United Republic of Tanzania

Ministry of Health and Social Welfare

General Principles of Good Chronic Care

INTEGRATED MANAGEMENT OF ADOLESCENT AND ADULT ILLNESS

GUIDELINES FOR HEALTH WORKERS AT DISPENSARIES, HEALTH CENTRES AND DISTRICT OUTPATIENT CLINICS IN TANZANIA

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Foreword

The HIV/AIDS Pandemic is not only a grave socio-economic and cultural issue but also a developmental problem calling for new and concerted efforts and initiatives from both developed and developing countries. The care treatment and support for people living with HIV/AIDS (PLHA) has been undertaken in various ways by different countries. There have been different approaches in which individual countries have implemented the care and treatment programmes. WHO with its mandate as the UN technical agency on health issues was concerned in the disparity and the pace in which individual countries were addressing the scourge and the benefits accruing from their discrete and ad hoc initiatives with minimal achievement outcomes. The concerns were even more echoed by the current country initiatives and challenge of scaling up Anti-Retroviral drugs in the care and treatment of the PLHA.

Therefore WHO has developed the Integrated Management of Adolescent and Adult Illness (IMAI) approach to scale up a comprehensive HIV/AIDS care, treatment and prevention within the framework of existing health systems. This public health approach is based on the principles of standardization, decentralization and integration, and covers the whole range of HIV/AIDS-related treatment issues, ranging from clinical staging, to treatment of acute conditions and opportunistic infections, to anti-retroviral treatment and palliative care, with prevention integrated throughout. This approach supports a network model, with back-up for services provided at health centre and district hospital level by clinical mentors within a strengthened consultative/referral and back-referral system.

The approach was tested in Uganda with very encouraging results. This approach puts in place a comprehensive approach to HIV/AIDS care and treatment by making sure that the approach assumes a "bottom –up and not just a top-down" strategy. Peripheral Health facilities i.e. communities, dispensaries and Health Centres, take an active role in not only care and treatment, but also in the follow-up of the PLHA to avoid treatment defaulters and subsequently improve adherence to anti-retroviral therapy.

The IMAI toolkit is new and evolving. It includes patients educational tools (Patient Self Management and Care Giver Booklet; Patients Flipchart); Simplified Guidelines and Training Materials for Primary Care Facilities (Acute care, Chronic HIV and TB Basic Care with ARV therapy, Palliative care, General Principles of Good Chronic care, Wall charts and others).

The IMAI strategy also involves PLHA as patients who are experts in their own illness to support the training of health workers. This is a very effective training intervention, and also addresses effectively the need of increased number of trainers necessary for capacity building during rapid ART scale-up.

The guidelines and manuals after pre-testing in Uganda were adapted in many various countries like Mozambique, Ethiopia, Zambia, Swaziland, Kenya, Egypt etc, and now Tanzania. In Tanzania our adaptation process involved scrutinization of the whole approach to suit our geographical, political, cultural and technical contexts. The purpose was to ensure easy understanding of the IMAI guidelines. The focus was

on editing in terms of content validity, language suitability and acceptability, cultural orientation of the text and pictures/illustrations including synchronization of the materials to our national policies, protocols, procedures, drug list/formulary etc was thoroughly done and involving various Stakeholders or Actors in health.

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Tanzania is also better placed to finding the materials useful by our communities because of the use of one common language (Kiswahili), which will make the translation of the materials very easy and have wider audience applicability.

It is my sincere hope and conviction that this approach will definitely compliment our already started country-wide initiatives in scaling up the care and treatment plan and enable us reach our set targets that result into unbeatable achievements. Let us all aspire for more success and achievement in the war against HIV/AIDS using these guidelines. Thank you so much.

Mr. Wilson Mukama
Permanent Secretary
Ministry of Health and Social Welfare

Acknowledgements

These guidelines and basic materials for training on ART and comprehensive management of HIV/AIDS in Tanzania were adapted from the generic WHO Integrated Management of Adolescent and adult Illness (IMAI) materials. The adaptation process took a long time undergoing changes at different stages and involving quite a number of experts from different organizations and institutions from within and outside the country.

The Ministry of Health and Social Welfare would like to thank all the different experts who were involved in various ways to ensure that the generic IMAI materials become adaptable to the Tanzania context. We would first like to thank WHO for accessing to us the IMAI materials and funding for the adaptation process, which started by first orientation and training of the initial 6 Tanzanian experts on these materials in Masaka – Uganda in 2004. We appreciate the initial training because it resulted into the subsequent IMAI orientation workshops for adaptation purposes within the country, which was held at Kibaha (January 2005), and at White Sands Hotel - Dar es Salaam (October 2005). This exercise involved much more people, facilitated by a team of experts from WHO Headquarters in Geneva and coordinated by experts from WHO country office. The Ministry wishes to sincerely thank the IMAI team of facilitators from WHO – Geneva, led by Dr. Sandy Gove, which also included Dr. Asfour Fareed Ramzi and Ms. Marie-Helen Vannson. The WHO – Tanzania HIV team included the HIV Country Officer, Dr. Lamine Thiam, and coordinated by Dr. Stella Chale. In addition we thank the Social-Cultural adaptation team, coordinated by Ms Feddy Mwanga, and involving Dr. Thomas Scalway from UK, and Dr. Ezekiel Mangi from Muhimbili University College of Health Sciences (MUCHS).

We very much appreciate the valuable inputs provided by the different experts who participated in the two adaptation workshops in Kibaha and Dar es Salaam. The experts came from the following institutions, organizations, departments and programmes: Muhimbili University Colledge of Health Sciences (MUCHS) and Muhimbili National Hospitals (MNH); Bugando Medical Center (BMC); Mbeya Referal Hospital (MRH); Kilimanjaro Christian Medical Center (KCMC), and the Human Resource Development in the Ministry of Health and Social Welfare. Similarly the different programmes of the Ministry of Health and Social Welfare, – particularly; the National AIDS Control Programme (NACP), the National TB and Leprosy Control Programme (NTLP), and the Health Department of Dar es Salaam City Council.

The output of the two workshops in Kibaha and Dar es Salaam resulted into semi-refined IMAI materials suitable for the Tanzanian context and health delivery. The materials were further worked on (layout, editing, etc); by a team of experts before the pre-testing exercise. The team included a consultant for WHO Ms. Moher Downing, from University of California, San Francisco (UCSF) and others as local consultants, comprising of Drs. Bennett Fimbo from NACP; Robert Josiah of MNH, and Amos Odea Mwakilasa (MOHSW) as well as Mrs. Agnes Kinemo and Dr. Adeline Saguti (MOHSW). We thank for their tireless hard work that produced the final IMAI materials for in-country pre-testing and later printing. Similarly we thank the secretaries who were involved in typing the changes during the adaptation and compilation process. They include: Ms Gerwarda Mwatuka (WHO), Ms. Janeth Mbwani (WHO), Ms. Kijakazi Salum (NACP) and Ms Frieda Shauri (WHO).

We would also like to appreciate the contributions made by experts from Uganda Knowledge HUB, WHO/Geneva, Multidisciplinary IMAI National facilitators, Health Care Workers from Health Centres, and Expert patients (PLHA) from various regions of Tanzania who participated in the different stages of field testing and corrections of the adapted IMAI materials. Last but not least, the MOHSW highly appreciates great contributions from Mrs Leila Asfour (Geneva) and Macrographic Company (India) towards graphic designing of all the documents.

To all of you, and those not mentioned, the Ministry of Health and Social Welfare says thank you so much.

Introduction

Integrated Management of Adolescent and Adult Illness (IMAI) is an approach to comprehensive care and treatment of HIV/AIDS aiming at decentralizing such provision of care to lower level health facilities. The approach delegates some of the care and treatment of HIV/AIDS responsibilites to the communities and families of patients and People Living with HIV/AIDS (PLHA).

GENERAL PRINCIPLES OF GOOD CHRONIC CARE

This is one of 5 IMAI modules relevant for HIV care:

- Acute Care (including opportunistic infections, when to suspect and test for HIV, prevention).
- Chronic HIV Care with ARV Therapy.
- General Principles of Good Chronic Care.
- Palliative Care: Symptom Management and End-of-Life Care.
- Patients self management and caregiver booklet

CHRONIC CARE
General Principles of Good Chronic Care

These general principles of good chronic care are relevant to the management of all chronic conditions and their risk factors.

Chronic care based at the primary-care facility near the patient's home

CLINICAL TEAM

Health workers at health centre or dispensary or on outpatient team at district hospital

- Assess, refer patient with suspected chronic illness

  Exception: initiate treatment without referral if:

  - TB treatment with positive sputum, or
  - Leprosy if characteristic skin lesions
  - ARV therapy in patients without complications (see Chronic HIV care module H22)

- Treat according to Treatment Plan

- Do regular follow-up as described in Treatment Plan

- Treat acute exacerbations

Clinicians at district clinic/hospital

- Diagnose
- Develop Treatment Plan
- Follow-up

  Modify diagnoses or Treatment Plan as needed

- Manage severe exacerbations

  Hospitalize when indicated

Consult/refer for certain patients

Treatment Plan

Refer back for scheduled follow-up for exacerbations/poor control of Treatment Plan

Effective communication

General Principles of Good Chronic Care

These principles can be used in managing many diseases and risk conditions.

1. Develop a treatment partnership with your patient.
2. Focus on your patient's concerns and priorities.
3. Use the 5 A's:
   Assess, Advise, Agree, Assist and Arrange.
4. Support patient self-management.
5. Organize proactive follow-up.
6. Involve "expert patients," peer educators and support staff in your health facility.
7. Link the patient to community-based resources and support.
8. Use written information—registers, Treatment Plan, treatment cards and written information for patients—to document, monitor and remind.
9. Work as a clinical team.
10. Assure continuity of care.

The 5 A's

1 **Assess**

2 **Advise**

3 **Agree**

4 **Assist**

5 **Arrange**

Coordinated Approach to Chronic Care

Community partners:

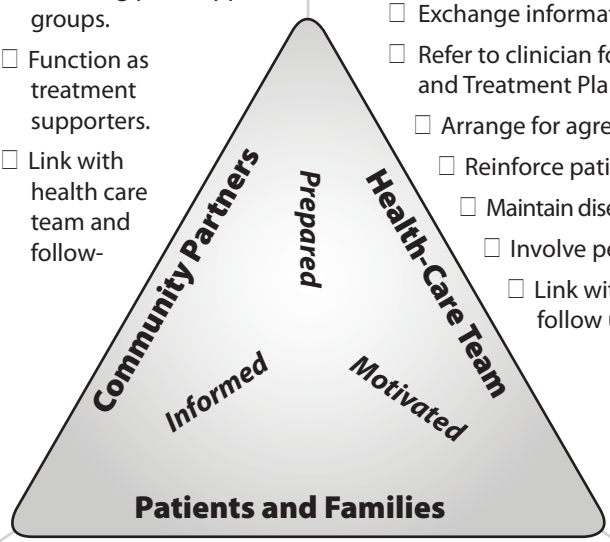
- ☐ Support patient goals and action plans.
- ☐ Provide care and support to patient and family.
- ☐ Where possible mobilize and provide resources to support patient self-management, including peer support groups.
- ☐ Function as treatment supporters.
- ☐ Link with health care team and follow-

Clinicians at district hospital

- ☐ Perform in-depth assessment, diagnose
- ☐ Elicit patient's goals for care
- ☐ Collaboratively agree upon Treatment Plan
- ☐ Revise Treatment Plan as needed

Health workers at the dispensary and health centre:

- ☐ Elicit patient's concerns.
- ☐ Assess patient's clinical condition.
- ☐ Assess readiness to adopt indicated treatments.
- ☐ Exchange information about health risks.
- ☐ Refer to clinician for further diagnostic work and Treatment Plan, if indicated.
- ☐ Arrange for agreed follow-up.
- ☐ Reinforce patient's self-management efforts.
- ☐ Maintain disease registry and treatment cards.
- ☐ Involve peer educators / "expert patients".
- ☐ Link with community partners and follow up periodically.



Patients and families

- ☐ Present concerns.
- ☐ Discuss goals for care.
- ☐ Negotiate a plan of care with provider/team.
- ☐ Manage their condition(s).
- ☐ Self-monitor key symptoms and treatments.
- ☐ Return for follow-up according to agreed plan.

Steps to Guide the Chronic Care Consultation

Use the 5 A's at every patient consultation

INITIAL CONSULTATION/VISIT

ASSESS

☐ Assess patient's goals/reasons for this visit.

☐ Assess patient's clinical status, classify/identify relevant treatments and/or advise and counsel.

☐ Assess risk factors.

☐ Assess patient's knowledge, beliefs, concerns, and daily behaviours related to his/her chronic condition and its treatment.

ADVISE

☐ Use neutral and non-judgmental language.

☐ Correct any inaccurate knowledge (as assessed above) and complete gaps in the patient's understanding of his/her conditions and/or risk factors and their treatments.

If you are developing the Treatment Plan:

- Discuss the options (risk reduction and/or treatment) available to the patient.
- Discuss any proposed changes in the Treatment Plan, relating them to the patient's specific concerns (as assessed above).
- Evaluate the importance the patient gives to the indicated treatment.
- Evaluate the patient's confidence and readiness to adopt the indicated treatment.

Assess

"What would you like to address today?"

"What do you know about ___ (e.g., HIV/AIDS)?"

"Tell me about a typical day including your problem and what you are doing to manage it."

"Have you ever tried to ___ (e.g., change your diet)? What was it like?"

Advise

"I have some information about ___. Would you like to hear it?"

"It has been shown that ___ (e.g., smoking) does great damage to your health. What do you think about that?"

"What questions do you have about what I just told you?"

AGREE

☐ Negotiate selection from the different options.

☐ Agree upon goals that reflect patient's priorities.

☐ Ensure that the negotiated goals are:

- Clear.
- Measurable.
- Realistic.
- Under the patient's direct control.
- Limited in number.

ASSIST

☐ Provide a written or pictorial summary of the plan.

☐ Provide treatments.

☐ Provide medication (prescribe or dispense).

☐ Provide other medical treatments.

☐ Provide skills and tools to assist with self-management and adherence.

☐ Provide/assist the patient to identify adherence equipment (e.g., pill box by day of week).

- Self-monitoring tools (e.g., calendar or other ways to remind and record Treatment Plan).

☐ Address obstacles.

☐ Provide psychological support as needed.

- Help patients to predict possible barriers to implementing the plan and to identify strategies to overcome them.
- If patient is depressed, treat depression.

☐ Link to available support:

- Friends, family.
- Peer support groups.
- Community services.
- For certain treatments, treatment supporter or guardian.

Agree

"Among the options we've discussed, what would you like to do?" Followed by: "Okay. So as I understand it, we've agreed that you will ___. Is this correct?"

Assist

"What problems might arise when you follow this plan? How do you think you could handle that?"

"What questions do you have about the plan or how to follow it?"

"Could you explain back to me in your own words what you understand that the plan is?"

Arrange

"I would like to see you again (specify date if possible) to assess how you're doing. It's important that you come for this follow-up even if you're feeling well."

ARRANGE

☐ Arrange follow-up to monitor treatment progress and to reinforce key messages.

☐ Schedule for group appointments or relevant support groups if available.

☐ Record what happened during the visit.

FOLLOW-UP VISIT

ASSESS

- ☐ Assess patient's goals for this consultation.
- ☐ Assess patient's clinical status.
- ☐ Assess risk factors.
- ☐ Compare assessment findings with those from previous examination and discuss with patient.
- ☐ Assess patient's understanding of the Treatment Plan.
- ☐ Assess patient's adherence to the Treatment Plan (by asking, counting pills, checking pharmacy records). If adherence problem, explore the reasons and obstacles to adherence (including depression).
- ☐ Acknowledge patient's efforts and successes with self-management, even if they are limited.

Assess

"To ensure we have the same understanding, could you tell me about the Treatment Plan in your own words?"

To assess adherence:

"Many people have trouble taking their medications regularly. What trouble are you having?"

ADVISE

- ☐ Repeat key information concerning the patient's condition and its treatment.
- ☐ Reinforce what the patient needs to know to self-manage:
  - Symptoms, when to change treatment or to seek care.
  - Treatment (why it is important; why adherence is necessary).
  - Problem-solving skills.
  - How to monitor one's own care.
  - How and where to seek support in the community.

AGREE

- ☐ Negotiate changes in the plan as needed (for some conditions, a revised Treatment Plan might require a return visit to the district clinician).

ASSIST

- ☐ Address problems with the following Treatment Plan; teach patient how to solve problems and learn from them.
- ☐ Discuss problems that occurred in adherence and develop strategies to overcome them in the future.

ARRANGE

- ☐ Arrange follow-up to monitor treatment progress and to reinforce key messages. (These should be part of a programme of care over time.)
- ☐ Schedule for group appointments or relevant support groups, if available.
- ☐ Record what happened during the visit.

TIPS FOR HEALTH CARE WORKERS

Tips for talking with the patient:

□ Express understanding and acceptance.

□ Avoid arguments.

□ Respect the patient's right to choose.

Tips for involving "expert patients" on the clinical team:

□ Choose patients who:

- understand their disease well;
- are good communicators;
- are respected by other patients; and
- have time to be involved on a regular basis.

□ Ensure they understand and will respect shared confidentiality.

□ Ensure they do not exceed their expertise or areas of responsibility.

Tips for group appointments:

Group appointments can help you make the most of scarce time.

□ Use group appointments to:

- educate patients about their conditions;
- develop peer support and expertise;
- promote self-management;
- conduct clinical follow-up; and
- address difficulties.

□ Use peer educators or "expert patient" to help organize group appointments and to present educational material.

Tips for team meetings:

The purpose of team meetings is to communicate, to share efficiently patient information and Treatment Plans, and to share responsibility for all aspects of care and outcomes.

□ Discuss only a subset of patients each week.

□ The team leader should prepare weekly patient list and agenda.

□ Develop among the team a consistent understanding of each patient's goals, the Treatment Plan and key messages to be delivered by the team members.

USE WRITTEN INFORMATION

Written information helps to:

- Remember the Treatment Plan.
- Monitor and evaluate progress.
- Remember when it's time for a follow-up appointment and facilitate response to missed appointments.
- Transfer pertinent information to others.
- Arrange for supportive care from community resources.

Written information for patients:

Written or pictorial information helps patients remember the plan and monitor their self-management.

- Provide patient with a written or pictorial summary of the plan to take home.
- Provide/assist patients to obtain self-monitoring tools.
- Review patient self-monitoring tools at each follow-up visit.

Tips for keeping health facility records:

Complete registers by the end of each day.

- Keep Treatment Plans/cards in a file box, divided by date of the planned follow-up visit.
- Ensure that registers and cards are kept in a secure and confidential location.

EFFECTIVE COMMUNICATION

Communicating with clinicians at the district hospital:

- These clinicians are part of your clinical team. If you are in a peripheral facility, methods need to be developed for good communication and at least yearly meetings.
- Communicate with district hospital concerning all chronic patients, even when treatment is initiated at the dispansary or health centre.
- Coordinate care with appropriate clinicians.
- Refer patients back to clinicians as appropriate.