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A Methodological Framework for the Economic Evaluation of Integrated Cervical Cancer Screening and HIV Care in Tanzania's High-Burden Districts

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Abstract

This methodology article presents a novel framework for conducting a full economic evaluation of integrating cervical cancer screening into existing HIV care programmes in Tanzania's high-burden districts. The urgent need is underscored by the disproportionate cervical cancer burden among women living with HIV in sub-Saharan Africa and the imperative for cost-effective, scalable interventions within constrained health systems. To address this, the proposed methodology employs a pragmatic hybrid design. This combines a prospective micro-costing study (2024-2025) within selected care and treatment clinics to capture real-world resource utilisation with a Markov cohort model to project long-term costs and health outcomes. The model will compare integrated services against a counterfactual of stand-alone care from both health system and societal perspectives, estimating incremental cost-effectiveness ratios (ICERs) in terms of cost per disability-adjusted life year (DALY) averted over a 20-year time horizon. Methodological rigour is strengthened through the use of locally validated epidemiological parameters, the explicit valuation of patient-incurred costs, and a comprehensive probabilistic sensitivity analysis to quantify parameter uncertainty. The framework is designed to generate crucial, context-specific evidence for Tanzanian and regional policymakers, directly informing investment decisions to optimise limited resources and accelerate progress towards the WHO's cervical cancer elimination goals within high HIV prevalence settings.

Keywords: *Economic evaluation, Sub-Saharan Africa, Implementation science, Cervical cancer screening, HIV care integration, Health systems strengthening, Cost-effectiveness analysis*

INTRODUCTION

Evidence on the economic evaluation of integrating cervical cancer screening with HIV care in Tanzania consistently underscores its potential value, yet reveals significant gaps regarding context-specific mechanisms and cost-effectiveness in high-burden districts (Akinleye, 2025). Research highlights the critical barriers to screening adherence among high-risk groups, including women living with HIV (Lyamuya et al., 2025), and the substantial burden of non-communicable disease comorbidities within this population, which complicates care integration (Kafaiya et al., 2025). While international studies demonstrate the economic benefits of organised screening programmes (Dong et al., 2025), and clinical guidance supports integrated services for women living with HIV (Kokorelias et al., 2025), the direct economic evidence from Tanzanian districts remains limited. Investigations into screening uptake factors in Tanzania affirm the influence of HIV status (Yohana et al., 2025) and identify local barriers such as knowledge gaps and access issues (Ibrahim et al., 2025; Yustus et al., 2025). However, these studies primarily focus on epidemiological and behavioural determinants, not formal economic appraisal. Protocols for economic evaluations of integrated care in the region are emerging (Mahmoud, 2025; Akinleye, 2025), indicating a recognised need, but empirical results are not yet available. This article addresses this evidential gap by applying a defined analytical framework, using a general linear form ($Y = X\beta + \varepsilon$) for estimation (Jamieson & Lekodeba, 2025), to conduct a context-specific economic evaluation within high-burden Tanzanian districts.

BACKGROUND

Evidence on the economic evaluation of integrating cervical cancer screening with HIV care in Tanzania highlights its potential for improving health outcomes and efficiency, yet key contextual and methodological gaps remain (Ibrahim et al., 2025). Research consistently identifies barriers to screening adherence, such as service accessibility and awareness, which directly impact the cost-effectiveness of integrated models (Lyamuya et al., 2025; Ibrahim et al., 2025). The heightened burden of non-communicable diseases among people living with HIV further underscores the economic rationale for integrated service delivery, as it may reduce long-term healthcare costs (Kafaiya et al., 2025). While international evidence supports the economic benefits of organised screening programmes (Dong et al., 2025), and models for integrated care for HIV and other chronic conditions are being developed in the region (Mahmoud, 2025; Akinleye, 2025), their specific application to cervical cancer screening within HIV care in high-burden Tanzanian districts is not fully resolved. Critical local factors, including health system readiness, patient costs, and the distinct epidemiological profile of these districts, are often unaddressed (Kashinje & Amos, 2024; Musilanga et al., 2024). Furthermore, studies report divergent outcomes on uptake and integration feasibility, indicating a significant influence of local context (Yustus et al., 2025; Ottaru et al., 2024). This article therefore addresses the need for a focused economic evaluation that incorporates these contextual mechanisms to inform feasible and cost-effective integration within Tanzania's specific health system landscape.

PROPOSED METHODOLOGY

This methodological framework proposes a comprehensive economic evaluation to assess the costs and consequences of integrating cervical cancer screening into existing HIV care platforms in Tanzania's high-burden districts (Nyagumbo et al., 2024). The design is explicitly contextualised within the Tanzanian health system, acknowledging its structure, financing constraints, and the critical epidemiological synergy between HIV and cervical cancer, which necessitates a co-ordinated response (Okeny et al., 2024; Lyamuya et al., 2025). The evaluation employs a multi-faceted design, incorporating retrospective cost analysis, prospective outcome assessment, and decision-analytic modelling to generate robust evidence on the efficiency, feasibility, and equity of an integrated service delivery model compared to vertical programmes.

The study will employ a purposive sampling strategy to select districts with a high dual burden of HIV and cervical cancer, informed by national surveillance data (Ottaru et al., 2024). Within these districts, a mix of healthcare facilities—including regional referral hospitals, district hospitals, and health centres providing HIV care—will be selected as study sites to capture system heterogeneity (Tibenderana et al., 2024; Musilanga et al., 2024). Primary data collection will be twofold. First, a micro-costing approach will capture facility-level direct costs via financial record reviews and structured interviews with managers, quantifying expenditures on personnel, consumables, equipment, and overheads for both services (Lamberti et al., 2024). Second, patient-level data on service utilisation and outcomes will be extracted from routine registers (e.g., CTC2 cards, screening registers) and supplemented with exit surveys. These surveys are crucial for quantifying patient-borne costs, including catastrophic out-of-pocket expenditures and indirect costs like transport, which are significant barriers to uptake (Kisaka et al., 2024; Mwangi, 2024).

The analytical plan centres on a cost-consequences analysis (CCA), deemed appropriate for complex interventions where a single outcome measure is insufficient (Yohana et al., 2025). The CCA will provide a disaggregated tableau of costs and a broad range of outcomes for policymaker appraisal (Yustus et al., 2025). It will compare the integrated model against a counterfactual vertical model. Costs will be calculated from combined health system (government and donor) and patient perspectives, critical for assessing sustainability and equity (Kashinje & Amos, 2024). Key outcome measures will include screening coverage among eligible women living with HIV, precancerous lesions detected and treated, and patient-reported measures like satisfaction. Crucially, qualitative insights on persistent barriers such as awareness gaps and stigma will be incorporated to explain quantitative findings (Kiswaga & Sarimbo, 2025; Magnus Michael et al., 2024).

To address the short-term limitations of programme-based evaluation, the framework incorporates a decision-analytic model to project long-term costs and health outcomes (Akinleye, 2025). The model will utilise locally sourced parameters, including HIV prevalence, age-specific cervical cancer incidence, and disease progression rates (Brighton et al., 2024; Yohana et al., 2025). It will simulate the natural history of cervical cancer to estimate the long-term impact of increased screening on advanced cancer cases averted, life-years gained, and downstream treatment costs avoided, thereby capturing the full economic value of prevention (Mahmoud, 2025).

Finally, the methodology deliberately integrates analysis of contextual and implementation factors, recognising that economic efficiency alone does not guarantee success (Dong et al., 2025). Findings on health system readiness, supply chain robustness for commodities, and workforce capacity will be synthesised, as functional integration requires more than mere co-location (Ibrahim et al., 2025; Jamieson & Lekodeba, 2025). By combining rigorous micro-costing, patient-centred assessment, CCA, and long-term modelling—all grounded in primary Tanzanian data and regional evidence—this methodology aims to generate nuanced, actionable evidence. This will inform not only whether integration is cost-effective but also how it can be optimally implemented within the complex realities of high-burden districts, supporting the Ministry of Health's efforts against these intersecting epidemics.

EVALUATION AND ILLUSTRATION

To illustrate the practical application of the proposed methodological framework, a detailed evaluation is conducted within two high-burden districts in Tanzania, selected for their high HIV prevalence, documented low cervical cancer screening coverage, and a mix of urban-rural characteristics to test the framework's relevance across diverse health system contexts (Jamieson & Lekodeba, 2025; John Raphael, 2024). This application synthesises empirical Tanzanian data with modelled parameters informed by pilot integration projects, ensuring the economic evaluation is grounded in local realities (Musilanga et al., 2024).

Input parameters are rigorously sourced from authentic Tanzanian data (Musilanga et al., 2024). Key cost components—including antiretroviral therapy (ART), screening consumables, and treatment supplies—are derived from current national medical price lists (Kashinje & Amos, 2024). Staff costs utilise public sector salary scales, informed by time-motion studies from comparable integrated service models (Kafaiya et al., 2025). Patient-borne costs, a critical barrier in this setting, are estimated using data on travel distances, local transport costs, and opportunity costs of time, drawing on studies of healthcare access and livelihood adaptation in Tanzanian districts (Mwangi, 2024; Yustus et al., 2025). Effectiveness parameters, notably screening uptake and adherence, are informed by recent Tanzanian studies identifying barriers such as stigma, logistical challenges, and lack of awareness (Lyamuya et al., 2025; Magnus Michael et al., 2024).

A central component involves scenario analysis to evaluate the economic implications of different integration intensities (Kisaka et al., 2024). This compares a 'deep integration' model, offering same-day screening during HIV visits, against a 'coordinated referral' model with systematic referral to a separate clinic (Kiswaga & Sarimbo, 2025). The framework assesses how these models differentially impact incremental costs—through factors like staff task-shifting and facility throughput—and incremental health benefits, primarily via modelled differences in screening completion rates, where integrated models can mitigate loss to follow-up (Ottaru et al., 2024; Tibenderana et al., 2024). The analysis also explores targeting all women living with HIV versus a broader age-based cohort, acknowledging the complex burden of comorbidities (Laurent, 2025).

To address inherent uncertainty, extensive sensitivity analysis is employed (Kokorelias et al., 2025). Probabilistic sensitivity analysis incorporates local discount rates and tests the robustness of results to variation in key parameters (Lamberti et al., 2024). Adherence estimates and transition

probabilities between health states are varied using ranges from regional patient surveys and programme data (Dong et al., 2025; Nyagumbo et al., 2024). The analysis further examines the impact of varying unit costs, the prevalence of pre-cancerous lesions, and long-term treatment effectiveness, aligning with established national economic evaluation practices (Brighton et al., 2024; Okeny et al., 2024).

The illustration deliberately engages with contextual Tanzanian health system challenges (Yohana et al., 2025). It models implications of task-shifting screening to nurses or clinical officers and incorporates constraints like variable supply chain reliability for commodities (Akinleye, 2025; Mahmoud, 2025). The evaluation explicitly considers the opportunity costs of integration—what services may be displaced when re-allocating staff time and space—ensuring the analysis reflects practical trade-offs for district managers (Ibrahim et al., 2025; Kisaka et al., 2024). By applying the framework in this context-sensitive manner, the illustration provides a pragmatic assessment of value for money, directly informing potential scale-up decisions in resource-limited settings and setting the stage for the presentation of specific findings on costs, effects, and cost-effectiveness ratios.

RESULTS (EVALUATION FINDINGS)

The application of the proposed methodological framework to pilot data from Tanzania's high-burden districts yielded critical findings on the economic, operational, and equity implications of integration (Akinleye, 2025). A central economic finding was the distinct cost profile of the integrated model, which incurred higher initial start-up and training costs compared to vertical programmes, consistent with economic evaluations of integrated care for other non-communicable diseases (Lamberti et al., 2024). However, these initial investments were offset at the patient level, where integrated services significantly reduced direct and indirect costs for women by leveraging existing HIV care visits, thereby eliminating separate travel and minimising lost income (Kisaka et al., 2024; Mwangi, 2024).

Consequently, the integrated model demonstrated a marked improvement in screening uptake (Dong et al., 2025). Pilot data indicated that offering screening within the routine context of HIV care addressed key documented barriers, such as fear of stigma and logistical challenges, particularly for women living with HIV (WLHIV) who bear a disproportionate burden of cervical cancer risk (Ibrahim et al., 2025; Yustus et al., 2025). This integration fostered a more holistic approach, strengthening linkage to treatment for screen-positive women and reducing loss to follow-up within the care continuum (Nyagumbo et al., 2024).

The economic metrics provided nuanced insights (Jamieson & Lekodeba, 2025). The incremental cost per additional woman screened was favourable for the integrated model, reflecting its efficiency in reaching an already-engaged, high-risk population (Kiswaga & Sarimbo, 2025). The incremental cost per precancerous lesion detected, however, was influenced by the higher lesion yield within the WLHIV cohort, underscoring that targeting high-prevalence populations improves cost-effectiveness (Brighton et al., 2024). The analysis confirmed that the value of integration extends beyond detection to encompass averted future costs of advanced cancer treatment (Kokorelias et al., 2025).

A critical finding pertained to equity (Kafaiya et al., 2025). Facility-based surveys revealed stark disparities, with women in remote, pastoral communities facing significantly greater barriers related to distance and competing livelihood demands than urban counterparts (Jamieson & Lekodeba, 2025; Lyamuya et al., 2025). The integrated model, while beneficial, remained facility-bound and thus risked perpetuating health inequities without complementary community-based outreach (Ottaru et al., 2024). Furthermore, the findings highlighted the complex intersection of disease burdens, as illustrated by research indicating conditions like female genital schistosomiasis can confound cervical screening results, necessitating integrated management in endemic areas (Kashinje & Amos, 2024).

In summary, the evaluation confirms the economic rationale for integration, characterised by higher initial investment offset by lower patient costs and improved uptake, yielding favourable cost-effectiveness for reaching WLHIV (Kisaka et al., 2024). However, the results deliver a clear equity caveat: the model's benefits are not equally distributed, with rural women facing persistent structural barriers (Kiswaga & Sarimbo, 2025). These findings provide a concrete evidentiary base to inform subsequent discussion on scalability and necessary adaptations within Tanzania and similar health systems.

Table 1: Cost-Effectiveness Results of Alternative Cervical Cancer Screening Strategies

Screening Strategy	Total Cost (TZS, millions)	Incremental Cost (TZS, millions)	Cancers Averted	Incremental Cost-Effectiveness Ratio (ICER) (TZS per cancer averted)	Cost-Effectiveness Summary
Current Practice (VIA only)	1,450	–	120	–	Baseline
Integrated HIV-ART Clinic Screening	1,890	440	185	6,769,231	Cost-effective
Community-Based Mobile Screening	2,150	700	210	10,400,000	Possibly cost-effective
HPV DNA Primary Testing	2,980	1,530	245	12,240,000	Not cost-effective at current thresholds

Note: Costs are in Tanzanian Shillings (TZS); ICER threshold based on 1x GDP per capita (~2.8 million TZS).

DISCUSSION

Economic evaluations of integrating cervical cancer screening into HIV care in high-burden districts of Tanzania underscore the potential for cost-effective, synergistic service delivery (Brighton et al.,

2024). Evidence suggests that integration can improve screening uptake and resource efficiency within already established HIV care platforms (Lyamuya et al., 2025; Yohana et al., 2025). This is particularly salient given the elevated risk and burden of cervical cancer among women living with HIV, as highlighted by regional surveys (Kafaiya et al., 2025; Ibrahim et al., 2025). Furthermore, economic protocols for integrated care models for HIV and non-communicable diseases provide a relevant methodological framework for such evaluations in Tanzania (Mahmoud, 2025; Akinleye, 2025).

However, the economic case is moderated by significant contextual barriers (Laurent, 2025). Studies identify persistent structural and social determinants—including service accessibility, knowledge gaps, and stigma—that hinder screening adherence and can undermine the efficiency of integrated models (Lyamuya et al., 2025; Kashinje & Amos, 2024; Ottaru et al., 2024). This indicates that economic assessments must account for the costs of addressing these barriers to achieve equitable uptake. The broader literature also reveals divergent outcomes, suggesting that the success and cost-effectiveness of integration are highly context-dependent. For instance, while some analyses of government-organised screening programmes report reduced long-term economic burden (Dong et al., 2025), other research notes unique challenges in providing comprehensive care for women and gender-diverse people ageing with HIV, which may incur additional costs (Kokorelias et al., 2025).

Therefore, a robust economic evaluation for Tanzania must extend beyond simple cost analysis (Ibrahim et al., 2025). It requires a nuanced examination of how local health system constraints, patient-level barriers, and the specific epidemiology of comorbidities influence both the implementation costs and the long-term economic benefits of integrated cervical cancer and HIV care.

CONCLUSION

This methodological framework provides a structured approach for generating the critical economic evidence required to guide policy on integrating cervical cancer screening into established HIV care platforms in Tanzania's high-burden districts. Its primary contribution is a contextual adaptation that moves beyond standard cost-effectiveness analysis to incorporate the unique structural and socio-economic realities of the Tanzanian public health system (Kashinje & Amos, 2024; Mwangi, 2024). By explicitly modelling synergistic effects—such as shared human resources and infrastructure—the framework captures efficiencies that isolated evaluations miss, an approach particularly salient given the high comorbidity burden among people living with HIV (Lyamuya et al., 2025; Magnus Michael et al., 2024).

The framework's utility for decision-makers lies in its direct alignment with national priorities, translating the documented need for integrated services into a language of fiscal feasibility (Ibrahim et al., 2025; Jamieson & Lekodeba, 2025). It accounts for local determinants of service uptake, such as awareness gaps and geographical barriers, which are major impediments to screening coverage (Kisaka et al., 2024; Ottaru et al., 2024). By incorporating these parameters, the resulting models more accurately reflect the real costs of reaching target populations and the potential long-term savings from averting advanced disease, a catastrophic financial burden for households and health systems (Brighton et al., 2024; Yustus et al., 2025).

Key methodological considerations emphasised include the paramount importance of locally sourced cost data, sensitivity analyses around volatile inputs, and the ethical imperative to adopt a societal perspective that includes patient-incurred costs (Kokorelias et al., 2025; Lamberti et al., 2024). The framework underscores that economic evaluations must be conducted prospectively alongside implementation research, as modelled estimates require validation against real-world delivery (Akinleye, 2025; Tibenderana et al., 2024). Without empirical data from integration pilots, policy will remain based on conjecture rather than evidence (Musilanga et al., 2024).

Consequently, the immediate next step is this framework's application in implementation science. Future research must prioritise collecting primary cost and outcome data from integrated service delivery pilots across diverse Tanzanian districts to populate and refine the model (Dong et al., 2025; Nyagumbo et al., 2024). Investigations should also explore the economic implications of different integration models and their differential impact on various demographic groups, including older women living with HIV (Kafaiya et al., 2025; Mahmoud, 2025). Furthermore, understanding the economic interplay with other co-endemic conditions, such as female genital schistosomiasis, represents a vital avenue for ensuring programmes are robust and equitable (Laurent, 2025; Yohana et al., 2025).

In conclusion, this framework offers a pragmatic blueprint for evaluating a critical public health convergence. It moves the discourse from advocating for integration based on clinical plausibility to demanding justification through rigorous, locally relevant economic evidence. Its application will yield actionable insights into where, how, and under what conditions integration constitutes both a clinical imperative and a fiscally prudent investment, thereby accelerating progress towards universal health coverage and the reduction of preventable mortality (Kiswaga & Sarimbo, 2025; Okeny et al., 2024).

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