



MSF BELGIUM

ACTIVITY

REPORT 2014



www.msf.org

The Medecins Sans Frontieres 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 honor 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.

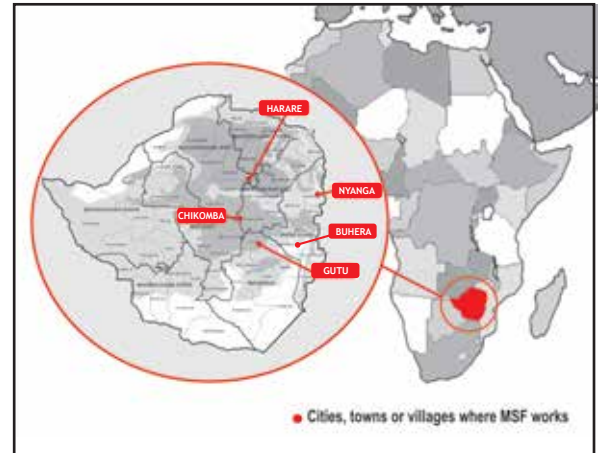
As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.

This report provides descriptive overviews of MSF Belgium operational activities in Zimbabwe between January and December 2014.

Project summaries are representational and owing to space considerations, may not be comprehensive.

CONTENTS

- 1** MSF BELGIUM PROJECT LOCATIONS
- 2** MSF-BELGIUM IN ZIMBABWE: OVERVIEW
- 3** BUHERA
- 11** GUTU
- 20** CHIKOMBA
- 24** NYANGA
- 32** UNITAID PROJECT
- 35** MBARE



**MSF BELGIUM
PROJECT LOCATIONS**

1



BUHERA

3



GUTU

11



NYANGA

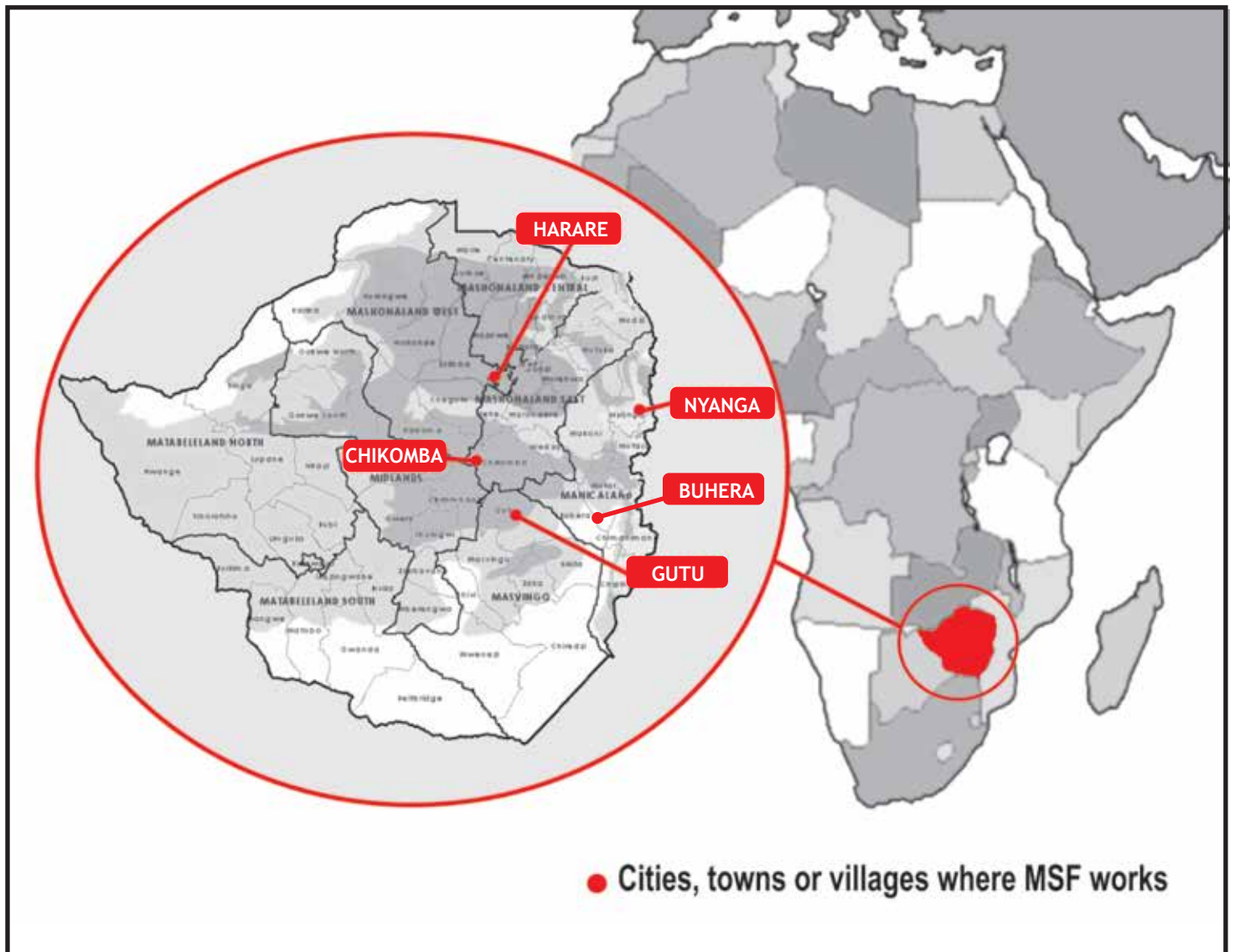
24



MBARE

35

MSF BELGIUM PROJECT LOCATIONS



MSF-BELGIUM IN ZIMBABWE: OVERVIEW

MSF Belgium started operating in Zimbabwe in 2002.

Prior to the beginning of new operations MSF Belgium conducted a situation assessment in June 2002, in response to the alarming food security situation in the region and in November of the same year, following this assessment, MSF opened the mission in Zimbabwe.

BUHERA

MSF Belgium started operating in Buhera district in 2002 during a drought that ravaged the district. After an assessment, there were high cases of varying degrees of malnutrition which led to the introduction of the Nutrition project at Murambinda Mission Hospital.

During the same period, Zimbabwe as a country was reeling under the scourge of HIV. It was then observed that the malnutrition was compounded by HIV and this led MSF to embark on a massive HIV project in 2004 and that same year, it initiated its first HIV patient in Buhera on antiretroviral therapy (ART).

Over the years, MSF in collaboration with MoHCC continued to provide treatment and care to HIV and TB patients, decentralising services to all clinics as well as mentoring nurses at all rural health facilities and attending to any medical emergencies in the district.

GUTU/ CHIKOMBA

MSF has been operating in Gutu District since January 2011, supporting MoHCC in providing free quality OI/ART and TB services through support to Gutu Mission hospital and other sites using the mentoring approach and in combined effort with other partners.

It introduced a similar mentoring approach in Chikomba district in October 2011. MSF is now concentrating on the roll out of viral load tests in both districts, supporting alternative models of testing and care while progressively handing over sites to the MoHCC teams.

MSF piloted the rolling out of Community ART Refill Groups in Chikomba and Gutu districts in 2013. Community ART Groups are a model of care whereby people living with HIV who are on anti-retroviral therapy form groups in the community and the group members rotate to attend the health facility to pick up ARVs for the whole group.

MBARE

Sexual Gender Based Violence

In Mbare, one of the biggest high density suburbs of the capital Harare, a new project was started to provide support for SGBV survivors in October 2011.

Working in conjunction with other national partner NGO, local clinics, the MoHCC and other community partners, MSF provides free medical and psychological care, counselling, as well as referral options for survivors of violence to psycho-social and legal support.

NYANGA

MSF started its support to Nyanga district in September 2013 with the objective of increasing coverage of antiretroviral treatment (ART) especially in children and to intensify case finding of Tuberculosis (TB) using a mentoring approach.

EMERGENCY PREPAREDNESS AND RESPONSE

In addition to providing HIV/TB and SGBV services, MSF also continues to monitor and respond to emergencies, such as epidemic outbreaks of cholera, typhoid and measles.

HANDING OVER OF PROJECTS TO MINISTRY OF HEALTH AND CHILD CARE

When programmes have been supported through the growth and development phase, MSF hands over project activities to the MoHCC, where people continue to receive uninterrupted treatment.

This handover is a process during which capacity is built to sustain the quality of care provided with MSF support.

BUHERA

Support to HIV/ TB patients



A nurse in Buhera attending to patients under mentorship of an MSF nurse

BACKGROUND

Buhera is a district in Manicaland Province with a population of 257,318. It is estimated that 21,657 people are living with HIV and 16,460 are eligible for ART.

MSF started to support HIV services in Buhera District in 2004 with a centralized OI-ART clinic at Murambinda Mission Hospital. Over the years, decentralization of anti-retroviral therapy (ART) initiation to clinics and task-shifting of ART initiation to nurses led to an increased access to ART services. By December 2014, a total of 30

health facilities were providing ART services, and 17,505 patients were on ART in the district.

The vast majority of patients on ART were monitored through routine viral load measurement so as to detect treatment failure early. A Ministry of Health and Child Care (MoHCC) mentoring team was formed and started to mentor clinic nurses as from August 2014 with regards to ART initiation and switch to second line ART.

In 2011, (MoHCC) with support

from MSF, introduced a new technology (GeneXpert) in the district to intensify diagnosis of TB and diagnose drug-resistant TB (DRTB). By the end of 2014, a total of 40 patients had been diagnosed in the district with DRTB. All DRTB patients were being managed by the District DRTB Committee with technical support from MSF. In 2014 the project started to prepare for its closure at the end June of 2015, consolidating the transfer of competencies to MoHCC staff.

Table 1: Major milestones achieved since the opening of Buhera project from 2003 to 2014

2004	Opening of an OI clinic in Murambinda Mission Hospital (MMH)
2006-2007	Decentralization of HIV/TB care to 22 clinics through mobile teams
2008-2009	Fast scaling up of ART initiations; increase to 4 mobile teams
2010:	Implementation of WHO recommendation to initiate at CD4 < 350
2011	Introduction of TDF/3TC/EFV; Scale up of access to viral load (VL); Introduction of GeneXpert® MTB/RIF and treatment for Drug resistant TB (DRTB)
2012	Integration of HIV/OI/TB services into OPD activities at MMH; Start of routine VL and EAC, complete switch of all patients from d4T towards TDF/3TC/EFV; Focus on EAC if high VL
2013	Fast-tracking of patients on ARVs-and 3 monthly drug pick-up system at MMH, BBH and Buhera Rural Hospital; sample collection handed over to Riders for Health; Implementation of DR TB continuation phase with DOT supporters.
2014:	A MoHC mentoring team is taking the lead of the mentoring of clinics. Management of DRTB patients done by staff from MoHCC. MSF mentoring team is supporting the implementation of the new 2013 Zimbabwean VL result delivery by SMS was rolled out. Community ART Groups have been set up in several clinics.

OI/ ART SERVICES

The year 2014 saw the implementation of the new OI/ART guidelines adopted by MoHCC. This included initiating HIV positive patients with a CD4 below 500 cells/ml, sero-discordant couples, HIV positive preg-

nant and lactating mothers (PMTCT B+) and all HIV positive children below five years of age.

A total of 2,363 patients were initiated in 2014 in the district, with an average of 197 per month. This

number included 97 children newly initiated on ART during the year (4.1% of the total). The table below shows the district achievements in terms of ART coverage (proportion of patients who were on ART, out of those who needed ART).

Table 2: ART Coverage in Buhera District by 31st of December 2014

Population	%	N	Source	
Catchment population	98.00%	257,318	<i>DMO-census 2012. 2% of the population is not accounted for.</i>	
Adult population	50.20%	129,174		
Population (0-14 y)	47.80%	122,998		
# HIV infected (adults)	14.10%	18,213	<i>HIV prevalence in adults (14-54): Zimbabwe Demographic and Health Survey, 2010-2011;</i>	
# HIV infected (0-14 y)	2.80%	3,444	<i>Global AIDS response Progress Report 2012 http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZW_Narrative_Report.pdf</i>	
# HIV infected adults and children		21,657	<i>Calculations for need of ART and coverage: estimation by MSF for CD4 threshold <500 cells/ml</i>	
Total # in need of ART		16,460		
Total # of adults in need of ART		13,842		
Total # of children (0-14y) in need of ART		2,617		
Total # patients on ART and remaining in care (Feb 2015)		17,505		
Adults remaining in care on ART (Feb 2015)		16,134		<i>close estimation</i>
Children (0-14 y) remaining in care on ART (Feb 2015)		1,371		<i>close estimation</i>
coverage all patients		106.4		
coverage of adults		116.6		
coverage 0-14y		52.4		

Comments:

By February 2015 the estimated ART coverage for all patients was 100%. This could be partly explained by an underestimation of the proportion of patients in need of

ART (76%), and also by the fact that Buhera district, and especially Murambinda Mission Hospital (MMH), remain a pole of attraction for people coming from outside the

district.

The number of children remaining in care decreased by end of the year (total of 1371 remained in care compared to 1469 end of the previous

year). This is mainly explained by the fact that children are outgrowing their status of “pediatric patients” to enter the cohort of

adults. Other factors could be decreased incidence of HIV among exposed children, or high loss to follow up or death among

children on ART. It was not possible to do an in-depth assessment of retention in care to analyze these latter factors.

Table 3: Quarterly Comparison of ART initiations for 2014

ART Initiations	Q1, 2014				Q2, 2014				Q3, 2014				Q4, 2014			
	Jan	Feb	Mar	Total	Apr	May	Jun	Total	Jul	Aug	Sept	Total	Oct	Nov	Dec	Total
B+	26	64	52	142	79	159	109	347	87	49	36	172	56	37	45	138
<5yr	1	4	4	9	5	12	10	27	21	11	4	36	6	7	12	25
CD4 < 350	85	75	89	249	74	81	66	221	75	50	73	198	63	53	42	158
CD4 350 - 500	3	1	3	7	44	82	92	218	106	88	90	284	47	29	25	101
Serodiscordant couple	0	0	0	0	0	6	9	15	0	4	1	5	3	2	5	10
Hep B Coinfection	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0
Total	115	144	148	407	202	341	286	829	290	202	286	695	175	128	129	432

Comments:

The monthly average of ART initiations was more than double the target due to the implementation of the WHO 2013 guidelines early 2014. The table shows a rise (more than double) in Q2, 2014 compared to Q1, 2014. This was because the implementation of the new guidelines started in March 2014, and picked momentum in Q2, 2014. The figures then started dropping from Q3, 2014 as most of the patients meeting the new initiation criteria had been put on ART.

Figure 1: Evolution of quarterly ART initiations in 2014 by patient category

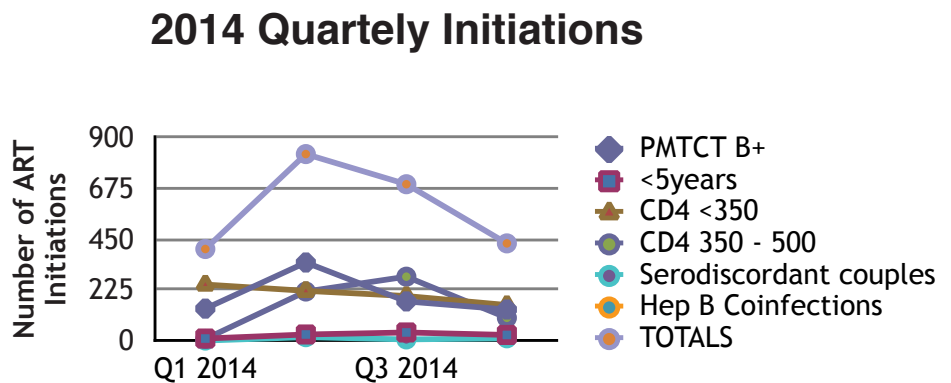
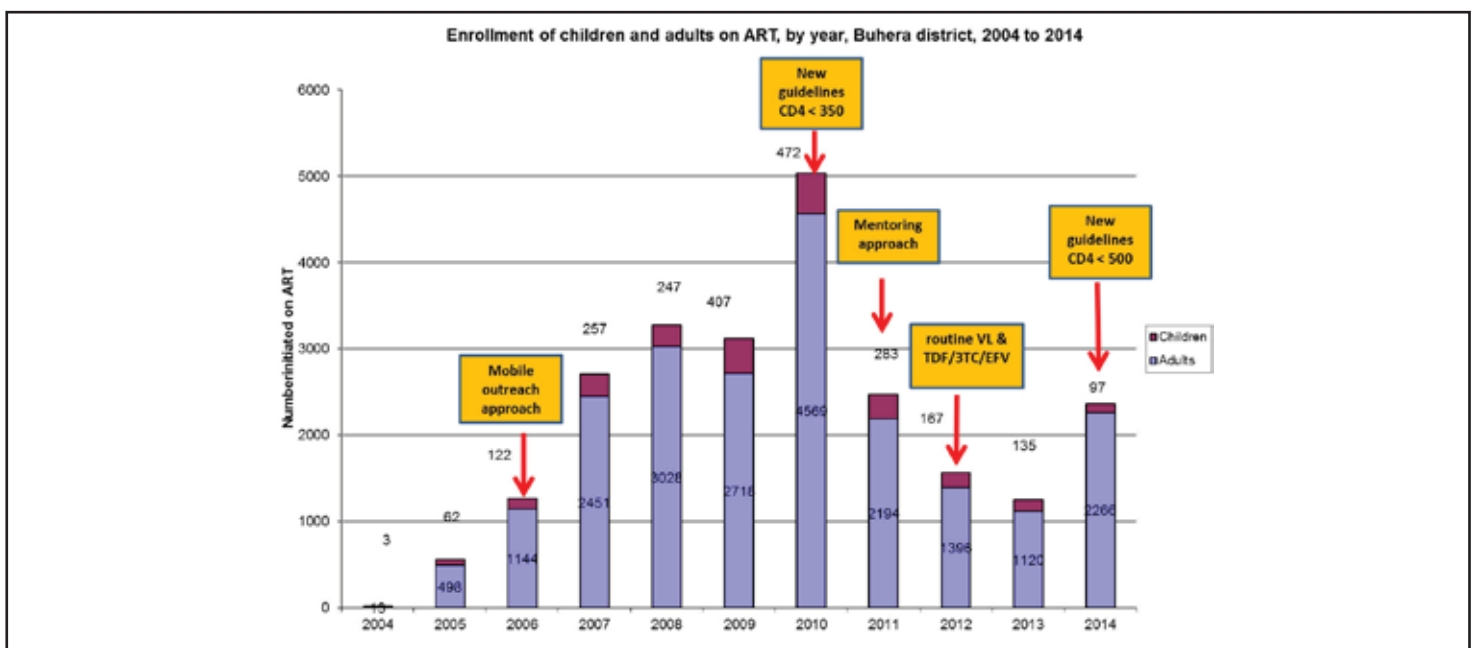


Figure 2: Evolution of ART enrollment for adults and children over a decade



The above graph permits to evaluate the progress in ART initiations over time, and more particularly the

increase in 2014 compared to 2013 due to the implementation of new ART initiation criteria and

higher initiation thresholds.

Number of clinics providing care, number of mentoring teams, integration with MoHCC

By the end of 2014, thirty out of thirty one health facilities in Buhera were able to provide comprehensive OI/ART services with support from mentoring teams. Most mentoring activities were taken up by the MoHCC where there was good collaboration between MSF and MoHCC.

Retention in Care

Retention in care is defined as the number of patients still alive and being followed compared with the number of patients ever initiated (excluding transfer out).

Total ever initiated: 24,213 (source: folder reviews)

Transfer out: 2,884 (12 percent)

The overall retention in care out of those ever initiated is 82% (17,505/21,329). Note that, 2,363 patients were initiated in 2014 and the majority were on ART for less than a year.

The majority of the OI/HIV/TB services were spearheaded by MoHCC with minimal support from MSF. At Birchenough bridge Hospi-

tal, MSF supported the Laboratory Manager with incentives. As in previous years, MSF supported Murambinda Mission Hospital with quarterly allocations; these however will be decreased gradually in 2015. In preparation of these decreasing allocations, MSF assisted MMH with the development of a five year strategic and a two year operational and financial plan.

PMTCT

In line with the new guidelines, **PMTCT B (+)** was implemented in Buhera in April 2014.

799 pregnant women were initiated on ART.

Early Infant Diagnosis

69 percent of infants with a DNA/PCR positive were initiated on ART. Out of 29 babies with positive DNA-PCR results reported in the district laboratory register, 20 were initiated on ART by end of 2014. Two died before ART initiation, One is LTFU. The overall positivity rate among EID DNA_PCR samples with results received by end of 2014 was 4.8 percent (29/602) for the year.

VIRAL LOAD ROLL OUT

In 2011, Buhera district introduced TDF/3TC/EFV (TLE) as the standard 1st line treatment and introduced Viral Load (VL) as a precaution for all patients before the switch from D4T to TDF.

Routine VL monitoring of patients on ART has been rolled out in the district since 2012. This includes early viral load measurement after three to six months of ART initiation, followed by viral load measurement at month 12 of ART initiation and there after yearly checks.

Samples were sent to the National Microbiology Reference Laboratory in Harare for VL measurement. There was a VL machine breakdown in Harare Laboratory for three weeks in the month of April 2014 and some samples were sent to South Africa with support of MSF.

The table below illustrates early viral load measurement, which allows detecting early adherence issues. In case of high viral load, enhanced adherence counseling would be given to the patient, after which viral load is rechecked. If the second viral load (VL2) remains high, switch to second line is considered.

Table 4: Percentages and N of VL done at month 3 of ART initiation (M3) per quarter 2014

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients reaching month 3 on ART	171	251	718	680
Total number of month 3 VL done	93	163	466	436
% who had VL done	54	65	65	64

Source -Mentoring check list and Viral load Information System

Viral load Cascade:

A “viral load cascade” exercise was done from 13 to 22 October 2014 with the objective to analyse the achievements and drawbacks from the routine measurement of VL to the switch to second line for patients failing on first line ART.

(a) Proportion having routine VL done at Month 12:

4,760 patient files were reviewed corresponding to about 25 percent of the total cohort. Of those 4,661 fulfilled the criteria for requiring their VL done at month 12 or yearly. Of those 4,289 (92 percent) had the planned VL done.

(b) Re-suppression of viral load after enhanced adherence counseling (EAC): (VL1 > 1000 and VL2 < 1000 after EAC):

- A total of 534 patients were found with a first viral load above 1000 copies/ml (considered as high VL). Of these, about 430 (75%) had EAC done, although for some it was not documented.
- Of 395 patients eligible for a second VL measurement, 268 (68%) had a second VL done.
- Of 248 patients still alive, in follow up and with results received for the second VL, 43% (107/248) re-suppressed their virus after EAC.

Note that the patients are diverse in terms of age and duration on ART. The re-suppression rate varied among different clinics (ranges from 56% to 20% were noted).

The re-suppression rate was also found to be higher in females than in males (48% versus 34%).

(c) Patients with Virological ART failure switched to 2nd line treatment:

51 out of 138 patients (37%) with high 2nd VL and who remained in

Table 6. Outcomes of patients with high VL2 > 1000

Patients switched to 2nd line ART	No	EAC doc	EAC not doc	Percentage
<i>Switched to 2nd line</i>	51	28	23	37
<i>2nd line switch pending</i>	87	55	32	63
<i>Loss to follow-up</i>	2	1	1	
<i>Transferred out</i>	1	1	0	
Total	138			

care were switched to 2nd line ART (2 were lost to follow up);

87 (63%) were still awaiting switch to 2nd line ART at the time of the cascade exercise.

Note that at the time of writing this report (July 2015) most had been switched through intensified visits to the clinics with the MOH/MSF mentors)

Some reasons for patients not being switched to second line ART are the following:

Adherence issues: If a stable patient has adherence issues, some additional time may be given to improve adherence. However, the switch to second line is not delayed in patients who are clinically or immunologically failing.

Presence of medical doctors in the clinic:

Currently the nurses are not authorized to switch patients to second line ART, while Medical doctors visit the clinic only periodically

(once per month or less). Some patients may have missed the appointment with the medical doctor.

Tests and drugs:

The unavailability of laboratory tests (especially Hep B surface Ag test) and drugs (ABC-based regimens) was another reason why patients could not be promptly switched to 2nd line, pending the decision on which regimen to choose.

TB/ MDRTB

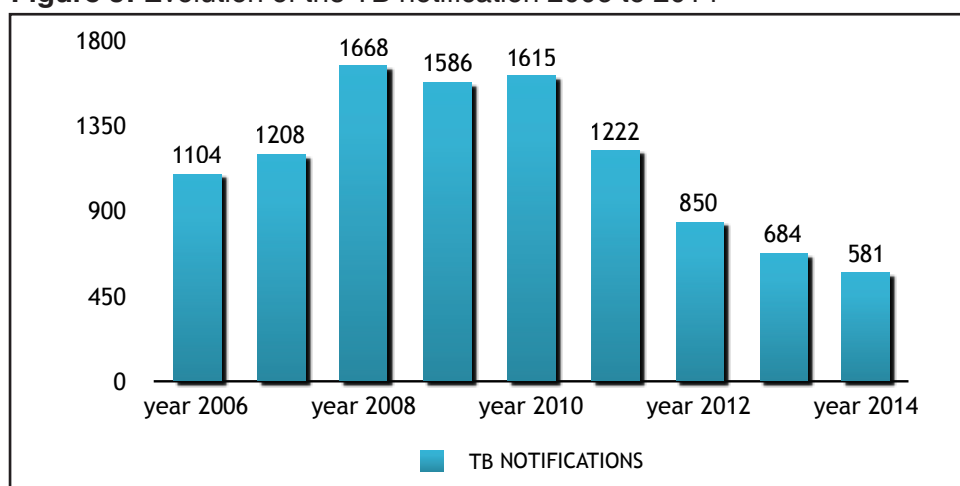
a. Number of new cases detected and Case notification rates

A total of 636 TB cases were notified for the whole year for a population of 250, 000. This amounts to a notification rate of 254/100,000/year.

The notification rate for Zimbabwe was 271/100,000 in the year 2013. Buhera achieved a TB notification rate of 94 percent.

The prevalence of HIV among TB patients was 80%.

Figure 3: Evolution of the TB notification 2006 to 2014



The graph shows that the TB notification rate in Buhera District has been on a downward trend, after a peak in 2008 with a 65 percent decrease by the end of 2014. This decreasing tendency seems to lessen over the last two to three years, and from 2013 to 2014 the number of cases notified decreased by 15 percent (from 684 to 581 cases).

b. MDRTB: New cases, total cases, how is care provided, outcomes so far.

By the end of Q4, the cumulative DRTB statistics were as follows:

- Out of 40 enrolled patients, 11 patients are still on treatment (by 31- Dec 2014) (One transferred out from our program).

29 patients have their treatment outcomes as follows:

- 20 patients: cured (including two that were transferred out from our program= 69 percent cure rate)
- Eight patients: died (including two that were transferred out from our program = 27.6 percent death rate)
- One patient: lost to follow- up after six months of treatment; was traced and found, but refused to continue. Last sputum was negative.

To note, no patients had treatment interruption in 2014.

Four new eligible DRTB patients were enrolled in Buhera district during the year. One of them, with a

negative GeneXpert, was diagnosed through culture and DST. All were initiated within the first week of diagnosis.

12 patients were found with at least one Xpert positive in 2014 including one patient from the previous year confirmed with DRTB in 2014). One was diagnosed by culture.

Out of 13 patients with at least one positive Xpert or culture positive:

- Three died before initiation
- Three were transferred out to other districts or Provinces.
- Three were put on category one (drug sensitive TB) as they could not be confirmed to be having DRTB
- Four were put on DRTB treatment.

In 2014 base line contact tracing was done for all new DRTB patients. All DRTB patients were treated in the community and there were no transfers.

At the end of the year, there were a total of 11 DRTB patients being followed up.

PATIENT SUPPORT SERVICES

HIV Testing and Counseling (HTC) Campaigns

In 2014, MSF continued to invest in testing and counseling with special emphasis on reaching adolescents, men and partners of HIV positive women. The main strategy was mobile night clinics.

10 patients out of 535 tested positive during night clinics but they were not eligible for ART initiation. There were some suspicions that judging on the high CD4 counts of some of the clients, they might have been on treatment. The rate of linkage to care was also low (25%) validating the suspicion that some of the clients might have been on treatment already but they probably just wanted to access promotional material or CD4 tests.

Community ART Groups (CAGs)

In 2014 MSF continued to work on new patient friendly models of care aimed at decongesting the health centers and bringing ART close to the community.

Community ART Groups (CAGs) are groups of patients that rotate for clinic visits and drug refill at the clinic while dispensing drugs to their peers in the community and ensuring continued peer support to facilitate adherence and address challenges of defaulting.

The Drug Pick Up model (DPU) offers the choice to individual patients by ensuring their three months drug supply is fast-tracked in such a way that they can go straight to the pharmacy without passing through the nurse unless they are sick.

By end of December, there were 477 members in 72 Community ART Groups around nine health centers.

In the second quarter the DMO had put on hold the roll out of the activity, wanting to monitor the initial groups. Then the activity resumed in the third quarter with approval from DMO. Clinic staff of eight clinics can now form and follow up CAGs on their own without technical support from MSF.

CAG Outcomes

An interim evaluation of 503 patients was conducted in September 2014, six months after the formation of the first groups. The

Table 7: Linkage to care of DRTB presumptive cases diagnosed in Buhera laboratories

DESCRIPTION	DIAGNOSIS	STATUS
Culture	1	
With at least one expert	12	
Died before initiation		3
Transferred ot before RX		3
Put on Cat I		3
Put on DRTB RX		4
TOTAL		13



MSF medical doctor examining a DR TB patient in Buhera

Table 8: Outcomes of CAG members in Buhera district, by September 2014

	CAG OUTCOMES									
	High VL (need for temporary clinic follow up)	Died	Back to conventional care	2nd line	Different regimen	TB	PMTCT	New patients that joined	Patients active in CAGs as at 30/9/14	
Total patients assessed	503	20	4	4	3	1	2	3	12	478

objective was to see if the groups were still intact six months after the formation before a decision to roll out into the rest of the district could be made.

a) High Viral Load

At the day of formation of the CAG, patients with VL older than three months must have VL repeated in order to synchronize the VL dates with the rest of the group.

No conclusions on the adherence of the 20 patients with high VL could be made since the most recent VL available on the day of formation was less than <1000, hence no link could be drawn between the high VL result (from the sample taken on the day of formation) and the patient being in the CAG.

b) Died

Four patients who had viral load

less than <1000 indicating they were taking their medication properly died and their deaths might not be related to them being in CAGs.

Of the four patients that died, two were from Zangama and the other two were from Betera clinic. Zangama reported that the two patients were 73 and 78 years old and the cause of death were not known. Betera reported that one death was caused by an accident,

for the other one the circumstances are not known; their ages are not recorded.

c) Back to conventional care

Four patients went back to conventional care and they were from Mudanda Clinic. The group had a social misunderstanding at community level and they agreed to disintegrate and go back into conventional care. This showed the need to emphasize on honesty and trust during the sensitization and formation of groups.

d) New patients joining in

The fact that 12 patients joined shows that the activity is slowly gaining confidence in the clinics as the uptake increases.

PHARMACY AND LABORATORY SUPPORT

During this year the MSF Central pharmacy in MMH was converted into a District Pharmacy. The MSF pharmacy building was handed over to MMH and the pharmacy management to the MoHCC district pharmacy team. MSF assumed a role of mentoring at clinic level and technical support to the pharmacy management team.

In quarter 2-2014 MoHCC launched a "pilot project" on a new ordering system called Zimbabwe Assisted Pull system (ZAPS) for which Buhera district was chosen as the first pilot to start followed by the rest of Manicaland Province. This system came with the following changes:-

1. Supply period increased from two to three months with two months buffer stock.
2. All drugs are now combined into one order instead of different supply systems.

3. NatPharm opened a new store in Mutare from where the drugs are supplied to individual clinics.

4. Drug orders are compiled by the district pharmacist at the clinics during assessment to all clinics in 10 days.

This system allows for a security stock to be set up at district hospital level.

The three months supply is essential to allow for three months drug refill to patients.

The first ZAPS delivery was done in April 2014. Enough quantities for ARVs were supplied both at the district pharmacy and clinics. The second was done in August – September 2014, and the last in November 2014.

While during Q1 2014, no shortages were experienced and 100% of needs covered by Natpharm, there was a challenge with the undersupply of ABACAVIR- based regimens from NatPharm in quarter 2-2014. MSF supplied ABACAVIR 300mg and LAMIVUDINE 150 mg tablet, so as to fill the gap. (96 percent NEEDS COVERED BY Natpharm)

During Q3, some problems were experienced on the availability of ABC based regimens and some PIs. An emergency top up of 9,000 tablets of ABC / 3TC for adults was secured from MSF.

(99 percent NEEDS COVERED BY Natpharm)

In quarter 4, supply of ARVs was constant. ZAPS commodities were received on time in a record lead time of thirty four days and that also included ARVs. (100 percent

NEEDS COVERED BY Natpharm) From the results below, it's quite clear that NatPharm has the capacity to cater for all the ARVs needs in Buhera district.

Support to laboratory services:

In 2014, MSF continued to provide technical support to the district laboratory managers including internal and external quality assurance schemes. MSF also continued to support sample transportation from clinics to MMH or BBH through funding of Riders-for-Health, and from the district to the NMRL. MSF ensured gap-filling of laboratory supplies and paid service contracts for maintenance of equipment such as CD4 machines, GeneXpert, hematology and chemistry machines.

REHABILITATION

MSF did an assessment of infrastructure of 30 health facilities and shared it with Buhera Rural District Council, Public Works Department and the DDF (District Development Fund) to take action. As a result, rehabilitation activities and repair works to infrastructure and water supply were carried out by the partners in several clinics while MSF assisted with donations of materials and diesel for transportation. The rehabilitation works included among others the roof repair in Nerutanga and Chimbudzi clinics and the repair of boreholes in two clinics.

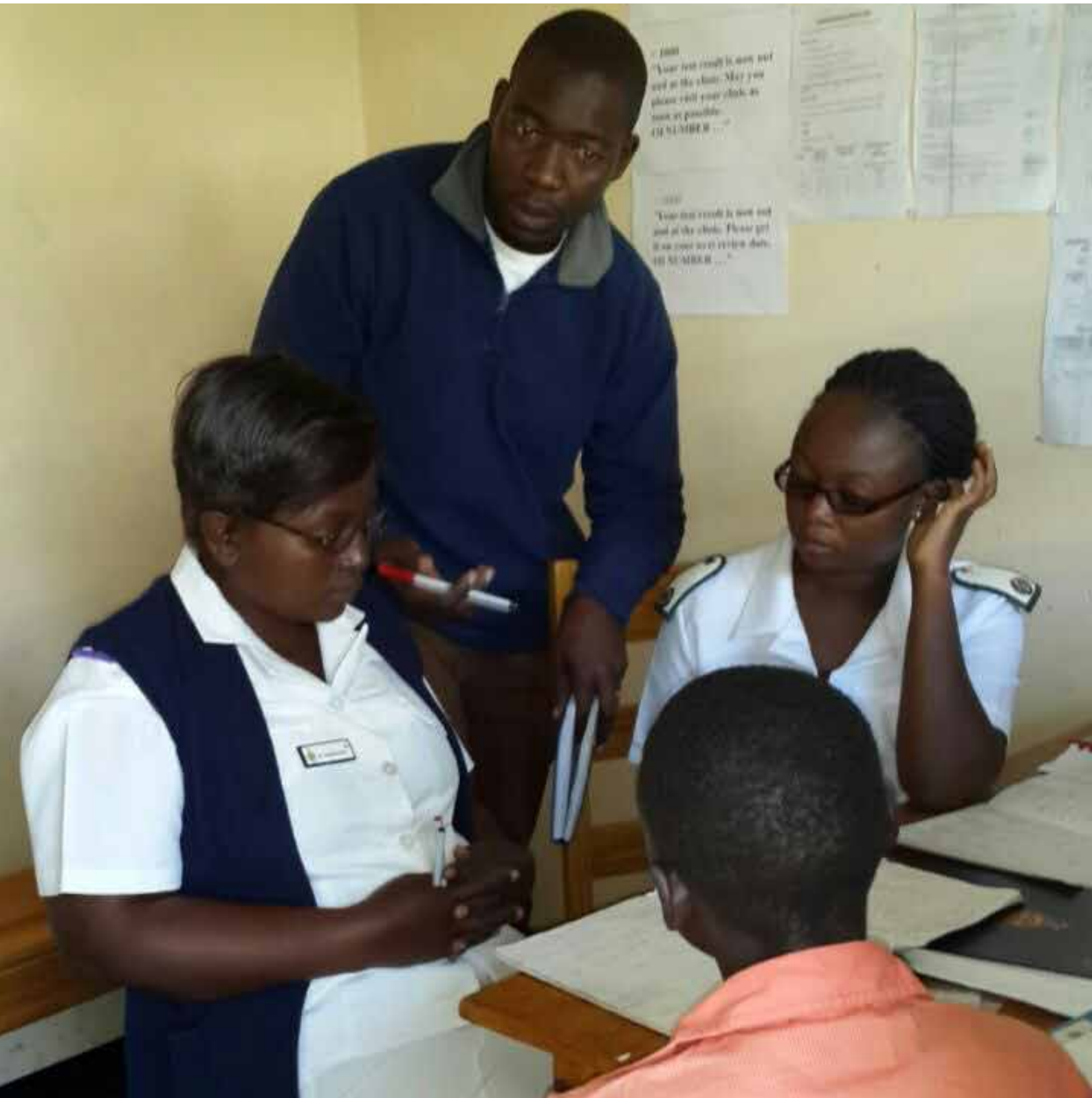
RESPONSE TO OUTBREAKS

The district did not face any outbreaks.

CONCLUSIONS

After more than a decade of support to MOHCC good quality services are available and accessible for HIV infected people and clients with TB.

GUTU



MSF nurse mentor mentoring MoHCC nurses

BACKGROUND

MSF started supporting opportunistic infections (OI)/ HIV/ TB care in Zimbabwe in 2004 in a neighboring district in Buhera.

Due to high quality care and easy access, this district attracted patients from very far and neighboring districts; among them Gutu. This led to the decision of MSF to extend its support to Gutu, so as to improve access to ART/ TB care for people in the district and also allowing the patients from Gutu on treatment in Buhera to access their treatment closer to home.

Since January 2011, MSF has been supporting MoHCC in Gutu District, Masvingo Province, to increase access to quality HIV/TB care and this through decentralization of ART diagnosis and treatment from hospital to clinics using a mentoring approach. As a result, the overall ART coverage in Gutu increased from an estimated 13% early 2011 (at CD4 < 200 for initiation) with only one site offering ART to 28 (= 90%) out of the 31 health facilities offering ART by end of 2013 (at CD4 < 350 for initiation). In 2014 - thanks to DGD funding - the project was extended with an additional three years to lift it up to a new dimension, with an overall objective to impact the progress (incidence) of the HIV epidemic by initiating ART at an earlier stage in the disease process (at < 500 CD4 count according to the WHO HIV treatment 2013 guidelines) and achieving community undetectable viral load, through close collaboration with MoHCC, using a mentoring of mentors approach.

This is translated in the specific objective of the project: "The population in Gutu district benefits of increased accessibility of quality

Opportunistic Infection/ ART/ TB services offered by MoHCC with support from MSF."

OI/ ART SERVICES

Scaling up access to ART for the population in Gutu is now well under way. In 2014, it was possible to enable all 31 health facilities to start ART initiation in Gutu, through the support of mentoring teams, meaning 100% of the public health sites in the district are now able to initiate people eligible on ART.

Prior to MSF's arrival in the district, there was only one site delivering ART. In 2014 – thanks to support from the President's Emergency Plan for AIDS Relief (PEPFAR) and especially the very big support of PMD (Provincial medical director) – two MoHCC mentoring teams were formed and are now actively taking charge of 18 and of the 31 facilities for supervision and mentoring.

The ART coverage of the total population has been progressively increasing in the district and reached 73% by the end of 2014 using the new 2013 WHO criteria for ART initiation. This new criteria increased the proportion of HIV positive people eligible for treatment from an estimated 50% to 76% of the total HIV infected people cohort. The high coverage was achieved due to the early approval of the new criteria by the PMD and the high uptake by MoHCC mentoring teams, clinic staff and patients.

Cumulatively, there were 12793 adult clients on treatment in Gutu District at the end of 2014. The new initiations in 2014 were 1856 adults and transfer in total was 879

adults. Children under 15 years cohort reached a cumulative total of 1175; with 204 new initiations in 2014 and 88 transfers. This figure corresponds with an estimated total coverage of 73.4%. The estimated coverage for adults was (76,3%), zero to four years (21,7%) and 5 to 15 years (86.9%).

Unfortunately, these figures show that the scale up wasn't homogeneous over the different age groups with especially the paediatric coverage lagging behind. Whilst the adult's ART coverage increased steadily over the year - from 68% at the start of 2014 to 76% at the end of 2014 – the paediatric coverage remained around 52% throughout the whole year.

Despite the new guidelines for initiation of all children below five years and PMTCT B+, the challenge remained specifically for the group 0-4 years, where this figure is extremely low, with only 22% of coverage. It could be due to wider roll out of option B (+) bringing a reduction in HIV infected children.

We hope the new Zimbabwe 2014 HIV estimates - which are anticipated to be released soon by MoHCC - will clarify if the prevalence in this group is estimated to be reduced or not. For the group 5 -14 years, the coverage is over 87%, exceeding the target of 85%. For 2015, this group 0 to 4 years will need to be targeted. MoHCC is drafting "An accelerated action plan to scale up for the Nationwide Scale –up of Paediatric and Adolescent ART in Zimbabwe: 2015-2018".

We hope that this consolidated plan – where all partners could give significant input according to their experiences and expertise – will help to find the possible solutions to increase coverage in Gutu district.

Table 9: ART coverage at the end of 2014 by age group in Gutu District

Q4	Adults	0 - 14 years	0 - 4 years	5-14 years	Total population
Population	120084	83 444			203533
Nb HIV infected	16812	2670			19482
In need of ART	12609		1172	1048	14806
RIC	9967	947	207	740	10914
% coverage Q4	76.3%	52.5%	21.7%	86.9%	73.4%
% coverage Q1	68.6%		26.6%	81.8%	66.7%
% coverage Q2	72.2%		30%	87%	70.3%
% coverage Q3	73.9%		20.2%	83.8%	71.1%

By the end of 2014 two mobile mentoring teams were formed by MoHCC; trained and mentored on the job by the MSF mobile mentoring team (= mentoring of mentors approach). These MoHCC mentoring teams have taken in charge mentoring and supervision of 18 of the 31 health facilities by the end of 2014; and will most likely be able to cover all the 31 sites by the end of 2015. Until then, MSF will assure the mentoring of the remaining centres. Mobile mentoring is a strategy used by MoHCC to decentralize ART care to all health facilities

in the country and assure continued supervision to ensure standards of care.

PMTCT

Gutu District moved to option PMTCT B (+) in mid-2013; with support of MSF for the training and on the job mentoring. In 2014, the total number of pregnant women booked at MoHCC clinics for 1st ANC was 6509 on an estimated total of 7073 pregnant women in the district using Crude Birth rate of 34/1000. This corresponds with an ANC attendance rate for 1st

visit of 92%. The number tested HIV-positive during ANC were 338, with a positivity rate around 5.5%. For all ANC attendants, the HIV-prevalence was 11.6%. From the 759 HIV+ women that attended ANC care, 421 had a known HIV status and 338 were diagnosed during their 1st ANC visit. Out of all HIV+ pregnant women (759), the total on ART was 748 (98.5%). Pregnant women already on ART were 355 (46.8%), whilst the number of pregnant women started whilst on ANC was 393 (51.8%).

Table 10: Prevalence of HIV among first ANC attendants in Gutu district during 2014

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	TOTAL
Nr pregnant women booked first ANC	1,753	1,657	1,574	1,525	
Nr pregnant women with known HIV+ status	82 (4.7%)	112 (6.8%)	116 (7.4%)	111 (7.2%)	421 (6,5%)
Nr pregnant women tested HIV+ during ANC	106 on 1,671 tested (6.3%)	93 on 1,545 tested (6%)	71 on 1,458 tested (4.8%)	68 on 1,414 tested (4.8%)	338 on 6,080 tested (5.5%)
Total pregnant women HIV+	188 (10.7%)	205 (12.4%)	187 (11.9%)	179 (11.7%)	759 (11.6%)

Concerning the PMTCT B+ programme, the retention in care data for the 2014 cohort (Jan to Dec 2014) is still being verified. Preliminary data obtained mid 2014 from the 10 operational research (OR) sites showed 66.5% retained in care (RIC) for this group at 6 months on ART. These results are still being verified in detail as we observed a lot of data entry missing at the clinics due to high workload; which could partly explain these low reported rates. At the same time this particular group is complex considering the challenges they face disclosing to their partner and family. Also geographical mobility during pregnancy, increases the chances of lost to

follow up. The ten OR sites in the district are the 10 facilities with the highest workload holding 58% of the ART cohort. Those have been selected to represent outcomes on retention in care for the entire district; as from these sites detailed data is collected on regular bases using the e-register data base. It is impossible to collect detailed data on regular bases from the other sites, which are just paper-based data collection sites. Male partners who got tested for HIV were 848 (13%), though no data available for their HIV status.

A total of 681 babies were tested by early infant diagnosis (DNA PCR) in the year by all MOH

clinics; and 19 were found to be positive (positivity rate of 2.8%). From all the identified HIV exposed children, 90% were tested and of the 19 positives 15 (79%) were started on ART, one was LTFU (lost to follow up) before result was communicated, one died and two were transferred out. Positive results are communicated to the clinics using mobile phones and nurses are actively tracing the mothers to bring their children for care. All children exposed to HIV were initiated on Nevirapine (NVP).

Table 11: Proportion of babies tested by PCR found to be positive during 2014 in Gutu District

GUTU DISTRICT	Q1	Q2	Q3	Q4	TOTAL
Infants less or equal to 2 month with DNA PCR sample collected	116	140	151	132	539
Infants greater 2 months with DNA PCR sample collected	31	54	25	32	142
Total DNA PCR Samples Collected	147	194	176	164	681
Number of PCR +ve of total infants tested	3 (2%)	5 (2.6%)	7 (4%)	5 (3%)	20 (2.9%)

VL ROLL OUT

Viral Load (VL) monitoring in the district is vital for ensuring the quality of care and to identify PLHIV in need of counselling support for adherence difficulties. Routine VL monitoring was launched mid-2013 and was further strengthened this year through intensive mentoring on the job as well for clinic staff and for MoHCC mentoring teams. All cost of viral load - such as equipment, reagents, laboratory staff, sample transport and SMS result transmission - are covered by MSF through the UNITAID funding. The actual collection of samples, counselling of patients and switch to 2nd line is covered under the routine mentoring/ training programme.

In 2014, MSF achieved 76% of

patients accessing yearly routine VL monitoring with 14.1% of patients reporting a detectable VL (= more than > 1000 copies/ ml). This is higher than our set target for 2014 which was 13%. In December 2014, a VL cascade exercise was carried out to help identifying which gaps there are in the continuum of care around viral load and adherence counselling in a cohort of patients. This exercise was carried out in 10 health facilities (representative sample size) in Gutu district. A total of 2,978 patient files were randomly picked and checked for VL1 done, VL1 detectable, enhanced adherence counselling (EAC) recorded, VL2 eligible and taken, VL2 more than > 1000 copies/ ml and switch to

2nd line. Outcome of this exercise was very encouraging showing that, in Gutu district in year two of implementing yearly routine VL, 74% of patients accessed VL, 14% were detectable, and of those eligible for enhanced adherence counselling 76% received it and of those eligible for VL2, 67% got VL 2 taken.

On the down side, it was noted that only 39% re-suppressed VL after EAC and that among those with high VL two only (35 percent) were switched to 2nd line. At this stage there are no WHO reference targets available to say if this rate of re-suppression/ switch to 2nd line is acceptable or rather low.

In 2015, the project will concentrate on trying to achieve better results on higher rates of re-suppression of VL 2 after EAC and higher rates of switch to 2nd line and will continue to share experience and ask advice from specialists.

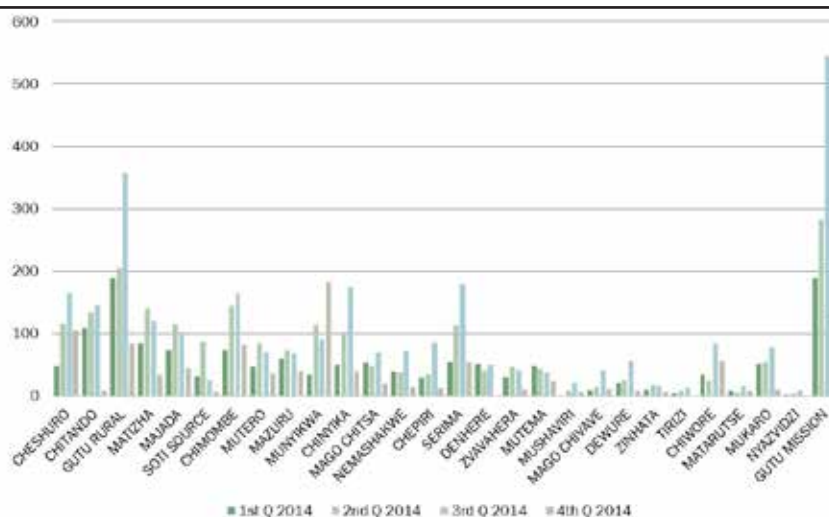
Up to date, 165 clients were switched to 2nd line in Gutu. This year alone accounts for more than

half of this with a total of 111 switches, due mainly to mentoring efforts to have the laboratory tests done and booking clients for the doctors' visit. The switch to second line still remains a task for doctors at district level. We are now lobbying for mentored and capable clinic nurses at decentralized sites to be allowed to switch to 2nd line ART, as this would make it simpler for

patients and would hopefully increase the switch rate. If this is allowed in 2015, the MSF teams will be putting a lot of emphasis on training nurses to switching to 2nd line ART, empowering MoHCC mentors as well as clinic nurses and continue exploring the bottlenecks and looking for alternative solutions to assist nurses with patients needing 2nd line switch.

Table 12: VL results for Children and Adults during 2014 in Gutu district

GUTU DISTRICT	1ST Q 2014	2ND Q 2014	3RD Q 2014	4TH Q 2014
Number VL performed	1792	2098	3187	1633
% VL results not know	17 (0.9%)	21 (1.0%)	11 (0.3%)	0
% VL < 1000	1518 (85.5%)	1755 (84.5%)	2550 (80.3%)	1327 (81.3%)
% VL ≥ 1000	257 (14.5%)	322 (15.5%)	628 (19.8%)	306 (18.7%)
% VL < 1000 (children)	50 (52.6%)	118 (70.2%)	146 (62.4%)	51 (52.6%)
% VL < 1000 (adults)	1468 (87.4%)	1637 (85.8%)	2404 (81.7%)	1276 (83.1%)
% VL ≥ 1000 (children)	45 (47.4%)	50 (29.8%)	88 (37.6%)	46 (47.4%)
% VL ≥ 1000 (adults)	212 (12.6%)	272 (14.2%)	540 (18.3%)	260 (16.9%)
Nb switched 2 nd line Q	16	14	39	31
Nb switched 2 nd to date	70	95	134	165



TB/MDRTB

MSF continued to support MoHCC for TB care provision. Regarding TB, the rate is close to the target with 181/100.000 and 361 notifications in 2014. Nevertheless, the number of notifications did not indicate an increase when compared to last year (374). It is hoped that by mid-2015 the National TB/MDRTB prevalence estimates study will be completed, which would give further clarification on the actual targets to aim for. The TB treatment success rate was 80%, above the estimated target for the year. Mid 2014, all TB cases were tested for HIV and

around 62% of the TB cases were co-infected with HIV. During the year, the mentoring team focused on the new TB screening algorithm and was reinforcing the use of the GeneXpert platform for diagnosing TB. Some other actions to be taken to increase TB notification include community awareness through community health workers and public campaigns in the district. This will be launched in 2015. Prior to arrival of MSF in the district majority of TB cases were diagnosed outside the district. With support and roll out of Xpert; it was now observed that the

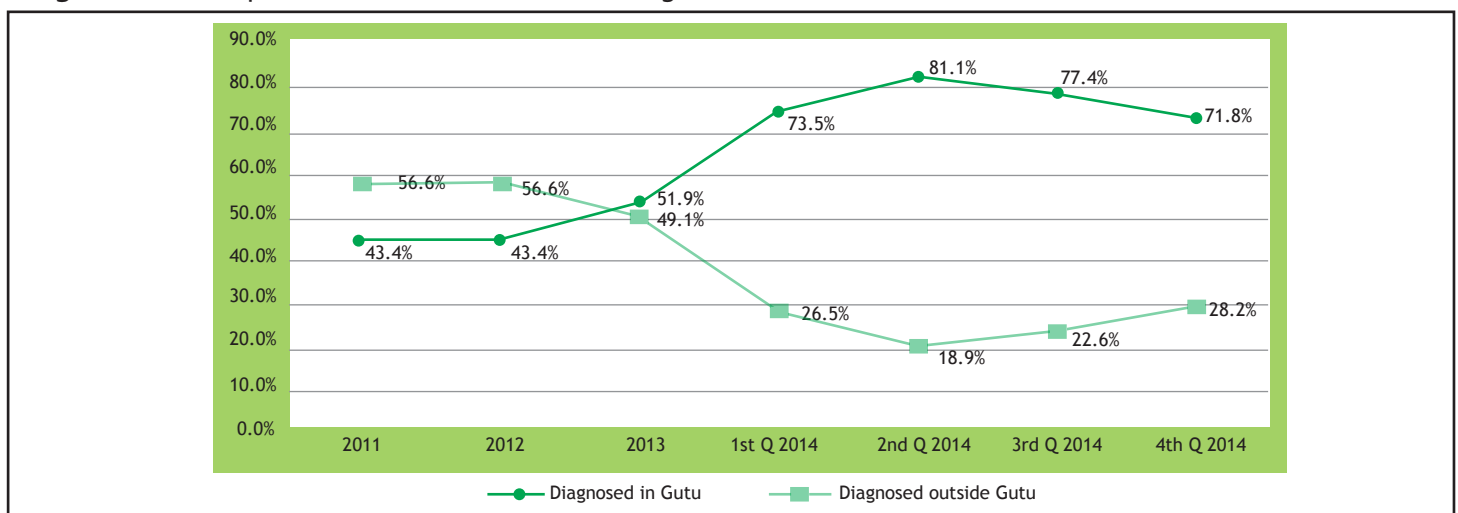
majority of patients are diagnosed in the district.

The number of cases on MDR-TB treatment increased, with a total of six additional patients starting treatment in 2014. By the end of 2014, 15 patients had thus been enrolled in the programme, with eight patients remaining under treatment, four completed treatment, two died and one defaulted. This corresponds with a treatment success rate of 57% - very close to the target - even though the cohort is small for conclusions.

Table 13: Total number of TB patients started on treatment during 2014 in Gutu

GUTU DISTRICT	Q1	Q2	Q3	Q4	TOTAL
TB notifications	68	90	93	110	361
Tested for HIV	67 (98.5%)	55 (61.1%)	93 (100%)	110 (100%)	325 (90%)
HIV Positive	43 (64.2%)	39 (70.9%)	73 (78.5%)	68 (61.8%)	223 (61.8%)

Figure 5: % of TB patients on treatment in Gutu; diagnosed in and outside Gutu District from 2011 till end of 2014



PATIENT SUPPORT SERVICES HIV Testing and Counseling (HTC)

The total number of clients tested for HIV at the health facilities in Gutu district in 2014 were 28,717. Of these 2,049 were HIV positive constituting an average positivity rate of 7.1%. In 2014, MSF also

conducted 13 HTC/AYA (adolescents and young adults) campaigns. In those campaigns a total 1,123 people were tested; including the 725 tested during the five AYA campaigns held in Gutu District. The average positivity rate was 1.6 percent. However, an important positive impact

observed was that some clinics started conducting HTC/AYA campaigns on their own (like in Chitando, Matizha and Majada). This indicates ownership by the MoHCC staff; organizing alternatives for reaching out to more people and especially to youth groups.

Figure 6: Number of clients tested during the 5 AYA/HTC campaigns in 2014

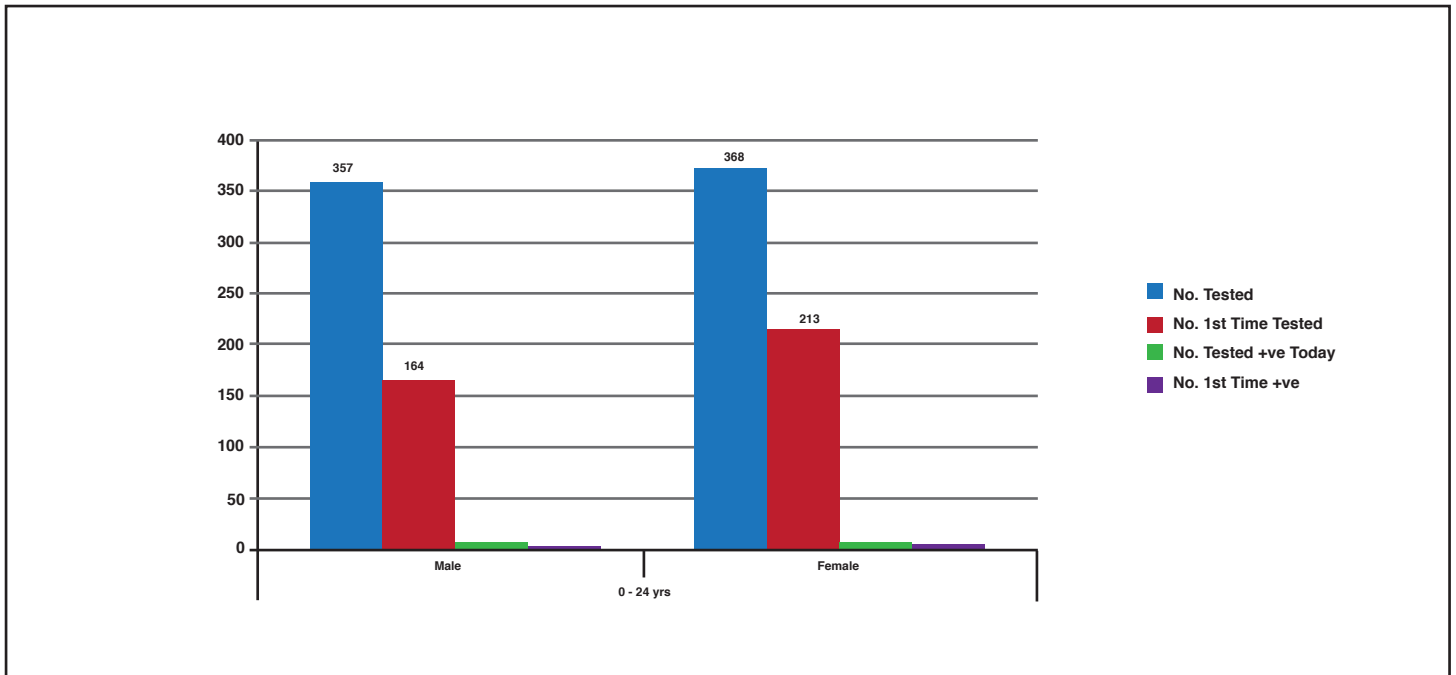
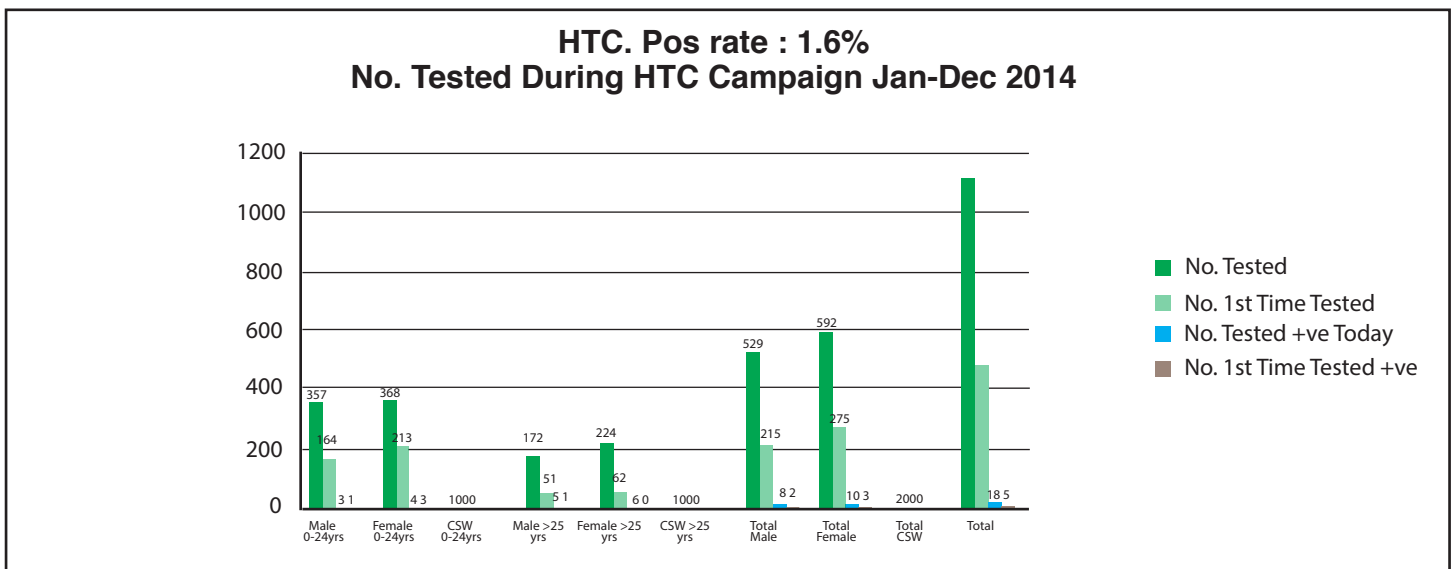


Figure 7: HTC campaigns conducted



Community ART refill groups (CAG's)

In July 2013 **Community ARV Refill through Support Groups (CARGs)** adapted from the Mozambican CAG example were piloted in two clinics in Gutu, the first district to take this up in Zimbabwe. The CARGs model aims at decreasing the number of loss to follow up (LTFU) and defaulters on ART due to geographical or financial bottlenecks, as well as aims greater responsibility and active participation of PLHIV in their own care by reinforcing social networks and peer support groups.

Additionally, it has advantages for the health system with a reduced number of patients visiting the clinic, relieving nurses' and clinicians' workload. It rests on the principle that patients take turns to go to the clinic and collect the ARVs for the other group members. Early 2014, a report with the main findings was presented to the Provincial Medical Director (PMD) whom then was convinced and allowed further expansion of the model in the district.

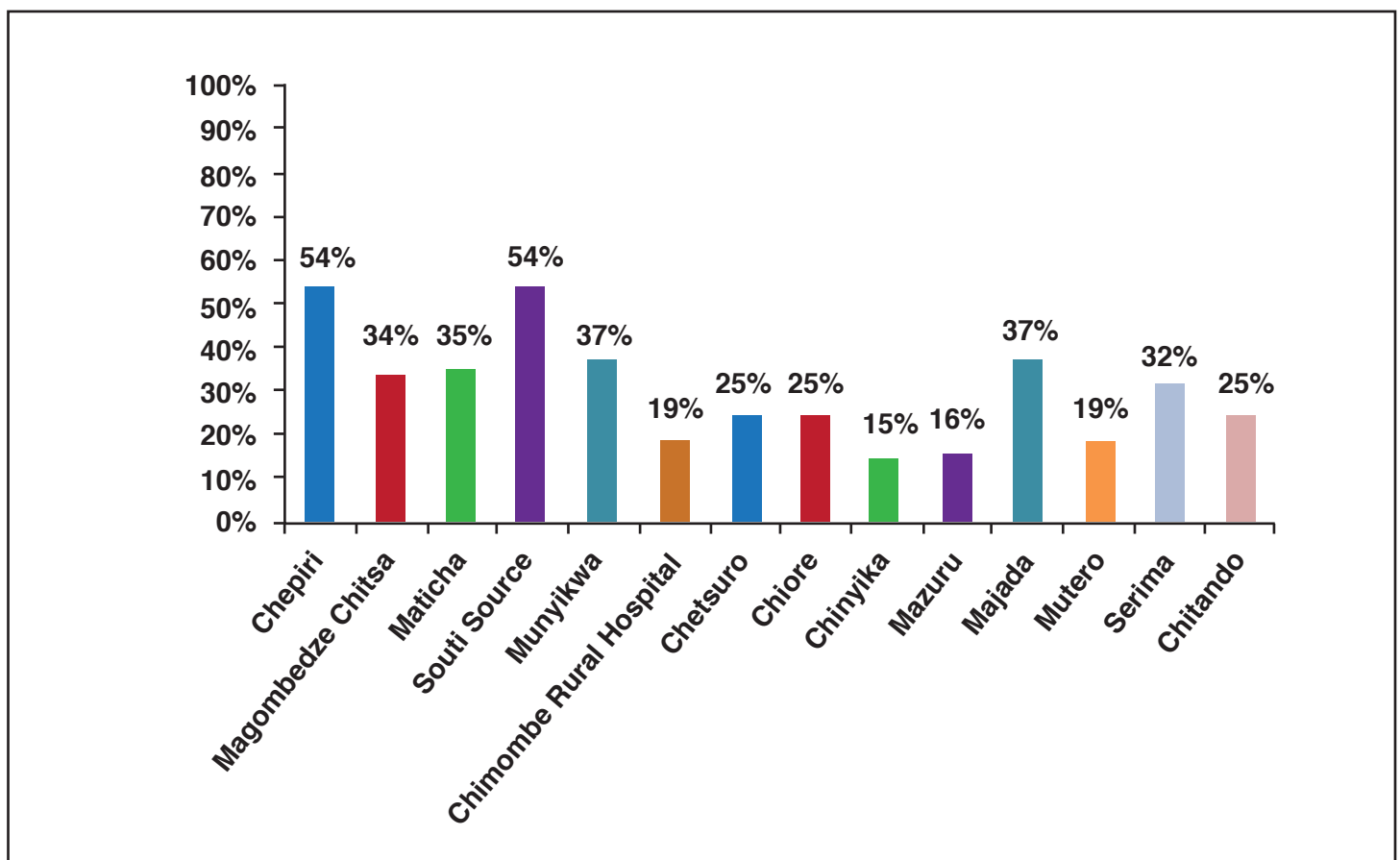
In 2014, CARGs were expanded to 12 additional clinics, bringing the

total of clinics offering CARG's to 14 sites, with 250 CARG's formed and 1,561 PLWH followed up under this dynamic. This corresponds with 14.3 percent of people on ART in Gutu in a CARG. When considering exclusively the active cohort of the sites with option of CARGs, the percentage of people in CARGs goes up to 27.4 percent (ranging from 15 percent to 54 percent depending on the clinic). The uptake of CARGs ranges from 15 percent of people in CARGs in Chinyka up to 54 percent people in CARGs in Souti source and Chepiri clinics as shown in graph.

Table 14: CARGs results for Gutu at the end Q4 2014

Health Facilities with CARGS in Gutu	14
Number of CARGs groups	250
Active Cohort of sites with option of CARGs	5680
Number Ever Enrolled in CARGs	1587
Number Remaining in CARGs	1561
Number Transferred out while in CARGs	2
Number of deaths while in CARGs	5
High VL while in CARGs	21
Diagnosed of TB while in CARGs	1
Breastfeeding while in CARGs	8
Pregnant while in CARGs	11
Pre ART clients in CARGs	38
Default while in CARGs	0
LTFU while in CARGs	0

Figure 8: % of people in CARGs by site in Gutu district at the end of Q4 2014



Night clinic

In 2014 MSF continued to support the night clinic in order to attract men for testing and care. Between April 2013 and March 2015 a total of 4052 people were tested at the night clinic; of these 317 (7.8%) were HIV positive. 72% of people tested were men compared to 28% women. CD4 testing is available at the night clinic; as well as treatment initiation and linkage to care to a static clinic within the months to follow.

PHARMACY AND LABORATORY SUPPORT

The proportion (in terms of cost) of **ART drugs donated by MSF** to MoHCC facilities to fill gaps at district level at the end of 2014 was 13%. The gaps that occurred for ART and MDRTB drugs were mainly caused by the late supply of NATPHARM or incorrect filled Consumption Report forms (CR forms) by the clinics (though MSF tried to correct as much as possible before submission to NATPHARM). This year, no major funding or drug supply gap occurred at NATPHARM. Most of the short supply by NATPHARM are rather linked to late delivery times (=logistics-, transport- and HR problems) rather than lack of drugs/funding. Challenges were encountered with

second line drugs and specific pediatric regimens, which were supplied consistently in minimal quantities and, as such, were never sufficient to reach the next delivery time. For 2nd line drugs this might be due to the fact that only MSF is supporting VL monitoring in Zimbabwe, hence the district sees its 2nd line cohort increasing above the average of other districts. There is an arrangement of three months' supply of drugs for CARG members. With the support of the Province, MSF continues to support GMH laboratory with commodities in case of gaps and technical support on the job.

REHABILITATION

Main rehabilitation works in Gutu were the construction of two incinerators, one at Gutu Rural Hospital and the other at Gutu Mission Hospital in December 2014. MSF also supported a Watsan consultant to perform an infrastructure assessment of all health facilities in Gutu and shared the results with stakeholders in March 2014.

CONCLUSIONS

After four years the project has been a catalyst for both districts in

their decentralization of OI/ART/TB services. Nevertheless pediatric ART coverage and RIC continue to present challenges. The project in Gutu can draw lessons as it was developed on a good collaboration with the stakeholders and community in the fight of the epidemic in similar settings to Zimbabwe. 2015 will see the majority of clinics for mentoring handed over to MOH/ GMH mentoring teams.

As MoHCC has initiated cervical cancer screening (VIA/ cryotherapy) in the district, as part of its basic package of HIV care, MSF decided to support this roll out in 2015 through provision of necessary equipment to 2 district hospitals and 2 rural hospitals, training and mentoring of staff in collaboration with a private- not-for-profit hospital in Harare with experience in providing VIAC services and setting up of quality assurance mechanism and networking with specialists. Evaluation of this pilot phase is planned for end of 2015; and if positive, further roll out to additional six rural health centers in 2016 is foreseen.

CHIKOMBA

BACKGROUND

The project in Chikomba District in Mashonaland East Province started in 2011. The project aimed to assist MoHCC to increase ART decentralization and increase ART coverage over a period of three years; which was achieved by end of 2013. Since 2014, the support of MSF in the district was limited to mentoring on OI/ ART with emphasis on routine VL roll out, enhanced adherence counselling, switch to 2nd line and roll out of CARGs.

OI/ ART SERVICES

Throughout 2014, the MSF mentoring team continued to visit the district two weeks per month; assisting the MoHCC mentors to implement the new 2013 Zimbabwe ART guidelines.

The ART coverage for the general population – based on the number of patients remaining in care - reached an estimated 72.2 percent with **a pediatric coverage of 51.3 percent and coverage of 72**

percent for adults respectively. The age group of 0-4 years reached a percentage of 23 percent while the 5-14 years age group for children was 82 percent. The new initiations in 2014 were 1329 adults and transfer in total was 385 adults. Children under 15 years cohort reached a cumulative total of 114; with 43 new initiations in 2014 and 88 transfers. Folder review exercise is carried out twice per year (July and January) to get more accurate estimation on the actual number of patients remaining in care.

Table 15: ART coverage/group at the end of 2014 in Chikomba District

Q4 (folder review)	Adults	0-14 years	0-4 years	5-14 years	Total population
Population	71 486	58 540	17 568	40 972	130 026
Nb HIV infected	10 008	1 873	562	1311	10 881
In need of ART	7 506	1 351	562	918	9 030
RIC	6 021	591	141	450	6612
% coverage Q4	72.2%	51.3%	23.2%	82.7%	72.2%
% coverage Q1	67.5%	54%	15.4.7%	57.697.2%	65.9%
% coverage Q2	76.6%	40.6%	17.1%	66.9%	72.2%
% coverage Q3	79.1%	42.6%	18.7%	69.3%	74.7%

VL ROLL OUT

During mentoring, emphasis was put on routine VL roll out; this comprises of on job training on samples collection, algorithm, support for sample transportation, training on enhanced adherence counselling and switch to 2nd line.

During 2014, 3408 VL samples were analyzed. Of these 22.2 percent came out with detectability

rate of more than > 1000copies/ml. This was significantly higher than what was noted in Buhera and Gutu district most likely due to the fact that fewer samples were sent for analysis and nurses are still prioritizing 'target' VL. Though towards the end of the year it was noted (like in Gutu) that in samples analyzed for VL among children, 54.4 percent had high viral load in

the last quarter of 2014; which was the highest from all quarters. By Q4, 75 clients had been switched to second line ARV treatment in Chikomba. The majority were switched during year 2014.

The tables show the number of VL performed in total in the district with rates of detectability.

Table 16: VL results for Children and Adults during 2014 in Chikomba district

CHIKOMBA	1ST Q 2014	2ND Q 2014	3RD Q 2014	4TH Q 2014
Number VL performed	703	681	1364	660
% VL results not know	17 (2.4%)	5 (0.7%)	8 (0.6%)	1 (0.1%)
% VL < 1000	538 (78.4%)	543 (80.3%)	1050 (77.4%)	499 (75.7%)
% VL ≥ 1000	148 (21.6%)	143 (21.2%)	306 (22.6%)	160 (24.3%)
% VL < 1000 (children)	27 (50.0%)	34 (60.7%)	56 (58.3%)	26 (45.6%)
% VL < 1000 (adults)	511 (80.9%)	509 (80.8%)	994 (78.9%)	473 (78.1%)
% VL ≥ 1000 (children)	27 (50.0%)	22 (39.3%)	40 (41.7%)	31 (54.4%)
% VL ≥ 1000 (adults)	121 (19.1%)	121 (19.2%)	266 (21.1%)	133 (21.9%)
Nb switched 2 nd line Q4	1	17	13	7
Nb switched 2 nd date	28	45	58	74

Mentoring teams are also closely following the uptake of VL in each clinic. The graphs below show a remarkable difference between the clinics; with some clinics showing a high uptake, though it also depends on the cohort size of the clinics.

Figure 9: Number of VL performed in Clinics of Chikomba District during 2014

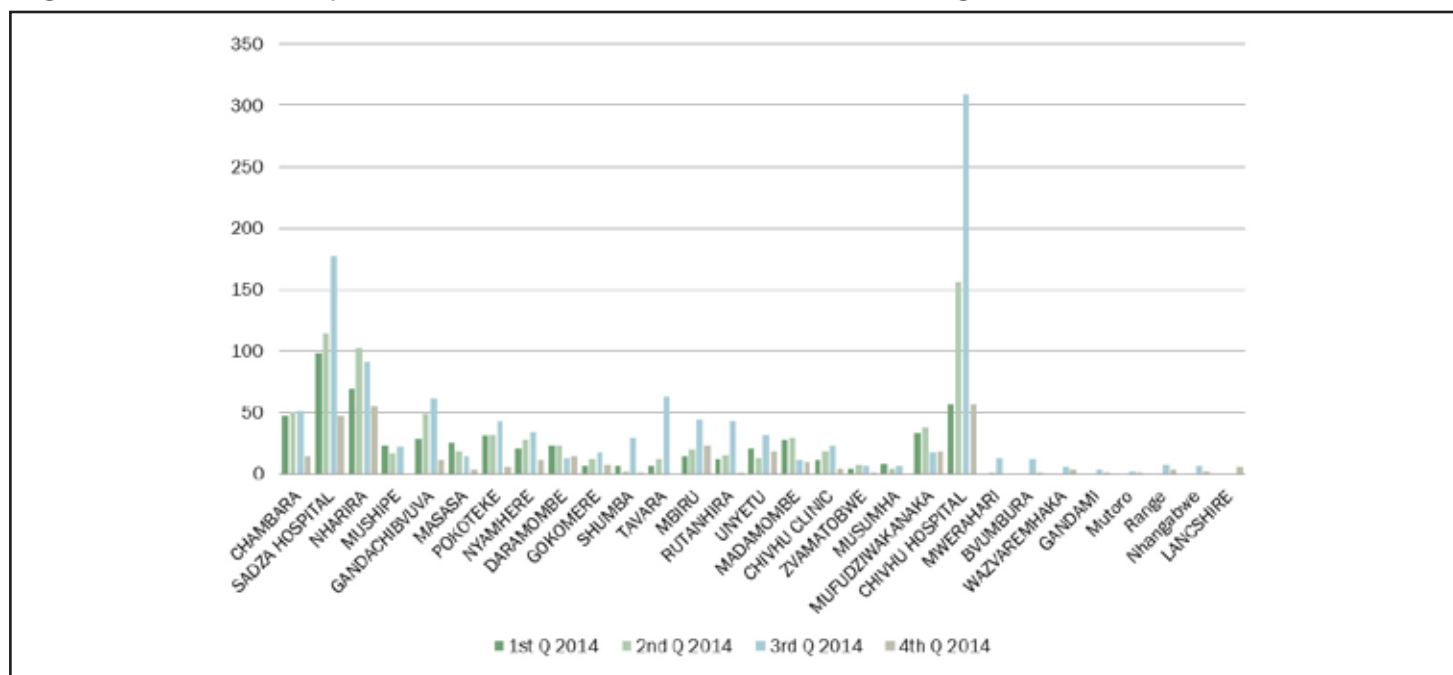
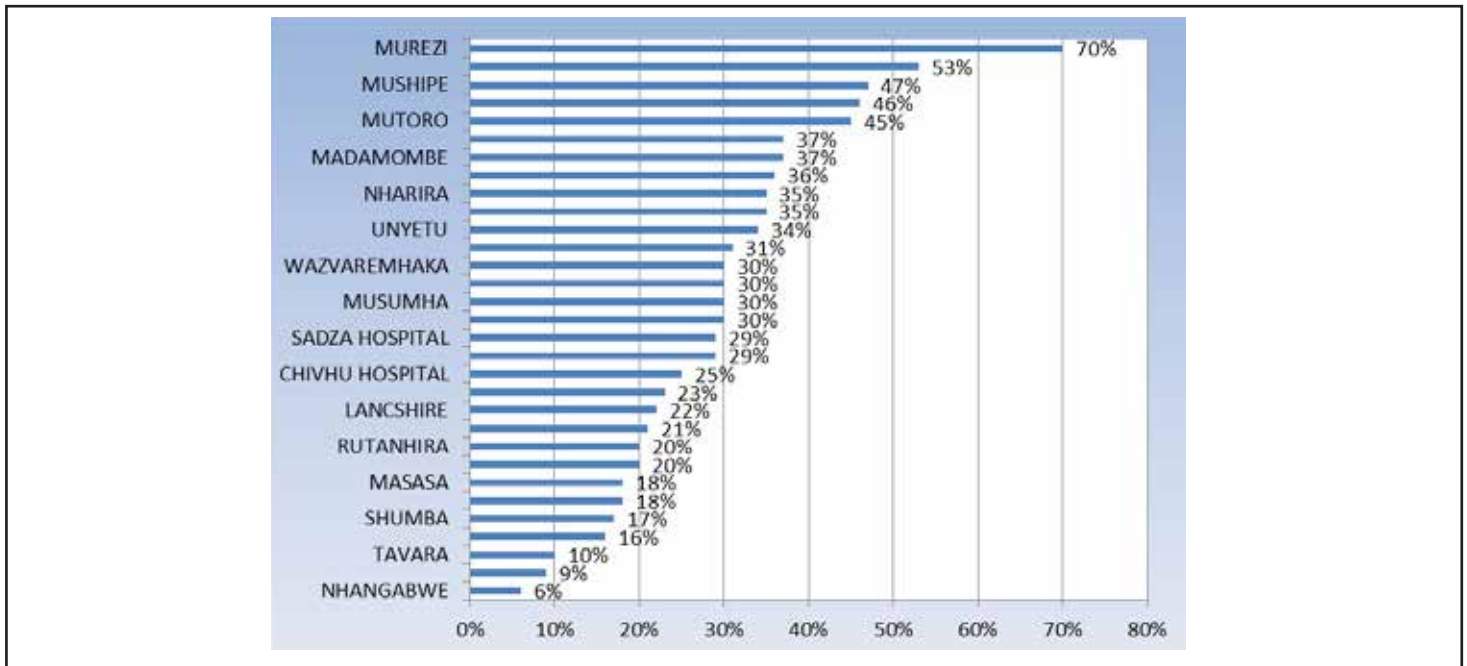


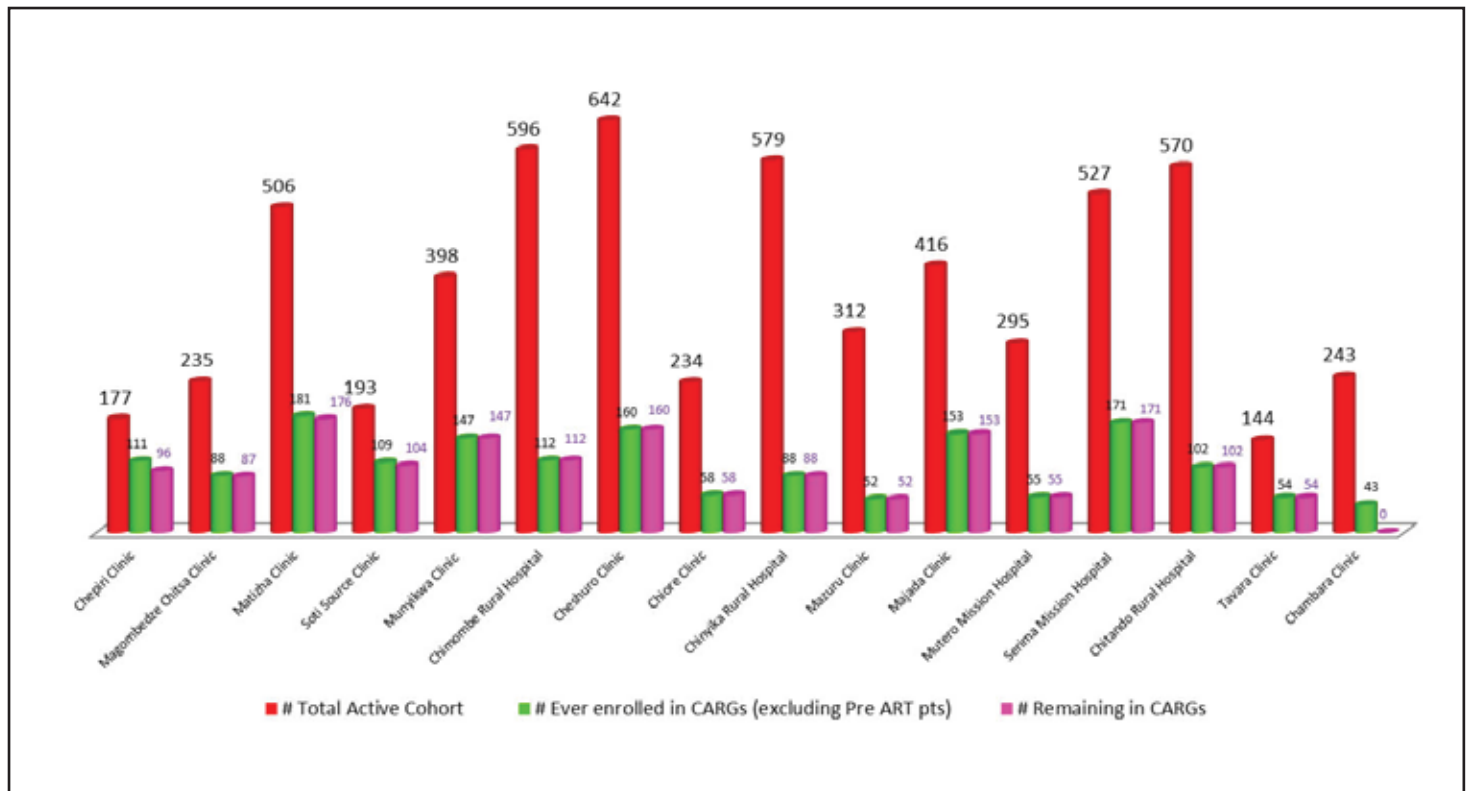
Figure 10: VL performed per cohort from each Health Facility Chikomba District in Q1 2014

PATIENT SUPPORT SERVICES

Community ART re-fill groups - based on the Gutu model - were started in two pilot sites in Chikomba district during the last quarter of 2014. The two pilot sites were Tavara and Chambara clinic. The

sites established 11 CARGs with a total membership of 54 people. Chambara site started only in November 2014 and by the end of the year patients were waiting for their viral load results so that they

could be confirmed as CARG members. In the set up, people are considered eligible for enrollment in CARGs when they reach VL undetectable. CARGs will be further rolled out in 2015.

Figure 11: CARGs results by clinic for Gutu and Chikomba districts at the end of Q4 2014

Health Facilities with CARGS in Chikomba	2
Number of CARGs groups	11
Active Cohort of sites with option of CARGs	387
Number Ever Enrolled in CARGs	97
Number Remaining in CARGs	54
Number waiting for VL results	43
Number Transferred out while in CARGs	0
Number of deaths while in CARGs	0
High VL while in CARGs	0
Diagnosed of TB while in CARGs	0
Breastfeeding while in CARGs	0
Pregnant while in CARGs	0
Pre ART clients in CARGs	0
Default while in CARGs	0
LTFU while in CARGs	0

REHABILITATION

MSF donated a car for the mentoring team for Sadza hospital. In addition, MSF supported the drilling of a borehole at Sadza Hospital with solar pump installation; since the district hospital had been struggling with water supply for a quite some time. The borehole installation was finished in December 2014, unfortunately some technical

issues prevented it from being fully operational. The contractor is working on solutions and hope this will be solved as soon as possible.

CONCLUSION

MSF will continue to support the MoHCC mentoring teams in Chikomba district in 2015, with emphasis on the roll out of routine

VL. MSF will ensure that routine VL is taken up in all clinics and that clinics know how to handle high VL results in terms of enhanced adherence counseling and switch to 2nd line.

NYANGA



MSF nurse treating a patient in Nyanga

BACKGROUND

Nyanga district has a population of 125 688 according to the 2012 census. The district has a total of 28 health facilities of which five are hospitals. Only three hospitals have medical doctors on site (Nyanga District Hospital, Regina Coeli Hospital and Elim Mission Hospital).

Situation before the start of the MSF project in mid September 2013:

ART services were available in the district since end of 2008. Only three hospitals out of 28 health facilities were able and accredited to initiate patients on ART (10 percent decentralization of care).

4,369 patients including 337 children less than 15 years had initiated on ART and remained in care. The adult ART coverage was

below the national targets with 48 percent for adults and 25 percent for children as per new guidelines.

The district had one MoHCC outreach team from the opportunistic infection (OI) department, Nyanga District Hospital (NDH), which was serving 16 outreach sites bi-monthly. The frequency of the team's visits to sites was erratic, depending on workload at NDH, drug supply, availability of vehicles and fuel.

The main role of the mobile team was ARV refills, and to a lesser extent, ART initiations. The mobile MoHCC team was not doing mentoring of clinic nurses, and there was lack of knowledge on ART/TB care among clinic nurses.

The average waiting time for ART

initiation was more than two months. Child initiation and follow up was centralised at the main hospitals with patients facing difficulties because of transport problems and bus fares to and from the hospitals.

Project objective:

The project aims to increase coverage especially in paediatric ART through intensified case finding (EID, VCT, PITC), to decentralise a full package of OI/ART services to rural facilities, to ensure proper initiation and monitoring of patients on ART and to improve TB case finding, management and support monitoring and evaluation. The approach is mentoring and capacitating of district health centre staff on clinical OI/ART management, pharmacy management, counselling, monitoring and evaluation and health promotion.

During the year decentralization of patients on ART from Nyanga District Hospital (NDH) to the clinics continued with support of MSF. MSF assisted clinic staff in the spreading and organization of patients for daily OI and ART consultations instead of specific days.

Capacity building of clinic staff was done through theoretical trainings, attachments and on-site mentoring. A MoHCC mentoring team was formed and mentored by MSF for on-the-job training and mentoring of clinic staff on ART and TB treatment initiation and follow up. MSF mentoring team mentored nurses, nurse-aids and primary counselors in 12 sites (increasing from 9 sites in the first semester to 12 sites by end of the year). With the increasing performance in some clinics, mentoring visits were reduced from twice a month to once monthly in five clinics.

Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe, December 2013

The district implemented the new ART guidelines gradually during the first quarter of 2014 in MSF-supported sites. By the end of 2014, all initiating sites implemented the new guidelines.

PMTCT B+ started in June 2014, and was officially implemented in all sites offering ANC during the 3rd quarter 2014 except one clinic (Nyangui) that is currently closed.

ART initiation sites

By the end of 2014, there were a total of 27 sites initiating and following up patients on ART or TB treatment, including five hospitals (2 are considered as decentralized sites) and 22 clinics. Note that in nine sites ART initiation was done only for PMTCT B+ mothers while general OI patients were still being

initiated at hospital level and then referred back to the clinics for follow up.

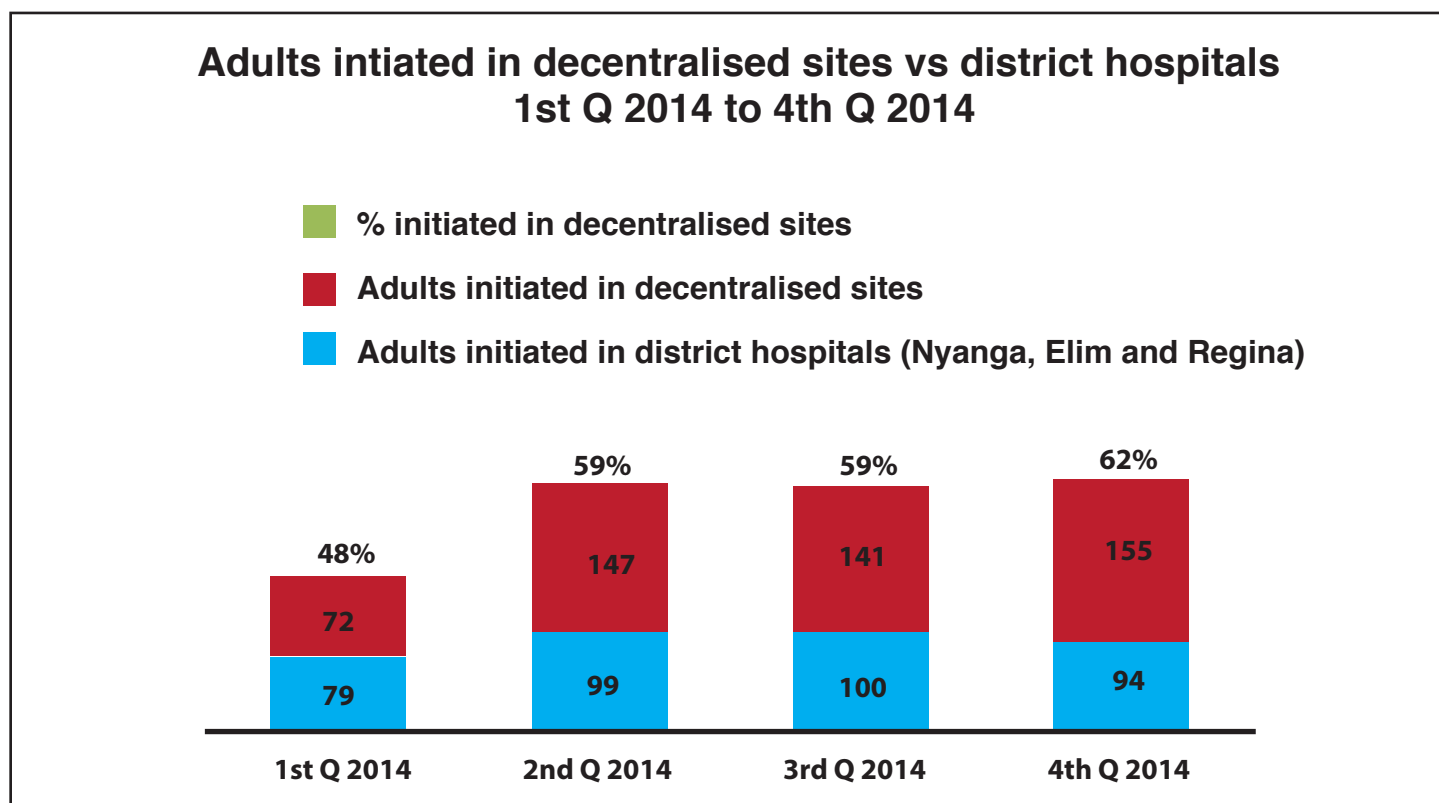
Mentoring of mentors: 13 health centres were being mentored by a joint MSF/MoHCC mentoring team, although the MoHCC mentoring team joined MSF only on few occasions due to critical shortage of staff in the OI department.

MoHCC mentoring team: Nine sites were being visited for ART re-fill by an MoHCC mobile team. MSF donated a vehicle to support the OI/ART outreach activities of MoHCC as they were hampered by shortage of transport.

ART initiations:

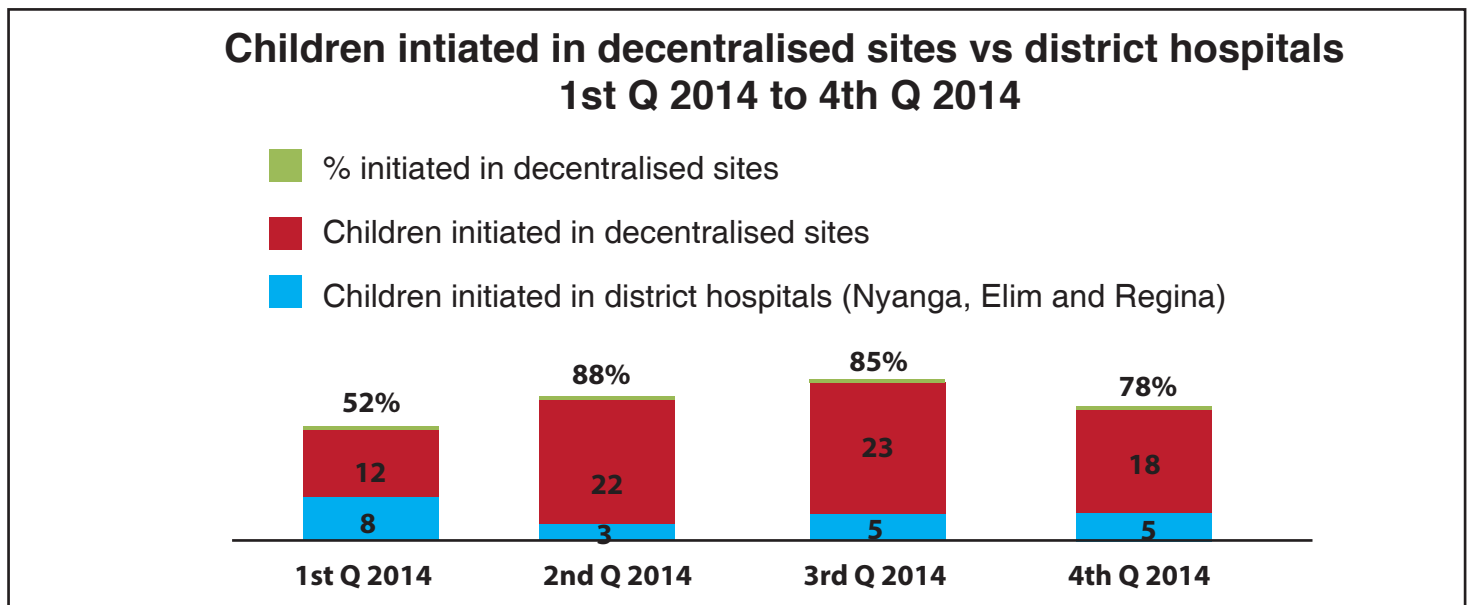
A total of 983 patients were initiated on ART in the district, 887 were adults and 96 were children; this amounted to an average of 81 per month.

Figure 12: Number and proportions of ADULT ART initiations in decentralized sites versus 3 hospitals, Q1 to Q 4- 2014, Nyanga district



Between 48 to 62% of adults were initiated on ART in decentralized sites (these include 2 hospitals).

Figure 13: Number and proportions of PEADIATRIC ART initiations in decentralized sites versus 3 hospitals, Q1 to Q 4- 2014, Nyanga district



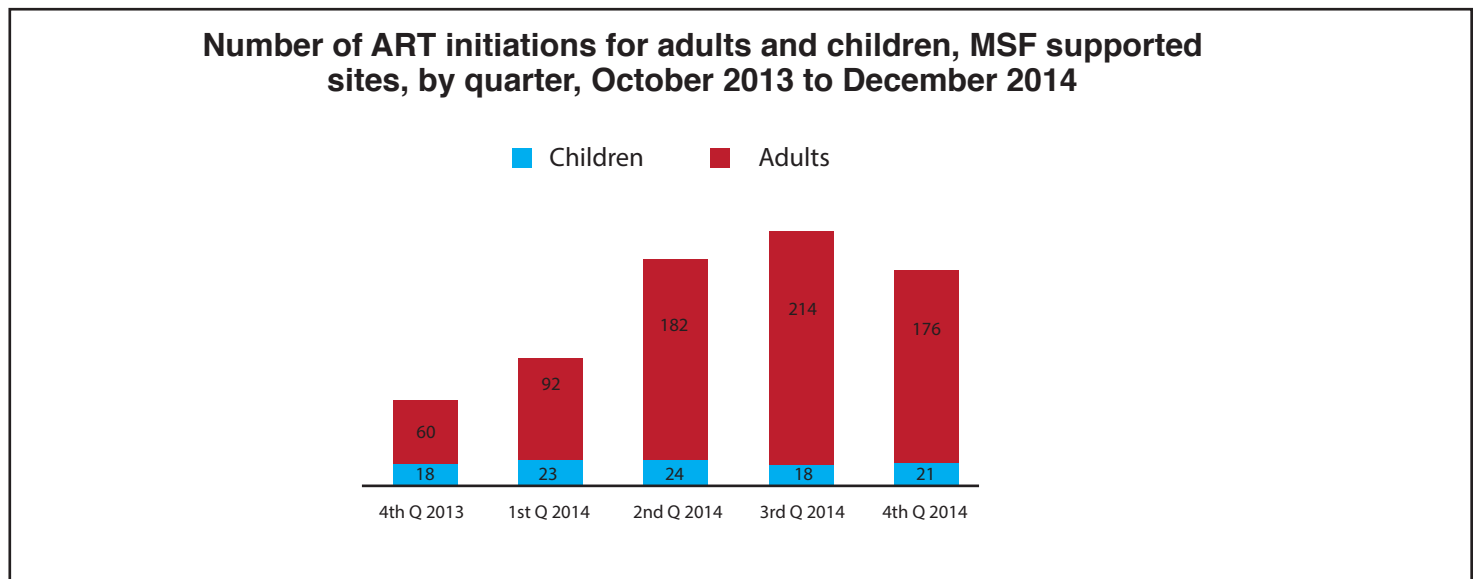
The proportion of children initiated at decentralized level was higher than for adults reaching up to 88 percent in second quarter 2014. These high proportions can be partly explained by the intensive mentoring done at clinic level on pediatric ART initiations.

ART initiations in MSF-supported sites:

Since the start of the project, the number of ART initiations has markedly increased in MSF supported sites, with a peak of initiations in quarter 3-2014. This is related to the fact that PMTCT

B+ was implemented in all sites offering ANC during the 3rd quarter 2014.

Figure 14: Evolution of ART initiations in MSF-supported sites since start of project in 2013



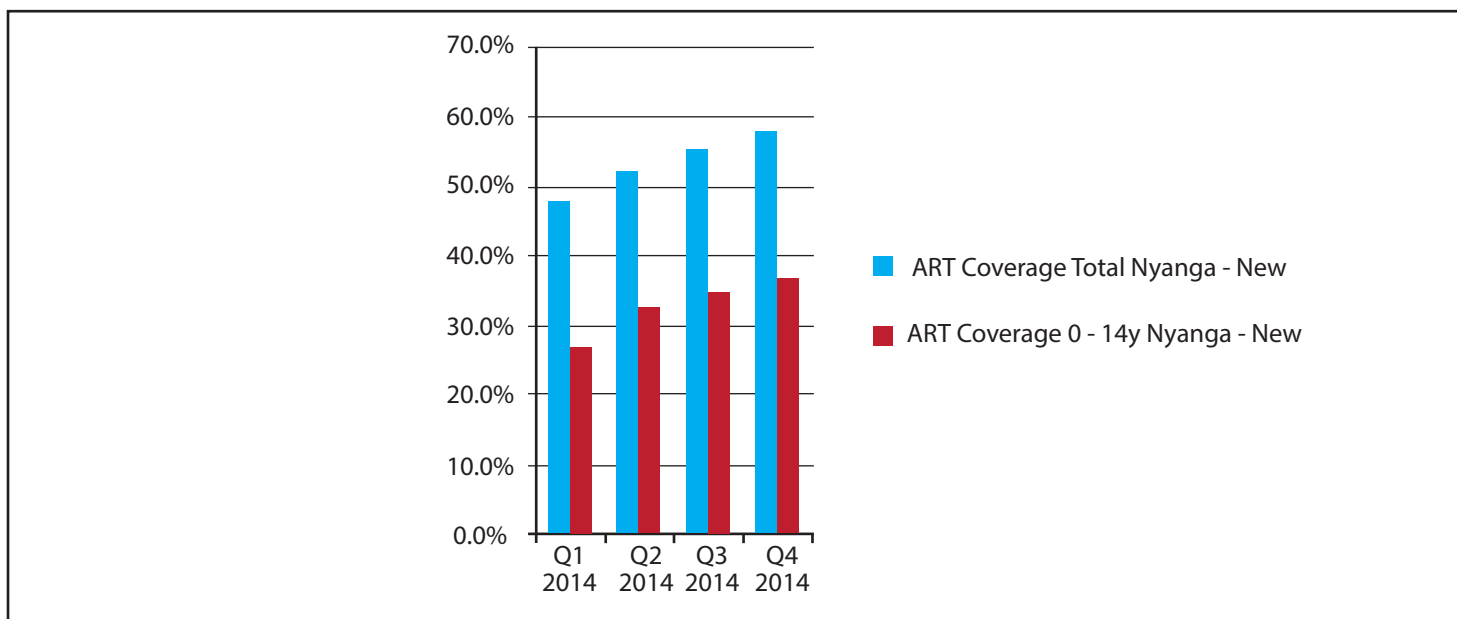
The decrease in ART initiations in December 2014 can be partly explained by a shortage of first response kits during the first two weeks of December 2014, and the general decrease in activities relat-

ed to the festive season at the end of the year.

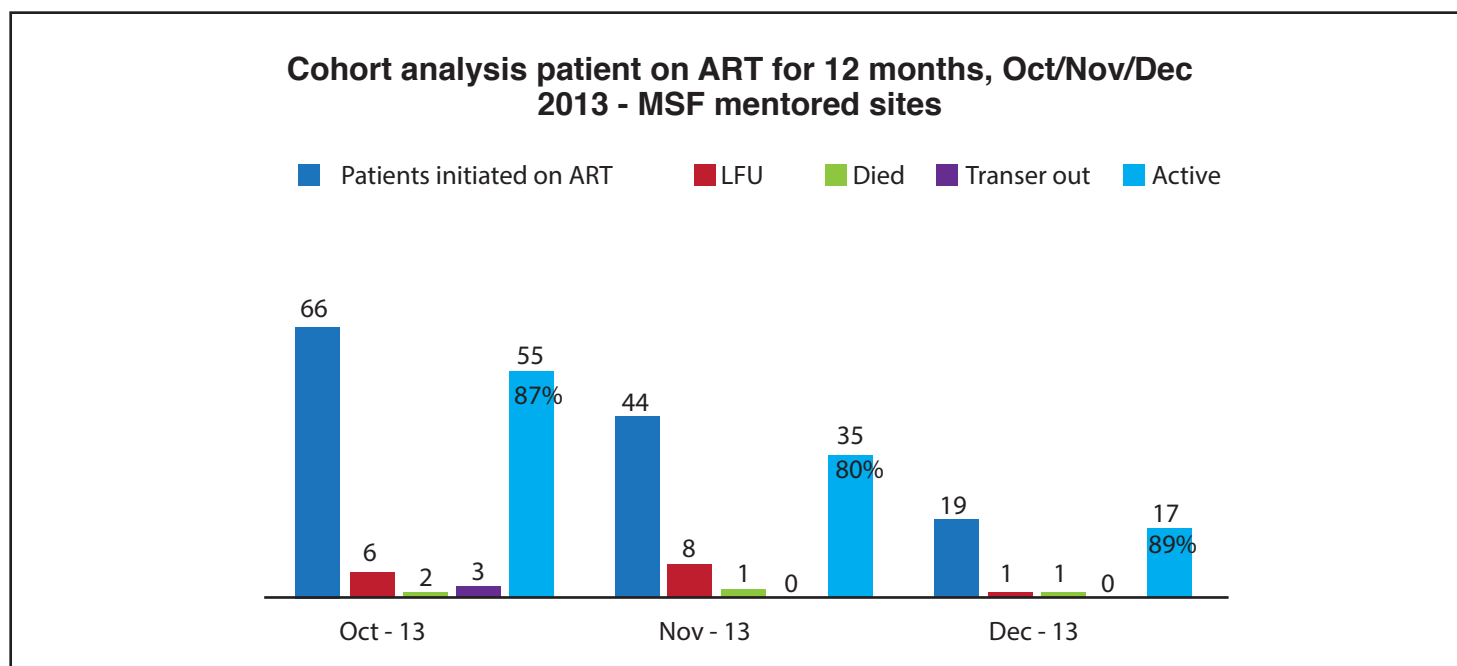
ART coverage

With the new initiation threshold defined by the 2013 guidelines,

overall ART coverage reaches almost 60 percent while pediatric ART coverage, although increasing over the year, remains below 42 percent (see graph overleaf).

Figure 15: Progress of ART coverage by end of Dec 2014, CD4 < 500

Retention in Care

Figure 16: Retention in care for Oct/Nov/Dec 2013 cohorts of patients on ART for more than 12 months, MSF-mentored sites, Nyanga District

This graph shows the retention in care by December 2014 for monthly cohorts of patients who initiated ART from October to December 2013 in MSF-supported sites. Out of a total of 129 patients initiated on ART, 107 (83 percent) are still active after 12 months on ART.

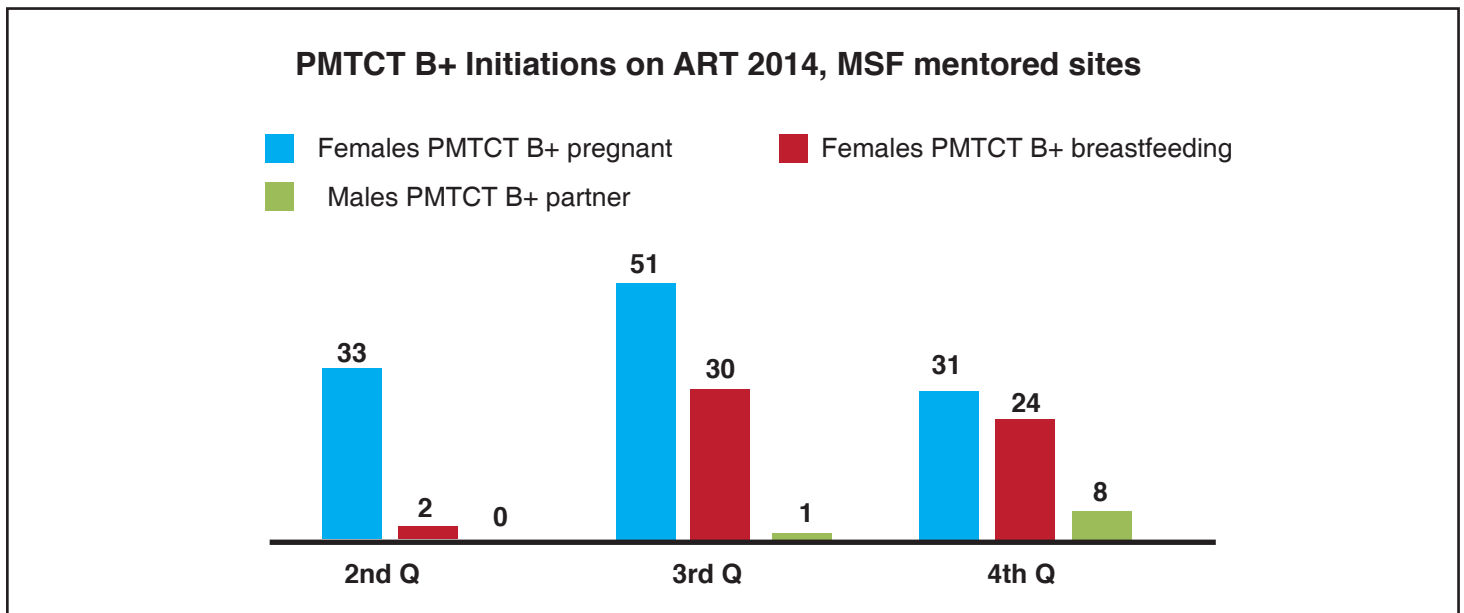
The target of more than > 85 percent retention in care was

reached for the October and December 2013 cohorts. However for the November 2013 cohort, achievements were below the target, which can be explained by a high percentage of LTFU in that cohort (08/44=18 percent). More in depth data analysis show that LTFU is higher in hospital settings than at clinic sites.

PMTCT

PMTCT B+ was officially implemented in all sites offering ANC during the 3rd quarter 2014 except in one clinic (Nyanguui) that is currently closed.

Throughout the year, MSF participated in promoting the new guidelines and PMTCTB+ through networking with other implementing partners.

Figure 17: PMTCT B+: ART initiations from quarter 3 to 4-2014, in MSF-supported sites

PMTCT B+ in MSF-supported sites

PMTCT B+ started in June 2014, and took off in the district during quarter three which explains the marked increase during that quarter, especially for breastfeeding women.

Early infant Diagnosis (EID)

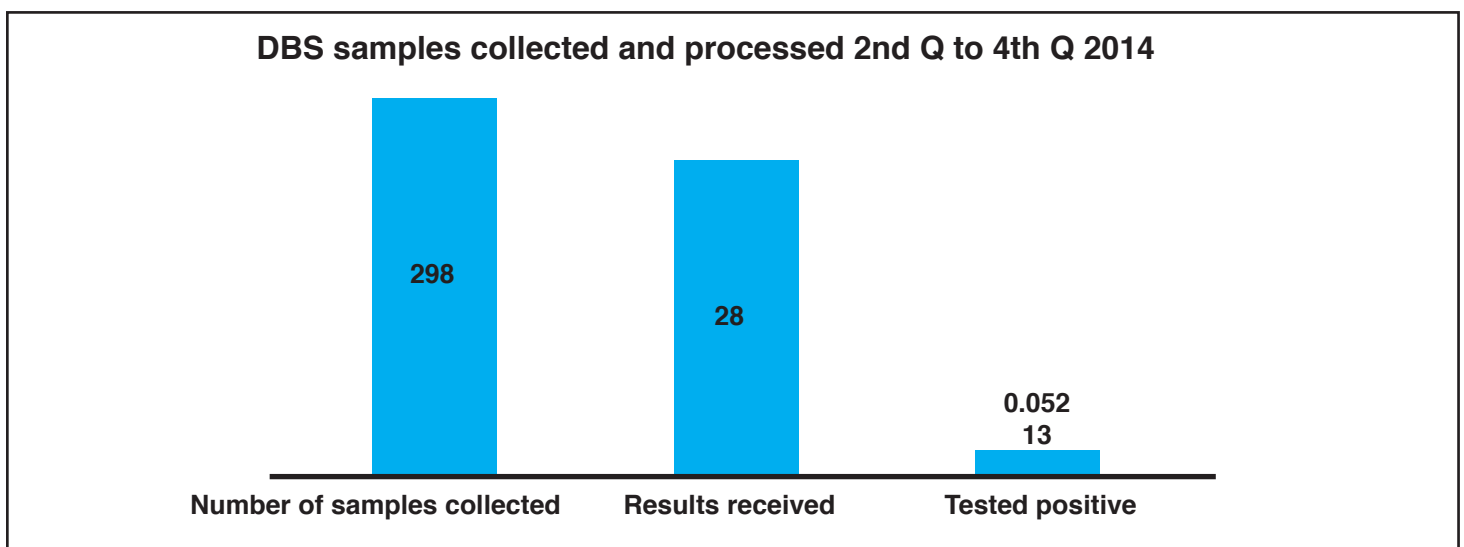
All clinics in the district are technically able to do EID. In four non MSF-supported sites, namely Spring Valley, Tombo, Nyafaro and

Fombe, the team conducted targeted mentoring to initiate ART for DBS positive children.

During the first half of the year, samples were sent to the NMRL. During the second half of the year, samples were sent to the Provincial Laboratory in Mutare. While results from NMRL used to take about six to 12 weeks; the turn-around period since second half of

the year was improved to two weeks for results to reach the district, three weeks at the clinic and four weeks for the patient, because of the R4H, MSF/MoHCC mobile team and decentralization to Mutare Laboratory.

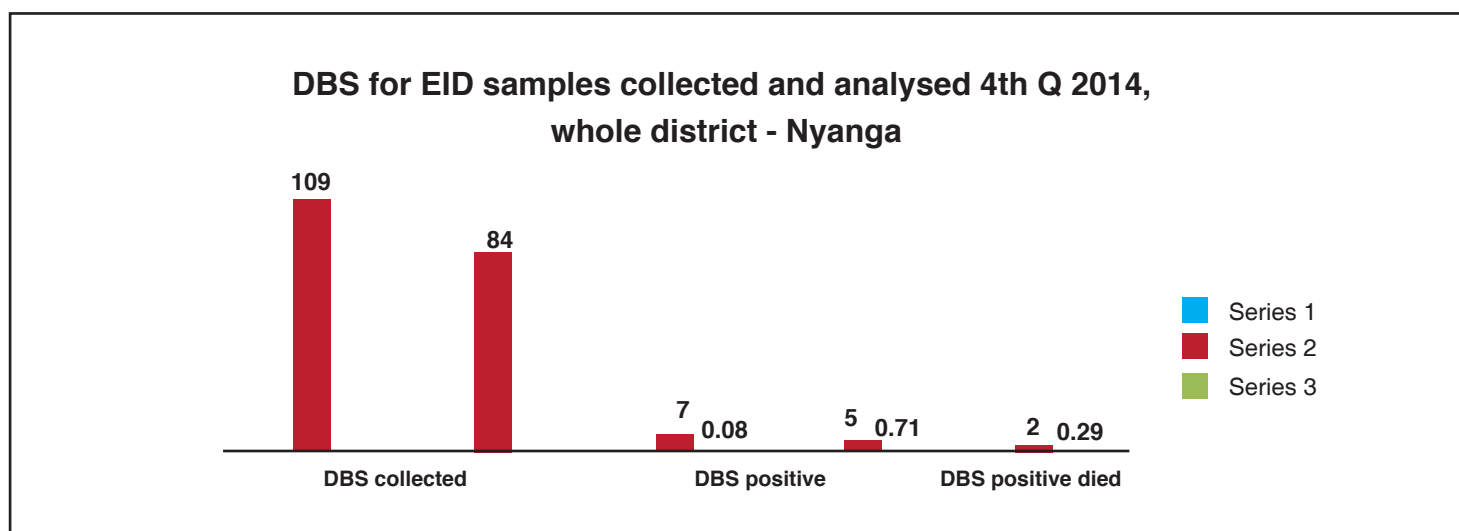
A tracking and targeted mentoring system is in place for all DNA-PCR positive children to ensure that all are initiated on ART.

Figure 18: Number of DBS collected and processed from Q2 to Q 4 – 2014, Nyanga district

A total of 298 DBS samples were collected for EID from quarter two to quarter four. Data for the first quarter were not available. Out of

252 results received, 13 were positive, which amounts to 5.2% of HIV prevalence. More detailed information was

collected in the last quarter of 2014 including data on ART initiation among exposed children. See graph overleaf.

Figure 19: DBS results for EID and outcome of PCR positive babies, Q4-2014, Nyanga District

A total of seven DNA-PCR positive children were registered during the last quarter of 2014 of whom five were alive and on ART and two died. Note that diagnosis of HIV infection and ART initiation was done in the post-natal period for five mothers out of seven (71 percent) of the exposed children described. This could be late diagnosis especially in home deliveries or post natal infection.

Retention in care at 12 months of ART initiation

This parameter has not been evaluated yet. In an intermediate evaluation done in November 2014 in 12 clinics and one hospital, MSF found that up to 24 percent of PMTCTB+

clients had not presented themselves at the time of the appointment date. This does not reflect the true retention in care, as they may have returned after the evaluation exercise.

VL ROLL OUT

At the start of the project, due to unavailability of viral load monitoring, a small number of patients were switched to 2nd line ART based on clinical or immunological criteria. In 2014, in collaboration with MoHCC, targeted viral load was made available at decentralized level with support of the mentoring teams. MoHCC nurses identify clients with suspected treatment failure and take the viral load

samples which are then sent to the NMRL for processing. The management of the viral load results and the switch to second line is done by the mentoring teams.

Access to Viral load

By end of December 2014, targeted viral load was offered in 11 sites (RCH, NDH and 9 clinics). During the year, 125 blood samples were sent for VL measurement. 107 were first VL samples; 18 were “repeat” VL after enhanced adherence counseling. The table below shows the results for 117 results received (8 were still pending by the end of the year).

Table 18: Targeted VL results for Viral load 1 and 2, by VL threshold, Nyanga, 2014

VL results	Number of VL samples received	Samples of VL1	Samples of VL2
< 1000	47	42	5
1000 - 5000	18	17	1
> 5000	52	40	12
TOTAL	117	99	18

57.6% (57/99) of all first targeted viral load analysis done showed a detectable viral load (> 1000

copies/ml). A total of 13 patients did not re-suppress after EAC and had a

second VL result of more than 1000 copies/ml. These 13 patients were diagnosed with virological failure

as per algorithm, and a total of 11 out of 13 were switched to second line (84.6%).

Challenges:

- Turnaround time for the viral load results was a challenge
- Two patients refused to be switched to second line.

TB/MDRTB

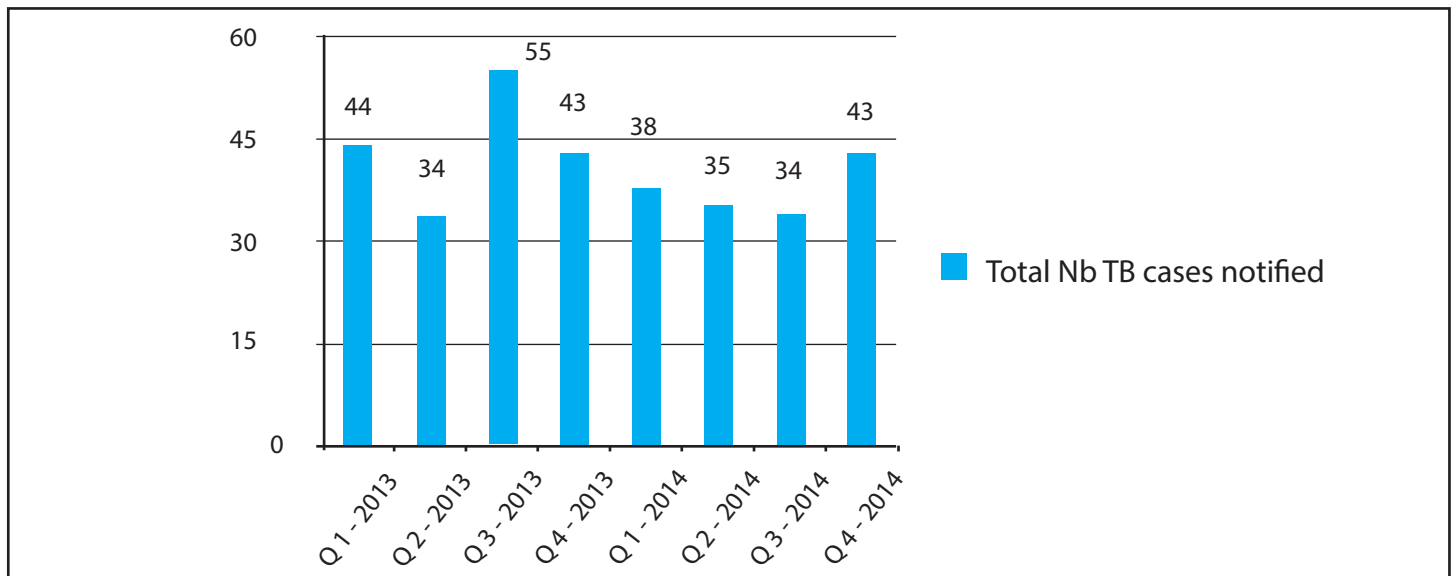
Sample transportation from clinics to the four microscopy sites and to NDH laboratory relied on one courier from Riders for Health and Environmental Health Technicians (EHTs).

In terms of prevention of TB, it is of note that Isoniazid Preventive Therapy (IPT) was rolled out at NDH during quarter 4. Sensitization of IPT in decentralized sites

was started with the hope to roll it out further.

Throughout the year, mentoring teams built capacity for initiation of sputum smear positive TB patients at decentralized level. By the end of the year, in 12 out of 13 MSF-supported sites nurses were capable of initiating sputum smear positive TB patients.

Figure 20 : Evolution of case detection of TB in Nyanga District, Q1-2013 to Q4-2014



The graph above shows that case notifications decreased during the first project year (from Quarter 4 – 2013 to quarter 3 – 2014). An increasing trend in case notification by the last quarter of the year 2014 was observed. This could be partly attributed to the installation of a GeneXpert machine at the end of July 2014. The positivity rate with Xpert increased substantially, as expected, from 4.5 percent with conventional sputum smear microscopy to 9.6 percent with Xpert.

Quality of sputum and proper screening needs to be improved. Sites that do sputum smear microscopy for diagnosing TB are being encouraged to send the samples to NDH for parallel testing by GeneXpert. Diagnosis of bacteriologically negative and extra-pulmonary cases needs to be reinforced.

Sample transportation was affected by the fact that Environmental Health Technicians (EHTs) usually contributing to sample transportation were deployed to the malaria residual spraying program hence they could not complement sample transportation and defaulter tracing.

Multidrug-resistant TB

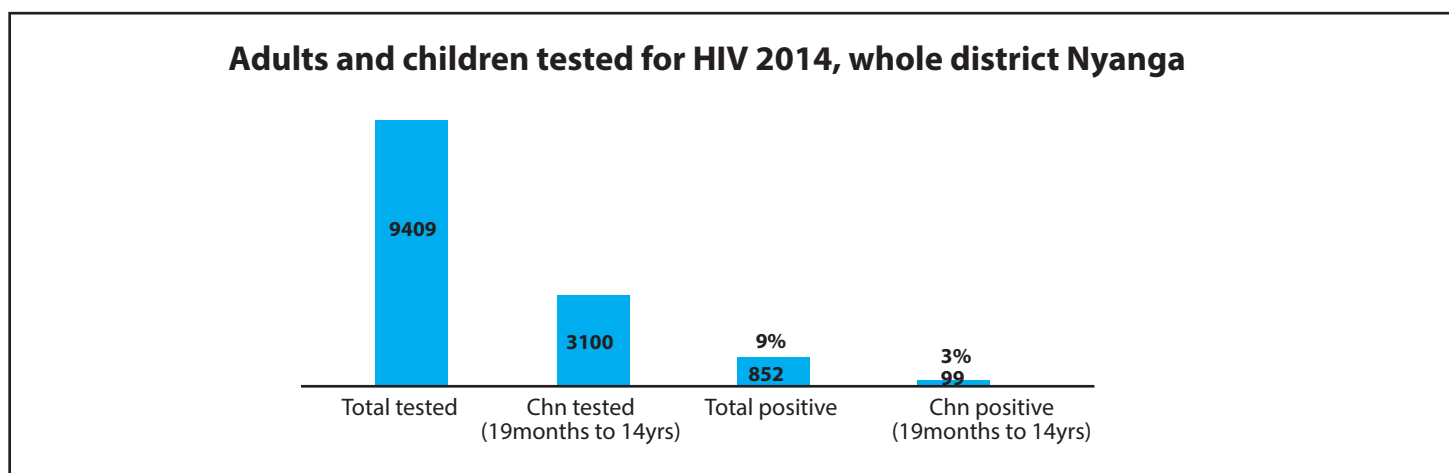
One case of presumptive DR-TB was diagnosed at NDH end of December 2014 who came as a referral from Nyafaru clinic. The patient was put on category one anti TB treatment. A Culture sample was collected and sent to Harare; it did not show resistance. At the end of the year there were two patients on DR-TB continuation phase in the district, diagnosed before the installation of the GeneXpert.

PATIENT SUPPORT SERVICES HIV Counseling and Testing (HTC) and Health promotion:

In May 2014, a health promoter joined the MSF team and started to do health promotion activities through networking with other implementing partners. Activities included participation in health talks at clinics, EPI outreach activities, HTC campaigns, distribution of IEC materials, awareness raising activities for traditional and religious leaders and other events such as the African Vaccination Week. A night clinic was done at Nyamuka Bus terminus targeting men and vendors, accessible also to the general population.

By the end of the year, a total of 9,409 adults and children were tested in the district for HIV in collaboration with MoHCC and other partners. 852 were diagnosed HIV positive (9 percent).

Figure 21: Adults and children tested for HIV in all sites in Nyanga District, 2014



PHARMACY AND LABORATORY SUPPORT

Pharmacy:

In 2014, the MoHCC started piloting a new system on receiving medicines and supplies in Manicaland Province including Nyanga District, the Zimbabwe Assisted Pull System (ZAPS).

From January to June 2014, MSF supplied increased proportions of TDF/3TC/EFV due to the switch of many patients to this regimen. Contribution of Natpharm for ART increased steadily, and by December 2014, contribution of Natpharm to the ART provision had reached almost 90 percent.

Throughout the year, MSF was supplying 100 percent of the pediatric formulations such as ABC/3TC 60/30 mg and EFV 200 mg since these items were out of stock at Natpharm, and 100 percent of LPV/r 200/50mg for second line patients on TB treatment.

Other specific items have been partly supplied by MSF in line with a gap-filling approach while strengthening the system through joint data collection for consumption and requisition and proper filling of consumption and requisition forms.

LABORATORY

In July 2014, MSF installed a Gen-

eXpert platform at NDH laboratory and donated a Deionizer machine. An air-conditioner was also installed by MSF.

NDH laboratory gets most of the reagents from the national supply, Zimbabwe Laboratory Commodities Distribution System (ZiLaCoDS). During the year the national supply had stock ruptures of some of these items and MSF provided commodities for gap filling to NDH laboratory, such as Partec Cyflow CD4 reagents, ALT and Creatinine on Keylab, GeneXpert cartridges.

MSF also supplied other consumables such as Pastorex Meningitis kit and Cryptococcal Lateral flow assay.

REHABILITATION

MSF supported rehabilitation of health facilities with main focus on safety of pharmacies in clinics mentored by MSF, and provision of furniture such as shelves, benches, filing cabinets and tables. Most rehabilitation was carried out in collaboration with Public Works Department. Some works were done in Nyanga District Laboratory related to the installation of the GeneXpert, and in the Family Child Health (FCH) department of the District Hospital.

RESPONSE TO OUTBREAKS

Malaria

The first quarter is usually charac-

terized by a peak of Malaria cases which subsides from April onwards. There were reports of increased Malaria cases in 13 sites in the district with stock outs of ACTs during the first quarter of 2014. MSF supported with gap filling and re-distribution of anti-Malaria drugs to the needy clinics.

Typhoid (Emergency Response)

In September 2014, MSF supported the MoHCC with the assessment and control of a typhoid outbreak. This included donations of drugs and non-food items, as well as fuel.

CONCLUSIONS

Ongoing mentoring and inclusion of an increasing number of sites in the mentorship activities have increased confidence and competence in terms of ART and TB treatment initiations among health workers in the district.

Access to ART and coverage of ART for adults and children has improved.

Follow up of patients on ART has improved through targeted viral load as recommended by the national guidelines.

Early detection of TB remains a challenge in the district despite the installation of a GeneXpert machine at Nyanga district hospital.

UNITAID PROJECT:

Support the roll out of VL services in Zimbabwe

MSF supports the National Microbiology Reference Laboratory (NMRL) to run the Nuclisense Viral Load Platform since June 2013. Up to end of 2014, this remained the main platform in Zimbabwe providing viral load to public health institutions. The only other platforms available were five Cavid machines in tertiary hospitals; running at much lower capacity.

Viral load is an essential part in the monitoring of patients on ART care and has been introduced in MSF supported districts of Buhera (since June 2011), Gutu and Chikomba (since January 2013). Those three districts provide routine yearly monitoring for patients with following schedule: M3, M12, M24, M36 etc... VL monitoring was taken up in the MoHCC ART guideline in 2013; although with realization that due to funding constraints the country will implement gradually from Target to Routine VL.

SUPPORT TO NMRL ACTIVITIES

For 2014, MSF targeted to reach an average of 3300 VL test/ month. An average of around 2843/ month corresponding with 86 percent of the target was achieved. A total of 34.124 VL tests were noted in 2014, which corresponded with only four percent of the total needed in the country.

As a result of not reaching the target and with continuous increasing demands; MSF decided to increase the VL staff at NMRL so that a two shift system could be established. One receptionist was recruited by mid-year and two 2 Lab

Scientists/ two Data encoders were recruited in November. After three days training by the provider and additional two weeks training on the job the 2nd shift could take effect from December 1st 2014. On average a turnaround time of 22 days is noted in the laboratory which is above the target of 14 days.

The human resources available for VL at NMRL (supported by MSF) by end of 2014 were six Lab scientists, four Data Encoders and one Sample Receptionist.

Another factor for not reaching the target of 3300 samples per month was machine breakdown. There were some breakdowns between January and April 2014 and then November; these breakdowns were fixed to by the local provider. In April 2014, MSF negotiated a maintenance contract with the provider; as the warranty period expired. MSF also managed to negotiate for a six months (bi-annual) preventative maintenance and as well have a contract where all breakdowns are covered by the company.

With regards to the supply chain management for laboratory products/ reagents the system ran smoothly. MSF Supply (BXL) managed to negotiate a good reagent price – and is already in the second year receiving the price promised for year three. It is hoped that further reduction is possible especially seeing the ROCHE price announcement of 9.4 USD/ test. In the 1st half of 2014, two containers were set up outside as

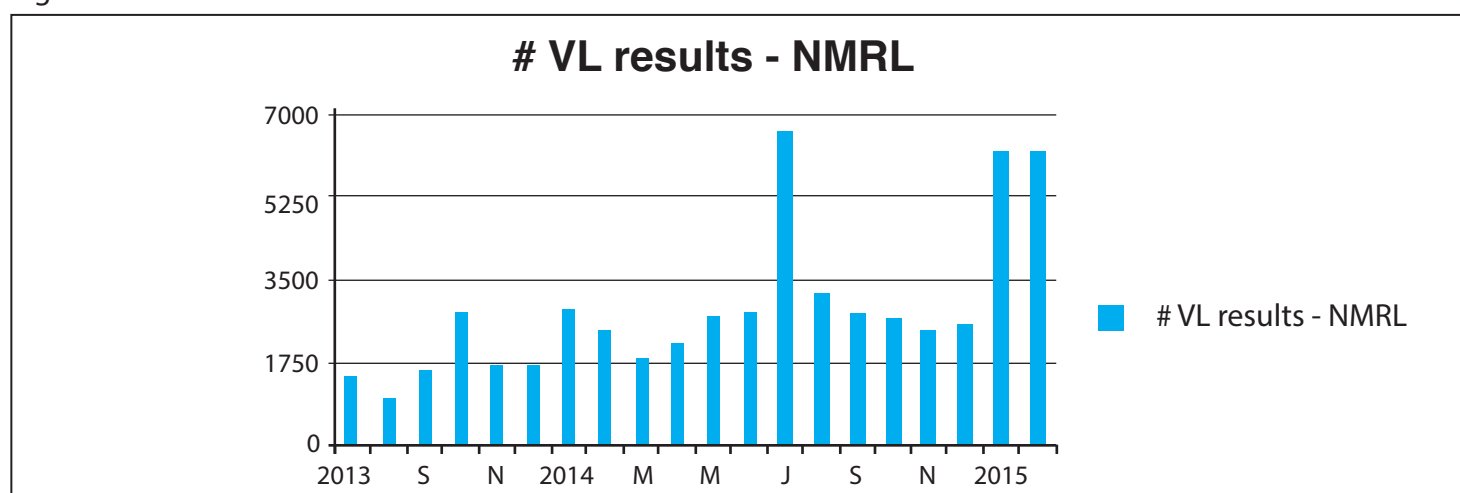
storage for none used equipment and archives. This helped to clear space within the laboratory for the data team. During the entire year, there was continued use of the VLIS data base.

Two (2) other logistical problems encountered in supporting NMRL were: frequent electricity cuts and water shortages. Water shortages resulted in staff carrying water with buckets up the stairs very frequently; which was an unacceptable situation for a laboratory.

MSF managed to connect one borehole in the hospital and set up a 10,000 liter tank on the ground (near the generator). A booster pump was then pumping the water to the storage tanks on top of the building from where it was then flowing downwards by gravity. The 10,000 liter tank that was set on the ground is supplied by both City Council and by the borehole; with the latter only feeding in if there were no supplies from City Council. The actual works were carried out by Public works, on UNITAID funding.

As part of the initial set up, MSF gave assurance that there was a back-up generator in place. The electric cut was due to combination of changes in HR that were serving the generator and fuel shortages. However, as NMRL has received new machines, the available generator (60 KVA) is too small and cannot cover the needs. Ideally a 100 KVA generator is needed; which NMRL director is trying to source.

Figure 22:



SUPPORT TRAINING OF CLINICAL STAFF AND VL UPTAKE / ROLL OUT

The number of sites trained and supported in terms of commodities (DBS kits, VL request forms) and accessing VL (Target) increased from seven in 2013 (4 MSF supported districts + 3 tertiary hospitals in Harare thus Harare,

Chitungwiza and Parirenyatwa Hospitals) to 12 sites (additional Epworth, Mutare hospital, two Bulawayo tertiary hospitals and Bulawayo city clinics) by March 2014. Since that time, no new sites were added even if national VL roll out plan aimed targeted VL to be introduced in all provincial hospitals by the end of 2014. The

reason for this not taking place was lack of resources and laboratory capacity. The only major change in terms of roll out that happened in 2nd half of 2014 was the move from Epworth site from Target to Routine VL testing; as MSF Holland (MSF OCA) came up with additional resources – technically and financially.

Table 19: Number VL samples performed at NMRL on the NucliSENS platform – 2014 – per health facility.

	Q1	Q2	Q3	Q4	Total
Pari - OA	338	81	1105	710	2234
Harare OD	341	285	207	233	1066
Chitungwiza	0	109	166	0	275
Buhera	3417	3725	4641	2624	14407
Mutare	27	17	5	12	61
Nyanga	30	25	38	29	122
Chikomba	703	691	1364	660	3418
Seke-Epworth	514	327	396	1202	2439
Gutu	1792	2098	3187	1633	8710
BYO city - OA	0	221	917	250	1388
UBH - OB	0	40	87	19	146
Ingiutsheni - OC	0	0	76	108	184
Mpilo - OD	0	301	499	182	982
Others	0	3	0	2	5
	7162	7925	12688	7664	35439

Monitoring and evaluation and mhealth

In 2014 the VLIS data base was further improved with automated connection to frontline sms, possibility to adapt the OI cohort number and other requirements demanded for WHO accreditation.

MSF started sending sms results to clinics (Buhera, Gutu) in February 2014 and sms reminders to patients at the end of June 2014. No new sites were included in the second half of 2014; as an evaluation was anticipated. This evaluation will be in the form of operational research (OR) "Analysing patients' satisfaction and Impact on Health seeking behavior of reminders to collect VL results delivered via sms to HIV (+) patients". MSF would like to acknowledge the technical support of MoHCC and RTI; they brought all know-how for the entire technical set up linking the VLIS data base with the frontline sms. Without their support sms messaging would not have been achieved.

One data encoder acted as "focal person for follow up of sms results" at NMRL by phoning each of the health facilities in the two participating districts (60) to ensure that the message has arrived. This was achieved. This follow up will continue for any new site added in future.

VL technical working group

Since April 2014, MSF joined the Viral Load Writing team which is chaired by MoHCC. This technical working group was responsible for

drafting the "Zimbabwe HIV Viral Load Scale up Plan: 2015-2018" and its corresponding budget. This plan describes how viral load would be gradually rolled out in the country (using a phased approach), aiming at offering access to yearly routine VL to > 90% of the people on ART by 2018.

OPERATIONAL RESEARCH

A number of researches – all contributing to the national VL roll out plan - were drafted and presented to MRCZ in 2014.

1. **Documenting the VL cascade at clinic level:** this analysis of routine data was carried out in 10 clinics in Buhera and 10 clinics in Gutu; and will continue regularly. Some of the results are discussed under the respective project presentations.
2. **VL pooling protocol:** "Feasibility and Impact of HIV 1 DBS pooled VL testing to reduce the cost of monitoring ART in Zimbabwe". Mid 2014 the protocol was approved. A first trial was done in December but was abandoned because samples were of bad quality. Study is planned to be repeated early 2015.
3. **Sms protocol:** "Patients satisfaction and impact on health seeking behaviour of reminders to collect Viral Load results delivered via SMS to HIV (+) patients". Protocol approved by MRCZ and MSF ERB. This

study will be executed in 2015 and runs in collaboration with MoHCC and RTI (Research Triangle Institute International – the NGO supporting all the technical set up for the mhealth).

4. **POC VL on Xpert:** by the end of 2014 the protocol was awaiting approval by MRCS and MSF ERB, agreement with FIND signed, training by Cepheid planned for March 2015. Study planned to start April 2015.

CONCLUSION

By and large, the viral load project has been a success besides some challenges and is expected to continue improving and meet the set targets. On the downside, MSF was worried that up to end 2014 UNITAID remained the main (and only donor) supporting VL implementation – reaching only four percent of coverage in Zimbabwe. No other major donors have come forward and even funds on GF/ GF incremental funding are small. Announced price reductions of Roche were received well in Zimbabwe as were their publication on a new protocol to do VL on DBS at ASLM. We are however awaiting WHO pre-qualification of this technique at a cut of point of 1000 copies/ml.

MBARE

Support survivors of sexual violence.

BACKGROUND

Mbare project is under the jurisdiction of City of Harare and is one of the most densely populated districts in Harare (Pop. estimates 139 500). MSF-B opened a stand-alone Sexual and Gender Based Violence (SGBV) clinic in Mbare in conjunction with City Health in September 2011 – with the objective of providing comprehensive care to survivors of SGBV within Harare and at large from peri-urban settlements and surrounding districts. By the end of December 2014, more

than 3500 survivors received free medical, psychological, legal and social support in this clinic.

Since the opening of the project in September 2011, there has been an upward trend in the number of new survivors seen per month over the years from an average of 31 in 2011, 76 in 2012 and 102 in 2013 to 113 in 2014. This could be associated with an increased awareness that rape is a crime, and the need for seeking medical

care in the event of rape and the increased profile of the Mbare clinic. In 2014, a total of 1357 new survivors were seen at the clinic.

As with previous years, quarter 2 (Q2) of 2014, saw a reduction in cases; whilst Q4 and Q1 saw an increase. This could be attributed to fewer festivities during Q2; when compared to the last and first quarter of the year in which the festive atmosphere leads to more abuse.

Figure 21: Evolution of new cases over the years

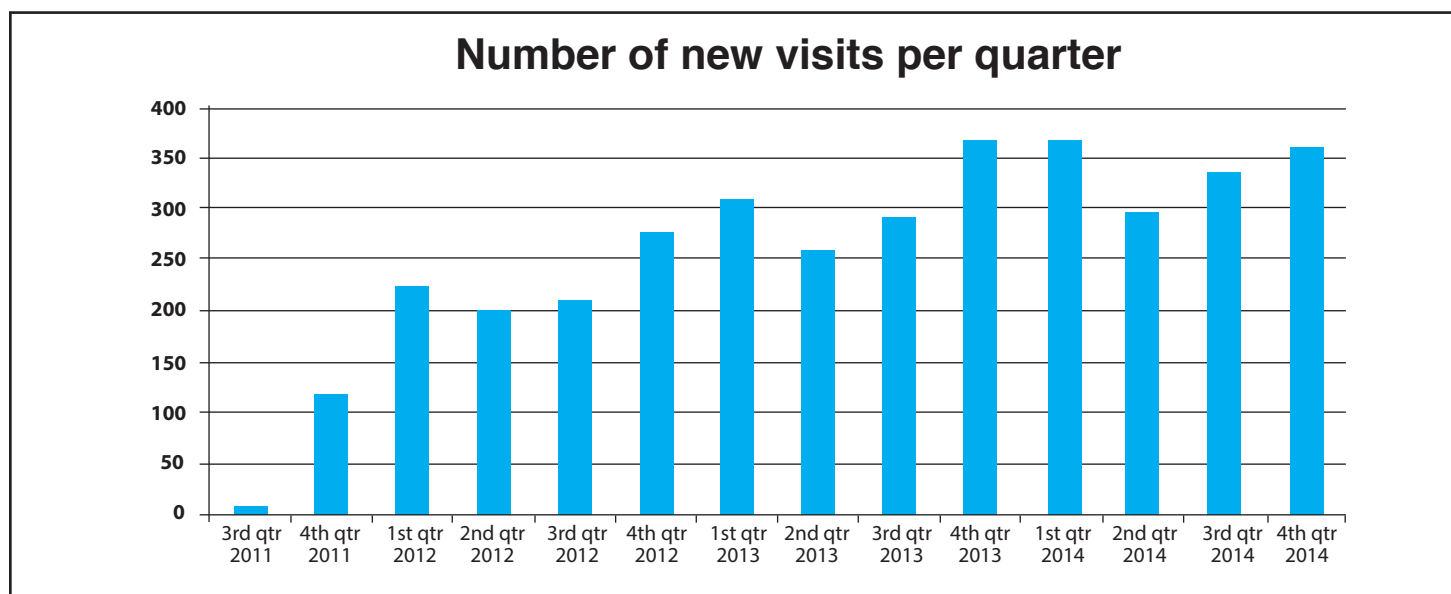


Table 20: Age and sex distribution of new visits in 2014

	FEMALE	MALE	TOTAL	TOTAL %	% FEMALE	% MALE
0-4 yrs	96	12	108	8%	7.1%	0.9%
5-12 yrs	242	31	273	20.1%	17.8%	2.3%
13-15 yrs	551	15	566	41.7%	40.6%	1.1%
16-19yrs	218	4	222	16.3%	16%	0.3%
20-44 yrs	165	19	184	13.6%	12.2%	1.4%
45+ yrs	4	0	4	0.3%	0.3%	0.0%
TOTAL	1276	81	1357	100.0%	94.0%	6.0%

From the 1357 new survivors seen in the clinic, 1276 or 94 percent were female and 81 or 6 percent male. Age and sex distributions

remained unchanged throughout the evolution of the project. Women remain the largest group seeking help mainly coming from

the age group of 13-15 years (41.7 percent), followed by the age group of 5-12 years (20.1 percent) and 16-19 years old (16.3 percent).

Table 22: Where survivors are referred by in 2014

Police	1267	93.5%
Childline	36	2.7%
Health structure	21	1.5%
relative/friend	16	1.2%
Other	7	0.5%
Awareness	6	0.4%
NGO	2	0.1%

The majority of the survivors continue arriving via the officers of the Victim Friendly Unit (VFU): 1267 survivors or 93.5 percent. 6 survivors came by their own initiative through awareness (0.4 percent), 16 were referred by a relative/friend (1.2 percent) and 7 by others (0.5 percent). Through Childline, 36 survivors were referred to Mbare clinic (2.7 percent), 21 by Health structure

(1.5 percent) and 2 by another NGO (0.1 percent). Despite a change in the regulation - up until 2012 it was compulsory for all survivors to report to the police prior to accessing medical care – we did not see a change in survivor's health seeking behaviour. Further analysis needs to be done to find the reason behind this. A study to assess the Mbare popula-

tion's knowledge, perception and assistance seeking behaviour related to SGBV will be carried out during the course of 2015 as follow up on the research conducted in 2010-2011; in close collaboration with the University of Zimbabwe-Centre for Applied Social Sciences. This study will help MSF to evaluate the impact of the project and to identify any remaining gaps.

Table 23: Type of aggressor reported in 2014

	OVERALL	≤ 19 YEARS OLD	> 19 YEARS OLD
Known civilian	87.3%	91.1%	68%
Unknown civilian	12.4%	8.6%	31%
Not known	0.3%	0.3%	1%

Table 4: Type of Known civilian reported in 2014

Know civilian	461	44%
Boyfriend	379	36%
Family member	197	19%
Pastor, Police, Teacher, Other	14	1%
Total	1051	100%

Contrary to conflict/ post conflict countries where aggressors are mainly coming from the military with high levels of violence (five percent in Masisi MSF project, DRC and 52 percent in Niangara MSF project, DRC); in Mbare clinic 87.3 percent of the aggressors were known to the survivors during the course of 2014 especially in the age group below 19 years

(91.9 percent). Children are vulnerable because they trust and often depend on adults they are close to. They are taught not to question. Perpetrators of child sexual abuse take advantage of these vulnerabilities in children. Females in the 13-19 year age group are most likely assaulted by their boyfriend although many survivors say that the perpetrator

is their boyfriend. The proportion of unknown perpetrators increased up to 31 percent for survivors older than 19 years old. This group is more mobile, working, taking kombi's, walking to and from the market-all places outside of the home where they are most likely to come into contact with strangers.

Description of type of event:

Table 24: Type of sexual assault/ year

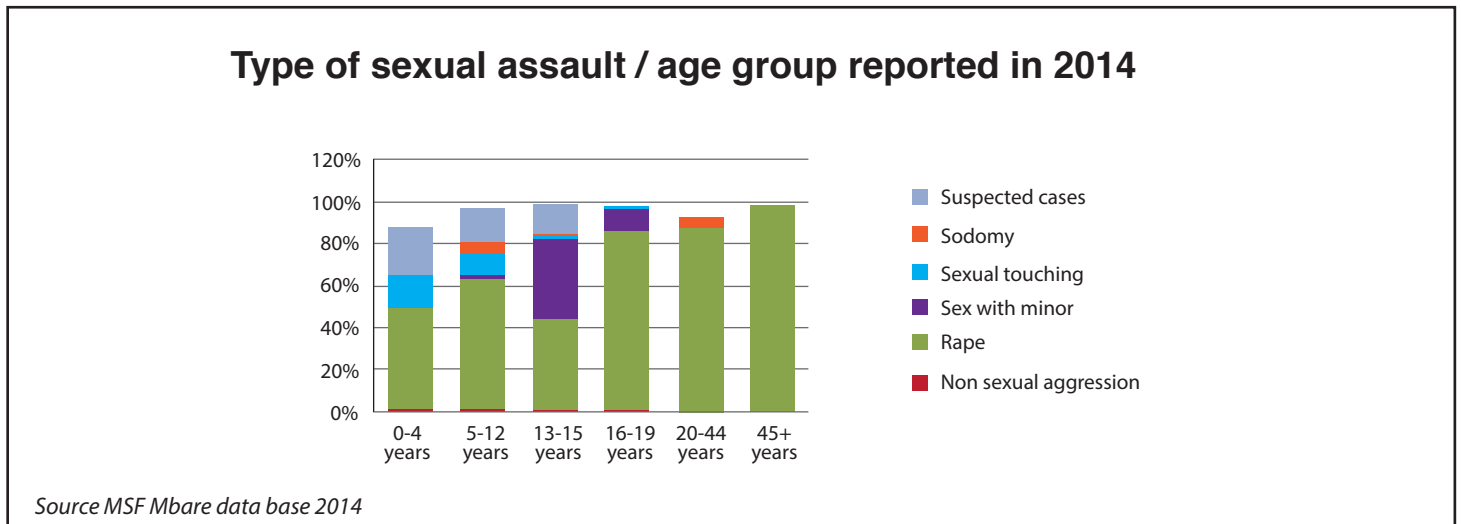
	2011		2012		2013		2014		TOTAL	
New visits	124		910		1226		1357		3617	
Type of event	No.	%	No.	%	No.	%	No.	%	No.	%
Rape	79	63.7 %	603	66.3 %	717	58.5 %	826	60.9 %	2225	61.5%
Aggravated indecent assault	2	1.6%	18	2.0%	30	2.4%	33	2.4%	83	2.3%
Compelled rape	1	0.8%	1	0.1%		0.0%		0.0%	2	0.1%
Non-sexual aggression		0.0%	9	1.0%		0.0%	11	0.8%	20	0.6%
Sex with a minor	23	18.5 %	134	14.7 %	238	19.4 %	236	17.4 %	631	17.4%
Sexual touching	4	3.2%	34	3.7%	37	3.0%	61	4.5%	136	3.8%
Sodomy	10	8.1%	31	3.4%	56	4.6%	32	2.4%	129	3.6%
Suspect case	5	4.0%	80	8.8%	148	12.1 %	158	11.6 %	391	10.8 %

Over time, the types of sexual assault presenting to the clinic remains largely the same. Rape remains the most commonly reported crime across all age groups (60.9 percent), followed by sex with

a minor or statutory rape (17.4 percent) and suspected cases (11.6 percent). There is however variations by age group. Sex with a minor is more common in the age group 13-15 years (37 percent)

and rape less common (44 percent) compared with other age groups e.g. for the 16-19 years age group. Rape accounts for 85 percent of all the reported cases.

Figure 22: type of assault by age group



Time of presentation:

Figure 23:

% within 72 hours and within 120 hours/ year

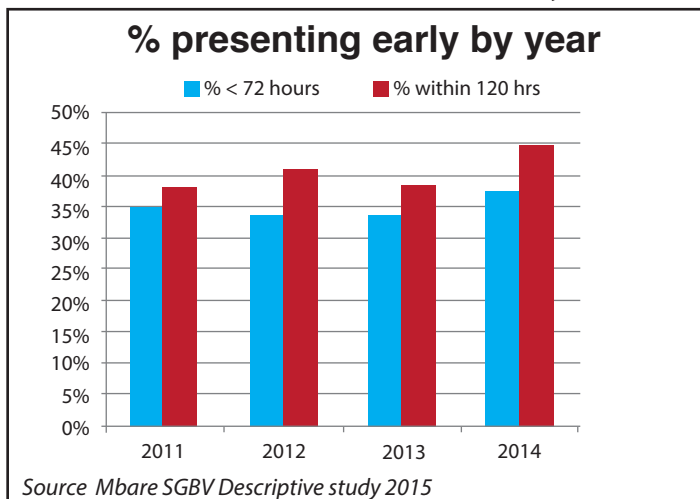


Figure 24

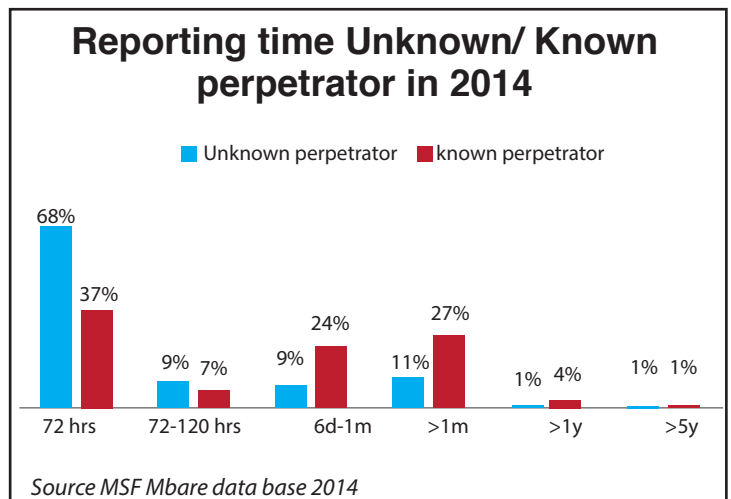
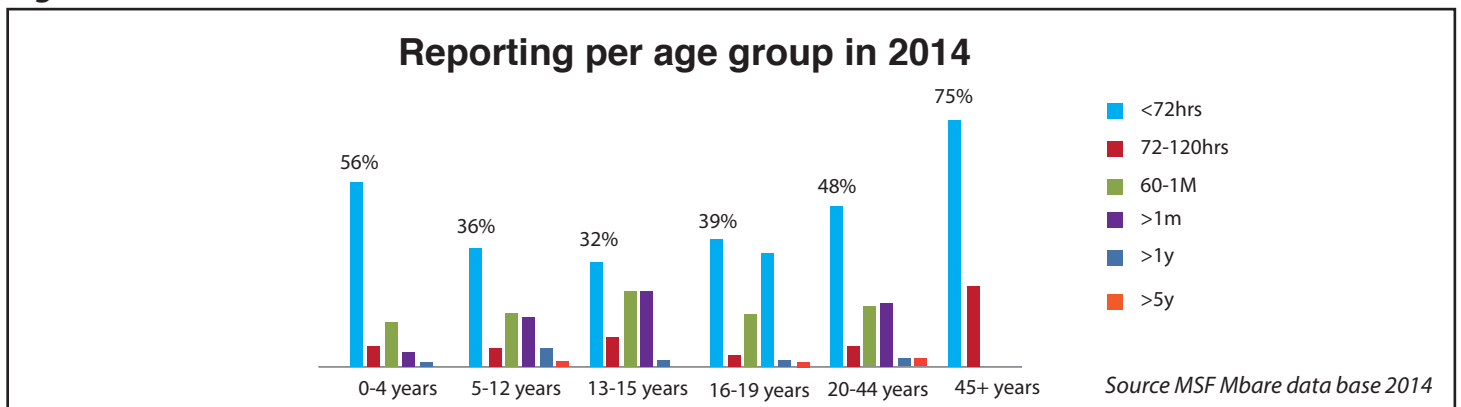


Figure 25



Despite increasing number of services and awareness, the number of survivors seeking treatment within the expected time remains more or less the same over the years.

2014 recorded a slight increase in the proportion reporting within 72

hours from 34 percent in 2013 up to 38 percent which could be achieved against a backdrop of constant health promotion activities within the project. MSF changed its health promotion message to “Medical Treatment after Rape is an Emergency” in the latter half of 2013 which could

potentially be linked with the slight improvement in 2014. However there is a clear link between the reporting time and if the perpetrator is known or not. In case the perpetrator is not known the number of survivors reporting within 72 hours increases up to 68 percent regardless of the age of the survivor.

Presentation within 72 hours improves with age, especially with the 19 year old age group and the 0-4 year age group. The slower reporting time in the 5-19 age groups could be because the survivor would in most cases, need to tell an adult before presenting for help or in case of sex with a minor the girl concerned does not see herself as being raped. In the case of infants, the care giver would likely take the decision directly and adults are also able to decide for themselves.

The reason for better reporting by adults might also be due to the fact that women above 19 years of age were more likely to be assaulted by an unknown civilian, so might conceive that the risk of HIV is higher and it might be clearer that a crime has been committed and immediate medical and legal help would be worthwhile. Adults may also perhaps be more likely to have access to health promotion messages.

MEDICAL CARE AND DECENTRALIZATION

Clients are offered a variety of services at the clinic which will be different depending on how much time has passed since the assault (within 72 hrs, from 72-120 hrs and above 120 hrs). Broadly the type of services offered can be broken down into four categories: medical, legal, psychological and social. The key components of the medical care provided are:

HIV testing.

All survivors who presented in the clinic were offered an HIV test. From the 1357 survivors who reported in the clinic, 13 turned down the HIV test or needed more

time before being tested (one percent). 1252 of the survivors tested negative (92.2 percent), 47 knew their HIV positive status already (3.5 percent) and 45 survivors tested positive (3.3 percent) and were referred to OI/ART services for further management. From the 45 survivors who tested positive, most of them were already HIV positive before the sexual assault. It is very difficult to ascertain how many victims became HIV positive following the assault. In order to have certainty, the HIV status of the perpetrator should be known as well as the reporting time between the sexual assault and the reporting time. To prevent HIV infection, PEP will be given if the survivor presented within 72 hours and a new HIV test will be done after three months.

PEP given if presented within 72 hours.

Of the 513 survivors who came within 72 hours, 386 or 75 percent of the survivors were initiated on post exposure prophylaxis (PEP), 118 did not need PEP (23 percent) and 11 were not started on PEP (two percent) because they refused the treatment. Most common reasons for not taking PEP were the following: the abuse that happened did not expose the survivor to the risk of contracting HIV, the survivor received PEP in another health infrastructure or (s)he knew HIV positive status already. Survivors also refused PEP for religious reasons.

During the course of 2014, two survivors tested HIV positive even after completing PEP.

Pregnancy test

Pregnancy test was done to all women of child bearing age who were at risk. In total, 984 pregnancy tests were done with 842 negative results (85.5%), 118 positive results (12%) were recorded. 24 results were unknown because the survivors refused to be tested (2.4%).

Emergency Contraception Pill (ECP)

Emergency contraception was offered to all the survivors who presented within 120 hours with a negative or unknown pregnancy test. From the 390 survivors in need of ECP, 311 accepted (80%) and 79 refused (20%).

The majority of survivors chose to keep the pregnancy even if it was as a result of rape.

21 survivors who were pregnant opted for a legal termination of pregnancy (TOP) and for 13 of them the TOP was granted by Court. Main reasons for not granting TOP were because the pregnancy passed the 20 week stage, it concerned consensual sex or there was a discrepancy between the date of gestation and date of sexual assault.

STI prophylaxis

All survivors in need of treatment or prophylaxis for STI's received this. In total 1176 received STI prophylaxis.

TT and Hepatitis vaccine

In total 207 survivors received Tetanus vaccine and 410 Hepatitis B vaccines.

Table 25: Follow up visits

YEAR OF FIRST VISIT	2011		2012		2013		2014		Total	
TIME TO PRESENTATION	No.	%	No.	%	No.	%	No.	%	No.	%
No follow up	40	32%	440	49%	642	52%	669	49%	1791	50%
At least 1 follow up	84	68%	466	51%	583	48%	687	51%	1820	50%
At least 2 follow ups	58	47%	311	34%	326	27%	354	26%	1049	29%
At least 3 follow ups	37	30%	189	21%	172	14%	164	12%	562	16%
At least 4 follow ups	14	11%	69	8%	73	6%	58	4%	214	6%

Source Mbare SGBV Descriptive study 2015

According to the national protocol, people should come back for three follow up visits. NGOs have added an extra visit into the schedule for some extra counselling. This would normally be the second visit. This has largely been accepted as an addition and is adopted by a number of providers, not just NGOs. However, follow-up remains a challenge in the Mbare project and there have been no major increases in the rate of follow up over the course of the project. During the course of 2014 only 51% of the survivors came for a follow up visit.

There are a number of explanations for the relatively low follow up rates. The first is that survivors come to the Mbare clinic from all over Harare, and some come from outside the city. For some, this may reduce the chance that they will travel for follow-up, especially if they have all of the medication required and HIV testing is available at the local clinic.

Phone follow-up may be a valid option for improving contact with survivors after the initial visit, and for many survivors this has been implemented. However, in many cases, the telephone numbers of survivors are not reachable,

perhaps due to telephones being cut off due to financial problems, or deliberate change of numbers or provision of false numbers to prevent follow up.

Referrals to tertiary hospitals are done when survivors require medical care due to physical injuries or when they request for TOP since the clinic doesn't cover those services. They are also needed for further psychological counseling by psychiatrist or for start-up of psychotropic medication.

Decentralization/ Capacity building

At the end of 2013, there were at least two nurses per polyclinic/Harare City trained in SGBV as well as nurses from the hospitals of St Joseph's Chishawasha (Mashonaland East), Makumbe Mission Hospital (Manicaland) and Mhondoro hospital (Mashonaland East) outside the province of Harare. Due to rotation and retrenchment of clinic staff; the City of Harare faced difficulties to send staff for training and attachment.

In total, 19 nurses were attached to Mbare clinic to build capacity from the following clinics: three from Overspill Epworth, one from

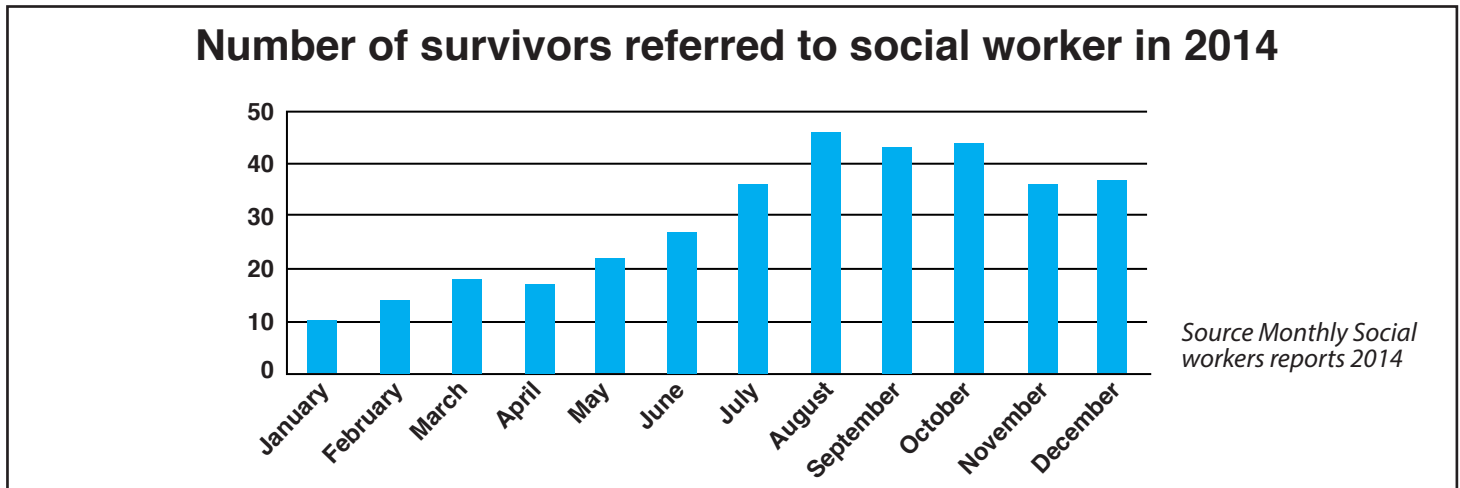
Rujeko, three from Kuwadzana extension polyclinic and satellite, one from Marlborough, one Mufakose polyclinic, one Highlands, one Hopely, one Mbare and seven from MSF OCA.

Plans are underway to decentralize SGBV services from Mbare to four poly clinics in Harare during the course of 2015; namely to Kuwadzana, Rujeko-, Mabvuku- and Glenview.

SOCIAL SUPPORT

In 2014, 350 survivors were identified by the nurse counselors in need of social support. The main task of the social workers is to provide community based social services to survivors of sexual violence in order to protect and improve the social well-being and functioning of families and individuals. This includes arrangement of placement of safety, case monitoring through follow ups, conducting family tracings, counseling, supporting survivors at court, escorts to other service providers of psycho social and legal support as well as reunification with family etc.

All survivors placed in protection will be escorted by the social workers when they need to be brought to other service providers as medical follow up, legal advice, psychologi

Figure 26: Number of survivors identified in need of social support referred to MSF Social Worker in 2014

cal support etc. Even when they go to court to witness, a social worker is present the whole time to give moral support.

Another main role of the social worker is supporting survivors in need of protection. The social workers will also link survivors needing further social, psychological or legal support within a network of service providers in the

government system and civil society. This will include:

- Adult women in need of a place of safety will be referred to Musasa while children are referred to Runyararo, Hupenyu Hutsa, Mathew Rusike to mention a few.
- Pregnancy support-counseling, ANC, birth preparation or for adoption cases.

- Minors with behavioral problems will be referred for counseling, a probation home or for talking and negotiations with the parents.
- Assistance for school fees for those out of school.
- Getting a birth certificate for those that do not have.

Table 26: External referrals to service providers for survivors in need of social support in 2014

SERVICE PROVIDERS	REASONS FOR REFERRAL	TOTAL
Department of social services (DSS)	minors in conflict with the law, safety shelter, birth certificate, adoption, ANC, rehabilitation, financial, educational support	125
Musasa	Safety shelter, pregnancy support, educational, financial support, income generative activities	79
ZWLA	Legal support	7
Justice for Children	Legal support	31
Leonard Cheshire	Logistical and disability support	9
Pregnancy crisis	Pregnancy support	15
Parirenyatwa hospital	Psychological support and Psychiatrist	6
Childline	Monitoring of Child Protection	1
Chitungwia hospital	Age estimation	2
VFU police	Protection order	1
School of psychological services	Psychological assessment for educational purposes	2
Total external referrals		278

All “Child survivors related” work is done in collaboration with the local Department of Social Services (DSS) as they are the legal custodians of children in need of protection. Escorts of child survivors will be reported to them and follow ups of all referrals by phone or in person will be done in conjunction with DSS to ensure that all activities being carried out are in the interest of the survivors.

The care provided by DSS and social workers is a key element of the response for survivors of sexual violence; however there is generally insufficient funding to cover need of protection or social support. Also the placing of pregnant minors in safety shelter is a challenge since there is no home to accept pregnant minors.

Given the high workload of the social worker and the increasing number of survivors in need of social support, a second social worker was recruited in the beginning of 2015.

LEGAL SUPPORT

The clinic works closely with the VFU of the Police, Department of Social Services, legal NGO’s and the Courts.

Medical affidavit and Expert witness in Court

Upon presentation to the clinic, in addition to the medical care provided, a medical affidavit documenting the details of the sexual aggression suffered and medical examination findings is filled in for all clients. In case the survivor wants to report the crime they can submit their medical affidavit to the police.

The medical affidavit is in absence of forensic evidence, the only piece of objective evidence admitted in the court. Each medical affidavit needs to be commissioned by a police officer (at the level of Inspector or above) prior to the collection within 48 hours otherwise the document has no legal standing. The nurses need to take the affidavit to the police personally which causes a signifi-

cant workload for them and they can be subpoenaed to give expert testimony in court.

During the course of 2014, 1353 or 99.7 percent of the medical affidavits were written and 1272 or 94 percent of the affidavits were collected by the police. 359 cases were reported in court and for 29 cases a nurse was summoned to give expert medical testimony during the trial process.

All survivors in need of legal aid were referred to NGOs in Harare for legal support –minors were referred to Justice for Children Trust (JCT) and adults to Zimbabwe Women’s Lawyers Association (ZWLA).

In December 2014, MSF facilitated a presentation on SGBV during the Magistrate Conference held in Bulawayo to emphasize on the importance of providing victim friendly approach in Courts especially seeing the challenges that child survivors face in speaking out and to testify particularly when the alleged perpetrator is a family member.

Table 27: Number of affidavits written from 2011-2014

	2011	2012	2013	2014	TOTAL
Number new patients	124	910	1226	1357	3617
Number affidavits written	123	904	1220	1353	3600
% affidavits written	99.2%	99.7%	99.6%	99.7%	99.5%
Number affidavits given to police	100	849	1118	1272	3339
% of affidavits written given to police	81.3%	93.9%	91.6%	94.0%	92.8%

Source Mbare SGBV Descriptive study 2015

Table 28: Number of cases reported in Court at any point from 2011-2014.

	2011	2012	2013	2014	TOTAL
Case reported in court at any	35	231	249	359	874
% Cases reported in court at any point	41.7%	49.5%	42.9%	52.5%	48.2%

HEALTH EDUCATION – AWARENESS

In order to improve uptake of services health promotion and education forms a substantial part of work in SGBV. A number of activities have taken place.

The message given by MSF has evolved from "Rape is a painful experience" and 'Rape is not your Fault' at the start of the project to 'Medical Treatment After Rape is an Emergency' from late 2013.

The HP activities include:

1. Wide reaching health promotion activities by MSF with focus on the message "medical treatment after rape is an emergency" and reporting all the service providers of SGBV: e.g. distribution of posters and calendars to other partners and stakeholders, bill boards on S. Mazoradze and Melborne road (8000 hits per day) and Mbare

Msika (2000 hits per day), pasting stickers in public vehicles, distribution of flyers during events, radio and television shows in collaboration with other partners etc

In total five radio shows and one television show were produced during the course of 2014.

RADIO SHOWS			
Power FM (Generation	MSF	Sexual violence	1
German radio station	MSF	Sexual violence	1
Power FM	MSF, JCT and Childline	Day against Child abuse	1
Zifm & Radio Zimbabwe	MSF, PSI	Effects and causes of SV	2
TELEVISION SHOW			
Amai Chisamba Show	MSF, PSI, FST and ARC	Sexual violence	1

Source monthly quarterly reports HP 2014

2. Target health promotion activities e.g. health promotion talks in clinics, drama activities in the community, roadshows and Health

promotion activities in collaboration with other stakeholders e.g. 16 days of activism against gender based violence, Agricultural shows,

World AIDS Day (WAD). An estimated 72 622 people were reached during the targeted health promotion activities in 2014, (excluding WAD).

Table 30: Target health promotion activities and events in collaboration with other stakeholders in 2014

HEALTH TALKS	NO. OF SESSIONS	NO. OF PEOPLE REACHED	TARGET GROUP
CLINICS			
Mbare polyclinic	147	38411	Patients
SCHOOLS			
Primary Schools	3	78	Teachers & School children
Secondary Schools	5	2429	Adolescents
High Schools	2	1224	Students & Teachers
COMMUNITY			
International drug abuse commemorations	1	250	Community members
Nyabira lilfordia grounds	1	50	Community members
Joint awareness raising Hopley, Mbudzi and Boka	3	1600	Community members, travellers, vendors and tobacco farmers
EVENTS IN COLLABORATION WITH OTHER STAKEHOLDERS			
Mbare District International Women's Day commemoration	1	914	women, men and children
Belvedere District International Women's Day commemoration	1	65	women, men and children
Dairiboard Rugby festival	6	6127	Adolescents
International Families day commemorations	1	1289	Community members
Zimbabwe Agricultural Show	11 days	5500	women, men and children
Day of the African Child commemorations	1	1200	Youths in school and out of school
16 days of Activism	16	10 000	women, men and children
WAD commemorations in Victoria falls	1		women, men and children
Apostolic Christian Council conference	2 days	2000	women, men and children
Hostel intervention with RC volunteers	6 months	11485	
Total		72622	

Source monthly quarterly reports HP 2014

3. Organizing of trainings on health promotion for CHW's, Childline, nursing staff working in the 12

polyclinics across the city of Harare. During the course of 2014,

418 people were trained in SGBV by the HP team.

Table 31: Trainings organized on SGBV by HP team during 2014.

Primary and Secondary Schools	School Teachers	168
Childline Flip Chart Training	Childline Helpline and community counselors	25
Childline Bulawayo and Sandra Jones Center	Childline Helpline and Counselors	47
CHW's	Mhondoro, Mbare, Sunningdale and Waterfalls	50
Community Volunteers Sexual violence Training	Redcross volunteers	20
Village Health workers	Makumbe, Chishawasha	73
Vision and Hope Foundation	Mbare and Hopley Community Volunteers	35
Total		418

Source monthly quarterly reports HP 2014

4. Distribution of IEC material to the police officers in the VFU and other NGOs working in SGBV

5. The 116 toll free number that MSF is involved with in partnership with Childline

Special events in 2014:

Mbare Hostel intervention in collaboration with 20 Red Cross volunteers

MSF worked in close collaboration with 20 Red Cross volunteers to do an intensified health promotion in the Mbare hostels with communication of one central message "medical treatment after rape is an emergency" using flipcharts and a face

to face approach for six months. All the cases reported to the volunteers were referred to other agencies for assistance and all medical cases were referred to nearest clinics. Major referral agents for the project included Mashambanzou, Musasa, Justice for Children, Zimbabwe Lawyers Association, Childline, Chiedza Child care Center, Leonard Cheshire, Pregnancy crisis center and Oxfam.

A total of 11 485 people were met during the six months hostel intervention.

A Body mapping workshop was organized for survivors to express and release painful feelings relat-

ed to the sexual abuse and how to overcome the abuse in groups through expressing their feelings by making paintings of different stages in their life which were collated later on in their drawn body shape. These paintings will be used with consent of the survivors in exhibitions to create a platform for sexual violence survivors to educate communities, raise levels of their self-esteem and help sexual violence organizations raise awareness and build support for their programs.

REHABILITATION

Due to shortage of space in the used facility, MSF constructed a new SGBV clinic in Edith Opperman Polyclinic. The construction of three additional rooms and the renovation of the two existing rooms (one of which was incorporated into the clinic) was completed mid-January 2014 and service has since moved. The old clinic rooms were cleaned and painted before hand over back to the clinic.

CONCLUSION

Our decentralized approach, community based, nurse-based care, opening 7 days a week, access for adults, children, male and female and the strong networking have all contributed to a very accessible and busy clinic. Although the decentralisation is proving difficult due to reshuffling of City Health nurses who have received training in SGBV management, due to lack of Human resources and space issue, MSF believes that decentralization of SGBV care to the level of a polyclinic will scale up the access for survivors of SGBV

throughout the whole province of Harare.

To evaluate the impact of the services that have been provided in Mbare clinic and to identify any remaining gaps, a study on Mbare population's knowledge, perception and assistance seeking behaviour related to SGBV will be carried out during the course of 2015 as well as a descriptive study on 'Provision of care for adolescent and adult survivors of sexual violence in Harare, Zimbabwe: Do we respond to the needs?'



Red Cross volunteers in partnership with MSF disseminated information on SGBV in Mbare hostels

MSF Principles and Values

Core MSF Humanitarian principles

- Humanity
- Impartiality
- Independence
- Neutrality

Guiding standards

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

Operation values

- Proximity
- Transparency
- Accountability
- Voluntarism
- Associative nature

CONTACT DETAILS

MSF - Operational Centre Brussels (OCB)

9 Bantry Road
Alexandra Park
Harare
Zimbabwe

Tel: + 263 772 150 679/80 or + 263 4 745823

Email: msfocb-harare@brussels.msf.org

Website: www.msf.org



Artworks crafted by survivors of sexual violence.

MSF Belgium provides medical care and psycho-social support to survivors of sexual violence at the Mbare Polyclinic and has now decentralised care to Kuwadzana and Glenview clinics. Medical treatment after rape is an emergency, seek treatment early.