Economic Commission for Africa

Mozambique: The Challenge of HIV/AIDS Treatment and Care

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Introduction

In spite of impressive recent growth rates, Mozambique remains among the less developed countries in the world, with a GDP per capita of USD 200 in 2001, and a Human Development Index (HDI) score of 0.356 in 2003 (ranking 170 of 175). The HDI has risen in absolute terms in recent years reflecting the improved growth performance of the economy and reductions in illiteracy, but the development performance continues to be highly skewed. Against this background, HIV/AIDS has been accelerating with increasing intensity. There are currently an estimated 1.5 million people living with HIV or AIDS in the country, constituting a prevalence rate of 13.6 percent (721,803 male and 920,130 female). In the next three years this figure will reach 1.8 million and the number of orphans, now estimated to be more than 300 000, will also escalate to 900 000 by the end of 2010 (INE, MISAU 2002). In what follows, CHGA provides a brief overview of the dominant challenges facing Mozambique in its struggle to engage with HIV/AIDS. The analysis is, however, located in the context of development.

Economic Overview

Mozambique displays many of the characteristics of a classic dual economy in which Maputo City has a more developed infrastructure, higher social expenditures and a significant proportion of formal [modern] sector employment than the rest of the country. This gap is reflected in the HDI data but also in the fact that Maputo City accounted for no less than 37 percent of national GDP in 2000. The country is also highly vulnerable to internal shocks such as natural disasters (floods, drought, cyclones etc.) as was shown by the devastating floods in 2000 and 2001, and the fact that the country remains highly food insecure. In 1997, about 69.4 percent of the population lived below the poverty line, with the incidence of poverty being higher in rural areas (71.3 percent compared to 62 percent in urban areas). Some 80 percent of the population live in rural areas, but

agriculture accounted for only 23 percent of GDP in 2000, a reflection of its low productivity. Of the population below the poverty line about 65 percent are illiterate and they are located disproportionately in households headed by women.

Epidemiological Situation

With an estimated HIV prevalence among adults (15 – 49 years) of 13 percent in 2001 (UNAIDS/WHO 2002), Mozambique ranks among the 10 most affected countries in the world. An estimated 500 people are infected every day. Of adults living with HIV/AIDS, an estimated 57 percent are women. Women are generally infected at much earlier ages than men, with consequential effects in terms of impact since women lose more years of life than men. This gendered pattern of HIV infection is typical of the region as a whole. It is clearly related to the low educational level and exceedingly high illiteracy rates among women [see below], as well as to women's subordinate economic, social and political position.

What is also clear is that Mozambique faces a major HIV epidemic, given the high average prevalence level, coupled with structural factors such as poverty, gender inequality, cultural conditions and high levels of labour mobility, all conducive to a rapid and continuing increase in HIV infection within the country. The fact that present rates of HIV/AIDS look as if they are "low" in comparison with some of the other countries in the region, such as Botswana, Zambia and Swaziland, should not be cause for complacency. These countries all had relatively low levels of HIV prevalence in the early/mid 1990s, but the epidemic then expanded with great speed. Mozambique may be facing a window of opportunity, and unless this is grasped, the epidemic may accelerate to levels similar to its neighbours.

Indeed the national rate of HIV prevalence masks considerable regional differences, with adult prevalence rates being estimated at 13.2 percent for the south, 16.5 percent for the centre and 5.7 percent for the north of the country. Table 1 provides data on the regional distribution of HIV in 2001.

Table 1. HIV/AIDS Prevalence rates by region

Region	Province	Provincial rate	Regional rate
South	Maputo city	13%	13.2%
	Maputo province	14.3%	
	Gaza	16%	
	Inhambane	9.6%	
	Sofala	18.7%	
Center	Manica	21.1%	16.5%
	Tete	19.8%	
	Zambezia	12.7%	
North	Nampula	5.2%	5.7%
	Niassa	6.8%	
	Cabo Delgado	6.4%	
	Mozambique national	12.2%	

Source: Ministry of Health 2001

The high prevalence in the central region is mainly attributed to a number of factors. These include the estimated two million refugees returning to Mozambique, after the peace agreement in 1992, from neighbouring countries where rates of HIV/AIDS are high, such as Malawi and Zambia. The mobility of the population along the transport corridors that link Mozambique and the port of Beira to Zimbabwe and Malawi is also a factor. While the prevalence in Zambezia is 12.7 percent, the province of Sofala with its provincial capital and major port of Beira has a rate of 18.7 percent, while Tete province neighbouring Malawi, Zimbabwe and Zambia has one of 19.8 percent. In the province of Manica, bordering Zimbabwe, and with the main transport corridor, the prevalence is estimated to be as high as 21 percent. In the southern region, the highest adult prevalence rates are measured for the province of Gaza. This is characterized by a large portion of adult men who earn their income as migrant workers in the mines of South Africa.

The National Response to HIV/AIDS

The Government's Plan of Action for the Reduction of Absolute Poverty (PARPA) 2001 – 2005 has set a target for the reduction of absolute poverty in Mozambique by 30 percent within the first decade of the new millennium. PARPA also includes a commitment to respond to HIV/AIDS through education and through health related activities. Furthermore, the government has endorsed the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly in June 2001, and the UN Millennium Development Goal to halt and reverse the spread of HIV by 2015.

The national response to the HIV/AIDS epidemic started in 1998 through the National Programme to Combat AIDS set up by the Ministry of Health. This programme was focused mainly on health related aspects of the epidemic, and was superceded in 2000. In 2000, the National AIDS Council (NAC) was set up as a government agency with the task of coordinating, monitoring and evaluating all HIV/AIDS-related activities in the country, as well as to mobilise resources for a comprehensive and multisectoral response to HIV/AIDS. The board of NAC is composed of members of government as well as of civil society representatives.

In 2000, the National Strategic Plan to Combat STD and HIV/AIDS 2000 – 2002 (NSP) was developed through extensive consultation processes, as well as an operational plan for its implementation in 2001 – 2003. Provincial HIV/AIDS coordinators were appointed in March 2000, and provincial plans were also developed. So far about 15 line ministries have developed sectoral operational plans and have started implementing programmes and activities addressing HIV/AIDS. The Ministry of Health (MISAU) has developed a National Strategic Plan for Health that comprises a sector wide approach which fosters partnerships for multi-sectoral interventions to respond to HIV/AIDS.

Alongside this Government response, the community response has grown, stimulated by the work of national and international actors such as non-governmental organizations (NGOs), faith-based organizations and community based organizations (CBOs). These organizations are in part being used as implementing partners for various programmes and projects, with an emphasis on information, education and communication (IEC) activities and promoting the use of condoms. At the present time activities are to a large extent focused on Maputo and a few other urban centres.

Impact mitigation activities, including orphanages, boarding schools for orphans, and support to PLWHA through home-based care and income-generating activities, are still limited in number and fall far short of the present and projected needs. The government has facilitated the formation of a number of organizations and associations, such as the Network of National Associations and NGOs work-

ing on HIV/AIDS (MONASO), the Business Against HIV/AIDS Group, and the Forum for Faith-Based Organizations.

In October 2001, parliament passed a law addressing HIV/AIDS in the workplace that specifically prohibits any discrimination of PLWHA. The NSP identified a number of principal determinants for the growth of the HIV/AIDS epidemic as follows:

- macroeconomic: poverty, unemployment, migration and illiteracy;
- social and cultural: sexual taboos, low status of women; and
- individual: reluctance to use condoms, multiple sexual partners.

In response, the NSP formulated four priorities:

1. prevention focused on young people and mobile populations and their sexual partners;
2. improved coverage of voluntary counseling and testing, as well as care and treatment;
3. impact reduction through support to PLWHA and children affected by AIDS; and
4. focus on the development corridors.

Within these rather limited priorities, the NSP establishes that specific attention be paid to vulnerable populations, including youth in and out of school, long-distance truck drivers, women with low levels of education, migrant workers and their wives, sex workers and their clients, police, military, people with STDs, street children and orphans, and PLWHA. While budgetary allocations were made for the implementation of the NSP, in practice it has remained largely unfunded, and many planned activities have simply not been undertaken. As the MDG report [2002] concluded,

> *"Unless significant efforts and resources are invested to scale-up prevention, care and treatment interventions, the country will not be able to reach the MDG target. Based on recent data it is projected that the prevalence rate among adults could reach 16.3% by 2010."*

The NSP is presently being revised, and there is a new commitment evident in government and among stakeholders to develop an expanded response to the epidemic. This commitment is borne out by the Integrated Workplan of the UN for HIV/AIDS [2003] where a comprehensive list of activities is identified. These include activities that directly and indirectly have a relevance to issues of the impact of HIV/AIDS on human resources, such as workplace programmes [UNDP/UNICEF/UNFPA], and impact studies on agriculture, health, education and communities [FAO/UNDP].

Whereas resources have limited the range of responses in the past, these may no longer be the primary problem given the availability of GF support, and funds from the World Bank through the MAP process. What persists, and will almost certainly worsen as a consequence of the impact of HIV/AIDS, are other constraints relating to organizational and human resource capacity. These are evident in the various evaluations of existing activities, and from other reports that exist on progress with the national response to the epidemic. Their conclusions can be summarized as follows:

- problems with implementing the NSP due to human resource constraints in the NAC which have unduly delayed the national response;
- the need to transform the whole of the public services so as to improve its performance at all levels, through systemic reforms that include action to raise the quality of human resources which are seen as limiting policy development and programme implementation; and
- a lack of capacity in implementing agencies for the national response to HIV/AIDS, such as NGOs and CBOs, where many of the necessary skills and capabilities need to be strengthened if GF targets are to be attained.

At the present time there is a need for greater focus and prioritization both within government and among key stakeholders on the importance of sustaining human resources capacity as an essential element in all programme activities – including those related specifically to HIV/AIDS. Thus the Public Sector Reform Strategy [Nov 2002] has rather remarkably left the development of a strategy to respond to HIV/AIDS until later, rather than ensuring its immediate development and integration across the whole of the public services.

Services Created to Combat the HIV Epidemic

The number of patients who are presumed to be in immediate need of antiretroviral treatment (ART) is 54,000, but less than 2000 are currently undergoing treatment. (MISAU, PEN 2003). Up to 2002, there was no mention of ART. The new National Strategic Plan (NSP) covering the period 2004-2008 presents a more comprehensive list of services, namely:

- VCT centres
- laboratory (only three existing) for CD4 and viral load measurements – two are in Maputo and one in Beira
- day hospitals

- youth and adolescent friendly services
- prevention of mother to child transmission
- home based care

These services only cover a very small geographical area of the country. The youth and adolescent friendly services provide several services related to reproductive health, counselling and testing. From 2000 to 2002 a total of

55,591 adolescent and young people aged 10 – 24 years used these services, of which only 18 percent were male (PEN 2004-2008). No health unit has equipment for serologic diagnosis of the disease, much less for the lab diagnosis of the majority of the opportunistic infections. The treatment of these diseases has been difficult partially due to insufficient training and experience of the majority of technicians and pharmaceuticals.

The Pharmaceutical Department estimates that an increase of 40 percent of antibiotics is needed for treatment of opportunistic infections. Since there are no additional funds to cover this need, it has not yet been translated into action. The promise of funds, namely from the Global Fund for Malaria, Tuberculosis and HIV/AIDS, MAP from the World Bank and the Bill Clinton Foundation, committed to provide more than 300 million USD in the next five years, led to the design of the current NSP. These funds will allow provision of ART, and improve the national health service and systems.

Funding of STI/HIV/AIDS Programme

The Strategic Plan from 2000-2002 was under funded and few of the planned activities were actually implemented. The costs for implementation of the Strategic Plan 2004-2008 are estimated at 500 million USD. Of the commitments made during 2003, only the World Bank Multi-Country Aids Program (MAP) has already disbursed actual money. The first two years of the proposal submitted to the Global Fund to fight against AIDS, Tuberculosis and Malaria have been approved. However, the agreement has not been signed yet. With the fundraising participation of the Bill Clinton Foundation, two donors (Canada and Ireland) committed USD 9 million to be allocated and executed through the General Common Fund mechanism. In all, the Common Fund, fed by the donors involved in the SWAP process, allocated more than USD 11 million to AIDS activities, plus some more resources in improving the Pharmaceutical Department storing capacity. Other donors include the CDC and USAID. Finally many NGOs providing services in the field have their own sources of funding.

Overall, up to USD 29 million of committed money have been allocated to AIDS interventions. The possibility of actually using these resources will depend on the timely disbursement and the MOH improved capacity for financial management. Nevertheless, even this level of funding, while allowing for some services to be set up and managed, will be inadequate to produce the improvements in the health network and human resources needed for the system to be able to open and run the integrated networks planned for the Strategic Plan 2nd and 3rd phase. Sustainability of the program is therefore a real issue.

Challenges for Scaling up Care and Treatment to PLWHA

The prospect of increased resources coupled with the decreasing costs of ART, provides an opportunity to scale up the national response, but it also presents enormous challenges due to the lack of adequate financial, human, technical and institutional capacities at all levels. Some of the challenges for scaling up care and treatment are listed below.

Human Resources

There are 17 000 health workers in Mozambique, of which 11 000 are trained. Only 6 percent are doctors, consequently less than 50 percent of the districts have a doctor. Until now, a very small number of doctors are credited to prescribe antiretroviral treatment. The number of doctors and nurses per patient is very low, if compared with other African countries. For instance, the number of nurses per patient is 1:1298 in Malawi, 1:704 in Zimbabwe, 1:610 in Zambia, 1:457 in Botswana and 1:215 in South Africa, while in Mozambique it is 1:5000.

The number of counsellors and pharmacists is limited. Counsellors have been trained incrementally according to number of VCT centres opened, and they are not enough to cover the whole National Health Service. To overcome the insufficient number of pharmacists, middle, basic and elementary level of pharmacy cadres are trained. However these cadres cannot replace the pharmacists, whose responsibilities include supervising the work of the team, defining procedures, and controlling the quality of the drugs. There are now 14 pharmacists in the National Health Services and Ministry of Health and 24 in the private sector. Twelve more pharmacists are expected to graduate this year to reinforce the workforce. It is however clear that these numbers are insufficient and many more pharmacists are needed.

Annually the districts lose 7 percent of their staff, mainly due to transfers or death. A study was conducted and showed that 10-15 percent of staff could die from AIDS between 2002 and 2010 (MISAU, Relatorio de Avaliação Conjunta, 2003). Another important conclusion from the same study was that the level of knowledge on AIDS was very low in all ranks of health workers. The study concluded that most health workers are neither able to give good information to patients and the public in general, nor able to treat opportunistic infections properly. Continuing education is therefore vital.

The management of human resources needs more attention as there are bureaucratic procedures in the government hampering the posting of staff; sometimes it can take months before workers are put on the payroll. There is also a general lack of motivation in the workforce due to a myriad of small issues that are not addressed. In relation to salaries, it is believed that they are paid well below their market rate. Some provinces have started an incentive program in order to retain the health personnel, especially the ones that are more marketable.

Health Infrastructure

Although the health system in Mozambique comprises a private and public sector, the latter is the main health provider at the national level. The quality of care it provides is hampered by the minimal qualifications of health personnel placed in the remote areas; chronic moral erosion, low motivation and professional ethics resulting from the difficult work conditions, difficult conditions of life and low salaries; poorly maintained infrastructures and deficient hygienic conditions; no or badly maintained equipment, deficient supervision from higher levels, and low quality perception from the users.

The health network is composed of 1000 units, where more than 50 percent are health posts with limited provision of services. There are 400 maternity wards, where less than 10 percent provide basic emergency obstetric care. Around 200 health units have laboratory facilities, but more than 75 percent of them are mini-labs, equipped with very basic equipment and personnel. The provinces of Nampula and Zambezia (in northern Mozambique) are the country's most populated, with the fewest number of beds per 1.000 people. The avalanche of HIV/AIDS patients take up most of the beds, and other patients have to be discharged to give room.

The laboratories in the hospitals and health centres are not equipped to test those who need it, as the tests are prioritised to blood donors. Others who seek testing have to use the VCT centres, which are sometimes situated outside the premises

of the hospitals. Therefore, handling the increased demand as a result of HIV/AIDS will require substantial strengthening of services. This includes management of drug procurement and distribution, rehabilitation and expansion of the physical infrastructure, acquisition of equipment and supplies, and improvement of laboratories.

Access to Health Care

The population has limited access to health services, with the population from towns benefiting more in comparison to the ones from the rural areas. Less than 40 percent of the population have access to health services and fewer than 50 percent of births are attended by skilled personnel. The roads and means of transportation available in some areas of the country do not allow proper communication to/from health centres. The number of people diagnosed and treated is still only a fraction of those actually needing treatment. Those treated come mainly from urban settings rather than the rural areas, where 80 percent of the population lives.

The Integrated Network provides the basic infrastructure of care, and includes in its network day clinics, VCT, treatment of opportunistic infections and chemoprophilaxy, as well as antiretroviral treatment. It links the different services, including the tuberculosis program, PMTCT, and home based care. Presently, the day clinics are located in urban centres. It is expected that 14 day clinics within the Integrated Network will provide treatment by 2004. In 2004-5, there will be 24 day clinics. These clinics will provide ART for an estimated 7924 patients in 2004, and increase to 132 280 patients in 2008. The health units are estimated to receive 100000 new patients with AIDS annually, requiring 1.5 million consultations and around 3000000 days in hospital, leading to an enormous strain on the system (PEN 2003).

Gender Norms

There is a broad spectre of gender discrimination in Mozambique, contributing to the increasing number of adolescents girls and women infected by HIV/AIDS. The gender norms are a key element for spreading the infection. This is because they impair both women's and men's capacity to take preventive measures, and in one way or another affect their access to health care and sound education of young people. First, women are anatomically more prone to STIs and HIV infections. Because the symptoms and signs are not always obvious, women should check up periodically in order to test the existence of any infections, and treat

them. Second, women are forced or pressured to engage in sexual relationship when they are still very young, when the vaginal mucous is tender and more vulnerable to infection. Third, rape of young girls and women, which is reaching astonishing levels especially in urban settings, is often linked to the spread of HIV/AIDS. Finally, where initiation rites are performed, there is a clear difference on what is taught to girls (obedience to their husbands, how to please him and the importance of fidelity); and boys, for whom the main idea is respect for the elderly and the male adult role (there are no words about fidelity, in fact there may be some encouragement on having many sexual partners).

Gender discrimination has to be addressed in the following context:

Education: Most women do not read or write. In the rural areas a great proportion do no attend school, and when they do, they tend to start schooling when they are almost at puberty. So, when they reach the second or third year at primary level they interrupt the studies, because it is time for marriage or to perform the initiation rites. This means that they cannot read any written material about STI, reproductive health, nutrition, etc. (Romao and Dedge, 2002)

Poverty: Women, even those in employment, are the poorest among the poor, as they generally do not have the formal education required for the well-paid jobs. The peasant women are generally not responsible for selling the products they produce in the field. The husbands take care of the sales, and keep the money. In case of sickness it is not easy for a woman to get to the health centre and pay for the expenses. Economic dependence leads to engagement in unprotected sex and a cycle of poverty and ignorance hard to break. If women are abused, they hardly have the desire to seek medical care, much less on HIV.

Future Challenges

Adherence

- Adherence to treatment is going to be a major challenge. The few pilot projects are requesting the patients to meet some criteria before being accepted for ARV treatment. One of these criteria is to have a family member or friend who will provide support to the patient, accompanying him or her to the health unit. The home based care program should concurrently provide this kind of support. However, the home-based care program is still limited to a few geographic areas. It means that

the system of tracking patients has to be carefully looked at. If the ARV treatment is interrupted, resistance to the drugs can be developed. Most pilot projects, with the support of international NGOs, use mechanisms to guarantee adherence (paid "volunteers", high number of trained and motivated personnel, higher levels of salary), that are simply beyond the possibilities of the MOH. While in the first 2-year pilot phase a number of schemes can be experimental, this will remain the single most difficult task to fulfill.

Community Support

- Community participation is still weak, but is important in order to build a strong prevention program integrated with care and treatment of PLWHA and support to orphans. Community participation is particularly vital for the scaling up of home-based care for PLWHA, including the development of community DOT systems as part of the ARV therapy.

Nutrition

- In relation to nutrition, the HIV patient develops malnutrition due to reduced ingestion of food, low absorption of nutrients and changes to the metabolism, which affects the cellular growth. These individuals need to receive additional nutrients. Taking into account the fact that the majority of the population in Mozambique is poor, it is not surprising that they cannot afford to eat properly. WFP has initiated a program to supply food to PLWHA, to be supplied through day clinics or NGOs involved in their care. The Ministry of Health developed a manual with nutritional guidelines for PLWHA, but its translation into practice is still going to take some time and resources.

Stigma and Discrimination

- Countering stigma and discrimination will be decisive for an effective response to HIV/AIDS. The government and civil society organizations are mobilizing political, religious and community leaders to fight stigma and discrimination. This mobilization has to be intensified and strategies to address theses two issues better articulated.

Continuum of Care

- The ideal situation would be to have VCT centres everywhere, where people can go anytime for testing and counselling and referred to day clinics if needed. The day clinic would be responsible for treatment and follow-up, as well as referring the patients for specialized services according to the needs. The decision to start ART would be taken as part of the periodic follow-up of the patient. At the same time, the prevention program has to be strong enough to prevent more people getting infected. In 1997, only1.8 percent of men used condoms (INE, 1997). In 2003 research among youth and adolescents showed that 90 percent had heard about AIDS. 76 percent of women and 87 percent of men believed that AIDS was spread through sexual intercourse and 65 percent of women and 87 percent of men knew that condoms were for prevention of STIs. However, the use of condoms is still low. It increased sharply from three million in 2000 to 15 million in 2002, but a survey report indicated that 80 percent of young people and adolescents did not use them in their last sexual relation (PEN IT/HIV/SIDA 2003).

Opportunistic Infections

- The primary challenge is to save the life of a patient with AIDS and not let him or her die from malaria, diarrhoea, cholera, tuberculosis or even malnutrition.

Improved Pharmaceuticals

- The success of ART is going to depend on the management of pharmaceuticals. The Pharmaceutical Department is responsible for acquiring and distributing ARVs, antibiotics for treatment of opportunistic infections, reagents for diagnosis and other consumables. Introduction of ART on a large scale is going to require special attention and mechanisms, due to the dramatic potential consequences that running out of stock can lead to. Delays in fund release lead to delays in provisions from suppliers, which becomes worse as the ARVs have such a short shelf life.

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