% are having social work or human sciences related qualification. Others are trained in other fields of study.

Category	No. of Personnel	Remarks
Support Staff (Certificate holders)	1,565	

2.19 As shown in the Table above, only officers with degree and diploma are directly involved with the clients. Whereas the support staff are merely providing support services in terms of management such as clerks, drivers, attendants and guards. It shows that from 6,527 staff, only 4,962 are involved directly and doing a case work for the clients. In general, the average ratio of social workers against welfare clients in Malaysia is 1:101. This is very far below the ideal ratio which is 1: 35 in social work (Australia). However, the ratio of social workers against the population ratio should not be emphasised because not the whole population are getting the services of the DSW.

2.20 With regard to qualification, between 1954 and 1975, welfare officers received their professional training from the University of Malaya in Singapore and later the University of Singapore. Officers were also sent to pursue their study in Masters Degree at the University of Swansea and the University of Cardiff in the United Kingdom. Now, most of the officers obtain their degree from the Science University of Malaysia which offers degree programme in professional social work.

2.21 To enhance the capacity and competency of its officers, the DSW conducted Training Need Analysis (TNA) since 2008. This is to ensure all social work officers are provided with appropriate trainings and skills in social work including the aspect of protection, rehabilitation and integration of children, handling the inmates of welfare institutions as well as the aspect of psycho-social of victims of violence. A technical working group was set up under the TNA program and the technical group has identified 92 trainings/courses (10 generic / 82 functional) throughout the year which is required and suitable for the development of professional social workers under the DSW.

The Training Institution

2.22 The DSW is working in collaboration with the Institute Social of Malaysia (the training institution of the Ministry of Women, Family and Community Development) to conduct trainings of social workers under the DSW. The ISM is a social training hub for civil servants other social practitioners. Apart from providing trainings, the ISM institute is also acts as a resource centre for new ideas and information in the field of social policy and social development. It is navigating itself to be a centre of excellence for training and research in social arena.

2.23 In 2010, 3,128 social workers had undergone training/courses conducted by the ISM in various specialisation of social work such as Social Work Course for Welfare Officers and Assistant Welfare Officers, Professionally Accountable

Practice Model for Social Workers, Early Child Care, Investigation and Prosecution Course for Child Care Centre, Managment of Domestic Violence, Productive Welfare and Capacity Building for Clients.

2.24 Apart from undergo the trainings and courses conducted within the DSW/ISM, officers are encouraged to pursue their specialised study in various fields of social work. From the period of 1994 until 2011, 48 officers had been offered to undergo specialised training at Masters and PhD levels. Currently, six welfare officers are pursuing their studies at local universities as well as abroad.

The Way Forward

2.25 Efforts are being undertaken by the DSW towards improving its services and professionalism. Towards this end, the Department has taken the initiative to establish national competency standards for social work practice and education. The implementation of the standards will set the competency benchmark for social work. The establishment of such standards would also provide the frame of reference for social work services in the country.

2.26 It also complements the efforts of the Government to set minimum standards for social work education and training through the development of a common curriculum for all schools of social work in Malaysia. All social work programmes are required to be professionally accredited and this would enhance the quality of social work services. In addition, a Social Work Act is being drafted to regulate and register social workers or practitioners in order to ensure quality social work.

Health Sector

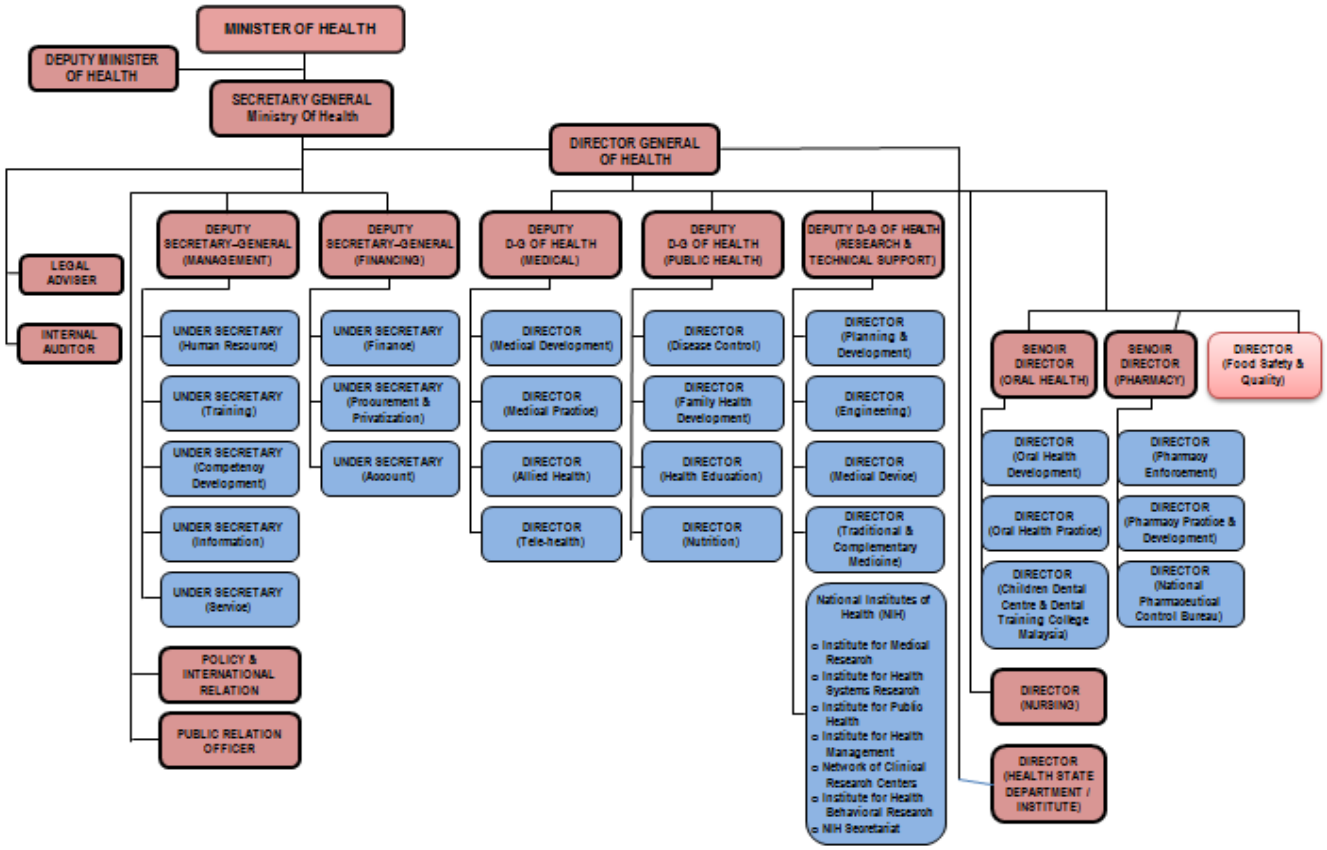
The Ministry of Health

2.27 The Ministry of Health (MOH) is responsible for health care governance in the country and is also the main public delivery agency. Public sector health services are organized under a civil service structure with services centrally administered by the Ministry of Health through its offices at central, state and district-level. Within the country, the health sector interacts with other sectors, such as agriculture, education, industry, trade and the environment, as well as NGOs. Examples include surveillance and control systems for communicable diseases, tobacco control programs, the school dental program, and adolescent health services. There is little coordination so far, however, between public and private sector health services.

2.28 The MOH offers universal health care through a comprehensive range of services across health promotion, disease prevention, curative and rehabilitative care. These services are delivered through community clinics, larger health clinics, district general hospitals, larger hospitals that include specialist care, state hospitals and national referral centres. Special institutions also provide long-term care for mental health, leprosy and respiratory patients. In the remote

areas some services are provided by mobile health teams and 'flying doctor' services. In addition, several other government ministries provide health-related services, such as teaching hospitals under the Ministry of Education, as well as health services for specific populations.

Figure 1: Organisation Chart of Ministry of Health, Malaysia



Rehabilitation services

2.29 Disability prevention and rehabilitation services in primary care include prevention of disabilities, early detection of disabilities, and confirmation of disability for registration with Department of Social Welfare, treatment and referral and habilitation and rehabilitation services.

2.30 Basic rehabilitation services are provided in 242 MOH health clinics by trained nurses and supervised by therapist. Examples of health clinic activities include assistance with sight and hearing disabilities, screening for autism,

counseling for sexual and reproductive health, and training multidisciplinary teams on the management of children with special needs.

2.31 Health personnel from larger MOH health clinics do regular sessions at the smaller clinics. Staff also do home visits to advise parents and caregivers on health care, nutrition and rehabilitation. In 2010, 1,925 new cases of children with disabilities aged 0-18 years were registered for MOH rehabilitation services, which is low compared to the 1996 population estimation of 210,000. A total of 29,614 children were on follow up at the health clinics with 53,266 attendances for rehabilitation services. Persons of all ages with a disability are under-registered; for example, in 1996 less that 10% of the estimated disability population was registered with the Department of Social Welfare. In 2009, the states were asked to expand their disability data collection to cover all public and private hospitals with pediatrics clinics.

Older Persons Care

2.32 MOH clinics deliver health care services for the older persons including health promotion and education, health screening, treatment, counseling, physical fitness activities and recreational, social and welfare activities. Although nearly 77% (629) of MOH health clinics offer health care for the older persons, only half (324) offer rehabilitation services. The National Health Council chaired by the Minister of Health promotes an inter-sectoral approach as do the district and clinic-level committees that plan and coordinate activities for the older persons. As the older population is projected to increase, government policies aim to encourage healthy older people to assist the less healthy through community and outreach work (such as through the 193 Clubs in 2010 for Older Persons '*Kelab Warga Emas*' based in MOH clinics). The MOH aims to increase the number of NGOs with an interest in older persons care, and to better link health policy and social policy.

2.33 The Department of Social Welfare, under the Ministry of Women, Family and Community Development, runs institutions for the poor. These institutions also provide long term care for the older persons and for mental patients who have no family support. The nearby hospitals and clinics provide outreach medical services to these institutions. NGOs also run some long term care homes supported by government grants and community donations. Private nursing homes are mandated by law to be registered under the Private Health Care Facilities Act. There are only a small number of registered private nursing homes (12 homes with 263 places in 2010) but there may also be some small unregistered homes. Private nursing homes mainly cater for older person's people and their families who are able to pay.

2.34 Community services for family carers of members with special needs and the older persons are not well developed. Some MOH health clinics have begun to offer training programs. Carers generally must manage alone or call on family and community support.

Community Participation

2.35 Malaysia has an active civil society or non-governmental organisations (NGOs). Major NGOs include the Red Crescent Society and St. John's Ambulance that provide mainly emergency ambulatory and relief services; the Lion's Club contributes to rehabilitative services; the Family Planning Association and others provide reproductive health services. Other NGOs cater for people with special needs, such as Down's syndrome, cancer, autism, and thalassaemia. NGOs also run community-based psychosocial and rehabilitation centres, halfway homes for victims of domestic violence, and cancer respite and hospice care. The large and fast-growing private health sector provides mainly curative and diagnostic health services in urban areas.

2.36 Community development initiatives earlier were confined to inviting people to participate in activities largely controlled by the health services, but since the 1980s the MOH has involved more community groups in promoting population health. Community participation is promoted especially in areas where access to health services is difficult. The origins of these groups lie in age-old community traditions of mutual support and cooperation. These include women's groups, youth groups, social clubs, cooperative societies, mutual aid societies and sporting clubs. Such community leaders are appointed as members of health centre advisory panels and hospital boards of visitors. As well as enlisting community members in managing health services, the MOH emphasizes community participation in the control of communicable and non-communicable diseases as well as community involvement in care for the older persons and persons with special needs.

Registration and Planning of Human Resource

2.37 Legislation, such as the *Medical Act 1971*, requires health professionals to be registered with respective professional bodies. These statutory bodies maintain a register, set standards and enforce codes of conduct. Some boards require professionals to fulfil a period of internship/apprenticeship prior to full registration. In order to practice, all health care professionals must have a current and valid practicing certificate or certificate of registration. Each profession issues codes of professional conduct and ethical guidelines.

2.38 In planning for human resources, the Ministry of Health sets up technical working groups to advise on future numbers and mix of health personnel (see section 4.2 Human resources). The country has insufficient numbers of trained health care personnel as most occupational categories are well below the desired ratio for the population set by the MOH. For example, the doctor: population ratio of 1 to 859 in 2010 is below the target of one doctor for every 600 persons.

2.39 The overall target for allied health professionals is 1:10,000 although there are considerable differences across categories. The number of allied health

personnel and their population ratios improved slightly between 2006 and 2010 for all occupational categories.

Table 2: Allied health personnel and population ratio, 2006 & 2010

Category	Ratio to population	
	2006	**2010**
Assistant Medical Officer	1:3,451	1:2,738
Assistant Environmental Health Officer	1:11,684	1:8,725
Physiotherapist	1:90,000	1:34,696
Occupational therapist	1:56,802	1:43,143
Nurses	1:559	1:314

Source: Health Facts, Ministry of Health, 2010.

2.40 The health care workforce is increasingly specialized. Registered nurses are the biggest group of professionals (over 54,000) in the public and private health sectors. Including community and dental nurses, the total number of nurses, at over 75,000, is triple the number of doctors. Nurses are also the largest group in primary health care. Doctors (family medicine specialists and medical and health officers) in primary health care number about 5% of public sector doctors, since most of the doctors work in hospitals.

Basic training

2.41 Paramedical and auxiliary training colleges are run mainly by the Ministry of Health and are located in public hospitals. In 2008, 35 MOH training schools provided basic, post basic (57 courses) and in-service training. Several private hospitals and university hospitals also conduct courses based on a MOH syllabus and approved by respective professional boards. The following training was conducted in 2010 by the MOH or in MOH approved programs:

2.42 Diploma programs (three years) including for registered nurses, assistant medical officers, assistant pharmacy officers, medical laboratory technologists, physiotherapists, dental nurses, dental technologists, occupational therapist, assistant environmental health officer and radiographer (a total of 23,000 trainees in MOH programs and 1,333 in outsourced programs).

2.43 Certificate programs (6 -12 months or more) for post basic training for nurses and medical assistants (2,564 trainees).

2.44 There is also a two-year MOH certificate program for dental surgery assistants (DSA), community nurses and public health assistants.

2.45 **Nurses** are the largest group of trainees followed by community nurses. Nurses graduate from a three-year diploma or a four-year degree program, with more nurses now opting for a degree given its better career prospects. The nursing diploma is offered by 16 colleges under the Ministry of Health and by over 50 private nursing colleges. All the colleges are accredited by the Ministry of Higher Education and approved by the Nursing Board. Nurses can also undertake post-basic training in particular disciplines and can train to undertake specific procedures.

2.46 Community nurses undertake a two-year certificate course. Historically, this category of nurses has been upgraded from midwives trained mainly in maternal and child health, to handle treatment of minor ailments and procedures. Midwives and assistant nurses are slowly being phased out through re-training subject to meeting entry requirements for community nurse or nurse courses.

Table 3: Intake for basic training, 2006 – 2010

No.	Discipline	2006	2010	
			KKM	Outsourced
1	Nurse	2199	2,878	696
2	Community Nurse	1323	1,434	nil
3	Assistant Medical Officers	613	827	64
4	Physiotherapist	59	131	31
5	Occupational Therapist	60	137	nil

Source: Ministry of Health, 2010

2.47 **Assistant Medical Officers (AMOs)** are similar to physician assistants or nurse practitioners in other countries. They undertake a three-year diploma course with an intake of 891 in 2010 in five training colleges under the Ministry of Health and in two private colleges. To practice, AMOs must register with the Medical Assistant Board under the *Medical Assistants (Registration) Act 1977*. They differ from nurses in that they can diagnose and initiate care plans for minor ailments. Their scope of training includes basic diagnostic and curative skills enabling them to assist the doctors, initiate care plans for acute minor ailments and emergency care, as well as carry out simple procedures, for example, sutures. In the rural areas, where there are no resident doctors, the AMO is

crucial in providing basic primary care for the population. In hospitals and urban clinics their role is more to assist doctors by triaging cases and by carrying out basic technical procedures. AMOs can under-take post-basic training in disciplines such as orthopedics and emergency services, as diabetes educators, and to carry out specific technical procedures, such as haemodialysis.

Post-basic and Specialty training

2.48 Specialty and post-basic training is conducted by universities, allied health colleges and the Public Health Institute. Most specialties have increased their requirements for post-basic training,. Doctors and dentists who have finished postgraduate studies in recognised specialties go through a period of supervision before they are gazetted as specialists. The quota of doctors and dentists undertaking masters and additional specialty training in local and overseas institutions has been increased from 400 to 600 per year.

2.49 The Ministry of Health was allocated RM300 million (USD87.6 million) under the Ninth Malaysia Plan (2006 - 2010) for in-service training, locally and abroad, for all categories of health personnel. Given increasing requirements for additional specialty training, the number of MOH personnel undergoing specialist training at PhD and Masters level is expected to increase from 2800 in 2008 to over 3400 in 2015.

2.50 Currently, there are 13 Geriatricians in the country distributed among the MOH (5) hospitals, the university (4) hospitals and private practice (4). There are eight psychogeriatricians, with 3 in the universities and the remainder in MOH hospitals. There are four Family Medicine Specialists who have gone for further studies in Community Geriatrics and five Medical officers with further studies in gerontology (2 MOH, 3 universities).

2.51 On-the-job and in-house training in older persons care is done by the MOH and as of December 2010, about 22,000 health personnel had been trained in healthcare of the older persons and almost 19,000 carers (health personnel, volunteers, public) had been trained in care of the older persons.

2.52 A selected few MOH professionals (doctors, family medicine specialists) and allied health staff (nurses, assistant medical officers, occupational therapists, physiotherapists) are also sent for overseas training in the field of medical gerontology (5), community geriatrics (14), short courses in gerontology (8), older persons care (1) and community participation in older persons care (2) in Australia, UK, Japan, Malta, Hong Kong and Singapore.

2.53 In rehabilitation care, a total of 2,000 health personnel and almost 300 carers have been trained.

Continuous Professional Development

2.54 Malaysia promotes continuous professional development (CPD) in order to ensure that the knowledge and skills of its health care workforce are up-to-

date. Maintaining competence to practice is mandatory for MOH staff but remains voluntary in the private sector. Many professional boards, however, require evidence of continuing professional development for professional registration. Doctors, pharmacists, dentists and allied health personnel must attain a certain number of credit points each year through CPD programs. These include post-graduate and post-basic courses, attachment training, teaching rounds and other professional activities. Professional boards issue an Annual Practicing Certificate (APC) based on evidence of participation in a CPD program. A website for online monitoring of CPD activities, called myCPD, was introduced in 2007, initially for MOH doctors, dentists and pharmacists. The MOH is in the process of integrating CPD with the Malaysian Civil Service 'competency level assessment' that evaluates personnel on core and some generic competencies. The MOH proposes to create more CPD training and mentoring programs as well as the following initiatives:

a. Design a Competency Development Framework;

b. Provide CPD programs at all levels;

c. Enhance the leadership capability of health care providers;

d. Develop a competencies dictionary and training roadmap;

e. Accredit post-basic training courses (with the Malaysian Quality Agency);

f. Design a credentialing and privileging mechanism;

g. Collaborate more with private medical colleges; and

h. Increase the capacity of MOH training colleges.

Future Plans

2.55 Malaysia has fewer health professionals for its population than some other countries in the region. Shortages of health professionals create serious shortcomings in public sector service delivery. The Ministry of Health expects shortages of medical specialists to continue through to 2020.

2.56 In response to the shortages of health professionals the Government has increased training places in public and private education institutions since 2004. For example, the number of nursing graduates and medical graduates nearly doubled between 2006 and 2009. Most MOH health clinics and hospitals now offer clinical training experience.

2.57 Medical schools have put more emphasis on community medicine since 1993 as Family Medicine doctors expand the capacity of primary care as they undertake a larger range of treatment including managing high-risk antenatal cases, follow-up on neonatal jaundice, complicated paediatric cases, management of chronic disease cases, older persons care and rehabilitative care but there are still relatively few Family Medicine specialists in the country.

2.58 Post-basic and postgraduate specialist training also has been increased. For example, the medical officer annual intake into postgraduate training places rose from 400-450 to 600-650 in 2010. In 2008, 24% of 2545 specialists completed subspecialty training although still below the 9MP target of 25%, and more scholarships are needed for postgraduate training in local and overseas universities.

2.59 In addition to increasing training places, other strategies to expand the supply of health professionals in the public sector have had only a minor impact including recruiting foreign doctors and nurses, re-employing retired professionals, and offering better working conditions.

Employment Sector

2.60 Significant efforts by the government have been exerted towards promoting employment for the vulnerable group especially the persons with disabilities and the older persons,

Related Policies and Regulations to promote employability for vulnerable social groups, especially the older persons and persons with disabilities.

Part Time Employment Regulations

2.61 The regulations took effect on the 1 October 2010. According to the regulations, part time employees are defined as persons who work more than 30 to 70 per cent of normal working hours. For instance, if a normal full time working hour is 8 hours a day, the working hours of a part time worker is between 2.4 hours and 5.6 hours per day.

2.62 The objective of the regulations is to attract more participation from the local workforce especially from 6.8 million latent workforces such as, housewives, single mothers, students, persons with disabilities and the older persons.

2.63 The enforcement of the regulations gives rights to employees as provided in the terms and conditions of employment i.e. public holidays, annual leave, medical leave, rest days and overtime. Other benefits are EPF (KWSP) and SOCSO.

Persons With Disabilities Act 2008

2.64 The **PWDs Act 2008,** which came into force on 7 July 2008, is an act to provide for the registration, protection, rehabilitation, development and wellbeing of PWDs, the establishment of the National Council for PWDs, and for matters connected therewith.

2.65 Section 29 of the Act stipulates that PWDs shall have the access to employment on equal basis with persons without disabilities.

Code of Practice for the Employment of Persons With Disabilities in the Private Sector

2.66 The code provides an overall procedure for the registration and placement of PWDs. The objectives of the code are:

a. To act as a guideline for employers, employees' association, employees, trade unions of employees, NGOs for PWDs and PWDs to register and to place suitable PWDs in employment in the private sector;

b. To promote awareness amongst employers in the private sector so as to provide employment opportunities for PWDs; and

c. To cultivate the confidence and awareness amongst PWDs so that they will equip themselves with the knowledge, qualifications and skills to compete in the employment sector and together contribute to the development of the country.

Policy on 1% Job Opportunities in Public Sector for Persons With Disabilities

2.67 The implementation of the policy is to gain and upgrade the capability and credibility of PWDs in Malaysia. Through this policy, PWDs who possess academic qualifications as well as skills which suits with jobs offered will be considered for the jobs in public sector. Each and every agency under the public sector is required to ensure that the recruitment of PWDs make at least 1% from the total number of officers in the department/agency. The appointment made based on the PWDs' fulfilment of the requirements, suitability with the jobs and accessibilities provided by the agency.

2.68 The introduction of this circular has brought about some positive results. As of April 2011, 3 out of the 24 Ministries (12.5%) and 7 out of 129 government agencies (5.4%) reported that they have achieve the 1% quota in their respective agencies. To date, there are 1,113 persons with disabilities employed in the public sector.

Business Encouragement Assistance Scheme for Persons With Disabilities

2.69 Business Encouragement Assistance Scheme for Persons with Disabilities is a scheme tailored to assist PWDs to enhance their businesses and employ other PWDs in their business. It was introduced in the year 2007 under The Ninth Malaysian Plan.

2.70 The scheme offers an amount as much as **RM100,000.00** depending on their eligibility and fulfilment of conditions and requirements. The assistance will be given in the form of equipment needed for the enhancement of the business, renovation of business premises and promotion/marketing. The Government has allocated a sum of RM16 million under the Ninth Malaysian Plan (from year 2007

to 2009) for the scheme i.e. whereas, for the Tenth Malaysian Plan, a sum of RM10 million is allocated for this scheme.

Home Working

2.71 Home Working Programme is introduced by Labour Department under the Ministry of Human Resources to assist vulnerable groups such as persons with disabilities (PWDs), single parents, and housewives to gain additional income through job opportunities offered by employers. Home Working refers to jobs offered by employers either directly or indirectly through a third party and the jobs are done in premises other than the employers' work place.

Establishment of the National Wages Consultative Council

2.72 The government has also initiated the establishment of the National Wages Consultative Council which would be responsible to conduct studies on all matters concerning minimum wages and to make recommendations to the Government. This initiative is part of the effort to introduce Minimum Wage Act in the private sectors.

Return To Work Programme

2.73 Return To Work Programme was launched on the 15th of January 2007. It is a rehabilitation program that is offered as one of the benefits of Social Security Organisation (SOCSO) for Insured Persons with injuries and diseases. The objective of the program is to enable the Insured Persons to return to work in a safe and fast manner.

2.74 Under the Program of Return to Work implemented by Social Security Organisation (SOCSO), Ministry of Human Resources, 1,026 persons have returned to work wherein 560 working with same employers and same jobs, 149 working with different employers but similar jobs, 74 working with same employers but different jobs, 18 working different employers but similar jobs, 96 working with different employers and different jobs and 93 are self employed. Appended below are the statistics of Insured Persons under Return to Work Programme:

CATEGORY	**NO. OF PERSON**
Return To Work	1,026
Seeking jobs	286
Under Rehabilitation Programme	172
Acute	434
TOTAL	**1,990**

Source : Social Security Organisation (SOCSO)

CATEGORY	NO. OF PERSON
Same Job Same Employer	560
Same Job Different Employer	149
Different Job Same Employer	74
Same Job Different Employer	36
Similar Job Different Employer	18
Different Job Different Employer	96
Self Employed	93
TOTAL	**1,026**

Source : Social Security Organisation (SOCSO)

PWDs Incentive Allowance

2.75 In addition to the above policies, to the Government through the Department of Social Welfare also give out PWDs Incentive Allowance to encourage person with disabilities to work. Person with disabilities with a monthly income of RM1, 200.00 are given RM300.00 per month. As an incentive and to encourage employers to employ persons with disabilities in the private sector, a double tax exemption is given to employers who trained and employ persons with disabilities.

Employment rate of the vulnerable people, especially the older persons and persons with disabilities

Employment rate for vulnerable people in Malaysia

2.76 According to a study carried out by the Ministry of Human Resource, out of the 232,437 establishments participated in the study, only about 1% to 2% of

them employ latent workforce, consisting, those with disabilities, ex-drug addicts, ex-convicts or ex-civil service pensioners. Even if they do, they are mostly employed in the non-executive job categories. Less than 0.5% of the total employed persons belong to these vulnerable groups.

	No. of establishments	%	Executives			Non-executives		
			Male	Female	Total	Male	Female	Total
Aborigine People	3,104	1.3%	431	286	716	3,098	2,602	5,700
Person With Disabilities	4,151	1.8%	225	103	327	1,799	1,239	3,038
Ex-Drug Addict	2,636	1.1%	17	0	17	168	62	231
Ex-Prisoners	2,651	11%	29	0	29	134	201	336
Public Service Pensioners	5,108	2.2%	1,661	1,009	2,670	5,750	2,189	7,939

Table 4: Employment of Latent Workforce

Source: National Employment Returns 2009 Malaysia

Age Structure

2.77 The reported age structure of the employees shows that the majority of them are in the prime working age group of 25-40 years. This age group constitutes 48% for local employees and 67% for foreign employees. There are about 3% of the local workforce age 58 years and above employed with these establishments.

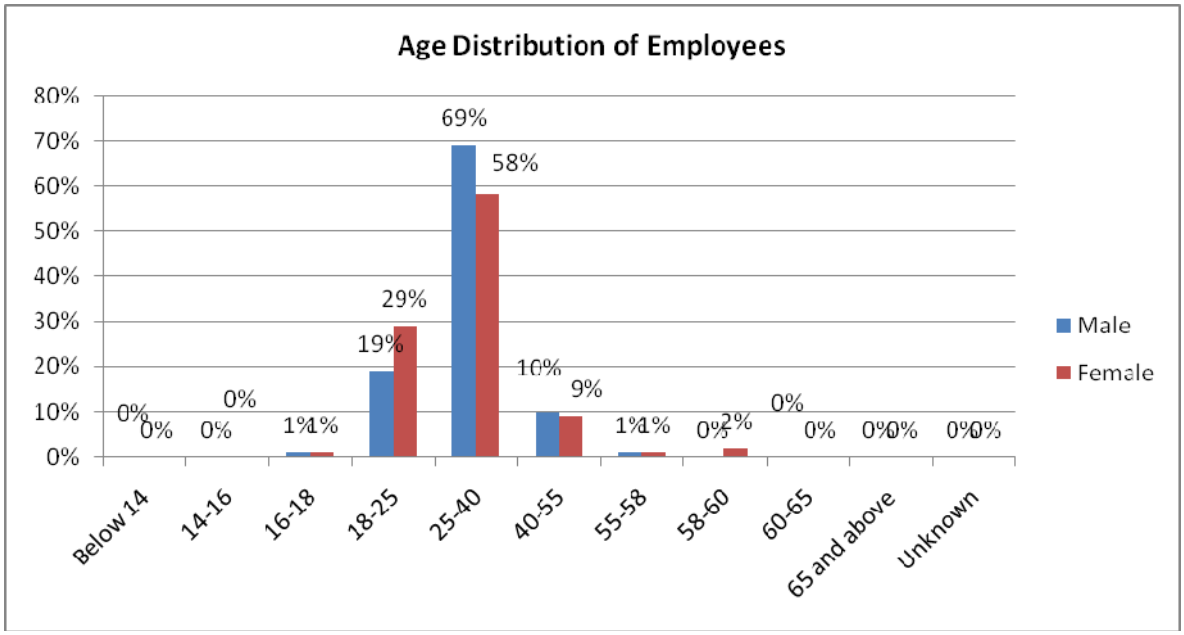


Table 5 : Age Structure of Local Employees by Job Category

Source: National Employment Returns 2009 Malaysia

Situations around and opportunities of the vulnerable social groups, especially the older persons and persons with disabilities i.e. industries, occupations, income, working time per week etc;

Employment of the Older Persons

2.78 Appended below is the table of age structure of local employees by job category:

Job Category	Age Group					Total
	<16	16-25	25-40	40-55	55+	
Managers	0.0	3.0	37.5	44.5	14.9	100.0
Professionals	0.0	12.7	61.6	22.1	3.7	100.0
Technician and Associate Professionals	0.0	14.8	58.7	23.6	2.9	100.0
Clerical Support Workers	0.0	23.2	55.9	18.2	2.6	100.0
Service & Sales Workers	1.0	34.8	41.3	18.5	5.3	100.0

Job Category	Age Group					Total
	<16	16-25	25-40	40-55	55+	
Skilled Agricultural, Forestry & Fishery Workers	0.0	10.8	41.9	38.1	9.1	100.0
Craft & Related Trades Workers	0.0	21.3	52.9	22.3	3.5	100.0
Plant and Machine Operator and Assemblers	0.0	19.5	52.5	24.5	3.5	100.0
Elementary Occupations	0.0	1.87	39.3	34.1	7.8	100.0
Total	**0.0**	**19.8**	**48.2**	**26.1**	**5.8**	**100.0**

Table 6: Age Structure of Local Employees by Job Category

Source: National Employment Returns 2009 Malaysia

2.79 In Malaysia, the entry age for employment is 16 years old and this stretches to up generally 55 years old in the private sector. In this regard, based on Table 3, 5.8% of people who are aged 55 years old and above are employed. Out of the total percentage, 14.9% are managers, 3.7% are professionals, 2.9% are technicians and associate professionals, 2.6% are clerical support workers, 5.3% are sales and service workers, 9.1% are skilled agricultural, forestry and fishery workers, 3.5% are craft and related trades workers, 3.5% are plant and machine operator and assemblers while 7.8% do elementary occupations.

Business Enhancement Opportunities for Person With Disabilities (PWDs)

2.80 The Malaysian government has allocated a total sum of RM19 million since 2007 to assist PWDs in enhancing their business and at the same time employ other PWDs in their businesses. Since it was implemented in year 2007, a total of 621 PWDs have received the assistance under the scheme and a total of 874 PWDs have been employed by the PWD entrepreneurs. The nature of business run by the PWDs entrepreneurs are, sewing, reflexology, provision shop, agriculture, food, manufacturing, textiles, workshop and livestock farm. Through this scheme, most of PWD are able to generate more reliable income and sustain their businesses. Appended below is the table showing the type of industries in which the PWDs are involved:

No.	Type of Industries	Total
1.	Workshop	53
2.	Sewing	68
3.	Livestock Farm	50
4.	Reflexology	73
5.	Provision	107
6.	Service	128
7.	Agriculture	9
8.	Food	93
9.	Manufacturing	34
10.	Textile	6
Total		**621**

Table 7: Type of Industries Involved by PWDs Entrepreneurs

Source: Labour Department Peninsular Malaysia

DETAILS OF PWDS' BUSINESS BY INDUSTRY UNDER BUSINESS ASSISTANCE SCHEME 2007-2011

RACE	TYPE OF DISABILITY	INDUSTRY										
		WORKSHOP	SEWING	LIVESTOCK FARM	REFLEX SOLOGY	PROVISON	SERVICE	AGRICULTURE	FOOD	MANUFACTURING	TEXTILES	TOTAL
MALAY	PHYSICAL	44	52	41	1	62	63	6	67	10	4	270
	VISION		2	6	34	8	13	1	8	9	1	81
	MENTAL		1			1	1					3
	DEAF	4	6	2			8		4	5	1	30
	DWARF		2			1	2	1		1		7
CHINESE	PHYSICAL	3	4		1	10	21		8	6		43
	VISION	1			28	1	1			1		20
	MENTAL											
	DEAF					2	2		2			6
	DWARF											
INDIAN	PHYSICAL		1			7	12	1	3	1		20
	VISION				5	1	2		1			9
	MENTAL					1						1
	DEAF											
	DWARF	1					1					
BUMIPUTRA	PHYSICAL			1		9			1	1		12
	VISION				4	4						8
	MENTAL											
	DEAF											
	DWARF											
SOCIETY	PHYSICAL											
	VISION											
	MENTAL						2					2
	DEAF											
	DWARF											
TOTAL		53	68	50	73	107	128	9	93	34	6	621

Source : Labour Department Peninsular Malaysia

No.	States	No. Of CO's	No. Of Participants					
			PWD	Housewife	Single Mother	Poor Family	Others	Total
1.	Perlis	1		4				4
2.	Kedah	24		306	2	15		323
3.	Pulau Pinang	10	6	15			6	27
4.	Perak	17	15	151	12	2		180
5.	Kuala Lumpur	5	4	6				10
6.	Selangor	27		1143	14	7		1164
7.	Negeri Sembilan	7	3	12	4	5		24

No.	States	No. Of CO's	No. Of Participants					
			PWD	Housewife	Single Mother	Poor Family	Others	Total
8.	Pahang	17		55				55
9.	Melaka	8		294			32	326
10.	Johor	34	21	556	60	11		648
11.	Kelantan	3		160	320			480
12.	Terengganu	24	9	25	29	12	1	76
13.	Labuan							
14.	Sabah							
15.	Sarawak							
Total		**177**	**58**	**2,727**	**441**	**52**	**39**	**3,317**

Table 8: Home Working: Companies and Participants (As at Jun 2011)

Source: Labour Department Peninsular Malaysia

2.81 The above table shows that 177 companies are involved in providing jobs from home. The participation of housewives shows the highest number i.e. 2,727 compared to others. Participation of single mothers records a total of 441, total of 58 PWDs and 52 from the poor family 52.

2.82 Types of works under home working programmes, among others are, sewing of school uniforms, dress, scarves and beads, food manufacturing, handicrafts, packing and fixing of electric components. Each individual in the group can earn as much as RM300.00 to RM500.00 per month or RM10.00 to RM15.00 per day.

Constraints and issues on employment of vulnerable social groups, especially on the older persons and persons with disabilities.

Employers' attitudes

2.83 One of the most significant impediments to hiring vulnerable group is the high payroll costs, especially in the open labour market. Given the high outlays involved, the prevailing view is that PWDs and older persons are inherently less productive, and the perspective (whether justified or not) of frequent absenteeism from work on health grounds. Thus, employers in the general labour market are

reluctant to hire persons with disabilities as their employees. Accordingly, only a few of PWDs and older persons who are currently employed have succeeded in obtaining employment in the open labour market; the remainder works at protected labour entities.

2.84 Some employers tend to perceive PWDs and older persons as inefficient and believe that hiring PWDs and older persons is fraught with inconvenience and risk. The PWDs and older persons believe that employers are convinced that they could not manage to perform the tasks conveyed to them. In addition, employers are afraid that the PWDs and older persons would frequently take time off to seek medical attention.

PWDs' Attitude

2.85 Barriers to employment created by persons with disabilities persons themselves are mostly connected with their labour market inactivity. Some PWDs cite their illness or disability as reasons to their unemployment.

2.86 Some PWDs, particularly those who have only recently become persons with disabilities, prefer to continue in the type of work that they performed before becoming disabled. Plans of persons with disabilities workers to return to the job held before suffering disability are symbolically associated with a desire to reclaim their status and their normal role in society. The reality in the job market, however, is that the offers of employment for PWDs are often associated with more simple, low-skilled work.

Accessibility to transport and buildings

2.87 Accessibility to transport is another challenge that is faced by the PWDs in particular that limits their mobility. Apart from this, accessibility to buildings poses problem to PWDs. This limits their selection of jobs.

2.88 Other impediments to the recruitment of PWDs and the older persons, include:

(i) Fear of losing benefits
(ii) Lack of confidence
(iii) Parents' concerns
(iv) A shortage of work stations adapted to the needs of PWDs/older persons

SECTION 3: CONCLUSION

3.1 Various efforts are being carried out by government through relevant agencies including NGOs to ensure that vulnerable groups is not marginalised or left behind in the efforts of the country moving towards high income nation. The vulnerable group is given every opportunity and assistances to participate in the labour market and economic activities to generate higher income and improve their standard of living. The maximum utilization of the vulnerable groups as part of our human capital development in the open labour market will help in reducing Malaysia's dependency on foreign workers in the country.

3.2 To leverage the diversity in the population, the government introduced the concept of *1Malaysia, People First, Performance Now* in April 2009. *1Malaysia* is based on the concept of fairness to all and stresses that no one group would be left out or marginalised. The Government also believes that in order to achieve the aspiration to become a fully developed nation by the year 2020, every citizen of the country should be given the opportunity to realise their full potentials and unity in diversity is the catalyst.

SECTION 4 CASE STUDY: GOOD PRACTICES ON CAPACITY BUILDING OF SERVICE PROVIDERS IN HEALTH AND WELFARE SECTORS AND EMPLOYABILITY PROMOTION OF THE VULNERABLE PEOPLE.

Overview

4.1 Employment is a big challenge facing persons with disabilities. Many qualified persons with disabilities are unable to find suitable employment. This is due to reluctance of employers to provide them opportunities. Most employers perceive persons with disabilities unable to work, unproductive and unemployable. In instances, where persons with disabilities are employed, the turnover rate is high.

Problem Analysis

4.2 It has been reported that about 60% of persons with disabilities that was successfully placed by the Ministry of Human Resources in various sectors left their job within six month of their placement. Besides lack of accessibility in the work place, majority left the job due to their inability to perform according to their job description, unable to make adjustment to the work environment and unable to meet the high expectations of their employers.

Institutions involved

4.3 Research has shown that person with disabilities have potential to make valuable contribution to the work force and have high retention rate in their employment if they are given the opportunity and appropriate support. Supported employment has been promoted and widely used in develop countries and has

proven to be effective in promoting sustainable employment even with people with severe intellectual/learning disabilities to work in open employment.

4.4 On this premise, in year 2005, the Department of Social Welfare with the support of Japan International Cooperation Agency (JICA) embarked into job coaching as the employment support service. This programme was carried out under the Project for Capacity Building on Social Welfare Services for Persons with Disabilities.

4.5 Job Coaching refers to training and related support given to disabled employees by job coaches to help them learn and perform job tasks as well as interpersonal skills necessary to be accepted as workers and to enable them stay on their employment. In addition, Job Coaches also help employers and other employees in understanding disabilities and the needs of disabled employees.

Strategy and Implementation of Job Coaching

Strategy Pursued

4.6 The initial part of the project (2005 to 2008) was focused on capacity building and raising awareness on supported employment and job coaching. Personnel from both government as well as private sectors were sent to Japan under the sponsorship of JICA to be trained as job coaches.

4.7 As at September 2011, 22 personnel (7 officers from the Department of Social Welfare, 4 from the Social Security Organisation, 4 from the Department of Labour, 6 from various non-governmental organisations and 1 from the private sector namely GCH Retails) were trained. In addition, 90 social welfare officers were also trained locally. JICA also sent experts from Japan to carry out training and awareness programmes on Job Coaching in Malaysia.

Implementation of Job Coaching

4.8 Job coaching was put into practice in year 2007 in GCH Retails which runs Giant hypermarkets, Guardian Pharmacy, Cold Storage supermarkets. The first batch of persons with disabilities recruited consists of 12 persons with learning disabilities who were employed as general workers in Giant Hypermarkets in July 2007. By July 2008, a total of 125 persons with learning disabilities were employed and placed in various Giant Hypermarket and Cold Storage outlets in the Klang Valley.

Impact of Job Coaching

4.9 Job coaches provide support to persons with disabilities during interview and accompany the newly recruited employee during the first week of intensive training by the Human Resource Department. During the training, the job coach explained the task using task analysis and systematic instruction when the disabled employee has difficulty understanding any of the given tasks. Along with the training session, the job coach also accompanies the disabled employee to

provide support during the first day of work. Support was provided until the employee was familiar with his duties. While assisting him, the job coach created natural support by training the supervisor at work on how to provide support to enable the disabled employee to work effectively. Once the disabled employee became familiar with the work, the job coach faded out but constantly kept in touch with the supervisor and the disabled employee through telephone and occasional visits. Three years after the initiation of job coaching, 115 or 92 per cent of the disabled employees remained in the employment with GCH Retails.

4.10 Job coaching in GCH Retails proven to be effective and bear some positive outcome. It has not only created sustainable employment but also broke the barriers of isolating persons with disabilities from participating equally in the open labour market.

Potential for up-scaling and replication

4.11 Job Coaching is seen effective in retaining the persons with disabilities in employment as well providing support to the employers in making necessary adjustments and accommodation in employing the persons with disabilities.

4.12 The Department of Social Welfare plans to further enhance Job Coaching as part of the Employment Support programme for person with disabilities. As part of its long term strategy, the Department of Social Welfare plans to embark on smart partnership with more non-governmental organisations in training more Job Coaches.

4.13 These trained Job Coaches will be mobilised in government agencies throughout the country to assist persons with disabilities who are employed in the government agencies to adapt their working environment. This strategy would in turn assist the government in achieving 1% of persons with disabilities employed in the public sector. The public sector as the biggest employer would be able to take the lead in realising the allocation of 1% job opportunities in public sector. Consequently, the implementation of the policy on 1% job opportunities for persons with disabilities would be extended to the private sector.