

Overcoming barriers for treating people who use drugs in an urban setting

Alan González, Alexandra Malm, Lucas Molfino, Carlota Silva • MSF Operational Centre Geneva

Reaching drug users in urban contexts is as much a challenge as it is a social and health requirement. In Maputo, the capital of Mozambique, Médecins Sans Frontières has developed a medical approach adapted to a population at high risk, stigmatised and criminalised.

In rapidly developing countries like Mozambique, unplanned urbanisation results in new social vulnerabilities and growing inequalities in access to healthcare¹. In some areas, violence and social exclusion create critical healthcare situations, which could be better addressed by local or international humanitarian organisations. With their own characteristics and challenges, such urban areas have long been a setting for humanitarian action, and humanitarian programmes need to be adapted accordingly.

Médecins Sans Frontières (MSF) has extensive experience in providing medical care in urban settings but faced considerable new challenges when starting a health programme for people who use drugs in Mafalala, a slum in Maputo, the capital of Mozambique. This entailed developing a new medical approach to address the broader needs of people who use drugs.

Healthcare for a marginalised population and a means to reduce transmission

Among vulnerable populations in urban settings, people who use drugs are particularly exposed to a range of severe health conditions. Those who inject drugs are among the most at risk of acquiring and/or transmitting HIV and HCV (hepatitis C virus), as well as co-infections such as tuberculosis (TB)². At the same time, they have limited access to healthcare and prevention or support services. The reasons are complex, but the fact that drug use is often stigmatised and criminalised is a major factor of exclusion.

Reducing transmission among people who use drugs is crucial in fighting the HIV epidemic in Mozambique. The spread of HIV/AIDS in Mafalala has so far been examined from a social perspective, emphasizing the role of young residents³. While epidemiological data is limited, existing information shows an alarming prevalence of HIV and hepatitis C among people who inject drugs in Maputo⁴. Analysis of patients treated at MSF's existing facility in the city⁵ showed

¹ Andersen J. E., Jenkins P, Nielsen M., "Who plans the African city? A case study of Maputo: Part 1 – the structural context", *International Development Planning Review*, 37(3): 2015, p.329-350.

² Ayesha B.M. Kharsany and Quarraisha A. Karim, "HIV Infection and AIDS in Sub-Saharan Africa: Current Status, Challenges and Opportunities", *Open AIDS Journal*, 2016; 10: p.34-48.

³ Paulo Margarida, *Sexuality and HIV/AIDS among young residents of Mafalala Barrio, Maputo, Mozambique*, 2003.

⁴ 46,3% HIV and 67,1% HCV prevalence among drug users in Maputo. Degenhardt L., Peacock A., Colledge S., Leung J., Grebely J., Vickerman P. *et al.*, "Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review", *Lancet Global Health*, 23 October 2017, 5(12):1192-1207.

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that people who use drugs constituted the majority of the patients co-infected with HIV and hepatitis C⁶. Consequently, MSF recently opened a new programme to provide comprehensive medical care for these people in the Mafalala slum.

There are many challenges and barriers to launching this kind of project, including the insecurity prevailing in urban slums, the difficulty in reaching people who use drugs, and the need for acceptance of innovative medical strategies by local authorities, the police, communities and the people who use drugs themselves. A new model of care was needed, with an outreach strategy tailored to a slum setting, offering services to a vulnerable population with very specific needs. This included the development and implementation of non-medical activities, including a holistic approach to harm reduction. Establishing the project within the community in Mafalala required partnering a local civil society organisation with previous experience in working with people who use drugs.

Specific considerations in an urban setting and with a criminalised population

People who use drugs are often concentrated in urban settings, in part due to the availability of illicit drugs⁷. This is the case in Mozambique, with Maputo being a significant heroin transit centre⁸. But there are other characteristics of urban settings that impact behaviour towards drug consumption, such as population density, residential segregation, unequal income distribution, social resources (networks and support), life stressors and psychological distress⁹. At the same time, authorities may use urban areas to advertise police and political action by targeting people who use drugs and have limited defences.

In Maputo, people who use drugs largely gather in slum neighbourhoods. These people are targeted by police and are pushed underground. In Mozambique, drug consumption is criminalised, and while not explicit, the law is widely interpreted in a way that criminalises carrying drug paraphernalia such as needles. People who inject drugs therefore share needles and syringes for fear of being arrested. So-called “doctors” rent needles and syringes to people who inject drugs, sometimes up to ten times per needle¹⁰. With a HIV prevalence of over 45% among people who inject drugs, this is an alarming practice. Mozambique’s current law against traffic and drug consumption¹¹ states that drug use is punishable by up to two years’ imprisonment and a corresponding fine, with a higher penalty if the person has already been sentenced in court for drug trafficking. The law is contributing to the exclusion of people who use drugs by preventing them from seeking healthcare. It makes people who inject drugs more vulnerable and marginalised, and results in further disease transmission. It is therefore detrimental in the battle against HIV, hepatitis C and TB.

⁵ Anne Loarec *et al.*, “Extremely low hepatitis C prevalence among HIV co-infected individuals in four countries in sub-Saharan Africa,” *AIDS*, Issue 33, February 2019, p.353-355.

⁶ Internal MSF medical data from its HIV project in Maputo.

⁷ Danielle Ompad and Crystal Fuller, “The Urban Environment, Drug Use and Health”, in Sandro Galea and David Vlahov, *Handbook of Urban Health: Populations, Methods, and Practice*, Springer, 2005, p.139.

⁸ Joseph Hanlon, “The Uberization of Mozambique’s Heroin Trade”, *LSE International Development working paper series* 2018, n°18-190, <http://www.lse.ac.uk/international-development/Assets/Documents/PDFs/Working-Papers/WP190.pdf>

⁹ Sandro Galea, Sasha Rudenstine and David Vlahov, “Drug use, misuse, and the urban environment,” *Drug and Alcohol Review*, Number 24, March 2005, p.127-136.

¹⁰ Internal MSF assessment 2018.

¹¹ Law n° 3/97, 13 March, Mozambique constitution.

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Reaching people who use drugs was therefore one of the main difficulties for MSF in launching its Mafalala project. The project requires an understanding, not only of the different hot spots and the complex underground environment, but also of how to access potential patients and how to gain their acceptance. As the slums are frequently targeted by the police, hard-to-find drug hot spots constantly change, thus requiring a network of key contacts to help continuously map the shifting dynamics.

Piloting a new model of community-based care

Given the specificities of the slum setting and the target population, an adapted model of care had to be considered, involving harm reduction measures carried out with the support of peer educators. Peer educators, including former and active drug users, are key to reaching this vulnerable community and their insights are essential in shaping effective programmes. Peers are the first entry point to medical care and are therefore responsible for outreach activities in the community¹².

However, there are limitations to working with peers. Firstly, it is a challenge to recruit peers, mainly because of the highly criminalised setting and the stigmatisation of people who use drugs in the community. Peers being often former drug users themselves, they can be at risk of relapse when exposed to hazardous environments, where drugs are readily available. Working with people who are actively using drugs is possible but not without challenges; specific codes of conduct need to be agreed and obtaining acceptance internally can take time.

Acceptance is also crucial for a project to be successfully implemented in a slum area. Piloting this model of care involves many steps to gain acceptance and leverage at community, local and national levels. Long and intense advocacy work to convince the relevant health and law enforcement authorities of the gains to public health preceded the launch of MSF's Mafalala project. Strategies have been put in place to raise awareness among the police, national and local health authorities, AIDS and civil society organisations, and the community in the area. It is important to explain why people who use drugs need free access to healthcare, including needle exchange programmes. We emphasize the fact that this would lead to reduced transmission of blood-borne diseases, ultimately benefiting the community at large. MSF has been working with the Mozambican Drug Prevention Agency, the National AIDS Council and the Ministry of Health to address key issues such as the implementation of needle and syringe programmes, as well as to produce harm reduction guidelines.

Community involvement is crucial to the success of a such programme. There is evidence¹³ that community outreach is effective in preventing HIV and hepatitis C amongst people who use drugs¹⁴, and that programmes are more effective when the affected population takes part in their development¹⁵. Specifically for people who use drugs, data suggests that outreach programmes are appropriate for reducing the risk of HIV and hepatitis transmission through: fewer opportunities to share injection paraphernalia, greater use of condoms, safer sex, and people injecting less

¹² Rhodes, Singer *et al.*, "The social structural production of HIV risk among injecting drug users", *Social Science & Medicine* 61, 2005.

¹³ Potts E., "Accountability and the right to the highest standard of health", *Colchester: University of Essex Human Rights Centre*, 2008.

¹⁴ World Health Organization, "Evidence for action: Effectiveness of community-based outreach in preventing HIV among injecting drug users", *WHO*, 2004, www.who.int/hiv/pub/idu/idu/en

¹⁵ Robert E. Booth *et al.*, "HIV incidence among people who inject drugs (PWID) in Ukraine: results from a clustered randomized trial," *Lancet HIV*, 3(10): October 2016, p.482-489.

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frequently¹⁶.

Using this strategy, MSF worked alongside the Mozambican civil society organisation UNIDOS, to open a drop-in centre for people who use drugs in Maputo's Mafalala slum. The centre opened in May 2018 with the aim of providing a first entry point to healthcare services, by creating a safe place for people who use drugs. At the centre, they have access to prevention services, such as free HIV and hepatitis testing and counselling, and TB screening. People in need of treatment are linked to medical care. The centre also provides harm reduction services such as a needle and syringe programmes. It is intended to be a place where people can feel safe, where they can come and rest, wash their clothes, brush their teeth and take a shower. It is a crucial link to healthcare for people who are otherwise largely excluded.

Since activities started in 2018, MSF has screened close to 800 people who use drugs for HIV and hepatitis infection, and over 150 for TB. MSF also introduced a new drug regimen for hepatitis C treatment, which allowed the first hepatitis C patients in Mozambique to be cured, including people who use drugs.

The drop-in centre is an important component of the strategy to reach these people, but another crucial element for success is to involve them in the actual planning and delivery of services. Peer educators work both in the community and at the drop-in centre. They go to the hot spots on a daily basis, and are a first point of contact.

To help overcome some of the daily obstacles mentioned above and to ensure accountability towards the community and the beneficiaries of the project, MSF engaged the local community in creating a steering committee, to improve communication. The steering committee comprises formal and informal community leaders, influential people in the slum and, above all, people who use drugs¹⁷. The committee acts as an advisory group for the management of the drop-in centre. It represents the community's perspective and addresses concerns, it relays recommendations and promotes public understanding of harm reduction interventions.

Modest activity, potentially high medical impact

The main aim of the programme in Mafalala is to help fight the HIV/TB epidemic and control hepatitis C transmission in Maputo, considering the extremely high prevalence of this disease especially amongst people who use drugs¹⁸.

Despite the challenges related to implementing harm reduction in Mozambique, current activities have demonstrated significant potential and clear public health benefits. MSF's experience in Mafalala shows that a progressive patient-centred model of care could be expanded nationally and be incorporated into national policies. Within MSF, this type of programme, if it proves successful, could be duplicated in other contexts, particularly as the organisation faces a growing need to intervene in urban settings.

Linkage to care and retention in care are still low, mainly because harm reduction is not yet fully

¹⁶ World Health Organization, "Evidence for action...", *op. cit.* See also Medley A., Kennedy C., O'Reilly K. *et al.*, "Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis", *AIDS Education and Prevention*, June 2009;21:181-206.

¹⁷ Medley A. *et al.*, "Effectiveness...", art. cit.

¹⁸ Lazarus J. V., Safreed-Harmon K. *et al.*, "The Micro-Elimination Approach to Eliminating Hepatitis C: Strategic and Operational Considerations", *Seminars in Liver Disease* 2018 Aug;38(3):181-192.

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implemented. As a next step, the aim is to pilot the implementation and decentralisation of the currently missing harm reduction components of opium substitution therapy and naloxone to treat overdoses. A further objective is to decentralise clinical services such as antiretroviral therapy and treatment for hepatitis C and TB to the drop-in centre. Much still remains to be achieved in Mozambique.

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Biographies

Carlota Silva • Biotechnologist, she holds a Master of Science in Clinical Tropical Microbiology, and joined MSF in 2004. Carlota is currently Deputy Head of Mission in Mozambique for MSF Operational Centre Geneva

Dr Lucas Molfino • MD, specialising in Internal Medicine, Lucas joined MSF in 2005 and is currently Head of Mission and Medical Coordinator in Mozambique for MSF Operational Centre Geneva.

Dr Alan González • MD, Alan González holds a Master of Science in International Public Health from the Liverpool School of Tropical Medicine, he joined MSF in 2009 and is currently Deputy Programme Manager at MSF Operational Centre Geneva.

Alexandra Malm • She holds a Master of Arts from the University of Exeter and initially joined MSF in 2013. Alexandra is currently Communications and Advocacy Advisor at MSF Operational Centre Geneva.

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