The future of HIV service delivery is simplification

AIDS 2026

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Lynne Wilkinson, IAS, South Africa

The future of HIV service delivery is…simplification, self-care, integration, and AI in practice

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WHY NOW

DSD was built to match care intensity to need — now we must finish the job

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DSD aimed to…

Reduce unnecessary burden for clinically stable clients and healthcare workers

Maintain retention, viral suppression and quality

Free capacity for people who need more support

Keep care client-centred, safe and engagement-protecting

Why it matters now — three structural pressures:

Funding pressure is structural, not temporary. USG funding is projected to decline 42–97% by 2030 across 11 country agreements; Global Fund HIV allocations are down ~18% on average.

Viral load testing is already declining — involuntarily. VL testing volumes have fallen ~21% (2024→2025), not through deliberate guideline redesign but through under-resourcing. This deck proposes making that reduction deliberate, targeted and safe — not accidental.

Workforce and laboratory support are contracting. Countries are expected to absorb large reductions in externally funded health worker and laboratory support in existing congested facilities.

Clinton Health Access Initiative, HIV Market Impact Memo, June 2026.

Simplification is no longer only about improving client experience — it is becoming essential to maintaining quality HIV care with fewer resources.

THE PROBLEM

Care is still more intensive than the evidence requires

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Across countries, stable ART clients are seen, tested and re-scripted more often than needed.

15 **Sub-Saharan African countries reviewed**

12 **schedule first VL at month 6, with result review thereafter**

9 **of those don't enable less-intensive DSD enrolment until month 12**

Policy review of 15 countries · Wilkinson, Golob & Grimsrud, CQUIN 2024 · IAS DSD policy dashboards, differentiatedservicedelivery.org

The bridge to why now: at exactly the time programmes have fewer resources, we continue asking stable clients to attend more often than evidence requires.

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Three shifts, one logic

One underlying idea — remove the clinical intensity that no longer buys better outcomes.

SHIFT 1

How often we see stable clients

Annual clinical review, not ART supply refill visits

SHIFT 2

Who is eligible — and enrolled

Include the groups still left out, and enrol those already eligible — biggest untapped gains in high-burden countries like South Africa and Mozambique

SHIFT 3

How we monitor over time

Test earlier, align and recall, then space out

Annual clinical review should be routine for stable people

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An annual clinical visit includes:

1. Structured clinical review
2. Viral load monitoring with recall capacity
3. 12-month prescription / script (12MMS)
4. Next annual review booked
5. ART refills accessed between clinical review visits through DSD models

MMS vs MMD

Different things. Both important.

MMS = Multi-month script
The length of the **prescription**.
(What the clinician writes)

How long the prescription is valid (e.g., 12 months)

Enables annual clinical visits Requires annual prescribing (12MMS)

MMD = Multi-month dispensing
The length of the refill (**dispensing**).
(What the pharmacy gives)

How much medicine is given each time (e.g., 6 months)

Does not have to be annual. It can be 1, 2, 3, 4, 6 months, etc.

New: IAS policy brief "Why annual clinical visits for stable people living with HIV are important"
www.differentiatedservicedelivery.org

Extend the clinical review interval — keep dispensing and refills unchanged

Both founding RCTs and national-scale data confirm it

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2 RCTs tested a full annual interval — Cassidy 2020 (Khayelitsha) and Fatti/Benade (Zimbabwe): retention and suppression non-inferior; the Zimbabwe trial isolates dispensing interval with review frequency fixed at annual.

428,926 clients, 7 SA provinces — Mokgethi, INTEREST 2026: 12- vs 6-month prescription. Retention equivalent (91–92%), suppression +1.3% adjusted gain.

1 vs 2 median visits/year — Lewis 2023 (JIAS, KZN): retention aRR 1.03 with 12- vs 6-month prescriptions — roughly half the visits.

↑ Quality of care score Improving 2018-2022 in Cape Town — annual review under an audited SOP; quality of comprehensive care rising, not falling, over time.

Both RCTs pair annual review with different dispensing intervals; Mokgethi and Lewis are the direct national-scale confirmation of the 12-month script itself.

SHIFT 1 · ECONOMICS

Fewer visits release capacity and roughly halve patient cost

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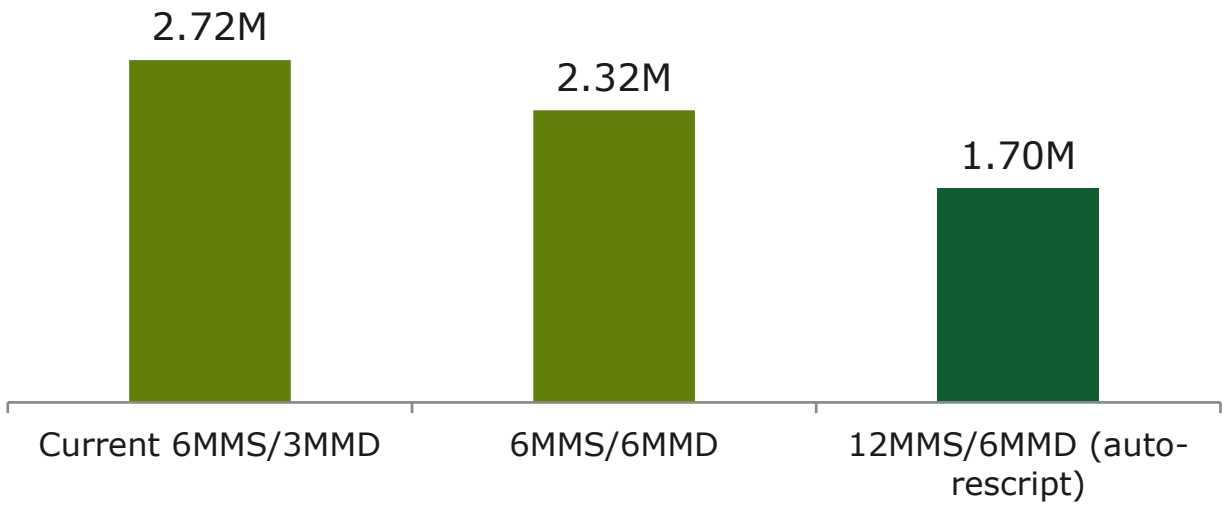
Total staff hours, Year 1 · South Africa modelling



≈ 38% less staff time — capacity released, not cash banked

Huber et al. (He2RO/Wits Health Consortium), AIDS 2026 oral presentation

~56% lower — **patient cost of care**
$10.03 → $5.12 → $4.40/yr as review moves to annual and pickup lengthens · Benade 2023

~halved — **patient costs, 5 SSA studies**
6MMD consistently slightly cheaper to the provider too · Rosen 2021

cost-saving — **6MMD to provider, Zambia**
client costs −12%; lab costs are the biggest driver · Lekodeba 2025

SHIFT 2 · ELIGIBILITY & ENROLMENT

Two levers: broaden who's eligible, and enrol who already is

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Lever 1 · Broaden eligibility
Extend simplified models to groups still excluded on historical grounds.

Lever 2 · Enrol who's already eligible
Even where policy already allows it, many eligible clients are not yet enrolled.

Lever 1 in detail — where eligibility itself is still too restrictive:

12 months on ART before DSD enrolment is possible	→	**Consider enrolment after the first EARLIER suppressed VL**
Children and post-partum women excluded	→	**Include children >2 years old & postpartum women**
Shorter refills for younger age groups	→	**Extend 6MMD to these groups**

https://www.differentiatedservicedelivery.org/resources/dsd-policy-dashboards

Where the biggest untapped gains are: Eligibility has broadened over time, but much remains based on historical caution rather than contemporary evidence. With resources constrained, enrolling those already eligible is one of the fastest ways to release clinical capacity without reducing quality.

The eligible pool is large — adolescents show the gap clearly

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80%+ of people on ART are stable enough to be considered for simplified models (UNAIDS cascade, approx.).

45% of PEPFAR clients outside SA already on 6-month dispensing by mid-2023 (6.67M people) — proof it works at scale (Grimsrud 2025).

Yet enrolment still lags — including among adolescents specifically:

28% of eligible adolescents enrolled in DSD (638 of 2,247) (Lewis L et al., CROI 2025 poster 1059/Lancet 2026 preprint

65%→72% 24-month retention without viraemia, not-in-DSD vs in-DSD (causal estimate, IPTW model).

Stable adults are also far from all being covered in some countries — illustrative, not exhaustive:

124,623

clients enrolled nationally as of end March 2026 (NDoH) — rollout began August 2025, target 1.5 million by March 2027 of approx. 6.1 million PLHIV on ART (Manganye M, cited in Spotlight, 27 May 2026)

47–70%

3 SA districts' 6-monthly clinical visits with 3MMD uptake by Q1 2025 — large numbers still not in any DSD model (Kachingwe, AIDS 2026)

9%→20%

6MMD coverage among eligible clients in one supported Mozambique province, Oct 2024–June 2025 — nearly doubled, still a fifth of those eligible (C-Saúde 2025)

Monitor earlier, then less often

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1 TEST EARLIER

First VL at month 3, not month 6. Month 6 was set for slow-suppressing efavirenz; dolutegravir suppresses fast — 97% of adults are now on DTG-based regimens.

2 ALIGN & RECALL

DSD clients receive quality clinical review, VL measurement and rescript at the same visit — no extra visit just to hear a good result.
Recall for EAC and repeat VL if ≥1000 c/mL; repeat VL 50–999 at the next scheduled clinical review or VL.

3 SPACE IT OUT

Once durably suppressed move toward 2-yearly VL.

Modelled support: *Two-yearly VL potentially cost-effective in Zimbabwe; adaptive three-yearly VL with rapid recall >1000 performed best in Uganda. (Phillips et al. 2015, Nature · Ssempijja et al. 2020, Clin Infect Dis)*
Programme evidence: *Zambia EMR — 97.2% suppressed at the first VL after 24–48 months (AIDS2026 Abstract EP296).*

Result-triggered recall is what makes this safe at scale

SHIFT 3 · EVIDENCE

SA's 2023 guideline change already shows the pathway works

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Rees et al. — 4 SA districts (pre n=91,723 vs early n=39,084), 2023 guideline change

First VL within 3 months

13.5% → 51.8%

Median time to first VL

175 days → 105 days

Time to DSD enrolment

367 days → 186 days

Suppression unchanged: <200 c/mL 84.9% → 85.5%.

Kachingwe et al., AIDS 2026 (n=53,945, 3 SA districts): 3-month VL testing rose 10%→45% (Ehlanzeni), 14%→72% (King Cetshwayo), 14%→77% (West Rand); viral suppression maintained >90% across all districts. **First-year clinic visits fell 10–12 → 6–7.**

On retention: *Zambia SmartCare cohort — early DSD enrollers had 3% LTFU vs 5% for established enrollers at 18 months (aRR 0.59, 95% CI 0.50–0.68).*

Why month 6 is the wrong default now: the schedule was set for efavirenz, which suppresses slowly. Dolutegravir — now standard first-line — suppresses faster and has a higher genetic barrier to resistance.

The through-line across all three shifts

Match intensity to clinical risk.

Every shift removes clinical contact that policy or practice still requires but evidence no longer justifies — for people who no longer need it, not for everyone.

The evidence gap is smaller than the implementation gap.

WHO, PEPFAR-wide practice and national guidelines already permit most of this. What lags is enrolment and consistency — not proof that it's safe.

Savings come from fewer visits, not faster ones.

Annual review, single-VL eligibility, aligned recall — every mechanism here works by removing a visit nobody needed, not by compressing the visits that remain.

Simplification reduces unnecessary clinical intensity while protecting outcomes.

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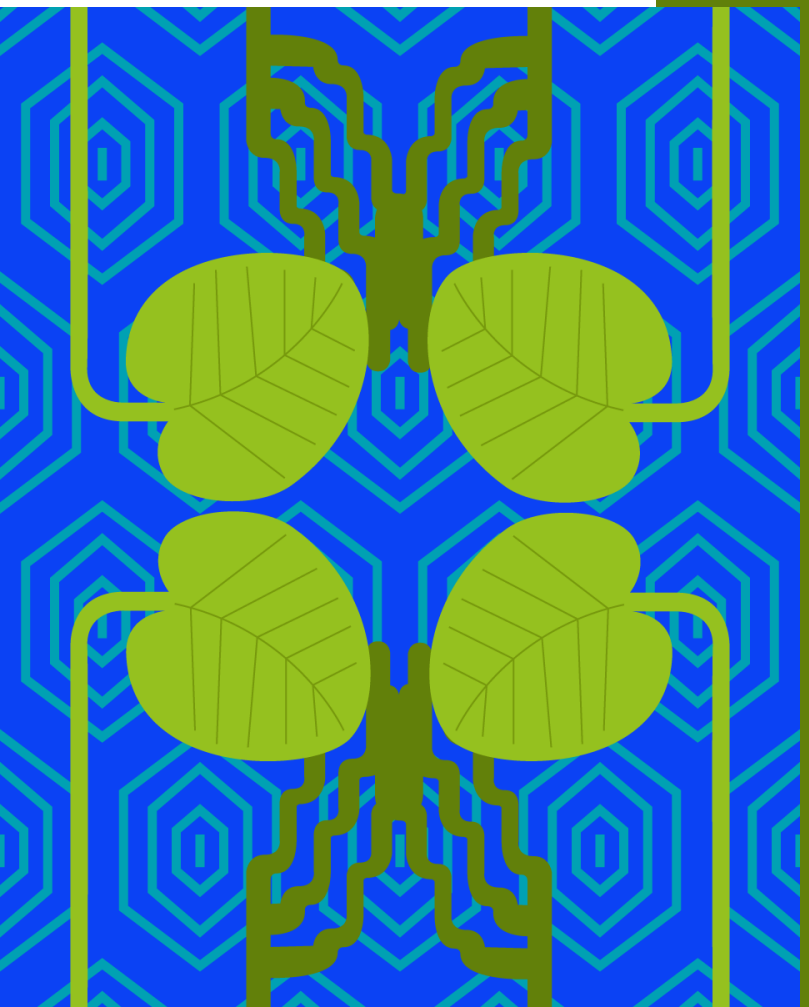

For stable clients, care should be simpler by default — and more purposeful when it happens

For the full evidence base: this reduced deck draws on a longer, fully-referenced master evidence deck covering additional studies, economics detail, and cross-cutting evidence for anyone wanting to go deeper.

IAS policy brief: Why annual clinical visits for stable people living with HIV are important" (July 2026)

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