Review of the National HIV and AIDS Treatment and Care Programme

2004-2007

Zimbabwe

Ministry of Health and Child Welfare

May 2008

Acknowledgements

The Review Team would like to thank the Permanent Secretary for facilitating its work especially during the visits to the provinces. Special appreciation goes to all the MOHCW AIDS & TB Unit staff, partners, key stakeholder and everyone who took their time to meet the review team. This review would not have been possible without their contributions and support. The support, which was given by the OI/ART Review Steering Committee, WHO, UNICEF, DfID, EGPAF, USAID (through JSI/DELIVER), CDC and CRS deserve special mention.

A very special acknowledgement is given to Professor Francis Onyango, Dr Christine Chakanyuka and Dr Tsitsi Apollo who worked closely and provided extensive technical and logistical support to the review team.

Last but not least, the review team would like to thank all the health workers and the many patients that readily came forward at various sites to give us their very valuable perspectives about the ART programme.

Members of the Review Team

Dr. Godfrey Sikipa, MBChB, MSc MCH, Technical Director, Management Sciences for Health (MSH), Washington DC, USA
Dr. Barnet Nyathi, MBChB, DPH, Public Health Specialist, Zimbabwe
Mrs. Margaret Mehlomakulu, RGN, MSc Community Health, Zimbabwe
Dr. Jabulani Nyenwa, MBChB, MPH, MBA, Public Health Specialist, GRM International, Zimbabwe
Dr. Mary Nyathi, MBChB, MMed Paeds,Paediatrician, Mpilo Central Hospital, Zimbabwe
Dr. Tapiwanashe Bwakura, MD, MMed Med, Physician, Harare Central Hospital, Zimbabwe
Dr. James Mugwisi, MBChB, Dip HIV Management, Medical Officer, Hippo Valley Medical Centre, Zimbabwe
Mrs. Irene Moyo, BSc Sociology, MSc Medical Demography, Consultant Social Scientist, Zimbabwe
Mr. Tonderai Chiduku, Certificate in Education, National Director, Zimbabwe National Network of PLWHIV, Zimbabwe
Dr. Eileen Burke, Laboratory Specialist, CDC, Kenya
Mr. Jan Dik, Supply Chain Specialist, SCMS, Netherlands
Mr. Alexis Ferrand, Economist, DfID, Zimbabwe

Table of Contents

Executive summary 6

1 INTRODUCTION 10
1.1 Background 10
1.2 Purpose and Objectives of the review 10
1.3 Key Evaluation Questions 10
1.4 Methodology 11
1.5 Organization of the Report 12

2. FINDINGS 13
2.1 Overview of progress made in the implementation of the plan for nationwide provision of ART (2005-2007) 13
Objective 1: Advocating for supportive policy environment to facilitate scale up of ART services 13
Objective 2: Advocating for the collective support for comprehensive HIV and AIDS care, including ART with meaningful involvement of PLWHIV 15
Objective 3: Strengthening the involvement of communities in the provision of ART services 15
Objective 4: Expanding the provision of ART services in all sectors in Zimbabwe 17
Objective 5: Ensuring continuous availability of good quality AIDS medicines, diagnostics and other medical supplies 23
Objective 6: Developing the national human resource capacity to meet the national ART targets 26
Objective 7: Developing systems for ART program monitoring, evaluation and research. 29
Objective 8: Strengthening programmeme management, coordination and supervision 33
Objective 9: Strengthening resource mobilization for increasing access to ART 35
2.2 Effect of the OI/ART Programme on other Programmes 38

3. ANALYSIS OF PROGRAMME PERFORMANCE 42
3.1 Relevance 42
3.2 Efficiency and Effectiveness 42
3.3 Equity 44
3.4 Sustainability 45

4. LESSONS LEARNT 47

5. KEY RECOMMENDATIONS 48

List of Acronyms

AIDS	Acquired Immune Deficiency syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4
CHAI	Clinton HIV/AIDS Initiative
CHBC	Community Home Based Care
CIDA	Canadian International Development Agency
CITC	Client Initiated HIV Testing and Counseling
CPT	Cotrimoxazole Preventive Therapy
CRIS	Country Response Information System
CTX	Cotrimoxazole
CXR	Chest X Ray
DAAC	District AIDS Action Committee
DFID	UK Department For International Development
DHE	District Health Executive
DHT	District Health Team
DNA	Deoxyribonucleic Acid
DTTU	Delivery Team Top Up
EC	European Commission
ECHO	European Commission Humanitarian Aid
EDLIZ	Essential Drug List of Zimbabwe
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
EQA	External Quality Assurance
ESP	Expanded Support Programme for HIV and AIDS
FBO	Faith Based Organisation
FCH	Family and Child Health
GMB	Grain Marketing Board
GOZ	Government of Zimbabwe
HAQOCI	HIV and AIDS Quality of Care Initiative
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSB	Health Services Board
HTC	HIV Testing and Counseling
IEC	Information Education and Communication
JSI	John Snow Incorporated
LMIS	Logistics Management Information System
LSU	Logistics Sub Unit
M&E	Monitoring and Evaluation
MCAZ	Medicines Control Authority of Zimbabwe
MCH	Maternal and Child Health
MOHCW	Ministry of Health and Child Welfare

MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
MUAC	Mid Upper Arm Circumference
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NGO	Non Governmental Organisation
NIHR	National Institute of Health Research
NMRL	National Microbiology Reference Laboratory
NPA-OVC	National Plan of Action for OVC
NTP	National TB Programme
NVP	Nevirapine
OI	Opportunistic Infection
OVC	Orphans and Other Vulnerable Children
PC	Primary Counselor
PCN	Primary Care Nurse
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PHE	Provincial Health Executive
PHT	Provincial Health Team
PITC	Provider Initiated HIV Testing and Counseling
PLWHIV	People Living With HIV
PMD	Provincial Medical Directorate
PMTCT	Prevention of Mother-to-child Transmission of HIV Infection
PR	Principal Recipient (The Global Fund)
PSI	Population Services International
PSS	Psychosocial Support
RBZ	Reserve Bank of Zimbabwe
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
UZ	University of Zimbabwe
VEN	Vital, Essential, Non-essential
VHSSP	Vital Health Services Support Programme
WAAC	Ward AIDS Action Committee
WASN	Women's AIDS Support Network
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on AIDS
ZINQAP	Zimbabwe National Quality Assurance Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council

Executive summary

The Ministry of Health & Child Welfare (MOHCW) introduced the Opportunistic Infections and Antiretroviral Therapy (OI/ART) programme in April 2004 and the 'Plan for Nationwide Provision of ART' was finalised in December 2004 covering the period 2005-2007. As part of its strategy to scale-up OI/ART services towards universal access in 2010, the MOHCW commissioned a review of the OI/ART programme. The objectives of the review were (a) to determine the current status of HIV and AIDS treatment and care service delivery; (b) to assess the progress made in the implementation of the plan for nationwide provision of ART (2005-2007); (c) to establish the effect of the OI/ART programme on other health programmes; (d) to identify and document challenges, opportunities and lessons learnt during the rapid expansion of the OI/ART programme; and (e) to make recommendations on how HIV and AIDS treatment and care service can be scaled up towards Universal Access by 2010.

The evaluation was a cross-sectional, qualitative review of the OI/ART programme during the period April 2004-December 2007. Data was gathered from over six hundred people at national level programme offices, three central hospitals, ART sites and communities in three provinces. Data collection methods included (i) Literature Review; (ii) Key informant interviews; (iii) Focus group discussions with key stakeholder groups; (iv) Review of clinical records and (v) Exit interviews and (iv) focus group discussions with patients.

Major Findings

The MOHCW estimates that there were 1.8 million people living with HIV (PLWHIV) of whom over 300,000 were in need of ART as of 2004. The OI/ART programme rapidly expanded from 5 sites in 2004 to currently over 150 initiating and follow-up sites in 55 out of the 62 districts in Zimbabwe. Although paediatric OI/ART services have been introduced, coverage remains disproportionately lower than adult coverage. ART coverage for both adults and children has increased from about 5,000 in 2004 to over 100,000 (29%) in December 2007 but falls short of set targets of 250,000 people on ART by end of December 2007. The demand for ART continues to rise characterised by long waiting lists at ART sites.

Cotrimoxazole preventive therapy (CPT) is offered at most hospitals in the country with over 130,000 HIV positive patients currently benefiting. HIV/TB collaboration and ART referral of HIV positive pregnant women were found to be relatively weak. The introduction of new child card and revised Prevention of Mother to Child transmission of HIV (PMTCT) guidelines are expected to strengthen ART/PMTCT linkages. Integration of ART services with reproductive health and family planning services was also found to be weak. Even though adherence rates to ART have been reported to be high, ensuring quality of care is a major concern given erratic supply of drugs, difficulties in follow-up and other access challenges. Human resource shortage of key cadres has been one of the most significant barriers to access.

ART services are predominantly provided through the public sector. Health facilities are using different approaches or models to provide ART services. Stand-alone

OI/ART clinics physically located from the main hospital building have been established at central hospitals. At provincial, district and mission hospitals most OI/ART clinics are situated in the general outpatients department (OPD) i.e. integrated in the health delivery system. In some districts ART initiation and follow-up has been decentralised to outreach sites at primary care facilities in order to bring services closer to the people and to decongest higher level facilities. Even though the MOHCW recommends delivery of family centered management of opportunistic infections and antiretroviral therapy (OI/ART) services, the team found varying degrees of implementation of this model. Apart from two private-public collaborations at Colin Saunders and Hippo Valley Medical Center, opportunities within the private sector have not been fully harnessed. There is evidence of willingness and untapped capacity for private sector delivery of ART. Current private sector involvement is limited to specialised private clinics such as the Connaught and Rowland Square. Several private medical practitioners throughout the country are reported to provide ART services but these are not adequately aligned to the national programme. Research centres including DART, ZAPP, and UZ-UCSF complement service delivery.

There has been high-level commitment by the Government of Zimbabwe (GOZ) and donors to supporting the OI/ART programme. Domestic resources were successfully used to initiate the ART programme in 2004. The GOZ committed 50% of the National AIDS Trust Fund (NATF) to ARV procurement but severe weakening of the Zimbabwean dollar has eroded the contribution. Policies to support local manufacture of ARVs are in place. These policies include issuance of compulsory licenses in line with the TRIPS and waiver of duty on raw materials by the GOZ. Further enabling policies includes the removal of user fees on ARVs. However its impact has been diminished by exorbitant costs of HIV diagnostics, which were not included in the policy.

Meaningful involvement of PLWHIV in the programme has increased significantly over the past four years. There is notable representation of PLWHIV in key coordination structures. Leadership and lower level coordination of networks of PLWHIV is however relatively weak. Overall the involvement of PLWHIV in service delivery has evolved but requires further support through training and funding. Similarly there has been significant involvement of community structures largely in mobilisation for behaviour change programmes. Community mobilisation for Testing and Counseling (T&C) and PMTCT has created high demand for OI/ART services. However community treatment literacy activities have moved considerably slower. The unmet need of ART has led to growing demand for hospice or nursing care for patients that otherwise would be able to take care of themselves had they had access to ARVs.

The OI/ART programme has resulted in improved capability of laboratories but there has been erratic supply of reagents and consumables. Financing for the programme was found to be adequate for HIV-rapid test kits but grossly inadequate for ARVs. Pharmacy operations and management were understood and executed at all facilities visited during the review. In addition a well structured ordering and distribution system for ARVs, test kits, and OI drugs has been developed. Inadequate supply of ARVs has led to rationing of prescriptions thereby compromising adherence. Supply chain challenges include multiple supply chains, multiple reporting requirements, delays in Medicines Control Authority of Zimbabwe (MCAZ) quality control and

geographical restriction of ARV supply. The team noted limited storage capacity at some district hospitals to handle future expansion.

A responsive system has been established to monitor programme implementation. Programme indicators were developed and targets set in line with national, regional and international commitments. Programme data is currently collected using paper based data collection and reporting tools at health facility level. A computerised programme-monitoring database has been developed for use at central level but there is no computerised patient monitoring system at lower levels. Even though a set of core programme indicators has been developed, there is no system for monitoring quality of care and other determinants of universal access (affordability, equity, quality, acceptability and effectiveness). The review found poor reporting due to inadequate capacity to consistently collect and send reports at site level. The current ART M&E data collection tools are too many and create additional workload for staff. As a result some sites were not using some of the programme registers.

The initial funding and commitment by Government was critical for programme initiation and early expansion. International partner and donor support clearly enabled rapid scale up of ART services in Zimbabwe. Although highly stretched, the public and mission health system remains committed and functional, and therefore an efficient means of providing ART services.

Lessons Learnt

The team also made and noted the following key observations and lessons from the programme during the review period (i) With adequate collaboration and coordination it is possible to scale-up and attain universal access; (ii) Decentralisation is an effective and efficient way to rapidly scale-up; (iii) Although seemingly resource-intensive, the outreach decentralisation is a good model of rapidly building clinic capacity through mentorship; (iv) Efficient delivery of ART services does not only require ARVs but adequate supply of human resources and diagnostics; (v) With adequate training and mentoring nurses and clinical officers can initiate ART; (vi) There is high potential and willingness by private service providers (doctors and hospitals) to participate in OI/ART service delivery; and (vii) With adequate support and coordination, communities are willing and ready to play an active role in OI/ART service delivery.

Recommendations

The following recommendations are proposed in order to scale-up access during the next phase of the OI/ART plan:

1. The MOHCW should urgently finalise the development of national human resources for health policy and strategy within the context of health systems strengthening.
2. Donors should commit to supporting the development and implementation of a harmonised health staff retention scheme.
3. The Review Team strongly urges the MOHCW to support task shifting of ART initiation by registered nurses and rapid HIV testing and counseling by PCs.

4. The MOHCW should rapidly scale up the implementation of the in-service training curriculum in comprehensive adults and paediatric OI/ART and make sure that practical sessions are applied.
5. The Review Team strongly recommends the Reserve Bank of Zimbabwe to honor its promise to make available US$ 1 million per month for the purchase of ARV. The erratic supply of ARVs could result in the rapid development of resistant HIV strains thus causing a bigger and costly problem for the nation.
6. The MOHCW should develop and disseminate a clear policy on user fees for comprehensive HIV and AIDS services, not only addressing ARVs, but OI drugs and diagnostics (laboratory and Xrays).
7. The MOHCW should urgently develop a policy and strategy to guide public-private partnership and full participation of the private sector in the delivery of ART in Zimbabwe.
8. The MOHCW should urgently delink donor funding for ARV procurement and distribution from a district to a national approach.
9. The MOHCW and its partners should rapidly scale-up ART access through the following strategies (i) Provide ongoing adequate resources to existing ART sites; (ii) Develop guidelines and provide support for decentralisation of ART initiation and follow-up to lower level health facilities.
10. The MOHCW in collaboration with other ministries, national stakeholders (civil society, private companies and communities) and development partners should mobilise and provide nutritional support to PLWHIV particularly those receiving ART. This is especially urgent in those areas that have had crop failure because of heavy rains or drought.
11. The MOHCW should urgently simplify OI/ART data collection tools (computers, cellphones) in order to facilitate data collection and transmission and reduce workload, especially at lower levels.
12. The MOHCW and other relevant ministries should urgently facilitate and support local pharmaceutical manufacturers to increase their capacity for domestic production of ARVs.
13. The review team urges government, development partners, private companies and civil society organizations to give much needed support (transport, bus fares, financial support and other material incentives) to strengthen the capacity of communities and networks of PLWHIV to effectively advocate for access to ART as well as to improve their involvement in the programme.

1 INTRODUCTION

1.1 Background

The Ministry of Health and Child Welfare (MOHCW) introduced the Opportunistic Infections and Antiretroviral Therapy (OI/ART) programme in April 2004 and the 'Plan for Nationwide Provision of ART' was finalised in December 2004 covering the period 2005-2007. The OI/ART programme was implemented in a phased approach starting with five pilot sites before rapid expansion to all central, provincial, district and some mission hospitals.

As part of its strategy to further scale-up OI/ART services towards universal access in 2010, the MOHCW commissioned a review of the OI/ART programme. It is intended that this end term review of the OI/ART programme will inform the further scale-up of services towards universal access by 2010.

1.2 Purpose and Objectives of the review

The purpose of this review was to evaluate the implementation of the OI/ART service delivery (paediatric and adult) since its inception in 2004. Findings of this review will assist the country in improving the delivery of OI/ART services. The review focused on the effectiveness, efficiency, equity, relevance and sustainability of the HIV and AIDS treatment and care services within the context of universal access. The **specific objectives** of the review were as follows

a. To determine the current status of HIV and AIDS treatment and care service delivery
b. To assess the progress made in the implementation of the plan for nationwide provision of ART (2005-2007)
c. To establish the effect of the OI/ART programme on other health programmes
d. To identify and document challenges, opportunities and lessons learnt during the rapid expansion of the OI/ART programme
e. To make recommendations on how HIV and AIDS treatment and care service can be scaled up towards Universal Access by 2010

1.3 Key Evaluation Questions

a) What approaches are used to create demand for HIV and AIDS treatment and care services? To what extent has the demand for services been met? Are there any vulnerable groups that are not reached by the programme? What key lessons have been learnt from the programme and can these be replicated to support further scale-up?

b) How appropriate are the current approaches in addressing availability and access to HIV treatment and care services within the prevailing epidemiological and socio-economic environment in Zimbabwe?

c) How can the potential of private providers best be utilised? What are the models for successful public-private sector partnerships?

d) What approaches are in use to ensure quality of care and the utilization of different service delivery?

e) How can communities be involved in the design and implementation of HIV and AIDS treatment and care programmes? What effect does community involvement have on care provision?

f) What is the effect of involvement of PLWHIV on the coverage, utilization, and success of treatment programmes?

1.4 Methodology

Study design and selection of field sites

The evaluation was a **cross-sectional, qualitative review** of the OI/ART programme during the period **April 2004-December 2007**. The two main cities, Harare and Bulawayo and four central hospitals, Harare, Parirenyatwa, Mpilo and United Bulawayo Hospitals were purposively selected, however Parirenyatwa hospital was not reviewed due to time constraints. A stratified random sampling procedure was then used to select three out of the remaining eight provinces. Matabeleland North, Mashonaland West and Manicaland were the provinces selected. In the next stratum, each provincial hospital was purposively selected in each province. The third stratum included the random selection of an ART district in each of the three provinces. The fourth stratum included random selection of two Global Fund supported ART districts in the three provinces. The final stratum included selection of at least one district that was not yet providing ART services. It was also decided that the team would meet with as many private general practitioner groups and private for profit institutions as possible.

Table 1 shows the selected field sites.

Province	**Site 1**	**Site 2**	**Site 3**	**Site 4**
Harare City	Harare Central Hospital	*Parirenyatwa Central Hospital	Wilkins Infectious Diseases Hospital (Municipality)	Rowland Park/Square Clinic (Initiating clinic) Marlborough Clinic (Follow-up clinic)
Bulawayo City	Mpilo Central Hospital	UBH Central Hospital	Mater Dei hospital (private hospital)	Khami Road Clinic (Municipality, initiating clinic) Pelandaba clinic (follow-up clinic)
Mashonaland West	Chinhoyi Provincial Hospital	Kadoma District Hospital	Father O'Hea Mission hospital (Global Fund supported site)	Zimplats clinic (private mininng)
Manicaland	Mutare Provincial Hospital	Sakubva Clinic (Mutare City) Murambinda Mission Hospital	Mutambara Mission Hospital (Global Fund supported site)	Mombeyarara Rural Health Centre (outreach initiating; follow-up
Matabeleland North	St Luke's Mission Hospital	Victoria Falls District Hospital	St Patrick's Mission hospital Hwange Colliery Hospital (private mining	Inyathi District Hospital (non-ART district hospital)

*Parirenyatwa was not visited

Data collection

The review team used a consultative and participatory approach. The following techniques were used to gather data during the review:

a) Review of programme documents and reports.
b) Key informant interviews with senior programme managers at all levels in the MOHCW, clinic staff and donors.
c) Focus group discussions with key stakeholder groups to gather their views about the progress of the OI/ART programme.
d) Review of clinical records to assess quality of care and compliance with national guidelines.
e) Exit interviews and focus group discussions with patients.
f) Stakeholder meeting which served to debrief as well as validate findings of the review

1.5 Organization of the Report

This report is presented in five chapters. The first chapter presents the introduction including background, purpose, objectives and methodology. The second chapter presents the achievements and challenges in implementing the plan for nationwide provision of ART. The third chapter presents an analysis of the relevance, effectiveness and efficiency, equity and sustainability of the programme. The fourth chapter summarises the lessons that were learnt during programme implementation. Chapter 5 proposes key recommendations in order to expand service delivery towards universal access.

2. FINDINGS

2.1 Progress made in the implementation of the plan for nationwide provision of ART (2005-2007)

The OI/ART programme rapidly expanded from 5 sites in 2004 to currently over 150 initiating and follow-up sites in 55 out of the 62 districts in Zimbabwe. The number of adults and children with advanced HIV infection receiving ART increased from about 5 000 in 2004 to over 100,000 at the time of this review in May 2008. The number of health facilities routinely offering cotrimoxazole prophylactic therapy (CPT) also increased and as of December 2007, over 130,000 HIV positive patients were receiving CPT[1].

This section presents findings of the key achievements and challenges experienced during implementation of each of the nine strategic objectives outlined in the Plan for Nationwide Provision of ART (2004-2007).

Objective 1: Advocating for supportive policy environment to facilitate scale up of ART services

The programme set out to create a supportive policy environment for ART scale-up through (a) advocacy for increased high-level policy support, (b) development of policies to facilitate ART scale up and (c) strengthening the public-private partnership in ART service delivery.

Advocacy for increased high-level policy support

1. The cabinet and different parliamentary committees were updated about the developments in HIV and AIDS including ART and requirements for providing ART services. Information packages including ART, workplace initiatives and male involvement were developed and disseminated to parliamentarians. Several sensitization workshops were also conducted.

2. Only a few line ministries including Education, Agriculture and Transport have developed workplace HIV programmes. The programmes in these ministries mainly focus on HIV prevention with little attention, if any, to treatment and care. The rest of the ministries are yet to develop workplace policies and programmes.

Policies to facilitate ART scale up

1. The Ministry of Finance approved the use of up to seventy percent (70%) of the National HIV and AIDS Trust Fund (NATF), better known as the AIDS Levy, for procurement of ARVs. The National AIDS Council (NAC) however opted to allocate fifty percent (50%) to ARV procurement and the remaining funding to other HIV and AIDS services such as community and home based care. The MOHCW successfully lobbied the Reserve Bank of Zimbabwe (RBZ) to provide USD 1million per month for procurement of ARVs. However the commitment was only honored for two months in 2005 and one month in 2007 and a total of USD 3 million was released.

2. The waiver of duty on raw materials for local production of ARVs was successfully lobbied for. In addition the Government of Zimbabwe (GOZ) issued compulsory licenses in line with TRIPS agreement. These developments led to

local production of ARVs by VARICHEM, a local pharmaceutical company. However shortage of foreign currency quickly brought the successful local production to a halt.

3. The MOHCW issued a circular to remove user fees on ARVs and medicines for treating opportunistic infections. However the circular did not include fees for consultation, laboratory and radiological investigations. The prohibitive cost of such essential investigations has constituted a major barrier to ART access for lower income groups. Public and mission sector user fees and transport costs for patients also act as a barrier to access to ARVs.

   Information gathered from patients and health workers in the field revealed that in most cases, transport costs provided an even higher barrier to access. A typical patient visiting a district or mission hospital (as at mid May 2008) was incurring costs of up to Z$1.9 billion (US$5) every month for transport and related treatment costs, a figure much above the monthly net income of most workers in Zimbabwe today.

4. The MOHCW planned to develop policies and guidelines to encourage expansion of employer-based ART services, including increased employer-assisted health insurance coverage. The plan to make ART a prescribed minimum medical aid benefit has not been achieved. Even though specific policies have not been developed, several private companies have started to provide ART through different in-house programmes or health insurance schemes.

Strengthening the public-private partnership in ART service delivery

1. Although advocacy for public-private partnership took place at all levels, it resulted in limited practical achievements. A significant finding of the team was the absence of a policy on Private-Public partnership or guidelines to facilitate the participation of the private sector in the national OI/ART programme.

2. Two private hospitals, Hippo Valley Estates Medical Centre and Colin Saunders Hospital expanded their ART programmes to cover surrounding communities with ARVs from the public sector. Hwange Colliery Hospital has been negotiating a similar arrangement since 2006.

3. There has been limited private sector participation, especially medical practitioners, in the National HIV and AIDS Treatment and Care Forum.

4. The MOHCW offered OI/ART training to private health providers in 2004 when seventy-nine doctors were trained. However this did not expand as rapidly as the public sector training. The MOHCW reported that private practitioners were being invited to attend the public sector courses in their localities.

5. Whilst private medical practitioners are very active in the provision of ART, opportunities for more effective partnership with the MOHCW have not been fully explored. Evidence from the field indicates broad willingness by private medical practitioners to participate more meaningfully in the National OI/ART programme.

Objective 2: Advocating for the collective support for comprehensive HIV and AIDS care, including ART with meaningful involvement of PLWHIV

The aim of this strategic objective was to increase support of the ART programme in planning, implementation and resource mobilisation and resource allocation by both government and cooperating partners at ALL levels. This was to be achieved through a) advocacy at different levels across sectors to increase support for comprehensive HIV and AIDS care, including ART and b) AIDS Treatment Awareness Campaigns

Advocacy at different levels across sectors to increase support for comprehensive HIV and AIDS care, including ART

1. The participation of PLWHIV in lobbying the Parliamentary Portfolio Committee on Health has resulted in significant high-level support for comprehensive HIV & AIDS Care.

2. There has been greater representation of PLWHIV in coordination fora at all levels from the National Partnership Forum to the decentralised NAC AIDS Action Committees.

3. Through the support of UNFPA twenty-six Meaningful Involvement of PLWHIV (MIPA) officers have been recruited to spearhead the National Behaviour Change Strategy and access to OI/ART services at district level. The MIPA officers are seconded to work with local NGOs in twenty-six districts supported by the ESP and EC.

AIDS Treatment & Awareness Campaigns

1. Notable achievements during the review period included treatment campaigns and treatment literacy training throughout the country by WASN and SAfAIDS. The Network of Zimbabwe Positive Women (NZPW+)[2] also trained their support groups using the SAfAIDS Treatment Literacy toolkit.

2. Involvement of PLWHIV in stigma reduction and treatment awareness campaigns has increased with support from local and international NGOs such as Batsirai and PSI. Despite notable efforts to reduce stigma, it remains a key barrier to ART uptake.

3. Lack of financial and material support has resulted in the collapse of support groups including some that had been established at OI/ART sites.

Objective 3: Strengthening the involvement of communities in the provision of ART services

The Plan for Nationwide Provision of ART aimed to strengthen the involvement of communities in ART through a) developing a framework and materials to support ART treatment literacy activities in all sectors, b) providing support to community leaders, PLWHIV and community support groups, c) providing support to the media to adequately address comprehensive HIV and AIDS issues including ART and d) supporting nutrition interventions for PLWHIV.

Framework and materials to support ART treatment literacy activities in all sectors

1. There was no officer at the AIDS and TB Unit at the beginning of the programme to spearhead development of a comprehensive Health Sector HIV and AIDS Communication strategy that incorporates ART. The condom promotion and IEC officer was recruited in the last quarter of 2006 and work to produce the strategy is in progress.

2. IEC materials on ART, management of OIs and infant nutrition were not available at most of the sites that were visited. The national HIV and AIDS Communication Strategy and standardisation of IEC materials are still under development. This has resulted in non-standard and at times inappropriate IEC materials. However SAFAIDS, MSF, WASN, UZ and HACOQI have made significant contributions to availability of useful HIV and AIDS information throughout the country.

Support to community leaders, PLWHIV and community support groups

1. The review found relatively high awareness of and demand for OI/ART services by communities. There was significant involvement of community leaders and support groups in HIV and AIDS activities.

2. Although most sites that were visited had active support groups that worked closely with OI clinics providing adherence and supportive counseling for adults, the majority of PLWHIV receiving OI/ART at the sites were not members of the support groups.

3. CBOs and NGOs were actively involved in community mobilisation for ART and community home based care (CHBC). Guidelines and standards for CHBC have been developed and were in use in the districts that were visited. The CHBC programme has been affected by lack of kits and incentives. In addition volunteerism has been ineffective, as most caregivers can no longer forego their income generating activities for voluntary work in a depressed economy.

4. While the structures exist for community involvement, there is poor monitoring, coordination and supervision of activities in the communities by health workers and sub-national NAC structures due to lack of transport and financial resources.

Providing support to the media to adequately address comprehensive HIV and AIDS issues including ART

1. During the period under review, NAC initiated mass media dissemination of HIV and AIDS information.

2. Print and electronic journalists were sensitized on HIV and AIDS in general and ART activities in the country. Training of 42 editors and journalists on responsible reporting was conducted in mid 2007.

3. An editor's forum to create dialogue on comprehensive HIV and AIDS care was also established.

4. It was noted that the main focus of radio and television programmes was prevention with minimal emphasis on treatment and care.

Supporting nutrition interventions for PLWHIV

1. While guidelines on nutrition and HIV and AIDS were developed in 2004, these were not readily available at sites visited. Limited information material on nutrition was available at most sites in the form of pamphlets, booklets and posters.

2. The shortage of food was reported to be a major barrier to adherence among patients receiving ART. During the period 2004 to 2007, a limited number of PLWHIV on ART in selected pilot sites were prioritised and received nutritional support from the MOHCW and in collaboration with international, national and local partners.

3. WFP in collaboration with the MOHCW is in the process of developing guidelines for food aid to PLWHIV especially those receiving ART.

Training of non-health workers

1. While training of non-health workers on HIV and AIDS has been conducted by NGOs and FBOs, there still remains a lot to be done in this area. The review noted the lack of standardised training materials for non-health workers and a register of organisations that have been providing such training.

2. Several members of ZAN have trained a variety of community-based non-health workers including adherence supporters, home based care givers, village health workers, peer educators, PLWHIV and support groups, community leaders, child protection committees and traditional healers. However the training was general and did not adequately address ART.

Objective 4: Expanding the provision of OI/ART services in all sectors in Zimbabwe

The plan aimed to expand the provision of comprehensive HIV and AIDS care, treatment and support including ART services in all sectors in Zimbabwe by a) continuing to identify and assess health facilities that can provide comprehensive care including ART, b) building up the capacity of the infrastructure, laboratory, pharmacy facilities of ART centres to deliver ART, c) registering health facilities in the public, NGO, FBO and private-for-profit to deliver ART, d) expanding the number of people accessing ART through the various entry points and e) delivering ART services through registered ART centres.

Expanding ART service delivery points in the public and private sectors

Public sector approach

1. The MOHCW developed a vertical model of delivery of comprehensive OI/ART services through the opening of OI clinics at public sector institutions. The programme has slowly expanded to include services for adolescents and children. National simplified standard treatment regimens adapted from the WHO

recommendations have been developed and are in use. A family-centred approach is encouraged in the provision of both adult and paediatric OI/ART services.

2. Five pilot sites (Harare Central Hospital, Mpilo Central Hospital in Bulawayo, Triangle Hospital in Chiredzi, Howard Mission Hospital in Mazowe district and Khami Road clinic in Bulawayo City) started offering services within the public sector in 2004 and acted as learning sites. A process through identification, assessment and approval of initiating sites using a standardized tool followed. Approval to offer ART was based on capacity rather than on level of care. A team previously did this from the national level with the support from partners. There has been decentralization of this function to the provinces and districts. Eleven districts had no facility offering ART. Table 2 illustrates the ART coverage by province and district.

Table 2: The health facilities delivering ART services – December 2007

Province	**Districts**		**Total Number of Health Facilities offering ART**	**Initiating and follow up**	**Follow up clinics****
	Total number of districts	**Districts offering ART**			
Manicaland	7	7	29	7	22
Mashonaland Central	8	6	28	9	19
Mashonaland East	8	7	9	9	-
Mashonaland West	6	6	11	10	1
Masvingo	7	6	10	10	-
Matabeleland South	7	5	7	7	
Matabeleland North	7	3	11	8	3
Midlands	8	7	9	9	1
Bulawayo	n/a	n/a	11	5	6
Harare	n/a	n/a	24*	7	15

*Including 2 research projects
**Some offer initiation on outreach basis

3. As at December 2007, 86 sites were initiating ART and approximately 64 follow up clinics were offering follow up services. Fifty-one of the sixty-two districts (82%) (including Harare and Bulawayo as districts), have at least one health facility offering ART services.

4. The process of assessment and approval of sites to provide OI/ART services by the provincial and district teams has been slow. Reasons for the delay include (i)

delays in assessment and approval of sites, (ii) high attrition of staff among provincial and district assessment teams, and (iii) lack of transport. ART coverage is still less than 100% with 11 districts having no facility offering ART as of December 2007.

Private sector initiatives

1. The private sector has offered OI/ART services on an ad hoc basis through private practitioners, private stand alone clinics, medical insurance and in-house schemes by a few individual companies.

2. The contribution of the sector to the national number of patients on ART as at December 2007 was estimated to be 10,000 patients. However the potential of the private sector to further contribute to the scaling up of OI/ART services towards universal access remains largely un-tapped.

Public private partnerships

1. A few public private partnerships such as Hippo Valley Sugar Estates, Colin Saunders Hospital, Connaught Clinic and Mutare private practitioners are working very well. The public sector provides drugs and commodities whilst the private companies avail their infrastructure and human resources, to provide services to their own staff and surrounding communities.

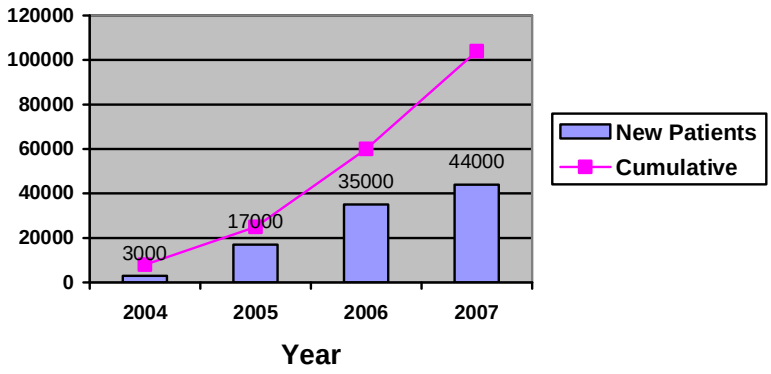
2. The Hippo Valley and Colin Saunders arrangements are guided by Memoranda of Understanding (MOU) with the MOHCW. A similar MOU with Hwange Colliery hospital is still to be signed despite a satisfactory capacity assessment of the hospital in 2006. In Mutare some private doctors are volunteering their time at the provincial hospital in exchange for access by their patients to ARVs, laboratory and radiological services at the public sector hospital.

3. A few research centres have been established and are supporting the programme to implement evidence-based interventions as well as contribute to numbers of PLWHIV receiving ART. The research centres include the DART trial clinic; UZ-Clinical Research Center (CRC) which is working in collaboration with the University of California San Francisco (UCSF), both operating in Harare and the Zimbabwe AIDS Prevention Programme (ZAPP) operating in Chitungwiza.

Strengthening delivery of quality ART services

1. There has been a significant increase in the number of people accessing ART from 5,000 (5% coverage) in 2004 to 104,000 in December 2007 (30 % coverage). This has been partly due to the high level of commitment among health care workers despite resource limitations[3] and the existence of a functional OI/ART model in the public sector. Fig 1 below shows the trend in overall ART coverage during the review period.

Figure 1: Number of Patients on ART by Year: 2004-2007



2. The MOHCW has established a national OI/ART training programme - more than 4000 health care workers (doctors, nurses, pharmacists, pharmacy technicians, laboratory scientists etc) have been trained in OI/ART. The national ART training course was detailed in theory but did not provide enough practical, hands-on training. Clinical attachments and mentoring was not standardized. Some trained cadres did not feel confident enough to initiate ART services, particularly in children. Currently there are two separate training programmes for paediatric and adult OI/ART. There is need to integrate these courses.

3. National ART treatment guidelines were developed, first published in 2003 and updated twice in 2005 and 2007 in line with international recommendations. The 2007 guidelines have not been widely disseminated and are in limited use both in the public and private sectors. The national ART guidelines clearly recommend ART initiation on the basis of WHO clinical staging in settings without CD4 testing facilities. However the review found reluctance by some doctors to use clinical criteria for initiating ART.

4. A procedure manual for the ART programme was developed including national minimum standards for infrastructure, human resources, laboratory and pharmacy. Most of the sites visited had critical shortage of human resources and inadequate space for consultation, confidential counselling and administration.

5. HIV testing and counselling services have expanded using both client initiated testing and counselling (CITC) and provider initiated testing and counseling (PITC) models. Primary counselors (PCs) were providing most counseling services (pre- and post-test, nutrition, adherence and on-going supportive counseling) at the visited sites.

6. Decentralisation of ART services was observed to have progressed faster in both GOZ and partner supported sites however with more activity at partner supported sites. Where decentralization had occurred, it assisted in bringing services closer to the people.

7. The growing demand for ART is not met and waiting lists of up to 6 months were noted at some district hospitals visited. The critical shortage of health workers and

inadequate and erratic supply of ARVs, compounded by the policy requiring ART to be initiated only by doctors, have contributed to the long waiting lists.

8. Access to ART by HIV positive pregnant women is limited by inadequate CD4 testing capacity. In addition poor follow-up and tracking of PMTCT women and their children was noted. Several sites reported a significant number of HIV positive pregnant women who failed to turn up at OI/ART clinics for ART initiation.

9. Uptake of ART and PEP services was reported to be very low among health workers at most of the sites that were visited despite prioritization of health workers to access services.

10. Systems to monitor quality of care have been established. However **patient tracking** systems at most sites are inadequate to accurately document deceased, defaulters, losses to follow-up and transfers. The MOHCW is planning to develop an electronic patient tracking database to improve **outcome monitoring.** Monitoring of clinical outcomes through regular check of weight and screening for OIs was done at most sites and most patients were still on the first line ART. However regular CD4 monitoring was a challenge at most sites. A system for cohort analysis is in place but needs strengthening and additional tools to improve its performance.

Management of HIV Drug resistance:

1. At the time of the review the Ministry was in the process of establishing an HIV Drug Resistance (HIVDR) surveillance system. A taskforce has been in place since 2006. The MOHCW has developed a draft HIVDR strategic plan for the period 2008-2012 and protocols for Early Warning Indicators (EWIs), HIV DR Threshold and HIV DR monitoring were being developed.

2. There is currently no access to viral load testing, which is essential for detecting virological failure at an early stage before development of resistance to all the drugs being administered. A gene sequencer and a viral load machine have been procured using The Global Fund and ESP funding. Installation of the machines and WHO accreditation will be done during the next two years. In the meantime samples for HIVDR will be sent to a WHO accredited laboratory.

3. Currently the country depends on high levels of adherence and clinical monitoring of patients to protect the first line regimen from early development of resistance.

4. Most sites reported inability to monitor drug adherence maximally and poor capacity to follow up defaulters thus putting first line regimens in danger of resistance development.

Expanding Paediatric and Adolescent ART services

The plan aimed to expand the number of patients on ART ensuring equity by gender, age (young people and children) and disability. It specifically sought to increase the

number of children accessing ART by updating ART guidelines and training materials to adequately cover the paediatric component.

1. The MOHCW has developed the PMTCT and paediatric HIV prevention and treatment strategic plan (2006-2010) to guide delivery of PMTCT and paediatric HIV and AIDS treatment and care services. When treatment started in 2004 only children who weighed at least 15 kg could access ART. Infants and very young children had severely limited access to ART. Paediatric syrups and FDC became available in 2006, with the support of partners. Availability of cotrimoxazole and nutritional support has also improved through the support of partners.

2. There has been thus a marked improvement in access to OI/ART services for children from the original eleven sites in 2004 to thirty two sites providing paediatric HIV and AIDS treatment and care services to children of all ages in 2007. However some children still travelled up to 400 kilometers to access ART.

3. MOHCW estimates that whilst 30% of adult ART need has been met, only 10% of children requiring ART are receiving treatment. Most sites visited only provided ART to children weighing at least 15kg because of the unavailability of paediatric formulations and inadequate trained staff. Health workers in some of the sites visited did not know how to access the paediatric formulations and most were experiencing prolonged cotrimoxazole stock outs.

4. Paediatric OI/ART training materials were developed and updated by the MOHCW and partners. This has enabled better identification and treatment of infected children. To date 448 HCWs have been trained in paediatric ART but most lack practical skills and confidence to treat infants and very young children because the training is mostly theoretical. A few sites did not have staff trained in paediatric HIV treatment and care.

5. A revised Child Health card, which captures HIV status, has been developed and is in use but most sites visited did not have the revised child health card in stock. Where the cards were available the PMTCT part was not consistently filled in thus making tracking of the exposed child difficult. Follow up was also compromised by the frequent and prolonged stock-outs of cotrimoxazole. Mothers would rather use the little money they had to buy drugs than spend it on transport coming for review.

6. Unavailability of definitive early infant diagnosis (EID) with HIV DNA PCR was noted at most sites visited. Many clinicians were unaware of the WHO clinical algorithm for presumptive diagnosis of severe HIV disease in exposed infants less than 18 months of age. National training in EID with HIV DNA PCR has been piloted with support from CHAI, EGPAF, UNICEF, WHO and Zvitambo. Four central hospitals are providing EID and roll out by the end of 2008 is planned.

7. Draft training materials on paediatric and adolescence HIV counseling have been developed. Psychosocial support services for adolescents and young children were inadequate at most sites visited with the exception of some central hospitals and partner supported sites. Most health workers were not knowledgeable about play therapy and its role in addressing developmental deficits due to malnutrition and

HIV. Similarly PCs currently lacked skills to counsel children and adolescents. Generally a poor supportive environment for orphans and vulnerable children was noted to be leading to variable access of OI/ART services and increasing defaulter rates among them. Most of the sites visited did not have support programmes for adolescents and youths hence issues of adherence, psychosocial support, stigma and disclosure were not adequately addressed. In addition, teachers had not received enough OI/ART education to carry out their supportive role in paediatric and adolescent care and support in the school environment.

8. Additional challenges for provision of quality paediatric ART included (i) unavailability of therapeutic feeding ingredients and supplementary feeding leading to adverse outcomes for those children with moderate and severe malnutrition and HIV and (ii) shortage of infant scales, MUAC tapes, weight for height charts and guidelines for the management of moderate and severe malnutrition in most sites visited.

Objective 5: Ensuring continuous availability of good quality AIDS medicines, diagnostics and other medical supplies

The MOHCW recognized that a strong logistics and supply chain management system is essential to the success of the national ART program and set a strategic objective in the plan to ensure the continuous availability of good quality drugs and other supplies for HIV and AIDS management. The object addressed (i) improvement in PSM of medicines and diagnostics, and (ii) ensuring quality and safety of medicines

Improvements in procurement and supply chain management of medicines, diagnostics and other medical supplies for HIV and AIDS

1. A logistics sub unit (LSU) of the AIDS & TB unit was set up in NatPharm with support from JSI/DELIVER. Capacity in quantification and management of OI drugs and ARVs was strengthened by expanding the team of dedicated staff, the introduction of forecasting and quantification tools together with logistics management information systems (LMIS). This strengthened the ordering system as well as the delivery of OI drugs and ARVs, which was appreciated by the visited sites.

2. Pharmacy operations, from ordering to stock management, are well understood and executed. The distribution of OI drugs and ARVs also improved with the provision of additional vehicles while supply of HIV test kits and PMTCT/NVP via the ZNFPC Delivery Team Topping Up (DTTU) has been piloted successfully and has improved the availability of these commodities at the sites. Site level training in stock management was conducted.

3. Financing for the OI/ART programme is adequate for HIV rapid test kits, condoms and contraceptives.

4. National ART guidelines have been updated and are waiting to be disseminated and put on to the MOHCW website.

5. TB fixed drug combination stocks were adequate in most sites visited.

Ensuring quality and safety of medicines and diagnostics

The MCAZ ensures the quality of drugs and its capacity has been strengthened by the provision of essential laboratory testing equipment and training of staff.

1. Inadequate capacity of MCAZ to handle multiple batches of drugs, imported by various partners through multiple supply chains, has led to a backlog of analysis of ARVs.

2. To address the above problem MCAZ has put in place an interim "pre-release arrangement" for drugs from registered suppliers.

HIV and AIDS Supply Chain Challenges

1. There is insufficient funding for drugs primarily because of a drop in the purchasing power of the Zimbabwean dollar. The GOZ remains unable to procure the required ARVs and resulting in low stock levels and stock outs. This has led to a growing number of patients getting less than one-month supply of ARV drugs due to rationing. Related to this shortfall, the extra transport costs are prohibitive for patients who must return frequently to the facility for their drugs. These conditions may threaten patient adherence and may lead to drug resistance.

2. ARV procurement planning remains weakly coordinated with multiple supply chains and parallel donor reporting requirements. The resultant geographical restriction of ARV distribution created complicated stock management systems at NatPharm and inequitable access to ART.

3. Critical shortages and high turnover of pharmacy staff in many sites remain serious impediments to scaling up. Support and supervision systems have broken down in most districts, as there are no pharmacists or pharmacy-technicians in post at provincial level to coordinate and supervise stock management. Communication/feedback between pharmacies and NatPharm/LSU was observed to be weak in some of the sites that were visited.

4. Stock status of ARVs was precarious during the period under review. Most sites have inadequate or no stocks of paediatric ARVs nor do they have PEP kits. The dual ordering system namely cotrimoxazole/ARV through Logistics Supply Unit versus essential drugs through Natpharm was causing confusion at health facility level particularly concerning which stocks of cotrimoxazole were free and which were not. Staff at some sites did not know how to order from the new LSU supply system. Most sites reported no stock of OI drugs or stocks that were below minimum level for cotrimoxazole. Some provincial hospitals had no second line ARVs even where specialist physicians were available. Most sites had low stocks of Vital Essential Non-essential (VEN) drugs such as basic antibiotics, with a range between 35% - 62.5% drug availability.

5. Some pharmacies will need an upgrade of their storage facilities to absorb larger volumes of drugs that would result from the envisaged scale up.

Strengthening Laboratory Systems for HIV and AIDS

MOHCW has recognized laboratory services as an integral part of the health delivery system and has placed emphasis on strengthening the laboratory services to support the OI/ART programme as evidenced by the following:

Procurement of laboratory equipment and reagents

1. With funding from CDC, Italian Cooperation, WHO, GFATM, ESP and other partners essential laboratory equipment in line with WHO's recommended guidelines has been placed in all provinces and some districts. For example CD4 machines have increased from only four in 2004 to forty six in 2007. These machines have been strategically placed to improve geographical coverage of CD4 testing services in the country.

2. At least 80% of major equipment has been standardized for each level of care and donors are in general complying with the national standards.

3. The HIV test kits pipeline has been filled and the distribution of HIV test kits through the DTTU system in pilot sites has worked well.

4. Provision of adequate laboratory reagents and associated supplies is a major deficit area with inadequate supplies to support the OI/ART programme. No additional funding has been received to support the already under funded laboratory services and consequently there is a severe shortage of reagents and basic supplies. Some of the visited sites were not providing CD4 testing due to lack of trained staff and/or sufficient reagents, despite having functional machines available.

5. Increasingly, patients are being referred to the private sector for CD4 testing and other diagnostic tests due to shortage of reagents and are therefore incurring additional charges. Even when these services are provided on site, other commodities such as blood collection tubes, needles and gloves are not available in some cases and again patients have to pay for these items creating a barrier to ART access.

Laboratory services management

1. Lack of an overall laboratory services management structure at all levels in MOHCW was assessed to be a major problem. There is only one coordinator of laboratory services at national level with no support staff or unit. Critical shortage of laboratory scientists and laboratory technicians is a major constraint to effective management and delivery of laboratory services at provincial and district levels.

2. A laboratory logistician has been assigned to the National Microbiology Reference Laboratory (NMRL) to assist the OI/ART programme to handle distribution of laboratory reagents. However there is no national system for handling laboratory diagnostics and there are frequent stock outs of reagents and

supplies. Multiple supply chains operate (ad hoc donors, open market purchases) resulting in duplication of cost and effort.

3. Although there has been an effort to standardize the equipment and supplies, there are still some remnants of non-standard equipment within the system. The Equipment Department in MOHCW does not have the capacity to manage the equipment and ensure that maintenance is properly undertaken according to the preventative maintenance contract.

Quality assurance of laboratory services

1. Quality is assured through the Zimbabwe National Quality Assurance Programme (ZINQAP), which offers an internationally accredited proficiency testing service for HIV testing sites to ensure the quality of the testing. ZINQAP offers an accredited external quality assurance (EQA) system. Most laboratories participate but this is not mandatory and there are no consequences for poor performance. Most facilities visited were not regularly participating in the EQA programme.

2. There is no regulatory body to assure the quality of laboratory reagents and other supplies imported into the country. The MOHCW has developed draft laboratory standards, which are yet to be adopted.

3. Some facilities visited did not have clinical chemistry capacity and CD4 equipment in many sites was not functioning. In some cases there was evidence that untrained or inadequately trained personnel were operating the sophisticated equipment.

Objective 6: Developing the national human resource capacity to meet the national ART targets

One of the key strategic objectives of the plan was to develop the human resource capacity to provide ART by (a) putting in place a national human resources plan for supporting scaling up ART in the private and public sectors; (b) providing pre-service ART competence to all trainee health care personnel; (c) providing ART delivery competency to all practising health personnel including the private sector; (d) recruiting and motivating health care workers; (e) training non-health personnel such as adherence supporters and home based care givers, to support ART delivery and (f) motivating and retaining non-health personnel.

The Human Resources for Health (HRH) crisis

1. In its report of 2007, the Health Service Board (HSB) reported the following selected vacancy rates (i) specialist consultants (73%); (ii) District Medical Officer (69%); (iii) Nursing Sister (14%); (iv) Pharmacists (69%); and (v) Medical Laboratory Scientists (61%). Table 3 shows the staffing situation as at December 2007.

Table 3: Vacancy returns from various government health institutions (2006 – 2007)

Grade	Established		In post		Vacancy		% Vacancy	
	2006	2007	2006	2007	2006	2007	2006	2007
SPECIALIST Consultant	307	307	65	82	242	225	79%	73%
JUNIOR REGISTRAR	94	94	8	21	86	73	91%	78%
NURSE TUTOR	248	248	90	80	158	168	64%	68%
PHARMACISTS	124	124	28	39	96	85	77%	69%
PHARMACY TECHNICIAN	185	185	87	93	98	92	53%	50%
RADIOGRAPHERS	159	159	30	65	129	94	81%	59%
RADIOGRAPHER/TUTOR	4	4	0	1	4	3	100%	75%
MED LAB SCIENTIST	385	385	209	151	176	234	46%	61%
HOSP EQUIPT/HIGH	95	95	30	32	65	63	68%	66%

Source: Health Service board; Annual report 2007

2. The severe staff shortage has affected the implementation and roll out of the ART programme in a variety of ways. Virtually all ART sites, including private sector and Mission hospitals were characterised by an acute shortage of health staff to meet the demand for ART.

3. This shortage affects ability to initiate ART at some potential sites, capacity to serve more patients at operating sites, ability to open satellite/outreach initiating sites and follow-up clinics and thus bringing services closer to the people and the ability to offer effective mentoring and supportive supervision.

4. The main reasons for the staff turnover are (i) low salaries that cannot meet basic living needs; (ii) poor working environment with shortages of drugs, equipment and other health supplies; and (iii) a difficult socio-economic environment with shortages of food and other essential commodities necessary for daily living.

Recruiting and motivating health care workers

1. The government, prior to the roll out of the ART programme, had established a Health Services Board (HSB) that has worked and continues to work to improve not only working conditions but also personnel management within the health sector.

2. Efforts by the MOHCW to stop the brain drain of skilled and qualified staff include the introducing of two retention packages: (i) the Global Fund (TGF) Round 5 support through NAC that targets a range of cadres in the 22 selected districts; (ii) the European Commission (EC) funded Vital Health Services Support Programme (VHSSP) that provides institutional and salary support in a further 24 districts; (iii) some NGOs such as MSF, some Mission Hospitals and others offer different salary packages and other non-monetary incentives; and (iv) the MOHCW through the RBZ is also supporting a programme of support for some health workers by providing vehicles.

3. The incentive schemes already in operation have been clearly successful in attracting specified staff to the selected districts. Central hospitals have not benefited from the schemes. Anecdotal evidence from existing Global Fund Round 5 and the VHSSP suggests unintended internal human resources market as health workers jostle for district jobs and follow the resources flows to supported districts. There is evidence to suggest growing demotivation of staff who are not benefiting from the retention package and yet are part of the team providing ART services in some Global Fund supported ART districts.

4. In order to mitigate these potential disruptive consequences, the MOHCW is in the process of harmonising human resource retention schemes through the development of Human Resources for Health Policy and Strategy. The team was informed that the HSB has done extensive research and has determined salary levels that are competitive in the SADC member states such as Namibia, Lesotho, South Africa and Swaziland where most of the Zimbabwean health workers are going. There has been notable increase in willingness by donors to support a standard retention scheme for health workers.

Providing ART competence to health care personnel

1. **Pre-service training:** Discussions have been conducted between the MOHCW and health training institutions for doctors and nurses to facilitate updates of training curricula to include HIV and AIDS including ART as an examinable subject. Practical HIV and AIDS tuition has been included in nursing training curricula. However inclusion in pre-service training curricula for doctors is yet to be finalised.

2. **In-service training:** HIV and AIDS training, including ART, have been established for key health cadres (doctors, clinical officers, nurses, counselors, laboratory, pharmacy) at all levels of the health delivery system including the public (government, local authorities, mission institutions) and the private sector. Training programmes include standardised theoretical training, practical training or clinical attachments however mentoring is minimal. Teams of trainers have been established in all provinces with at least six members in each team. The ministry recently completed the adaptation of the Integrated Management of Adult and Adolescence (IMAI) guidelines and training materials for first level health workers.

3. The training programme included (i) rapid HIV testing; (ii) management of opportunistic infections; (iii) ART management in adults and children; (iv) nutrition and HIV and AIDS; (v) counselling and psychosocial support; (vi) follow up of patients on treatment to ensure adherence; and (vii) monitoring of OI/ART programme using the data management registers and tools.

4. More than 4,000 health care workers (doctors, nurses, clinical officers, pharmacists, pharmacy technicians, nutritionist, laboratory personnel etc) have been trained in OI/ART.

5. A key challenge to the above training efforts is the high staff attrition rate resulting in high losses of trained staff and the need for continual training of new

staff. While the above measures have gone some way in addressing the issue, by the end of the plan period the nation was still facing a major human resource gap between what is needed and available manpower especially in public health facilities.

6. Primary counselors (PCs) have turned out to be an invaluable cadre in addressing the high demands for counseling in caring for people with HIV infection. The plan to have the PCs assimilated into the MOHCW establishment was not approved. The MOHCW did not support creation of the post largely due to concern about an unclear career path for the PC and thus directed that PCs should be absorbed against vacant nurse aide posts. At the time of the evaluation, of the 480 that were trained, the majority had not received salaries for several months, leading to many resignations.

7. While responsibility for training on OI/ART has been decentralised to provinces and districts, the provinces reported that the funds have not been similarly decentralised and are not easily accessible.

Objective 7: Developing systems for ART programme monitoring, evaluation and research

As the country scales up the national HIV and AIDS treatment and care programme towards universal access by 2010, it is increasingly important to strengthen strategic information in order to inform policies and improve the effectiveness of the programme. This requires the development of a core set of indicators to monitor and report on the country's progress response towards universal access[4].

Programme indicators

1. The OI/ART plan included nine impact and outcome as well as several input, process and output indicators related to the involvement of health sector and other sectors in the delivery of OI/ART services in Zimbabwe. In reviewing the main programme indicators, the team considered the ability of the system to monitor **availability, coverage, outcome and impact** of services[5]. Table 4 presents a review of the main quantitative indicators collected and reported through the current system.

2. Although the ART programme was well known, the ART scale up plan was generally unknown by stakeholders. Some partners, especially civil society organisations, were not well informed about the OI/ART plan and some did not know output indicators and targets they were responsible for reporting according to the plan. It was therefore difficult to quantify the notable progress that has been made in expanding service delivery.

Table 4: Key OI/ART programme indicators

Indicator	Level	Comment
Several input indicators were included in the plan	Input	No efficient system for monitoring especially those activities done by the non-health sector
Number of new staff trained to prescribe ARVs by a nationally recognised institution by month	Process (availability)	Training is on-going but there are delays in consolidating reports from the several training partners
Number of new staff trained in ART management by a nationally recognised institution by month	Process (availability)	
Percentage of sites currently delivering ART with adequate staff according to set national standards	Output (availability)	Only those sites that report to the MOHCW are recorded. Some follow-up sites and private sector ART sites are not tracked. In addition there is no system to timeously track the number of staff at ART sites
Percentage of ART sites with a minimum stock of ARVs available by month	Process (availability)	The revised MOHCW ARV and Fluconazole ordering and distribution system adequately captures LMIS data from reporting sites
Total number of new patients receiving ART each month (stratified by age {children vs. adults} and gender)	Outcome (coverage)	Being routinely measured from monthly progress reports. Challenges in updating and late reporting by sites and delays in data entry at central level
Total number of patients (old and new) receiving ART each month (stratified by age {children vs. adults} and gender)	Outcome (coverage)	
Percentage adults on ART who increase their weight by at least 10% at 6 months after initiation of treatment (stratified by gender) (***from ARV Surveillance system***)	Outcome Impact	The ARV surveillance system mentioned in the plan does not exist. A cohort analysis tool is available and health workers are being trained in its use. This tool is used to measure quality of care
Percentage of people remaining on ART at 6, 12, and 24 months from initiation of treatment (stratified by age {children vs. adults} and gender) (***from ARV Surveillance system***)	Outcome Impact	
Percentage of people still alive at 6, 12, and 24 months after the initiation of antiretroviral therapy (stratified by age {children vs. adults} and gender) (***from ARV Surveillance system***)	Outcome Impact	

3. Efforts have been made to monitor implementation of the plan for scaling up ART through the monthly progress reporting system. However baselines were not constructed for most of the programme outcome and impact indicators within the plan.

4. Indicators of care e.g. number/percentage of adults and children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) currently receiving CTX prophylaxis and number/percentage of infants born to HIV-infected women started on cotrimoxazole prophylaxis within two months of birth are routinely monitored.

5. Other determinants of universal access which do NOT explicitly appear in the current programme indicators and have not been measured include: (i) affordability of services; (ii) equity of intervention access and coverage (occupational group, socio-economic and other demographic categorisations, vulnerable groups, other groups that may receive differential treatment or less

likely to receive services); (iii) quality of interventions and services provided; (iv) acceptability of services, user perceptions of service provision; and (v) effectiveness of services provided to improve implementation.

Data collection

1. In order to collect data for the programme indicators, the MOHCW developed a set of data collection tools, which should provide up to date information. The tools include a series of ART registers, record reviews and special surveys. When OI/ART services were introduced, there were vertical M&E systems for the thematic interventions run by the AIDS & TB Unit. The PMTCT, Testing and Counseling, ART and TB programmes all used different data collection tools and reporting. An integrated HIV and AIDS monthly progress report form for PMTCT, OI/ART and Testing and Counselling was developed in 1997.

2. It was noted that despite its ability to fulfill the MOHCW's obligation to monitor and report progress made in delivering OI/ART services, the current system has increased the burden of reporting by health workers. The system is largely paper-based.

3. Several challenges including the following are associated with the current paper based system for ART patient tracking and reporting (i) too many registers which create huge work load for the few staff; (ii) several sites have developed their own simpler data collection tools; (iii) most health information officers have not been trained in the use of the system and there is high staff turnover and attrition with most sites not having anyone in post; and (iv) as the number of patients on ART increases, health facilities are facing tremendous challenges in tracking patients using the current paper based system mainly due to staff shortage.

4. Computerisation is planned in the near future at the site level wherever applicable and at the central level. Lessons and experience from other activities will be used to improve data management.

Data reporting, analysis and feedback

The aim of monitoring is to provide the programme managers with information for monitoring progress, timely identification of problems hindering smooth implementation and capturing best practices and lessons for duplication during expansion. This information assists in fine tuning the implementation and scaling up. In order to monitor and evaluate progress of the OI/ART programme more effectively, the MOHCW has developed an integrated OI/ART reporting form.

1. A set of output and outcome indicators have been developed and are being routinely collected and reported through the monthly OI/ART progress report form. During the first two years of the programme data flowed from ART sites directly to the AIDS & TB Unit but reporting rate was poor. Forms were filled in duplicate. Original copies of the filled forms were sent to the AIDS & TB Unit every month, while copies remained at the sites.

2. Programme and M&E activities at site level were supervised from the central level without active involvement of provincial staff and Health Information Management System (HMIS) headquarters. However this has been corrected to

foster greater involvement, leadership and better coordination by the PMD. Sites are now required to fill reporting forms in triplicate and send one copy to the PMD to provide a backup set of data as well as to provide the PMD with an opportunity to process and analyse data. However most facilities lack the human capacity in skills and numbers to routinely analyse data for local decision-making.

3. In 2007 the MOHCW initiated the development of an electronic database to collate and analyse routine programme reports. However the current Microsoft Access database was not well designed for efficient data storage, retrieval and analysis. The system has been further developed to produce consolidated programme reports. In addition an indicator database has been developed and will be piloted in selected districts.

4. Whilst there has been tremendous progress in strengthening data generation and analysis, including sex and age disaggregation, the reporting requirements for the OI/ART programme were not streamlined with the existing HMIS. Currently the HIV and AIDS M&E system is vertical with no linkage at all levels to the HMIS. Whilst the HIV and AIDS M&E system is relatively well funded, the HMIS is poorly funded and lacks capacity especially at central level. Similarly the CRIS system by NAC which has been installed in all districts in order to monitor and report activities in the multisectoral HIV and AIDS response, is NOT linked with the health sector HIV and AIDS M&E system.

5. Most sites do not have email access for efficient reporting to the central level resulting in poor reporting rate (less than 60%). The courier system used by some sites to send reports to the central level is erratic.

6. There is no system for validating progress reports from sites. Some discrepancies were reported between reports from Global Fund supported sites and verifications done by the NAC (Global Fund PR).

7. Reporting by the private sector remains a key challenge. Only the five private sector organisations namely Hippo Valley, Triangle, Connaught Clinic, Rowland Square clinic (a Medical Insurance run clinic) and Hwange Colliery report regularly to the MoHCW.

8. Another issue of note is that apart from this end term review, the programme design did not include a mid-term evaluation to measure the effectiveness of the OI/ART programme and determine changes that were needed to improve programme effectiveness.

HIV and AIDS Research

1. A research agenda for Zimbabwe was developed in October 2005 but not widely disseminated. There is no mechanism for coordinating and systematically following up OI/ART operations research being conducted by various players in the country.

2. Central hospitals have not actively taken their ideal role of centres of excellence in research. Funding and critical shortage of both consultant and middle level cadres have been key bottlenecks to operational and clinical research.

3. The NIHR has not fully taken its role of spearheading research and collating data on what research is being conducted in the country on HIV and AIDS in particular ART in order to inform the ART programme.

Objective 8: Strengthening programme management, coordination and supervision

The plan aimed to strengthen programme management, coordination and supervision through (a) strengthening of MOHCW ART coordination capacity at central, provincial and district level; (b) strengthening coordination mechanisms between government and its partners at central level; (c) increasing sharing of information on ART between all partners; (d) developing national standards for support and supervision; and (e) providing vehicles and incorporating ART in ongoing support/supervisory visits.

Programme management

1. The OI/ART plan is well aligned to the ZNASP and national, regional and international commitments to scale-up access to HIV and AIDS treatment and care services. Partner supported programmes have been integrated into the national programme through monitoring of sites, participation at the national partnership forum, and use of national guidelines and procedures. However some elements of the programmes have not been well harmonised e.g. procurement of ARVs. Districts that were supported tended to have clear plans and ART targets compared to non-donor funded sites.

2. The national OI/ART programme is led by the AIDS & TB Unit, which falls under the preventive directorate of the MOHCW. It was noted that there is inadequate joint planning between the AIDS & TB Unit and other MOHCW departments at national level. However at lower levels the HIV and AIDS programme has been gradually integrated into planning and management of general health services.

3. During the period under review, the Treatment and Care team has only one officer with no support staff. In 2006 the staff was increased to have a training officer, M & E officer and a secretary.

4. The role of supportive supervision of the OI/ART programme has been gradually shifted from the national team to provincial and district teams.

5. A bi-annual newsletter on HIV and AIDS prevention, treatment and care was developed starting in 2006 in collaboration with WHO but is not regularly produced.

6. Separate OI/ART planning across programmes, sectors and implementers have led to weak linkages e.g. HIV/TB collaboration, access to ART by OVC and HIV positive pregnant women, and HIV/nutrition. Some of the national strategic plans have differing cycles, which can negatively impact planning; examples are the PMTCT and ART.

7. There is no standardised approach to mentoring and supportive supervision. The ministry developed an assessment tool, which has a checklist for supportive supervision. However there has been limited training in HIV and AIDS supervision and mentoring.

8. Most provinces do not have adequate staff and transport to regularly supervise ART sites. Supportive supervision to check on completeness and correctness of filling of the data forms, safe storage of data, completeness and accuracy of computer data entry and smoothness of data flow from the site level upwards is also lacking.

Programme Coordination

1. The AIDS & TB Unit chairs the National HIV Treatment and Care Partnership forum with membership of most funding and implementing partners supporting the OI/ART programme, civil society, private sector, and organizations of PLWHIV etc. This is a forum were technical and funding issues for the OI/ART programme are discussed. This has been successfully hosted once every other month during the period under review.

2. Donor support for the programme including the ESP, Global Fund, USG and others, is well coordinated and complements the Government of Zimbabwe. Existing donor coordination mechanisms include the ESP Working Group, CCM, and donor forum. Stakeholders reported mixed views about the current coordination mechanisms with some saying the mechanisms are many and parallel while others thought the mechanisms created platforms for information sharing. There is however need for further strengthening of coordination and information sharing to improve procurement planning and ARV supply management.

3. The coordination arrangements at national level for HIV and AIDS programmes if not streamlined risk duplication, ineffective use of time in many meetings and programme staff burnout. Programmes like HTC, PMTCT, Workplace programme need to be coordinated under HIV Prevention, while HIV Treatment & Care and TB need to be coordinated under HIV/TB Treatment and Care.

4. There is no clear coordination mechanism for OI/ART programme at provincial and district level. Whilst the provincial health executive (PHE) is responsible for coordination of all health services in the province, most PHEs that were visited were not actively overseeing the provision of OI/ART services within their provinces. This has been largely attributed to the lack of provincial HIV and AIDS coordinators at PMD level, a position that does not currently exist in the MoHCW structure.

5. Representatives of PHEs and DHEs that were visited mentioned that their existing coordination mechanisms such as PHT and DHT are appropriate fora to coordinate OI/ART activities. However these structures do not have adequate funding for regular meetings.

6. The involvement of the private-for-profit sector in OI/ART services remains inadequate. The few private sector organisations that are providing services do not participate in the existing coordination arrangements.

7. The NAC system although well structured and staffed, has not been an effective mechanism for OI/ART service planning and coordination at lower levels including the private sector. For example the involvement of the health sector in recent integrated HIV and AIDS district plans was weak in most of the districts that were visited. There is therefore need to strengthen collaboration between the MOHCW and NAC structures at all levels

Objective 9: Strengthening resource mobilisation for increasing access to ART

The purpose of the strategic objective is to strengthen financial resource mobilisation for increasing access to ART by (a) integrating ART activities in all strategic and other planning processes of all partners at national, provincial, district and local levels in the public and private sectors and (b) mobilising adequate local and international resources for ART scale up.

Government funding

1. In keeping with its mandate and responsibility for health care including ART the GOZ through the MOHCW started the ART programme primarily with its own resources. From 2006 government funding included 50% of the NATF (AIDS levy). Positive impacts resulting from engagement with other parts of Government, including more effective coordination and resource pooling with other parts of MOHCW are less obvious. Exceptions identified have been the provision of ART to the uniformed services, and integration of HIV-related information into the educational system, albeit primarily focused on prevention.

2. A functioning public health system helps enable cost-effective use of scarce resources. Although highly stretched, the Zimbabwe health system remains functional and geared towards the expansion of ART.

3. A broader challenge for Zimbabwe will be a return to sustained economic growth. The economic crisis reduces the Government resources available for health and HIV, expressed most obviously by falling numbers of PLWHIV receiving ART through national resources despite the strong commitment by government through the MOHCW and NAC. The purchasing power of the NATF resources has fallen to negligible amounts, and the MOHCW budget has faced a steady annual reduction in its capacity to fund health care.

4. Although the government of Zimbabwe has a strong history of generous allocation as a percentage of total government spending on health, the estimated resources of the MOHCW has fallen by over 30% since 2004, with the estimated allocation for 2008 at the equivalent in purchasing power terms of US$120 million[6]. This is similar to the total value of ART and other drug and treatment related support by donors. The inability of the RBZ to honor a commitment to provide US$1 million per month for ARV procurement has further reduced government contribution to the programme.

Donor support

1. Additional donor support increased substantially during the period under review. Table 5 shows the sources of funding during the review period and commitments during the period 2008-2009.

Table 5: ART Support and Funding Commitments

Partner	Supported patients end 2004	Supported patients end 2005	Supported patients end 2006	Supported patients end 2007	Supported patients end 2008	Supported patients end 2009
Global Fund	0	0	7000	14000	54000	74000
ESP	0	0	0	17000	48000	48000
USG (USAID/CDC)	500	500	500	40000 (from mid 2007)	40000	40000
EC	0	0	0	0	3000	3000
CHAI (all 2nd line drugs	0	0	0	0	1636	2312
CHAI (paediatric first line)	0	0	5000	10000	20000	20000
DRI (alternative 1st line drugs)	0	0	0	2500	2500	2500
TOTAL	**500**	**500**	**12500**	**83500**	**191636**	**212312**

2. The increased donor support requires an effective partnership coordinated by Government to ensure effective allocation of scarce resources to the maximum benefit of patients.

Private sector contribution

1. The private sector provision of ARVs has also played its role, especially in benefiting a substantial number of employees in the formal economy. Some major national health insurance organisations have established schemes, which cover ART and related costs. This provides a real option for employers to provide ART services. Some of the larger employers have opted for in-house financed schemes for their employees. In addition, private doctors initiate and manage patients who access drugs from private pharmacies.

A key challenge in the context of the private sector is that the economic situation has limited the capacity of the sector and individuals to access ART privately due to reduced purchasing power. This places a heavy negative burden given that out of pocket expenditure is the main financing source of health care for PLWHIV[7].

Funding gap

1. The declining domestic contribution presents a major challenge to sustainability of the programme. At the inception of the programme the NATF contributed an equivalent of US$1 million monthly for ARV procurement. However the

contribution has shrunk considerably due to to a rapid fall in purchasing power as a result of the shrinking economic base and hyperinflation.

2. Although Zimbabwe has been successful in two rounds of Global Fund bids, it has received relatively fewer resources compared to other countries with similar resource constraints and HIV epidemics. A strong record of implementing the two successful rounds, including fully overcoming exchange rate issues, would strengthen Zimbabwe's capacity to successfully attract future Global Fund resources.

3. The flow of approved Global Fund resources was delayed by protracted negotiations between the RBZ and TGF to establish a flexible foreign exchange rate mechanism that would ensure hyperinflation does not compromise agreed targets. This was recently resolved through the appointment of a Fund Manager and resources are expected to start flowing by July 2008.

4. A further increase in resource mobilisation is required if universal access is to be achieved. Success in TGF Round 8 proposals is therefore critical, as well as continued efforts to ensure Zimbabwe's wider partnership with the Global Fund is effective.

2.2 Effect of the OI/ART Programme on other Programmes

The effect of the OI/ART services on other health programmes was assessed by reviewing the (i) linkages with and (ii) direct positive and negative effects of OI/ART services on other programmes.

2.2.1 Linkages with other HIV programmes

1. Strengthened programme linkages improve efficiency and the quality of service delivery. This evaluation found that important linkages have been developed between OI/ART and other HIV programmes namely PMTCT, TB, Nutrition, STI and Reproductive Health and Family Planning at service delivery levels. The strength of the linkages varied from one level to the other and from site to site.

2. At the central level, HIV and AIDS, TB, PMTCT and STI programmes are vertical. However, efforts to link these HIV interventions have been made through joint planning, sharing of reports, information and occasionally undertaking supportive visits to the health facilities as a team.

3. At the Provincial level, HIV and AIDS interventions begin to converge and link better as one person often leads more than one programme. At service delivery level, linkages are more pronounced as programmes are undertaken under the same roof and in the same communities.

4. In some institutions, OI/ART clinics are located far from other health services. This has presented a barrier, as some patients get lost to follow-up during referral from other departments. Table 6 shows ideal linkages in the provision of OI/ART at the service delivery level.

Table 6: ART Programme Linkages

Programme	Activity	Linkage
TB/HIV	TB patients counselled and tested for HIV	▪ HIV positive patients screened for TB ▪ TB patients offered ART
HTC	Entry point into OI/ART programme (VCT/PITC)	▪ HIV positive patients referred for ART
CHBC	Patients on CHBC, offered HTC	▪ HIV positive patients on CHBC, commenced on ART ▪ Patients on ART referred for CHBC
PMTCT	HIV positive pregnant and post partum women commenced on ARV prophylaxis and ART (sd-NVP/HAART)	▪ Pregnant women on HAART referred for antenatal care ▪ Women who have received sd-NVP, referred for HAART & fast tracked to access services in OI/ART clinics ▪ Child health card allows for HIV exposed & infected children to access OI/ART services
Nutrition	Malnourished patients sent for HTC and then referred for ART if positive	▪ HIV positive patients have nutrition assessment done and then referred for therapeutic feeding and nutritional assistance
In-patient and	PITC	▪ HIV positive patients referred for

out-patient including STI and family planning		OI/ART services. ▪ Check for STI and encourage family planning in patients with HIV
Patients on OI/ART	Given information on support groups existing at the treatment sites and communities	▪ Referred to support groups for continued psychosocial support and adherence counselling
EPI	Given information on PMTCT and child card checked for PMTCT Information, offered HTC	▪ HIV positive children at OI given necessary vaccinations

Demonstration of programme linkages

5. **TB:** At most sites, there is a reported increase in the number of TB patients being offered HTC. More TB patients are also being commenced on cotrimoxazole prophylaxis and are given priority when referred for ART. Patients on TB treatment who are HIV positive are being given priority in commencement of ART. There is however need to strengthen the documentation of these collaborative TB/HIV activities. A serious cause for concern is the widespread lack of diagnostic services for TB (mantoux, sputum examination, CXR), which may lead to a delay in the treatment of TB and initiation of ART.

6. **PMTCT:** Most sites are prioritising pregnant women, their partners and children in the provision of ART. Unfortunately this was limited by inadequate CD4 support. Clinical staging is a very insensitive way of identifying pregnant women who need ART. It was also noted that some women referred for ART never arrived at the OI clinic if no escort was provided.

7. **Paediatric HIV care:** Half of the exposed children who turn out to be HIV infected die before their second birthday, hence the need for strengthening the follow-up of these children. Tracking of HIV positive mothers and exposed children was found to be generally ineffective resulting in missed opportunities for cotrimoxazole prophylaxis and ART.

8. **Family planning:** It was noted that in some institutions, linkages of the OI/ART programme with family planning services were weak. Couples presenting for family planning services were not always offered HTC and couples with HIV were not always advised about family planning options. Also of concern is the absence of regular annual screening for cervical cancer among HIV positive women of childbearing age.

9. **HIV/STI:** The STI programme has also seen increased linkages in most sites as health care workers realise that patients with STIs are at an increased risk of HIV infection. Screening and treatment of STIs, has been combined well with HTC, with provision of ART for those requiring treatment. However clients with HIV infection are not always checked for STI.

10. **HIV/Nutrition:** Whilst the importance of nutrition in PLWHIV was appreciated, nutritional support and therapeutic feeding for the moderately or severely

malnourished HIV patients was not readily available in most sites visited. Much more effective integration and strengthening of the nutrition programme in OI/ART is needed. In some districts, NGOs were providing ART patients with food. Opportunities to fortify communal food stores through the Zunde raMambo project have not been fully harnessed. An innovative solution to address shortage of nutritional ingredients was the use of goat milk from a hospital herd for therapeutic feeding at St Luke's Mission hospital.

2.2.2 Effect on other Health Programmes

The OI/ART services have grown very rapidly from zero status in 2004 to one of the largest health programmes in the public sector. It was therefore anticipated that the programme would have an impact on the provision of existing and emerging health services. The evaluation findings indicate that the programme has had mixed effects on the general health service delivery.

Positive effects

1. Overall, the introduction of the ART programme has tended to increase the confidence in the hospital services and utilisation of non-HIV related services. Staff in Manicaland and Mashonaland West provinces reported increased numbers of children and adults seeking and receiving care for non-HIV related conditions than was the case before ART. This is particularly the case where services are largely free such as Murambinda mission hospital. Members of the community reported a marked change in the well being of the PLWHIV, including a decline in HIV related funerals.

2. Reports from the visited sites indicate reduction in stigma and increased disclosure as PLWHIV developed hope through access to ART and improved better management of OIs. There were anecdotal reports of declining outpatient and inpatient attendance as more PLWHIV benefited from ART. However more detailed research is required to verify such reports.

3. The ART programme has contributed to the strengthening of health systems in general e.g. Laboratory services have improved in most ART sites, thereby benefiting health services in general. Examples are the introduction of equipment for the determination of CD4 cell counts, full blood counts and chemistry.

4. The introduction of ART was reported to have initially improved the morale of clinical health workers because they were able to offer drug treatment for HIV infection, often with dramatic improvement. However the shortage of ARVs and other bottlenecks to ART have eroded the morale.

5. The introduction of staff retention schemes supported by the TGF and VHSSP has attracted key staff to previously underserved health institutions and enabled more patients to access ART and other medical services. Examples are Mutambara Hospital in Chimanimani district and Murambinda Hospital in Buhera district, and Hwange and Lupane districts.

Negative effects

1. Initiating ART sites are experiencing marked increases in workload due to the progressive increase in the numbers of OI/ART patients. In some cases more patients are attending OI clinics than the rest of the outpatients department examples are (i) Mutare provincial hospital where the team was informed that 75% of outpatients seen were OI/ART patients; (ii) St Patrick Mission hospital and Sakubva clinic where the OI/ART clinics have simply overwhelmed the small outpatient units and (iii) Father O'Hea mission hospital where the MCH unit stops functioning on "ART days" to make way for the OI clinic. The marked increase in workload was exacerbated by staff shortages.

2. The selective award of incentives has resulted in demoralisation of staff that is not included in the schemes and is negatively affecting teamwork. It has also resulted in an internal market for health workers as staff jostles for positions at supported sites.

3. At some sites there has been competition for space e.g. at Harare hospital the OI clinic displaced the Family Support Clinic.

3. ANALYSIS OF PROGRAMME PERFORMANCE

This chapter presents a broad analysis of the relevance, efficiency, effectiveness, equity and sustainability of the programme.

3.1 Relevance

The review defined relevance as the extent to which programme activities were closely connected with or appropriate to national priorities. This section summarises the extent to which the programme inputs and activities set out in the Plan for Nationwide Provision of ART were relevant to the scaling up of OI/ART services in Zimbabwe.

1. Overall the programme goals and objectives were aligned to the ZNASP and other key national strategies and priorities in order to effectively mitigate the impact of HIV and AIDS in Zimbabwe. The plan was developed through a wide consultative process in which key gaps in OI/ART service delivery were clearly articulated.

2. The implementation of the plan took into account the country context in terms of capacity, policy and institutional frameworks. In order to achieve optimal performance and service delivery, specific activities were planned to address pertinent bottlenecks. This ensured that the plan remained relevant within its operating environment.

3. Examples of such flexibility of the plan are seen in (i) the phased introduction and expansion of ART where experience from one phase informed the next; (ii) the presence of a supportive policy environment that enabled creation of innovative funding models such as the ESP, to ensure ART programme continuity in line with the 'Three Ones Principle', (iii) establishment of systems for rapidly responding to changes in technical guidelines and recommendations such as the WHO recommendations for ART; and (iv) embracing regional and international commitments such as the 3 by 5 initiative and currently universal access by 2010. Although Zimbabwe did not achieve the 3 by 5 target by December 2005, the initiative created huge momentum for the ART programme, which undoubtedly contributed to the rapid expansion of ART coverage in a short space of time, largely guided by the plan for ART.

3.2 Efficiency and Effectiveness

Efficiency was defined as 'how well inputs were turned into outputs and outcomes' whereas **effectiveness** was defined as 'the extent to which outputs produced desired outcomes' which were subsequently measured by the indicators under each strategic objective in the plan.

1. The key outcome of the OI/ART programme is the number of PLWHIV receiving high quality OI treatment and ART. The progress of the Zimbabwean ART programme in numbers can be described as relatively successful in comparison to its regional neighbours which have managed to achieve similar ART coverage but with substantially much higher resources.

2. Even though the progress to date is highly commendable, the MOHCW should improve the efficiency of the programme if universal targets are to be achieved. In reviewing efficiency and effectiveness of the programme, the team examined (i) capacity of management teams to coordinate service delivery, (ii) treatment preparedness and community engagement, (iii) reliability and efficiency of procurement and supply chains, (iv) training and capacity building, and (v) systems for monitoring the programme.

(i) Management and coordination for effective and efficient service delivery

In an environment of severely constrained resources, it is prudent to ensure strengthening of health systems including existing infrastructure and equipment, human resources, information management and financing mechanisms instead of creating parallel structures and systems.

1. In most cases the OI/ART programme has made use of existing structures and systems. Whilst the establishment of arguably vertical OI clinics has worked relatively well at central hospital level, its appropriateness to sustain efficient and effective service delivery at lower levels is questionable.

2. Multiple coordination structures exist, especially at national level in the public sector. Numerous meetings at national level, often attended by the same people, have the potential for duplication and ineffective use of time as well as staff burnout.

3. Progressive weakening of management teams, especially at provincial and district levels, threatens service delivery. The private sector was noted to have poor programme reporting and suboptimal utilisation of potential capacity in this sector.

4. The capacity of initiating ART sites is severely stretched and clearly failing to cope with increasing demand for ART. Long queues and waiting lists in excess of six months are common to the programme.

(ii) Demand creation: treatment preparedness and community engagement

1. The role of community systems in demand creation as well as supporting delivery of OI/ART services cannot be debated. There is clear evidence that the MOHCW plan for ART made a good attempt to ensure community involvement including MIPA. However major challenges for more meaningful community participation and involvement were centered on lack of skills, financial and material resources.

2. Significant progress has been made to reduce stigma and discrimination. However in some communities stigma remains a major barrier to ART access.

3. The overwhelming demand for ART that has been created for ART has not been matched by supply of services. Heightened community engagement for advocacy has resulted in improved political will and commitment to the programme. However ongoing advocacy is essential for attainment of universal access.

(iii) Reliable and efficient procurement and supply chains

1. Uninterrupted and efficient supply of AIDS medicines and diagnostics is a cornerstone of ART programmes.

2. Multiple supply chains for ARVs have not only created a burden on quality assurance and stock management systems but have also resulted in inefficiencies in ARV supply due to geographical restriction by donors. Stock-outs of ARV were experienced in several parts of the country and in many instances have led to rationing of prescriptions thereby compromising treatment adherence.

3. Prohibitive costs and unreliable supply of HIV related diagnostics is a major bottleneck to ART access in Zimbabwe.

(iv) Training and capacity-building

1. The MOHCW and its partners have invested substantial resources in training health workers at all levels in OI/ART. However the impact of the investment has been minimised by high staff turnover. The result is an incessant shortage of skilled staff to meet the rising demand for ART, especially in remote rural areas.

2. Similarly provincial teams that have been trained to conduct site assessments and approval have not resulted in sufficiently rapid expansion of service delivery largely due to inadequate staff and transport.

(v) Systems for monitoring the programme

1. Successful performance of the OI/ART programme hinges on the capability of information management systems to collect, collate, analyse and use programme data. The AIDS & TB Unit has developed a fairly responsive system for monitoring the OI/ART programme. However the data collection and reporting system is not linked to the NHMIS at all levels.

2. Whilst it was appropriate to have a separate and dedicated system during the inception and early expansion of the OI/ART, lessons learnt show the need to develop a set of core health indicators to which the HIV and AIDS database contributes. Such a linkage will ensure that relevant data on agreed indicators to measure the national disease burden is collected efficiently and is readily available for decision making at all levels.

3.3 Equity

Equity was defined as fairness and impartiality in the delivery of services. An equitable OI/ART programme should ensure access to service, when they need it, by boys and girls, men and women from all socioeconomic groups living with HIV in any rural, urban and other parts of the country.

1. The programme has developed indicators and to monitor some dimensions of equity including OI/ART access by gender and age.

2. Given that almost 51% of PLWHIV in Zimbabwe are women, the fact that 60% of PLWHIV on ART are women demonstrates good gender equity. However access

to ART by HIV positive pregnant women was initially limited by the lack of CD4 test access and weak referral systems.

3. Whereas approximately 33% of adult patients in need of ART are already on treatment, only 12% of children are currently receiving ART. This is attributed to the delayed introduction of paediatric ART and subsequent slow expansion. In particular children under 18 months of age are still seriously underserved. Adolescent services are also currently limited to very few sites. This needs to be taken into consideration in the next expansion phase.

4. Access for poor people is not routinely monitored and the system. The expansion of OI/ART services to rural areas was initially constrained by shortage of health workers and difficulties by PLWHIV to reach ART sites. However human resource retention schemes and donor support to rural sites have resulted in improved capacity of several rural sites to deliver OI/ART. In addition decentralisation of ART initiation to the district level and a few health centres, and decentralisation of follow-up to a number of health centres has led to increased access.

5. A matter for concern is the system's inability to monitor access by marginalised and vulnerable population groups such as prisoners, people in squatter camps and the homeless.

6. Uptake of ART increased rapidly after user fees were abolished. However this was quickly reversed by a sharp increase in cost of diagnostics. This is of particular concern at sites where clinicians insist on CD4 testing for ART initiation thus creating a huge economic barrier for the poor.

3.4 Sustainability

Sustainability referred to the programme to be maintained at current and higher levels even in the absence of donor funding. In examining this characteristic of the programme, the team reviewed (i) models of service delivery; (ii) human resource capacity and (iii) financing.

(i) Sustainable models of ART service delivery:

1. The establishment of vertical OI clinics has been useful in early introduction of ART services particularly at central hospital level. However its sustainability for scale-up at lower levels is questionable.

2. Decentralisation of ART initiation and follow-up has been introduced using outreach and static approach to varying degrees. Although seemingly resource-intensive, the outreach decentralisation is a good model of rapidly building clinic capacity through mentorship. The approach is however human and transport intensive, resources that are in short supply in most non-partner supported sites. This may render such mode of ART delivery unsustainable in the long term.

3. Decentralisation of ART follow-up to clinic level has resulted in decongestion of initiation sites hence enrolment of more patients into the programme. This approach has been demonstrated to be an efficient and potentially sustainable model for rapid scale-up of ART access.

(ii) Sustainable human resource capacity:

1. The main bottleneck to ART scale-up is undoubtedly the shortages faced within health workforce. Sustainable ART delivery requires adequate human resources both in numbers and skills. The high turnover of skilled health workers is therefore a major risk factor to the sustainability of the OI/ART programme.

2. In addition, delay in task shifting ART initiation to registered nurses is unsustainable especially in an environment with severe shortage of doctors. Task shifting to PCs and registered nurses has resulted in improved HIV counseling and testing services respectively.

(iii) Sustainable financing:

1. Donors, including but not limited to, TGF, ESP and USG are covering the immediate and medium term (1-3 years) financial requirements of the programme. Over 90% of current ARVs donors provide supply and yet the unmet need for ART still remains higher than 60%.

2. The dwindling government financial allocation to health in general and ARV procurement in particular, threatens the sustainability of the programme. Local production of ARVs has been demonstrated to improve sustainability of national programmes in resource constrained settings. The failure of local production of ARVs in Zimbabwe negatively impacts on sustainability of the OI/ART programme.

4. LESSONS LEARNT

One of the objectives of the OI/ART programme was to scale-up access through doing by learning. This was to be achieved through relevant operational research and experiential learning from ongoing programme implementation. The following key lessons were learnt from the programme during the review period

1. With adequate collaboration between government, international partners, civil society, private sector and communities; and effective coordination of all efforts, it is possible for Zimbabwe to scale-up and possibly attain universal access to ART in the near future.

2. Decentralisation of both initiation and follow-up services is an effective and efficient way to rapidly scale-up access to ART.

3. Two approaches can be used for decentralising ART services (i) the outreach approach and (ii) static clinic decentralisation. However there is no single model that fits the needs of all health facilities and communities. The selection of an appropriate model of decentralising ART services should be informed by human resource, infrastructure and equipment capacity of the referring site as well as that of the receiving site.

4. Although seemingly resource-intensive, the outreach decentralisation is a good model to rapidly build the capacity of clinic staff through mentorship.

5. Efficient delivery of ART services does not only require ARVs but adequate supply of human resources and diagnostics.

6. With adequate training and mentoring nurses and clinical officers can initiate ART without necessarily compromising treatment outcomes.

7. There is high potential and willingness by private service providers (doctors and hospitals) to participate in OI/ART service delivery.

8. Communities are willing and ready to play an active role in OI/ART service delivery adequate support and coordination.

5. KEY RECOMMENDATIONS

The following are the key recommendations, which the team considers well within the capability of Government and its partners, and that if implemented, would facilitate further scale up of ART towards universal access. The main issues requiring attention are: (a) strengthening human resource capacity, (b) enhancing OI/ART service delivery and stakeholder involvement, (c) resource mobilization and (4) programme monitoring and evaluation.

Strengthening human resource capacity

1. Addressing the HRH crisis is a critical requirement towards redressing key bottlenecks to ART scale-up. The MOHCW should therefore urgently finalise the development of a national human resources for health policy and strategy within the context of health systems strengthening. The HRH policy should articulate the MOHCW position on how donor support should be channeled to support staff retention in a standardized and consistent manner that eliminates distortions in the system and inequitable distribution of health workers. Donors should commit to supporting the development and implementation of a harmonised health staff retention scheme. Donor commitment to the harmonised health staff retention scheme should include revision of current salary top-up levels to realistic and sustainable pay scales that the GOZ can subsequently take over when the economy stabilises. Innovative mechanisms should be explored to ensure effective and efficient administration of the health staff retention scheme in line with national policy, existing institutional framework and donor architecture in Zimbabwe.

2. The PC has been demonstrated to be critical in the delivery of consistent and high quality HIV counselling services and yet the position has not been incorporated in to the MOHCW structure. The MOHCW is encouraged to conduct a comprehensive evaluation of key functions in the delivery of comprehensive HIV and AIDS services including ART at sub-national level. The evaluation should specifically examine the appropriateness of the current MOHCW decision for PCs being recruited as nurse aides.

3. The MOHCW is strongly urged to introduce task shifting of ART initiation by registered nurses and rapid HIV testing and counseling by PCs.

4. The MOHCW should rapidly implement the revised in-service training curriculum in comprehensive adults and paediatric OI/ART. This will ensure improved paediatric ART coverage. In addition the training should be made more practical by introducing a structured clinical attachment and mentorship programme as an integral part of the OI/ART training curriculum.

OI/ART service delivery and stakeholder involvement

1. The MOHCW and its partners should rapidly scale-up ART access through the following strategies (i) Provide ongoing adequate resources to existing ART sites; (ii) Develop guidelines and support sites to decentralise ART initiation and follow-up to lower level health facilities; (iii) Support expansion of private sector involvement in the ART programme in line with a national strategy.

2. The MOHCW should develop and disseminate a clear policy on user fees for comprehensive HIV and AIDS services, not only addressing ARVs, but OI drugs and diagnostics.

3. The private sector presents vast untapped potential to support the national ART programme. The MOHCW should urgently develop a policy and strategy to guide public-private partnership and full participation of the private sector in the delivery of ART in Zimbabwe.

4. There is urgent need to strengthen the capacity of communities and networks of PLWHIV to effectively advocate for access to ART as well as to improve their involvement in the programme. The support should include allocation of financial resources and organisational development.

5. The lack of adequate and appropriate nutritional support to PLWHIV receiving ART has been demonstrated to be a key barrier to quality ART services. The MOHCW should finalise development and dissemination of HIV and AIDS nutritional guidelines. The MOHCW mobilise domestic and partner support to provide nutritional support to PLWHIV particularly those receiving ART.

6. The proposed evaluation should also include a review of the organisational structure of the laboratory service delivery and establishment of a system for supportive supervision of laboratory services at all levels.

Resource mobilisation

1. Mobilisation and allocation of domestic resources should reflect the GOZ commitment to ensuring expanded and sustainable access to ART. The MOHCW should therefore lobby the Ministry of Finance and the RBZ to honour GOZ commitment to prioritise allocation of foreign currency support to the ART programme.

2. The MOHCW should ensure rational utilisation of scarce resources for optimal and cost effective ART programming. This can be achieved through harmonized programme planning that ensures involvement of all key partners at each level to eliminate duplication and waste. In line with effective programme management and coordination the MOHCW should provide adequate resources for provincial and district level coordination, including identification and support to relevant focal persons. Streamlined coordination of ART at all levels should result in

leveraging available HIV and AIDS resources to strengthen health systems for improved delivery of essential but currently underfunded health services.

3. The current district linkage of donor-supported procurement has created inequitable availability of ARVs. The MOHCW should urgently delink donor funding for ARV procurement and distribution from a district to a national approach.

4. The MOHCW should resuscitate support to local pharmaceutical manufacturers to increase their capacity for domestic production of ARVs. The support should include advocacy to the RBZ to prioritise and honour commitments for foreign currency allocation for local ARV production.

Monitoring and Evaluation

1. The MOHCW should urgently simplify OI/ART data collection tools in order to reduce workload, especially at lower levels. More data clerks should be employed to assist with data management. Staff at all levels should be trained in the simplified data collection tools, data management and data analysis for local decision-making.

2. The MOHCW should initiate the process of harmonizing the HMIS and the HIV and AIDS M&E systems by revising the core health indicators (T5 form) to include HIV and AIDS in general and ART in particular. This should include strengthening capacity of HMIS to adequately provide for the needs of the old ongoing programmes as well as the new programmes such as OI/ART.

ANNEX 1: Terms of reference

1 INTRODUCTION

The Ministry of Health & Child Welfare (MoHCW) Zimbabwe, in collaboration with its national and international partners, will undertake a review of the Roll out of the ART programme in Zimbabwe. The Zimbabwe National AIDS Strategic Plan (ZNASP) as well as the Strategic Plan will guide this for the Nationwide Provision of Anti-retroviral Therapy, which covers a three-year period, 2005-2007. This review will be conducted in the first quarter of 2008. The findings of this review will feed into the development of the Strategic plan for the roll out of the ART programme for the period 2008-2010 as the country moves towards the goal of Universal Access for HIV/AIDS Prevention, Treatment, Care and Support by 2010.

The MoHCW with technical assistance from WHO will engage the services of external consultants who will be assisted by locally recruited experts. The team will have technical expertise in HIV/AIDS Treatment and Care programme management and evaluation including an in depth knowledge of related HIV programmes etc. The team will directly report to the AIDS & TB Programme of the MOHCW, Zimbabwe. This document specifies the terms of reference of the review team and stipulates the objectives of the review and elaborates on the main tasks to be undertaken during the review, the expected output and timeframe.

2. BACKGROUND

The MOHCW introduced the OI/ART programme in April 2004. A strategic plan for the scaling up of the ART programme was finalized in December 2004 covering the period 2005-2007. The OI/ART programme has been providing services for the past four years and significant progress has been made. The first year of the programme saw the initiation of ART at a few learning sites. This was then followed up by rapid scale up of services to cover most of the country. The number of health facilities offering Opportunistic Infection prophylaxis has increased considerably with over 130,000 patients benefiting from this service on a regular basis. The number of patients on ART has increased from about 5 000 in 2004 to close to 100,000 by November 2007.

This significant progress has been as a result of the high-level commitment and leadership by the MOHCW as well as technical and financial support from local, multi-lateral and bi-lateral development partners, national civil society, the private sector as well as People living with HIV (PLWHIV). The country is now gearing itself to consolidate the gains of the OI/ART introduction and the rapid roll out in order to further scale up ART service delivery towards Universal Access by 2010. It is against this background that the MOHCW has planned a review the OI/ART programme in Zimbabwe. The findings of this review will inform the development of the next National ART strategic plan (2008-2010) and will also assist the programme to establish innovative approaches in the provision nationwide quality, effective and efficient OI/ART services.

3. OBJECTIVE OF THE REVIEW

The purpose of this review will be to evaluate the implementation of the OI/ART service delivery since inception of the National OI/ART programme in 2004. Findings of this review will assist the country improve delivery of OI/ART services within the context of Universal Access to HIV prevention, treatment, care and support.

Broadly this review will focus on the **effectiveness, efficiency, equity (Universal Access), relevance and sustainability** of the HIV and AIDS Treatment and Care Programme and related interventions.

3.1. Specific Objectives of the review (also take into cognisance the 9 strategic objectives of the scale up plan)

3.1.1 To determine the current status of HIV/AIDS Treatment and Care service delivery in Zimbabwe

3.1.2 To assess the progress made in the implementation of the Nationwide Plan for ART roll out in Zimbabwe

3.1.3 To establish the impact of the OI/ART programme on other health programmes

3.1.4 To identify and document challenges, opportunities and lessons learnt during the rapid expansion of the HIV/AIDS Treatment and Care programme in Zimbabwe

3.1.5 To make recommendations on how the programme can be scaled up as the country moves towards Universal Access by 2010

In addressing the above specific objectives, the review will include the following programme components or domains:

- Programme management and coordination
- Clinical services
- Linkage of the HIV/AIDS treatment & care programme with other HIV interventions (PMTCT, HTC, CHBC, TB, STI, etc) and services
- Laboratory services
- Supply chain management
- Involvement of the community and PLWHIV
- Funding issues
- etc

4. METHODOLOGY OF THE REVIEW

The review team will use the following methodology:

4.1 Desk review

An overall assessment of the National HIV/AIDS Treatment and Care Programme through a desk review of the relevant policies, guidelines, plans, progress reports or study reports etc.

4.2 Interviews with key informants (including FGDs)

The team will conduct a range of interviews with key informants at all levels of the

health delivery system, programme managers in MOHCW, NAC programme managers, PLWHIV including patients on ART, Health Training Institutions, partners and key stakeholders (for policy, technical & managerial issues, Natphram (for procurement & logistics), Provincial & district focal persons etc

4.3 Field visits

The team should visit a representative sample of health facilities at the different levels of the health delivery system including some private facilities

5. DELIVERABLES

The review team will produce the following:

5.1 A report with preliminary findings at the end of the review period

5.2 Power point presentation to be presented first to the MOHCW officials and later at the stakeholders' feedback meeting before the end of the mission

5.3 The review team will deliver 2 hard copies and two CD/ROM copies of the report on the review of the HIV/AIDS Treatment and Care programme before departure of the team from Harare.

5.4 The final report with an executive summary indicating identified and prioritized practical recommendations is to be submitted to the AIDS & TB Unit, MOHCW within two weeks from the end of the assignment. This should also be provided as both electronic and hard copies

Annex 2: List of people interviewed

Name	Designation	Organization
Dr O.L. Mbengeranwa	Chairman	HSB
Mr F.H. Munyira	Board member	
Mrs J.C. Kadandara	Board member	
Mr Mavambe	Acting Executive Director	
Dr T. Magure	Chief Executive Officer	NAC
Raymond Yekeye	Operations Director	
Mr E. Nyamutswa	Audit Director	
Mr A. Manenji	Finance Director	
Mrs S. Ntombie	HR & Admin Director	
Mr A Mpofu	M&E Director	
Medelina Dube	Infor & Communication Director	
Dr C. Madembo	Medical Officer	Harare City Health
Dr P. Chonzi	Deputy DHS	
Dr S. Mashaire	DMO	
Dr S. Mungofa	DHS	
D Chibanda	Ass. DHS (E)	
R. Chigerwe	Ass. Director (A&F)	
P. Munyaradzi	ADHS (N)	
N. Manyangadze	Med Lab	
Clare Zungudzo	Nutrition Specialist	
Dr H. T. Bara	DMO	
G.T. Mutahwa	GP	Harare
H.B. Mubako	GP	
G. Mupikata	GP	
M. Murwira	GP	
I. Mutengwa	GP	
T.R.L. Muzamhindo	GP	
S.S. Nasir	GP	
C. Ncube	GP	
B. Masimbe	GP	
O.L. Mbengeranwa	GP	
R. Mhlaba	GP	
R. Mhangwa	GP	
P.L.T. Mhiribidi	GP	
W. Msika	GP	
F.A. Macquire	GP	
S. Maforo	GP	
N. Makoni	GP	
M.C. Makuchete	GP	
C. Manchadi	GP	
C.H.S. Manyarara	GP	
P. Marett	GP	
S. Mashaire	GP	
B.C. Groves	GP	
R. Gupta	GP	
G. Gwinji	GP	
R. Harawa	GP	
M.Y. Haq	GP	
H.E. Heath	GP	
D.H. Hikwa	GP	
K.R. Jenkins	GP	
T.T. Kambarami	GP	
B. Katenga	GP	
T. Kasu	GP	
A. Lamprecht	GP	

I. Landman	GP	Harare
A. Louizidis	GP	
E.A. Adam	GP	
Takawira M. Andreeva	GP	
T. Beta	GP	
B. Bhagat	GP	
P. Chidembo	GP	
M.N. Chimedza	GP	
F. Chinenere	GP	
A.B. Ndawana	GP	
M. Nyamwanza	GP	
K.F. Oconnor	GP	
R.I. Parekh	GP	
J.H. Posen	GP	
D. Pringle	GP	
H. Robelo	GP	
S.J. Rothwell	GP	
P.K. Runyowa	GP	
D.M. Sadza	GP	
Khan Sarfraz	GP	
M.Z.A. Sarfraz	GP	
P.J.W. Sang	GP	
W. Sharief	GP	
M. Sharief	GP	
N.F. Sharief	GP	
D.W. Shennan	GP	
J.L. Stack	GP	
B. Svoren	GP	
N.A.S. Syed	GP	
M. Taruvinga	GP	
S.H. Williams	GP	
R.G. Bonde	GP	
I.S. Dombo	GP	
Dr Pesen	GP	
Dr Adoobakar	GP	
Dr Wingwiri	GP	
Mr L. Gwino	GP	
Dr I. Makukutu	GP	
Ms C. Karimanzira	Personal Assistant	NAC - Central
Ms S. Govah	M7&E Officer	NAC - Central
Mrs E. Zowa	Program Officer	NAC – Harare Province
Mr E. Mushambi	BC Coordinator	NAC- Harare Province
Mr B. Chimhanda	School Head, DAAC Chairperson	Zengeza
Rev. L. Dube	DAAC Chairperson	Eastern
Mr S.T. Mudzamiri	DAAC member Education	Epworth
Mr C. Matope	DAAC Chairperson	South-western
Mr P. Chikandamara	DAAC Chairperson	Northern
L.B. Chavhonga	DAAC Chairperson	Western District
Mr J.J. Geza	DAAC Chairperson	W.S.W.
Mrs C. Kawocha	Student	ZAD
Mrs S. Awditary	CHED	PAC Harare province
Mrs N. Tugwete	DAAC Chairperson	ZNNP+
Mr S. Chinhaire	Provincial Chairperson	ZNNP+
Ms S.L. Zikhali	Administrative Officer	Ministry of Local Govt
Mr L. Koro	Administrative Officer	Ministry of Local Govt
Mr H. Chirowodza	Ass. District Health	PAC Chitungwiza Municipality
Mrs T.L. Mudenha	Education Officer Guidance & Counseling	Ministry of Education
B.K. Chikwaiwa	Medico Social Worker	

Rosyline Ribatika	Nurse Counselor	Wilkins Hospital
J. Gorejena	SRN/Nurse Counselor	
C. Tichivangani	HIV Clinician	
Dr H.T. Bara	DMO	
E.K. Mabaudi	Hospital Matron	
Dr S. Mashaire	HI Programme Coordinator	
E. Pakamisa	Primary Counselor	
F. Mudzimu	Stores Pharmacist	Natpharm
L. Mavingire	Data Analyst	
T. Chitsike	Logistics Officer	
B. Mudzudzu	Logistics Officer	
Richard Sauramba	Upstream Logistics Coordinator	
M. Nyandoro	RH Unit	Ministry of Health
Dr Edwin Mpeta	Assistant ART Coordinator	
S. Xaba	National Condom Programme coordinator	
Beatrice Dupwa	Testing and Counselling	
Anna Vinya	STI/HIV Prevention Officer	
Charles Sandy	TB Programme Manager	
Dr O. Mugurungi	Chief Coordinator	
Dr C. C Chakanyuka	National ART Coordinator	
Stanley Mashumba	M&E Officer	
Tichaona Nyamundaya	Assistant National ART Coordinator	
Luke Chimhanda	M&E	
Christohper Ncube	M&E officer	
Sheillah Matinhure	Training Officer OI/ART	
Elizabeth Mbizvo	PMTCT Coordinator	
R.C. Madzima	Head Nutrition	
D.S. Sithole	Deputy Director Mental Health Services	
J.Z. Chiware	Deputy Director Nursing	
D.G. Dhlakama	Principal Director Policy Planning M&E	
J. Mudyara	Director Human Resources	
Dr S.M. Midzi	Deputy Director Disease Prevention & Control	
D. Mangwanya	Director Laboratory Services	
Dimitri Peffer	Residents Logistics Advisor	JSI
David Alt	Country Director	SCMS Deliver
Joe Simango		Varichem Pharmaceuticals
K.E. Noko		Unilever
D. Mutambara	Executive Director	ZBCA
P. Musonza	Clinic Sister	OK
V. Pswarayi	HIV/AIDS Coordinator	OK
S. Gavi	Doctor	Zimplats
Dr Murwira	Deputy Director	ZNFPC
Tomas Jensen		MSF Holland
Tendayi Simoyi		CHAI
Choice Makufa		Pact
Roy Dhlamini		PSI
Sazzy Makumbe		Pact
Ima Chima		EGPAF
Nyika Mahachi		ZAPSO
Lynde Francis		The Centre
Tsitsi Apollo		MOHCW
Patricia Darikwa		ESP
Shelly Chitsungo	Health Specialist	UNICEF
Beula Senzanje	HIV/AIDS Specialist	UNICEF
Frances F Onyango	MO/HIV/AIDS	WHO
Dr G. Vera	Clinical Director	Harare Central Hospital
Masike Manas	SNO II	H.C.H. Psychiatric hospital
C. Charumbira	SNO II	

C. Zambe	SNO III	Harare Central Hospital
JTS Sithole	PMTCT Site Manager	
E. Mupunga	Adult OI Counselor	
E.Z. Makahamadze	Adult OI Nurse Counselor	
M. Chigonga	Data Capturing OI clinic	
L. Ganda	SIC OI Clinic	
R. Machingambi	SNO II Adult General Hosp	
M. Guzha	SNO II Adult General Hosp	
Zukwa	Secretary (Clinical Director's Office)	
C. Mukahanana	SNO II Children's Hosp	
MJV Mukotsanjera	Public Relation Officer	
Dr R.G. Choto	Paediatrics Consultant	
N. Muhwati	SNO III in charge OI	
Dr T.C. Mutandwa	SHO Adult OI clinic	
Matron Tengende	Children's hospital	
Dr Chimhini	Children's Hospital	
Dr Ntando	Paeds Consultant	
Prof Nathoo	Paeds Consultant	
E. Garanganga		HOSPAZ
C. Chifamba		Triconsult
G. Guveya		ZACH
K. Basikiti		Mashambanzou
J.F. Matenga	SCN-2	
L. Jalisi		SPW – Zim
Dr Hemant Pangtey		MSF-Luxenburg
Cielo R		MSF-Luxenburg
Manuel Lopez Iglasias		MSF Spain
Evince Mugumbate		WASN
Angeline Chiwetani		Thamaso-Zim
Judith Gwaringa		Thamaso-Zim
Judith Chitando		ZAN
C. Payarira		Chiedza Home
Eunice Kapandura		Childhood HIV and AIDS Zim
Evellyn Chamisa		ZNNP+
E.N. Mazhetese		Tractive Power Holdings
Ngoni Chibukire		SAFAIDS
Patricia Mbetu		EGPAF
Mary Mtisi		Island Hospice Service
W. Chandisareva		ZAPP-FAI
Allan Chiweshe	General Manager Admin Radio Services	ZBH
Walter Mufanochiya	Manager TV Scheduling @ Prog Procurement	ZBH
R Mhannyara	PMO	St Luke's Hospital
B. Moyo	MLSC	
L.F. Ncube	Tutor (Sch of Midwifery)	
L. Duru	Pharm Tech	
D.J. Mathe	DNO	
R Mthinsi	Matron	
S. Ndlovu	SIC	
F. Ncube	Tutor (sch of Nursing)	
M. D. Dube	RGN OI/ART Clinic	
E. Muchesa	TB Nurse	
T. Chauta	Counsellor	
V. Zondo	A/DEHO	
S. Moyo	District AIDS Coordinator	
S. Bhebhe	HIC	
Dr Marape Gladys	Public Health Officer	
N.T. Gombe	PEHO	

S. Ncube	DNO	PMD Mat North
T. Mangena	Accountant	
C. Nhleya	Provincial Therapist	
F. Tou	HRO/APHSA	
D. Matyatya	Nutritionist	
Sibongile Shumba	Programme Officer	National AIDS Council Bubi
Sithabile Shumba	District AIDS Coordinator	Bubi
Brian Nkala	OI focal person	Inyathi hospital
S. Magabo	TB Coordinator	
B. Moyo	PMTCT Focal person	
N. Phiri	A/DHSA	
D.N.T. Ndari	Health Information Officer	Bubi
B. Sibanda	DEHO	Bubi
Fanyana L. Mguni	Matron III	Inyathi District Hospital
S. Nzima	DNO	Bubi
B.J. Moyo	Primary Counsellor	Bubi
D. Moyo	Tutor	Inyathi hospital
H. Ndlovu	DAAC Member	Department of Social Welfare
B. Gobodi	DAAC Member	Ministry of Youth Dev
M. Ncube	DAAC Member	Bongani Orphan Coordinator
V. Nongo	DAAC Member	Bubi Rural District Council
S. M. Nhongo	DAAC Member	Bekezela HBC
M. Mpofu	District AIDS Coordinator	Victoria Falls Hospital
G. Mazonde	Pharm Tech	
Dr S. Katsande-Chibanda	GMO	
K. Moyo	Accountant	
M. Nkomo	A/Adm	
J. Mafira	ZNNP+ Chairperson	
Mr M. Mapani	DEHO	
N. Masenga	A/Matron	
Dr K. Ngarivumwe	ADMO	
Sr L. Moyo	RGN 01	
T. Musaidzi	Counsellor	
Mr S. A. Mhlanga	RGN 01	
H. Mose	Human resources Ass	
S. Gumbo	SIC OIC	United Bulawayo Hospital
Dr B.S. Dube	Department Medicine	
Mr F. Mhlanga	Health Information	
D. Sibanda	Pharmacist OIC	
Mrs P. Nago	M.L.Scientist	
Dr N. Dzvanga	Clinical Director	
Dr T. Gunguwo		
B. Gowera	FP/ANC	
Omega R. Mutambisi	Primary Counselor	Harare Central hospital
Susan Madavanhu	Primary Counselor	
Phoebe Muchechetere	Primary Counselor	
Nathaniel Potoriro	Primary Counselor	
Annah Chiponda	Primary Counselor	
Lovemore Chiposi	Primary Counselor	
Edward Mupunga	Primary Counselor	
Jeneth Ngwenya	RGN ISCM	Khami Road Clinic
Harald Moyo	MLSc	Khami Road Clinic
Gladys Mazibisa	RGN	Khami Road Clinic
S. Khosa	Sister in Charge	Khami Road Clinic
S. Sibanda	CHS	Pelandaba Clinic
Dr Paco Trinchan	MSF Doctor	MSF
Samuel	MSF Coordinator	MSF
Sharifah Qureshi	MSF Nurse	MSF

Anja Lund	MSF Medico	MSF
Dusica Peric	MSF Coordinator	MSF
Dr Diana Pov	New Project Coordinator	MSF
Dr M. Chendume	GMO	St Patrick's Hospital
Sr C.J. Tembo	SIC (OPD)	
M. Mabaleka	District AIDS Coordinator	
T.I. Zoma	Pharmacy Manager	
Sr Johanna Brandstetter	A. Hospital S. Administrator	
Sr N. Nyoni	RGN OI Clinic	
Mr J. Munsaka	RGN OI Clinic	
Mr T. Ndlovu	PCC	
N. Ndlovu	BC Programme Officer	MAC
A. Sibanda	IDCC	Hwange Colliery Hospital
Dr Nylander	MO/OI Manager	
E. Matsinde	RGN SCMN	
M. Mono	Health Officer	
I.D. Munzabwa	RGN/SCM	
M. Ngoma	Primary Care Counselor	
F. Gambya	OPD Sister	
D.H. Mutemararo	Hospital Administrator	
A.T. Munhengami	Lab Scientist	
R.H. Nekatambe	Principal Matron	
R.R. Ndlovu	Hospital Accountant	
A. Mutasa	Dental Therapist	
A. Atwabi	Pharmacy Disp Assistant	
Charles Govo	Director Finance	Mpilo Central Hospital
Wedu Ndebele	Paediatrician	
Mtandazo Ncube	MSF Counselor	
Bahle Njini Dube	SIC	
Hilary Chigu	Medical Doctor	
Victor Illanes	Medical Doctor	
Constance Makoni	Principal Matron	
Dr S. Ngwenya	Cons. Obs & Gyne	
Silungile Moyo	OI/ART Trainer	
Ellen Chikerema	PPTCT Coordinator	
MacLoud Neshiva	Pharmacy Technician	
Ukelia Maseko	Health Promotion Officer	
Adini Saidi	MSF Data Officer	
A. Waldman	CMLS	
P. Nleya	PMLSC	
Dr R. Gwini	Consultant Physician	
Dr M.Z. Ndlovu	Consultant Gynaecologist	
Dr L. Mlilo	CEO	
C. Sibanda	Deputy Chief Nursing Officer	Bulawayo City Health
S. Sibanda	Community Health Sister	
P. Nyathi	Deputy Chief Nursing Officer	
S. Hove	IHC Coordinator	
Dr Z. Hwalima	Director of Health Services	
Mr Q.A.K. Bhebhe	Chairperson	Magwegwe DAAC
Mr F. Joe Dube	Pumula Councilor	
B. Nkomo	Programme Officer	
B.B. Ncube	WAAC sec/Edu sector	
C. Nkomo	PAAC Member	
D. K. Ndoro	CBO Chairperson	
S. Sibanda	CHS	Pelandaba Clinic
S. Gasela	SCN	
B. Moyo	RGN	
O. Hadebe	RGN/SCM	

Dr F.T. Mufunde	Medical Practitioner	Chinhoyi
Dr L. Chitando	Medical Practitioner	Chinhoyi
Dr J. Kutshwa	Medical Practitioner	Chinhoyi
Dr S. Mataruse	Medical Practitioner	Chinhoyi
Lawrence Kupara		PAAC
Jonathan Muchuchu	Vice Chairperson	PAAC Mutare
P.F. Mabambe	Chairperson	PAAC Mutare
K. Masunungure	Committee Member	PAAC Mutare
N. Mirato	Sister in Charge (OPD)	Mutambara Mission Hospital
E. Mapanda	A/Admin	
C.Mundoringisa	Matron	
S. Mtokoma	Sister in Charge (maternity)	
R. Mutambara	HIV/AIDS Coordinator	
J.T. Binzi	A/Sister in Charge (OI)	
F.L. Manhanga	Pharmacy Technician	
K. Zvinoira	Laboratory	
P. Nyamudzura	Chaplain	
E. Mefor	Medical Superintendent	
G. Mhlanga	Nurse Counselor	
R. Mupazi	Nurse Counselor	
S. Marange	Nurse Counselor	
Dr Emilio Mashant	OI Coordinator MSF	
Kim Gielens	Head of Mission MSF	
J. Masocha	OHIO	
Makwindi C.C.	OI/ART Decentralisation	
A. Gwasira	SICC	
E. Chinowawa	HAAR Mutambara Mission Hospital T Counsellor	
Dr Nduw	DMO	
L. Mutendereki	Pharm Tech	
F. Mhlanga	Pharm Tech	
E. Sithole	Site Manager – New Start	
L. Muchuwa	Admission Department	
D. Ngodzore	Site Manager – New Life	
Nelia Mvere	Nurse counselor – New start	
Mabika Cecilia	Nurse Counselor – New life	
Primrose Huruva	Nurse Counselor – New life	
Getrude Chigwedere	Nurse Counselor – New start	
Hazvineyi Gorah	Primary Counselor	
Simbarashe Magwaro	Primary Counselor	
Partison Mavangira	Primary Counselor	
H. Chara	Pharmacy Technician	Mutare City Health
M. Saungweme	Senior Nursing Officer	Mutare City Health
M. Mawadza	Clinical Officer	Mutare City Health
S. Mashababe	Acting Director Health Services	Mutare City Health
N. Mashanga	PMLSC	Chinhoyi Hospital
M.C.K. Dube	Matron	
A. Makamure	RGN	
C. Sithole	Pharm Tech	
R. Maponga	Accountant	
T. Zvidza	A/HSA	
Mr Mvurume	A/Med Superintendent	
Dr C. Masocha	DMO Makonde	
Zvenyika P	Executive Assistant	
T. Karonga		
Lindah Mutetwa	Member	National AIDS Council
Musabayana Godfrey	Member	National AIDS Council
Noster Musarurwa	Member	New Life
Joseph Mpanda	Member	New Life

P. Kuguta	Pharmacy Technician	Father O'Hea
R. Nyandoro	HFSS/Dietitian	
W. Mazhambe	PEHT/TB Programme Coordinator	
J.N. Murerekwa	OI Nurse (RGN)	
C. Makoni	RGN	
J. Kufa	P.C.C.	
C. Mafika	RGN PMTCT	
C. Marimo	Rehab Tech	
Dr J.J. Kanonhuhwa	Doctor	
S. Kawanza	RGN (acting SCN)	
Shiri P.	Agritex Officer	Murombedzi
Mutsvanga D	Murombedzi Local Leader	Ministry of Education
Mudzongo O.N.	Murombedzi Local Leader	Department of Social Services
Mhembere P.	Humana resources Manager	Murombedzi
Makota D.	PCIC Secretary	
Gomera	ZANU PF secretary	
Forosi T	Processing Officer	
Shonhiwa L.T.	Registered Nurse	
Katsande Z	District Development Officer	
A.R. Mutumburi	ZHBC Counsellor	
J. Tumbikani	PWA	
Rudo Nyamangara	PWA	
Virginia Marowa	PWA	
Ranganai Mkono		
Augustine Tambu		
Chiradza Floritah	DAAC Chairperson	
Chogura Antony	DAAC Coordinator	
Dr T.P. Manyeza	GMO	Mutare
Dr M. Chikanga	GDO	Mutare
Dr M.B. Mutseyekwa	GP	Mutare
Dr T. Maphosa	GMO	Mutare
Dr E. Tatira	GP	Mutare
Dr T. Nyamangondo	GP	Mutare
Dr C. Mapepa	GP	Mutare
Dr J.A. Mandeya	GP	Mutare
Dr B.N. Mutseyeka	GMO	Mutare
Dr J. Chakonda	GP	Mutare
J.W. Pfumojena	Physician	Mutare
Dr J.M. Nyadundu	A/Medical Superintendent	Mutare
Dr Mukuzunga M.	GP	Mutare
Dr E.H. Sidile	GP	Mutare
Dr S. Murahwa	GP	Mutare
Dr F.N. Mukora	GMO	Mutare
A.P. Akinjide-Obonyo	Physician	Mutare
Dr N. Sithole	GP	Mutare
Dr Z. Kamwende	OB Gyn	Mutare
Christopher Ali	Secretary Rio Zim	David Whitehead
S. Mangozho	Human Resource Manager	
P. Chinembiri	Secretary	
T. Zhou	Chairperson	
C. Raradza	V/Chairperson	
W. Gabriel	V/ Secretary	
E. Nyamukondiwa	Nurse DWT Clinic	
Mrs C. Dobbie	Patron Budapachena	
M. Huseni	Budapachena Support group	
B. Josi	Training Officer	
T. Zinyuke	Committee Member	
P. Javachava	Committee Member	

O. Malunga	Maintenance Employee	David Whitehead
F. Munhenga	Committee member	
B. Phiri	Committee member	
P. Mukandiweyi	Peer Educator & Training instructor	
L. Chikama	Instructor	
J. Justen	Shift Manager	
A. Nyamukondiwa	Peer Educator	
B.B. Roki	H&S Officer	
E. Gwende	District Rep ZNNP+	
G. Chikasha	National Treasure ZNNP+	
G. Makaza	Kadoma Paper Mills	
J. Kutadzashe	District AIDS Coordinator	
M.T.N. Mupundu	Acting Matron	Kadoma Hospital
S. Mwambe	Lab Scientist	
M. Nyakuwanika	Accountant	
S. Alidi	Acting HSA	
T.W. Munyaradzi	Medical Superintendent	
C. Devere	District Environment Health Officer	
M.T. Dube	Student in matron's office	
T. Jowah	RGN	
J. Dandadzi	GMO	
T. Chikwandare	Pharm. Techn	
A.H. Pagiwa	District Nutritionist	
I. Jenje	District Health Promotion Officer	
A. Denhere	Community Health Nurse -PMTCT	
Maria Kupeta	Primary Counselor	
Jacob Chimhashu	Primary Counselor	
Choice Gwemwe	Primary Counselor	
Simbarashe Dzavakwa	Primary Counselor	
Jack Kutadzaushe	District AIDS Coordinator	Kadoma DAAC
Crispen Dever	Ministry of Health	
E. Gwanyiwa	MNRDC	
Shylette Dzivai	Social Welfare	
A.C. Vambe	Education Officer	
Bandawe Louis	District AIDS Coordinator	
G. Chikasha	ZNNP+	

NB: Not included in the above list are more than 50 support group members

Annex 3: Central and Provincial Level Questionnaire

A. Program design

1. How has your OI/ART program evolved in this province/district/city?
2. What have you done to ensure the following support for the program?
   (a) Political commitment, (b) Leadership, (c) Resource mobilisation,
   (d) General support
3. Describe the process of approving ART sites in this province/district/city.
4. To date, how many ART site assessments have been conducted in this province/district/city?
5. Have there been any delays in approval of ART sites in this province/district/city? If yes, explain
6. How many ART initiating sites are there in your province/district/city?
7. How many sites in your province/district/city initiate through dedicated OI/ART clinics?
8. What other entry points for ART initiation are used in this province/district/city?
9. Are there any unregistered ART sites in this province/district/city? If yes how many?
10. Do you have guidelines for ART decentralisation (follow-up and initiation)?
11. How many ART follow-up clinics do you have in this province/city/district?
12. Describe the lessons learnt from each of the different models of ART delivery in this province/city/district.
13. Who provides HIV counselling services in this province/district/city?
14. How have you recruited PC's in this province (e.g. against nurse aide posts, secondments with donor funding)?
15. Who is doing rapid HIV testing in this province/district/city?
16. Describe the challenges faced in offering ART services in your province/city/district.

B. Program Linkages

1. Is the OI/ART program in this province/city run as a vertical program
2. Can you describe the linkage of OI/ART services to other programs in this province/city (e.g. TB, PMTCT, Family planning, Nutrition)
3. Do existing data collection tools monitor OI/ART linkages with other programs e.g. number of pregnant women on ART, number of TB patients on ART, number of TB patients counselled and tested for HIV, number of HIV positive patients screened for TB, number of ART patients receiving therapeutic feeding
4. What key challenges have you faced in ensuring linkages of OI/ART services with other programs

C. Funding

1. Do you have a budget for OI/ART services?
2. Who is funding your program and what are they funding (staff salaries, drugs, equipment, laboratory reagents)?
3. What funding gaps are there in your program?
4. How do you access funding for OI/ART services from the MOHCW or your funding partners (normal MOHCW planning and budgeting cycle, proposals to donors, etc)?
5. What challenges have you faced in accessing funding for the program?
6. What is the policy on user fees for adults, pregnant women and children?
7. How are you enforcing the policy on user fees for (i) adults, (ii) children, (iii) pregnant women?
8. Do you have a policy on rationing of ARVs? What has been your experience with rationing drugs supply to (i) sites and (ii) to patients

9. What are your plans for future funding to ensure sustainability of the program (health services fund, partner support, local resource mobilisation, etc)?

D. Management and Coordination

1. Do you have copies of the following strategic documents?
    a. Zimbabwe National HIV/AIDS Strategic Plan (2006-2010)
    b. Plan for the nationwide provision of ART (2005-2007)
    c. ART assessment tool
    d. PMTCT and Paediatric HIV Prevention Treatment and Care National Plan (2006-2010)
    e. ART National Treatment Guidelines (adult and paediatric)
    f. HIV/AIDS Nutrition Guidelines
    g. Management of severe acute/severe malnutrition in Zimbabwe
    h. Discharge plan
    i. Community home based care standards
    j. HIV & AIDS Prevention, Care and Treatment Newsletter
    k. 4th Edition of EDLIZ
    l. New child health card
2. How have you been working with the central level to plan OI/ART and laboratory services?
3. Have you been involved in the procurement of HIV related laboratory equipment in the province? Is the lab equipment standardised in this province?
4. Do you have a laboratory maintenance plan in this province/district/city?
5. What is your system for laboratory quality assurance? How do ensure compliance to the system by health facilities – support/supervisory visits? Are the visits integrated across disease programs?
6. Do you have documented plans for delivery of OI/ART and integrated laboratory services in your province/city/district (If yes get a copy)?
7. Where you involved in integrated HIV/AIDS district planning coordinated by NAC? Do you have a copy of the integrated district HIV/AIDS plan/s? (get copies)
8. Do you know the national annual ART targets?
9. How were you involved in national ART target setting?
10. What were your annual ART targets in this province/district/city in 2004, 2005, 2006, 2007, 2008?
11. How were these targets set?
12. Has the AIDS & TB Unit ever asked you to slow down ART initiation?
13. If Yes, how has this affected OI/ART program management?
14. What coordination mechanisms for OI/ART and laboratory services are in place at the following levels?
    a. program management (provincial HIV & AIDS partnership forum, PHE, PHT, special committees, etc)
    b. health facility (OI/ART committee, DHE)
    c. community (DAAC or others)
15. What challenges have you faced in coordinating OI/ART service delivery at the following levels?
    a. program management
    b. health facility
    c. community
16. What are you doing to ensure Meaningful involvement of PLWHIV (MIPA)?
17. What are you doing to ensure wider community involvement in the program (community sensitisation, training of community groups such as traditional leaders, community care givers etc)?
18. Do you have standardised IEC materials on HIV & AIDS Treatment and Care services (get copies)

19. What are the barriers to accessing OI/ART services by the following population groups in this province/city/district?
    (a) Adult men and women, (b) Pregnant women,
    (c) Adolescents (10-19 years), (d) Children (0-10 years)
20. What are you doing to improve access to OI/ART services by the following population groups in your province/city/district?
    (a) Adult men and women, (b) Pregnant women,
    (c) Adolescents (10-19 years), (d) Children (0-10 years)
21. How are you working with the private sector to strengthen their involvement in the OI/ART program?
22. What other challenges in program expansion do you face in your province/city/district?
23. What are your plans to expand OI/ART services?

E. Human Resources

1. How has your program been affected by lack of adequate human resources?
2. What have you done to motivate and retain health workers in this province/district/city – (task shifting, improving conditions of service, salary top –ups, opportunities for training, career path)?
3. Has this resulted in retention of staff
4. How many hospitals in this province/city/district that are benefiting from the Global Fund and EC human resource support?
5. What positive or negative effect have these programs of human resource support had in this province/district/city?
6. Do you have an HIV and AIDS workplace policy to ensure access to PEP and treatment and care services by MOHCW employees in this province/district/city?
7. What challenges have you faced in implementation of the policy?
8. What would you recommend to the MOHCW and HSB to improve health worker motivation and retention?

F. Effect on other programs

1. How is the OI/ART program perceived by other program managers?
2. Have other programs (T&C, PMTCT, TB) created demand for OI/ART services?
3. Is your program capable of meeting such demand?
4. How has the OI/ART program created demand for other services (nutrition, laboratory, family planning etc)?
5. How has the OI/ART program positively or negatively impacted on other programs in terms of the following?
    a. Staffing
    b. Funding
    c. Equipment
    d. Space
    e. Vehicles
    f. Supplies
6. What has been the effect of the OI/ART program on the following?
    a. Morbidity
    b. Mortality
    c. Quality of life of PLWHIV

G. Monitoring and evaluation

1. Do you have copies of the OI/ART program data management tools?
    a. Daily Attendance register
    b. Pre ART register
    c. ART register
    d. Pharmacy first line ART register

    e. Pharmacy second line ART register
    f. Diflucan dispensing register
    g. Monthly progress report form
    h. Cohort analysis forms
    i. MOHCW ARV and Fluconazole consumption/requisition form
2. Do ART sites routinely submit OI/ART reports to this level? (get copies of last reports and compare with those from the national level)
3. How do OI/ART sites in this province/district/city send reports to this level?
4. How do you validate the data from ART reporting sites?
5. How do you send OI/ART reports to the next level?
6. What is the average monthly reporting rate by OI/ART sites to this level? How many sites submitted reports in the last month?
7. How do you utilise routine data from OI/ART sites in this province/city/district?
8. What challenges are you facing in collecting and reporting data at all levels
9. Comment on the process and frequency of feedback to your OI/ART reports from the next level

Annex 4: Health Facility Questionnaire

LOCATION: _____

DATE:

A. Program design

1. How has your OI/ART program evolved in this district/city/health facility?
2. What have you done to ensure the following support for the OI/ART program?

(a) Political commitment
(b) Leadership
(c) Resource mobilisation
(d) General support

3. Have there been any delays in approval of ART sites in this district/city/health facility? If yes, explain
4. How many ART initiating sites are there in your district/city/health facility?
5. Are there any unregistered ART sites in this district/city/health facility? If yes how many?
6. Do you have guidelines for ART decentralisation (follow-up and initiation)?
7. To date, how many ART follow-up site assessments have been conducted in this district/city/health facility?
8. How many ART follow-up clinics do you have in this district/city/health facility?
9. Describe the lessons learnt from OI/ART delivery in this district/city/health facility.
10. Who provides HIV counselling services in this district/city/health facility?
11. How do you ensure provision of quality HIV counselling services
12. How are you providing HIV testing and counselling services to children, pregnant women and adults – VCT or PITC?
13. What other entry points for HTC do you use?
14. How have you recruited PC's in this district/city/health facility (e.g. against nurse aide posts, secondments with donor funding)?
15. What challenges have you faced in the provision of HIV counselling services?
16. Who is doing rapid HIV testing in this district/city/health facility?
17. Describe the challenges faced in offering ART services in your district/city/health facility.

B. Service delivery

1. Describe the OI/ART services you provide at this health facility
2. Where are your clients referred?
3. Do you have an ART waiting list?
4. If yes how long is the waiting list for children and adults?
5. What is the average waiting time for a patient (adults and children) between registration and initiation of ART?
6. Have you ever turned away patients needing ART booking and/or follow-up?
7. What are you doing to ensure a family focussed approach in OI/ART service delivery?
8. What are your inclusion criteria for initiating ART among children, adolescents and adults?
9. Do you have any system of prioritisation of patients for ART initiation? If yes explain.
10. What are you doing to ensure access to ART by disadvantaged groups such as OVC, disabled, prisoners, pregnant women?
11. What are your exclusion criteria for ART (e.g. alcohol abuse, geographical restriction)?
12. Have you experienced any challenges in pressure or coercion to initiate certain individuals on ART ahead of the waiting list?
13. What system do you use to identify HIV exposed children who need paediatric HIV and AIDS care?
14. Do you ever initiate children and adults on ART without a CD4 test?
15. Are there any laboratory test that stops you from initiating ART to children and adults?
16. Have you decentralised patients for ART follow-up? If yes where have you decentralised to?
17. Have you decentralised patients for ART initiation? If yes where have you decentralised to?
18. What challenges have you faced in decentralising ART follow-up?
19. How and where do you refer ART patients for further management?
20. What challenges are you facing in feeding malnourished children?

21. Have you established support groups in your OI/ART program? If yes how are these functioning?
22. Has the AIDS & TB Unit ever asked you to slow down ART initiation? If yes, how has this affected OI/ART program management?

C. Program Linkages

1. Is the OI/ART program in this district/city/health facility run as a vertical program
2. Can you describe the linkage of OI/ART services to other programs in this district/city/health facility (e.g. TB, PMTCT, Family planning, Nutrition)?
3. Do existing data collection tools monitor OI/ART linkages with other programs e.g. number of pregnant women on ART, number of TB patients on ART, number of TB patients counselled and tested for HIV, number of HIV positive patients screened for TB, number of ART patients receiving therapeutic feeding?
4. What key challenges have you faced in ensuring linkages of OI/ART services with other programs?

D. Funding

1. Do you have a separate budget for OI/ART services?
2. Do you receive additional funding for your program and what are they funding
   - staff salaries:
   - drugs:
   - equipment:
   - laboratory reagents:
3. How do you access funding for OI/ART services from the MOHCW or your funding partners (normal MOHCW planning and budgeting cycle, proposals to donors, etc)?
4. What funding gaps are there in your program?
5. What challenges have you faced in accessing funding for the program?
6. What is the policy on user fees for adults, pregnant women and children?
7. How are you enforcing the policy on user fees for (i) adults, (ii) children, (iii) pregnant women?
8. Do you have a policy on rationing of ARVs? What has been your experience with rationing drugs supply to (i) sites and (ii) to patients?
9. Do patients pay for

(i)	Consultation	Yes [ ] No [ ]	and how much	[$]
(ii)	Cotrimoxazole	Yes [ ] No [ ]	and how much	[$]
(iii)	ARVs	Yes [ ] No [ ]	and how much	[$]
(iv)	HIV test	Yes [ ] No [ ]	and how much	[$]
(v)	CD4 count	Yes [ ] No [ ]	and how much	[$]
(vi)	ALT	Yes [ ] No [ ]	and how much	[$]
(vii)	FBC	Yes [ ] No [ ]	and how much	[$]
(viii)	CXR	Yes [ ] No [ ]	and how much	[$]

10. What are your plans for future funding to ensure sustainability of the program (health services fund, partner support, local resource mobilisation, etc)?
11. What are the top two or three resource constraints to expand treatment (egg: staff numbers, staff turn-over, drugs, space, etc)?

E. Management and Coordination

1. Do you have copies of the following strategic documents?
   - Zimbabwe National HIV/AIDS Strategic Plan (2006-2010)
   - Plan for the nationwide provision of ART (2005-2007)
   - ART assessment tool
   - PMTCT and Paediatric HIV Prevention Treatment and Care National Plan (2006-2010)
   - ART National Treatment Guidelines (adult and paediatric)
   - HIV/AIDS Nutrition Guidelines
   - Management of severe acute/severe malnutrition in Zimbabwe
   - Discharge plan

- Community home based care standards
- HIV & AIDS Prevention, Care and Treatment Newsletter
- 4th Edition of EDLIZ
- New child health card
- Zimbabwe National Guidelines on HIV counseling and testing
- National VCT Guidelines
- PITC Guidelines

2. How have you been working with the central level to plan OI/ART and laboratory services?
3. Have you been involved in the procurement of HIV related laboratory equipment in the province? Is the lab equipment standardised in this district/city/health facility?
4. Do you have a laboratory maintenance plan in this district/city/health facility?
5. What is your system for laboratory quality assurance? How do ensure compliance to the system by health facilities – support/supervisory visits? Are the visits integrated across disease programs?
6. Do you have documented plans for delivery of OI/ART and integrated laboratory services in your district/city/health facility (If yes get a copy)?
7. Where you involved in integrated HIV/AIDS district planning coordinated by NAC? Do you have a copy of the integrated district HIV/AIDS plan/s? (Get copies)
8. Do you know the national annual ART targets?
9. How were you involved in national ART target setting?
10. What were your annual ART targets in this district/city/health facility in 2004, 2005, 2006, 2007, 2008?
11. How were these targets set?
12. What coordination mechanisms for OI/ART and laboratory services are in place in this district/city/health facility?
13. What challenges have you faced in coordinating OI/ART service delivery in this district/city/health facility?
14. What are you doing to ensure Meaningful involvement of PLWHIV (MIPA) in this district/city/health facility?
15. What are you doing to ensure wider community involvement in the program (community sensitisation, training of community groups such as traditional leaders, community care givers etc)?
16. What challenges have faced in ensuring community involvement?
17. Do you have standardised IEC materials on HIV & AIDS Treatment and Care services (get copies)?
18. Who developed the materials?
19. What are the barriers to accessing OI/ART services by the following population groups in this district/city/health facility?
    (a) Adult men and women
    (b) Pregnant women
    (c) Adolescents (10-19 years)
    (d) Children (0-10 years)
20. What are you doing to improve access to OI/ART services by the following population groups in your district/city/health facility?
    (a) Adult men and women
    (b) Pregnant women
    (c) Adolescents (10-19 years)
    (d) Children (0-10 years)
21. How are you working with the private sector to strengthen their involvement in the OI/ART program?
22. What other challenges in program expansion do you face in your district/city/health facility?
23. What are your plans to expand OI/ART services?

F. Human Resources

1. How has your program been affected by lack of adequate human resources?
2. What have you done to motivate and retain health workers in this district/city/health facility – (task shifting, improving conditions of service, salary top –ups, opportunities for training, career path)?
3. Has this resulted in retention of staff?

4. What positive or negative effect have programs of human resource support had in this district/city/health facility (egg: GF, EC, mission hospitals receiving external support, etc)?
5. Do you have an HIV and AIDS workplace policy or plan to ensure access to PEP and treatment and care services by MOHCW employees in this district/city/health facility?
6. What challenges have you faced in implementation of the policy/plan?
7. What would you recommend to the MOHCW and HSB to improve health worker motivation and retention?

G. Staffing status

Cadre	**Staff Establishment**	**Number in post**	**No. trained in Adult OI/ART**	**No. trained in Paediatric OI/ART**	**No. trained in HIV/AIDS Counselling**	**Number trained in Rapid Test**
Doctors						
Nurses						
Clinical Officers						
Nurse Counselor						
Primary counsellors						
Lab Scientists						
Lab Technicians						
Pharmacists						
Pharm Technicians						
Dispensary Assistants						
Nutritionists						
Health Info Officers						
Data Clerks						
Community focal persons						
TB Coordinator						
STI Coordinator						
EHT						
Others (Specify)						

H. Effect on other programs

1. How is the OI/ART program perceived by other program managers?
2. Have other programs (T&C, PMTCT, TB) created demand for OI/ART services?
3. Is your program capable of meeting such demand?
4. How has the OI/ART program created demand for other services (nutrition, laboratory, family planning etc)?
5. How has the OI/ART program positively or negatively impacted on other programs in terms of the following?
   - Staffing
   - Funding
   - Equipment
   - Space
   - Vehicles
   - Supplies
6. What has been the effect of the OI/ART program on the following?
   - Morbidity
   - Mortality
   - Quality of life of PLWHIV

I. Monitoring and evaluation

1. Do follow-up sites routinely submit OI/ART reports to this level? (Get copies of last reports and compare with those from the national level)
2. How do follow-up sites send reports to this level?
3. How do you validate the data from follow-up ART reporting sites?
4. How do you send OI/ART reports to the next level?
5. What is the average monthly reporting rate by OI/ART sites to this level? How many sites submitted reports in the last month?
6. How do you utilise routine OI/ART data?
7. What challenges are you facing in collecting and reporting data
8. Comment on the process and frequency of feedback to your OI/ART reports from the next level

J. Community: PAAC and DAAC Focus Group Discussion Guide

1. What is the role of your organisation or programme in ART/OI?
2. What activities have you implemented especially in the period 2004 to 2007?
3. What lessons were learnt?
4. What were the challenges?
5. What recommendations would you like to make to improve the ART programme?
6. How can access for ART be improved?

K. ART Patient Focus Group Discussion

1. How are you benefiting from the ART programme?
2. Overall are you satisfied with service provision in this clinic?
3. What challenges have you experienced in accessing ART or OI?
4. Do you have to know someone in order to get ART or OI?
5. Have you experienced stigma and discrimination at the ART clinic?
6. What else is not working well in accessing ART?
7. In your experience have you been asked to pay a bribe in order to get ART?
8. Is the site assisting you to access support such as for food, legal, education, psycho-social and home based care.
9. What are the problems you have in adhering to ART?
10. Have you been encouraged to have a peer treatment buddy?
11. For patients seen at central site, would you like to be referred to a follow up clinic close to your home?
12. How has ART improved your quality of life?
13. What impact has the programme had on the community?
14. Have you received/seen IEC materials?

L. Primary Counsellors Focus Group Discussion Guide

1. **Did the counseling training you attended prepare y**ou adequately for the job you are doing.
2. Do you want to comment about your training.
3. Are you getting adequate supervision and support.
4. Do you have reference materials to assist you in providing counselling service
5. Have you had any refresher courses since your training? How many?
6. What are the challenges you are having in doing your work?
7. Do you have recommendations for improving counselling services to support OI/ART?

M. OI/ART Clinic Checklist

a. Registers

1. Check if copies of the following OI/ART program data management tools are available

a. Daily Attendance register
b. Pre ART register
c. ART register
d. Pharmacy first line ART register
e. Pharmacy second line ART register
f. Diflucan dispensing register
g. Monthly progress report form
h. Cohort analysis forms
i. MOHCW ARV and Fluconazole CR Form

j. Other registers:_____
2. Are they being used? If not in use what are they using

b. Look at 20 random sample of patient files:

1. To extract treatment outcome indicators

Pt ID	Age	Sex	Date initiated	CD4 baseline	CD4 at 6 mnths	**Regular monitoring**			Missed drug pick up Y/N	ART regimen at initiation	Current ART regimen
						Hght Y/N	Wgt Y/N	Adherence Y/N			

c. Observe

1. Clinic space for adequacy: current and expansion
2. Client flow
3. Computers for management of health information

d. Management guidelines:

1. Check if copies of the following management guidelines are available
   - Management of Paediatric HIV and AIDS
   - Adults OI/ART guidelines
   - Management of severe acute/severe malnutrition in Zimbabwe
   - Discharge plan
   - New Child Health Card
   - 4th Edition of EDLIZ
   - IMAI guidelines
   - IMCI guidelines
   - WHO Staging charts
   - Paediatric ARV dosing charts
   - Weight for height charts
   - Weight for age charts
2. Check if the following clinical management tools are available
   - Height meter
   - Hanging scale
   - Bathroom scale
   - Infant scale
   - Tape measure
   - BP machines
   - Thermometers

e. IEC materials:

1. List the IEC materials that are available for
   - Infant feeding and nutrition
   - Basic HIV and AIDS Information
   - Management of OIs
   - Treatment literacy
   - PMTCT
   - Other (specify)
2. Conduct Brief Interviews with (i) Clinic nurse, (ii) Doctor, (iii) Clinical Officer
   - Do they feel equipped to deal with the work, Lessons learnt
   - What challenges do they face? What recommendations for the future program expansion

N. Other questions to check answered:

1. How do you assess patient adherence? What is your average adherence rate for children and adults?
2. Describe your system for patient follow-up. How do you follow-up defaulters? What is your average defaulter rate? What are the common reasons for defaulting among children and adults?
3. What IEC materials do you have for adult and paediatric HIV and AIDS management?
4. How many health workers have been trained in conventional management of sever malnutrition?
5. How many health workers have been trained in community-based management of sever malnutrition?

Annex 6: References

[1] Draft ART Report, 2007, AIDS & TB Unit, MOHCW

[2] NZPW+/SAfAIDS Treatment Literacy Workshop

[3] Plan for the Nation wide Provision of Antiretroviral Therapy 2005-2007: MOH&CW, Zimbabwe

[4] Health Services Board Report for 2007.

[5] **Availability** defined in terms of reach-ability (physical access), affordability (economic access) and acceptability (socio-cultural access) of services that meet a minimum standard of quality. To make services available, affordable and acceptable is an essential pre-condition for "universal access". **Coverage** defined as the proportion of the population who receive an intervention among those who need it. Coverage is influenced by supply (provision of services) and demand by people in need of services. **Outcome/Impact** defined in terms of behavioural change, reduced new infection rates or survival improvements; it is the result of coverage of services, modulated by the efficiency and effectiveness of the interventions and changes in other relevant factors.

[6] Estimated using World Bank estimated GDP figures for Zimbabwe, applied to updated figures provided in MOHCW Zimbabwe Situation Analysis Report: 2008

[7] Zimbabwe HIV & AIDS Sub-account 2005 (draft)

Annex 7: Biographies of the OI/ART Review Team

Dr. Godfrey Sikipa, is a Public Health physician. He has worked in various leadership and management positions at senior levels leading multinational, multicultural teams in both developed and developing countries. For sixteen years Dr. Sikipa worked in the health sector in Zimbabwe in various capacities, starting off as Junior Resident Medical Officer and rising through the ranks of Government Medical Officer, Medical Superintendent, Provincial Medical Director, Principal Medical Director and finally Permanent Secretary to the MOHCW. Dr. Sikipa has extensive international experience in HIV/AIDS/STDs prevention and control - advising governments, NGOs and private companies on various aspects of HIV/AIDS prevention, care and impact mitigation. He is currently working as Technical Director of the Extending Service Delivery (ESD) project based in Washington DC. Before his current posting, he was Coordinator of HIV and AIDS Programs at Management Sciences for Health (MSH). Prior to joining MSH, he worked as a Senior HIV/AIDS and Infectious Disease Specialist at RTI International based in the Research Triangle Park in North Carolina. He served as UNAIDS Sub-regional Coordinator for Eastern and Southern Africa covering twenty-two countries in the sub-region. For about six years, he was employed by Family Health International as Regional Director for Africa on the USAID-funded AIDSCAP project based in Nairobi from where he supervised ten country teams that provided Technical Assistance to USAID Mission-funded HIV/AIDS activities. Since 2004 he has been serving on the Technical Review Panel of the Global Fund to fight AIDS, Tuberculosis and Malaria

Dr Barnet Nyathi is a Public Health Physician, Venereologist and HIV and AIDS consultant. He is the former UNAIDS Country Coordinator (South Africa). He has conducted several consultancies for WHO Country Office, the Regional Office and for SADC in HIV/AIDS especially in the areas of Planning and Evaluation. Dr Nyathi was the Director of Health Services, City of Bulawayo from 1982 to 1997. He is the chairperson of the Family Health Practitioners group of consultants.

Mrs. Margaret Mehlomakhulu, holds a Masters Degree in Public Health from Liverpool School of Tropical Medicine (UK); diplomas in Adult Education from the University of Zimbabwe, General Nursing, Midwifery and Community Nursing. In addition, she holds certificates in International Health (Oslo University, Norway) and a Certificate in Advances in Family Health Communication (Johns Hopkins University, Maryland, USA).Previously she worked for the City of Harare as the Chief Nursing officer for eight years, Ministry of Health, Zimbabwe as a Deputy Director of the National AIDS Programme for six years on secondment by WHO, worked for UNICEF Zimbabwe and Botswana for six years as Chief of the AIDS programme and also being the PMTCT Programme officer, worked for CHF International, Kigali, Rwanda first as the Palliative Care Coordinator and later as the AIDS Technical Advisor for fourteen months. In these positions, she has provided leadership and technical guidance to various government ministries, private sector, NGOs and Faith Based Organisations to design, develop, implement, monitor and evaluate targeted HIV/AIDS prevention, care and support programmes. Margaret has engaged communities and carried out community capacity strengthening to enable them to develop, implement and monitor their HIV/AIDS prevention, care and support programmes.

Dr. Jabulani Nyenwa, MBChB, MPH, MBA is a public health specialist with over 10 years experience in HIV and AIDS in Zimbabwe and Southern Africa. He has held leadership and technical advisory roles in Zimbabwe has provided technical and consultancy services to the World Bank Institute, UN Agencies, DfID, USAID and ministries of health. Jabulani is currently a senior project manager at GRM International where he oversees the GRM Zimbabwe operations. He has recently been appointed an alternate member of the Technical Review Panel of the Global Fund to Fight AIDS, TB and Malaria. He is the current president of the Zimbabwe College of Public Health Physicians and is also the chairman of the Zimbabwe HIV and AIDS National M&E Advisory Group.

Dr. Mary Kaluma- Nyathi, MBChB, MMed (Paediatrics). She is a consultant paediatrician and head of the Department of Paediatrics at Mpilo Central hospital, one of the tertiary institutions in Zimbabwe. She has special interest in paediatric HIV and AIDS and has worked with HIV infected children since the onset of the Zimbabwe epidemic. The Mpilo paediatric HIV clinic which she was instrumental in founding in 2004, has the greatest number of children and adolescents on ART in the country and has a dynamic psychosocial component. She is a founder member and chairperson of the Bulawayo PMTCT programme and deputy chairperson of the National Nutritional Task force and specialises in the management of severe malnutrition. At the national level she is involved in IMCI, Malaria, Tuberculosis,and EDLIZ. She participates in international research on Paediatric HIV and AIDS.

Dr. Tapiwanashe Bwakura is a Consultant Physician and has been working in the public health sector for the past twenty-three years and during the last fifteen years he has been working in the field of HIV and AIDS. He has worked at various leadership and management positions in the Department of Medicine, University of Zimbabwe. He has immense experience in clinical management, monitoring and evaluation of programmes at local and national level. He was instrumental in the establishment of the first HIV/AIDS clinic at Harare Central Hospital, a tertiary institution within the country. The centre is now being utilized by the Medical and Nursing Schools for practical purposes to make sure that medical personnel are well equipment on HIV/AIDS management before they are deployed to the field. Dr Bwakura has been a committee member of the National Emergency Taskforce on HIV and AIDS (NETA) in Zimbabwe since 2003. NETA is an advisory body to the Ministry of Health on HIV and AIDS Treatment and Care.

Dr. James Mugwisi holds a Bachelor of Medicine and Surgery from the University of Zimbabwe. He also has a Diploma in HIV Management (S.A), is a member of the College of Primary Care Physicians of Zimbabwe (CPCPZ). He is the Chairman of the Hippo Valley Estates AIDS Committee, a trustee of Tunza Trust, and the secretary to the Lowveld faculty of CPCPZ. As a Medical Officer with Hippo Valley Estates, he has been with this private company for the past four years and is responsible for the management of HIV/AIDS on the estates He has a keen interest in HIV management and Public Health medicine.

Mrs. Irene Moyo is a Social Scientist with a Bachelor of Sociology degree from the University of Zimbabwe and a Masters in Medical Demography from the University of Liverpool, School of Hygiene and Tropical Medicine. She is a free lance consultant with over 25 years research experience in the health sector, has expertise in medico-social issues and health information development. She has been involved in HIV and AIDS evaluations since the late eighties and has published a number of articles. Having started her research career with Harare City Health Department, she was involved in national and international studies funded by government, local and international partners.

Mr. Tonderai Chiduku is the only surviving founder of the Zimbabwe National Network of PLHIV (ZNNP+), where he is currently the National Advocacy Coordinator and Acting National Director. Mr. Chiduku with an Education background has since knowing his HIV status in 1992 been involved in networking, advocacy and skills building for PLWHIV at local, regional and international levels. He has been responsible for providing strategic direction to organizations of PLWHIV, capacity building, advocacy and resource mobilization. Tonderai has often represented PLHIV on various for a and has done a lot of work in Meaningful Involvement of PLWHIV (MIPA), access to care, treatment and support, Memory Work, establishing and sustaining support groups, Treatment Literacy and Psychosocial Support. He is also founder and life member of Family AIDS Support Organisation (FASO) in Mutare, Manicaland.

Mr. Jan Dik is an architect from the Netherlands, who graduated from Delft University in 1968; he focused the first part of his career particularly on social housing. In 1976 he moved to Kenya where he became responsible for Government Housing and for training of upcoming Kenyan professionals. From 1979 he took all professional steps in developing countries, mainly in Africa. Around 1985, he felt the need to go beyond the limitations of a building component and became increasingly involved in planning of supply systems, donor co-ordination, drug financing and procurement. The early nineties, showed a favourable climate for Health Sector Reform as decentralisation appeared on the agenda. Mainly through Danida, Dik participated in reform plans in Ghana, Uganda, Zambia and Zimbabwe; he was author of Ethiopia's National Drugs Programme, followed in '96 by a comparable task in Ghana. This resulted into piloting of Revolving Drug Funds; successes were seen in Ghana, Tanzania, Tajikistan and Kenya. Since 2003, Jan Dik's work was mainly in Supply Chain Management. The growing emphasis upon HIV/AIDS issues dominates the work; soon he may try to revive the attention for other vital pharmaceuticals.

Mr. Alexis Ferrand is a development economist with 15 years experience. His main specialist areas are health and HIV programmes, macro-economic analysis, international debt, and rural development. He has worked as a consultant for various donors (IDRC-Canada, IFAD, UNAIDS, UNDP, EC, Australian and Japanese governments) and also private sector clients. From 1999 to 2007 he was employed as a DFID economist, and continues to do regular work for DFID as well as other short-term consultancies. Originally from Uruguay, he has been a resident of Zimbabwe since 2003

Eileen Burke is a Laboratory Systems Specialist currently working with CDC, Kenya. She has over 20 years experience in laboratory systems working for Irish AID, UNICEF, DANIDA, APHL and CDC at both policy and implementation levels. She has extensive international experience having worked in Australia, Bhutan, Russia, Zimbabwe, Mozambique and Kenya. Originally from Ireland she holds a degree in Biomedical Science, post graduate degrees in Medical Microbiology and Public Health. She has lived and worked in Zimbabwe for over 9 years, employed by DANIDA for 4 years and CDC for 5 years. She has a good knowledge of health delivery systems.