Zimbabwe has one of the highest HIV prevalences in sub-Saharan Africa at 12.8%, with 1.4 million people living with HIV in 2019.1

The HIV epidemic in Zimbabwe is generalised and is largely driven by unprotected heterosexual sex. Heterosexual people in stable unions account for around 55% of all new HIV infections.2 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. Information on these populations is lacking as only a minimal amount of data is collected and reported in national documents.

In 2019, there were 40,000 new HIV infections, down from 62,000 in 2010. Behaviour change
communication, high treatment coverage and prevention of mother-to-child transmission are all thought to be responsible for this decline. Deaths from AIDS-related illnesses continue to fall – from 54,000 in 2010 to 20,000 in 2019.3

Zimbabwe is making strong progress towards the UNAIDS 90-90-90 targets. As of 2019, 90% of people living with HIV in the country were aware of their status, and 94% of those diagnosed were on treatment. Of the people diagnosed and on treatment, 86% are virally suppressed, meaning that they are likely to be in good health and wont to pass HIV on to anyone else. Overall, this equates to 85% of all people living with HIV in Zimbabwe being on treatment and 73% of all HIV positive people being virally suppressed.4

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 certain population groups who are at higher risk of HIV (often referred to as ‘key populations’). National data on these populations is sparse. Only a minimal amount of data is collected and reported in national documents.

Women

An estimated 730,000 women were living with HIV in Zimbabwe in 2018.5 In the same year, 19,000 women became HIV positive, compared to 14,000 men.6 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 her husband sexual intercourse if she knows he has sex with other women. 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).7
Around 20% of women who have been married have experienced physical or sexual violence from their partner in the past 12 months. Overall, 14% of adult women reported experiencing sexual violence at least once in their lifetime and 8% reported experiencing it in the last 12 months. This prevents many women from being able to negotiate using a condom and puts them at higher biological risk of HIV.

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%).

These factors help to create a situation in which women are disproportionately affected by HIV compared to men. For instance, the 2015/16 Population-Based HIV Impact Survey found HIV prevalence among adults who had intercourse before the age of 15 years was nearly three times as high for women (25%) than for men (9%). Among people reporting two or more sexual partners in the 12 months before the survey, prevalence was more than twice as high among women (31%) as among men (12%).

Young people

In 2018, around a third of all new HIV infections in people above the age of 15 in Zimbabwe were among young people (under the age of 24). There were 9,000 new infections among young women, more than double the number of new infections among young men (4,200).

Around 59% of young people surveyed by the country’s 2016 population-based HIV impact survey had tested for HIV, however, young men were less likely to test than young women (52% compared to 65%). Among young people living with HIV, 60% were aware of their status, much lower than the proportion of adults aware of their status overall. The proportion of young people on treatment and virally suppressed is also lower.

Young people are more likely to engage in risky sexual behaviours than older adults, making them vulnerable to HIV, yet they have less frequent contact with the healthcare system in general, including HIV prevention and treatment services.

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. Intergenerational relationships (with older partners) are thought to be one of the main drivers of new HIV infections in young women. In these relationships, older partners are more likely to determine condom use, and are also more likely to have HIV than women’s younger peers.

In Zimbabwe, only 42% of young women and 47% of young men have comprehensive knowledge about HIV, limiting their ability to take control of their sexual health.

Sex workers

There are around 44,500 female sex workers in Zimbabwe, around 40% of whom are living with HIV. This is concerning in an environment where sex work is illegal, condoms are being confiscated and gender inequality makes condom negotiation difficult.

Despite this, some progress is being made; just under half (44%) of all sex workers were being reached with HIV prevention programmes in 2018. In 2017, 96% of sex workers reported using a condom with their most recent client. Around 93% of HIV positive sex workers were aware of their
status of whom 72% are on treatment.\textsuperscript{19}

Sex workers’ vulnerability to HIV is exacerbated by police intimidation, harassment and arrest. This creates fear that stops sex workers from accessing health services. In 2016, the Centre for Sexual Health, HIV and AIDS Research (CeSHHAR) found that 20% of female sex workers in Zimbabwe had experienced violence from the police in the past year.\textsuperscript{20}

The possession of condoms is often used as proof of sex work, and in the past many sex workers have been arrested or had their condoms confiscated. This heightens their risk of HIV, hampering their ability to negotiate condom use.\textsuperscript{21} However, in 2015, nine sex workers’ won a landmark case against them after they were arrested without a client being present. This case was widely interpreted by the media to mean that the police were no longer able to arrest sex workers for merely being on the street.\textsuperscript{22} In a survey of just under 3,000 female sex workers, around 50% reported being stopped by the police in 2013, but by 2016, only 30% said they’d been stopped.\textsuperscript{23}

\begin{quote}
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.

- Female sex worker in Zimbabwe.\textsuperscript{24}
\end{quote}

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)**

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 result national statistics are rarely available for men who have sex with men.

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 or access treatment. From the data that is available, it’s estimated that around a third (31%) of men who have sex with men are living with HIV.\textsuperscript{25}

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), but many are routinely punished and shutdown or have their members arrested.

In 2018, 50% of HIV positive men who have sex with men in Zimbabwe were estimated to be aware of their status, of whom 77% were on treatment. In addition, around 72% of men who have sex with men have access to HIV prevention programmes.\textsuperscript{26} However, these findings are based on limited data so may not accurately represent the reality of the situation.

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, but government restrictions mean this has not materialised.

**HIV testing and counselling (HTC) in Zimbabwe**

It is estimated that 90% of people living with HIV in Zimbabwe knew their status in 2018. However, there is significant discrepancy between men and women, with 94% of women living with HIV aware of their status, compared to 86% of positive men.

The number of HIV tests carried out in Zimbabwe has increased from 19.4 million in 2011 to 28 million in 2017, however this figure is still below the government’s target of 25.2 million.

Findings from ZIMPHIA, a population-based survey carried out in 2015/16, suggest around 74% of all adults have tested for HIV and received their results; 66% of men and 81% of women. Around 36% of those questioned had tested for HIV and received their results in the past 12 months. ZIMPHIA conducts HIV testing as part of its research and around 9% of adults testing positive had not previously tested for HIV before.

Young people are less likely than older age groups to test for HIV. For example, findings from ZIMPHIA suggest three-quarters (75%) of 25 to 29-year-old men had been tested and received their results, compared to 44% of adolescent men (aged 15 to 19). Similarly, around half (47%) of adolescent women (aged 15 to 19) had tested for HIV, compared to 90% of women aged 25 to 44.

It is thought that masculinity norms in Zimbabwe inhibit men from getting tested and engaging in treatment. However, conducting testing in men’s places of work can increase testing among men, with a 2013 trial reporting a 53% uptake when workplace testing was offered.

**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.

Through STAR, close to 1 million self-testing kits will be distributed in Zimbabwe by 2020. Interim results published in 2017 suggest STAR is working; 20% of those using self-testing kits were first time testers, 39% were aged between 16 and 24 and 35% were adult men. The findings also suggest relatively good linkages to care for men, with 80% of men testing positive via self-testing kits linked to treatment.

**HIV prevention programmes in Zimbabwe**

The number of people acquiring HIV each year is falling in Zimbabwe, although levels are still relatively high. In 2018, there were 38,000 new infections (33,000 among adults and 4,800 among children). In comparison, 62,000 people became HIV positive in 2010 (47,000 adults and 15,000 children).
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 developed a regional roadmap with South Africa and Kenya to increase HIV prevention services and investment. In 2017, the government published the Extended Zimbabwe National AIDS Strategic Plan III (ZNASP III), which will run to 2020. Some of its key strategies are discussed below.

Condom availability and use

The availability and distribution of condoms in Zimbabwe is good, with 120 million male condoms and 5.3 million female condoms distributed in 2017. 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. Use of condoms in multiple concurrent partnerships (when one or both partners have sexual relationships with other people) is thought to be 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.

In a 2017 evaluation conducted by the Zimbabwe National AIDS Council and partners, women and men indicated a dislike of the free condoms provided (a brand called Puma), reporting that they had an unpleasant smell and tended to break easily. The female condom was also disliked by both women and men.

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.

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.

Knowledge of HIV is poorer among young people, despite their elevated HIV vulnerability. In 2015, less than half of 15 to 24-year-olds had comprehensive knowledge about how to prevent HIV. In terms of individual questions, around nine out of 10 young people (87%) knew it was not possible to get HIV by sharing food with someone. However, only three quarters (75%) knew that a person can protect themselves from HIV by using a condom correctly every time they had sex.

Previously, a lack of lifeskills education and comprehensive social and behaviour change communication materials had been shown to prevent young people from having the knowledge they need to reduce their HIV vulnerability and prevent onward transmission.
To address this, the government has been rolling-out comprehensive sexuality education (CSE) in primary and secondary schools. Between 2015 and 2017, around 12,000 teachers were trained to deliver CSE and the topic is now included in national education curriculums, including a component on safe sex education. Other topics include sexuality, reproductive health, gender, rights, services and related lifskills. A programme aimed at reaching out of school youth has also been developed, and will be delivered by community-based youth leaders and mentors.

### 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.

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.

As part of this, community-based Behaviour Change Facilitators (BCFs) go door-to-door to speak to people about HIV and their risk of acquiring the virus. However, this has been found to be ineffective at reaching men and young people. As the BCFs are community volunteers there has also been an issue with their lack of capacity to address social and cultural factors that influence behaviour.

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

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

Since 2014 Zimbabwe has been rolling out Option B+, whereby HIV-positive mothers receive antiretroviral drugs for life in line with WHO treatment guidelines.

As a result, in 2018, over 94% of pregnant women living with HIV in Zimbabwe received antiretroviral treatment to prevent mother-to-child transmission. Testing rates among all pregnant women have remained steady in recent years at around 85%, meaning that a significant proportion of women are still unaware of their status and are not accessing treatment if needed.

In 2015, mother-to-child transmission was estimated to account for 6.39% of all new HIV infections in children aged 0-14 years. In 2017, this had risen slightly to 6.74%, however Zimbabwe still appears to be on track to achieve the global elimination target of less than 5% by 2020. As a result of this success, new infections among 0-14 year olds have fallen by two-thirds since 2010, from 15,000 to 4,800. However, despite the expansion of PMTCT services, only 63% of infants born to HIV-positive mothers received an HIV test within the first two months of life.
Voluntary medical male circumcision (VMMC)

Zimbabwe is one of UNAIDS’ priority countries for the scale up of voluntary medical male circumcision (VMMC), and VMMC being listed in the country’s current prevention strategy Zimbabwe. By 2018, Zimbabwe aimed to reach 1.3 million men with VMMC (80% of 13-29 year olds) By 2017, 89% of this target had been reached, and in 2018 around 326,000 men underwent VMMC. This means that, although accelerated, the number of men undergoing VMMC is still below target.

Access to VMMC is irregular between regions due to the limited number of health facilities offering the intervention. People’s awareness of the link between VMMC and HIV prevention is also relatively low. As a result, some areas are already at saturation level for VMMC among the main target age group (15 to 29-year-olds), while others very unlikely to meet programmatic goals. Overall, in 2017 VMMC coverage among men aged 15-29 was 33%, 16% among men in their thirties and 12% in men aged 40 and over.

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 run to this effect.

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.

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.

Zimbabwe’s current HIV prevention strategy lists priority populations for PrEP as being adolescent girls and young women, sex workers, men who have sex with men, prisoners, truck drivers, sero-discordant couples, transgender people and women in relationships with men of unknown status.

In 2018, around 4,900 people in Zimbabwe were accessing PrEP. Initially, PrEP was offered through the DREAMS partnership, meaning young women and girls have been the main beneficiaries. The key challenges for implementing PrEP in Zimbabwe relate to funding, identifying and agreeing on target populations and areas, and navigating existing limitations within health systems in relation to HIV services. In addition, the criminalisation and social exclusion of men who have sex with men and sex workers makes it difficult for programmes to reach them, despite them being named as priority populations.

One study examined the extent to which female sex workers in Zimbabwe are aware of, and using, PrEP. Around 61% of HIV negative sex workers participating in the study had heard of PrEP, around 29% had been offered it, and 16% were taking it. Those on PrEP were more likely to be older and were less likely to drink alcohol.
Antiretroviral treatment (ART) availability in Zimbabwe

Zimbabwe is one of the sub-Saharan African countries with the greatest access to antiretroviral treatment (ART), with 88% of all people living with HIV on treatment.71 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.72 Since 2016, between 120,000 and 150,000 adults have initiated ART each year.73 In 2018, it was estimated that 93% of all adult women living with HIV were on treatment compared to 83% of men.74 In 2016, the most recent data available, 67% of all women living with HIV were virally suppressed, compared to 67% of HIV positive men.75

Zimbabwe is currently scaling up viral load testing. The expansion was made possible as a result of South African negotiations with Roche – a leading producer of viral load testing platforms. They managed to agree a maximum price of US$ 9.40 per viral load test, making viral load tests more affordable for low and middle income countries.76 However, budgetary issues, weak infrastructure and capacity challenges means viral load testing is far from routine, and existing facilities are mostly located in cities.77 In 2017, around 431,300 people received a viral load test 78, equivalent to around 40% of people on treatment that year.79

In 2018, 76% of children (0-14 years) living with HIV had access to ART.80 It is hoped the introduction of specialised ARV pellets for children being piloted by Zimbabwe will increase treatment coverage for this age group further.81

A study of around 300 HIV-positive children in Zimbabwe found a third were being prescribed incorrect doses of at least one component in their ART regimen due to the diversity of the children’s body weights. However, those with access to a fixed-dose combination (FDC) antiretroviral (ARV) were less likely to have been given an incorrect dose. This highlights the importance of monitoring children’s weight during HIV care to ensure their treatment is effective and their risk of developing drug resistant HIV is reduced. It also suggests access to FDC ARVs should be improved for children.82

The proportion of people retained in care after 12 months is relatively good in Zimbabwe, standing at between 85% and 90% since 2011 (the 12 month retention rate was 87% in 2018).83 Both men and women have comparable HIV treatment retention rates, however children, adolescents and young people are less likely to stay in care.84

Drug resistant HIV is an issue in Zimbabwe. In 2018, the World Health Organization found levels of pre-treatment HIV drug resistance above 10% among those initiating first-line ART.85

CASE STUDY: Helping young positive adolescents in Zimbabwe stay in care

Zimbabwe has successfully introduced community adolescent treatment supporters (CATS) to help adolescents living with HIV stay in care. CATS are volunteer counsellors aged between 18 and 24 who are HIV positive themselves. They provide a range of peer support to others to help them start and stay in treatment.
A 12-month trial was conducted in Gokwe South district to assess the CATS’ impact among 10 to 15-year-olds living with HIV. Around 100 teenagers were enrolled in the trial, half received standard HIV care and half received standard care plus CATS services.

Those in contact with CATS were found to be 3.9 times more likely to adhere to treatment compared to the control group. The intervention group also reported a significant increase in confidence, self-esteem, self-worth and quality of life, compared with a decrease in the control group.86

“Seeing people I have helped, getting better, motivated me...through the training I received, I realised that one can live a normal life and pursue dreams of choice just like anyone else.” - Thabiso, 22, a CAT from Binga, Zimbabwe87

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.88

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.89

The ousting of President Mugabe by military coup in November 2017 has seen civil society further at threat. The elections in 2018, which returned the ruling Zanu-PF party, did little to resolve this. In 2019, CIVICUS described the state’s attack on civil society as “systematic”, reporting that CSOs across the country were facing an increase in surveillance, abductions, arbitrary arrests and detention. Under the Public Order and Security Act, the work of many CSOs that support and protect
vulnerable groups are now criminalised. Zimbabwe’s state-controlled media has also spread anti-CSO messages and a number of civil society activists have been arrested, some of whom have been charged with offences designed to criminalise human rights work.90 91

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.92 In 2017, 63% of people in TB care were HIV positive. Although the incidence of TB in Zimbabwe has increased dramatically in recent years, TB remains the most common cause of death for people living with HIV.93 In 2017, 6,300 people with HIV died of a TB-related illness, although this is an improvement from 2010 when 11,000 TB-related deaths among HIV positive people occurred.94 In 2017, 23,000 people living with HIV developed active TB, although coinfection rates are falling. 95 In 2014, around 15% of people newly enrolled in HIV care had active TB, compared to 0.5% in 2018. Only 11% of people living with HIV began TB preventative therapy in 2017.96

Barriers to the HIV response in Zimbabwe

Social and cultural barriers

The prolonged economic crisis facing Zimbabwe has seen resulted in many people being unemployed or working informally. Around 6 million are estimated to work in Zimbabwe’s informal sector, including roadside stallholders, miners and sex workers. Their line of work means they are unable to claim social welfare or qualify for health insurance schemes, making treatment access difficult. Many are also unable to visit health clinics as they cannot afford time off work.97

Gender-based violence (GBV) persists in Zimbabwe. Survey results from 2015 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. 98 GBV is closely linked to inability to negotiate condom use, and greater vulnerability to HIV. In 2015, around one in five women who had ever been married or partnered (aged 15–49 years) had experienced physical or sexual violence from a male intimate partner in the past 12 months.99

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.100 However, a new national survey in 2015 did not include data on this.

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 some form of discrimination due to their HIV status.101

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.102

The effects of stigma are far reaching. Around 40% of sex workers questioned said they avoid healthcare due to stigma and discrimination.103 Around 6% of people living with HIV report being denied some form of healthcare due to their positive status.104

Still the most current data

Funding for the HIV response in Zimbabwe

The Zimbabwean government collects an AIDS levy, made up of 3% payee and corporate tax, which contributes to Zimbabwe's domestic share of funding for the HIV response.105

However, in 2017, roughly two-thirds of Zimbabwe’s HIV response was still funded by international donors. Domestic funds contributed around US$127 million compared to US$289 million from international contributions, totalling US$417 million. The biggest funder of the country’s HIV response is the Global Fund to Fight AIDS, Tuberculosis and Malaria, followed by PEPFAR.106

The future of HIV in Zimbabwe

Prevention of mother-to-child transmission (PMTCT) services are proving successful, and this effort must be maintained in order to end child infections.

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, as does continued, persistent discrimination and criminalisation of men who have sex with men and others from the LGBT community.

Although improving, HIV education and knowledge is still lacking, especially for young people. This is especially important where patriarchy, gender inequality, polygamous relationships and intergenerational relationships 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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