Integrated HIV/HTN

WP 5 – Communication, Dissemination and Exploitation

Stakeholder Engagement Meeting Report

January 20th 2023

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Contents

1. List of Abbreviations

DHO …….. District Health Officer

HIV ……..Human Immuno Deficiency Virus

NCD ……Non Communicable Diseases

FP …… Focal Persons

MOH ……. Ministry of Health

HTN…….Hypertension

PI …….Principal Investigator

IDRC ……..Infectious Diseases Research Collaboration

BP ……Blood Pressure

NCDFP……Non-Communicable Diseases Focal Person

CME…….Continuous Medical Education

NMS ……..National Medical Stores

RBF …….Results Based Financing

ART……..Anti-Retroviral Therapy

1. Introduction

The stakeholder engagement meeting was convened on January 20, 2023, in Mbarara district, bringing together District Health Officers (DHOs), clinicians, HIV/NCD Focal Persons, and other health facility staff from 26 districts, as stakeholders in the districts where the Integrated HIV/HTN Project is implemented.

The meeting was hosted by the Ministry of Health, which is mandated with the Communication, Dissemination and exploitation Work Package (WP5). The stakeholder engagement meeting was convened in order for the project team and the district health teams to discuss lessons learned, best practices, challenges, and sustainability plans after the project has ended. It was an interactive session where constructive feedback was shared and members were able to express themselves freely.

The meeting was presided over by Dr. Gerald Mutungi, the Co-Principal Investigator and Assistant Commissioner NCDs at the Ministry of Health (MOH) Uganda, who made the opening remarks. This was followed by introductions from the participants, who then set the pace by pointing out their expectations for the meeting.

2. Prayer

The opening prayer was said by Dr. Brian Twinamatsiko.

3. Opening remarks – Dr. Gerald Mutungi, Co-Principal Investigator, MOH.

Gerald Mutungi addressing the stakeholders at the meeting in Mbarara.

The meeting was opened by Dr. Gerald Mutungi who started by thanking the health workers and DHOs for making a difference. He further pointed out that the Ebola Virus Disease did not afflict the south western part because the health teams employed good surveillance efforts. He also appreciated the team for fighting COVID-19. He informed the attendees that the MoH was implementing evidence-based policy and encouraged them to continue supporting the project willingly.

Dr. Mutungi further expressed that there was still need to understand that hypertension (HTN) can be controlled, citing that People Living With HIV/AIDS (PLWHIV/AIDS) were much more likely to live longer than those living with Non-Communicable Diseases (NCDs). He cautioned the health teams, saying that they should not manage HIV among patients and uncontrolled HTN kills them. He advised that screening should be made wide spread and not only in the HIV clinics.

He also went on to tell the District health teams to always measure the patients' blood pressure before performing ay kind of treatment or diagnosis on them. He gave an example where he once went to a Health Centre IV and said that he was experiencing headache and general body weakness for two weeks. He was given Coartem and Panadol. He noted that at his age of 50+ years, they should have checked for HTN, diabetes but they did not. He said that with the Results Based Financing (RBF) and other funding options, there was no reason why health workers should lack Blood Pressure measuring machines.

Dr. Mutungi communicated that he was interested in listening to the district health teams in order to understand their submissions and feedback for the past three years. He reminded them that there were no specific signs of high blood pressure. He said that the symptoms normally presented as complications, mentioning that all patients of over 40 years should know their blood sugar and blood pressure statuses at least once a year.

He resounded a wakeup call with the message of blood pressure measurement his is a wake-up call about the need to measure BP start patients who are found to have high BP on pharmacological treatment.

He also announced that MOH updating the clinical guidelines and essential drugs list, since drugs such as Nifedipine that were no-longer working due to the side effects. He also reemphasised the need for the district health teams to continue supporting the Integrated HIV/HTN project, because of it capacity to inform policy planning.

Finally, Dr. Mutungi, declared the workshop open, on behalf of the Ministry of Health.

4. Project overview – Ms. Jane Kabami – Principal Investigator, PI, IDRC

Ms. Jane Kabami makes a presentation at the stakeholder meeting.

The project overview was presented to the team by Ms. Jane Kabami, the Principal Investigator. She started by thanking Dr. Mutungi for his kind remarks. She went on to welcome all the attendees to the meeting and discussion. She emphasized that that HTN was a real burden to the nation and that there was need for joint effort to manage the burden.

She recapped that the Integrated HIV/HTN project was launched 3 years ago, pointing out that almost one in three adults has HTN today. She prevalence is at 30%. At the time we started, diagnosis, treatment and control were very low. She expressed to the team that the project was conducting a survey and that the District and health worker teams would be notified once the results from were available.

She also said that the project encouraged screening and intervention as recommended in the 2014 World Health Organization (WHO) guidelines. She added that the project adopted that to integrate

HTN control in HIV positive patients. She however noted that despite the efforts, the HIV burden was still prevalent, given that fourteen million people are still living with HIV in Uganda. She stressed the need to continue managing both HIV and HTN.

She also explained that our focus was mainly on HTN which was more prevalent causing mortality. The Integrated HIV/HTN project is implemented in 26 districts and focuses on 3 primary outcomes.

- Screening which focused on proportions of HIV patients screened for HTN.
- Control which focused on proportions of HIV patients whose BP was controlled.
- Dual control which focused on HTN control and viral load suppression at the same time.

In total, have conducted three surveys including the 12, 18, and 24-month surveys.

Only 27% of adults living with HIV had ever been screened. This was a key barrier. Other barriers included:

- Poor access to drugs.
- Weak Monitoring and Evaluating (M&E) system.
- Issues around task shifting.
- Fragmented HIV/HTN services where HIV and HTN services were given on different days for patients who had both HIV & HTN.

To date, the project had further provided the following to support implementation.

- Provision of BP machines.
- Green cards.
- Training and capacity building
- WhatsApp platform
- Ensuring that HTN parameters end up in Electronic Medical Systems EMR systems,

In the control arm, we only supported the health facilities with Blood Pressure Machines and Green Cards.

4.1 Overview of our findings

At baseline, our screening rate was less than 1% among HIV positive patients. After one year, it had increased to 28%. We hope that it will keep getting better. The treatment rate was at 17% and increased to 79% at one year. The control rate was at 13% and increased to 29.5% after one year.

At month 18, blood pressure control had increased to 30%. Some of the health facilities are doing well while others are struggling. Some of the reasons cited for poor control include lack of patient tracking and monitoring and challenges with prescription.

Jane acknowledged to the teams that despite the challenges, there was hope and progress. She urged the team to continue with the good work. She went on to appreciate their work saying that there was progress across the facilities. She said that the project was in its last quarter in year 3 of implementation. Support supervision was ongoing and she hoped that the teams would maximize and discuss how we could keep improving with regard to HTN control. She told the attendees that the project had provided control drugs and expected feedback on what could be done to control HTN in the patients.

Jane suggested that both the project team and the district health teams continue to work together to forge a way forward on how HTN management could be done after buffer drug distribution and when the project ends.

She finally thanked attendees on behalf of the consortium for their support and expressed her gratitude. She said that she hoped that the cooperation between the project and the district health team would continue working together.

5. Expectations

The following were the expectations that were set by the DHOs and health facility teams.

- How best to control hypertension among our clients.
- To find out how we performed in the last year (Year 2).
- Feedback about what has been transpiring in regard to integration of HIV and HTN.
- To find out results for the survey.
- Progress of the implementation from the action items.
- Feedback from support supervision.
- To know the facilities that are participating in the project, both in the control and intervention arms and why there is not control of BP in some facilities.
- To come up with strategies in managing hypertension and HIV.
- To know the plans to engage other facilities not engaged in the project.
- To learn from facilities with high BP control.
- Strategies for sustainability of drug supply.
- Clarity on BP control.

- Clarity on drug holidays.

6. Discussion on lessons learned and best practices, Facility feedback and discussion, Discussion, recommendations and way forward.

District health teams taking part in the lessons learned, best practices exercise from their participation in project implementation.

6.1 Rakai

The Rakai Team resented the following:

6.1.1 Lessons learned

- Health care provider-initiated screening, which increased client identification.
- Increased identification of HTN clients following screening, which enhanced health education in all service points.

6.1.2 Best practices

- Conducting HTN screening as part of triage.

- Follow up and monitoring of clients using refill schedules.
- Every staff was trained and made aware of the need to screen for HTN.
- HTN discussion were made part of the agenda in every facility monthly meeting.

6.1.3 Strategies

- Adoption all the best practices mentioned above.

6.2 Lyantonde

6.2.1 Best practices and lessons learned

- The HIV clinic was made a one stop centre where patients could receive both HIV and HTN care at the same time.
- Dual management of both HIV&HTN was found to reduce patient transport costs and the health worker patient burden at the same time.
- Team work between the HIV and HTN clinics was enhanced through cooperation.
- Routine screening at all service points was made compulsory at the health facilities.
- Health workers demonstrated increase in knowledge gain in NCDs and their management.

6.2.2 Feedback on Project implementation

6.2.2.1 Positive

- The project was well coordinated.
- There was continuous communication with health facilities.
- Regular support supervision had improved performance.
- IEC materials, registers, batteries, BP machines, cards , drugs were all well provided.

6.2.2.2 Negative

- Irregularities in provision of Data money were hindering communication, hence leading to poor reporting.

6.2.3 Strategies

- HTN-DM-HIV support groups for patient support were formed.
- Data review meetings were held regularly.
- Continuous CMEs were conducted at the health facilities.

- The National Medical Stores (NMS) and other stakeholders to provide NCD drugs were engaged.

6.3 Kamwenge district

6.3.1 Best practices

- HIV/HTN screening at all entry points was intensified.
- HIV/HTN patient group formation was supported.
- The HIV and HTN clinic days were integrated for clients.

6.3.2 Lessons Learned

- Strengthening HTN screening led to early identification and management of HTN clients.

6.3.3 Challenges

- Drug stock outs .
- Knowledge gap among some staff members.
- Documentation Challenges.
- Lost follow ups and missed appointments.

6.3.4 Strategies for improving BP Control

- Advocating for regular supply of HTN drugs from NMS.
- Redistribution of HTN drugs within the district.
- Capacity building on management of HTN/ HIV especially for newly recruited staff members.
- Endeavour to maintain trained and experienced staff members at the implementing sites.
- Proper use of appointment registers and follow up of missed and lost HIV/HTN clients.

6.4 Buhweju District

6.4.1 Best practices/lessons learned

- Weekly CMEs on NCD screening,
- Assigning a peer at every entry point to screen for HTN.
- Quarterly performance reviews.
- Weekly reports on performance which helped to identify the gaps.
- Formation of NCD clubs.

6.4.2 Challenges

- Lost follow up of clients.

- Referral system for patients with High BP was still a challenge.
- Some members in the NCD clubs do not subscribe with payment.
- Transfer of health centre staff and understaffing affected performance.

6.4.3 Strategies for sustainability

- Scheduling Pre – ART meeting reminders.
- Strengthening NCD patient clubs.
- Including NCD commodities in work plans.
- At district level, HTN/HIV indicators to be discussed in performance meetings.
- Introduction of quality improvement projects on NCD screening and Control.
- Strengthening mentorship and support supervision.

6.5 Isingiro

6.5.1 Best practices/lessons learned

- Routine screening at all entry points was intensified.
- Supply of drugs, BP machine batteries made a difference in screening rates.
- Formulation of patient health clubs at Mbaare HCIII was welcomed by patients.

6.5.2 Feedback on project implementation

- Screening/enrolment of patients was intensified.
- Improved control of BP.
- Regular supply anti HTN drugs, NCD cards, batteries and BP machines was helpful.

6.5.3 Sustainability strategies

- Pooling funds through patient health clubs to help patients during drug stock outs.
- Primary Health Care to help on supplies such as batteries etc.
- HTN/DM (NCDs) FPD.

6.6 Kyenjojo district

6.6.1 Best practices

- Health education talks and CMEs.
- Prioritizing BP taking at triage.
- Opening quality improvement projects.
- Recording patients' findings in both NCD cards and patient files.
- Second person at the dispensary to check for BP taken.

- Ensuring that all staff in the ART clinic know how to take and record BP.

6.6.2 Lessons learned

- High prevalence of HTN in HIV clients.
- Many clients would go undiagnosed.
- Integration of care for both HIV and HTN as this saves time.
- Patient tracking and monitoring using NCD cards and patient files.

6.6.3 Strategies for improving BP control and sustainability

- Health education including lifestyle changes and adherence to drugs.
- Ensuring availability of drugs (HTN) the right quantities.
- Regular measurement of blood pressure to decide on whether to increase doses or maintain the same doses.
- Group discussions and meetings among the clients (both controlled and not).
- Planning to open patient clubs by buying drugs through pooling funds.
- Engaging stakeholders (politicians, community leaders, and HUMC)
- Identifying champions of these clubs to always gather these clients for purposes of disease control.

6.6.4 Feedback on project implementation

- Increased screening in the ART clinic.
- All HTN patients started on PX.
- Held facility meetings regarding management of HTN.
- Reporting using the reporting templates provided.

6.7 Rubanda district

6.7.1 Best Practices and lessons learned

- Screening all patients above 18 years at all service points.
- Initiation of treatment to all diagnosed patients with very high BP.
- Improvement in providing psychosocial support to clients.
- Formation of hypertension patient clubs in our facilities.
- Reduction on hypertension complications like stroke.
- Adequate supply of medicines.

6.7.2 Feedback on the integrated HIV/HTN Project

- Attainment of knowledge in integrate management of HTN/HIV.

- Constant supply of medicines and other logistics.
- Improvement in lifestyle modification leading to control in HTN and viral suppression.

6.7.3 Exit - Strategies

- To maintain HTN clubs at the facility.
- Intensifying of health education talks about NCDs,
- Strengthening od counselling on lifestyle modifications.
- Inclusion of HIV/HTN presentations in our routine quarterly facility performance review meetings.

6.8 Kabale District

6.8.1 Best Practices

- Screening for HTN at all entry points at the health facility.
- Increased awareness creation on the importance of HTN screening among Health Centre. workers and peers.
- Bi monthly NCD clinics.
- Formation of self-support groups.

6.8.2 Feedback on the integrated HIV/HTN Project

- Increased availability of buffer stocks and adherence resulting in good control of BP.
- Provision of equipment and tools used in monitoring HTN.
- Inadequate F/U strategy and tools.
- Limited scope of the study.

6.8.3 Exit – Strategies

- Integrate HIV, DM, mental health into chronic care clinics.
- Carry out monthly CMEs.
- Maintain and support self-help groups.

6.9 Rukiga Distict

6.9.1 Best practices and lessons learned

- Integration of HIV and HTN appointment dates; for example, on one clinic day monthly.
- Regular phone-calls and contacts between patients and health workers.
- Integrated screening for HTN at triage; i.e., BP check-up for all patients including HIV+ patients.
- Integrated follow up of missed appointments.

- Regular health education on prevention and non-pharmacological measures of HTN (lifestyle modifications; such as exercise.
- Identification of a focal at the facility to lead the team for quality care.

6.9.2 Challenges

- Drug stock outs affect Multi Month Drug Distribution (MMD) in HIV care.
- Equipment breakdown.
- Inadequate staffing at the health facility.
- Stigma and missing appointments.
- Lack of funds for following up clients.
- Poverty – clients are unable to buy drugs to control their blood pressure.

6.9.3 Lessons learned

- There has been improved service delivery.
- There is an increment in identified HTN cases.
- Reduced cases of stroke and other HTN related complications in HIV clinics.

6.9.4 Feedback/recommendations

- To ensure sustainability measures with other stakeholders; such as the Ministry of Health and other NGOs.
- To integrate quality improvement in HTN/HIV care services.
- Continuous capacity building and mentorship to new staff at the heath facilities.

7. Rubirizi District

7.1 Best Practices / Lessons learned

- Non-technical staff like peers and VHTs can be engaged on management of NCDs (screening/education and community mobilization).
- High prevalence of NCDs especially HTN among HIV positive patients.
- HIV positive clients have misconceptions about feeding that predisposes them to NCDs.

7.2 Feedback on best practices

- Routine screening for all and documentation reading on both the clients' books and the health cards.
- Re-assessment of all clients who are suspected to have HTN when screened.

7.3 Strategies to improve or maintain

- Continuous CMEs about HIV/HTN for new staff members, and newly transferred members at the facility.
- Districts to emphasise routine reporting on HIV/HTN management in health facilities.
- Districts to plan to scale up HTN/HIV to other facilities through mentorships.

8. Rwampara District

8.1 Best practices and lessons learned

- Improved access to NCD/HTN services.
- Capacity building (CMEs).
- Demand creation for HTN services.
- Reduction in frequency of clients to HTN/ART clinic.

8.2 Feedback on project implementation

- Support in essential medicines and other health supplies.
- Capacity building.
- Data for reporting.

8.3 Strategies for sustainability

- Use of standard Rx (Medical prescription) guidelines for initiation of guidelines.
- Continued capacity building.
- MOH to streamline the supply of NCD drugs and commodities.
- Strengthening established HTN clubs.
- Incorporate HTN in quality improvement initiatives.

8.4 Challenges

- Bp machines need recalibration for accuracy.
- Loss to Follow up (LTFU) clients.

9. Ntungamo district

9.1 Lessons learned

- The more patients screened, the more the HTN cases are identified.
- Some newly diagnosed cases of hypertension can have their BP reduced without necessarily starting on HTN drugs as long as proper counselling is done.
- Community demand for screening has increased.

9.2 Feedback on implementation Challenges.

- Inadequate supplies from NMS.

9.3 Strategies for improving BP control and sustainability of screening and documentations.

- Mobilization of clients to form groups for resource mobilization.
- Supportive education and counselling of patients on diet and lifestyle modification.

9.4 Recommendations

- To train VHTs on Community based HTN and DM screening.
- Conduct targeted home-based screening and management of BP among uncontrolled patients.

10. Kibaale district

10.1 Best and lessons learned

- Active involvement of volunteer staff in screening of HTN.
- Routine sensitization of clients about HTN.
- Formation of HTN clubs that help in information sharing and confidence building.

10.2 Feedback on project implementation

- Improved screening, diagnosis and management.
- Stock sustainability.
- Awareness of HTN among clients.
- Awakening health workers' minds on screening and management of HTN.

10.3 Strategies for sustainability

- Sustaining HTN clubs.
- Aligning HTN drug refills with ART refills.
- Assigning a HTN focal person to monitor screening and audit documentation.
- Monthly facility-based performance review meetings.

7. Program for the Stakeholder Engagement Meeting on 20th January 2023

Moderators:

- Dr. Mucunguzi Atukunda
- Dr. Brian Twinamatsiko

Rappoteur/ Reporters:

- Ms. Amanda Atukunda
- Ms. Charity Ainembabazi

Registration:

- Linda Nassaka

General Meeting Support

- Mr. Frank Sande

DAY	TIME	ACTIVITY	PERSONS RESPONSIBLE
20th January 2023	8:00 -8:30am	Arrival and registration	Ms. Charity Ainembabazi Ms. Linda Nassaka Ms. Elizabeth Arinitwe
	8:30 – 8:45am	Introductions	Dr. Mucunguzi Atukunda
	8:45 – 9:00am	Opening remarks	Dr. Gerald Mutungi
	9:00 - 9:20am	Project update	Ms. Jane Kabami
	9:20-10:00am	Discussion on lessons learned and best practices	Dr. Mucunguzi Atukunda/Dr. Dr. Brian Twinamatsiko

DAY	TIME	ACTIVITY	PERSONS RESPONSIBLE
	10:00-10:30am	Tea Break	Mr. Frank Sande
	10:30 -11:30am	Facility feedback and discussion	Dr. Gerald Mutungi
	11:30 -12:45pm	Discussion, recommendations and way forward	Ms. Jane Kabami
	12:45 -1:00pm	Closing remarks	Dr. Mutungi Gerald
	1:00 pm	Lunch and departure	Mr. Frank Sande

8. Attendance

No.	Name	Designation	Organisation
1.	Ms. Jane Kabami	Principal Investigator, PI	Infectious Diseases Research Collaboration, IDRC
2.	Dr. Gerald Mutungi	Co – Investigator & Assistant Commissioner, NCDs, Uganda Ministry of Health	Ministry of Health, MoH
3.	Dr. Mucunguzi Atukunda	Project Coordinatior	Infectious Diseases Research Collaboration, IDRC
4.	Dr. Brian Twinamatsiko	Project Coordinator	Infectious Diseases Research Collaboration, IDRC
5.	Ms. Elizabeth Arinitwe	Training Coordinator	Uganda Heart Institute, UHI
6.	Mr. Micheal Ayebare	Data Officer	Infectious Diseases Research Collaboration, IDRC

7.	Ms. Linda Nassaka	Regulatory Officer	Infectious Diseases Research Collaboration, IDRC
8.	Ms. Charity Ainembabazi	Communication Specialist	Ministry of Health, MoH
9.	Ms. Amanda Atukunda	Communications Officer	Ministry of Health, MoH
10.	Mr. Frank Sande	Administrative and Logistics Officer – Western Region	Infectious Diseases Research Collaboration, IDRC
11.	Mr. Justus Tumusiime	Monitoring and Evaluation Specialist	Infectious Diseases Research Collaboration, IDRC

9. Conclusion

The stakeholder engagement meeting in Mbarara district was a successful one, with a number of key issues addressed, discussed and conclusions reached. The constructive feedback from the participants demonstrated their commitment to the success of the project and affirmed the role of the partnership between the Ministry of Health and the district health teams with regard to the Integrated HIV/HTN Project. The Ministry of Health was praised for its leadership in the coordination of the meeting and for providing an environment conducive for open dialogue. The success of the meeting is indicative of the commitment of all stakeholders to the success of the Integrated HIV/HTN Project and to the betterment of health outcomes in the districts.