Findings from the AHD Quality Standards Pilot in Mozambique

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Outline

- **Where are we now?**
  - Progress towards 95:95:95 targets
  - AHD CMM self-staging results
- **AHD quality standards**
  - Quality standards
  - Methodology
  - Results
  - Challenges
- **What's next?**

Progress towards the 95:95:95 targets

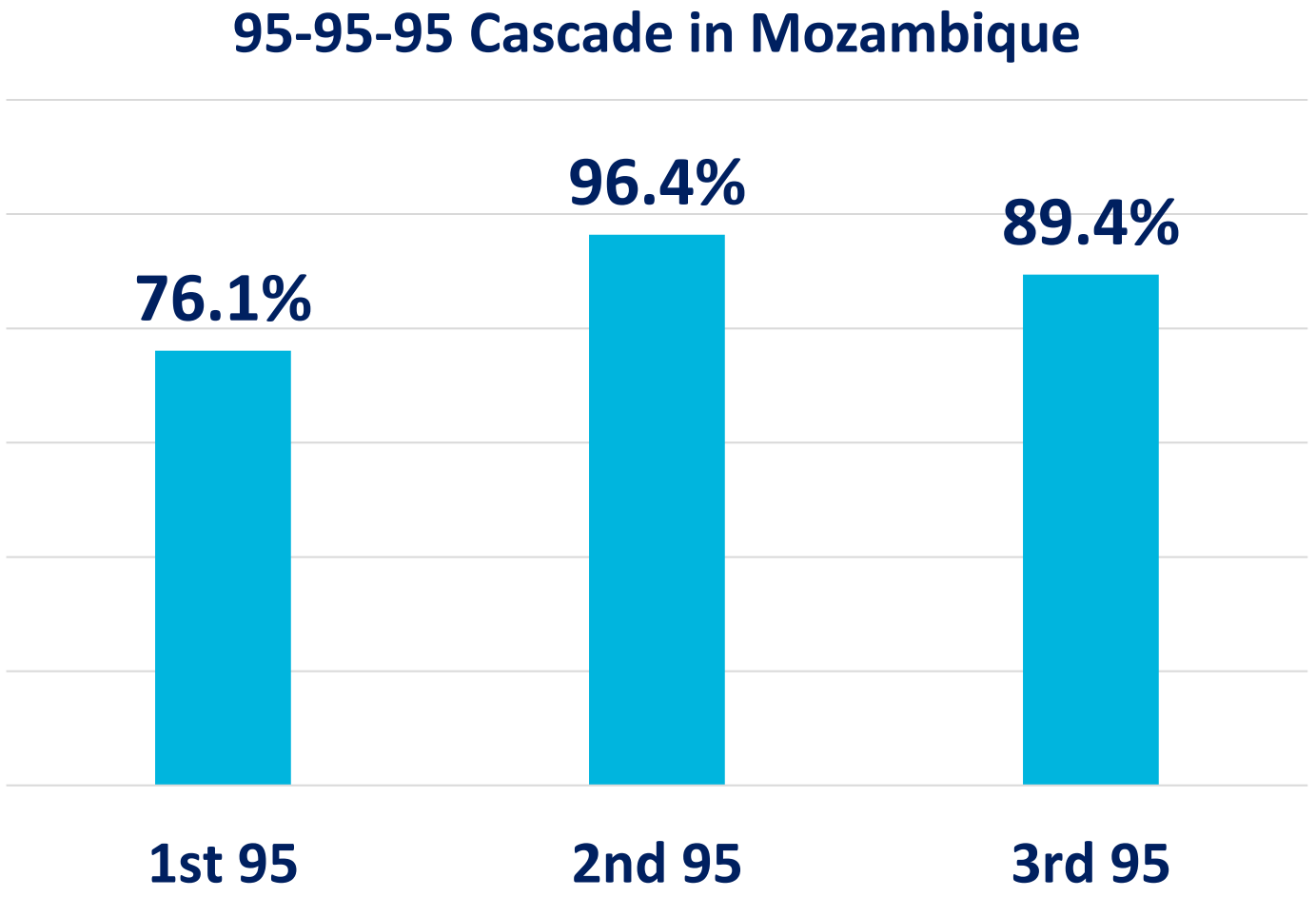
12.5% HIV prevalence

89000 New infections (yearly)

40000 Deaths (yearly)

2,105,907
People living with HIV on treatment

1,755 health facilities providing ART services



CQUIN Treatment Dashboard Results: 2023

Policies				Scale Up Plan
Guidelines				Key Populations
Diversity				MCH
Coordination				HTN
Training				Family Planning
Procurement				
Facility Coverage				
Client Coverage	Community Eng.	M&E System		
Impact	TB/HIV	Quality	AHD	

The national HIV treatment policy includes a national strategy for AHD identification and AHD services

Most mature domains

Least mature domains

- M&E Systems do not capture comprehensive DSD data
- Quality standards were not all met
- AHD engagement of ROC and coverage is not optimal
- No specific DSD for each KP group
- No less intensive models for PBFW
- NCD and FP not fully integrated into less intensive models

CQUIN AHD Dashboard Results 2023

Policies		Diagnostic Capability 2		AHD Scale-up Plan
Guidelines		Client Coverage 3		ROC Engagement
SOPs		Client Coverage 4		Client Coverage 1
Coordination		Supply Chain		Client Coverage 2
Training		Quality		Impact
Diagnostic Capability 1	M&E System		Facility Coverage	

Most mature domains

Least mature domains

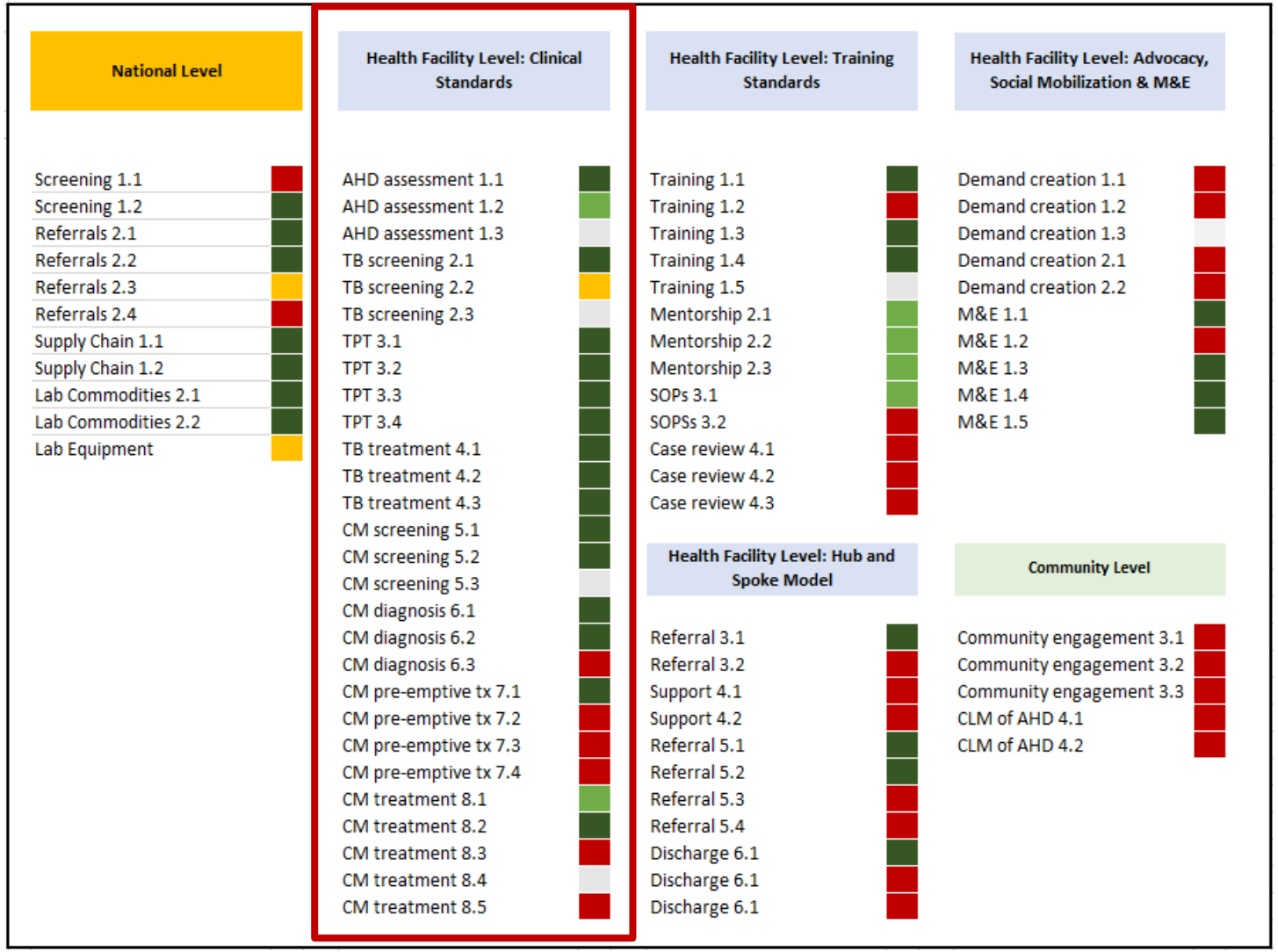
- AHD is being implemented in a phased approach
- AHD diagnostic capability is currently available only at AHD designated HF (81)
- Improvements on the supply chain are needed to ensure full availability of AHD commodities
- Plans to scale up AHD discussed on a quarterly basis
- Recipients of care are not fully engaged in the development of AHD policies
- Quality domain at yellow (one evaluation done that did not meet national standards)

AHD Quality Standards Pilot in Mozambique

Methodology

- **The AHD standards and indicators were shared and discussed at the CQUIN / MOH strategic meeting in February 2023**
- **Mozambique was among five countries identified to pilot these AHD standards and to provide both technical feedback and feedback to improve the tools**
- **These AHD standards and indicators tailored for assessment at**
    1. **National Level**
    2. **Health Facility Level – Hubs and Spokes**
    3. **Community Level**
- **These are generic AHD standards that Mozambique adapted and customized to fit the country context and guidance on AHD service delivery at these three levels**

AHD Quality Assessment Summary Results – May 2023



National Level Quality Standards

- Out of 11 indicators that were assessed, **7 (64%)** were dark green

Health Facility Level Standards (1HF)

- Out of 62 HF indicators, 56 were assessed and **26 (46%)** were dark green

Community Level Standards

- Out of five community level indicators that were assessed, none were dark green

Health Facility Level Findings - AHD Clinical Standards and Indicators

1. AHD Clinical Standards and Indicators

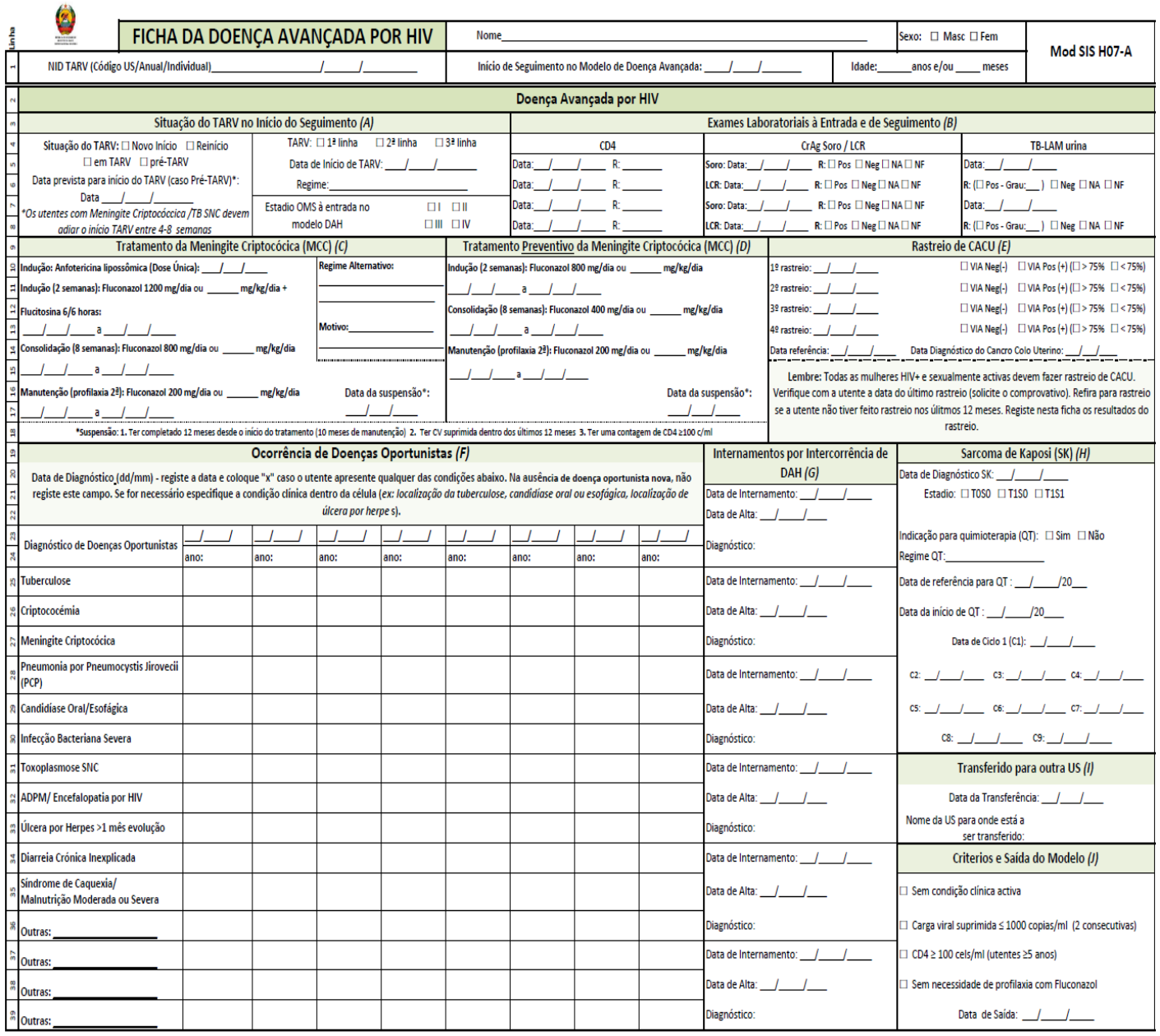
		Mz
Quality Standard 1: All people at risk of Advanced HIV Disease (newly diagnosed initiating ART, presenting with an illness requiring admission, children under five diagnosed with HIV, viremic, and returning to treatment) should be promptly* assessed for AHD using a CD4 cell count test in addition to a comprehensive review of the clinical history and physical examination		
Process Indicators		
1.1	Availability of SOPs to guide assessment of at-risk PLHIV for AHD	
1.2	HF's capacity to provide CD4 testing	
Outcome Indicators		
1.3	Proportion of PLHIV at risk of AHD presenting at this health facility assessed for advanced HIV disease	
Quality Standard 2: All people with AHD should receive prompt* diagnostic testing for TB with rapid molecular tests (TB-LAM and Xpert MTB/rif assay)		
Process Indicators		
2.1	Availability of written SOPs to guide TB screening and diagnosis	
2.2	HF's capacity to provide rapid molecular testing for TB	
Outcome Indicators		
2.3	Proportion of people with AHD with a documented result of a TB rapid molecular test within 24 hours of AHD diagnosis in the past 12 months	
Quality Standard 3: All people with AHD should be screened for TPT eligibility, and if eligible, should be offered TPT		
Process Indicators		
3.1	Availability of written SOPs to guide assessment of TPT *eligibility*	
3.2	Availability of written SOPs to guide TPT *delivery*	
3.3	HF's capacity to provide TPT	
Outcome Indicators		
3.4	Proportion of PLHIV with AHD eligible for TPT who were initiated on TPT in the last 12 months	
Quality Standard 4: All people with AHD and diagnosed with TB disease, should receive immediate* TB treatment		
Process Indicators		
4.1	Availability of written SOPs to guide TB treatment	
4.2	HF's capacity to provide TB treatment	
Outcome Indicators		
4.3	Proportion of RoC diagnosed with TB who were initiated on TB treatment within 24 hours of diagnosis in the last 12 months	

Health Facility Level Findings - AHD Clinical Standards and Indicators

		Mz
Quality Standard 5: All people with AHD should be promptly* screened for cryptococcal meningitis (CM) using serum CrAg		
Process Indicators		
5.1	Availability of written SOPs to guide screening with serum CrAg	
5.2	HF's capacity to provide serum CrAg screening	
Outcome Indicators		
5.3	Proportion of people with AHD that were promptly screened for CM using serum CrAG.	
Quality Standard 6: All PLHIV with a positive sCrAg should receive prompt* diagnostic testing with CSF CrAg		
Process Indicators		
6.1	Availability of written SOPs to guide CSF CrAg testing	
6.2	HF's capacity to provide CSF CrAg screening	
Outcome Indicators		
6.3	Proportion of PLHIV with a positive serum CrAg who received prompt diagnostic test of CSF CrAg	
Quality Standard 7: All people with AHD with a positive sCrAg and a negative CSF CrAg should receive prompt* pre-emptive CM treatment as part of standard of care. This should be initiated within 24 hours		
Process Indicators		
7.1	Availability of written SOPs to guide pre-emptive CM Treatment	
7.2	Adequate medicines for all clients needing pre-emptive CM treatment	
7.3	Any delayed or deferred pre-emptive treatment of people with AHD, with sCrAg positive and CSF CrAg negative due to lack of medication/medication stockout in the past 6 months	
Outcome Indicators		
7.4	Proportion of people with AHD, with sCrAg positive and CSF CrAg negative, receiving pre-emptive CM treatment	
Quality Standard 8: All people with AHD with a positive sCrAg and a positive CSF CrAg should receive prompt* CM treatment as part of standard of care. This should be initiated within 24 hours		
Process Indicators		
8.1	Availability of CM treatment	
8.2	Availability of written SOPs to guide CM Treatment	
8.3	Adequate medicines for all clients needing CM treatment	
8.4	Any delayed or deferred CM treatment due to lack of medication/medication stockout in the past 6 months	
Outcome Indicators		
8.5	Proportion of people with AHD, with sCrAg positive and CSF CrAg positive, receiving CM treatment	

Feedback from the AHD Quality Assessment

- This is a comprehensive easy to use self-staging tool that needs repeated use following quality improvement activities.
- Of note is that AHD quality assessment needs to be conducted at national, facility and community levels.
- The criteria to select a HF to be assessed was not clear as Mozambique is using a phased approach to expand AHD services. Some HF implement the AHD package, and some do not. The score will depend on the HF assessed.
- Some of the questions could be reworded for clarity e.g., (Outcome indicator 1.5 – Does the facility have at least 2 HCWs providing HIV services trained in AHD – which services? Clinical? Psychosocial? Lab? Pharmacy?)
- It is critical to adapt the standards to the country's context:
  - For Mozambique, all components regarding screening, diagnosis and treatment of AHD conditions are described in one National AHD Guideline and a broader question on the availability of written SOPs to guide prompt AHD screening and diagnosis and treatment is needed.
  - Because some components of the AHD package of care are available in all HF, for Mozambique these will always score >90%, regardless of whether the HF has all AHD services (e.g., initiating TB treatment within 24 hours and screening for TPT eligibility)



FICHA DA DOENÇA AVANÇADA POR HIV

Nome_____ Sexo: ☐ Masc ☐ Fem

Mod SIS H07-A

NID TARV (Código US/Anual/Individual)_____/_____/_____ Início de Seguimento no Modelo de Doença Avançada: ____/____/_____ Idade:_____anos e/ou ____ meses

Doença Avançada por HIV

Situação do TARV no Início do Seguimento *(A)*

Situação do TARV: ☐ Novo Início ☐ Reinicio ☐ em TARV ☐ pré-TARV

Data prevista para início do TARV (caso Pré-TARV)*: Data ___/___/_____

Os utentes com Meningite Criptocóccica /TB SNC devem adiar o início TARV entre 4-8 semanas

TARV: ☐ 1ª linha ☐ 2ª linha ☐ 3ª linha

Data de Início de TARV: ___/___/_____

Regime:_____

Estadio OMS à entrada no modelo DAH ☐ I ☐ II ☐ III ☐ IV

Exames Laboratoriais à Entrada e de Seguimento *(B)*

CD4	CrAg Soro / LCR	TB-LAM urina
Data:___/___/___ R: _____	Soro: Data:___/___/___ R: ☐ Pos ☐ Neg ☐ NA ☐ NF	Data:___/___/___
Data:___/___/___ R: _____	LCR: Data:___/___/___ R: ☐ Pos ☐ Neg ☐ NA ☐ NF	R: (☐ Pos - Grau:___) ☐ Neg ☐ NA ☐ NF
Data:___/___/___ R: _____	Soro: Data:___/___/___ R: ☐ Pos ☐ Neg ☐ NA ☐ NF	Data:___/___/___
Data:___/___/___ R: _____	LCR: Data:___/___/___ R: ☐ Pos ☐ Neg ☐ NA ☐ NF	R: (☐ Pos - Grau:___) ☐ Neg ☐ NA ☐ NF

Tratamento da Meningite Criptocócica (MCC) *(C)*

Indução: Anfotericina lipossômica (Dose Única): ___/___/___

Indução (2 semanas): Fluconazol 1200 mg/dia ou _____ mg/kg/dia +

Flucitosina 6/6 horas:

___/___/___ a ___/___/___

Consolidação (8 semanas): Fluconazol 800 mg/dia ou _____ mg/kg/dia

___/___/___ a ___/___/___

Manutenção (profilaxia 2ª): Fluconazol 200 mg/dia ou _____ mg/kg/dia

___/___/___ a ___/___/___

Regime Alternativo:

Motivo:

Data da suspensão*: ___/___/___

Tratamento Preventivo da Meningite Criptocócica (MCC) *(D)*

Indução (2 semanas): Fluconazol 800 mg/dia ou _____ mg/kg/dia

___/___/___ a ___/___/___

Consolidação (8 semanas): Fluconazol 400 mg/dia ou _____ mg/kg/dia

___/___/___ a ___/___/___

Manutenção (profilaxia 2ª): Fluconazol 200 mg/dia ou _____ mg/kg/dia

___/___/___ a ___/___/___

Data da suspensão*: ___/___/___

*Suspensão: 1. Ter completado 12 meses desde o início do tratamento (10 meses de manutenção) 2. Ter CV suprimida dentro dos últimos 12 meses 3. Ter uma contagem de CD4 ≥100 c/ml

Rastreio de CACU *(E)*

1º rastreio: ___/___/___ ☐ VIA Neg(-) ☐ VIA Pos (+) (☐ > 75% ☐ < 75%)

2º rastreio: ___/___/___ ☐ VIA Neg(-) ☐ VIA Pos (+) (☐ > 75% ☐ < 75%)

3º rastreio: ___/___/___ ☐ VIA Neg(-) ☐ VIA Pos (+) (☐ > 75% ☐ < 75%)

4º rastreio: ___/___/___ ☐ VIA Neg(-) ☐ VIA Pos (+) (☐ > 75% ☐ < 75%)

Data referência: ___/___/___ Data Diagnóstico do Cancro Colo Uterino: ___/___/___

Lembre: Todas as mulheres HIV+ e sexualmente activas devem fazer rastreio de CACU. Verifique com a utente a data do último rastreio (solicite o comprovativo). Refira para rastreio se a utente não tiver feito rastreio nos últimos 12 meses. Registe nesta ficha os resultados do rastreio.

Ocorrência de Doenças Oportunistas *(F)*

Data de Diagnóstico (dd/mm) - registe a data e coloque "x" caso o utente apresente qualquer das condições abaixo. Na ausência de doença oportunista nova, não registe este campo. Se for necessário especifique a condição clínica dentro da célula (*ex: localização da tuberculose, candidíase oral ou esofágica, localização de úlcera por herpes*).

Diagnóstico de Doenças Oportunistas	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:	___/___/___ ano:
Tuberculose								
Criptococémia								
Meningite Criptocócica								
Pneumonia por Pneumocystis Jirovecii (PCP)								
Candidíase Oral/Esofágica								
Infecção Bacteriana Severa								
Toxoplasmose SNC								
ADPM/ Encefalopatia por HIV								
Úlcera por Herpes >1 mês evolução								
Diarreia Crónica Inexplicada								
Síndrome de Caquexia/ Malnutrição Moderada ou Severa								
Outras: _____								
Outras: _____								
Outras: _____								
Outras: _____								

Internamentos por Intercorrência de DAH *(G)*

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Data de Internamento: ___/___/___ Data de Alta: ___/___/___ Diagnóstico:

Sarcoma de Kaposi (SK) *(H)*

Data de Diagnóstico SK: ___/___/___

Estadio: ☐ T0S0 ☐ T1S0 ☐ T1S1

Indicação para quimioterapia (QT): ☐ Sim ☐ Não

Regime QT:_____

Data de referência para QT : ___/___/20___

Data da início de QT : ___/___/20___

Data de Ciclo 1 (C1): ___/___/___

C2: ___/___/___ C3: ___/___/___ C4: ___/___/___

C5: ___/___/___ C6: ___/___/___ C7: ___/___/___

C8: ___/___/___ C9: ___/___/___

Transferido para outra US *(I)*

Data da Transferência: ___/___/___

Nome da US para onde está a ser transferido:

Criterios e Saída do Modelo *(J)*

☐ Sem condição clínica activa

☐ Carga viral suprimida ≤ 1000 copias/ml (2 consecutivas)

☐ CD4 ≥ 100 cels/ml (utentes ≥5 anos)

☐ Sem necessidade de profilaxia com Fluconazol

Data de Saída: ___/___/___

Next steps

- The tool is comprehensive and easy to use.
- Mozambique has incorporated some of the standards into our national AHD quality standards.
- Some of the standards will not be possible to adapt at this time and the Ministry of Health will reevaluate during the AHD scale-up.
- Mozambique is also rolling out AHD specific tools and M&E systems (AHD master card) that will improve our reporting capacity

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Thank you!