



Morocco

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KEY POINTS

1. To date, no brochures, posters or information booklets specifically discussing prevention of vertical transmission have been prepared by either the Ministry of Health or any NGOs, and no NGOs are involved in programs promoting or offering VCT to women during pregnancy.
2. Access to antenatal services remains insufficient: just 68 percent of Moroccan women have access to at least one antenatal exam during pregnancy, and only 63 percent of births are assisted by healthcare professionals.
3. Breast-feeding by HIV-positive mothers is contraindicated by the Ministry of Health, however, more than 40 percent of rural-dwellers do not have access to safe drinking water sources, and formula is available free of charge in only three cities.
4. A lack of coordination among international agencies working in Morocco limits their overall effectiveness. Currently, for example, both UNFPA and UNIFEM are focusing on improving maternal and child health and promoting reproductive health for women and girls, but are not fully coordinated.

RESEARCH PROCESS AND METHODOLOGY

Research for this report was conducted in two phases. The first phase (November and December 2008) consisted of collecting and reviewing recent documents and reports produced by government agencies and NGOs. The second phase, in January 2009, included interviews with a total of 11 stakeholders: representatives from UNAIDS, the National AIDS Program, the Global Fund management unit, and civil society groups (including those focusing specifically on HIV and human rights); health-sector workers (including paediatricians, infectious-diseases specialists, and social workers); and consultants who have worked on prevention of vertical transmission issues for the MoH, UN agencies and civil society organizations. A focus group with five HIV-positive mothers was organized in Marrakech in January 2009.

1. BACKGROUND INFORMATION

An estimated 22,000 Moroccans were HIV-positive in 2008, which corresponds to a relatively low prevalence of just 0.1 percent. However, epidemiological data show signs of emerging concentrated epidemics among specific populations including female sex workers and IDUs.

HIV is also becoming more common among women in general. In 2008, they comprised 38 percent of all recorded AIDS cases¹⁵, up from 28 percent in 1995 and 19 percent in 1990. Marriage is no barrier to HIV infection: according to official sources, three quarters of women living with AIDS are currently married, divorced or widowed. Studies on STIs¹⁶ indicate that it is mostly husbands' sexual behaviour that put Moroccan women and, subsequently, their infants at risk of HIV infection. Vertical transmission is responsible for about 3 percent of reported AIDS cases. Local and global demographic and epidemiological data indicate therefore that some 200 Moroccan infants contract HIV through vertical transmission each year.

Systems for care, treatment and support for people living with HIV are relatively well advanced, with antiretroviral drugs and treatment now available free of charge. So-called centres of excellence and referral centres have been established, and they are adequately trained and equipped to treat HIV. Since 1990 these centres have provided treatment

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¹⁵ The MoH provides data only on recorded AIDS cases, not cases of HIV infection. The ministry defines 'AIDS' as per standard WHO guidelines.

¹⁶ Ryan CA, Zidouh A, Manart L et al., "Reproductive tract infections in primary health care, family planning and dermatovenereology clinics: Implications for syndromic management in Arab Muslim women." January 1998

for HIV-positive pregnant women to prevent vertical transmission. Prior to ARVs becoming widely available and free of charge to all in need, in 2003, treatment for pregnant women consisted first of zidovudine (AZT) monotherapy and then of dual therapy (AZT+3TC). In 1998, triple-combination therapy became available to HIV-positive pregnant women in need.

In terms of identifying PLWHA, over the past decade Morocco has undertaken extensive efforts to reach high-risk individuals with HIV/AIDS information, education and VCT services. Those efforts have not been successful in regards to pregnant women, however. According to the most recent UNGASS report, only 7.5 percent of HIV-positive pregnant women had access to prevention of vertical transmission services in 2007. In September 2008, there were 156 children in Morocco (0 to 14 years of age) followed in reference services for HIV infection. In 80 percent of cases, the HIV status of one or both of the parents was revealed only after the child's status was confirmed¹⁷. Such poor performance highlights the fact that prevention of vertical transmission remains a major weakness of the National AIDS Program.

2. STATUS OF SERVICE DELIVERY AMONG AND FOR WOMEN

Policymakers recognize the shortcomings in availability of prevention of vertical transmission services and are trying to address the situation. With the support of UNAIDS and UNICEF, the MoH since 2006 has sought to assess vertical transmission in the country and develop recommendations for improved services. As a result, prevention of vertical transmission is one of the innovations of the new National AIDS Strategic Plan 2007-2011, and a pilot program has been initiated recently in the cities of Agadir, Marrakech and Casablanca¹⁸. The results of this pilot program will help determine whether, and how, prevention of vertical transmission services will be expanded throughout the country. The current prevention of vertical transmission strategy is much more limited in that it focuses primarily on services for women already known to be HIV-positive.

The MoH's pilot program was preceded by a much smaller one launched in 2006, in the city of Rabat. That pilot study, initiated by the University Hospital Ibn Sina and supported by the French quasi-governmental organization ESTHER¹⁹, was the first program in Morocco offering "comprehensive" prevention of vertical transmission services to pregnant

17 Évaluation rapide de la situation des enfants infectés ou affectés par le VIH/SIDA au Maroc, Marc Eric Gruenais, 2009 (Moh, UNAIDS, IRD, Soleil)

18 The program started in September 2008. Of the total of 916 pregnant women tested through December 2008, just two were diagnosed as HIV-positive. As of March 2009, it was unclear when the pilot program would end or when results, preliminary or otherwise, would be made available.

19 Ensemble pour une solidarité thérapeutique en réseau.

women. From October 2006 to June 2008, a total of 1,527 pregnant women enrolled in the program. Of them, five tested positive for HIV and received ARV prophylaxis. All five babies are HIV-negative.

To date, with the exception of the ESTHER-supported pilot study in Rabat and the pilot program recently launched by the MoH, there are no other programs offering a comprehensive package of prevention of vertical transmission for pregnant women in the country.

PRIMARY PREVENTION AMONG WOMEN AND GIRLS

The MoH and various NGOs have taken the lead in raising general awareness about HIV through a growing number of HIV/AIDS education campaigns in recent years. These campaigns have taken several forms, including media campaigns and prevention programs in schools and at work places.

Campaigns specifically targeting women have been initiated. Some NGOs, such as ALCS²⁰, have built alliances with women's organizations in order to provide information and testing services to their beneficiaries. AMSED²¹, a national development organization, works with a large network of community-based organizations (especially in rural areas) and has offered information about HIV in its programs. None of these interventions provides detailed information about prevention of vertical transmission, however; in most cases, the focus is on sexual transmission and condom use, with vertical transmission of HIV discussed only superficially²². To date, no brochures, posters or information booklets specifically discussing vertical transmission have been prepared by either the MoH or any NGOs. Moreover, no NGOs are involved in programs promoting or offering VCT to women during pregnancy.

PREVENTION OF UNINTENDED PREGNANCIES AMONG HIV-POSITIVE WOMEN

There is a lack of data concerning reproductive choice and HIV in Morocco, with the exception of a small study undertaken in Casablanca in 1999²³. According to one respondent²⁴, all HIV-positive women followed in specialized care facilities that provide HIV treatment and care (two centres of excellence and seven referral centres) receive adequate

20 Association de Lutte Contre le SIDA (www.alcsmaroc.ma).

21 Association Marocaine de Solidarité et de Développement.

22 Researchers for this report analyzed materials (brochures, posters, PowerPoint presentations, audiovisuals, etc.) used by NGOs working with women. None of these focus on all components of prevention of vertical transmission.

23 Chakib A, Laghzaoui Boukaidi M, Najib J et al. Grossesse et SIDA. A Propos de 9 Cas. La Tunisie Médicale, Vol. 79, N. 10 2001 ; 530-535. The study found that two of the nine HIV-positive pregnant women treated at the Maternity Service of the Teaching Hospital Ibn-Rushd from 1990 through 1999 said their pregnancies had not been planned. However, all women surveyed who knew their HIV status before pregnancy said they decided themselves to have babies after consulting with their doctor.

24 Dr. Hakima Himmich, president of ALCS (Association de Lutte Contre le SIDA) and head of the infectious disease department at Casablanca's University Hospital Ibn Rochd.

information about family planning from medical personnel and have access to contraceptive information and materials. (All HIV-positive women respondents for this case study confirmed having received such information.)

Abortion is illegal in Morocco, but HIV/AIDS is an indication for the therapeutic interruption of pregnancy if the woman desires it. This interruption is possible only after the mother is provided a thorough explanation as to the HIV transmission risks and the potential fetal toxicity of ARVs. After receiving such information, she can decide whether she wishes to interrupt her pregnancy or carry to term. Of the 23 pregnant HIV-positive women followed in the Casablanca centre of excellence in 2008, four chose to have an abortion.

“I fell sick after the birth of my son. My child had TB. The doctor ended up advising me to have an HIV test. It was positive... During my pregnancy I was followed in a clinic, but I never heard about the possibility of taking an HIV test. I vaccinated my child and breast-fed him... he died at nine months. Today, I feel guilty.”

35-year-old HIV-positive woman

PREVENTION OF HIV TRANSMISSION FROM MOTHER-TO-CHILD

Treatment and care of HIV infection in Morocco is provided at two centres of excellence and seven referral centres. ART and key diagnostic tests are provided free of charge to all in need, including pregnant women.

HIV/AIDS treatment and care protocols have recently been revised to meet WHO recommendations. The guidelines stipulate that all HIV-positive pregnant women be assessed upon first presentation at a centre to determine whether they need ART and other therapies such as cotrimoxazole prophylaxis. The usual ART regimen provided is AZT+3TC+Kaletra (lopinavir/ritonavir). That combination regimen is available immediately, if deemed necessary, or beginning at the 28th week of gestation if it is intended to serve as prophylaxis. The treatment protocols also specify when other ARVs may be more appropriate, such as when just one dose of nevirapine is given during birth to help reduce transmission risk to the newborn.

All newborn infants receive AZT within eight hours after birth and remain on treatment for four weeks. When there is high risk of vertical transmission (when women have high viral load), a single dose of nevirapine is given to the newborn within 72 hours of birth as well.

HIV-positive pregnant women are strongly encouraged to give birth in one of the nine specialized centres in the country. However, some women do not follow this advice and choose to deliver elsewhere, usually at their local maternity clinic, because of the stigma associated with the specialized centres.

BARRIERS TO COMPREHENSIVE SERVICE DELIVERY AND LESSONS LEARNED

- For many years, different stakeholders were sceptical, mainly because of the very low HIV prevalence in Morocco, as to the cost effectiveness of a dedicated prevention of vertical transmission program. This points to a lack of documented best practices from low-prevalence countries regarding this issue. The strategy ultimately adopted was to treat known HIV-positive women and to continue raising awareness (including the promotion of VCT) among the general public. At the same time, several discussions and debates took place around the country to define the most appropriate future strategy to promote prevention of vertical transmission. This resulted in the MoH-organized pilot program now in place.
 - For the time being, it is considered neither practical nor reasonable from a cost point of view to recommend that all pregnant women in the country be tested for HIV. Previous STI studies indicate that it is difficult to identify women at risk of HIV infection in Morocco because it is the sexual behaviour of their husbands that often puts those women at risk. However, efforts have been made to determine the types of behaviours and circumstances that pose a risk of HIV infection for pregnant women in Morocco. Key factors include a history of multiple sexual partners or professional sex work, multiple diagnoses of STIs, and having male partners (including husbands) who work away from home for extended periods of time.
 - Although progress has been made during the last decade to reduce gender inequalities, 38 percent of Moroccan women are illiterate and therefore cannot obtain information about HIV from brochures, posters and the written media.
 - Access to antenatal services remains insufficient. Just 68 percent of Moroccan women have access to at least one antenatal exam during pregnancy, and only 63 percent of births are assisted by health care professionals.
 - Women seem to bear the burden of prevention of vertical transmission and the consequences of a possible positive HIV test by themselves. Husbands are rarely if ever involved. For example, they hardly ever accompany their wives to antenatal consultations and have limited awareness of anything related to vertical transmission.
 - There are relatively few sites in the country that offer dedicated HIV-related services, notably prevention of vertical transmission, to pregnant women. (At the moment, in fact, there are only four: the sites established in 2008 as part of the MoH's pilot program.) The most convenient option for the majority of pregnant women who wish to be tested is to use a VCT centre run by an NGO. However, they rarely utilize that option because they fear being identified as perhaps having HIV.
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“For now, I do not think we should rush to generalize the practice of testing pregnant women all over the country. We must await the results of the pilot program and draw the necessary lessons. Personally, I do not think we’ll go toward a generalization but rather focus the program in the most affected areas with the highest prevalence rates.”

Dr. Kamal Alami, administrator of the UNAIDS program in Morocco

3. HIV TESTING: ACCESS AND OTHER ISSUES

HIV TESTING POLICIES AND PROCEDURES

Morocco has a good national policy on HIV testing under a legal framework contained in an MoH decree from 1989²⁵. Testing is voluntary, anonymous (except diagnostic testing²⁶) and free of charge. Informed consent is required. Only trained physicians are permitted to give HIV tests. Recently, though, with the launch of the prevention of vertical transmission pilot program, nurses are authorised to provide pre-test counselling—but only doctors are allowed to give patients their test results, whether negative or positive.

To date, testing in Morocco is offered primarily by NGOs²⁷ in close collaboration with the MoH, which provides the test kits (rapid tests and Western Blot confirmation tests) and other equipment for VCT centres. More than 40 VCT centres are currently run by NGOs across Morocco (including at least six mobile units operated out of vans), but several regions of the country still have no testing facilities. About 14,000 HIV tests were performed between July 2007 and December 2008. Nearly three quarters of all HIV tests in 2008 were performed at VCT sites and mobile vans operated by one NGO: ALCS.

UPTAKE AND ACCESS TO TESTING AMONG WOMEN

According to available data, women are relatively well represented at testing sites in urban areas. In 2008, for example, women comprised more than half (53.5 percent) of all people tested for HIV at ALCS-operated freestanding centres, the majority of which are located in urban areas. Women’s share is much lower in rural and remote areas.

However, all NGO testing sites reported few, if any, pregnant women coming for HIV tests. The majority of female clients are most at-risk women (notably, regular or occasional sex workers). Since few of them become (or remain) pregnant, testing this cohort does not play an important role in prevention of vertical transmission.

HIV TESTING FOR PREGNANT WOMEN

Because there have been no systematic efforts to educate pregnant women about the risk of vertical transmission and the benefits of VCT, the actual level of demand for VCT among pregnant women in Morocco is unknown. With the exception of the few prevention of vertical transmission programs currently in operation, HIV testing is not available in antenatal

²⁵ Ministry of Health Decree N° 1078/DT/217/SLMSTD (21/09/1989).

²⁶ Diagnostic testing is not technically anonymous because it takes place after the patient is already registered in a health care facility and has a medical record containing his or her name. However, health care providers are required to respect patients’ confidentiality.

²⁷ Association de Lutte Contre le SIDA (ALCS), Organisation Panafricaine de Lutte contre le SIDA (OPALS), Ligue Marocaine de Lutte contre les MST (LM-LMST) and smaller NGOs such as the Association de Lutte Contre les IST-SIDA (ALIS).

care facilities. Some physicians in the private health sector reportedly give HIV tests to their pregnant patients without informing them. In such cases, according to respondents, the physician will refer a woman to a centre of excellence if the test comes back positive—and she is only told that the test was administered, and the result, after registering at the centre. The ethics of this practice are questionable.

TESTING IN PREVENTION OF VERTICAL TRANSMISSION PROGRAMS

In the actual prevention of vertical transmission pilot program covering the cities of Agadir, Casablanca and Marrakech, HIV testing is offered to all women after a counselling session. The test is never compulsory, and women are free to decline it. Recent data indicate that most women agree to be tested. Confidentiality of HIV status is, in theory, guaranteed in the protocol—but is not always assured in practice. According to a respondent for this case study, the only woman who had tested positive in one of the pilot programs was visited at home by a health worker who sought to force her to disclose her HIV status to her husband.

4. INFANT FEEDING GUIDELINES AND TRENDS

In Morocco, about one third of mothers exclusively breast-feed their babies within the first six months of life²⁸. The MoH's position on infant feeding for HIV-positive mothers is clear: breast-feeding is contraindicated. In Morocco, it is estimated that 80 percent of the population (99 percent of those in urban areas and 56 percent of rural-dwellers) have access to safe drinking water sources²⁹; as such, formula feeding is likely to be appropriate for babies born to HIV-positive women if they receive adequate counselling in safe formula preparation.

All mothers interviewed for this report said that treatment educators carefully explained all relevant aspects of replacement feeding, including how to prepare bottles, after they were informed of their HIV status. Formula is provided free of charge as long as the child needs it in three cities only (Casablanca, Marrakech, and Agadir) as part of recently initiated pilot programs. Elsewhere in the country, formula may be provided by hospitals or NGOs depending on their capacity; this means, however, that some families must buy their own formula, particularly in the cities where there are no NGO programs to support mothers and children.

5. IMPACT OF VIOLENCE AND STIGMA

In the cultural and religious context of Morocco, PLWHA are sometimes considered “sinners” because of the link between HIV and sexuality. Such attitudes underpin and reinforce the relatively high levels of HIV-related

28 As cited in a speech by Aloys Kamuragiye, the UNICEF representative in Morocco, during the 4th Regional Forum on Media and the Rights of Children, 28 November 2008.

29 UNICEF, State of the World's Children Report, 2006.

“When I was giving birth in the clinic, the entrance to my room was marked ‘HIV+ patient’. I felt that nurses treated me differently than other women. Some have refused to change my sheets.”

36-year-old HIV-positive woman

stigma and discrimination in the country. As a result, the majority of PLWHA avoid disclosing their HIV status to their families and closest friends. It was only in 2005 that an HIV-positive person (a woman) publicly disclosed her status – on TV, as it turned out.

Women living with HIV seem to face double stigma because of their status and their gender. For many Moroccans, contracting HIV is a sign that a woman has acted immorally and inappropriately. A double standard exists because although unmarried or extramarital sex is mostly accepted for men, women are expected to remain virgins until marriage and face great risk of violence or abuse if engaged in adultery. According to NGO respondents, many HIV-positive women have been abandoned by their husbands, which contrasts sharply with the fact that in general women care for their HIV-positive husbands. The fear of stigma is a major barrier for women to get tested.

Another challenge stems from the fact that HIV-related stigma and discrimination in health services are far too common. According to the preliminary results of a study carried out by ALCS, and to be published in the coming months, most discrimination actually occurs in health settings. This does not necessarily mean that health workers are more stigmatizing or intolerant than the rest of the society, but the impact is far greater because health care facilities are supposed to be nonjudgmental and open to all. Many of the women interviewed for this case study said they had experienced stigmatizing behaviour, including delays in attention or refusal to provide care, from health workers.

In most cases such behaviour occurred in antenatal care facilities, not in HIV-specific care structures. This proves that with adequate training, the attitudes and actions of medical personnel can improve immensely. It also points to a need to provide HIV training to staff throughout the health care system in order to reduce stigma and discrimination.

6. ASSESSING THE WORK OF GLOBAL AGENCIES

The French organization ESTHER was the first external partner to support prevention of vertical transmission in Morocco. The organization helped organize the launch of the pilot study in Rabat by providing funding, training and technical assistance. Today, the organization supports HIV care and treatment for adults and paediatric services in four cities of the country.

UNICEF and UNAIDS have played a major role in prevention of vertical transmission in Morocco. They have offered assistance to draw lessons from the pilot study initiated by ESTHER and to develop a strategy adapted to the Moroccan context. The two agencies are also strong

partners of the MoH-supported prevention of vertical transmission pilot program. They have a support role and provide the necessary technical assistance for the development of the protocol through diverse consultancies as well as the organization of national workshops and trainings.

The Global Fund is the major international donor of HIV programs in Morocco, supporting 46 percent of the cost of the national AIDS strategy. It provides funds for both the government and civil society to implement treatment and prevention programs. The country is currently implementing its second Global Fund program³⁰, to which a prevention of vertical transmission component was added in 2008. The funds from this component are being used to purchase equipment and supplies (including reagents) for the MoH's prevention of vertical transmission pilot program.

International agencies have played an important role in the implementation of prevention of vertical transmission interventions in Morocco as well in terms of advocacy, technical support and funding. However, a lack of coordination among the involved agencies often limits their overall effectiveness. Currently, for example, both UNFPA and UNIFEM are focusing on improving maternal and child health and promoting reproductive health for women and girls. Better coordination between these two organizations could improve and facilitate the transition to the scale-up of prevention of vertical transmission.

RECOMMENDATIONS

The following recommendations aim to improve the quality, scale and scope of prevention of vertical transmission services in Morocco:

- UNAIDS and WHO should identify and document best practices from low-prevalence countries to provide guidance in developing and implementing prevention of vertical transmission programs in such settings.
- To date, the National AIDS Program (NAP) has been the only entity involved in prevention of vertical transmission. The engagement of other partners, both governmental and non-governmental, is essential to ensure effective scale-up. The NAP must develop partnerships with:
 - the MoH's maternal and child health³¹ sector, because antenatal services play a crucial role in the delivery of prevention of vertical transmission;

³⁰ Morocco has been awarded two HIV/AIDS grants to date, in Rounds 1 and 6.

³¹ Santé Maternelle et Infantile (SMI)

- other departments and ministries of a social nature³²; and
- civil society.
- Partners involved in the existing prevention programs targeting women and young girls (the MoH, global agencies, civil society) must evaluate such programs in terms of addressing prevention of vertical transmission issues. An important goal would be to increase the programs' capacity and ability to generate testing demand among pregnant women. The MoH must take the lead in this evaluation.
- The MoH, in partnership with civil society and other government agencies, should develop a clear strategy to scale up IEC about prevention of vertical transmission for women of reproductive age.
- The MoH must conduct research in the frame of the pilot prevention of vertical transmission program to identify a reliable list of potential HIV risk factors for pregnant women.
- The provision of prevention of vertical transmission services requires an integrated approach as part of a package of services offered to pregnant women. The MoH's mother and child health clinics must include HIV testing and counselling for their clients.
- The MoH and civil society must improve understanding and awareness of vertical transmission among obstetricians and gynaecologists in the private sector. This would help promote HIV counselling and increase pregnant women's demand for testing.
- Morocco's family planning program has been relatively successful in birth control. It should be systematically used to educate women of reproductive age about vertical transmission, and about the benefits of VCT for high risk women who are planning to have children in the future.
- Specific materials (posters, brochures and other information materials) must be developed by the MoH and civil society for women and couples. At the same time, specialized materials of a similar nature should be developed for health workers in order to promote prevention of vertical transmission.
- NGOs involved in HIV testing must engage in research to explore the possibility of providing counselling and testing to pregnant women through their existing network of centres, especially in areas where MoH-supported prevention of vertical transmission services are not available.

32 Including, for example, the Ministry of National Education, the Ministry of Youth and Sports, the Ministry of Social Development Family and Solidarity, and the National Initiative for Human Development (INDH).

- A national strategy to combat HIV-related stigma must be developed and implemented in partnership between the MoH and civil society. This strategy must target the general public as well as health care providers.
 - The MoH, medical professionals and civil society must collaborate to provide training to personnel at all health care facilities, and not only those involved in prevention of vertical transmission, on HIV awareness and care, ethics, confidentiality, and stigma. The training should also focus on increasing knowledge about specific concerns in prevention of vertical transmission such as safe delivery techniques and ARV prophylaxis.
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