GLOBAL AIDS RESPONSE PROGRESS REPORT 2016

FOLLOW-UP TO THE 2011 POLITICAL DECLARATION ON HIV/AIDS

INTENSIFYING OUR EFFORTS TO ELIMINATE HIV/AIDS

ZIMBABWE COUNTRY REPORT

Reporting Period: January 2015 -December 20 15

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Status at Glance

The inclusiveness of the stakeholders in the report writing

The National AIDS Council coordinated the compilation of this report with support from the AIDS and TB Unit of Ministry of Health and Child Care (MoHCC) and partners . The country set up the Global AIDS Response Progress Report Technical Working Group (TWG), composed of the Zimbabwe National Research Monitoring and Evaluation Advisory Group, a multi-sectoral group of research, monitoring and evaluation experts, which includes government, private sector, civil society, UN Family and development partners representatives. TWG chaired by NAC created an enabling environment for the data gathering process. Data was collected and populated on the online reporting tool. The final draft of the report was presented to stakeholders for validation before submission.

The Status of the epidemic

The HIV epidemic in the country remains generalized, feminized and homogenous and continues to decline in new infection rates, prevalence and AIDS related mortality. However, there are areas of high HIV transmission which includes border districts, growth points, small scale mining areas, fishing camps and commercial farming settlements (HIV Hotspots Mapping Report 2014).

The Government of Zimbabwe remains committed to ending AIDS by 2030 and adopted 2013 ART guidelines in order to increase access to services. Enabling policies exists to support the multi-sectoral response in line with the High Level Meeting targets.

The AIDS Levy established in 2000 remains the sustainable homegrown innovative domestic financing mechanism although seventy percent of the total cost of the national response is externally funded (NASA 2011/2012).

Table 1and 2 below highlights the performance of core indicators of the national response.

Table 1: Performance of impact indicators – HIV Estimates 2015

Impact indicators	2011	2012	2013	2014	2015
Deaths averted by ART (Thousands)	40.42	48.22	45.7	57.4	62.3
Infections averted by PMTCT (Thousands)	6.41	12.75	15.11	16.3	13.9
Life years gained by ART and PMTCT (Thousands)	210.02	269.79	323.47	428.3	501.6
Deaths averted by PMTCT (0-4) (Thousands)	2.91	4.06	5.4	5.9	5.65
HIV incidence rate	1.29	1.25	0.98	0.92	0.74
Annual HIV related deaths	115117	87335	61476	54994	31217
Total AIDS orphans	1151235	1084906	810135	719477	524581

Table 2: Overview of performance of core indicators

Year	2007	2009	2012	2013	2014	2015
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	22%	59%	85%	82%	79%	85%
Number of Adults 15-49 who were tested and received results	579,767	1,108,264	2,240,344	2,274,328	1,755,179	2,201,246
Number of males circumcised according to national standards (cumulatively)		2,801	40,775	112,084	400,235	601,303
Percentage of eligible adults and children currently receiving antiretroviral therapy.	Adults - 31.3%, Chn –	Adults - 62%, Chn -	Adults- 85% Chn- 43%	Adults – 76.8%, Chn –	Adults – 63.6%, Chn –	Adults – 72%, Chn –

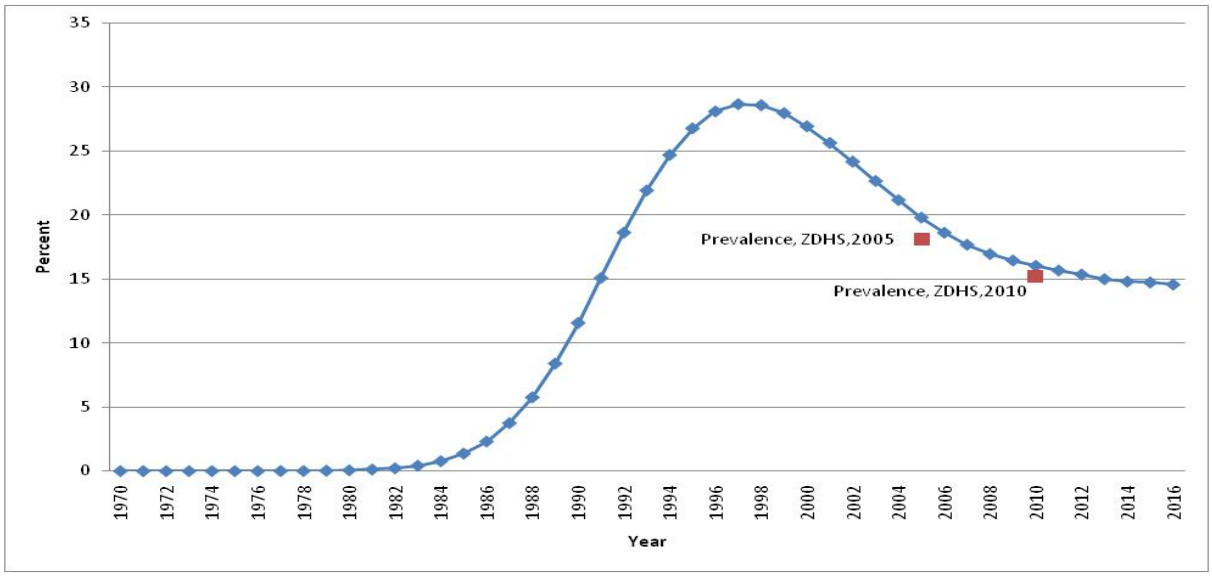
	9.7%	22.2%		40.5%	45.5%	99.8%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	93.1%	75.0%	85% (Adults – 85.4%, Chn – 82.8) ;	85.7% (Adults- 87.1% Chn – 85.6%)	89.5% (Adults- 89.7% Chn- 88.3)	86% (Adults- 85.5% Chn- 91.2%) *ART outcome Report 2015-16*

Overview of HIV epidemic

Zimbabwe has a projected population of 13 million [1] people and is among the countries in Sub-Saharan Africa worst affected by the HIV and AIDS epidemic.[2] The HIV prevalence among adults 15 years and above was 15% according to the Zimbabwe Demographic Health Survey in 2010/11.[3,4] The figure 1 below shows the trend in adult HIV prevalence.

Figure 1: Trends in adult (15-49 years) HIV prevalence

[1] Census 2012 report
[2]ZIMDAT; Census Report 2012
[3]ZIMDAT; Zimbabwe Demographic Health Survey Report 2010/11.



Source: National HIV and AIDS Estimates Report 2014

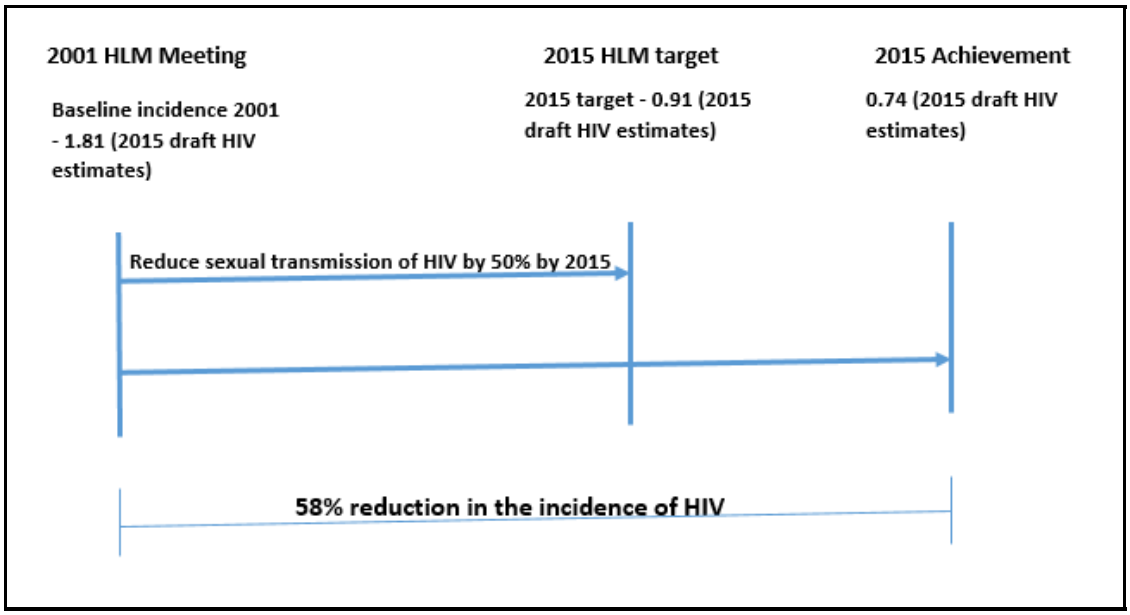
The adult HIV prevalence has shown a declining trend and is now plateauing. The decline in prevalence is attributed to the impact of prevention programs aimed at behavior change (high condom use and reduction in multiple sexual partners), prevention of Mother to Child Transmission services, and successful treatment care and support services.

Status of the Implementation of the High Level Meeting Targets.

Reduce Sexual Transmission of HIV by 50% by 2015

Progress towards the desired target is illustrated below with the trends in incidence rate.

Figure 2: Progress towards target of reduction of new infections.



Reduction in new infections is attributed to reduction in sexual partners and increase condom use in risk sexual relationship. Similar behavioral change pattern has been observed through cross sectional studies among sex workers and other key populations.

In an effort to address the key drivers of the epidemic, the country has scaled up interventions on social and behavioral change, condom promotion and distribution coupled with intensified awareness on correct and consistent use of condoms; Voluntary Male Circumcision, HIV Testing Services, prevention and control of sexually transmitted diseases. These interventions were implemented as combination prevention services. The coverage of the interventions are as follows:

a) Social and Behaviour Change (SBC)

SBC interventions were implemented in the community, workplace and in schools. A total of 2,437,632 person were reached in 2015 against a target of 2,649,600 and 44.2% were referred for integrated HIV services. Behaviour Change Facilitators (BCFs) are using the door to door approach to enhance information dissemination through Inter-Personal Communication (IPC) reaching families, couples and individuals. The programme has deliberately considered young people through the Sister to Sister and Brother to Brother initiative that aims to enhance self-efficacy of young people to access and utilise integrated HIV prevention, SRH

and Gender Based Violence (GBV) services by empowering them to make responsible reproductive health decisions.

b) Condom Promotion and distribution

Condoms are distributed through public and private channels using the social marketing approach. In 2015, 109.4 million male condoms and 5.6 million female condoms were distributed. Targeted condom promotion and distribution was done in high transmission areas.

c) Voluntary Medical Male Circumcision (VMMC)

Male circumcision is one of the key components of the National Combination Prevention Strategy. Table 3 outline number of people circumcised by age by year from 2009 to 2015.

Table 3: Circumcision procedures done from 2009 to 2015

Year	(<1Yr)	(1-9Yrs)	(10-12Yrs)	(13-14Yrs)	(15-19Yrs)	(20-24Yrs)	(25-29Yrs)	(30-49Yrs)	(50Yrs+)	Total
2009	-	-	-	17	216	765	794	994	15	**2,801**
2010	-	-	-	1,792	1,954	2,626	2,069	2,506	229	**11,176**
2011	-	-	-	8,771	11,403	6,502	4,382	5,207	477	**36,742**
2012	-	-	-	11,087	12,572	6,916	4,503	5,150	484	**40,712**
2013	-	-	-	46,471	35,324	13,173	7,949	8,327	840	**112,084**
2014	-	-	-	97,687	62,533	23,067	11,699	12,748	1,322	**209,056**
2015	46	3,777	38,804	39,819	54,011	25,027	14,294	11,788	1,166	**188,732**
Total	**46**	**3,777**	**38,804**	**205,644**	**178,013**	**78,076**	**45,690**	**46,720**	**4,533**	**601,303**

It is estimated that 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 601,303 men were circumcised translating to 46.3% of the target. The main methods used for VMMC are still the Forceps Guided Method, followed by the Dorsal Slit and the Prepex device. In order to scale up VMMC the

country has finalized the task sharing policy thus allowing nurses to conduct male circumcision and capacity building of nurses took place. Roll out of the Prepex device is underway.

d) Key Populations

Table 4 below outline key population reached with HIV prevention programmes for 2014 and 2015. These prevention interventions are offered as a package for combination prevention.

Table 4: Key populations reached with HIV prevention programmes

INDICATOR	2014	2015
Number of sex workers reached with HIV prevention programmes	7320	16904
Number of truck drivers reached with HIV prevention programmes	5684	6407
Number of prisoners reached with HIV prevention programmes	10542	13583
Number of small scale miners reached with HIV prevention programmes	3494	4610

CeSHHAR Zimbabwe conducted Respondent Driven Sampling Survey for three site (Hwange, Victoria Falls and Mutare) with a sample size of 913 sex workers. The country is in the process of carrying out size estimates for sex worker. The CeSHHAR programme provides health education, reproductive health services, HIV testing and referral to treatment and care services plus access to legal advice for female sex workers.

e) HIV Testing Services (HTS)

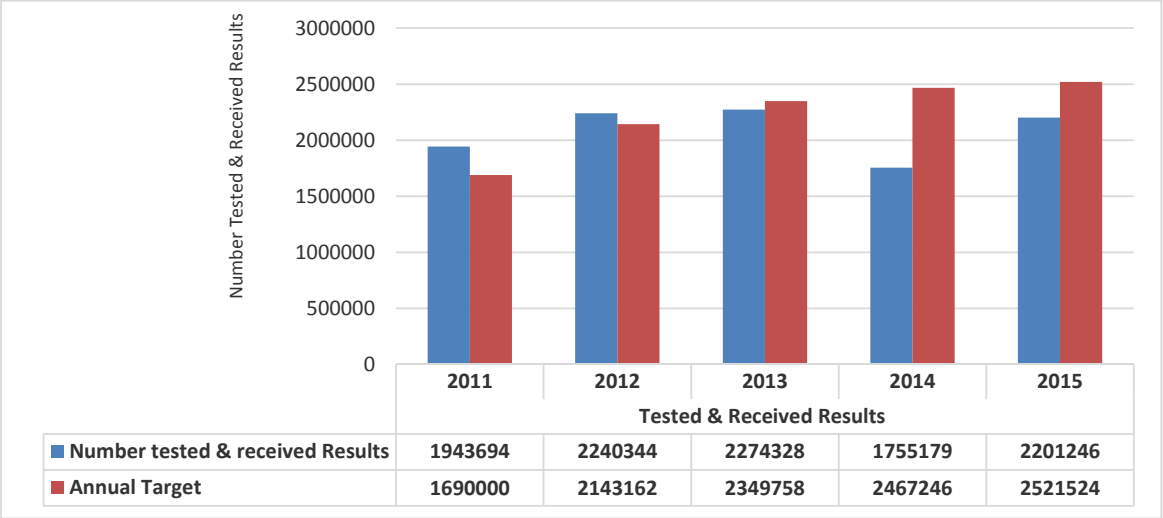
HIV testing is a crucial first step in the cascade of HIV treatment and an entry point to other prevention and care interventions including male circumcision, prevention of mother-to-child HIV transmission, and treatment of opportunistic infections. Currently a total of 1,460 health care facilities are providing integrated HIV Testing services through Antenatal Clinic (ANC), OI clinics, standalone Testing and Counseling centers, outreach centers, TB clinics and STI clinics. HT services are available to all citizens inclusive of key populations.

90% of all people living with HIV will know their HIV status

PLHIV who knew their HIV status was at 66% (ZDHS 2010/2011). Testing rates among general population (15-19 years) remains low (Male-40.3% Female-50.6% MICS 2014).

Figure 3 shows HTS targets and achievements for 2011 to 2015

Figure 3: HIV Testing Services

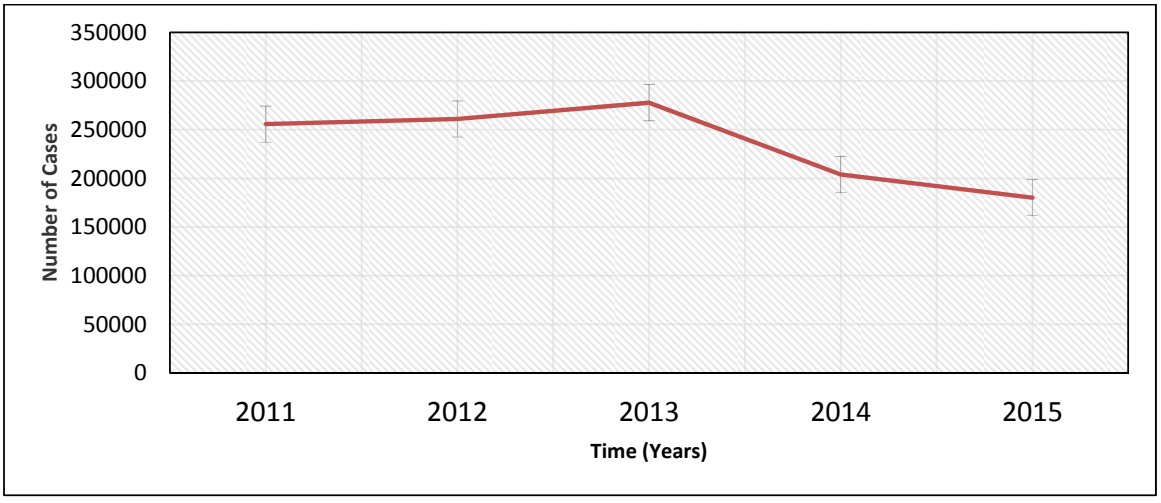


HTS campaigns were conducted in all districts with more extensive campaigns conducted in the Matabeleland region because of high incidence of HIV in the region. The main focus of the campaigns was to serve the hard to reach populations who include children, adolescents and workers especially those in the informal sector and artisanal miners.

f) Sexually Transmitted Infections (STIs)

The number of new STI cases declined from 2013 to 2015 as shown by the graph below. This could be due to expansion of community mobilization campaigns that were supported by NAC and other organisations focusing on equipping communities with information on STI prevention and appropriate referrals to clinical services.

Figure 4: New STI cases by year



Source: NAC Annual Report 2015

Forty percent (40%) of clients newly treated for STIs were tested for HIV and 15% tested HIV positive. Contract tracing was done for 24% of the clients newly treated for STIs.

Eliminate New HIV Infections among Children by 2015 and Substantially Reduce AIDS Related Maternal Deaths

Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive. Progress towards the desired target is illustrated below with the trends in MTCT rate.

Figure 5: Progress towards eMTCT target

HIV transmission from mother to child was at 6.39[4] in 2015 indicating that we are close achieving the global elimination target of less than 5%. Based on the households surveys maternal mortality ratio have reduced from 960 (DHS 2010/11) to 614 (MICS 2014) per 100 000 but this is still unacceptably high.

There are 1,560 health facilities that offer high quality, comprehensive PMTCT services in Zimbabwe.

Table 5 bellow shows PMTCT programme indicators.

[4] 2015 Draft HIV Estimates Report

Table 5: PMTCT

Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths							
Year	**2007**	**2009**	**2011**	**2012**	**2013**	**2014**	**2015**
3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	22%	59%	86%	85%	82%	79%	85%
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)	59% (Evaluation of PMTCT population based survey – UCB/CeSHHAR)	54.9% (PMTCT programme data and Spectrum)
3.3 Percentage of child infections from HIV infected women delivering in the past 12 months - Mother-to-child transmission of HIV (modeled).	No programme data available for this indicator	31.0% [MOHCW, PMTCT Report]	21% (National HIV Estimates Report 2009)	18% (National HIV Estimates Report 2011)	9.61% (National HIV Estimates Report 2013)	6.6% (Evaluation of PMTCT population based survey – UCB/CeSHHAR)	6.39% (Draft National HIV Estimates Report 2015)
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	Only had ANC figure which is 71%	85%	96% [MOHCW, PMTCT Data base]	97% (PMTCT programme data)	99% (PMTCT programme data)	99,26% (PMTCT programme data) 94% (Evaluation of PMTCT population based survey – UCB/CeSHHAR)	99% (PMTCT programme data)

hours), including those with previously known HIV status							
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)	19.8% (PMTCT programme data)	23% (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)	67% (Evaluation of PMTCT population based survey – UCB/CeSHHAR)	75.6% (PMTCT programme data and Spectrum)

The country conducted PMTCT impact study in 2015 and noted that MTCT rate was at 6.9%. NAC and other partners supported MoHCC through mobilization of communities for PMTCT services.

90% of all people diagnosed with HIV will receive sustained antiretroviral therapy

In order to realign treatment strategies to address the third 90 target, the country has adopted viral load monitoring and is in the process of rolling out and equipping health facilities. The

following figure shows a schematic cascade of the programme based on draft 2015 HIV estimates.

Figure 6: 90-90-90 Cascade

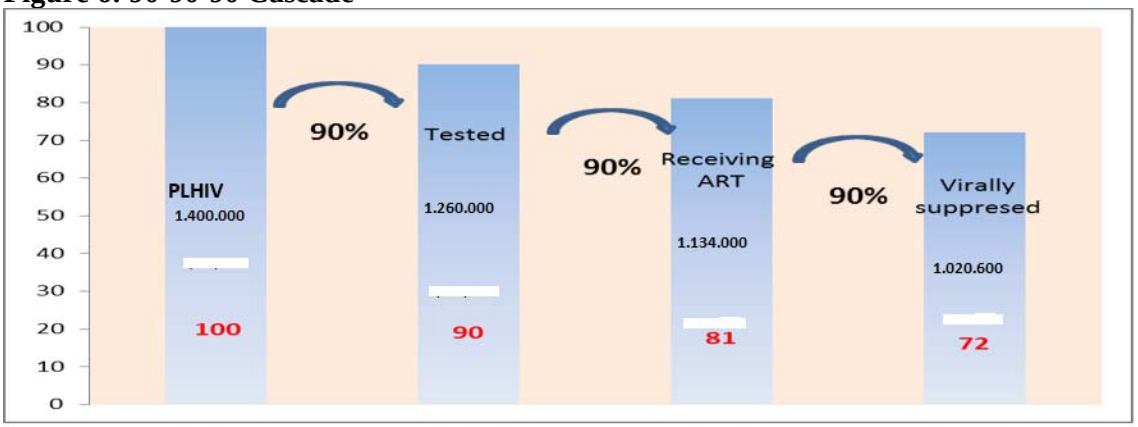
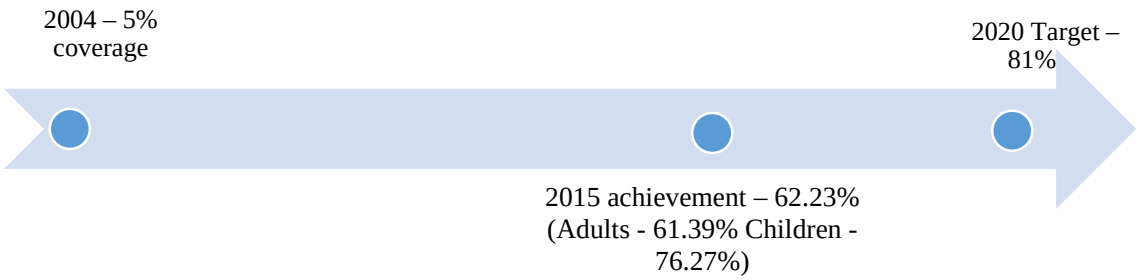


Figure 7 bellow shows progress towards the target of 81% of the PLHIV on treatment

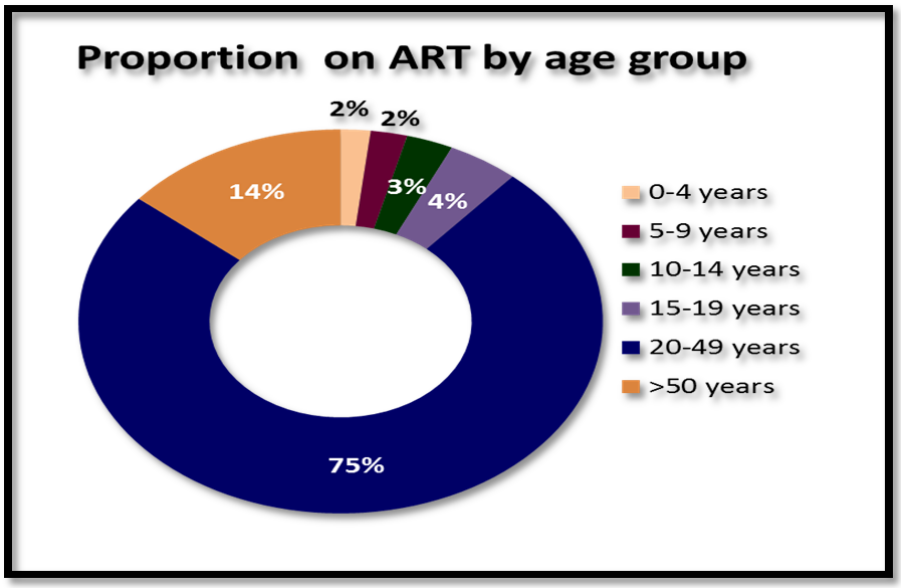
Figure 7: Progress towards the desired target



The country is on track towards achievement of the desired target. Sixty two percent (62%) of all people living with HIV are receiving antiretroviral therapy. The total number of PLHIV who were receiving ART in Zimbabwe by the December 2015 were 879,271 and initiated more than 9,000 PLHIV on treatment each month.

The following figure 8 shows proportion of people on ART by age group.

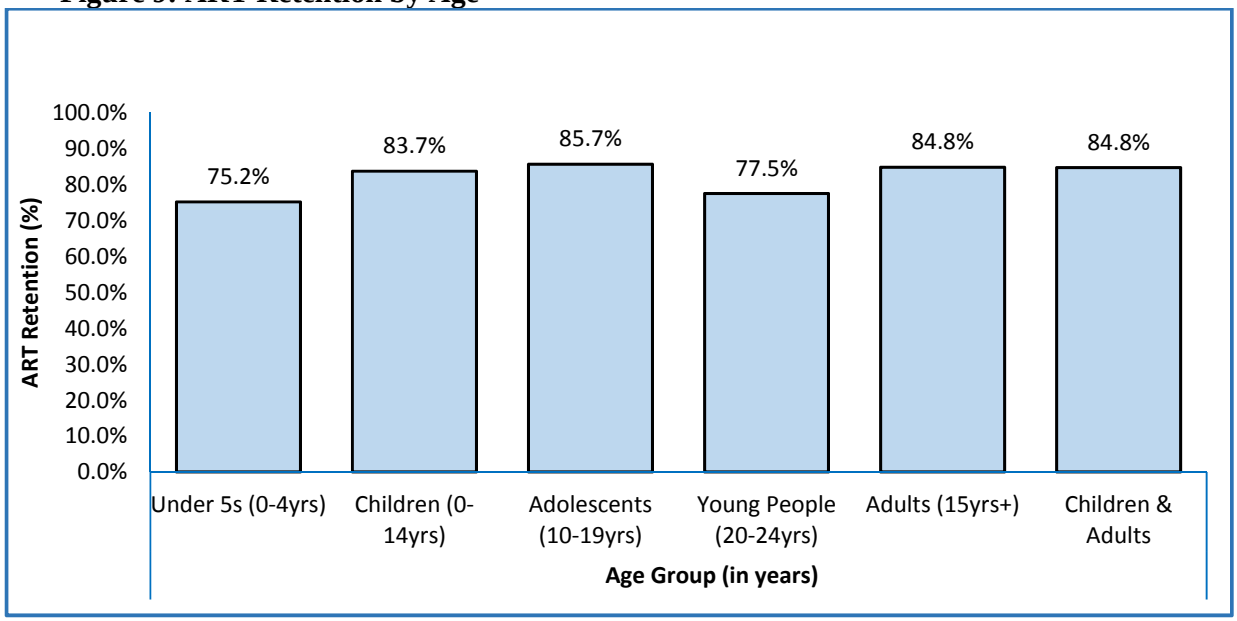
Figure 8: PLHIV on ART by age group



ART coverage in children and adolescents is relatively high due to deliberate effort by government to scale up treatment among children and adolescents.

The following figure shows 12 months retention on ART by age group.

Figure 9: ART Retention by Age

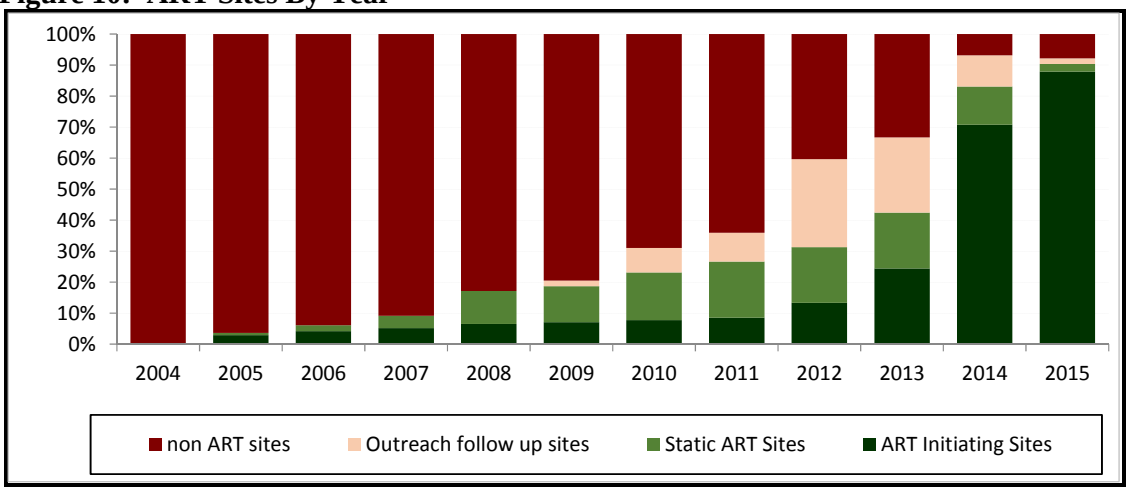


Source: ePMS data – September 2015

Retention of children and adolescents on ART is fairly high due to deliberate and accelerated activities aimed at improving ART services on children and adolescents. Compared to ART Outcomes study results from the 2012 investigation, retention has increased from 78% to 85% in 2015 after 12 months among adults.

There were 1545 ART sites (initiating and follow up) that were providing ART services by December 2015 however not all of the sites were providing ART services for children. The graph below outlines the increase in number of ART sites by year.

Figure 10: ART Sites By Year



More than 90% of the health facilities in Zimbabwe are offering ART services in Zimbabwe.

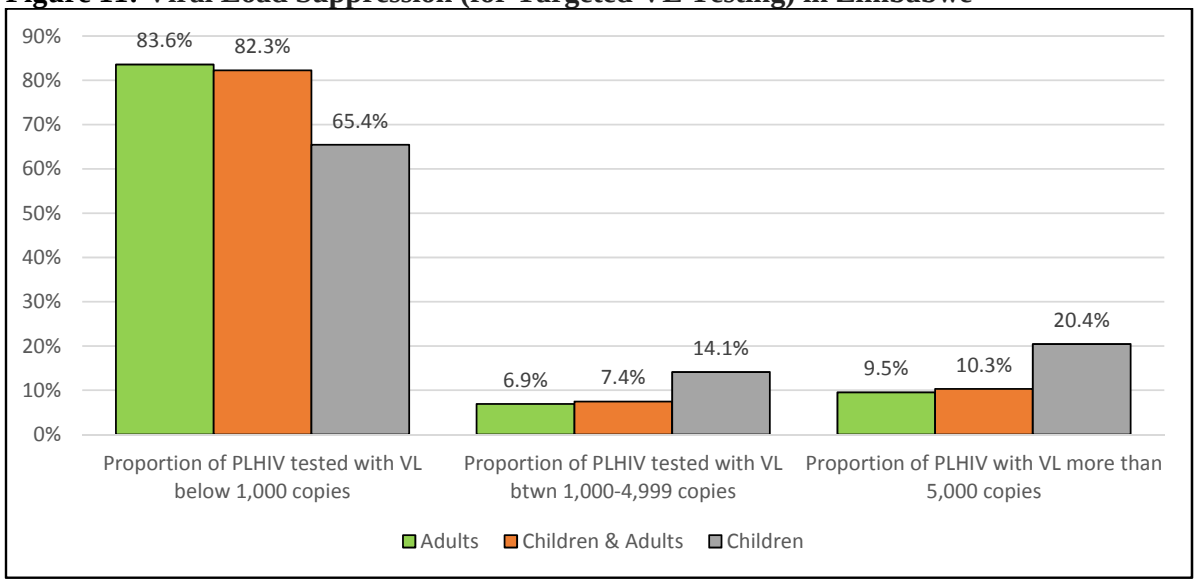
The key success factors that contributed to the massive scale up of the ART programme were: Leadership and Political Commitment and partnerships, effective ART programme management and implementation, Investment on strengthening of the health system, Integrated Human resources capacity building and training activities, Integrated service delivery and Scaling up ART Services, Community participation, demand creation and Home Based Services, HIV Drug Resistance monitoring and timely generation of strategic information to inform programming on quality of services and use and Effective Mobilization of financial resources.

73% of all people receiving antiretroviral therapy have durable suppression.

Viral load testing in the country is still targeted meaning that those who are tested for Viral Load are the ones already presenting with signs of failing treatment. The results presented

below are for targeted viral load testing meaning that Viral Load suppression in the country is certainly better than what these results are showing.

Figure 11: Viral Load Suppression (for Targeted VL Testing) in Zimbabwe



Source: ePMS data –December 2015

Table 6: Performance of ART programme

Year	2007	2009	2012	2013	2014	2015
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%	Adults – 63.6%, Chn – 45.5%	Adults – 72%, Chn – 99.8%
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%)	89.5% (Adults- 89.7% Chn- 88.3)	86% (Adults – 85.5% Chn – 91.2%)
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%)	84.6% (Adults – 84.3%, Chn – 87.6%)	82.8% (Adults – 82.6% Chn – 85.2%)

Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy				**73.3% (Adults – 73.6%, Chn – 69.5%)**	78.4% (Adults – 77.6%, Chn – 75.4%)	

HIV/TB collaboration

HIV and TB co-infection rates rate in Zimbabwe is more than 80% hence continues to experience a major HIV driven TB epidemic. TB/HIV service coverage are high with 80% of TB patients with HIV receiving ART. Fifty three percent (53%) of the HIV patients were screened for TB in 2015 and 46% of HIV positive TB patients were started on ART. Progress on implementation of the 3I's has been very slow especially Isoniazid preventive therapy (IPT). IPT is currently being offered at 46 sites. TB and HIV services are available to all key populations that need it.

Orphans and Vulnerable Children

The government has continued to implement the National Case Management System in order to address the needs of the OVC. School related assistance has coverage of more than 40% through the Basic Education Assistance Module (BEAM). NAC made a contribution of $ 1,207,000 towards the Basic Education Assistance Module in 2015

Coordination of the National Response

National AIDS Council led the coordination of the national response in line with UNGASS three ones principle. Sectoral coordination was strengthened for all the 6 sectors. 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.

National AIDS Council reviewed its coordination structures in order to take into consideration the epidemic changes and re-align the response.

Monitoring and Evaluation

The country conducted two population based survey, the Demographic and Health Survey and Population based HIV Impact Assessment. These studies will provide data that will be used as evidence and to initiate other studies like the Modes of Transmission (MoT) survey in order to inform programming. A census of clients picking medicines through the private sector was also conducted to inform ART programming and the results are yet to be published. The country improved data quality, evaluation culture, reporting through the DHIS tool and conducted drug resistance monitoring.

Major Challenges

The following challenges were experienced in 2015:

- Low coverage of VMMC
- Diminishing of international funding for HIV and AIDS and yet the response rely on external funding
- No statutory instrument to enforce data reporting by all sectors
- Slow scale up of Isoniazid Preventive Treatment services