Zimbabwe:

Success story at risk as country scrambles to cover HIV treatment gap

Despite having the third-highest HIV burden in southern Africa, Zimbabwe has achieved positive results over recent years by taking purposeful steps to improve its HIV/AIDS programmes. However, the funding shortfall is likely to result in shortages of antiretroviral (ARV) drugs which threatens to affect almost 70,000 patients in 2012.

The immediate funding gaps in Zimbabwe are due to the transitioning out of a pooled donor fund (the Expanded Support Programme) by the end of 2011. Funding for ARVs was not part of the new basket fund initiative (Health Transition Fund/HTF), as the assumption was that providing ARVs for the supported ARV cohort would be done with domestic and Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) support. However, despite the fact that Zimbabwe's AIDS levy currently pays for over 25% of its ARVs, it has not yet been possible to close the treatment gap.

The critical treatment gap, together with the international push for African countries to find domestic solutions, has led to a public debate on introducing user fees for those patients who can afford to pay for their treatment. After continuous advocacy from civil society and other actors, donors such as US President's Emergency Fund for AIDS Relief (PEPFAR) and the Department for International Development (DfID) are now trying to help close the HIV treatment gap; however, most of these efforts will not be felt until later this year or early next year.

In the meantime, national buffer stocks are currently being depleted to cover some of the shortages, while GF money allocated for later during the grant's time period (2014) has been requested in order to build up the buffer stocks again, onlt shifting the burden forwards to the future. The country currently receives approximately 50% of its ARVs (covering about 193,500 patients) through the GF's Round 8, which will run out at the end of 2014. By that time, the treatment gap will have increased to an estimated 428,068 people eligible for treatment who will be unable to access ARVs. The GF will need to address a significant part of this shortfall, while additional funds to continue initiating new patients on ARV treatment also need to be ensured.

Facts and figures

- One million adults (or 14% of adults) are living with HIV.
- 150,000 children are living with HIV.
- ARV treatment coverage has grown from just 5% in 2006, to 77% among adults and 39% among children in May 2012, according to the Ministry of Health and Child Welfare, with 435,000 adults and 41,000 children under treatment.
- ARV treatment is now available in 616 of the country's public health facilities, up from only 32 in 2006.
- Expanded ARV coverage has reduced annual AIDS deaths by 42% since 2006.

What is at stake?

- Zimbabwe has adopted the latest World Health Organization (WHO) guidelines to provide early ARV treatment (at a CD4 count of 350) and to provide short-course ARVs during pregnancy to reduce the transmission of HIV from mother to child (PMCTC)

- Zimbabwe has expanded HIV paediatric testing by increasing early infant diagnosis sites from only four in 2008 to 900 by the end of 2011. It hopes to continue expanding it to all the 1,560 facilities in the country in order to increase the percentage of infants diagnosed and treated.

- Zimbabwe has plans for ARV treatment to be available to 85% of those in need by the end of 2012. This would mean reducing annual deaths by a further 27%. However, this will require ARVs; lab commodities; support to upgrade rural health facilities into static start-up sites; and progress in the task-shifting policy that will authorise nurses to initiate adults and children on treatment.

- Targets were set to circumcise 1.2 million men by 2015, resulting in an estimated 25-35% reduction in HIV transmission. With the cancellation of Round 11, targets have been revised to cover just 15% of the male population by 2015.

- Zimbabwe wants to implement the WHO-recommended first-line treatment tenofovir (TDF) for all patients, but so far only a limited subgroup of patients (HIV-positive pregnant women and patients co-infected with TB) have been initiated on the better-tolerated drug. The phased approach aims to have 50% of patients on TDF and 50% on the old regimen d4T (stavudine) by the end of 2012, and to have 100% of patients on TDF by the end of 2013.

- Whereas no gap is foreseen in paediatric HIV treatment in 2012, about 12,800 children eligible for ARV treatment are at risk of not receiving it by 2013.

- Depletion of buffer stocks has led to patients needing to return to clinics on a more frequent basis (weekly or fortnightly), instead of once every two months. This has increased the burden on patients in terms of travel costs and time, which is known to be a key barrier for patients' adherence to treatment. It is also a burden on the health system, as more staff are needed to attend to more patient visits. This situation will continue for the coming months.

"We have been supporting Zimbabwe's national HIV response for more than 10 years and have seen remarkable progress over that time. There is a genuine commitment on national level in the fight against HIV/AIDS. Domestic resources are mobilised through a special AIDS levy, new WHO recommendations have been adapted into national policy, and incredible headway has been made in access to treatment. But external funding is still needed to continue on the path taken, and it's tragic to see the progress made risked being stopped in its tracks, or worse, reversed."

Fasil Tezera
MSF Country Director in Zimbabwe

CONTACT

July 2012

Médecins Sans Frontières (MSF)
Analysis and Advocacy Unit Brussels
Rue Dupré 94
1090 Brussels
Belgium

For further information, please contact: aau@brussels.msf.org
Or Marielle Bemelmans, MSF HIV Policy Advisor: 00 32 476 87 44 69

MEDECINS SANS FRONTIERES