ZIMBABWE AND HIV/AIDS

Physician in Zimbabwe, 2007

ABSTRACT

I observed during 2007, massive inflation of the Zimbabwean currency and the wages of civil employees being insufficient to pay for food and transport. The public health institutions were more closed than functioning due to lack of human resource and lack of basic supply. I saw that health workers were either on perpetual strike, or found they had left their jobs, and left the country. The rate of HIV infection was high, and no resources were available for treatment.

INTRODUCTION

Zimbabwe is in Southern Africa, in 1979 it changed its name from Rhodesia. It gained its independence from Britain in 1965. The continuing economic crisis in Zimbabwe is well documented and from eye-witness reports, is getting worse.(1)

Inflation has made the local currency value useless because salaries were out of line with the costs of necessities. The impact on the lives of common Zimbabweans is unprecedented. Unemployment rate in 2002 rose to more than 80%.(1)

Humans are finding ways to survive in a no-cash economy. Many are leaving to generate currencies that can be exchanged for goods in South Africa and Botswana. Cross-border trading has increased.

The other crisis in Zimbabwe which started earlier was HIV/AIDS. HIV/AIDS infection rates in Zimbabwe have been one of the highest since early in the start of the pandemic with records as high as 27% in 2002.(2)

Because of HIV/AIDS, life expectancy has declined according to WHO figures. As much as 70% of hospital admissions were due to HIV/AIDS-related illnesses in 2003.(3)

The focus of the HIV/AIDS response was for a long time primarily on prevention and mitigation of the effects of the disease through psychosocial support and home based care. More recently Testing & Counselling, Prevention of Mother to Child Transmission, and finally since 2004 also expanding access to antiretroviral therapy have climbed on the priority agenda of the Government of Zimbabwe. Recent data from the national surveillance system show a decline in HIV/AIDS prevalence among pregnant women from 27% in 2002 to 21% in 2004. Changes in sexual behavior appear to have contributed to the decline. However, infection rates in Zimbabwe continue to be among the highest in the world. Critics put high mortality rates to be the more important contributing factor for the recent decline in HIV/AIDS prevalence.

MÉDECINS SANS FRONTIERS IN ZIMBABWE

Médecins Sans Frontiers (Physicians Without Borders) is an international humanitarian medical non-governmental organization primarily focusing on emergency medical relief for populations affected by natural and man-made disasters all over the world. In addition to responding to acute emergencies, Médecins Sans Frontiers also works in combating infectious diseases of public health significance like HIV/AIDS, tuberculosis and malaria, wherever the local response is inadequate. Finding the public response too slow to curb the mortality from HIV/AIDS in Zimbabwe, a section of Médecins Sans Frontiers administered from Luxemburg started a treatment program in one of the remote districts called Buhera district in Manicaland province in the year 2004.

I joined this Médecins Sans Frontiers mission in early 2007. By then the Médecins Sans Frontiers project has been providing antiretroviral therapy at the district hospital and the antiretroviral therapy clinic was more than overloaded with about 7,000 HIV diagnosed patients registered for care and 2,000 started on antiretroviral therapy. More than 90% of the clients of the hospital were coming out of the catchment area of the district hospital posing serious concern for their long term follow-up. In addition the availability and affordability of transport from different parts of the district to the hospital was getting scanty by the day. All these problems were calling for an immediate solution.

DECENTRALIZATION

The idea of decentralization of HIV/AIDS treatment was not new to Médecins Sans Frontiers, and ideas and plans had been started already. An expatriate doctor was also employed specifically for the decentralization process. There were 25 primary healthcare centers and 2 rural hospitals in the district in addition to the district hospital which were staffed with nurses and nurse assistants. There were only 7 physicians in the district hospital including the hospital director and the Médecins Sans Frontiers physi-

Map of Zimbabwe, http://www.cia.gov.

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World Food Bank press releases late 2008.

cians running the HIV/AIDS program. The total population was more than 200,000 with HIV/AIDS prevalence of 21% in 2005.(4) The only areas the Primary Care Centers were involved was referring the HIV/AIDS patients to the hospital and when resource allows in providing HIV/AIDS testing.

The Zimbabwe national antiretroviral therapy roll out plan which started at 5 pilot hospitals in 2004 was allowed to expand only to the level of some accredited district and mission hospitals by the end of 2006. Most district hospitals can not expand to primary healthcare levels, were also not able to provide the antiretroviral therapy because of lack of resources and strict accreditation process. Moreover, only physicians were allowed to prescribe antiretroviral therapy. By the end of 2006, less than 20% of HIV-diagnosed patients in Zimbabwe who should be on therapy were getting the treatment.(5)

As part of the plan, a detailed decentralization proposal was made including necessary technical and operational manuals. The plan was projected to show that primary care settings can be actively involved in a step wise manner, coordinated with a district hospital to provide antiretroviral therapy services which will not only greatly multiply the coverage of the needy population but also result a much needed better outcome in terms of treatment adherence. Though universal coverage was not the main goal of Médecins Sans Frontiers, it was a known fact that full decentralization of the services meant close to 100% coverage in terms of the needs. The first phase of the plan was to transfer out patients who were stable on antiretroviral therapy from the district hospital. The characteristics of a stable antiretroviral therapy patient are a patient more than 3 months after initiation of antiretroviral therapy, which mostly correspond to a patient with no more active opportunistic infections, tolerating the antiretroviral medications well, understood the basics of HIV/AIDS and antiretroviral therapy and with good adherence to the treatment. Stable patients constituted the majority of the patients on antiretroviral therapy coming to the hospital merely to collect their regular medications. Therefore it was considered safe to transfer out all these patients to the respective health center nearest to their homes and send the medications to the nurses in the health center to distribute the medications.

The second and final step in the decentralization process is actually for the health centers to be able to initiate antiretroviral therapy for uncomplicated HIV/AIDS cases and only refer to the hospital severe opportunistic infections and special cases to the hospital for initiation. Severe opportunistic infections was defined as mainly WHO Stage IV cases (infections in the advanced HIV/AIDS stage) and antiretroviral side effects not responding to initial treatment. Special cases also referred to hospital included children, who need more complicated diagnosis and treatment formulations and pregnant mothers.

Dr Teketel photographed with nurses he was training in Zimbabwe.

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The challenges of this project were numerous, some already known before even the project began.

As explained initially, antiretroviral therapy prescribing was allowed only for physicians, and only in hospitals. Moreover, the staffing of nurses in the entire district was less than half of what was required just to run the routine health services, without adding the activities of the planned antiretroviral therapy services. The 25 health centers were usually staffed with one nurse and one nurse assistant who were burdened with a lot of routine primary care activities. They were also at their lowest level of motivation because of the dwindling value of their salaries and the poor infrastructure and resource setting they have to work with. Another clear gap to cover for was the lack of training on HIV/AIDS and antiretroviral care of the health staff.

Among the first steps taken during the conception of the decentralization proposal was to meet with the district, provincial and national health authorities concerned and discuss the proposal. Agreement was prompt with most of district bodies but reception was lukewarm to unwelcoming at national level. The local authorities lacked the power, especially on policy issues like physician-based prescription. However, the goals were welcome and cooperation started by launching series of trainings to all health staff including the nurses from health centers. To start transferring out antiretroviral patients, the trainings were not considered adequate and therefore the need for a continued technical support to the clinics was raised. Médecins Sans Frontiers organized mobile medical teams made of physicians and nurses experienced in antiretroviral therapy (in the antiretroviral therapy clinic of the district hospital). The mobile teams visited the peripheral health centers with regular schedules to achieve managing the transferred antiretroviral therapy patients with the clinic nurses which gave an opportunity to provide on the job trainings. These teams also provided the antiretroviral therapy and other medicines to the clinics and ferried back and forth between the clinics and the district hospital laboratory samples and patient data. The teams also helped organize the clinics in setting up the HIV/AIDS clinics and in sharing their non HIV/AIDS clients and services.

Organization of the mobile teams also helped come around the strict only doctor policy of antiretroviral therapy prescription as it allowed all clinic nurses to give the prescriptions under the responsibility of the mobile team doctor who would supervise the patient files during field visits.

Another major challenge to tackle was the lack of human resources. As explained earlier, even before this program was started, the peripheral clinics were understaffed, undermotivated and overburdened with other healthcare tasks. Therefore the acceptance of the proposal by the clinic staff was minimal. Moreover, the projection in terms of the expected number of patients eligible for antiretroviral showed that by the end of 3 years the project will start more than 10,000 patients on antiretroviral, which is 5 times the number at the beginning. As the number of nursing staff available for the patient follow-up is not expected to increase after 3 years, the nurse to antiretroviral patient ratio will be 5 times lower. Therefore, we knew we could not pursue the project without remedial strategies for this crucial matter. The proposal was to do task shifting.

Task shifting in this context means the planned transfer of technical responsibilities between health personnel for more efficient and effective use of human resources. In this context, it means the task of prescribing and monitoring antiretroviral therapy to be transferred from physicians to nurses, and health education and adherence support activities to be transferred from nurses to community health workers and expert patients. The role of physicians was managing difficult and complicated cases, training the nurses, and supervising the program. Expert patients are literate, understand health education, and, best of all, adhered to their treatment. Training and continuous supervision are of course basic strategy and pre-requisite for successful task shifting.

In our project, after a series of trainings supplemented by on-the-job trainings for nurses in the primary health centers by the visiting mobile team, the decentralization process was initiated fully at 23 of the 25 health centers. Though the government still opposed the prescription of antiretroviral therapy by the nurses, the overlooking of all antiretroviral therapy prescriptions by the physicians in the mobile team got acceptance and it worked well. The nurses, previously dealing with all the work for 1 or 2, found their team strengthened by the trained community and patient volunteers who assisted in almost all non-technical work in the centers and by the regular visit from the mobile HIV/AIDS expert teams. In one year, the 23 primary health centers shared more than 60% of the antiretroviral therapy patients of the district and together with the district hospital, managed to double the number of patients on antiretroviral therapy to 4,000. The patient dropout rates also reduced at the primary health centers, where they were closer to where patients lived, and it was easier to trace a lost patient from his home by the community volunteers who knew the whereabouts of every patient from the community. To keep the government nurses motivated, Médecins Sans Frontiers proposed 6 monthly cash bonuses and rehabilitation of the living and working

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Voice of America press release

Washington 09 Dec 2008 - The Voice of America is broadcasting to Zimbabwe with vital information on health, politics and international developments.

Studio 7 is a daily radio program that has been on the air since 2003. It is reporting in detail on the humanitarian crisis that intensified as the death toll from a cholera epidemic climbed to over 600, largely as a result of a lack of water treatment and broken sewage pipes.

Studio 7 had previously reported the virtual closure of the state hospital system in Harare and other cities shortly before the cholera epidemic. In addition, Studio 7 has interviewed local health experts and international officials daily. Discussion segments allow listeners to voice concerns about the country, which has few basic commodities, soaring unemployment and sky-high inflation.

In recent days, Studio 7 brought listeners interviews with former United Nations Secretary General Kofi Annan and former United States President Jimmy Carter, both members of a delegation dispatched to Zimbabwe by the international organization of eminent persons known as the Elders. The group was barred from entering Zimbabwe by the government.

Studio 7 is funded through a grant from USAID to VOA.

structures of the rural healthcare centers.

Public health medicine is a function of human collaboration for a common goal more than sophisticated technical capacity. The success would not have been possible without the commitment of the local government health workers and authorities, the community health workers and the patients themselves. For me, it affirms the notion that the primary and ultimate responsibility of healthcare lies with the affected community.

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In southern Africa, most orphans result from HIV/AIDS. Very often the orphaned children become destitute, and young girls in particular become more vulnerable to HIV and AIDS as they try to fend for the rest of the family. The study was carried out in Nyamhunga and Mahombekombe high-density residential areas of Kariba, Zimbabwe. All households in the study area were visited, and a semi-structured questionnaire aimed at enumerating orphans and obtaining information regarding general problems of orphans was administered to heads of households present. The prevalence of orphans in Kariba, based on a sample of 3,976 households, was 56%; most orphans were 6 to 12. The majority of the orphans were paternal and under maternal care. Over 30% of the orphans of schoolgoing age were not in school, and some young girl orphans became involved in commercial sex work. The survival wish list of the orphans included school fees, accommodation, health care provision, adequate food and income-generating projects. However, suggestions on orphan care and needs given by community members diverged from the orphans' wish list. The study did not categorise orphans according to cause of parental death, but indications suggeted most were orphaned by HIV/AIDS.

From Medecins Sans Frontiers

"Since 2002, MSF has implemented projects in Zimbabwe to prevent and treat HIV/AIDS. Despite the efforts of the Ministry of Health and other donors, the prevalence of HIV/AIDS among pregnant women in some areas of Zimbabwe is above 30% and the general prevalence is 15.6%, still one of the highest in the world.

By the end of 2007, MSF was providing care to 35,000 patients with HIV/AIDS, approximately 16,000 of whom were receiving antiretroviral treatment (ARV treatment).

MSF has worked in Zimbabwe since 2000."

Web-site http://www.msf.org.uk/zimbabwe.focus