Global AIDS Response Country Progress Report

Zimbabwe 2014

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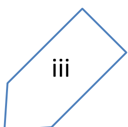
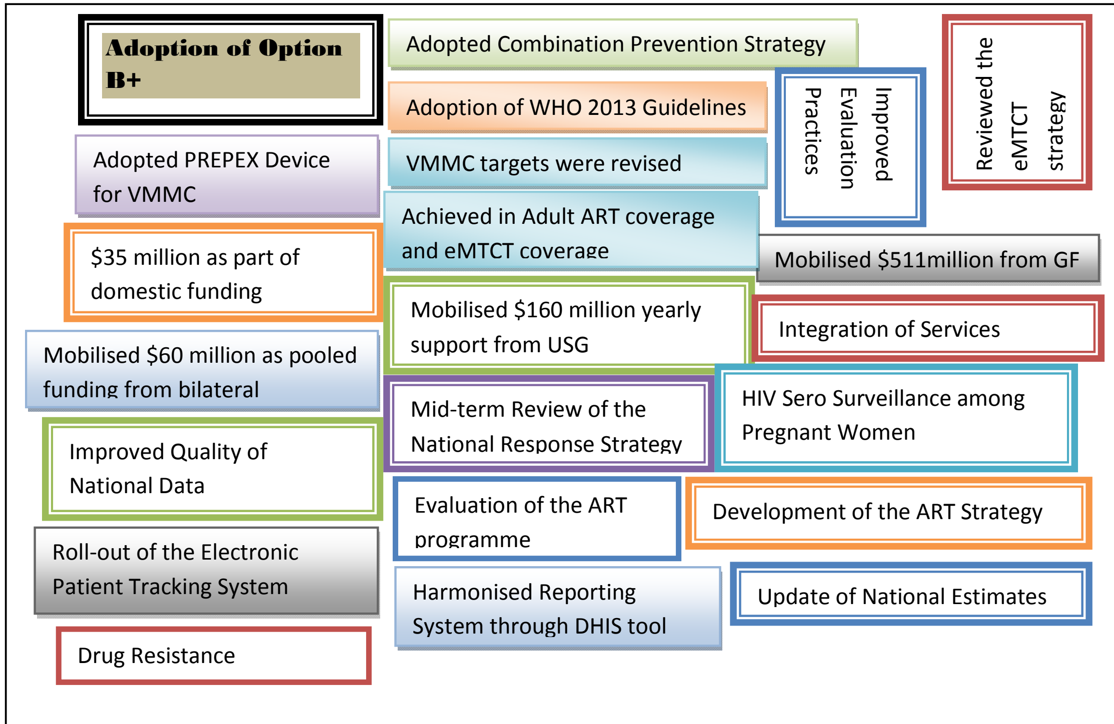


Highlights of Key Achievements



1 Status at a glance

This section highlights the impact and outcome results achieved in the AIDS response so far. There are visible tremendous gains made as show by table 1, 2 and 3 below with respect to numbers of deaths averted, new infections averted and life gain years.

1.1 Estimates of the Impacts of the National Response 2013

Table 1: Impact Estimates

Impact indicators	2011	2012	2013
Deaths averted by ART (Thousands)	40.42	48.22	45.7
Infections averted by PMTCT (Thousands)	6.41	12.75	15.11
Life years gained by ART and PMTCT (Thousands)	210.02	269.79	323.47
Deaths averted by PMTCT (0-4) (Thousands)	2.91	4.06	5.4
HIV incidence rate	1.29	1.25	0.98
Annual HIV related deaths	115117	87335	61476
Total AIDS orphans	1151235	1084906	810135
HIV prevalence among pregnant women aged 15-24	12.5%	11.56%	9.85%

1.2 Programme Performance

The country has achieved universal access coverage in most of the lifesaving interventions. Table 2 provides the details.

Table 2: Programme Performance

Year	2007	2009	2012	2013
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	22%	59%	85%	**93%**
Number of Adults 15-49 who were tested and received results	579767	1108264	2240344	**2274328**

Number of males circumcised during the past 12 months according to national standards		2801	40775	**112084**
Percentage of eligible adults and children currently receiving antiretroviral therapy.	Adults - 31.3%, Chn – 9.7%	Adults - 62%, Chn -22.2%	Adults- 85% Chn- 43%	**Adults – 76.9%, Chn – 46.12%**
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	**93.1%**	**75.0%**	**85% (Adults – 85.4%, Chn – 82.8) ;**	**85.7% (Adults- 87.1% Chn – 85.6%)**

2 Background

2.1 Introduction

The Global AIDS Response Progress Report 2014 provides an appraisal of progress towards achieving High Level Meeting (HLMs) targets set in 2001. Zimbabwe participated in the high level meeting during the 65th Session of the United Nations General Assembly held in June 2011 to review progress made in the HIV and AIDS response since 2001. Goals were set in the National HIV and AIDS Strategic Plan (ZNASP 2011-2015) in order to achieve the HLMs targets. In 2013 the country conducted a midterm review of the national strategy in order to refocus and align the national strategies with the international commitments.

The data gathering and report writing process was coordinated by National AIDS Council in collaboration with the Ministry of Health, Child Care (MoHCC) and partners. The country setup a Global AIDS Response Progress Report Technical Working Group (TWG) including the civil society organizations, association of PLHIV and members from the Zimbabwe National Research Monitoring and Evaluation Advisory Group. NAC chaired the TWG and led the data gathering and analysis process. Data gathering and validation meetings were held with all sectors including public, private, civil society and development partners. A desk review of available literature on the country's response efforts to HIV and AIDS was also conducted. The final draft of the report was presented to national partners for validation.

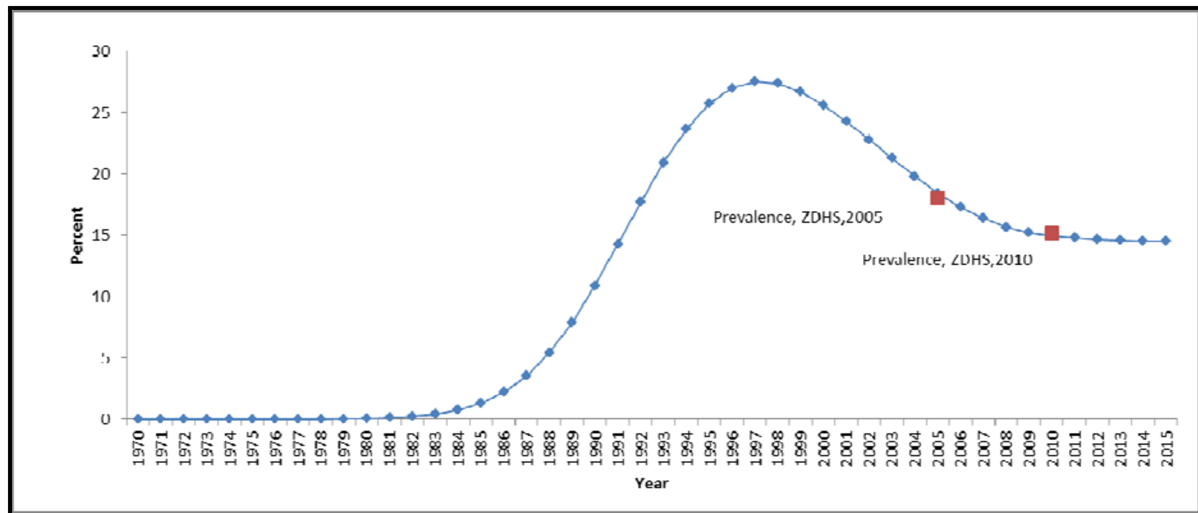
2.2 Status of HIV Epidemic

Zimbabwe has a total population of 13 million, with a population growth of 1.1%[1]. Zimbabwe has a generalized heterosexually driven HIV epidemic with adult prevalence of 15%[2] and an incidence of 0.98%[3]. The epidemic looks fairly homogenous with similar HIV prevalence levels across the ten provinces. However there are hot spots of HIV which are border towns, mining areas, growth points and resettlements farms. The HIV prevalence is slightly higher in urban areas than in rural areas. HIV prevalence in 15-24 age group women is 1.5 times higher than in men.

[1] Zimbabwe Population Census Report 2012.
[2] Zimbabwe Demographic Health Survey Report 2010/11
[3] National HIV and AIDS Estimates Report 2013

The decline in HIV prevalence was projected to have started in the late 1990's according to the 2012 version of Epidemic Projection Package spectrum (Figure 1). The prevalence peaked in 1997 at 26.48% (24.96 – 27.77%) and started declining thereafter as shown by figure 1 below.

Figure 1: Trends in Adult (15+) HIV Prevalence, Zimbabwe 1970-2015



Source: National HIV and AIDS Estimates Report 2012

There was a sharp drop in HIV incidence from about 5.5% in adults in 1992 to about 0.98% in 2013. The decline of new infections is attributed to gains from positive behaviour change and high ART coverage. New HIV infections in children up to 15 years of age have been declining due to overall lower levels of both HIV infection in women at child-bearing age and mother-to-child transmission interventions.

2.3 Policy and Programmatic Response

Zimbabwe has over the last 25 years developed a policy environment for HIV prevention culminating in a multi-sectoral approach lead by National AIDS Council. In 1999, the National Policy on HIV and AIDS was adopted, followed by creation of the National AIDS Council through an Act of Parliament. There is a large number of policy instruments relevant to HIV prevention at national and sectoral level.

The country has crafted and passed bills that help uphold rights of vulnerable people. Among them are the 1997 Criminal Procedure and Evidence Amendment Act No. 8, the

Criminal Procedure and Evidence Amendment Act and, the Sexual Offences Act of 2000, the 2006 Child Adoption Act, and the 2007 Domestic Violence Act.

The national response has been guided by the following policies and strategic documents in Zimbabwe:

- National AIDS Council Act
- Income Tax Act
- National HIV Policy 1999
- National Health Policy
- ZIMASSET
- Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) – 2011-2015
- National Health Strategy 2011 - 2015

The Government of Zimbabwe has continued to demonstrate great commitment and leadership to the fight against the HIV and AIDS. The government facilitated the review of the National HIV and AIDS strategy in order to align with international commitments. Zimbabwe has adopted the investment case model to implement the prioritised interventions that contribute to specific impact results. The ZNASP 2011 - 2015 has articulated four impact level results outlined below.

- Impact 1: HIV incidence reduced by 50% from 0.85% (48, 168) for adults (2009) to 0.435% (24,084) by 2015
- Impact 2: HIV incidence reduced among children from 30% in 2010 to less than 5% by 2015
- Impact 3: HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2010) to 44,205 for adults and 8,304 for children by 2015
- Impact 4: The national multi-sectoral response improved: The NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015

Several structures at national and decentralized levels have a mandate to coordinate the complex multisectoral HIV response. There is acknowledgement of NAC as the overall coordinating body while the Zimbabwe AIDS Network coordinates the civil society response. Also of importance is the role of faith and community based networks and organizations

The Government of Zimbabwe continue to collect the AIDS Levy which is 3 % of payee and corporate tax. The tax is collected by the Zimbabwe Revenue Authority and is directly remitted on a monthly basis to the National AIDS Council. The AIDS levy is the major contributor of domestic funding to the national response. The government continues to receive external support from the Global Fund, US Government, Department for International Development (DfiD) and other international partners.

3 Performance of the National Response

3.1 Status of Key Impact Indicators

1. **HIV incidence reduced by 50% by 2015**

   Over 50% reductions in adult HIV incidence for the past decade

   The target of achieving 50% reduction as stated in the ZNASP 2011-15 seems achievable with the current gains that have been made.

2. **HIV incidence reduced among children from 30% in 2010 to less than 5% by 2015**

   73% reduction in HIV incidence among children

   Zimbabwe is a signatory to the Global HIV Elimination plan from mother to child transmission. The country is likely to meet its elimination target of <5% by 2015

3. **HIV and AIDS related mortality reduced by 38% by 2015**

   47% reduction in HIV and AIDS related mortality

   The country has already achieved the stated target in the ZNASP due to high coverage of ART and PMTCT programme.

4. **The national multi-sectoral response improved:**

   National Composite Policy Index rating at 8.0

   The NCPI rating has improved from 6.2 in 2010 to 8.0 in 2013. This reflects an improvement in policy, political commitment and overall strategic environment required for a multisectoral national response.

3.2 National Response to the AIDS Epidemic

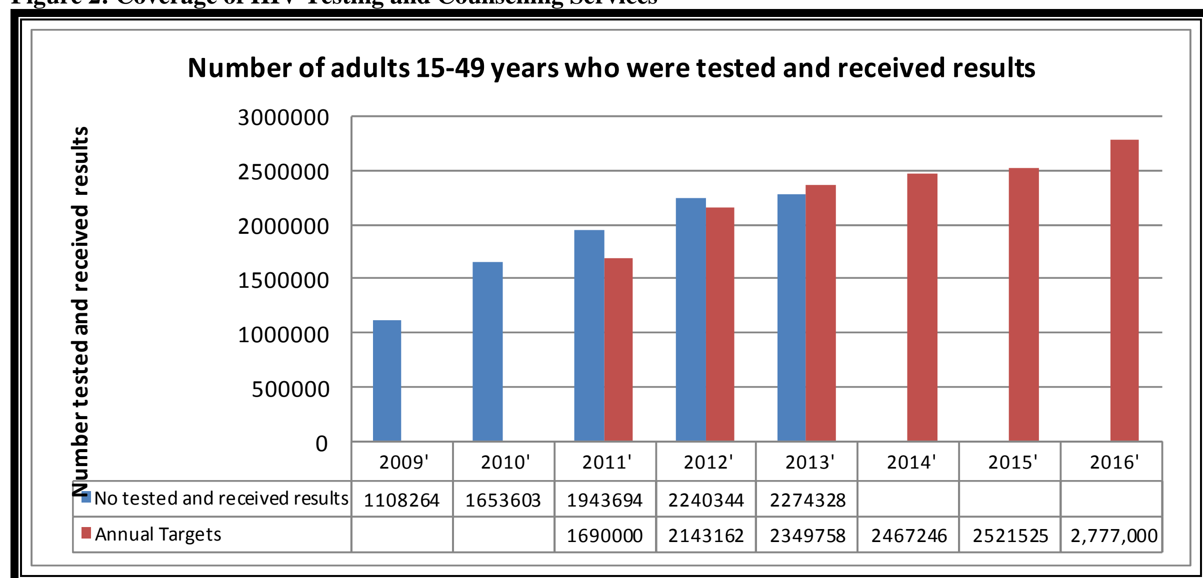
3.2.1 Prevention

HIV Testing and Counselling

HIV testing is a crucial first step in the cascade of HIV treatment and an entry point to other prevention and care interventions including male circumcision, prevention of mother-to-child HIV transmission, and treatment of opportunistic infections. The DHS 2010/11 shows a marked increase in HIV testing coverage among both men and women. Furthermore, 91% of women and 88% of men knew where to access HTC services. In 2013 a total of 2,274,328 adults aged 15-49 accessed HTC in Zimbabwe against a target of 2,349,758 (Figure 2). Currently a total of 1,456 health care facilities are providing integrated HTC services through Antenatal Clinic (ANC), OI clinics, stand alone Testing and Counselling centres, outreach centres, TB clinics and STI clinics. HTC services are available to all citizens that need, inclusive of key populations. The key implementing partners of the program are; PSI; OPHID; ZAPP and WHO

Despite the gains made there is need to continue strengthening linkages and referral systems between HIV testing and subsequent interventions in the continuum of care. Emerging issues including community based HIV testing and counselling and the potential introduction of self-testing to reach the hard to reach populations needs to be explored.

Figure 2: Coverage of HIV Testing and Counselling Services



	2009'	2010'	2011'	2012'	2013'	2014'	2015'	2016'
No tested and received results	1108264	1653603	1943694	2240344	2274328			
Annual Targets			1690000	2143162	2349758	2467246	2521525	2,777,000

Social and Behaviour Change Communication

The country has adopted the combination prevention strategy of which the National Behaviour Change programme is guided. The programme adopted the home visit model to share integrated behaviour change information. The Zimbabwe National Behaviour Change Programme (NBCP) is operative in all 65 districts of the country and is well integrated into different sectors. Outreach includes prisons and prison officers and prisoners have been trained in behaviour change courses.

The SBCC programme targets the sexually active in the 15 to 49 age group (men, women, boys and girls). A total of 7,947,109 person exposures were achieved in 2013 against a target of 5,480,000. Reviews have acknowledged SBCC as a high impact programme in Zimbabwe, and as one of the key interventions in the decline of HIV prevalence. SBCC interventions were intensified in the community, workplace and in schools, targeting most at risk and key populations. Key implementing partners of the programme are, World Vision; Regai Dzive Shiri; ZiCHIRe; Batsirai; FACT Mutare; Zimbabwe AIDS Support Organisation (ZAPSO); Matebeleland AIDS Council; Midlands AIDS Support Organisation and UNFPA

Condom Promotion and distribution

100 million male and 5.2 million female condoms distributed in 2013

Condoms are distributed through public and private channels using the social marketing approach. In 2013, 100 million male condoms and 5.2 million female condoms were distributed. Key populations access female and male condoms in selected sites and health facilities. Implementers in the condom programme are mainly the local authorities, MoHCC, ZNFPC, PSI and PSZ.

Zimbabwe has remained an internationally acclaimed best practice in condom distribution. Despite the large scale distribution, gaps in consistent condom use persist, particularly

within concurrent sexual relationships. Additionally, levels of condom use among PLHIV are low despite high levels of sexual activity.

Voluntary Medical Male Circumcision (VMMC)

VMMC Coverage 14%

Male circumcision is one of the key components of the National Combination Prevention Strategy. It is estimated 1.3 million men aged 15-49 (2012 to 2017) are required to be circumcised to achieve 80% coverage required to have public health benefit from the programme. Cumulatively about 176604 men were circumcised translating to 14% of the target. In order to scale up effort for VMMC, the country has adopted the PrePex device. Integrating early infant male circumcision in a horizontal approach as part of routine care of mothers and infants would make this programme more sustainable in the long term. The providers of this service are; PSI; ZAPP, ZACH/ITECH; UNFPA; MOHCC, WHO.

Prevention of Mother to Child Transmission of HIV (PMTCT)

PMTCT coverage 93% in 2013

High quality, comprehensive PMTCT services are currently provided in 95% of the 1,560 health facilities in Zimbabwe. PMTCT is one of the programmes that have achieved universal access (93% in 2013). Table 4 bellow shows programme performance in details

Table 3: PMTCT

Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths1					
Year	**2007**	**2009**	**2011**	**2012**	**2013**
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	22%	59%	86% [MOHCW, PMTCT Data base]	85% (PMTCT programme data)	93% (PMTCT programme data)
3.2 Percentage of infants born to HIV-positive women receiving. a virological test for HIV within 2 months of birth	Unable to report on this because our Lab MIS could not disaggregate	Unable to report on this because our Lab MIS could not disaggregate	29% [MOHCW, PMTCT Data base]	36% (PMTCT programme data)	57%(PMTCT programme data)
3.3 Percentage of child infections from HIV infected women delivering in the past 12 months -	No programme data available for	31.0% [MOHCW, PMTCT	21% (National HIV Estimates	18% (National HIV Estimates	9.61% (National HIV Estimates

Mother-to-child transmission of HIV (modeled).	this indicator	Report]	Report 2009)	Report 2011)	Report 2013)
3.4 Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	Only had ANC figure which is 71%	85%	96% [MOHCW, PMTCT Data base]	97% (PMTCT programme data)	99% (PMTCT programme data)
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	4%	6%	10% [MOHCW, PMTCT Data base]	14% (PMTCT programme data)	18% (PMTCT programme data)
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	Indicator not collected	7%we assessed 3335 of the expected 50069 pregnant women. This is only for 7 districts that were offering MER 28	71% [MOHCW, PMTCT Data base]	78% (PMTCT programme data)	66% (PMTCT programme data)
3.7 Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks	26%	46%	85% [MOHCW, PMTCT Data base]	81% (PMTCT programme data)	86% (PMTCT programme data)

Zimbabwe adopted Option B+ in order to enable the elimination agenda. The recent national estimates reviewed that eMTCT rate has reduced from 18% in 2011 to 9.61% in 2013. The country is currently conducting PMTCT impact study which will inform future scale up of the programme. The programme is supported by USG, EGPAF, WHO/CIDA,

UNICEF/CIDA, Global Fund, CHAI and NAC. The resource envelop available for the elimination of mother to child transmission is as follows:

Table 4: eMTCT Funding Matrix

Funding Source	2012-13		2013-14	
US Government	13,944,189	33.6%	12,401,489	32.3%
CIFF	10,946,727	26.4%	10,946,727	28.5%
DFID	7,936,742	19.1%	8,275,000	21.6%
Global Fund	3,548,743	8.5%	424,650	1.1%
CIDA	1,682,303	4.1%	2,074,519	5.4%
UNICEF	1,291,464	3.1%	1,291,464	3.4%
WHO	1,105,000	2.7%	1,000,000	2.6%
GOZ-AIDS Levy	532,470	1.3%	532,950	1.4%
Axios	224,000	0.5%	224,000	0.6%
AUSTRALIAN AID	150,789	0.4%	176,000	0.5%
PSI	141,120	0.3%	141,120	0.4%
ESP	3,176	0.0%	3,176	0.0%
UNITAID Diagnostics	-	0.0%	900,000	2.3%
Grand Total ($USD)	41,506,723	100.0%	38,391,095	100.0%

3.2.2 Treatment, Care and Support

Antiretroviral Therapy (ART)

The country has adopted WHO 2013 guidelines. The total number of PLHIV receiving ART in Zimbabwe is 665,299 including 618,980 adults and 46,319 children with more than 9,000 PLHIV initiating treatment each month.

ART coverage; Adults 77% and Children 46%

Table 5: Performance of ART programme

Year	2007	2009	2012	2013
Percentage of eligible adults and children	Adults -	Adults - 62%,	Adults- 85%	Adults – 76.9%,

currently receiving antiretroviral therapy.	31.3%, Chn – 9.7%	Chn -22.2%	Chn- 43%	Chn – 46.12%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	93.1%	75.0%	85% (Adults – 85.4%, Chn – 82.8) ;	85.7% (Adults- 87.1% Chn – 85.6%)
Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy			79% (October 2010 Cohort data)	83.2% (Adults – 88.8%, Chn – 82.6%)

There was an evaluation of the National Treatment programme that has culminated into the revision of its five year strategy. Despites all these strides, the paediatric ART coverage remain at 46%, which is significantly below the universal access target of 85%.The key partners are*:* MSF, Private Sector, SafAIDS, MOHCC, NAC, ZHAU, CDC and UN

HIV/TB collaboration

Zimbabwe continues to experience a major HIV driven TB epidemic with co-infection rates of 82%. Considerable progress has been made towards addressing the 12 point WHO collaborative TB/HIV activities. As of 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 71% received ART. Progress on implementation of the 3I's has been very slow especially Isoniazid preventive therapy (IPT). TB/HIV services are available to all key populations that need it. The key implementing partners for the programme are: Private Sector and MOHCC

Orphans and Vulnerable Children

The government developed a National Case Management System in order to address the needs of the OVC. School related assistance has a coverage of more than 60% through the Basic Education Assistance Module.

3.2.3 Management and Coordination of the Response

Coordination of the National Response

National Composite Policy Index rating improved from 6.2 to 8.0

National AIDS Council led the coordination of the national response in line with UNGASS three ones principle. Sectoral coordination was strengthened and public sector coordination board was established. Other sectoral coordination was assured through associations, committees, Councils and networks such Country Coordinating Mechanisms, Zimbabwe Network of People Living with HIV, Council of Churches and Zimbabwe Business Council on HIV and AIDS.

The country conducted a mid-term review of the National HIV Strategic Plan which informed the response.

National Commitment and Policy Instruments

The political, legal, social and economic situation in 2013 was conducive for the broad-based multisectoral and multilevel participation in the national response to HIV and AIDS. High level commitment on HIV and AIDS was evidenced through continued strong support for the AIDS Levy and active leadership engagement on HIV and AIDS issues. Political support was further demonstrated by the establishment of Zimbabwe Parliamentarian Portfolio thematic Committee on HIV and AIDS and the Zimbabwe Parliamentarians on HIV and AIDS participating in HIV prevention programmes as role models.

The country conducted a stigma index study aimed to assess the prevalence of stigma and identify its determinants so as to inform designing of appropriate remedial interventions.

Monitoring and Evaluation

The country reviewed the National Monitoring and Evaluation Plan to monitor the National Strategic Plan. The country improved data quality, evaluation culture, harmonised reporting system through the DHIS tool, conducted drug resistance monitoring, ANC survey and rolled out the electronic patient monitoring system. The nation has adopted the quality improvement monitoring as a tool to ensure quality service provision.

Health and Community Systems Strengthening

The nation has adopted the community-based models for patient tracking, treatment adherence support and home based care. Monitoring and Evaluation tools were developed for community care workers to monitor programme performance.

Retention of health staff has improved largely due to increased remuneration through the Global Fund and Health Transition Fund supported retention scheme. The country adopted integrated training curriculum to support decentralization and integration of programmes

4. Major Challenges

The following challenges were experienced in 2013:

- Stock outs of HIV test kits and the country has mobilised more resources to procure HIV test kits.
- Low peadiatric ART and the country is in a process of scaling up and decentralizing peadiatric ART services
- Low coverage of VMMC and the nation has adopted the demand generation model and the PrePex model to increase uptake of VMMC services
- Stock out of ART medicines that prompted the country to improve on ordering and delivery system of medicines
- Limited funding due to withdrawal of other funders and the country has developed a resource mobilization strategy
- Some 7% of HIV + pregnant women are still receiving single dose regimen (less efficacious)
- Logistics and Supply chain management challenges
- Delays in review of policy to broaden nurses' scope of work
- Slow decentralization of ART initiation, especially for children
- Weak linkage between Health and Community systems
- Multiple committees/working groups creates bottlenecks for more effective coordination

- Civil society organizations (CBOs, NGOs) are under-funded
- No statutory instrument to enforce data reporting by all partners in particular the private sector
- Data quality issues
- Limited funding for Isoniazid Preventive Treatment scale-up services

5. Conclusions and future priority Actions

Opportunities for enhanced sector coordination exist through: ZNASP 2011-2015 Evaluation recommendations; using HIV experience to support other sector coordination; new members of the House of Assembly to advocate for stronger support on policy and legislative issues on AIDS; realignment of laws in line with constitution and HIV perspective of the reviewed National Gender Policy. Most important policy issue in 2014 is to strengthen systems and infrastructure in order to increase content alignment of ZNASP and ZIM ASSET.

Priority areas of focus for the future, common to the national AIDS strategy and the ZIM ASSET strategy, include:

1. Harmonize and strengthen procurement and distribution systems for ARVs for uninterrupted supply
2. Improve laboratory performance (especially turn-around time for DNA-PCR test results).
3. Health care workers capacity to initiate ART among TB/HIV co-infected and among children.
4. Community health worker multi-skilling and capacity to tackle other health problems
5. Intensify programming for adolescents and other key population and remove barriers to service access
6. Strengthen harmonization and alignment of partners' contribution to ZNASP priorities and results.
7. Based on the MTR of ZNASP, develop costed action plan that can show programmatic priorities, funding needs and gaps
8. Develop National investment case to advocate for filling of the funding gaps
9. Mobilize more resources to fill up funding gap that will be generated by the National action plan