

# Prioritizing Low-Cost and Effective Differentiated HIV Testing Services: Frequently Asked Questions (FAQ)

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HIV testing is an essential health service and a gateway to lifesaving treatment and high-impact strategies that stop new HIV infections. However, reductions in international funding for global health—including national HIV programs—are causing disruptions in service delivery. This FAQ, developed alongside the 12 May WHO-PSI webinar, offers practical guidance for countries aiming to sustain HIV testing services by implementing cost-effective and differentiated strategies.

## Q1: Why is it urgent to prioritize low-cost HIV testing services?

Global resources for HIV programmes are increasingly limited and declining and appear to be declining. These funding constraints are threatening the future delivery of HIV testing—which remain an essential step toward HIV treatment and prevention.

Even though HIV testing remains a critical component that of all programmes, it generally comprises less than 10% of the total HIV programme budget.

Most HIV testing costs are driven by: (1) the personnel who carry out testing services and (2) the test kits and commodities delivered. Together, these two account for over 80% of HIV testing costs.

Through targeting cost-saving efforts in these areas substantial savings can be achieved.

## Q2: How should countries adopt low-cost quality assured rapid tests, starting with the first test in the national HIV testing algorithms?

The first test (assay 1, A1) in a country's national HIV testing algorithm is the biggest driver of test kit costs. Switching to a low cost, quality-assured option, such as those WHO prequalified (PQ) and listed in the [WHO catalogue](#) or available through [pooled procurement mechanisms](#) (e.g. Wambo) can yield substantial savings.

Key priorities for easing algorithm transition for more rapid savings:

- Removing a third test (often referred to as assay three, A3) will not have much impact on the cost of the testing algorithm or programme;
- Changing the first test in the algorithm (A1) while retaining second and third test (assay two and three, A2/A3) in the algorithm simplifies transition and helps preserve quality—this applies to programmes using the dual HIV/syphilis rapid test and as the first test in antenatal care;
- Compare and negotiate with landed prices in mind (inclusive of shipping and logistics) to maximize savings;
- Adopt country waivers to expedite access to low-cost WHO PQ HIV RDTs WHO PQ;
- Engage industry/manufacturers to cover quality assurance and training costs.

The [WHO toolkit on HIV algorithm verification studies and product selection](#) is a helpful tool that can be used for planning algorithm transition and helping countries maintain quality while reducing overall costs.

### **Q3: How can countries leverage HIV self-testing (HIVST), to mitigate limited stock of the first test (A1) and limited human resources?**

HIV self-testing (HIVST) continues to be a valuable approach as it is flexible and can be used by individuals independently. Also, because all those with a negative self-test result do not need further testing, follow-up and health worker time can be prioritized toward those with reactive self-test results.

WHO recommends facility-based HIVST. Any country facing staffing shortages that affect testing coverage and capacity should consider using HIVST to continue access to essential services.

Countries should prioritize the use of quality-assured HIV self-tests and the adoption of low-cost HIV self-tests to maximize limited resources. Any country facing a stock-out or limited testing capacity can consider using a self-test as the first test in the national algorithm.

### **Q4: What other strategies support cost-effective HIV testing?**

The following strategies 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
  - o 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).

### **Q5: Which populations should countries prioritize 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 prioritised 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 ( $\geq 5\%$  HIV prevalence) at any clinic/hospital;

- Pregnant women at first antenatal visit, or catch-up testing at earliest possible time if missed;
- 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)<sup>i</sup>;
- Sexual and injecting partners, and biological children, of newly diagnosed PLHIV;
- Network-based testing for individuals from key populations or other risk networks.

## **Q6: How should programmes optimize retesting?**

Programmes should consider:

- 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;
  - o Reserving maternal retesting to only high HIV burden settings ( $\geq 5\%$  HIV prevalence) or women is from a key population;
  - o Implementing only one additional test after 1<sup>st</sup> 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.

Additional options to support retesting options may be considered if affordable and linked to impactful programming. Offering convenient and user-paid options for additional retesting may also be an option for some settings where appropriate.

## **Q7: How should community-based testing services adapt when it is no longer feasible to fund past approaches?**

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 (1-3 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.

### **Q8: Should countries continue to test for Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP)?**

Yes. HIV testing remains essential, but should be simplified:

- For PEP, oral PrEP and the dapivirine vaginal ring: Use RDTs and/or HIVST – including for initiation, continuation, and re-initiation;
- For long-acting injectable (LA) PrEP: Use RDTs for initiation and monitoring;
- 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.

### **Q09: Should blood donations be screened for HIV?**

Yes, 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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