

Exploring HIV Care Services within the Framework of Universal Health Coverage in a Low-Resource Setting of Zimbabwe

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Abstract

Universal Health Coverage (UHC) is celebrated for expanding access to comprehensive, quality healthcare without financial hardship; however, its effectiveness in reducing health disparities in Africa depends on the equity and quality of care delivery. This study explored the lived experiences of rural women living with HIV in Zimbabwe, examining how health system design and provider practices influence well-being, stigma, and health equity. A qualitative, exploratory design was employed, using purposive sampling for in-depth semi-structured interviews and focus group discussions (FGDs). Forty participants were recruited (16 interviews and 24 FGDs), with data saturation achieved. Data were analysed thematically following Braun and Clarke's six-phase framework. Findings reveal persistent gaps between service availability and patient-centredness. While community-based support groups for people living with HIV (PLHIV) foster resilience, dignity, and social solidarity, institutional care often fails to safeguard patient confidentiality and respect. Public disclosure of HIV status in hospital settings exemplifies these breaches, undermining trust and perpetuating stigma and structural inequities within the health system. Three key themes emerged: (1) Breaches of Confidentiality and Compromised Privacy; (2) Resilient Sources of Dignity and Psychosocial Support; and (3) Loss of Dignity and Respect in Patient Care. The study concludes that achieving UHC requires integrating privacy, personalisation, and respect for patient agency into the design and delivery of health services. Strengthening these



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person-centred elements is crucial for developing resilient, equitable, and genuinely patient-centred health systems.

Keywords: health systems; HIV care services; low-resource setting; person-centred care; Universal Health Coverage (UHC); women; Zimbabwe

Introduction

Universal Health Coverage (UHC) is a cornerstone of global health policy. It is designed to ensure that all individuals and communities receive the necessary health services without incurring financial hardship (Royston et al. 2020). On the other hand, Barron et al. (2023) assert that universal health coverage would prioritise equitable access to healthcare services. Universal Health Coverage enables access to vital health information. As such, Royston and colleagues have argued that universal access to health information is a prerequisite for achieving UHC, as it would facilitate informed decision-making and enhance service utilisation among communities (Royston et al. 2020). In many low-resource settings, particularly in sub-Saharan Africa, HIV care has been a testing ground for health system resilience and inclusivity. Gebremeskel and colleagues confirm that Zimbabwe and other African countries, such as Tanzania, Kenya, and Nigeria, have a poor level of health, which is linked to the lack of long-term investment in health and low spending on health, thereby jeopardising the expansion of service coverage (Gebremeskel et al. 2021). The integration of HIV services into broader health systems has enhanced accessibility (Lazarus et al. 2021); however, Fifield and colleagues have noted that health outcomes suggest that responsiveness is a crucial component of high-quality healthcare systems (Fifield et al. 2022). This reveals a persistent gap in the protection of patient rights, confidentiality, and trust. The World Health Organisation (WHO) also declared that shortcomings in health systems and accessibility could risk undermining the effectiveness and ethical foundations of UHC implementation (World Health Organization 2025). Several studies report that health facilities themselves may breach confidentiality (intentionally or unintentionally), through gossip, non-private counselling, or through how clinic spaces are set up (for example, HIV clinics being identified publicly) (World Health Organization 2022; Rokach and Boulazreg 2022); Mpofu and Ganga Limando 2024a; Mulubale et al. 2022; Nicol et al. 2023). Thus, the fear of breach of confidentiality is a substantial barrier to testing, linkage to care, and retention. For example, a study in Kenya showed that some clients avoid HIV services or adopt strategies to hide their identity because mere attendance at an HIV clinic signals status (Kwena et al. 2023). Another example is that of Rwanda, with its Treat-All policies, in that early ART increases visibility of HIV in patients' lives, which has mixed effects: normalisation (positive), but also increases anticipated stigma or concern about being seen or judged (Ingabire et al. 2023).

Patient-Centred Care (PCC) is consistent with patients' values, needs, and desires. Wachira and colleagues suggest that such care provision is achieved when clinicians involve patients in healthcare discussions and decisions (Wachira et al. 2023). As such, health systems should embrace patient-centred care (PCC), as this necessitates a broader

set of processes that includes empathy, respect, engagement, relationship, communication, shared decision-making, holistic focus, individualised care, and coordinated care. The only drawback becomes the significant variability in how PCC is defined, implemented, and evaluated (Wachira et al. 2023); as they are key structural constraints that undermine PCC, like the staff shortages, high workload, limited training or competency (especially in managing HIV alongside comorbidities), lack of continuity of care, fragmented services, poor infrastructure (Rajagopaul and Naidoo 2025; Bosire et al. 2020; Wachira et al. 2023). There are also provider-patient relational issues, such as provider attitudes, poor counselling, and a lack of provider awareness of how stigma/confidentiality affect care engagement (Drossman et al. 2020; Nicol et al., 2023; Mpofu and Ganga-Limando 2024b; Wachira et al. 2023). Rathert and colleagues, on the other hand, argue that these relational dimensions are crucial as they facilitate communication in patient-provider relationships (Rathert et al. 2022).

Literature has also highlighted a burden on health systems because of the demand increase for treat “Treat All” policies, under UHC OR “Universal Test and Treat” (UTT) (Nicol et al. 2023). These researchers also indicate that some facilities struggle to maintain the quality of counselling, confidentiality, and patient-centredness in the face of increased volumes (Nicol et al. 2023). Moreover, Mboweni et al. (2023) note that the variations in staff training, for example, some primary healthcare facilities have many nurses trained in nurse-initiated management of antiretroviral therapy, while others have few, which leads to inequities in care quality.

Further still, often, support networks are used by people living with HIV. This means that these support groups can even be made up of family, peer groups, or community groups. They serve as a buffer against stigma, loneliness, or a lack of personalised care (Ninnoni et al. 2023; Ingabire et al. 2023). Often, some patients might adopt “quiet navigation” strategies to avoid stigma or breaches of confidentiality: choosing which clinic to attend, in order to avoid being “HIV-labelled.” They would prefer locations farther away and even self-management of care, where possible (Mulubale et al. 2022; Dadi et al. 2024). Other concerns of being HIV-labelled have come in the form of digital health, with an example coming from Malawi, where ART clients expressed concerns about data security, privacy, etc., as they viewed it as affecting their trust in digital tools (Oarii et al. 2024).

While UHC has improved access to essential services, questions remain about these systems’ quality, personalisation, and equity of care within these systems. Achieving UHC is not solely about expanding service coverage; it also requires that care be patient-centred, dignified, and responsive to the diverse needs of populations. Thus, this study aimed at exploring the lived experiences of rural women living with HIV, with a focus on examining how health system design and provider practices shape patient well-being, influence stigma, and affect health equity

Methods

Research Design

This research employs a qualitative, exploratory design grounded in health systems and equity frameworks. Both in-depth semi-structured interviews and focus group discussions were conducted to understand rural women's experiences of patient-centred care and the resilience of health systems in the healthcare centres.

Study Setting

This study was conducted in a selected hospital and community-based support groups in the low-resource rural area of Mtshabezi in Matabeleland South Province. This province has a relatively higher prevalence of PLHIV (21.6%), and the people there share the same culture and language (Mpofu and Ganga-Limando 2024a). The geographical environment is crucial for this study because women-headed households are typical in this province, as men migrate to neighbouring South Africa and Botswana for employment and sometimes do not return. They leave the women to take care of the family.

Recruitment of Participants

The study participants were purposively selected, and these were women living with HIV (WLHIV) who were also healthcare workers or community health volunteers. They were recruited through consultation with the community leaders who keep a register for all people living with HIV in these communities.

Data Collection

The study used semi-structured interviews, focus group discussions, and field observations. It was conducted between February and July 2024. The rural women living with HIV were contacted through the community health educators at the community's primary healthcare facilities. These would provide information on these women and select them for the study, including the time and venue for the interview. An interview guide was used to ask open-ended questions of these women. The researchers also used focus groups to collect data; therefore, participants were asked to sign non-disclosure documents before the focus group discussions took place. They were asked questions about their experiences with treatment at the hospital, including ethical standards, support groups, family support, and whether they encountered any discrimination or stigma. Additionally, they were asked whether they felt they were treated as customers at the healthcare institute. The interviews were conducted in their local language (Ndebele language). Each in-depth interview and focus group discussion lasted between 50 and 75 minutes and was audio-recorded and transcribed verbatim.

Data Analysis

The research utilised thematic analysis guided by principles of patient-centred care and health systems resilience, following Braun and Clarke's six-phase framework (Braun and Clarke 2006). These steps include (1) the researchers' description of their own experience of the phenomenon; (2) the researchers develop a list of significant statements from the participants' description; (3) grouping of the multiple reports into themes; (4) textual description of the experience and inclusion of verbatim examples; (5) structural description or the description of how the encounter happened; (6) writing of a composite report of the phenomenon incorporating the textual and structural stories. The data collected were transcribed and translated from Ndebele to English. The researchers read through all the transcripts and followed these six steps to categorise the themes and present them in sections. The research also incorporates direct quotes from the women to lend greater emphasis. The researchers had carefully selected the quotes, which demonstrate the reliability and validity of the data analysis.

Ethical Consideration

The researchers obtained ethical approval from the Medical Research Council of Zimbabwe (MRCZ) before commencing data collection (Ethical approval number MRCZ/A/2398). This ethical clearance ensured voluntary participation, informed consent, and confidentiality throughout the research process. The researchers would explain the study's objectives to the participants and obtain their permission to record their voices. The researchers sought their consent and assured the participants of confidentiality regarding the information they provided, while also offering them the option to opt out at any point in the interview process without consequence.

Findings

The study recruited and interviewed 40 rural women living with HIV (WLHIV). It employed a combination of face-to-face and focus group sessions. The face-to-face sessions consisted of 16 participants, while the focus group discussions comprised 24 participants, with eight women per group, resulting in three focus groups. Their demographic composition was as follows: 21 (primary level), 12 (high school), and seven (tertiary education). On the other hand, their relationship status was as follows: 26 (single, divorced, or widowed); 14 were married women. Concerning the unemployed or retired category, there were 27, while 13 were in part-time or full-time employment. However, their time since they were diagnosed HIV positive was similar to their time since they enrolled for ART, which ranged from three to five years.

The three themes that appear to portray patient-centred care for HIV in rural settings of Matabeleland South Province, Zimbabwe, are presented in Table 1.

Table 1: Summary of themes and related sub-themes

Themes	Sub-themes
1 Breaches of Confidentiality and Compromised Privacy	Undignified treatment Limited observance of ethical standards in information management.
2 Resilient sources of dignity and psychosocial support.	Support groups for resilience and emotional strength Family support that reduces isolation and stigma.
3 Loss of dignity and respect in patient care	Fragmented care Ethical violations and erosion of patient dignity

Themes

The study explored issues of breaches of confidentiality, lack of privacy, stigma in health worker attitudes, resilient sources of dignity, psychosocial support, and institutional practices that promote losses of dignity and respect in patient care.

Theme 1: Breaches of Confidentiality and Compromised Privacy

The disclosure of patients' health information without consent portrayed some lack of respect and undignified treatment as reflected by the hospital staff's social behaviour towards women living with HIV. This social behaviour from the hospital staff affected the women's self-esteem and social respect.

Sub-theme 1.1: Undignified Treatment

Women living with HIV felt they were not treated with the dignity and respect they deserved as human beings and responsible members of their community, a community they respected and thought principles of Ubuntu embodied it, so they felt disregarded.

This was best illustrated by an in-depth interview with a 40-year-old married woman who said that:

Being HIV-positive in this community means loss of dignity and respect in this community and its hospitals. Before being tested HIV positive, I was respected. Hospital staff talk to you as they wish... they give you degrading nicknames, I don't know whether this is intentional or unintentional, because sometimes they just divulge HIV status to everyone by calling out our HIV status loudly like (those with HIV, follow). (ID 06, does babysitting).

Another illustration is from a 51-year-old widower who said:

You see, these people don't consider what we want. They plan for us. They don't even ask me whether the set review day will be convenient for me. They just set the day convenient for them. They are the ones who can cancel the appointment. We are not allowed. When you arrive earlier than the scheduled date, they insult you. There is no 'Ubuntu' in this hospital, even the young nurses don't care, or respect our age, "they just put you in place" (what they usually claim to do). (ID 16, does jersey knitting).

However, some women interviewed expressed satisfaction with the treatment they received at the hospital, as illustrated by a 32-year-old unmarried woman.

As for me, I am lucky because any nurse that I encounter speaks softly. They don't shout my name or mention my status. So, I always feel safe as they see me as a person and not as someone with HIV. (ID 08, unemployed).

While the 27-year-old unmarried woman admitted there was a designated area for all the people living with HIV, she had something good to say about the treatment she was receiving from the clinic staff.

Of course, they call our section 'Opportunistic Infection' (OI), but the staff there are good people. They make me feel valued, and I always leave the hospital feeling strong and respected. They don't make us feel ashamed. (ID 10, does agriculture).

Sub-theme 1.2: Limited Observance of Ethical Standards in Information Management

These experiences were described with a lot of emotion and disbelief. It was best captured with the following narrative from a 43-year-old married woman:

What bothers me the most is the lack of consideration for our humanness. We are treated as outcasts and do not have the right to belong and be respected. You see, the nurses here can even give you information about HIV in corridors and don't care who is listening. (ID 04, does agriculture).

A 39-year-old married woman shared her experience with the hospital.

I used to hide my pills from my family. It does not matter anymore; I did not consent to group consultations at this hospital, but they ask us, all HIV patients, to come on Wednesdays. Everyone knows that Wednesday is our day. There is nothing to hide anymore. (ID06, does hairdressing).

Theme 2: Resilient Sources of Dignity and Psychosocial Support

Sub-theme 2.1: Support Groups for Resilience and Emotional Strength

Support groups, on the other hand, provided the women with benefits related to adherence and treatment monitoring. These support groups also restored women's dignity, belonging, and psychosocial resilience among women living with HIV. Compared to the formalised generalised institutional care, support groups provided a source of resilience, dignity, and psychosocial support.

The following statements from focus groups bear:

Our support groups do not look down upon us. Everyone here understands each other, as we refrain from gossiping about one another, unlike in our clinic or outside our community. We are free here, and we feel human once more. (FDG1).

In our support groups, we are not patients. They value my ideas, and it is here that I regain my sense of self. (FDG2).

There is no rush here, unlike in the hospital. Everyone gives you an ear to your story. I sense that my dignity is back. (FDG3).

Sub-theme 2.2: Family Support That Reduces Isolation and Stigma

My family is now supportive. I think it's because I have support from the support group I joined. So now, I don't hide my pills from my family. In fact, they remind me when I forget to take them. I am not alone anymore. (ID08, 29 years old, female, teacher).

I gained the confidence to attend family meetings and gatherings, and to speak out when someone hurts my feelings, because my mother-in-law understands me. She advised me to stand up for myself, and because of her support, I am no longer silent. (ID12, 32 years old, female, unemployed).

The narratives from these women highlight that peer-led support would compensate for structural deficiencies in formal healthcare delivery, such as privacy, continuity, and compassion.

Theme 3: Loss of Dignity and Respect in Patient Care

In this study, institutional practices (staff behaviour, policies) were enablers of breach of confidentiality as highlighted by women's voices when they were describing their lived experience as follows:

Sub-theme 3.1: Fragmented Care

There is no continuity at this hospital because nurses change frequently. This means we should continuously explain our stories from time to time; as you can see, we are treated as a group. Trust issues are a challenge here. (FGD3).

We are not comfortable asking questions at this hospital. We are unfamiliar with these new nurses. They come here and become our peer leaders from nowhere. (FDG1).

The health system is failing us; we would rather rely on support groups that we are assured of their continuity. The group is even helpful as we help each other with transport and food money, unlike our clinics. (FGD2).

The last statement from the woman shows that patient-centred care can emerge from community-level initiatives, even when institutional systems are weak.

Sub-theme 3.2: Ethical Violations and Erosion of Patient Dignity

Moreover, the right to make decisions on sexual and reproductive health issues was often exercised by husbands, family members, and healthcare professionals. Pregnant women living with HIV were discouraged by their husbands from having children. Family members' comments restricted them from getting pregnant. A 32-year-old woman narrated:

I wanted advice from the hospital, but I was discouraged by some people. My family strongly opposed the idea, treating me as a cruel and uncaring person to think of bringing a child to earth while having HIV. For sure, I never received any support on that. (ID08, does beads work).

A 50-year-old woman lamented about the family members' decision not to adopt a child, and even to have a child from relatives to live with her. They categorically said that as an HIV-positive person, she has no right to adoption or guardianship.

In this community, you cannot adopt a child or get a child from a relative to come to stay with you because you are HIV positive. We are treated as if we have no right to have a child. Look at me now; my son is working in town and rarely comes here. I feel deserted and unwanted, and I even blame my relatives for not giving me a child to stay with. (ID05, does agriculture).

Discussion

While UHC initiatives have expanded access to HIV services in low-resource settings, this study finds that care often remains generalised rather than personalised, and confidentiality breaches are common. In institutional settings, patients' HIV status is frequently disclosed in public spaces, compromising privacy and reinforcing stigma. This research then concludes that integration would improve access, while also exposing the system's weaknesses. Other scholars have also agreed with this view, as they have demonstrated that integration serves as a booster of service uptake, while also linking care and implementing it without compromising clinical outcomes (Bulstra et al. 2021; Goldstein et al. 2023). However, there are also implementation gaps, such as the patient volumes, under-resourced primary facilities, and poorly designed care processes, which erode the quality dimensions of care, especially privacy, continuity, and the relational aspects of person-centred care. This means that UHC is compromised in rural Matabeleland South Province of Zimbabwe, as it jeopardises the integration, as the treatment makes HIV attendance at these clinics more visible, as in the case of identifiable clinic days and designated areas such as the Opportunistic Infection (OI) areas (where the women were getting the ARVs). Psychologically, the women were affected as they felt that such designated areas were a way of telling the world that they were HIV positive. These women desired HIV services to be integrated with other care services. Such practices reflect more profound inequities and cultural norms within health systems that prioritise efficiency or coverage over individualised, respectful care,

just as seen in studies by Assefa et al. (2020). This disconnect undermines patient trust and discourages service utilisation, especially among vulnerable populations.

Just as Bulstra et al. (2021) found, this study also confirms that identifiable processes increase the risk of involuntary disclosure and stigma. Mpofu et al. (2025) note that it also fails to uphold the principles of both Ubuntu and UHC. The study highlights an urgent need to reframe UHC implementation to ensure that confidentiality, dignity, and patient autonomy are considered core dimensions of quality and resilience, rather than optional ethical add-ons.

This study also found that these ethical breaches, which occur in the form of patient flow, record systems, staffing models, and organisational cultures, do not prioritise patient rights during scale-up and thus compromise UHC implementation, as confirmed by studies by North (2020) and Khatri et al. (2023).

There is also evidence that peer-led and community-based models reliably improve psychosocial outcomes, adherence, and retention (Mark et al. 2019; Meng et al. 2021). Our study also emphasises that community-based models, like support groups and family support, offer personalised attention and a sense of belonging, which can also restore dignity and social capital for people living with HIV (PLHIV). They create safe spaces for disclosure, mutual aid (including food and transportation), emotional support, and practical problem-solving (Meng et al. 2023). UNAIDS (2019), in their programme evaluations, have also shown that community adherence groups, peer support, mentor-mother models, and youth peer networks create safe spaces for women living with HIV, even to disclose their status. Meng et al. (2023) have also claimed that community supports can also function as a compensatory resilience mechanism that preserves dignity when system design falls short.

Evidence in this study portrays a generalised institutional care and sometimes rushed care, which produces loss of dignity that compounds stigma and undermines adherence and trust. These findings are also reflected in other studies, which highlight overburdened clinics, fragmented services, and task-oriented encounters that leave little room for empathy, confidentiality safeguards, or individualised counselling (Beres et al. 2024; Kwame and Petrucka 2022).

Recommendations

Based on the findings, the study recommends that confidentiality protocols, privacy infrastructure, and patient empowerment training be made an explicit UHC quality metric. This can be achieved by incorporating routine monitoring that includes patient-reported measures of privacy and dignity to influence resource allocation. Again, the researchers recommend integrated care to conceal visible markers that would label patients. As this study revealed, support groups and family support are core components of UHC packages for HIV. Therefore, community groups and peer support services need

to be scaled up, institutionalised, and adequately funded to provide formal supervision, training, and remuneration, as well as to sustain quality and confidentiality protections. Above all, stigma reduction and patient communication must be paired with manageable workloads and accountability mechanisms so that respectful, private, person-centred interactions are feasible. Again, confidentiality must be treated as a core quality indicator for UHC, as highlighted in the positive statements by these women, who value privacy, respectful communication, and recognition of personhood that extends beyond diagnosis. Meaning that, if it is not, the expanded access can widen inequities by deterring marginalised groups from seeking care.

Conclusion

In summary, this study suggests that expanding coverage without addressing dignity and rights would result in an incomplete UHC, which risks perpetuating inequity. These findings serve as a practical reminder that UHC is relational and ethical, as it involves designing systems that protect privacy, honour personhood, and formally recognise community actors who restore dignity. Policymakers and implementers need to measure patient experience and fund community supports as they are integral to UHC and equitable health systems. Ultimately, the study argues that achieving UHC requires embedding privacy, personalisation, and respect for patient agency into the heart of health system reform. Strengthening these elements will help build resilient, equitable, and truly patient-centred health systems that deliver care and justice.

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References

- Assefa, Yibeltal, Peter S. Hill, Wim Van Damme, Judith Dean, and Charles F. Gilks. 2020. "Leaving No One Behind: Lessons from Implementation of Policies for Universal HIV Treatment to Universal Health Coverage." *Globalization and Health* 16 (1): 17.

- Barron, Gabriela Cuevas, Justin Koonin, Svetlana Akselrod, Helga Fogstad, Corine Karema, Lucica Ditiu, Katie Dain, and Neena Joshi. 2023. "Universal Health Coverage is a Matter of Equity, Rights, and Justice." *The Lancet Global Health* 11(9): e1335–e1336.
- Beres, Laura K., Ashley Underwood, Noelle Le Tourneau, Christopher Galloway Kemp, Gauri Kore, Lauren Yaeger, and Jingjia Li. 2024. "Person-centred Interventions to Improve Patient– Provider Relationships for HIV Services in Low-and Middle-income Countries: A Systematic Review." *Journal of the International AIDS Society* 27(5): e26258.
- Braun, Virginia, and Victoria Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3(2): 77–101.
<https://doi.org/10.1191/1478088706qp063oa>
- Bosire, Edna N., Emily Mendenhall, Shane A. Norris, and Jane Goudge. 2020. "Patient-Centred Care for Patients with Diabetes and HIV at a Public Tertiary Hospital in South Africa: An Ethnographic Study." *International Journal of Health Policy and Management* 10(9): 534.
- Bulstra, Caroline A., Jan AC Hontelez, Moritz Otto, Anna Stepanova, Erik Lamontagne, Anna Yakusik, and Wafaa M. El-Sadr. 2021. "Integrating HIV Services and Other Health Services: A Systematic Review and Meta-analysis." *PLoS Medicine* 18(11): e1003836.
- Dadi, Tegene Legese, Yadessa Tegene, Nienke Vollebregt, Girmay Medhin, and Mark Spigt. 2024. "The Importance of Self-Management for Better Treatment Outcomes for HIV Patients in a Low-Income Setting: Perspectives of HIV Experts and Service Providers." *AIDS Research and Therapy* 21(1): 28.
- Fifield, Jocelyn, Griffith A. Bell, Lisa R. Hirschhorn, Simon PS Kibira, June-Ho Kim, Fredrick Makumbi, Elizabeth Nabiwemba, Dan Schwarz, Fred Wabwire-Mangen, and Hannah L. Ratcliffe. 2022. "Person-Centered Care in Uganda: Analysis of Responsiveness, Patient Satisfaction, Patient-Reported Health Outcomes, and Trust among Adults." *IJQHC Communications* 2(1): lyac005.
- Gebremeskel, Akalewold T., Akaninyene Otu, Seye Abimbola, and Sanni Yaya. 2021. "Building Resilient Health Systems in Africa beyond the COVID-19 Pandemic Response." *BMJ Global Health* 6(6): e006108.
- Goldstein, Deborah, Michael Salvatore, Robert Ferris, Benjamin Ryan Phelps, and Thomas Minor. 2023. "Integrating Global HIV Services with Primary Health Care: A Key Step in Sustainable HIV Epidemic Control." *The Lancet Global Health* 11(7): e1120–e1124.
- Ingabire, Charles, Dana Watnick, Josephine Gasana, Francine Umwiza, Athanase Munyaneza, Gallican Kubwimana, Gad Murenzi, Kathryn Anastos, Adebola Adedimeji, and Jonathan Ross. 2023. "Experiences of Stigma and HIV Care Engagement in the Context of Treat All in Rwanda: A Qualitative Study." *BMC Public Health* 23(1): 1817.
- Khatri, Resham B., Eskinder Wolka, Frehiwot Nigatu, Anteneh Zewdie, Daniel Erku, Aklilu

- Endalamaw, and Yibeltal Assefa. 2023. "People-Centred Primary Health Care: A Scoping Review." *BMC Primary Care* 24(1): 236.
- Kwame, Abukari, and Pammla M. Petrucka. 2022. "Universal Healthcare Coverage, Patients' Rights, and Nurse-Patient Communication: A Critical Review of the Evidence." *BMC Nursing* 21(1): 54.
- Kwena, Zachary A., Rivet K. Amico, Tsitsi B. Masvawure, Kenneth K. Ngure, Elizabeth A. Bukusi, Robert H. Remien, Perez O. Ochwal, Nadia Nguyen, and Joanne E. Mantell. 2023. "Barriers to Linkage and Retention in HIV Care Still Persist among Adolescent Girls and Young Women in Western Kenya." *African Journal of AIDS Research* 22(2): 71–84.
- Lazarus, Jeffrey V., Kelly Safreed-Harmon, Adeeba Kamarulzaman, Jane Anderson, Ricardo Baptista Leite, Georg Behrens, and Linda-Gail Bekker. 2021. "Consensus Statement on the Role of Health Systems in Advancing the Long-Term Well-Being of People Living with HIV." *Nature Communications* 12(1): 4450.
- Mark, Daniella, Susan Hrapcak, Wole Ameyan, Ronnie Lovich, Agnes Ronan, Kathrin Schmitz, and Luann Hatane. 2019. "Peer Support for Adolescents and Young People Living with HIV in Sub-Saharan Africa: Emerging Insights and a Methodological Agenda." *Current HIV/aids Reports* 16 (6): 467–474.
- Mboweni, Sheillah Hlamalani, and Lufuno Makhado. 2023. "Perspective Chapter: Enhancing the Nurse-initiated Management of Antiretroviral Therapy Training and Implementation—A Conceptual Framework." *Health and Educational Success-Recent Perspectives*. IntechOpen.
- Meng, Xiaojun, Hanlu Yin, Wenjuan Ma, Jing Gu, Zhen Lu, Thomas Fitzpatrick, and Huachun Zou. 2023. "Peer-Led Community-Based Support Services and HIV Treatment Outcomes Among People Living with HIV in Wuxi, China: Propensity Score-Matched Analysis of Surveillance Data From 2006 to 2021." *JMIR Public Health and Surveillance* 9(1): e43635.
- Mpofu, Limkile, and Makombo Ganga-Limando a. 2024. "The Lived Experiences of HIV-Positive Women in Rural Zimbabwe: A Qualitative Focus Group Study." *South African Family Practice* 66(1): 5823.
- Mpofu, Limkile, and Makombo Ganga-Limando b. 2024. "Exploring the Lived Experiences of Women Living with HIV in Rural Zimbabwe: A Qualitative Study." *Medicine* 103(36): e39485.
- Mpofu, Limkile, Idah Moyo, and Azwihangwisi H. Mavhandu-Mudzusi. 2025. "Caring for the Elderly in the African Context: An Integrative Review." *Discover Global Society* 3(1): 127.
- Mulubale, Sanny, Sue Clay, Corinne Squire, Virginia Bond, Kasoka Kasoka, Lucy Stackpool-

- Moore, Tessa Oraro-Lawrence, Mutale Chonta, and Chipso Chiiya. 2022. "Situating HIV Stigma in Health Facility Settings: A Qualitative Study of Experiences and Perceptions of Stigma in 'Clinics' among Healthcare Workers and Service Users in Zambia." *Journal of the International Association of Providers of AIDS Care (JIAPAC)* 21: 23259582221100453.
- Nicol, Edward, Ngcwalisa Amanda Jama, Vuyelwa Mehlomakulu, Mbuzeleni Hlongwa, Desiree Pass, Wisdom Basera, and Debbie Bradshaw. 2023. "Enhancing Linkage to HIV care in the 'Universal Test and Treatment' Era: Barriers and Enablers to HIV Care among Adults in a High HIV Burdened District in KwaZulu-Natal, South Africa." *BMC Public Health* 23 (1): 1756.
- Ninnoni, Jerry Paul, Sampson Opoku Agyemang, Lydia Bennin, Elizabeth Agyare, Leveana Gyimah, Kafui Senya, Nyonuku Akosua Baddoo, Francis Annor, and Dorcas Obiri-Yeboah. 2023. "Coping with Loneliness and Stigma Associated with HIV in a Resource-Limited Setting, Making a Case for Mental Health Interventions; A Sequential Mixed Methods Study." *BMC Psychiatry* 23(1): 163.
- North, Jonathan. 2020. *Achieving Person-Centred Health Systems: Evidence, Strategies And Challenges*. London: Cambridge University Press.
- Orii, Lisa, Caryl Feldacker, Jacqueline Madalitso Huwa, Agness Thawani, Evelyn Viola, Christine Kiruthu-Kamamia, Odala Sande, Hannock Tweya, and Richard Anderson. 2024. "HIV Client Perspectives on Digital Health in Malawi." In *Proceedings of the 2024 CHI Conference on Human Factors in Computing Systems*, pp. 1–13.
- Rajagopaul, Althea, and Mergan Naidoo. 2025. "Healthcare Workers' Perception of Quality of Care Rendered to People Living with HIV and Non-communicable Diseases at an Urban District Hospital in KwaZulu Natal, South Africa: A Mixed Mode Study." *BMC Health Services Research* 251: 1302.
- Rathert, Cheryl, Jessica N. Mittler, and Yuna SH Lee. 2022. "Patient–Provider Therapeutic Connections to Improve Health Care: Conceptual Development and Systematic Review of Patient Measures." *Health Care Management Review* 47(4): 317–329.
- Rokach, Ami, and Samir Boulazreg. 2022. "The COVID-19 Era: How Therapists Can Diminish Burnout Symptoms through Self-care." *Current Psychology* 41(8): 5660–5677.
- Royston, Geoff, Neil Pakenham-Walsh, and Chris Zielinski. 2020. "Universal Access to Essential Health Information: Accelerating Progress Towards Universal Health Coverage and Other SDG Health Targets." *BMJ Global Health* 5:5.
- UNAIDS JUNP on H. At a Glance - HIV among Women and Girls in Sub-Saharan Africa. 2019.https://www.unaids.org/sites/default/files/women_girls_hiv_sub_saharan_africa_en.pdf

Wachira, Juddy, Becky L. Genberg, and Ira B. Wilson. 2023. "Promoting Patient-Centered Care within HIV Care Settings in Sub-Saharan Africa." *Current Opinion in HIV and AIDS* 18(1): 27–31.

World Health Organization. 2025. *Global Standards for Quality Health Care Services for Adolescents*. World Health Organization
https://books.google.co.za/books?hl=en&lr=&id=Tn-UEQAAQBAJ&oi=fnd&pg=PR4&dq=health+facilities+themselves+may+breach+confidentiality+on+personal+care+&ots=ELjYJO46_&sig=8A_Q_1qxf3YLQIP_sObkQ5J_kgM&redir_esc=y#v=onepage&q&f=false

World Health Organization. 2022. *WHO Guideline On Self-Care Interventions For Health And Well-Being, 2022 Revision*. World Health Organization.
https://books.google.co.za/books?hl=en&lr=&id=ZnoOEQAAQBAJ&oi=fnd&pg=PR6&dq=health+facilities+themselves+may+breach+confidentiality+on+personal+care+&ots=CgPgMzFp7U&sig=ouR3_iliv_77H-q6CbIUyn30sfc&redir_esc=y#v=onepage&q=health%20facilities%20themselves%20may%20breach%20confidentiality%20on%20personal%20care&f=false