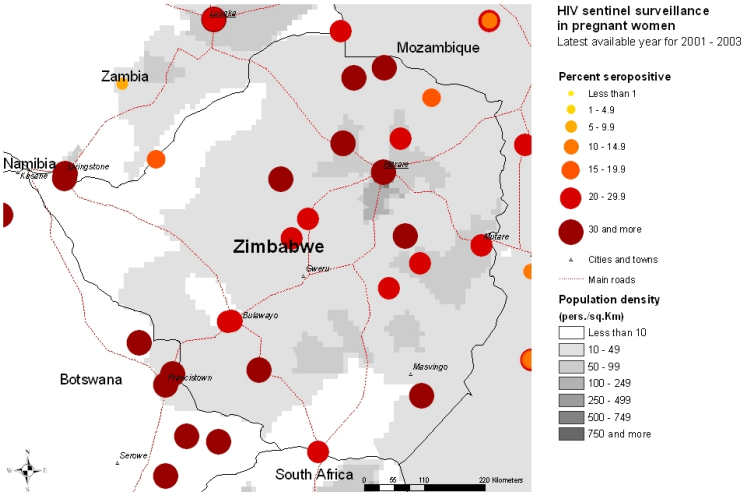
ZIMBABWE

December 2005

Estimated number of people needing antiretroviral therapy (0-49 years), 2005: 321 000*
Antiretroviral therapy target declared by country: 55 000 by the end of 2005



Map Data Source:
WHO/UNAIDS Epidemiological Fact Sheets and the United States Census Bureau
Map production:
Public Health Mapping & GIS
Communicable Diseases (CDS)
World Health Organization

World Health Organization

SUMMARY COUNTRY PROFILE FOR HIV/AIDS TREATMENT SCALE-UP

1. Demographic and socioeconomic data

	Date	Estimate	Source
Total population (millions)	2004	12.9	United Nations
Population in urban areas (%)	2005	35.8	United Nations
Life expectancy at birth (years)	2003	37	WHO
Gross domestic product per capita (US$)	2002	1 385	World Bank
Government budget spent on health care (%)	2002	12.2	WHO
Per capita expenditure on health (US$)	2002	118	WHO
Human Development Index	2003	0.505	UNDP

2. HIV indicators

	Date	Estimate	Source
Adult prevalence of HIV/AIDS (15-49 years)	2003	21.7 - 27.8%	WHO/UNAIDS
Estimated number of people living with HIV/AIDS (0-49 years)	2003	1 500 000 - 2 000 000	WHO/UNAIDS
Reported number of people receiving antiretroviral therapy (0-49 years), 2005	Nov 2005	23 000	Ministry of Health and Child Welfare
Estimated number of people needing antiretroviral therapy (0-49 years), 2005	Dec 2005	321 000*	WHO/UNAIDS
HIV testing and counselling sites: number of sites	Sep 2005	436	Ministry of Health and Child Welfare
HIV testing and counselling sites: number of people tested at all sites	May 2005	293 000	Ministry of Health and Child Welfare
Knowledge of HIV prevention methods (15-24 years)% - female°		NA	
Knowledge of HIV prevention methods (15-24 years)% - male°		NA	
Reported condom use at last higher risk sex (15-24 years)% - female°°	1999	42	DHS**
Reported condom use at last higher risk sex (15-24 years)% - male°°	1999	69	DHS**

°= Percentage of young people 15-24 years who correctly identify two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy looking person can transmit HIV.

°°=Percentage of young people 15-24 years reporting the use of a condom during sex with a non-regular partner in the last 12 months.

* The Ministry of Health and Child Welfare estimated that 342 000 people needed antiretroviral therapy in Zimbabwe at the end of 2004.
** Demographic And Health Surveys

3. Situation analysis

Epidemic level and trend and gender data
The first cases of AIDS in Zimbabwe were identified in the mid-1980s. Today the country is experiencing a generalized HIV epidemic, with an HIV prevalence in the adult population (15-49 years) of about 24.6%. Each day an estimated 564 adults and children become infected with HIV. The total number of adults and children living with HIV/AIDS is between 1.5 million and 2.0 million. About 50% of the people living with HIV/AIDS are infected during adolescence and young adulthood. At the end of 2003, an estimated 980 000 children younger than 17 years had lost one or both parents to HIV/AIDS. Women are disproportionately affected by HIV/AIDS, constituting 51% of the population and 53% of people living with HIV/AIDS in 2003. The estimated number of women living with HIV/AIDS has been higher than that for men since 1989, and the number of new infections among women has exceeded that among men since 1989. Recent data from the national surveillance system show a decline in HIV prevalence among pregnant women from 26% in 2002 to 21% in 2004. Changes in sexual behaviour appear to have contributed to the decline. However, infection rates in Zimbabwe continue to be among the highest in the world.

Major vulnerable and affected groups
The prevalence of HIV infection varies with place of residence. The most severely affected areas (with average HIV prevalence of about 35%) are large-scale commercial farms, administrative centres, high-growth areas outside cities and towns, state lands and mines. Urban areas have an average HIV prevalence of 28% versus about 21% in rural areas. Other groups severely affected by HIV/AIDS include women who engage in sex work, uniformed personnel and orphaned children.

Policy on HIV testing and treatment
HIV testing is provided within the context of voluntary testing and counselling, diagnostic testing (preventing mother-to-child transmission, opportunistic infections and antiretroviral therapy) and blood safety. Rapid tests are most frequently used, and other tests are used for quality assurance. The country has a comprehensive response to HIV, especially for care and treatment, which includes treatment for opportunistic infections; community and home-based care and support; and antiretroviral therapy. Guidelines on antiretroviral therapy have been developed and disseminated. Treatment is provided free of charge under the government's antiretroviral therapy programme, but coverage is limited and expansion has been limited due to a lack of funds. The government is committed to providing access to care and treatment to all people living with HIV/AIDS.

Antiretroviral therapy: first-line drug regimen, cost per person per year
Zimbabwe follows WHO-recommended treatment guidelines for antiretroviral therapy. The first-line regimen is stavudine + lamivudine + nevirapine. The average cost is about US$ 220 per person per year. There are two local manufacturers of generic antiretroviral drugs. All first-line and alternative generic drugs for antiretroviral therapy have been registered with the Medicines Control Authority of Zimbabwe.

Assessment of overall health sector reponse and capacity

In 1987, the government established the National AIDS Coordination Programme to lead the national response to the epidemic. A multisectoral National AIDS Council was established in 2000 including representation from the government, private sector, nongovernmental organizations, churches and people living with HIV/AIDS. The health sector response to HIV/AIDS in Zimbabwe is led by the National AIDS and Tuberculosis Programme within the Ministry of Health and Child Welfare. In 1999 the President launched the National AIDS Policy and National Strategic Framework, which formed the policy and operational base for responding to HIV/AIDS. Recent activities have included HIV/AIDS national policy development, the development and provision of voluntary counselling and testing and prevention of mother-to-child transmission services, promotion of comprehensive training and treatment protocols for sexually transmitted infections, HIV surveillance activities and overall HIV/AIDS coordination. In 2002, the government declared HIV/AIDS and the lack of antiretroviral therapy to be an emergency and committed funds to support the scaling up of antiretroviral therapy. The government intends to provide access to treatment to everyone in need. However, because of resource constraints, a phased approach has been adopted for scaling up antiretroviral therapy. Treatment guidelines and training materials have been developed. Antiretroviral therapy sites have been assessed and plans developed for building the capacity for delivering antiretroviral therapy services. Zimbabwe has a relatively organized health system with reasonable infrastructure. A fairly strong network of health facilities in both urban and rural areas serves as a ready platform for expansion. Tuberculosis clinics are already operating at many hospitals. Special opportunistic infection services are being set up at major health facilities. Services for preventing mother-to-child transmission are delivered at sites throughout the country. Laboratory facilities are being upgraded in line with agreed minimum standards. The National Microbiology Reference Laboratory at Harare Hospital is now equipped to perform viral load tests and plays a vital role in ensuring the quality control of supplies and reagents related to HIV/AIDS. Training activities are ongoing to equip health providers with skills to develop comprehensive HIV/AIDS care, including in testing and counselling, management of opportunistic infections, use of antiretroviral drugs, psychosocial support and nutritional support. Plans are underway to decentralize the provision of antiretroviral therapy services and reach out to rural communities. A comprehensive monitoring and evaluation system is being developed.

Critical issues and major challenges
Zimbabwe's health system is currently experiencing numerous difficulties due to the prevailing harsh economic conditions and reduced donor support, hindering the progress of the national response to the epidemic. The shortage of human resources is one of the major constraints, as trained health personnel continue to emigrate to other countries and a growing number of other health workers succumb to HIV/AIDS. Shortages of drugs and supplies comprise another major constraint essentially due to high and rising costs, the inadequate availability of foreign exchange reserves and fragmented procurement and distribution systems for drugs and supplies. Additional laboratory support (especially with regard to equipment and reagents) is required. The policy framework for expanding antiretroviral therapy services needs to be developed, including policies regarding payment of antiretroviral therapy services, social criteria for setting priorities among people receiving treatment in the public sector and workplace antiretroviral therapy programmes. Links between testing and counselling services and services for preventing mother-to-child transmission and antiretroviral therapy need to be strengthened. The treatment of children and training guidelines for this need to be developed. Stigma surrounding HIV and AIDS remains one of the biggest obstacles to the effective treatment and care of people infected and affected by HIV.

4. Resource requirements and funds committed for scaling up treatment and prevention in 2004-2005

• WHO estimates that between US$ 360 million and US$ 375 million was required to support scaling up antiretroviral therapy to reach the WHO "3 by 5" treatment target of 145 000 people by the end of 2005.
• In 1999, the Government of Zimbabwe introduced a levy to finance HIV/AIDS activities. Revenue from the National HIV/AIDS Levy (3% of all taxable income) goes into the National AIDS Trust Fund, which is managed by the National AIDS Council. The National AIDS Council and its district structures disburse the funds directly to beneficiaries. Following the declaration of the lack of access to HIV/AIDS treatment as an emergency in June 2002, the government together with the National AIDS Council set aside approximately US$ 700 000 in 2003 and US$ 2.9 million in 2004 solely for the procurement of antiretroviral drugs. The Ministry of Finance has also put in place a facility to provide up to US$ 1 million per month to the Ministry of Health and Child Welfare for the purchase of antiretroviral drugs.
• Zimbabwe submitted a successful Round 1 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria for total funding of US$ 14.1 million and two-year approved funding of US$ 10.3 million to support the national response to HIV/AIDS. The grant agreement was signed in May 2005, and as of November 2005, US$ 4.3 million had been disbursed for implementation of activities. Zimbabwe also submitted a successful Round 5 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria with a total funding request of US$ 62.4 million and two-year approved funding of US$ 35.9 million. The focus of the proposal is to support a decentralized roll-out of antiretroviral therapy services in the country.
• Some multilateral and bilateral partners also provide support to HIV/AIDS programmes in Zimbabwe, including United Nations agencies, the United States Agency for International Development and the European Union.

5. Treatment and prevention coverage

• In 2003, WHO and UNAIDS estimated Zimbabwe's total treatment need to be 290 000 people, and the WHO "3 by 5" treatment target was calculated at 145 000 (based on 50% of estimated need). In 2005, WHO and UNAIDS estimated that Zimbabwe's total treatment need had risen to 321 000 people.
• The government declared a national treatment target of 55 000 people by the end of 2005.
• The number of centres providing antiretroviral therapy increased progressively from 5 in June 2004 to 48 in September 2005, covering 32 of 60 districts. As of June 2004, an estimated 6000 people were receiving antiretroviral therapy, of which most were catered for by private practitioners and largely via their own means. Provision of antiretroviral therapy through the public sector has expanded since then. As of March 2005, 12 000 people were reported to be receiving antiretroviral therapy. This expanded to 15 000 people in May 2005, and 23 000 people receiving antiretroviral therapy by November 2005, of which close to 15 000 were receiving treatment through public facilities. Treatment is also provided through operational research projects such as Development of Antiretroviral Therapy in Africa and the Zimbabwe AIDS Prevention Programme. Both are concentrated in urban areas. Rural faith-based organizations are also providing treatment. The United States Agency for International Development is supporting three antiretroviral therapy delivery sites: one private sector, one mission hospital and one local authority, using branded drugs. The government has developed a plan to decentralize the provision of antiretroviral therapy to district and mission hospitals across the country.
• As of September 2005, every health district had at least one site providing voluntary counselling and testing services and one providing services for prevention of mother-to-child transmission. The number of sites providing voluntary counselling and testing services is increasing gradually, from 292 at the end of 2004 to 436 in September 2005. The number of sites providing services for mother-to-child transmission is also increasing gradually, with 1346 centres as of September 2005.
• The Global Fund Round 5 proposal aims to provide testing and counselling services to close to 1 million people and antiretroviral therapy services to 700 000 people living with HIV/AIDS by the end of the third year of implementation of activities.

6. Implementation partners involved in scaling up treatment and prevention

Leadership and management
There is strong political commitment to address HIV/AIDS and expand antiretroviral therapy provision in Zimbabwe. The National AIDS Council was created by Parliament and charged with the responsibility for overall multisectoral coordination of the response to HIV/AIDS in Zimbabwe. The National AIDS Council is also responsible for allocating resources for HIV/AIDS. It manages funds from the National HIV/AIDS Levy and is the principal recipient of the grant for HIV/AIDS of the Global Fund. The AIDS and Tuberculosis Unit of the Ministry of Health and Child Welfare is the lead implementing body in scaling up the health sector response to HIV/AIDS. It develops policies, plans, strategies and guidelines for HIV/AIDS prevention, care and treatment as well as coordinating with other implementing partners.

Service delivery
The Ministry of Health and Child Welfare is responsible for delivering HIV/AIDS prevention, care and treatment services, including the national antiretroviral therapy programme, with support from various partners. More than 70 hospitals of different sizes operated by the government, nongovernmental organizations and the private sector have been identified for delivering antiretroviral therapy services. WHO provides normative guidance in developing treatment and training guidelines and other tools for delivering antiretroviral therapy. The Zimbabwe office of the United States Centers for Disease Control and Prevention provides technical support for a range of areas including reinforcing laboratory capacity, management capacity, surveillance and research. UNICEF is currently supporting the procurement of antiretroviral drugs, and the National Pharmaceutical Company is responsible for drug storage and distribution. The Medicines Control Authority of Zimbabwe is the drug regulatory authority.

Community mobilization
A range of nongovernmental organizations, United Nations agencies and bilateral donors work alongside the government in mobilizing communities and supporting people living with HIV/AIDS. Several nongovernmental organizations are involved in community-related work. The nongovernmental organizations operate under the umbrella organizations Zimbabwe AIDS Network and the Zimbabwe National Network of People Living with HIV/AIDS. Other institutions involved in community mobilization include the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS).

Strategic information
The Ministry of Health and Child Welfare is responsible for overall monitoring and evaluation of the programme and for operational research. Other agencies involved in generating strategic information include WHO, the United States Centers for Disease Control and Prevention and the University of Zimbabwe.

7. Staffing input for scaling up HIV treatment and prevention

WHO's response so far

• Conducting a scoping mission to Zimbabwe in February 2004 in collaboration with UNAIDS and the Ministry of Health and Child Welfare to assess the current status of antiretroviral therapy implementation and the opportunities for scaling up access to treatment and to identify areas for WHO support
• Supporting the AIDS and Tuberculosis Unit of the Ministry of Health and Child Welfare and other partners in developing a comprehensive national plan for scaling up antiretroviral therapy
• Supporting the development of the National Health Sector Strategy for HIV/AIDS
• Supporting capacity-building for training in comprehensive management of HIV/AIDS including antiretroviral therapy at the provincial and district levels; supporting adaptation and implementation of the WHO Integrated Management of Adult and Adolescent Illness (IMAI) strategy to enhance training of first-level health workers and community support groups; and supporting the mentoring process to ensure sustained quality care for people living with HIV/AIDS
• Providing support for implementing the Global Fund Round 1 grant and developing the Global Fund Round 5 proposal
• Supporting the strengthening of the monitoring and evaluation system for the antiretroviral therapy programme within the context of the existing monitoring and evaluation system
• As part of the WHO/Italian Initiative on HIV/AIDS in Sub-Saharan Africa, supporting the improvement of access to information on HIV prevention, sexual and reproductive health and infant feeding in the context of preventing mother-to-child transmission; making HIV counselling and voluntary testing available for couples, pregnant women and women contemplating pregnancy; and providing access to antiretroviral drug prophylaxis for the mother-to-child transmission of HIV and access to follow-up programmes for infants exposed to HIV
• Supporting the Ministry of Health and Child Welfare in establishing a team to implement and manage the rapid scale up of antiretroviral therapy
• Establishing an HIV/AIDS country team to support the government and all partners in scaling up antiretroviral therapy

Key areas for WHO support in the future
• Assisting the government in reviewing policies and normative documents and standards on HIV/AIDS treatment and care for different levels of the health care system (primary, secondary and tertiary)
• Providing technical assistance in setting up systems for tracking people receiving antiretroviral therapy
• Providing technical support in developing systems for monitoring drug resistance
• Providing ongoing support for capacity-building
• Supporting the implementation of Phase II of the WHO/Italian Initiative on HIV/AIDS in Sub-Saharan Africa

Staffing input for scaling up HIV treatment and prevention
• Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include an international HIV/AIDS Country Officer and one National Programme Officer for HIV/AIDS.

This country profile was developed in collaboration with national authorities, the WHO Country Office for Zimbabwe and the WHO Regional Office for Africa.