2016

ZHCT

Strengthening community-health facility linkages

Zimbabwe HIV Care and Treatment Project Baseline Assessment Report

" CARG members in Chipinge meet for drug refill in the community. Photo Credits// FHI 360 Zimbabwe"

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FOREWORD

The Government of Zimbabwe (GoZ) through the Ministry of Health and Child Care (MoHCC) is committed to strengthening the linkages between public health facilities and communities for HIV prevention, care and treatment services provision in Zimbabwe. The Ministry acknowledges the complementary efforts of non-governmental organisations in consolidating and scaling up community based initiatives towards achieving the UNAIDS '90-90-90' targets aimed at ending AIDS by 2030. The contribution by Family Health International (FHI360) through the Zimbabwe HIV Care and Treatment (ZHCT) project aimed at increasing the availability and quality of care and treatment services for persons living with HIV (PLHIV), primarily through community based interventions is therefore, lauded and acknowledged by the Ministry.

As part of the multi-sectoral response led by the Government of Zimbabwe (GOZ), we believe the input of the ZHCT project will strengthen community-based service delivery, an integral part of the response to HIV. The Ministry of Health and Child Care however, has noted the paucity of data on the cascade of HIV treatment and care services provided at community level and the ZHCT baseline and mapping assessment provides valuable baseline information which will be used to measure progress in this regard. We believe the community based evidence on the provision of HIV treatment and care services, will inform development effective policies and services. The study targeted 126 health facilities in eight districts of Manicaland (Buhera, Chipinge, Makoni, Mutare, and Mutasa) and Midlands (Gokwe South, Gweru, and Kwekwe) provinces in Zimbabwe. These are health facilities with high numbers of PLHIV receiving HIV services.

The report highlights four key findings which are critical in improving HIV treatment and care services of PLHIV. First, the baseline report highlights that more female clients are reached with HIV services across all districts. This has also been confirmed in the ZIMPHIA which indicated that more females are aware of their HIV status as compared to males. There is therefore need for innovative approaches to reach more males with HIV services. Second, in order, to reach more at- risk clients or those already infected, the report suggests improved targeting particularly in Manicaland province where programmatic positivity rate (5.9%) is lower than the Provincial HIV Prevalence of 14.1%. Third, in Midlands, fewer clients were enrolled and initiated on ART as compared to Manicaland. This could be attributed to fewer implementing partners in Midlands. Fourth, viral load testing is extremely low, with only 6.1% of PLHIV accessing this important service. Scaling up of viral load services is vital across the two provinces so that the quality of HIV services can be objectively assessed. These services are almost none-existent in Manicaland.

This report provides a basis on which we can evaluate the progress on closing the gap in the provision and strengthening HIV services in the selected districts. It will be a vital document for future evaluation of HIV services in these two provinces and we encourage all stakeholders to make use of the information provided in this report.

Dr. Owen M. Mugurungi

Director, AIDS & TB Unit: Ministry of Health and Child Care

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CONTENTS

Executive Summary

HIV testing and counseling (HTC) services act as critical gateway to testing, early diagnosis and treatment. In Zimbabwe, access to knowledge of one's HIV status has mainly been through client initiated voluntary counseling and testing (VCT) and provider initiated testing and counselling (PITC). There are new opportunities which can lead to rapid scale-up of HTC services and linkage of those in need to care and treatment. ART coverage among adults rose very rapidly since the programme started, reaching 85%, (82 – 89%) coverage among adults by December 2012. By June 2015, approximately 842,372 PLHIV were on ART.

The United States Agency for International Development (USAID-Zimbabwe) funded Family Health International (FHI 360) in September 2015 with a five-year project called Zimbabwe HIV Care and Treatment (ZHCT) Project. ZHCT is implemented in a phased approach starting with eight scale-up districts located across two provinces – Manicaland and Midlands – with scale-up to 5 additional districts. These are among the 36 districts with 80% of PLHIV in Zimbabwe. ZHCT implements its services in the catchment areas of facilities which are considered to be high-volume sites with over 200 ART patients. ZHCT's baseline assessment will enable the identification of service gaps in the HIV Cascade in order to develop and implement measures to reduce attrition rates during the five-year period of performance.

This was a descriptive study design using mixed quantitative and qualitative methods to establish the HIV cascade and describe the perspectives of key stakeholders on existing HIV services in target areas. Data were obtained through review of the patients' records, in-depth interviews with key informants (KIIs) and focus group discussions (FGDs). The study targeted health facilities in eight districts of Manicaland (Buhera, Chipinge, Makoni, Mutare, and Mutasa) and Midlands (Gokwe South, Gweru, and Kwekwe) provinces in Zimbabwe. A total of 126 health facilities were included in the data extraction portion of this baseline assessment.

HIV positivity rates among individuals tested and counseled for HIV in supported Manicaland and Midlands facilities was found to be 5.9% and 9.3%, respectively. While is it expected that programmatic positivity rates are below HIV prevalence rates (14.1% in Manicaland and 15.5% in Midlands), evidence supports the need to increase targeting of individuals at highest risk for infection or are already infected. This is particularly true in Manicaland where the programmatic positivity rate among supported facilities is much smaller.

Of those testing HIV-positive, 84.2% of PLHIV were enrolled in care and 70.4% were initiated on HIV treatment (97.2% and 78.0% in Manicaland; 74.2% and 64.5% in Midlands). These data show that there are still gaps in HIV care and treatment coverage in supported facilities, particularly in Midlands where the gap is larger, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is extremely poor, with only 6.1% of PLHIV across ZHCT supported sites having been tested. In fact, viral load testing was only conducted in Manicaland, where district-wide coverage of viral load testing ranged from 0.3% of PLHIV in Chipinge to 29.9% of PLHIV in Buhera. Of those that had viral load tests performed, viral suppression was fairly high at 74.6%; however, it still falls short of UNAIDS's third target of 90% viral suppression. Given the low access to viral load testing, it is difficult to determine the true level of viral supression among PLHIV in the community. Expansion of viral load machines and utilisation is urgently needed to determine the impact of HIV services in Zimbabwe.

Introduction

The global burden of HIV is unevenly distributed, with sub-Saharan Africa having the greatest share of the spread and sequelae of the pandemic[1,2]. An estimated 24.7 million people living with HIV (PLHIV) are in sub-Saharan Africa accounting for almost 71% of the global HIV burden[3]. The emergence of antiretroviral therapy (ART) transformed HIV from a terminal illness to a chronic disease[4,5] and has resulted in significant decreases in HIV-related morbidity and mortality; however, good clinical outcomes depends on entry into and retention along the HIV continuum of care – specifically, diagnosis, linkage to clinical care, disease-stage monitoring, initiation of ART, and high rates of adherence to ART. Despite the massive scale-up of national HIV testing programs, studies suggest that up to 80% of HIV-infected adults do not know their status in some sub-Saharan African settings, although rates of testing vary substantially by country[3,5].

Generally, in low- and middle-income countries (LMIC), access to ART has dramatically expanded in the last decade, yet it is estimated that only 47% of adults and 23% of children who are eligible are accessing treatment[6]. In most of these countries, the effective tracking and monitoring of HIV infected patients presents a daunting challenge that urgently need to be addressed. This has compromised the quality of HIV care programmes in the sub-Saharan Africa region[1]. There is a myriad of barriers to retention along the HIV continuum and these are setting specific. As such, improving clinical outcomes will require interventions that address the specific barriers at each level of action while also considering how these barriers operate at the multiple stages of treatment, across different contexts, and among diverse populations.

Zimbabwe, with an estimated population of 13 million, has an estimated 1,425,762 PLHIV[7]. Of these, 1,323,437 are reported to be in need of antiretroviral treatment (ART)[7]. About 55% of PLHIV are women, while less than 10% are children under 15 years old[7]. In April 2004, the National ART program in Zimbabwe began to implement a comprehensive care and support package that addresses the medical, social, emotional, and economic needs of PLHIV. The Ministry of Health and Child Care (MOHCC), through the AIDS and TB Unit, implements programs aimed at HIV prevention, care treatment, support, and mitigation. The Government of Zimbabwe collects an AIDS Levy which is 3% of payee and corporate tax and is directly remitted on a monthly basis to the National AIDS Council NAC). The AIDS levy is the major contributor of domestic funding for the national response. Additional funding from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR), and other donors, help the MOHCC and NAC to strengthen and scale-up the ART program in Zimbabwe.

HIV testing and counseling (HTC) services act as critical gateway to testing, early diagnosis and treatment. In Zimbabwe, access to knowledge of one's HIV status has mainly been through client initiated voluntary counseling and testing (VCT) and provider initiated testing and counselling (PITC). There are new opportunities which can lead to rapid scale-up of HTC services and linkage of those in need to care and treatment. In the 2015 Zimbabwe Demographic and Health Survey[9], knowledge of HIV prevention has increased mostly among men, with 85% of men and 79% of women aged 15-49 knowing that using condoms and limiting sexual contact to only one faithful and uninfected partner helps prevent contracting HIV, compared to 79% and 77% respectively in 2010[9,10]. While 95% of men reported knowing where to get an HIV test, men report lower levels of past HIV testing and receipt of their results (62%)[9]. The percentage of women who were tested for HIV in the past 12 months and received the results had increased from 34 percent in 2010-11 to 49 percent in 2015 while among it rose from 21% to 36%[9,10].

ART coverage among adults rose very rapidly since the programme started, reaching 85%, (82 – 89%) coverage among adults by December 2012[8]. By June 2015, approximately 842,372 PLHIV were on ART[8]. This rapid scale up has been mostly attributed to widespread decentralisation that has taken place throughout the country with the number of facilities offering ART services increasing from 282 (17%) in December 2008 to 1592 in June 2015 (94%) of all public sector health facilities[8]. Patients on treatment for HIV do not pay for services related to HIV care including ART medicines in all public health facilities.

United States Agency for International Development (USAID-Zimbabwe) funded Family Health International 360 (FHI 360) in September 2015 with a five-year project called Zimbabwe HIV Care and Treatment (ZHCT) Project. FHI 360 is the prime partner and Plan International is a sub-awardee. ZHCT aims to increase the availability and quality of care and treatment services for persons living with HIV and AIDS (PLHIV), primarily through community based interventions that complement the public health sector as part of the multi-sectoral response led by the Government of Zimbabwe (GOZ). The main goals of the project are: (i) to increase the availability of quality comprehensive care and treatment services for HIV-positives at community level and (ii) to strengthen community-level health systems to monitor, track and maintain PLHIV in care. These are in line with the PEPFAR/Zimbabwe Country Operational Plan (COP) 2015 which recognizes community-based care and support activities as crucial in ensuring adherence to therapy and retention within treatment programs[11].

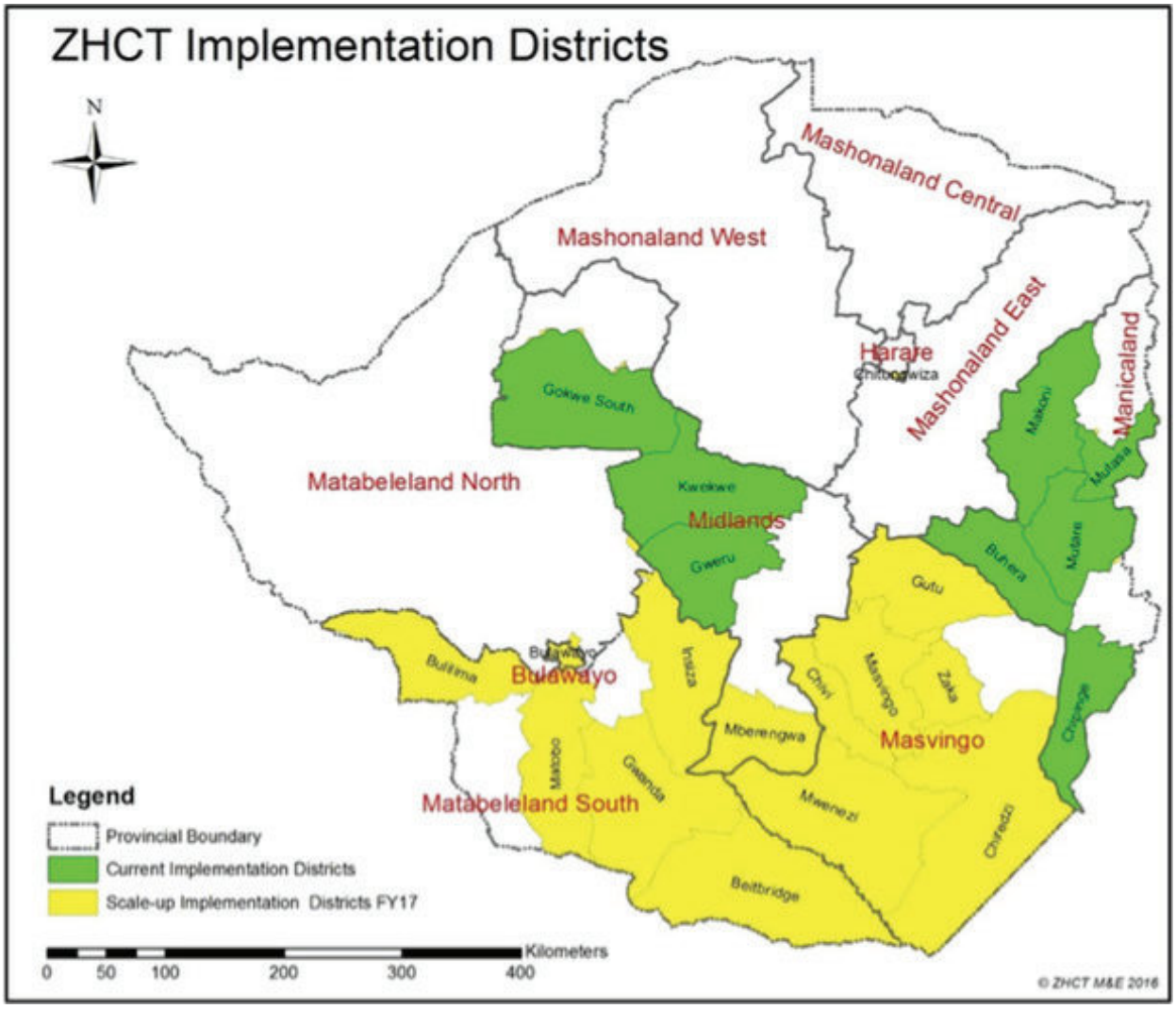
Through its objectives, ZHCT will contribute to the GOZ's efforts to reach the '90-90-90' UNAIDS goals[12] by consolidating and scaling up community based activities while targeting priority groups such as adolescents and the male population. In Uganda[13] as well as Zambia14 the uptake of HTC services through home-based interventions were much higher than the traditional facility based approach. Although this could be a novel approach to reach the first UNAIDS target, there is growing evidence that individuals testing positive are not effectively linked to care, resulting in only 30% – 62% being linked[4]. Data on retention in care is also concerning such that data from 15 large-scale HIV treatment programs in LMIC revealed an average of 21% of patients were lost to follow-up by 6 months and 4% were lost after receiving their first ART prescription[15]. Zimbabwe is reported to have limited data on linkage to care, adherence, and viral suppression[16]. Considering the high attrition rates from one step to the other in HIV care and treatment services[16], programmers should put measures to monitor and reduce leakages in this cascade.

ZHCT's core activities are:

1. HIV testing services including HIV testing for households of index cases, using PMTCT, VMMC, OI, TB, OVC and Outreach as platforms for identification of positives.
2. Preparation of PLHIV for enrolment into care and treatment including disclosure support.
3. Linkage to care for positives identified and ensuring referral completion through working with Village Health Workers (VHWs) and other community based health workers.
4. Adherence support including the following; adherence counselling, defaulter detection and tracking with linkage to care.
5. Facilitation of the formation of ART refill clubs and support groups.

ZHCT mechanism is implemented in a phased approach starting with eight scale-up districts located across two provinces – Manicaland and Midlands in financial year 2016 and then scaled-up to 14 additional districts in two and half provinces as shown in Figure 1. These are among the 36 districts with 80% of PLHIV in Zimbabwe and are currently supported in the PEPFAR 3.0 strategy[11]. ZHCT implements its services in the catchment areas of facilities which are considered to be high-volume sites (tier 1 &2)[11], thus sites with over 200 ART patients. In order to achieve the above mentioned goals, FHI 360 works in partnership with Organization for Public Health Interventions and Development (OPHID) who is currently providing technical assistance at the facility level within these districts.

Figure 1. Map of ZHCT Implementation Districts



Justification

ZHCT's baseline assessment will enable the identification of service gaps in the HIV Cascade in order to develop and implement measures to reduce attrition rates during the five-year period of performance. The assessment had the following specific objectives:

1. To understand the baseline data in relation to the HIV care cascade, including testing and treatment in target areas, by age and gender
2. To map the project sites and key stakeholders delivering relevant HIV and AIDS services in target areas
   To identify high burden areas within a district for targeted interventions
3. To gain community leaders, district government, facility and NGO service providers perspectives on existing
4. HIV services in target areas, including barriers and facilitators to
   service utilization and treatment adherence for men and women, adults and youth
5. To use the findings to guide ZHCT project implementation

SECTION 2.

Research Methodology

Study Design

This was a descriptive study design using mixed quantitative and qualitative methods to establish the HIV cascade and describe the perspectives of key stakeholders on existing HIV services in target areas. Data were obtained through review of the patients' records, in-depth interviews with key informants (KIIs) and focus group discussions (FGDs). In addition, facilities and other areas of interest (e.g. police stations, churches etc.) were physically mapped.

Study Sites and Population

The study targeted health facilities in eight districts of Manicaland (Buhera, Chipinge, Makoni, Mutare, and Mutasa) and Midlands (Gokwe South, Gweru, and Kwekwe) provinces in Zimbabwe. A total of 126 health facilities, which are classified by the number of ART patients into Tier 1 (over 1,500 patients) and 2 (between 200 and 1,499 patients), were included in this data extraction portion of this baseline assessment. These are the health facilities with the communities which are supported by ZHCT project. Key informants selected included community leaders, district health executives and representatives of NGOs and public health facilities were targeted. Focus group discussions were conducted with PLHIV and community-based health workers (CBHW).

Sample Size

A convenience sampling approach was used to identify participants for the KIIs and FGDs. This approach was selected to enable FHI 360 to develop a good understanding of HIV service provision in the two provinces by engaging participants who were knowledgeable and were willing to share their perspectives. A total of 126 facilities were sampled for the KIIs with health officers. To sample for the FGDs, facilities were ranked according to the number of clients on ART and only those with 500 and above were selected; participants were then purposefully selected from the communities under the catchments of these facilities. The same communities were selected for KIIs with community leaders. Districts with more than half of the ZHCT supported facilities with clients less than 500 had each one FGD each for PLHIV and CBHW while the other districts had two each (see Table 1). All Tier 1 and 2 facilities (129) were included for the data extraction.

Participant Recruitment

Permission to conduct KIIs with representatives of provinces, districts, facilities, community leaders and non-governmental organizations (NGOs) was sought from the Provincial Health Executives (PHEs) and NGO directors. Upon receiving permission letters, the assessment team made appointments for the interviews via a phone call or an email with the nominated representatives of the NGOs, PHEs, and district and facility health officers. The assessment team (interviewer) then physically visited the key informant for an in-depth interview. In an event the participant did not show up on the first appointment the team rescheduled the appointment.

The assessment teams made arrangements with representatives of the selected facilities to assist with participant selection of PLHIV and CBHCs. The PLHIV were individuals who were receiving their HIV services from these facilities while CBHCs were those assisting these facilities with community HIV activities. Schedules were made with the community leaders and were visited at their places of preference. All potential participants were led through a proper informed consent process prior to data collection.

Table 1 Summary of the selection of Participants for Interviews

Key Informants	Expected Number of Individuals	Data Collection Method	Inclusion Criteria
Representatives of HIV NGO operating in Manicaland and Midlands*	10 (1 per organization)	In-depth Interview	1. Have oversight of HIV programs in these districts 2. Aged ≥ 18 years 3. Provide written consent 4. Have been in their current role for at least 6 months
Provincial Medical Directors or Provincial Nursing Officers (PMD/PNO)	2 (one from each province)		
District Medical Officer/DNO	8 (one from each ZHCT district)		
District Community Nurse	8 (one from each district)		
District AIDs Coordinator	8 (one from each district)		
Health Facility Managers	129 (one from each site)		
Community Leaders (Chiefs, Headmen, Traditional leaders, Political leaders, Religious leaders)	9		1. Willing to provide written consent 2. Aged ≥ 18 years 3. Have been residing in the community for at least 6 months
Community Stakeholders (PLHIV community based health cadres (CBHC))	One group each with PLHIV and CBHC per district in Gokwe South, Chipinge, Mutare and Mutasa. Two groups with PLHIV and CBHC per district in Buhera, Makoni, Kwekwe and Gweru. Each of these groups had 8-10 participants.	Focus Group Discussion	1. Aged ≥ 18years 2. Provide written consent for participation in the assessment and audio recording during data collection 3. Community leaders have resided in the community for 6 months 4. Community leaders held their positions in that community for at least 6 months 5. PLHIV have been living with HIV for at least 6 months.

**Plan International; Organization for Public Health Interventions and Development; Zimbabwe Private Sector HIV and Wellness Board; Zimbabwe national Network of People Living with HIV; Regional Psychosocial Support Initiative; Zimbabwe AIDS Network; Students and Youths Working on Reproductive Health Action Team; Centre for Sexual Health and HIV/AIDS Research Zimbabwe; Population Services International; Family AIDS Caring Trust.*

Data Collection Methods

This study used standardized data extraction sheets, KII questionnaires, and FGD guides. The study was conducted from the May 16th to July 8th 2016.

Interviewer and Data Extractor Training

The interviewers and data clerks were trained on different aspects of the protocol so that they have skills required to effectively carry out their roles in the survey. Interviewers and field supervisors were trained on how to recruit and consent prospective participants, how to conduct FGDs and interviews with key informants using the tools developed specifically for the assessment. In addition, the field supervisors were trained on organizing, coordinating and supervising data collection activities in their respective sites, including data verification and how to remotely transfer assessment data from their site to the provincial and central office. Role plays were core in this training.

Pre-testing

A pre-test of the baseline assessment tools was conducted in the district which was not under the assessment. Three health facilities were selected in the district in consultation with the DistrictMedical Officer and data collection teams who had been trained on the different tools were assigned to collect data. Key informant interviews were conducted with MOHCC staff at district and health facility level, NGO representative and community leader. Two FGDs were conducted with PLHIV and CBHWs at two facilities. A feedback session was then conducted and gaps were addressed. The data collectors were also trained on the use of the GPS machines for coordinates collection.

Data Entry

Data extracted from the facility registers was captured into a database system developed in in MS SQL Server with a web based system for interfacing between the data capture clerk and the database. Using defined user roles limited to data entry only, each clerk was restricted to their data that they capture. An audit of each entry was kept so as to keep track of progress for each clerk for progress monitoring purposes. An excel sheet was developed to capture data from representatives of facilities. Data from FGDs and in-depth interviews was translated and transcribed by the interviewers from Shona and Ndebele to English. Transcript were verified to ensure headings and content are correct. Once data was translated, transcribed and verified, audio recordings were deleted from the recording devices.

Data Analysis

Queries were developed to present data in different layouts that will make it easy to perform data analysis. Data from facility registers and representatives of facilities were exported into MS Excel for data analysis. Coding of qualitative data was done with thematic coding thus with general topics or categories. Common themes from qualitative data were analysed using content analysis grouped and quantified according to the volume of similar responses. District, provincial and national tables, charts, and thematic areas were produced. The charts included cascades in the continuum of HIV care. These generated cascades will be used as baseline data for the subsequent evaluations of the project which could be midterm and end term evaluations.

GIS mapping data

Geographic information system (GIS) is one of the most useful techniques in analysing and mapping targeted areas. ArcGIS 10.3 was used to analyse and develop maps. Colour coding on the maps, was done for all levels. Sites of interest mapped include: health facilities, civil society organizations, OVC sites, police stations, churches, schools, prison camps etc.

Ethical Considerations

The study was conducted in compliance with ethical guidelines, after permission was obtained from the Ministry of Health and Child Care (MoHCC), Medical Research Council of Zimbabwe (MRCZ) and FHI 360's Institutional Review Board (IRB). Further fieldwork clearance was obtained from relevant local authorities and leadership at district sites, and followed the necessary clearance protocol.

Study Limitations

The findings are limited to the selected health facilities and their catchment areas in the eight programmatic districts and cannot be generalized to other facilities in Zimbabwe. The study used service data that was extracted from the 126 health facilities; however, the project was not able to verify the accuracy and completeness of the data. As such, data are subject to the quality of data available.

Results
ZHCT PROJECT LEVEL

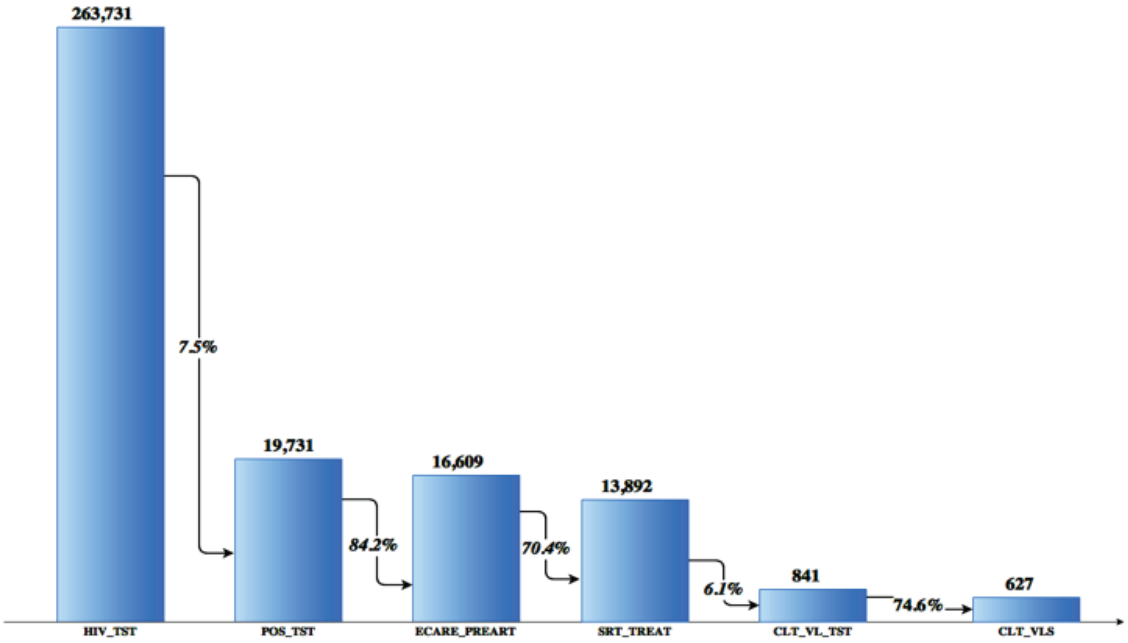
HIV CASCADE ANALYSIS

Across all ZHCT's supported 126 health facilities, a total of 263,731 individuals were tested, 7.5% (19,731) of whom were identified as HIV positive (Figure 2). HIV prevalence in Manicaland and Midlands is 14.1% and 15.5%, respectively7. While it is expected that programmatic HIV positivity rates are lower than HIV prevalence, the positivity rates in both Manicaland (5.9%) and Midlands (9.3%) are far below adequate (data not shown), indicating that current HIV testing strategies are not reaching those highest at risk for infection or are already infected.

Of those testing HIV-positive, 84.2% of PLHIV were enrolled in care and 70.4% were initiated on HIV treatment. These data show that there are gaps in HIV care and treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV. Access to viral load testing is extremely poor, with only 6.1% of PLHIV across ZHCT supported sites having been tested. In fact, viral load testing was only conducted in Manicaland, where district-wide coverage of viral load testing ranged from 0.3% of PLHIV in Chipinge to 29.9% of PLHIV in Buhera (refer to district-level cascades).

Of those that had viral load tests performed, viral suppression was fairly high at 74.6%; however, it still falls short of UNAIDS's third target of 90% viral suppression. Given the low access to viral load testing, it is difficult to determine the true level of viral supression among PLHIV in the community. Expansion of viral load machines and utilisation is urgently needed to determine the impact of HIV services in Zimbabwe.

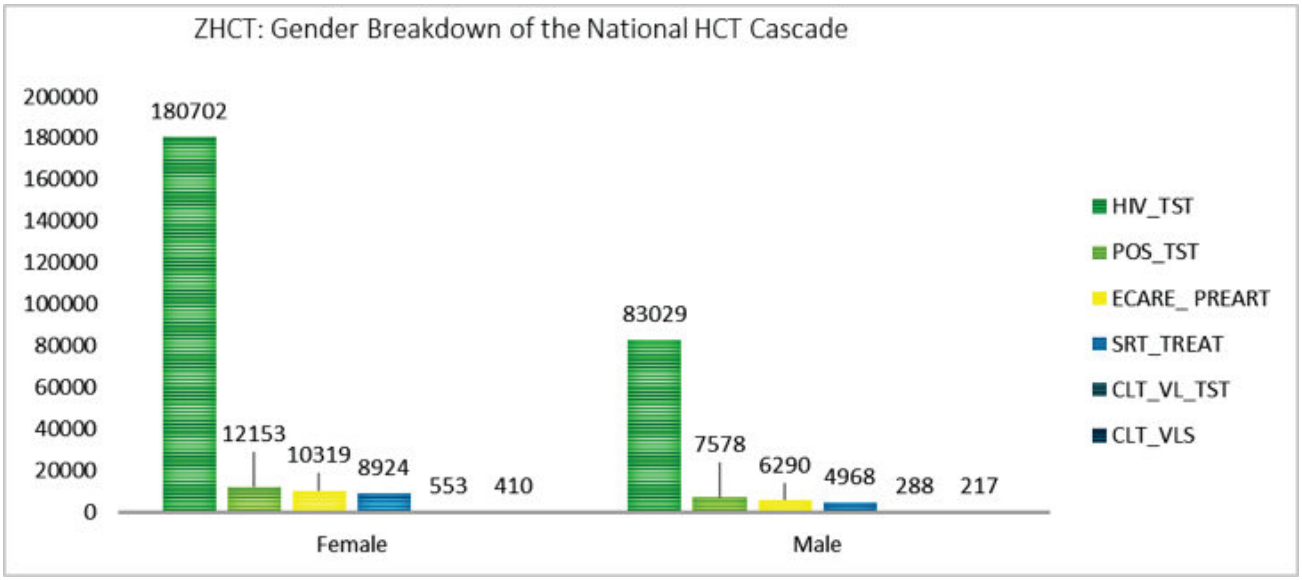
FIGURE 2: HIV CASCADE IN ZHCT SUPPORTED FACILITIES



The HIV cascade is slightly varied by gender, as seen in Figure 3. Programmatic positivity rates vary by gender, with 6.7% of females tested being infected with HIV compared to 9.1% of men. This indicates that there is a large number of low-risk women who are being tested for HIV, whereas men are more

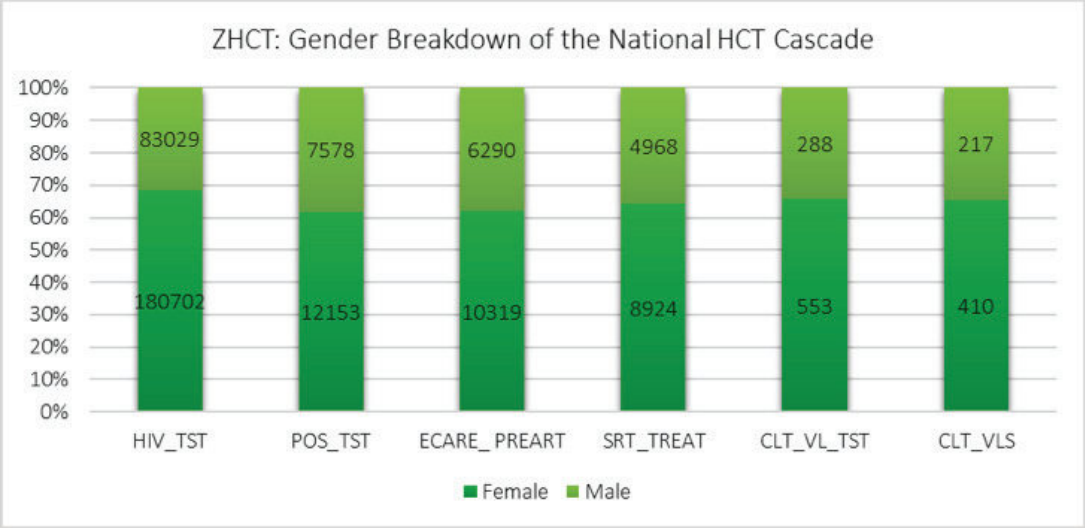
likely to be HIV positive when acessing services. Enrolment into care by both genders is high, with over 80% of female and male PLHIV being effectively linked. ART intiation varies by gender, with 73.4% of female PLHIV and 65.6% of male PLHIV being intiated on treatment. Access to viral load testing and viral supression is comparable between genders.

FIGURE 3: HIV CASCADE BY GENDER



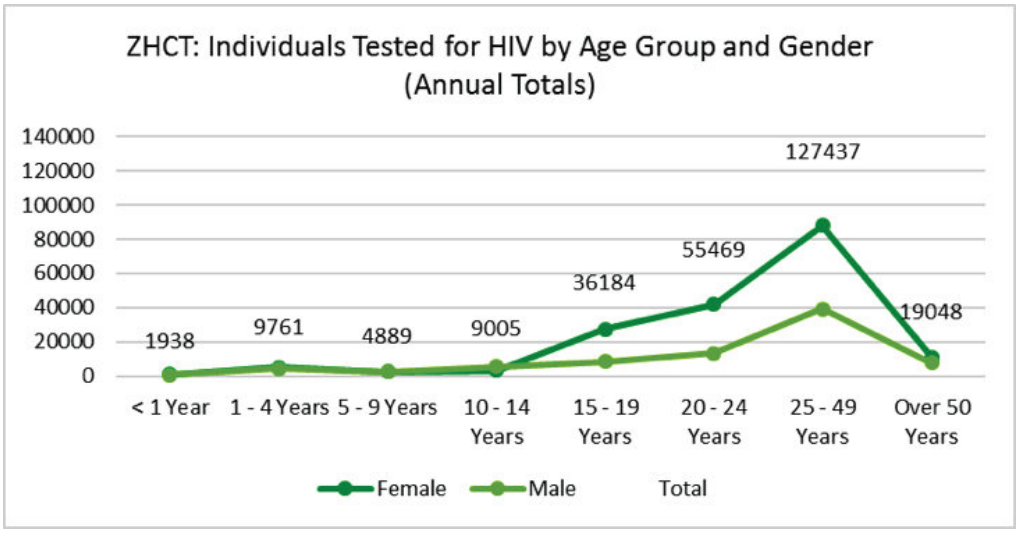
Across ZHCT supported districts, about 52.0% of the total population is female and 48% of the population is male7. However, service utilisation varies from this gender distribution among the population, with more females utlising services compared to males. Breakdown of the HIV cascade by gender (Figure 4) shows that roughly two-thirds of individuals who utlised services along the HIV cascade are female, showing that there is prevasive gender inequity in service utilisation. Data disaggregated by province are similar to that observed for all ZHCT supported facilities (data not shown). This observation is common in terms of health utlisation, whereby more females tend to seek health care compared to males.

FIGURE 4: GENDER BREAKDOWN OF THE NATIONAL HIV CASCADE



As shown in Figure 4, inequity in service utilisation is observed at entry into HIV services, HIV testing. Upon analysis by age group, it is apparent that the extent of gender inequity varies by age group (Figure 5). Looking at HIV testing alone, service utilization looks fairly equal among young (14 years and younger) and older (50 years and older) age groups. However, among youth and adults aged 15 – 49, where the majority of HIV testing occurs, there are notable differences in HIV testing numbers.

FIGURE 5: HIV TESTING, PLHIV, AND ART INITIATION BY AGE GROUP AND GENDER



Service utlisation along the cascade is evenly distributed between female and male children aged less than one year, 1 – 4 years, and 5 – 9 years of age (data not shown). The discrepency in service utlisation is highest among adolescents aged 15 – 19 years and 20 – 24 years, whereby females account for about three-quarters of those access services along the cascade (Figures 6 and 7).

FIGURE 6: GENDER BREAKDOWN OF THE NATIONAL HIV CASCADE AMONG YOUTH AGED 15 – 19 YEARS

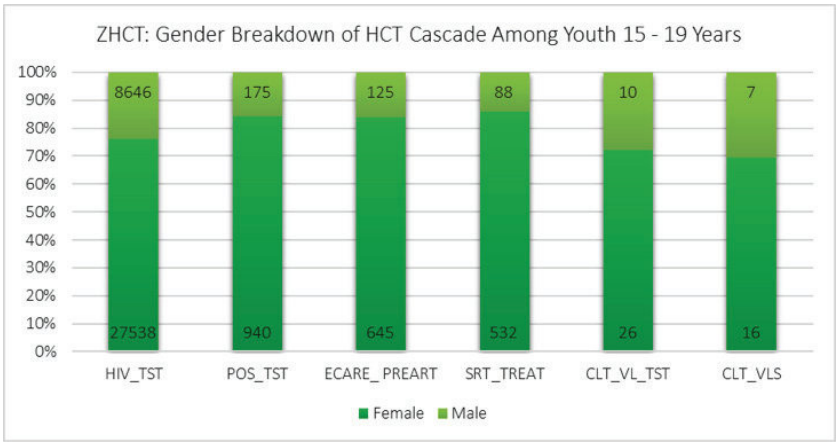
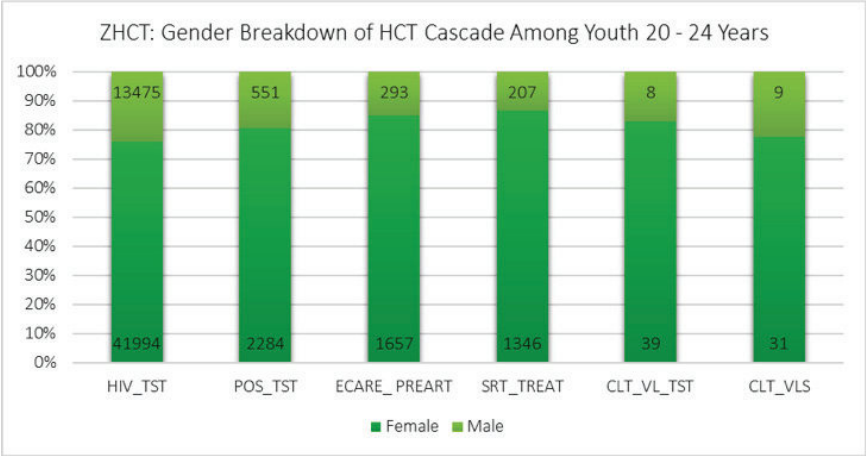


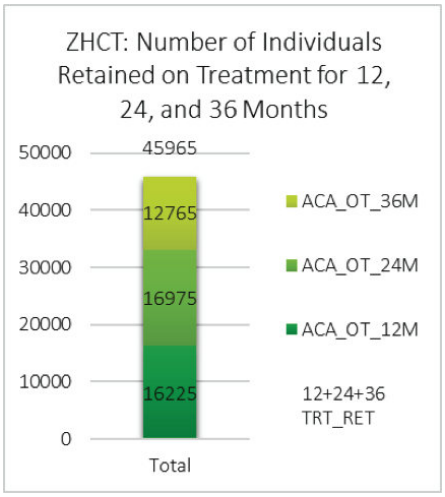
FIGURE 7: GENDER BREAKDOWN OF THE HIV CASCADE AMONG YOUTH AGED 20 – 24 YEARS



ART Retention, Lost-to-Follow Up, Defaulters, and Death

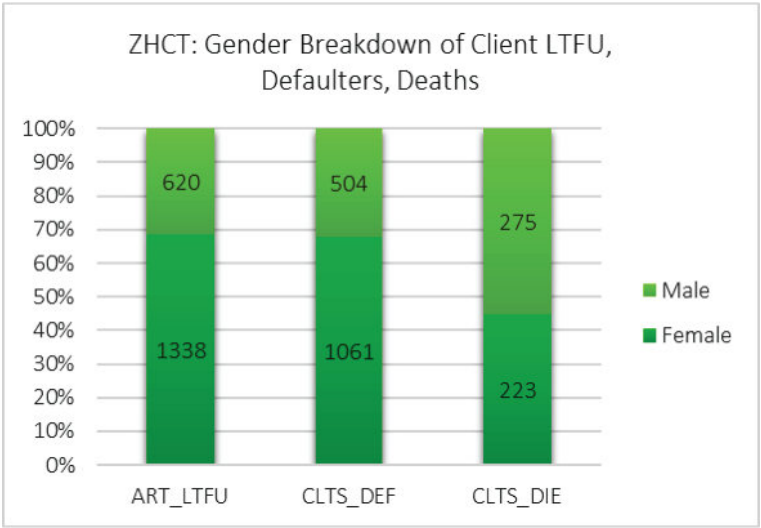
Currently, there are a total of 45,965 PLHIV who have been retained on ARV Treatment (ART) for 12 (16,225), 24 (16,975), and 36 (12,765) months (Figure 8).

FIGURE 8: ART RETENTION



As shown in Figure 9, a total of 4,021 clients were lost-to-follow-up (1,958) (LTFU), defaulted (1,565), or died (498) in the last year. Gender breakdown of LTFU and defaulting clients mimics ART initiation profiles, whereby roughly two-thirds are among females and the remaining one-third among males. Client deaths, however, were recorded in slightly less females than males despite there being many more females than males receiving HIV services. Adjusted for the number of female and male HIV positive individuals enrolled in care, deaths occurred among 2.2% of females and 4.4% of males (data not shown).

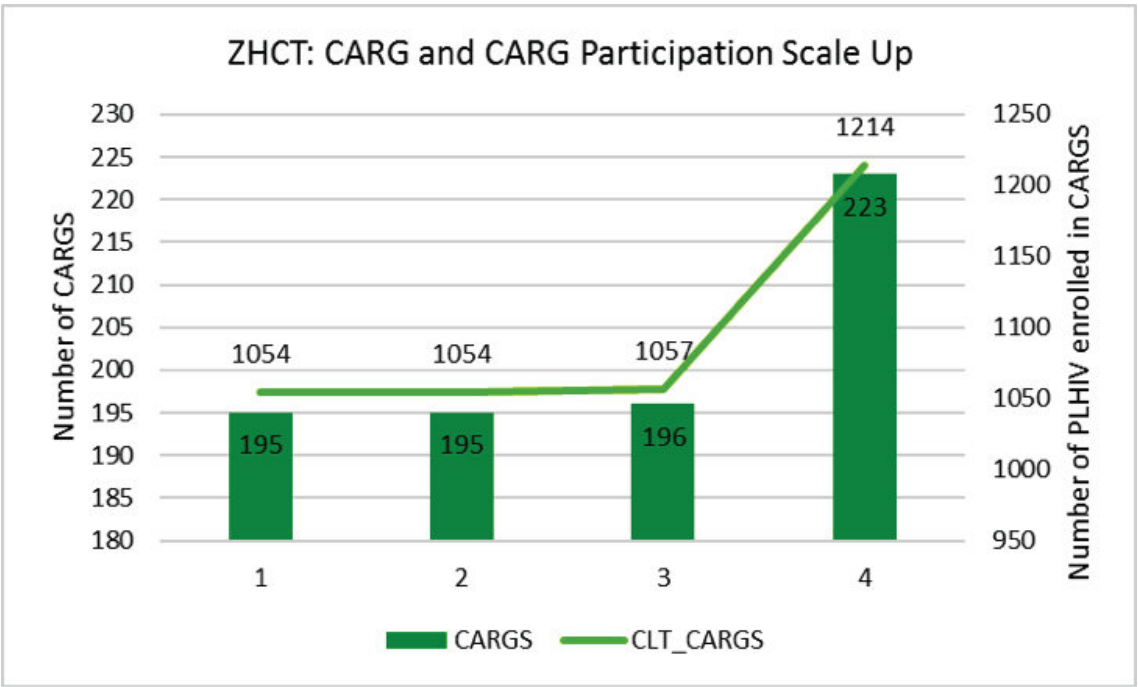
FIGURE 9: CLIENT LTFU, DEFAULTERS AND DEATHS



Community ART Groups

The formation of Community ART Groups (CARGs) is a strategy recently adopted in Zimbabwe as a means to improve the retention of patients on ARVs by reducing the number of visits to the health centre or hospital to collect their medicines. In addition, participation in CARGs can help decongest ART clinics, thereby also reducing the wait times necessary to fulfil prescriptions. According to data collected from the 126 ZHCT-supported health facilities, there are a total of 223 operating CARGs with a total of 1,214 CARG members in Quarter 4.

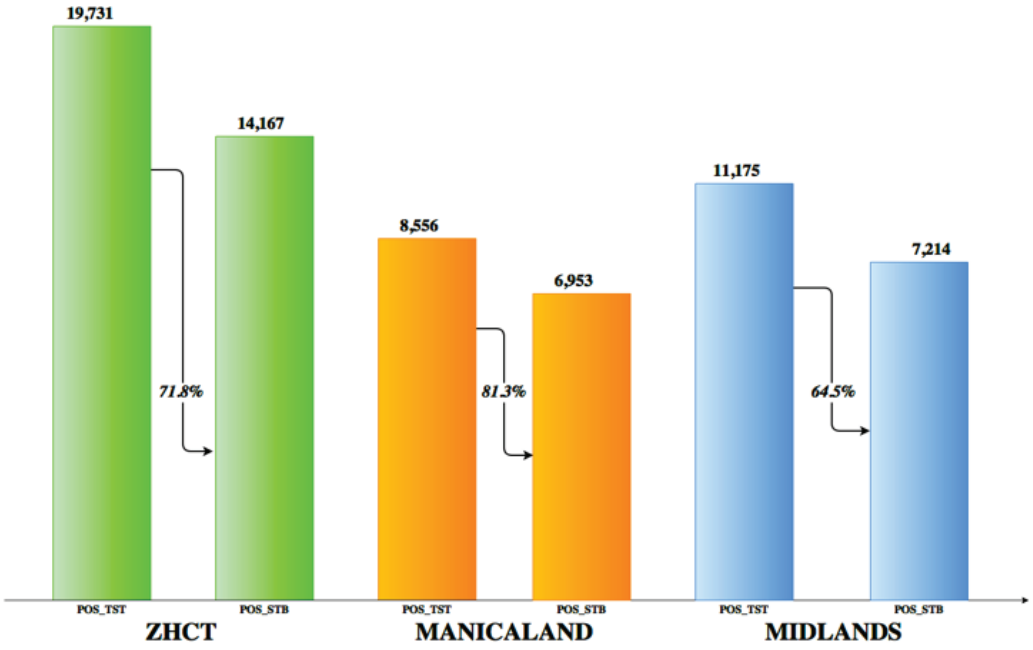
FIGURE 9: CARG AND CARG PARTICIPATION



TB screening among HIV positive Clients

As shown in Figure 10, 71.8% of PLHIV across all ZHCT supported facilities were screened for TB – this varied from 81.3% screened in Manicaland to 64.5% screened in Midlands.

FIGURE 10: PLHIV SCREENED FOR TB



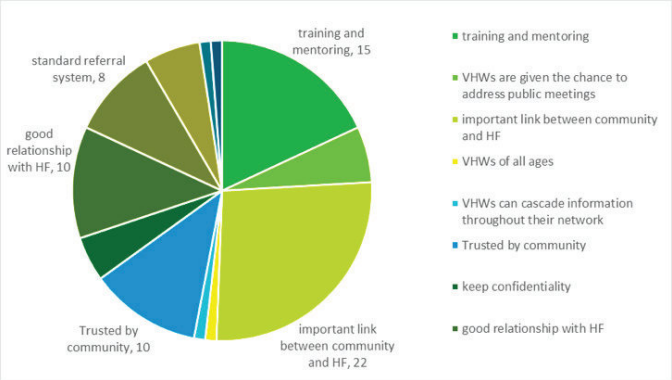
Strengths in / Facilitators to Service Utilisation

Service-level

VHW perspectives

Focus group discussions (FGDs) among community health workers (e.g. village health workers (VHWs)) discovered a number of strengths, as shown in Figure 11 below.

FIGURE 11: SERVICE STRENGTHS HIGHLIGHTED BY CHWs



Important link between community and health facilities: VHWs consistently described how their role hasn't always been accepted by communities, but now this has changed and they are seen as key players in community health.

"long back VHWs were looked down upon but nowadays people are appreciating the work of VHWs since they approach them for health assistance before going to the clinic" (Buhera district)

A number of activities were listed as strengths in this regard, as summarized below:

- networked with 'lead mothers and fathers' who are assisting VHWs in weighing children
- nurses direct VHWs to monitor certain cases in the community
- assist the facility track TB and ART defaulters
- close working relationship with clinic, part of the health center committee
- participate in outreach activities with health facility staff
- refer pregnant mothers for ANC
- refer suspected TB patients
- HIV clients referred to VHWs for adherence and track lost to follow up
- convenience of services at home
- work together with HF staff during times of bereavement
- escorting patients to the clinic
- health education in churches, ward meetings, schools and water points etc. followed by Q&A

Some quotations which illustrate the valuable role VHWs play in linking patients with health facility services are as follows:

"we have exposed babies and most of the time the nurse tells you to be constantly monitoring that baby in the village and if any problem to come back (P3), Mutare

"VHW is the first reporting line for patients before they decide to go to clinics" (p7), Buhera district

'we intercede between the community and the hospital, there is good relaitonship with hospital staff"(Makoni district)

"when someone is sick, the CHW is approached to assess and make referrals. The sick allow them to visit their homes and exercise their duty without restrictions" (Gokwe South)

Training, equipment and mentoring: An important strength mentioned in all districts is the preparation that VHWs receive before beginning their service, and continuing mentoring afterwards. There is a standard training package for VHWs, and they also receive topic specific trainings as well as refresher trainings and certain manuals as reference materials, though these tend to be topic specific (e.g. malaria, or early childhood care).

Ongoing mentoring is a feature including bringing reports to supervisors and share problems and achievements on a monthly basis, or meeting with health facility staff every Thursday.

Good relationships with health facility staff: In addition to structural support mentioned above, good relationships between health facility staff and VHWs is an important strength, which contributes to improved outcomes for patients on ART.

"The way we work with patients is basically the same. 'Siyano iripo pakati pedu maVHW nemanurse iuniform chete'. We have our meetings every month. We also have meetings with the Health Centre Committees and some of us are a part of the committee. We give referral slips to patients we refer to the clinics and nurses respect these"(Buhera district)

"If we diagnose someone sick in the community we fefer to the clinic and one the facility nurse realizes that there is need for constant follow up to the client, they refer the person to us and we do home visits and give reports to the facility" (Kondo clinic, Makoni district)

Trusted by Community: A strong theme in the majority of districts was the trust that has built up between community members and VHWs, a trust that has been built up gradually over time, and allows them to serve as an effective link in the health system.

"some are free to say things that they would not say to their families but confide in the VHWs" (Gokwe South)

"when someone is sick, the CHW is approached to assess and make referrals. The sick allow them to visit their homes and exercise their duty without restrictions" (Gokwe South)

"Most clients have trust in us in terms of confidentiality and reveal their secrets to us, for example someone had not disclosed to her husband for fear of victimisation but I counselled her and talked to the husband and they are now all on ART (Chipinge)

Standard referral system: Another theme that was mentioned in several districts as a strength of the program is the standard referral system. A lot of the work of a VHW is to refer clients to health facilities ("at times the problem is big for us and we refer them to the clinic", Chipinge District), and to receive referrals from health care providers to follow up community members at home and in communities. The quotation below summarizes the essence of referrals from health facilities to VHWs:

"The referral process is such that those clients referred from the clinic to the community are visited by the VHWs to check on their progress and condition including adherence. They check to see if patients are taking their drugs as prescribed by the clinic. they are sent to make follow ups of defaulters, and bring them to the facility." (Gokwe South)

The use of referral slips was also highly appreciated by VHWs, as a way to standardize, document and help track referrals.

"using the referral slip is more organized than writing on an ordinary slip" (Mutare district)

A very important part of the referral system that contributes to ART retention is verifying whether PLHIV late for refills tracked in the community actually make it back to the health facility. Here the VHWs also play a role:

"I come to the clinic and inquire if the client came, if not I make a follow up with the client again" (Mutare district)

PLHIV Perspectives

FGDs among PLHIV focused primarily on the role of support groups for PLHIV in the communities. As shown in Figure 12, three key themes emerged.

Psychosocial support: This peer support extends further than dealing emotionally with one's HIV positive status, and includes advice on disclosure and positive living.

Income generation: Activities geared at this was an important strength as well as area for improvement that was regularly discussed in the FGDs. Participants mentioned they teach and support each other to engage in farming activities.

In Chipinge district, participants mentioned collaborating together to build home gardens and also work in village savings and loans schemes.

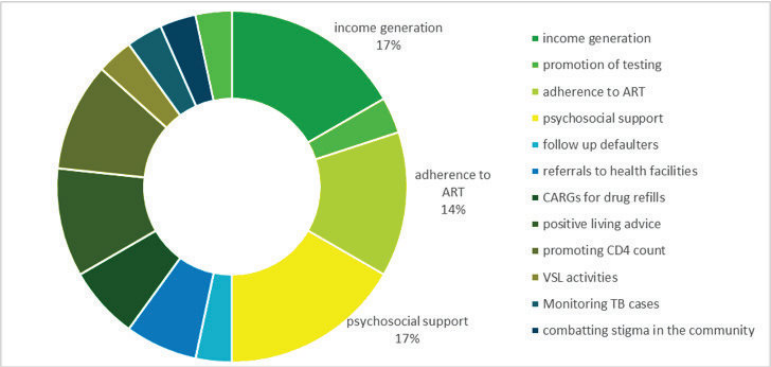
"we are being encouraged to do projects that give us an income."

There was also quite a bit of interest in poultry based income generating projects, which was listed both as a strength, but more prominently as a recommendation for the future.

Support for adherence to ART. This support goes beyond simple advice and includes active defaulter tracing, and liaising with health facility personnel

"In groups you can also share the dangers of defaulting on ART, I also gave advice to a colleague who was not taking their drugs in time". (Makoni District)

FIGURE 12: SERVICE STRENGTHS HIGHLIGHTED BY PLHIV SUPPORT GROUP MEMBERS



Another common theme in the FGD transcripts was appreciation for health facility-based services, and good working relationships between health facility staff, VHWs and support group members.

"assistance is only found at the clinic and we are thankful to the government, and if you adhere to drugs you live normally like the rest of other community members. Other health staff are friendly and kind' (Makoni district)

'the CHASA Mai Madziva is readily available all the time, she is there to assist members when they are faced with a problem, particularly in relation to getting their supplies of medication" (Mutasa district)

This indicates a degree of maturity in relations between support groups and health facilities. The support group members obviously feel they have a valued and important role to play, and that communication and coordination is generally working well with health facility counterparts. In some cases, PLHIV are given preferential treatment at the health facility (Gokwe South), while the lack of user fees at both health facilities and support groups (not in all districts) were also listed as a strength:

"there are no user fees that we pay and our clinic staff has appointments with each and evey member for replenishment of their drugs and symptom screening" (Gokwe South)

Finally, the importance of CARGs were also mentioned in Kwekwe and Buhera districts in promoting retention by sharing the burden of drug pick ups between members of support groups.

"CARGs make it easy on drug refill for members and this saves time, money, and reduces congestion at the clinic". (Buhera district)

Community leader perspectives

Discussions with community leaders echoed sentiments expressed by VHWs and PLHIV. One important strength in recent years has been the expansion and decentralization of treatment services, to the point where community leaders in five out of seven districts were highly appreciative of the wide spread, easy access to treatment, particularly compared to the past:

"Before it was available at the local clinic people would have to travel to town to get medication which was really not sustainable" (Mutasa)

"Everyone is accessing ART in this community" (religious leader, Chipinge)

Also mentioned in five out seven districts as a strength, is the free access to treatment services, another important strength in support of access to services and patient retention, although there were reports of user fees, which also appears in the next section, gaps.

Client/Individual-level

VHW perspectives

Discussions with VHWs reinforced what was stated above about service provision, whereby VHWs are trusted and accepted in communities

"I like that people confide in me easily, I keep secrets and communities trust me" (Weya clinic, Makoni district)

Communities envy us because we are the entry point to the community" (dendera clinic, Kwekwe district)

"Patients find CBHWs more approachable" (Mayo clinic, Makoni district)

Clients also being more accepting of their status is making the work of the VHWs easier, which agrees with the findings from FGDs with PLHIV, as well as the benefits of ART itself:

"People are motivated by HIV patients that have regained their health after treatment" (Makoni district)

PLHIV perspectives

Discussions with PLHIV identified two client-related strengths which were raised consistently as impacting positively on service utilization and treatment adherence: Acceptance of one's status – acceptance of one's HIV status was listed in three districts as an essential step in seeking support from others and gaining optimism towards life; and Disclosure of HIV status to others – the importance of disclosure was mentioned in FGDs in all districts but one, and is a dominant theme in client related factors which improve treatment outcomes. Talking about disclosure often followed closely behind the acceptance of one's status. There are several compelling quotes which indicate the importance of disclosure in mobilizing support from friends, family and co-workers, lifting the burden and being able to resume a normal life

"I was one of the first to reveal my status to the community. I can stand in public and talk about it'. (p5), Mutasa district

'me and my wife disclosed our status to my relatives and work colleagues. My employer accepted my status' (Mutasa district)

"there is no problem with disclosure because you get support from colleagues" (Makoni district) "I am reminded to take my medication by my children when I am on a visit" (Buhera district)

"everyone knows that I am positive in my neighbourhood. May family and friends also know my status" (Chipinge district)

"we know that we are better than those who hide because ART makes us stronger" (Chipinge district) "disclosure strengthens and motivates us to live positively" (Chipinge district)

"when doing hard labour and manual work at home, they understand about my health and they give me lighter jobs" (Chipinge district)

The number of quotes included here indicate the importance PLHIV placed on disclosing their status, and the Gweru district FGD listed a number of benefits associated with disclosing one's status, namely: i) enabling them to get support on time; ii) enhance adherence; iii) teaches others to refrain from behaviours that may lead to infection; iv) are now knowing their status which enables them to plan accordingly; and v) they are able to take charge of their life.

Community leader perspectives

One key strength mentioned in five out of seven districts was the **support from community leaders,** which is perhaps not surprising as community leaders were the respondents. In addition to being a strength, this is an important opportunity for continuing to strengthen the program, particularly galvanizing improved male involvement, one of the critical gaps, as some of the quotes below show:

"Every man should be tested together with his wife. i will reinforce this at community meetings...I will also assign village heads to spread the message" (Gokwe South),

"Leaders are also leading by example by getting tested first" (Kwekwe)

"I would also encourage you to tell me those who are refusing to get tested. Most women are widows due to men who refuse to get tested" (Mutare)

"Community leaders support them with education on adherence and living positively" (Chipinge)

Structural-level

VHW perspectives

The most common supportive factor in the environment mentioned by VHWs is support from community leadership. Community leaders are seen to be creating a supportive environment for their work, allowing them to speak on health issues at community meetings, and helping the community accept their role

"a healthy village is a rich village so we work in tandem with village heads" (Chipinge district)

"they always give health cadres some platform to discuss HIV issues during community meetings" (Gweru District)

The overall **reduction in stigma** in communities was the next most common environmental strength in support of better treatment outcomes, and was mentioned in two districts (Buhare and Makoni districts). Lower stigma makes people more comfortable to discuss HIV issues:

"nowadays people are very free to open up and discuss HIV issues" (Buhare district)

Other environment related strengths mentioned in FGDs with VHWs included: pastors supporting VHW messages through preaching (mentioned once), community members coming to support the role of VHWs, and other complementary services in some districts, such as CATS (Gweru district).

PLHIV perspectives

Among PLHIV, the main factor mentioned repeatedly as creating a supportive environment for improved service utilization and treatment outcomes is **reducing levels of stigma and discrimination** in the community. Stigma and discrimination also appears in the gaps/barriers section as it is still prevalent, but the situation is better than before, according to FGD participants.

In Gweru district, participants mentioned there has been a lack of stigma and discrimination of late, and attributed this to the fact that most people have been affected by HIV:

"considering that most people have been affected by HIV, there is now a higher acceptance and appreciation of PLHIV"

A similar sentiment was shared in Gokwe district, where they noted stigma and discrimination is significantly reduced, but 'pockets' remain:

"there are however pockets of hard to change characters in the community"

In Kwekwe district, respondents saw stigma and discrimination as having disappeared from the home but still prevalent in some community settings.

In Buhera district, one respondent pointed to a reduction in stigma and discrimination related to improving knowledge of HIV transmission:

"We are treated very well as HIV positive people in our community; we are now eating together. Previously people thought HIV could be transmitted through sharing utensils like cups"

In Chipinge district, the contrast between how PLHIV used to be treated and the current situation was stark:

"Previously we used to be treated like animals and people were afraid to share a meal with us and we could not use the utensils that the HIV free people were using. Right now we are now the same and are treated with dignity."

Community leader perspectives

The most commonly reported responses, the reduction in **stigma** against PLHIV, and the community having adequate information and knowledge about HIV, are clearly related, although these issues also appear as gaps. It seems that some transition has occurred and they are viewed in all districts more as strengths now than weaknesses or gaps. Starting with the issue of stigma, the quotations below highlight the diversity and commonality in responses across districts:

"My community is slowing accepting people with HIV. Most people here are affected, so there is need for us to support each other. Now there is no stigma. It's mostly self-stigma. People shun themselves and do not disclose. Those who disclose get a lot of support" (community leader, Gokwe South)

"Generally there is less stigma now because most of them are now fit. they are involved in most community activities and there is no problem" (Gokwe South)

"Stigma is now a thing of the past" (Kwekwe)

"Before people used to shun HIV positive people, of course there still remains a few culprits who are ignorant" (Mutare);

"Previously it was unheard of for people to socialize with a positive person, but now people are even free to share a beer and plates of food" (Mutasa)

"Previously people were very afraid of being known HIV positive. This has greatly changed" (Buhera).

"Our ward coordinators always talk and inform people on shunning stigmatization" (Buhera)

Raised awareness of HIV and AIDS in communities is clearly one of the driving forces behind the reduction in stigma, and interestingly, the fact that PLHIV are now able to live healthy, normal lives, was also quoted as helping reduce stigma above from the Gokwe South community leader. Following are some quotations that illustrate the community leaders' impressions around awareness raising activities in their communities:

"People in my community are always raising awareness on HIV and AIDS" (Kwekwe),

"There are always awareness campaigns by nurses on prevention of HIV" (Gokwe South)

Gaps in / Barriers to Service Utilisation - Service-level

VHW perspectives

Gaps or barriers to services discussed by VHWs included:

Distance to health facilities – the challenge of clients accessing care due to distance and related costs (transport) were mentioned in four districts, namely Mutasa, Buhera, Gweru and Gokwe South. Distance was also mentioned as a constraint as far as community testing efforts were concerned – if a person tests positive in the community and far from health facilities, the linkage to care will be a challenge due to transport needs, and for hard to reach communities (Gokwe South).**Waiting times at health facilities** – this challenge was mentioned in Mutasa and Kwekwe districts, including by 2 respondents in Mutasa.

"some clients might give up after waiting so long before being served at health facilities" (Mutasa)

The voluntary nature of VHW work – the lack of payment for VHWs was listed as a constraint in Chipinge, Kwekwe and Buhera districts. In Chipinge respondents complained about the lack of incentives, airtime and transport, while also having too much work to do. In Buhera, one respondent mentioned that the lack of incentives was a barrier to attracting more men to be VHWs, which links to the related problem that women have difficulty engaging men.

VHWs lack basic equipment, materials - A related problem in how VHWs are resourced is the lack of functioning equipment to facilitate their outreach:

"we were given bicycles and scales and they have long since stopped working" (Mutare).

Other equipment and supplies that are in short supply include: scales, uniforms, airtime, gloves, cotton wool. Two districts (Kwekwe and Makoni) also reported that not all VHWs have been trained.

Lack of male VHWs – feedback from VHWs is consistent with PLHIV support groups in highlighting a lack of male involvement in VHW activities. This was raised in three districts. The problem is similar to how PLHIV described it:

"sometimes you see a male client and because I am a woman he will not free for me to fully examine him" (Mutare)

'men cannot easily disclose to women" Mutare)

"men are free to tell each other their problems (Mutare)

PLHIV perspectives

A number of service-related gaps and barriers to improved service utilization and treatment adherence were mentioned across all PLHIV FGDs. Groups in Buhera, Makoni and Kwekwe were particularly articulate in defining health-facility related gaps that mitigate against treatment outcomes.

User fees at health facilities: several FGDs listed the lack of user fees as a strength, however this was not consistent across districts. User fees for health services were quoted as a limitation particularly in Makoni district:

"at clinic one has to pay and pays again at referral hospital. What is the justification for these charges?'

"I was once referred to the hospital and they question why I had a clinic card without a stamp. There are double payments at the clinic and at the hospital"

"the clinic is alright but at Rusape hospital is the problem because they are always asking for money"

Long waiting times: long waiting times were mentioned in Mutare, Buhera, Makoni, Kwekwe and Gweru districts. The explanation for long waiting times varied, and included factors such as: insufficient staffing, poor attitudes from health care providers, and complicated referral processes within health facilities.

"nurses spend time socializing during working hours" (Makoni)

"one can be referred but doctors are not available at the referral hospital" (Makoni)

"The process should be improved so that clients will not stand in queues for a long time" (Kwekwe)

Lack of community based HIV services – this was mentioned in Buhera, Makoni, Chipinge, Gokwe South and Gweru districts. In some cases the comments focused on VHWs being too busy or not active in some communities such as Gweru district

"VHWs..should be monitored so that they provide their services. They also have multiple roles in the community thereby compromising the quality of their work" (Chipinge)

"they (VHWs) are not mobile and don't come to us", "if we want a service we go to their residence..., they should improve on that area. We need them to visit us and not the other way round" (Makoni)

The lack of community based HIV services are also included in this finding ("There is no physical or material support except awareness raising" (Buhera FGD, P4)) and communities without support groups were also singled out (Chinamasa, Gweru district; Nyazura in Makoni district).

Stigma/negative attitudes from health care providers – some nurses were singled out in Gweru, Mutasa and Buhera as having bad attitudes, while others were concerned about their lack of confidentiality.

"at clinics/hospitals that's where all the stigma exists because nurses have attitudes, that's why you will find some people will collect their pills in Dangamvura' (Mutare)

But not all were in agreement with this finding in Mutare district:

"in clinics they no longer look down upon us that much since they have knowledge themselves"

"I collect my pills at MPH and there has been improvement in services and the way they treat us"

Other gaps and barriers that were mentioned more than once included: having to make payments to support groups (Mutasa and Gweru districts); distance/cost to reach services (Makoni and Buhera districts); and drug or CD4 not being available (Makoni and Buhera districts)

Community leader perspectives

One key barrier noted by community leaders is the distance from health facilities.

"some experience difficulties in raising transport fares so that they can go for treatment" (Kwekwe)

"the issue of distance for clinic resupply at times is a deterring factor as the clinic has a large catchment area with people coming from as far as old Murapa which is more than 10kms away" (Mutare)

Community leaders also noted a **lack of community based HIV services.**

"There are no community organizations that are testing or providing any care services. There used to be MASO" (Gokwe South)

"Danai HBC program used to offer services but has since left. They tested, gave food handouts and treated. They supported poultry and many other projects" (Buhare)

"Min of Health and NGOs such as PLAN and MASO used to support PLHIV with supplementary food" (Kwekwe),

"ART can only be accessed from the clinic" (Gokwe South)

Client-level

VHW perspective

The main client-related gaps and barriers from the FGDs with VHWs were as follows:

Negative attitudes towards VHWs – just as with stigma and discrimination, perceptions towards VHWs are listed as both strengths and barriers, and there is a perception that it takes time for VHWs to establish themselves as a trusted cadre within the health system. Negative attitudes towards VHWs take several different forms, as seen in the quotations below. It was by far the most common client- related barrier in these discussions, mentioned in five districts

"people in the community give the impression that the health workers are out there to bother people and disturb them (p3, Mutasa)

"Some men are not accommodative. They feel we are lazy to work and thus opt for female jobs... some think as we visit their houses we are there to snatch their husbands" (p3, Buhera)'

"our worst thing is that people talk bad about us if they find out that we don't have the resources to assist them" (Kwekwe district)

There were also complaints about too much health education, and that some people expect benefits for participating in programs. In Chipinge district respondents mentioned they are sometimes accused of stealing drugs, as well as pressurizing people too much to complete referrals. It is worth mentioning that in one or two FGDs, the VHWs mentioned that the behavior of other VHWs is sometimes a concern, which means the negative impressions may have a solid basis in some cases:

"their work is put into disrepute by some of their colleagues who display bad behavior in the community e.g. husband snatching, drunkenness, dishonesty" (Kwekwe district)

Concerns over confidentiality – this is one of the contributors to the negative attitudes towards VHWs, but deserves separate attention as it was mentioned in three districts. Concerns about confidentiality at clinics were also mentioned. Some community members are afraid the VHWs will disclose their status

"we are verbally abused by those who do not want to disclose that you are the ones who are going to disclose our status to others" (Mutare)

Men as barriers – continuing with the lack of male involvement theme, there were a number of instances where men were highlighted as a significant barrier, partly due to the lack of male VHWs ("for a female health worker to engage in a discussion on the issue of safer sex is unwise", p4, Mutasa), and partly due to negative gender norms

"females are complaining that their partners do not want to use protection" (p2, Mutasa)

Men were identified to be the culprits who are not forthcoming to HIV testing services and HIV programs in general" (Gweru district)

Increasing male involvement in VHW work may also face some constraints. In Buhare district, for example, it was mentioned that some women don't want their husbands to become VHWs, because they are afraid of them visiting households with single women:

"since they are afraid their husbands may be snatched away since the job requires getting into people's homesteads", and 'Male VHWs are viewed with suspicions that they may fall in love with women in the communities" (Buhera)

Other client-level barriers mentioned only once or twice by VHWs included: clients lacking food, lack of interest in knowing one's status, prevalence of domestic violence, and lack of understanding regarding the referral system.

PLHIV perspectives

The most consistent feedback in terms of client-level barriers was lack of male involvement in support groups, in care, and poor health seeking behavior by men.

"Men don't participate in support groups. they are busy at work, they take time to accept their status, they only seek treatment when very sick, men just don't like to be gathered around" (Makoni)

"My husband gave me HIV and he did not want to get tested until he died. He was arrogant about getting tested. Men have a big problem and they want to keep on spreading HIV"

"Ladies easily accept issues compared to men" (Mutare)

"Generally men are slow at acceptance of programs" (P4) "men are very few in the groups" "men are few because they do not easily accept their positive status", "some men come for tests and drug refills at night and do not disclose to their spouses or family members" (Buhera)

*"There is need to involve more men in support groups since the groups are female dominated." (Chipinge)*With low representation in PLHIV support groups, obstacles to greater male involvement that were raised during the FGDs, included: shyness on behalf of men, pre-occupation with income generation on behalf of the families, community care/support work being seen as women's work, poor health seeking behavior in general, lack of acceptance of HIV status. While their impact on HIV treatment outcomes is potentially very significant for the whole family: "women usually default because their spouses do not allow them to take drugs" (Kwekwe district).

But not all agreed that men were the main problem:

"In drinking places ...girls engage in sex and these girls do not inform their male clients they are HIV positive. So the problem is 50-50 for both men and women" (Makoni district)

The second common client related barrier to better treatment outcomes, mentioned in three districts, was defaulting after feeling better.

"People tend to relax after their health improves" (Kwekwe district)

"Some default when they feel better" (Makoni district)

Other client-level barriers that were mentioned in two districts included excessive alcohol consumption (Kwekwe and Buhera districts), not having enough food to take drugs with (Gweru and Makoni), and self-discrimination or living in denial (Mutasa and Gweru) as mitigating against better treatment outcomes. Men were mentioned as being more likely to be in denial than women.

Community leader perspectives

Lack of male involvement/engagement in HIV and health issues – reinforcing the feedback from both VHW and PLHIV discussions, following are some quotes that emphasize the importance of this problem, and how it affects the program goals, objectives:

"the men do not want to visit clinics, this makes it difficult for women to disclose to their husbands...when they tell their husbands they are positive at times they are blamed" (Gokwe South),

"mainly women are getting services at the local clinic with men still not getting tested" (Mutasa)

"some of them say if my wife is negative then so am I" (Mutasa)

"more men are dying in the community than women. This is due to delays in seeking treatment. men suffer silently...it's the attitude problem" (Buhera)

Structural-level

VHW perspectives

Three key constraints mentioned by VHWs were **lack of male involvement/gender issues, stigma/discrimination, and unhelpful advice by religious leaders.** A few new points were also mentioned here.

One of which, from Buhera district related to other organizations sometimes sidelining VHWs who choose different people to work on health issues. Food shortages and transport difficulties were also mentioned, while in Gweru district participants felt that people in rural communities and mining areas were underserved by services compared to those living along the roads, and in Gokwe South, there was a concern reported that VHWs may be viewed as being linked to political parties.

PLHIV perspectives

Two dominant themes arose in the text related to barriers to improved treatment outcomes in the broader community. These were:**Counter-productive messaging from churches/religious sects:** This barrier was mentioned in 6 out of 8 district FGDs as an important barrier to better treatment outcomes, with healers/pastors/prophets often convincing PLHIV that they don't need ART to manage HIV, that spiritual healing is a better alternative. The 'white garment' churches were singled out for this practice in two of the FGDs.

"churches are also causing followers to default saying they have prayed for you and you have been healed" P3 (Mutare)

"others go to prophets and replace their medication with anointed water from prophets", Makoni

"some churches misinform their congregants not to take ARV drugs because they believe their prayers are enough to heal them and this forces clients to default" (Chipinge)

"most churches are also misleading PLHIV by telling them they are healed after praying for them. This has resulted in many deaths and defaulters", "negative traditional and religious beliefs are reversing the gains made in fighting HIV" (Kwekwe)

"they are told the condition can be reversed when they are prayed for. There are some who have died due to this" (Gokwe south)

In some cases, people also opt for traditional medicine, rather than modern medicine, believing their HIV infection was a curse:

"There are still people out there who believe that being HIV positive is a curse and one should allow death to take toll, who would consult a traditional healer for ailments associated with the virus and who would believe the ailments are a result of being bewitched" (Gokwe South)

Stigma and discrimination in the community: While in most districts participants felt that stigma was much lower than before, community-level stigma was listed as an important barrier to better treatment outcomes in five out of eight districts. PLHIV are still seen as unfaithful, or "people without life" and the subject of harmful gossip and name-calling, particularly at social events, religious events, funerals and gatherings:

"Stigmatization is common in social places like drinking and worship places" (Makoni)

"People in the community pass negative comments once they found that one is HIV positive. This is very common at gatherings such as funerals and churches" (Kwekwe)

"On gatherings like funerals or any other social event we do not feel free because people talk a lot about us" (Mutasa)

In Mutasa district, community leaders are also involved:

"some community leaders engage in meetings discussing issues of PLHIV but not in good terms"

As well as partners:

"My girlfriend had accepted my status however due to the pressure from other people in the community she changed her mind and left me" (Mutare)

"It is not safe to communicate you are HIV positive because you will suddenly be dumped by your lover" (Makoni)

It may be evident as schools:

"HIV positive school children...are usually not allowed to participate in sport as they are considered not to be fit due to illness" (Kwekwe district)

It can also affect employment prospects:

"I was also rejected and denied to be the chairperson of the irrigation scheme because of my status" (Chipinge)

And worryingly, respondents made a direct link between stigma and ART adherence in Mutare district:

"stigma still exists here in Sakubva causing people not to go to collect their medications because they don't want to be known"

"a lot of people are reluctant and unwilling to get tested because of the stigma if they are to test positive"

"I was blamed for the death of others in my family"

"others are shy to take drugs especially at gatherings such as funerals" (Makoni District)

Food and water insecurity: The third main structural challenge mentioned by respondents in four districts (Mutasa, Gokwe South, Kwekwe, Chipinge) is food insecurity related to the current drought. The water shortage was cited as a barrier for farmers growing crops in Mutasa, whereas in Chipinge one participant mentioned "we don't have enough money for (borehole) rehabilitation and our gardens are now dry". In Gokwe South one respondent noted that income generating projects that rely on farming won't work right now, whereas in Kwekwe this situation was directly linked to ART adherence:

"they also require food since they are supposed to take their drugs after they have eaten something"

Community leader perspectives

Lack of Food/Nutrition: This was another gaps/barrier mentioned in six out of seven districts, which affects society in general (particularly due to the ongoing drought) and directly impacts the success of the program as follows:

"everyone is experiencing it, as you can see our economy and the rains did not come as expected" (Mutare)

"no social welfare program though the facility assists TB patients" (Makoni),

"PLHIV are faced with many challenges such as food shortages and some end up defaulting" (Kwekwe)

Stigma and discrimination against PLHIV is still pervasive.

"Mayo community is still backward and stigmatization is high towards PLHIV" (Makoni),

"Regardless of efforts made most people are still finding it difficult to disclose their status to their families" (Chipinge),

"Stigma is very high among men who drink alcohol as they always send the wrong messages about being tested" (Kwekwe)

Certain Religious Groups/Sects

"we have a few apostolic people who do not allow medications. these are few and some of them attend clinics secretly" (Gokwe South),

"we still have some members of while garment churches who are resistant, most members in those families died" (Mutare)

"those from the apostolic sect will come when the clinic is closed so that the community does not see them but we hear they are now coming which is a good thing" (Mutasa),

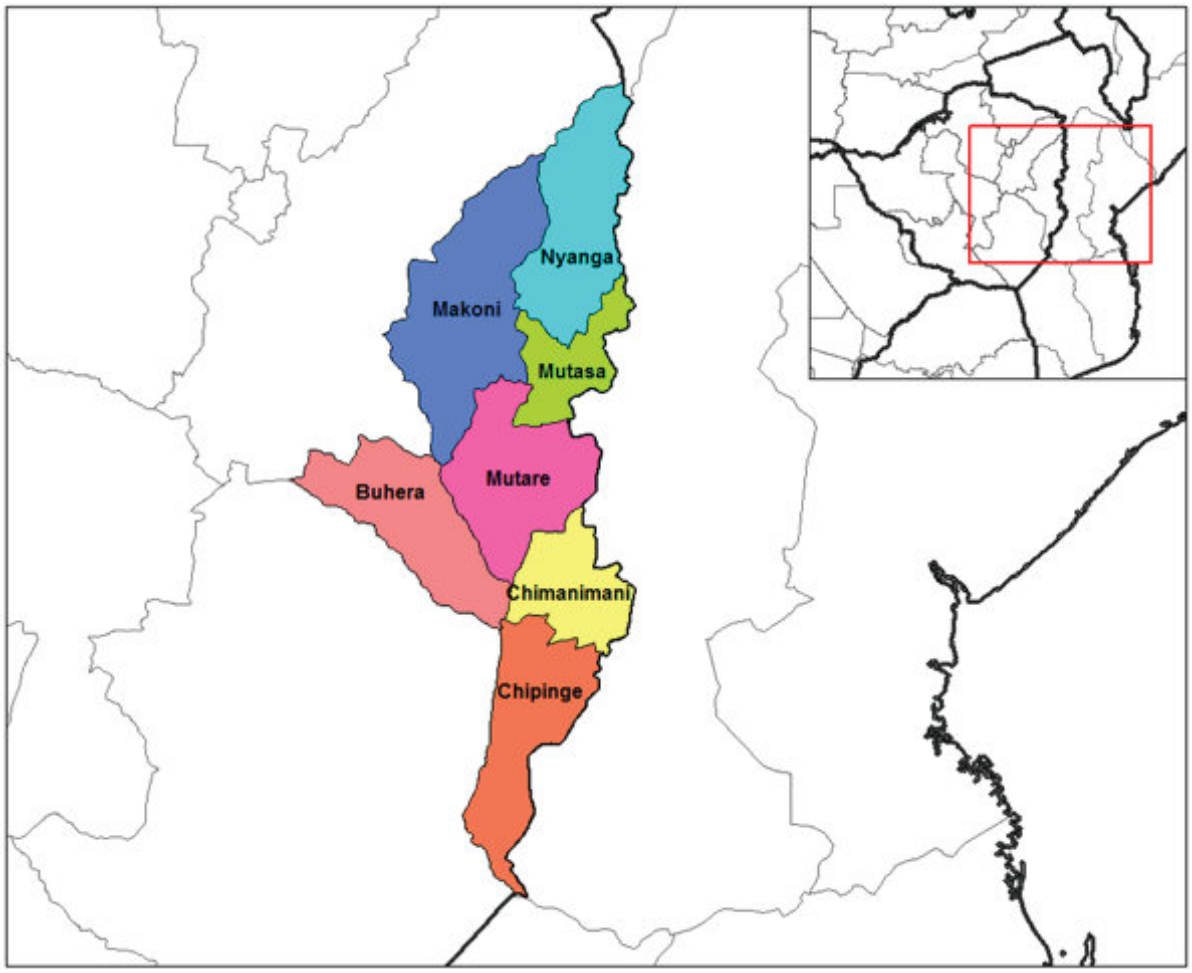
"mostly vapositori. They are hard to reach and yet polygamous" (Buhera);

"all groups access drugs except the apostolic sect" (Chipinge), "the only problem I have in my area are the Marange people. They do not believe in Western medicine, and use their own anointed water" (Gokwe South)

MANICALAND PROVINCE

ZHCT districts in Manicaland Province include Buhera, Chipinge, Makoni, Mutare, and Mutasa. HIV prevalence in Manicaland is 14.1%7. About three-quarters (72.8%) of women and 55.5% of men aged 15 – 49 years in Manicaland have ever been tested and received their results; 44.5% of women and 29.2% of men have been tested in the last 12 months and received their result9.

FIGURE 13. MAP OF MANICALAND PROVINCE



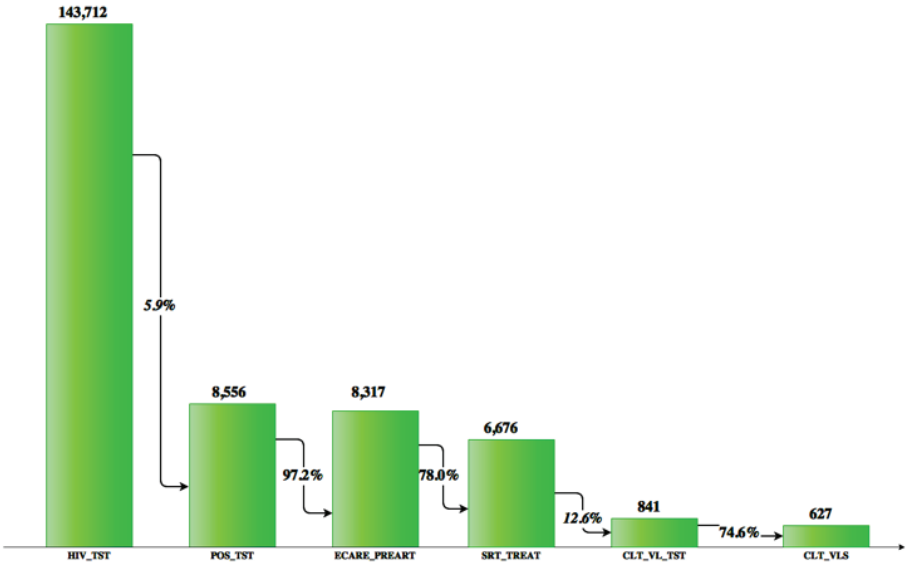
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Midlands province indicates a total of 143,712 individuals tested in the last year, 5.9% (8,556) of whom were found to be HIV positive (Figure 14). This programmatic positivity rate is much lower than the reported prevalence in the province (14.1%), and much lower than that in Midlands Province. Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in the province are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, 97.2% of PLHIV were enrolled in care and 78.0% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively) indicating that facilities in Manicaland are having more success than those in Midlands at linkage to care and treatment. While generally successful, facilities in Manicaland can implement enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is low in Manicaland Province, with only 12.6% PLHIV having been tested. Of those tested, 74.5% achieved viral suppression, indicating that additional efforts should be targeted at ensuring adherence to treatment regimens. Expansion of viral load machine coverage and utilisation in Midlands is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 14: HIV CASCADE, MANICALAND



BUHERA DISTRICT

Buhera District has a total population of 245,878 people, with a female to male ratio of 54% to 46%.

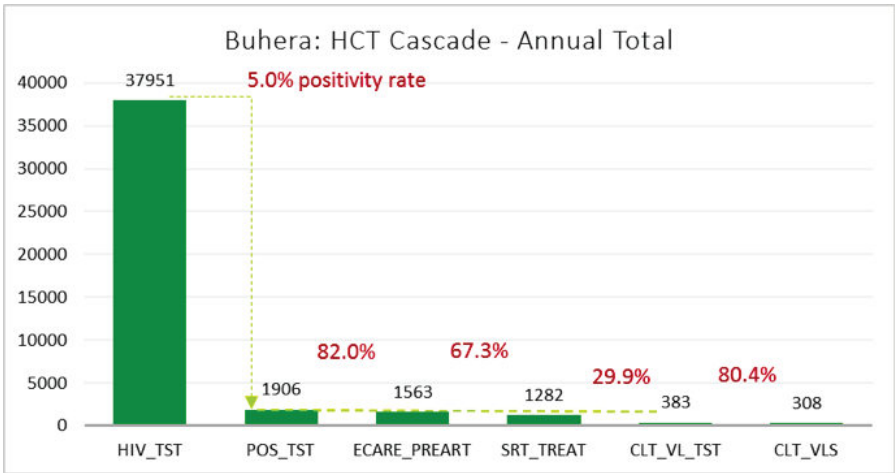
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Buhera indicates a total of 37,951 individuals tested in the last year, 5.0% (1,906) of whom were found to be HIV positive (Figure 15). This programmatic positivity rate is much lower than the reported prevalence in Manicaland Province (14.1%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Buhera are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, 82.0% of PLHIV were enrolled in care and 67.3% were initiated on HIV treatment – slightly lower than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that there are gaps in HIV care and treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is higher in Buhera compared to other ZHCT-supported districts; however, it is still low with only 29.9% of PLHIV having been tested. Of those that had viral load tests performed, viral suppression was high at 80.4%; however, it still falls short UNAIDS' third target of 90% viral suppression. Expansion of viral load machine coverage and utilisation in Buhera is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 15: HIV CASCADE, BUHERA



Service Availability and Readiness

HIV Service Readiness

Seventeen facilities reported that they were short staffed; while seven felt that they had sufficient staff to provide services. Various challenges were reported in the provision HIV services. The most common were problems with M&E systems and stock outs of ARVs. The M&E challenges are due to a multitude of reasons, including: shortage of trained staff, heavy workload, lack of paper to do data collection, and lack of internet to transmit M&E data. In terms of ARV stock outs, participants specifically mentioned lack of pediatric and infant medications (3), and lack of second line drugs (2), the latter of which was unique to Buhera.

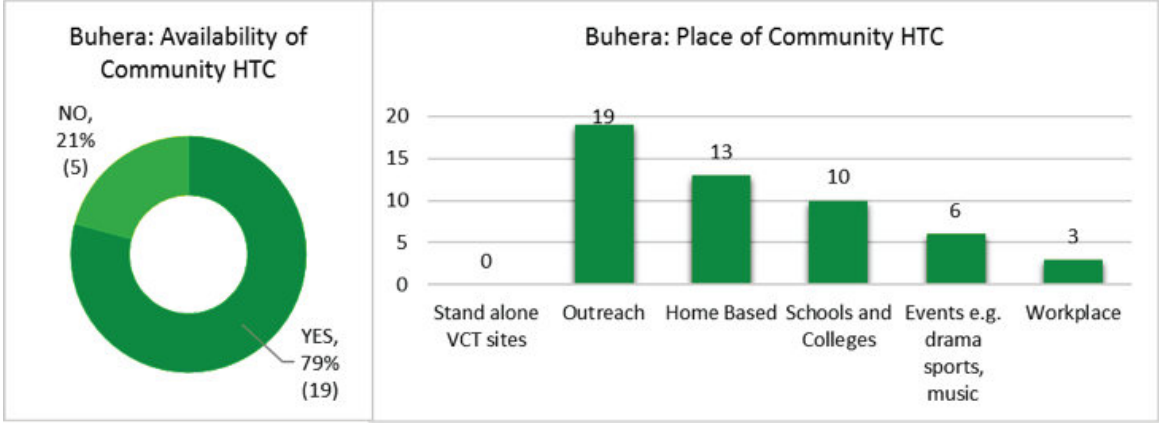
TABLE 2. HIV SERVICE READINESS, BUHERA

	N = 24
How well staffed are HIV Service?	
Short staffed	16
Adequately Staffed	8
Challenges in provision of care and treatment:	
HTC Kit stock out in the past 3 months	0
ARV stock out in past 3 months	11
Has CD4 machine	5
If yes, failed to do CD4 counts in the past 3 month	1
M & E challenges	11

Community Based HIV Testing and Counseling

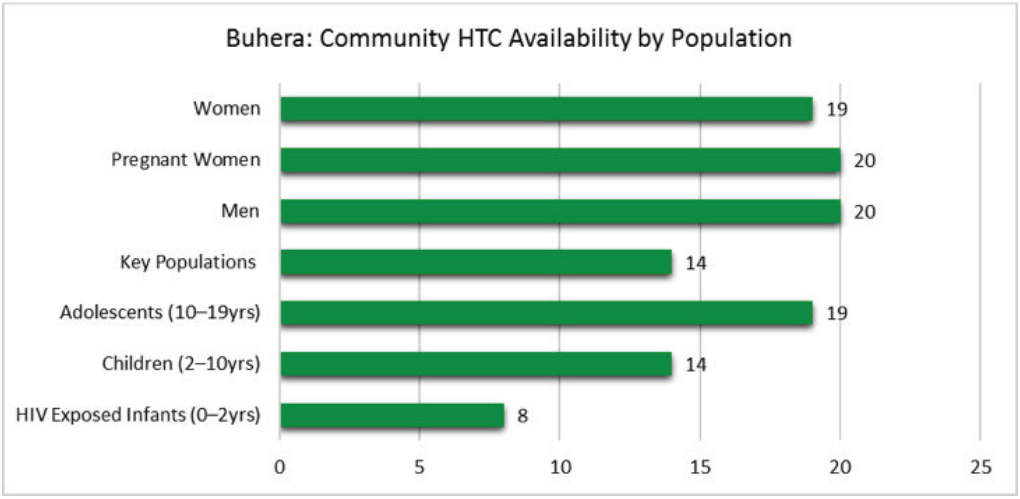
Of the 24 health facilities in Buhera, 19 have community HIV testing and counseling (CHTC) services available (Figure 16). Outreach was the most common means of CHTC followed by home-based index testing. Testing was done by various cadres of health workers, primarily by nurses, but in a few cases by primary counselors (data not shown). Various organizations support testing, including: MOHCC, FHI 360, New Start, PSI, and Rujeko. FHI 360 and MOHCC were the most commonly mentioned organizations, with FHI 360 focusing mostly on index testing while MOHCC supported outreach.

FIGURE 16. AVAILABILITY OF CHTC, BUHERA



All facilities offering CHTC test adolescents, men, pregnant women and women, and most offer services to children and key populations. CHTC was available in less than half of facilities for HIV exposed infants. Each facility identified one or two organizations that provide support for all populations that they serve. These include MOHCC, FHI 360, New Start, PSI, and Rujeko. Again, FHI 360 and MOCC were the most commonly mentioned organizations.

FIGURE 17. AVAILABILITY OF CHTC BY POPULATION TYPE, BUHERA



Provision of community based HIV testing is variable, with the number of days per week of service provision ranging from 0-6. The majority of facilities provide community based HIV testing less than once a week. Six facilities offered testing outside of normal working hours. Many (16) facilities reported interruptions in CHTC in the past four weeks (Table 3). Ten facilities that provide services said they had problems with the tester being unavailable. Many participants (8) mentioned that the partner organization comes very irregularly. One explained that this was due to them only having one vehicle, also making it a transport issue.

TABLE 3. AVAILABILITY OF CHTC, BUHERA

	N = 24
Testing and counseling offered outside normal work hours	7
Interruptions in community testing and counseling in past four weeks	16

Type of interruptions	
Stock out of HIV test kits	0
Tester non-available	10
Transport not available	4

Linkage to Care and Treatment

Most (21) of the facilities have a referral mechanism for clients who test positive for HIV to ensure they enroll into care and treatment (Table 2). The majority use referral slips, and some use both referral slips and registers. Respondents from all but one of the facilities with referral mechanisms felt that they did "well" or "very well" in ensuring the referrals are complete; however, one thought their facility did "very poorly". In that facility, the respondent said that a partner is responsible for scheduling follow-up appointments, but they do not think they provide referral slips.

TABLE 4. LINKAGE TO CARE AND TREATMENT, BUHERA

	N = 24
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	21
Mechanism used:	
Referral slip	18
Registers	10
Follow-up / tracking of defaulters	3
Follow-up appointment made	1
How well the facility ensures referrals are complete:	
Very well	12
Well	8
Reasonably poorly	0
Very poorly	1

Community-Based ART Services

Community-based ART (CART) services is only provided in 6 of 24 health facilities in Buhera (Table 5). All six facilities provide ART follow-up (resupply) through CARGs. Two of these facilities experienced stock-outs of ART, causing interruptions in community service delivery.

TABLE 5. AVAILABILITY OF COMMUNITY ART, BUHERA

	N = 24
Provides community-based ART services in facility catchment area	6
Type of service provided:	
ART initiation	0
ART follow-up	6
How are services delivered:	
Outreach	0
Community ART refill groups	6
NGO operated facilities	0

Interruptions in provision of ART community-based services in past 4 weeks	
Types of interruptions	2
ART stock outs	2

Retention in Care and Treatment

All of the facilities reported that they identify ART clients who do not come back for review and/or resupplies (Table 6). All facilities identify clients by use of appointment diary, while some also employ a second method of identification through VHWs, registers, or "other" methods, including: EPMS, through primary counselors, and by phone (all mentioned once). Furthermore, 20 facilities attempt to follow up the ART clients who do not return to the clinic. They do this mainly through CBHWs (all facilities), and phone calls (21), but also via community members (5), EHTS (2), and home visits by PCs (1).

Through open-ended responses, the respondents cited numerous challenges they face in following- up clients. The challenge cited most often was that clients provided the wrong address or phone number. One participant explained, "As some clients have not disclosed, they give false addresses."Another common response was distance or geographic barriers, mainly flooding. One participant said, "the river in flood times is a challenge...", which was unique to Buhera. Other responses are summarized in Table 6

.TABLE 6. RETENTION IN CARE AND TREATMENT, BUHERA

	N = 24
Identifies ART clients who do not come back for reviews and or resupplies	24
How identifies clients:	
VHW	6
Appointment diary	24
Registers	12
Other	4
Follows up ART clients who do not come back for clinic reviews and/or resupplies	24
How does facility follow up:	
CBHWs	24
Phones	21
Other	8
Challenges in following up clients	
Wrong address or phone number	12
Distance and geographic barriers	7
Mobile or migrant population	5
Lack of cell phones	5
Transport challenges	4
Disclosure	1
Staff shortages	1
Parents do not bring children	1
Men deny wife treatment	1

Other Community Services Available

Twenty-one facilities offer additional services within the community, as outlined in Table 7. Counseling services were the most widely available (adherence and family planning), while screening for opportunistic infections was also offered in eight facilities. No facilities offered CD4 count or viral load testing within the community.

TABLE 7. AVAILABILITY OF OTHER COMMUNITY SERVICES

	N = 24
CD4 count	0
Viral load testing	0
Adherence counseling	13
Screening for OIs	8
Family planning counseling	19

Barriers to Accessing Services

We asked about barriers that patients face for accessing specific services. Short response answers were coded to extract themes by service area. Responses were categorized as either personal barriers or external barriers. Many barriers were common across multiple service areas. Results are summarized in Table 8 below.

TABLE 8. BARRIERS FOR INDIVIDUALS SEEKING CARE

Barrier	HIV Testing and Conselling	Art Intiation	HIV Testing and Conselling
Personal Barriers			
Religious barriers	10	8	2
Stigma	8	4	6
Lack of understanding or knowledge	5	2	4
Disclosure	4	4	4
Parents don't want to bring kids	2	-	1
Economic challenges	2	1	3
Mobile or migrant population	-	-	1
Lack of privacy in communities	-	1	2
External Barriers			
Distance / geographic barriers	4	3	4
Clinic quality	4	4	3

HIV Testing and Counselling: Facilities mentioned a wide range of barriers. The most common barrier to HIV testing and counselling was religious and cultural beliefs. One participant said, “In the Johane Maranke sect, at times followers may want (testing), but fear eviction from the church.” Another common barrier was stigma. Many responses indicate that stigma and disclosure are closely related.

ART Initiation: The most common barrier to ART initiation was religious beliefs, with reasoning similar to that provided above. Another common response was clinic quality, which manifested as lack of qualified staff (3) and lack of resources (1).

ART Adherence and Retention in Care: The most common barrier to ART adherence and retention in care was stigma., followed by lack of knowledge, disclosure, and distance or geographic barriers.

Service Delivery Partners

These facilities work with a range of partners to provide services to their catchment areas (Table 9). FHI 360, New Start, and World Vision are the partners mentioned most often. Many facilities work with partners to provide community mobilization, HIV testing and counseling, linkage to care and treatment, and nutrition support. Gaps in support lie in ART initiation, ART resupply, CD4 testing, and viral load testing.

TABLE 9. PARTNER MAPPING

Community - Based Services	N = 24	Organizations*
Community Mobilization	18	FHI 360, FACT, MSF, PSI, MOHCC, World Vision, Rujeko
HIV testing and counseling	19	FHI 360, New Start, PSI, Zimphia, MOHCC ART initiation 0
Linkage to care and treatment	12	New Start, FHI 360, Cersha, Zimphia
ART Initiation	0	None
Treatment support/ adherence counseling	10	FHI360, CARG, NewStart, Rujeko
ART resupply/ follow-up	3	(OI/ART)MOHCC, FHI360
CD4 testing	0	None
HIV Viral load testing	0	None
Sample transportation	5	Riders for Health, MSF
VMMC	9	PSI, MOHCC
Nutrition support	14	World Vision, Rujeko
Economic Strengthening Activites	10	World Vision,Goal,CARG Rujeko, SAFIR
OVC/ home-based care and support	10	World Vision, Africaid, FACT, CARG, Individual in UIC

Community Linkages

All facilities have linkages to their communities with different cadres or structures, as summarized in Table 10. We asked about the main ways these community cadres help with demand creation and delivery of care at the community level. Short response answers were coded to extract themes by cadre. Many services were common across multiple cadres. Results are summarized below.

VHWs: VHWs in Buhera are responsible for a wide range of services, including 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, and 3) providing health education 4) support of home and community based care, 5) nutrition assessments, and 6) M&E.

Expert Patients, Behavior Change Facilitators: Expert patients and behavior change facilitators both work in the community to provide information and support to clients. They are responsible for 1) providing health education, 2) referring clients to services, and 3) coordinating support groups.

Health Centre Committees, Community leaders: Health centre committees and community leaders refer clients and provide education and awareness campaigns.

DAAC and WAAC: DAAC and WAAC assist by performing the following: 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, and 3) M&E and data management

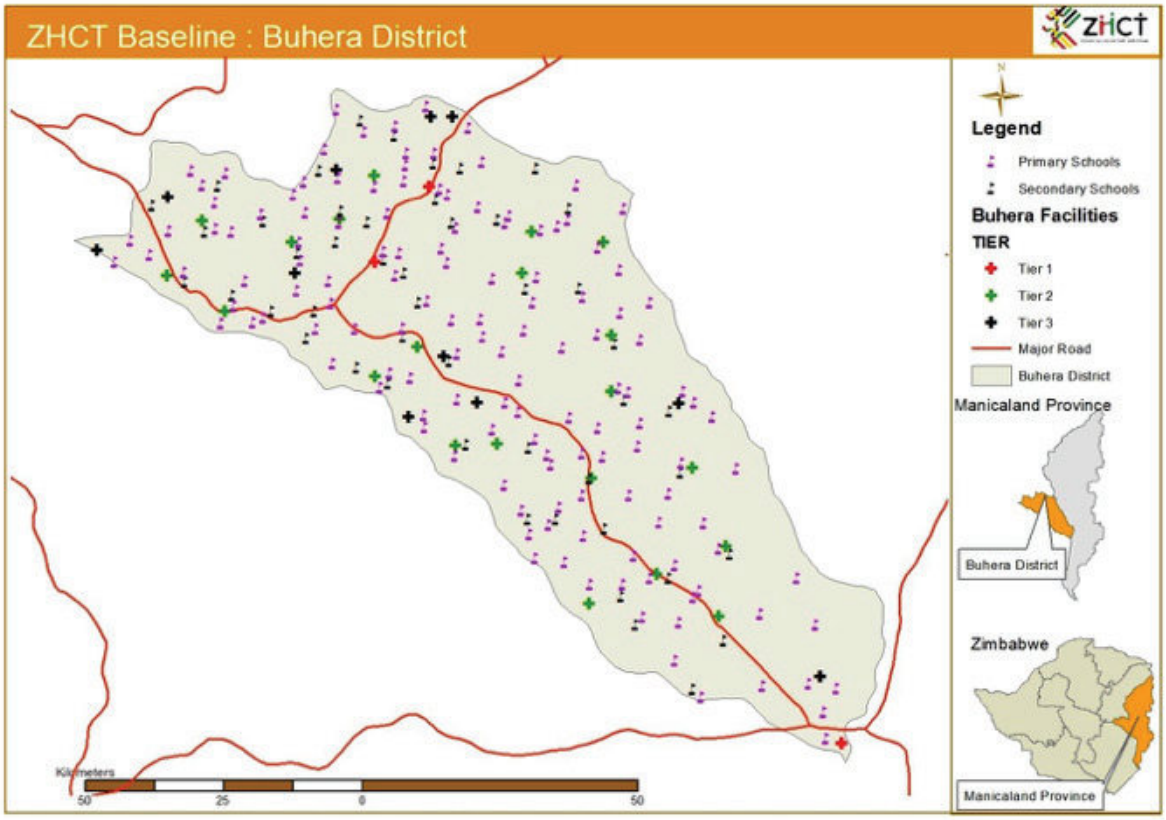
Other: Other groups identified include volunteers, CATS, and church leaders. Volunteers refer and mobilize clients. CATS provides behavior change, referrals, data management, and coordinate and run support groups. Church leaders encourage community members to seek care.

TABLE 10. COMMUNITY LINKAGES

	N = 24
VHW	24
Expert patients	14
Behavior change facilitators	17

Health centre committees	24
Community leaders	23
WAAC	9
DAAC	11
Other	13

MAP OF BUHERA DISTRICT



CHIPINGE DISTRICT

Chipinge District has a total population of 324,133 people, with a female to male ratio of 54% to 46%

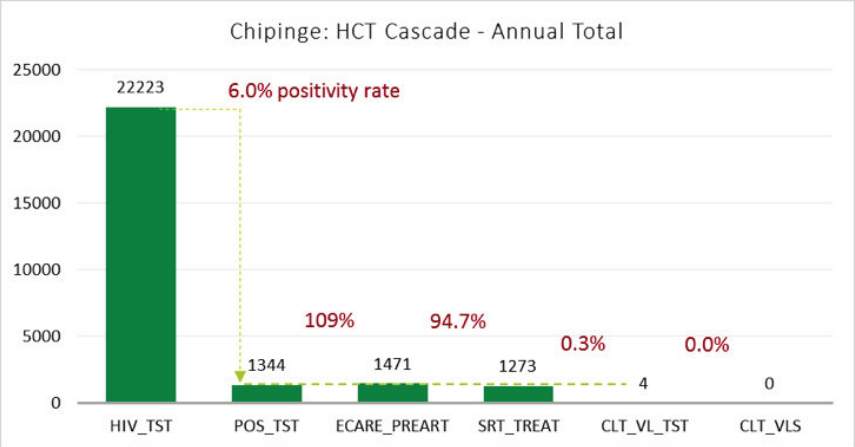
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Chipinge indicates a total of 22,223 individuals tested in the last year, 6.0% (1,344) of whom were found to be HIV positive (Figure 18). This programmatic positivity rate is much lower than the reported prevalence in Manicaland Province (14.1%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Chipinge are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, more than 100% of PLHIV were enrolled in care and 94.7% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Chipinge are successful in linking HIV-positive individuals to care and treatment, and in Chipinge, facilities have met UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is almost non-existent, with only four PLHIV having been tested. None of those four individuals were virally suppressed. Expansion of viral load machine coverage and utilisation in Chipinge is urgently needed in order to assess viral suppression in the community.

FIGURE 18: HIV CASCADE, CHIPINGE



Service Availability and Readiness

HIV Service Readiness

All (10) but one of the facilities feel that they are short-staffed; only one felt that they had sufficient staff to provide services. A few facilities mentioned that there is an increase in client load that is burdening their facilities, however, many pointed out that they are receiving help from partner organizations both in the communities and in facilities. Two respondents specifically mentioned that there is a lot of paperwork and that this is a burden to staff.

All facilities had at least one challenge in the provision of care and treatment services. The one cited most often was challenges with the M&E system. The reasons for this included: DBS forms were out of stock; clients provide incorrect phone numbers and addresses; staff did not have sufficient training in completing M&E forms; there are too many registers; PMTCT forms are difficult; some information has to be transmitted over the phone but there is no network in the area; and it is difficult to track defaulters and referred clients. The second most common was having a CD4 machine that failed to do CD4 counts in the past three months. Three facilities specifically mentioned expired cartridges as the reason why the CD4 machine did not work.

The one facility that mentioned the stock out of HTC kits said they lacked resources including gloves. Finally, the facility that had a stock out of ARVs said specifically that they were out of ABC for pediatric patients.

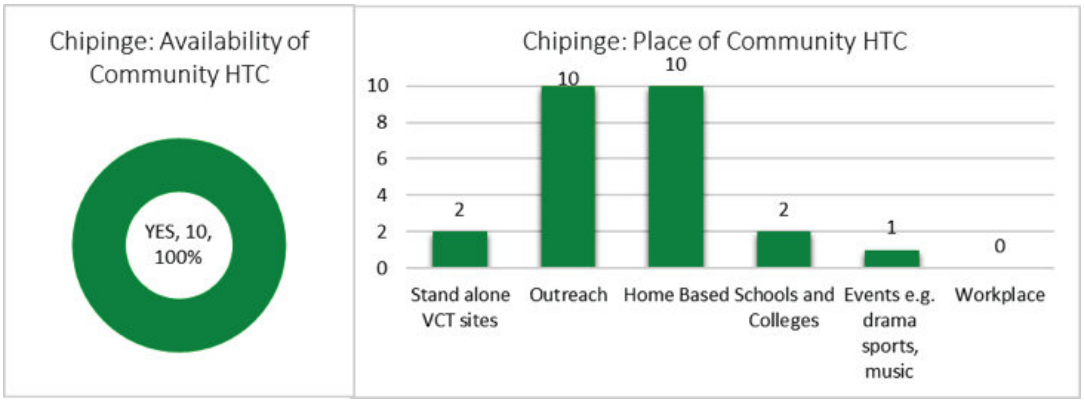
TABLE 11. HIV SERVICE READINESS, CHIPINGE

	N = 24
How well-staffed are HIV services?	
Short-staffed	9
Staffing is sufficient	1
Challenges to HIV service delivery:	
HTC kit stock out in past 3 months	1
ARV stock out in past 3 months	1
Has CD4 machine	6
If yes, failed to do CD4 counts in past 3 months	3
M&E challenges	7

Community-based HIV Testing and Counseling

All of the facilities in Chipinge that were included in the assessment had community-based counseling and testing available (Figure19). While all facilities provided HIV testing through outreach (either through mobile units or community settings) and home-based index testing, only a few offered testing through a stand-alone VCT clinic, door to door testing, schools or colleges and none offered them through the workplace. Almost all CHTC is provided through nurses with one facility also offering CHTC provided by counselors. FHI 360 and FACT were the organizations that provided most of the services.

FIGURE 19. AVAILABILITY OF CHTC, CHIPINGE



Community-based testing and counseling services were available through all facilities for adolescents, key populations, men, and women. Most offered them for pregnant women and children (2-10 years old). FHI 360 and FACT provided most of these services. Testing for HIV exposed infants was only available at the Chipinge hospital. All facilities reported that they provide services to key populations; the one that did not, stated that it was because they are in a rural setting and there are no key populations there.

The schedule for testing varied widely across facilities and ranged from once a week to once a month and even to once a quarter. Three facilities offered testing outside of normal work hours either through an appointment or due to staff working late or overtime on regularly scheduled testing days. Only two facilities cited interruptions in testing and counseling services in the past four weeks; for both they experienced stock outs of HIV test kits and non-availability of testers.

TABLE 11. AVAILABILITY OF CHTC, CHIPINGE

	N = 10
Testing and counseling offered outside normal work hours	3
Interruptions in community testing and counseling in past four weeks	2
Type of interruptions:	
Stock out of HIV test kits	0
Tester non-available	1
Transport not available	1

In open-ended questions, respondents cited stigma and disclosure as the two biggest barriers to providing HIV counseling and testing services. These were each mentioned by half of the facilities. A few noted a fear of disclosure or stigma specifically when providers doing the testing are known in the community and noted that they would prefer outsiders to perform the testing. Lack of female empowerment was cited by three respondents. This included a fear of gender-based violence and the need to get partner consent for themselves and their children. Finally, clinic quality (staff or equipment shortages) was mentioned by two.

Linkage to Care and Treatment

All of the facilities report they have a referral mechanism for clients who test positive for HIV to ensure they enroll in care and treatment (Table 12). They all use referral slips with their clients although two also make use of registers. Only one facility specifically mentioned that they make a follow-up visit to ensure that the client actually went to the facility. Respondents from eight facilities felt that they did "very well" in ensuring the referrals are complete; one thought their facility did "well" and only one said "reasonably poorly."

The challenge to getting clients to begin ART therapy mentioned most often by respondents in open- ended responses were issues with drugs (including fear of side effects, too many drugs and fears of interactions). Three respondents cited disclosure as an issue and two each mentioned clinic quality and that the health system is burdensome (i.e. the process of ART initiation is too long or the sessions are too long).

TABLE 12. ENROLMENT INTO CARE AND TREATMENT

	N = 210
Facility has referral mechanism for clients who test 10 HIV+ to ensure they enroll in care and treatment	
Mechanism used:	
Referral slips	10
Registers	2
How well does facility ensure referrals are complete?	
Very well	8
Well	1
Reasonably poorly	1
Very poorly	0

Community-based ART services

Community-based ART services were not common in the facility catchment areas and only three provided these services (Table 13). All three provided ART follow-up or resupply; one also provided ART initiation services. These services were provided through outreach and/or community ART refillgroups. Only one facility experienced an interruption in the community-based provision of ART services in the past four weeks; the interruption was due to the lack of availability of transport and per diems.

TABLE 13. COMMUNITY-BASED ANTIRETROVIRAL THERAPY

	N = 10
Provides community-based ART services in facility catchment area	
Type of service provided:	
ART initiation	1
ART follow-up (resupply)	3
How are services delivered:	
Outreach	0
Community ART refill groups	2
NGO operated facilities	2

Interruptions in provision of ART community-based services in past 4 weeks	1
Types of interruptions*	
Transport non available	1
Per diem	1

*Multiple responses possible

Retention in care and treatment

All of the facilities reported that they identify ART clients who do not come back for review and/or resupplies (Table 14). The facilities identify clients by use of registers and appointment diaries. In addition, six facilities identify them through VHWs. Furthermore, all facilities attempt to follow up the ART clients who do not return to the clinic. They do this through CBHWs and nine also use phones for follow-up. Through open-ended responses, the respondents cited numerous challenges they face in following-up clients. The one cited most often is the challenge of working with mobile or migrant populations. The second most common challenge are airtime challenges with phones (e.g. lack of phones, bad reception). Other challenges mentioned by more than one respondent included lack of or incorrect addresses and phone numbers, geographic barriers, transport challenges and disclosure.

In open-ended responses, six respondents felt that a lack of understanding or knowledge about adherence is a challenge to getting clients to adhere to their ART regimen and stay in care. This included not knowing the need to continue with their drugs even if they are feeling better. One specifically mentioned that adolescents do not understand the need to take the drugs daily. It was also mentioned that some communities lack food which makes it difficult to take some of the drugs. Three each cited clinic quality and disclosure. Finally, two mentioned the issue of mobile or migrant populations.

TABLE 14. RETENTION IN CARE/ ON TREATMENT

	N = 10
Identifies ART clients who do not come back for reviews and/ or resupplies	10
How identifies clients:	
VHW	6
Appointment diary	10
Registers	10
Follows up ART clients who do not come back for clinic reviews and/or resupplies	10
How does facility follow-up:*	
CBHWs	
Phones	10
Other	9
Challenges in following up clients	
Mobile / migrant population	7
Airtime challenges	4
No/ wrong address or phone number	3
Geographic barriers	3
Transport challenges	2
Disclosure	2
Other	5

***Multiple responses possible**

Other Community Services Available

Nine facilities offer other services aside from those discussed above (Table 5). All but one offer adherence counseling and family planning counseling and most offer screening for opportunistic infections (OIs). Only three offer CD4 counts and one offers viral load testing.

TABLE 15. AVAILABILITY OF OTHER COMMUNITY SERIVES

	N = 10
CD4 count	3
Viral load testing	1
Adherence counseling	9
Screening for OIs	8
Family planning counseling	9

Service Delivery Partners

These facilities work with a range of partners to provide services to their catchment areas. FHI 360, FACT and ZACH are the partners mentioned most often. All facilities work with partners to provide community mobilization, HIV testing and counseling, linkage to care and treatment, and treatment support and adherence counseling. Most work with partners to provide VMMC and to transport samples. Fewer partners are involved in the provision of other services.

TABLE 16. PARTNER MAPPING

Community - Based Services	N = 24	Organizations*
Community mobilization	10	**FHI360,** Plan, OPHID, Zach, CBHW, Dream Africa, Dreams, MSF, H4, ZNNPT, EGPAF, PSI, Africare
HIV Testing and Counseling	10	**FHI360, FACT,** OI Dept., Zach, MSF, GF, Plan
Linkage to care and treatment	10	**FHI360, FACT,** MSF, GF
ART Initiation	2	Chipinge Hospital, MSF
Treatment support / adherence counseling	10	**FHI360,** CDH, OHID, PSI, MSF, FACT
ART resupply/follow up (OI/ART)	5	FHI360, FACT, ZACH, MSF
CD4 Testing	5	FACT, Chipinge, ZACH, MSF GF
HIV Viral load testing	2	MSF
Sample Transportation	7	**MOHCC, MSF,** CDH, GF, courier services
VMMC	9	**PSI, MOHCC**, FACT, CDH
Nutrition Support	3	World Vision, Ensure, Africaid
Economic Strengthening Activities	1	Youth and Women's Affairs Department
OVC / home-based care and support	5	NAC, FACT, DOMCAP, community educators, Plan

***ORGANIZATIONS IN BOLD ARE THE ONES MOST OFTEN CITED**

Community Linkages

The facilities work through a range of community cadre or structures to create demand for testing and services and to assist with service provision (Table 7). All facilities have linkages to their communities with VHWs, health centre committees and community leaders. Most also have linkages through expert patient, behavior change facilitators, WAAC and DAAC. Finally, six have linkages through other groups including churches, schools, farmers, male mobilizers, politicians, CBOs through the RBF program and N'angas. The main ways that these community cadres assist in creating demand or providing services is as follows:

VHWs: The main ways that they assist include by tracking or following-up clients and defaulters, provide health education and by supporting home – and community-based care.

Expert patients: These patients share their status and assist primarily through providing health education and by referring, encouraging or motivating clients and community members to get tested and treated.

Behaviour change facilitators: The facilitators also assist primarily by providing health education on a range of topics including HIV, condom use, family planning and abstinence for example.

Health Centre Committees: The committees mainly refer, encourage or motivate clients and community members to get tested and treated, link clients to services and provide health education. They may also assist in raising funds for HIV programs. It was reported that one committee has monthly meetings to get feedback on HIV programs and to report on defaulters.

Community Leaders: Community leaders mainly use their influence to refer, encourage or motivate clients and community members to get tested and treated, link clients to services and also provide some health education. For example, some may write "Please assist" letters for those who cannot afford care.

DACC and WAAC: The main ways the DAAC assists is by providing health education and by linking clients to services. They may also organize donations for PLHIV. The main way the WAAC assists is by providing health education.

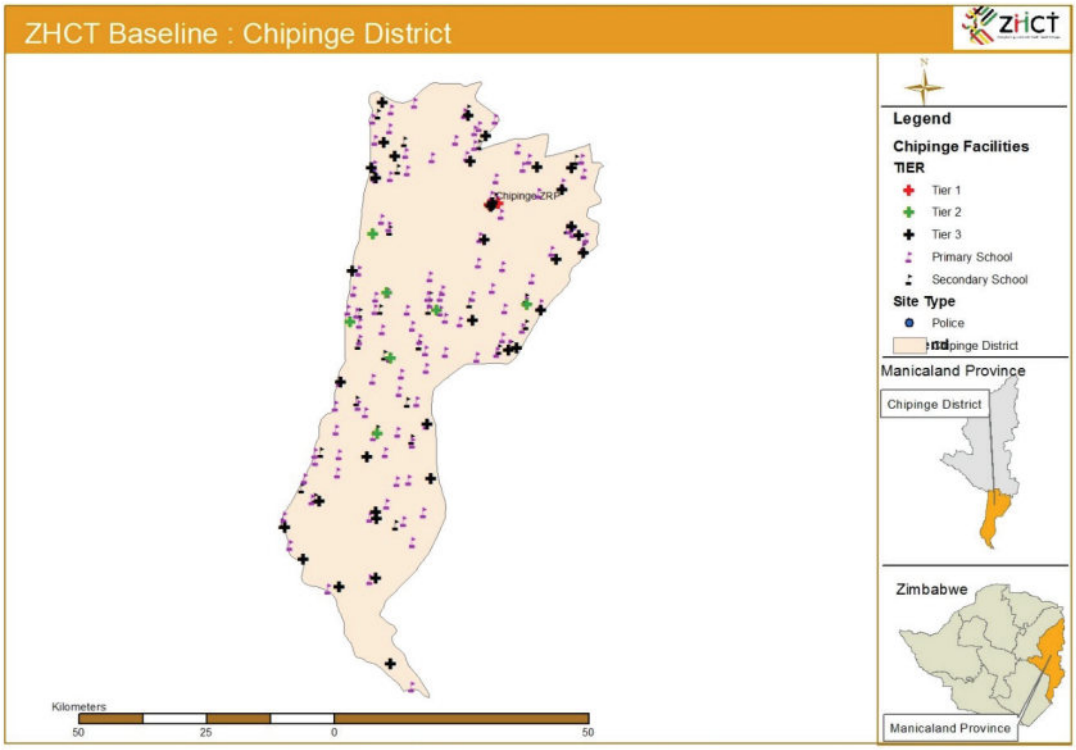
Other: Many in these groups provide health education. Male mobilizers specifically encourage men to escort their wives to ANC and to deliveries. School programs pick up drugs for students, do follow- up of adolescents and work to prevent stigma of adolescents.

TABLE 17. COMMUNITY LINKAGES

	N = 10
VHWs	10
Expert patients	6
Behavior change facilitators	7
Health centre committees	10
Community leaders	10
WAAC	7
DAAC	8
Other	6

MAP OF CHIPINGE DISTRICT

Map of Chipinge District



MAKONI DISTRICT

Makoni District has a total population of 302,656 people, with a female to male ratio of 51% to 49%7.

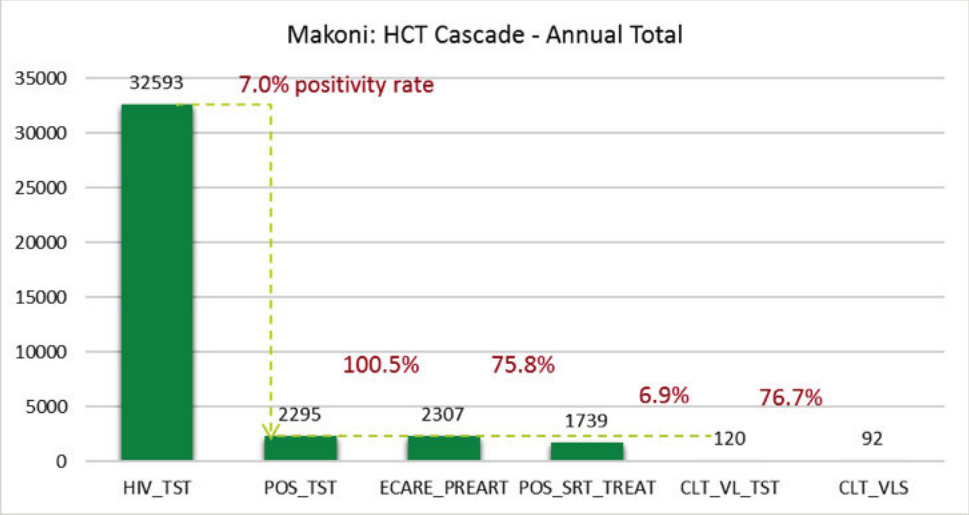
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Makoni indicates a total of 32,593 individuals tested in the last year, 7.0% (2,295) of whom were found to be HIV positive (Figure 21). This programmatic positivity rate is much lower than the reported prevalence in Manicaland Province (14.1%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Makoni are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, more than 100% of PLHIV were enrolled in care and 75.8% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). While promising, there are gaps in HIV treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is low, with only 6.9% of PLHIV having been tested. Of those that had viral load tests performed, viral suppression was fairly high at 76.7%; however, it still falls short UNAIDS' third target of 90% viral suppression. Expansion of viral load machine coverage and utilisation in Makoni is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warented to ensure that those on treatment achieve viral supression.

FIGURE 21. HIV CASCADE, MAKONI



Service Availability and Readiness

HIV Service Readiness

Thirteen facilities reported that they did not have enough staff to handle more demand for HIV services. One clinic also mentioned that though they had adequate staff that had received training, staff couldn't properly provide the services.

The most widely reported issue with care and treatment was "M&E challenges," with 11 facilities reporting that they struggled with this part of providing care. Facilities mentioned being short on registers, not having enough staff to adequately complete M&E activities, having poor documentation systems, or having indicators that were not relevant or that were impossible to track.
Seven facilities reported providing services to key populations such as sex workers and truck drivers.

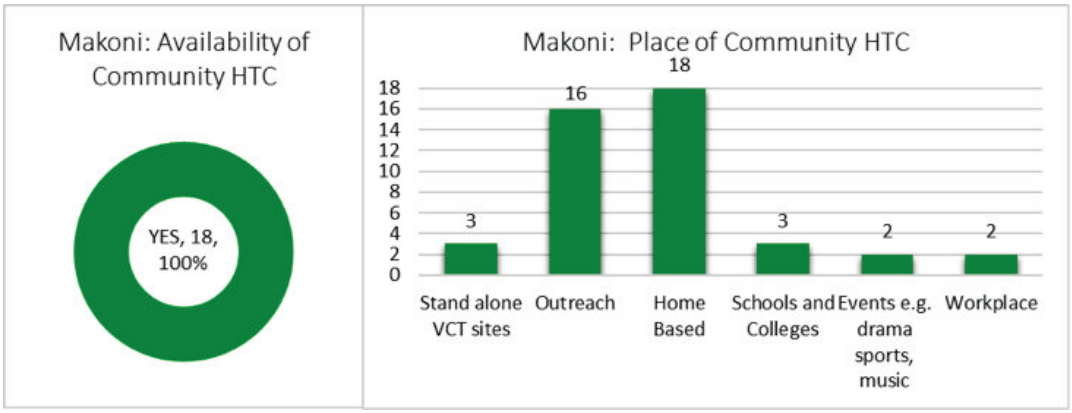
TABLE 18. HIV SERVICES READINESS, MAKONI

	N = 18
How well-staffed are HIV services?	
Short-staffed	13
Staffing is sufficient	4
Challenges to HIV service delivery:	
HTC kit stock out in past 3 months	4
ARV stock out in past 3 months	5
Has CD4 machine	8
If yes, failed to do CD4 counts in past 3 months	4
M&E challenges	11

Community-based HIV Testing and Counseling

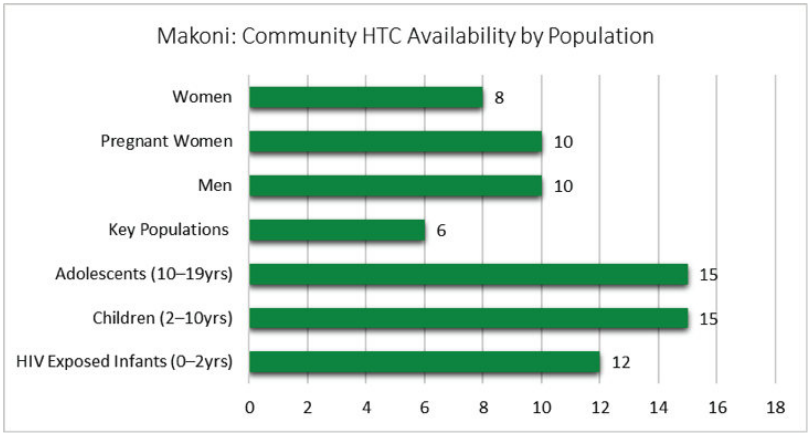
All 18 facilities in Makoni District reported that community-based testing and counseling was available (Figure 22). The most common venues for these services were through outreach (18), home-based index testing (14) and home-based door-to-door (4) testing. CHTC is provided solely through nurses.

FIGURE 22. AVAILABILITY OF CHTC BY POPULATION, MAKONI



Most facilities specified that they did not specifically target several groups. Of those that served HIV-exposed infants, seven specified that they do not treat patients younger than 9 months, unique to Makoni. Regarding key populations, several facilities mentioned that they are not targeted but are met in the community, and two stated that it was difficult to know if a patient is a sex worker.

FIGURE 23. AVAILABILITY OF CHTC BY POPULATION, MAKONI



Most facilities reported that testing was available "periodically" or "occasionally," and was dependent on partner organizations' schedules. Other facilities reported that testing was available once per month, or for two weeks out of the month. One facility reported offering testing and counseling outside of normal working hours, and 11 reported that there had been interruptions in those services in the previous four weeks. Seven reported that interruptions were due to the fact that organizations supporting HIV testing and counseling had not been in their area for the previous month, highlighting the dependency on partners to deliver CHTC.

TABLE 19. COMMUNITY-BASED HIV TESTING AND COUNSELING

	N = 18
Testing and counseling offered outside normal work hours	0
Interruptions in community testing and counseling in past four weeks	10
Type of interruptions:	
HIV test kit stock outs	0
Tester non-available	2
Transport not available	2
Other	7

Linkage to Care and Treatment

All facilities included in the assessment reported having a referral mechanism to ensure that clients who test HIV positive during community-based HIV testing and counselling are enrolled into care and treatment (Table 20). The majority of facilities utilized referral slips to track referrals. One facility reported that they contacted the referral hospital via telephone. Most respondents thought that their facility ensured that referrals were completed either "very well" (4) or "well" (12). One respondent stated that their facility handled this task "reasonably poorly," and one reported that the facility did "poorly."

TABLE 20. LINKAGE TO CARE AND TREATMENT

	N = 18
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	18
Mechanisn used (some had more one method):	
Referral slip	14
Registers	4
Referral to hospital	1
Verbal communication	2
How well does facility ensure referrals are complete:	
Very well	3
Well	1
Reasonably poorly	1
Very poorly	1

Community-based ART

Ten of the facilities included in the assessment provided community-based ART services in the facility's catchment area (Table 21), although one of those reported that they were only able to do so "sometimes." Of these, all provided ART follow-up and resupply services, while four also provided ART initiation. One facility provided community ART through outreach alone, whereas the remaining facilities provided ART through CARGs. Three facilities reported interruptions in community ART in the last four weeks.

TABLE 21. COMMUNITY-BASED ART

	N = 18
Provides community-based ART services in facility catchment area	10
Type of service provided:	
ART initiation	4
ART follow-up (resupply)	10
How are services delivered:	
Outreach	7
Community ART refill groups	9
Interruptions in provision of ART community-based services in past 4 weeks	3

Types of interruptions:	
ART stock outs	0
Staff shortage	0
Transport not available	1
Other	2

Retention in care and treatment

All seventeen facilities reported that they identified ART clients who did not turn up for clinic reviews and/or resupplies (Table 22). The most common ways of doing this were through appointment diaries and registers. Some facilities also relied on partner organizations and EPMS or phones.Fifteen facilities reported systematically following up those clients that were identified as having not turned up for reviews and resupplies. One respondent said their facility did not have a systematic way of doing this, and one did not answer the question. Most facilities reported using CBHWs and phones to follow-up clients, and many relied on outside organizations and other electronic systems as well.

Facilities faced many types of challenges in following-up clients. The most commonly reported challenge was staff shortages, including shortages of VHWs to perform follow-up, unique to Makoni. Some facilities noted that VHWs are overworked or are not effective at following-up clients. Lack of phones or incorrect phone numbers were also common problems, as were geographic barriers including distance and flooding, and the fact that many clients are mobile and often do not stay at one address.

TABLE 22. RETENTION IN CARE AND TREATMENT

	N = 18
Identifies ART clients who do not come back for reviews and/ or resupplies	18
How identifies clients:	
VHW	2
Appointment diary	18
Registers	18
Other	10
Follows up ART clients who do not come back for clinic reviews and/or resupplies	16
How does facility follow up:	
CBHWs	16
Phones	16
Other	1
Challenges in following-up clients (open):	
Manpower/VHW issues	8
No/wrong phone number or address	6
Lack of airtime/phones or bad reception	4
Mobile/migrant population	4
Distance/geographic barriers	4
Transport challenges	1
Lack of disclosure	1
Self-referrals/transfers	1
Lack of interest/client resistance	1

Other Community Service Available

Fifteen of the facilities reported providing other services for clients (Table 23). One facility that did not offer other services noted that an outside organization offers adherence counseling on their behalf. The most commonly offered services were adherence counseling and screening for OIs, followed by family planning counseling. Only one facility reported offering CD4 counts and viral load testing.

TABLE 23. OTHER COMMUNITY SERVICES AVAILABLE

	N = 17
Other services:	
CD4 count	2
Viral load testing	1
Adherence counseling	14
Screening for OIs	14
Family planning counseling	11

Service Delivery Partners

All facilities included in the assessment in Makoni district worked with at least one partner organization. The most commonly reported partners across the district were FHI 360 and MOHCC.Facilities most commonly partnered with other organizations to provide HTC, linkages to care and treatment, and treatment support and adherence counseling. Of the 15 facilities with partnerships to provide VMMC, 10 of them partnered with PSI. All 15 partnerships for nutrition support included provision of plumpy'nut sachets. The fewest facilities had partnerships to provide economic strengthening activities and OVC or home-based care and support.

TABLE 24. PARTNER MAPPING

Community Based Services	N = 18	Organization
Community mobilization	11	**FACT, FHI360,** MOHCC, OPHID, Africaid
HIV testing and counselling	16	**FHI360, MOHCC,** New Start Center, FACT, OPHID,ZIMPHIA, DOMCAP
Linkage to care and treatment	16	**FHI360,** New Start Center, MOHCC
ART initiation	6	**MSF, MOHCC,** OPHID
Treatment support/adherence counseling	16	**FHI360, MSF,** FACT, Africaid, DOMCAP
ART resupply/follow-up (OI/ART)	15	**FHI360,** MSF, MOHCC
CD4 testing	11	**MOHCC**, DOMCAP, MSF RG Hospital
HIV viral load testing	14	**MSF, MOHCC,** DOMCAP, FACT, EPAZ, MSF, Rusape General Hospital
Sample transportion	14	**MOHCC,** DOMCAPP, Couriers, MSF, Council Ambulance
VMMC	15	**PSI,** Global Fund, New Start Center, MOHCC, Courier Service
Nutrition support	15	**MOHCC,** Goal, PSI
Economic strengthening activities	3	FACT, DSS MOHCC, YMCA
OVC/home-based care and support	4	Africaid, FACT, Glory Orphan Care, Rusape Town Council

Community linkages

Facilities included in the assessment worked with a variety of community-based structures or cadres. Most of these groups worked to refer or encourage clients and communities to utilize available HIV care services and create a conducive environment for HIV care. Many also carried out health or behavior change education and awareness, worked to disseminate information, and tried to destigmatize HIV. The main ways that the community groups worked with facilities are summarized below.

VHWs: Almost all facilities worked with VHWs. The most common tasks carried out by VHWs were health and behavior change education and tracking and following-up defaulters. Some VHWs also refer clients to services.

Expert patients: Expert patients also carry out health education and de-stigmatization campaigns, and worked to create a conducive environment for HIV care in their communities. Several facilities reported that expert patients mobilize or coordinate support groups, and in one facility they provide psychosocial support as well.

Expert patients: Expert patients also carry out health education and de-stigmatization campaigns, and worked to create a conducive environment for HIV care in their communities. Several facilities reported that expert patients mobilize or coordinate support groups, and in one facility they provide psychosocial support as well.

Behavior change facilitators: At most facilities, behavior change facilitators carry out health and behavior change education. They also refer clients to care and create a conducive environment in the community. In some cases, they support home- and community-based care. One facility reported that behavior change facilitators provide condoms to the community, and another reported that they coordinate care for sex workers.

Health centre committees: Most facilities reported that health centre committees disseminate information about available services to the community and provide a link between the community and health facility. One facility noted that health centre committees work with the government officials to identify gaps in care and challenges faced by the community.

Community leaders: The role of community leaders was most often described as creating a conducive environment in the community and encouraging people to use HIV services. It was noted that ifcommunity leaders disseminate information, it is "readily received." Community leaders also give time to health care staff at community gatherings.

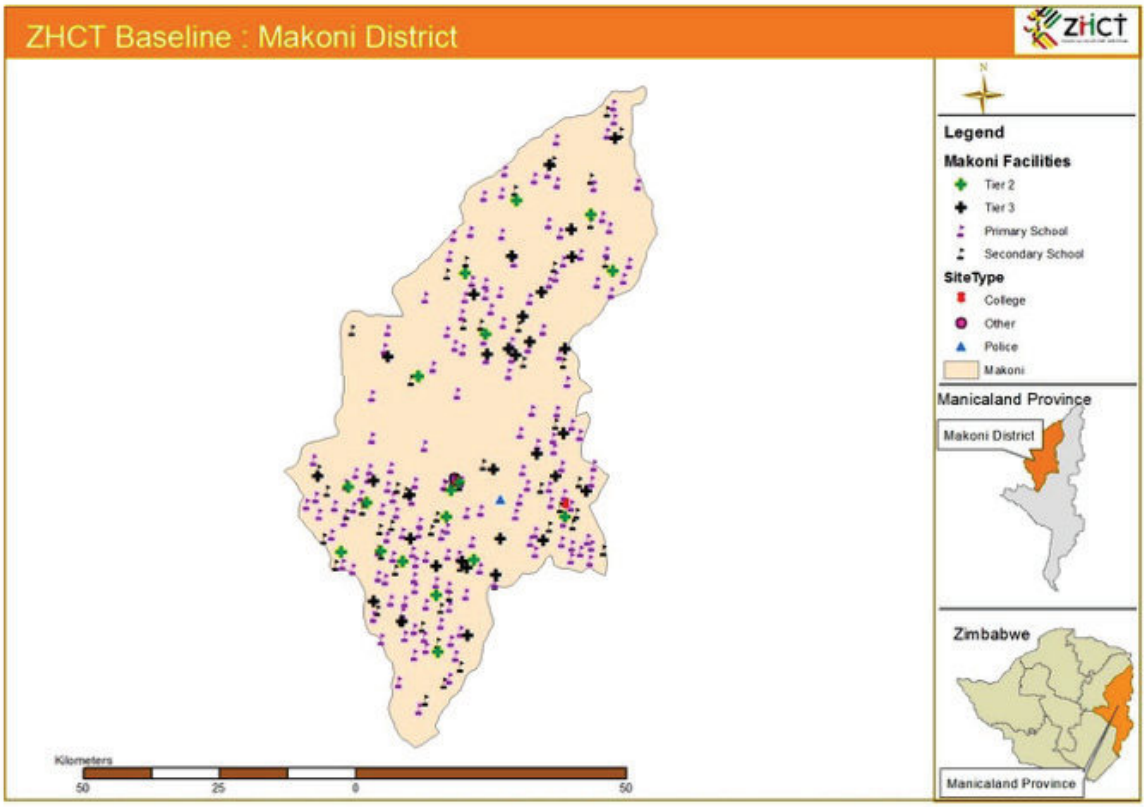
DAAC and WAAC: DAACs were the second-least commonly reported community cadre in the district. DAACs were described as coordinating care between the district and community levels. WAACs were the least commonly reported community cadre among the 17 facilities included in the assessment. Their main roles are to help coordinate care, disseminate information, and encourage people to use available services.

Other: Eleven facilities reported NGOs or other partners in this category. The twelfth facility reported working with volunteer care-givers who provided programs for adolescents on HIV prevention and treatment.

TABLE 25. COMMUNITY LINKAGES

	N = 18
Cadre / structure worked with for care and treatment:	
VHW	15
Expert patients	16
Behavior change facilitators	14
Health centre committees	16
Community leaders	17
WAAC	5
DAAC	7
Other	12

MAP OF MAKONI DISTRICT



MUTARE DISTRICT

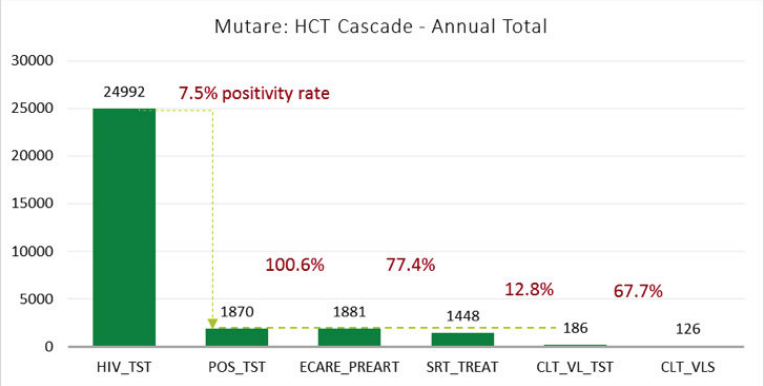
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Mutare indicates a total of 24,992 individuals tested in the last year, 7.5% (1,870) of whom were found to be HIV positive (Figure 24). This programmatic positivity rate is much lower than the reported prevalence in Manicaland Province (14.1%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Mutare are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, more than 100% of PLHIV were enrolled in care and 77.4% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Mutare are successfully linking PLHIV to care services. However, there are gaps in HIV treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is low, with only 12.8% of PLHIV having been tested. Among those tested, 67.7% were virally suppressed. Expansion of viral load machine coverage and utilisation in Mutare is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 24: HIV CASCADE, MUTARE



Service Availability and Readiness

HIV Service Readiness

Many challenges were reported in the provision of care and treatment services. The most common challenge was problems with M&E systems. Again, many facilities cited staff shortages and the resultant lack of time as barrier causing backlogs in M&E. Another common challenge was CD4 machines that failed to do counts in the past 3 months. Six facilities had CD4 machines, and of those, three facilities were not operating at one point in the last three months. Two facilities cited lack of necessary supplies (no slides, no cartridges), and one facility cited lack of trained staff due to staff turnover.

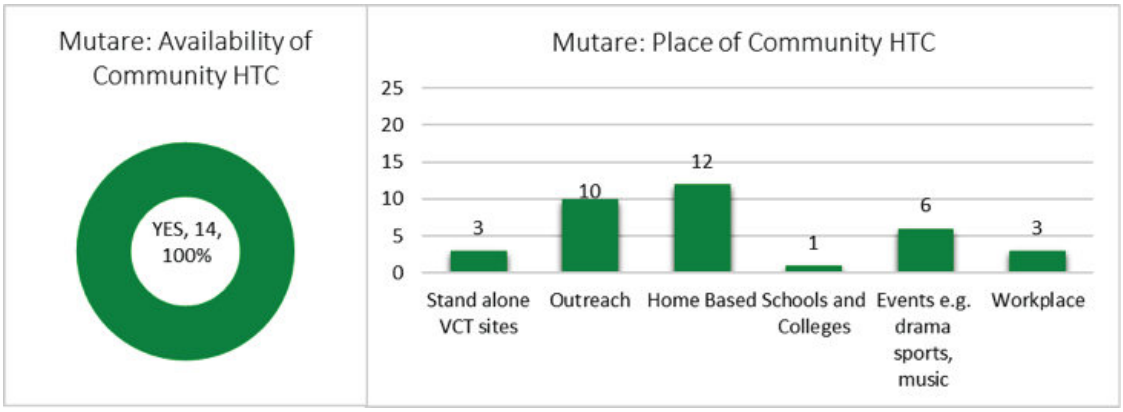
TABLE 26. HIV SERVICE READINESS, MUTARE

	N = 14
How well-staffed are HIV services?	
Short-staffed	10
Stuffing is sufficient	4
Provides services to key populations	10
Challeges to HIV service delivery:	
HTC kit stock out in past 3 months	1
ARV stock out in past 3 months	2
Has CD4 machine	6
If yes, failed to do CD4 counts in past 3 months	3
M&E challenges	7

Community-based HIV Testing and Counseling

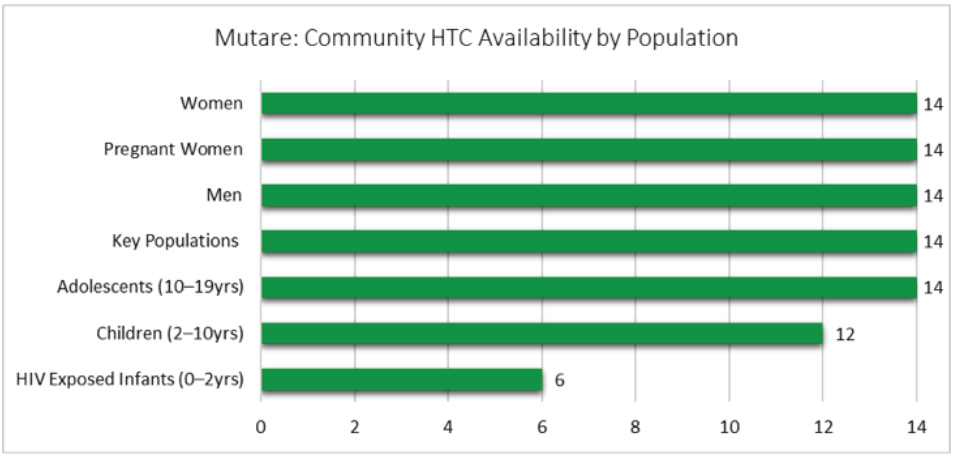
All 14 facilities in Mutare that were included in the assessment had community-based counseling and testing available (Figure 25). Outreach and home-based index testing were the most common means of service provision. All testing was done either by a nurse or primary counselor. Various organizations support testing, including: PSI, MOHCC, FHI 360, MSF, DAC, New Start, Chiedza, ZIMPHA and New Life. FHI 360 and MOCC were the most commonly mentioned organizations.

FIGURE 25. AVAILABILITY OF CHTC, MUTARE



Most populations can receive community testing and counselling from all of the surveyed facilities, with the exception of infants. Each facility identified one or two organizations that provide support for all populations that they serve. These include MOHCC (2 facilities), OPHID (1 facility), FHI 360 (4 facilities), DAC (2 facilities), New Start (3 facilities), Chiedza (1 facility), and PSI (1 facility).

FIGURE 26. AVAILABILITY OF CHTC BY POPULATION, MUTARE



The schedule for testing varied widely across facilities and ranged from seven days a week to once a quarter. Half of facilities offer community based testing monthly (n=7), and two facilities each offer services bi-monthly and daily. Six facilities offered testing outside of normal working hours. No facilities reported interruptions in provision of testing and counseling services in the four weeks prior to the survey.

TABLE 26 COMMUNITY-BASED HIV TESTING AND COUNSELLING

	N = 14
Testing and counseling offered outside normal work hours	6
Interruptions in community testing and counseling in past four weeks	0

Linkage to Care and Treatment

All but one of the facilities have a referral mechanism for clients who test positive for HIV to ensure they enroll into care and treatment (Table 27). The majority of facilities use referral slips, and some use both referral slips and follow-up tracking. Respondents from twelve facilities felt that they did "well" or "very well" in ensuring the referrals are complete; however, two thought their facility did "very poorly".

Of these two facilities, one had no referral mechanism, while the other used solely referral slips. As one of these respondents noted, "We use referral slips which the patient brings to one facility, but there are no follow up mechanisms as the hospital does not have community health workers who report directly to the hospital." Lack of adequate staff appears as a theme throughout the interviews: half of the facilities reported that they were short staffed; while five felt that they had sufficient staff to provide services.

TABLE 27. ENROLLMENT INTO CARE AND TREATMENT

	N = 14
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	13
Mechanism used (some had more than one method):	
Referral slip	12
Follow-up appointment made	1
Follow-up / tracking of defaulters	6
How well does facility ensure referrals are complete:	
Very well	2
Well	10
Reasonably poorly	0
Very poorly	2

Community-based ART services

Community-based ART services were not common in the facility catchment areas and only one facility provided these services (Table 28). This facility provided ART follow-up and resupply. These services were provided through outreach and community ART refill groups. The facility experienced no interruptions in the community-based provision of ART services in the past four weeks.

TABLE 28. COMMUNITY-BASED ANTIRETROVIRAL THERAPY

	N = 14
Provides community-based ART services in facility catchment area	1
Type of service provided:	
ART initiation	1
ART follow-up (resupply)	1
How are services delivered:	
Outreach	1
Community ART refill groups	1
NGO operated facilities	0
Interruptions in provision of ART community-based services in past 4 weeks	0

Retention in Care and Treatment

All of the facilities reported that they identify ART clients who do not come back for review and/or resupplies (Table 29). All facilities identify clients by use of appointment diaries, while two facilities also use VHWs and registers. Furthermore, all facilities attempt to follow up the ART clients who do not return to the clinic.

They do this mainly through CBHWs and phone calls. Through open-ended responses, the respondents cited numerous challenges they face in following-up clients. The one cited most often was lack of airtime or bad reception for cellular phones- in fact, all facilities that reported using phones for follow-up also reported issues related to phone use as a challenge.

TABLE 29. RETENTION IN CARE/ ON TREATMENT

	N = 14
Identifies ART clients who do not come back for reviews and/ or resupplies	14
How identifies clients:	
VHW	2
Appointment diary	14
Registers	2
EPMS	3
Follows up ART clients who do not come back for clinic reviews and/or resupplies	
How does facility follow up:	
CBHWs	12
Phones	10
Challenges in following up clients	
Airtime challenges or bad reception	10
Client provided wrong phone number	1
Distance	1
Mobile population	1

Other Community Services Available

Twelve of the fourteen facilities offered additional services, as outlined in Table 30. Counseling services, for adherence and family planning were the most widely available, while different types of diagnostic tests including CD4 count, viral load, and screening for opportunistic infections were offered in half of the facilities.

TABLE 30. AVAILABILITY OF OTHER COMMUNITY SERVICES

	N = 14
CD4 count	7
Viral load testing	7
Adherence counseling	9
Screening for OIs	7
Family planning counseling	9

Service Delivery Partners

These facilities work with a range of partners to provide services to their catchment areas (Table 13). FHI 360, FACT and MSF are the partners mentioned most often. All facilities work with partners to provide HIV testing and counseling, linkage to care and treatment, and HIV viral load testing. Most work with partners to provide community mobilization and treatment support/adherence counselling. The large number of organizations working in the same catchment area point to the potential for collaboration or consolidation of services provided.

TABLE 31. PARTNER MAPPING

Community Based Services	N = 14	Organization
Community mobilization	13	**FACT ,** OPHID, FHI360, DAC, Chiedza, PSI
HIV testing and counselling	14	**FHI360,** New Start Center, OPHID, EGPAF, PSI, Chiedza
Linkage to care and treatment	14	**FHI360, FACT,** HENLite, EGPAF, Chiedza, MSF, OPHID, Africaid, New Start
ART initiation	10	**MOHCC,** FACT, OPHD, MSF, Chiedza, New Start, FHI360
Treatment support/adherence counseling	13	FHI360, **MSF, FACT,** Africaid, FASO, HGF, OPHID
ART resupply/follow-up (OI/ART)	5	**OPHID,** MSF, MOHCC, PSI, New Start, FHI360
CD4 testing	11	**Riders for Health,** MSF, MOHCC, OPHID, FHI360
HIV viral load testing	14	**MSF,** OPHID, EGPAF, Riders for health, Fact, DOMICCAP MOHCC, FHI360
Sample transportion	13	**Riders for Health,** MSF, MOHCC, OPHID, FHI360
VMMC	10	**PSI**
Nutrition support	6	**Plan International,** IRC, Chiedza, ASAP
Economic strengthening activities	6	**DOMCCAP,** Plan International, FACT, Chiedza, ASAP
OVC/home-based care and support	4	**FACT,** OPHD, Mrana Trust, DORCAS, Plan International, SWEDISH, Windows of Hope, Social Welfare

Community Linkages

All facilities have linkages to their communities with different cadres or structures, as summarized in Table 32.

We asked about the main ways these community cadres help with demand creation of delivery of care at the community level. Short response answers were coded to extract themes by cadre. Many services were common across multiple cadres. Results are summarized below.

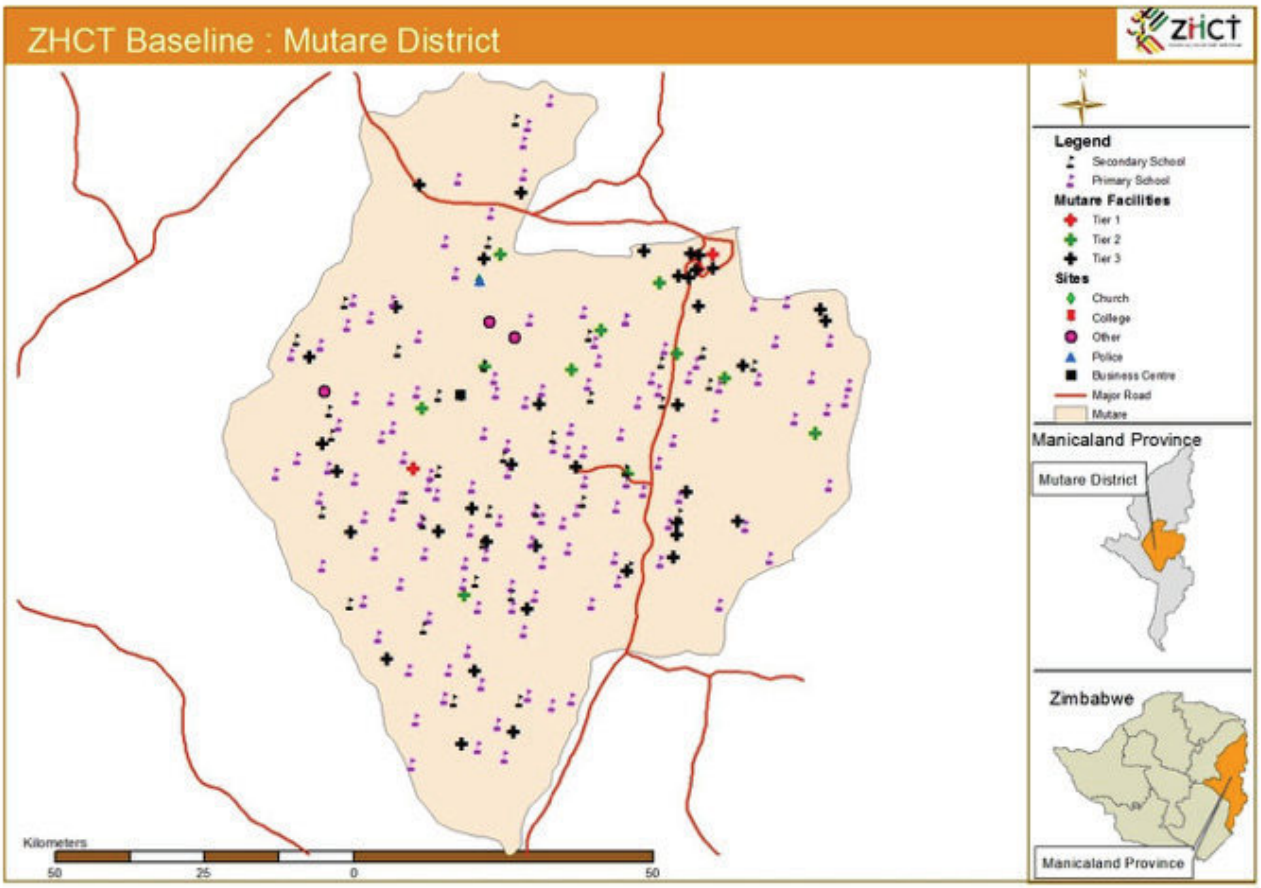
VHWs, Expert patients, Behaviour change facilitators, Health Centre Committees, Community Leaders: These cadres all perform similar functions in creating demand for HIV services. They perform the following: 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, and 3) providing health education.

WAAC, DAAC, and Mother's support groups: WACC, DAAC, and Mother's support groups assist by providing health and behavior change education to community members.

TABLE 32. COMMUNITY LINKAGES

	N = 14
VHW	11
Expert patients	7
Behavior change facilitators	12
Health centre committees	12
Community leaders	10
WAAC	1
DAAC	5
Mother's support groups	0

MAP OF MUTARE DISTRICT



MUTASA DISTRICT

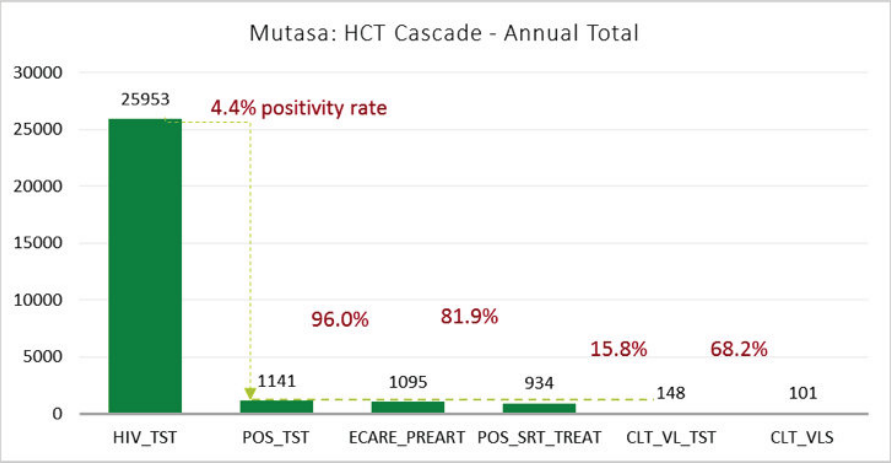
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Mutasa indicates a total of 25,953 individuals tested in the last year, 4.4% (1,141) of whom were found to be HIV positive (Figure 27). This programmatic positivity rate is much lower than the reported prevalence in Manicaland Province (14.1%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Mutasa are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, 96.0% of PLHIV were enrolled in care and 81.9% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Mutasa are successfully linking most PLHIV to care services. However, there are still gaps in HIV treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is low, with only 15.8% of PLHIV having been tested. Among those tested, 68.2% were virally suppressed. Expansion of viral load machine coverage and utilisation in Mutasa is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 27: HIV CASCADE, MUTARE



Service Availability and Readiness

HIV Service Readiness

Eight facilities reported that they were adequately staffed and could manage increased demand for HIV services and four respondents felt their facilities were under-staffed. Six facilities reported facing challenges to provision of care. Of the five facilities that reported having a CD4 count machine, four had failed to do CD4 counts in the previous three months. Of those four, all reported that this was due to their machine not functioning or a lack of other materials, such as reagents or cartridges, necessary to use the machine. The fifth facility reported not having failed to do tests in the past three months only because they sent samples to another facility with a functioning machine. No facilities reported stock-outs of HIV testing kits or ARVs in the previous three months.

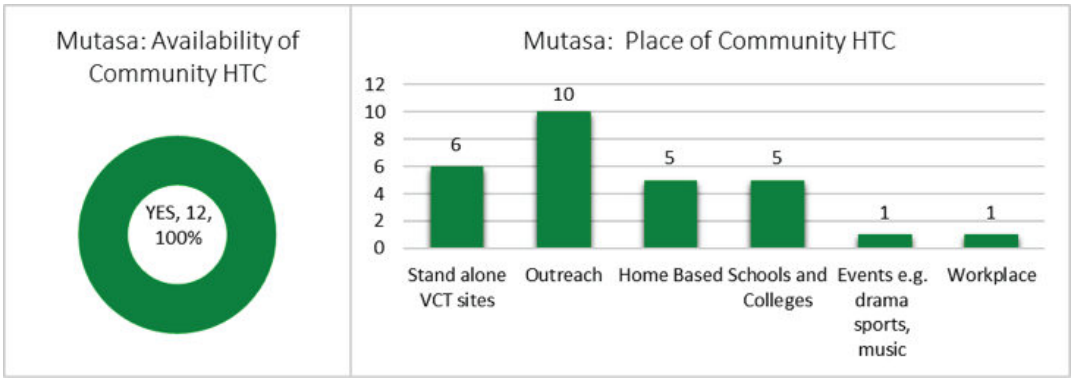
TABLE 33. ENROLMENT INTO CARE AND TREATMENT

	N = 12
How well staffed are HIV services?	
Short staffed	4
Adequately staffed	8
Challenges to provision of care and treatment:	
HTC kit stock out in past 3 months	0
ARV stock out in past 3 months	0
Has CD4 machine	5
If yes, failed to do CD4 counts in past 3 months	4
M&E challenges	1

Community-based HIV Testing and Counseling

All twelve facilities included in the assessment in Mutasa district had community-based testing and counseling available. The most common venue for testing was through outreach (10). CHTC is provided at stand-alone VCT sites by six facilities, and five facilities each offered home based index case testing. Only one facility reported that testing and counseling were available at events such as sports, music, drama, or at workplaces. Most care was reported to be provided by nurses, though a few facilities reported services provided by primary counselors or other clinic staff. FACT, the MOH, and NAC supported most of these services, with FHI 360, OPHID, OFID, and Chiedza also providing some support.

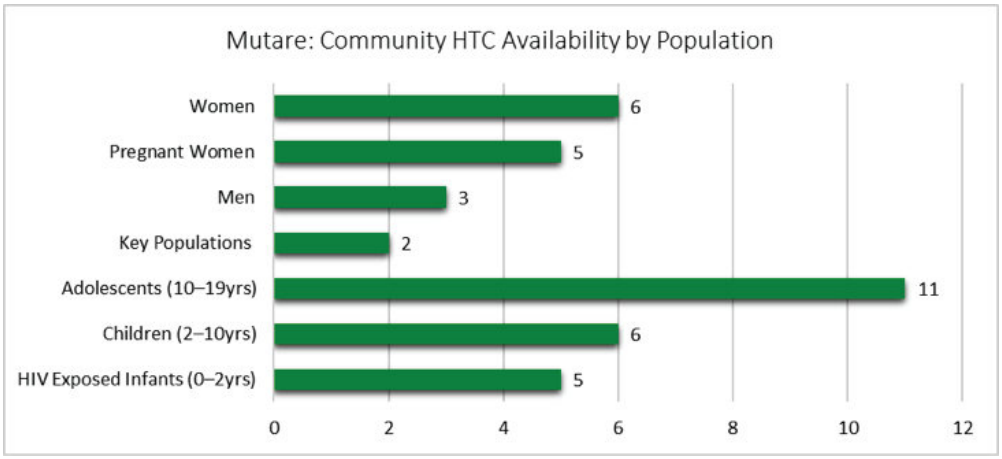
FIGURE 28: CHTC AVAILABILITY, MUTASA



Adolescents were the most-targeted group for services, with 11 out of 12 facilities reporting that testing and counseling was available for adolescents. No more than half of the facilities reported having services available for other groups. Only two facilities reported providing services to key populations such as sex workers and truck drivers, which is different compared to other districts where the majority of facilities report serving KPs.

It is possible that more facilities offered services to more populations, but that they are not specifically targeted and so were not reported.

FIGURE 29. AVAILABILITY OF CHTC BY POPULATION, MUTASA



Days per week that CHTC was available varied among facilities, with four facilities offering it every day, six facilities offering it five days per week, and two facilities offering it twice monthly. One facility noted that they offer testing five days per week, with the caveat that they do so only as long as there is a qualified and trained person available. Eight facilities reported that testing was available outside of normal working hours. One facility, Tsonzo RHC, reported having services available 24 hours a day.

Several facilities noted that members of certain religious sects made appointments outside of normal business hours, and two facilities mentioned having services available for pregnant mothers outside of normal hours. No facilities reported interruptions in testing and counseling in the previous four weeks.

TABLE 34. COMMUNITY-BASED HIV TESTING AND COUNSELING

	N = 12
Testing and counseling offered outside normal work hours	8
Interruptions in community testing and counseling in past four weeks	0

Linkage to Care and Treatment

Facilities reported using a variety of methods to make referrals (Table 35). All but one facility reported having some sort of referral mechanism to help clients enroll into care and treatment; the most common methods were registers, patient health booklets, and VHWs. The majority of participants reported that their facility handled the referral process "well," with some reporting that the facility handled it "very well." No facilities reported handling the referral process either "reasonably poorly" or "very poorly."

TABLE 35. ENROLMENT INTO CARE AND TREATMENT

	N = 12
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	11
Mechanism used (some had more than one method):	
Referral slip	3
Registers	4
Follow-up/tracking defaulters	1
Health/green booklets	4
VHWs	4
Verbal communication	3
How well does facility ensure referrals are complete:	
Very well	4
Well	8
Reasonably poorly	0
Very poorly	0

Community-based ART Services

Only one facility reported providing community-based ART services in its catchment area (Table 36). The facility only provided ART follow-up and resupply, and did not initiate patients into ART. All of the services were delivered via outreach, and no interruptions in service in the previous four weeks were reported.

TABLE 36. COMMUNITY-BASED ART

	N = 12
Provides community-based ART services in facility catchment area	1
Type of service provided:	
ART initiation	0
ART follow-up (resupply)	1
How are services delivered:	
Outreach	1
Community ART refill groups	0
NGO operated facilities	0
Interruptions in provision of ART community-based services in past 4 weeks	0

Retention in Care and Treatment

All facilities included in the assessment reported having a systematic way of identifying ART clients who missed clinic reviews and resupplies (Table 37). All facilities indicated using an appointment diary. Village health workers and registers were also common ways of identifying defaulting clients. Three facilities reported using other methods, such as CHASAs and electronic patient management systems (EPMS).

All facilities reported having a systematic way of following-up those clients who did not turn up for clinic reviews and resupplies. Most facilities used CBHWs and phone calls to follow-up clients, and one reported using an EPMS.All but one facility reported at least one challenge to following-up clients. The most common challenges were not having any or correct phone numbers or addresses for clients; clients being mobile or migratory, particularly those working in nearby mines; and clients living at the very edges of the facility catchment areas and having to travel long distances. Two facilities reported "airtime challenges" as an issue in following-up clients.

TABLE 37. RETENTION IN CARE AND TREATMENT

	N = 12
Identifies ART clients who do not come back for reviews and/ or resupplies	12
How identifies clients:	
VHW	7
Appointment diary	12
Registers	8
Other	3
Follows up ART clients who do not come back for clinic reviews and/or resupplies	
How follows-up:	
CBHWs	10
Phones	11
EPMS	1

	N = 12
Challenges in following-up clients:	
No/wrong phone number or address	3
Transport challenges	0
Lack of airtime/phones or bad reception	2
Mobile/migrant population	3
Distance/geographic barriers	3
Lack of interest/client resistance	1

Other Community Services Available

All facilities reported providing other services in the community (Table 38). All facilities provided adherence counseling, screening for OIs, and family planning counseling. Five reported providing CD4 counts, though as mentioned earlier, many CD4 machines were not functioning. Only three reported providing viral load testing.

The majority of these services were provided by nurses, with primary counselors, expert patients, and CHASAs providing some services as well.

TABLE 38. AVAILABILITY OF OTHER COMMUNITY SERVICES

	N = 12
CD4 count	5
Viral load testing	3
Adherence counseling	12
Screening for OIs	12
Family planning counseling	12

Service Delivery Partners

All facilities included in this assessment worked with partners to provide services (Table 39). The most commonly reported partners across all of the facilities were PLAN and FACT. Ten out of the twelve facilities partnered with PLAN, with the same number partnering with FACT to deliver at least one service. Either PLAN or FACT, or both, were partnered with every facility. Seven facilities reported working with Riders for Health to transport test samples and results. Six facilities partnered with DOMCCP.

Eleven of the twelve facilities reported working with partners to provide HIV testing and counseling. The specific activities of partners supporting HTC varied greatly, and included supporting HTC through in-kind assistance, such as providing fuel for others to perform outreach or providing refreshments forHTC campaigns, to directly performing referral, outreach, and awareness activities. Two facilities noted that their partners performed targeted outreach.

All but one facility worked with partners, most commonly PLAN, to provide some sort of nutrition assistance to the community. Specific populations mentioned to receive nutrition assistance included children under two, pregnant or lactating mothers, and clients on ART with low BMI.

TABLE 39 PARTNER MAPPING

Community Based Services	N = 12	Organization
Community mobilization	10	**FACT , DOMCCP,** PLAN, NAC
HIV testing and counselling	11	**FACT,** OFID, OPHID, OUTREACH, NAC, New Start,PSI,DOMCCP, FHI, Chiedza, Tariro
Linkage to care and treatment	3	**FACT,** FHI, OFID, DAAP
ART initiation	1	OPHID
Treatment support/adherence counseling	4	**FACT, DOMCCP,** BRTI
ART resupply/follow-up (OI/ART)	5	OPHID, MSF, MOHCC, PSI, New Start, FHI360
CD4 testing	1	MOH, DOMCCP, MCHIP
HIV viral load testing	5	OPHID, MOH, MSF, EGPAF, DOMCCP
Sample transportion	9	**Riders for Health,** DAPP, RBF Fund, FedEx, MSF
VMMC	5	**PSI,** UNFPI
Nutrition support	11	**PLAN,** EHT, WVI, DAAP
Economic strengthening activities	6	**DOMCCP,** FACT
OVC/home-based care and support	6	**FACT,** MOHCC, ARISE, Kubatana

Community Linkages

Facilities included in the assessment worked with a variety of community-based structures (Table 8). The majority of these community groups carried out HIV or other health education and awareness programs, helped de-stigmatize HIV in the community, and created a conducive environment for the facility to reach patients. Many also referred clients to the facility and helped track and follow-up defaulting patients.

All facilities reported working with VHWs and behavior change facilitators, and nearly all reported linkages with expert patients and health center committees. Seven reported working with community leaders, while fewer were linked to either WAAC or DAAC. Apart from the seven types of community cadres that facilities were specifically asked about, the Tsonzo RHC also reported working with Case Care Workers, unique to Mutasa.

The main ways that each community cadre worked with facilities are discussed below.

VHWs: Eight facilities reported that VHWs track and follow-up clients and defaulters. VHWs also deliver health or behavior change education and conduct awareness campaigns, and help create a conducive environment by mobilizing community support groups. At many facilities, VHWs refer clients to care, and one facility reported that they provide psychosocial support to clients.

Expert patients: Expert patients refer and follow-up patients, provide adherence counseling, supervise support groups, and at one facility help manage paperwork.

Behavior change facilitators: Behavior change facilitators raise awareness about health behavior and cancer screenings. They also track and follow-up clients and provide adherence counseling.

Health center committees: Health center committees provide education and counseling, and encourage people to use facility services. In some facilities, they identify people in the community who need assistance and coordinate care

Community leaders: Community leaders raise awareness and encourage community members to use HIV testing and care services. Three facilities mentioned that community leaders use communitygatherings as fora to promote HIV testing and use of HIV services, with one facility stating that community leaders specifically encourage people to get tested with their partners.

WAAC: Two facilities mentioned linkages with WAAC, with one facility stating that they "promote testing and encourage adherence and positive living."

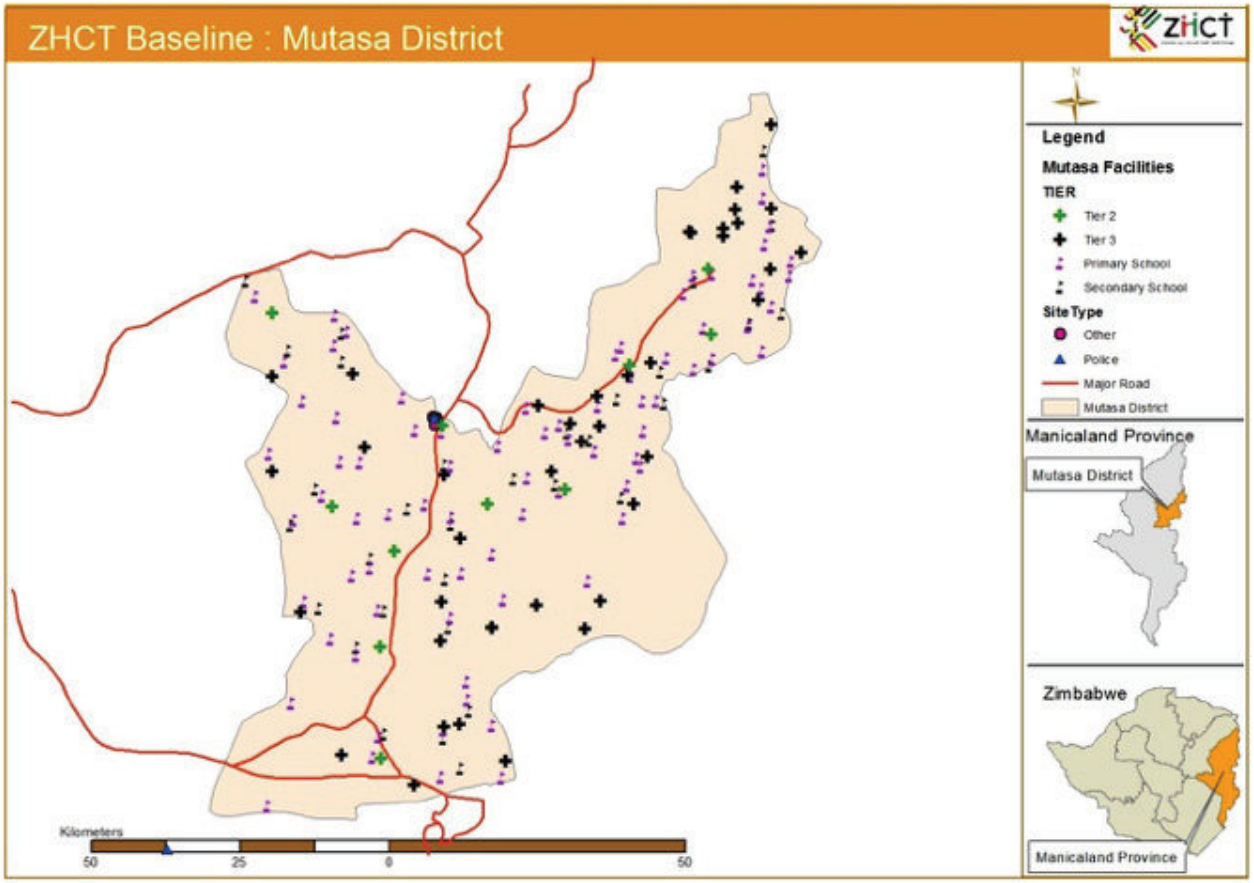
DAAC: Three facilities have linkages with DAAC. DAAC provides fuel for outreach activities, trains nurses on M&E, and conducts data verification.

Other: At the Tsonzo RHC, case care workers encourage testing, track defaulters, and work with children.

TABLE 40. COMMUNITY LINKAGES

	N = 12
Cadre / structure worked with for care and treatment:	
VHW	12
Expert patients	10
Behavior change facilitators	12
Health centre committees	9
Community leaders	7
WAAC	2
DAAC	3
Other	1

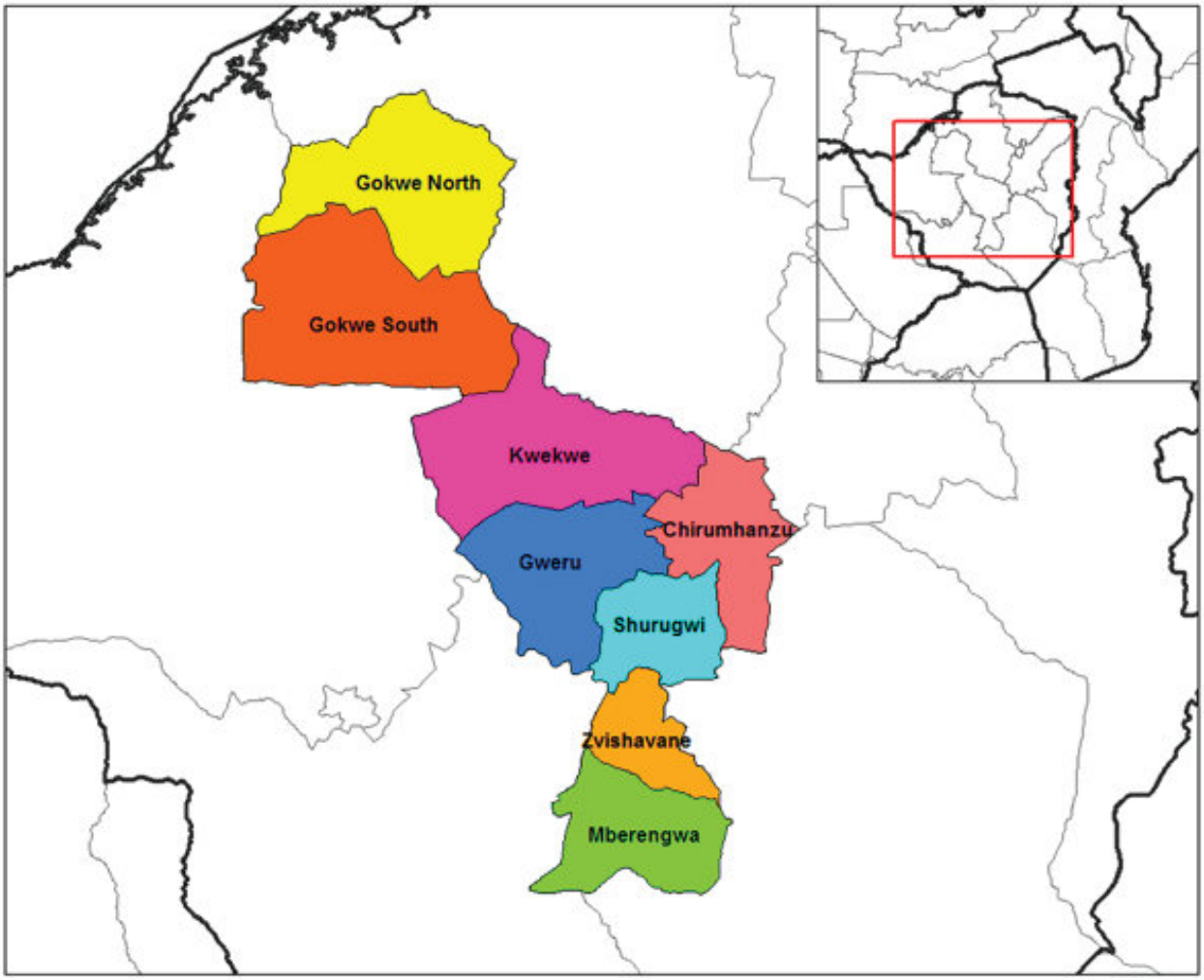
MAP OF MUTASA DISTRICT.



MIDLANDS PROVINCE

ZHCT districts in Midlands Province include Gokwe South, Kwekwe, and Gweru. HIV prevalence in Midlands is 15.4%7. More than three-quarters (83.5%) of women and 60.9% of men aged 15 – 49 years in Manicaland have ever been tested and received their results; 54.2% of women and 38.2% of men have been tested in the last 12 months and received their result.

FIGURE 30. MAP OF MIDLANDS PROVINCE



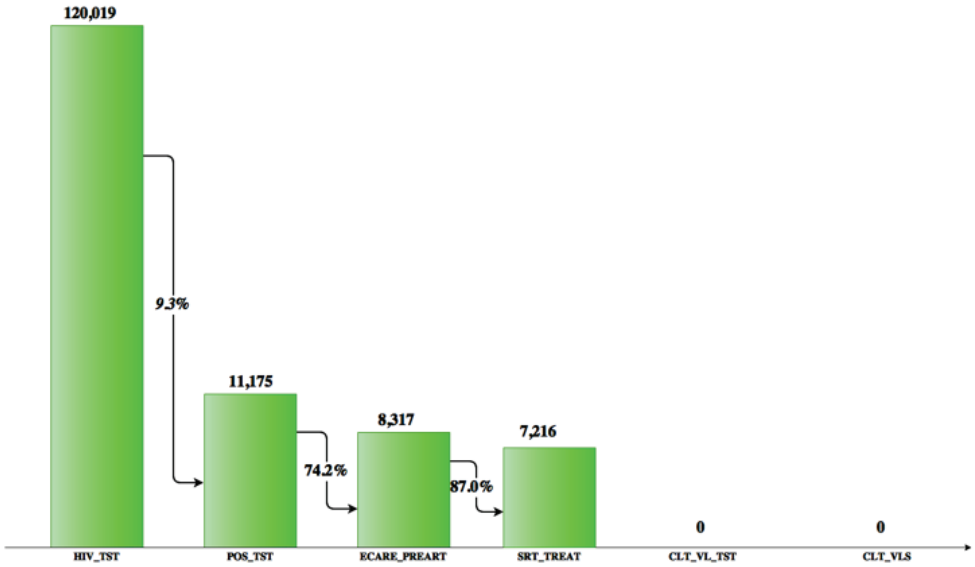
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Midlands province indicates a total of 120,019 individuals tested in the last year, 9.3% (11,175) of whom were found to be HIV positive (Figure 31). This programmatic positivity rate is much lower than the reported prevalence in the province (15.4%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in the province are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, 74.2% of PLHIV were enrolled in care and 64.5% were initiated on HIV treatment – lower than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Midlands are facing challenges in linking PLHIV to care and treatment services and that facilities in Midlands lagging behind compared to Manicaland facilities. This indicates a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

Access to viral load testing is non-existent in Midlands Province, with zero PLHIV having been tested. Expansion of viral load machine coverage and utilisation in Midlands is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 31: HIV CASCADE, MIDLANDS



GOKWE SOUTH DISTRICT

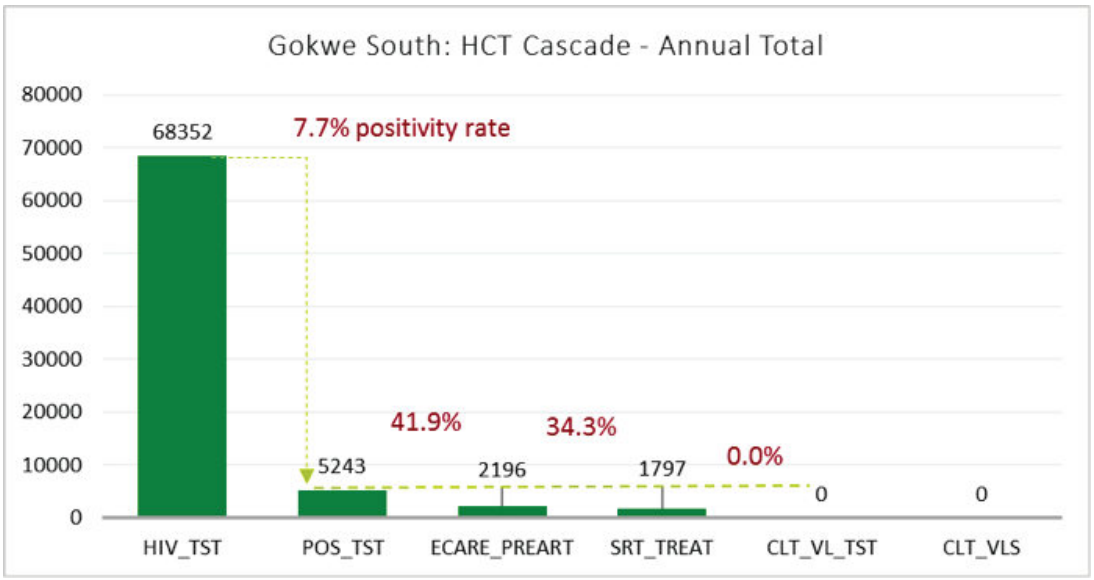
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Gokwe South indicates a total of 68,352 individuals tested in the last year, 7.7% (5,243) of whom were found to be HIV positive (Figure 32). This programmatic positivity rate is much lower than the reported prevalence in Midlands Province (15.4%). Accounting for the difference between the positivity rate and prevalence, coupled with data indicating less than half of the population having been tested in the last 12 months, these data suggest that HIV testing services in Gokwe South are not targeting individuals at highest risk of infection.

Of those testing HIV-positive, 41.9% of PLHIV were enrolled in care and 34.3% were initiated on HIV treatment – much lower than the figures across all ZHCT facilities (84.2% and 70.4%, respectively), and by far, the lowest of all ZHCT supported districts. These data show that facilities in Gokwe South are facing critical challenges in linking PLHIV to care and treatment services. This indicates a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

As previously mentioned, access to viral load testing is non-existent in all districts in Midlands Province. Expansion of viral load machine coverage and utilisation in Midlands is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 32: HIV CASCADE, GOKWE SOUTH



Service Availability and Readiness

HIV Service Readiness

Lack of adequate staff was very common, with eleven of twelve facilities reporting that they were short staffed. Many challenges were reported in the provision of care and treatment services. The most common challenge was problems with M&E systems, reported by eleven of twelve facilities. Respondents cited staff shortages and the resultant lack of time, in combination with the large number of registers that they were expected to complete, as the major barriers. Another common challenge was stock outs. Five facilities mentioned stock outs of Determine Rapid Test kits, and the two facilities who experienced ARV stock outs commented that pediatric medicine was commonly out of stock. Lastly, three facilities noted that their CD4 machines failed to do counts in the past three months. Two facilities cited broken machines, while one was out of cartridges.

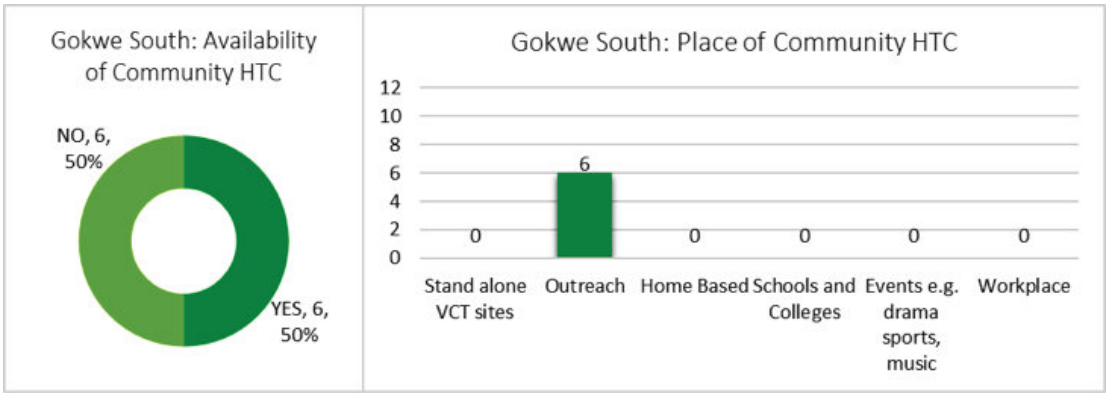
TABLE 41. HIV SERVICE READINESS

	N = 12
How well staffed are HIV services?(open responses)	
Short staffed	11
Adequately staffed	1
Challenges in provision of care and treatment	
HTC kit stock out in past 3 months	6
ARV stock out in past 3 months	2
Has CD4 machine	4
If yes, failed to do CD4 counts in past 3 months	3
M&E challenges	11

Community-based HIV Testing and Counseling

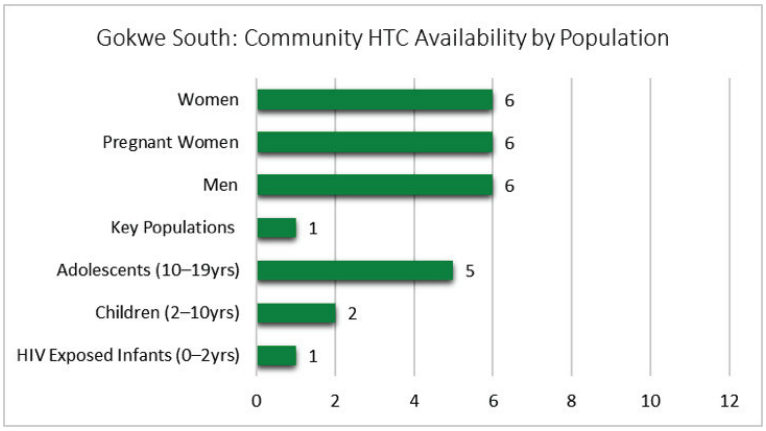
Of the twelve facilities in Gokwe South that were included in the assessment, six had community- based counseling and testing available (Figure 33). Outreach was the only means of service provision. All testing was done by nurses and supported by PSI.

FIGURE 33: CHTC AVAILABILITY, GOKWE SOUTH



Of the facilities that offer CHTC, services are provided to men, women and pregnant women while five provides them to adolescents. Only one facility each has testing services for infants and key population while two provide services to children. Again, PSI was the only organization supporting community testing and counselling for any of these populations.

FIGURE 34. AVAILABILITY OF CHTC BY POPULATION, GOKWE SOUTH



Of the facilities that offer CHTC, all facilities reported doing so once per month. No facilities offer testing and counselling outside of normal work hours, and none reported interruptions in community testing and counselling in the last four weeks.

TABLE 41. COMMUNITY-BASED HIV TESTING AND COUNSELING

	N = 12
Testing and counseling offered outside normal work hours	0
Interruptions in community testing and counseling in past four weeks	0

Linkage to Care and Treatment

Of the six facilities that offer CHTC, four have a systematic mechanism for linking PLHIV to care and treatment services (Table 42). Those that do use referrals, registers, and tracking of defaulters. Respondents from three of the four facilities felt that they did "well" or "very well" in ensuring the referrals are complete; however, one thought their facility did "very poorly". This facility used only referral slips, but did not provide a reason for the poor completion of referral.

TABLE 42 ENROLMENT INTO CARE AND TREATMENT

	N = 12
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	4
Mechanism used (some had more than one method):	
Referral slip	2
Registers	1
Tracking and following - up with defaulters	1
How well does facility ensure referrals are complete:	
Very well	2
Well	1
Reasonably poorly	0
Very poorly	1

Community-based ART Services

Community-based ART services in facility catchment areas was provided by six facilities (Table 43). Of these, none provided ART initiation, but all provided ART follow-up and resupply. These services were provided through community ART refill groups. One facility experienced interruptions in the community-based provision of ART services in the past four weeks, but did not specify the type of interruption.

TABLE 43. COMMUNITY BASED ANTRIRETROVIRAL THERAPHY

	N = 12
Provides community-based ART services in facility catchment area	6
Type of service provided:	
ART initiation	0
ART follow-up (resupply)	6
How are services delivered:	
Outreach	0
Community ART refill groups	6
NGO operated facilities	0
Interruptions in provision of ART community-based services in past 4 weeks	1

Retention in Care and Treatment

All of the facilities reported that they identify ART clients who do not come back for review and/or resupplies (Table 44). All 12 facilities identify clients by use of registers; one facility also uses an appointment diary, 10 facilities use a combination of register, appointment diary and VHWs. Furthermore, all facilities attempt to follow up the ART clients who do not return to the clinic. One facility uses just CBHWs, one facility only uses the phone, and the remaining 10 facilities uses both CBHWs and phone. Through open-ended responses, the respondents cited numerous challenges they face in following-up clients. The challenge cited most often was distance to the clinic. Other challenges are shown in Table 44.

TABLE 44. RETENTION IN CARE / ON TREATMENT

	N = 12
Identifies ART clients who do not come back for reviews and/ or resupplies	12
How identifies clients:	
VHW	10
Appointment diary	11
Registers	12
Follows up ART clients who do not come back for clinic reviews and/or resupplies	12
How does facility follow up:	
CBHWs	1
Phones	11
Challenges in following up clients*	
Distance	5
Mobile population	2
Lack of staff	2
Airtime challenges or bad reception	1
Client provided wrong phone number	1
Client resistance	1

Note: *Data missing from four participants

Other Community Services Available

Nine facilities offer additional services within the community, as outlined in Table 45. Counseling services were the most widely available (adherence and family planning), while screening for opportunistic infections was also offered in two facilities. No facilities offered CD4 count or viral load testing within the community.

TABLE 45. OTHER SERVICES AVAILABLE

	N = 12
CD4 count	0
Viral load testing	0
Adherence counseling	5
Screening for OIs	2
Family planning counseling	7

Service Delivery Partners

These facilities work with a range of partners to provide services to their catchment areas, although many service delivery areas, specifically those related to diagnostic tests, are not supported (Table 46). Gaps in support lie in ART initiation, ART resupply, CD4 testing, viral load testing, and sample transportation. No one organization seems to be more active than others in the area.

TABLE 46 PARTNER MAPPING

Community Based Services	N = 12	Organization
Community mobilization	9	MASO
HIV testing and counselling	6	PSI
Linkage to care and treatment	2	MASO, KAPNEK, EGPAF
ART initiation	0	None
Treatment support/adherence counseling	2	AFRICAID
ART resupply/follow-up (OI/ART)	0	None
CD4 testing	0	None
HIV viral load testing	0	None
Sample transportion	0	None
VMMC	2	ZACH, ZICHIRE
Nutrition support	1	Social Welfare
Economic strengthening activities	5	CARITAS, CARE, CODAID, Germany AGRO
OVC/home-based care and support	2	ZNNP+, CARITAS

Community Linkages

All facilities have linkages to their communities with different cadres or structures, as summarized in Table 47. We asked about the main ways these community cadres help with demand creation and delivery of care at the community level. Short response answers were coded to extract themes by cadre. Many services were common across multiple cadres. Results are summarized below.

VHWs, Behaviour change facilitators: These cadres perform the same function in creating demand for HIV services. They perform the following: 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, and 3) providing health education.

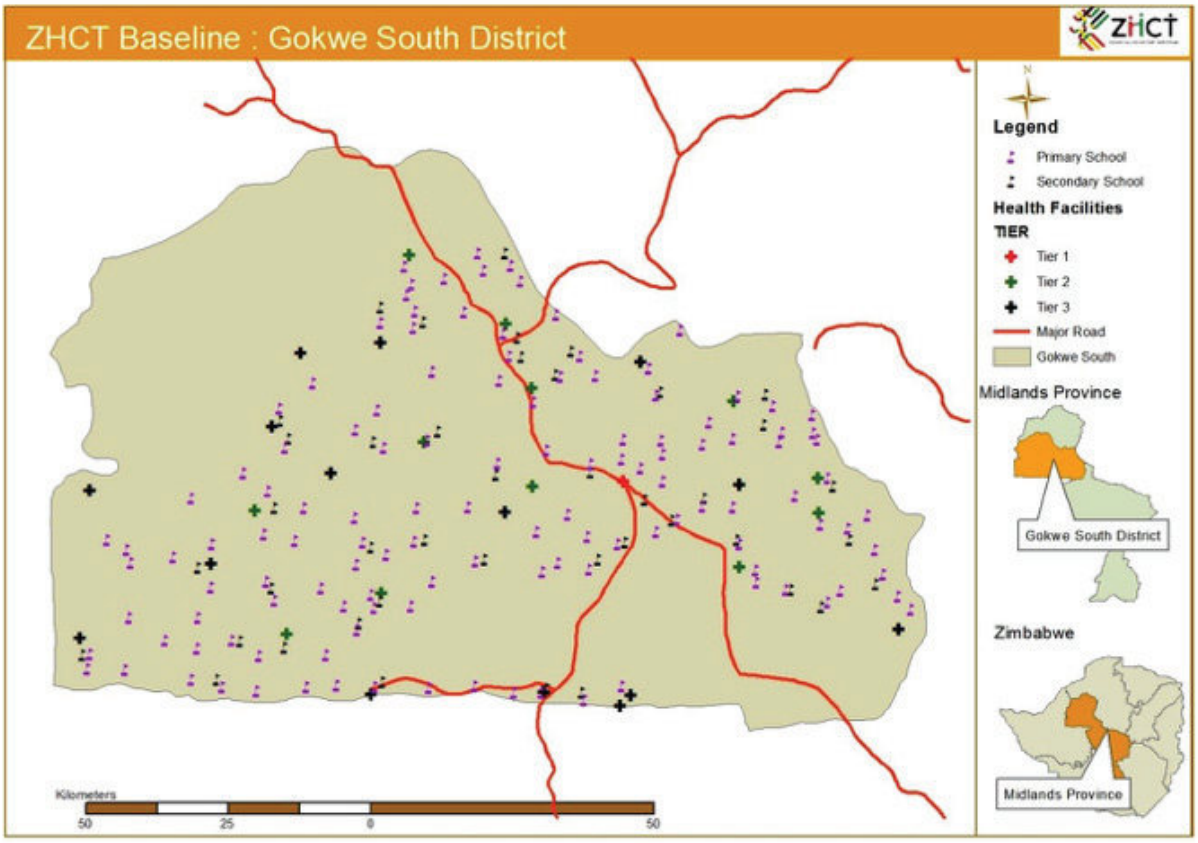
Health Centre Committees, Community leaders: Health centre committees and community leaders refer clients and provide education and awareness campaigns.

DAAC: DAAC assist by performing the following: 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, and 3) support of home and community based care.

TABLE 47. COMMUNITY LINKAGES

	N = 12
Cadre/ structure worked with for Care and Treatment:	
VHW	11
Expert patients	1
Behavior change facilitators	8
Health centre committees	8
Community leaders	11
WAAC	0
DAAC	1
Other	0

MAP OF GOKWE SOUTH DISTRICT



GWERU DISTRICT

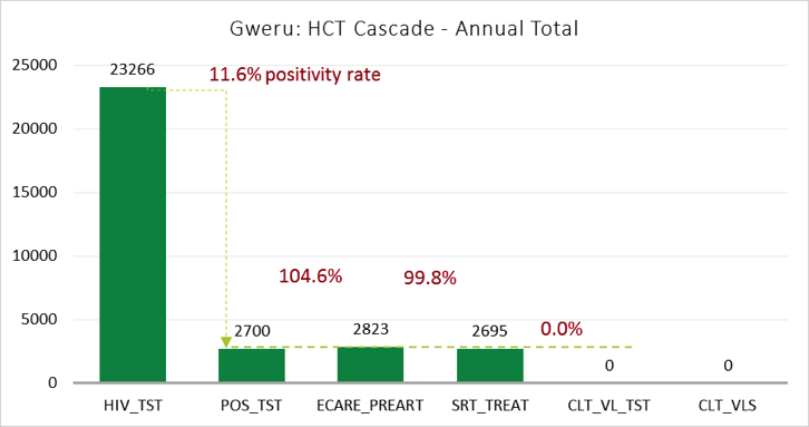
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Gweru indicates a total of 23,266 individuals tested in the last year, 11.6% (2,700) of whom were found to be HIV positive (Figure 35). This programmatic positivity rate is not much lower than the reported prevalence in Midlands Province (15.4%), indicating that individuals at high risk for HIV infection are accessing services.

Of those testing HIV-positive, 104.6% of PLHIV were enrolled in care and 99.8% were initiated on HIV treatment – much higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Gweru successfully linked PLHIV to care and treatment services in the last year. Facilities in Gweru should continue to implement their strategies to ensure linkage to care andtreatment to maintain achievement of UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

As previously mentioned, access to viral load testing is non-existent in all districts in Midlands Province. Expansion of viral load machine coverage and utilisation in Midlands is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 35: HIV CASCADE, GWERU



Service Availability and Readiness

HIV Service Readiness

Nine facilities reported that they were short staffed, while six felt that they had sufficient staff to provide services. Some challenges were reported in the provision of care and treatment services. The most common were problems with M&E systems. The M&E challenges are due to: lack of trained staff (3), and a partner organization that does not submit their forms (1). One participant did not explain the answer. One CD4 machine was reported as failing in the past three months. The participant stated that the machine was still down, and that they also had a shortage of specimen tubes.

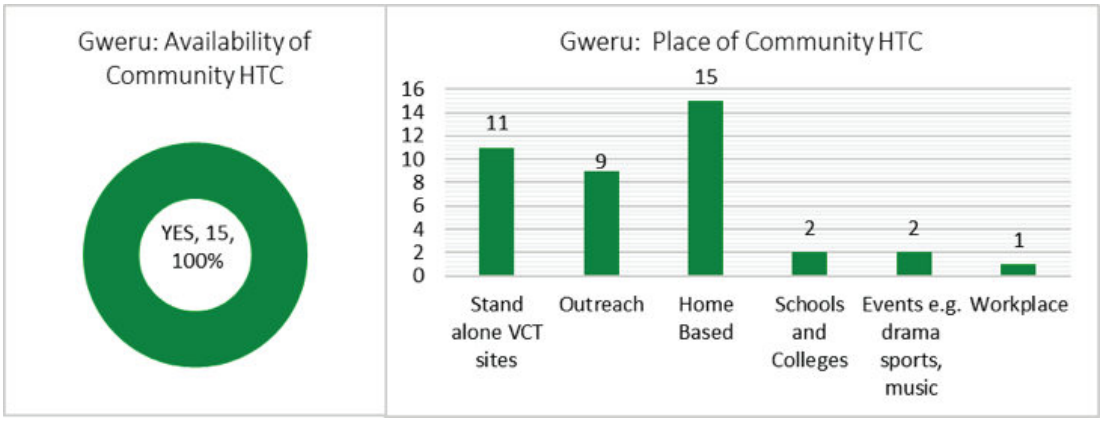
TABLE 48 HIV SERVICE READINESS, GWERU

	N = 15
How well staffed are HIV services?	
Short staffed	9
Adequately staffed	6
Challenges to provision of care and treatment	
HTC kit stock out in past 3 months	0
ARV stock out in past 3 months	0
Has CD4 machine	3
If yes, failed to do CD4 counts in past 3 months	1
M&E challenges	5

Community-based HIV Testing and Counseling

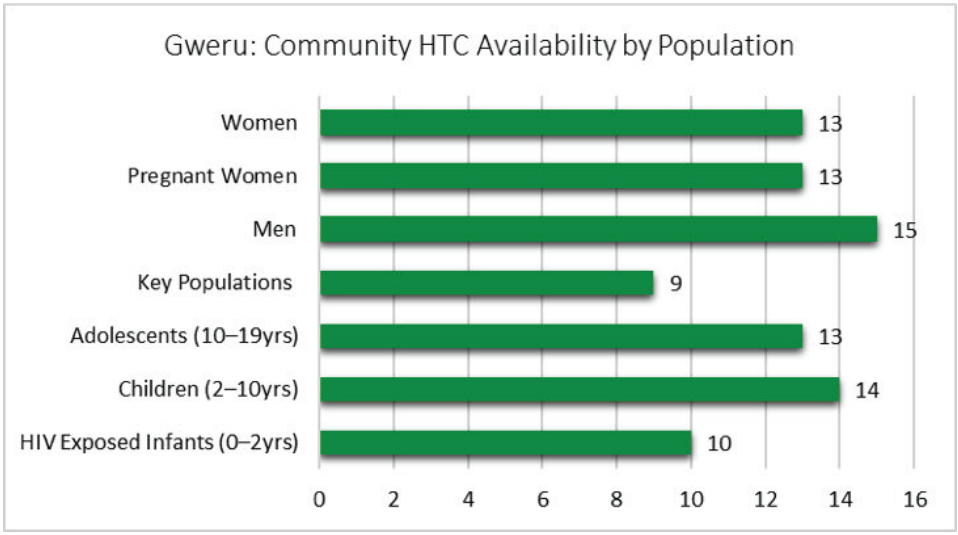
All of the fifteen facilities in Gweru that were included in the assessment had community-based counseling and testing available (Figure 36). All provided home-based index testing, while some also provided additional kinds of testing. Testing was done by nurses and supported by various organizations, including MOH, ZIMPHIA, FHI 360, CITY Health, JAHO, PSI, Jointed Hands, New Start, ZEMPHCA, and JHWO. FHI 360 is the most commonly mentioned, and supports home-based index testing in 14 of 15 facilities.

FIGURE 36: CHTC AVAILABLILITY, GWERU



All populations can receive community testing and counselling from many of the surveyed facilities. MOH was the most commonly listed organization for serving different populations.

FIGURE 37: CHTC AVAILABILITY BY POPULATION, GWERU



All facilities provide CHTC, between five and seven days per week and 10 offered it outside of normal working hours. None reported that they experienced service interruptions in the four weeks preceding the survey.

TABLE 49. COMMUNITY-BASED HIV TESTING AND COUNSELING

	N = 15
Testing and conseling offered outside normal working hours	12
Interruptions in community testing and counseling in past four weeks	0

Linkage to Care and Treatment

All facilities have a referral mechanism for clients who test positive for HIV to ensure they enroll into care and treatment (Table 50). The majority of facilities use referral slips, but some use both referrals to hospitals, notes in health booklets, or make a follow-up appointment. Respondents all facilities felt that they did "well" or "very well" in ensuring the referrals are complete.

TABLE 50. ENROLLMENT INTO CARE AND TREATMENT

	N = 15
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	15
Mechanism used (some had more than one method):	
Referral slip	9
Referral to hospital	3
Note in health booklet	2
Follow-up appointment made	1
How well does facility ensure referrals are complete:	
Very well	12
Well	3
Reasonably poorly	0
Very poorly	0

Community-based ART Services

Community-based ART services were provided by six facilities in the catchment area (Table 51). All six facilities provided both ART initiation and ART follow-up and resupply. The majority of services were provided through community ART refill groups, with two facilities also providing outreach. No facilities experienced interruptions in provision in the past four weeks.

TABLE 51. COMMUNITY BASED ANTIRETROVIRAL THERAPY

	N = 15
Provides community-based ART services in facility catchment area	6
Type of service provided:	
ART initiation	6
ART follow-up (resupply)	6
How are services delivered:	
Outreach	2
Community ART refill groups	6
NGO operated facilities	0
Interruptions in provision of ART community-based services in past 4 weeks	0

Retention in Care and Treatment

All of the facilities reported that they identify ART clients who do not come back for review and/or resupplies (Table 52). All 15 facilities identify clients by use of appointment diary and registers, while 14 also employ a third method of identification through VHWs. Seven facilities use "Other" methods, including: care facilitators (2), CATS (2), EHT (1), cell phone calls (1), and outreach workers (1). Furthermore, all facilities attempt to follow up the ART clients who do not return to the clinic through CBHWs and phone calls. "Other" methods mentioned include: FHI 360 (2), outreach workers (1), EHT (1), expert clients (1), and CATS (1).

Through open-ended responses, the respondents cited numerous challenges they face in following- up clients. The challenge cited most often was that the community was mobile. One participant explained that many clients are gold panners, who often move to find work. Others said that clients leave the country for work and do not let the hospital know.

TABLE 52. RETENTION IN CARE/ ON TREATMENT

	N = 15
Identifies ART clients who do not come back for reviews and/ or resupplies	15
How identifies clients:	
VHW	14
Appointment diary	15
Registers	15
Other	7
Follows up ART clients who do not come back for clinic reviews and/or resupplies	15
How does facility follow up:	
CBHWs	15
Phones	15
Other 5	
Challenges in following up clients *	
Mobile community	7
Wrong address or phone number	2
Lack of cell phones	1

Other Community Services Available

All of the facilities offered additional services within the community, as outlined in Table 53. Screening for opportunistic infections was available in all facilities, while counseling services (adherence and family planning) and CD4 counts were offered in most. No facilities offered viral load testing within the community.

TABLE 53. OTHER SERVICES AVAILABLE

	N = 15
CD4 count	11
Viral load testing	0
Adherence counseling	14
Screening for OIs	15
Family planning counseling	13

Service Delivery Partners

These facilities work with a range of partners to provide services to their catchment areas (Table 54), with Gweru having the most number of different partners within Midlands. FHI 360 and MOH are the partners mentioned most often. All facilities work with partners to provide HIV testing and counseling and linkage to care and treatment, while many also provide community mobilization, ART initiation, treatment support/adherence counselling, ART resupply/follow-up, CD4 testing and sample transportation. Gaps in support lie in viral load testing and economic strengthening.

TABLE 54. PARTNER MAPPING

Community Based Services	N = 15	Organization
Community mobilization	13	FHI360, AFRICAID, RedCross, JAHO, NAC, JHWD, MASO, ZAPPTRUST, CWGH
HIV testing and counselling	15	FHI 360, Jointed Hands, Welfare.org, JHWD, XIMPHIA, JAHO, PSI,ZAPP TRUST, MOH, NEW START
Linkage to care and treatment	15	FHI 360, MOH, MASO, AFRICAID, ZAPP TRUST,ZIMPHIA, CWGH
ART initiation	12	HI360, AFRICAID, JWHO, MOH, NEWSTART
Treatment support/adherence counseling	12	ZAPP TRUST, FHI 360, AFRICAID, MOH
ART resupply/follow-up (OI/ART)	13	ZAPP TRUST, FHI 360, AFRICAID, MOH, CWGH,
CD4 testing	12	FHI 360, MOH, Riders for health
HIV viral load testing	0	None
Sample transportion	14	MOH, FHI 360, TB Care Union, Riders for Health
VMMC	9	Air Force of Zim, PSI, Thornhill Hospital, MOH, GPH
Nutrition support	6	MOH, DSS
Economic strengthening activities	2	MOH
OVC/home-based care and support	10	DAC, AFRICAID, MASO, Red Cross, JAHO, MASO, Community CCW, MOH

Community Linkages

All facilities have linkages to their communities with different cadres or structures, as summarized in Table 55. We asked about the main ways these community cadres help with demand creation and delivery of care at the community level. Short response answers were coded to extract themes by cadre. Many services were common across multiple cadres. Results are summarized below.

VHWs: VHWs in Buhera are responsible for a wide range of services, including 1) tracking or following-up clients and defaulters, 2) referring and motivating clients to seek care, 3) providing health education and 4) linking clients to services.

Behavior Change Facilitators, Community leaders, and WAAC: Behavior change facilitators, community leaders, and WAAC provide health education and encourage clients to seek care.

Health Centre Committees: Health centre committees provide all the services of VHWs, but also help coordinate facilities that provide HIV care.

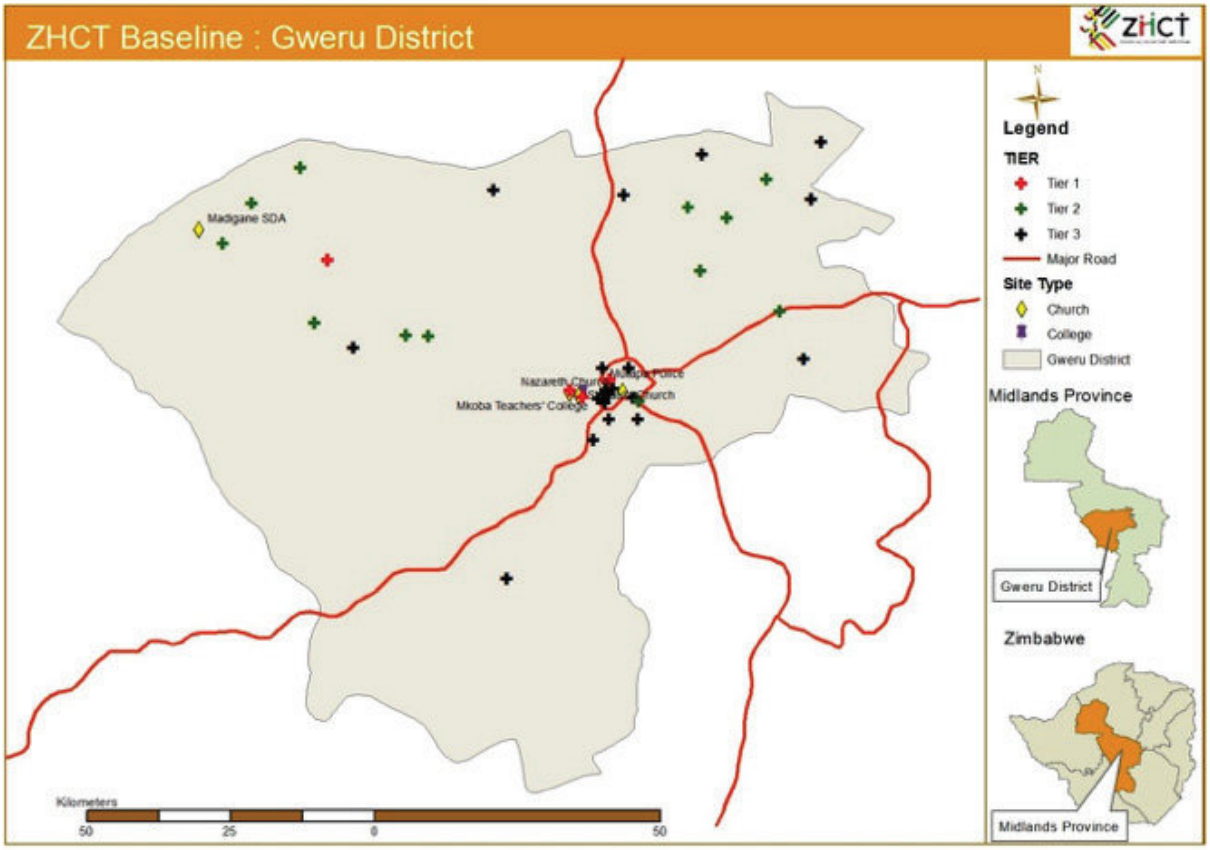
DAAC: DAAC assists by providing health education, referrals, and coordination of facilities.

Other: Other groups identified include, CATS, and CWGH. CATS provides health education, and counselling. CWGH facilitate for accountability issues between the facility and community

TABLE 55. COMMUNITY LINKAGES

	N = 12
Cadre/ structure worked with for Care and Treatment:	
VHW	13
Expert patients	15
Behavior change facilitators	12
Health centre committees	14
Community leaders	15
WAAC	1
DAAC	10
Other	1

MAP OF GWERU DISTRICT



KWEKWE DISTRICT

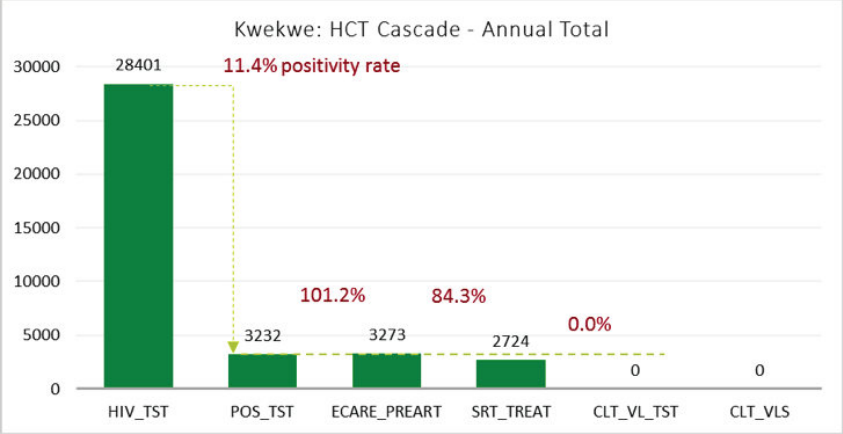
HIV Cascade Analysis

Data collected from ZHCT-supported facilities in Kwekwe indicates a total of 28,401 individuals tested in the last year, 11.4% (3,232) of whom were found to be HIV positive (Figure 38). This programmatic positivity rate is not much lower than the reported prevalence in Midlands Province (15.4%), indicating that individuals at high risk for HIV infection are accessing services.

Of those testing HIV-positive, 101.2% of PLHIV were enrolled in care and 84.3% were initiated on HIV treatment – higher than the figures across all ZHCT facilities (84.2% and 70.4%, respectively). These data show that facilities in Kwekwe successfully linked PLHIV to care and treatment services in the last year. However, there are still gaps in HIV treatment coverage, indicating a need for enhanced strategies to improve service linkage across ZHCT supported sites in order to achieve UNAIDS' second 90-90-90 target, 90% ART coverage among PLHIV.

As previously mentioned, access to viral load testing is non-existent in all districts in Midlands Province. Expansion of viral load machine coverage and utilisation in Midlands is urgently needed in order to assess viral suppression in the community. Furthermore, strategies to support PLHIV in adherence to and retention on treatment are warranted to to achieve UNAIDS third 90-90-90 target, 90% of PLHIV on treatment are virally suppressed.

FIGURE 38: HIV CASCADE, KWEKWE



Service Availability and Readiness

HIV Service Readiness

The majority of facilities reported that they were understaffed and that any additional demand for HIV services would be a burden. Only four facilities stated that they were adequately staffed. Thirteen of the sixteen facilities provided services to key populations such as sex workers and truck drivers.

Thirteen facilities reported challenges to providing care and treatment. The most common challenge was issues with M&E. Facilities reported that they struggled to keep accurate registers due to understaffing and the large number of registers required. Others reported that they used EPMS with manual registers for back-up, but that their EPMS did not allow for entry of all necessary information. Seven facilities reported stock-outs of HTC kits and three reported stock-outs of ARVs in the previous three months. Although five facilities had CD4 machines, four reported that they had failed to carry out CD4 tests in the previous three months due to lack of cartridges or reagents, or because the machines were not functioning

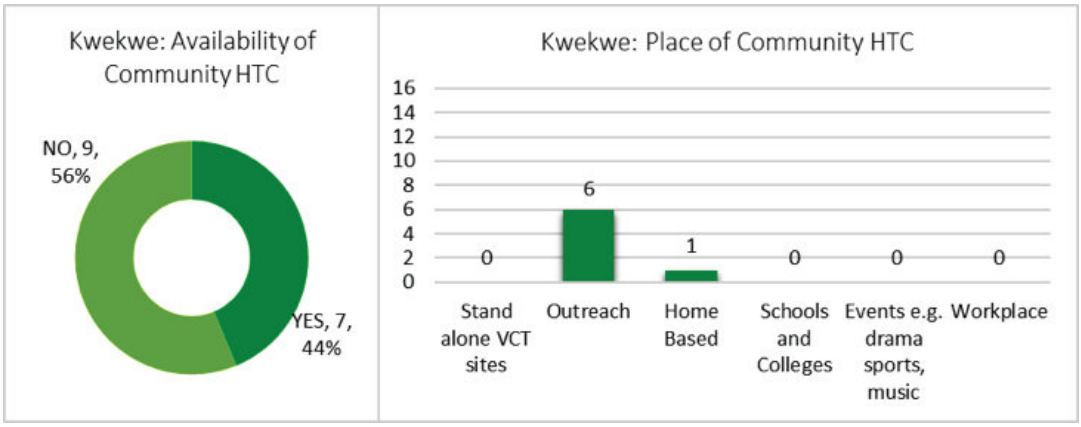
TABLE 56. ENROLMENT INTO CARE AND TREATMENT

	N = 16
How well staffed are HIV services? (open responses)	
Short staffed	12
Adequately staffed	4
Challenges to care and treatment:	
HTC kit stock out in past 3 months	7
ARV stock out in past 3 months	3
Has CD4 machine	5
If yes, failed to do CD4 counts in past 3 months	4
M&E challenges	12

Community-based HIV Testing and Counseling

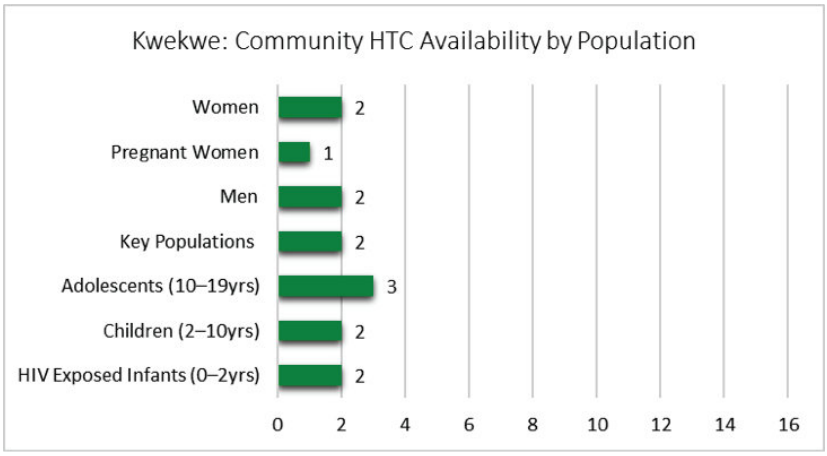
Sixteen facilities were assessed in Kwekwe District. Less than half of the facilities reported that community-based HIV testing and counseling were available (Figure 39). All seven facilities that offered the service reported that it was offered through outreach only. Nurses were the main providers of HTC, with primary counselors or nurse aids also providing the services at four facilities. The MOH, NC, DAC, City Health Department, City Council, and PSI were reported as partners or supporting organizations for community-based HTC.

FIGURE 39: CHTC AVAILABILITY, KWEKWE



There was limited availability of CHTC services reported across populations. At least one facility reported providing CHTC services to each population group. Kapnek, NAC, and the City Council were reported as the main supporting organizations in the district

FIGURE 40. CHTC AVAILABILITY BY POPULATION, KWEKWE



No facilities reported having HTC services available outside of normal working hours. Three facilities reported that HTC was available anywhere from intermittently when campaigns came through to five days per week; the rest of the facilities did not respond to this question. Only one facility reported interruptions to community testing and counseling in the previous four weeks, due to stock-outs of HIV test kits.

TABLE 57. COMMUNITY-BASED HIV TESTING AND COUNSELING

	N = 16
Testing and counseling offered outside normal work hours	0
Interruptions in community testing and counseling in past four weeks	1
Type of interruptions:	
HIV test kit stock outs	1
Tester non-available	0
Transport not available	0
Other	0

Linkage to Care and Treatment

Five of the seven facilities providing CHTC reported having a referral mechanism for clients who test positive for HIV to ensure enrolment into care and treatment (Table 58). Of those, one provided details on the referral mechanism, and stated that they use a pre-ART register to track patients. However, three facilities reported handling referrals "very well," one reported handling them "well," and one reported handling them "reasonably poorly."

The majority of facilities reported that they were understaffed and that any additional demand for HIV services would be a burden. Only four facilities stated that they were adequately staffed. Thirteen of the sixteen facilities provided services to key populations such as sex workers and truck drivers. Thirteen facilities reported challenges to providing care and treatment. The most common challenge was issues with M&E. Facilities reported that they struggled to keep accurate registers due to understaffing and the large number of registers required.

Others reported that they used EPMS with manual registers for back-up, but that their EPMS did not allow for entry of all necessary information.Seven facilities reported stock-outs of HTC kits and three reported stock-outs of ARVs in the previous three months. Although five facilities had CD4 machines, four reported that they had failed to carry out CD4 tests in the previous three months due to lack of cartridges or reagents, or because the machines were not functioning.

TABLE 58. ENROLMENT INTO CARE AND TREATMENT

	N = 16
Facility has referral mechanism for client who test HIV+ to ensure they enroll into care and treatment	5
Mechanism used:	
Registers	1
How well does facility ensure referrals are complete:	
Very well	2
Well	1
Reasonably poorly	1
Very poorly	0
No answer	1

Community-based ART

None of the facilities in Kwekwe district reported providing community-based ART (data not shown).

Retention in Care and Treatment

All 16 facilities had a systematic way of identifying ART clients who did not turn up for clinic reviews or resupplies. Fourteen facilities use an appointment diary, and of those, 12 additionally use a register and another seven also use VHWs. Two facilities only used VHWs. All facilities reported at least one method to follow-up patients who did not return to clinics for check-ups or medication resupplies. Fourteen facilities reported using both CBHWs and phones while one facility each reported use of only CBHWs or only phones for follow up. Facilities faced a wide variety of challenges when following-up clients. The most commonly reported challenge was a lack of interest from clients or client resistance. This included many facilities who reported that clients did not want to be followed-up because of stigma in the community. Other common challenges were having false addresses or phone numbers and the fact that many people are migrant, particularly in the mining areas. Five facilities did not report any challenges.

TABLE 59. RETENTION IN CARE AND TREATMENT

	N = 16
Identifies ART clients who do not come back for reviews and/ or resupplies	16
How identifies clients:	
VHW	9
Appointment diary	14
Registers	12
Follows up ART clients who do not come back for clinic reviews and/or resupplies	16
How does facility follow up:	
CBHWs	15
Phones	15
Challenges in following-up clients (open):	
Lack of interest/client resistance	11
No/wrong phone number or address	8
Mobile/migrant population	5
Distance/geographic barriers	3
Disclosure	2
Transport challenges	1

Other Community Services Available

Seven facilities reported providing other services for clients (Table 60). Adherence counseling was the most commonly offered service, followed by family planning counseling. One facility reported providing screening for OIs, and no facilities said they offered CD4 counts or viral load testing. Nurses and CBHWs or VHWs were the most common providers for these services.

TABLE 60. AVAILABILITY OF OTHER COMMUNITY SERVICES

	N = 16
CD4 count	0
Viral load testing	0
Adherence counseling	6
Screening for OIs	1
Family planning counseling	5

Service Delivery Partners

Twelve of the sixteen facilities worked with partner organizations to deliver one or more services (Table 61). PSI and MOHCC were the most common partners. Nine facilities partnered with PSI to provide VMMC services, and five of the seven facilities with partnerships to transport samples worked with Courier Services. The third-most common partnership was to provide linkages to care and treatment; each facility with this type of partnership worked with a different organization

TABLE 61. PARTNER MAPPING

Community Based Services	N = 16	Organization
Community mobilization	2	MASO, PSI
HIV testing and counselling	3	NAC, MOHCC, PSI
Linkage to care and treatment	4	Kapnek, PSI, MASO, Community Working Group
ART initiation	2	Kapnek, PSI
Treatment support/adherence counseling	1	Community Working Group
ART resupply/follow-up (OI/ART)	1	Kapnek
CD4 testing	1	Kapnek
HIV viral load testing	0	-
Sample transportion	7	**Courier Services, Global Fund,** Kapnek, MOHCC
VMMC	11	**PSI,** MOHCC
Nutrition support	3	**MOHCC,** MASO
Economic strengthening activities	1	Heifer International
OVC/home-based care and support	2	PLAN, Community Working Group.

Community Linkages

Facilities worked with a variety of community-based structures or cadres (Table 8). All facilities worked with health centre committees and community leaders, and almost all worked with VHWs and behavior change facilitators. Most of these groups carry out education and mobilization activities, and several support facilities directly. The main ways that each community structure support HIV care are described below.

VHWs: VHWs work with 13 facilities, and provide health education, track patients, and help identify people in need of care and refer them to facilities. One facility reported that VHWs assist in ferrying patients to and from the facility.

Expert patients: Expert patients act as role models in the community, provide adherence counseling, and also encourage and mobilize the community to use HIV care.

Behavior change facilitators: The main role of behavior change facilitators was to provide health and HIV education to the community. At some facilities, behavior change facilitators target adolescents specifically. They also encourage the community to utilize services offered by the health facility.

Health centre committees: Health centre committees were generally described as linking the community and the facility; they notify the community of available services and encourage use of those services. In some cases, they act in an advisory role, and in other cases they provide direct support to the facility by maintaining the facility or assisting with procurements.

Community leaders: Community leaders help mobilize the community to accept and use the facility. They provide time for health education talks at community gatherings, and at one facility they provide support such as groceries, money, and clothing for children at the facility.

WAAC: Four facilities reported working with WAACs. WAACs help mobilize the community and provide health education.

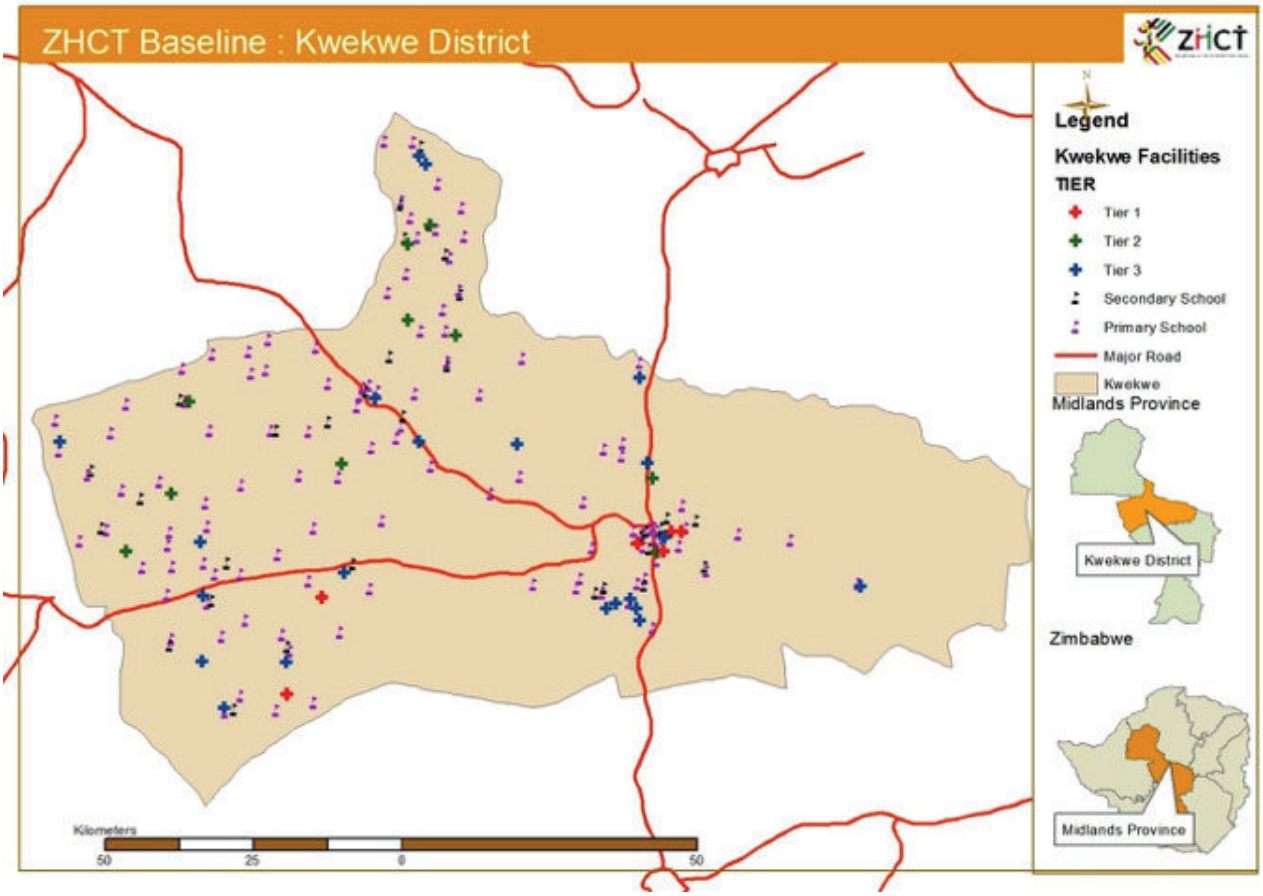
DAAC: DAACs provide outreach, health education, and help facilities find additional resources.

Other: Four facilities reported working with other community structures, including church leaders, peer educators, and the Community Working Group, unique to Kwekwe. These groups provide a wide range of services, including encouraging clients to adhere to medication and cleaning up the areas around the facilities.

TABLE 62. COMMUNITY LINKAGES

	N = 16
Cadre / structure worked with for care and treatment:	
VHW	13
Expert patients	7
Behavior change facilitators	14
Health centre committees	16
Community leaders	16
WAAC	4
DAAC	9
Other	4

MAP OF KWEKWE DISTRICT



Conclusion

The results highlighted above suggest that more females were reached with HIV services in the ZHCT supported facilities than males. This has been noted across the whole HIV Care cascade in these two provinces and supports the need to have other approaches which can result in more males being reached. While is it expected that programmatic positivity rates are below HIV prevalence rates (14.1% in Manicaland and 15.5% in Midlands), data on positive rate supports the need to increase targeting of individuals at highest risk for infection or are already infected. This is particularly true in Manicaland where the programmatic positivity rate among supported facilities is much smaller.

In Midlands, fewer clients were enrolled and initiated on ART thus 74.2% and 64.5% respectively compared to Manicaland which reported 97.2% and 78.0% respectively. These data show that there are gaps in HIV care and treatment coverage in supported facilities in Midlands. This could be due to fewer and widely spaced facilities in Midlands's supported districts; staff shortages, staff attitudes towards clients, stigma and lower numbers of HIV partners in these districts. Of note also is the access to viral load testing which is extremely poor, with only 6.1% of PLHIV across ZHCT supported sites having been tested. In fact, viral load testing was only conducted in Manicaland again highlighting challenges in Midlands in terms of HIV services. Expansion of viral load machines and utilisation is urgently needed to determine the impact of HIV services in Zimbabwe.

FGDs and KII which were conducted resulted in the following recommendations highlighted below. These should be considered with the quantitative findings when ZHCT project addresses the gaps identified. ZHCT's collaboration with other partners in these provinces is pivotal in addressing these gaps and recommendations.

Recommendations for Improvement from qualitative data

PLHIV recommendations

Increased support for income generating projects: While there were a number of recommendations related to capacity building of support groups (refresher courses on adherence, support to establish CARGs, uniforms, support group management guidance) the most consistently recommended activity in four out of eight districts was to help support groups establish income generating projects. This was seen as a possible way to improve male involvement:

> ***"mostly they would want to work for their families and hence can be lured into groups if there are opportunities for fund-raising" (Chipinge)***

Three out of four of the districts indicated an interest in poultry raising for income generation. Gardening was also mentioned to a lesser extent, with the caveat that the elderly may be too old to pump water, and concerns around the current drought.

Improve male involvement in support groups: The recommendation to improve male involvement in support group activities was raised in Mutare, Buhera and Chipinge districts. In Mutare a participant suggested getting men currently involved to recruit other men, whereas in Buhera one respondent suggested "use the previous strategy where positives are enrolled and get food could promote men's attendance". As mentioned above, one respondent also felt that a stronger emphasis on income generating activities in support groups would promote more male involvement.

Health service specific recommendations: There were a number of specific recommendations aimed at making health services better equipped to ensure ART adherence and retention, including:

- 3 months drugs supply refills
- Food assistance for ART clients
- User charges of $2 upon ART refill should be removed
- X-rays for TB should be free for ART clients
- ART clients prioritized within health facilities
- Need more CD4 machines
- Mobile PLHIV should always take their medical cards so they can be assisted elsewhere in the country
- Establish HTC at workplaces
- Improve education on the benefits of being tested
- Pregnant mothers shouldn't have to pay ANC fees
- More nurses at the clinic
- Improved motivation for community cadres
- Support to establish CARGs

VHW Recommendations

On the topic of recommendations from VHWS for improved services, their recommendations can be categorized into recommendations for health facilities, and recommendations for improved effectiveness of VHW services. There were four main types of recommendations that were mentioned in four of more districts, with each key point underneath, as follows:

Improved support/equipment for VHWs: Including, some form of identity/uniform for VHWs (Buhera); refresher training on confidentiality; a toolkit for VHWs, or formal working documents "so they can be taken seriously" (Kwekwe district); provide cellphone or airtime for follow up of patients; more motivation for VHWs

lmproved Coordination with Health Facility Services: Including, sharing clients review dates with VHWs; referral return slips from the facility to the VHW (Chipinge); improve coordination among implementing partners on referral processes; give clients referred from VHWs first preference

More male involvement in VHW: This was mentioned in four districts, together with a suggestion from Gweru district:

> ***"involvement of men can be improved if the programs do not take up a lot of their time, do not give them empty promises. Men do not want to be kept waiting for meetings while the conveners take their time to arrive" (Gweru district)***

Improved Health Facility Services: Including, nurses to help people presenting with referral slips first; give clients food to take their meds with; improve the transport system for clients in need (Kwekwe); bus fares for clients living far away (Chipinge); improved work ethics for nurses and VHWs.

Community leader recommendations

Better targeting of Men: Community leaders provided quite a few practical recommendations for better engaging men in HIV programs, and several personally committed to champion the efforts themselves:

"to get men maybe you can target the days when there is no work done in the community which is usually Wednesday" (Mutasa)

"going to their homes would work but also having platforms to talk to them as just men for them to agree to the idea. It would be better for the men to actually invite you into their homes so that they still feel as if they are in control..so i would encourage you to have discussions with them and get them to see the need and have them invite you to thei homes" (Mutasa),

"call for men only meetings" (Buhera),

"support groups with projects such as poultry and gardens, this will lure more men" (Chipinge)

More income generating projects for PLHIV

"there is a shortage of educators who have expertise in teaching various domains such as nutrition and skills training" (Kwekwe),

"Income generating projects should be decided by the people themselves and not dictated" (Makoni),

"PLHIV should be supported with livelihood projects such as poultry" (Kwekwe),

"PLHIV should take advantage of their support groups to embark on income generating livelihood programs such as gardening which is in two fold in that it raises income levels of project beneficiaries through selling of the produce as well as improving their nutrtion status" (Kwekwe)

Support for HIV testing in households: The quotations indicate strong support for home testing on the part of community leaders, once again as a valuable means of increasing male involvement

"It is such a great idea to test people in their households. There is no excuse. The man will be tested also." (Gokwe South),

"I definitely support the idea of home testing because if one tests positive in the home the family will be there and it will help with disclosure and this way people will be free to take their medication" (Mutasa)

"It saves time since you don't have to go to the clinic or hospital, no fear of confidentiality since you are at home" (Chipinge)

Expansion of community based ART distribution, CARGS: From the interviews with community leaders, it is clear that while some were knowledgeable of the existence of CARGs, they were still in the early stages of formation and implementation. They expressed a strong demand for further decentralization of services to fill the remaining gaps for those who continue to have transport/distance challenges in relation to the nearest ART dispensing site.

"I feel the CARG initiative is a noble idea and it will also reduce the number of defaulters" (Kwekwe)

Food for ART Clients

"People with HIV need food. We might lose many of them if help does not come" (Gokwe South)

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'' FHI360 nurse testers collecting viral load specimen from CARG members// Photo Credits: FHI360 Zimbabwe''

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