Why simplify HIV service delivery now?

Why now

Cuts are already happening – the choice is which contacts to keep

IAS

The bigger risk is worse care, not less care

1. **Rigid care pushes people out**

   Malawi: travel (32%) and life events such as funerals (18%) are the most common reasons for interrupting.

2. **Interruption creates more need**

   People who disengage often return with advanced HIV disease – needing more clinical contact, not less.

3. **Losing simplified models adds to this**

   Zambia lists fewer DSD and multi-month models among the causes of rising loss to follow-up.

Sources: Lemani et al., AIDS 2026, presented at the Global DSD Research Collaborative, 28 Sept 2026 (n=252); Sivile, Ministry of Health Zambia, AIDS 2026.

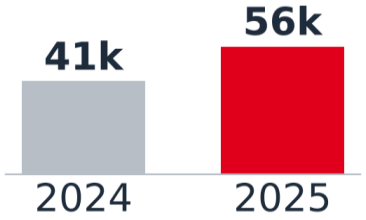
IAS

Cuts are already happening – and we are starting to see their impact

+36%

Zambia

Lost to follow-up, Feb–Jun 2025 vs 2024.

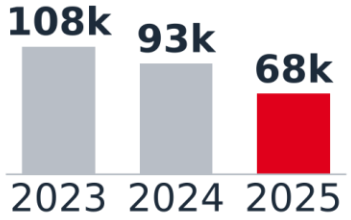


Sivile, MoH Zambia, AIDS 2026

−27%

Gauteng, South Africa

People starting ART, 2025 vs 2024.



Chauke et al., African Diagnostics Forum 2026

−38%

Mozambique

Fewer adult viral load tests, Feb–May 2025 vs 2024.

Moiana Uetela et al., IAS 2025

IAS

The harm will show later – as more advanced HIV disease

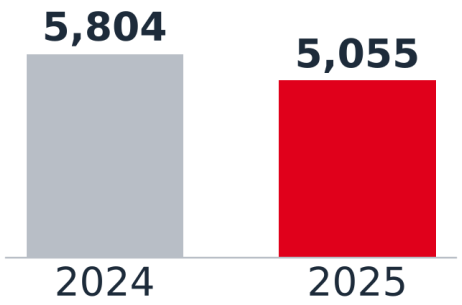
What we cannot see yet

Fewer people starting ART and more people interrupting will mean more advanced HIV disease.

People who disengage return with more advanced HIV – and need more care, not less.

CD4 testing was already limited. As it falls further, advanced HIV disease is increasingly missed.

Zambia: new ART starts recorded with AHD



−13%

Fewer CD4 tests – not less disease.

Source: Sivile, MoH Zambia, AIDS 2026 (DHIS2; monthly totals 5,804 in 2024 vs 5,055 in 2025). In Zambia, one in four AHD cases follow a treatment interruption (same source).

IAS

Planned or by default: the choice is which contacts to keep

By default

Unplanned erosion of services.

Tests, recall for elevated VLs and visits fall wherever shortages hit – including the contacts that matter most.

Planned

Simplification that keeps essential safeguards.

Remove contact that no longer improves outcomes – and protect rapid access to care when risk increases.

IAS

DSD has moved a long way – but three parts of care have not



1

Review for people established on ART

Six-monthly review is still the limit – even after years on ART.

2

The first year on ART

First viral load at month 6, so DSD starts at month 9–12, after many visits.

3

Return after an interruption

People coming back are commonly all managed the same – more intensively.

IAS

From why to what: three shifts

1

Annual clinical review

For people established on ART

In depth: this afternoon

2

Earlier first viral load

And monitoring aligned to the clinical review

In depth: tomorrow morning

3

Differentiated re-engagement

By clinical status and time out of care

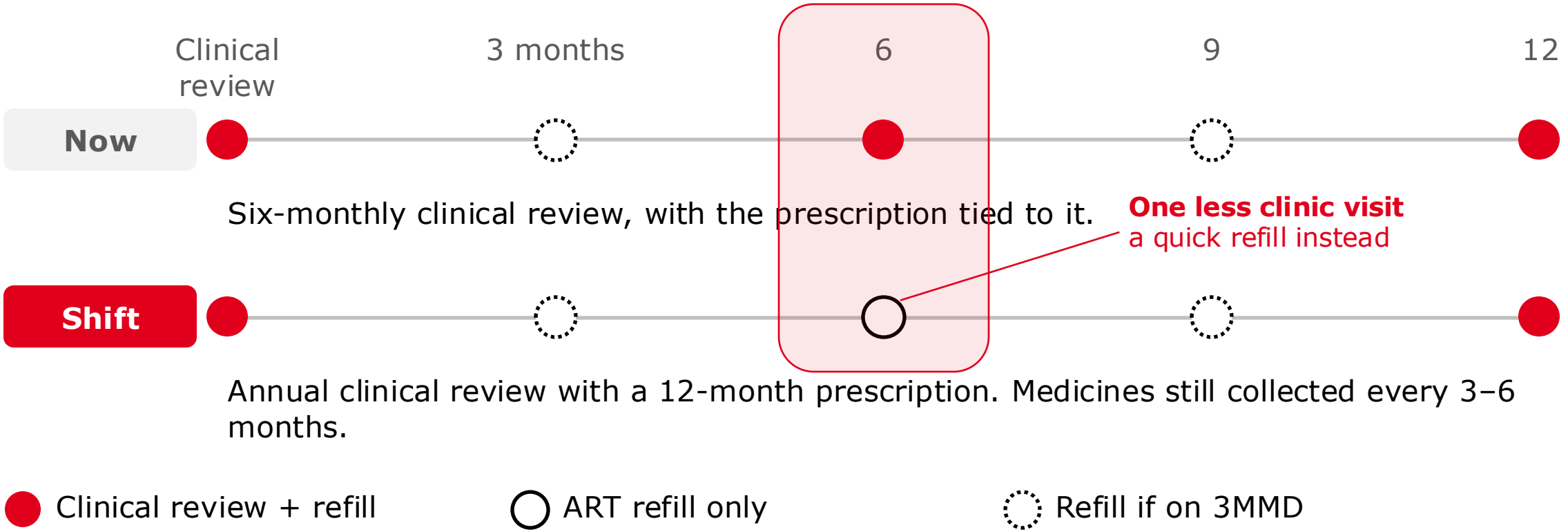
In depth: tomorrow afternoon

Shift 1: Annual clinical review

For people established on ART, with a 12-month prescription

IAS

Make annual clinical review routine for people established on ART



IAS

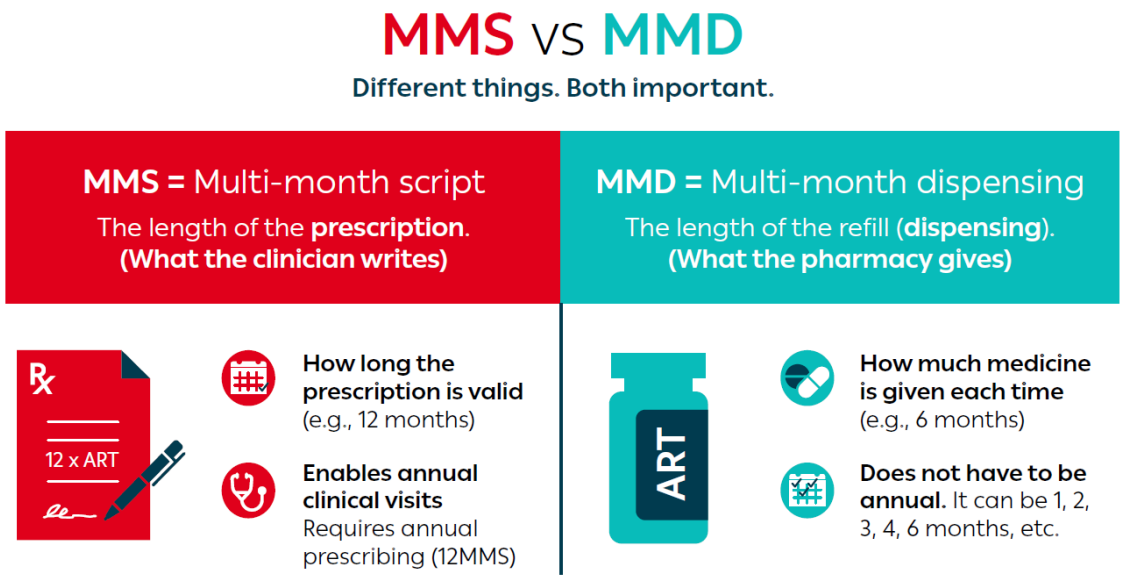
Separating clinical review from refill collection removes clinical visits that do not change outcomes

Why

Annual clinical review is non-inferior to six-monthly review – and saves time and cost for clients and the health system.

A 12-month prescription, not 12-month dispensing.

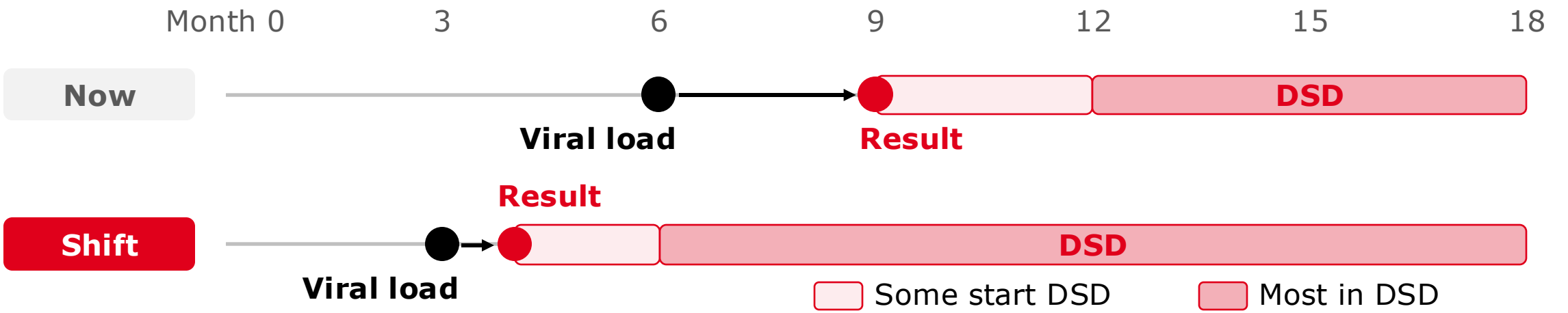
One well-planned clinical review a year may be easier to deliver well.



Shift 2: Earlier first viral load and aligned monitoring

Test earlier, align monitoring with the clinical review, and recall the few who need action

Test earlier: a month-6 first viral load delays DSD entry to month 9–12



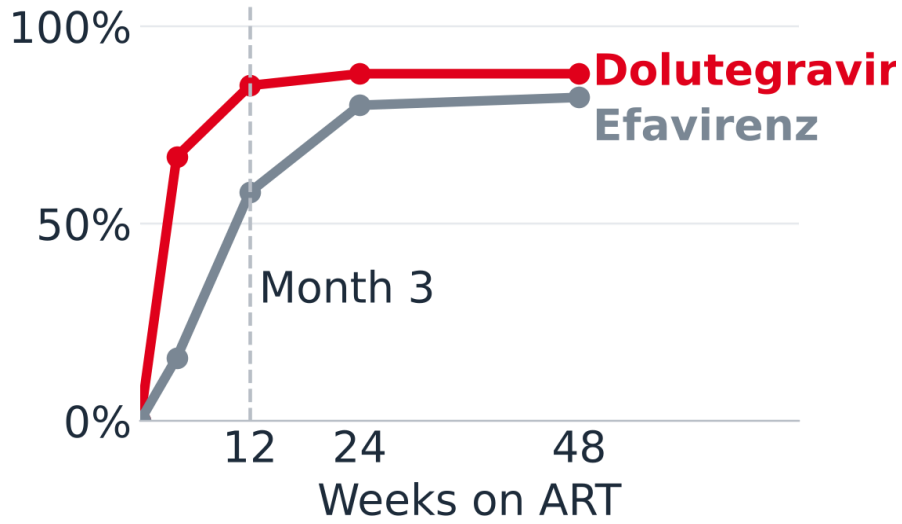
Earlier DSD means easier care sooner – fewer clinic visits in the first year.
In South Africa, the minimum clinic visits in year one fell from 8 to 5.

Source: Rees et al., South Afr J HIV Med, in press.

IAS

Dolutegravir suppresses faster – and 2021 WHO guidelines allow it

Viral suppression after starting ART



Why

By week 12 on dolutegravir, as many are suppressed as by week 24 on efavirenz.

WHO asks for the result by month 6 – not the test at month 6.

WHO 2021 had to fit efavirenz too. Today 97% of adults on ART are on dolutegravir.

Sources: Kanters et al., EClinicalMedicine 2020;28:100573, Fig. 3 (modelled; ≈ read from figure); Walmsley et al. (SINGLE), N Engl J Med 2013;369:1807–18; WHO consolidated guidelines 2021, Fig. 4.2 (p.148) and p.151; CHAI HIV Market Report 2025, p.37 (generic-accessible LMICs, 2024).

Aligned monitoring and recall: most people in DSD come back just to hear a good result

Viral load drawn at the clinical review

Now

A return visit to hear the result – most in DSD are suppressed.

DSD continuation delayed.

Unnecessary visits.

Shift

In DSD: >90% suppressed
Stay in DSD – result shared at the next contact, or sooner by the laboratory direct to the person. No extra visit.

Few need action
Earlier recall – only elevated VLs trigger an extra visit.

Once in DSD, stay in DSD – no need to requalify after each viral load unless a result is flagged.

Suppressed <1,000 in DSD: Mozambique 6MMD 98% (Chacha et al., AIDS 2024, OAE3903); Zambia 6MMD 90.6% (Lekodeba et al., JIAS 2025;28:e70003, Table 3); Malawi community ART 97% (n=285; Songo et al., PLOS GPH 2023). KwaZulu-Natal community ART: 2.3% ≥1,000 (373/16,568; Dorward et al., PLOS Glob Public Health 2026;6:e0005890).

Few results need action – but recall must reach them, and the people who need it most

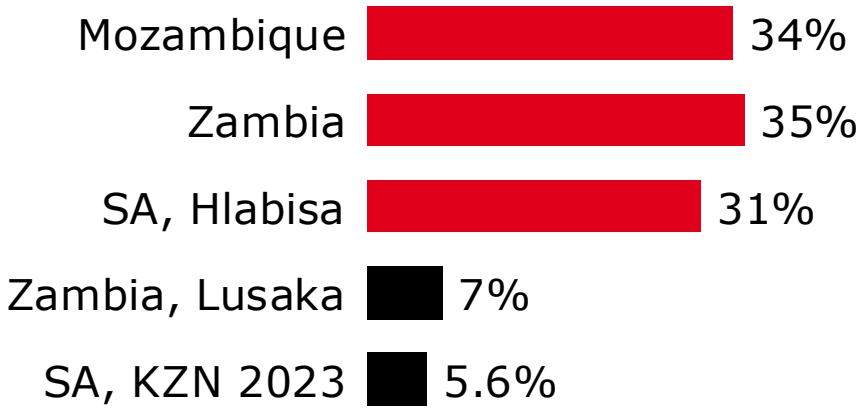
Why

Most people in DSD models stay suppressed.

Recall matters most for people newly started, unwell, re-engaging or struggling with adherence – and **is a safety net** if adherence changes.

Follow-up after an elevated VL often does not happen.

Repeat VL after an elevated VL



Time windows differ; the two most recent studies are lowest.

Sources: Kippen et al., BMC Public Health 2024 (Swannet, 6 MSF-supported sites in Maputo 2014–15, threshold >3,000; Warrier, Zambia 2016–18, within 90 days; Iwuji, SA 2010–16); Sikombe et al., PLoS Med 2025;22:e1004720 (24 Lusaka clinics, 2019–21; by 3 months); Dorward et al., PLOS Glob Public Health 2026;6:e0005890 (21/373 within 16 weeks).

Shift 3: Differentiated re-engagement

Most people who interrupt come back – care should match their needs

Differentiate care when people return after an interruption

Now

One pathway for everyone returning.

Commonly intensive monthly follow-up.

Often managed as if starting ART again.

Shift

Differentiate by clinical status and time out of care.

Different needs: easier care, psychosocial support and/or clinical support.

IAS

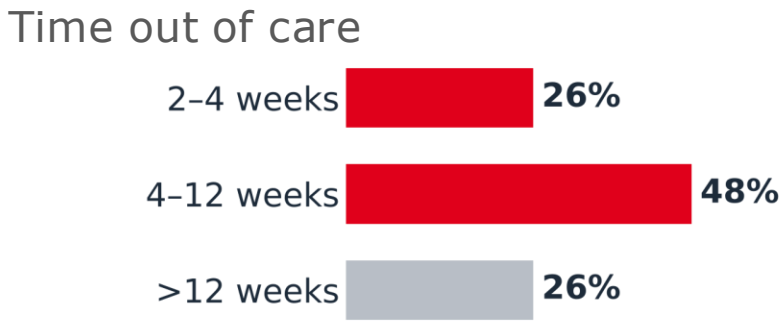
Most people who interrupt come back – and quickly

Malawi · national data

82%

of interruptions ended within 6 months, among 1.1 million people on ART (2020–2023).

Johannesburg · people re-engaging



Three quarters back within 12 weeks.

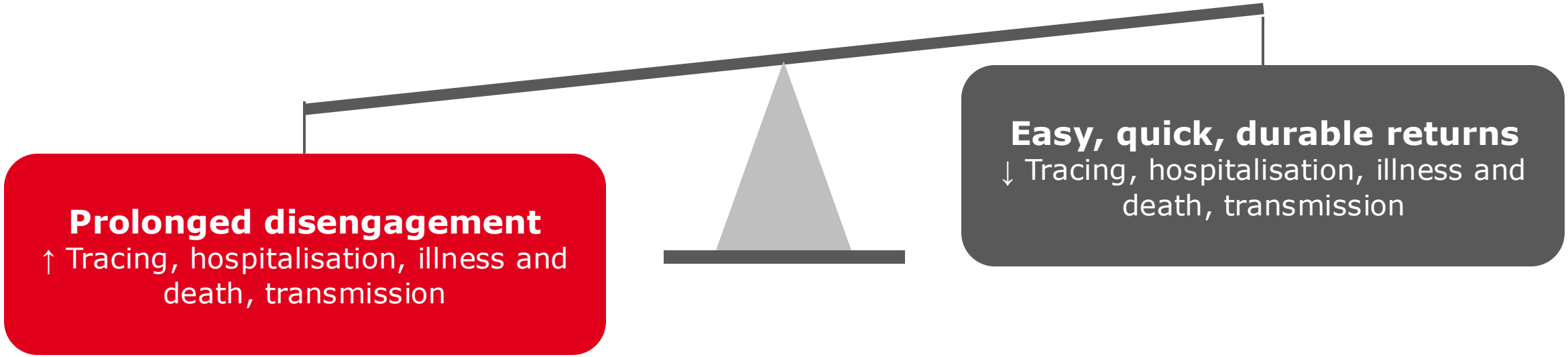
Sources: Norwood et al., AIDS 2024, abstract 1265 (Malawi); Mutyambizi et al., JIAS 2024 (Johannesburg, n=623 re-engaging).

IAS

Experience at return tips the balance

Barriers: punitive actions on day of return (shouted at, long wait), multiple visits to restart, increased visit intensity after return

Facilitators: welcomed back, same-day ART, MMD, flexible appointments, clinical/psychosocial support when needed



IAS

Three principles for re-engagement

1

For returning patients, the first return visit experience is critical

Welcoming, supportive and empathetic

Clear visit flow focused on a positive experience



2

Not all patients late for appointments are re-engaging patients

Set the interruption length for continuing routine or DSD care



3

Re-engaging patients do not all have the same service delivery needs

Easier access to treatment

Psychosocial support

Clinical management



IAS

A differentiated return pathway

1 Assess on return: 1) clinical status 2) time out of care

2 Differentiated by need	**MMD / DSD**	**Counselling / support**	**CD4 / AHD screening**	**Clinical care**
- Well, short interruption	✓			
- Psychosocial or adherence needs	✓	✓		
- Well, longer interruption	✓	**If needed**	✓	
- Unwell	**Once stable**	**If needed**	✓	✓

3 Everyone: same-day restart · VL after 3 months · back into DSD quickly

IAS

Return is part of the pathway – many interrupt, and most come back well

Why

Quick, respectful re-entry helps people stay in care.

Many return after a missed visit – easier, more flexible care helps prevent the next interruption.

Intensive care is kept for those who return unwell.

IAS

Five principles to test together

1

Quality is maintained.

2

Clinical review is separate from refill-only contacts – 12-month scripting, not 12-month dispensing.

3

Intensity is matched to need.

4

Safety nets are in place – including recall + clinical care.

5

No one loses access to DSD while a VL result is reviewed.

Up next: Helen Bygrave