Zimbabwe's Challenge: Equity in Health Sector Responses to HIV and AIDS in Zimbabwe

EQUINET DISCUSSION PAPER 9

Regional Network for Equity in Health in Southern Africa

In co-operation with

Oxfam

By
Sunanda Ray,
Tendayi Kureya

Southern Africa HIV/AIDS Information Dissemination Service Zimbabwe

SAfAIDS

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Health sector responses to HIV/AIDS

Editors: R Loewenson, C Thompson

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ZIMBABWE'S CHALLENGE: EQUITY IN HEALTH SECTOR RESPONSES TO HIV AND AIDS IN ZIMBABWE

Sunanda Ray, Tendayi Kureya

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Contents

Executive Summary

Background

This paper discusses some of the equity concerns faced by the health sector in its response to access to treatment for HIV and AIDS in Zimbabwe. It is part of a larger review carried out in four southern African countries: Malawi, South Africa, Tanzania and Zimbabwe and at southern African regional level by the Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam GB. The review focuses on availability, accessibility, affordability and use of antiretroviral drugs (ARVs) and medication for opportunistic infections in Zimbabwe. The report was compiled using grey and published literature, interviews with key informants, Internet searches and materials obtained from workshops that were held during the time of the review. We presented a draft of the report to a stakeholder workshop held in Harare in August 2003, and incorporated comments raised by the participants to this meeting.

Background information shows that HIV/AIDS prevalence rates in Zimbabwe are high, estimated at 34% of the adult population. Poorer people, especially those living on commercial farms, resettlement areas and growth points, are most vulnerable to the effects of HIV. The stigma and fear of discrimination that still shroud HIV and AIDS remain major barriers to effective responses to the epidemic in Zimbabwe. Much of this stigma is reinforced by the attitudes of health staff.

Findings

Our review of treatment in Zimbabwe showed that there is more activity related to provision of treatment for AIDS than a year ago. Most of this has been undermined by the rapid decline in the quality of care provided within the public health service, financial instability in the private sector, and poor communication between the different interest groups in the field of HIV and AIDS. Doctors in the private sector are providing treatment for AIDS, but often in an unregulated, chaotic manner. ARVs are available in some pharmacies but the costs fluctuate with precarious foreign exchange rates, leading to inconsistent use. Several organisations are investigating the feasibility of establishing treatment programmes for the public sector. These initiatives largely depend on a functional health service and are currently constrained by the financial crisis in the country and the collapse of the entire health service. With poor central management of health service delivery and dwindling health budgets, many primary healthcare centres are unable to provide even basic medication for palliative care such as pain relief or anti-diarrhoeal remedies. We heard considerable concern whether health service infrastructure could initiate and sustain provision of ARVs in these conditions or whether they would be provided mainly through small projects, and therefore only available to small selected groups of people.

The Ministry of Health and Child Welfare (MoHCW) and the National Drugs and Therapeutics Policy Advisory Committee (NDTPAC), published in May 2003 guidelines for antiretroviral therapy (ART) in Zimbabwe. Most doctors in private and public practice are not yet familiar with these guidelines. Many are keen to prescribe ARVs even though they may not have been trained for this. At the time of writing the paper there were no accreditation requirements for prescribing ARVs. The HIV Clinicians of Zimbabwe, an affiliate member of the Southern African Clinician Society, is setting up a training programme for doctors for both their private and public sector practice. At present, provision of ARVs is more or less non-existent in the public sector, and haphazard and inconsistent through the private sector, with people buying treatment when they can afford it. The threat of resistance to current first line ARVs is a very serious one, and will reduce our access to effective affordable therapies if not managed appropriately. Although the impact of AIDS is much worse than TB, we are not yet treating it as a public health hazard with the principles learnt about communicable disease control from past experience.

The number of people needing treatment is calculated to be between 200,000 and 600,000. The MoHCW estimates that of the 1.8 million HIV positive people in Zimbabwe, the number of people on ART is as little as 900. We estimated the number of people on regular ART to be probably much higher; between 3000–5000 countrywide, based on the data we collected from the pharmacies, corporations, NGOs and the Mission Hospitals.

The burden of disease has increased up to sevenfold in Zimbabwe as a result of HIV-related illness, increasing demand for health services, displacing other health needs and doubling hospital bed occupancy rates. Households have been forced to take on the burden of caring for their family members dying of AIDS with fewer resources to do so in adequate and dignified ways. We therefore concluded that planning for equity was not seriously considered in treatment for HIV and AIDS.

Zimbabwe developed a national policy and strategic framework in 1999, and the National AIDS Council (NAC) was set up in 2000 to coordinate responses to the HIV epidemic; mobilise resources; and monitor progress and impact of the responses. A 3% levy on all taxpayers was established to feed into a National AIDS Trust Fund (NATF) to support NAC's activities. Disbursement of funds from the NATF has been problematic from the outset, and the fund is insufficient to purchase ARVs for all the people who need them. In May 2002, the country declared AIDS a national emergency to facilitate the importation of low-cost generic medicines under the provisions of the Doha Declaration to the World Trade Organisation Agreements. A National Emergency Taskforce on AIDS (NETA) made up of experts from government, NGOs, and the University of Zimbabwe was formed to coordinate activities that would arise from the national emergency.

This review identified the following organisations as developing new initiatives for provision of ARVs:

a. The Medicines Control Authority of Zimbabwe (MCAZ) regulates what drugs can be brought into the country. As of February 2003, MCAZ had approved six patented ARVs and two generic combinations, including one by a local manufacturing company, Varichem Pharmaceuticals.

b. Most government hospitals provide diagnostic HIV testing, blood screening and clinical services, but are limited by poor access to test kits and other resources. Some centres are running prevention of parent to child transmission (PTCT) programmes, sometimes with external funding. Voluntary counselling and testing (VCT) is provided by NGOs and social marketing projects. We identified two church hospitals already implementing ART programmes. The Caring for HIV and AIDS, Prevention and Positive Living (CHAPPL) initiative under the Zimbabwe Association of Christian Hospitals (ZACH) plans to implement an occupational health programme for post exposure prophylaxis for health staff.

c. The Centre, an NGO set up by people living with HIV, is providing donated ART to a limited number of people, but has a waiting list of over 3000 people.

d. Some private corporations such as Delta Corporation are implementing treatment programmes for their staff. Others such as De Beers plan to start soon. We did not encounter any workplace ARV programme that included all employees, apart from the proposal by CIMAS and PSMAS where companies can now contribute an additional amount to their existing medical aid schemes to cover for ARVs.

e. Websites and email discussion fora have played a vital role in informing advocates and activists on current issues regarding access to treatment.

Conclusions and recommendations

The review concludes that there is considerable momentum to establish ART programmes in Zimbabwe, mainly from the non-governmental sector. These efforts, however, cannot be extensive enough to provide for the majority of the people who need treatment, who would mainly be provided for through the public sector. An equitable national programme for HIV-related services, therefore, needs extensive international and national collaboration to mobilise the financial and technical resources required. Communication continues to be a major problem, with little information dissemination between key institutions and organisations, so that most interested parties struggle to find out what is happening either on the policy front or in practice. The time taken for programmes to be designed and implemented does not reflect the urgency of the HIV crisis in Zimbabwe.

The table below summarises the challenges and recommendations:

Challenges	Recommendations
1. Urgency of HIV epidemic: Although Zimbabwe has nearly 800,000 orphans and 500 deaths a day, there are few programmes that include ART.	National and international organisations and networks need to advocate more effectively for Zimbabwe to take the HIV epidemic more seriously.
2. Principle of equity: There is very little commitment to ensuring that services are provided on the basis of need rather than ability to pay.	As a principle of quality health services and justice, equity of access, based on need, should be built into all negotiations related to developing services for HIV-related illnesses.
3. If resistance to first line ARV medications develops, more expenditure will be required using second line drugs for fewer people	Preservation of first line medication by preventing resistance developing is possible if the same principles of using TB drugs apply, with good regulation ensuring adherence to regimes and good public health practices.
4.Centres of excellence: The Ministry of Heath and University of Zimbabwe are directing the setting up of treatment initiatives in the main cities away from the areas of greatest need.	District based hospitals, including mission hospitals that have already developed the infrastructure required for community based VCT, home based care and prevention of PTCT, are preferable sites for treatment initiatives. These are usually closer to areas of greatest need, thereby ensuring equitable and efficient services reaching more people.
5. No regulation of who prescribes ARVs.	There is urgent need for MoHCW to accredit doctors based on training and service provided.
6. Funding: the funds currently available are not sufficient for equitable provision of treatment.	Advocacy groups need training and support to challenge the government on its governance procedures, and in the interim, encourage international donors to channel funds to organisations embarking on treatment programmes. There is scanty information on the status of the funds allocated to Zimbabwe from the Global Fund for AIDS, TB and Malaria.
7. Lack of information: At the moment, very few beneficiaries of existing and impending programmes know about them.	Treatment literacy and educational materials that have been developed on access to treatment should be disseminated widely.
8. Inadequate monitoring and evaluation on expenditure of resources allocated and activities done, especially within existing national programmes.	The national treatment programme should be more accountable to the beneficiaries. It is important to facilitate the development of a strong national group of activists for treatment. The group could partner national and international networks in advocating for a transparent national response.

9. Priorities set often do not depict the situation on the ground, especially regarding where to place interventions, who to target, and what to offer in the intervention.	We recommend that programme planners, policy makers and implementers of public HIV intervention programmes utilise data and evidence from previous interventions.
10. GIPA: Limited involvement of people infected or affected by HIV and AIDS.	Activists should be assisted to obtain sufficient knowledge so that they can lobby for equitable access to treatment. Without activism, national programmes can continue at a pace determined by the public health service without considering the urgency needed to address the situation, as seems to be the case in Zimbabwe.
11. The national HIV policy and strategic framework was developed when treatment using ARV drugs was not seen as a potential reality. As such it is silent in advocating for ART.	We recommend that the national policy and strategic framework be appended to strongly include ART.
12. Uncoordinated efforts: Various organisations, are embarking on an assortment of treatment interventions in different parts of the country without reference to a national strategic plan or framework.	A comprehensive national framework for HIV services should include rational use of ARVs, and would ensure that each additional initiative adds to a carefully planned basket of initiatives rather than being ad hoc. It is important to share information between all stakeholders, including public and private sectors, so that programmes are aware of where they fit in the national mix of interventions, thereby leading to greater transparency. This would also lead to more efficient use of resources and sharing lessons learnt.
13. Community education and mobilisation is not often planned for as an integral part of a treatment package when using a health-based response to a social and development problem.	Lessons from the management of TB need to be applied here, recognising that overcoming stigma and acceptance of people living with HIV by communities are essential components for the success of programmes related to HIV treatment and care.

1: Introduction

HIV has severely affected the overall health of people in the southern Africa region, by impacting directly on individuals and their families, and by placing additional burdens on economies, social structures and health services of these countries. Poorer people are disproportionately affected because they have fewer resources to deal with the impact of HIV on their daily lives. Public policies are usually inadequate at addressing inequities that exist within access to healthcare in general, and HIV-related care in particular. Now that international advocacy has led to reductions in prices of antiretroviral drugs (ARVs), there is concern that poorer people will not have access to these drugs, and that the patterns of disadvantage that lead them to have lower life expectancy and more ill-health compared to richer people will be perpetuated in the arena of HIV and AIDS care.

To examine these issues, a study was commissioned by the Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam GB to highlight equity issues in HIV and AIDS, health sector responses and treatment access in four countries in southern Africa. This paper presents the findings from Zimbabwe. The other countries included in the study are Malawi, South Africa and Tanzania, a regional study and review of health sector equity issues in relation to health personnel and nutrition and food security. The paper discusses the global and national social, economic, political, legal and institutional factors influencing decision-making and allocation of resources for treatment responses to HIV. A team from SAfAIDS headed by Dr Sunanda Ray and Tendayi Kureya undertook the review between March and May 2003.

1.1 Purpose and Objectives

The main objective of the study was to develop a review report that can be used to inform the policy debates and advocacy that have grown around health sector responses to HIV and AIDS in Zimbabwe, particularly with respect to care and treatment access within the country.

The work sought to inform policy and advocacy using available evidence on the three issues below:

- equity issues in current health sector responses to HIV and AIDS in Zimbabwe
- public policy choices now being faced and made in relation to the health sector response to the HIV epidemic in Zimbabwe, analysing the equity implications of these policy options and the choices currently proposed or being made
- recommendations for including equity in public policy within the health sector, indicating how this can be taken forward.

1.2 Methodology

We used three core methods to carry out the study: literature review, primary questionnaire-based research, and input from four related workshops that took place within the duration of the study that enabled us to identify key informants and other sources of information. These were a regional access to treatment symposium facilitated by SAfAIDS and Zimbabwe Women's Resource Centre and Network (ZWRCN) in January 2003; a national discussion on the National AIDS Trust Fund organised by ZWRCN in March 2003; an HIV and AIDS Quality of Care Initiative (HAQOCI) feedback meeting organised by the Department of Community Medicine, University of Zimbabwe in April 2003; a feedback session facilitated by SAfAIDS on assessments made on Zimbabwe's ART programme carried out by Deliver, John Snow International and USAID in May 2003; and a national discussion forum set up by SAfAIDS with EQUINET on 27 August 2003 to present a draft of this report to stakeholders.

Our main source of documentation was the SAfAIDS' resource centre, which has a comprehensive index of over 8000 documents. An initial search using the keywords 'HIV, AIDS, treatment, Zimbabwe' revealed over 1500 documents of which less than ten referred to equity issues pertaining to access to treatment in Zimbabwe. A further search for grey literature was done on the web and produced substantial material from the AF-AIDS discussion e-forum, UNAIDS, World Health Organisation (WHO), and other reliable regional organisations' web pages. We used AF-AIDS to follow-up on expert opinions and asked users of the forum for relevant publications they were aware of. We conducted semi-structured interviews with key informants in person where we could, and by telephone or email for those based outside Harare. We also gave questionnaires to those we could not interview directly, including those attending the conferences mentioned before. Our list of key informants comprised national and district level experts from government, private sector, pharmacies, and non-governmental organisations (NGOs) as well as other important players that included civic and religious leaders, people living with HIV or AIDS (PLWHAs), and networks of AIDS service organisations (ASOs) in Harare and Chitungwiza. The list of interviewees is available from the authors. We presented a draft of the report to a stakeholder workshop held in Harare in August 2003, and incorporated comments raised by the participants to this meeting.

There was meagre published or grey literature on the treatment situation in Zimbabwe, as well as little reference to equity of access to treatment in the reports or publications available. Our analysis therefore looks at equity in access to both treatment and information, as these were observed to be inter-related. Many organisations are in the process of reviewing their policies regarding provision of antiretroviral drugs (ARVs). The availability of ARVs is also in transition. By the time this report is issued, the situation on the ground regarding availability, costs and legislation regarding ARV treatment in Zimbabwe may have changed. As this review was not intended to be a comprehensive assessment of all aspects of HIV and AIDS management in Zimbabwe, we have presented here what we see as the key equity issues in health sector responses to HIV and AIDS as they arose during our investigations.

2: Framing the context for managing HIV and AIDS in Zimbabwe

2.1 The burden of HIV in Zimbabwe

HIV prevalence in Zimbabwe is high. In the past, UNAIDS estimated that average HIV prevalence among pregnant women rose from 29% in 1997 to 35% in 2000 based on antenatal sentinel surveillance.[1] There were higher rates among women aged 25–29 years (40.1%), among marginalized women such as farm workers (43.7%), those living around growth points (38.3%) and resettlement areas (40.3%). New figures released by the Ministry of Health and Child Welfare (MoHCW) in August 2003 are lower with a mean prevalence rate of 24.6% (range 20–28%). The estimated number of HIV-positive people was 1.8 million with over 50% being women.[2,3] MoHCW noted that the data indicated a decline in prevalence, but more data was needed to verify this. In response, various HIV experts in Zimbabwe have pointed out that the reduction in prevalence is more likely from a correction of flawed estimates from previous surveys.[4] Within this range of prevalence, even one in four pregnant women being HIV positive is high and reflects a considerable burden of HIV in our communities.

Using the data contained in UNAIDS' 2002 report on the epidemic in Zimbabwe, based on an adult prevalence of 33%, it is estimated that by December 2001: [1]

- 2 million adults (15–49) were living with HIV out of an estimated total population of Zimbabwe 12.9 million
- an estimated 230,000 people had progressed to AIDS
- 200,000 people died of AIDS during 2001 alone
- an estimated 780,000 children under the age of 15 had lost their mother or father or both parents to AIDS.

UNAIDS also estimated that life expectancy at birth in Zimbabwe had fallen to 43 years, a reduction of 26 years since 1980–85, undoing all the gains made by improved living conditions and healthcare since independence in 1980. The majority of children with HIV die before their fifth birthdays, a considerable influence on life expectancy and overall mortality statistics. Prevention of HIV in adults and thereby in children is the main way that the epidemic will be halted. However, the decline in life expectancy could be reversed in the short term by preventing most childhood AIDS through programmes aimed at prevention of parent-to-child-transmission (PTCT) and by provision of effective antiretroviral treatment to keep those already infected healthy for longer. Many of the estimated 500 deaths from AIDS per day could be postponed if not prevented altogether, if treatment were available. In addition, mortality and suffering that comes with deprivation in orphanhood would be reduced if parents were kept alive for longer.

The impact of HIV and AIDS in Zimbabwe is felt in every sector of life, manifested for example by:[1,5]

- threat to national cohesion through collapse of social networks and community structures through illness and death of key social figures from leaders to community workers
- loss of skills, institutional knowledge and intellectual capital at all levels of the workforce
- increased costs of employee benefits such as medical aid, insurance, funeral benefits, and pension schemes
- reduced consumer purchasing power leading to reduced demand for products and reduced economic activity
- reduced remittances from urban to rural economies, with reduced inputs into agriculture for fertiliser, pesticides, and seeds
- estimated annual loss of 2.1% of teachers due to AIDS between 2000 and 2010
- increasing absenteeism and poor quality teaching because of sickness affecting teachers
- projected falls by 24% in primary school age population by 2010
- affected families resorting to selling assets and withdrawing savings to cover extra healthcare costs and funerals
- severe family hardship through loss of income through illness and death of family breadwinners
- increasing gender inequity through impoverishment of widows and women-headed households, burden of caring for sick family members, fewer opportunities for formal employment, poor negotiation ability for safer sex, poor access to treatment, and declining family support
- children taken out of school because of families' inability to pay school fees and because more children are taking on care-giving roles at home or working in agriculture to provide for family income and food needs
- estimated 780,000 orphans growing up without parental guidance and care, deprived of basic rights of shelter, food, health and education
- more street children growing up in environments of destitution, crime and commercial sex work.

Poverty makes HIV worse and AIDS makes poverty worse. As well as the deteriorating economic situation for political reasons, the Demographic and Health Survey (2000) demonstrates that AIDS has had a devastating impact at household level and a consequent reduction in school enrolment rates is already felt.[6] Research on agricultural outputs show a reduction in production, while the business sector shows rising production costs due to HIV-related illness and deaths amongst employees. The following table provides data from the World Bank[7] showing how the economy has been eroded over the years. The extent to which this can be attributed to the impact of HIV and AIDS has not been fully documented. However, the estimated reduction in gross domestic product growth by 2.6% annually because of AIDS has a significant effect on livelihoods. Productivity is seriously affected by increasing workplace labour shortages and absenteeism. For instance, research with a bus company in Zimbabwe showed that AIDS-related absenteeism accounted for 54% of all AIDS-related costs followed by HIV-related symptomatic illness at 35%.[1,5]

Table 1: Selected historical economic data, Zimbabwe 1981–2001

	1981	1991	2000	2001
Domestic price (% change)				
Movement of consumer prices				
(year on year inflation rates for food and non-food items)	..	23.3	55.7	75.1
Government finance (% of GDP, includes current grants)				
Current revenue	20.7	26.6	27.4	23.3
Current budget balance	16.3	0.3	-19.9	-10.7
Overall surplus/deficit	-6.5	-6.3	-22.5	-11.6
TRADE (US$millions)				
Exports of goods and services	1,575	2.056	2,118	1,977
Imports of goods and services	1,985	2,301	1,956	1,872
Resource balance	-410	-245	162	105
Net income	-140	-304	-244	-246
Changes in net reserves	318	126	-163	-80
Reserves including gold (US$millions)	368	371	22	18
EXTERNAL DEBT and RESOURCE FLOWS				
Total debt outstanding and disbursed	812	3,436	4,022	3,780
Total debt service	114	461	471	136
Composition of net resource flows				
Official grants	91	95	..	..
Official creditors	80	139	-15	-1
Private creditors	3	98	-50	-33
Foreign direct investment (FDI)	-26	3	..	..

Source: The World Bank Group

2.2 Health services in Zimbabwe

Health services in Zimbabwe are provided within public and private sectors, with public sector contribution constituting 65% of health finance in 1993, and private sector (including donor agencies) contributing 35%.[8] By 2000, government expenditure on health was 43% of total expenditure on health; per capita government expenditure on health was US$18 compared to total expenditure on health of US$43.[9] The changes probably reflect more increased charges within the private sector rather than volume of services, though there has been some shift to private care as public services have become undermined by the current economic crisis. Central, provincial and district hospitals provide the bulk of public health inpatient care. The MoHCW has the largest fiscal share of the national budget, but this does not match the level required to fulfil the needs of this sector.

Table 2: Year 2003 budget allocation to top four ministries[10]

Health and Child Welfare*	18.7%
Defence	15.4%
Public Service	12.4%
Higher and Tertiary Education	11.4%

*Z$2.5 billion (3.4% of the Ministry's budget) was set aside to buy ARVs

Mudayarabikwa (2000)[8] estimates that the private sector covers up to 10% of the population, while mission hospitals serve 70% of rural population, or 49% of total. The public health sector provides annual grants to mission hospitals for recurrent expenses. Because of perceived better quality of care, private sector facilities attract people with formal employment. The private health sector includes private corporations, such as industries, mines, commercial farms, institutionalised medical practitioners and individual practitioners. In 1996, the sector comprised 1020 allopathic doctors and about 50,000 traditional healers.[8] Some 60% of all traditional healers are affiliated to the Zimbabwe National Traditional Healers Association (ZINATHA). Other networks include the Zimbabwe Traditional Healers Association and smaller networks operating at provincial and subprovincial levels. The Traditional Medical Practitioners Council of Zimbabwe (TMPCZ) under the MoHCW is mandated to regulate their activities. Up to 80% of the population consult traditional healers,[11] often in parallel with using allopathic medical practitioners, but also when they cannot afford hospital fees, or when recovery seems to be taking too long.

The National Association of Medical AID Societies (NAMAS) is made up of all 21 Medical AID societies operating in the country. The Commercial and Industrial Medical Aid Society (CIMAS), the largest private sector insurance society has 420,000 people registered with them. NAMAS estimates that up to one million people are on medical cover and that the three largest medical insurance schemes (PSMAS, CIMAS and RAILMED) provide cover for 90% of all people on medical insurance. As public health services have deteriorated, more patients are resorting to the private sector. Half of all doctors were registered with NAMAS in 1998, but in reality the proportion currently engaged in private practice might be much higher for two reasons. Firstly, many of the doctors registered with the Health Professions Council are living outside Zimbabwe and may not update their NAMAS registration. Secondly, many government doctors working in rural areas treat patients privately for cash rather than medical aid and so may not be registered with NAMAS.

Zimbabwe's public health sector has multiple players as indicated in the following table:[12]

Table 3: Health institutions in Zimbabwe

Hospitals	Number	Number of beds	Clinics	Number
Government	42	6814	Government	336
Rural District Council	3	89	Rural District Council	463
Town Council/ Municipality	2	89	Town Council/ Municipality	99
Mission	42	5459	Mission	48
Corporate mining /Private	10	1222	Army/Police	18
Army	10	500	Other	180

Source: Ministry of Health[12,13]

The current political and economic crisis in Zimbabwe has weakened central management of health services and diminished real per capita spending on health. Service delivery is variable, with rural areas harder hit in many ways. Central drug stores have failed to supply drugs to remote hospitals and clinics because of the current shortage of fuel. According to the Public Sector Essential Drugs Survey of 2001:[14]

- There were three times more remote rural health centres experiencing shortages of vital drugs compared to the year 2000.
- Overall availability of vital drugs at all public health facilities dropped from 86% in 1998 to 70% in 2001, with availability of supplies at centres below district level dropping by up to 40%. The corresponding drop in essential drugs was 4% i.e. from 69% in 1998 to 65% in 2001.
- There were three times more health facilities with less than 40% availability in 2001 than in 2000.
- The availability of 19 selected STI and TB drugs dropped from around 92% in 1995 to 70% in 2001. Rural, urban and mission hospitals supplied by the government through NatPharm were most affected. Overall availability of TB drugs however remained unchanged over the same period.
- 31% of health institutions poorly calculate correct minimum stock of medicines required.
- The percentage of expired drugs in the system rose from 3% in 1998 to 9% in 2001.

Most hospitals now only have drugs if they buy them privately. Some mission hospitals have been able to source external funding for this and carry on providing reasonable services albeit with considerable uncertainty. Other factors play a part in depriving people of access to services. For instance, fuel shortages and transport problems affect referrals for patients from rural areas to hospitals. In the major central hospitals, mothers of infants admitted to neonatal wards are no longer being fed since they are not strictly defined as patients even though they are breastfeeding their infants.[15]

2.3 Concepts of equity in healthcare and HIV

According to EQUINET, seeking equity in health implies 'addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region.' Equity-motivated interventions should aim to allocate resources preferentially to those with the worst health status (vertical equity), to address the power and ability people and social groups have to make choices over health inputs and their capacity to use these choices towards health.[16] Planning for equity requires identification of groups disadvantaged in terms of health status or utilisation of services. In the context of HIV and AIDS, this involves identifying those at risk of HIV infection to target prevention activities at them, and to identify those most in need of care and treatment of HIV-related illness.

WHO has defined **access** as consisting of three components:

- **therapeutic** access: there should be drugs developed and marketed for the disease
- **physical** access: the drugs should be available within one hour's travelling
- **financial** access: the drugs should be affordable

In this review, interventions set in place within Zimbabwe will be considered in terms of these components of equity and access. Prevention of transmission of HIV continues to be a priority so how services address this in an equitable manner needs consideration, as well as the interrelationship with STI (sexually transmitted infections) management and tuberculosis control.

2.4 Activism and access to information

Although HIV NGOs have existed in Zimbabwe since the late eighties, they have not, in the main, taken a lobbying or rights approach to government, donors and other agencies. An exception is the Women and AIDS Support Network petition and campaign to have female condoms licensed in Zimbabwe. More recently, there have been demands for better accountability on how the National AIDS Trust Fund is disbursed. NGO activity has not been well coordinated in Zimbabwe, and there have been few deliberate campaigns to publicly advocate for better quality care or treatment for HIV and AIDS until recently. In particular, HIV-positive people have not been vocal in organising their rights to care and services. This is changing now under the influence of organisations like the Treatment Action Campaign (TAC)[17] in South Africa, which emphasises human rights in their campaigning.

People living with HIV are mainly represented by the Zimbabwe National Network of People living with HIV (ZNNP+) and a newly formed group, Zimbabwe Activists on HIV and AIDS (ZAHA). ZNNP+ was formed in 1992 as an association of HIV affected resource persons and used to be represented by their director on the NAC until he was discredited for being involved in corruption. ZAHA

has recently been established by PLWHAs to lobby for access to affordable treatment for AIDS, following the example of the TAC model. Apart from cost of ARVs, concerns of HIV positive people in these organisations regarding treatment are:

- sustainability of supplies of ARVs, since they have to be taken for life
- clinical monitoring including CD4 counts, viral loads and monitoring disease progression should be more available and affordable
- maintaining food supplies as well as treatment. Taking ARVs without adequate food could be dangerous rather than helpful
- 'Fat Cats'– people getting paid high salaries working for HIV organisations, are benefiting from HIV but do not necessarily act in the best interest of PLWHAs
- corruption – people who access national funds, such as NATF, use the epidemic to further their own interests, without meeting the obligations for which they access the money
- better representation – there are no longer PLWHAs in NAC's lead structures following the discreditation of the former head of ZNNP+, and there is little real involvement of HIV-positive people in decision-making and programme design.

In South Africa, TAC has been promoting treatment literacy as a good way of families living with AIDS finding out what they need to know about treatment so that they can ask health workers the right questions about their care, without feeling intimidated and undermined. Health practitioners have to become better informed to respond to patient demands for participation. The South African Medical Association has finally joined forces with TAC to act as advocates for their patients in putting pressure on the government to provide better quality HIV care. This has not yet happened in Zimbabwe with little leadership from the medical profession in advocating on behalf of people living with HIV. Treatment literacy initiatives in Zimbabwe have been led by ASOs with support from TAC, though they would benefit from improved local health worker partnerships. Activists in Zimbabwe who formed ZAHA receive solidarity support from TAC through training workshops and materials posted on their website and email newsletter.

A number of parliamentarians in Zimbabwe are keen to take treatment issues to their constituencies but are not yet familiar enough with the issues, so need to be supported with adequate treatment literacy materials. One[18] indicated that MoHCW were not giving parliamentarians clear indications of what financial, human and logistical resources were available, and members of parliament were therefore less able to take the debates forward. Women parliamentarians in particular expressed their support for a treatment programme that used PTCT programmes as entry points for treatment of women, so that HIV-positive mothers were not merely used as conduits of preventing transmission to their infants.

There is very little systematic information produced at present by ZAHA or ZNNP+ specifically for other people living with HIV. They need capacity building and resources to overcome the struggles with corruption faced by earlier attempts by HIV-positive people to organise. At present they rely heavily on

materials produced by regional organisations and TAC. They are aware that to reach wider audiences in Zimbabwe they need to improve access to local information and disseminate it in local languages to the many organisations and support groups working on HIV, such as those registered with ZAN. They also contribute more to regional discussions and debates, such as through AF-AIDS and international conferences, than to local organisations but have started to mobilise more locally, for example through setting up their own conference held in 2003 and contributing to ZIM-Net email discussions.

3. The health sector response to HIV and AIDS

3.1 Government response to HIV and AIDS in Zimbabwe

National efforts to combat HIV and AIDS began as early as 1987 with the establishment of an AIDS unit within the Ministry of Health. By 1992, Zimbabwe had received significant World Bank funds for HIV prevention.

The major steps in the national response in Zimbabwe were

- 1985: Screening blood for HIV started with formal identification thereafter of the first cases of AIDS
- 1987–88: Short Term Plan for training and surveillance
- 1988–93: Medium Term Plan 1 focussing on behaviour change, public awareness and counselling and care for PLWHAs
- 1987: National AIDS Control Programme (NACP) established within the Ministry of Heath and Child Welfare
- 1994–98: Medium Term Plan 2 calling for a multisectoral approach to the epidemic, including transmission of HIV and STIs, personal and social impacts, and socio-economic consequences
- 1998: Statutory Instrument 202 of the Labour Act, introduced to address HIV issues at the workplace
- 1999: National Interdisciplinary and Intersectoral Task Force established to develop policy and strategy framework that culminated in the National HIV and AIDS Policy and National Strategic Framework
- 2000: National AIDS Council (NAC), established by an act of Parliament, introduces AIDS levy of 3% individual and corporate tax to fund its activities (later renamed the National AIDS Trust Fund or NATF)
- 2001: AIDS declared a national disaster
- 2001: Sexual Offences Act amended to prohibit non-consensual sex within marriage, and to make wilful transmission of HIV a crime
- 2002: National emergency declared for 6 months, later extended to 5 years

Although Zimbabwe has a sound national strategic framework on paper, implementation of the strategy has been poor and adequate leadership and resources have not been made available for this purpose. An assessment by NANGO and ZAN of the level of implementation of the Zimbabwe National HIV/AIDS policy and accessibility of NATF by civil society in 2001 showed that the efforts made by NAC 'though commendable, have lacked in their comprehensiveness to engage and include all civil society actors' and that 'government leadership must be clearer in their intent and more aggressive in the promotion of viable prevention, care, control and mitigation interventions.'[19] There has also been insufficient commitment from government in the other areas of multisectoral action, poverty reduction and fighting stigma, but good initiatives on the part of some communities and NGOs. The existing National Strategic Framework notes that HIV and AIDS 'continue to have a low priority status in the nation's consciousness', and that political commitment is not only

'patchy and sporadic', but also absent on the greater part.[20] There is also very little public and political acknowledgement of the work that is done by non-government efforts.

At the time the policy was developed, it appeared unlikely that affordable, accessible and appropriate treatment for AIDS with ARVs would be possible. Now that treatment initiatives have started it is preferable that they are coordinated within the national framework. The national policy is guided by 43 principles, some of which are relevant to the introduction of treatment programmes. These include principle 13, which states, 'People with HIV/AIDS have the right to choose the type of care they want and should have access to accurate information regarding orthodox and traditional medicine.' Principle 6 stipulates that quality STI care services should be made available and accessible at all levels of the healthcare delivery system, to 'ensure availability of appropriate technical capacity and drugs… in all health facilities.' Whereas efforts to do this through primary healthcare structures and through private initiatives in workplaces made advances in the past, presently STI services are also starved of drugs, staff and financial resources. Similarly past successes in management of tuberculosis have become undermined by shortages such as fuel and transport that prevent health staff from carrying out community outreach work. In the present context, it would be surprising for government services to be able to provide treatment for AIDS in a comprehensive integrated manner that could address areas of greatest need.

The National AIDS Council (NAC) was established by an act of Parliament, the National AIDS Council Act (2000) to achieve three main objectives of a multisectoral national response to HIV and AIDS:

- ensure effective leadership and coordination of the wide range of activities in the national response
- mobilise resources to scale up interventions
- monitor progress and impact of the responses.

NAC set up a nationwide structure of 83 District AIDS Action Committees (DAACs) through which it aims to meet these objectives. The AIDS levy of 3% individual and corporate tax was also established to fund its activities (later renamed the National AIDS Trust Fund or NATF). The concept of this fund was hailed internationally as good, to raise local funds to pay for interventions, as a national response to the HIV crisis, and to provide collective support for people living with AIDS. However, since its inception NATF has been beset with controversy over lack of transparency in how funds were disbursed. For a long time there was no systematic way of ensuring that funds got to appropriate target groups. More recently, NAC has commenced distribution of NATF through DAACs to support district level support for ASOs and families living with AIDS. The stated emphasis is on community capacity building rather than payment for healthcare, although some funds (Z$966 million) were used by the MoHCW to buy cotrimoxazole for prophylaxis against pneumonia.

The Zimbabwe Women's Resource Centres Network (ZWRCN) investigated the impact of the NATF on various groups of people.[21] They report problems with the administration of the fund in that it is used primarily as a source of capital for HIV support group members to set up income-generating projects. Financial management training for PLWHAs was not included to support these projects, so they are not efficient in sustaining income generation and have been generally fragile and unsuccessful. The way in which the NATF was used at district level was unstructured and did not follow the strategic framework recommendations. For example, funds were used to provide school uniforms for children affected by AIDS and basic materials for home-based care. Other government resources have been used to provide food packs through DAACs.[21]

As of March 2003, NATF was estimated at Z$8 billion (approximately US$3.5 million).[22] About 50% of the fund has already been distributed through DAACs, with each receiving Z$10 million quarterly. Other recipients of the fund include NGOs and ASOs, such as the Zimbabwe AIDS Prevention Support Organisation (ZAPSO), Red Cross, and the National Blood Transfusion Service, and these receive funds based on proposals. Funds have been diverted to other government ministries such as the Ministries of Education (Z$200 million to pay school fees), Social Welfare and Health. The allocation given to MoHCW has been disbursed to provinces, but provincial hospitals have difficulty converting these funds to foreign currency to purchase drugs.[22] Because of the lack of transparency around how NATF was used, especially in the earlier stages of its inception, there is little public confidence that it will be genuinely used to support community structures to organise around addressing AIDS issues.

3.2 Declaration of a national emergency

The Doha Declaration,[23] adopted in November 2001, was signed as a separate declaration on the World Trade Organisation Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), to respond to concerns about the possible implications for access to medicines, especially by developing countries. While recognising the importance of intellectual property protection for the development of new medicines, it also states that 'the TRIPS agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.'

Using Article 5c of this declaration, Zimbabwe declared a national emergency in May 2002 in recognition of the 'public health crisis' caused by AIDS, with the intention of facilitating importation of low-cost generic antiretroviral drugs. The emergency was initially for six months, but later extended to five years after lobbying by ZAN (the Zimbabwe AIDS Network), to allow sufficient time to put this process in place.[24] The provisions within TRIPS that protect patents for medicines would no longer be a serious impediment to cheaper options for HIV drugs reaching Zimbabweans during the emergency period. Legislation within Zimbabwe has needed amendment to allow these changes to take place.
The sense of 'extreme urgency' described by the Doha Declaration in allowing for declaration of national emergencies is not apparent in any of the other measures put in place by the government to deal with the HIV crisis.

The National Emergency Taskforce on AIDS (NETA) was formed to coordinate activities that would arise from the national emergency. NETA is made up of leading University of Zimbabwe (UZ) staff in medicine and pharmacy, the HIV/AIDS and TB Unit of the MoHCW, WHO, Centre for Disease Control and Prevention (CDC-Zim), Medicines Control Authority of Zimbabwe (MCAZ), NatPharm (responsible for procurement and disbursement to government health facilities), physicians from central hospitals and other co-opted members.

The critical foreign exchange shortage caused by withdrawal of donor funding and collapse of commercial sector exports makes it difficult for local resources to be used to purchase ARVs. Most retailers use 'black market' rates for drug prices because it is impossible to source foreign exchange through the banks. For example, most of the Z$2.5 billion fund set aside to buy ARVs in the fiscal year 2003 is still unused because it cannot be used to buy foreign exchange at parallel market rates, and much of it has since been eroded by inflation and rapidly fluctuating exchange rates. Zimbabwe was granted US$5.3 million from the Global Fund for HIV/AIDS, TB and Malaria for the HIV and AIDS component for 2002. As of September 1 2003, these funds had still not been received in the country[25,26] for reasons that are not in the public domain.

3.3 Prevention and care

Prevention and care have been managed in Zimbabwe mainly as separate activities, often conducted by different organisations. There is more promotion now of an integrated approach though commitment to this in the health sector is somewhat superficial. Health staff do not take an opportunistic approach towards giving HIV education at every chance, such as using antenatal clinics to promote condom use, or TB clinics to promote voluntary counselling and testing (VCT).

3.2.1 Prevention and education

Easy access to condoms for HIV prevention is crucial for protection of HIV-negative people, but also so that positive people do not get infected with other STIs or other strains of HIV that would compromise their immunity. At present, people in Zimbabwe do not have access to sufficient quantities of condoms to consistently protect themselves. A study assessing condom supplies in Africa using data from UNFPA and USAID found that provision in the six countries with highest levels (Botswana, South Africa, Zimbabwe, Togo, Congo and Kenya) averaged about 17 condoms per man aged 15–59 in 1999.[27] Research in South Africa showed that 84 condoms per year per man would be more appropriate.[28] This work does not take into account individual risk of exposure to infection.

Statutory Instrument 202 of 1998 outlines labour relations and regulations on HIV and AIDS at private sector workplaces. Its provisions include that workplaces have to provide education on HIV and prevention; that discrimination on grounds of HIV status is illegal; and that employees are entitled to sick and compassionate leave on the same grounds as every other employee. Zimbabwe workplace programmes were well known internationally for peer education initiatives,[29] STI clinics and community outreach, but many of these have been abandoned as a result of economic constraints faced by industry.

VCT services are provided for a small fee (free for those who state they are unable to pay) by 14 New Start Clinics across the country, established in collaboration with Population Services International (PSI), and funded by USAID and DfID. The sites are integrated into existing public health facilities where possible, with three freestanding sites in Harare and one in Bulawayo linked with an NGO. PSI publicises the importance of VCT through billboard and media advertising and is investigating closer linkages with referral to STI and TB services.

Parent-to-child-transmission (PTCT) programmes are primarily directed at identifying HIV-positive women to prevent HIV transmission to their infants during childbirth and the breastfeeding period. The majority of women attending these services in Zimbabwe are HIV negative (approximately 70%) and can be supported to stay that way, especially if their partners are also tested and advised. At present 5–10% of HIV-negative women become positive during the two years of pregnancy and breastfeeding,[30] which may be prevented by consistent condom use during these times. As of August 2002 there were 17 functional PTCT sites in the country, mainly in mission hospitals, using donated Nevirapine and AZT. This programme is being expanded to cover 155 centres throughout Zimbabwe of which 41 are provincial or district government hospitals and some are mission hospitals. About 180 nurse counsellors are being trained for the expansion, and the Ministry of Heath has directed development of guidelines, manuals and protocols to standardise PTCT implementation.[31] Some facilities are using trained lay counsellors to decrease the work burden on nurses. While provision of Nevirapine for PTCT has improved greatly at these sites, availability of rapid HIV testing (same day results) remains a problem.

Part of positive living is early treatment for infections, such as use of antibiotics for STIs or TB to maintain good immunity. Cotrimoxazole is recommended in EDLIZ (Essential Drugs List and Standard Treatment Guidelines for Zimbabwe) as prophylaxis for opportunistic infections (Ois) such as pneumonia and salmonella infections in adults and children, but is rarely provided. Although antibiotics were readily available through primary care clinics in the past, now supplies are precarious for the reasons already discussed. Reported STI cases have gone down by 30% from 920,940 in 1995 to 624,888 in 2000, mainly as a result of better prevention, while TB cases have risen by 68% from 30,831 to 51,805 over the same time period because of the link with HIV.[32] Between 60–80% of TB patients are HIV positive, so ideally every person given a positive result for HIV should be advised on screening for TB, and screening for TB should include discussion on risk of HIV. The social marketing VCT services in Zimbabwe do not provide diagnostic HIV testing so this process does not happen. In integrated HIV centres, such as those being established by some mission hospitals, HIV testing for VCT is being done through the hospital laboratories, so they are more able to provide both HIV and TB screening. Community home-based care (CHBC) volunteers often do not know how to deal with the potential TB risk in families living with terminal AIDS.

3.2.2 Continuum of care

A comprehensive service for management of HIV-related illness needs to build on the continuum-of-care integrated approach from hospital or health centre to CHBC, with management of STIs, family planning and reproductive healthcare, TB services and outreach, VCT services, prevention of PTCT programmes and linkages to support groups. Clients and patients need information at every point on what other services they should link with. This does not happen anywhere in Zimbabwe, partly because of resource shortages but also because health staff have not been adequately trained to use this integrated approach.

HIV and AIDS activities in public hospitals in Zimbabwe mainly comprise HIV testing conducted in multiple settings for surveillance, some VCT, prevention of PTCT, clinical diagnosis in health facilities in the context of individual medical care, and donor blood screening. The burden of disease has increased up to sevenfold as a result of HIV-related illness, increasing demand for health services at all levels, displacing other health needs and doubling bed occupancy rates in all health centres. Patients are sicker for longer periods and may need multiple admissions to health institutions. Between 50%[1] and 75%[33] of inpatients in public sector wards are estimated to be HIV positive. Because of the drug shortages, many primary healthcare centres are unable to provide basic medications for palliative care for AIDS, such as pain relief or anti-diarrhoeal remedies.

Households in Zimbabwe have been forced to take on the burden of caring for their family members dying of AIDS with fewer resources to do so in adequate and dignified ways. Most CHBC services are provided by NGOs and faith-based organisations with little institutional support or resources. Stigma and fear of disclosure are still big obstacles to linking CHBC with education and prevention. Many volunteers are involved in CHBC in the hope that they will also receive care when it is their turn but may not be able to deal with the reality of death and dying in non-judgemental ways.

3.2.3 Addressing stigma

The stigma and fear of discrimination that still shroud HIV and AIDS remain major barriers to effective responses to the epidemic. Without hope of a cure, HIV is accompanied by a sense of despair, shame and fear that lead into denial. These emotions act to deter people from seeking treatment for fear of prejudice, as health staff do not usually encourage openness or discuss the risks or need for testing with vulnerable or high-risk individuals. People with HIV are anxious that they may bring shame to their families if their status is known and avoid discussing this with family members, thereby potentially denying themselves support and comfort from their loved ones. There are many that have travelled abroad to get treatment and prefer to die away from home rather than face the shame their families may feel.

Religious leaders, who should be at the forefront of role modelling compassion and acceptance, often perpetuate 'bad' images of HIV. A positive woman, who gave testimonials about living with HIV, was publicly shamed in church when the priest announced that all HIV-positive people were sinners and should be treated as such. She has never been back to that church and did not receive comfort from any of the congregation, many of whom would also have been HIV positive. Other churches such as the Seventh Day Adventist Church in Zimbabwe see the importance of tackling HIV and AIDS issues with their congregations and have developed policies and guidelines on HIV and AIDS for churches under their denomination.[34] Although the policy for the Adventist church does not accept using condoms as a prevention method, it outlines how the church intends to tackle stigma and other HIV-related issues amongst its followers.

Shortage of drugs and declining service conditions have affected morale amongst staff throughout the health sector, as they feel less and less able to respond to the health needs of people with AIDS and see the quality of care they provide falling with declining resources. Health workers themselves may be suffering from HIV-related illnesses for which they cannot access treatment and they are further disheartened by the distress they witness in their patients. These emotions often translate into an attitude of 'better not to know' that reinforces denial and stigma. There are currently few occupational health programmes in Zimbabwe that address these issues in health staff though the Zimbabwe Association of Church Hospitals (ZACH) is developing one. Poor morale combined with absence of treatment in turn contribute to brain drain of health professionals as they leave for richer countries, where they can access treatment for themselves, better salaries, training facilities to improve their income and provide remittances for their families back home. They are also then better positioned to pay for treatment for other members of their families who may have AIDS.

3.3 Treatment in progression from HIV to AIDS

3.3.1 Background to treatment issues

Priorities in managing HIV-related illness have been considered in the past in this order:

1. Pain relief and other symptomatic therapies for terminal AIDS related conditions
2. Treatment for opportunistic infections (OIs)
3. Antiretroviral therapy for AIDS.

The above ordering was based on numbers of people currently needing treatment, the potential availability of medications through the public health system, and the costs. It was considered that the greatest ability to benefit was in symptomatic relief, with more people benefiting from certain levels of expenditure (including on staff training and time as well as costs of medications), followed next by management of OIs. The shift in thinking towards more integrated treatment regimes that start with ART has been in the hope that people with HIV will live for longer with better quality lives, and be able to contribute as

relatively healthy members of their communities for longer, especially in providing and caring for their own children who would otherwise be orphaned or completely preoccupied as carers themselves. Clearly if people with AIDS live longer but on ART, their total treatment costs would be higher but should be balanced against longer family productivity.

With sound disease management, when positive people start to develop symptoms suggestive of AIDS, indicating that their immunity is dropping (and their CD4 counts if measured, may be below 200), they would be assessed for eligibility for ARV therapy. Presently many people will develop OIs when their immunity is lowered because they do not have access to ARVs or because they get side-effects from ARVs and discontinue them. It is not yet clear to what extent treatment need for OIs would be avoided in providing ART or whether the need would be postponed to a later time. Treatment of OIs is important in extending quality of life for people with AIDS. In some cases they will prolong life itself. For instance, people with AIDS often develop oro-pharyngeal thrush that leads to difficulty in swallowing, followed by malnutrition, further immuno-suppression, starvation.

Once positive people are in the stage considered terminal AIDS, they need palliative care that provides symptomatic treatment for pain, diarrhoea, vomiting and so on. A quarter of people with HIV-related diseases will require strong pain control at some point. Sometimes pain relief is needed even before the AIDS stage, such as if people develop herpes zoster (shingles), a very painful skin rash related to chicken pox and lasting several weeks, but responsive to pain treatment. Health workers trained in looking after cancer patients have knowledge about management of pain and other symptoms, which is useful for HIV-related illnesses. Simple drugs like aspirin, paracetamol, amytriptylline and codeine can be provided through primary care clinics and pharmacies, and are useful if given at regular intervals before pain becomes established and unbearable. Palliative care programmes may be able to provide stronger drugs such as morphine. There are local traditional remedies that are useful in pain relief but may need to be used with caution.[35] Local knowledge about these should be documented so that they can be used, but also to monitor side effects from them. Drugs for management of persistent diarrhoea and vomiting should also be available through primary care clinics and home based care programmes.

3.3.2 Targeting groups in areas of high prevalence and poverty

According to UNAIDS, an estimated 230,000 people in Zimbabwe had progressed to AIDS by December 2001, providing an estimate of the minimum number who currently need treatment for AIDS-related illness (assuming that deaths did not exceed new cases of progression). The MoHCW puts the figure of those eligible for treatment closer to 600,000 and estimate that only 900 people are currently on ART countrywide.[36] It is not clear how these figures were arrived at. Through our interviews for this paper we observed that the number of people currently on ART was much higher than 900, maybe as high as between 3000 and 5000. It still remains that the majority of people with HIV-

related illness do not get the specific treatments they need because of poverty, ignorance of their status and unavailability of treatment through the public health service. A handful of support groups and NGOs provide basic care for people living with AIDS but are usually severely under-resourced. One organisation in Harare (the Centre) gets donated drugs for their members. Mostly, they rely on positive living, nutritional advice and emotional support. Even those who are getting treatment through the private sector get it in a fairly unregulated, inconsistent way, with practices that may provide an environment conducive for drug resistance to develop. In the year 2000 this situation was described as a 'therapeutic anarchy in the private sector in Harare'.[37] This is an alarming situation since Zimbabwe's potential treatment programme relies heavily on using first line drugs that are becoming more affordable. If resistance forms to these drugs because of poor therapeutic practice in the private sector, it wipes out the opportunity for many to have effective ART.

In exploring vertical equity of access to HIV care and treatment, it is important to identify areas of greatest need based on HIV prevalence and poverty. The 2000 antenatal surveillance report[38] indicated that Masvingo and Midlands provinces have the highest prevalence rates in the country at 49% and 45% respectively. Groups of women with the highest prevalence were those attending clinic sites in commercial farming and mining areas, followed by border posts and growth points. By comparison, the cities of Harare and Bulawayo had prevalence marginally lower than the national average, but significantly lower than Masvingo and Midland provinces. We found that much of the discussion around treatment initiatives proposed setting up projects at the main hospitals in Harare and Bulawayo, with the justification that these were the centres of excellence and would set the standard of care for the rest of the country. There was no consideration of how to target vulnerable groups such as farm workers or border traders, concentrating instead on those who were able to get to central hospital clinics. There has been limited consultation regarding access to treatment with healthcare consumer groups and with organisations representing people living with HIV. This emanates from the supply approach to delivering health services through the public sector, and loses out on the benefits that derive from involving those affected in designing and implementing programmes. Initiatives planned by church hospitals located in deprived areas are better placed to address equitable access but are not yet targeting marginalised but high risk groups.

We found little serious consideration of addressing gender equity in access to treatment and care. Some workplaces are considering providing ART for their employees in the formal sector, who are mainly men. Whether partners and children with AIDS will be provided with treatment is still under scrutiny in most places because of the costs involved, geographical separation between male migrant workers and their families, and sensitive issues of how wives each man may have. Expansion of the PTCT programmes has led to more discussion on access for women to treatment from these programmes, especially as one or two projects are making applications to be sites for PTCT+ where pregnant HIV-positive women are given triple therapy for six months rather than one drug such as AZT or Nevirapine.

3.3.4 Legal frameworks, standards, guidelines

Medications required for pain relief and most OIs are already licensed for use in Zimbabwe. As with all 'new' drugs, ARVs have to be registered with the Medicines Control Authority of Zimbabwe (MCAZ), on the basis of scientifically proven and documented safety, quality and efficacy of the medicine, which must be submitted with each application. Their control falls under the provisions of the Medicines and Allied Substances Control Act (15:03) and the Medicines and Allied Substances Control (Principal) Regulations (Statutory Instrument 150 of 1991). This legislation stipulates that any medicine intended for use in Zimbabwe has to be registered with MCAZ before it is made available to the public. The legislation governing MCAZ's activities provides for donations of either registered or unregistered medicines to be imported into Zimbabwe. MCAZ prefers that donated medicines be among those already registered in Zimbabwe. The MoHCW has developed guidelines setting the conditions on which donated medicines can be accepted.

There are provisions where the MCAZ may grant authorisation for a doctor to arrange for the importation of an unregistered life-saving medicine for a named patient. This provision can be used for antiretroviral drugs. The practitioner would be required to write to MCAZ requesting authorisation to import specified quantities of the ARV medication for their named patient(s). The importation may be effected through a licensed pharmaceutical wholesale or a retail pharmacy or directly by the patient as long as the authorisation letter at the point of entry into Zimbabwe accompanies the consignment. In other circumstances, individuals who have had ARVs prescribed and legally dispensed for them outside Zimbabwe are permitted to import reasonable quantities that they bring on their person, as part of their baggage. If the medications do not accompany the person, they have to be imported using the procedure above for named individuals. In all cases the confidentiality of the patients and their ailments are protected with the utmost care and such protection is already provided for in the legislation.

As of February 2003, MCAZ had approved six patented ARVs and two combinations as indicated in the following two tables. A complete list of all ARVs registered or pending registration for use in Zimbabwe is given in Appendix 1.

Table 4: Registered Patented ARVs in Zimbabwe

Drug name	Trade name	Manufacturer/supplier
Nevirapine	Viramune 200mg tablets	Ingelheim
Zidovudine	Retrovir 50mg/ml syrup, 100mg capsules, 300mg Tablets	Glaxo Wellcome
Lamivudine	Epivir (3TC) 150mg tablets, 10mg.ml solution	Glaxo SmithKline
Abacavir	Ziagen 300mg Tablets, 20mg.ml solution	Glaxo Wellcome
Lamivudine + Zidovudine	Combivir 150/300 mg tablets	Glaxo Wellcome
Amprenavir	Agenerase 50mg, 150mg capsules	Glaxo SmithKline

Source: Deliver/USAID/John Snow, 2003.

MoHCW has, through an ART subcommittee of the National Drugs and Therapeutics Policy Advisory Committee (NDTPAC), developed guidelines for ART in Zimbabwe. These guidelines, published in May 2003, are meant for both private and public sector health practitioners to implement a standardised approach to treatment of HIV and AIDS using ARV drugs. The guidelines also suggest treatment regimens for both adults and children, as well as which drug combinations could be taken and what monitoring is necessary for administering ART. They set the minimum standards that the Ministry hopes will ensure efficacy, freedom from serious adverse effects, ease of administration, and affordability of the drugs and their combinations.[39] The guidelines recommend that ART be considered on both clinical and lab-based criteria in:

- patients with moderate to severe symptomatic HIV infection (combinations of pneumonia, persistent diarrhoea, weight loss >10%, pulmonary TB)
- patients with HIV infection and CD4+ count of <200/mm^3
- HIV positive individuals who also have tuberculosis or any other opportunistic infections or AIDS.

Inclusion of medicines into EDLIZ (Essential Drugs List and Standard Treatment Guidelines for Zimbabwe) is the prerogative of MoHCW on recommendation by NDTPAC. The current edition of EDLIZ (4th Edition 2000) does not list ARVs. It has been agreed in principle by NDTPAC to include them in the next edition expected by 2005.

At present, any doctor can prescribe ARVs regardless of whether they have received specific training or not. The quality of care is very variable and there is no register of doctors with expertise in prescribing ARVs. If only accredited doctors were given this facility along with systems for monitoring services, this would ensure a better quality of service and address the danger of resistance to ARVs, in a similar manner to tuberculosis treatment. It took more than two years to develop the present treatment guidelines, so it may be some time before the ministry puts in place regulatory instruments to govern who can prescribe. Besides, guidelines on their own will not change clinical behaviour by medical practitioners, unless supported by advocacy, accountability and effective monitoring.

3.3.5 Procurement, quality control and supply

Most ARVs have been imported into Zimbabwe through the private sector; some have been imported for research projects conducted through the university, while small amounts have been donated by individuals and international organisations to support groups such as the Centre. The Centres for Disease Control-Zimbabwe (CDC-Zim) has offered branded ARVs for a limited number of people (initially about 400) to NETA through Harare Central and Mpilo Hospitals.

NatPharm is the government owned company that procures drugs for public health institutions (central hospitals, district hospitals and health centres, uniformed forces, City Health departments and national wholesalers). It also procures important drugs for the private sector if the drugs are in short

supply. NatPharm's activities are mainly guided by what drugs are listed in EDLIZ. Government institutions are not charged duty on medicines supplied through NatPharm. At the time of writing they were not involved in procuring ARVs for the public sector, but were providing treatments for other HIV-related illnesses within the limitations of foreign exchange shortages mentioned earlier.

We visited ten pharmacies operating in different areas and serving different socio-economic groups of patients around the cities of Harare and Chitungwiza, to assess the extent of their provision of ARVs and other treatments for HIV and AIDS. Two pharmaceutical wholesalers in Harare were also visited. It was beyond the scope of the study to visit pharmacies outside of Harare. In the private sector, most pharmacies had drugs for OIs and pain relief, including treatment for meningitis, diarrhoea, thrush and severe headaches. The Table 5 gives the range of medicines available for OIs and pain relief.

Table 5: Medicines for OIs available at pharmacies

Disease	Medication available	Price per month's supply**
Meningitis	Amphotericin B	Z$70,000 per dose, up to 14 doses necessary per month.
Meningitis	Diflucane*	$200,000 for a month's supply (30 tabs)
Diarrhoea	Codeine phosphate and other anti-diarrhoeals are available	up to $12,000 for a month's supply
Thrush (Candida)	Various drops and creams are available	$4000 or more
Pain	Paracetamol is the cheapest option available, but often other pain killers such as morphine are prescribed	$1000 for 30 tablets

*Diflucane has been donated by Pfizer and is now available in selected public health institutions for free.
**At the time of the interviews, 1US$equalled Z$1500 on the parallel market.

Suppliers of ARVs in Zimbabwe include Independent (Managed) Healthcare, Geddes Pharmaceuticals, Greenwood Wholesalers and Avakash. Most ARVs in circulation pass through South Africa, but originate from Europe, the USA or India. When drugs are close to their expiry dates suppliers return them to the manufacturers to check if they are still usable.

Table 6: Antiretroviral drugs available in Harare pharmacies visited

Drug	Cost per month's supply in Z$	Number of pharmacies with stock	Comments
Videx (100mg) Videx (150mg)	50,000–60,000	3	Taken as combination with Zerit, Viramune or Crixivane
Zerit	20,000	4	
Crixivane 40mg	170,000–200,000	4	
Viramune	100,000–120,000	3	
Combivir	150,000–200,000	3	
AZT + Lamivudine (generic)	40,000	1	
Didanosine	48,000	1	Taken as combination with Stavudine
Stavudine	16,000	1	

Note: At the time of the interviews (March 2003), 1US$ equalled Z$1500 on the parallel market.

The pharmacies we visited stock medicines according to what their customers are buying, and what wholesalers are offering. They usually take drugs with long shelf lives, and return unsold drugs when they still have at least three months' shelf life. According to the pharmacists, people bought ARVs erratically. The main reasons for this were that costs prohibited regular purchases; patients stopped the costly treatment when they felt better; most patients scout around for cheaper sources; and some clients died. The pharmacy mark up for ARVs was lower than for other drugs – approximately 10% compared to up to 50% – because of the high costs involved with ARVs. We made the following observations, which probably apply to all the major towns of Zimbabwe:

- Some pharmacies had ARVs readily available in stock, and these were sold against a doctor's prescription.
- The ARVs available in pharmacies are very expensive, and the income of ordinary Zimbabweans means they are unaffordable.
- The number of people buying ARVs directly from pharmacies was small. Only one pharmacy reported that it had sold to more than 20 clients, and even then, less than 10 of these were regular clients.
- A significant number of the purchases were against company orders where the company was purchasing the medication for its senior personnel.

Three pharmacists mentioned that there was a parallel market for ARVs coming into the country from South Africa and Botswana. Cheaper ARVs are brought over borders illegally and sold to clients who usually pay in advance. Most people involved in cross-border trade do not have import licences for these drugs as required by MCAZ.

Even though international advocacy has brought down the prices of ARVs, they are still too expensive for most people in developing countries because they are still under patent. One reason for the declaration of the state of emergency was to allow the government of Zimbabwe to import generic

versions of the same drugs on grounds of the urgency of the public health crisis caused by HIV. Following the declaration, there has been a significant increase in the number of applications for generic ARVs submitted for registration to MCAZ. These were given priority status for evaluation without prejudice to the standard requirements. Clinical trials to gather local data were approved and continue to be considered for ARVs, as this information is not available in Zimbabwe for these medicines. However, some generic manufacturers do not appear to have sufficient experience with ARV manufacturing, quality testing and clinical testing, and have, to date, failed to satisfactorily address MCAZ's requirements on safety, quality and efficacy. The criteria are based on WHO guidelines on review of generic ARVs. The current WHO list of essential drugs already includes ARVs and this will be used for reference purposes in addition to the national treatment guidelines.

Table 7: Registered generic ARVs

Drug name	Generic trade name	Applicant/manufacturer
Zidovudine	Apo-Zidovudine 100mg capsules	ApotexInc. Canada
	Zidovir 100mg Capsules	Cipla Ltd India
	Zidovir 300mg Capsules	Cipla Ltd India
	Zidovir Solution 50mg/ml	Cipla Ltd India
	Aviroz 300mg Capsules	Ranbaxy Lab India
Lamivudine + Zidovudine	Lamivudine/Zidovudine 150/300mg tablets	Varichem Pharmaceuticals, Zimbabwe

Source: MCAZ

MCAZ raises the following as its specific areas of concern regarding provision of ARVs:

- ARVs are generally very expensive in Zimbabwe, so uncontrolled use could lead to pilferage because of their high resale value.
- ARVs may only be imported for wholesaling purposes by an approved pharmaceutical wholesaler that operates under the continuous personal supervision of a licensed pharmacist or pharmacy technician.
- Undeclared/smuggled medicines pose a serious threat due to their current ready market and are difficult to control.
- A formal mechanism is available to deal with reports of any treatment failures, product defects and adverse effects but depends on the pharmaceutical sector, the public and the health professionals to give such details.

3.3.6 Local production of ARVs

Zimbabwe does not have the infrastructure for manufacture of drugs, but local companies can formulate imported raw materials that would provide better access to treatment by reducing costs. Varichem Pharmaceuticals[40] obtained a licence in March 2003 from the Ministry of Health to produce a generic combination of two drugs, Lamivudine+AZT, priced at US$15 for a month's

supply. This price is pegged at the parallel rate that fluctuates frequently.[i] This combination will be taken with Nevirapine, which is available locally at Z$5000 for a month's supply. Varichem is also registering a triple combination (Lamivudine, Nevirapine, Stavudine) for local production. Their initiative will make ARVs available for purchase in Zimbabwe dollars, albeit at a price too high for most people, because they have to obtain foreign currency on the parallel market to buy raw materials. They see availability of cheaper foreign currency as the only option for cheaper drugs in Zimbabwe.

Varichem's drive to produce ARVs locally comes from their company strategy to lead in the local manufacture of antiviral, antifungal and antibiotic medicines, for which there is high demand in southern Africa. The compulsory licence awarded to Varichem was strictly on the basis that AIDS has caused a state of emergency in Zimbabwe, and they can only sell their drugs to Zimbabwe, or other countries that have declared HIV and AIDS a state of emergency. As a business-driven initiative, it remains to be seen how this could benefit more people. Varichem claims to have the capacity to produce sufficient ARVs for everyone needing treatment in Zimbabwe. An initial government requirement that 75% of locally produced ARVs had to be sold to NatPharm or to government public health institutions has now been reversed. If, however, NatPharm were able to source funding to purchase significant quantities of their product for the public health system, this would go a long way towards equitable access to ART in Zimbabwe. Varichem raised concerns that the technical and infrastructure requirements for administering ARVs through the public health sector were not yet in place. If the programme was not properly sustained, it could hurt their business through drug resistance problems, small market share and loss of capital injected.

3.3.7 Training programmes and materials production

The HIV/AIDS Quality of Care Initiative (HAQOCI) is developing training modules for OI prevention and pilot testing the materials at training workshops.[41] The overall plan is to conduct training on opportunistic infections for all healthcare providers in Zimbabwe and it will link up with the establishment of an OI clinic at Harare Hospital where more than half of patients are suffering from HIV-related illnesses. This clinic will be funded and supported by CDC-Zim. CDC-Zim is also a partner in the Caring for HIV and AIDS, Prevention and Positive Living (CHAPPL) initiative, with mission hospitals through Zimbabwe Association of Christian Hospitals (ZACH). The initiative will include developing materials for HIV care, capacity building for healthcare workers, and post exposure prophylaxis for healthcare workers. The HIV Clinicians of Zimbabwe, an affiliate member of the Southern African Clinician Society, was formed in 1997 and particularly focuses on education and training for HIV treatment in the private sector. In addition, a 'treatment literacy' workshop was held in January 2003 in collaboration with the Treatment Action Campaign from South Africa in conjunction with ASOs in Zimbabwe, with the purpose of better informing people living with HIV.

[i] At the forum to review the draft report, a representative from Greenwood Pharmaceutical Wholesalers indicated that Combinir was now available from Varichem at Z$150,000 (approx US$182 at the official rate, or US$27 at the parallel rate). It had just doubled in price from the previous week.

3.3.8 Treatment initiatives

Zimbabwe has enrolled onto Pfizer's Diflucan Partnership Programme that provides free the antifungal medication Diflucan (fluconazole) to patients suffering from cryptococcal meningitis or oesophageal candidiasis, opportunistic infections associated with HIV.[42] The programme is being implemented in 23 hospitals: the four central hospitals (Parirenyatwa, Harare Central, Mpilo, and United Bulawayo hospitals), Chitungwiza General Hospital, all Provincial Hospitals, and ten mission hospitals, including at least one mission hospital in each province (Bonda, Murambinda, St Luke's, St Theresa's, Chidamoyo, Louisa Guidotti, St Albert's, Gutu, Tshelanyemba and Howard mission hospitals). All Diflucan Partnership hospitals have undergone initial training and received their first allocations of Diflucan in March 2003. While this was well received in Zimbabwe, critics of large pharmaceutical companies' dealings with developing world economies were suspicious that the initiative had hidden strings attached, or that participating governments may have sacrificed their right to obtain generic fluconazole, directly or indirectly. Critics also questioned why[43] there is no free provision for HIV-positive women suffering from chronic vaginal candidiasis, which can be a very debilitating condition and often only needs a single dose of fluconazole. It was suggested that although the donation has no dollar or time limit, it might be cheaper in overall terms to invest in generic fluconazole, which would provide wider benefit with more flexibility.

There are two church hospitals already providing ART: Howard Mission Hospital in Chiweshe district and Luisa Guidotti Mission Hospital in Mutoko district. Luisa Guidotti Mission Hospital has 200 people already on treatment using donated ARVs secured for 5 years from Don Gnocchi Foundation and Bazzoni Foundation of Italy. Participants for the ART programme were identified from health workers at the hospital, patients already within their system of care, and community members in the surrounding areas that were identified as able to adhere to treatment regimens. About 30% of these patients are children from the local orphanage. Those who can pay are asked to contribute while those who cannot pay are treated free. International NGOs Medicin du Monde and Medecins sans Frontiere (MSF) are investigating setting up treatment projects in partnership with local hospitals and organisations in high HIV prevalence areas of Chipinge and Masvingo respectively. These treatment initiatives rely mainly on external sources of funding and expertise from international consultants and NGOs.

The Centre, a PLWHA support NGO set up in 1992, gives advice on nutrition, psychosocial support and palliative care for people with HIV. They receive donated and highly subsidised ARVs from well wishers and solidarity NGOs outside Zimbabwe, which they administer to 76 people from a waiting list of over 3000 people.[44] Those who receive free treatment are selected from urban and peri-urban Harare, and have to demonstrate their commitment to health by taking the prescribed supplements, attending support groups and other needs as medically prescribed.

The Commercial and Industrial Medical AID Society (CIMAS) has developed a 'Chronic Diseases Add-on' scheme (starting July 2003) where companies

can contribute an additional amount of money (Z$3600 per employee or adult dependant per month) to cover for HIV-related illness. The scheme covers for laboratory expenses for viral load testing, CD4 counts and antiretroviral drugs. The scheme is applicable at the firm level, that is, if an employer decides to enrol their employees, they do so for all employees and dependants registered on the company scheme. CIMAS currently provides medical cover for 420,000 people.[45] Premier Service Medical AID Society (PSMAS) has also developed a similar initiative where individual members contribute Z$23,000 per month. Some private corporations are considering treatment programmes for employees. Coca Cola Central Africa, for example, is working closely with CIMAS to establish a clinic that will treat their staff for STIs and OIs as part of the medical aid benefit that staff already have, in line with international guidelines proposed to companies manufacturing Coca Cola. The programme will not initially include ARVs. Unifreight Africa plan to expand their HIV education programme to include treatment with ARVs in the future. Other initiatives by corporations in Zimbabwe are shown in Table 8 below.

Table 8: HIV-related initiatives in selected Zimbabwean corporations

Name	Work force	Medical AID	HIV testing	Coun-selling/ Education	Providers on site	HBC	ART (# on Prog)
Anglo American Group	>20,000	Yes	Yes	Yes	Some sites		
Hippo Valley Estates	7000	Yes	Yes	Yes	Yes	Yes	
Delta Corporation	14,000	Yes			Yes		Yes (10)
TA Holdings	3500	Yes	Yes	Yes	Yes		
De Beers Zim. Prospecting	100	Yes	Yes	Yes			Yes (to begin in '03)

Source: Deliver, 2003

Many people with AIDS consult traditional healers, who do not have the same judgemental approach found in conventional clinics but readily provide symptomatic remedies for pain, opportunistic infections, and HIV. Most traditional healers are secretive about their treatments and do not submit their medications for scientific scrutiny. There has also been a proliferation of fake claims of cures for AIDS, a regulation issue that neither the Traditional Medical Practitioners Council nor the Zimbabwe National Traditional Healers Association has been able to resolve, because of the autonomous nature of traditional healing. ZINATHA and TMPCZ are working separately to document and formalise their approach to treating people for HIV and related illnesses. TMPCZ has put together a team of 23 chemists, biologists and biochemists to test the efficacy of herbs supplied by traditional healers. In one instance a traditional herb was evaluated and considered effective in suppressing TB in a study at the sole national TB lab in Bulawayo.[11] The Medical Herbal Centre in Harare provides a treatment package for AIDS using a combination of herbs provided by seven traditional healers. This combination, known to boost the immune system and stimulate appetite, is administered in six-month doses costing up to Z$40,000 in total. Prices for treatment are set according to the patient's ability to pay. The clinic is run part-time, and treats 20 people per day. We were not able to follow up with any patients that were on the programme or to find efficacy data.

4. Discussion, conclusions and recommendations

4.1 Discussion

In this review we established that addressing equity in access to healthcare has low priority in planning or provision of services for HIV and AIDS. As far as the WHO definition of access is concerned, Zimbabwe has achieved therapeutic access in that ART and treatment for OIs have been developed internationally and are available through the private sector in Zimbabwe. The majority of people do not however, have physical or financial access to ARVs and other drugs because neither they nor the government has the ability to pay for them in the current economic and political crisis.

4.1.1 Health service delivery

Where public money is used to provide services, it is essential that those who have the greatest need be offered services designed to prioritise those with the least ability to pay. At present, inequitable prevention through unreliable supplies of condoms; inequitable access to treatment for STIs through unreliable supplies of antibiotics; as well as treatment for other infections that compromise immunity, mean that poor people with HIV are likely to develop AIDS quicker than rich people who have better healthcare provision. This vulnerability exacerbates the interrelationship between poverty and HIV with poorer families carrying the burden of HIV in their communities. Improving access to healthcare as a means of preserving health therefore has to be a way of tackling worsening of poverty.

Good management of HIV-related illness also requires good quality health service delivery and integrated approaches rather than creating alternative vertical programmes. At the same time, the need associated with HIV care can drain resources from other services, putting considerable pressure on health budgets and health insurance schemes where they exist. Annual direct medical costs of AIDS (including the cost of treating and preventing OIs but excluding ARVs) in sub Saharan Africa have been estimated at about US$30 per capita. Overall public health expenditure is less than US$10 for the majority of African countries.[1] Although international advocacy has led to price reductions for some ARVs, the costs of counselling, testing, monitoring, and follow up add significantly to overall expenditure on medical management of AIDS. It is hard to calculate savings through treatment with ARVs for instance through avoidance of OIs in a context where most people are not receiving treatment for those conditions.

We found little attempt to address equity in the public policy choices being made. Until recently ARVs and treatment for most OIs were available mainly to those who could pay for them. Market-driven approaches tend to focus supply on higher income groups while low-income groups have to rely on other forms of treatment, such as through the informal sector. Many poor people visit traditional healers, but these also charge a range of prices and tend to be shorter term rather than providing consistent life-long supplies of treatment. Where

public health services are seriously under-resourced and staff operate in poor morale environments, quality of service suffers, and clients invest more of their personal funds and savings into acquiring private care. With such limited availability of public funding for healthcare in most developing countries, public-private partnerships are considered more seriously because of the realised benefits of integrating the two sectors in national health services provision.[8] The relationship between Varichem and NatPharm in local formulation of ARVs with guaranteed investment and markets is one such possibility.

When members of the public challenge use of the NATF they often ask why it is not used to provide treatment for PLWHAs. As part of public accountability, NAC needs to present to the public in accessible forms, analysis and justification for how decisions regarding public expenditure are made. As it stands at present, NATF would purchase ARVs for only 6000 people for one year if that was all it was used for. With an estimated national figure of more that 230,000 people needing ART annually, NATF could not provide a reasonable source of funds for a national programme. However, they could support the structures that are needed for such programmes to take off, such as identifying people in need, especially in deprived areas. Although the disbursement of NATF through DAACs sought to ensure equitable distribution geographically, DAACs need far more capacity building, especially in financial accountability to adequately carry this out. Since each district has received equal allocation, there has also been no deliberate targeting of districts with the greatest need, such as in Masvingo or Midlands provinces.

4.1.2 Targeting greatest need

There is a striking correlation between poverty and high HIV prevalence that should prompt equitable interventions to target both these areas. In Zimbabwe, the high prevalence areas are well known (the growth points, farming and resettlement areas) but HIV treatment interventions are proposed for areas with previously good health infrastructures, such as the major cities and large central hospitals where HIV prevalence is lower. Health experts within the centralised public health sector prefer to develop centres of excellence to manage the epidemic close to their reach and within their areas of expertise, rather than close to the areas with the greatest need, giving consideration to the dynamics of the epidemic experienced there.

If there are not already reasonable services existing in these areas, it is often too complex to start from scratch to build up infrastructure to respond to the greater need. Often, population groups have higher prevalence because health services are poorer in those areas, such as on commercial farms. It is more likely to be successful to initiate services in those areas that have already started providing reasonable HIV-related services of PTCT, VCT and CHBC, so that they contribute towards further integrated and continuing care approaches. Most of these initiatives are currently in mission hospitals that have traditionally served poorer rural areas and growth points. They could expand their efforts with support from NGOs and DAACs and also attract funding from international

agencies. These initiatives need assistance to focus their efforts more on the most vulnerable communities in their areas, to identify areas of greater prevalence in their communities and to monitor how well they are achieving goals of equity. Ideally they should work within a national framework that sets out desirable standards and expectations of care.

Despite Zimbabwe's background of health service collapse, it is important to promote equity of access to treatment within the public sector. Government health infrastructures have the most extensive outreach nationally, so the widest access to treatment would only be achieved through these, including the urban and rural municipal facilities. The present funding and leadership crisis in the health service is the main barrier to achieving the objective of a functional national treatment framework to respond to the urgency of the situation. Allowing treatment programmes to emerge wherever possible is a possible option to allow for the creativity that comes from diverse responses. The main drawback to this approach is of duplication of efforts, delays in initiating programmes as each international NGO considers its own strategy, and somewhat chaotic programmes being established that are hard to draw together within one national framework. With no framework for systematic lesson learning from these initiatives, monitoring and evaluation of these diverse programmes also becomes more difficult. As public services for ART are set up, experience from other countries on managing provision of ARVs has to be studied carefully. Criteria will be needed to decide who has priority for getting treatment; to define eligibility for free drugs; how much medication each patient will be given; how to avoid patients selling or sharing treatment if there is not enough to go round; clinical monitoring and resistance surveillance.

4.1.3 Links between treatment programmes and stigma reduction

Studies have shown that improving access to ART should be based on appropriate attitudes, skills and behaviours of those providing and receiving treatment, with greater involvement of those with HIV, their families and the community. Projects providing treatment – such as through the AIDS Support Organisation (TASO) in Uganda and the Khayelitsha project in Capetown – have demonstrated that provision of treatment gives hope, and this has a positive effect on dispelling stigma and denial.[46] The Khayelitsha project has shown how provision of treatment significantly strengthened prevention efforts by providing an incentive for people to seek VCT, promoting openness about HIV and reducing stigma. Uptake of VCT since introduction of a comprehensive package of AIDS care has increased from 1000 in 1998 to over 12,000 in 2002.[47] In Cambodia, treatment improved family and community understanding of HIV and made it easier to educate on prevention.[46] As numbers go, the potential demand for treatment is high, but denial and fear of disclosure hold people back from getting tested, a prerequisite for then getting on the road to ART. VCT services that should be at the forefront of prevention, advice on positive living and acceptance of HIV are mainly concentrated in urban centres of Zimbabwe, so do not serve the areas that need that guidance the most. This may change as treatment programmes are implemented in various centres and more mobile units are set up for rural areas.

Workplace treatment programmes are at an early stage in Zimbabwe and seem to concentrate more on protecting the investment made in middle and senior management. This is especially the case if medical insurance is used to pay for treatment. Addressing equity requires corporate sector programmes that tackle the needs of their 'shop floor' workers as much as managers. Shop floor workers tend to use public sector health facilities while management level employees use the private sector, usually covered by medical insurance. Since poorer people disproportionately carry the burden of HIV, workplace programmes have to extend the work they have done in the past on education to now ensuring care and treatment for shop floor employees. The Zimbabwe Congress of Trade Unions (ZCTU) was a key player in the development of Statutory Instrument 202 of the Labour Act and has been an active promoter of the human rights approach to prevention of discrimination in the workplace. Its negotiating efforts are presently undermined by the prevailing political crisis but need to take on the arena of quality of HIV care and access to treatment for all employees and their families. Linkages between developing workplace policies, tackling disclosure and worker support for HBC and child support for co-workers are important facets in challenging stigma.

4.1.4 PTCT and TB programmes as entry points for treatment and care

There has to be greater effort to reach pregnant women in marginalised groups on commercial farms, at growth points and border posts, especially since they are less likely to attend for ANC. In the longer term, the socio-economic reasons why young women in these areas are more vulnerable to HIV infection have to be resolved, but in the meantime, evidence of what works in enabling these young women to protect themselves must be applied as a matter of urgency. PTCT programmes are a good way of ensuring that HIV positive women get access to treatment programmes, as they are often excluded from formal workplace or research centred programmes. PTCT programmes are also a good entry point for women to learn about access to other programmes and resources, such as support groups, nutrition, home based care, and for bringing in their partners and children who may also be HIV positive. Women identified as clinically already eligible could be referred to treatment programmes, while those who were still relatively healthy would be followed up through community outreach, advice given for child health including vaccinations, and providing ongoing support for them to stay healthy. Some countries are considering PTCT+ that involves providing triple therapy for HIV positive mothers for 6 months over the pregnancy and breast-feeding period, to provide more effective protection for the baby and to preserve the mother's health over this vulnerable period. The programme also involves monitoring CD4 counts and continuing triple therapy for those women whose immunity is falling. These women and their partners (if their immunity were also falling) would then enter treatment programmes.

TB services are another possible entry point for better care for HIV that is under-utilised at present. Integrating AIDS related care into national TB services could assist in bringing treatment closer to the people who need it, by utilising the same nursing staff that are administering TB drugs.[48] The

advantages are that they are already well established, use a systematic protocol-led approach with registration, follow-up and community outreach systems built in, and with staff trained in dealing with stigmatising conditions. An AIDS treatment programme could also build on the experience of TB programmes in record keeping, direct observed medication, and drug supplies management. TB services are available at district level in Zimbabwe, still with good structures despite resource shortages affecting the entire public health service. Staff are trained to advise patients on taking medication over long periods, even though there is some difference between lifelong therapy as with AIDS and TB that is completed usually within a year. In addition, reciprocal screening for TB and HIV when clients present for one or other service, would assist with case-finding but also support education of individuals. Contact tracing and home-based care for TB can be extended to following up family members that need HIV testing and education. Additional resources will be essential to ensure continued quality for the combined facility, otherwise both services will be compromised.

The inconsistent use of ARVs reported by pharmacies because of the high costs involved is extremely worrying. The lessons from tuberculosis must be learnt here. Treatment for TB also comprises 3 or 4 drugs to prevent resistance, but provided free of charge through the public health system to ensure that these drugs remain useful for the whole nation, rather than leaving management of this disease to the vagaries of the private sector. Although the impact of AIDS is much worse than TB, we are not yet treating it as a public health hazard with the principles learnt about communicable disease control from past experience.

4.1.5 Advocacy and GIPA (greater involvement of people living with HIV/AIDS)

NGOs, ASOs, community based organisations and PLWHA groups in Zimbabwe who have been delivering prevention and support services are a resource that has been under-utilised thus far. A study[46] has shown that these groups could be much more beneficially involved in implementation of ART at various levels of provision of care. They can identify families that need support, can provide feedback on quality and appropriateness of services provided, act as mediators between services and groups of families living with HIV, provide lay counselling services, and disseminate information in accessible forms to their constituency groups. In order to be more effective they need better coordination, communication and accountability. As with most support groups those with access to information can provide valuable inputs to programme design and priorities. For example, Lynde Francis, former director of The Centre, feels that ART could go further if administered with structured treatment interruptions. The equity argument used here is that with structured interruptions, more people could be treated using the same volume of drugs.[49] Similarly, support groups can inform PLWHAs what possibilities already exist and how to call on health workers to advocate for them. This will help prevent sad situations, such as that of two well known HIV activists who died of meningitis because they did not get treatment in time even though Diflucan is now available free through the OI clinics. Researchers at UZ have not customarily involved affected people at

early stages of study design, but could learn from successful initiatives from the West where such collaborations have proven useful and effective.

TAC has rightly been acclaimed as a model of GIPA and has helped the treatment access process all over southern Africa through:

- publicising the equity issues that need to be addressed
- constantly reminding governments, private sector and other players of their roles and responsibilities in ensuring treatment for all
- campaigning internationally for lower drug prices
- providing important information on treatment, including treatment literacy, human rights and where treatment is available
- promoting the concept that people with AIDS have the right to life, to healthcare, to treatment; that they have the right to pride rather than shame, and that they are 'worth' treating just for themselves, rather being regarded as 'worthless'. They also have worth because many of them can continue serving society by continuing in their roles as carers, workers, community developers, parents, educators, and so on.

The lesson from TAC is that until activists make sufficient noise about the discrepancies in programmes (such as rural/urban, high/low prevalence areas, male/female, rich/poor status) development programmes will continue to be supply driven and progress at the pace of their implementers. In the West, policy makers, health professionals and pharmaceutical companies were forced to pay attention to the outcry about the slowness of research, legislation and funding because of the pressure they were placed under by activist communities. So long as no one is banging on the door, decision makers can take as long as they like to get things done, especially since they usually have preferential access to resources for their own personal needs.

4.1.6 Information access

It is crucial that the momentum that has emerged around access to treatment advocacy be maintained and accelerated. Evidence is emerging from regional experiences using public and private sector initiatives in Uganda, Malawi and South Africa that needs to be carefully documented so that other countries and organisations can build from that experience. A key catalyst in informing advocacy groups and activists in the region about successful campaign work, the issues around Doha, TRIPPS and WTO, government responses and so on, has been faster access to information networks than five years ago. Electronic media provide up-to-date accounts on all issues surrounding access to treatment. The AF-AIDS and PATAM (Pan African Treatment Action Movement) email discussion forums carry discussions on what organisations like TAC are doing, which give activists ideas on what they could take on in their own countries. TAC has an email newsletter with wide regional circulation that has influenced similar initiatives in other countries of the region, including Zimbabwe. It is now possible to share news, seek solidarity, mobilise the activist community within hours for meetings, email campaigns, demonstrations, and to identify key resource persons to attend conferences within the region.

Information that used to be exclusive and difficult to understand is now more accessible and summarised on websites. Organisations are able to download the Doha Declaration from the Internet. If someone does not understand what parallel pricing means they can look it up on the Internet, or ask someone from a listserve. More people can find out what international solidarity activities are being carried out through VSO,[50] ACT-SA, International HIV/AIDS Alliance[46] and OXFAM[51] documents and websites regarding prices. Internet servers are the fastest source of information on global programmes such as UNAIDS, the Global Fund for AIDS, TB and Malaria, WHO and initiatives by pharmaceutical companies such as Pfizer's free Diflucane initiative. In addition, sharing information on prices of drugs and the cheapest sources of high-quality generics through a fast medium such as email has facilitated advocacy groups putting pressure on drug companies. The VSO document 'Street Prices' gives an example of the price for 200mg fluconazole tablets being significantly higher in the Ugandan government listed price compared to Indian pharmacies, which may be because they are not aware of the cheaper option. VSO recommends a systematic approach to global equity pricing, using a price database and global price negotiations, accessed through website searches and VSO documentation.

The challenge is getting this information to people who want to take part but do not have easy access to email or Internet. Examples of good practices that would benefit organisations and people living with HIV need wide dissemination that is feasible through a combination of electronic and print media. We carried a report in SAfAIDS News on the MSF treatment initiative in Khayelitsha, Capetown, and the writer received over 100 enquiries by email and post from readers as a result. Capacity building PWA groups and advocacy organisations on how to access information is a vital part of the solidarity movement, which enables them to use information to further their cause. Activism can be used as a means to make informed demands, building up a sense of community amongst HIV-positive people and bridges to overcoming stigma. Individuals trained on use of web-based resources to access information from the Internet show a keen interest to stay connected.[52] There have to be especial efforts to include the people that need information most. Advocacy groups in Zimbabwe and elsewhere need resources and training for further disseminating this information to wider groups of PLWHAs, activists and supporters to mobilise the pressure needed to achieve the goal of equity in access to care and treatment.

4.2 Conclusions and recommendations

In this review we note that there is considerable interest to establish ART programmes in Zimbabwe but there is little planning for how this can be done with equity. Some have argued that without a properly functioning health service it is impossible to provide the necessary facilities for ART and that advocacy should concentrate on improving this before recommending programmes for treatment. In the current political and economic crisis, church hospitals and NGOs are seeking their own funds to access treatment and PLWHAs are mobilising to put pressure on national and international agencies to support them. There is a danger that a chaotic response will lead to problems of drug resistance

and poor overall care as scarce resources are stretched over duplication of services. Advocacy for improvement of national healthcare delivery is essential for equitable services, but can continue alongside and in support of pilot projects that help to establish standards of good practice. Monitoring tools, logistical support, training for personnel, and sufficient funding is urgently needed for a countrywide ART programme. An equitable national programme for HIV-related services needs extensive international and national collaboration to mobilise the financial and technical resources required.

Initiatives from non-government players (NGOs, mission hospitals and international assistance programmes) make treatment using ARVs an immediate possibility, albeit, for limited numbers of people. As local treatment systems develop, aided by international pressure to reduce prices and produce generic formulations within Zimbabwe, it will be possible for those who can pay to access treatment through the private sector. The challenge is also to make provision for those who cannot pay. A new energy is emerging from the activism of people living with HIV to address concerns of access to treatment. There are opportunities here to direct this energy towards advocacy for overall improvement in quality of care for HIV-related illness, integration of services and prioritisation of those at greatest need. For this to happen, PLWHA groups need capacity building, better communication and information access, coordination, training and resource building. Mechanisms to share knowledge and experience from other countries' successes, and to set in place processes to learn from them, are essential and need investment from all who are concerned about equity in healthcare.

The most responsive interventions to date tend to follow areas with programmes providing HIV services such as VCT, prevention of PTCT and CHBC. Some are provided by mission hospitals in deprived areas, so provide for people with greater need. They are also in communities already mobilising to support people with HIV and are therefore best placed to consolidate this work by integrating treatment as part of the continuum of care. These programmes could focus more on groups known to have the highest prevalence of HIV such as in commercial farming areas, resettlement areas and growth points.

National efforts to address HIV still fall short in Zimbabwe because of a combined absence of political will and commitment on the part of the government and relevant ministries, as well as a fragmented activist movement that does not hold institutions to account. The medical profession has also reneged on its duty by not advocating for the best interest of their patients, as they are professionally obliged to do. The state of emergency in place in Zimbabwe has enhanced the ability to override patent issues for HIV drugs and locally made repackaged generics a potential reality. However, this has been under-utilised as an opportunity to really address issues of treatment access with urgency and in an equitable timely fashion. People living with HIV and AIDS, as well as organisations acting in their solidarity, need to mobilise around the urgency of the AIDS situation in Zimbabwe. With around 500 AIDS-related deaths a

day, there is a compelling argument for a strategic integrated response to all aspects of the impact of HIV in the country. This would need to address the challenges shown in the table below, with options for how this can be done:

Challenges	Recommendations
1. Urgency of HIV epidemic: Although Zimbabwe has nearly 800,000 orphans and 500 deaths a day that could potentially be postponed if not prevented by ART, there are few programmes for HIV-related illness on the ground today that include ART.	National and international organisations and networks need to advocate more effectively for Zimbabwe to take the HIV epidemic more seriously at every level of society. The leadership needs to address the urgency of ameliorating the current and anticipated impact on every aspect of development. Access to equitable treatment is one part of this response.
2. Principle of equity: There is very little commitment to ensuring that services are provided on the basis of need rather than ability to pay	As a principle of quality health services and justice, equity of access based on need should be built into all negotiations related to developing services for HIV-related illness. Good practice lessons on how to reach the poorest communities with high prevalence should be documented and disseminated to highlight the need to plan for equity.
3. Resistance to first line ARV medications: If this develops, these drugs will become useless for wide use for the greatest number of those eligible and more expenditure will be required using second line drugs for fewer people	Preservation of first line medication by preventing resistance developing is possible if the same principles of using TB drugs apply, with good regulation ensuring adherence to regimes and good public health practices. This is more possible if treatment is provided free rather than based on ability to pay, which encourages inconsistent use when people run out of money.
4.Centres of excellence: The Ministry of Heath and University of Zimbabwe are directing the setting up of treatment initiatives in the main cities away from the areas of greatest need	District based health centres (such as mission hospitals) have already taken the initiative to set up community based VCT and home-based care and are now expanding into prevention of PTCT. They are preferable places to develop treatment initiatives as they are closer to the areas of greatest need and will ensure equitable and efficient programmes reaching more people.

5. Regulation: There is currently no of who prescribes ARVs.	There is urgent need for MoHCW to accredit doctors based on training and service provided.
6. Funding: The funds currently available are not sufficient for equitable provision of treatment based on need.	A major reason for resistance to providing funding to the government is the current political situation and poor financial accountability. Advocacy groups need training and support in challenging the government on its governance procedures. In the interim, international donors should be encouraged to channel funds to organisations embarking on treatment programmes within an NGO framework that still considers equity and other standards of care.
7. Lack of information: At the moment, very few beneficiaries of existing and impending programmes know what is on offer. Resources that have been developed by international NGOs have also had limited distribution.	Treatment literacy and IEC materials on access to treatment that have been developed should be disseminated widely, especially to areas with high HIV prevalence. This will also equip HIV positive people with the information they need to demand treatment as their basic right. Organisations and support groups will benefit from capacity building initiatives that help them access treatment through email discussions (such as Af-AIDS) and websites. There needs to be more transparency on the part of the NAC as far as sharing information on its activities is concerned, especially in advising the NGO sector about government initiatives such as the national emergency.
8. Monitoring and evaluation: There is inadequate monitoring and evaluation on expenditure of resources allocated and activities done especially within existing national programmes.	The national treatment programme should be more accountable to the beneficiaries. It is important to facilitate the development of a national strong group of activists for treatment. The group can partner national and international networks in advocating for transparent national responses.

9. Priorities: These often do not depict the situation on the ground, especially regarding where to place interventions, who to target, and what to offer in the intervention.	We recommend that programme planners, policy makers and implementers of public HIV intervention programmes utilise data and evidence from previous interventions. For example, the sentinel surveillance statistics can be used to identify areas of greatest need, and programmes should target those before piling services where they already exist.
10. GIPA: Limited involvement of people infected or affected by HIV and AIDS. The GIPA Principle (i.e. true involvement of people with HIV rather than simply tokenism) is rarely put into practice in the important structures, including NAC, NGOs and ASOs.	Activists should be assisted to obtain sufficient knowledge so that they can lobby for equitable access to treatment. Without activism, national programmes can continue at a pace determined by the public health service without considering the urgency needed to address the situation. It is recommended to include HIV positive people with relevant skill in the important structures of the national response, following the GIPA principle set by UNAIDS.
11. The national HIV policy and strategic framework: Developed when treatment using ARV drugs was not seen as a potential reality. As such it is silent in advocating for ART.	We recommend that the national policy and strategic framework be appended to include ART. Part of the strategy should be to enable the government, on behalf of the people, to lobby for external funding (such as through the Global Health Fund), and to negotiate with pharmaceutical industries to lower their prices. Further, it could be a means by which an overall strategy for ARV procurement could be incorporated at the SADC level, as part of a regional framework.
12. Uncoordinated efforts: Various organisations are embarking on an assortment of treatment interventions in different parts of the country without reference to a strategic national plan.	A comprehensive national framework for HIV services, including rational use of ARVs, would ensure that each additional initiative adds to a carefully planned basket of initiatives. It is important to share information across the board so that programmes are aware of where they fit in the national mix of interventions. This can also lead to greater transparency and more efficient use of resources rather than duplicate efforts.

13. Community education and mobilisation: This is not often planned for as an integral part of a treatment package when using a health based response to a social and development problem.	Lessons from management of TB need to be applied here, recognising that overcoming stigma and acceptance of people living with HIV by communities are essential components for the success of programmes. Community education and mobilisation have to form integral parts of any treatment package. The work of NGOs, CBOs and support groups has a vital contribution to make here.

There is good will on the part of the donor community to support the current interest in setting up treatment programmes providing they see commitment from the government to implement the existing strategic framework, to restore and improve the health service delivery infrastructure, and mobilise the political will necessary to address the urgency of the situation. In the meantime, NGO and church hospital projects are getting ad hoc support. However, the wider HIV networks in Zimbabwe need to act to support collaboration and coordination of this process so that it feeds in to a national framework, particularly when the healthcare environment has improved. Equitable access to healthcare including treatment for HIV-related illness is crucial for reducing the further impoverishment of families living with HIV.

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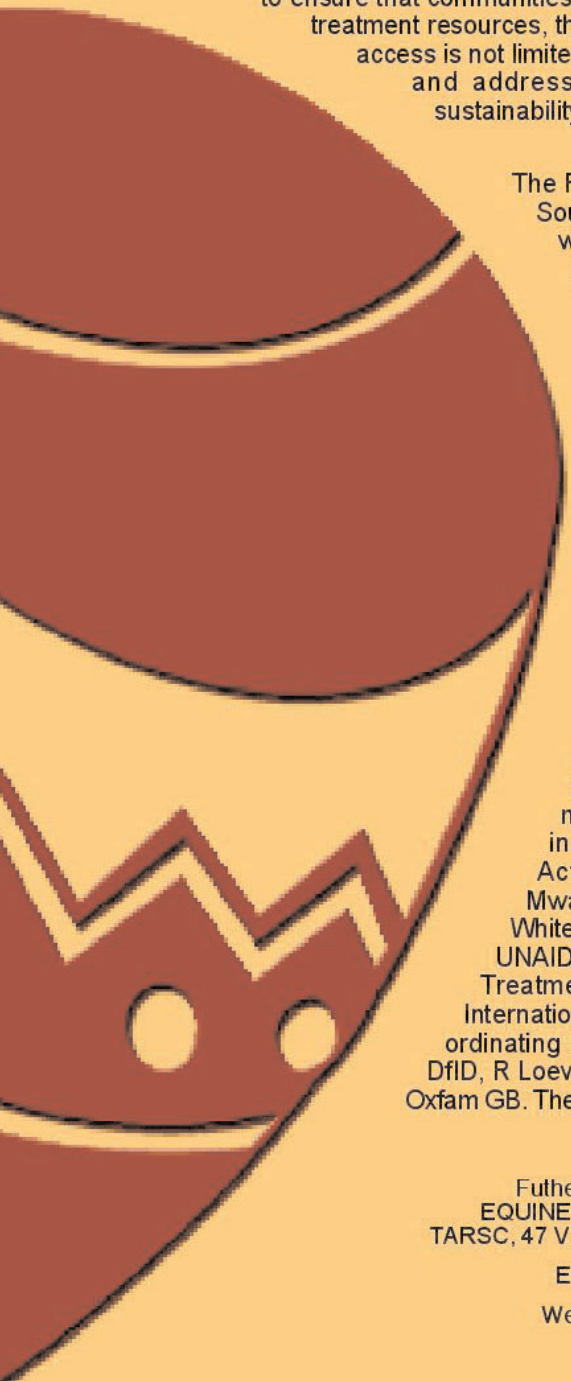
Appendix 1: List of ARVs Registered in Zimbabwe

Type	Drug	Brand Name	Manufacturer /Supplier	Patent	Registered	Strength	Form
Non-nucleoside reverse transcriptase inhibitors	Nevirapine	Viramune	Ingelheim	0	Yes	200mg	Tablets
		Viramune	Ingelheim		Yes	50mg/5ml	Solution
		Nevimune	Cipla		Pend	200mg	Tablets
		Flaminev	Flamingo		Pend	200mg	Tablets
		Nevtpan	Ranbaxy		Pend	200mg	Tablets
		Nenivir	Hetero		Pend	200mg	Tablets
	Efavirenz	Stocrin	Merck		No		
		Sustiva			No		Capsules
	Delavirdine	Prescriptor	Pharmacia		No		
Nucleoside Reverse transcriptase Inhibitors	Zidovudine	Retrovir	Glaxo Wellcome	0	Yes	50mg/ml	Syrup
		Retrovir	Glaxo Wellcome	0	Yes	100mg	Capsules
		Retrovir	Glaxo Wellcome		Yes	300mg	Tablets
		Zidovir-100	Cipla		Yes	100mg	Capsules
		Zidovir	Cipla		Pend	300mg	Tablets
		Zidovir	Cipla		Pend	50mg/ml	Solution
		Aviro-Z	Ranbaxy		Pend	300mg	Tablets
		Apo-ziduvodine	Apotex		Yes	100mg	Capsules
		Flamizid	Flamingo		Pend	300mg	Tablets
		Zido-H	Hetero		Pend	300mg	Tablets
		Ginevir	Gosun Phamaceuticals		Pend	100mg	Capsules
	Didanosine	Videx	BMS		Yes	25mg	Tablets
		Videx	BMS		Yes	50mg	Tablets
		Videx	BMS		Yes	100mg	Tablets
		Videx	BMS		Yes	150mg	Tablets
		Videx-Paediatric	BMS		Yes	2g	Powders
		Videx-Paediatric	BMS		No	4g	Powders
	Zalcitabine	Hivid	Roche		No		Tablets
	Stavudine	Zerit	BMS		No	15mg	Capsules
		Zerit	BMS		Yes	20mg	Capsules
		Zerit	BMS		Yes	30mg	Capsules
		Zerit	BMS		Yes	40mg	Capsules
		Zerit	BMS		Yes	1mg/ml	Powders
		Stavir	Cipla		Pend	30mg	Capsules
		Stavir	Cipla		Pend	40mg	Capsules
		Avostav	Ranbaxy		Pend	30mg	Capsules
		Avostav	Ranbaxy		Pend	40mg	Capsules
		Flamistav	Flamingo		Pend	30mg	Capsules
		Flamistav	Flamingo		Pend		
		Stag-30	Hetero		Pend		
		Stag-40	Hetero		Pend		

Nucleoside	Lamivudine	Epir	Glaxo Wellcome	0			
Reverse		3TC	Glaxo Wellcome		Yes	150mg	Tablets
transcriptase		3TC	Glaxo Wellcome		Yes	10mg/ml	Solution
Inhibitors		Zeffix	Glaxo Wellcome		Yes	5mg/ml	Solution
		Zeffix	Glaxo Wellcome		Pend	100mg	Tablets
		Lamivir	Cipla		Pend	150mg	Tablets
		Flamivud	Flamingo		Pend	100mg	Tablets
		Heptavir	Hetero		Pend	150mg	Tablets
		Anolam	Ranbaxy		Pend	150mg	Tablets
	Abacavir	Ziagen	Glaxo Wellcome	0	Yes	300mg	Tablets
		Ziagen	Glaxo Wellcome		Yes	20mg/ml	Solution
	Tenofovir		Unknown		No		
Combination	Lamivudine + Zidovudine	Combivir	Glaxo Wellcome	0	Yes	150mg/ 300mg	Tablets
		Avocomb	Ranbaxy		Pend	150mg/ 300mg	Tablets
		Duovir	Cipla		Pend	150mg/ 300mg	Tablets
		Zidolam	Hetero		Pend	150mg 300mg	Tablets
		Lamivudine -Zidolam	Varichem		Pend	150mg/ 300mg	Tablets
	AZT/ Lamivudine + Abacavir	Trizivir	Glaxo Wellcome		Yes	150mg/ 300mg/ 350mg	Tablets
Protease inhibitors	Saquinavir	Fortovase	Roche	0	No		
		Invirase	Roche		Pend	200mg	Capsules
	Ritonavir	Norvir	Abbott		Yes	100mg	Capsules
		Norvir	Abbott		Yes	80mg/ml	Capsules
	Indinavir	Crixivan	MSD		Yes	200mg	Capsules
		Crixivan	MSD		Yes	400mg	Capsules
		Indinavir	Hetero		Pend	400mg	Capsules
		Avorodin	Ranbaxy		Pend	400mg	Capsules
		Flamind	Flamingo		Pend	400mg	Capsules
	Nelfinavir	Viracept	Roche	0	Pend	250mg	Tabelts
		Viracept	Roche	0	Pend	50mg/ml	Powder
	Amprenavir	Agenerase	Glaxo Wellcome	0	Yes	150mg	Capsules
		Agenerase	Glaxo Wellcome	0	Yes	50mg/ml	Capsules
Combination	Lopinavir + Ritonavir	Kaletra	Abbott		Pend		Capsules

Source: DELIVER, 2003.

HIV/AIDS has had a deep impact on health and health equity issues in Southern Africa. Health services in southern Africa have faced a significant challenge to ensure that communities access prevention and care. With new treatment resources, this now includes ensuring that treatment access is not limited to the wealthiest globally or nationally, and addresses wider health system needs for sustainability and equity.



The Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam GB with government and civil society partners have initiated a programme of research, policy analysis and intervention on equity in health sector responses to HIV/AIDS. The programme has reviewed policy issues relevant to equitable health care responses to HIV/AIDS in Malawi, South Africa, Tanzania and Zimbabwe and in relation to health personnel and nutrition. The discussion papers in this series arise out of this work. They are also available on the EQUINET and Oxfam Websites.

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Futher information is available from:
EQUINET Secretariat/Theme co-ordinator:
TARSC, 47 Van Praagh Avenue, Milton Park, Harare

Email: admin@equinetafrica

Website: www.equinetafrica.org