

# Zimbabwe: PMTCT



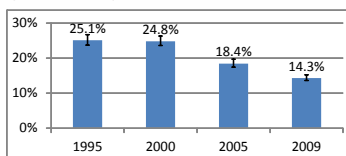
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## Statistics, 2010

Estimated # of children (0-14) living with HIV	150,000 [92,000-200,000] (2009)[19]
Population	12,523,000 (2009)[9]
Annual births	379,000 (2009)[9]
Neonatal mortality rate	36/1,000 (2004)[20]
Infant mortality rate	56/1,000 (2009)[10]
Under 5 mortality rate	90/1,000 (2009)[10]
Maternal mortality ratio	790/100,000 (2008)[15]
Adult HIV prevalence	14.3% [13.4%-15.4%] (2009)[19]
Estimated # of pregnant women living with HIV	50,000 [28,000-69,000] (2009)[3]
Exclusive breast-feeding for infants <6 months	6% (2010)[21]
HIV prevalence young people (15-24)	female: 6.9% [5.3%-9.3%] male: 3.3% [2.5%-4.4%] (2009)[19]
Comprehensive knowledge about HIV (15-24 yrs)	female: 53% male: - (2009)[2]
Condom use at last higher-risk sex (15-24)	female: 42% male: 68% (2005-2006)[5]
Unmet need for family planning:	13% (2005-2006)[5]
% ANC facilities that provide testing and ARVs for PMTCT	55% (2008)[3]
Timing of first ANC visit (months)	No ANC: 5% <4 months: 27% 4-5 months: 43% 6-7 months: 22% 8+ months: 3% DK: <1% (2005-2006)[5]
% of women attending at least 4 ANC visits during pregnancy	overall: 71% urban: 76% rural: 69% (2005-2006)[5]

## HIV prevalence among adults appears to be declining, though it remains high

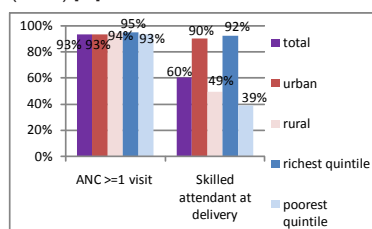
Adult HIV (15-49) prevalence (%) (1995-2009) [1]



Adult HIV prevalence has been declining, and in 2009 was estimated to be 14.3%. It was estimated at 16.1% among pregnant women (15 to 49 years) attending antenatal care (ANC) in 2009, and also shows evidence of decline. [1] Women are disproportionately affected - the prevalence in young women (15-24) was reported to be 6.9%, as compared to 3.3% in young men in the same age range. [19]

## Nearly all women receive skilled care during pregnancy; not enough poor and rural women do during delivery

Percentage of pregnant women attended at least once during pregnancy & % of births attended by skilled health personnel (2009) [16]

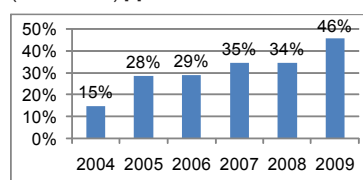


\* indicators were measured among women 15-49 who gave birth in the preceding 2 years.

93% of women were reported to have utilized antenatal care (ANC) services at least once during pregnancy in 2009, though 2005-2006 data suggests that >65% did so after the 3rd month of pregnancy. [5] 60% had a skilled attendant during delivery, though disparities exist in utilization, with 92% of the richest women and 90% of urban women receiving care by a skilled attendant during delivery, as compared to 39% of the poorest and 49% of rural women.

## Less than half of all pregnant women are tested for HIV

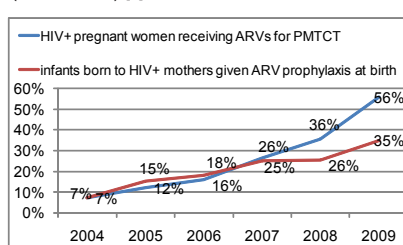
Trends in the percentage of pregnant women tested for HIV (2004-2009) [3]



In 2009, HIV-testing in pregnant women increased to 46%, compared to 15% in 2004. In 2008, 55% of ANC sites were reported to have HIV testing services. [3] There is evidence of high ANC utilization, suggesting either low utilization of testing services, or other barriers to HIV-testing in ANC.

## Increasingly more women and children are receiving ARVs for PMTCTs, but the gap between mothers and infants is vast

Trends in percentage of HIV+ pregnant women and HIV-exposed infants receiving ARVs for PMTCT (2004-2009) [3]



In 2009, 56% of HIV-positive pregnant women received antiretrovirals (ARVs) for PMTCT; only 35% of HIV-exposed infants received prophylactic ARVs for PMTCT. With continued efforts to reach women with PMTCT services, and renewed commitment to addressing gaps in ANC access and delivery by a skilled attendants, national targets for PMTCT can be met.

## DRAFT: National Targets by 2015 [18]

- 30% fewer HIV positive women have unmet need for family planning in 2015 than 2011
- 85% of HIV positive pregnant women receive antiretrovirals for PMTCT
- 100% of HIV-exposed infants receive virologic testing within 6 weeks of life
- 100% of HIV-positive pregnant women assessed for ART eligibility via CD4 testing
- 100% of sites that provide antenatal care also provide HIV testing & ARVs for PMTCT

## Strategic Focus of National Plan [18]

### Integrate:

- HIV prevention into ANC services;
- Family planning (FP) into HIV counseling and testing (HCT), PMTCT services, and pre-ART and ART services;
- HIV services into HCT and FP services; and
- PMTCT into HIV prevention programmes.

### Expand:

- Availability of comprehensive PMTCT services for pregnant women;
- Early infant diagnosis; and
- Coverage of ART to sites that offer PMTCT.

### Strengthen:

- Retention of mother-infant pairs in PMTCT;
- PMTCT monitoring & evaluation; and
- Participation of men in PMTCT services.

## POLICY ENVIRONMENT

- Costed ZNAPSII 2011-2015 first draft developed [6]
- No costed sub-national plans [6]
- WHO option A adopted [6]

## BUDGET ENVIRONMENT

- Global Funds (GFATM) recipient: R 1,5 & 8 [7]; limited re-programming of GFATM funds from R8 phase 2 for PMTCT underway [6]
  - PEPFAR Programme Country [8]
- ### Domestic Health Financing
- Govt expenditure on health, as per cent of total govt spending: 8.9% [4]
  - Total Health Financing: [11]  
Out of pocket: 24%; Public: 34%; Aid: 19%; Private: 23%

## THE BOTTOM LINE

If Zimbabwe is to reduce new infections among children, the following actions are essential:

- ✓ preventing new HIV infections among young women and improving access to family planning services among women living with HIV
- ✓ improving equitable access to skilled delivery by rural and poor women
- ✓ expanding PMTCT services in ANC sites and improving access to HIV testing within PMTCT services. The high reach of ANC services is an opportunity to reach HIV-positive pregnant women.
- ✓ improving access to PMTCT ARVs for HIV-exposed infants and women and therapy for the woman's own health.

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