Essential non-communicable disease interventions in Kosovo PHC

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2023

Accessible Quality Healthcare project - AQH

Improve the health status of the population of Kosovo

Outcome 1

Primary Health Care (PHC) providers deliver quality services for non-communicable diseases (NCDs) to informed citizens

Outcome 2

Health managers ensure delivery of quality PHC services that respond to communities' needs

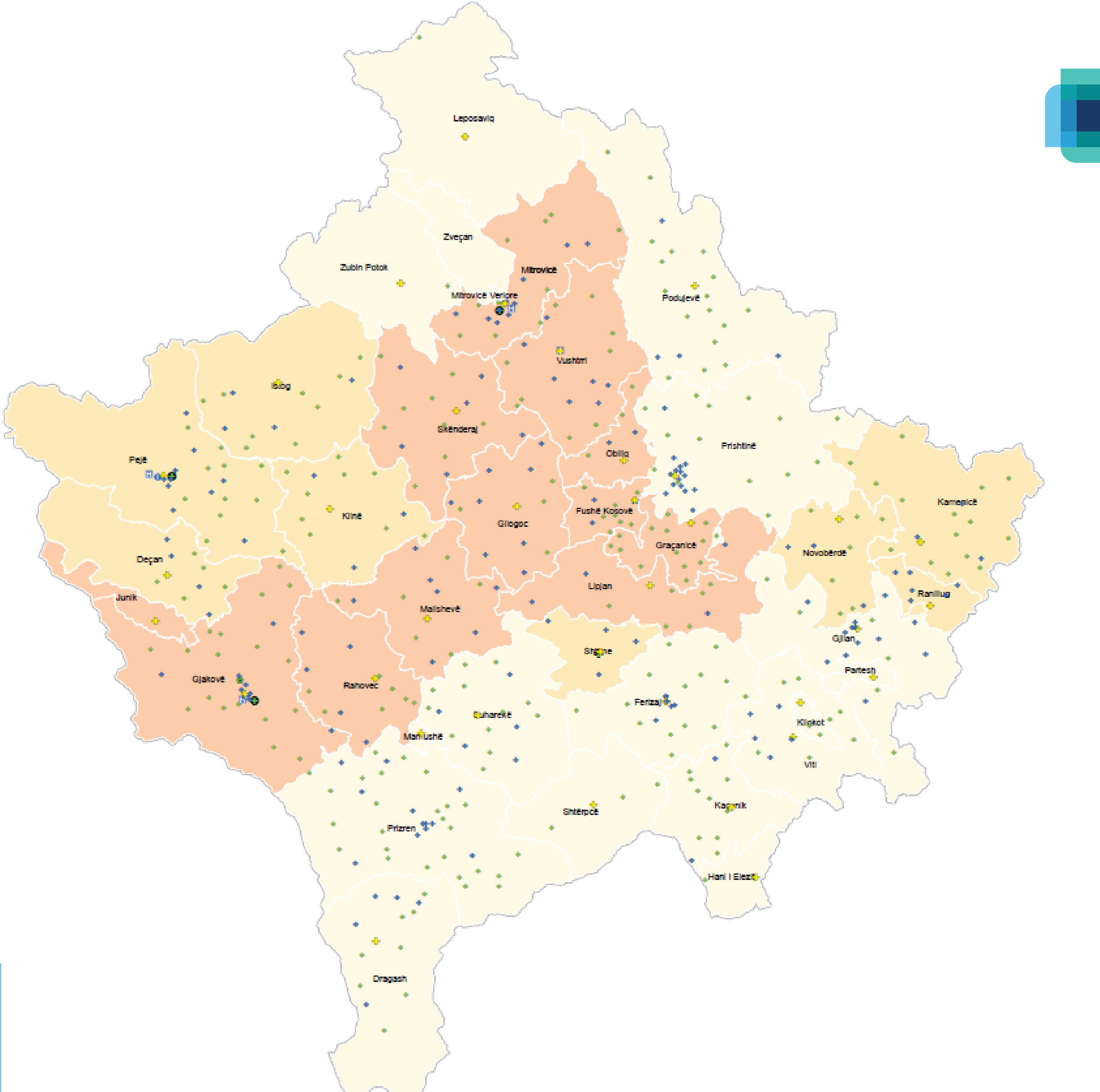
Outcome 3

The population improves its health literacy and demands better access to high quality care

AQH implementation scale

Fushë Kosovë, Gjakovë, Drenas, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skënderaj, Vushtrri

Pejë, Ranillugë, Istog, Deçan, Kamenicë, Klinë, Novobërdë, Shtime



NCD SYMPOSIUM

Patient at the center of PHC service provision

Patient Feedback Mechanisms
- Community Score Cards
- Complaints' management
- Patient Councils

Improve health literacy and health seeking behavior
- National Health Education / Health Promotion campaigns
- Community awareness sessions
- Health caravans

Patient rights and responsibilities
- National campaigns
- Training sessions for patients and for healthcare providers

WHO Package of essential non-communicable (PEN) disease interventions for primary health care in low-resource settings

WHO PEN Framework

Assess Capacity & Coverage Identify Needs

Rapid Assessment
Strengthening the role of PHC nurses
Develop training plans

Essential Equipment

Basic sets of equipment
Infrastructure rehabilitation
Health education corners

Essential Medicines

Support to managerial capacities development and improved logistics

Essential recording tools/data management

Patient 'Passports'
Patient registries to support data monitoring by NIPH and MoH

WHO Tools

Translation of WHO PEN protocols and tools (Risk Charts)
Dissemination to MFMCs

Protocols for Primary Care

Development of national CPGs
Training for clinicians and nurses
Integration of HE/HP into service packages
Development of HE/HP materials

PHC supported interventions in project partner municipalities

Roll out the WHO Essential Service Packages for NCDs for hypertension, diabetes type 2, asthma

Implement motivational interviewing and motivational counseling

Pilot the health and social integrated care for diabetic patients 65+

PHC essential interventions based on the WHO model

AQH Accessible Quality Healthcare

SDC project implemented by Swiss TPH

Rapid Assessment for Service Packages

Assessment of capacity to prevent and manage major non-communicable diseases (NCDs) in primary healthcare centres

To be completed by managers of primary care facilities.

Thank you for taking time to respond to this questionnaire.

Date:

Name of person completing the questionnaire:

Title:

Facility name:

Address:

Telephone number:

Classification of facility:

WHO PACKAGE OF ESSENTIAL NONCOMMUNICABLE (PEN) DISEASE INTERVENTIONS

FOR PRIMARY HEALTH CARE

World Health Organization

Personat me Diabet Mellitus

Personat pa Diabet Mellitus

Libreza për shtypjen e lartë të Gjakut (Hipertensioni)

AQH Accessible Quality Healthcare

Chronic patient pathway within PHC

HE/HP activities

Target for campaigns, awareness sessions, health caravans:

W&M 40 yrs+ being at risk and focus on vulnerable groups:

- RAE
- Women
- Elderly

PHC consultation (based on protocol)

Noticed risk factors but no diagnosis of hypertension, diabetes type 2 or asthma

Diagnosis of hypertension, diabetes type 2 or asthma Continued by the provision of therapy and treatment according to disease protocols

Refer to health educator/Nurse

Health educator = Trained nurse in motivational interviewing and motivational counseling

Chronic patient pathway within PHC (2)

Health educator/Nurse of the HRC/MFMC

Health educator provides:
- One-to-one or group counselling
- Patient information materials
- Referral back to Doctor as per the protocol

Health educator/Nurse of the HRC/MFMC

Health Educator make use of:
- The Health Educator Guide
- Discusses the risk factors and establishes, together with the patient, the individual care plan

Health educator/Nurse of the HRC/MFMC

Integrated care:
- Geriatric Assessment
- Individual care plan
- Physical activity sessions

Follow-up:
- Periodic counseling sessions
- Phone call assessments
- Geriatric reassessments

Dissemination and sustainability

- Horizontal dissemination
- Scale up to non project partner municipalities
- Transfer the ownership of processes to national and local stakeholders

Thank you