

# Integrating Advanced HIV Disease (AHD) into Routine Health Care: *Using Data to Inform Policy, Prioritization, and Scale-Up*

May 26, 2026



# Agenda

## **CQUIN Framing Remarks:**

- **Maureen Syowai, ICAP in Kenya**

## **WHO Global Perspective: WHO guidelines on the Management of AHD (December 2025)**

- **Ajay Rangaraj, WHO, Geneva**

## **Country Experiences: Kenya-Integration of AHD at a tertiary level: Service Delivery & Use of Data for Decision-Making**

- **Sharon Kimani, Nakuru Country Teaching and Referral Hospital, Kenya**

## **Community Perspectives:**

- **Immidex Akinyi, AFROCAB – THRIVE Project, Kenya**

## **Panel Discussion:**

- **Rachel Mudekereza and Marline Jumbe, ICAP – CQUIN**

## **Closing Remarks:**

- **Maureen Syowai, ICAP in Kenya**

# Presenters/Panelists



**Maureen Syowai**  
Program Director  
(CQUIN/HIVE)  
ICAP in Kenya



**Ajay Rangaraj**  
Technical Officer  
Department of HIV,  
Tuberculosis, Hepatitis and STIs  
World Health Organization,  
Geneva



**Sharon Kimani**  
Medical Officer, AHD  
Focal Person, Nakuru  
Country Referral &  
Teaching Hospital,  
Kenya



**Immidex Akinyi**  
Country Lead  
AFROCAB, Kenya

# Framing Remarks

**Maureen Syowai**

**Program Director (CQUIN / HIVE), ICAP in Kenya**



# Framing the Moment for HIV Programs

- HIV programs continue to undergo major shifts due to funding changes initiated 2025
- Countries are putting more emphasis on high-impact, sustainable interventions embedded in routine health systems
- Countries are also taking greater ownership while navigating resource and workforce constraints
- There is an urgent need for practical, efficient, and scalable approaches

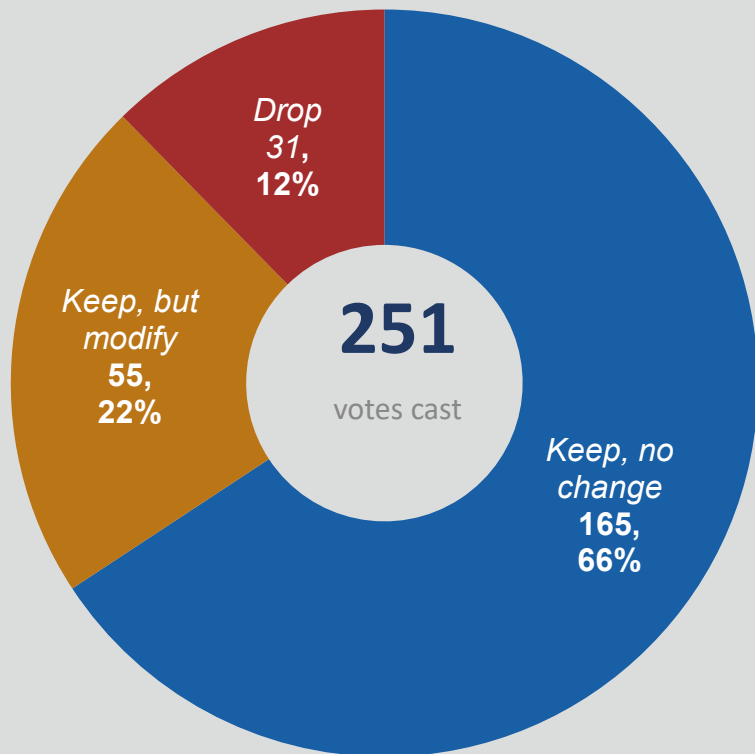
# Why AHD and why the focus on data use

- AHD persists as a major public health concern, even with significant ART scale-up
- AHD remains a leading cause of HIV-related illness and mortality
- HIV services are increasingly shifting into routine healthcare
- Reduced external funding demands more efficient and sustainable models of care
- Integration of HIV services into routine healthcare offers a pathway for countries to sustain HIV service coverage, quality, efficiency, and long-term program performance
- CQUIN's AHD priority is strengthening data use to drive improvements in service delivery, policy and program decision-making

# Advanced HIV Disease M&E: Results from Prioritization Exercise

Session 9 | CQUIN April Meeting 2026 | N=251 posted results

AHD Indicator Prioritization

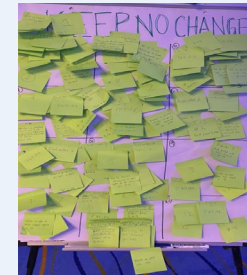


**66%**

**Keep, no change**

165 votes

- Core AHD cascade indicators broadly endorsed
- TB, CM screening and mortality indicators retained
- Strong consensus on existing indicator structure

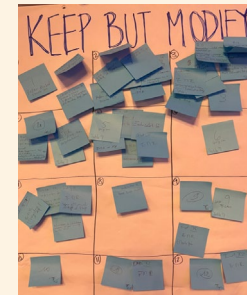


**22%**

**Keep, but modify**

55 votes

- Interruption threshold: change >3 months to >28 days
- Indicators **4**: specify CD4 testing explicitly | **7**: expand paediatric age to <15 years |
- **9**: specify TB-LAM | **18**: remove age cap | **24**: replace 'fluconazole' with 'prophylaxis'

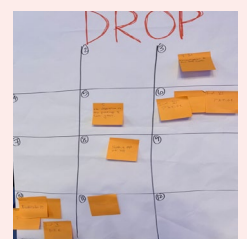
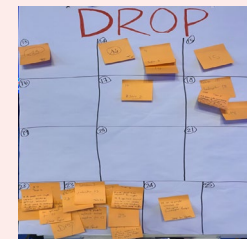


**12%**

**Drop**

31 votes

- Indicator **10** (screened negative for TB)
- Indicator **22** (optimal CI treatment): redundant — standard practice



<sup>4</sup>No. of PLHIV newly initiating ART screened for AHD; <sup>7</sup>No. of children under 5 living with HIV; <sup>9</sup>No. of people with AHD screened for TB; <sup>18</sup>No. of people with AHD aged ≥10 years eligible for CM screening using CrAg testing; <sup>24</sup>No. of people initiated on pre-emptive fluconazole therapy

# Objectives

- Understand how the WHO 2025 guidelines on the management of AHD support integration of the AHD package into routine healthcare and strengthen service delivery monitoring
- Examine how routine AHD data inform decision-making, including policy dialogue, resource prioritization, and commodity forecasting in the context of evolving HIV financing
- Explore how priority AHD indicators (e.g., CD4 testing, CrAg screening, TB-LAM, mortality monitoring) guide decentralization and improve service delivery
- Learn from country experience on integrated AHD service delivery, including nurse-led screening, task-sharing, referral systems, and community engagement

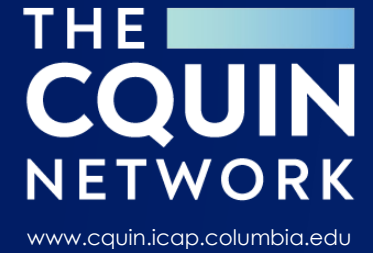
**This webinar is the first of a two-part series of webinars on AHD and the next AHD webinar is scheduled for 9 June 2026**

# Thank you





World Health  
Organization



# WHO Guidelines Overview on Advanced HIV Disease

*Strengthening Identification, Management and Continuity of Care*

**Ajay Rangaraj Technical Officer**  
**Department of Global HIV, Hepatitis and STI Programmes**  
**WHO, Geneva**



# Why Advanced HIV Disease Remains a Priority

**630,000**

AIDS-related deaths  
(2024)

**2.1M**

Adults living with AHD  
in Sub-Saharan Africa

**30%**

PLHIV presenting to care  
with AHD

**112,000**

Deaths from cryptococcal  
infection (2021)

**150,000**

TB deaths among PLHIV  
(2024)

**75,000**

AIDS-related deaths  
in children

# 1. Early Identification of AHD Through CD4 Testing

## WHO

### RECOMMENDATION

**CD4 testing is the preferred method to identify Advanced HIV Disease.**

*Strong recommendation | Moderate-certainty evidence*

Where CD4 unavailable: WHO clinical staging can be used (conditional rec., very low-certainty).

## Evidence Base

- CD4 testing has declined sharply despite 2017 AHD guidance
- AHD burden: ~30% of PLHIV at care entry; ~44% in inpatient settings
- Clinical staging misses ~25% of AHD cases (sensitivity 61%, specificity 72%)

## Who needs a CD4 test?

- Initiating or re-initiating ART
- Re-engaging in care after disengagement
- Treatment failure or clinically identified failure
- Hospitalized, seriously ill or clinically unstable
- Support identification of treatment failure (VL unavailable)
- Assess eligibility to stop co-trimoxazole prophylaxis
- Assess eligibility for fluconazole prophylaxis

# The story of CD4 testing – transition to a different use-case

2006

- ART initiation in PLHIV with a CD4 <200cells/mm<sup>3</sup>

2010

- Viral load if available
- ART initiation in PLHIV with a CD4<350cells/mm<sup>3</sup>

2013

- Viral load as preferred for treatment monitoring and identification of treatment failure

2016

- ART for all PLHIV regardless of CD4 cell count
- Consensus definition for advanced HIV disease (<200cells/mm<sup>3</sup>)

2017

- CD4 for identifying Advanced HIV disease

## 2. Integrated Management of Opportunistic Infections

*AIDS (mostly TB) accounts for 42% of hospital admissions and 67% of hospital deaths in PLHIV. Bacterial infections are 2nd in every region.*

### Tuberculosis

19% of admissions  
29% of hospital deaths

- **Screen all PLHIV with LCNAT + LAM for TB**
- 3HP preferred for TB preventive therapy among PLHIV
- Rapid molecular diagnostics (Xpert) as first-line

### PCP & Toxoplasmosis

7% + 4% of admissions

- Co-trimoxazole prophylaxis for CD4<200
- first-line treatment for PCP
- Also helps treat several other infections

### Cryptococcal Disease

5% of admissions  
10% of hospital deaths

- Screen with serum CrAg LFA for CD4<200
- Single-dose liposomal amphotericin B + flucytosine as induction regimen
- Fluconazole prophylaxis where appropriate

### Kaposi's Sarcoma

3% of HIV-related malignancies

- Paclitaxel OR pegylated liposomal doxorubicin recommended
- Early ART initiation is essential
- KS persists in countries with high AHD burden, regionalized

# 3. Integration of AHD Services into Health Systems

## Outpatient / ART Clinics

- CD4 testing at ART initiation and re-initiation
- CrAg screening for eligible PLHIV
- TB preventive therapy and active TB screening
- Clinical staging where CD4 unavailable
- Integration with viral load monitoring
- Differentiated service delivery for stable patients

## Inpatient Settings

- CD4 at hospital admission for all PLHIV
- Standardized OI diagnostic workup
- Initiate or optimize ART during admission
- Discharge planning and linkage protocols
- Transitions to outpatient/community care
- Inpatient mortality review and QI processes

## Primary Health Care

- Point-of-care CD4 testing at PHC level
- Task-sharing with non-physician clinicians
- Co-trimoxazole dispensing and prophylaxis
- Early recognition of clinical AHD signs
- Community health worker engagement
- Integration with TB and MNCH programmes

*Implementation requires coordination across vertical HIV programmes, hospital services, and community health platforms.*

# 4. Continuity of Care: Post-Discharge and Re-engagement

## Post-discharge Evidence

**18%** Readmitted within 12 months

**14%** Died within 12 months

**RR 0.87** Risk reduction in readmissions (post-discharge interventions)

**RR 1.24** Improved linkage/retention (post-discharge support)

## WHO RECOMMENDATION (Conditional | Low-certainty)

**Hospitalized PLHIV may be provided interventions to support transitions to outpatient care and reduce avoidable readmissions.**

## Recommended Transition Interventions

- **Pre-discharge goal setting:** Individualized plans reviewed before discharge
- **Medication review:** Reconcile all medications, OI prophylaxis
- **Transitional care planning:** Structured linkage to outpatient ART care
- **Telephone follow-up:** Check-ins within 1–2 weeks of discharge
- **Home visits / peer support:** Community health workers or peer navigators

*Systematic review (2022): >30% of successfully discharged PLHIV were readmitted (18%) or died (14%) within one year.*

# 5. Routine AHD Data, Monitoring & Sustainable Scale-Up

## Core AHD Indicators

- % PLHIV initiating ART with CD4 <200
- % AHD patients receiving OI prophylaxis package
- % PLHIV screened with CrAg where CD4 <200
- In-hospital mortality rate among PLHIV
- 30-day and 90-day readmission rates
- % patients with documented discharge plan

## Using Data for Decisions

- Facility-level AHD dashboards for real-time review
- Monthly mortality audits in inpatient settings
- Link CD4 data to OI prophylaxis dispensing
- Track CrAg screening rates and treatment uptake
- Monitor KS chemotherapy access and outcomes
- Cascade analysis: diagnosis → treatment → VL suppression

## Sustainable Scale-Up

- National AHD roadmaps aligned to WHO guidance
- Costing models: AHD package is highly cost-effective
- CD4 POC procurement and supply chain strengthening
- Training and mentorship for HCW task-sharing
- Peer educator and community linkage networks
- Quarterly programme review with feedback loops

*AHD package of care interventions are highly cost-effective and deliver population-level benefits through reductions in TB, CM and severe bacterial infection mortality.*

# Summary: New WHO Recommendations on Advanced HIV Disease

01

## CD4 Testing

CD4 testing is the preferred method to identify AHD.

*Strong recommendation | Moderate-certainty evidence*

02

## Clinical Staging

Where CD4 unavailable, WHO staging may be used.

*Conditional recommendation | Very low-certainty evidence*

03

## Kaposi's Sarcoma

Paclitaxel or pegylated liposomal doxorubicin are suggested for HIV-associated KS.

*Conditional recommendation | Low-certainty evidence*

04

## Post-Discharge Care

Hospitalized PLHIV may receive interventions to support transitions to outpatient care and reduce readmissions.

*Conditional recommendation | Low-certainty evidence*

# From Evidence to Action

- Scale up CD4 testing at all ART entry points
- Implement the full AHD package of care
- Integrate inpatient–outpatient AHD pathways
- Strengthen post-discharge follow-up systems
- Track AHD indicators in national M&E frameworks

# Thank you



# Integrating HIV Services at the Nakuru Country Teaching and Referral Hospital [NCTRH]

## *Experiences and Lessons in AHD Management*

**Sharon Kimani**

**Medical Officer, Nakuru Country Referral & Teaching Hospital, Kenya**



# OUTLINE



- 01 INTRODUCTION**  
NCTRH in context
- 02 INTEGRATION IMPLEMENTATION**  
How integration happened
- 03 Data Systems**  
Kenya EMR, ward logs & decision-making
- 04 Results & Impact Assessment**  
Outcomes & impact on patient care
- 05 Lessons & Sustainability**  
Challenges and the solutions implemented



# 01

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## INTRODUCTION

NCTRH in Context: From a vertical CCC model to fully integrated ward-based AHD care at a Level 5 referral hospital

# How did our story start?



“ *The CQUIN AHD Capability Maturity Model self-staging was a true wake-up call for our national HIV program. It provided an honest reflection of where we stood, particularly highlighting domains that required urgent strengthening. That clarity catalyzed action — prompting deliberate efforts to address gaps and accelerate progress. The improvements we are seeing now are a direct result of that process. While we still have work ahead, the momentum generated has been both encouraging and transformative.* ”



**Dr. Jack Nyaliech**

Co-Chair, South Rift Valley Regional AHD TWG | NASCOP

Senegal → Kenya C2C Learning Exchange · Nakuru County Referral Hospital · April 23, 2026

# NCTRH-WHO WE ARE



Attribute	Detail
Facility	Nakuru County Referral & Teaching Hospital (NCTRH)
Level	Level 5 Referral Hospital
Location	Nakuru County, Nakuru West Sub-County
Catchment	Large regional catchment across the Rift Valley
Specialist Services	Internal Medicine, Pediatrics, OB/GYN, Surgery
HIV Services	HTS, ART, OI Management, Adherence Counselling
Period under review	15 months (Jan 2025 – Mar 2026)



**Start of Integration: January 2025**

**“**From a vertical ised Comprehensive Care Clinic [CCC] model to a fully integrated ward-based AHD care.....”

# EPIDEMIOLOGICAL PROFILE |

## Advanced HIV Disease Burden



# 1 in 12

HIV-RELATED DEATHS IN KENYA are from Nakuru County

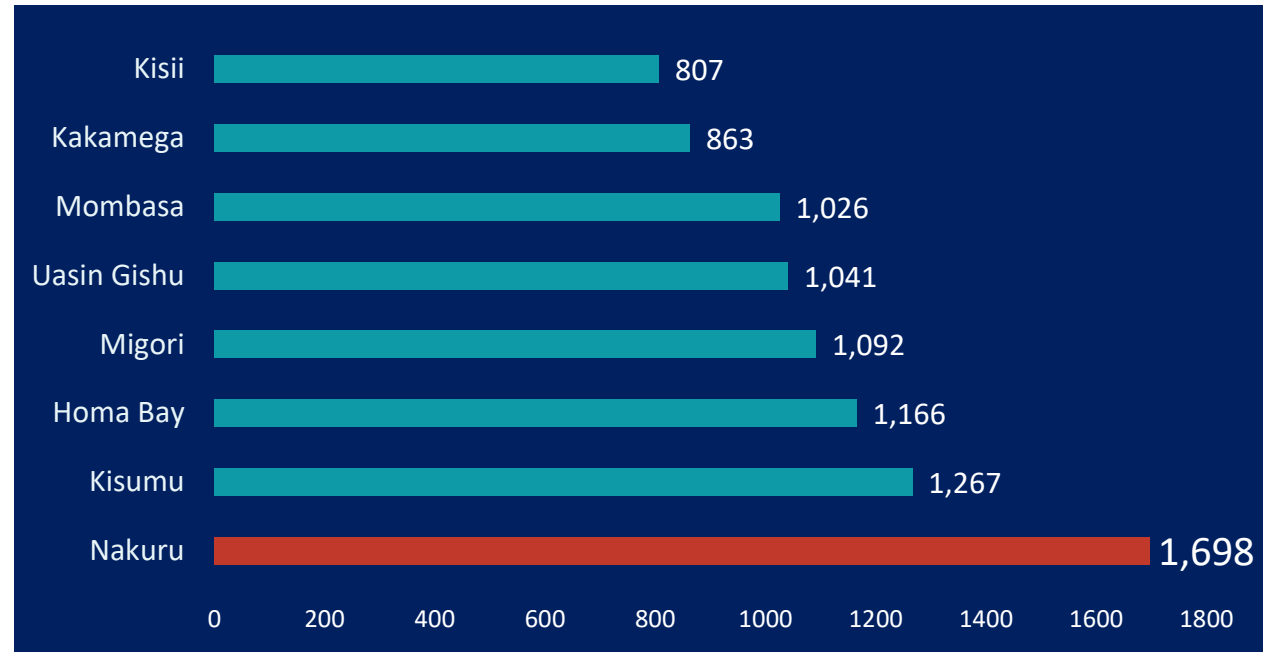
- Nakuru county carries a disproportionate share of Kenya's AHD mortality — highest of all 47 counties — despite advances in ART scale-up across the Rift Valley.
- Persistent gaps in identifying and managing patients with AHD (CD4 <200 or WHO Stage 3/4) drive preventable deaths.
- This burden demands integrated, facility-level action — not parallel vertical program.

**Key Context:** HIV-related deaths remain a significant concern, driving the need for integrated AHD management approaches

**~51,139** People living with HIV *Nakuru County — 2025 estimate*

**1,698 #1** AIDS-related deaths *Highest of all 47 counties nationally Outpacing Nairobi, Kisumu & Homa Bay*

### AIDS-RELATED DEATHS BY COUNTY — TOP 8 (Kenya, 2025)



Source: National HIV Estimates-2025

# AHD Context



## The Challenge of Advanced HIV Disease

Major contributor to HIV-related morbidity and mortality in Kenya.

Despite progress in HIV care, patients with advanced disease require specialized interventions and comprehensive management approaches.

**KEY ISSUE:** AHD patients need enhanced care cascade (CD4 counts, OI screening, etc. ); however, inadequately trained HCWs due to overdependence on CCCs result in poor patient outcomes.



## Paradigm Shift in Service Delivery

Following the move from **Comprehensive Care Centres (CCC)** to integrated management of HIV & AHD at Nakuru County Referral & Teaching Hospital in **January 2025**, a facility-based integration of the AHD package of care was implemented.

### Multi-Stakeholder Partnership

 Nakuru County Government

 NASCOP





 CHAI

 SRVRTWG

## Study Methodology

- 1 Retrospective Analysis**
- 2 Quantitative Assessment**
- 3 14-Month Period**

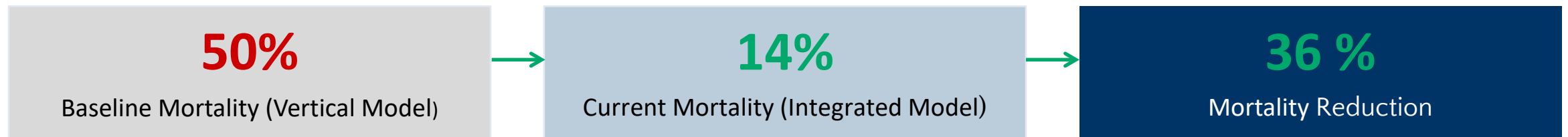
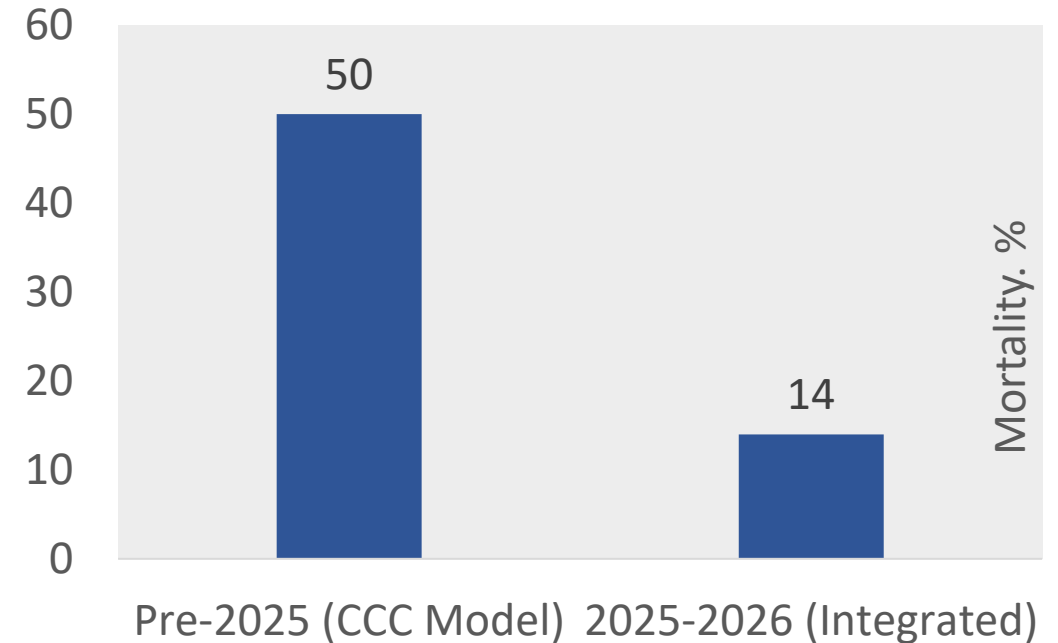
## Key Focus Areas

-  Service delivery impact
-  Patient outcomes assessment
-  Integration facilitators
-  Lessons for scale-up

# ADVANCED HIV DISEASE: THE PROBLEM



- **Before Jan 2025:** Vertical Standalone Comprehensive Care Clinic(CCC) model — HIV care siloed in one clinic
- **The Gap:** Inpatient/OPD staff lacked AHD skills; patients arrived critical, undiagnosed
- **Result:** 50% inpatient mortality (*Source- 2023 Kenya EMR*); missed OIs; delayed **ART initiation**
- **AHD remains a major contributor to HIV-related morbidity and mortality in Kenya**



# Critical Gaps Identified and their Impact on Service Delivery



#	Gap	Impact
01	Limited Technical Capacity	AHD missed in general wards — IPD/OPD staff lacked skills
02	No CD4, CrAg, TB-LAM Testing	Could not stratify AHD severity or diagnose CM/TB early
03	No AHD Commodities	Could not treat cryptococcal meningitis as per guidelines — no Liposomal Ampho B, Flucytosine
04	No Dedicated AHD Team	No coordination, no accountability — patients fell through cracks
05	Uncoordinated Hub-and-Spoke	Critical patients arrived untested from spoke facilities
06	No Job Aids or Algorithms	Inconsistent care by shift — quality depended on who was on duty



# 02

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## INTEGRATION IMPLEMENTED

How integration was implemented at facility level and the six pillars that made it happen — from 50% mortality to a fully operational AHD care model

# THE SIX PILLARS OF INTEGRATION

## 1. CAPACITY BUILDING

45 HCWs trained in 3-Day AHD package

All departments competent

## 2. TEAM FORMATION & GOVERNANCE

AHD Coordination Team + Technical Lead Appointed

Clear Accountability

## 3. SYSTEMS & TOOLS

Job Aids, Algorithms, Dosing Charts Deployed

Standardized Care

## 4. DIAGNOSTICS

CD4, CrAg, TB-LAM Introduced

Full AHD Cascade Capacity

## 5. COMMODITIES

Ampho B, Flucytosine, Fluconazole Secured

CM Treatment Available

## 6. CONTINUOUS MONITORING & LEARNING

Monthly CMEs, Case Reviews, Data Collection

Sustained Quality Improvement



Lumbar Puncture Demonstration in AHD training | Aug 2025



NASCOP, SRTWG, and Partners meeting with County Government CEC



A HRIO updating the Kenya EMR



Dr. Maritim Demonstrating how to do an LP at first AHD capacity building | Jan 2025



A bedside case discussion on an AHD patient | May 2026

# PATIENT FLOW BEFORE AND AFTER SERVICE INTEGRATION

## THE OLD WAY: Vertical CCC Model

1. Patient arrives at OPD/Emergency → Not screened (delayed)
2. Admitted to general ward → AHD not considered
3. Condition worsens → Referred to CCC
4. CCC does workup → Returns to ward
5. Treatment starts late → Poor outcomes

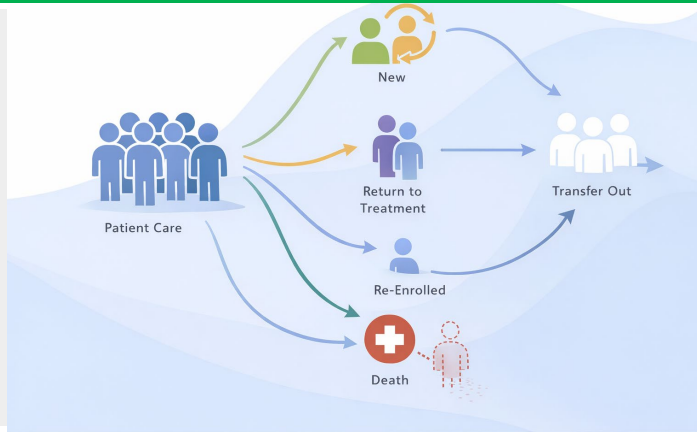
## THE NEW WAY: Integrated AHD Pathway

### OPD Flow:

1. Screening Desk → HTS Room → Records
2. Consultation → Lab → Pharmacy → Follow-up

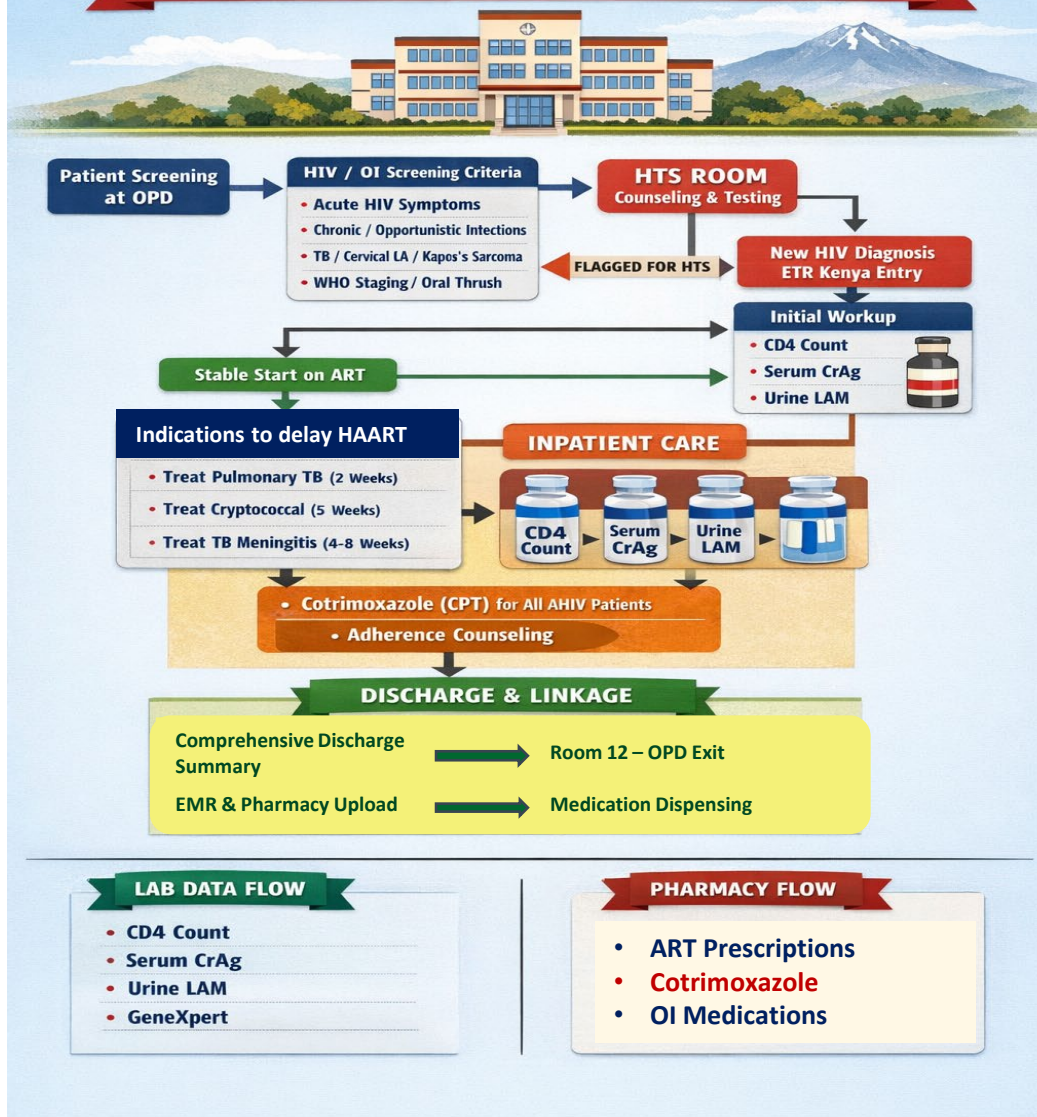
### IPD Flow:

3. Admission → AHD screening on all admissions
4. Ward Round → Diagnostics → Treatment
5. Discharge Planning → Follow-up



**Admission Process:** All inpatients are screened for AHD upon admission, with diagnostics and treatment initiated through the integrated ward-based care model.

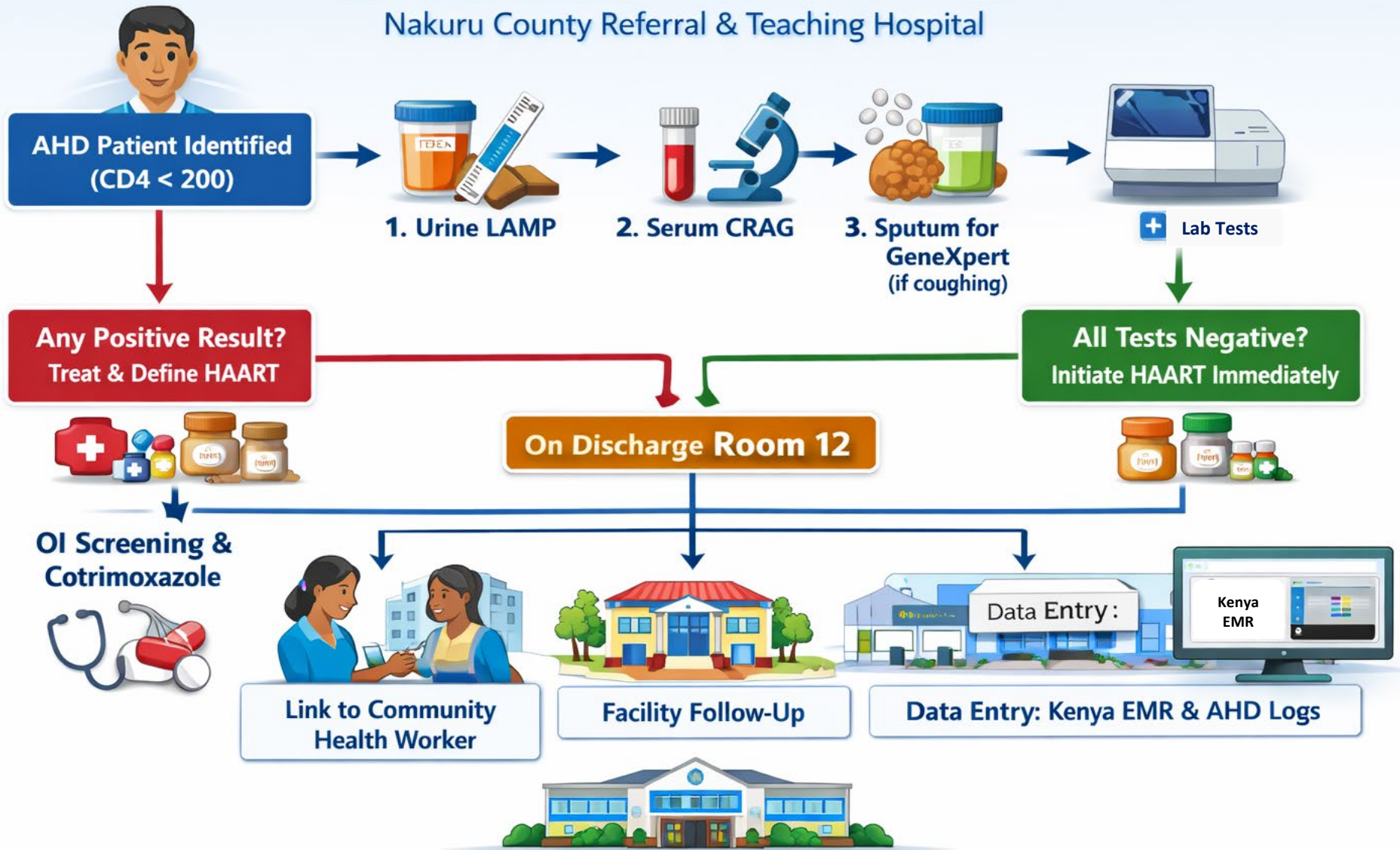
## PATIENT FLOW IN NAKURU COUNTY REFERRAL & TEACHING HOSPITAL



CCC = Comprehensive Care Clinic / HIV clinic

# NCTRH AHD PATIENT FLOW

Nakuru County Referral & Teaching Hospital



## Diagnostic Capacity:

CD4 (Visitect/Partec), CrAg-LFA, and TB-LAM testing are now integrated into routine care, enabling full AHD cascade capacity.

# SERVICE POINTS & RESPONSIBILITIES



Service Point	What Happens	Who Does It
OPD Triage / Screening	HIV screening, eligibility check	HTS Counsellors
HTS Room	Testing, initial counselling, linkage	HTS Counsellors + Link Person
Records / EMR	Registration, enrollment, data entry	Records Officers
Consultation Room	Clinical review, CD4 request, OI screening	Clinicians
Laboratory	CD4 count, CrAg-LFA, TB-LAM	Lab Technologists
Pharmacy	Prescription verification, dispensing	Pharmacists
Ward (IPD)	Daily tracking, AHD management	Ward Team + HRIO + AHD Focal Person
Community	Follow-up, phone calls, home visits	Expert Clients + CHVs

**8 service points** across OPD, IPD, laboratory, pharmacy, and community — ensuring no patient is missed at any entry point.

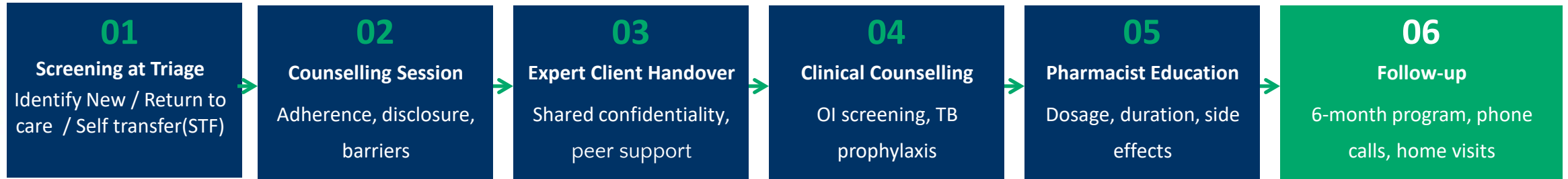
# MULTIDISCIPLINARY COUNSELLING: SCREENING TO FOLLOW-UP



## THE TEAM



## THE PROCESS



**Follow-up Methods:** Phone calls for appointment reminders and adherence checks | Home visits for high-risk and defaulted patients | Linkage to community support systems | Regular viral load monitoring

# 03

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## DATA SYSTEMS

Kenya EMR, ward logs and using data for clinical and management decisions

# KENYA EMR: THE NATIONAL DATA SYSTEM



Operated exclusively by Health Records and Information Officers (HRIOs) — what it captures

Data Element	Purpose
Patient identifiers	Unique tracking across facilities
Patient category	New / Defaulter / STF — major AHD triggers
Current ART regimen	Identify initiation or switch needs
TB screening status	Document TB screening completion
TPT status	Record TPT provision
CD4 count	Immunological status monitoring
Last viral load	Virological monitoring
Next viral load due	Predictive scheduling
Next appointment	Refill scheduling & defaulter tracking



A Doctor at NCRTH Reviewing an AHD Patients CT Scan

**Note:** Kenya EMR is operated by **HRIOs**, not clinicians. Clinicians request HRIOs to pull records or enter data — a daily workflow dependency.

# THE CRITICAL GAP: TWO SEPARATE SYSTEMS



System	Operated By	Captures	Access
Kenya EMR	HRIOs	Longitudinal HIV care data	Outpatient / program side
Ward AHD Log	Clinicians, MOs, Interns, Ward HRIOs	Acute inpatient episode	Inpatient / ward side

## THE DISCONNECT

- Ward teams **cannot access Kenya EMR** from inpatient side
- Outpatient teams **cannot access ward logs**
- **No electronic integration** between the two systems
- Clinician cannot pull full HIV history at bedside

## HOW WE BRIDGE THE GAP

- **Monthly MDTs** reconcile both datasets
- HRIOs **physically present** in the ward
- **Manual coordination** for discharge planning
- Joint review enables cross-system learning

Data Signal	Clinical Action
Kenya EMR: Newly diagnosed patient	Immediate AHD screening; CD4 and CrAg ordered
Kenya EMR: Defaulter returned, overdue	High suspicion for AHD; full diagnostic cascade; adherence counselling
Kenya EMR: Suspected treatment failure	EAC, Assign a case manager, MDT, DOTS; OI screening
Ward Log: Rising CM cases in a month	Alert lab to ensure CrAg kit stock; CME on CM management
Ward Log: Deaths with TB not screened	Mortality review: Was TB-LAM done? Was TPT given?

**Key Principle:** Every data signal triggers a specific clinical action. Data is not collected for reporting alone — it drives real-time patient care decisions at the bedside.

## Six management functions powered by data



### RESOURCE ALLOCATION

Kenya EMR volume + ward admission trends inform drug and lab supply needs



### SUPPLY CHAIN

Stock-out documentation + requisition patterns trigger procurement and buffer planning



### PERFORMANCE MONITORING

Screening coverage + diagnostic completion identifies wards needing support



### STRATEGIC PLANNING

County distribution + referral patterns inform decentralization planning



### QUALITY ASSURANCE

Mortality cases + defaulter rates trigger reviews and gap investigations



### EXTERNAL REPORTING

Kenya EMR auto-generates NASCOP indicators; ward log supplements inpatient detail

**Data-Driven Procurement:** Monthly data review shows what is being used, at what rate, for which conditions — justifying procurement requests to county and national levels for urine LAM, CD4 strips, GeneXpert cartridges, CrAg strips, Ampho B, and Flucytosine



# 04

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## IMPACT ASSESSMENT

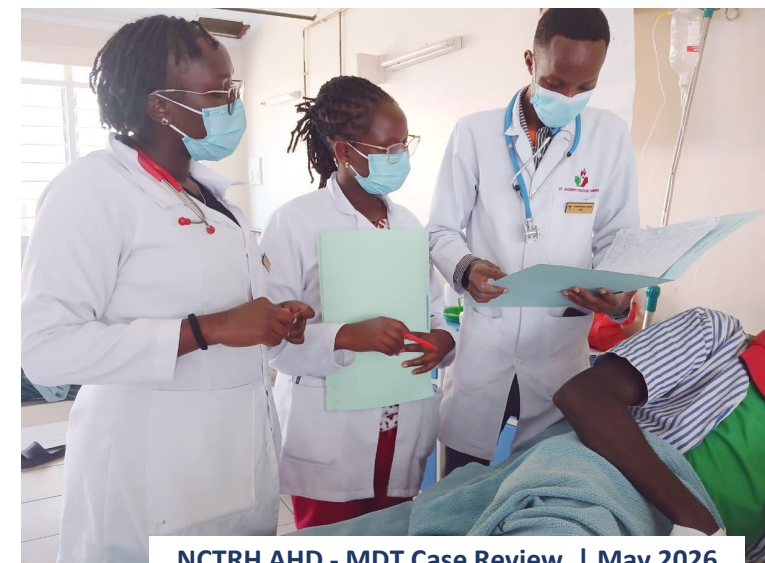
Results of Integration, how it impacted patient care and outcomes

# WHAT CHANGED? BEFORE vs AFTER

Metric	Before (Pre-2025)	After (2025-2026)
Care Model	Vertical CCC	Integrated all wards
AHD Screening	Initiated by CCC	All entry points
ART Initiation	Delayed (referral to CCC)	Same-day at point of care
Patient Movement	Shuttled between departments	One-stop within department
Staff Ownership	"CCC's problem"	"Everyone's responsibility"
Stigma	Reinforced by separation	Reduced by normalization
Mortality	<b>50%</b>	<b>14%</b>

**Improved Patient Experience:** Seamless, coordinated care with reduced waiting times, fewer transfers, and dignified treatment in any department.

Activity	Frequency	Purpose
AHD patient tracking	Daily	Real-time census, no missed patients
MDT case reviews	Monthly	Peer learning, gap identification
CMEs	Monthly	Knowledge refresh, new staff onboarding
Mortality reviews	Monthly	Root cause analysis, protocol refinement
County TA	Monthly	External quality check
NASCOP/SRVRTWG*	Quarterly	National alignment, Comparative Learning



NCTRH AHD - MDT Case Review | May 2026

PLAN

DO

CHECK

ACT

\* South Rift Valley Regional Technical Working Group



"Integration is not a one-time event – it's a continuous cycle of learning, reviewing, and improving."

# IMPACT ASSESSMENT



## Mortality Reduction

Significant decrease in inpatient mortality post-integration



## Discharge & Recovery

High proportion of AHD inpatients successfully discharged



## Diagnostic Capacity

Full AHD cascade operational — CD4, CrAg, TB-LAM

## High Discharge Rate Achievement

Through strengthened AHD cascade implementation, the facility achieved an impressive discharge rate, indicating improved treatment success and patient recovery.

Discharge Rate

**74%**

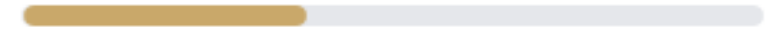
Patients successfully discharged

- ✓ Improved treatment adherence
- ✓ Better care coordination
- ✓ Enhanced patient support

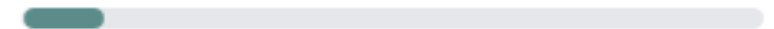
## Improved OI Detection

HCW training enabled confident, guideline-based AHD management with better opportunistic infection detection and management.

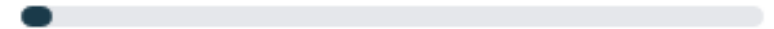
PTB (Pulmonary TB)



Diarrheal Illness



CCM (Cryptococcal Meningitis)



## Training Impact

- 🕒 **Reduced Turnaround Time**  
Faster consultations and decision-making
- 🌞 **Guideline-Based Care**  
Confident, evidence-based management
- 👤 **Enhanced Capacity**  
Better OI detection and treatment

## LAB

- Increased CD4 count uptake
- Increased Urine LAM uptake
- Increased AHD patient identification
- Reduced TOT in receiving results reducing decision making time for patients
- More Cryptococcal Meningitis patients identified
- Correct AHD cascade implemented

## PHARMACY

- Steady supply of Liposomal Amphotericin B, Flucytosine, CTX and ART
- Good communication between pharmacy & wards
- Improved drug stock utilization



# 05

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## LESSONS, SUSTAINABILITY & RECOGNITION

**Recognition**, challenges, and priorities for sustaining integrated AHD care





















# AHD PROGRAM: CHALLENGES & SOLUTIONS

Strengthening Systems. Improving Care. Saving Lives.

## CHALLENGES

CHALLENGE	ROOT CAUSE	IMPACT	KEY EVIDENCE / DATA
 <b>Commodity stock-outs</b>	 Supply chain gaps	 Ampho B critically low (10 vials)	<ul style="list-style-type: none"> <li>Liposomal Amphotericin B: 10 vials</li> <li>Abacavir 300mg: 22 packs (running low)</li> <li>Reliance on fluconazole when Ampho B out of stock</li> </ul>
 <b>Staff turnover</b>	 Only 2 of 45 trained remain	 Variable care quality	<ul style="list-style-type: none"> <li>45 HCWs trained (AHD package)</li> <li>Only 2 remain in facility</li> <li>Affects continuity and quality of AHD care</li> </ul>
 <b>Data burden</b>	 1 MO, ~50 records/month, paper-based	 Incomplete documentation	<ul style="list-style-type: none"> <li>One MO handling ~50 records/month</li> <li>Manual systems lead to gaps and delays</li> <li>High workload and risk of data inaccuracies</li> </ul>
 <b>High readmissions</b>	 Weak discharge planning	 Resource strain	<ul style="list-style-type: none"> <li>Inadequate discharge linkage and follow-up</li> <li>Patients return due to poor continuity of care</li> <li>Increased burden on IPD and hospital resources</li> </ul>

## SOLUTIONS IMPLEMENTED

PROBLEM	SOLUTION	WHAT WAS DONE	STATUS	IMPACT / OUTCOME
 <b>Data burden</b>	 <b>Google Forms + intern/MO involvement</b>	<ul style="list-style-type: none"> <li>Developed Google Forms for AHD data capture</li> <li>Intern &amp; MO support for data entry and validation</li> </ul>	 DONE	 Improved data completeness, timeliness and accuracy
 <b>Training gaps</b>	 <b>AHD in internship orientation + monthly CMEs</b>	<ul style="list-style-type: none"> <li>AHD incorporated into intern orientation</li> <li>Monthly CMEs for continuous capacity building</li> <li>Focus on AHD diagnosis, management &amp; updates</li> </ul>	 DONE	 Improved staff knowledge, skills and confidence
 <b>Readmissions</b>	 <b>Strengthened discharge planning + linkage</b>	<ul style="list-style-type: none"> <li>Standardized discharge checklist</li> <li>Linkage to OPD, CCC &amp; community follow-up</li> <li>Patient education &amp; appointment scheduling</li> </ul>	 DONE	 Reduced readmissions, better continuity of care
 <b>HRIO capacity</b>	 <b>AHD data transferred to trained HRIOs</b>	<ul style="list-style-type: none"> <li>Trained HRIOs on AHD indicators and tools</li> <li>Data roles redistributed for workload balance</li> <li>HRIOs now lead data quality assurance</li> </ul>	 DONE	 Reduced workload on MO, better data quality
 <b>Digital tracking</b>	 <b>Real-time ward-based AHD tracker</b>	<ul style="list-style-type: none"> <li>Development of real-time AHD tracker</li> <li>Ward-based data entry and dashboards</li> <li>Pilot testing and iterative improvement</li> </ul>	 IN PROGRESS (60% COMPLETE)	 Near real-time visibility and decision-making



**OUR COMMITMENT:** Addressing challenges with innovative solutions to ensure quality, integrated AHD care for every patient.



# LESSONS AND ACHIEVEMENTS


## KEY LESSONS

- |  |   |  |  |  |
|--|---|--|--|--|
| <p><b>1</b><br/>                 Integration improves outcomes — no question</p> | <p><b>2</b><br/>                 Multidisciplinary care is non-negotiable</p> | <p><b>3</b><br/>                 Leadership ownership drives success</p> | <p><b>4</b><br/>                 Data-driven review improves quality</p> | <p><b>5</b><br/>                 One-time training is never enough</p> |
|--|---|--|--|--|

## RECOGNITION

 **National Recognition**  
 Nakuru County recognized for AHD excellence nationally

 **Best Oral Presentation**  
 Health Integration Summit 2026:  
 Dr. Sharon Kimani

 **Model Facility**  
 NCTRH designated model facility for AHD integration , Hosted Senegal C2C team



Outreach on Maternal Health and AHD



Dr. Sharon Kimani awarded at Health Integration Summit



Comparative Learning Session at NCTRH | April 2026



# Acknowledgements

## PARTNERS



TUJENGE JAMII

Nakuru County Government | NASCOP | UNITAID | CHAI | SRVRTWG | TuJenge Jamii

# Thank You | Asante | Merci

Health Without Barriers for Holistic HIV Response

**Dr. Sharon Kimani, AHD Focal Person, NCTRH**

PARTNERS

Nakuru County Government | NASCOP | CHAI | SRVRTWG | TuJenge Jamii

# Afrocab Treatment Access Partnership

## Communities at the Centre: Sustaining AHD Care During Health Service Integration

*Immidex Akinyi*  
*Country Lead, Kenya*





- Community Role in Sustaining AHD Care during Service Integration
- Community-Led Monitoring, Feedback, and Accountability
- The community in action (photos)





## Communities are critical to sustaining AHD care by:

- Supporting referral and linkage to care for people with AHD
- Following up patients at risk of treatment interruption or loss to follow-up
- Providing peer navigation, adherence support, and psychosocial care
- Reducing stigma and helping patients navigate integrated services



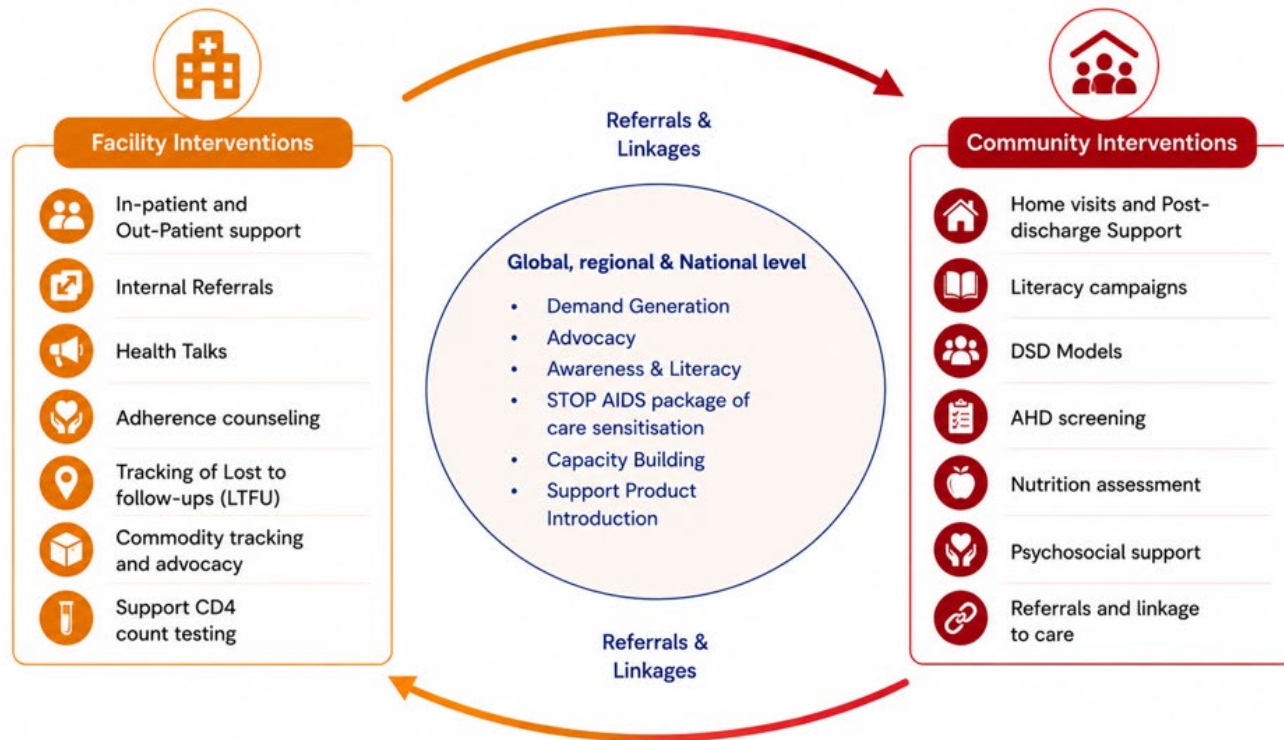
Creating spaces for conversations on AHD in churches in Kenya

## Communities Must Lead!



# Community Role in Sustaining AHD Care during Service Integration

Communities are central to ensuring that AHD services remain accessible, people-centered, and continuous as services are integrated into routine health systems



- Communities are the first point of contact and last line of defense
- Trust, access, and lived experience position communities uniquely
- Evidence shows improved outcomes when communities are engaged
- Community engagement:
  - Improves Case finding, Access, and Uptake of services
  - Reduces Stigma and Discrimination and Promotes Self-Care
  - Strengthens Program Accountability
  - Strengthens Health Systems
  - Enhances Sustainability



# Community-Led Monitoring & Patient Feedback



## Communities as Accountability Partners

### Community-Led Monitoring Identifies:

- Referral and linkage gaps
- Delays in diagnostics and treatment
- Drug stockouts
- Stigma and poor patient experiences






## Patient Feedback Mechanisms

- Peer support groups
- Community dialogues
- Facility-community review meetings
- Patient satisfaction surveys



## Feedback Loop



Community →  Health Facility →  Action →  Improved Services



- Community-led monitoring captures patient experiences and service delivery gaps affecting AHD care
- Feedback from recipients of care helps identify challenges such as missed appointments, delayed testing, commodity gaps, stigma, and referral barriers.
- Community data supports dialogue with facility teams, MoH, and partners to improve service delivery
- Regular review meetings and supervisory visits strengthen accountability between communities and health systems
- Sustaining AHD care requires formal recognition of community voices within facility, county, and national coordination structures



Creating spaces for conversations on AHD in churches in Kenya



Training of community cadres on Nutrition in Zimbabwe



Re-establishment of Uganda People Defense Forces (UPDF) peer groups within the armed forces



Community follow-up visit to support TB drug refill, adherence, and continuity of care for discharged co-infected ROCs in Nigeria



Commemoration of the International AIDS candlelight memorial vigil



Care in Crisis: Holding the Line Against AHD amid devastating floods in Kenya

# Acknowledgments

Through the generous support of Unitaid, the Clinton Health Access Initiative, AFROCAB and Penta through the THRIVE Project is enabling access to critical prevention, screening, and treatment commodities for advanced HIV disease to dramatically reduce mortality among adults and children living with HIV.

Afrocab is leading community and civil society engagement in collaboration with global and local stakeholders.



# Upcoming CQUIN/HIVE Activities-June2026

## CQUIN

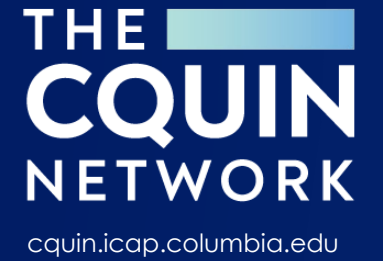
- **Webinar:** 9 June: Part two of the AHD webinar series on *Integrating AHD Services into Routine Health Care: Using Data to Inform Policy, Prioritization and Scale-Up*
- **Communities of Practice Meetings:**
  - M&E: 2 June
  - Service Delivery: TBD
  - Quality: TBD

## CQUIN Communities of Practice



## HIVE

- **Webinar:** 18 June: Expanding PrEP coverage for PBFW: Integrating PrEP into postnatal care
- **Communities of Practice Meetings:**
  - PrEP CoP: 4 June - Person Centered Approaches to Initiating PBFW on PrEP
  - M&E of PrEP for PBFW: 11 June



Thank You!

