TRANSLATING SCIENCE TO END HIV IN SOUTHERN AFRICA

AIDS 2018 POST-CONFERENCE SYMPOSIUM

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HIV in Zimbabwe

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Background

• HIV in Zimbabwe emerged in the 1980s fuelled by high risk migrant labour & sex work
• In early 90s infection ‘crossed’ to low risk the general population
• By 1995 infections peaked at incidence of 5% and prevalence was estimated at 28%
• Since 2004 the country has experienced steady decline in both incidence & prevalence
Zimbabwe Current (2018) HIV Estimates

Person living with HIV

Total: 1,361,055
Adults: 1,249,172
Adolescents: 74,460
Children: 76,650

Prevalence 14.04 %
Incidence 0.49 %
Final MTCT rate 6.74 %

Number of PLHIV

- New HIV Infections
- Total Deaths (All Causes) Among PLHIV

Year: 1990 - 2018
Number of PLHIV: 0 - 326,095
Geographic variation exists in the distribution of HIV burden

• These measures of disease rates by district show the generalized nature of our epidemic and present opportunities to conduct geographical targeting of interventions

• HIV Hot spots should be prioritized for investments in both prevention and treatment. In addition, further risk analysis is needed to understand the risk
HIV prevalence peaks at nearly 30 percent for both females (29.8 percent) and males (28.7 percent), but occurs at a slightly older age among males (45 to 49 years) as compared to females (40 to 44 years). The disparity in HIV prevalence by sex is most pronounced among young adults: HIV prevalence among 20- to 24-year-olds is three times higher among females (8.5 percent) than males (2.7 percent).

Source: ZIMPHIA 2016
Summary: Sources of HIV infection in Zimbabwe 2010: Estimates based on various sources

80% of infections among adults 1)
47,309 adult (15+) infections

72% infections through heterosexual contact 2)
co-facilitated by low levels of male circumcision & low risk perception

20% casual heterosexual 2)
44% low-risk heterosexual 2)
(~ 43% other short & long-term multiple concurrent/serial relations)
(~ 21% within serodisc. couples 3)

22% vertical transmission

3% MSM
2% IDU 1%
8% sex work + clients + partners 2)

20% among children 1) (14,152)
1% Abuse, early sex / marriage
% blood/injections >1%

Sources:
1) Zimbabwe National HIV Estimates 2009
2) 2010 Modes of Transmission Analysis (cited from ZNASP)
3) Based on DHS 2005/6 calculated 1.4 million couples, 13.3% sero-discordant, ie 189,000 discordant couples, annual transmission: 9%; the proportion of all infections refers to 2005/6 and may have changed since then!
The ‘Highway of HIV Transmission’

Multiple Concurrent Partnerships
Combined with:
- Low risk perception in long-term relationships
- Low condom use in long-term relations
- Low levels of male circumcision
- “Dry sex”?
- Early debut
- MTCT
- Cross-generational relations

Underlying vulnerability factors:
- Gender imbalances
- Stigma
- Mobility

Sex work
Serial casual relations
STIs (HSV-2)
Zimbabwe adopted a multi-sectoral and multidisciplinary response to the HIV epidemic. Implementation is guided by the international commitments (SDGs, UHC etc), ZNASP III, eMTCT strategy, Combination HIV prevention Strategy.

A public health approach to scale up of HIV prevention, care & treatment:
- Population based
- Evidence based
- Simplified tools and guidelines

Implementation is undertaken in the context of a comprehensive combination HIV prevention, treatment, care and comprehensive HIV support package that addresses all.

Combination prevention refers to a systematic approach to implementing a range of HIV prevention interventions: behavioural and biomedical in synergy with structural...
Combination HIV Prevention Strategy - Priorities

Core Program Areas
- HIV Testing Services
- Behavior Change & Demand Creation
- e-MTCT
- Condoms
- Prevention with Positives
- Male Circumcision

Delivered in Combination (wherever efficient) through:
- Biomedical
  - Service provider capacity
  - Referral system/integration
  - Service models
- Combined communication (behavioral)
  - Mass media
  - Interpersonal
  - Sexuality education
  - Advocacy with leadership
- Combined enablers/synergies/policy advocacy (structural)
  - Gender equity
  - Health systems
  - Community systems
  - Social protection and education
  - Legal and policy reform;

Adjusted to the needs and involving:
- Adult men
- Adult women
- Adolescent girls young women
- Young men
- Children
- Sero-discordant couples/PLHIV

Key Populations:
- Sex workers
- Prisoners

Considering age groups and areas most affected.
REVITALISING PREVENTION IN ZIMBABWE

- Set clear goals for revitalising prevention
- Advanced shifts in HIV prevention paradigms
- Deliver on agreed prevention outputs & outcomes
- Focus on hotspots, key populations & programmes that maximize impacts
- Fast track combination prevention pillars
- Improve management and coordination of HIV prevention intervention
- Increase efficiency in delivery
- Strengthen HIV research, monitoring and evaluation
Every child deserves an HIV-free beginning.
- The Global Plan spurred remarkable progress, reducing new HIV infections among children by 60% in 21 of the highest burden countries in sub-Saharan Africa.
- In 2015, 110,000 children were newly infected with HIV in these 21 countries, and 150,000 worldwide. Elimination of new HIV infections among children is possible.

When children have an HIV-free start, we must support them to stay that way as they enter adolescence and age into adulthood.

Everyone who is living with HIV should have access to antiretroviral treatment to stay AIDS free and reduce their risk of onward transmission to an uninfected partner.
- Children and adolescents are easily left behind and the impact is devastating.
Zimbabwe has made progress in controlling the HIV epidemic and achieving the 90-90-90 Fast Track targets.

- The biggest gap to achieving the 90-90-90 targets is in **testing**.
- The new national HTS Strategy (2017-2020) shifts focus from testing for coverage to targeted testing for identification of those living with undiagnosed HIV.
Though prevention gaps persist, the treatment cascade suggests the country is on track to achieve the 90-90-90 targets. As of 2016,

- 74.2% of all PLHIV know their status, (Gap 15.8 %)
- 86.8% of those are on treatment (translating to 879,271 people as of 2015)
- 86.5% of people on treatment are virally suppressed
Evidence of Progress by age

• However, men and young people still experience lower level of testing: 42% of women 15-24 and only 26% of men 15-24 had tested in the last 12 months in Zimbabwe.

• Nearly half of young people (15-24 years) living with HIV in Zimbabwe do not know their status.
Despite progress among gen populations ...... significant gaps still exist for key pops
1st 90 (reducing new infections)

– 90% of persons at risk of HIV have access to comprehensive HIV combination prevention services including all key populations
– 90% of young persons have skills, knowledge and capacity to protect themselves from HIV
– Ensure universal access to quality and affordable SRH services
– ensure access to Harm reduction programmes
– Expand access to combination prevention
– Strengthen HIV Testing Services
  • Expand existing HTS, strengthen HIV Index case testing & HIV self testing, and Targeted testing for key populations and other priority groups (AGYW, Men, STI clients, IDUs)
2\textsuperscript{nd} 90 (ART programme)

- Introduced in 2004
- Use a standardised public health approach
- On ART 1 019 854 \((\text{October 2018})\)
- Coverage \((\text{March 2019})\)
  - Adults 85%  
  - Children 79%  
  - Loss to follow 7.1%

- Adopted 2016 WHO guidelines in 2017, \((\text{treat all, use of more efficacious regimens and VL for monitoring})\)
- Rx decentralised to primary care and optimised through DSD
- DTG in use since 2019
Current National ART Coverage by Age/Sex

Source: PLHIV Denominator Spectrum 2019 and Numerator Program Data
Rates of ART Retention in Zimbabwe, 2013-2015

Source: Zimbabwe MOHCC, 2016
ART retention at 12 months among adolescents & young people still relatively low.

Retention in ART care (%)

- 3 months
- 6 months
- 12 months

Time since ART initiation (in months)
- 0-9 years
- 10-19 years
- 20+ years

NB: Age groups exclude pregnant women at ART initiation

Barriers to Retention
- Parent/caregiver interpretation of health status of child
- Understaffing at clinics
- Long clinic wait times
- Advanced Disease
- Inadequate clinical/laboratory services
- Malnutrition
- Mental health problems
- Proximity to clinic
- Stigma
- Age (<2yo)
- Loss of caregiver
- Lack of Disclosure
- Economic Barriers (transport costs and caregiver's lost wages)

B. Phelps, Linkage, initiation and retention of children in the antiretroviral therapy cascade: an overview, AIDS. Nov 2013; 27.

ART Outcome Study Report, 2016
### Innovations to reach 2nd 90

#### Treat All
- Adopted treat all in phased approach since 2016
- Targeting back to care clients on pre-ART and newly diagnosed clients
- Initiations expedited within a week and latest by 2 weeks from identification
- Counselling tailored to ensure client readiness before initiation
- Treatment optimization

#### Community based ART initiation
- Country piloting community based ART initiation targeted at clients identified within community
  - Index case testing
  - Outreach testing
- Clients followed up within community until ready to attend follow up at the clinic
- Referral to clinic should be completed by 6 months from initiation

#### Expert clients
- Facilities identify experienced clients who have been in care and doing well
- Expert clients trained to offer counselling and treatment support
- Expert clients assist with counselling newly diagnosed clients
- Expert clients escort clients from testing point to enrolment point to reduce attrition before enrolment
- Community Adolescent Treatment Supporters (CATS)
Innovations for reaching 3rd 90

- Maximise adherence counselling & support
- Reliable & uninterrupted supply of HIV medicines
- Strengthen community support systems
- Reduce stigma & discrimination
- Guidance on VL monitoring

- Community Adolescent Treatment Supporters (CATS)
- Differentiated Service delivery
- Support groups/Peer support
- Treatment literacy awareness
Some key issues for consideration?

• Quality of care
  – Patient centred care, effective, accessible, efficient, safe, equity
  – Enhancing adherence and retention in care
• Strengthened M&E systems to meet 90-90-90 targets
  – Case based surveillance
• Strengthen laboratory systems & quality assurance
• Human Resources for Health
  – Implementation of Differentiated Service Care models
• ‘Greater involvement’ of the communities in HIV response
• Pharmacovigilance & monitor for HIV drug resistance
Parting shots!
– no one left behind

• **Prevention! Prevention! Prevention! Works**

• **Design & develop HIV programmes** to respond to the needs of the beneficiaries especially programs for key populations, AGYW

• **Coverage** : continue to scale up services to attain coverage
  – To effectively and adequately reach all populations (including all key & at risk populations)

• **Design strategies** to address the major obstacles in reaching key populations, AGYW
  • review, changed & introduced policies, guidelines and strategies to facilitate an enabling environment
‘No one is left behind’

- Mobilize resources needed to achieve the fast track targets and ending AIDS by 2030
- **Strengthen Strategic Information Systems** across all HIV programmes to improve data for decision making
- **National ownership** of all HIV programs to avoid duplication, standardize approaches and maximize impact
- **Involve communities** in program design, implementation and review e.g. for programs targeting AGYW, key pops, pregnant women
Thank You:

Know Your Status

Mystatus, MyHealth, MyLife