

HIV in Mozambique: starting, and staying on, treatment

Mozambique has set ambitious targets for getting more people with HIV on treatment, and it is testing innovative ways to help them stay on the life-saving drugs. Andrew Green reports.

Mozambique is fighting to gain control of its HIV epidemic, leading with a plan to strategically enrol substantial numbers of people with HIV in treatment programmes in an effort to end transmission of the virus. The number of people who have started antiretroviral therapy (ART) has already jumped from 308 000 in 2012 to more than 676 000 by March of last year. Officials expect to reach nearly a million people with ART by the end of next year—most of the 1·5 million people who are presently living with HIV in the country.

Enrolment on treatment is only the first step, though, for a country with one of the ten highest HIV prevalence rates in the world. For Mozambique to succeed in ending its epidemic, it is going to need to figure out how to keep those patients on ART.

The country's ART retention rates are also some of the worst in the world—the result of a deadly combination of stigma, access problems (especially in rural areas), and people's frequent movements in search of work. Within 1 year of

starting treatment, nearly a third of patients have dropped out, according to the US President's Emergency Plan for AIDS Relief (PEPFAR). By the end of 3 years, that number falls to nearly half. By comparison, data from 18 countries with at least 2000 people on ART showed an average retention rate of 86% after 1 year, according to WHO. That dropped to just 72% after 60 months.

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Not only does Mozambique's poor retention undermine enrolment efforts and increase the likelihood that the disease will continue to be transmitted, said UNAIDS country coordinator José Enrique Zelaya Bonilla, but also "that becomes treatment failure and drug resistance, which makes access to treatment more expensive. The country is not in the position to make second, third, fourth-line treatment accessible to people."

To prevent that from happening, a range of experts—from emergency relief groups to major international agencies to small health advocacy associations—are experimenting with innovative programmes to keep Mozambicans with HIV on their ART.

Stigma survey

First they had to understand why people are dropping out. It has been nearly 30 years since the first patient was diagnosed with HIV in Mozambique, yet Amos Sibambo, a programme officer with the country's Associations of people living with

HIV/AIDS (RENSIDA), said there is still a lot of judgment about how a person became infected, judgment that colours a range of interactions. Among the nearly 750 people living with HIV who participated in a national stigma survey, more than half reported experiencing some form of discrimination in the previous year, according to results released in 2013. And nearly 40% said their status had made it more difficult to get work, housing, or social services—including health care. "We have got many people who know about [HIV], but are afraid to go to the hospitals because they don't want to be discriminated [against]", Sibambo said. "They don't trust the health services. And people die."

Stigma keeps people from seeking additional information, he said, such as learning that life-saving treatment is available and expanding for people who meet national criteria. Even active members of RENSIDA who are aware of their status and know that ART can save their lives, quit treatment because of the constant disapproval they meet.

What they need, he said, are more advocates not only within their communities, but also at the places where people living with HIV access health care. That's exactly what Namati Mozambique, first established in 2012 in the country's capital, Maputo, is trying to do. Executive director Ellie Feinglass said the founders wanted to evaluate how Mozambique's health system upheld patients' rights. "What I gathered is most of the response around HIV has been very biomedical", she said. "There really hasn't been adequate attention to what barriers exist. It's not just about getting the medicine in the mouth, it's about stigma and discrimination, [and] mistreatment."



Andrew Atchison/In Pictures/Corbis

At the start of 2013, Namati's team drafted a manual cataloguing Mozambicans' health rights. And by March they were training their first health advocates, who are stationed at health centres or within communities to intervene on behalf of patients or to shore-up health workers by providing patients with the information they need. There are currently 16 advocates in three districts and Maputo city, with plans to expand to four more.

Feinglass said about half of the complaints advocates receive centre around HIV services—or the lack thereof. In one incident, an HIV-positive woman went to her local health facility to pick up her antiretrovirals. "Apparently they called her from the waiting room and she didn't hear", Feinglass said. By the time she made it to the counter, a health worker started berating her. "She yelled at her, insulted her. She was really trembling."

Normally in those situations a patient would just leave—skipping her monthly refill and possibly dropping off ART completely. Instead, the patient sought out the Namati advocate, who approached a supervisor, lodged a complaint against the health worker, and ensured the patient got her medicine. "My point isn't, 'Aren't we great?", Feinglass said. "It's that, if that's what we're seeing, then what aren't we seeing?"

Shared responsibility

The other complication officials said they hear repeatedly is that it is time consuming and expensive to stay on treatment. Each month, a patient must travel, often long distances, to the clinic and queue to receive their next supply of medicine.

Augusto Viação was diagnosed with HIV in 2013 and—his immune system already dangerously weak—was quickly enrolled on ART. Viação is also unemployed and found it difficult to pay the bus fare every month to travel to his nearby health facility. Instead, he would walk to the clinic—setting out

early to avoid the sun—and then take the bus back because the medicines were too heavy to carry. Just over a year ago, a nurse at the clinic asked if he might be interested in joining several other HIV patients who lived near him in forming a *grupo de apoio a adesão comunitário* (GAAC), or community adherence and support group.

A unique system developed in Mozambique in 2008 by Médecins Sans Frontières (MSF) in collaboration with local health officials, GAACs operate on the idea of shared responsibility—each GAAC member takes a turn collecting antiretrovirals for the entire group. That way it substantially reduces the number of times each patient must

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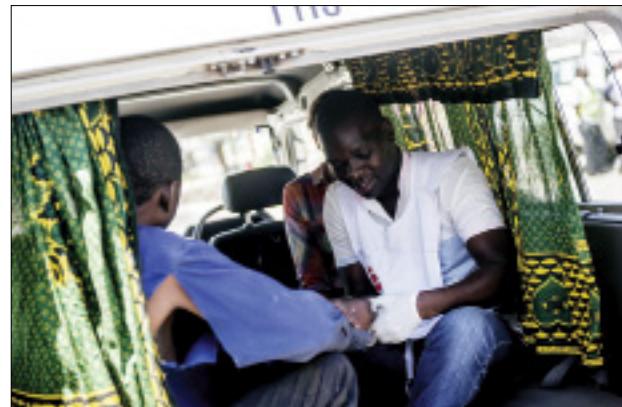
visit the clinic to collect drugs each year. The national government has now adopted the GAAC model and is expanding it with assistance from the US Centers for Disease Control and Prevention and others.

But GAACs are also about creating shared responsibility for each other's health. Viação gathers with his other GAAC members each month. Before the pills are distributed, they talk about how they are feeling and whether they are adhering to their treatment regimens. If not, they are encouraged to explain why. The team leader can then notify a health officer about the problem, so that they can help address it.

For Viação, who describes himself as "just trying to push to stay on treatment", the group's support, along with the reduced trips, have been crucial to maintaining his treatment.

Drug access

Officials are quick to explain that neither model is a panacea. For instance, most patients cannot enrol in a GAAC until they have



An MSF health worker does HIV testing in Beira, Mozambique

Gianluigi Guerri

demonstrated an ability to maintain treatment for 6 months. "The first 6 months are where patients are at most risk of quitting treatment, because it's the first shock that they have with the new life of lifelong treatment", said Alyssa Leggoe, the chief integrated health officer with USAID Mozambique.

So her team has been beefing up services provided by *activistas*—a cadre of community health workers supported by PEPFAR. Over the past 3 years, they have tried to expand the work of *activistas* from home-based palliative care to include recruiting people for testing and tracking down HIV patients who have defaulted from treatment.

And although MSF created the GAACs, Amaury Gregoire, the group's head of mission in Mozambique, said they are "not one size fits all. Some patients would actually prefer not to be linked to any other patients and just get the drugs quickly at the facility." Which is why MSF is looking at models to speed up drug access at health centres. "We believe there is a range of models that should be adapted to a country and that could constitute a bunch of options that are possible for a health centre to do", Gregoire said, ensuring that as ART enrolment surges, patients will have fewer and fewer reasons to drop out.

AG's reporting was supported by a grant from the independent International Reporting Project

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