Strengthening Community Health Systems for HIV Treatment, Support and Care Goromonzi District – Zimbabwe

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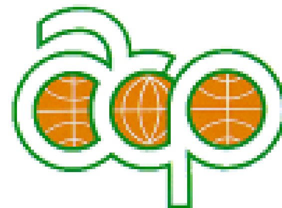
Training and Research Support Centre (TARSC) in the Community Based Systems in HIV Treatment (CoBaSys) programme

ACP-EU co-operation programme in the field of science and technology



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1. Executive Summary

Zimbabwe has been highly affected by AIDS, with a high HIV prevalence, falling only after 2003 from 24.6% to 13.7% in 2009 and up to 1.8 million PLWHA in the 1990s The high adult mortality due to AIDS began to fall after the decline in HIV prevalence in 2003. This fall in prevalence has been attributed to falling population levels due to out-migration and mortality, changing youth behaviors and an increase in number of people on ART. The country aimed to treat 171 000 people by 2005, but by end 2005 only 25 000 PLWHA were on ART, with 319 000 in need. By December 2009 this had increased to 215,000 leaving a treatment gap of about 340,000. Based on the 2009 WHO recommendation of initiating ART at a CD4 count of 350, an estimated 570,000 adults were eligible for ART in 2009, or an ART coverage of 38% of people in need.

The Community based systems in HIV treatment (CoBaSys) programme 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 project focuses on building solid 'community based systems that support HIV treatment amongst most vulnerable social groups at primary care level. The learning and evidence from this tier of the health system is collated, synthesized for national level advocacy and further integrated at regional level for global engagement. This report documents finding from the Participatory Action Research (PAR) conducted in Goromonzi District in January 2011 by TARSC working with CWGH under the COBASYS programme. The PAR involved participants from Gutu, Gosha, Chikwaka, Rusike Chinamhora communal areas, and aimed to explore the factors that facilitate and block access to, use and effective coverage of services for and responses to HIV treatment, to inform approaches to building community systems and services for responding to HIV and AIDS.

The qualitative PAR approach brought in community dialogue and facilitated partnership between researchers, services and beneficiaries. The approach demands commitment to take action on the problems identified. The protocol was developed by TARSC; peer reviewed and pretested prior to implementation. Participants were drawn from the community (PLWHA, men, women, and youth); Ministry of health and Child Welfare (MOHCW), local authorities, health workers, local leadership representatives, District AIDS Action Committees (DAAC) and others.

In the PAR, participants raised perceptions that HIV positive women are more likely than men to be blamed, stigmatized and abandoned by their families, and are vulnerable to violence and to being abandoned. Almost all households in Goromonzi face enormous pressure to provide for themselves and for their extended families. Women's financial dependence on men was reported to compromise their ability to change behaviors to prevent HIV or adhere to treatment.

Local facilities lacked specialized laboratory equipment and diagnostics (eg CD4 count machines), lacked comfortable waiting space and were understaffed, undermining service provision and discouraging PLWHA on ART from returning to services once their health improved.Stigma and discrimination is deeply rooted in the health system and at community level, PLWHA, while facing stigmatising responses to HIV disclosure, and while courageous in wishing to fight stigma, were not willing to sacrifice '*confidentiality'* with no prospect of success.

The level of stakeholder participation in the health sector and in HIV was questioned, and described by participants as tokenistic in that it was posed as an end, rather than a means to

greater say and role in programmes.. Participants also noted the lack of support from line ministries to the MOHCW to support HIV and health related programmes at community level, such as from Ministry of Agriculture for nutrition for PLWHA. They also noted the reliance on external funding, such as from the Global Fund, with poor co-ordination across different funding sources, parallel programmes, and lack of integration with wider health programmes.

Through the PAR, participants identified elements they felt should be present in a comprehensive community based model for HIV treatment. at community level, in the frontline health system, and in the interaction between community and health system

At the community level, participants proposed that resources for comprehensive AIDS services at the community level be.channelled through MoHCW. Communities can contribute to the retention of Health workers by providing non financial incentives .e.g. through construction of a health worker home. non government, community and faith based organizations and traditional leadership should to support treatment literacy to support treatment adherence and support health workers with bicycles, motorbikes, cars or fuel to enable follow up of those on treatment. Treatment literacy should be coupled with campaigns against stigma. .

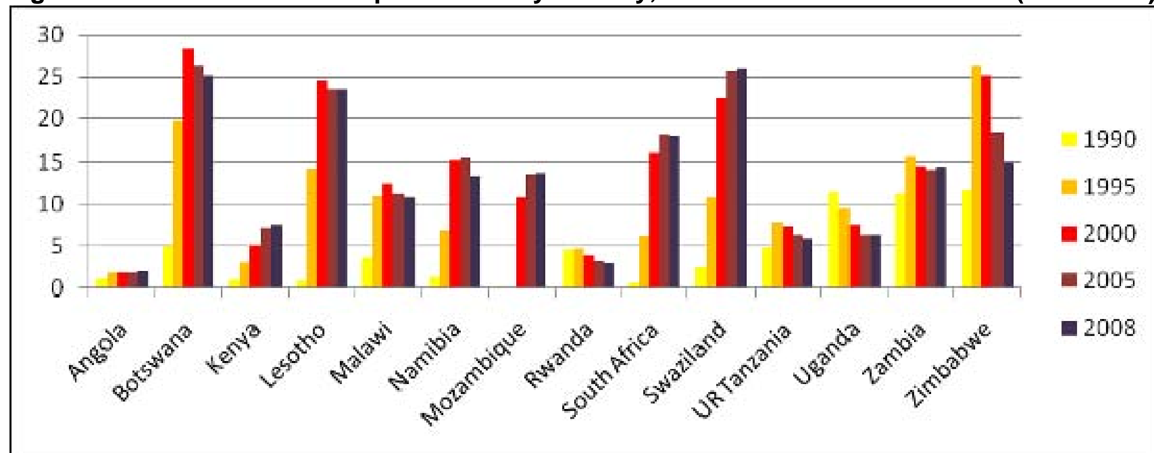
In the frontline health system, government should not rely on international funding and should increase national budget allocations for HIV treatment attention, support and care; promote local drug production; remove the barriers of user fees; make ART more accessible through making clinics ART sites, invest in health worker deployment to and training in clinics to support service provision and ensure that clinics get the medicines they need for comprehensive treatment programmes. Government should also prevent the fragmentation of parallel projects in international agencies fragmenting the health system and creating differences in income amongst the health workers.

The interaction between community and health system agencies should prioritize strategies to increase women's income and employment and thus economic autonomy and support MOHCW's efforts to stop discrimination against PLWHIV, measures to protect people living with HIV. Participants suggested interaction would improve if communities were more aware of their right **to health, of the** legal services for PLWHIV, and thus more able to hold the health system accountable for widening access to antiretroviral drugs in line with the resources available. Health Centre committee and Village Health workers can support health system by organizing labor for security services to prevent theft, while Village Health Workers and community Home based Care programmes were seen as key to facilitating uptake of treatment, adherence and treatment literacy. Participants suggested that communities should also participate in the development of community health financing schemes to match resources allocated by government to improve access to treatment, and that international and government resources should be pooled in a public sector fund and allocated according to need with stringer public reporting on how money is spent. It is thus evident that improved community systems not only call for policies that integrate communities as central, for resources, capacities that are oriented to community needs, but are systems that provide for more meaningful information, participation and roles to ensure that this is achieved.

2. Background

Zimbabwe is one of the Sub-Saharan African countries most hard hit by the AIDS epidemic. At its peak in 2003 it one of the highest levels of HIV prevalence globally, (See Figure 1).

Figure 1: Estimated adult HIV prevalence by country, eastern and southern Africa (1990-2008)



Source: UNAIDS/World Bank (2009). The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact. June 2009

The HIV prevalence rate declined from 24.6% in 2003 (MoHCW to an estimated 13.7% in 2009 (MOHCW 2005; 2009). At the end of the 1990s Zimbabwe had an estimated 1.8 million people living with HIV (UNAIDS 2010). Over 100,000 people have died every year due to AIDS-related causes up to 2007. In 2010, Zimbabwe had one of the highest rates of pre-mature adult mortality in the world, largely due to AIDS. Annual mortality among increased from 244 per 100,000 in 1990 to 725 per 100,000 among adult women 15-49 (MOHCW 2007). However, AIDS-related mortality is following a decreasing trend. This decreasing trend 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 (from over 3% in the 1980s to less than zero by 2005) out-migration and 3) deaths due to AIDS. (Gregson et al. 2010).

Sustaining treatment for existing AIDS cases and preventing new HIV infections are therefore both pressing issues. The country targeted that 171 000 people should receive ARVs by 2005, however by the end of 2005, only 25 000 PLWHA were on ART, leaving as many as 319 000 in need. The number of people currently on ART increased from 85,000 to 215,000 between December 2008 and December 2009 (NAC 2009) leaving a treatment gap of about 340,000. Based on the 2009 WHO recommendation of initiating ART at a CD4 count of 350, an estimated 570,000 adults were eligible for ART in 2009, translating into 38% ART coverage by end 2009.

The Community based systems in HIV treatment (CoBaSys) programme is empowering 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 project primarily focuses on the building solid 'community based system that supports the HIV treatment to benefit most vulnerable social groups at primary care level. The learning and evidence from this tier of the

health system is collated, synthesized for national level advocacy and further integrated at regional level 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.*" (Machingura et al 2010)

PRA group-Goromonzi District

The Participatory Reflection and Action (PRA) research in Goromonzi 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 Goromonzi PRA research aimed to:**

1. 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
2. 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.
3. Map the resources, institutions and actors available at community and primary care level to respond to the epidemic.
4. 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)
5. 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)
6. 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 and an analysis from a PRA research held in Goromonzi in January 2011 to investigate and provide collective recommendations to community based systems in HIV treatment.

3. Methods

The study used qualitative Participatory Reflection and Action (PRA) approaches. PRA is time-consuming, thus resesearchers should be committed to the follow-up action on problems identified. However, these weaknesses are necessary tradeoffs in this research design, in that in the process of additional follow up is well worth the additional information obtained through a PRA approach. There are significant strengths action research holds for this kind of research:

1) PRA research provides a powerful means of improving and enhancing practice by involving community dialogue at the very early stages of programme planning. Thus, it builds a basis for negotiation and partnership between researchers, resource holders and beneficiaries.

It is therefore important to note that the tools used to define the PRA research in this study 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. significance of tools in a sound research manner.

However, there are other weaknesses associated with PRA important to note:

- The sampling technique can be biased. This is so because key informants (PRA research participants) who may provide with narrow and rigid views of the problems may be inadvertently selected. Nonetheless, the selection of the participants was done rigorously with this in mind, further the research was implemented in three different sites with three different sets of audiences to undermine the bias that could be caused by solely relying on one group.

- Time consuming: Adequate time is needed to complete the planning process. Thus data collection without the development of a plan/protocol of action compromises the objective of the research, the findings and the conclusions of the research analysis. Thus to overcome this problem, the research should be conducted over a period of time while other factors are put on constant.

A PRA study protocol used in the research was developed; peer reviewed and pretested prior to implementation (Machingura F et al 2010). The protocol was co-authored by Machingura F, Loewenson R and Kaim B from TARSC and peer reviewed by PRA experts, University of Manchester, University of Eduardo Mondhlane, University of Namibia, University of Botswana, University of Modena, University of Helsinki, REACH trust Malawi and by the University of Zimbabwe. The tools were pre-tested in Goromonzi district by the researchers with a sample of 30 community members representing the target social groups. Researchers were trained over a 3-day regional training workshop in April 2010 (Harare) on participatory methods for community based systems in HIV treatment –'*Strengthening capacitates for qualitative research using PRA approaches*' run by TARSC (TARSC 2010)

The following table shows how the methodology was staged in the protocol for each objective of the research

Table 1: Staging of Methodology and how each of the aims was addressed

Objective	Method
Stage 1 meeting	
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	• Social mapping, • Map interview • Discussion
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.	• Stepwise diagram and Focus Group Discussion (use FGD guide)
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 for prevention, treatment and care for HIV and AIDs (including community knowledge on social rights)	• Ranking and scoring • Problem tree • Discussion
Map the resources, institutions and actors available at community and primary care level to respond to the epidemic.	• Stakeholder analysis • Plenary roundtable (community roundtable)
Review the evidence to assess the opportunities and mechanisms to enhance facilitators and overcome priority blocks to access	• Leaping blocks • Market place • Discussion
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	• Margolis wheel • Spider web • Group discussions • Market place

(Refer to Loewenson R et al 2006, Loewenson R et al 2007, Loewenson et al 2008, Loewenson et al 2009 and Machingura F et al 2010) to understand the meaning of method tools used)

The PRA research meeting participants were drawn from NGOs and Community Based Organisation working on HIV AIDS issues (Island Hospice; Community Working Group on Health; Jekesa Pfungwa, ZiCHIRE, ZNNP+) Ministry of Health and Child Welfare (opinion leaders), local authorities (District administrator's office) health workers (District Nursing Officer, nurses in charge, primary care nurses, Environmental Health Technicians, Midwives), home based care givers (HBCG), people living with HIVAIDS (PLWHA), OVC, Youth representatives, HIV AIDS support groups, other health service providers, local leadership, herbalist and religious group representatives (70 participants). The participants were selected from six wards from the 25 wards in Goromonzi district. The selected wards included communal, resettlement/farming areas and the peri- urban group. The. Mashonaland East Province houses Chikomba, Goromonzi, Hwedza, Marondera, Mudzi, Mutoko, Murehwa, Seke and Uzumba Marambapfungwe (UMP) districts. . The field research team comprised Fortunate Machingura, Itai Rusike, Esther Sharara, and Edgar Mutasa.

The TARSC local organizer in Chikwaka Ward-Goromonzi District supported prior research implementation with logistical arrangements and related community organisation. This included a planning meeting which was attended by health civil society organizations (CSOs), local authorities, district officials and health workers. The planning meeting introduced the programme to key stakeholders and the district authorities.

4. Findings of the PRA research

4.1. Mapping social and economic differentials in Goromonzi district

The characteristics of the community were identified through **social mapping,** particularly the socio-economic differentials in Goromonzi (wards: Chikwaka, Gutu, Rusike, Domboshava-Chinamhora, Dzvete communal lands) that affect risk and vulnerability to HIV/AIDS and that had an impact on uptake of available services for treatment and care) (see map)

Using the map, communities discussed how the socio-economic differentials may have an impact on uptake of available services for HIV/AIDS.

Participants were divided into groups according to gender and age from their wards and drew a map of their community on flip charts, highlighting landmarks such as clinics, hospitals, church. AIDS service organisations, churches, dams, schools, shops and social and community features.

When the maps were presented and discussed, the major social features were noted as

- **Economic facilities**: Supermarkets/shops (Buying and selling), vendors market, market gardening, commercial farms
- **Social services**, particularly schools, clinics (ANC (Antenatal Care), PITC (Provider initiated Testing and Counselling, VCT(Voluntary Testing and Counselling) and PMTCT (Prevention of Mother to child Transmission) services) , orphanage homes NGO (Non Governmental organisations
- **Community facilities** such as churches, bus terminuses, lodges, Village Health Workers, Home based care givers, support groups, households

Figure 2: Social maps of Chikwaka Area-Goromonzi District

Social groups that were identified included: commercial sex workers, Orphans and Vulnerable children, PLWHA, Traditional Healers, Faith healers, traditional birth attendants (TBAs), Home Based Care Givers, Village Health workers. Participants observed that condom use amongst commercial sex workers in Goromonzi is low and like the general population access to health care service is poor. In the absence of effective interventions, sex worker clients transmit infection both to sex workers and to their regular partners, extending transmission into the general population. In the absence of effective interventions, high rates of transmission in commercial sex continue to drive HIV epidemic even after HIV has decreased more widely in the generalized population. TBAs have potential to contribute to delivering PMTCT interventions to women who deliver outside health facilities, if they acquire additional skills and are sufficiently

motivated. They can also support and refer pregnant mothers for facility-based PMTCT services to improve coverage. While the role of Traditional Medicine and healers in the Zimbabwe is significant, traditional healing interventions can facilitate spread of HIV/AIDS due to unsafe treatment of infected patients. Similarly the presence of Faith healers, members of the apostolic faith sect in particularly poses significant threats in the use and adherence of HIV treatment (faith practices have been reported to deny members from using modern medicines and modern treatment facilities in favor of spiritual healing).

Major **economic facilities** included buying and selling in the form of vending mainly from market gardening in the Domboshawa Chinhamhora areas. However the greater part of Domboshava relies on menial jobs and petty vending. This has implications on ability to afford health care services particularly on the cost associated with accessing ART (diagnostic cots, user fees and out of pockets payments).

Health services: The District Hospital –Makumbi Mission is far away from the wards it serves i.e the Chikwaka-Mwanza, Gutu-Gosha, Rusike areas. Patients in these areas are forced to go o Hrare first (Capital City) before they get a bus to Makumbi mission. The journey will demand half of patient's day. Consequently a patient is forced to organise separate accommodation arrangements to enable them to access service on the next day. Clearly, there is a huge burden on the client on out of pocket costs. Mwanza clinic the government local clinic serving more than its designated population provides VCT, PMTCT and PITC services. Goromonzi District is only able to access CD4 services from the provincial hospital in Marondera. Marondera Provincial Hospital is more than a 100km away from the district hospital. Most patients from Goromonzi prefer to use services provided from another districts. This was reported to have negative implications on planning and resource allocation. Some districts end up receiving more than they actually need based on distortions resonating from service access.

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

Participants defined the major health needs in their social groups using the ranking and scoring Participatory tool. They did this in groups divided by sex and one other group with health workers and distributed seeds against the health problems they felt needed greatest attention. The total seeds for each problem were used to determine the three top health priorities. This was done to Identify 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 for prevention, treatment and care for HIV and AIDs (including community knowledge on social rights in

Table 2: Social Groups' Priority problems

Problems identified	prioritizing of the problem (ranking)
Women	
Long distances to access ART facilities and services	1
Forced sex within Marriage	2
Gender inequality	3
Men	
Lack of intimacy (sex) within marriage	1
Poor communication with health workers	2
Long distances to access ART facilities and services	3
Health Workers	
Shortage of drugs (ARVs)	1
Shortage of Equipment (CD4 count machines)	2
Shortage of Staff (huge workloads)	3

key social groups. Results of the activity are shown on the table below:

Women participants prioritized **long distance to accessing ART facilities and services; forced sex in marriage and gender inequality as** their top three priorities respectively. They noted that their biggest needs at community level that relate to HIV were mainly centered on gender-related barriers in access to services. **Gender inequalities** was perceived to limit women's access to HIV/AIDS treatment, care and support, including antiretroviral therapies. Women participants reported that HIV positive women face stigmatization and are more likely than men to be blamed, stigmatized and abandoned by their families.

"Unotonzi uri hure, urikuda kuuraya murume, kana murume akangofa unotonzi ibva pamusha, unodzingwa pamusha wawakavaka, kazhinji unenge uine vana apa hauna kana chekubata!"

Loosely translated as

"They will say you are prostitute once they know you have HIV, when a husband passes on the relatives will chase you away violently, you are forced to leave your home, assets and other things. Often you are abandoned alone with children with nothing!" **Participant**

Women reported that if they are known or suspected to be HIV positive they become more vulnerable to violence. They face the possibility of being abused or abandoned. On the other hand, men participants reported denied sex and intimacy while women argued that it was lack of care and 'love' in these relationships that resulted in the lack of intimacy. Men noted that the denied sex and lack of intimacy often compelled them "*to look for sex*"outside their matrimonial homes. This is often viewed as one of the main drivers of HIV.

Some social and economic determinants were common across groups (men, women and young people). These included: **Long distances to access ART facilities and services** There is insufficient coverage and unequal geographic distribution of services. More remote wards such as Gutu and Mwanza are marginalized and have lower levels of knowledge about HIV prevention services and stakeholders tend to focus on the same groups and areas creating both the duplication of activities and the exclusion of some groups. Most surprising, there is a general lack of information about what services are available, where and for what cost. **Adherence to treatment** remains unsatisfactory due to long distances that need to be travelled to get to the ART centre. Transport costs to the clinics are prohibitive for the majority of the rural people.

Shortage of Drugs and staff: Human resource and infrastructure crisis in the health sector means there are never enough dedicated staff for ART services and laboratory technicians to meet the burden of increased demand for access to ARV. Limited availability of specialized laboratory equipment such as CD4 Count Machines also poses serious limitations to improving access to quality care

.

" ku Makumbe hakuna kana Mushini we CD4, Hapana nzvimbo svinu yecancelling, unenge uchidawo pako woga kuti unyatsotsnangurirwa zvakanaka asi munongonzi mukamwena kana kutio panze parikungopfuura vanhu. Hakuna kana Lab tech kune mumwe ku Marondera Provincial, ndiye anofanira kuita Mash east yese, zvinhu izvi zvinonyatsakuda kurongerwa"

Loosely translated as

"There is no CD4 Counting machine at Makumbe Mission Hospital, there is no space for adherence counseling, and often we are forced to receive the counseling in groups outside. You can imagine how embarrassing it is if you see someone you know while you are seated in the counseling session. Further you need specialized sessions that are individualized so that one can self prepare. Sometimes we get in very small spaces for counseling. These services are being forced in never planned for spaces. We need to really plan strategically on how this will be done, otherwise it compromises the quality of care" **Participant**

Shortage of Equipment: ARV services are offered in existing Hospitals in never-planned-for spaces with little resources to purchase key equipment for HIV diagnostics such as CD4 count machines and Liver function tests. The serious shortage of comfortable waiting space coupled with understaffing, discourages ART clients from returning for services once their health starts improving. The long waiting period in overcrowded environments traumatizes PLWHA and violates their right to human dignity and humane treatment.

4.3. Underlying, intermediate and immediate causes of health needs

Identifying the causes of the problems entailed using the '*problem tree'* a participatory tool that connects underlying causes of priority needs with intermediate and immediate causes. While the immediate causes of participants' problems varied, the intermediate and underlying causes remained resolutely the same across social groups. Thus, the table below shows a consolidated table presenting the structural and intermediate causes of priority needs of People living and affected by HIV AIDS in Goromonzi District.

Table 3: Consolidated underlying, intermediate and immediate causes of health needs

Underlying causes	Intermediate causes	immediate	Priority problems in Goromonzi	Burden
• Poverty, • Poor economic policies, • Fragile political environment • Unpredictable economic environment	• Religion, • Culture • Out migration of key health workers • Drug stock outs • Inefficient national level planning and resource allocation for Health (Absence for social security) • Marginal agriculture • Poor road network	• Defaulting in ARV treatment • Lack of knowledge/ education, • Financial vulnerability • Huge workloads • Lack of retention schemes of resources • Financial vulnerability • Stigma and discrimination	Long distances to access ART facilities and services Lack of intimacy (forced sex and or denied sex)Gender inequality Poor communication with health workers Shortage of drugs (ARVs); equipment and Staff	**HIV/AIDS vulnerability**

Deep-rooted structural poverty, arising from such things as gender imbalance, lack of access to services, marginal agriculture, social disruption and fragile political environment signified an effect on individuals' and communities' vulnerability to the spread of HIV, their ability to handle risks, and opportunity to participate in prevention and care activities. Participants reported that the experience of HIV/AIDS by poor individuals, households and communities is likely to lead to an intensification of poverty, push some non-poor into poverty and some of the very poor into destitution. In turn, poverty can accelerate the onset of HIV/AIDS and tends to exacerbate the impact of the epidemic.

"Urombo ne kushaya chekubata ndiyo hosha huru, izvi zvinonyanyo perekedzwa nehosha dzakaita se husarapavana, mukadzi wandinenge ndapihwa anenge arimudikidiki apa anenge akangotarisa ini, ungatadze kumupa bonde ipapo? Chawaziva hapana-ndiyo EDZI yacho yawatobata, chakaendesa munin'ina ndicho chondiyendesawo...haa, panemutambo, tinotoda dzidziso yakasimba inomedza tsika dzinouraisa saidzodzi. Kazhinji vazhinji vedu vanotsvaga mishonga yepachirongwa Angove hari yofanzirofa"

Loosely translated as:
"Poverty, shortage of basic life needs is the biggest illness; this is often accompanied by such ills as cultural inheritance of a brother's wife upon the death of the brother. Often they leave young wives whom we take as our wives. Before long you find yourself with AIDS. What killed my brother is likely to kill me too. There is a lot of work that still needs to be done to educate us in order to address customary practices that continue to spread the HIV infection. Most seek HIV treatment when it's too late"

Financial risk dominates the risk scope of most households in Goromonzi under enormous pressure to provide not only for themselves but also for extended families. Participants reported that that women's financial dependence on men compromises their ability to practice low-risk behaviors perpetuating the spread of HIV and more social problems related to HIV.

Actions proposed: First: Long-term success in responding to underlying, structural and intermediate cause of HIV requires sustained strategies in addressing human rights violations, gender inequality, stigma, and discrimination. This should be complimented by evidence-informed programmes to forge norms of gender equity with particular attention to initiatives focused on men and boys.
Second: International donors should prioritize strategies to increase women's economic independence and support MOHCW's efforts to enforce antidiscrimination measures to protect people living with HIV.
Third: Communities should engage in income generation projects; public awareness and **"right to health"** campaigns, coupled with knowledge on legal services for people living with HIV. This should be supported by the health system in the expansion of access to antiretroviral drugs, and expressions of national solidarity in the HIV response.

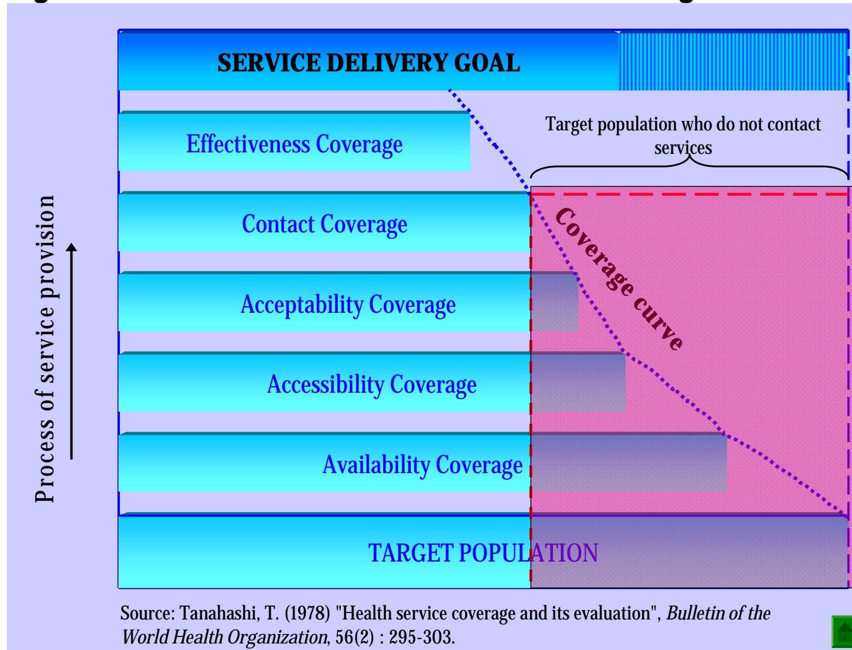
4.4. identifying current service coverage gaps and barriers.

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)*

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 the Tanahashi model was used. 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 3):

Figure 3: Tanahashi model of health care coverage



Three social groups (men, women and youth) each identified a service where resources where available but were 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, utilizations that did not translate to effective coverage.

Tanahashi model was used to discuss the health service coverage in terms of HIV treatment in Goromonzi district. 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 utilisation, 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

Available resources	Unavailable resources
Health workers Counselors, Nurses, Midwife Environmental Health Technician, Village Health Workers Home based care givers (mainly women); **Drugs** ARVs (only at the district Hospital), **Services (health facility, NGOs, CBOs and Faith Based Organizations)** Voluntary Counseling and Testing (VCT), Provider Initiated Testing and counseling (PITCT), Health education, Nevirapine for PMTCT(*VCT, PITCT, PMTCT services at the clinics only accessed by those who can afford the user fees at the local authority clinic),* Condoms (both female and male), support groups; Antenatal Care (ANC) **Equipment and sundry** Gloves, soap, Rapid HIV treatment Kits **Infrastructure** Health facilities; Opportunistic infection services (OI Clinic);	**Health workers** Doctors, nurses and other staff trained for ARV administration (these are available only in small numbers in the public sector), **Drugs** ARVs (inadequate), Occupational and non occupational Post Exposure Prophylaxis, cotrimoxazole, Paracetamol, **Services** youth friendly centers; Nutrition services; Treatment Literacy; Occupational and non occupational Post Exposure Prophylaxis, social welfare services, psychosocial support, workplace clinical services **Equipment and sundry** CD4 counting machines; Other diagnostic testing equipment such as X-Ray machines, Transport/Ambulances

	Recommendations and actions to address flaws in availability Coverage
actions in the community	• NGOs can support Ministry of Health by providing the resources needed for comprehensive AIDS services at the community level. However, their contributions should be channelled through (coordination of) Ministry of Health.
actions in the interface between community and health system	• Health Centre committee and Village Health workers can support health system by organising labour for security services. For instance to prevent shortage of resources due to theft can be dealt with through the management of the Health Centre committees.
actions in the health system	• Government should not rely on international funding assistance such as Global fund for AIDS, TB and Malaria because it is not reliable. Not qualifying for funding undermines progress in universal coverage and availability of ARVs. Therefore government should o Increase the national fiscal and pool resources towards health to increase allocation to HIV treatment attention, support and care o Promote local drug manufacturing industry to manufacture generic drugs (that are cheaper and would increase availability coverage) • Government should challenge international trade barriers that cripple local drug industries. • Governments should have control over international donor assistance such as Global fund. Global fund fragment the health system and create systemic disparities in income amongst the Health Workers.

Accessibility coverage: Access to health care is important to obtaining quality care. Inaccessibility of health services and resources predicts an individual's likelihood of receiving care, thus it has implications in improving health outcomes. The most important factors were consistent across wards The discussions around accessibility coverage were therefore centered on the distance and cost of Makumbe Mission (District) hospital and the clinics in the area. In the social group discussions, participants identified the interventions, factors and resources that

recognize that the health problems result from deficiencies in behavior, settings or the availability of products and tools (transport) and seek to address the deficiencies.

The distance to Makumbi Mission hospital (District Hospital) was too long (more than a 100km) from the wards (Chikwaka, Rusike, Gutu, Gosha). Those who can afford the service take long to get there. Those who do not have money delay seeking health care, leading to default on treatment. Some patients seek health care services from neighboring districts such as the Murewa District and visit the Musani Mission Hospital. This affects planning and resource allocation for Goromonzi District (ARV supply will be less than what is actually needed). Treatment of opportunistic infections is affected by distance as people reported a preference to work in their crop fields than spend one and half days trying to get cotrimoxazole. . Some opt to buy drugs on the streets, which may be falsified counterfeits

Time spent before contact with service: Due to the long distance to the district Hospital participants reported that most patients arrive at the hospital late and are forced to seek accommodation in the neighboring Chinhamhora communal lands with strangers (or in a lodging facilities). These paid facilities are often expensive ranging from US$5-US$30, out of reach of many. Thus, out of pocket costs are significantly and unnecessarily heighted perpetuating inequalities in health service provision. The time spent waiting for service is further elongated by the number of ARV patients waiting to get their treatment. This is so due to the congestion emanating from Makumbe mission being the only ART site in the whole District of more than 20 wards and more than 100000 people.

Some of PAR participants-Goromonzi District

Fee payments: Participants argued that the biggest challenge in accessing HIV treatment is 'money', ie user fees and other payments. These costs are further increased when a person is

asked to travel to the provincial Hospital (Marondera Provincial Hospital) to get the CD4 count and other diagnostic tests. In this case the person is forced to travel home, wait for between 3-7 days depending on the type of tests and then travel back to the district Hospital for the results. The costs associated with the logistics to receive free ARV are higher than the costs of purchasing ARVs.

For instance, participants reported that first line treatment Combir, lamivudine ,Navirapine costs about US $15-US$17 from the pharmacies for one month supply . While the costs of travelling from Juru Growth point to Harare is US$4, Harare-Makumbe US$2 lunch US$2, travelling back at the same costs would get the total transport costs to US$14. In some cases people are forced to sleep over increasing the out of pocket costs through the lodging costs and food costs to about US$20. This increases the total costs to US$38. In some cases a person travels to the hospital and is told that there are no drugs they should come back the following week or on a later date. Again, this increases the costs.

The following quote corroborates this assertion

"Ndinodakutenda chaizvo kuti basa rose iri ririkuitirwa munzvimbo ino ye Goromonzi, Ndinovimba kuti zvinhu zvatichataura kuti zviitwe isu pano tichaita, asi imiwo ve TARS muchatibatsira kuti tiite chaizvo. Ndiyo ka Action Research yacho? MaARVs tinoda kuti awanike nyore nyore muno mumwanza, pakowoyo apa Rusike imo munomatigere, kwete kuti munhu unokwira mabhazi maviri matatu kuti awane mishonga…". participant

Loosely translated as

"I want to thank you for conducting this research work here in Goromonzi. The actions that we shall agree on shall be implemented by us, and TARSC with its partners will support is to implement action that brings change to our current health problems, is this not what you are calling Action Research? We want ARVs to be easily accessible in our local clinics- at Mwanza, at Kowoyo, at Rusike Health centers, not to continue with boarding two-three buses to get medication" participant

	Recommended actions to address gaps in accessibility coverage
actions in the community	• Communities to participate in health through advocacy in improving health service provision by improving the road network and lobbying for government to make clinic ART sites (to cut on travel time and travel costs)
actions in the interface between community and health system	• Strengthen capacity of lay health workers such as Village Health Workers and community Home based Care programmes to facilitate uptake of treatment, adherence and treatment literacy • Communities should participate in the development of community health financing schemes that should support and strengthen an equitable resource allocation formulae that ensures that those who need treatment and cannot access it are able to access it
actions in the health system	• Reducing out-of-pocket payments by removing public sector user fees • Reduce other health care costs (transport costs) by making clinics ART sites • Train Health workers in clinics (primary health facilities) to administer ART (coupled with VCT, PMTCT and basic HIV counseling)

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.

From the discussions, participants observed their priority health problems in Goromonzi were associated with acceptability issues. There were differences in the care-seeking behavior of patients, which varied due to differing cultural beliefs, language barriers, degree of trust of health care providers, variations in the predisposition to seek timely care. In addition, the availability of care is dependent upon such factors as the ability to pay for care, the location, management and delivery of health care services, clinical uncertainty, and health care practitioner beliefs, among others.

In particular, Health worker community interaction was observed as one challenge with propensity to flaw acceptability coverage of HIV AIDS resources. Patients described the nature of professionalism presented by Health workers in their areas as *'hooliganism, and bullyism'*.

Participants observed that, most health workers share patient privacy information with the public, come to work late if they (Health workers) open the health facility at all, and selling counterfeit medicines at their homes for patients. While the Ministry of Health has specific mechanisms to ensure performance management and public integrity management of public resources, participants expressed concern over the extent to which and nature at which such conduct issues are managed.

	Actions to address flaws in acceptability coverage
actions in the community	• NGOs and other stakeholders working in the health sector should orient interventions basing on human rights based approaches. These should involve programmes that strengthen and support interaction between communities and Health workers
actions in the interface between community and health system	• Health Centre committee members should provide the interface between communities and health workers by operating as the management committee between health workers and communities. Thus, HCCs should be trained to execute their functions . • Other stakeholders such as CBOs and NGOs can support HCCs with resources to enable this.
actions in the health system	• The MOHCW should employ effective performance management and public integrity management tools that ensure public accountability. Health workers should be made to account for resources (time or otherwise) to the public. Thus codes of conducts should be used to address community-health worker conflicts.

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 provider compliance, patient adherence and diagnostic accuracy. The research considered 'continuity' of access for HIV treatment including such things as adherence to ART, defaulting, abandonment of ART. The lack of this continues contact undermines potential for contact coverage to translate to effective coverage.
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Provider compliance: Participants reported that in some instances patients are informed that ARVs have expired (contrasting with instances where patients are told drugs are not there and some patients succumb to opportunistic infections before they get enrolled on the national ART programme). In such cases patients noted that Health workers still ask patients if they would want to use the expired drugs. The lack of health provider compliance with National Health regulations raised a lot of heated debate leading to close discussions with health workers. While some health workers could not support these assertions the researcher observed the need to highlight these issues and state the lack of consensus on these issues.

Patient adherence: Participants observed the increased trend in defaulters and lack of adherence. While participants observed such social barriers as stigma, long distances, user fees, out of pocket payments as some of the biggest challenges in adhering to treatment. They also added that stock outs and lack of health provider attending to ART side effect are contributing factors to treatment defaults.

One participant highlighted that ART side effects continue to proliferate stigma and discrimination

" hondo hombe ndeyekuti, munoona vamwe vedu tine matumbu mhombe setine nhumbu nenyaya yechirongwa iyi. Kutonwa ndiko kurarama, ASi nahu iri pamaside effects emishonga iyi, ndizvo zvikikukomekedza stigima"

Loosely translated as

"The greatest war is on these big tummies that we carry, you see- we move around with sticking tummies like pregnant women due to the ARVs we take. These side effects continue to make us vulnerable due to stigma associated with this"

	Actions to address flaws in contact coverage
actions in the community	• Communities can contribute to the retention of Health workers by proving health worker non financial incentives .e.g. through construction of a health worker home • NGOs, CBOs, FBOs and traditional leadership to support patients on ART with treatment literacy to prevent defaulting in HIV treatment. They should also support health workers with bicycles, motorbikes, cars or fuel to enable health workers to follow up on patients. • Massive campaign and treatment education should be coupled with campaigns against stigma and discriminations
actions in the interface between community and health system	• Health workers should be trained in strategies to support PLWHA and those on treatment on drug adherence, side effects • HIV AIDS support groups should be supported with skills In HBC to support adherence several contacts with the health service.

	• Health Centre committees should be involved in addressing some community-health worker interaction issues i.e. communication problems
actions in the health system	• HIV treatment should be integrated with other services to promote universal health coverage. For example it should be coupled with TB DOTS treatment, PMTCT, VCT (Particularly preventive services) • Ministry of Health to invest in training health workers to administer ART and increase the number of health workers per site to match with the population demands particularly in resettlement areas. • Drug procurement systems should consult health centres and clinics on the drugs required by these centres • Equipment such as CD4 count machines should be made available and staff should be trained on how to use it and how to maintain it

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 reported that health service provision integrates other services including VCT, PMTCT and Male circumcision programmes all provided at Makumbe mission hospital. Mwanza and Kowoyo clinic were noted as the primary sources of patient referral through the Ante-Natal Care programme. Thus the ANC programme assumes the lead in making referrals to clinical and non-clinical service providers in the Chikwaka-Gutu, Rusike, Gosha catchment area. It was also highlighted that linkages between organizations providing services are informal and communication is ad hoc based on immediate need. Other than in discussion during the patient's next appointment at the health facility, there is no formal mechanism for following up on a referral to determine if the need has been satisfied.

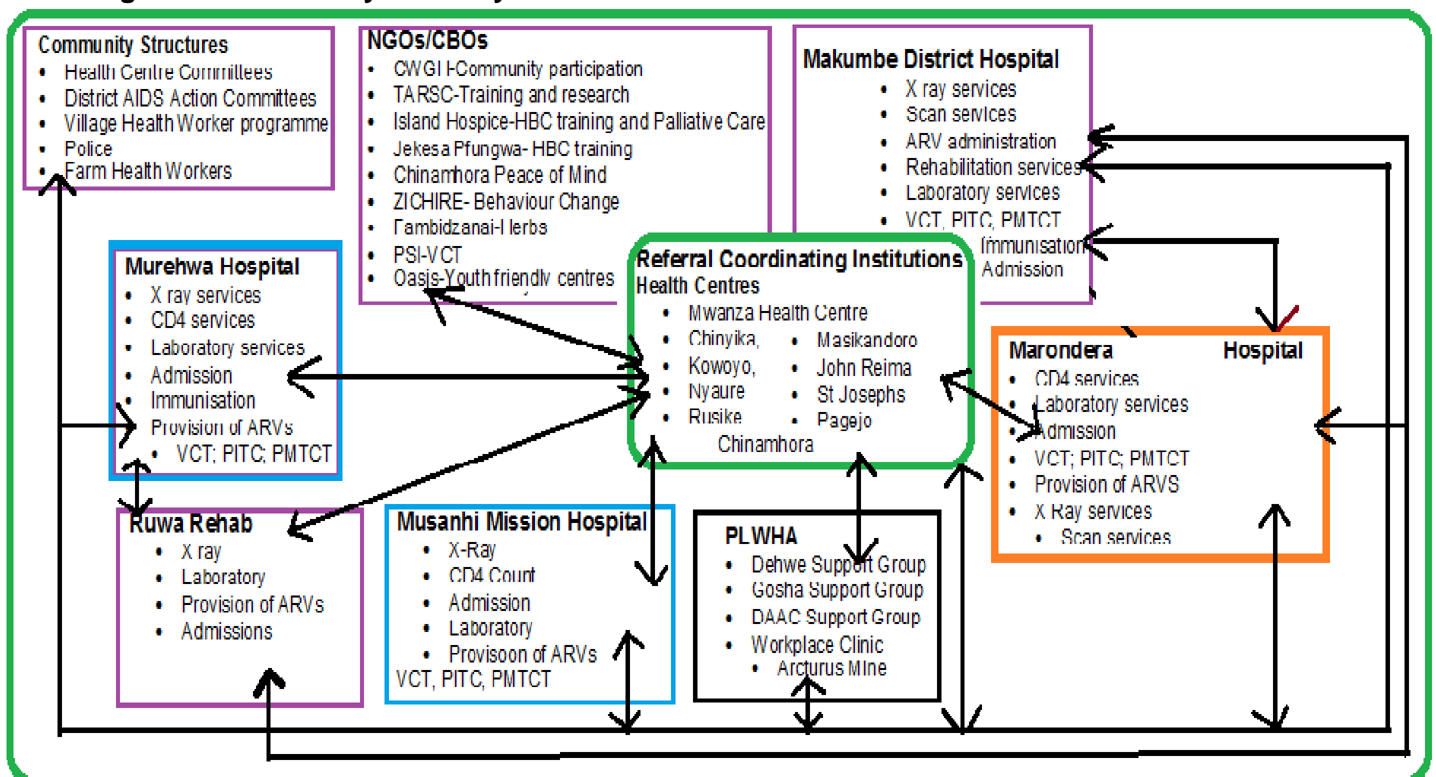
On the other hand, Makumbe Mission provides HIV prevention, care, treatment and support services through the VCT, PITCT, PMTCT, HBC and clinical care (including managing opportunistic infections and other HIV-related conditions, prophylaxis for opportunistic infections, TB management and antiretroviral therapy). Facility-based services also include nutritional support and counselling for PLWHA. The mission refers patients to the Marondera Provincial Hospital. The DNO and the DEHO serve as the focal point for linkages between the health facility-based services and community, Village Health Workers, with community health workers (CHW) from the HBC project functioning as intermediaries.

The flow diagram below is a summary of the HIV treatment referral network in Goromonzi District showing how the referral points are networking at community level

Recommendations: Participants highlighted the need to support and strengthen the DOTS programme and integrate it with ARV programmes. Further to this procurement and distribution of ART should be integrated into the same procurement and logistics systems used for other health programmes such as the TB programme. Because the referral network in Goromonzi did not show participation of private sector, participants noted the importance of Private sector collaboration with the public sector in providing ART, for reasons of local sustainability, and opportunities for cost-sharing.

Community health system should make integration of the referral network a central principle to help PLWHA, family support, Home Based care givers, Village Health workers, and HIV AIDS support groups. These groups should obtain information and access services on health to facilitate their active participation in decisions affecting their lives and to promote social acceptance and respect for those living with HIV and those caring for HIV-infected persons.

Figure 4: Community based system for HIV treatment in Goromonzi - the referral network



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)

During the focus group discussion, health worker participants reported that there were no experienced, practising clinicians with strong teaching skills and with time to mentor less

experienced health workers in the administration of HIV treatment and management of AIDS. While there was a general consensus that mentoring should be viewed as part of health worker in service learning, participants observed deficiencies in the number of trained health workers operating at health centre level.

Lack of experienced health workers to work as mentors, was perceived as a reason for the absence of decentralized delivery of HIV care, antiretroviral therapy and prevention with high-quality care at all levels. At district Hospital level, i.e. at Makumbe Mission Hospital managing unfamiliar and or complicated cases (antiretroviral therapy toxicity, immune reconstitution inflammatory syndrome, complicated HIV/tuberculosis (TB) cases, and treatment of children or pregnant women) or referring them when appropriate has been restricted, compromised or delayed..

Participants acknowledged the presence of supportive supervision particularly from the District Nursing Officer from Makumbe Mission Hospital. They added that while supportive supervision is one of the most critical components of capacity-building. Proper supervision and follow-up after training ensures that health care workers can implement the lessons learned during initial training sessions. Supportive supervision from DNO was reported to include such elements as whether key requirements for HIV care, antiretroviral therapy and prevention in place and if there are mechanisms for case management in place.

Recommendations:

- The clinical mentoring should be provided for in budgetary terms to improve the clinical environment rather than to police the quality of care.
- Clinical mentoring is made part of the non financial incentives for them; it may a go a long way in improving the motivation of health care workers by providing effective technical support.

4.7. Organisation of Primary Care Patient flow in HIV treatment

Understanding of Patient flows within Health facilities provides an in-depth appreciation of flaws that exist within health facilities for delivering HIV treatment.

These flaws were observed to resonate with long waiting times and health worker –client interaction. Due to low staffing levels compounded by shortage of trained man power, clients spend long hours waiting for service (and long queues). These waiting hours are often characterized by patients with empty stomachs, frustrated and angry for slow service. By the time the client gets in contact with the health worker they are angry, hungry and tired leading to vindictive communication. This often leads to spiteful discrimination against HIV status from the Health worker to the Patient. Resentment that builds particularly from the client’s side can lead to ART or non adherence.

Another barrier that was noted was the labeling of the Opportunistic Infection (OI) clinic at the Hospital. Participants reported that the label “OI Clinic” leads to stigma. .User fees, lack of confidentiality, power outages, machine/ equipment breakdown and staff absenteeism were observed at almost each point of the patient flow

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Participants in a focus Group discussion on Referral networks at community level

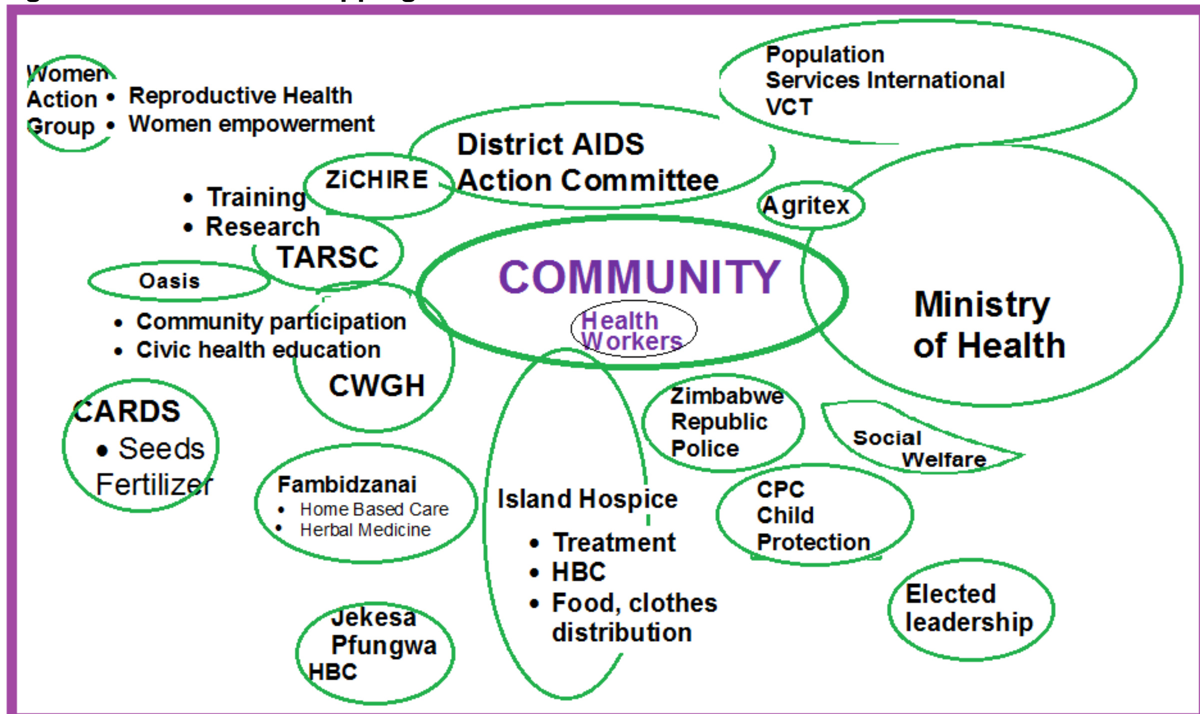
4.8. Mapping community resources, institutions and actors that respond to HIV AIDS

Using the stakeholder mapping tool, participant argued that Multisectoral integration in HIV treatment should not be ignored. The lack of support from line ministries to the MOHCW to support HIV and health related programmes at community level were noted. An example given showed that while nutrition for PLWHA is a MOHCW issue, it was equally a ministry of Agriculture issue. The argument given was that while a lot resources every year are evidently channeled to the mechanization and agricultural support, there was nothing substantive for health, let alone HIV. Most of the resources for HIV AIDS, particularly HIV treatment were reported to be financed through the Global Fund, funders and donors alike. Even with these donors, communities observed that the funding schemes on HIV treatment, support and care were often parallel lacking integration with a bias on HIV treatment. While policy stakeholders and organizations working on health do appreciate the fundamental need to integrate services, it seems there is a sudden plague that lifts the same institutions to want to meet set target goals

than to address the problem more holistically. Equally, the integration of resources now looks like a war that has been wedged, unfortunately with an army ill prepared to face the consequences of war. Further the proliferation of NGOs and CBOS working on HIV issues was noted with caution. Participants expressed concern over the extent of duplication of efforts and roles, with most of the participants with conviction that the work operations were more to do with job security than saving lives.

The **Venn diagram** below shows the stakeholders present in Goromonzi, the bigger the circle the more presence the stakeholder has in the community, the closer the circle is to the community the more interaction it has with communities.

Figure 5: Stakeholder mapping-Goromonzi District



As **recommendations,** participants suggested the need for Global Fund resources including other assistant funding to be channeled through government Ministries, particularly the Ministry of Health. Furthermore, non state actors including NGOs should support the Government in enforcing public accountability mechanisms to ensure effective use of resources. This was not only observed as key addressing duplication but also instrumental in addressing coverage barriers in availability, accessibility, acceptability, contact and effective coverage systematically.

Further, participants suggested that stakeholders operating in Goromonzi should 1) hold collective annual planning meetings to avoid duplication 2) hold quarterly meetings for feedback and communication 3) liaise with local authorities, Ministries of Health and Education for joint effort in health issues and 4) Communities need empowerment to demand duty bearers to be

accountable for public resources e.g. the AIDS levy and the GFHTM[1]. Policy provisions such as the Public Health Act, constitutional provisions on the right to health, public expenditure management systems can systematically support the channeling of HIV resources to areas of highest need

A 'leaping blocks' participatory tool was used to reinforce the learning in the PRA tools used to expose the factors that disable effective delivery of HIV treatment at community level. Overall, user fees and lack of community participation were noted as the immediate barriers in building community systems in HIV treatment. At systems level, the interaction between patients and health workers was observed to play huge role in disabling use of services. This was further corroborated by huge shortages in human resources for health particularly those trained to manage HIV AIDS. Lack of transport services such as ambulances, equipment such as CD4 count machines, were all observed as important factors in enabling or disabling provision of services at community level. Broadly the issues were all summarized more systematically in the Tanahashi model of coverage in section 4.4 above.

4.9. Strengthening communication opportunities for health workers and communities.

Health workers act as a bridge between health system and community in providing HIV treatment and care. Knowledge, capacity and communication skills of the workers are key to both their own confidence and building trust within communities. This is thus, fundamental for the success of the health system. Engaging communities and workers in building systems that are capable to manage HIV treatment at community level demands a system that recognises effective health worker-patient interaction.

Using a PRA tool- Margolis Wheel to determine the issues that patients face and those that health workers face that affects their interaction, quite a number of factors were exposed.
The table below provides the summary of the discussion from the activity:

Health worker-patient interaction problems	Solutions
Health Workers: Poor remuneration; huge workloads; low staffing levels; shortage of trained health workers; shortage of drugs, equipment; sundry;. All these factors were cited as causes of ill-attitude i.e. Rudeness; lack of urgency; lack of sympathy; lack of attention to detail; absenteeism, lateness	• Communities to mobilise self to create massive campaigns (people driven) of adequately remunerated, trained motivated staff • The training curriculums of health workers should include communication skills • Communities to support health workers with non capital incentives such as moulding bricks to build a house • Joint Health Worker-community action can strengthen their relations. Communities get to understand the problems faced by health workers and vice versa
Patient/community: Long distances to health facility, long waiting times, stock outs, and unavailability of drugs including ARVs are factors cited for arrogance, stubbornness, vindictive and spiteful characteristics reflected by communities in their interaction with health workers.	• HIV treatment should be decentralised to health centre/clinic level to cut on long distances • Incentives to motivate health workers should be in place to retain them and prevent long waiting times

[1] Global Fund for HIV, TB and Malaria

5. Discussion

Resources for HIV treatment have significantly increased in Zimbabwe over the past decade. However, from the research it is clear that the PLWHIV we included in Goromonzi area find themselves in a lonely island of treatment insecurity in the midst of a vast ocean of material prosperity. This is particularly significant when we consider Global Funding and donor aid contributions into the country. While donor aid has contributed significantly in pooling resources for HIV treatment, general underfunding in health has largely left other important sectors of the health system crippled and battling to stand. The social mapping exposed the economic barriers that exist within the health system cripple the same HIV system that donor aid intends to lever. For instance, barriers such as out of pocket direct payments and user fees that are often worsened by long distances to the district hospital (Makumbe mission) and resultant accommodation/lodging fees (as patients arrive late in the night, require accommodation to contact the facility on the morrow day); card fees and diagnostic tests often are conducted in Marondera (Provincial Hospital) increase the total cost of care. These null the zero costs that ARVs are said to have. These barriers often cause people to discontinue treatment or falter in treatment adherence.

In the priority Health problems of social groups, Stigma was not pointed out as a priority. However, participants noted that stigma was deeply rooted and entrenched within the health system and at community level. It was acknowledged that while HIV disclosure is a step in addressing stigma against HIV AIDS, participants expressed concern that as long as administration of ART was not provided as for other conditions like malaria at clinic level, PLWHA are likely to face stigma when the disclose their status and are poorly prepared to deal with this reaction. Though there was consensus that desperation has led this social group to fight stigma, but that they were however not willing to express the commitment to '*confidentiality suicide'* with no prospect of a positive outcome. Gender disparities, lack of economic independence, low income earning opportunities, violence against women, stigma and discrimination, traditional/religious and cultural impediments faced by women continue to increase levels of treatment defaulters.

The stakeholder analysis shows that Multisectoral integration in HIV treatment is currently not operationalised, with sector ministries pledging support that does not come, rhetoric that is not realized, and propaganda that communities struggle to comprehend. Some participants noted these problems but felt that there must a starting point, and that it is unwise to spurn any breakthrough no matter how limited. This position has certain validity, and a community based system in HIV treatment is more likely than not attain broad victory from small victories particularly in low resource settings. There is a critical distinction however, between a modest start and tokenism. Participation may be tokenistic when its purpose is not to begin a process, but as an end in itself to qualify a process as 'participatory', or when health is seen as a ministry of health issue, rather than a multi-sectoral issue.

6. Recommendations and conclusions

Overall, research identified recommendations that policy should consider in defining a comprehensive community based model for HIV treatment, support care amongst PLWHA and those affected. 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.

6.1. **At the community level,** participants proposed that resources for comprehensive AIDS services at the community level be.channelled through MoHCW. Communities can contribute to the retention of Health workers by providing non financial incentives .e.g. through construction of a health worker home. Non government, community and faith based organization sand traditional leadership should to support treatment literacy to support treatment adherence and support health workers with bicycles, motorbikes, cars or fuel to enable follow up of those on treatment. Treatment literacy should be coupled with campaigns against stigma. .

6.2. **In the frontline health system, g**overnment should not rely on international funding and should increase national budget allocations for HIV treatment attention, support and care; promote local drug production; remove the barriers of user fees; make ART more accessible through making clinics ART sites, invest in health worker deployment to and training in clinics to support service provision and ensure that clinics get the medicines they need for comprehensive treatment programmes. Government should also prevent the fragmentation of parallel projects in international agencies fragmenting the health system and creating differences in income amongst the health workers.

6.3. **The interaction between community and health system agencies** should prioritize strategies to increase women's income and employment and thus economic autonomy and support MOHCW's efforts to stop discrimination against PLWHIV, measures to protect people living with HIV. Participants suggested interaction would improve if communities were more aware of their right **to health, of the** legal services for PLWHIV, and thus more able to hold the health system accountable for widening access to antiretroviral drugs in line with the resources available. Health Centre committee and Village Health workers can support health system by organizing labor for security services to prevent theft, while Village Health Workers and community Home based Care programmes were seen as key to facilitating uptake of treatment, adherence and treatment literacy. Participants suggested that communities should also participate in the development of community health financing schemes to match resources allocated by government to improve access to treatment, and that international and government resources should be pooled in a public sector fund and allocated according to need with stringer public reporting on how money is spent. It is thus evident that improved community systems not only call for policies that integrate communities as central, for resources, capacities that are oriented to community needs, but are systems that provide for more meaningful information, participation and roles to ensure that this is achieved.

7. 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
NGO	Non Governmental Organization
OVC	Orphans and other Vulnerable Children
PAR	Participatory Action Research
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counseling
PLWHA	People Living with HIV AIDS
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Reflection and Action
MOHCW	Ministry of Health and Child Welfare
TARSC	Training and Research Support Centre
TBA	Traditional Birth Attendant
VCT	Voluntary Counseling and Testing

8. References

1. Family Health International (2005); Establishing Referral networks for comprehensive HIV care in low resource settings: USAID
2. Gregson, Garnett, Nyamukapa, et al (2006); HIV Decline Associated with Behaviour Change in Eastern Zimbabwe; Science
3. Loewenson R, Kaim B, Mbuyita S, Chikomo F, Makemba A, Ngulube TJ (2006) Participatory methods for people centred health systems A toolkit for PRA methods, TARSC, Ifakara , Ideas Studio, Harare
4. Loewenson R, Kaim B, Machingura F (TARSC) Rusike I, Chigariro T, Mashingaidze L, Makone A (CWGH) (2007) Health Literacy guide for people centred health systems: Zimbabwe, TARSC: Harare
5. Loewenson R, Kaim B, Machingura F (TARSC) Kawale P, Kwataine M (MHEN) (2008) Health Literacy Manual for people centred health systems: Malawi, TARSC: Harare
6. Loewenson R, Kaim B, Machingura F (TARSC) Kelemi C (BONELA), Mhotsha G (BFTU) (2009) Health Literacy guide for people centred health systems: Botswana, TARSC: Harare
7. Machingura F, Loewenson R ,Woodhouse P, Kaim B, and CoBaSys PRA teams (2010); Participatory Research Protocol for Community PRA meetings in community based HIV treatment in Zimbabwe, Malawi, Tanzania, Botswana, Namibia and Mozambique; Training and Research Support Centre; Zimbabwe; Harare
8. MoHCW (2005) ART Progress Report as of November 2005; Government of Zimbabwe, Harare.
9. MOHCW (2007) Maternal and Perinatal mortality study (ZMPMS). Government of Zimbabwe, Harare.
10. MOHCW (2009); Zimbabwe National HIV AIDS Estimates 2009; Government of Zimbabwe; Harare
11. National AIDS Council, 2009. Annual Report 2009. National AIDS Council
12. Tanahashi T (1978). Health service coverage and its evaluation. Bulletin of the World Health Organization
13. TARSC (2010); Participatory methods for community based systems in HIV treatment – '*Strengthening capacitates for qualitative research using PRA approaches*' –Workshop Report- April 2010: TARSC Harare
14. UN data cited on http://www.nationmaster.com/time.php?stat=peo_urb_pop_gro_ann&country=zi
15. UNAIDS/World Bank (2009). The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact- June 2009; UNAIDS
16. UNAIDS (2010) 'Report on the global AIDS epidemic'. UNAIDS
17. WHO (2006). Antiretroviral therapy for HIV infection in adults and adolescents: Recommendations for a public health approach- 2006 revision. WHO