RBF and NCD Control Saint Lucia

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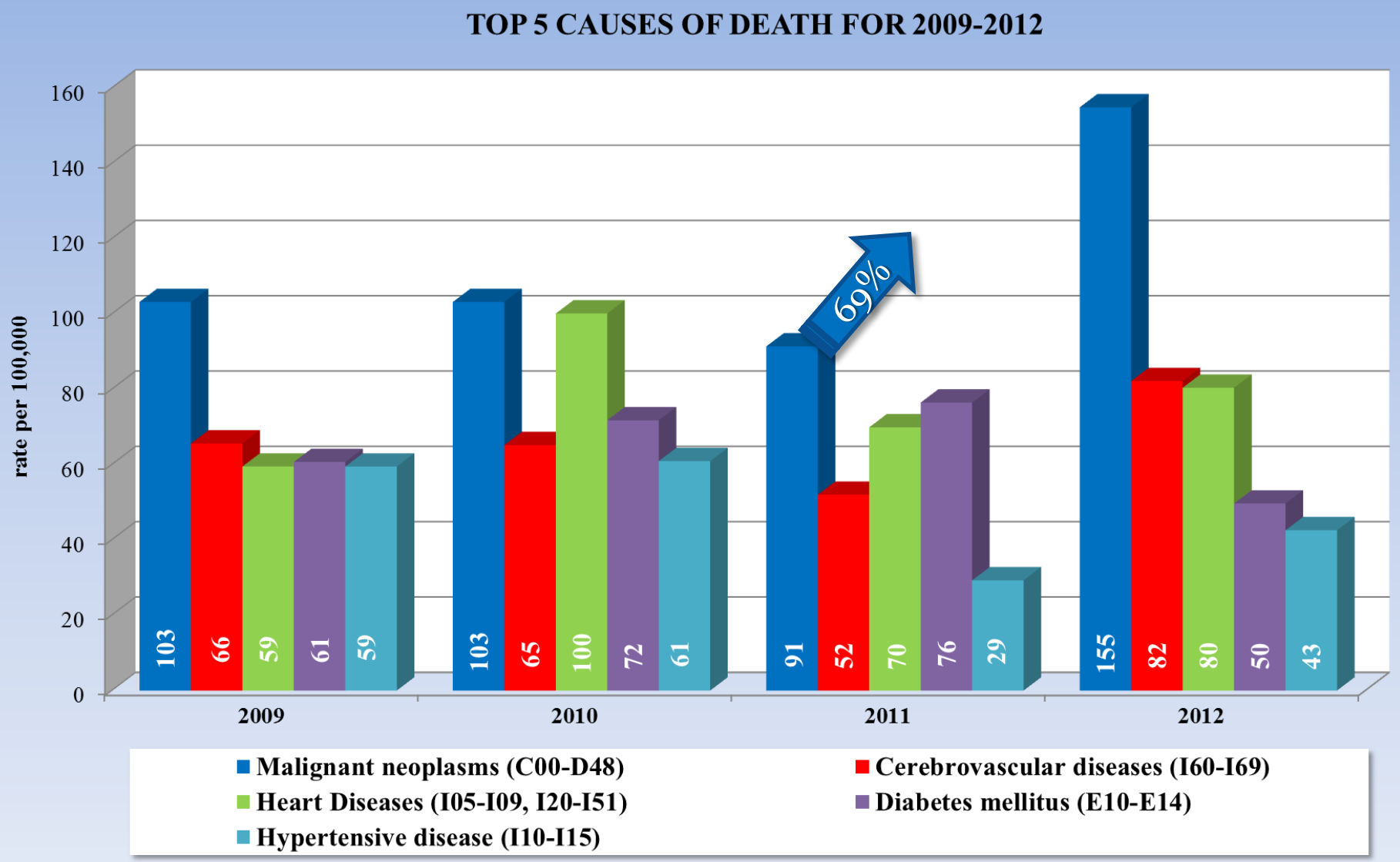
CNCD Mortality

TOP 5 ACCOUNTS FOR 54% OF TOTAL2012 MORTALITY *(SOURCE: EPI UNIT)*



Key Features: RBF – CNCD Project

Goals

- To reduce the incidence and negative outcomes of diabetes and/or hypertension within the selected region.

- To enhance the management and coordination of diabetes and hypertension programmes

Objectives

- Improve health and wellness in the study population
- Strengthen the stewardship role of the Ministry of Health
- Strengthen regional health care networks aimed at a decentralized approach of health care delivery
- Empower communities and families

Specific Objectives

- To improve **early detection** of diabetes and/or hypertension conditions through scaled up screening of the at-risk population.
- To **increase the level of knowledge and awareness** of the at-risk population through health education and behavioural impact interventions.
- To **improve access to safe and effective services** provided to persons diagnosed with diabetes and/or hypertension through clinical management, self-care management and complications screening.
- To **improve the capacity of the primary health care to deliver**, in a timely fashion, quality services at the Primary care level.

Design

Phased approach

- Roll out in health region No. 5 at the PHC level
- Roll out at the national level

Selection Criteria

- Burden of Disease, regional and national level and treatment gap
- poverty levels
- Presence of established treatment guidelines/protocols
- Presence of established programmes at the community level
- Capacity at the regional level

Main Focus – Phase 1

- improving the **quality** of care for the areas of intervention, based on the standard care protocols.
- the **comprehensive prevention, management and control** of CNDS, specifically diabetes and hypertension.
- addressing some of the **barriers that impact access** to quality care at the PHC level
- improving **accountability mechanisms**

Target Group

- 24 + age group,
- Entire population in the selected region - public health activities –
- persons who live and access care in the health region who have been diagnosed with diabetes and/or hypertension.
- persons who can be classified as having pre-diabetes or pre-hypertension.

Intervention

- Preventive care and health promotion
- Integrated disease management
- Self-Care management
- Foot Care services

Management and Administration

- Ministry of Finance and Economic Affairs - Project coordinating Unit (PCU)
- Ministry of Health
- Regional Coordination
- Family and Community involvement

Management and Administration

- Purchasing and procurement of supplies or services
- **Contractual arrangements** with regions - provision of a package of services which will be incentivised through the RBF mechanism

- coverage of services
- Degree of autonomy, roles and responsibility of the MOH and Region 5

Management and Administration

- Mapping exercise to identify households and individuals every three months in the catchment areas served by the region
- Funding will be registered as credit in a special account available to project expenses for the region
- PCU will be responsible for the specific accounts, information will be forwarded to the region on a periodic basis

Management and Administration

- Participant list reviewed every 3 months and 15 days before the next quarter
- Participatory approach to identifying targets for each indicator on a quarterly basis
- Payments made based on the achievement of predefined targets and objectives for the enrolled population

Funding – Capitation

- **Start –up cost**

- population –based interventions

- Clinical management services intervention :

Funding – Institutional Strengthening

- Start –up cost for clinics and central agency:

- Promotional materials
- Equipment

- Policy and legislative frameworks

- Quality management and CQI
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Participation

- Central agency support staff
- Public community Clinics :Medical and nursing staff
- Target population
- Residents of Region 5 (Public Education)

Monitoring and Evaluation Mechanisms

The Epidemiology unit will assume the responsibility for Monitoring and Evaluation :

- coordinate and oversee the strengthening of the monitoring and evaluation systems
- oversee in close coordination with the HMIS Unit the development of appropriate information systems with individualized data for an adequate functioning of results-based financing.

Monitoring and Evaluation Mechanisms

- Review defined target population
- Monitor HMIS for data quality and accuracy and relevance

Scaling- UP Plans

- Phase 2 - National focus

Challenges

- defining of results at the appropriate levels
- determining the causal relationships of project outcomes as opposed to other interventions
- Change management – results oreitnation
- Intersectoral support
- Client and community responsibility

Enabling Environment

LEADERSHIP AND CO-ORDINATION

- Nomination of a CNCD Focal Point
- Formation of a CNCD Technical Committee
- Establishment of CNCD Commission
- Existing Safety net programmes
- Intersectoral support – technical

Enabling Environment

- Development of National CNCD Policy and Multi-sectoral Action Plan.
- Development of National Food and Nutrition Security Policy.
- Launching of the Dietary-Based Guidelines

Enabling Environment

- Increased collaboration with NGOs in health promotional activities.
- Ongoing Screening- health fairs and other activities.
- Re- introduction of physical activities in schools

Enabling Environment

- Enhancing competencies of Health care workers in managing CNCDs.

- Training in:
- Management of diabetes and hypertension (LS 1,2 & 3)
- Physical Fitness
- Foot care (all category of staff)
- Chronic Care Model (CCM)
- Use of Diabetes & Hypertension Protocol (all categories of staff)

Enabling Environment

- Launching of the Chronic illness care passport Pilot Project in April 2011.
- Establishment of specialized CNCD clinics within some regions
- Provision of free medication to persons with Diabetes
- Integrated Care management