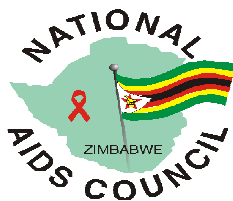
National Review of Community Home Based Care and Access to Treatment Services in Zimbabwe



National Review of Community Home Based Care and Access to Treatment Services in Zimbabwe

Commissioned
By

National AIDS Council

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ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
ART	:	Anti Retroviral Therapy
ARV	:	Anti Retroviral
CADEC	:	Catholic Development Commission
CAZ	:	Cancer Association of Zimbabwe
CBO(s)	:	Community Based Organisations
CEPHAC	:	Centre for Environment Preventive Health Care and Counseling
CHBC	:	Community Home Based Care
CMED	:	Central Mechanical Equipment Department
DAAC	:	District AIDS Action Committee
DACHICARE	:	Dananai Child Care Programme
DNOs	:	District Nursing Officers
DOMCCP	:	Diocese of Mutare Community Caring Project
DOTS	:	Direct Observation Treatment
FACT	:	Family AIDS Caring Trust
FCTZ	:	Farmers Community Trust in Zimbabwe
FGDs	:	Focus Group Discussions
GIPA	:	Greater Involvement of PLWHA
HIV	:	Human Immuno-Deficiency Virus
HOSPAZ	:	Hospice Association of Zimbabwe
IEC	:	Information Education and Communication
IGAC	:	Insiza Godlwayo AIDS Network
IGP	:	Income Generating Projects
M & E	:	Monitoring and Evaluation
MASO	:	Midlands AIDS Services Organisation
MIMA	:	Meaningful Involvement of Men Living With HIV/AIDS
MIWA	:	Meaningful Involvement of Women Living With HIV/AIDS
MOHCW	:	Ministry of Health & Child Welfare
MSF	:	Medicines San Frontiers
NAC	:	National AIDS Council
NGO	:	Non Governmental Organisation
OI	:	Opportunistic Infections
OVC	:	Orphans and Other Vulnerable Children Support
PACT	:	Post AIDS Counseling Trust
PLWHA	:	People Living With HIV and AIDS
PMD	:	Provincial Medical Director
PMTCT	:	Prevention of Mother to Child Transmission
PSI	:	Population Services International
PSS	:	Psychosocial Support.
RUDAC	:	Rural Urban Development Assistance and Care
RUDO	:	Rural Unity for Development
SEVACA	:	Sesithule Vamanani Caring
SIDA	:	Swedish International Development Agency
SPSS	:	Statistical Package for Social Sciences
STI	:	Sexually Transmitted Infections

STRIVE	:	Supports to Replicable and Innovative Village Efforts for Children Affected by HIV and AIDS
T&C	:	Testing and Counselling
TB	:	Tuberculosis
UAAT	:	Universal Access to AIDS Treatment
UDACIZA	:	Union of the Development of Apostolic Churches in Zimbabwe Africa
UNICEF	:	United Nations Children's Fund
UNIFEM	:	Development Fund for UNIFEM
UZ-UCSF	:	University of Zimbabwe in Collaboration with the University of California San Francisco
VCT	:	Voluntary Counseling and Testing
WAAC	:	Ward AIDS Action Committee
ZACH	:	Zimbabwe Association of Church-Related Hospitals
ZAPSO	:	Zimbabwe AIDS Prevention Support Organisation
ZINATHA	:	Zimbabwe National Traditional Healers Association
ZNFPC	:	Zimbabwe National Family Planning Council
ZNNP+	:	Zimbabwe National Network for People Living with HIV and AIDS
ZWP	:	Zvishavane Water Project

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EXECUTIVE SUMMARY

Background: The HIV and AIDS epidemic continues to strain health delivery services in Zimbabwe. Community Home Based Care (CHBC) has played a critical role in providing a continuum of care for chronically ill and PLWHA while in their home environments. The review of CHBC activities was commissioned in order to the findings to inform the development of the Zimbabwe National AIDS Strategy P (ZINASIP) which at the time of this review was being developed.

Research Methodology: The research team included 76 researchers mainly drawn from the health sector. The review was conducted in all the 10 provinces and their respective districts. The target population groups were: Health Institution workers, the chronically/terminally ill, caregivers (both primary and secondary), community/local leadership and civil society organisations. In-depth interviews with selected key stakeholders, 677 structured interviews and 224 focus group discussions (2674 participants) were conducted to gather both quantitative and qualitative data. Document reviews and stakeholders workshops were conducted to complement field data.

KEY FINDINGS

The review though mainly focusing on Community Home based Care issues, also addressed issues of access to AIDS treatment and coordination and linkages of CHBC with other complementary services. The key findings highlight issues from the following sub-themes:

- Community Home Based Care
- Access to Treatment
- Linkages between CHBC and Testing and Counseling, Nutrition and AIDS Treatment
- Coordination, Standardisation and Monitoring & Evaluation

Community Home Based Care (CHBC): Under this theme the review covered a number of topical issues. The following are highlights of the findings:

Common CHBC Services: included provision of nutritional support to patients, training of caregivers, services rendered to patients by care givers, and most recently access to AIDS related treatment. ***Training and Capacity:*** majority of caregivers (82%) have received some form of training, indicating some significant levels of capacity among care givers. However gaps still remain in terms of quality, duration, standardisation and inadequate refresher courses.

Motivation issues: There are variations in the forms of incentives for caregivers across CHBC service providers. There is need to standardise incentives for caregivers and to introduce incentives in CHBC programmes which have none. The review recommends a menu of CHBC incentives from which CHBC programmers can pick. ***CHBC Kits:*** The provision and replenishment of CHBC kits is critical in determining the quality of service

delivery by caregivers. Only 43% of the caregivers have access to CBHC kits. Replenishment of Kits is generally spaced, ranging from six months (for better resourced providers) to replenishment after over a year (for poorly resourced organisations). CHBC kits contents also vary form organisation to organisation and most kits do not carry items as specified in the MOHCW Standard kit. On average, CHBC kits are managed by community nursing sisters, caregiver team leaders and individual caregivers. Most caregivers preferred that each caregiver be provided with a CHBC kit.

Discharge Planning Guidelines: The 1998 Discharge Planning Guidelines provides stages to be followed when discharging patients form health institutions for CHBC. While over 60% of the health institutions indicated that they were following discharge planning guidelines, most caregivers held the view that such guidelines where not being followed mainly due to pressure of work on the health worker against a growing number of patients with AIDS related illnesses. The key five stages included: health assessment, planning, implementation, evaluation and discharge, and handover of the patient.

Involvement of CHBC Key Stakeholders: Male involvement in CHBC was reported to be on the increase yet still remains a contentious subject. Areas of concern for male involvement included; domination of male caregivers in leadership positions and their demand for better incentives compared to those given to women on grounds that they are breadwinners. Child involvement in CHBC remains an area requiring attention as children are often left in CHBC training and other programme activities. There is need for development of child specific CHBC training packages which are sensitive to needs and rights of children. Youth involvement in CHBC was reported to be on the increase. Like children, youth have also not been well targeted for CHBC training. Over 70% of caregivers reported meaningful involvement of PLWHA in CHBC. Their involvement was said to be critical in areas of lobbying and advocacy and in contributing to reduction of stigma and discrimination for the affected and infected.

Overall Challenges in CHBC: Key challenges for CHBC included: limited funding for the sector which compromises the quality of CHBC programming, the need to address issues of incentives for caregivers and burnout, limited male involvement in CHBC programming, the need to address special needs for youths and children in CBC programming, quality and standardisation of training for caregivers, weak coordination, and monitoring and evaluation for CHBC.

Access to AIDS Treatment: Access to AIDS treatment is a critical component in reducing morbidity thereby increasing longevity, productivity and quality of life for PLWHA. Access to treatment therefore becomes an important complementary intervention for CHBC. The following issues were highlighted by the review:

Services for Access to Treatment: About 77% of the caregivers reported familiarity with issues of AIDS treatment. Topical issues they were more aware of included importance and significance of testing and counseling, the role of nutrition for treatment, treatment of opportunistic infections (OIs) and STIs, ARVs, and PMTCT. Overall rural communities

indicated less awareness of access to treatment issues. Support group members in urban areas shared a lot on important treatment subjects such as side effects of particular ARVs, dealing with stress and OIs. They were also knowledgeable on concepts of viral load and CD4 count. Support groups in rural areas indicated a need for treatment literacy.

Forms of AIDS Treatment: The two major reported forms of AIDS treatment were ART and herbal treatments. Both health institutions and NGOs were providing various services in ART. Use of herbs has become a more accessible and affordable alternative for AIDS patients particularly those in rural communities. A significant and growing proportion of NGOs are involved in building capacity for communities to develop herbal gardens, increase their knowledge of types and uses of herbs, training on processing and marketing of herbs. Most respondents from the review were aware of the risks associated with combining ARVs with herbal treatments.

Overall Challenges in Access to Treatment: Key challenges for universal access to treatment included: shortages in foreign currency, low uptake of testing and counseling services, inadequate paediatric formula for ARVs and limited literacy among communities particularly rural communities on access to treatment issues.

Linkages: CHBC, Testing and Counselling, Nutrition and AIDS Treatment: A comprehensive CHBC programme which includes provision of T&C, nutrition and AIDS treatment is likely to result in a successful CHBC programme. Such an approach contributes to reduction in morbidity, increase in longevity and productivity for PLWHA. The following were key highlights with regards to linkages of CHBC and other complementary services:

CHBC and Testing & Counseling Linkages: There are relatively weak linkages between CHBC and testing and counseling services. Most CHBC clients die without knowing their HIV status thus miss opportunities for accessing the ever increasing services in access to AIDS treatment. ***CHBC and Nutrition Linkages:*** Good outcomes of CHBC programming are reached when nutritional support is provided to the chronically ill and PLWHA and their families. The review indicated a significant of CHBC programmes which included food distribution as part of their services thereby ensuring food security for clients. Programmes with food distribution have also reported significant improvement in status of CBHC patients with some graduating from being bed-ridden to being active productive individuals. ***CHBC and AIDS Treatment:*** Overall, most CHBC did not have clear linkages between CHBC and access to treatment services. Only a few CHBC programmes had such linkages. However strong linkages between CHBC and access to treatment were reported for mission hospitals that provided ART and also had CHBC programmes running. They were also well served with testing and counseling services thereby providing a one stop shop for comprehensive services for CHBC patients.

Coordination, Standards, Monitoring and Evaluation for CHBC: The multi-sectoral and multidisciplinary approach to CHBC provision requires effective coordination systems and mechanisms. The following key issues emerged from the review:

Coordination Mechanisms: CHBC information is not well coordinated as most CHBC providers preferred to report only to NGO central offices. They did not see reporting to NAC as important. NAC has the responsibility of coordinating information from all key stakeholders in CHBC as well as disseminating emerging patterns and trends in the sub-sector.

Information Sharing and Dissemination: Information sharing among key stakeholder particularly at district level varied from district to district with some having good examples of information sharing. In districts were networking was good, key players in the sector met at least quarterly and shared their work. Some NGOs were skeptical about the coordination role of NAC and viewed NAC as a body only interested in financial resources and its utilisation and not the complementary role their work. In the vein of 3 – ones principle (one HIV and AIDS Action Framework, one coordinating body and one monitoring and evaluation system) it is important for NAC to know who the key players in CHBC are, where they are operating, what resource base they have and what areas still remain un-served in order to coordinate and direct the service provision of new players.

Standards of CHBC: National standard Guidelines for CHBC were not adequately distributed among key stakeholders. Only a few players where adhering to the standards. Some of the key players reported that the guidelines were complex and required simplification.

Monitoring and Evaluation: While NAC should be complemented for working towards a unified monitoring system, the review indicated some flows in the operationalisation of the M&E systems. Some CHBC players were not using NAC M&E reporting forms. Some CHBC players focused more on CHBC data only for their mother organisations and respective funding partners and not for NAC coordination purposes.

Recommendations for Effective CHBC and Access to Treatment programming

The following are the key recommendations for improving CHBC and Access to Treatment programming:

CHBC

- There is need for standardisation of CHBC, training package, incentives and Kits contents/replenishments among CHBC players.
- The CHBC standard guidelines require simplification and wider dissemination
- There is need to incorporate youths and children in CHBC programming and develop relevant training materials for the target groups
- More funding for CHBC should be sourced in order to improve the quality CHBC programming.

- Mainstreaming gender issues in all CHBC programmes and policies.
- There is need to monitor operationalisation of the Patient Discharge Guidelines Plans.

Access to Treatment Issues

- In the context of CHBC, there is need to build capacity of caregivers on issues of treatment in order for them to play a key role in adherence issues for those patients on ARVs
- There is need for service providers in this field to scale up treatment literacy on access to treatment for communities
- More research is needed on herbal therapy as most rural communities rely heavily on herbs. Issues for research could include: names and usage, dosage and toxicity issues.
- There is need to scale up access for testing and counseling for communities particularly rural communities and reinforcement of MOHCW policy encouraging WHO staging of HIV and AIDS stages to enlist deserving patients on treatment (in the absence of CDC4 count machines).

Linkages: CHBC, T&C, Nutrition and Access to Treatment

- CHBC services should be designed in a holistic manner where the relevant complementary services such as testing and counseling, nutrition and access to treatment are well coordinated and are also characterized by a strong referral system
- There is need to encourage CHBC patience to know their status in order to maximize on services provided in access to treatment
- Nutritional support for CHBC patients should be an important component of CHBC where resources are permitting.

Coordination, Monitoring and Evaluation

- Enhance capacity of CHBC and Access to Treatment stakeholders in monitoring and evaluation.
- In the context of poor coordination of CHBC information, there is need for NAC to and MOHCW and relevant stakeholders to develop a policy enforcing the operationalisation of the 3 –ones for CHBC sub-sector.

1.0 INTRODUCTION

1.1 Contextual Background

Zimbabwe is one of the Sub-Saharan African countries most hard hit by the HIV and AIDS pandemic. The HIV prevalence rate has declined from 24.6% in 2003 to 20.1% for adults aged 15-49 by end of 2005[1]. Bed occupancy has remained high in all the hospitals in the country, with at least 70% of patients suffering from HIV/AIDS related illnesses. The country has an estimate of 1.4 million People Living with HIV and AIDS (PLWHA) and an estimate 342 000 people are in urgent need for Antiretroviral therapy (ART)[2]. This shows that HIV and AIDS has reached a mature stage.

Community Home Based Care (CHBC) has received wider attention in Zimbabwe for its ability to provide continuum of care for the chronically ill and PLWHA in their home environment. It provides services in a relatively cost effective, sustainable and comprehensive manner, in a complementary approach to institutional care. CHBC has therefore been hailed for reducing congestion in hospitals, thereby reducing health/hospital expenditures in the face of increasing number of chronically ill (PLWHA, Cancer, TB patients and other incurable illnesses). Apart from providing care and support to clients/patients, the programme also seeks to enhance or build the capacity of clients' families to offer affordable, quality care for their relative.

Zimbabwe has made extensive progress in the development of a Zimbabwe National HIV and AIDS Strategic Plan (ZNASP). Components of CHBC and Access to treatment are part of the draft ZNASP. Stakeholders' in CHBC at a workshop organized by NAC, made efforts to contribute to a working draft of the CHBC component. It is hoped that this review will add value and complement the already existing information for the development of a relevant and realistic ZNASP, to guide the provision of CHBC and Access to treatment services for Zimbabwe.

1.2 The Policy Environment

The Government of Zimbabwe has demonstrated strong commitment to fight the pandemic by creating an enabling policy environment, which provides for the participation of civil society organisations. Within this policy context, several government and civil society stakeholders in the field of HIV and AIDS have harnessed their efforts towards the provision of CHBC and Access to treatment services in Zimbabwe. This has also seen the production of a variety of strategic documents that relate to the policy guidelines, standards, and requirements for implementation of CHBC and access o treatment programmes. The following is a summary of key policy provisions in this sector.

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[1] Ministry of Health and Child Welfare: 2005
[2] Zimbabwe National Guidelines on HIV Testing and Counselling: 2005

Curriculum Guidelines for the Training of Community Home Based Care (CHBC) Volunteers: June 1997. The guidelines were developed in response to requests for standardizing training guidelines from various groups involved in training volunteers in CHBC. The guidelines highlight the following key issues to be addressed in the trainings of Community Home Based Care Volunteers: communication skills, basic facts about STIs and HIV/AIDS, basic nursing, infection control, counseling, home visits, referrals, monitoring and supervision and community mobilization. The guidelines also articulate the common roles and responsibilities of volunteers or caregivers.

Discharge Planning Guidelines for the Chronically Ill/Terminally Ill patients: 1998, reprinted in 2001. The guidelines provide the process involved in moving a patient from one level of care to another whilst ensuring that there is continuity of quality patient care and support. The guidelines also help the health practitioners to identify resources and support systems for the chronically ill for the purposes of discharging from health institutions.

National AIDS Policy 1999: The CHBC component of the policy's highlights the need for the provision of medical and nursing care for PLWHA, including nutrition, equitable access to ARVs, a well-coordinated referral system between stakeholders, integration of traditional medicine and capacity enhancement for service providers. CHBC is explicitly defined as an extension of the health care delivery system and integral component of the continuum of care for the chronically ill and/or PLWHA. The policy emphasizes the need for integrating orphan care into CHBC programming. Although the policy does not suggest key components or issues to consider for standardizing CHBC, it is interesting to note that the policy highlights the importance of linkages for CHBC, VCT and ART.

The CHBC Policy for the Republic of Zimbabwe: 2001. The policy seeks to ensure that there is continuity of care from the health care institutions to the community. It also prescribes the minimum package of care for the CHBC programme. Among other main provisions of the policy is to strengthen the existing referral system and to explore the alternative models of community care such as respite and Island Hospice. It also seeks to solicit support for the communities and caregivers, highlight the value of CHBC to the people of Zimbabwe and ensure that the community and health caregivers know the available CHBC resources.

National Community Home Based Care Standards: 2004. CHBC service provision in Zimbabwe has been falling short of the ideal quality, efficiency and effectiveness due to lack of standards. The standards provide guidelines and indicators for effective team service provision, good governance and management, training, information and education and monitoring and evaluation of CHBC programmes. These guidelines therefore provide an opportunity for designing programmes that are relevant, efficient, effective and sustainable.

Guidelines on Dietary Management for PLWHA: February 2005. The guidelines were developed in recognition of the importance of nutrition in reducing morbidity and mortality, thus improving the quality of life for human beings, although with a bias

towards PLWHA. They provide health practitioners and PLWHA, with correct, consistent, reliable and appropriate information on nutritional care and support to enhance communication, assist in the development of appropriate interventions and prevent commercial exploitation of PLWHA and addresses nutrition across the life cycle and in different stages of HIV and AIDS progression. The guidelines however acknowledge that many nutrition and HIV/AIDS issues are still unknown hence, the need to regularly update them as research and studies continue.

Guidelines for Antiretroviral Therapy in Zimbabwe: December 2003. The guidelines acknowledge the importance of ARVs in AIDS treatment through reducing morbidity and mortality and increasing longevity of PLWHA, in the absence of a cure for HIV and AIDS. They seek to promote a standardised approach to treatment, to minimize drug resistance and ensuring sustainability of the programmes.

1.3 CHBC and ART Practice in Zimbabwe: An Overview

CHBC Issues: The immense burden and challenges facing the health delivery system, has contributed to a deliberate shift from institutional care to Community Home Based Care (CHBC) and hospices for the terminally ill patients, including those with HIV and AIDS related illnesses. Community Home Based Care and support has been seen as an avenue through which communities and varied professional and non professional health service providers can contribute towards qualitative care and support for the chronically ill who are based at home. There have been maximum cooperation and involvement of a number of Non governmental organisations and the governmental through the Ministry of Health and Child Welfare, especially on integrating the Antiretroviral (ARV) roll out programmes into CHBC programmes. The search for an efficient and effective holistic approach to CHBC has led to the implementation of a number of initiatives to provide services to in CHBC.

Access to treatment Issues: In May 2002, the government of Zimbabwe declared the lack of access to ART, an emergency. The country also adopted the global 3 by 5 initiative (providing ART services to 3 million people globally by end of 2005). Initially the national 3 by 5 target which was calculated using the disease burden was to provide at least 171 000 patients with ARVs by year 2005. This however was revised to a new target of reaching 60 000 patients based on resource availability. However by the end of 2005, only 25 000 PLWHA were on ART, leaving as many as 319 000 in need. The government has made considerable efforts towards preparation for scaling up access to treatment. By end of 2005, over 50 sites in all provinces had been assessed for the provision of ART services, with 48 sites already providing them.

The following are some of the main issues of concern in CHBC and Access to Treatment in Zimbabwe:

- CHBC programmes are still fragmented and coordination is weak.
- Quality of care within organisations is not known because of lack of self-assessment tools and weak monitoring and evaluation systems[3].
- Gender inequality still exists with regard to care and supporting the chronically ill and their families, with women shouldering the great burden of care although recently, programmes have begun mobilizing men.
- Programmes have largely depended on volunteers who have suffered from burnout, coupled with less training and motivation[4]. Training of caregivers has not been fully been standardised, despite the presence of Training Manuals.
- Stigma and discrimination is still a barrier to the expansion of care and treatment programmes.
- CHBC and ART programmes have not been well linked.
- CHBC programmes have not paid enough attention to address the needs of the affected and infected children.
- Human resource capacity lacks among many stakeholders.
- Coordination between the public and the private sector for scaling up of Antiretroviral Therapy (ART) is still limited.
- Accesses to treatment programmes have failed to cope with the increasing demand for services.
- There have been limited operational studies to influence programming.
- Lack of adherence to one of the ***"Three Ones***" principle, with regard to the utilization of one monitoring and evaluation system for CHBC and ART programming.
- Funding for the CHBC and ART programmes has not been adequate.

Overall, the translation of CHBC and ART policies and guidelines into programmes has remained a big challenge for programmers.

1.4 Problem Statement

Zimbabwe is one of the first African countries with a conducive legal and policy framework for Community Home Based Care (CHBC) and Access to treatment programming, especially the National Standards on Community Home Based Care. This has greatly facilitated the involvement of both the government and the civil society in the provision of CHBC and access to treatment services. Despite the maximum stakeholder participation in CHBC and access to treatment programming, the responses have not been well coordinated and linked. Therefore, due to this challenge, little is known with respect to the nature and approaches of different stakeholders in CHBC and access to treatment programming and whether these responses are following the policies and guidelines

[3] HOSPAZ Membership Assistance Program Survey Report: July 2005
[4] Report on Experience Sharing Workshop on Home Based Care in Zimbabwe: 15 June 2005

governing CHBC and access to treatment in Zimbabwe. Monitoring and evaluation (M & E) of CHBC and access to treatment programming in Zimbabwe, has also been silent in many programmes. The following are key concerns in CHBC in Zimbabwe, which the study will attempt to address:

- Who are the key players in CHBC?
- What are the common approaches to CHBC?
- What are the strengths, challenges and gaps in CHBC?
- What are the linkages between CHBC and access to treatment programmes?
- What are the good practices and lessons learnt from CHBC and access to treatment programming in Zimbabwe?

1.5 Goal and Objectives of the Study

The Ministry of Health and Child Welfare and/or National AIDS Council commissioned this study/review within the context of inadequate data/information with respect to CHBC and access to treatment programming and desire to come up with a Strategic Plan for CHBC and ART in Zimbabwe.

The objectives of the study were:

i. To identify organisations implementing CHBC
ii. To map the geographical distribution of CHBC programmes
iii. To ascertain the numbers of chronically ill reached by CHBC programmes
iv. To identify the various CHBC models being used
v. To outline the objectives of the different CHBC programmes that are being implemented
vi. To determine synergy of functions and complementarities between CHBC and ARV roll-out programmes
vii. To evaluate the effectiveness of current CHBC programmes
viii. To identify the different cadres involved in CHBC
ix. To identify support systems for CHBC volunteers
x. To identify strengths and weaknesses of training materials used for training CHBC care givers
xi. To identify the reporting and monitoring systems in place regarding CHBC activities
xii. To identify gaps and constraints in provision of CHBC services
xiii. To identify the best practices and lessons learnt from CHBC programming
xiv. To make recommendations for the national strategy on CHBC

1.6 Key Thematic Areas of Review

The review focused on the following thematic areas:

- Community Home Based Care
- Access to Treatment
- Involvement of PLWHA and other chronically ill
- Reporting, Monitoring and Evaluation

2.0 RESEARCH METHODOLOGY

The national review of CHBC and access to treatment services, was conducted in all the 10 provinces and their respective districts to ensure that the findings were representative of CHBC and access to treatment programming in Zimbabwe. This chapter presents and discusses the research design and research limitations.

2.1 Research Design and Data Collection

Research Geographical Coverage and Target Population*:* The study was conducted in all the 10 provinces and all districts. This was to provide baseline information on the status of CHBC and access to treatment issues in the country. The study's target population included: Health Institutions, the chronically/terminally ill, caregivers (both primary and secondary), community/local leadership, and civil society organisations.

Sampling: Since the study covered the whole country, all provinces and all districts, purposeful, convenient sampling was employed at district level to target the respondents and key informants.

Data Collection Methods: The study utilized a wide range of participatory social research methodologies.

Stakeholder Workshops: In November 2005, a CHBC and access to treatment stakeholders' workshop was conducted in Kadoma. The workshop provided a platform for stakeholders to brainstorm and on the review's objectives and design as well as sharing expectations of the Strategic Framework for CHBC and access to treatment programming. In January 2006, before the research started, the Community Home Based Care National Taskforce met at a workshop where key issues relating to the study were shared. Among other issues, it was recommended to involve the key implementers in the field of CHBC in the research exercise. To neutralize target group bias, the team of researchers was supplemented by independent research assistants. In addition, the research team underwent training prior to the research.

Literature Review: A review of relevant materials, policy documents, evaluation and workshop reports on CHBC and access to treatment issues was conducted**.** The review provided the most needed background information to inform the development of data

collection tools or research instruments. This enhanced the researchers' appreciation of CHBC and ART policies and programming in Zimbabwe.

Questionnaires: The research administered questionnaires (677) to three categories of informants (Health Institutions, NGOs and other Civil Society Institutions and Caregivers). A total of 344 Health Institutions that included; provincial, central, district, private and mission hospitals as well as clinics were targeted with the questionnaires. Respondents to the health questionnaires included pairs or more health personnel drawn from District Nursing Officers (DNOs), Matrons, Medical Superintendents, Sisters in Charge, Nurse counselors, nurses and doctors, Community Health Sisters, Environmental Health Technicians, Testing and Counselling, CHBC, PMTC and ART Coordinators, OI Clinics, Sisters in Charge and Nurse Aides. Of the 200 caregivers reached 30.5% were primary care givers while 69.5% were secondary caregivers. The research also administered 133 questionnaires to NGOs and NAC Provincial and District Offices.

Focus Group Discussions (FGDs): FGDs were conducted to complement other data collection methods. Discussions covered similar themes as were covered in the interviews and the questionnaire method. A total of **224 FGDs** were conducted in the 10 provinces among four categories of informants who included Community Leadership, Civil Society Organisations, Caregivers and PLWHA/Chronically ill. A total of **2674** discussants/informants (66% females and 34% males), were reached through the FGDs. The research showed that more males than females were among the community leaders FGDs while females dominated FGDs for Caregivers and PLWHA. At district level, it was difficult for NGOs to make a quorum for FGDs. Instead, in most cases the NGOs were interviewed through a questionnaire, while in other cases NGO FGDs were held at provincial level where NGO officials were more accessible.

In-Depth Interviews: Most NGOs were interviewed through the Questionnaires. In addition, in-depth interviews were conducted with other strategic informants to fill up information's gaps. These included interviews with NAC officials and other strategic CHBC organisations like ZACH, Island Hospice and Chiedza home of Hope who had been reached during the fieldwork, officials from NAC and Ministry of Health Head Offices and other relevant UN Agencies.

Data Analysis: Quantitative data was analyzed using a Statistical Package for Social Sciences (SPSS® for Windows), whilst qualitative data was analyzed manually. Given the coverage of the research, the study generated a big volume of data particularly qualitative data. Data collection, entry and analysis lasted more than two weeks.

2.2 Research Team

The review was conducted by a 76-member team of professionals and researchers from relevant and diverse backgrounds under the leadership of a Lead Consultant. The Lead Consultant was responsible for overseeing the whole review; from document review and development of research tools up to data analysis and report writing. Two National Team

Leaders assisted the Lead Consultant in designing research instruments and conducted data collection monitoring visits to ensure effective and quality data collection. They also assisted the Lead Consultant in supervising data entry, collation, and analysis. Two National Project Supervisors and Ten Provincial Project Coordinators, who were representatives of the Ministry of Health and Child Welfare and National AIDS Council, coordinated all the data collection activities at both national and provincial levels respectively. The respective Provincial Team Leaders managed data collection at provincial levels. Forty-one Provincial Research Assistants were solely responsible for data collection: conducting interviews, facilitating FGDs, and note taking. Nine Research Assistants conducted quantitative data entry and cleaning as well as qualitative data collation, under the supervision of the Lead Consultant and two National Team Leaders.

2.3 Research Highlights and Limitations

The study had both positive highlights and challenges worth mentioning. After the fieldwork, the Provincial Research Coordinators and Teams Leaders shared their experiences of the fieldwork exercise.

2.3.1 Positive Aspects of the Research

Action Research: For almost all the provincial coordinators, the research was beneficial and relevant to their day-to-day work. Asked to share their experiences of the fieldwork, they had this to say. .

> *"It was a good research, an eye opener, which covered critical areas that had not been looked at before, such as issues of access to treatment, comprehensive provision of CHBC, involvement of children, youths and males"*
> **(Harare Provincial Research Coordinator).**

> *"In my capacity as Provincial coordinator for the research team and as the Provincial nursing officer, I was able to get hands on information on what is happening in my province, picked up challenges, which require immediate attention. We will have discussions with my team upon returning to the office".*
> *(***Midlands Provincial Research Coordinator)**

> *"One important thing in my Province Mashonaland West, Ministry of Health, is not involved in CHBC. Most programmes are initiated by NGOs that do not come through the PMD or DNO's offices, neither do they go through NAC structures. Their reports and statistics on CHBC, go directly to their NGO Head-Offices, mostly in Harare. Thus contributing to poor coordination of the programme at country level".*
> *(***Mashonaland West Provincial Research Coordinator).**

> *"This is a long overdue study. It revealed so many gaps in the CHBC programmes in terms of coordination, information sharing, reporting systems and*

monitoring. Stigma is very rife. The health worker has worse stigma than that of the communities". **(Mashonaland East Provincial Research Coordinator)**

Support from Key Stakeholders: All the provincial teams acknowledged the immense support from key stakeholders who included NAC Provincial Coordinators, Leadership form Health Institutions, some NGOs, and other administrative leadership (Governors, Provincial Administrators and District Administrators). The strategic stakeholders provided logistics for entry into the field, transport and fuel support.

Working with Implementing Partners: The involvement of key implementing partners mainly from the Ministry of Health, National AIDS Council, Airforce and ZNPP+ made the research a lot easier with regard to logistics, mobilizing of informants and collection of data. Most of the researchers were very familiar with the language for the research topic.

2.3.2 Research Limitations

Below are key research limitations:

Data Collection Tools: While data collection tools were reported to be comprehensive and detailed, the research teams indicated that the tools were too long. This could have been addressed if a pre-test of the tools (particularly the questionnaires) had been done to refine them.

Harsh Weather: The research was conducted in the midst of heavy, non-stopping rains in most areas. This affected some research teams. Some cars got stuck in the mud, for example the Matebeleland North Team's vehicle got stuck in mud for about twenty-four hours until CMED came to their rescue. Some roads were slippery and not passable and the teams had to drive long distances to by-pass poor roads. In some cases informants had difficulties to get to their meeting points.

Transport and Fuel: While all teams had a vehicle, the research was done at a time when fuel was generally in short supply. There were delays caused by late dispatch of fuel to some teams. Research teams also reported the challenges of long distances within provinces.

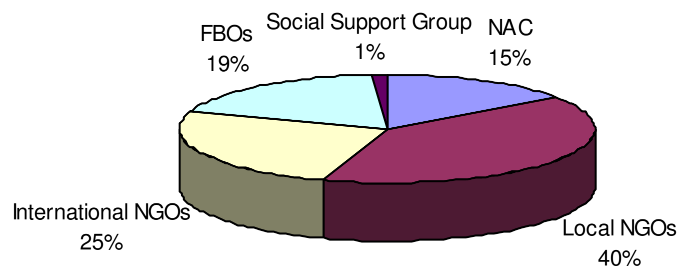
Timeframe: While the majority of the teams were able to complete data collection within ten days of fieldwork, the teams indicated they could have done with extra time. Time was spent on mobilizing informants. In the case of private sector institutions, there were challenges of getting information at short notice, as they required following long protocol procedures.

KEY FINDINGS

Demographic Data

Data presented and discussed in this report reflects the views and experiences of 200 caregivers (17.5% males and 82.5% females), 133 organisations and 344 health institutions. A total of 2274 participants were reached through 224 focus group discussions, which comprised 30% caregivers, 20% PLWHA, 18% chronically ill, 28% community leadership and 4% NGOs. About 30.5% of the interviewed caregivers were primary whilst 69.5% were secondary. Of the 133 organisations interviewed, 40% were local NGOs, 25% were International NGOs, 19% were FBOs and 1% were Social Support Groups.

Figure 3.1 Percentage Distribution of Organisations Interviewed



Health Institutions: The 344 health institutions were consulted during the review. They included:

- Government clinics
- Municipality clinics
- Government hospitals
- Mission hospitals and
- Private health centers

3.0 COMMUNITY HOME BASED CARE (CHBC)

As a complementary approach to the high-cost institutional care, CHBC promotes continuum of care and support for the chronically ill, who include PLWHA. Overall, most respondents interviewed had good appreciation of the concept of CHBC.

> *"Looking after the terminally ill at home after being referred by the hospital and getting home visits by care facilitators"*
> **PLWHA, Hurungwe District, Mashonaland West Province**

> *"It involves nursing of the terminally at home through feeding, bathing, dressing and cooking among others. In this case, the community is involved in caring for the sick"*
> **Community Leader, Magwegwe District, Bulawayo Province**

> *"Caring for patients in their homes after discharge from hospital"*
> **Secondary Caregiver, Chiredzi District, Masvingo Province**

While the chronically ill includes PLWHA, it also includes those with chronic conditions such as hypertension, cancer, asthma, diabetes and epilepsy, in this study, two categories will be used: chronically ill and PLWHA. The term chronically ill will refer to people living with any of the above-mentioned chronic conditions except HIV and AIDS.

Although CHBC originally came about with a primary focus on chronically ill patients, this realisation has since been overshadowed by the emergence of HIV and AIDS, and the consequent increase in the number of PLWHA. The general perception from the review was that CHBC programming was largely meant for PLWHA compared to the focus on other chronically ill.

This section highlights the common services, key service providers, geographical coverage, training and capacity, supply of CHBC kits, caregiver motivation and involvement of men, children and youths in CHBC programming. It also provides highlights of selected good practices, key challenges, suggestions and recommendations for effective future CHBC programming.

3.1 Common Services in CHBC

CHBC service provision varies with each organisation and health institution. Health Institutions and NGOs are the major CHBC service providers. The study established that all organisations and majority (64.5%) of health institutions interviewed are providing the CHBC services with the latter also providing other CHBC related services like Access to treatment and Testing and counselling. From the study common CHBC services provided include the following;

Nutritional Support: Nutritional support is a critical component for effective CHBC. DAAC has wide coverage in food distribution as it was found in all provinces. Other distributors of food include NGOs such as World Vision, Red Cross Society, CARE International, Island Hospice and Mashambanzou FACT Rusape, FACT Chiredzi, Roman Catholic Church, Tsungirirayi in Chegutu and Chiedza Home of Hope in Highfields district.

Training of caregivers: DAAC coordinates the training of caregivers and the Ministry of Health and Child Welfare (MOHCW) conducts the training. There are other organisations that are also training caregivers and these include Island Hospice and Red Cross Society who have wide coverage of training as they train country wide. Other organisations are involved in training at a lower scale such as Eden in Gokwe South, Batsiranai in Mberengwa.

Caregiver Service Provision: Caregivers provide patients with basic nursing care, health and hygiene education, psychosocial support (PSS) and spiritual support, referrals to health centres, assistance with household duties, monitoring drug compliance and escorting them to clinics.

Access to treatment: Provision of access to treatment services is also an integral component of CHBC. Access to treatment services are mainly provided in the form of ARVs, Prevention of Mother to Child Transmission, treatment of opportunistic infections (O.I) and sexually transmitted infections (STIs). Major government hospitals, which include Parirenyatwa Hospital, Wilkins Hospital and Harare Central hospital, some Mission hospitals and some NGOs such as The Centre, are providing ARVs. The clinics generally provide drugs for prevention and treatment of opportunistic infections such as cotrimoxazole prophylaxis, Direct Observation Treatment (DOTS) for Tuberculosis and drugs for pain relief such as paracetamol. The increasing demand and cost for ARVs are the major challenges for improving ART. Testing and counselling services were also identified as important in most NGOs and health institutions providing ART.

Other common CHBC services include:

- Distribution and replenishment of CHBC kits.
- Financial support through funding of income generating projects and funeral assistance.
- Integration of OVC support through education assistance.
- Material support (in the form of wheel chairs, bicycles, foot wear, uniforms, blankets, building material) and spiritual support mostly common among organisations and churches.
- Improving water and sanitation
- Health and hygiene education
- HIV and AIDS awareness.

3.2 Nutritional Support

Nutrition is of paramount importance in CHBC programming. For PLWHA, good nutrition helps improve their health and quality of life through their ability to continue generating income for food, health care and other responsibilities. Food security ensures adequate supply of nutrition and comes in different forms which include provision of agricultural inputs and the production process, training in and establishment of nutritional gardens and distribution of supplementary feeding. From the study, supplementary feeding in the form of food packs was the most common form of food security mentioned by respondents. The following were noted in the distribution of these food packs.

3.2.1 Adequacy of food packs

- The review indicated that almost all districts have at least one organisation distributing food, with the exception of Hwedza and Chikomba districts in Mashonaland East Province. Some districts such as Binga and Chipinge are well covered by two or more organisations.
- Shortages in quantities and contents of food packs and the irregularity in distribution are reported almost in all provinces. This was mentioned as having adverse effects on uptake of drugs for people on treatment.

3.2.2 Variations in Food Packs

- The review established that the contents of food supplements vary with each service provider.
- The common contents for the food packs included mealie meal, beans, cooking oil, corn soya blend, matemba, peanut butter, barley, sugar and salt and these are packed in different quantities.
- Nutritional value is well balanced

3.2.3 Challenges

Below are key challenges to effective nutritional support:

- Occurrence of natural disasters such as droughts which reduce food reserves in the country
- Inadequate knowledge on nutrition, especially use of locally available food
- Lack of nutritional gardens to subsidize food assistance from organisations
- Ad hoc distribution of food packs
- Non-standard food packs
- Limited income generating programmes to complement nutritional support programmes.
- Some areas have poor transport and communication facilities, to foster efficient and effective nutritional support.

3.2.4 Recommendations

The following are the key recommendations for improved nutritional support:

- Incorporate nutritional support in CHBC programming
- Standardise food packs and regularise distribution, with a special focus on OVC, chronically ill and PLWHA
- Establish and revive nutritional gardens and irrigation systems, especially in drought prone areas
- Enhance the capacity of orphans, PLWHA and chronically ill's families to establish and run IGPs through training and financial support
- Provision of seeds and fertiliser as a long term measure
- Develop and maintain infrastructure enabling NGOs and other beneficiaries to distribute food packs in inaccessible areas
- Improve coordination for even distribution of nutritional services

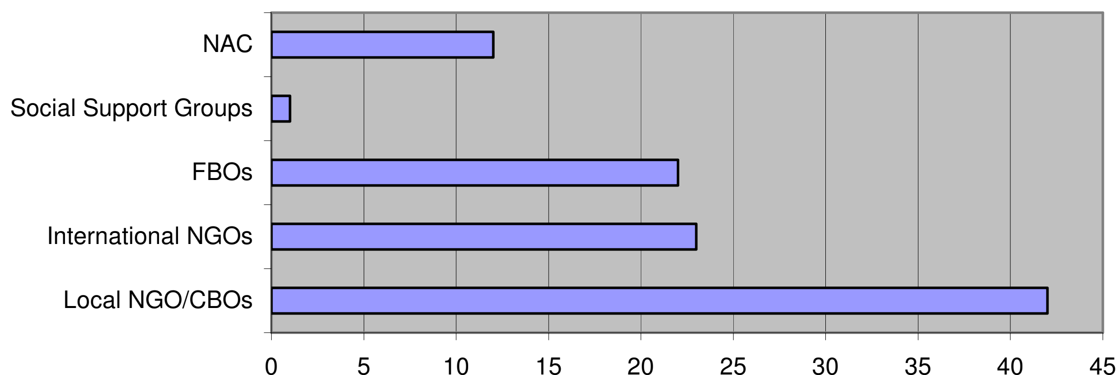
3.3 Training, Capacity, Motivation Issues in CHBC

Training of service providers is critical in enhancing quality and cost effective service delivery. Provision of Training of Trainers (TOT) also ensures the attainment of a critical mass of service providers in a cost effective and sustainable manner. In Zimbabwe, training of caregivers is expected to be conducted within the curriculum guidelines for the training of CHBC volunteers, which were reprinted in 2001 and under review at the time of the review. Motivation of carers is an equally important component for CHBC as it fosters quality and sustainability. This section assesses the quality of caregiver trainings and motivation issues.

3.3.1 Training and Capacity:

The majority (82%) of the organisations interviewed are providing CHBC training. Both the government through the Ministry of Health and Child Welfare and the civil society are the key stakeholders in CHBC training provision. Adherence to the standards on the training of caregivers/volunteers was highly recorded among government health institutions and NAC. Organisations that provide CHBC training differ in terms of geographical coverage, with Island Hospice and Red Cross Society having wider coverage. Other organisations providing training though limited geographically include Matebeleland AIDS Council, Deseret International and Alliance in Bulawayo, FACT Chiredzi and Lutheran Development Service in Masvingo, Sikhetimpilo, Umzingwane AIDS Network and Insiza Godlhwayo AIDS Action Committee in Matebeleland South, Lubancho House, CADEC and Save the Children in Matebeleland North, Batsiranayi and Tsungirirayi in Mashonaland West, Hope Humana in Mashonaland Central, DOMCCP and FACT Rusape in Manicaland, Batsiranai, Midlands AIDS Support Organisation, Hope in AIDS Network in Mashonaland East. Figure 3.2 shows the proportion of caregiver who had received training form the various organisations.

Figure 3.2: Civil Society Organisations Providing CHBC Training



The research also indicated that as much as 54% of health institutions are providing CHBC training. These health institutions comprised of clinics, government and mission hospitals, private clinics/hospitals and central hospitals. A comparative assessment of the results shows that the proportion of civil society organisations providing training is

higher than that of health institutions. Interviews with organisations also revealed that some of their training was conducted in partnership with the MOHCW and NAC, to maximize on quality.

Adequacy of CHBC Training: The majority of caregivers (79%), have received CHBC training across all the districts. These results show that Zimbabwe has a significant proportion of caregivers who have accessed some form of training. Such training has reached more of the secondary (97%) than primary caregivers. While the proportion of those who have ever received CBHC training is relatively, there are still gaps in the quality of training.

Gaps in CHBC Training:

- *Variations in duration of caregiver training*. From the research it was noted that duration of caregiver training varies from 2 days to six months.

- *Variations in course content for HICB*: Despite the existence f national guidelines on CHBC, the research showed that differ organisation used different course content for caregivers.

- *Lack of adherence to MOHCW National Guidelines*. Although health institutions perceived their training as adequate because they were using national guidelines and had also included issues of access to treatment and nutrition in their programmes, caregivers and other stakeholders are of the opinion that there are some gaps which exist in the training they receive. They were of the opinion that they needed further training in counseling, basic nursing care, infection control, first aid, herbal therapy, and report writing skills.

- *Lack of or long periods between refresher courses*. Refresher courses provide stakeholders with an opportunity for experience sharing and updating each other with current debates and information. However, this has not been fully prioritized by many organisations and health institutions. Despite the fact that 51% of caregivers had once received refresher courses, the majority of them (83%) had received them within a period of 1 and 2 years and as much as 14%, within a period of 3 to 4 years.

> *"We were trained in 2001 and received our first refresher course after 4 years"*
> **Secondary Caregiver: Harare West District, Harare Province**

> *"I was trained in the early 1990s and up to now I have not received any other training or refresher course, I can't even remember all the issues that were covered in the training, it's going with age. We need refresher courses, especially on ARVs and herbs"*
> **Secondary Caregiver, Shamva District, Mashonaland Central province**

Interviews with caregivers from communities of Chivi, Shurugwi, Bikita, Luveve, Chikomba, Uzumba Maramba Pfungwe, Goromonzi, Mwenezi and Chimanimani highlighted that they had never received any refresher courses.

*3.3.2 **Motivation** Issues*

Traditionally, care giving was largely dominated by women and therefore regarded as unpaid domestic or voluntary work. Recently, caregiver motivation has become a critical issue in CHBC programming, in the face of increasing number in clients and high cost of living. Motivation can be material (monetary or non monetary) or non-material. The debate on caregiver has begun receiving much attention despite the absence of national guidelines and standards on this component. Therefore, caregiver motivation varies from programme to programme.

Forms of incentives: The following are the common forms of benefits /incentives being given to volunteers:

- Food packs/handouts
- Soap, uniforms
- Bicycles
- Petroleum jelly
- Monetary allowances ranging from z$15000 to z$500 000 per month (red cross society being the highest paying)

From the study, only 29% of caregivers (62% NGOs, 22% NAC, 2% Church, 7% MOHCW and 7% not representing any organisation) were receiving direct benefits/incentives. Interviewed caregivers from Midlands and Mashonaland West provinces reported that they were not receiving any incentives at all.

Challenges

From the study the following challenges on incentives emerged:

- Lack of or poor incentives have led to serious caregiver dropout rates in some programmes, as caregivers join programmes with better incentives

  "There are no incentives. Most caregivers have turned back. We used to be 66 but only 16 of us are left"
  Secondary Caregiver, Gokwe North District, Midlands Province

  "We wish if these NGOs would prioritize giving us allowances and food packs every month so that our husbands appreciate the need for us to continue with the programme" **Secondary Caregiver, Gokwe South District, Midlands Province**

- Non standardization of caregiver incentives has also led to competition for caregivers among programmes.
- Secondary caregivers are alleged to be taking food packs for their own consumption to compensate their "voluntary" services.

Recommendations

- The concept of principle of volunteerism in the Zimbabwe context needs to be debated and clarified among key stakeholders.
- There is also a need for the CHBC to address gender gaps where women constitute the bulk of care givers. It is however noted that there are emerging programmes on male involvement in CHBC.
- It is recommended that CHBC incentives be standardised to include the following suggested menu.

Box 1: Suggested Menu of CHBC Incentives

- Uniforms for identification in the community
- Bicycles for transport
- Food packs
- Monthly allowances that vary from Z$500 000 to Z$5 000 000 a month
- Other material incentives may also include:
  soap, free medical treatment, financial support for income generating projects, raincoats, umbrellas, agricultural inputs, part time employment in hospitals, funeral assistance, stationery and transport allowances
- Non-material incentives could complement materials incentives. These include:
  - community recognition,
  - respect appreciation and encouragement
  - training to become nurses,
  - certificates on completion of training and
  - social support

3.4 CHBC Kits

The provision and replenishment of CHBC kits is critical in determining the quality of service delivery by caregivers. CHBC kits provision through different organisations has happened in the absence of national standards or guidelines on the standard contents of the kit. This section assesses and discusses CHBC kits provision, replenishment and management issues.

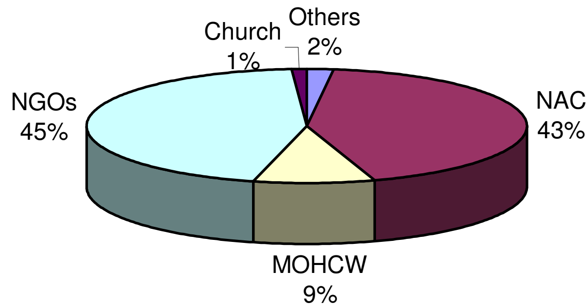
CHBC Kits Provision: To some caregivers, the absence of CHBC kits in their programming was likened to *"going for war with empty guns"*. :

> *" kushaya kit kwakafanana ngekuenda kuhondo usine nyere, ngekuti gidi rakona harindoseenziba, ……. Makit aya anotipawo simba rekushanyira warwere wedu.."*

(caring without a kit is just like going for war with a n empty gun, it will be of no use……..these kits also provide strength and motivation to work…)
(Secondary Caregiver: Chipinge; Manicaland)

Figure 3.3 shows percent distribution of organisation providing CBHC kits.

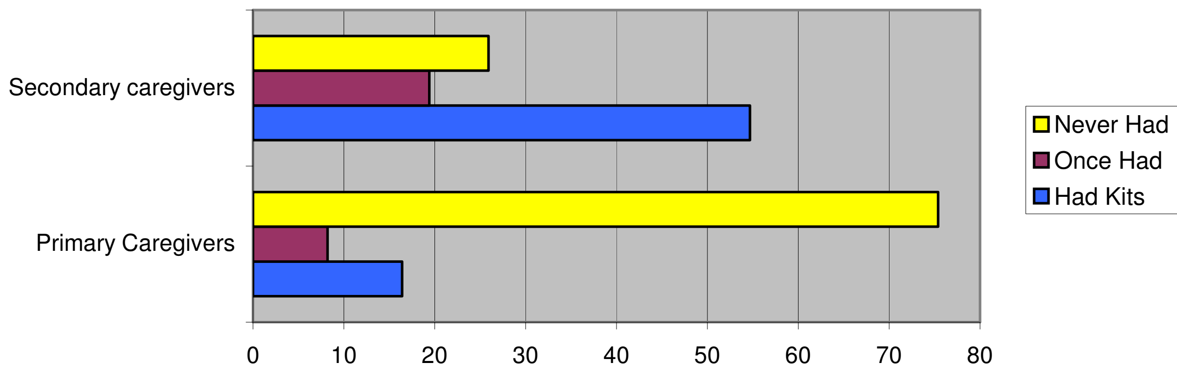
Figure 3.3: Percentage Distribution of Sources of Caregivers' CHBC Kits



The study revealed that only 43% of the caregivers have CHBC kits, 16% confirmed that they had once received but were never replenished, whilst 41% had never received CHBC Kits.

"We don't have any kits we use our own bare hands since NAC did not provide any" **Secondary Caregiver, Harare North, Harare Province**

Figure 3.4: Percentage Distribution of Caregivers by CHBC Kit Status



At the time of the study, interviewed caregivers from the following districts reported not having ever received CHBC kits:

- Harare North
- Harare West
- Bikita,
- Mwenezi
- Chiredzi
- Hwange,
- Umguza
- Binga

CHBC Kit Contents: The absence of guidelines and standards on CHBC Kits results in variations in terms of contents from provider to provider. The review indicated that various organisation offered different kit contents from the recommended kits. An example of variations is drawn from three organisation form which data could be collected.

Table 1: Variations in CBHC Kits

Kit content	Standard MOHCW Kit	NAC	UNICEF	Red cross
Cotton wool	X	X	X	X
Plastic apron	X			
Latex gloves	X	X	X	X
Heavy duty gloves	X		X	
Face cloth	X			
Linen savers	X			
Adult Napkins	X			
Mackintosh	X			
Gauze			X	
Draw sheet	X		X	
Tablet dispenser	X			
Dispensing envelopes	X			
Paracetamol tablets	X			X
Bucket	X			
Washing soap	X	X		
Bath soap	X	X		
Disinfectant	X			
Betadine solution	X	X		X
Crepe bandage	X			X
Note book and pen			X	X
Petroleum jelly	X	X		
Gentian violet			X	
Povidone Iodine Solution			X	

The majority of organisation interviewed acknowledged that the CHBC kits were not adequate. The commonly perceived missing CHBC items were:

- Methylated spirit
- Eye ointment
- Facemasks
- Oral gel
- Increased quantity of jik, gloves, bandages and betadine.

CHBC Kits Management and Replenishment:

Management

Management of kits varied from programme to programme. The study showed that the following people managed the kits:

- Community nursing sisters at the clinics/hospitals,
- Caregiver team leaders
- Individual caregivers at their homes.

The study indicated that were organisations had scarce resources HBC kits are kept by care giver team-leaders, while in organisations were resources were relatively more, individual care givers kept them in their own homes. Very few primary care givers kept HBC kits. Nearly all care givers preferred to have their own HBC kits.

Replenishment

Health institutions reported that replenishment of kits is done at local clinics and hospitals as well as by suppliers such as Natpharm. The majority (52%) of health institutions noted that they replenished their kits quite often, as per need, whilst 7% of the health institutions acknowledged that they were not replenishing their kits at all. . Interviews with caregivers and organisations revealed that replenishment of kits varied from one month to over a year. Overall, 95% of caregivers noted that replenishment of their kits was done within six months, whilst 50% of church caregivers highlighted that they would go over a year without replenishment

3.5 Discharge Plans

The 1998 Discharge Planning Guidelines for the Chronically ill/Terminally ill patients explains clearly the stages to be followed when discharging patients from health institutions. Box 2 summarises the stages

Box 2: Stages for Discharge Planning

Stage 1: Health Assessment

- History taking, physical examination, data analysis, medical diagnosis, home assessment
- Assessment of: availability of community resources and care givers needs
- Documentation of information and communication of findings to relevant multi-disciplinary team leaders

Stage 2: Planning

- Setting of short and long term objectives
- Use of multi-disciplinary approach to plan for interventions
- Consideration of available human, financial and material resources and
- Drawing up the schedule for implementing interventions such as counseling and physical home adjustments

Stage 3: Implementation

- Provision of services required by the patient
- Information giving and counseling about services offered on CHBC
- Training of the patient, family members or care giver
- Assessment of the patient on an ongoing basis and adjustment of care plan
- Mobilization of resources and record keeping of care plan
- Liaison and coordination of patient care with other team members

Stage 4: Evaluation

- Monitoring and evaluation of the care plan
- Use of check list to assess progress of implementation
- Reviewing of records and replanning where necessary

Stage 5: Discharge and Handover of The Patient

- Carry out final assessment and filling in of discharge and referral forms
- Advise patient and relatives on the need to seek hospital assistance when needed
- Discharge Plan Coordinator coordinates and liaises with receiving institution and discharges and hands over the patient

Source: MOHCW 1998: Discharge Plan for the Chronically ill/Terminally ill patients

The majority of health institutions admitting patients (64%) revealed that they are following discharge guidelines. The proportion of health institutions adhering to the discharge guidelines was higher among central and provincial hospitals. Overall, adherence to discharge plans is high among provincial, district, mission, rural hospitals, central hospitals and private clinics and/or hospitals in their order. While health institutions indicate adherence to discharge planning guidelines most care givers reported the opposite.

3.6 Geographical Coverage

The study revealed that DAAC was found in all the districts for the purposes of coordination. Health Institutions and civil society organisations are the major CHBC service providers. Every district was covered by at least one organisation. Refer to Annex 1 for the geographical coverage of organisations implementing CHBC.

3.7 Involvement of Key Stakeholders in CHBC

Recently, the issue of male involvement has begun receiving wide attention due to the realization of the adverse impacts of the HIV and AIDS pandemic on women. In worst circumstances, the girl child is forced to drop out of school to care for the sick parent(s). Children and youths have therefore been viewed as vital players in CHBC, both as clients and service providers. This section assesses the levels and forms of involvement of men, children and youths in CHBC programming.

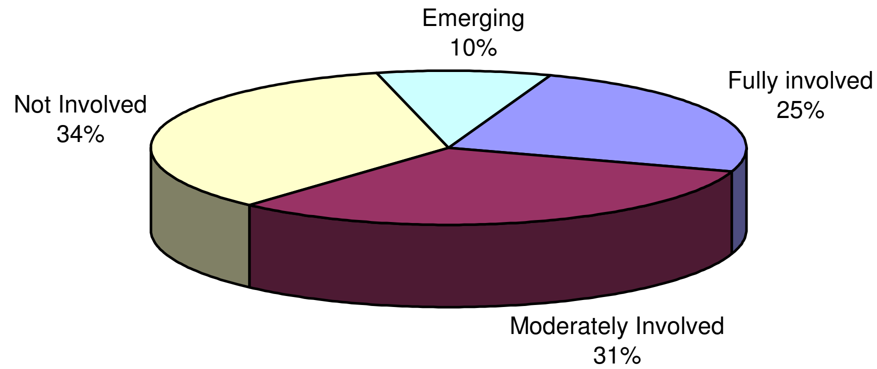
3.7.1 Male involvement

Caring for the sick has traditionally been the responsibility of women. Generally in the Zimbabwean societies, men are expected to be breadwinners and therefore should highly prioritize income-paying jobs instead of voluntary work. The role of caring for the sick has been viewed as the responsibility of women and the girl child.

> *"Vanhurume havawanzoda kushandira zvinhu zvisina mari"*
>
> (*Men do not want to be involved in non- paying jobs)*
> **PLWHA, Harare South District, Harare Province**
>
> *"Males do not care as they spend most of their time drinking. They believe caring is a woman's job and furthermore they do not want to work for free. Men are real devils"* **(Secondary Caregiver, Chipinge District, Manicaland Province**

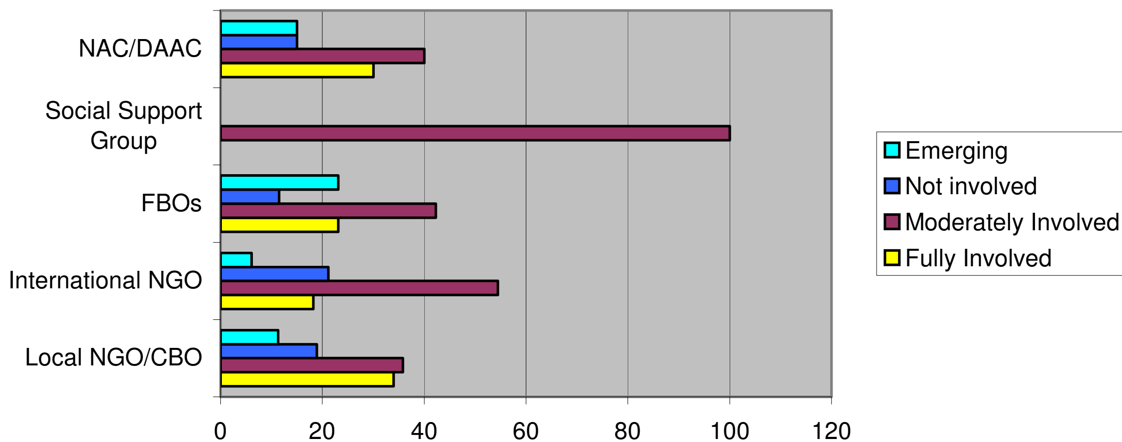
Levels of Involvement: Male involvement in CHBC programmes varies from programme to programme and by location: rural or urban. Only 25% of the caregivers reported men as being fully involved in their programmes and 31% reported male involvement as moderate. On the other hand, 34% of the caregivers reported no male involvement in their programmes.

Figure 3.5: Percentage Distribution of Caregivers' Perception of Male Involvement



Of the organisations interviewed, 27% reported full male involvement in their programmes. As much as 43% of the organisations reported moderate male involvement men whilst 17% reported no male involvement in their programmes. There is a growing trend of involving men in HBC programmes These results show that male involvement in CHBC programming is still very low. .AFRICARE is one of the leading NGOs which has a greater to proportion of male involvement in their programmes. PADARE is also a good example of a CHBC programme involving men. Through the study it was also noted that men in CHBC to tend to care for their male counterparts who are bedridden.

Figure 3.6: Organisations' Perception of Male Involvement



Male involvement was higher in health institutions' programmes that served rural communities than those, which served urban communities. A comparative assessment of quantitative data shows that male involvement is higher in programmes of organisations than of health institutions and in rural areas than in urban areas. The differentials in levels of male involvement between the two settings might be attributed to the differentials in social and economic systems or structures between rural and urban areas.

Forms of Involvement: Male involvement was noted to be at both family and community level. At household level males provided physical nursing care in cases of ill male relatives or family member and were involved at community level through provision of transport for CHBC clients to clinics and hospitals, provision of draught power in the fields and through assistance with chores such as fetching firewood and water. Male involvement was high in organisations, which had deliberate programmes on enhancing their participation. These included and AFRICARE CHBC programs.

Box 3: AFRICARE-MANICALAND

AFRICARE is one of the leading NGOs which is implementing a successful male involvement intervention. In its community groups of care givers, it has a fifty-fifty gender composition. Both male and female care givers take care of patients in need of care but men tend to focus more on male patients requiring special attention. All care givers receive the same incentives and are provided with head to toe gear for identification and bicycles for communication.

Concerns in Male Involvement: While male involvement is seen as a positive intervention to reduce the burden of care giving by women, it still remains a contenscious area with regards to the following concerns:

- Men tend to assume leadership positions at the expense of women
- Men view themselves as breadwinners and thus justify getting better incentives compared to those given to women
- Men are more demanding on incentives

3.7.2 Child Involvement

Involvement of children in CHBC is largely through primary care giving. Most children have to look after their parents, sibling or other relatives due to the absence of older relatives to do it. The greatest challenge faced by these children is the lack of adequate training and CHBC kits thereby exposing them to cross infections as well as compromising their ability to perform their duties well. Their involvement could be enhanced through:

- Peer counseling,
- CHBC training that takes into account the rights of children
- Integrating them in refresher courses.

3.7.3 Youth Involvement

Youth involvement in CHBC was generally reported as minimal. Their involvement is mainly through primary care giving at family level, in cases of sick parents, siblings or other relatives. At community level, youth were involved through assistance with household chores that include gardening, fetching of firewood and water and transporting patients to hospitals and clinics. Involvement reported was also through peer education and awareness and information dissemination campaigns for example, the "Young People We Care Programme" of Union for the Development of Apostolic People in Zimbabwe (UDACIZA) in Ruwa-Epworth district in Harare province. Youth involvement was reported as vibrant in faith-based responses, for example; at Howard hospital in Mashonaland Central province, where they have an IGP, from which 90% of profits are donated to orphans.

Challenges faced with youth involvement in CHBC

- Youth mobility in search of employment
- Youth being still in school therefore decreasing their involvement in CHBC.
- Youth being by passed for training in CHBC

Their involvement could be enhanced through training them as well as integrating income generating activities in their CHBC programmes.

3.7.4 Community Involvement

The issue of programme acceptability and sustainability also rests on community support and involvement. Communities are involved in CHBC largely through collective activities for the chronically ill or PLWHA and orphan families. This includes ploughing fields, weeding, fencing gardens, maintenance of roads, provision of transport to ferry patients to and from clinics and hospitals, collective farming (Zunde raMambo), and fetching firewood, nutritional, spiritual and material support and caregiver selection and motivation.

> *"They strengthen us through their words of encouragement as well as giving us food when we are visiting clients"*
> **Secondary Caregiver, Mt Darwin District, Mashonaland Central Province**

Box 4: Chinyunyabili Project: Matebeleland South Province

In Bulilima District in Matebeleland South province, there is a project called Chinyunyabili, where the community collectively donates cement to build fowl runs, brew beer to sell and raise funds to pay school fees and buy books for the orphans. Community members donate one chicken per family towards the project. They also have a granary where they keep maize to support the orphans. They donate Z$5000-00 each per month to fundraise towards the project of orphan care.

Qualitative data showed that community involvement is higher in rural than the urban settings. This disparity is largely due to the set-up of rural areas in which people share similar and norms and values and the way they are structured in terms of leadership. However, all the church caregivers noted that their programmes were not receiving any community support for their programming.

3.7.5 Involvement of PLWHA and the Chronically ill

- About 70% of care givers from the review indicated that PLWHA were involved in provision of CHBC services in their communities
- Most PLWHA were involved as secondary care givers
- PLWHA involvement contributes towards the reduction of stigma and discrimination for the infected and affected
- PLWHA shared experiences in treatment adherence, infection and re-infection control, alternative therapy, side effects of particular medication and
- Involvement of PLWHA in lobbying and advocacy provides them with self esteem, confidence and hope in promoting their rights. Their involvement in lobbying and advocacy was recorded in all provinces and attributed to ZNNP+ s decentralized structures.
- Not all communities were comfortable in PLWHA in CHBC

"There is no way a prostitute (now PLWHA) can teach us about morals when he/she has none. They refused to listen to us elders when they were healthy and now want to us to choose them to be caregivers"
Community leader, Mwenezi District, Masvingo Province

"*As PLWHA, we have always tried to participate in community issues but the response has not been positive. The level of resentment we receive from our community makes us feel like outcasts to an extent that we have resort to passive participation.*" **PLWHA, Mangwe District, Matebeleland South**

- The review showed showed that CHBC programmes targeted PLWHA more than the chronically ill. This was attributed to the increase and overwhelming proportion requiring CHBC services

3.8 Key Challenges

Despite the remarkable contribution of CHBC in contributing to the continuum of care and support of the chronically ill and PLWHA, there still exist a number of challenges that compromises quality, efficiency and effectiveness. These challenges include;

- **Limited funding:** for both programming and administration: this compromises quality of service delivery, for example in training of service providers, quality of CHBC kits, retention and motivation of caregivers.
- **Caregiver motivation and burnout:** there is no standard menu for care giver motivation which provides room for some organisations to provide more incentives than others, making it difficult for less resourced organisations to operate effectively. As the number of patients requiring attention increases care givers reported burnout.
- **Low male involvement:** male involvement in CHBC programming is still low in Zimbabwe, especially in the urban areas although it is now emerging in isolated programmes.
- **Inadequate CHBC training for caregivers:** Caregiver training is still not yet fully standardised, especially in terms of selection of caregivers, content and duration of trainings. This was largely attributed to resource constraints.
- **Un-standardised CHBC kits:** No standardisation of the contents of CHBC kits and regular replenishment of kits remains a challenge in most organisations.
- **Food security:** the recurrent droughts and food shortages were a major challenge for chronically ill clients, people on treatment and orphans.
- **Poor communication infrastructure:** Poor communication in the rural areas has affected effective linkages between health institutions and other CHBC programmes. Many clients are reported to be using scotch carts and wheel barrows which in most cases is uncomfortable. There is need for CHBC programmes to have their own vehicles.
- **Effective Monitoring and Evaluation:** There is poor coordination between NAC as a coordinating body and CHBC service providers. On the other hand service

providers have weak M&E systems. On a positive note establishment of a taskforce on CHBC is a welcome development.

3.9 Recommendations for Effective CHBC

Below is an outline of suggestions and recommendations that could improve CHBC programming:

- **CHBC Kits:** Standardised CHBC kits should be developed in consultation with all stakeholders and they should be regular and timely replenishment of medical supplies
- **Increasing Male Involvement:** CHBC programmes/stakeholders need to devise strategies for improving male involvement and motivation in CHBC
- Issues of caregiver selection, recruitment, definition and motivation need to be standardised
- **Training:** Ensure that CHBC training is standardised. This could also be strengthened by reviewing the existing guidelines on the training of caregivers, to incorporate issues of Access to Treatment, nutrition and orphan care.
- **Standards and Guidelines:** There is need for simplifying of CHBC standards and guidelines, to make it easy to develop training packages for care givers.
- **IEC and Training materials:** Development of appropriate IEC and training materials and dissemination to all stakeholders, for the purposes of refresher courses. These materials if possible might be translated into local languages.
- **Refresher courses:** CHBC implementers should prioritise provision of refresher courses to service providers.
- **Community involvement:** Increase community participation, especially in urban areas and health institutions' programmes
- Lobby and advocate for youth and male involvement
- **Linkages between CHBC and Access to treatment:** Improve linkages between CHBC and access to treatment.
- **Integration of OVCs:** Integrate issues of orphan care and nutritional support in CHBC programming
- **Mainstreaming gender issues:** There is need to mainstream gender issues in CHBC programmes, training guidelines and policies.
- **Youth and young children:** There is need to target youth and young children for CHBC training and to develop appropriate training material for them.
- **Community sensitization on CHBC:** There is a great need for conscientisation of communities on embracing the infected and the affected. More awareness campaigns should be conducted to reduce stigma and discrimination.
- **Inclusion and involvement of PLWHA and the chronically ill in decision-making:** The chronically ill and PLWHA need to identify capable cadres among themselves to be incorporated and represent them at strategic levels in some coordinating committees and organisations.

- **Addressing chronically ill issues in CHBC Training Manuals**: The curriculum guidelines for caregivers should be revised and incorporate other chronically ill conditions apart from AIDS.
- **Awareness on issues of Access to AIDS Treatment:** PLWHA and the chronically ill are involved in access to AIDS treatment mainly as recipients of the treatment. More work is needed especially with the PLWHA, as some are still not aware of some of treatment options that are emerging on ART and herbal therapy.
- **Maximum and meaningful involvement of the chronically ill:** Strategies should be devised to ensure that the chronically ill meaningfully participate in issues affecting their lives. This could be achieved through training them in CHBC and establishment of support groups and networks.
- **Reducing stigma and discrimination:** Strategies should be developed that may help in reducing stigma and discrimination against PLWHA.

4.0 ACCESS TO AIDS TREATMENT

National Targets and Progress on AIDS Treatment: HIV and AIDS is at its mature stage in Zimbabwe. The implication among others is an increasing number of PLWHA with AIDS and therefore requiring care and treatment. In the context of the 3x5 global initiative for access to treatment, the Zimbabwe Government plans to reach 60 000 patients with ART by 2005. This is a figure based on resource availability which would ensure that those put on ART would continue receiving treatment. This target however implies that as many as over 320 000 are in need of ART. This figure could also be an underestimation of people requiring ART given that they are a lot of people in rural areas who have not had the opportune to register through the required structures: OI clinics, government district and provincial health centers. The new thrust in ART is ensuring universal access to treatment for all who require it. In this section of the report, attention to is given to issues of treatment.

Access to AIDS Treatment is a critical component in reducing morbidity, thereby increasing longevity, productivity and quality of life for PLWHA and mortality. It thus becomes a complementary intervention to CHBC. While reviewing CHBC, the study also made efforts to assess issues related to access to treatment and its linkage to CHBC.

4.1 HIV Testing and Counselling (T &C) Services

The national HIV/AIDS Policy's (1999) guiding Principle 17 states that HIV testing and counselling services should be made available and accessible to all members of the public. The policy recognizes that HIV Testing and Counselling is the entry point for access to AIDS treatment. Apart from facilitating behavior change, those people who test positive can have early access to a wide range of services, which include PMTCT, OI, STI treatment and TB prophylaxis.

Box 5: Routine Testing and Counselling

In Zimbabwe, access to one's HIV status has mainly been through the client-initiated approach (VCT), whereby clients proactively seek the service. However, with the new opportunities for prevention and care, especially the availability of anti-retroviral drugs (ARVs), for PMTCT and AIDS treatment, there is need to complement VCT services by routinely offering HIV testing to all patients seeking health care, using the provider- initiated approach.

Source: MOHCW 2005: Zimbabwe National Guidelines On HIV Testing and Counselling

T&C Service Providers: Document review revealed that by end of 2005, there were 27 stand-alone T&C sites (largely urbanized) and 389 integrated sites in health institutions, scattered largely in the rural areas of the country[5]. Mobile T&C services were also being

[5] Zinyemba, R, Progress Report of the National Consultation on Universal Access to HIV and AIDS Prevention, Treatment, Care and Support, 7 February 2006.

provided by some organisations to areas not routinely served, through coordination with resident organisations or health institutions. The major T&C service providers were NGOs, private companies and health institutions. The study established that only 23% of the interviewed NGOs, comprising local NGOs (40%), International NGOs (33%) and FBOs 27% were providing T&C services. Quantitative data also revealed that 90% of the organisations highlighted a high demand for T&C services, although uptake was low. Interviews with health institutions revealed that 61% of them were providing T&C services.

4.2 Services for Access to AIDS Treatment

This section highlights the national targets and progress on Access to AIDS Treatment, discusses issues of familiarity on issues of AIDS Treatment among caregivers, forms of AIDS treatment and service providers.

Familiarity with Issues of AIDS Treatment: Awareness and familiarity with issues of AIDS treatment is imperative to facilitate effective drug adherence on people on ART and drug monitoring and counseling among carers. Interviews with caregivers revealed that 77% of caregivers perceived themselves as familiar with issues of AIDS treatment. Greater awareness was reported in urban (87%) than in rural areas (68%) The common issues caregivers were familiar with were testing and counselling, nutrition, OI and STI treatment. Qualitative data showed that caregivers, especially those in the rural areas were not very familiar with issues of ARVs and PMTCT.

> *"We are not well informed on issues of ARVs: their administration and their side effects. This limit our confidence in counseling, we would appreciate if we could be provided with refresher courses on this subject"*
> **Secondary Caregiver, Mwenezi District, Masvingo province**

> **"***We are a poor family and do not have enough financial resources for our father to go on ARVs, yet we do not have enough knowledge about these herbs which we hear through radios and newspapers of their effectiveness"*
> **Primary Caregiver, Mutoko District, Mashonaland Central province**

4.3 Forms of AIDS Treatment

Anti Retroviral Therapy (ART)

Management of HIV and AIDS is mainly through ARVs which are not a cure but will reduce OIs, boost immunity and improve morbidity and productivity of patients. ART included access to anti-retrovirals, PMTCT programmes and treatment of OIs. The nature of ART related services vary with each organisation and health institution.

- ART services provided by NGOs and health institutions included: ARVs, testing and counseling services, assessment of CD4 and viral load counting, PMTCT programmes, treatment and referrals of OIs and STIs.

- Only 29% of the interviewed health institutions were providing ART
- The review also indicated that a number of NGOs were also providing all ART services.

Herbal Therapy

Use of herbs has also become a more accessible and affordable alternative for AIDS treatment particularly in rural communities.

- Knowledge and familiarity on use of herbs varied from district to district
- A significant proportion of NGOs had started training initiatives in communities on herbs with regard to development of nurseries for herbal gardens, processing and marketing herbs and use of herbs.
- While the review did not go into detail on the type of herbs and their usage, moringa tree was the most commonly cited herb.
- Most respondents were aware of the risks of combining ARVs and herbal treatments. Most clients on ARVs reported that they were advised through their health institutions not to combine the two.

4.4 Key Challenges

Effective provision of AIDS Treatment services has been hampered by a number of challenges, which include the following:

- **Shortage of foreign currency** for the importation and production of ARVs and their consequent shortage
- **Testing and counselling:** Limited availability and accessibility of testing and counselling service centres in rural areas
- **Inadequate paediatric formulae:** Inadequate supply of paediatric formulations for ARVs
- **Limited CD4 and viral load counting machines** in the private sector. However most recent policy recommends use of the WHO staging system to determine enrolment on ART.
- **Human resource problems:** shortage of nurses, pharmacists for ART roll out
- **Stigma and discrimination** is still high in the rural areas thus compromising effective access to ART services.
- **Limited knowledge:** Limited capacity and knowledge by caregivers on access to treatment issues which hampers creation of a supportive and enabling environment for drug adherence and counseling
- **Inadequate nutrition:** Recurrent droughts have compromised the nutritional status of PLWHA and chronically ill people on treatment
- **Lack of financial resources** for transportation to reach the nearest testing centre and to pay for the required tests.

4.5 Recommendations for Increased Access to treatment

The following are key recommendations for increasing access to treatment:

- More awareness on HIV and AIDS, to reduce stigma and discrimination.
- Enhance the capacity of caregivers (both primary and secondary), chronically ill and PLWHA on drug adherence and counseling through training and refresher courses.
- Production of IEC information packages targeting CHBC and access to treatment issues
- CHBC standards need to standardise information on AIDS Treatment.

5.0 LINKAGES: CHBC, T&C, NUTRITION and AIDS TREATMENT

CHBC, T&C and AIDS Treatment are mutually dependent services towards promoting continuum of care for PLWHA and other chronic illnesses. In some instances, these services are provided at different stations by different stakeholders, whilst in some instances, these services are provided in a *"one-shop station"* approach. This section assesses and discusses the linkages between CHBC, T&C and AIDS treatment services.

5.1 Linkages within CHBC services

The provision of comprehensive CHBC services can only be fostered in a system where there are strong linkages among service providers themselves. This section assesses the linkages that existed within CHBC services, challenges and provides suggestions for improvement.

5.1.1 Linkages

Strong linkages were associated with clear referral systems, documentation and sharing of information among CHBC implementers. Good practices were noted among some emergency food relief organisations that used the already existing leadership structures and caregivers of other CHBC implementers, for their activities. Health institutions, which adhered to the discharge plans and guidelines, cited strong linkages and referral systems with organisations' programmes in the communities. Linkages were also noted between child welfare organisations and organisations which provided public health and hygiene education, CHBC kits and nutrition, to ensure that orphan families benefit from these services.

5.1.2 Challenges

The following are the key challenges for effective linkages within CHBC services:

- Some stakeholders are not so much concerned about the complementary nature of their services. In some communities, caregivers and community leadership highlighted that it is rare for organisations to share their programme community meetings. Community members commented this as costly as they were forced to spend more time and days attending meetings for different organisations.

  "*Maorganisations aya anongouya akaparadzana, havabatanivo ngei ivo vachiita zvevarwere vese"*

  (These organisations always come to our communities separately, why can't they come together yet they are all into CHBC)
  Community Leader, Zaka District, Masvingo province

- Poor infrastructure (communication and transport) was also highlighted as a challenge to promoting linkages between hospitals and caregivers in the local communities.

5.1.3 Suggestions and Recommendations for Strengthening Linkages

Below are the key suggestions and recommendations for improving linkages:

- NAC should take the lead in strengthening coordination and networking among stakeholders to foster strong linkages. NAC could take a leadership role in bringing CHBC, access to treatment, testing and counseling and nutrition players together
- CHBC implementers also need to prioritize provision of comprehensive trainings and up to date refresher courses to caregivers to enhance their appreciation of linkages in CHBC programmes.

5.2 CHBC and T&C

5.2.1 Linkages

A holistic approach to CHBC is made easier if clients know their HIV status. T&C facilitates clients to come up with risk reduction plans. Counselling promotes the development of self-esteem and helps clients to identify support systems for the purpose of referrals to CHBC and AIDS treatment programmes in cases of a positive result. T&C therefore prepares clients to plan their future and live positively. Most respondents appreciated the importance of T&C in CHBC, since the greater focus of CHBC is on PLWHA, as opposed to the chronically ill. The study showed that although most T&C Centres appreciated the need for linking their services with CHBC, linkages were strongly recorded between them and Post-HIV/AIDS clubs and support groups rather than comprehensive CHBC programmes.

5.2.2 Challenges

Below are the key challenges in linking CHBC and T&C:

- **Non comprehensive linkages:** T&C centres were more biased in linking up their clients with ART services and not CHBC programmes per se.
- **OVC and nutrition**: Linkages between CHBC and T&C were weak in addressing issues of orphan care, nutrition and community involvement.
- **HIV status for CHBC clients:** Linkages between T&C and CHBC programmes are generally weak due to the fact that some CHBC programmes do not emphasise knowledge of one's HIV status. This affected the patients' knowledge and uptake of the healthy plate. About 26% of interviewed caregivers indicated that their clients did not know their HIV status.

- **HIV status of children:** A major concern for CHBC implementers is the issue of consent for HIV testing for children who are in CHBC for children with no parents or guardians.

  "When we get to the homes of clients who do not know their HIV status, we get stuck don't know what to say, with regard to issues of nutrition, herbal therapy, family planning and re-infection control"
  Secondary Caregiver, Gokwe North District, Midlands Province

  "A-h ndinongotiwo wakaroiwa ngekuti awangamborwari nguwa imwe chete, uye marwariro acho atiazwisisiba"

  (A-h we think of witchcraft because they got ill at the same time and we don't understand the illnesses)
  Primary Caregiver, Chipinge District, Manicaland Province

Overall, the study showed that linkages between T&C and CHBC are still weak, given that most of the T&C centres are still urban-based. This compromises the quality of services provided under the CHBC programmes.

5.2.3 Suggestions and Recommendations for Strengthening Linkages:

The following are the key recommendations for improving linkages between CHBC and T&C:

- T&C service providers to need to prioritize the decentralization of T&C centres and increase awareness of the importance of T&C to increase uptake.
- There is need for development of National policy that addresses HIV testing among minors especially OVCs.
- Incorporating issues of T&C in CHBC training could enhance caregivers' understanding and appreciation of T&C in CHBC.

5.3 CHBC and Nutrition

Nutritional support is of paramount importance in CHBC programming. Adequate nutrition promotes improved recovery form illnesses and wound healing, thereby reducing morbidity[6]. This section assesses the importance of nutritional support, linkages between CHBC and nutritional support, key challenges and recommendations.

5.3.1 Linkages

Although food packs vary from provider to provider in terms of contents, nutritional support helps prevent involuntary weight loss and provides energy. For PLWHA, good nutrition helps improve their health and quality of life through reviving energy and ability to continue generating income for food, health care and other responsibilities. Strong

[6] Eating healthy, staying positive: Manual book on nutrition for HIV Positive People, SAfAIDS: 2004

linkages are found when nutritional support is provided to the chronically ill, PLWA and their families. Provision of training on the *"healthy plate"* for PLWHA and support through establishment of nutrition gardens as well as provision of food handout were the key strategies for strengthening the linkages between CHBC and nutritional support. Examples of good linkages were established in orphan care programmes, through provision of nutrition and agricultural inputs for the gardens. These include: Manna Orphan Care programme, Red Cross and Revival Mission in Harare, Lubancho House, Bekezela Home Based Care and Hlengwe for Community Help Trust in Matebeleland North province.

5.3.2 Recommendations

Key recommendations for improving linkages between CHBC and Nutritional Support include:

- Nutrition support should be incorporated into CHBC programming
- Food packs should be standardised
- Establishment of irrigation programmes in drought prone areas
- Training and financial support of communities in the establishment of nutritional gardens
- Financial support for community income generating programmes
- Developing and maintaining infrastructure to enable NGOs and other beneficiaries to distribute food packs in inaccessible areas
- Education on nutrition for PLWHA
- Provision of seeds, fertilizer and farming equipment where needed.

5.4 CHBC and AIDS TREATMENT

AIDS treatment is a potentially critical intervention if value for money has to be achieved from CHBC programmes. This section will discuss the linkage between AIDS Treatment and CHBC, assess the challenges being encountered and provide suggestions and recommendations for improving the linkage between the two components.

5.4.1 Linkages

AIDS treatment has largely been through ARVs although herbal therapy recently begun to receive attention. If discharging of PLWHA on AIDS Treatment is conducted following the discharge guidelines, linkages are fostered with CHBC through referrals. CHBC programmes therefore complement AIDS Treatment through nutritional, psychosocial support and establishment of support groups. In some instances, PLWHA on ART were getting drug adherence follow-ups and counselling through caregivers during their home visits. Strong linkages between AIDS Treatment and CHBC were noted among mission hospitals which provided ART and their CHBC programmes which provided material, nutritional and spiritual support, physical care through caregivers, collective community support through ploughing fields, repairing houses and roads for

transporting patients to health institutions. These mission hospitals included: St Theresa and Musume in Midlands province, Regina Coeli Mutambara and Murambinda in Manicaland province, St Marys and Nyadire in Mashonaland East province. In this respect CHBC, programmes promote continual linkage between clients with health institutions, for the purposes of ARVs and periodic check ups.

5.4.2 Challenges

The following are the key challenges for improving CHBC and AIDS Treatment:

- Poor linkages were noted among central and private hospitals, which had no direct links and effective coordination with communities as well as health institutions, which were not adhering to the discharge plans and guidelines.
- The majority of caregivers were not conversant with issues of T&C, ART and herbal therapy, thereby limiting their capacity to provide drug adherence monitoring and counseling services to PLWHA on ART.
- Poor infrastructure, especially in the rural was a challenge to facilitate client referrals to health institutions for the treatment of other opportunistic infections.

5.4.3 Suggestions and Recommendations for Strengthening Linkages

Below are key recommendations for strengthening linkages between CHBC and AT:

- The review suggests the need for sensitizing all relevant health institutions to adhere to the discharge planning guidelines and decentralization of ART roll out programme.
- CHBC implementers also need to prioritize integrating issues of AIDS Treatment training and refresher courses for caregivers.

5.5 CHBC, T&C, Nutrition and AIDS Treatment

CHBC programmes can only be described as comprehensive if they address issues of AIDS treatment, Nutrition and T&C. This section discuss the linkages between these concepts, any challenges faced and provides suggestions and recommendations for improvement.

5.5.1 Linkages

- T&C facilitates early detection and management of opportunistic infections and formalizes the entry into AIDS Treatment.
- T&C promotes behavior change, which can consequently help patients make risk reduction plans for positive living.

  "Our motive to provide T&C services does not end in clients confirming their HIV status but prepares clients to make plans about living positively, this entails

clarifying on issues of disclosure and AIDS Treatment in cases of an HIV positive result. We even refer HIV positive clients to support groups and other health institutions for viral load and CD4 count prior taking any form of AIDS Treatment"
T&C service Provider, Harare Province

- T&C promotes cooperation among family members in cases of status disclosure. This in-turn helps patients who are put on ART to be monitored on drug adherence by family members and caregivers.
- T&C also provides a ticket for PLWHA to join support groups and enjoy membership benefits like counseling and AIDS treatment: ARVs and herbal therapy.
- This review showed the linkage between T&C, AIDS treatment, nutritional support and CHBC was strong in PLWHA led organisations like The Centre and Chiedza Home of Hope in Highfields district in Harare province.

"Our organisation provides with information to do with nutrition, but does not have food packs, therefore we refer PLWHA to DAAC"
Local NGO, Masvingo province

- Whilst some programmes acknowledged existence of linkages between T&C, nutritional support, CHBC and AIDS treatment, some organisations and health institutions noted that their programmes were not linked as they were treated separately, with limited coordination between the thematic areas.
- Overall, linkages between CHBC, AIDS treatment, nutrition and T&C were associated with good coordination and networks among stakeholders.

"There is no linkage at all in the programmes, since they are treated as separate entities and are being managed by different people, u-m-m it's even very difficult to think about existence of any linkages"
Private Hospital Respondent, Harare province

5.5.2 Challenges

Challenges that hindered effective linkages between T&C, Nutrition, CHBC and AIDS Treatment include:

- Poor coordination among stakeholders,
- Unavailability of T&C services in rural communities,
- Unavailability of ARVs at local clinics
- Unavailability of pediatric solution for children living with AIDS.
- The general populace, including caregivers is not yet fully conversant with issues of ARVs and herbal therapy.
- Erratic food supplies were an issue of concern among the chronically ill and PLWHA.

Suggestions and Recommendations:

Key recommendations for improving linkages include:

- Need for stakeholders to improve on coordination and networking to foster the complementary nature of T&C, CHBC and AIDS treatment.
- Decentralization of T&C and increased operationalisation of MOHCW policy encouraging use of WHO staging for enlisting on ARVs
- Increase awareness on ARVs and nutritional support.

5.6 Issues of Orphan Care

Integration of children's issues in CHBC has been hailed for its ability to holistically address the needs of both the chronically ill parents and their children. Promotion of child involvement is critical in promoting the best interests of children, as they meaningfully participate in issues affecting them.

5.6.1 Linkages

Child involvement promotes communication between carers, parents and their children long before death of parents, to foster continual close and trusting relationship in cases of death. Apart from being cost effective in addressing needs of chronically ill parents and their children, it promotes family counseling and communication. Therefore, children can be regarded both as beneficiaries and service providers. Interviews with organisations revealed that 48% of them were integrating children's (mainly orphans and those with chronically ill parents) issues in their CHBC programmes. These organisations provided a wide range of services for OVC, which included education assistance (school fees, uniforms, and stationery), nutritional, spiritual and material support. Qualitative data showed that children and youths were commonly involved in CHBC programming through providing basic care, Psycho Social Support(PSS), as peer educators and counselors, household chores. CHBC therefore helps parents develop plans, for example, through wills writing well before they die. These linkages were highly recorded among CHBC programmes of FBOs, mission hospitals, CBOs and DAAC. Linkages were limited in programmes of government health institutions, which largely focused on physical nursing care and ART.

5.6.2 Challenges

Challenges to integration of orphan care include:

- **Mistrust on resource allocation:** Poor working relationship between primary and secondary caregivers. There was a general mistrust of secondary caregivers by orphans especially in material resource allocation: food packs and clothing. This compromises the level of participation in issues affecting them.

- Appreciation of OVCs: Limited appreciation of the importance of involving children, including orphans in issues affecting them, and hence their involvement is still limited. Linkages between orphan care and CHBC could however be strengthened by involving orphans in CHBC trainings and refresher courses. Orphans should also be incorporated into IGPs, to enhance their involvement.

5.7 Key Recommendations

Below are key suggestions and recommendations for improving linkages between T&C, Nutrition, AIDS Treatment and CHBC in Zimbabwe.

- **Coordination among stakeholders:** There is need for improvement in coordination systems among CHBC and AIDS Treatment related service providers, including the private sector.
- **Scaling up outreach of T&C:** T&C service providers should also prioritize provision of mobile services to remote areas and most high-risk mining and farming areas. Encouraging of using WHO staging system for enlisting patients.
- **Operationalising discharge plan guidelines:** The MOHCW should advocate for adherence to the discharge planning guidelines to ensure a strong linkage between health institutions and CHBC programmes.
- **Refresher courses:** CHBC implementers also need to prioritize provision of refresher course to caregivers of herbal therapy, ARVs and drug adherence monitoring as well as other support services for the chronically ill and PLWHA, for the purposes of referrals.
- Integrate nutritional support with herbal therapy, such that the gardens are used for dual purposes.

6.0 COORDINATION, STANDARDS, MONITORING AND EVALUATION OF CHBC

Coordination, monitoring, and evaluation are critical components of HIV and AIDS programming, including CHBC. These concepts seek to enhance efficiency and effective quality service delivery, through improved collaboration or partnership among partners and routine assessment of programme progress. In this respect, the 2003 International Conference on AIDS and STIs in Africa (ICASA) prioritized these concepts as part of the "Three One Principle":

- One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all parties.
- One national AIDS coordinating authority with a broad based multi-sect oral mandate
- One agreed country level monitoring and evaluation system.

This section assesses the existing coordination, monitoring and evaluation systems for CHBC programming in Zimbabwe. It presents an assessment of quality of service provision among stakeholders, in line with the national standards on CHBC. Good practices, key challenges in coordination, monitoring and evaluation and recommendations are also presented in this section.

6.1 Coordination of CHBC Services

The multisectoral and multidisciplinary approach to CHBC provision requires effective coordination systems and mechanisms. In this view, Government of Zimbabwe established NAC in 1999 to coordinate all national HIV and AIDS responses, including CHBC. This seeks to ensure maximum collaboration, partnership, information sharing and networking among key stakeholders. Effective coordination strengthens relationships and complementarities of services and prevents duplication and competition among stakeholders.

Coordination Mechanisms: NAC and its decentralized structures at all levels are responsible for the coordination of CHBC programmes, as such are the primary recipients of information from CHBC implementers. This entails ensuring that CHBC programmes are well networked. These local structures organise information sharing and reporting meetings or forums for stakeholders at each respective level, at varied intervals. These meetings help stakeholders share experiences, identify gaps, challenges, possible solutions as well as good practices. The study revealed that coordination between NAC and MOHCW was unsatisfactory, especially in terms of attendance to DAAC coordinated monthly meetings and submission of the NAC data collection tools. Some organisations highlighted that coordination by their respective funding partners was better, more interactive and educative than that of NAC structures.

Reporting Mechanisms: Caregivers are the main source of information about clients as they are the key cadres on the ground for all CHBC implementers. They report weekly and monthly to their respective grassroot NAC structures, implementing organisations and community nurses. Some church related health institutions also report to ZACH and MOHCW. Public health institutions highlighted that information with regard to CHBC programming could only be accessed by NAC through the Nursing Directorate, thus was not directed to NAC. This is in conflict with NAC's expected flow of information, in which they are the custodians of the reporting procedures.

The review established that some organisations are also not reporting to NAC. Most NGOs sent their CHBC reports directly to their head offices, overlooking NAC structures. They felt that they were not mandated or obliged to report to neither NAC nor MOHCW. This creates a challenge in that NAC will have information gaps to provide a true picture of CHBC programming at national level.

> *"Why should we give DAAC reports when they do not recognize our CHBC work. If they did, why are we not included in the disbursement of food packs and receiving of grants. They only want our contribution when it comes to reports and attending meetings"* **NGO official, Nyanga District, Manicaland Province**

> *"As NGOs, we are not happy reporting to many stakeholders. We think the reports we give DAAC are enough. It is up to DAAC to share or give to other stakeholders. Why should we give the ministry, the same reports when DAAC is an arm of it"* **NGO official, Zvishavane District, Midlands Province**

Through consultation with NAC management, it was established that they have enforcing powers on errand organisations. However, some NAC representatives at local levels were not aware of these powers.

> *"As PAAC, we are not receiving adequate reports from NGOs and other implementers of CHBC as some are not sending their reports. Government should give us enforcing powers so that we can deal with those errand NGOs accordingly"*
> **PAAC member, Marondera District, Mashonaland East Province**

Information sharing and dissemination: Information sharing was found by the study to be low and disappointing. Most NGOs and health institutions did not have a clear information sharing policy in place. One of reasons cited was that of bureaucracy. Information gathered in most organisations can only be shared through heads or directors. The problem was that most implementing officials were at district levels and programme heads at provincial or national level. Therefore, organisational information remained trapped at strategic levels and rarely trickled to the cadres that encountered problems on the ground to share with peers. Some NGOs like Island Hospice had newsletters for information dissemination on their programming, including CHBC. Though most organisations acknowledged submitting reports to either NAC or MOHCW, the feedback was poor.

"We do not know what happens to our reports we sent to the community nurse" **Secondary caregiver, Magwegwe District, Bulawayo Province**

"There is need for a two way communication system. We report and hence expect someone to give is feedback so that we know if we are in the right track and where attention is required" **NGO official, Gwanda District, Matebeleland Province**

Networking: One of the expectations of the National Standards on CHBC is the strengthening of collaborations among support networks involved. This could be achieved through creation of linkages and partnerships among HBC implementers. Results from the survey showed that there were linkages among some implementing CHBC organisations. The level of networking varied from organisation to organisation, with some, interested in networking among themselves and neither with NAC nor MOHCW. Some of the organisations perceived that MOHCW and NAC were only interested in their financial resource baskets and utilization and not their complementary role.

"NAC has lots of money in their coffers raised through AIDS levy but they expect us to do more on CHBC than them. They should know that we are only there to complement their efforts" **NGO official, Kwekwe District, Midlands Province**

"Networking is good for the success of every community programme but that should develop naturally. Some organisations think if we know some of their activity plans, we can steal their ideas and duplicate their effort"
NGO official, Harare Province

Such perceptions emanated possibly because most implementing CHBC did not fully adhere to the National Standards on CHBC, which stress the need for networking in developing of multi-agency plans for care and support. It also advocate for regular collaborative stakeholder meetings in order to review plans and optimal resource allocation.

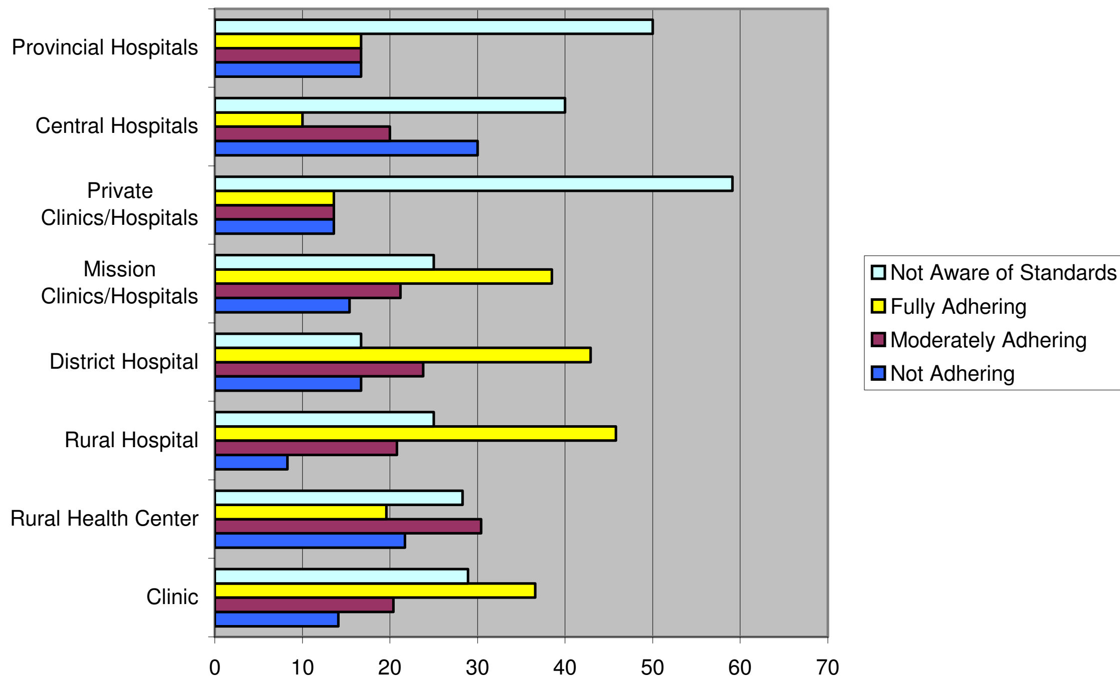
6.2 Standards of CHBC

The national standards were developed in 2004 by the MOHCW in a bid to standardise service provision, especially in terms of coordination, resource allocation, training and support of caregivers, monitoring and evaluation. These standards ensure that CHBC programmes are designed in a manner that will foster effective and effective quality service delivery. Therefore, adherence to the national CHBC standards, other policies and other professional principles related to CHBC assures quality care management. Quality continuum of care provision to the chronically ill however rests on dissemination and adoption of these standards and related policies to stakeholders.

Adherence to national standards on CHBC was measured by the perception of CHBC service providers' experiences against knowledge and adoption of the standards.

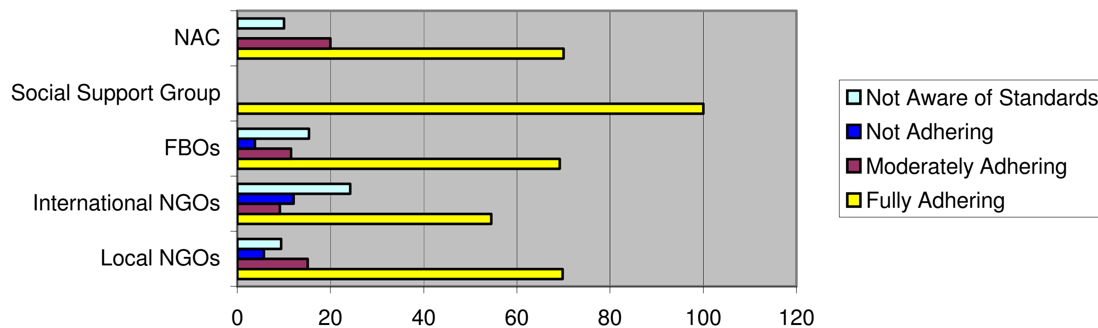
Interviews with health institutions revealed that only 33% of the health institutions were aware and fully adhering to the standards, 16% were aware of the existence of the standards but were not adhering and 29% of them were not even aware of the existence of standards. Figure 3.10 show that the majority (59%) of private clinics/hospitals and provincial hospitals (50%) were not aware of the standards. This results show that there is need for improved reprinting and dissemination of these standards to all stakeholders.

Figure 3.7: Percentage Distribution of Health Institutions By Adherence to National Standards



Th*e* majority (66%) of organisations interviewed perceived their programmes as fully adhering to national CHBC standards whilst 14% of the organisations were not even aware of standards. Organisations fully adhering were composed of 42% local NGO/CBOs, 20.5% International NGOs, 20.5% FBOs, 1% Social Support Groups and 16% NAC. Overall, as shown by Figure 3.11, the majority of the organisations in each category were fully adhering to the national CHBC standards.

Figure 3.8: Percentage Distribution of Organisations By Adherence to National Standards



Adherence to standards was highly noted on training of caregivers, where most organisations used the MOHCW training manual and involvement of the ministry personnel in training. Overall, the results showed that CHBC programming is not yet fully standardised, given that other CHBC implementers were not yet conversant with the National CHBC standards/guidelines on CHBC.

6.3 Monitoring and Evaluation

Monitoring and Evaluation is a critical component in HIV and AIDS programming, including CHBC. These two mutually dependent processes help to measure and assess programme acceptability, efficiency and effectiveness. The national CHBC standards provide a comprehensive M & E framework for CHBC programmes. This framework enhances effective record keeping, establishment of proper organisational structures, collection of relevant and reliable data and analysis to inform policy and programming. It also provides major M & E questions, key indicators, major forms of evaluations, enables effective identification of problems and potential solutions, and makes informed decisions on resource mobilization and allocation.

Monitoring and Evaluation Systems: Despite the need for the adoption of one monitoring and evaluation framework, interviews with organisations revealed that at the time of the review, organisations had varied monitoring and evaluation systems and tools. Some of the implementers had no systems in place, whilst others were in the process of developing them. Some implementers had adopted the NAC M & E system, into their already existing systems. At the time of the review, NAC was reviewing and developing the standard M & E systems for all HIV and AIDS responses, including CHBC. The study established that the major monitoring and evaluation systems were client visits and activity reports. Some organisations had ready budgets and officers specifically responsible for M & E and conducted periodic review of their monitoring and evaluation systems and tools. In most instances, the caregiver was noted as the key person for primary data collection. On other hand, some organisations, especially the local church-based programmes did not have budgets, systems and tools for M & E activities. Most of the organisations noted that their M & E systems were largely donor driven, to meet the information needs of funding partners rather than the national M & E framework.

6.4 Challenges

- **Inadequate coordination:** Poor communication and feedback systems from NAC structures were highlighted as major challenges in coordination among CHBC implementers.
- **Inefficient use of NAC monitoring activity report forms:** DAACs reported that most CHBC stakeholders/implementers were not attending coordination meetings and neither were utilizing and submitting NAC Monthly Activity Report Form.
- **Reporting to NGO HQs:** Most international NGOs highlighted that they had their own internal bureaucratic reporting systems that were not friendly with NAC's reporting procedures, thus information could only be accessed through their head/national offices.
- **Non integration of NAC M&E system:** Despite the existence of one M & E framework (under review), the study established that most organisations had not fully integrated it into their own systems. Therefore, these organisations faced a challenge of inadequate data in completing the NAC data collection forms.
- **Transport challenges:** Transport and fuel problems were also identified as a challenge to monitoring and evaluation of programmes, especially among local NGOs.
- **Capacity of M&E:** The review also established relatively limited appreciation of the importance of M&E in CHBC programming in some small organisations. Most organisations also reported limited capacity of their staff on M&E.

6.5 Recommendations for Improved Coordination and M & E

Below is an outline and highlights of major recommendations for improved coordination and monitoring and evaluation.

- **NAC authority:** There is need for NAC to enforce its powers and mandate of coordination and respond appropriately on errand organisations or CHBC implementers. This will ensure maximum cooperation and participation of CHBC stakeholders, especially in meetings and completing NAC M & E tools. This might be fostered by the adoption of an effective registration system of all CHBC implementing agencies. There is need for policy review to ensure that the mandate and powers of NAC and its structures are fully strengthened, to foster the realization of the "Three Ones Principle".
- **Capacity for care givers:** There is need to enhance the capacity of care givers particularly I the area of capturing reports on their work. There is need for CHBC implementers to prioritize training of caregivers in standard reporting writing as well as provision of enough stationery.
- **Reporting to NAC:** NAC should devise a system to access information from organisations which are bureaucratic to ensure flow of information from all CHBC players to NAC monitoring system.

- **Improved transport systems:** CHBC implementers should also prioritize establishment of local structures and provision of bicycles to their leadership to facilitate coordination of CHBC programmes.
- **Tracking resource utilization among CHBC stakeholders:** There is need for NAC to devise a strong and viable standard mechanism to track resource utilization among CHBC implementers. Knowledge by NAC of geo coverage of key players and resource avail will assist it, to manage new players who are entering.
- **Improved information sharing:** There is need for NAC to improve information sharing and networking and NAC can use it's newsletter and website could be used effectively to this end. NAC should enhance the capacity of CHBC implementers in M & E of CHBC programmes, in line with national standards on CHBC and the national M & E framework.

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

Zimbabwe has a rich and enabling policy environment for the operation of CHBC and Access to AIDS Treatment services. It is encouraging to note that there are many players (Government, NGOs, CBO, FBOs) involved in CHBC. The geographical coverage of CHBC services is not uniform, there are districts where such services and still required. The decentralization of NAC structures has contributed to an increase in CHBC services. There are many different services offered by programmers in CHBC. Involvement of PLWHA in CHBC is noble as this contributes to improved lobbying and advocacy for CHBC patients as well as reduction in stigma and discrimination for the affected and those living with HIV and AIDS. Key challenges in CHBC include the need for standardization of many CHBC services (training packages, kits, incentives and more), the need to address special needs for youths and children and limited funding which compromises quality of services.

Access to treatment is a critical programme intervention for CHBC if value for money is to be achieved for investment into this sub-sector. The integration of CHBC and other important and complementary services such as testing and counseling, nutritional support and access to treatment is an important programme design issue for CHBC. A holistic and comprehensive CHBC programming should also be characterized by strong referral systems for all services.

Coordination of CHBC activities among all key stakeholders is important. Coordination of CHBC stakeholders particularly in districts is generally weak. Most CHBC player prefer to report information on CHBC directly to their mother organisation or funding partners by-passing sharing of information with NAC. This contributes to poor quality data at national level for monitoring trends and patterns in this sector.

7.2 Recommendations

The following are the key recommendations for improving CHBC and Access to Treatment programming:

CHBC

- There is need for standardization of CHBC, training package, incentives and Kits contents/replenishments among CHBC players.
- The CHBC standard guidelines require simplification and wider dissemination
- There is need to incorporate youths and children in CHBC programming and develop relevant training materials for the target groups
- More funding for CHBC should be sourced in order to improve the quality CHBC programming.

- Mainstreaming gender issues in all CHBC programmes and policies.
- There is need to monitor operationalisation of the Patient Discharge Guidelines Plans.

Access to Treatment Issues

- In the context of CHBC, there is need to build capacity of caregivers on issues of treatment in order for them to play a key role in adherence issues for those patients on ARVs
- There is need for service providers in this field to scale up treatment literacy on access to treatment for communities
- More research is needed on herbal therapy as most rural communities rely heavily on herbs. Issues for research could include: names and usage, dosage and toxicity issues.
- There is need to scale up access for testing and counseling for communities particularly rural communities and reinforcement of MOHCW policy encouraging WHO staging of HIV and AIDS stages to enlist deserving patients on treatment (in the absence of CD4 count machines).

Linkages: CHBC, T&C, Nutrition and Access to Treatment

- CHBC services should be designed in a holistic manner where the relevant complementary services such as testing and counseling, nutrition and access to treatment are well coordinated and are also characterized by a strong referral system
- There is need to encourage CHBC patience to know their status in order to maximize on services provided in access to treatment
- Nutritional support for CHBC patients should be an important component of CHBC where resources are permitting.

Coordination, Monitoring and Evaluation

- Enhance capacity of CHBC and Access to Treatment stakeholders in monitoring and evaluation.
- In the context of poor coordination of CHBC information, there is need for NAC to and MOHCW and relevant stakeholders to develop a policy enforcing the operationalisation of the 3 –ones for CHBC sub-sector.

ANNEXES

Annex 1. GEOGRAPHICAL COVERAGE OF CHBC PROGRAMMING IN ZIMBABWE

Province	District	Organisations
Harare	Harare North	DAAC, Red Cross Society, Island Hospice, Padare, City Health, Dominican Sisters, Inter Peoples AIDS Connect, Population Services International (PSI), AIDS Counseling Trust (ACT), UDACIZA, Christian Care, UNICEF, DART, Revival Mission International
	Chitungwiza	DAAC, Island Hospice, Red Cross Society, Revival Mission International, UTANO Project, University of Zimbabwe in Collaboration with the University of California San Francisco (UZ-UCSF), Apostolic Faith Mission, Population Services International (PSI)
	Mabvuku-Tafara	DAAC, Red Cross Society, Island Hospice, Mashambanzou, Padare, City Health, Total Control Epidemic, AIDS Counseling Trust, Diocese of Harare,
	Harare West	DAAC, Red Cross Society, Island Hospice, Mashambanzou, Population Services International (PSI), Diocese of Harare, AIDS Counseling Trust (ACT),
	Epworth-Ruwa	Mashambanzou, Red Cross Society, Zimbabwe Association of Church Related Hospitals (ZACH), UDACIZA, United Methodist Church, Revival Mission International, Diocese of Harare, Assemblies of God, Population Services International (PSI)
	Harare South	DAAC, Red Cross Society, Mashambanzou, Diocese of Harare, AIDS Support Care, Population Services International (PSI)
	Highfields	DAAC, Mashambanzou, Red Cross Society, and Diocese of Harare
	Harare Central	DAAC, City Health, Population Services International (PSI), Revival Mission International, Diocese of Harare
Bulawayo	Luveve	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Revival of Hope, Catholic Development Commission (CADEC), STRIVE, Seventh Day Adventist Church, Salvation Army Church, Methodist Church, Health Service Development, Loving Hands, Tembelihle,
	Bulawayo South	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Medicines San Frontiers (MSF), World Vision, Catholic Development Commission (CADEC), Cancer Association of Zimbabwe, Population Services International (PSI)
	Nkulumane	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Medicines San Frontiers (MSF), Catholic Development Commission (CADEC), Salvation Army Church, Asikhulumane, Alliance Church, Tembelihle, Cancer Association of Zimbabwe, Population Services International (PSI)
	Emakhandeni	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Medicines San Frontiers (MSF), Maibongwe, Revival of Hope, Tembelihle, Cancer Association of Zimbabwe, Population Services International (PSI)
	Magwegwe	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Medicines San Frontiers (MSF), World Vision, ORAP, Christian Health Sevices, Catholic Development Commission, (CADEC), Tembelihle, Cancer Association of Zimbabwe, Population Services International (PSI)
	Bulawayo North	Bulawayo City Council, Island Hospice, Silundika AIDS Health Council, Medicines San Frontiers (MSF), Cancer Association of Zimbabwe, Population Services International (PSI), Rural and Urban Development Assistance and Care (RUDAC)
Midlands	Kwekwe	DAAC, Midlands AIDS Service Organisation, Zimbabwe Network OF People Living with HIV and AIDS (ZNNP+), CEPHAC, PATHAIDS, Plan International

	Mvuma	DAAC, Ministry of Health and Child Welfare (MOHCW), CARE International, Muvonde, Midlands AIDS Service Organisation (MASO) and OXFAM
	Gweru	DAAC, MOHCW, CARE International, Batsiranai, Department of Social Welfare, MASO, PSI and PATHAIDS
	Zvishavane	DAAC, Bethany, Red Cross Society, OXFAM, Zvishavane AIDS Caring Trust (ZACT) and Midlands AIDS Service Organisation (MASO)
	Mberengwa	DAAC, Bethany, Red Cross Society, OXFAM, Zvishavane AIDS Caring Trust (ZACT) and Midlands AIDS Support Organisation (MASO)
	Gokwe North	DAAC, MOHCW, World Vision, Population Services International (PSI)and PATHAIDS
	Gokwe South	DAAC, MOHCW, Eden and Midlands AIDS Support Organisation (MASO)
	Shurugwi	DAAC, Midlands AIDS Service Organisation (MASO), MOHCW, Red Cross Society and PATHAIDS
	Silobela	Plan International
	Zhombe	Plan International and PATHAIDS
	Lower Gweru	Red Cross Society
Mashonaland East	Seke	DAAC, MOHCW, Seke Rural HBC, ZICHIRE, UZ-UCSF, Farmers Community Trust in Zimbabwe (FCTZ) and Population Services International (PSI)
	Marondera	DAAC, MOHCW, Red Cross Society, FCTZ, Kunzwana, Zimbabwe National Family Planning Council (ZNFPC) and Hope in AIDS Network
	Mutoko	DAAC, MOHCW, World Vision, ZICHIRE, UZ-UCSF, Plan International, UNIFEM, Mother of Peace, PACT and Red Cross Society
	Goromonzi	DAAC, MOHCW, World Vision, FCTZ and HOSPAZ
	UMP	DAAC, MOHCW, World Vision, Batsirai and Uzumba Maramba Pfungwe Orphan Care Trust
	Mudzi	DAAC, World Vision, Plan International, Red Cross Society and Hope in AIDS Network
	Chikomba	DAAC, MOHCW and Zimbabwe Network OF People Living with HIV and AIDS (ZNNP+)
	Hwedza	DAAC, Red Cross Society and ZICHIRE
Masvingo	Gutu	DAAC, CARE International, PSI, Alliance Church, Holy Cross, OXFAM, ZNNP+, Rural Unity for Development (RUDO)
	Masvingo	DAAC, MOHCW, Catholic Development Commission (CADEC), Alliance Church, Family AIDS Caring Trust Chiredzi, ZNNP+, Rural Unity for Development (RUDO), OXFAM, Population Services International (PSI)and Heifer Zimbabwe
	Zaka	DAAC, CARE International, Rural Unity for Development (RUDO) and ZNNP+
	Bikita	CARE and Family AIDS Caring Trust Chiredzi,
	Chivi	DAAC, Lutheran Development, Red Cross Society, ZWP, Rural Unity for Development (RUDO), Zimbabwe Network OF People Living with HIV and AIDS (ZNNP+)
	Mwenezi	Alliance Church
	Chiredzi	Family AIDS Caring Trust Chiredzi, Christian Care, Muongoli, Alliance Church, SEVACA (Sesithule Vamanani Caring), Zimbabwe Network OF People Living with HIV and AIDS (ZNNP+), World Vision

Manicaland	Chimanimani	Mutambara Mission Hospital, Family AIDS Caring Trust Mutare, Red Cross, Tsuro- Chimanimani (DZE) and Population Services International (PSI)
	Mutasa	DAAC, MOHCW, Farmers Community Trust in Zimbabwe (FCTZ), Munyaradzi, Africare and ARISE
	Buhera	Dananai HBC, Rujeko, Murambinda, Africare, New Start Centre, FACT Mutare and MSF Luxemburg
	Mutare	DAAC, Mutare City Health, FACT Mutare , CADEC, Farmers Community Trust in Zimbabwe (FCTZ), Population Services International (PSI) and DOMCCP
	Nyanga	DAAC, CADEC, AFRICARE, Regina Coeli, FACT Rusape , and DOMCCP
	Chipinge	DAAC, FACT Rusape, St James HBC
	Makoni	DAAC, FACT Rusape, AFRICARE, DOMMCP, FCTZ,
Mashonaland West	Kariba	DAAC, Red Cross Society, Save the Children UK, Catholic Healthcare Commission and Batsirai HIV/AIDS Centre
	Chegutu	DAAC, Tsungirirai, Chegutu council, Batsirai HIV/AIDS Centre and COSV (Haban Solidarity in the World)
	Hurungwe	DAAC, MOHCW, Red Cross, ZNNP+, Batsirai HIV/AIDS Centre, CADEC, World Vision, ZINATHA, SIDA and Catholic Health Service Commission
	Kadoma	DAAC, Red Cross Society, Batsirai HIV/AIDS Centre, St Michael's, Jekesa Pfungwa and PSI
	Makonde	DAAC, Batsirai HIV/AIDS Centre, COSV (Haban Solidarity in the World) and Catholic Health Care Commission
	Sanyati	Batsirai HIV/AIDS Centre and Catholic Healthcare Commission
	Zvimba	DAAC, MOHCW, Red Cross Society, Kudzanayi, Mumvuri Project and Operation Mobilization, CADEC, KAPNECK, Save the Children UK, Batsirai HIV/AIDS Centre and Catholic Health Service Commission
	Karoi	
Matebeleland South	Insiza	DAAC, MOHCW, Insiza Godlwayo AIDS Network (IGAC), Matebeleland AIDS Committee and World Vision
	Beitbridge	DAAC, Red Cross, Lutheran Development, Sikhetimpilo, Beitbridge Peer Education Project, Women Action Group, World Vision and Thusanang
	Matobo	DAAC, Sikhetimpilo, World Vision, Red Cross and CADEC
	Umzingwane	DAAC, MOHCW, Umzingwane AIDS Network and Rural and Urban Development Assistance and Care
	Mangwe	DAAC, CADEC and World Vision
	Gwanda	DAAC, World Vision, Methodist and CADEC
Mashonaland Central	Muzarabani	FCTZ, St Albert's, World Vision
	Mazowe	TCE, ZNNP+, ZINATHA, Salvation Army
	Rushinga	DAAC, Catholic, World Vision, DAPP Child AID
	Guruve	MOHCW, Lower Guruve Development Association
	Mt Darwin	Red Cross, DAAC, TCE, UNICEF, World Vision
	Shamva	Hope Humana, ZNNP+, DAPP Child AID
	Bindura	Trojan, Hope Humana, MOHCW,
Matabeleland North	Bubi	World Vision, DAAC, Red Cross, SDA, ORAP, Catholic
	Tsholotsho	DAAC, MSF, MOHCW
	Binga	DAAC, MSF, MOHCW

	Hwange	DAAC, Lubancho
	Lupane	DAAC Christian care, World Vision
	Nkayi	DAAC, Help Age, Red Cross, Catholic, COSV, Ginyinhlupo, AGAPE
	Umguza	DAAC, MOHCW, Red Cross, CADEC, AFM, BICC, World Vision, Zenzele, Thusang, Souls Comfort

Annex 2: Institutions and Organisations Interviewed

Name of Province	**Name of NGO or Private Institution**	**Services provided**		**Districts Covered**
		CHBC	**ART**	
Midlands[7]	Bethany Project	-Training CHBC training, food for clients, CHBC Kits	-	Zvishavane
	OXFAM	-CHBC Kits,	-	Mvuma, Zvishavane, Gutu,
	ZACT	-CHBC training, CHBC Kits,	-Source drugs and give them to clinics and hospitals for distribution, Organise mobile PSI VCT services	Zvishavane, Mberengwa
	Care International	- CHBC Kits, CHBC Training, Supplementary food Relief, Hygiene items,	-	Mberengwa
	Betseranai	-CHBC training, CHBC Kits and Replenishment, Support groups,	- VCT, Lobbying and Advocacy for treatment, ART literacy and Awareness, Adherence Counseling	Mberengwa
	Africare Zimbabwe	- CHBC training, CHBC Kits, HIV/AIDS awareness, Nutritional Support, Advocacy for male involvement	-	Mberengwa
	World Vision International	- CHBC Training, CHBC Kits, HIV/AIDS awareness.	-	Gokwe
	Population Services International	-Referrals	-VCT, treatment of STIs and OIs	Gweru, Gokwe
	Plan International	-Funds for CHBC and HIV/AIDS training, Provide CHBC Kits, Nutritional Support, OVC care	- VCT, OI drugs,	Kwekwe, Silobela, Zhombe,
	Midlands AIDS Support Organisation	- CHBC Kits, CHBC Training, capacity enhancement for CBOs in CHBC	- OI drugs	Gweru, Shurungwi, Zvishavane, Gokwe South
	Eden	-Orphan care, CHBC training,	-	Gokwe South
	PATHAIDS	- CHBC training, CHBC Kits, PSS, Nutritional Education	-	Gweru, Shurugwi, Kwekwe, Kadoma, Gokwe, Zhombe
	Zimbabwe Red Cross Society	- CHBC training, CHBC Kits, PSS, Food Security, Medical Supplies.	- OI drugs, Referrals.	Zvishavane, Lower Gweru, Shurugwi,
	Heifer Zimbabwe	- CHBC training,	-	Vungu

[7] In Mvuma District, there is no NGO or private institution providing CHBC training and VCT services. There is no private institution or NGO providing ARVs in the province.

Name of Province	Name of NGO or Private Institution	Services Provided		Districts Covered
		CHBC	ART	
Mashonaland West[8]	Batsirai HIV/AIDS Centre	- CHBC training, CHBC Kits, Orphan Care	- VCT, OI drugs	Kariba, Hurungwe, Makonde, Zvimba, Chegutu
	Save the Children UK	- CHBC Training, CHBC Kits	-	Zvimba, Kariba
	Mumvuri Project and Operation Mobilization	- Orphan Care, PSS	-	Zvimba
	Tsungirirai	- Orphan Care, CHBC Training and Awareness, CHBC Kits	- Herbal Treatment, Referral	Chegutu
	Zimbabwe Red Cross Society	- Orphan Care, CHBC Training, CHBC Kits	- Referral	Kariba, Hurungwe, Zvimba, Kadoma
	COSV (Haban Solidarity in the World)	- CHBC Training, CHBC Kits	- PMTCT and ARVs for PMTCT Clients	Chegutu, Zvimba, Makonde
	Catholic Health Care Commission	- Orphan Care, CHBC Training, CHBC Kits	- Herbal Treatment	Zvimba, Makonde, Kariba, Hurungwe,
	World Vision International	- CHBC Training, CHBC Kits, HIV/AIDS awareness.	-	Hurungwe,
	Population Services International	-Referrals	-VCT, treatment of STIs and OIs	Kadoma
Mashonaland East	Seke Rural Home Based Care	- Orphan Care, CHBC Training, CHBC Kits	- OI drugs	Manyame
	Uzumba Orphan Care Trust	- Orphan Care, CHBC Training, CHBC Kits, Nutritional Support	- Herbal Treatment	UMP
	Mother of Peace	- CHBC Training, CHBC Kits	- VCT, ARVs	-
	Farm Community Trust of Zimbabwe	- CHBC Training, CHBC Kits , HIV/AIDS awareness.	-	Goromonzi, Marondera, Murewa, Seke.
	World Vision International	- CHBC Training, CHBC Kits , HIV/AIDS awareness.	-	UMP, Rushinga, Mudzi,
Matebeleland South	Sikhetimpilo Centre	- Orphan Care, CHBC Training, CHBC Kits	- Referral	Matobo
	Zimbabwe Red Cross Society	- Orphan Care, CHBC Training, CHBC Kits	- Referral	Matobo, Gwanda, Beitbridge
	Umzingwane AIDS Network (UAN)	- Orphan Care, CHBC Training, CHBC Kits	-	Umzingwane

[8] In Hurungwe district there is no VCT services. Karoi and Sanyati districts are not covered by all interviewed NGOs.

	Beitbridge Peer Education Programme	- CHBC Training	-	Beitbridge

Name of Province	Name of NGO or Private organisation	Services Provided		Districts Covered
		CHBC	ART	
Matebeleland South[9]	Women Action Group (WAG)	CHBC Training, CHBC Kits,	-	Beitbridge
	Thusanang	Orphan Care, CHBC training,	-	Gwanda, Beitbridge
	World Vision International.	CHBC training, Nutritional support, Orphan care, HIV/AIDS awareness, Nutritional support	-	Gwanda, Beitbridge, Mangwe
	Souls Comfort	Orphan Care, HIV/AIDS awareness, CHBC training, CHBC Kits	-	Gwanda
	Insiza Godlwayo (IGAC)	CHBC training, CHBC Kits, HIV/AIDS awareness	-	Insiza
	Rural and Urban Development Assistance and Care (RUDAC)	Orphan Care, nutritional support, PSS, CHBC training, CHBC Kits	-	Umzingwane, Umguza
	CADEC	- CHBC training, CHBC Kits, Nutritional Support,	- Herbal gardens	Matobo, Bulilima, Mangwe
Masvingo[10]	Catholic Development Commission (CADEC)	CHBC Kits, CHBC Training, Orphan Care	-	Masvingo
	Rural Unity for Development Organisation (RUDO)	Orphan Care, Nutritional Support, PSS, CHBC training, CHBC Kits	- Herbal treatment	Gutu, Chivi, Zaka, Masvingo,
	Alliance Church HBC	Orphan Care, CHBC training, CHBC Kits	-	Chiredzi, Masvingo, Gutu, Mwenezi
	Family AIDS Caring Trust (FACT)	Orphan care, HIV/AIDS awareness, CHBC Kits, CHBC training	- VCT	Chiredzi, Masvingo
	Sesithule Vamanani Caring (SEVACA)	Orphan Care, CHBC training, CHBC Kits,	-	Chiredzi
	Muongoli HBC	Orphan Care, CHBC training,	-	

[9] There are neither private institutions nor NGOs providing VCT and ART services.
[10] There are neither private institutions nor NGOs providing ARVs and VCT services are only available in Chiredzi, Masvingo and Gutu.

	ZNNP+	Orphan Care, CHBC training, HIV/AIDS awareness	-	Gutu, Chivi, Zaka, Masvingo, Chiredzi, Bikita
	Care International	Orphan Care, CHBC training, CHBC Kits	-	Zaka
	OXFAM	CHBC Kits,	-	Masvingo, Gutu,
	Population Services International	Referrals	-VCT, treatment of STIs and OIs	Gutu, Masvingo
	Heifer Zimbabwe	CHBC training,	-	Masvingo
	World Vision International.	CHBC training, Nutritional support, Orphan care, HIV/AIDS awareness, Nutritional support	-	Chiredzi

Name of Province	Name of NGO or Private Institution	Services Provided		Districts Covered
		CHBC	ART	
Bulawayo	Adventist Disaster and Relief Agency	Orphan Care, CHBC Training, HIV/AIDS awareness, nutritional Support	-	Bulawayo
	Rural and Urban Development Assistance and Care (RUDAC)	Orphan Care, nutritional support, PSS, CHBC training, CHBC Kits	-	Bulawayo North
	Thembelihle Home	Orphan care, CHBC training, nutritional support, PSS	-	All districts
	Loving Hands	CHBC training, CHBC Kits, PSS	- Community awareness on ART	All districts
	Methodist Church	Orphan Care, CHBC training, CHBC Kits	- VCT	All districts
	Island Hospice	PSS, CHBC and Palliative Care training,	-	All districts
	Jireh Uthembekile	Orphan Care, Nutritional and Spiritual Support	-	Bulawayo North
	Silundika AIDS Health Council	Orphan Care, Nutritional Support, CHBC Training, CHBC Kits	-	All districts
	Sikhulilezenzele	Orphan Care, Nutritional and Spiritual Support PSS, CHBC Training, CHBC Kits	-	Bulawayo North
	Medicines San Frontiers (MSF)	-	-ART Training, STI treatment, ARVs, Advocacy	All districts
	Cancer Association of Zimbabwe	PSS,	- Chemotherapy,	All districts
	Gugulethu Development Trust	- CHBC training, Nutritional Support, PSS	- Herbal Treatment	Bubi

	Population Services International New Start Centres	Referrals	-VCT, treatment of STIs and OIs	All districts

Mashonaland Central	World Vision International	-Orphan Care, HIV/AIDS Awareness	-	Guruve, Muzarabani, Mt Darwin, Rushinga
	Hope Humana People to People	- CHBC Training, Orphan care, CHBC Kits	-VCT, ARVs, Herbal gardens	Bindura, Shamva
	DAPP Child Aid	- Orphan Care, CHBC Training, CHBC Kits, PSS	-	Rushinga, Shamva,
	Lower Guruve Development Association	- Nutritional Support, CHBC Training, CHBC Kits, HIV/AIDS awareness	- OI drugs, Herbs	Guruve
	Zimbabwe Red Cross	- PSS, CHBC Training, CHBC Kits, Nutritional Support, Orphan Care	- VCT, ARVs, OI Drugs	Bindura, Mt Darwin
Harare	United Methodist Church Home Based Care Programme	- CHBC Training, Orphan Care, Nutritional Support, CHBC Kits, HIV/AIDS awareness	- OI drugs,	Epworth
	Manna Orphan Care Zimbabwe	- PSS, Nutritional Support, Orphan Care,	-	Highfields
	Union of the Development of Apostolic Churches in Zimbabwe Africa (UDACIZA)	- Orphan Care, Advocacy, PSS, CHBC Training, CHBC Kits	-	Epworth and Highfields
	HAQOCI	- CHBC Training, CHBC Kits,	- OI drugs, Drug Adherence Monitoring	Murehwa
	PSI New Start Centres	- CHBC training, Counseling	- VCT	All Districts
	Zimbabwe Red Cross	- CHBC Training, CHBC Kits, Nutritional Support, Orphan Care, PSS	- ARVs, OI Drugs	All Districts
	Diocese of Harare	- CHBC Training, CHBC Kits, Nutritional Support, PSS, Spiritual Support	- OI drugs	All Districts
	Revival Mission International	- PSS, Material and Nutritional Support, Training and financing IGPs for the chronically ill.	- VCT	All districts
	Chiedza Home of Hope	- Orphan care, Nutritional Support, PSS, CHBC Training, CHBC Kits	- OI Drugs	Highfields

	Men's Action Group	- CHBC Training, Advocacy,	- Herbal Gardens	Highfields
	UZ - UCSF	- Advocacy, Counseling, CHBC training	- VCT	All Districts
	Padare	- HIV/AIDS awareness, Nutrition Education, Advocacy for male involvement	-	Harare North
	Mashambanzou	- Orphan Care, CHBC Training, CHBC Kits, PSS, HIV/AIDS awareness, Nutritional Support	- OI drugs	All districts
	Island Hospice	- Counseling, CHBC Training, CHBC Kits	-	All Districts
	St Stephen AIDS Awareness	- HIV/AIDS awareness, CHBC training, CHBC Kits, Nutritional Support, Counseling	- Basic Drugs, Herbal therapy	All Districts
	Chitungwiza Utano Project	- Counseling, PSS, CHBC Training, CHBC Kits	-	Chitungwiza
	AIDS Counseling Trust	- CHBC Training, CHBC Kits, Counseling Training, Nutritional Support,	- Herbs, Basic Drugs	Harare South, Highfields
	DART	- Research on CHBC	- Liver function and CD4 Count tests, Clinical monitoring	All districts
	Hatcliffe Northern District.	-	- VCT, ARVs, PPTCT	Harare North.

Manicaland[11]	ARISE	- Counseling	- VCT	Mutasa
	Dananani	- CHBC training, PSS, CHBC Kits	-	Buhera North
	DOMCCP	- CHBC Training, CHBC Kits, PSS, Material Support, Orphan Care, HIV/AIDS awareness	- OI Drugs, Herbal remedy, Nutritional and Spiritual Support	Nyanga, Mutare
	Farm Community Trust of Zimbabwe	- CHBC Training, CHBC Kits	-	Mutare, Mutasa, Makoni
	Murambinda New Start Centre	-	- VCT	Buhera
	FACT Rusape	- CHBC Training, CHBC Kits, Orphan Care, PSS	- VCT, OI Drugs	Makoni, Chipinge, Nyanga
	MSF Luxemburg	-	- OI drugs, ARVs, Drug Adherence Counseling, Nutritional Support	Buhera
	CADEC	- CHBC Training, CHBC Kits	-	Mutare, Nyanga

[11] ARVs are only being provided in Buhera, whilst VCT services are provided in all districts.

	FACT Mutare	- CHBC Training, Orphan Care, Nutritional and Spiritual Support,	- VCT	Mutare, Chimanimani, Buhera
	Red Cross	- CHBC Training, Orphan care, HIV/AIDS awareness,	- OI drugs, Nutritional Support	Chimanimani
	Mutambara Ruvheneko Programme	- CHBC Training, Orphan care,	- VCT, PMTCT, Nutritional Support, OI Drugs	
	Africare Zimbabwe	- CHBC training, CHBC Kits, HIV/AIDS awareness, Nutritional Support, Advocacy for male involvement	-	Mutasa, Makoni, Buhera, Nyanga,
	Rujeko	- CHBC Training, CHBC Kits	-	Buhera
	Tsuro – Chimanimani (DZE)	- CHBC Training, CHBC Kits	-	Chimanimani
	St James Home Based Care	- CHBC Training, CHBC Kits, PSS	- OI drugs	Chipinge
	PSI New Start Centres	Referrals	-VCT, treatment of STIs and OIs	Mutare, Chimanimani
Matebeleland North[12]	MSF	-	- OI drugs, ARVs, Drug Adherence Counseling, Nutritional Support	Tsholotsho
	Save the Children	- CHBC Training, CHBC Kits, Orphan Care, PSS,	-	Binga
	CADEC	- CHBC Training, CHBC Kits, PSS,	- Basic Drugs	Binga
	Red Cross Zimbabwe	- CHBC Training, CHBC Kits, Nutritional Support	- VCT	All districts
	Hlengwe for Community Help Trust	- CHBC Training, HIV/AIDS awareness, Orphan care, Nutritional Support	-	Binga
	Lubancho House	- CHBC training, CHBC Kits, Orphan Care, Nutritional support,	- VCT	Hwange, Lupane, Binga
	World Vision International	- CHBC training, CHBC Kits	-	Lupane, Bubi
	Ginyinhlupho Care Centre	- CHBC Training, CHBC Kits, Orphan Care, Nutritional and material support	-	Bubi, Nkayi
	Helpage Zimbabwe	- Nutritional Support, HIV/AIDS awareness	-	Nkayi
	Catholic Church	- CHBC Training, CHBC Kits, Orphan Care, Spiritual Support	-	Nkayi

[12] VCT Services are being provided in all the districts whilst ARVs are being provided only in Tsholotsho District.

	Bekezela Home Based Care	- CHBC Training, CHBC Kits, Orphan Care, Nutritional Support	- OI Drugs	Bubi

Annex 3: Health Institutions Interviewed

Province	Type of Health Institution	Name of Health Institution	District
Harare	Central Hospital	Parirenyatwa	Harare Central
		Harare Hospital	Harare Central
		Chitungwiza Central	Chitungwiza
		Wilkins Hospital	Harare Central
	District Hospital	Hatcliffe Northern District	Harare North
	Polyclinic/Clinic	Highlands FHS Clinic	Harare North
		Mabvuku Polyclinic	Mabvuku-Tafara
		Rujeko FHS-Dzivarasekwa	Harare West
		Warren Park Polyclinic	Harare West
		Kambuzuma Polyclinic	Harare West
		Tafara FHS	Mabvuku-Tafara
		St Mary's Polyclinic	Chitungwiza
		Hatcliffe Polyclinic	Harare North
		Epworth Polyclinic	Epworth-Ruwa
		Mbare Polyclinic	Harare South
		Mbare Hostels	Harare South
		Sunningdale Clinic	Harare South
		Waterfalls Clinic	Harare South
		Glen Norah Satellite Clinic	Highfields
		Glenview Satellite Clinic	Highfields
		Rutsanana Polyclinic	Highfields
		GlenView Polyclinic	Highfields
		Parirenyatwa Primary Care Clinic	Harare Central
		Avenues Clinic	Harare Central
		Mount Pleasant	Harare North
		Suburban Medical Centre	Harare West
		Zengeza Clinic	Chitungwiza
	Mission Hospital	Epworth Mission Hospital	Ruwa/Epworth
Mashonaland Central	Provincial Hospital	Bindura Provincial Hospital	Bindura
	District	Mvurwi	Mazowe
		Concession District Hospital	Mazowe
		Chimhanda District Hospital	Rushinga
		Shamva District Hospital	Shamva
		Mt Darwin Hospital	Mt Darwin
		Guruve District Hospital	Guruve
	Rural Hospital	Madziwa Rural Hospital	Shamva
		Rosa Rural Hospital	Mazowe
	Polyclinic/Clinic and RHC	Dotito Clinic	Mt Darwin
		Nzvimbo Clinic	Mazowe
		Chimhanda Clinic	Rushinga
		Rushinga Clinic	Rushinga
		Mukonde Clinic	Rushinga
		Chawarura Clinic	Muzarabani
		Rusambo Clinic	Rushinga
		David Neilson Clinic	Muzarabani
		Mtungagore Clinic	Mt Darwin
		Chakonda Council Clinic	Shamva
		Muzarabani RHS	Muzarabani
		Bepura Clinic	Guruve

		Trojan Clinic	Bindura

Province	**Type of Organisation**	**Name of organisation**	**District**
Mashonaland Central (contd)		Goora Clinic	Shamva
		Wadzanayi Clinic	Shamva
		Manhenga Clinic	Bindura
		Rutope Clinic	Bindura
		Chipadze Clinic	Bindura
		Bakasa Clinic	Guruve
		Chawanda Clinic	Mt Darwin
	Rural Health Centres	Muzarabani RHS	Muzarabani
		Hwata	Muzarabani
	Mission Hospital	Howard Mission Hospital	Mazowe
		Mary Mount Hospital	Rushinga
		St Albert’s Hospital	Muzarabani
		Karanda Mission Hospital	Mt Darwin
		Mazowe Citrus Estate Hospital	Mazowe
		PSMI Shashi Private Hospital	Bindura
Mashonaland East	Provincial Hospital	Marondera Provincial Hospital	Marondera
	District/General Hospital	Mutoko District Hospital	Mutoko
		Makumbe Hospital	UMP
		Mutawatawa District Hospital	UMP
		Chivhu Hospital	Chikomba
		Sadza District hospital	Chikomba
		Mudzi District Hospital	Mudzi
		Musami Hospital	Murewa
		Murewa District Hospital	Murewa
	Rural Hospital	Wedza Rural Hospital	Wedza
		Garaba Rural Hospital	Wedza
		Beatrice Rural hospital	Seke
	Clinic/Polyclinic and RHC	Nyamapanda RHC	Mudzi
		Kowoyo Clinic	Goromonzi
		Hoyuyu/Chitangazuva RHC	Mutoko
		Chihota RHC	Marondera
		Acturus Mine Clinic	Goromonzi
		Maramba Clinic	UMP
		Zhakata RHC	Seke
		Igava Clinic	Marondera
		Nhakiwa Clinic	UMP
		Nharira RHC	Chikomba
		Suswe Clinic	Mudzi
		Kawere RHC	Mutoko
		Murewa Polyclinic	Murewa
		Kunaka RHC	Seke
	Mission Hospital	St Mary’s Mission Hospital	Wedza
Matebeleland South	Provincial Hospital	Gwanda Provincial Hospital	Gwanda
	District/General Hospital	Beitbridge District Hospital	Beitbridge
		Esigodini District Hospital	Umzingwane
		Maphisa District Hospital	Matobo
		Plumtree District Hospital	Mangwe
		Filabusi District Hospital	Insiza
	Rural Hospitals	Matobo Rural Hospital	Matobo

		Kezi Rural Hospital	Matobo
		Tshelanyemba Rural Hospital	Beitbridge

Province	**Type of Organisation**	**Name of organisation**	**District**
Matebeleland South (contd)	Clinic/RHC	Zhuluba Rural Clinic	Insiza
		Tongwe Clinic	Beitbridge
		Makakabule Clinic	Beitbridge
		Dulibadzimu Clinic	Beitbridge
		Mbizingwe Clinic	Umzingwane
		Mawabeni Clinic	Umzingwane
		Nkankezi Clinic	Insiza
		Natisa RHC	Matobo
		How Mine Clinic	Umzingwane
		Habani Clinic	Umzingwane
		Tshithu Clinic	Mangwe
		Ingwizi RHC	Mangwe
		Dingumuzi Clinic	Bulilima
		Ndiweni RHC	Bulilima
		Sikhatini Clinic	Bulilima
		Stanmore RHC	Beitbridge
		Sengezani Clinic	Gwanda
		Phakama Clinic	Gwanda
	Mission Hospital	Wanezi Mission Hospital	Insiza
		Manama Mission Hospital	Gwanda
		Mtshabezi Mission	Gwanda
		Brunapeg Mission Hospital	Mangwe
Masvingo	District/General Hospital	Masvingo General Hospital	Masvingo
		Ndanga Hospital	Zaka
		Neshuro District Hospital	Mwenezi
		Chivi District Hospital	Chivi
		Chiredzi Hospital	Chiredzi
		Chikombedzi Hospital	Chiredzi
		Collin Saunders (Triangle)	Chiredzi
		Hippo Valley	Chiredzi
	Rural Hospital	Gutu Rural Hospital	Gutu
		Bikita Rural Hospital	Bikita
		Chikuku Rural Hospital	Bikita
		Chivi Rural Hospital	Chivi
	Clinic/Polyclinic and RHC	Makurira Memorial Clinic	Masvingo
		Ngomahuru RHC	Masvingo
		Zimuto Clinic	Masvingo
		Mucheke Clinic	Masvingo
		Mushandike RHC	Masvingo
		Gumbo Clinic	Zaka
		Siyawareva Clinic	Zaka
		Bota RHC	Zaka
		Matizha Clinic	Gutu
		Nhema Clinic	Bikita
		Nyika Clinic	Bikita
		Murwira RHC	Bikita
		Ngundu Clinic	Chivi
		Mandamabwe Clinic	Chivi
		Nyahombe Clinic	Chivi

		Rutenga Clinic	Mwenezi
		Chimbudzi Clinic	Mwenezi
		Chizvirizvi Clinic	Chiredzi
		Chingele Clinic	Chiredzi
		Muhlanguleni Clinic	Chiredzi

Province	**Type of Organisation**	**Name of organisation**	**District**
Masvingo(contd)	Mission Hospital	Musiso Mission Hospital	Zaka
		Mukaro Mission Hospital	Gutu
		Gutu Mission Hospital	Gutu
		Silveira Mission Hospital	Bikita
		Mashoko Mission Hospital	Bikita
		Matibi Mission Hospital	Mwenezi
		Maranda Mission Hospital	Mwenezi
		Lundi Mission Clinic	Mwenezi
		Morgenster Mission Hospital	Masvingo
Bulawayo	Central Hospital	Ingutsheni Central Hospital	Nkulumane
		Mpilo Central Hospital	Bulawayo North
	District/General Hospital	Mater Dei Hospital	Bulawayo South
		United Bulawayo Hospital	Bulawayo South
	Private Hospital/Nursing Home	Dr Shenan	Bulawayo South
		Thembelihle Nursing Home	Luveve
		Hillside Nursing Home	Bulawayo South
		EF Watson	Emakhandeni
		Princess Margaret Rose	Bulawayo South
	Clinic	Cowdray Park Clinic	Luveve
		Luveve Clinic	Luveve
		Entumbane	Emakhendani
		Pelandaba Clinic	Emakhendani
		Njube	Emakhendani
		Emakhendani Clinic	Emakhendani
		Pumula	Magwegwe
		Pumula South Clinic	Magwegwe
		Magwegwe Clinic	Magwegwe
		Khami Road Clinic	Bulawayo North
		Mzilikazi Clinic	Bulawayo North
		Northern Suburbs Clinics	Bulawayo North
		Maqhawe	Nkulumane
		Nkulumane Clinic	Nkulumane
		Tshabalala Clinic	Nkulumane
		Nketa Clinic	Nkulumane
Manicaland	District/General Hospital	Chimanimani Hospital	Chimanimani
		Nyanga District Hospital	Nyanga
		Rusape General Hospital	Makoni
		Bonda Hospital	Mutasa
		Murambinda District Hospital	Buhera
	Rural Hospital	Buhera Rural Hospital	Buhera
		Weya Rural Hospital	Makoni
	Clinic and RHC	Bumba RHC	Chimanimani
		Sakupwanya RHC	Mutasa
		Munyanyi Clinic	Buhera
		Chinyamukwakwa Clinic	Chipinge
		Headlands Clinic	Makoni

	Mission Hospital	Regina Coeli	Nyanga
		St Peters Mission Hospital	Chipinge
		Elim Mission Hospital	Nyanga
		Mount Selinda Mission Hospital	Chipinge
		Mutambara Mission Hospital	Chimanimani

Province	**Type of Organisation**	**Name of organisation**	**District**
Mashonaland West	Provincial Hospital	Chinhoyi Provincial Hospital	Makonde
	District/General Hospital	Kadoma General Hospital	Kadoma
		Banket District Hospital	Zvimba
		Chegutu District Hospital	Chegutu
		Kariba District Hospital	Kariba
		Karoi Hospital	Hurungwe
	Rural Hospital	Ngezi Rural Hospital	Kadoma
		Darwendale Rural Hospital	Zvimba
		Zvimba Rural Hospital	Zvimba
		Musami Rural Hospital	Hurungwe
		Hurungwe Rural Hospital	Hurungwe
		Siakobvu Rural Hospital	Kariba
	Clinic/Polyclinic and RHC	Sanyati Clinic	Kadoma
		Domboshava RHC	Kadoma
		Waverly Clinic	Kadoma
		Kuwadzana Clinic	Zvimba
		Zvipani Clinic	Hurungwe
		Trelawney Clinic	Zvimba
		Alaska Clinic	Makonde
		Murereka RHC	Makonde
		Zvimbara Clinic	Makonde
		Umboe Clinic	Makonde
		Chikangwe Clinic	Hurungwe
		Mola RHC	Kariba
		Kanyati RHC	Kariba
		Mahombekombe Clinic	Kariba
		Nyamhunga Clinic	Kariba
		Pfupajena Clinic	Chegutu
		Selous Clinic	Chegutu
		Norton Clinic	Chegutu
		Chegutu Rural Council Clinic	Chegutu
		Msengezi Clinic	Chegutu
	Mission/Church Hospital	Chidamoyo Christian Hospital	Hurungwe
		St Rupert Mission Hospital	Makonde
		Father Oltea Memorial Hospital	Zvimba
		Sanyati Mission Hospital	Kadoma
		Makonde Christian Hospital	Makonde
		St Michael’s Mission Hospital	Kadoma
Matebeleland North	District/General Hospital	Inyati District Hospital	Bubi
		Nkayi District Hospital	Nkayi
		Victoria Falls Hospital	Hwange
		Binga District Hospital	Binga
		Tsholotsho District Hospital	Tsholotsho
		Sipepa District Hospital	Tsholotsho

	Rural Hospital	Lukosi Rural Hospital	Hwange
		Nyamandlovu Rural Hospital	Umguza
	Private Hospital	Hwange Colliery Hospital	Hwange

Province	**Type of Organisation**	**Name of organisation**	**District**
Matebeleland North (contd)	Clinic and RHC	Fingo Rural Clinic	Umguza
		Siganda Council Clinic	Bubi
		Mbembeswana Clinic	Bubi
		Zenka Clinic	Nkayi
		Zinyanjeni Council Clinic	Nkayi
		Sesemba RHC	Nkayi
		Jotsholo Clinic	Lupane
		Lupane RHC	Lupane
		Fatima Clinic	Lupane
		Mabale RHC	Hwange
		Pete Clinic	Hwange
		Tinde Clinic	Binga
		Chinego Clinic	Binga
		Sianziundi Clinic	Binga
		Madlangombe Clinic	Tsholotsho
		Tsholotsho Council Clinic	Tsholotsho
		Sikente Council Clinic	Tsholotsho
		Ntabazinduna Clinic	Umguza
		Muntu Clinic	Umguza
		Mdutshane/Sikhuni RHC	Bubi
	Mission Hospital	Mbuma Mission Hospital	Nkayi
		St Pails Rural Hospital	Lupane
		St Luke’s Mission	Lupane
		Kamativi Mission Hospital	Hwange
		St Patrick’s Mission	Hwange
		Lukunguni Mission Clinic	Hwange
		Kariyangwe Mission Hospital	Binga
Midlands	Provincial Hospital	Gweru Provincial hospital	Gweru
	District/General Hospital	Kwekwe General Hospital	Kwekwe
		Gokwe District Hospital	Gokwe South
		Zvishavane District Hospital	Zvishavane
		Mberengwa District Hospital	Mberengwa
		Shurugwi Hospital	Shurugwi
		Mvuma District Hospital	Mvuma
	Rural hospital	Lundi Rural Hospital	Zvishavane
		Jeka Rural Hospital	Mberengwa
		Zvamavande Rural Hospital	Shurugwi
		Svika Rural Hospital	Shurugwi
		Chilimanzi Rural Hospital	Mvuma
	Clinic/Polyclinic and RHC	Gomola RHC	Kwekwe
		Redcliffe Clinic	Kwekwe
		Al davies Clinic	Kwekwe
		Mbizo II Clinic	Kwekwe

		Mangwandi Clinic	Gweru
		Maboleni clinic	Gweru
		Mkoba Polyclinic	Gweru
		Makepesi Clinic	Gweru
		Mapanzure Clinic	Zvishavane
		Msipani/Maketo RHC	Zvishavane
		Mandava Clinic	Zvishavane
		Mposi Clinic	Mberengwa
		Mataga RHC	Mberengwa

Province	**Type of Organisation**	**Name of organisation**	**District**
Midlands(contd)		Maziofa Clinic	Mberengwa
		Gumunyu RHC	Gokwe North
		Kadzirire RHC	Gokwe North
		Kuwirirana RHC	Gokwe North
		Goredema RHC	Gokwe North
		Cheziya Clinic	Gokwe South
		Chizhou Clinic	Mvuma
		Chemahororo RHC	Gokwe South
		Nyanje RHC	Gokwe South
		Svisvi RHC	Gokwe South
		Tongogara Clinic	Shurugwi
		Makusha Clinic	Shurugwi
		Lynwood Clinic	Mvuma
	Mission Hospital	Zhombe Mission	Kwekwe
		Lower Gweru Mission	Gweru
		Mnene Mission Hospital	Mberengwa
		Musume Mission Hospital	Mberengwa
		Mtora Mission Hospital	Gokwe North
		Chireya Mission hospital	Gokwe North
		Kana Mission Hospital	Gokwe South
		Sasame Baptist Mission	Gokwe South
		Hanke Mission Clinic	Shurugwi
		St Theresa Hospital	Mvuma
		Holy Cross Mission	Mvuma
	Private Hospital	Clay Bank Hospital	Gweru
		Shabani Mine Hospital	Zvishavane
		Muonde	Mvuma

Annex 4: Research Team

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