



# Zimbabwe Presentation

*Towards Virtual Elimination of Pediatric  
HIV: Adaptation of WHO HIV and AIDS  
Guidelines  
IAC, 2010*



# Presentation Outline

- Introduction
- Background
- Process of Guidelines revision
- Current Status
- Challenges
- Lessons Learnt
- Next Steps

# Introduction

- HIV is the top most indirect cause of maternal mortality in Zimbabwe (Maternal Mortality Study, MOHCW, 2006)
- Estimated prevalence of HIV is 13.63% (Zimbabwe HIV Estimates, 2009)
- About 1,000 people die weekly due to HIV-related illnesses
- By the end of 2009, about 1,1 m Zimbabweans estimated to be living with HIV and AIDS
- Over 593,168 in need of ART (Adults and children)

# Background

- 12 million People
- 493,889 Expected Deliveries/yr
  - 94% received ANC (DHS )
  - 68% deliver in Health Institutions
- 47,494 HIV infected pregnant women expected annually
- 17,370 new pediatric HIV infections annually



# Guiding Principles for Revision of ART Guidelines

- **First, do no harm**  
Seek to maintain the current progress of treatment programs
- **Accessibility**  
Ensure that all clinically eligible PLHIV are able to enter treatment services
- **Quality of care**  
Ensure that care achieves the highest standards possible.
- **Equity of access**  
Ensure fairness and justice in access to treatment services.
- **Efficiency in resource use**  
Aim to achieve the greatest health impact with the optimal use of available human and financial resources.
- **Sustainability**  
Understand the long-term consequences of changes with the vision to provide continued, life-long access to ART for those in need.

(Source: WHO Adaptation Guide, 2010)



# Approach

- The Zimbabwe Ministry of Health agreed in principle to adapt the WHO Global HIV and AIDS Guidelines
- The National Drug Therapeutics Policy and Advisory Committee (NDTPAC) is mandated to provide advisory role on appropriate treatment regimens for Zimbabwe
- NDTPAC was tasked to revised the National ART Guidelines incorporating the new WHO Guidelines
- Concurrent revisions of ART, PMTCT, and Infant Feeding Guidelines were conducted
- An Adaptation committee was constituted to work in close liaison with NDTPAC to develop operational plans for implementing the revised guidelines

# Approach cont'

- TOR for Adaptation committee and NDTPAC were developed
- It was agreed that the process should be consultative with multiple stake-holders to gain consensus and aimed at enhancing commitment and ownership
- Phased approaches will be used during implementation phase
- Small Working Groups were constituted to work on specific thematic areas- *PMTCT and Infant Feeding, ART, Laboratory services, and Logistics (quantification and costing)*
- The Adaptation process would feed into GFR10 proposal development



# Status of Guidelines Review

- A Road Map for adaptation process was developed early 2010
- NDTPAC held several meetings to review the Global WHO Guidelines and made country specific recommendations based on the *feasibility*, *acceptability*, and *financial implications*
- Adaptation Committee met jointly with NDTPAC to review the ART Guidelines recommendations from the advisory body
- A situational analysis was conducted to assess country's preparedness, health system strengths & weakness and ability to adapt the WHO guidelines (Adult, Adolescent & Paediatric Guidelines)



# Status of Guidelines Review cont'

- Critical decisions were made through consensus regarding when to start (ART); what to start; IF Recommendations etc
- Costing of various implementation scenarios is being worked out
- Adaptation process and regular updates are shared with partners (HIV Care and Treatment and TB Forum, PMTCT Forum, etc )
- Adaptation guides from EGPAF and WHO were regarded as key reference tools to guide the adaptation process
- Revision of National ART Guidelines is now completed awaiting printing and dissemination
- Revision of HIV Treatment Targets in June 2010 based on new HIV Estimates

# Highlights of the Revised National ART Guidelines

- ART *must* be started in those with WHO clinical stages 3 and 4 or CD4 less than 350 cells/mm<sup>3</sup> in all adults and adolescents including pregnant women.
- Preferred 1<sup>st</sup> line regimen for adults, adolescents, and older children will be TDF/3TC and NVP and ZDV/3TC/NVP as alternative 1<sup>st</sup> line regimen
- d4T will be phased out over a 2-3 year period
- More efficacious regimens for PMTCT will start at 14 weeks including extended use of NVP for infants
- Option A has been recommended for pregnant women who are not eligible for ART (see next slide)
- Exclusive breastfeeding for the 1<sup>st</sup> 6 months and prolonged breast feeding up to 2 years is being recommended
- First-line regimens for infants previously exposed to single-dose nevirapine during PMTCT will include the use of a protease inhibitor (PI).

WHY OPTION A?	
<p><b>OPTION A</b></p> <p><b>ADVANTAGES</b></p> <p><b>Acceptability:</b> HCWs + mothers + community already familiar with drugs</p> <p><b>Feasibility:</b> Minimal additional training required Minimal adjustment of training and M&amp;E tools required Easier to pack (as part of essential UNICEF/UNITAID/WHO-supporting mother baby pack), and drug procurements already secured</p> <p><b>Costs:</b> Cheaper ARV drugs + less laboratory monitoring (although no formal cost comparison done)</p> <p><b>Others:</b> Opportunity for mother to bring their children for follow-up when mother is collecting NVP</p>	<p><b>OPTION B</b></p> <p><b>ADVANTAGES</b></p> <p><b>Efficacy:</b> <i>"Both options A and B provide significant reduction of the MTCT risk",</i></p> <p><b>BUT</b></p> <p>? More viral suppression with triple therapy, ? More efficacy, ? Less resistance</p> <p><b>Feasibility:</b> Shorter infant prophylaxis</p> <p><b>Future developments:</b> May be more in line with future guideline developments – move towards triple therapy</p>
<p><b>DISADVANTAGES</b></p> <p><b>Health implications:</b> Extended NVP prophylaxis –risk of toxicity, non adherence and resistance</p> <p><b>Future developments:</b> May not be in line with future guideline developments – move towards triple therapy</p>	<p><b>DISADVANTAGES</b></p> <p><b>Feasibility:</b></p> <ul style="list-style-type: none"> <li>• More extensive training required (including adjustments of training manuals)</li> <li>• Delivery of HAART in all ANC settings (? nurse prescribing)</li> </ul> <p><b>Costs:</b></p> <ul style="list-style-type: none"> <li>• More expensive ARV drugs; More intensive laboratory monitoring required; HAART for mother until BF stops</li> </ul> <p><b>Health implications:</b></p> <ul style="list-style-type: none"> <li>• More drugs, more side effects</li> </ul>

# Lessons Learnt

- Strong and committed leadership provided strategic direction
- The development of ToR with clear roles and responsibilities at the beginning enhanced a shared vision and focus for each stake-holder
- Use of existing committee (NDTPAC) helped to leverage on local expertise and improved efficiency in the guideline revision process
- Broad stake-holder participation enhanced commitment and ownership of the adaptation process

# Challenges

- 85% of sites still using SD NVP; few sites offering MER & EID
- High staff attrition rates: constant need to train and retrain
- Limited capacity for ART initiation (currently only doctors authorized to initiate ART)
- High user fees leading to drop in ANC attendance
- Weak program linkages- patient referral systems
- Limited access to lab services- Rapid HIV testing, CD4 testing, PCR for EID, Viral load testing; weak SCMS; transportation of DBS specimens



# Challenges cont'

- Unavailability of CD4 counts

- Inadequate machines
- Machines breaking down
- Stock outs of reagents
- Results not getting back to site



**POC CD4 machine**

- Shortages of commodities and medicines- ARVs, CTX, HIV Test kits and essential equipment for good ANC and MCH services
- Weak recording and reporting
  - challenges in data quality, timeliness of reporting, data transmission, patient tracking systems, too many registers & forms to fill, nurses spend too much time on data recording
- Weak follow-up of mother-baby pairs



# Next Steps

- Finalization of the quantification and costing of various scenarios
- A WG meeting for Laboratory will be convened to determine new country requirements for an expanded lab support and identify gaps
- Resource mobilization will be conducted
  - Partners will be approached to garner their buy in to support the implementation of the new ART Guidelines
  - Lobbying ministry of finance for increased resources from the fiscus
- An effective Communication Strategy will be developed targeting the public and implementers to guide the phased implementation plan
  - Health worker sensitization meetings & training on revised guidelines
  - Demand creation for new services
  - Frequent updates provided at partnership fora, meetings, conferences etc

ACTIVITY	TIME-LINES	BUDGET (US\$)
Presentation of Revised WHO Guidelines to partners during the Partnership Forum for a for HIV and AIDS Care and Treatment and Tuberculosis	28 <sup>th</sup> January, 2010	0 (Budgeted under ART Programme)
Re-defining TORs for Adaptation committee and NDTPAC	Feb, 2010	0
Hold at least monthly adaptation committee meetings for 1st 6 months and bi-monthly thereafter (Working Groups)	2010-2011	7,500 (600 under ESP)
Conduct Situational Analysis using the WHO Adaptation Guide	May-June, 2010	15,000
Inclusion of recommended treatment guidelines into GFR10 proposal	April-August, 2010	0 (covered under CCM budget)
Present progress updates to Partnership Forum for HIV and AIDS Care and Treatment and TB and PMTCT Partnership Forum, ESP WG, and TMT (MOHCW)	2010-2011	0 (covered under Programme budgets)
Hold periodic Stake-holder Consultative Meetings and as and when required (2-3)	2010-2011	4,500 (2,500 under ESP)
Resource Mobilization for recommended treatment options	2010-2011	0
Printing of Revised Treatment Guidelines	July, 2010	40,000
Health worker sensitization meetings on revised treatment guidelines (2 workshops)	2010-2011	20,000
<b>TOTAL</b>		<b>89,400</b>
<b>Available Funding</b>		<b>3,100</b>
<b>Funding Gap</b>		<b>86,300</b>



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