Integrating Advanced HIV Disease (AHD) Services into Routine Health Care: Using Data to Inform Policy, Prioritization, and Scale-Up, Part 1 Q&A
Recorded: May 26, 2026

This is a curated list of answers to panelists from the audience based off their presentations at this webinar

1. **In addition to diagnostic testing and possible use of prophylactic meds, what specific care or follow-up considerations are important to consider for clients diagnosed with AHD? And how should this be adapted or modified for children?**

   WHO currently recommends the STOP AIDS package, which is adapted to account for the fact that children often face a different set of opportunistic infections, challenges with nutrition, and also challenges in identifying certain opportunistic infections. Vaccination remains an important component of the STOP AIDS package. (ofc, excluding live attenuated vaccines). It is true that all children with HIV presenting to care are considered to have AHD, given the significantly elevated risk of morbidity and mortality in a much shorter time compared to adults. The STOP AIDS package was recently updated to reflect evolution in guidance on TB in children with HIV. Please refer page 16 in the AHD guidelines. Link here - https://iris.who.int/server/api/core/bitstreams/68dfe26f-ad54-4f60-b92f-b943b1a0d82c/content

2. **How can we overcome the challenge of high out-of-pocket expenditure in managing clients with cryptococcal meningitis in the clinics?**

   The CM treatment recommendation on the use of single, high dose liposomal amphotericin offers significant reductions in cost (either to the individual or the system), reduction in hospital stay, lab monitoring requirements and costs, reduction in time for repeat IV injections (few days Vs. 14 days)

3. **How do we handle AHD services vs MMD? For example, in a case where a clinician gives a person MMD but then 2 weeks down the road, their VL results return unsuppressed. Many PLHIV in care whose VL is done at the last encounter and are doing clinically well from the previous visits tend not to return once their VL is unsuppressed, and they are called back because they still have medicines.**

   MMD is appropriate only after a confirmed reduction in viral load, at least 1 year on ART, and clinical stability. The definition for established on ART is provided in the 2021 WHO consolidated HIV guidelines document. The query relates more to adherence and adherence counseling services. I am wondering why VL is checked again at such a short frequency? But it remains the case that only a proportion of individuals remain continuously engaged in care, while many cycle in and out of care, and is a challenge in programs today.
   WHO launched a policy brief on this specific issue a year or so ago. Link here - https://www.who.int/publications/i/item/9789240097339
   This document helps explain some of the reasons behind disengagement and also offers guidance on how to approach this. The causes for disengagement are numerous. Here is a systematic review done on the subject recently - https://pmc.ncbi.nlm.nih.gov/articles/PMC10945039/

4. **Si vous faites une comparaison du taux de patients qui interompent le traitement ARV avant et après intégration. La retention aux ARV est bonne avec l'intégration ou avant?*(If you compare the rate of patients who discontinue ARV treatment before and after integration, is ARV retention good with integration or before?)***

C'est une excellente question. À l'heure actuelle, les données probantes sur l'impact de l'intégration des services dans les programmes sur l'observance thérapeutique sont très limitées. D'autres études pourront apporter des éléments de réponse. *(That's an excellent question. Currently, there is very limited evidence on the impact of integrating services into programs on treatment adherence. Further studies may provide some answers.)*

5. **I notice that you have not included any indicators specifically for TB in AHD. It would be beneficial to determine the extent of TB disease in this particular population and enable access to early treatment and follow-up care, including care post treatment for TB. This is also the case that there are a number of pre-existing indicators for TB that would need to be reported independently of AHD - that would also include testing rates and coverage**.

   Currently, we recommend a minimum data set (ie., data elements that need to be collected as a priority). The official list of indicators will be launched later this year. The information on minimum dataset is included in the 2025 AHD guidelines document.

6. **Eastern Africa, and Africa more broadly, continues to experience frequent outbreaks of emerging and re-emerging infectious diseases. People living with HIV (PLHIV), particularly those with advanced HIV disease (AHD), represent a highly vulnerable population during such outbreaks. The recent Mpox outbreak in Kenya demonstrated disproportionately high morbidity and mortality among PLHIV, especially those with AHD. Nakuru County recorded a particularly high burden of Mpox cases within the country. In light of these challenges, what strategies are currently in place to ensure adequate protection and continuity of care for patients with AHD, particularly during infectious disease outbreaks?**

   Great question! WHO recently developed a document that provides guidance on sustaining priority services. Please refer here- https://www.who.int/publications/i/item/9789240112759
   More emergency specific guidance can be obtained here - https://www.who.int/teams/primary-health-care/health-systems-resilience/essential-services-during-emergencies

7. **Quel est le modèle d'intégration pour les structures qui ne font que la prise en charge du VIH *(What is the integration model for structures that only provide HIV care?)***

   It is important to note that, the integration model is defined according to the specific context and capacity of each facility and health system. For facilities that only provide HIV care, AHD integration is mainly done by embedding services within the HIV clinic rather than creating separate programs.This includes routine AHD screening and management in the HIV clinic, task-sharing among staff, and use of standard clinical algorithms for OIs and advanced disease. Where diagnostics or inpatient care are not available, strong referral linkages are essential. Facilities should also ensure access to key tests (CD4, TB, cryptococcal diagnostics) through national systems and integrate AHD indicators into routine reporting for decision-making and quality improvement.
   Il est important de noter que le modèle d'intégration est défini en fonction du contexte et des capacités spécifiques de chaque structure et système de santé. Pour les structures qui assurent uniquement la prise en charge du VIH, l'intégration de la prise en charge de la maladie à un stade avancé (AHD) se fait principalement en intégrant ces services dans la clinique VIH, plutôt que de créer des programmes séparés.Cela comprend le dépistage et la prise en charge systématiques de l'AHD au sein de la clinique VIH, le partage des tâches entre les membres du personnel, ainsi que l'utilisation d'algorithmes cliniques standard pour les infections opportunistes et les cas de maladie avancée. Lorsque les diagnostics ou les soins hospitaliers ne sont pas disponibles, des mécanismes de référence solides sont essentiels. Les structures doivent également garantir l'accès aux tests clés (CD4, tuberculose,

cryptococcose) via les systèmes nationaux et intégrer les indicateurs AHD dans les rapports de routine pour améliore

8. **Excellent problem analysis, Nakuru team, on the drivers of the high AHD Mortalities. Just wondering if the CCC team implemented any CQI interventions to address the root causes of the problem?**

   Hello, yes indeed, CQI interventions were implemented. However, due to the disconnect between ward and CCC care in the pre-integration model, the feedback often never reached the ward or implementation. As we stand in an integrated model, we are able to do facility root cause analysis reviews and address problems immediately with an MDT that addresses issues at their point of service.

9. **In Nakuru County and especially the NCTRH, the recipients of care (AHD Champions) are resourced by partners. Is this something the county government can take up - in terms of funding?**

   NCRTH this has already been taken up by our County Government, as currently our full AHD cascade is by already existing staff, and we have very little partner support currently

10. **Quelle est la place de la communauté dans l'intégration des services VIH dans les services de santé en générale *(What is the role of the community in integrating HIV services into healthcare services in general?)***

    The community helps integrate HIV services by supporting testing, adherence, follow-up, home visits, stigma reduction, defaulter tracing, and linkage to care through CHVs and expert clients, ensuring continuous patient-centered care beyond the hospital

    How will the team track these patients across the "cascade of care" after discharge, especially since AHD is more of a facility-based care model? And is there a DSD model for AHD? What is the experience from the Nakuru Team?

    Great question. In Nakuru, we realized AHD care cannot stop at discharge; otherwise, patients are quickly lost to follow-up or readmitted.
    Our approach has been:

    - Structured discharge planning before leaving the ward
    - Immediate linkage to CCC/outpatient HIV care
    - Phone follow-ups, adherence support, and home visits for high-risk patients
    - Use of Kenya EMR + ward AHD logs to track patients across care points
    - MDT reviews to reconcile inpatient and outpatient data

    Regarding DSDs, AHD patients usually require an enhanced, high-intensity follow-up model first because they are clinically unstable. They are not immediately suitable for routine stable-patient DSD models like multi-month dispensing.
    In Nakuru, patients transition gradually:

    - Inpatient stabilization
    - Intensive post-discharge follow-up
    - Routine HIV care
    - Standard DSD models once stable
    - Currently, we are using the Visitect CD4 as our point-of-care screening test for CD4 testing, alongside other diagnostic platforms within the AHD cascade.

    The biggest lesson is that continuity of care and active tracking are just as important as inpatient treatment itself.

11. How are you handling AHD screenings among Non-suppressed PLHIV?

All non-suppressed PLHIV are considered high risk for AHD and undergo targeted AHD screening, especially those with high viral loads, treatment interruption, poor adherence, or clinical symptoms. We perform CD4 testing, OI screening, including TB and cryptococcal screening where indicated, while simultaneously initiating EAC, MDT review, and close follow-up to identify treatment failure or advanced disease early.

12. **Sharon and Immidex. Your perspective on the integration of AHD into the model of care for PLHIV was very informative. I wanted to invite you to comment on the broader issue of integration of HIV care and treatment services into PHC. This is something that countries are beginning to roll out in earnest. What are some of the key learnings from your integration experiences for countries that are planning to integrate into PHC?**

One of the key lessons from our experience is that integration of HIV services into PHC should not result in loss of visibility or prioritization of Advanced HIV Disease (AHD) and other high-risk populations. Integration works best when it remains people-centered and maintains strong systems for early identification, referral, follow-up, and continuity of care.
Another important learning is the critical role of community systems during integration. As services become decentralized and integrated into PHC, community actors such as peer supporters, CHPs, mentor mothers, and AHD Champions become even more important in supporting linkage, adherence, retention, and navigation across services. Without strong community–facility coordination, there is a risk of increased loss to follow-up, delayed identification of AHD, and weakened accountability. We have also learned that integration requires investment in health worker capacity, commodity security, data systems, and referral pathways. PHC facilities must be equipped not only to provide routine HIV services, but also to recognize and manage complex cases such as AHD, TB co-infection, mental health needs, and malnutrition. At the same time, community feedback mechanisms and community-led monitoring should remain embedded within PHC systems to ensure services remain responsive and client-centered. Finally, integration should be gradual, well-coordinated, and informed by continuous learning. Countries should actively involve recipients of care and communities in planning and monitoring integration processes to ensure that quality of care, trust, and continuity are maintained throughout the transition.

13. Could you give a sense of what the AIDS related causes of death among the 14%? In what ways could residual mortality be further reduced?

At Nakuru County Referral & Teaching Hospital, we recognized the high risk of mortality and re-admission immediately after discharge among AHD clients. To address this, we strengthened discharge planning and community linkage through expert clients, CHVs, phone follow-ups, home visits for high-risk patients, and close monitoring of appointments. We also link patients to nearby facilities and community support systems to ensure continuity of ART, adherence support, and early identification of clinical deterioration after discharge.

14. Dr. Sharon, how are you linking AHD-discharged clients with community structures? Considering the presentation by WHO on re-admission and mortality immediately after discharge.

Discharge should not mark the end of care, especially for AHD clients who remain highly vulnerable during the immediate post-discharge period. To address this, we have strengthened linkage between facilities and community structures through AHD Champions, Community Facilitators, CHPs, peer supporters, and PLHIV networks.

Before discharge, the facility team and community teams coordinate to identify clients requiring close follow-up. Once clients return home, community teams conduct home visits, adherence support, psychosocial follow-up, appointment reminders, and physical tracing where needed. They also monitor for danger signs, treatment challenges, social barriers, and missed appointments, and link clients back to facilities early before deterioration occurs.

We have also found that continuous communication between facility teams and community actors is very important. Community feedback helps facilities monitor recovery progress, identify risks for re-admission, and intervene early.

In some settings, we are also strengthening peer support groups and caregiver engagement to provide ongoing social support after discharge.

Community engagement has been a critical pillar of our integration model. We work closely with expert clients, community health volunteers (CHVs), counsellors, and linkage teams to strengthen awareness creation, adherence support, and continuity of care beyond the hospital setting.

We also integrate counselling from the point of screening through discharge, ensuring patients and families understand the importance of follow-up and adherence. After discharge, patients are actively followed up through phone calls, appointment reminders, home visits for high-risk or defaulting patients, and linkage to community support systems and nearby facilities where appropriate.

In addition, ongoing collaboration with community-based structures helps sustain awareness of creation and early identification of vulnerable patients, especially those returning to care, newly diagnosed patients, and those with advanced HIV disease.

15. **Dr. Sharon, could you share best practices in reporting and data use in the inpatient space? Are separate tools used in inpatient and outpatient spaces? Are they all on the EMR? Could you also share how post-discharge plans are followed up?**

At NCTRH, we use both the Kenya EMR and ward-based inpatient AHD tracking tools. The Kenya EMR mainly captures longitudinal outpatient HIV care data such as ART history, viral load, CD4 counts, TB screening, and appointment tracking, while the inpatient ward AHD log captures acute admissions, inpatient management, outcomes, and discharge planning.

Currently, these are separate systems and are not yet electronically integrated. The EMR is largely outpatient/program-facing, while ward logs are used within the inpatient setting by clinicians, medical officers, interns, and ward HRIOs. To bridge this gap, we conduct regular multidisciplinary team (MDT) reviews where both datasets are reconciled for patient tracking, quality improvement, and mortality reviews. Regarding post-discharge follow-up, we use a multidisciplinary approach involving clinicians, expert clients, counsellors, CHVs, and linkage teams. Before discharge, patients receive adherence counselling, appointment scheduling, and linkage planning. Follow-up is then done through phone calls, appointment reminders, home visits for high-risk patients or defaulters, and linkage to community support systems to strengthen retention and continuity of care.