**Secondary distribution of HIV self-tests improves coverage**

Despite growing consensus that the tools to end the HIV epidemic are within reach, their successful implementation relies on high uptake of HIV testing. Although much progress has been made in improving uptake of testing, one in five people living with HIV worldwide are unaware of their status.1 Attaining testing targets will require innovative strategies for reaching those individuals who have thus far avoided or been missed by testing programmes, such as men, young people, and key populations as defined by WHO.1 HIV self-testing in particular has been shown to improve uptake of testing among individuals who would not otherwise test;2 consequently, there is a growing literature on novel HIV self-test distribution models.

In The Lancet HIV, Alain Amstutz and colleagues3 report on the effectiveness of secondary distribution of HIV self-test kits for improving coverage of HIV testing in 106 villages in Lesotho. In a cluster randomised trial, door-to-door, provider-delivered HIV testing using point-of-care blood tests was offered to consenting household members in all clusters. In communities in the intervention group, self-test kits were left for absent or declining household members, whereas in the control group, absent or declining individuals were referred for testing at local clinics. The primary outcome, HIV testing coverage among those aged at least 12 years, was measured within 120 days of the campaign using health facility records, patient-held HIV testing records, or village health worker reports of HIV self-test use. Confirmed HIV tests included known HIV positive results, recent negative test results (within the previous 4 weeks), and tests done during the study period, including self-tests.

On the day of the testing campaign, uptake of testing was high among household members who were at home (around 90%). However, testing coverage on the day of the campaign among all eligible household members—including those who were absent or declined—was only 2545 (61%) of 4174 in the intervention group and 2163 (59%) of 3642 in the control group. Yet within 120 days of the campaign, an additional 841 (53%) of 1601 absent or declining household members in the intervention group had a confirmed test by either a self-test (99%) or at local facilities (1%), compared with an additional 38 (3%) of 1455 absent or declining household members in the control group who tested at local facilities, resulting in an overall testing coverage of 3386 (81%) of 4174 in the intervention group and 2201 (60%) of 3642 in the control group (odds ratio 3·00, 95% CI 2·52–3·59). The study adds to the literature on the effectiveness of community-based testing strategies in increasing the uptake of testing,4,5 with a novel finding about how secondary HIV selftesting kit distribution can enhance testing coverage in door-to-door campaigns.

Of note, the combined intervention resulted in improved testing coverage among groups that often have low rates of testing:1 men (74% coverage in the intervention group vs 44% coverage in the control group), adolescents (76% coverage vs 30% coverage), and migrant populations (55% coverage vs 24% coverage), potentially by leveraging several behavioural nudges to encourage testing (eg, salience6 ). Although promising, a potential challenge with this approach, which involved leaving a labelled HIV self-testing kit for absent or declining household members, is coerced testing.7,8 Although there is evidence that individuals who have been persuaded to test eventually appreciate the support and have positive views of community-based HIV self-testing programmes,7,8 vulnerable groups such as adolescents need protection from forced testing, and if they choose to test, they need privacy.9 Upholding these values is likely to enhance programme satisfaction and sustainability.

Ultimately, cost will determine the potential scalability and sustainability of secondary distribution of HIV selftesting kits within large-scale testing campaigns. Results from the costing study that was nested to the study by Amstutz and colleagues3 will be illustrative, particularly given the quite low uptake of HIV self-testing—only 58% of test kits that were left for absent or declining household members were documented as used within 120 days of the campaign. Costs of communitybased HIV self-testing programmes can be high,10 but increasing the number of options for individuals to learn their serostatus might be justified, even if some options are more popular than others.

In summary, Amstutz and colleagues3 report novel findings on the beneficial effect of secondary distribution of HIV self-testing kits in increasing testing coverage within the context of a door-to-door campaign. They report large effect sizes overall and particularly among men, young people, and migrant workers. The findings are important because they offer another tool for reaching the groups that are least likely to be tested for HIV. However, before this programme is scaled up, protections must be in place to ensure that vulnerable groups are not coerced to test and more data on costeffectiveness could guide where and when this strategy might be warranted.

We declare no competing interests.

Euphemia L Sibanda, Sandra I McCoy euphemia@ceshhar.co.zw

The Centre for Sexual Health and HIV/AIDS Research (CeSHHAR) Zimbabwe, Harare, Zimbabwe (ELS); Department of International Public Health, Liverpool School of Tropical Medicine, Liverpool, UK (ELS); and Division of Epidemiology, School of Public Health, University of California, Berkeley, Berkeley, CA, USA (SIM)

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