Background

MSF supports HIV care and treatment programs in:
- Kenya: Homabay District Hospital (rural setting, some mobility among the population for fishing);
- Malawi: Chiradzulu district hospital and 10 health facilities (rural setting, some mobility for work in Blantyre);
- Mozambique: Maputo at a referral center for complex cases and second-line ART (urban setting, mobile population).

The number of patients requiring second- and third-line antiretroviral therapy (ART) regimens is increasing in these programs.

Understanding of the elements on which to base adherence interventions for these treatment-experienced patients is limited.

A cross-sectional study on virological failure and drug resistance was conducted in Nov 2014-Dec 2015 among patients ≥ 5 years receiving second-line ART since ≥ 6 months in the 3 programs. A qualitative component explored issues influencing adherence.

Aim: As part of this study we investigated patients' understanding of the relationship between treatment failure, viral load and adherence among those on 2nd and 3rd line ART regimens in MSF programmes in Kenya, Mozambique and Malawi.

Results (quantitative)

N=700 adult participants interviewed: Kenya 299 (51% female); Malawi 212 (59% female); Mozambique 198 (58% female).

- ART knowledge: was good in all sites, notably high in Malawi.
- VL knowledge: Can you explain what a VL test is for? (non-probed)
  - Don’t know: 19% (Kenya), 15% (Malawi), 32% (Mozambique)
  - VL test checks if VL is undetectable/measures VL: 67% (Kenya), 73% (Malawi), 55% (Mozambique)
  - VL test checks if the ARTV treatment still works: 21% (Kenya), 66% (Malawi), 5% (Mozambique)
  - VL test checks if I am taking the ARTV treatment: 4% (Kenya), 38% (Malawi), 1.6% (Mozambique).

- Mostly no association found between virological failure (VL > 1000 copies/ml) and knowledge about ART or VL testing (table 1).
- Overall, knowledge of ART and VL was lower in the Mozambique site.

Results (qualitative)

- Accurate knowledge of ART and its relationship to VL can help motivate some patients to adhere to ART.
- However, good understanding of ART and VL results are not sufficient for good adherence. Other individual-level and context-specific factors (e.g. stigma, poverty, mobility) and health systems issues undermined regular pill-taking and varied between sites.
- Adherence intentions improved for some patients after switching regimens but “relapse” remained a risk if previous barriers to adherence were not continuously addressed.

Table 1: Patient knowledge of ART and VL testing by virological outcome and site

<table>
<thead>
<tr>
<th>Site</th>
<th>Total Respondents</th>
<th>Knowledge of ART (%)</th>
<th>Knowledge of VL (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>45</td>
<td>79%</td>
<td>64%</td>
</tr>
<tr>
<td>Malawi</td>
<td>53</td>
<td>77%</td>
<td>60%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>32</td>
<td>65%</td>
<td>55%</td>
</tr>
</tbody>
</table>

- “I got shocked when I was joining third line, I was told the amount of my CD4 and my viral load, so it is in my mind that I have to adhere to them (ART) well the way I am told, and I break...that’s where my life ends.” [Man, 3rd line ART, Kenya]
- “Sometimes they miss their appointments...because of the finances, they can not be able to reach the hospital, at times they come late because of the terrain. At the time the reception (at the hospital) is not welcoming them. They are seen as people who are rejects...Yah so those are some of the reports that clients give. And at times they lament the long queues.” [Health worker, Kenya]
- “I sometimes have appetite of eating fruits, many other things. Nonetheless I can't afford them...the same difficulties I used to go through when I was on the first line. Regarding difficulties, nothing has changed. Just to have something to eat is a big problem.” [Man 2nd line ART Mozambique]
- “If one uses condoms the virus would die because I hear the virus' food are the sperms so it is like we are feeding...so smoking, condomising, stress, good nutrition, how you work; how you work affects how the medicine works. Don't work a lot...Where did you hear that HIV virus eats sperm? At the hospital, from counselors.” [Man, 3rd line ART, Malawi]
- “Only one of the twins survived...I had a lot of thoughts. I stopped taking drugs for 2 years. [name of counselor] kept on teaching us...I joined the support group and you could hear people had challenges more than what you are going through, I listened to them then gathered courage and started taking drugs.” [Woman, 2nd line ART, Kenya]

- Counseling was a source of both correct and incorrect knowledge about ART and VL among patients in this study.
- Moralistic messages from staff in all sites meant some patients believed that detectable VL and treatment failure were due to unprotected sex, drinking alcohol, smoking, or using traditional medicine. These patients did not explicitly link their VL results to their pill-taking, which could undermine their adherence.
- Good quality individual or group counselling was important for helping patients to understand ART and VL results, as well as giving them the morale to maintain pill-taking.

Conclusion

- Despite overall good knowledge of ART, many second-line patients had limited understanding of viral load and its relationship to adherence and treatment failure.
- Health workers need better training on explaining the relationship between viral load, adherence and treatment failure to patients. Better explanations of these relationships can support adherence for some patients.
- Counselling messages need to be i) patient-centered, ii) convey correct information, and iii) focus on problem-solving and identify strategies to address persistent adherence barriers, rather than blaming patients’ social and sexual behaviors for treatment failure.
- Site differences in treatment literacy and virological failure can be explained by social, contextual and programmatic differences.
- Study limitations include potential site-specific differences in administration of the survey questionnaires and social desirability bias in patients’ responses, although efforts were taken to reduce this through fieldworker training and for the qualitative component, use of repeated interviews to build rapport with participants.

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Figure 1: study sites

Knowledge of viral load and treatment failure amongst patients on second-line and third-line antiretroviral therapy regimens

A mixed methods study in Malawi, Kenya and Mozambique

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