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https://escholarship.org/uc/item/46d450tj

Journal

The Lancet Global Health, 14(7)

ISSN

2572-116X

Author

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Publication Date

2026-06-01

DOI

10.1016/j.langlo.2026.103970

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Enabled self-care for HIV infection: an inflection point for sustainable epidemic control

Lancet Glob Health 2026; 14: 103970

Published Online June 29, 2026 https://doi.org/10.1016/j.langlo.2026.103970

See Articles https://doi.org/10.1016/S2214-109X(26)00088-4

As global HIV programmes confront a period of fiscal constraint, the modelling analysis by Andrew Phillips and colleagues[1] offers a timely and policy-relevant proposition: that a transition to enabled self-care could sustain, and potentially accelerate, progress towards HIV epidemic control in sub-Saharan Africa. At stake is not only the trajectory of HIV incidence and mortality but also the future architecture of HIV service delivery.

Over the past two decades, remarkable improvements in the treatment outcomes of HIV infection have been achieved through investments in clinic-based testing, antiretroviral therapy, and prevention services.[2] Yet, these improvements remain fragile. Declining donor funding, competing health priorities, and workforce constraints threaten to stall progress across Africa, where an estimated 500 000 incident HIV infections still occur annually.[2] The concept of enabled self-care anchored in widespread access to HIV self-testing and decentralised provision of pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and antiretroviral therapy through pharmacies and providers of community-based services represents a pragmatic response to an evolving financing landscape.

Across a wide range of epidemiological scenarios, the authors predict that enabled self-care could reduce HIV incidence by 27% and HIV-related mortality by 18% over a decade while remaining cost-effective, and in many cases cost-saving, under constrained budgets. These projected improvements are driven by increased uptake of HIV testing, improved reach of interventions among populations previously underserved by clinic-based systems, and modest improvements in the prevention and treatment coverage of HIV infection. Importantly, the model suggests that such an approach could enhance equity, extending access to individuals facing structural barriers to care.

These results align with a growing policy consensus around differentiated service delivery and self-care interventions. WHO guidance increasingly emphasises the role of community-based platforms, pharmacies, and lay providers in expanding access to essential health services.[3] The COVID-19 pandemic highlighted the feasibility, and necessity, of decentralising health care and empowering individuals to manage aspects of their own health. Enabled self-care is not a departure from established policy directions but rather their logical next step.

For policy makers, the implications are substantial. First, the study underscores the value of investing in simplified, scalable delivery models that reduce reliance on overstretched health systems. The low annual per-capita cost of the intervention (~US$12 per adult) highlights its potential affordability, even in resource-limited settings. Second, the findings suggest that prioritising access through the removal of prescription barriers, decentralisation of health services, and strengthening of supply chains can yield substantial population-level benefits.

Translating this vision into practice will require careful attention to implementation. Regulatory frameworks in many countries currently restrict over-the-counter access to HIV testing and antiretrovirals for PrEP, PEP, or treatment.[4] Revising these policies will be essential to enable the delivery of pharmacy-based and community-led services. Meanwhile, investments in training, quality assurance, and community education will be key to ensure safe and effective use of HIV self-testing, PrEP, PEP, and treatment. A 2025 review, however, indicates that HIV, sexually transmitted infection, and contraceptive interventions can be task-shifted to lower cadres in health facilities, community, or pharmacies.[5]

Enabled self-care should be viewed as a complement to, rather than a replacement for, existing health services. Hybrid models that integrate self-care with facility-based care, particularly for individuals requiring clinical monitoring, management of advanced disease, or tailored prevention interventions, are likely to offer the greatest benefit. Maintaining core system functions, including viral load monitoring and linkage to care, will remain essential to long-term epidemic control.

Real-world implementation should ensure that all populations, including key populations, are not left behind. For pregnant and breastfeeding women, integration of self-care approaches into antenatal and postnatal care could further improve the prevention of maternal HIV acquisition and vertical transmission. The modest projected reductions in perinatal transmission highlight both the promise of expanded access and the need for targeted strategies in this population.

Empirical evidence on the large-scale implementation of self-care models remains scarce, particularly regarding sustained uptake, adherence, and linkage to care following self-testing. As countries consider policy shifts, implementation trials will be crucial to validate model assumptions and identify context-specific adaptations. Emerging innovations, including long-acting PrEP, might enhance the effects of decentralised service delivery models and should be incorporated into future analyses.

Enabled self-care offers a pathway to reimagine HIV programmes as more resilient, accessible, and person-centred systems, capable of sustaining progress even as external funding declines. The challenge now is that of translation, ie, moving from modelling to policy and from policy to practice. With thoughtful implementation, strong community engagement, and continued investment in health systems, enabled self-care could mark a pivotal shift in the global HIV response, one that aligns efficiency with equity and innovation with sustainability.

DJD reports research funding from ViiV Healthcare and Merck.

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