n'weti

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HEALTH SYSTEMS STRENGTHENING AS A SOLUTION FOR THE PROVISION OF QUALITY SERVICES FOR PEOPLE LIVING WITH HIV

1. KEY MESSAGES

- The National AIDS Council (CNCS, Conselho Nacional de Combate ao HIV/SIDA) and the Ministry of Health (MoH) should improve coordination and alignment to overcome the challenges that persist in terms of functional coordination, capacity building of institutional structures and the alignment of priorities;
- Sharing HIV status within the family remains a challenge, creating social ruptures and tensions. As an alternative to mitigate this and other challenges in service delivery to People Living with HIV (PLHIV), the MoH and partners should strengthen the implementation of the Community Adherence and Support Group Strategy, especially in terms of providing psychosocial support to patients on antiretroviral treatment (ART) and fighting stigma;
- Ensure that health facilities have separate compartments for screening, consultation, pharmacy and treatment, the MoH and its partners should increase financial resources for the investment line;
- Lack of courtesy on the part of some technicians, approaching patients in a loud voice, publicly exposing their diagnosis, not only reinforces the stigma in the health facilities but also represents a violation of the rights of PLHIV. The MoH should ensure that such practices are sanctioned as a way of discouraging providers who do not act in accordance with the Charter of the Rights and Duties of the User;
- The results of the community consultations indicate that the family approach puts financial pressure on families by generating transport costs not foreseen in their budget, as well as exposing families to stigma and inhibiting patients from speaking freely. To address this and other challenges, the MoH must create flexible approaches and encourage patients to be accompanied by their spouses or partners;
- Cleaning and hygiene in the health facilities depend on the availability of service staff who can perform this task. The MoH and partners should ensure that outsourcing arrangements also include this professional group in order to improve environmental comfort in health facilities;
- The quality of the surrounding environment in many facilities has been classified as "bad" as screening rooms are not always clean, the yard is dirty and toilets have no water. To overcome this challenge, which can be detrimental to the health of providers and users, the MoH and its partners should ensure that all health facilities are equipped with a borehole.

2. EXECUTIVE SUMMARY

People Living with HIV/AIDS (PLHIV) face obstacles in accessing specialized health due to poorly equipped health facilities, with shortcomings in infrastructure, insufficient human resources, limited community involvement in the management of health facilities and the occurrence of unethical behaviour by some providers that promote stigma and discrimination, resulting in the violation of the rights of PLHIV. Addressing these challenges depends on strengthening of health systems, which implies clarity about the types of activities for capacity building and those that are only part of the operation of the health facilities. The evidence systematised in the present policy brief indicates the need for the training of technicians in courtesy and, in general, in the rights and duties of users, the creation of additional spaces for personalised care and an in-depth reflection on differentiated models in health.

3. POLITICAL AND LEGAL CONTEXT

The Annual Report of HIV/AIDS Related Activities (2021), indicates that Mozambique has 2,101,222 million People Living with HIV, of which 1,976,250 are adults, and 1,253,516 are women. While in 2021 the country had 35,463 HIV/AIDS related deaths, this number is expected to continue to decline. The rate of vertical transmission is 12% in 2021 and is projected to fall to 10% by 2025. With regard to Health Counselling and Testing (HCT), one aspect to consider is the fact that, with the exception of 2018 and 2019, the implementation of HCT has been below the targets, especially in 2020, where the implementation was 69%. In the HCT component, Maputo City, Maputo Province and Manica are below 50% in terms of compliance with the corresponding targets. With regard to the Case Index (CI), specifically in terms of the number of tests done per contact, the country stands at 52% for children <15 years old, 45% for sexual partners and 3% for Mother/Father (CI Ped <15 years old). Testing in sexual partners shows the highest positivity at national level, followed by Mother/Father (CI Ped <15 years) with 23% and the lowest rate was observed in children <15 years of age. Zambézia and Nampula Provinces contributed 43% of the tests done at national level. However, the highest percentages of positivity were observed in Sofala (41%), Manica (39%), Niassa (34%), Tete (33%) and Cabo Delgado with 28%. Regarding serostatus knowledge, 99% of pregnant women were aware of their HIV serostatus in the antenatal consultation (MoH 2021).

The provision of health care to People Living with HIV/AIDS has been done under the National Strategic Plan for Response to HIV and AIDS - PEN V (2021-2025). Since the year 2000, Mozambique has guided its response based on a National Strategic Plan, in order to control the spread of HIV. The previous generations of Strategic Plans (PEN I-2000-2002, PEN II-2005-2009, PEN III-2010-2014), including the Prevention Acceleration Strategy (2008), the National Strategy for Response to HIV and AIDS in the Public Service (2009), and the President's initiative on reflection for a multi-sectoral response to HIV and AIDS have focused on a communication approach to create a baseline to guide the national response.

Mozambique has a multi-sectoral response to HIV/AIDS. The main structures involved are the Ministry of Health and the CNCS. The National AIDS Council coordinates the response to HIV/AIDS, with a particular focus on prevention and community interventions led by civil society organisations (CSOs), while MoH focuses mainly on the provision of clinical services including HIV testing. Both entities are supported by the Government and the donor community with resources and technical assistance, as well as by national and international Non-governmental Organisations (NGOs) and organisations such as N'weti in achieving the first objective of the Joint United Nations Programme on HIV/AIDS (UNAIDS) under the 95-95-95 initiative. However, despite rhetoric suggesting coordinated efforts, some evidence reveals a lack of coordination and alignment between the CNCS and the MoH. Indeed, challenges remain in terms of functional coordination, capacity building of institutional structures and the alignment of priorities (OIM 2018).

The Health Sector Strategic Plan 2021-2024, in the area of access/use, in the indicator on No. (and %) of HIV+ pregnant women who received antiretroviral (ARV) drugs in the last 12 months to reduce the risk of mother-to-child transmission aims to reach a target of 99% in 2024 from 90% in 2019. The same is true for No. of children (and % under PLHIV) receiving paediatric ART which, starting from a target of 80%, aims to reach 95% by 2024. The Mid-Term review of the Health Sector Strategic Plan (PESS) points to the fact that the paediatric ART indicator - No. of children receiving paediatric ART - did not meet any target in 2017 [2015: performed 64,273 children versus 99,086 of the target and for 2017: performed 86,508 children versus 87,039 of the target]. Another indicator whose target was not met in 2017 is the ART Retention Rate after 12 months of treatment (MoH 2019).

The aforementioned lack of coordination between the CNCS and the Ministry of Health, including the challenges created by the vertical nature of the HIV/AIDS programmes, may be some of the factors behind the non-achievement of some targets. In fact, for some indicators there is a lack of information, which may have to do with the fact that most of the activities related to the HIV programme are not under their control and, in some circumstances, partners do not make all the information available.

4. BRIEF METHODOLOGICAL NOTE AND SAMPLE FRAME

This policy brief results from the findings presented in the Community-led Monitoring (CML) report produced under the USAID/PEPFAR funded N'weti Zambézia programme. The main tool for monitoring the quality of ART services is the Community Score Card (CSC). The CSC enables the active participation of users of public health services (PLHIV) in monitoring the quality of services provided by health facilities. The methodological approach to implementing the CSC considered, at all stages of the cycle, qualitative and participatory techniques for data collection and analysis, particularly focus group discussions. The focus groups were made up of 8 to 12 people, guided by a pair of Facilitators, in which the members spoke freely and spontaneously about the researched subject. The discussions were a valuable qualitative tool for capturing users' and providers' perceptions of the quality of ART services provided in the health facilities elected for the exercise. The groups included:

a) Adult women living with HIV and on ART;

b) Adult men living with HIV and on ART;

c) Young boys and girls living with HIV and on ART;

d) Caregivers of children living with HIV and families (men and women);

e) Pregnant and breastfeeding women on Prevention of Mother to Child Transmission (PMTCT); and

f) Providers (in health facilities).

The CLM exercise covered 76 health facilities in the three elected provinces, comprising 760 user groups, 76 provider groups, for a total of 836 groups. In all, 7,191 users and 480 providers were reached, as illustrated in Table 1 below:

Table 1: CLM II Cycle Participant Data

Province	District	# health facilities where the CLM was performed	# of groups formed			Participants by gender								
						Users			Providers			Total (Users+Providers)		
			Users	Providers	Total	F	M	Total	F	M	Total	F	M	Total
Zambézia	Alto Molócuè	2	20	2	22	148	92	240	11	8	19	159	100	259
	Gurué	2	20	2	22	152	64	216	18	6	24	170	70	240
	Mocuba	18	180	18	198	1239	788	2027	70	52	122	1309	840	2149
	Milange	11	110	11	121	756	534	1290	44	37	81	800	571	1371
	Namacurra	10	100	10	110	720	408	1128	51	32	83	771	440	1211
Inhambane	Massinga	2	20	2	22	161	49	210	12	4	16	173	53	226
	Maxixe	2	20	2	22	163	52	215	9	5	14	172	57	229
Gaza	Chókwè	15	150	15	165	747	311	1058	48	13	61	795	324	1119
Maputo Província	Manhiça	12	120	12	132	505	221	726	40	15	55	545	236	781
	Marracuene	2	20	2	22	52	29	81	4	1	5	56	30	86
Total		76	760	76	836	4643	2548	7191	307	173	480	4950	2721	7671

The following population sub-groups were involved in the process: pregnant women, mothers with children aged 0-5 years; adult women and men, including members of the Health Committee and the Co-management and Humanisation Committees. The provider group included providers who attend the sessions of the ART Committee of the catchment health facility.

The discussion presented in the following section is based on results from two cycles of the Community Scorecard, namely the first and second cycles carried out in the same facilities, read in a comparative manner. This approach made it possible to quickly visualize the performance of the indicators and provide recommendations for poorly performing facilities.

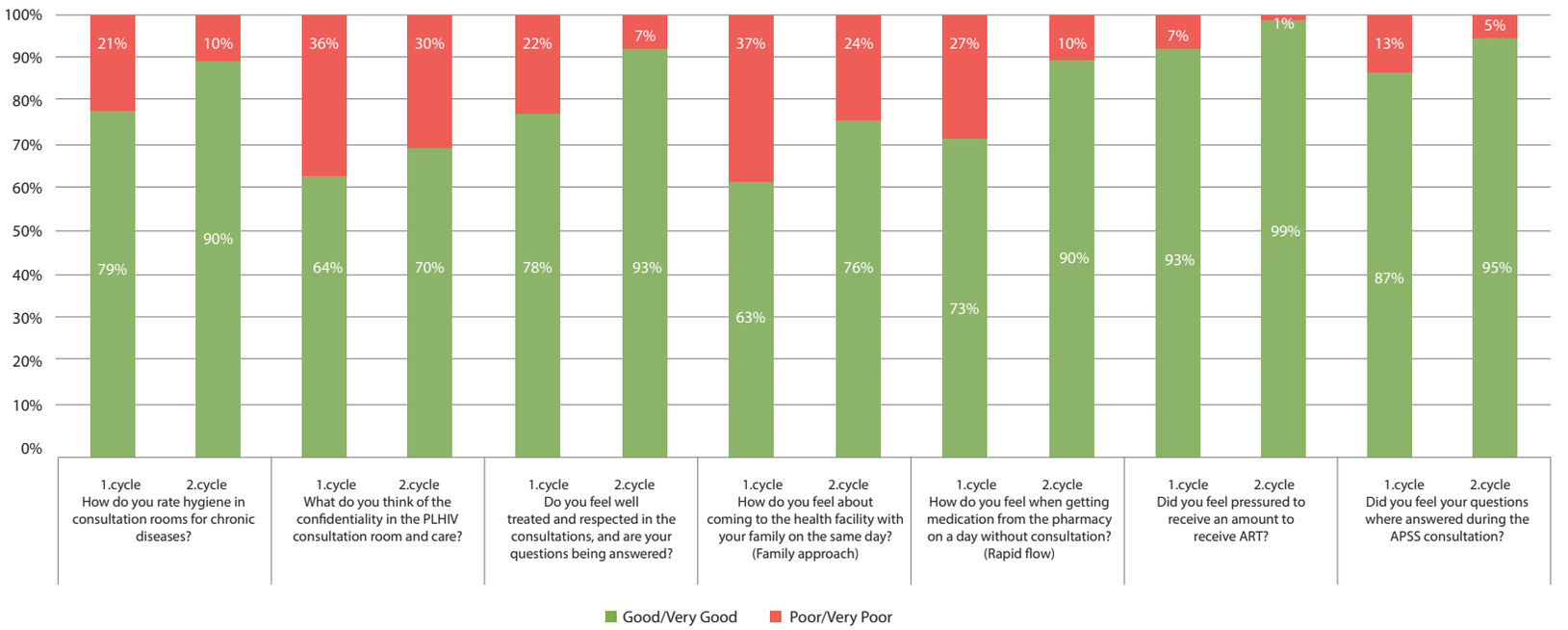
5. QUALITY IN THE PROVISION OF ART SERVICES: **HOW USERS SEE IT**

Figure 1 below shows the performance of seven indicators, namely hygiene conditions in the consultation rooms for chronic illnesses, confidentiality in the consultation room / care of PLHIV, courtesy in attendance (respect for questions asked by users), family approach, rapid flow, pressure to pay fees in exchange for ART services, and clarification of doubts in the psychosocial support (APSS) consultation. In the first indicator, concerning hygiene in consultation rooms for chronic illnesses, the incidence of negative perceptions showed a reduction, with the response category Poor/Very Poor falling from 21% in the 1st cycle to 10% in the 2nd cycle. The District of Namacurra stands out with the worst performance in both cycles, despite having dropped from 50% in cycle 1 to 39% in cycle 2. The explanation for the still problematic performance of Namacurra lies in the fact that hospital premises, delivery rooms, toilets and screening rooms are dirty with dust and cobwebs, and baby nappies are in inappropriate places. In some facilities, screening, consultation and treatment are done in the same room, which makes it difficult to clean the space. In general, these health facilities do not have enough water and service staff to ensure the hygiene and maintenance of the spaces. The health units of Massinga stand out for their excellence, with no incidences of negative perceptions.

The indicator on confidentiality in the consultation room / care of PLHIV appears as one of the most worrying, with a reduction of only 6% from one cycle to the other (from 36% in the 1st cycle to 30% in the 2nd cycle). In this indicator, the District of Namacurra reappears with high incidences in the categories Poor/Very Poor 69% in the 1st cycle, and 66% in the 2nd cycle. Next comes the District of Gurué with 18% in the 1st cycle and 37% in the 2nd cycle. The users pointed to the use of a single room for testing, screening, pharmacy and ART services, preventing personalised treatment, which leads to discomfort and shame. Additionally, there are cases in which providers approach users discourteously, in a loud tone, exposing patients.

On the other hand, the indicator that captures the level of courtesy and response to possible queries and doubts presented by the users, recorded remarkable progress, having gone down from 22% in the 1st cycle to 7% in the 2nd cycle. Districts such as Chókwè, Marracuene and Milange did not register any negative perceptions in the 2nd cycle. These results are clearly a consequence of the Community-led Monitoring, specifically the implementation of the action plan resulting from the CSC cycles.

Graph 1: User perceptions of ART services - Part 1



The family approach showed a worrying performance in the 1st cycle with a 37% negative perception, however in the 2nd cycle it dropped to 24%, showing a remarkable progress. Part of this performance was due to the performance of the Milange District which dropped from 46% in the 1st cycle to 4% in the 2nd cycle, and the same pattern was observed in Marracuene District, which decreased from 23% in the 1st cycle to 7% in the 2nd cycle. One of the lessons to be learned from the CLM is that districts with excellent performance in the 1st cycle, such as Massinga, which scored 99% Good/Very Good in the 1st cycle and 100% Good/Very Good in the 2nd cycle, have maintained this positive performance in the 2nd cycle, suggesting that the family approach, when successfully implemented in the first cycle, tends to last over time.

While the family approach aims to improve the quality of services offered to members of the same family with 2 or more people living with HIV (MoH 2018), on the extreme, the performance of this indicator reveals there is still much to do in terms of reducing stigma. Some of the participants in the community consultations indicated that this approach puts financial pressure on families due to transportation expenses. They also reported aspects such as the exposure of the family to stigma, including the fact that the presence of the family inhibits the patient from expressing himself freely, with a preference for the company of the partner or spouse. Added to these aspects is a sense of insecurity, due to the fact that families suffer thefts in their homes while they are at the health facility.

With regard to the differentiated service models, the indicator on rapid flow also shows a decrease in the incidence of negative perceptions, from 27% in the 1st cycle to 10% in the 2nd cycle. The Alto Molócuè District had an excellent performance in the first cycle, with a total of 97%, but these gains were lost in the second cycle, with the perception of dissatisfaction rising to 23%. The same trend, although not very significant, is present in the District of Marracuene, with a total of 12% in the Poor/Very Poor response category, in

the 1st cycle, and 2% in the 2nd cycle. The greatest progress was registered in Namacurra with a total of 41%, in the 1st cycle, for the response categories Poor/ Very Poor and 4% in the 2nd cycle. Everything indicates that there is a need to increase the effectiveness of the combination of the two approaches that characterise this differentiated model, namely clinical consultations every 3 or 6 months, APSS (Psychosocial Support) every 3 months and quarterly ARV collection (MoH 2018). Previous reports of Community Consultations highlight the need for users to be seen more frequently by a health professional, even if it is on a preventive basis. Of the various issues of concern to users, the need for body mass weighing, addressing side effects of medication and the pharmacy as a potential site of stigmatisation stand out. The positive score is mostly explained by the fact that PLHIV do not have to queue up, making the process "fast and flexible".

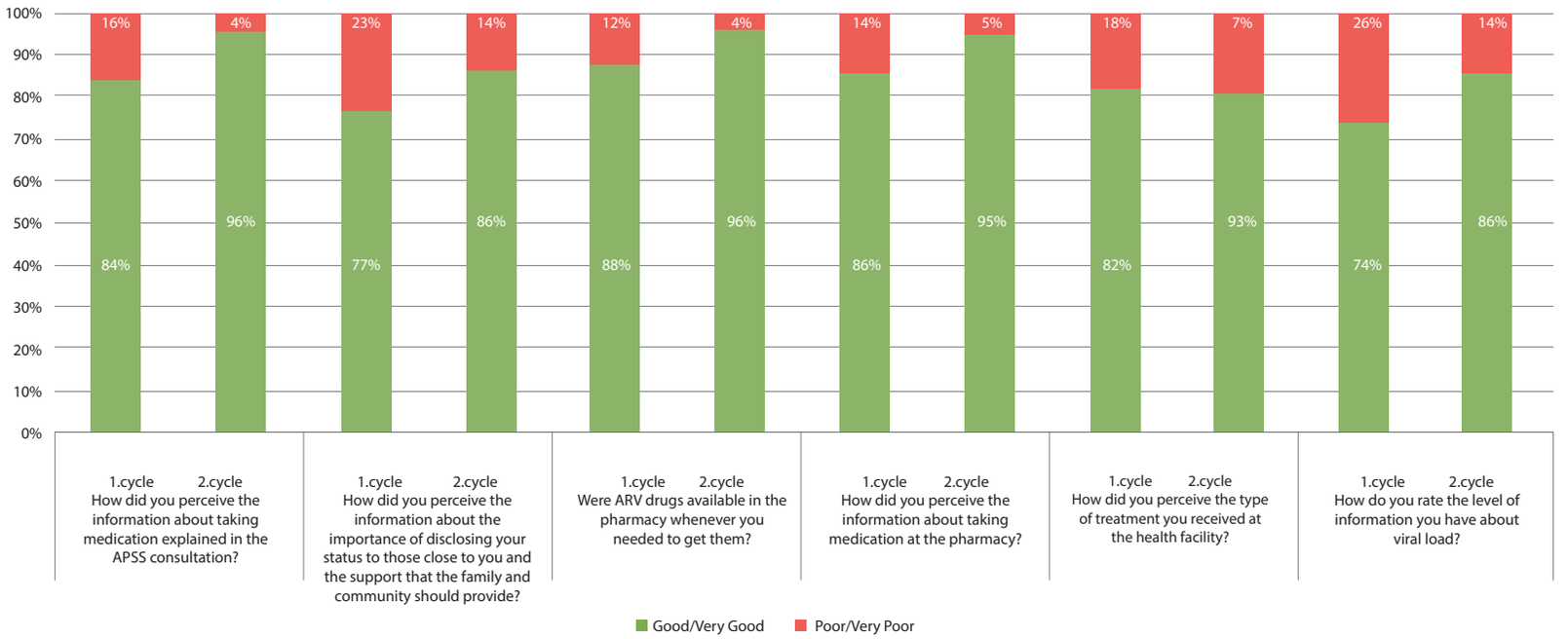
The indicator on illicit charges for access to ART is one of the indicators with the best performance in both the 1st and 2nd cycles throughout the entire series on the services dimension. In fact, even those districts which presented pockets of discontent in the 1st cycle, namely Manhiça, with 15% in the response category Poor/Very Poor, Chókwè, with 12% and Marracuene with 15%, in the 2nd cycle, all come close to 0%, with no negative perceptions. It should be noted that this results from the monitoring and follow-up actions and advocacy done by the project. Similar to the indicator on family approach, these results raise important questions about the inequality in the application of the instruments for quality and humanisation throughout the programmes of the National Health System. This statement results from the fact that illicit charges constitute one of the obstacles, abundantly documented, for the negative user experience in the country's health facilities. An explanatory hypothesis, yet to be confirmed, may be related to the fact that the HIV Programme funding includes a line for strengthening of health systems, which may contribute to reaching a large number of professionals in terms of trainings, capacity building and increased information outreach, including monitoring activities.

In turn, the APSS dimension, composed of three sub-indicators - namely the satisfaction of the user regarding the clarification of doubts by the technician during the APSS consultation, the level of satisfaction regarding information on the administration of medication, and finally the indicator on the disclosure of the HIV status to family members and community support - also shows an excellent score with a reduction in dissatisfaction clusters from 13% in the 1st cycle to 5% in the 2nd cycle.

The same pattern is evident in the indicator related to the explanation about taking medicine (Graph 2). This indicator shows extremes, with the district of Gurué scoring 19% in the Poor/Very Poor response category for the 1st cycle and 15% for the 2nd cycle, indicating little significant progress, and Namacurra repeating the feat achieved in the previous indicator, scoring 46% in the Poor/Very Poor response category for the 1st cycle and 8% for the 2nd cycle. These results may indicate the effectiveness of the APSS/PP (Positive Prevention) services in the quarterly modality for children aged 2 to 9 years and patients older than 10 years, for the rapid flow model. Regarding Gurué District, users again highlighted persistent arrogance and abandonment by the providers.

The indicator for the importance of disclosing the HIV status to those close to them and the support from family and community brings to light the need to make a greater effort to improve this component, to the extent that from an incidence of 23% in the response category Poor/Very Poor in the 1st cycle, there was a fall to only 14% in the 2nd cycle, with the District of Massinga being the main responsible for this fall, due to its characteristic excellent performance. The remaining districts recorded marginal progress, such as Maxixe, Milange, Mocuba and Gurué, which maintained the 1st cycle results. The results of the Community Consultations raise issues such as the whole family being invited to test, fear of repudiation in marriage, abuse and discrimination, family isolation, lack of confidentiality, discomfort and lack of clarity in the information provided by the technicians. In general terms, the sharing of the HIV status within families remains dramatic, creating ruptures and other social tensions. It is in this context that the implementation of the Community Support and Adherence Groups Strategy (MoH 2014) is relevant, especially in the specific objective of providing psychosocial support to patients on ART and in the need to keep communities united in the fight against stigma.

Graph 2: User perceptions of ART services - Part 2



With regard to the availability of ARV drugs in the pharmacy, the data show a development towards total availability in the 2nd cycle, with districts such as Manhiça, Marracuene and Milange standing out by reducing negative incidences from the 1st to the 2nd cycle. In this indicator, Namacurra joins the group of districts with a stationary trend, having registered limited progress between the 1st and 2nd cycles. Factors such as poor interaction between the patient and the technician, not explaining the side effects of medication and the difficulties in understanding the technicians' explanation about taking medication are among the causes of the low performance in some of the districts analysed in this CLM series.

The indicator that evaluates the type of treatment received at the health facility, shows remarkable progress with a shift from 18% in the 1st cycle to 7% in the 2nd cycle. Although Namacurra (1st cycle: Poor/Very Poor = 42% and 2nd cycle: Poor/Very Poor = 17%) and Alto Molócuè (1st cycle: Poor/Very Poor = 22% and 2nd cycle: Poor/Very Poor = 11%) have made noteworthy gains, the prevailing pockets of negative perception need to be addressed. In this series, Gurué stands out negatively for the increase in dissatisfaction clusters between the 1st and 2nd cycles. Prescription of incorrect medication, delay in attendance and lack of courtesy on the part of technicians stand out as causes behind user dissatisfaction in this district.

The indicator on disclosure of HIV status and family and community support follows the same pattern of decreasing perceptions of dissatisfaction, with a performance of 26% in the 1st cycle and 14% in the 2nd cycle. Despite this progress, users continue to signal concerns about levels of confidentiality in the care of PLHIV. As often mentioned in previous reports, part of the challenges of this indicator relate to the limited capacity of the infrastructures of the national health system. Some attendance rooms, in some health facilities in the district, are simultaneously being used

as pharmacy and warehouse. The Districts of Gurué (1st cycle: Poor/Very Poor =12% and 2nd cycle: Poor/Very Poor =13%) and Mocuba (1st cycle: Poor/Very Poor =10% and 2nd cycle: Poor/Very Poor =6%) are seen to be stationary in terms of confidentiality. Another aspect worth mentioning is linked to the line of financing for strengthening systems, within the framework of PEPFAR funds, and consideration of possible investment in infrastructure for the treatment of PLHIV. This reasoning is especially important when considering the framework of global funding to the health sector, and its focus on the operating budget and very little on investment.

Other relevant concerns have to do with the information provided by technicians on viral load. The results of the CLM show strong challenges in transmitting information to PLHIV on viral load, as the levels of negative perceptions captured in the 2nd cycle remain almost the same as in the 1st cycle. The reasons for the unsatisfactory performance of this indicator have to do with the lack of freedom for the user to express their feelings, the use of technical language by the provider and the non-disclosure of the viral load test result.

6. CONCLUSIONS

This policy brief shows that strengthening the implementation of the Community Adherence and Support Groups Strategy, especially in the dimension of psychosocial support for patients on ART and in combating stigma, can be one of the responses to the ruptures that occur within the family due to the revelation of the serological status. Similarly, the training and compliance of health professionals with the Charter of the Rights and Duties of the Patient may represent a solution to encourage seeking health care and reducing the level of abandonment of ART. Maintaining hygiene in the premises, treatment and care rooms, depends on greater involvement of the Co-management and Humanisation Committees, providing daily cleaning supplies and other consumables. The distinction of compartments for screening, consultation, pharmacy and treatment can be achieved by allocating more financial resources to the investment line. Finally, differentiated models in health need better adjustment to local contexts as approaches such as the family approach put financial pressure on households by generating transport expenses not foreseen in their budget. The data indicates that all these challenges are part of the need to strengthen health systems, which implies "agreement" on what it means and what kind of activities it represents.

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TECHNICAL DETAILS:

Ownership: N'weti
Author: Andes Chivangue
Technical Team: Denise Namburete, Albino Francisco, Sansão Dumangane and Elves Francisco
Graphic design: Maurício Matapisse
Editing: Ilundi Durão de Menezes
N'weti's Executive Director: Denise Namburete
Date: February 2023

www.nweti.org
@nweti.org
@n_weti
nweti01
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