



Progress towards ending the HIV epidemic in Zimbabwe

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Presentation Outline

- Country HIV Epidemiology
- Achievements & Challenges
- Innovations

Country Context:

- Zimbabwe remain one of the countries in the world heavily burdened by HIV/AIDS & TB
 - 1.36m PLHIV
 - 1,25m adults
 - 74,460 adolescents
 - 76,650 children
- (2018 HIV estimates)*

 - HIV Prevalence: 14.04% among 15-49 yr age group
 - Female 16.7%
 - Male 10.5%
 - HIV Incidence: 0.49% (down from 1.42% in 2011, 0.98% in 2013)
- (2018 HIV estimates)*

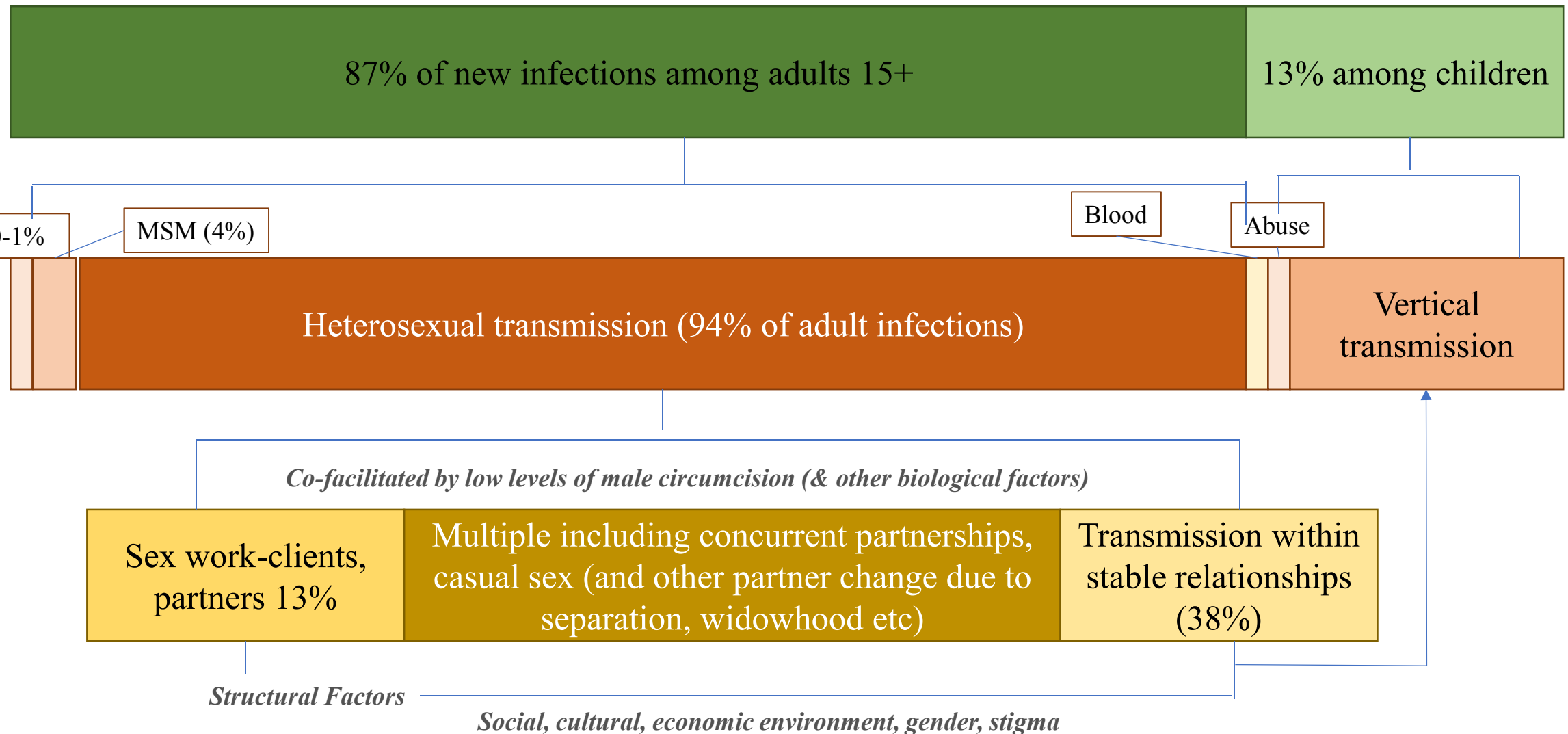
 - MTCT rate 6.74%
- (2018 HIV estimates)*

 - TB/HIV co-infectivity rate of 63% [*Global TB Report, 2018*]

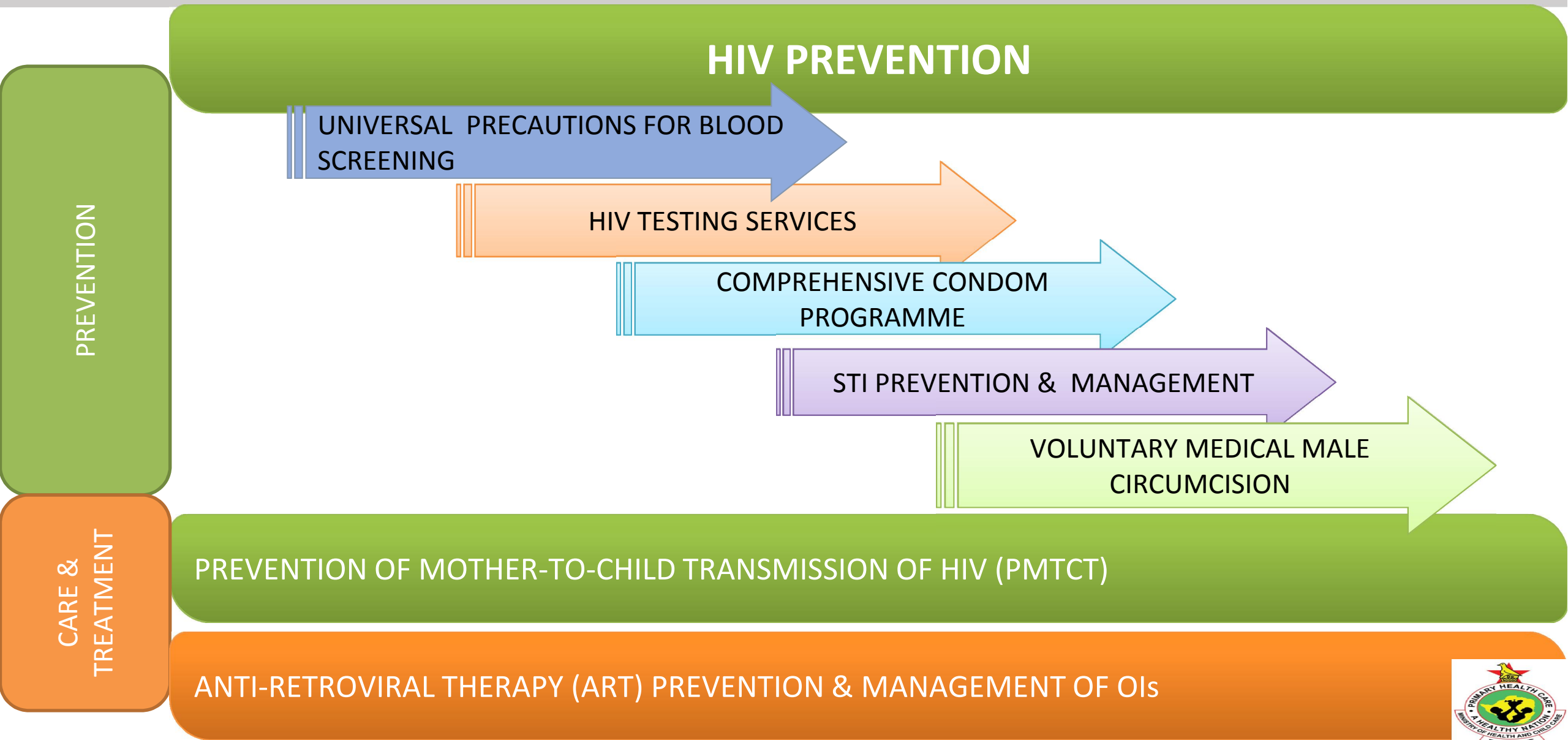
Total Popn ~ 13 million (2012 Census)



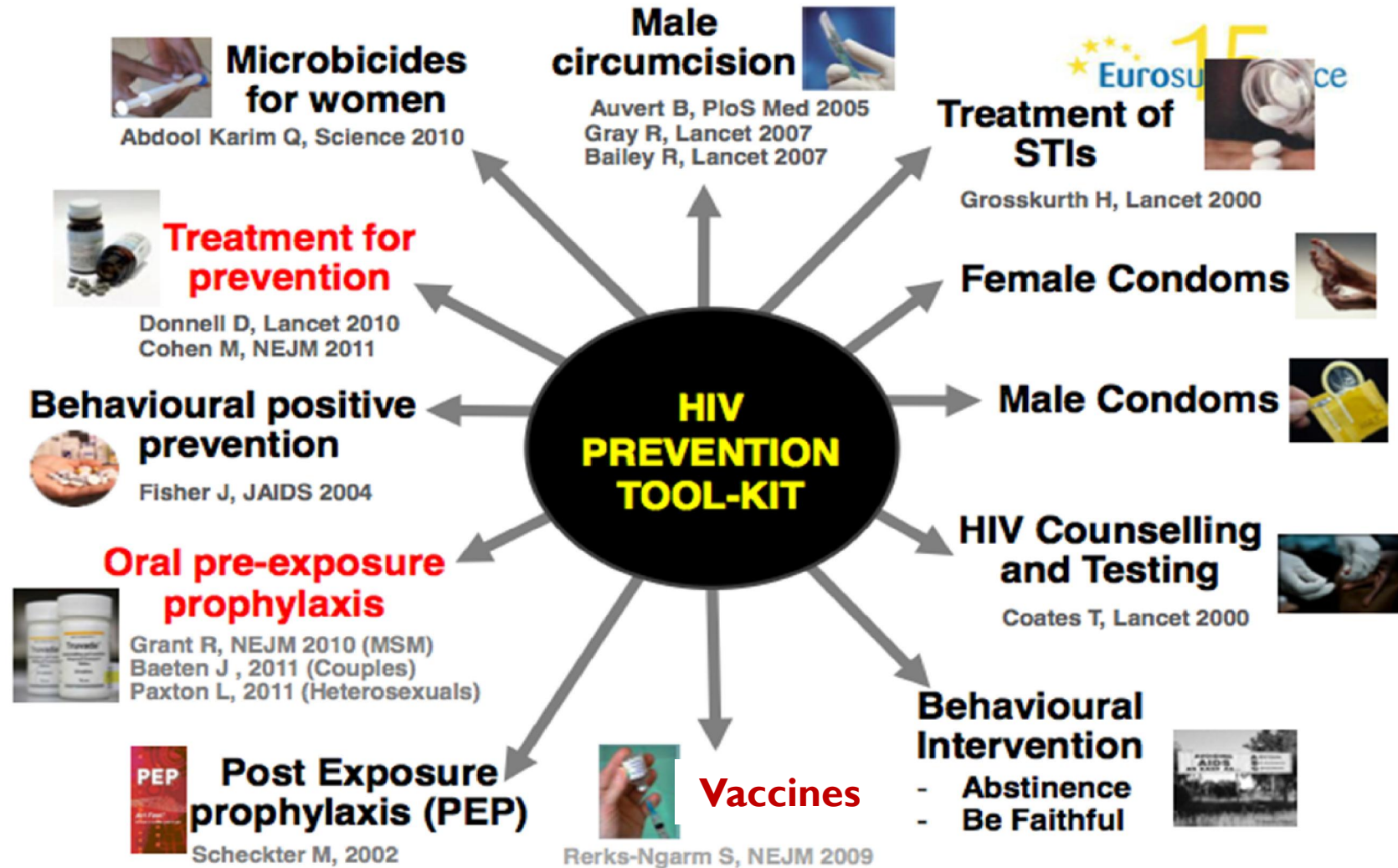
New HIV infections in Zimbabwe are primarily sexually transmitted among adults.



The Health Sector Response



Zimbabwe utilizes and promotes a combination approach to HIV prevention to reduce heterosexual transmission



Note: PMTCT, Screening transfusions, Harm reduction, Universal precautions, etc. have not been included – this is focused on reducing sexual transmission

The national Response to HIV has been cross cutting and comprehensive to address the complex issues associated with the epidemic

Guided, Cross-cutting Response

- Zimbabwe adopted a **multi-sectoral and multidisciplinary** response to the HIV epidemic
- Implementation is **guided by** the ZNASP III, eMTCT strategy, Consolidated ARV Guidelines for Preventing and Treating HIV,VMMC Operational Plan etc

Public health Approach

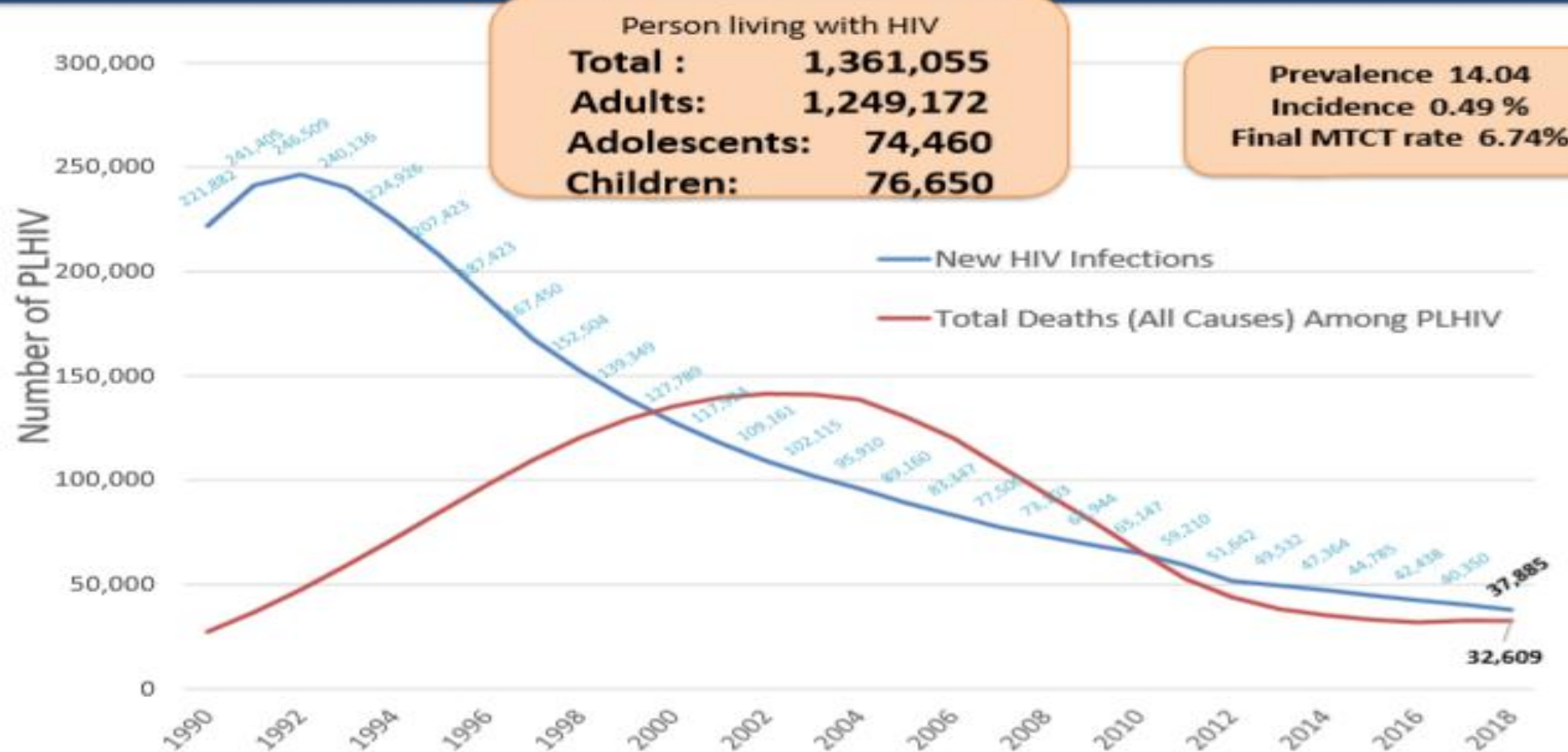
- A **public health approach** to scale up of HIV prevention, care & treatment
- Population based
 - Evidence based
 - Simplified tools and guidelines

Comprehensive context for implementation

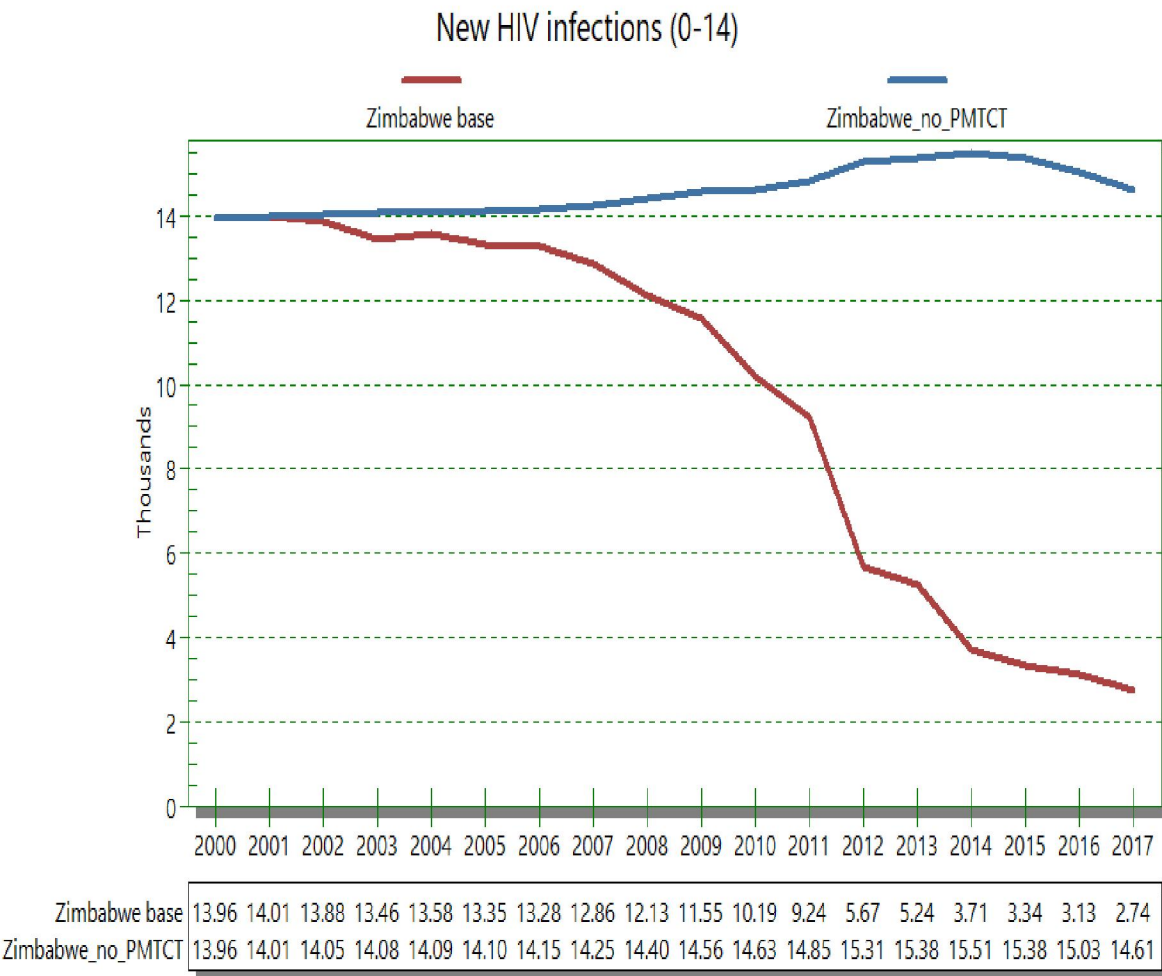
Implementation is undertaken in the **context of a comprehensive combination HIV** prevention, treatment, care and comprehensive HIV support package that addresses all

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

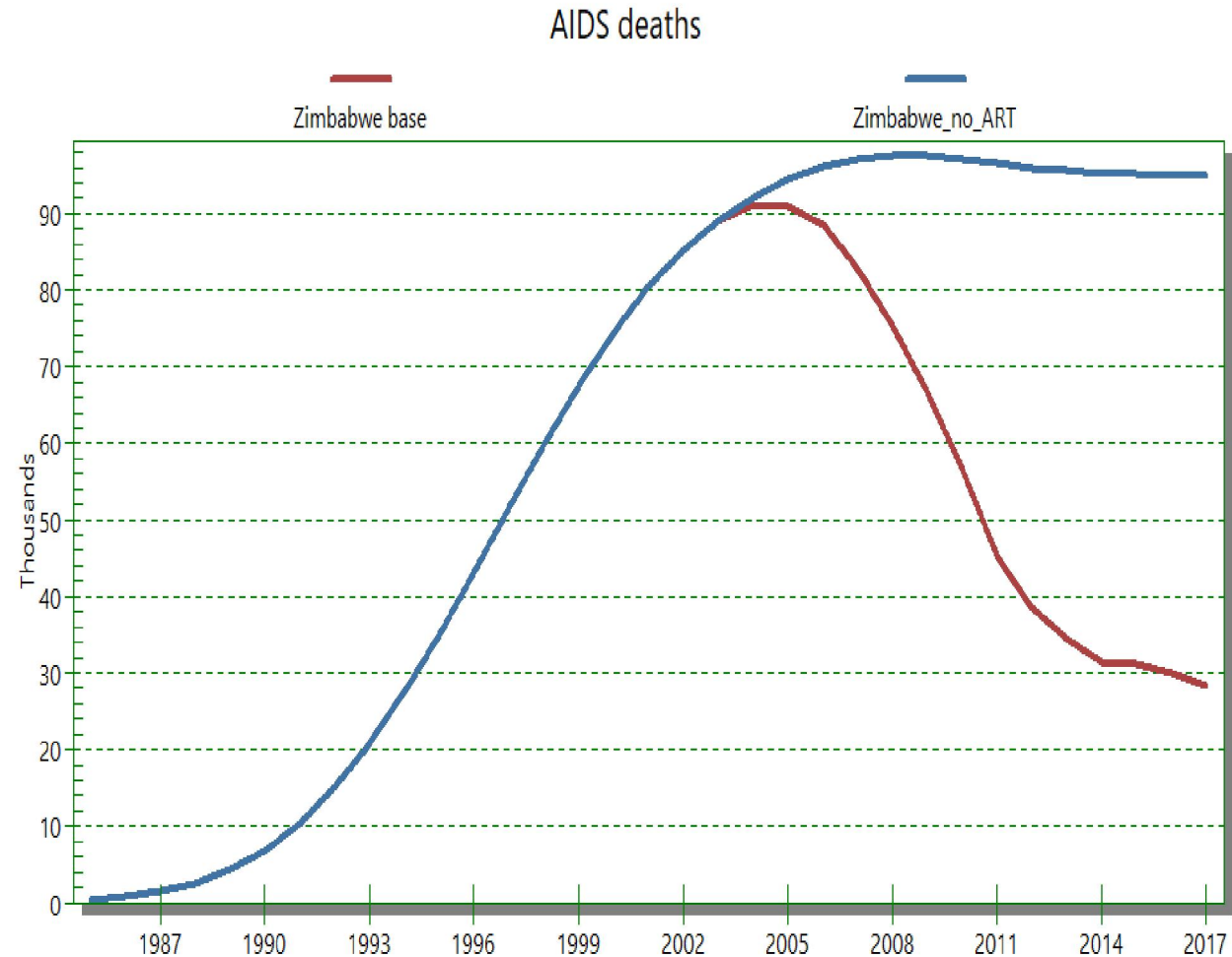
Zimbabwe Current (2018) HIV Estimates



Infections averted by eMTCT and ART programs (2017 HIV Estimates)



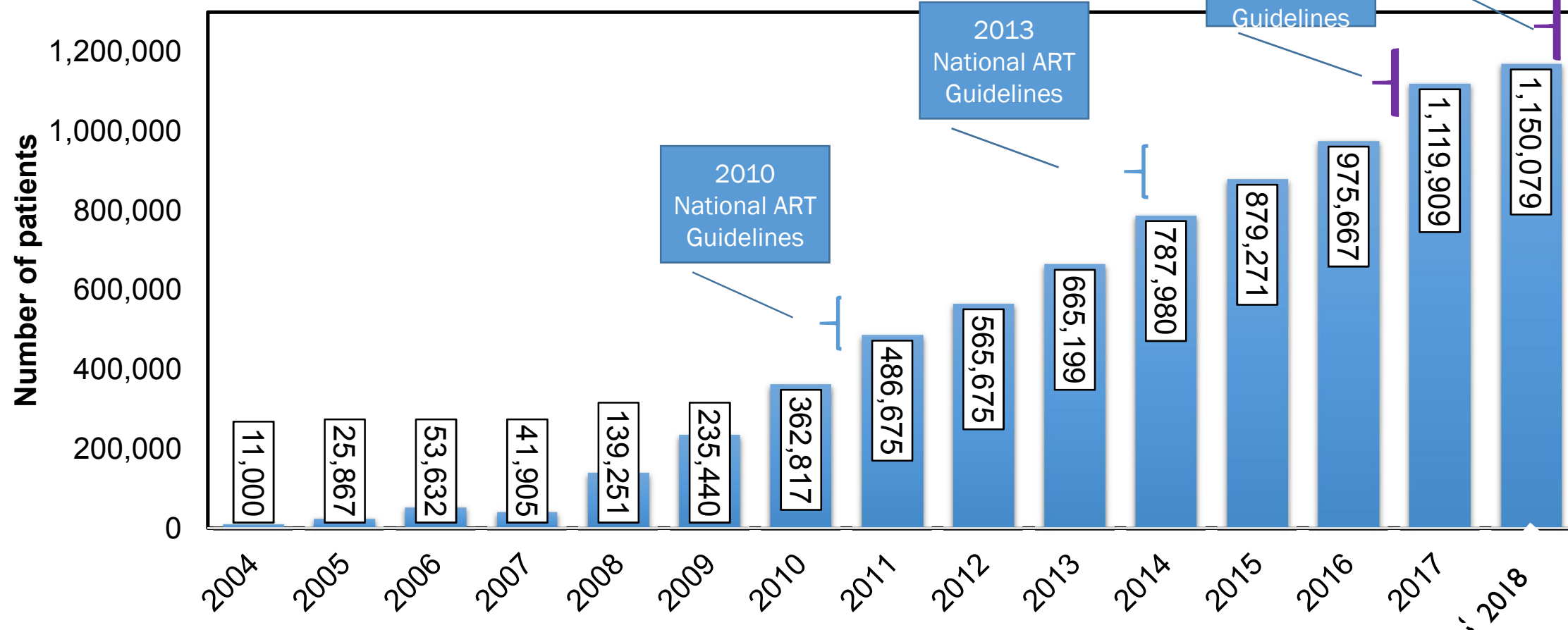
In 2017, 11,860 new child infections were averted by eMTCT programme



In 2017, an estimated 66,600 deaths were averted by ART in both adults and children

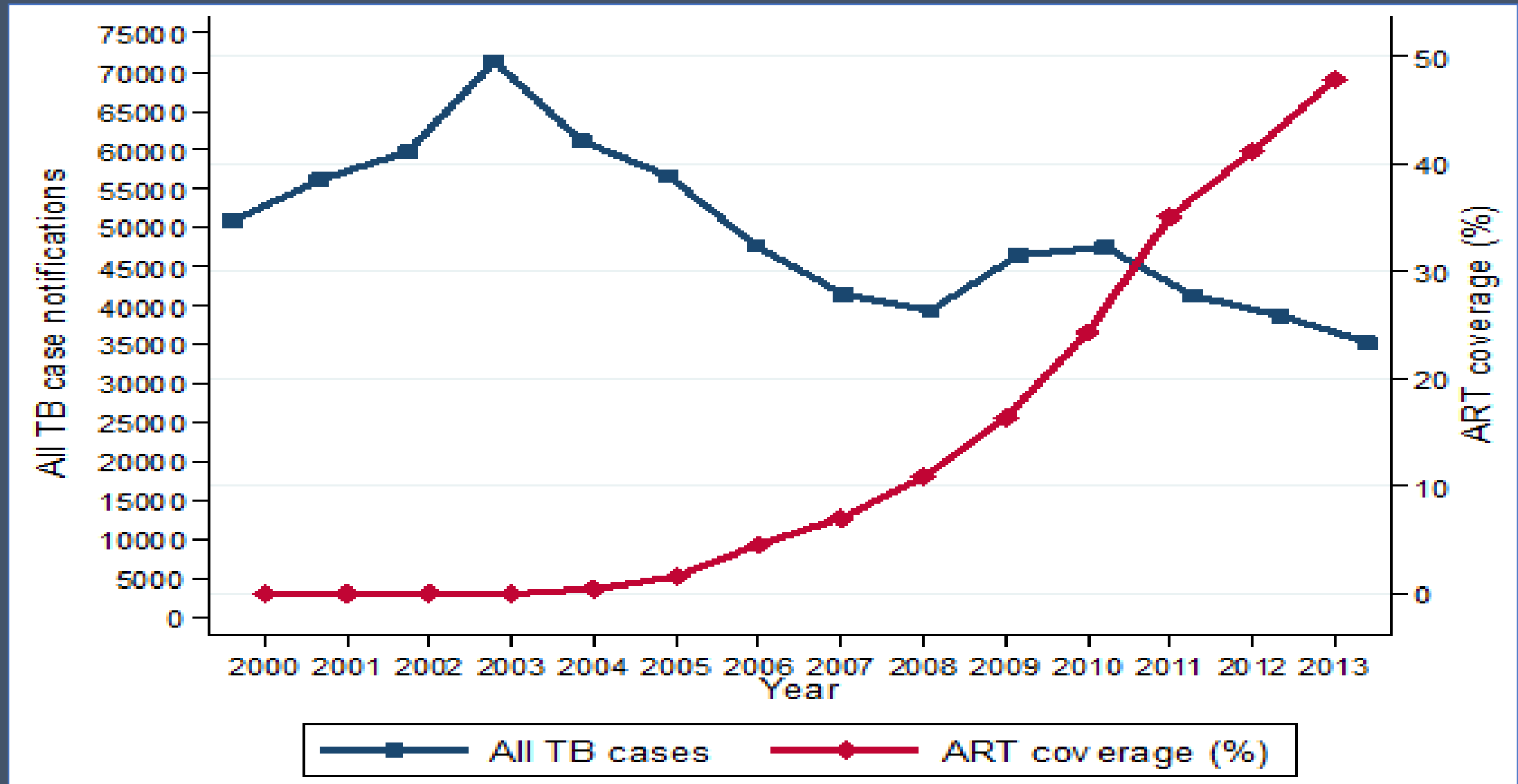
Evolution of the OI/ART Programme, 2004 - 2018

Addendum to the
2016 National
ART Guidelines

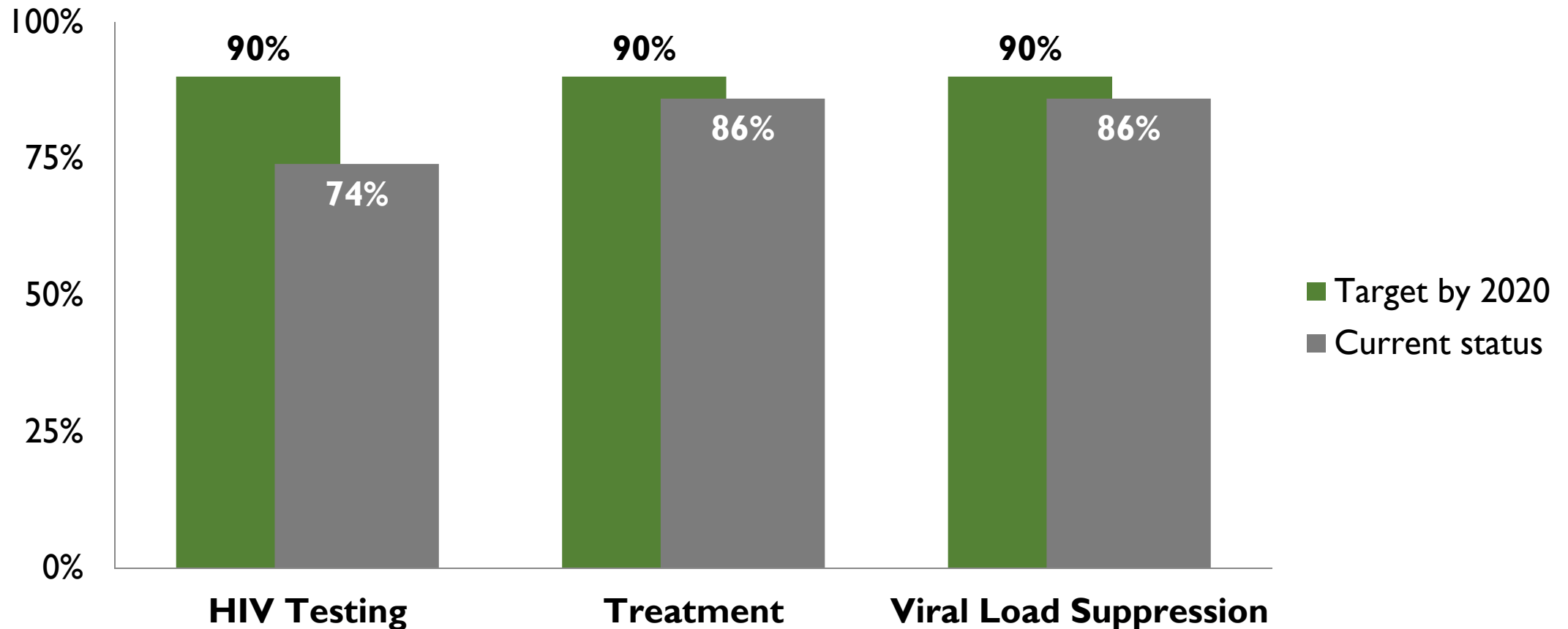


- Country introduced OI/ART programme in April 2004 guided by
 - Nationwide Scale-up of ART plans covering periods 2005-2007; 2008 - 2012 & 2013 - 2017,
 - Plan feeds into overarching extended Zimbabwe National AIDS Strategic Plans (ZNASP), coordinated by one coordinating body (NAC) and monitored by one monitoring framework - The 'Three Ones Principle'

Zimbabwe TB case notifications versus ART coverage, 2000-2013



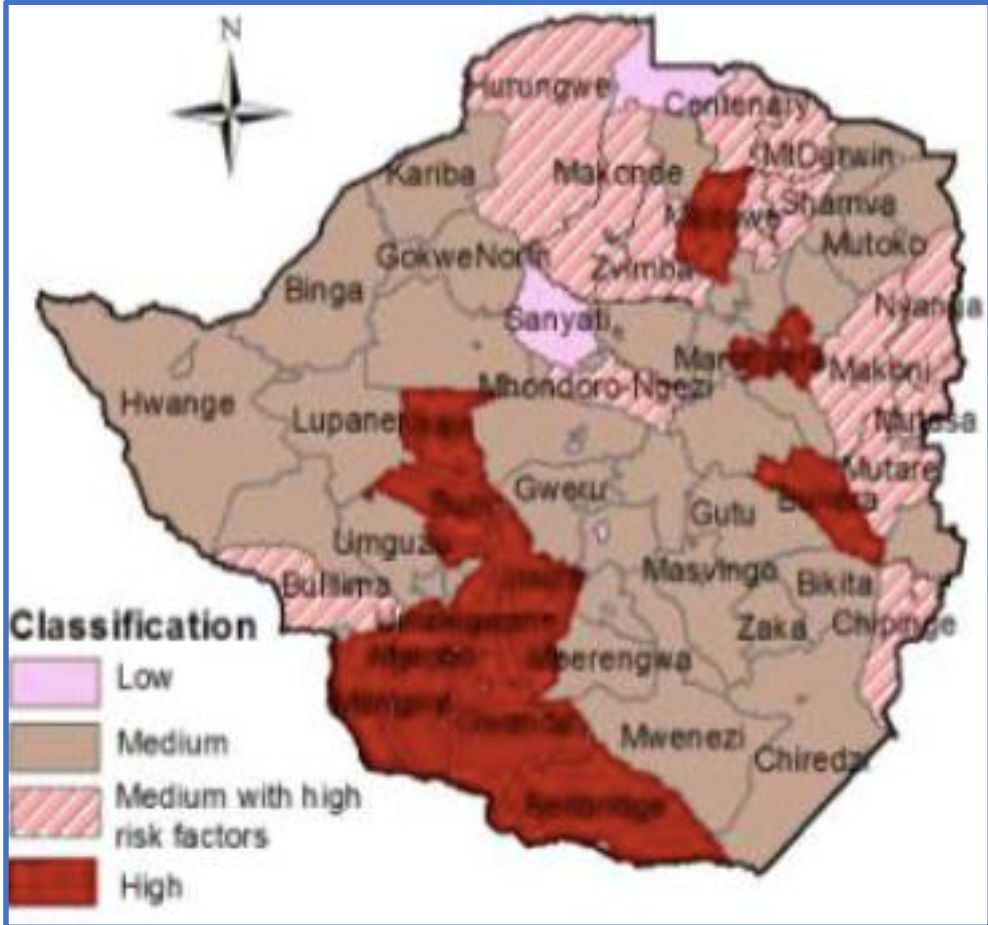
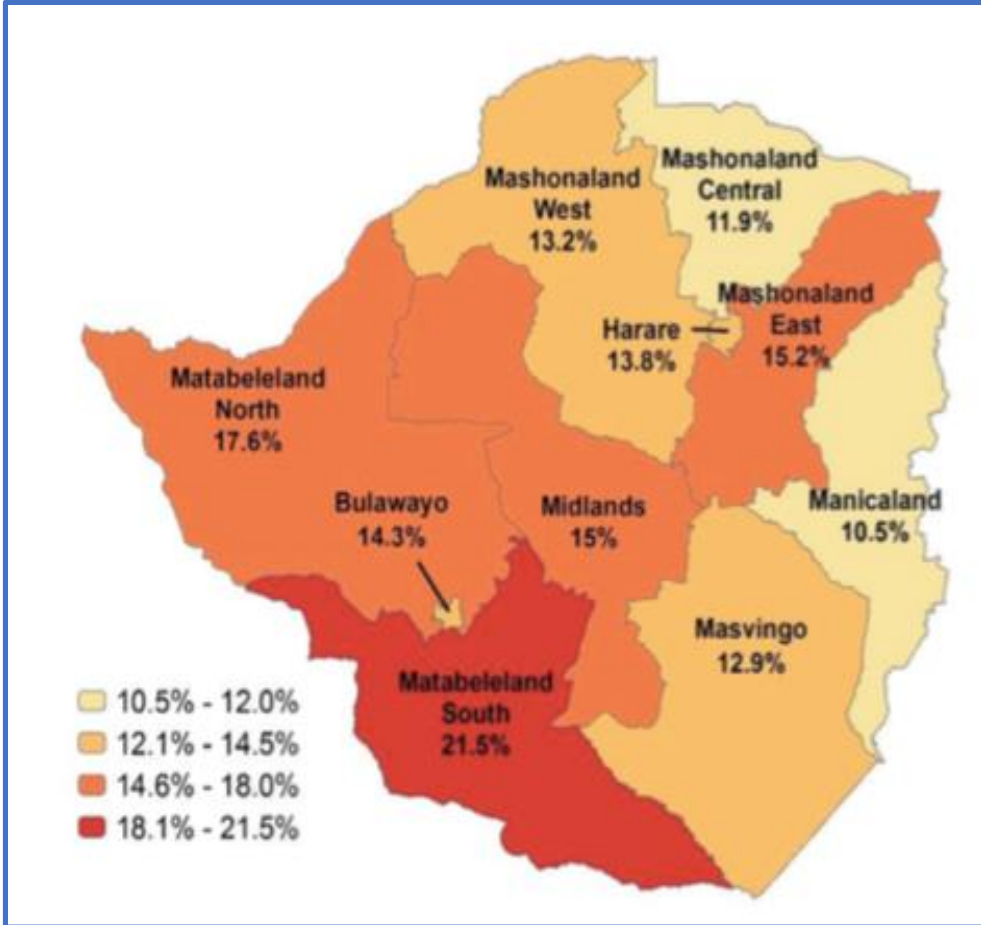
Zimbabwe has made great progress in controlling the HIV epidemic and is well positioned to achieve & surpass the 90-90-90 Fast Track targets



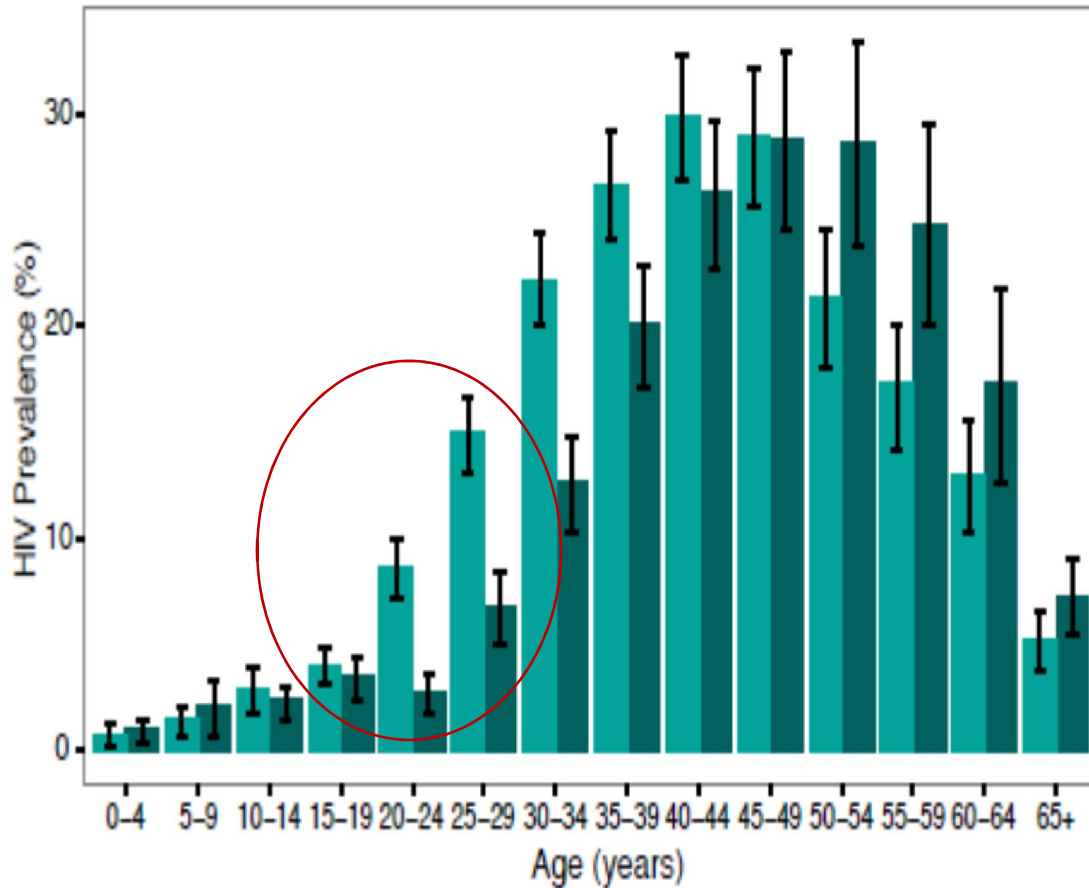
- The biggest gap to achieving the 90-90-90 targets is in HIV testing (16%).
- The new national HTS Strategy (2016- 2020) shifts focus from testing for coverage to targeted testing for identification of those living with undiagnosed HIV.

Source: ZimPHIA, 2015; Spectrum, Zimbabwe National HIV Estimate

Despite recording remarkable progress in reducing HIV prevalence & incidence, wide variations still remain across provinces (Left) and districts (Right)....



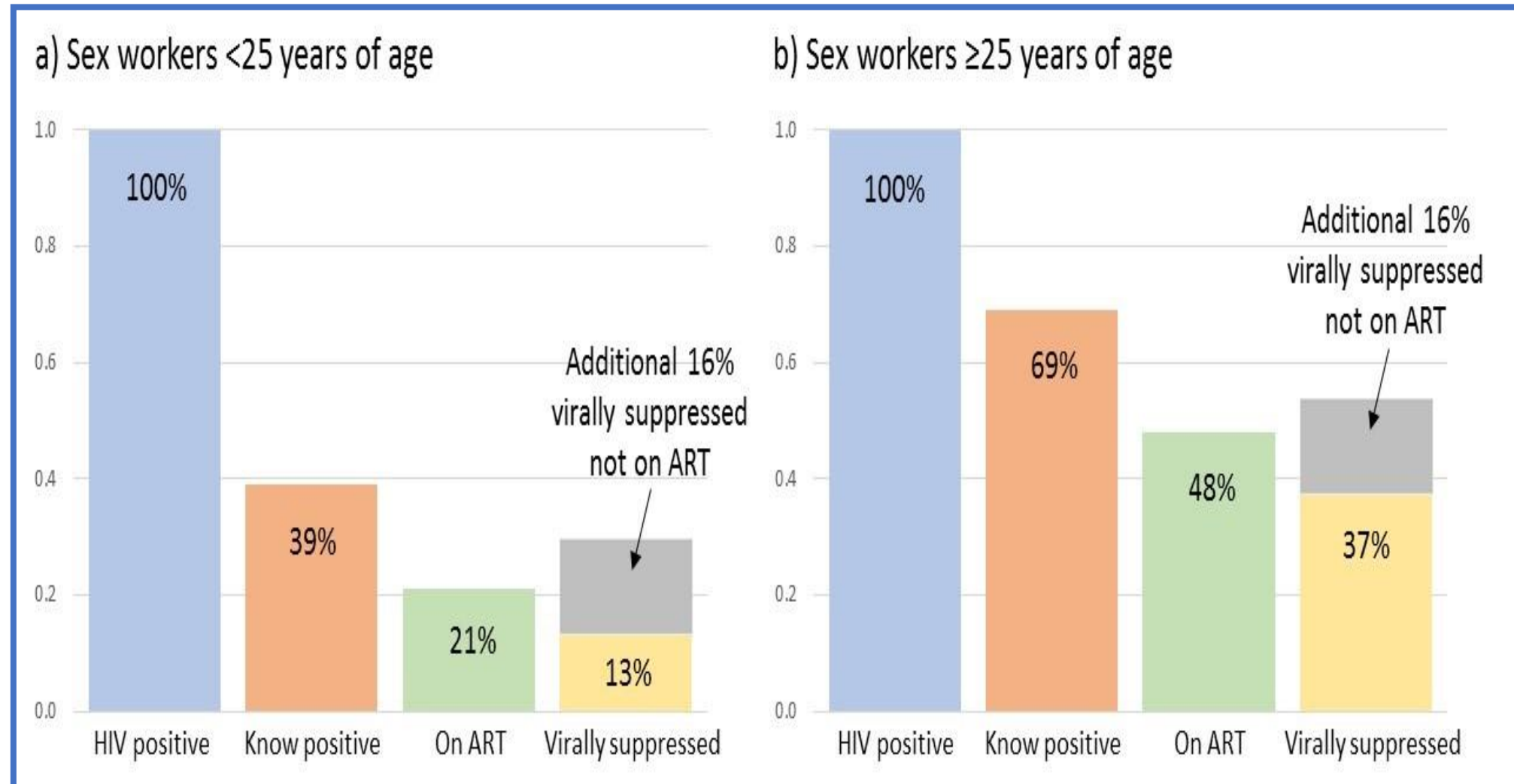
HIV burden still high among adolescent girls and young women...



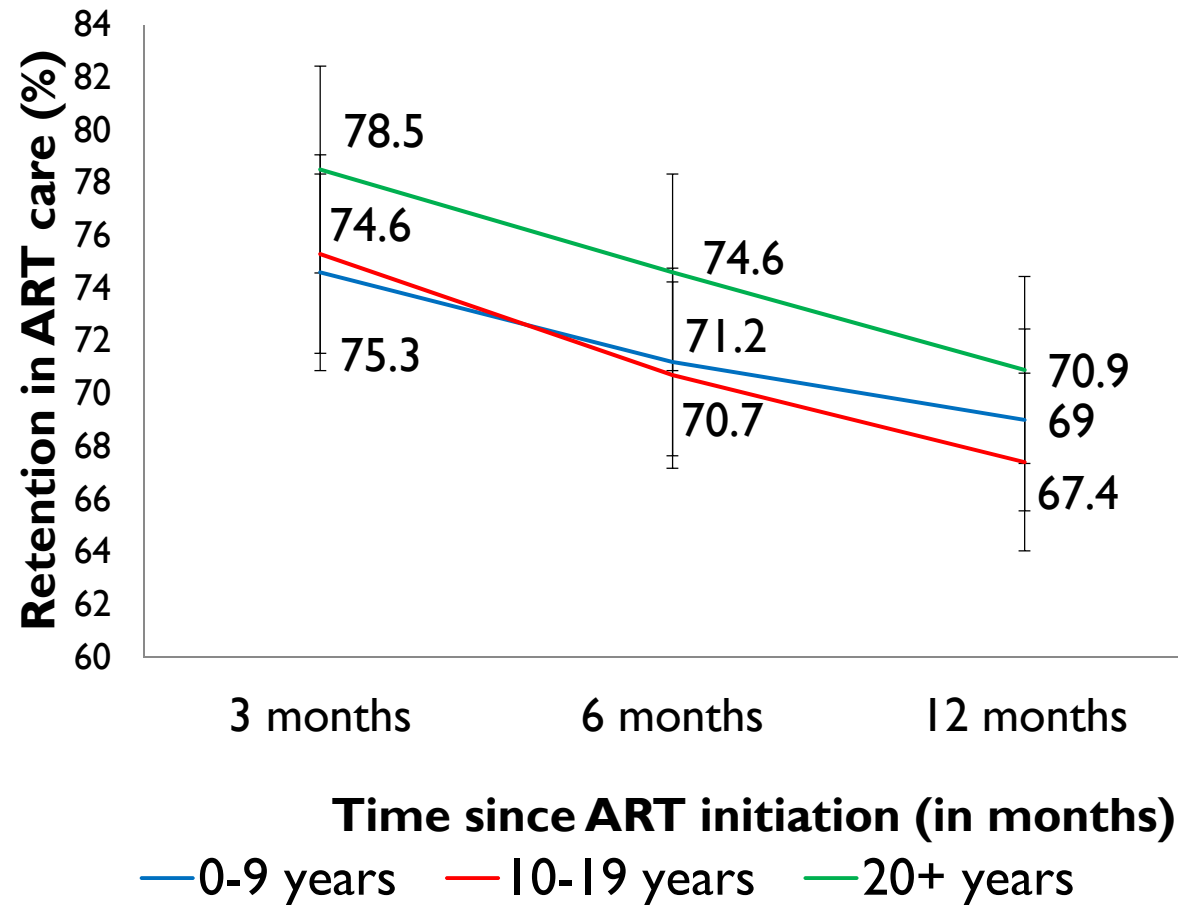
Source: ZIMPHIA, 1 Dec, 2016

- HIV prevalence among 20- to 24-year-olds is three times higher among females (8.5 percent) than males (2.7 percent) which calls for urgent attention

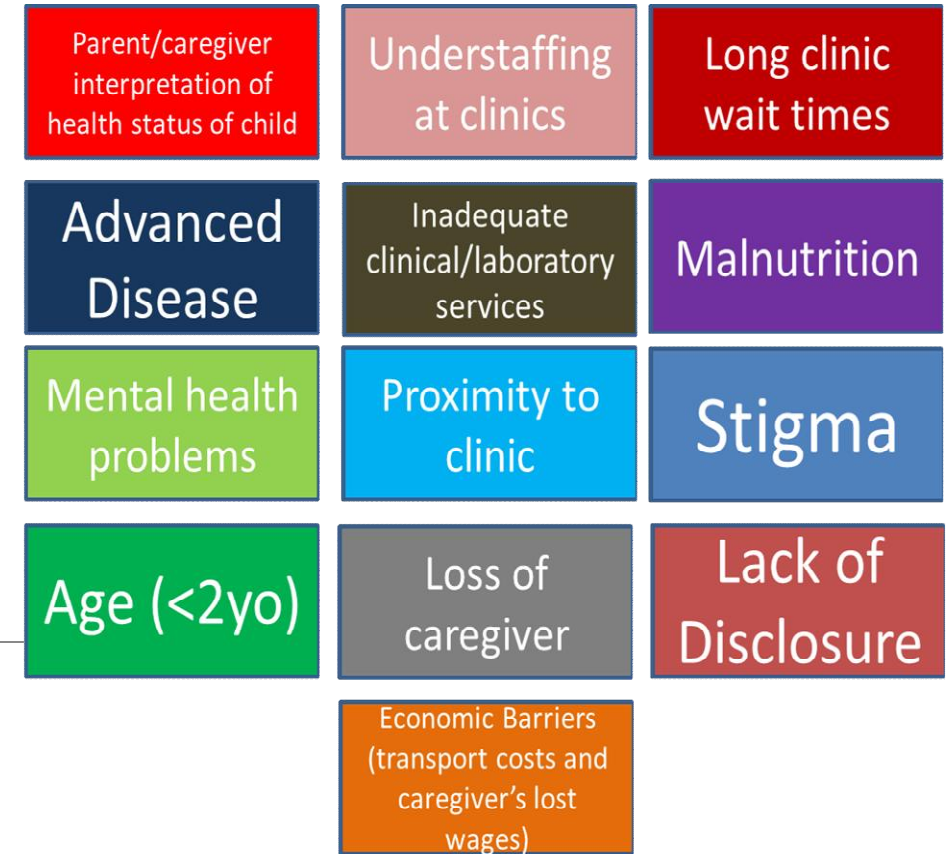
Significant gaps remain particularly pronounced among key populations.....



Despite achieving high overall retention rates of at least 88% & 83% at 12 & 24 months respectively, there still remains missed opportunities among adolescents & young people...



NB: Age groups exclude pregnant women at ART initiation



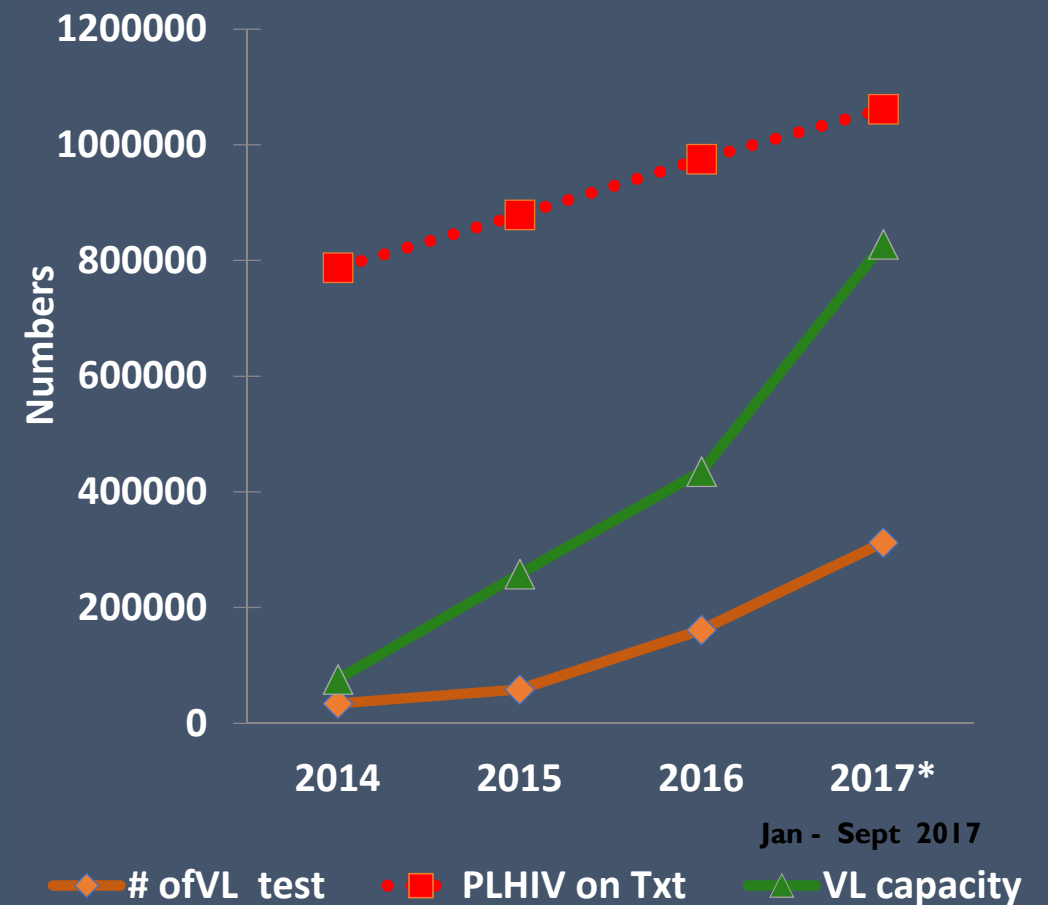
Barriers to Retention

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

Despite routine VL having been scaled up significantly since 2016, VL *testing coverage remains low* ...

- By end of Dec 2018, a total of **508,917 VL tests** had been done translating to **44% testing coverage** with a suppression rate of 85%
- Country has adequate VL testing platforms deployed country wide [both conventional (22) & POC (100)] however, with limited capacity utilization
- Challenges relating to VL testing include:
 - Sample transportation system
 - Extended total Turnaround Time

Low viral load capacity utilization....

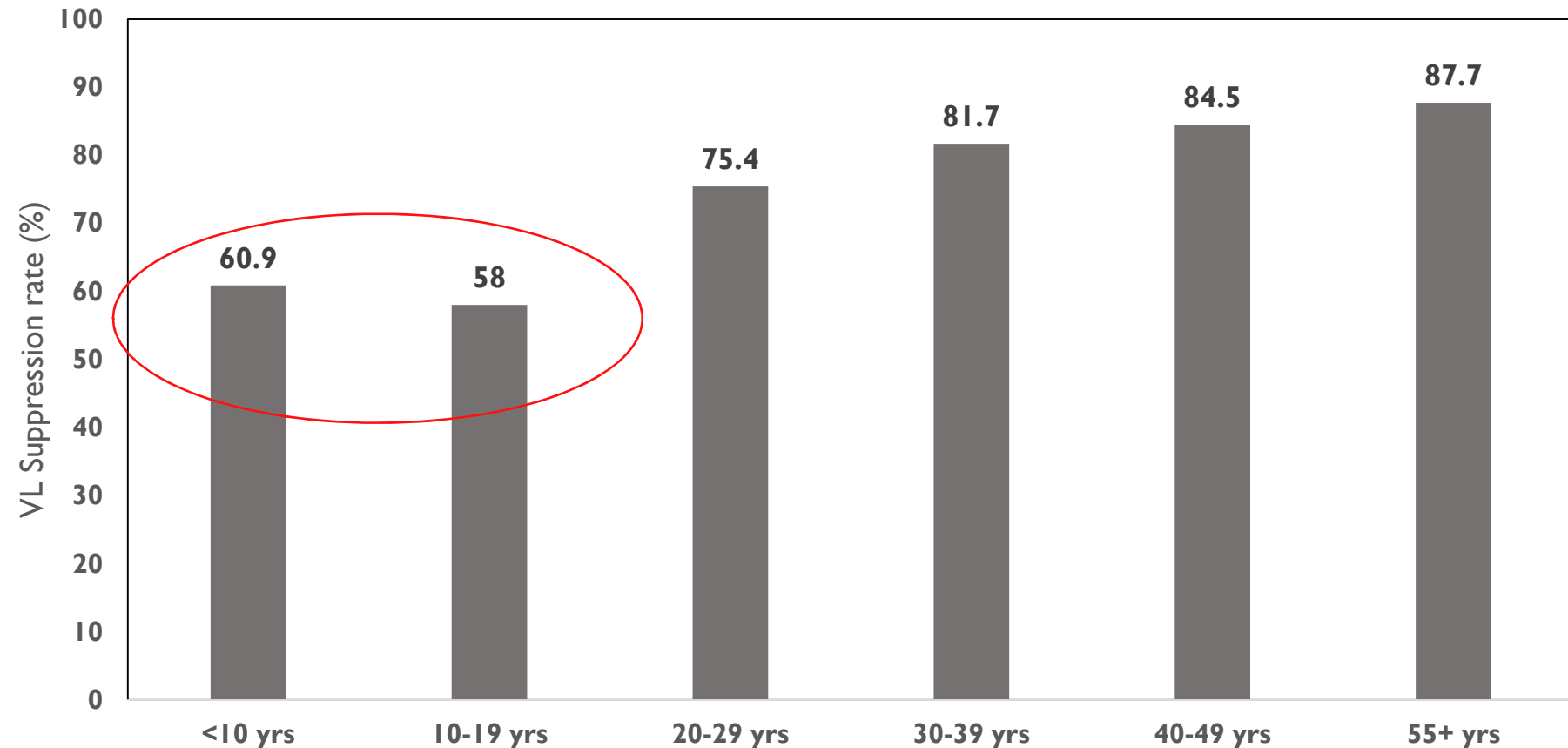


Source: 2017 ART End Term Programme Review

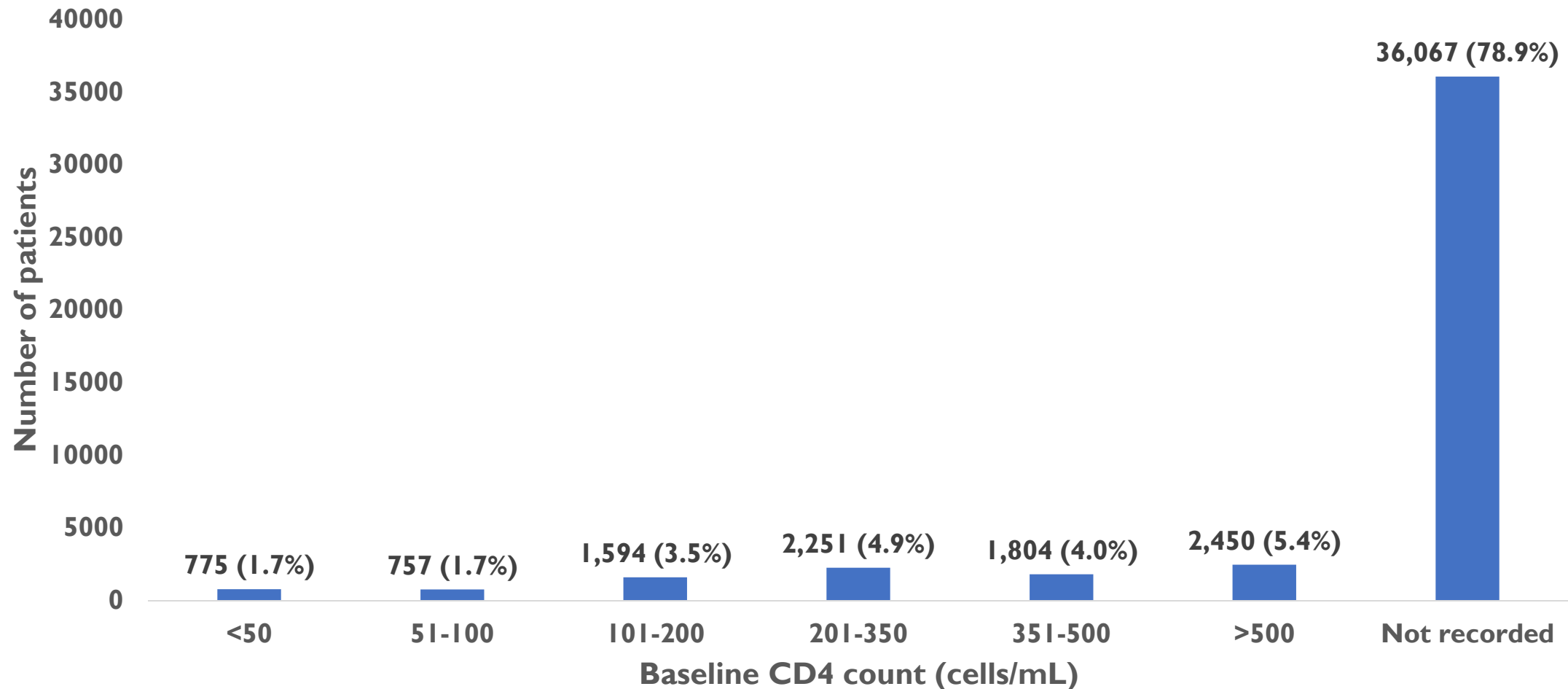
Proportion of active patients enrolled in ART from 2013-2017 with suppressed VL from the first VL test stratified by age at health facilities with ePMS and in ART care for at least 12 months from ART initiation (N=114,857)

Adolescents aged 10-19 years had the least proportion of active patients that were suppressed (58%) compared to all the other age groups.

Older age groups tended to have higher proportions of active patients on ART that were virally suppressed



Baseline CD4 testing uptake for the 2017 ART Cohort



Baseline CD4 test done within 3 months after ART initiation. Only 21% of all new patients (2017 Cohort) had a baseline CD4 test done.

Source: ePMS, MOHCC

Paediatric and Adolescent HIV Issues:



Long TAT for EID VL
results with limited use
of POC EID devices;
limited access to VL
testing services

Sub-optimal
integration of HIV
services with
adolescent sexual and
reproductive health

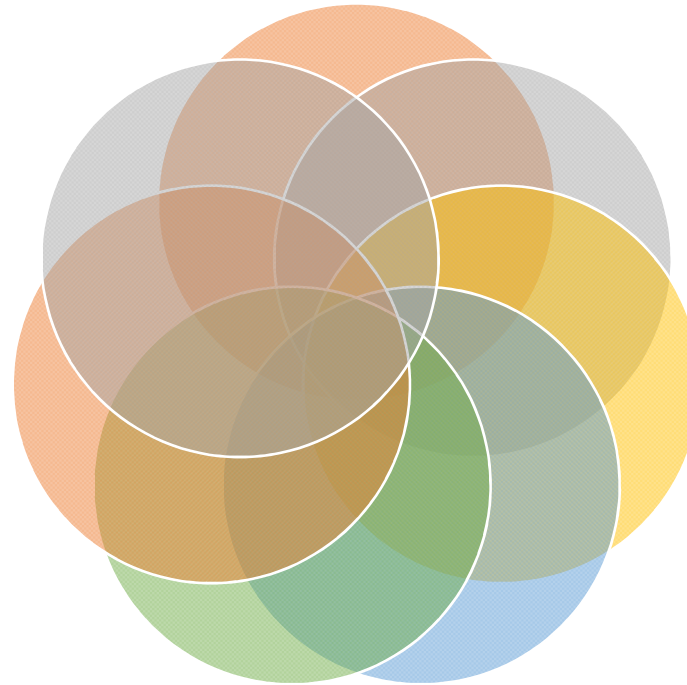
Weak sample
transportation system
for DBS and VL
samples

Elevated levels of
common mental
disorders among
ALHIV

Adolescents
experiencing
challenges with
adherence to
medicines

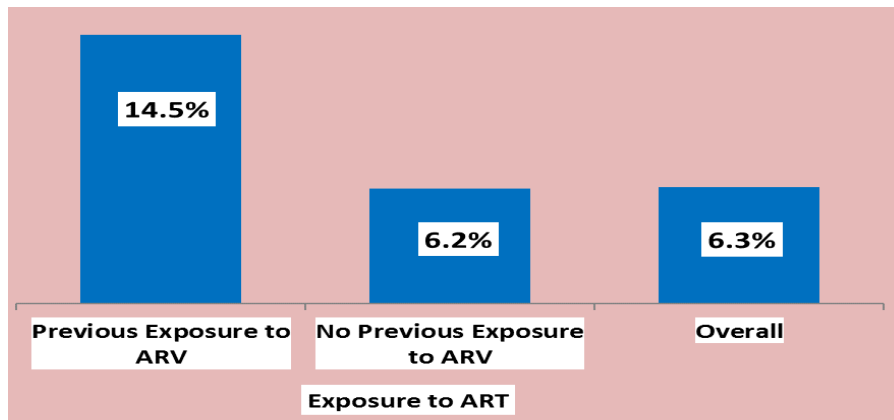
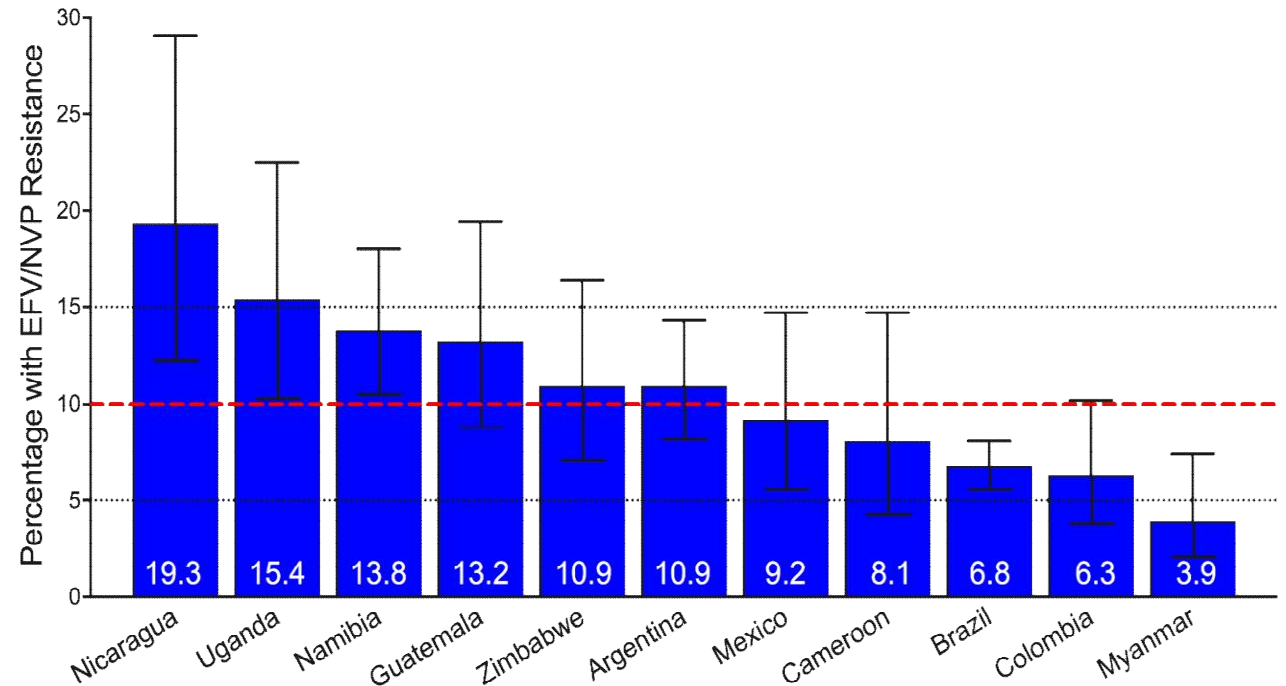
Stigma and
discrimination in health
facilities, especially
towards ALHIV

Disclosure of HIV
status



Increasing call for country to reconsider its 1st line regimen based on periodic HIV Drug Resistance Surveillance being done...

- Country has HIV DR prevention strategy
- TWG in place to guide implementation
- Country implementing all components of HIV DR prevention as per WHO Guidance
- Conducts Early warning Indicator (EWIs) surveys almost on an annual basis
- Conducted Pre-treatment (2016) and Acquired (2017) HIV DR surveys



- Results of Pre-treatment HIV DR survey indicates resistance to NNRTIs of 10.9% which is above WHO recommended level and this warrants country to reconsider its 1st line regimen

Innovations

HIV Testing Services:

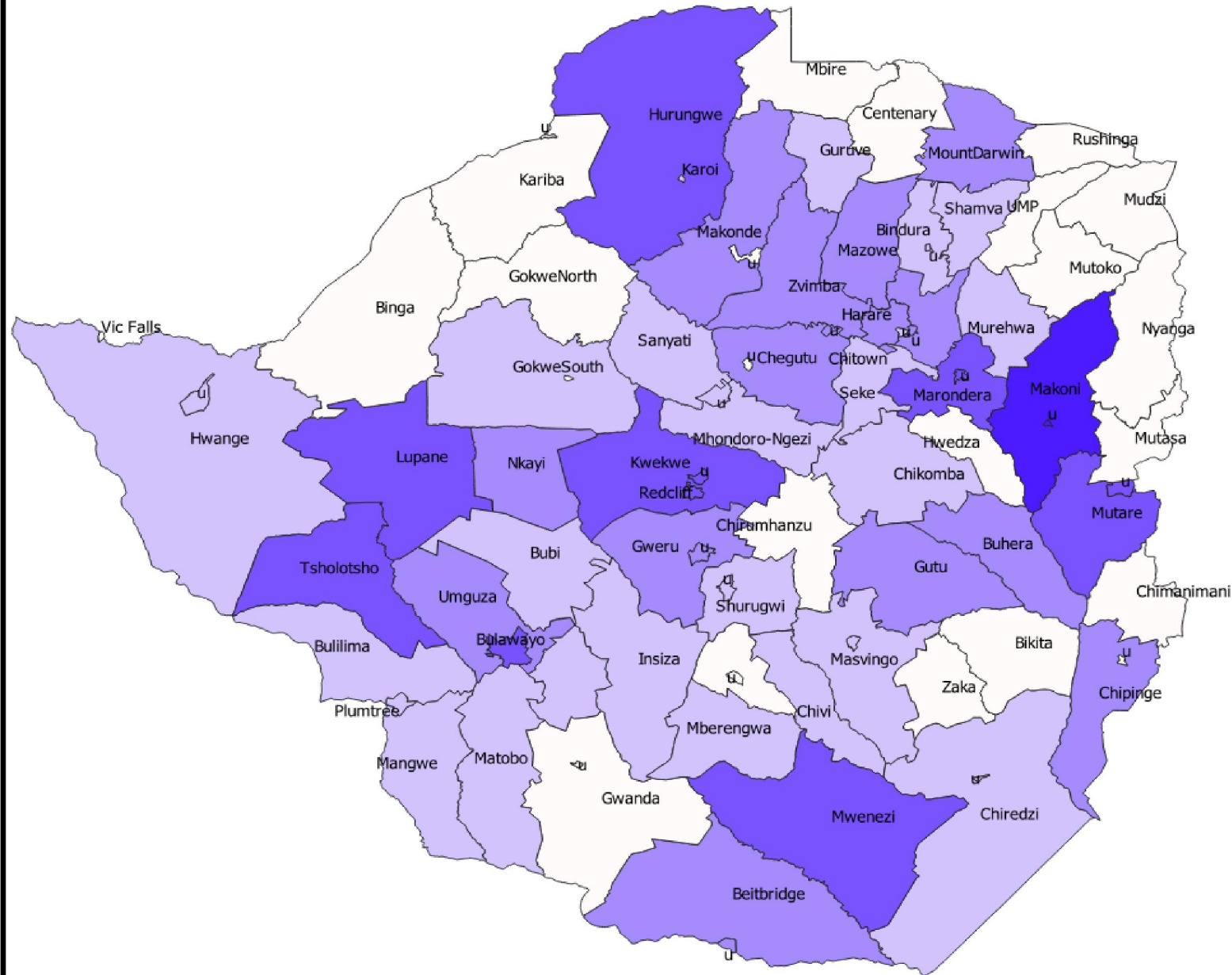
- Shift from testing from coverage to targeted testing
- **Models and approaches:**
 - Facility based (PITC, Index case testing and HIV ST)
 - Community based- outreach, index case and HIV ST
- **Job aid developed** to screen children, adolescents and adults for HIV prior to testing aimed at reducing # of re-testing and supporting compliance to testing algorithms

1.2 HTS screening tool for children and adolescents

For each child or adolescent (aged 5 - 19 years) attending the facility, ask the following questions and tick either YES/NO. ALL children under 5 years of age should be offered an HIV test.		
For children and adolescents aged 5 - 14 years, ask:	YES	NO
1. Has the child ever been admitted to hospital?		
2. Has the child had recurring skin problems?		
3. Has 1 or both of the child's natural parents died?		
4. Has the child experienced poor health in the past 3 months?		
Only for adolescents aged 15 - 19 years, also ask them:	YES	NO
5. Have you experienced any symptoms and/or signs of an STI, such as vaginal/urethral discharge or genital sores?		
If the answer is YES to any 1 of the above questions, offer an HIV test.		
If the child or adolescent answers yes to any 1 of the above questions:		
1. Obtain consent		
<ul style="list-style-type: none">• If the child is above 16 years, ask for consent from the child or adolescent directly• If the child is below the age of 16 years, ask for consent for an HIV test from their parent or caregiver• If the child is below the age 16 years, but is an emancipated/mature minor (married, pregnant or a parent), ask for consent from the child or adolescent directly• If the child is below the age 16 years, but it is in the best interest of the child to be tested for HIV, seek consent from the person in charge of the health facility• If consent is refused, offer additional pre-test counselling, and allow the child or adolescent to proceed to the services for which they attended the facility		
2. Conduct pre-test counselling with child or adolescent, and parent or caregiver		
3. Conduct HIV test with child or adolescent		
4. Determine HIV test result.		
<ul style="list-style-type: none">• If the child tests NEGATIVE, provide post-test counselling and refer to appropriate services.• If the child tests POSITIVE, provide post-test counselling and initiate the process of enrolling the child or adolescent on ART		
If the child or adolescent does NOT answer yes to any of the above questions:		
The child or adolescent proceeds to the services for which they attended the facility.		
If the child or adolescent answers yes to any of the above questions, but opts out to being tested for HIV:		
The child or adolescent has the right to proceed to the services for which they attended the facility (It is important to continue offering pre-test counselling and to discuss the matter further with the person in charge of the health facility)		

1. HIV Self Testing

- **Expansion of coverage** to 44 districts in all the country's 10 provinces
- **Capacity building** - 865 healthcare workers to date
- **Different models used:**
 - Community-based
 - Facility based
 - Secondary distribution



2. Birth HIV Testing to support Early Infant Diagnosis

- Protocol approved by MRCZ (CHAI/UNICEF)
- Training of implementing sites done
 - (Harare & Parirenyatwa – Specialist Centres) Data Collection March until June 30 2019
- EGPAF arm Data collection October 2018-April 2019
- Outputs will inform
 - Feasibility of roll out of Birth testing in Zimbabwe
 - Care and treatment of HIV+ Neonates
 - Dosing guidance for RAL & dosing charts development



Timely ART initiation upon accurate EID



WHO Infant testing algorithm



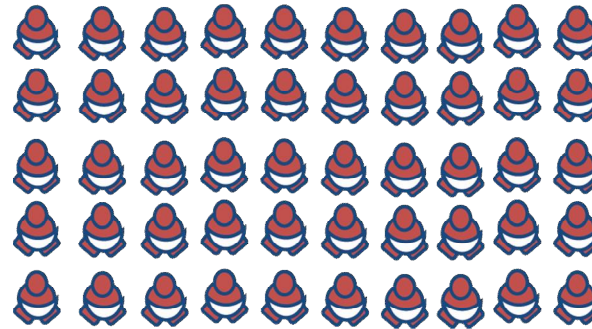
Infant is HIV infected

Immediate START ART

Repeat NAT to confirm HIV infection

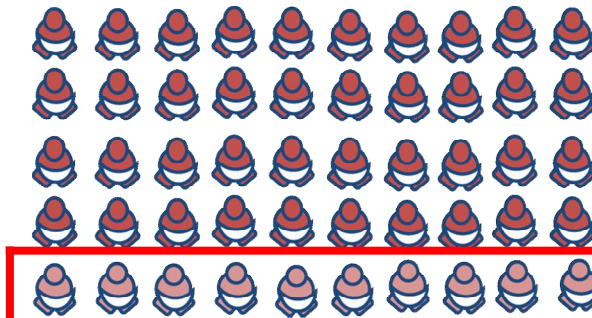
Start ART, without delay and new specimen collected at the time of ART initiation

20% MTCT



x 400

1% MTCT



x 9,900



True positive



False positive

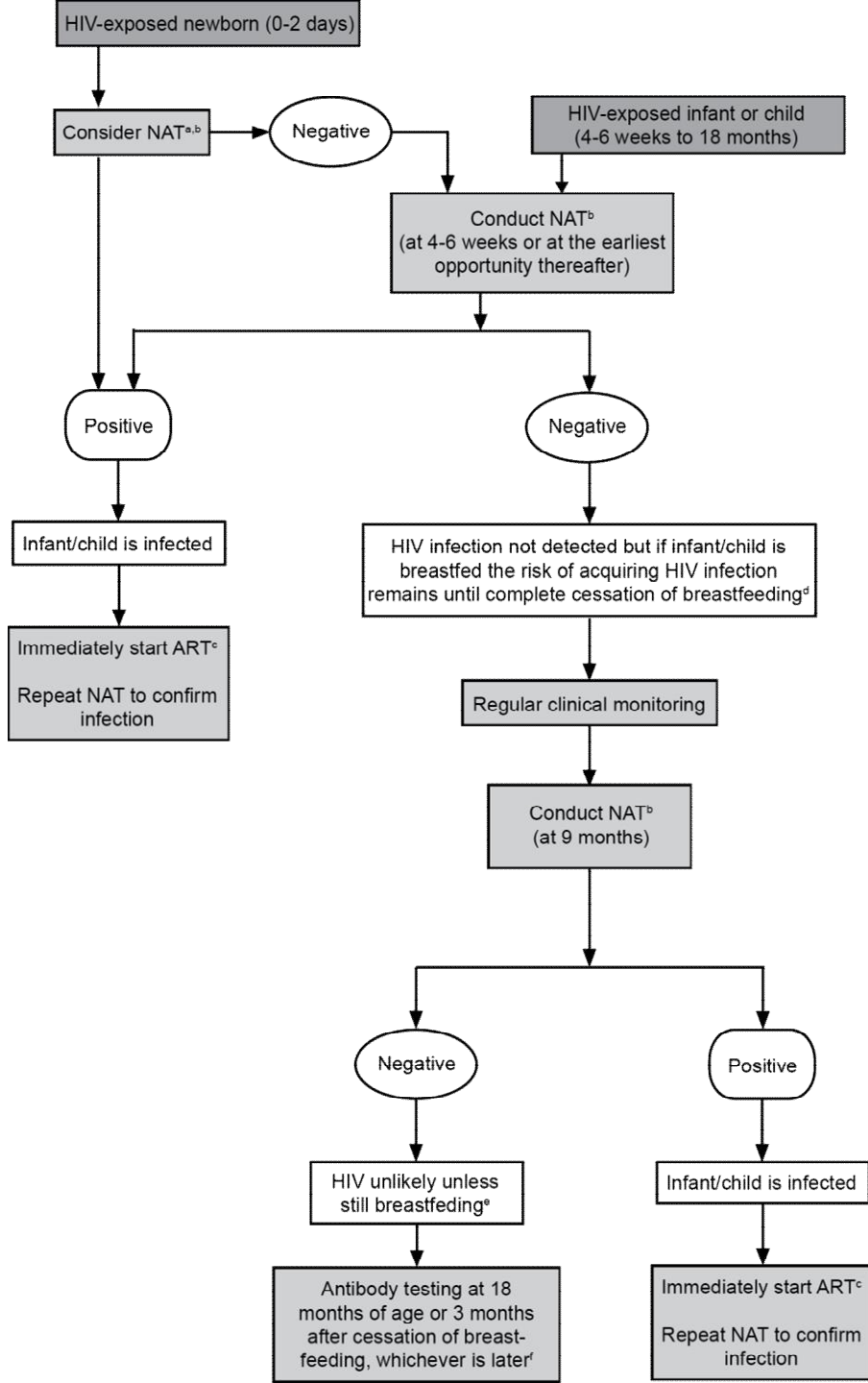


True negative

Confirmatory NAT is poorly implemented: how do we minimize unnecessary ART?

And let's remember that Infant diagnosis is a process!

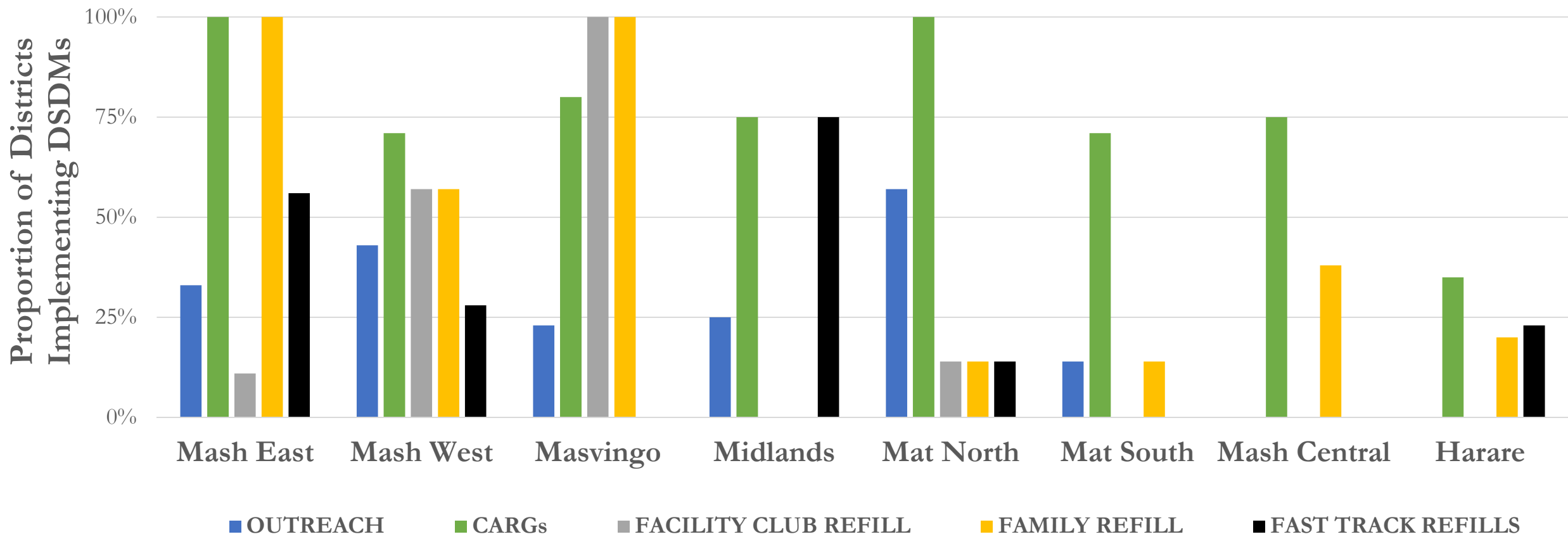
- Moving to a multi-HIV NAT algorithm
 - Birth (where of value)
 - 6 weeks
 - 9 months
 - Any time HIV exposed infants present sick
- Ensuring confirmatory testing of a positive NAT result is undertaken
- Diagnosis is not completed without “final diagnosis” at the end of the risk period for HIV transmission



3. Differentiated Service Delivery:

- Provision of tailored care that meets the preferences and expectations of the client
- 82 % of *adults and adolescents* receiving ARV refills for 3+ months

Proportion of Districts that have at least one facility implementing any one DSD model



4. Treatment Optimization: Key Considerations



Safety

- Minimum adverse events
- Good adherence



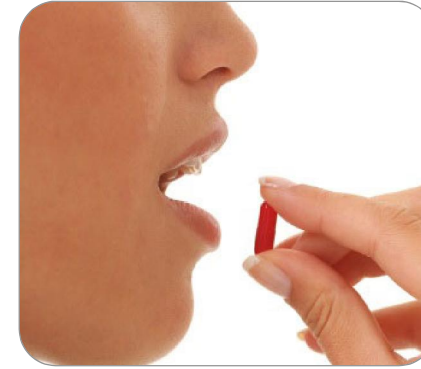
Efficacy

- Potency of the medicine in achieving viral suppression



Affordability/ availability

- Cost of the ARV medicines
- Generic formulations
- Availability in the market



Reduced pill burden/ od vs bd

- Preferably Fixed-dose combinations
- Once daily regimes preferred (convenient)

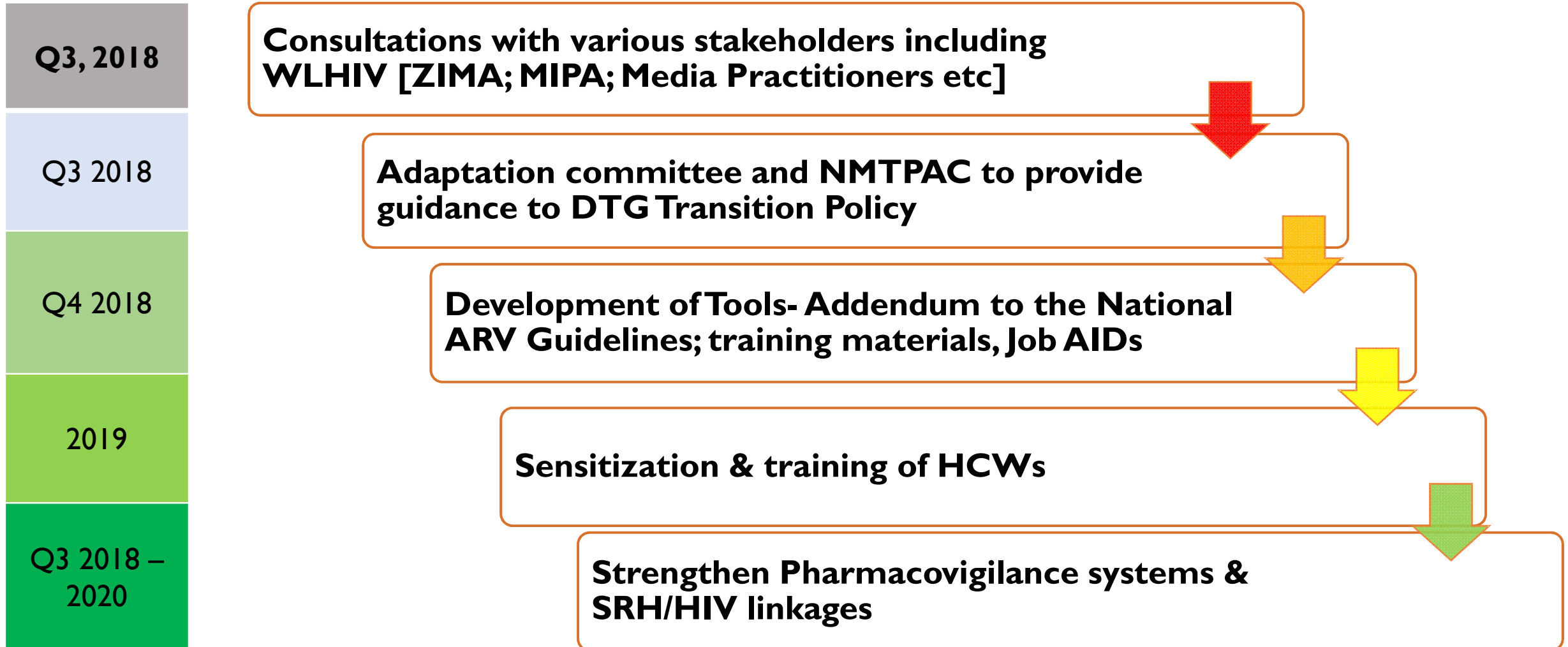


Harmonization across different age-groups & populations combinations

- Limited number of options used across populations

Other considerations - simplicity of use/prescribing by lower level cadres, cold chain requirements, existence of comorbid conditions

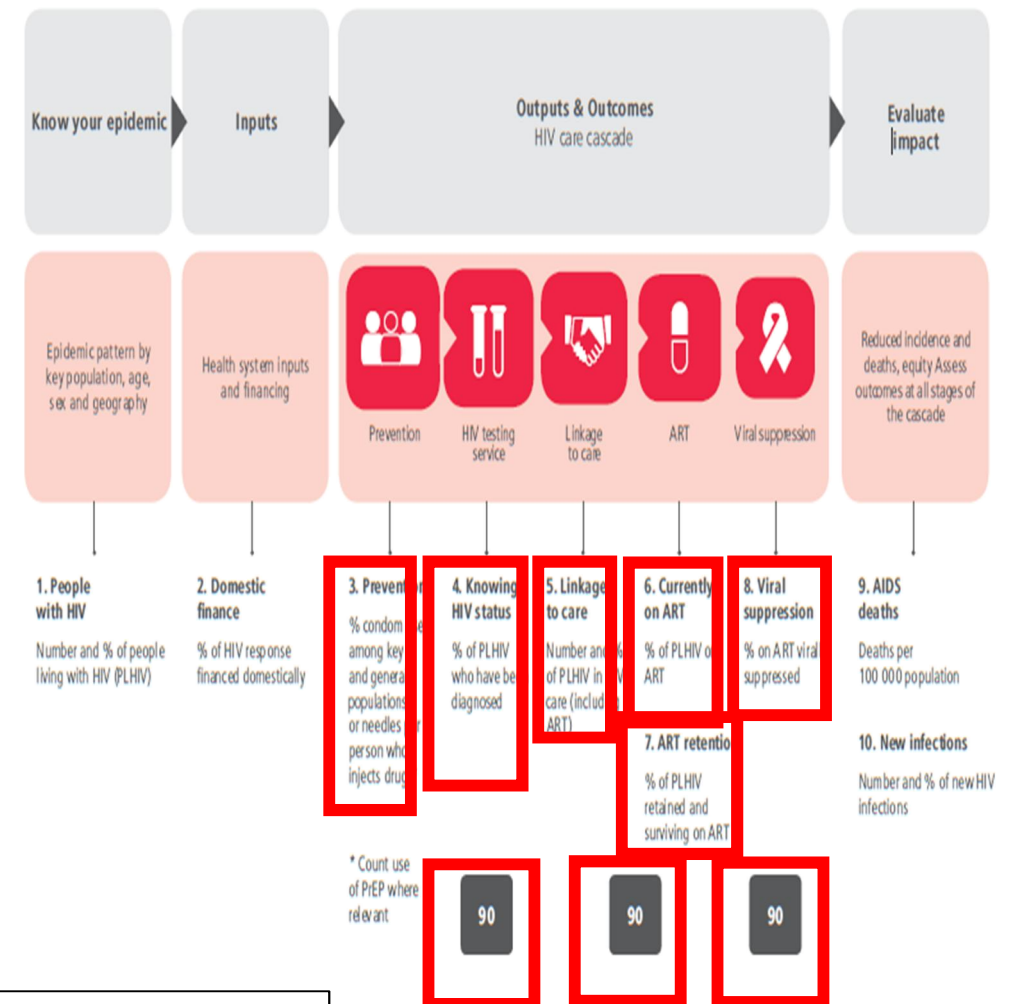
DTG Transitioning Roadmap



- Country adopting a phased in approach in introducing DTG based treatment regimens for 1st and 2nd line clients
 - All 'eligible' ART naïve clients starting from May 2019
 - All 'eligible' existing clients on ART after Aug 2019

5. HIV Case-Based Surveillance (CBS)

- Country entered a new treatment era with potential to eliminate HIV, MTCT & syphilis
 - Increased **focus on prevention in high-risk population groups** and geo-locations/ hot spots to reduce and interrupt HIV transmission and end AIDS
 - High need to **provide an accurate (unduplicated) measure of the HIV care cascade** indicators disaggregated by age, sex, risk population, geography and by individual
 - Increased **focus on targeting of resources and evaluation of program impact**
 - Increased **focus on retention of long term patient follow up** and **tracking patient outcomes**
- Zimbabwe selected with 3 other countries (Tanzania, Malawi and DRC) for first round of support by WHO to introduce CBS
 - Lessons learnt from implementation to inform subsequent roll out & introduction of CBS in region.



Thank You & Acknowledgements

- NAC
- Global Fund
- PEPFAR
- USAID and CDC
- UN Family (WHO, UNDP, UNICEF, UNFPA, UNAIDS)
- PSI, ITECH, OPHID, CHAI, FHI 360, ZACH, EGPAF, KAPNEK, PANGEA, AHF, MSF, SOLIDARMED
- MOHCC AIDS and TB Programs
- PMDs, DMOs
- All levels of health care delivery systems

