HIV and AIDS in Zimbabwe

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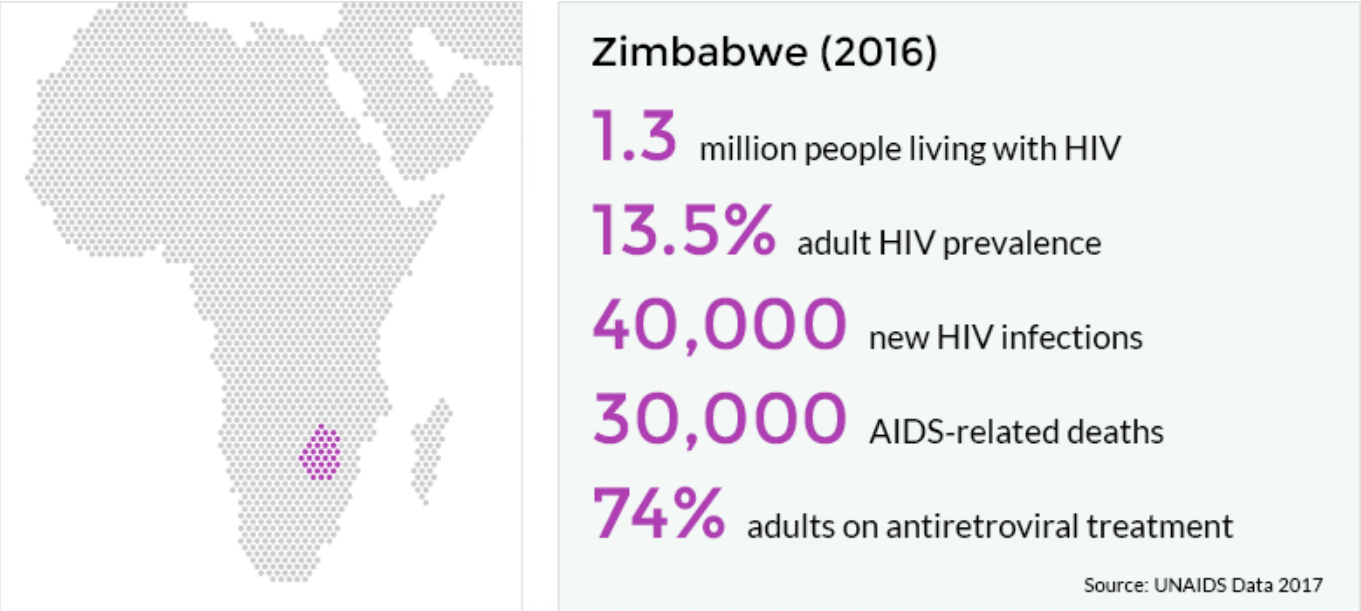

KEY POINTS:

- Zimbabwe has a high HIV prevalence, with unprotected heterosexual sex continuing to be the main route 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 populations most affected by HIV, testing and counselling programmes, antiretroviral treatment, prevention programmes, barriers to prevention, funding and the future of HIV and AIDS 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

New infections dropped from 79,000 in 2010 to 40,000 in 2016, 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 reduce, falling from 61,000 in 2013 to 30,000 in 2016.3

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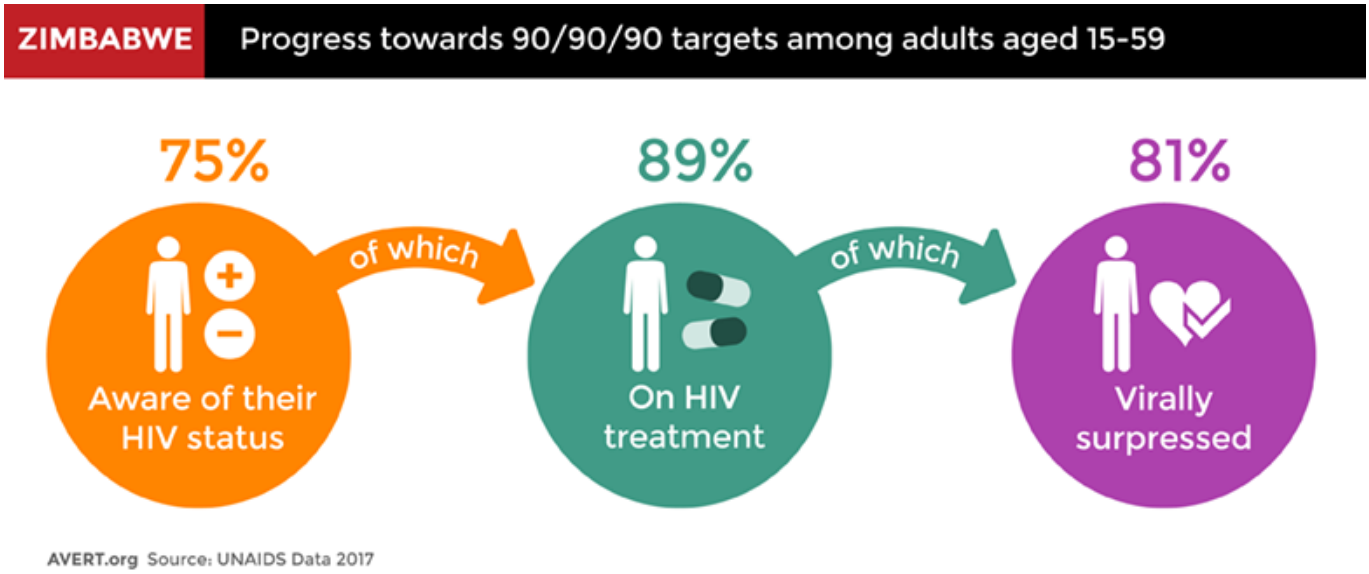

Key affected populations in Zimbabwe

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.5 National data on these populations is sparse. Only a minimal amount of data is collected and reported in national documents.

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.

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. 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. UNAIDS reported in 2016 that just one in seven men who have sex with men who are living with HIV (14.1%) are aware of their status. 4

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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.

Sex workers and HIV in Zimbabwe

More than half of all sex workers in Zimbabwe are living with HIV with a last recorded prevalence of 57.1% in 2016. 5 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

2015.6

Case study: Victoria Falls, Hwange and Mutare

In a study of 870 Zimbabwean sex workers, the prevalence of those living with HIV was found to be between 50% and 70%. Of those who tested positive, half did not know they were infected and between 25% and 30% were accessing antiretroviral treatment.

Participants reported high rates of gender-based violence and police harassment, and their levels of prevention, treatment and care were limited. The study concluded that intensified prevention and care interventions could significantly reduce the workers' HIV and social risks. 7

Sex work is illegal in the country, with police often using their powers to intimidate, arrest and harass sex workers. 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, if they haven't got any condoms of their own, heightening their risk of HIV.8

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. I have made this change due to the fact that CeSHHAR Zimbabwe is now mentioned in Zim’s GARPR report 2016

Women and HIV in Zimbabwe

An estimated 720,000 women are living with HIV in Zimbabwe. 9 At 15.2%, Zimbabwe also has the lowest reported unmet need for family planning among married women in sub-Saharan Africa.10

Gender inequality is present within relationships and marriages, with only 68% of men believing a woman has the right to refuse sexual intercourse if she knows he has sex with other women. Similarly, only eight out of 10 women believe women have the right to ask their partner to use a condom if he has a sexually transmitted infection (STI).11

More than a quarter of women with a married or stable partner have experienced physical or sexual violence from their partner.12 This prevents women from being able to negotiate using a condom, and puts her at higher biological risk of HIV.

A fifth (22%) of women report that their first sexual intercourse was forced or against their will. This rises to almost a third (28%) among women whose first sexual experience was under the age of 15.13

Young people and HIV in Zimbabwe

13.5% of young people aged 15-24 are living with HIV.14 Only 45% of young women and 62% of young women have ever tested for HIV, prevalence among this group is likely to be significantly higher.15

Only 46% of young women and 47% of young men have comprehensive knowledge about HIV, limiting their ability to engage in safer sex. Young people who do not know where to get a condom are much less likely to have had sex compared to those who do know where to get a condom. This suggests that people in this group understand the risks involved in not using a condom.16

Relationships with large age-differences are common in sub-Saharan African countries, and 15% of young women aged 15-19 in Zimbabwe report having had sex with a man 10 years older. 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 hold the power in the relationship.17

Some Zimbabweans hold the belief that promoting condoms to young people encourages them to experiment with sex at an early age. Indeed, more than half of adult respondents in the 2010/2011 Demographic and Health Survey felt it inappropriate to teach young people aged 12-14 about condoms.18 Avoiding education about condom use is detrimental to the health of young people and put them at greater risk of HIV, sexually transmitted infections (STIs) and unwanted pregnancy. Findings from ZDHS 2015 on young people and HIV are due to be released by the end of 2016.

HIV testing and counselling (HTC) in Zimbabwe

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.

Initial findings from ZDHS 2015 suggests an increase in testing from the previous 2010/2011 survey 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 2015.19

Despite this reported increase, estimated overall rates remain low at 40.3% for men and 50.6% for women. It is estimated that only 66% of people living with HIV know their status.20

To increase testing rates, in 2015 Population Services International and UNITAID began a two-year project to scale up self-testing in Zimbabwe, Malawi and Zambia.21 This project is focusing on places and people where access to testing is restricted such as rural areas and among female sex workers and men who have sex with men.

Antiretroviral treatment (ART) in Zimbabwe

Zimbabwe is part of the group of sub-Saharan African countries with the greatest access to antiretroviral treatment (ART), at more than 61% for adults.22 In fact, 5% of all people worldwide who began ART since 2010 were in Zimbabwe, showing that efforts to increase access are improving. It is thought that 9,000 people initiate treatment every month. Among children (0-14 years), and access to ART stands at 80%.23

HIV prevention programmes in Zimbabwe

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.29.

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.24

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.25

As a result, in 2016, 93% of pregnant women living with HIV in Zimbabwe received antiretroviral

treatment to prevent mother to child transmission.[26]

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.[27]

Despite the expansion of treatment access, only 54.9% infants born to HIV-positive mothers received an HIV test within the first two months of life.[28]

Voluntary medical male circumcision (VMMC)

Despite Zimbabwe being one of UNAIDS' priority counties for the scale up of voluntary medical male circumcision (VMMC), and VMMC being listed in the country's National Combination Prevention Strategy,[29] Zimbabwe currently has one of the poorest VMMC coverage rates in sub-Saharan Africa. By 2018, Zimbabwe aims to reach 1.3 million men with VMMC (80% of 13-29 year olds)[30]

As of 2016, it has only achieved 46.3% of this target. HIV prevalence is slightly higher among men who are circumcised (14%) than those who are not (12%), although the reason for this is unknown. [31] [32] In order to increase motivation to circumcise, the country is now using the PrePex device (a non-surgical circumcision device), which speeds up the circumcision process and is less likely to lead to complications that need extra medical attention.[33]

A 2014 study found only 68% of women and 53% of men participating in the research had heard about VMMC as an HIV prevention method. Only 11% of men questioned were circumcised, and half of the remaining men said they would be willing to be circumcised, motivated by HIV prevention and improved hygiene. Barriers reported included perceived pain and 18% said they were not at risk of HIV. The study found answers varied by age group. [34]

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.[35]

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 before potential exposure to the virus.

In Zimbabwe, this has been specifically targeted at young women and girls among whom HIV prevalence is high.[36] UNAIDS recorded 403 people living with HIV in Zimbabwe accessing PrEP treatment as a method of HIV prevention in 2016. [37]

Behaviour change communication

Case study: The Zimbabwe National Behaviour Change Programme

Running in all districts of the country, this strategy has been successful at reaching all sectors of society. In 2015, 2.4 million people were reached with messages about HIV and 44.2% were referred for integrated HIV services.[38]

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.[39]

Recent reductions in the number of new HIV infections in the country are however 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.[40]

Despite this, men are still 14 times more likely to have multiple sexual partners than women.[41]

Condom programming

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.[42] 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.[43]

Use of condoms in multiple concurrent partnerships (when one or both partners have sexual relationships with other people) remains low. ZDHS 2015 found 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.[44] However, this is a slight increase from ZDHS 2010/2011, which reported 48% of women and 33% of men in multiple concurrent partnerships using a condom the last time they had sex.[45]

HIV education and knowledge

Initial findings of the ZDHS 2015 reports knowledge of HIV prevention to have increased since the 2010/2011 survey, particularly among men.

It finds knowledge about HIV to be generally widespread, with 84% of women and 88% of men questioned aware that HIV may be prevented by using condoms during sexual intercourse.[46] Moreover, 92% of women and 94% of men questioned were also aware that limiting sexual intercourse to one uninfected partner can reduce the chances of getting HIV.

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.[47]

Barriers to HIV prevention in Zimbabwe

Social and cultural barriers

Polygamous relationships are commonplace in Zimbabwe, with 20% of those in such a relationship living with HIV compared to 16% of those in a monogamous relationship. Surprisingly, HIV prevalence among men in polygamous relationships was actually lower than those in monogamous relationships, although this may be due to dishonesty when answering survey questions.[48]

Gender-based violence (GBV) persists among Zimbabwean society and within the household. Results from ZDHS 2015 on GBV are yet to be published. The previous 2010-2011 survey found 40% of women thought their husband was justified in beating her 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.[49]

The latter is the most concerning regarding HIV - 17% of women believe their husband has a right to beat them if they refuse sex, suggesting that they therefore would be unlikely to refuse sex. With such gender imbalances, condom negotiation is difficult for a woman.[50]

Alarmingly, young women are even more likely to believe men are justified to beat their wife.

Interestingly, men are much less likely to believe wife-beating can be justified.51

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 a big issue. One study found that 65% of people living with HIV had experienced it.52

Findings on stigma and discrimination from ZDHS 2015 are yet to be published. ZDHS 2010-11 found that, although people showed more accepting attitudes towards family members with HIV, they continued to show discriminatory attitudes towards shopkeepers or teachers who had HIV.53

Out of the four scenarios asked in the survey (willingness to buy vegetables from an infected shopkeeper, let others know the HIV status of a family member, take care of a family member with HIV, agree that a teacher with HIV should be allowed to continue teaching), only 40% of women and 39% of men showed accepting attitudes to all four situations.54

But 95% of respondents were willing to care for a family member with HIV, suggesting that personal beliefs about HIV may differ to beliefs expressed in society outside of the home. This is reflected in the fact that only half of people said they would tell other people about a family member with HIV.55

HIV and AIDS funding 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. 56

86% of HIV funding in Zimbabwe still comes from international sources according to the UNAIDS 2016 report. 57

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.58

The future of HIV and AIDS 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. The fact that HIV prevalence is entirely unknown for most key affected populations is a major barrier to addressing Zimbabwe's HIV epidemic. Without data, there is little evidence to inform prevention interventions, or how to encourage people to use HIV services. Ultimately, access to treatment could curb transmission among these groups and this must be recognised as a priority.

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.

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