

So HIVST costs more than HTS in early introduction- what can we do about it for scale up?

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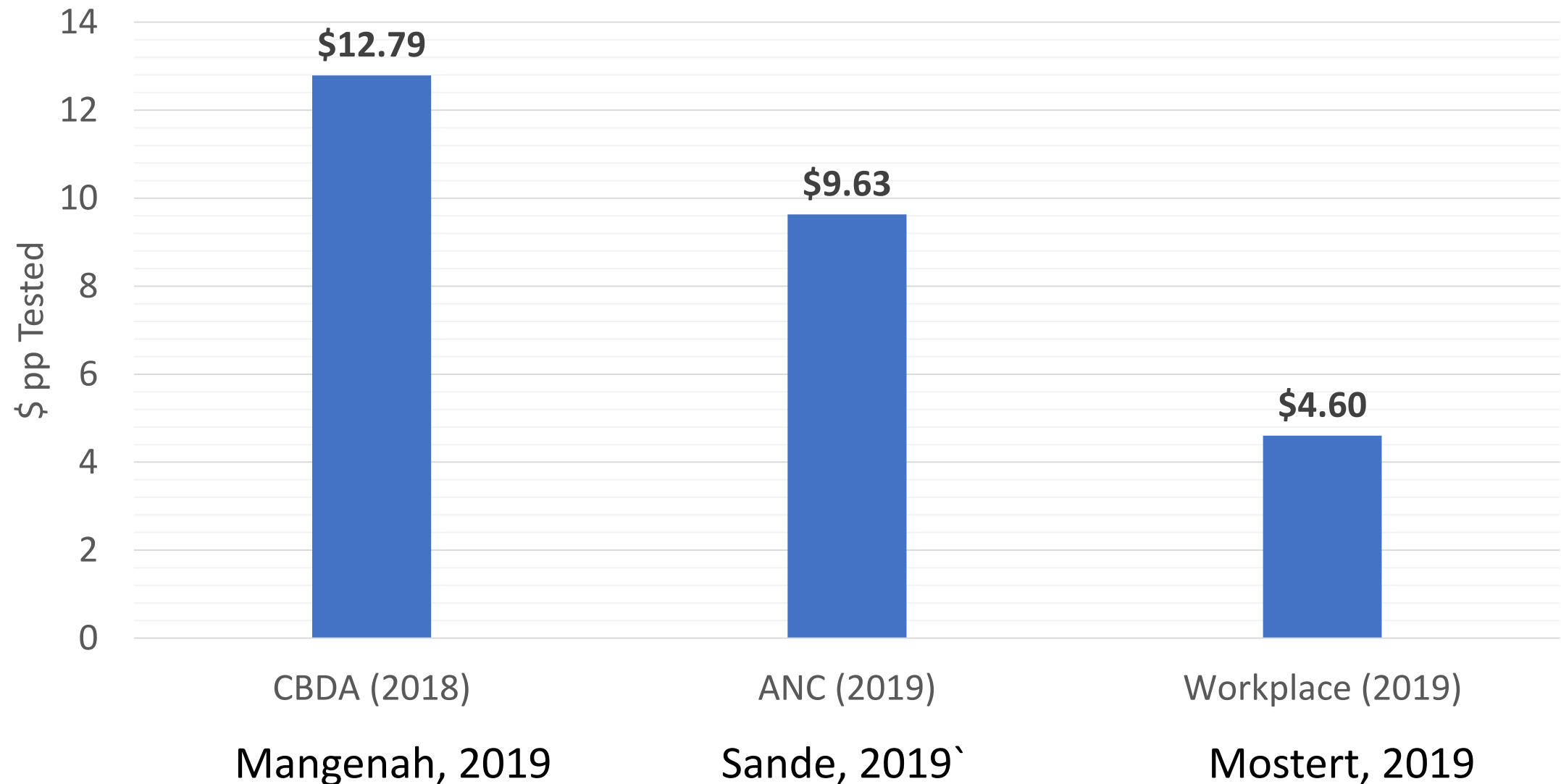


1. The costs we found

across models, countries and STAR phases

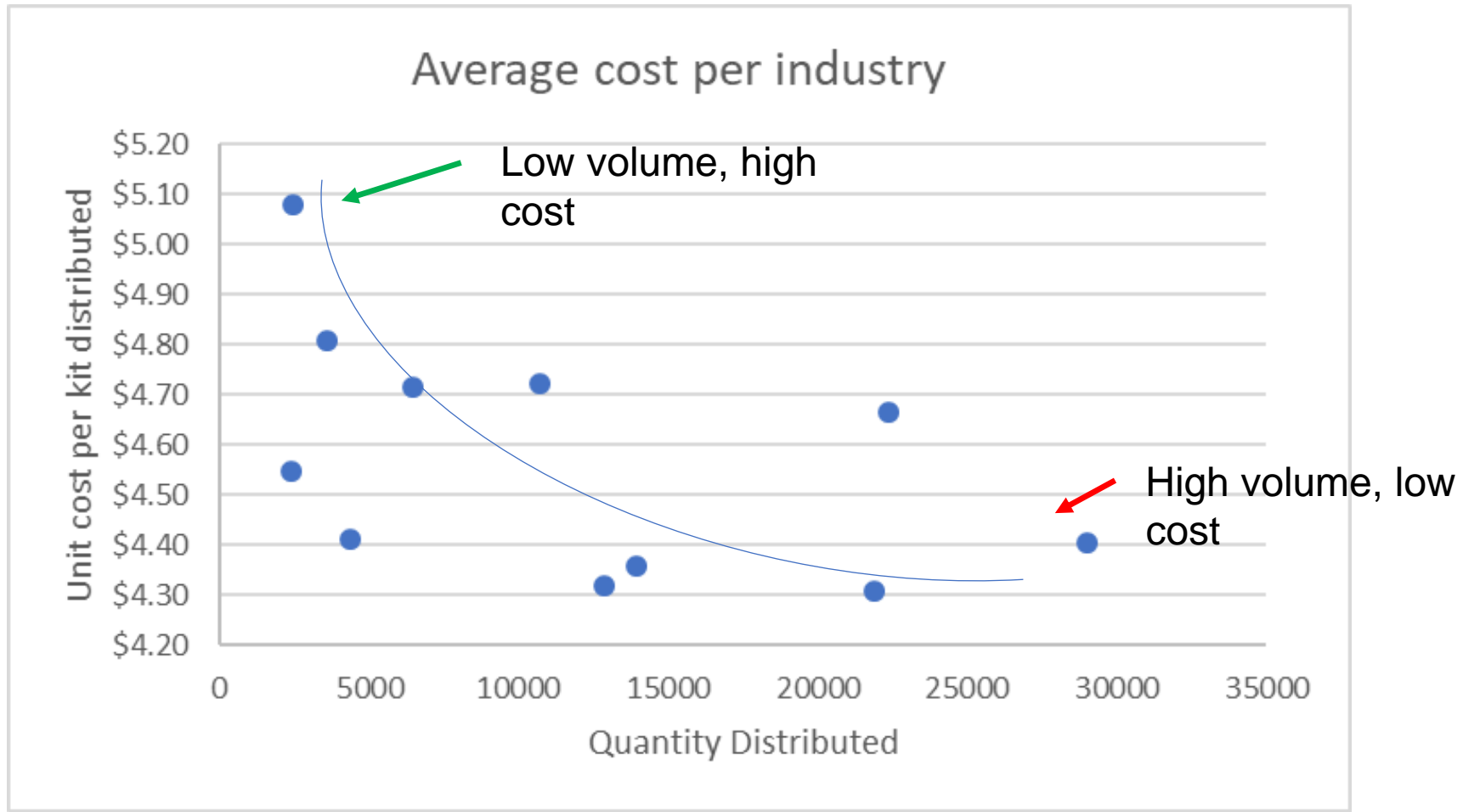
- Cost ^ product maturity
- Cost ^ scale
- Cost ^ yield
- Cost ^ baseline knowledge of status
- Cost ^ incentives (incl. targets)

Cost ^ product maturity: Costs evolve along the product introduction lifespan



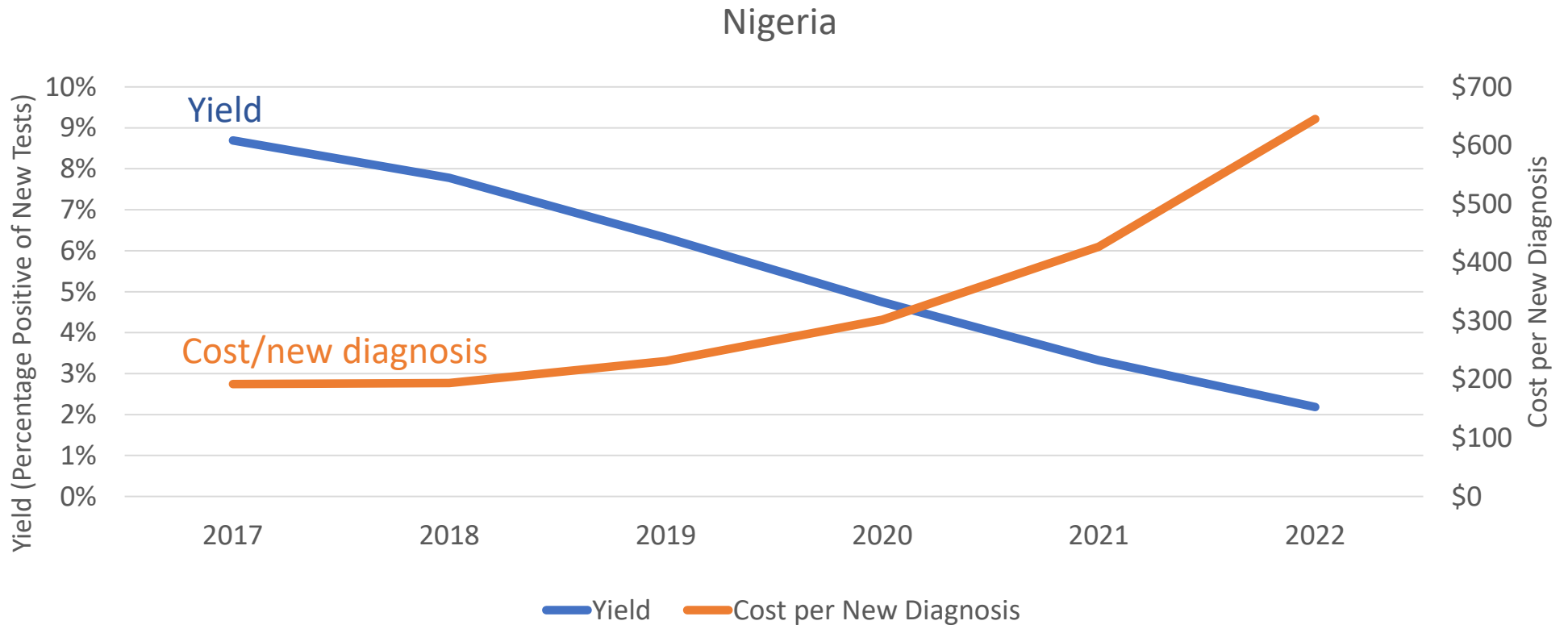
Cost ^ scale:

Results of workplace cost analysis (SA, Ph. 2) suggest economies of scale



Cost ^ yield:

Yield declines and cost per new diagnosis increases as knowledge approaches 90%



Yield declines as most PLHIV are diagnosed and on ART. At the limit, new diagnoses will represent new infections since most existing infections will already be diagnosed.

Some efficient models

- Large scale distribution is easier in spaces with lots of people
 - Workplaces after everyone has been brought into one large room
 - Taxi ranks
 - OPD waiting rooms
- Models with repeated testing of individuals
 - ANC (South Africa now calls for monthly HIV testing)
 - PrEP (once we have more sensitive HIVST kits!!)
 - Key pop programmes

In summary,

- Across phase 1 and 2 countries, **HIVST costs between \$4 and \$16 per kit distributed** (not including the cost of confirmatory testing in people screening positive)
- Wide variation in unit costs within models and countries
- Large economies of scale (lower costs with higher outputs)
- But scale up will lead to fewer PLHIV identified per kit distributed
- Expect higher unit costs → trade off between
 - implementation efficiency (cost per PLHIV) & cost-effectiveness
 - identifying those last PLHIV as we approach 1st 90 across all pops
- Think sustainability at the start of intervention design.

2. Challenges and lessons learned

across models, countries and STAR phases

- Costing of early implementation/ proof of concept vs routine implementation
 - Above-implementation costs
 - Tension between full expenditure (top-down costs) and micro-costing (bottom-up costing)
 - Programmes aiming for efficacy or feasibility need to quickly transition into aim of sustainability.
- Prevalent demand/ incident demand
- Capital vs recurrent costs
 - What is the saturation point for explanation/ training by distributors?
 - Should first contact w new HIVST-er be treated as training cost and annualised?

3. Points to consider in budgeting for your country's HIVST programme

- Collect **cost per kit distributed** across a range of models at a representative scale and implementation maturity (or adjust ours to your locally relevant prices and salaries)
 - Estimate the **number of people** likely approachable in each distribution model and their likely **uptake**
 - Assume **replacement effects** (ie, how many people will no longer access regular HTS after self-testing)
 - Calculate **follow-on costs**
 - Confirmatory testing and ART for PLHIV
 - MMC, PrEP, etc for HIV negs
- **Calculate annual budget for HIVST programme**

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Senior and mid-level health economists needed!

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