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MÉDICOS SEM FRONTEIRAS

MSF IN MOZAMBIQUE 2001-2010 :
Ten years of HIV projects

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Introduction

In the late 1990s, the introduction of antiretroviral (ARV) treatment transformed AIDS from a death sentence to a chronic lifelong disease. However, the extremely high cost of ARV drugs meant that treatment was restricted to people in richer parts of the world, and the millions of people suffering from the disease in places like Africa remained untreated. National and international decision makers actively refrained from embarking on the fight against HIV/AIDS, believing that an insufficient budget and a scarcity of both technical means and human resources would lead to inadequate HIV care and management. Their fear was that this would ultimately lead to the emergence of widespread drug-resistant strains of the virus, which would exacerbate an already dire situation.

Médecins Sans Frontières (MSF) – determined that the plight of people with HIV/AIDS in African countries would not be ignored – has been working with HIV in Mozambique since 2001, where it has been helping the Ministry of Health develop a comprehensive plan for widespread provision of ARV treatment. During the first few years, around half of all patients on treatment were supported by MSF. MSF's objectives were to demonstrate that it was feasible to provide ARV services in low-resource settings, to explore possible modes of operation and to help create a national capacity for treating people with HIV/AIDS. At the time, the organisation of the Mozambican health system needed to be adapted to allow the development of comprehensive ARV treatment programmes, in terms of human resources (both numbers and skills), laboratory capacity, technical means, and the overall management of HIV/AIDS. MSF has spent a total of 58 million Euros on its HIV/AIDS activities in Mozambique since 2001, of which the majority comes from private funding.

The number of patients on treatment has risen dramatically over the last few years. At the end of August 2010, more than 200,000 patients were on ARV treatment in Mozambique[1], of whom more than 33,000 were being treated with the assistance of MSF. The growing number of patients on treatment shows that the scale-up and provision of ARV treatment is indeed possible in a country like Mozambique. MSF has helped to put HIV/AIDS firmly on the national health agenda and, along with the Ministry of Health, has developed innovative strategies for HIV care and management. This report details MSF's work and achievements in Mozambique in the field of HIV/AIDS over the last ten years, as well as pointing to the challenges that lie ahead.

1 http ://www.misau.gov.mz/pt/hiv_sida/programa_de_tratamento_antiretroviral_tarv/dados_tarv_nacionais.

Five sites, three contexts

MSF made the decision to invest in a number of projects based in different locations, in order to be able to explore innovative solutions adapted to specific contexts and population groups.

The sites where MSF has been active can be classified into three main categories:

Urban context

MSF started its HIV/AIDS activities in the Chamanculo and Mavalane districts of Maputo in late 2001. The Maputo metropolitan area is one of the most prevalent areas of HIV/AIDS in the world, partly due to its large migrant population, which includes miners, commercial sex workers and economic refugees. MSF is currently supporting five health centres in the Chamanculo district and four health centres in the Mavalane district.

Semi-urban context

MSF has been working in the city of Tete and its surrounding districts since 2001 Tete is enjoying an economic boom, driven by the discovery of reserves of natural resources in the region, which have attracted large numbers of migrants. The influx of people has created a breeding ground for the burgeoning HIV/AIDS epidemic. In 2007, ARV treatment was decentralised from hospitals to health centres, and MSF's project was extended to two more districts. Project activities were subsequently reoriented towards training, supervision and running mobile teams. As of 2011, the project will focus on the implementation and monitoring of a number of community-based patient groups which are aimed at empowering patients to partly manage the disease by themselves.

Rural context

MSF works in rural Angonia (in central Mozambique) and Lichinga (in the north of the country). Rural areas characteristically have a lower HIV prevalence than urban areas, but have more severe shortages of health staff. This shortage contributes to the very limited access to health & HIV/AIDS services for people living in rural contexts.

How MSF's HIV activities have evolved

Over the years, MSF's activities in Mozambique have evolved and changed. This evolution can be characterised in five main steps, from an initial period when ART implementation in low-income countries was widely considered unfeasible, to the current situation where the Ministry of Health is developing the capacity to take over a complete set of HIV/AIDS interventions with partner support.

Initiation (2001-2002)

This was the period when treatment first became available for HIV/AIDS patients in Mozambique. Curative care mainly involved treating and preventing opportunistic infections, and treating sexually transmitted infections. HIV/AIDS programmes at this time were reinforced by the development of Voluntary Counselling and Testing (VCT) centres, which have played an important role in persuading individuals to take HIV tests and in reducing the stigma associated with the disease. The VCT centres were supplemented by information, education and communication services. Prevention of mother-to-child transmission (PMTCT) was also being piloted. This era provided MSF with the leverage to lobby for the adaptation and scaling up of ART programmes in Mozambique.

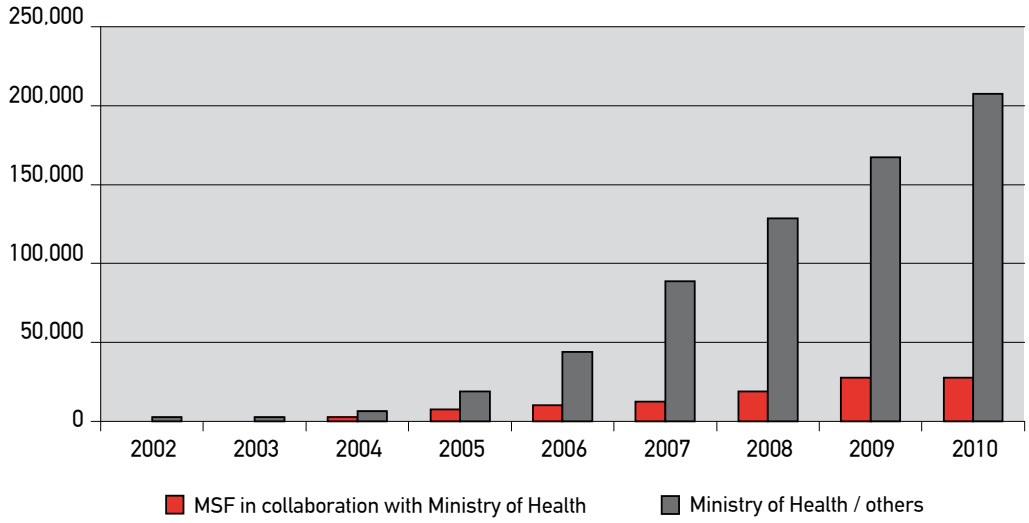
Curative care and implementation of ARV treatment (2002-2005)

MSF started providing free ARV treatment in Mozambique in 2002. The treatment programmes were developed in line with the Ministry of Health protocol, and also drew on MSF's experience in other African settings. The programmes established a standard package for HIV care and treatment, with special attention paid to tuberculosis (TB) co-infections. The programmes were complemented by measures to tackle issues such as shortages of health staff and drug procurement issues, as well as improving laboratory capacity. Psychosocial activities were also extended, with lay counsellors providing support to VCT activities and helping patients adhere to their treatment. During this period, the price of HIV drugs plunged dramatically from US$10,000 per patient per year to just US$100 per patient per year, enabling many more people to start receiving treatment.

Scale-up and decentralisation (2005-2008)

As patient numbers increased, hospitals became overwhelmed and waiting lists were introduced. This created an obstacle to guaranteeing good quality treatment. It also became harder to start people on treatment, especially in peripheral areas where there were no hospitals close by. As the number of patients grew, moving HIV care and treatment from hospitals to primary health clinics became a necessity. As a result, the Ministry of Health launched an ambitious plan in 2006 to expand the national capacity to provide ARV treatment, and to decentralise patient cohorts from hospital to health centre level. Between 2005 and 2008, the number of treatment sites for HIV/AIDS rose from 20 to 220.

Number of Patients on ART 2002 - 2010



Quality consolidation (2007-2009)

A variety of activities were conducted to improve the quality of services provided to people living with HIV/AIDS. MSF was progressively moving away from direct, hands-on treatment, towards adopting a role which included technical support, human resource strengthening and the integration of activities with the Ministry of Health's workforce and guidelines. This resulted in initiatives that included training medical personnel to handle difficult cases and deal with side effects, and developing innovative models of care, such as Community ARV Treatment Groups, whereby patients were enabled to help manage their own treatment of the disease.

Phase-out preparation and reorientation of HIV/AIDS activities (2009 onwards)

MSF's project support in Tete, Angonia and Lichinga will be handed over to the Ministry of Health in 2010 and 2011. However, MSF will still be involved in the Tete province, implementing and monitoring community ARV treatment groups. MSF's medical activities in Chamanculo and Mavalane will carry on, and MSF will continue to work with the Mozambican health system to address the challenges that lie ahead. Particular focus areas include improving PMTCT services, integrating TB and HIV services, creating one-stop services for pregnant women, and implementing new WHO protocols.

ISABEL MARIA FRANCISCO, 43

*"My name is Isabel Maria Francisco and I am 43 years old and HIV-positive. For two years I have been working with MSF as a counselor to prevent **Mother-to-Child Transmission** of **HIV in Maputo city**. In the past, I suffered a lot from discrimination in my community but now things are changing. People have started to understand that HIV/AIDS can be treated."*

Addressing the HIV problem : progress and innovation

HIV prevalence among the adult population in Mozambique is estimated at 11.5 percent in a recent Ministry of Health study[2]. Although there is currently no cure for HIV/AIDS, adherence to ARV treatment helps slow progression of the disease to a near halt, enabling people to live longer, healthier lives. MSF's comprehensive HIV/AIDS programmes offer : HIV testing, with pre and post-test counselling ; the treatment and prevention of opportunistic infections ; paediatric diagnosis and treatment ; the prevention of mother-to-child transmission ; and the provision of ARV treatment for people in the advanced clinical stages of the disease. At the end of August 2010, more than 33,000 people in Mozambique were being treated for HIV/AIDS with MSF's assistance.

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SUPPORT TO HIV-POSITIVE CHILDREN AND MOTHERS

HIV prevention of mother-to-child transmission (PMTCT)

The vast majority of children with HIV have been infected by their mothers, either in the womb or in the course of childbirth or breastfeeding. Working to prevent this transmission from mother to child is crucial, yet access to PMTCT treatment remains extremely limited nationwide, especially in rural areas, where traditional home-based deliveries remain the norm. MSF is involved in helping Ministry of Health staff improve the quality of PMTCT treatment, and has put in place a strategy to improve treatment adherence among HIV-positive pregnant women. A one-stop service has simplified procedures for women who come for consultations.

Treatment

Treating babies who are born with HIV as early as possible is known to have a significant impact on reducing mortality. An increasing number of babies and children receive ARV treatment in Mozambique. Between 2003 and 2009, the number of children receiving ARV treatment increased from 300 to 13,510 (representing an increase of 0.3 percent to 19 percent of all children in need of treatment)[3]. Yet 47,000 out of an estimated 147,700 HIV-infected children[4] were still without ARV treatment in 2009.

Counselling for children

Children treated by MSF receive counselling sessions in which their HIV-positive status is explained and discussed in a sensitive manner. HIV infection and its consequences are also explored through fairytales and drama sessions based on local folklore and African an-

2 INSIDA, 2009 Relatório Preliminar sobre a Prevalência da Infecção por HIV, July 2010. NOTE : Prior to this study, official sources estimated the HIV prevalence to be at 16%.

3 UNGASS – The United Nations General Assembly Special Session dedicated to HIV/AIDS. Progress report, 2010. Mozambique.

4 Impacto Demográfico do HIV/SIDA em Moçambique. September 2008.

imals. MSF-supported health facilities have been made more child-friendly with the introduction of educational tools, colourful wall paintings and playgrounds. The improved quality of care for children has facilitated the scaling up of treatment for this age-group.

MANAGEMENT OF CO-INFECTIONS

The weakened immune systems of HIV-positive people make them prone to 'opportunistic' infections such as TB, which remains the leading cause of death among people with HIV. MSF is supporting the Ministry of Health in TB activities in five projects throughout the country, by enhancing laboratory capacity, providing training and technical support to health staff, and introducing measures to reduce the risk of infection in health facilities. MSF is also working to raise awareness of HIV/TB co-infection, providing counselling sessions to discuss the transmission and symptoms of HIV/TB and running patient support groups.

In Angonia, MSF has developed a model whereby designated community members are responsible for checking that HIV patients are taking their TB medication regularly and in the correct way. These community members, also known as 'DOTS volunteers', play a support role for TB-infected HIV patients; they are responsible for identifying and referring people with suspected TB-infection to the health centre, and also trace defaulting patients. The introduction of the DOTS volunteers means that the patients do not need to visit the health centres as often, therefore reducing the burden on the health services and the financial and economic cost to the patients.

PATIENT EMPOWERMENT AND A REDUCED BURDEN ON THE HEALTH SYSTEM

MSF is increasingly working on developing models of care whereby patients are empowered to manage the disease in part by themselves.

In MSF's project in Tete, patients are divided into groups of about six, all of whom live near each other. Each month, the group chooses one person to go to the health centre and collect the ARV refills for the rest of the group. The representative usually takes the opportunity to have a medical check-up while they are there. On their return, the representative distributes the ARV drugs to other group-members, who confirm that they have received the medication by signing a document. The representative also checks that all the members of the group have been adhering to treatment, so that this information can be relayed to the health centre. This model of care has a number of distinct advantages. It has led to a reduced burden on healthcare services, as fewer patients need to queue up at the health centre to get their medication. It has the potential to facilitate the scaling-up of ARV treatment. It also makes it simpler for patients in remote areas to obtain their ARV refills, as they only have to pay for transport for the designated group leader, and do not need to sacrifice a day's work each month to travel to the health centre. Finally it enables group members to support each other in overcoming problems related to the stigma associated with HIV/AIDS. The model has been accepted as national policy by the Ministry of Health who is planning to introduce it nationwide.

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Margarida Smith was diagnosed with HIV in 2006 and is the leader of two patient groups.

'I live in a village outside the city of Tete. Other people know that I'm HIV-positive, but I'm not worried or ashamed of my disease. MSF encouraged me to help others with HIV. I am now the leader of one of MSF's HIV patient groups. My role is to collect medication at the health centre and distribute it to the others in the group. Before, each member used to pay 100 meticais to travel to the health centre and back. Now, each member pays me seven meticais, and I bring the medication to their house. The patients in the group appreciate this, because many don't have enough money to travel to the health centre. It's great to be able to help others to take care of their illness. I'm taking medication, but I am healthy and working like other people. I want other HIV-positive people to join me and enjoy life.'

EXPERT PATIENTS

A number of patients who have demonstrated good adherence to their treatment and a commitment to helping other HIV-positive people have been encouraged by MSF to assist in the areas of health promotion and prevention, tracing defaulting patients, providing adherence support, and leading support groups and therapeutic educational sessions. These expert patients' have played an important role in breaking down taboos and showing that it is possible to live a normal life as an HIV-positive person. They have contributed to reducing the stigma that surrounded the disease during the early years of HIV treatment.

PSYCHOLOGICAL SUPPORT

Patients who are anxious or depressed often find it hard to adapt and adhere to their treatment. To help tackle the adverse effects of negative emotions, MSF offers psychological support to patients. Those suffering from depression and anxiety are seen by a psychologist and offered psychotherapy. Patient support groups, where patients can share emotions and experiences with their peers, also provide an additional means of support.

STRENGTHENING HEALTH INFORMATION SYSTEMS

MSF has developed the FUCHIA system, a database tool which enables analysis of the HIV cohort. MSF has also developed an adherence card system, containing the personal data of each patient, as a means of improving the routine monitoring and tracing of patients, and of identifying problem areas that may lead to patients delaying or dropping out of treatment.

REINFORCING DRUG SUPPLY

MSF has supported improvements in the drug supply chain, mainly through construction and building upgrades, but also by providing staff with training on stock management and drug consumption. In instances when there have been drug shortages in the national system, MSF has provided support in the purchase of drugs and medical material.

TACKLING HUMAN RESOURCES SHORTAGES

In order to address shortages of staff, MSF has developed a system of task shifting, whereby non-clinical tasks are re-allocated from doctors to nurses, and from nurses to lay workers. This allows doctors to focus on providing hospital care for inpatients and the most complicated cases, while supervising clinics via mobile teams, and handing over some of the clinical management of patients to nurses. Nurses no longer exclusively support doctors, but are able to independently assess patients, diagnose and treat opportunistic infections, and initiate and monitor ARV treatment. Lay workers are able to provide testing and counselling, to provide treatment adherence support, and to assist with general clinical support.

MSF has also developed a number of other innovative approaches, in partnership with the Ministry of Health, for attracting and retaining health workers. These include:

- "Retired but not tired": This scheme aims to reintegrate retired nurses and clinicians into the health service on health facility contracts funded by MSF.
- Reducing attrition on health staff: HIV is a growing cause of falling numbers among health staff. As a result, MSF provides ARV treatment for all its health workers who are infected with HIV/AIDS.
- Bridging contracts for newly graduated staff: Newly graduated and appointed staff members often have to wait up to 18 months before receiving their first salary. Bridging contracts, in the form of a cash advance by MSF, mean that new staff are not forced to quit their jobs through financial hardship.
- Expatriate staff: MSF helps to plug the human resources gap by employing expatriate staff for specific periods of time in specific locations. In 2008, international medical doctors represented more than 26 percent of all medical doctors working in Mozambique[5].

CONTRIBUTING TO DEVELOPMENT OF NATIONAL POLICY

MSF and the Ministry of Health has been working together on developing planning and policy in the field of HIV/AIDS and on the development of innovative approaches. Through these collaborations, MSF has contributed to the larger national policy development process, as in the development of clinical protocols and drug regimen guidelines.

MSF has taken an active part in technical working groups, sharing and discussing key lessons learnt with other stakeholders. MSF helped to found – and is currently on the board of – NAIMA+, which is a network of non-governmental organisations working on health and HIV/AIDS in Mozambique, and which acts as a link between NGO work and government decisions.

5 Mozambican Ministry of Health, Human Resources report, December 2008

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Remaining challenges for Mozambique

In addition to bringing HIV/AIDS onto the national political scene, MSF has played a significant part in exploring innovative ways to provide comprehensive HIV/AIDS care services in resource-limited settings. In most cases, national authorities and other stakeholders acknowledge the positive impact of these strategies.

However, MSF's model of care is not a prescriptive cure for all problems, and there are some significant remaining challenges to be addressed on a national level. More than 350,000 people in Mozambique are in need of ARV treatment but do not have access to it[6], which equates to two-thirds of all HIV-positive Mozambicans not receiving the treatment they need.

Below are some specific problem areas that need to be addressed in the future.

FUNDING

MSF has recently started to observe a worrying turnaround among the international donor community. After years of political willingness and financial commitment to combat HIV/AIDS, donors are now either flatlining, reducing or withdrawing their funding for HIV, thus abandoning those who are still in dire need of lifesaving treatment. Donors have increasingly voiced concerns regarding the cost, sustainability and relative priority of HIV/AIDS, against the background of an ostensible lack of funds.

This donor retreat will not make the numbers of people in need of lifesaving treatment simply disappear. Instead they are likely to increase, with a resulting impact on families, communities and the healthcare system as a whole. If funding is not forthcoming, it will also be impossible to implement the new, improved WHO guidelines, which recommend improved drug regimens and earlier initiation of treatment.

The global economic crisis, which began in 2008, is expected to result in a decrease in support to Mozambique's general health budget from US$85 million in 2010 to US$70 million in 2012, which is certain to have an impact on HIV care and treatment. Although countries like Italy and Canada will increase their funding for the health sector in Mozambique, France and Finland, for example, plan to discontinue their support in 2011. The Global Fund, the largest international contributor to the fight against HIV/AIDS, is also facing a funding shortfall, which will make it a lot harder to drum up support for the scale-up of HIV treatment.[7] As of 2010, the US will decrease direct support for ARV treatment by 15 percent[8].

6 Relatório de Progresso de Actividades de Combate ao HIV e SIDA – I° Semestre de 2010, June 2010 and WHO website, www.who.int

7 Mozambique's Mid Term Expenditure Framework (MTEF) for 2009-2011 for the health sector, all funding included.

8 2009-2014 PEPFAR II Partnership Framework, August 2010

BARRIERS TO ACCESSING TREATMENT

HIV-infected people continue to face major barriers in their access to services, even in a context of free treatment. Although figures from December 2009 show that every district in the country now has at least one site where patients can access ARV treatment, many patients still face long and expensive journeys to their nearest health facility.

The proportion of patients defaulting from treatment needs to be reduced. The main reasons for abandoning treatment include clinical staff lacking the time to provide effective counselling, the cost of making monthly trips to distant clinics, and lengthy waiting times for clinical consultations and obtaining drugs at the pharmacy.

HUMAN RESOURCES GAP

Efforts to increase patients' access to treatment and maintain and improve the quality of care are coming up against a wall due to the severe shortage of health workers. With only 3 doctors and 143 nurses per 100,000 people, Mozambique has one of the lowest workforce per population ratios in the world[9].

Understaffed facilities are overwhelmed by patient numbers, health workers are put under pressure, and patients end up waiting in long queues. Low staff salaries lead to poor motivation, short working hours, and frequent absenteeism amongst staff. The main cause of health worker attrition is death, with a significant proportion attributable to HIV/AIDS[10]. Apart from increasing the health workforce, a challenge for the next few years will be to implement measures such as task shifting amongst staff in order to make optimal use of the available resources.

DRUG AVAILABILITY AND PROCUREMENT

ARV drugs are provided by the Ministry of Health in more than 220 health centres. Drug procurement remains one of the main weaknesses of Mozambique's public health system, which affects HIV/AIDS services. The main causes are inappropriate orders, delays in the procurement and verification chain, and insufficient staffing and infrastructure. For example, since 2008, there have been significant delays in the disbursements of grants by the Global Fund, which have resulted in drug stock-outs and delays in the procurement.

RESISTANCE TO TB DRUGS

More and more people with HIV/AIDS are contracting drug-resistant forms of TB, either as a result of treatment failure or by coming directly into contact with the resistant form of the TB bacteria. The rapid rise in drug-resistant strains, particularly in southern Africa, is a major cause for alarm. A 2007 survey showed the prevalence of multi drug-resistant TB in Mozambique to be 3.4% among new cases and 12.5% among re-treatment cases.[11] The rise of drug-resistant strains poses a serious problem, due to a lack of available treatment and diagnostics, complicated treatment procedures, expensive drugs, and serious side-effects which frequently result in patients defaulting from treatment.

LUIS JÚNIOR MARIQUELE, 38

Luis Júnior Mariquele is a 38-year-old Mozambican who lives in Mateque, in Maputo province. Mariquele and his wife are both HIV-positive, and have been receiving ARV treatment through MSF for the last eight years. Luis remembers what his life was like before starting ARV treatment:

"I frequently used to get sick, and lost a lot of weight. One time I spent five days at the Central Hospital of Maputo. I could not even speak – I was unconscious. My family thought I was dead, but the doctor verified that I was still alive because my heart was still beating," says Luis.

But everything changed when the doctor put him on ARV treatment.

"Antiretroviral drugs have changed my life from negative to positive. Without them, I would not be on this planet. I have not had a single major health problem since I started taking them. They have saved my life," he says.

JOSÉ CARLOS, 44

"My name is José Carlos and I am 44 years old. I was diagnosed as HIV-positive in 2008. In the same year I started antiretroviral treatment (ART) in the Malhangalene Health Centre. Before starting treatment, I used to feel physically weak and tired. Nowadays I live an active, normal life. I believe it is important for people to know that HIV-positive people can work and practice sports like I do."

9 WHO, World Health Report, 2006
10 MSF, Help Wanted report, 2007
11 WHO document: «Country Cooperation Strategy: Republic of Mozambique 2009 - 2013

Conclusion

The situation in Mozambique today is very different from ten years ago, when MSF began treating HIV patients in the country. The cost of HIV drugs has dropped enormously, the number of people on treatment is increasing each day, the quality of treatment and care is improving, and there is less stigma associated with the disease.

Yet many challenges remain. Two-thirds of Mozambicans who need ARV treatment are still unable to get the medicines that would save their lives. Although MSF will be handing over some of its project activities to local health authorities in the near future, MSF will remain in Mozambique and will continue to work with the Mozambican health sector to address the many challenges that lie ahead.