

AHD –mentorship module

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AHD –challenges

- **Two types of AHD clients** managed at Primary care –**initiators or re-initiators** on ART who develop AHD due to inadequate adherence or resistance
- **Once started on ART**, AHD clients outcomes are at as good as non AHD clients
- **Variation in clinical needs of client –unwell vs well with low CD4 count**
- Guidelines for AHD management well developed and consistently applied will benefit patients at all levels of the DHS

KEY RISK FACTORS FOR AHD

1. **Delays to ART initiation**
2. **ART interruptions**
3. **Time period off ART**
4. CD4 count nadir
5. Immunovirological discordant response

Tom Boyles, Gary Maartens, Jeremy Nel, David Stead Southern African HIV Clinicians Society Clinical Guidelines for Hospitalised Adults With Advanced HIV Disease 2022

Fiegan,WC data centre –unpublished data (2017 -2021)

ADMITTED PLWH -much higher risk of death

- 25% die during admission
- 25% die within 48hours of admission
- 80-90% die within two weeks
- Further 30% die after discharge

Risk might persist after discharge

Ford ,Nathan etal Outcomes of PLWH after hospital discharge –a systematic reviewand metaanalysis .The Lancet vol 9,3(2022)

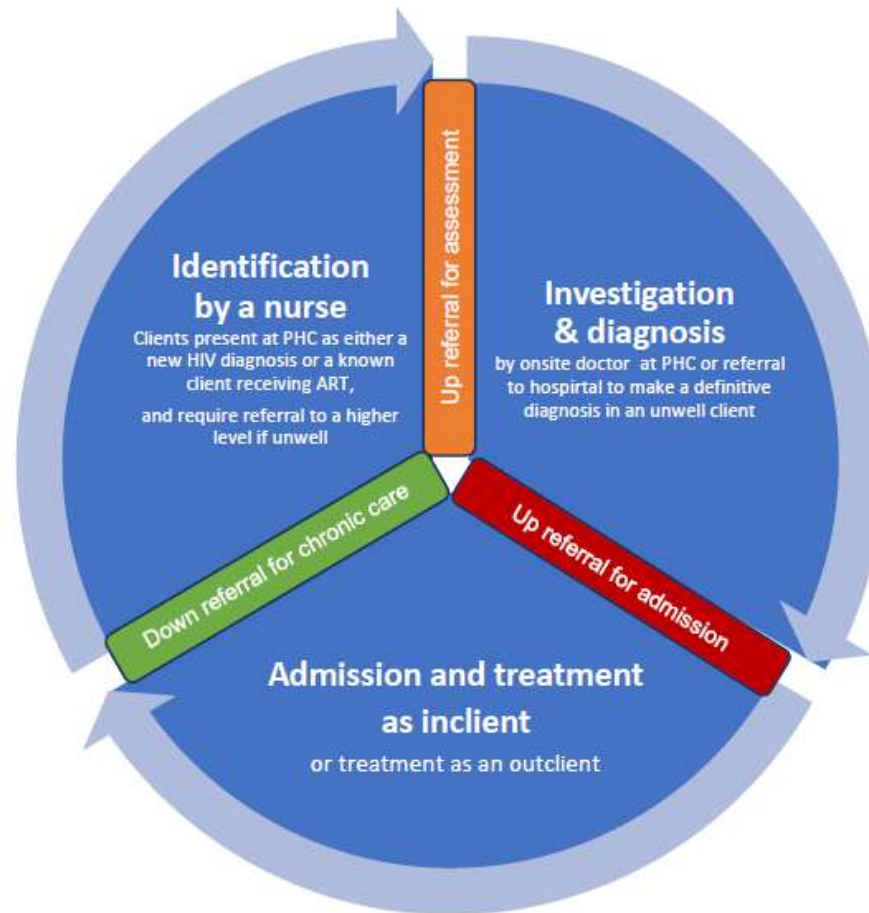
Major Causes of death

- TB
- Severe bacterial infections
- Cryptococcal meningitis
- PCP

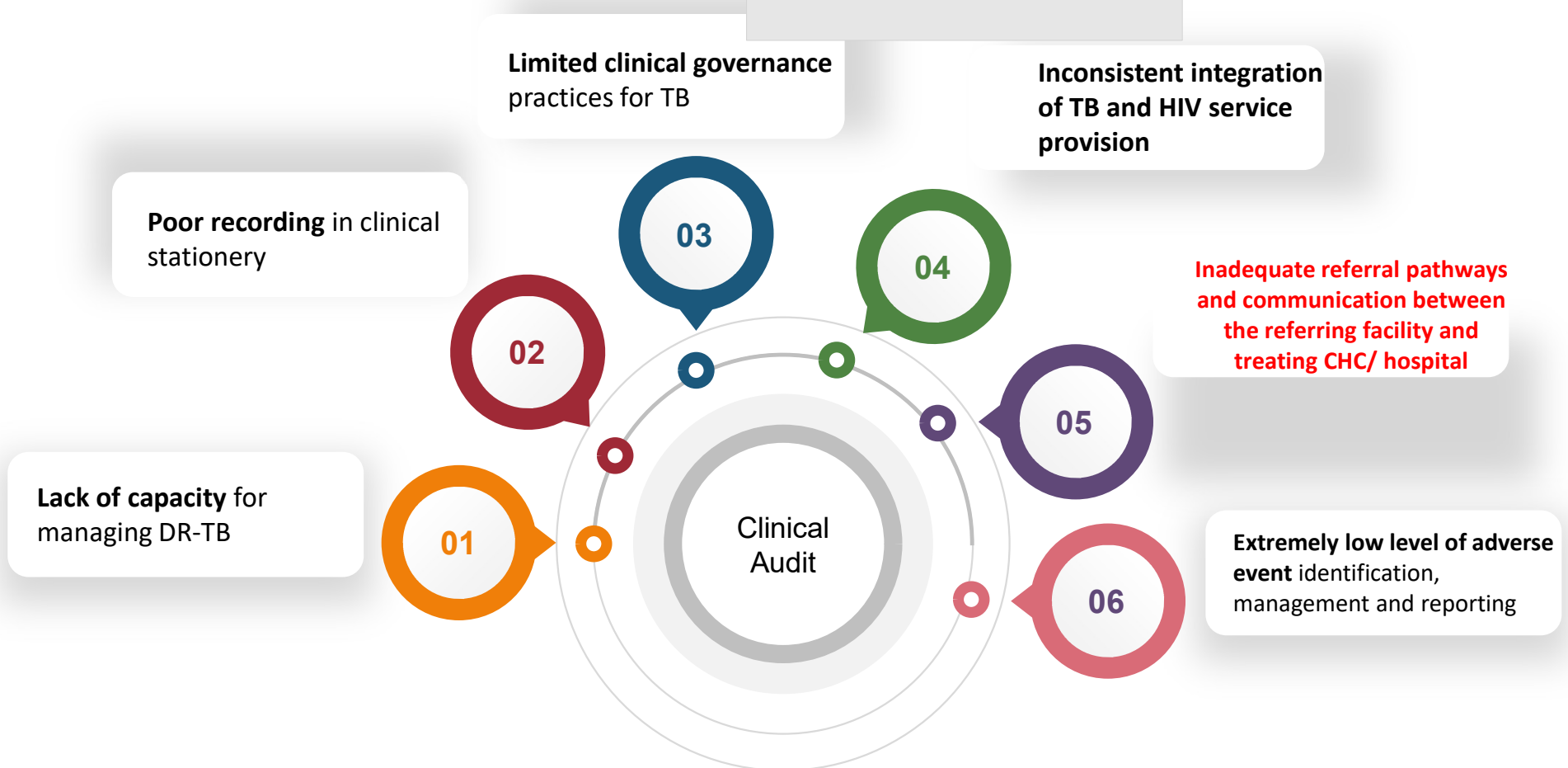
NEED TO MAINTAIN
CONTINUITY OF CARE

The key –continuity of care (CDC –AHD and ACC draft)

Identifying common opportunistic infections among people with advanced HIV disease: policy brief. Geneva: WHO; 2023



Findings: Clinical Audits



**GOOD COMMUNICATION BETWEEN LEVELS OF CARE
TO PROMOTE RETENTION IN CARE AND ADHERENCE
TO TREATMENT**

**HOW TO MAINTAIN CONTINUITY OF
CARE ?**

1-PHC facilities /OPD in hospital

- Call receiving clinician to arrange referral
- Write comprehensive referral letter – **as per requirements of up-referral site**
- Ensure client reaches facility and receives necessary services
- Provide two weekly follow up for first three months, where clinically needed
- ENSURE that missed appointments can be identified and clients can be traced and recalled

2.-Hospitals -There is still a significant mortality rate for clients after discharge from the hospital for HIV-related conditions.

- Provide feedback for services rendered
- Write detailed community and home based recommendations and follow up plans on DC
- Ensure client reaches down referral facility and continues to receive care by making appointments and /or assigning linkage officers /community liaison officer e

3.-Multidisciplinary team role

- All sites -link with social work services ,community based organisations,and community health workers where needed

Conditions requiring up referral for admission or assessment by MO



Complications associated with HIV infection

Pulmonary disease:

- Respiratory failure is the most common reason for ICU admission in HIV +ve patients.
- Conditions- PCP, TB and severe pneumonia(sometimes in combination)
- IRIS
- Acute respiratory distress syndrome

Liver disease:

- Hep B co-infection is common.
- Toxicity associated with some non allopathic medication – liver failure
- Drug induced liver injury due to TB drugs

Renal disease:

- End-stage renal disease may be caused by HIV chronic kidney disease
- Acute renal failure more common –requires fluid resuscitation and may need dialysis

- Patients who are SCrAg positive that require lumbar puncture
- Mental health assessment –acute presentation or relapse that require inpatient management
- Sudden onset neurological deficit
- Danger signs with systemic symptoms

RR > 30

HR > 120

T > 39

BP –diastolic < 40

Develop an SOP at each hospital to ensure continuity of care

- Guidelines to PHC –CHC staff for up referral of PLWH for assessment and /or admission
- Urgent /immediate referral vs non urgent / booked referral
- Guidelines for discharge –process and communication to down referral site – OPD /PHC
- Use of existing stationery –educate all levels of care regarding key information required before up-referral and down referral .
- Improve quality of discharge summary
- Ongoing mentorship of staff entering the unit

SERVICE DELIVERY RESEARCH

AREA OF INTERVENTION	RESEARCH GAPS	METHODS
FREQUENCY OF CLINIC VISITS	Outcomes of spacing clinic visits /drug refills> 6 months	Quantitative comparative
TRACKING AND REENGAGEMENT	Tailored support to reduce disengagement and support reengagement	Mixed methods
ASSESSING ADHERENCE	Accurate ,feasible measure of adherence	Diagnostic accuracy
INTEGRATION WITH SRH services	Approaches to integration for uptake of services including contraception Strategies in different health systems and social contexts Provision of contraception - less frequent clinic /ART collection visits	Health service intervention Quantative
INTEGRATION WITH HPT/DM/NCD	Long term outcome data on PLWH with NCD Cost effectiveness of different models of integration Supply chain optimisation Health promotion to encourage life style changes Integration of care for NCDs into differentiated models of care Values and preferences related to care delivery	Longitudinal cohort Economic evaluation Health service research Quantative Implementation science Qualitative Eg I HEART study
PSYCHOSOCIAL INTERVENTIONS ADOLESCENTS/ CHILDREN	Interventions that improve outcomes Content and delivery strategies that involve parents and caregivers Training supervision and support for facilitators of psychosocial interventions .Cost effectiveness of interventions	Quantitative –comparative Health service research Health service research Economic evaluation Longitudinal cohort