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Background: Impoverished men have lower rates of facility-based HIV counseling and testing and higher unknown HIV-positive status than women. Economic theory suggests that rational individuals will test for HIV if the expected benefits are greater than the expected costs. Yet, few studies have investigated the range of financial incentives and disincentives of self-collecting and self-performing specimen-based HIV tests among poor men who decline or do not frequent HIV testing in health facilities.

Methods: Twenty-four in-depth interviews were conducted to qualitatively assess perceived costs saved and costs incurred from use of HIV self-test (HIVST) kits among infrequent and never HIV-tested urban men in Dar es Salaam, Tanzania. To ensure familiarity with HIVST, all men were shown an HIVST video and a rapid oral fluid self-test. Participating men were then asked what were the costs associated with HIV testing in general, what were the perceived financial benefits and concerns of HIVST, and what they were willing to pay for HIVST. All interviews were audio-recorded. Data were translated, coded, and analyzed using inductive content analyses.

Findings: Perceived cost advantages were reduction in money lost to test at facilities, omission of fees for follow-up visits, affordability relative to private clinics, and increased time for earning and other activities. Men also discussed the imbalance of the financial benefit of accessing free HIV testing at public health facilities with the resources spent for transport, meals purchased away from home, and long wait times in line. Perceived cost disadvantages of HIVST were prohibitive initial and cumulative kit costs, required prior savings to purchase kits, effects of ill-omened expenditures; and preference for free provider-performed tests. Men also expressed concerns regarding the psychological costs of inaccurate HIVST results. Reported price ranges for HIVST that men were willing and/or able to pay varied considerably.

Interpretation: Acceptable cost structures, such as low fees, financial incentives, or subsidies, may be needed to overcome barriers preventing some men from learning their HIV status. Enhancing the perceived cost advantages of HIVST may mean that HIVST is an affordable and more readily-used option for impoverished men who infrequent or decline facility-based HIV counseling and testing.

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Uncontrolled Hypertension amongst People Living with HIV on Antiretroviral Therapy at an Urban HIV Clinic in Swaziland

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Background: In sub-Saharan Africa, the burden of cardiovascular disease (CVD) amongst people living with HIV (PLWH) is rising, due to the increasing prevalence of CVD risk factors (CVDRF) such as hypertension (HTN). We explored CVDRF prevalence amongst PLWH on antiretroviral therapy (ART) at an urban hospital in Swaziland. This analysis focuses on the subset of patients found to have stage 3 HTN (hypertensive emergency) on their initial screening.

Methods: A convenience sample of PLWH > 40 years on ART were screened for CVDRF, including HTN. Trained clinic staff measured BP using calibrated electronic BP monitors. Two sitting BP measurements were made, with five minutes' rest before each one. Patients with Stage 3 HTN (systolic BP > 180 mmHg and/or a diastolic BP > 110 mmHg) were referred to the emergency or outpatient departments for immediate clinical management. We subsequently conducted medical records review using a structured abstraction tool to assess demographic information (age, sex), HIV status (CD4 count, ART regimen), weight, height, and HTN management subsequent to the initial screening visit. Data were entered into an EXCEL database, which was used to analyze descriptive statistics.

Findings: 1,826 patients were screened for CVDRF between September 2015 and July 2016. Of the 407 patients (22%) with high BP, 24 had Stage 3 HTN with a median systolic BP of 189.5 mmHg (range 164– 232) and median diastolic BP of 110 mmHg (range 87– 141). 15 of the patients were not on BP medication at the time of screening; medication was subsequently initiated for 14 patients by August 2016. Antihypertensive regimens were changed for 6 9 patients who were on BP medications at the time of screening. By August 2016, BP had improved for 18 patients (75%) and was controlled for 4 patients (16.5%).

Interpretation: 1.3% of patients screened had Stage 3 HTN. Despite being engaged in ongoing chronic care for their HIV, less than half had previously been diagnosed with HTN. During the study period, BP control was only achieved for 4 patients (16.5%). This suggests that efforts to strengthen the diagnosis and management of HTN in this setting are needed.

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A Typhoid Epidemic in Rural Malawi: Real-world Challenges

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Program/Project Purpose: Typhoid fever is a major global health problem, with an estimated 22 million cases and 269,000 deaths annually. Caused by *Salmonella enterica* serovar Typhi it is transmitted via the faecal-oral route and is associated with poverty and