# GLOBAL AIDS RESPONSE PROGRESS REPORT 2015

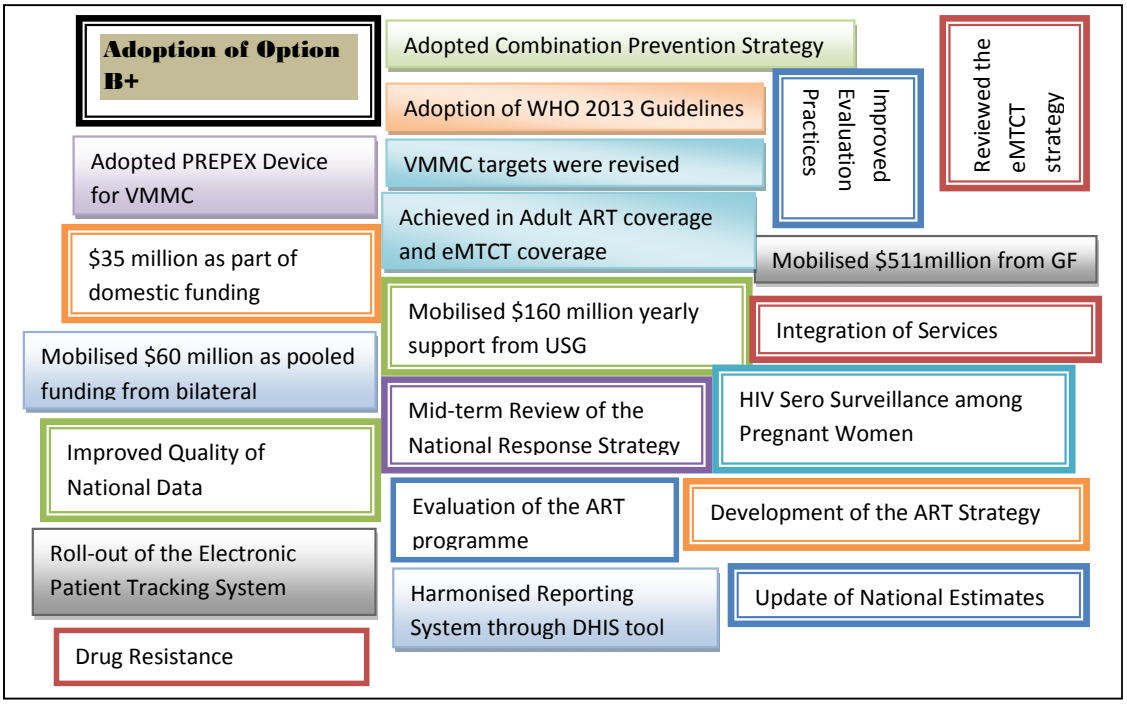
**FOLLOW-UP TO THE 2011 POLITICAL DECLARATION ON HIV/AIDS**

**INTENSIFYING OUR EFFORTS TO ELIMINATE HIV/AIDS**

## ZIMBABWE COUNTRY REPORT

## Reporting Period: January 2014 -December 20 14

## Highlights of Key Achievements



# Contents

## Status at Glance

The 2014 Zimbabwe National Response Status Report was developed using an inclusive process involving all stakeholders from public sector, civil society, private sector and development partners. The generation of the national report was coordinated by the National AIDS Council in collaboration with the Ministry of Health and Child Care.

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 localized areas (11 districts, described as hot spots) of high HIV transmission which includes border districts, growth points, small scale mining areas, fishing camps and commercial farming settlements.

The Government of Zimbabwe remains committed to achieving zero new infections, zero HIV related deaths and zero HIV stigma and discrimination. All required policy environment exists to support the multi-sectoral response in line with the High Level Meeting targets by 2015. So far we have achieved universal access by 2012 in most of the key prevention services – PMTCT as well as adult ART services. In an effort to improve quality services the country adopted the new 2013 WHO guidelines which resulted in the increase of the number of people requiring ART Services for adults and pregnant women.

The AIDS Levy remains a homegrown innovative domestic financing mechanism that has remained a best practice in the region. Eighty five (85) percent of the total cost of the national response is externally funded, however domestic spending increased by 40 percent from 2011 to 2014.These successful gains have not been without challenges one of which is the low uptake of pediatric ART services. Table 1and 2 below highlights the performance of core indicators of the national response.

**Table 1: Performance of impact indicators – HIV Estimates 2014**

| **Impact indicators** | **2011** | **2012** | **2013** | **2014** |
|---|---|---|---|---|
| **Deaths averted by ART (Thousands)** | 40.42 | 48.22 | 45.7 | 67.1 |
| **Infections averted by PMTCT (Thousands)** | 6.41 | 12.75 | 15.11 | 14.4 |

| | | | | |
|---|---|---|---|---|
| **Life years gained by ART and PMTCT (Thousands)** | 210.02 | 269.79 | 323.47 | 428.3 |
| **Deaths averted by PMTCT (0-4) (Thousands)** | 2.91 | 4.06 | 5.4 | 1.15 |
| **HIV incidence rate** | 1.29 | 1.25 | 0.98 | 1.1 |
| **Annual HIV related deaths** | 115117 | 87335 | 61476 | 54994 |
| **Total AIDS orphans** | 1151235 | 1084906 | 810135 | 719477 |

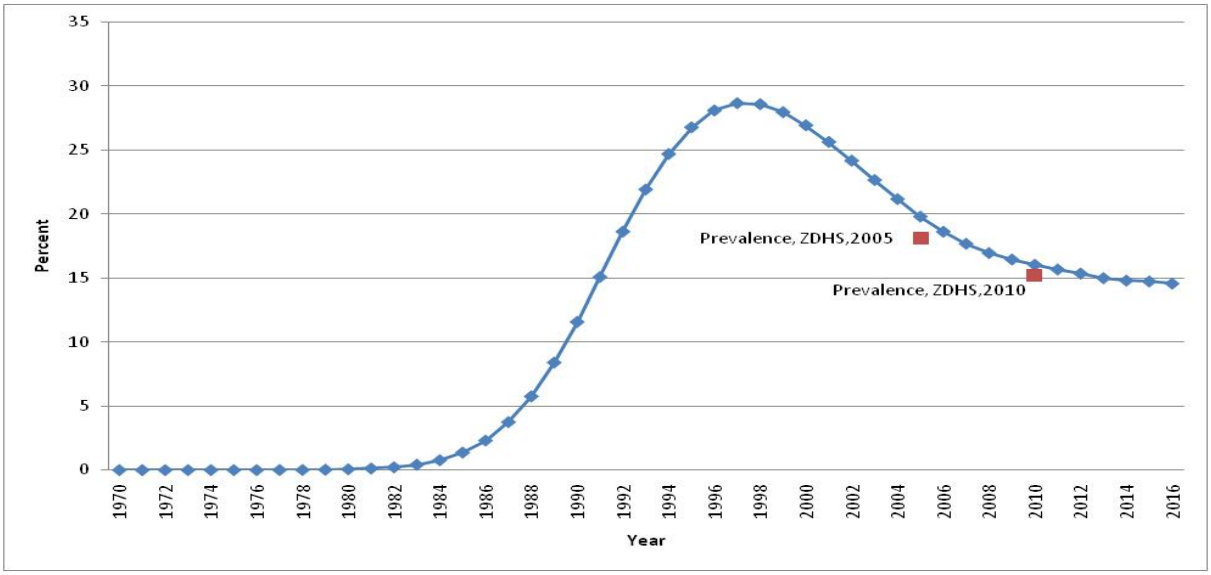
**Table 2: Overview of performance of core indicators**

| Year | 2007 | 2009 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission. | 22% | 59% | 85% | 82% | |
| Number of Adults 15-49 who were tested and received results | 579,767 | 1,108,264 | 2,240,344 | 2,274,328 | 1,465,289 |
| Number of males circumcised according to national standards | | 2,801 | 40,775 | 112,084 | 400,235 |
| 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 – 40.5% | Adults – 63.4%, Chn – 54.8% |
| Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy. ***Source – NAC cohort report*** | 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) |

## Overview of HIV epidemic

The first AIDS case was reported in 1985 in Zimbabwe, from 1985 to the mid-90s the HIV prevalence rose sharply to reach a peak of 27.7% in 1997 and started declining thereafter as shown by figure 1 below. 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]

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




*Source: National HIV and AIDS Estimates Report 2014*

The adult HIV prevalence declined by three percentage points from 18% to 15% over the five-year period of 2005-06 ZDHS and the 2010-11 ZDHS. 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), elimination of Mother to Child Transmission services, and successful treatment care and support services.

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

There were an estimated 1,328,535 adults and children that were living with HIV and AIDS in 2013 and estimated 786,299 PLHIV adults and children were in urgent need of antiretroviral therapy by the end of 2013.[4]

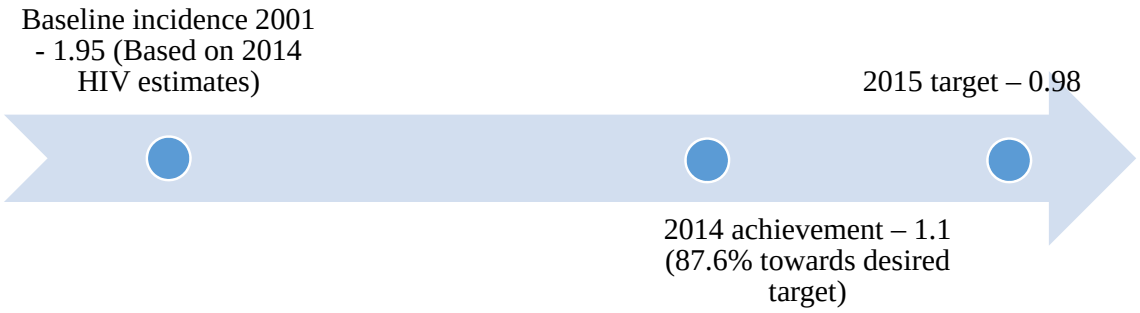
The epidemic is mostly heterosexual and the risk factors include migration, high risk sex and key populations.

## Status of the Implementation of the High Level Meeting Targets.


1. **Reduce Sexual Transmission of HIV by 50 % by 2015**[5]

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

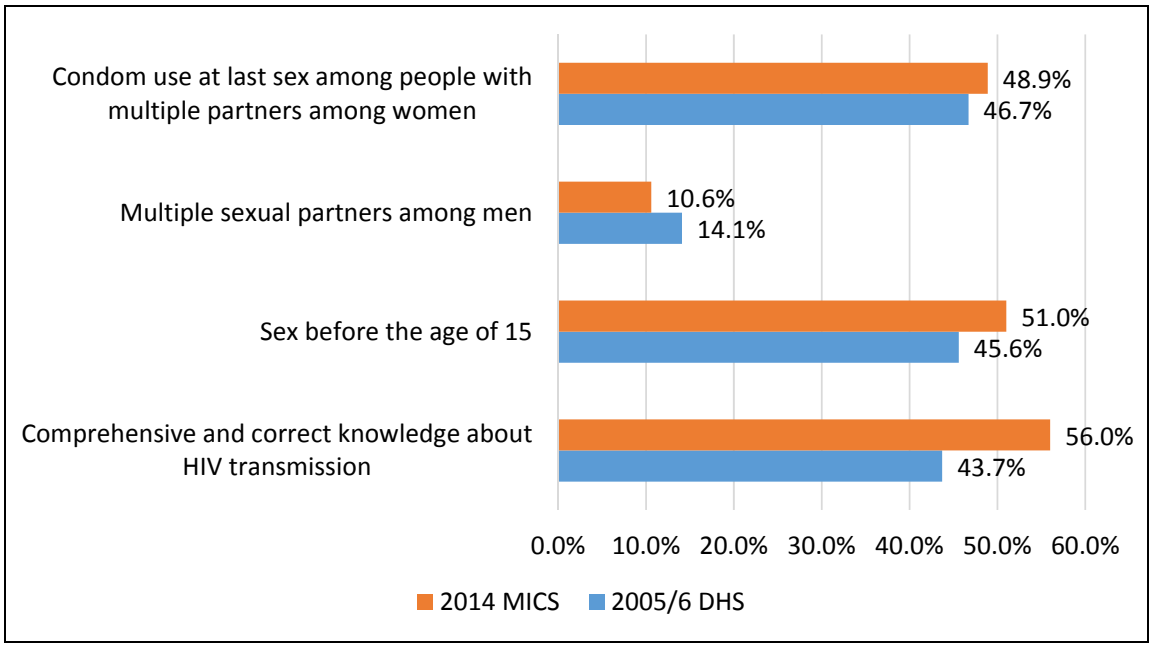
**Figure 2: Progress towards target of reduction of new infections.**




Reduction in new infections is attributed to the following outcome results

**Figure 3: Outcome results for the reduction of sexual transmission**

[4]Ministry of Health and Child welfare; 2013 National HIV Estimate Report, July 2014




Comprehensive knowledge of HIV among young females increased by 13.7 percent (43.7 % in 2005, 51 % in 2010 and 56% in 2014); among young males increased by 5.4 percent (45.6% in 2005, 47% 2010 and 51% in 2014)[2] over a period of ten years. Significant changes appear to have contributed to the declining new infections: household survey data show an improvement in age at first sex, reduction in number of partners and also increase in condom use at high risk sex.[2,6] Similar behavioral change pattern has been observed through cross sectional studies among sex workers and other key populations.

In addressing sexual transmission of HIV, the country has prioritized interventions around social and behavioral change, increased condom promotion and distribution coupled with intensified awareness on correct and consistent use of condoms; Voluntary Male Circumcision, HIV Testing and Counseling, prevention and control of sexually transmitted diseases. These strategies are addressing the key drivers of the epidemic which include multiple and concurrent partnerships, inter- generational sex discordant couples and low circumcision rates. Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive.

The scale up of high impact prevention interventions and the pattern of coverage are as follows:

[6] Zimbabwe Multiple Cluster Indicator Survey Report

- Social and Behaviour Change

The SBCC programme targets the sexually active in the 15 to 49 age group (men, women, boys and girls). SBCC interventions were intensified in the community, workplace and in schools, targeting most at risk and key populations.

A total of 1,132,760 person exposures were achieved in 2014 against a target of 2,649,600. Training of the Behaviour Change Facilitators (BCFs) stated off late hence target was not met. BCFs adopted the home visit approach in order to create demand for services for all the components of the Combination Prevention approach. BCFs are using the door to door approach to enhance information dissemination through Inter-Personal Communication (IPC) reaching families, couples and individuals.

Key implementing partners of the programme are, World Vision; RegaiDzive Shiri; ZiCHIRe; Batsirai; FACT Mutare; Zimbabwe AIDS Support Organisation (ZAPSO); Matebeleland AIDS Council; Midlands AIDS Support Organisation and UNFPA.

- Key Populations

The Sisters with a Voice Programme is run by CeSHHAR Zimbabwe. The programme provides health education, reproductive health services, HIV testing and referral plus access to legal services for female sex workers at 36 sites around the country. Over 24000 women have been accessing HIV prevention services to date. The programme is run by a network of trained and supported by peer educators and participatory community mobilisation activities. Programmatic data indicate that HIV incidence is around 10% per annum. A study is being conducted at 3 sites. The SAPPH-IRe trial (PACTR201312000722390) is nested within the Sisters programme. SAPPH-IRe is a cluster randomised trial of ART for prevention (including offer of oral Pre Exposure Prophylaxis for women testing HIV negative). Baseline data shows that HIV prevalence among female sex workers is at 58%. Endpoint data from this trial will be combined with data from a size estimation study in 2015 to provide a national size estimate (based on data collected from 18 sites including the 3 largest cities in Zimbabwe).

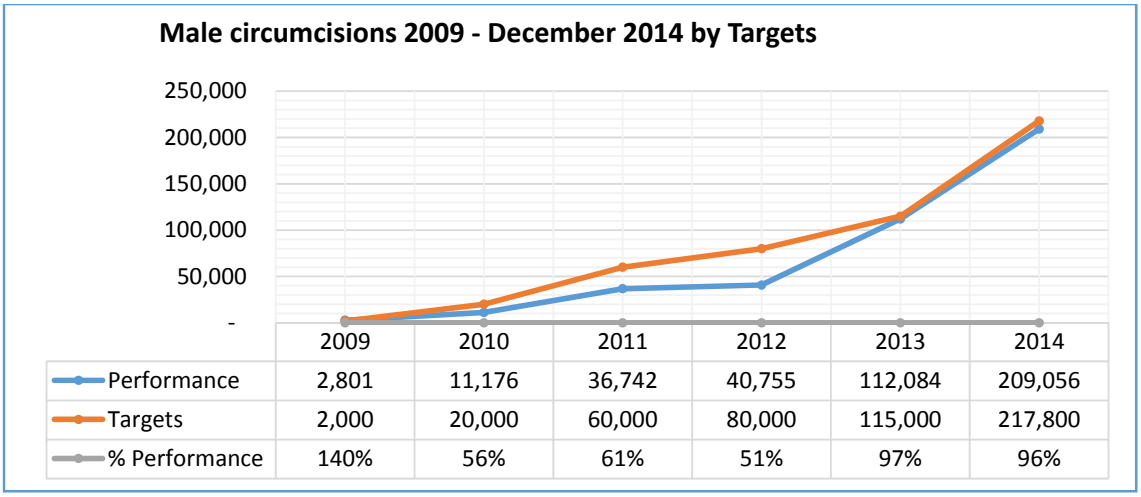
- Condom Promotion and distribution

Condoms are distributed through public and private channels using the social marketing approach. In 2014, 104 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[7].

- Voluntary Medical Male Circumcision (VMMC)

**Figure 4 : Male Circumcision**




| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|
| Performance | 2,801 | 11,176 | 36,742 | 40,755 | 112,084 | 209,056 |
| Targets | 2,000 | 20,000 | 60,000 | 80,000 | 115,000 | 217,800 |
| % Performance | 140% | 56% | 61% | 51% | 97% | 96% |

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 400,235 men were circumcised translating to 31% of the target. In order to scale up effort for VMMC, the country has adopted the PrePex device. Integrating

[7] Stigma Index report December 2014

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.

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

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 has reduced from 21% in 2009 to 6.6%[8] in 2014 indicating that we are close achieving the global elimination target of less than 5%. HIV contributes to reduction of maternal deaths by 21%. Based on the households study overall maternal mortality rate have reduced from 960 to 581 per 100 000.

Interventions being implemented to reduce new infections among children as well as contribute to reduction in AIDS related maternal deaths are as follows:

- Prevention of Mother to Child Transmission of HIV (PMTCT)

[8] Community survey report UCB 2014

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 has achieved universal access (85% in 2012).

Table 4 bellow shows programme performance in details

**Table 1: PMTCT**

| **Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths1** | | | | | | |
|---|---|---|---|---|---|---|
| **Year** | **2007** | **2009** | **2011** | **2012** | **2013** | **2014** |
| 3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission. | 22% | 59% | 86% [MOHCW, PMTCT Data base ] | 85% (PMTCT programme data) | 82% (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 - 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% (Community survey report-UCB) |
| 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) | 99,26% (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) | 19,8% (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 6.6% in 2014. 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 2: eMTCT Funding Matrix**

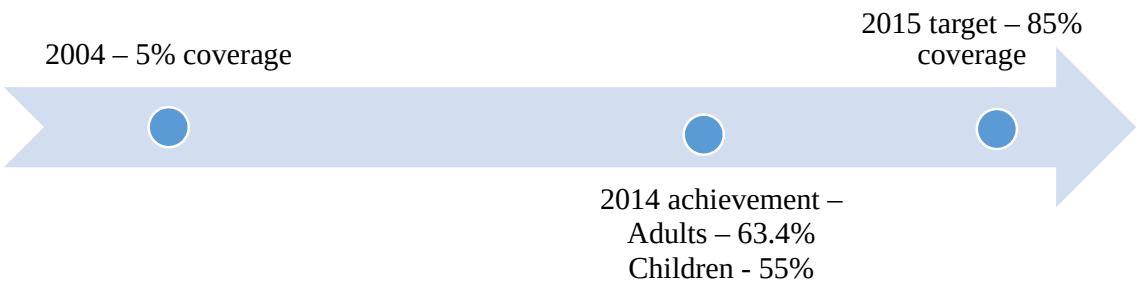
| Funding Source | 2012-13 | | 2013-14 | |
|---|---|---|---|---|
| **US Government** | 13,944,189 | 33.6% | 12,401,489 | 32.3% |
| **CIFF** | 10,946,727 | 26.4% | 10,946,727 | 28.5% |
| **DFID** | 7,936,742 | 19.1% | 8,275,000 | 21.6% |
| **Global Fund** | 3,548,743 | 8.5% | 424,650 | 1.1% |
| **CIDA** | 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% |

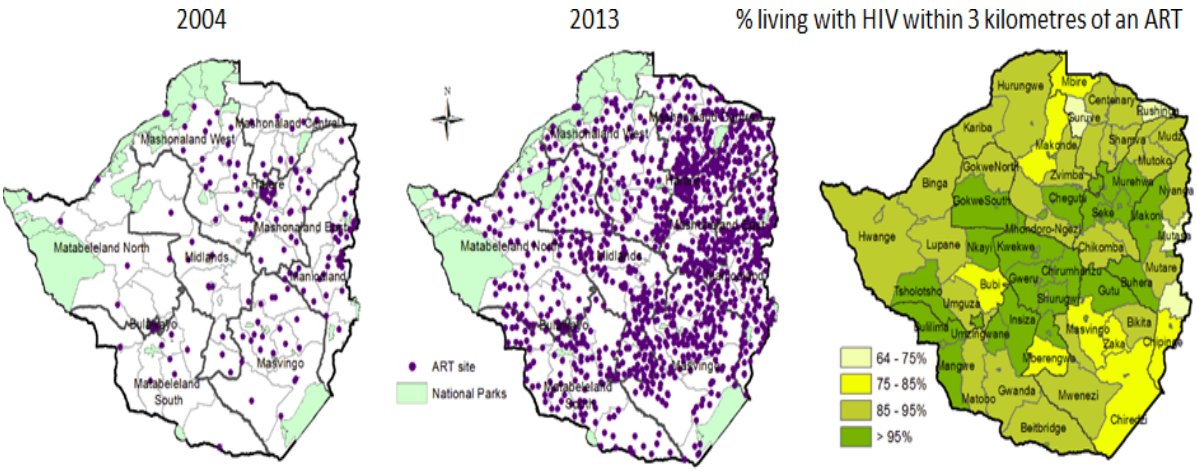
### 3. Contribute to Reaching 15 Million People Living With HIV with Life Saving Anti-Retroviral Treatment by 2015

Progress towards the desired target is illustrated below.

**Figure 6: Progress towards the desired target**




The country is on track towards achievement of the desired target. The following maps shows distribution of ART facilities and proximity to services.

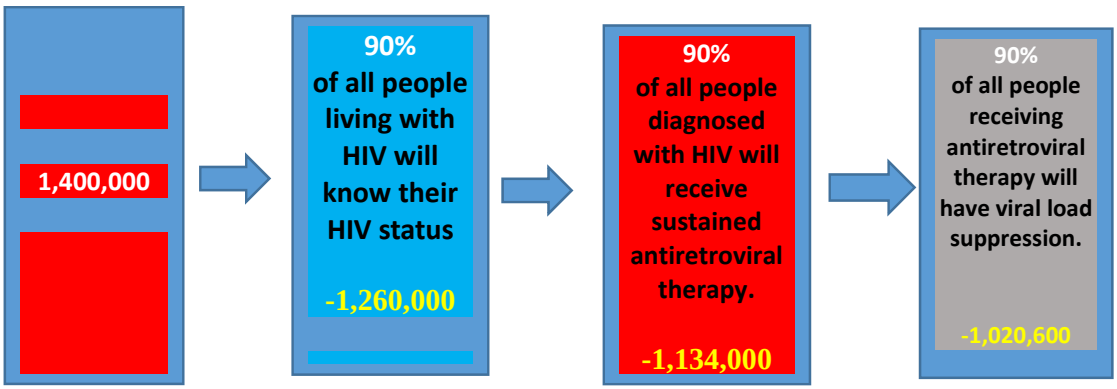



Zimbabwe is committed to the provision of Anti-Retroviral Therapy for all people living with HIV who need it as a lifelong treatment measure. The ART programme is being implemented within the context of comprehensive care and support that addresses the medical, social and emotional needs of PLHIV. ART services have increased steadily from 2004 to 2013 by up to five times. Most districts have more than 85% of their population living within 3 km of an ART site as shown by the map above. A deliberate effort should be made to increase accessibility of HIV-AIDS services and investments should be geared to ensure that the already existing sites are fully functional and are operating at their maximum capacity.

Treatment sites have increased from 530 in 2010 to 1459 sites in 2014. Coverage of ART has increased from 5% 2004 to 83% in 2011 and now 77% in 2014 due to changes in eligibility as well indicator definition. There is an upward trend of TB/HIV service coverage of which 75% of TB patients with HIV are receiving ART. 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 and efficient use to support for ART scale-up the treatment programme has also been reprogrammed to achieve the 90.90.90 ambitious targets:

The 90-90-90 targets mean that 90% of all people living with HIV will know their HIV status; 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have durable suppression. What this means for Zimbabwe is indicated on figure 7 below:

**Figure 7: What are the benchmark figures for Zimbabwe**

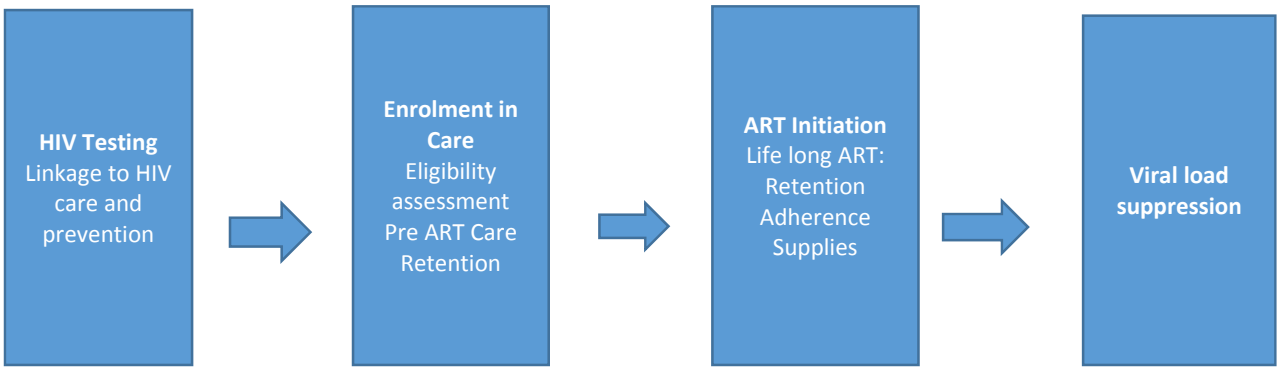



Based on the 2013 national estimates, we currently have 1.4 million PLHIV of which, by 2020, we will need to have 1,260,000 (90% of 1.4 million) tested and identified as HIV positive; 1,134,000 (90% of 1,26m) put and sustained and retained on treatment and 1,020,000 (90% of 1,134m) to be virally suppressed

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

Zimbabwe mobilizes 2M citizens for HIV testing annually which is very impressive. About 33% of PLHIV that need to know their status in order not to afford late enrolment into care and treatment. For us to achieve this efficiently, we may need to explore our HIV testing efforts in the future towards areas of greater yield and improved targeting of beneficiary populations.

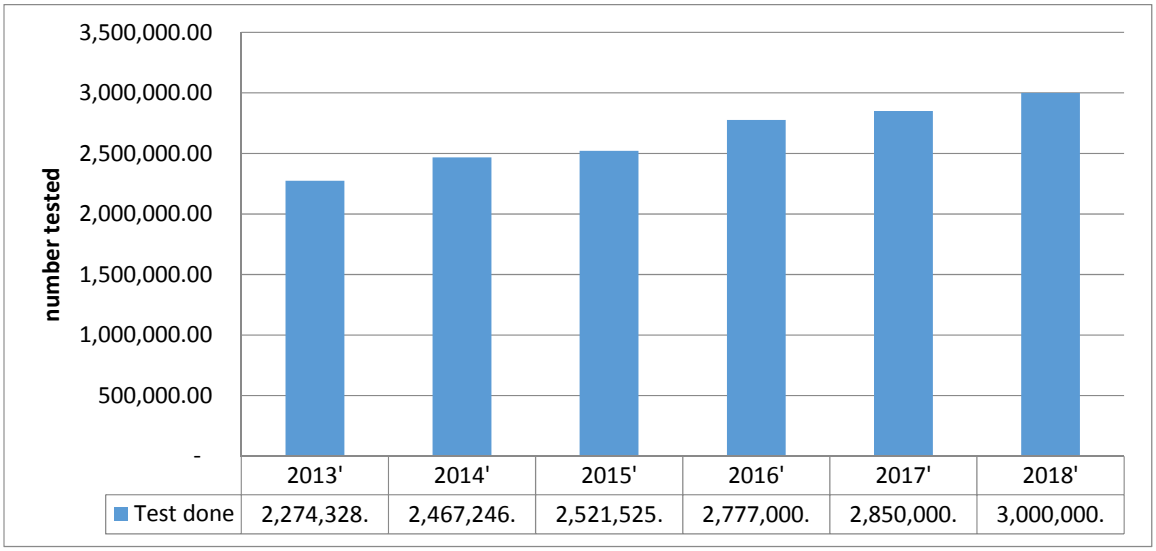
**Figure 8: National HIV testing to treatment cascade in Zimbabwe**




PLHIV who know their HIV status was at 66% (ZDHS 2010/2011). Testing rates among female 15-19 years is higher at 49% (MICS 2014). Low testing rates among men in general with only 24% of males aged 15-19 knowing their HIV status and having received a result- MICS 2014. HIV testing for HIV exposed infants (EID) is at 50%. Need to deal with retesting of those who are already know positives or living with HIV.

Figure 5 shows the testing needs of the general population on annual basis.

**Figure 9: HIV testing needs in Zimbabwe 2013-2018**



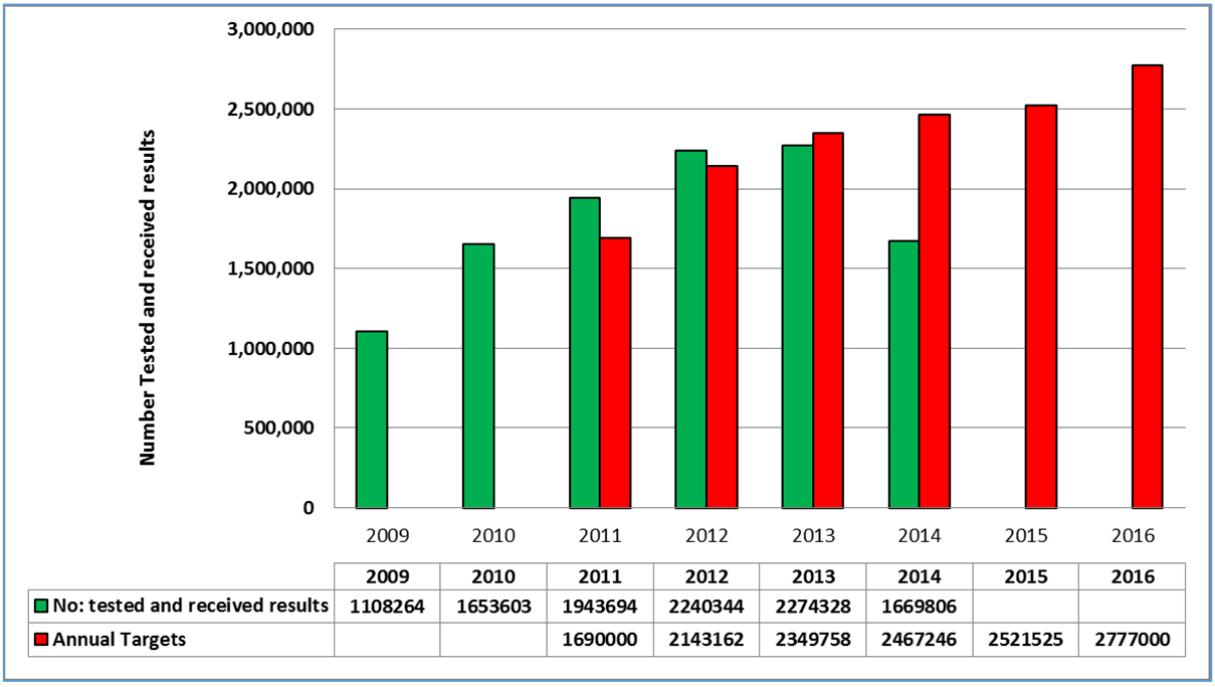

***Source: MOH HTC Strategy***

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 ZDHS 2010/11 shows a marked increase in HIV testing coverage among both men and women from 7% 2005/6 to 21% 2010/11 and 7% 2005/6 to 34% 2010/11 respectively. Furthermore, 91% of women and 88% of men knew where to access HTC services.

Currently a total of 1,460 health care facilities are providing integrated HTC services through Antenatal Clinic (ANC), OI clinics, standalone Testing and Counseling centers, outreach centers, TB clinics and STI clinics. HTC services are available to all citizens inclusive of key populations. The key implementing partners of the program are; PSI, OPHID, ZAPSO , ZACH and WHO.

In 2014 a total of 1,465,289, adults aged 15-49 accessed HTC in Zimbabwe against a target of 2,467,246 (Figure 2).

**Figure 10: HIV Testing and Counseling Services**




| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|
| No: tested and received results | 1108264 | 1653603 | 1943694 | 2240344 | 2274328 | 1669806 | | |
| Annual Targets | | | 1690000 | 2143162 | 2349758 | 2467246 | 2521525 | 2777000 |

Since 2009, the number of people tested and received results have steadily increased until 2014. However, the figures decreased to 1,669,806 owing to the following:

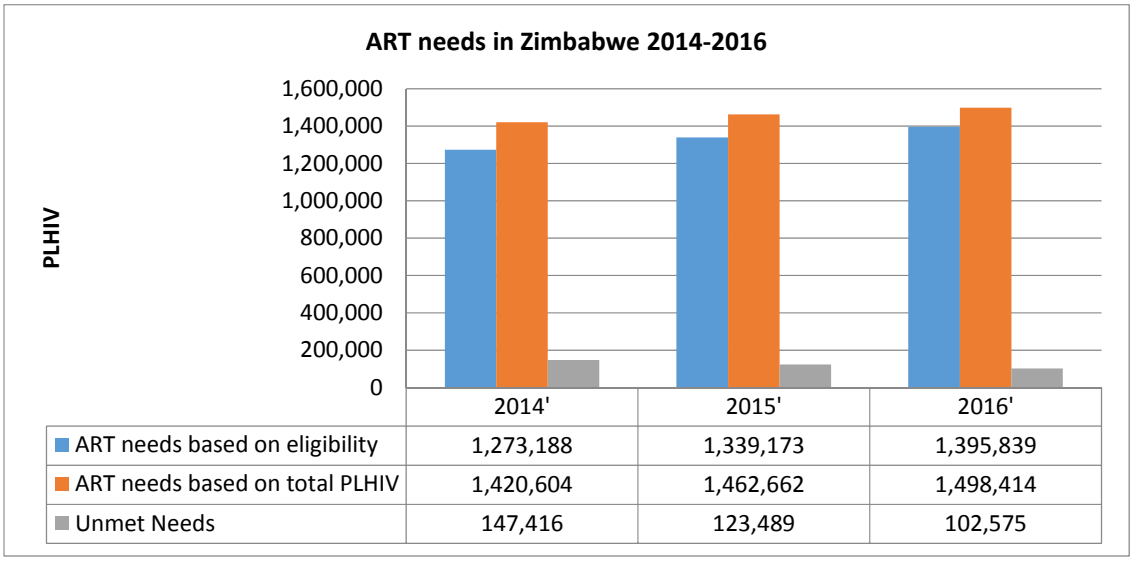
- The change of the new register and transition from manual reporting to online reporting (DHIS2) affected the reporting system.
- Inadequate funding to support and cascade M&E trainings (12 per year).
- OSDV conducted in October 2014 revealed that health facilities are not aggregating HTC data from all service delivery points when producing the facility report. This led to under reporting of most high volume health facilities.

There is need to continue strengthening linkages and referral systems between HIV testing and subsequent interventions in the continuum of care despite the achievements made. Emerging issues such as community based HIV testing and counseling and the introduction of self-testing need to be explored.

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

Seventy seven percent (77%) of all people diagnosed with HIV will receive sustained antiretroviral therapy. ART coverage in children and adolescents is disproportionately low. Further scale-up and sustainability depend on efficient use of resources, integration of services, decentralization and quality of services. Over 50% of national HIV resource envelops currently goes to support treatment and care. Demand creation, community system linkage to health care systems be strengthening in prioritized geographical locations. ART coverage in children and adolescents is disproportionately low. Further scale-up and sustainability depend on efficient use of resources, integration of services, decentralization and quality of services.

**Figure 11: Number of people diagnosed and will need treatment in Zimbabwe**




*Source: NAC/MOHCC 2013 Estimates*

## Antiretroviral Therapy (ART)

The country has adopted WHO 2013 guidelines. The total number of PLHIV receiving ART in Zimbabwe is 787,980 including 732,919 adults and 55,061 children with more than 9,000 PLHIV initiating treatment each month.

**Table 3: Performance of ART programme**

| Year | 2007 | 2009 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| 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 - 63.4% Chn- 55% |
| 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%) |
| Percentage of adults and children with HIV known to be on treatment 24 | | | 79% (October 2010 | 83.2% (Adults – 88.8%, Chn | 84.6% (Adults – 84.3%, Chn – |

| | | | | | |
|---|---|---|---|---|---|
| months after initiation of antiretroviral therapy | | | Cohort data) | – 82.6%) | 87.6%) |
| 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%) |

** ART coverage declined because of change in indicator definition, whereby the denominator increased due to implementation of the 2013 ART guidelines

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 55%, 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

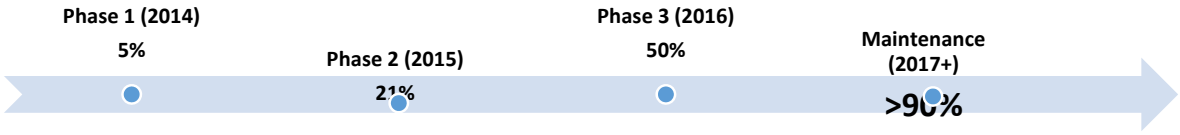
Zimbabwe continues to experience a major HIV driven TB epidemic with co-infection rates of 82%. Considerable progress has been made towards addressing the 12 point WHO collaborative TB/HIV activities. As of 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 71% received ART. Progress on implementation of the 3I's has been very slow especially Isoniazid preventive therapy (IPT). IPT is currently being offered at 46 sites. TB/HIV services are available to all key populations that need it. The key implementing partners for the programme are: Private Sector and MOHCC

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

Zimbabwe adopted viral load as gold standard to monitor patients on ART in Dec 2013. The national scale-up plan is in phases as shown. Currently, no nationally representative data exist on viral load suppression. Available data is from surveys or limited clinics. Existing data from surveys showed that 89,9% Viral load suppression after 12 months on ART (data from HIV DR monitoring survey of 12 sentinel sites, 2009-2010). 70.3% if we consider all patients (alive on Rx, LFTU, deaths etc). 85% VL suppression for patients from Buhera District supported by MSF, 86% VL suppression for patients from Gutu District. Viral load testing in the country is still very low – achieved 3% in 2014.

There is need to maintain the current centralized Viral Load monitoring system and gradually move to routine Viral Load testing

**Figure 12: Phasal scale-up of viral load support system**




## Orphans and Vulnerable Children

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

## 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.

The political, legal, social and economic situation in 2014 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.

## Monitoring and Evaluation

The country mapped the HIV hotspot in order to inform programming and revised the National Monitoring and Evaluation Plan in line with the National Strategic Plan 2015-2018. The country improved data quality, evaluation culture, harmonised reporting system through the DHIS tool, conducted drug resistance monitoring, and continued to rolled out the electronic patient monitoring system.

**Major Challenges**

The following challenges were experienced in 2014:

- Low peadiatric ART and the country is in a process of scaling up and decentralizing peadiatric ART services and broaden nurses' scope of work
- Low coverage of VMMC and the nation has adopted the PrePex model to increase uptake of VMMC services
- Heavy reliance on external sources (77%) which are declining significantly
- Supply Chain Management systems is fragmented
- Low coverage of key programmes -Pediatric ART VMMC, consistent condom use, Key populations interventions
- Weak linkage between Health and Community systems affecting quality of services
- Civil society organizations (CBOs, NGOs) under-funded affecting enhanced community response
- No statutory instrument to enforce data reporting by all sectors
- Slow scale up of Isoniazid Preventive Treatment services

**Future priority Actions**

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. Intensify programming for adolescents and other key population and remove barriers to service access
5. Finalization of the National investment case to advocate for filling of the funding gaps