WHO Operational Guide:
Prioritizing the HIV package of care aligned to the national context

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World Health Organization

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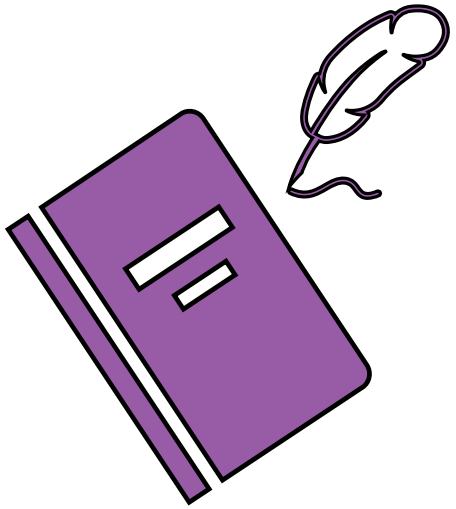
Upcoming publications on priority setting

Final stages – *"Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: Operational guidance" – First Edition* – June 2025

This is a ***'living document'*** and future editions are planned in 2025 to respond to feedback from countries, communities and partners

Under development – *Interim guidance on priority-setting processes to respond to shocks across disease areas* – HFE Q3 2025



Sustaining HIV, viral hepatitis and STI priority services in a changed funding landscape: An operational guidance

The Problem	The ASK	Target audience
Funding gaps for human resources and commodities for service delivery	WHO guidance to support countries to identify, prioritize, and sustain essential HIV, viral hepatitis, and STI services in a changed funding landscape	Ministries of Health, communities and civil society, donors, development and implementing partners

Operational Guidance provides two elements:

1. Prioritization Process Guidance

- Guidance to support countries in prioritizing HIV, viral hepatitis, and STI services to sustain under reduced funding.

2. Baseline Service Prioritization Exercise

- A structured 'starting point' list of prioritized services and interventions for countries to adapt based on global review.
- An example of an approach to rapid priority setting that can inform countries to set up their own procedures, until further guidance is issued.

The Problem

The impact of suspensions and reductions in health official development assistance on health systems (7March–2 April 2025)

Service Delivery Disruptions

- Disruptions and scaling back of essential health services, with over 70% of country offices reporting service-level disruptions, particularly in HIV, TB, maternal and child health, vaccination campaigns, and neglected tropical disease services.

Health and Care Workforce Losses

- Reductions in the health and care workforce, with 63% of countries noting job losses, furloughs, or salary suspensions, particularly among community health workers and frontline clinical staff.

Health Financing Pressures

- Increased out-of-pocket costs for ients, delays in public budget disbursements, and halted reimbursements, highlighting critical health financing gaps.

Supply Chain and Commodity Shortages

- Commodity and supply shortages, including diagnostics and essential medicines, with severe stockouts reported for vaccines, HIV/STI medications, and critical care products in up to one-third of countries.

Disruptions to Health Information Systems

- Disruptions to health information systems, including disease surveillance and health workforce monitoring platforms.

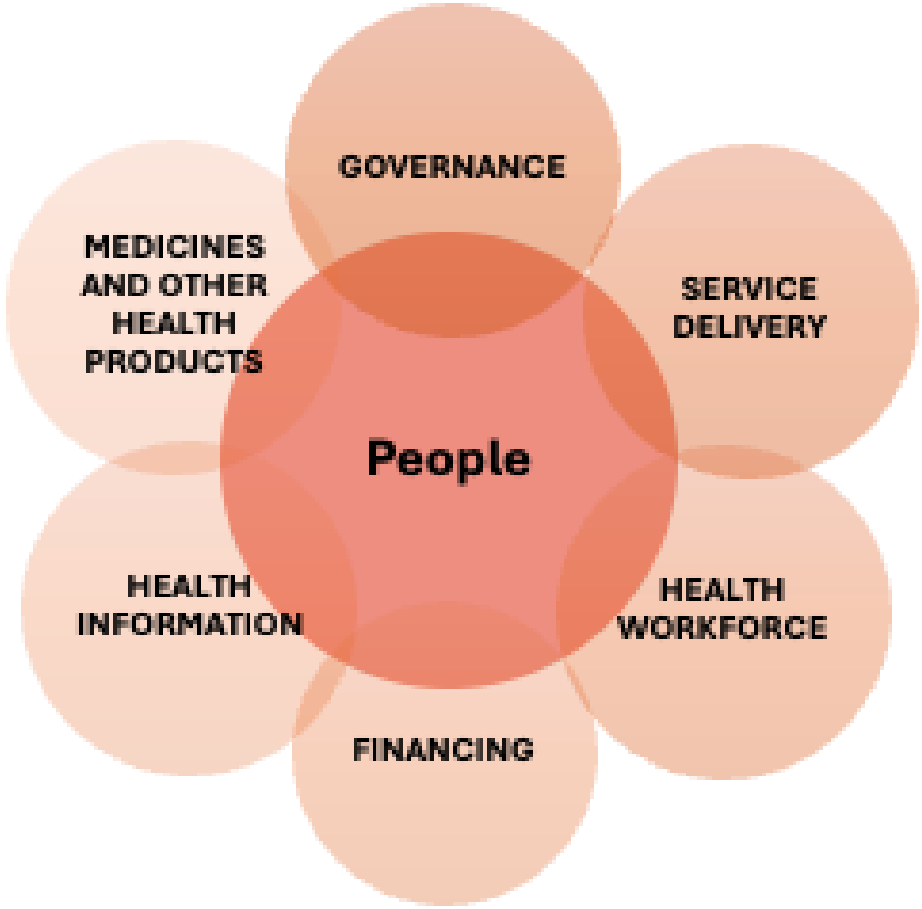
Governance, Planning, and Coordination Gaps

- Governance and coordination gaps, with over 60% of countries pausing key planning, review, and collaboration mechanisms

3 Foundational Pillars

1. WHO Health System Framework Building Blocks

The guidance adopts a systems approach, recognizing that service delivery decisions occur within and affect broader health system functions.



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2. Primary Health Care (PHC) strategic and operational levers

STRATEGIC LEVERS

1. Political commitment and leadership
2. Governance and policy frameworks
3. Funding and allocation of resources
4. Engagement of communities and other stakeholders

OPERATIONAL LEVERS

5. Models of care
6. Health and care workforce
7. Physical infrastructure
8. Medicines and other health products
9. Engagement with private sector providers
10. Purchasing and payment systems
11. Digital technologies for health
12. Systems for improving the quality of care
13. Primary health care-oriented research
14. Monitoring and evaluation

The ASK: WHO Prioritization Process Guidance

3 Foundational Pillars

3. Priority-setting steps PRIORITE framework

- Identify the guiding committee and secretariat.
- Provide technical support as needed.
- Establish the overarching policy framework.
- Ensure high-level policy support, alignment with core health policy goals.
- Consider existing institutionalization of priority setting.
- Conduct a situation analysis of core capacities.

- Define the scope of services/interventions to be assessed.
- Establish criteria and methods for assessment.
- Identify technical expert communities for assessment and appraisal.

- Collect and analyze evidence on services/interventions.
- Use agreed-upon criteria (e.g., burden of disease, cost-effectiveness, budget impact, equity).
- Assess how well each service/assessment meets these criteria.

- Facilitate transparent and inclusive appraisal of options.
- Arrive at a prioritized list of services for decision makers/payers.

- Develop evidence-based prioritization recommendations.
- Ensure recommendations are legitimate, aligned with values, and policy relevant.
- Authorities make decisions and communicate them, including to health workers and populations.
- Allow for appeal of decisions.

- Operationalize decisions via revised guidance, essential medicines/products lists, implementation plans.
- Integrate decisions into financing instruments, public financial management, and procurement.

- Clearly communicate guidance, plans, and access conditions.
- Establish mechanisms for accountability.

- Monitor delivery and spending against plans.
- Generate insights for revision.
- Ensure long-term financial and programmatic sustainability and improvement.

The ASK: WHO Prioritization Process Guidance

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P Prepare the groundwork

R Refine the scope
I Implement the assessment
O Organize the appraisal
R Recommend actions

I Implement decisions

T Translate and uphold entitlements

E Evaluate and sustain progress

Ethical Principles

Substantive principles:
- Efficiency,
- Equity,
- Social and economic impact,
- Feasibility

Procedural Principles:
- Transparency,
- Participation and inclusion,
- Evidence and responsiveness,
- Accountability

These form the moral and decision-making backbone of the guidance. They ensure that all prioritization decisions are fair, non-discriminatory, and based on values like equity, efficiency, and transparency.

Governance
(Strategic and Operational Enablers for Prioritization)

- Institutionalizing priority-setting within national governance mechanisms.
- Establishing leadership and coordination led by health authorities.
- Engaging multisectoral and community stakeholders from the outset.
- Aligning prioritization with national strategies, budgets, and planning cycles.
- Building ownership and accountability through transparent, participatory processes.

Services Prioritization
(Scoping, Assessment, Appraisal and Recommendations)

Refining the Scope

Assessment Methods and Results
- Defining Prioritization Criteria
- Scoring Process

Organization of Appraisal
- Stepwise Prioritization Approach
- Ensure all population groups (Common barriers to maintaining engagement)

Formulating and Finalizing Decisions
- Engaging in Follow-up Stakeholder Consultation
- Ensure Accountability and Integration of Appraisal Results

Systems, Strategic and Operational considerations

Integrating priority-setting into broader health systems resilience strategies.

Integration of service delivery within PHC person-centered models of care

Health Workforce and Systems Resilience
- **Sustaining Community Health Workforce**

Medicines and other health products

Health Financing Considerations:
- **Urgent, Medium to longer term actions**

Communicate Decisions

Document and Disclose Decisions

Communicate clearly and Strategically

Use multiple channels and trusted messengers

Ensure accessibility and Clarity

Support Health Providers

Enable Feedback and Accountability

Evaluate and Sustain Progress

Data and Monitoring Systems Support:
- Monitoring implementation progress using simple, actionable indicators.
- Evaluating priority-setting outcomes and system performance.
- Using disaggregated, integrated data systems to guide adaptive decisions.

Documenting and sharing lessons, tools, and good practices for learning

Continuing to work toward a sustainable response

As programmes adapt due to funding changes, pharmacy-based testing and self-care can be cost-effective

Sustaining Progress in HIV in Africa Through Enabling of Self-Care: Model-Predicted Effects of Local Free Provision of HIV Self-Tests and Antiretroviral Drugs

24 Pages • Posted: 28 May 2025

Andrew N. Phillips
University College London - Institute for Global Health

Kenly Sikwese
African Community Advisory Board

More...

Abstract

Background: The acute funding crisis for HIV services in ECSW means that innovative strategies are needed. We modelled the test/ARV access, including the provision of free HIV self-tests (PrEP (pre-exposure prophylaxis) and TLD (tenofovir-lamivudine pharmacies/communities to enable self-care, compared with c

Methods: We used an established individual-based model (HIV setting-scenarios representing diversity in setting characteristi Informed by studies of barriers to accessing clinics, communit is assumed to lead to an increase in testing (from median 4.9% per 3 months to 12.6% (6.8% - 21.1%)) and modest increases i +2.2%)) and in retention on ART for people with diagnosed HI

Findings: The assumed effects of the policy on PrEP/PEP use, H result in a median 19% (3% - 35%) lower number of HIV death incidence over 10 years. Overall, the policy is predicted to cut p to be cost-effective at a cost effectiveness threshold of $300 pe

Interpretation: Introduction of community self-test/ARV access for prevention and treatment is very likely to be cost-effective i incidence declines to be sustained at reduced cost. Policy-mak health worker organisations leaders who wish to consider such their own country settings.

EPIDEMIOLOGY AND SOCIAL

Estimated cost-effectiveness of point-of-care testing in community pharmacies vs. self-testing and standard laboratory testing for HIV

Mital, Shweta[a]; Kelly, Deborah[b]; Hughes, Christine[c]; Nosyk, Bohdan[d]; Thavorn, Kednapa[e]; Nguyen, Hai V.[b]

Author Information

AIDS 37(7):p 1125-1135, June 1, 2023. | *DOI:* 10.1097/QAD.0000000000003526

BUY SDC

Abstract

Objective:

Point-of-care-testing (POCT) for HIV at community pharmacies can enhance care linkage compared with self-tests and increase testing uptake relative to standard lab testing. While the higher test uptake may increase testing costs, timely diagnosis and treatment can reduce downstream HIV treatment costs and improve health outcomes. This study provides the first evidence on the cost-effectiveness of pharmacist-led POCT vs. HIV self-testing and standard lab testing.

Design:

Dynamic transmission model

Methods:

We compared three HIV testing strategies: POCT at community pharmacies; self-testing using HIV self-test kits; and standard lab testing. Analyses were conducted from the Canadian health system perspective over a 30-year time horizon for all individuals aged 15–64 years in Canada. Costs were measured in 2021 Canadian dollars and effectiveness was captured using quality-adjusted life-years (QALYs).

Results:

Compared with standard lab testing, POCT at community pharmacies would save $885 million in testing costs over 30 years. Though antiretroviral treatment costs would increase by $190 million with POCT as more persons living with HIV are identified and treated, these additional costs would be partly offset by their lower downstream healthcare utilization (savings of $150 million). POCT at community pharmacies would also yield over 5000 additional QALYs. Compared with HIV self-testing, POCT at community pharmacies would generate both higher costs and higher QALYs and would be cost-effective with an incremental cost-effectiveness ratio of $47 475 per QALY gained.

Conclusions:

Offering POCT at community pharmacies can generate substantial cost savings and improve health outcomes compared with standard lab testing. It would also be cost-effective vs. HIV self-testing.

Pharmacy-based testing **and self-testing can reach those missed by existing services**

Recent modelling across regions shows pharmacy-based testing can be highly cost-effective compared to standard lab-based options

- **In Africa, broader pharmacy-based HIV self-care (including self-testing) could cut programme costs by 7% and avert DALYS and to be cost-effective at a cost effectiveness threshold of $300 per DALY**

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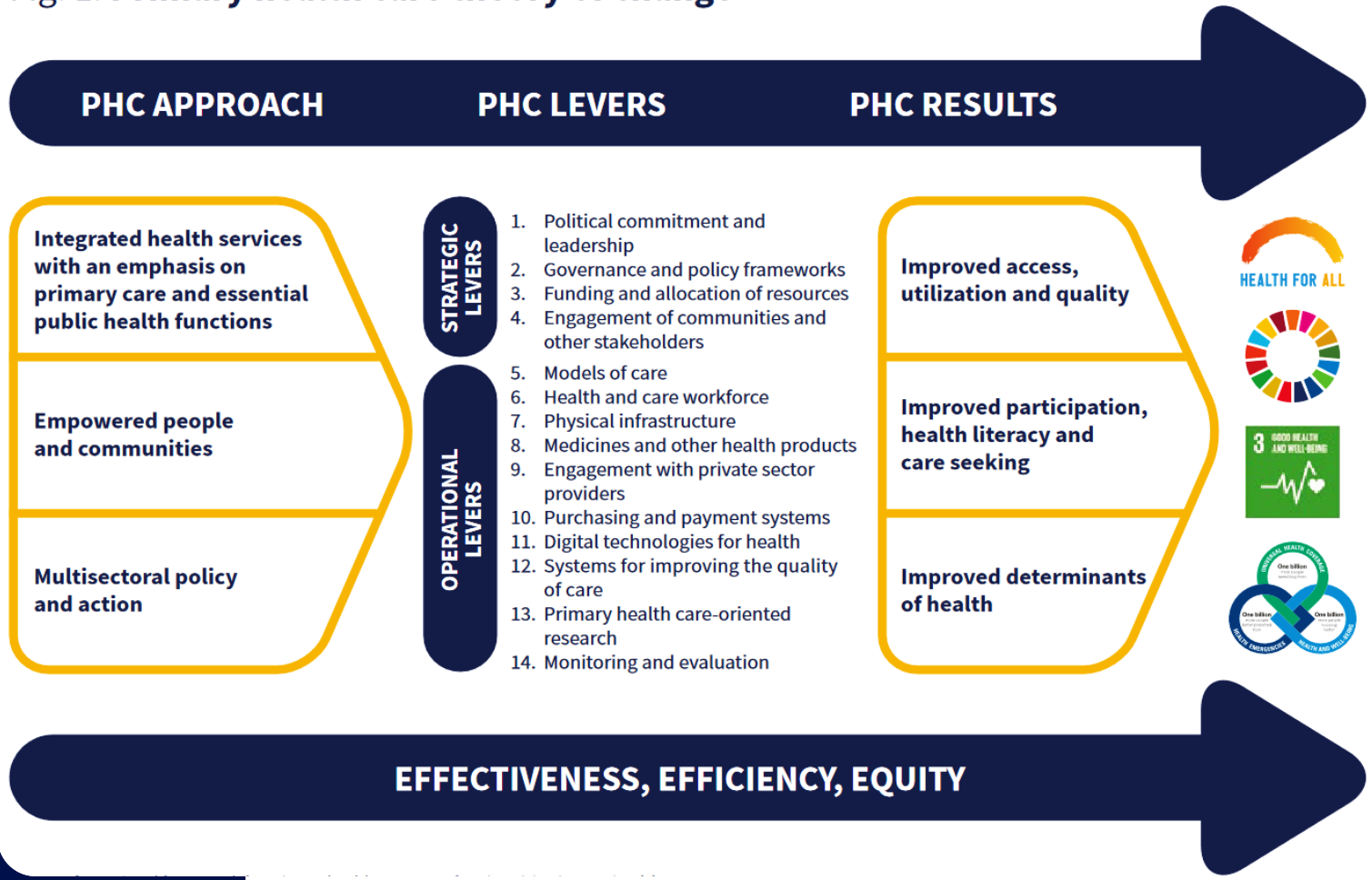
Source: Phillips 2025; Mital 2023.

PHC and HIV – Shared Principles, Common Challenges, Convergent Actions

Fig. 1. **Primary health care theory of change**



- Scaling up high-quality people-centred services through a **PHC approach can be critical** for achieving both disease-specific and broader health aims.
- Sustained success requires that all members of **all populations** can access health services and benefit from health system resources **free from stigma and discrimination**.
- Wherever we are in the health ecosystem there is value in focusing on convergent actions - there is a clear common agenda that can be achieved.

The WHO/UNICEF PHC Operational Framework offers a coherent pathway to select, implement and then learn from PHC and HIV convergent actions
https://www.who.int/publications/i/item/9789240017832

https://www.who.int/publications/i/item/9789240077065

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Rapid Global Assessment Exercise (adapted version PRIORITE)

Objective: Provide indicative global exercise on priority-setting for HIV, viral hepatitis, and STI services

Scope: Global-level analysis based on WHO normative guidance, using 6 criteria

Process: Conducted rapidly by WHO with global expert input, without direct implementation planning.
Focused on one scenario:

- Generalized epidemic,
- High-burden,
- LMIC)

Output: Consolidated, indicative global priorities to inform—but not dictate—country decisions.

Limitations of the Global Exercise (Adapted PRIORITE)

⚠️ Not directly implementable: Global results must be adapted to local contexts—countries should not adopt them as-is.

⚠️ Limited local nuance: The global assessment does not fully capture country-specific challenges, resources, or social/political dynamics.

⚠️ Omits full set of criteria in the global scoring, which are vital at country level.

⚠️ No operational plans: The global process stops at prioritization—it does not address implementation, financing, or monitoring for countries.

Think of the global prioritization exercise findings like a basic cake recipe—it gives you the structure, but you still need to choose your own ingredients.

What works in one country or sub-national level might be too sweet, too dry, or missing key flavors in another. The real art is in using local ingredients, tailoring to different tastes, and what's available in your pantry.

WHO Rapid Global Assessment Exercise: Methodology

R Refine the scope
I Implement the assessment
O Organize the appraisal
R Recommend actions

Roles and Responsibilities

WHO Global Programme on HIV, Hepatitis and STIs	Manages and oversees the process
Dept. Health Financing and Economics & Ethics group at WHO	Designs the process, with inputs from ethics and WHO experts
Expert Group	Conducts the assessment, the appraisal and makes recommendations
Peer Review Group	Reviews the full guidance, including the results of the assessment and appraisal
WHO Steering Group	Informed by expert group recommendations, makes final decisions

Expert Engagement

Selection Process

- 24 experts confirmed interest and participated in the process. Identified reference groups, and expression of interest
- 5 ministries of health, 6 civil society/CBOs/NGO, 8 academic/ research/clinical institutions, 5 implementing partners

Participation

- 17 joined initial consultation (methodology discussion)
- 14 completed assessment exercise (intervention scoring)
- 10 joined deliberation meeting (review/prioritization)
- 10 provided peer review of the draft guidance

Representation

- Gender: 14 women, 10 men
- Regions: AFRO (11), EMRO (4), AMRO (3), EURO (3), SEARO (3), WPRO (1)
- 3 contributors openly from the PLHIV community

Areas of Expertise

- 24 engaged in some level of the HIV cascade (prevention, testing or treatment)
- Including areas of expertise related to the mapped activities: STIs, Viral Hepatitis, Mental Health, Service Integration/DSD, Key Populations, Harm Reduction, Strategic information, Health Systems.

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WHO Rapid Global Assessment Exercise: Methodology

R Refine the scope
I Implement the assessment
O Organize the appraisal
R Recommend actions

Key Steps	Description
1. Mapping & Framework Development	Developed a rapid prioritization framework (adapted from PRIORITE) based on WHO guidance and health technology assessment principles. Used to map and assess interventions.
2. Expert & Stakeholder Consultations	External expert group from all WHO regions—including community reps, governments, and partners—reviewed mapped interventions to ensure relevance, feasibility, and alignment with country realities.
3. Ethics & Governance Review	The WHO Ethics and Governance Steering Group reviewed the framework to ensure consistency with ethical principles.
4. Evidence-Informed Deliberative Assessment	Interventions were scored using six criteria: health impact, cost-effectiveness, equity, feasibility, budget impact, and social/economic impact. The scoring guided (not prescribed) initial tier assignments.
5. Consensus-Building & Peer Review	WHO's Economic Evaluation and Analysis Unit led deliberations. Trade-offs were reviewed and consensus on tiered priorities was achieved with input from all WHO regions.

1a. Mapping Services and Interventions

PREVENTION

- Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis
- Follow-up of syphilis-exposed newborns
- Post-exposure HIV prophylaxis (PEP)
- Pre-exposure prophylaxis (PrEP)
- Blood banks
- Opioid Agonist Maintenance Therapy (OAMT) to treat and monitor opioid dependence, and provision of naloxone
- Harm reduction services, including needle and syringe programmes
- Voluntary medical male circumcision (VMMC)
- Provision of condoms and lubricants

TESTING

- Differentiated HIV Testing Services (HTS)
  - Facility-based HTS
  - HIV self-testing (HIVST)
- Network-based testing services
- Linkpage to care
- Facility-based testing for syphilis
- Facility-based testing for viral hepatitis
- Community- based testing for HIV, viral hepatitis, and syphilis

TREATMENT AND CARE

- Routine ART for Adults, adolescents and pregnant, breastfeeding women
- Routine ART for Children
- Preventives and diagnostics for patients with advanced HIV disease (AHD)
- TB-HIV coinfection services
- Management of Mpox (essential for outbreak control)
- Reduced frequency of ART refills 3- to 6-month - Multi-month dispensing (MMD) and Differentiated service delivery (DSD) for HIV treatment models
- Routine screening for people with HIV
- ART treatment monitoring
- Viral hepatitis treatment and monitoring
- Syndromic management of STIs (genital discharge; ulcer disease)
- Task sharing
- Prevention and continuation care of common comorbidities in HIV infection Cervical cancer screening and treatment
- Adherence and Psychosocial support for HIV treatment and care
- Tracing and Re-engagement support

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1b. Setting Criteria for prioritization

Disease Burden, Epidemiological Impact, Progress Towards Global Targets	Cost-Effectiveness and Resource Optimization
Ethical and Equity Considerations	Feasibility and Health System Readiness
Social and Economic Impact	Acceptability and Community Engagement

1c. Stepwise Three-Tier Prioritization Approach

Tier 1
- Must continue to fund.

Tier 2
- May not be able to fund at this time due to limited funding, but important to reevaluate in the short term.

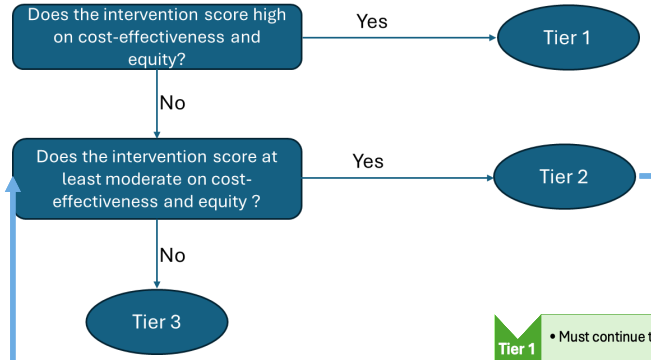
Tier 3
- Not possible to continue to fund until additional resources become available.

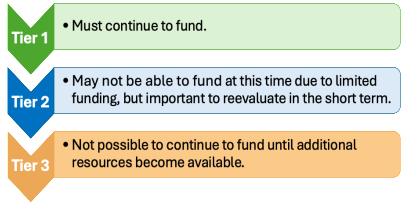
Review criteria "information sheet" where available

Review best available evidence

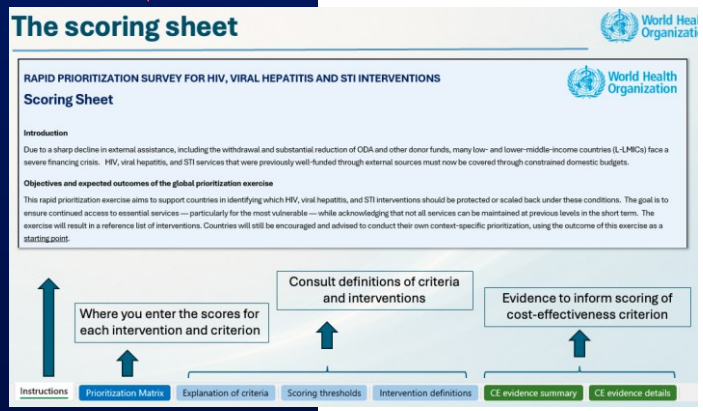
Provide scoring based on evidence and judgment

Criteria					
Health impact & effectiveness	Cost-Effectiveness	Feasibility & Health System Capacity	Equity & Vulnerability	Budget impact	Social and Economic Impact
Green	Green	Yellow	Yellow	Green	Green
Green	Red	Yellow	Yellow	Yellow	Yellow
Yellow	Yellow	Yellow	Yellow	Green	Red
Yellow	Yellow	Yellow	Green	Yellow	Yellow
Green	Cannot score	Green	Yellow	Cannot score	Green
Green	Yellow	Red	Green	Green	Red
Green	Green	Green	Yellow	Yellow	Green
Green	Green	Yellow	Yellow	Cannot score	Green





Use consensus and summarize the scores, flagging areas of disagreement to inform dialogue on formulation of recommendations



Criteria	Summary of scores				Overall score
	Green	Yellow	Red	Cannot score	
Health impact & effectiveness	3	11	0	0	
Cost-Effectiveness	4	7	3	0	
Feasibility & Health System Capacity	4	6	4	0	
Equity & Vulnerability	11	2	1	0	
Budget impact	3	4	7	0	
Social and Economic Impact	7	6	1	0	

Preliminary assignment to tier: **Tier 2**

Notes for deliberation:
- 3 experts indicated that this intervention is not cost-effective. Furthermore, 7 experts determined that this intervention had a high budget impact, and 4 determined that it had a low feasibility. Do these considerations affect the tier assignment?

Consultative expert group meeting: deliberative appraisal using the consensus scores and make recommendations on the 3-tiered list

WHO steering Group: Make decisions on the final list of interventions to be retained in each tier

WHO Rapid Global Assessment Exercise: Methodology

ATTENTION PLEASE !!

Preliminary results:
Expert group deliberation + WHO steering group refinement

TIER 1: ESSENTIAL

PREVENTION

Interventions	Key Rationale and Decision-Making Notes
Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis (includes PrEP)	Critical for elimination of vertical transmission; integration enhances service delivery.
HIV Post-exposure prophylaxis (PEP)	Critical intervention, not limited to occupational settings & delivered through community networks
Blood product safety and health care infection control	Foundational component of a functioning health system ⟷
Harm reduction services (including OAMT, needle and syringe programmes and naloxone provision for opioid overdose management)	Moved to Tier 1 in countries where already implemented; interruptions carry significant risk.
Provision of condoms and lubricants	Important for primary prevention, especially among key populations.

TIER 2: IMPORTANT

Interventions	Key Rationale and Decision-Making Notes
Pre-exposure prophylaxis (PrEP) – including Long-Acting PrEP ⟷	Should be made available and accessible, particularly for key populations, and those already on PrEP. Delivered through community networks
Voluntary Medical Male Circumcision (VMMC) ⟷	Rec for 15 high-priority countries in East/South Africa; Tier 2 overall, elevated to Tier 1 in priority contexts
Prevention and continuation care of common comorbidities in HIV infection	Important for holistic care but often outside core HIV package and constrained by resources
Vaccination for HBV ⟷	Birth vaccination should be prioritized; adult catch-up tailored to context and resources

⟷ Indicates movement between tiers depending on contextual and population needs factors

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ATTENTION PLEASE !!

Preliminary results:
Expert group deliberation + WHO steering group refinement

TESTING

TIER 1: ESSENTIAL

Interventions	Key Rationale and Decision-Making Notes
Facility-based HIV Testing Services (HTS)	Reclassified as Tier 1 due to its central role in case finding, especially when guided by epidemiological data and health system capacity.
Community-based testing for HIV, viral hepatitis, and syphilis ⟷	Prioritize for underserved/high-risk populations; self-testing and peer-delivered options encouraged.
Facility-based testing for syphilis	Reinforced due to links with maternal health outcomes.

TIER 2: IMPORTANT

Interventions	Key Rationale and Decision-Making Notes
Facility-based testing for viral hepatitis	Tier 2 overall but may be elevated to Tier 1 in countries with high burden and program capacity.
Multiplex Testing approaches	To be considered by countries as upcoming evidence that contributes to integration and leveraging resources.

⟷ Indicates movement between tiers depending on contextual and population needs factors

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Preliminary Results from a Rapid Global Assessment Exercise

ATTENTION PLEASE !!

Preliminary results: Expert group deliberation + WHO steering group refinement

TREATMENT AND CARE

TIER 1: ESSENTIAL

Interventions	Key Rationale and Decision-Making Notes
Routine ART (ALL children, adolescents, adults, pregnant, breastfeeding women and key populations)	Universal access is foundational to HIV treatment programs & access tracking through CLM.
ART treatment monitoring (viral load monitoring)	In resource-limited settings, reduced frequency may be applied to ensure cost-effectiveness.
Routine screening for people with HIV (CD4 and other screening tests)	Moved to Tier 1; interruptions carry significant risk to AHD identification.
Advanced HIV disease (AHD) management	Early identification and comprehensive management is required for effectiveness.
TB screening, diagnosis, treatment and prevention in PLHIV	Early identification and management prevent TB mortality among PLHIV
Adherence for HIV treatment and care	Classified Tier 1 as an integral part of ART programs.
MMD 3- to 6-month ART (Reduced Frequency of ART pick-up) ⟷	Improves client convenience, reduces HF burden, and supports adherence, part of Community led services. Depends on commodity availability
Tracing and Re-engagement support ⟷	Tracing is going to be important and cost-effective for some but not all. Should be prioritized, especially for AHD, pregnant women, and children.
Syndromic management of STIs (genital discharge; ulcer disease)	
Cervical cancer screening ⟷	

TIER 2: IMPORTANT

Interventions	Key Rationale and Decision-Making Notes
Viral hepatitis treatment and monitoring ⟷	Tier 2 overall but may be elevated to Tier 1 in countries with high burden and program capacity.
Mental health support for HIV treatment and care	Valuable and increasingly recognized; should be integrated with differentiated service delivery, depending on available resources.
Prevention and continuation care of common comorbidities in HIV infection	NCD treatment in people living with HIV should be continued. Important for holistic care but often outside core HIV package and constrained by resources.
Management of Mpox (essential for outbreak control) ⟷	Should be prioritized where relevant, based on outbreak dynamics and national/WHO guidance.

⟷ Indicates movement between tiers depending on contextual and population needs factors

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Lessons Learned and key aspects to consider

Meaningful community engagement must inform all decision making: roles for WHO, UNAIDS, GF & partners to ensure engagement. Including safe-guarding CBO tools and interventions (e.g. CLM and Stigma Index)

Ethics must remain central: Prioritization processes must explicitly safeguard marginalized and high-risk populations, grounded in ethical principles.

Country-specific context is key for meaningful prioritization: the global results can be seen as a starting point, however, plans must reflect local disease burden, existing coverage, and implementation readiness.

Disaggregation enables more precise and effective decision-making: Global-level interventions grouping obscured critical distinctions; countries must disaggregate (e.g. pop. specific) and assess activities individually to ensure context-appropriate prioritization.

Within Tier 1, prioritization may still be necessary: Limited resources will require hard decisions, prioritize high-impact Tier 1 interventions, document and communicate the rationale.

Transparency strengthens adaptation and planning: Clear narratives help justify prioritization, build stakeholder trust, and guide operational action.

Many Complementary tools: UNAIDS, PEPFAR Sustainability Plans (Part A, RAFT & Part B) & Global Fund Guidance.

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Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes:
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This guideline process was coordinated by Clarice Pinto, with guidance from Nathan Ford and under the leadership of Meg Doherty, Director of the Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes. Other technical staff also contributed to these guidelines, including Wole Ameyan, Antons Mozalevskis, Magdalena Barr-Dichiara, Ismail Maatouk, Mateo Prochazka Nunez, Carlota Baptista Da Silva, Cheryl Case Johnson, Elena Vovc, Ajay Rangaraj, Marco Vitoria, Boniface Dongmo Nguimfack, Cheryl Johnson, Olufunmilayo Lesi, Daniel Low-Beer, Niklas Luhmann, Morkor Newman Owiredu, Ivy Kasirye, Annette Verster, Adriana De Putter, Francoise Renaud, Hiwot Haile-Selassie, Ivy Kasirye, Busisiwe Msimanga, Celine Lastrucci, Diana Faini, Maeve Brito de Mello, Nandita Sugandhi, Annelise Monroe-Wise, Harilala Nirina Razakasoa, Pascal Jolivet, Michelle Rodolph, Remco Peters.

WHO Regional and Country Offices: These individuals contributed to the development of the first drafts of the document. Dr. Mónica Alonso Gonzalez (Pan American Health Organization), Akudo Ezinne Ikpeazu and Agnes P. Adilakshmi Chetty (Regional Office for Africa), Kiyohiko Izumi (Western Pacific Regional Office), Po-lin Chan (SEARO), Lastone Chitembo (Zambia), Kafui Senya (Ghana), Arouna Tena and Danièle Simnoue Nem (Cameroon).

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Other WHO departments that contributed to this operational guidance

WHO Department of Health Financing and Economics Department: Under the leadership of Kalipso Chalkidou, these experts provided valuable guidance and inputs on the overall methodology, process, and health finance and economics contributions. Contributors included Susan Sparkes and Helene Barroy (Financing and Policy for Health unit), Anna Vassall, Altea Sitruk, Filip Meheus, Andrew Mirelman, and Vittal Mogasale, and Karin Stenberg (Economic Evaluation and Analysis unit).

WHO Health Workforce Department: Under the leadership of Pascal Zurn, Giorgio Cometto, and Onyema Ajuebor, the department contributed expertise on health workforce considerations throughout the guidelines process.

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World Health Organization

THE CQUIN NETWORK

cquin.icap.columbia.edu

Thank You!

CQUIN Network Meeting | June 10-12, 2025 – Johannesburg, South Africa

Questions from the presenter to the Audience

- Are there elements in this guidance that are similar to activities or prioritization processes already underway in your countries?
- What would be some risks if countries tried to apply global prioritization results directly without adaptation?
- In your setting, what additional steps would be needed to tailor these global results into something practical and relevant for your national and sub-national planning?

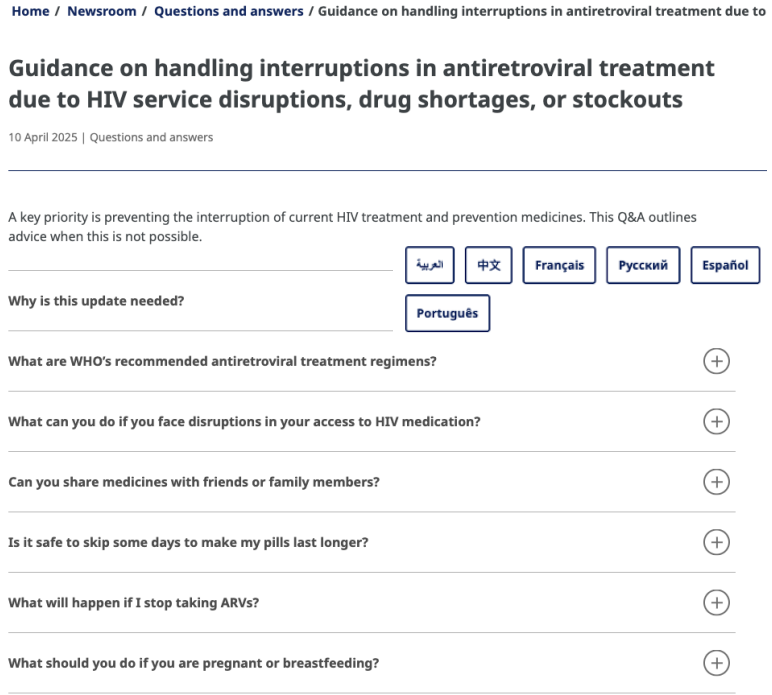
Clarice Pinto, pintoc@who.int

Resources:

Sustaining HIV, hepatitis and STIs services amid declining health aid

World Health Organization

https://www.who.int/activities/sustaining-hiv-hepatitis-and-stis-services-amid-declining-health-aid



https://www.who.int/news-room/questions-and-answers/item/guidance-on-handling-interruptions-in-antiretroviral-treatment-due-to-hiv-service-disruptions--drug-shortages--or-stockouts

Resources:

Precipitated aid transition in health – priority actions for low-and-middle income-countries

Hélène Barroy, Susan Sparkes, Kalipso Chalkidou (WHO/HQ)

With contributions from Christabel Abewe (WHO/Uganda), Kingsley Addai Frimpong (WHO/Ethiopia), Georgina Bonet (WHO/AFRO), Riku Elovainio (WHO/ Democratic Republic of Congo), Sophie Faye (WHO/AFRO), Jayendra Sharma (WHO/SEARO), Tsolmongerel Tsilaajav (WHO/Vietnam), Anna Vassall (WHO/HQ) Ding Wang (WHO/Cambodia), MyMai Yungrattanachai (WHO/HQ).

https://www.pfm4health.net/blog/precipitated-aid-transition-in-health-priority-actions-for-lowandmiddle-incomecountries

https://openknowledge.worldbank.org/entities/publication/8878fbd9-879d-43d4-ab1f-ecaed1a4576a

https://www.who.int/publications/i/item/9789240044982

https://www.who.int/publications/i/item/9789240049666

Contact: healthfinancing@who.int

Annexes

1. WHO Department Health Financing and Economics Policy and Methods

2. WHO Testing services

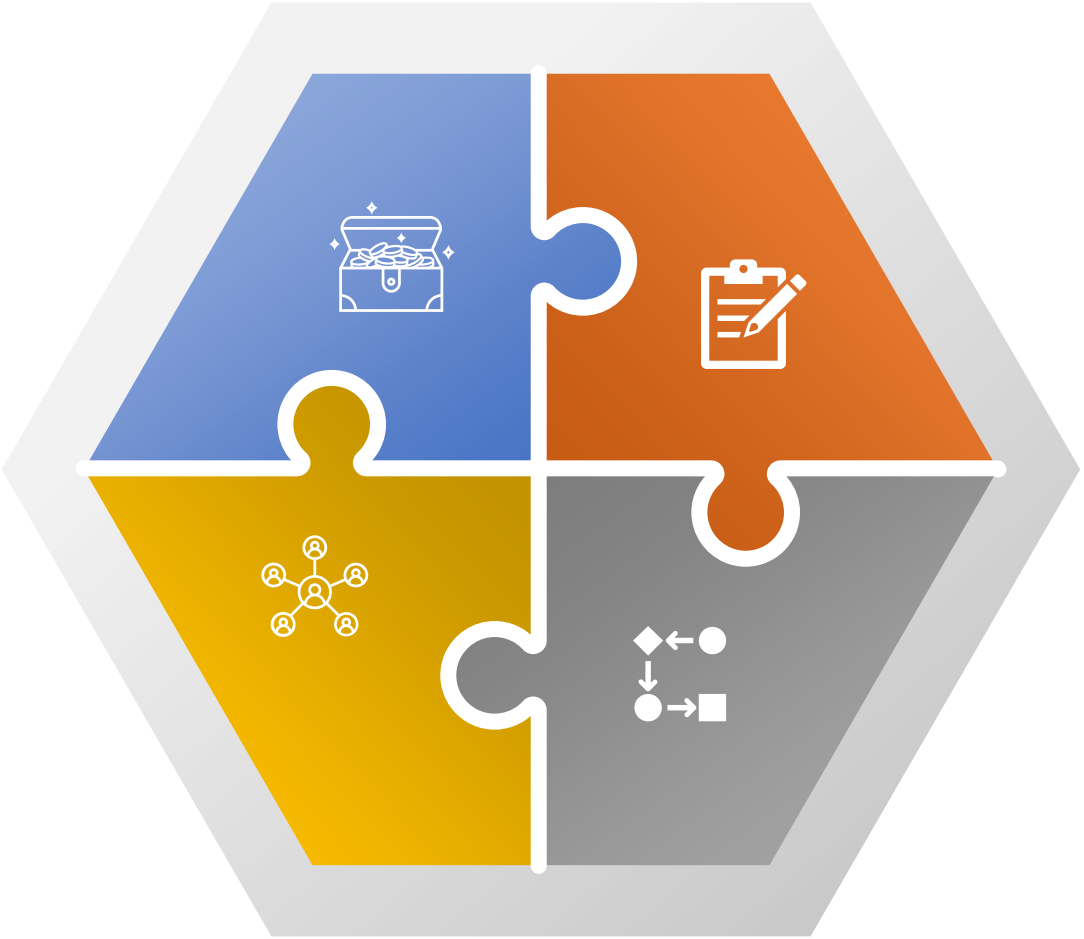
Navigating the health financing emergency

1. Fiscal capacity

Engage with finance and parliament to address underlying revenue generation

2. Efficiency and priority setting

Improve public financial management (PFM) systems, reducing duplications, improving alignment, strategic integration, deliberately setting priorities within boundaries



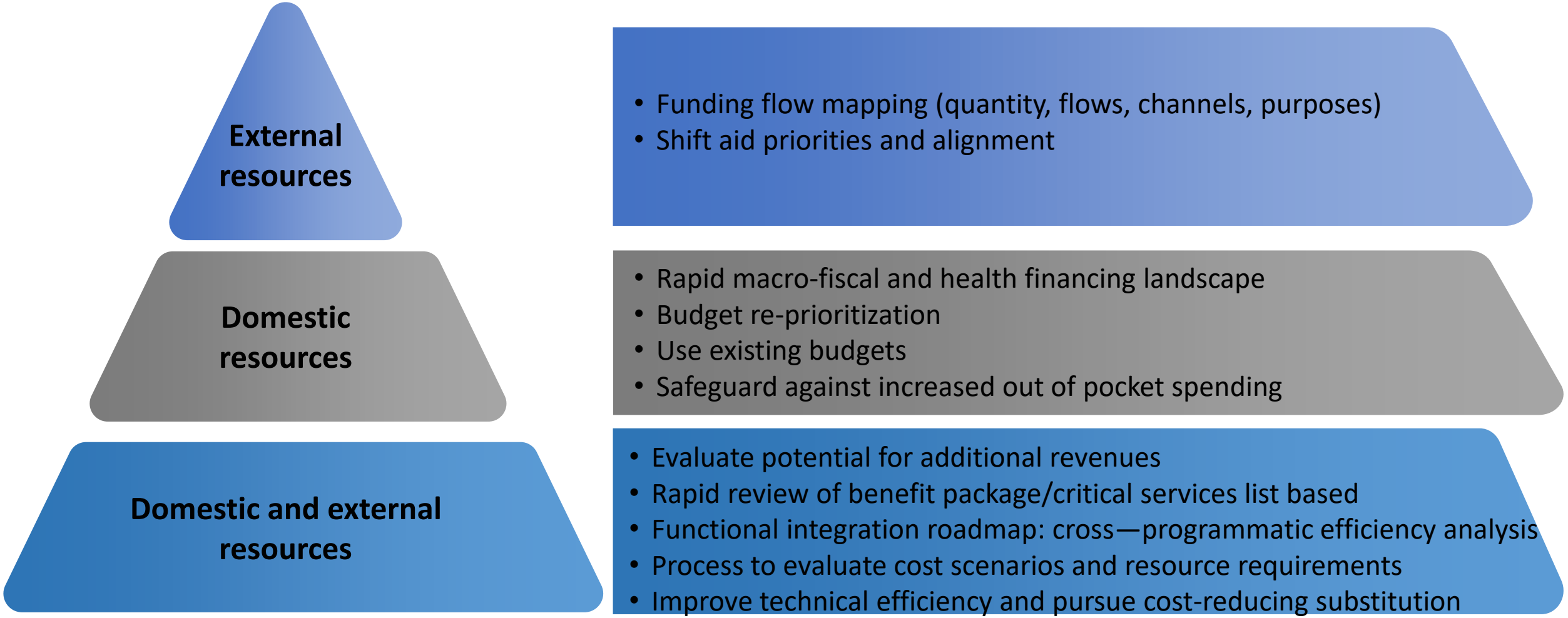
3. Political advocacy domestically and globally for health

Continue to make the case for prioritization of health in budgets

4. Different approach to donor funding

Align with domestic PFM systems, supporting institutional development (not replacing), avoiding recurrent costs, aligning to country priorities

System-wide actions to navigate the health financing emergency



Sector-wide decision-making, analytics, prioritization, and reforms
Donor- and programme-specific considerations need to plug into sector-wide, domestic health budget dialogue
Focus on efficiency/cost reductions and sustaining coverage wherever possible

Resources to support global and country-led priority-setting

Interim guidance on priority-setting processes to respond to shocks

Evidence-informed

Participatory

Aligned with ethical principles

Methodological support

Synthesizing and using economic data for priority-setting

Real-world examples

Practical application on global prioritization of HIV interventions

Upcoming country sector-wide applications

South-south exchange

Exchange of knowledge, experience and data

Contact: whochoice@who.int

The scoring sheet

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RAPID PRIORITIZATION SURVEY FOR HIV, VIRAL HEPATITIS AND STI INTERVENTIONS

Scoring Sheet

World Health Organization

Introduction

Due to a sharp decline in external assistance, including the withdrawal and substantial reduction of ODA and other donor funds, many low- and lower-middle-income countries (L-LMICs) face a severe financing crisis. HIV, viral hepatitis, and STI services that were previously well-funded through external sources must now be covered through constrained domestic budgets.

Objectives and expected outcomes of the global prioritization exercise

This rapid prioritization exercise aims to support countries in identifying which HIV, viral hepatitis, and STI interventions should be protected or scaled back under these conditions. The goal is to ensure continued access to essential services — particularly for the most vulnerable — while acknowledging that not all services can be maintained at previous levels in the short term. The exercise will result in a reference list of interventions. Countries will still be encouraged and advised to conduct their own context-specific prioritization, using the outcome of this exercise as a starting point.

Where you enter the scores for each intervention and criterion

Consult definitions of criteria and interventions

Evidence to inform scoring of cost-effectiveness criterion

Instructions | Prioritization Matrix | Explanation of criteria | Scoring thresholds | Intervention definitions | CE evidence summary | CE evidence details

Criteria information sheets exist for two criteria to facilitate a consistent understanding

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COST-EFFECTIVENESS INFORMATION SHEET

for Rapid Global HIV/Hep/STI Prioritization

Why it matters

Cost-effectiveness analysis explores which interventions deliver the greatest health benefit to populations within a budget or resource constraint. It is commonly used for determining how to use public funds for health system investments and spending. This is especially important in contexts with limited budgets, where difficult choices may have to be made.

Cost-effectiveness is not the same as choosing the 'lowest cost' intervention. Rather, it identifies which options offer the highest value, in terms of providing the most health for the resources available.

What is cost-effectiveness?

- Cost-effectiveness compares the additional cost of an intervention to the additional health benefit it delivers.
- Results are summarized using an ICER (incremental cost-effectiveness ratio).
- The ICER is usually expressed as cost per DALY averted, representing a reduction in population disease burden.
- The ICER is a comparison to alternatives such as the 'current standard of care', or 'no intervention'.

To calculate this, analysts:

- Define a comparator and intervention and consider how services are, or would be, delivered for the population in need;
- Choose a perspective (e.g. health system or societal), which determines what costs and benefits are included;
- Use summary health outcomes like DALYs or QALYs, which combine mortality and morbidity. For this exercise, DALYs are the focus given that they are more commonly used in LMICs.
- Estimate costs and health outcomes over a sufficient time period to capture all important costs and effects for the analysis.

Interpreting results

- A lower ICER value (change in cost divided by change in effect) means better value for money.
- To establish whether the ICER value is cost-effective in a given context, a cost-effectiveness threshold is used. The threshold establishes whether the intervention is good use of funds, given what is currently being provided in that context.
- Another conclusion from a cost-effectiveness study can be that it is **"cost-saving"**, meaning that the intervention provides better health at a lower cost. In this situation, the decision to adopt or maintain the intervention would be very strong based on the cost-effectiveness.

BUDGET IMPACT INFORMATION SHEET

for Rapid Global HIV/Hep/STI Prioritization

What is it?

This criterion assesses whether an intervention can be financed and maintained within the country's health budget, especially in contexts where external donor support is uncertain or declining.

It assesses the implication for the health budget, now and in the future. In principle all interventions that are cost-effective should be afforded. However, in some cases where interventions take up large proportions of the budget, there may be concerns about sustaining funding.

Budget impact examines financial resource requirements, now and in the future compared to budget availability (i.e., what is the intervention's total cost compared to available financial resources?). It is concerning that, when prioritising an intervention requires rapid reallocations, it may not be feasible to assess budget impact with high confidence.

It focuses on:

- The cost of the intervention at scale, though periods of scale-up can be included and should be specified;
- The relative size of the resources used compared to available health budgets;
- In the case of transition from external to domestic spending, impact will depend on whether the intervention is already domestically financed, co-financed, or fully donor/externally-financed. In this case, additional cost to domestic budgets may also be considered, rather than overall total cost.

Key concepts

Budget impact refers to the *cost* of implementing an intervention (usually at scale), and its *relative size* compared to the total health budget, which can be estimated by looking at the domestic government health spending (per capita) and the share of spending covered by external aid.

A high budget impact signals that an intervention may:

- Crowd out other more cost-effective interventions before full re-priorisation can be considered;
- Be infeasible in terms of adjusting public financial management systems.

Budget impact analysis (BIA) is typically conducted from the budget holder's perspective (in this case the Ministry of Health, Ministry of Finance, Social Security Agency, or Government Health Insurance Agency), and includes costs and savings, but not health outcomes.

How to assess budget impact

Implementing the assessment

Approach:

- Evidence-informed but deliberative.
- Involves expert judgment and dialogue.
- Rapid evidence synthesis.

Count of Traffic score	Column Labels			
Row Labels	High	Moderate	Low	#N/A
Adherence and Mental health support for HIV treatment and care		**2**	**2**	
ARV adherence interventions: Intervention comprised of elimination of ART copayments, Provision of free OI medications, increased training of healthcare workers, reimbursment of trans		1		
ARV adherence interventions: Link4Health intervention			1	
ARV adherence interventions: Two types of interventions: (1) risk reduction, (2) outreach: re-link			1	
ARV adherence interventions: Weekly interactive SMS interventions		1		
Advanced HIV disease (AHD) management		**1**		
Advanced HIV disease (AHD) management		1		
Cervical cancer screening and treatment				**8**
Cervical cancer screening and treatment				2
One-off vaccination and treatment				2
PAP, every 3 yearsfrom age 20 until age 65+ vaccination + treatment				1
PAP, every 5 yearsfrom age 20 until age 65+ vaccination + treatment				1
screening by visual inspection with acid+ vaccination + treatment				2
Community-based testing for HIV	**6**	**7**		
Community-based HIV self-testing Adult men		1		
Community-based HIV self-testing WTS	1			
Community-based HIV self-testing Young		1		
Community-led HIV self-testing		1		
HIV self-testing/Community-based self-test followed by confirmatory testing and counseling - Adult men, (25–49 years)		2		
HIV self-testing/Community-based self-test followed by confirmatory testing and counseling - Women having transactional sex	2			

Goal: Guide—not dictate—prioritization decisions.

Basis: Ethical principles + health technology assessment norms

Key Considerations:

- Rapid yet structured
- Inclusive of local context and expert insight
- Supports fair, transparent, and evidence-based decision-making

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Criteria for consideration

- Health impact
- Cost effectiveness
- Financial sustainability and budget impact
- Equity
- Feasibility
- Social and economic impact
- Financial risk protection
- Acceptability

- Criteria should be:
  - explicit
  - locally-defined and relevant to context
- They are primarily derived from two pairs of health system objectives:
  - to improve population health and access to services
  - to distribute health and health services fairly

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Scoring system

- Simple color-coded for each criterion indicating high, moderate, or low performance on that criterion.
  - High
  - Moderate
  - Low
- Cutoffs defined for each criterion.
- Factsheets and instructions provided to assist in the assessment of the criteria and deliberation.
- Use scoring sheets & pilot tests
- Individual scoring → group consensus
- Document reasoning for transparency

Score	What it means	Criteria*
High	Strong value for money	Consistent evidence suggesting an incremental cost per DALY averted < 0.5x GDP per capita or cost-saving
Moderate	Acceptable value	Consistent evidence suggesting an incremental cost per DALY averted between 0.5 and 1x GDP per capita
Low	Weak value for money	Limited evidence of an incremental cost per DALY averted < 1x GDP per capita or dominated

Services and Interventions	Criteria						Comments
	Health impact & effectiveness	Cost-Effectiveness	Feasibility & Health System Capacity	Equity & Vulnerability	Budget impact	Social and Economic Impact	
Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis	[select]	[select]	[select]	[select]	[select]	[select]	
Vaccination for HBV	[select]	[select]	[select]	[select]	[select]	[select]	
HIV Post-exposure prophylaxis (PEP)	[select]	[select]	[select]	[select]	[select]	[select]	
HIV Pre-exposure prophylaxis (PrEP)	[select]	[select]	[select]	[select]	[select]	[select]	
Blood product safety and health care infection control	[select]	[select]	[select]	[select]	[select]	[select]	
Prevention and Harm reduction services for people who use drugs	[select]	[select]	[select]	[select]	[select]	[select]	
Provision of condoms and lubricants	[select]	[select]	[select]	[select]	[select]	[select]	
Voluntary Medical Male Circumcision (VMMC)	[select]	[select]	[select]	[select]	[select]	[select]	
Differentiated HIV Testing Services (HTS)	[select]	[select]	[select]	[select]	[select]	[select]	
Facility-based testing for syphilis	[select]	[select]	[select]	[select]	[select]	[select]	
Differentiated testing for viral hepatitis	[select]	[select]	[select]	[select]	[select]	[select]	

Criteria	Summary of scores				Overall score
	Green	Yellow	Red	Cannot score	
Health impact & effectiveness	14	0	0	0	
Cost-Effectiveness	10	2	0	2	
Feasibility & Health System Capacity	6	8	0	0	
Equity & Vulnerability	11	3	0	0	
Budget impact	7	6	1	0	
Social and Economic Impact	13	1	0	0	

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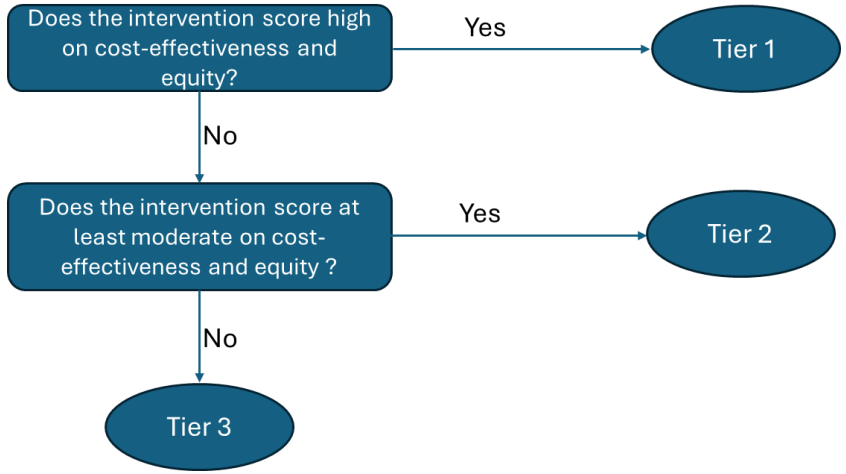
Organizing the appraisal

Approach

- Uses consensus scoring to inform—not replace—dialogue on formulation of recommendations.
- Deliberation via consultative meetings.
- Scores highlight strengths/weaknesses; qualitative nuances considered.
- Decision rules may also be established.
- Documentation of decisions, stakeholder views, and disagreements is critical.

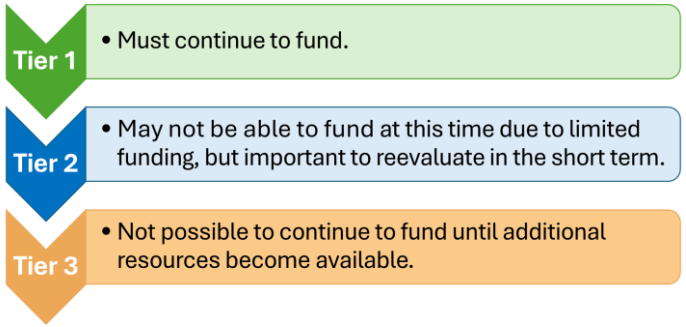


Key Considerations

- Focus on maintaining equity—avoid widening disparities.
- Time-bound deliberations to avoid delays in planning.
- Adaptable to country-specific contexts and evolving needs.

Stepwise Prioritization

- Structured approach aligned with national priorities and context.
- E.g. Three-tier model based on funding necessity.



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Prioritizing Low-Cost and Effective Differentiated HIV Testing Services

Adapting HIV testing services in the context of reduced and declining funding

June 2025

WHO/HQ
Global HIV, Hepatitis and STI, TPP

World Health Organization

Objectives

- Provide practical guidance for countries to sustain HIV testing services.
- Address the impact of reduced international funding on national HIV programs.
- Promote the implementation of cost-effective and differentiated HIV testing strategies.
- Ensure continued access to HIV testing as a gateway to lifesaving treatment.
- Support efforts to prevent new HIV infections through sustained testing services.

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Presentation outline

1. Prioritize & adopt low-cost HIV Testing services.
2. Leverage HIVST to mitigate limited stock and limited human resources.
3. Additional strategies to support cost-effective HIV testing.
4. Prioritize populations for HIV testing when resources are limited.
5. Optimize HIV retesting strategies to improve efficiency and impact.
6. Adapt community-based testing services in response to funding constraints and changing feasibility.
7. Continue HIV testing for PrEP and PEP programs.
8. Maintain HIV screening protocols for blood donations.

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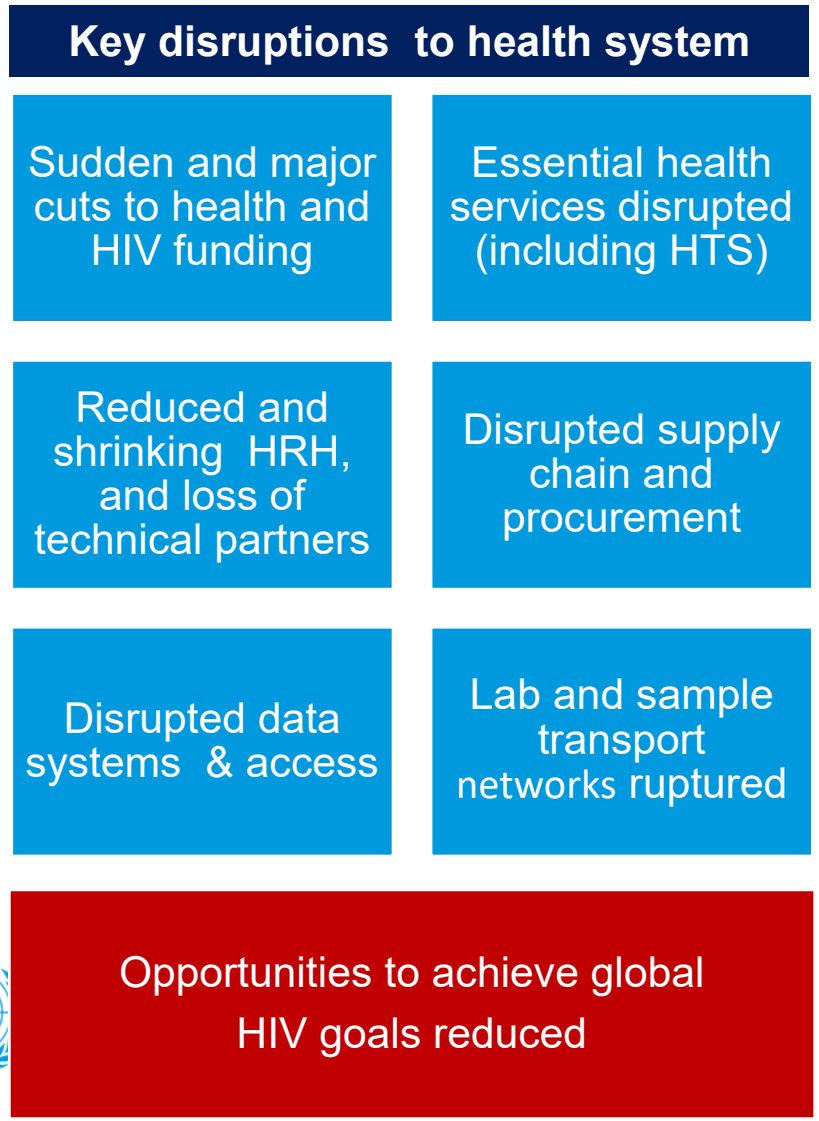
Reduced funding and policy shifts impact HIV services



Key findings from WHO rapid country assessments post policy and funding shifts:

- Substantial programme disruptions, but variable by country and region
- Many adopting '*integration of HIV into PHC*'
- Focusing adaptations to maintain ART for PLHIV
- Other areas such as **HIV testing and prevention** under review and/or being deprioritized
- Finding cost-savings is essential

It is critical to meet the moment and provide strategic insight and guidance

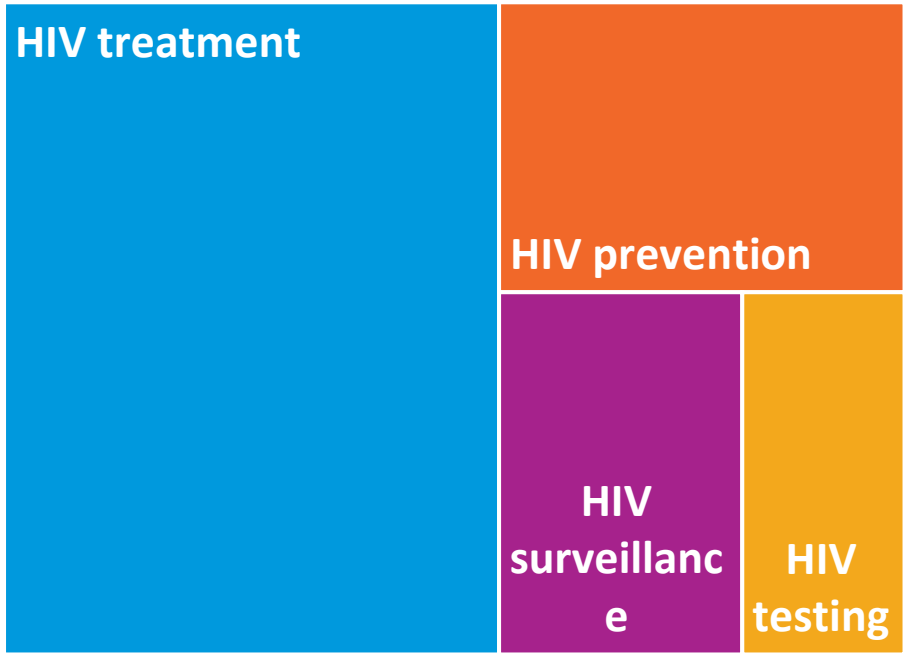
- Webinar focuses on some strategic adaptations for HIV testing services

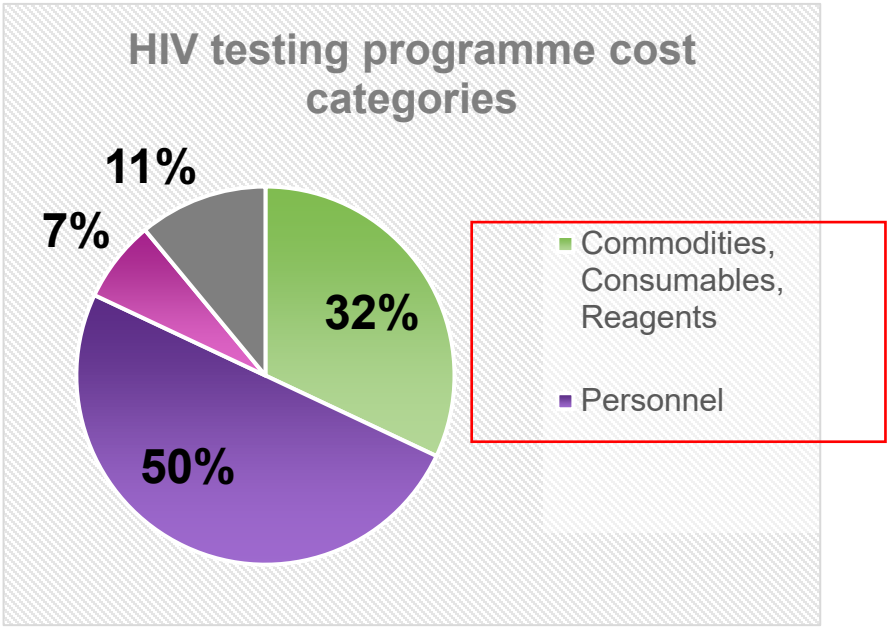
Understanding HIV Testing programme costs

HIV testing is generally <10% of previous national HIV budgets*

Testing is *'small, but mighty'* service that **enables access to**:

- life-saving treatment
- high impact prevention
- simple and routine surveillance





+1 billion HIV RDTs were procured in 101 LMICs 2015-2023.

18% increase in HIV RDTs procured from 2021 to 2023*.

Main HIV testing costs are **personnel (testers) and commodities (test kits)**

Focusing on these **two areas is a strategic way to cut costs**

Illustrative figure based on data and reporting from UNAIDS 2022; *5-7% of budgets in many African countries due to wide-scale RDT use

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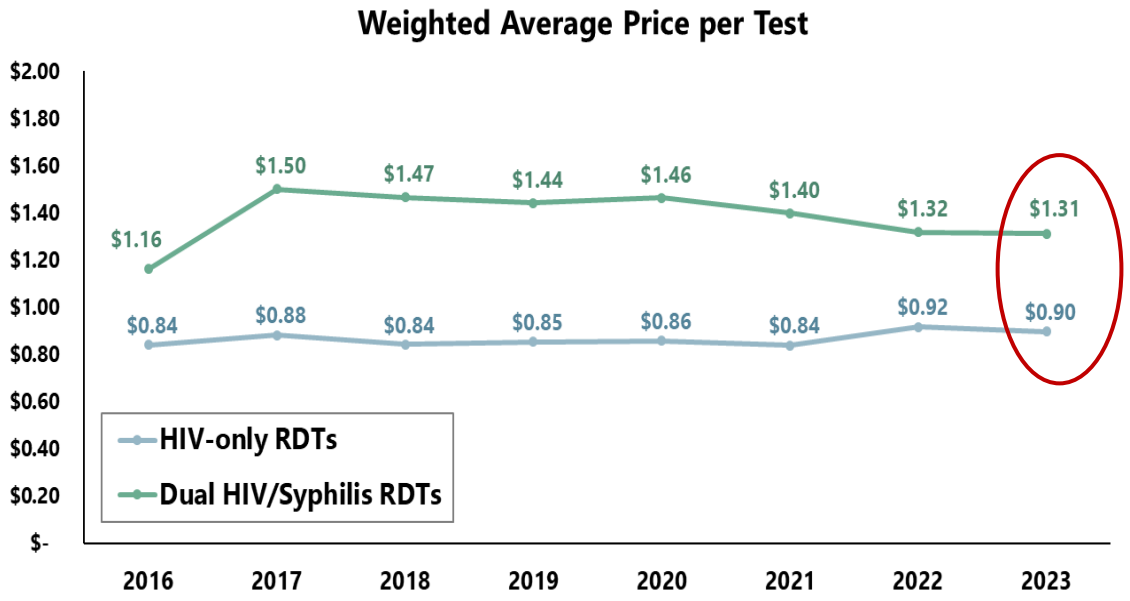
1 Prioritize & Adopt low cost HIV Testing services



Source: WHO-Eureka Procurement Database

Average weighted price of HIV tests remains high, yet low-cost quality-assured options are available

- HIV RDT: $0,90
- HIV/syphilis RDT: $1,31
- HIVST: $2,00

Current opportunities in the WHO catalogue

- **HIV RDT:** +21 PQ'ed ($0,53-$2,79)
  - 5 manufacturers have tests **<$0,70-0,75** (**Premier, Meril, SD Biosensor, Abon** and **Trinity**)
  - 4 manufacturers have tests **<$0,70** (**Wantai, Wondfo, KHB** and **InTec**)
  - All with A1 characteristics
- **HIV/Syph RDT**: 3 PQ'ed ($0,90-$0,95)
  - **SD Bionsensor, Abbott (SD Bioline)** and **Premier**
- **HIVST**: 7 PQ'ed ($1-$3,29)
  - 2 manufacturers have tests **<$1,50** (**Wondfo** and **Abbott**)

**Note price information includes cost of accessories per WHO sources and catalogue as of 5 May 2025*
Reference information: EIC/WHO 2024, WHO catalogue 2025; WHO tool kit 2021; Global Fund 2025

** Abon – owned by Abbott*
*** SD Bioline – subsidiary of Abbott*

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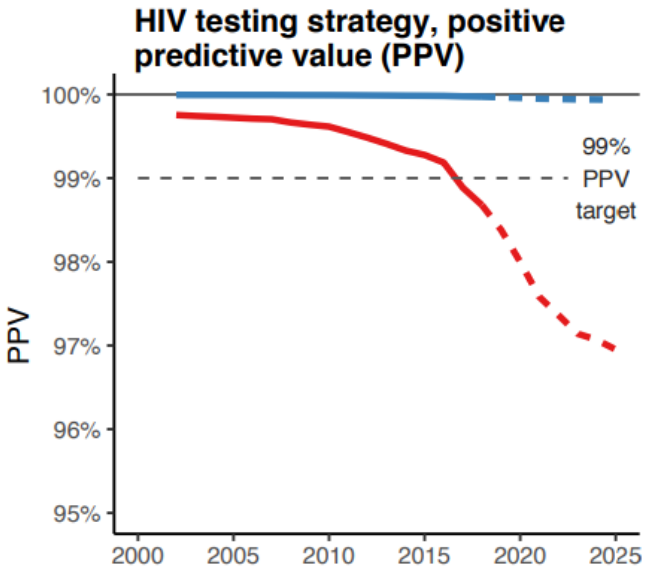
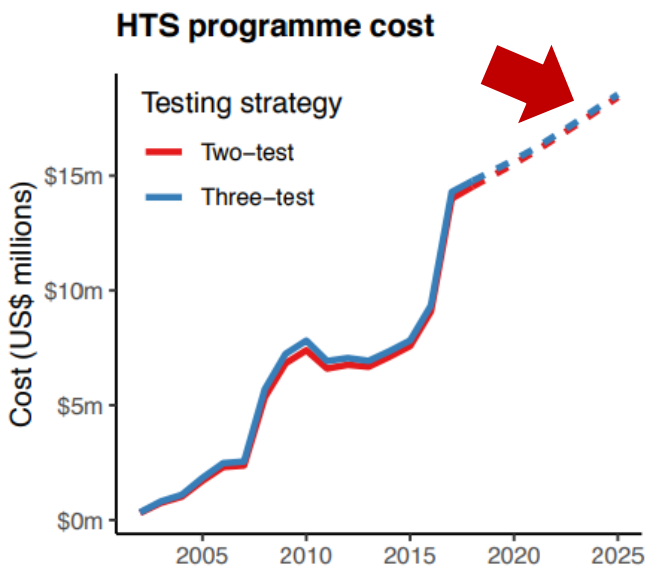
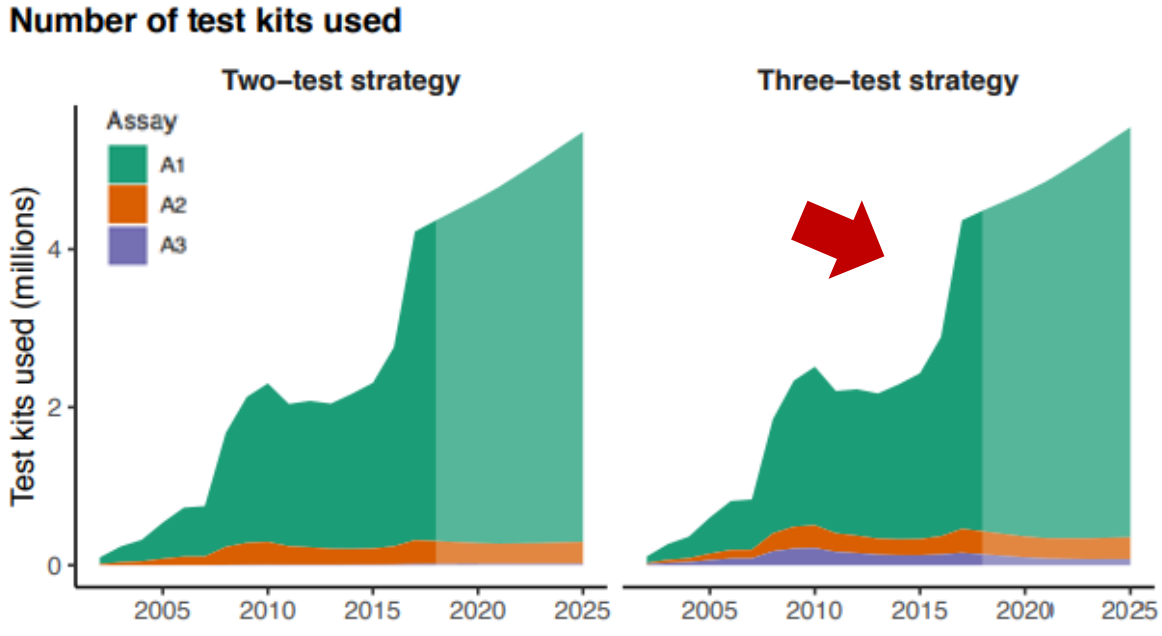
1 Prioritize & Adopt low cost HIV Testing services

Low-cost first test (A1) in algorithm will have greatest impact on savings







3-test strategy remains best buy

- Removing 3rd test does not lead to sufficient savings (cost virtually the same)
- Avoiding misdiagnosis and cost of unnecessary lifelong ART remains critical for countries

Strategic savings by focusing on first test

- Cost of the first test drives HIV testing programme costs
- Changing to low-cost delivery and test kits (A1) will lead to greatest saving

2 Leverage HIV self-test (HIVST) to mitigate limited stock and limited human resources

HIVST could lead to savings if replacing provider testing

- WHO recommends facility-based self-testing (2024)
- HIVST filled important gaps during COVID-19, especially in facilities
- HIVST provides flexibility – enables triage model
- HIVST can fill gaps in work force and save health worker time

Additional adaptations can further enhance savings

- Continue task-sharing testing wherever incomplete
- Revamp delivery to include pay for virtual services, convenience models, private sector, workplace, and pharmacy for population segments and settings where feasible

Source: WHO 2024, WHO 2021, WHO 2023, WHO 2015

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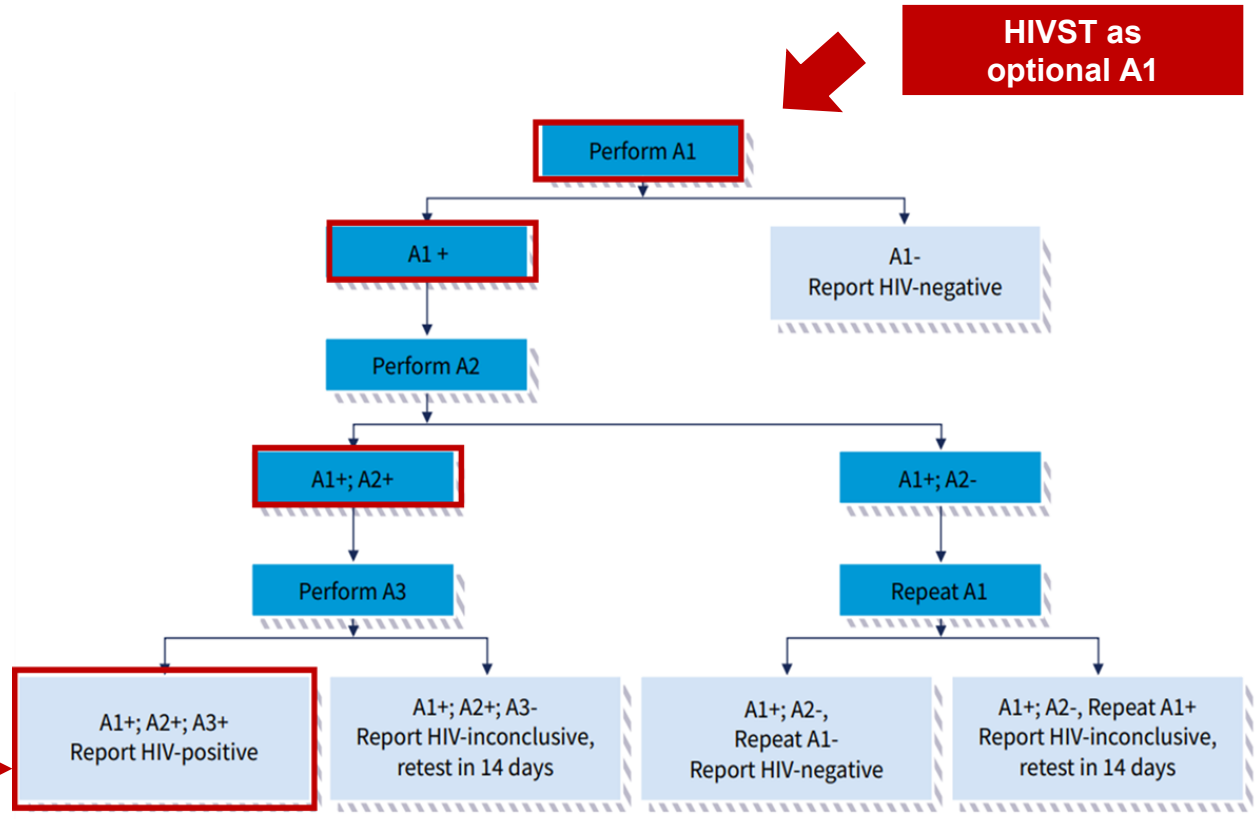
2 Leverage HIV self-test (HIVST) to mitigate limited stock and limited human resources

HIVST is recommended as a "test for triage"

- Countries need flexibilities now due to limited HRH capacity and stock-outs
- When needed (awaiting stock) use HIVST as A1
- Prioritize quality-assured HIVST kits
- Prioritize confirming all reactive self-test results with available A2 and A3 (per WHO 3-test strategy)
- Do not start ART based on a single reactive test
  - Substantial risk of misdiagnosis and unnecessary ART initiation

Adapted HIV testing strategy implementation considerations



A1: Assay 1 (first test); A2: Assay 2 (second test); A3: Assay 3 (third test).

Source: WHO 2024

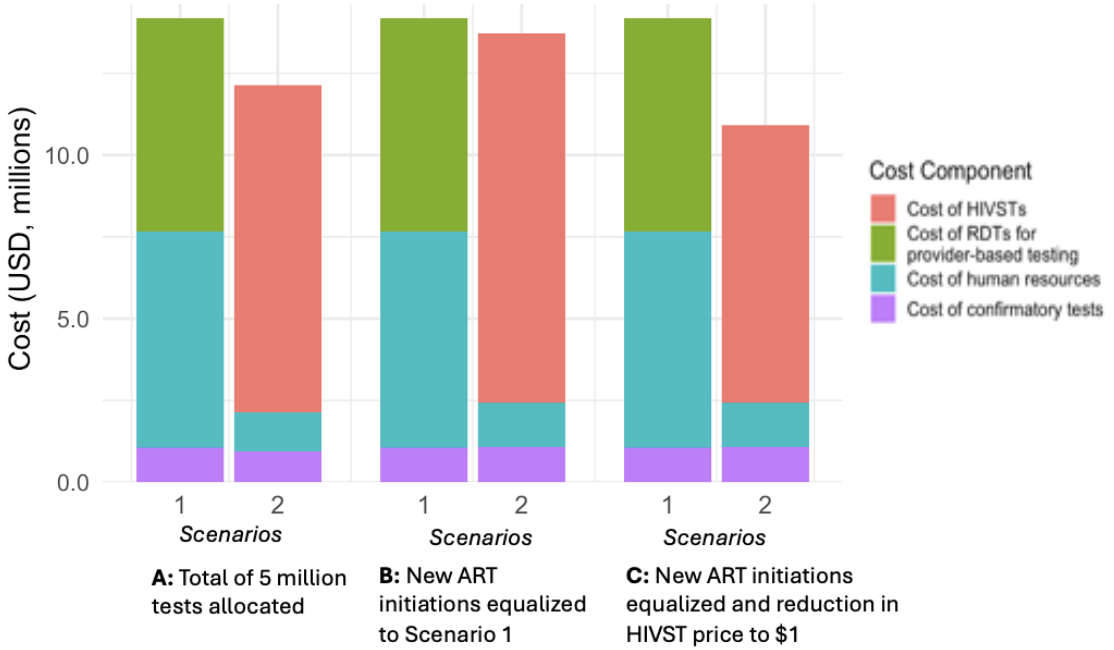
2 Leverage HIV self-test (HIVST) to mitigate limited stock and limited human resources

Modelling on the cost-effectiveness of using HIVST in facilities to fill HRH gaps shows:

- **At least 15% cost-saving – up to 23% savings if using $1 WHO PQ HIVST**
- **Up to 85% reduction in staff-time**
- **If considering local economic impact (putting $$ toward jobs versus commodities)**
  - Return of investment (ROI) is the same at $1.50 but is favorable with high ROI at $1
- **Cost of change and scale-up?**
  - Costs still 1.5–3.0% lower, and total staff-time for testing still falls by 40% and 80% respectively, when considering scale-up costs

Preliminary results

Total cost, by component, of HIVST vs provider-testing scenarios



Country-facing calculator in development for local planning for optimal savings for HRH and HIVST

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Source: WHO 2024, Nichols, Edun, Imai-Eaton, Bernsteyn, Johnson 2025 in preparation; for copy of the country calculator that is in beta-testing email johnsonc@who.int

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Key WHO actions on HIV testing commodities

💰 **Cut costs without cutting quality**

- Stick to the 3-test strategy to avoid misdiagnosis and unnecessary treatment.
- Discontinue other complex and costly testing practices and products (e.g. use simple RDT)
- Focus on adopting lower cost tests: HIV RDTs: ≤ $0.70, Dual HIV/syphilis RDTs: ≤ $0.95, HIV self-tests (HIVST): ≤ $1.50

🚀 **Support rapid country transition**

- Focus on switching out A1 for greatest and most immediate savings
- Use policy waivers to accelerate importation and implementation
- Push industry to fund training and QA/QC in new agreements and tenders.

🤝 **Coordinate for bigger impact in longer-term**

- Share data and experiences with WHO to inform updates to operational guidance
- Work with key partners to increase access to low-cost

🤝 **Support flexibility to maintain testing services**

- Support policies that include the use of HIVST to avoid additional disruption
- Highlight benefits of HIVST: it's flexible, fills staffing gaps, allows private sector use and worked well as critical adaptation during COVID-19

💰 **Optimize resources to maintain testing services**

- Review staffing plans and HIVST data to find right balance based on country needs and gaps due to reduced personnel and testers
- Review and use WHO country calculator (for details contact johnsonc@who.int)
- Share HIVST data with WHO to help update guidance

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3 Additional strategies to support cost-effective HIV testing

- **Task-sharing to trained lay providers and community health workers**, who can provide these services at a low cost and with little infrastructure, per WHO guidance;
- Discontinue the **use of recency assays, western blot/LIA, NAT** (RNA or DNA) for routine HIV testing
  - **Reserve NAT for infant diagnosis** (< 18 months of age);
- **Adopt serial testing algorithms and discontinue parallel testing**, which is more expensive;
- **Streamline quality systems** by using **rapid assessments**, **simplified verification studies** with data collection during or after algorithm transition;
- **Further simplify testing** – such as **HIVST for PEP and PrEP** (initiation, continuation and re-initiation);
- **Utilize virtual platforms and private sector partnerships** (including workplace and pharmacies).

3 Additional strategies to support cost-effective HIV testing

Pharmacy-based testing and self-care can be cost-effective

Sustaining Progress in HIV in Africa Through Enabling of Self-Care: Model-Predicted Effects of Local Free Provision of HIV Self-Tests and Antiretroviral Drugs

24 Pages • Posted: 28 May 2025

Andrew N. Phillips
University College London - Institute for Global Health

Kenly Sikwese
African Community Advisory Board

More...

Abstract

Background: The acute funding crisis for HIV services means that innovative strategies are needed. We mode test/ARV access, including the provision of free HIV se PrEP (pre-exposure prophylaxis) and TLD (tenofovir-la pharmacies/communities to enable self-care, compare

Methods: We used an established individual-based mo setting-scenarios representing diversity in setting char Informed by studies of barriers to accessing clinics, co is assumed to lead to an increase in testing (from med per 3 months to 12.6% (6.8% - 21.1%)) and modest in +2.2%)) and in retention on ART for people with diagn

Findings: The assumed effects of the policy on PrEP/PI result in a median 19% (3% - 35%) lower number of H incidence over 10 years. Overall, the policy is predicted to be cost-effective at a cost effectiveness threshold of

Interpretation: Introduction of community self-test/AR for prevention and treatment is very likely to be cost-e incidence declines to be sustained at reduced cost. Pol health worker organisations leaders who wish to consi their own country settings.

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EPIDEMIOLOGY AND SOCIAL

Estimated cost-effectiveness of point-of-care testing in community pharmacies vs. self-testing and standard laboratory testing for HIV

Mital, Shweta[a]; Kelly, Deborah[b]; Hughes, Christine[c]; Nosyk, Bohdan[d]; Thavorn, Kednapa[e]; Nguyen, Hai V.[b]

Author Information

AIDS 37(7):p 1125-1135, June 1, 2023. | *DOI:* 10.1097/QAD.0000000000003526

BUY SDC

Abstract

Objective:

Point-of-care-testing (POCT) for HIV at community pharmacies can enhance care linkage compared with self-tests and increase testing uptake relative to standard lab testing. While the higher test uptake may increase testing costs, timely diagnosis and treatment can reduce downstream HIV treatment costs and improve health outcomes. This study provides the first evidence on the cost-effectiveness of pharmacist-led POCT vs. HIV self-testing and standard lab testing.

Design:

Dynamic transmission model

Methods:

We compared three HIV testing strategies: POCT at community pharmacies; self-testing using HIV self-test kits; and standard lab testing. Analyses were conducted from the Canadian health system perspective over a 30-year time horizon for all individuals aged 15–64 years in Canada. Costs were measured in 2021 Canadian dollars and effectiveness was captured using quality-adjusted life-years (QALYs).

Results:

Compared with standard lab testing, POCT at community pharmacies would save $885 million in testing costs over 30 years. Though antiretroviral treatment costs would increase by $190 million

- Pharmacy-based testing and self-testing can reach those missed by existing services
- Recent modelling across regions shows pharmacy-based testing can be highly cost-effective compared to standard lab-based options
  - In Africa, broader pharmacy-based HIV self-care (including self-testing) could cut programme costs by 7% and avert DALYS and to be cost-effective at a cost effectiveness threshold of $300 per DALY

Source: Phillips 2025; Mital 2023.

4 Prioritize populations for HIV testing when resources are limited

- Focus on **facility-based HIV testing** along with ensuring easy access and availability of **HIVST.**
- Populations to be prioritized for testing are:
  - **Sexually active adults and adolescents** (15+) with HIV-related symptoms or risks, including key populations, at any clinic/hospital;
  - **Sick children in high HIV burden** (≥5% HIV prevalence) at any clinic/hospital;
  - **Pregnant women at first antenatal visit**, or catch-up testing at earliest possible time if missed (if feasible use dual HIV/syphilis RDT)
  - **HIV-exposed infants at 6 weeks and at 6–9 months** if breastfeeding;
  - **Individuals with TB, HCV and STI co-infection** (tailored based on HIV/TB burden);
  - **Sexual and injecting partners, and biological children**, of newly diagnosed PLHIV;
  - **Network-based testing for individuals from key populations** or other risk networks.

5 timize HIV retesting strategies to improve efficiency and impact

- **Discontinuing general "window period"** testing (3.g. every 3-months);
- **Stopping general and high frequency maternal retesting** as it is not cost-effective, particularly in low HIV burden settings;
  - Reserving maternal retesting to only high HIV burden settings (≥5% HIV prevalence) or women is from a key population;
  - Implementing only one additional test after 1st ANC visit during the third trimester/labour and delivery (and if missed, one catch-up test can be considered);
- **Stopping quarterly retesting for all key populations** and focusing on annual or biannual testing if resources are available;
- **Focusing on annual or less frequent re-testing of sexually active people** in high HIV prevalence settings (>5% HIV prevalence);
- **Continuing retesting as part of reengagement in care** among people with HIV who have fallen out of care may continue as it is a simple and affordable welcome back service that supports the treatment programme.

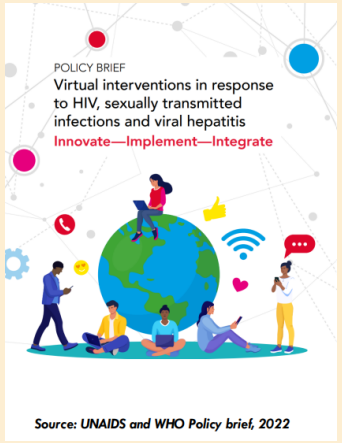
6 Adapt community-based testing services in response to funding constraints and changing feasibility

Where community testing is no longer feasible, programmes should consider:

- **Network-based HIV testing strategies focused specifically on key and high-risk populations** outside of healthcare facilities.

Implement **strategies tailored to local needs and priorities,** such as:

- Collaborating with community stakeholders to **plan periodic (1 to 3 years) outreach testing activities** based on latest epidemiology;

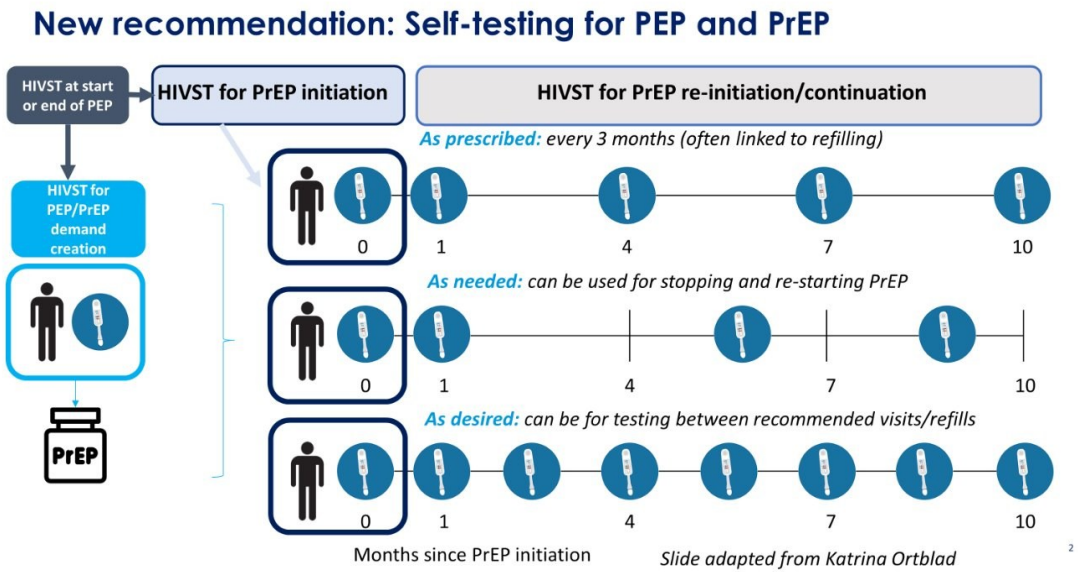


- Offering **workplace testing for men in high-risk industries** through financing and partnerships with the private sector;
- Promoting **virtual service delivery and expand HIVST** access through pharmacies and user-paid delivery options.

7

- **For PEP, oral PrEP and the dapivirine vaginal ring: Use RDTs and/or HIVST,** including for initiation, continuation, and re-initiation;
- **Testing time points should also be aligned** to the most feasible and affordable option **according to refill or injection visit schedule,** as well as the PrEP service delivery approach used, e.g. **multi-month dispensing, TelePrEP**.

Source: WHO 2024, WHO 2024



Source: Consolidated guidelines on differentiated HIV testing services

Long-acting PrEP new upcoming recommendation

Rapid diagnostic tests may be used for HIV testing for Initiation, continuation and discontinuation of long-acting PrEP.
(strong recommendation, very low certainty of evidence).

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8

Maintain HIV screening protocols for blood donations

- **WHO recommends systematic screening of all blood donations for HIV, as well as hepatitis B, hepatitis C, and syphilis among others**, before use in clinical care.
- This is generally a high impact investment and should be maintained.

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WEBINAR SERIES

TEST. ADAPT. DELIVER.
HIV Testing Services in a Shifting Landscape

Navigating change, driving innovation and delivering impact in HIV testing services and beyond.

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HIV testing services are in crisis due to funding reductions, with rapid funding shifts prompting changes and interruptions in service delivery. Ensuring testing services remain accessible is critical to sustaining HIV treatment and prevention outcomes. More than ever, evidence-based guidance is critical to the prioritization, focusing, and planning of services across countries and regions.

This webinar series presents the latest evidence-based innovations, tools, and guidance in HIV testing services. It features experts sharing global guidance, country implementation experiences, practical toolkits, and strategies for maintaining quality and access in a rapidly evolving landscape. Topics include HIV testing in pregnancy, virtual-space interventions, self-testing, network-based approaches, and testing in prevention. Whether a policymaker, implementer, or researcher, this series offers valuable insights to strengthen HIV responses worldwide.

Each session will be conducted with simultaneous interpretation in English and in French.

DATE & TIME	SESSION
May 12, 2025 12:30 pm - 2 pm CAT/CET	**Prioritizing High-Quality, Low-Cost Diagnostics to Sustain HIV Testing Services**
May 15, 2025 2 pm – 3:30 pm CAT/CET	**Elimination: Maximizing the Impact of HIV Testing for Pregnant and Postpartum Women**
June 12, 2025 2 pm – 3:30 pm CAT/CET	**Operationalizing Facility-Based HIV Self-Testing: Launch of the Implementation Toolkit and Training Modules**
June 26, 2025 2 pm – 3:30 pm CAT/CET	**Launching of Budgeting and Resource Planning Guidance for Implementing Virtual Interventions as Part of HIV Responses**
July 9, 2025 2 pm – 3:30 pm CAT/CET	**Closing the Gaps: Launch of a Network-Based Testing Toolkit to Expand HIV, Hepatitis, and STI Testing Reach**
August 7, 2025 2 pm – 3:30 pm CAT/CET	**Innovating with HIV Self-Testing for Impact in Southern Africa: Lessons Learned from the STAR (Self-Testing Africa) Initiative**
September 4, 2025 2 pm – 3:30 pm CAT/CET	**Supporting PrEP Access: HIV Self-Testing in Uptake and Scale-Up**
October 9, 2025 2 pm – 3:30 pm CAT/CET	**Advancing Testing Quality: Launch of the WHO Management System Toolkit for Non-Laboratory Settings**
November 13, 2025 2 pm – 3:30 pm CAT/CET	**Delivering HIV Testing Services in a Changing Environment: Planning, Prioritization, and Maintaining Access**

For more information about this webinar series, visit our webpage.

Save the date!

- More content available and coming soon
- More WHO webinars on strategic adaptations for efficiency and savings for HIV testing
  - Register here
- **Need more support?**
  - Connect with the testing team
    - johnsonc@who.int
    - msimangaradebeb@who.int
    - barrdichiaram@who.int
    - baptistac@who.int

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Acknowledgements

WHO HQ

Global HIV, Hepatitis, STI - TPP

HTS Team

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WHO catalogue prices, May 2025

No.	Product name	Manufacturer	Clinical Sensitivity (%)	Clinical Specificity (%)	Price per test
1	MERISCREEN HIV 1-2 WB	Meril Diagnostics Pvt. Ltd.	99.4	99.9	US$ 0,74
2	STANDARD Q HIV 1/2 Ab 3-Line Test	SD Biosensor, Inc	100	99.3	US$ 0.72
3	First Response HIV 1-2.O Card test (Version 2.0)	Premier Medical Corporation Private Limited	100	100	US$ 0,75
4	ONE STEP Anti-HIV (1&2) Test	InTec PRODUCTS, INC	100	100	US$ 0.55
5	One Step HIV1/2 Whole Blood/Serum/Plasma Test	Guangzhou Wondfo Biotech Co., Ltd	100	100	US$ 0.68
6	Genie Fast HIV 1/2	Bio-Rad	100	98.5	EUR 1.2
7	Diagnostic kit for HIV (1+2) antibody (colloidal gold) V2	Shanghai Kehua Bio-engineering Co., Ltd	100	100	US$ 0.70
8	Determine HIV Early Detect	Abbott Diagnositcs Medical Co. Ltd.	100	99.4	US$ 0.9
9	DPP HIV 1/2 Assay	Chembio Diagnostic Systems Inc.	100	99.9	US$ 2.75
10	OraQuick HIV 1/2 Rapid Antibody Test	OraSure Technologies, Inc.	99.1	99.8	US$ 3.0
11	Rapid Test for Antibody to HIV (Colloidal Gold Device)	Beijing Wantai Biological Pharmacy Enterprise Co.	100	98.5	US$ 0,53
12	SURE CHECK HIV 1/2 Assay	Chembio Diagnostic Systems Inc.	99.8	99.9	US$ 2.1
13	ABON HIV 1/2/O Tri-Line HIV Rapid Test Device	ABON Biopharm (Hangzhou) Co. Ltd.	100	99.7	US$ 0.71
14	INSTI HIV-1/HIV-2 Antibody Test	BioLytical Laboratories, Inc.	100	99.7	US$ 2,79
15	Bioline HIV-1/2 3.0	Abbott Diagnostics Korea Inc	100	99.7	US$ 0.82
16	Uni-Gold HIV	Trinity Biotech Manufacturing Ltd.	99.8	99.9	EUR 0.71
17	HIV 1/2 STAT-PAK	Chembio Diagnostic Systems Inc.	99.5	100	US$ 1.2
18	Determine HIV-1/2	Abbott Diagnositcs Medical Co. Ltd.	100	98.9	USD$ 0.90
19	Geenius HIV 1/2 Confirmatory Assay	Bio-Rad	100	97.3	EUR 17.5
20	TrinScreen HIV	Trinity Biotech Manufacturing Ltd.	100	100	USD$ 0.75
21	Panbio HIV	Abbott Rapid Diagnostics Jena GmbH	100	99,7	US$ 1,2

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Source: WHO catalogue 2025; WHO tool kit 2021

Key background and terminology

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What is a quality-assured HIV test?

- **Test shown to meet performance and quality standards** by a recognized and responsible regulatory authority and/or WHO prequalification
- **Test meets minimum international standards**
  - Minimum 99% sensitivity and 98% specificity
  - Can be used together to achieve ≥99% positive predictive value
- **Additional resources**
  - **WHO PQ Reports:** https://extranet.who.int/prequal/vitro-diagnostics/prequalification-reports
  - **WHO PQ TSS**: https://iris.who.int/bitstream/handle/10665/341653/9789240020801-eng.pdf
  - **Global Fund QA Policy for IVDs**: https://www.theglobalfund.org/media/hc5hxug2/psm_qa-medical-devices_policy_en.pdf
  - **GHTF**: https://www.imdrf.org/sites/default/files/docs/ghtf/final/sg1/procedural-docs/ghtf-sg1-n045-2008-principles-ivd-medical-devices-classification-080219.pdf
  - **IMDRF**: https://www.imdrf.org/

What does A1, A2, A3 mean?

- **A1 = First test in testing strategy and algorithm**
  - These tests are optimized for sensitivity to ensure they detect a high number of people with HIV
  - These tests “rule in” potential infection
  - After A1, confirmatory testing is essential
- **A2/A3= Second and third test in testing strategy and algorithm**
  - These tests are optimized for specificity to ensure that the people diagnosed truly have an HIV infection
  - These tests “rule out” HIV infection
  - 3-tests have been shown to be needed based on current HIV epidemic to achieve minimum positive predictive value for all people being tested
- **Additional resource**
  - WHO 2024: https://www.who.int/publications/i/item/9789240096394