



## GLOBAL AIDS RESPONSE PROGRESS REPORT 2020

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



### GAM ZIMBABWE COUNTRY REPORT

Reporting Period: January 2019 - December 2019



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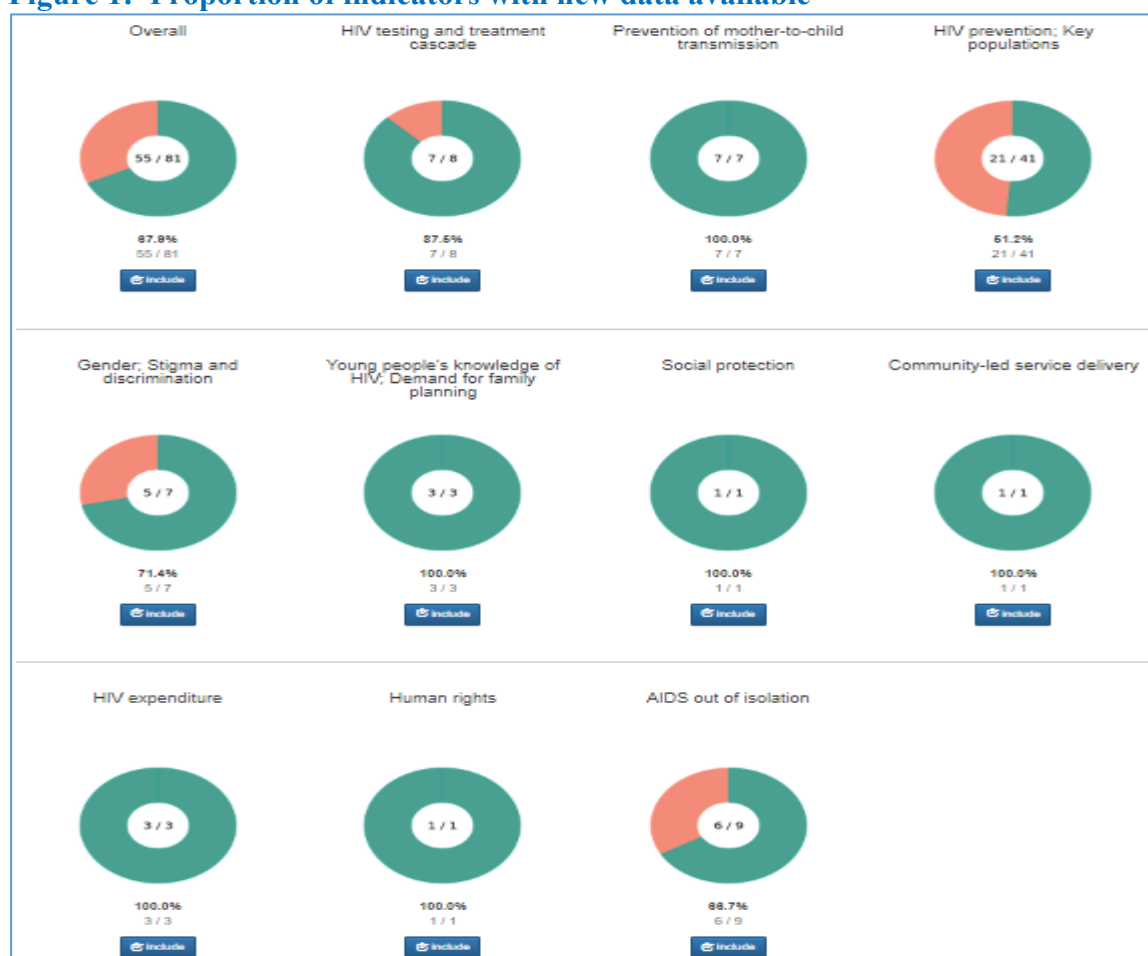
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## Processes in Report Production

### Inclusiveness of the Stakeholders in the Report Writing Process

The National AIDS Council led the process of compiling the Global AIDS Monitoring (GAM) 2020 report. The process was supported by UNAIDS and Ministry of Health and Child Care (MoHCC). Data was collected and populated on the online reporting tool. The National Commitments and Policy Instruments data was collected through virtual online meetings and consultations due to lockdown in effort to prevent COVID 19. The draft report was produced and presented to stakeholders for validation before submission on a skype business meeting. 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. The following chart shows completeness of the GAM 2020 report and proportion of indicators with new data available.

**Figure 1: Proportion of indicators with new data available**



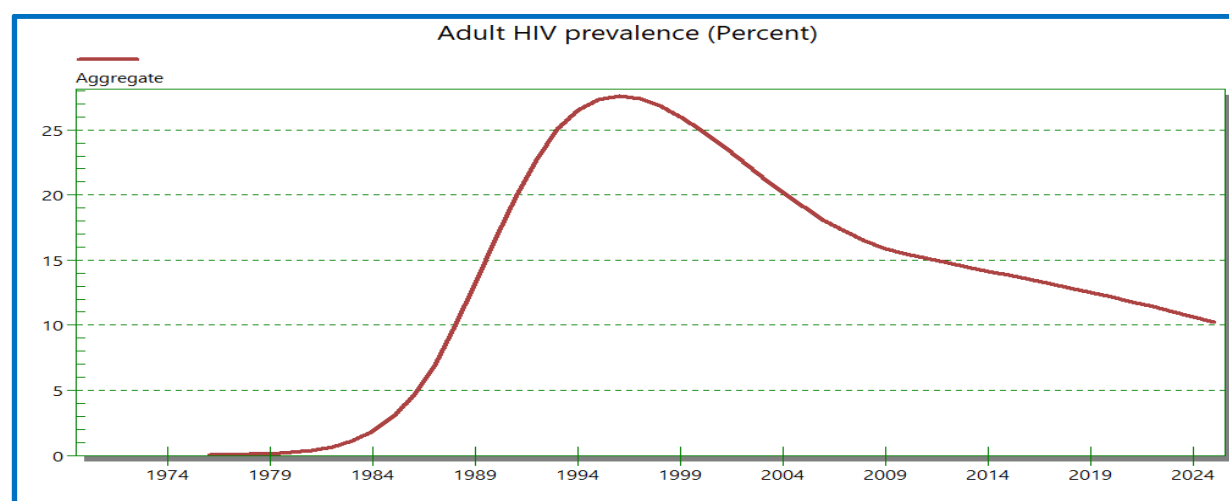
Over 65% of the indicators have new programme and survey data available. There remain challenges in routinely generating and accessing data for key populations, particularly for transgender people, people who use/inject drugs and prisoners.

## Status at Glance

### Overview of HIV epidemic

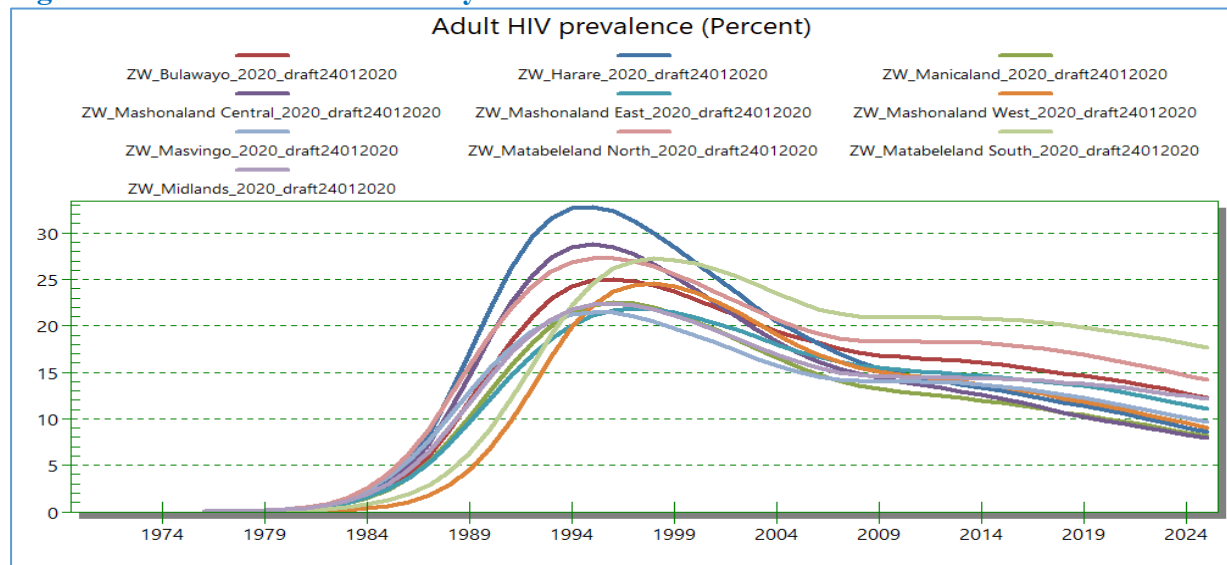
Zimbabwe has an estimated projected population of 15.8 million for 2019 according to the 2017 Inter -Censual Demographic Projections Report. The country has an estimate of 1.4 million people living with HIV (PLHIV). HIV prevalence continued to decline at national level both among males and females, but there is substantial subnational heterogeneities in HIV prevalence levels and trends. In line with population-based surveys and other models, HIV estimates suggest that HIV prevalence among the population aged 15-49 declined from 15.1% in 2010 to 12.8% in 2019 and is projected to decline further to less than 10.4% among 15-49 years old by 2025. The following epidemic curve shows the trend in HIV prevalence over the years.

**Figure 2: Trend in HIV prevalence among adults (15-49) in Zimbabwe**



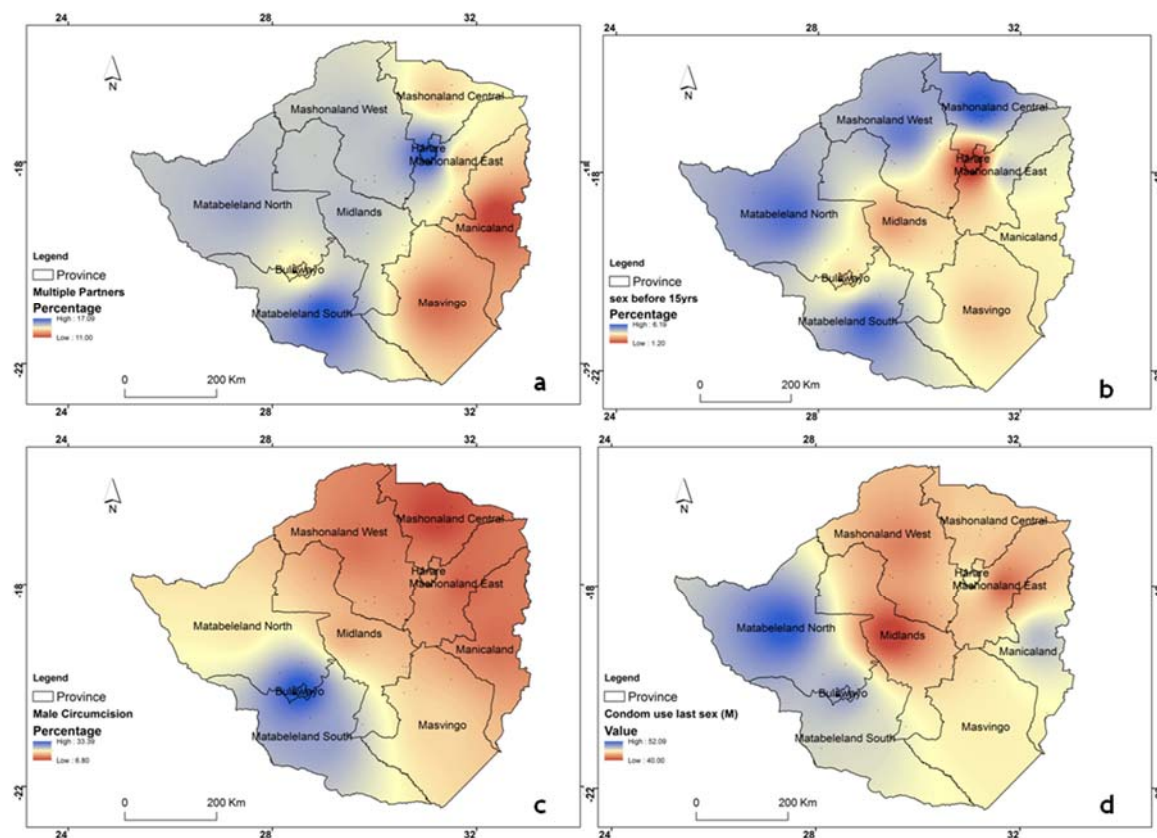
The decline in HIV prevalence is more pronounced in the northern and eastern provinces, while in the southern provinces (Bulawayo, Matabeleland South & North), HIV prevalence declined moderately or stabilized.

**Figure 3: Estimated Prevalence by Province**



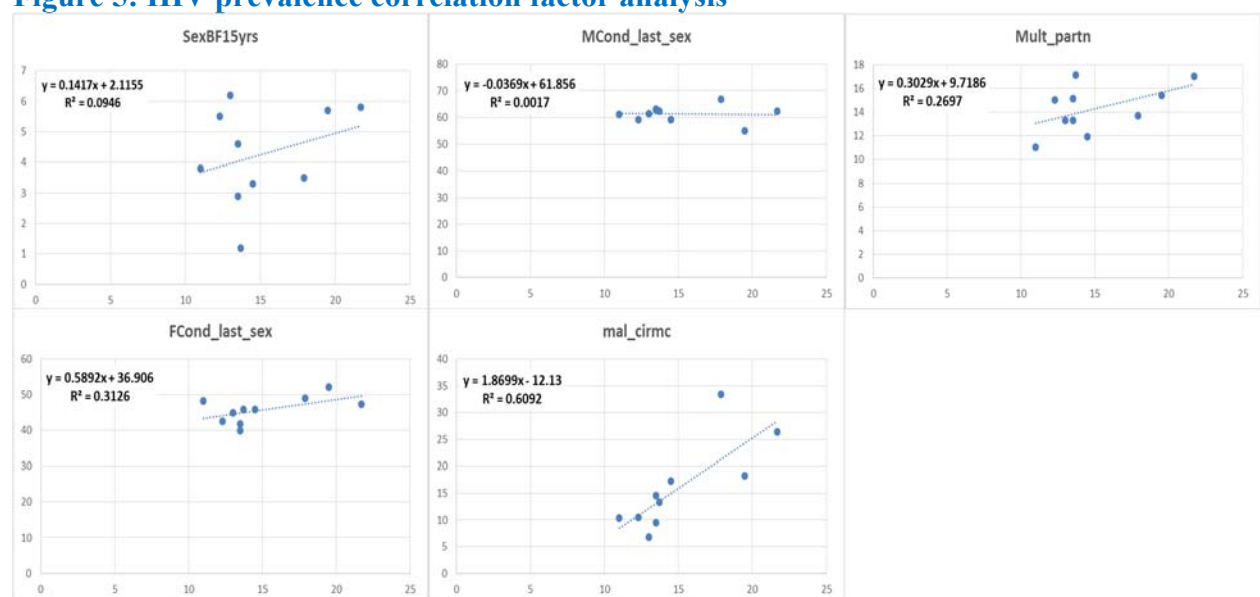
Declines in risk behavior recorded between the 1990s and 2010 may have begun to be reversed by 2015 (DHS). Risk behaviors remain higher in the south-western provinces, where HIV prevalence is higher. The 2015 DHS recorded an increase in risk behaviors after 2010 including increases in proportion of people reporting having sex with non-regular partnership, multiple sexual partnerships and paid sex. There are major geographical differences in the level of non-regular partnerships, which are highest in Bulawayo, Matabeleland South & North. The following maps shows risk factors for HIV prevalence.

**Figure 4: Continuous surfaces for risk factors**



Results of correlation analysis between HIV prevalence and potential risk factors shows that there is a strong positive correlation between HIV prevalence and male circumcision (protective), multiple partners and sex before 15 years.

**Figure 5: HIV prevalence correlation factor analysis**



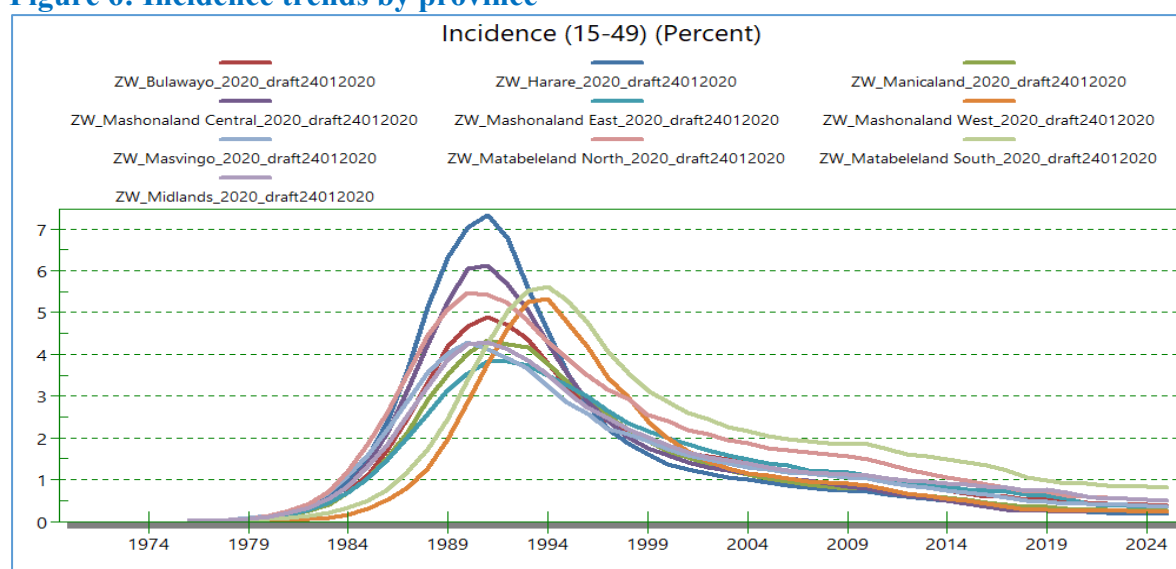


Using the linear relationships, it was noted that only male circumcision could explain up to 60% of the variation observed in HIV prevalence. All the other bivariate linear models explained between 0.2% and 0.31% of the variation in HIV prevalence.

The high HIV prevalence and slower decline in HIV prevalence in southern provinces despite similar and partially higher level of HIV service coverage requires further analysis and programmatic attention. Zimbabwe's three south-western provinces experience a combination of several risk factors for high HIV transmission. In addition to already high HIV prevalence and higher non-regular partnerships, sex work is relatively more frequent in Bulawayo, the major city of the region. In Bulawayo, 3.3 % of female adults are sex workers compared to 1.3 % nationally and 1.9% in Harare. Temporary migration to high prevalence areas in Botswana and South Africa is also likely to contribute to elevated HIV incidence. Strategies to address the three potential causes of elevated HIV transmission (higher risk behavior, sex work, temporary migration) need to be addressed.

According to 2019 HIV estimates, the HIV incidence in Zimbabwe was 0.49. The incidence varies by province with Matabeleland South having the highest incidence of 0.98 while Mashonaland Central recorded the lowest incidence of 0.25. The following figure shows trends in HIV incidence by province.

**Figure 6: Incidence trends by province**



National HIV estimates and projections predict a continued decline in HIV incidence based on current epidemic patterns and program coverage but not a sufficient decline to reach global 2020 and 2030 targets.

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

Year	2013	2014	2015	2016	2017	2018	2019
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	82%	79%	85%	92.1%	95.5%	89.98%	90.8%
Number of Adults 15-49 who were tested and received results	2,274,328	1,755,179	2, 201,246	2,664,844	2,851,049	3,011,027	2,382,768
Cumulative number of males circumcised according to national standards	112,084	400,235	601, 303	839,681	1,141,046	1,466,731	1,821,550
Percentage of adults and children currently receiving antiretroviral therapy.	Adults – 76.8%, Chn – 40.5%	Adults – 63.6%, Chn – 45.5%	Adults 72% Chn 99.8%	Adults 66% Chn 83%	Adults 84% Chn 89%	Adults 89% Chn 65%	Adults 86% Chn 71%

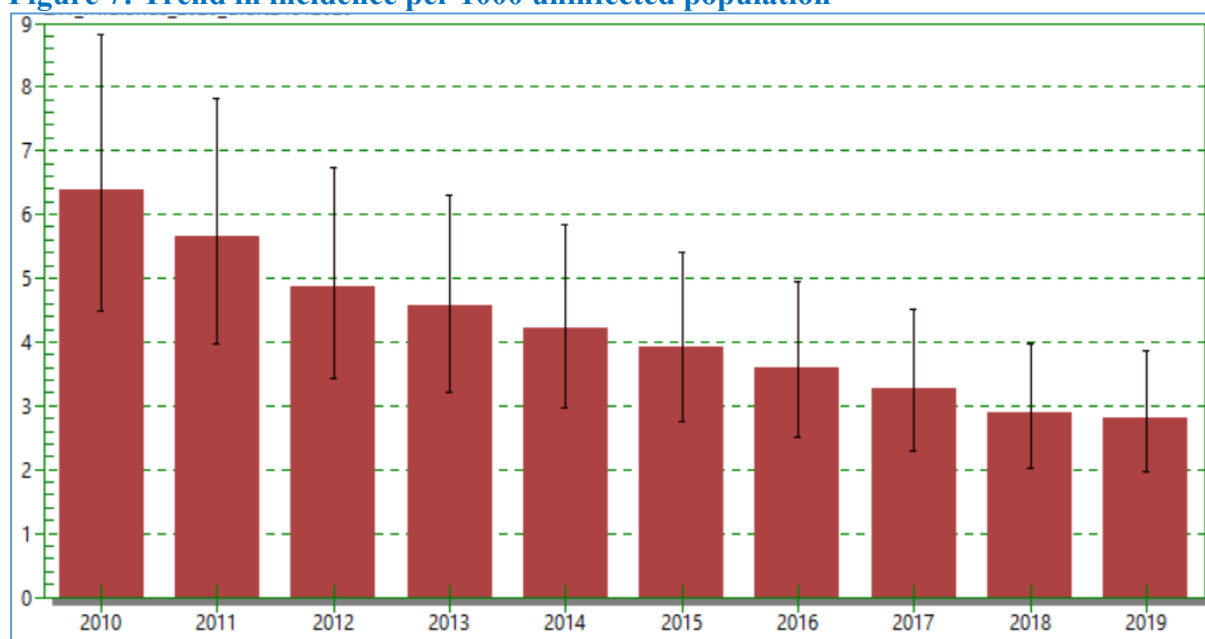
## Progress towards Fast Track Commitments to end AIDS by 2030

### Overall Fast-track targets

#### i) HIV incidence rate per 1000, Zimbabwe (2010-2019)

The following figure shows trends in the number of people newly infected with HIV per 1000 uninfected population.

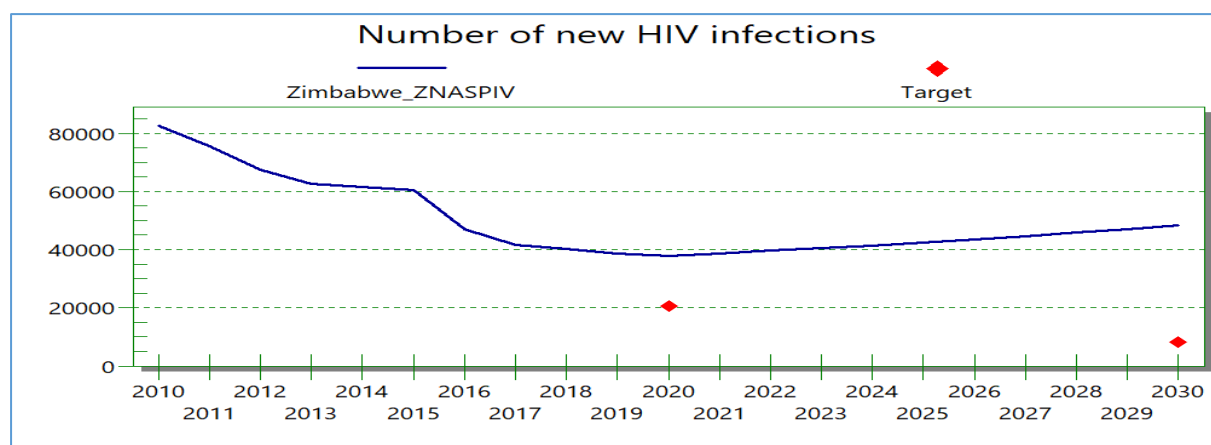
**Figure 7: Trend in incidence per 1000 uninfected population**



HIV incidence continued to decline at national level both among males and females. HIV estimates suggest that HIV incidence significantly declined by 56% from 6.39% in 2010 to 2.81% in 2019 per 1000 uninfected population.

National HIV estimates and projections predict a continued decline in HIV incidence based on current epidemic patterns and program coverage but not a sufficient decline to reach global 2020 and 2030 targets as shown by the figure below.

**Figure 8: Projected trends in New HIV Infections**

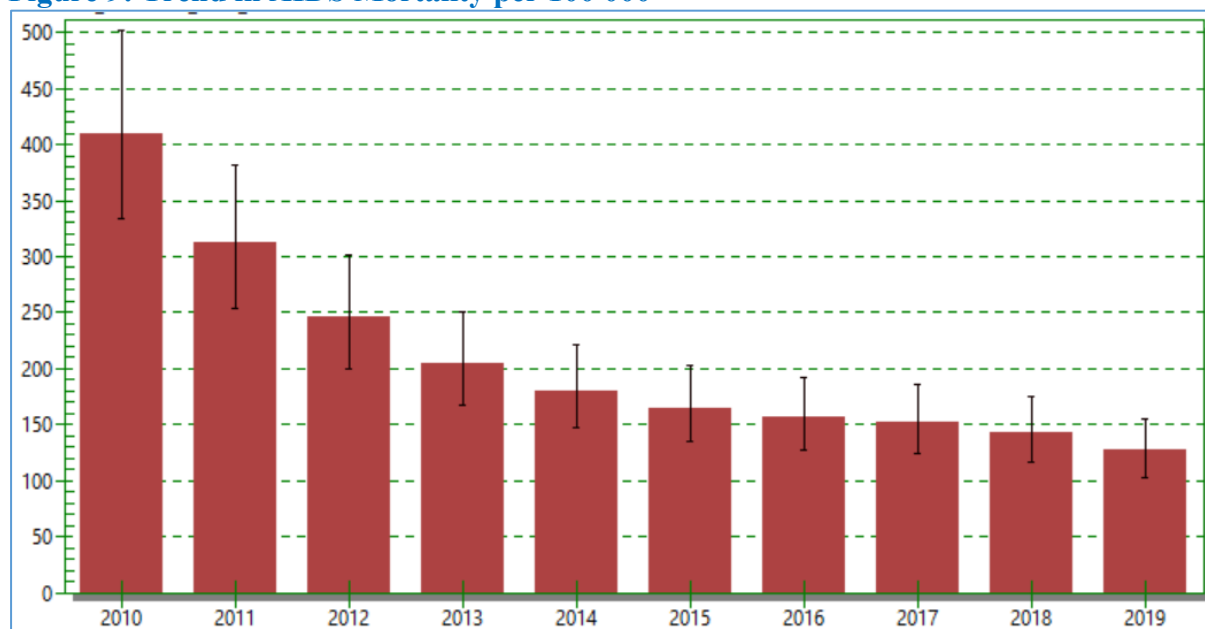


If we continue to do business as usual there will be a rebound in new HIV infections. The country is supposed to adopt innovative approaches such as national scale-up of interventions targeting populations most at risk for HIV, including adolescent girls and young women, high-risk men and boys and key populations in responding to HIV epidemic.

## ii) AIDS mortality per 100 000, Zimbabwe (2010-2019)

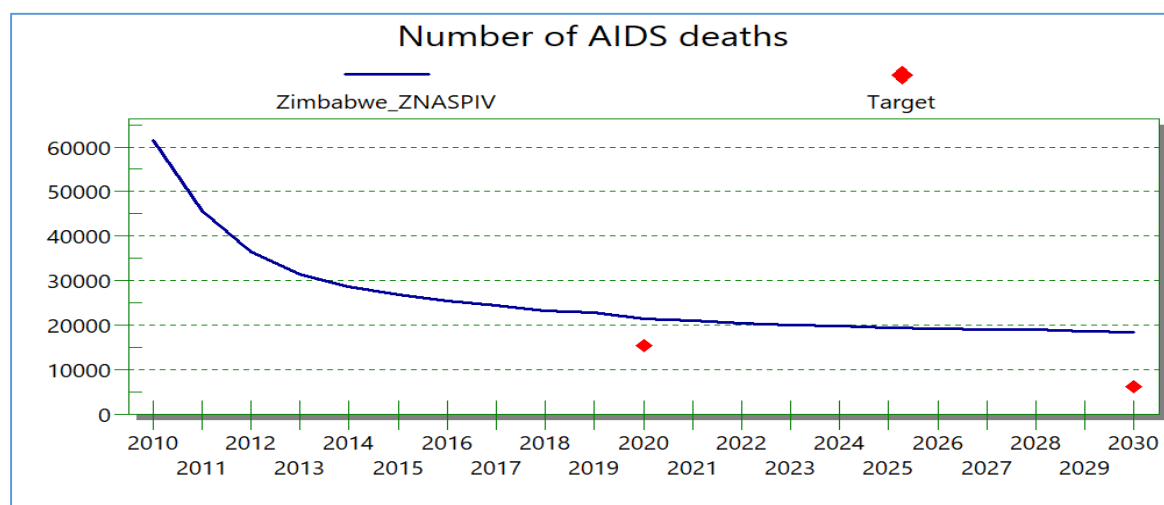
The total number of people who have died from AIDS-related causes per 100 000 population continued to decline as shown by the figure below.

**Figure 9: Trend in AIDS Mortality per 100 000**



AIDS Mortality significantly declined by 69% from 409.4 in 2010 to 126.7 in 2019 per 100 000. National HIV estimates and projections predict a continued decline in AIDS Mortality based on current epidemic patterns and program coverage but there will be a near miss of 2020 global target and significant miss of 2030 target as shown by the figure below.

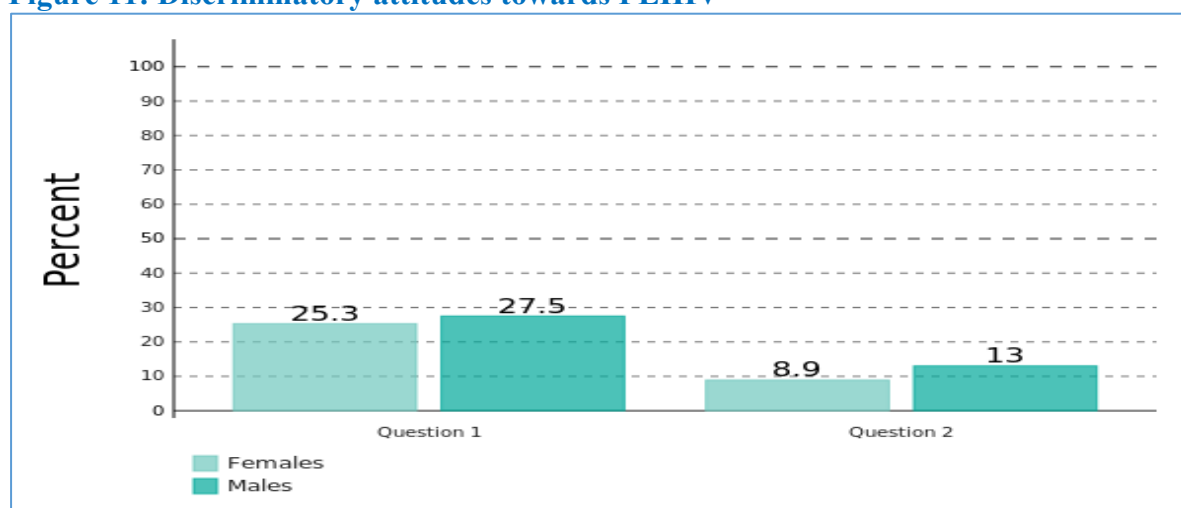
**Figure 10: Projected trends in AIDS Deaths**



**iii) Discriminatory attitudes towards people living with HIV, Zimbabwe (2019)**

Percentage of respondents (aged 15-49 years) who respond "No" to: Question 1 - "Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?"; Question 2 - "Do you think that children living with HIV should be able to attend school with children who are HIV negative?" are shown by the figure below.

**Figure 11: Discriminatory attitudes towards PLHIV**



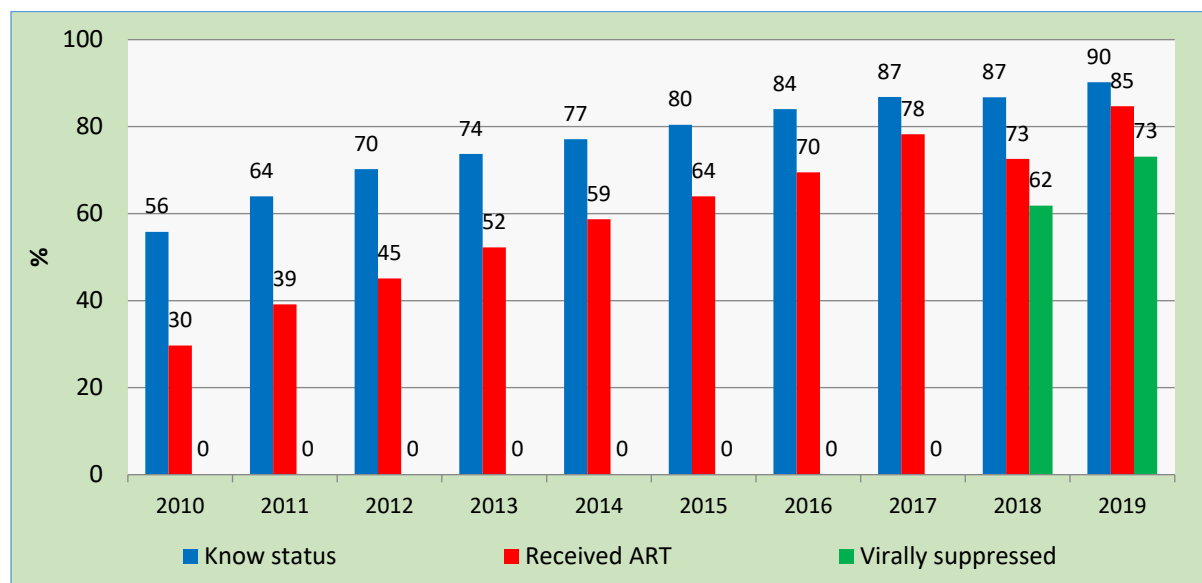
There are still discriminatory attitudes towards PLHIV as 20% of respondents reported experiences of HIV-related discrimination in health-care settings according to the Key Populations PLHIV Stigma Index Study of 2019.



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

The Spectrum estimates the treatment cascade for progress towards the 90-90-90 as shown by the figure bellow.

**Figure 12: National Treatment Cascade and Progress towards 90-90-90 Targets**

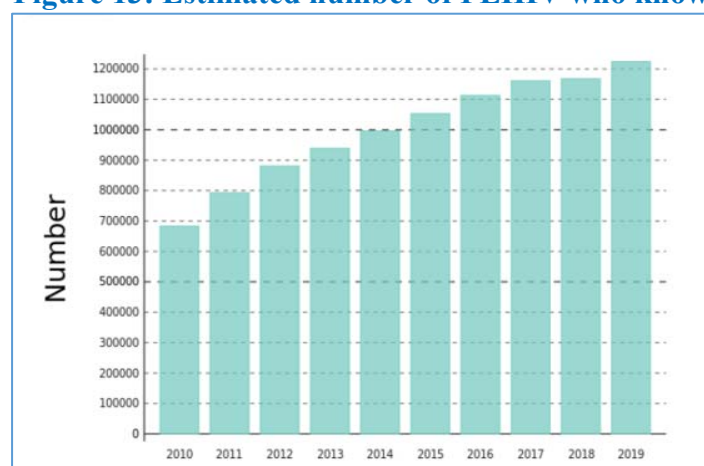


The treatment cascade shows that the country is on track to achieve the 90-90-90 targets if current investments are sustained. The country has already achieved the second 90 as shown by the figure above.

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

The Spectrum estimates that there are more than 1,200,000 people who know their HIV status in Zimbabwe. Figure 13 shows the trends in knowledge of HIV status.

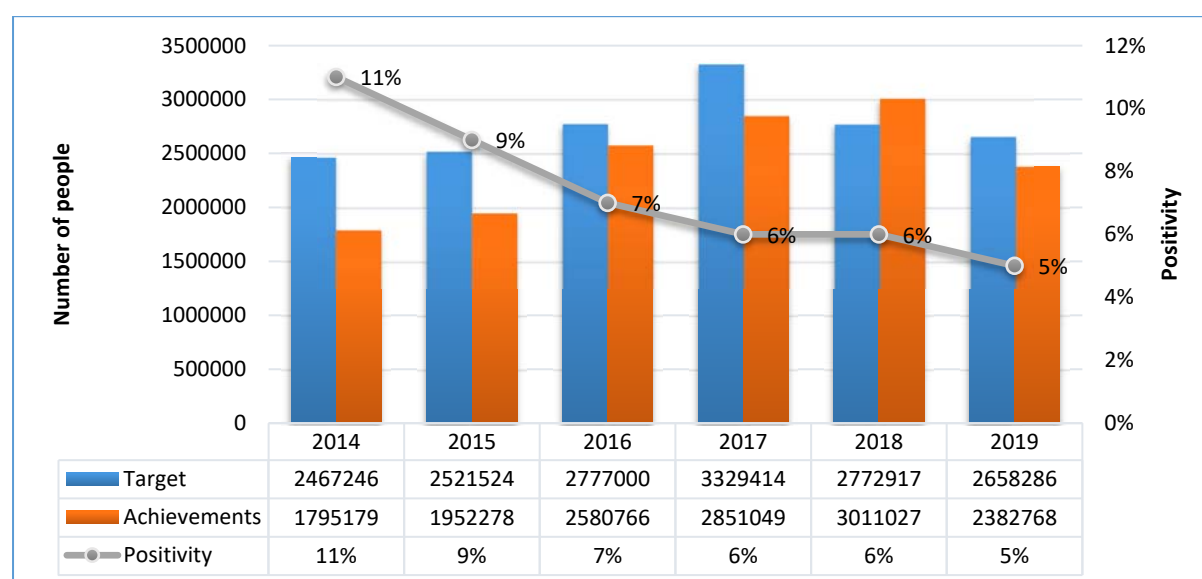
**Figure 13: Estimated number of PLHIV who know their HIV status**



To achieve the first 90% treatment cascade target, the country implemented an integrated HTS model, which deployed different testing approaches for different populations. The approaches included facility-based testing (provider initiated and client-initiated testing and counselling), facility and

community-based index testing, HIV self-testing and targeted mobile outreach testing, HTS is offered in several primary healthcare sites including TB, ANC, STI and MNCH. It is also integrated into other prevention services such as VMMC, PrEP, PEP and is part of the package for the DREAMS initiative for AGYW.

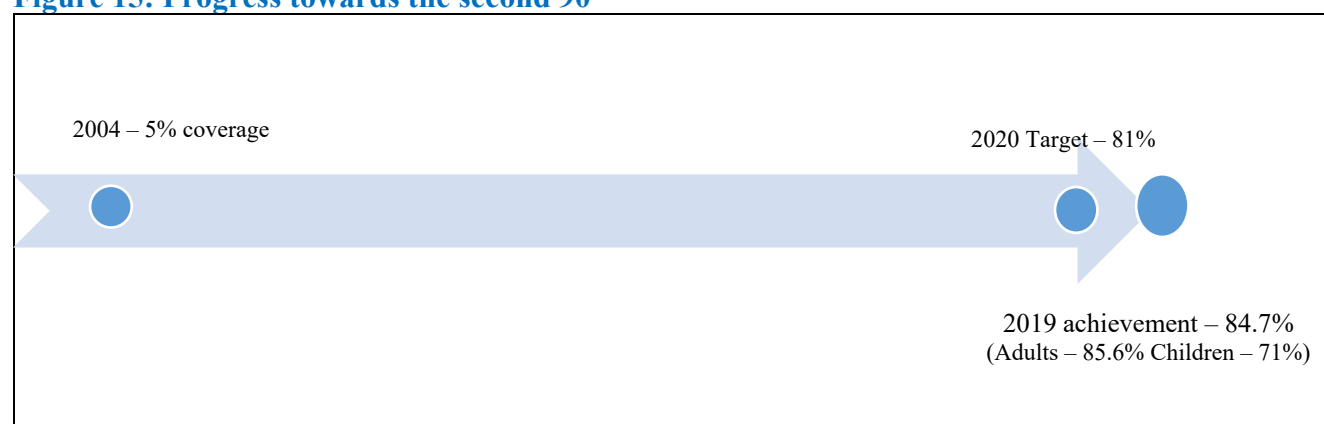
**Figure 14: HTS Clients Tested and Received Results by year against set Targets**



There is need to scale up high yield HIV testing models and intensify HTS in districts recording high new HIV infections. HTS models that have proved to have high yield include facility and community index testing, PITC, HIV partner self-testing and HIV testing for key populations, TB and STI patients among others.

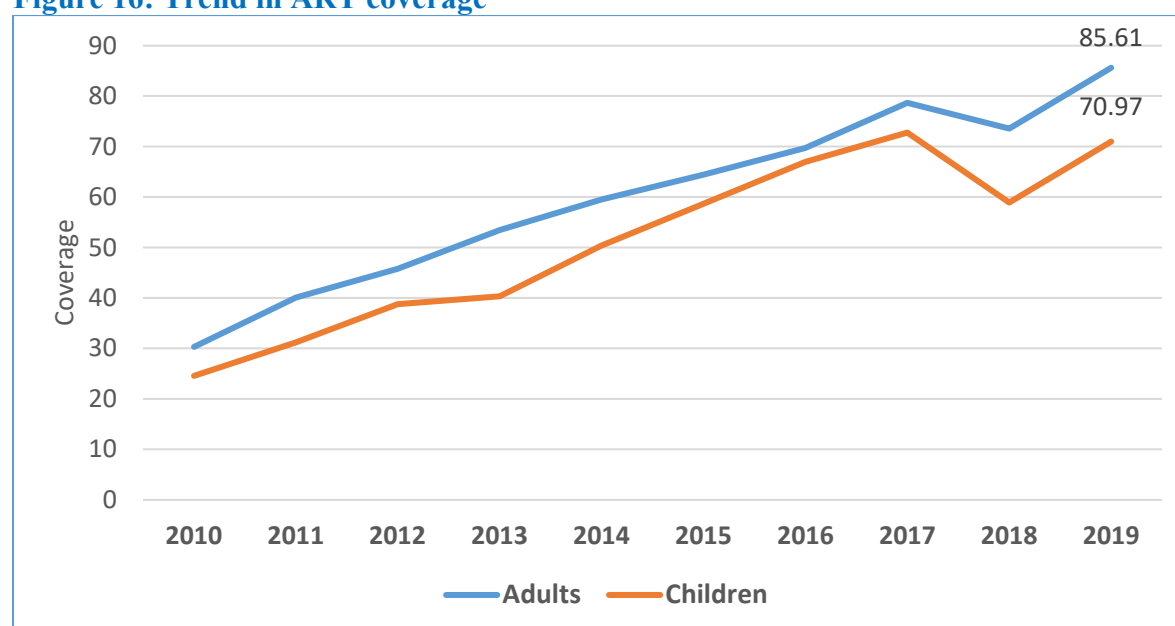
## Second 90 - 81% of all people living with HIV will receive sustained antiretroviral therapy

**Figure 15: Progress towards the second 90**



The country has achieved the desired target, based on 2019 HIV Estimates, 84.7% of all people living with HIV are receiving antiretroviral therapy. The total number of PLHIV who were receiving ART in Zimbabwe by the December 2019 were 1,149,191. The following figure shows trend in ART coverage.

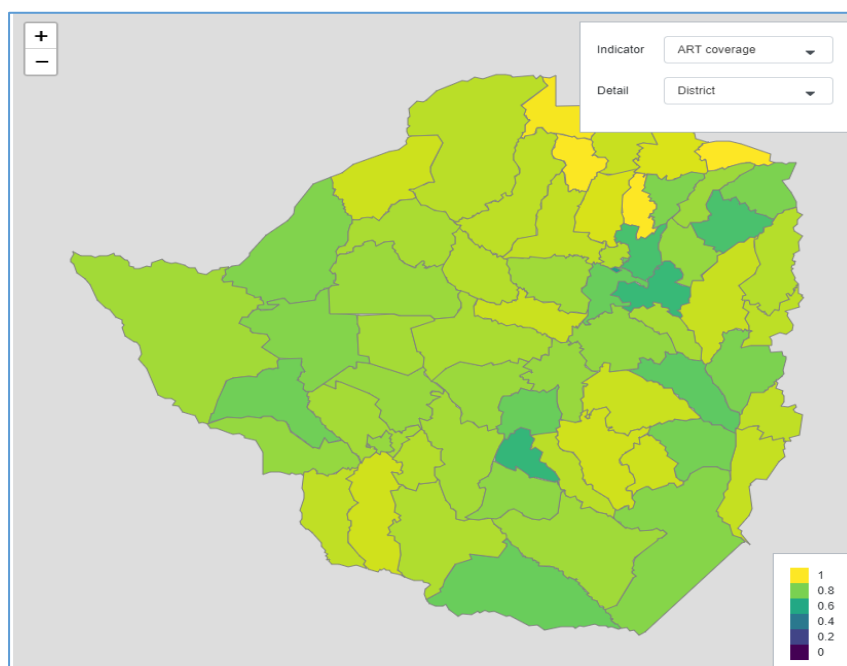
**Figure 16: Trend in ART coverage**



There was an increase in ART sites (initiating and follow up) offering ART services from 1598 in 2018 to 1522 in 2019. The following figure show ART coverage by district.

**Figure 17: ART coverage by district**

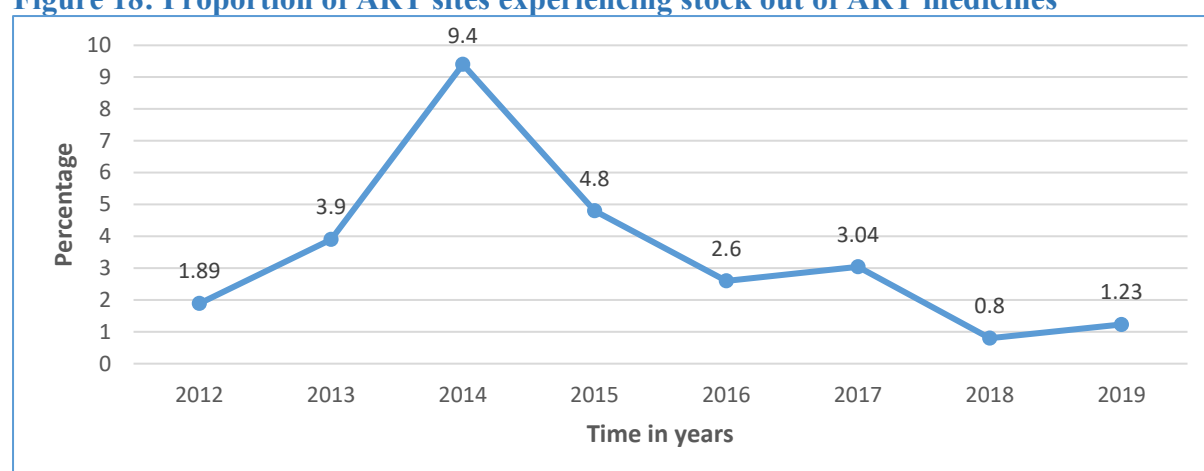




ART coverage varies with district. The highest ART coverage was recorded in Bindura (103) while the lowest was recorded in Chitungwiza (58%). 74.6% of the districts in Zimbabwe have an ART coverage of more than 81%. There is need to sustain the investments in treatment.

About 1.23% of the health facilities in Zimbabwe are offering ART services in Zimbabwe reported stock out of ART medicine. The following figure shows trend in stock outs of ART medicine.

**Figure 18: Proportion of ART sites experiencing stock out of ART medicines**



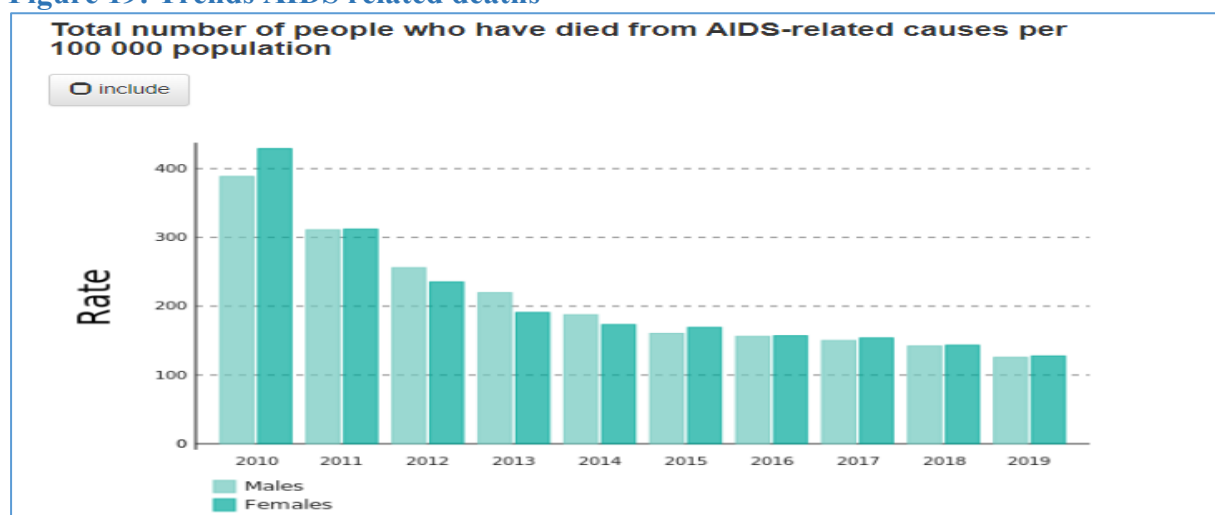
Despite the increase in medicines stock outs rate from 2018 to 2019, there were no treatment interruptions recorded in 2019.

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

The ability of the ART programme to retain PLHIV initiated on ART is critical for achieving viral load suppression. The ART programme introduced Differentiated Service Delivery (DSD) models designed to increase patient retention on ART. These include Community ART Refill Groups (CARGS), Community Adolescent Treatment Support (CATS) and Family ART

Refill Groups (FARGS). Although the effectiveness of these models has not been evaluated, they provide a platform for enhancing retention and adherence to HIV treatment. The following figures shows trends in AIDS related deaths.

**Figure 19: Trends AIDS related deaths**



The decline in AIDS related deaths is as a result of increase in survival on ART clients on treatment.

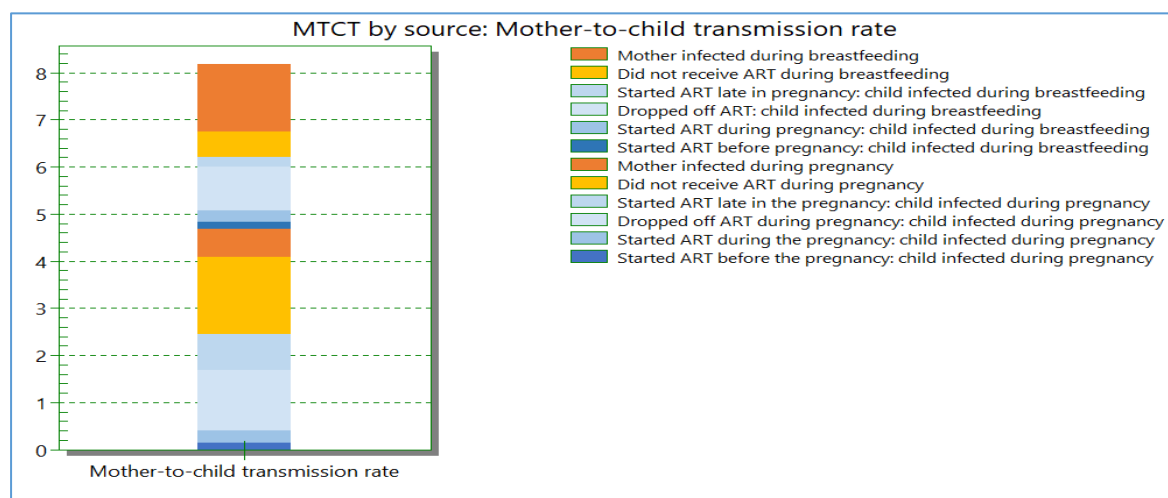
The country implemented viral load monitoring in line with the Viral Load (VL) Scale up plan. Laboratory capacity for VL testing was decentralised to 13 regional laboratories. Viral load coverage among adults increased from 6% in 2015 to more than 44% in 2019. Among children, the number of VL tests increased from 44,062 in 2015 to more than 400,000 in 2019.



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

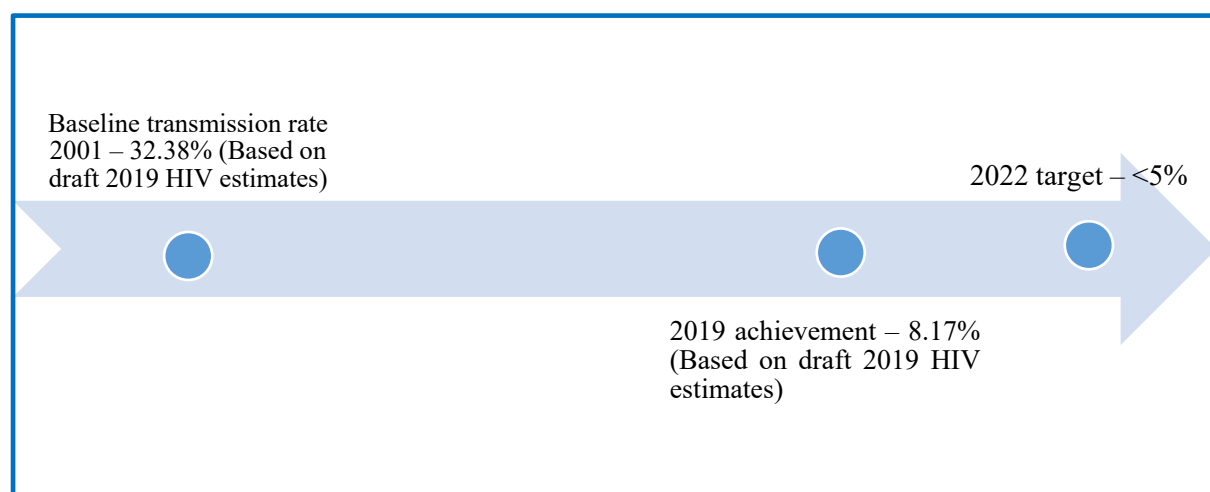
The country continued to implement the Operational Plan for eMTCT of HIV and Syphilis (2018 – 2022). Mother to child transmission of HIV is caused by pregnant and lactating women not receiving ART to reduce risk of transmission, HIV infections during pregnancy and lactating period, weak retention of pregnant and lactating women and infants in care and pregnant women receiving ART late at more than 32 weeks gestation age. The figure below provides a detailed analysis of drivers of MTCT in Zimbabwe.

**Figure 20: MTCT by source**



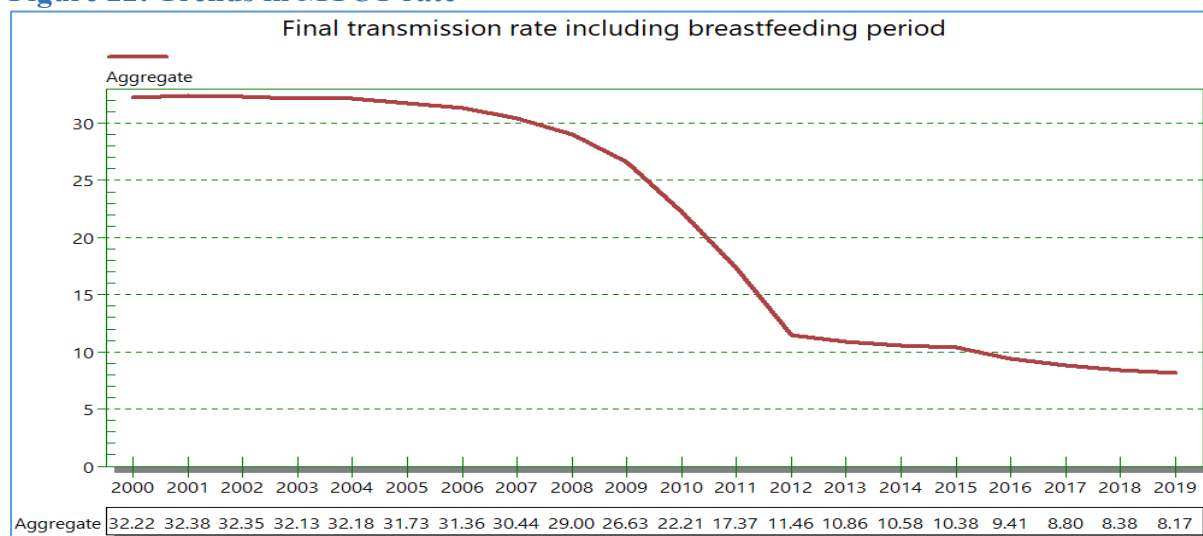
The figure below shows progress towards the desired target of eliminating mother to child transmission by 2022.

**Figure 21: Progress towards eMTCT target**



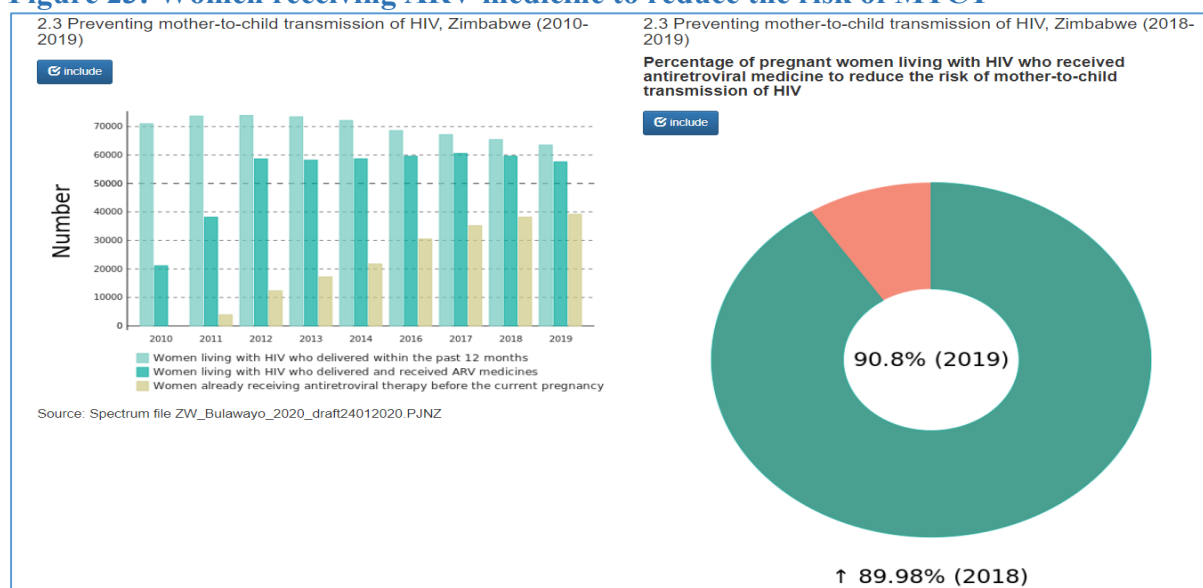
Final transmission including breastfeeding period was at 8.17% in 2019 indicating that we are on track towards achieving the global elimination target of less than 5% by 2022. The following figure shows the trend in estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months.

**Figure 22: Trends in MTCT rate**



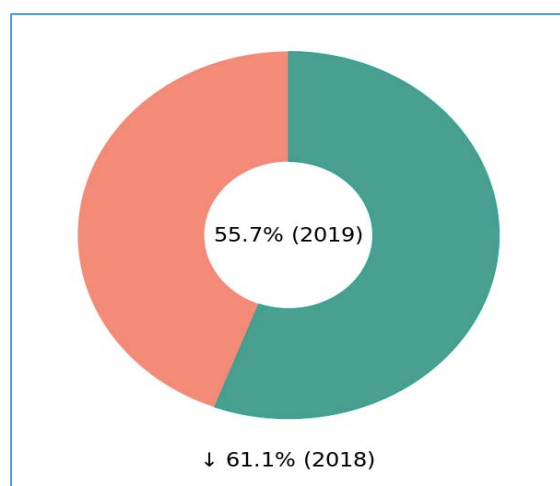
The MTCT rate continues to decline since 2004, although from 2012 the decline became slow. There are 1,560 health facilities that offering Option B+ services in Zimbabwe. The following figure shows women receiving ARVs to reduce mother-to-child transmission.

**Figure 23: Women receiving ARV medicine to reduce the risk of MTCT**

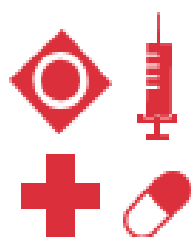


There was an increase in percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV between 2018 and 2019.

**Figure 24: Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth**



Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth decreased between 2018 and 2019.



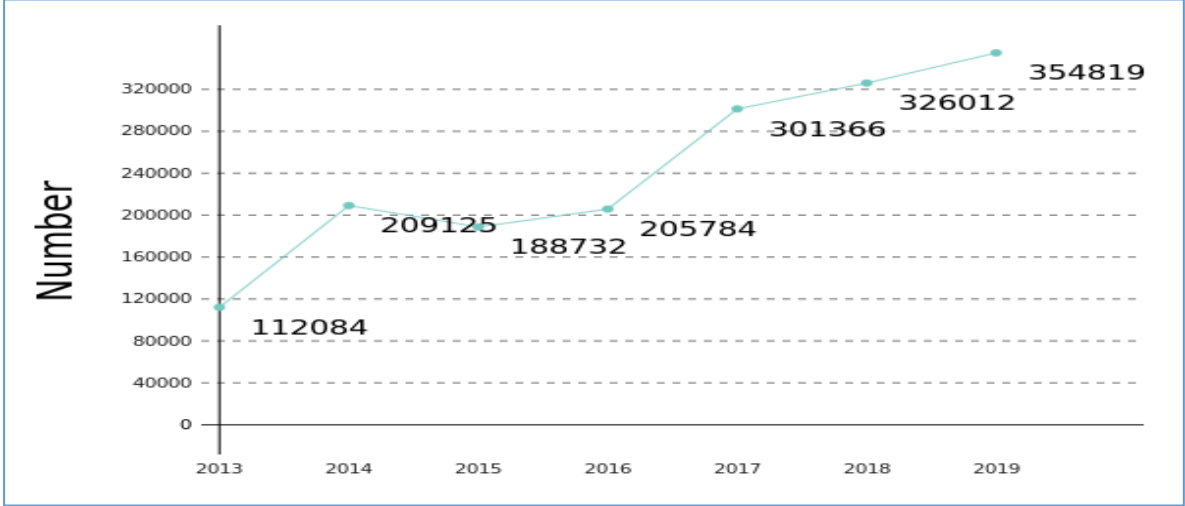
**Target 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and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

### **Voluntary Medical Male Circumcision (VMMC)**

VMMC services are offered through three models – static model through which services are offered in health facilities, outreach model involving MC teams traveling to perform circumcisions at other health facilities especially those in rural areas and mobile clinics where VMMC teams conduct circumcisions in caravans mainly in remote areas with no access to health facilities or during MC campaigns. Demand creation for MC is carried out by village health workers, circumcised men, school health coordinators, chiefs, traditional and religious leaders; and through road shows, soccer galas and community dialogue meetings. Standard Operating Procedures (SOPs) and protocols for MC have been developed and are available in most health facilities. Adverse Events rate is estimated at 0.1% which is below the internationally recommended threshold of 2%.

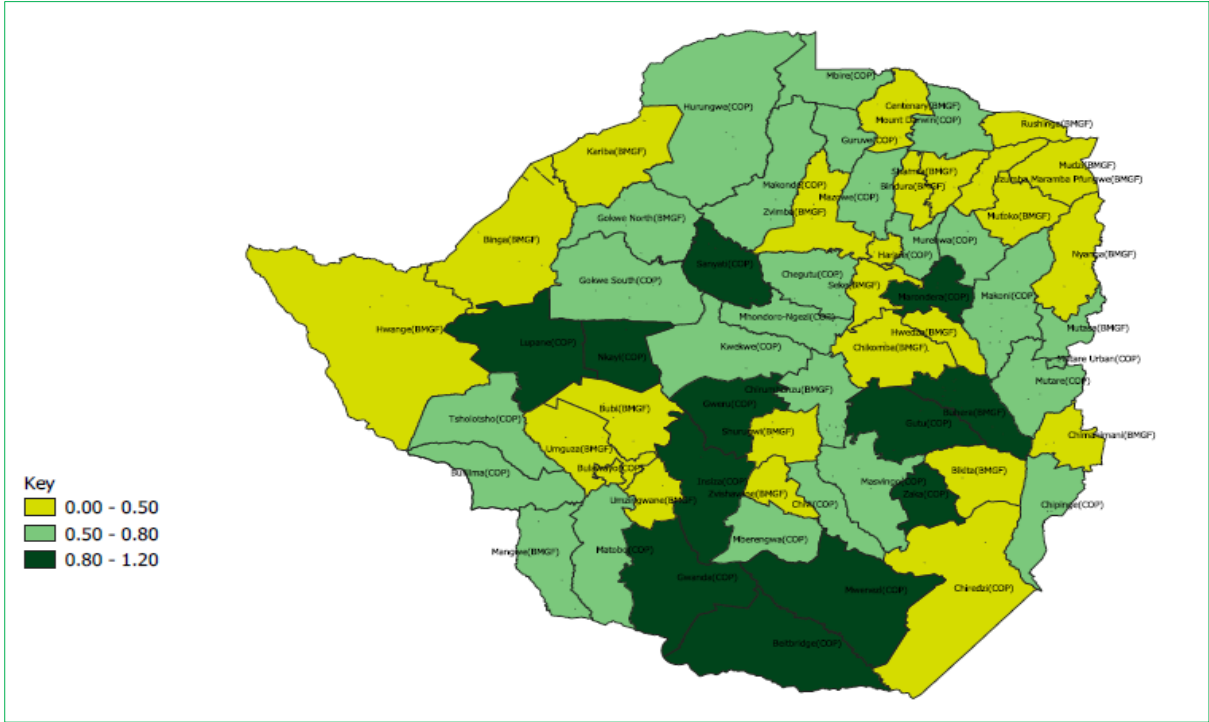
A total of 354,819 men were circumcised from January to December of 2019, which is 86.7% achievement against an annual target of 409,000. The MC programme has not been meeting targets since 2014. At the current level of programming, the country is not likely to meet the target of 80% male circumcision coverage by 2020. The following graph shows trend in VMMC.

**Figure 25: Trend in number of people circumcised**



VMMC coverage also varies across districts. In 2019, 12 districts had surpassed 80% coverage while 25 districts were below 50% of their annual target as shown by the figure below.

**Figure 26: VMMC coverage by district**

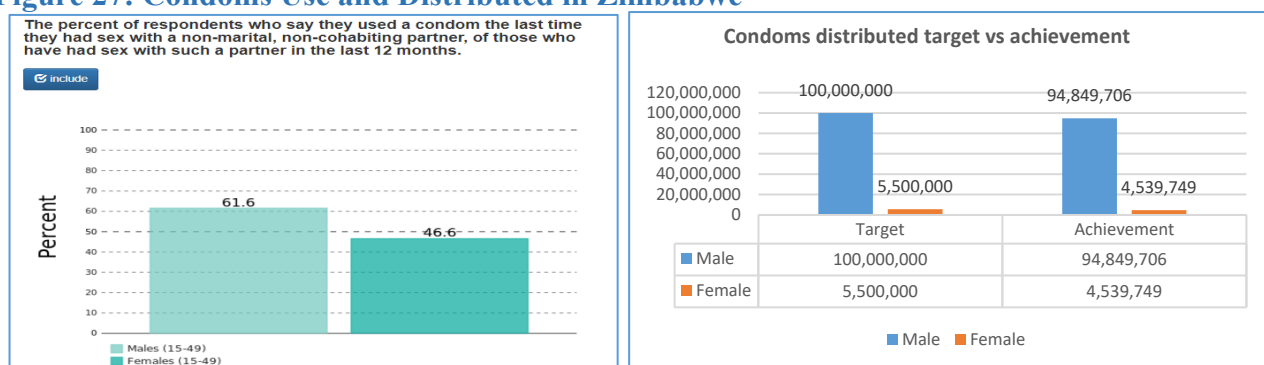


## Condom Promotion and distribution

The condom market has undergone significant changes in the last 10 years. In 2008, social marketing distribution contributed a major portion of total distribution (70%) followed by public sector. This situation changed by 2016 with the public sector taking a lead in market share contributing 77% of the distributed condoms followed by social marketing at 21%. The commercial sector distribution remained largely stable at 2% over this period. This change is attributed to the hyperinflation experienced which peaked in 2008 and wiped out a significant portion of social marketing distribution with a loss of about one-third retail outlets. Since 2016, further decline in donor funding has also contributed to further shrinking of condoms distributed through social marketing and the public sector serving as the major source of condoms.

There was a decrease in uptake of male condoms from 135m in 2018 to 95m in 2019; female condoms uptake also decreased from 5.3m in 2018 to 4.5m in 2019. These declines may be attributable to decreases in donor support and economic inflation. Inflation both raised the cost of socially marketed male condoms and eliminated much of the commercial sector.

**Figure 27: Condoms Use and Distributed in Zimbabwe**



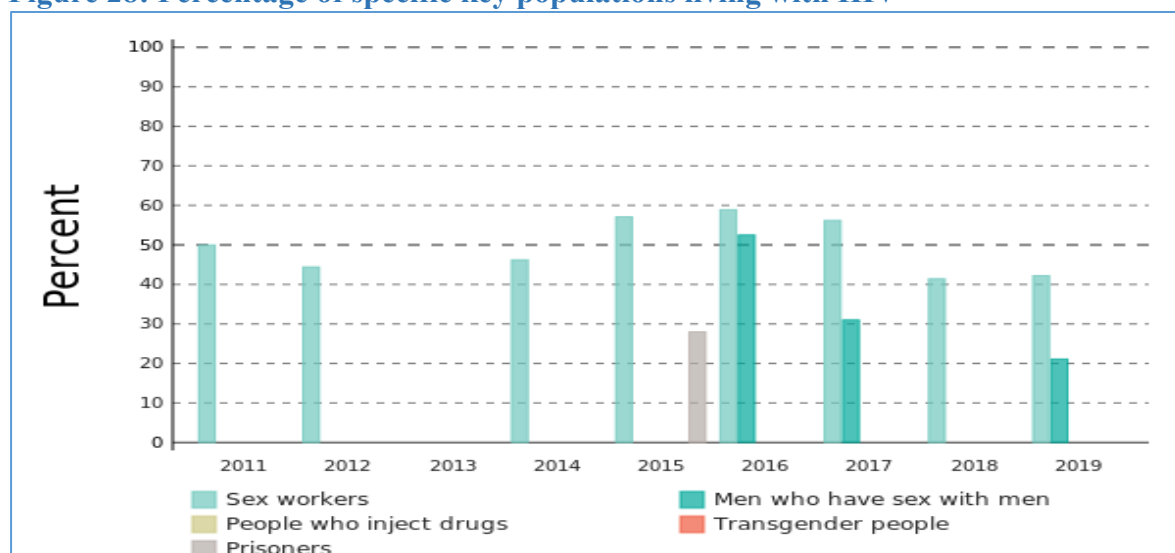
Given the changes in the condom market shown above, Zimbabwe faces an uncertain future in sustaining gains made in condom availability and use. The public sector free condoms, accounting for the largest market share, face uncertain future in terms of condom funding. Donor funding for condoms is declining, with PEPFAR-supported condom distribution becoming more targeted in regions and populations with higher HIV burden, while no domestic funds are allocated to condom procurement.

## Key Populations

The Modes of Transmission (MOT) study conducted in 2017 found that FSWs contribute about 4,000 new HIV infections while nearly 2,000 new infections occur among men who have sex with men (MSM) annually. These numbers of new infections are significant when considered

relative to the sex workers and MSM population. In 2019, HIV prevalence among FSW was 42.2% and 21.1% among MSM while prevalence among prisoners in 2013 was estimated at 28% (26.8% males, and 39% females). HIV prevalence data for the wider Lesbian, Gay, Bisexual and Transgender (LGBT) community is, however, lacking. The following figure shows the trend in Key populations living with HIV.

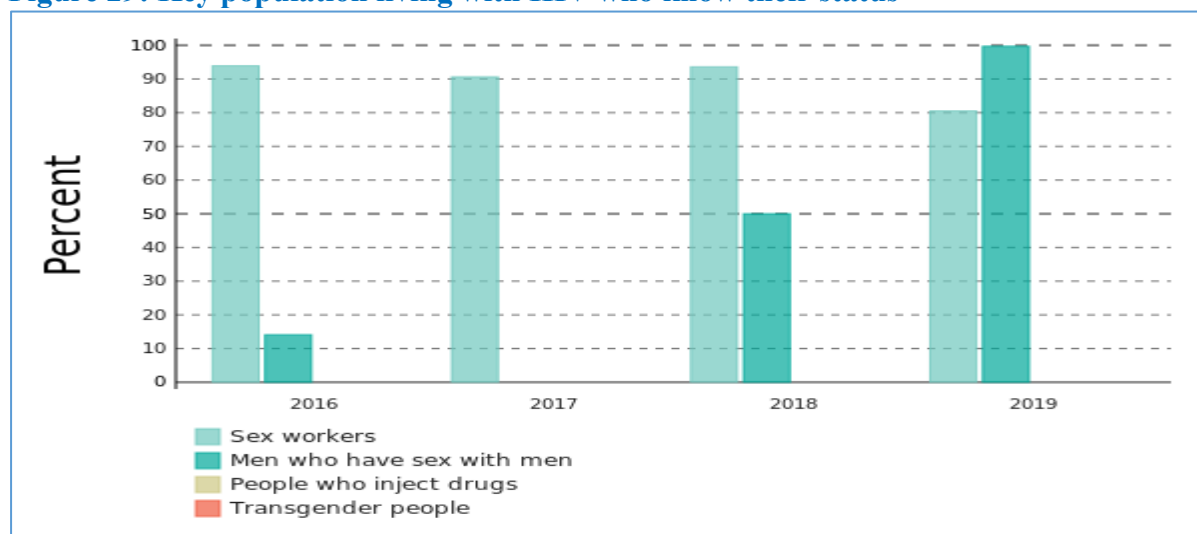
**Figure 28: Percentage of specific key populations living with HIV**



The country has made progress in improving HIV outcomes among key populations. Among mostly young survey participants identified through respondent-driven sampling conducted in 2019, knowledge of HIV status among FSWs was 81% and 99% among MSM as shown by the figure below. However, it is important to note that among the sample of MSM in Harare and Bulawayo who tested HIV positive during the bio-behavioral survey, only 33.8% HIV-positive MSM in Harare and 53.7% HIV-positive MSM in Bulawayo were aware of their HIV-positive status, indicating the need to increase rates of testing among MSM. Index testing, self-testing, provider-initiated testing and counselling, mobile testing and moonlight testing are the key models used to reach SWs and MSM. Prison inmates are offered HTS on admission into prison with immediate linkage to ART for HIV positives. There is no data for transgender people and PWID.

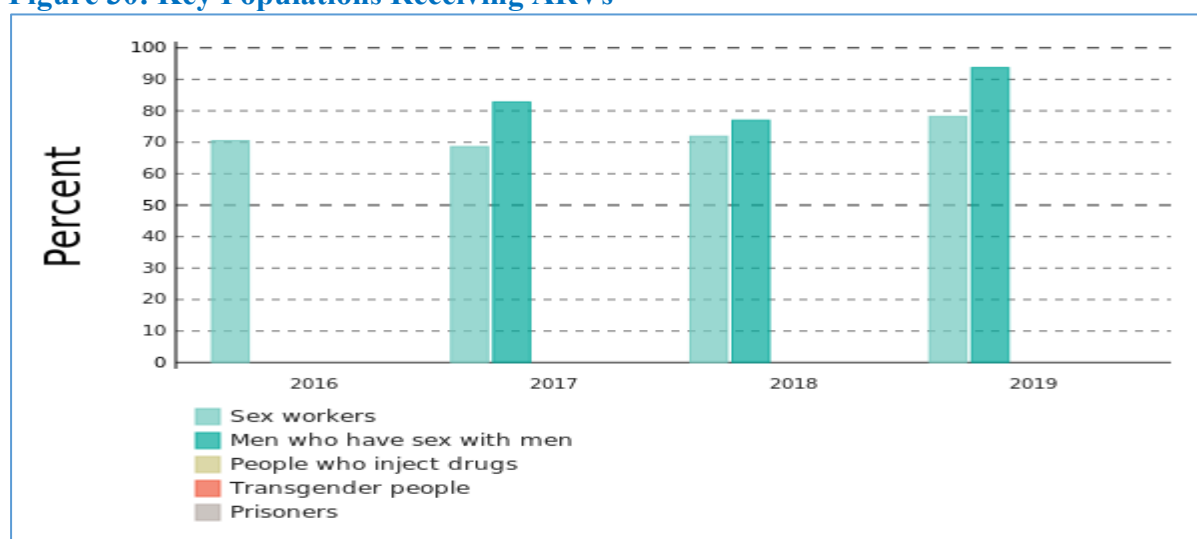


**Figure 29: Key population living with HIV who know their status**



Coverage of ART among PLHIV in key populations was high. Female Sex Workers testing HIV positive and put on ART increased from 72% in 2018 to 78% in 2019 and in MSM increased from 76% in 2018 to 94% in 2019. Figure below shows coverage of ART among PLHIV in key populations.

**Figure 30: Key Populations Receiving ARVs**



Prison inmates are offered HTS on admission and those testing HIV positive are put on ART. Inmates are also retested for HIV every six months. ART is provided to inmates using a directly observed treatment approach to ensure adherence. Various partners including UNODC, VSO also run projects to improve access and quality of health and HIV and AIDS services in prisons and support the Zimbabwe Prison and Correctional Services to adopt and implement policies and health reforms in line with international standard.

From the 2019 integrated bio-behavioral survey conducted for MSM and transgender women/genderqueer individuals (TGW/GQ) in Harare and Bulawayo using responded driven sampling, the population size estimate for Harare is 15,875 MSM and TGW/GQ [95% CI (11,907 – 19,843)], about 2.1% of the adult population born biologically male. Bulawayo is 7,451 MSM and TGW/GQ [95% CI (6,353 – 8,549)]. This is about 3% of the adult population born biologically male. This estimates 1.5% of the adult population born biologically male in Zimbabwe are MSM and TGW/GQ individuals.



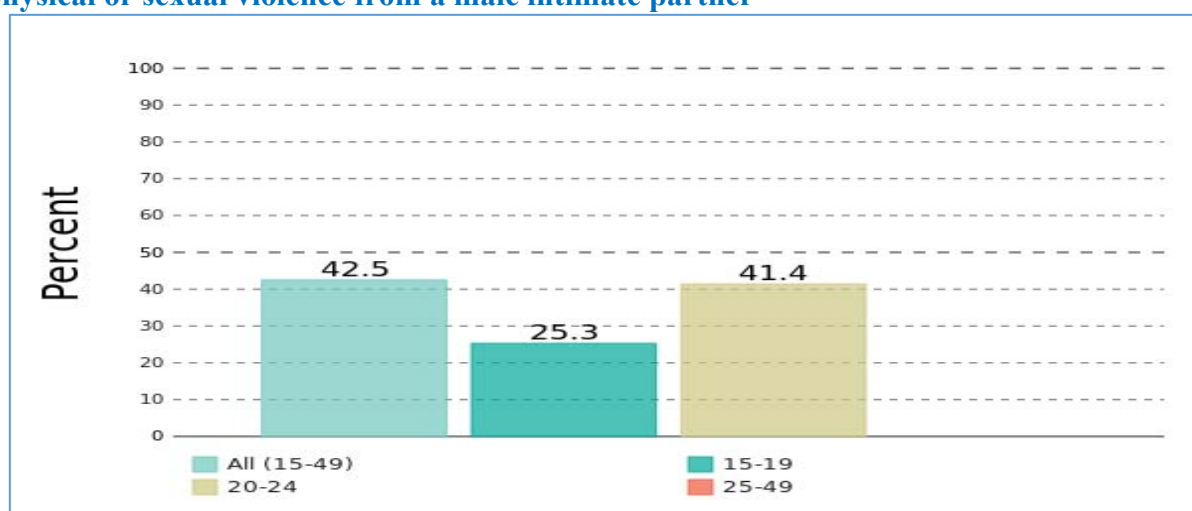
#### **Target 4: Gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020**

In order to combat and prevent gender-based violence and HIV, the country adopted the SASA (Start, Awareness, Support, and Action) Model which focuses on changing uneven power dynamics between genders. The SASA Model is a community mobilization approach to preventing gender-based violence and HIV against women and girls and is meant to influence communities to rethink and reshape social norms. The model which is currently being implemented in six districts of Zimbabwe is based on the understanding that violence against women does not occur in isolation but within families, communities and societies.

**Table 2: Violence and discrimination against women and girls, people living with HIV and key populations**

Indicator	2017 Achievement	2018 Achievement	2019 Achievement
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	19.8% (DHS 2015/6)	19.8% (DHS 2015/6)	42.5% (MICS 2019)
Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings	5.9% (CeSHHAR)	39.3 % (CeSHHAR)	19.5 % (Stigma Index Study 2019)

**Figure 31: Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner**



Sexual violence is most prevalent in young women and this them at high risk of HIV.

Implementation evidence gathered through programmes that targeted men in pursuit of reducing HIV and GBV risk of women and girls have revealed clear attribution of strategic gender transformative approaches to increased gender equality practices, reduction in harmful cultural and religious norms and practices, reduced risk for, and increased access to HIV testing services by women and girls within communities.

NAC supported a procees of coming up with a srategic framework for male engagement in the HIV response .This followed the realisation that men and boys were being left behind and there was need to come up with strategies to accelerate efforts to reach boys and men in their diversity with HIV-related services while advancing gender transformative and responsive programmes. This is critical for men and boys health and will in return be critical for the health of women, girls and health for all.



Dialogue with men from the Islamic community



Dialogue with religious leaders



Dialogue with Chiefs

### *NATF Gender Supported Male Engagement Dialogue*

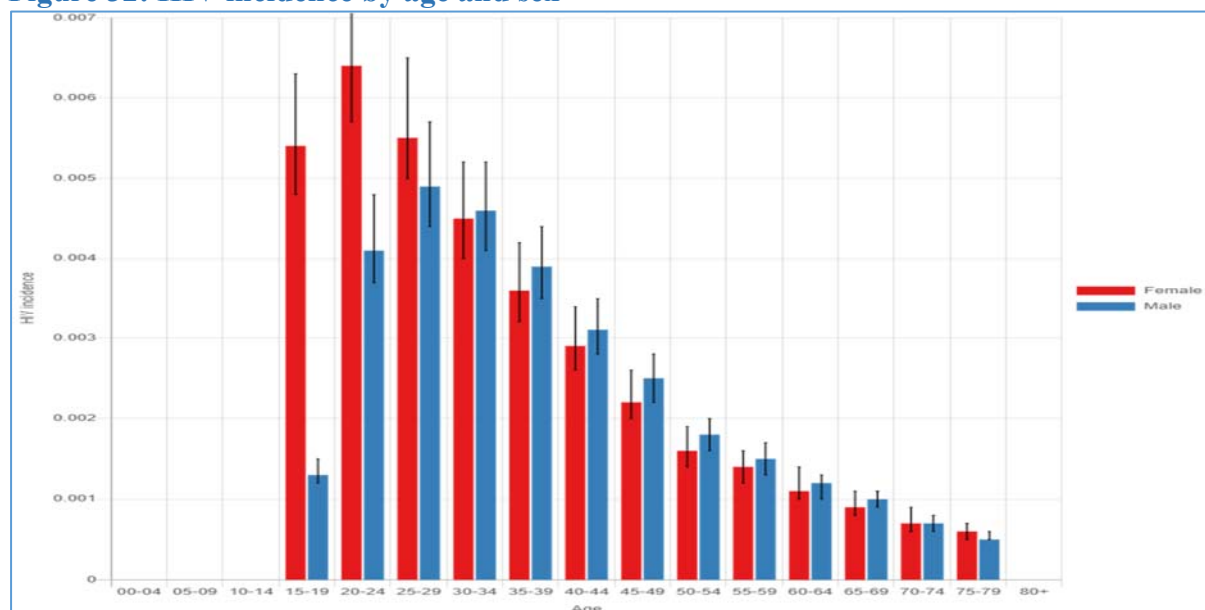
There is still significant pockets of stigma and discrimination associated with being a FSW especially on access to HIV prevention and treatment services. The proportion of FSW reported that they avoided seeking healthcare in the last 12 months because of stigma was 22% in 2019.



**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.**

HIV incidence is high among Adolescent, Girls and Young Women (AGYW). The difference in incidence is most pronounced among young Adolescents 15-19 years in which females have incidence that is five times higher than male counterparts. The following figure shows the difference in incidence by age.

**Figure 32: HIV incidence by age and sex**



Zimbabwe has an education policy that guide the delivery of life skills-based HIV and sexuality education, according to international standards in schools. About 50% (1,990,998) pupils in schools were taught on Life Skills, Sexuality, HIV& AIDS Education out of a target of 4,000,000, and 60% (241,160) of the learners referred for SRH services out of a target of 400,000 learners. Several strategies were used to disseminate HIV and AIDS information to youth in schools so as to empower them to prevent against HIV.



*Schools quiz competition as part of HIV Information dissemination platform*

A total of 33,324 vulnerable girls were enrolled in sista2sista clubs in 2019. Of these, 12,252 (37%) were referred for HTS by sister 2 sister mentors against a target of 100%. A total of 8,142 (66%)

of the girls who were referred for HTS accessed the service. There is need to roll out self-test kits for easy of HIV screening.

A cohort of 3,293 vulnerable boys were followed up through brother2brother program. Of these 1,983 were referred for HIV prevention services by brother2brother mentors and 584(29%) accessed the HTS service.



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

UNICEF continued to fund NAC to implement HIV Sensitive Social Protection Programmes for adolescents and children living with HIV (ACLHIV) and their families in 23 districts of the country in all the 10 provinces of the country.

The Government of Zimbabwe and National AIDS Council committed to support children with school related assistance through the BEAM programme.

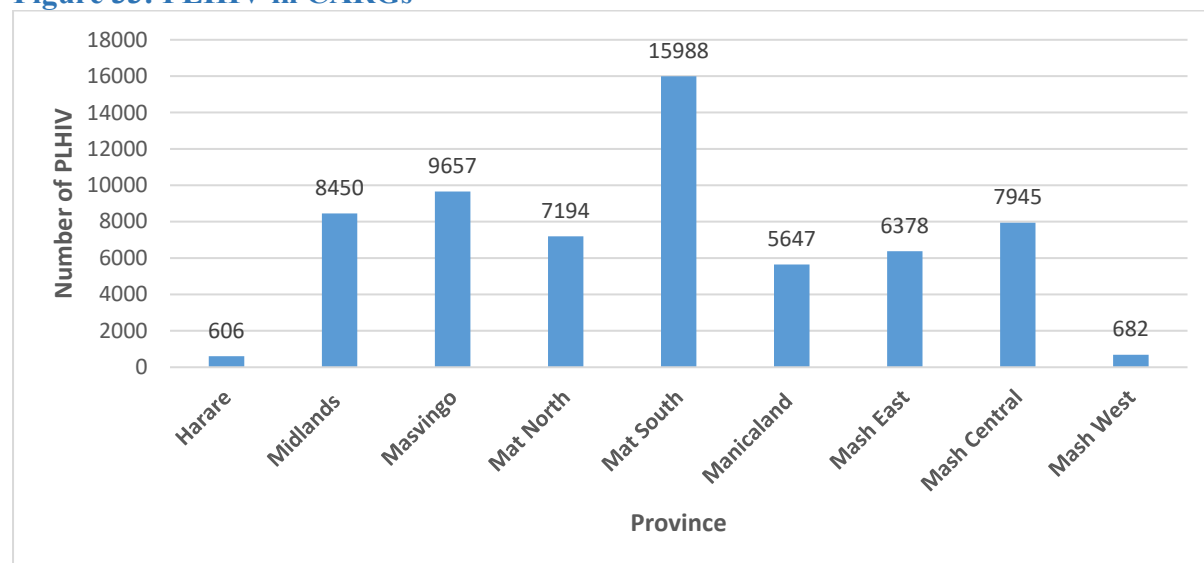
NAC and its partners such as FHI 360 and ITECH, facilitated the formation of support groups and CARG working with communities and organizations of PLHIV. There were over 270,000 PLHIV who were supported in 2019.



**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. There are community cadres in place that include sister2sister mentors, brother2brother mentors, male motivators, expert patients, village health workers, community-based distributors for sexual and reproductive health (SRH) services, PLHIV support groups and community case care workers. These facilitate the delivery of health services at community level. The ART programme is using the differentiated care delivery models community cadres in monitoring treatment adherence through CARGs, FARGs and CATS. There were more than 62,000 PLHIV in CARGs in 2019. The following figure shows number of people in CARGs by province.

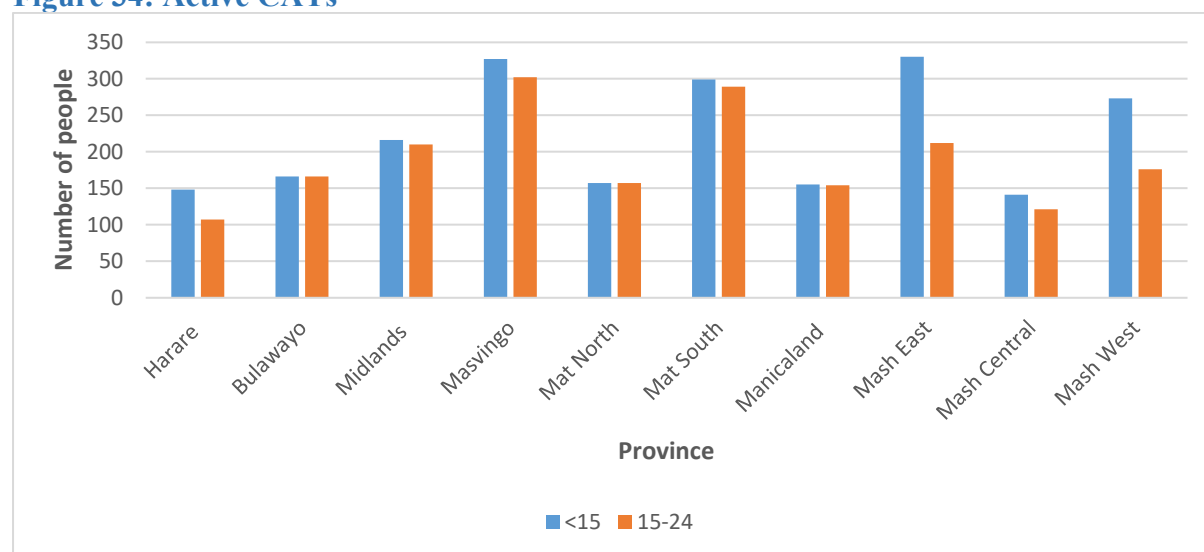
**Figure 33: PLHIV in CARGs**



There are still few people in CARGs as compared to number of people on treatment that needs adherence support.

There were 4,106 active CATs in in 2019 and the distribution is shown below by province.

**Figure 34: Active CATs**



The CATs reach out to their peers through home visits, counselling, adherence counselling sessions and make referrals for HIV services.



**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 funding landscape of the national HIV and AIDS response is dominated by external funding which accounts for 69% of the expenditure on HIV response while domestic resources account for 31% (NAC, 2019). It is worth noting that 97% of external funding is from two sources: The Global Fund and PEPFAR. Also, for the domestic investments, a substantial proportion is out-of-pocket (OOP) from individual with deleterious impoverishing consequences. The following table shows trend in country HIV expenditure.

**Table 3: Trend in HIV Expenditure**

Indicator	Achievement						
	2013	2014	2015	2016	2017	2018	2019
<b>Total HIV Expenditure</b>	259m	341m	396m	409m	418m	383m	396m

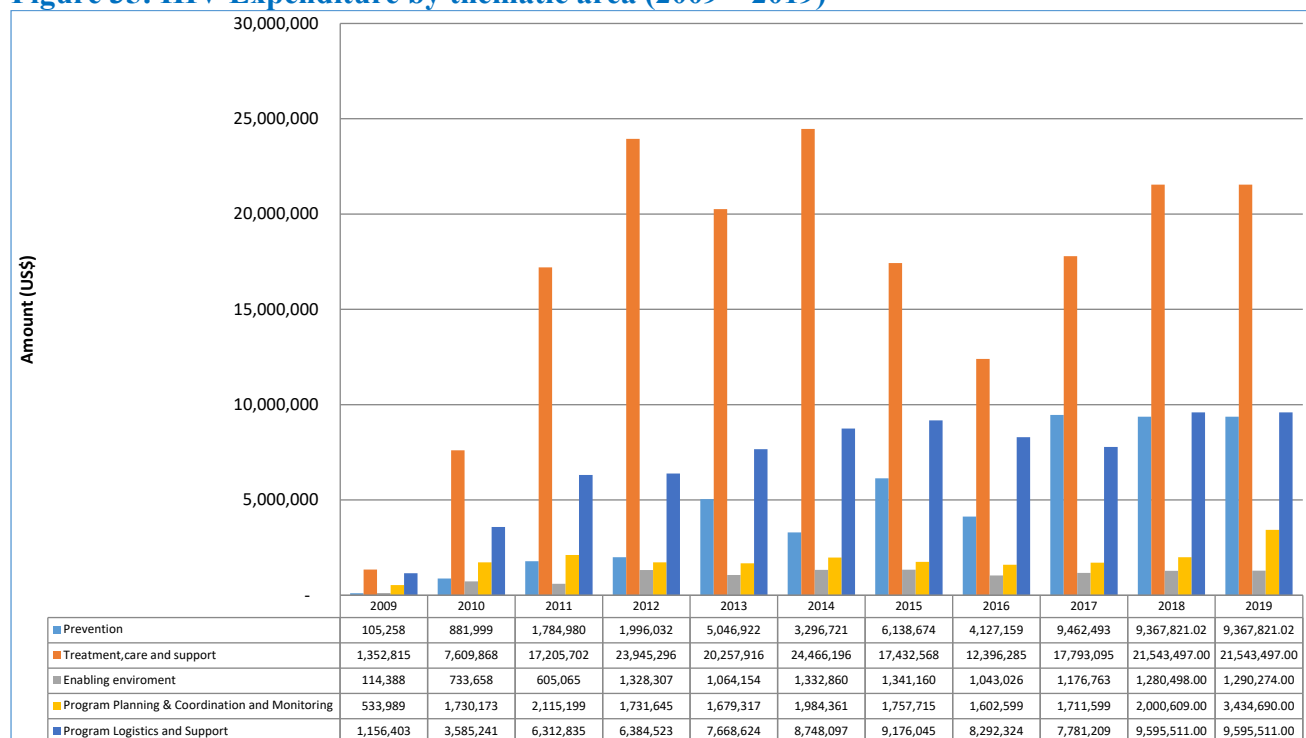
The expenditure on HIV by year is generally decreasing, and the local contribution is also dwindling. The sustainability of the funding is not certain. There is still a huge anticipated gap in ARV funding.

Given the likelihood of donor funding flat-lining or even declining, sustainability of the results of some of the key programmes is threatened. These include condom procurement and VMMC. The country is also planning to continue initiating people on ART to reach 95% target by 2025 and this will require additional funds.

In terms of funding by programmatic expenditure, there is dismal investments in the core pillars of HIV prevention – far below the recommended Quarter for Prevention. The same is true for investments in social enablers. Given that the bulk of investments are committed to HIV treatment, this reflects limited room for improving allocative efficiencies. The following figure shows NATF resources expenditure by thematic area.



**Figure 35: HIV Expenditure by thematic area (2009 – 2019)**



**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.**

Mechanisms are in place to record and address cases of HIV-related discrimination. Accountability mechanisms in relation to discrimination and violations of human rights in healthcare settings were also put in place to prevent violation of human rights.

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) was done.

The Legal Environment Assessment (LEA) for HIV, TB and SRH completed in 2019 found that Zimbabwe has protective provisions in existing laws and policies such as criminal laws protecting women against violence, legal protections ensuring inclusion of people with disabilities in all sectors, child laws protecting the rights of orphans and vulnerable children and laws protecting employees against discrimination in the work place. Employment laws in place prohibit discrimination of employees because of several factors including health.

The Zimbabwe constitution includes various human rights provisions relevant to HIV and TB and for protecting the rights of vulnerable and key populations. These include equality and

non-discrimination (section 56), rights to healthcare (section 76), labour rights (section 65), enforcement of fundamental human rights and freedoms (section 95), rights to privacy (section 57) and access to information (section 65).

Human rights obligations assumed by Zimbabwe at regional and international level have been domesticated through the Constitution and other laws, policies and programmes such as the National AIDS Council of Zimbabwe Act, Criminal law Act, National HIV and AIDS policy, national HIV strategic plans, national health strategic plans, labour HIV and AIDS regulations and the Public health act.

The country has an institutional framework for enforcing and implementing the laws and policies relevant to HIV and TB. The Ministry of Justice, Legal and Parliamentary Affairs leads the review and updating of laws in the country and is also a coordinator of the justice system actors. Currently, the Ministry coordinates the implementation of guidelines and protocols for addressing sexual and gender-based violence. Parliament plays a key role in enactment of laws and has in place the health committee, which leads on health and HIV issues. The law enforcement agencies, particularly the police have in place the victim friendly unit which supports GBV survivors (among other clients) to access justice. In addition, National AIDS Council is mandated to facilitate and monitor an enabling environment for provision of HIV services (as per the National HIV Policy) through working with government Ministries and departments and non-state actors.

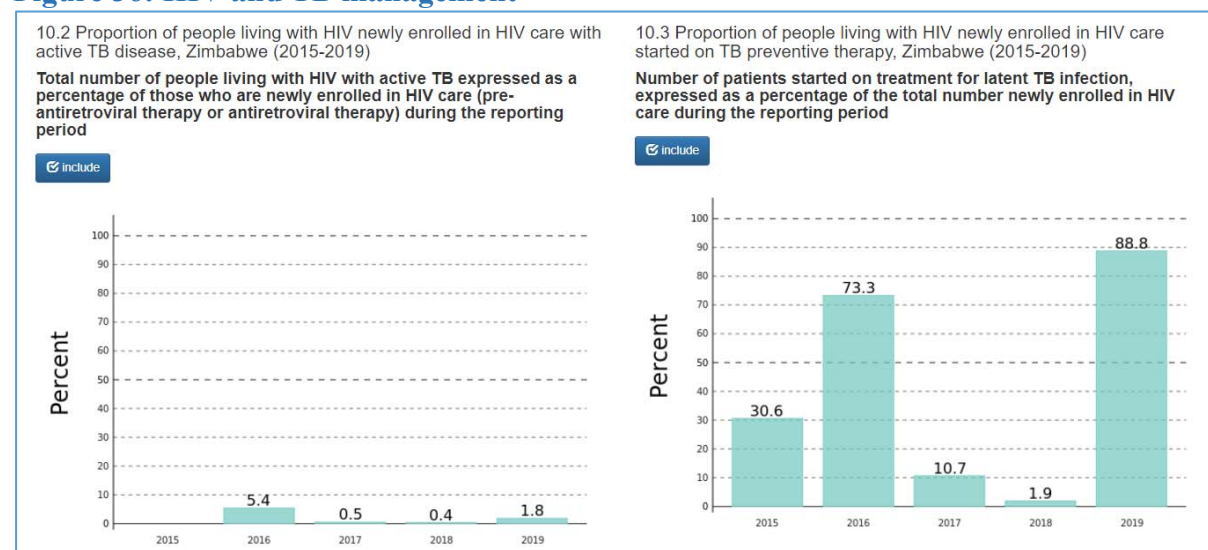


**Target 10: Commit to taking AIDS out of isolation through people-centered systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.**

#### **HIV and TB**

Zimbabwe is classified as a high TB burden country. Zimbabwe provides integrated HIV/TB services to ensure PLHIV are screened for TB, presumptive cases are tested and those with active TB are treated while that test HIV negative are put on TB preventative Therapy (TPT). However, coverage of IPT was estimated at a low 1.9% in 2019. On the other hand, TB patients are also tested for HIV and those who tested positive are put on ART.

**Figure 36: HIV and TB management**



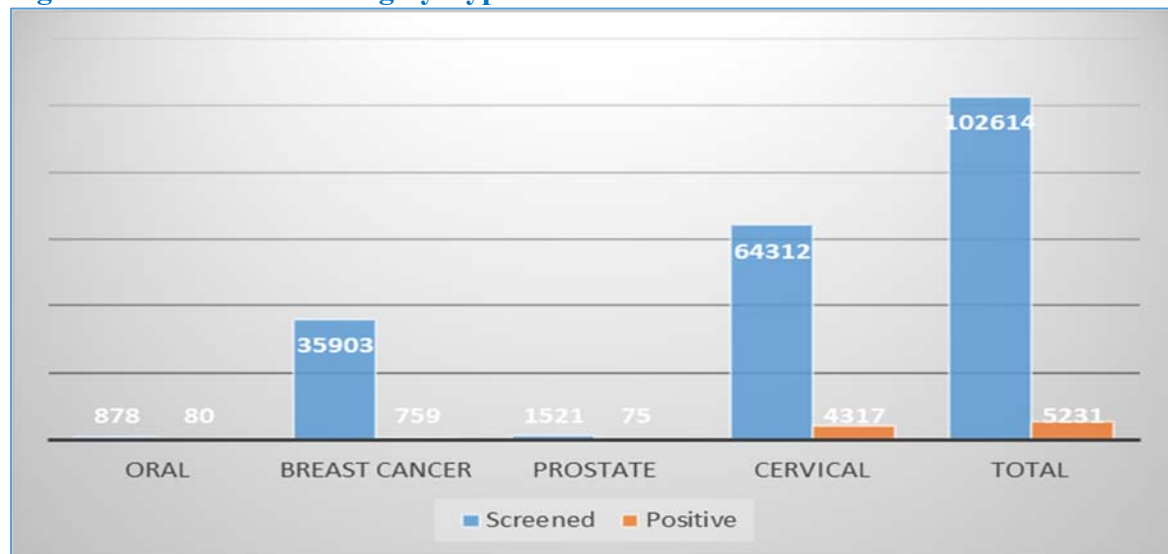
The country had made efforts to scale up TB/HIV co-infection treatment through strengthening health and community systems. In the 32 high burden TB districts, Traditional and Faith Healers were sensitised in TB screening and referral, communities were sensitised on HIV, TB, MNCH and Nutrition integration, the HIV/TB treatment literacy manual was revised and disseminated to civil society organisations and community support groups.

### Cervical cancer Screening

National AIDS Council Supported the MOHCC to procure cancer medicines and create awareness.

During the year under review adult males who were screened for cancer make up only 2.9% of all the people screened. This is attributed to the wide availability of screening tests for cancers in women than those for males and usually only those men who have symptoms are actually screened and as a result 3.7% of males screened for cancer were confirmed cancer positive. On the other hand, women contributed 97.1% of the number screened and out of the women screened, 3.9% of them were cancer positive. Below is an outline of the adults who were screened for the different types of cancers at health institutions and those that were diagnosed with cancer.

**Figure 37: Cancer screening by Type of Cancer**



## Hepatitis

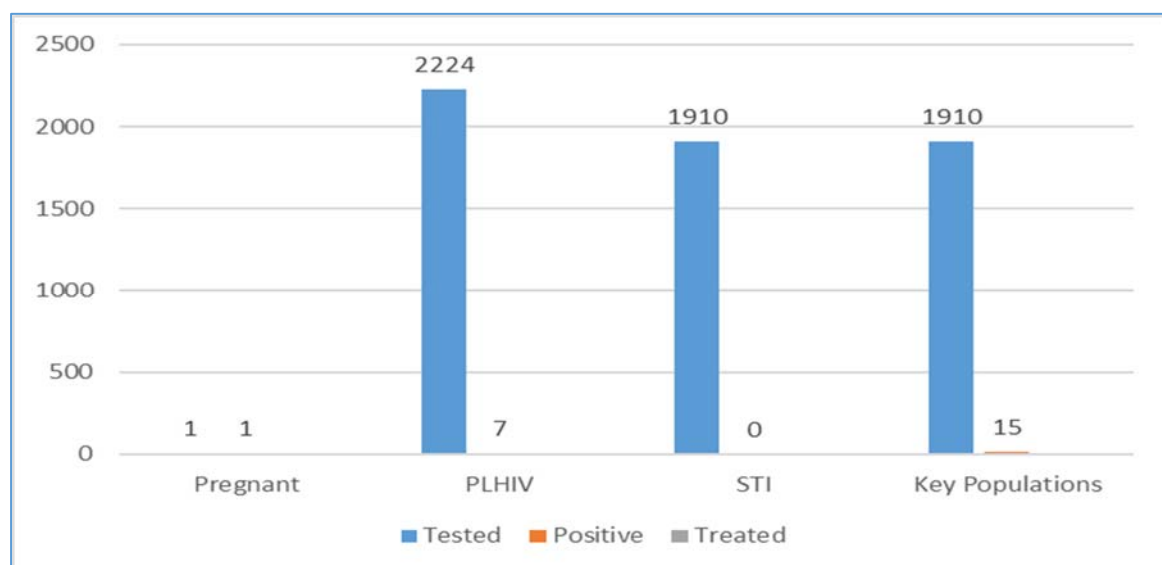
Viral Hepatitis strategy for HIV was developed in 2019 and the plan is awaiting costing. The development of the M & E tools and clinical guidelines will be done in 2020

## Hepatitis B

The Hepatitis B programme focusses on testing, giving the correct diagnosis and giving treatment to clients diagnosed with Hepatitis B. During the period under review, a total of 4,362 adults were screened for hepatitis B and 24 cases were confirmed positive.

The graph below depicts the different categories of people tested for Hepatitis B, their diagnosis and their management

**Figure 38: Hepatitis B Screening**



Of the total number screened for Hepatitis B, 2224 were PLHIV and 1910 were STIs clients. Key populations contributed 31.6% of the total number screened for Hepatitis B while Pregnant women had 0,016% of cases screened.

## Hepatitis C

There was an increase in the cases of Hepatitis C screening from 402 in 2018 to 1402 in 2019.

## Coordination of the National Response

National AIDS Council led the coordination of the national response in Zimbabwe and has cascaded the coordination structures to provincial and district levels. All the six sectors conducted their coordination meetings with support from NAC, several coordination meetings we held at all levels. In the last five years, notable progress has been made in strengthening coordination in line with the way the HIV response is evolving. Some of the key improvements in coordination are as follows:

- (i) Establishment of coordination mechanisms for the Key Populations Programme. These include the Key Populations Forum which brings together KP-led organisations and implementers to review progress in implementation of the programme and address needs of KPs, and a KP Technical Working Group which reviews technical issues with regard to planning, implementation and monitoring of the programme and advises on strategic and programmatic issues. Additionally, in 2019 Zimbabwe established the KP Technical Support Committee (TSC). Co-chaired by the Ministry of Health and Child Care and NAC, the objective of the TSC is to strengthen the National KP Program through the harmonization of KP activities, stakeholders and programs, including standardization of policies and best practices at national, provincial and district levels.
- (ii) Strengthen private sector coordination structures: Two bodies have been set up to coordinate private sector response with NAC providing secretariat services. The Private Sector Coordination Board was established to coordinate formal private sector firms in providing HIV services. The Informal Economy Council was also established to coordinate informal private sector HIV interventions.

- (iii) Programmatic TWGs are also in place (some under NAC and others under MOHCC) to lead technical implementation of the response. The TWGs are largely functional and play a key role in HIV programming.

## Monitoring and Evaluation

The country conducted end term review of the national strategic plan in preparation of the development of the 2021- 2025 HIV strategy. In an effort to understand the geographic variation of the epidemic, the country conducted geo-spatial modelling of the epidemic.

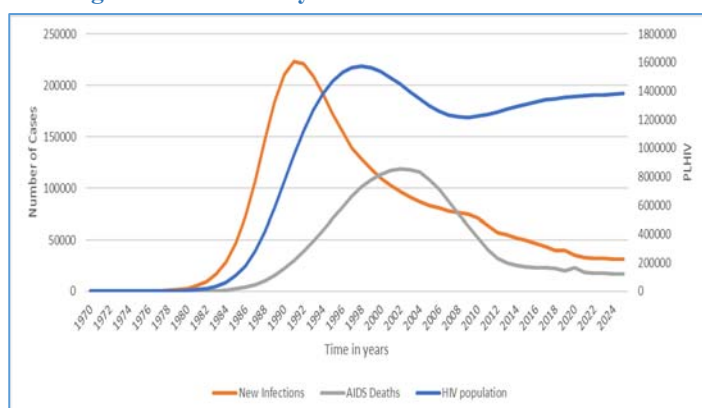
An incidence study in prison setting was implemented and follow up of inmates was done. The study is a mini integrated bio-behavioral survey.

NAC with support from GF led the economic analysis of PrEP to inform investment in the program and targeting.

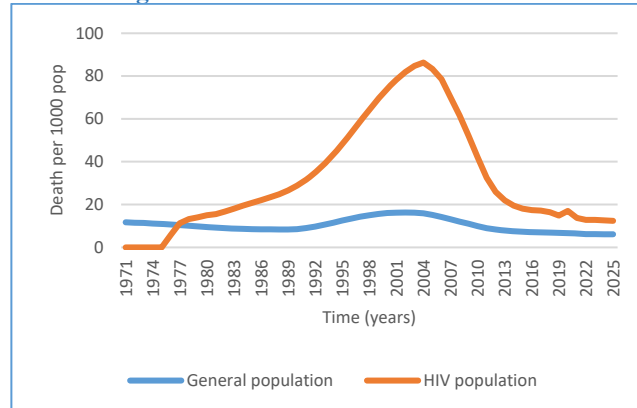
## Conclusion

The country will not reach the epidemic control phase if it continues to do business as usual as shown by the figures below. There is need to adopt high impact innovative geo-targeted strategies in response to HIV.

**Figure 39: PLHIV by New Infections and Deaths**



**Figure 40: Crude death rate**



## Major Challenges

The following challenges were experienced in 2019:

- Limited information on key populations like prisoners and Transgender
- Limited integration of HIV, Cervical Cancer and Hepatitis B and C testing and treatment
- Dwindling of international funding for HIV and AIDS while response rely on external funding