MSF ZIMBABWE NEWSLETTER

MEDECINS SANS FRONTIERES

Médecins Sans Frontières Charter

- Médecins Sans Frontières (MSF) is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

- Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

- Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

- Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, or religious powers.

- As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

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COUNTRY DIRECTOR'S NOTE

Welcome to the second edition of the Medecins Sans Frontieres (MSF) in Zimbabwe newsletter. This is a newsletter that highlights various activities and developments that took place within MSF in Zimbabwe in the first half of the year.

In March this year, Zimbabwe was hit by a catastrophic cyclone that ravaged parts of Manicaland. The worst affected area was Chimanimani, where the cyclone caused massive flooding and landslides that affected tens of thousands of people. Many lives were lost while property and infrastructure was destroyed. In this edition of the newsletter, we will share with you stories about our intervention in Chimanimani where our teams were among the first responders to the devastating Cyclone Idai. We will share testimonies from our staff members as well as testimonies from some survivors of the cyclone.

MSF doctors and nurses together with other health service providers delivered medical assistance to survivors of Cyclone Idai and provided essential items and basic water and sanitation interventions. Our teams also provided medicines for chronic conditions, and assisted with psychosocial support to affected communities; through Psychological First Aid (PFA), Training of Trainers on basic counseling skills and identification of trauma, anxiety, depression and grief, mentoring and training for nurses and village health workers in selected clinics in Chimanimani. We will also share stories on how our teams managed to access other health centres in Chimanimani either on foot or bicycles or motorbikes and covering distances between 12 to 30 kilometers in order to save lives after roads were damaged. The Cyclone did not only affect Zimbabwe but it also affected parts of Mozambique and Malawi. You will also read about our interventions in Mozambique.

From our Gutu project, we share with you success stories from two women who were screened for cervical cancer and received treatment early.

We will also share our work on working with migrants. In Beitbridge, MSF is providing a comprehensive outpatient health care package to migrants and mobile populations through targeted and differentiated interventions that include: out-patient department (OPD) services, mental health, sexual and reproductive health, HIV Testing and ART Refills, TB screening, NCD drug refills, health promotion, treatment of SGBV as well as counselling and psychosocial support to the returned migrants.

You will also read articles about our sexual and reproductive health project in Mbare, Harare where MSF provides adolescent friendly services that include general health check-ups, HIV testing and counselling, screening for sexually transmitted infections (STIs), and family planning, all free of charge in collaboration with the City of Harare Health Department, since November 2015. As part of its sexual and reproductive health services, MSF is providing free menstrual cups to adolescents and young women aged between 10 and 24 years at the Edith Opperman clinic in Mbare, Harare.

In the remaining months of the year, we plan to handover the Mwenezi HIV project where we introduced new models of HIV treatment and care to patients in the hard to reach areas. We are also rolling out cervical cancer outreach programmes in rural Gutu where MSF is supporting the Ministry of Health and Child Care (MoHCC) to provide cervical cancer screening. MSF is continuing to provide treatment, care and support to people living with HIV and non-communicable diseases like hypertension and diabetes. MSF projects in Zimbabwe are currently located in Beitbridge, Chipinge, Gutu, Harare and Mutare.

3 CHIMANIMANI: A COMMUNITY IN DISTRESS

Chimanimani, a district located in the eastern part of Zimbabwe, is a community in distress after cyclone Idai wreaked havoc in this mountainous region.

A visit to the area showed an unbelievable trail of destruction on property and infrastructure. Houses, shops and police centres in some communities were completely destroyed and all that remained were boulders. A person who had not been to the area could not tell that there were constructions in the area before. Roads were damaged, bridges destroyed and some trees were uprooted.

MSF Emergency Coordinator asseses a damaged road in Chimanimani

MSF set up a stabilsation centre at Skyline in Chimanimani to provide medical assistance to survivors of Cyclone Idai

Norman Makaruke, an MSF nurse, attends to a survivor of Cyclone Idai at Skyline stabilisation centre in Chimanimani

The night of 15 March 2019, is a night that many will not forget in a hurry. It is difficult to understand what really happened but community members have different tales to tell. Some say they experienced something that felt like an earthquake while others heard sounds that felt like moving heavy trucks. Some believe that the catastrophe was caused by flooding and landslides after local rivers and their tributaries burst their banks.

All these sounds were heard slightly before houses were destroyed by heavy rocks killing hundreds of people. A look at faces in the community told a very sad story of a community that was still in shock and traumatized.

In these small communities, almost everyone knows the other, as such, everyone was affected in one way or the other. It's either one had lost a child, brother, sister, mother, father, neighbor, a relative, a workmate or the whole family. Others had relatives and colleagues who were still missing. Hundreds of people were reportedly missing and thousands of people were displaced.

In the community, some people were still trapped and buried under boulders at the time of visiting the area. Villagers spent days digging trying to recover the remains of their beloved ones. Whenever they detected a smell or where they saw flies lingering, for them it was a signal that there was a dead body underneath. Some bodies were retrieved using this cruel tactic.

This catastrophe, the first of its kind to be experienced in the area, left a trail of destruction in the community and changed the lives of many in an instant. Many were left destitute as they were left with nothing after having lost everything including food, shelter, clothing and their sources of livelihood. Many also lost their life saving medications.

A team from MSF set out from Mutare on Sunday while the cycone was still wrecking havoc inside Chimanimani trying to gain access. With roads and bridges having been destroyed, it became very difficult for the humanitarian community to quickly provide aid.

MSF in collaboration with MoHCC set up a stabilization centre at Skyline, on the outskirts of Chimanimani. At this centre, patients were being ferried by helicopters from inside Chimanimani to Skyline stabilisation centre. People who were severely injured were being transferred to the nearest referral hospital, Chipinge district hospital.

There were also concerns and fears of outbreaks of water borne diseases like cholera and typhoid because there were still bodies that were buried under the rubble. Water pipes were cut off by the cyclone and the lack of water supplies was now a major concern.

MSF teams supported MoHCC to provide medical assistance including provision of chronic care medicines to people that were affected by Cyclone Idai.

The teams also conducted health needs assessment in the hard to reach areas of Chimanimani.

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Before Idai hit, Marthe was working in MSF's innovative pilot project with the health ministry for the management of diabetes and hypertension in nearby Chipinge district. **Writing from the worst-hit districts of Chimanimani and Chipinge,** she describes the events of the first six days as MSF staff rapidly switched from regular activities into emergency mode.

MSF medical team leader Marthe Frieden was part of MSF's emergency team responding to Cyclone Idai, which hit Zimbabwe's mountainous Manicaland province on the night of 15 March, causing flooding and deadly landslides particularly in Chimanimani district.

Nyamavhuvhu - the month of wind. That's what the month of August – the windiest month before the first rains - is called since time immemorial in Shona, one of the local languages in Zimbabwe. Mhepo iri kuvhuvhuta! The wind is blowing! Yet this year, winds of more than 200 kilometres an hour came on the night of 15 March, amidst an unusual drought in the rainy season, with a cyclone that dumped tonnes on Zimbabwe's Manicaland province.

Until that night, our project in Chipinge had slowly, slowly, (mbichana mbichana), been building the bridge between infectious diseases like HIV and TB and non-communicable diseases, like diabetes and hypertension, treating patients who arrived in clinics with multiple diseases. Our biggest headaches were the economic melt-down in Zimbabwe and the unreliable, unaffordable medication supplies that plague the country. We were progressing at a quiet pace, occasionally interrupted by an outbreak of malaria or diarrheal disease.

Then Idai arrived. It knocked down trees and turned rivers into wild streams. It swept away bridges and essential roads. It destroyed roofs and entire houses. It triggered landslides raging down the mountains, "like angry tears" as one villager described it. It lifted up rocks and rushed them down "like roaring trucks with no brakes". The rockslides smashed houses and buried people in mass graves while the floods swept away whole families. Idai battered people to the depths of their hearts and their spines.

Day 1 (Saturday 16 March):

I attend an urgent meeting called by the Civil Protection Unit with the MSF team. There is a sense of desperation and helplessness as the extent of the damage becomes clear, and the understanding that the devastated areas are cut off from the world. Instinctively we know that we have to accelerate our usual pace and change our approach.

OUR LEADERSHIP STYLE GOES FROM **PARTICIPATIVE TO DIRECT INSTRUCTION.** WE ARE IN EMERGENCY MODE.

We swap our casual football T-shirts for official MSF T-shirts. We cut short the traditional flow of salutations: we have to be straight to the point. We know we have to act now – although 'now' is always longer than intended. Over the next few days we notice that our metabolism changes to another mode too: we eat and sleep less, but perform far more.

Day 2 (Sunday 17 March):

We leave Mutare with the aim of dropping off medical supplies at Mutambara hospital in Chimanimani district. After muddling our way for a whole day through a labyrinth of collapsed bridges and inaccessible roads blocked by land and rockslides,

we conclude that neither the main two roads nor the secondary dirty roads into the district are accessible. The district is completely cut off. Change of tactic: with the health ministry, we decide to set up a stabilisation centre for survivors at a strategic point on top of a hill overlooking the affected area in Chimanimani, known as 'Skyline'.

Day 3 (Monday 18 March):

We establish contact with the Zimbabwean army to ask permission to erect three tents at 'Skyline' and to ask for help in a desperate effort to send much-needed supplies to cut-off hospitals. We are given the choice on where to pitch our tents as no other NGOs have arrived yet.

In the distance I see a group of people looking out over the affected area, discussing feverishly. They are from the local community and impatient to fly helicopters down into Chimanimani valley to save the lives of a population they know. They are worried and frustrated about the delays, and don't want their wings cut by procedures and lengthy coordination mechanisms. Meanwhile the rains continue to pour down, the mist turns into fog, and the helicopters remain grounded.

By now, dozens of people are already reported dead, with even more reported missing. Reports come through of hundreds of homes collapsed or swept away. The clock is ticking.

PARTICIPATIVE TO DIRECT INSTRUCTION | SETTING UP A STABILIZATION CENTRE | SETTING UP PHARMACY STORE

Day 4 (Tuesday 19 March):

Our emergency coordinator arrives from Harare, and meets us at 'Skyline'. A team of young, highly specialised Zimbabwean volunteer doctors have seemingly popped out of nowhere and taken possession of our tents. They are from an energetic network of churches, hospitals and the University of Zimbabwe. Some have already been flown into the cut-off territory by helicopter. Tinokugamuchirai mose – we welcome you! Let's work together: your technical skills with our emergency experience. As more organisations arrive throughout the day, collaboration happens ad hoc, according to immediate synergies and complementarities. We start setting up a coordination mechanism with the health Ministry and other actors on the scene. Social media becomes a part of efficient communication, and a 'Cyclone Idai medical group' is created on WhatsApp.

The first patients arrive before any beds can be organised. Some patients have infected wounds, but there is no water for handwashing yet. Lying on plastic sheeting on the floor, patients are examined and stabilised by doctors and nurses.

As the sky clears up, more and more patients with broken bones or deep lacerations are evacuated by helicopter out of the low-lying flooded area to Skyline. Private ambulances take patients to hospital, while MSF transports people with less severe injuries to Chipinge district hospital around 50 kilometres away.

Processes and paperwork are bypassed when circumstances require speedy coordination between helicopter pilots and doctors departing for health facilities inaccessible by road.

Accountability becomes a question of conscience, trust and rapid assessments of risk versus benefit.

Day 5 (Wednesday 20 March):

We meet a crowd of people marching uphill to salute the Zimbabwean President expected the same day, and receive the first humanitarian donations. A well-known soft drink company gains my respect by dragging up hundreds of bottles of drinking water. A fuel company comes in with heavy equipment to reopen or rebuild roads. Mobile toilets have arrived and a national life insurance company has provided beds.

We are setting up a pharmacy store when the tents are ripped off by a whirlwind caused by a helicopter flying dangerously close. What a blunder! Nevertheless, the process of rescuing the injured, stabilising them and transferring them to hospital continues. Meanwhile, we worry endlessly about the situation out there. What about the hard-hit areas not

being reached, corners inaccessible to helicopters, blind spots? Walking into the valley isn't an option. The army and private companies on site are trying to open a direct road. Can our team get into the district tomorrow?

Day 6 (Thursday 21 March):

Finally a water tank arrives at Skyline. The number of patients arriving with trauma injuries decreases rapidly. Residents from the mountainous area surrounding the skyline, some of which were hardly touched by the cyclone, turn up on foot in search of medication for HIV, diabetes, hypertension and asthma. Some lost their supplies during the floods, many can no longer access their health facilities. We have to bridge the gap and the stabilisation centre becomes a primary healthcare unit. Good news arrives: a road has opened up. Our mobile teams are now able to access the affected areas by vehicle, as long as the rain stops. Among the major findings they will report in the coming days are chronic conditions and a lack of medication.

With the emergency response ongoing, the dead being buried, the survivors being supported to rebuild their lives and infrastructure being reconstructed, it becomes clear to me that a bridge must be built between the emergency response and chronic care. Trauma victims with fractures or those who sustained severe injuries need follow-up care in the medium or long term, especially those with spinal injuries. Survivors with post-traumatic stress disorder risk joining those whose mental health problems go untreated as many mental health medicines are not readily available in Zimbabwe. Some of the cyclone survivors will join the queues at local health facilities desperately looking for available and affordable medication to treat their chronic conditions, like diabetes, hypertension, asthma and epilepsy.

Even before the cyclone, it wasn't all milk and honey in Manicaland province. A crisis was already brewing before disaster even struck. Picking up the pieces from Idai is going to take time and energy.

In the aftermath, we are witnessing a multi-layered calamity: A drought, an economic crisis, a devastating cyclone, an underlying HIV epidemic that is not over yet and growing rates of diabetes, hypertension and other non-communicable diseases. A broad approach in the medium and long-term is needed. Our MSF teams will remain, alongside the health ministry, building bridges where we can.

The consequences of Cyclone Idai on Zimbabwe are on a massive scale. Many bridges and whole roads have been washed away, or remain blocked by rock fall, leaving some communities only reachable on foot. In some areas, the flooding swept away entire houses, shops and factories, destroying people's homes and livelihoods. Access to safe drinking water is a major issue after many pipes were carried away.

THE SKYLINE STABILIZATION CENTER HAS NOW FULFILLED ITS ROLE AND IS NOW BEING CLOSED. WITHIN CHIMANIMANI DISTRICT, AN MSF TEAM IS NOW WORKING IN CHIMANIMANI HOSPITAL ALONGSIDE MINISTRY OF HEALTH STAFF IN PATIENT MANAGEMENT AND FILLING GAPS IN SUPPLIES OF ESSENTIAL MEDICATIONS. WATER TREATMENT AND PREVENTION OF DIARRHEAL DISEASES IS AN ESSENTIAL COMPONENT OF MSF'S RESPONSE.

Two MSF mobile teams are currently moving around the district on foot, trying to reach as many as possible of chimanimani's 20 health centres and surrounding settlements to assess people's health needs and distribute medicines to clinics and village health workers. They are also distributing basic supplies and aqua tablets to purify water for drinking. Currently people's main health needs in Chimanimani district include trauma injuries, antiretroviral treatment refills for HIV patients and chronic disease medications.

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5 MSF TEAMS REACHING AFFECTED COMMUNITIES ON FOOT AND BIKES

"We realised that in a situation like this, one cannot stop working and assisting communities in need, because the car cannot move. It's not an entitlement to be moving in a car all the time. It's a great feeling when you manage to walk into these areas and you know that you are bringing in medicines for the affected communities and the medicines can help to save someone's life," says Mr Nissen.

Medical teams from MSF conducted outreach programs to assess health needs and provide medical supplies in hard to reach communities and health centres in Chimanimani and Chipinge that were affected by Cyclone Idai.

"We learnt that the cyclone struck on a Friday night and that's when they had the first injuries and deaths, and we only got to know what had happened on Sunday. The MSF team went straight away to conduct an assessment but the roads were inaccessible. On Monday, the team decided to set up a stabilization centre at Skyline junction on the outskirts of Chimanimani and MSF was among the first organizations to set up at the stabilization centre before other partners joined," said MSF Country Director for Zimbabwe, Mr Bjorn Nissen. From the assessments conducted by MSF teams in Chimanimani and Chipinge, there was a lack of medication for chronic diseases like hypertension and diabetes.

MSF teams resorted to walking on foot or using mountain bikes to cross-rivers and climb mountains to reach patients in affected areas that were difficult to reach.

MSF teams supported MoHCC to provide medical assistance including provision of chronic care medicines to people that were affected by Cyclone Idai. MSF was concerned that if this situation was left unaddressed, people were going to end up dying from diseases that should not kill anyone culminating into another disaster, explained Mr Nissen.

MSF was also concerned that the lack of clean water sources in Chimanimani could result in outbreaks of water borne diseases like cholera and typhoid. Water pipes were destroyed by the cyclone. MSF teams distributed aqua tablets to purify water and conducted health education sessions on prevention of cholera, safe hand washing techniques and general hygiene practices in collaboration with MoHCC.

When most of the roads in Chimanimani became inaccessible following massive infrastructure destruction caused by Cyclone Idai, MSF teams resorted to walking on foot or using mountain bikes to cross-rivers and climb mountains to reach patients in affected areas that were difficult to reach.

"Our teams crossed rivers and climbed mountains to reach affected communities either on foot or cycled, covering distances of between 12 to 30 kilometers. It's a nice challenge because we had a mission to accomplish.

You forget the suffering and you are more focused on getting to the destination," explains Mr Nissen.

"I am proud of our contribution although it was frustrating in the beginning because we could not get direct access. In this kind of disaster you have 48 hours to make a difference, especially on treating injuries."
52 patients were treated at the stabilisation centre.

6 THE ROLE OF MSF LOGISTICIANS DURING EMERGENCIES

BY GUILLAUME MALIN

We arrived in Chimanimani after six hours of driving. Three of these had been along a mud track, cluttered with construction vehicles.

The situation we found when we arrived was consistent with the reports we'd heard from the on-site team: roads half-collapsed into flooded rivers and huge rocks covering the places that had been villages.

The damage meant many of the routes were cut off to vehicles, and we saw men, women and children of all ages walking along what remained of these roads.

When we arrived at the hospital, we found the Mutare project team, who had been responding to the emergency since the beginning.

While the medical team was hurrying to the patients, Zozomera (the Mutare project logistician) and I went to assess the state of the infrastructure. As a logistician, my job is to think about the equipment, buildings, and supplies that the medical team need to save lives.

Zozomera Zozomera, Chipinge Project Logistician

MSF Logistics Coordinator Guillaume Malin assessing the possibility of crossing the river with a vehicle in order to reach some affected communities of Chimanimani.

Managing the morgue

Hundreds of people were killed when Cyclone Idai hit Zimbabwe, many of them in the Chimanimani region. In a situation like this, management of the dead becomes critical, as their bodies represent a risk of contamination.

So, after introducing ourselves to the manager, we equipped ourselves to visit the morgue.

The morgue was visible from the entrance of the hospital car park, with empty coffins stacked in front, and a strong smell.

Following our visit, and in collaboration with the medical coordinator, we decided we needed to act quickly.

A meeting was organized with morgue staff. Cyclone Idai was a major natural disaster - we learned that the morgue team didn't have the equipment or training to manage such a high number of deaths.

Zozomera quickly organized the purchase of gloves, essential for the handling of chlorinated solution. For my part, I organized the medical donation of mortuary bags – non-porous bags that bodies can be stored and transported hygienically. Meanwhile, a member of the hospital staff dug a drain to channel the clean up water into a disused well.

We gave the team a booster session on how to prepare disinfectant solutions using the chlorine granules we had brought. Once the bodies were properly prepared in the body bags, teams of two people began, in turn, cleaning the walls, tables and floor

of the morgue.

Once the team briefing was done and cleaning started, Zozomera was able to organize the construction of a fence so that the morgue would no longer be visible (while leaving direct access for ambulances). A handwashing point at the entrance and an area for staff to change their clothing were also installed to minimize the risk of contamination.

Assessment at Charleswood

After the first patient visit and a discussion with the authorities, a team consisting of the country director, the medical coordinator, and a nurse from the Ministry of Health, decided to visit Charleswood, a local area that we suspected had not received support since the cyclone.

While trying to reach the village, we came to an abrupt halt. The road ahead of us had disappeared in a landslide. Where there was a road there was now a river cutting us off.

The river was not wide and it was shallow. The passengers could easily cross on foot.

For the vehicle crossing seemed possible but we had to make sure we did not get stuck in the middle of the current with the risk of losing our driver, Vuso as well as our car.

So, I went to check the river bed – looking at the depth of the holes and the size of the rocks. We were stopped on the first attempt by very soft sand that hid a rock beneath it.

After removing the rock, the car was able to pass unhindered.

But after a few hundred metres, our car had to stop because a landslide had taken a long stretch of the road; there was nothing left to cross.

As the medical team continued on foot, with just a radio handset for communication, Vuso and I returned to the river. Looking at the sky we could see the threat of rain.

I didn't want the driver to be stranded by a sudden rise in the water level, so, maintaining communication with the team en route to Charleswood, Vuso and I returned to Chimanimani.

On the road, we spotted a young woman and her husband. The woman was about to give birth, and we immediately helped them into the car and drove to the hospital.

Meanwhile, Zozomera had almost finished cleaning the morgue and had made the pile of coffins disappear from the sight of all. He even managed to contact the authorities responsible for the water supply and to have them urgently repair the pipes supplying the hospital.

Two hours later, the hospital had running water again.

Nature of roads in Chimanimani

After the Cyclone Idai, the town of Chimanimani was cut off. Chimanimani is in a mountainous region, and the landslides and flooding meant that the community could not be reached. The only way was the helicopter, which we could not use for security reasons.

As soon as a "road" was opened, a first MSF team could go on site to start assessing people's medical needs after the cyclone.

This first pass was relatively easy. On the last part of the road we managed to cover the last 30 kilometers on an open track in the mountain in only two hours, because it was dry.

After our visit, we had been planning to return to Harare, Zimbabwe's capital, to organize the support that would be needed to start providing the much-needed medical care. However, it had rained during the night, which we knew would make the roads impassable, so we took advantage of this opportunity to deepen our evaluation of the medical and logistical needs in the area.

The next day we were able to arrange a start at sunrise. Unfortunately, after joining the track, we realized that the condition of it had worsened.

We drove only about 300 metres before our vehicle was mired in 80cm of liquid mud.

The whole team set about trying to free the car.

After 20 minutes we were operational, covered with mud, but ready to leave.

Luckily, other vehicles, belonging to a local association seasoned on this kind of terrain, had joined us. Together we covered the 30km in 3 hours and 30 minutes.

It was a difficult journey for both men and machines. In this kind of situation, it's easy for everyone to realise why MSF invests in 4x4 Land Cruisers, a well-known model at MSF.

For the logistics team, keeping our vehicles in top working order is essential as it allows us to react immediately in this kind of situation, without which we could not reach the people who urgently need our care.

Knowing how to choose the right path, where the wheels will have traction, and how to handle the gearbox without damaging the car or risking an accident are all key. Knowing how to use the kits we carry to help vehicles out of the mud is also vital.

Do not be afraid to get dirty, and always think about safety: nothing can stop a two-tonne Land Cruiser that's starting to slip!

Role of logistics in disaster responses

Practically, logisticians will (in agreement with the field) come up with the technical and practical solutions needed to care for people in need. For something like a cyclone, there can be a huge number of things to think about. It might mean setting up shelters, but can also include the management of corpses, the storage of drugs, as well as all the ancillary services for medical teams like transport, communication, IT, access to electricity, plus accommodation and team life.

In parallel, the supply team works with the medical team to prepare the medical equipment and supply logistics. Sometimes things are needed which are really specific to the context, and in those situations, the shopping race begins! Unfortunately(or fortunately), our project is used to emergencies and our supply teams are very responsive.

In the fields, the logisticians get things set up so that the medics can take care of patients within an hour of arriving on site. In Chimanimani, three tents were installed, including the patient care tent and a medical stock tent, vehicles and the most essential supplies were made available.

Within two days, the team had set up a water storage solution which allowed water to be treated on the spot, and taps were installed so that the beneficiaries could have access to clean water. Electric light was in place in the medical tents 24 hours a day, seven days a week. Latrines had also been set up for beneficiaries and medical staff among others.

General comment on what I saw in Chimanimani

It's a disaster, the community has been traumatized. Their landscape had been shaken, family members disappeared in minutes, along with everything the people they knew. But this community is strong; despite the trauma, very quickly they went to work to rebuild their lives in this chaos.

The needs are immense in terms of water supply and reconstruction, the infrastructure is destroyed and it will take time for the authorities to rebuild everything. After being able to interact with our local team and some of the community here, the trauma seems immense.

I was also impressed by the responsiveness of Zimbabweans to set up their own support network, donations of clothes, medicines, food, construction equipment ...

MSF's response to the cyclone disaster

MSF was among the first organizations that was operational the day after the disaster. MSF was able to focus on patients, but also to take into account the wider situation. This meant not only providing immediate patient care, but also taking steps to minimise other health risks caused by the disaster.

For example, the team worked to minimise the risk of epidemics, which are always a possibility after a disaster like Cyclone Idai, as supplies of clean water are disrupted and people can find themselves living in very crowded conditions. Another risk is for patients undergoing long-term treatment, who, because of the disaster, can't access their usual medicines or other important supplies.

MSF's dual approach, looking at immediate needs as well as the bigger picture, allowed the organisation to achieve its goal, demonstrating accessibility and openness to the population, other humanitarian actors and the authorities.

From the very beginning we knew how to be part of communication networks and to share information.

Final message

I want to thank my logistics and procurement teams for their professionalism and readiness.

7 "MOST PATIENTS WE SAW WERE TRAUMATIZED"

MSF's Dr Virginia Moneti is one of the medical doctors who was treating patients who were brought to the stabilisation centre that was set up by MSF to provide medical assistance to survivors of Cyclone Idai in Chimanimani, eastern Zimbabwe.

She describes the nature of patients that she saw at the stabilisation centre.

Humanitarian aid to the affected people including emergency medical care was delayed because the road network was damaged.

Dr Virginia noted that the people in Chimanimani were traumatized and there was need for psycho social support. "People in Chimanimani spent days alone isolated from the world. They suffered alone. Some did not know whether their relatives were alive or not," she explains.

From assessments that were done by MSF teams in Chimanimani and Chipinge, there was a lack of medication for chronic diseases like hypertension, diabetes and HIV. Many people lost everything including their medication. Affected people needed their supplies to avoid relapses, she points out.

MSF teams conducted assessments of the medical needs of the people and provided medical supplies in the hard to reach areas of Chimanimani. Where the roads were inaccessible, the teams resorted to walking to reach patients. MSF supported with WASH activities and continuity of chronic care and provided psychosocial support.

8 "If I try to sleep, I continue to see visions of bodies being swept away in the floods"

In Copper, just like many other places in Chimanimani, many people perished. Properties and infrastructure such as houses, shops, police post and roads were destroyed.

Peter was however luck to have been thrown onto a tree which he hung on before eventually climbing up the tree for safety. He spent three days stranded in the tree, only to climb down after the rains had subsided.

"I survived by clinging onto a tree for three days. That is how I survived. I was saved by that tree. I did not have anything to eat or drink, explains Peter.

"In Copper, I left my brothers and their families. I fear that I might have lost all of them and I might be the only person in my family who is still alive," explains a visibly shaken Peter.

He recalled that when it started raining, he alerted his brothers of the rains and that that he was going back to his own home.

"Now I hear that many people in that area died because of Cyclone Idai, says Peter, regretting that if they had also run away like him maybe they would have also escaped death. Peter lost his source of livelihood to the rains. He laments that his identity documents were swept away, his maize field and banana

Peter Matonhodze (25) from Runyowani village in Chimanimani, eastern Zimbabwe is grateful to be alive after surviving the devastating effects of cyclone Idai by a whisker. Peter was swept away by the rains while trying to run back home from a nearby location called Copper, where he had gone to sell bananas, from his banana plantation, something he does to earn a living.

plantations were destroyed and he does not know how he is going to survive. Although Peter is grateful to be alive and that he had not gone with his wife and two children, the scenes of people being swept away in the floods are still haunting him.

"My mind is still unsettled. The memories are still fresh. If I try to sleep, I continue to see the pictures and visions of bodies being swept away in the floods. I am continuing to see visions as if I am playing a film of what happened. I also saw cars being washed away and some were hitting the tree that I was climbing," explain Peter. Peter is one of many patients that were treated at the stabilization centre set up by MSF to provide medical assistance to survivors of Cyclone Idai.

"When I came here, I had fever and nausea and my ley was very painful. I now feel much better after receiving some treatment although I still have pain on my leg," says Peter, looking relieved.

Peter was accompanied to the stabilization centre by his wife, Melody Matonhodze and their two children.

Melody explained that she worried when her husband didn't come back home after some days. She had heard that many people had died and she thought her husband could also have died.

"When he came back home, I was grateful to God and the first thing I did was to kneel down and pray. Although he lost everything, and we are now stranded, I am grateful that he is still alive. When he came back home, he appeared very confused.

"I want to thank everyone who has assisted my husband with treatment. His condition had deteriorated but he is now showing signs of recovery.

People who saw him as he arrived did not think that he was going to survive. I want to thank you for the assistance you gave to my husband," says Melody Matonhodze.

9 "I WAS WORRIED BECAUSE I DIDN'T KNOW HOW I WAS GOING TO SURVIVE AFTER LOSING MY MEDICATION"

Rudo Mukuruzadu of Ngangu suburb in Chimanimani lost a bag which had all her medicines and medical records after her bag was washed away by the rains.

Tormented that she may not be able to remember all the medicines she used to take, Rudo decided to go to the hospital to check if they still had her medical records.
The nurses checked her blood pressure levels and they found that her blood pressure was too high.

"I think my blood pressure shot up because of the stress induced by cyclone Idai. I was worried because I didn't know how I was going to survive after losing my medication. I was not not sure if I was going to remember all the medicines that I take, says Rudo. I am grateful because the nurses and doctors have really assisted me. I feel like my life is in their hands, she adds.

Rudo is one of many people in Chimanimani who lost their chronic medicines. MSF teams supported the ministry of health and child care to provide medical assistance including **provision of chronic care medicines to people that were affected by cyclone Idai.**

10 THE MAP DURING FLOODS

BY LAST MUFOYA

MSF facilitated a mapathon training for 30 volunteers from HigherLife Foundation, Missing Maps, Smart Harare and Youth Mappers

When the world awoke to the news of the Cyclone Idai having wrecked havoc in Chimanimani and surrounding parts within Masvingo and Manicaland Provinces it became apparent that the disaster had reached another level. All access routes into Chimanimani Township had been cut-off by the rains including communication channels hence the emergency response and aid teams were hindered by these obstacles from reaching the survivors.

In the quest to reach the affected communities, Médecins Sans Frontières employed the use of Geographical Information Systems in their response strategy.

Combining available geographic datasets with the official reports from the Civil Protection Unit (CPU) as well as other unofficial reports, the MSF GIS personnel developed a map displaying the extent of the damage and affected areas. Thereafter MSF activated the Open Street Map (OSM) volunteers' community to crowd-source geographic data for the affected region by use of the HOT online portal service. Since the majority of the area of concern had never been mapped before, focus of this mapping task was on natural water drainage systems, road and settlement patterns as depicted by buildings. Over the next few days the OSM community mapped out this base data using historical satellite imagery as well as recently acquired imagery available from different satellite hosting agencies and partners. This data would then be the basis upon which more specialized analytic maps were drawn in-order to identify the extent of the damage throughout the district.

Furthermore data was obtained from narratives of individuals with local area knowledge and MSF was able to plot out the possible access routes as well as the different obstacles and road damage points on each route.

This is one of the reasons why the MSF response team again was among the first to reach the survivors in Chimanimani Township. With the access route now established and verified, the maps were shared with different partners, from multiple sectors ranging from other NGOs, Government departments as well as those from the private sector. This allowed all the organizations involved to strategize their response based on a common point of view.

As the days progressed, GPS data collected from the field was now being sent to MSF for the updating of the Maps produced. Not only was data received from MSF personnel, but also from numerous other quarters such as the "4x4 Association", "Bikers Association" (a group of individuals moving on mountain bikes) and Miracle Missions to mention but a few, as they would also rely on the maps in planning their movements for distribution of aid in the affected villages. GIS support from other organizations began to trickle in, and thus the burden was lessened on MSF to following up on providing this support, keeping in mind that MSF had begun to wind down its activities in the areas affected. However, for the duration of the relief activities, GIS had proved its worth in aiding the humanitarian work.

11

LIFE IN PEMBA MOZAMBIQUE

BY SHACKMAN MAPURANGA

MSF emergency nurse and health promoter, Shackman Mapuranga, was recently in Pemba, Mozambique to support the team with water, sanitation and hygiene (WASH) techniques. He shares his story.

"Mozambique proved an exciting and workable environment with an immaculate staffing compliment."

Shackman Mapuranga conducts a CHC training in Pemba, Mozambique

"The huge success stories registered in the MSF Zimbabwe, Water, Sanitation and Hygiene (WASH) intervention in the high density suburbs of Harare shone beyond the borders and attracted the attention of our neighboring cholera ravaged countries.

The new and community health club (CHC) based approach which ensures sustainability, practicability and demand driven technique, registered an 80 percent success rate hence the need to adopt the technique. The success rate was measured in terms of reduction in cases in the clinics around e.g during the 2018 cholera outbreak in Harare only one person was affected from these communities. Community health clubs are groups of people that are responsible for the management and maintenance of water points.

My first port of call was Pemba, a notoriously cholera hit region in the northern part of Mozambique which is a predominantly Muslim region with a population of around 200 000 people. Portuguese is the main language there. The area is a resort town hence the kind of diverse culture and vibrant activities along the coastal areas.

After arriving in pemba, I went straight into training for the community health promoters. It all went well until the third day when alerts were raised over an impending cyclone called kenneth that was to hit the coastal area in a few days to come.

We had to be evacuated into the safe regions of Nampula, 400 kilometres away from Pemba, where we stayed for the next two days until it was safer to come back. Most of the predicted scenarios didn't really happen after the cyclone, except the predicted rise in diarrheal disease and cholera cases which were reported in some of the areas and alert systems were activated which decisively managed the situation in no time. Nevertheless, there was a relatively uneasy atmosphere after the cyclone, with a lot of 'what ifs' and what could have been. After the cyclone, we had to assist in the fight against an imminent outbreak of cholera by engaging the local authorities in strategizing on health promotion activities, using the same health promoters whom we had partially trained. We managed to avert the situation as few cases were reported. We worked with support from so many partners. The concept of WASH as prevention was used as we were giving out health promotion to the communities affected in order to avert imminent danger from cholera. Because the WASH CHC component was very new to them, they were eager to learn and understand how it works. I gladly took the opportunity to explain by giving our context as referral point. As it was the first of such kind of visit in Mozambique and first of such kind of an approach, everything was positive and we look forward to an incredible positive story to tell. I hope to record more success stories in Malawi, my next port of call."

To read more about MSF toolkit available for WASH interventions see: https://www.msf.org.za/water-and-sanitation-toolkit

12

SHUVAI: "I AM HAPPY BECAUSE THE NURSES TOLD ME THAT I AM NOW VIAC NEGATIVE"

MSF nurse mentor, Sr. Mercy Mandizvo talks to Shuvai Munyaradzi, a hairdresser from Hwiru village in Gutu.

Shuvai Munyaradzi, a 24 year old hairdresser from Hwiru village in Gutu is extremely happy that she was screened for early signs of cervical cancer and that she got preventive treatment after being detected with lesions on her cervix, an early sign of cervical cancer.

"I was suffering from back and stomach pain. A neighbor advised me to go to the clinic for cervical cancer screening. My husband was very supportive and accompanied me to the hospital," explains Shuvai, who had stopped working due to the pain.

In June 2018, Shuvai was screened for cervical cancer using a method called visual inspection with acetic acid and cervicography (VIAC) at a rural hospital in Gutu.

Shuvai's on-the-spot results came back positive, meaning the images revealed the presence of abnormal, precancerous cells. "When I went to the clinic for screening, the nurses realised that I was developing cancer cells," she says.

There was 'good' news however. The results showed that the precancerous lesions were covering less than 75 percent of her cervix and not encroaching into the cervical opening, meaning she was eligible for treatment using a procedure called cryotherapy. Using the 'see and treat' approach, Shuvai's cryotherapy was done on the same day.

Cryotherapy is a procedure that freezes a section of the cervix using nitrogen gas to destroy precancerous cells. If destroyed successfully, the cells are prevented from developing into cervical cancer.

"When the nurses told me that I had pre-cancerous lesions, I was shocked and shaken, as I wasn't expecting this. It unsettled me for a long time. I have two young children and wondered if I would be able to take care of them. When the nurse showed me the picture of my cervix on the screen, I saw the lesions on the pictures of my cervix, and I could see that it didn't look the same as a normal cervix.

"After the cryotherapy, I was asked to come back to the hospital for a repeat screening after six months. I came back in January this year, and the result was negative. This meant that I no longer had pre-cancerous lesions and the cancer cells had been destroyed. I was advised to continue with routine cervical cancer screening every three years. Sr Mercy Mandizvo, a nurse mentor with Medecins Sans Frontieres (MSF) explains: "Women who are HIV negative are encouraged to get screened for cervical cancer once every three years while women who are HIV positive are encouraged to get screened once every year."

"I want to encourage other women to go for screening early so that they can be helped like me and don't go to the clinic when it is too late, says Shuvai.

In Gutu district, MSF has been supporting the health ministry to provide A **COMPREHENSIVE PACKAGE** of prevention and early treatment for cervical cancer at **SIX HEALTH CENTRES SINCE 2015.**

Between 2015 and December 2018, 17 430 women were screened for cervical cancer at the six health centres. Of these, 850 women underwent cryotherapy. In 2018, 59 women received LEEP treatment provided by a LEEP machine donated by MSF to Gutu rural hospital in March 2018. While many women in rural Zimbabwe now have access to the screening and treatment of precancerous lesions, the best way of stopping the disease from developing is to vaccinate girls against the human papilloma virus (HPV) before they are exposed to the virus. In 2018, MSF supported MoHCC to roll out the HPV exercise to more than 15 000 girls in Gutu.

13 SHINGAIRAYI: "NOW I EDUCATE OTHER WOMEN ON THE IMPORTANCE OF SCREENING EARLY"

"MSF assisted me again with this process. They provided transport and paid the bills for the procedure to be done. Now I am very fit. I am continuing to do my work."

While passing through Mukaro Mission hospital, Shingairayi Mutuda, 44 years, from Gutu agreed to be screened for early signs of cervical cancer because she hadn't been screened before.

She was screened using a method called Visual Inspection with Acetic Acid and Cervicography (VIAC), which involves swabbing the opening of the womb, or cervix with a vinegar-like solution of dilute acetic acid and taking images of the cervix (cervicography), which help to identify the presence of abnormal, precancerous cells.

Shingairayi's results showed that she had lesions on more than 75 percent of the cervix, and she was referred for Loop Electrosurgical Excision Procedure (LEEP). During the LEEP procedure, patients are given local anaesthesia before an electrical current is passed through a wire loop to remove or cauterise more advanced lesions from the cervix. Shingairayi was assisted by MSF to travel to Harare where she underwent LEEP at Newlands clinic.

"When I was first told that I had lesions that could develop into cervical cancer, I was shocked, says Shingairayi, who earns a living as a farmer and through vending around her village. In my community, we always tell each other that if someone has cancer, she will die.

I thought I was going to die despite assurances from nurses because people would say that cancer cannot be treated" says Shingairayi. One month after the procedure, Shingairayi was asked to come back to Mukaro hospital where she was told her uterus needed to be removed because the lesions were too extensive.

"When I heard about the results, I was angry. Some of the people, whom I had gone for LEEP with, had good results. "The nurses asked me if I was willing to remove my uterus. I was scared of the operation, but it was successful.

Shingairayi Mutuda, 44 years, from Gutu agreed to be screened for early signs of cervical cancer.

I thought I was not going to wake up but nurses kept on counseling and encouraging me. Now I am very fit. I am continuing to do my work. My children are supportive. "I am not sure how I developed lesions that cause cervical cancer. It might be because I had been using traditional herbs. I heard during health education sessions that inserting traditional herbs in one's private parts is an unsafe hygienic practice that can cause cervical cancer. I do not have relatives who died of cervical cancer. Now I educate other women on the importance of screening early."

While thousands of women in rural Zimbabwe now have access to the screening and treatment of precancerous lesions, the best way of stopping the disease from developing in the first place is to vaccinate girls against the human papilloma virus (HPV) before they are exposed to the virus.

14 MANICALAND NCD PROJECT IN PICTURES

Doctor Nyagadza examines an adolescent diabetic patient during a diabetes clinic. There are different kinds of diabetes. The main ones are Type 1 and Type 2. Type 1 diabetes is commonly diagnosed in children and adolescents and it is characterized by insufficient insulin production.

A diabetic woman from Mutare is being tested for blood sugar during a consultation at Mutare Provincial Hospital. Testing of blood sugar is important because it shows whether the patient is responding well to treatment or not. Patients are supposed to monitor their blood sugar regularly.

A diabetic patient receives insulin and syringes from a pharmacist at Mutare Provincial Hospital Pharmacy. MSF is supporting the Ministry of Health and Child Care with diabetes medication.

Every Monday, an MSF team supports MoHCC to provide treatment and care to diabetic patients at Mutare Provincial Hospital. Since 2016, MSF has been providing treatment to patients with diabetes and hypertension in Manicaland.

An MSF Pharmacy technician, Vimbai Mutsvedu dispenses medicine to a diabetic patient at Chitakatira clinic in Mutare. Patients are happy because it helps them cut on transport costs, time and money to buy food on the way.

MSF Data Officer, Norma Kudya retrieving patient files from a filing cabinet at Mutare Provincial Hospital diabetes clinic.

MSF introduced files for each diabetic patient to better capture patient level data for the NCD pilot project in Mutare.

15

"I GET WORRIED WHEN I DO NOT HAVE THE GLUCOMETER STRIPS AND I HAVE TO GUESS WHETHER THE BLOOD SUGAR LEVELS ARE LOW OR HIGH."

Mrs Kamba and her daughter

When *Rumbidzai was three years old, she experienced some symptoms, which her mother, Mrs Kamba did not understand. She developed frequent excessive thirst. Even though she drank a lot of water, it was not enough to quench the thirst.

Rumbidzai was diagnosed of Type 1 diabetes on 11 July 2017 after she was taken to hospital when she collapsed while at home. In four days, she was wasted and her health deteriorated. She was discharged after spending two weeks in the hospital intensive care unit.

Before Rumbidzai reached five years, Mrs Kamba used to get her medication free of charge from the pediatric unit but when she reached five years, she started to pay for her medication and syringes. Patients with Type 1 diabetes inject themselves with insulin twice a day for survival. Insulin is a chemical produced by our body to help push sugar from the blood stream into the cells. Insulin facilitates the entry of glucose into the cells so that it generates energy.

"During difficult times, when I could not afford to buy many syringes to inject my daughter with insulin, I was forced to use one syringe for about four consecutive days so that I could utilise the few syringes that were available," explains Mrs Kamba. "I was informed that I was supposed to use one syringe only once or at most, twice a day. Unfortunately, I could not follow that instruction because I could not afford to buy syringes."

Mrs Kamba accompanies her daughter, who is now five years old for medical check-ups and collection of medicines from Mutare Provincial Hospital every month.

"When I come for check-ups at the hospital and if I get enough syringes, I follow the prescribed instructions but if I don't get enough syringes, I still continue to use one syringe for a number of times.

"I also need to buy glucometer strips for monitoring my

daughter's blood glucose. It is now difficult because the strips are now expensive. One strip is going for 8 to 10 RTGs dollars. However, when I get money I just buy a few because I can no longer afford to buy the whole pack," Mrs Kamba explains.

Enrolment into the diabetic clinic pilot program

MSF is working in partnership with the Ministry of Health and Child Care (MoHCC) to provide treatment and care to patients with diabetes in Manicaland. Rumbidzai has enrolled in the MoHCC/MSF diabetic pilot program and she is getting free medication every month.

"Before Rumbidzai enrolled in the MSF program, I used to buy medication for 6USD. Buying medication on my own was not easy. It was also expensive to buy glucometer strips to monitor Rumbidzai's blood glucose. Sometimes I could not afford to buy.

"To monitor her condition, I learnt how to pick up the signs and symptoms of high and low blood glucose. At times, I would not trust my own judgement but I had no choice.

"From my own assessment, I noted that when Rumbidzai's blood sugar was low, she would hallucinate and she would sweat a lot. If her blood glucose was below 2.5, she would start to shake her body vigorously or she would cry a lot then I would know her blood sugar is low. When this happens, I would give her either a sweet or food. If it is high, her face would swell or she would crave for food and water. If her blood sugar is high, she also wet her blankets while sleeping. If it is not high, she does not wet them.

Mrs Kamba receives insulin and syringes from MPH Pharmacy

"Now I educate other people and tell them that it is normal for a child to be diabetic. I want to encourage parents to screen their children for diabetes".

Administering insulin

"We were taught how to administer the insulin while at home. It is easy if you follow instructions. I was advised to inject the insulin right into the skin, on the leg, below the stomach and on the hand.

"The good thing about administering medicine at home is that my child leads a normal life just like everyone else. Administering medicine at home is actually easier for me than having to come to the hospital every now and again. It would deprive me of doing many things but if I administer at home, I can do that while continuing with other chores. My main responsibility is to inject her with insulin twice a day, before breakfast and before dinner and I monitor her diet.

"The first days, she used to cry a lot but now she has adjusted to the situation and has accepted it. She can come to tell me that she is hungry and she wants to be injected so that she can have her food.

Counselling

"When I was told that I was now supposed to inject my child with insulin, I got some counselling while in hospital. We also had counselling sessions with staff from Medecins Sans Frontiers (MSF) and they

taught me that I had to accept my daughter's condition. Counselling was also aimed at capacitating me to cope with my daughter's condition.

Misconceptions

"During the initial days, people used to say many things about my daughter's condition. They said it was abnormal for a child to be diabetic. They thought she was bewitched so they used to encourage me to give her herbs. Many people would get shocked and advise me to visit traditional healers. Some went to the extent of telling me that this was happening because I was not prayerful. Some asked me to stop going to the church where I was going.

"When I did not have money to buy glucometer strips, it used to affect me a lot because my relatives could not assist. Due to different beliefs my relatives could not understand my situation. I got enlightened when I attended a health education session at the hospital. After the counselling session, now I know that diabetes can occur in childhood. There is no witchcraft involved when a child is diabetic.

"I now understand. I met other children at the hospital who were also diabetic. I want to encourage parents to have their children screened for diabetes. We are depriving our children of healthcare access because of superstitions.

"I also explained to my daughter that she was diabetic and that she has to accept her condition. She seemed to understand.

"I have stopped my daughter from going for parties so that she is not tempted to eat other foodstuffs likes cakes that she is not supposed to eat. If we take a walk and she sees other children taking ice cream, she looks at them in a craving manner. As a parent, I can tell that she wishes she could also eat but she understands her condition," explains Mrs Kamba.

Challenges

Mrs Kamba encounters many financial challenges because of the prevailing economic hardships. Some of the challenges include lack of money to buy glucometer strips to monitor blood sugars. For 12 strips, she needed about 100 RTGs dollars at the time of writing the story.

The other challenge that she faces includes stigma from people. "Someone might come to you and say, your child is diabetic it means, you have demons and you do not pray. This is not something pleasing to hear. Support from family members is also scarce. When relatives suggested that Rumbidzai's condition was demonic, she was cursed and they encouraged me to go to faith healers, I refused to listen to them and I was adamant that I would take my child to hospital. I put a lot of effort in trying to ensure that my daughter gets everything she needs.

How to address stigma

"To address stigma, I give people time to air their views and then correct any misconceptions.

Support from school

"I went to my daughter's school to inform her teachers on the diagnosis of the diabetes in my child as well as the appropriate dietary needs for the child. I also taught them how to test her sugar levels using the glucose strips. If I have strips, I put them and the glucometer in her bags so that they can monitor her when necessary. Her classmates are also supportive. If they observe any symptoms, they quickly report to the teacher. Her friends also understand. They know that she has to eat her food on time.

Worries

"What worries me is the economic situation because it is difficult to get money. I get worried when I do not have the glucometer strips and I have to guess whether the blood sugar levels are low or high. Failure to assist my child due to economic hardships stresses me most.

Wishes

"I wish my child could grow up so that she can become a doctor or nurse so that she can also assist others on the management of diabetes.

I wish various stakeholders could hold more campaigns like what we did with HIV so that people can get to know more about diabetes. Mrs Kamba is a Primary school teacher in Mutare. She is married with four children

**Not real name.*

16

MSF OFFERING FREE MENSTRUAL CUPS TO ADOLESCENT GIRLS AND YOUNG WOMEN IN MBARE

As part of its sexual and reproductive health (SRH) services, MSF has been providing free menstrual cups to adolescents and young women aged between 10 and 24 years at the Edith Opperman clinic in Mbare, Harare.
Between April and May 2019, MSF gave out more than 400 menstrual cups to young women and girls in Mbare.
"We started to give menstrual cups after realising that most of the adolescent girls and young women who accessed SRH services in our clinic lacked access to safe and sustainable options of menstrual hygiene, explained Brian Hove, the Health Promotions Supervisor for the MSF Mbare project.

"Some of the girls seen in the clinic reported that they were using rugs during their menstrual period because they could not afford to buy pads due to inhibitive costs. Some reported that they either missed school due to heavy flow or period pains.

"Most parents and care givers prioritised other basic things over sanitary pads and all these issues prompted MSF to start providing free menstrual cups because they are a sustainable method for menstrual hygiene," explained Mr Hove. A menstrual cup is worn internally like a tampon, but it collects menstrual fluid rather than absorbing it. Cups can hold more blood than other methods, leading many women to use them as an eco-friendly alternative. And depending on one's flow, cups can be worn for up to 12 hours.

Menstrual cups are budget friendly and affordable. They are reusable. One cup can be used for long period of time, up to ten years. Menstrual cups are safer to use because they collect rather than absorb blood.

Menstrual cups are not widely used in Zimbabwe but they are being introduced as a cheaper and sustainable alternative.

MSF has been providing adolescent friendly sexual and reproductive health services that include general health check-ups, HIV testing and counselling, screening for sexually transmitted infections (STIs), and family planning, all free of charge in collaboration with the City of Harare Health Department, since November 2015.

A menstrual cup is a feminine hygiene product that is inserted into the vagina during menstruation to catch and collect period fluid. Its purpose is to prevent menstrual fluid from leaking onto clothes.

17 VILLAGE HEALTH WORKERS TURNING THE TIDE ON HIV– ONE LONG BIKE RIDE AT A TIME

BY ANGELA MAKAMURE

Village Health Worker in Mwenezi

Every November, nearly 30,000 cyclists hit the streets of Johannesburg in the world's second largest cycle challenge on a demanding 94, 7-kilometre route. The event raises funds to support charity organisations in South Africa, motivating many cyclists to go the distance in demonstrating their determination to help people in need.

In rural Zimbabwe, two women, village health workers Gloria Musingarimi (48) and Silethiwe Paswana (43) show even more grit and commitment in serving people living with HIV, in their community. Love for their neighbours drives them to cycle an astonishing 120km to the nearest clinic to collect and deliver life-saving HIV medicines for patients.

And unlike the annual challenge of a 94, 7 km course on Johannesburg city streets, they make this journey at least four times a year!

Their main role is to lead the support and supervision of HIV positive patients receiving antiretroviral treatment through the Out-of-Facility Community ART Distribution (OFCAD) programme.

For Gloria and Silethiwe neither the distance nor the gruelling 14 hours in the saddle deter them from offering health services to their village community near Mwenezi in the southern Masvingo District.

Their main role is to lead the support and supervision of HIV positive patients receiving antiretroviral treatment through the Out-of-Facility Community ART Distribution (OFCAD) programme. They ensure patients enrolled in this programme get their medication on time, adhere to treatment and to keep the medication in a safe place.

"Our role as village health workers and OFCAD facilitators is to give patients their treatment and review dates, to remind them of their upcoming viral load tests that are meant to measure the level of HIV in the blood, and arrange community meetings where we discuss issues affecting them to offer moral support," Gloria explains.

OFCAD is a new and alternative community-led model of care for HIV patients which Doctors Without Borders (MSF) developed to ensure people get treatment and care closer to their homes in rural areas.

The programme entails training village health workers to distribute ARVs to registered people living with HIV in their communities every three months and to keep stocks in their homes, this avoids many patients having to travel long distances to clinics to collect their medication, sometimes losing out on a days' work as subsistence farmers.

Gloria and Silethiwe are breaking new ground with this treatment support model: it is the first time that this approach is piloted in any rural setting in the southern African region. Only patients who are stable on HIV treatment and maintaining viral load levels below 1000 or at undetectable.

Together the duo is responsible for following up on 20 patients (combined), and they've offered their homes as meeting points for the groups. Here they keep patient cards and registers along with the medication in huge lockable trunks. Both women guard the keys to the trunks with their lives because they know their neighbours' lives depend on them.

At three month intervals, Gloria, Silethiwe and other OFCAD facilitators, take to their bikes to cycle for seven hours to reach the nearest Chirindi Clinic – about 60 km away from their village. Once they get there it's a quick stop to pack the medicines, eat a meal and rest before taking on the return leg.

They embark on the trip with other OFCAD leaders from other neighbouring villages for camaraderie and to avoid being targeted by thieves on the long road.
"We normally leave home at 4 am and arrive at Chirindi clinic at 11 am. We are served first to make sure we can cycle back before sunset," says Gloria. "When it rains, we hire a car. But because of the poor state of the roads and inaccessibility or because of fuel shortages, we are dropped off way before reaching our destination. We then have to finish our trip on foot which is a huge challenge for us."

Life in drought prone Mwenezi is not easy. Villagers depend on subsistence farming for survival and growing your own food is serious work. They keep livestock and they grow millet and sorghum that are resistant to drought.

Gloria's passion to assist people living with HIV is invaluable. She

OFCAD facilitators store ARVs in a trunk for safe keeping.

herself is HIV negative but goes all out to help her neighbours. Aside from running the OFCAD and her village health worker duties, Gloria is a mother of six who is responsible for the care of her own family as well.

She has her own fields to tend to ensure the family can feed itself and to earn a livelihood. She also sells dresses she sews and raises chickens and turkeys to supplement the family's subsistence farming income.

As an HIV patient herself, Silethiwe says before the OFCAD programme, trying to adhere to treatment was very hard.

"We would spend three days on the road by foot to get to Chirindi Clinic and back, normally we would have to sleep on the way. Because of this burden some people stopped taking their medication. Some died and others' health deteriorated. I can see exactly why my role as a village health worker and OFCAD facilitator is so important," Silethiwe says.

Their commitment and love for their community is changing lives. Treatment adherence has improved and life is now easier without having to interrupt their daily work just to make a trip to the clinic to get medicines.

Eunice Shumba from Chegumwe village had much praise for the OFCAD programme: "I take my medication from Gloria. It is easier, faster and I only have to come to her once or maybe twice in three months. Before OFCAD, I would walk for two hours to the Tshobelele outreach point but now I walk for just 30 minutes to Gloria's house. I can even go to the fields before coming to get my medication. In the past, when the river floods we had to walk through mountainous areas to get to the clinic. Now it is a different story."

The Village Health Workers (VWH) programme began in the 1980s as part of Zimbabwe's transition toward Primary Health Care (PHC).Village health workers are volunteers selected by their communities to serve as a key link between the community and the formal health system.

They focus on disease prevention and provide community care at the primary level in rural and peri-urban wards (Katarine Shelly, 2019).

The Ministry of Health and Child Care (MOHCC) conducts an initial 8-week classroom and practical training for the VHWs and thereafter occasionally offer refresher trainings.

18 INNOVATION OF DSD: HOW WE'RE GETTING LIFE-SAVING HIV DRUGS TO PEOPLE IN REMOTE ZIMBABWE

The right medication means people with HIV can live long, healthy lives. But for those living in remote communities, getting access to these vital medicines can be a challenge. Valeria writes about a team aiming to change that…

Behind the scenes on an outreach visit

One of the activities in our project is the outreach program, providing medical services to remote communities who might not otherwise have access to them. Outreach means MSF teams travel distances of about 60 to 200 kilometres to meet patients.

For our team, a normal day of outreach starts at Chirindi Clinic, one of the health facilities run by the Zimbabwean Ministry of Health and Child Care.

All the HIV drugs, green books (green booklets where demographic information and patient care information is recorded), tables, chairs and other items are packed up and loaded into the MSF car. We then have a flash meeting with the team to share updates and relevant news before leaving the clinic.

Makugwe and Sovelele are villages in distant areas of the district. A 'typical' journey might mean travelling by car for approximately an hour and a half to get to Sovelele. The road is very challenging to drive on at any time; during the rainy season it's impassable. On the way we see many aspects of the community: people's huts, cattle, women washing clothes in the rivers, children walking barefoot to go to school and sometimes wildlife.

Arrival

When we arrive at the outreach point, the whole team unpacks everything and we set up the tents where we'll be delivering the different services. MSF has been working here for more than two years and the logistics for the outreach are very well planned. The tents are very simple to fix to the ground, and if we work all together, in ten minutes we are ready.

The next step is another flash meeting, this time with the village health workers and community HIV/AIDS support agents. The nurse mentor from MSF leads the meeting and one of the nurses from Chirindi Clinic assigns the different tasks for the day.

A key part of the team

Village health workers are a key link between the community and the formal health system in Zimbabwe. They have a broad range of roles and responsibilities, including health promotion and referring people who need more care to higher levels of the health system.

Working alongside the village health workers are the community HIV/AIDS support agents. These are members of the community who receive and counsel their peers when they come to collect their medication at health centres. They also assist health staff with minor duties.

More than testing

During my first day on an outreach visit I rolled through them all, but nowadays I'm assigned to work on the HIV testing station. At our station, we provide not only HIV testing, but lots of other things too.

One of the key things we offer is support for patients who have missed a review date, have stopped their medication or have fallen out of touch with health services. To help address this, working alongside me are Thulisiwe Muzezewa, a counselor-educator from Chirindi Clinic and Oniwell Nyekete, who is an MSF counselor-educator mentor.

Why HIV counselors are so important

Having a counselor helps people to

understand HIV and the treatment, and to let go of misconrceptions, misinformation and stigma.

People living with HIV have to deal with more than just the practicalities of managing a chronic health condition. Frequently the challenges include a combination of the psychological and the social (the attitudes of family and the wider community).

Counselors like Thulisiswe and Muzezewa carry out individual or group counseling, as well as basic psycho-educational sessions for patients and, when needed, their families.

Alongside these activities we have a support group for children and young people living with HIV. At the group they learn more about the importance of sticking to their treatment plans and good health practices. They also talk about disclosing your HIV status as an important part of living with HIV, since people living with HIV need psychosocial support from family, friends and community.

What else happens on an outreach visit?

As well as testing, counseling and support we provide a re-fill service for patients who are on medication for non-communicable diseases like diabetes or high blood pressure.

Our team gets people who are HIV positive started on anti-retroviral therapy (ART). People with HIV can be susceptible to infections, so we offer care for these, as well as monitoring for the levels of HIV in people's blood (their 'viral load'). And, importantly, we refer people to "OFCAD."

Getting medicines to the people who need them

OFCAD stands for "Out-of-Facility ART Distribution". It's a way of delivering anti-retroviral therapy to HIV positive patients living in hard-to-reach areas by providing them easy access to the medication. For patients to be included in OFCAD, they should have been on ART for at least six months and their viral load should be below 1000, or undetectable. They should be taking the fixed dose regimen which is Tenolum E. There should be a village health worker near to where they stay.

How it works...

The way the program works is very efficient: patients who would benefit are identified at a health centre or at an outreach site, enrolled and referred to the distribution location of their choice. There are currently seven different distribution points in Makugwe and Sovelele, Mwenezi. The village health workers order and pick up the anti-retroviral drugs from the health facility. Then, following a schedule, they refill drugs to the patients within their own communities.

The village health workers support patients in viral load monitoring, managing other illnesses, TB screening and with referrals for those who need additional healthcare. OFCAD should be implemented in other parts of Zimbabwe as part of a comprehensve package.

MSF Health Promoter Valeria Corona (seated in the middle) at work during an outreach programme

19 "Through this detachment, I got to understand more about MSF and what it stands for."

Laston Mutendereki, Pharmacy Supervisor for MSF Zimbabwe was detached to Iraq. He shares his detachment experience.

"Through this detachment, I got to understand more about MSF and what it stands for. We spent long hours at work. The mission I was detached to, was very new in Iraq and there were a lot of trainings to impart knowledge and skills to national staff."

"In February 2017, I was detached to Northern Iraq, Kurdistan region and based in Erbil. I was detached as a Mission Pharmacy Manager responsible for the management of the pharmacy services in the mission.

"The mission had two projects in Hama al alil for first line lifesaving surgery and Hamdaniya for post-operative care. It was my first experience to work in a conflict and high risk context. At first, I was very afraid.

"As I was travelling to Iraq, all that was in my mind was war…bombs… guns and death. I passed through our headquarters in Brussels, Belgium for work briefings. It was only when I reached Brussels during my briefing when I realised that I was not alone after all! That in itself motivated me and gave me courage and motivation to proceed.

"This detachment was an exciting adventure for me. It was exciting because working in an emergency set up invigorates, gives plenty of energy and most of the activities and tasks are non-routine. A different and ever changing context altogether made it a lifetime experience for me.

The coordination office was based in Erbil, some 70km away from West Mosul, the war front. Every morning we would gather as a team for briefings and discussions on plans for the day. The context was highly unpredictable and we dwelled much on short term plans.

"I spent my three months mission trying to answer to the needs of the projects, covering the gaps left by a delay in international importation process and developing a local purchase network. I had to work on a lot of local purchases to have two projects up and running. When some big international orders started to arrive, I had to spend a lot of time at the warehouse trying to organize all the entries and prepare the several orders from the fields.

MSF routinely detaches staff to projects globally to train them and cover gaps.

20 BEING AN ASSOCIATION MEMBER

Charity Chimwaza is the Vice President of the MSF Zimbabwe Association.

"I joined the MSF-Southern Africa Association in 2012 mostly because of encouragement from peers and the opportunities for travelling to different countries for Association debates. I did not have much information on the role I was supposed to play in this association and I was not sure what value I was expected to add by joining the Association. No one explained to me clearly what the purpose of the Association was, its goal or objective. I joined the Association because all my friends and colleagues were members. Although I attended the Field Associative Debates (FADS) and General Assembly (GA), I was not very active in the debates."

What are Field Association Debates and General Assembly?

Field Associative Debates are organised on a yearly basis in all countries where MSF has operations. They bring together MSF field staff and board members to share experiences and discuss topics that are relevant at the local level but also of interest for the movement as a whole.

The outputs from these debates, especially the recommendations and motions that are adopted, are taken on by the associative and executive at General Assemblies and the International General Assembly. This facilitates the flow of opinions, ideas and expertise within the association and keeps it close to the field.

The General Assembly is an opportunity for members to voice their opinion, to propose and vote on motions and to elect new board members.

General Assemblies also provide a space for members to bring in fresh ideas, drive the movement forward and raise issues from the field to the associative and executive leadership.

What changed?

"One board member of the Association took time to explain to me, what being an Association member meant and what my role as a member was. After reflection I realised that being an Association member meant:-

Love and belief: - in the humanitarian work that MSF does globally and the desire to see the work continuing hence the importance of contributing during debates and being part of the

movement.

Define: - I realised being a member helps one to define what MSF is and what it should be like. So by being part of the Field Associative debates one contributes to the betterment of MSF. Some of motions we voted for passed and changed MSF or brought in new interventions to the project activities. For example, projects like cervical cancer screening and treatment of non-communicable diseases (NCDs) were birthed through motions from the Association.

Mandate:- I believe in MSF's principles and its work as a medical organisation and I would like to see the work continuing. As such, I feel I have a role to play in maintaining or changing the mandate by bringing to attention, the medical problems or conditions affecting the population that I live or work with so that people in need can get the necessary assistance.

Being an association member is bigger than any club membership. It's a life changing experience for me and for the beneficiaries. As a member, I gain the satisfaction that I contributed to saving lives of people in need.

Educational:-As a member, I get to be informed about new trends of diseases, new medication on the market and what is happening globally. This has encouraged me to read widely so I can be up to date with new information.

For me being an association member is important because I get to define what MSF is and what I would like it to be. Even though, I am not currently employed by MSF, I still serve as a member because I believe in the organisation's mandate of saving lives."

MSF Association membership

The commitment of individuals working with MSF goes beyond completing an assignment: current and former staff, including returned volunteers, can decide to dedicate their time to contribute to MSF as Association members, and join in the co-ownership of the organisation.

Becoming a member of MSF is a personal choice, involving a commitment to participate in the life and direction of the Association and in reflection on MSF's work and ambitions. MSF membership does not grant any advantage in terms of employment.

Any MSF staff or former staff at headquarter or project level can decide to join one or several associations, whether national, regional and international, provided they meet the requirements.

Members should choose the association they identify with most, based on personal interest, experience with MSF, language, country of origin or residence, and or the time available to dedicate to associative action.

There is no limit on the number of memberships an individual may hold. The Movement as a whole can only benefit from the flow of ideas between associations and from the enriched debates and stronger sense of community.
Membership criteria may differ slightly depending on the association. For that reason, one should directly get in touch with the association he or she wants to join to check eligibility requirements.

Charity is currently working as an OI/ART nurse consultant at I-tech in Harare. She previously worked as a nurse at MSF.

21 OUTPATIENT HEALTH CARE IN BEITBRIDGE

COLLABORATION

MSF in collaboration with MoHCC is providing treatment, care and support to migrants in Beitbridge. MSF nurse Blackson Chirwa attends to a migrant during an outreach in Beitbridge.

HEALTH PROMOTION

MSF health promoter, Israel Chingosho conducts an HIV test for a deported migrant at the Beitbridge Reception centre.

MIGRANTS

Sr Grace Ngulube talks to a deported migrant at the Beitbridge Reception centre.

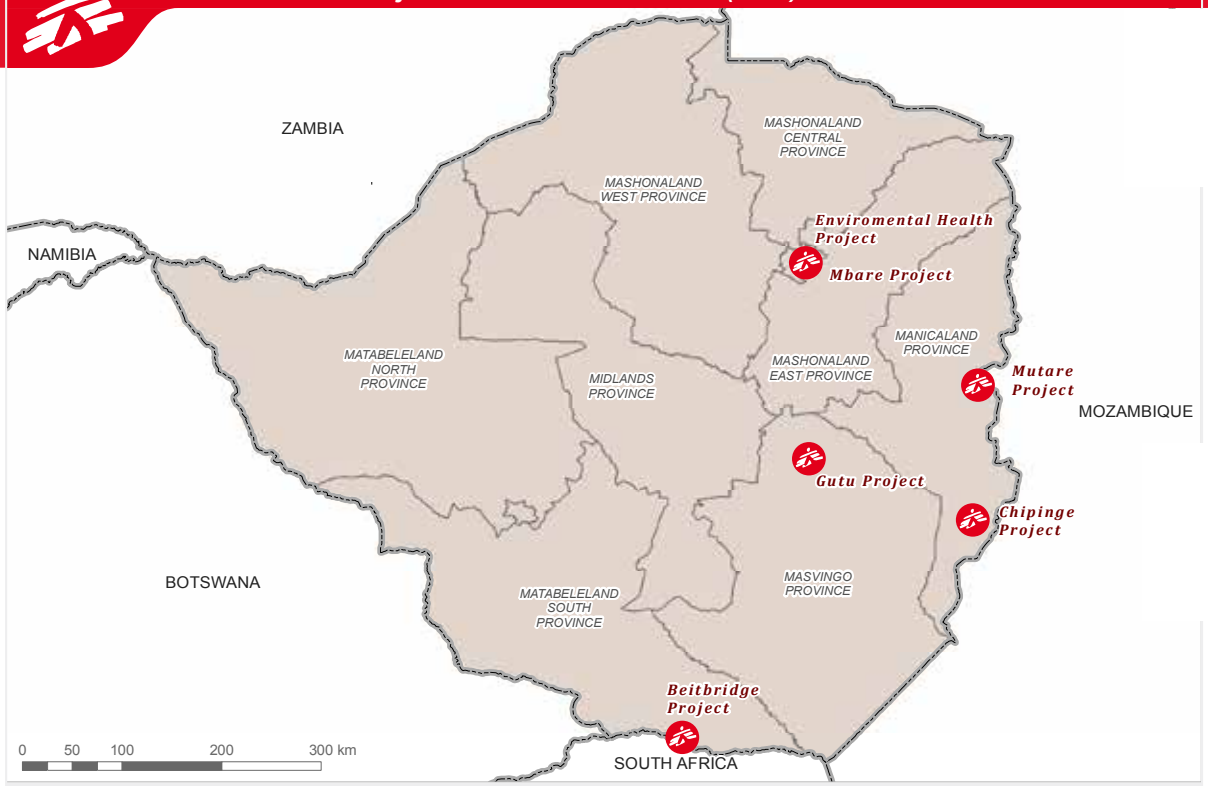
MSF IS PROVIDING A COMPREHENSIVE OUTPATIENT HEALTH CARE PACKAGE TO MIGRANTS AND MOBILE POPULATIONS THROUGH TARGETED AND DIFFERENTIATED INTERVENTIONS:

- OUT-PATIENT DEPARTMENT SERVICES,
- MENTAL HEALTH, SEXUAL AND REPRODUCTIVE HEALTH,
- HIV TESTING
- ART REFILLS, TB
- SCREENING,
- NCD DRUG REFILLS,
- HEALTH PROMOTION,
- TREATMENT OFSGBV
- COUNSELLING
- PSYCHOSOCIAL SUPPORT TO THE RETURNED MIGRANTS.

HIV TESTING

MSF nurse, Elizabeth Karavhina conducts an HIV test at Beitbridge Reception Centre

ZIMBABWE - MSF Project locations in Zimbabwe (2019)



MSF Principles and Values

CORE MSF HUMANITARIAN PRINCIPLES

- Humanity
- Impartiality
- Independence
- Neutrality

GUIDING STANDARDS

- Medical ethics
- International humanitarian law
- Human rights norms and law

OPERATIONAL VALUES

- Proximity
- Transparency
- Accountability
- Voluntarism
- Associative nature

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