

**Title: Mobile Clinics for Scale-up of HIV Care and Treatment in Rural Mozambique**

**Track and Category:** Track E- Scale-up and Sustainability of HIV Prevention, Care and Treatment Programmes

**Authors:** Ouenzar MA, Mbalane E, Mehta N, Nyirabahizi E

**Affiliation:** Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Mozambique

**Background:** Mozambique has one of the world's highest rates of HIV, with a prevalence of 11.5%. Human resource and infrastructure shortages limit access to care for Mozambique's rural poor. The National HIV/AIDS Response Acceleration Plan, launched in 2013, promotes massive scale-up of antiretroviral therapy (ART) over 3 years. Consequently, EGPAF initiated the mobile health clinic (MHC) program in Gaza, the province with the greatest HIV burden. This evaluation seeks to look at the contribution and effectiveness of MHC in reaching programmatic goals.

**Description:** In 2013, EGPAF-supported MHCs began operating in three southern districts. Each MHC, comprised of one clinician, one nurse, two counselors, and one driver from the Ministry of Health, visits seven catchment areas every two weeks. MHCs provide comprehensive services, most notably prevention of mother-to-child transmission (PMTCT) and care and treatment (C&T), as well as access to drugs and CD4-count machines, which were not previously available at peripheral health centers (PHCs). These teams also provide technical assistance and mentoring to PHC staff members. Since 2013, the program has expanded to three more districts and 40 new sites.

**Lessons Learned:** Using 2013-2014 annual program results, EGPAF compared the proportion of services provided by mobile clinics to overall achievement. Each period shows wider geographic coverage, significant contribution of MHCs in reaching new populations, and improved quality indicators. MHCs also access areas where little information was previously available; and the bimonthly visits have created a strong supply chain for drugs. The multidisciplinary MHC training of PHCs has resulted in improved quality of services as well as the ability to perform independently as needed.

**Conclusions:** MHCs efficiently allow for rapid HIV C&T expansion to remote populations and improved on-site capacity of PHCs, even with significant geographic and economic barriers. Next steps include continued evaluation and identification of sites ready to transition to fixed sites.

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Table 1. MHC Contribution in 3 Southern Districts of Gaza, 2013-2014

Indicators	2013 Observed (Fixed, MHCs)	2013 MHC Contribution (Point Estimate, 95% CI)	2014 Observed (Fixed, MHCs)	2014 MHC Contribution (Point Estimate, 95% CI)	Significant Increase in MHC Contribution from 2013-2104 (p-value)
HIV-positive adults and children receiving a minimum of one clinical service	30,291 3,311	9.9*** [9.5,10.2]	32,761 7,644	18.9*** [18.5,19.3]	<.0001
Number of HIV-positive cotrimoxazole(CTX) eligible persons receiving CTX prophylaxis	12,552 1,326	9.6*** [9.1,10.1]	12,569 3,968	24.0*** [23.4,24.7]	<.0001
Number of new HIV clinical care patients enrolled during the reporting period	11,742 3,096	20.9*** [20.2,21.5]	9,670 5,098	34.5*** [33.8,35.3]	<.0001
Number of HIV clinical care patients enrolled during the reporting period with CD4 count recorded within 1 month of being enrolled in care	6,444 2,230	25.7*** [24.8,26.6]	5,988 3,659	37.9*** {37,38.9}	<.0001
Number of adults and children with advanced HIV infection newly enrolled on ART	6,886 1,202	14.9*** [14.1,15.7]	6,971 3,351	32.5*** [31.6,33.4]	<.0001
HIV-positive adults and children currently receiving ART	16,121 1,370	7.8*** [7.4,8.2]	20,666 5,065	19.7*** [19.2,20.2]	<.0001
Number of ART patients who have ever defaulted (LTFU)	5,735 17	0.3*** [0.2,0.5]	9,296 632	6.4*** [5.9,6.9]	<.0001

\*\*\* p<.0001, \*\* p<.001, \* p<.01