

Morocco: a national AIDS response

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Highlights



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Morocco: a national AIDS response

UNAIDS Best Practice



Questions to ask.



Points to note.



Information to carry.

You wish to read more information?

This publication gives a brief overview of the national response to AIDS in Morocco. Many other useful information materials can be accessed on the UNAIDS website at <http://www.unaids.org/DocOrder/OrderForm.aspx?doctype=cp>

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Overview

The Moroccan AIDS response gave rise to the National Strategic Plan, which now serves as a reference throughout Africa. The National Strategic Plan has contributed to keeping the national seroprevalence at a low level. In a population of 32 million, prevalence of 0.1% among pregnant women¹ has been found and an aggregate number of 1878 cases of AIDS were declared at the end of 2005.

The first case of AIDS was registered in Morocco in 1986. By 1988, the National AIDS Control Programme had been organized to provide a structure for the response to the disease. The mechanisms that were adopted were designed to:

- understand and monitor the spread of the disease;
- inform and protect the population; and
- provide treatment for people living with HIV.

The success of the National Strategic Plan can be traced to the level of commitment shown, from the involvement of His Majesty Mohammed VI, the King of Morocco, to the Government, and in particular the Ministry of Health, which has been successful in involving the Ministry of Habous (religious property) and of Islamic Affairs, the Ministry of Justice, the Ministry of National Education, the Ministry of Communication and the State Secretariat for Youth.

Nongovernmental organizations have also played an important role, whether specialized or not, and despite limited resources. Their determination is an example of the good practice that has led Morocco to be an example to others in their response to HIV.

In April 2000, the National AIDS Control Programme started defining the 2002–2005 National Strategic Plan, which formed part of a “project to reduce vulnerability to HIV in Morocco” undertaken with the support of UNAIDS. The plan involved six ministries and 20 nongovernmental organizations, four of them specialized in HIV. The rationale for its development was participation, decentralization, and a multi-disciplinary and multicultural approach.

This document outlines the process of development and the key elements of the plan:

- sentinel surveillance of HIV;
- syndromic case management of sexually transmitted infections;
- social communication in respect to HIV;
- confidential voluntary HIV counselling and testing; and
- case management.

¹ UNAIDS (2006). Report on the global AIDS epidemic. Geneva.

I. A harmonized national strategy

In 1988, the objectives of the first National AIDS Control Plan were to evaluate transmission and prevalence of sexually transmitted infections and HIV, to monitor trends, and to determine which populations at higher risk of exposure were to be assigned priority to determine the measures to be adopted. The National AIDS Control Programme set out the main actions to be undertaken in an initial short-term plan for 1989 and in two medium-term plans for 1991–1995 and for 1996–2000. The Ministry of Health was responsible for implementing these plans, in collaboration with its governmental and nongovernmental partners.

Actions carried out under the initial short-term plan included:

- the introduction of an epidemiological surveillance system;
- monitoring of blood safety; and
- an information, education and communication programme involving several ministries, including National Education, Youth and Sports, and Justice.

These actions provided the National AIDS Control Programme partners with experience and knowledge, which made it possible to develop a strategic national AIDS control plan.

The National Strategic Plan sets both quantitative and qualitative objectives in terms of prevention and reduction of the impact of HIV. It identifies populations likely to be exposed to HIV and priority geographic regions on which actions are focused, and defines the essential actions to be undertaken.

The Plan has an overall strategy that sets objectives in terms of:

- quality assurance and efficacy for the essential activities;
- greater coverage for groups at risk of exposure to HIV;
- advocacy to reduce political obstacles to HIV control;
- social mobilization to overcome social and cultural obstacles; and
- mobilization and assignment of financial resources to ensure the sustainability of the plan.

Specific operational strategies include:

- faster and easier access to drugs;
- the development of free, anonymous testing centres and of outpatient treatment centres;
- enhanced detection and treatment of sexually transmitted infections;
- improved epidemiological surveillance; and
- reduction of accidental exposure to HIV in medical environments.

The budget of US\$ 20 million assigned to the National Strategic Plan was based on itemized activities for a five-year period and on the unit cost of each action or product.



Development of the National Strategic Plan (2002–2005)

A steering committee was charged with monitoring the four different phases of the National Strategic Plan. Monitoring was carried out in accordance with the methods recommended by UNAIDS and with the assistance of a consultant provided by UNAIDS.

The Plan was the outcome of a concerted effort involving some 250 persons (national and local officials, facilitators from the civil service and nongovernmental organizations) in a participative process. The development process gave priority to the pooling of information and expertise, helping to ensure the reliability, legitimacy and sustainability of the activities under the Plan.

Initial phase

A committee was set up to analyse the initial situation and current response to draw up an inventory of needs. The committee (made up of officials from the National AIDS Control Programme and representatives of nongovernmental organizations and other sectors) was assisted by national consultants and facilitators.

The situation analysis adopted three lines of investigation: an epidemiological analysis; two qualitative socio-anthropological studies; and an analysis of economic and demographic data. The social and behavioural data were collected through two qualitative surveys carried out in Agadir and Tangiers, across various populations at risk of exposure to HIV, and in particular youth, hotel employees, women workers and prisoners. People living with HIV were also surveyed. Individual interviews were held with people to whom access is often described as difficult, such as sex workers, injecting drug users and clandestine migrants.

The data collected were analysed from three viewpoints: the sexual concerns and expectations of the groups studied; drug and alcohol consumption; and knowledge, attitudes and practices in respect to sexually transmitted infections and HIV.

Second phase

This phase consisted of summarizing results from the situation analysis and the analysis of the current response by all those involved in developing the National Strategic Plan, through regional workshops organized around the following topics:

- analysis of the initial situation on the basis of epidemiological and socio-anthropological data relating to HIV infection in the home and the consequences of the disease on individuals, families, communities and wider society;
- analysis of factors determining likelihood of exposure to HIV;
- analysis of the current response to HIV;
- obstacles to carrying out essential activities;
- identification of activities that may overcome those obstacles;
- drafting a basic data sheet; and
- mapping the presence of operators at each service site.

Third phase

During this phase, the objectives, priorities and strategic activities of the National Strategic Plan were determined.

Fourth phase

In the last phase, a consensus workshop was charged with ensuring the support of all the stakeholders for the objectives and to make new recommendations. By creating a consensus, it was possible to draw up the National Strategic Plan document and to have the plan adopted by participants. Finally, the National AIDS Control Programme distributed the Plan to all stakeholders in the project prior to its definitive adoption in November 2001.

Implementing the National Strategic Plan

The National AIDS Control Programme (part of the Ministry of Health) is responsible for the direction, supervision and evaluation of the implementation and follow-up of the National Strategic Plan. The primary tasks of the Sexually Transmitted Infection/AIDS Department, also within the Ministry of Health, are to monitor and coordinate all the activities carried out under the National Strategic Plan. This department continually seeks to involve all partners in the implementation of different preventive actions and provision of treatment.

UN support

The UNAIDS Theme Group, which is supported by the UNAIDS funds and programmes, was established in 1999 and played an active role in developing the current National Strategic Plan. The Theme Group advocated a consistent approach based on implementation of the “Three Ones” principles. The UNAIDS office in Morocco was established in 2001 and is headed by a UNAIDS Country Coordinator. The office provides regular assistance both to the implementation of the National Strategic Plan and to coordination of the efforts of UN system organizations in support of the HIV response in Morocco.

Under the chairmanship first of WHO and then of UNFPA, and with the support of the national UNAIDS office, UNAIDS Theme Group efforts have focused on strengthening partnerships and on support both for monitoring and evaluation capacities, and for management of strategic information. This enabled the Theme Group to:

- assist in the elaboration of the National Strategic Plans for 2002–2004 and for 2004–2006;
- prepare a UN Implementation Support Plan for the National Strategic Plan;
- help finalize Morocco’s proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the establishment of the Morocco Country Coordinating Mechanism;
- provide support for the activities of the different partners in the national response; and
- help organize national AIDS control days.

The 2004–2006 UN Implementation Support Plan on AIDS was drawn up with the participation of UNAIDS’ cosponsors and in close collaboration with the National AIDS Control Programme. The Support Plan focused UN assistance for the period 2004–2006 on five strategic areas:

- support for projects designed to reduce groups’ risk of exposure to HIV;
- help in implementing a social communication programme aimed at youth and women;
- assistance to update and develop voluntary HIV counselling and testing;
- support in order to improve access to antiretroviral drugs for people living with HIV;
- assistance in laboratory monitoring services for people living with HIV.

Global Fund to Fight AIDS, Tuberculosis and Malaria support

The Moroccan Country Coordinating Mechanism (CCM) of the Global Fund was set up in February 2002. It is chaired by the Director of Epidemiology and Disease Control and includes representatives of the following sectors.

- Public sector: the Ministries of Health; National Education; Higher Education; Managerial Training and Scientific Research; Religious Property and Islamic Affairs; Communication; Justice; and the Secretariat of State for Youth.
- Private sector: National Council of the Medical Association and General Confederation of Moroccan Enterprises.
- Universities: Internal Medicine Service of the Rabat Ibn Sina and the Casablanca Ibn Rochd teaching hospitals.
- Civil society: thematic and other nongovernmental organizations.
- International partners: UN agencies and bilateral cooperation agencies.

The Moroccan Country Coordinating Mechanism can expand its membership to include other key partners. It coordinated and prepared Morocco's first application to the Global Fund within the framework of requesting support for the implementation of the National Strategic Plan. With the help of a management unit from the Global Fund's support programme and from ad hoc technical committees, the Country Coordinating Mechanism aims to ensure coordination of the implementation of the Global Fund's support programme. It also serves as a national AIDS control entity.

A management unit (set up to assist with the overall implementation of the programme) provides the secretariat for the Country Coordinating Mechanism. This unit ensures the circulation of information among the members of the Country Coordinating Mechanism, prepares meetings and writes and distributes reports of the meetings.

The Country Coordinating Mechanism has established three subcommittees responsible for developing certain areas more fully.

- The Information, Education and Communication subcommittee is responsible for validating the educational materials produced as part of the programme.
- The Monitoring and Evaluation subcommittee is responsible for preparing and carrying out the monitoring plan and for evaluating activities.
- The Case Management subcommittee, which is responsible for coordinating technical aspects of case management, scheduling drug requirements and drawing up distribution strategies.

These subcommittees meet as often as required and submit their work to the Country Coordinating Mechanism, which is responsible for final approval.

Financial support

The National Strategic Plan budget required for implementation is US\$ 20 million, shared between prevention (36%), impact reduction (33%) and related activities (31%). The Ministry of Health has been able to finance more than one quarter of this budget, providing between 2002 and 2004 some US\$ 5 million for implementation. Essentially, these funds make it possible to procure antiretrovirals, condoms, drugs to treat opportunistic infections, and reagents and laboratory equipment.

The United States Agency for International Development (USAID) provided support for the regional management project for health activities, especially in two priority regions, Souss-Massa-Drâa and Tangiers-Tétouan. Belgian technical support contributed to the greater Casablanca region with support for the Ibn Rochd University teaching hospital centre of excellence for case management of AIDS. French cooperation provided support for the case management departments at Casablanca Ibn Rochd University and Rabat Ibn Sina University teaching hospitals and at Agadir regional hospital in the form of training and equipment for health-care providers. As part of the Support Programme for the Regionalization and Decentralization of the Reproductive Health System (PADRESS), the German Agency for Technical Cooperation (GTZ) provided support in carrying out sexually transmitted infection/HIV prevention activities among youth in the regions of Al Hoceima, Taounate and Taza.

Morocco obtained funding from the Global Fund amounting to US\$ 9.23 million for the four-year period March 2003 to February 2007 (US\$ 4.73 million for March 2003 to March 2005 and US\$ 4.5 million for April 2005 to February 2007). This support was granted subject to the reservation that the activities scheduled for the first period were completed. Morocco is the only country in the Middle East and North Africa Region to have obtained funding after the Global Fund's first call for proposals in 2002.

In addition to receiving international support, the implementation of the National Strategic Plan has benefited from external support for national nongovernmental organizations. Of particular significance was the support given to the AIDS Control Association (ALCS) by the International Therapeutic Solidarity Fund (ITSF), which mobilized some US\$ 1 million during the period 1999–2002. The Fund's role was then taken over by the public interest group, Together in a Hospital Network of Solidarity in Care and Treatment.

In addition, partnerships have been developed with thematic nongovernmental organizations such as the Moroccan chapter of the Pan African Organization for the Fight against AIDS (OPALS), the Moroccan League for the Control of Sexually Transmitted Infections (LM-LMST), the Moroccan Association of Youth against AIDS and the Moroccan Association for Solidarity and Development, all of which play an active role in activities to raise awareness and contribute to the AIDS response.

II. Sentinel surveillance

Epidemiological surveillance in Morocco is based on three lines of action: notification of sexually transmitted infections, HIV infections and AIDS cases by clinical practitioners; surveillance of blood for transfusions; and sentinel surveillance of HIV infection.

Sentinel surveillance was introduced in 1993, in accordance with protocols and recommendations from WHO. The first operational phase only observed patients consulting for a sexually transmissible infection in five sites chosen among Morocco's main towns, where provincial laboratories were equipped to carry out the ELISA test. These provincial laboratories were required to send positive sera to the National Institute of Hygiene for confirmation by Western Blot technique.

Due to low patient numbers at some sites, surveillance was limited to the three spring months (March–May) and included the principal health centres in the towns selected as HIV surveillance sites. It was then gradually extended to other groups and sites.

On the basis of WHO recommendations, the National AIDS Control Programme introduced second-generation HIV surveillance. This is based on the observation that the different sub-groups making up the population determine the dynamics of the HIV epidemic in a country.

In December 2002, a national workshop, organized with WHO support, strove to achieve consensus among partners regarding the strategy to be used to introduce this new form of surveillance. The workshop brought together representatives of central and regional entities, nongovernmental organizations and representatives of other sectors, in particular the central administration. It produced the following recommendations.

- The surveillance system already in operation should be strengthened to better adapt it to the epidemiological situation, and to transform it into a planning, monitoring and evaluation tool for the National AIDS Control Programme.
- The components of second-generation surveillance of HIV infection specific to epidemics that are at a low level or concentrated should be integrated.
- HIV seroprevalence among at-risk and gateway populations (populations that are part of the wider population but engage in sexual relations with members of populations likely to have been exposed to HIV) should be monitored.
- Surveillance of risk behaviour among risk groups including sex workers should be integrated.
- Nongovernmental organizations and other entities should be engaged in HIV surveillance.
- Behavioural surveillance studies should focus principally on young people.
- Confidentiality and ethics should be respected by all the components of the surveillance system.

As a result, from 2002, certain additional population groups at risk of exposure to HIV were incorporated into sentinel surveillance at a number of sites.

In 2004, sentinel surveillance was undertaken at 23 sites, four more than in 2002, and a total of 32 274 tests were carried out. Results showed that prevalence had remained stable among pregnant women since 2000 (0.10% in 2004, 0.13% in 2003 and 0.12% in 2002).

Strict rules have been introduced regarding observance of ethical standards by the epidemiological surveillance system to ensure respect for the rights of persons living with or affected by HIV.

III. Syndromic case management

Control of sexually transmitted infections is one of the main aims of the national strategy for preventing HIV infection. Accordingly,

for case management of sexually transmitted infections, the Ministry of Health has adopted the syndromic approach advocated by WHO.

Three flowcharts have been adopted for management of urethral discharge, genital ulceration, vaginal discharge and/or lower abdominal pain. Introduction of syndromic case management began in 1998 and was gradually generalized in stages to all health facilities in Morocco by 2000, with the following objectives:

- to improve the quality of case management of sexually transmitted infections; and
- to develop a core team of managers and trainers at the provincial level to permit decentralization of management of the sexually transmitted infection control programme.

The flowcharts proposed needed to be adapted to Moroccan circumstances and validated. Several studies were undertaken concerning:

- perception of symptoms by patients and their attitude when seeking treatment;
- common practices in case management of sexually transmitted infections;
- evaluation of quality of case management of sexually transmitted infections using measurement of two prevention indicators, P16 and P17².
- local prevalence/incidence of sexually transmitted infections, aetiology of sexually transmitted infection syndromes, validity of the flowcharts and their acceptability.

Monitoring and evaluation of the implementation of the syndromic approach relies on regular supervision and annual internal reviews. The vital elements for the success and sustainability of the syndromic approach include:

- training of managers and local trainers;
- regular contact between national programme officials and health-care providers in health facilities; and
- development and application of a regular monitoring and evaluation process.

The strengths worth noting include:

- use of flowcharts facilitates case management;
- satisfactory inclusion of the educational component; and
- constitution of dedicated teams at the regional level.

Difficulties in implementing this approach may include:

- reluctance to use the case management flowcharts; and
- poor case management of sexual partners.



The findings of the reviews led to the adoption of a number of corrective measures, including organizing training sessions for new recruits and inclusion of a module on syndromic case management of sexually transmitted infections in the medical training curriculum; improving

regional laboratories to enable them to carry out referral tests for patients in case of failure of syndromic case management; completing a reference form on sexual partners; and revision of the flowchart for vaginal discharge and lower abdominal pain.

² P16 corresponds to the number of patients consulting for sexually transmitted infections who are correctly examined and treated as a proportion of the total number of patients consulting. P17 corresponds to the number of sexually transmitted infection patients consulting who receive proper advice about the use of condoms and partner notification as a proportion of the total number of sexually transmitted infection patients consulting.

IV. Social communication

The national social communication strategy is part of the National Strategic Plan and funding for its implementation was included in Morocco's proposal to the Global Fund.

The National AIDS Control Programme partners established a multisectoral implementation committee that included representatives from the Ministry of Health,

thematic nongovernmental organizations and donors. The committee was entrusted with monitoring the organization and progress of the communication campaign. The campaign was built around four phases, each with its own messages, target audience and media. The strategy was designed to increase the intensity of the messages gradually, to consolidate their impact on the target populations.

→ *First phase: drawing attention to the existence of HIV and of preventive measures.*

The generic message for this first stage was, "Affrontons la réalité: le sida progresse au Maroc" ("Let's face up to it: AIDS is progressing in Morocco"). This message was presented in several radio and television spots and on posters. Different versions were produced to target men and women, as well as versions in different languages suited to Morocco's different regions.

→ *Second phase: how HIV is transmitted and explaining the means of prevention*

This phase began six weeks after the start of the campaign. Its objectives were to provide information on the routes of transmission and to make people aware of the means of prevention, without upsetting traditional beliefs. The generic message was, "Le sida existe dans notre pays, la prévention aussi" ("AIDS is here in Morocco; so are the means to prevent it").

This phase of the national AIDS control campaign was innovative in many respects, because for the first time in Morocco, the Maghreb, and the Arab world, the mass media displayed images of male condoms outside of family planning campaigns. To enhance its impact, the campaign also used mobile displays in two caravans that criss-crossed Morocco, covering more than 4000 km.

To validate the choice of message and image used in the first two phases of the campaign, a specialized firm organized pre-tests among representative samples of the population. These confirmed the appropriateness of the images and messages, and young people's needs for information on AIDS.

→ *Third phase: promotion of testing services and of case management of patients*

The generic message for the third phase of the campaign stressed solidarity, and the strong bonds between people living with HIV and their families, work teams and companions. This phase of the campaign involved the production of a television spot and two radio spots. In addition, a poster specially designed for display in hospitals aimed to improve the image of AIDS patients and people living with HIV among the different categories of health-care providers.

→ *Fourth phase: understanding and accepting people living with HIV*

This phase was built around the single slogan, "Faire le test, un premier pas vers un traitement efficace" ("Take the test, the first step towards effective treatment"). It aimed to promote free, anonymous testing services. This phase of the national communication campaign was associated with the presence of a testing centre in the region and made use of the main regional communication media.

V. Confidential voluntary HIV counselling and testing

The National Strategic Plan includes ambitious targets for anonymous testing to respond to the spread of HIV infection. While provision of testing was focused initially on populations at risk of exposure to HIV and in targeted areas, counselling and testing has now been extended to the entire population of Morocco and all regions of the country. This increase in coverage was especially important following the launch of the national communication campaign and more precisely after each AIDS-themed event or initiative.

Increasing the availability of testing beyond the initial priority populations and areas, while a step forward, was not without its problems. Offering the service to a larger part of the population implied that the capacity to deliver the service existed; this was not always true. From the outset, testing was performed by the health authorities. It very quickly became apparent that, to achieve the objectives, the geographical range of the testing would have to be extended to communities in outlying districts of big cities and occasionally to remote villages and regions, and to inaccessible places with few or poor links to health-care services. Only by undertaking concerted action with nongovernmental organizations was it possible to ensure greater field coverage and thus get closer to local communities. In addition to the health authorities, three nongovernmental organizations have been carrying out anonymous testing, namely ALCS, OPALS and LM-LMST. Overall, partnerships with nongovernmental organizations have been good, despite occasional problems.

Free, anonymous, information and testing centres

From the outset, ALCS has opted for the physical separation of free, anonymous, information and testing centres from public-sector health structures; a policy driven by the concern to preserve the anonymity of people seeking testing. This is because one of the criticisms of the testing arrangements in health centres, hospitals or clinics is that clients seeking testing mingle with other patients attending for different reasons. Moreover, ALCS has the resources to realize this segregation, which is not always the case for other nongovernmental organizations performing anonymous testing. ALCS currently has 14 free, anonymous, information and testing centres.

Mobile, free, anonymous, information and testing centres

ALCS has acquired buses and converted them into mobile testing centres. The principal objective is to ensure that as many Moroccans as possible get tested; outreach to rural areas is essential in view of the shortage of fixed centres that are confined to the biggest towns.

Outpatient treatment centres

To bring anonymous testing services closer to the population, OPALS has opted to integrate the activities of its outpatient treatment centres into facilities and structures administered by the health authorities. In such cases, OPALS is allocated premises to carry out its awareness-raising activities, treat sexually transmitted infections and perform HIV tests. Another solution, which consists of placing all or part of a health facility at the disposal

of OPALS, has been adopted in certain cities or urban areas. In places where its activities are integrated into a health facility administered by the Ministry of Health, the outpatient treatment centre's timetable must conform to official opening hours, which is already a constraint. In most of its outpatient treatment centres, OPALS actually prefers a system of consultation by appointment.

Testing centres run by LM-LMST

LM-LMST has only offered confidential voluntary counselling and testing since 2004 at two centres. Its activities are integrated into a health facility administered by the Ministry of Health, with the constraints that this entails. At both centres, LM-LMST has opted for a system of consultations by appointment.

VI. Case management

Although Morocco is a country in which HIV prevalence is low, development of high-quality case management for people living with HIV has been a priority from the very outset, along with prevention. In November 1997, a workshop was held by the Ministry of Health and the Communicable Disease Service on the case management of HIV infection. The decisions taken at the workshop were set out in a ministerial circular, which was subsequently updated in 2001 and again in 2004.

Case management of patients infected with HIV is under the supervision of the Ministry of Health. In addition to deciding that treatment should be free of charge, the Ministry set up and is still strengthening the services of clinical case-management services. Case management of HIV infection is currently organized into two zones, each of them around referring centres in the regional hospitals.

Casablanca Ibn Sina University teaching hospital

This has been the reference service for case management since 1988. Because it is located in a teaching hospital, the service has the benefit of better medical and laboratory services than those available in the provincial hospitals. It is the only communicable diseases service in Morocco to have ophthalmology, gynaecology, dermatology and dental clinics, as well as an endoscopy unit specializing in HIV case management. Currently, more than 70% of all AIDS patients receiving medical care in Morocco are managed at this facility.

Rabat Ibn Rochd University teaching hospital

The Medicine A service has become, in effect, a second centre of excellence. Despite their small numbers, several members formed a team to be involved in training sessions and in case management of people living with HIV, and to participate in all the actions carried out by the Ministry of Health.

VII. Antiretroviral therapy

In 1996, triple therapy (zidovudine, lamivudine and indinavir) cost 12 500 dirhams (US\$ 1562) per patient per month. At this price, antiretroviral therapy was unaffordable to most individuals and completely unfeasible at the public health level. In 2005, the same treatment regimen cost approximately 1100 dirhams (US\$ 137) per patient per month. This drop in price (which made antiretroviral multidrug therapy accessible) took place in three stages.

1. The antiretroviral drugs were purchased directly by the Ministry of Health from the manufacturing pharmaceutical companies to eliminate the mark-up charged by middlemen. Also, antiretroviral drugs were exempted from customs duties in 1997, due mainly to lobbying by the nongovernmental organization ALCS at the national level and particularly with parliament.
2. Morocco was the first country with low HIV prevalence to benefit from price reductions of antiretroviral drugs under the UNAIDS ACCESS programme.
3. Further cost reductions and generalized access to antiretroviral drugs have been made possible by access to generic drugs.

Financing antiretroviral treatment

In Morocco, people receiving antiretroviral therapy have never been expected to contribute to the cost of treatment, for fear that the contribution (which would naturally be very expensive) might lead to poor compliance with treatment. As early as 1999, the Ministry of Health assigned almost US\$ 500 000 from its budget for the exclusive purchase of antiretroviral drugs. This amount has been regularly increased since 2001 but is insufficient to cover the cost of multidrug therapy, so it has become necessary to identify complementary sources of funding.

In June 2002, Morocco's application for support for the implementation of the 2002–2004 National Strategic Plan was the only one in the entire Middle East and North Africa region to be approved on first examination in the first round by the Global Fund. As a result, Morocco was the first country with low prevalence to receive funding from the Global Fund, with a prevention component and a component for antiretroviral drug supply.

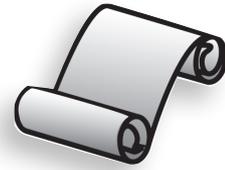
Among other sources of funding is the civil servants' mutual insurance society, which has covered treatment of its members since 1999. A total of 90 of its employees have been receiving multidrug therapy since this coverage was introduced. Four private companies also pay for their employees' antiretroviral treatment.

Therapeutic literacy

In January 2000, a therapeutic literacy programme was introduced in Morocco by ALCS. This is composed of teaching modules, provided at the centres of excellence by physicians and volunteers from ALCS.

During the sessions, the treatment schedules and calendars for taking each drug are drawn up in close cooperation with the patient, taking into account the constraints they are subject to and their habits. The trainer spends as much time as is necessary with each patient (usually between 90 minutes and two hours per session) for a total of eight sessions on average, to explain to them how best to look after themselves. The therapeutic literacy modules are taught by physicians and tutors, but also by people living with HIV, which has greatly enhanced the effectiveness of these sessions. Patients are more attentive to them because they are talking about something they have actually experienced.

Therapeutic literacy training is being systematically offered to all patients living with HIV. On the basis of this experience, a foundation has published a handbook to help introduce similar programmes in other countries.



Notes

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten United Nations agencies in a common effort to respond to the AIDS epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to AIDS on all fronts. UNAIDS works with a broad range of partners—governmental and nongovernmental, business, scientific and lay—to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

UNAIDS BEST PRACTICE COLLECTION

The UNAIDS Best Practice Collection:

- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the AIDS epidemic;
- is a UNAIDS interagency effort in partnership with other organizations and parties.

Find out more about the Best Practice Collection and other UNAIDS publications from www.unaids.org. Readers are encouraged to send their comments and suggestions to the UNAIDS secretariat care of the Best Practice Manager, UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland.

Morocco: a national AIDS response

Morocco is a country with a low-level AIDS epidemic. But this status has not been the result of chance; being successful in countering the potential spread of HIV has been due to the work of a number of different actors who have brought different skills and worked together sharing vision, taking action and sustaining it. This document is a brief summary of actions taken, problems encountered, and successful outcomes.

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