Combat HIV and AIDS, Malaria and other Diseases

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TARGET 7:

Have halted, by 2015, and begun to reverse the spread of HIV and AIDS.

INDICATORS:

25. HIV prevalence among 15-24 year old pregnant women.
26. Number of children orphaned by HIV and AIDS

TARGET 8:

Have halted, by 2015, and began to reverse the increasing incidence of Malaria, TB and Diarrhoeal diseases.

INDICATORS:

27. Incidence of Malaria
28. Incidence of TB
29. Incidence of diarrhoeal diseases

STATUS AND TRENDS

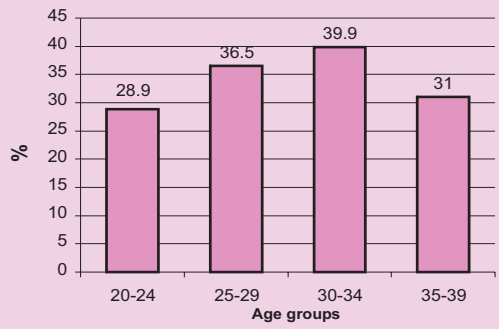
The HIV and AIDS epidemic, malaria, TB and diarrhoeal diseases are bringing additional pressure on the health sector. Overall, there has been a reported increase of incidence in all these diseases in the past 10 years.

HIV and AIDS

The first HIV and AIDS case in Zimbabwe was reported in 1985. By the end of 2002, UNAIDS estimated that 2.3 million people had been infected and the adult prevalence rate was 34%. The country is experiencing one of the world's most severe HIV and AIDS epidemics and is the second highest in prevalence after Botswana at 36% in 2002. Recent data from ante-natal clinic 2000 and surveillance surveys indicate that prevalence increased from 29% in 1997 to 34% 2000. However, in 2001 ante-natal information revealed a prevalence rate of 30.4% among pregnant women.[19]

Infection rates among women aged between 20-39 years are very high. According to the same antenatal survey of 2000, the prevalence rate among the 15-24 age group was 32%. Other age group HIV prevalence rates were as follows: age group 20-24 years at 28.9%, 25-29 years at 36.5%, 30-34 years at 39.9%, and 35-39 years at 31% see (figure 6.1). Although the sex ratio between males and females is about 1:1, HIV prevalence of women below the age of 20 is five times higher than their male counterparts.

Figure 6.1: Pregnant Women who Attended Antenatal Clinic Who are Infected by HIV by Age Group, Zimbabwe, 2001



Source:MOHCW 2001, National Survey of HIV and Syphyllis Prevalence Among Women Who Attend Antenatal Clinic In Zimbabwe, 2001

Key

- ♦ Actual
- ● Target
- Current rate of progress
- Rate of progress required to reach goal

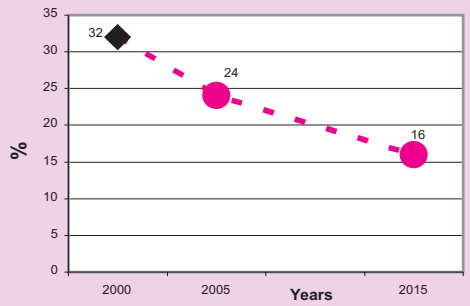
According to the Ministry of Health AIDS Programme, by 2003, an estimated 600,000 people would have full blown AIDS out of a total of 2.1 – 2.3 million persons infected with HIV.

[19] Ante-natal used by UNAIDS

The number of children orphaned by AIDS in Zimbabwe is estimated at around 780,000 in 2001. Of the total Zimbabwean children (0-14 years), 240,000 were estimated to be living with AIDS in 2002. 70% of hospital admissions in medical wards are due to HIV and AIDS related conditions, while among the under-fives, HIV and AIDS is now considered to be the number one killer.

The national targets are: to reduce HIV prevalence in the medium-term (2005) to 24%; and to 16% by 2015 (in the 15-24 age group) see Figure 6.2.

Figure 6.2: HIV/AIDS Prevalence among 15-24 year old Pregnant Women, Zimbabwe

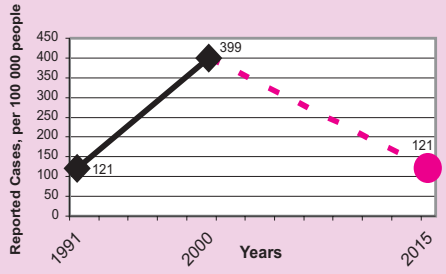


Source: MOHCW 2000, National Survey of HIV and Syphillis prevalence among women who attend Antenatal Clinics in Zimbabwe, 2000

TUBERCULOSIS

Rising poverty levels, poor environments and the HIV virus have contributed to the resurgence of TB, which thrives on immune systems weakened by chronic infections and by malnutrition. It is currently estimated that the number of TB cases increased by five-fold in the last 15 years, from 9,132 cases in 1990 to 30,831 cases in 1995, and 51,918 cases in 2000. The incidence of TB increased from 121 cases per 100,000 people in 1991 to 399 cases per 100,000 in 2000. The national target is to return to 121 cases per 100,000 people by 2015.

Figure 6.3: Tuberculosis Incidence, Zimbabwe, 1991-2015.

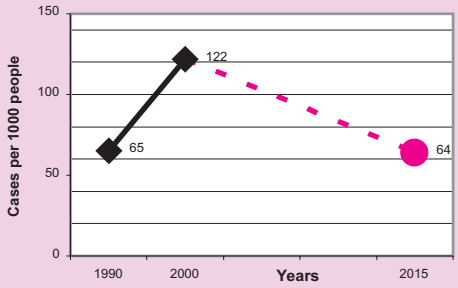


Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW

MALARIA

Overall, there has been an increase in the incidence of clinical malaria from 65 per 1000 people in 1990 to 122 per 1000 in the year 2000 (see figure 6.4). HIV and AIDS has compromised the general immunity in the population, thus making people more vulnerable to malaria-related illnesses and deaths. In 1999 for example, an estimated 2,201 people died from malaria related complications. Pregnancies are also put at risk through malaria, yet few pregnant women have access to effective intervention. In addition, recent natural disasters such as floods have contributed significantly to the spread of the breeding grounds for the vector carrying mosquitoes. The national target is to reduce clinical malaria incidence to 60 per 1000 people by 2015.

Figure 6.4: Clinical Malaria Incidence, Zimbabwe, 1990-2015.

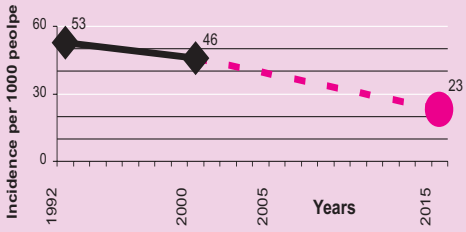


Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW: Note:These are cases reported at the Out Patient Departments.

DIARRHOEAL DISEASES

In 1999, it was estimated that about 25% of households were without access to safe water supply and 42% lacked access to improved sanitation. Diarrhoeal diseases, largely preventable through access to safe drinking water, sanitation and food hygiene, are responsible for frequent deaths. There has been a slight improvement in the incidence of diarrhoea/ dysentery, from an incidence of 53 cases per 1000 people in 1992 to 46 per 1000 in 2000 (see figure 6.5). Many of these deaths could have been avoided by the use of simple and inexpensive oral re-hydration salts. The national target is to reduce the incidence of diarrhoea/dysentery to 23 cases per 1000 people by 2015.

Figure 6.5: Incidence of Diarrhoea/Dysentry, Zimbabwe, 1992-2015.



Source: Zimbabwe National Health Profile 1999, MOHCW and MOHCW

CHALLENGES

This is the priority goal that underlies the achievement of all other goals. As such, the major challenge faced by the nation is to combat and reverse the spread of HIV and AIDS within

the immediate future (4-5 years). Some of the operational challenges in this area are as follows:

Behavioural Change

It is estimated that over 96% of the sexually active population (age 15 years and above) are generally aware of the dangers associated with HIV infection. This knowledge has, however, not been translated into behavioural change (condom use, reducing multiple sexual partners, etc.). The challenge is to understand what continues to drive the epidemic in Zimbabwe, in spite of all the knowledge, institutional mechanisms and programmes put in place to date.

Improving Access to Essential Drugs

One of the major challenges beyond prevention is making HIV and AIDS drugs available at affordable cost as well as establishing an adequate and responsive drug distribution system. Of key importance is the provision of antiretroviral drugs and essential drugs for the treatment of opportunistic infections. The current shortage of foreign currency stands as a limiting factor in the areas of drug procurement.

Inadequate resources to combat the epidemic

The health sector is experiencing a significant reduction in its budget in real terms, while at the same time undergoing human resource depletion due to HIV and AIDS related deaths and brain drain. The brain drain phenomenon is largely induced by a decline in real wages and generally unattractive conditions of service. The challenge is to revamp the health delivery system by availing the sector more resources and continuously improving working conditions.

Stigma and discrimination

HIV and AIDS related stigma and discrimination continue to sustain the HIV and AIDS epidemic. Stigma and discrimination prevent those in need from accessing care, treatment and support, and increase the vulnerability of others to HIV infection. Tackling the root causes of vulnerability to HIV and AIDS, therefore, requires that particular attention be paid to the causes of stigma and discrimination, and how they reinforce stereotypes and inequalities related to gender, ethnicity, race, sexuality and social status. The challenge is to declare HIV and AIDS a public health disease to reduce the stigma.

Coordination of AIDS programmes

The response to HIV and AIDS requires a multi-sector, bio-medical and developmental approach. The challenge, therefore, is to design appropriate developmental interventions for each economic sector, as well as strengthening the newly established National AIDS Council (NAC) for it to be effective in implementing and coordinating the broader multi sector strategy.

Care and Support for orphans

The rapid increase in the number of children orphaned due to HIV and AIDS is a cause of concern. For children, this may lead to increased pressure of social disintegration (e.g. child labour, street kids, child abuse etc). The challenge is to provide care and support as well as putting in place prevention strategies for the increasing numbers of orphans.

Gender

High levels of poverty and harmful cultural and traditional practices in sexual and reproductive health and relationships are some of the factors that make women more vulnerable to HIV infection. The challenge is to effectively address gender inequalities in the economic and cultural spheres through empowerment via education.

Poverty reduction

High poverty levels underlie the vulnerability of the population at large to the HIV and AIDS epidemic. The biggest challenge in addressing HIV and AIDS is to tackle vulnerabilities through designing and implementing broad-based national poverty reduction strategies.

TUBERCULOSIS

To control tuberculosis, the challenge is to expand and increase the Directly Observed Treatment Short Course (DOTS) coverage as well as combating the HIV and AIDS epidemic.

MALARIA

A major challenge in malaria control is the need to substantially increase the use of preventive strategies (insecticide treated nets, etc.).

DIARRHOEA

The challenge is to provide safe water and sanitation to the entire population, with particular attention being paid to newly resettled areas.

SUPPORTIVE ENVIRONMENT

There has been an enhanced political commitment to the fight against HIV and AIDS, malaria, TB and other diarrhoeal diseases in Zimbabwe.

In 1985, at the onset of the HIV and AIDS epidemic, the Government of Zimbabwe set up the National AIDS Coordinating Unit under the National AIDS Coordinating Programme to address the challenge of the HIV and AIDS pandemic. It was through the National Aids Control Programme that the National AIDS Policy was produced and, later through an Act of Parliament the National AIDS Council, was established. Other policies include HIV Prevention in the Workplace and The Orphan Policy.

In addition, a Cabinet Committee on HIV and AIDS was set up to focus on HIV and AIDS issues. In order to scale up the national response and to raise resources, a National AIDS Trust Fund was set up with funding from a 3% levy on personal incomes of formal sector employees.

The Government of Zimbabwe has also fostered strong partnerships with various stakeholders and other development agencies in the fight against HIV and AIDS. Zimbabwe's membership in the Global Fund to fight AIDS is testimony to this partnership.

The setting up of voluntary counselling and testing (VCT) centres, provision of life skills education in schools, the piloting activities on the prevention of mother-to-child transmission and peer education programmes in the uniformed forces and parliament are all initiatives for combating the HIV and AIDS epidemic.

On TB control, the country has committed itself to expanding the Directly Observed Treatment Short Course (DOTS) and continues to participate in the Global Plan to stop TB, launched in October 2001.

On malaria control, the country has also committed itself to the Roll Back Malaria Programme initiated in 1998.

On water and sanitation, the Government has entered into partnerships to expand the provision of safe water and sanitation in the rural and remote areas of the country.

PRIORITIES FOR DEVELOPMENT

In order to facilitate the reversal of the epidemic, three main areas of intervention have been identified, namely, prevention, care and support.

In the area of Prevention, the following priorities have been identified:

Reversing the spread of HIV and AIDS epidemic

Reducing HIV transmission, through promoting behavioral change will be central to combating the epidemic. It is important to recognize that behaviour change will not take place until strategies are put in place to address the current developmental vulnerabilities being experienced by the population. These vulnerabilities are primarily responsible for risky sexual behaviour, which underlies the epidemic. Thus designing and implementing broad-based national poverty reduction strategies is a national priority.

Combating stigma and discrimination

There is need to address issues of stigmatisation and discrimination, by reconsidering the public health classification of the disease.

Gender equality in all spheres, including Reproductive Health

As a way of reducing women's vulnerability to the epidemic, there is need to promote gender equality in all spheres of life, respect for each other's sexuality, gender sensitive HIV and AIDS programmes, and combating gender violence.

Information, Education and Communication (IEC) about HIV, AIDS and STIs

There is need for the dissemination of clear and accurate information on HIV and AIDS/STI at all levels of society. Such information should promote positive family and cultural values. IEC promotional materials should be developed together with stakeholders and include the supportive role of mass media on the epidemic.

HIV and AIDS/STI Research

Research should be multi-disciplinary, collaborative and participatory, focusing on priority needs for Zimbabwe. Research should feed into the design of programme interventions to facilitate the holistic approach to combating the epidemic.

In the area of Care, the following priorities were identified:

Effective management of the national response to HIV and AIDS

There is need to strengthen the newly established National AIDS Council (NAC) for the effective delivery of services to the intended beneficiaries with minimum bureaucracy. For example, the utilization of the AIDS levy and other resources for multi-sector programming should face minimum delays in disbursement.

Care and support for people living with HIV and AIDS

There is need to consolidate and expand the following programmes:

- Medical and Nursing care,
- Community home-based care (CHBC) with institutional support,
- Nutrition support to slow the onset and progression of AIDS,
- Counselling and psychosocial support,
- Voluntary counselling and testing, etc.

In the area of Support, the priorities are as follows:

Rights of children or young people infected or affected by HIV and AIDS

There is a need to protect and respect the rights of children and young people infected or affected by HIV and AIDS. In this respect, support is required in the following areas:

- Orphaned children require support to grow up with respect and dignity, while in their communities.
- Children and young people need protection from sexual abuse, and provision of necessary information on sexual behaviour and protection.

- Nutrition support to slow the onset and progression of AIDS.

Need for essential Health Sector imports

Government should endeavour to ensure that the health sector has sufficient resources to import drugs and equipment requirements to ensure sustained combating of HIV and AIDS, Malaria, TB and other diseases.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenges of halting and reversing the spread of HIV and AIDS and control of Malaria, TB and other diarrhoeal diseases are as follows:

- Support for economic revival and sustained growth and development.
- Capacity development to respond to the HIV and AIDS epidemic.
- Support for scaling up HIV and AIDS interventions for young people.
- Orphans Care and Support.
- Need for essential Health Sector imports.
- Increase in the coverage of DOTS and (Insecticide Treated Bed Nets) ITN.
- Water and sanitation.
- Data collection on HIV and AIDS, Malaria and other diseases.

COSTING THE HIV and AIDS GOAL

Overview: The comments made under the health goals, particularly the kind of priority accorded by the household to healthy living and longer survival are also relevant to this goal. The HIV costing represents a compromise between the anticipated needs based on the projected scale of the pandemic, on the one hand, and the response capabilities, absorptive capacities and scope for scaling up responses of the various sectors, on the other. The cost estimates have been informed by the expenditures of some sectors to date, finding proposals submitted to the National Aids Council (NAC) since the establishment of the National Aids Trust Fund, as well as the costing work by Kumaranayake and Watts (October 1999).

The costing elements: The costing only relates to HIV and AIDS and not the other diseases under this goal. The six strategic areas of intervention were costed as follows:

1. Prevention strategies and activities
2. Care strategies and activities
3. Mitigation strategies and activities
4. Enhanced sector response strategies,
5. Monitoring and evaluation, and
6. Development of District Aids Action Plans.

The costing was done in two parts; a conservative option and a pragmatic option over a five-year period (2001-2005).

Cost on HIV and AIDS projections (1999 US$)

Reversing the spread of HIV AND AIDS over the 13 year period, 2002-2015, will cost an estimated US$32 million *(conservative option)* to US$38 million *(pragmatic option),* or between US$2 million to US$3 million per year. These cost estimates do not include full-scale provision of anti-retroviral drugs for the estimated 600,000 full-blown cases, or the 3.3 million sufferers of the disease as at 2003.

HIV AND AIDS COSTING 2001- 2005 AND PROJECTION FOR 2015 (IN 1999 US$)

	Conservative Option	Pragmatic Option
1. Prevention strategies & activities	US$ 6,483,636	US$ 7,209,090
2. Care Strategies & activities	US$ 2,881,818	US$ 4,409,090
3. Mitigation Strategies & activities	US$ 872,727	US$ 872,727
4. Enhanced Sector response strategies	US$ 1,490,909	US$ 1,563,636
5. Monitoring & Evaluation	US$ 72,727	US$ 272,727
6. Development of District Aids Action plans	US$ 181,818	US$ 281,818
TOTAL	**US$ 11,983,635**	**US$ 14,609,088**
Cost Per Year	**US$ 2,396,727**	**US$ 2,921,817**
Projected cost to 2015	**US$ 31,157,451**	**US$ 37,983,628**

Source: Ministry of Health & Child welfare, Zimbabwe National AIDS Council, UNAIDS/Harare (1999)

"As a Nation with Oneness of Purpose, Together we can Score this Goal!"