PEOPLE'S COP21 MOZAMBIQUE

COMMUNITY PRIORITY INTERVENTIONS

FOR PEPFAR MOZAMBIQUE IN 2021

COMMUNITY PRIORITY INTERVENTIONS FOR MOZAMBIQUE'S COP 2021

INTRODUCTION

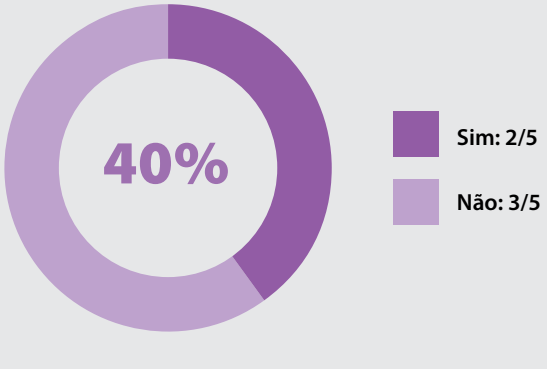
In Mozambique, an estimated 2,307,842 million people are living with HIV (141,968 people <15 years old and 2,265,874 people >15 years old).[1] PEPFAR estimates that by Quarter 4 2019, 59% or approximately 1,354,408 people with HIV were on antiretroviral treatment (ART).[2] For certain populations, treatment coverage is much lower than the average, such as adolescent boys and young men (45% treatment coverage).[3] In the midst of the COVID-19 epidemic as well as conflict in the North, during FY 20, Mozambique expanded its treatment program to achieve the highest TX_NET_NEW (new people initiated and retained on treatment) since 2017, of 194,773 people.[4] [5] However, Mozambique has the second largest HIV epidemic in the world, and is far off track from achieving epidemic control, with:

+ high rates of new HIV infections and AIDS-related deaths,
+ continued gaps in treatment and prevention coverage,
+ large gaps in access to viral load,
+ high rates of ART interruption/loss to follow up (LTFU),
+ persistently high rates of advanced HIV disease,[6]
+ lack of investment in truly community-led treatment literacy and anti-stigma interventions, and
+ key populations investments that are too limited geographically and in budget size to meet the needs of communities and are not accountable to those communities.

1. Mozambique COP 2020. Strategic Direction Summary, March 16, 2020, p. 9
2. COP19/FY20 Quarter 4 POART, December 8 2020
3. Reaching Epidemic Control: Clinical Cascade and Retention, Mozambique COP20. February 25, 2020, slide 61
4. *Supra* note 2 slide 23
5. PEPFAR Planning Level Letter COP2021 Mozambique. January 13 2021, p. 10
6. *Supra* note 1, p. 16

Approximately 13.2% of Mozambicans are HIV positive, and 130,000 new infections occur per year. Untreated or poorly managed HIV is a leading cause of death nationwide, with an estimated 65,042 AIDS-related deaths in 2020.[7] Untreated HIV also drives high rates of new HIV infections in Mozambique. 66% of all estimated new HIV infections among adolescent girls and young women (AGYW) 15-24 years, and 51% of all estimated new infections are among young men (20-29) and AGYW (15-24).[8] Key populations, including men who have sex with men, transgender people, people who use drugs, sex workers and prisoners, continue to experience serious gaps in access to combination prevention and continuous, quality HIV treatment services provided with respect. According to COP21 recommendations developed by Mozambican key population organizations, in 2020 PEPFAR reached only 34,468 key population members with services—leaving a gap of 60% who have no access to services.[9]

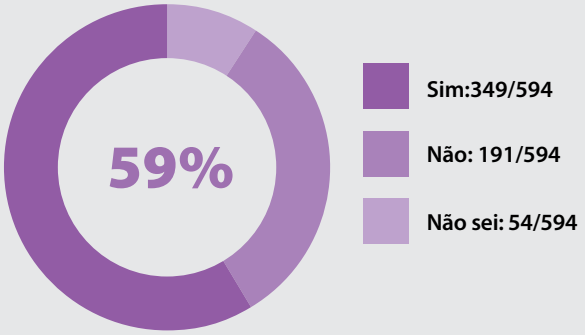
Figure 1. Is PrEP provided in this facility?



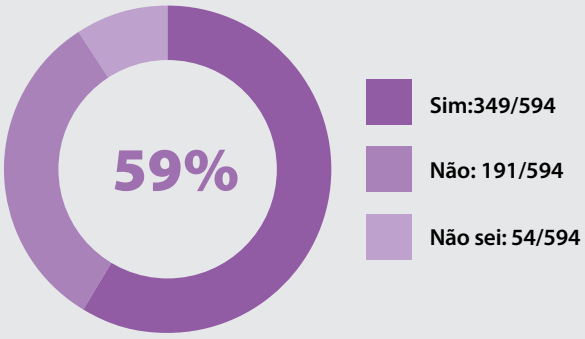
PrEP_NEW targets have increased slowly in Mozambique, and COP20 included an expansion of PrEP to all provinces and from 38 to 74 districts. Because PrEP is not available in all facilities, access is still impeded despite program growth. IPs exceeded their annual PrEP targets for 2020 despite COVID-19 restrictions, pointing to the need for much greater ambition in service delivery targets for COP21. Some populations have hardly started to benefit from PrEP: between July - October 2020 in Manica Province, for example, only 28 men who have sex with men were enrolled on PrEP and only 19 AGYW.[10] This is unacceptable. Data from the community-led monitoring (CLM) pilot in January 2021 in 5 clinics in Maputo province indicate that of 638 people with HIV interviewed, only 40% reported that PrEP was available at the clinic. (Figure 1.)

Current testing, treatment coverage, and viral load suppression rates are far below the 2020 target committed by the government and global partners of 90-90-90 by 2020. Unacceptably high rates of loss to follow-up (LTFU) cut across age groups and communities, particularly during the first three months after people start treatment, but are most alarming for young men and AGYW.[11] Most PEPFAR implementing partners delivering care and treatment are underperforming in reaching their service delivery targets.[12] Some even set artificially low targets to avoid being classified as "underperformers." PEPFAR's most recent program data point to improvements in people returning to care and treatment and adherence to ART, but the progress is slow. LTFU prevention interventions led by trusted, paid, and equipped community health workers, reducing clinic wait times, and bringing essential biomedical and peer-led psychosocial support interventions closer to communities have been associated with improvements in LTFU in Mozambique.[13] The COP20 commitments to expand differentiated service delivery through community-based drug distribution, pharmacy fast track drug refills, mobile brigades, and mobile clinics all need to be expanded to a further reach geographically to make greater progress in retaining more people in lifesaving care.

Figure 2. Do you know your viral load (is the amount of HIV in your blood)?



Knowledge about treatment: do patients understand viral load and their health?



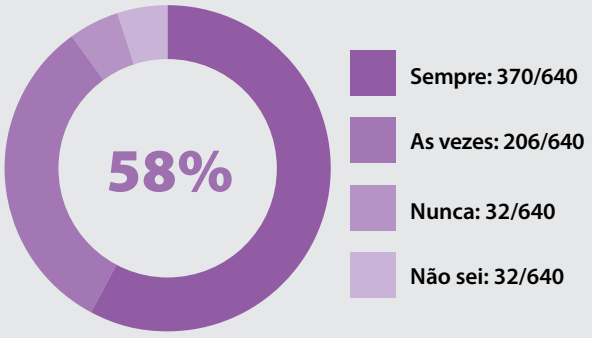
The effects of underinvestment in treatment and prevention literacy for communities and HIV-related stigma and discrimination are substantial: Mozambicans living with HIV experience high rates of human rights violations and routinely report poor treatment by health workers in clinic settings.[14]

7. *Supra* note 1, p. 13
8. PEPFAR Mozambique Outbrief Presentation. February 28, 2020
9. PEPFAR COP21 Moçambique. Recomendações para a melhoria da componente de Populações-Chave, COP21, p 2
10. *Supra* note 2, slide 83
11. A roadmap to 1.8 million. COP2020 outbrief, February 28, 2020, slide 7.
12. *Supra* note 1, p. 11
13. *Supra* note 3, slide 58
14. *Supra* note 3, slide 36

While COP20 committed to developing a treatment literacy and stigma reduction program to increase community demand for quality HIV services, there was no commitment to implementation of the program by people living with HIV themselves—a serious concern. Among patients interviewed during a CLM pilot in 5 clinics in Maputo, 41% either did not know their viral load or could not say whether or not they knew their viral load. 41% either did not know that an 'undetectable' viral load meant ART was effective or couldn't say whether or not they knew (see Figure 2).

When asked if there were enough staff in the clinic, 58% of patients reported there were "always" enough staff, while 42% reported either that there were "sometimes" enough staff, "never" enough staff, or that they did not know the answer. (See Figure 3.) But across facilities, the average wait time patients reported waiting at the clinic was 4 hours and 49 minutes.

Figure 3. Is there enough staff at the clinic?



COVID-19 also brought serious challenges: during 2020, access to viral load testing dropped substantially for adults and children due to reduced in-clinic access. HIV testing in particular for pediatrics has been substantially set back.[15] Interventions that take place in community settings, including DREAMS activities, key populations services, and services provided by mentor mothers to ensure HIV positive women and their children have continuous treatment access. Recovering from these interruptions through intensified efforts to find people lost to care; providing funding to communities that experienced economic hardship due to COVID-19 restrictions and could not take their medicine due to lack of food; and investing in effective adaptations so that community programs can carry out high impact activities safely are important community priorities for COP20 and COP21. COVID-19 also revealed areas of growth and success as well: for example, Mozambique was able to rapidly accelerate the provision of multi-month dispensing (MMD) for all people with HIV between Q2-Q3 2020.[16]

This set of community recommendations to PEPFAR was developed based on the priorities developed by civil society organizations (CSOs) and people living with HIV at the start of the PEPFAR 2021 COP planning process and outcomes from subsequent engagement by civil society.

The national Key Populations constituency also supports and endorses these recommendations.

CLM of PEPFAR-supported programs in Mozambique was carried out by people living with HIV during a pilot program in order to better establish a relevant and effective model for CLM in the country. The purpose of the pilot was to test CLM assessment tools and methods, learning lessons for adoption during an eventual national roll-out. Communities use CLM to identify the main challenges people encounter when using health services and use data-informed advocacy to push for the policy and program shifts they need. We conducted patient interviews in five facilities over three days (20-22 January 2021), collecting observational data and interviewing the facility manager for each health facility. We interviewed 638 patients in the five facilities. Of these, 93% were PLHIV. 61% of the total interviewed patients were women. PEPFAR Is currently funding several organizations or institutions to carry out CLM (combined budget of approximately $3.3 million).[17] We hope the outcomes from the small CSO-led pilot will help ensure CLM delivers real impact for people living with HIV and people most affected by the AIDS crisis in Mozambique by improving the accessibility and quality of HIV services through community-led advocacy efforts to resolve the problems highlighted by community-generated evidence.

15. *Supra* note 2, slide 42-43
16. *Supra* note 2, slide 29
17. *Supra* note 2, slide 121

COMMUNITY RECOMMENDATIONS TO PEPFAR

TREATMENT

Gaps in treatment access, high rates of loss to follow up and AIDS-related deaths in Mozambique are unacceptable. The priorities committed in COP20 to address this crisis must be urgently rolled out and taken to scale as quickly as possible, with priority placed on reducing clinic wait times; increasing viral load access; and bringing quality services closer to patients—from ART initiation and refills to lifesaving advanced HIV disease services.

Importantly, the treatment literacy program agreed to in COP20 must be overhauled: instead of a marketing campaign, it should be developed and implemented by communities, with direct funding to networks of people living with HIV to implement the program. Lack of grassroots ownership over anti-stigma and "U=U" campaigns will lead to poor strategy and limited impact.

***COP21 TARGET:** Fund a national, ongoing treatment literacy effort designed, led and implemented by people living with HIV in Mozambique, in order to increase demand for quality services for HIV positive people; reduce loss to follow up; find hundreds of thousands of people with HIV who have fallen out of care; combat HIV stigma; and focus funding, strategies and activities with communities.*

***COP21 TARGET:** DSD interventions to increase retention on treatment and support faster treatment initiation that are having an impact should be scaled beyond the limited geographic footprint agreed to in COP20, such as KP Mobile Clinics. IP budgets should be revised to ensure maximum investment in service delivery—not administration or technical support.*

***COP21 TARGET:** the package of Advanced HIV Disease (AHD) services agreed to in COP20 must be aggressively decentralized and available throughout the country, provided outside of hospitals, in communities where people are still dying.*

***COP21 TARGET:** PEPFAR should expand investment in sufficient numbers of trained and supervised community health workers, paid a living wage, providing a range of population-specific support services to help people stay on treatment for life. The ratio of CHWs to patients must be low enough to ensure adequate coverage and sufficient quality. PEPFAR should further expand investments in the salaries and deployment of professional health workers, targeting high volume, poorly performing sites.*

KEY POPULATIONS

COP21 must urgently prioritize closing the coverage gaps in prevention, linkage and treatment faced by key populations in Mozambique. These interventions range from expanding differentiated service delivery for key populations (such as through KP-friendly mobile clinics and drop-in centers providing comprehensive clinical and psychosocial support services), safely restarting community-based activities, and aggressively scaling up PrEP access nationally.

Priority must be given to funding KP programs that are designed and implemented by key populations themselves, rather than funding large IPs that have no track record in KP service delivery and typically use small community organizations to deliver against their PEPFAR program targets, providing extremely limited funding, unrealistic timelines, and no commitment to fund capacity transfer to indigenous KP networks.

***COP21 TARGET:** Please refer to the document: "PEPFAR COP21 Moçambique. Recomendações para a melhoria da componente de Populações-Chave." We endorse those recommendations.*

PREVENTION

With an unacceptably high rate of 130,000 new HIV infections annually, 66% of which are among AGYW, scaling up combination prevention is an urgent priority, ranging from condoms and lubricant to PrEP, with a focus on earlier detection of HIV as well as other STIs.

***COP21 TARGET:** PrEP should be rolled out as a truly national program that is a foundation of combination prevention for Mozambique in 2021, with a substantial increase in national PrEP_NEW targets compared with COP20 for all subpopulations, in particular key populations (KPs), pregnant and breastfeeding women, as well as AGYW. People <15 years of age and prison populations should be eligible for PrEP. In addition, PEPFAR should work with MISAU to rapidly pursue access to long-acting injectable PrEP as a critical new prevention option.*

***COP21 TARGET:** Scale up self testing, particularly among communities and populations such as men, key populations, and adolescents that face barriers to health services.*

PEDIATRICS

Despite some improvements in prevention, diagnosis and treatment access in Mozambique, rates of perinatal infection is unacceptably high with a national estimate of 13%.[18] FY20 TX_NET_NEW was only 10,802.[19] Delays in diagnosing children with HIV, high rates of pediatric treatment interruption, poor viral load coverage and suppression, and high rates of death among are alarming. Clinics are failing children with HIV and their caregivers. PEPFAR has detected poor quality service delivery among IPs requiring major "reboot" by CDC and USAID as part of COP20.

***COP21 TARGET:** Immediately implement new WHO guidelines on Point of Care (POC) early infant diagnosis (EID) for HIV exposed infants, providing 100% POC EID for children <18 months, the critical period where untreated HIV kills children rapidly. This pivot should be implemented alongside POC viral load testing for pregnant women, with appropriate budget shifts (to procure sufficient machines, reagents, staff etc.).*

***COP21 TARGET:** Fully fund a national expansion of the mentor mothers program to ensure mothers and children are retained in care with suppressed viral load.*

***COP21 TARGET:** Accelerate elimination of nevirapine-based pediatric regimen, which is still in use among more than 10% of pediatric patients (11,172 children), and rapidly introduce DTG 10mg dispersible for children <20 kg.*

***COP21 TARGET:** While MMD has been introduced for HIV exposed infants and breastfeeding women as a national policy, the COVID-19 adaptation has now been reversed for pregnant women. Requiring pregnant women to return 9 times to the clinic for ART is inconsistent with evidence and denies this subpopulation a quality, client-centered service. MMD for pregnant and breastfeeding mothers and their children saves lives.*

COMMUNITY SYSTEMS

Investing in the capacity of community systems is critical for provision of quality services alongside programs designed and implemented by people living with HIV to promote treatment and prevention literacy. Other priority health education interventions for social change include

ensuring policies, laws and regulations that reinforce stigma and prevent or hinder equitable access to social and health services for key populations and other vulnerable groups are removed. CLM holds important promise for improving the quality and accessibility of services, but at this stage a truly PLHIV and KP-owned, independent CLM structure has not been established or funded.

***COP21 TARGET:** The scope of action for community grants should be increased to at least $50,000, in order to ensure stronger impact.*

***COP TARGET:** GAACs should be revilitizes along with programs to deliver economic empowerment of people on ART.*

***COP21 TARGET:** PEPFAR should support an independent, robust, PLHIV- and KP-owned and led CLM program providing sufficient, ongoing monitoring with a focus on poorly performing facilities and underserved populations such as KPs. The $3.3 million for CLM should be prioritized for direct investment in PLHIV- and KP-owned and led independent models that will generate community evidence in service of advocacy to resolve chronic problems uncovered during monitoring.*

18. *Supra* note 1, p 45
19. *Supra* note 2, slide 138

Distrito Municipal
Kamubukwane