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HIV/AIDS among people aged 50 and older in Zimbabwe

Fortunate Machingura[1], Gibson Mhlanga[2], David Hulme[3] and Tapuwa Magure[4]

Briefing Paper 2018

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Epidemiology and Demographics of HIV in Zimbabwe's older age groups

With the scale-up of antiretroviral treatment in Zimbabwe, many people are living longer with HIV. Although relatively few HIV surveys have been conducted among individuals aged 50 years and older, those available reveal high HIV prevalence. For instance, the recent demographic and health survey in Zimbabwe (2015-2016) reports that the HIV prevalence among men age 50 - 54 increased from 19.5% in 2010 to 28.9% in 2015 (ZimSTAT and ICF international, 2016). Similarly, a recent population-based cohort study in the eastern part of the country, from 1998-2011, reports that 56.3% of people aged 50 years or more, seroconverted – the process of becoming HIV positive – after their 50th birthday (Negin et al. 2014). But whether HIV incidence is also increasing among this age group requires additional research. This increase in prevalence may not adequately account for a potential increase in HIV prevalence among the population age 50 and older; it may however, also account for the ageing epidemic. The "ageing" of the Zimbabwean HIV epidemic is mainly due to three factors:

- The increased coverage of antiretroviral therapy (now at 75%) and especially its role in prolonging the lives of people living with HIV allowing them to live well past the age of 50 (UNAIDS, 2017).
- The decreasing HIV incidence among younger adults reducing the proportion of people living with HIV in the more youthful adult age groups, shifting the disease burden to older age groups (from 8.83 HIV incidence per 1000 population in 2005 to 3.03 per 1000 in 2016) (GoZ, 2016; UNAIDS, 2017).
- Although less often measured, people aged 50 years or older exhibit many of the risky behaviours and attitudes also found among younger ages.

1 Global Development Institute, University of Manchester, United Kingdom
2 Government of Zimbabwe, Ministry of Health and Child Care, Division of Preventive Services, Zimbabwe
3 Global Development Institute, University of Manchester, United Kingdom
4 Directorate, National AIDS Council, Zimbabwe

Understanding the ageing of the epidemic among people aged 50 years or older through their sexual behaviour and patterns of new infections, as well as comprehending their knowledge and their attitudes, is crucial for appropriately responding to the changing demographics of people living with HIV and the targeting of prevention programmes at this age group. HIV programmes for these older populations need to be specifically tailored to their needs because they potentially have different social and clinical needs than the other age groups; this could be a result of the higher levels of social isolation or accompanying comorbidities including non-communicable diseases.

This briefing paper provides a snapshot of HIV/AIDS among people 50 years or older in Zimbabwe.

Fast facts

- Almost half (47. 8%) of men aged 50-54 years do not have comprehensive knowledge about HIV. This includes the attribution of HIV infection to mosquito bites or sharing food with an HIV infected person; the belief that a healthy-looking person cannot possibly have HIV, and not acknowledging that the use of condoms correctly and consistently during sexual intercourse, and having just one uninfected faithful partner, can reduce one's chances of getting an HIV infection.
- Almost a quarter (22.2%) of men aged 50-54 years have discriminatory attitudes towards people living with HIV. In particular, this includes the belief that that children living with HIV should not be able to attend school with children who are HIV negative or and not buying fresh vegetables from a shopkeeper who has HIV
- Among the 15.6% of men aged 50-54 who had sexual intercourse with more than one partner in the 12 months preceding the country's 2015 population-based survey, only 33.3% used a condom the last time they had sexual intercourse.
- Among sexually active men aged 50-54 years who had sexual intercourse in the12 months preceding country's 2015 population-based survey, about 16.1% had intercourse with a non-marital, non-cohabitating partner and of these, 15% did not use a condom during the last occurrence of sexual intercourse with such a partner,
- Paying for sex in Zimbabwe exhibits an uneven negotiating ground for safer sexual intercourse. Among the 2.9% of men aged 50 – 54 who paid for sex in 12 months preceding the country's 2015 population-based survey, less than half used a condom the last time they paid for sex.
- HIV prevalence reaches a peak in the 40-44 age group among women (31.3%) and in the 50-54 age group among men (28.9%).

Source: ZimSTAT and ICF International (2016)

Why we must focus on older people

HIV prevention challenges among older people in Zimbabwe

Unlike younger age groups, older people in Zimbabwe are more likely to have an HIV late-stage diagnosis, which suggests that they often commence their HIV treatment late and are therefore likely to suffer more immune-system damage. Late diagnoses can occur because the older people are less likely to consider themselves at risk of HIV infection or are likely to mistake HIV symptoms for ageing and not consider HIV as a cause. They also face some unique issues:

- Sexually active widowed, married and divorced older people may be less aware of the risks of HIV than younger age groups, believing that HIV is not an issue for older people. Thus, they may be less likely to use HIV prevention methods to protect themselves from infection.
- Postmenopausal women are less worried about becoming pregnant and may thus be less likely to practice safer sex. The thinning and dryness of vaginal tissue associated with ageing may raise older women's risk for HIV infection.
- Older men and women are more likely than younger people to avoid discussion of their sexual behaviours and healthcare workers are less likely to ask their older patients about these issues.
- Older people are more likely than younger age groups to face isolation due to illness or the loss of family and friends, and HIV stigma may prevent them from seeking HIV care and disclosing their HIV status for fear of abandonment and isolation.
- Ageing with HIV infection also presents unique challenges for preventing other diseases because both age and HIV heighten the risk of cancers, bone loss and cardiovascular disease (Source: Machingura, 2016)

HIV treatment challenges among older people in Zimbabwe

Whether older people living with HIV are at an increased risk of adverse side effects from antiretroviral therapy than younger ages is not well documented – there is limited research on the efficacy and safety of antiretroviral regimens for this demographic in Zimbabwe. Although drug-related adverse events could be related to medication nonadherence, the available data to date suggests that older people living with HIV experience more adverse events and are at higher risk of lab abnormalities (Silverberg et al. 2007) than both younger HIV-infected patients receiving Antiretroviral Therapy (ART) and non-infected persons in the same age group cohort. For example, in comparison to noninfected persons, HIV-infected patients undergoing long-term use of HIV protease inhibitors (in ART) appear to have a higher prevalence of metabolic syndrome, which is characterised by reduced glucose tolerance and increased insulin resistance, high blood pressure, and abdominal obesity (Bonfanti et al. 2007; Palacios and Santos 2007). These medicine-induced metabolic changes, along with old age, have been associated with an increased risk of cardiovascular disease and myocardial infarction (DAD study group, 2007). Even with the initiation of antiretroviral therapy, CD4 cell count response among the elderly may be slower during the initial phase of ART therapy. Furthermore, interactions of medicines used to treat HIV and age-related conditions such as hypertension, elevated cholesterol, obesity and diabetes, can undermine efforts to manage HIV/AIDS (Gaber et al. 2004). Additional research is needed to test the pharmacovigilance of available HIV treatment among older HIV patients.

Conclusions

Growing awareness, improved utilisation of HIV prevention and treatment approaches, and the increased coverage of HIV treatment (now standing at 75%) in Zimbabwe has changed the course of the HIV epidemic. With the reductions in new infections from an estimated 8.83 HIV incidence per 1000 population in 2005 to 3.03/1000 in 2016, the country's demographic pattern of HIV infection is changing. The HIV population is ageing, and thus clinicians should be aware of the increasing need to manage HIV care and co-morbid conditions associated with ageing simultaneously.

Going forward, people-centred, participatory HIV responses will therefore need to prioritise this critical demographic. Health literacy interventions (TARSC, 2009) targeting this demographic cohort will need to reflect the risks and trends and facilitate the provision of the appropriate prevention, testing and treatment services.

We strongly recommend that effective and efficient additional participatory research is conducted in order to understand better the impact of ageing on the course of HIV infection, to develop and implement practical education and prevention measures, and to determine the efficacy and safety of antiretroviral therapy in older HIV-infected patients in Zimbabwe.

These changes in the demographics of the HIV population are a reminder that the epidemic defies a single, universal approach and continues to demand solid knowledge and focused responses from us all.

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This work is a collaborative undertaking by the Global Development Institute, University of Manchester UK; the Overseas Development Institute; the Government of Zimbabwe -Ministry of Health and Child Care; the National AIDS Council and the Colleges of Health Sciences at the Universities of Zimbabwe and Kwazulu Natal - South Africa. It is based on a desk review and consultations with relevant health staff and local nongovernmental organizations in Zimbabwe.

This is one of a series of the Briefing Papers at gdi.manchester.ac.uk/ . This is part of the Global Development Institute's and the Overseas Development Institute's work which aims to engage with policy actors to fast track action to 'leave no one behind' and facilitate the achievement of Sustainable Development Goals. This publication is based on work funded by the UK's Economic and Research Council (ESRC) grant number ES/P010245/1 under the Global Challenges Research Fund and the Bill and Melinda Gates Foundation through the Overseas Development Institute. The content contained within are those of the authors and do not necessarily reflect positions or policies of the ESRC or the Bill and Melinda Gates Foundation. Global Development Institute is the largest dedicated development research and teaching institute in Europe.

Global Development Institute
The University of Manchester
Oxford Rd, Manchester
M13 9PL
UK
Tel: +44 (0)161 306 6000
Email: GDI@manchester.ac.uk