



**GLOBAL AIDS RESPONSE PROGRESS REPORT 2017**

**FAST-TRACK COMMITMENTS TO END AIDS BY 2030**

**GAM ZIMBABWE COUNTRY REPORT**

**Reporting Period: January 2016 -December 20 16**

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## Report writing process

### The inclusiveness of the stakeholders in the report writing

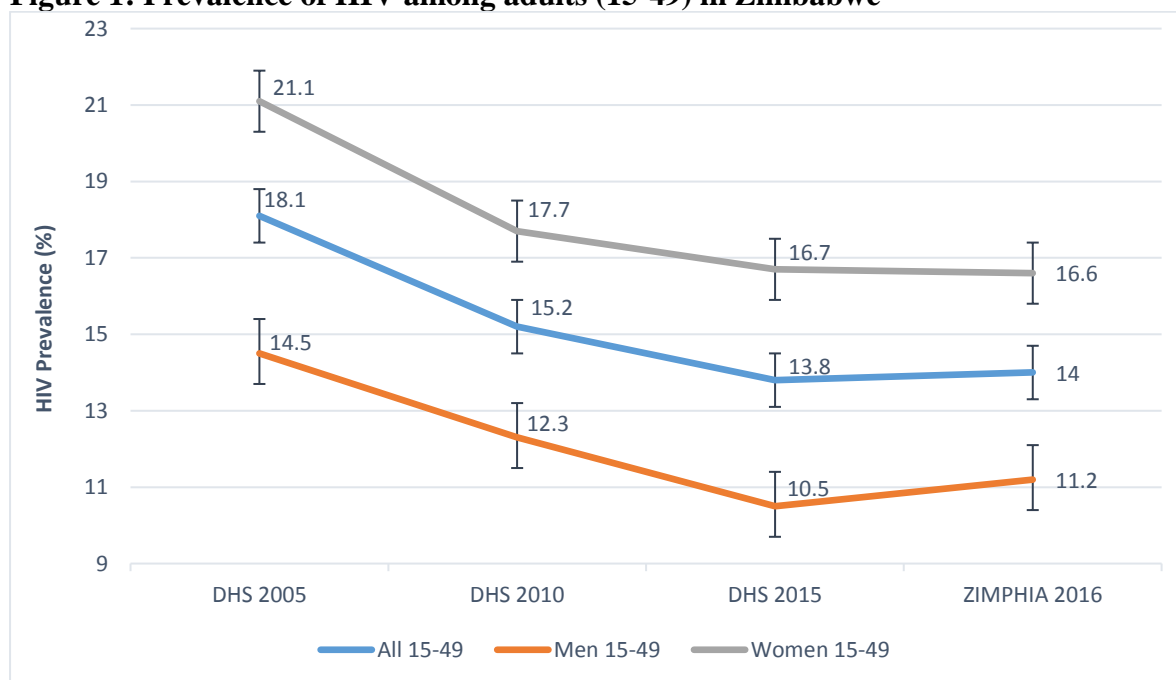
The National AIDS Council led in the compilation of this report with support from the AIDS and TB Unit of Ministry of Health and Child Care (MoHCC) and partners. A Technical Working Group (TWG), composed of members of the National Research Monitoring and Evaluation Advisory Group was set to have an oversight role on the compilation of the report. Data was collected and populated on the online reporting tool, the draft of the report was presented to stakeholders for validation before submission.

## Status at Glance

### Overview of HIV epidemic

Zimbabwe has an estimated 1.3 million people living with HIV (PLHIV)<sup>1</sup>. Adult HIV prevalence has steadily decreased by 24% over the last ten years, from 18.1% in 2005 to 13.8% in 2015<sup>2</sup>. While the epidemic has declined among both men and women, women continue to bear disproportionate burden with prevalence levels of 16.7% compared to 10.5% among men in 2015.

**Figure 1: Prevalence of HIV among adults (15-49) in Zimbabwe**

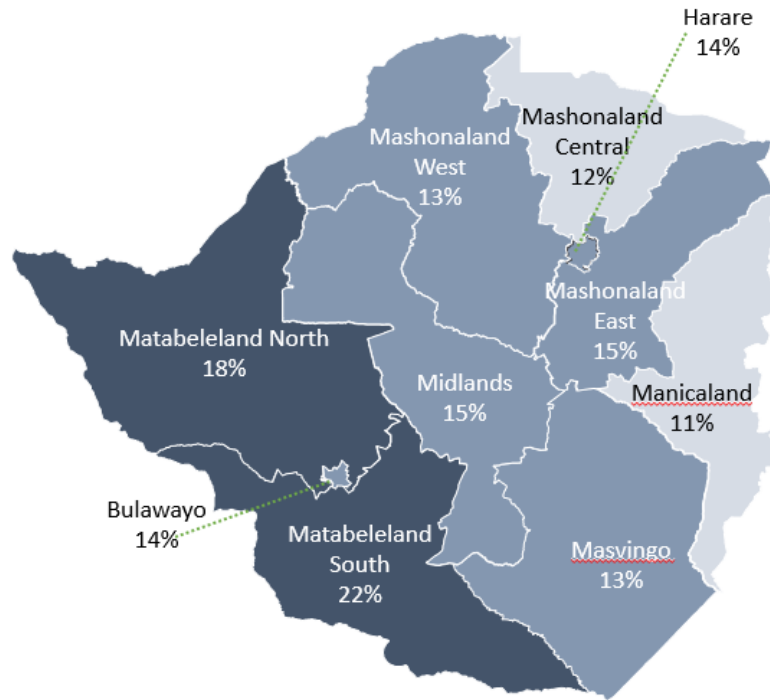


<sup>1</sup> Draft 2016 HIV Estimates Report

<sup>2</sup> Zimbabwe Demographic and Health Survey Report 2015

HIV prevalence varies by region with Matabeleland South having the highest adult prevalence of 21.5% while Manicaland has the lowest prevalence of 10.5%. The figure below illustrates the provincial distribution of HIV prevalence.

**Figure 2: Adult HIV Prevalence 15-49 years**

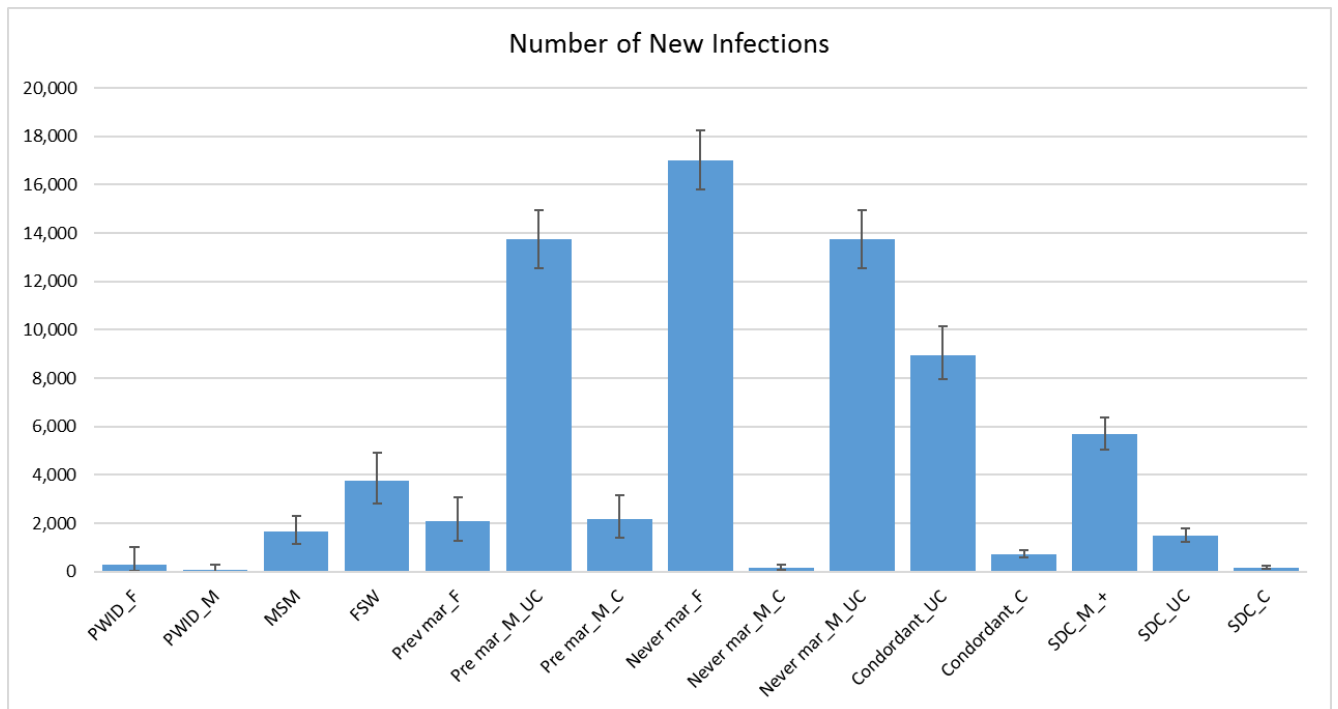


The HIV incidence in Zimbabwe was 0.48<sup>3</sup>. Zimbabwe’s 2017 modes of transmission study shows that the greatest number of new infections, more than 16,000 a year – are occurring among never married women. Young women in particular experience dramatically disproportionate burden; in the 20-24 year age group, women have an HIV prevalence that is 2.78 times higher than their male peers. The following figures shows the output from the MOT 2017 study.

**Figure 3: New Infections by population groups**

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<sup>3</sup> ZIMPHIA Factsheet 2016



Social and structural drivers influence the circumstances within which adolescent girls and young women (AGYW) are made more vulnerable. For instance, 17% of women aged 15-19 who had sex in the last year had sex with a partner ten or more years older than them, 41% of girls report that their sexual debut before 18 years was unwanted and rates of transactional sex are high and increasing (from 2.9% in 2005 to 4.5% in 2015 among sexually active men age 25-49).

Table below highlights the performance of core indicators of the national response.

**Table 1: Overview of performance of core indicators**

Year	2007	2009	2012	2013	2014	2015	2016
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	22%	59%	85%	82%	79%	85%	92.1% (Draft 2016 HIV Estimates)
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	2,664,844
Cumulative number of males circumcised according to national standards		2,801	40,775	112,084	400,235	601,303	839,681
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 - 76.8%, Chn - 40.5%	Adults - 63.6%, Chn - 45.5%	Adults 72% Chn 99.8%	Adults 66% Chn 83%
Percentage of adults and children with HIV known to	93.1%	75.0%	85% (Adults - 85.4%,	85.7% (Adults- 87.1%	89.5% (Adults- 89.7%	86% (Adults 85.5%	87% ( <i>ePMS data</i> )



be on treatment 12 months after initiation of antiretroviral therapy.			Chn – 82.8) ;	Chn – 85.6%)	Chn- 88.3)	Chn- 91.2% <i>ART outcome Report 2015- 2016</i>	
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## Progress towards Fast Track Commitments to end AIDS by 2030



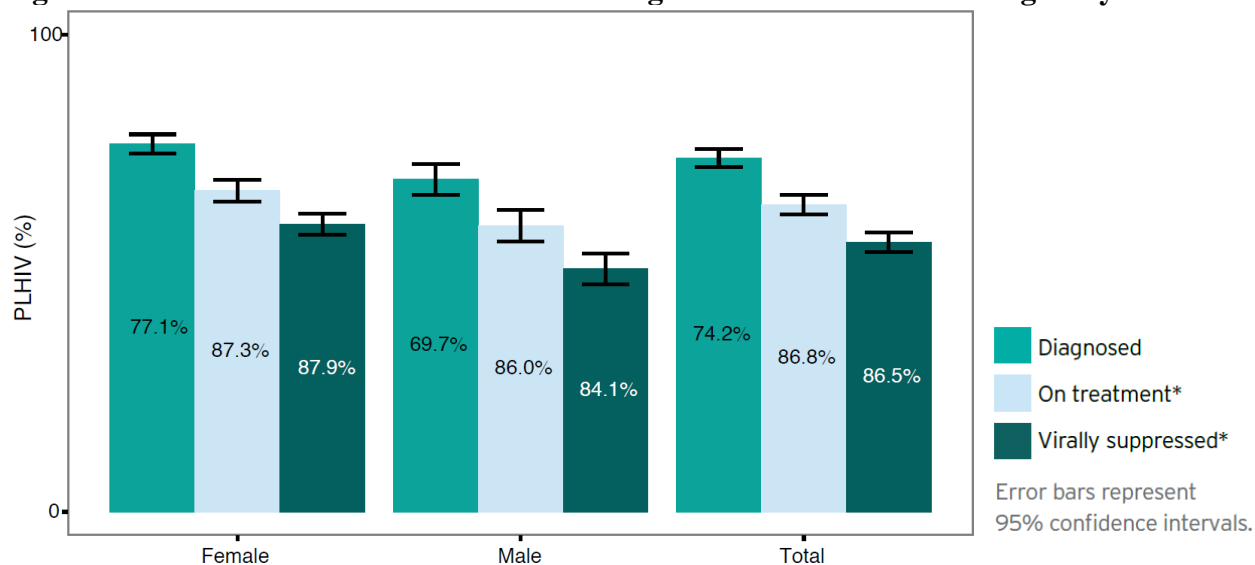
**Target 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020.**

The treatment cascade in Zimbabwe suggests that the country is on track to achieve the 90-90-90 targets if current investments are sustained and strategies to scale-up testing uptake among young people, men and key and vulnerable populations are explored. As of 2016, 74.2% of all people living with HIV know their status, 86.8% of those who know their status are on treatment (975,667) and 86.5% of those on treatment are virally suppressed<sup>4</sup>. The following figure shows the cascade towards the 90-90-90 targets.

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<sup>4</sup> ZIMPHIA Factsheet

**Figure 4: National Treatment Cascade and Progress towards 90-90-90 Targets by Sex**



**Table 2: Provincial Treatment Cascade and Progress towards 90-90-90 Targets**

Province	First-90	Second-90	Third-90
Bulawayo	73%	86%	92%
Harare	74%	85%	87%
Manicaland	75%	88%	86%
Mash Central	76%	86%	84%
Mash East	70%	82%	97%
Mash West	74%	86%	83%
Masvingo	74%	86%	90%
Mat North	79%	88%	90%
Mat South	76%	92%	87%
Midlands	74%	91%	83%

National and provincial-level 90-90-90 analyses clearly indicate that the biggest gap in Zimbabwe’s treatment cascade is in the first target – ensuring that 90% of all people living with HIV know their status. Strategies are put in place to increase testing including removing stigma and other human rights barriers to accessing HIV testing services.

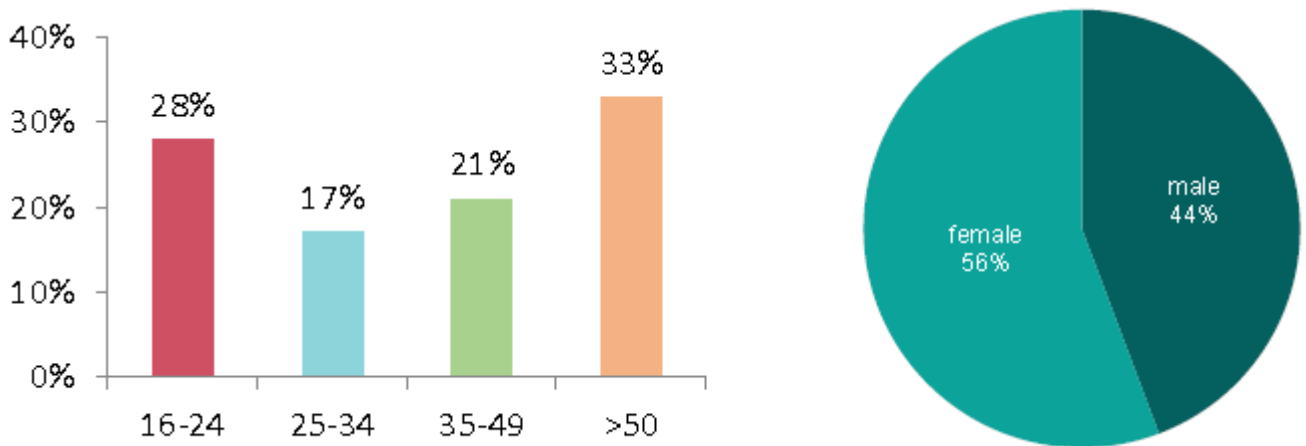
### **First 90 - ensuring that 90% of all people living with HIV know their status**

The country is scaling up innovative and differentiated HIV testing models to achieve the first 90, including lay testing, partner testing and index testing, focusing on high yield populations (including key populations and presumptive TB cases). HIV testing models are facility and community-based, and also include index testing.

### Pilot of HIV Self-testing

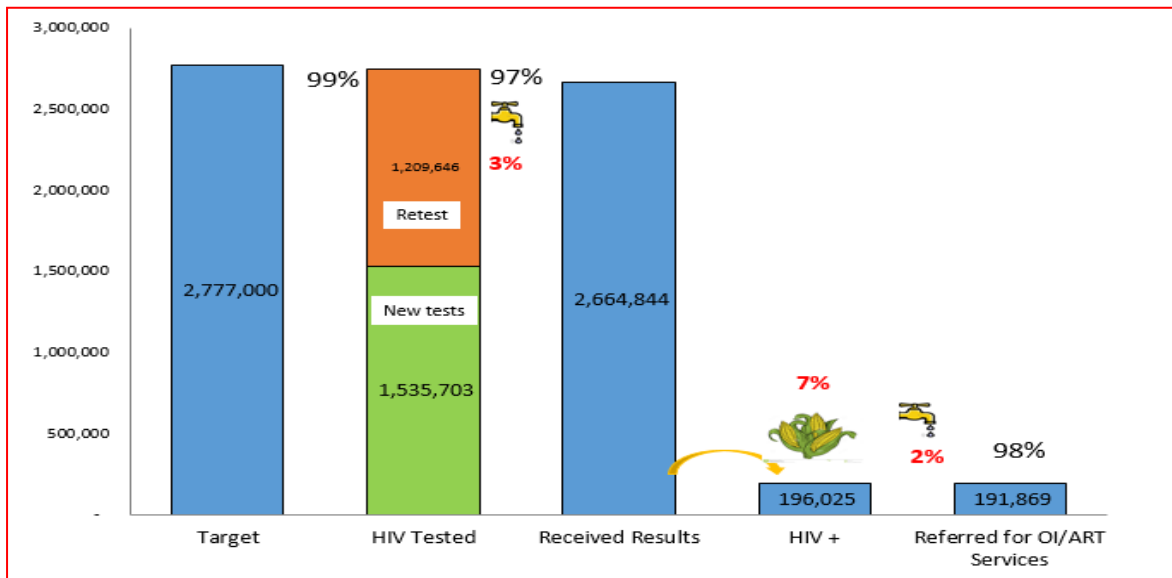
Lessons from Zimbabwe’s HIV self-testing pilot suggest self-testing as an effective strategy to boost testing among young people and among men. To date, 65,000 test kits have been distributed in pilot sites, primarily through community-based distributors, with a 65-70% return rate. 28% of all self-testers were young people age 16-24 and 44% of were men. 21% of those who self-tested were first time testers.

**Figure 5: HIV Self-Testing Uptake at Pilot Sites in Zimbabwe, by Age and Sex**



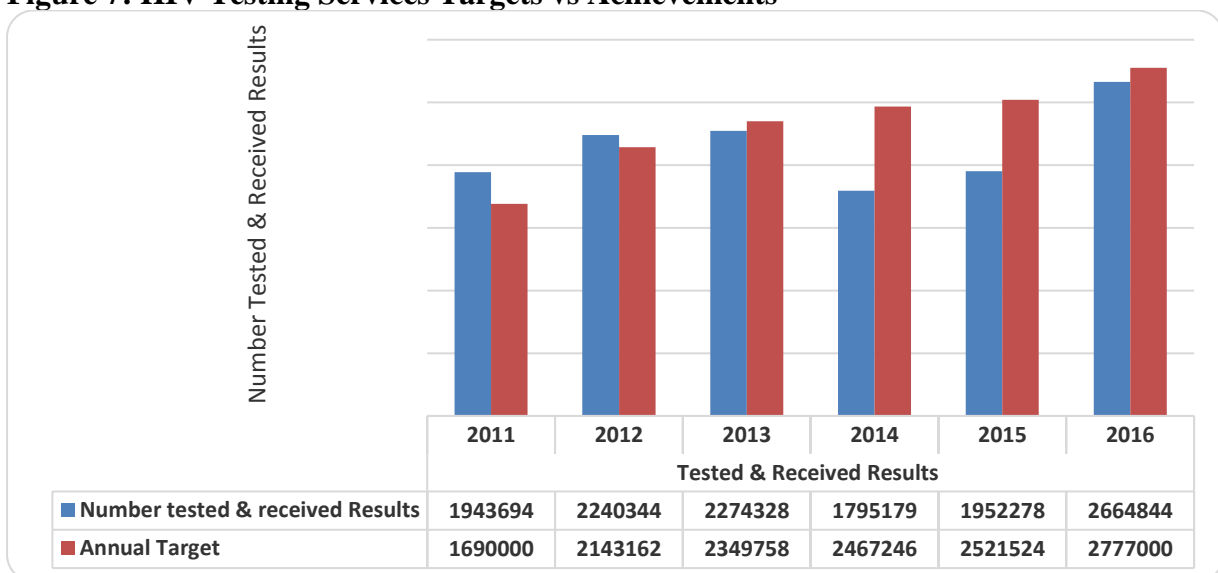
The adaptation of the latest WHO guidelines resulted in the revision of the HIV Testing Algorithm and re-testing recommendations. The HIV Testing Service (HTS) Strategy 2016 to 2020, embracing the ART guidelines and the 90-90-90 global targets was developed through multi sectoral participation in 2016. The following figure shows the national HTS cascade.

**Figure 6: National HIV Testing Services Cascade**



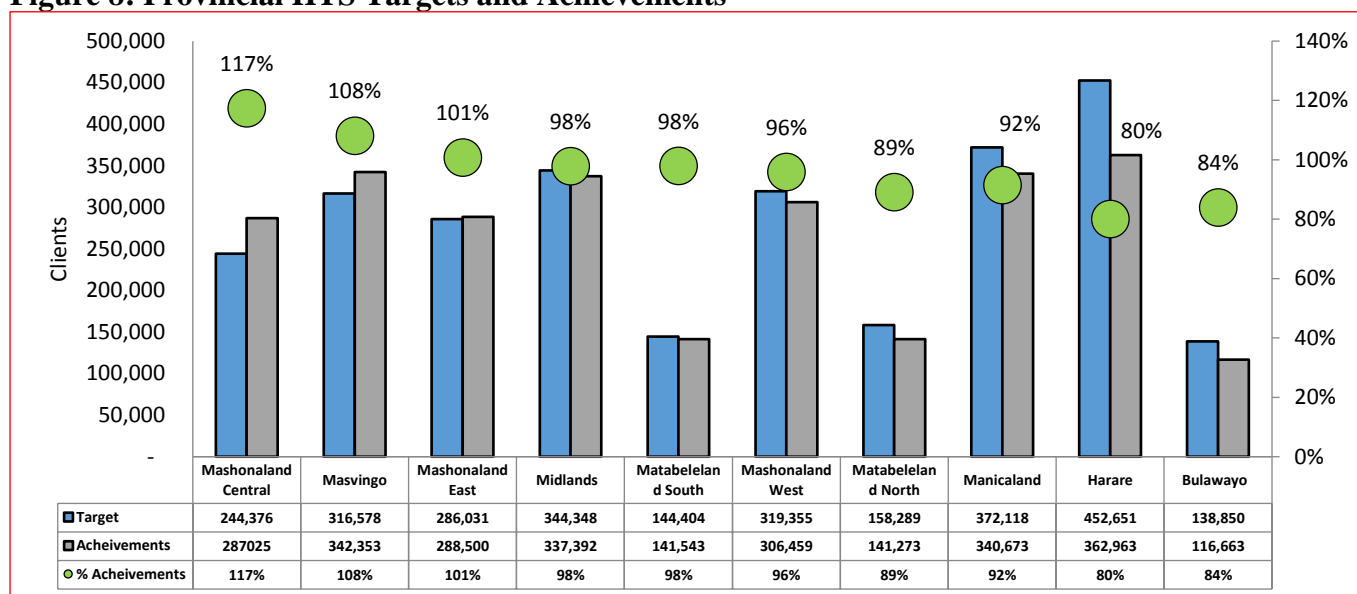
National AIDS Council and other implementing partners have been supporting with HIV Testing Campaigns through the outreach approach. These have been able to increase the numbers who accessed HTS services although the achievement is still below what the country has set as its target as shown below.

**Figure 7: HIV Testing Services Targets vs Achievements**



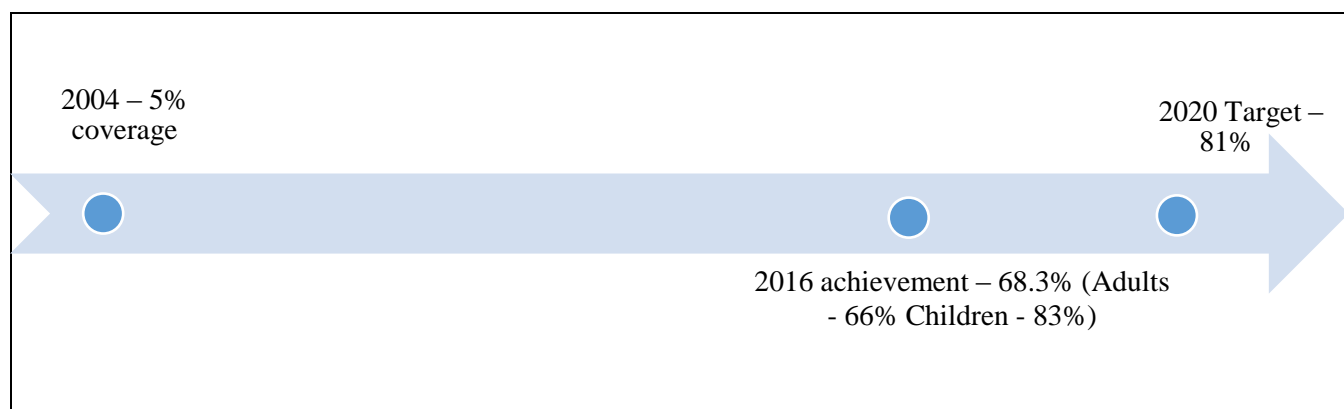
The following figure shows provincial achievements for HTS.

**Figure 8: Provincial HTS Targets and Achievements**



Mashonaland Central, Masvingo and Mashonaland East surpassed their targets for HTS and these provinces conducted HTS campaigns and reached 60374 people.

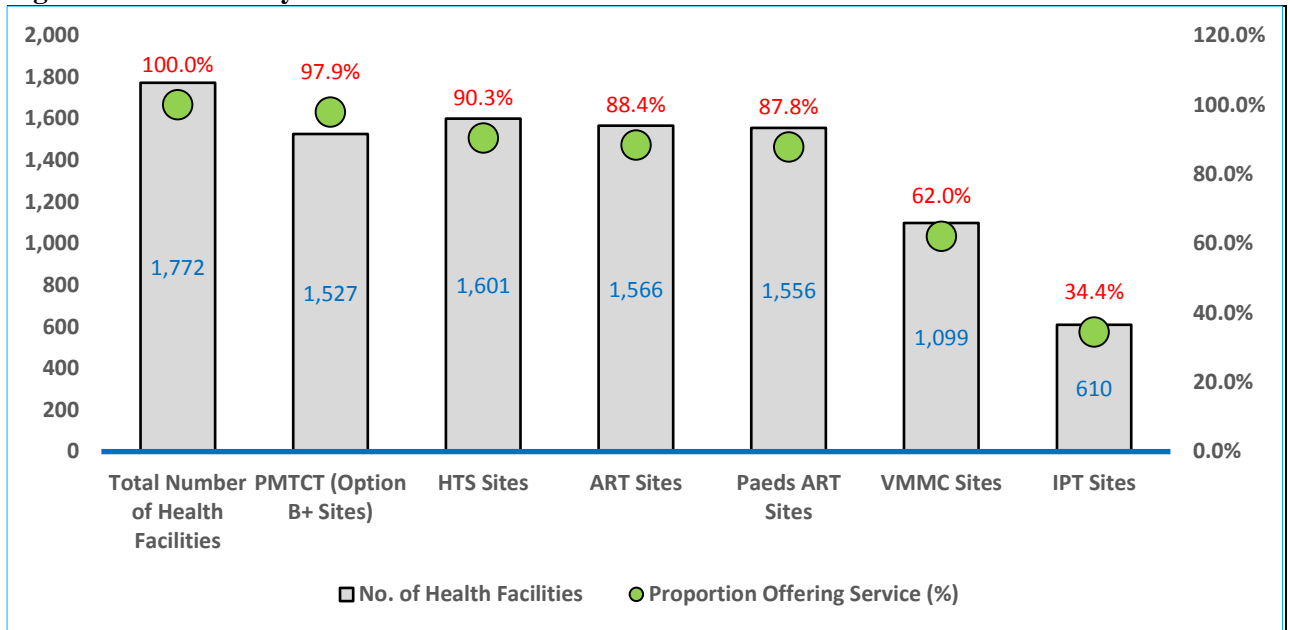
**Second 90 - 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy**



The country is on track towards achievement of the desired target. Sixty two percent (62.3%) of all people living with HIV are receiving antiretroviral therapy. The total number of PLHIV who were receiving ART in Zimbabwe by the December 2016 were 975,667 and 129,373 were initiated on ART in 2016.

There were 1566 ART sites (initiating and follow up) against an annual target of 1550. The following figures show health facilities offering HIV Services in Zimbabwe.

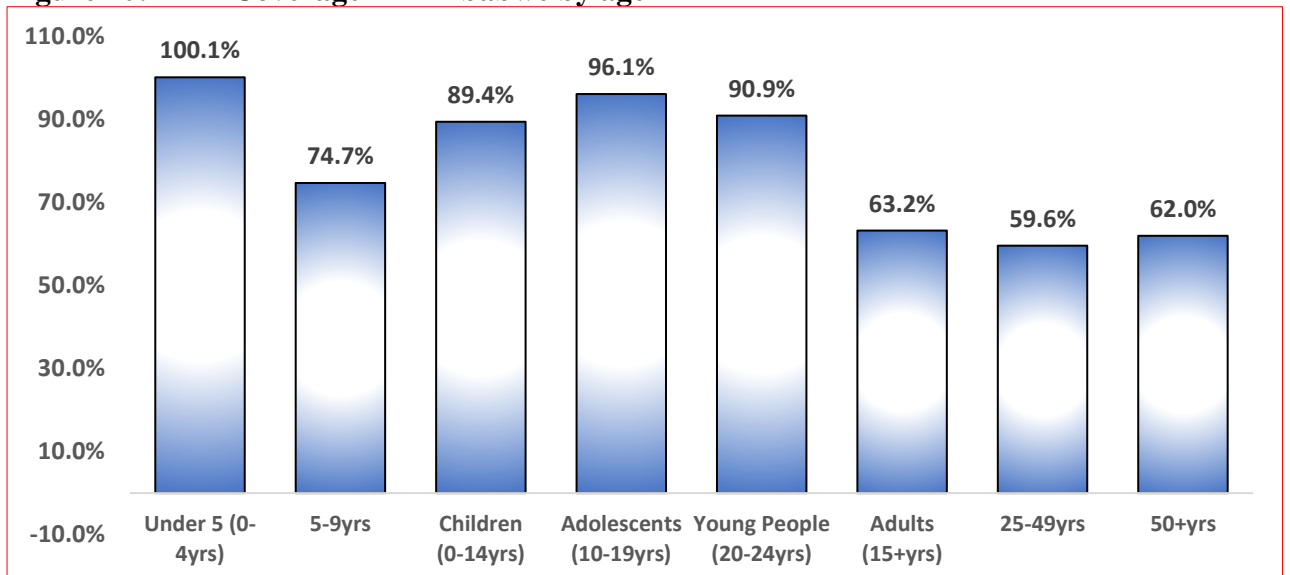
**Figure 9: ART Sites by Year**



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

The programme is doing so well on paediatrics and there is need to improve coverage on adults and the following figure shows ART coverage by age.

**Figure 10: ART Coverage in Zimbabwe by age**



There is need to improve uptake of HIV among adults buy testing more adults so that they know their status and be put on treatment.



The table below shows retention on ART by follow up time

**Table 3: Overall Retention Rates by time of follow up**

Outcome	Follow-up time (in months)															
	3 months				6 months				12 months				24 months			
	Frequency	Total	%	95% CI	Frequency	Total	%	95% CI	Frequency	Total	%	95% CI	Frequency	Total	%	95% CI
Currently on ART	336,856	389,538	86.5	(86.4 - 86.6)	329,873	389,086	84.8	(84.7 - 84.9)	315,822	377,742	83.6	(83.5 - 83.7)	279,948	308,603	90.7	(90.6 - 90.8)
Died	1,527	389,538	0.4	(0.4 - 0.4)	1,617	389,086	0.4	(0.4 - 0.4)	1,515	377,742	0.4	(0.4 - 0.4)	611	308,603	0.2	(0.2 - 0.2)
LFTU	39,067	389,538	10	(9.9 - 10.1)	45,020	389,086	11.6	(11.5 - 11.7)	46,306	377,742	12.3	(12.2 - 12.4)	19,072	308,603	6.2	(6.1 - 6.3)
Defaulted	6,405	389,538	1.6	(1.6 - 1.7)	4,900	389,086	1.3	(1.2 - 1.3)	5,043	377,742	1.3	(1.3 - 1.4)	4,748	308,603	1.5	(1.5 - 1.6)
Stopped ART	86	389,538	0	(0 - 0)	104	389,086	0	(0 - 0)	97	377,742	0	(0 - 0)	29	308,603	0	(0 - 0)
Transfer-out	5,597	389,538	1.4	(1.4 - 1.5)	7,572	389,086	1.9	(1.9 - 2)	8,959	377,742	2.4	(2.3 - 2.4)	4,195	308,603	1.4	(1.3 - 1.4)
Retained in ART care*	343,261	383,941	89.4	(89.4 - 89.3)	334,773	381,514	87.7	(87.6 - 87.9)	320,865	368,783	87.01	(86.9 - 87.1)	284,696	304,408	93.52	(93.4 - 93.6)

\*Retained in ART care consists of those who were alive on ART or defaulted ART at the respective follow-up time points and also excludes transfers-out from the denominator and the numerator due to uncertainty of these patients being alive and on ART at health facilities they transferred into.

Retention in care for 12 months was lower than the targeted 90% 2016. There is need to improve quality of care.

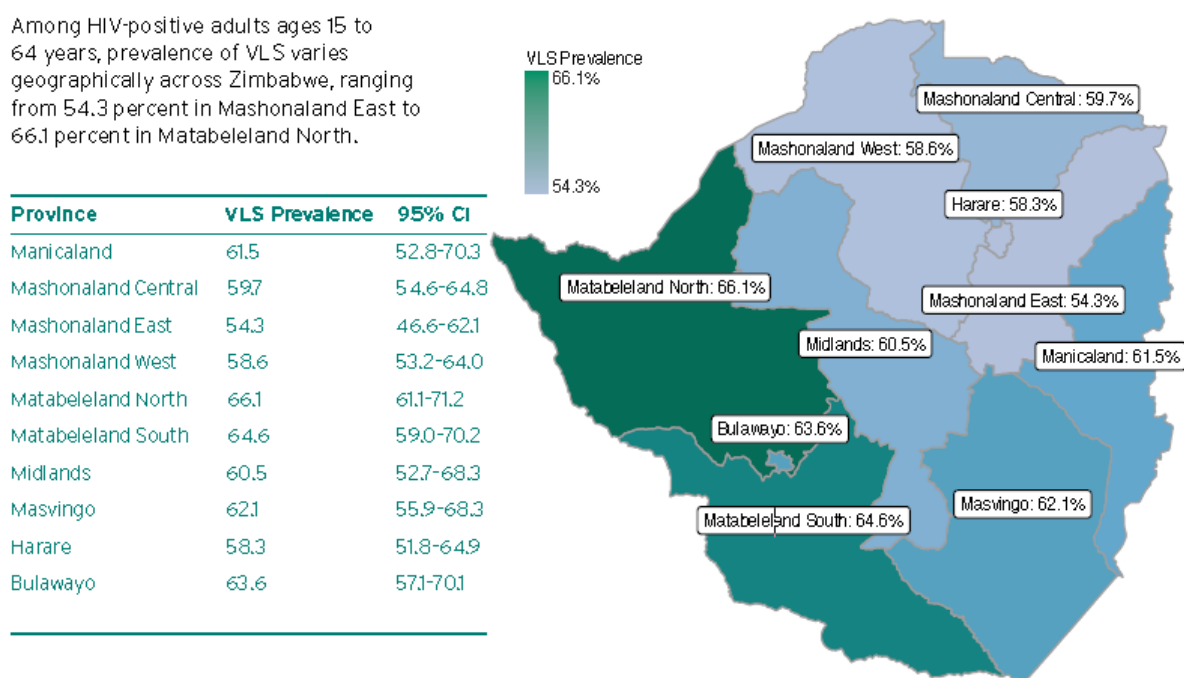


**Third 90 -73% of all people receiving antiretroviral therapy have durable suppression.**

Viral load testing is being scaled up in a phased approach in line with the country’s Viral Load Scale-up Plan (2015-2018). The phased approach targets patients from throughout the country, with differing timing to launch routine VL testing for selected patients and routine VL testing for all patients depending on patient location.

Currently in Phase 3 of the viral load scale up plan, were rural clinics/health centres have started offering routine testing to selected patients for monitoring, prioritising children and pregnant women.

**Figure 11: Viral Load Suppression among HIV-positive adults (15-64yrs), by province<sup>3</sup>**



Matabeleland Region had high viral load suppression among HIV positive adults and it’s the same region with high prevalence of HIV. Viral load suppression reduces the probability of transmission hence the incidence of HIV is going down (from 1.59 in 2005 to 0.53 in 2016<sup>5</sup>).

<sup>5</sup> Draft 2016 HIV Estimates

**Table 4: Performance of ART programme**

Year	2007	2009	2012	2013	2014	2015	2016
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%)	87% (ePMS data)
Percentage of health facilities dispensing ARVs for ART that have experienced a stock out of at least one required ARV in the last 12 months			1.89%	3.9%	9.4%	4.8%	2.6%
Percentage of adults and children receiving ART who were virally suppressed in the reporting period			No data	No data	No data	82.3%	86.6% (PHIA)



**Target 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018**

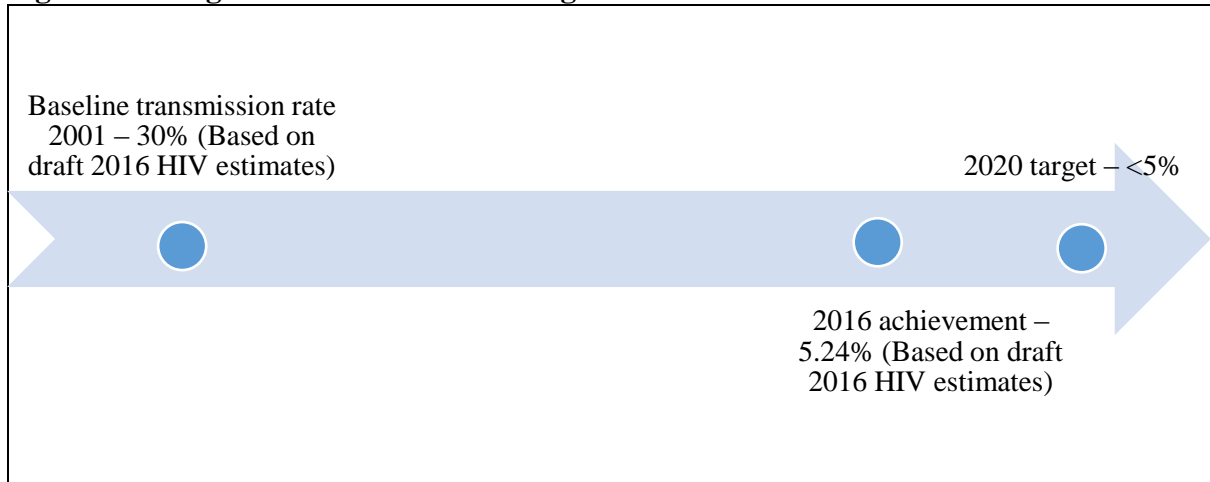
The country adopted and launched the Start Free, Stay Free and AIDS Free framework as part of the strategies to achieve pre-elimination which seeks to reduce mother to child transmission to zero percent, protect adolescents and young women from getting HIV infection and keeps those who are HIV infected healthy and AIDS free.

Investment in Zimbabwe’s vertical transmission efforts has the potential to achieve key targets of elimination in this program area. This is possible over the next few years by closing gaps in eMTCT and ANC coverage in priority districts, and shifting to a case finding, response and elimination approach. The major gaps that need to be addressed are: Focused activities among hard-to-reach communities in specific geographical locations (i.e. Manicaland); Case

surveillance, finding and response linked to M&E components of patient and case monitoring, to ensure feedback to facilities allowing individualized responses to close gaps.

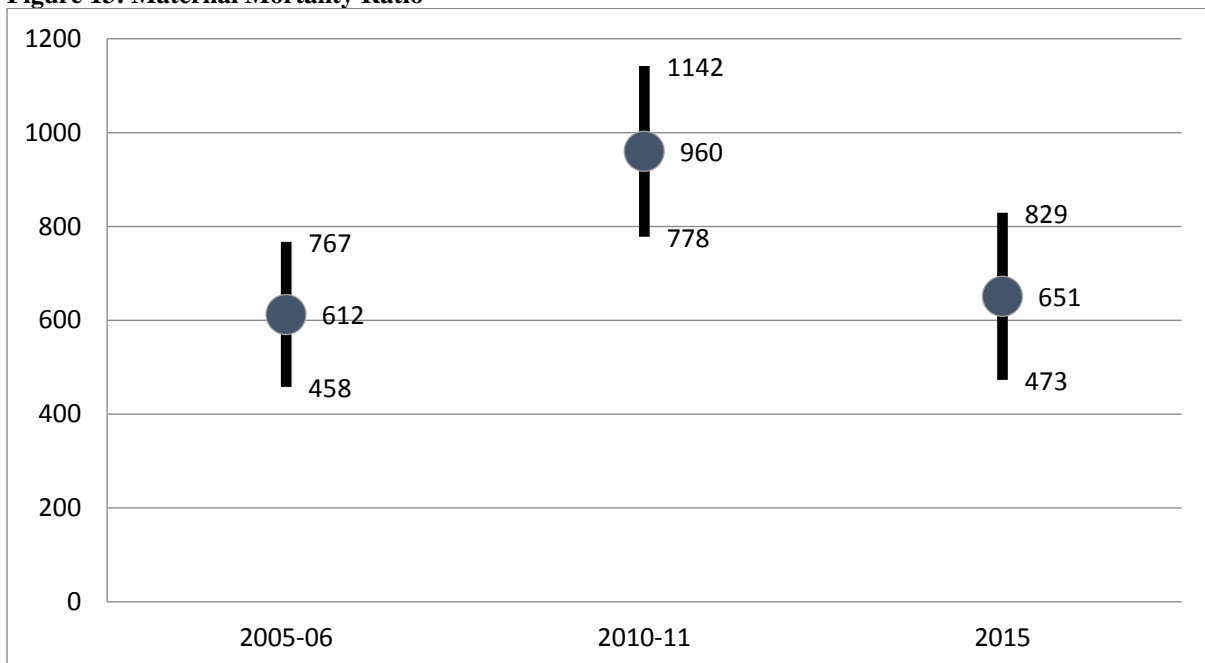
Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive. Progress towards the desired target is illustrated below.

**Figure 12: Progress towards eMTCT target**



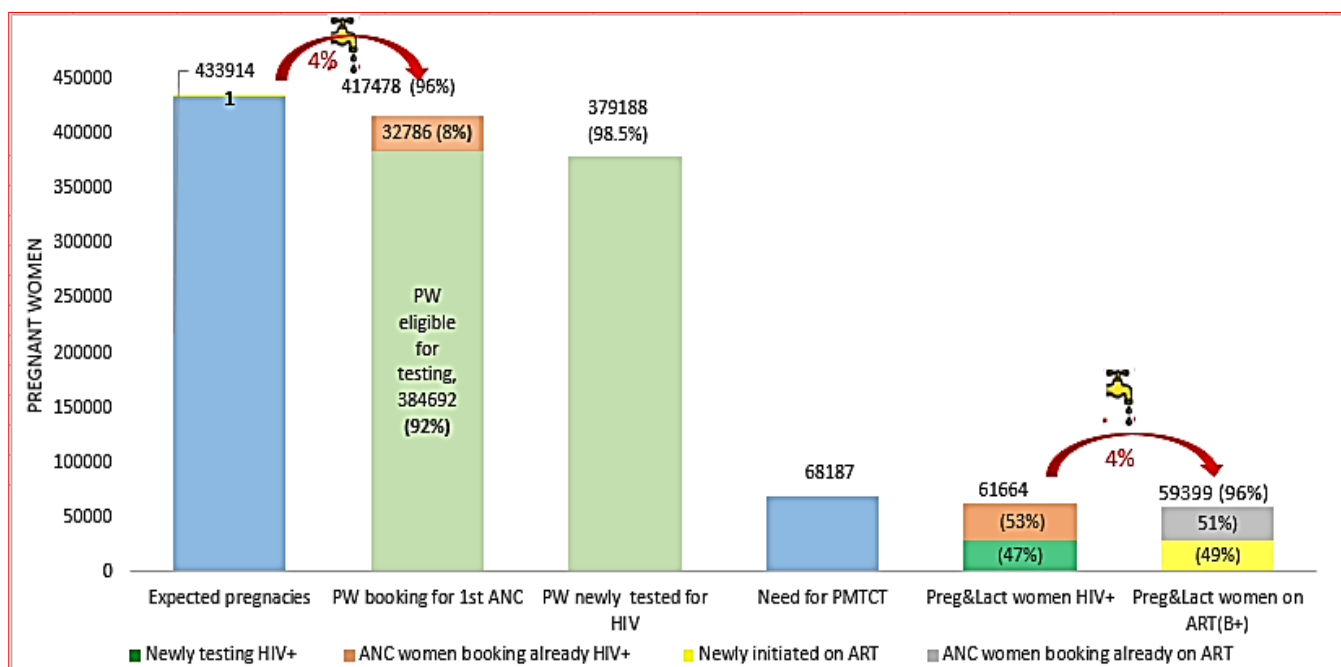
Final transmission including breastfeeding period was at 5.24<sup>4</sup> in 2016 indicating that we are close achieving the global elimination target of less than 5% by 2020. Based on the households surveys maternal mortality ratio have reduced from 960 (DHS 2010/11) to 651 (DHS 2015) per 100 000 but this is still unacceptably high for the past ten years as shown by the figure below.

**Figure 13: Maternal Mortality Ratio**



There are 1,560 health facilities that offer high quality, comprehensive PMTCT services in Zimbabwe. The following cascade outline the coverage of PMTCT services for the year 2016.

**Figure 14: PMTCT Cascade**



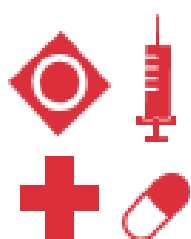
Ninety six percent of the HIV positive pregnant and lactating women were on ART in 2016

Table below shows PMTCT programme indicators.

**Table 5: PMTCT performance**

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018								
Year	2007	2009	2011	2012	2013	2014	2015	2016
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%	92.1% (National HIV Estimates Report 2016)
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	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/CeSH HAR)	54.9% (PMTCT programme data and Spectrum)	69.5% (PMTCT programme data and Spectrum)

	disaggre gate							
Percentage of child infections from HIV infected women delivering in the past 12 months - Mother-to-child transmission of HIV (modeled).	No program me data available for this indicator	31.0% [MOHC W, 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/CeSH HAR)	7.24% (National HIV Estimates Report 2015)	5.24% (National HIV Estimates Report 2016)



**Target 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.**

### Social Behaviour Change

SBC interventions were implemented in the community, workplace and in schools. In addition to the home visit approach the demand generation programme rolled out the sista2sista clubs in 20 hot spot districts in 2016. In order to ensure demand was effectively created, Behaviour Change Implementing Partners were also supported by National AIDS Council to carry out and participate in community sensitisation activities, awareness campaigns and commemorations.

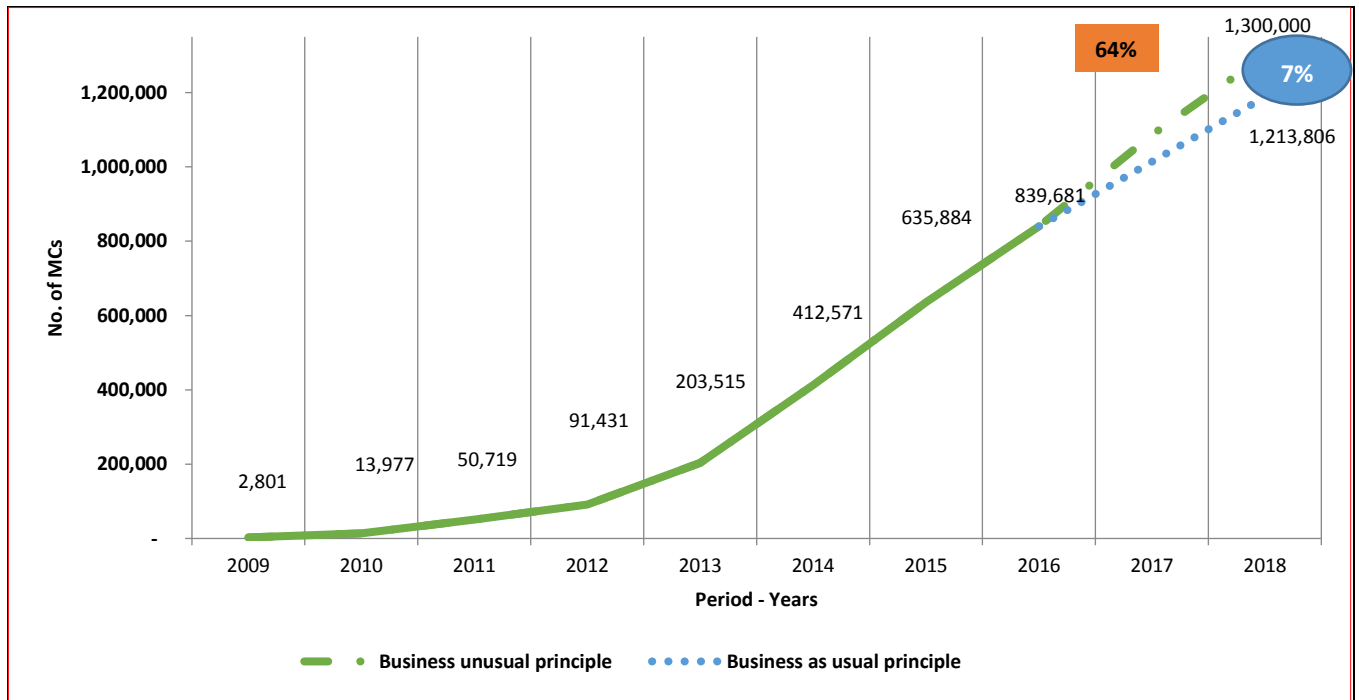
A total of 811,962 new households were visited by the Behaviour Change Facilitators (BCFs) reaching 2,366,063 people. A total of 1087303 were referred for HIV services after home visits.

### Voluntary Medical Male Circumcision (VMMC)

According to 2015 ZDHS, the Percentage of men age 15-49 who report having been circumcised was 14%. Male circumcision prevalence is very low despite all the efforts. VMMC should focus on older men and low-coverage districts VMMC as part of combination prevention. As of 2016, 839,681 procedures have been done, representing 64% of the 1.3 million target. The graph below shows that the program should not be conducted in the “business unusual mode” if we are to achieve the target of 1,3Million. If business remains as

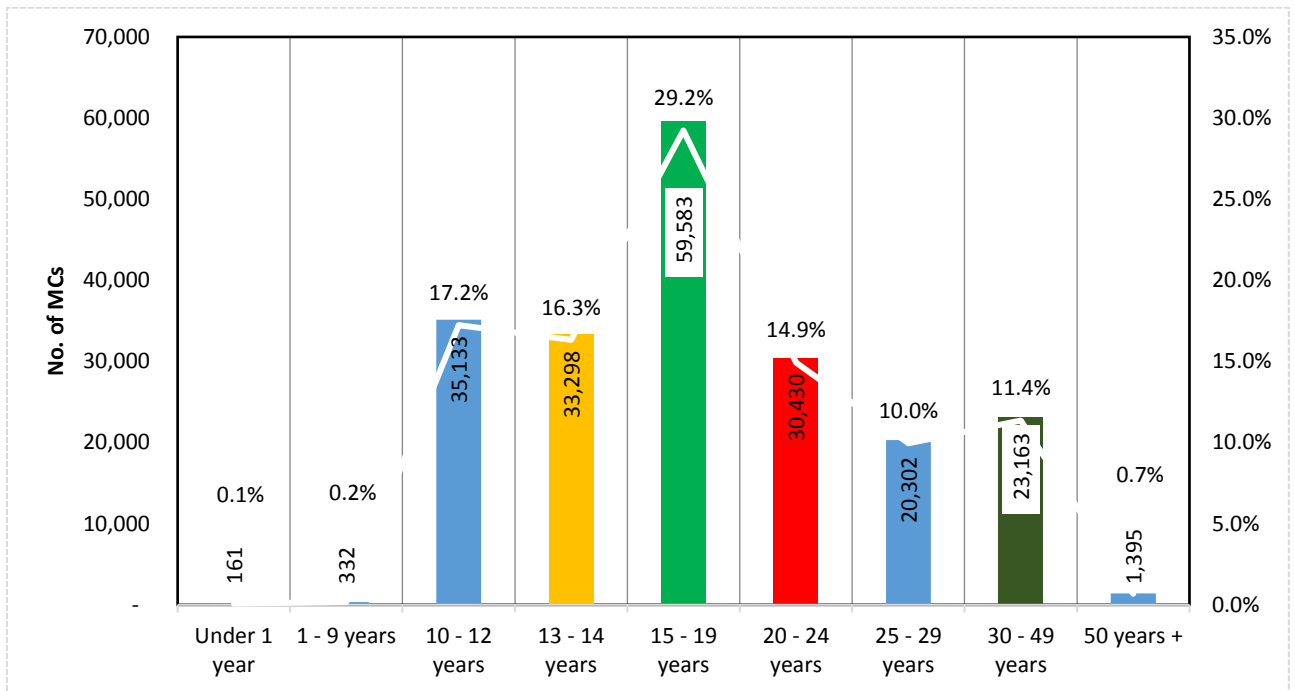
usual the program will miss the target by 7% (86,194). Continued innovation and intensification of strategies is required to bend the curve.

**Figure 15: Cumulative VMMC since 2009**



VMMC is not uniform across regions however; the coverage is highly inconsistent, with some districts already at saturation levels among the target group (15-29) while others lag far behind. Significant gaps also exist among older men. VMMC coverage among men age 15-29 is 33%, but this drops to 16% among men in their thirties and 12% in men older than 40. The following figure shows VMMC done by age.

**Figure 16: Number of people circumcised by age in 2016.**



There is need to scale up VMMC among older men in DREAMS districts, linked with reducing HIV incidence among AGYW.

### Condom Promotion and distribution

Condoms are distributed through public and private channels using the social marketing approach. The chart below shows that the uptake of male condoms in 2016 was 104,423,569 against an annual target of 100,000,000 and 4,899,651 for the female condom against a target of 5,500,000. This was a decrease from 109,402,154 male and 5,573,786 female condoms distributed in 2015.

**Figure 17: Condoms Distributed in Zimbabwe**



A total of 3861 condoms and lubricants were distributed to men who have sex with men in 2017. Condom use among sex workers was high, with 96% of sex workers reporting using a condom with their most recent client

### Key Populations

The HIV sub-epidemics among other key and vulnerable populations in Zimbabwe also signal the need for a more targeted response. Modes of transmission study results show nearly 4000 new HIV infections yearly among female sex workers (with a prevalence around 59%<sup>6</sup>) and nearly 2000 new infections each year among men who have sex with men (MSM) (with a prevalence of about 23.5%<sup>7</sup>) (see Figure 3). HIV prevalence among the wider LGBT community has been linked to risks associated with forced sex, a key gender-related consideration<sup>8</sup>. People with disabilities are twice as likely to self-report having HIV as those without disabilities<sup>9</sup>. Among prisoners, HIV prevalence is estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees)<sup>10</sup>. Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services. Indeed, the 2014 PLHIV Stigma Index found that 90.8% of sex workers, 77.8% of MSM, 64.5% of people with disabilities and 100% of prisoners reported experiencing stigma and

<sup>6</sup> Draft 2016 RDS survey CeSHHAR Report

<sup>7</sup> BRTI Sexual Minorities and HIV in Zimbabwe Draft Report (2013); PEPFAR Zimbabwe Country Operational Plan (COP) 2016, Strategic Direction Summary

<sup>8</sup> Sandfort, T. G., Baumann, L. R., Matebeni, Z., Reddy, V., & Southey-Swartz, I. (2013). Forced sexual experiences as risk factor for self-reported HIV infection among southern African lesbian and bisexual women. *PLoS One*, 8(1), e53552.

<sup>9</sup> Ministry of Health and Child Care (2013). Living Conditions Among Persons with Disability Survey: Key Findings Report. Online at [http://www.unicef.org/zimbabwe/National\\_Survey\\_on\\_Disability\\_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

<sup>10</sup> Zimbabwe Prison Service (2011). Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe. NAC & UNODC.



discrimination<sup>11</sup>. Interventions for key populations include activities to remove human rights barriers to access, creating more enabling environments to scale HIV services.

HIV incidence among sex workers is estimated at 10%, more than 22 times the general population (0.48%). As a result, sex workers and their clients together account for approximately 12% of new HIV infections in Zimbabwe. Zimbabwe is implementing a comprehensive package of prevention, treatment and support services through a peer-led model, with outreach conducted from six fixed sites, to provide a comprehensive package of care based on the international guidance for implementing comprehensive HIV/STI programs with sex workers.

The comprehensive package include condom programming, HTS that includes diagnosis and treatment of STIs, syndromic management and cervical cancer screening and linkage to care, among other RMNCAH services (including PMTCT) for sex workers and their children.

PrEP is being offered, combined with intensified adherence activities such as support groups and mobile phone follow-ups. Harm reduction services as well as interventions to address stigma, discrimination and violence against sex workers combined with legal support, legal literacy, and service to prevent and respond to sexual, physical and GBV are being offered for sex workers.

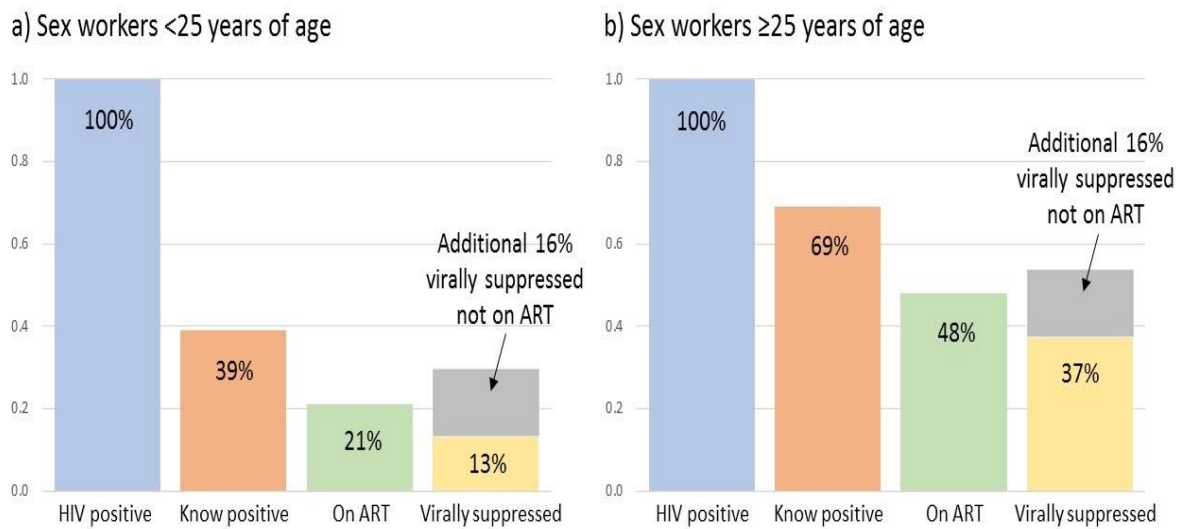
Though prevention gaps persist, the treatment cascade in Zimbabwe suggests the country is on track to achieve the 90-90-90 targets if current investments are sustained and strategies to scale-up testing uptake are explored, particularly among young people, men and key and vulnerable populations.

Treatment cascades for sex workers also reveal significant gaps that are particularly pronounced for young sex workers (<25 years of age). There was an increase in proportion of young HIV positive sex workers are accessing treatment from 21% in 2015 to 40% in 2016. In 2016, a total of 1196 FSW self-reported to be on ART and 106 were receiving PrEP. A total of 2,603,520 condoms were distributed to sex workers.

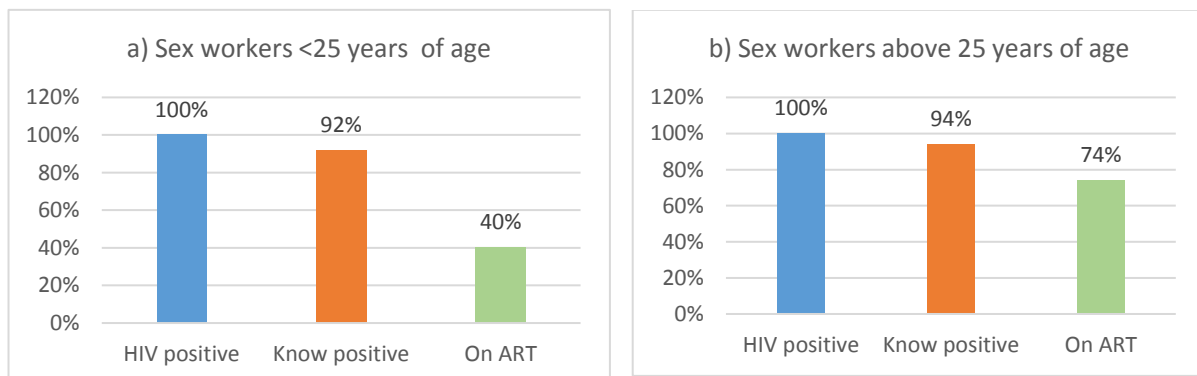
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<sup>11</sup> ZNNP+ (December 2014). The Zimbabwe People Living with HIV Stigma Index. Online At <http://www.stigmaindex.org/zimbabwe>. Page 43.

**Figure 18: Treatment Cascade for HIV Positive Sex Workers in Zimbabwe, by Age Group (2015)**



**Figure 19: Treatment Cascade for HIV Positive Sex Workers in Zimbabwe, by Age Group<sup>6</sup>(2016)**



There was great improvement in the coverage of services for sex workers between 2015 and 2016 as shown by figure 19 and 20. A size estimation study of sex workers is currently ongoing in the country, so it is anticipated that interventions will be guided by that forthcoming information.

Provision of services for the key populations was affected by erratic and dwindling funding resulting in temporary closures of clinical sites run by some of the partners offering clinical services.

Homosexuality is criminalized in Zimbabwe therefore comprehensive package of services to men who have sex with men is delivered by CSOs. The services are 14 sites, and these include; the provision of condoms and lubricant, STI screening, VMMC, PrEP, PEP, links to TB

services, comprehensive HTS and including point-of-service treatment initiation. There were 4,600 MSM reached with individual or small group level HIV prevention interventions. A total of 340 MSM were reported to be on ART in 2016.

The government of Zimbabwe is implementing the HIV prevention and treatment programmes in prisons. About 0.4% of prisoners are co-infected with HIV and TB. A total of 7,511 prisoners were tested for HIV and 3,495 were on ART in 2016.

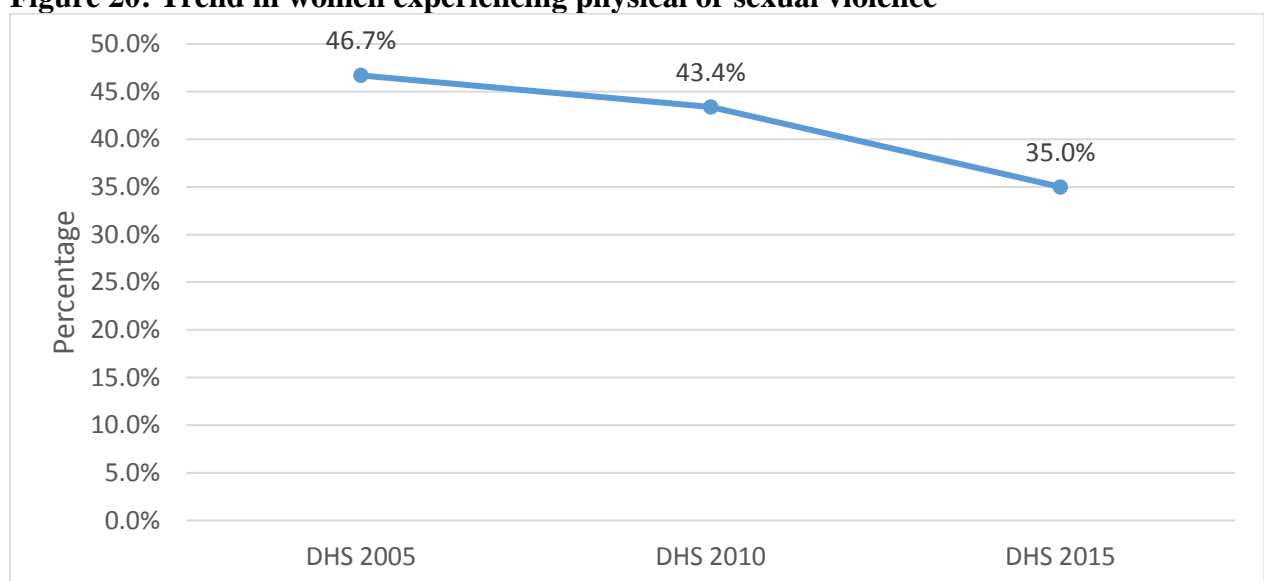


**Target 4: Gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020**

The HIV prevalence among young women (18-24) who have had two or more transactional sex partners in the last six months is estimated at 32%, compared to 10% among those who have never had transactional sex. Interventions which address the social and structural factors that lead to intergenerational, forced and/or transactional sex - particularly gender inequality and gender-based violence - are critical for HIV prevention among AGYW.

The following figure shows the proportion of ever-married or partnered women 15–49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months over the past ten years.

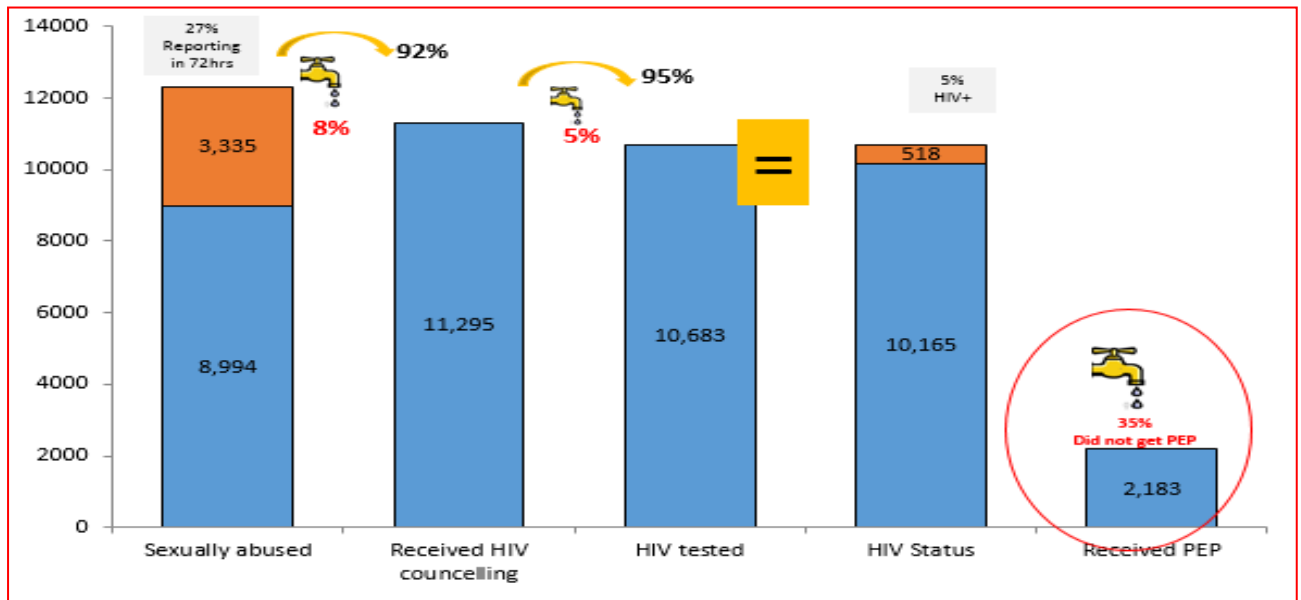
**Figure 20: Trend in women experiencing physical or sexual violence**



The proportion of women reporting experience of physical or sexual violence decreased by 25% for the past 10 years.

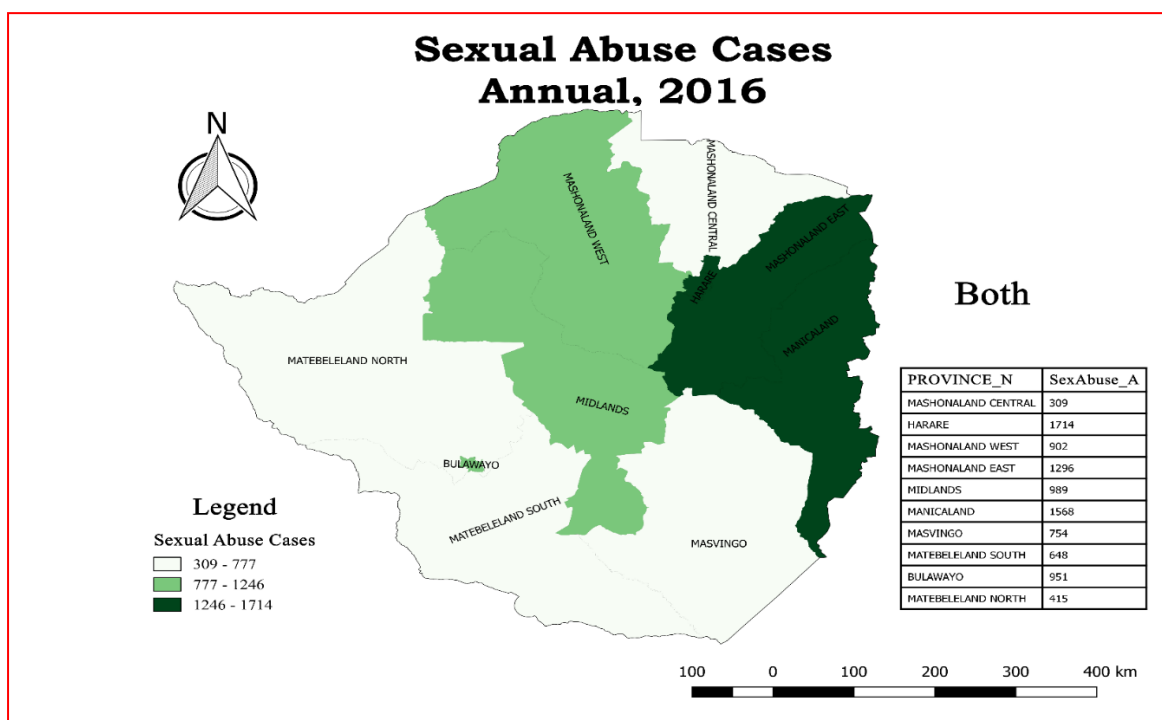
The following figure shows sexual abuse cascade in 2016

**Figure 21: Sexual Abuse Cascade**



There is huge leakage along the cascade, from late reporting to not accessing PEP. There is need to educate the community about PEP

**Figure 22: Sexual Abuse Cases by Province**



The highest number of cases were recorded in Harare province in 2016.



**Target 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.**

The country adopted and launched the Start Free, Stay Free and AIDS Free framework as part of the strategies to achieve pre-elimination which seeks to reduce mother to child transmission to zero percent, protect adolescents and young women from getting HIV infection and keeps those who are HIV infected healthy and AIDS free.

Through Global Fund and UNFPA investments, the National AIDS Council introduced the sista2sista (S2S) program, reaching 9,882 vulnerable girls in 20 hotspot districts. 7,957 girls completed the five-module curriculum, and more than half accessed HIV testing services (4,086 girls against a target of 4,000 accessed HIV testing). These successes suggest that the S2S initiative has the potential to significantly increase HIV testing uptake among vulnerable AGYW. The country adopted peer-to-peer models as prevention and treatment strategies to reach AGYW. In addition, the Africaid Zvandiri Community Adolescent Treatment Supporters (CATS) model has been successful in providing peer adherence support to young PLHIV. An evaluation of the CATS model found that those in the program are 3.9 times more likely to adhere to treatment.<sup>12</sup>

### Dreams Project

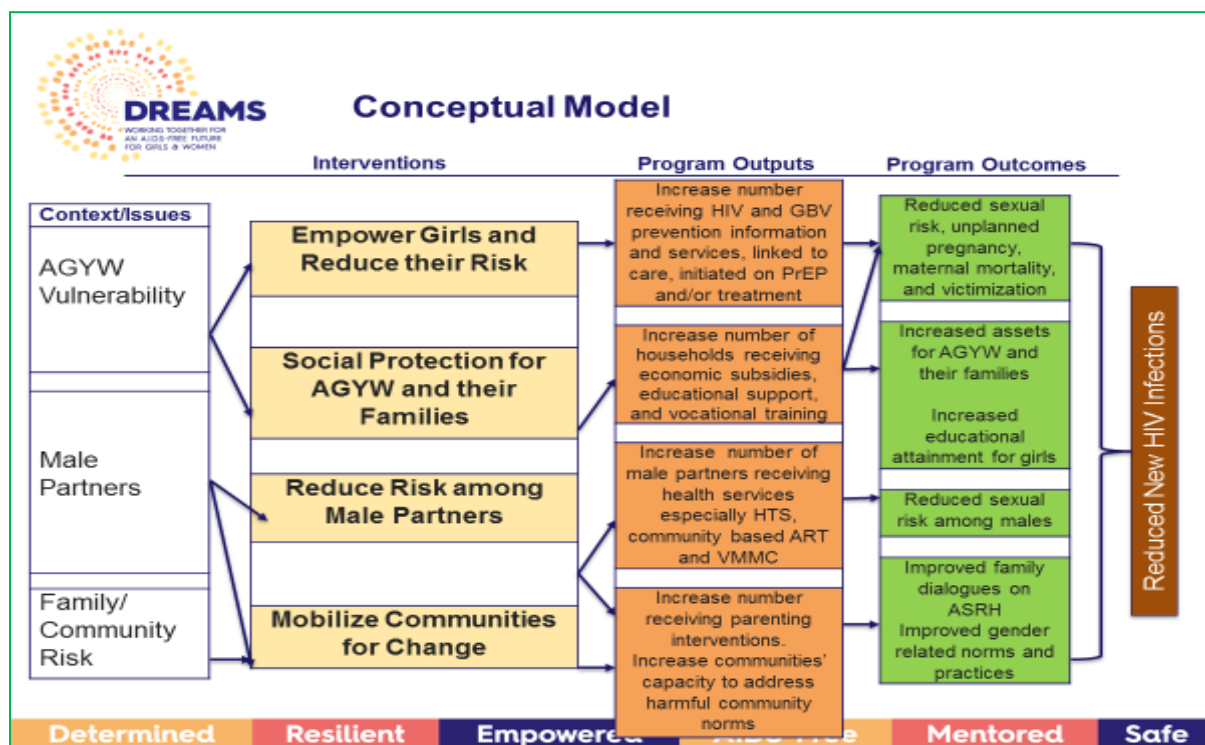
Zimbabwe is implementing the DREAMS project is being implemented in six HIV high-burden hot spot districts namely Bulawayo, Gweru, Mazowe, Makoni, Mutare and Chipinge with support from PEPFAR. The programme seeks to produce Determined, Resilient, Empowered, AIDS free, Mentored and Safe lives (DREAMS), with a target to reduce incidence by 40% amongst girls and women aged 10 – 24 years.

The DREAMS programme offers a comprehensive package as demonstrated below to Adolescent Girls and Young Women (AGYW) in a layered manner by various partners

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<sup>12</sup> Willis, N. (2016). Findings from a community peer support treatment intervention. Presentation delivered at the International AIDS Conference 2016 in Durban, South Africa. Online at [http://programme.aids2016.org/PAGMaterial/PPT/4636\\_6533/2016\\_07\\_06%20IAS%20Clinical%20Models%20of%20Service%20Delivery%20N%20Willis.pptx](http://programme.aids2016.org/PAGMaterial/PPT/4636_6533/2016_07_06%20IAS%20Clinical%20Models%20of%20Service%20Delivery%20N%20Willis.pptx).

**Figure 23: Dreams Conceptual Framework**



The programme managed to reach 96,674 young women and girls with HIV prevention services (including HIV and GBV prevention activities in and out of school, social asset building, HTS and other community mobilization activities) out of a target of 91,571.

The success of DREAMS is hinged upon layering of interventions, targeting most vulnerable AGYW with education subsidies, HTS, family planning commodities, post-violence care, livelihoods programs and family strengthening. This layered approach has demonstrated direct impact on reducing HIV incidence in AGYW.

The country reviewed and finalized the National Adolescents' Sexual and reproductive Health Strategy and the HIV sex and sexuality teacher and learner's manuals in an effort to increase knowledge dissemination amongst the young people.

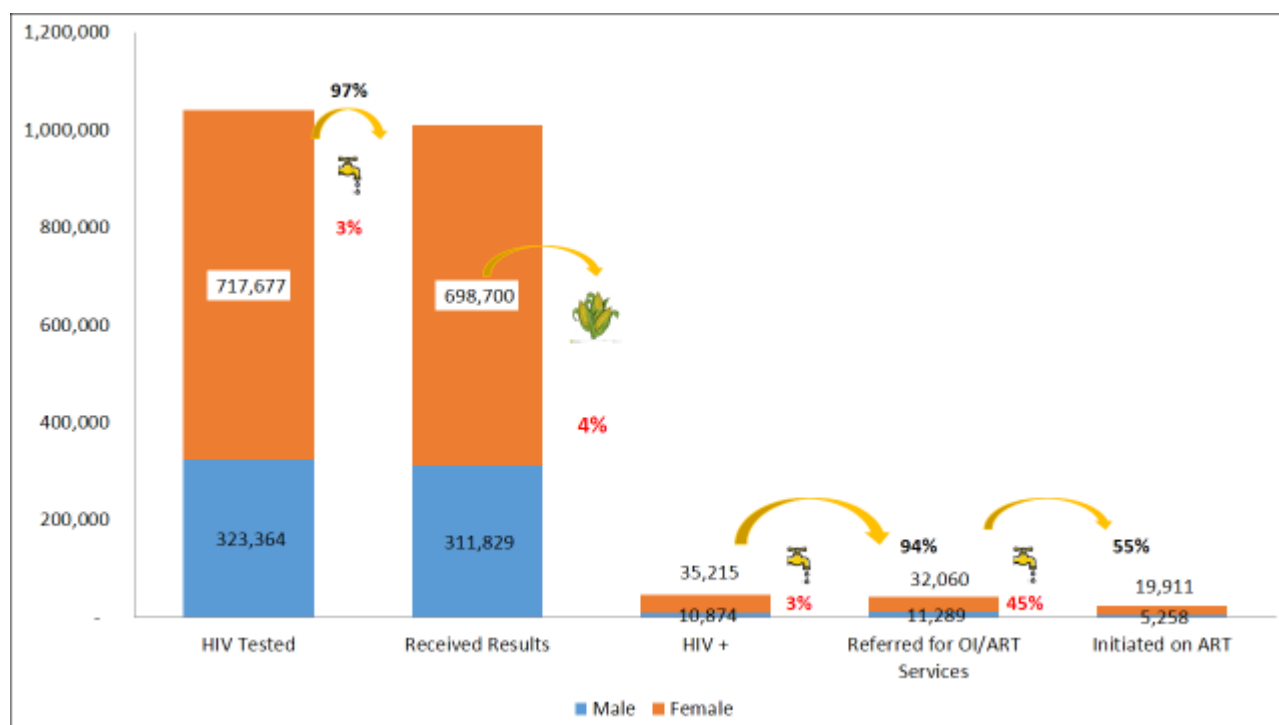
**Table 6: Target 5 Achievements**

Indicator	2016 Achievement (DHS)
5.1 Percentage of respondents aged 15-24 years who gave the correct answer to all five questions	46.5%
5.2 Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods	84.8%

In Zimbabwe, 46 percent of young women and 47 percent of young men have comprehensive knowledge of HIV. Among both sexes, the proportion with comprehensive knowledge increases with age and educational attainment. Urban young people are more likely than rural young people to have comprehensive knowledge of HIV and AIDS.

Although fewer than half of young people have comprehensive knowledge of HIV, knowledge of a source for condoms is relatively high. Forty-eight percent of young women and 86 percent of young men know a place where they can obtain a condom.

**Figure 24: Adolescent and Young people HIV Care Cascade**



Progress towards 90-90-90 among adolescents and young people in Zimbabwe is distinctly lagging compared to the adult population cascade. This is largely driven by a significant gap in achieving the first 90; among young people aged 15-24, just 52% know their HIV status.

Further, the ZIMPHIA survey results indicate that prevalence of viral load suppression is markedly lower among youth aged 15-24, at 48.6% among HIV-positive females and 40.2% among HIV-positive males.

With incentive funding from the Global Fund, a total of 11,060 young people were mobilized through the CATS model to receive HTS through index case finding and were linked to care for accessing ART and a range of other integrated services.

Moonlight testing is done targeting key populations including young people selling sex. Innovative strategies like music galas and sports galas are being implemented to mobilise the youth to access services.



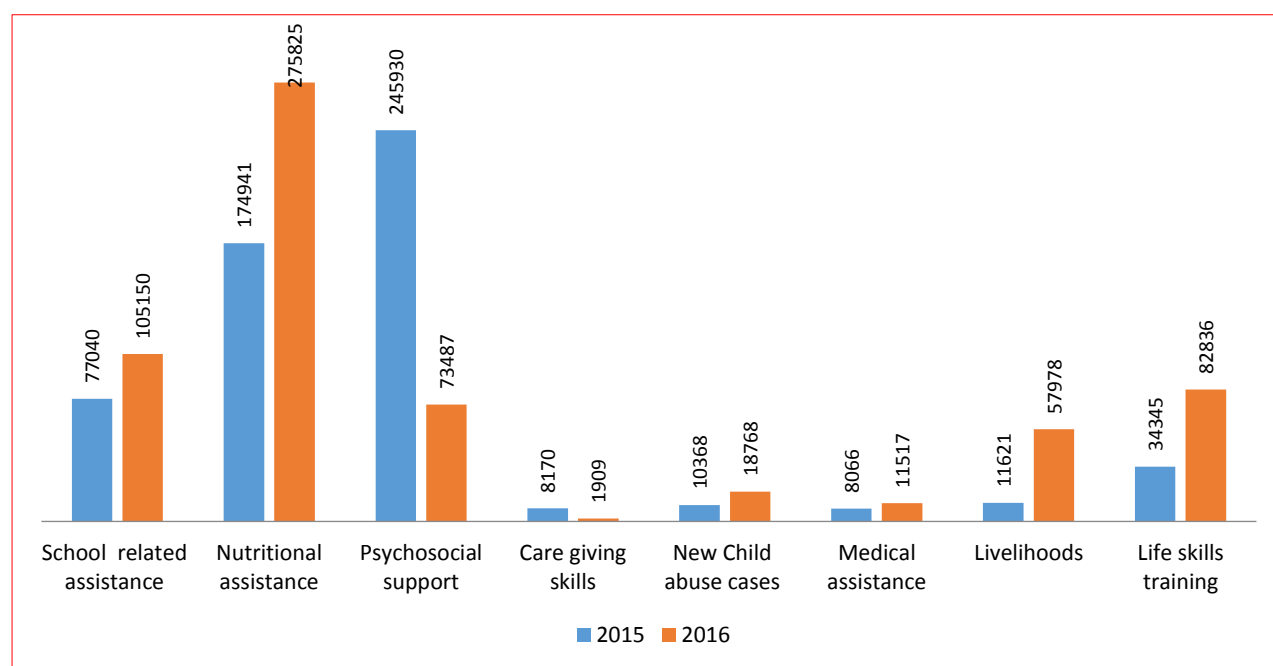
**Target 6: Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020**

The Positive Health, Dignity and Prevention programme (PHDP) was developed as a follow up to the Stigma Index Research in 2016 which led to the development of a training manual and training of champions. Community monitoring of ART/OI services is now embedded in the response. The activities, implemented in communities, at district and national level, contribute to ensuring that there is an increase in public accountability and responsiveness of national HIV and AIDS institutions to the needs of people living with HIV. Of the people living with HIV, 40% are benefiting from various forms of social support. 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 \$ 1,000,000 towards the Basic Education Assistance Module in 2016.

The figure below outline various forms of support for OVC in 2016, compared with the previous 2015.



**Table 7: Support for OVC**



Support to PLHIV

The psychosocial, livelihoods, financial, medical, food and nutrition support extended to People Living with HIV during the year is shown in the table below.

**Table 8: Support to PLHIV**

Indicator	Annual 2015			Annual 2016		
	Male	Female	Total	Male	Female	Total
No of PLHIV provided with food /nutrition	11567	17559	<b>29126</b>	22284	40113	<b>62397</b>
No of PLHIV provided with PSS	89588	180341	<b>269929</b>	81751	152150	<b>233901</b>
Number of PLHIV provided with medical support	13366	28031	<b>41397</b>	47376	28031	<b>75407</b>
Number of PLHIV provided with financial support	2168	6859	<b>9027</b>	730	2151	<b>2884</b>
Number of PLHIV benefiting from livelihoods	8285	36683	<b>44968</b>	8285	36683	<b>12603</b>



**Target 7: Ensure that at least 30% of all service delivery is community-led by 2020**

Zimbabwe does not have restrictions to the registration and operation of civil society and community-based organizations that affect HIV service delivery. National AIDS Council maintains an Organisational Details Registration Form (ODF) that keeps track of the community organisations that deliver services in each of the districts in Zimbabwe.

CSOs and CBOs are responsible for services delivery at community level and for Key Populations groups. Community cadres including behavior change facilitators, expert patients, village health workers, community-based distributors for sexual and reproductive health (SRH) services, PLHIV support groups, among others, exist to drive Zimbabwe’s community systems and responses. A recent community mapping exercise highlighted approximately 77 different types of community health cadres, which require further scaffolding and coordination for more coherent community responses.

The social and behaviour change programme is being driven by Behaviour Change Facilitators at community level and they create demand for health services. The country has put a strategy to use lay HIV testers for HIV screening. Currently PLHIV are actively involved in their treatment through the treatment adherence counselors, CARGs and community monitoring by PLHIV teams.



**Target 8: Ensure that HIV investments increase to US\$26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers.**

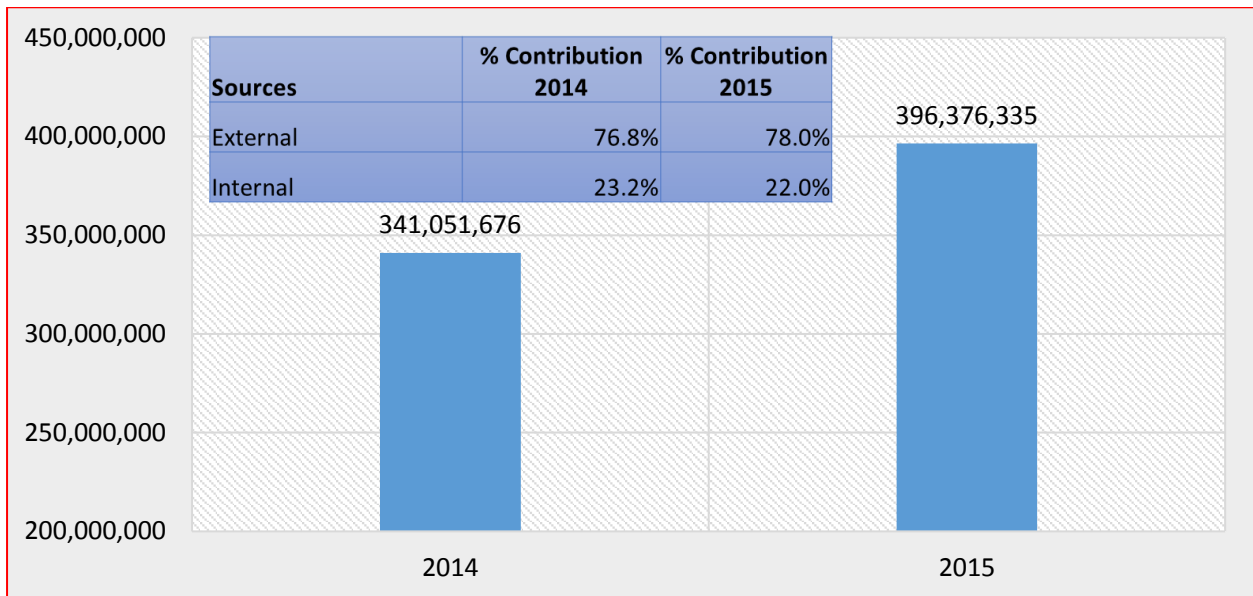
The AIDS Levy remains a homegrown innovative domestic financing mechanism that has remained a best practice in the region. Although the collections are shrinking due to economic hardships in Zimbabwe. The following table shows expenditure by year.

**Table 9: HIV Expenditure**

Indicator	Achievement				
	2011	2012	2013	2014	2015
Total HIV Expenditure	257.7m	308.8m	259m	341m	396m

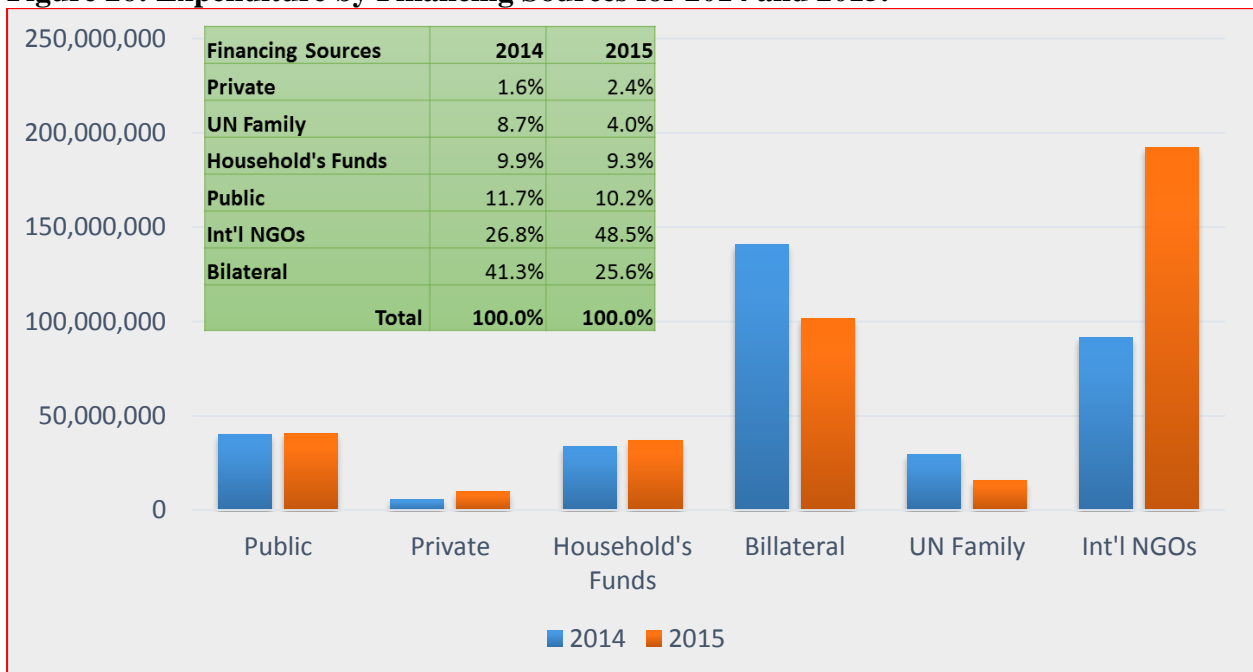
The expenditure on HIV by year is generally increasing, while the local contribution is dwindling as shown by the following figure. For 2014 to 2015 expenditure increased by 16.2%.

**Figure 25: AIDS Spending for 2014 and 2015**



The response is heavily funded by externals. The sustainability of the funding is still questionable. The highest proportions of funds are from international and bilateral sources as shown by the figure below.

**Figure 26: Expenditure by Financing Sources for 2014 and 2015.**





**Target 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights.**

The country, commissioned a Legal and Regulatory Environment Assessment (LEA) with the overall objectives of assessing the legal, regulatory and policy environment in relation to HIV and AIDS in Zimbabwe. Specifically, the LEA aimed at assessing the extent to which the current legal, regulatory and policy environment protects and promotes the rights of all people, including people living with HIV and other vulnerable and key populations to universal access to HIV prevention, treatment, care and support.

Key highlights of the 2016 included the formal registration and strengthening of the sex work led associations of male sex workers (Zimbabwe Rainbow Community and Zimbabwe Sex Workers Association), female sex workers (Women against All forms of Discrimination) and the trans-movement (Trans-Smart and TREAT). The strengthened voice of the KP community in Zimbabwe added its voice to the global community through their participation at the 2016 Durban International AIDS Conference.

Delegations comprising of Members of Parliament, Home Affairs Officers, the Judiciary as well as MoHCC, NAC and a Sex workers representative was supported to undertake international and regional look and learn visits. To support these initiatives sensitisations and trainings were conducted with the uniformed forces, parliamentarians, health workers and the media fraternity.

Capacity building programmes for people living with HIV and key populations to educate them and raise their awareness concerning their rights (in the context of HIV) done at small scale.



**Target 10: Commit to taking AIDS out of isolation through people-centered systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.**

Zimbabwe's TB incidence has sustained a downward trajectory from as high as 799/100,000 population in 2005<sup>13</sup> to 242/100,000 population in 2015<sup>14</sup>. TB mortality excluding HIV has

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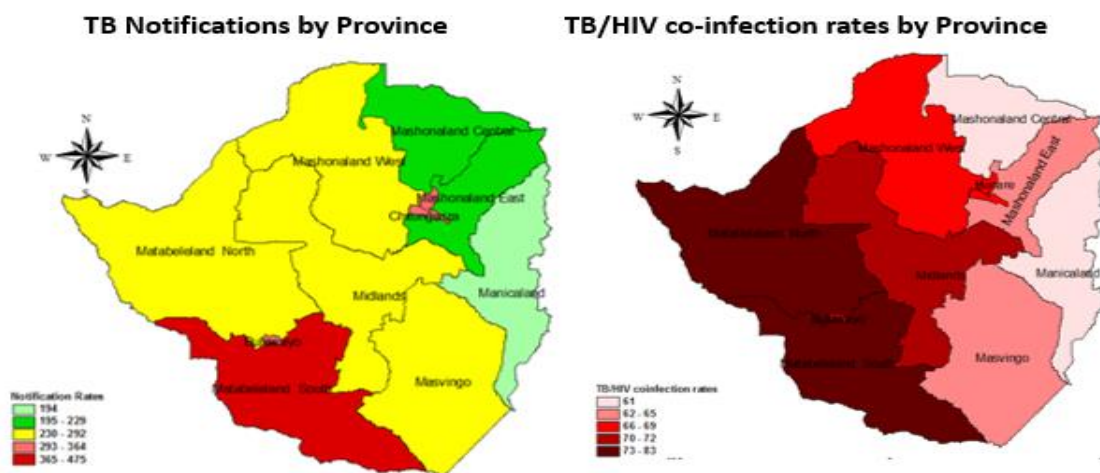
<sup>13</sup> Global TB Report 2013, page 159

<sup>14</sup> The Epidemiological review of TB disease and surveillance (May 2016) (As cited in team's 7 Feb template)

declined by 50%, from 22/100,000 in 2005 to 11/100,000 in 2015, and TB mortality including HIV has significantly declined by 75% from 158/100,000 in 2005 to 40/100,000 in 2015. These gains are largely due to increased investment in TB diagnosis and treatment and stronger TB/HIV collaboration such as the scale up of antiretroviral therapy (ART) in the general population. Thirty five percent (35%) of facilities are now offering Isoniazid Preventive Therapy (IPT).

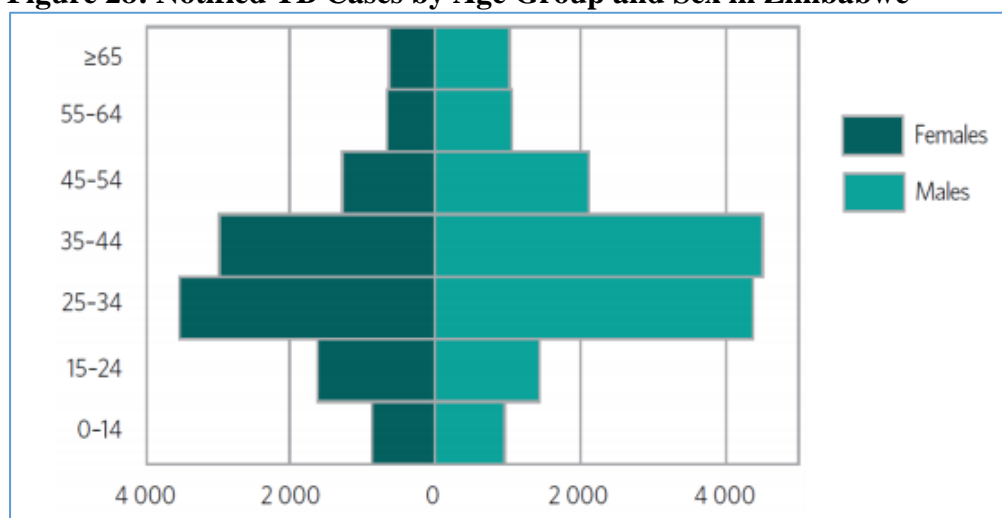
Despite this progress, the country remains among the World Health Organization’s (WHO) list of 14 countries that are considered high-burden for TB, MDR-TB as well as TB/HIV co-infection. Further, latest treatment coverage data (72%) indicates nearly a third of TB cases go undetected and continue to act as a reservoir for community transmission, making intensified TB case finding a top priority. The following figure shows TB notification and co-infection rate by province

**Figure 27: TB notifications and TB/HIV co-infection by province**



The figure 27 shows that the TB epidemic in Zimbabwe is predominantly driven by HIV

**Figure 28: Notified TB Cases by Age Group and Sex in Zimbabwe**



The greatest numbers of new TB cases occur among men aged 35-44, while men aged 25-34 also bear a significant burden. Gender dynamics expose more men to TB than women in all age brackets, except for AGYW (15-24), who had more case notifications than their male peers. This may be linked with disproportionate HIV burden among this age group as compared to their male counterparts.

**Table 10: Distribution of TB in Zimbabwe, by High Risk Group**

Risk Group	% of population in risk group	% of TB Cases	# TB Cases
Children u15 suffering from severe malnutrition	0.8%	0.60%	265
Adults with low BMI	0.6%	0.43%	191
Smoking	6.5%	2.58%	1,133
Alcohol dependence	2.0%	1.06%	468
Diabetes	2.9%	1.65%	726
Elderly	3.1%	0.79%	347
Prisoners	0.15%	0.14%	61
Miners	4.9%	2.70%	1,187
Persons living in high density areas	20.0%	9.17%	4,037
PLHIV	*	68.00%	29,920
TB not found in a high risk group	**	12.88%	5,666
<b>Total</b>		<b>100.00%</b>	<b>44,000</b>

\* determined with TIME Estimates  
 \*\* not directly modelled, but as 100% (sum of high-risk groups)

Several high risk groups bear disproportionate TB burden in Zimbabwe. PLHIV, children, miners, prisoners, smokers, the elderly and people living in high density areas are particularly vulnerable. An assessment of TB prevalence in prisons in 2016 found prevalence to be

574/100,000 population screened, which is much higher than the national prevalence<sup>15</sup>. Overcrowding of detention facilities is a critical human rights consideration which drives high rates of TB among inmates

Cervical cancer strategy has been developed but it is integrated in some of the health facilities. There is no active screening of people living with HIV for cervical cancer. There is limited integration of the HIV and hepatitis C treatment.

### **Coordination of the National Response**

National AIDS Council led the coordination of the national response in Zimbabwe. Sectoral coordination was strengthened for all the 6 sectors. Several coordination meetings were held at all levels. The organization is leading in mobilizing resources to finance the epidemic. National AIDS Council reviewed its coordination structures in order to take into consideration the epidemic changes and re-align the response.

### **Monitoring and Evaluation**

Low coverage of electronic data systems, uncoordinated data analysis (with limited discussion across programmes and communities), and “verticalized” program-specific M&E and data quality activities compromises data quality and data utilization for decision-making. The MOHCC has made the strategic decision to integrate all electronic health systems (Zimbabwe EHR roadmap) and ensure that the Electronic Health Record (EHR) is the backbone of electronic health systems and all other disease specific systems.

The country finished the two population based survey, the Demographic and Health Survey and Population based HIV Impact Assessment. The country went on to conduct a Modes of Transmission (MoT) survey in order to inform programming. The country centralized reporting source of all Health Indicators as the DHIS 2. Pre-treatment drug resistance survey was done to inform the ART program on the quality of service.

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<sup>15</sup> University of Zimbabwe and UNODC (2016). Assessment of TB Prevalence and Factors with TB among the Prison Population in Zimbabwe. Page 49-50.

## **Major Challenges**

The following challenges were experienced in 2016:

- Low coverage of services for key populations
- Low coverage VMMC
- Limited integration of HIV, Cervical Cancer and Hepatitis B and C testing and treatment
- Slow scale up of Isoniazid Preventive Treatment services
- Dwindling local funds for the epidemic and 78% of the response is donor funded.
- Diminishing of international funding for HIV and AIDS and yet the response rely on external funding
- Limited monitoring of HIV-sensitive social protection