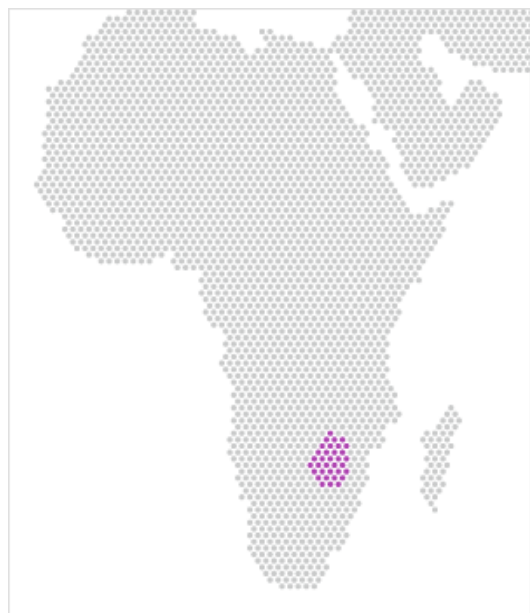


# HIV and AIDS in Zimbabwe



## Zimbabwe (2017)

**1.3m** people living with HIV

**13.3%** adult HIV prevalence (ages 15-49)

**41,000** new HIV infections

**22,000** AIDS-related deaths

**84%** adults on antiretroviral treatment\*

**89%** children on antiretroviral treatment\*

\*All adults/children living with HIV

Source: UNAIDS Data 2018

## KEY POINTS

- Zimbabwe has a high HIV prevalence. Unprotected heterosexual sex continues to be the main transmission route for new infections.
- The illegal nature of sex work and homosexuality in Zimbabwe presents huge barriers for sex workers and men who have sex with men from accessing HIV services.
- Nearly every pregnant woman now has access to antiretroviral medicines thanks to the success of PMTCT services in Zimbabwe – also contributing to a decline of new infections among infants.
- Over three quarters of HIV expenditure in Zimbabwe comes from international donor sources.

Explore this page to find out more about [groups most affected by HIV](#), [testing and counselling programmes](#), [prevention programmes](#), [antiretroviral treatment](#), [civil society's role](#), [HIV and tuberculosis](#), [barriers to the HIV response](#), [funding](#) and the [future of HIV in Zimbabwe](#).

Zimbabwe has the sixth highest HIV prevalence in sub-Saharan Africa at 13.5%, with 1.3 million people living with HIV in 2016. [1](#)

The HIV epidemic in Zimbabwe is generalised and is largely driven by unprotected heterosexual sex. Women are disproportionately affected, particularly adolescent girls and young women. However, there are growing epidemics among key populations such as sex workers and men who have sex with men who are at higher risk of HIV. National data on these populations is sparse as only a minimal amount of data is collected and reported in national documents.

In 2016, new infections dropped to 40,000 from 79,000 in 2010, with behaviour change communication, high treatment coverage and prevention of mother-to-child transmission services thought to be responsible for this decline. [2](#)

Deaths from AIDS-related illnesses continue to fall – from 61,000 in 2013 to 30,000 in 2016.[3](#)



Source: UNAIDS Data 2018

Avert) [www.avert.org](http://www.avert.org)

## Groups most affected by HIV in Zimbabwe

The Zimbabwean HIV epidemic is largely driven by unprotected heterosexual sex. But there are now growing epidemics among [key populations](#) who are at higher risk of HIV.<sup>5</sup> National data on these populations is sparse. Only a minimal amount of data is collected and reported in national documents.

### Women and HIV in Zimbabwe

An estimated 720,000 women are living with HIV in Zimbabwe. <sup>4</sup>

Gender inequality is present within relationships and marriages, and drives HIV infections. For example, only 69% of men believe a woman has the right to refuse sexual intercourse if she knows he has sex with other women. And although in the minority, 23% of females believe women do not have the right to ask their partner to use a condom if he has a sexually transmitted infection (STI).<sup>5</sup>

More than a third of women who have been married have experienced physical or sexual violence from their partner.<sup>6</sup> This prevents women from being able to negotiate using a condom, and puts them at higher biological risk of HIV.

In 2015, 14% of women reported experiencing sexual violence at least once in their lifetime and 8% reported experiencing it in the last 12 months.<sup>7</sup>

In terms of broader reproductive health, Zimbabwe fares better. Zimbabwe has the lowest reported unmet need for family planning among married women in sub-Saharan Africa (15.2%).<sup>8</sup>

### Young people and HIV in Zimbabwe

Among young women, HIV prevalence increases with age, with 2.7% of women aged 15-17 living with HIV, increasing to 13.9% of women age 23-24. Among young men, HIV prevalence holds steady at around 2.5% until the age of 23-24 when it increases to 6%.<sup>9</sup>

However, as only 64% of young women (15-24) and 47.5% of young men have ever tested for HIV, prevalence among this group could be significantly higher.<sup>10</sup>

In 2015, 17% of young women aged 15-19 in Zimbabwe reported having had sex with a man 10 years older in the past 12 months. This 'sugar-daddy' culture can contribute to an elevated risk of HIV for young women as they are exposed to older men who may be more likely to have HIV, or who hold the power in the relationship and determine condom use.<sup>11</sup>

Only 46% of young women and 47% of young men have comprehensive knowledge about HIV, limiting their ability to take control of their sexual health.<sup>12</sup>



## Sex workers and HIV in Zimbabwe

More than half of all sex workers in Zimbabwe are living with HIV. The most recent data in 2016 recorded prevalence of 57.1%.<sup>13</sup> This is concerning in an environment where condoms are being confiscated and gender inequality makes condom negotiation difficult.

Despite this, some progress is being made; the number of sex workers reached with HIV prevention programmes in Zimbabwe has more than doubled in recent years, from 7,300 in 2014 to 16,900 in 2015.<sup>14</sup>

Sex work is illegal in the country, with police often using their powers to intimidate, arrest and harass sex workers. This exacerbates sex workers' vulnerability to HIV as fear of arrest often stops sex workers from accessing health services. Findings on police harassment and abuse by the Centre for Sexual Health, HIV and AIDS Research in 2016 found 20% of female sex workers in Zimbabwe experienced violence from the police in the past year.<sup>15</sup>

In addition, the possession of condoms is used as proof of sex work, with many sex workers reporting being arrested due to their work, or having their condoms confiscated. This hampers sex workers' ability to negotiate condom use with clients, heightening their risk of HIV.<sup>16</sup>

However, a criminal case against nine sex workers in 2015, which found in the sex workers' favour due to the absence of a client being present at their time of arrest was widely reported in Zimbabwe's media as signifying that the police were no longer allowed to arrest sex workers. In a survey of just under 3,000 female sex workers, around 50% reported having been stopped by the police in 2013, but by 2016, among this same group of sex workers, 30% reported being stopped.<sup>17</sup>

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We used to be rounded up in the streets even if we were caught just standing there, but now they can't do that unless there is a client there as well. So cops are finding it hard to arrest us. I'm sure it will also make them think and realise that we are also human beings.

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- *Female sex worker in Zimbabwe.*<sup>18</sup>

Sex workers, and the organisations representing them, have minimal involvement in the Zimbabwean response to HIV. This marginalises them and prevents them from accessing services. Better inclusion of sex worker-led groups in HIV prevention initiatives would help improve the

health of sex workers and the population as a whole.

## Men who have sex with men (MSM) and HIV in Zimbabwe

Homosexual acts are illegal in Zimbabwe for [men who have sex with men \(sometimes referred to as MSM\)](#), but legal for women who have sex with women. As a consequence of this punitive law, national statistics are rarely available.

Criminalising men who have sex with men drives this vulnerable group away from HIV services. As a result, many do not know their HIV status, let alone access treatment.

However, Zimbabwean organisations that support the rights of men who have sex with men and their access to HIV services do exist, such as Gays and Lesbians Zimbabwe (GALZ). Many are routinely punished and shutdown or have their members arrested.

UNAIDS reported in 2016 that just one in seven men who have sex with men in Zimbabwe (14.1%) are aware of their status. [19](#)

International donors such as the Global Fund to Fight AIDS, Malaria and Tuberculosis and PEPFAR have attempted to ensure some of their funding is directed towards men who have sex with men. Government restrictions mean this has not materialised.

## HIV testing and counselling (HTC) in Zimbabwe

It is estimated that 75% of people living with HIV in 2016 knew their status.[20](#) However, there is a large discrepancy between men and women, with 76% of women and girls living with HIV aware of their status, compared to 68% of positive men and boys.[21](#)

The number of HIV tests carried out in Zimbabwe has increased from 19.4 million in 2011 to 22 million in 2015, although this figure is below the government's intended target of 25.2 million.[22](#)

The Zimbabwe Demographic Health Survey 2015 (ZDHS 2015) shows an increase in testing, with 49% of women reporting being tested in the last 12 months compared to 34% in 2011. Among men, this increased from 21% in 2011 to 36% in 2015.[23](#)

It is thought that masculinity norms in Zimbabwe inhibit men from getting tested and engaging in treatment.[24](#)

### Scaling up self testing in Zimbabwe

Another way to increase testing, particularly among hard-to-reach groups, is self-testing. In 2015, Population Services International and UNITAID began HIV Self-Testing Africa (STAR), a four-year project to scale up self-testing in Zimbabwe, Malawi and Zambia.

In the first year, nearly 380,000 free HIV self-test kits were distributed in 27 districts in Malawi, Zambia and Zimbabwe.

Results suggest self-testing is enabling more young people (aged 16-24 years) and men to be aware of their HIV status. In the first year, young people comprised 28% of self-tests and resulted in testing coverage among this age group increasing by 39% in the project's catchment areas. Men accounted for 44% of self-test users, and testing coverage increased by 28% in testing areas. Among those using the kits in Zimbabwe, 23% were first-time testers.[25](#)

# HIV prevention programmes in Zimbabwe

The number of people acquiring HIV each year is falling in Zimbabwe, although levels are still relatively high. In 2016, there were 40,000 new infections, compared to 73,000 in 2010.[26](#)

Zimbabwe's National HIV and AIDS Strategic Plan 2011-2015 saw the country adopt a Combination Prevention Strategy approach, which focuses on a number of areas to prevent new infections. This approach remains in place and includes prevention of mother-to-child transmission, voluntary medical male circumcision, behaviour change communication, condom programming and STI management.

In 2015, as the 2011-2015 strategic plan came to an end, Zimbabwe held a national consultation to explore how the country's prevention responses can be revitalised. As a result, it is currently developing a regional roadmap with South Africa and Kenya to increase HIV prevention services and investment.[27](#)

## Condom availability and use in Zimbabwe

The availability and distribution of condoms in Zimbabwe is good, with 109.4 million male condoms and 5.6 million female condoms distributed in 2015.[28](#) This equates to 33 male condoms per man per year, making Zimbabwe one of only five countries to meet or exceed the United Nations Population Fund's regional benchmark of 30 male condoms per man per year.[29](#)

Use of condoms in multiple concurrent partnerships (when one or both partners have sexual relationships with other people) remains low. Survey data from 2015 reported that, of respondents who had two or more sexual partners in the past 12 months, only 50% of women and 37% of men used a condom the last time they had sex.[30](#) However, this is a slight increase from the 2010/2011 survey, which reported 48% of women and 33% of men in multiple concurrent partnerships using a condom the last time they had sex.[31](#)

## HIV education and approach to sex education

Findings from 2015 suggest knowledge of HIV prevention is increasing in Zimbabwe, particularly among men.

Knowledge of HIV is generally widespread, with 84% of women and 88% of men questioned aware that HIV may be prevented by using condoms during sex.[32](#)

However, some misconceptions about HIV transmission remain, with 16% of women and men wrongly thinking that HIV can be transmitted by mosquito bites, 7% believing a person can become infected by sharing food with a person who has HIV, and 5% suggesting HIV can be transmitted by supernatural means.[33](#)

### The Zimbabwe National Behaviour Change Programme

In 2015, 2.4 million people in Zimbabwe were reached with messages about HIV and 44% were referred for integrated HIV services.[34](#)

The programme targets sexually active people and members of key affected populations, and has scaled-up efforts to reach schools, workplaces and community-centred activities. In prisons for example, both staff and inmates have been trained in the programme in order to pass on knowledge to others.[35](#)

However, recent reductions in the number of new HIV infections in the country are thought to be due to a reduction in the number of people with multiple sexual partners. This shows a shift towards making conscious behavioural changes in light of a serious HIV epidemic.<sup>36</sup>

Despite this, men are still 14 times more likely to have multiple sexual partners than women.<sup>37</sup>

## Prevention of mother-to-child transmission (PMTCT)

In 2014, Zimbabwe rolled out Option B+, whereby HIV-positive mothers receive antiretroviral drugs for life in line with WHO treatment guidelines - a promising move for Zimbabwe's HIV response.<sup>38</sup>

As a result, in 2016, 93% of pregnant women living with HIV in Zimbabwe received antiretroviral treatment to prevent mother-to-child transmission.<sup>39</sup>

In 2015, mother-to-child transmission was estimated to account for 6.39% of all new HIV infections in children aged 0-14 years. The number of new infections in this age group has itself fallen from 12,000 in 2010 to 4,900 in 2015.<sup>40</sup> In 2015 HIV prevalence among this age group was 1.8%. When broken down more specifically by age, prevalence among 0-4 year olds was 1.1% and 2.7% among 10-14 years.<sup>41</sup>

Despite the expansion of PMTCT services, only 54.9% of infants born to HIV-positive mothers received an HIV test within the first two months of life.<sup>42</sup>

## Voluntary medical male circumcision (VMMC)

Despite Zimbabwe being one of UNAIDS' priority countries for the scale up of voluntary medical male circumcision (VMMC), and VMMC being listed in the country's National Combination Prevention Strategy,<sup>43</sup> Zimbabwe currently has one of the poorest VMMC coverage rates in sub-Saharan Africa with 14.3% of men aged 15-49 circumcised as of 2016.<sup>44</sup>

By 2018, Zimbabwe aims to reach 1.3 million men with VMMC (80% of 13-29 year olds)<sup>45</sup> As of 2016, it had only achieved 46.3% of this target group.<sup>46</sup>

But 2015 survey data did find HIV prevalence to be lower among men who are circumcised (7.6%) than those who are not (11%), a change from previous findings when it was found to be higher. This suggests that, where available, the intervention is working.<sup>47</sup>

A study on how to encourage uptake among adolescents recommended promoting VMMC as an intelligent lifestyle choice rather than a medical intervention. Various youth campaigns on radio, social media and in schools, including celebrity endorsements, have been running over the last few years to this effect.<sup>48</sup>

Using football to engage adolescent men has also proven successful. A study conducted at 26 schools in Bulawayo, Zimbabwe, found that a soccer programme called Make-The-Cut-Plus, more than doubled the odds of service uptake.<sup>49</sup>

## Pre-exposure prophylaxis (PrEP)

Zimbabwe is currently implementing ongoing demonstration and research projects to investigate the uptake and impact of pre-exposure prophylaxis (PrEP). PrEP uses antiretroviral drugs to protect HIV-negative people from HIV.



In Zimbabwe, this has been specifically targeted at young women and girls among whom HIV prevalence is high.<sup>50</sup> UNAIDS recorded 403 people living with HIV in Zimbabwe accessing PrEP treatment as a method of HIV prevention in 2016.<sup>51</sup> The total target number for current trials is 3,000-3,300.<sup>52</sup>

## Antiretroviral treatment (ART) availability in Zimbabwe

Zimbabwe is one of the sub-Saharan African countries with the greatest access to antiretroviral treatment (ART), with 75% of people living with HIV on treatment, equivalent to over a million people.<sup>53</sup>

In 2016, the country adopted a 'treat all' policy towards ART, meaning all people should be started on treatment immediately, regardless of their CD4 count.<sup>54</sup> It is thought that 9,000 people are initiating treatment every month.<sup>55</sup>

In 2015, it was estimated that 65% of women living with HIV were on treatment compared to 54% of men.<sup>56</sup> This has resulted in Zimbabwean men being less likely than women to be virally suppressed.<sup>57</sup>

In 2015, 80% of children (0-14 years) living with HIV had access to ART.<sup>58</sup> It is hoped the introduction of specialised ARV pellets for children being piloted by Zimbabwe will increase treatment coverage for this age group further.<sup>59</sup>

Zimbabwe is scaling up viral load testing, which is key to measuring viral suppression. This expansion is partly due to South Africa leveraging its market weight to reduce viral load testing prices to a maximum of US\$ 9.40 per test, making it more affordable for low and middle income countries.<sup>60</sup> However, budgetary issues, weak infrastructure and capacity challenges means viral load testing is far from routine, and existing facilities are mostly located in cities.<sup>61</sup>

## Civil society's role in Zimbabwe

In Zimbabwe, the long-standing ruling party Zanu-PF and civil society organisations (CSOs) in the country, particularly those working on human rights and governance issues, have had an adversarial relationship, imbued with mutual mistrust.<sup>62</sup>

The contested elections of 2013 resulted in some concessions from government who granted CSOs the right to freedom of assembly and association, freedom to demonstrate and petition, freedom of conscience, and freedom of expression.<sup>63</sup>

Despite these gains, the government continues to constrain the efforts of many CSOs. For instance, the government can restrict specific CSO activities if deemed contrary to 'national security', has criminalised activities relating to the promotion of LGBT rights, and limits the type of activities non-local CSOs can engage in if they receive foreign funding. Such hostile regulations mean many 'controversial', rights-based organisations cease to exist, rebrand, or switch to less sensitive work.<sup>64</sup>

## HIV and tuberculosis (TB) in Zimbabwe

Tuberculosis (TB) remains a major issue for people living with HIV in Zimbabwe, with the country ranked in the top 30 high burden TB countries by the World Health Organization. <sup>65</sup>

In 2015, 70% of people diagnosed with TB were HIV positive. The incidence of TB in Zimbabwe has increased dramatically in recent years, with TB now being the most common cause of death for

people living with HIV.<sup>66</sup>

However, Zimbabwe has had an increase in tuberculosis treatment success, from 79% of people with TB reaching successful outcomes in 2014 to 83% in 2015. This has been the result of increased integration between HIV and TB services.<sup>67</sup>

## Barriers to the HIV response in Zimbabwe

### Social and cultural barriers

Polygamous relationships are commonplace in Zimbabwe. According to 2011 data, 20% of those in such a relationship were living with HIV, compared to 16% of those in a monogamous relationship.<sup>68</sup> However, a new national survey in 2015 did not include data on this.

Gender-based violence (GBV) persists among Zimbabwean society and within households. Survey results from 2015 on GBV found 39% of women and 33% of men thought a husband was justified in beating his wife for at least one of the following reasons: burning the food, leaving the house without telling him, arguing with him, neglecting the children or refusing sex with him. Tolerance of wife beating is declining though, as these figures stood at 48% of women and 37% of men in 2005.<sup>69</sup> GBV is closely linked to inability to negotiate condom use, and greater vulnerability to HIV.

### Legal and data collection barriers

The illegal nature of sex work and homosexuality presents huge barriers for these populations in accessing HIV services to take care of their health. It also means that the country is unaware of the demographics of people living with HIV, meaning targeted prevention, testing and treatment services are impossible. If people who are living with HIV cannot access treatment to prevent onwards transmission, this allows HIV to continue as a public health issue.

### Stigma and discrimination

Stigma and discrimination towards people living with HIV in Zimbabwe remains rife - with one study finding that 65% of people living with HIV had experienced them.<sup>70</sup>

Survey data from 2015 found 22% of women and 20% of men who were aware of HIV had discriminatory attitudes towards people living with HIV. Around 6% of women and 9% of men did not think children living with HIV should be allowed to attend school with children who are HIV negative. Additionally, 19% of women and 16% of men would not buy fresh vegetables from a shopkeeper with HIV.<sup>71</sup>

## Funding for the HIV response in Zimbabwe

The Zimbabwean government collects an AIDS levy, which is made up of 3% payee and corporate tax which contributes considerably to the domestic share of funding for the national HIV response.<sup>72</sup> However, 86% of HIV funding in Zimbabwe still came from international sources in 2016.<sup>73</sup>

In 2015, Zimbabwe produced a national HIV investment case promoting effective, efficient and sustainable investments in its HIV responses by targeting specific locations and populations.<sup>74</sup>



# The future of HIV in Zimbabwe

PMTCT services are proving successful, and this effort must be maintained in order to end child infections. However, VMMC coverage continues to fall behind other countries in the region.

Without data on HIV among key population groups such as men who have sex with men, there is little evidence to inform prevention interventions, or how to encourage people to use HIV services.

The fact that there is no statutory requirement to enforce data reporting by all sectors also hampers monitoring and evaluation<sup>75</sup>, as does continued, persistent discrimination and criminalisation of men who have sex with men and others from the LGBT community.

HIV education and knowledge could be more wide-reaching, with schools responsible for providing the education that young people need. This is especially important in a culture where patriarchy, gender inequality, polygamous relationships and a sugar daddy culture persist.

The diminishing international funding for the HIV response also poses a threat to Zimbabwe's progress on HIV, particularly in relation to HIV prevention.

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