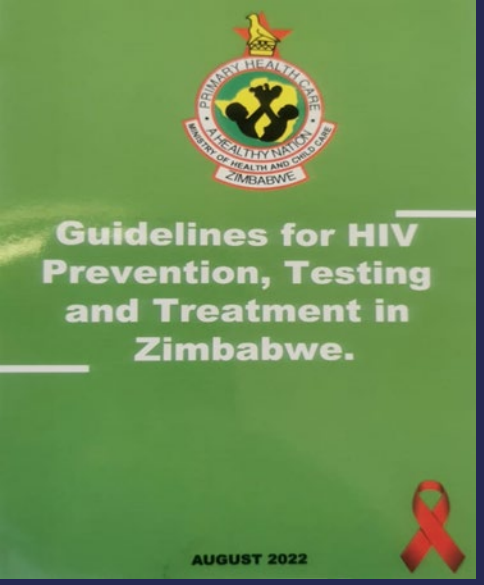
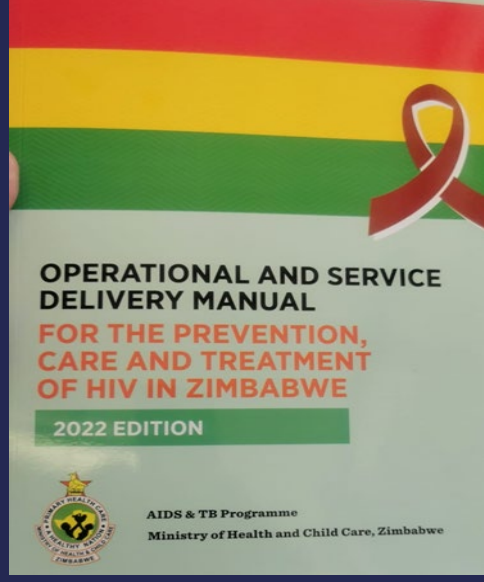




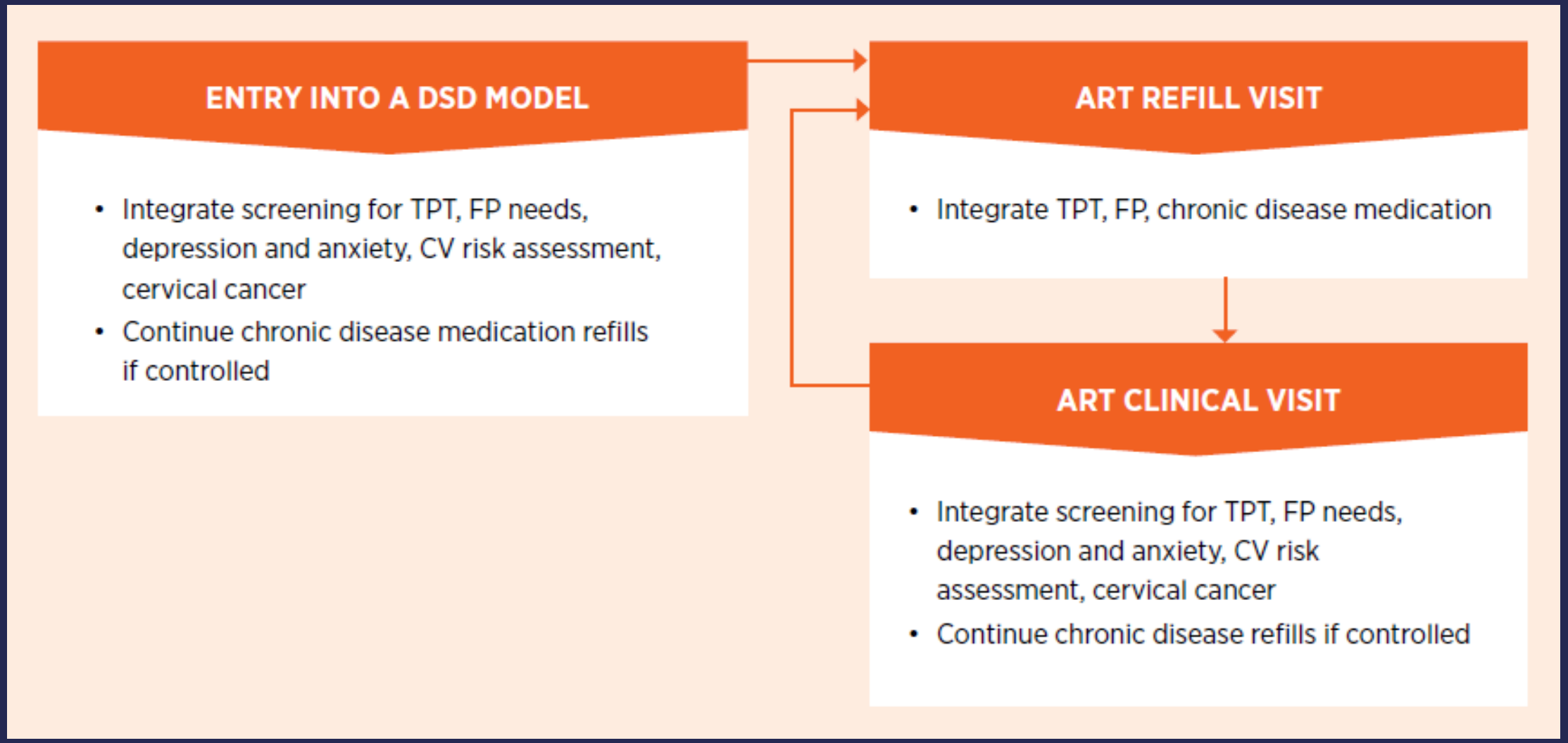
National Guidelines and Tools Adaptation for the Integration of non-HIV services in HIV Services and DSDs for ART (NCDs, FP, Mental Health)

Dr Clorata Gwanzura
Mr Takura Matare
MoHCC, Zimbabwe

Background

- Zimbabwe developed guidance for integration of HTN, DM, Family Planning and Mental Health into DSD for HIV care
  - DSD models provide simplified and adapted HIV services for screening, diagnosis, treatment, and monitoring for NCDs & help reduce clinic visits
  - Guidance incorporated into national HIV Clinical Guidelines and Operational and Service Delivery Manual (OSDM) which outlines operationalization of clinical guidelines
- Clinical guidelines & OSDM
  - Provide guidance to healthcare providers on integrating HTN, DM, Family Planning and Mental Health into DSD models for HIV
  - Have evidence-based recommendations and standardized practices
- Multi-stakeholder approach
  - Involving MoHCC departments (AIDS & TB; NCD, Mental Health); HIV Technical experts, MoHCC healthcare providers from subnational units and implementing partners

Guidance on When Integration Should be Considered



Integration of FP: When

FP may be integrated using the building blocks into any of the four standard DSD for HIV treatment models (Chapter 2.6) and into those models adapted for specific populations.

FP must be offered to adolescents and young adults with a non-judgemental approach and integrated into their adapted DSD for HIV treatment models.

WHEN:

- A quality FP consultation should be carried out at entry into a DSD model and at each clinical visit.
- Those methods requiring ongoing commodities should be given on the same day and time as ART.
- Align pill refills and depot with ART refills.
- Women should always be still offered a six-month ART refill.
- For pills, if the supply chain cannot match 6MMD, provide a multi-month script that can be collected directly from the pharmacy, community distributor or via a refill model.
- Injections should be booked for the same date as ART refills or clinical visits. Women on three-monthly injectables should still be able to receive 6MMD of ART, and the additional visits should be offered at the site they receive their ART.

WHERE:

- Same location as ART
- In some settings, referral may be needed for insertion of IUDs and implants, but the goal should be for other methods to be available where ART is delivered.
- Contraceptive pills and condoms can be distributed in community locations.

WHO:

- The same HCW as providing ART
- Referral may be needed for IUDs and implants.
- In high-volume sites, the goal should be for one HCW to be trained to insert IUDs and implants.
- Community distribution of pills may also be performed by family planning community distributors.
- Condoms may be distributed by community distributors, VHWs, CATS and key population peer supporters.

At entry to DSD

At clinical visits

If oral pills or depo provera - at ART refill

6MMD of pills should be provided

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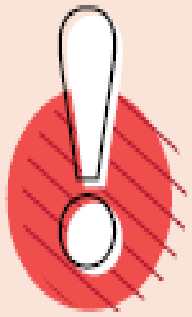
Same HCW as ART

Integration of Hypertension and Diabetes

Recommendations



To identify cardiovascular risk factors, all RoCs living with HIV and on ART should have their blood pressure and cardiovascular risk* assessed during the annual clinical review.

Diabetes and hypertension care should be integrated with HIV services.

Criteria for Established on treatment HTN & DM

CONSIDERATION FOR INTEGRATION	HTN	DM
Control target	<140/90 measured on two occasions at least one month apart	HbA1C <7% recorded in the last 3 months Or Fasting blood sugar (FBS) < 7 mmol/L recorded in the last 3 months
Duration on current regimen	At least three months on current regimen	At least three months on current oral regimen
Other co-morbidities	No other uncontrolled co-morbidities requiring more frequent clinical interventions	No other uncontrolled co-morbidities requiring more frequent clinical interventions
Adherence	Good understanding of lifelong adherence: adequate adherence counselling provided	Good understanding of lifelong adherence: adequate adherence counselling provided

Hypertension and Diabetes Mellitus integration

	HYPERTENSION/ DIABETES SCREENING/ DIAGNOSIS	INITIATION HYPERTENSION/ DIABETES MEDICATION	TITRATION HYPERTENSION/ DIABETES MEDICATION	MAINTENANCE HYPERTENSION/ DIABETES MEDICATION
WHEN	At ART initiation/re-initiation Entry into DSD Clinical visits If normal, repeat BP annually Repeat screening for DM according to national NCD guidance	At ART initiation/re-initiation Entry into DSD Clinical visits	Booked monthly visits until hypertension is controlled	Three monthly clinical and refill visit for HTN/DM When controlled, repeat 3 monthly checks for fasting blood sugar (or HbA1c), BP & BMI. Annual clinical visit and three or six-monthly refills for ART Align HTN/DM/ART clinical and refill appointments
WHERE	Same location as ART	Same location as ART	Same locations as ART	Same location as ART
WHO	Nurse Community cadres	Same healthcare worker as ART Doctor Nurse	Same healthcare worker as ART Doctor Nurse	Same healthcare worker as ART Nurse VHW, key population peer supporter for distribution
WHAT	Correct measurement of BP; fasting glucose; HBA1C	Correct selection of initial BP or DM medication according to algorithm	Correct measurement of BP/ testing of FBG or HBA1C and titration of HTN/DM medication according to algorithm	Hypertension, DM and ART refills

Screening/Diagnosis

Initiation

Titration

Maintenance

Frequency of Hypertension/Diabetes integration

	HYPERTENSION/ DIABETES SCREENING/ DIAGNOSIS	INITIATION HYPERTENSION/ DIABETES MEDICATION	TITRATION HYPERTENSION/ DIABETES MEDICATION	MAINTENANCE HYPERTENSION/ DIABETES MEDICATION
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WHAT	Correct measurement of BP; fasting glucose; HBA1C	Correct selection of initial BP or DM medication according to algorithm	Correct measurement of BP/ testing of FBG or HBA1C and titration of HTN/DM medication according to algorithm	Hypertension, DM and ART refills

Three monthly clinical and refill visits for HTN/DM

Integration of Hypertension/Diabetes Mellitus: When

WHEN:

- Same day and time as ART
- Align duration of all chronic medications: ART, diabetes and hypertension.

What if we cannot provide multi-month medication refills for HTN and DM?

- Multi-month refills of all chronic medications should be the goal.
- **BUT, if that is not possible, DSD models are the means to reduce the burden on the health system and RoCs.**
- Provide multi-month scripting as you would for a refill model.
- Dispensing then will be according to availability or how much the RoC can afford to purchase.
- The dispenser will indicate how much has been dispensed, but the RoC can collect the remaining refill directly from the dispensing point, rather than attending the clinic again for another script.

Don't we have to check the blood pressure every month?

WHO 2021 recommendation: Once established on treatment, BP can be checked every three to six months.

WHERE:

- Same location as ART (facility, out of facility)
- Consider out-of-facility BP checks when RoCs collect their six-monthly refill to enable annual clinical visits.

WHO:

- The same HCW as providing ART
- Community distribution of refills may also be performed by community cadres, including key population peer supporters.

Same day and time as ART

Align refills

If MMD not possible to dispense provide a MMD script which can be collected via a refill mechanism

Integration of Hypertension/Diabetes Mellitus: Where

WHEN:

- Same day and time as ART
- Align duration of all chronic medications: ART, diabetes and hypertension.

What if we cannot provide multi-month medication refills for HTN and DM?

- Multi-month refills of all chronic medications should be the goal.
- **BUT, if that is not possible, DSD models are the means to reduce the burden on the health system and RoCs.**
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WHERE:

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- Consider out-of-facility BP checks when RoCs collect their six-monthly refill to enable annual clinical visits.

WHO:

- The same HCW as providing ART
- Community distribution of refills may also be performed by community cadres, including key

Same location as ART

Consider out of facility BP checks to facilitate out of facility models

M and E System Adaptations to Support Integration Guidance

- Zimbabwe revised national M and E tools to support integration guidance
  - Patient level tools – OI Care Booklet which is source documents for electronic systems (EHR)
  - ART Registers – source documents for the aggregated monthly reporting form/tool
  - Monthly reporting form – source document for the DHIS 2
    - The DHIS 2 was also updated to accommodate these changes

OI/ART NUMBER

P	P	-	D	D	-	S	S	-	Y	Y	Y	Y	-	A

1	2	3 / 4	4.1	4.2	5	6	7	8	9			10	10.1	
Visit No. (Includes visits made at other facility while the patient is away)	Date of review / Visit Type (Use codes below)	3.Weight (kg) / 4. Height (for <15 years measure in cm)	BMI = Weight (Kilograms) / Height² (in meters) (Use codes below)	BP (mmHg)	Pregnancy & Breast-feeding Status (see codes below) / Date of 1st ANC booking or Delivery date	Family Planning Status (multiple response: use codes below)	Functional Status (use codes below)	WHO Clinical Stage (1-4) refer to Page 1	TB status (use codes below) 9a-TB Screening	9a,-TB Investigations: Xpert MTB/Rif (Ultra)LF-LAM TST (Children)	9b-TB Investigation Results	Opp. Infecti-ons & Other Problems (use codes below)	Mental Health Disorders Screening 10.1b. Result (Use Codes Below)	10.1c. Management (Use Codes Below)

2: Visit Type
- A. = Present Self/conventional care (not in a DSD model)
- B. = Sent Care Giver / Treatment Supporter (not in DSD model)
- C = Visit made at another clinic
- D = oMalayitsha / Cross Border Transport
- E = CARG (Family, KPs, General Population)
- F = Clubs (Teen, Carer & Child, Post partum)
- G = Fast Track
- H = Outreach by Facility HCW
- I = Drop in Centre
- J = Out of Facility Community ART Distribution (OFCAD)
- K = Private Pharmacy
- L = Other, Specify

4.1: BMI Classification

BMI	Nutritional status	Code
Below 18.5	Underweight	UW
18.5-24.9	Normal weight	NW
25.0-29.9	Pre-obesity	PO
30.0-34.9	Obesity class I	Ob1
35.0-39.9	Obesity class II	Ob2
Above 40	Obesity class III	Ob3

6. Family Planning Status (multiple response)
- A= Abstinence
- O= Not using
- P= Pills
- J= Injections (e.g Depo)
- M= Implants
- Z= Sterilization
- C= Condom
- T= Traditional/Withdrawal
- L= IUD
- D= Dual Method

5. Pregnancy/Breastfeeding Status
- P= Pregnant
- EFF= Exclusive Formula Feeding
- MF= Mixed Feeding (Below 6 Months)
- BFCF= Breast Feeding & Complementary Feeding
- SBF= Stopped Breastfeeding
- NPL= Neither Pregnant nor lactating (for women)
- N/A=Not Applicable (for men & minors)

10. Opportunistic Infections and Other problems
- Z=Zoster
- P=Pneumonia
- D=Dementia/Encephalitis
- T=Thrush: oral/Vaginal
- U=Ulcers: mouth, genital, etc.
- I=IRIS
- W=Weight Loss
- To=Toxoplamosis
- STI=Sexual Transmitted Infection
- H=Hypertension — HPT 2: Diagnosed; HPT 3: Managed
- Cx=Cancer
- DM=Diabetes Screened — D1: Screened; T1D: Diabetes Type I; T2D: Diabetes Type II; D3: Managed for Diabetes
- HBV=Hepatitis B= — HBV 1 - Tested; HBV 2 - Positive; HBV 3 - on a TDF based regimen
- HCV=Hepatitis C= — HCV 1 - Tested; HCV 2 - Positive; HCV 3 - Treated; HCV 4 - Cured
- O= Other, specify.....

9b. TB Investigation Results
- 1=Investgated and has **Active TB not started on TB treatment.**
- 2=Investigated and had active Tuberculosis started TB treatment
- 3=Investigated and **has No Active TB**
- 4=Not Investigated
- 5=Not Applicable
- *Presumptive cases only.

10.1b. Result
- N=Not screened
- ND=No Mental Health Disorders
- D=Depression
- A=Anxiety
- SA=Substance Misuse
- O=Other, Specify

10.1C. Management
- R=Referred
- Rx=Treated
- NT=Not treated
- N/A=Not Applicable

12a) TPT Eligibility:
- Y = Eligible for TPT
  If ineligible, specify reasons for ineligibility:
- TB = Active TB disease.
- ON = On TB treatment
- AL = Active Liver disease
- AA = Heavy Alcohol Abuse.
- CPT = Completed IPT in the past = 3yrs
- DDI = Drug to Drug interactions

12b. TPT Status
- AT= Active TB disease
- II = INH Initiated
- 3I = 3HP Initiated
- CT= Continue INH
- TC= INH Completed
- AT= INH Stopped due to client developing Active TB disease
- PB= Client became Pregnant and changed from 3HP to INH
- RI= Restart INH
- R3= Restart 3HP
- TNI= TPT Not Initiated due to available regimens
- PN= INH Stopped due to Peripheral Neuropathy
- PP= Patient Refused INH

OI/ART Attendance Register records daily attendance of RoCs and the services that they receive at each visit

14. CSF Investigation (Yes=Positive Yes=NegativePositive, N=Not Assessed)	15. Pre-emptive Treatment with fluconazole (Yes/No)	16. CM Treatment (Checkbox)	17. Hepatitis B Screening and Treatment			18. Hepatitis C Screening and Treatment				19. Screened and managed for Chronic Mental Health Disorders				20. Screened and managed for Hypertension			21. Screened and managed for Diabetes			22. Cotri-moxa-zole (Yes/ No)	
			Tested	Positive	On TDF/3TC Regimen	Tested	Positive	Treated	Cured	Screened	Diagnosed for CMD	Received Interventions for Mental Health	Referred for mental Health	Screened	Diagnosed	Treated	Screened	Diagnosed	Treated		
																				Y	N
																				Y	N
																				Y	N
																				Y	N
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																				Y	N

11. TB Status	
Screened	**Investigations**
Yes- if no signs	Yes, has TB
S-Presumptive if there are signs	Yes, has no TB
ON- on treatment	Not investigated
No- if TB status is not assessed	Not Applicable

16. Cryptococcal Meningitis Treatment
a=Liposomal Amphotericin B, Flucytosine+Fluconazole
b=Liposomal Amphotericin B + Flucytosine
c=Fluconazole+Flucytosine
d=Others, Specify

Pre-ART/ART CHRONIC HIV Register

MINISTRY OF HEALTH AND CHILD CARE

PRE-ART / ART REGISTER

PROVINCE: ..... PROVINCE CODE: .....

DISTRICT: ..... DISTRICT CODE: .....

FACILITY NAME: ..... FACILITY CODE: .....

PERIOD: ..... FROM ..... TO .....

Version 7: January 2024

ART Register

Write in date of visit in the number column			
30. Routine Follow-Up Visits	*Month 0*	*Month 1*	2
a) Date of visit:			
b) WHO staging (1,2,3,4)			
c) Weight / Height			
d) CTX. (I=Initiated, R=Resupply, N/A)			
e) TB screening (Y/N)			
f) TB investigated (Y/N)			
g) TB positive result (Y/N)			
h) Eligible for TPT (Y/N)			
I) TB Treatment (I=Initiated, R=Resupply, N/A)			
j) Tuberculosis Preventive Therapy (TPT)			
k) Cryptococcal Meningitis Status (use codes below)			
l) Other medical problems *(use codes below)*			

30(l) - Other medical problems:

1 - Hypertension
2 - Cancer
3 - Diabetes Mellitus
4 - Hepatitis
5 - Mental Disorders
6 - Others specify.....

Monthly Return Form and DHIS 2

MINISTRY OF HEALTH AND CHILD CARE ZIMBABWE

PMTCT, HIVST, HTS, HIV/TB, OI/ART, PrEP, KPs, PEP, STI/HIV, SEXUAL VIOLENCE, DSD, VMMC & CERVICAL CANCER

MONTHLY PROGRESS RETURN FORM

REPORTING UNIT:							CODE:
PROVINCE:		CODE:		DISTRICT:			CODE:
TELEPHONE:		E-MAIL:					
Start date	Day:	Month:	Year:	End Date	Day:	Month:	Year:

Report timeliness:

The reporting deadlines for all the monthly progress **return** forms are as **follows**;

- **Health** Facility to District (Paper based report): By the 7th
- **District** to Province (Electronic system - DHIS2): By the 21st
- **Province** to Head Office (Electronic system - DHIS2): By the 28th

Site Level	District Level
Prepared By: ..... Date:	Received By ..... Date.....
Checked By..... Date Sent:.....	Checked by ..... Date:.....

Version 6: January 2024

SECTION L: NCDS INTEGRATION SERVICES

NCDs Integration																																					
AGE		≤2 months		3-12 months		13 -24 months		25 -59 months		5-9 years		10 - 14 years		15 - 19 years		20 - 24 years		25 -29 years		30 – 34 years		35-39 years		40-44 years		45-49 years		50-54 years		55-59 years		60-64 Years		65+ Years		Total
SEX		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
NCD 1. Number of PLHIV on ART **(OI ART Attendance Register**	Screened for mental health																																				
	Diagnosed for mental health																																				
	Received interventions for mental health																																				
	Referred for mental health																																				
NCD 2.Number of PLHIV on ART **(OI ART Attendance Register**	Screened for hypertension																																				
	Diagnosed with hypertension																																				
	Managed for hypertension																																				
NCD 3.Number of PLHIV on ART **(OI ART Attendance Register**	Screened for diabetes																																				
	Diagnosed with diabetes																																				
	Managed for diabetes																																				

Thank You