Members of the community mobilised for access to health services at Velcom Outreach site.

BHASO Capability Statement Ver. May 2019

Support group members in Chivi pose for a photo with BHASO staff after receiving supporting materials for their poultry project.

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List of Acronyms

AYPLHIV: Adolescents and Young People Living with HIV

BHASO: Batanai HIV/AIDS Organization

MoHCC: Ministry of Health and Child Care

CARG: Community Antiretroviral therapy Refill Group

ASRHR: Adolescents Sexual Reproductive Health and Rights

CHASA: Community HIV and AIDS Support Agent

PLHIV: People Living with HIV

K.Ps: Key Populations

READY+: Resilient and Empowered Adolescents and Young people living with HIV

G.E.N.D.E.R: Gender Empowerment and Development to Enhance Rights

PITCH: Partnership to Inspire, Transform and Connect the HIV response

1 Overview

1.1 About us

Batanai HIV/AIDS Service Organisation (BHASO) is a registered private voluntary organization PVO (09/96). It was established in 1992 when 12 people living with HIV from different parts of Zimbabwe came together in Harare to discuss their plight as people living with HIV&AIDS. They decided to go back home and start HIV&AIDS support groups. Auxillia Chimusoro, the first woman in Zimbabwe to publicly disclose her HIV positive status came back home to Rujeko T/Ship in Masvingo and in the face of stigma, discrimination, ridicule, poverty and sickness, started the first HIV&AIDS support group in the country and called it Batanai which later developed into a fully fleshed Organization now called BHASO.

BHASO work feeds into and is guided by the global commitment to end AIDS in 2030 and its strategic plan focuses on 3 programming components namely Community HIV/TB Management, Key populations and Adolescents and Sexual Reproductive Health and Rights (ASRHR). Since its inception BHASO worked with 12 funding partners (Funds for partnerships and Development in Africa (FEPA), Population Services International (PSI), OXFAM, Egmont Trust, World Food Programme, UNICEF, Voluntary Services Overseas (VSO), Médecins Sans Frontières *(*MSF*)*, Regional Psychosocial Support Initiative (REPSSI), SAFAIDS) to push forward its mandate of community mobilisation for improved access to and utilization of health services. BHASO's strategic approach is a one programme approach where BHASO programmes components are integrated to empower PLWHIV using tried and tested, and innovative community engagement models putting people living with HIV at the forefront.

Director of BHASO Simbarashe Mahaso

Our Vision: Total empowerment for positive living

Our Mission: To empower people infected and affected by HIV and AIDS by providing services that will enable them to improve the quality of their lives.

Our Values

People are the best agents of change
Accountability
Transparency
Good governance

1.2 Coordination and Partnerships

Recognising the complex and demanding nature of ensuring access to health services for People living with HIV and Key populations, the design and implementation of the interventions require continuous and sustained cooperation between various stakeholders in the government, PLWHIV & KP communities, the civil society and private sectors. The health sector response to HIV/AIDS in Zimbabwe is led by the National AIDS and TB Programme and National AIDS Council (NAC) coordinating the interventions with in MoHCC, BHASO is collaborating very well with AIDS and TB Programmes and NAC which witnessed its involvement in development of national strategic documents like National AIDS policy and strategic framework, Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) and Zimbabwe`s National Key populations HIV and AID Implementation Plan and many other national strategic documents guiding HIV response.

BHASO has experience in implementing or providing technical support for the implementation of HIV programs and projects. BHASO works with key partners in the field of health, HIV and AIDS. Apart from implementing partners, BHASO strategic and collaborative partners, include; Government Line Ministries such as Ministry of Health and Child Care (MOHCC), Ministry of Justice, Legal and Parliamentary affairs, Ministry of Youth, Sport, art and recreation, Ministry of Primary and Secondary Education and the Zimbabwe Prisons and Correctional Services (ZPCS).

1.3 Key milestones

The diagram below provides a synopsis of the journey travelled by BHASO in the fight against HIV and AIDS since its inception in 1992. Following is a brief description of what the diagram is showing.

1992-2000

Auxilia Chimusoro (The founder of BHASO) facilitated the formation of Batanai Support Group soon after coming out openly on National Television declaring her HIV positive status. This period was marked by high levels of HIV prevalence as well as stigma and discrimination because most people in Zimbabwe had limited knowledge on basic facts of HIV and treatment was not yet readily available. High rates of HIV/AIDS related deaths were also on the pick because people resorted to complementary and alternative medical systems as they associated the sickness to witchcraft and bad omen. BHASO therefore came in with formation of support groups, awareness campaigns, advocacy to encourage positive living, improve knowledge on HIV/AIDS basic facts so as to reduce stigma and discrimination.

As a result, National HIV prevalence rate fell from 27.8% to around 22% and a noticeable decrease in the cases of stigma and discrimination was realised in communities and BHASO contributed to this result significantly. Issues of disclosure were improved as well since support group members encouraged each other to make

partial disclosure to families and relatives so as to avoid witchcraft accusations and also enhance assistance to access modern scientific medicine from friends and relatives.

2001-2010

While enormous efforts were made by BHASO and other humanitarian actors in the fight against HIV from 1992 to 2000 gaps still remained in the areas of high numbers of bed ridden clients, HIV related deaths as well as stigma and discrimination. BHASO therefore continued with scaling up and strengthening support groups, awareness campaigns and trained Community HIV and AIDS Support Agents (CHASA) a peer model developed to improve patient support system, improve knowledge on basic facts of HIV/AIDS as well as reducing stigma and discrimination in the community. Community Home Based Care facilitators were also trained to provide door to door care and treatment support in the community working closely with the health facilities. This period also marked the introduction of life long HIV treatment but it was still difficult to access since it was centralised at provincial and district hospitals. Given the transport challenges faced by ART patients in Masvingo Province for instance, BHASO created advocacy teams at grassroots level and advocated for the decentralisation of ARV treatment to rural hospitals.

Remarkable success was realised in Gutu district where BHASO engaged MSF which was providing ART in the neighbouring Buhera district and ART patients from Gutu were walking to Buhera for their resupplies. As a result of BHASO's advocacy initiatives MSF managed to come and provide ART and other HIV related services in Gutu using the Outreach model with BHASO playing the patient support and community mobilisation role. CHBC facilitators managed to make a significant reduction in the number of HIV bed ridden clients which also indicated an improvement in the uptake of ART as well as treatment adherence.

2011 to 2019

This period was mainly characterised by a number of improvements in knowledge on basic facts of HIV, reduced stigma and discrimination and improved access to ART. While these improvements are greatly appreciated, new challenges were realised and they called attention of different humanitarian actors of which BHASO was also included. Accessibility of treatment remained a big challenge especially for the hard to reach areas of Masvingo Province such as Mwenezi district. HIV testing services were also limited in such areas while issues of High viral loads were realised in most areas across the province. AYPLHIV and Key Populations were also other groups lacking HIV related support such as SRHR issues.

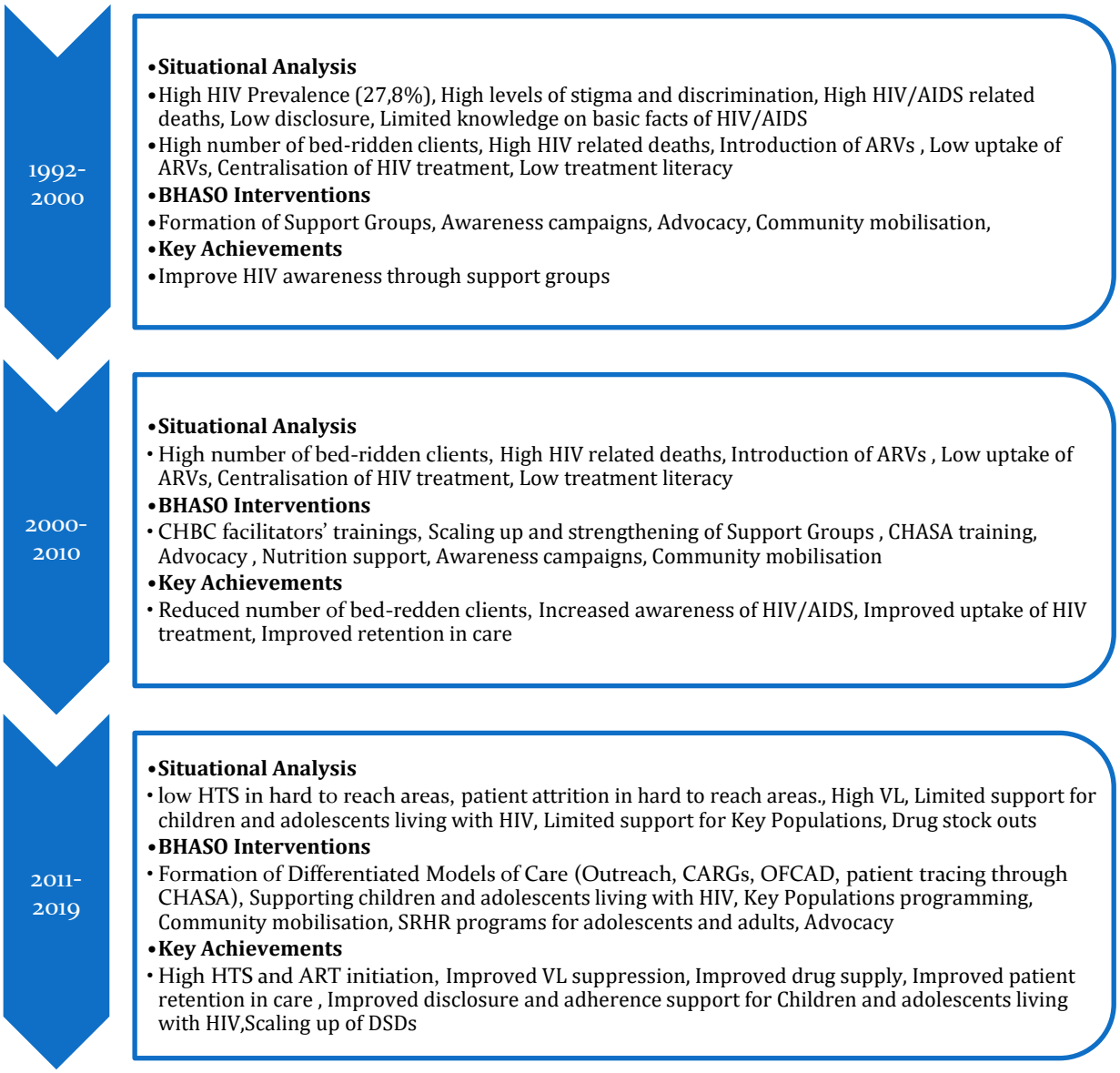


Figure1: BHASO's experiences in the journey of fighting HIV

2. Our Core Program Areas

Our expertize is characterized with the following 4 program areas

- Integrated Community HIVand TB Management
- Key Populations
- Adolescents Sexual and Reproductive Health and Rights
- Research and Advocacy

2.1 Integrated Community HIV and TB Management

Having support from and collaboration with various partners (MoHCC, FEPA, SOLIDAR MED, HSPAS, MSF, and PSI), BHASO has been involved in many achievements since early 90s to date in terms of HIV prevention, care and support. We have been contributing effectively to the national HIV response putting people living with HIV at the forefront in the response to the epidemic. We were actively involved in the caring work from the era of high stigma and discrimination; home based care where we build the capacity of community home based care cadres to care for the bedridden clients until there was a paradigm shift to focus on putting more people living with HIV on the lifelong treatment (ARVS). To align ourselves with the ARV treatment guidelines BHASO designed interventions and models which aimed to promote universal access to HIV treatment in Zimbabwe. These interventions and models also aimed to develop, establish and roll out differentiated service delivery models that will bring medication closer to the patient so as to improve retention in care.

Mwenezi Community HIV/TB Program

Our most recent achievement was the work in Mwenezi District, Masvingo Province. The size of the population is 166,933 of which more than 95% live in the rural area. The district is also characterized by ecological farming, drought prone (poor food security) with large scale commercial farms and game parks, which makes people's access to health service challenging. 17% of the pop has ready access to health facilities whilst 83% travel between15-200 km to reach one. Due to existence of a highly mobile young population who usually migrate to SA in search of employment, its lost to follow up rate is high.

BHASO therefore came up with differentiated service delivery models to increase access to ART and HIV related health services by

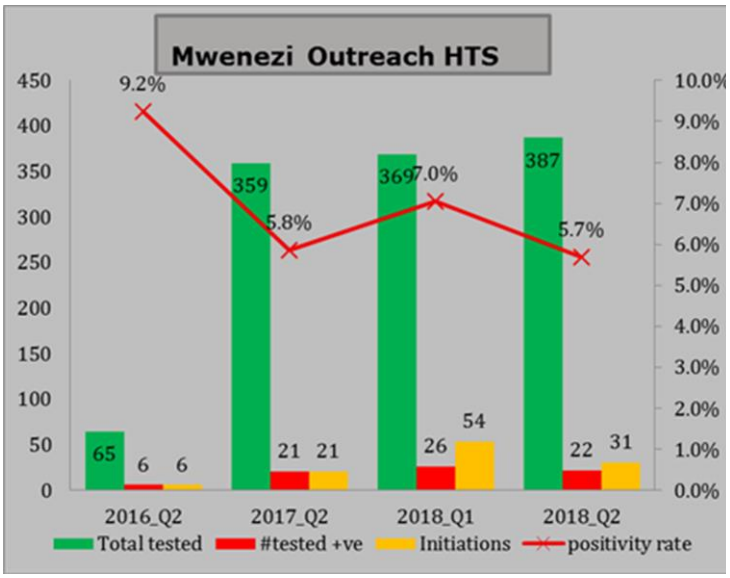


Figure2: HTS uptake and the positivity rate in Mwenezi

taking services and medications closer to beneficiaries. Patient tracing and adherence support was provided through the CHASA model of which the cadres were also instrumental in initiating support for Adolescents and children living with HIV. The Outreach model also continued to be a critical model of care for improved access to HIV related services such as VL bleeding and IPT.

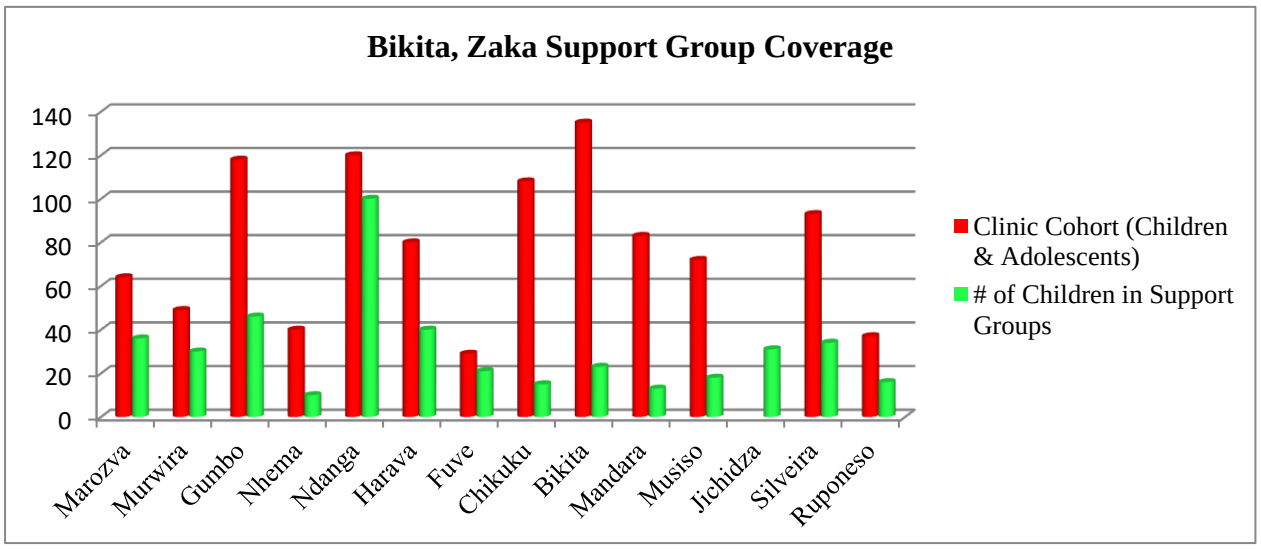


Figure 3: A Bar chart showing a comparison of support group coverage per Health Facility against total clinic cohort for children and adolescents living with HIV

Significant achievements were realised in the areas of HTS, DSDs uptake and supporting AYPLHIV and the graphs shows the statistical information on these achievements.

From the chart above it is clear that only 5 Health facilities have good support group coverage of at least 50% of the total cohort while the remaining 9 have less than 50% of children living with HIV in support groups. While this might have been by default, it may also be of paramount importance to put into cognizance the needs of the larger population who did not manage to be part of the project by being members of support groups. The great achievements and benefits realized by those who were fortunate to become support group members in this project might as well still be a need for those who were not and as such, should funds permit we would recommend that efforts be channelled towards increasing support group coverage at all the health centres.

OFCAD (Out Of Facility Community ART Distribution)

Above all, the most significant work done in Mwenezi was to develop and operate OFCAD. BHASO was involved in the development of this model of care from the beginning and has been supporting the operation till date.

OFCAD is an ARV distribution model carried out **in community** (outside of health facility) **by Community Health Workers** such as Village Health Worker (VHW) or CHASA. They collect ARVs at health facilities for those who are OFCAD members and distribute them in their community.

This model is beneficial particularly in an area like Mwenezi where people live in hard-to-reach area and lost-to-follow-up rate is low due to geographical and demographic characteristics. The benefits of the model are not only for ART clients but also for health care providers and even community. From providers' perspective, this model is beneficial for its sustainability and also in order to strengthen collaborations between HF, community actors and other partners. From community's perspective, this model contributes to community ownership and empowerment, stigma reduction, and increase of community awareness and knowledge on HIV.

The model was piloted in the most hard-to-reach areas in the district (Ward 17) and 11 OFCAD points with over 200 members are active at the time of writing. 20 CHWs have been trained to operate it and it is in the process of its expansion.

One BHASO officer has been involved in the development and operation of the program – training and supervision of CHWs in collaboration with MOHCC and MSF.

2.2 Key Populations

The Sustainable Development Goal (SDG) on Health and the move towards Universal Health Coverage (UHC) emphasise "leaving no one behind" and special consideration to be given to key populations who have greatest HIV risk and vulnerability. Within the SADC region and globally, new HIV infections continue to decrease among the general

population, however Key Populations have been left behind in this wave owing to their criminalized ways of life, stigma, and discrimination in the community and by service providers. In order to contribute to the ending of AIDS by 2020, BHASO commitment to work towards Key Populations HIV service delivery. We endeavor to contribute more to the attainment of global 90-90-90 targets for ending HIV by 2030 so that we leave no one behind. Our work with key populations is in line with the Global Human Rights guidance all persons, including Key Populations, have a right to equitable health services, which includes access to adequate HIV prevention, treatment and care, support services and Sexual Reproductive Health Rights (SRHR). It is therefore extremely important to deliberately address structural barriers that hinder access to services such as stigma and discrimination, gender-based violence and criminalization.

Prison program in Masvingo District

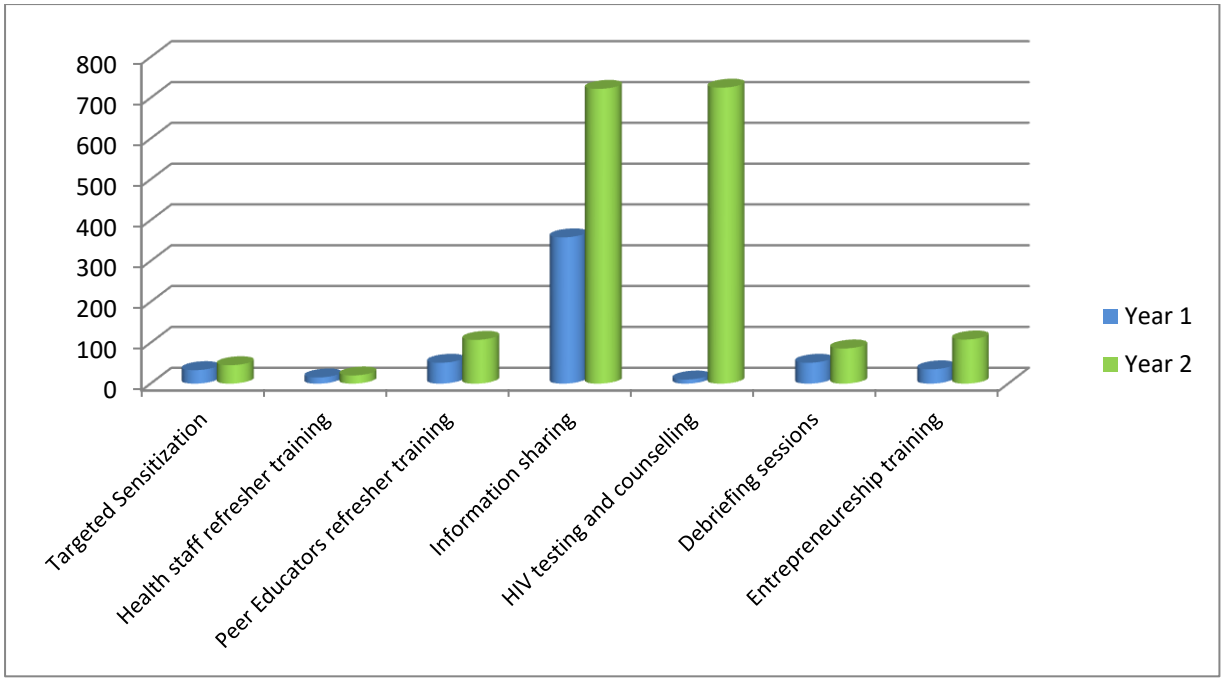
BHASO interventions with prisons and sex workers seek to improve availability and access to quality comprehensive HIV/SRHR services. Many prisoners have had no access, or very limited access to health services. Access to, as well as quality of, health services in prison is of vital importance therefore BHASO is partnering ZPCS health department to improve the health status HIV positive inmates and has been working in Mutimurefu Prison and Masvingo Remand Prisons since 2015.

Inmates graduating at Mushagashe Vocational Training Centre

Before the intervention, HIV/TB management in the prisons was weak and our partnership with ZPCS has strengthened ZPCS health department through capacity building workshops and training for ZPCS health staff such as HIV/TB management, HIV testing and counseling. 46 prison officers have been trained on HIV management. The figure below shows the number of services provided to inmates and the increase of services given are obvious after the training (year 2).

Peer support model was introduced as well as support group model to encourage HIV/TB information sharing and promote HIV testing, disclosure and adherence. 158 inmates have been trained as peer educators.

BHASO also enhance entrepreneurship and vocational skills of inmates to facilitate rehabilitation and reintegration in to the communities. A referral path way was also developed to ensure smooth referral of HIV positive inmates to community services upon their release from prison

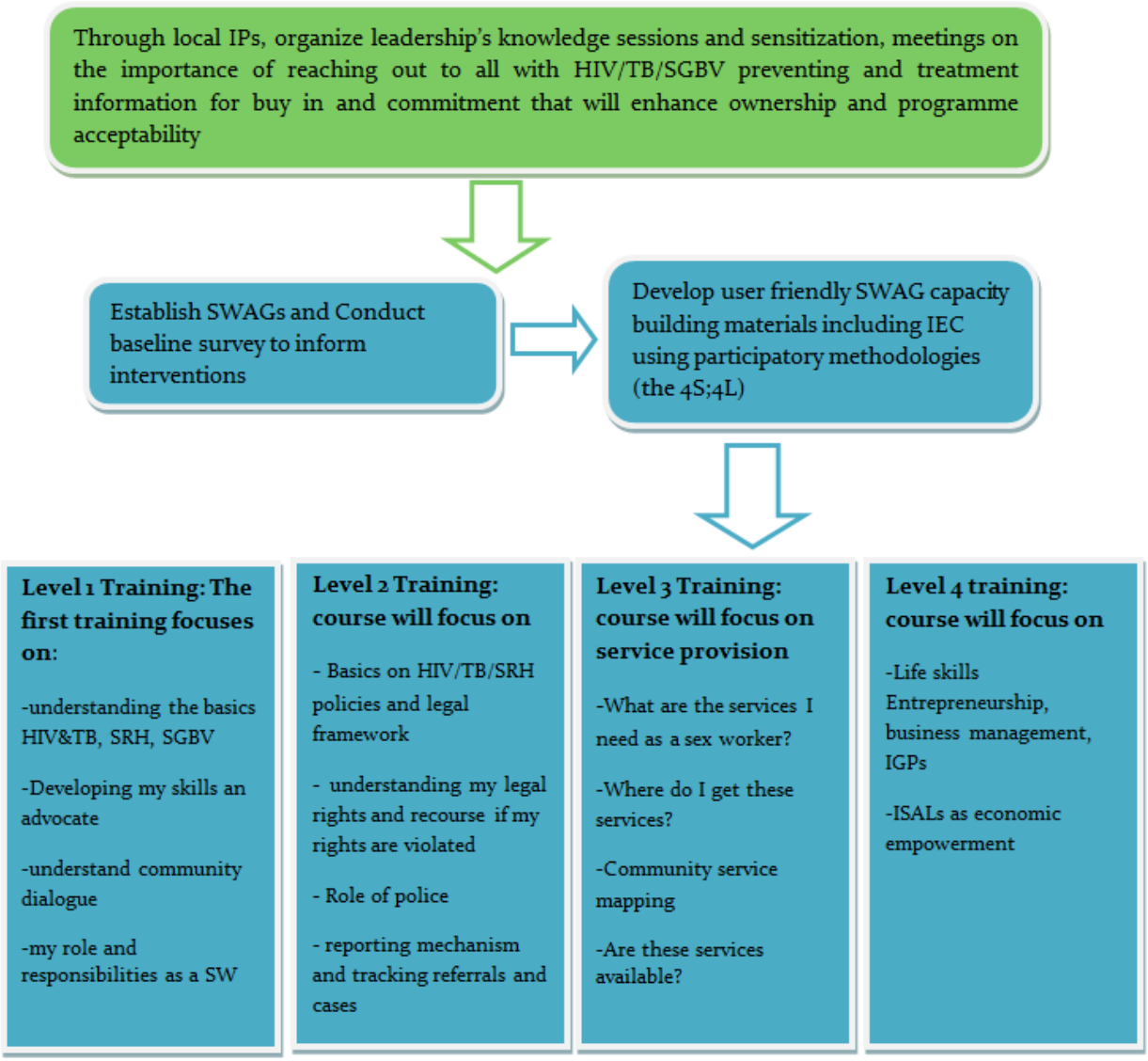


Figute4: A bar chart comparing targets reached in various areas of concern in the Prison Health project between Year 1 and Year 2.

SRHR services among sex workers in Chivi and Masvingo Districts

BHASO build the capacity of sex workers in advocacy work so that they would be able to advocate for their access to services as well as fight sexual harassment through the proper channels. To facilitate this process, BHASO developed advocacy concept called Sex Worker Advocacy Groups (SWAG), SWAG are local action groups of sex workers that support access to services for their peer sex workers and also raise the awareness of SRHR issues affecting sex workers. Currently there are 300 sex workers enrolled in the group and the members are led by team leaders, who are trained and empowered on advocacy skills and SRHR. 30 sex workers have been trained to be the team leaders. The team leaders coordinate SWAG activities in the community and participate in advocacy forums after going through an orientation process. The diagram below illustrates SWAG model works:

KP Gala: Sex Workers vs MSM



2.3 Adolescent and Youth Sexual and Reproductive Health and Rights

Our dream is that all adolescents and young people have access to quality sexual and reproductive health and rights (SRHR) services and support in a safe and receptive environment. In this regard, we envisage a community with resilient and empowered adolescents and young people who are better informed to make healthier choices. We help young people gain confidence and information about their SRHR to reduce the risk of early marriages, early sexual debut, teenage pregnancy, HIV and STIs. This was enhanced through implementation of 5 projects; Sustainable Communities Of Real Excellence (SCORE) , Gender Empowerment and Development to Enhance Rights (GENDER), Fresh Communication with Young People (FRESHCOM), National Action Plan (NAP1) and Egmont Trust Project.

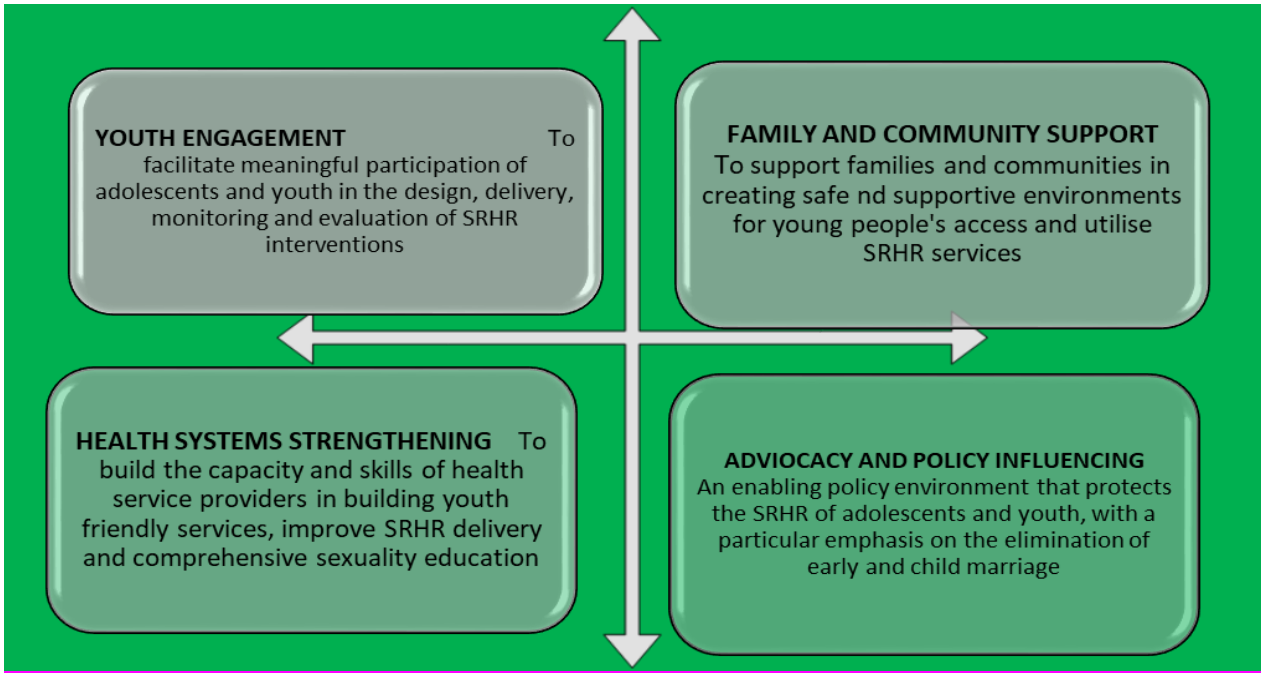
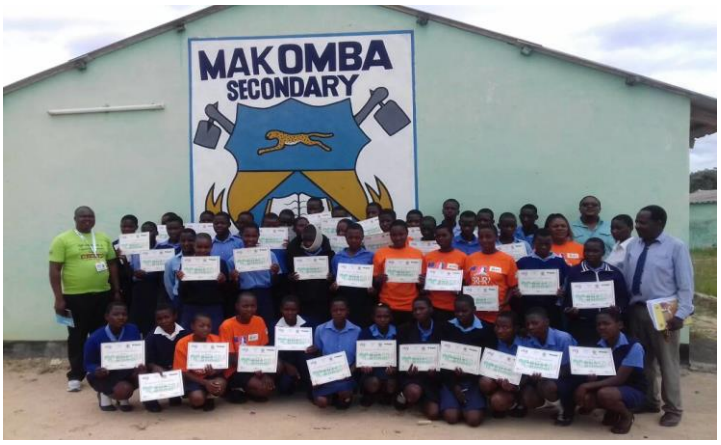


Figure5: AYSRHR - programme pillars

AYSRHR program in Chivi and Masvingo Districts

BHASO has been working since 2014 to improve the sexual and reproductive health, economic opportunities and evidence based advocacy for the health and economic empowerment of adolescents and young people and women in Chivi and Masvingo Districts. The primary focus was to improve knowledge on HIV prevention and SRHR as well as access to ASRH services for young people in school as well as community settings. Adolescents and youth (in and out of school) are empowered through access to appropriate and accurate SRHR information and services**.** BHASO learnt that they are two key ways to improve the SRHR outcomes of adolescents and youth which include 1) gender-sensitive, life-skills-based comprehensive sexuality education; and 2) access to adolescent and youth friendly sexual and reproductive health services1.

This intervention consists of two main components which is a school-based activity and community-based activity.



In the school based activity, BHASO used methodology of peer education. 1429 peer educators in 22 schools have been trained to raise awareness on HIV & SRHR issues and to refer their peers to appropriate services. Additionally 44 teachers have been trained to assist learners.

In the community based activity, BHASO operates peer educations (45 peer educators have been trained) and also conducts community dialogues additionally. Young people and community elders participate in the dialogues to discuss intergenerational gaps and SRHR issues. Capacity building of health workers and community volunteers on SRHR was done to facilitate child friendly services at health facilities

An enabling policy environment that protects the SRHR of adolescents and youth, with a particular emphasis on the elimination of early and child marriage was facilitated through creating a unique space to form an enabling policy environment for AYSRHR and the elimination of early and child marriage. With our diverse experience in advocacy we conducted grassroots advocacy, gathering contextual evidence that was utilized to better understand and address deeply rooted social norms and behaviours, which perpetuate sexual and gender based violence, including early and child marriage. Chiefs, village heads local and traditional leaders, key government ministries (Ministry of Primary and Secondary Education officials, Local government, Zimbabwe Republic Police and Ministry of Health officials) were engaged to help facilitate the process of translating policy into practice. Fourteen youth leaders, councillors and junior parliamentarians participated in joint community advocacy sessions with parliamentarians, partners or service users on the SADC model law on child marriages.

BHASO also made deliberate effort to reach out and penetrate the mining, farming communities and religious sects with sexual and reproductive health including HIV and AIDS information. As a way of building sustainability the programme capacitated young people to become champions of SRHR education, advocacy, motivating and referring of their peers for SRHR services within their own communities through the (young people information and services advocates) YPISA Champions. SHHR programme also contributes towards provision of support towards gender equality including a commitment to address gender dynamics, the norms and socio-cultural structures underlying inequality, as well as harmful gender roles and discriminatory practices by women and men of diverse cultures in marginalized settings

Key Highlights of our innovative SHRH activities

ACTIVITY	DESCRIPTION
Radio listening and reading clubs	This has proved to be unique methodology which provides edutainment to young people on SRHR issues. Discussions are initiated from the radio skits and books on SHHR
KKA dialogues with YPISAs	The KKA dialogues increased awareness on young people's sexual rights and constitutional rights. Many young people needed information on contraceptives
Hop on Mobile Taxis dialogues	This activity uses drama skits on the radio to identified Taxis and kombis. Drama skits are played during bvtrips which

	highlight issues around SRHR like intergenerational relationships, inability of children to be able to make choices because they are guided by the parents' interests, importance of parent to child communication, poverty being a cause of intergenerational relationships, sexual networks. Taxi drivers and conductors are trained first to sensitize them the objectives of the hop on taxi dialogues and also to Guide them on how to moderate the discussions after playing drama skits.
Music bash\Sports Gala	This is an activity of reaching out to high volume of young people in schools and communities with edutainment. Information dissemination will be done through music, drama and poems to promote access to quality SRHR issues
Intergenerational Dialogues	These dialogues are conducted with young people and key community gate keepers to discuss inter-generational relationships and HIV

2.4 Research Work: The Prevalence and Processes of Paediatric HIV Disclosure (2016-2017)

This was a population-based prospective cohort study in Zaka and Bikita conducted in conjunction with Duke Global Health Institute, University of Zimbabwe, George Mason University and Regional Psychosocial Support Initiative (REPSSI). The study was mainly aimed at measuring the prevalence of pediatric HIV disclosure; follow up caregivers of non-disclosed children to learn about the processes and consequences of disclosure. It also aimed to develop an easy and valid tool to assess a parent/ guardians' readiness and self-efficacy for pediatric HIV disclosure.

Findings from the study shows that while HIV mortality rates have decreased by 30% in adults; it has increased by 50% in adolescents. Disclosure was also found out to be still low at 15 years when young people are becoming sexually aware. The study also established that disclosure is a process, a very individual and unique experience and there is need for tailored interventions to support the caregiver especially around stigma and guilt. The role of the health worker in the disclosure process was also found out to be still significant.

3. Moving Forward Building on Practical experience

Considering our experiences and gaps in the HIV/ TB program, we state 3 focuses in our programs to achieve Universal Health Coverage (SDG 4);

- Integrated Community Decentralization and universal access to ART
- Adolescents Sexual and Reproductive Health (ASRH)
- Key Population (Prison, sex workers, MSM)

While significant strides have been made in relation to HIV prevention, treatment, care and support, there still exists a huge gap in universal access for HIV treatment, care and support given the vastness of the other districts where people travel long distances as far as 60 kilometres to collect their life saving anti-retroviral treatment from the clinics. In extreme cases, patients collect their treatment from neighbouring districts and are forced to walk for two days or more to reach their destination to collect medication. In the light of this analysis, Decentralization and universal access to ART was achieved in other districts in Zimbabwe but there is need to increase access to HIV care and treatment through putting our decentralization efforts in vast districts with **HARD** to reach areas expanding different DSD options including the OFCAD model which emphasises more on putting HIV treatment into the community and increase uptake of services at community level. The ZIMPHIA report of 2015 notes that the goal of ending the AIDS epidemic in Zimbabwe by 2030 is within reach, provided there is continued expansion of HIV treatment programs and targeted HIV testing therefore BHASO seek partnerships and collaborations in the following strategic focus arrears:

Integrated Community Decentralization and universal access to ART	
Programmatic Intervention	Resource needed
Scale up Patient Oriented Models in Mwenezi and to other districts in Masvingo Province. (OFCAD, CARG, family refill and Outreach Model) Scale up community patient support and mobilization models CHASA, Support groups Increase HTS through Index testing in hard to reach areas of Masvingo Province Scaling up Adolescents and Young people living with HIV Group Safe Spaces in Masvingo Province	***Movement support to outreach sites*** Vehicle with a trailer to transport drugs, MoHCC nurses and BHASO staff to outreach sites, fuel and jerry cans to support uptake of DSDs, mentoring and follow-up visits ***Outreach site equipment:*** Trunks, tents, tables, chairs, camera, laptops (to provide working space) ***Human Resources Support***: BHASO staff to support MoHCC (1 Nurse, 1 Field officer, 1 professional counselor and 1 driver)

	Stationary and IEC Material : Booking diaries for appointments with clients and IEC material for awareness and visibility ***CHW requirements:*** carrier bags, registers, folders, order books, OFCAD stamp, raincoats, canvas shoes (tennis) ***Nurses and CHWs trainings***: Venue, accommodation, transport, facilitators fees and allowances ***CHASA Trainings***: Venue, accommodation, transport, facilitators fees and allowance
Adolescent sexual reproductive health	
Programmatic Intervention	Resource needed
Comprehensive sexual and reproductive health education for adolescents in school and out of school, including those living with disabilities In and Out of school Peer Education model Health and Education professionals – SRHR trainings Parent to Child communication trainings Community leaders and Adult champions training on SADC model Law on the elimination of child marriages and Intergenerational/ community dialogues in Masvingo Rural district. Hop on mobile taxis dialogues Music bash and sports galas	***Trainings:*** Transport, meals, refreshments, venue, stationery, reproduction of manuals, accommodation, communication, facilitation and allowances ***Dialogues:*** Meals and refreshments , transport, facilitation allowances and stationery ***Hop on mobile taxis dialogues, Music bash and sports galas IEC Materials:*** Television sets, Radios, flash drives/ discs, Information packs/ guide books, T/Shirts, banners and fliers ***Mobilization:*** Transport and communication ***Human resource:*** AYSRHR Officer and YPISAs
Key population	
Programmatic Intervention	Resource needed

Training and facilitating peer (SWAGs) mobilization for HIV prevention, treatment and care linkages. Also supporting SWAGs among Sex workers Mobilization of sex workers for health, rights, literacy, safety and security trainings. Documentation of human rights violations, advocacy campaigns, sensitization trainings, research, peer to peer support Community mobilization covering PrEP and ART sensitization and clinic linkages. Support the development of HIV/AIDS and implementation of SRHR services in prisons Improving social accountability in Prisons, building resilience, Psychosocial support, improving the health status of HIV+ inmates Sexual and Reproductive health for inmates	***Mobilization:*** Transport and communication ***Documentation***: Development of tools, referral slips, transport, allowances and refreshments ***Trainings:*** Transport, meals, refreshments, venue, stationery, reproduction of manuals, accommodation, communication, facilitation and allowances ***Dialogues:*** Meals and refreshments , transport, facilitation allowances and stationery ***Administering Community Score card:*** Reproduction of tools, transport, refreshments, stationery ***Human Resources***

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