

# Institutionalizing AHD Services: Uganda's Journey Toward Integrating AHD Services into Routine Care

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# Outline

- **Context**
- **Why integrate AHD services into Routine Health Services**
- **Steps taken to integrate AHD services into Routine Health Services**
- **What are we seeing**
- **Challenges and solutions**
- **Next steps**

# Context: Advanced HIV Disease Remains a Pressing Concern in Uganda's HIV Response

1.4 M PLHIV active in care of which approx. 5% are non suppressed

30% of non suppressed clients have AHD

**A quarter** of people initiating ART have CD4<200

**25%** of new PLHIV/Returning into care with AHD have TB

**10%** of new PLHIV with AHD have positive crypto antigenemia

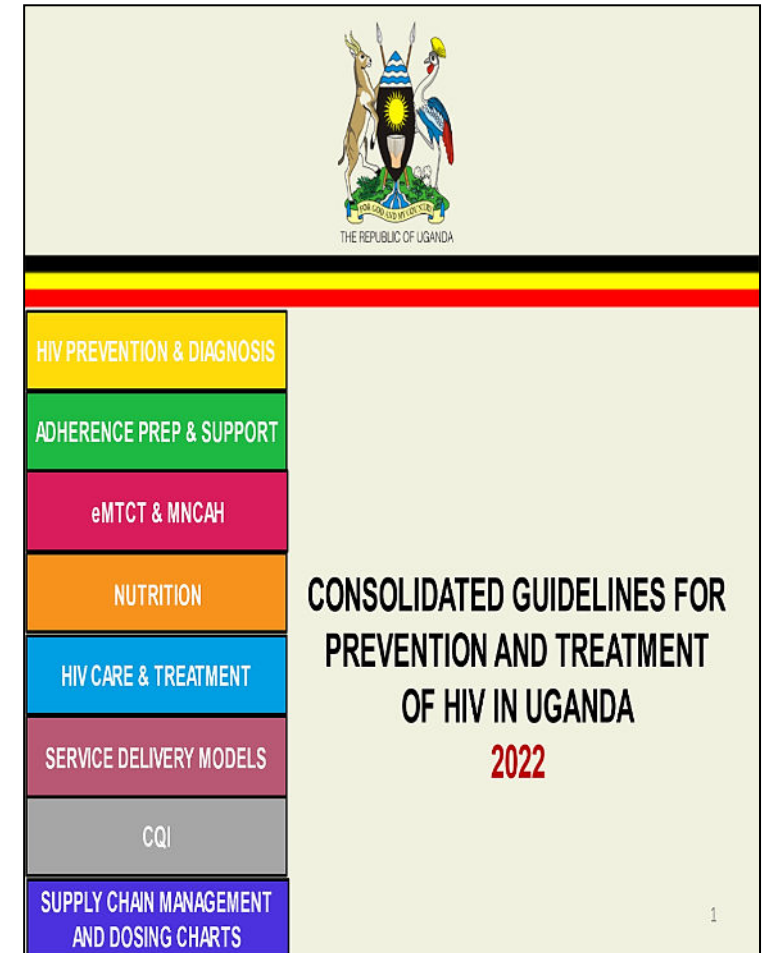
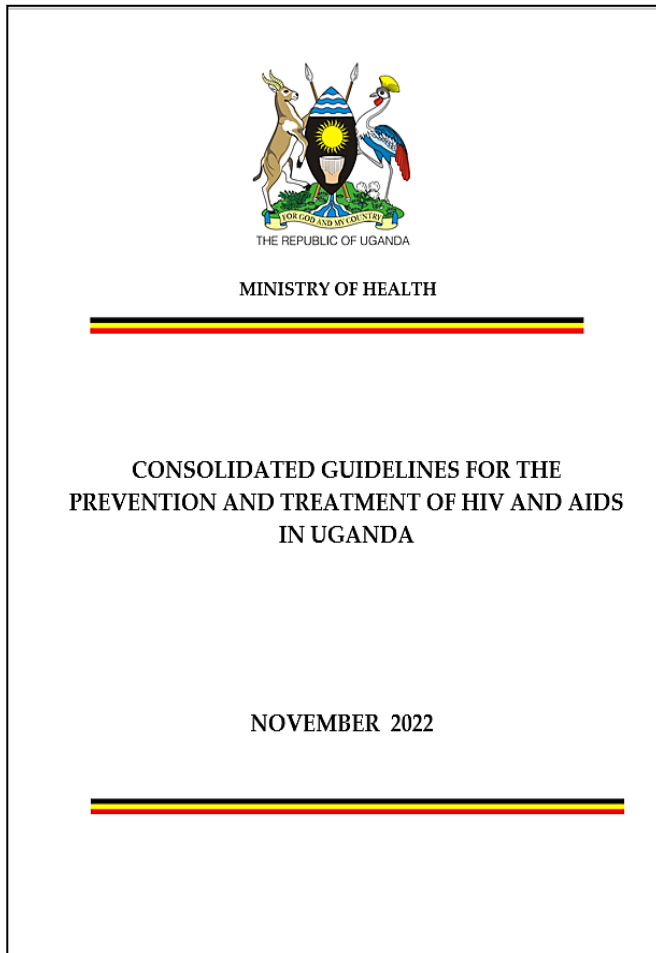
**~25,000** PLHIV in care suffer from AHD annually

Mortality 20000 cases per year

**Aspergillosis & Histoplasmosis, not routinely monitored.**

**EPIDEMIC CONTROL**

# AHD Protocols are Incorporated into the National Integrated Comprehensive HIV Guidelines



# Uganda is Implementing a Structured, Integrated Model for Delivering AHD services

SN	Issue	Solution towards integration
1	HRH capacity to deliver AHD service	<ul style="list-style-type: none"> <li>• Shifted from relying on project to <b>GoU staff</b> to offer clinical HIV services</li> <li>• Maintained skeleton staff to offer <b>psychosocial support</b></li> <li>• Currently conducting <b>refresher trainings on AHD service delivery in integrated clinics</b> for HCWs in chronic care clinics</li> </ul>
2	Device based CD4 testing rolled back in RRH	<ul style="list-style-type: none"> <li>• Adapted to more <b>reliance on device free CD4 testing</b> wherever commodities for machine based CD4 stock out</li> <li>• Currently operating at a ratio of 59%:41%</li> </ul>
3	TBLAM deprioritized for GF and PEPFAR funding	<ul style="list-style-type: none"> <li>• TBLAM to be funded through GoU /+ Strengthening annual <b>CXR TB screening</b> among PLHIV using already existing <b>mobile X-rays</b></li> </ul>
4	Printing HMIS tools constrained by lack of funds	<ul style="list-style-type: none"> <li>• MoH currently <b>rolling out electronic point of care systems</b> (Uganda EMR and eAFYA) to reduce reliance of paper-based tools</li> </ul>

# AHD Services Delivered through Coordinated Efforts of a Multidisciplinary Team

Program Element	What was done
<b>Program coordination</b>	<ul style="list-style-type: none"> <li>• MoH coordinating team (ACP, Lab)</li> <li>• Established a national AHD Technical Working Group (TWG) - MoH, CSOs, DPs &amp; IP</li> <li>• TWG meets on a quarterly basis</li> </ul>
<b>Optimized AHD services delivery</b>	<ul style="list-style-type: none"> <li>• Operationalization of the AHD hub-and-spoke model of care</li> <li>• Decentralized access to AHD diagnostics and therapeutics</li> </ul>
<b>AHD supply chain management</b>	<ul style="list-style-type: none"> <li>• Planning, assumption building &amp; quantification for AHD commodities</li> <li>• Procurement and distribution of AHD commodities</li> <li>• Supported by PEPFAR &amp; Global Fund (GF)</li> </ul>
<b>Capacity building</b>	<ul style="list-style-type: none"> <li>• Building and sustaining capacity to deliver quality AHD package of care</li> <li>• Developed a curriculum for AHD, AHD surge/CQI activities, TSS/mentorships</li> </ul>
<b>Monitoring &amp; Evaluation</b>	<ul style="list-style-type: none"> <li>• Improving the collection and reporting of AHD data</li> <li>• Revision of data collection and reporting tools for adequate AHD data reporting</li> </ul>

# AHD Data is Captured and Reported through the National Health Information System

## Revised AHD Screening tests in the HIV Care Card

CA14					
Tests and Investigations					
CD4/ CD4% CrAg, RPR	TB LAM	LFTs	Date/ Comorbidity Test		
	TB LAMP	RFTs			
	GeneXpert/ Truenat	Viral Load			
	Miscroscopy Xray	HIV Drug Resistance			
	Others				
CD4/CD4%	TB LAM	LFTs Done YES/NO	RFTs Done YES/NO	DDMM/YYYY	HEP B
CrAg	TB LAMP	VL date	VL result	DDMM/YYYY	HEP C
RPR	GeneXpert/Truenat	VL status		DDMM/YYYY	RFTs
	Microscopy	dd/mm/yyyy		DDMM/YYYY	LFTs
	X-Ray	DR result		DDMM/YYYY	RBS/FBS
Others: __	Others: __	DR status		DDMM/YYYY	CBC
				DDMM/YYYY	Others

## Revised Quarterly reporting indicators – HMIS 106a

At ART Initiation

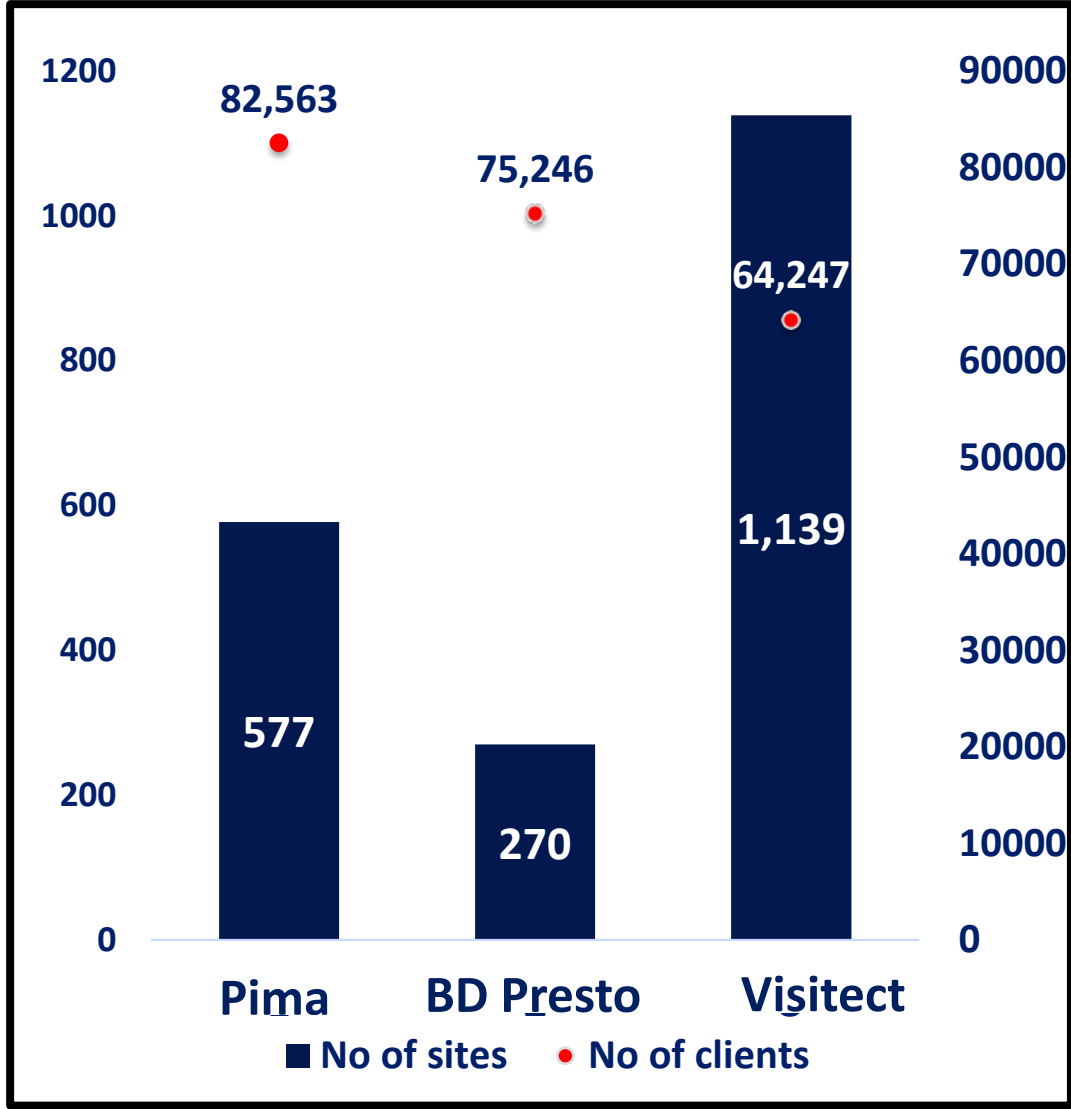
HC10	No. of new clients started on ART with baseline CD4		
HC11	No. of new clients started on ART with baseline CD4 <200		
HC12	No. of new clients with a baseline CD4 <200 that	Tested for TB LAM	
		Positive for TB LAM	
		TB LAM Positive treated for TB	
		Tested for CRAG	
		CRAG Positive	Total Diagnosed with CCM
		CRAG Positive treated with pre-emptive fluconazole	Treated for Cryptococcal meningitis

Non Suppressed Clients

HC41	Number of non-suppressed clients that received CD4 test	Total CD4 < 200	
HC42	Number of Non-Suppressed Clients with CD4 < 200 that;	Tested for TB LAM	
		Positive for TB LAM treated for TB	
HC43	Number of non-suppressed Clients with CD4 <200	Tested for CRAG	
		CRAG Positive	Total Diagnosed CCM
		CRAG Positive treated with pre-emptive fluconazole	
		Treated for Cryptococcal meningitis	

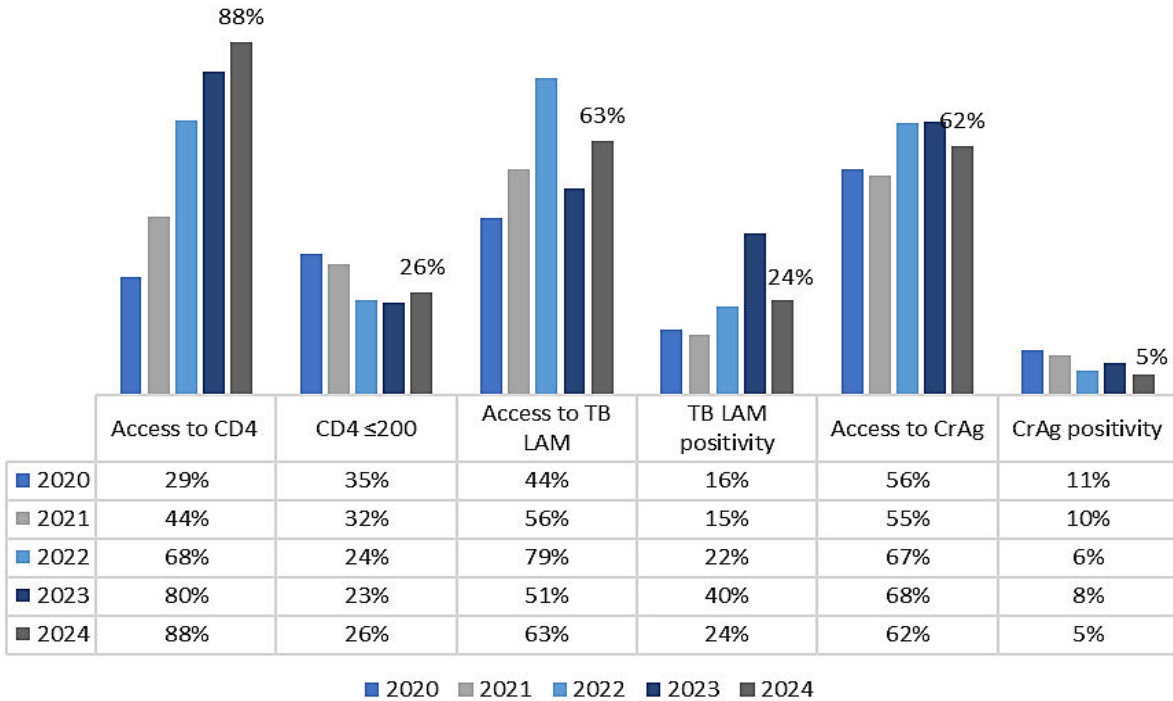
# Visitect has the highest health facility coverage - Sept 2025

- Test Considerations**
  - CD4 testing
  - Cryptococcal Meningitis
  - Tuberculosis
  - Histoplasmosis*
  - Aspergillosis*
- CD4 Testing Guidelines**
  - Newly diagnosed PLHIV Initiating on ART
  - PLHIV on ART with non-suppressed VL and WHO clinical stage 3 or 4 disease
  - PLHIV Re-engaging in care after interrupting treatment for 3 or more months
  - PLHIV who are on treatment or prophylaxis for CM infection to inform decision on when to stop fluconazole
- Program targets**
  - CD4 Testing Target is 95%
  - TB LAM Testing Target is 95% (AHD & Non-AHD)
  - CrAg Testing Target is 95%

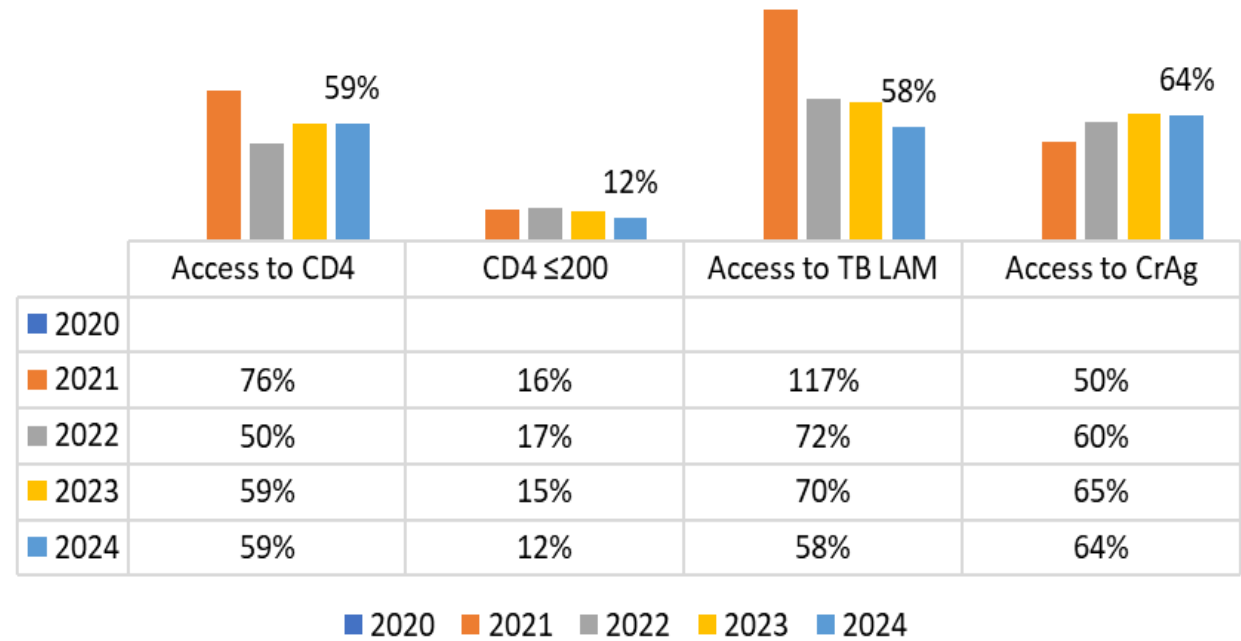


# AHD Monitoring

Tx New AHD cascade

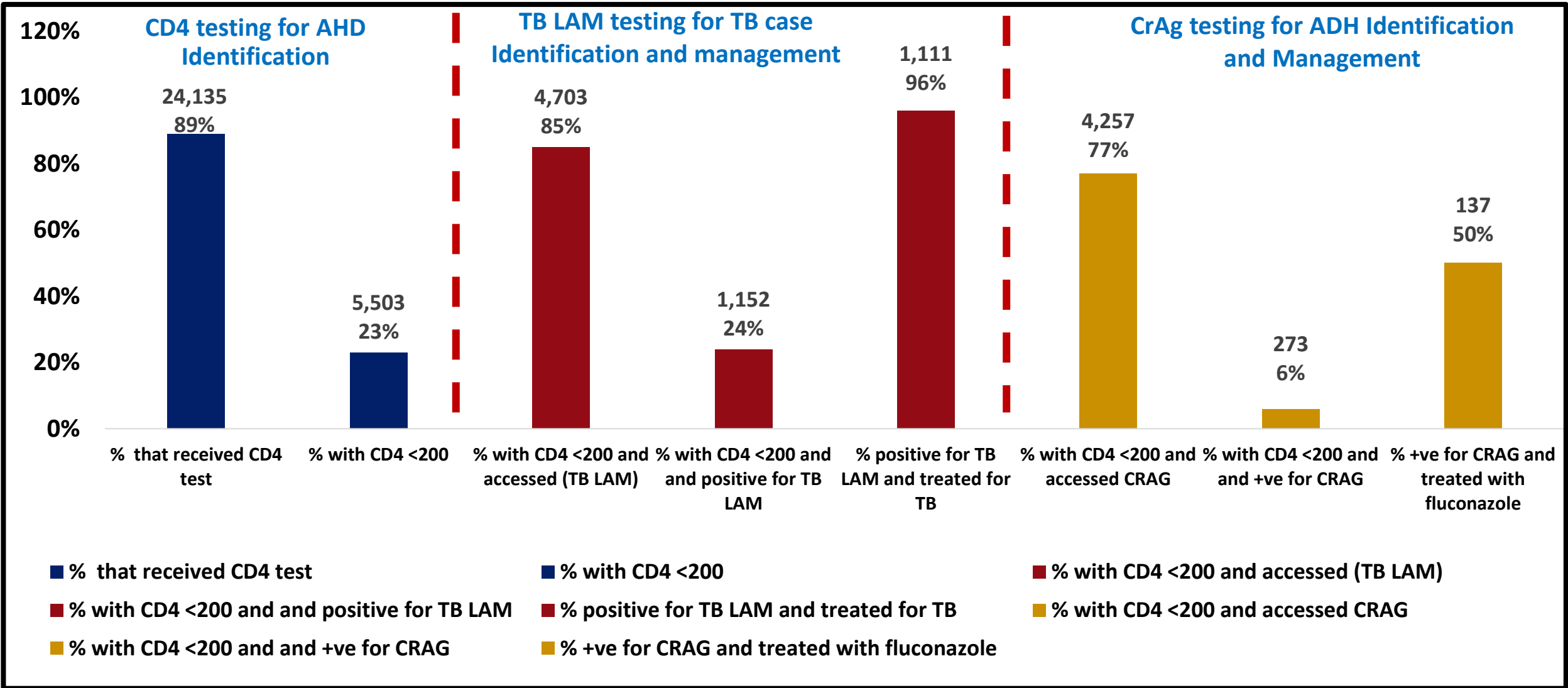


Non suppressed clients cascade



- Disproportionate AHD screening among the NS clients, indicating patient flow gaps, likely contributions by MMD.
  - Underscores the need to scale up CD4 Visitect testing in the community
    - Low access to CrAg, limited by the packaging size of the kit
      - TB LAM stock out & long lead times affected access

# AHD cascade July-Sept 2025 for New Clients: 23% AHD prevalence, 24% TB LAM positivity, 6% CRAG positivity



# Despite Scaleup of AHD Coverage, Several Challenges Persist

SN	Challenge	Mitigation mechanism
1	Suboptimal CD4 testing especially among the non-suppressed RoC	<ul style="list-style-type: none"> <li>• Risk assessment of patients before offering MMD</li> <li>• Scaleup of CD4 testing in the community</li> </ul>
2	Low CrAg and TB LAM access which also affects the treatment cascade	<ul style="list-style-type: none"> <li>• Build the capacity of the health workers to offer quality AHD services</li> <li>• Uninterrupted availability of TB LAM and CrAg commodities at national and facility level</li> </ul>
3	CD4 equipment breakdown and prolonged downtime, decommissioning of some CD4 technologies	<ul style="list-style-type: none"> <li>• Validate and adopt new CD4 technologies to support quality CD4 testing</li> </ul>
4	Monitoring and evaluation gaps especially in the Jan-Mar period	<ul style="list-style-type: none"> <li>• Support for recording and quality reporting of AHD indicators</li> <li>• Conduct routine technical mentorship and supervision</li> <li>• Implement continuous quality improvement (CQI) projects</li> </ul>

# Plans and Efforts to Sustain AHD Services

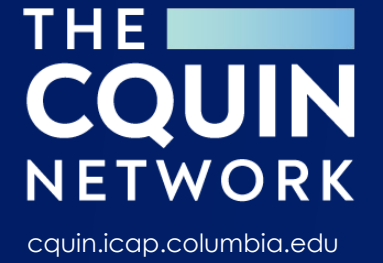
## How are we sustaining our gains?

- More meaningful **community engagement** to monitor recipients of care with AHD within the community and strengthen facility community linkage
- Continued **implementation of CQI** project to improve/maintain the enabling and outcome domains
- Ensure continuous **commodity security** of AHD commodities
- **Integration** of AHD into other services including community pharmacy model



# Thank you for making Uganda a learning destination on Integration and AHD





Thank You!

