

**Proceedings of the National
Stakeholders Meeting to Build
Consensus on HIV/AIDS Quality of Care
Improvement in Zimbabwe**



**13th to 15th February 2002
Harare Holiday Inn**

**HIV/AIDS Quality of Care Initiative
(HAQOCI)
Clinical Epidemiology Unit
University of Zimbabwe**

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We would like to acknowledge the sincere expression of interest in improving the quality of HIV/AIDS care in Zimbabwe that was shown by all participants at this meeting.

All participants brought special strengths and expertise and contributed significantly to a broad array of issues and recommendations on improving the quality of HIV/AIDS care.

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ACRONYMS:

• AIDS	-	ACQUIRED IMMUNODEFICIENCY SYNDROME
• ART	-	ANTIRETROVIRAL TREATMENT
• ARV	-	ANTIRETROVIRALS
• ASOs	-	AIDS SERVICE ORGANISATIONS
• CDC	-	CENTRES FOR DISEASE CONTROL
• CEU	-	CLINICAL EPIDEMIOLOGY UNIT
• CHBC	-	COMMUNITY HOME BASED CARE
• CTX	-	COTRIMOXAZOLE
• DAAC	-	DISTRICT AIDS ACTION COMMITTEES
• DAC	-	DISTRICT AIDS COUNCIL
• DOT	-	DIRECTLY OBSERVED THERAPY
• EDLIZ	-	ESSENTIAL DRUGS LIST OF ZIMBABWE
• EPI	-	EXPANDED PROGRAM OF IMMUNIZATION
• GOVT	-	GOVERNMENT
• HAQOCI	-	HIV/AIDS QUALITY OF CARE INITIATIVE
• HCW	-	HEALTH CARE WORKERS
• HIV	-	HUMAN IMMUNODEFICIENCY VIRUS
• IEC	-	INFORMATION EDUCATION COMMUNICATION MATERIALS
• MOHCW	-	MINISTRY OF HEALTH AND CHILD WELFARE
• MTCT	-	MOTHER TO CHILD TRANSMISSION
• NAC	-	NATIONAL AIDS COUNCIL
• NACP	-	NATIONAL AIDS CONTROL PROGRAMME
• NGOs	-	NON GOVERNMENTAL ORGANISATIONS
• OI	-	OPPORTUNISTIC INFECTIONS
• PRA	-	PARTICIPATORY RURAL APPRAISAL
• PAC& DAC	-	PROVINCIAL AIDS COMMITTEES & DISTRICT AIDS COMMITTEES
• PACT	-	PREVENTION AIDS CARE TRUST
• PCP	-	PNEUMOCYSTIS CARINII PNEUMONIA
• PLHWA	-	PEOPLE LIVING WITH HIV/AIDS
• PLWA	-	PEOPLE LIVING WITH AIDS
• PLWHA	-	PEOPLE LIVING WITH HIV/AIDS
• PMD	-	PROVINCIAL MEDICAL DIRECTOR
• PMTCT	-	PREVENTION OF MOTHER TO CHILD TRANSMISSION
• PTCT	-	PARENT TO CHILD TRANSMISSION
• SAFAIDS	-	SOUTHERN AFRICAN AIDS INFORMATION SERVICE
• STDs	-	SEXUALLY TRANSMITTED DISEASES
• STIs	-	SEXUALLY TRANSMITTED INFECTIONS
• TB	-	TUBERCULOSIS
• VCT	-	VOLUNTARY COUNSELLING AND TESTING
• WHO	-	WORLD HEALTH ORGANISATION
• ZAN	-	ZIMBABWE AIDS NETWORK
• ZIMA	-	ZIMBABWE ASSOCIATION OF MEDICAL PRACTITIONERS
• ZINATHA	-	ZIMBABWE NATIONAL ASSOCIATION OF TRADITIONAL HEALERS
• ZNNP+	-	ZIMBABWE NATIONAL NETWORK OF PEOPLE LIVING POSITIVELY

EXECUTIVE SUMMARY

AIDS related illness remains a major cause of the disease burden in Zimbabwe with worsening prospects. It is estimated that two million people are infected and prevalence among the sexually active is 25%. This disease has become the commonest cause of morbidity and mortality on 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 for AIDS related illness. Provision of good quality care has been compromised making this a great challenge for health providers particularly in resource poor environments.

The fight against HIV/AIDS calls for full GOVT commitment and involvement, development of strong partnerships involving all sectors (including governmental, non governmental, political organisations, private sector, religious sector and many others), resource mobilisation, clear evidence based policies and management guidelines which are accessible to all who provide care.

Priority issues that emerged from the consensus meeting in the area of community home based care (CHBC) included:

- Lack of resources for drugs and training of health workers and community volunteers on AIDS care.
- Shortage of basic household commodities such as soap, food.
- Lack of medical supervision of care in the home which, is worsened by not having a hospital discharge plan.
- Lack of networking and a co-ordinated approach to home care.
- Poor knowledge of best practices for HIV/AIDS care.

Recommendations on high priority near term achievable steps for improving quality of CHBC included:

- Conducting a situation analysis of patient care needs as well as provider needs in order to target interventions more appropriately.
- Improving GOVT's involvement in CHBC.
- Making the AIDS levy more available for CHBC support programs.
- Reviewing the hospital discharge plan and increasing medical supervision of CHBC.
- Mobilising resources for training and drugs.

Priority issues pertaining to TB and opportunistic infections (OIs) included:

- Lack of diagnostic capacity and capability for OIs.
- Inadequate VCT centres for HIV.
- High levels of perceived resistance against drugs for OIs.
- Drug shortages.
- Lack of information on good quality care.
- Lack of standardised clinical care guidelines

Recommended high priority achievable steps for improving care included:

- Getting access to free fluconazole.

- Increasing availability and accessibility of drugs for OIs.
- Implementing projects within the framework of operational research that will increase CTX prophylaxis in the public health setting.
- Institute training on recognition and management of OIs.
- Disseminate information on good quality care.

Pertaining to ARVs issues, it was noted that there were no available national treatment guidelines and no training on use of ARVs, both of which are urgent. There is need to fast track this process as well as the process broadening access to ARVs in the public sector in the context of comprehensive HIV care. ARVs should be a major element of Zimbabwe's application to the global fund.

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 level of stress and burnout resulting from multiple bereavements as well as poor working conditions and remuneration are recognised. 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 GOVT.

It is hoped that partnerships developed at this meeting will be strengthened and that the proceedings of the consensus meeting will assist policy makers, managers, directors, formal and informal health care providers involved in HIV care in their planning activities.

Rkambarami

Dr R.A. Kambarami
CEU Director

1. INTRODUCTION

Professor J. Matenga welcomed the participants to the meeting and indicated that the response to the meeting was overwhelming. He said that, it was an indication of the importance of the subject to be discussed. He then called upon Dr Rose Kambarami HAQOCI Project Director and Director of the Clinical Epidemiology Unit to give an outline and objectives of the workshop.

2. Clinical Epidemiology Unit, HIV/AIDS Quality of Care Initiative (HAQOCI) and Objectives of this Meeting by Dr R. KAMBARAMI

The Clinical Epidemiology Unit (CEU)

Dr Kambarami introduced the CEU by saying that the CEU was established in 1989 with a membership of two people. It currently holds a membership of 56 persons, comprising of Physicians, Pediatricians, Surgeons, Obstetricians, Gynecologists, General Medical Officers, Laboratory Scientists, Pharmacist, Pharmacologist, Statisticians, Health promoters and others. The members are trained in; clinical epidemiology, health social sciences, health economics, biostatistics and pharmarco-epidemiology.

The mission statement of the CEU is: **to be a center of excellence in research and teaching in the areas of epidemiology, biostatistics and social sciences related to health and to offer professional service to GOVT and other agencies to prevent disease and, from a population perspective, improve health care and outcomes.**

The objectives of the Unit are **teaching, research and professional service.**

The overall objectives include the following:

- **Teaching** - Providing high quality education in the disciplines of clinical epidemiology.
- **Research** - Conducting high quality clinical and population based research of an interdisciplinary nature, which will impact on health policy, practice of outcomes.
- **Professional service** - To provide expertise and advice to GOVT and other agencies to improve health care and outcomes as well as to influence health policy and practice to provide more cost effective and equitable health care.

- **The HAQOCI project is currently one of the major activities within the CEU.**

HAQOCI

In a brief presentation, Dr Kambarami said that HAQOCI is an initiative that started in October 2001 and is being funded by the Centers for Disease Control, Atlanta, with technical support from CDC-Zimbabwe AIDS Program and is housed in the Clinical Epidemiology Unit (CEU), Faculty of Medicine, University of Zimbabwe.

The **goal** of the HAQOCI is to develop and implement an initiative that will improve the quality of HIV/AIDS care in Zimbabwe.

This is supported by the following objectives: -

1. To develop CEU infrastructure and capacity for HIV/AIDS quality of care improvement .
2. To characterise the HIV/AIDS quality of care situation through consensus meetings and surveys.
3. To develop, evaluate and recommend models of improved HIV/AIDS care.
4. To develop clinical guidelines for HIV/AIDS care improvement.
5. To support, promote and advocate for the provision of high quality HIV/AIDS care in Zimbabwe through collaboration with GOVT, NGOS, the Private Sector and others involved in HIV/AIDS care.

Dr Kambarami then gave a definition of quality, which she said was pivotal in all the deliberations to be under taken.

She defined quality as **the degree to which health services for individuals and populations increase the likelihood of desired health outcomes for clients' satisfaction and are consistent with current and professional knowledge.**

She, however, raised the question of cost, noting that the issue of cost often affected the provision of good quality care. The issue of cost often led to resource-poor countries resorting to second rate interventions.

Objectives of this Meeting

She said the objectives of this meeting are:

- To involve stakeholders in the development and early plans of HAQOCI.
- To identify priority areas for improving HIV/AIDS quality of care for affected and infected persons in the short term.
- To identify areas that require operational and other research, related to improving HIV/AIDS Care in Zimbabwe.

3. OFFICIAL OPENING by Dr S.M. MIDZI

The workshop was officially opened by Dr Midzi who represented the permanent secretary in the MOHCW, Dr Elizabeth Xaba, who could not be present, due to other business.

The speech highlighted the fact that the first HIV/AIDS case was identified in 1985. He also said that to date there are two million people living with HIV/AIDS in Zimbabwe and the figures are increasing at an alarming rate. A survey of pregnant mothers conducted in 2001 revealed that approximately 35% of pregnant mothers are HIV positive.

Approximately 60% of hospitalised patients are suffering from AIDS or AIDS related conditions. He said the epidemic is a major challenge to the health sector and to the delivery of good quality care. Another highlight from this presentation is that life expectancy has dropped from 63 years to 40 years in 10 years alone; he indicated that the cost of care has become astronomical.

He alluded to GOVT's efforts in coming up with an AIDS policy document which is intended to provide us with a framework to operate within and an enabling environment for those who provide care to affected persons. Dr Midzi also talked of the AIDS levy which, is intended by GOVT to facilitate and alleviate the financial burden for AIDS victims and their care givers.

Despite these efforts many complex challenges in the prevention, treatment and care of HIV/AIDS remain and hence the need to collaborate with other bodies in the fight against AIDS. The fight against AIDS calls for resources as well as a multi-sectoral and multi-disciplinary as well as a well co-ordinated approach.

He agreed that whilst the initiative by GOVT is sound, so much work on the

ground is uncoordinated and the need to build effective partnerships is fundamental at all levels including local, regional, and international, private and public sectors, GOVT and non-governmental organisations, church groups and many others. He welcomed the partnership that exists between the University of Zimbabwe and centers of excellence, like the Center for Disease Control (CDC) and applauded the Clinical Epidemiology Unit at the Faculty of Medicine for taking the initiative to assist with improving quality of care of persons affected by HIV/AIDS. He said such initiatives get the backing of the MOHCW.

He proposed a few challenges for the meeting namely:-

- Is provision of ARVs an appropriate way to go given our limited resources and who should benefit from ARVs?
- How best can the national AIDS TRUST FUND benefit the affected and infected persons and be used to improve the quality of care?
- How best can we improve the quality of care of HIV affected persons?
- How can emotional trauma, psychological stress and stigma be dealt with?
- What is the best way of providing and ensuring that every person in Zimbabwe who has HIV infection receives CTX?
- What strategies should be used to fill the gap that exists in the continuum of care between hospital and home based care?

He hoped that this meeting would come up with implementable recommendations on the above posed challenges and many other issues that affect quality of care.

With these few words he wished the meeting fruitful deliberations and declared the meeting open.

4. PRESENTATIONS

4.1 Update on HIV Pandemic in Zimbabwe by Dr N. MATANHIRE

This presentation by Dr Matinhire from the National AIDS Council highlighted the following.

1. The HIV/AIDS epidemic in Zimbabwe is transmitted principally through heterosexual means.
2. Prevalence amongst the sexually active population is at 25%.

3. Levels of morbidity and mortality have risen sharply amidst a deteriorating economic environment and has made a permanent dent in the private and public sector in terms of manpower, as those productive are those infected and hence the epidemic has become a developmental issue.
4. Generally women have a higher risk of infection and are acquiring infection at a much younger age.
5. The epidemic undermines fragile economic and social gains that have been made in advancement of society in general and women in particular.

The two tables below sum up Dr Matinhire's presentation.

HIV/AIDS in Zimbabwe 2002: Projection Summary

Cumulative HIV Infections	1.9 Million
Cumulative AIDS Cases	977 500
Annual deaths (15 - 49 yrs)	131 000
Orphans due to AIDS (cumulative)	726 500
Fertility rate	
1994:	4.3/1000
2005:	3.4/1000
Infant Mortality Rate	64/1000
Child Mortality Rate	80/1000
Bed occupancy due to HIV/AIDS	50% - 70%
MTCT (HIV sero-prevalence rates)	35% (overall) 28.7%(15 - 19 yrs)

AIDS in Zimbabwe, NACP, MOHCW (1998).

Source: National Survey of HIV and Syphilis Prevalence among women attending Antenatal clinic in Zimbabwe, 2000.

The table below shows the relationship between age and HIV sero-prevalence in Zimbabwe.

Relationship between age and HIV sero-prevalence in Zimbabwe

AGE	SAMPLE SIZE	PREVALENCE (%)
15	32	28.1
16	116	27.6
17	282	24.8
18	426	27.0
19	421	30.6
20	473	31.9
21	416	33.2
22	399	36.6
23	380	37.6
24	355	36.9

4.2 Conceptual Framework for Comprehensive HIV/AIDS Care by Dr S. HADER - CDC Atlanta

Dr Shannon Hader was introduced as a visiting Pediatrician/Public Health Specialist/Infectiologist from CDC Atlanta.

Dr Hader said that the purpose of an AIDS program is to reduce HIV transmission rates and improve HIV/AIDS treatment and care. She went on to give a brief outline of the major AIDS program activities, which she said, are: -

- HIV prevention programs (including behaviour change, VCT. Prevent/treat other sexually transmitted infections, and prevent MTCT)
- HIV/AIDS treatment and care programs (including prophylaxis, diagnosis and treatment of opportunistic infections and TB, ART, and blood safety)
- Program infrastructure (including surveillance, training and laboratory support, and monitoring and evaluation.)

AIDS Treatment and Care

- To date, much of AIDS treatment and care in resource-restricted countries is primarily palliative
- Consequently, many health needs are not being addressed

- To address these needs, practical and achievable strategies for comprehensive AIDS care should be identified and implemented

Comprehensive AIDS Care

According to Dr Hader's presentation, comprehensive care entails the following:

- Providing ART
- Providing prophylaxis and treatment of TB
- Providing prophylaxis and treatment of other opportunistic infections (OIs)
- Providing prevention counselling
- Monitoring and enhance adherence to medications
- Linking with organisations that provide support services

To enhance AIDS care and prevention, links should be made with organisations that provide:

- VCT
- Social services
- Mental health care
- Home based care
- MTCT services
- Hospital care

Strategies for Comprehensive AIDS Care also incorporate the following:

- Strengthening country infrastructure to deliver AIDS Care
- Improving AIDS care and prevention at all levels of the health care system
- Incorporating prevention, diagnosis, and treatment of TB and other OIs into AIDS care programs
- Linking AIDS care programs with organisations that provide support services
- Development of treatment guidelines and standards of care for AIDS, TB, and other OIs
- Monitoring and improving AIDS care programs
- Training health care providers in early recognition, prophylaxis, and treatment of TB and other OIs
- Strengthening laboratory capacity to diagnose TB and other OIs
- Evaluating and implementing alternative monitoring and diagnostic algorithms
- Improving the provision of ARV drugs

- Developing drug management systems for AIDS care programs
- Monitoring resistance to ARV drugs

Why ART?

- One component of comprehensive AIDS care
- These therapies are effective in reducing death and disease due to HIV/AIDS, but broad access has been limited
- Increasing international community interest in increasing access to ART
- Strengthening infrastructure for ART can strengthen that for other aspects of AIDS care

Objectives of an AIDS Program:-

1. Decrease sexually transmitted HIV infections
2. Develop the capacity for HIV prevention and care efforts
3. Expand and strengthen HIV/STI/TB surveillance programs
4. Improve basic scientific knowledge of HIV and the safety and efficiency of newly developed biomedical interventions
5. Decrease HIV infections transmitted from mother to child
6. Increase access to improved HIV treatment and care, including ART
7. Decrease parentally transmitted HIV infections

By all of us working together, we have the opportunity to stop HIV transmission, prevent TB and other OIs, and restore good health in persons with AIDS.

4.3 Opportunities and Challenges for providing High Quality HIV/AIDS Care: A Rural Situation by Dr E. MABHIZA

Dr Mabhiza is the Provincial Medical Director of Mashonaland East Province. Dr Mabhiza said that when we discuss high quality, there has to be a holistic approach to care which should address the physical, psychological and social needs of the clients or the population being saved.

He presented the scenario that exists in rural Zimbabwe as that characterised by:-

- Vast distances between health institutions and clients with no proper roads, or bridges and at times poorly serviced transport systems.
- Poor staffing at the health institutions and at times the nurse is not there

(staff shortage, if he/she is there, they cannot spend much time with you because of the number of patients waiting, which means no counselling and if she attends to you she is rude and tired).

- There is also a drug shortage.
- No lab tests can be done.

So according to Dr Mabhiza, there is, therefore, a contradiction that exists between the situation on the ground and provision of good quality care. He said in as much as one might look at opportunities that exists, these are outweighed by the challenges which include:-

- Lack of a shared vision in responding to the pandemic i.e. conflict between the expectations of the health professionals and community etc.
- High staff turn-over
- Essential drugs availability and the accessibility of these in terms of cost
- Over reliance on volunteers
- Overly advocating for CHBC without resources such as gloves and antiseptics etc.
- Monitoring is compromised for patients and those nursing the patient
- Stigmatisation
- ARV drug availability and ability to use them

4.4 Opportunities and Challenges to providing High Quality HIV/AIDS Care: The Urban Situation by Dr L. MBENGERANWA

Dr Mbengeranwa is the Director of Health Services in the City of Harare. Dr Mbengeranwa, was of the opinion that there used to be a rural-urban migration as a developmental process. However the reverse is now happening today because of the problem of HIV and AIDS, people are now moving from urban areas to the rural areas, sadly to die. Dr Mbengeranwa noted that our projected population for 2000 was at 13.5 million (92 census) of which 61% would be rural and 39% urban. The 2002 census is awaited with interest. He also said that most infections are through heterosexual contact (92%) and 7% through perinatal transmission. About 30% of babies born of HIV positive mothers will be infected around the time of birth. He added that the virus may be transmitted to the child during breast-feeding and most children infected perinatally will die before their fifth birthday.

Dr Mbengeranwa highlighted findings of a survey conducted in Zimbabwe on the prevalence rate of syphilis and HIV among women presenting at the antenatal clinics in the year 2000 in Zimbabwe. The survey revealed that out of the 6 121 women tested, 50% were in rural areas and 45% in urban areas. It also revealed that of the attendees were in the age group of 15 to 44 years and 35% tested positive for HIV. For women in towns and cities the prevalence rate was higher at 36,9% (MOHCW).

In his presentations Dr Mbengeranwa highlighted the fact that urban areas are the hub of industrialisation and economic development and HIV/AIDS has had an impact on socio-economic development. The economic impact has been three-fold, namely rising medical costs, rising absenteeism from work and rising costs regarding investment in education and training. The epidemic has resulted in escalation of costs in health care delivery and in escalating costs in training manpower for the labour market.

Within the urban area for example, the household incomes have dwindled, leading to poverty. Health costs are soaring and yet 70% of the urban population lives below the poverty datum line. Harare has a huge population leading to over crowding and consequently antisocial behaviour is found.

The other challenges are the other levels of knowledge versus the attitudes and practices. He also indicated that much research has been conducted and that the challenge is in putting the results of this research into operation.

Towns are also challenged by quantity versus quality of services provided. Importantly there is the Public Health Act, which stresses the importance of a healthy labour force, but HIV/AIDS knows no boundaries (age, sex, and class) and it has hit the core of production hard.

As is the current practice with communicable diseases, should the local authorities be screening for HIV/AIDS? Is this ethical one would ask?

Dr Mbengeranwa said that the opportunities, however, do exist and these include an accessible population and the good governance of local authorities.

He highlighted the following:

- Local Government System

He said that the local government system is highly developed and comprehensive because of election process of mayors, town chairmen and councillors making them accountable to residence themselves.

- Local Authority Health Services

Dr Mbengeranwa alluded to the fact that populations are gathered in one

locality making them very accessible. He, however, indicated that such a set-up could also pose serious health risks, such as overcrowding, poor housing and unemployment. The threat of a spread of communicable diseases is very high. He argued that with the passage of time local authorities have developed a comprehensive health care system, although dependant on the financial standing of the local authority.

The main activities include:-

- Health promotion and disease prevention
- Provision of infectious diseases hospitals
- Provision of primary health care facilities which include maternity services, immunisation clinics, community nursing care and social health services
- According to the Public Health Act STIs and other venereal diseases are well catered for and the urban local authorities have developed a well funded comprehensive health care infrastructure to deal with sexually transmitted diseases and the treatment of TB

He gave a brief outline of priority areas in improving HIV/AIDS prevention and these included:

- Health education
- STI prevention and treatment
- VCT
- Treatment of opportunist infections including TB
- Home based care is provided in collaboration with other care givers in the community
- Prevention of MTCT in our maternity units.
- Provision of ART at designated centers in future
- Research, training, collaborative efforts and partnerships with the private sector

Dr Mbengeranwa did mention the major constraint city health faces in terms of mushrooming squatter camps, which pose a threat in terms of service delivery because they are unreachable areas. A major threat highlighted is that of STIs because of the migrant nature of urban populations, but efforts have been made in decentralising services and ensuring that satellite clinics have adequate drugs as well as well trained staff. Other services the local authorities have put in place include:

- VCT Clinics
- Prevention of MTCT of HIV. In Maternity Units (*pilot work has already started and with availability of resources work will soon start in most urban clinics*). He said

this needs to be strengthened by ensuring that a comprehensive testing and counselling service is available and that there is a sustainable supply of ARV drugs

- Partnership with the private sector (*there are plenty of opportunities for collaborative work and partnership in funding for care through medical aid societies and with other civic organisations in terms of home based care*)

In conclusion Dr Mbengeranwa called for the creation of community resources and the expansion of these, which enable people to mutually support each other in performing all functions of life and said that this calls for a common vision.

4.5 Plans to Improve HIV/AIDS Care in Zimbabwe by Dr O.M. MUGURUNGI

Dr Mugurungi is the Director of the AIDS and TB Unit in the MOHCW. In his view the major challenge in improving HIV/AIDS care in Zimbabwe is in breaking the silence and this has to be all encompassing so as not to divide people in the mining sector, farming community and other sectors.

He stressed the need for the following:-

- That the basic package of HIV care in the country has to be defined because this will lead to:
 - promoting rational use of resources available
 - improving the quality of life for PLWA
 - promoting participation of families and communities in caring for PLWA
- Encourage co-operation and collaboration between orthodox and traditional medical practitioners in order to strengthen HIV/AIDS control and care.
- Provision of holistic and acceptable community care in collaboration with communities, churches, NGOs, traditional and medical practitioners etc.

Dr Mugurungi talked of what constitutes a basic package of HIV care.

It is made up of the following:-

- VCT
- Prevention, management and treatment of STIs
- Prevention and treatment of OIs including TB.
- Nutrition and psychosocial support for people living with HIV/AIDS
- Prevention of MCTC of HIV
- Provision of drugs to include ARVs to treat HIV complications, cancer and HIV disease

He said that comprehensive, cost effective and affordable care should be made accessible to people living with HIV/AIDS through the following strategies:

- Strengthening the capacity of the health care delivery system through provision of adequate resources.
- Making essential drugs available at all levels of the health care delivery system
- Developing cost effective management protocols for HIV-related illnesses backed by research
- Developing an essential HIV/AIDS drug policy based on proven efficacy, safety and cost effectiveness of the drugs, supported by information on nutrition, sanitation, exercise and other aspects of healthy living
- Providing health workers in the public and private health care delivery system with appropriate training in HIV/AIDS education, counselling and management
- Ensuring that the patient referral system adequately caters for people with HIV/AIDS
- Eliminating any form of discrimination in the health care delivery in respect of HIV/AIDS through education and information to change attitudes
- Promoting good nutritional habits, including information on vitamins and other micro-nutrients
- Educating HIV/AIDS patients about their rights by promoting and publicising widely the patient's charter
- Increasing the accessibility of ARVs and ensuring their safe and equitable management

4.6 Clients' Needs to Improve HIV/AIDS Care in Communities by Mr B. DHLIWAYO

Mr Dhliwayo was representing people from ZNNP+.

The presentation highlighted the fact that the gathering at this conference was basically discussing quality care and the needs of PLWHA. He, therefore, stressed the fact that, all had to hear it from those affected.

Mr Dhliwayo said that PLWHA needs can be split into four segments, namely:

1. Psychological
2. Financial
3. Religious
4. Emotional

These segments, they argue, cannot be discussed in isolation; they are inter related and share symbolic attributes: PLWHA have basic needs of food, clothing and shelter. They say these basic needs transcend to CHBC, economic support, media response training, encouragement and support and results from research.

Psychological:-

- PLWHA need to lead a stress free life. They said medically it has been proven that the CD4 cell count is very relative to the psychological state of an individual
- PLWHA need emotional and spiritual support

Food Supply:-

- Food is vital in building the immune system . Even ARVs can not be administered without a good, balanced diet. He alluded to the introduction of food baskets, nutrition gardens and the Zunderamambo ideology

Community Home Based Care:-

- This, they argue plays a key role in the improvement of people. It brings people together. Children also need to be taken care of and some of their needs like fees and shelter have to be met

However, it is highlighted that overcrowded housing conditions, unsafe drinking water, poor sanitation and under nutrition has a negative impact and decrease survival potentials of PLWA and therefore needed to be addressed.

Economic:-

- Poverty increases the vulnerability of a person to HIV/AIDS
- AIDS strains resources available to a household
- Cost of care and the cost recovery policies that have been introduced in the health sector need to be reviewed for HIV affected persons.
- In addition utilities that are used are expensive e.g. toiletries, food and bed linen.

The economic burden of clients is therefore enormous.

Religion:-

In their presentation they stress the fact that "religion is the opium of the oppressed" and PLWHA seem to be in agreement with the statement. Spiritual guidance and divine intervention is what they say kept them going. They want the church to give them adequate support.

In conclusion, Mr Dhliwayo presented what is perceived to constitute quality of care as:

1. Clinical management (early diagnosis, rational treatment and follow up)
2. Nursing care (promote and maintain hygiene and nutrition, education of families and individuals and practice infection control)
3. Counselling (psychological support, promoting positive living, planning for future and behavioural change)
4. Social support including information about and referral to support groups, welfare services and legal and services made available for individuals and families

Information would help one make an informed decision

4.7 Community Home Based Care Needs by Ms L.B. LUNGA

Ms Lunga is currently working with PACT on CHBC.

This presentation looked at community home based care needs and highlighted what can be done to improve the quality of care.

The following is what Ms Lunga highlighted.

- Capacity building for volunteers.
It is acknowledged that volunteers are the backbone of CHBC.
This capacity building should focus on:-
 - CHBC skills
 - Counselling skills
 - Supervisory skills
 - Setting up structures
 - Psychological support skills (bereavement support)
- Quality assurance
 - Supervisory structures
 - CHBC kits
 - Replenishment of CHBC kits
 - Follow up visits by CHBC coordinators; supervisors feedback

She posed the question, what role can the health system play?

The following are the suggestions given:-

- Scaling up (increasing access to those in need)
 - Catchment area / population
 - Volunteer numbers

- Patient requirements
 - Transport to the clinic
 - Pain relief
 - Food (or nutri packs) to enable patients to take drugs especially anti-TB drugs.
 - Drugs for OIs
 - Psychosocial support
 - Physiotherapy
 - Children's issues where the parents are sick e.g. obtaining birth certificates, school fees and food
 - Will writing
 - Family member/primary carers support
 - Skills training on how to care
 - Respite services
 - Access to counselling and psychosocial support services
 - Materials like gloves, hypochlorite, mackintosh, draw sheets

Equipment for CHBC

- CHBC kits
- Bicycles for supervisors
- Replenishment of CHBC kits

Volunteer incentives (how do you keep volunteers motivated?)

It was pointed out that incentives for volunteers were critical over time given the commitment expected from them in the long run.

Suggestions included:-

- Uniforms
- CHBC kits
- Skills training
- Income generating project funding e.g. soup making
- Refresher courses
- Periodic tokens

Community mobilisation

- Role of the community in CHBC
- Community sensitisation and awareness meetings prevention activities
- Linked to ongoing CHBC program

Administration issues

- CHBC coordinator preferably a nurse
- Finance person
- Transport
- Communication
- Consumables

4.8 IEC Needs to Improve HIV/AIDS Care in Zimbabwe by Mrs J. MUTEIWA

Mrs Muteiwa is the Health Education officer for the AIDS and TB Unit in the MOHCW. She introduced IEC as standing for Information, Education and Communication. She stressed that in all IEC materials the message should be relevant and appropriate. Mrs Muteiwa indicated in her brief presentation that the information currently available is **Basic** and it is on the care of both STIs and TB. The information is in English and the vernacular.

What is needed for quality of care improvement?

The client needs information before the family and the community. However, information that is given at client level focuses on prevention of infection, knowledge of infection, fatigue, pain control and diet. The same information is necessary for the family and community. The other information produced focuses on the psychosocial issues such as fear of pain, isolation, anxiety, death, legal issues, the living, financial issues, art, humour and references to support groups.

At the second level, the IEC materials focus on the affected or worried well or the primary care givers. The information is on the illness itself; palliative care diet and nutrition, infection control and referral procedures.

In her presentation, she stipulated that the community includes professionals. Therefore the community in its varied nature needs information such as:-

- Our update of information on HIV/AIDS
- Communication skills
- Basic counselling skills
- Refraining from stigmatisation

- Positive living with HIV/AIDS
- PMTCT of HIV
- Prophylaxis and ARVs
- Diet and nutrition

The challenges that are there are basically financial and she said that funds are not always available to produce materials. It has proved costly to use the electronic media to disseminate information. She suggested that perhaps advocacy and interpersonal communication would be the best. She thinks that the use of a hotline may be useful.

4.9 Role of Operational Research in Improving HIV/AIDS care by Professor J. MATENGA

Professor Matenga is a Professor of Internal Medicine at the University of Zimbabwe.

According to Professor Matenga research is critical to informed action and policies.

He then said that operational is all about extrapolating research findings from a small sample to the whole population and noting variables of interest such as:-

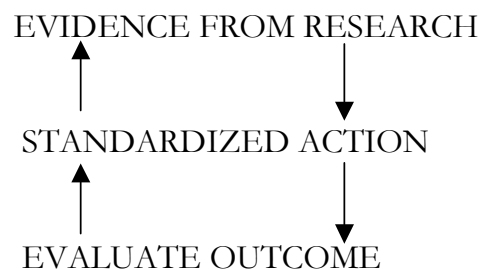
- Does this intervention work in the real world
- Is it practical
- What are the limitations
- Is it cost effective

Prof. Matenga went on to give a few examples:-

- He said that CHBC is an ideal example where there is need to conduct operational research to see whether the availability of the CHBC policy and the Discharge Plan are having an impact on CHBC as practiced in the real world. Another example was the idea of linking introduction of ARVs to the current TB program. One would conduct operational research to determine whether this would work in a real situation, what problems would arise and how may they be solved. He posed some questions saying, would it work given the manpower levels, limited resources and DOTS
- Another example given was that of ARV treatment. Would it work in places with limited resources, ARV drugs, and laboratory capacity to do CD4 counts and viral loads? What about the issue of continued care? On research, he said there is need to compare the role of clinical monitoring to that of monitoring using laboratory tests
- Regarding MTCT of HIV, questions that could be answered through operational research include, when should the tablet (nevirapine) be given

- optimally? What about the issue of drug resistance
- On OIs he indicated that there is PCP prophylaxis and asked whether it should be tagged to TB programs or alternatively, should operational research answer this question

He said that what should be happening is like this:



Professor Matenga said that very often, on issues that concern communities, the communities themselves are not consulted. He maintained that policies should be dynamic and should be able to change with time. Ironically people/institutions/professionals do not exchange information or share information in order to improve the quality of care.

4.10 Integrated Management of TB and HIV Care by Dr P. Dhliwayo, World Health Organisation

Dr Dhliwayo is currently coordinating STIs, AIDS and TB activities between the MOHCW and the WHO local office.

Dr Dhliwayo gave an over view of the treatment and care of HIV/AIDS in the region and said Zimbabwe is no different from Malawi or Zambia. The number of notifications for TB have gone up over the years in the region.

He highlighted the following important issues:-

- That we cannot control TB without controlling HIV.
 - 90% of people living with HIV do not know they are infected
 - Up to 50% of people living with HIV in poor countries will develop TB, which will spread to others
 - People who know their HIV status should be targets for specific TB and HIV interventions

Community HIV groups involved in social mobilisation should include TB on their agenda.

The following are also the five most common OIs reported in Thailand and this situation is not very different from our own:-

TB	27.4%
<i>Pneumocystis carinii</i>	19.5%
Cryptococcosis	16.7%
Candidiasis	5.3%
Recurrent pneumonia	3.7%

Of note is that TB is the commonest opportunistic infection.

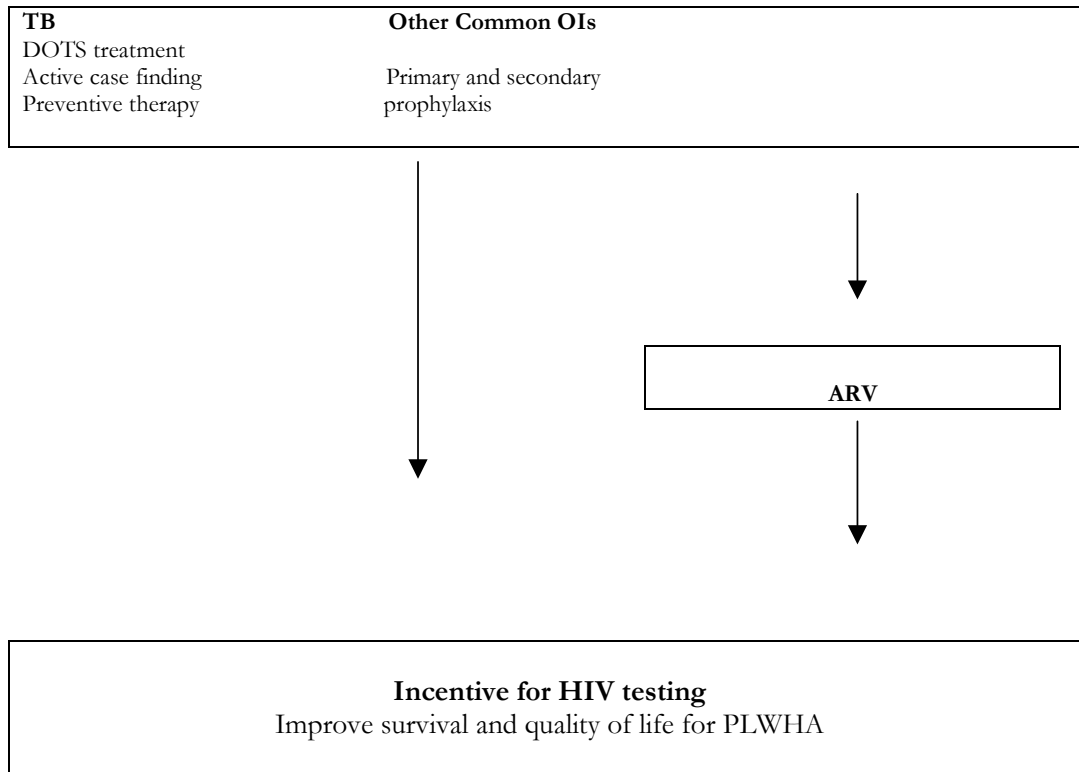
He gave an example of the standard HIV/AIDS Care Package in Northern Thailand where there are accessible VCT centers for HIV. HIV positive clients from VCT centers are routinely screened for TB and either treated for TB if sputum positive or put on TB prophylaxis if sputum negative.

Operational and technical guidelines on IPT

Four main criteria for assessing health center readiness include:

1. Political commitment and support for IPT
2. Effective TB control program
3. Functional laboratory and radiology support
4. Ability to provide VCT and care for people with HIV/AIDS
5. Coordination and referral system.

The following was a model given for effective implementation of TB/HIV/AIDS care.



5. GROUP WORK

The above presentations were followed by group work. Group work was intended to discuss the following topics and come up with critical issues to be considered, areas for more information or research and short term high priority achievable recommendations for improving HIV/AIDS care.

- Group 1** CHBC: What can it reasonably be expected to accomplish and how can that be more fully achieved?
- Group 2** TB and other OIs: What are the achievable priorities to enhance care in Zimbabwe?
- Group 3** ARV drugs in Zimbabwe: Is there a foundation and a basis for expansion?
- Group 4** Mental health needs

- Group 5** Women and HIV/AIDS
- Group 6** Children and HIV/AIDS
- Group 7** Health care worker
- Group 8** Organisational response, including the private sector, and capacity for coordinating HIV/AIDS care in Zimbabwe.

Group work was presented in plenary sessions followed by discussions.

5.1 Group Presentations

Group 1

Home and community based care in Zimbabwe: What can it reasonably be expected to accomplish and how can that be more fully achieved?

Question 1

What is the situation regarding the quality of CHBC?

CRITICAL ISSUES

- Lack of training on CHBC for care givers
- Lack of resources for care
- No standard model of care
- No knowledge of how to practice infection control at home level
- Family of patients not involved in care in hospital but expected to care for patient at home
- Care givers' needs are not met
- No feedback system between home and hospital
- Patient dumping post hospital discharge. Health care workers have no knowledge of where the patient is going or who is looking after the patient at home and with what resources
- Families already struggling find themselves having to care for patient at home
- Confidentiality issues
- Cultural barriers to care
- Lack of patient involvement or empowerment to determine own care needs

- Stigma is a major problem, need for breaking the silence
- Availability of food is a problem and nutritional advice not often given
- No home to go to on discharge
- No discharge plan
- Age of provider an issue. Occasionally too old or too young

KEY INFORMATION OR RESEARCH NEEDS

- Surveys of patients' needs urgently needed
- What do patients consider as quality care
- What are the expectations of patients regarding quality care
- What is the best model of CHBC that can be adopted by the country
- What are the needs of carers
- What are the infection risks of carers

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Utilise research findings currently existing
- Develop exchange programs where lessons can be learnt
- Provide a forum to disseminate research findings and discuss the way forward
- Develop capacity to translate research findings into action programs
- Educate people at household level

Question 2

Are guidelines for CHBC in communities sufficient to guide practice, operations, and resource mobilisation? What are specific information, training, resources, or other needs and priorities? (For GOVT, for CHBC providers, and for clients?)

CRITICAL ISSUES

- Lack of dissemination of policy document and guidelines
- Lack of awareness of existence of policy document and guidelines
- No feedback between policy makers and implementers on policy document performance.
- No training on how to implement policy
- Lack of resources for dissemination and training on CHBC policy

KEY INFORMATION OR RESEARCH NEEDS

- Is the current CHBC policy implementable
- What factors contribute to the fact that some people that PLWHA stay well while others succumb to disease, despite good nutrition and drugs
- What are levels of skills of CHBC volunteers and what is their impact on outcomes

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- GOVT needs to play a major role in CHBC activities
- Improve GOVT's commitment to providing quality care
- GOVT must provide the major resources for CHBC
- Request for better management of AIDS fund with allocations for care

Question 3

Is CHBC adequately linked with medically qualified supervision? How is or can this linkage be strengthened? Are there structures (such as community TB treatment strategies, village health worker programs, etc.) or strategies to build on?

CRITICAL ISSUES

- No standardised supervision by medically trained persons
- No resources to make linkages possible
- Linkages between CHBC and medical supervision are weak
- Discharge plan not implemented

KEY INFORMATION OR RESEARCH NEEDS

- What other models of supervision exist
- Assess linkages between medical supervisors and CHBC

RECOMMENDATION FOR NEAR TERM IMPROVEMENT IN CARE

- Orient health professionals regarding CHBC programs.
- Implement the discharge plan
- Improve health worker knowledge on HIV and AIDS issues

- Disseminate information on nutrition with focus on indigenous foods
- Standardise supervision of CHBC taking into account varied and dynamic situations that exist
- Make available resources to facilitate supervision
- Develop capacity of volunteers with motivation to care for patients
- Develop community mobilisation strategies to support CHBC
- Evaluate what is currently happening
- Decentralise programs on CHBC based on best practices backed by scientific evidence
- Conduct analyses of what exists in communities and promote good practice

Question 4

What are achievable, high priority steps for strengthening CHBC in Zimbabwe in 2002?

CRITICAL ISSUES

- Networking with other NGOs currently weak
- Knowledge of best practice poor

KEY INFORMATION OR RESEARCH NEEDS

- Conduct research on what the dynamics of communities regarding stigmatisation
- Develop monitoring tools for CHBC
- Conduct participatory research on community mobilisation
- What are the methods of mobilisation of communities in generating local resources
- Look for methods of integration of ZINATHA into main stream of care
- Conduct research into the possibility of using cannabis by people with HIV/AIDS for pain relief
- Develop and introduce support mechanisms for people who would have been tested to live positively (i.e. "moving on clubs") for easy access to medical, spiritual, social, nutritional and many other supporting mechanism that improves the quality of life

Group 2

TB and other Opportunistic Infections (OIs): What are the achievable priorities to enhance care in Zimbabwe?

Question 1

What is the situation regarding the treatment of OIs? What factors hinder the delivery of high quality management of OIs ?

CRITICAL ISSUES

- Limited diagnostic ability to diagnose OIs:-
 - Laboratory
 - Clinician availability
 - Clinician training
- Lack of HIV VCT even for patients recognised to have OIs or other symptoms of HIV infection
- Drugs:-
 - Lack of availability, accessibility, and compliance

KEY INFORMATION OR RESEARCH NEEDS

- What is the current practice with respect to diagnosis and management of principal OIs at different levels of the health care system in Zimbabwe
- What OI management protocols can be implemented at a CHBC level

RECOMMENDATIONS

- Get access to free fluconazole donations from manufacturer (and other low cost options for OI management)
- Drugs for treatment of other key OIs should be accessible and affordable; priorities should be determined according to burden of diseases and cost effectiveness
- Training of HCW in diagnosis and management of OIs should be expanded and co-ordinated

Question 2

Do examples exist of best practice for integrating or coordinating TB and HIV care in Zimbabwe? What are the most important barriers to be addressed? What are the potential strategies to address those barriers?

CRITICAL ISSUES

- HIV and TB (and STIs) are integrated at the national Ministry level, but with little to no integration at the service delivery level
- Will integration of HIV and TB services lead to more stigmatisation
- Unclear how best to integrate HIV VCT into TB treatment services in Zimbabwe

KEY INFORMATION OR RESEARCH NEEDS

- How can HIV VCT be best integrated into TB treatment services in Zimbabwe
- Can TB treatment programs, which have a broad coverage in Zimbabwe, be used as a platform for detecting and treating other OIs
- How can issues of stigma be minimised or addressed in integrated HIV and TB programs

RECOMMENDATIONS

- Need to actively explore ways to better integrate or coordinate HIV/TB services down to level of service delivery, including pragmatic issues of clinic space, patient flow, available services (like VCT), lab and monitoring strategies
- Expand health care work force to accommodate the dramatically expanded health care needs related to the HIV/AIDS epidemic

Question 3

CTX prophylaxis is recommended in EDLIZ. Do we understand its use in the private and public sectors? How may we improve the use of CTX? Prophylaxis?

CRITICAL ISSUES

- Lack of information on what is happening vis-à-vis CTX prophylaxis at the service delivery level, including both primary prophylaxis for OIs and secondary prophylaxis for PCP
- Lack of consistent access to CTX on the part of patients and providers
- There are relatively high levels of antimicrobial resistance to CTX in Zimbabwe. How does these influence recommendations for use of CTX prophylaxis in EDLIZ

KEY INFORMATION OR RESEARCH NEEDS

- Assessment of actual CTX prophylaxis (prevalence of secondary + primary prophylaxis, adherence, side effects, effectiveness, etc.) in private and public

sectors

- Feasibility of and optimal strategy for giving CTX, promoting adherence, and monitoring effectiveness and side effects at primary care level
- Potential impact of broader use of CTX on community patterns of antimicrobial resistance

RECOMMENDATIONS

- Assure (and monitor) widespread implementation of secondary prophylaxis for persons diagnosed with PCP and HIV infection
- Implement demonstration projects within operational research framework of CTX primary prophylaxis in public health settings in Zimbabwe
- Monitoring effectiveness, side effects, and resistance
- Consider universal antenatal HIV screening to identify children eligible for CTX prophylaxis
- Consider procurement and assured supply at periphery of CTX as an especially critical drug procurement issue for Zimbabwe

Question 4

What other OIs offer the most feasible areas for improving quality of life in PLWHA in Zimbabwe?

- Candidiasis - highly prevalent; has a great impact on nutrition and quality of life, feasibility of broad access to treatment
 - Gentian violet is widely available, backed up by ketoconazole
 - Does gentian violet really improve quality of life in primary health care center? At district level
 - Recurrence is a major problem
 - Huge advance to get access to donated fluconazole

Question 5

What are achievable, high priority steps for strengthening care for TB and other OIs in Zimbabwe in 2002?

Tier 1

1. Implement a survey or other research study on the current practice and availability of diagnostic and treatment services with respect to diagnosis and management of principal OIs at different levels of the health care system in Zimbabwe (need to obtain baseline information)
2. Implement an integrated HIV counselling, testing, and care service

within TB treatment programs in at least two provincial and municipal settings in Zimbabwe, and carefully evaluate the experience

3. Find or develop a curriculum in diagnosis and management of OIs, and then implement training of HCW.

Tier 2

4. Implement demonstration projects within operational research framework of CTX primary prophylaxis in public health settings in Zimbabwe, monitoring effectiveness, side effects, and resistance
5. Assure (and monitor) widespread implementation of secondary prophylaxis for persons diagnosed with PCP and HIV infection
6. Explore providing drugs for other OIs to TB programs to allow TB programs to serve as framework for treating and preventing other OI
7. Get access to donated fluconazole

Group 3

ARV drugs in Zimbabwe: Is there a foundation and a basis for expansion?

Question 1

What is the extent of ARV drug use in the private and public sector in Zimbabwe? Are guidelines easily available for ARV use?

CRITICAL ISSUES

- 16 ARV drugs currently available for use in private practice - not all registered, not all easily available
- ARVs are also being provided by some mission hospitals, also by some NGOs who do not necessarily have medical training or support. Otherwise, ARVs only available in public sector in programs for MTCT
- Currently, national guidelines are not available (under review)
- Other guidelines are not easily available for practitioners

KEY INFORMATION OR RESEARCH NEEDS

- Need for national treatment guidelines that are approved and available for health care providers
- What support for persons providing ARVs is needed to encourage proper use

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Approve and distribute national treatment guidelines
- Support movement toward broadened access to ARVs in the public sector, in context of comprehensive HIV care

Question 2

Has the use of ARV drugs in private practice been well characterised and monitored? What would be the most cost-effective approaches to consistently improving quality of ARV management in the private and public sectors?

CRITICAL ISSUES

- Lack of accessible information and formal training in ARVs
- Lack of ongoing monitoring of current private sector use

KEY INFORMATION OR RESEARCH NEEDS

- Need to describe actual use of ARVs in current practice.
- Need to define who will be prescribing ARVs publicly so training can be tailored
- How much of sub optimal ARV use is provider driven, how much is patient driven

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Institute a monitoring system for current use - annual audit, of members of ZIMA, pharmacies, pharmaceutical wholesalers, (for example)
- Development of Zim ARV training manual, useful and detailed for all levels and roles of health care providers.
- Identification of specific persons responsible for country wide ARV training - such as creating a specific unit/dedicated staff responsible for training, producing materials, etc.

Question 3

What is the critical infrastructure and system support needed for expansion of ART into the public sector? (e.g. in the areas of clinician supply and training, pharmacy, lab, community awareness and support for adherence with medication regimens, etc.)

CRITICAL ISSUES

- Need for voluntary HIV testing mechanisms to increase appropriate/frequent use of testing in clinical practice (normalise testing for HIV)
- Need for laboratory systems for availability of CD4, viral load, and resistance testing for referral. Don't need to wait for widely available technical infrastructure to implement ARV treatment
- Possible to model based on TB program - levels of care and diagnostics, drug delivery, adherence support (DOTS) - strengthen this existing system for HIV

KEY INFORMATION OR RESEARCH NEEDS

- Need to define levels of monitoring and prescribing roles within the public infrastructure - how far down to go initially
- What is the need for routine non-clinical monitoring
- Need for central experience to then allow determination of decentralised treatment process

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Support the development of reference laboratory capacity
- Consider development of an HIV treatment model structured similarly to current TB treatment - that will ultimately allow for central centers of excellence but, more importantly, provision of ARVs in comprehensive drug
- Delivery and adherence system at the district level
- Develop regional links regarding standardised HIV treatment so that regionally, information and experience can be shared to better tailor treatment programs

Question 4

What are achievable, high priority steps for strengthening care regarding ART in Zimbabwe in 2002? Should the use of ARVs be a major element in Zimbabwe's application for funds from donors and the Global Fund for HIV, TB, and Malaria?

- ARVs should be a major element of Zimbabwe's application to the Global Fund, and they should be complemented by attention to OI prophylaxis and treatment, nutrition, and other important care issues. Strengthening of infrastructure for ARV treatment should strengthen "best practices" for comprehensive HIV care
- Potential GOVT actions towards increasing availability of less expensive

ARVs should be explored - tariff limitations, TRIPS compliance, parallel importing, agreements with drug companies, production of generics. It would be helpful to explore mechanisms by which other countries - Thailand, Brazil, Uganda, and Kenya - have obtained less expensive ARVs

- Define drug delivery needs for widespread ARV use and potential Governmental role in distribution - does there need to be national pharmacy control, stores, security, distribution, etc.
- Decide on classification or categorisation of ARVs in National formulary (EDLIZ)
- Health education and training, that includes not only provider but also patient education on ARVs, is crucial for strengthening appropriate use of ARVs. Patient education could include counselling but also support/discussion groups regarding HIV and ARVs
- Adherence support for ARVs should be an integral part of public ARV drug delivery programs. This may include counselling, education, and also potentially home visits, and DOTS-like approaches
- Monitoring parameters/operational research should be included in ARV treatment programs so that evaluations may be done in real-time to strengthen and revise programs
- Support industry provision of ARVs for employees - this support could include education to companies on potential benefits/cost effectiveness of ARVs, and also informational/training support
- Explore additional international donor support to enhance the provision of public sector ARV availability

Group 4

Mental Health Needs

Question 1

What are the psychological, emotional, or other mental health issues that contribute to the runaway epidemic of HIV/AIDS in Zimbabwe? On the part of the overwhelming majority of persons who don't know their status, on the part of HIV positive persons, on the part of policy makers and on the part of health care workers? What is the role of VCT in alleviating mental health problems?

CRITICAL ISSUES

- Fear of implications of:-
 - Positive HIV status
 - Disclosure
 - Stigma
- Lack of a comprehensive psychosocial support system along with lack of continuum care
- Absence of high equality systematic counselling training at all levels

KEY INFORMATION OR RESEARCH NEEDS

- What are the strategies for breaking the silence surrounding HIV infection
- There is need for operational research on the key elements of psychosocial issues related to HIV/AIDS e.g. anxiety, fear, depression, denial

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Enhance care giver counselling skills at all levels and support through monitoring, supervision and collaboration.
- Holistic care to be a practical reality such that psychosocial care becomes an integral component of the continuum of care.

Question 2

Which of and how do these mental health issues influence the quality of health care for HIV/AIDS in Zimbabwe? What are practical ways of addressing the most critical mental health issues to help improve quality of care for HIV/AIDS?

CRITICAL ISSUES

- Fear by care givers of contracting HIV - reduced comfort levels - barrier to care
- Stigma - barrier to access and to care and support - patient will not seek care for fear of exposing status
- Lack of caregiver support leads to emotional exhaustion and burnout and compromises quality of care and decreases motivation

KEY INFORMATION OR RESEARCH NEEDS

- Identify ways of demystifying mental health issues related to HIV/AIDS
- Develop indicators of psychosocial needs of communities

Question 3

What are achievable, high priority steps for making headway on addressing mental health needs regarding improving health care for HIV/AIDS in 2002?

- Make psychosocial needs/issues an integral and indispensable component of care - by end of **workshop**
- Undertake a situation analysis on quality of VCT services and psychosocial support services
- Ensure integration of psychosocial issues into the whole continuum of care:-
 - Need for a task force, which will liaise with the HAQOCI
 - Put into operation the concept of psychosocial care as to demystify HIV/AIDS. Highlight its various facets i.e. psycho-emotional, social, etc.

Group 5

Women and HIV/AIDS

Preamble

- In Zimbabwe the prevalence of HIV infection is higher among women compared to men especially in the young age groups
- In the young age group up to 19 years of age the ratio of HIV infection is six girls to one boy
- Women are infected at a much younger age compared to males.

Question 1

Consider findings and recommendations from Day 1. What are the gaps in women's health needs regarding HIV/AIDS that were not addressed?

CRITICAL ISSUES

Gaps in women's health not covered include:-

- Burden of home based care is carried almost exclusively by women who might be infected themselves (including the increasing burden of orphans)
- Cultural expectations are that even when sick, women should continue to be carer givers
- Women have limited access to information in all forms and are also economically disadvantaged

- May have information but not the power to make decisions even about their own health
- Cultural practices increase risk of HIV infection e.g. wife inheritance, early arranged marriages
- Post rape HIV prophylaxis and comprehensive care, not readily available

Question 2

Plans are underway for scaling up programs for prevention of mother-to-child transmission (PMTCT) of HIV infection in Zimbabwe in 2002. What are the threats and opportunities to women's health? What is a minimal package of services to promote for HIV positive women in such settings without unduly constraining the expansion of PMTCT? How can we monitor improved quality of care for women in such a context?

Scaling up of PMTCT Programs

- GOVT of Zimbabwe through MOHCW has accepted the establishment of PMTCT sites (recommend two sites per province)

Opportunities

- To expand health education and VCT
- To involve partners (husbands invited to antenatal clinics)
- To improve obstetric care and extend coverage
- To link PMTCT activities with other ongoing health promoting activities
- To provide PCP prophylaxis

Threats

- An additional burden for care givers who are already overworked
- Increasing psychosocial pressures on the health workers
- It may lead to disruption within families and increase domestic violence against women

Minimal Package of Services to Support HIV+ Women

Preamble

- About 50% or less of women come for antenatal care
- 30 to 40% of pregnant women deliver in health facilities and very few come for post natal care
- Unless the above figures are improved the PMTCT program will cover only

a small percentage of mothers

Proposals for the minimum package - to be financed from the AIDS levy ASAP include:-

- **Antenatal**
 - VCT and improved health education
 - Breast feeding counselling
 - Family planning - involvement of partners
 - Screening for STDs and treatment
 - Provide condoms - emphasis for baby protection
 - Identification of symptomatic HIV infection and need for CTX prophylaxis
 - Nutrition education + micronutrients supplements

- **Intrapartal**
 - Educate caregivers on "Modified Obstetric Practices"
 - Provide ARV in use - depending on the protocol

- **Post Partum**
 - Continuous health education and psychosocial support
 - Breast feeding education and support of chosen infant feeding
 - Method - may include free formula
 - Family planning and continuing condom use
 - Continuous PCP prophylaxis as appropriate
 - Continuous micronutrients supplements especially if breast feeding
 - Provide nutritional support for the very poor
 - Screening for cervical cancer

Monitoring of Improved Quality of Care for Women

Preamble

Currently difficult since only 30% of mothers come for post natal care and there is a shortage of staff.

To implement monitoring:-

- Develop a discharge plan utilising existing community support groups and home based care providers and village health workers (where available)

Question 3

What are the information, training, research, or other associated needs and opportunities? Are there structures (women's clubs or associations, other?) to take advantage of or link with, to efficiently expand knowledge and access to needed services for HIV positive women?

Training and Orientation of Health Workers on the New Intervention Programs

KEY INFORMATION OR RESEARCH NEEDS

- How can women's participation in PMTCT be increased? (For instance in one mission hospital which offered PMTCT for the whole year, with an average of 100 deliveries per month, only nine women accepted the intervention)
- Situation analysis of maternity care and needs assessment from the women's perspective
- How to increase the participation of males in all HIV related issues
- What participatory research methods can be used

Question 4

Overall, what are achievable, high priority steps for strengthening care for HIV positive women in 2002?

Pregnant Women

- Minimum PMTCT package is achievable if AIDS levy or other funds are available
- Screening for cervical cancer
- Inviting husbands to the antenatal clinic
- Ask husbands/men to bring wives/partners when they present with symptoms
- Re-orientation of health care providers to focus on "couples"
- Identifying ways of increasing numbers of women participating in PMTCT programs

Non Pregnant Women

- Identify through VCTs, support groups, symptomatic partners and health institutions
- All infected women should be given health education and effective family planning free of charge

- PCP prophylaxis for symptomatic women free of charge

Ultimately, all women with symptomatic infection (AIDS) should be treated with ARV drugs free of charge including nurses.

Group 6

Children and HIV/AIDS

Preamble

Children are not being identified as HIV infected frequently enough to benefit from services at all levels - funding, medications, support services, mental health services. Also, as many organisations that address the needs of children have a variety of responsibilities, the immediate needs of children may be overshadowed.

Question 1

How do the priorities and recommendations for Day 1 apply to children? What is the situation regarding the quality of care of HIV infected infants and children?

CRITICAL ISSUES

- There are no available guidelines for quality of care for HIV infected children
- Quality of care of children is intricately linked with treatment of children. There is a lack of resources for child health in general
- Children may not be evaluated for HIV+ or referred for evaluation when they present with illnesses, when their parents present with illnesses, or when they are seen to be ill by other community members (such as in schools)
- HIV seronegative orphans also have care needs that have not been addressed

KEY INFORMATION OR RESEARCH NEEDS

- What resources are or are not available and what are the constraints to making resources available locally
- What are the psychological and physical care needs of children whose parents are critically ill, and what is available to meet these needs
- What are the barriers to diagnosing children with HIV (among health workers, among family, etc) and how can these barriers be reduced

- What are the additional needs of older children with HIV. What resources are needed for older children to deal with their HIV status and to prevent further transmission

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Need to start support groups for meeting the needs of children especially those whose parents are critically ill with HIV
- Need to increase advocacy for testing and diagnosis of children/increase information given to parents regarding their HIV status
- Need to determine an approach and provide resources for dealing with HIV in older children/adolescents, age specific information, regulations/structural barriers regarding direct discussions with children, support for parents/caregivers in how to discuss HIV with their children
- Need to approve and disseminate guidelines on treatment of HIV infected children

Question 2

What structures or initiatives exist in Zimbabwe to provide leadership on care for the child with HIV/AIDS?

CRITICAL ISSUES

- Existing structures or initiatives with some involvement in children's issues include: NAC, MOHCW, NGOs, Village Health Committees, District Health Committees, faith based organisations, other local institutions
- No single structure currently coordinates activities among these organisations or provides leadership for children's care issues
- Parents may not be aware of existing structures and initiatives in their communities and thus may not utilise existing care services

KEY INFORMATION OR RESEARCH NEEDS

- What initiatives exist for supporting the care of children in different communities - including organisations that provide services to children in particular? (Need easily available listings)
- How can parents or caregivers better access existing resources and be integrated into activities

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Define a leadership position (central coordinator) so that the incumbent can help expand, train, and coordinate efforts of organisations/committees that currently address needs of children
- MOHCW should consider working directly with the Department of Social Welfare and multidisciplinary agencies (Departments of Education, Social Welfare, Agritex, Youth and Gender, Police, churches). Need to address the needs of the children
- Within existing care structures, identify one person who is directly responsible for needs of children who will serve as a focal point for coordination of activities
- Linkages between educational system and health care system should be strengthened - children identified as being in poor health in school need to be linked to health care centers for evaluation

Question 3

What are achievable, high priority steps for strengthening care of HIV/AIDS/TB/OIs for children in Zimbabwe in 2002?

CRITICAL ISSUES

- CTX not consistently available for prophylaxis; liquid formulation needs to be available for children
- Children must be diagnosed with HIV in order to be identified as in need of primary and secondary prophylaxis
- Contact tracing for adult TB cases has broken down in some cases, and children may not be identified/receive necessary treatment
- Education on diagnosis and treatment of OIs in children may be lacking at a variety of health care levels - especially in rural areas

KEY INFORMATION OR RESEARCH NEEDS

- What is the current practice in diagnosis and management of OIs for children
- What is the optimal strategy for provision of prophylaxis
- What is the level of expertise/awareness among health care providers in diagnoses and treatment of OIs in children
- What is the potential impact for community resistance to CTX, which is used to treat other childhood illnesses

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Identify a person at the national (preferably) and/or local level with primary responsibility for monitoring and improving care for HIV/AIDS/TB/OIs among children
- Coordinate activities between NAC, schools/Ministry of Education, local NGOs in order to better identify potentially HIV infected and affected children and to direct funds/resources accordingly at a local level/schools and parental support groups/local NGOs may be very important sources of information
- Increase testing and diagnosis of HIV among children so that primary and secondary prophylaxis may be offered, and so that those who can benefit from NAC funds and services may access them. Sensitise all stakeholders - parents, clinical care providers, teachers, etc; on the need to identify potentially ill children so that services can be provided
- Strengthen contact tracing of smear positive TB patients' parents to identify children in need of TB treatment or prophylaxis
- Evaluate current practices in training, diagnosis, and management of OIs in children
- Increase consistent availability of CTX for prophylaxis
- Evaluate barriers to diagnosis of HIV among children

Question 4

Should ARVs be offered to children? If so, should these be offered to children of all ages or targeted to specific age groups? If targeted which age group should benefit most?

CRITICAL ISSUES

- ARVs have the potential of decreasing suffering from opportunistic infections and enhance the quality of life
- Adherence to ART is vital for a successful outcome and the following factors impact on adherence
- Affordability of ART is currently a problem
- Level of motivation or commitment of parent/caregiver to the child's lifelong therapy
- Parental/caregiver understanding that poor adherence is the single most important factor associated with drug failure or resistance and that it compromises future therapeutic options

- Extended family should be involved in decision making regarding initiation of ART and should be intricately involved with ongoing care
- Criteria for selection of patients for initiation of treatment (particularly if relying on donor funds) must be addressed
- Age groups may be difficult to use as criteria due to challenges in HIV diagnosis in infants. May need to rely largely on clinical criteria

KEY INFORMATION OR RESEARCH NEEDS

- Operationally, how can treatment and monitoring (response to treatment and side effects) be implemented in an effective way
- What is the extent and pattern of ARV use in children in the private sector currently? How are the adherence issues being handled? It may be interesting to obtain information from the care givers or even the children

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Design and disseminate ART guidelines for children and organise training to guide appropriate use of ARVs. Standardise ART guidelines and training
- Perform operational research on children being treated with ARVs in private or public sectors
- Scale up PMTCT programs and strengthen programs to enhance the survival of HIV infected parents.
- An AIDS free generation is most desirable but who could do a better job of raising these children than their own parents. Therefore treat the parents

Group 7

Health Care Workers

Definition of Health Care Worker

Health care providers are either formal (trained/skilled/professional) or informal. These groups will need to be to be considered separately.

Question 1

How does caring for HIV affected persons affect the health care provider and caregivers in the community? Do the diverse impacts of HIV/AIDS on health care workers (HCW) have an impact on the way they care for clients and patients with HIV/AIDS? Has that impact been adequately addressed, or how can it be optimally addressed? What is the level of

mental stress and burn out related to providing care to HIV/AIDS patients (private and public sectors)? What is the solution to this problem?

CRITICAL ISSUES

- High level of stress – frustration, because of poor working conditions, staff shortages and multiple bereavements
- Low staff morale
- Burn out - overwhelmed by the numbers of sick people, both at work place and home and in one's own community
- Multiple bereavements give a sense of hopelessness
- Lack of support systems supervisory counselling, debriefs both at :-
 - Institutional level
 - Community level
- Inadequate resources available for trained personnel, materials, drugs, care kits etc.
- Weak referral system
- High personal risk area of work
- Training inadequate e.g. training on self care, new drugs, avoiding stress and high attrition rates
- Fear of getting infected, helplessness, high staff absenteeism
- Staff attitudes towards patients who have more information than HCW e.g. regarding new drugs

KEY INFORMATION OR RESEARCH NEEDS

- Review SAFAIDS research
- Assess needs i.e. living experience of HCWs and the informal sector care giver
- Assess the situation regarding sick leave, absenteeism, resignations

RECOMMENDATIONS

Formal Carers

- Provide training of HCWs on e.g. self-care, recognising signs of burn out, prevention of infection, post exposure treatment
- Provide insurance for the infected care giver to enable access to free treatment
- Provide support systems including emotional and psychosocial support
- Provide resources for personnel to enable health worker to go on leave – and for drugs, protective clothing, etc.

- Improve conditions of service and give risk allowance, better working hours to avoid burnout

Informal Carers

- Provide respite care
- Provide training e.g. basic care, hygiene, self-protection, nutrition, and supervisory structure
- Strengthen referral system - give information on where to get help
- Develop incentives for providing prolonged care
- Revisit the curriculum for CHBC and strengthen it
- Provide resources for care from:-
 - Social Welfare
 - AIDS Levy
 - Global AIDS Funds

Question 2

Based on recommendations from Day 1, what are the information, training, research, resources, or other needs for HCWs needed as part of a national, multisectoral response to improving quality of care for HIV/AIDS?

CRITICAL ISSUES

- No training
- No recognition of burn out
- Lack of up to date information

KEY INFORMATION OR RESEARCH NEEDS

- Research on the magnitude of the problem and needs
- Situational analysis on training and resource availability levels on a national scale

RECOMMENDATIONS

- Training
 - Counselling/communication skills
 - Self-care and recognition of burnout
- Skills for recognising burnout and caring for other HCWs
- Provide up to date information for health care providers to boost confidence

Question 3

What are achievable, high priority steps for supporting HCWs as part of improving the quality of care HIV/AIDS in 2002?

CRITICAL ISSUES

- Conditions of service, remuneration, risk allowance
- Provide training at all levels on the following:-
 - Self-care, recognition and management of own burn out
 - Nutrition
 - Recognition and management of OIs
- Provide supportive infrastructure and resources
- Provide counselling services, debriefs etc. for care providers
- Monitoring and evaluation of how staff are coping
- Revisiting training curriculum for HCWs to assure appropriateness
- Create halfway homes from the AIDS levy
- Revisit HIV/AIDS policies in respect to confidentiality of information given about patient's condition to spouse and care giver

Group 8

Organisational response, including the private sector, and capacity for coordinating HIV/AIDS care in Zimbabwe.

Question 1

What is your impression or experience of the quality of HIV/AIDS care delivered in the private sector?

CRITICAL ISSUES

- Great diversity of "private sector", some large businesses have comprehensive HIV/AIDS programs, but unclear across range of businesses
- To properly address "private sector", we will need to identify categories of different segments and ways to approach each
- Large businesses with self-contained health services (Hippo Valley, Triangle, etc.)
- Private employers with medical assistance plans
- Private hospitals, clinics and other group practice
- Solo practitioners in private practice

- Non-governmental, non-profit organisations (Island Hospice, most other ASOs, etc.)
- Very uneven practice in private practitioner sector; encounters often indicate lack of sophistication in dealing with HIV/AIDS care issues
- Private practitioners typically accommodate to patient needs and preferences - this has advantages for patients, but may not represent good quality of care by standards of medical and public health practice
- Suspicion that private practitioners often either lack communication skills or are reluctant to provide or promote access to HIV testing, either to not upset patients or even to maintain a full practice
- Private practice has an enhanced image, so important for good quality care to be modelled in private practice and in large companies with adequate resources
- Spontaneous development of HIV Medicine Association of ZIMA and similar groups reflect interest willingness of private providers to adopt guidelines and promote quality of HIV/AIDS care within the sector

KEY INFORMATION OR RESEARCH NEEDS

- What are practice patterns regarding HIV/AIDS in the private sector (including each of the categories of private sector care listed above)
- Do private sector care providers know about, have access to, and follow Zimbabwe guidelines re HIV/AIDS policy and HIV/AIDS care (e.g. the national HIV policy, EDLIZ guidelines on CTX, guidelines for ARV use, etc.)
- Where does the private sector get its updated HIV/AIDS information? Do they know that they can get information from the medical library? What are the needs and what are the cost effective and accessible

RECOMMENDATIONS FOR SHORT TERM IMPROVEMENT IN CARE

- Implement situation analysis and needs assessment of private sector for information for HIV/AIDS care
- Make training in HIV management more widely available
- Support and strengthen ZAN to serve as an efficient and cost effective way for MOHCW to promote high quality CHBC being provided by all NGOs in Zimbabwe

Question 2

Are there areas where the private and public sectors could work together to the benefit of the patient? If so, which are these areas and who should take the initiative?

CRITICAL ISSUES

- Information dissemination
- Training on skills sharing
- Must promote concept of **shared** responsibility for promoting information dissemination and sharing, (ZIMA, ZAN, PACs, HAQOCI, etc.) not just MOHCW that always must take the initiative
- Can donated Nevirapine from Boeringer-Ingelheim for PMTCT be used in private sector (like EPI vaccines?)? What about allowing supervised use by private providers of TB drugs? Are policies needed to govern such use

KEY INFORMATION OR RESEARCH NEEDS

- Need to evaluate medical and health promotion practices across private and public sectors in Zimbabwe, with a goal of identifying "best practices" for the cultural and health services context of Zimbabwe

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Multi-sectoral responsibility (possibly Task Force) for promoting coordination and communication - not just one way communication flowing from MOHCW to private sector
- Research on "best practice" models that cut across public and private sector practice and help to link the two
- Public sector may play critical role in creating access to donated drugs (e.g. fluconazole)
- Promote linkage systematically and in diverse ways between public and private sectors (including NGO sectors)

Question 3

What are two to three achievable, high priority steps for strengthening HIV/AIDS care through or in coordination with development of district AIDS action plans?

CRITICAL ISSUES

- How does the health sector, including CHBC providers, interact with or be represented at DAACs
- Should discharge planning for HIV/AIDS patients or other AIDS care needs be an issue for District AIDS action plans

KEY INFORMATION OR RESEARCH NEEDS

- How is the health sector, including CHBC, represented in DAACs
- Which facilities and organisations are providing good quality care (including CHBC) in each district? Does the DAAC have that information? Is it using it to provide services to the most efficient organisations? Is system of accreditation needed

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Need to connect the District Hospital (which is supported and supervised by MOHCW personnel and resources) with DAAC program.

Question 4

Who (which organisation and post) is the focal point(s) for coordinating, promotion information sharing, and otherwise enhancing these diverse efforts in HIV/AIDS care at the national and provincial level? How can this process of quality improvement be effectively and acceptably monitored?

CRITICAL ISSUES

- Central-NAC/AIDS/TB Unit, Province-NAC Coordinator/MOHCW (PMD Office), ZAN represented in PACs/DAACs
- "Quality of care" new concept not included in the original NAC/PAC/DAC set up

KEY INFORMATION OR RESEARCH NEEDS

- Need to incorporate concept of quality of care into cycle of setting priorities, determining best practice, setting standards, implementation of plans, monitoring and evaluation
- NAC need to have mandate and capacity to carry out this monitoring and evaluation process

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Strengthen capacity of NAC for monitoring and evaluation
- Scale up from central level

Question 5

Who is responsible for monitoring and coordinating? Comprehensive HIV/AIDS care within MOHCW facilities at the district and provincial levels? What tools and resources do those leaders have available to them?

CRITICAL ISSUES

- Structures, posts, functions already in place; with networking of varying degrees
- But resources are inadequate (staff, transport, finances, etc)
- Scrambling for funding, splintering of activities and not always well coordinated

KEY INFORMATION OF RESEARCH NEEDS

- Details of organisations carrying out AIDS control activities
- Extend of overlap of activities

RECOMMENDATIONS FOR NEAR TERM IMPROVMENT IN CARE

- Mobilisation of more resources from other sectors (private, NGO's)
- Better networking of organisations involved in order to pool resources and minimise competition

Question 6

What are the most critical needs from MOHCW at national level being experienced at provider levels? Is staffing sufficient? What would be a minimal complement of staffing for coordination at the national, provincial, and district level?

CRITICAL ISSUES

- Staffing insufficient at all levels, many established medical posts vacant, many persons assigned to HIV/AIDS responsibilities as additional responsibilities in addition to other duties (e.g., STI coordinator, health educator, etc.)
- Restructuring process led to downsizing; process very unlikely to be reversed
- New structure currently at national level only. Too early to assess how this affects activities at peripheral levels

KEY INFORMATION OR RESEARCH NEEDS

- Prioritize needs - staff, money, equipment, drugs for OI treatment
- Need to have basic tools to be able to deliver quality HIV care

- Transport a particularly critical area, one where NGOs and other partners could be of assistance

RECOMMENDATIONS FOR NEAR TERM IMPROVEMENT IN CARE

- Minimum of one person at each of provincial and district levels to coordinate activities
- Need closer liaison between MOHCW body responsible for CHBC, NGOs and other partners in HIV care
- "Fast track" development of new MOHCW structures at lower levels in order to fully appreciate optimal staffing levels in relation to functions required

Question 7

What are two to three achievable, high priority steps for strengthening coordination for HIV/AIDS/TB in Zimbabwe in 2002?

- To treat HIV/TB as "brother and sister" in IEC campaigns
- To increase resources (staff, training, drugs) to national training programs in order for it to cope with increased workload (counselling, treatment of OIs, etc.)
- The need for VCT at every TB clinic, to increase openness and reduce stigma
- To improve referral system between VCT services and TB diagnostic and treatment centers
- To develop OR to look at ARV drugs and ATT in urban and rural settings, public and private sectors
- The need to urgently reconsider staffing at national level: the few people currently there are stretched, and priorities regarding HIV/AIDS care are not always clear
- The need for health services and economics research directed to staffing patterns at MOHCW. Is staffing sufficient to promote national coordination and therefore assure cost effective use of national and international resources for HIV/AIDS

DEFINITION OF QUALITY OF CARE FROM PARTICIPANTS OF THE MEETING'S PERSPECTIVE.

Mr Chingono asked the participants to express what, from their point of view, constitutes quality of care and what has to be done to improve the quality of care. The following are the responses that came from the participants themselves.

What Constitutes Quality of Care?

- Provision of holistic care, meeting the biopsychosocial needs of the client
- Good diet and health, free of OI and stress
- A continuum of care where there is open communication and treatment of OIs. It is about measuring minimum standards in caring for those with incurable diseases
- A holistic approach that encompasses physical social, psychological and spiritual care for both the patient and his family. It is resource availability, training and skills sharing and support for carers
- Providing comfort including food, pain relief, emotional and social support enabling people to help themselves
- Changing behaviour and attitudes towards the disease and breaking the silence so that others may gain courage.
- Receiving love and getting medication
- Getting ARVs and treatment of OIs
- Getting food, drugs, school fees for children
- Receiving friendly and caring help
- Having structures that are well defined, CHBC and CBC
- Having your basic needs met and being able to meet these needs cheaply
- Adequate, prompt and appropriate interventions including health care provisions
- Education and awareness campaigns focused on behavioural change
- Quality human resources, quality information and involvement of local leadership.
- Receiving financial support and support to families
- Provision of essential drugs, and having a clear policy put in place
- Provision of resources such as drugs, infrastructure, shelter, linen and care workers
- Having a good diet and psycho-social support and basic health care
- A holistic approach based on the need to live positively with the virus, prevent rapid progression of disease and empower patients to actively participate in the control of their treatment. Having timely access to support systems both medical and psychosocial
- The use of CTX and prophylaxis and provision of ARVs
- Adequate knowledge of the condition
- Sensitive legislation of OIs and to avoid contracting STIs
- Giving clients the self-respect they deserve and enabling them to be well cared for
- Enabling people living with HIV/AIDS to live as full a life as possible

- Getting VCT
- Taking care of both the affected and infected
- Having a multi-sectoral approach to care
- It entails communication and assessing whether the patient understands their condition, the discharge plan, informing the family or community and putting support systems in place
- The provision of the necessary resources to care givers

What does Improving Quality of HIV/AIDS Care Entail?

- Meeting the physical needs, i.e. food, drugs, linen and psychologically, the provision of counselling services and emotional support
- Providing essentials including drugs, nutri-packs, and psychosocial support
- Enabling patients to be as independent as much as possible and coordinating the efforts of all those who enable patients to achieve the points outlined above
- An improvement in behaviour change by not stigmatising the ill.
- Knowing one's rights and providing people with HIV/AIDS training skills on CHBC
- Treatment of OIs and getting nutritious food, hygiene and psychosocial support
- Having political will and commitment to the whole issue of HIV/AIDS and getting financial banking
- Counselling, nutrition and CHBC
- Giving respect, being friendly and understanding of circumstances and providing care in response to or guided by a needs assessment
- Being responsible, effective, loving and able to share
- Having team spirit; promoting condom use and empowering the PLWHA logistically
- Access to affordable treatment and food provision
- Research and interviews with people concerned and knowledge and training on the part of the carers
- Training of volunteers and giving the volunteers incentives
- Improving the availability of drugs
- Giving health education, vital statistics and support both locally and externally
- Provision of quality CHBC and well-trained primary care givers and care facilitators
- Having a collaborative approach from all stakeholders
- Providing basic drugs and nutrition packs

- Mass education of the public and health workers at all levels on what constitutes quality care
- Having an integrated approach and strong collaboration with stakeholders
- Improving nutrition
- Doing baseline data on what care the HIV/AIDS patients are receiving and identifying gaps in care and the reasons for them and attempting to address them
- Prolonging life expectancy
- Providing the missing links
- Providing the minimum basic requirements of the health care provider
- Dialoguing progress, constraints and achievements and charting the way forward
- Stakeholder involvement
- Making available more resources and setting up a system for monitoring
- Setting goals and objectives to meet health interventions that are well implemented, monitored and evaluated to determine the effectiveness of care
- Reducing stigma, improving diet, drug compliance and community empowerment
- Providing adequate funding, teamwork, coordination and avoiding duplication of activities
- Increasing the number of counsellors at the clinic
- Providing knowledge of available facilities. Ensuring proper training of staff and other caregivers
- Making available health insurance to facilitate treatment of caregivers
- Breaking the silence
- Capacity building of existing initiatives

PLENARY COMMENTS FROM GROUP DISCUSSIONS

Group 1 Discussion

CHBC

With respect to Group 1's presentation on CHBC, plenary thought was that:-

1. There was very little information dissemination and often no feedback on what is happening on the ground.
2. It was pointed out that the existing policies on HIV/AIDS and care giving have not been evaluated to test their feasibility.

3. No proper research has been carried out to ascertain why some people who suffer from HIV/AIDS succumb to the disease early while others manage to contain it longer.
4. The role played by GOVT is not clearly spelt out, especially in resource allocation for CHBC. Questions raised were who and what type of resources and when and how often should these be made available.

There was heated discussion on what happens when a patient is discharged from hospital. Health personnel said that there was a discharge plan but it was only known by a few. PLWHA said often the health personnel do not know where the patient is going on discharge, or who was going to be taking care of them. They also said that even some health personnel do not know the realities of HIV/AIDS except the learned. They have no idea of what happens when a patient goes home.

The participants kept reminding each other that their objective is to improve the quality of care. Therefore they kept on discussing the discharge plan and the home based care policy document and agreed that they needed to review them to ensure that people involved in client care are well informed. They also agreed amongst themselves that transparency is lacking between MOHCW and service organisations. The argument was that information is not being properly disseminated to implementers of policies.

They recommended that hospitals establish care groups that are taught how to take care of patients (or protocols for implementing the discharge plan).

Group 2 Discussion

TB and OIs

Issues raised were the following:-

1. CTX resistance. They said it was necessary to monitor CTX resistance, because some argued that CTX is not 'working' for ordinary infections but works for PCP.
2. There is need to carry out a situational analysis of what is happening to those discharged after being on PCP prophylaxis. Need to do a cost-effectiveness analysis of CTX and also to ascertain the entry point of CTX prophylaxis and who should give it.
3. Also discussed were drugs appropriate to HIV/AIDS.
4. It was highlighted that there are some people who react to sulphur and it was suggested that alternatives could be found e.g. dapson.
5. Laboratories were not always within reach and tests could be limited. However

someone was quick to say that ideas can be borrowed from Professor Latif's syndromic management approach

Group 3 discussion

ARVs

Issues raised on the use of ARVs in Zimbabwe were the following:-

1. The critical issue was the type of food that PLWHA should eat. The argument from an infected person indicated that it was better to get healthy food than ARVs because of their side effects.
2. He also cited affordability and availability of drugs. The question posed is that of one drug being available today and not available tomorrow so it becomes unsuitable. Important to note also was rate of infection versus supply of ARVs therefore ARVs are NOT THE BE ALL AND END ALL!

Group 4 Discussion

Mental Health Needs

There was no discussion that followed this group presentation.

Group 5 Discussion

Women and HIV

Issues raised included:-

1. Structures. Maternity homes are not friendly to men; there are no toilets and no privacy among patients making it difficult for husbands to be involved in their wives health.
2. Cost recovery measures have made the health-related gains of five to 10 years ago. Antenatal care attendance had plummeted from 95% to 65%.
3. Disagreements arose on the issue of payment where ministry officials were saying antenatal care is free and others saying women are being detained for a day or more until they pay hospital fees. Ministry officials were challenged to go and see for themselves what is happening at Harare Hospital. In fact this means that there was a variance between policy and implementation, urban and rural practices.
4. It was suggested that part of the AIDS levy be directly targeted at women

as a special group since they are affected as well as infected in their multiple roles.

Group 6 Discussion

Children and HIV

Issues raised were:-

1. In terms of information, there was no age specific IEC material available targeted at those below the age of 18 years.
2. Facilities that are available for the youth are not publicised.
3. How can children be dealt with? Pediatricians are not consulted for information as has happened in the drafting of Children's Act.
4. That in terms of treatment, children need syrups and not capsules (ARVs) and these are not available.
5. The street kids are a special group that needs to be taken care of.
6. Where does a practitioner draw the line between infancy related illnesses and diagnosis of HIV/AIDS.

Group 7 Discussion

Health Care Workers

Who guards the guards was the issue!

1. The number of people who went into this group was small, which was a reflection of how great the burden is on the very few health workers.
2. There is need to review conditions of service so that the great trek can be reduced.
3. There is need to recognise that HCW do need counselling and help with stress management and failure to recognise how stressed they are would compromise the quality of care.

Group 8 Discussion

Private and Public Sector Organisational Response

Two issues were raised:-

1. How can information be obtained from private doctors if they are allowed to treat TB and HIV?
2. How far can treatment or administration of ARVs go in the current economic environment?

Way Forward by Professor J. Matenga

He highlighted the following as the most important issues in providing quality care:-

- HIV/AIDS is a burden for Zimbabwe
- Our population is 12 million yet the overall prevalence is at about 25%
- So far prevalence of infection in antenatal clinic attendees is at 35%
- Annual deaths recorded are about 131 000
- The number of orphans is at 726 500 cumulative
- Bed occupancy in the major hospitals is between 50% and 70% for HIV cases

Quality of comprehensive care according to Professor Matenga should encompass; prevention of transmission, sound clinical management and nursing care accompanied with counselling and social support.

He emphasised that CHBC is achievable, only if it is clearly guided by evidence based policy e.g. the Discharge Plan and training given at all levels. He, however, emphasised the need to review, discuss and streamline the referral system. In the long term, he called for the evaluation of the TB and OIs treatment currently done. According to him, and verified by others present, prophylaxis was not being done.

High on the list of priorities that can be accomplished are a **situational analysis on the number of re-admissions of OIs and the cost of hospitalisation.**

This information he said can be used for advocacy purposes. He gave an example of how through advocacy Britain was made to revisit its health policy following an accident and a fracture to one old lady's hipbone. He said that the case raised a storm in a teacup to a point where the issue was discussed in parliament, pressing the GOVT to commit itself in the process.

He said that, for example, there is controversy over ARVs. There are no clear

treatment guidelines regarding them and there is really no one who is taking stock of who has been treated by use of ARVs both in the public and private sectors.

On mental health needs, Professor Matenga said, "**this was fragmented**". However, he went on to elaborate on research needs regarding health workers, such as why they are absent from work; and is early retirement the best? These research findings could be used to advocate for improvement in the conditions of

service for health workers.

Regarding children, he said it was paramount to know the children's needs, but advocated prevention through strengthening the MTCT prevention through strengthening the MTCT prevention strategy already in place. He also highlighted the need for psychosocial support through the involvement of other professionals such as child psychologists, child counsellors, social workers and peer and other support groups.

A question posed was:-

How much of the AIDS levy is directed to children who are HIV/AIDS victims?

Conclusion

The conclusion was in the form of "food for thought," he said. **"Until the population recognises that it is their right to quality health care, and they ought to demand it, the health provider is not likely to take any action."**

Vote of Thanks

Dr C.E. Ndhlovu heartily thanked all the participants and especially thanked the following:-

- presenters of papers
- chairpersons of sessions
- organisations present
- participants
- MOHCW
- UZ
- CDC
- NAC
- NDT PAC
- Holiday Inn

Dr Ndhlovu specifically thanked Dr Rose Kambarami for working tirelessly to get everyone to come to this successful workshop and Mike St Louis and Shannon Hader for their technical and financial support. She wished everyone a safe journey home.

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