

Comunità di  
SANT'EGIDIO

# DREAM

Drug Resources Enhancement against AIDS and Malnutrition

Report no 3

May 2005



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## Activities and results

This report describes the activities and results of DREAM from its launch up until December 2004.

The expansion of the model in several African countries (table1) is one of the foremost, substantial innovations which should be recorded for the past year. Already operational on a nationwide level in Mozambique, DREAM also started to welcome patients in Malawi and Tanzania, while new centres and laboratories are in advanced stages of realisation in Guinea Conakry, Kenya and Guinea Bissau. Meanwhile, activities in Nigeria, Ivory Coast, Cameroon, Central African

Republic, Congo, Rwanda, Ethiopia, Eritrea and Angola, are at research and negotiating stages. At the same time, training of personnel coming from these countries continues, with international courses of a theoretical and practical nature. The last was held in February 2005: 160 doctors, nurses, laboratory technicians, biologists and campaigners from 10 African countries received training. It is estimated that through DREAM, around 20,000 patients are currently undergoing treatment and care in Africa. No less than 5,000 of this number are currently on HAART (Highly Active Antiretroviral Therapy).

With regard to Mozambique, it may be noted that:

To date, around 15,000 people accepted voluntary counselling and testing in the provinces of Maputo, Sofala, Gaza and Zambesia; there is a growth rate of 44.6% in 2004 (fig.2-3). The percei-



## DREAM program in Africa

*DREAM was launched in Mozambique in March 2002, after two years of groundwork. However, the idea for the project was born in 1998 when the Sant'Egidio Community (see the box) decided to fight the devastating impact of HIV/AIDS. Within the framework of the national health system, the DREAM program aims to introduce the essential components of an integrated strategy for the prevention and treatment of HIV/AIDS. The program is intended to*



*model for a wide-ranging scale-up of the response to epidemic. The main objective was achieved through the establishment of free-of-charge services providing diagnosis and comprehensive treatment. The prevention of HIV transmission in the general population and of mother-to-child transmission through Community Care and Home Care services (CCHC) and Mother and Child Prevention and Care (MCPC), respectively, are additional key components of the program.*

ved slowdown in growth in comparison to 2003 is actually due to the fact that some major centres stopped this service, following the wide expansion and development throughout the country of National Health Service centres dedicated to this task.

In fact it may be noted in tables 4-5 that the number of HIV-positive patients on treatment has increased in absolute terms in 2004 more than in 2003. In practice, the centres are currently receiving patients who have undergone testing and counselling elsewhere.

Statistics of patients currently started on antiretroviral therapy (HAART) reveal an even more noticeable growth rate (tables 6-7). In this case, the net increase on an annual basis was equal to 1167 units compared to 799 of the preceding year. Therefore in Mozambique, the total number of people under treatment and on prophylaxis or control of opportunistic infections is 8,991. From these, 4,001 are already on HAART. It's clear that in coming years, the absolute and relative increase of patients on antiretroviral treatment will be linked to new admissions. However, to a greater degree, growth will also be linked to HIV-positive patients already on the program, who for the moment are on prophylaxis treatment or on control of opportunistic infections. Therefore, it is not difficult to predict that the threshold of 10,000 people on HAART will be reached before the end of the next biennial 2005-2006.

As for the sector of prevention of vertical transmission and pregnant women (tables 8-9), the number of children born in the MCPC regime stood at 922 on 31/12/2004. The net increase was equal to 306 children that year, with a growth rate close to 100% compared to the former. The data of a sub-sample presented to the CROI Conference in Boston, 2005, is available above (table 11). It's clear that the cumulative incidence of HIV-positive children at 12 months was 5.5%, one of the lowest values reported in scientific literature in recent years. If only "on treatment" results are taken into account, that is, of women who have followed and completed the recommended protocol properly, then the rate of transmission to children drops to 1.9%. This gratifying result was reached in the context of a rate of protocol adherence and acceptance which ranks among the highest ever noted (tables 12-13). In practice, four out of five women completed the protocol, starting from the 25th week of pregnancy until the baby reached 12 months of age. Besides, infant-mortality and abortion rates were quite well contained (1.8% and 1.9% respectively) and less than overall national averages. Of great importance is the fact - as shown in table 12 - that more than 80% of women offered treatment completed the protocol, at least up to six months after delivery. This information assumes no mean significance from a public health viewpoint, since it reflects one of the fundamental parameters - of adherence or feasibility - together with effectiveness of the intervention itself.

The last two tables (13 -14) illustrate the work of molecular biology laboratories. It must be emphasized that this service caters not only for DREAM patients but also for government centers currently attending to HIV-positive patients. As may be observed, the number of processed blood samples has nearly reached the threshold of 35,000 and the monthly threshold of 3,000 analyzed samples has been surpassed. In particular, some 2,500 CD4 cell counts and a good 1200 viral loads are executed each month.

## Community of Sant'Egidio

*The Community of Sant' Egidio is a large Christian movement founded in Rome in the late 1960s.*

*Today it is a movement of lay people and has more than 50,000 members, dedicated to evangelization and charity, in Rome, Italy and in more than 70 countries throughout the world. Sant' Egidio's previous experience in*

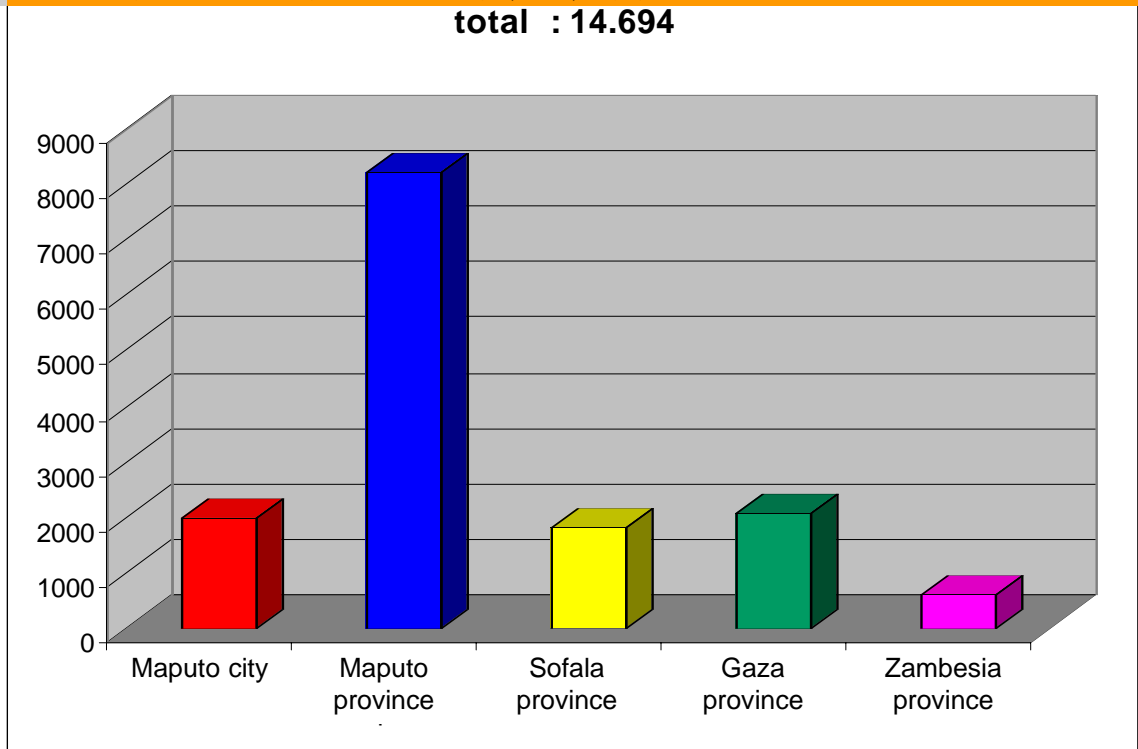


*dealing with deadly conflicts in Africa greatly helped in initiating the war against HIV. The community was the leading mediator in the peace process to end the civil war in Mozambique. An agreement to end that war was, in fact, signed at the Sant' Egidio headquarters in Rome following two and half years of intense negotiations.*

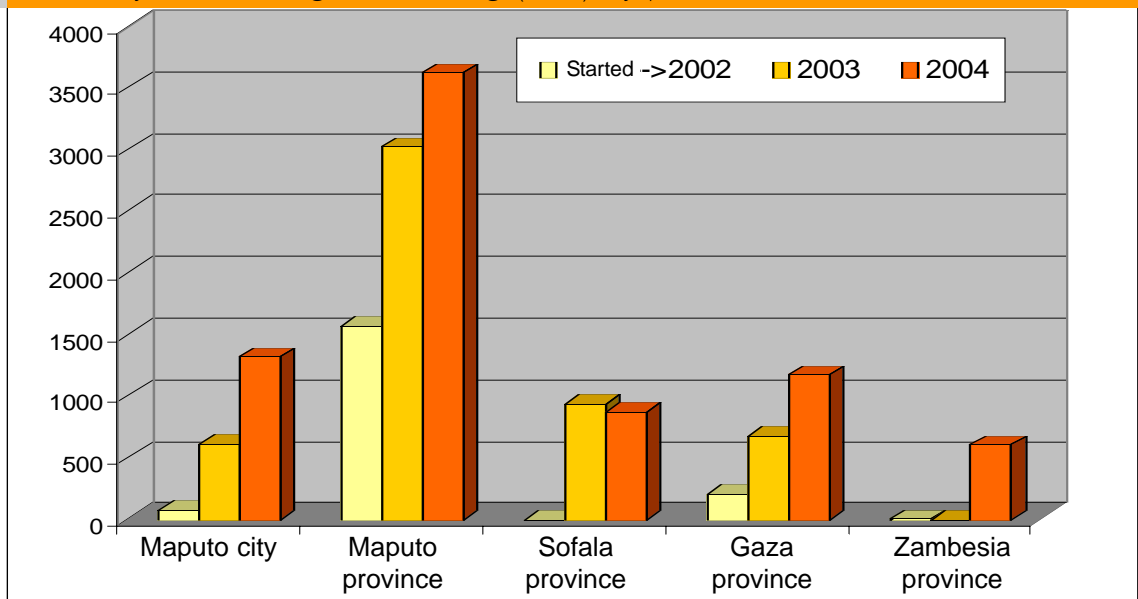
DREAM activity data

Activity data

Tab. 2 Voluntary counselling and testing (VCT) by province, at 21/12/2004

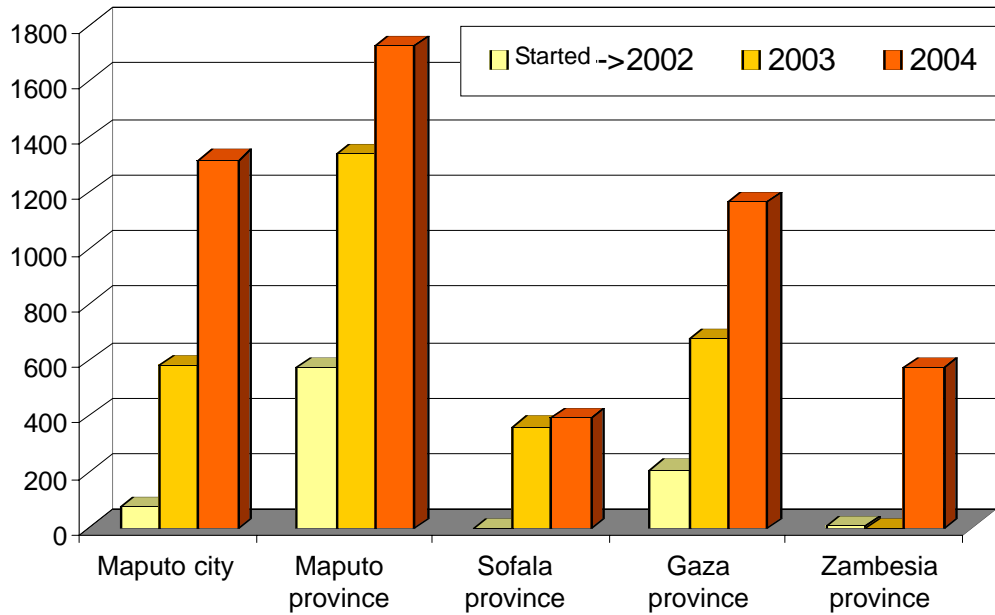


Tab.3 Voluntary Counselling and Testing (VCT) by province and time



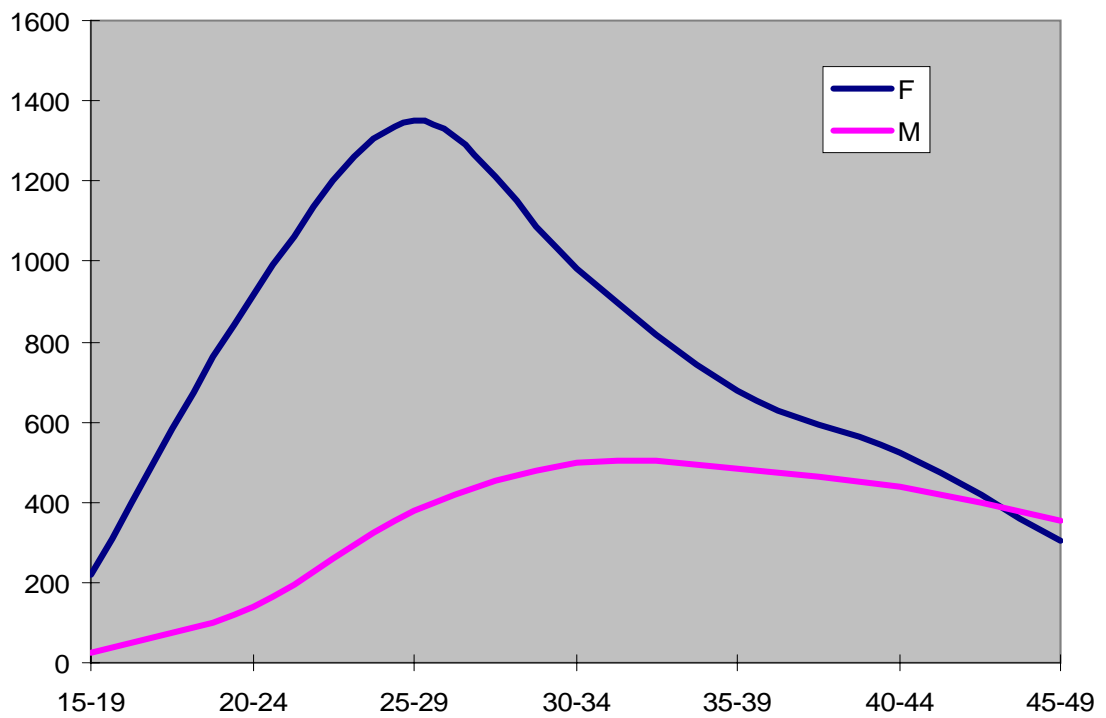
Annual Growth Rate 2003/2002:	181,4%	Difference:	3382
Annual Growth Rate 2004/2003:	44,6%		2338

Tab.4 Patients on treatment by province



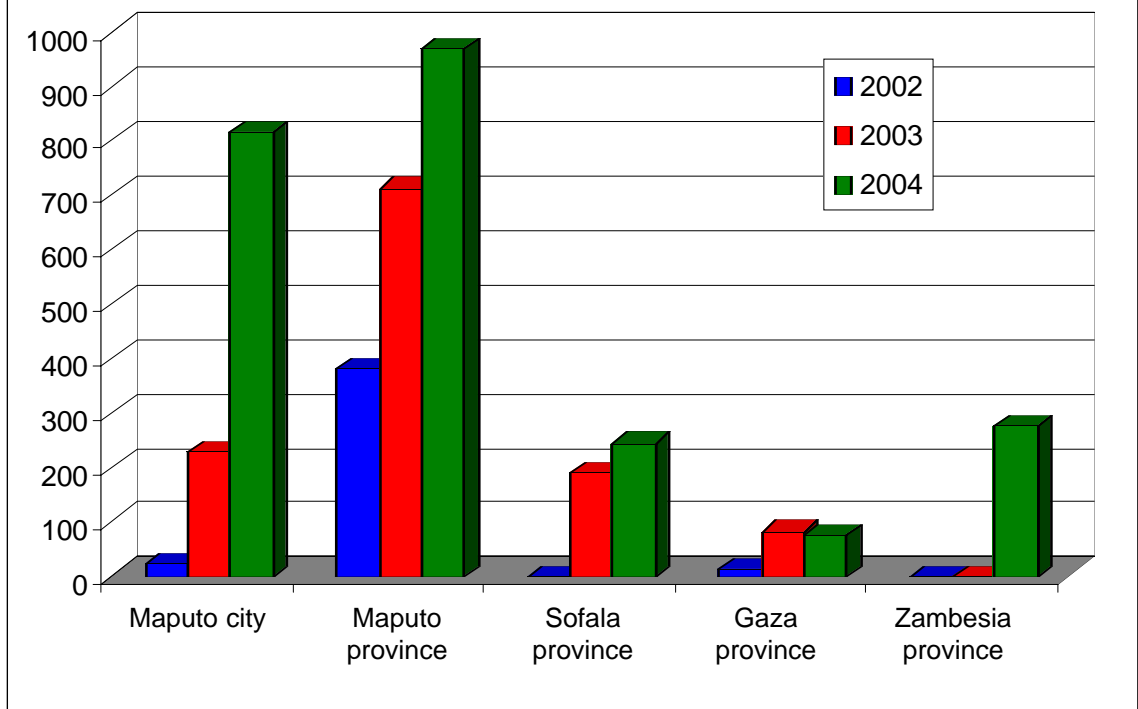
Total HIV+ on treatment from starting to 31/12/2004: 8991

Tab.5 Adults on HAART treatment by age and sex

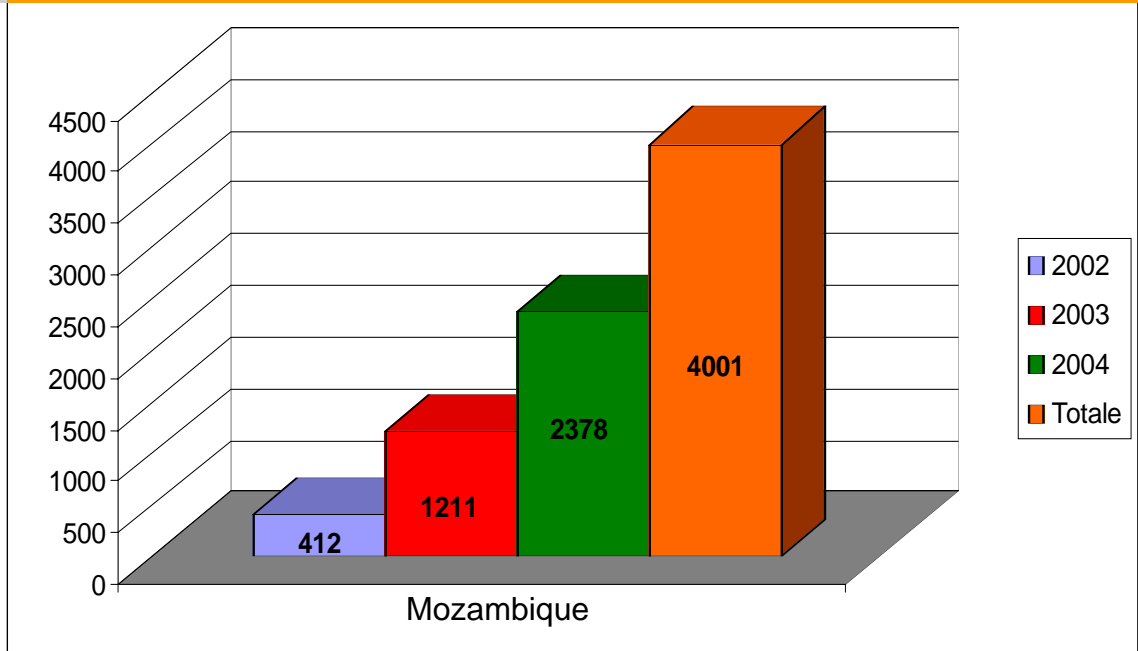


Annual Growth Rate 2003/2002:	243,9%	Difference:	2100
Annual Growth Rate 2004/2003:	74,6%		2208

Tab.6 Patients starting HAART treatment by province and year

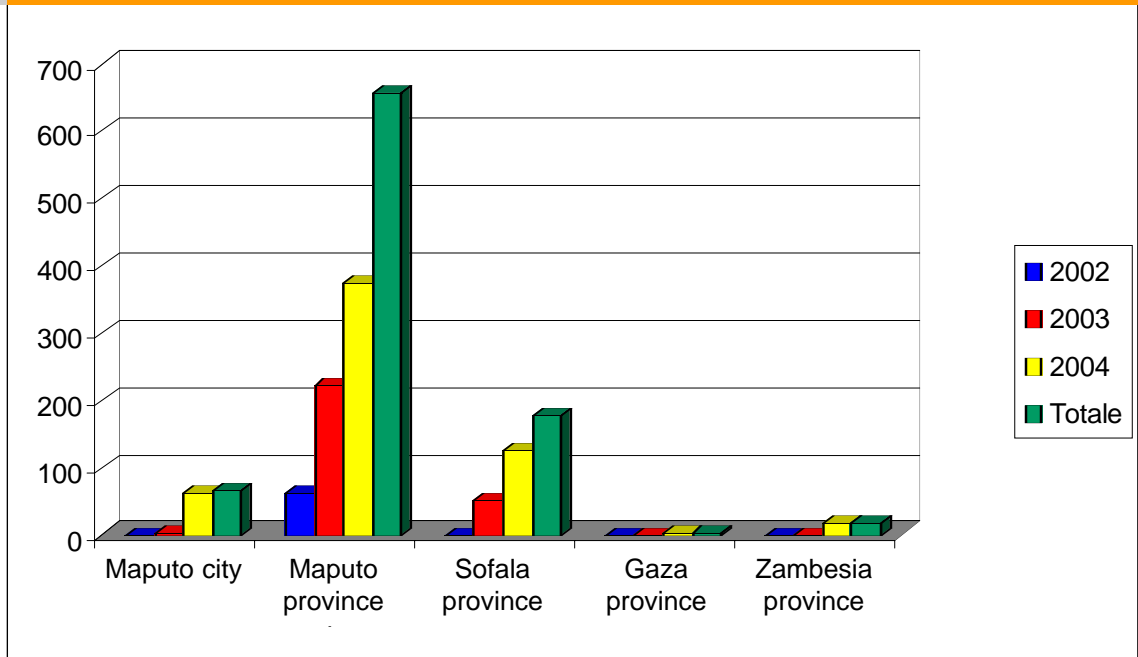


Tab.7 Patients starting HAART treatment by year

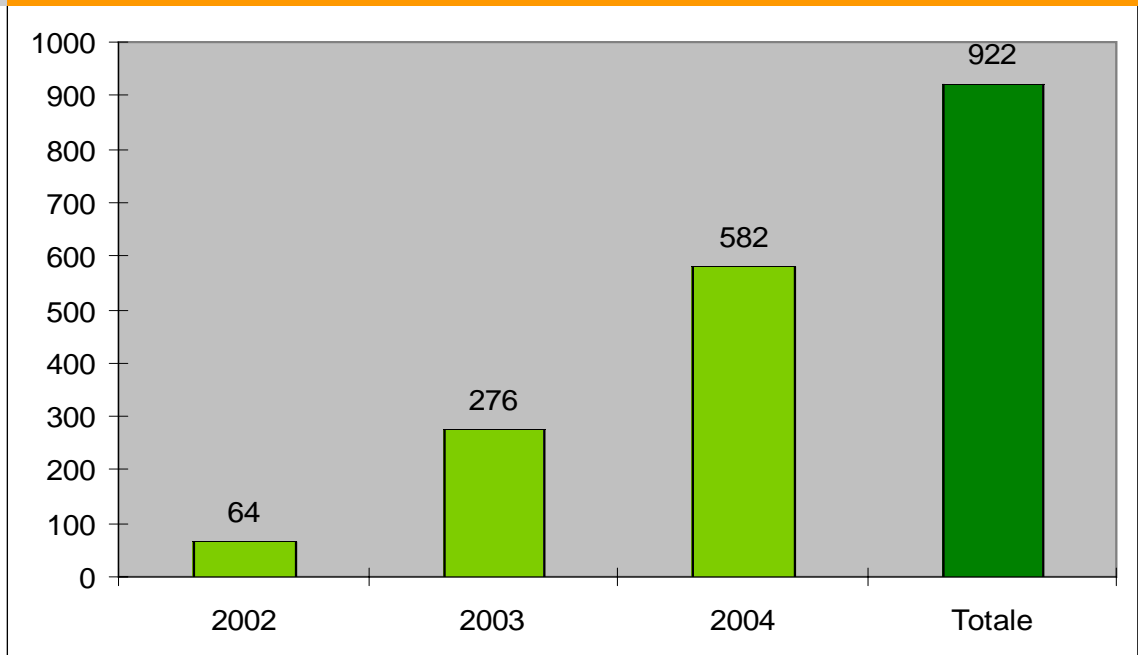


Annual Growth Rate 2003/2002:	193,9%	Difference:	799
Annual Growth Rate 2004/2003:	96,4%		1167

Tab.8 Children born in Mother & Child Prevention & Care (MCPC) by province



Tab.9 Children born in MCPC

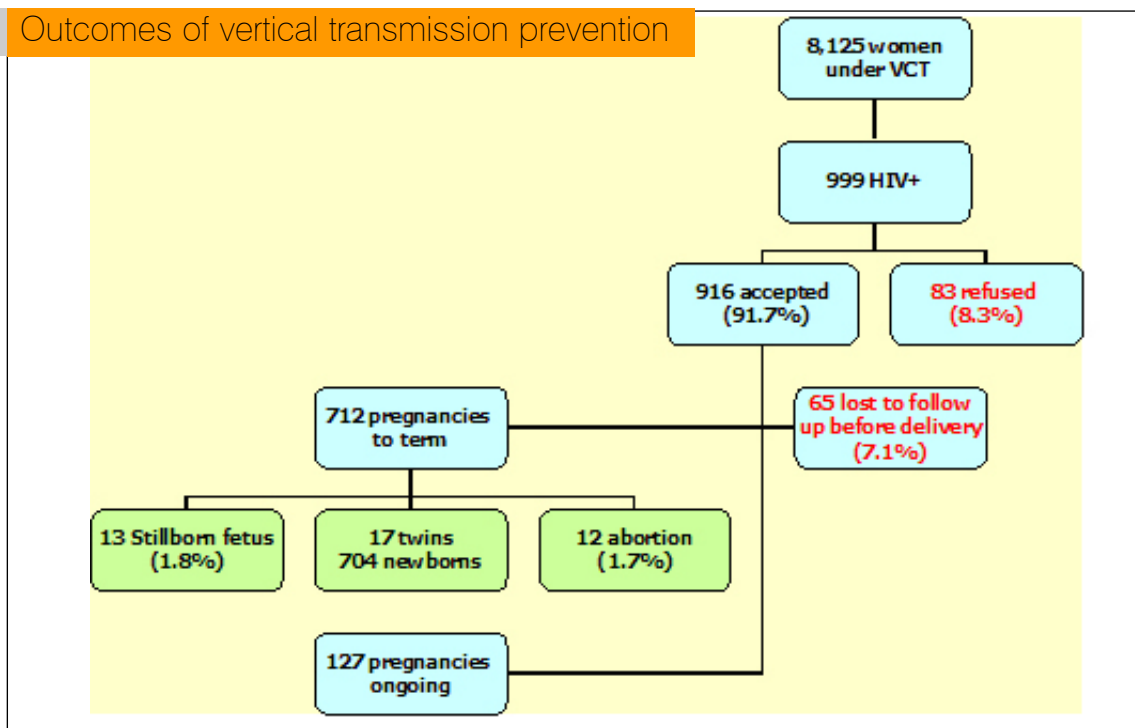


Annual Growth Rate 2003/2002:	331,3%	Difference:	212
Annual Growth Rate 2004/2003:	110,9%		306

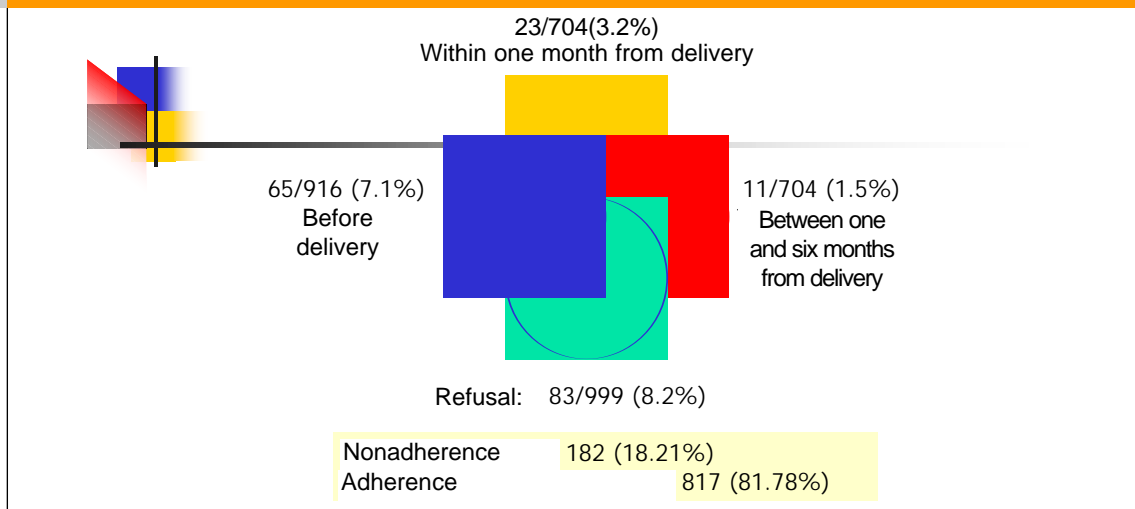
Tab.10 Outcomes of vertical transmission prevention

	No.(%) of HIV positive children		
	1 <sup>st</sup> Month	6 <sup>th</sup> Month	12 <sup>th</sup> month
Children tested	519	283	67
(ITT) Incidence rate	21(4.1%)	4 (1.4%)	0
Cumulative incidence rate	4.1%	5.5%	5.5%
On treatment Incidence rate	10 (1.9%)	0	0

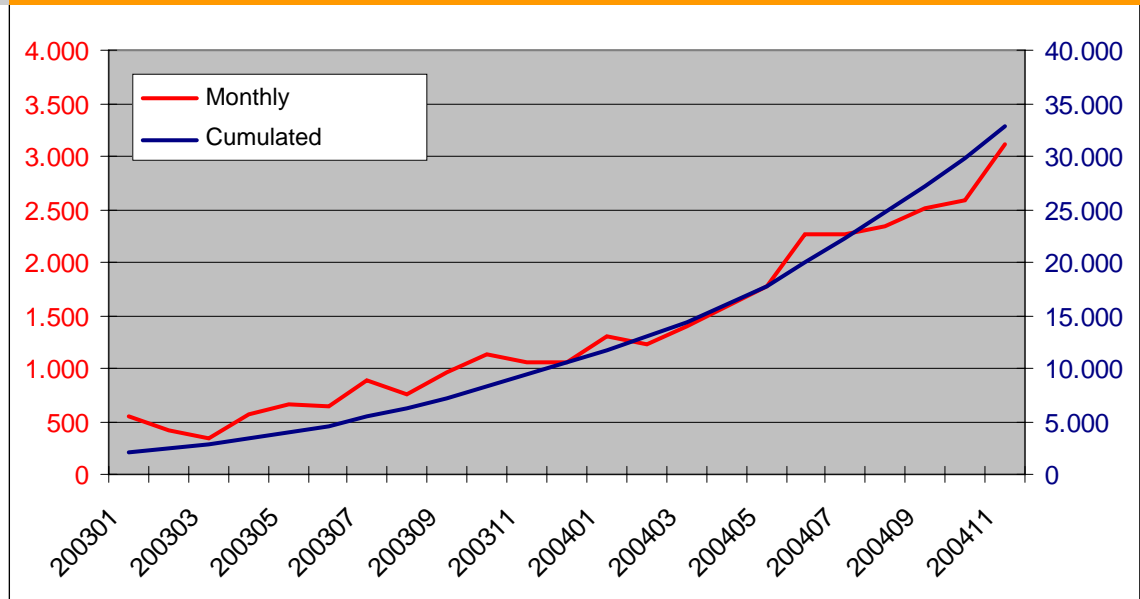
Tab.11 Outcomes of vertical transmission prevention



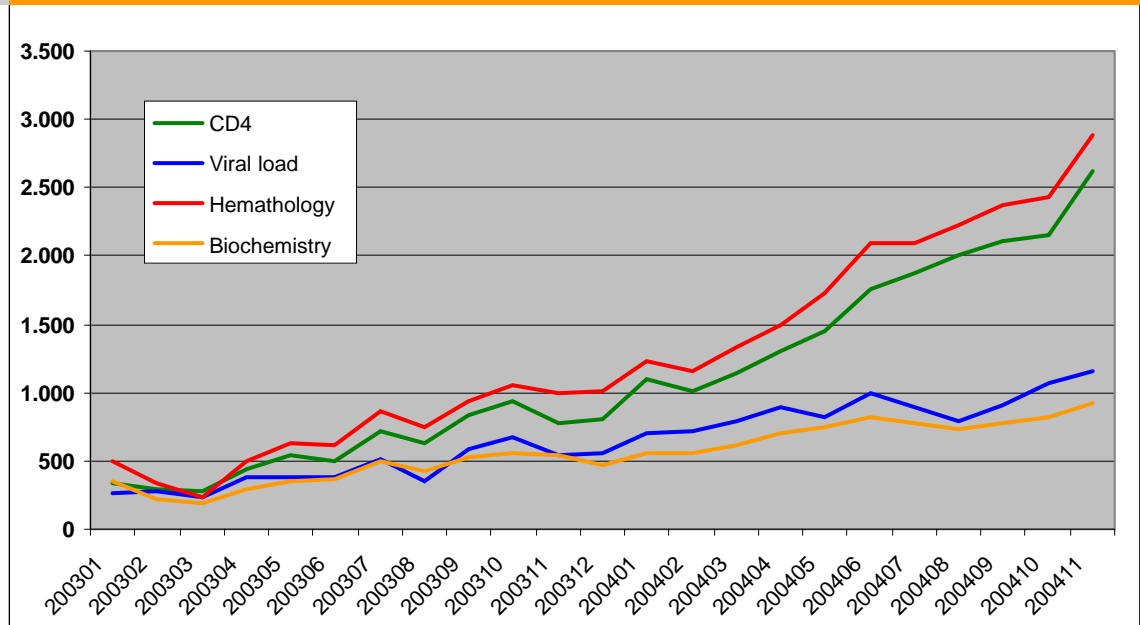
Tab.12 Refusal and abandonment rate



Tab.13 Processed blood samples per month and cumulate



Tab.14 Monthly processed samples by analysis



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