Improving Adherence & Retention: Community Adherence and Support Groups in Mozambique

**COUNTRY:** Mozambique  
**IMPLEMENTING PARTNER:** Médecins Sans Frontières

Faced with challenges to patient adherence and retention on antiretroviral therapy (ART), Mozambique implemented a community approach to service delivery. This approach provides patients with easier access to their antiretroviral, in addition to peer support.

**WHAT WAS THE PROBLEM?**

Frequent clinic visits and high volumes of patients in large facilities create challenges for patients, which can reduce long-term antiretroviral therapy (ART) adherence and retention. In Mozambique, patient access to treatment and over-burdened health facilities were major challenges with HIV service delivery. With over 70% of the population living in rural areas, patients had to travel long distances and often had to wait hours to receive services. This placed extra hardship on patients who lost the opportunity to work and paid significant costs to pick up antiretrovirals from the health facility. These challenges also contributed to a loss to follow-up (LTFU).

**WHAT IS THE SOLUTION?**

Community Adherence and Support Groups (CASGs) are groups of stable patients on ART who take turns attending the facility for a clinical assessment and tests, whilst collecting drugs for themselves and the other members of the group. The CASG provides a means of accessing ART for the group members and a source of social support, both of which are intended to reduce LTFU. In addition to reducing LTFU, CASGs can reduce the workload of overburdened healthcare workers by decreasing the number of patients individually attending the clinics while still maintaining good health outcomes for patients on ART. The CASG model also fosters patient self-management and independence.

**WHAT WAS THE IMPACT?**

CASGs were originally piloted by Médecins Sans Frontières (MSF) in 12 health facilities in Tete province, beginning in 2008. A retrospective analysis of 5,729 adults who joined
CASGs between February 2008 and December 2012 in Tete, showed rates of retention on ART of 98% at 12 months, 96% at 24 months, and 93% at 36 months, and 92% at 48 months (Decroo, 2014). This is substantially higher than national retention, which was around 70% at 12 months in 2012 (in sites with electronic patient tracking systems).

A national pilot of CASGs began in 2011. Multiple retrospective evaluations were done to compare retention 2-3 years after the pilot among patients enrolled in CASGs with non-participants, using data from electronic patient tracking systems (EPTS) supported by the Centers for Disease Control and Prevention (CDC)/PEPFAR-funded implementing partners. Of 288 ART facilities in CDC-supported provinces, 170 had EPTS and 68 were implementing CASGs in early 2014. Retention was significantly higher in the 6,760 patients who had participated in CASGs at these sites from 2011-2014 as compared to a matched cohort; with 12-month retention of 91% compared to 83% in non-CASG participants. This was almost entirely due to decreased LTFU among CASG participants (there was no significant difference in mortality) (Jobarteh, 2016). A similar evaluation of the same time period showed a 55% reduction in LTFU among CASG participants compared to non-participants (Auld, 2016). Data from the South African experience with CASGs shows a similar 67% reduction in LTFU among CASG members (Grimsrud, 2016).
Overall, data on effectiveness in rural versus urban settings is limited. There appears to be a greater benefit in rural areas where transportation and access to care are a challenge. However, one study showed that retention was actually higher among CASG participants in peri-urban areas as compared to rural areas, though this study did not compare CASG participants to non-participants in both of these locations to see where the benefit was greater (Decroo, 2014). The investigators believed that this difference was due to higher mortality in rural areas due to lower quality care and not related to any difference in the effectiveness of CASGs.

**HOW DOES IT WORK?**

**INDIVIDUAL LEVEL**

Patients on ART learn about the CASG system through messages in health facility waiting areas, during clinical consultations or through support groups or lay counselors. Health providers assess patients for eligibility. Eligible clients include those who have been on ART for six months, are stable on treatment with no active opportunistic infections (i.e. TB or Kaposi sarcoma), and have an undetectable viral load (<1000 copies/ml) and/or CD4 count >200 cells/mm3. Eligible patients are enrolled in a CASG only if they agree to participate. Every month one member of the CASG goes for a clinical visit to represent the group. Each CASG member visits the clinic at a frequency between 3-6 months, depending on the size of the CASG (from 3-6 members). During the visit, the representing CASG member receives a clinical evaluation and any lab testing necessary; they also pick up the medications for all other members of the CASG, and bring back any relevant counseling messages for the other group members. If at
any time clinical symptoms develop when receiving ARVs through a CASG, the symptomatic patient should go to the ART facility for evaluation. On a monthly basis, members of the CASG gather to provide support to each other, receive medications from the member who visited the health facility, and discuss any additional messages from the clinic. Community lay counselors are sometimes present.

LOCAL ENVIRONMENT

CASGs are patient-driven and the patients themselves serve as their own internal community support group. There is no additional involvement of official community leaders. This is based on feedback provided by patients during the pilot, due to their concerns about confidentiality. CASG members, however, develop a leadership role in their communities as a consequence of their participation.

NATIONAL ENVIRONMENT

The Ministry of Health (MoH) National Strategy on CASGs was developed in 2013 and approved in 2015. The CASG model has also been included in national ART guidelines and is being included in a current document under development summarizing differentiated service delivery in Mozambique.

Tools for monitoring and evaluation that had been developed as part of the national pilot were updated and incorporated into the approved national M&E system. This includes a CASG register and routine reporting indicators related to CASGs. Uptake of CASGs is reported monthly to the MoH.

SCALABILITY

The CASG initiative, which began as a local pilot in 2008, was subsequently piloted nationally in 2011 and then scaled nationally beginning in 2014. High-volume sites were the focus of the initial scale-up and scale-up to additional smaller facilities is on-going. As of September 2017, 717 (61%) of the 1,172 facilities supported by PEPFAR offered CASGs and a total of 97,255 patients were enrolled in CASGs, representing approximately 10% of patients nationally. Demand creation tools were developed in 2016 and approved in early 2017 to improve CASG uptake. These are still in the process of being rolled out.

Mozambique guidelines specify that a patient should be stable on ART for >6 months with a CD4>200 cells/mm3 (or VL<1000) in order to be eligible for CASG; however, evaluations have shown that a significant proportion of those enrolled did not meet eligibility criteria (nearly 20% in the national pilot - Jobarteh, 2016). Overly strict criteria regarding patient adherence may have unnecessarily prevented patients from
enrolling who could benefit from CASGs. Current guidelines specify that patients without 100% adherence can be enrolled, though overall they should make up no more than 30% of the group members. As CASGs reached greater scale, the average number of patients per CASG has fallen from the recommended six to anywhere from two to four, which results in an increased frequency of visits to the facility for each participant.

**MANAGEMENT & OVERSIGHT**

**PEPFAR Team Involvement:** An early evaluation conducted by MSF showed a large impact on retention rates among CASG patients. The PEPFAR team requested MSF to organize a workshop, and supported the participation of the MoH and implementing partners. PEPFAR supported the implementation of CASGs through implementing partners. When the MoH decided to adopt the CASG as a national retention strategy, PEPFAR supported development of national guidelines, M&E tools, and demand creation tools. Implementing partners that receive PEPFAR funds continue to play a role in scale-up and oversight, and are beginning to focus on demand creation and community support components.

**Implementing Partner:** The MoH created a CASG team comprised of MoH and USG staff. The main role was to provide trainings and technical assistance to each site selected for the pilot. During the pilot, the main responsibility of the implementing partners was to provide M&E tools and technical assistance to the health providers.

**Implementing Mechanism Management:** Because the strategy was included in the routine COP planning process, partners were required to modify their retention plans in order to incorporate CASGs. Guidance is being provided to partners to improve their approach to providing community-level support for CASGs and to roll out ministry-developed demand creation tools.

**Monitoring:** M&E tools were created for the initial CASG pilot and were subsequently disseminated during the national scale-up. For monitoring, each site implementing the CASG strategy has a CASG registry. One person from the MoH was assigned per health facility as the CASG focal point. Facilities complete a CASG monthly report, allowing the MoH to evaluate the uptake of the program on a routine basis. Currently, provincial and district leadership, with the support of implementing partners, are responsible for providing supervision and technical assistance.
IM MANAGEMENT:

Communications and Feed-Back Loops: A specific communication system was designed in which all implementing partners were responsible for sending monthly CASG reports to CDC, where data was aggregated and presented to the MoH.

BUDGET

Cost of Innovative Solution: While one of the core objectives of the CASG model is to reduce the cost of providing ART services by improving efficiency at ART clinics, formal costing data is still limited; anecdotal reports from similar models in the Democratic Republic of the Congo suggest that the time saved on paperwork completion was not substantial. The model in Mozambique does require additional staffing costs as many of the CASGs are supported by lay counselors. Funding is also used to support training for CASG implementation, supportive supervision and M&E, community support, and demand creation.
CITATIONS


