The role of HIVST in protecting access to testing

Evidence and experience from implementation to-date

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HIV testing is the lynchpin of the HIV response, critical for treatment, prevention, and long-term sustainability

Closing remaining gaps in the HIV response and sustaining progress will require **rapid initiation and re-engagement** onto treatment and **scale-up of prevention. <u>All of these require HTS</u>.**

- **Testing drives time to diagnosis**
  - Critical for individual client health and prevention of AHD, and prevention of onward transmission

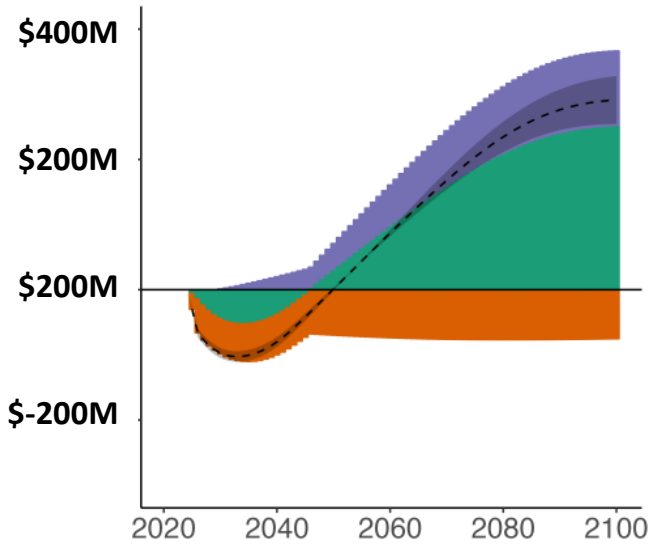
    ↓ 50% in HTS

    ↑ 2x average time to diagnosis[1]

- **Testing is the gateway to prevention**
  - Enables identification of clients at ongoing risk, linkage to appropriate services, and monitoring
  - Without reliable access to testing, prevention goals—including scale-up of new biomedical options like LEN—are at risk

Future HIV program costs with 80% reduction in HTS

South Africa, modelled[2]



In addition to higher long-term costs, over 50 years:

+ 2.5M infections (64%)

+795K deaths (46%)

1. https://cquin.icap.columbia.edu/wp-content/uploads/2024/07/Imai-Eaton_CQUIN_hts-to-sustain-epidemic-control_2024-07-11_FINAL-1.pdf
2. https://www.medrxiv.org/content/10.1101/2023.12.19.23300231v1.full.pdf

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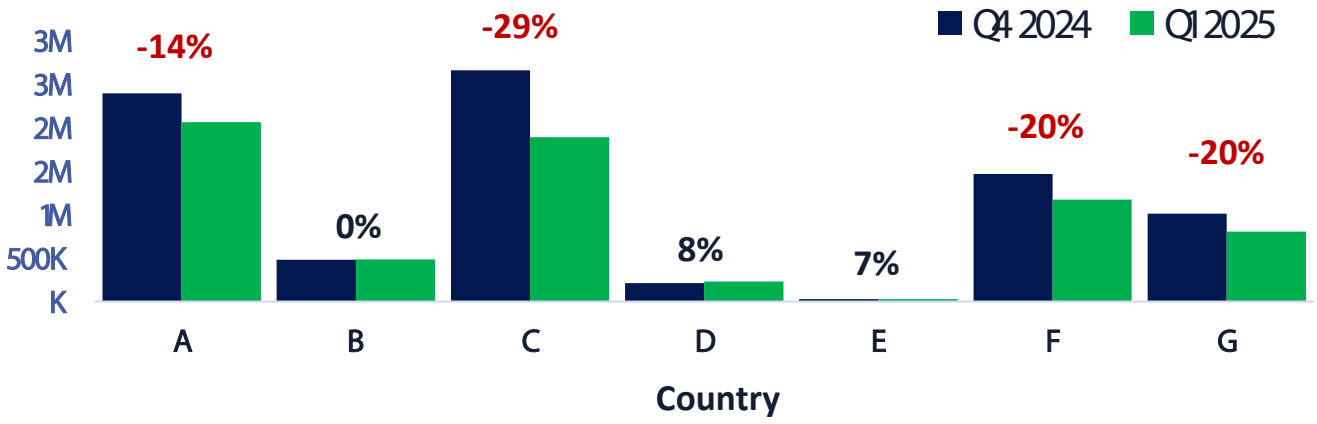
We are at a pivotal moment to protect access to HTS, and HIVST will be a critical tool to protect access to testing in a dramatically reduced funding context

The PEPFAR stop-work-order and subsequent disruptions had immediate, dramatic impact on HTS across countries.



- **<u>Testing fell 7-29% in Q1</u>**[1] 2025 across 7 countries in SSA
- Rebounded significantly in Q2, but it is still **<u>8.4% below 2024</u>**[2] averages
- Reflects high dependence on partner-supported cadres for HTS delivery
- Direct impact on treatment and prevention

HIVST can mitigate immediate disruptions, and also support longer-term transition to more sustainable, self-directed models of care.

✓ Dramatically reduces HCW burden, critical as Ministry cadres absorb partner-supported service delivery

✓ Introduces efficiencies and savings with lower-priced blood-based products

Presentation will highlight evidence and experience on:

1) Programmatic impact
2) High-quality, low cost products
3) Operationalizing HIVST in the context of integration

1. CHAI Market Impact Memo, July 2025. https://www.clintonhealthaccess.org/wp-content/uploads/2025/07/2025-Q2-CHAI-HIV-Market-Impact-Memo.pdf
2. CHAI Market Impact Memo, Nov. 2025. *Forthcoming*.

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Evidence and experience from a number of countries show that HIVST increases testing uptake and introduces savings and operational efficiencies

HIVST can drive key programmatic outcomes

Increased uptake, including among key and priority populations

- In Malawi, HIVST in OPD drove 3x increase in testing, including among men and young people[1]

High rates of linkage to Tx

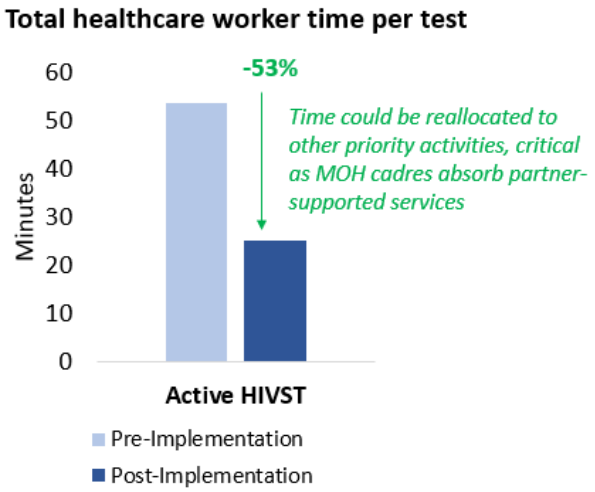
- A pilot of HIVST distribution in OPD and PNC in Uganda showed no difference in linkage to ART from HIVST and professional testing[2]
- Modelling from Kenya showed an additional 6.7 ART initiations for every 100 HIVST distributed[3]

Efficient, client-centered PrEP delivery[4]

- Decreases burden of facility visits for clients and HCW
- Can increase PrEP uptake, is acceptable, and often preferable

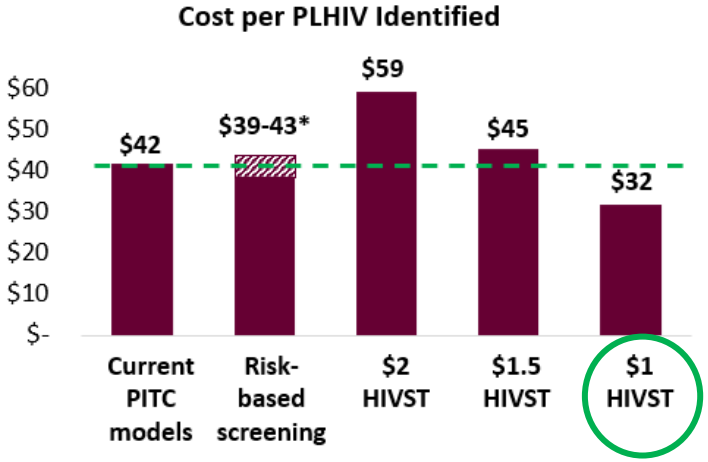
1. https://pubmed.ncbi.nlm.nih.gov/31981557/
2. Nichols, B., et al. (2025, July 13). **HIV self-testing and PrEP services** [Conference presentation]. *IAS 2025*
3. https://www.who.int/publications/i/item/9789240053694

And introduce urgently needed efficiencies and savings*



Same pilot in Malawi found HIVST distribution dramatically reduced HCW time required for testing

Modeling with data from both Malawi and Uganda shows that with a $1 HIVST, cost per PLHIV is lower than existing testing service delivery and with screening tools.



Two WHO PQ'd HIVST are $1 or less

** Sources and modelling assumptions are on the meeting resource page.*

To realize these gains, it will be critical to adopt lower priced products, which demonstrate high performance, useability, and acceptability

There are two WHO PQ'd blood-based HIVST products ≤ $1, which will allow countries to significantly increase HIVST procurement within constrained budgets, while increasing client choice and uptake.

Studies* in Malawi, Nigeria, Uganda, and Zambia assessed the usability and acceptability of a $1 blood-based HIVST, with overwhelmingly positive results

Key takeaways

- ✓ **Easy to use :** 90-99% of clients reported it easy or very easy to use (*all*)
- ✓ **Accessible across education levels:** no significant difference in ease of usability by education level (*assessed in Mw and Zam)*
- ✓ **Highly acceptable to clients and HCW:**
  - ✓ 98-100% of clients would recommend the product to a friend (*all*)
  - ✓ 100% of HCW willing to recommend to clients (*Mw*)
- ✓ **High linkage to treatment rates:** 92-95%, comparable to standard RDT (*assessed in Ug, Ng*)
- ✓ **Reaches first time, and hard-to-reach testers:** In Zambia, 58% of users were men, 78% were between 16-35 yrs, and 17% had never tested before

** Non-exhaustive, highlighting key results. Full results are shared on the conference resource page.*

Uganda is leveraging facility-based HIVST (FBHIVST) as a tool for rapid integration of HIV services

- In response to stop work order, Uganda accelerated integration of HIV services into OPD and chronic care
- Dramatically increased HCW roles, with major operational questions around how to absorb HIV services
- FBHIVST is part of HTS policy, but not yet operationalized at scale

Ministry leveraged site-level mentorship visits to quickly activate of FBHIVST in 150 high-volume sites

Successes

- HCWs expressed clear interest and need for HIVST to manage workload
- Feasible to operationalize at multiple entry points including OPD, PNC, chronic care
- Clear demand for oral and blood-based products
- Rapidly increased uptake – 109% of target
- Maintained high linkage rates of 98%

Challenges

- 75% of facilities with stockouts of at least one product, due to delayed ordering or lack of awareness of new blood-based products
- Gaps in HCW capacity, especially for staff newly absorbing HIV services
- Poor documentation, with data discrepancies between registers and HMIS

Early implementation in Uganda highlighted key lessons and operational considerations for scale-up across countries

Offer choice: 79% of facilities reported demand for multiple HIVST types

- Aligns with evidence from literature that preference between blood-based and oral HIVST is mixed and that **offering both can increase uptake of HTS**
- *How can network countries leverage existing evidence to introduce lower priced blood-based products?*

Strengthen supply chain systems to manage multiple products

- Most countries only have experience managing one BBHIVST product, and need to adapt tools and approaches
- Uganda moved to a push system to better align supply with consumption, and encourage facility uptake of new products

Facility-level focal point and action plans can create ownership to drive implementation

- Can help address facility-specific operational bottlenecks, like space and client flow
- May be particularly critical as different cadres newly absorb previously partner-supported services

Rapid upskilling of HCW with ongoing mentorship, including for reporting

- Also critical for staff newly responsible for HIV services
- *Given limited resources, how can countries leverage low-cost digital tools and training platforms?*

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Thank You