Treatment Optimization Initiative Meeting III report:

"Decentralization of HIV Prevention, Care and Treatment: Linking Community level Interventions with health care delivery systems."

Convened by NAC and supported by UNAIDS, ZAN, MOHCW, WHO and Pangaea Global AIDS Foundation

Bronte Hotel, Harare, August 6-7th, 2012

1. Background

On the 29th of March, the Ministry of Health & Child Welfare co-hosted, with WHO and Pangaea, a national meeting entitled, *"Decentralization of HIV Prevention, Care and Treatment: Linking Community Interventions with health care delivery systems."* This meeting explored the challenges faced as the country endeavors to expand geographic access to HIV prevention, treatment, and care services but with a special focus on HIV Treatment and Care issues.

Participation in the meeting included representatives from organizations supporting HIV prevention, treatment, care services in Zimbabwe, including a mixture of policy makers, facility and community-based service providers, health managers, technical experts, HIV treatment funders, and the beneficiaries of HIV services especially people living with HIV. Approximately 100 people attended, 30 of which were from outside Harare. All participants were provided with IEC materials on the MOH&CW 2011 decentralization guidelines and the WHO 2010 HIV/AIDS treatment guidelines.

Key themes were identified as priorities during the meeting, including the importance of community systems in the care and treatment of people living with HIV, and the need for these community systems to be integrated with care provided through health facilities.

It was decided that a follow-up consultation focused on this topic that ensures and promotes comprehensive community engagement with public sector, was necessary in order to move towards developing an operational framework on strengthening linkages between public sector and community Systems to codify the integration of community and health care delivery systems. This consultation took place on the 6-7 of August, 2012, at the Bronte Hotel in Harare.

2. Objectives

The objectives of the consultation were to:

1. Identify effective community models that support HIV care and treatment, including HIV testing, linkage to and retention in care, with the goal of achieving universal access to HIV services by 2015.
2. Recognize critical success factors and barriers to integration of community interventions with the health care system.
3. Strengthen linkages between the community and health system at the different levels of health care delivery.

Expected Outputs

The expected output for the meeting included recommendations to feed into a decentralization operational plan that prioritizes strengthening linkages between the public sector and community systems as well as the replication of successful community models, and the integration of these models with the health care delivery system. Follow up of actions will be conducted via existing Partnership Forum for HIV and AIDS Care and Treatment and TB Control and the HIV Review Forum organized by the National AIDS Council.

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3. Meeting Agenda and Activities –Day 1

3.1The meeting was opened by the chair, Mr. Raymond Yekeye, Operations Director of the National AIDS Council, followed by introductions. Dr. Megan Dunbar, Pangaea Global AIDS Foundation, then laid out the goals and objectives of the meeting and a provided a brief run through of the Programme (attached as Annex B). The flow of the meeting was to have a series of presentations and discussions centered on three main questions:

1. What does the public sector have to offer and what does it need from community for effective service delivery?

2. What do community systems have to offer and what do they need from the public sector for effective service delivery?

3. What do the clients need from both the public sector and community systems?

Day two was to focus on small group work to develop recommendations for strengthened linkages to improve access to services and quality of service provision.

All presentations are provided as pdf files, attached as Annex C.

3.2 The meeting began with an overview of the Treatment Optimization Initiative (presented by Dr. C. Chakanyuka, WHO), followed by an overview of Global Community Systems (presented by Dr. M. Gbounm, UNAIDS) to provide the background and context for the meeting. In summary, Treatment 2.0 is an initiative designed to achieve and sustain universal access and maximize the prevention benefits of anti-retroviral therapy. The success of this multi-partnership framework, and optimizing treatment benefits overall depends on every sector. Community systems strengthening can help optimise health outcomes by promoting service availability; through direct provision of health services - in cooperation with or separately from public health services; by increasing demand; by expanding access to and uptake of health-related services at the community level; by provide quality assurance and feedback; and by improving adherence and monitoring of supply availability.

The discussion following these presentations highlighted the need to address how communities can mobilise resources, and not look at resources as an entry point for action. It was also raised that technical people need to be guided by how communities identify their problems and solutions, and that programmes should study communities before coming up with interventions.

After these background presentations, Dr .O. Mugurungi, Director of AIDs and TB Unit, gave a keynote address, highlighting that decentralization was recognized as a public health approach to scaling up HIV services towards Universal Access and acknowledged that opportunities exist to strengthen collaboration between public health sector and community systems to improve treatment outcomes.

3.3. Following these opening talks, presentations were made from the Public Sector representatives, mainly represented by MOH, addressing the key theme questions

What does the Public sector offer and what does it need from the community?
- PMTCT: How Community Action can be Harnessed for Eliminating New HIV Infections Among Children: Gains and gaps (Dr. A. Mushavi, MOH)
- National ART Programme Update: Building Bridges with Community Systems (Dr. T. Mutasa- Apollo, National Coordinator of ART, AIDS & TB Unit, MOH)
- Role of Public sector in providing linkages between Health and Community (VHW) (Mrs.   Chasokela, Director of Nursing, MOH)

 In summary from these presentations and the discussions that followed, it was noted that the public health sector is the custodian of all health related services and the major implementer in prevention, care and treatment, and including retention in care. The public sector offers health service delivery which depends on having key resources: motivated staff, equipment, information and financing, and adequate drugs supply. While resources have been limited, the health sector endeavors to serve the people to ensure universal access by 2015.Improving access, coverage and quality of health services also depends on the ways services are organized and managed, and on the incentives influencing providers and users. The public sector is working towards making these improvements. The public sector also provides the National policies and frameworks that guide how health services are delivered, for example "The National Health Strategy for Zimbabwe 2009-2013", the Zimbabwe Communications Strategy, Supporting the elimination of new HIV infections in children and keeping mothers and their children alive 2011-2015.The Public Sector provides training packages and guidelines that outline how services should be delivered as well as health information.

Through the National AIDs Council, the Public sector also coordinates the multi sectoral response and is responsible for rresource mobilization as well as monitoring and evaluation.

During the discussion that followed, the Public Sector acknowledged that:

- Problems existed because of user fees, e.g. that some women were not accessing ante- natal care because of these fees. Participants were informed that the Health Transition Fund (HTF) was now funding maternity fees. It was observed that as much as the HTF was available, there was need to look at the hidden costs (women still have to buy gloves, cotton wool and needed money to travel to the health centre).

- It was also raised that ART and SRH services for young people were not youth friendly and youth are often humiliated by the conduct of the health staff.

- Community systems were recognized as an underutilized resource that could be mobilized and/or linked to in order to deliver more equitable and sustainable primary health care in low-income settings, as envisaged in the Alma Ata Declaration of 1978

- The Role of community is critical to support the limited numbers and capacity of health workers to appropriately counsel women on infant feeding; given other competing demands on their time including all of the bottlenecks along the PMTCT/EID cascade.

- Community Home Based Care (CHBC) service is vital to ensure continuum of care & support for PLHIV outside health facility environment

3.4. Following the presentations and discussions on the public sector response, the programme moved on to focus on community systems, following the same format.

b) What do the Community Systems have to offer and what do they need from the public sector?

- Role of Civil Society and communities in providing linkages between health systems and community systems (Joyce Siveregi, Zimbabwe AIDS Network)
- Role of (Public Sector/Community) in promoting linkages to care and retention in care (Ropafadzo Magwaza, FACT, Chiredzi)
- Role of community in supporting testing and linkages to care (Farai Mahaso, Bhaso, Masvingo)

In summary, it was noted that the role of Civil society includes:
- Community mobilization and empowerment for demand creation for uptake of available services.
- Basic treatment literacy and promotion of community action to compliment health services- e.g. Community Mobilization and Empowerment of Improved Access to Support and Treatment (CMEIAST)
- Rights based approach-Sensitization of communities and providers on rights and entitlements.
- Brokering engagement and raising practical realities and health care issues from communities.
- Act as a watchdog

Community systems offer a range of services including;

- Support for beneficiaries of health services, reduction of stigma and discrimination, provision of care and support services and adherence counseling for the people living with HIV
- Nutritional support and livelihood strategies, referrals of clients to secondary caregivers.
- Provision of other materials for training workshops e.g. firewood, water, utensils.
- Advocacy on a variety of health-related issues
- Construction and maintenance of critical infrastructure e.g. roads, clinics, toilets, houses for clinic staff, day care centre construction and protection and maintenance of water points.

In response to what the Community needs from the Public Sector, the presentations and discussion pointed out that:

- The Community needs political leadership from the Public Sector
- A strong dedication to quality health service delivery
- Community systems need services to be decentralized and task shifting/sharing to be effected to improve efficiencies and address inequities e.g. Nurses to initiate ART
- Community systems need accessible and affordable health care services, access to comprehensive services including periodic diagnostics and laboratory services and provision of integrated, holistic services. They also need Provision of technical support, two way referrals and recognition by health service providers.
- Well coordinated responses e.g. District Action AIDs Committees (DAAC) to focus more on multi sectoral linkages.
- De politicization of care activities.
- National resource mobilization strategy to be set up.
- A Holistic care package to be put in place.
- Community share trust funds to contribute towards care activities.
- An increase in the national health budget - for at least 15% of GDP as per the Abuja agreement
- policies that are user friendly and adapt to ever changing approaches in HIV programming
- Strengthen the monitoring and evaluation systems for community based health & HIV responses

The discussion highlighted a wide-range of issues and gaps that the Public sector should fill and these included:

- Young people are not accessing services e.g. testing, treatment and Sexual reproductive health
- Inadequate targeting of key populations
- Woman sexual reproductive health rights and services were still lacking
- A lack of coordination among civic society and resulting in failure to coordinate programmatic and advocacy activities.
- Community leaders should be practical role models leading in the forefront of getting tested, seeking treatment.
- Community organizations should have social accountability and be able to work closely with the Ministry.
- Community System was not having enough synergy when advocating for health issues resulting in failure to synchronize activities.

It was agreed that Community participation and ownership increases effectiveness and sustainability, and that the issues of care and continuum of care's success rests on involvement of all players: public sector, private sector, community and civil society.

In Conclusion, there was broad agreement that community systems have the potential to be more responsive to certain needs and priorities of beneficiaries (allocative efficiency) and comparatively cost effective (productive efficiency) because of lower levels of bureaucracy and better knowledge

of local costs. The key is identifying how best to link the public sector and community systems to optimally meet the needs of the clients.

3.5. The final session for day one focused on what clients need from both the Public Sector and the community, including a panel discussion on how the needs of Youth and other key populations are addressed.

- What do clients need for HTC and to be linked, engaged and retained in care (Judith Feremba, ZNNP+)
- How community Systems can support and integrate with Public systems (Shingirai Nziradzepatsva, ZNNP+)
- What do clients need from Public and Community Systems (Hatina Musanhu, Positive Initiative Trust)
- How are the needs of the Youth addressed?(Modest Muziringa, Mugove Kwaramba, AFRICAID)
- How are the needs of sex workers addressed (Talent Jumo)
- Integrated Public sector and Community Models (Sam Mataruse, GALZ)

Below is a summary of the presentations:

3.5.1. Positive Initiative Trust (PIT) was founded by members of support groups of PLWHIV and utilizes the popularity of sports as an entry point to HIV prevention, care and support programmes. Clients, benefit from both public and community systems services of HTC, treatment, care and support.

The Public Sector provides:

- Health services and also functions as referral point for clients
- Information and cheaper health services as compared to the private sector
- Free anti-retroviral initiative rolled out in 2004.
- Health material and equipment
- Infrastructure and Health personnel

In addition the Community:

- raises awareness, disseminates information and reduces stigma and discrimination through education, and advocacy for acceptance and political buy-in
- provides Demand creation for services
- Improves treatment and care outcomes by providing community leadership support.
- Provides Infrastructure for services e.g. community halls

There were gaps identified in the Public Sector and community systems and these include:

- Inadequate resources for the provision of quality treatment services e.g. CD4 Count Machines. These are not available at local clinics/level
- Long distances to collect ARVs and access other health services especially in the rural areas e.g. Marange

- Pediatric ART is not initiated at local level and there is no supply of other breast feeding options e.g. Formula feeds
- Weak linkages between the community and health systems as far as referral and feedback e.g. Suggestion boxes.
- Inadequate health personnel resulting in burn-out that lead provision of poor quality health services.
- One "stop shop" whereby health services are available and accessible at one site e.g. SRH, O.I Clinic CD4 count and HIV testing services at one site.
- No clear task shift policy to allow nurses to initiate ART

Recommendations included:

- Enhance and utilize the potential PLHIV in providing HTC treatment, care and support services
- Develop guidelines for an effective two way referral and communication system between the public health and community systems
- Enhance collaboration of community and health systems.
- More and consistent ART outreach sites for localized supply of HCT & ART services

3.5.2 The day ended with a panel representing high-risk groups, including representation from youth, sex workers and men-who-have-sex-with-men (MSM).   Some of the issues highlighted include:

- A need to promote research among MSM so as to establish behavioral, biomedical and structural interventions which are appropriate for Zimbabwe

- Partnerships in programming and service delivery should be strengthened between MSM, Health services provide, MOCHW and NAC. It was also noted that as long as minorities were not considered in programming, then we can never achieve our targets of universal access by 2015.

- Sex workers face criminalization even though its recognized as work in other parts of the world
- The disabled were not included in policy making and efforts to be inclusive of key populations were needed. Of commendation were SAfAIDS and THAMASO for working on producing a dictionary in sign language.
- Youths were concerned that there were not enough youth friendly services to meet their needs and were judged at health centres if presented with an STI or enquired about Family Planning. It was also noted that some communities had support groups for children but all age groups were mixed together. They recommended that there be a division between pediatrics and adolescents at OI clinics and support groups as their needs were different
- Chiefs were encouraged to have a relationship with young people within their communities to ensure their support. It was also noted that some communities had support groups for children but all age groups were mixed together.

4. Meeting Agenda and Activities - Day 2

4.1 Day two built on from Day one, reflecting on how to build a systematic and integrated system that links community effectively with the public health system. The format was generally more interactive with presenters giving brief presentations followed by more time for discussion, plus small group work.

4.2. A series of short presentations provided examples of integrated models of HIV prevention, Testing and Linkages to care and treatment from across different sites in Zimbabwe including:

Social Capital and HIV Competent Communities: Evidence from Eastern Zimbabwe (Dr. C. Nyamukapa, BRTI)

4.2.1) The BRTI study was looking at the evidence for community mobilisation increasing HIV avoidance and access to AIDS care and treatment services. Findings - including those from the Manicaland Cash Transfer trial - show that local communities, if engaged with as full partners, can play a positive role in ensuring programme success .Possible approaches to enhance & harnesses the community response include:

- Working with existing local groups (including non-AIDS groups) to encourage critical dialogue (possibly using community conversations) to allow members to conceive of positive local responses to HIV & to challenge harmful social norms (including stigma) & incorrect information
- Provide social action funds (particularly in the poorest districts – e.g. Matobo) to support local community responses to the HIV epidemic
- Work with churches to reduce moralistic & negative attitudes that underpin the high levels of stigma that remain among church members
- Promote analytical frameworks & tools amongst Government & NGO policy-makers for use in developing & implementing new/improved health services & programmes – e.g. the HIV Competent Community concept

Wild for Life Project (Alfred Chingono)

4.2. 2) The Wild 4 Life model seeks to leverage available resources by partnering with existing non-health organisations (e.g. the Painted Dog Conservatory) to improve access to health services in remote and rural areas, like Hwange. Through this model, organisations were encouraged to create synergies which would cover more with available resources.

Integrated models supporting key populations: The Zvandiri Model (Felistus Ngubo, AFRICAID)

4.2. 3) The Zvandiri programme was developed in partnership with children and adolescents living with HIV to complement clinic-based services and is now a combination of integrated community support services (health, PSS, training and advocacy) linked with clinic services with the aim of

improving both PSS and health outcomes. The Zvandiri model and its combination of services are replicable and is already in other provinces.Lessons learned include;

- Integration of community based services which complement and support the MoHCW, greatly enhances the psychosocial and clinical outcomes for children and adolescents with HIV.

- Strong linkages with and referral pathways with health services are critical

- Engaging HIV positive adolescents as service providers, with effective training, support and supervision from experienced mentors, promotes access for children with HIV to needs-based services

There were issues raised regarding disclosure of adolescents to partners and the youth responded by saying they would disclose once they have established that the partner is serious about the relationship.

The experience of PADARE/Men's Forum on Gender on Turning the Tide against paediatric HIV (Nakai .G. Nengomasha, PADARE)

4.2.4) PADARE /Enkundleni Men's forum on gender is a movement of men advocating for gender justice in Zimbabwe that operates in rural, semi urban, farming communities and urban areas of the country. The organisation targets men and boys in all settings, workplaces, rural communities, farming communities, urban communities, schools, agricultural colleges and teacher training colleges.

What has worked in this model includes;

- Approaching **men as facilitators of change in their communities** as compared to oppressors through involving men and boys in community dialogues on gender and HIV issues has been a strategy that has been accepted by men and traditional leaders in different communities.
- PADARE has provided practical intervention in community transformation by using contextualised messages in both print and electronic in mobilising traditional; leaders to fully participate in PMTCT interventions
- Having community day of testing spearheaded by traditional chiefs, headmen and village head which are mostly men. This is done to mobilise men to know their statues so that they can know responses.
- Working with Positive speakers: these are people that have disclosed their HIV statuses to families and communities and they get to share their experiences on an open forum to challenge issues of discloser and discrimination.

Integrated Public Sector and Community Models: The National Behaviour Change Programme (Gertrude Shumba, Family AIDS Caring Trust Mutare)

4.2.5) The National Behaviour Change Programme covers 61 districts and NAC coordinates those activities.As the programme is nationwide and targeted towards all sexually active, it is conducted within both sectors (the public and community).Linkages with both areas were formed through

establishing decentralised sub-national institutional frameworks to address behavioural change at district and ward levels encompassing the FBOs, Workplaces, Residential areas and Institutions. The programme is at the centre of most prevention services that is Testing &Counselling (pre and post), MC, condom distribution, PMTCT as it acts as a referral agent to public sector for service uptake within the community. The strengths of this model include;

- National coverage and a consistent and coordinated approach with interventions that are evidenced based
- Capacities of other key players such as line ministries and NGOs are enhanced.
- Institution and Community driven
- High level of sustainability
- Rich in IEC material
- increased uptake of Testing &Counselling and condoms

The weaknesses of this model include llimited involvement (participation and empowerment) of leaders and men as advocates and public role models.IEC material is not for all populations neglecting the needs of the disabled. It is also labour intensive hence requires more funding.

Integrated Models of Supporting HIV, Care Treatment, Retention and Adherence: Experiences in Tsholotsho, Bulawayo and Beitbridge, Zimbabwe (Dr. Jean François Saint-Sauveur, MSF Spain, Zimbabwe)

4.2.6) The MSF Community ART Groups (CAG) project is a model that has demonstrated positive results. PLWHA self-form groups of maximum six .Community ART Group (CAG) members are registered on a group card and members meet monthly in the community to verify adherence, fill in group card, chose a representative to go the clinic and Share transport costs (if any).The representative, who goes to the clinic reports about the other members, receives refill for all members and has a routine consultation and CD4 taken. Back in the community the representative delivers the refill to the other members.

This model of decentralization decongests the health centre and is less costly while facilitating support for PLWHIV. The CAG model should be replicated in Zimbabwe piloting particularly in rural areas where there is stronger support systems in collaboration with Community based organizations (CBOs) leveraging on the village health worker to bring the drugs to the CAGs. The Community and CBOs' role would be to educate PLWH on CAG (advantages, disadvantages),Help PLWH to form groups that will help for long term adherence, prepare for eventual negative impact – disclosure and identifying defaulters and tracing.

The Public Sector would define medical criteria who can join CAG (inclusion criteria), train VHW and patients on when to refer back to clinic (referral mechanism). They would train persons that will be allowed by MOH to transport the drugs (VHW or CHASA), provide monitoring books/ tools – drug accountability & monitoring of patients as well as keep appointment diary well updated - identifying defaulters.

The Hard to Reach Community ART Service Facilitation and Monitoring Model (Tonderai Chikuni, DOMCCP)

4.2. 7) DOMCCP is a Christian, relief and development organisation covering Manicaland province. Its model complements HIV prevention, care and treatment initiatives through;

- Secondary community care givers support model

- Patient support grouping model

- Livelihood support models (The pass on pass in model)

- Community herbal support model

- The hard to reach community ART service facilitation and monitoring model through CD4 and viral load tests.

- Improved management of ART service provision by health personnel(regular monitoring of the CD4 and the viral load in patient's blood)

Through the DOMCCP model, there has been reduced waiting period for one to be initiated on ART, over 250 Patients have been initiated on ART (2/3 being women and ¼ Children) as from last year. The model is socially inclusive and there is improved integration of community effort and the public sector (involvement of caregivers, community health workers, local leadership and building on traditional knowledge systems)

Experience of MSF with Community-based ARV groups in Tete, Mozambique (MSF Spain)

- 4.2.8. MSF-Spain has supported a Mentor Mother programme (M2M) in Bulawayo in Luveve since 2009 and in Pelandaba since 2011.HIV positive pregnant women and mothers of HIV exposed babies are provided mentorship in the PMTCT programme to provide support and advice. There were 24 trained mentor mothers in the programme, each with approximately 15 clients at any one time. The study was cross sectional with a combination of qualitative and quantitative methods.
- Results from this study showed an increase in infants who were tested for HIV in the M2M programme (99%) and knowledge of PMTCT facts (averaging 93%) and compared to those not in the programme (48%) and an average of 18%. Results also showed increase in disclosure, adherence, condom use and exclusive breastfeeding compared to those not in the group. This model can act as a catalyst for appropriate PMTCT responses within communities affected by AIDS may dramatically improve retention in PMTCT programmes.
- MSF-Spain also piloted an adolescent Model between 2007-2008 developing an adolescent specific clinic (corner) and outside of clinic services.This ensured adolescents' participation in assisting the program development and flow.Outside of the clinic, there were youth club meetings, overnight camps, Saturday debates on disclosure, adherence, condom use and nurturing talents, etc. Groups were divided between 10-14 and 15+ and there was important collaboration of clinic staff and guardians in and outside of clinic activities. Comparing adolescent and adult outcomes, adolescent survival equalled that in adults and there was

low Loss to follow up (LFU) and high retention in adolescents. This proves that good adolescent results are feasible with dedicated adolescent specific services in resource constrained settings.

A brief discussion of the presentations followed, highlighting that service integration and linkages can improve care and reduce missed opportunities for key interventions such as HIV testing, provision of ART, PMTCT, and adherence support. Integration of care is an important strategy to improve patient retention in long-term HIV care and treatment.

5.Participants were then split into small groups to discuss on how to build effective bridges between health systems and community with a special focus on Access (Groups 1, 5), funding (Groups 2, 6), Capacity Building (Groups 3, 7) and Key Populations (Group 4). Participants were asked to reflect on what is working, what should be strengthened and recommendations across the four themes. Reports were fed back into the larger meeting, the as highlighted below:

5.1 Feedback from Group Discussions

5.2Access to HIV prevention, care and treatment services including ART (Groups 1 and 5)

What is working?
- The "Supermarket" approach, which provides all services in one decentralized location, was seen as a powerful model. For example in Gwanda (Mat South), MOH has a mobile clinic with health personnel from the OI clinic, Nurses from the District Medical Office, Family Planning for Adolescent Sexual and Reproductive Health, and staff from legal resources present. –It was recommended that such a service needs to be scaled up and made age specific, and capable of targeting key populations.
- Integrating HIV and SRH services through mobile clinics
- Comprehensive and all inclusive HIV education within schools, health facilities and within the communities
- Involvement of community leaders because they have influence over their communities and they have been instrumental in reaching hard to reach communities e.g. men, religious and traditional sects
- Mentor mothers models, as those introduced by MSF, which have been proven to work
- Programmes with a clear link between public and community like Behaviour Change and HIV Testing and Counselling should be replicated and brought to scale
- Wildlife project brings resources closer to communities by sharing and utilising existing resources

What should be strengthened?

- Community participation (Communities should be involved right from the start in identifying their own problems and come up with their own solutions. They should be capacitated to make decisions that affect their communities).

- Emphasis on sustainability as resources are dwindling particularly from foreign aid, we need to develop home grown solutions that are sustainable.
- Early Infant Diagnosis, Paediatric ART and follow up should be strengthened to cover the gaps that are evident in the treatment cascade.
- Integration of HIV in other health services
- CHBC programme should be strengthened in terms of the referral system between the MOH and Community caregivers
- Enabling environment by health workers by way of better remuneration, better working facilities and gear

What is not working?

- Bunching children services for youth and children: it should be sex and age specific (0-5yrs, 6-15yrs, +15yrs)
- Imposing interventions onto communities, they should be consulted before any programmes are introduced
- There is not enough feedback to communities from NGOs and researches
- Mobile clinics for adolescents not working as they are concerned about confidentiality and accessing services in public places, what why?
- Suggestion boxes are not considered by health staff
- Training of service providers for Family Planning not adequate
- Confidentiality in caregivers or health care providers is lacking.
- Linkage between +HIV caregivers and health workers are not working as the former are undermined by the latter. It is necessary to ensure a commonality and strong linkages.

Recommendations & Comments

- Address issues of burn out for Village Health workers
- Inform breastfeeding mothers about the latest guidelines and the options available when infected with HIV
- Caregiver selection should be done using one structure to avoid duplication. Currently, caregivers are selected through different organizations. This process could be optimized if institutions came together and pull resources, draw up a criterion and select one cadre.
- There should be youth caregivers to ensure that the youth feel comfortable and free to interact with service providers. Communities need to be sensitized on the fact that they need to create a platform to ensure youth volunteers.
- Strengthen use of health centre committees
- Home Based Care needs to be strengthened to have good referral systems
- Utilise already existing resources, i.e. resource sharing at local levels by all stakeholders
- Involvement of local stakeholders in capacitating them
- Give +HIV caregivers a chance to offer support to their communities
- Need specific clinics for pediatrics and adolescents
- Target mobile outreach services for targeted groups
- Strengthen institutional framework

- PMTCT is facility based; it needs to have a strong people component and should be decentralized
- Health services to refer Community Home Based Care (CHBC) and vice versa

5.3 Funding (Groups 2, 6)

What is working?

- 3% HIV/AIDS levy is a good initiative and has been working, National AIDs Trust Fund (NATF) regarded as a best practice globally
- International funding in terms of sourcing funds has been good

What is not working?

- External funding has been coming with a lot of conditions attached to it.
- There is no consultation on allocation of funds thus funding is not allocated properly nationally. There is no internal control on use of funding.
- Procurement procedures and protocols are not being cost efficient
- NATF, a huge % is going to admin 30%, at the expense of programmes.
- There are no exit strategies once international funding ends

What needs to be strengthened?

- NATF needs to be reviewed in terms of its budget line
- About only 20% of population is contributing to NATF so there is need to look at increasing the percentage contributing.
- Encourage corporate social responsibility by encouraging the Corporate sector to put their employees on medical coverage

Recommendations

- Culture of transparency with regard to use of funds
- Policies to include public audits
- Government to allocate more funds towards HIV/AIDS and accountability on funding usage.
- Cut funding horse-pipe by offering community empowerment
- Empower beneficiaries to be able to demand results and transparency
- Advocate for key ministries to be able to receive public funding-country needs to look for exist strategies well in advance e.g. that of NAP OVC
- Need for advocacy strategies where we shift from blame and have open discussions as people with one goal of developing the community and not foster their personal needs
- Need to review 15% allocated to health budget. There should be a petition carried out and presented to the Minister of Health.
- Need to pursue regional procurement of drugs to be able to provide cost effective medication
- Restructuring of organizations to ensure that salaries do not take up most of the funds for organizations when funding is a constraint

- MoH to include community cadres in T5 in their planning for training.

5.4 Capacity Building of all sectors (Groups 3 and 7)

What is working?

- There are policies and guidelines in place which are being used and are working.
- Production of training materials
- Capacity building to caregivers and VHWs as they are there at the grassroots
- Efforts have been made to standardize training e.g. Behaviour Change, Home Based Care, and PMTCT
- Trainers have been capacitated
- Meaning involvement of Community
- Involvement of young people (Zvandiri Model, MSF-Spain, YPN)

What should be strengthened?

- Need to strengthen dissemination and sensitization of policies, e.g. Zimbabwe National AIDS Strategic Plan (ZNASP)

What is not working?

- Funding driven on donor objectives
- Traditional are leaders not enlightened and capacitated on programming activities e.g. PMTCT, MC programmes
- Prescribing programmes for the youths, there is need to involve the youths at all levels of planning
- Little or no corporate social responsibility, companies are meant to exercise this
- HIV policies in workplaces are not comprehensive enough
- Lack of SRH packages for schools
- Decentralization of paediatric ART is not working as capacity building in this field is low or has not been efficient

Recommendations

- Need for community involvement and consultation in capacity building (CB) and CB funding priorities.
- Need for private public partnerships
- Develop comprehensive manuals on programming like PMTCT, MC, HBC and conduct training for traditional leaders
- Streamline community based cadres to avoid duplication and improve efficiency
- Develop guidelines on facilities in the community
- Making use of technology to communicate with communities. This however needs to be thought through taking into consideration the confidentiality issues.

5.5 Key Populations (People with Disabilities, Sex workers, MSMs, Youth and PLWHIV) (group 4)

5.5.1 What is working?

- SAFAIDS in collaboration with THAMASO developed a dictionary for those who have hearing impairments
- There is evidence that consultations are starting to include people with disabilities and its translating in policies
- Increased access to HIV education as all media platforms are actively taking part
- MSM have an organization that is representing them
- The NAC – Sex worker Peer Education Programme is working as there is a lot of involvement and consultation which is bearing fruit
- The Africaid Zvandiri Programme, Young4Real, SAFAIDS, NAC- Young People's Network -All of these programmes are showing increase in youth involvement in representing their own issues
- Decentralisation of some HIV programmes
- Reduction in prevalence rate
- PMTCT programmes
- Provider Initiative Community Training
- Integration of HIV & SRH services

What is not working?

- Poor inclusion or representation of people with disability and most at risk populations especially the Sex workers and MSMs.
- Social welfare does not cater for children with all forms of disability
- Infrastructure not friendly to the disabled
- The segregation and illegal nature of MSM impedes them from seeking health provisions
- Police abuse sex workers instead of helping them
- There is duplication of services for HIV treatment and care

Recommendations

- More materials on HIV/AIDs to be developed for those with disabilities, e.g. blind
- Include people with disabilities, give them a voice
- Build friendly infrastructure for the disabled
- Recognition that MSM exist and start to include MSM in decisions making
- Adopt a rights based approach in order to improve Sex workers and MSM s' health outcomes
- Need to scale up programming on male sex workers
- Criminalise abuse and not sex work
- There is need for open relationships or mentoring opportunities for youth especially those in rural areas.
- Strategies that incorporate the needs and appeals of the young people should be included in planning services for this group.
- OI clinics need to be open on weekends to cater for the needs of youths in school

- Need youth friendly OI clinics for youth with integrated Sexual Reproductive Health services
- PMTCT programmes need to improve to get to hard to reach mothers.

6. Upon completion of the small group feedback, NAC provided closing remarks and assured the participants that issues raised and recommendations brought forward will be followed up and synthesised into a document that will be drafted and circulated, and that the recommendations will be taking up in the development of the decentralization framework.

Next Steps

7. The meeting report will be circulated to workshop participants for review and comment by Mid – September, 2012

8. NAC, with secretariat support from Pangaea, will convene a steering Committee drawing from various stakeholders appointed to develop an Operational Plan for Strengthening Linkages between public sector and community Systems, leveraging existing policies and documents, that respond to the recommendations laid out here. A. A draft of this plan will be available by the end of 2012.

9. We will circulate the Operational Plan on Strengthening Linkages between public sector and community Systems for feedback at the end of the year.