AWACC :
CHALLENGES AT PHC/CHC TO IDENTIFY AND MANAGE AHD CLIENTS

DR. THANDOKUHLE ZIKALALA

DATE: 29/10/2026



AHF
AIDS HEALTHCARE FOUNDATION

PRESENTATION OUTLINE

1. Background & rationale- why timely identification of Advanced HIV disease matters
2. Basis of analysis
3. Key findings
4. Learning points
5. Proposed improvement plan

AHF
AIDS HEALTHCARE FOUNDATION

BACKGROUND : WHY IDENTIFICATION OF AHD MATTERS?

1

Why is this important?

- **Advanced HIV Disease (AHD) remains a major contributor to HIV-related morbidity & mortality.**
- **Early identification of AHD** → timely interventions. (screening, prevention & management)
- **Clients at risk include-** late presenters, re-engaging in care, key population & treatment failure.

2

Why did we review our patients?

- To better understand challenges in identifying AHD at PHC & CHC level, we **reviewed 55 patients enrolled** in the Advanced Clinical Care (ACC) programme in AHF supported facilities.

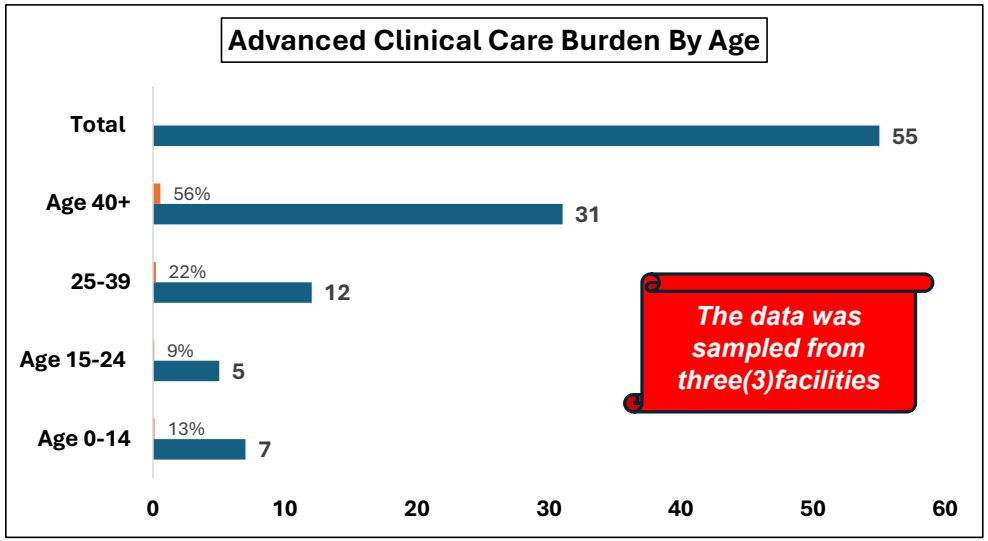
AHF
AIDS HEALTHCARE FOUNDATION

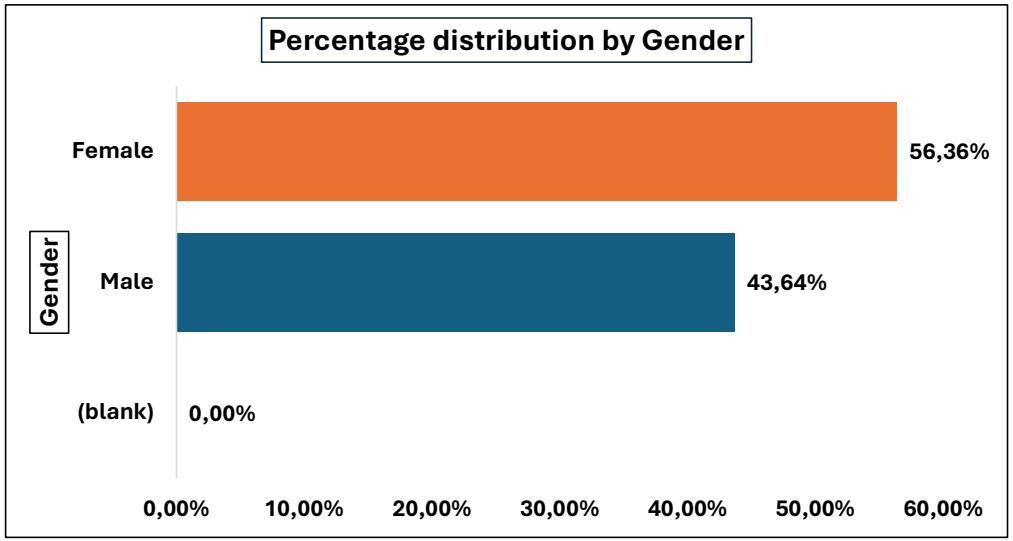
ANALYSIS: CHALLENGES IN IDENTIFYING AHD IN PHC & CHC

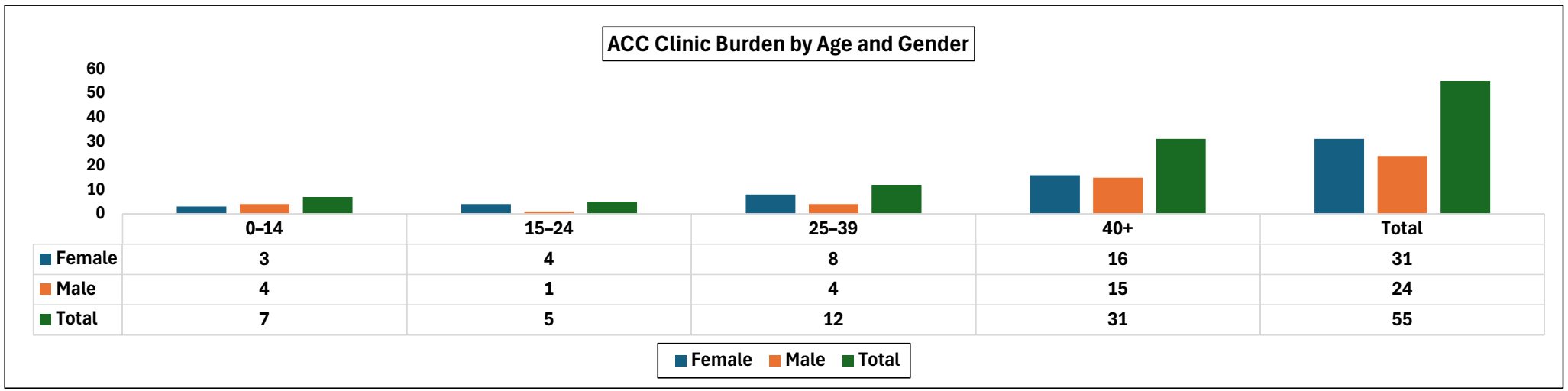
- This analysis was conducted across **three Advanced Clinical Care (ACC)** pilot sites in the Gauteng region, 1 Johannesburg Health District facility & 2 facilities from a more remote Lesedi District
- **ACC clinics were implemented & operated on a weekly or bi-weekly basis**, led by Medical Officers in collaboration with the Department of Health (DoH).
- Findings are based on a **55-patient pilot cohort from 2025**
- The analysis provided valuable insights into **barriers and gaps in the identification of Advanced HIV Disease (AHD)** at **Primary Health Care (PHC)** and **Community Health Centre (CHC)** levels.
- These findings informed the identification of key operational, clinical, and system-level challenges that impact timely AHD diagnosis and linkage to appropriate care.

AHF
AIDS HEALTHCARE FOUNDATION

ADVANCED CLINICAL CARE SUPPORT –AHF SUPPORTED SITES

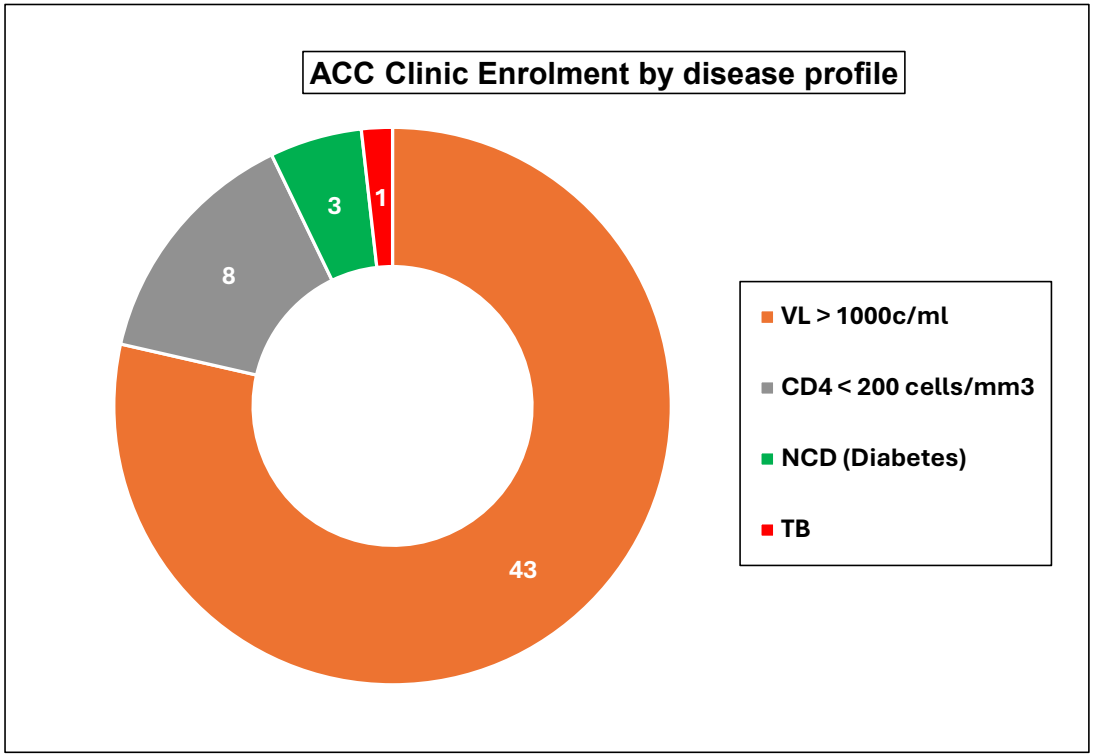






	0–14	15–24	25–39	40+	Total
Female	3	4	8	16	31
Male	4	1	4	15	24
Total	7	5	12	31	55

ADVANCED CLINICAL CARE CLINIC CARE SUPPORT



Summary :

- **78%** of patients enrolled due to high VL at admission
- **15%** enrolled by CD4< 200 cells/mm3 (Advanced HIV Disease)
- **5%** enrolled by NCD - Diabetes Mellitus
- **2%** enrolled by complicated TB Disease
- AHD Surveillance by CD4< 200 still lagging behind
- Focus of care still focused on unsuppressed VLs vs CD4 Count and optimization of NCDs.

- **Key Message**: *the findings suggest that AHD is frequently identified after treatment failure rather than through proactive screening, resulting in missed opportunities for earlier intervention and improved patient outcomes.*

AHF
AIDS HEALTHCARE FOUNDATION

SUMMARY OF THE SHORTCOMINGS OF ACC MODEL IMPLEMENTATION

Implementation of ACC perceived as a replacement of previous - Special Clinics/ VL clinics, hence the bulk of clients seen in ACC are patients with VL>1000c/ml

Viral Load Suppression superior to immunological competence - extensive VL monitoring (cohort VL, VL due & overdue lists etc.) vs CD4 cell count monitoring & WHO staging

Reactive approach to AHD management (identification closely linked to VL monitoring time frames)

Fractured integration of services - NCDs with ART (clients collecting treatment in multiple facilities, other monitoring bloods neglected).

Implementing Partner(IP) driven activity - DOH clinicians left behind in the implementation- seen in the collapse of ACC Clinics post work stop order

Children <15 years scattered between multiple service points EPI, mother & child

Limited access to comprehensive psychosocial package

SYSTEM-LEVEL FACTORS AFFECTING EARLY IDENTIFICATION OF AHD

SCENARIO :
*A **YOUNG** man living with HIV arrives at a busy CHC after several months of treatment interruption **DUE TO WORK RELATED MATTERS.** He waits for hours, receives ART, and leaves **WITH no RE-ENGAGEMENT CD4 COUNT COLLECTION.** No symptom screen is completed. Three weeks later he is admitted with cryptococcal meningitis."*
The question is not whether he attended care.
The question is:
"where along the PHC journey did we miss the opportunity to identify advanced HIV disease?"

???Health system challenges

1. **Healthcare/System related Factors**

- Operational - admin (ineffective record management (filing,) prolonged waiting times, inefficient appointment system etc.)
- Suboptimal referral systems between levels of care
- Human resource constraints – result in very busy clinics

2. **Clinical & Psychosocial Factors**

- Inadequate clinical surveillance of AHD
- Delayed actioning of results- CD4 count, Viral load, TB NAAT etc
- Inconsistent prophylactic therapy – TB Preventive Therapy(TPT), Co-trimoxazole Preventive Therapy(CPT)
- Inadequate psychosocial support for eligible patients
- HAST (HIV/AIDS,TB & STI) Services – Nurse driven program - the culture of Drs not seen as frontline recipients for PLHIV (NIMART)

AHF
AIDS HEALTHCARE FOUNDATION

PATIENT RELATED FACTORS CONTRIBUTING TO AHD BURDEN



Patient related Factors

1. Barriers to accessing care/ late presentation
2. HIV Stigma - Internal & external stigma
3. Psycho- social problems
4. Misinformation & limited health literacy
5. Underlying & often undiagnosed mental health conditions
6. Non-adherence resulting from treatment fatigue
7. Recreational drug use
8. Cultural & Spiritual beliefs influencing health-seeking behaviour
9. Non-disclosure / Late (delayed) disclosure
10. Immigration-related challenges, including documentation, mobility & access to services.

AHF
AIDS HEALTHCARE FOUNDATION

Key message: AHD can be hidden and missed at PHC/CHC level in view of health system and/or patient related factors.

EXISTING CHALLENGES AT PHC/CHC LEVEL

AHD management is commonly perceived as:

1.Complex

2.Time-consuming

3.Doctor-dependent

Common conditions considered complex are :

1. Cryptococcal disease, TB/HIV co-infection
2. Immunocompromised clients- CD4 < 200 &/ WHO stage 3&4, Malignancy
3. NCDs : Liver & Renal Disease (Optimization of NCDs)
4. Virological/ Treatment Failure eligible for Drug Resistance Test(DRT)

Impact of the identified challenges may be :

1. Missed opportunities for early AHD identification
2. Missed opportunities for early diagnosis of opportunistic infections
3. Delayed decision-making e.g., referral to Medical Officer PHC & up-referral to next level of care for assessment which may include DRT

.

AHF
AIDS HEALTHCARE FOUNDATION

TZ1

MORTALITY AUDITS FINDINGS

	Q4 2025	Q1 2026	Q2 2026	Total
Total no. of deaths in the period under review:	25	33	28	86
Total audited	22	23	28	73 **(85%)**
Not audited	3	1	0	4
No. of HIV-related deaths:	13	10	12	35 **(48%)**
No. of non-HIV related deaths:	9	13	15	37
Of the HIV-related deaths, how many were AHD?	11 **85%**	9 **90%**	12 **100%**	**32** **91%**
Total TROA (province):	37831	36369	38376	38376
Mortality Ratio (average):	**0.66**	**0.90**	**0.73**	**0.76**

AHF
AIDS HEALTHCARE FOUNDATION

- Of the 35 HIV-related deaths reviewed, 32 (91%) occurred in patients with Advanced HIV Disease, demonstrating that AHD remains the predominant driver of HIV-related mortality despite widespread ART availability.

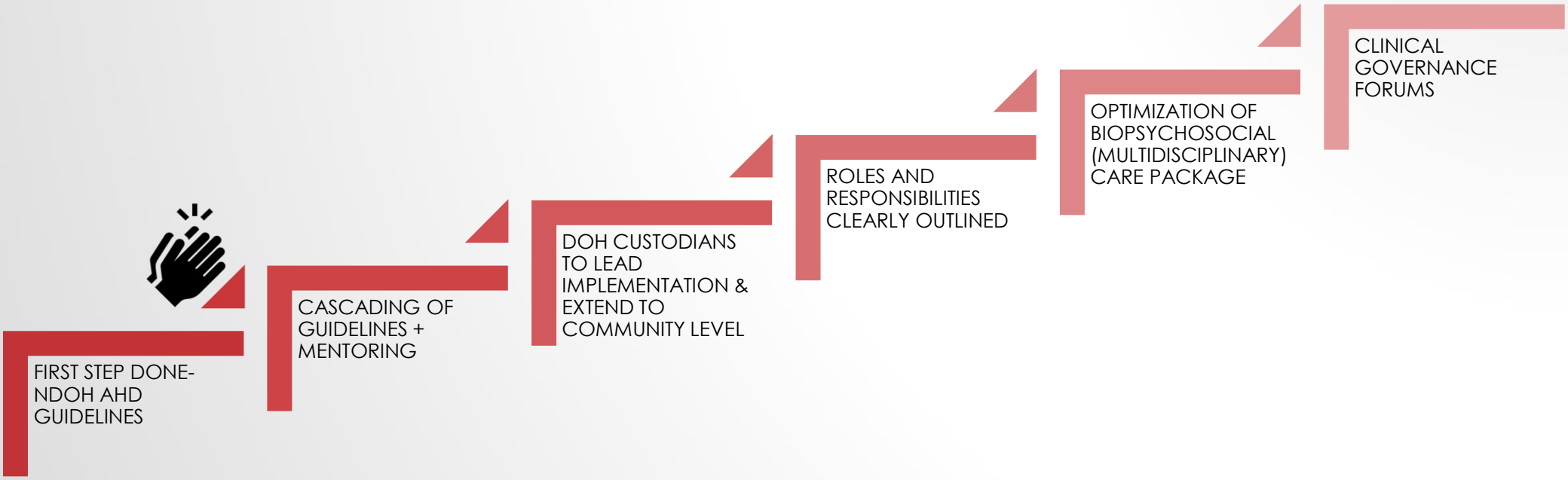
Slide 11

TZ1 @ M&E kindly confirm Q1 total number of deaths so that we can narrate properly
Thandokuhle Nonjabulo Zikalala, 2026-08-03T12:47:25.623

JM1 0 [@Nkosinathi Tlabakoe]
Jeanette Monyayi, 2026-08-17T13:36:47.322

AT1

THE MULTIFACETED PROPOSED REMEDIAL PLAN



AHF
AIDS HEALTHCARE FOUNDATION

AT1 Lets elaborate a little bit more

Annah Thipe, 2026-10-07T04:46:15.995

THANK YOU



AHF
AIDS HEALTHCARE FOUNDATION