# IMPROVING THE CARE LANDSCAPE IN MALAYSIA FOR HEALTHCARE WORKERS AND PEOPLE LIVING WITH NCDs

## Recommendations from a roundtable discussion with high-level stakeholders

NCD MALAYSIA

# TABLE OF CONTENTS




**Editors**

Dr Murallitharan M., Mandy Thoo

**Authors**

Hj. Mustafa bin Abd Majid, Prof. Abdul Halim bin Abdul Gafor, Nur Hidayah Ong bt Abdullah, Dr Zainul Abidin, Datin Mariani Ahmad Nizaruddin, Dato' Hatijah Ayob, Dr Jessie Anne de Bruyne, Dr Edward Chan, Dr Nor Saleha binti Ibrahim Tamin, Dr Noor Haslinda binti Ismail, Dr Khairul Hafidz Alkhair bin Khairul Amin, Prof. Kwa Siew Kim, YB Dr Lee Boon Chye, Samson Lim, Datin Mariani Dr Hilmi Lockman, Dr Raj Kumar Maharajah, Hj Jaafar bin Md Shariff, Pn Nor Shahrina Mohd Zawawi, Dr Nur Nabila binti Nasharuddin, Dr Malina Osman, Dato' Dr Saunthari Somasundaram, Syarifah Madhiyah binti Syed Murthadh, Dr Tee E Siong, Wong Chai Yi, Wong Yan Ke, Dr Woo Mei Yuan, Datin Dr Nazita Yaacob, Dr Hazli Zakaria

# BACKGROUND

Even prior to the pandemic, close to 70% of all premature deaths in Malaysia were linked to non-communicable diseases (NCDs) (1). The burden of NCDs, specifically the morbidity and mortality, is projected to worsen amidst and even long after the Covid-19 pandemic (1,2).

Multiple approaches are continuously adopted to tackle the NCDs problem, including the introduction of national-level strategic plans, and the deployment of trained community health workers (3). However, there has been little success; either in effectively managing those living with the disease, or in preventing the rising incidence of NCDs nationally (4).

Five main factors have been identified to impede the delivery of care across the NCD landscape, especially in low-and-middle-income countries (LMICs) such as Malaysia (5). These are: i) limited universal health coverage; ii) gaps in the implementation of regulations; iii) availability and distribution of healthcare workers; iv) lack of intersectoral partnerships; and v) gaps in availability of data (5).

Simply put, the current health system has been 'configured' for the delivery of care for acute illnesses, and not designed for managing chronic conditions such as NCDs. As a result, the system is unable to provide effective, quality care across the NCD landscape (5,6).

**The healthcare worker: the cornerstone of the health system**

Underpinning any health system is its healthcare workers (HCWs) (9,10). HCWs are the quintessential 'human' component that drives the provision of healthcare across every process; including the education and promotion of risk-reduction efforts for NCDs; the screening and early diagnosis of NCDs; and subsequently the treatment and management of those diagnosed with NCDs (9,10).

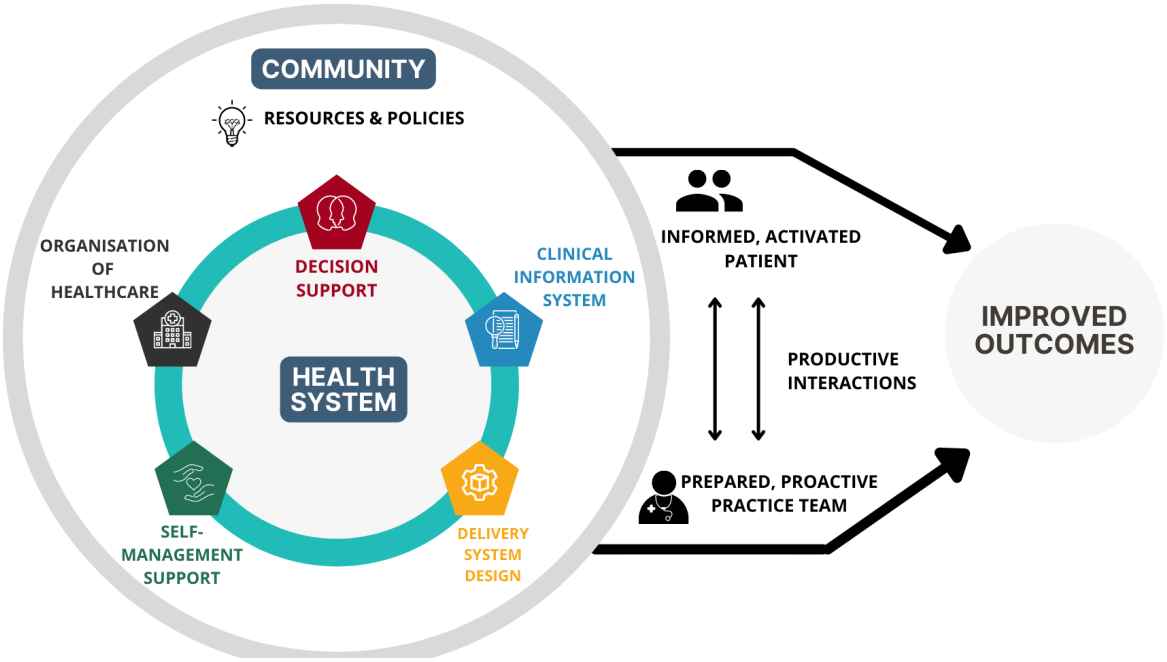
In fact, healthcare workers are the only individuals who 'walk with' the individual living with NCD throughout their entire journey of treatment and care (9,10).

However, HCWs face many challenges that make it difficult for them to provide quality NCD care, including working conditions; staff shortages; a lack of training; and mental health issues (11). As for people living with NCDs, the challenges they face from their HCWs include language barriers; discrimination; and a lack of patient-centred care provision (6, 12,13).

As such, the first area of focus in transforming NCD care must be targeted towards HCWs: to improve their working conditions as well as to equip them with the required skillsets to provide effective and quality NCD care.

## The Chronic Care Model: Possibilities of A Transformative Strategy

To ensure an effective and sustainable delivery of NCD management and care, a holistic transformation in the entire health system, especially in processes of care provision, is required (6). One such validated model to provide care for people living with NCDs is the Chronic Care Model (CCM) (7,8). CCM requires a whole-of-society approach and integrates formal care delivery; the person living with the disease; and the surrounding community network into a framework for the delivery of comprehensive, sustainable, and quality care (7,8).




**Chronic Care Model (7,8)**

## About this consensus statement

NCD Malaysia convened a roundtable discussion of high-level stakeholders within the Malaysia healthcare landscape including public healthcare organisations, private healthcare organisations, the Ministry of Health Malaysia, policymakers, academicians, civil society organisations, and healthcare professional organisations to develop recommendations for improving the NCD care landscape for healthcare workers as well as people living with NCDs. The recommendations aim to provide solutions for some of the challenges faced in Malaysia by:

(i) HCWs in the provision of NCD care; and
(ii) people living with NCDs in obtaining the optimum level of care from their HCWs.

## Data sources for this consensus statement

The data and insights used by the expert panel members or authors to develop the following recommendations were derived from two reports. These reports were studies carried out within the Malaysia NCD care landscape:

i) The Our Struggles, Our Stories: Perspectives of the NCD Care Landscape by People living with NCDs in Malaysia report, of which the 'asks' were encapsulated in the The Malaysia National Advocacy Agenda of people living with NCDs

ii) NCD and the Healthcare Worker: An Introspective Look into the Malaysian Care Landscape for Non-Communicable Diseases report

# Malaysia National Advocacy Agenda of people living with NCDs

The Malaysia Advocacy Agenda encapsulates the challenges and needs of people living with NCDs in Malaysia. It is a part of **Our Views, Our Voices** – a global initiative of the NCD Alliance and people living with NCDs, aiming to promote meaningful involvement of people living with NCDs in the NCD response.

Advocacy Agendas have also been developed in other countries including Vietnam, India, Kenya, Ghana, Rwanda, Mexico, and Tanzania. Similar to the Malaysian chapter, these agendas aim to support people living with NCDs to advocate, play a key role in making decisions about NCD management, and engage in dialogue with policymakers.

The Malaysian Agenda was developed through two phases: focus group discussions (FGDs) involving 108 participants, and a survey involving 501 participants. The qualitative phase (FGDs) was an in-depth exploration of the challenges, as well as an identification of prominent themes. The quantitative phase then sought to validate the findings from the qualitative phase.

Participants of both phases resided in Perlis, Kedah, Penang, Perak, Kelantan, Terengganu, Selangor, Pahang, Negeri Sembilan, Melaka, Johor, Sarawak, and Kuala Lumpur. The represented diseases included arthritis, asthma, cancer, cardiovascular diseases, chronic kidney disease, lung diseases, diabetes mellitus, hypertension, mental health illness, neurodegenerative conditions, and psoriasis.

Four themes emerged from the FGDs: human rights and social justice; treatment, care and support; prevention; and meaningful involvement. From the survey results, the major challenges included accessing early diagnosis; affording treatment; treatment literacy; obtaining education and skills to self-manage their disease(s); affording healthy food; having safe spaces for physical activity; and providing personal care for the person living with NCDs.

A list of 'asks' was developed based on these themes, adapted for: the Government; the Ministry of Health; the people's representatives; HCWs; the private sector; CSOs; and individuals as well as groups of people living with NCDs.

# NCD AND THE HEALTHCARE WORKER REPORT

'NCD and the Healthcare Worker' is a research report on the Malaysian care landscape for Non-Communicable Diseases. The report sought to determine challenges faced by healthcare workers (HCWs), particularly on managing NCDs, in Malaysia.

The three phases of the project included: (i)the pilot phase, involving 10 in-depth interviews with 10 healthcare workers in top-level management of NCDs; (ii) the qualitative phase, involving focus group discussions with 100 HCWs; and (iii) the quantitative phase, involving a survey of 403 HCWs involved in the management of NCDs in Malaysia.

For a wide and varied perspective, the research included top-management and hospital directors, consultants or specialists from public as well as private hospitals; heads of departments of specific tertiary clinical units in public hospital; former state directors of health; executive committee members of leading medical professional organisations as well as patients or disease-based NGOs; and allied healthcare workers.

The areas of NCDs represented included cardiovascular diseases; diabetes; cancer; primary care; respiratory medicine; stroke; and mental health.

Five themes emerged from the consultative processes, all of which were further validated by the survey. These are: the lack of financial or human resources; an increased constrained budget due to the Covid-19 pandemic; the lack of remuneration or opportunity for specialty training in the public health sector; the lack of overall support to encourage innovation; and the inability to carry out patient-centred care.

Based on the themes and through the discussions, ten key recommendations were developed. These recommendations were drawn from examples of successful strategies carried out in other settings and documented in peer-reviewed literature. Implemented well, the solutions aim to help alleviate, reduce, or eliminate some of the issues discovered in this study.

# METHODOLOGY

NCD Malaysia used an ordered series of processes to develop the evidence-based recommendations detailed below.

| No | Process | Description of process |
|---|---|---|
| 1 | Preparation of data sources | Relevant insights and data were compiled from the two primary source documents namely the Our Struggles, Our Stories: Perspectives of the NCD Care Landscape by People living with NCDs in Malaysia report; and the NCD and the Healthcare Worker: An Introspective Look into the Malaysian Care Landscape for Non-Communicable Diseases report<br><br>Other relevant peer-reviewed publications were reviewed extensively on recommendations and guidance within the context of this topic. |
| 2 | Convening of expert panel | A high-level panel was convened with representatives from different healthcare organisations and relevant stakeholders in the Malaysian NCD care landscape including the Ministry of Health, Malaysia. This panel was then presented with the data from both reports.<br><br>Subsequently, the input of the expert panel was obtained in both qualitative and quantitative formats.<br><br>Qualitative input was obtained from a focus group discussion which was used to obtain input from panellists on questions related to:<br>i) challenges faced by people living with NCDs in care and management of NCDs in Malaysia as well as possible solutions; and<br>ii) challenges faced by HCWs in the care and management of NCDs in Malaysia as well as possible solutions<br><br>Quantitative input was obtained from two exercises where panellists were asked to rank on a 10-point scale possible solutions proposed from people living with NCDs (termed as 'asks' from people living with NCDs) and possible solutions proposed from HCWs (termed as 'asks' from people living with NCDs) in terms of:<br>i) priority – defined as how urgently the panellist thought these solutions should be implemented (rated from 1-of least priority to 10- of utmost priority); and<br>ii) viability – defined as how viable the panellist thought these solutions were in terms of being implemented (rated from 1-least viable to 10-extremely viable). |

| No | Process | Description of process |
|---|---|---|
| 3 | Input analysis from expert panel | The input from the panellists was analysed as follows:<br>Quantitative input was computed using a weighting-scoring prioritisation strategy. Both the parameters of priority and viability were weighted at 50%, and panellists had ranked each 'ask' in terms of priority/viability from 1-10.<br><br>The percentage of the panellists who had ranked each ask with a rank of 8-10 (high priority/viability) was calculated. This percentage was multiplied against the weighting of the parameter to provide a score. The total score reflecting priority and viability was obtained by summing up the weighted score of each 'ask'. These total scores were then used to rank each ask from 1-10, reflecting their priority and viability.<br><br>Qualitative input was analysed using a content analysis technique, with the discussions being used to derive relevant themes and concrete recommendations to be utilised. |

Members of the expert panel met over a 4-month period to review the data and evidence, formulate the content and develop the final consensus recommendations.

# RESULTS

From the expert panel input, the following top five prioritised and viable asks from people living with NCDs and HCWs are listed as below:

| No | Top FIVE prioritised and viable 'asks' from people living with NCDs to HCWs | Top FIVE prioritised and viable 'asks' from HCWs |
|---|---|---|
| 1 | To continue being active advocates of effective NCD prevention across all level of society | Strengthen and offer wider training and specialisation pathways for HCWs both in medical and allied health |
| 2 | To create and promote educational strategies that can better equip HCWs on improving treatment for people living with NCDs | Strengthen continuous professional development and training frameworks for HCWs |
| 3 | To strengthen referral systems across the different levels of care, and to better integrate access to nonclinical services (such as social protections) for people living with NCDs | Widen and strengthen public-private partnerships in the public and private hospital sector |
| 4 | To engage with people living with NCDs individually in a meaningful manner when determining their own care | Incentivise the performance of HCWs |
| 5 | To better integrate care delivery to provide multidisciplinary, integrated care for people living with NCDs | Create specialist non-administrative positions and career pathways for non-administrative specialist HCWs |

# RECOMMENDATIONS

Based on the top five prioritised and viable 'asks' from people living with NCDs to healthcare workers; as well as the top five prioritised and viable 'asks' from healthcare workers, the following consensus recommendations are made for the healthcare workforce. Each recommendation is followed by an example of a Community in Practice.

| **Recommendation 1: Transformation of Continuous Professional Development (CPD) programmes for HCWs** | **Community of Practice for the transformation of Continuous Professional Development (CPD) programmes for HCWs** |
|---|---|
| • Specific Continuous Professional Development (CPD) programmes need to be systematically developed and instituted in a comprehensive manner for all healthcare workers.<br><br>• The contents of these programmes need to be structured and specifically catered to the individual healthcare profession and skillset.<br><br>• To ensure uniformity and standardisation, healthcare professionals' associations or gazetted supervisory bodies should be involved in the standardisation, deployment, and monitoring of these annual programmes- and over the long run, ensure that this is tied to annual fitness to practice or licensing of individual healthcare workers (if not already in place). | An example of this is the Continuous Professional Development (CPD) points for Medical Specialists on the National Specialist Register (NSR). Each specific speciality has a number of specialty-related or field-of-practice (FOP) CPD activities; which are available in addition to the general CPD activities that need to be fulfilled in order to renew their Annual Practising Certificate (APC). More details on this can be found at: https://www.nsr.org.my/home.html and https://nsr.org.my/FAQ_CPD.html |

**Recommendation 2: Development and incorporation of skillsets relevant to needs of people living with NCDs within undergraduate, postgraduate and CPD programmes of HCWs**

- Specific modules need to be developed in order to equip HCWs with skillsets and information relevant to the needs of people living with NCDs.

- Contents of these modules need to include: i) patient-centred care practices; ii) patient education practices; iii) shared-decision making processes; iv) patient ethics and communication; v) patient advocacy; and vi) non-clinical resources and assistance available for people living with NCDs.

- These modules should be specific for the educational level of the HCW and also specifically catered to the different type of HCWs.

- Modules should be integrated into existing undergraduate or postgraduate programmes as a part of formal education as well as being continuously available within ongoing CPD programmes.

**Recommendation 2 (continued):**

- New HCWs coming into an institution or into the field altogether such as new 'house-officers' should be required to compulsorily complete these modules as part of their orientation process.

- Practising HCWs should be required to undergo 'refresher' programmes pertaining to these skillsets/knowledge on a regular basis.

**Community of Practice for the development and incorporation of skillsets relevant to needs of people living with NCDs within undergraduate, postgraduate, and CPD programmes of HCWs**

An example of this is the E-Pembelajaran Sektor Awam portal for all civil servants which contains specific modules on a variety of topics. This can also be used to assign and track HCWs in the public sector in terms of signing up and completion of specific modules which may provide them with the skillsets and information relevant to the needs of people living with NCDs. More details on this can be found at: https://www.epsa.gov.my/?language=en

**Recommendation 3: Restructure career pathways for all HCWs working in the NCD care landscape to embrace the multi-disciplinary, multi-faceted approach required for care provision**

- Many HCWs with the 'specialist' skillsets required for managing NCDs need to be provided with career progression pathways that continue to retain their services within the care landscape.

- HCWs who may be equipped with the 'special' skills to manage people living with NCDs should also be provided with flexible career progression pathways to retain their services within the care landscape.

- In addition to strengthening the current workforce of HCWs, new types of HCWs are also needed to manage the delivery of care for people living with NCDs such as health educators, health communicators, mental health professionals; and psychosocial health workers.

- These roles could be filled by existing HCWs who may choose to acquire additional skillsets and specialise into these roles; but could also be filled by new professionals trained from the outset in these fields.

**Recommendation 3 (continued):**

- Such flexibility of re-orientating job matrices can and has been carried out within the private sector, but is almost impossible within the public sector due to the structure of the healthcare profession which continues to be under the purview of the Public Service Commission. This may require a fundamental transformation in terms of administrative processes, perhaps by enabling the sector to have its own Health Services Commission, for example.

- HCW professional organisations, especially those involved in creating newer 'specialist' HCW roles or even new types of HCWs altogether need to lead the development of specific frameworks for guiding and governing their own 'professions' as it were.

- The ability to retain and increase more 'specialist' HCWs performing NCD-specific tasks; as well as to complement these with different newer type of HCWs also working in NCD-specific tasks are part of the building blocks to develop and delivery multidisciplinary, multi-faceted, integrated NCD care.

**Community of Practice for restructuring career pathways for all HCWs working in the NCD care landscape to embrace the multi-disciplinary, multi-faceted approach required for care provision**

An example of an HCW professional organisation that has created the entire governance and administrative framework for its profession in Malaysia is the Malaysian Society of Clinical Psychologists (MSCP). MSCP has specific requirements for who is eligible to be a clinical psychologist in Malaysia and even maintains a list of registered clinical psychologists. The organisations also acts to govern and regulate the profession. More details on this can be found at: https://www.mscp.my/

**Recommendation 4: Optimisation of public-private partnerships in NCD care provision**

- HCWs with the specific skillsets to manage NCDs are spread out between the public and private health sectors in Malaysia.

- In addition, the private sector has in place a multitude of equipment and facilities which can be utilised to share the burden of NCD care across the landscape.

- These efforts can reduce the overcrowding of public sector facilities; reduce the burden and stress of public sector HCWs and enable them to provide better care; and optimise the available resources in the private health sector for national good.

- In parallel, widening of private services within public sector hospitals need to have better processes for reimbursing all HCWs involved, segregation of duties, and conflicts of interest that may arise in the public sector care provision process.

**Recommendation 4 (continued):**

- Steps to optimise public-private partnerships in NCD care provision include the development of frameworks and processes to enable movement of HCWs across the public and private sectors; reimbursement mechanisms to be put in place for reimbursing private sector for services provided; and most crucial- health financing reform to enable sustainable funding and regulatory oversight to be in place.

**Community of Practice for the optimisation of public-private partnerships in NCD care provision**

One example of a community of practice in place for public-private partnerships in NCD care provision are the use of private sector primary care practitioners for the screening and early detection of NCDs in low income groups via the PEKAB40 programme, overseen by Protect Health Corporation. More details on this can be found at: https://protecthealth.com.my/

**Recommendation 5: Incentivisation of HCWs**

- HCWs with the specific skillsets to manage NCDs need to be better incentivised in order to ensure their commitment and support over the long-term in management of people living with NCDs.

- These incentives should:

a) include financial incentives such as basic wages and conditions, bonuses, and/or access to other financial support such as sponsorship of training;
b) include non-financial incentives such as recognition of their specific skillset, work flexibility and provision of autonomy;
c) be underpinned by the idea of performance-based patient outcomes, as patients are the end result of the care provision process;
d) include components of successful delivery of patient-centred care practices, patient education practices, shared-decision making processes, and patient advocacy; and
e) prior to introduction, be preceded by development of governance and oversight mechanisms to prevent ineffectiveness, or even abuse. This applies especially to schemes.

**Community of Practice for the incentivisation of HCWs**

One example of a community of practice in place incentivising HCWs is the National Health Service (NHS) UK's pay-for-performance scheme which are in place for both primary and tertiary care. More details on this can be found at the National Institute for Health and Care Excellence, UK: https://www.evidence.nhs.uk/search?ps=40&q=pay+for+performance

# CONCLUSION

A transformation of the healthcare workforce requires an entire transformation of the health system. Thus, in order to succeed, these consensus recommendations need to be embraced and implemented by a wide range of stakeholders, each with their own individual roles to be played. More importantly, many of these recommendations require space and time to be developed and put into action in order to be able to visualise its successful impact. The Covid-19 pandemic has provided everyone with an opportunity to relook at healthcare delivery, and this may prove too opportune a time to not take a step towards effecting, lasting, sustainable transformative change that will benefit healthcare workers and the people living with NCDs that they are in partnership with.

## Organisations endorsing this statement

Lung Cancer Network Malaysia • Malaysian Thoracic Society • Malaysian Association of Psychotherapy • Nutrition Society of Malaysia • Malaysian Public Health Physicians' Association • Medical Practitioners Coalition Association of Malaysia • Malaysian Association of Medical Assistants • Malaysian Association of Speech-Language & Hearing • Malaysian Pharmacists Society • Malaysian Society for Occupational Safety and Health • Rare Disease Alliance Foundation Malaysia • Malaysian Psychiatric Association • ProtectHealth Corporation Sdn Bhd • Academy of Family Physicians of Malaysia • MedTweetMY • Malaysian Health Coalition • International Psychology Centre • Malaysian Physiotherapy Association • Malaysian Society of Nephrology

# REFERENCES


1. Institute for Public Health. Malaysian Burden of Disease and Injury Study 2009- 2014. Kuala Lumpur: Ministry of Health Malaysia (2017).

2. Chang AY, Cullen MR, Harrington RA, Barry M. The impact of novel coronavirus COVID-19 on noncommunicable disease patients and health systems: a review. Journal of Internal Medicine. 2021 Apr;289(4):450-62.

3. Ministry of Health. National Strategic Plan for Non-Communicable Disease (NSPNCD) 2016-2025. Putrajaya: Ministry of Health (2016).

4. Institute for Public Health (IPH), National Institutes of Health, Ministry of Health Malaysia. 2020. National Health and Morbidity Survey (NHMS) 2019: Vol. I: NCDs – Non-Communicable Diseases: Risk Factors and other Health Problems. Available from: https://iku.gov.my/images/IKU/Document/REPORT/NHMS2019/Report_NHMS2019-NCD_v2.pdf

5. Outcome document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases [homepage on the Internet]. UN General Assembly; 2014. Available from: http://digitallibrary.un.org/record/774662/files/A_68_L.53-EN.pdf.

6. Yasin S, Chan CK, Reidpath DD, Allotey P. Contextualizing chronicity: a perspective from Malaysia. Globalization and Health. 2012;8(1):4.

7. Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving Chronic Illness Care: Translating Evidence Into Action. Health Affairs. 2001 Nov;20(6):64–78.

8. Bulgaru-Iliescu D, Oprea L, Cojocaru D, Sandu A. The Chronic Care Model (CCM) and the Social Gradient in Health. Revista de Cercetare şi Intervenţie Socială. 2013 Mar;41:176–89.

9. Hanlon P, Yeoman L, Gibson L, Esiovwa R, Williamson AE, Mair FS, Lowrie R. A systematic review of interventions by healthcare professionals to improve management of non-communicable diseases and communicable diseases requiring long-term care in adults who are homeless. BMJ open. 2018 Apr 1;8(4):e020161.

10. Widyahening IS. The role of primary health care in the prevention of noncommunicable diseases. Review of Primary Care Practice and Education (Kajian Praktik dan Pendidikan Layanan Primer). 2019;2(1):5-7.

11. Workforce Resources for Health in Developing Countries [homepage on the Internet]. World Health Organisation. Available from: https://www.who.int/workforcealliance/media/KeyMessages_3GF.pdf. Accessed February 21, 2022.

12. Rai SS, Syurina EV, Peters RM, Putri AI, Zweekhorst M. Non-communicable diseases related stigma: a mixed-methods systematic review. International journal of environmental research and public health. 2020 Jan;17(18):6657.

13. Waweru E, Smekens T, Orne-Gliemann J, Ssengooba F, Broerse J, Criel B. Patient perspectives on interpersonal aspects of healthcare and patient-centeredness at primary health facilities: A mixed methods study in rural Eastern Uganda. PloS one. 2020 Jul 30;15(7):e0236524.

# ABOUT NCD MALAYSIA

## WHO WE ARE

NCD Alliance (NCDA) consists of 300 member organisations, spread across 81 countries and 66 national and regional NCD alliances. It is a civil society network that works towards ensuring people lead healthy and productive lives, without the preventable suffering, stigma, disability, and death due to non-communicable diseases (NCDs).

NCD Malaysia is the Malaysian chapter of the Global NCD Alliance. The alliance represents non-communicable diseases (NCDs) at national and international levels. NCD Malaysia was founded in 2018 by four organisations, each representing a different NCD. The founding organisations include the National Cancer Society of Malaysia (NCSM), National Heart Association of Malaysia (NHAM), Alzheimer's Disease Foundation Malaysia (ADFM), and Malaysian Green Lung Association.

## WHAT WE DO

### ADVOCACY

Advocacy activities are carried out so that health is prioritised and stays central to the national government, and that concrete achievements are attained for national NCD prevention and control.

### KNOWLEDGE EXCHANGE

Knowledge exchange between national and international stakeholders also play an important role in ensuring continued promotion of NCD prevention and control.

### CONVENING

Convening activities consist of events, meetings, forums, and other formats of discussions which bring together stakeholders to discuss and build consensus on priority issues surrounding NCDs.

### ACCOUNTABILITY

Accountability activities are carried out to ensure governing bodies in the country stay committed to the commitments made at the national and global levels to improve NCD prevention and control.

### CAPACITY DEVELOPMENT

Capacity development include key activities to empower and encourage national and regional civil society organisations (CSOs) in the field of NCDs to ensure effective and maintained action by the government in controlling NCDs.

# APPENDIX A

## Appendix A: assessment of 'asks' by people living with NCDs

| No | 'ASKS' BY PEOPLE LIVING WITH NCDs (N=27 panellists) | Priority | | Viability | | Total score (Priority + Viability) *total score=1.0 | Rank (1 - 10) |
|---|---|---|---|---|---|---|---|
| | | % of panellists ranking as high priority | Priority Weighted score (x 0.5) | % of panellists ranking as high viability | Viability Weighted score (x 0.5) | | |
| 1 | To ensure the development of a workplace culture where PLWNCDs are treated with respect and dignity during the course of their care | 80.8% | 0.404 | 46.2% | 0.231 | 0.635 | 6 |
| 2 | To plan for and incorporate delivery of services specifically for PLWNCDs within minority groups | 61.5% | 0.308 | 30.8% | 0.154 | 0.462 | 11 |
| 3 | To continue being active advocates of effective NCD prevention across all level of society | 92.3% | 0.462 | 69.2% | 0.346 | 0.808 | 1 |
| 4 | To become stronger advocates for PLWNCDs | 61.5% | 0.308 | 34.6% | 0.173 | 0.481 | 10 |
| 5 | To create and promote educational strategies that can better equip HCWs on improving treatment for PLWNCDs | 76.9% | 0.385 | 57.7% | 0.289 | 0.674 | 2 |
| 6 | To better integrate care delivery to provide multidisciplinary, integrated care for PLWNCDs | 92.3% | 0.462 | 34.6% | 0.173 | 0.635 | 5 |
| 7 | To strengthen referral systems across the different levels of care, and to better integrate access to nonclinical services (such as social protections) for PLWNCDs | 88.5% | 0.442 | 42.3% | 0.212 | 0.654 | 3 |
| 8 | To develop and implement educational initiatives for healthcare workers to ensure PLWNCDs are treated with respect and dignity at all times | 69.2% | 0.346 | 42.3% | 0.212 | 0.558 | 9 |
| 9 | To develop and implement structured patient engagement and patient education programmes for PLWNCDs at all levels | 73.1% | 0.365 | 42.3% | 0.212 | 0.577 | 8 |
| 10 | To engage with PLWNCDs individually in a meaningful manner when determining their own care | 84.6% | 0.423 | 46.2% | 0.231 | 0.654 | 4 |
| 11 | To support and foster meaningful and effective collaborations with networks/CSOs of PLWNCDs to be integrated into their daily patient care | 80.8% | 0.404 | 46.2% | 0.231 | 0.635 | 6 |

# APPENDIX B

## Appendix B: assessment of 'asks' by healthcare workers

| No | 'ASKS' BY HEALTHCARE WORKERS (N=27 panellists) | Priority | | Viability | | Total score (Priority + Viability) *total score=1.0 | Rank (1 - 10) |
|---|---|---|---|---|---|---|---|
| | | % of panellists ranking as high priority | Priority Weighted score (x 0.5) | % of panellists ranking as high viability | Viability Weighted score (x 0.5) | | |
| 1 | Improve planning, deployment, and use of HCWs, and decentralize Human Resource Management Mechanisms | 43.5% | 0.217 | 21.7% | 0.109 | 0.326 | 10 |
| 2 | Incentivise the performance of HCWs | 69.6% | 0.348 | 43.5% | 0.217 | 0.565 | 4 |
| 3 | Create specialist non-administrative positions and career pathways for non-administrative specialist HCWs | 56.5% | 0.283 | 34.8% | 0.174 | 0.457 | 5 |
| 4 | Widen and strengthen Full-Paying-Patient (FPP) and private-wing options in public sector institutions | 39.1% | 0.196 | 34.8% | 0.174 | 0.370 | 9 |
| 5 | Allow free movement of specialist HCWs across the public and private sector | 47.8% | 0.239 | 39.1% | 0.196 | 0.435 | 6 |
| 6 | Widen and strengthen public-private partnerships in the public and private hospital sector | 73.9% | 0.370 | 47.8% | 0.239 | 0.609 | 3 |
| 7 | Strengthen continuous professional development and training frameworks for HCWs | 73.9% | 0.370 | 56.5% | 0.283 | 0.653 | 2 |
| 8 | Strengthen and offer wider training and specialisation pathways for HCWs both in medical and allied health | 91.3% | 0.457 | 65.2% | 0.326 | 0.783 | 1 |
| 9 | Formalise and initiate task-shifting to community health workers across different settings | 56.5% | 0.283 | 30.4% | 0.152 | 0.435 | 7 |
| 10 | Formalise and incorporate elements of patient-centred care into disease management protocols | 47.8% | 0.239 | 30.4% | 0.152 | 0.391 | 8 |

**NCD Malaysia Secretariat**
c/o Department of Health Education, Literacy, Promotion, and Policy (HELPP)
3rd Floor, No. 66, Jln Raja Muda Abdul Aziz, 50300, Kuala Lumpur, Malaysia
03 2698 7300 ext:35 ncdmsia@gmail.com NCD Malaysia

In collaboration with

Supported by