Adapting a Positive Prevention intervention for use in Mozambique

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Background

- HIV prevention efforts have expanded to address people living with HIV/AIDS (PLWHA)

- Prevention with Positives (PwP), Positive Prevention (PP), or Positive Health, Dignity, and Prevention, aim to address HIV prevention needs and ultimately decrease HIV transmissions.
The HIV epidemic in Mozambique

- 1,500,000 people infected with HIV
- Of the infected population, 60% are adult women
- Of new infections, 43% are 15-24 years with highest infection rate (16%) among girls between 15-19 yrs.

(WHO 2008; WHO 2005; UNAIDS, 2008; International HIV/AIDS Alliance in Mozambique)
Lessons from the US literature

- Numerous intervention options and models - difficult to decide which model best fits needs of PLWHA

- Meta-analysis of U.S.-based studies found most efficacious interventions for reducing HIV-risk behaviors had certain characteristics.

(Crepaz et al., 2006)
Local issues to note

- High rates of poverty and unemployment – transactional sex
- Gender disparities
- Migration for work
- Rural populations with limited access to healthcare services
- Low levels of condom use and/or family planning
- Sero-status assumptions
- Risks of MTCT
- Stigma
Adaptation process

- At request from Mozambique MOH and CDC, UCSF began project to adapt and implement an evidence-based PP program in Mozambique.
- Started at 2 rural pilot sites
  - MOH facility, supported by international NGO
  - NGO supported VCT site
- Site-specific objectives defined
- In depth interviews with HIV-infected women and HIV care providers to identify key issues
- Observational site visits
Adaptation process continued

- Bottom-Up approach: PLWHA and Service Providers involved in intervention design and selection – chose interventions most needed and feasible at their sites
- Joint work plan developed
- Interventions designed, adapted, implemented
Assessment Results: Provider concerns

- **Skills** - Assess transmission risk & deliver prevention messages that support behavioral change, discuss strategies for prevention in sexual relationships, develop individualized prevention plans

- **Messaging** - Consistent / systematic prevention counseling across services with various health cadres working at different service points, messages repeated / re-enforced at various points of contact with clients

- **Stigma** - Not comfortable discussing stigma, help clients disclose HIV status to partners and family members

- **Access to care** - family planning, issues of time with clients
Assessment Results: Client concerns

- **Reducing transmission** - Do not want to infect others, help managing HIV risk behaviors, desire to increase understanding of risk transmission, learn risk-reduction techniques, safer sex negotiation skills

- **Stigma** - Counseling / support to address stigma of HIV infection, support for disclosure to partners / family members, need for community based support, negative experience with providers

- **Access to care / services** - Family planning, SRH services, safe infant feeding options
Pilot Activities

- In 2006, UCSF, in partnership with CDC Mozambique, adapted and piloted a PP training that targeted health care workers in Mozambique and focused on specific HIV prevention needs in country.

- The intervention: a three-day PP training adapted from the US-based HIV Intervention for Providers curriculum (HIP) that emphasized a harm reduction framework within a full-site approach that was provider-based, facility-focused.

- Piloted with provincial level healthcare workers and counselors as well as senior trainers from USG clinical partner organizations at two sites in Maputo province.

(Dawson Rose, Colfax, IAC 2008)
Pilot Activities - continued

- Goal of the training: Build knowledge and comfort among health care providers so they are able to assess patient HIV transmission risk behavior and prevention needs and work with patients to develop individual strategies to address their transmission risk behaviors.

- Content adapted to represent the context of risk and HIV care in Mozambique
Lessons Learned

- **Harm reduction framework well received** - Training participants were able to employ this method when counseling clients.

- **Relevance to participants**
  - Strong willingness and desire to learn about HIV prevention
  - Focus on pressing topics

- **Providers ready to engage on these topics & highlighted their importance in daily interactions with patients**
Challenges

- Treatment literacy was poor among providers
- Cultural practices to consider – polygamy
- Language – official language vs. local tribal languages
- Civil society not well developed because of war, colonization
Conclusions

- When adapting US based interventions - need to consider the specific needs and desires of PLWHA and their care providers before exporting messages globally.
- Interventions should always be culturally specific and sensitive. By using a collaborative approach, process of adapting interventions and obtaining local input promotes stakeholder buy-in for finished product.
- Although not all challenges are surmountable, important to think creatively and try to address local concerns, issues, gaps.
Future Directions

- Expanding quality, comprehensive, evidence-based prevention services for PLWHA which are integrated across HIV disciplines in clinic and community based settings
- Integrating prevention with PLWHA into various clinical settings
- Increasing access to key populations in need of targeted prevention with PLWHA services
- Increasing collaboration with international stakeholders and across USG partners on the design and dissemination of technical and program principles of prevention with PLWHA services

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QUESTIONS ???
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