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WELCOME

Simplifying HIV service delivery: From evidence to national policy

Multi-country policy workshop

26–28 October 2026
Johannesburg, South Africa

The workshop will begin shortly

Welcome, introductions and workshop objectives

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In this session

Monday 26 October
09:00–09:30

1

Welcome and introductions

2

Where we have come from

3

Where we are today

4

This workshop

Part 1 of 4

Welcome and introductions

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Welcome to the country teams

 **Malawi**

 **Mozambique**

 **Zambia**

Each team brings around six people from across the policy process

Ministry of Health	National HIV programme: who writes and approves the guidelines
Researchers and partners	Scientists and partners who bring the evidence and programme data and support implementation
Communities	Civil society, community organizations and networks of people living with HIV

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Welcome to faculty and partners

IAS team: Helen Bygrave, Lina Golob, Anna Grimsrud, Maeva Villard, Lynne Wilkinson

Colleagues, partners, and collaborators

Lazarus Momanyi
NASCOP, Ministry of Health, Kenya

Clara Nyapokoto
Ministry of Health, Eswatini

Baker Bakashaba
AIDS Information Centre, Uganda

Tendai Nyagrura, Liesl Page-Shipp, Patrick Odawo
Gates Foundation

Cassia Wells
ICAP / CQUIN

Alex De Nooy
TIER-Plus, University of Amsterdam

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Introductions

In your country tables:

- Introduce yourself to the table
- Then, as a table, choose a rapporteur to introduce your country team to all the workshop participants

Order

1	Malawi
2	Mozambique
3	Zambia

Part 2 of 4

Where we have come from

Ten years of differentiated service delivery

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Where we were in 2015: everyone eligible for ART, but one model of care

16.8M

people on ART globally at the end of 2015

WHO "treat all", September 2015: everyone living with HIV eligible for ART

Care built for people starting treatment
Most people seen at the facility every one to three months, whether well or unwell

Clinical review and refill in the same visit
Every collection of medicine meant a consultation and a queue

One model for everyone
The same schedule, however long someone had been on treatment or however well they were doing

Sources: UNAIDS Global HIV Factsheet 2026; WHO Guideline on when to start antiretroviral therapy, 2015

DSD set out to match care to need

Adapting how HIV services are delivered to the needs and preferences of different groups, so the health system can focus on those who need more.

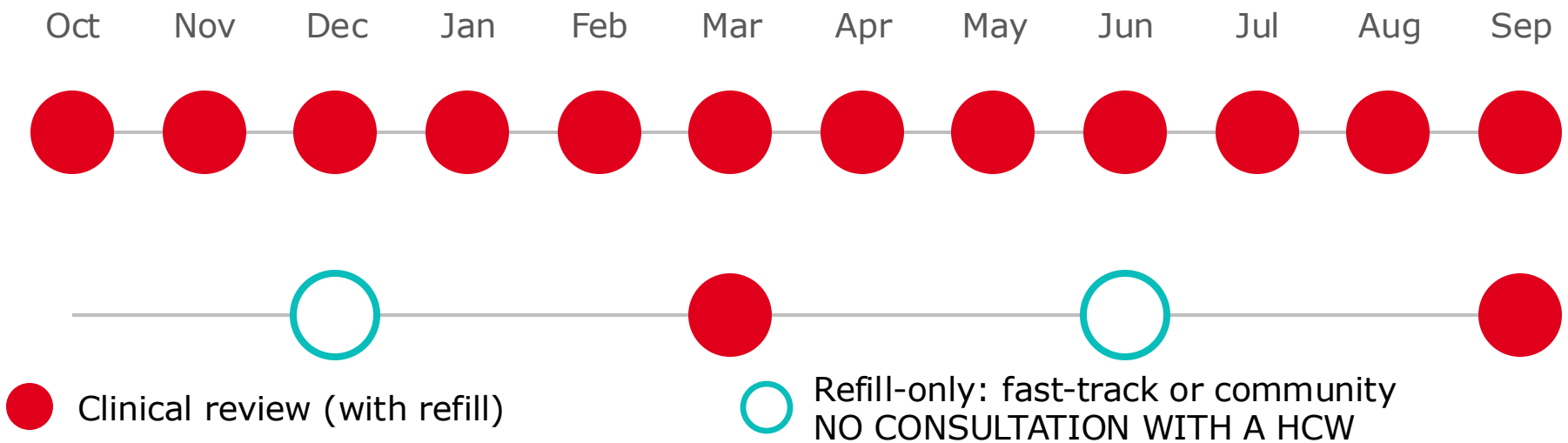
- **Established on ART:** fewer, more convenient contacts
- **Needing more:** more intensive support



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DSD separated refills from clinical reviews

One year of care for a person established on ART (illustrative)



12 facility visits became 2 clinical reviews; refills moved to faster, more convenient options

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Many models, in and out of the facility, plus longer refills

Facility-based individual

Fast-track refill collection, appointment spacing

Out-of-facility individual

Community pick-up points, outreach, home delivery

Healthcare worker-managed groups

Adherence clubs at facility or community venues

Client-managed groups

Community adherence groups, rotating collection

Multi-month dispensing

3–6

months between refills in most countries, up from monthly

Longer refills made every model more efficient

And multi-month scripting (MMS)

2 x 3 MMD
1 x 6MMD

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What DSD achieved: more people treated, more resilience

×2

Treatment cohort doubled

16.8M (2015) to 32.1M (2025) people on ART, during flat or declining resources

COVID-19

Resilience under pressure

DSD models and MMD let programmes extend refills and keep people on treatment

Normalized

Demedicalized living with HIV

Treatment fits around people's lives: fewer clinic days, less time off work

Source: UNAIDS Global HIV Factsheet 2026

Part 3 of 4

Where we are today

Less external funding, more country ownership, and a push to integrate

External funding is falling

−18%

International HIV funding, 2025

The largest decline in almost two decades

US$11.3bn

Global Fund 8th replenishment

Pledged November 2025, against a US$18bn target

2026–30

US government: PEPFAR to bilateral agreements

The US share falls each year as co-financing rises

Sources: UNAIDS Global HIV Factsheet 2026; Aidspan GFO 467 (Nov 2025); Think Global Health, Tracking the America First bilateral health agreements (2026)

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Five-year US health agreements: less US funding, more co-financing

Country	Agreement	US funding over five years	Change vs historical US funding
Malawi	Signed January 2026	Up to US$792M Malawi adds US$143.8M in health spending	**−34%** (−US$407M)
Mozambique	Signed December 2025	Up to US$1.8bn Health's budget share to rise by nearly 30%	**−24%** (−US$588M)
Zambia	Reached October 2026	US$1.5bn Zambia commits US$975M	**−30%** (−US$643M)

Sources: US State Department announcements as reported by Mirage News (Jan 2026), AIM (Dec 2025) and Semafor (Oct 2026); KFF, as of 8 October 2026

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Impact on key HIV service indicators

Change in key HIV service indicators across reporting countries, 2024 to 2025

	Testing		Adults on treatment		Paediatrics on treatment		Monitoring	Advanced care
Indicator	Number of tests run	Confirmed HIV-positive identifications	Number of new ART initiations	Total number on ART	Number of new ART initiations	Total number on ART	Viral load tests run	CD4 tests run
Percent change 2024 to 2025	**-12%** (8 countries)	**-28%**	**-9%** (8 countries)	**+0.6%** (8 countries)	**-15%** (8 countries)	**-11%** (9 countries)	**-21%** (10 countries)	**-35%** (6 countries)

Note: Percentage change calculated as aggregate across all reporting countries, comparing full-year 2024 totals to full-year 2025 totals, except for total number on ART, which is calculated using Q4 2024 totals compared to Q4 2025 totals.

Source: CHAI, HIV Market Impact Memo, June 2026

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Governments are absorbing functions that donors funded

Staff	Including peer and lay cadres who run many DSD models: clubs, community refill, tracing
Laboratories	Viral load and CD4 testing, specimen transport, results return
Data systems	Electronic records, appointment and tracking systems, reporting

Every contact we keep in the schedule increasingly relies on the national system.

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Integration… to save us?

The promise

HIV care delivered within primary health care or out-patient departments

One visit for HIV, hypertension, diabetes and contraception

Shared staff, labs, supply chains and data systems

The risk

Integration only simplifies if visit and refill intervals line up

Busy PHC clinics may pull stable clients back into frequent visits

DSD gains need to be carried into integrated care, not lost

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What does this mean for care?
Change by design, not by default

−21%

viral load tests run, 2024 to 2025

10 reporting countries

Because resources were lost, not because care was deliberately redesigned

Source: CHAI, HIV Market Impact Memo, June 2026

By default	By design
Cuts fall where systems are weakest	Prioritize openly; make the tough choices together
Tests and visits lost unevenly and unseen	Re-design contacts intentionally
CD4, a cautionary tale: capacity eroded with no decision taken	Protect continuity and quality as services integrate – opportunity to enhance quality of other health areas

Part 4 of 4

This workshop

Three areas for national policy change

1 Annual clinical visits

2 Viral load timing and frequency

3 Differentiated re-engagement after treatment interruption

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Why a policy workshop?

"What remains is not further evidence of safety but the decision to act."

For each area, five questions: faculty and guest countries bring **1–3**, country teams answer **4–5**

1	2	3	4	5
Why change?	**What does the evidence say?**	**What have other countries done?**	**What should change in our country?**	**What will it take to make the change?**

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Three areas, one approach

1

Annual clinical visits

One clinical review a year, with multi-month scripting?

Day 1 afternoon

2

Viral load timing and frequency

When should the first viral load be done, and how often after?

Day 2 morning

3

Differentiated re-engagement

How should care differ for people returning to care?

Day 2 afternoon

One approach

1

Plenary presentation

Evidence, guidance, country experience

2

Facilitated discussion and Q&A

3

Country table work

Facilitated, with template and summary

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How we will work:
what's in your workshop folder

Overview and agenda	• So that you know where we're going
Country tablework templates	• Five in total (one per country tabletop discussion) – country stock take and annual clinical visits (day 1), VL (x2) and re-engagement (day 2)
Plus…	• Four "empty" re-engagement algorithms • Two blank visit schedules • Your "peer challenge & commitments" template for Day 3

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Ground rules and commitments

Follow the lead of the countries	Country teams own the decisions; faculty bring evidence and experience
Listen	To each other, across ministries, researchers and communities
Arrive, start and finish on time	Every session feeds the next, and the Day 3 package
~2 facilitators per country group	Support at every table, throughout the three days

If you need help…

Ask your facilitators	They are friendly and knowledgeable ☺
Check on the workshop SharePoint folder	Where all the presentations, templates and other information is available

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Day 1, Monday 26 October:
Framing the opportunity and annual clinical visits

Time	Session	What happens
09:00–10:30	**1 Welcome and overview**	Welcome · Why simplify now? (Lynne) · How the three changes fit together (Helen) · Plenary
11:00–12:45	**2 Country stocktake***	Where are we now, and what is the context? · Country presentations
13:45–17:00	**3 Annual clinical visits**	Evidence and guidance (Anna) · Annual review within DSD · Country table work
17:30–19:00	**Welcome reception**	Ocaso restaurant, 199 Oxford St

* Country deliverable 1: a 10-minute country presentation

Outputs Current-state policy and practice map · proposed policy position on annual clinical visits

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Day 2, Tuesday 27 October:
Viral load and re-engagement

Time	Session	What happens
08:45–10:20	**4 Earlier first viral load**	Evidence (Lynne) · Kenya experience (Lazarus) · Country table work: timing of the first VL
10:40–12:25	**5 VL monitoring frequency**	How often after the first test? (Lynne) · Plenary · Country table work
13:25–16:30	**6 Re-engagement**	Evidence and guidance (Helen) · Eswatini experience (Clara) · Country table work
16:30–16:50	**Country walk-around***	Visit the other two countries to learn from their progress

* Country walk-around: share your draft positions with the other two teams and gather feedback

Outputs Proposed policy position on VL timing and frequency · draft or refined re-engagement approach or algorithm

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Day 3, Wednesday 28 October: Consolidate, commit and prioritize

Time	Session	What happens
08:30–10:30	**Finalize country plans**	Check-in: where have we landed? · How might integration affect implementation? (Helen) · Finalize the package
10:50–13:00	**7 Report-back and commitments***	Country presentations · Peer challenge · Individual commitments
14:00–15:30	**Choose a session**	Prioritization with TIER-Plus (Alex De Nooy) · or DSD for chronic diseases (Helen)

* Country deliverables 2 and 3: country report-back and 30-90-180-day action plan
* Individual deliverable: Commitments

Outputs A consolidated policy-change package across all three areas, with a 30-90-180-day action plan

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Each country will leave with

1

A map of current policy and practice

Day 1

2

Positions on the three areas

Days 1, 2 & 3

3

A 30-90-180-day action plan

Day 3

The aim: policy changes that simplify HIV treatment while maintaining quality and responding to the needs and preferences of people living with HIV

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Each participant will leave with

1–3

personal commitments

to support your country's policy-change package

Day 3

Start thinking now

What is one thing you can do in the next 90 days, in your own role, to move one of the three policy changes forward?

Why simplify HIV service delivery now?

Up next | Lynne Wilkinson, IAS, 09:30 | Then: How the three policy changes fit together, Helen Bygrave, IAS, 09:50