Evaluating the Acceptability, Feasibility, and Linkage to Care in a Pharmacy-Based HIV Self-Testing Program in Zambézia Province, Mozambique

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Summary

Introduction

HIV self-testing (HIVST) is a WHO recommended strategy to increase testing, especially among key populations, specifically, men and young adults (18-29 years of age). From May to December 2019, a pilot was implemented in Zambézia province involving 3 public and 11private pharmacies, allowing clients to purchase up to two HIV self-tests at a subsidized price of 50Mzn (~USD 0.80). The study assessed the acceptability and uptake of this strategy.

Methods

During the pilot project, pharmacy-based exit-surveys were conducted in a random sample of 10 clients (≥18 years of age), at initiation and three months later, independent from test purchase. A pharmacy-based survey was also done for a random sample of up to 10 clients who purchased a test and accepted being contacted 1-12 weeks later. Both surveys used structured questionnaires on acceptability, with additional questions on use of the test for the latter group. Univariate analysis (Chi-squared (x^2)test) was done comparing clients who purchased an HIVST versus not. In-depth qualitative interviews were done with pharmacy staff/managers.

Results

During the pilot period, 1,139 adults purchased 1,344 tests. Those purchasing tests were predominantly male (70%), from age group 15-34 years (69%); 58% visited one of the six rural pharmacies.

A total of 280 participated in the exit-survey, with 83 persons completing the additional post-purchase survey. Of the 363 interviewed people, median age was 29 years (IQR; 22-38 years), 168 (65%) were male and 252 (69%) attended a rural pharmacy. The main advantage found for HIVST was confidentiality, while primary disadvantages were fear of the result and lack of counseling.

Among the pharmacy clients who purchased a test, 78 (94%) performed the test. Self-reported ease of test instructions and of test performance was 35% and 31%, respectively. Almost all (97%) were confident in their test result. Self-test results were revealed by 45 (58%), with 10 (13%) reporting linking to a health facility to confirm their result.

In the qualitative component, males were thought to be the main target group for HIVST, but demand creation for the search and purchase of tests was felt as a need. Pharmacy employees/managers thought that a pharmacy is a good place to get an HIVST, however, the desire for more privacy within the pharmacy was highlighted, which would require appropriate conditions/infrastructure, such as an available private room or meeting corner. In addition, to bolster the uptake of such an approach if pharmacies are to be utilized, a major challenge that remains is human resources, as currently available pharmacy technicians reported not having the time to provide counseling and information for HIVST.

Conclusions

Offering HIVST at public/ private pharmacies is acceptable for those able to purchase a test and is reached by younger adults and male populations. The perceived lack of counseling is concerning, suggesting the need for counseling tools at pharmacies and/or offering assisted self-testing options. Purchased tests were utilized, but additional demand creation initiatives are needed. Moreover, to attain the first 95 of the

UNAIDS 95-95-95 goals, HIVST is one of the various strategies for HIV testing (health facility and community-based) that should be considered/continued.

Program Background

The greatest burden of the HIV/AIDS epidemic continues to be shared across the sub-Saharan African (SSA) region, where approximately 47% of all new cases occurred in 2018. Globally, Mozambique continues to rank among the top five countries most severely affected by the disease, with an estimated 2.2 million HIV-infected Mozambicans in 2018[1]. The national HIV survey (2015) data show that 39% of women and 60% of men have never been tested for HIV[2].

In 2013, the Government of Mozambique's Ministry of Health (MOH) announced their commitment to a new National HIV and AIDS Response Acceleration Plan, which prioritized increasing access to combination antiretroviral therapy (ART) as a key method for prevention of new infections and for decreasing rates of morbidity and mortality among persons living with HIV[3].

Consistent with individual countries' HIV acceleration plans, the global community is now working toward achievement of the Joint United Nations Programme on HIV/AIDS (UNAIDS) recently announced 95-95-95 goals. One of the strategies to attain the first goal is the use of HIV self-tests (HIVST) as recommended by the World Health Organization (WHO)[4]. Despite being a promising strategy, various aspects need to be addressed to achieve effective implementation and outcomes, including counseling, linkage to care, privacy/ human rights considerations, and quality of services[5]. In addition, consensus in terms of deciding the optimal locations for making HIVST available has not been reached. The majority of HIVST evaluations or pilot studies to date in SSA have been performed through partner mobile clinics or health facilities[6]. In Kenya, the majority of people preferred the government health facility as a place for receiving self-testing[7]. However, public pharmacies have been explored to identify clients and refer for HIV screening at the clinic[8, 9].

At the time of the protocol writing of the study in 2018 (see *Study setting* section below), Mozambique did not have a national guideline, or guide for implementing HIVST. Through means of a public-private partnership, a pharmacy-based HIV self-testing strategy was piloted. The overall objective of the study was to assess the acceptability, feasibility, and linkage to care through the availability of HIV self-tests at pharmacies as a means to engage individuals and link them to care in Zambézia Province.
The costs of the evaluation were estimated at $USD 83,000, which included purchase of tablets for the implementation, hiring of research assistants, training, supervision, airtime, and staff. The HIV self-tests were received as a donation from the manufacturer.

Purpose and questions

In line with President's Emergency Plan for AIDS Relief (PEPFAR) and MOH guidelines, Friends in Global Health (FGH)'s HIV program goals include ensuring that a large majority of the general population knows their serostatus, and that those who test positive are linked in a timely manner to HIV services and initiated on treatment.

To explore additional evidence-based strategies for increasing HIV testing, especially among key populations such as men and adolescents, we conducted this pilot study to evaluate the acceptability and feasibility of making HIV self-tests available (at a relatively affordable price of 50 Mzn (~$US 0.80) at participating pharmacies.

Specific objectives were:

1. To assess acceptability of HIV self-testing among pharmacy clients and pharmacy employees/ managers;
2. To assess feasibility as ascertained via uptake of HIVST as a means for HIV testing, specifically the number of HIV self-tests performed;
3. To assess linkage to health care rates among persons undergoing HIV self-testing using kits purchased in a pharmacy setting.

This evaluation is meant to inform FGH's and the MOH's current HIV prevention, care and treatment programming so that the number of people who know their HIV status might increase and options for linkage to care and treatment were assessed.

Design/ Methods/ Limitations

Evaluation type

The evaluation completed was an internal process evaluation.

Study setting

The evaluation was conducted in Zambézia province, Central Mozambique. The province's HIV prevalence in 2015 was estimated at 15.1% (15-49 years of age), 16.8% among females, and 12.5% among males[2], and had a coverage of HIV testing (ever tested for HIV) of 30% among men, and 51% among women[2].

The HIV self-testing pilot was implemented between May and December 2019, while the surveys took place between May and November 2019.

Pilot description

Pharmacies (public – those who are managed under the state pharmacy company "FARMAC", and private) that were registered at the provincial health authorities were approached and assessed for eligibility for participation in the HIVST pilot program (i.e., to offer HIVST kits for purchase at their pharmacy location).

To be eligible to participate, the following criteria needed to be met:

- Be a registered pharmacy at Provincial Health Directorate;
- Be located in a district that was supported by FGH at the time of protocol writing;
- Provided services to a minimum of 20 clients per day on average;
- Confirmed their willingness to participate;
- Have a functional climate-controlled storage area for the HIVST kits.

Fourteen eligible pharmacies agreed to participate; these were located within seven Zambézian districts (two urban and five rural) (**Table 1**).

Table 1. List of participating pharmacies

District		Type of pharmacy	Number of pharmacies
Urban	Quelimane	Public	1
		Private	3
	Mocuba	Public	1
		Private	3
Rural	Nicoadala	Private	1
	Alto Molócuè	Private	1
	Milange	Private	1
	Gurué	Private	1
		Public	1
	Ile	Private	1

Before project implementation, the following activities were provided to prepare the participating pharmacies/ pharmacy staff for offering HIVST at their locations:

1. Training for pharmacy technicians who served clients interested in obtaining an HIVST:

- Basic counseling: HIV education, the benefits of HIV testing, diagnostic disclosure, and the available options for receiving support and care after self-testing for HIV;
- Instruction on using the HIVST kit including practical experience and guidance on teaching the technique to clients.

2. Creation of a 'corner' within the pharmacy setting that offered privacy for clients to receive information on HIV, on what self-testing is, pre-test instructions and advice.

3. Provision of information through leaflets and posters on self-testing to distribute to clients.

The HIV test that was used was the Oraquick HIV1/2® (Orasure Technologies Inc., Bethlehem, PA, US), through a donation from Orasure Technologies. This test is an FDA-approved oral home test for HIV[10] and has been pre-qualified by the WHO[11].

Any person aged 15 years or older could purchase a maximum of two (for client and potentially his/her partner) HIV self-tests at a fixed price of 50 Mzn (~USD 0.80) per test which was based on existing prices of other self-tests (i.e., pregnancy, malaria test).

Interested pharmacy clients were asked to watch a demonstration video with duration of maximum five minutes, which explained how to perform the self-test, before they could buy an HIVST kit. The video was adapted from the manufacturers' video (http://www.oraquick.com/Taking-the-Test/How-To-Video) to local context and language. After purchasing a self-test kit, clients who agreed to could leave their contact information for a possible follow-up interview after purchase.

Activities to spread awareness regarding the availability of HIVST were done mainly through distribution of leaflets, posters at the pharmacies and local radio messages. Clients who bought a test were given: 1) an

information booklet with general information about HIV, instructions for HIV self-testing, information on linkage to care, and answers to frequently asked questions; 2) a leaflet with summary information; and 3) a reference voucher to the respective health facility (HF) (see **Appendix 3**). They could also be sent a demonstration video about HIVST via WhatsApp, either in Portuguese or local language, if desired. Counseling and HIV testing staff at six public health facilities located nearby seven of the participating pharmacies were provided orientation regarding the pilot program and were trained on how to screen patients for previous HIV self-testing (**Table 2**).

Table 2. List of participating health facilities (HF)

District	**Health Facility**
Quelimane	HF Coalane
	HF 24 de Julho
	HF 17 de Setembro
	HF 4 de Dezembro
Alto Molócuè	HF Alto Molócuè
Mocuba	HF Mocuba

At the community level, demand generation was done through the provision of various information, education and communication (IEC) activities such as local radio spots and educational messages broadcast on television.

Evaluation design

The study used a mixed-method design:

- Key-informant interviews (via in-depth interview) were done with pharmacy technicians and managers, to understand their perceptions regarding HIV self-testing in terms of perceived acceptability among clients, as well as cost, barriers, facilitators, and sustainability;
- Exit interviews (via survey) at the participating pharmacies were conducted with clients of the pharmacy to understand knowledge regarding HIV and HIVST, willingness to buy and use an HIVST, and to explore barriers and facilitators of purchasing and using HIV self-tests;
- Post-purchase interviews (via survey) were done with pharmacy clients who purchased an HIVST and accepted (i.e., shared their contact information) to be called for follow-up and scheduling of an in-person interview, to ask additional questions about their experience in the use of HIVST.

Eligibility criteria for the three groups of participants (for above-mentioned activities) included being 18 years of age or older and providing written informed consent for the respective interview(s). For the pharmacy staff, additional eligibility criteria included being an employee or manager at the participating pharmacy for at least six months and being an employee or manager who attends clients at the pharmacy. For the pharmacy clients invited for an exit-interview, seeking any pharmacy service at one of the participating pharmacies was the additional eligibility criteria.

Stakeholder engagement

Various staff from the MOH and FGH/Vanderbilt University Medical Center (VUMC) have been involved in these program pilot and evaluation activities. From the MOH, this included the Health Counseling and Testing Focal Point, and the head of the MOH's National STI and HIV/AIDS Control Program (Maputo), and the Supervisor of HIV Program participated from the Provincial Health Directorate of Zambézia (DPS-Z). All individuals have been involved since the design of the study, through the monitoring of the evaluation implementation, and throughout discussion of evaluation results. From the CDC Mozambique (Maputo), the Project Officer has been involved since the beginning of the evaluation. At FGH, aside from the Evaluation team members who have led and managed the pilot and evaluation activities, the HIV Prevention Advisor has been involved since the design of the evaluation.

Sampling strategy

Systematic random sampling was used for the exit interviews, whereby every third person exiting the pharmacy was approached and invited to participate in the HIVST acceptability survey, independent of self-test purchase. The survey was done after confirming eligibility criteria and obtaining informed consent (Appendix 1). Pharmacy clients who purchased a self-test between study initiation and August 30th, 2019 and agreed to be contacted were randomly selected to participate in the survey. In-depth interviews were conducted via convenience sampling with pharmacy staff and managers, whereby research team members invited those who met eligibility criteria and were available on the day of the data collection.

Procedures

Before any data collection, participants signed the informed consent.

The structured interview included questions on previous HIV testing, knowledge of HIVST, willingness to purchase an HIVST, perceived advantages and disadvantages of HIVST, preferred testing modality, perceptions regarding cost of HIV self-test, perceived benefits, and preferred place of acquiring the HIV self-test. Clients who purchased an HIV self-test were also asked about the experience of HIV self-testing, receiving the test result, and about linkage to the health facility. Participants' responses to the surveys were recorded using mobile cellular devices and were stored in a cloud-based repository (REDCap™). Additional quantitative data on linkage were extracted from the MOH register books on Counseling and Testing for HIV(VCT) at indicated referral health facilities.

During the qualitative interviews among pharmacy technicians and managers, questions from a semi-structured interview guide were asked to participants about perceptions regarding acceptability, potential barriers and facilitators of HIV self-testing and linkage to care, readiness to give information on HIV and HIV testing, and perceived needs for implementation of the strategy. Data were collected via tape recorder and/or notes, if consent was given for these.

All interviews were done in Portuguese, and transcriptions of the interviews were written in Portuguese by evaluation team members fluent in Portuguese.

Sample size

For exit interviews (via survey): Consistent with routine practice for exploratory studies, we interviewed a total of 10 pharmacy clients exiting each of the participating pharmacies, at baseline and three months later (i.e., 10 different clients at each of the two time points). This sample was expected to i) provide us with the requisite baseline preliminary data, and ii) be able to inform regarding a possible implementation (or not) of this intervention.

For post-purchase interviews (via survey): A random sample of maximum 10 pharmacy clients who purchased a self-test and agreed to be contacted were selected from each of the participating pharmacies, using random.org software. In the case of any person who did not accept to participate in the follow-up interview or was not reachable at the time of inquiry, the next randomly selected client on the list was contacted.

In-depth interviews were done with one to two people (employees or managers) at each pharmacy, at baseline and three months later. Sample size was based on saturation.

Ethical aspects

The protocol and instruments were approved by the institutional health ethics committee of the "Instituto Nacional de Saúde" (INS) (CIBS-INS, reference 080/CIBS-INS/2018), the VUMC Institutional Review Board (IRB) (#181834), and the National Directorate of Pharmacies, and was reviewed in accordance with the Centers for Disease Control and Prevention (CDC) human research protection procedures and was determined to be research, but CDC investigators did not interact with human subjects or have access to identifiable data or specimens for research purposes. All participants gave written informed consent prior to data collection (for all respective study activities).

Deviations from the protocol

Two protocol deviations occurring during evaluation data collection phase (neither of which resulted in any harm to the participants involved) were reported to the local ethics committee on i) July 26th, 2019, with response from CIBS-INS on August 21st, 2019; and ii) October 22nd, 2019, with response from CIBS-INS on October 30th, 2019 (100/CIBS-INS/2019). These deviations were also reported to the VUMC IRB (i) submitted July 31, 2019 with response letter August 7th, 2019; ii) Submitted October 22nd, 2019 with response received October 29th, 2019). Notification was provided to the CDC-MZ on July 30th, 2019 and October 22nd, 2019, respectively.

Quality Assurance

Training

Before data collection, trainings were provided to the pharmacy technicians and health counselors (at health facilities) on the implementation of the pilot program, and to the evaluation team members on the study protocol procedures. A refreshment training was provided to the evaluation team before the second round (month three) of interviews.

Monitoring and data safety

Continuous monitoring and mentoring were done by the FGH Evaluation Officer, in coordination with the DPS-Z Focal Point. Survey data were entered in a password-secured cloud-based repository (REDCap), only accessible to the study investigators.

Analysis plan

Descriptive statistics were used and presented as medians (with interquartile ranges [IQR]) for continuous variables and frequency breakdown (percentages) for categorical variables. Univariate analysis using Chi-square test for categorical variables and Mann-Whitney test for continuous variables was done for covariates, comparing clients who purchased an HIVST versus those who did not. Qualitative data were analyzed using thematic analysis[12]. Coding was done by two independent researchers and compared to assess inter-rater reliability. The software STATA.SE Version 15.0 (StataCorp LLC, Texas, USA) supported the quantitative analysis and the software MAXQDA Standard 12 (Verbi GmbH Berlin, Germany) was used in the qualitative analysis.

Limitations of the study

Data are not representative for the country, as the study was only done in select sites in one province in Mozambique. Additionally, only pharmacy clients having the capacity to buy an HIVST were included in the post-purchase survey, thus the opinions of those unable to buy were not captured in the results of that survey. Data of registration of any HIV self-test result confirmation done in private clinics were not available, and some pharmacy clients who purchased and used an HIVST could also have registered in a health facility from another province to do confirmatory HIV testing. Both of these possibilities could have led to an underestimation of the linkage to care following HIVST.

Results

The pilot was implemented in the period May to December 2019, while the surveys and interviews were held in May/June (baseline) and in September/October (month three).

During the total pilot period (May - December 2019), 1,344 HIV self-tests were sold to 1,139 persons. The majority (636, 70%) of buyers were male, and younger than 35 years of age (613, 69%). Fifty-eight percent (651) of people bought in a rural setting (**Table 3**).

Table 3. Characteristics of individuals purchasing HIVST

Urban/rural (n=1139)	Urban (8 pharmacies of 2 districts)	481 (42%)
	Rural (6 pharmacies of 5 districts)	658 (58%)

Sex (n=906)	Male	636 (70%)
	Female	270 (30%)
Age (categories), years (n=518)	15-24 years	186 (21%)
	25-34 years	427 (48%)
	35-44 years	177 (20%)
	45+ years	104 (12%)

1. *Characteristics*

A total of 363 participants responded to the surveys. The flow chart (**Figure 1**) shows the number of persons interviewed: 280 pharmacy clients were interviewed at the time they exited the pharmacy, and 83 people who bought an HIV self-test and consented for a follow-up interview were interviewed at a later time. From the 280 exit-interviews, 20 people reported they purchased an HIV self-test.

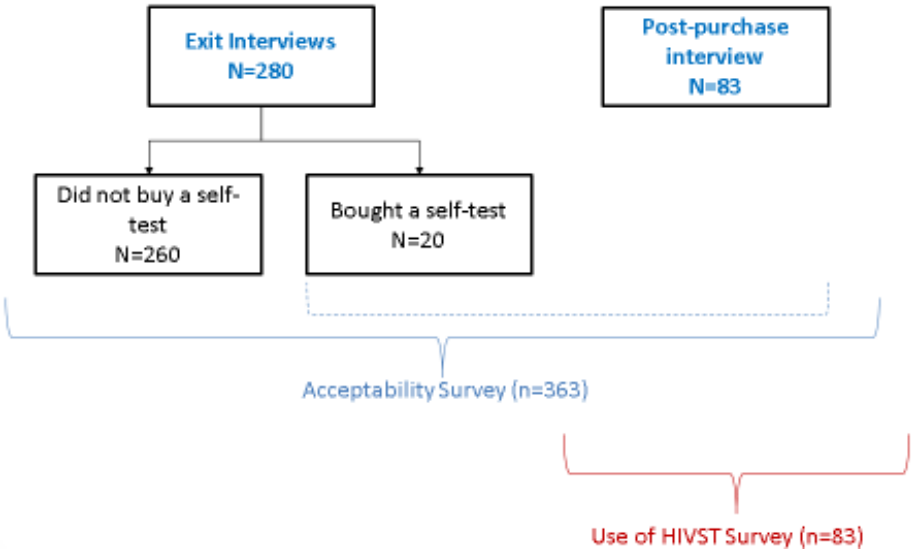

Figure 1. Flow chart of people who were interviewed (via survey) during the pilot project (n=363).

A total of 363 participants completed exit (n = 280) and post-purchase (n = 83) interviews (**Figure 1**). In terms of aggregate interview completion data, 252 (69%) of 363 participants visited one of the urban pharmacies. Two thirds (66%) of the participants were male, and the majority (70%) were less than 35 years

of age, with 29% being 15-24 years of age and 41% being between 25-34 years of age (**Table 4**). Pharmacy clients who purchased an HIVST were more educated with 81% of participants, compared to 57% of participants who did not purchase an HIVST, completing advanced education in the form of secondary (12th grade) and/or advanced/university level training (p <0.0001; **Table 4**). There were no significant differences among participants purchasing an HIVST versus not by religion, occupation, and/or marital status. However, consistent with educational level, participants who purchased an HIVST had higher levels of self-reported Portuguese language skills, with 87% of those purchasing HIVST reporting good/very good Portuguese language skills, compared to 76% of those not purchasing an HIVST reporting good/very good Portuguese language skills (p = 0.034). Of note, there was no difference among those purchasing an HIVST versus not when asked about their preferred language to receive information and converse in (p = 0.18) with similar high proportions (87% among those purchasing an HIVST and 92% among those not purchasing an HIVST) preferring local language over Portuguese.

Table 4. Characteristics of the participants (n = 363)

	Pharmacy clients who did not buy an HIVST (n=260)	**Pharmacy clients who bought an HIVST (n=103)**	**Total (n=363)**	**p-value***
Sex				
Male	168 (65%)	73 (71%)	241 (66%)	0.255
Female	92 (35%)	30 (29%)	122 (34%)	
Age (years) (median, IQR)	29 (22-38)	29 (26-35)	29 (23-37)	0.467*
Age (years) (categories)				
18-24 years	87 (33%)	17 (17%)	104 (29%)	***<0.001***
25-34 years	90 (35%)	60 (58%)	150 (41%)	
35-44 years	50 (19%)	18 (17%)	68 (19%)	
45+ years	33 (13%)	8 (8%)	41 (11%)	
Level of education				***<0.001***
Never went to school/ alphabetization	20 (8%)	3 (3%)	23 (6%)	
Primary (7th grade)	49 (19%)	4 (4%)	53 (15%)	
Basic (10th grade)	43 (17%)	12 (12%)	55 (15%)	
Secondary (12th grade)	116 (45%)	56 (54%)	172 (47%)	
Superior / University	32 (12%)	28 (27%)	60 (17%)	
Religion				0.111
Muslim	34 (13%)	14 (14%)	48 (13%)	
Catholic	132 (51%)	58 (56%)	190 (52%)	
Protestant	80 (31%)	31 (30%)	111 (31%)	
Other	14 (5%)	0 (0%)	14 (4%)	
Occupation				0.234

No income	22 (8%)	6 (6%)	28 (8%)	
Agriculture/ Fishing	20 (8%)	3 (3%)	23 (6%)	
Sales	32 (12%)	14 (14%)	46 (13%)	
Health Care Professional	14 (5%)	12 (12%)	26 (7%)	
Teacher	42 (16%)	23 (22%)	65 (18%)	
Domestic workers	4 (2%)	1 (1%)	5 (1%)	
Guard	2 (1%)	0	2(1%)	
Police	7 (3%)	2 (2%)	9 (2%)	
Other	117 (45%)	42 (41%)	159 (44%)	
Marital status				0.416
Married/ officially living together	156 (60%)	60 (58%)	216 (60%)	
Divorced	5 (2%)	1 (1%)	6 (2%)	
Widow	5 (2%)	0	5 (1%)	
Single (not living with partner)	94 (36%)	42 (41%)	136 (37%)	
Location of pharmacy visited				***<0.001***
Rural	56 (22%)	55 (53%)	111 (31%)	
Urban	204 (78%)	48 (47%)	252 (69%)	
Mother Language				0.18
Portuguese	21 (9%)	13 (13%)	34 (9%)	
Other	239 (92%)	90 (87%)	329 (91%)	
Self-evaluation Portuguese reading skills				***0.034***
Cannot read Portuguese	6 (2%)	0	6 (2%)	
Not good	20 (8%)	5 (5%)	25 (7%)	
Moderate	38 (15%)	8 (8%)	46 (13%)	
Good	77 (30%)	26 (25%)	103 (28%)	
Very good	119 (46%)	64 (62%)	183 (50%)	
HIV testing history				
Ever done an HIV test before				0.487
No	43 (17%)	14 (14%)	57 (16%)	
Yes	217 (83%)	89 (86%)	306 (84%)	
Place of last HIV test (not including self-test) (n=306)				0.133
HF near where I live	173 (80%)	71 (80%)	244 (80%)	
HF in a different district	22 (10%)	9 (10%)	31 (10%)	
Private clinic	4 (2%)	0	4 (1%)	
Community testing	10 (5%)	1 (1%)	11 (4%)	
Other	7 (3%)	8 (9%)	11 (4%)	
No response	1 (0%)	0	1 (0 %)	
Time of last HIV test (not including self-test) (n=306)				***0.042***
<3 months ago	96 (44%)	22 (25%)	118 (39%)	
3-5 months ago	34 (16%)	18 (20%)	52 (17%)	
6-11 months ago	24 (11%)	15 (17%)	39 (13%)	
12-23 months ago	37 (17%)	17 (19%)	54 (18%)	
>2 years ago	23 (11%)	16 (18%)	39 (13%)	

Don't remember	3 (1%)	1 (1%)	4 (1%)	
Result of last HIV test (not including self-test) (n=306)				***0.009***
HIV negative	182 (84%)	86 (97%)	268 (88%)	
HIV positive	26 (12%)	2 (2%)	28 (9%)	
Prefer not to say	9 (4%)	1 (1%)	10 (3%)	

*Mann-Whitney test

2. Acceptability of HIV self-testing among the interviewed population

As anticipated, a low proportion (28% overall) of participants had ever heard about HIVST, with a significantly higher proportion (51%) having heard about the HIVST strategy among those pharmacy clients purchasing an HIVST ($p < 0.0001$; **Table 5**). The most frequently reported advantage of HIVST was that it maintained confidentiality, highlighted as being a main advantage in 291 (80%) of 363 participants overall and among a slightly higher proportion (84%) of those that purchased an HIVST. Another significant advantage of HIVST that was highlighted by 51% of participants overall and a significantly higher proportion (64%; $p = 0.001$) of those purchasing an HIVST was that the test was simple with no need to interface with a health provider. Other reported advantages that were not significant between the groups, those purchasing an HIVST versus not, included HIVST being fast and providing the opportunity for people to test with their partners, which were reported by 37% and 13% of overall respondents, respectively. In terms of disadvantages, a sizable proportion (31%) of overall respondents reported the lack of nearby counseling, which was not significant ($p = 0.26$) by HIVST purchase status, despite a slightly higher proportion (35% vs. 29%) of those purchasing an HIVST reporting that this was a disadvantage. The only significant disadvantage reported in a small proportion (9% overall) of participants, by 11% of those not purchasing a test compared to 3% of those purchasing an HIVST, was the fear of someone discovering their test results ($p = 0.016$). Other reported disadvantages that were not significant by HIVST purchase status included fear of test results, doubts on the quality of the test itself, and the test being too expensive, reported by 24%, 10%, and 6% of overall respondents, respectively (**Table 5**). Regarding price of the HIV self-test (which in the pilot project was offered at a fixed price of 50 Metical (~USD 0.80)), approximately one quarter (24%) of overall respondents perceived the HIVST as being too expensive, with a significantly higher proportion of clients not purchasing an HIVST (28%) compared to 14% among those purchasing the test ($p = 0.034$). Overall, only 4% of the interviewed pharmacy clients were not willing to pay for an HIVST. Clients who purchased an HIVST were also willing to pay more for the test compared to those who did not buy an HIVST. While the majority (59%) of respondents stated that the pharmacy was a preferred setting to undergo HIV self-testing, one third (33%) of people completing the interviews still preferred to get a

self-test at a public health facility. No difference in preference of modality of self-testing was seen (oral versus finger-prick) among respondents, with more than one third (37%) still favoring finger-prick over saliva-based testing.

Table 5. Acceptability of the use of an HIV self-test (n = 363)

	Pharmacy clients who did not buy an HIVST (n=260)	**Pharmacy clients who bought an HIVST (n=103)**	**Total (n=363)**	
	n (%)	n (%)	n (%)	p-value
Ever heard about HIV self-testing				***<0.001***
No	211 (81%)	51 (50%)	262 (72%)	
Yes	49 (19%)	52 (51%)	101 (28%)	
Advantages of HIVST*				
Maintains confidentiality	204 (78%)	87 (84%)	291 (80%)	0.196
Simple/ no need of health provider	118 (45%)	66 (64%)	184 (51%)	***0.001***
Result is fast	89 (34%)	44 (43%)	133 (37%)	0.130
To be able to test with my partner	35 (13%)	26 (12%)	47 (13%)	0.643
Disadvantages of HIVST*				
No counseling nearby	75 (29%)	36 (35%)	111 (31%)	0.255
Fear of test result	65 (25%)	22 (21%)	87 (24%)	0.464
Doubts on the quality of the test	28 (11%)	9 (9%)	37 (10%)	0.564
Fear of somebody discovering	28 (11%)	3 (3%)	31 (9%)	***0.016***
Do not know how to use it	17 (7%)	5 (5%)	22 (6%)	0.544
Too expensive	18 (7%)	2 (2%)	20 (6%)	0.061
Not able to read the instructions	4 (2%)	2 (2%)	6 (2%)	0.786
Opinion on price of the test				***0.034***
Very cheap	22 (8%)	7 (7%)	29 (8%)	
Cheap	22 (8%)	9 (9%)	31 (9%)	
Acceptable price	142 (55%)	73 (71%)	215 (59%)	
Expensive	73 (28%)	14 (14%)	87 (24%)	
Price willing to pay for HIVST				***<0.001***
Do not want to pay	14 (5%)	0 (0%)	14 (4%)	
Up to 10 Mzn	77 (30%)	16 (16%)	93 (26%)	
Up to 50 Mzn	131 (50%)	48 (47%)	179 (49%)	
Up to 100 Mzn	20 (8%)	25 (24%)	45 (12%)	
Up to 200 Mzn	8 (3%)	8 (8%)	16 (4%)	
Up to 500 Mzn	4 (2%)	3 (3%)	7 (2%)	
More than 500 Mzn	4 (2%	2 (2%)	6 (2%)	
Preferred place to get an HIVST				0.108

Private/public pharmacy	145 (59%)	70 (68%)	215 (59%)	
Public health facility	97 (37%)	24 (23%)	121 (33%)	
Private clinic	9 (3%)	6 (6%)	15 (4%)	
Other	8 (3%)	3 (3%)	11 (3%)	
Preferred testing modality (oral versus finger-prick self-test)				0.231
Oral	141 (54%)	67 (65%)	208 (57%)	
Finger-prick	103 (40%)	30 (29%)	133 (37%)	
Either	15 (6%)	5 (5%)	20 (6%)	

* Participants were instructed to mark all that apply for these survey questions.

3. Use of HIV self-test

In the period of May - August 2019, 614 individuals bought a test, and post-purchase follow-up contact was successful for 143 people. Of those, 83 (58%) consented for the survey interview.

Among the 83 surveyed people who bought an HIV self-test, 78 (94%) used it. Description of their reported experiences are shown in **Table 6**. Most felt the use instructions were clear (71, 91%) and procedures were easy to understand (69, 89%). Those survey respondents who reported difficulty felt that preparation of the kit and reading the results were the more difficult steps of all the procedures. However, 29 individuals (37%) felt they needed additional information or counseling before taking the self-test.

Among the survey respondents who performed the HIV self-test, 45 (58%) revealed their HIVST results, with 43 reporting HIV negative, and two HIV positive. Of the respondents reporting HIV negative self-test results, nine stated that they went to the health facility to confirm their (HIV-negative) result, and one of the two people reporting a positive HIV self-test result stated that they linked to the health facility to confirm.

Registered linkage to the health facility (for anyone having done an HIVST) was very low: the routine HIV testing register books at the public health facilities supported by FGH in Zambézia reported only three people who confirmed their positive HIV self-test result.

Table 6. Experience of the use of HIV self-test by participants (n=78)

	n (%)
Did the test alone or with somebody	
Alone	53 (68%)
With family member or friend	17 (22%)
In the pharmacy	3 (4%)
With other	5 (6%)

Clearness of the instruction	
Very easy	27 (35%)
Easy	44 (56%)
Difficult	1 (1%)
Very difficult	0 (0%)
No information	6 (8%)
Difficulties in reading and understanding instructions	
Very easy	24 (31%)
Easy	45 (58%)
Difficult	2 (3%)
Very difficult	0 (0%)
No information	7 (8%)
Difficulties in doing test	
Very easy	32 (41%)
Easy	39 (50%)
Difficult	5 (6%)
Very difficult	2 (3%)
Most difficult step	
Step 1 - preparing the kit	13 (17%)
Step 2 - taking the sample	6 (8%)
Step 3 - doing the test	2 (3%)
Step 4 - reading the results	11 (14%)
No step was difficult	45 (58%)
Feeling if test was correctly done	
Yes	78 (100%)
No	0 (0%)
Belief in the test result	
Yes	76 (97%)
No	2 (3%)
Did you feel you needed additional information or counseling before the test	
Yes	29 (37%)
No	49 (63%)
Preference of doing test alone or with help of somebody	
Unassisted, alone	67 (86%)
Assisted at home	3 (4%)
Assisted at pharmacy	3 (4%)
Assisted at health facility	3 (6%)
You recommend HIVST to somebody	
Yes	76 (97%)
No	1 (1%)
Do not know	1 (1%)
Preference for HIVST or test at a Voluntary Counseling and Testing (VCT) site	
HIVST	65 (83%)
VCT	13 (17%)

You want to reveal the result of the HIVST?		
	HIV negative	43 (55%)
	HIV positive	2 (3%)
	Invalid	0 (0%)
	Prefer not to say or no response	33 (42%)
Did you go to the HF after doing the HIVST		
	Yes	10 (13%)
	No	68 (87%)
You want to reveal result of HIV test done at health facility?		
	HIV negative	9 (90%)
	HIV positive	1 (10%)
	Indeterminate/Invalid	0 (0%)
	Prefer not to say or no response	0 (0%)

4. Perceptions of Pharmacy Technicians and Managers

Over the study period, in-depth interviews were conducted with 45 pharmacy managers/employees, 28 at baseline (i.e., at study start, prior to self-tests being available for purchase at these pharmacies) and 17 during implementation (four months after pilot initiation). The socio-demographics data of the participants is shown in **Table 7**.

Table 7. Sociodemographic data of the pharmacy staff

		Baseline (n, %)	Implementation (n, %)	Total (n, %)
District				
	Urban	15 (58)	13 (68)	28 (62)
	Rural	11 (42)	6 (32)	17 (38)
Sex				
	Male	15 (58)	10 (53)	25 (56)
	Female	11 (42)	9 (47)	20 (44)
Age, years (median, IQR)		29 (27-41)	28 (23-41)	28 (25-41)
Years since graduation (median, IQR)		4 (3-7)	6 (2-18)	5 (2-14)
Years working at the pharmacy (median, IQR)		2 (1-6)	3 (1-7)	3 (1-7)

It was observed that many of the answers provided in the initial phase of the pilot project, where the respondents gave opinions about how they anticipated their customers would react/ behave towards the HIV self-test in a more hypothetical situation, were similar to responses and experiences provided related to what was observed during the period of self-test sales.

- **Target population and interest in HIVST purchase**

Respondents indicated at the initial round and second round of interviews that young males would be the group most interested in the tests.

Before starting sales, pharmacy staff predicted that HIVST users would use the tests for a variety of reasons, with the main reason being that it would maintain confidentiality. The respondents also said that people would use it because this test is easy to use and because they do not have to go to the health facility. In the second phase of data collection, it was observed that these continued to be the same reasons and in the same order of perceived importance.

Regarding the reasons for not using the tests, the respondents foresaw (and confirmed during the second round of interviews) that the possibility for some users to not trust the results of this type of HIV test could compromise the use of this self-test. Another perceived barrier mentioned was fear of seeing the test result.

- **Preference of acquiring an HIVST**

Most pharmacy employees, both before starting the sale of oral HIV self-tests as well as after they were already selling them, thought that pharmacies were the best places to sell this test, and most believed that this was also the opinion of users. Some pharmacy staff, although few, said that users could consider health facilities the best place to get such a test.

- **Pharmacy needs**

In terms of resources needed to make sales feasible, in addition to providing the self-tests, pharmacies participating in this pilot project received a set of informational/educational materials, as a resource to provide information to potential users.

As such, pharmacies received the following informational/educational materials 1) advertising posters that were posted in the pharmacies' windows, 2) fold-out information leaflets to display on the countertops, 3) laminated forms with testing procedures and test result explanations so they could offer additional information if needed. To enrich the information for those customers who were interested in buying the test, pharmacies also received a tablet device on which a pre-recorded demonstration video was uploaded to show test procedures. Booklets with additional information on the HIV self-test and on HIV prevention in general was offered to those who bought a self-test, as well as a reference voucher for linking to the nearest health facility.

During the interviews, pharmacy staff were asked their opinion for any additional needed material(s) to provide information to users, and respondents indicated they relied on the materials made available to them prior to study implementation; no one mentioned any other materials they would suggest as needed. One respondent, when asked about the materials to be used when meeting with a potential user/ purchaser, stated they made use of:

"Yes, first the pamphlets, then the explanation that is already here at the counter and the information leaflets that we have and the video." (Baseline, Pharmacy technician, Urban)

Although the video explaining the testing procedures was designed to be watched by customers who had already purchased the test, it also was widely used as an advertising video; most respondents reported that they let customers watch the video to see if it aroused their interest in purchasing/using the HIV self-test. Despite receiving information on the objective/intended use of the video, the same was mentioned during the second round of interviews.

"We have that video that we already, sorry (pause), so we show the video, then he watches, besides the video, if he didn't notice we tried to explain it in a more current way and, in the true sometimes what is missing is this, no, our advice is just not enough, it is not enough, of course it is always full here so it makes it difficult." (Baseline, Pharmacy Technician, Urban)

"In the beginning, every customer who comes here we have to inform, give pamphlets for the person to take. Usually the customer arrives, says he is in a hurry, another patiently reads, and we also give the person the option to watch the video." (Baseline, Pharmacy Technician, Rural)

Some respondents informed that as they had to explain HIV self-test and its procedures many times, they chose after a while to send the demonstration video via WhatsApp so that those interested could watch it at home, consider and decide whether or not they would like to buy the self-test. In fact, the video was often referred to as the material used for advertising the test; some said that if the client was in a hurry they would provide the information leaflet and ask if they could send them the video to watch at home.

"Of all the resources, the tablet is because nowadays you read to someone you will get tired of listening to that reading, show leaflets he will take the leaflet and leave it alone and the video is more practical." (Implementation, Pharmacy technician, Rural)

In some cases, the respondents mentioned that they chose to show the video, not only because they perceived it to be more practical, but also because their pharmacies do not have the necessary conditions/space for the discussion of private issues or counseling within the pharmacy.

"Many times, because the place is not an adequate place at first, I often use video." (Implementation, Pharmacy Technician, Rural)

Pharmacy technicians requested more brochures, a table and chair, screens, and cell phone credit to be able to send WhatsApp videos on the spot (instead of the client sending a request to the helpline). Some respondents suggested to have the video displayed in the pharmacy and that the space in the pharmacy be improved to have the necessary privacy restrictions.

"First I would ask you to add more brochures, because it is easier with the brochure than the video, it takes a little more time and the person will read at home, when walking, instead of (watching in the pharmacy), if you have to the watch the video here, he/she will stay here for a long time, the brochure is faster." (Implementation, Pharmacy Technician, Urban)

- **Sales challenges**

The biggest challenge mentioned at project initiation and during implementation was human resources, as a greater dedication of time is needed from the pharmacy technicians for additional explanation and registration of the HIVST. Additionally, because of the sensitivity of the type of test in question, pharmacists said that one of their main challenges in selling these self-tests was the absence of a trained psychologist; they felt having this resource would greatly help in advising clients who buy the HIV self-test.

> *"A psychologist would help a lot considering that this test is psychological and people are afraid so the existence of a psychologist would help in the sale because he will advise potential clients." (Baseline, Pharmacy Manager, Urban)*

- **Pre- and Post-test Counseling**

Pharmacy staff reported that the pharmacy (i.e., where the test is purchased) is the location where clients/users should receive counseling on using the HIVST prior to doing the self-test.

> *"..In the pharmacies who sell the tests, right? Because the patient needs first the psychological preparation, right? So I don't see any other place outside the place where he buys the test." (Implementation, Pharmacy Manager, Urban)*

However, recognizing the complexity and sensitivity of the counseling needed after taking an HIV test (in any setting), respondents felt the health facility is the best place where users should go to receive counseling after taking the self-test.

> *"After taking the test, I think it is better that the client has more advice, more information in the health units, because there are people more equipped to address this." (Baseline, Pharmacy Technician, Urban)*

Comparing interview results before and after the initiation of the HIVST sales, it was notable that before starting sales there was a large number of pharmacy staff respondents that mentioned that pharmacies could be an equally good place for counseling both before and after the test, but after starting sales most respondents thought that for post-HIVST counseling users should be counseled at the health facility and not at the pharmacy as had been indicated before starting sales.

- **Demand creation**

As a way of supporting sales, pharmacists suggested that there should be actions to create demand in public places, such as markets and other mass assemblies of individuals within the community. They also mentioned the need to advertise the HIV self-tests more frequently on television channels, in health facilities, and on the radio.

According to the pharmacy staff respondents, and more frequently mentioned at initiation (i.e., interviews done prior to HIV self-tests being sold), the tests are not widely known about in the communities; the few who do know of the test are those who visited the pharmacy for other reasons and the pharmacists took advantage of the opportunity to tell them about the existence and availability of the HIV self-test.

- **Linkage to care**

Pharmacy technicians reported that they advised HIVST users to go to the health facility for follow-up in the event of a positive result for confirmation and enrollment in care. Some proposed that to facilitate linkage, there should be a first phase of more in-depth counseling at the pharmacy, but the technicians and the pharmacies themselves are not (yet) prepared for this as such. Two respondents said that clients/users should receive all their counseling and (if found to be HIV-positive) their initial care (i.e., opening of a patient file) at the pharmacy; if conditions to offer these services at the pharmacy would be met, then the person should be referred to the health facility to collect their medications.

> *"… this is what I meant, I think there should have been a first linkage if it (the test) was positive; there had to be a confirmation right away and there had to be a counselor there who understands well about the not even talk to the person to make them understand more." (Baseline, Pharmacy Manager, Rural)*

Pharmacy respondents were aware of the need for HIV test confirmation at the health facility; they recognized that this is where follow-up care is given. However, the technicians reported that people often do not go to the HF for necessary follow-up.

> *"One of the disadvantages is that we never know if the result, since the person does it alone, and not all of them, when positive, go to a health unit." (Baseline, Pharmacy Technician, Urban)*

One of the respondents suggested that a client with a positive result should return to the pharmacy who then should contact the health facility to ensure better linkage to care.

> *"We just sell it so at some point there is a disadvantage. So if they compared if they were positive, they would return to the pharmacy, at some point the pharmacy would enter the unit, in, in communication with the health facility, maybe we would have a little advantage." (Baseline, Pharmacy Technician, Quelimane)*

The technicians suggested that users should also be given clear information about the specific place/location where they should seek follow-up care at the health facility, with a detailed explanation of who will receive them there.

Although many stated that they never received users who returned to the pharmacy with a positive result, they communicated a clear knowledge on how to guide them if they return. Even in the second round of interviews, it was noted that many of the pharmacy customers did not return.

> *"No, they never came back, never came back." (Implementation, Pharmacy Technician, Rural)*

> *"Some, some usually come even after buying or even after buying but not having used it, others bought it used it, some do, not so many, but they do come."(Implementation, Pharmacy Technician, Rural)*

For the few people that did return after buying an HIVST, the interviewed staff said they advised these individuals to go to the health facility if the self-test result was positive, and if it was negative, they advised to re-test three months later.

> *"I could tell the person to continue taking care of themselves, if the result is negative. If the result is positive, I would advise you to go to the nearest health facility to be able to do the other confirmation test with blood." (Implementation, Pharmacy Technician, Mocuba)*

Discussion

The study implemented in Mozambique evaluated acceptability of the use of HIVST through a pharmacy-based strategy. The results showed that HIVST at public/private pharmacies was successfully implemented, reaching primarily males and younger adult persons. Acceptability was high, but routine reporting of linkage to care was very poor.

We found that keeping confidentiality was the main advantage reported, and this is in line with what is seen in other SSA countries[9, 13]. Not having to reveal to somebody about your desire or need to get an HIV test can increase testing coverage, but can create also uncertainty and insecurity for people, as no additional counseling or information is readily available. Health literacy, particularly on HIV prevention and HIV testing, is crucial when expanding HIV self-testing strategies. Mozambique has a low literacy rate of 52%[14], and knowledge regarding HIV transmission remains less than desirable, with only 30% of young adults (15-24 years of age) having a comprehensive knowledge on HIV prevention[2]. This could explain why lack of counseling nearby was seen as a disadvantage for HIVST. In our context, additional strategies of information and education regarding HIVST are needed, and could be offered at pharmacies, or through community initiatives.

The pilot program in Mozambique was a pharmacy-based strategy, as a way of not putting any additional burden on the weak, often overloaded, health system. The cost per test may be a barrier for individuals, as found in our study (mainly reported in rural settings). In Tanzania, where clinic-based HIV testing is also provided free of charge, costs associated with the purchase of an oral HIV self-test outweigh the disadvantages of losing time by going to and from the health facility and travel costs[9]. In Zimbabwe, the demand was price sensitive where different approaches were suggested for different settings[15]. Mozambique is one of the poorest countries in the world, and our finding that a quarter of the pharmacy clients found the test expensive was expected, especially as HIV testing (and treatment) services are free of charge within the national health system. Our study population were pharmacy clients, who usually have a higher purchase possibility, and this might explain why about half of them were willing to pay 50 Mzn or ~0.80 USD for a self-test. However, the network of private pharmacies countrywide consists of 793 private pharmacies [16] This network will not be able to cover the demand, if only a pharmacy-based strategy would be offered. Additionally, it is not certain that the private network would be able to fix the HIV self-test at a lower price as was done in this pilot, if manufacturers would not be able to adjust selling prices. Health insurance coverage is low in Mozambique, which could increase the use of HIVST.

This strategy requires the buy-in of the pharmacies and pharmacy staff. The study shows some of the first data of pharmacy technicians' perceptions on the use of HIVST. The findings are important to have a

successful pharmacy-based strategy. The majority of pharmacy staff (technicians and managers) thought that the strategy can specifically reach young male populations. Counseling can be a challenge, but with training, and additional human resources allotted to the pharmacy locations, this can be overcome and HIVST could successfully be offered at pharmacies. The pharmacy could play an active role in HIVST user linkage to the health facility through establishment of a helpline at the health facility where a dedicated health care worker can guide the client to the specific location for HIV test result confirmation and further follow-up as needed.

Linkage to health facilities was measured through self-reported use of HIVST, with a very low registration in the HF followed in this study. It could be that individuals do not want to report their results, or they could have sought follow-up at a private clinic (since the study tracked only registration at six public health facilities), or they registered in a health facility outside the province. Additionally, linkage confirmation depends as well on patient disclosure (of HIVST) at health facilities. Linkage to care after HIV self-testing is a known challenge, with various success rates in the context of free distribution (community- or health facility-based)[17]. Individual follow-up, for example, by lay counselors can be beneficial but seems only practical when HIVST is offered through community- or health facility-based distribution. Pharmacy-based strategies could be strengthened by adapting other mechanisms, where mobile-based health (mHealth) initiatives can play a role, by sending messages with key information, and reminders on linkage to care.

Different HIVST strategies have been studied, from community-based to health facility distribution. Eswatini adopted HIVST as a national strategy, after it was shown to be feasible and successful under routine conditions, using a combination of offering HIVST as an alternative at the health facility and mobile community-based distribution and testing[18]. Uptake of enrollment into HIV care was 51% when clinic-based HIVST was done compared to standard counseling and testing strategy[19]. Mozambique has not (yet) adopted any additional HIVST strategies, however, community distribution is currently being piloted.

Conclusions/ Recommendations

This is one of the first studies in Mozambique on a successfully implemented pharmacy-based strategy for HIV self-testing. Pharmacy clients show a high degree of acceptability, although the price of the test can be a barrier, as well as lack of counseling nearby following use of self-test. More men and young people might benefit from this strategy. Strategies to improve post-HIVST linkage to health facilities need to be explored. Pharmacy-based HIV self-test distribution appears to be a feasible approach for mainly male and young people, who have financial means to get an HIV self-test. Engaging the private sector should be seen as an additional strategy in order to achieve the first 95 of the UNAIDS 95-95-95 goals.

In the qualitative component, the desire for more privacy within the pharmacy was highlighted, explaining why many interviewed reported that clients preferred to watch the HIVST video on their own time and schedule. In addition, to bolster the uptake of a self-testing approach if pharmacies are to be utilized, a major remaining challenge noted and needing to be addressed is the human resources gap, as per reported concerns of available pharmacy technicians regarding not having the necessary time and/or the appropriate training to provide high quality, detailed counseling that is required for HIVST. For this to be effective in a larger roll-out, dedicated, trained staff will need to be allocated at participating pharmacy locations.

Dissemination Plan

Preliminary and final results have been discussed within a priority stakeholders' group of investigators and collaborators. The preliminary results have been discussed with the Mozambique Ministry of Health (MOH), and Public Health Directorate in Zambézia (DPS-Z).

Preliminary results were also presented as a poster exhibit at the 2020 Conference on Retroviruses and Opportunistic Infections (CROI) (abstract #TUPEE648). Additionally, a manuscript is currently being developed to submit to a peer-reviewed journal for wider public dissemination.

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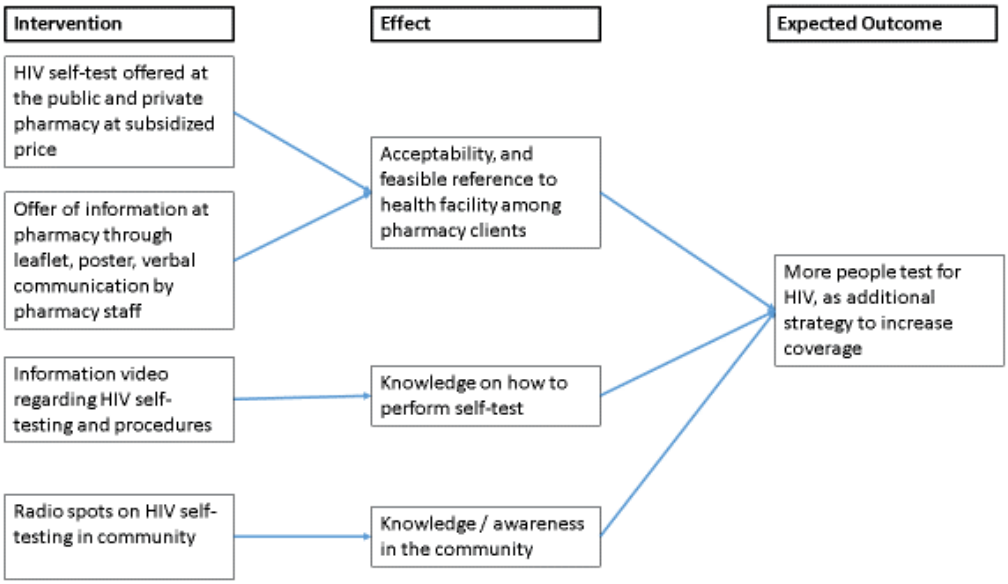
Appendices

Appendix 1. Approved protocol (Version 2.0), including all instruments, consent forms, co-investigator biosketches, conflict of interest statements

Appendix 2. Framework



Appendix 3. Communication materials

1. Poster at pharmacy

	Nome	Local
1	Calêndula	Quelimane
2	Coalane	Quelimane
3	Patrício	Quelimane
4	Quelimane	Quelimane
5	Nicoadala	Nicoadala
6	Licungo	Mocuba
7	Lugela	Mocuba
8	Mocuba	Mocuba
9	24	Mocuba
10	Milange	Milange
11	Molócuè	Alto-Molócuè
12	Ile	Ile
13	Gurúè	Gurúè
14	Faude	Gurúè

2. Leaflet

Como faço para obter ajuda caso o resultado do autoteste seja positivo?

Se o resultado confirmar-se positivo, você deve iniciar o tratamento o mais cedo possível. Se feito correctamente o tratamento do HIV pode mantê-lo saudável por muitos anos e reduzir o risco de transmitir o vírus para outras pessoas.

Caso você obtenha um resultado positivo poderá ir a qualquer Unidade Sanitária para poder receber os serviços necessários, como testes de confirmação, tratamento de HIV e outros, incluindo:

- aconselhamento
- apoio psicossocial
- teste de contagem de células da defesa (chamadas células CD4)
- teste para saber se tem a tuberculose
- assistência para referência para tratamento
- outro apoio que você pode precisar.

Se você for HIV positivo e estiver a receber o tratamento para o HIV (TARV), não faça o autoteste de HIV, porque você pode obter um falso resultado.

AUTOTESTE DE HIV

O TESTE ORAL

que podes fazer no conforto da tua casa

O autoteste está disponível para compra por um período limitado nas seguintes farmácias:

	Nome	Local
1	Calêndula	Quelimane
2	Coalane	Quelimane
3	Patrício	Quelimane
4	Quelimane	Quelimane
5	Nicoadala	Nicoadala
6	Licungo	Mocuba
7	Lugela	Mocuba
8	Mocuba	Mocuba
9	24	Mocuba
10	Milange	Milange
11	Molócuè	Alto-Molócuè
12	Ile	Ile
13	Gurúè	Gurúè
14	Faude	Gurúè

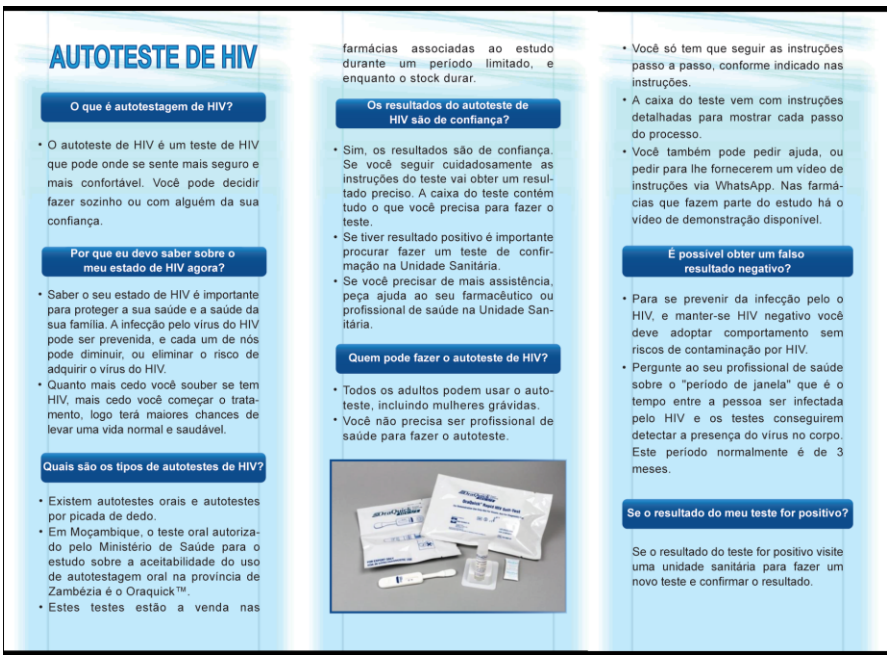
O nosso maior valor é a vida!

AUTOTESTE DE HIV

Apenas 50,00 meticais

O TESTE que posso fazer em qualquer lugar da minha escolha

Folheto informativo



AUTOTESTE DE HIV

O que é autotestagem de HIV?

- O autoteste de HIV é um teste de HIV que pode onde se sente mais seguro e mais confortável. Você pode decidir fazer sozinho ou com alguém da sua confiança.

Por que eu devo saber sobre o meu estado de HIV agora?

- Saber o seu estado de HIV é importante para proteger a sua saúde e a saúde da sua família. A infecção pelo vírus do HIV pode ser prevenida, e cada um de nós pode diminuir, ou eliminar o risco de adquirir o vírus do HIV.
- Quanto mais cedo você souber se tem HIV, mais cedo você começar o tratamento, logo terá maiores chances de levar uma vida normal e saudável.

Quais são os tipos de autotestes de HIV?

- Existem autotestes orais e autotestes por picada de dedo.
- Em Moçambique, o teste oral autorizado pelo Ministério de Saúde para o estudo sobre a aceitabilidade do uso de autotestagem oral na província de Zambézia é o Oraquick™.
- Estes testes estão a venda nas farmácias associadas ao estudo durante um período limitado, e enquanto o stock durar.

Os resultados do autoteste de HIV são de confiança?

- Sim, os resultados são de confiança. Se você seguir cuidadosamente as instruções do teste vai obter um resultado preciso. A caixa do teste contém tudo o que você precisa para fazer o teste.
- Se tiver resultado positivo é importante procurar fazer um teste de confirmação na Unidade Sanitária.
- Se você precisar de mais assistência, peça ajuda ao seu farmacêutico ou profissional de saúde na Unidade Sanitária.

Quem pode fazer o autoteste de HIV?

- Todos os adultos podem usar o autoteste, incluindo mulheres grávidas.
- Você não precisa ser profissional de saúde para fazer o autoteste.

- Você só tem que seguir as instruções passo a passo, conforme indicado nas instruções.
- A caixa do teste vem com instruções detalhadas para mostrar cada passo do processo.
- Você também pode pedir ajuda, ou pedir para lhe fornecerem um vídeo de instruções via WhatsApp. Nas farmácias que fazem parte do estudo há o vídeo de demonstração disponível.

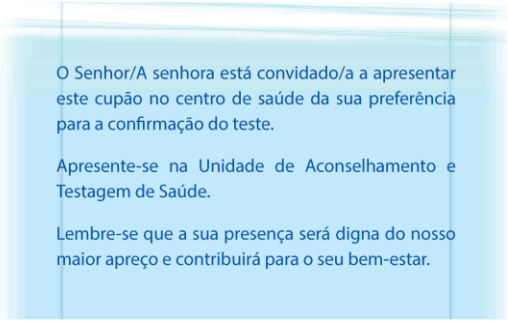
É possível obter um falso resultado negativo?

- Para se prevenir da infecção pelo o HIV, e manter-se HIV negativo você deve adoptar comportamento sem riscos de contaminação por HIV.
- Pergunte ao seu profissional de saúde sobre o "período de janela" que é o tempo entre a pessoa ser infectada pelo HIV e os testes conseguirem detectar a presença do vírus no corpo. Este período normalmente é de 3 meses.

Se o resultado do meu teste for positivo?

Se o resultado do teste for positivo visite uma unidade sanitária para fazer um novo teste e confirmar o resultado.

3. Reference voucher



4. Booklet (see separate document)