30 Years into the HIV Epidemic: Experiences by PLHIV in Zimbabwe and opportunities for ending AIDS by 2030

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Abstract
Zimbabwe has been one of the countries with the highest HIV burden in Southern Africa over the 30 year period that HIV and AIDS have been causing havoc to the nation. Zimbabwe has an estimated 1.2 million people living with HIV, with a prevalence rate of 13.7% according to 2015 estimates. Zimbabwe HIV epidemic is dynamic and heterogeneous. With increased amount of strategic information made available on the epidemic from 1985 when the first case was identified. Tremendous progress has been made in raising awareness about HIV, through behavior change programmes implemented among other prevention programmes. Stigma and discrimination was also reduced over time due to availability and access to information by the general public.

The government of Zimbabwe through an act of parliament introduced the AIDS levy which is administered through National AIDS council in an effort to fight the scourge. Civil society play a bigger role in the fight though voluntary work within communities. United Nations and the global community embarked on strategies to end AIDS by 2030 and the 90/90/90 targets by 2020 which includes up scaling HTS through self testing and decentralizing ART to more than 1560 sites in Zimbabwe. Reduction of the pill burden has a remarkable acceptance from within communities of PLHIV. As Zimbabwe adopted and domesticated firstly the 2013 and now the 2015 WHO guidelines including Option B+, this is widely seen as the positive steps towards ending AIDS by 2030 and the achievement of the 90/90/90 targets. Communities and networks of people living with HIV play an integral part in harnessing social capital which is critical for the achievements of the goals set. Opportunities to end AIDS have been explored. Treatment literacy and stigma reduction activities will go a long way in achieving the set targets.

Key words: CD4 count, HIV Transmission, HIV Self testing, Stigma, Viral load

LIST OF ACRONYMS
AIDS Acquired Immune Deficiency Syndrome
ANC Antenatal Care
ART Antiretroviral Therapy
ARV Antiretroviral
HIV Human Immunodeficiency Virus
HTS HIV Testing and Services
IEC Information Education Communication
M&E Monitoring and Evaluation
MOHCC Ministry of Health and Child Care
MNCH maternal, newborn and child health
MTCT Mother to child transmission
NAC National AIDS Council
NATF National AIDS Trust Fund
PLHIV People Living With HIV
PMTCT Prevention of Mother-to-Child Transmission of HIV
POC Point of care
PSS Psychosocial Support
TB Tuberculosis
UN United Nations
VL Viral load
WHO World Health Organisation
ZDHS Zimbabwe Demographical Health Survey
ZNASP Zimbabwe national AIDS Strategic Plan

Introduction
Zimbabwe is one of the countries with the highest HIV burden in Southern Africa with an estimated 1.2 million people living with HIV in the country. The majority of people living with HIV (PLHIV) in the country are between the ages of 15 and 49 years. The predominant mode of HIV transmission in Zimbabwe is sexual (primarily heterosexual) followed by vertical transmission during pregnancy, childbirth and breastfeeding. Antenatal sentinel surveillance has reported a decline from 25.7% in 2002, 21.3% in 2004, 17.7% in 2006 and 16.1 in 2009 and a continued decline over the years. The Zimbabwe demographic health survey (ZDHS) has also shown a similar decline in HIV prevalence in Zimbabwe from 18.1% (2005/2006) to 15.2% (2010/2011) as depicted below.
Several epidemiological studies in Zimbabwe have supported the conclusion that HIV prevalence has steadily declined since the late 1990s. This has been made possible by various interventions in Zimbabwe by the local NGOs, INGOs, private sector and the Government of Zimbabwe. Data has shown however that of the 15-24 age group girls have higher prevalence rate than boys of the same age 12% and 8% respectively. This is attributed by the age mixing with girls and young women going out with men who are much older than them and commonly known as the sugar daddies. Another dimension is for HIV new infections being noticeably higher in long term unions like marriages. This has been as a result of poor condom use in extra marital relationships due to poor personal risk assessment. Correct and consistent condom use has been seen as the greatest challenge in long term love relationships where one or both partners have other partners hence the slow prevalence decline in those circumstances.

2015 marked exactly 30 years after the first case of HIV was diagnosed in Zimbabwe. The first PLHIV in Zimbabwe was confirmed in 1985. From then onwards more patients began to present with illnesses suggestive of HIV infection (opportunistic infections) and these included severe respiratory infections, herpes zoster, persistent generalised lymphadenopathy and diarrhoea associated with weight loss.

The view that HIV was mainly spread through sex attached a great deal of stigma to HIV and AIDS. In the absence of a cure or vaccine people felt that getting a positive HIV result was like getting a death sentence. Stigma and discrimination for PLHIV permeated every space from the workplace to the family. A person living with HIV was shunned by family, friends and the community at large and this greatly hindered disclosure and demand for VCT services - an entry point into care.

Most people living with HIV suffered silently because of this fear of stigma. The 1988 ZDHS revealed that only 8.3% of respondents felt that an HIV positive teacher who is not sick should be allowed to continue to work. Thanks to the efforts that have gone into awareness raising, the situation has gradually improved over the years as reflected by a change to 42.4% (1999 ZDHS), 71.4% (2005-6 ZDHS) and 97.9% (ZDHS 2010-11).

Overall, there is still more to be done on stigma. The combined measure for stigma revealed stigma levels of 82.9% (2005-6 ZDHS) and 60.2% (2010-2011 ZDHS). The stigma index research for Zimbabwe also revealed that overall 65.5% of PLHIV reported that they had experienced one or more forms of HIV-related stigma and discrimination.

In 1992 a group of 12 PLHIV made history by openly disclosing their status and started the first support group. This encouraged others to come out into the open and seek services. In 1999, in an effort to bolster the national response to HIV and AIDS, the Government of Zimbabwe (GOZ) introduced, through an Act of Parliament, the National AIDS Trust Fund (NATF) also known as the AIDS levy, a 3% tax on all taxable income, introduced, through an Act of Parliament, the National AIDS Trust Fund. The NATF is administered by the National AIDS Council (NAC) that was created through the 1999 Act to support the national response to the HIV/AIDS epidemic.

The country has seen a steady decline in HIV prevalence among the general adult population from over 25% in 2002 to 18% in 2005-6 and finally to 15% in 2010-11. During the 2010-11 survey; it was found that 18% of women and 12% of men were infected with HIV with prevalence being highest among those who were widowed and those who were divorced or separated. Among respondents aged 15-49 years, HIV prevalence was higher in urban areas than in rural areas (17% versus 15%) with differences observed by province as well. Matebeleland South had the highest prevalence at 21% while Harare had the lowest at 13%. Among couples, 79% of the couples were both HIV negative and in 10% of the couples both partners were HIV positive while 12% of couples were reportedly discordant (meaning one partner was infected and the other was not). Six percent of young people aged 15-24 were HIV-positive. Today there are over 5000 support groups of PLHIV providing PSS and treatment adherence support to members.

ACCESS TO CARE AND TREATMENT SERVICES

Only a few PLHIV with money could access ART in the early years. A draft “Plan for the Nationwide Provision of ART” of 2001-2002 called for a detailed implementation strategy to be developed for all aspects of ART. The 2001–2002 plan recommended that ART be introduced initially at a limited number of central sites and gradually decentralized to the provinces as more health personnel receive in-service training. The first four “pilot” hospitals were Harare and Mpilo Central hospitals, Wilkins Infectious Diseases Hospital, and the Genitourinary Centre in Bulawayo. Today the ART programme has expanded to over 1560 health facilities in Zimbabwe with PLHIV on treatment which made it possible for PLHIV to access treatment at their door step, a great achievement.

Opportunities for ending AIDS by 2030;

The new WHO targets

The UN launched 90-90-90 ambitious targets among adults and children living with HIV there is need to look at how best this can be achieved through a multi-sectoral approach. It is achievable if we leave no one behind and use the all inclusive approach. Below is how this can be done;

90% PLHIV know their status Environment free of stigma and discrimination

This is achievable through advocating for favourable policies to encourage HTS and contributing to a favourable environment to encourage disclosure among spouses, parents and children, partners before marriage ( in cases of adolescence born with infection). Testimonial from children (parents not telling children of their status Demand creation for HTS is done by PLHIV with emphasis on HIV exposed children. Demand Creation for Option B+ retaining the patients, testing HIV exposed children. The following are issues for advocacy if we are to achieve the first 90 targets

90% of all People diagnosed with HIV will receive sustained antiretroviral therapy

This is achievable through vigorously advocating for an enabling environment addressing the following factors;

- Availability- stock raptures, shortages of regency of CD4 count machines, human resources at institutions. Viral load testing machines, cancer screening. Accessibility – distances and waiting time

- Appropriateness- pill burden and reported side effects. The availability of an electronic system for patient management system

- Acceptability- perception among PLHIV and social accessibility ( herbs and spiritual interventions

- Affordability- transport, treatment of opportunistic infections, diagnostic services, user fees

- Institutional factors- attitudes from service providers, waiting periods, separating the paediatric, adolescence and adults,

- We need to strengthen disaster management systems to cater for ART patients in light of floods and other disasters that have been recurring for the past 5 years

- Coming up with support systems for children and adolescent that is relevant to the time

90% of all people receiving antiretroviral therapy will have durable suppression

To achieve this target the following are essential;

- Treatment Literacy- Community initiated ART adherence support system should be strengthened.

- Eliminate the number of the loss to follow up ensuring ART retention

- Drug adherence must be improved
• Counselling and support systems- revising the support group module in line with changing times ( e group)

Decentralisation of Viral load testing (action plan for ZIM 2015-2018)

WHO is recommending VL testing as the gold standard for monitoring response to ART medicines and this should be done routinely once a year. Due to limited resources, Zimbabwe will do targeted VL testing until such a time when the country can afford routine VL testing. A rational deployment and integration of conventional and POC platforms would provide full access to viral load testing and avoid the mistakes made with CD4. Like POC CD4 products, POC VL products will be placed in sites with limited infrastructure, limited logistical access, and lower cadres of healthcare workers. POC VL when it becomes available, will unlikely be appropriate for very high volume facilities especially at provincial and district hospitals where close to 50% of HIV patients access treatment. Access to conventional testing deployed here now will positively impact a significant proportion of patients and is likely to remain relevant for the foreseeable future. Based on the conventional VL platform patients detected as having signs of failure under targeted algorithm including Clinical failure, Immunological failure and <95% adherence can be attended to at POC. This then improves adherence and improved well being for PLHIV.

Prevention of mother to child transmission (PMTCT)

Adoption of the option B+ Lifelong ART to eligible HIV positive pregnant women in need of treatment for their own health (critical need for a CD4 count) ARV Prophylaxis provision of ARVs to prevent HIV transmission from mother-to-child are the two main approaches being used. P& WLHIV with advanced HIV disease (WHO clinical stage 3 and 4) or those with a CD4 count of 350 or less irrespective of clinical stage need to go on lifelong ART for their own health and also for PMTCT. Eligible HIV positive P&L women will be initiated on lifelong ART with Tenofovir/ Lamivudine/Nevirapine HIV positive pregnant women who meet criteria for ART are the sub-group of women most likely to transmit HIV to their infants “the high transmitters” as they have high viral load account for >75% of MTCT risk, account for > 80% of postpartum transmission. Strong benefit for maternal health and PMTCT (lowers VL during pregnancy, L&D and breastfeeding decrease in 12-month infant mortality in recognition of this, MOHCC has introduced ART in MNCH settings (to minimize missed opportunities) As a recommendation, all pregnant and breastfeeding women infected with HIV should initiate triple ARV’s (ART), which should be maintained at least for the duration of mother-to-child transmission risk. Women meeting treatment eligibility criteria should continue lifelong ART. PMTCT prevents mother to child transmission in future pregnancies and reduces potential risks from treatment interruption

Decentralisation of ART

Decentralisation of ART has been a great success in Zimbabwe enabling PLHIV to travel shortest possible distance to the nearest health facility to get ART medication. This has been achieved through training of health personnel manning primary health care facilities and the improved pharmaceutical supply chain management. Medicines are now available at the patients’ door steps. This is a good opportunity to reduce new infections and ending It is our hope that community-based HIV testing and counselling that is linked to prevention, care and treatment services will be UPScaled in Zimbabwe to increase HIV testing and counselling in addition to provider-initiated testing and counselling.

Testing and treat and the role of civil society

HIV testing is the cornerstone of the UN launched 90-90-90 initiative, which aims to ensure that 90 percent of everyone living with HIV know their HIV status by 2020, and that 90 percent of those individuals are on ART and 90 percent of individuals on ART are virologically suppressed. Civil society and networks of people living with HIV are essential to the roll-out and implementation of HIV test and treat as part of a programme and within the context of research. Civil society offers an in-depth knowledge of experience to ensure it is implemented in a quality way. This is to ensure that test and treat information is reaching to people and providing the community with important messages on what HIV test and treat is, this includes self testing what it is , how it can be done and should be used, and where to access confirmatory testing and onward referrals and linkages to prevention, treatment and care s With this in mind, introducing HIV self-testing as an additional option in sub-Saharan Africa and Zimbabwe in particular has vast potential to contribute to closing the testing gap and reaching the first 90 across the region.

But there are still a few questions to answer before making HIV-Self-testing available on a wider scale in our countries: before Zimbabwe introduces HIV-Self-testing, we will need more evidence on how well and how accurate even people with low literacy rates in very rural areas of our countries can indeed use HIV self-test kits. Furthermore, linkage into care and treatment after HIV Self-Testing: Increasing access to HIV testing through HIV self-testing is not enough. We need also to ensure that linkages between HIV testing and care and treatment services are good and that people can indeed access these. While we are scaling up testing, we have to ensure that people who test HIV positive are adequately linked to counseling, care and treatment and that treatment is available for them.

We have to assess whether people after HIV self-testing are indeed linking to care and treatment and assess what measures have to be put into place to facilitate this. We have to evaluate whether there are any social harms associated with HIV self-testing and we have to establish community systems that can report on any negative impact of HIVST. We have to evaluate ways in which people can access HIV Self-test kits in a way that is convenient and acceptable to them.

Based on the experiences with HIV self-testing in Malawi, community-based monitoring and reporting systems were essential to identifying and addressing issues of misuse or abuse. We will also be critical to monitoring and reporting when something occurs and if misuse or abuse happens, as we currently do with existing HIV testing services

So the question still remains: How can the public health authorities expand HIV testing when many people avoid it because they fear stigma and discrimination or because they cannot easily access testing services, because they would have to travel long distances or because they would have to access testing at health care facilities, with long waiting lines and inconvenient services. From the Human rights perspective we have to ensure that that HIV Testing options, including HIV-Self-testing are available to everyone at an affordable price and to those that cannot pay the price of HIV testing, services should be provided free of charge, to ensure equitable access. People should have the opportunity to test themselves on their own, like for any other chronic disorder, such as diabetes or arterial hypertension or conditions, such as pregnancy.

There should not be any difference for testing for HIV from those testing blood sugar or pregnancy. With wider access to HIV testing, many more people will be identified and are requiring access to treatment. While we are scaling up testing, we have to ensure that people who test HIV positive are adequately linked to counseling, care and treatment and that treatment is available for them. People should be made aware of the available options when one tests positive and Zimbabwe should scale up resources for test and treat. Use of fixed-dose combinations or single pill a day to reduce the pill burden and simplify the regimens and treat adherence-Treatment as prevention undetectable viral load means less transmission

Treatment as prevention and role of civil society

Civil society need to support the test and treat as this would eventually reduce the rate of transmission since treatment is prevention. At community level, it is acknowledged that treatment would not succeed without a comprehensive care and support system within the community. Communities are the frontline response to TB, HIV and AIDS and are therefore key stakeholders in addressing underlying causes of health problems and reducing barriers to access care, support and treatment. Communities hold the key to solving their problems as community structures blend sustainably with government structures Build social
Civil society organizations have the comparative advantage of a bi-directional influence on community structures as well as governmental institutions; Community systems strengthening – giving communities knowledge and skills to promote the new guidelines and prolong life capacity building of implementing partners involved in treatment, care and support. Engaging with grassroots structures-community leaders, community volunteers, the infected and affected constituencies in; early identification, early referral, early treatment and effective follow up of the infected population. Continuum of care in the community through strengthening linkages between communities and health facilities.

Advocacy- health is a human right and solutions to lasting health change can be found through advocacy and that the community is all powerful. Rights-based approaches in overseeing the implementation of the new guidelines and creating an enabling environment, while monitoring drug stock outs, improving healthcare seeking and utilization behaviour by religious objectors. Meaningful involvement of PLHIV, other key population groups including people living with disabilities is also key. Preparedness and knowledge of how and when to self-manage adverse effects and when to return to the clinic are essential. Manage HIV with mental health disorders, alcohol and other substance use disorders and link with community and social support. Awareness raising on the new guidelines by providing accurate information to patients and their families and increase peer support

Train community workers on how to: reduce stigma; improve treatment preparedness, adherence and retention; provide adherence support and care for key populations; and provide simplified approaches for educating patients and their families. Engage and integrate community health workers, volunteers and people living with HIV in peer support, patient education and counselling, and community-level support. Secondary and primary caregivers assist by counting the remaining pills in bottles and this helps to assess and improve adherence, Increase paediatric ART and reduce home deliveries and use PMTCT champions to track loss to follow up. It should be noted that community volunteers play a critical role and should not be taken advantage of but should be incentivized so that they do not suffer from burn out. In Zimbabwe village health workers and Community HIV and AIDS activists have been given bicycles, hats, T-shirts and uniforms as well as small allowances including mobile phones and air time to transmit information and mobilize communities. The incentives depended upon the funding partner and availability of funds. Incentives play a critical role so that the community cadre who is a vehicle of positive change feels worthy. Recognizing the role played by volunteer and rewarding the efforts makes the work achieve the targets as they become motivated to do the work. It the best practice which some authorities say compromise sustainability of projects but I feel there is nothing for free. Volunteers need to be taken into account in budgets if we are to achieve the 90/90/90.

Of note is developing mechanism(s) for ongoing communication and dissemination and implementation of the Guidelines, such as a bulletin board and/or home page on the Internet allowing for input and exchange of information on human rights and HIV and database linkages between groups working on human rights and HIV. Promoting discussion of the Guidelines in their newsletters and other publications, as well as through other media would also go a long way.

**Public-Private partnership and its role to end AIDS by 2030**

National AIDS Council led the coordination of the national response in line with UNGASS three ones principle. Sectoral coordination was strengthened for all the 6 sectors. Other sectoral coordination was assured through associations, committees, Councils and networks such as Country Coordinating Mechanisms, Zimbabwe Network of People Living with HIV, Council of Churches and Zimbabwe Business Council on HIV and AIDS. The stability in the political, legal, social and economic situation in 2014 was ideal for the broad-based multisectoral and multilevel participation in the national response to HIV and AIDS. High level commitment on HIV and AIDS was evidenced through continued strong support for the AIDS Levy for all the taxable income both from public and private sector which National AIDS council being the custodian of the National AIDS Trust funds (NATF).

In addition, the active leadership engagement on HIV and AIDS issues including political, religious and community leaders makes the whole Zimbabwean community work together for the common cause-ending AIDS. The public-private partnerships established in Zimbabwe if given due attention could help to end AIDS by 2030. This has been seen as the great opportunity to achieve the ambitious global targets. People from all walks of life have a sound knowledge of HIV and AIDS through awareness raising and Information sharing in various spaces created by both public and private sector. This includes Work place HIV and AIDS program which has also taken centre stage in public and private companies. Furthermore, In Zimbabwe HIV and AIDS education is taught from the 4th grade to form 6 (which is age 10-18 approximately). This has gone a long way in broadening knowledge base of young people and work towards an AIDS free generation.

**Task shifting – Health care workers**

In order to ensure the strategic integration and mainstreaming of HTS provision into coordination, management and supervision structures and systems, health providers; program and service managers at all levels will be mandated to include HTS in their annual plans. District-level supervisory teams will also be capacitated to proactively support facilities to develop plans for integrating HTS in all their HIV and AIDS services. A culture of joint support, supervision and program reviews across all HIV/ AIDS programs will be promoted.

In pursuance of its mandate to coordinate the activities of the different HTS implementing partners within the context of the comprehensive district HIV and AIDS services, the MOHCW has to continue to mobilise support for the national HTS partnership forum which will meet quarterly to share lessons and discuss challenges, opportunities and policy issues related to HTC.

**New WHO guidelines**

These consolidated guidelines provide guidance on the diagnosis of human immunodeficiency virus (HIV) infection. Provide guidance on the care of people living with HIV and the use of antiretroviral (ARV) drugs for treating and preventing HIV infection. The guidelines are structured along the continuum of HIV testing, care and treatment. Behavioural, structural and biomedical interventions that do not involve the use of ARV drugs are not covered in these guidelines. Why the guidelines are important, it is because of New Science Early treatment trials starting to report, data on safety of key ARVs in specific populations, new Commodities new ARVs at new doses & formulations, treatment optimization for children and adolescents (pills, new strategies), New Technologies and balance of Point Of Care technologies versus standard CD4, VL and EID platforms. Preparation for greater numbers on ARV; improve linkage, referral, adherence approaches; Enhance efficiency and maintain quality.

**Life expectancy trends**

In 1980, life expectancy in Zimbabwe was around 60 years of age. In 2000, when the MDGs were set, life expectancy had dropped to just 44 years of age, largely owing to the impact of the AIDS epidemic. By 2013, however, life expectancy had risen again to 60 years of age as new HIV infections were reduced and access to anti-retroviral treatment expanded.

**Conclusion**

Whilst it is acknowledged and appreciated that civil society plays a critical role in the fight against HIV through demand generation support of PLHIV on ART and advocate for improved services, community volunteers cannot replace professionals, but can play a key role in terms
of community health education especially in hard to reach areas. There is need for standardised incentives for community volunteers. There is need for innovative incentives to motivate the volunteers. Culturally sensitive topics need time to be discussed and it is only through community dialogues that these issues can be fully debated. The gains made towards the 30 years with the epidemic can only be sustained through budgetary support and political commitment towards the set targets. Collective efforts are needed, fighting stigma and discrimination from all the angles of society is key while encouraging PLHIV to adhere to treatment, healthier and fulfilling lives can be realised. Strong public and private partnerships should be enhanced throughout the global community.

References
15. Zimbabwe Demographical Health Survey 1988 Calverton, Maryland: ZIMSTAT ICF International Inc
16. Zimbabwe Stigma index research 2015-Zimbabwe National Network of People living with HIV