Advanced HIV Disease Rapid Landscape Assessment Cross Country Findings and Recommendations

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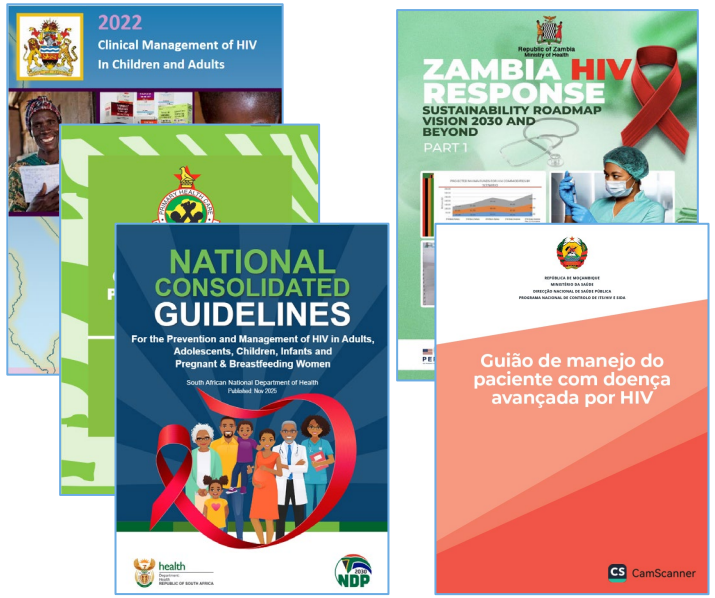
Methodology | Approach and Sources Used

This rapid multi-country assessment used mixed qualitative and quantitative methods to assess AHD service availability, implementation of guidelines, and system-level constraints across Malawi, Mozambique, South Africa, Zambia and Zimbabwe

Review of guidelines and strategic documents



Analysis of nationally available epidemiological data

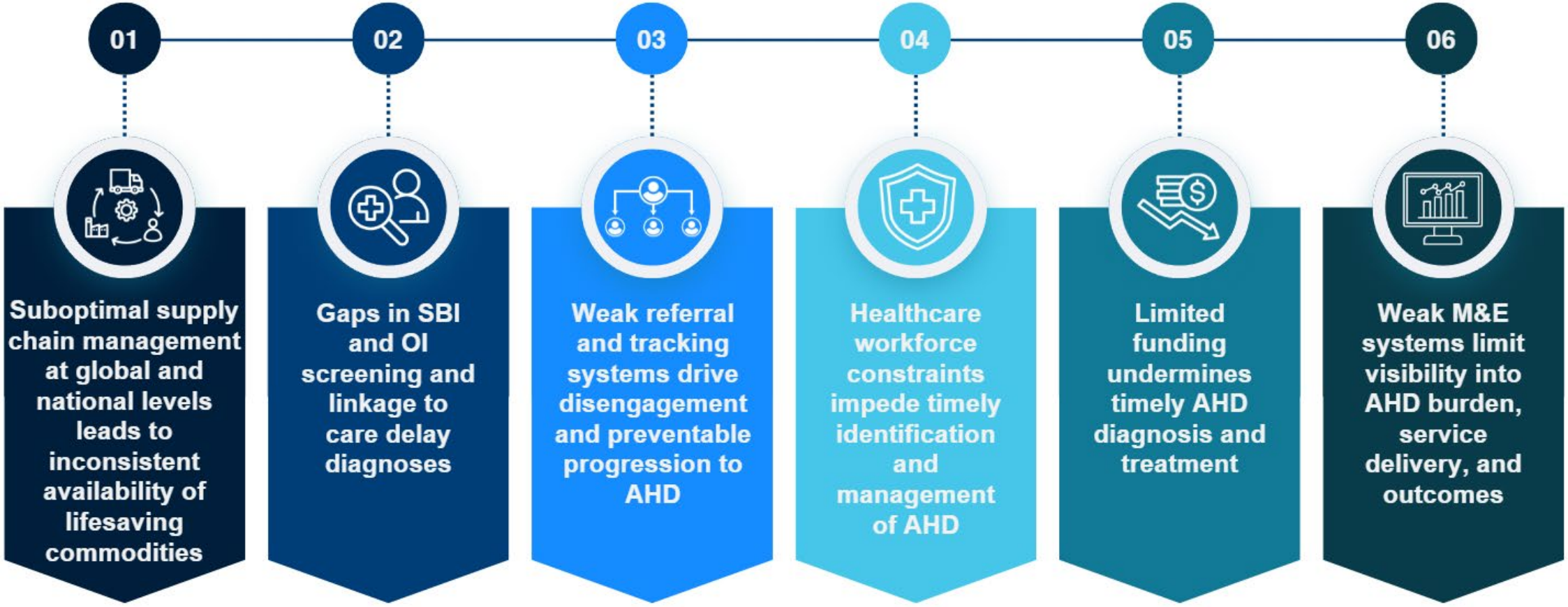
Section	Q#	Question
HIV Stats	1	HIV Prevalence
HIV Stats	2	Status on the 95-95-95 targets for 2030
HIV Stats	3	Annual AIDS related deaths
HIV Stats	4	Virally unsuppressed PLHIV
HIV Stats	5	Children under 5 living with HIV
HIV Stats	6	Children under 5 living with HIV, on ART for <1 year
AHD Stats	7	AHD Prevalence - total reported in data system
AHD Stats	7a	Of those, which were clinically staged
AHD Stats	7b	Of those, which received a CD4 >200
AHD Stats	7c	Of those, which were classified as AHD through another method
AHD Stats	8	TB Prevalence among people with AHD
AHD Stats	9	CM Prevalence among people with AHD
AHD Stats	10	Histoplasmosis among people with AHD
AHD Stats	11	SBI prevalence among people with AHD
AHD Stats	12	Virally unsuppressed PLHIV who received a CD4 test
AHD Stats	12a	Time between unsuppressed VL and CD4 test

Key Informant Interviews (KIIs)

Across the 5 countries, a total of 70 stakeholders representing a range of departments and institutions

Findings | Key barriers to AHD access and service delivery

Assessment findings are grouped into six priority areas that constrain effective AHD service delivery and outcomes. Addressing these is critical to improving access, quality, and outcomes for people living with AHD

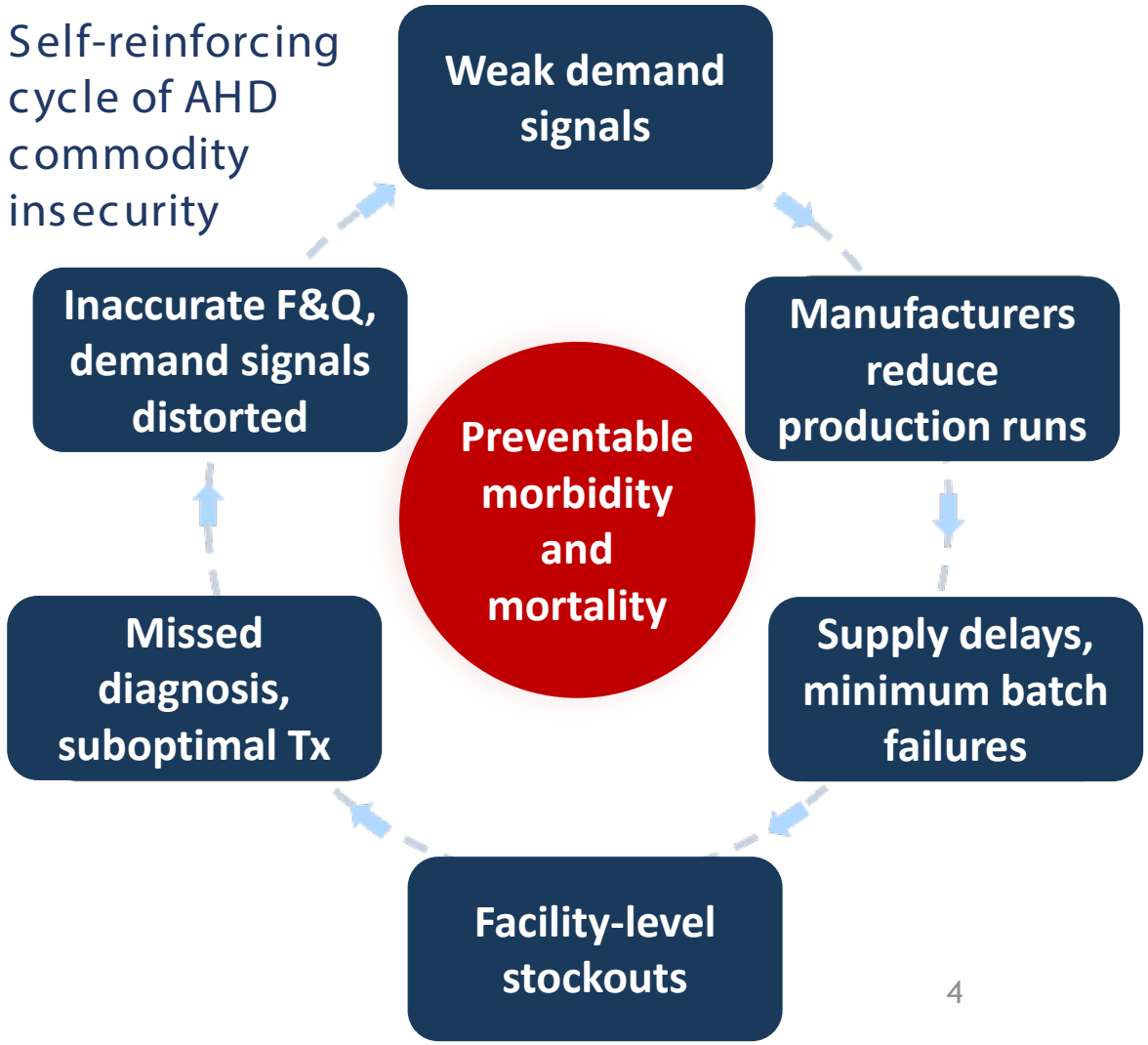


Findings | Suboptimal SCM at global and national levels leads to inconsistent availability of lifesaving commodities

01

Fragile global commodity markets and persistent national SCM weaknesses combine to create unreliable access to essential AHD diagnostics and treatments across countries and within facilities.

- **Single-supplier dependence and low aggregate demand** reduce incentives for manufacturers to maintain buffer stock or prioritize small orders. Infrequent production cycles, long lead times (up to 6 months) and minor supply disruptions can trigger global shortages.
- **National SCM systems lack end-to-end visibility** with fragmented stock management platforms preventing real-time oversight from central warehouses to facility level. Stockouts occur even when national stocks exist.
- **4/5 assessed countries** do not have domestic budget allocations for core SCM processes, leaving them vulnerable during funding transitions.
- **The vital role of USG and Chemonics in the global supply chain for HIV commodities,** including securing prices, supply security and lead times, has abruptly ended, creating critical gaps and uncertainty for all countries.



Findings | Gaps in SBI and OI screening and linkage to care delay diagnoses

Suboptimal diagnostic **coverage**, fragmented referral pathways, and limited capacity for SBI management leave many people with AHD unidentified and untreated.

- **CD4 testing coverage remains inconsistent,** ranging from as low as 16% of new ART initiates in one country to 80%+ in another.
- **CrAg and TB LAM testing gaps are severe,** with one country reporting 3% of eligible AHD clients receiving either test.
- **HCW hesitancy and stigma around lumbar punctures** contribute directly to missed cryptococcal meningitis diagnoses across all five countries.
- **SBI identification is hampered by the absence of accessible POC diagnostics,** with blood cultures and FBC not routinely used outside of major facilities.
- **Gaps is understanding of OI and SBI burden** limits effective planning, provision of care and most importantly resulting in preventable deaths

Snapshot of AHD cascade across 2 countries

During the period June ’24 – June ’25, among PLHIV with AHD


2 in 5 received a CD4 test


1 in 3 received TB LAM test


7 in 100 were diagnosed with TB


4 in 5 diagnosed with TB were linked to TB treatment; 1 in 5 was not


7 in 10 received a CrAg test (although the range varies hugely)


5 in 200 CrAg tests were serum positive

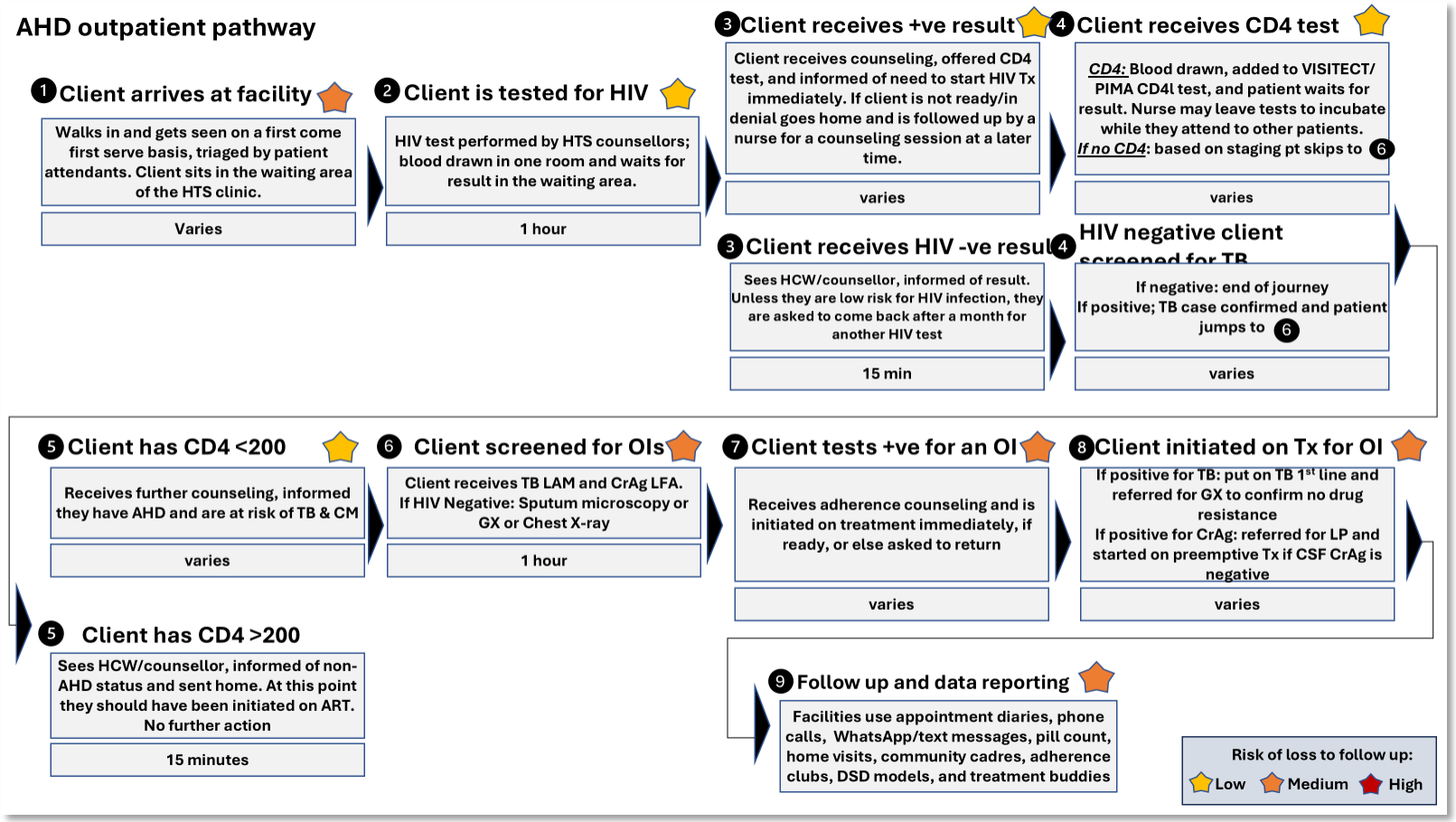

True burden of SBIs and other OIs is largely unknown

Findings | Weak referral and tracking systems drive disengagement and preventable progression to AHD

Loss to follow-up is a defining failure of AHD service delivery, driven by weak systems rather than individual patient behavior.

- **Country programs have inadequate visibility into referral completion** for clients diagnosed with AHD or screened for OIs.
- **Most LTFU occurs at predictable points:** between OI screening and treatment, following hospital discharge, and during ART treatment interruption.
- **Inpatient AHD care is a structural blind spot for national programs.**

Typical AHD patient outpatient pathway



04

Findings | Healthcare workforce constraints impede timely identification and management of AHD

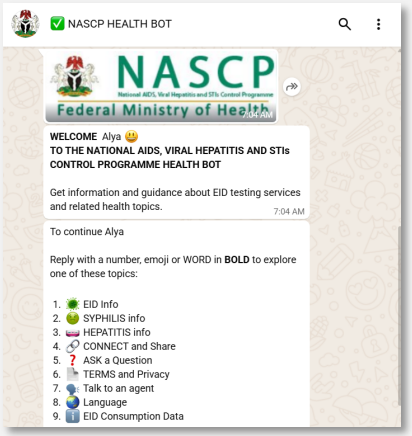
High attrition, infrequent training, and resource-intensive models leave health workers without the knowledge or support to reliably deliver the AHD package of care.

- **HCW attrition rates exceed 50% annually in two out of five assessed countries.**
- **Training is provided at best annually** (in two countries), or as seldom as every 2-3 years (in two countries). The fifth country did not report a number as the program does not track when AHD trainings are conducted.
- **Funding disruptions have halted training entirely in some settings,** with PEPFAR previously financing up to 40% of HIV training costs.
- **Current training models are resource-intensive and lack accountability systems** to ensure skills are disseminated or retained. There is currently no mechanism in any assessed country to systematically track AHD competency across the workforce.

Available AI tools with potential to meet service needs in light of reduced health workforce – potential for adaptation and integration with AHD

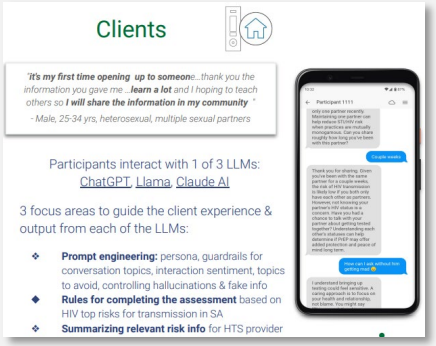
Health Bot

WhatsApp tool to disseminate guidance about EID testing services



Audere Your Choice

LLM service for clients with questions about HIV testing and prevention



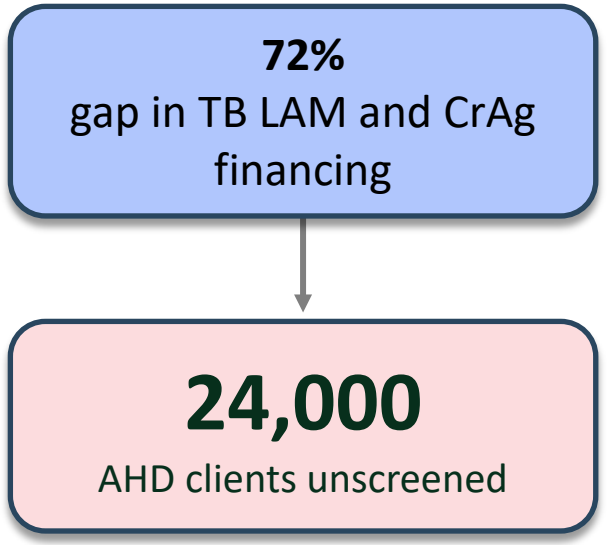
05

Findings | Limited funding undermines timely AHD diagnosis and treatment

Funding disruptions are not just a volume problem — they have revealed structural procurement inefficiencies that inflate costs and reduce coverage.

- National health budgets have contracted sharply, with some budgets covering as little as 35% of the minimum requirements for 2026. This widens the gap created by donor funding cuts which requires countries to assume greater programmatic ownership.
- **Countries transitioning to domestic procurement are paying inflated prices,** as local tender processes do not have access to optimal global sourcing platforms. Local distributor markups have resulted in commodity costs nearly double the global access price in at least one country.
- **The shift to bilateral MOUs has created transition gaps** where activities previously supported by multilateral partners, including SCM coordination, HCW training, and data management, face uncertain funding.
- **Procurement of commodities alone will not suffice.** New ways of delivering services outside of the current hub and spoke models must be found.

Gaps in financing for diagnostics driving preventable deaths in one assessed country



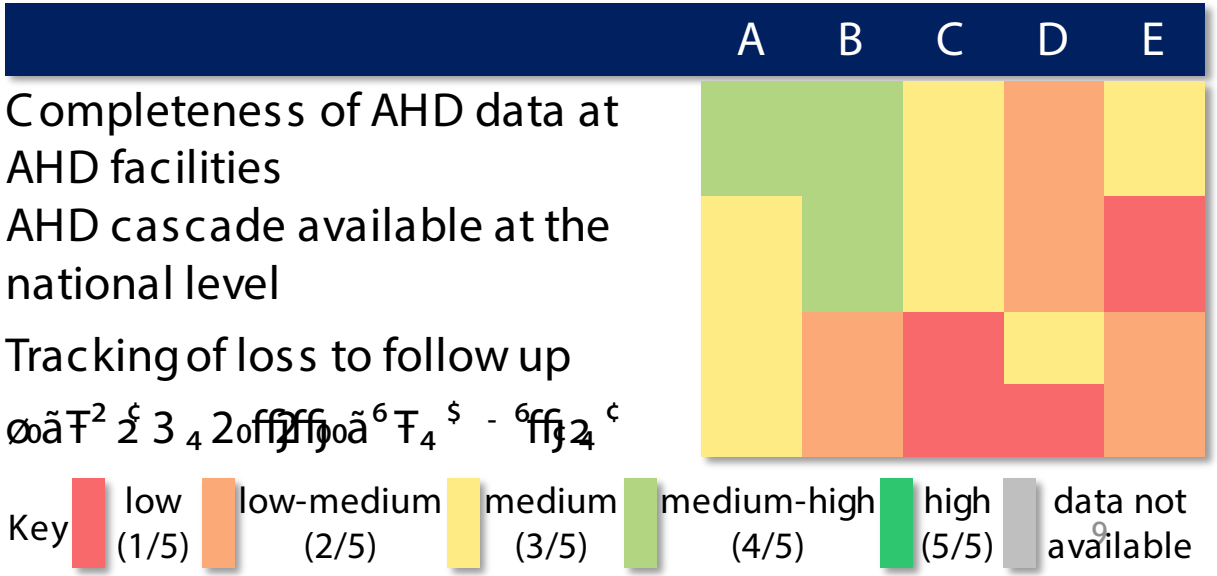
06

Findings | Weak M&E systems limit visibility into AHD burden, service delivery, and outcomes

The lack of AHD data inhibits AHD program management and preventing effective responses across countries

- **HCWs navigate a heavy reporting burden, completing multiple paper-based registers for different programs and partners,** which contribute to incomplete, delayed, and inconsistent data.
- **AHD indicators are frequently missing or inadequately disaggregated from wider HIV data:** systems often capture testing volumes without linking results to clinical action, making it difficult to measure the impact of AHD care implementation.
- **Inpatient AHD data is almost entirely absent from national monitoring systems.** Diagnoses made, OI treatment, and post-discharge outcomes are not captured, meaning the burden of AHD-related mortality in clinical settings cannot be quantified.

Quality and completeness of AHD data across the five assessed countries



Areas For Intervention| Recommendations Across the Six Priority Areas

Supply Chain Management & Global Market Fragility 01

DIGITAL INVESTMENTS

Strengthen and integrate national stock management systems and dashboards to enable real time end to end visibility of AHD commodity availability and reduce stockouts.

MARKET COORDINATION

Coordinate global and regional stakeholders to pool procurement for low volume AHD commodities, improving pricing, supply predictability, and delivery reliability.

Gaps in SBI & Opportunistic Infection Screening 02

PROGRAM SUPPORT

Expand HCW training, EQA systems, and diagnostic capacity to ensure routine SBI, TB, and cryptococcal screening for patients presenting with advanced HIV.

NEW PRODUCT INTRODUCTION

Support introduction and scale up of next generation diagnostic tools including quantitative POC CD4 and semi quantitative CrAg testing to simplify and accelerate linkage to care.

Weak Referral, Client-Tracking & Service Delivery Systems 03

DIGITAL INVESTMENTS

Scale digital referral tracking platforms and interoperability solutions to ensure AHD referrals are completed and patient information follows clients across facilities.

Expand use of machine learning and predictive analytics tools to identify patients at highest risk of disengagement and enable targeted follow up.

Healthcare Workforce Constraints 04

NEW PRODUCT INTRODUCTION

Introduce high impact diagnostic readers and automated interpretation tools that reduce clinical burden and support task shifting to lower-level health workers.

DIGITAL INVESTMENTS

Develop scalable digital learning platforms and mobile clinical decision support tools to maintain AHD clinical competency in decentralized settings.

Funding Limitations & Inefficiencies 05

PROGRAM SUPPORT

Support national AHD TWGs to assess the impact of service integration, identify remaining gaps, and define sustainable national AHD response strategies.

Provide targeted sourcing and procurement support to help countries secure optimal pricing and maintain access to essential AHD diagnostics and treatments.

Weak Monitoring & Evaluation Systems 06

BUILDING EVIDENCE

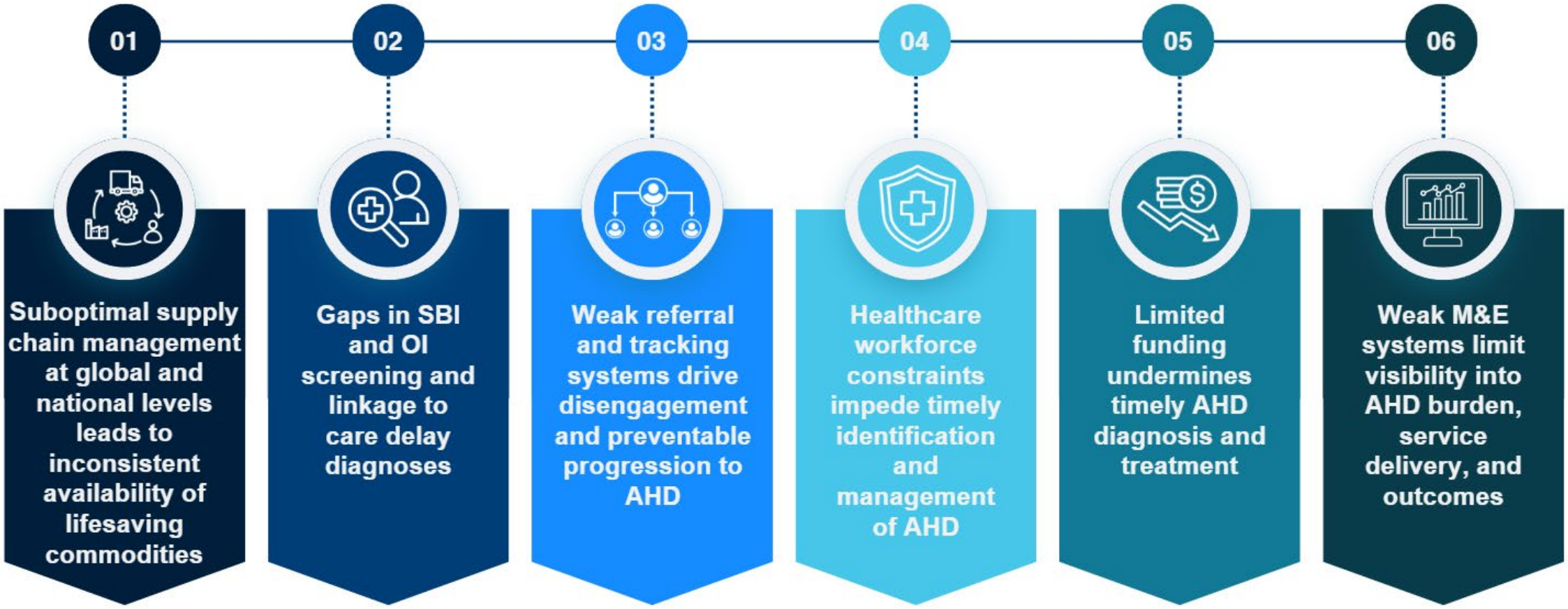
Conduct mortality audits and economic analyses to quantify the impact of delayed AHD diagnosis and strengthen the investment case for earlier detection.

DIGITAL INVESTMENTS

Expand EMR coverage and hybrid digitization approaches to improve visibility of AHD service delivery and outcomes for real time decision making.

Conclusions |

Targeted investments in



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Thank You!