

Outcomes & Pathway

Outcome	Education & Advice	Pathway
Normal BP and glucose	Preventive lifestyle counselling	End of screening journey
Existing patients with controlled BP and/or controlled blood glucose	Preventive lifestyle counselling	End of screening journey
Uncontrolled BP/glucose (on treatment)	Lifestyle counselling + adherence counselling + referral to participating Healthcentre	Refer to health centre
Uncontrolled BP/glucose (not on treatment)	Lifestyle counselling + referral counselling + referral to participating Healthcentre	Refer to healthcentres for confirmation and initiation of treatment
High BP / high glucose at screening	Immediate counselling + referral counselling + referral to participating Healthcentre	Refer to healthcentres for facility-level assessment and confirmation of diagnosis
High Body Mass Index (weight /height ²)	Preventive lifestyle counselling	Educate on healthy lifestyle and good food choices

Follow-up visits by CHNs after patients have been manged at Healthcentre for Hypertension and/or Type 2 Diabetes

- Check blood pressure and/or blood sugar for referred patient on hypertension and/or diabetes management
- Encourage the patient to take medicines as instructed by the prescriber
- Reinforce healthy lifestyle habits

After patients have been referred to the health centre and management for Type 2 diabetes and/or hypertension has been initiated, they will return to the community.

Follow-up and ongoing management will continue in line with the appointments scheduled by the health facility until blood pressure and/or blood glucose levels are brought under control.

Follow-up household visits between review months



Once the patient has attained control, the CHN/CHO should conduct household follow-up visits to encourage treatment adherence, monitor progress, and reinforce health education.

These visits can be done by:

- Home visit, or
- the CHPS compound

Conduct patient follow-up visits once or twice before the patient's scheduled review at the health facility, based on the potential review dates given to them.



The role of Community Health Nurses and CHPS Compounds in Hypertension & Type 2 Diabetes Management

Objectives

The AYA Integrated Healthcare Initiative is a project that aims to strengthen the early detection, prevention, and management of non-communicable diseases in Ghana by supporting community screening, linkage to care, strengthened referral and follow-up systems, and targeted health education.



Screening Points:

- Households: Routine community visits by CHNs/CHOs using randomized household selection.
- Community pharmacies and Over-the-counter medicines sellers: Walk-in clients.

Target Population and Scope

- Target Population:
- Hypertension:** Adults ≥18 years, with focus on high-risk groups
 - Diabetes:** Adults ≥35 years, with focus on the same high-risk groups. (obese, sedentary, family history).
 - Other potential target groups:** Younger persons with risk factors (obese, sedentary, family history).
- Inclusion criteria:
- Adult residents within participating districts.
 - Individuals who voluntarily provide informed consent.

Screening Parameters

Referral Cut-off values

Parameter	Target Value	Notes
Blood Pressure	≥ 140/90 mmHg	Clients without comorbidities; Refer to healthcentre for further evaluation
	≥ 130/80 mmHg	Clients with diabetes, chronic kidney disease or ≥3 risk factors; Refer to healthcentre for further evaluation
Fasting Blood Sugar	≥7.0 mmol/L	Refer to healthcentre for further evaluation
Random Blood Sugar	≥ 7.8 mmol/L to 11.0 mmol/L	Conducted 2 hours postprandial / after meals indicates Impaired Blood sugar; Conduct lifestyle counselling and refer to healthcentre for further evaluation
Random Fasting	≥ 11.0 mmol/L	Conducted 2 hours postprandial / after meals; Refer to healthcentre for further evaluation
Fasting Blood Sugar or Random Blood Sugar	≤3.0 mmol/L	Indicates hypoglycaemia or low blood sugar

Screening Urgencies

Immediate referral to nearest hospital if:

- Hypertensive Urgency:** BP ≥180/120 mmHg without evidence of acute organ damage (stroke, heart failure, etc) and with or without mild symptoms (e.g., headache, anxiety).
 - Hypertension Emergency:** BP ≥180/120 mmHg with evidence of acute organ damage or complications often with symptoms.
 - Hyperglycemia:** RBS ≥16.7 mmol/L or FBS ≥13.9 mmol/L with symptoms (frequent urination, excessive thirst, increased hunger, fatigue or weakness, blurred vision, dry mouth)
 - Hypoglycemia for diabetic patients:** Blood glucose ≤3.0 mmol/L.

Anthropometric Measurements

Measure	Values/ symptoms	Categorization	What to do
Body Mass Index (BMI)	18.5– 24.9kg/m ²	Ideal BMI	
	≥25 kg/m ²	Overweight	Patient education on Lifestyle modification
	≥30 kg/m ²	Obese	Patient education on Lifestyle modification
Waist circumference	Males <94cm Females <80cm	Ideal waist circumference	
	Males >94cm Females >80cm	Truncal obesity	Patient education on Lifestyle modification

Screening Process

