World Health Organization

REGIONAL OFFICE FOR Europe

Workshop on implementation of a package of essential noncommunicable (PEN) disease interventions for primary health care in Eastern Europe and Central Asia

Samarkand, Uzbekistan
17–19 May 2016

ABSTRACT

A workshop held in Samarkand, Uzbekistan on 17–19 May 2016 provided an opportunity for the teams from the European PEN pioneer countries to meet together again after October 2015 meeting, and to be joined by other countries from eastern Europe and central Asia that have a similar interest in implementing essential NCD interventions in primary care. The Meeting was organized by the WHO Regional Office for Europe in the context of the Project on the Prevention and Control of Noncommunicable Diseases (NCD Project), financed through a voluntary contribution of the Ministry of Health of the Russian Federation. It aimed to support member countries in the implementation of the WHO PEN protocols and to establish a platform for regular discussion of issues of common interest in their implementation. The workshop provided opportunities for sharing experience and learning about evidence-based strategies for clinical guideline implementation, quality systems, training and education, and monitoring and evaluation of impact. The programme benefited from the expertise of WHO Collaborating Centres and international experts, and was interactive.

Keywords

CHRONIC DISEASE – prevention and control
PRIMARY HEALTH CARE
DELIVERY OF HEALTH CARE
PROGRAM EVALUATION
RESPIRATORY TRACT DISEASES – prevention and control
ASIA, CENTRAL

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Abbreviations

CVD	cardiovascular diseases
NCD	noncommunicable diseases
PEN	package of essential noncommunicable disease interventions
PHC	primary health care
WHO	World Health Organization

Introduction

Background

Achieving the global target of 25% reduction in premature mortality by 2025 from noncommunicable diseases (NCD), requires a mixture of population-wide and individual-level interventions. Such cost-effective interventions have been identified, are already available and include methods for early detection of NCDs and their diagnoses using inexpensive technologies, non-pharmacological and pharmacological approaches for modification of NCD risk factors and affordable medications for prevention and treatment of heart attacks and strokes, diabetes, cancer and asthma. The WHO Package of Essential Noncommunicable disease (PEN) interventions is a conceptual framework for strengthening equity and efficiency of primary health care (PHC) in low resource settings. It defines a minimum set of essential NCD interventions to be implemented and comprises four clinical practice protocols.

The workshop provided opportunities for sharing experience and learning about evidence-based strategies for clinical guideline implementation, quality systems, training and education, and monitoring and evaluation of impact, and was held on 17–19 May 2016 in Samarkand, Uzbekistan. The event was hosted by the Ministry of Health of Uzbekistan was organized by the WHO Regional Office for Europe in the context of the Project on the Prevention and Control of Noncommunicable Diseases (NCD Project), financed through a voluntary contribution of the Ministry of Health of the Russian Federation. The programme is in Annex 1 and the list of participants is in Annex 2.

Opening

Both WHO and the Ministry of Health welcomed participants to the meeting, expressing the hope that new information from the workshop would help national experts in implementation of the programmes.

Provisional Agenda and Expected outcomes

The strategic and technical context and orientation for the workshop was presented. This included an overview of relevant international policy, goals and commitments of Member States for NCD prevention and control. The content of PEN protocols, its history as well as contribution to health system building blocks were presented further. In addition, approaches to the implementation of protocols, progress across European region as well as the next steps for the development of PEN were considered. The rationale for the content and design of the programme was shared and its structure was presented. It builds on the experience from the previous workshop and is designed to be interactive with lectures, group work, discussions and field visits to the pilot region.

Implementation of PEN in Uzbekistan

An overview of PEN implementation in Uzbekistan followed. The population of Uzbekistan is 31 million. The national nutrition and NCD strategy was approved in 2015. WHO PEN protocols are being implemented in the context of the Health-3 project funded by the World Bank with the support of WHO. There is a national coordination body comprising Ministry of Health, leading specialists, the Health-3 project and WHO. The coordination body identified two pilot regions in

Fergana and Kashkadarya, one with a high-density population and the other with low density in the rural areas, and selected four medical facilities (three rural with a population of at least 6000 and one urban family polyclinic) in each oblast. NCD capacity (50 PHC facilities) was assessed based on WHO questionnaire in 2013 and WHO PEN protocols No. 1, 2, and 3 were adapted. The technical working group developed a comprehensive training course and held two four-day programs of training on PEN protocols to prepare national trainers. Leading specialists from the republican, oblast and district levels as well as GPs and nurses from pilot health facilities received training, as well as national GP trainers and 8 university professors. Implementation of WHO PEN protocols is being supported by broader population-based NCD interventions which are coordinated by intersectoral coordinating councils under the local governing authority. These have plans to implement initiatives such as health-promoting schools, healthy cities/ villages and healthy workplaces (starting with health facilities). Monitoring and evaluation systems include periodic assessment of facility capacity, observation of doctors and interviews with patients, and measuring a set of indicators. Regular monitoring visits are carried out in order to check progress in implementation and provide supportive supervision. Continuous quality mechanisms are in use in order to improve quality within each facility. Changes observed as a result of the implementation of the protocols include increased role of nurses in assessment and counselling on NCD risk factors, introduction of individual patient management plans according to PEN, and improved quality of patient counselling on NCDs. Barriers to implementation included: a lack of basic equipment and access to basic diagnostic tests as well as shortages of basic drugs in primary care; ensuring sustainability of a recording and reporting system for NCDs and risk factors; insufficient GP availability. There are plans to train PHC specialists throughout the republic, incorporate PEN into curricula for GPs and family nurses, to develop distance learning courses and certified training programs on brief interventions for NCD risk factors, and ultimately to introduce PEN in all regions.

Implementation of clinical guidelines/protocols

This last session of the morning of the first day focused on implementing clinical practice guidelines and protocols. It started with a presentation on implementing guidelines in primary care, and then was followed by a country experience.

Implementation of clinical guidelines/protocols in primary care: the evidence for what works

In order to be effective implementation of clinical guidelines should be premised on the principles of evidence-based medicine, which includes the integration of three domains: the best (highest quality) scientific evidence; clinical expertise; patient needs, values, and preferences. Clinical guidelines should be based on the best available evidence and local adaptation and evaluation are essential when implementing and scaling these. Implementation of clinical guidelines is complex and unpredictable. Contextual judgments about what is likely to work in a particular situation for particular people in a particular organization with particular constraints is needed, and evidence should be generated accordingly to inform practice. Shared experience and collective expertise is a valuable resource. Whereas evaluation and research are useful when the correct intervention to achieve a specific outcome is not known, clinical audit is useful when it is already known. Its goal is to identify the gap between practice and guidance, reasons for this, and to improve the quality of care. Clinical audit is a repeating cycle of standard setting, measuring current practice, comparison with the standard, then developing and implementing recommendations.

Kyrgyzstan: country experience in implementation of clinical guidelines/protocols in primary care

Kyrgyzstan then shared their experience. The population of Kyrgyzstan is 5.9 million. The relevant authorities have been implementing the WHO PEN since 2015. Initially piloting in 10 family medicine centres in Bishkek, WHO PEN protocols have since been integrated into other programmes and projects such as those on health care reform, community-based action and results-based financing, some of which involved other donors. At the start, WHO PEN protocols were adapted and harmonized with clinical protocols for CVD and diabetes and translated into the Kyrgyz language. Trainings were conducted in the field and modules were designed to be accessible and interactive. Monitoring of implementation includes, amongst other things, assessment of the involvement of health workers, their level of knowledge and identification of cardiovascular risk factors. PEN protocols are being incorporated into the training programmes of educational institutions (medical colleges, universities, institutes of postgraduate education), thus maintaining continuity in the implementation of programs. Among the barriers to implementation, is a low political commitment due to the frequent change of leadership, low motivation of doctors and population, and weak intersectoral cooperation. Measures to overcome barriers might be in constant work with the government, strengthening of the regulatory framework, strengthening the community outreach, development and approval of programmes aimed to reduce tobacco use, alcohol consumption and unhealthy diet, as well as strengthening cooperation with other sectors.

Discussion and Group Exercise

In the discussion that followed, participants were interested to learn more about the experience in Kyrgyzstan with specific points on training of PHC professionals, financial incentives for nurses and doctors as well as use of national health insurance funds in supplying drugs and laboratory tests.

In the subsequent group work, two exercises were carried out, first in relation to training frontline health workers in primary health care, and secondly on how to engage stakeholders in guideline implementation and evaluation. In identifying the main actors in the mechanisms of PEN protocol implementation, participants considered it necessary to involve the whole society in this work, including doctors, nurses, patients, social services, various sectors of government. Among the mechanisms identified were media, non-governmental organizations, associations of patients, as well as the preparation of well trained staff at the undergraduate and postgraduate stages. The moderator pointed out that implementation of evidence-based medicine is likely to require a cultural change, moving away from a top-down approach, and mechanisms need to be put in place that help achieve this.

Clinical practice guidelines as part of comprehensive quality systems

This last session of the day focused on clinical practice guidelines as part of comprehensive quality systems. It started with a presentation on how quality of care can be improved through quality circles and peer groups.

Clinical practice guidelines in primary care: improving quality of care through Quality Circles/Peer Groups

Improving quality of care is not possible without considering the system of quality, that is, its structure, processes and outcomes, as well as its aspects such as measurable, objective standards, peer judgment and patient perception. Furthermore it is important to take into account the active involvement of the medical community in the process. Taking account of adult learning theory and the principles of adult teaching, it should be recognized that adults are internally motivated and goal oriented, practical and relevancy oriented. They bring their own knowledge and life experience that should be respected and used. They have practical experience of guideline implementation, know what to measure and can give appreciative feedback. Given this, the best way to do quality control is to involve practitioners in quality circles or peer groups. These can be organized at rayon level and are relatively inexpensive. They do not require a big infrastructure but some organization is required though. Each group needs a facilitator as leader who is respected by his/her peers and has been educated for the task. They need to be visited and supported by a clinical supervisor /central agency,

Tajikistan: Improving quality of practice

In the presentation that followed, Tajikistan shared their experience. The population of Tajikistan is 8 million. It has a national strategy entitled Future Opportunities for the Prevention and Control of NCDs and Injuries 2013–2023 and a working group to implement it. The WHO PEN package was introduced in 2014 and is being implemented in Dushanbe and seven pilot districts with mainly rural populations. Assessments of PHC capacity have been carried out and, after adaptation and translation of the protocols into local languages, training seminars were held for doctors in the districts. For monitoring the implementation process and to support continuous learning, regular workshops are conducted at the regional level for groups of PHC specialists, with 10-15 persons in each. The main aim of such workshops was to analyze existing barriers and find ways to overcome them. Implementation of the PEN protocols has led to more accurate assessment of the current situation in PHC and its capacity for prevention and control NCDs. Among the barriers, there is a lack of staff, low level of awareness among population on healthy lifestyle and NCD prevention, and low availability of information for healthcare workers and population. Next steps might be in improving the efficiency of intersectoral cooperation, introducing the PEN package into the curriculum at the postgraduate level for family doctors and improving provision of information to health care providers on healthy lifestyle aspects.

Discussion

Participants considered quality control of medical care and shared their experiences of national regulation during discussion. All countries have some form of quality control for medical practice. In some countries, state agencies are assuming control functions or, less frequently, insurance companies or other actors such as professional associations take this role. These institutions may or may not be facilitating peer review or quality circles.

The example of Switzerland was shared. Here, there is general regulation for quality control then it is left to the medical and professional associations to organize it. Each city has a chapter of medical association. Each doctor is required to be a member of at least one quality circle. Quality circles meet 10 times a year, are organized by the doctors themselves, and each meeting usually includes a case-based presentation followed by discussion.

Participants were asked to consider how quality control/peer groups might be implemented in their country for example: would legal approval be needed, how might financing be assured, how to select and train facilitators, how to implement local organization, how to design the reporting system. A number of countries shared their current situations and suggestions on what would need to be done. To improve quality control of medical care, participants came to the conclusion that there several components for the success including continuing education and training, involvement of health professional organizations, development of clear indicators and rating system, and large-scale information campaigns.

Field Visits

The second day of the meeting was taken up with field visits to Karshi where there was the opportunity to visit two pilot sites (one rural clinic, one urban polyclinic) for implementation of WHO PEN protocols and a local community fair showing examples of prevention and health promotion activities.

Within Karshi region, participants visited a village with a population of about 5000 people, which is governed by the principle of local self-government - the Mahalla. The Mahalla committee headed by the Chairman covers issues related to organization of life and leisure time, and educating people about health. They aim that no-one is neglected and no-one is forgotten.

Participants also had the opportunity to familiarize how care within polyclinics is organized, the equipment available in nurses' and doctors' offices, as well as to speak with the staff about using PEN protocols in their daily work. There were several ways for people to get their blood pressure checked, for example through the PEN implementation pilots, an annual screening programme for working age people carried out by visiting narrow specialists, and preventive health examinations by general practitioners.

Supporting implementation of clinical guidelines/protocols: community engagement

After a brief reflection on the field visits, the first session on the third day focused on community engagement.

The main presentation in this session illustrated how community engagement can be used in NCD prevention and control through supporting identification of high risk individuals and early detection of disease, management of risk factors, and treatment and secondary prevention. Examples from Finland were used to illustrate each of these areas. For example, multiple actors such as media, non-governmental organizations, private sector and expert institutions could be involved in raising public awareness of type 2 diabetes and opportunities for prevention and early detection, Activities could include dissemination of information through multiple media as well as screenings and counselling in public places. The same actors could be used in improving management of risk factors, with the examples given of a project to improve children's nutrition and physical activity counselling as part of the work of multi-disciplinary teams in primary health care. Finally, to illustrate how community actors can support treatment, the example was given of heart disease, type 2 diabetes and asthma programmes in pharmacies through which trained experts in pharmacies offer counselling related to medicine and lifestyles.

Discussion

In the discussion that followed, participants expressed interest in practical work among various population groups (adults, adolescents, women etc) to control different risk factors. In addition, aspects of managing the double burden of chronic NCDs and mental disorders were raised.

Participants then worked together in groups to discuss community engagement possibilities further. For each of the groups identified in the earlier presentation (media; sectors other than health; non-government organizations; private sector; expert institutions; others), workgroups considered how they were already engaging these stakeholders in identification of high risk individuals, early detection, management of risk factors, treatment and secondary prevention. They were also asked to identify the barriers that currently exist and the opportunities to fill the gaps or improve. Ideas were written and displayed on flipcharts which groups then shared with each other.

Implementation of clinical guidelines/protocols: monitoring and evaluation of impact

In this last session of the morning, international experts contributed suggestions on monitoring and evaluation from different perspectives.

Economic evaluation can be useful for assessing the economic burden of NCDs and resources needed to overcome it, as well as for demonstrating cost-effectiveness of interventions. Such evaluation can be useful for convincing policy makers of the rationale for implementation of preventive measures and to guide resource allocation. Some existing tools and approaches were demonstrated. These could be used to estimate costs of PEN implementation for planning purposes or for modelling the short-, medium- and long-term effects of interventions for example. Cases from the Russian Federation were used as illustration. In one case, the economic burden of cardiovascular disease (CVD) had been calculated,. .This had shown that the CVD economic burden in the Russian Federation was equivalent to 3% of its GDP. Only 21% of the costs were direct health care costs whereas 79% were indirect costs. Such information was then used by different policymakers to support increased investment in prevention programmes. In another case, the long-term economic effects of the national screening programme (‘dispanserization’) were modelled to demonstrate potential years of life saved and deaths prevented that might be achieved. This showed that all but one component (prostate cancer screening) were cost-effective so the programme was changed.

Another presentation showed **how routine data can be used to monitor the quality of prevention programmes**. The district of North Karelia, Finland has 200,000 inhabitants living in 13 municipalities of different sizes. Primary health care and hospital information systems are unified. A map of prevalence of type 2 diabetes in North Karelia illustrated the importance of using age-adjusted rather than unadjusted prevalence, and showed that some municipalities were more successful than others in active screening. Hospital data for acute cardiac events was used to calculate age-standardized prevalence of coronary heart disease (CHD) in each municipality of North Karelia. Differences between municipalities could at least partly be explained by differences in primary prevention and treatment of risk factors. These figures could be used to indicate the numbers of patients eligible for secondary prevention. These unified data systems could also be used for follow up of patients for example indicating more than two-fold differences between municipalities in measurement of glycated haemoglobin (HbA1c) and low-

density lipoprotein (LDL) in patients after diagnosis of diabetes. Finally, the systems could also be used for monitoring treatment outcomes such whether HbA1C levels in patients with diabetes and LDL levels in patients with CHD reach treatment targets.

WHO and international experts added their reflections on the topic. They agreed that hospital data can be used to indicate the quality of primary health care. A series of WHO studies on ambulatory care sensitive conditions had shown that up to 80% of hospitalizations for diabetes could have been avoided through better care at the primary care level. As hospital beds reduce in many countries, it is even more important that primary health care is able to react.

Differences in risk factor detection rates and treatment outcomes can be due to individual practitioners doing a good job. It was a good opportunity to recall the principles about implementing guidelines in primary care given on Day 1, as well as the differences between audit, evaluation and research. Clinical audit can be used for monitoring the quality of implementation of clinical guidelines in practice. For implementation of WHO PEN, this could mean reviewing the actions of individual health professionals to see if CV risk scores have been calculated correctly and if doctors and nurses understand the utility. Motivation is important for learning. For primary health care workers, reflecting on practice and learning in small peer groups is likely to be more effective than face-to-face teaching and fits better with adult learning theory.

In the discussion that followed, several countries expressed their interests in the topics, particularly for the economic assessment approaches described.

Conclusions and next steps

The aim of this afternoon session was for participants to reflect on findings and discussions from the workshop and suggestions for further support. Members of each delegation made comments within plenary.

A number of countries were interested in monitoring and evaluation of existing programmes in the field of control of NCDs, for example analysis of the effectiveness of PEN protocols in the pilot regions compared to other regions. In particular, many countries expressed interest in conducting economic evaluations, if possible to demonstrate cost-effectiveness of NCDs interventions in primary care. Development or evaluation of training materials for primary care health professionals. A number of countries that are not ready to fully implement the PEN protocols have expressed interest in the implementation some of its elements. In general, participants supported the continuation of the exchange of experience by organizing such meetings.

For the next meetings participants would like to know more about existing experience of countries in NCD control (particularly experience of Finland). Also, the participants would be interested to learn about training of PHC workers to communicate with patients with risk factors, and active involvement of nurses in this work, as well as get more information about Quality Circles/ Peer Groups..

Following expressions of thanks to those who had contributed to the smooth organization of the meeting, the meeting was then formally closed.

Annex 1

Final programme

Tuesday, 17 May 2016

08:15–09:00	*Registration*
09:00–10:30	**Opening**
	Welcome and Opening *Dr Asilbek Khudayarov, First Deputy Minister, Ministry of Health of Uzbekistan & Dr Ogtay Gozalov, WHO Representative /Head, Country Office a.i., Uzbekistan*
	Provisional Agenda and Expected outcomes *Dr Jill Farrington, Head a.i., NCD Project Office and Senior Technical Officer, Division of NCDs and Promoting Health through the Life Course, WHO Regional Office for Europe*
	Introduction of delegations
	Implementation of PEN in Uzbekistan *Dr Asilbek Khudayarov, First Deputy Minister, Ministry of Health of Uzbekistan*
10:30–11:00	*Coffee break*
11:00–12:30	**Session I: Implementation of clinical guidelines/protocols**
	Implementation of clinical guidelines/protocols in primary care: the evidence for what works *Dr Dylan Collins, WHO Collaborating Centre for Self Care, University of Oxford, Oxford, UK*
	Implementation of clinical guidelines/protocols in primary care: country experience *Kyrgyzstan presents their experience*
	Discussion
	Facilitator *Dr Dylan Collins, WHO Collaborating Centre for Self Care, University of Oxford, Oxford, UK*
12:30–14:00	*Lunch*
14:00–15:30	**Session II: Supporting changes in clinical practice: training and education**
	Introduction to session *Dr Dylan Collins, WHO Collaborating Centre for Self Care, University of Oxford, Oxford, UK*
	Group Exercise 1: Training Frontline Health Workers in Primary Health Care
	Group Exercise 2: Engaging Stakeholders in Guideline Implementation and Evaluation
	Facilitators *Dr Dylan Collins, WHO Collaborating Centre for Self Care, University of Oxford, Oxford, UK & Prof. Dr med. Renata Galeazzi, St. Gallen, Switzerland & WHO Temporary Advisor*
15:30–16:00	*Coffee break*

16:00–17:15	**Session III: Clinical practice guidelines as part of comprehensive quality systems**
	Clinical practice guidelines in primary care: improving quality of care through Quality Circles/Peer Groups
	Prof. Dr. med. Renato Galeazzi, St. Gallen, Switzerland & WHO Temporary Advisor
	Improving quality of practice *Tajikistan presents their experience*
	Group Exercise: *Participants share experiences in their country with each other, with feedback into plenary*
	Discussion
	Facilitator *Dr Juan Tello, Programme Manager, Service Delivery, Division of Health Systems and Public Health, WHO Regional Office for Europe*
17:15	*Close of Day 1 and transfer back to hotels*
From 18:30	**Ministry of Health Reception: Gala dinner**
	Pick up by bus from hotel receptions (see Information Circular) for dinner starting at 19:00 and return to hotels afterwards

Wednesday, 18 May 2016

Field Visits

08:00	*Buses transfer participants from hotels to the train station (see Information Circular)*
	Train from Samarkand to Karshi
10:15-10:45	*Buses transfer participants from train station to pilot sites*
10:45-12:00	2 parallel groups: 1. Visit to the 1st PEN Pilot site – Rural point (SVP) "Uzbekiston mustakilligi" 2. Local community fair, showing results of joint work in NCD prevention and health promotion
12:00-12:30	*Buses transfer participants to pilot site*
12:30-13:45	Visit to 2nd PEN Pilot site: Family polyclinic #6.
13:45-14:00	*Buses transfer participants to lunch*
14:00-15:30	*Lunch*
15:30-16:00	*Buses transfer participants to train station*
	Train to Samarkand
18:00-18:30	*Arrival and transfer to hotels*
Evening	Free - participants make own arrangements for dinner

Thursday, 19 May 2016

08:15-08:30	*Pick up by bus from hotel receptions to travel to venue*
09:00–10:30	**Session IV: Supporting implementation of clinical guidelines/protocols: community engagement**
	Supporting implementation of clinical guidelines/protocols: community engagement *Professor Tiina Laatikainen, WHO Collaborating Centre for Noncommunicable Disease Prevention, Health Promotion and Monitoring, Helsinki, Finland*
	Group Exercise: *Participants share experiences in their country with each other, with feedback into plenary*
	Discussion
	Facilitator *Dr Jill Farrington, Head a.i., NCD Project Office and Senior Technical Officer, Division of Noncommunicable Diseases and Promoting Health through the Life Course, WHO Regional Office for Europe*
10:30–11:00	*Coffee break*
11:00-12:30	**Session V: Implementation of clinical guidelines/protocols: monitoring and evaluation of impact**
	Implementation of a package of essential NCD interventions: approaches to monitoring and evaluation of impact *Contributions from a panel of international experts covering different perspectives*
	Exercise: *Participants share experiences in their country with each other, with feedback into plenary*
	Discussion
12:30-14:00	*Lunch*
14:00–15:00	**Session VI: Supporting implementation of clinical guidelines/protocols in primary care: synthesis**
	Reflections on findings and discussions from the workshop and development of plan of action for country support *Facilitated session in which participants synthesise the lessons learnt and plan next steps*
	Discussion
	Facilitators *Dr Dylan Collins, WHO Collaborating Centre for Self Care, University of Oxford, Oxford, UK & Dr Jill Farrington, Head a.i., NCD Project Office and Senior Technical Officer, Division of NCDs and Promoting Health through the Life Course, WHO Regional Office for Europe*
15:00-15:15	**Closing session** Conclusions and next steps: *Dr Jill Farrington, Head a.i., NCD Project Office and Senior Technical Officer, Division of NCDs and*

	Promoting Health through the Life Course, WHO Regional Office for Europe
	Closing speeches of WHO and the Ministry of Health
15:15	*Close of meeting*
16:00	*For those participants flying from Tashkent on Friday 20 May: Bus transfers participants to train station for train to Tashkent*
	Other participants transferred back to hotels

Annex 2

List of participants

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