



## HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
<b>Total Population*</b>	11.7 million (mid-2010)
<b>Estimated Population Living with HIV/AIDS**</b>	1.02 million [930,000–1,150,000] (2010)
<b>Adult HIV Prevalence**</b>	13.6% [12.7–14.7%] (2010)
<b>HIV Prevalence in Most-at-Risk Populations***</b>	Female Sex Workers: 57.2% (2005)
<b>Percentage of HIV-Infected People Receiving Antiretroviral Therapy****</b>	17% (end 2007)

\*U.S. Census Bureau \*\*Zimbabwe National EPP-Spectrum Estimates 2009 \*\*\*UNAIDS  
 \*\*\*\*WHO/UNAIDS/UNICEF *Towards Universal Access*, 2008

The first reported case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, approximately 10 percent of the adult population was infected with HIV. This figure rose dramatically in the first half of the 1990s, peaking at more than 36 percent between 1995 and 1997. Since the late 1990s, prevalence has been consistently declining. With a national adult prevalence of 15.3 percent at the end of 2007, Zimbabwe was one of the 10 highest-prevalence countries in sub-Saharan Africa. According to national estimates, prevalence decreased to 13.6 percent in 2010. The epidemic has reduced life expectancy, deepened pervasive poverty among vulnerable households and communities, skewed

the size of populations, undermined national systems, and weakened institutional structures. However, it can be difficult to disentangle the epidemic's effects from other social and economic changes that occurred over the last two decades.

Surveillance data from several studies suggest a trend of declining prevalence, which has been observed among men and women in rural areas and in pregnant women. Among the latter, HIV prevalence declined from 17.7 percent in 2006 to 16.1 percent in 2009. A similar decline occurred in the 15 to 24 age groups, where prevalence dropped from 12.5 percent in 2006 to 11.6 percent in 2009. The epidemic is believed to be declining as a result of prevention programs, changes in sexual behavior, and increases in the availability of prevention of mother-to-child transmission (PMTCT) of HIV services. Mortality among cases diagnosed during the epidemic's peak also contributes to reduced prevalence. The World Health Organization (WHO) reports that average life expectancy at birth for women in Zimbabwe – 43 years – is among the lowest in the world; for men, it is estimated to be 44 years.

According to the Zimbabwe National AIDS Council (NAC), factors contributing to the rapid spread of HIV and the sustained high level of HIV/AIDS in the country include high prevalence of other sexually transmitted infections; low levels of male circumcision; high rates of multiple concurrent sexual relationships; low, incorrect and/or inconsistent condom use; the low socioeconomic status of women; settlement patterns and mobility; poverty; and distressed economic conditions in general. The United Nations Development Program (UNDP) reported in 2007 that 94 percent of the population was without a job and almost 50 percent were in need of food aid. Food shortages, impoverishment, forced removals, and drought have compelled hundreds of thousands of Zimbabweans to migrate in search of livelihood opportunities.

The country's weak economy and hyperinflation, coupled with the collapsed health system, have compromised spending on health services, and many international donors have scaled back support due to uncertain political conditions. The country has substantial human resource shortages and continuing challenges due to the decay of health facilities, which also face severe shortages of essential supplies, suffer from frequent breakdowns of equipment, have poor transport and communications support, and must cope with the mass exodus of trained health workers. The low rate of antiretroviral therapy (ART) coverage for people living with HIV/AIDS (PLWHA) – 17 percent in 2007, according to the WHO/UNAIDS *Towards Universal Access* report, and the lowest of any country in southern Africa, according to *The Lancet* – is a reflection of these conditions. As of 2010, more than 590,000 persons need ART, but fewer than half receive treatment. According to the Ministry of Health, ART coverage was 44 percent in May 2010.

The primary mode of HIV transmission in Zimbabwe is heterosexual contact, and women are disproportionately affected by the disease. According to estimates of the Joint United Nations Program on HIV/AIDS (UNAIDS), almost 60 percent of Zimbabwean adults living with HIV at the end of 2006 were female. This gender gap is even



wider among young people, with prevalence among young women 15 to 19 years of age (6.2 percent) two times higher than prevalence among young men of the same age (3.1 percent); prevalence in 20- to 24-year-old women (16.3 percent) is nearly threefold that in same-aged men (5.8 percent). For youth who have had sex, 16.6 percent of young women were HIV positive compared with 6 percent of young men. However, prevalence among young women seen at antenatal clinics decreased, from 20.8 percent in 2002 to 11.6 percent in 2009. The economic environment has also forced many women to engage in cross-border trading, exposing them to risks of sexual and other forms of abuse during the course of their work.

High-risk groups, including migrant laborers, commercial sex workers, girls involved in intergenerational sexual relationships, discordant couples, and members of the uniformed services, warrant special attention in Zimbabwe's fight against HIV/AIDS. Low rates of condom use among sex workers (42.3 percent for male sex workers and 38.3 percent for female sex workers at last encounter, according to a 2009 behavioral survey), coupled with unclear policy guidelines for the

protection of this subpopulation present a challenge. Though the country has allowed informal lobby groups for high-risk populations to exist, there are no legal frameworks targeting high-risk groups like sex workers, prisoners, men who have sex with men, or injecting drug users. The International Organization for Migration offers select outreach services to high-risk populations, primarily at border posts.

Children in Zimbabwe are affected by the epidemic by contracting the disease from their mothers and/or by losing a parent to the disease. At the end of 2009, approximately 1 million children under age 18 had been orphaned by AIDS, according to Ministry of Health and Child Welfare (MOHCW) estimates. The Government estimates that one in four children under 18 has lost one or both parents to HIV. An estimated 152,000 children under age 15 are HIV positive, and, according to UNAIDS, HIV is the underlying cause of more than one-third of all deaths among children under age five.

The traditional extended family and other support systems are overwhelmed by this situation. The majority of these children have no extended family networks to rely on following the death of their parents. The elderly have also been affected by the AIDS-related deaths of their grown children who had previously supported them, and, according to the United Nations Children's Fund (UNICEF), 40 to 60 percent of orphans in Zimbabwe are now cared for by their grandmothers. The percent of orphans and vulnerable children (OVC) reached by support services has been declining due to the impact of hyperinflation on national budgets, further burdening those caring for children orphaned by HIV.

PLWHA are particularly vulnerable to developing drug-resistant tuberculosis (TB) because of their increased susceptibility to infection and progression to active TB. TB is one of the main causes of death for PLWHA. According to the WHO, Zimbabwe is one of 22 high-burden countries for TB, with an estimated 760 cases per 100,000 population in 2008. TB-HIV co-infection is also extremely high, with estimates as high as 68 percent.

## National Response

The Government of Zimbabwe has demonstrated commitment and leadership on the national response to HIV/AIDS. The NAC, created in 1999, continues to combat the spread of HIV. In 2008, this board was restructured to include representation from the labor and business sectors and PLWHA, and to increase women's representation from two seats to three. Despite several economic challenges, Zimbabwe was the first country in the world to introduce a 3 percent levy on taxable income from all sectors to mitigate the impact of HIV/AIDS. Funds are channeled to the NAC by the Ministry of Finance. In 2009, the Government contributed \$7.5 million from the national budget to support HIV/AIDS programs, and the AIDS levy contributed an additional \$5.1 million.

The NAC and the HIV/AIDS and TB directorate of the MOHCW oversee the implementation of the National HIV/AIDS Strategic Plan (2006–2010). The overall goals of the Plan are to reduce the spread of HIV; improve the quality of life of those infected and affected; and mitigate the socioeconomic impact of the epidemic. A core goal of the plan is to ensure universal access to care and treatment. In order to achieve these goals, the following four main strategies have been agreed upon: 1) HIV prevention to reduce the number of new infections, with a focus on behavior change promotion; 2) increased access and utilization of treatment and care services; 3) improved support for individuals, families, and communities, including OVC infected with and affected by HIV/AIDS; and 4) effective management and coordination of the national HIV/AIDS response, including resource mobilization. The Strategic Plan is complemented by the National Behavior Change Strategy (2006–2010), which recognizes the

need to move from awareness to action by providing guidance to all stakeholders on their contributions to behavior change promotion.

The Government's approach is integrated to include prevention, care, support, and treatment and recognizes that HIV/AIDS is a national emergency. It emphasizes a multisectoral approach that includes promotion and protection of the human rights and dignity of PLWHA; avoidance of stigma and discrimination; and recognition of the need for gender sensitivity and respect for the rights of children and young people. The Plan for the Nationwide Provision of ART (2005–2007) was finalized in December 2004, and followed by a national plan for 2008 to 2012. Trade policies and use of local manufacturers of antiretroviral drugs (ARVs) began in 2008, which helped improve the supply of ARVs in 2009 and minimize stock-outs. Funding gaps and insufficient ARVs are still barriers to achieving universal access to ART. New 2009 WHO recommendations on the appropriate CD4 count for initiating treatment increase the number of PLWHA in need of ART, creating additional challenges for universal access.

In mid-2007, the International Labor Organization and the Swedish International Development Agency introduced a two-year program for employers and workers' organizations to design and implement effective HIV/AIDS workplace policies and programs. Using a range of behavior change strategies and other interpersonal interventions to increase knowledge and awareness of HIV, the project brings workers and employers together to build capacity and achieve a common goal of protection against HIV and its impact. The initiative is led by the Employers' Confederation of Zimbabwe and the Zimbabwe Congress of Trade Unions. Workers' unions have set up drop-in centers for their members in six regions around the country, and employers have embraced the theme of "Making HIV and AIDS a Boardroom Issue," ensuring HIV issues are included in all key employer activities.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has disbursed \$66.6 million since 2005 to support HIV/AIDS programs in Zimbabwe. Most recently, the country received \$20.1 million from an eighth-round grant administered through UNDP. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

## **USAID Support**

Through the U.S. Agency for International Development (USAID), Zimbabwe received \$27.2 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Zimbabwe are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In Zimbabwe, assistance has always been integrated into the country's national program to mitigate HIV/AIDS. PEPFAR activities cover all regions and are organized around three main technical areas: 1) strengthening and intensifying systems for prevention, care, and treatment services; 2) developing innovative, evidence-based program models and tools that will be expanded to national scale with leveraged resources; and 3) developing technical and organizational capacity of indigenous organizations to scale up and sustain programs. In addition to contributing directly to the country-led HIV/AIDS program, USAID closely coordinates with other donors to identify opportunities for complementary support of common HIV/AIDS mitigation goals. These efforts have produced active collaborative support approaches with USAID, UNFPA, WHO, the Global Fund, and UNICEF.

Due to the generalized HIV epidemic, the USG's HIV/AIDS activities are critical to the successful implementation of the entire country assistance portfolio. USAID provides HIV/AIDS support to Zimbabwe both on a bilateral basis and through its Regional HIV/AIDS Program for Southern Africa. The Mission has worked to create synergies with other programs in-country, integrating HIV outreach with other health services. Major emphasis is placed on efforts to address TB-HIV co-infection and integrate family planning services with voluntary counseling and testing (VCT) and PMTCT activities. Program linkages with the humanitarian assistance portfolio include targeted feeding programs for OVC, HIV-infected and -affected households, ART recipients, and infants who benefit from the PMTCT program. USAID has also enhanced the capacity of civil society organizations that engage in HIV/AIDS issues. Other USG activities include HIV/AIDS counseling and testing services; social marketing of condoms; strengthening the capacity of civil society to formulate and advocate for improved HIV/AIDS policies; support for community responses to the needs of OVC; and support services for those living with HIV/AIDS. USAID supports PMTCT efforts and scaling up ART interventions. USAID assistance accounts for nearly all male and female condoms distributed through both public and private sector channels in the country.

In 2009, additional successes from USAID and PEPFAR assistance included:

- provision of ARV prophylaxis for PMTCT to more than 17,700 pregnant women
- delivery of ART to 40,000 people in 2009 and to 59,000 as of March 2010
- palliative care services for 118,000 new clients
- approximately 59,000 OVC served by support programs
- counseling and testing for more than half (345,000) of all VCT clients in the country
- more than 580,000 persons reached with prevention communication messages through community outreach
- more than 88 million male condoms and 2.5 million female condoms distributed through public and private sector channels

USAID's HIV/AIDS assistance also strengthens health systems within Zimbabwe. A particular focus for strengthening is the national health logistics system, which provides essential drugs and supplies to more than 1,600 health facilities across the country. To improve the health workforce, USAID-supported programs trained more than 6,000 persons in HIV/AIDS service delivery skills in 2009. These achievements represent significant progress toward the development and implementation of a comprehensive HIV/AIDS prevention, treatment, and care program in Zimbabwe, despite the difficult operating environment.

### **Important Links and Contacts**

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USAID's Regional HIV/AIDS Program for Southern Africa

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[http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/saregional.html](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/saregional.html).

USAID's HIV/AIDS Web site for Zimbabwe:

[http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/zimbabwe.html](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/zimbabwe.html).

For more information, see USAID's HIV/AIDS Web site: [http://www.usaid.gov/our\\_work/global\\_health/aids](http://www.usaid.gov/our_work/global_health/aids).

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