Elimination: Maximizing the Impact of HIV Testing for Pregnant and Postpartum Women

Test. Adapt. Deliver. - Webinar Series

15th May 2025

Testing, Prevention, and Populations Unit
Global HIV, Hepatitis and STI Department

World Health Organization

Population Services International

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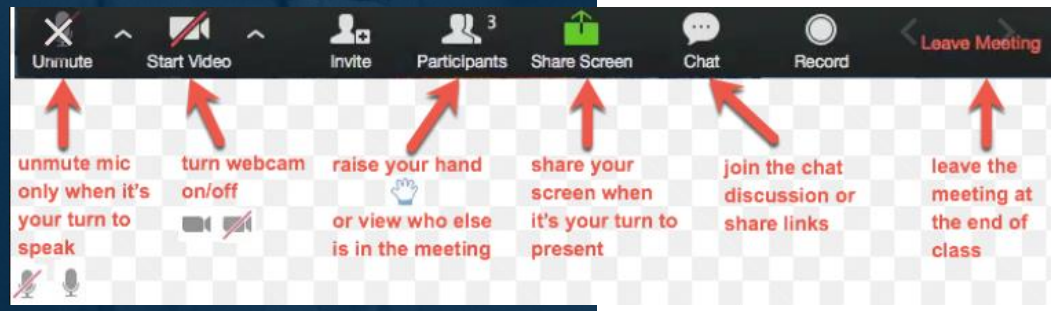

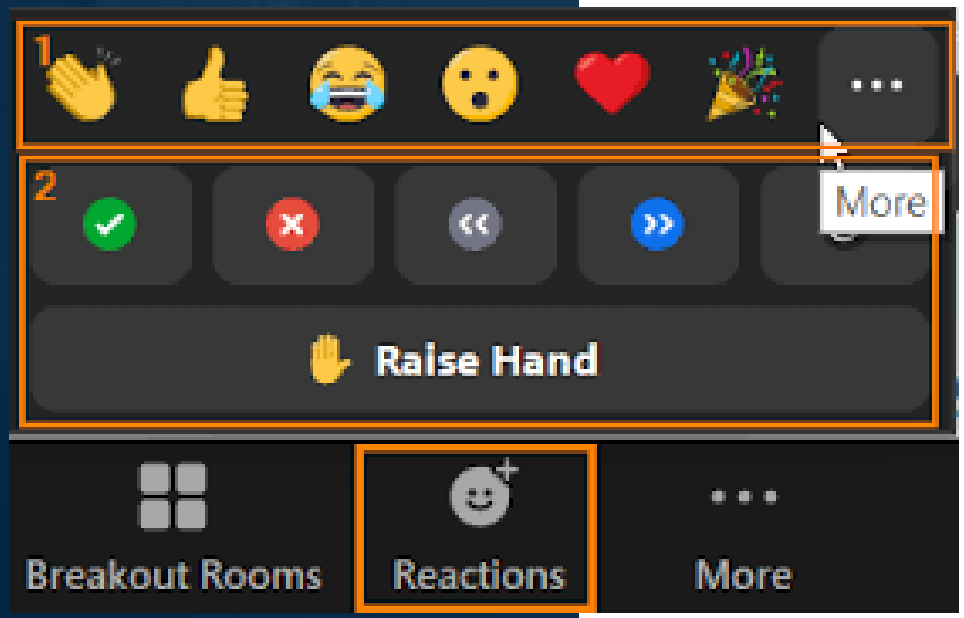

Introduce yourself

- Say hi in chat and update your name (name, country and affiliation)
- We will record for note keeping and sharing content internally.
- Slides will be shared after webinar.
- Translation options in English and French—click "Interpretation"

We want to hear from you – but time is limited

- Ask questions ask in the Q&A or chat – or raise your hand
- Be concise and provide space for others to share and talk
- Stay muted and keep videos off unless presenting and speaking
- No AI bots for notetaking allowed

We are available for further follow-up

- Magdalena Barr-DiChiara: barrdichiaram@who.int
- Aliza Monroe-Wise: monroewisea@who.int

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Webinar objectives

1. Review WHO guidance and adaptations on HIV testing for pregnant and postpartum women and their partners in 4 major areas:

- Early maternal testing and catch-up testing
- Retesting in third trimester and/or during breastfeeding
- Linkage to ART or PrEP
- Network-based testing services

2. Highlight implementation of different aspects of WHO guidance from different countries

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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
  - Next webinar is on June 12 (facility-based HIVST)
  - Register here
- WHO operational guidance coming end-May 2025
- **Need more support?**
  - Connect with the testing team
    - johnsonc@who.int

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Today's programme

Time	Session	Presenter
14:00 - 14:05	**Welcome Remarks**	Moderator: Morkor Newman Owiredu, WHO
14:05 – 14:20	**Setting the Scene: HIV Testing Services in Pregnant and Postpartum Women** **Maternal HIV Retesting in high and low burden settings: Too much or not enough?**	Magdalena Barr-DiChiara, WHO Alison Drake, University of Washington
14:20 – 14:30	**Strengthening Third Trimester Maternal HIV Retesting Using HIVST in Nigeria**	Oluwakemi Sowale, CHAI Nigeria
14:30 – 14:40	**Stratégie de dépistage maternel du VIH et VHB de routine lors de l'accouchement à Abidjan, Côte d'Ivoire: Projet DEPISTNEO**	Amorissani Folquet Madeleine, UFRSM Abidjan Côte d'Ivoire (UFHB)
14:40 – 14:50	**Integrating PrEP into Maternal Health: Advancing HIV Prevention for Pregnant and Breastfeeding Women in Zimbabwe**	Idah Moyo, MOHCC Zimbabwe
14:50– 15:00	**Bridging the Gap in Partner Testing: HIV Self-Test Distribution Through Pregnant and Postpartum Women**	Karin Hatzold, PSI
15:00– 15: 25	**Q &A**	Karin Hatzold (PSI), Stephanie Dowling (CHAI)
15:25 – 15: 30	**Key messages and closing**	Aliza Monroe-Wise, WHO

Setting the Scene: HIV Testing Services for Pregnant and Postpartum Women

Magdalena Barr-DiChiara
HIV, Hepatitis, and STI Department
World Health Organization

1. Background
2. WHO guidance
3. Optimizing services during scarcity

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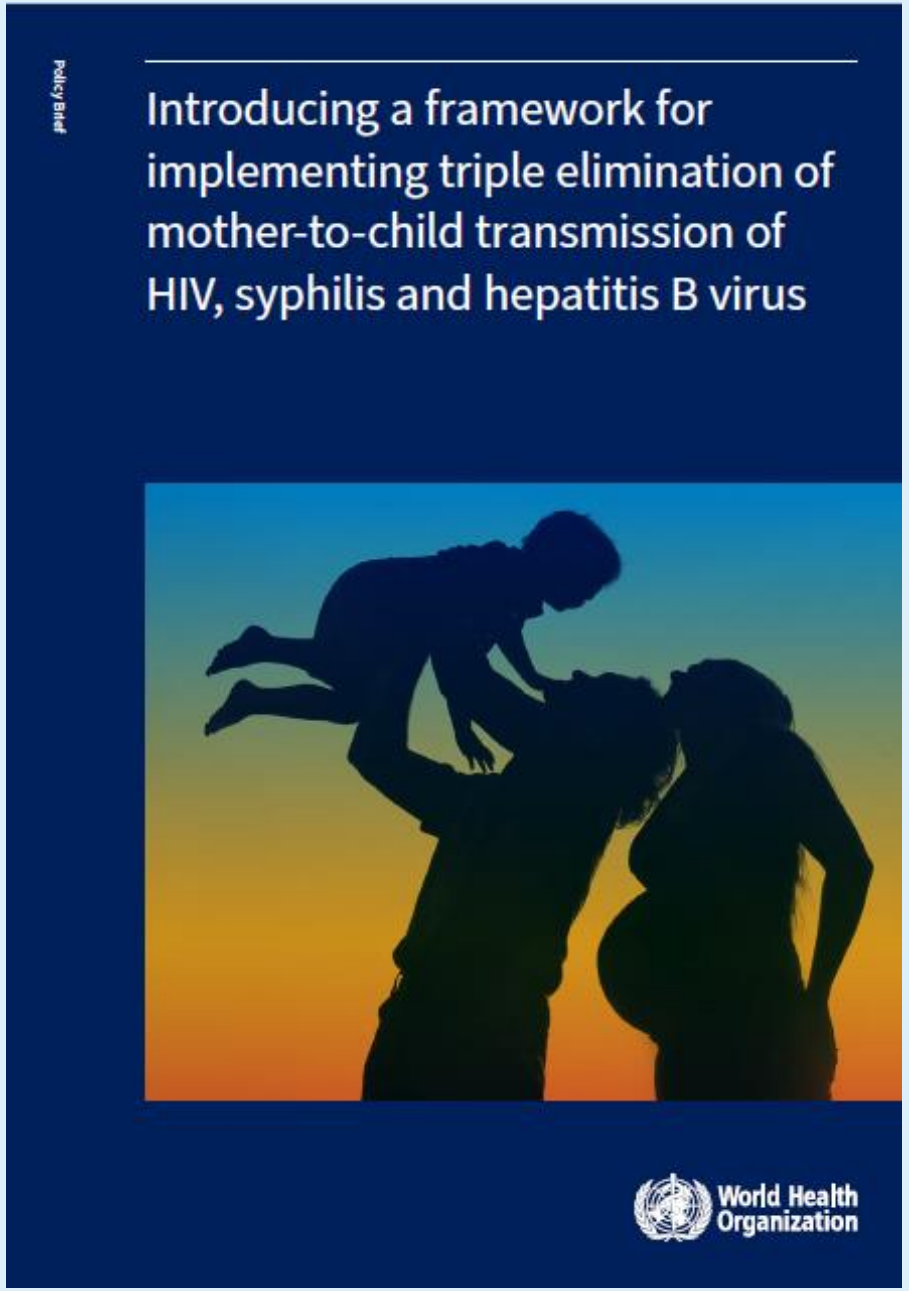
Triple Elimination Framework: 2024

- In light of recent funding cuts, integrating service delivery to achieve shared goals is more important than ever
- In many country programmes, investment in testing treatment and prevention services is less impacted
- Triple elimination of vertical transmission (EVT) of HIV, syphilis, and hepatitis B is a global priority
- ***Elimination of vertical transmission of HIV is a critical backbone on which to build the triple elimination platform***



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WHO Guidance

The four main components of testing services needed to achieve EMTCT are:

Early maternal testing and catch-up testing

Ensuring every pregnant woman is tested at first antenatal care (ANC) visit for HIV, syphilis and hepatitis B. Providing catch-up testing whenever a testing opportunity is missed, for pregnant or breastfeeding persons of unknown HIV status.

Retesting in third trimester and/or during breastfeeding

Strengthening maternal retesting in the third trimester and during breastfeeding to maximize prevention of new infant infections in high-burden settings and for key populations.

Linkage to ART or PrEP

Engaging pregnant and breastfeeding women in HIV prevention and care, including ART and PrEP as needed.

Network-based testing services

Expanding access to partner services, social network testing, and family testing through innovative testing strategies (e.g., self-testing) and enhancing male engagement in ANC.

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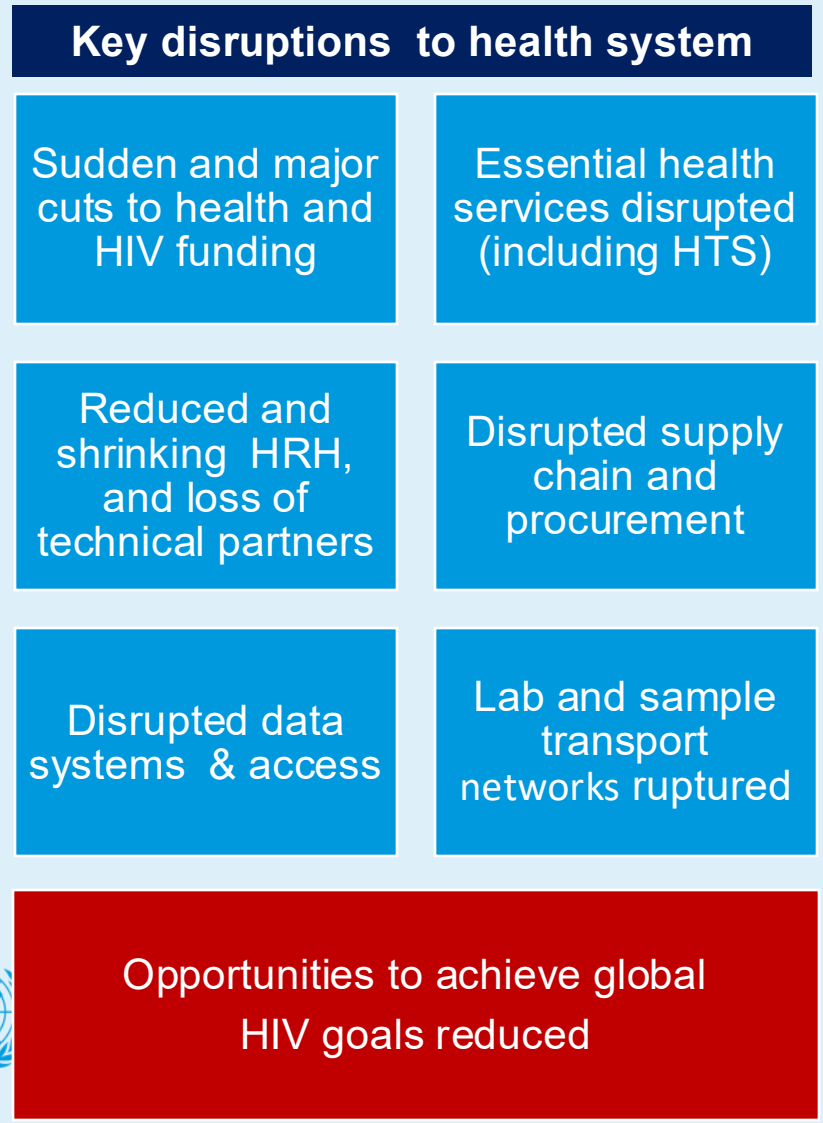
Reduced funding and policy shifts impact HIV services



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
- **More webinars and content coming**

WHO Guidance and adaptations

Guidance	Adaptations
Early maternal testing and catch-up	• Use **low-cost** quality assured A1 testing commodities and streamlined service delivery • Focus on **high coverage of ANC-1 testing** • **Fill gaps** with new testing modalities and approaches: use self-testing where workforce constraints limit ability to deliver HIV and syphilis testing to pregnant women at high coverage • **Mitigate supply interruptions** with appropriate available diagnostic products: *when* there are stock-outs of dual HIV/syphilis RDT, use syphilis and HIV RDTs, lab-based syphilis tests
Retesting in high burden settings	• Limit retesting, use geographical targeting
Linkage to ART and PrEP	• Build on established ANC integration to ensure provision of ART for PW • PrEP for pregnant women remains supported by PEPFAR in some settings
Network-based testing services	• **Adapt partner testing approaches:** when resource constraints prohibit implementation of provider delivered partner services methods, use secondary distribution of HIVST

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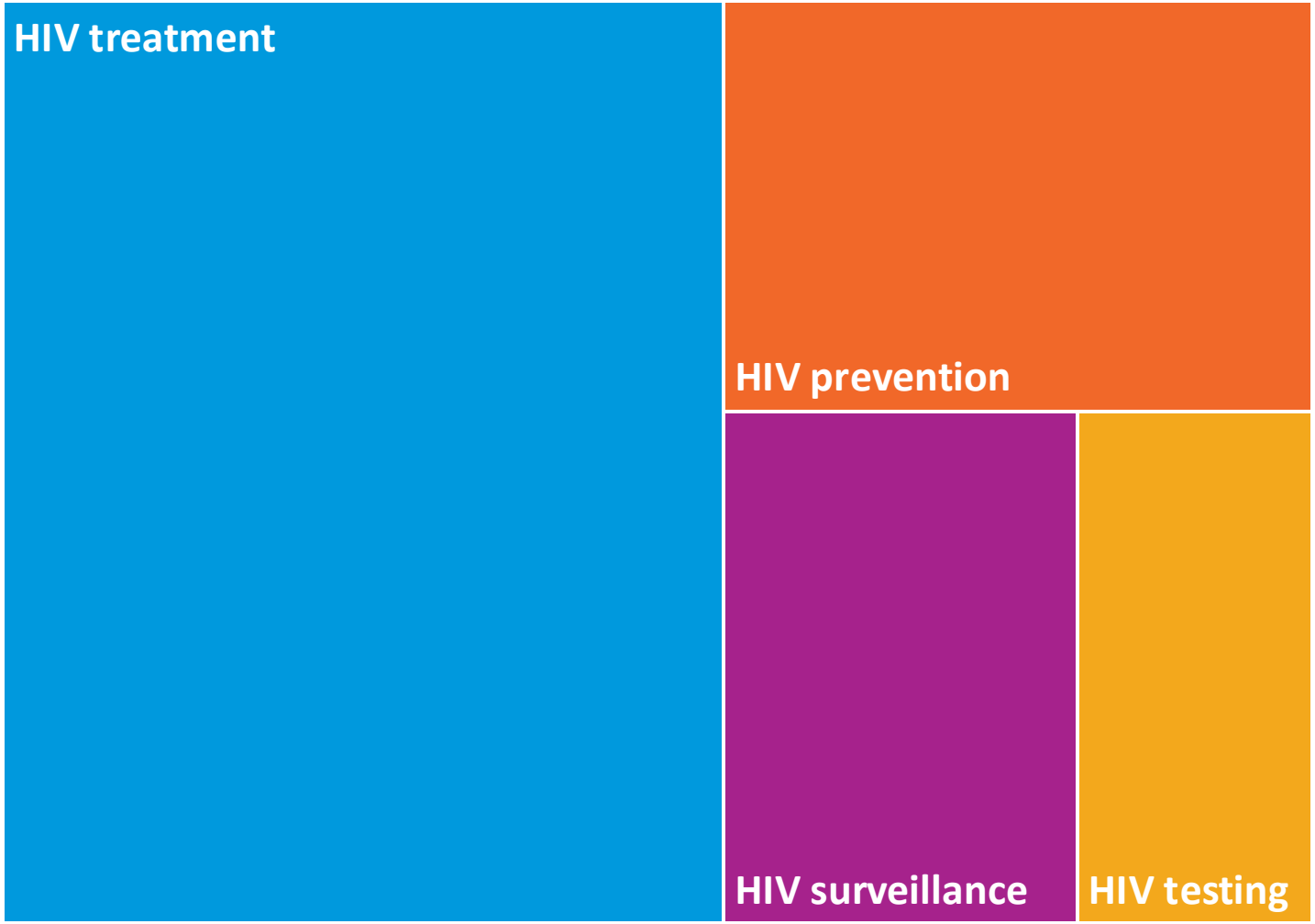
Understanding HIV programme costs



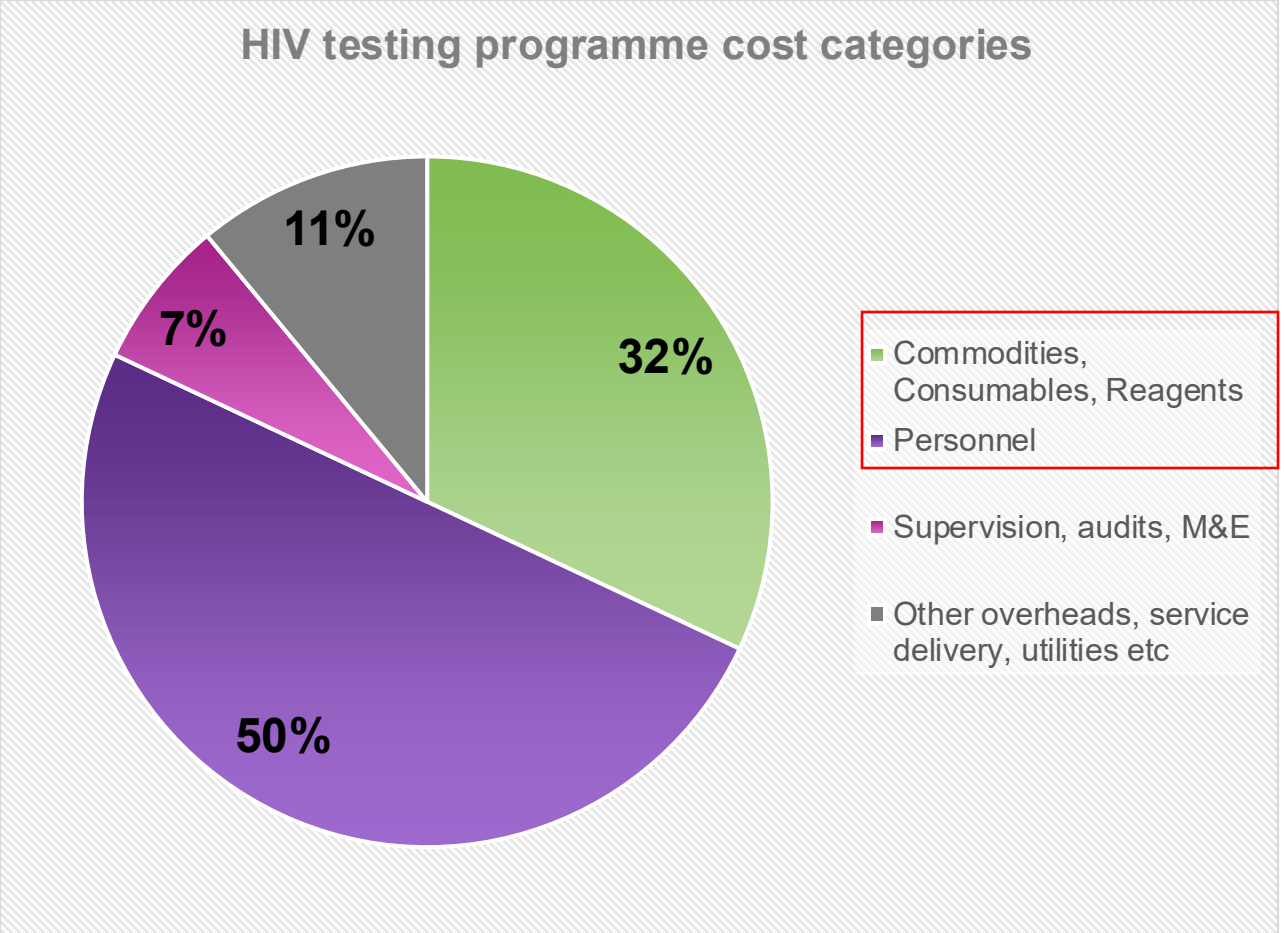
HIV testing is generally <10% of previous national HIV budgets*

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

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

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

Understanding HIV testing costs



+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

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*This represents much of large procurers and donor resources not direct procurement figures from EIC/WHO report 2024.

Graph is illustrative and adapted from Vyas et al 2020 https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05446-5

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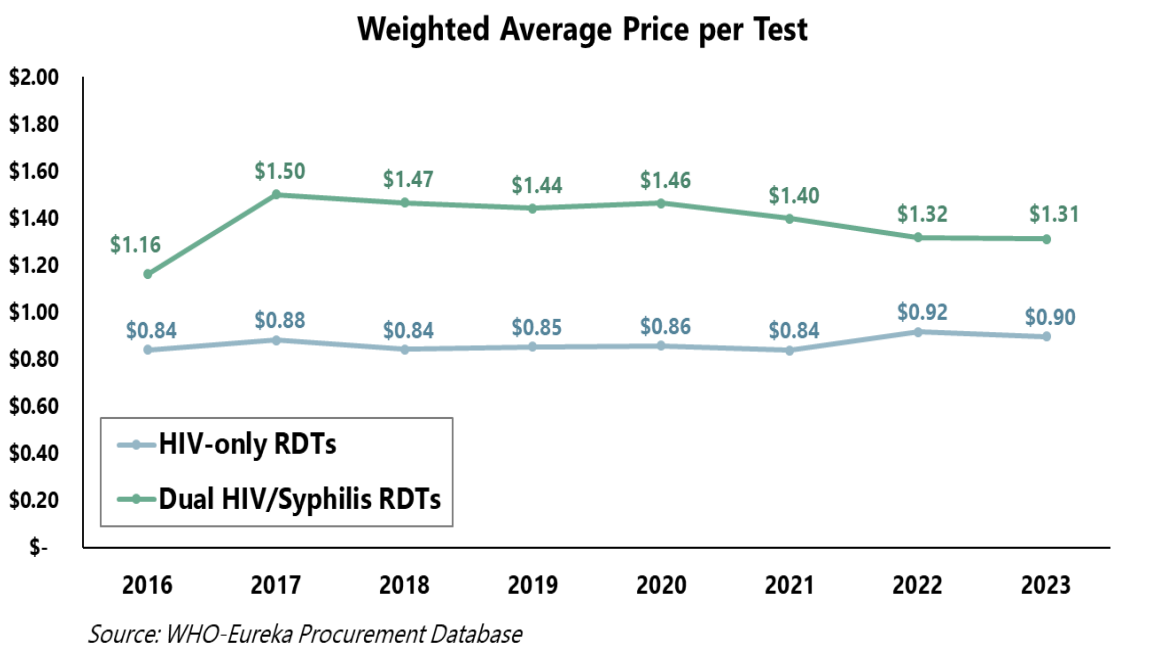
Switch to lower A1: Average weighted price of HIV tests remains high, yet low-cost quality-assured options are available



Source: WHO-Eureka Procurement Database

Average weighted price of HIV tests:

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

Yet, lower cost quality-assured tests exist

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)**

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**Note price information includes cost of accessories per WHO sources and catalogue as of 5 May 2025*

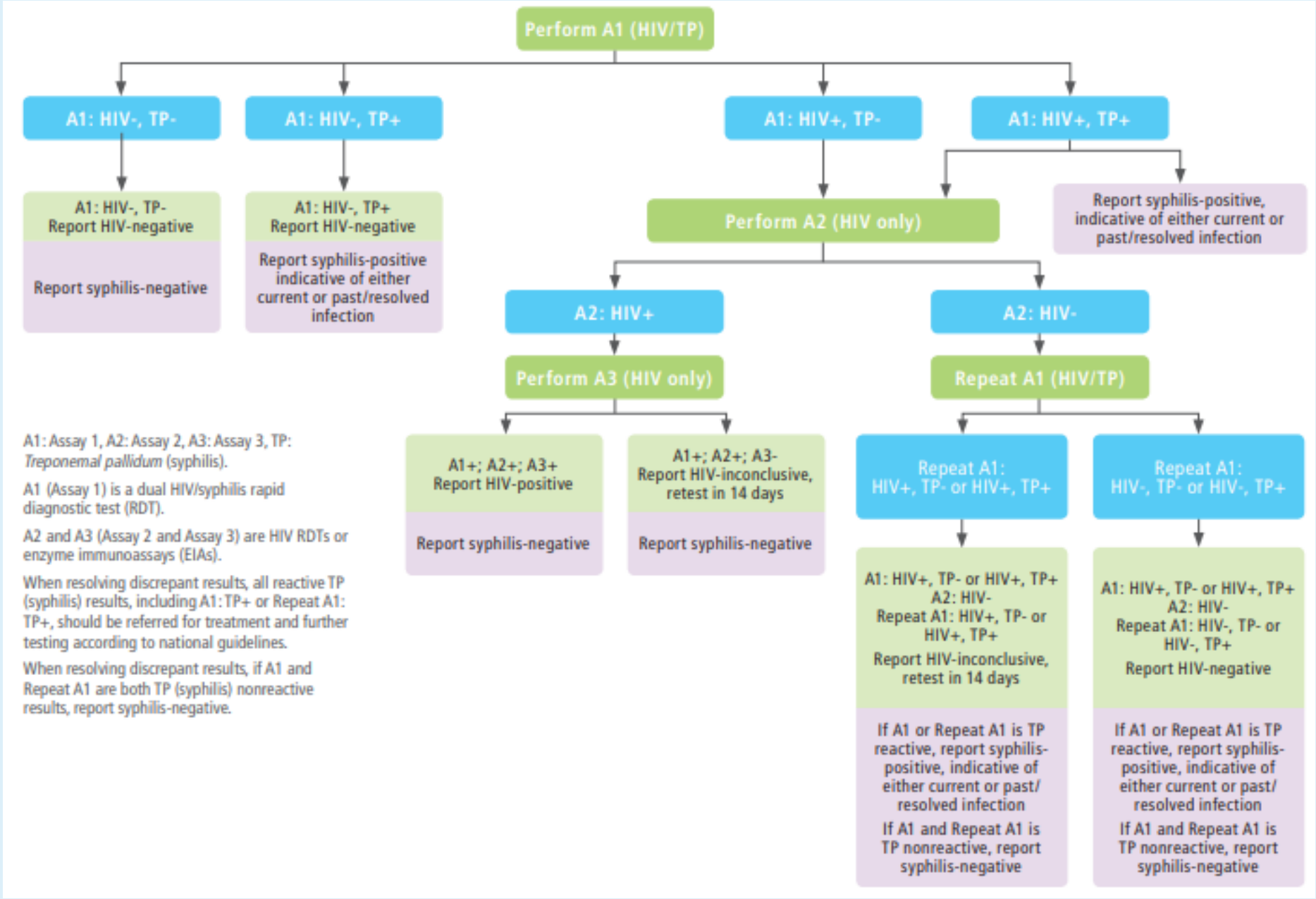
Reference information: EIC/WHO 2024, WHO catalogue 2025; WHO tool kit 2021; Global Fund 2025

***Abon – owned by Abbott*

*** SD Bioline – subsidiary of Abbott*

Strategy for dual detection of HIV and syphilis

Prioritize lower cost A1, including dual HIV/syphilis RDT



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2.1 Initial testing and catch-up testing

All pregnant women should be tested for HIV, syphilis and hepatitis B surface antigen (HBsAg) at least once and as early as possible, ideally at the first ANC visit (1).

Dual HIV/syphilis rapid diagnostic tests (RDTs) can be used as the first test in HIV testing strategies and algorithms in ANC settings (1).

Catch-up testing following a missed or delayed first test or retest is needed (1).

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- Focus on achieving high coverage of testing at ANC-1
- Mitigate impact of supply disruptions with catch-up testing: use self-testing to fill gaps
- Use available tests: HIVST, single HIV and syphilis tests
- Efficient reporting and recording mechanisms can support targeted catch-up testing instead of blanket retesting

Case: Cote D'Ivoire
Madeleine Amorissani Folquet, UFHB

2.2 Third trimester and postpartum retesting

In settings where HIV prevalence is greater than or equal to 5%, WHO recommends retesting all pregnant women with HIV-negative status in late pregnancy, within the third trimester. An additional retest in the postpartum period can be considered, based on resources and HIV risk in a specific region or for high-risk populations (1).

In settings where HIV prevalence is less than 5%, WHO does not recommend universal maternal retesting in late pregnancy. Here, retesting should be offered to women at high ongoing risk, including those from key populations and their partners, and additional postpartum testing can be considered based on resource availability (1).

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- Retesting is only recommended in high burden setting
- With limited resources approaches will need to be adapted
- Implement catch-up testing to fill gaps for those who have missed testing early in pregnancy, consider HIVST options
- Use data to target (ex. geographically)
- Avoid blanket retesting outside of high prevalence or high incidence settings
- Review and adapt monitoring and evaluation systems to support programme learning

Case: Nigeria

Oluwakemi Sowale, CHAI Nigeria

WHO Guidance

	Time points		
Setting	Early in pregnancy (first antenatal care visit)	Late in pregnancy (third trimester ANC visit)	1 additional postpartum retest (14 weeks, six-months or nine-months post-partum)
High HIV burden settings	All	All	Can be considered for those at high ongoing risk
Low HIV burden settings	All pregnant women as part of EMTCT	Can be considered for those at high ongoing risk	Can be considered for those at high ongoing risk
Among key population groups and their partners	All settings	All settings	All settings

Identify priorities & adapt to limited resources

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2.3 Linkage to ART or PrEP

ART initiation should be offered immediately and same-day initiation encouraged following a confirmed HIV diagnosis and clinical assessment for people with no clinical contraindication (1).

PrEP is safe to use during pregnancy and ideal for those with substantial HIV risk, such as pregnant and postpartum women in high incidence settings and from a high-risk group. All pregnant women who are HIV-negative but at ongoing risk should be linked to prevention services relevant to them (11).

- Testing should be an entry point for services
- Women with positive test results need to be linked to ART
- In high incidence settings (where available), following a negative test result pregnant women at high ongoing risk need to be linked to prevention services like PrEP

Case: Zimbabwe
Idah Moyo, MOHCC Zimbabwe

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2.4 Network-based testing services

Couples and partner testing services are recommended in antenatal care settings, particularly high HIV-burden settings, facilitating interventions including prevention in serodiscordant couples in all settings (1).

In all settings, biological children of a parent with HIV should be routinely offered HTS (1).

- Network-based testing is a continuum and includes voluntary provider-delivered and secondary distribution options
- Provider-delivered partner services options are most effective
- Consider secondary distribution of HIVST when provider delivered options are not feasible to implement
- WHO toolkit for Network-based Testing (coming soon)

Case: STAR in South Africa and Malawi
Karin Hatzold, PSI

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Adapt across HIV testing services

Optimize

- Integration, task sharing advances have already been successful in ANC: Opportunities to advance these efforts with use of self-testing
- Use low-cost tests
- 3-test strategy + linkage

Streamline

- Focused ANC testing and retesting
- Target high coverage of ANC-1
- Focused retesting
- Secondary distribution to reach partners

Targeted

- Catch-up testing to fill gaps
- Geographic prioritization

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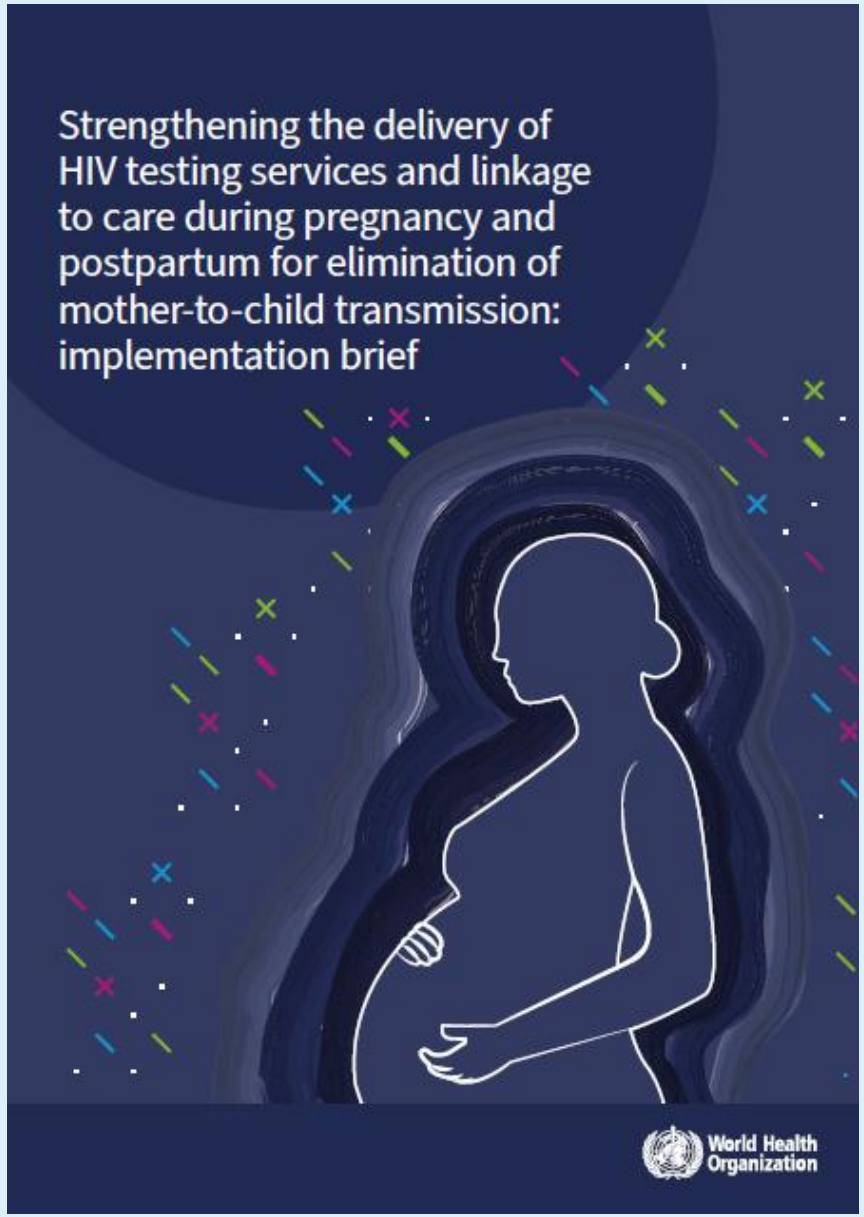
Thank you!

Aliza Monroe-Wise, Morkor Newman, Oriwedu, Caitlin Quinn, Busi Msimanga, Celine Lastrucci, Cheryl Johnson

HIV Testing Services During Pregnancy and postpartum Implementation Brief

- Consolidates guidance from previous guidance documents, including 2024 HTS Guidelines
- Provides simple framework to consider approaches to improve and streamline HIV testing service delivery for pregnant and postpartum women to achieve elimination of vertical transmission



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https://www.who.int/publications/i/item/9789240101371

MATERNAL HIV RETESTING IN HIGH AND LOW HIV BURDEN SETTINGS: TOO MUCH OR NOT ENOUGH?

Alison Drake, MPH, PhD

Associate Professor

Department of Global Health

University of Washington

Maternal HIV incidence during pregnancy and postpartum

- High incidence after initial ANC screening
  - Post-2014: 2.1 (95% CI 0.7-6.5)[1]
  - Range by African region between 2.4-4.2[1]
- MTCT impact
  - 9- to 16-fold higher than chronic infections if undetected and untreated[2]
  - May be preventable with retesting
- Strategies to prevent MTCT
  - Early initiation of antenatal care (ANC)
  - High coverage of testing and treatment
  - ***Maternal HIV retesting***

Photo with permission; credit Paul J. Brown Photography

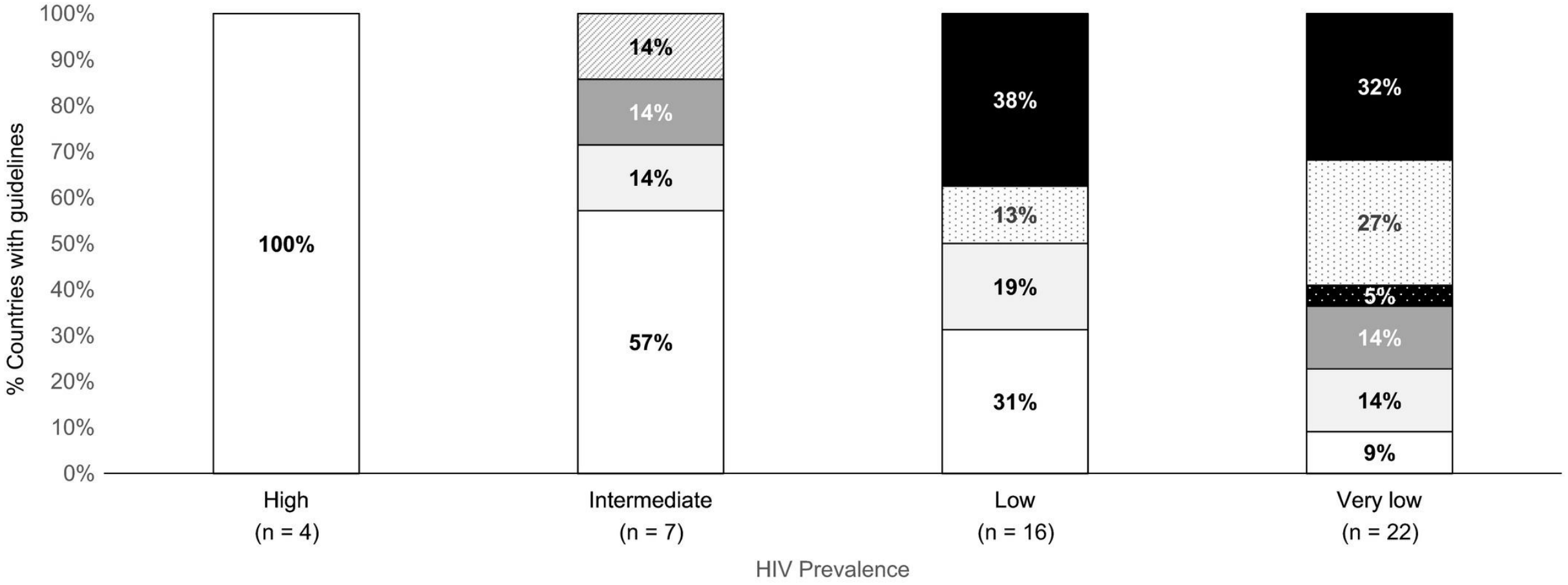
1 Graybill L, et al, AIDS 2020; 2 Drake AL, PLoS Medicine 2014.

Maternal HIV retesting recommendations in 49 countries, by HIV prevalence (2007-2017)

Drake AL et al. Journal of the International AIDS Society 2019, 22:e25271
http://onlinelibrary.wiley.com/doi/10.1002/jia2.25271/full | https://doi.org/10.1002/jia2.25271

Retest and treat: a review of national HIV retesting guidelines to inform elimination of mother-to-child HIV transmission (EMTCT) efforts

Alison L Drake[1§], Kerry A Thomson[2], Caitlin Quinn[3], Morkor Newman Owiredu[3], Innocent B Nuwagira[4], Lastone Chitembo[5], Shaffiq Essajee[6], Rachel Baggaley[3] and Cheryl C Johnson[3,7]



Objective: Determine health and economic impact of maternal HIV retesting in high and low HIV burden settings

- **Provide evidence for utility, and specificity on timing, of maternal HIV retesting** during pregnancy and postpartum
  - *Inform prioritization of resources*
  - *Including key populations*

- **Evaluate impact on infant infections averted and disability-adjusted life years (DALYs)**

- Definition of HIV burden based on prevalence
  - High: >15% (South Africa)
  - Intermediate: 5-15% (Kenya)
  - Low <5% (Columbia and Ukraine)

GOAL: Inform development of global operational guidance on retesting for HIV in varying HIV burden settings

Maternal HIV retesting scenarios

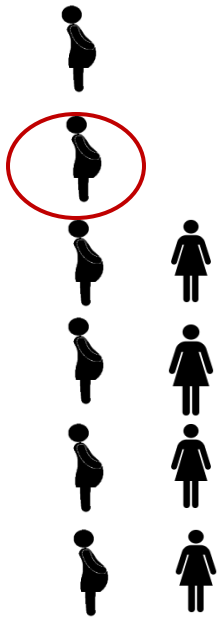
Meisner J et al. Journal of the International AIDS Society 2021, 24:e25686
http://onlinelibrary.wiley.com/doi/10.1002/jia2.25686/full | https://doi.org/10.1002/jia2.25686

Optimizing HIV retesting during pregnancy and postpartum in four countries: a cost-effectiveness analysis

Julianne Meisner[1,*], D Allen Roberts[1,*], Patricia Rodriguez[2], Monisha Sharma[3], Morkor Newman Owiredu[4], Bertha Gomez[5], Maeve B deMello[6], Alexey Bobrik[7], Arkadii Vodianyk[8], Andrew Storey[9], George Githuka[10], Thato Chidarikire[11], Ruanne Barnabas[1,3,12], Shiza Farid[3], Shaffiq Essajee[13], Muhammad S Jamil[4], Rachel Baggaley[4], Cheryl Johnson[4] and Alison L Drake[3,§]

Detects infection acquired

No sexual activity after delivery



Scenario	Late pregnancy (or "catch-up testing" at delivery or 6 wks pp)	Postpartum: 14 weeks	Postpartum: 6 months (mid)	Postpartum: 9 months (late)
1				
2	✓			
3	✓	✓		
4	✓		✓	
5	✓			✓
6	✓		✓	✓
7	✓	✓	✓	✓

Initial HIV testing at 1st ANC assumed under the base case (Scenario 1) and all retesting scenarios; women who miss 1st ANC testing by mean gestational age included in retesting scenarios.

Model parameters, costs, and cost-effectiveness

Key model parameters

- HIV prevalence, incidence
- Test coverage (ANC attendance, uptake, stockout)
- Test performance (sensitivity/specificity)
- MTCT risks and breastfeeding practices
- Maternal ART/PrEP

Incremental costs (2017 USD)

- Time and motion studies; published literature
- HIV-related labor, supplies, medication
  - Testing*
  - Infant ARV/ART
  - Maternal ART/PrEP

**Time and motion studies*

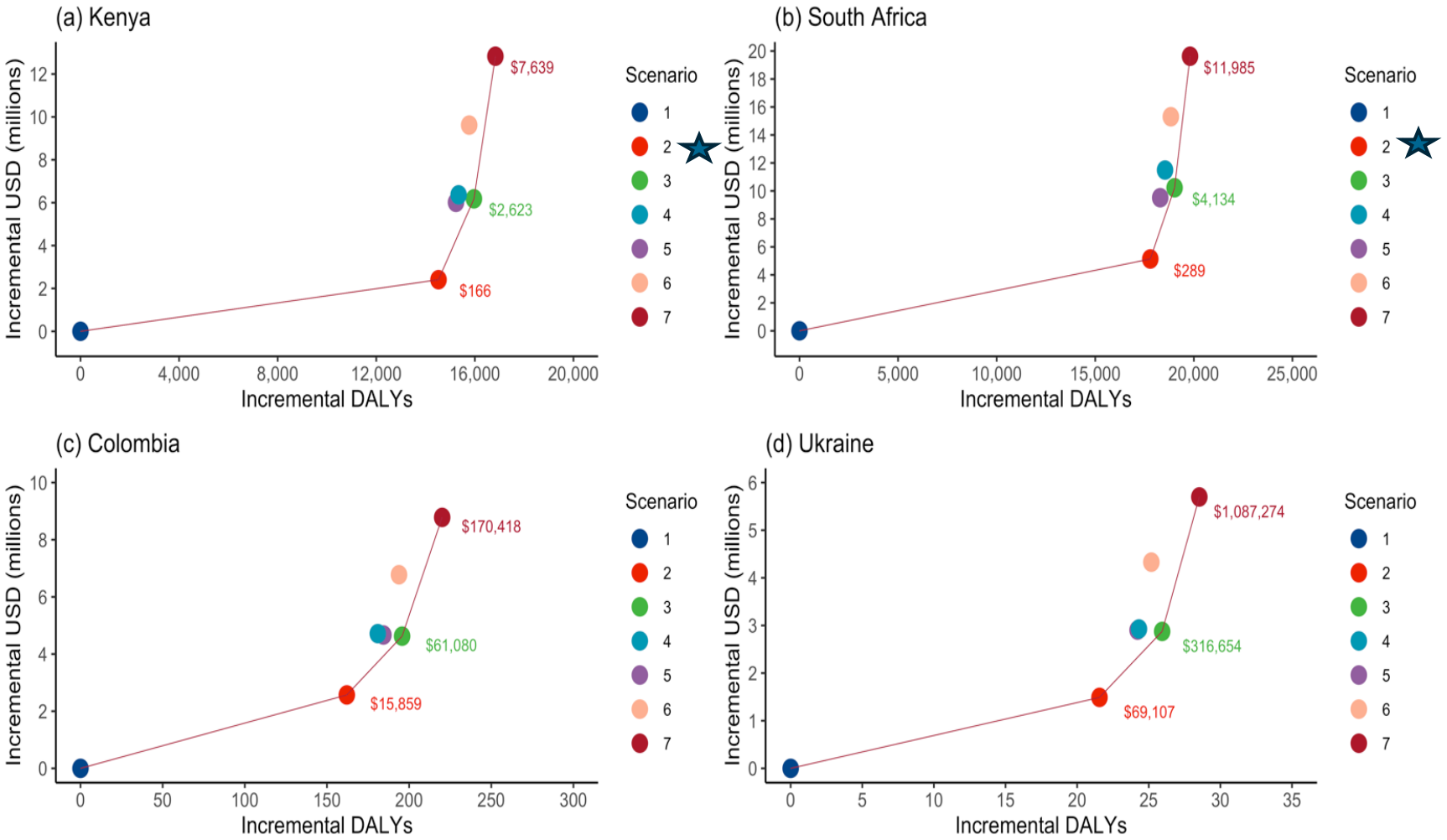
Cost-effectiveness

- Global burden of disease (GBD)
  - Convert infant infections/adverse birth outcomes into DALYs (WHO GBD)
  - Disability weights for HIV/AIDS (UW IHME GBD)
- DALYs = sum of years lived with disability (YLDs) and years of life lost (YLLs)
- Incremental cost-effectiveness ratio (ICER)=

  [costs of retesting – costs of base case scenario]

  [DALY retesting – DALY under base case scenario]
- **Cost-effective** if ICER < $Threshold value /DALY averted (country specific)

Maternal HIV retesting in late ANC + catch up testing cost-effective (★)in high, but not low, HIV burden settings



% MTCT averted among women with incident HIV

Kenya: 19%

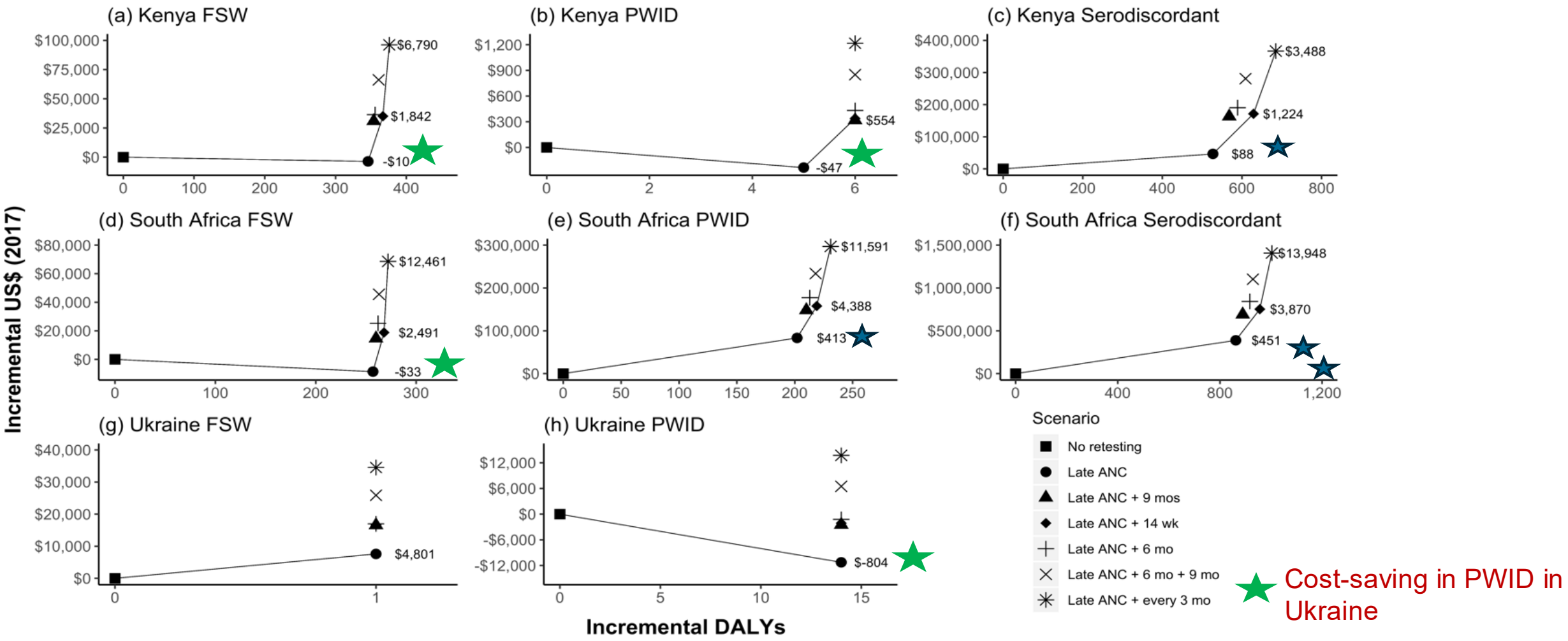
South Africa: 12%

Colombia: 17%

Ukraine: 6%

ICER thresholds: $500 (Kenya), $750 (S. Africa), $3000 (Colombia), $1000 (Ukraine)

Maternal HIV retesting in late ANC + catch-up testing for *key populations (KP)* cost-effective (★)or cost-saving (★) in high HIV burden settings



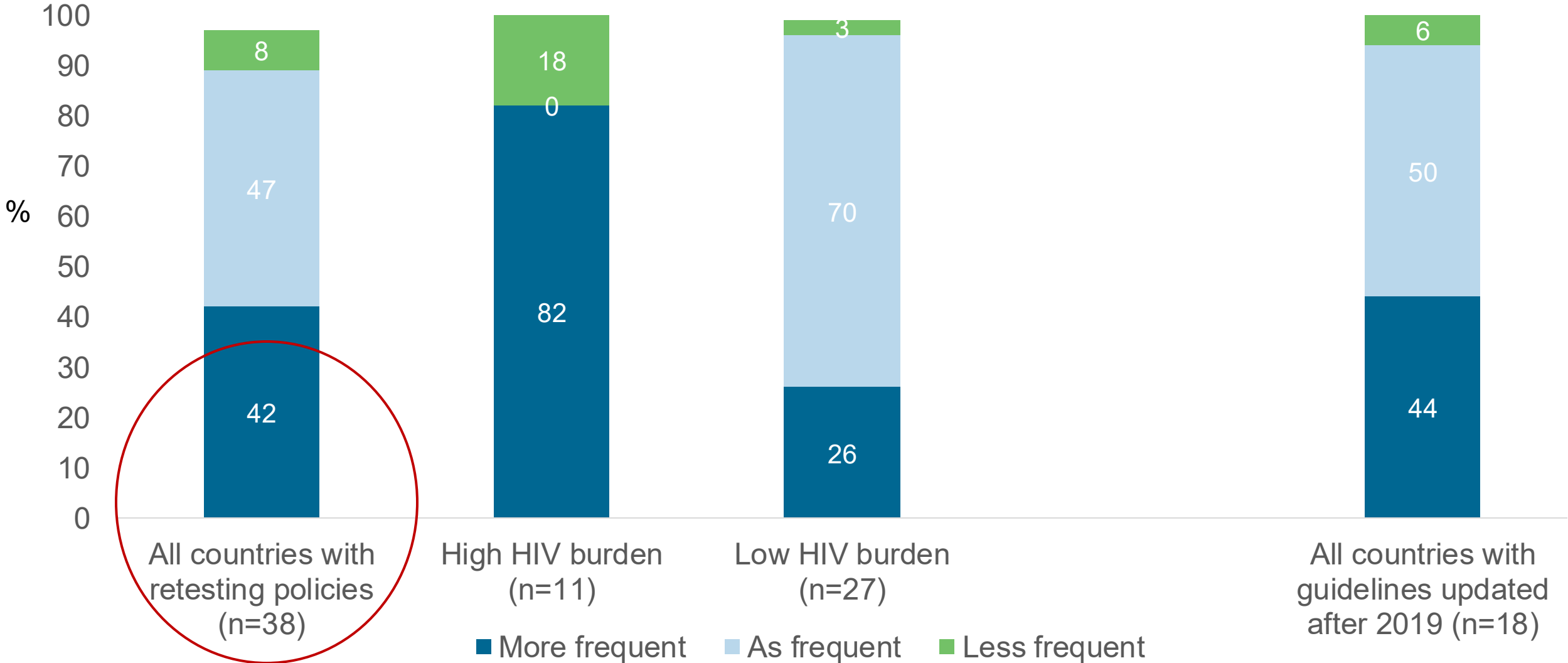
ICER thresholds: $500 (Kenya), $750 (S. Africa), $3000 (Colombia), $1000 (Ukraine)

Key points from maternal HIV retesting models

- **Cost-effective** in late ANC + "catch-up" testing in high HIV burden settings
  - Averts 12-19% of infant HIV infections attributed to new maternal HIV infections
- **Not cost-effective** in low HIV burden settings in the general population, but cost-saving among pregnant PWID in Ukraine
  - *Data lacking in Colombia to conduct modeling*
- 6 week catch-up testing is detecting infections acquired in pregnancy; value of separate testing from ANC/delivery is small
- **Additional postpartum testing marginally contributes to MTCT and is costly**
  - No optimal time-point identified, optimization is likely driven by feasibility and attendance, and will be context specific
- Empiric data on maternal HIV incidence, and implementation of retesting, during pregnancy and postpartum is important to evaluate public health and economic impact in real-world settings

Maternal HIV retesting guidelines in African region, by HIV burden and after WHO 2019 guidelines

38 of 46 (83%) of countries had maternal HIV retesting policies



Considerations for implementing maternal HIV retesting

- Clear guidance on timing and frequency of retesting, and eligibility
  - How to implement catch-up testing or record retests when testing is missed in ANC
  - Consider value-add for testing at multiple-times
- Counseling messages for women and providers about
  - Potential for continued HIV risk beyond initial ANC HIV test
  - Need for retesting, linkage to PrEP
  - Elevated risks of MTCT with incident infections
- Procurement
  - Adequate supply necessary to provide consistent testing coverage for all

Acknowledgements

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- Kellie List

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NASCOP

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health Department: Health REPUBLIC OF SOUTH AFRICA

- Thato Chidarikire

For more information contact Alison Drake
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Strengthening 3rd Trimester Maternal HIV Retesting using HIVST in Nigeria

Presenter: Oluwakemi Sowale

Date: May 15, 2025

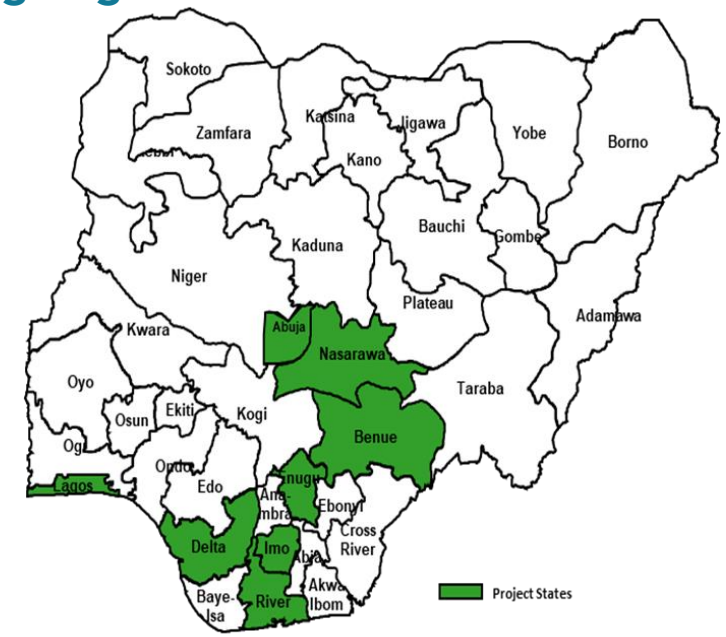
Although Nigeria is a low HIV prevalence country, it faces high vertical transmission in certain states, requiring targeted intervention

Problem: Although Nigeria is a low HIV prevalence country, defined by WHO as <5%, with a prevalence of 1.3%, programmatic data showed high rates of vertical transmission.

Background & Opportunity:

- The FASTER project (2019-2022), focused on accelerating HIV testing and treatment for children and adolescents, operated in 8 high-burden states
- Vertical transmission in these states ranged from 5-22% at 6 weeks, and 11-33% during breastfeeding
- WHO guidelines recommend 3rd trimester testing in high-burden settings (2024 HTS Guidelines, 2025 Maternal Retesting Brief)

Under FASTER, MOH and CHAI identified an opportunity to strengthen HIV retesting for PBFW at high ongoing risk



With support from the U.S. President's Emergency Plan for AIDS Relief, through Catholic Relief Services and Clinton Health Access Initiative

To strengthen uptake of 3rd trimester retesting, the FASTER project innovatively utilized HIV self-testing to further decentralize access

Intervention Design (June - December 2021)
Held Maternal Retesting Strategic Development Meeting with NASCP
Developed SOPs and IEC materials
Trained 223 heath workers and 27 traditional birth attendants (TBAs) to conduct HIVST or rapid retesting at third trimester
Offered partner retesting via secondary distribution of HIVST by consenting PBFW
Analyzed data monthly

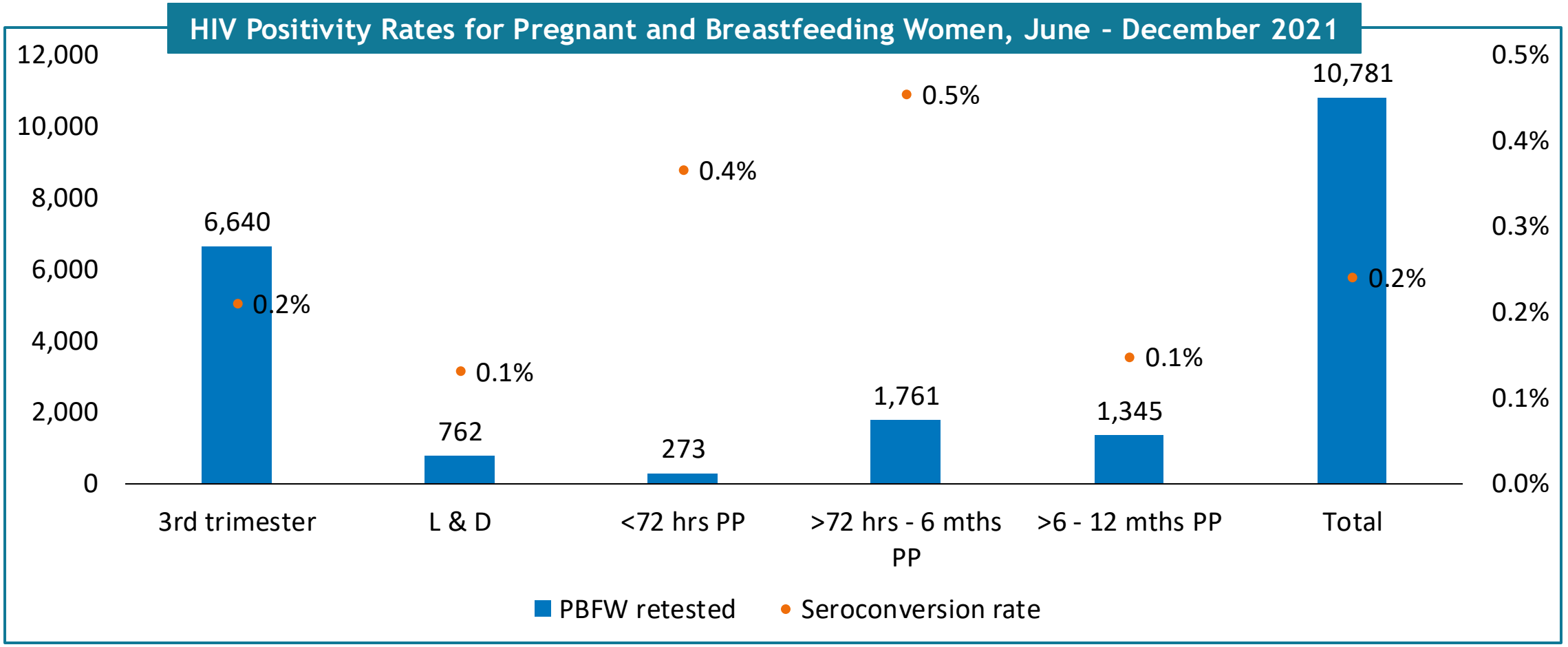
Critical Opportunity for HIVST

- Limited availability of conventional test kits
- Low number of staff dedicated to maternal testing
- Facility access barriers including cost of transportation

HIVST demonstration at HCW training

With support from the U.S. President's Emergency Plan for AIDS Relief, through Catholic Relief Services and Clinton Health Access Initiative

Majority of PBFW were retested during the 3rd trimester; others required catch-up testing during L&D and postpartum time points



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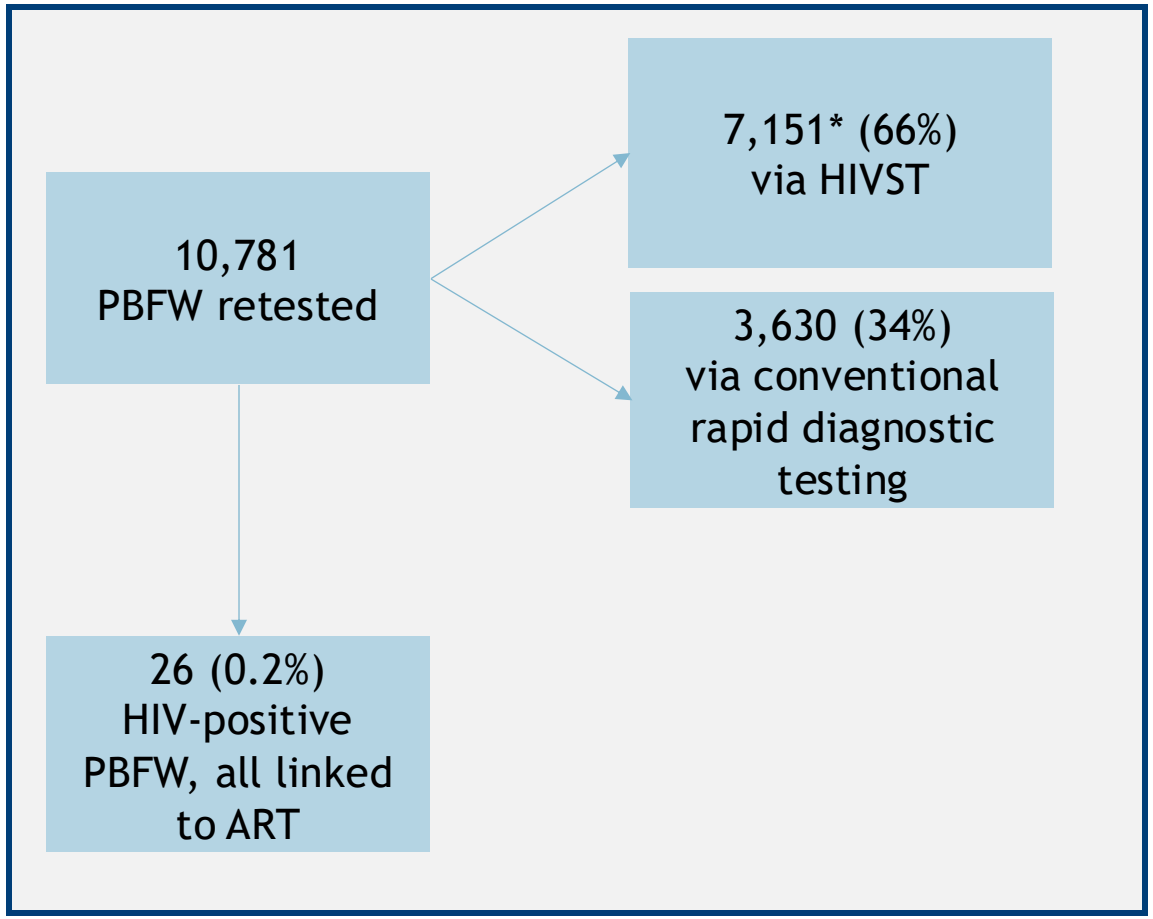
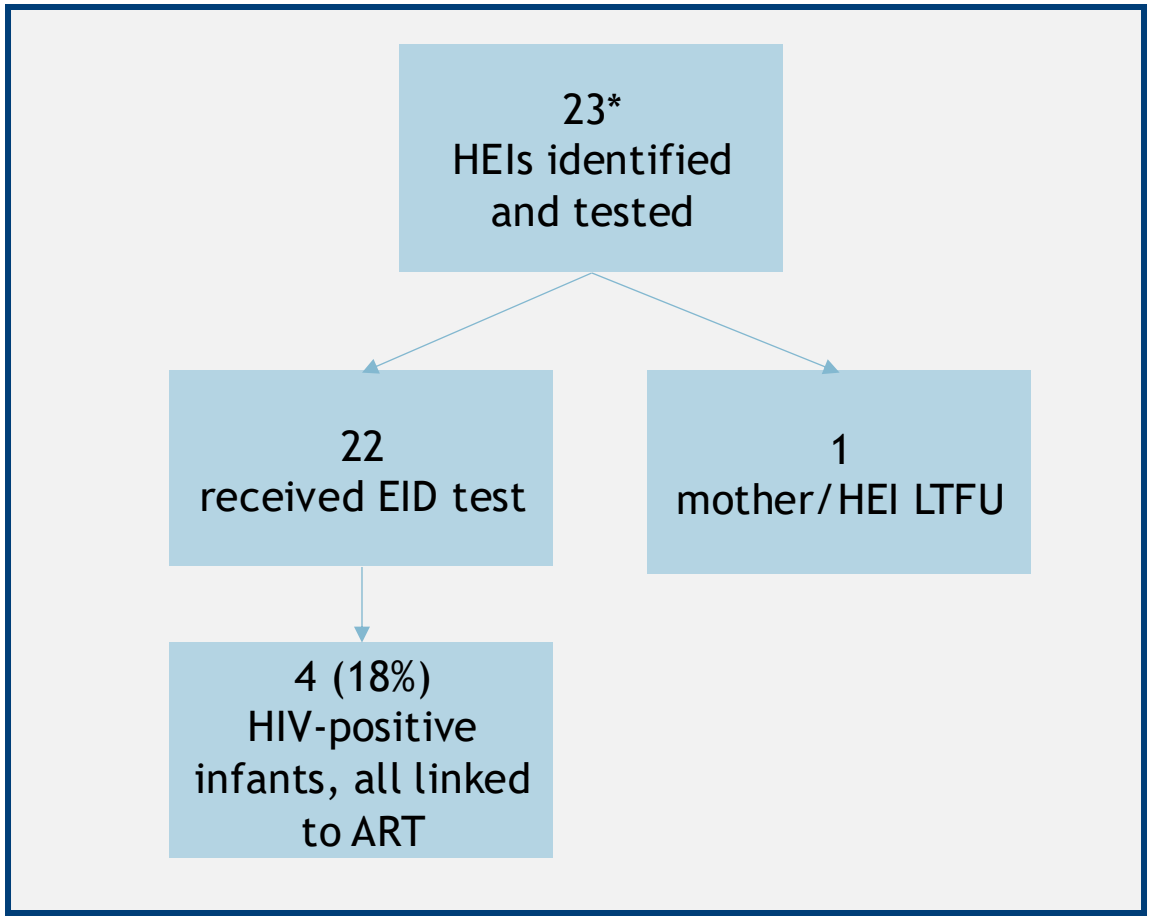
The majority of PBFW retested utilized HIVST and all PBFW and infants identified HIV-positive were immediately placed on treatment



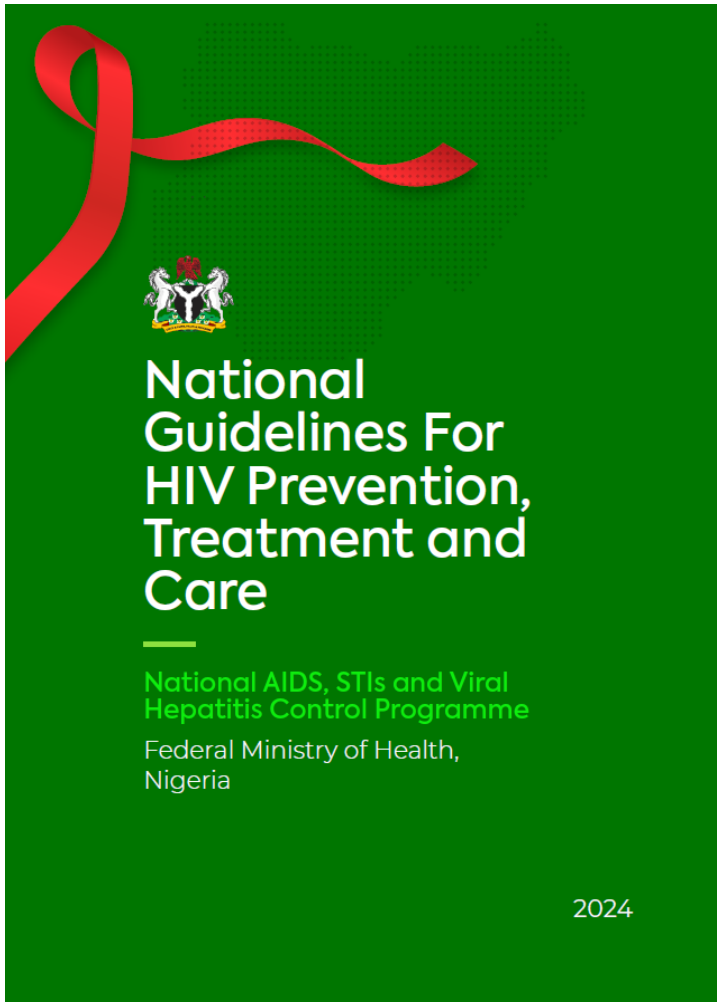


*Of 7,151 HIVST kits returned out of 7,188 distributed (99.5% result return)

*3 of the 26 HIV-positive women identified through retesting were still pregnant at end of implementation period

With support from the U.S. President's Emergency Plan for AIDS Relief, through Catholic Relief Services and Clinton Health Access Initiative

HIVST offers a promising strategy for decentralizing access to PMTCT and increasing retesting coverage, identifications, and linkage to care



- The intervention demonstrated that **expanding HIV self-testing (HIVST)** for pregnant and breastfeeding women (PBFW) at high ongoing risk—both in facilities and communities—**may boost third-trimester retesting**, identify **seroconversions**, and improve **early** infant **diagnosis** and **rapid linkage** to care.

- In 2024, Nigeria's **National HIV Guidelines** incorporated **third-trimester retesting** (with catch-up testing during labor and postpartum) and recommended integrating HIVST into ANC settings, supported by national data reporting tools.

- This strategy aligns with **Nigeria's ongoing efforts to decentralize PMTCT**, embedding HIV testing and retesting into routine ANC and reproductive health services at primary care and community levels, including non-traditional providers like TBAs.

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Decentralized, integrated care is essential to strengthen efforts to prevent vertical transmission—within HIV and beyond

Impact of Foreign Aid Cuts and Key Considerations

- Following foreign aid cuts, the Nigerian government is accelerating the health sector integration agenda, guided by recently launched HIV Service Integration in Nigeria Guideline
- Despite the constrained funds, provision is still being made for one additional test for PBFW for retesting
- Focused efforts to promote care integration and decentralization, including through use of HIVST, are more important now more than ever, to mitigate service disruption

Looking Ahead – Integrating Service Delivery for Triple Elimination in Nigeria

🎯 Objectives:

- Assess feasibility and acceptability of offering integrated triple RDT for HIV, syphilis, and HBV in ANC settings
- Demonstrate feasibility of integrating HBV "Test and Treat" within PMTCT

🌍 Expected Impact:

- Improve integrated screening and linkage to care
- Enhance health system efficiency
- Inform national scale-up

With support from the U.S. President's Emergency Plan for AIDS Relief, through Catholic Relief Services and Clinton Health Access Initiative

www.clintonhealthaccess.org

Stratégie de dépistage maternel du VIH et VHB de routine lors de l'accouchement à Abidjan, Côte d'Ivoire : Projet DEPISTNEO

Pr M. Amorissani-Folquet

pour le

Projet DEPISTNEO, Expertise France

Introduction

- Prévalence du VIH en prénatal : 5,6% en 2012
- Malgré les interventions de PTME, taux estimé de transmission mère-enfant en 2014 = 21%
- Depuis 2011, stratégie recommandée par le PNLS
  - Dépistage du VIH à l'accouchement
  - Diagnostic précoce par PCR à 6 semaines de vie
- → Fréquentes opportunités manquées

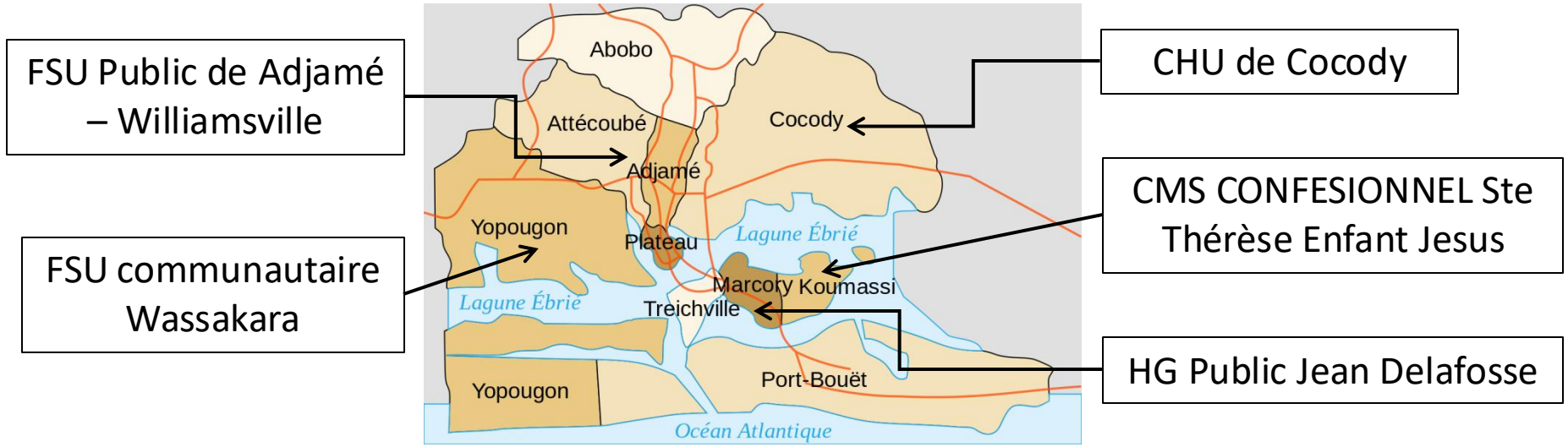
Objectifs du projet DEPISTNEO

Développer, mettre en œuvre et évaluer un système d'informations (SI) pour faire un lien entre la mère et l'enfant exposé au VIH ou au VHB lors de l'accouchement et les suivre au long du continuum de soins pour :

1. Identifier dès la naissance les enfants exposés au VIH, promouvoir leur dépistage précoce à 6 semaines par PCR et leur traitement antirétroviral précoce le cas échéant,
2. Donner une seconde opportunité d'entrée dans les soins pour la mère infectée par le VIH non identifiée avant l'accouchement
3. Identifier les mères infectées par le VHB, les référer vers une prise en charge adéquate, et proposer un vaccin anti-VHB à J0 aux enfants exposés

Méthodes

- Sous l'autorité du Programme National de Lutte contre le Sida (PNLS)
- Echantillon aléatoire de 5 maternités à Abidjan→ 13% des accouchements à Abidjan & 1,6% au niveau national (2016-2018)

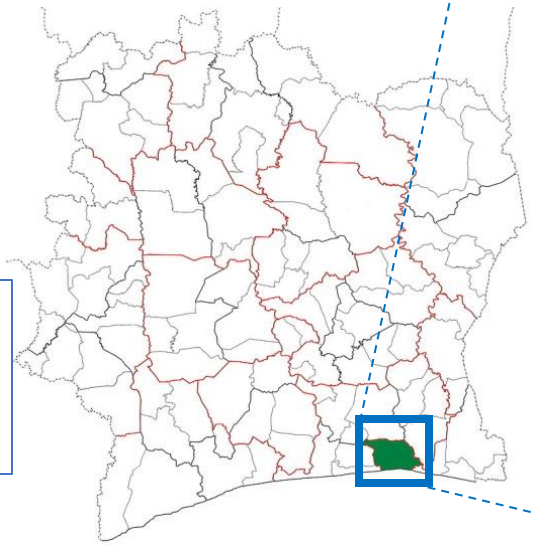


- **Critères d'inclusion** : toutes les naissances de femmes ayant accouché dans les 5 sites et donné leur consentement
- **Critères d'inclusion** pour le suivi des enfants nés dans DEPISTNEO:
  Etre né(e) de mère infectée par le VIH ou;
  Etre né(e) de mère infectée par le VHB ou ;
  Etre né(e) de mère co-infectée par le VIH/VHB;

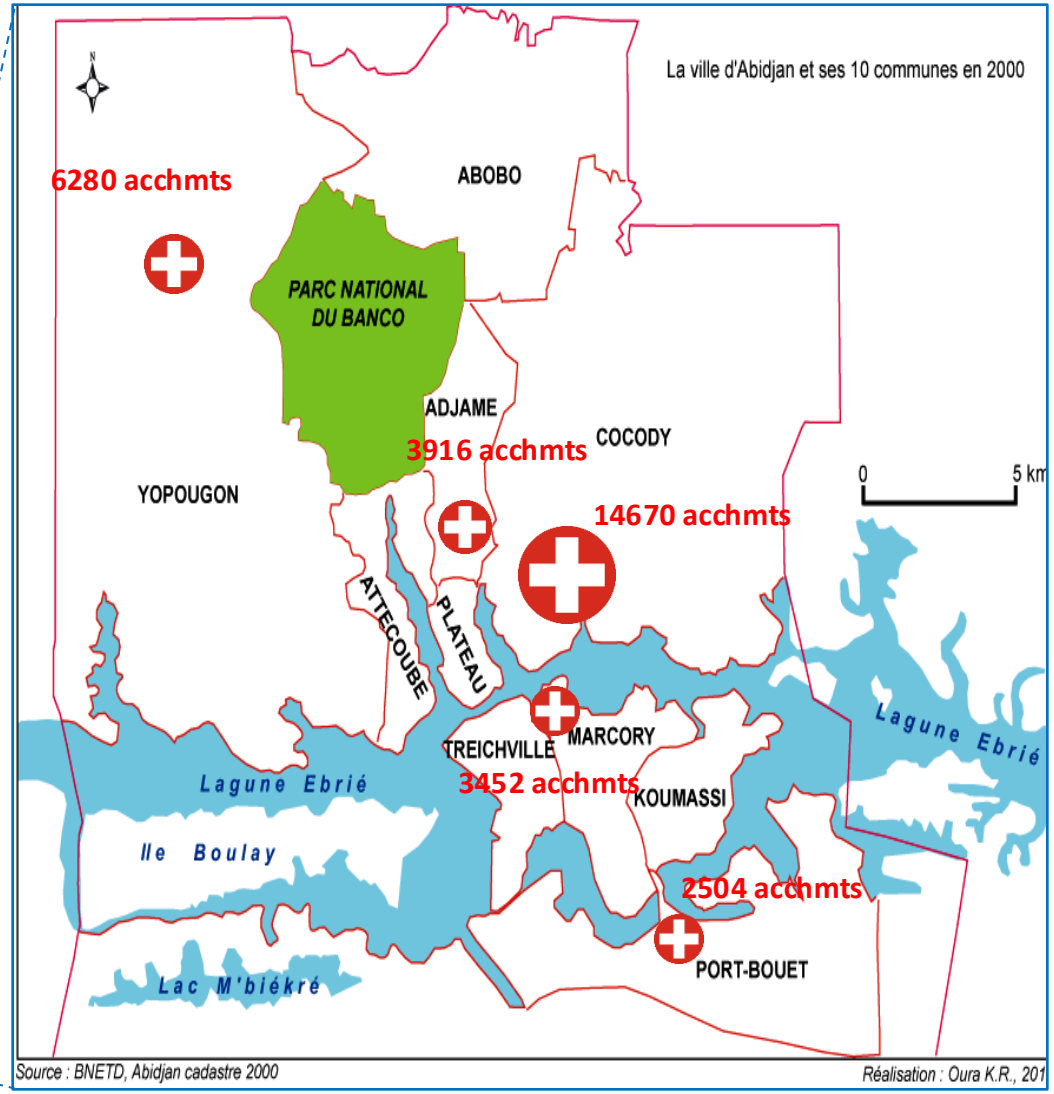
Méthodes

Population de 5 maternités d'Abidjan, 2016-2018 (13% des accouchements à Abidjan et 1,6% en CI)

- Proposition systématique de dépistage du VIH et du VHB par TDR à toutes femmes à l'accouchement,
- Vaccination monodose contre le VHB des nouveau-nés exposés à J0 et PEC adéquate des mères
- Suivi des couples mère-enfant => dépistage précoce du VIH dès 6 semaines (S6) par PCR, et du VHB à 9 mois



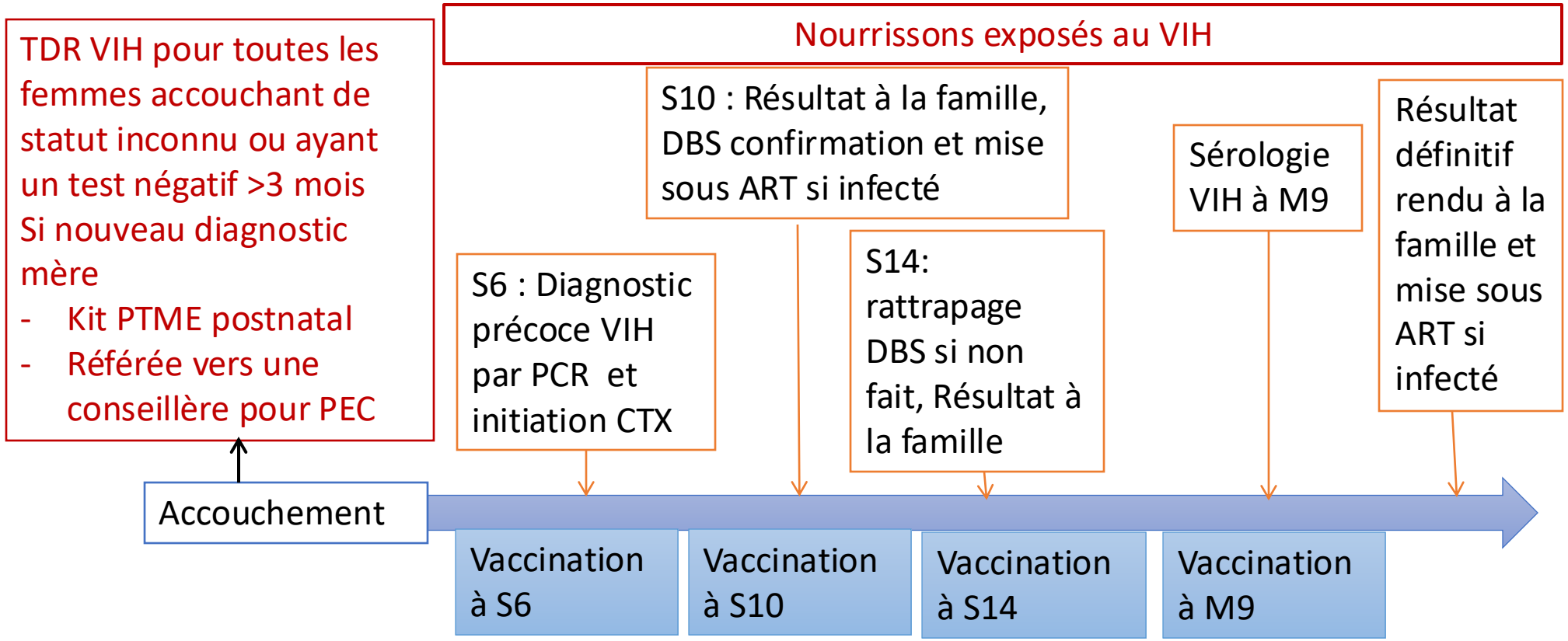
- **Implication des conseillères communautaires**



Tâches de la conseillère communautaire

- Renforcement du dépistage de l'infection à VIH en salle d'accouchement
- Suivi actif des couples mère-enfant selon les directives nationales du PNLS grâce au système d'information DEPISTNEO
  - Chaque étape de l'algorithme pour le diagnostic précoce est renseignée prospectivement dans le SI
  - Alerte auprès de la conseillère projet si délai de diagnostic dépassé
  - Intervention de la conseillère auprès de la famille pour ramener l'enfant dans les soins

Déroulement des interventions DEPISTNEO intégrées aux directives nationales pour optimiser la prise en charge du VIH



Résultats et Discussion

Prévalence du VIH parmi les femmes parturientes et seconde opportunité d'entrée dans les soins VIH dans DEPISTNEO

	Nombre de parturientes à qui on a proposé le test VIH	Couverture dépistage VIH maternel (%)	Prévalence maternelle du VIH		Traitement antirétroviral maternel prénatal		Seconde opportunité d'entrée dans les soins VIH (%)
			%	IC 95%	%	IC 95%	
TOTAL	**30 878 (97%)**	**99,4**	**3,9**	***[3,6-4,1]***	**81,5**	***[79,3-83,7]***	**18,5**
CHU Cocody	14 661	99,7	3,9	*[3,6-4,2]*	82,8	*[79,7-85,8]*	17,3
Wassakara	6 279	98,3	4,2	*[3,7-4,7]*	66,4	*[60,6-72,2]*	33,9
Williamsville	3 916	99,3	3,3	*[2,7-3,9]*	82,8	*[76,3-89,4]*	17,2
Koumassi	3 452	99,7	4,3	*[3,6-5,0]*	94,6	*[91,0-98,2]*	5,4
Treichville	2 570	99,3	3,0	*[2,4-3,7]*	94,8	*[90,0-99,8]*	5,2

Couverture du dépistage précoce du VIH à S6 sur DBS avant et après relance

	Nombre d'enfants exposés au VIH avec recul ≥ 6 semaines	Couverture dépistage S6 avant relance		Couverture dépistage S6 après relance DEPISTNEO		Effet relatif de la relance DEPISTNEO (%)
		%	IC 95%	%	IC 95%	
TOTAL	1142	58,8	[56,0-61,7]	65.9	[63.2-68.7]	*+12.1*
CHU Cocody	545	50,1	[46,0-56,7]	56.9	[52.7-61.0]	*+13.6*
Wassakara	249	57,4	[44,9-62,1]	69.5	[63.8-75.2]	*+20.9*
Williamsville	124	60,5	[32,5-55,2]	64.5	[56.1-72.9]	*+6.7*
Koumassi	150	82,7	[78,5-92,9]	86.7	[81.2-92.1]	*+4.8*
Treichville	74	77,0	[71,9-95,7]	81.08	[72.1-90,0]	*+5.3*

Leçons apprises

- Dépistage en routine du VIH en salle de naissance: faisables et acceptés.
- Couverture du dépistage précoce du VIH passée de 59% à 66% après alerte du système DEPISTNEO
- Délai encore long du rendu de résultat et accès au traitement précoce reste perfectible.
- Nécessité d'un engagement de l'état pour renforcer la prise en charge de l'infection à VIH en Côte d'Ivoire
  - Stratégie de dépistage prénatal, dépistage en salle d'accouchement
  - Nécessité d'intégrer les conseillers communautaires dans le dépistage et la rétention des enfants dans les soins.

Conclusion

Le projet DEPISTNEO montre l'intérêt de l'approche intégrée du projet DEPISTNEO aux directives nationales du PNLS

- Le dépistage maternel par TDR du VIH est faisable et bien accepté (99,4%) en routine en salle d'accouchement à Abidjan
- Le projet permet d'offrir une seconde opportunité d'accès aux soins à 18,5% des femmes infectées par le VIH, qui n'étaient: soit pas informées de leur statut VIH; soit pas prises en charge.
- La couverture du dépistage précoce VIH par DBS à 6 semaines chez les nourrissons est
  - Significativement améliorée passant de 59% avant relance à 66% après relance par DEPISTNEO
    - Effet du projet : augmentation relative significative globale de +12%
    - Effet d'autant plus important que la couverture initiale est basse

Perspectives

- Identification des pistes d'interventions pour améliorer la couverture du dépistage du VIH des nourrissons
  - Réduire la stigmatisation du VIH en population
  - Impliquer les conseillères communautaires pour favoriser la ré-intégration dans les soins VIH des femmes ayant échappé à la stratégie de dépistage prénatal du VIH et sa prise en charge antirétrovirale
  - Utiliser des POC dans les grosses structures pour réduire le délai de rendu des résultats
  - Sensibiliser les populations et le personnel de santé pour améliorer la couverture du diagnostic définitif du VIH après la fin de l'exposition à l'allaitement maternel

Merci de votre attention

Equipe projet

- Pr Madeleine Amorissani-Folquet (co-investigatrice Sud), CHU de Cocody
- Dr Valériane Leroy (co-investigatrice Nord), Inserm U1027, Univ Toulouse 3, France
- Dr Maika Bangali (chef de projet Sud)
- Dr Sophie Desmonde (chef de projet Nord)
- Séverin Lenaud (responsable SI)
- Jeanne Eliam Kouacou (assistante sociale)

Experts associés

- Pr Andre Inwoley (Biologie)
- Pr Marie Jeanne Lohoues (Hepatologie)
- Dr Mathurin Kouadjale (PNLS)
- Sophie Karcher (MEREVA)

Sites

- CHU Cocody
- FSUCom Ouassakara
- FSU Williamsville
- Hôpital Général Jean Delafosse Treichville
- CS Ste Thérèse de l'Enfant Jésus Koumassi

Partenariats

- Pr Allah Kouadio E. (PNLHV)
- Dr Abo Kouamé. (PNLS)
- Dr Ahoba Irma. (PNLS)
- Pr Ekra Daniel. (DCPEV)

Bailleur

EXPERTISE FRANCE

Integrating PrEP into Maternal Health: Advancing HIV Prevention for Pregnant and Breastfeeding Women in Zimbabwe

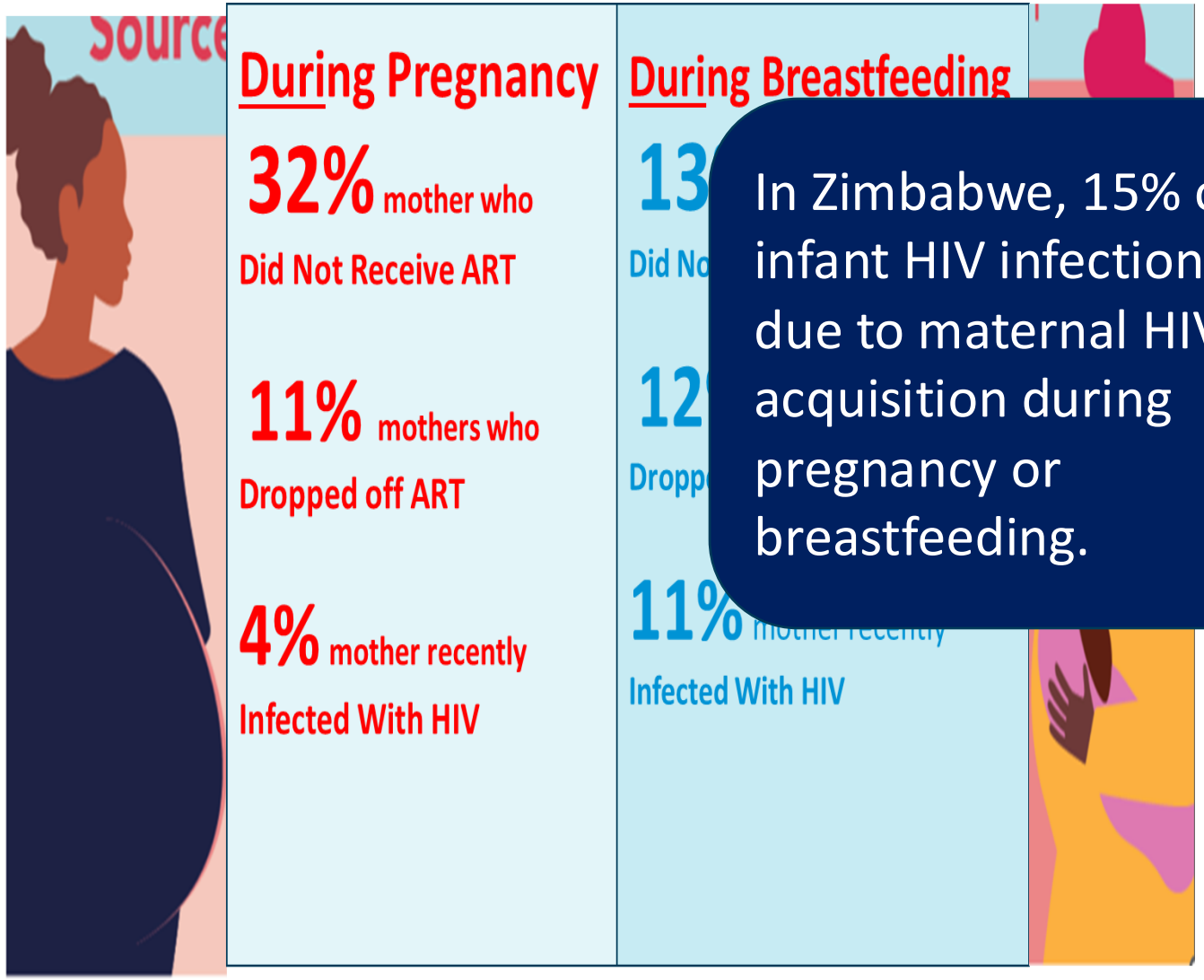
Webinar
Elimination: Maximizing the Impact of HIV testing for Pregnant and Postpartum women
15 May 2025

Idah Moyo, Ministry of Health and Child Care Zimbabwe

World Health Organization

Introduction

- Risk of HIV acquisition increases during pregnancy and breastfeeding
- Acute HIV infection during pregnancy/postpartum associated with higher risk of vertical transmission
- Estimated 30–50% of vertical transmissions may occur among women who seroconvert during pregnancy or breastfeeding



In Zimbabwe, 15% of all infant HIV infections are due to maternal HIV acquisition during pregnancy or breastfeeding.

Source: WHO technical brief (2019); Drake AL et al. (2014)

Source: UNDP Zimbabwe (2023). Overview of the HIV Epidemic in Zimbabwe.

PrEP Linkage and Initiation in MNCH Services

- Linkage to PrEP for HIV-negative pregnant women at substantial risk
- HIV risk assessment using **PrEP screening tool during HIV testing**
- HIV-negative clients at significant risk linked to PrEP.
- PrEP services integrated within MNCH as a **one-stop service model** for seamless linkage and initiation.
- Clients receive adherence counselling before starting PrEP.
- In facilities with structural limitations, a **linkage facilitator** accompanies clients to PrEP service points.
- Ongoing access to **PrEP resupply** when clients remain at risk.
- Updated combined **HTS and PrEP registers** capture screening, offer, acceptance, initiation and maintenance data.

MTCT HIV Risk Screening tool

HIV NEGATIVE: WOMEN MTCT RISK SCREENING		
PART I: Priority MTCT Risks – check appropriate responses. Any response with * indicates woman is at high risk of MTCT and should receive immediate intervention.	**YES**	**NO**
1. Have you been HIV tested during the current pregnancy/breastfeeding period? **Key message:** Women who are HIV infected during pregnancy and breastfeeding are at increased risk of MTCT – timely HIV (re)testing is important for PMTCT.		*
2. Is your partner HIV positive and/or are you unaware of your partner's HIV status? **Key message:** HIV negative women in discordant couples or unaware of their partners status are at increased risk of HIV infection.	*	
3. Are you currently using an HIV prevention method (if pregnant) or dual protection method (if post-delivery)? **Key message:** All women should be supported to select and HIV prevention method that works for them and counselled on how to use it correctly and consistently.		*
4. Will you be travelling between now and your next scheduled ANC/PNC appointment? **Key message:** women who travel during pregnancy and breastfeeding may experience delays in accessing services that increase MTCT risk. If you will be travelling notify your home facility for a transfer letter.	*	
PART II: MTCT Red Flags – check appropriate responses. Any response with * indicates increased MTCT risk. Provide key messages, services and referrals to reduce risk as appropriate.	**YES**	**NO**
1. Are you less than 24 years of age? **Key message:** Young women may face challenges to access to information about HIV prevention, PMTCT, service uptake and ART adherence that may increase personal HIV risk and MTCT risk.	*	
2. Have you been accessing ANC and PNC services as recommended? **Key message:** Delayed/no uptake of essential PMTCT services during pregnancy and breastfeeding period can increase MTCT risk – refer to motivation package for schedule of services and planning tools.		*
3. Has your partner attended ANC or PNC with you? **Key message:** Male involvement in service uptake and couples HIV testing reduces MTCT risk.		*
4. Have you recently had or experienced any of the following signs or symptoms in the past month?		
i. Do you have a cough, night sweats, fever, weight loss? (assess for TB/Refer to TB screening tool)	*	
ii. Do you have vaginal/urethral discharge or genital sores? (assess for STI)	*	
iii During the past month, have you: Felt like you were losing interest or pleasure in doing things? AND/OR Have you felt down, depressed or helpless? (assess for depression or anxiety SSQ14)	*	
Key message: Clients with TB, STIs, Depression or Anxiety may have reduced immune functioning or prevention behaviours and be at increased of HIV infection and MTCT. Screen and refer as appropriate.		
IMPORTANT: All MTCT Risk areas should be addressed with client and referrals and services provided documented as appropriate – with confirmation/follow-up on next appointment. Complete for all clients: **Action taken:** **Referral made: Yes / No Referred to:**_____		

Rapid scale up through intensified cascade training and mentorship of providers

- Capacity building for facility and community healthcare workers
- On-the-job training to support knowledge transfer to new cadres
- Site-level support and mentorship visits
- Appointment of PrEP champions in selected districts
- Implementation of the LIFT-UP equity programme to enhance service access for women of childbearing age and pediatric clients

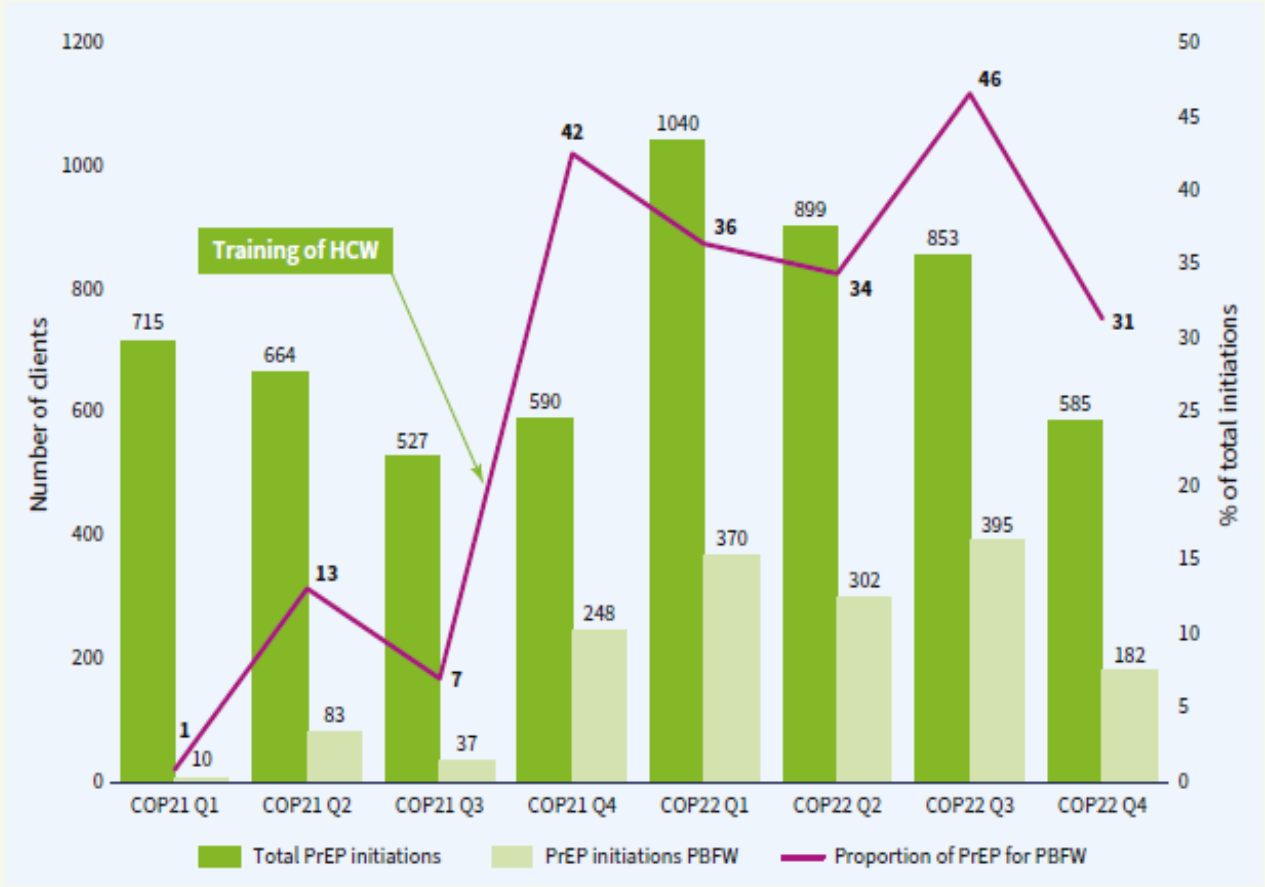
- Training of trainers (ToT) in five provinces
- 40 provincial trainers capacitated to cascade trainings to districts and provide post-training mentorship.
- Tailored curriculum: Special considerations for pregnant and breastfeeding women; HIV retesting algorithm; MTCT risk screening tool

Intensified PrEP education for pregnant AGYW

- Developed and distributed PrEP SOPs, job aids for and community-targeted education materials to strengthen provider knowledge and support client education across health facilities.
- Conducted PrEP literacy sessions at facility and community levels, led HCW and designated PrEP Champions
- Focused sessions on raising awareness of oral PrEP among pregnant adolescent girls and young women (AGYW), aiming to generate demand and increase uptake of PrEP.

Impact of PrEP Support Activities

Increase in PrEP initiations following intervention and training, Mazowe District, Zimbabwe



Before intervention: Average of 40 PrEP initiations per quarter among pregnant and breastfeeding women

After intervention launch: Initiations increased to **300 per quarter**

Conclusions

- Strengthening provider capacity on HIV testing and PrEP service delivery for pregnant and lactating women through on-the-job training, mentorship, coaching, and supportive supervision proved to be an effective strategy within the PMTCT program.
- The one-stop-shop model integrating PrEP into MNCH services, combined with intensified linkage support via peer navigators, significantly improved PrEP uptake among eligible clients.
- Strong coordination between healthcare providers and implementing partners across different intervention areas was a critical factor contributing to the program's success.

Recommendations and way forward

- Scale up peer-led, community- and facility-based models to provide differentiated, client-centered HIV prevention and eMTCT support
- Engage policymakers, program implementers, and service providers to institutionalize and expand the intervention as part of national HIV and eMTCT strategies.
- Invest in training, mentorship, and ongoing support for peer navigators and community health workers to strengthen their role in demand generation and service linkage within MNCH platforms.
- Leverage the low costs and simplicity of the intervention to replicate and adapt it across other low-resource settings in the region

THANK YOU

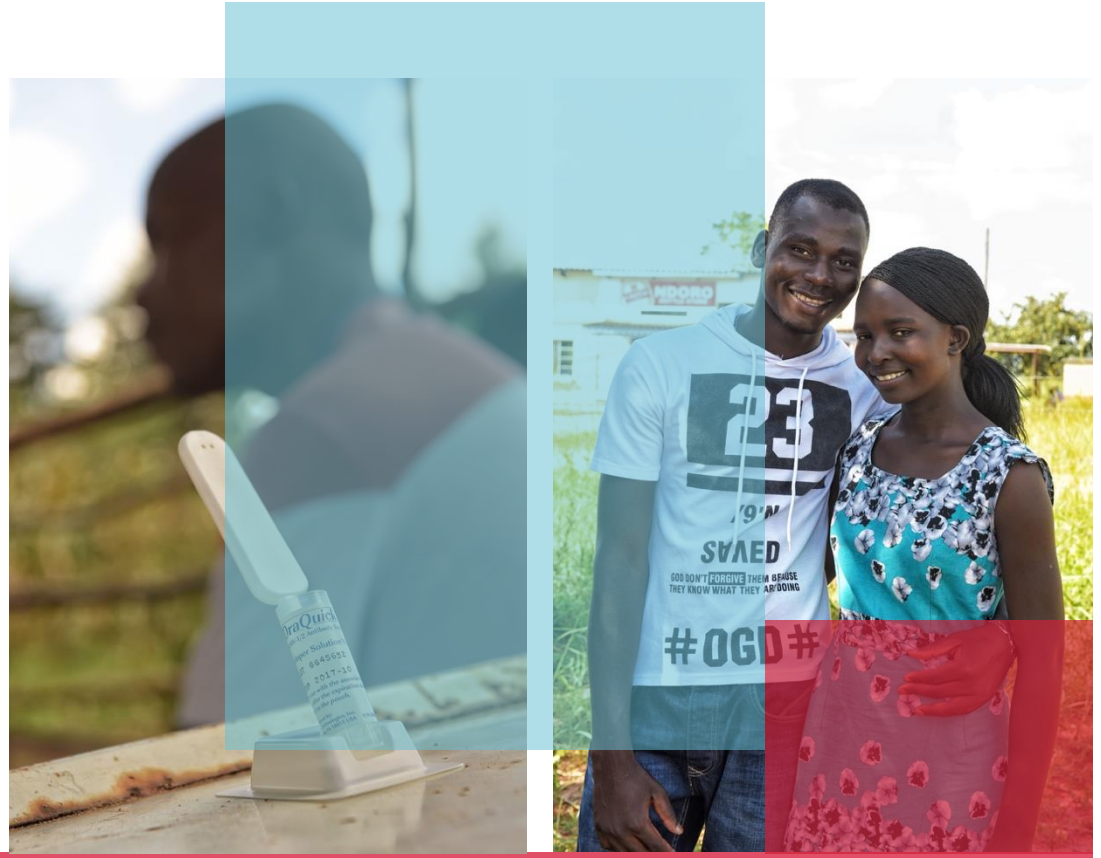
Acknowledgements:

Special thanks to the health care providers in MNCH, and to the pregnant and breastfeeding women who participated in the program.

We gratefully acknowledge the collaboration of our partners:
WHO Zimbabwe, ZimTTECH, and PSI

STAR
SELF TESTING

Bridging the Gap in Partner Testing: HIV Self-Test Distribution Through Pregnant and Postpartum Women



Karin Hatzold, Population Services International

Webinar Maximizing the Impact of HIV testing
for Pregnant and Postpartum women
15 May 2025

Context

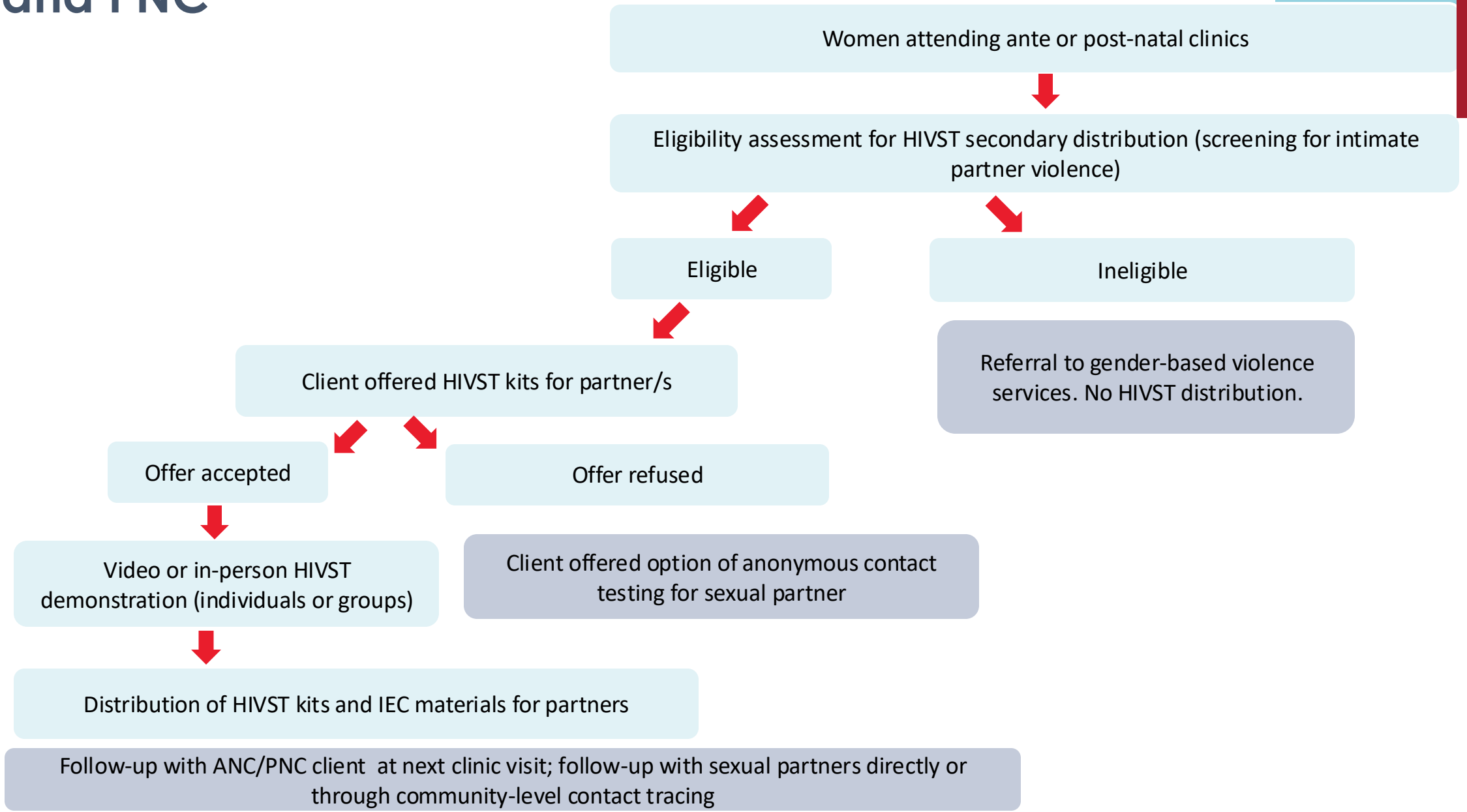
HIV incidence during pregnancy and breastfeeding is well above rates in women who are not pregnant, underlining the importance of male partner testing and diagnosis of HIV in sero-discordant partners with immediate treatment of HIV-positive partners and PrEP for pregnant women as crucial strategies to eliminate mother-to-child transmission of HIV.

Male partner HIV testing uptake during pregnancy remains low in many low- and middle-income countries, particularly in Africa. Studies have reported testing rates ranging from 19% to 41% among male partners of pregnant women.

HIVST delivered by sexual partner provides a convenient, confidential approach that can bypass facility access barriers among men:

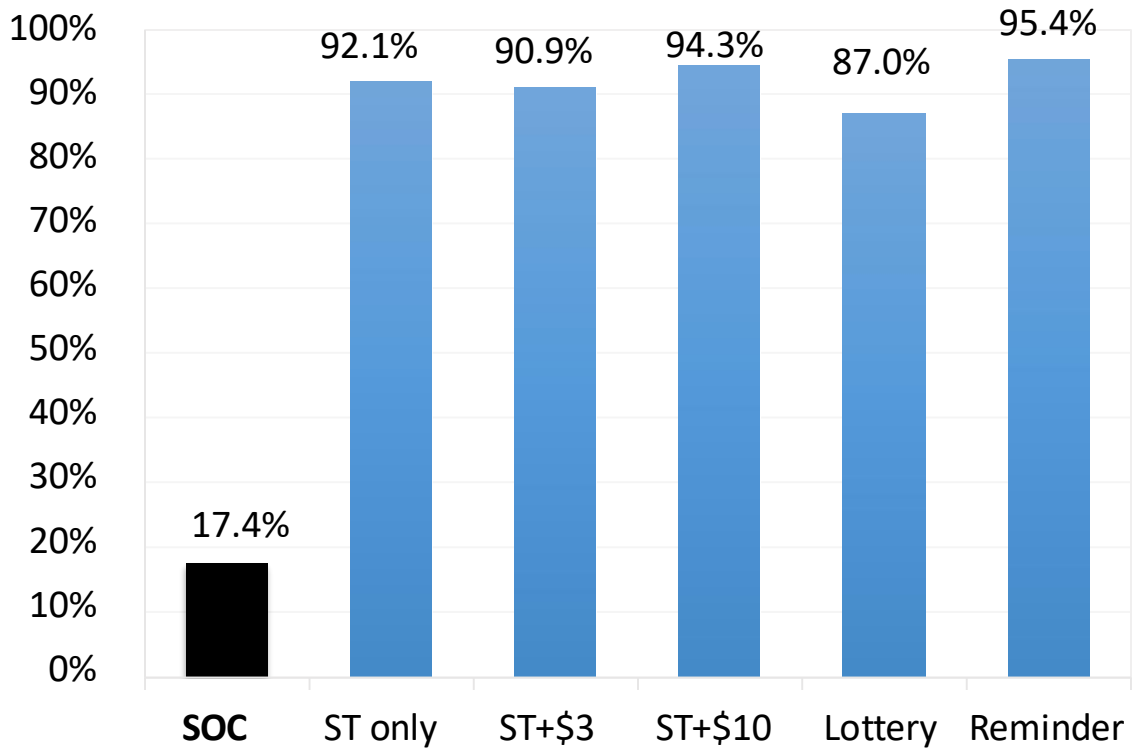
- High opportunity costs
- Confidentiality concerns
- Fear of loss of control, stigma and cultural norms

HIVST secondary distribution through PBFW in ANC and PNC

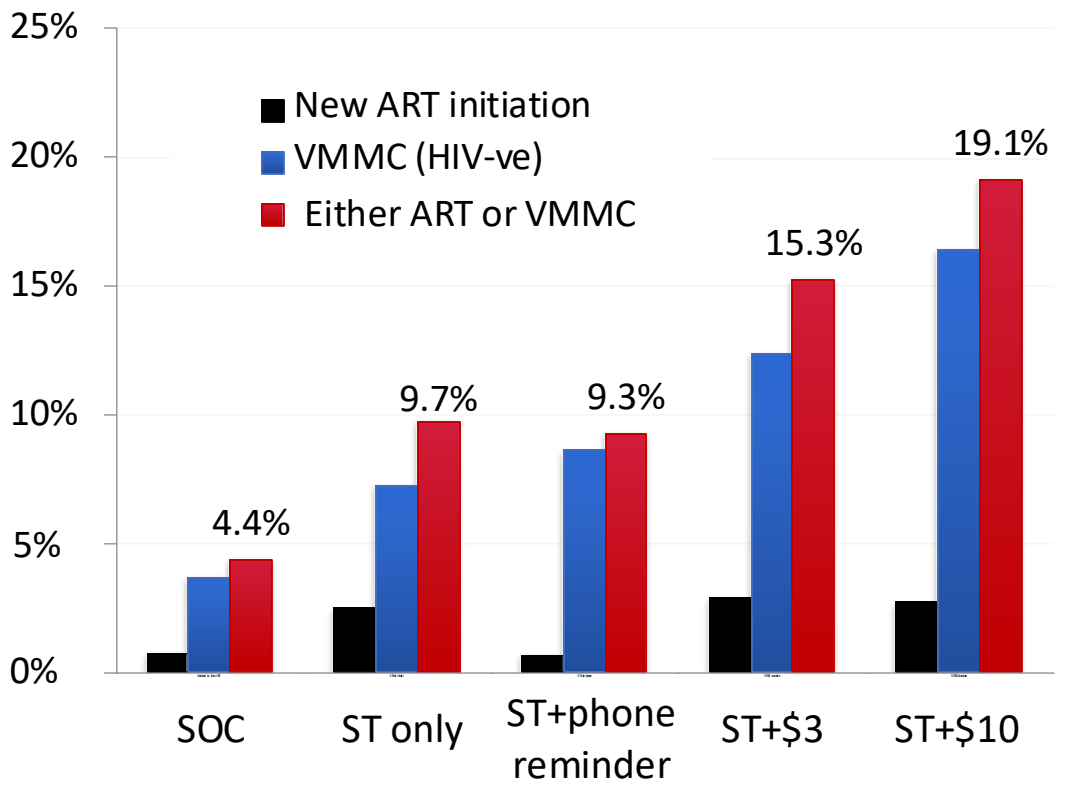


Secondary HIVST Distribution to Reach Men Via Antenatal Clinics, Blantyre, Malawi STAR Project

% male partners testing for HIV during pregnancy (as reported by woman)



% male partners starting ART or being circumcised <u>within 28 days</u>



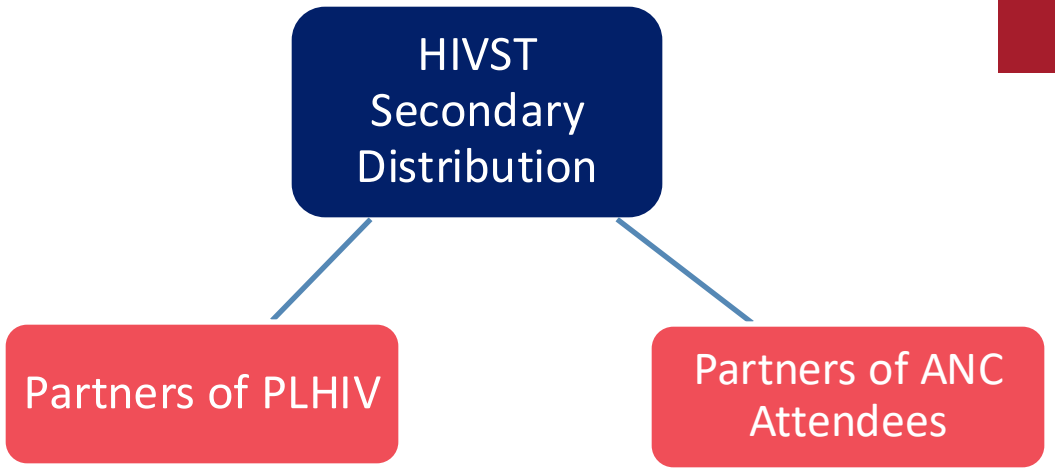
Partner-tested: All HIVST arms outperformed SOC
No effect of incentive (already fully motivated to use kit)

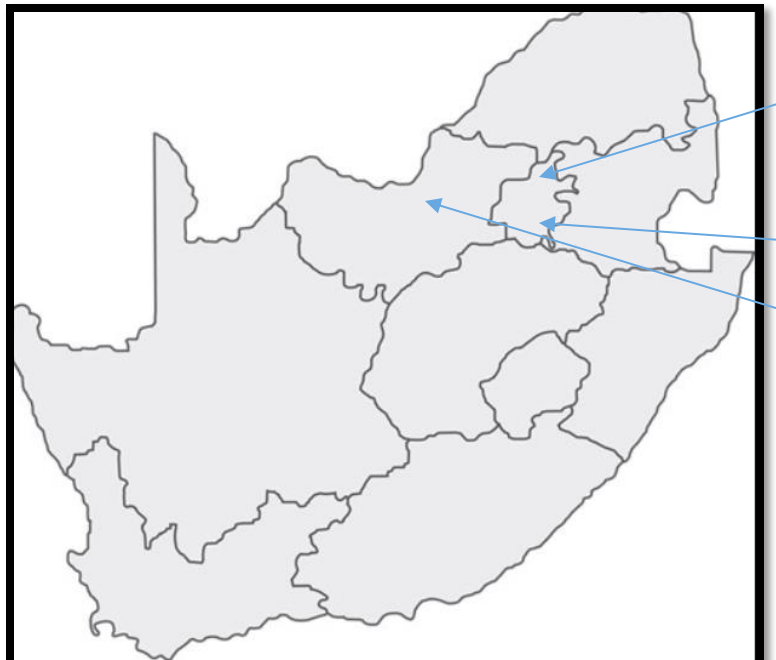
Choko PLoS Med 2019

Linkage of partner for ART or circumcision
Effect of incentive: strong + dose-effect.
Both Financial Incentive arms better than SOC

STAR South Africa: Partner Testing Secondary HIVST Distribution

- Secondary distribution of HIVST through community health clinic attendees (12 clinics) in three communities across 3 Districts in RSA May 2018 – October 2019
- HIVST test was offered for partner to newly diagnosed PLHIV and to antenatal clinic attendees, with partner(s) of unknown status.
- Participants consented to receive up to three follow up calls by the provider.
- Clients who were successfully followed up were asked for the partners test results.
- Sexual partners with reactive HIVST results were invited for confirmative testing and treatment and care at health facilities





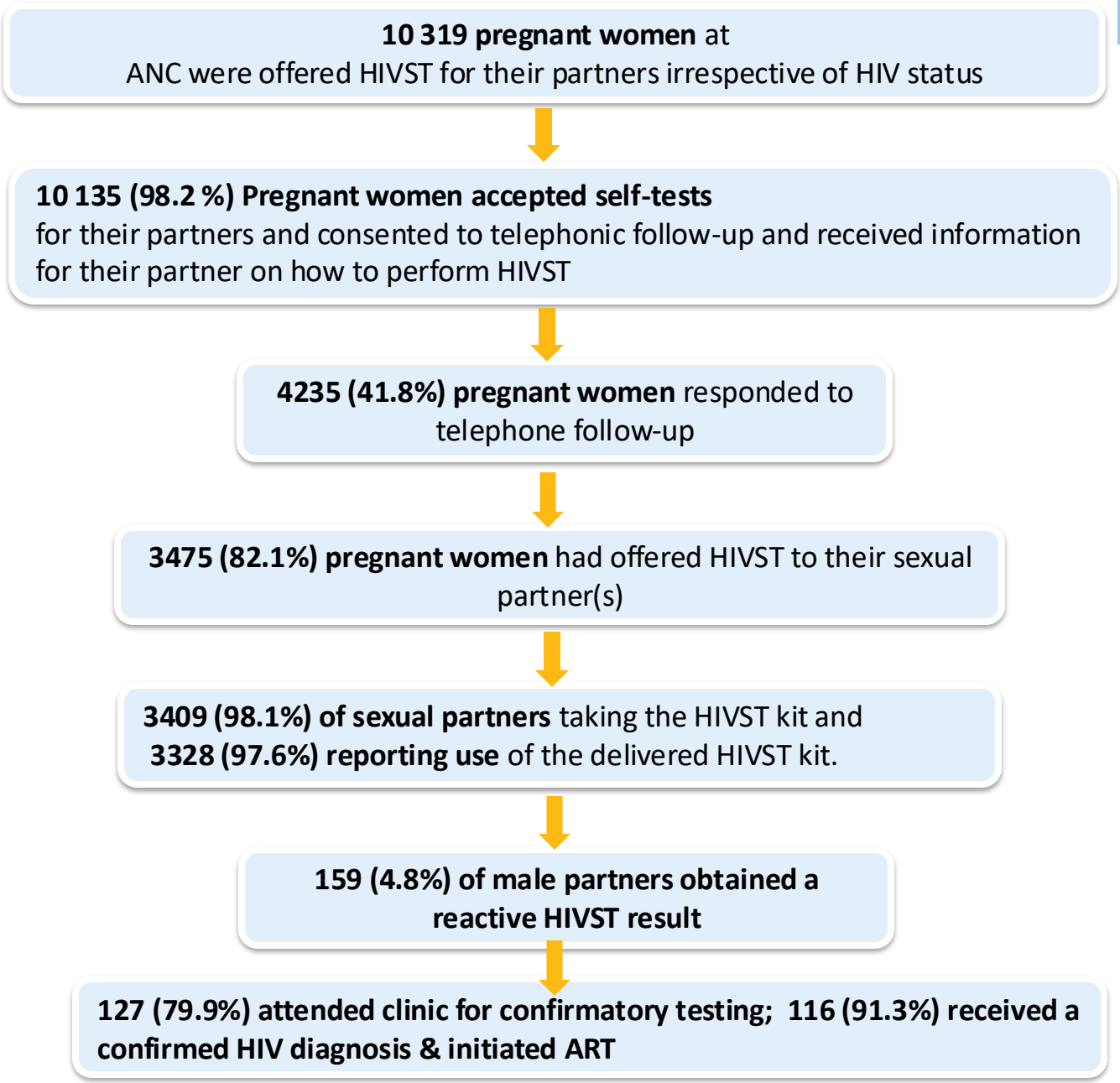
4 clinics City of Tswhane

5 clinics in City of Joburg

3 clinics Dr Kenneth Kaunda (DKK) district NW Province

Zishiri, V., Conserve, D.F., Haile, Z.T. Majam M *et al.* Secondary distribution of HIV self-test kits by HIV index and antenatal care clients: implementation and costing results from the STAR Initiative in South Africa. *BMC Infect Dis* **22** (Suppl 1), 971 (2022

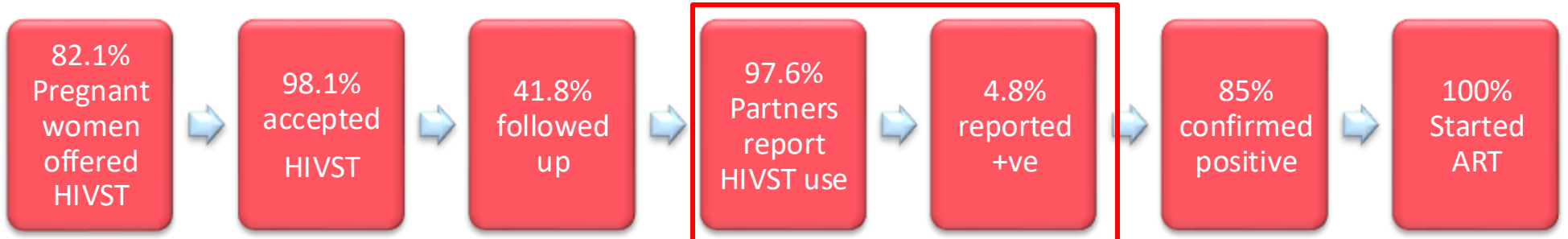
Results



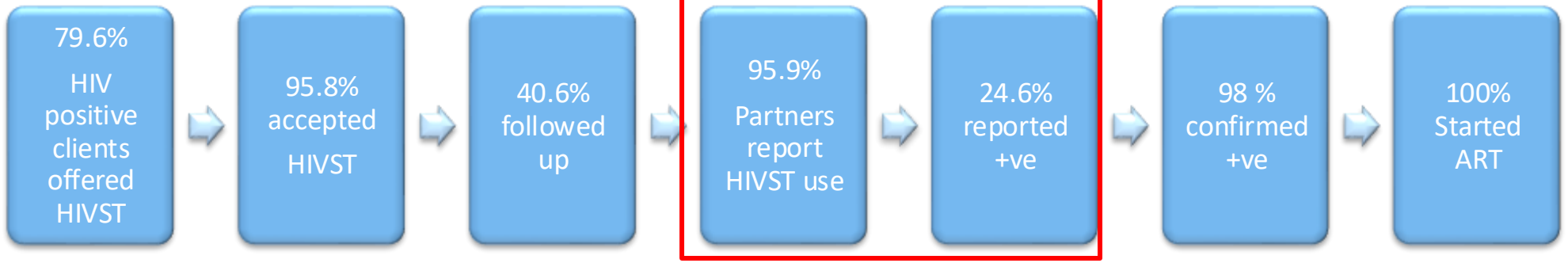
Zishiri, V., Conserve, D.F., Haile, Z.T. Majam M *et al.* . *BMC Infect Dis* **22** (Suppl 1), 971 (2022

High Uptake of HIVST and Post-Test Referral among partners reached through secondary distribution

PBFW Partner Testing



HIV (+) Partner Testing: 79% to male partners



Zishiri, V., Conserve, D.F., Haile, Z.T. Majam, M. *et al.* Secondary distribution of HIV self-test kits by HIV index and antenatal care clients: implementation and costing results from the STAR Initiative in South Africa. *BMC Infect Dis* **22** (Suppl 1), 971 (2022

Costs per HIVST through secondary distribution South Africa

District	DKK				COJ				COT			
	ANC	%	Index	%	ANC	%	Index	%	ANC	%	Index	%
Volume	**566**		**80**		**3,463**		**2,896**		**623**		**854**	
Capital costs												
Start-up training	$0,27	4,08%	$1,90	11,16%	$0,06	0,43%	$0,05	0,53%	$0,25	1,63%	$0,05	0,33%
Building & storage	$0,00	0,06%	$0,03	0,15%	$0,00	0,00%	$0,00	0,00%	$0,00	0,02%	$0,00	0,01%
Sensitisation	$0,05	0,76%	$0,00	0,02%	$0,02	0,17%	$0,01	0,10%	$0,11	0,74%	$0,00	0,02%
Start-up other	$0,01	0,10%	$0,02	0,10%	$0,01	0,10%	$0,01	0,10%	$0,02	0,10%	$0,02	0,10%
Equipment	$0,06	0,95%	$0,25	1,44%	$0,07	0,56%	$0,05	0,49%	$0,17	1,13%	$0,09	0,59%
Total capital costs	**$0,39**		**$2,19**		**$0,17**		**$0,13**		**$0,55**		**$0,15**	
Recurrent costs												
Personnel	$2,76	41,71%	$6,17	36,23%	$9,97	74,80%	$7,00	67,63%	$10,44	68,85%	$10,58	72,71%
Test kits	$2,24	33,90%	$2,24	13,16%	$2,24	16,80%	$2,24	21,63%	$2,24	14,77%	$2,24	15,40%
Other Supplies	$0,62	9,39%	$4,67	27,45%	$0,42	3,13%	$0,56	5,45%	$1,33	8,78%	$0,99	6,83%
Transportation	$0,02	0,23%	$0,04	0,23%	$0,03	0,23%	$0,02	0,23%	$0,04	0,23%	$0,03	0,23%
Building operation & maintenance	$0,35	5,29%	$1,11	6,53%	$0,03	0,26%	$0,03	0,32%	$0,04	0,23%	$0,03	0,24%
Other recurrent	$0.23	3.52%	$0.60	3.52%	$0.47	3.52%	$0.36	3.52%	$0.53	3.52%	$0.51	3.52%
Total recurrent costs	**$6,22**		**$14,83**		**$13,16**		**$10,21**		**$14,62**		**$14,38**	
Average cost per test kit distributed	**$6,61**	**100%**	**$17,02**	**100%**	**$13,33**	**100%**	**$10,34**	**100%**	**$15,17**	**100%**	**$14,55**	**100%**

Secondary Distribution – Challenges & Solutions

Accurate Use

Challenge: Effective secondary distribution relies on clients understanding proper kit usage and conveying it correctly to others.

Solution: Provide clear instructions on kit usage and emphasize the steps to take if a reactive result is obtained.

Challenge: Support by health providers usually not feasible, limiting guidance and support for individuals requiring more support.

Solution: Implement digital health interventions, such as remotely-supported testing via video or online support platforms. These tools provide step-by-step guidance, ensuring clients have the support needed for accurate test use and linkage to care.

Ensuring Linkages

Challenge: Tracking whether individuals with reactive results follow through with confirmatory testing, or linkages to HIV preventive services

Solution: Include contact information for follow-up care or counseling and provide local facility cards to ease access to services for clients needing support, follow up with the client who distributed HIVST kit to partners to identify ways to follow up with secondary recipient.

Secondary Distribution – Challenges & Solutions

Stigma and Client Discomfort

***Challenge*:** Clients may feel hesitant to suggest testing to partners and close contacts due to perceived stigma, discomfort, or fear of social judgment.
***Solution*:** Provide counseling and stigma-sensitive materials to help clients initiate respectful discussions about HIVST with close contacts.

Risk of Partner Violence

Challenge*: Sharing HIVST kits with partners could increase tension or risk of partner violence for certain clients.*
Solution*: Screen clients for potential risks of partner violence and offer additional counseling or alternative testing options*

Key Points

- Secondary distribution of HIVST consistently demonstrates high acceptability & uptake and minimal adverse events across multiple studies, including the STAR Initiative.
- Partner-delivered HIV self-testing (HIVST) was highly acceptable among sexual partners in South Africa, with substantial proportions of male partners successfully linking to care following a reactive HIVST result.
- In Malawi study, financial incentives emerged as a strong motivator for male partner engagement, highlighting the persistent structural and economic barriers that may prevent men from accessing confirmatory testing and antiretroviral therapy.
- The costs associated with delivery of secondary HIVST distribution are comparable to facility-based conventional testing approaches and hold potential for further reduction through integration, reduced test kit unit costs, HR costs and economies of scale.
- Integrated partner delivered HIVST distribution model has been widely adopted across LMICs with high HIV burden and offers significant opportunity for optimization to improve coverage and impact.

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