Strengthening Community Health Systems for HIV Treatment, Support and Care: Case of Chitungwiza – Zimbabwe

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Training and Research Support Centre (TARSC) in the Community Based Systems in HIV Treatment (CoBaSys) programme

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Cover photo: Esther Sharara (June 2011- Chitungwiza PAR meeting- women group discussing the causes of their priority health problems) © TARSC / COBASYS 2011
Executive Summary

By 2010, Zimbabwe had one of the highest rates of pre-mature adult mortality in the world, largely due to AIDS. Annual mortality among adult women aged 15 to 49 increased from 244 per 100,000 in 1990 to 725 per 100,000 (MOHCW 2007). However, Zimbabwe is experiencing a decline in HIV AIDS prevalence and in new HIV infections. The estimated HIV and AIDS prevalence in adults in the 15-49 age groups of 14.1% in 2008 declined to an estimated 13.7% in 2009 (MOHCW 2009). This decreasing trend has been attributed to:

1) an increase in number of people on ART;
2) decreasing urban (from over 6% in the 1980s to an estimated 1.7% in 2005) and rural out-migration (from over 3% in the 1980s to less than zero by 2005) and
3) deaths due to AIDS (Gregson et al. 2010).

While the decline in HIV prevalence is encouraging, the prevalence remains high with more than one in seven Zimbabweans still infected with HIV.

The National Health Strategic Plan 2009-2013 acknowledges the role of communities in contributing meaningfully to a more people centred community health system for HIV treatment, prevention, support and care. However, communities do not have adequate platforms and institutionalised mechanisms for decision making to influence local decisions to respond to their priority needs. There is great potential to promote transparency, accountability of health service management, and community ownership of HIV interventions if communities are given the chance, space and opportunity to express their needs.

This background is the premise for the role of the Community Based Systems for HIV treatment (COBASYS) work that aims to empower communities to support antiretroviral delivery programmes for patients with HIV infection in east and southern Africa (ESA) at community level. The PAR approach used in this study demands commitment to take action on the problems identified. The research protocol was developed by TARSC; followed by a peer review and pretest prior to implementation. The study was conducted in the high-density dormitory town of Chitungwiza, the third-largest and fastest-growing urban centre in Zimbabwe. Participants were drawn from the community - PLWHA, men, women, and youth; MOHCW, local authorities, health workers, local leadership representatives, NAC representatives and others.

The findings suggest that economic hardships in Chitungwiza and lack of employment opportunities have led to an increase in residents buying and selling sex away from their homes. Stigma around sex work was reported to scupper the best intentioned participation programmes in the community. Lack of income affects women’s ability to pay school fees for their children, to provide adequate nourishing food for themselves and their children and often women either forget or deliberately skip their treatment when they do not have food. The costs associated with the acquisition of CD4 count machines were reported as increasingly high - with total costs needed for a CD4 check amounting to US$50 and higher. Repeat CD4 counts were often not done due to the shortage of machines, making the process getting ARVs cumbersome and expensive.

Stigma was viewed as a factor that strongly legitimizes discrimination against women who are HIV positive, often in family and community settings. Non-disclosure of HIV-infection within families often leads to lack of forward planning, leaving orphans and other bereaved dependents economically deprived once the bread winner dies. Common concerns in the discussion on patient flow from both health worker and community participants included long waiting times, insufficient staff, and drug and equipment shortages all of which undermine contact coverage.

Governance and accountability was noted as one of the important underlying causes of priority health problems for HIV responses. Accountability was reported as weak, often
leading to suspicion and distrust from donors and funders alike. At a more global level the international aid for HIV is reported to be associated with excessive administrative work and administrative costs, often accompanied by huge reporting demands.

Clinical mentors with substantial expertise in antiretroviral therapy and opportunistic infections who should in ideal circumstances respond to questions, review clinical cases, provide feedback, assist in case management and who can provide ongoing mentoring to less-experienced HIV clinical providers are not available. The discussion suggested that clinical mentoring should be integrated at national strategic planning level so funding could be provided for this. Lack of time, huge workloads, limited clinical experience and lack of effective communication skills were provided as reasons why health workers often limit conversations with HIV clients.

These findings show that it is essential to move the debate beyond ‘vertical’ disease specific funding to a more people centred approach that strengthens a community system for effective HIV AIDS responses. There is an urgent need to expand HIV treatment to a comprehensive PHC based approach – one that takes into account the wider needs of communities that are copings with an already enormous burden from other acute and chronic diseases such as chronic hypertension and diabetes.

**Recommendations for community level responses**

- Community based awareness and education campaigns on HIV treatment, prevention, support and care should involve debates on sexual pleasure and satisfaction within ongoing mechanisms to address community systems for HIV.
- Civil society should be capacitated and informed to demand the government of Zimbabwe to commit to the Abuja declarations. At regional and international level civil society should demand commitment to the global political commitments made to facilitate access to HIV treatment, prevention, and care resources and to further provide additional resources for accelerating actions against AIDS.

**Recommendations in the interface between community and the health system**

- Drugs, diagnostic equipment and other commodities that are locally manufactured should be procured and distributed in pre-packed form to operational levels through partnership with local manufacturing companies. For imported drugs, bulk purchasing mechanisms should be strengthened through supporting NATPHARM to lower their costs. Accountability mechanisms should be put in place and monitored by communities and by MOHCW to prevent leakages of drugs purchased at reduced prices.

**Recommendations for the interaction in the health system**

- The larger global health initiatives should engage with each other, and the Government of Zimbabwe through the MOHCW as well as local stakeholders should embrace and move beyond the Paris Declaration and develop coherent and user-friendly systems for the disbursement of funds, alignment, and coordination ‘down to community levels’.
- Efforts to assist in translating the Paris Declaration into practice and to improve coordination between HIV AIDS response actors should be heightened.
- Operational research should be incorporated and funded as part of Chitungwiza health plans. This would ensure that solutions to accessibility and other implementation constraints and the most effective approaches to scaling up access are identified.
- Clinical mentoring should be integrated into the national strategic plan to encompass a public health approach to antiretroviral therapy and opportunistic infection management in similar ways as that of TB strategies such as the Directly Observed Short course (DOTS) treatment that is based on simplified clinical decision-making.
- Promotion of long-term, sustainable HIV responses through strengthening community health systems for HIV - tackling the social determinants of health that both drive the epidemic and hinder the responses should be supported by multi actors including other line ministries to support the MOHCW.
1. Background

In 2010, Zimbabwe had one of the highest rates of pre-mature adult mortality in the world, largely due to AIDS. Annual mortality among adult women aged 15-49 increased from 244 per 100,000 in 1990 to 725 per 100,000 (MOHCW 2007). However, AIDS-related mortality is decreasing and this has been attributed to:

1) an increase in number of people or ART
2) decreasing urban (from over 6% in the 1980s to an estimated 1.7% in 2005) and rural out-migration (from over 3% in the 1980s to less than zero by 2005) out-migration and
3) deaths due to AIDS. (Gregson et al. 2010).

International commitments, declarations, national policies and strategies provide the context to Zimbabwe’s HIV response. As an UNGASS signatory, the country tracks and reports on the UNGASS indicators on a biennial basis. Zimbabwe signed the Abuja Declaration of 1998, in which governments committed that a minimum of 15% of total government budget should go towards health care for the nation. In relation to this, the Government introduced the National AIDS Trust Fund (“AIDS Levy”) which collects 3% of all taxable individual and corporate income to fund HIV programmes in the country. The National AIDS Council (NAC), established by an Act of Parliament in 1999, has a broad-based mandate to provide for measures to combat HIV and AIDS.

The national HIV response is heavily dependent on multilateral and bilateral partners and international foundations. The number of people currently on ART increased as a result of programme decentralization as well as expansion of outreach programmes particularly in Global Fund supported districts. Based on the 2009 WHO recommendation of initiating ART at a CD4 count of 350 or less, adults eligible for ART increased to almost half a million (570,000) by the end of 2009 (Zimbabwe National HIV/AIDS Estimates, 2009 AIDS and TB Programme, MoHCW).

Multi-sectoral collaboration interlaced with community participation and civil society engagement has been strategically structured to support and coordinate the public in the delivery of community-based systems for HIV responses. The National Health Strategic Plan 2009-2013 acknowledges the role of communities in contributing meaningfully to a more people centred community health system for HIV treatment, prevention, support and care. However, communities do not have adequate platforms and institutionalised mechanisms for decision making, to influence local decisions to respond to their priority needs. If communities are given a chance, space and opportunities to express their needs there is potential to promote transparency, accountability of health service management, and promoting community ownership of HIV interventions. Thus, communities are left disempowered thereby undermining opportunities to build primary health care oriented responses for HIV responses at community level.

This background is the premise for the role of the Community Based Systems for HIV treatment (COBASYS) work that aims to empower communities to support antiretroviral delivery programmes for patients with HIV infection in east and southern Africa (ESA). This is done through a regional network for policy advocacy targeting vulnerable groups in ESA and Europe with support from the European Commission through the African Caribbean and Pacific (ACP) group of States. The work primarily focuses on building a solid ‘community based system that supports HIV treatment to benefit the most vulnerable social groups at primary care level. The learning and evidence from this tier of the health system is collated, synthesized (from other study sites) for national level advocacy and further integrated at regional level (from 21 research sites in 6 countries) for global engagement.
Thus in this context “Treatment of HIV/AIDS encompasses a range of curative services, including treatment of opportunistic infections, tuberculosis, sexually transmitted infections and the provision of antiretroviral drugs. Beyond this clinical component, treatment is also understood to include a range of management and support interventions such as treatment literacy, psychosocial support, nutrition education and integrated management of HIV/AIDS and STIs. These measures, aimed at maximizing treatment adherence and efficacy, are essential complements to medical interventions. Treatment may involve the actions of a single provider, but often involves the actions of different providers acting simultaneously.”

The Participatory Reflection and Action (PRA) research in Chitungwiza was conducted to explore the factors that facilitate and block access to, use and effective coverage of services and responses to HIV. This is aimed at identifying effective approaches to building community systems for responding to HIV AIDS and services that support these systems. Within the overall framework of the research programme, the Chitungwiza PRA research aimed to:

i. Map the social economic differentials within the communities that affect risk and vulnerability to HIV and AIDS, and that may have an impact on uptake of available services for prevention, treatment and care of AIDS.

ii. Using this identify the nature of the epidemic in the community in terms of risk groups and environments, the public health stage and burdens of the epidemic and discuss the nature of the responses needed for key social groups.

iii. Map the resources, institutions and actors available at community and primary care level to respond to the epidemic.

iv. Identify for key social groups the priority social and economic determinants at individual, household, community and system level that facilitate and block availability, access, acceptability, uptake, quality of care in and adherence to the resources above for prevention, treatment and care for HIV and AIDS (including community knowledge on social rights)
v. Review the evidence to assess the opportunities and mechanisms to enhance facilitators and overcome priority blocks to availability, access, acceptability, uptake, quality of care in and adherence to services: (e.g. opinion leader and health worker attitudes and practices; communication processes and skills, mechanisms for social dialogue and communication; resource transfers, service organization and so on)

vi. Identify strategies for strengthening these opportunities and mechanisms as recommended by communities, health authorities, opinion leaders and key stakeholders, the actions that can be taken in the medium and long term for these strategies and the progress markers for these actions.

This report provides findings, discussion and recommendations from an action research conducted in Chitungwiza held in May 2011

2. Methods

The study used qualitative Participatory Action Research (PAR) approaches. Action research is time consuming, thus researchers and research participants are obliged to jointly follow up and provide possible actions to the identified priority needs. However this often depends on feasibility and actions within their capacities and resources. On a positive note, action research provides means of improving and enhancing practice by involving community dialogue at the very early stages of programme planning. It therefore builds the basis for negotiation and partnership between researchers, resource holders and beneficiaries. The tools that have been used to collate and synthesise the findings have been peer reviewed and pre-tested to assert and determine usefulness in drawing out responses and discussions that frame the data needed to address the research questions. The selection of participants was done carefully and rigorously to represent the target group. The target group included people living with HIV and those affected by it, health workers involved in HIV and ART management from Chitungwiza, local civil society and NGO representatives working in Chitungwiza, NAC representatives, MOHCW representatives, social welfare representatives, youth living with and affected by HIV, representatives of HIV AIDS support groups in Chitungwiza, representatives from the Community Working Group on Health, local headmasters, local authorities and local leadership.

This action research was not only implemented in Chitungwiza but also in Goromonzi and Kariba districts to enable meaningful synthesis and drawing of conclusions at national level. Importantly, action research unlike quantitative research is not undermined by numbers of respondents (sample size) but by the quality of participatory action research tools and ability of researchers to collate and synthesize the evidence for action.

To this end, a Participatory Reflection and Action (PRA) study protocol authored by the Training and Research Support Centre (TARSC) (Machingura F, Loewenson R and Kaim B) was peer reviewed by research experts from University of Manchester, University of Eduardo Mondlane- Mozambique, University of Namibia, University of Botswana, University of Modena- Italy, University of Helsinki - Finland, REACH Trust Malawi and by the University of Zimbabwe. The tools were pre-tested in Chikwaka - Goromonzi with members representing the target social groups. Researchers from east and southern Africa were trained over a 3-day regional training workshop in April 2010 (Harare) on participatory research methods for community based systems in HIV treatment – ‘Strengthening capacities for qualitative research using PRA approaches’ by TARSC (TARSC 2010)

The table below shows how the methodology was staged in the protocol for each study objective.
Table 1: Staging of Methodology and how each of the aims was addressed

<table>
<thead>
<tr>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 meeting</td>
<td></td>
</tr>
<tr>
<td>Map the social economic differentials within the communities that affect risk and vulnerability to HIV and AIDS, and that may have an impact on uptake of available services for prevention, treatment and care of AIDS.</td>
<td>• Social mapping,</td>
</tr>
<tr>
<td></td>
<td>• Map interview</td>
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<tr>
<td></td>
<td>• Discussion</td>
</tr>
<tr>
<td>Using this, identify the nature of the epidemic in the community in terms of risk groups and environments, the public health stage and burdens of the epidemic and discuss the nature of the responses needed for key social groups.</td>
<td>• Stepwise diagram and Focus Group Discussion (use FGD guide)</td>
</tr>
<tr>
<td>Identify for key social groups the priority social and economic determinants at individual household, community and systems level that facilitate and block availability, access, acceptability, uptake, quality of care in and adherence to the resources for prevention, treatment and care for HIV and AIDS (including community knowledge on social rights).</td>
<td>• Ranking and scoring</td>
</tr>
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<td></td>
<td>• Problem tree</td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
</tr>
<tr>
<td>Map the resources, institutions and actors available at community and primary care level to respond to the epidemic.</td>
<td>• Stakeholder analysis</td>
</tr>
<tr>
<td></td>
<td>• Plenary roundtable (community roundtable)</td>
</tr>
<tr>
<td>Review the evidence to assess the opportunities and mechanisms to enhance facilitators and overcome priority blocks to access.</td>
<td>• Leaping blocks</td>
</tr>
<tr>
<td></td>
<td>• Market place</td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
</tr>
<tr>
<td>Identify strategies for strengthening these opportunities and mechanisms as recommended by communities, health authorities, opinion leaders and key stakeholders, the actions that can be taken in the medium and long term for these strategies and the progress markers for these actions.</td>
<td>• Margolis wheel</td>
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<td>• Spider web</td>
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<td></td>
<td>• Group discussions</td>
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<tr>
<td></td>
<td>• Market place</td>
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</table>


3. Findings of PRA research

4.1. Mapping social and economic differentials in Chitungwiza

Chitungwiza, a high-density dormitory town in Zimbabwe with three main suburb sections including (a) Zengeza composed of 5 different sub-sections i.e. Zengeza 1 to 5; (b) Seke composed of 15 different housing estates named after the alphabet i.e. Unit A, B, C, D, E, F, G, H, J, K, L, M, N, O, and Unit P and (c) St Marys divided into several sections. The houses are high density units with small yards. Public transport is composed of “makombi”-emergency taxis - minibus taxis. Chitungwiza is the third-largest and the fastest-growing urban centre in Zimbabwe. Most of the people work in Harare, as there is very little industry in Chitungwiza.

The socio economic characteristics of Chitungwiza that have an impact on responses to HIV treatment, prevention support and care were defined through a participatory tool termed the social mapping. The PRA activity mapped the social economic differentials within the communities that affect risk and vulnerability to HIV and AIDS, and that may have an impact on uptake of available services for prevention, treatment and care of AIDS. The features, social groups, clinical sites and community groups that were perceived as important, that also profiled HIV responses at primary care level were noted. Participants in groups of gender and age used the map to discuss how these features and social groups affected HIV responses in Chitungwiza.
The social features and activities identified in the area included clinics ANC (Antenatal Care), PITC (Provider Initiated Testing and Counselling), VCT (Voluntary Testing and Counselling) and PMTCT (Prevention of Mother to Child Transmission services). Community Based Organisations, churches, NGOs (Non Governmental Organisations), recreational centres, commuter bus terminuses, lodges, Home based care givers, community health volunteers, women and youth groups, HIV support groups, households, schools, pre-schools, youth centres, colleges, civic centre, beer halls, night clubs, ‘flea’ markets and brothels.

**Economic sources identified through the mapping activity in Chitungwiza disaggregated by sex include:**

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art and crafts</td>
<td>Vegetable vending</td>
</tr>
<tr>
<td>Photography</td>
<td>Miscellaneous vending</td>
</tr>
<tr>
<td>Fish monger</td>
<td>Money changing /black market</td>
</tr>
<tr>
<td>Firewood sellers</td>
<td>Hair salon</td>
</tr>
<tr>
<td>Formal employment in Harare and in supermarkets around Chitungwiza</td>
<td>Prostitution</td>
</tr>
<tr>
<td>Cross borderer traders</td>
<td>Formal employment in Harare and in supermarkets around Chitungwiza</td>
</tr>
<tr>
<td>Carpentry</td>
<td>Cross borderer trading</td>
</tr>
<tr>
<td>Brick moulding</td>
<td>Dress making</td>
</tr>
<tr>
<td>“Stealing”</td>
<td>Begging</td>
</tr>
<tr>
<td>Phone credit vending</td>
<td>Urban farming</td>
</tr>
</tbody>
</table>

Interesting to note was the fact that men participants viewed stealing as a source of money while women viewed begging as a livelihood strategy in accessing resources for health.

The economic hardships in Chitungwiza and lack of employment opportunities were reported to have led to an increase in people who buy and sell sex away from their homes. Stigma around sex work was reported to undermine some of the HIV community programmes that could otherwise enhance sex worker participation in HIV AIDS community responses. For example male participants reported that it is often difficult to meet the female sex workers participating in any community health related functions such as those supported by civil society organisations working on HIV AIDS.

“The problem is that sex workers are ignorant, arrogant and hypocritical. They do not want to learn, the continue sleeping around spreading infections because of poverty and economic challenges. On Sunday, you will see them at church pretending to be people of good morals, this on its own shows that they deny who they really are, therefore their full participation in HIV AIDS related activities at community level is gravely undermined” Participant

The discussion clearly exposed the stigma surrounding sex work in Chitungwiza. Female participants reported that the stigma within communities in Chitungwiza is sometimes premised on the lack of understanding between the sex workers and development workers including the MOHCW. They further reported that in some places sex workers complain that participating in HIV activities seems to provide a licence to scrutinise around brothels and red light areas, and pry into their personal lives. They are frequently accused of being immoral and blamed for spreading the virus while male clients are hardly mentioned.

**4.2. Priority socio-economic determinants affecting health service coverage**

**Poverty** as a proxy for lack of income was reported to be the second highest priority problem. Men participants reported that lack of income in Chitungwiza affected access to health care particularly HIV AIDS resources. Women participants also agreed and noted that lack of income affected their ability to pay school fees and to provide adequate nourishing
food for themselves and their children and caused a good deal of stress. They reported that often times most women forgot to take their treatment or deliberately skipped it food was not available. In most cases, they reported that they would turn to other sources of income such as vending, cross border trading and some were reported to use sex for money.

**Access to CD4 counting machines** was reported to be the leading health problem amongst women in Chitungwiza. It was also noted among the priority problems amongst men. Participants reported that people are dying because they cannot afford charges at the private clinics and private doctor surgeries. These clinics have sprung up because the government run Chitungwiza Central Hospital did not have adequate diagnostic machines such as the CD4 Count Machines. Chitungwiza Central Hospital was reported as the only ART initiation site in the whole of Chitungwiza leading to congestion, long waiting hours and huge health worker workloads at the hospital. The huge workloads often resulted in sour relationships between health workers and clients, condescending behaviour towards clients and inadequate counselling provided to clients. The $35 costs of CD4 count (user fees) was reported to be exorbitant and unaffordable given that communities struggled to pay the $5 initial costs before the cost hikes.

Participants at the research meeting noted that the **costs associated with access to ARVs and CD4 count machines** were too high:

1. For instance the transport costs needed to reach the hospital and return home (*from Makoni Shopping Centre one would need about $2 to and from Chitungwiza Central Hospital*);
2. The user fees at the Hospital (one needs to pay $35 for a CD4 count);
3. The long waiting times (opportunity costs - It’s likely that one would spend the time in an income generating project such as selling tomatoes by the road side where they are likely to make about $10-$30 a day depending on the quality of the produce than waiting for a CD4 count or for counselling at the Hospital);
4. Food costs (due to the long waiting times the client is likely to buy food while waiting (local sadza and a ‘cool drink’ which requires an average of $3 to $5).

In total participants reported that the money needed on just a single visit to access treatment is often more than the average salaries in the community. Further the repeat CD4 counts are not being done due the shortage of the machines (also a lot of people will be relying on one machine so priority is given to those who are starting). So the process to get ARVs is lengthy, cumbersome and expensive.

Due to these high costs both women and men participants reported that most ARV clients have reverted to indigenous medical practitioners and religious faith healers, whom they understand and trust and from whom they receive sympathy if not “cures”. The discussion showed that there is a tragedy associated with this. For instance when a person on HIV treatment defaults on treatment; they may develop resistance to the first line drugs and as a result they may develop complications with which traditional healers and “prophets” may not be able to deal with effectively.

**Negative attitude towards sexual health** was rated the second leading priority health problem amongst men. The male participants reported that despite a relatively high degree of awareness about HIV/AIDS, levels of condom use are sporadic and low; the need to use condoms is related to the idea of “untrustworthiness” in the partner, and perceived as bringing an expectation of *unfaithfulness*. They further reported that there is lack of sensation when using condoms which often leads to perceived lack of pleasure and satisfaction during intercourse. Some men participants highlighted that they think the condom is unreliable and immoral (for married partners). They reported that the condom should be worn when the penis is erect, at which point the mind is ready for intercourse, making it very difficult to wear it properly if one puts it on in the first place and
also, they have an uncomfortable tight ring. Participants in a plenary discussion disclosed that most sexual companions withheld their status from their partners out of fear of blame, domestic violence, divorce and loss of economic support that might ensue. This was reported to cause difficulties in avoiding unprotected sex to prevent re-infection as suggesting safe sex often gives rise to suspicion.

In this discussion, one woman participant expressed huge concern over such perceptions among men saying:

“The strongest influence on how quickly the epidemic spreads in Chitungwiza is the sexual behaviour and your attitudes... you men. It is you (pointing at men) not us (pointing at herself) who determine when, where, with who and frequency of sex, and on top of that condom use. It you who often have ‘small houses’
, so you have the opportunity to transmit HIV to your wife and to your small houses. Also, you are the ones who purchase sex; you drive the commercial sex work. How many times have we heard or witnessed a woman looking for or wanting to buy sex? Zero if there are cases, they are too few. Your attitudes and behaviour are at the helm of our challenges!!” Female participant

In this discussion, it was clear that sexual pleasure and satisfaction questions need more attention in sexual Health and HIV AIDS treatment debates. This can be viewed as both an underlying determinant of effective or ineffective HIV community systems for HIV treatment in Zimbabwe. From this discussion one more conclusion can be made: sexual pleasure and satisfaction is a more important consideration to some individuals than protection from diseases as most men may not consider the problem of HIV/AIDS as an overriding factor in how they conduct their sexual practices or relationships, because they may not perceive themselves at the risk of HIV/AIDS.

Stigma and discrimination was the third highest priority amongst women. It was not a priority on the men’s list of health problems. Women participants described stigma as a factor that causes and increases discrimination for HIV positive women, often around family neighbors and wider community settings. At particularly big family gatherings, women reported that they were often asked ‘to rest, to take it easy’, so that they are not made to cook, wash dishes, cut vegetables or meat- duties they would have otherwise been asked to do.

“kazhinjizhinji unoti wasvika kumusha panhamo kana pachristmas unenge uchingonzi aiwa chimbozororai, musazvinetse mirai tite isu, musacheke maveji mungazovicheke, aah mungabikire vanhu vose ava here? Mungavagone? Vanotoda isu kana ava vanemabonzo akasimba”. Loosely translated as:

“often times in big family gatherings such as back home in the rural areas at funerals or during Christmas gatherings you are often told, rest a bit, take it easy-don’t bother yourself, wait we will do this, don’t cut the veggies you may cut yourself, aah can you cook for all these people? Will you be able? They will need us or those ones with strong bones (physical strength)” Participant

“Pane vamwe vanoti vakangoziva kuti ndine HIV kana hope, chido kana shungu neupenyu zvinobva zvati mhomho. Vamwe kana kucollege anobva arega kuuya, basa anotanga

1 (Other women partners outside the matrimonial home- often these are long term relationships, some can have children with these partners.
Loosely translated as:
“There are some whom if they get to know about their positive HIV status they lose hope, will, vision, their dreams and inspirations in life. Some can drop out of college, some do not show up at work until they lose their jobs, some will often skip meals, some commit suicide, some become violent or begin to hate relatives and their friends, they become total strangers!”

Participant

The discussions showed that such shame often has powerful psychological influence over how people with HIV see themselves and adjust to their status, making them vulnerable to blame, depression and self-imposed isolation. Exaggerated kindness in the community often seen from neighbours, church colleagues, work colleagues and from other social group friends was reported as a significant predictor of psychological distress. Further, this was also seen as one of the reasons associated with non-disclosure and difficulty in seeking treatment, care and support reinforcing stigma and discrimination. Such labels and fear are perpetuated when communities often only recognize people living with HIV when they are in the weakening and symptomatic final stages of AIDS, and denial and silence buttress the stigmatization of these already-vulnerable individuals. Also, women participants reported that the non-disclosure of HIV-infection within families often leads to lack of forward planning, leaving orphans and other bereaved dependents economically deprived once the bread winner dies and often marginalized, if their association with AIDS becomes known.

The unfriendliness (in use) of the Femidom- the female condom was ranked 6th by women participants. Women participants reported that:
1) The condom frustrates sexual intercourse as one is often forced to hold the outer ring to keep in the position while having sex. The mind is shifted from intercourse to keeping the condom in place;
2) the condom produces a “xa-xa crackling’ irritating sound which disgusts and kills the mood for sex;
3) It is only to satisfy men and leaves a woman without pleasure, satisfaction or reaching an orgasm;
4) The drum shape is upsetting - the insertion of the condom is difficult, especially just before intercourse. While inserting it prior to intercourse is acceptable, it comes with challenges because the mood for sex is very unpredictable.

While the distribution of female condoms is high in Chitungwiza in hair salons, and other public places frequented by women, it was argued that they do not take the condom to use it, but to extract the lubricant oil to apply to hair, wigs and weaves.

“The oil is very good for the hair wigs, they become very shiny and lustrous! This is what we do, very few people use the female condom, it’s just unusable, the noise, the insertion, the amount of work needed to keep in place…it’s not for us but for us to wear it for men so that the same men can have the best moments of their lives!”

Participant

Table 2 below gives a summary of priority health problems (men and women) in Chitungwiza

<table>
<thead>
<tr>
<th>Rank</th>
<th>Priority health problems</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low access to treatment (CD4)</td>
<td>Low access to treatment (CD4 counting machines)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lack of adequate knowledge</td>
<td>Negative attitude towards sexual health (mentality)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Stigma and Discrimination</td>
<td>Poverty (lack of basic needs –food, shelter, clothing)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Gender inequalities</td>
<td>Promiscuity (multiple partners and buying sex)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Economic hardships (poverty)</td>
<td>Policy issues</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Lack of user friendly female condom</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.3. Underlying, intermediate and immediate causes of health needs

Low access to treatment was collectively agreed to be one of the most significant barriers in effective community health systems on HIV treatment. In order to understand the causes of this problem we used a PRA tool to explore the immediate, intermediate and underlying causes of low access to treatment. Two groups (one for men and one for women) discussed the causes and later jointly discussed the outcomes of their discussion. The following highlights the results of the discussion.

Immediate causes:

- **Stigma and discrimination:** leads to non-disclosure and difficulty in seeking treatment, care and support.
- **Congestion at the ART initiation centre – Chitungwiza Central Hospital:** leads to sour relations between clients/patients and health workers which in turn leads to lack of confidentiality, reduced quality of care; increased favouritism and corruption to access service; drug stock outs; prolonged process to get ARVs and or a CD4 count.
- **Distance and transport:** only the Chitungwiza Central Hospital initiates ART. This often creates long travel distances for people coming from Rural Seke and Dema areas. Even for those in the Zengeza Chitungwiza areas, transports costs increase the costs of accessing ART. This was reported as hidden out of pocket costs that reduce access to ART.
- **Inadequate infrastructure:** Counselling - adherence counselling in particular is done at the back of the hospital close to the mortuary. Due to unavailability of proper infrastructure clients scheduled for counselling end up attending group sessions close to the mortuary. A person attending this counselling session for the first time, will feel discriminated and excluded from decent facilities or from what is thought to be normal service. They feel drawn closer to death and thrown in the deep-end, often not ready for treatment adherence counselling, let alone an encounter with a group of unfamiliar people or even familiar neighbours and friends who might have already accepted their status, perhaps coming for the umpteenth time. The environment was also reported to be unfavourable for young people as they often face stigma when they visit the facility for any form of STIs.
- **Shortage of Equipment –** (CD4 Count Machines; Liver Function Testing machines; Full blood count machines): to qualify for ARVs, one’s individual CD4 should be 350 cells/mm³ or less. To determine the CD4 count one has to wait on a queue and often patients are given a date weeks or months away. When their turn finally comes they are asked to pay $35 for the count. This was reported to be due to expensive Fluorescent Activated Cells-FACS machines (for CD4 count), expensive antibodies and shortage of trained persons necessary to perform the tests and maintain the equipment. This immediately reduces access to ARVs.
- **User fees and out of pocket costs:** significantly increase the costs of accessing ARVs. The $35 fee needed to check the CD4 count is exorbitant for poor communities. There is only one initiation site making it expensive in terms of transport, food and other related costs.

Intermediate causes:

- **Lack of knowledge** which was reported to often lead to stigma, discrimination → shame → failure to seek and or get treatment, support and care on time → further weakening of the immune system (symptomatic HIV) → AIDS → Seek treatment but too late → others in the community develop impressions that HIV is the same as AIDS = death penalty → Fear → discrimination → stigma.
- **Shortage of computers:** makes workloads huge and unbearable leading to congestion.
- **Centralisation of ART initiation:** increased congestion, workloads, out of pocket costs.
• **Low allocation of resources to health**: makes health care very expensive because government fails to subsidise the cost of health. It creates shortages of equipment and maintenance becomes impossible. Where financial resources are made available at central level, they fail to reach operational levels; thus implementation of district plans is often hampered by failure of disbursement of allocated and approved budgets. For example the Chitungwiza health plans were reported not to have adequately reflected the strategies that are included in the National Strategic Plan 2009-2013.

**Underlying causes**

- **Governance and accountability** (both at national and international level): At national level, participants reported that the little resources allocated to health particularly for HIV including the AIDS levy do not reach the target beneficiary to the extent they should. Accountability is weak, often leading to suspicion and distrust from donors and funders alike. At a more global level the international funds for HIV such as the Global Fund for HIV, TB and Malaria is reported to be associated with a lot of administrative work and administrative costs, often accompanied by huge reporting demands. This takes away the attention of the fund to ‘petty unnecessary avoidable’ processes that burden the process of acquiring resources such as CD4 count machines.

- **Economic hardships** at national level undermine other sectors of production and development affecting the ability of a country to purchase equipment, drugs and sundries and adequately resource the health facilities.

- **Weak comprehensive Primary Health Care** continues to undermine management of HIV, opportunistic infections, access to health services and health information, uptake of treatment, support and care.

**4.4. Gaps and barriers in current service coverage.**

We understand health service coverage as “the extent to which services reach out to communities needing it. In this context it is the extent to which health services reach out to
communities affected and living with HIV including some vulnerable groups and other social
groups in similar social networks. It also addresses how communities interact with the
services provided by community health systems and the wider health systems in terms of
access, provision and uptake of HIV treatment, support, prevention and care services.
Services will include those provided by health care systems, those demanded by
communities, resources generated for health, financing of health systems and stewardship”
(Machingura et al 2010)

the Tanahashi model was used to identify the nature of the epidemic in the community in
terms of risk groups and environments, the public health stage and burdens of the epidemic
and discuss the nature of the response needed for key social groups.. Tanahashi (1978)
provided a concept of coverage that helps to understand the level at which inequalities in
peoples’ contact with health care may arise. Tanahashi provides for five domains for this
(See Figure 2):

**Figure 2:** Tanahashi model of health service coverage.

- **SERVICE DELIVERY GOAL**
- **EFFECTIVE COVERAGE**
- **CONTACT COVERAGE**
- **ACCEPTABILITY COVERAGE**
- **ACCESSIBILITY COVERAGE**
- **AVAILABILITY COVERAGE**
- **TARGET POPULATION**

Source: Tanahashi, 1978

Three social groups (men, women and youth) each identified a service where resources
were available but where the social group faced challenges in accessibility, acceptability of
those resources up to the point of contact and effective coverage. All the social groups noted
that HIV treatment systems and services were available., However there were challenges
associated with accessibility, acceptability and utilizations that did not translate to effective
coverage. The Tanahashi model was used to discuss the health service coverage in terms
of HIV treatment in Chitungwiza city. The tool was designed to enable communities to
express coverage of HIV treatment relative to need of the population requiring treatment who
have used the service. Reasons for flaws in availability, accessibility, acceptability, contact
and effective coverage were identified and possible solutions were discussed, including
recommendations on how to strengthen the community based system on HIV treatment.

The five domains of coverage were expressed in terms of availability, accessibility,
acceptability, contact and effective coverage as outlined below.
i. Are the care resources (infrastructure, drugs, personnel) available, and for whom? Termed availability coverage.

ii. Are these resources accessible, and for whom? This is termed accessibility coverage. There may be physical or financial barriers to access.

iii. Are the resources/services acceptable to the population, and for whom? This is termed acceptability coverage. This includes social, cultural and perception financial barriers to using services.

iv. Are people making contact with the services, and who?, termed contact coverage, or utilization, and finally

v. Effective coverage, or what share of the population in need of an intervention effectively receive that intervention? This does not include the health impact of the intervention, but does include successful and complete compliance with the entire intervention, whether treatment, maternal health services etc. (Tanahashi 1978)

### Availability coverage

<table>
<thead>
<tr>
<th>Available resources</th>
<th>Unavailable resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers</td>
<td>Health workers</td>
</tr>
<tr>
<td>Counsellors, Nurses, Midwife, visiting Dr, Environmental Health Technician, Village Health Workers, Home Based Care-givers (mainly women);</td>
<td>There are very few doctors, nurses and other staff trained for ARV administration</td>
</tr>
<tr>
<td>Drugs</td>
<td>Drugs</td>
</tr>
<tr>
<td>ARVs, one CD4 machine</td>
<td>ARVs (inadequate), second line</td>
</tr>
<tr>
<td>Services (from Hospital, NGOs, CBOs and Faith Based Organizations)</td>
<td>Services</td>
</tr>
<tr>
<td>Voluntary Counseling and Testing (VCT), Provider Initiated Testing and Counseling (PITCT), health education, Nevirapine for PMTCT (VCT, PITCT), condoms (both female and male), support groups; Antenatal Care (ANC)</td>
<td>Counselling rooms; youth friendly centres; nutrition services; treatment literacy; Occupational and non Occupational Post Exposure Prophylaxis, social welfare services, psychosocial support, workplace clinical services</td>
</tr>
<tr>
<td>Equipment and sundry</td>
<td>Equipment and sundry</td>
</tr>
<tr>
<td>Gloves, soap, Rapid HIV Treatment Kits</td>
<td>CD4 counting machines; other diagnostic testing equipment such as X-Ray machines; liver function testing machine; viral load monitoring machines; Transport/Ambulances</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Infrastructure</td>
</tr>
<tr>
<td>Health facilities; Opportunistic Infection services (OI Clinic);</td>
<td>Small-inadequate spaces</td>
</tr>
</tbody>
</table>

The discussion on availability coverage recommended some actions possible to address flaws present. Key actions include ensuring effective decentralization of ART initiation sites and other treatment, prevention, support and care services to local clinics; strengthening human capacity (in both numbers and skills), increasing financial resources, improving the infrastructure, ensuring uninterrupted provision of affordable drugs and supplies, and increasing the involvement of communities, NGOs, CBOs and the private sector.

Drugs, diagnostic equipment and other commodities that are locally manufactured should be procured and distributed in pre-packed form to operational levels through partnership with local manufacturing companies. For imported drugs, bulk purchasing mechanisms should be strengthened through supporting NATPHARM to lower costs. Accountability mechanisms should be put in place and monitored by communities and by MOHCW to prevent leakages of drugs purchased at reduced prices.

### Accessibility coverage:
Access to health care is important to obtain quality care. Accessibility of health services and resources predicts an individual’s likelihood of receiving care, thus it has implications in improving health outcomes.

Distance, time and money were found to be the strongest barriers to accessing HIV treatment resources and ARVs in particular. Distance was the single most important factor affecting the choice of the facility attended. However participants reported that most people are left with no choice at the initiation stage of ART as they have to rely on one hospital. The longer the distance the more likely the patient would spend on transport. In addition to that, due to the congestion at the busy hospital it often takes long before one gets service or is attended to.

The $35 dollar user fee was reported to be too expensive for most people in Chitungwiza (given that the majority is either unemployed or self employed) as corroborated by the quote below:

“vanhu vakawanda muno muChitungwiza maVendor, macrosd border, hamuna employment muno, remember kuti Chitungwiza was built se satellite dormitory town ye Harare providing labour to Harare industries, saka takawanda asi hatina mabasa, saka on average munhu anogona kwana about $50 -$70 pamwedzi, so if the total costs yekuchipatara plus transport nechikafu chemusi wekuchipatara zvakaita $50 yacho saka equity, justice, universal coverage yatiri kuswerotaura ndeyipi? hapana chatiri kuita, awa! Awal No, no, no, no $35 should go down back to $5 or less, please!!!!!”

Loosely translated as
“Most people here in Chitungwiza are petty vendors, cross borders, there is no formal employment, remember that Chitungwiza was built as a satellite dormitory town for Harare providing labour to service the Harare industries...so we are so many here but we do not have our own industries to create and support employment; so on average a person can get about $50-$70 per month. If the total costs for hospital services plus transport and food needed on the day for check up or collection of medicine is $50 or more, then what equity, justice, universal coverage are we talking about, No, no, $35 should go down, back to $5 or less please!!! Participant

Acceptability coverage:
While resources can be available and accessible to the population, these services may not be acceptable to this share of the population. Thus, these HIV treatment resources may end up not being used if they are unacceptable to the population. Acceptability coverage measures the proportion of people for whom services are acceptable. This domain of coverage includes non-financial factors such as culture, attitudes, norms, values, religion, gender, class, creed, taste, type of facility, area where facility is located, and so on, as well as aspects of affordability that relate to people’s perceptions of taste and preference. These are the elements that were considered in the discussion.

In the discussion, we realised that the majority of the people able to access HIV AIDS resources are likely to make contact with the facility. However, due to lack of privacy and confidentiality in public health services most prefer to use private clinics instead of public services despite the cost. Taste was viewed as the one factor that also affected acceptability coverage, due to the congestion experienced at the public health facilities. Most elite clients would prefer to spare themselves the trouble, shame and harassment associated with the multitude of people seeking care; and instead travel all the way to Harare (Zimbabwe Capital City) to seek expensive private care. Participants argued that private health facilities provided quality care, highly trained and motivated caring human resources, state of the
ART equipment including CD4 count machines and other much needed diagnostic equipment.

**Contact coverage:**
When services are available, accessible and acceptable to the population and people make contact with them, contact coverage is achieved. The Focus Groups in the PRA research meeting considered interventions aimed at addressing compliance by health workers to national guidelines and ethical protocols on counselling, confidentiality, treatment, care, patient adherence and diagnostic accuracy.

While efforts to accelerate and facilitate availability, accessibility and acceptability coverage can significantly support contact coverage, there is a huge commitment needed in the health system to see the vision shaping up. Participants argued that at much more strategic levels political will is needed at both national and international level to address flaws in availability, accessibility and acceptability coverage. For instance at national level, civil society should advocate and demand the government of Zimbabwe to commit to the Abuja declaration which clearly set out the aspirations of African Heads of State for the actions to be taken in intensifying the response to HIV/AIDS, tuberculosis and other related opportunistic infectious diseases. While at regional and international level participants observed that civil society should advocate and demand commitment to the global political commitments made on facilitating access to HIV treatment, prevention, and care resources and to further provide additional resources for accelerating actions against AIDS i.e.

1. The 2001 United Nations General Assembly Special Session on HIV/AIDS Declaration;
2. The World Bank Multisectoral AIDS Programme;
3. The Global Fund to Fight AIDS, TB and Malaria;
4. The Partnership for Africa’s Development and other initiatives for poverty reduction.

4.5. **Community systems and mechanisms for referral network in HIV treatment**
In this context of community based systems in HIV treatment, ‘a referral is the process by which immediate client needs for comprehensive HIV care and supportive services are assessed and clients are helped to gain access to services, such as setting up appointments or giving directions to facilities. Referral should also include reasonable follow-up efforts to facilitate contact between service providers and to solicit clients’ feedback on satisfaction with services. (Family Health International 2005)

Participants in focus group discussions discussed the referral network both at the Chitungwiza hospital and its connections with the wider community through Community Based Organisations and Non Governmental Organisations.

“I am the one who writes a referral letter directly to an ART site in another district outside Chitungwiza or another clinic within Chitungwiza depending on the area from which the client comes. Often, if a client is going to stay in the rural areas, I will write a referral letter to that hospital or clinic to inform them about the condition, the line of drugs and other requirements as relevant. Often the Chitungwiza hospital functions as the ART initiation site, once the initial procedures are satisfied we then refer the patient to take their drugs from a clinic ART site close to them” Sister in charge Chitungwiza hospital-Participant

Often the relationship begins after an HIV diagnosis. In the event that the client is negative they are counselled within the hospital facilities on how they should remain negative and encouraged to utilise VCT facilities. In the event that the client is positive and pregnant they are counselled on PMTCT and thus referred to obtain PMTCT services also offered within the hospital.
In other circumstances, participants highlighted that a client can be brought to the hospital by home based care givers from civil society organisations such as LESO Care Trust, DREAMS and the Red Cross Society. These institutions were reported as community institutions that function as focal institutions in referrals. They also operate as community based counselling organs and support and care bases- see box below:

<table>
<thead>
<tr>
<th>Life Empowerment Support Organisation Care Trust – LESO Care Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESO Care Trust was founded on the March 2nd, 2008 and is run by nurses who were the first to break the silence in the health sector disclosing their HIV sero status. Three quarters of LESO staff are HIV positive thus the meaningful involvement of PLWHIV. The organisation has covered a lot of ground in serving the communities of Chitungwiza, Dam Falls and Crowborough Harare in Zimbabwe. The organisation aims to provide psychosocial support to PLWHIV, the aged and their dependents. It does this to reduce HBC cases by providing quality palliative care, counselling, supportive counselling and psychosocial support for those living with, affected by, and made vulnerable by HIV AIDS in order to prolong life. Thus Health education of HIV, ART, treatment literacy is central to these social groups. LESO provides home based care programmes through door to door visits to bed ridden clients to support on ART initiation, counselling and management. This work also involves equipping this target group with innovative ways of income generating projects. LESO has a well received time table for support group sessions. More information can be sourced through contact with them at <a href="mailto:lifesupport.leso@gmail.com">lifesupport.leso@gmail.com</a> <a href="mailto:orolimutabs.leso@yahoo.com">orolimutabs.leso@yahoo.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DREAMS HIV and AIDS Youth Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a community youth based organisation formed by youth and run by youth in Chitungwiza urban and peri-urban areas. Most of its members consist of school going teenagers living with HIV. It was formed based on the experiences of founder members who in 2006 made a snap survey in Chitungwiza and realised that most school going adolescents were living with HIV but could not disclose their status, withdrew from social activities and were discriminated in school, churches and other community social gatherings. The network, amongst other objectives aims to break the silence associated with stigma and discrimination among young people in and out of school living with HIV. They can be contacted at 14006 Hadziananhanga Road; Zengeza 4; Chitungwiza PO Box SK 150 Seke, Chitungwiza, Zimbabwe: Email <a href="mailto:dreamsyouth@yahoo.com">dreamsyouth@yahoo.com</a> / +263772481270 / +263772883452</td>
</tr>
</tbody>
</table>

While these two examples of institutions amongst other civil society organisations support the referral network for PLWHIV in Chitungwiza, participants highlighted that linkages between institutions providing services are informal and communication is often ad-hoc and peripheral based on the relationships between the community organisations. Often the programme managers in these organisations link the client to another association depending on their knowledge of the the other institution – what they do and how they do it. Thus in such cases (more common) a referral letter does not exist. Other than in discussion with the patient (viewed as confidential) participants reported that there is no formal mechanism for following up on a referral to determine if the client’s problem has been addressed.

4.6. Community systems and mechanisms for clinical mentoring in HIV treatment

“Clinical mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes in HIV treatment. Expertise in managing antiretroviral therapy and opportunistic infections is often not found on the district management team in programmes that are starting to scale up HIV treatment. A clinical mentor in the antiretroviral therapy context is a clinician with substantial expertise in antiretroviral therapy and opportunistic infections who can provide ongoing mentoring to less-experienced HIV clinical providers by responding to questions, reviewing
clinical cases, providing feedback and assisting in case management. This mentoring occurs
during site visits as well as via ongoing phone and e-mail consultation. Clinical mentoring is
critical to building successful district networks of trained health care workers for HIV care
and treatment in resource-constrained settings.” (WHO 2006)

The group discussion on clinical mentoring was done by a group of health worker
participants at the meeting. The group reported that while the visiting doctors and senior
nurses and midwives at the hospital had the knowledge and expertise in managing
antiretroviral therapy and opportunistic infections, they did not have ample time to cascade
the knowledge to low level clinical staff at the hospital and even less at clinic level. This was
due to the heavy workloads at the facility and the huge shortage of staff dedicated to take
this role. They added that while there are platforms to train low level clinicians to administer
ART, including adherence counselling amongst other ART management requirements such
as through workshops, the training was described as short and often not adequate to instil
and equip the clinicians with knowhow of how this should be done. Thus, the quality of care
in ART and HIV management was described as poor and less supported through the
national and district budgets.

Clinical mentors with substantial expertise in antiretroviral therapy and opportunistic
infections, who in ideal circumstances, should respond to questions, review clinical cases,
provide feedback, assist in case management and who can provide ongoing mentoring to
less-experienced HIV clinical providers are not available. Health worker participants argued
that the decision to implement this was more broad based and integrative thus complex and
resource demanding. They added that the initiative should be integrated at the national
strategic planning level to encompass a public health approach to antiretroviral therapy and
opportunistic infection management in similar ways as that of TB strategies such as the
Directly Observed Short course (DOTS) treatment that is based on simplified clinical
decision-making.

The discussion further revealed that to enable effective clinical mentoring, decentralisation of
HIV care and antiretroviral therapy is essential in order to allow increased access, equity and
better support of adherence and treatment preparedness. This, it was argued, is to enable
the facilitation to a more primary health care oriented people centred approach where clinics
become the point of entry into the wider health system for people living with HIV. This was
observed as a more strategic approach to decongesting Chitungwiza General Hospital and
enabling the senior level staff to function and mentor, thus accelerating the much needed
and useful clinical mentoring mechanisms in HIV care and ART management.

4.7. Organisation of Primary Care Patient flow in HIV treatment
Common concerns in the discussion on patient flow from both health worker and community
participants included long waiting times, insufficient staff, and drug and equipment shortages
all of which undermine contact coverage. More significantly, participants expressed a
negative view of vertical ART and more generalised Outpatient Department (OPD) services.
The most collective issue was centred on the Opportunistic Infection (OI) clinic which is
separated from the OPD services stating that it significantly contributed to stigma and
undermined service uptake. While health worker participants generally agreed to this
argument, they argued that the facility enabled ART patients to be more comfortable in the
presence of other HIV clients. In principle participants unanimously agreed that combined
services accelerate service uptake and promote both acceptability and contact coverage and
ultimately foster principles of equity and quality in service provision. The view is that when
clients access the health facility, no one will guess the reason why the client has visited the
facility, thus no stigma is attached to them. Only the client and the health worker would know
the reason for the visit - improving privacy and confidentiality. Further, stigma associated with accessing HIV treatment is reduced. On the other hand, others expressed that when services are combined waiting times increase and uptake may still be reduced. 

“Once you get to the hospital and you go straight to the OI clinic people give you an eye that talks! It says there is an HIV positive person; she probably has genital warts or TB. The next thing is they do not even want to be near you because they think that you will give them TB, It sucks! We do not want the OI clinic separate from OPD, in fact, if this is too difficult please remove the door label “OI” clinic, the nurses should be the ones responsible for showing us where to go, have you ever gone to a hospital and you see a label on the door written ‘headache clinic’ or ‘abdominal pain clinic’ why ‘OI’ clinic. This is why some refer to the ‘OI clinic’ as ‘Obviously Infected clinic’ instead of ‘Opportunistic Infections clinic’. It just reinforces stigma”. Participant

4.8. Mapping community resources, institutions and actors that respond to HIV AIDS

In this discussion we used the stakeholder mapping participatory tool that enabled mapping of stakeholders in Chitungwiza in relation to their interaction and communication with communities and health providers.

In this discussion participants argued that fostering partnerships between communities, community organisations and health services improves local responses for HIV. First, participants noted that while civil society engagement in HIV AIDS responses was useful, there was a perception that resources were being wasted due to duplicated efforts. The reason for this stemmed from two areas - poor planning at both district and national level on who operates in the districts with what resources and how and - poor policy implementation as there was clearly no mechanism to track the number of registered and unregistered NGOs operating in Chitungwiza.

Participants argued that the Declaration of Commitment issued by the UNGASS demands strengthening of the health systems for implementing comprehensive strategies in the expanded global response to HIV/AIDS., However the implementation of this declaration was far from being realised. More so because the partnerships that participants witness in Chitungwiza were viewed as unequal where the partner with more financial resources was reported as the one with the upper hand and therefore more powerful. In this case the resourceful partner makes the most critical decisions. An example of how this distorted health system could be illustrated, is that when an NGO, particularly an international NGO, often well resourced, is partnered with a health facility, they create new mechanisms of operation within the facility, creating vertical and often parallel systems within the same facility. For example one participant argued that: “Up to now I’m not sure if the Ministry of Health has ownership of the donor initiated and driven ‘new start centre’- VCT run by PSI. We all know and appreciate the noble initiative but I seriously think that PSI should not employ PSI people to man these services; PSI should support health workers at that facility with skills to do this work. This is important so that we do not have cases where a counsellor usually [ranked] lower than the nurse or the sister in charge at the clinic, earns five times more than the same nurse. This was reported as a way of demotivating health workers, killing team spirit”

Second, there was acknowledgement of the networks in Chitungwiza that strengthen family and community-based care such as LESO Care Trust and Red Cross working with the social services to support individuals, households, families and communities affected by HIV/AIDS.

The impressive record of civil society groups in Chitungwiza coordinated by the National AIDS Council District AIDS coordinator responding to HIV consolidated the recognition that
their full involvement and participation are crucial. However participants highlighted that a mechanism should be made available to mobilize and harmonize resources so that the responses from health service provision structures and those from communities do not hinder but strengthen one another.

“The private sector and the corporate sector is just here to make money; we do not see their community service at all, what is Coca-Cola or the Delta Corporation doing on HIV AIDS? What are the Chinese doing on HIV AIDS responses except selling Chinese cheap products? What are private medical health insurance schemes doing? Cellphone companies? Internet providers? Absolutely nothing. If they are doing something it’s too small to be seen. They should scale up and benefit the neediest! It’s high time we pool these folks together to do at least one thing each to respond to HIV AIDS problems in our communities”

Participant

Third, participants reported that while there were partnerships forged between CBOs, NGOs with communities and amongst themselves there were no formalised mechanisms for community participation at local level. These include such structures as the Ward Health teams, Village Health teams and their local government bodies such as the Ward Development Committees and Village Development Committees., If supported, these institutionalised organs can strengthen local level planning. However, participants highlighted that sometimes when planning takes place at the lower levels, it is not in concert with the overall planning process and so implementation may be disjointed. The capacity for planning, even at district level, is inadequate and the situation is worse at the lower levels. Given this, it was clear that the capacity within the health system for participatory planning is low. Moreso, the structures that form links with the communities are either not fully understood or not known thereby undermining potential for institutionalised community participation. In some cases, participants added that it is the NGOs such as the Training and Research Support Centre (TARSC) working with the Community Working Group on Health (CWGH) that often have the knowledge and skills in participatory planning methods. But, unless these partnerships are institutionalised then the impact goes unnoticed. Effective partnerships on HIV were argued to be achievable only when the communities working with PLWHIV are informed, have the capacity to assess the problem and are able to identify what they want and what they can do to solve their own problems together with development partners and relevant ministries of government.

4.9. Strengthening communication opportunities for health workers and communities. Lack of time, huge workloads, limited clinical experience and lack of good communication skills were proffered as reasons why health workers often tend to curb their conversations with HIV clients. Community participants reported that health workers give treatment recommendations without understanding how realistic they are for the clients to follow them, and what obstacles patients face in completing treatment. In order to improve understanding of problems faced by communities when interacting with health workers and vice versa we used a PRA tool called the Margolis wheel to establish cooperation on communicating to each other on what problems they face that can hinder progress in HIV responses.

Health worker participants reported that sometimes how much people know comes as a surprise. Therefore building on existing knowledge and practices is central in building dialogue and interactions between communities and health workers. This process was reported as one that increases respect, understanding and confidence. They reported that in Chitungwiza, UTANO Network was built through confidence and understanding of roles of civil society community and health workers in Chitungwiza area. They regularly meet to discuss common health concerns particularly on HIV AIDS in the area. This has formed the basis for collaborative planning process to orient and focus HIV AIDS resources and activities in the area.
Community participants reported that health workers often present themselves as experts, knowledgeable and therefore claim more power. For instance they reported that while PLWHIV appreciate and know that HIV adherence counselling is supposed to be carried out in private rooms, health workers conduct the adherence sessions in groups and outside the hospital under a tree close to the mortuary, in spaces where other people who may not be part of the sessions can identify them. This often brings people who are not ready for treatment into situations that they may not be able to deal with. This was reported as one way of disabling a possible next visit, thus treatment readiness is gravely compromised.

The following table is a summary of the problems raised and solutions suggested by these two groups (communities and health workers)

<table>
<thead>
<tr>
<th>Health worker-patient interaction problems from:</th>
<th>Solutions from:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health workers:</strong></td>
<td>Communities</td>
</tr>
<tr>
<td>• Communities come with their own expectations on health service albeit resource shortages. They do not see health workers as rights holders and often insult them, offend them or blame them for shortages, worsening illness and in some cases even death.</td>
<td>• Health worker-community joint action is instrumental in building community and health worker confidence, disclosure, understanding and trust between the two social groups. This will accelerate the understanding of one another's problems and improve communication and power dynamics.</td>
</tr>
<tr>
<td>• Communities pretend not to understand that health workers are going through very hard economic hardships that further affect their social and family lives.</td>
<td></td>
</tr>
<tr>
<td><strong>Communities:</strong></td>
<td>Health workers</td>
</tr>
<tr>
<td>• Health workers conduct their personal business at the health facilities, thus reducing the time they have to serve clients.</td>
<td>• Ministry of Health should in its annual plans provide incentives for health workers such as accommodation allowances and transport allowances.</td>
</tr>
<tr>
<td>• Health workers show preference in providing service to their friends, neighbours and relatives. They show unethical favouritism in the health facilities.</td>
<td>• More low level health workers should be trained to take on other roles to reduce burnout and workloads. This will also provide health workers with spare time to conduct their personal businesses and attitude may also change towards clients (more empathetic).</td>
</tr>
<tr>
<td>• Health workers are rude, ruthless and show no sympathy when talking to/with clients.</td>
<td>• Each health facility should be manned by at least one health worker who can communicate in sign language to prevent wrong diagnosis and perceived ‘discrimination’ against the deaf and dumb.</td>
</tr>
<tr>
<td>• Health workers discriminate against deaf and dumb people because most of them cannot use sign language.</td>
<td></td>
</tr>
<tr>
<td>• Health workers do not give adequate time to a patient to explain basic procedures such as ‘BP’ checks.</td>
<td></td>
</tr>
</tbody>
</table>

4. Discussion
The findings of this study seem to support the views of several researchers in that we need to move beyond the debate about ‘vertical’ disease specific funding to a more people centred approach that strengthens a community based health system particularly for HIV
AIDS responses. One of the underlying causes of priority problems was linked to weak comprehensive Primary Health Care. It would be prudent to therefore discuss the need to expand HIV treatment to a comprehensive PHC based approach – one that takes into account the wider needs of communities that are already coping with an already enormous burden from other acute and chronic diseases such as chronic hypertension and diabetes. Further, there is potential to increase knowledge and access to HIV information when people access services for other problems not linked to HIV. Provision of:

- chronic treatment at the primary care level;
- adequately trained and experienced health workers at health centre level;
- adequate drug supplies to avoid drug stock outs (observed in the findings) and
- essential care, counselling, support and care at the lowest level of the health system seem to be the most effective way of tackling barriers of access and uptake of HIV preventive, treatment, support and care services.

For PLWHIV, PHC can provide treatment, care and support, close to their homes. This supports the management of HIV more easily. Largely, this can deal with stigma identified in the findings as a barrier in acceptability coverage. In addition, the provision of comprehensive and integrated services ensures that important diseases or infections often linked to HIV, such as TB and cancers, can be easily diagnosed and treated.

Importantly, PHC can also provide vital care services for ‘at risk populations’ such as sex workers as shown in the findings in terms of prevention services and in the provision ART. Ensuring these responses are available at primary care level has the potential to lessen HIV management and increasing the chances of early diagnosis, treatment, counselling, support and care.

Based on the findings we have observed that there is effort at community level for NGOs to collaborate through the UTANO network that puts together local NGOs and CBOs to plan collectively and where possible pool resources for concerted effort. There should be national mechanisms that support this correlation more systematically. For instance the National AIDS Council (NAC) is mandated to pool together AIDS service organisations at community level for local planning and implementation; we see that NAC has limited control of resources and is seen as relatively disempowered.

Health worker participants emphasised the strong influence of donor resources on priorities and what gets funded, despite a broad agreement with the core principles of the Paris Declaration of national ownership, harmonisation and accountability. Whilst participants argued that there is strong acknowledgement that communities are central to HIV responses, community organisations feel constrained, not only in accessing resources but also in having a say as to how the money should be spent based on their perceived priority problems that undermine availability, accessibility, acceptability and contact coverage. At the level of setting priorities and agendas, civil society groups often feel their influence over these perceived priorities is negligible and that they frequently only end up doing what there is money allocated for.

Clearly, the findings suggest a need to promote long-term, sustainable HIV responses through strengthening community health systems for HIV –and tackling the social determinants of health that both drive the epidemic and hinder the responses. It is even more important to invest and strengthen comprehensive Primary Health Care responses. Counselling for voluntary testing, provider initiated testing, treatment readiness and adherence should be confidential to support safe disclosure of HIV status.

National level health budget allocations should respect the Abuja declaration, by ensuring commitment to investing in the health sector by allocating resources at the primary care level.
to revitalize PHC and improve social security services for PLWHIV in poor communities in order to significantly minimize out-of-pocket expenditures, cover health services at the point of care, and do away with user fees to accessing HIV services.

The Participatory Action Research (PAR) has potential to create community driven responses for HIV. The study findings reflect that communities know what their problems are and how to address these problems. However there is a clear gap between what they can do at community level and what national and global responses should do to collectively address their challenges. There is potential though to address this if communities are involved, participate and are informed. This can enhance community capabilities to demand their health rights.

5. Conclusions and Recommendations

On the basis of the discussion in section 5 above and the analysis therein, we would argue that several recommendations made by participants in the study can be considered for effective and positive change to policy. These recommendations have been framed into three main health system domains for HIV treatment. These include the recommendations at community level, those in the frontline health system, and those on the interaction between community and health system.

Community level
- Community based awareness and education campaigns on HIV treatment, prevention, support and care should bring in debates on sexual pleasure and satisfaction within ongoing mechanisms to address community systems for HIV.

Interface between community and the health system
- Drugs, diagnostic equipment and other commodities that are locally manufactured should be procured and distributed in pre-packed form to operational levels through partnership with local manufacturing companies. For imported drugs, bulk purchasing mechanisms should be strengthened through supporting NATPHARM to lower costs. Accountability mechanisms should be put in place and monitored by communities and by MOHCW to prevent leakages of drugs purchased at reduced prices
- Community participation should be strengthened so that it shapes HIV AIDS strategies, thus its implementation should be supported by adequate orientation and equipping of health workers with skills to effectively facilitate the interface with communities. The Global Fund for HIV TB and Malaria and other international aid partners should support Community Based Organizations that often have no access to funding which would
enable them to take their own initiatives, create demands and force health systems to respond.

**Interaction in the health system**
- Large global health initiatives should engage with each other, and the government of Zimbabwe through the MOHCW as well as local stakeholders to move beyond the Paris Declaration and develop coherent and user-friendly systems for the disbursement of funds, alignment, and coordination 'down to community levels.
- Efforts to improve coordination between HIV AIDS response actors and to assist in translating the Paris Declaration into practice should be heightened.
- Operational research should be incorporated and funded as part of Chitungwiza health plan. This would ensure that solutions to accessibility and other implementation constraints and the most effective approaches to scaling up access are identified.
- Clinical mentoring should be integrated in the national strategic plan to encompass a public health approach to antiretroviral therapy and opportunistic infection management in similar ways as that of TB strategies such as the Directly Observed Short course (DOTS) treatment that is based on simplified clinical decision-making.
- Promotion of long-term, sustainable HIV responses through strengthening community health systems for HIV - tackling the social determinants of health that both drive the epidemic and hinder the responses should be supported by multi actors including other line ministries to support the MOHCW.
- The national health budget allocations should respect the Abuja Declaration by ensuring commitment to investing in the health sector by allocating resources to revitalize PHC and improve social security services for PLWHIV in poor communities in order to significantly minimize out-of-pocket expenditures, cover health services at the point of care, and do away with user fees to accessing HIV services.
6. Acronyms

ACP   Africa Caribbean Pacific
AIDS  Acquired Immune-Deficiency Syndrome
ART   Anti-Retroviral Therapy
ARV   Anti-Retroviral
ANC   Ante-Natal Care
CBOs  Community Based Organizations
CD4   Cluster of differentiation 4
CoBaSys Community Based Systems in HIV treatment
CSO   Civil Society Organisation
CWGH  Community Working Group on Health
DEHO  District Environmental Health Officer
DOTS  Directly Observed Treatment Short-course
DNO   District Nursing Officer
FBO   Faith Based Organizations
HBC   Home Based Care
HBCG  Home Based Care Giver
HCC   Health Centre Committee
HIV   Human Immune-deficiency Virus
MOHCW Ministry of Health and Child Welfare
NAC   National AIDS Council
NGO   Non Governmental Organization
OVC   Orphans and other Vulnerable Children
PAR   Participatory Action Research
PHC   Primary Health Care
PITC  Provider Initiated Testing and Counselling
PLWHA People Living with HIV AIDS
PMTCT Prevention of Mother to Child Transmission
PRA   Participatory Reflection and Action
REACH Research for Equity and Community Health
TARSC Training and Research Support Centre
TBA   Traditional Birth Attendant
UNGASS United Nations General Assembly Special Session on HIV AIDS
VCT   Voluntary Counselling and Testing
VIDCO Village Development Committee
WADCO Ward Development Committee
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