Annual clinical visits: what do the evidence and guidance tell us?

Anna Grimsrud, IAS | Simplifying HIV service delivery: from evidence to national policy | Johannesburg, 26 October 2026

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In this session

Monday 26 October
13:45–14:10

1

Why annual clinical visits?

Matching clinical intensity to need

2

What does the evidence say?

Guidance, trials, routine data and costs

3

Making it work

Quality, integration and safeguards

Part 1 of 3

Why annual clinical visits?

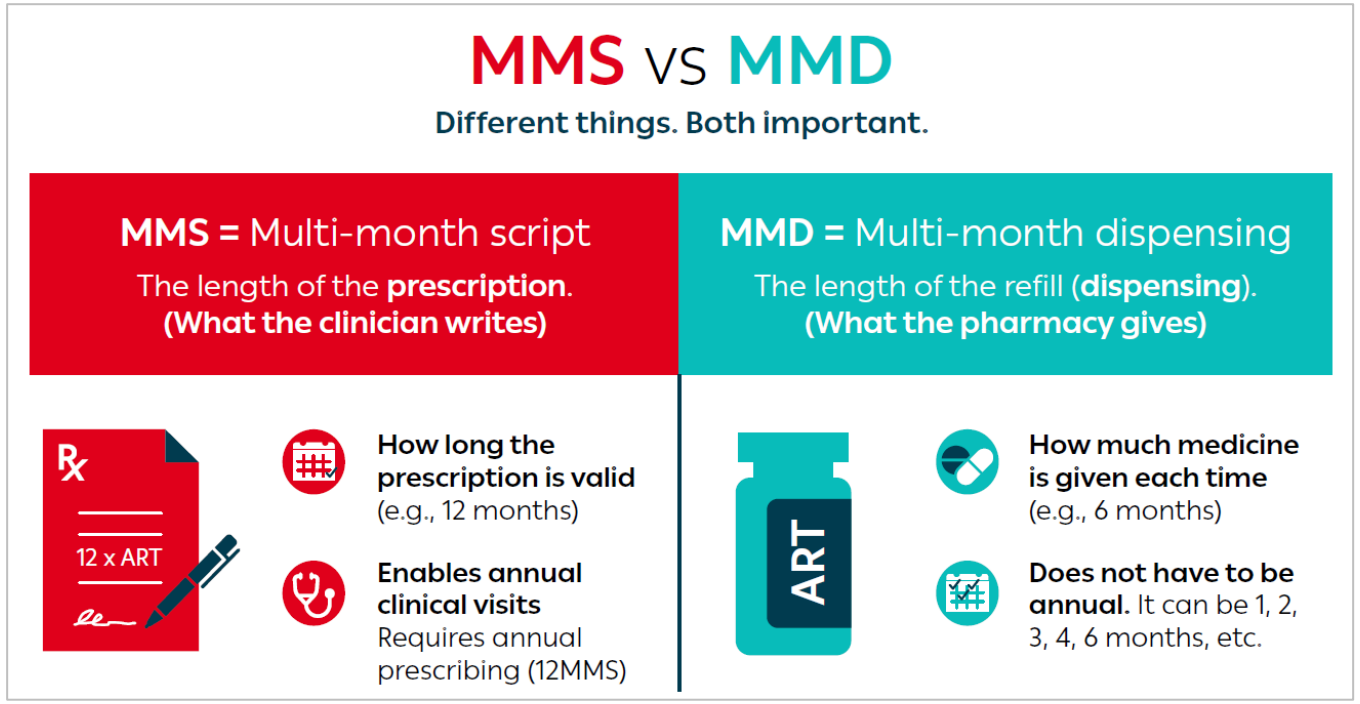
Matching clinical intensity to need

What we are proposing, and what we are not

We are proposing	We are not proposing
One structured clinical review a year for adults established on ART	Dispensing 12 months of ART at once (12MMD)
A 12-month prescription, with refills still every 3–6 months through DSD	Annual visits for everyone, regardless of need
An open door to return any time, and recall when a viral load is raised	Less care for people who need more: new on ART, unsuppressed, advanced HIV disease

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12MMS is not 12MMD:
the script and the refill are different things



The script (MMS)

Written once a year at the clinical review: sets how often a clinician needs to see someone

The refill (MMD)

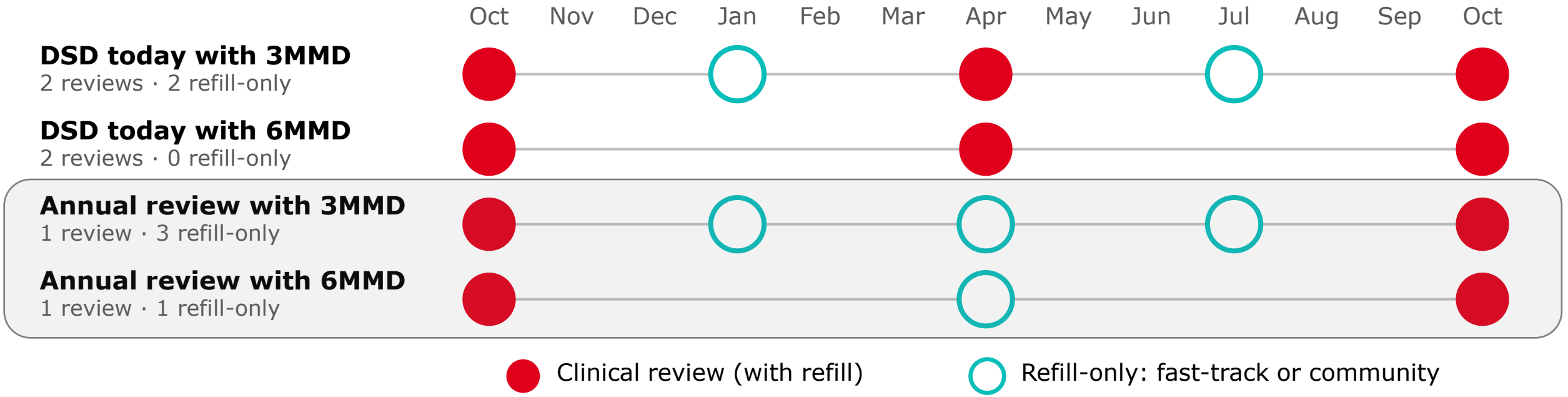
Unchanged: 3–6-monthly through fast-track, community or group models, as national policy sets

Annual visits need 12MMS, not 12MMD

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The next step: one clinical review a year

One year of care, plus the following visit, for a person established on ART (illustrative)



Clinical reviews halve; refills stay on whatever schedule national MMD policy sets

HIV care moved from monthly to 6-monthly visits. Is annual next?

"For all chronic prescriptions, an annual consultation is required."

Personal story – Adolescent chronic auto-immune condition

Then: monthly
Early ART programmes saw everyone every month

Now: every 6 months for people who are stable
WHO and most national guidelines

Next: Consider annual

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For someone doing well, what does a six-monthly visit add?

3–5 hrs

often spent at the clinic for a single visit

Plus transport costs and a day away from work, school or caregiving

Often no new result to act on
With annual viral load, one of the two reviews usually happens without a new result

The same script, rewritten
Same regimen, same refill model: the main output is a new prescription

Minutes of clinician time
Time that could go to people who are unwell, unsuppressed or new on treatment

A clinic visit spent mainly waiting for a new prescription is not good care, and it costs the next person in line their time with a clinician.

Part 2 of 3

What does the evidence say?

Guidance, trials, routine data and costs

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Guidance: WHO every 3-6 months (preference for 6), and several countries already go further

Policies supporting annual clinical visits

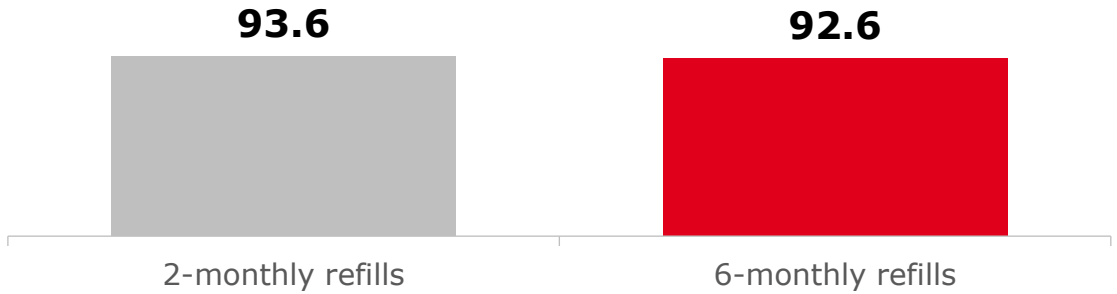
Zimbabwe	National guidance since 2015, with routine viral load
South Africa	City of Cape Town since 2011; 12-month scripts (and clinical visits) during COVID-19
Kenya	Annual clinical visits in new national guidelines
Ghana	Moving to annual visits
Also	Guinea, Lesotho, Namibia

Sources: WHO guideline on HIV service delivery, 2025 (visit and refill recommendations carried forward from 2021); IAS policy brief, Annual clinical visits, 2026

Randomized evidence: annual clinical review held up in both trials (retention)

Cassidy 2020 · Khayelitsha, South Africa

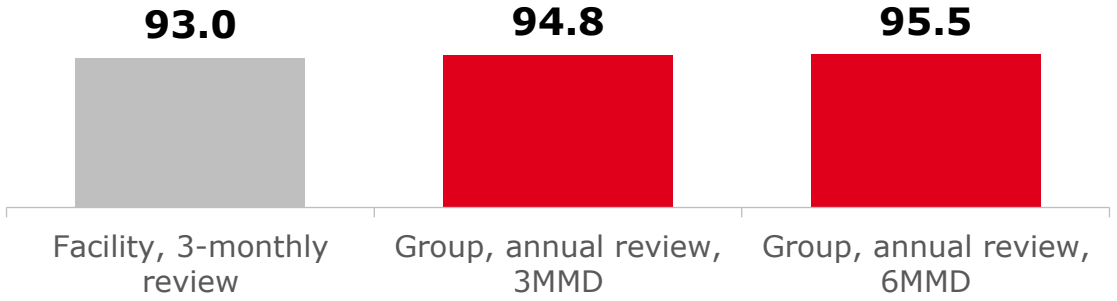
Adherence clubs, annual clinical review in both arms; refills 2- vs 6-monthly (n=2,150)



Retained at 24 months, %. Non-inferior; suppression 82.6% vs 87.3%

Fatti 2020 · Zimbabwe

Quarterly facility review vs community groups with one clinical visit a year (n=4,800)



Retained at 12 months, %. Non-inferior; viral load data limited

Systematic review: 6- or 12-monthly vs 3-monthly consultations, no difference in retention (RR 1.01, 95% CI 0.97–1.04; 10 studies, 33,599 adults, 8 countries; low certainty). Most data are 6-monthly; only one study compared 12- with 6-monthly.

Cassidy T et al. JIAS 2020;23:e25649 · Fatti G et al. JAIDS 2020;84:162–72 · Le Tourneau N et al. PLoS Med 2022;19:e1003959

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At scale: South Africa's 12-month scripts (and visits) during COVID-19

428,926

clients, 7 provinces, public sector

12- vs 6-month scripts: retention equivalent (91–92%); suppression 1.3% higher (adjusted) with 12-month

1 vs 2

clinic visits a year, KwaZulu-Natal

27,148 clients: retention 94.6% vs 91.8% (aRR 1.03); viral suppression 91.0% vs 89.7% (aRR 1.01)

–11%/yr

odds of unsuppressed viral load, private sector

73,884 clients: kept improving under 12-month scripts, then worsened 6% a year when 6-month scripts returned

All three are routine-data analyses: large and real-world, but not randomized

Mokgethi et al., INTEREST 2026 · Lewis L et al. JIAS 2023 · Patten G et al. JAIDS 2025

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Good for clients, and good for the health system

For clients

Fewer trips and less waiting
One review a year instead of two; client costs roughly halved

Care that fits around life
Less time off work, school or caregiving; easier for people who move

Treated as well, not as patients
Normalizes living with HIV; self-care; satisfaction maintained or improved

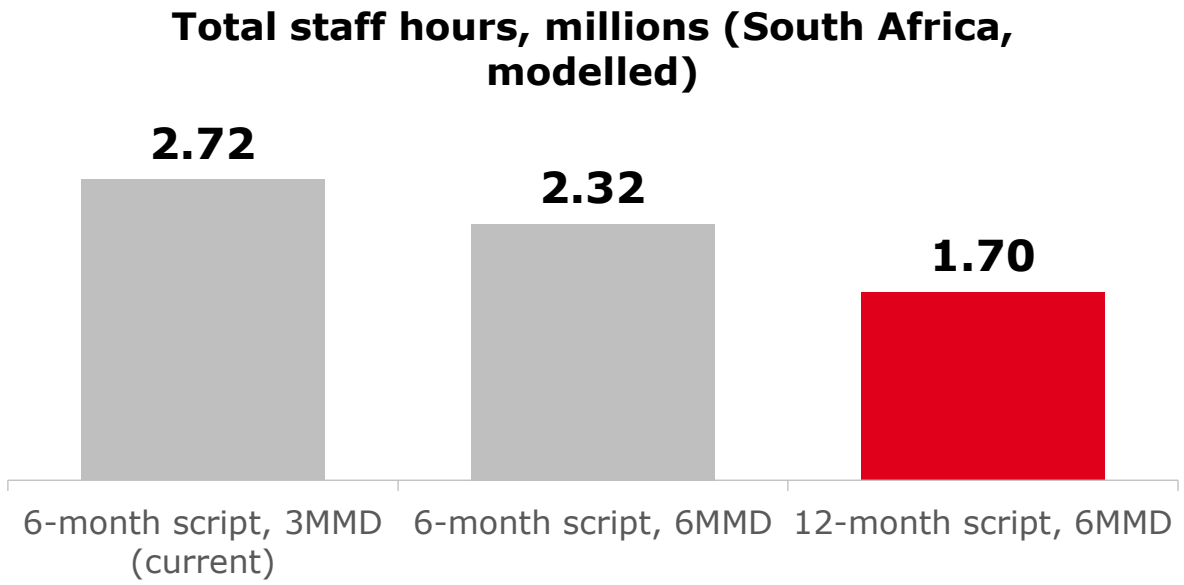
For the health system

Clinician time released
About 38% less staff time, for people who need more

Less congested clinics
Shorter queues and more time for each consultation

Fewer points of failure
Fewer expired scripts; more resilient in a crisis

The numbers: less staff time, lower client costs



−38% **staff time**
with 12-month scripts and 6MMD vs current; capacity released, not cash saved

−56% **client costs, Zimbabwe**
US$10.03 to US$4.40 a year: quarterly facility care vs annual review with 6-monthly group refills

~1/2 **client costs, 5 countries**
community DSD models roughly halve client costs; 6MMD models slightly cheaper for providers

Huber A et al., AIDS 2026 (oral) · Benade M et al. PLOS Glob Public Health 2023 · Rosen S et al. Gates Open Res 2021;5:177

Part 3 of 3

Making it work

Quality, integration and safeguards

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Fewer visits, better visits: what an annual clinical visit includes

1. **Structured clinical review**
   History, examination, psychosocial check, management of co-morbidities and screening for other conditions
2. **Viral load, with recall**
   A result that needs action brings the client back; it does not wait for next year
3. **A 12-month prescription**
   For ART and, where possible, other chronic medicines
4. **Next annual review booked**
   With an open door to return sooner if needed
5. **Refills between reviews**
   Through fast-track, community or group DSD models

New IAS policy brief

Why annual clinical visits for stable people living with HIV are important

differentiatedservicedelivery.org

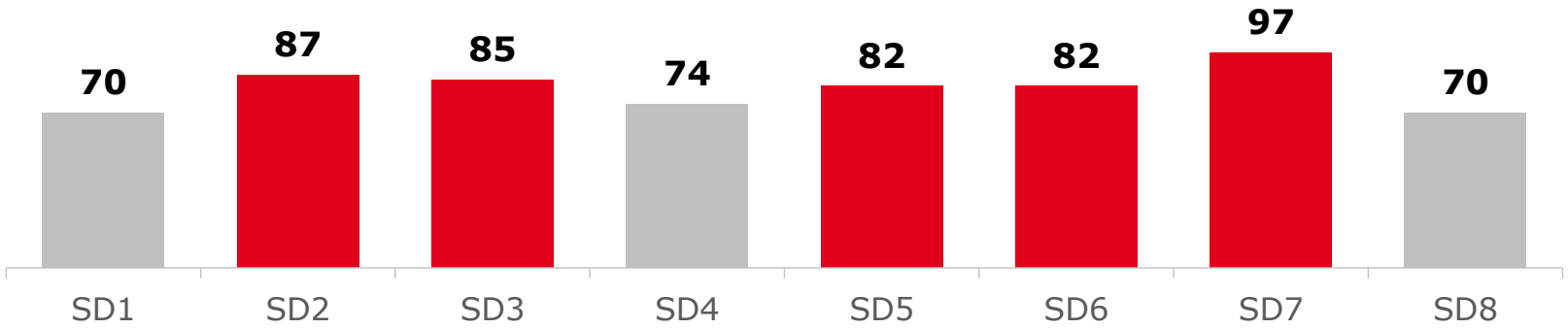
Annual reviews, with a quality improvement cycle, can result in high-quality visits

82,000

on ART, about half in annual-review clubs

Annual review standard since 2011

Quality of clinical visit audit score by sub-district, 2022, %



61% → 78%

annual visit recorded in folder, 2018 to 2022

75% → 85%

viral load result in folder, 2018 to 2022

> 80%

weight, family planning, TB and STI screening, 2022

49% · 58%

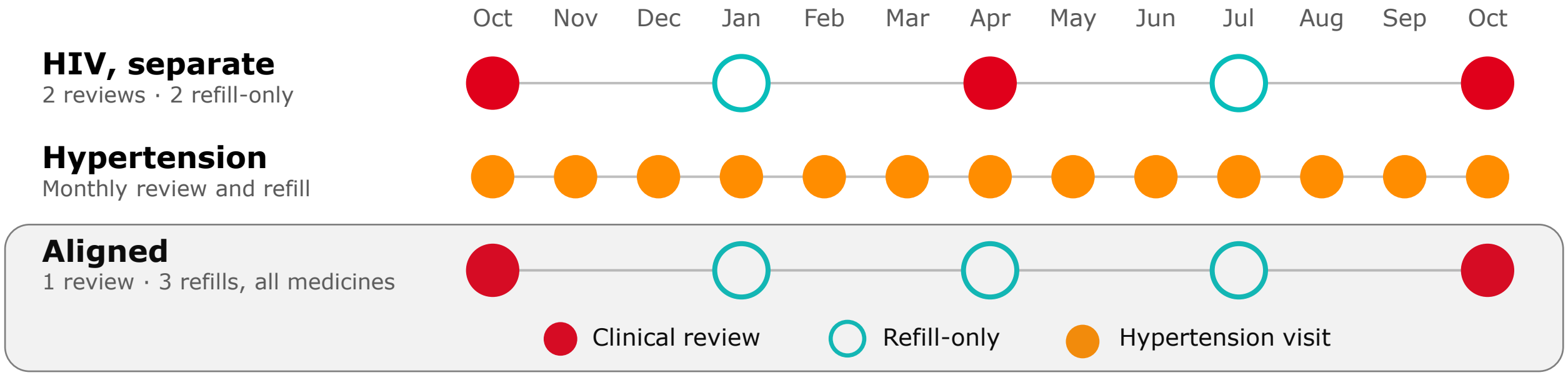
the gaps: BMI and Pap smear, 2022

Harley B et al. DSD for HIV treatment in the City of Cape Town: providing quality care alongside annual clinical visits. CQUIN 6th Annual Meeting, Durban, December 2022

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Annual review as the anchor for integrated chronic care

One year of care, plus the following visit, for a person with HIV and hypertension (illustrative)

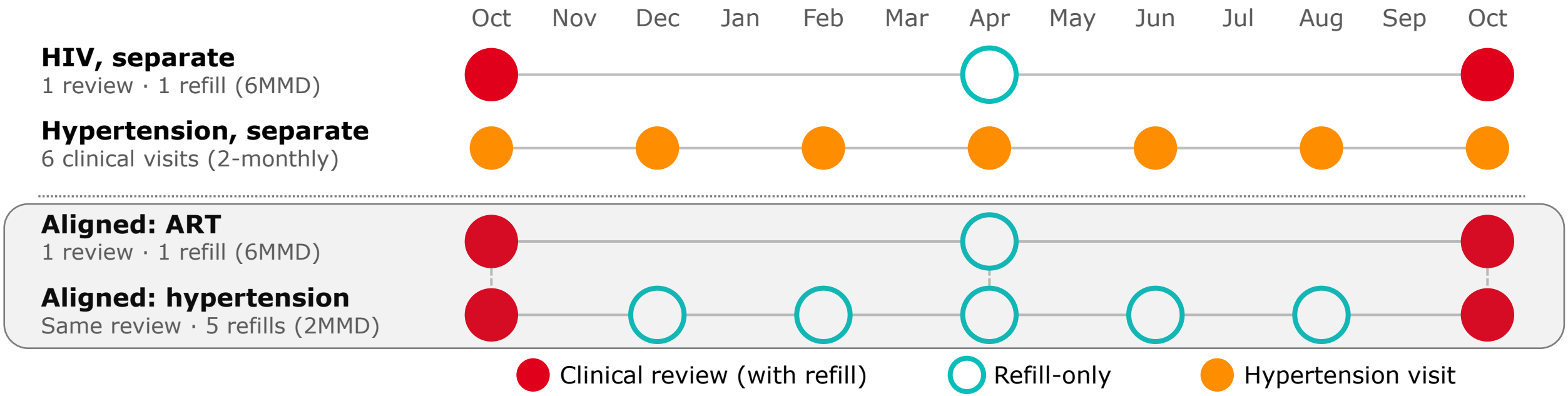


16 contacts become 4: one review, one script and one refill schedule for all chronic medicines

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Even when there’s limited stock – an aligned annual script is helpful

One year of care, plus the following visit, when hypertension stock allows only 2MMD (illustrative)



Clinical visits fall from 7 to 1: refills follow each medicine's MMD schedule

What it takes:
Enablers and safeguards

Clear eligibility	Established on ART: at least 6 months on ART, suppressed, no current clinical concerns; clear criteria to step back up
Recall that works	An elevated viral load or other red-flag result brings the client back, without waiting for the annual visit
An open door	Clients know they can return any time they are unwell, and are seen when they do – investment in strong treatment literacy (when and how to come back)
12-month scripts allowed	Pharmacy rules/regulations, stock and refill models able to dispense against a 12-month prescription
Quality and monitoring	A structured review checklist, routine audit, and tracking of retention, refills and suppression

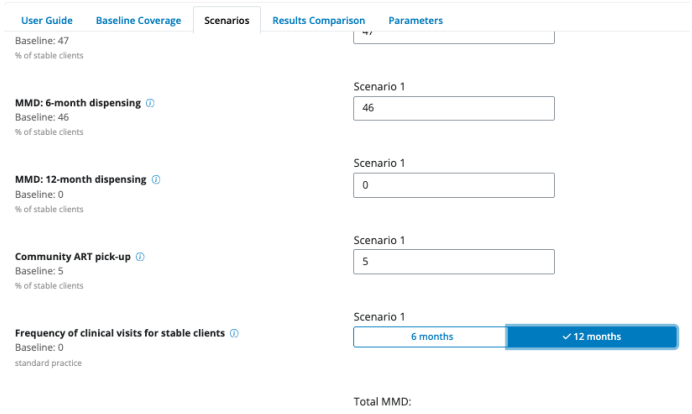
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TIER-Plus shows what 12-month scripts mean for your country

Model the change in programme costs and staff time against how you dispense today

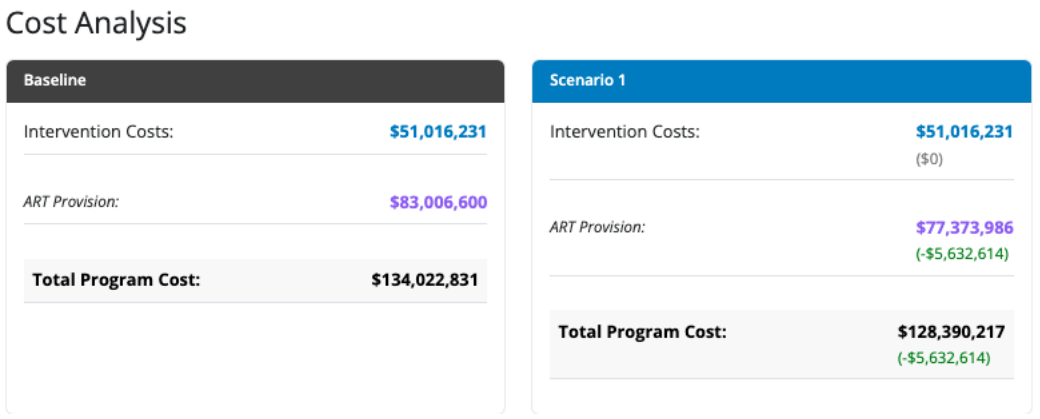
1 Set the scenario

12-month scripts and annual visits



2 Compare with today

Example run: baseline vs scenario



In this example (Malawi)

−$5.6M

total programme cost: $134.0M becomes $128.4M

All of the saving is in ART provision ($83.0M to $77.4M)

Try it: http://204.168.166.9:3838/tier-plus/

Day 3 afternoon optional session 1

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For your country table this afternoon

1

Where are we now?

How often are clients seen? Is the script separate from the refill?

2

What do we propose?

Annual review for whom, and what it includes

3

Which safeguards?

Eligibility, recall, an open door, quality checks

4

Where must it change?

Guidelines, SOPs, pharmacy rules, tools and registers

5

What about other conditions?

Aligning HIV, hypertension, diabetes and contraception

TIER-Plus can model what 12-month scripts would mean for costs and staff time in your country: Day 3 afternoon option

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In summary

Safe

Retention and suppression the same or better

Two randomized trials, a systematic review, and routine data on hundreds of thousands of clients

Efficient

Half the clinical visits

About 38% less staff time; client costs roughly halved

Integrating

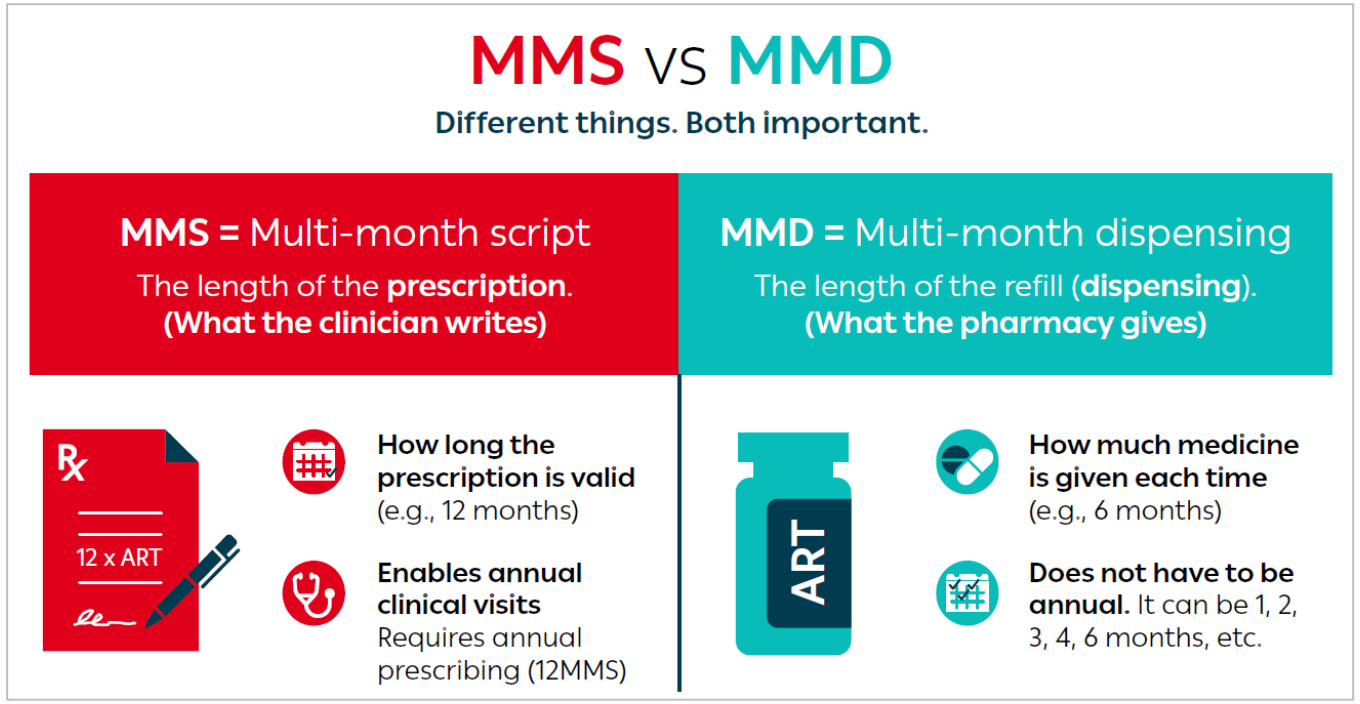
An anchor for chronic care

One review and one script for HIV and other chronic conditions

The ask: annual clinical visits with 12-month scripts for adults established on ART, written into national policy

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