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REPORTS

A report on the Zimbabwe Antiretroviral Therapy (ART) programme progress towards achieving MGD6 target 6B: Achievement and challenges

*T APOLLO, *K TAKARINDA, *O MUGURUNGI, **C CHAKANYUKA, ***T SIMBINI, ****AD HARRIES

Abstract

Zimbabwe's target to achieve Universal Access to treatment for HIV and AIDS, was severely affected by a decade long economic recession that threatened to reverse all the country's social and economic indicators. Despite these challenges, by September 2010, 282,916 adults and children (47.7% of those in need of treatment) were on treatment at 509 sites countrywide since national scale up started.. ART services are predominantly offered through the public sector, with the private sector being an untapped potential resource for ART services for the future. Challenges of skilled and adequately trained human resources have hindered progress towards service availability. Providing access to children in particular has been constrained by lack of clinical mentorship for health workers, weak systems for support supervision, and inadequate HIV diagnostic services especially for children under 18 months and challenges with follow up of the HIV-exposed infants. Though the country has not met its target of Universal Access by 2010, significant progress has been made with over a 30- fold increase in service availability.

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Background

Zimbabwe is party to the Millennium Declaration signed by 189 countries in September 2000, which translated into eight Millennium Development Goals (MDGs) that focused on specific goals and targets for development and poverty alleviation.[1] Goal 6 seeks to combat HIV and AIDS, malaria and other diseases. Target 6B of this goal is to achieve, by 2010, universal access to treatment for HIV and AIDS to all those who need it. Universal Access is defined as coverage of at least 80% of the population in need.[2] Ten years on, the United Nations MDG Report of 2010[3] notes that encouraging trends have put many regions on track to achieve at least some of the goals. For universal access to antiretroviral therapy (ART), the number of people receiving ART globally increased ten fold from 400,000 to 4 million, between 2003 and 2008, corresponding to 42 percent of the 8.8 million people who needed treatment for HIV. At the end of 2009, 5.25 million people were reported to be on ART, which represents an increase of over 1.2 million since December 2008.[4]

For Zimbabwe, the period of September 2000 to 2008 was a period of severe social and economic challenges, and in particular negative economic growth threatened to reverse all social and economic development indicators. The aim of this study is to report on Zimbabwe's performance towards achieving universal access to treatment for HIV and AIDS during the period 2004 to 2010, performance being assessed by analysis of in-country reports, surveys and reviews. The baseline report is a review of the National HIV and AIDS Treatment and Care Programme for the period of 2004 to 2007, carried out by the Ministry of Health and Child Welfare and its partners.

Scale of ART services

The Ministry of Health and Child Welfare (MOHCW)

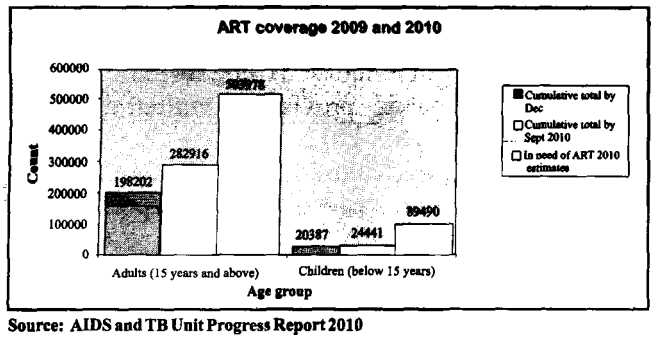
*AIDS and TB Unit
Ministry of Health and Child Welfare
Harare, Zimbabwe
**World Health Organisation
Harare, Zimbabwe
***Centre for Evaluation of Public Health Interventions
Department of Community Medicine
College of Health Sciences, University of Zimbabwe
Harare, Zimbabwe
****International Union Against Tuberculosis and Lung Disease
Paris, France and London School of Hygiene and Tropical Medicine
London, UK.

Correspondence to:

Dr T Apollo
AIDS and TB Unit
Ministry of Health and Child Welfare
P O Box Cy1122
Causeway, Harare
Zimbabwe
E-mail: tsitsiapollo@gmail.com

introduced the Opportunistic Infections and Antiretroviral Therapy (OI/ART) programme in April 2004. The programme aims to reduce morbidity and mortality due to HIV and AIDS. In 2004, there were an estimated 1.8 million people living with HIV of whom 340,000 were in need of ART. The number of ART initiating and follow-up sites increased from 5 in 2004 to 150 (in 55 out of a total of 62 districts) in 2007.[5] This number has further increased to 509 sites in all the districts of Zimbabwe by 2010. ART coverage reached 29% of the people in need by December 2007.[5] By the end of December 2009, 218,589 of a total of an estimated 501,564 adults and children in need of ART (43.6%) were on treatment.[6] Based on the revised World Health Organisation (WHO) guidelines an estimated 503,678 adults and 89,490 children were estimated to be in need of ART in 2010.[7] By September 2010, 258,475 adults (51% of the adults in need of ART) and 24,441 children (27.3% of the children in need of ART) are currently on treatment.[8] Figure 1 shows the number of adults and children on treatment relative to those in need of treatment.

Figure I: Cumulative ART coverage in 2009 and 2010 by age group.



Source: AIDS and TB Unit Progress Report 2010

ART provision models

The Ministry of Health has adopted two models for ART service provision. Stand-alone OI/ART clinics physically located from the main hospital have been established at central and provincial hospitals. At district and mission hospitals OI/ART services are integrated in the general outpatient departments. The MOHCW advocates for a family-centered approach to OI/ART service provision. There are varying degrees of implementation of this model.[5]

There is evidence of willingness and untapped capacity in the private sector in the delivery of ART. Currently, a frame-work for Public-Private Partnership is under development to guide private sector co-investment in the HIV and AIDS response.

Human Resources

According to the Human Resources Department report in December 2008 the vacancy levels in the public health sector were 69% for doctors, 80% for nursing midwives, 61% for environmental health technicians and 63% for medical school lecturers. In the short term the Ministry of Health and Child Welfare, in collaboration with its partners the Global Fund (GF) and the Expanded Support Program (ESP) for HIV and AIDS introduced incentive schemes to recruit and retain key personnel in selected districts, institutions, departments and offices in the health delivery system to support delivery of OI/ART services.[9] This short term scheme has since been harmonised to include all health workers accessing harmonises incentives.

Training

As part of the roll out of the ART programme and to enhance the OI/ART skills of the cadres in post, a cascade training approach was used, where a core national team of trainers were trained. They in turn supported the development of capacity for ART training in the provinces and districts. The latter in turn trained health workers in their localities. Standardized national OI/ART training guidelines have been developed for use in training health care workers in both the public and private sectors. More than 4,800 health care workers (doctors, nurses, clinical officers, pharmacists and pharmacy technicians) had been trained in OI/ART by December 2009.[10]

Drug Availability

The government declared lack of access to ART as an emergency in May 2002. Following the declaration, a legal framework was put in place to facilitate access to ART. Patent Laws were amended to allow for parallel importation and compulsory licensing of generic AIDS drugs. This led to a considerable increase in the availability of antiretroviral drugs (ARVs) with a number of generic formulations, being registered and imported. Domestic resources were successfully used to initiate the ART programme in 2004. The Government of Zimbabwe (GOZ) committed 50% of the National AIDS Trust Fund (NATF) to ARV procurement but severe weakening of the Zimbabwean dollar eroded the contribution. Although ARVs are provided free of charge to the end-user; costs related to HIV diagnostics and for patient monitoring remain prohibitive. The country has multiple supply chain systems for ARV procurement from the GF, ESP, Clinton Health Access Initiative, the United States Government, and from the AIDS Levy.

Discussion

Achievements

Despite a severe economic recession, and limited funding from donors in the period of 2000 to 2009, Zimbabwe has registered significant progress in scaling up ART services to those in need. Numerous factors have contributed to the delivery of ART services in Zimbabwe. These include: committed leadership, scaled and standardised training programmes, simplified treatment guidelines, structured accreditation and expansion of ART sites, and strong partnership and collaboration between the

MOHCW and its partners.

Challenges

Though Zimbabwe has made progress in the provision of ART surpassing its set annual targets, it has not yet achieved universal access. The challenges have included: limited financial resources to support the provision of comprehensive OI/ART services; significant vacancies of key human resources; weak public-private partnerships; and lack of competence and skills for Paediatric HIV/AIDS management. The provision of ART to children in particular has been significantly affected by non availability of clinical attachments/mentorship for health workers to gain practical skills and confidence in the provision of paediatric care, weak systems for support supervision, inadequate and untimely HIV diagnostic services especially for the children under 18 months and challenges with follow up of HIV-exposed infants.

Conclusion

Progress has been made towards achieving MDG 6, target 6B despite a decade of severe economic challenges. However gaps, especially in children, still exist in increasing access to services.

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