

CLINICAL EPIDEMIOLOGY RESOURCE & TRAINING

CENTER

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF ZIMBABWE



HIV/AIDS QUALITY OF CARE INITIATIVE (HAQOCI)



**SITUATIONAL ANALYSIS REPORT ON
HIV/AIDS-RELATED PSYCHOSOCIAL
CARE AND SUPPORT SERVICES
IN ZIMBABWE**

**Based on the National Situational Analysis Survey of HIV/AIDS Quality
of Care conducted in June-September, 2002**

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
C.E.U.	Clinical Epidemiology Unit
DMO	District Medical officer
DNO	District Nursing Officer
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
HAQOCI	HIV/AIDS quality of Care Initiative
HIV	Human immunodeficiency virus
PMDs	Provincial Medical officers
SOPS	Standard Operations Procedures
VDRL	Venereal Disease Research Laboratory
OI	Opportunistic Infections

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BACKGROUND

AIDS-related illness remains a major cause of the disease burden in Zimbabwe with worsening prospects. This disease has become the commonest cause of morbidity and mortality in Zimbabwe. Life expectancy at birth has dropped from 60 years to 38 years in the last decade. Up to 80% of all hospital admissions are due to AIDS related illness. Provision of good quality care has been compromised making this a great challenge for health providers, particularly in resource poor settings like in Zimbabwe.

A stakeholders' consultative meeting held from 13th – 15th 2002 at the Harare Holiday Inn Hotel recognized, among other observations, that psychosocial issues and *“issues pertaining to mental health needs included the great fear of the stigma associated with knowing ones HIV status. This fear interferes greatly with seeking good quality care for illnesses associated with HIV infection. There is, therefore, urgent need for on-going, good quality, widely available and accessible counselling services.*

Regarding health care providers, high levels of stress and burnout resulting from multiple bereavements as well as poor working conditions and remuneration are recognized. These are major, long standing issues that have led to the high attrition rate of health professionals in Zimbabwe. Psychosocial and emotional support for health workers is urgently needed. Further to this, training on self-care and recognition of signs of burnout, better working conditions and an infection risk allowance need to be

put in place. Free and easily accessible post exposure prophylaxis against HIV must be made available in both the private and public hospitals. Insurance cover for health care providers infected with HIV should be created by government”.

One of the major observations of the meeting was that there is a dearth of reliable baseline data on the quality of HIV/AIDS care in Zimbabwe and that most of the programs are being driven by anecdotal data and insights. It was therefore recommended that the CEU through HAQOCI conducts a countrywide HIV/AIDS situation analysis.

The overall objective of the situational analysis survey was to characterize the prevailing HIV/AIDS situation countrywide. As part of this effort tools were developed to assess the baseline situation with respect to the HIV/AIDS quality of care that obtains in the country.

The specific objectives for which tools 2a – 2e were developed were the characterization of:

- (i) Policy issues and treatment guidelines with respect to psychosocial care and support
- (ii) Training and manpower development programmes and their implication for the provision of psychosocial care and support services.
- (iii) Staff deployment and impact on psychosocial care and support delivery.

- (iv) Quality control and quality assurances measures that are in place in relation to psychosocial care and support.

METHODS

The C.E.U., through the steering committee, engaged a total of six group leaders to spearhead the development of tools to be used in surveying the areas of OI treatment, Laboratory support services, Discharge planning, *Psychosocial care and support*, Community home-based care and Maternal and Child Health.

A total of 5 tools on psychosocial care and support were developed (tool 2a-2e) to capture management-level, hospital implementation-level, clinic/health centre-level, community-level and household-level perspectives on HIV/AIDS-related psychosocial care and support in the country.

The draft tools were presented to stakeholder representatives at a meeting held at the Harare Safari lodge on the 17/5/02 for their review and comments following which the amended tools were field-tested.

The tools were pilot tested in one province and one city, namely Mashonaland East and Harare using research assistants from the respective areas. The sites for the testing included the provincial hospital, district hospital and three rural health centres in Mashonaland East. In Harare, piloting was conducted at one urban referral hospital, polyclinic and one national referral hospital. The pilot exercise was undertaken to field

test the tools vis a vis their appropriateness, their comprehensiveness, their user-friendliness, as well as logistical and technical issues in administration, data handling and analysis. Following the pilot exercise, a debriefing meeting was undertaken with research assistants involved in the field work and a feedback report was prepared and presented to the tool developers so that they could incorporate insights from the pilot exercise in the finalisation of the tools.

Respondents

The targeted respondents in this survey of the prevailing psychosocial care and support situation at the various levels were as follows.

a). Management level

National counselling Coordinator, PMDS City Health directors, PNOs, PHEOs, DMOs, DNOs, Medical superintends and Matrons

b). Hospital Implementation level

Counsellors, Doctors, Clinical officers, Nurses, Clinical psychologists and social workers.

c). Clinic/Health Centre level

Nurses and EHTs

d). Community Level

CBO staff and Village health/ Community workers

e). Household level

Clients and their caregivers

Sampling

The sampling plan adopted for the survey was based on the national profile that comprises of 10 provinces including the cities of Harare, and Bulawayo. The multi stage sampling procedure that was followed is summarized in the organ gram below. This sampling plan that was drawn up was designed to maximise representativeness by insuring that all 8 provinces and 2 cities were incorporated in the survey. The resultant sampling frame included all provincial hospitals, 3 districts within each province, 3 rural health centres within each district and the catchments area surrounding the rural health centres (See SAMPLING FRAME appendix 1)

Researcher training

Once the tools had been finalised, a three-day workshop was held at the Cresta Lodge Hotel to train research assistants who were identified by the responsible authorities from the provinces and cities from a list of randomly selected sites. In addition, a team of three data entry clerks was trained during the same period. The research assistants were taken through the objectives of HAQOCI and the aims of the situation analysis survey. They were then introduced to each of the survey tools and together with tool developers,

went through each tool item by item. Points which needed clarification were dealt with there and then until there was unanimity on what each tool item meant and what it was designed to uncover/assess given the objective of the overall tool. The next stage involved a translation of the tools through group work until there was consensus on semantic equivalency. In addition, trainees were briefed on the logistics of conducting the survey, procedures in the completion of questionnaires and interviewing techniques.

Field survey

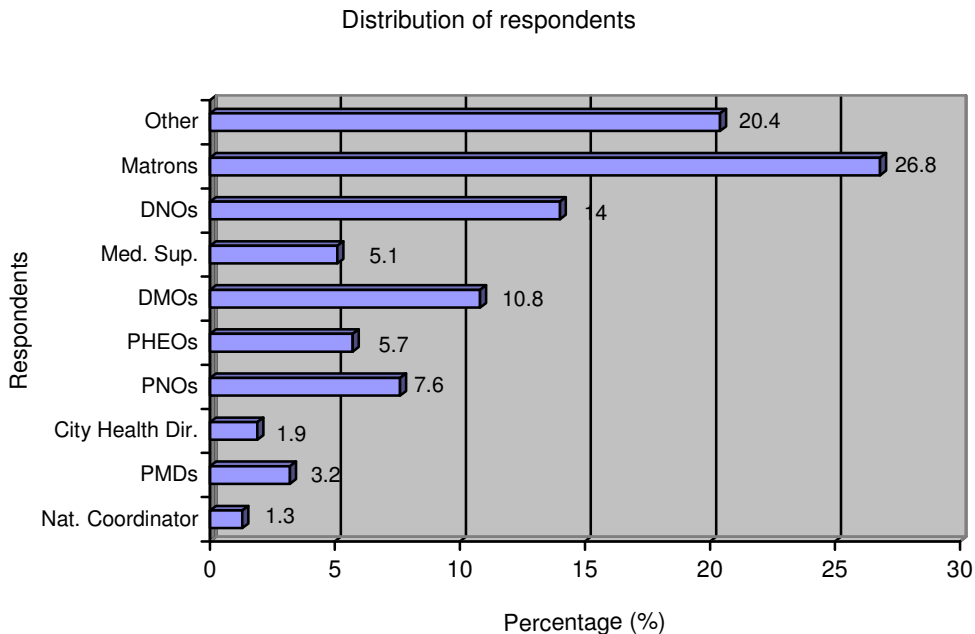
The field survey for the psychosocial component was conducted as part of the overall HAQOCI situation analysis survey during the months of August and September 2002 which took 30 working days to complete. In each province the survey was conducted by a team comprising of one co-ordinator and 3 research assistants backed by a field supervisor who reported to a 3-member situation analysis task force. The co-ordinators were tasked to facilitate entry into the field, supervise and monitor data collection and liaise with the task force. The provincial supervisors' major task was to trouble shoot, monitor the progress of data collection in their area, perform quality control checks on the completed questionnaires and forward completed questionnaire to the CEU for Data entry and analysis.

RESULTS

MANAGEMENT -LEVEL PERSPECTIVE

For tool 2a, a total of 157 management level health workers were interviewed and they were distributed as per Figure 2a.1 below. The majority of respondents were Matrons (26.8%), DNOs (14%) and DMOs (10.8%).

Figure 2a.1



The respondents to tool 2a were by and large evenly distributed across provinces and cities with Harare having slightly more than the rest (see Figure 2a.2 appendix 2)

Management-level perspective with respect to Policy and Guidelines on psychosocial care and support.

Table 2a.1 below reflects the situation with regards to the availability, distribution and implementation of national policies and guidelines. Of note from Table 2a.1 is the fact

that 146 out of 157 respondents reported that there were national policies and guidelines on HIV/AIDS. Of the 146 reporting availability of national policies and guidelines on HIV/AIDS, 136 (93.2%) of them reported that there were policies and guidelines on providing psychosocial support to people infected and affected by HIV/AIDS. Over 75% of respondents reported that the available policies and guidelines cover issues related to the conduct of and provision of HIV/AIDS counselling, voluntary counselling and testing, psychosocial support groups for PLWHA and psychosocial support groups for caregivers/counsellors. A total of 95 respondents (88%) reported that their sites were currently implementing and following the policies and guidelines.

Table 2a.1 Policy/guidelines on Psychosocial care and support		Frequency N = 157 N(%)
1a.	Number of respondents reporting that their facilities have national policies and guidelines on HIV/AIDS.	146 (93.0)
1b.	Number of respondents reporting that their facilities have policies and guidelines on providing psychosocial support to people infected and affected by HIV/AIDS.	136 (93.2)
1c.	Number of respondents reporting that the available policies and guidelines cover issues related to the conduct of and provision of the following:	
	HIV/AIDS Counseling	135 (99.3)
	Psychosocial Support Groups for PLHA	117 (86.0)
	Voluntary Counseling and Testing	127 (93.4)
	Psychosocial Support Groups for Caregivers/Counsellors	107 (78.7)
2a.	Number of respondents who reported that policies and guidelines had been distributed to all:-	
	Provinces	23 (82.1)
	Cities	8(69.2)
	Districts	49(90.7)
	Hospitals	51 (81.0)
	Clinics.	35 (97.2)
2c.	Number of respondents reporting that all provinces/cities/districts/hospitals/clinics were implementing and following these policies and guidelines.	95 (88.0)

Management-level perspective on Training

Table 2a.2 reflects the situation with regards to training in psychosocial care and support. Of the 157 respondents, 112 indicated that training courses on HIV/AIDS-related psychosocial support were being run. Of these, 67.9% indicated that the training courses were being run at district level, at hospital level (59.8%), and at provincial level (52.7%). With regards to the development of training materials, less than 50% of the respondents indicated that training manuals, curricular and other materials had been developed for training cadres in psychosocial care and support. The majority of respondents reported that the majority of people trained in HIV/AIDS counselling to date were at provincial levels followed by city health level and that most of those being trained as counsellors were nurses (cited by 138 respondents), PLWHA (78) and doctors (60). Regarding the type of training offered, over 70% of respondents indicated that training in basic counselling, pre-test counselling, post- test counselling and supportive counselling was being offered for a median duration of 1 month (range 1-52 months)

Table 2a.2 Training in psychosocial care and support		Frequency N = 157 N(%)
3a.	Number of respondents who reported that their institutions have run training courses on HIV/AIDS related psychosocial.	112 (71.3)
3b.	Number of respondents who indicated that training courses on HIV/AIDS were being run at the following levels.	<u>N=112</u>
	National	37 (33.0)
	Provincial	59 (52.7)
	District	76 (67.9)
	City	35 (31.3)
	Hospital	67 (59.8)
	Clinic	54 (48.2)

	Testing site	47 (42.0)
	Other	26 (23.2)
4.	Numbers of respondents reporting that the following material had been developed for training cadres.	
	Manuals	67 (42.7)
	Curricula	42 (26.8)
	Other materials	50 (31.8)
5	Number of respondents reporting that the following median number of counsellors had been trained in HIV/AIDS counselling to date per	
	Province	28 Range (1 - 800)
	City	24 Range (5 - 120)
	District	10 Range (0 - 175)
	Clinic	15 Range (3 - 70)
7.	Number of respondents reporting that cadres with the following backgrounds had been trained as counsellors.	
	Nurses	138 (87.9)
	Doctors	60 (38.2)
	Clinical officers	49 (31.2)
	Social workers	55 (35.0)
	PLHA	78 (50)
		91 (58.0)

Management-level perspective on availability of Psychosocial care and support services

Table 2a.3 below reflects the situation with regards the availability of psychosocial care and support services. The majority (over 2/3) of respondents reported that there were no directories of available psychosocial support services. Out of 157, only 27 respondents answered the questions on what proportion of those providing psychosocial services were aware of the organisations in their locale that were providing psychosocial care and support. Of these, only 18 (67.7%) indicated that over 50% of those providing these services had such awareness. Only 3 people responded to the question on whether there were adequate referral services for psychosocial support for their catchment area with only 1 indicating that this was so.

Table 2a.3: Availability of Psychosocial care and support services		Frequency N = 157 N (%)
11a.	Number of respondents reporting that there was a directory of available psychosocial support services.	44 (28.0)
11c.	Proportion of respondents providing psychosocial services who are aware of the organizations in their locale providing these services.	
	>75 %	13 (46.3)
	50 – 75 %	5(21.4)
	25 – 49 %	4(14.3)
	<25 %	5 (17.9)
13.	Number of respondents claiming that there were adequate referral services for psychosocial support in the country/province/district/city/hospital/clinic/your area.	N = 3 1 (33.3)

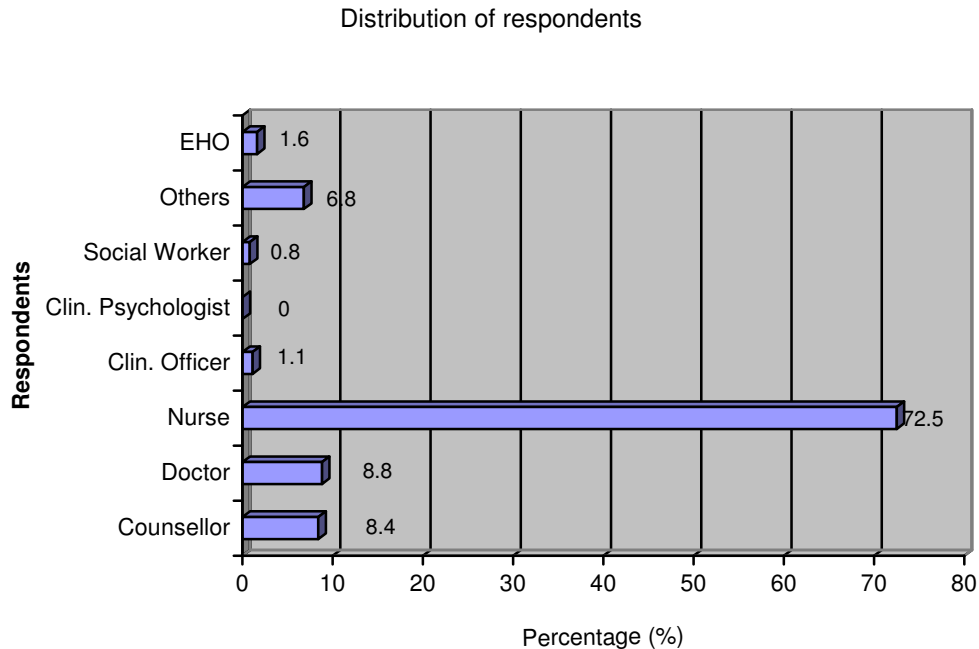
Management-level perspective on monitoring of standards and quality of Psychosocial care and support services

Only 14.6% of respondents reported that specific tools had been developed to monitor the quality of psychosocial care and support. It was not clear from the information provided by management-level respondents how the standards and/or quality of psychosocial care and support were being monitored at the various levels from the national down to the household.

HOSPITAL IMPLEMENTATION - LEVEL PERSPECTIVE

For tool 2b, a total of 730 hospital implementation level health workers were interviewed and they were distributed as per Figure 2b.1 below. The majority of respondents were nurses (72.5%), doctors (8.8%) and counsellors (8.5%).

Figure 2b-1



As can be seen from Figure 2b.2 appendix 2, the respondents to tool 2b were by and large evenly distributed across provinces and cities with Harare having slightly more than the rest.

Hospital implementation - level perspective with respect to policy/guidelines/ethics

Table 2b.1 reflects the situation with regards to the reported availability, distribution and implementation of policy guidelines. Of note from Table 2b.1, is the fact that 281 out of 730 respondents reported that they were aware of a national policy on counselling. Of the 281 reporting awareness of the national policy on counselling, 259 (91.8%) of them reported that their hospital follows the national policy guidelines on counselling. Over 65% of respondents reported that their hospital had a written policy on confidentiality

and of these, over 80% reported that the following procedures had been taken to ensure confidentiality:-

- Test result disclosed only to person tested (cited by 95.5% of respondents)
- Test result disclosed to partner with the consent of tested clients (90.3%)
- Test result disclosed to other family members with the consent of client tested (84.8%)
- System put in place to protect clients' records (93.8%).

Table 2b.1 Policy /Guidelines/Ethics in relation to Psychosocial care and support		Frequency N = 730 N(%)
13a.	Number of cadres who reported that they were aware of the national policy on counseling	281 (38.5)
13b.	Number of cadres who reported that their hospitals follow the National Policy Guidelines on counseling.	259 (91.8)
14a.	Number of cadres who reported that their hospitals have a written policy on confidentiality.	487 (66.7)
14b.	Number of respondents who reported that the following procedures had been taken to ensure confidentiality.	
	❖ Test result disclosed only to person tested	465 (95.5)
	❖ Test result disclosed to partner with the consent of tested client.	440 (90.3)
	❖ Test result disclosed to other family members with the consent of client tested.	413 (84.8)
	❖ System put in place to protect clients records.	457 (93.8)

Hospital implementation - level perspective on psychosocial services provided

Regarding the type and frequency of psychosocial services offered, Table 2b.2 highlights that the most frequently offered services were basic counseling (cited by 43.8% of respondents as always provided) followed by supportive counseling (37.8%) and bereavement counseling (33.7%) whilst the services least offered were PMTCT counseling (cited by 41.3% of respondents as never provided) followed by post test counseling (33.7%) and pretest counseling (30.4%).

Table 2b.2

Services provided	Always	Sometimes	Never
Basic counseling	320 (43.8)	372 (51.0)	38 (5.2)
Basic HIV/AIDS Counseling	201 (27.5)	420 (57.5)	109 (14.9)
Pre-test Counseling	203 (27.8)	305 (41.8)	222(30.4)
Post-test Counseling	207 (28.4)	277 (37.9)	246 (33.7)
Supportive Counseling	276 (37.8)	336 (50.1)	88 (12.1)
Bereavement Counseling	246 (33.7)	375 (51.4)	109 (14.9)
Family Counseling	165 (22.6)	422 (57.8)	143 (19.6)
PMTCT Counseling	139 (19.0)	288 (39.5)	303 (41.5)

Hospital implementation - level perspective on standards and quality of psychosocial services provided

Table 2b.3 reflects the situation with regards to supervision, support, time and space to ensure high standards of psychosocial care and support services. Less than 50% of the respondents reported having access to a designated counselling supervisor and the most cited counsellor support mechanisms available were debriefing with counsellors and debriefing with supervisor. Less than a ¼ of the respondents reported having adequate time in their job to carry out their counselling duties whilst 64.5% reported having adequate space to ensure privacy during counselling sessions. In over 85% of the cases, respondents mentioned that counselling normally takes place in private offices.

Table 2b.3: Standards and Quality		Frequency N = 730 N (%)
4a.	Number of respondents who reported that they had access to a designated counselling supervisor	357 (49.0)
6.	Number of respondents who reported the availability of the following counsellor support mechanisms	
	Debriefing with supervisor	237 (32.5)
	Debriefing with co-counsellors	289 (39.6)
	Counsellor support groups	104 (14.2)
	Others	22 (3.0)
8.	Number of respondents who reported that they had adequate time in their job to carry out their counselling duties?	172 (23.6)
2a	Number of respondents who reported that they had adequate space to ensure counselling sessions are private?	471 (64.5)
2b	Number of respondents reporting that counselling normally takes place in the following:-	
	1. Private office	399(85.3)

1. Cubicle	26 (5.6)
2. Curtained off area	17 (3.6)
3. Other (describe).....	26 (5.6)

Psychosocial care and support providers’ perspective on work-related stress and intrinsic rewards

Table 2b.4 below reflects the situation with regards to how providers of psychosocial care and support feel valued by their clients, superiors and colleagues in the discharge of their duties. Of note, is the fact that 22.1% of the respondents reported *never* feeling valued by their superiors. However, over 50% of the respondents reported feeling valued by their clients and their colleagues at least *some of the times*.

Table 2b.4 Perceived value of counsellors role

Perceived value of counsellors roles by	Always	Sometimes	Never
Clients	294 (40.3)	375 (51.4)	61 (8.4)
Superiors	209 (28.6)	360 (49.3)	161(22.1)
Colleagues	271 (37.1)	366 (50.1)	93 (12.7)

Table 2b.5 below is an indicator of perceived stress and risk for burnout and shows the following highlights

- Only 28.6% of the respondents had *never* felt emotionally drained by their work as counsellors.
- Over 50% felt that they could help their clients.
- Over 40% felt that they learned something new everyday in their work.

Table 2b.5: Levels of stress

	Always	Often	Occasionally	Never
9. Please indicate to what extent the following applies to you.				
“ I feel emotionally drained by my work as a counsellor”	45 (6.2)	124 (17.0)	352 (48.2)	209(28.6)
“ I feel my work is very stressful”	104 (14.2)	151 (20.7)	319 (43.7)	156 (21.4)
“ I feel my work is very rewarding”	237 (32.5)	212 (29.0)	197 (27.0)	84 (11.5)
“ I feel my work environment is very stressful”	148 (20.3)	150 (20.5)	274 (37.5)	158 (21.6)
“ I feel I learn something new in my work everyday”	327 (44.8)	223 (30.5)	153 (21.0)	27 (3.7)

“ I feel isolated in my work”	19 (2.6)	49 (6.7)	148 (20.3)	514 (70.4)
“ I have problems communicating with my colleagues”	7(1.0)	27 (3.7)	150 (20.5)	506 (74.8)
I feel I can help my clients”	404 (55.3)	203 (27.8)	97 (13.3)	26 (3.6)
“I feel I have no confidence in my counselling skills”	70 (9.6)	104 (14.2)	244 (33.4)	312 (42.7)

Table 2b.6 below highlights the source of work related problems and of note are the following:-

- 35.7% of the respondents reported that they had always experienced problems due to workload
- 20.3% mentioned the problems of being due to staff attrition.

The least cited problem areas were those of completing the report forms and lack of supervision.

Table 2b.6 Perceived source of work-related problems

	Always	Often	sometimes	Rarely	Never
22. How often have you experienced problems due to the following in your work?					
Work load	260 (35.7)	176 (24.1)	255 (35.0)	19 (2.6)	19 (2.6)
Lack of training	89(12.2)	101 (13.9)	347 (47.6)	104 (14.3)	88 (12.1)
Lack of ongoing training	121(16.61)	144 (19.8)	321(44.0)	74 (10.2)	69 (9.5)
Lack of emotional support	71 (9.7)	95 (13.0)	314 (46.0)	112 (15.4)	111 (15.2)
Lack of technical support	87 (11.9)	140 (19.2)	324 (44.4)	99 (13.6)	79 (10.8)
Lack of administrative support	86 (11.8)	93 (12.8)	322 (44.2)	123 (16.9)	105 (14.4)
Lack of Supervision.	48 (6.6)	73 (10.0)	232 (31.8)	184 (25.2)	192 (26.3)
Staff moved to other posts	116 (15.9)	141 (19.3)	280 (38.4)	96 (13.2)	96 (13.2)
Staff left to work elsewhere	148 (20.3)	146 (20.0)	285 (39.1)	73 (10.0)	77 (10.6)
Completing the report form	39 (5.3)	46 (6.3)	249 (34.2)	118 (16.2)	277 (38.0)
Other	31 (47.7)	13 (19.7)	21(31.8)	1 (1.5)	0 (0)

CLINIC/HEALTH CENTRE -LEVEL PERSPECTIVE

For tool 2c, a total of 286 clinic/health centre-level health workers, the majority of whom were nurses, were interviewed. As can be seen from Figure 2c.1 (appendix 2), the respondents were by and large evenly distributed across provinces and cities with the exception of Midlands and Mashonaland East which had more than double the number of respondents.

Clinic/Health Centre - level perspective with respect to policy/guidelines/ethics

Table 2c.1 Guidelines/Policy/Ethics on Psychosocial support and care		Frequency N = 286 N(%)
1a.	Number of respondents who reported that there were national policies and guidelines on HIV/AIDS.	215 (75.2)
1b.	Number of respondents reporting availability of policies and guidelines on psychosocial support to people infected and affected by HIV/AIDS.	194 (90.2)
1c	Number of respondents reporting that the available policies covered issues on:-	
	HIV/AIDS Counselling	191 (98.5)
	Psychosocial Support Groups for PLHA	182 (93.8)
	Voluntary Counselling and Testing	166 (85.6)
	Psychosocial Support Groups for Caregivers/Counsellors	165 (85.1)
2.	Number of respondents reporting that their health centres had copies of the policies and guidelines.	177 (82.3)
3.	Number of respondents reporting that their health centre were currently implementing the policies and following the guidelines	188 (87.4)

Table 2c.1 above reflects the situation with regards to the availability, distribution and implementation of policy guidelines. Of note from Table 2c.1 is the fact that 215 out of 286 respondents reported that there were national policies and guidelines on HIV. Of the 215 who reported that there were national policies and guidelines on HIV/AIDS, 194 (90.2%) said that there were policies and guidelines on providing psychosocial support to

people infected and affected by HIV/AIDS. Over 85% of respondents reported that the policies and guidelines covered issues related to :

- HIV/AIDS counselling (cited by 98.5% of respondents)
- Psychosocial support groups for PLHA (93.8%)
- Voluntary counselling and testing (85.6%)
- Psychosocial support groups for caregivers/counsellors (85.1%)

A total of 177 respondents out of 286 reported that they had copies of policies and guidelines at the clinic/health centre. In all, 87.4% of the respondents said they were currently implementing the policies and following the guidelines.

Clinic/Health Centre - level perspective with respect to training in psychosocial care and support

Table 2c.2 Training in Psychosocial care and support

Type of training on offer	N %	Duration – Median Range
Basic counselling	138 (75.8)	1 Range 1- 12
Basic HIV/AIDS Counselling	134 (73.6)	1 Range 1- 76
Pre-test Counselling	83 (45.6)	1 Range 1 – 76
Post-test Counselling	80 (44.0)	1 Range 1- 76
Supportive Counselling	125 (68.7)	1 Range 1 –76
Bereavement Counselling	94 (51.6)	1 Range 1 –76
Family Counselling	105 (57.7)	1 Range 1-76
PMTCT Counselling	76 (41.8)	1 Range 1 –12
Advanced training	4 (2.2)	12 Range 4 – 76

Tables 2c.2 and 2c.3 reflect the fact that the most commonly offered type of training as cited by the majority of the respondents were basic counselling training , followed by training in basic HIV/AIDS counselling and supportive counselling. Over 60% of the respondents indicated that training courses on providing HIV/AIDS related psychosocial support were being run mostly at community level (cited by 69.8%).

Table 2c.3 Training		Frequency N = 286 N(%)
4a.	Number of respondents reporting that their facilities had run courses on providing HIV/AIDS related psychosocial support.	182 (63.6)
4b.	Number of respondents reporting that training courses were being run at the following levels:- District Health centre Community level	112 (61.5) 112 (61.5) 127 (69.8)
5.	The Median number of counsellors who have been trained to date in your community in HIV/AIDS counselling as reported by respondents.	6 Range (0 - 200)
6.	Number of respondents reporting that cadres being trained have the following backgrounds. Nurses PLHA Lay persons Others (<i>Specify</i>)	185 (64.7) 120 (42.0) 159 (55.6) 108 (37.8)

Clinic/Health Centre - level perspective regarding the availability of Psychosocial Services and referral mechanism

Table 2c.5 below reflects the situation obtaining with regards to the existence of psychosocial support services and referral mechanisms within the community. About 25% of the respondents stated that there was a directory of psychosocial support services in the community whilst 17.5% reported that there were adequate referral services for psychosocial support in their catchment areas.

Table 2c.5 Psychosocial Services and referral mechanism		Frequency N = 286 N(%)
8.	Number of respondents reporting that their facilities had a directory of psychosocial support services in the community.	73 (25.5)
10	Number of respondents reporting that there were adequate referral services for psychosocial support in their catchment area.	50 (17.5)

COMMUNITY LEVEL PERSPECTIVE

For tool 2d, a total of 738 community level respondents were interviewed and these comprised of community based organisation staff, and village health/community workers. Figure 2d.1 below which shows their distribution highlights the fact that Mashonaland East, Matebeleland South and Masvingo had the highest number of respondents in this category.

Community - level perspective with respect to policy/guidelines/ethics

Table 2d.1 below reflects the situation pertaining to policies and guidelines on providing HIV/AIDS psychosocial care and support. A total of 510 out of 738 respondents reported that they were aware of the existence of such policies and guidelines with 494 of them reporting that they were currently implementing the policies and following the guidelines in their work.

Table 2d.1 Guidelines/ Policies on Psychosocial Care and Support		Frequency N = 738 N(%)
1a	Number of respondents who were aware of policies and guidelines on providing HIV/AIDS psychosocial care and support.	510 (69.1)
1c	Number of respondents reporting implementation of the policies and following of the guidelines at their workplace?	494 (96.9)

Community - level perspective with on training in psychosocial care and support provision

Table 2d.2 below relates to the training of cadres in psychosocial care and support. A total of 576 out of 738 (78%) cadres reported that training courses on HIV/AIDS-related psychosocial support were being run mostly at community and rural health centre levels. The majority of the respondents indicated having

received training in basic counselling (cited by 84.4% of respondents), basic HIV/AIDS counselling (81.9%) and post test counselling (78.5%).

Table 2d.2 Training in Psychosocial Care and Support		Frequency N = 738 N(%)
2a.	Number of respondents who reported that courses on HIV/AIDS related psychosocial support were being run.	576(78.0)
2b.	Number of respondents who reported that courses were being run at the following levels.	
	District	190(33.0)
	Rural Health Centre	347 (60.2)
	Community	354 (61.5)
2c.	Number of respondents who reported that cadres had been trained in the following:	
	Basic counselling	486 (84.4)
	Basic HIV/AIDS Counselling	472(81.9)
	Pre-test Counselling	237 (41.1)
	Post-test Counselling	224 (38.9)
	Supportive Counselling	452 (78.5)
	Bereavement Counselling	433 (75.2)
	Family Counselling	437 (75.9)
	PMTCT Counselling	232 (40.3)
	Advanced training (<i>Please specify</i>)	28 (4.9)
	Other (Specify)	29 (5.0)

Community - level perspective with respect to availability of psychosocial services

All in all, 34.3% of the respondents indicated that a directory of psychosocial support services in the community was available.

CLIENTS AND PRIMARY CARE GIVERS' PERSPECTIVE

There were 1553 (51.7%) clients and 1452 (48.3%) care givers interviewed in this study using tool 2e and they were distributed as per figure 2e1 appendix 2.

Clients and primary care givers' reports on Psychosocial Support received

In table 2e.1 below is highlighted the fact that the type of psychosocial support services reported as having been received by most clients were: social visits (cited by 64.3% of respondents), information and education on preventing HIV transmission and infection control (41.3%) and counseling (25.2%).

Table 2e.1: Psychosocial Support received

Number of clients who reported having received the following types of psychosocial support	Frequency N = 3005 N(%)
- Information and education on preventing HIV transmission and infection control .	1242 (41.3)
- Counselling	757 (25.2)
- Financial Support	526 (17.5)
- Legal services	63 (2.1)
- Material support	678 (22.6)
- Social Visits (Define purpose)	1932 (64.3)

Clients and primary care givers' satisfaction with Psychosocial Support services

Table 2e.2 below reflects the levels of clients' and primary caregivers' satisfaction with several aspects of psychosocial services . Overall, very few respondents reported being very satisfied with the range, quality, appropriateness and accessibility of psychosocial services. However around a 1/5 of the respondents indicated that they were satisfied with the range, quality, and appropriateness of psychosocial services available with around a 1/3 saying that they were very dissatisfied with the appropriateness and accessibility of the services.

Table 2e.2 Clients Satisfaction with various aspects of Psychosocial care and support

Number of clients indicating different levels of satisfaction with respect to the following:-	Very satisfied	Satisfied	Dissatisfied	Very Dissatisfied
The range /types of available psychosocial services available.	77 (2.7)	656 (23.0)	1346 (47.3)	768 (27.0)
The quality of psychosocial services available.	80 (2.8)	637 (22.3)	1346 (47.2)	789 (27.7)
The appropriateness of the psychosocial services available.	74 (2.6)	615 (21.5)	1329 (46.6)	832 (29.2)
The accessibility of psychosocial services available.	80 (2.8)	496 (17.4)	1378 (48.4)	896 (31.4)

DISCUSSION

Availability of policy documents and guidelines on psychosocial care and support was not verified during the survey, as this was not strictly speaking an audit but a situation analysis. However, there were apparent contradictions in the reports during the survey on what really obtains at the various levels with respect to the availability of policy documents and treatment guidelines.

As regards training and manpower, what is apparent is that although a lot of training in psychosocial care and support, especially through training in HIV/AIDS counselling, has been taking place the staff attrition rate has been very high across the board, with rural areas being worst affected. This obviously has implications for the quality of care that can realistically obtain in a situation of chronic staff shortage and other resource constraints. There is therefore a need to increase the pool of appropriately trained cadres by, first and foremost, integrating HIV/AIDS related psychosocial care and support into the pre-qualification training syllabus of health workers across the board. Secondly, in-service training needs to be scaled up and sustained in order to equip cadres in the field with the necessary sensitization and skills to respond to the ever-changing landscape of clients' HIV/AIDS-related psychosocial needs.

In order to ensure that psychosocial care and support becomes an integral component of a comprehensive response to HIV/AIDS pandemic and a key entry point to the continuum of HIV/AIDS prevention, treatment, care and impact mitigation, there is need for a clearly articulated policy framework that is well understood by all. In addition, treatment

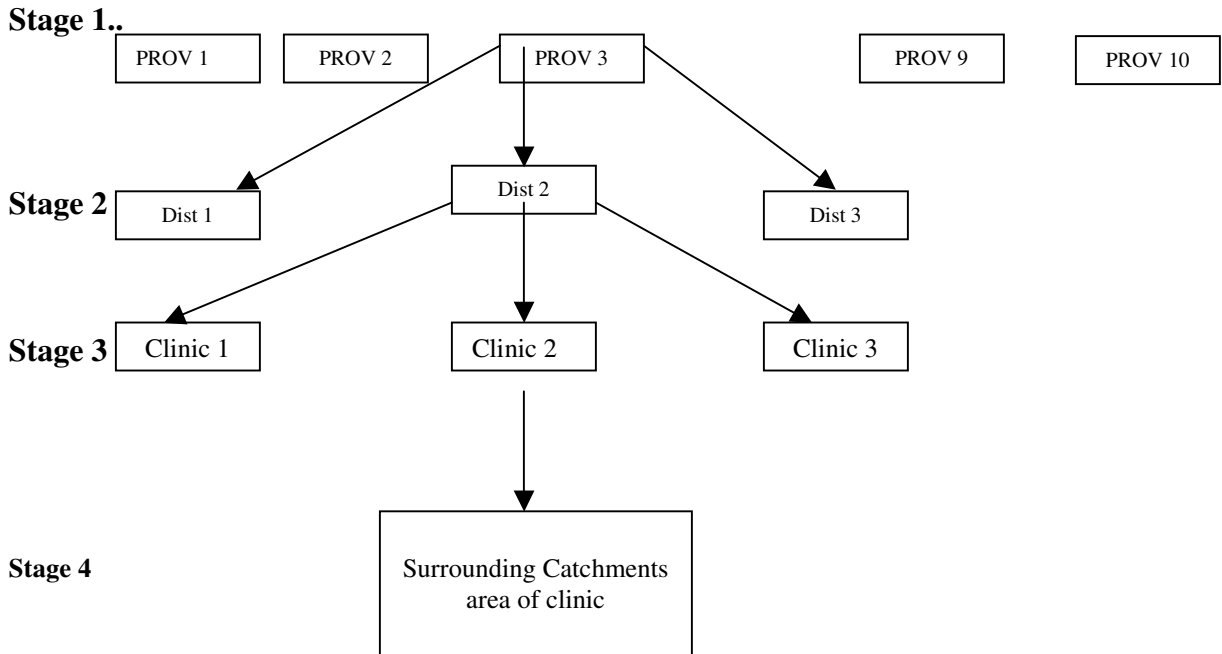
and care guidelines on psychosocial care and support need to be developed and disseminated across the board with a built in provision for their timeous update and revision.

This situation analysis survey has also highlighted the apparent inadequacies in the provision of psychosocial support services at the various levels as well as the lack of knowledge about what psychosocial support services are available, if at all. Hence there is a need to compile and publicize directories of what such services are available and where.

Lastly, quality of care requires a carefully managed and proactive quality assurance and quality monitoring undertaking. To this end a lot still needs to be done to develop monitoring tools and to train supervisors to monitor the quality of psychosocial care and support that is being availed to clients throughout the country.

APPENDIX-1

FLOW CHART 1- SAMPLING OUTLINE



APPENDIX 2

Figure 2a.2

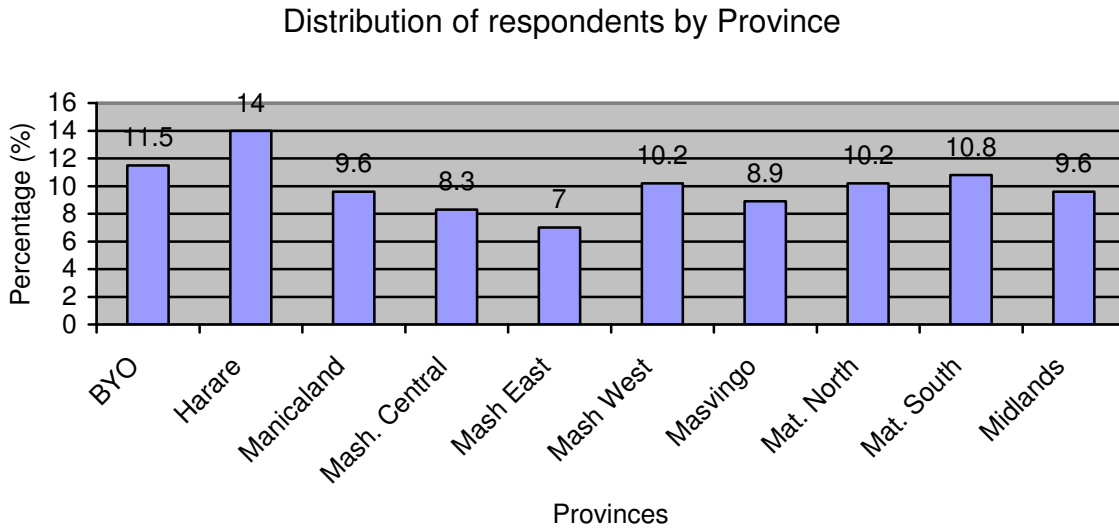


Figure 2b.2

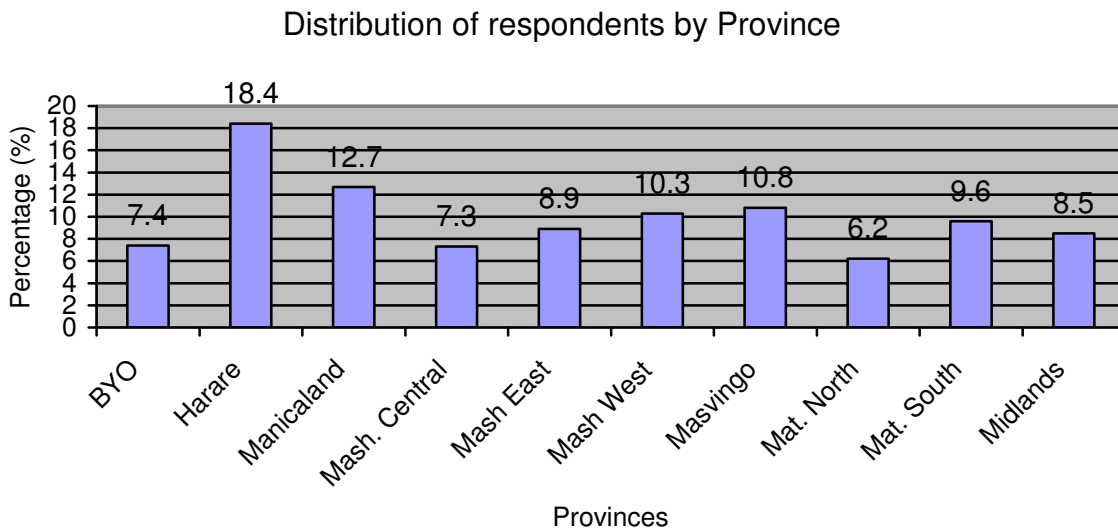


Figure 2c.1

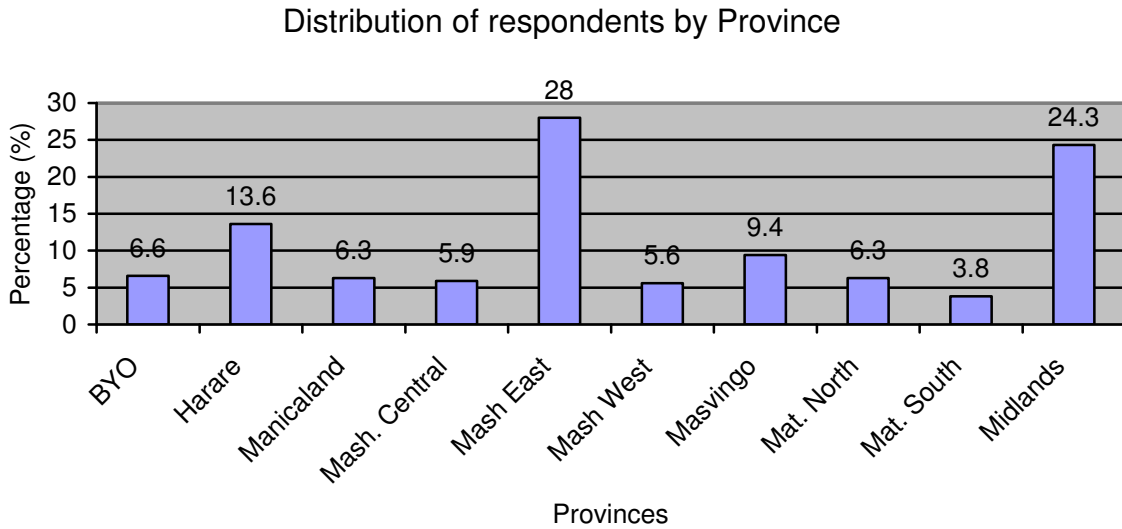


Figure 2d.1

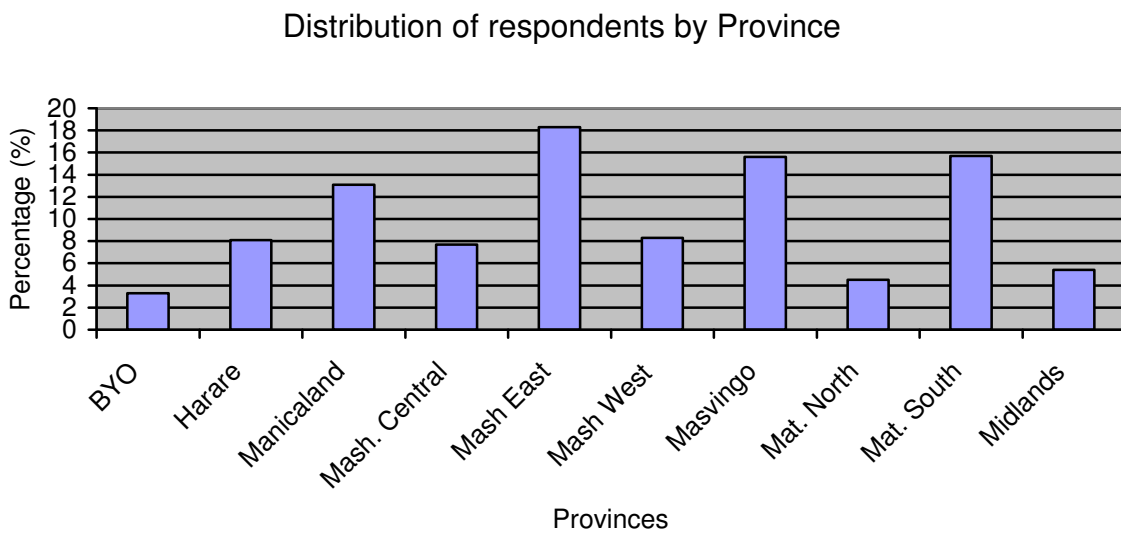


Figure 2e.1

