

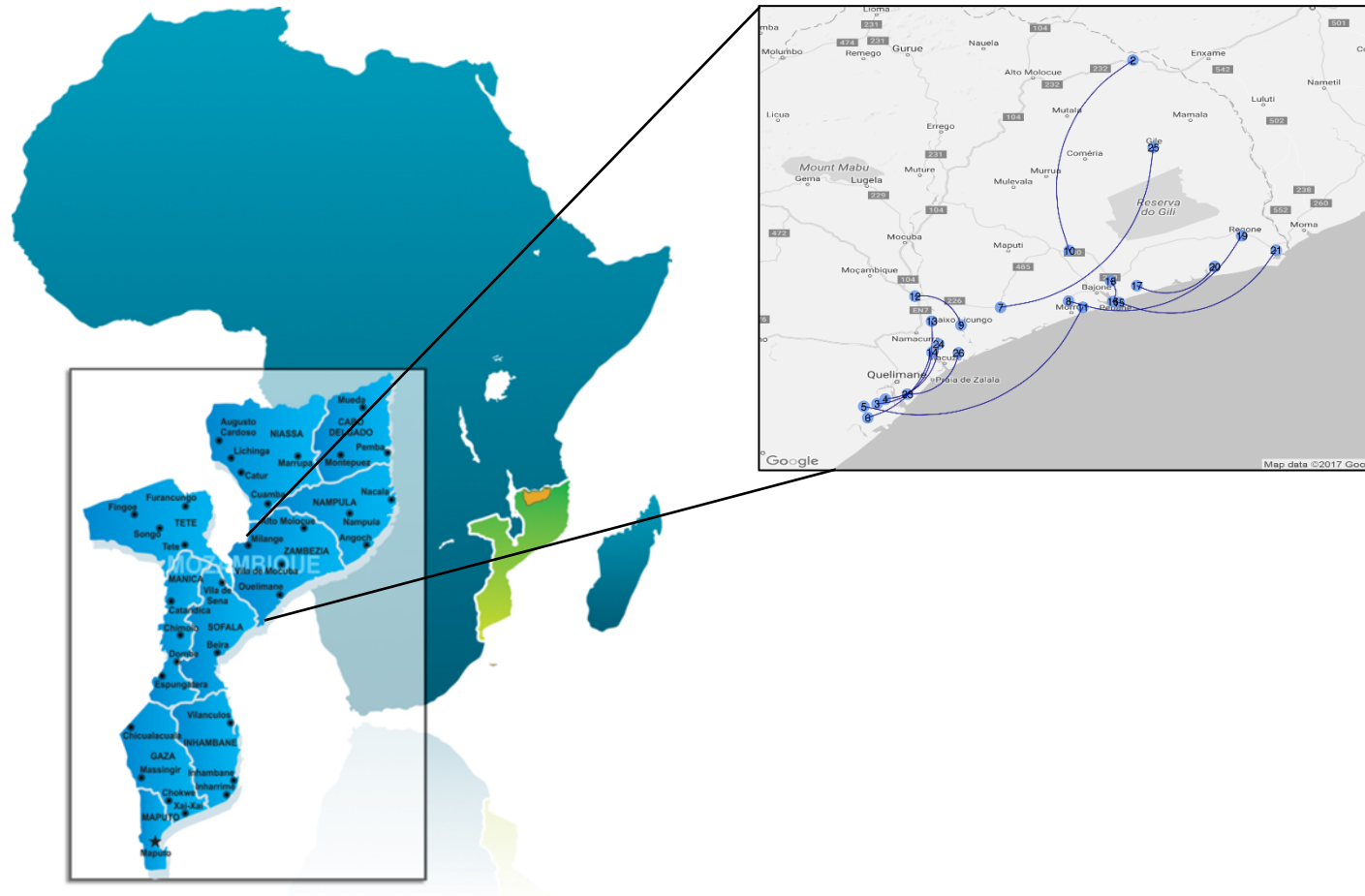
Partner-based HIV care and treatment for expectant couples in rural Mozambique

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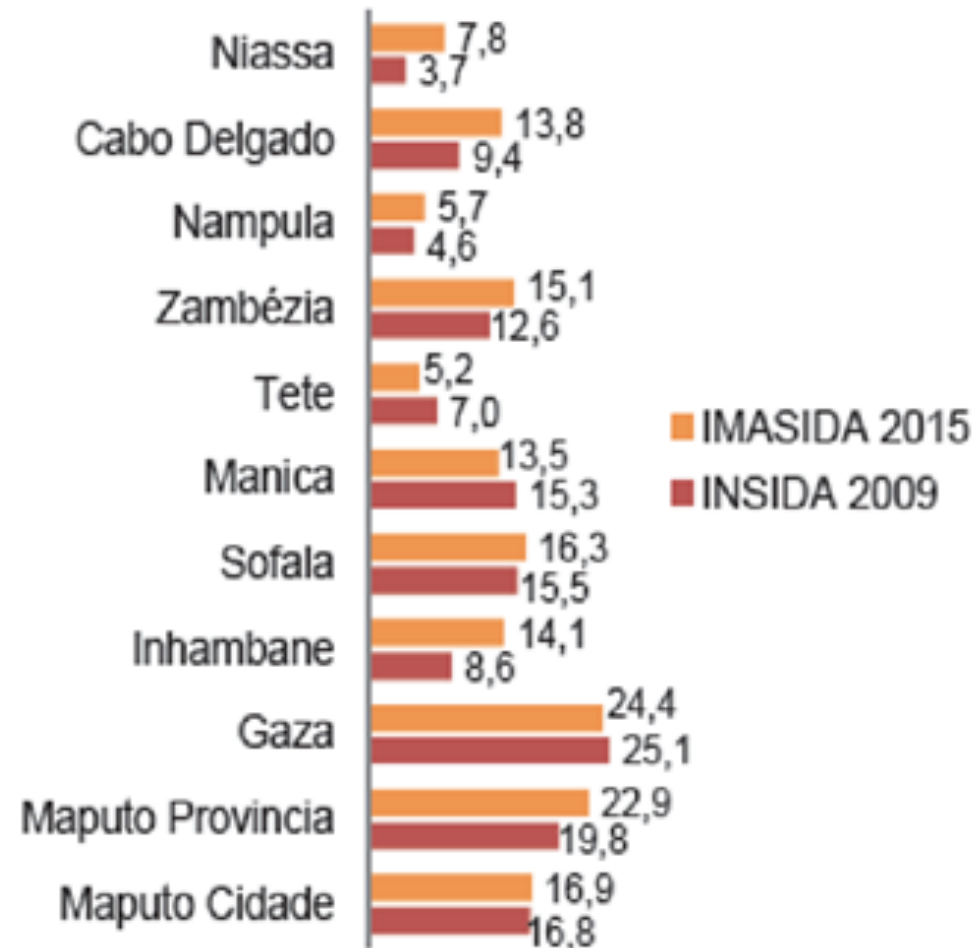
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Map of Study Sites in Mozambique



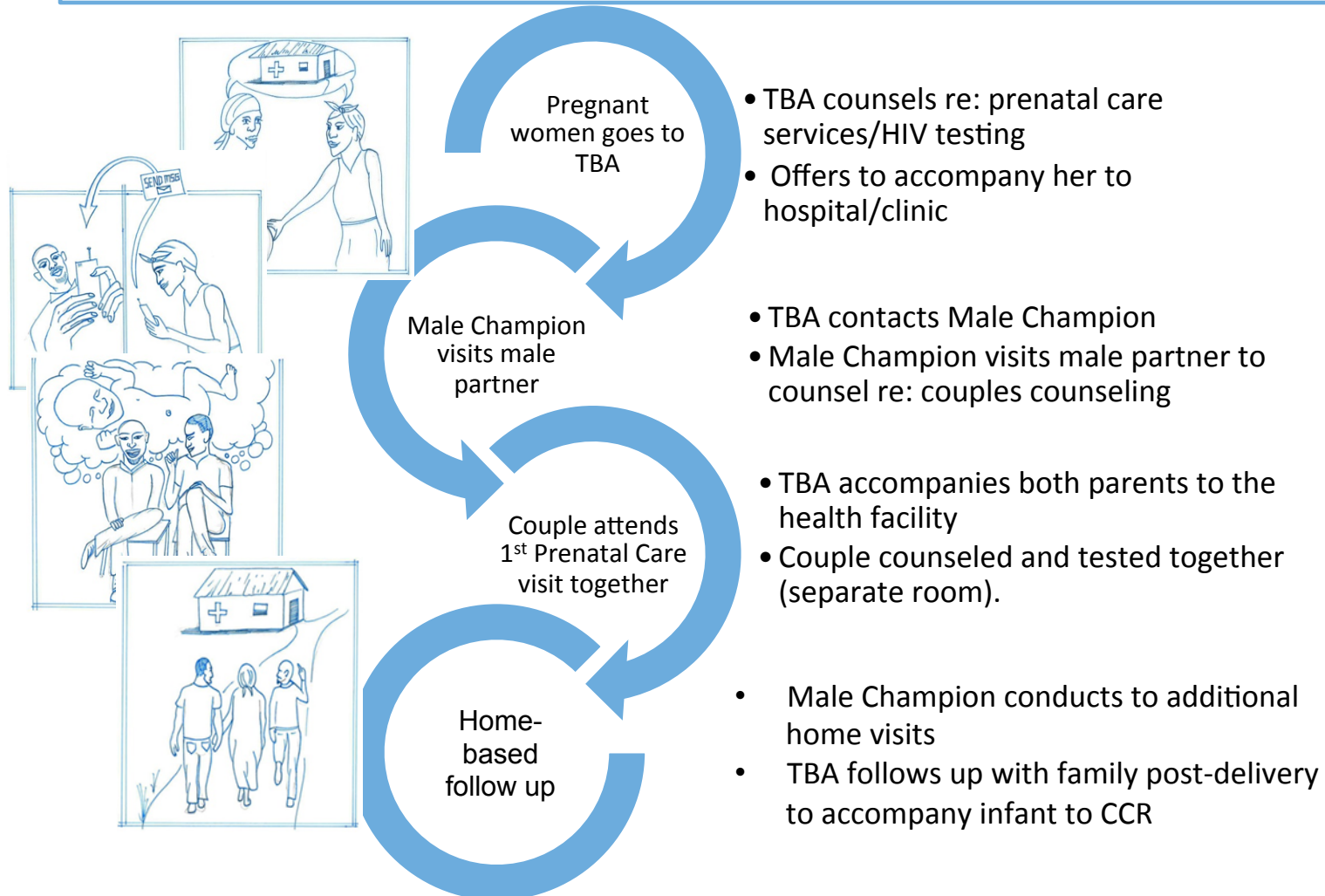
HIV Epidemic in Mozambique

*Percentagem de mulheres e homens de
15-59 anos de idade HIV positivo*



The Original Male Engagement Design

Male Champions give community lectures about importance of prenatal care services and support of partners during pregnancy

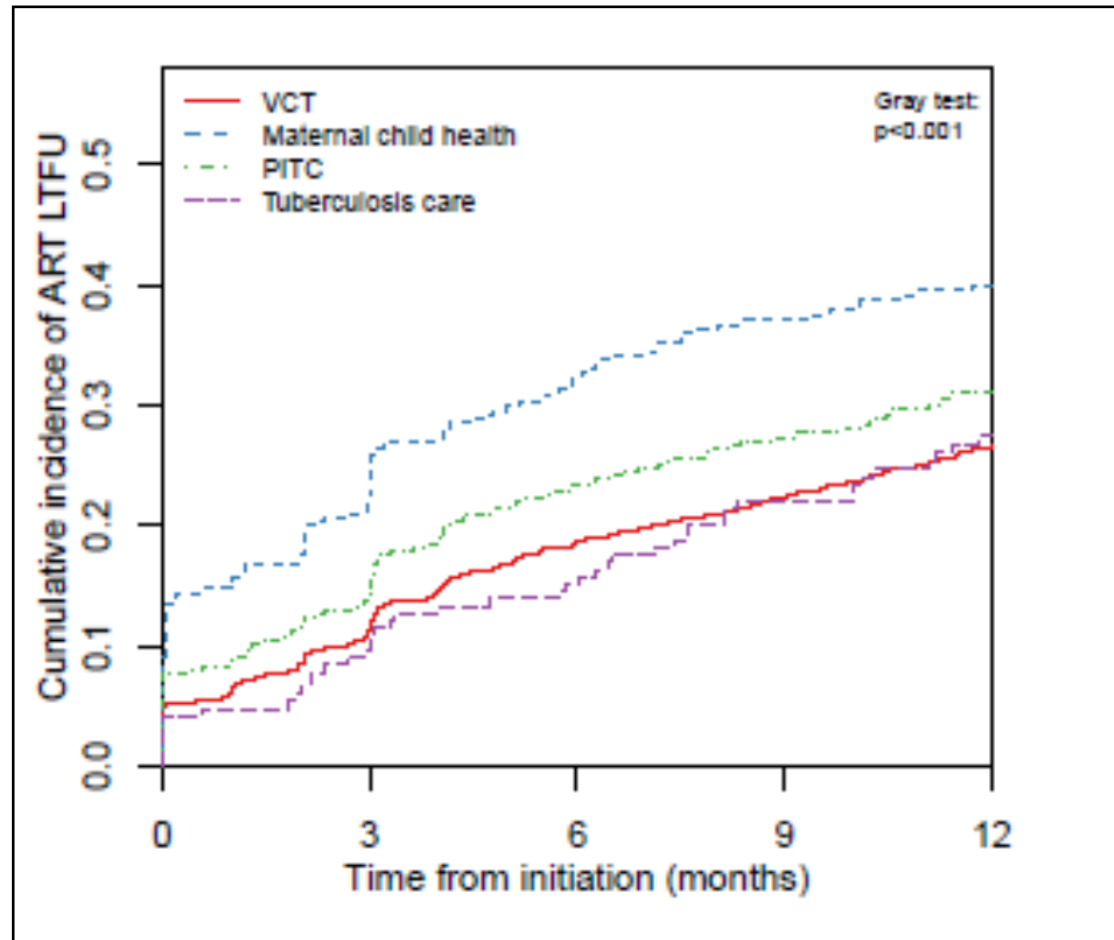


Male Partner Accompaniment and Couples Testing Uptake

- Male partner accompaniment 2% - 60%
- Maternal testing rose 76% - 92%
- Women who arrived with their partner were 7x more likely to receive an HIV test
- Women in male engagement sites had 23% lower hazard of being LTFU at 6 months

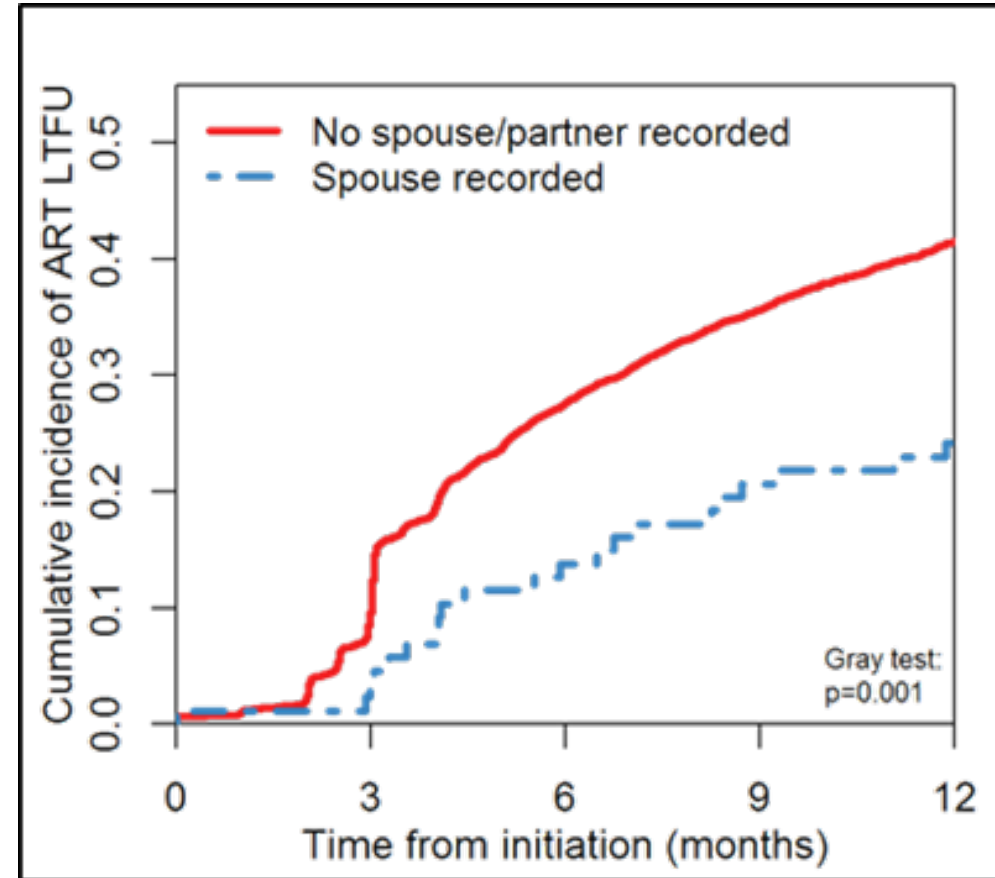
But what about the male partners?

- In 2016, we doubled the number of males tested for HIV through MES program (up to 68,000 in 2016)
- Male partners referred to Adult HIV care
- Males tested in ANC had highest LTFU



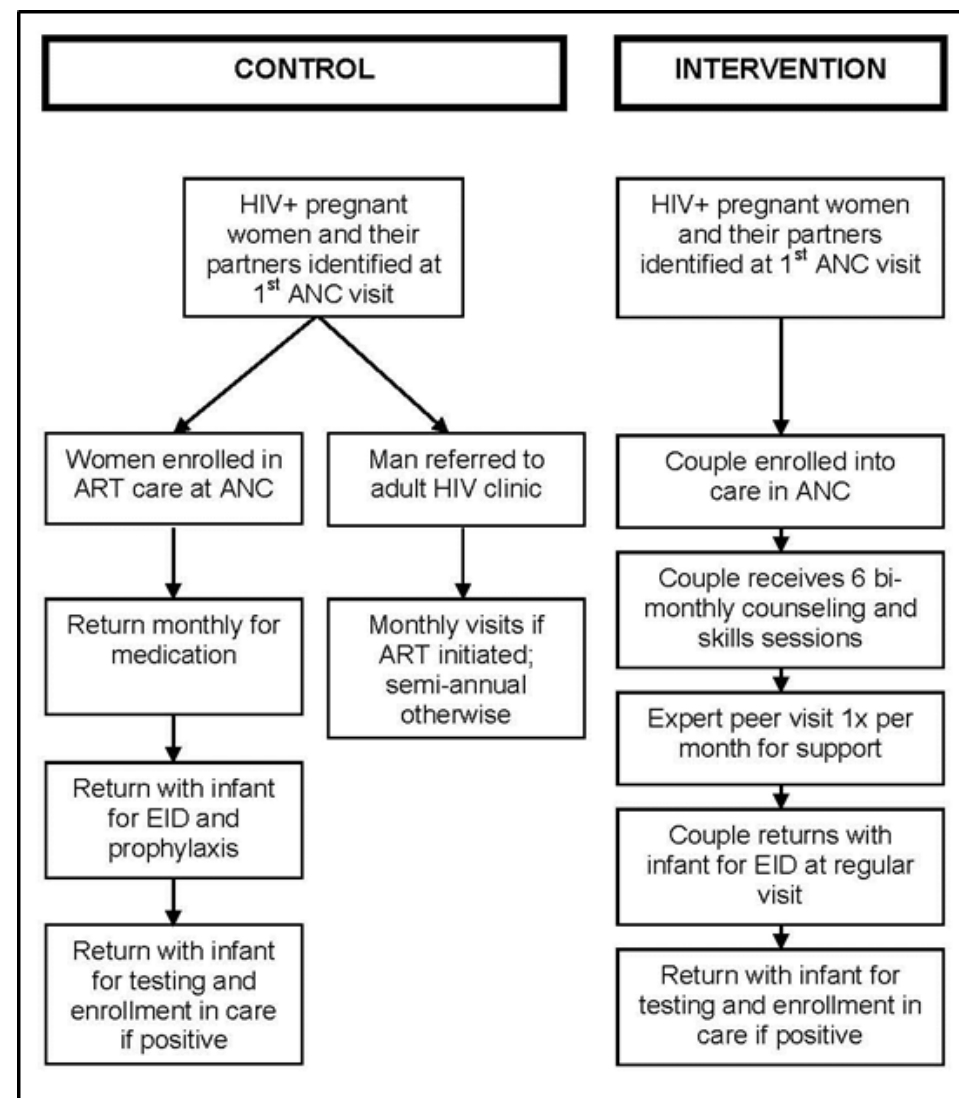
Couples vs. Individual HIV care

- Couples enrolled on ART together demonstrate improved 12-month retention rates.
- Can we use this strategy to improve male partner outcomes?



NIMH R01 (2017): Couples-based Services

- *Hybrid Type 2 trial*
- *Hypothesis:* Expectant couples who enroll in treatment together through ANC & post-natal services will have improved retention in care.
- Focus on maternal and paternal retention, MTCT outcomes, infant retention
- Focus on implementation process and sustainability



Implementation Questions

1. Will a couple-based care and treatment intervention be possible in this extremely resource limited setting? Will patients accept it?
2. Which patients benefit most from a couple-based program? Do all patients benefit from peer and professional counseling?
3. Does the implementation method (couples counselors & peer supporters) show promise in facilitating couple-based care?

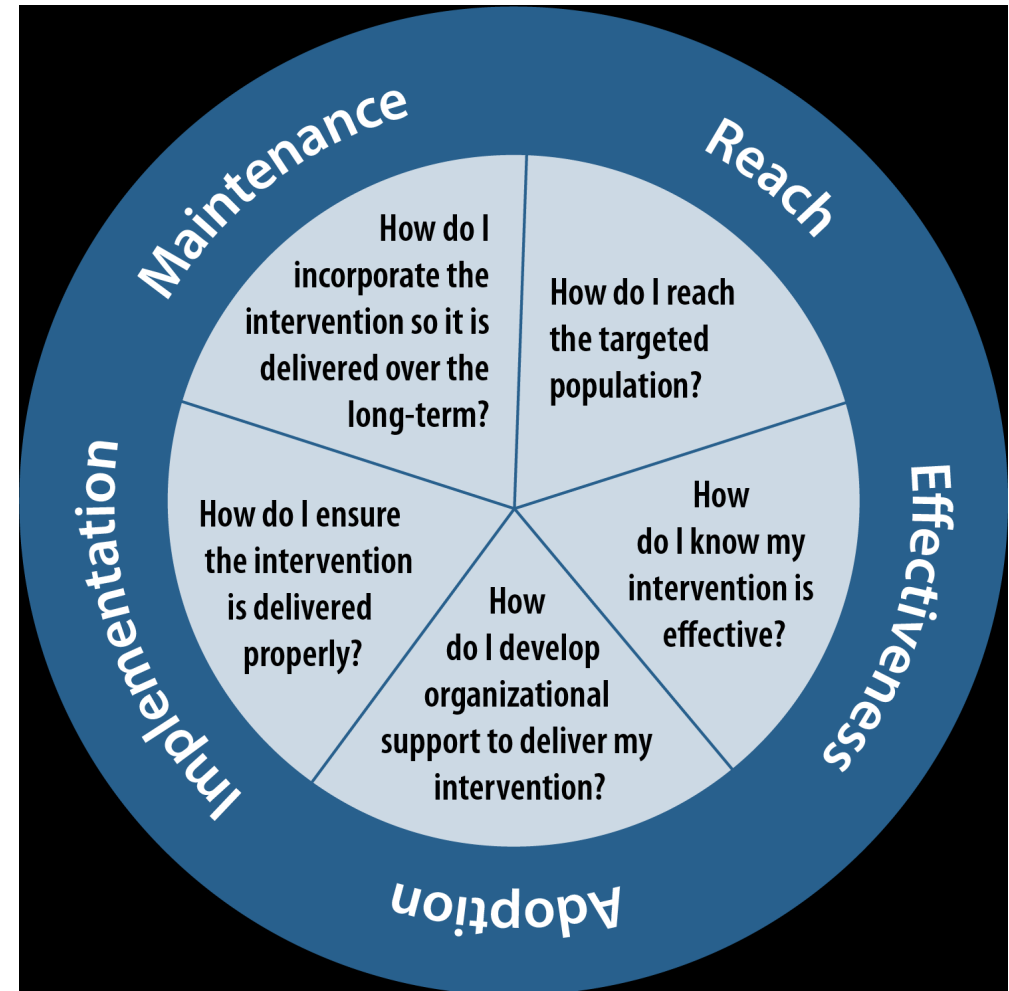
Re-AIM framework for implementation assessment

Qualitative Interviews

- Health Care Providers (clinicians, counselors, peer supporters)
- Participants (including those LTFU)

Quantitative Data

- Recruitment and retention in study
- Clinical outcomes
- Broad health outcomes (depression)
- Costs (to patients, health system)



Reach

Goal: Target newly enrolled patients (or those previously LTFU) to not artificially inflate effect of the intervention. Couples currently enrolled together in adult care who became pregnant are not eligible

Acceptance: Currently acceptance rate is 82% among eligible couples (171 couples enrolled)

Reasons for enrollment: In July we will begin interviews with participants to understand decision making related to study enrollment

Effectiveness

Should this intervention be targeted to specific patients?: Should the intervention be tailored for couples with depression, low levels of social support, high HIV stigma, low couple empathy scores?

How can we improve our professional and peer counseling strategies?: Couple participation in monthly counseling sessions, including reasons why one member did not participate (if applicable); what support was requested/provided.

Adoption-Setting Level

Health facility staff “resistance”: Use of qualitative interviews with study team members to understand clinician/counselor resistance to implementation.

- Identify minimum space issues required to manage patient flow.
- Identify minimum time needed to support couple vs. individual patient

Implementation

Counselor Activities

- Percentage of counseling sessions completed within 30 days across health facilities.
- Percentage of phone calls/home visits made within 3 days of missed visit.
- Concerns with training, preparation, and delivery of counseling sessions... what else do they need to be successful?

Costs

- Cost of intervention

Maintenance

Individual Level:

- Do couples transition to family care 18 months post-partum?

Setting Level:

- If program is still ongoing at >6 months post-funding
- If and how program was adapted long-term (what remains post-funding)

Initial Thoughts

- Ministry of Health buy-in is high, but we have already encountered resistance- mostly due to competing desires for space.
- The intervention has been acceptable to patients (particularly those who are not eligible) but we have some men leaving medication pick-up to their female partners.
- Counselors have felt confident in delivering educational and supportive sessions; finding peer counselors has proven difficult as few people can read and write in rural areas

Special Thanks

NIMH R01

HoPS+ Team

- Erin Graves (Study Manager, VUMC)
- Ezequiel Barreto (Study Manager, Mozambique)
- Caroline Deschacht (Physician, Mozambique)
- Sara Van Rompaey (Physician, Mozambique)
- Bryan Shephard (Biostatistician, VUMC)
- Wu Gong (Biostatistician, VUMC)
- Rivet Amico (Psychologist, U Michigan)
- Matt Diemer (Psychologist, U Michigan)
- Andrea Ciaranello (Cost-effectiveness, Harvard)
- HoPS+ couples counselors (24) and study assistants (5)!

Mentors/DSMB members

- Sten Vermund (mentor, Yale)
- Milton Wainberg (DSMB, Columbia)
- Katherine Fielding (DSMB, LSHTM)
- Keith Horvath (DSMB, U Michigan)
- Peter Rebeiro (DSMB, Vanderbilt)

