MSF BELGIUM

Zimbabwe Mission

Activity Report 2012

MEDECINS SANS FRONTIERES

Médecins Sans Frontières Charter

Doctors Without Borders/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.

The project text in this report provide descriptive overviews of MSF Belgium's operational activities in Zimbabwe between January and December 2012.

Project summaries are representational and, owing to space considerations, may not be comprehensive. Some patients' names have been changed for reasons of confidentiality.

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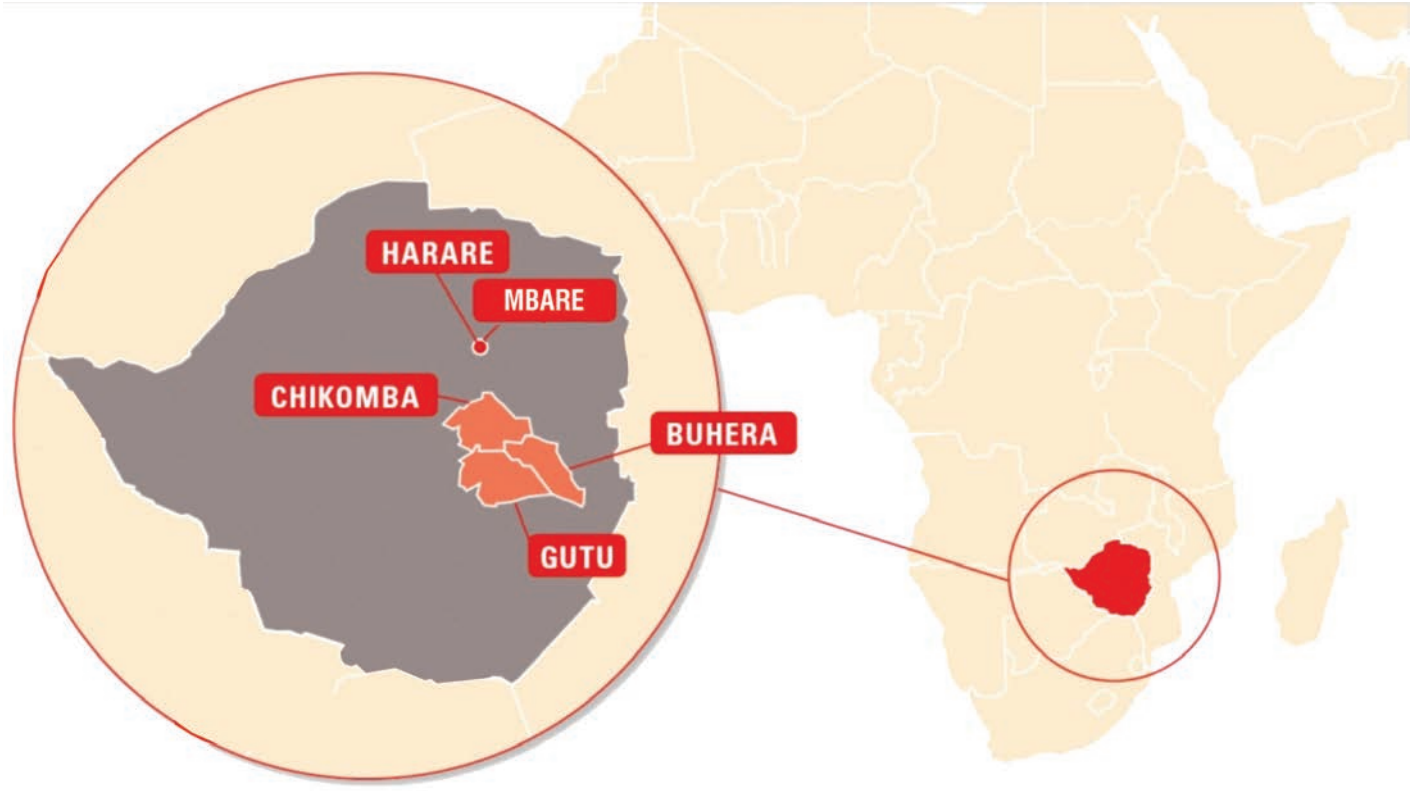
MSF BELGIUM PROJECT LOCATIONS IN ZIMBABWE



Districts where MSF Belgium has projects

OCB (Harare, Manicaland, Masvingo and Mashonaland East Provinces)
Mbare [project for survivors of SGBV]
Buhera District [Murambinda hospital and 23 rural clinics]
Gutu and Chikomba Districts [ART initiation and follow up through mentoring approach to MoHCW]

A health promoter during a treatment adherence session with a support group of people living with HIV

OVERVIEW OF MSF ACTIVITIES IN ZIMBABWE

A nurse conducting a consultation with a couple in Buhera

Médecins Sans Frontiers/ Doctors without Borders (MSF) has been working in Zimbabwe since the year 2000, and runs projects in partnership with the Ministry of Health and Child Welfare (MoHCW), that include treatment and care of people with HIV, tuberculosis (TB) and drug-resistant TB (DR-TB), Sexual and Gender based Violence (SGBV) interventions and emergency preparedness. Projects are currently located in Beitbridge, Buhera, Chikomba, Epworth, Gokwe North, Gutu, Mbare, and Tsholotsho.

FIGHTING HIV/AIDS

Our major focus in Zimbabwe is on the fight against the HIV/Aids epidemic and related opportunistic infections which continue to overwhelm the healthcare system in Zimbabwe. Our programmes provide comprehensive HIV/AIDS care, offering counselling, testing, treatment and the prevention of mother-to-child transmission of the virus (PMTCT).

MSF programmes, which are implemented within the Zimbabwean health structures, are ensuring medical care to more than 57,000 people living with HIV. More than 54,000 of these people living with HIV are receiving life-saving antiretroviral therapy (ART) since the beginning of the programme.

TRAINING MEDICAL STAFF

MSF is also implementing task-shifting and clinical mentoring in our programmes, training nurses in routine HIV care, including the administration of ARV drugs, so that more staff are able to treat more patients in more locations.

IMPROVING TUBERCULOSIS CARE

The integration of the management of TB and HIV co-infection is a vital component of the HIV projects. There is growing concern over the spread of DR-TB mainly because it often remains undiagnosed and untreated and thus continues to spread. MSF is providing support and technical assistance to health authorities in the implementation of a national DR-TB strategy.

CLINICAL MANAGEMENT OF SURVIVORS OF SEXUAL ABUSE

All of MSF's HIV programmes offer care for survivors of sexual abuse. Through community outreach and health promotion, our teams are working to increase the number of people who seek assistance after they have been abused. They offer medical treatment and psychological services, establish support group for survivors of sexual and gender-based abuse, and campaign for education about the issue.

BUHERA

Number of patients ever initiated on ART end 2012

Since 2004 until the end of 2012 MSF has so far initiated 20,588 patients on anti-retroviral therapy (ART); 15,031 (73%) of those patients are still actively enrolled in our programme. Based on the estimated total population of Buhera District of 240.000, and on national HIV prevalence of 13.5 % (3.2 % for children) and 55% of eligible patients with CD4< 350, we reached 115 % overall coverage. This high coverage might be due to an underestimated total population, an underestimation of the HIV prevalence and/or due to the fact that some of our patients come from neighbouring districts. So far we have ever initiated 1,743 children (< 15 yrs) on ART; our active cohort is 1,398 children on ART (9.3% of active cohort).

Total ART initiations done in 2012 was 1,563 patients and of these were 157 children below 15 yrs of age. This was achieved through close collaboration with Ministry of Health and Child Welfare staff.

12 Months Outcomes for 2012 Initiations				
All six sites	Children		Adults	
	N	RIC%	N	RIC%
BBH	44	87	284	83
Munyanyi	18	94	204	87
Buhera	22	95	160	78
Nerutanga	16	94	140	92
Garamwera	11	100	87	93
MMH	46	91	440	83
Total	157	0	1315	85

In 2012 a total of 1,222 tuberculosis (TB) patients were tested for HIV, this comprises 83%. 71% of those were found to be HIV positive.

PMTCT

From January to December 2012, a total of 7,555 mothers were seen in Buhera ante-natal clinics by MoH staff. 7,172 (95%) of these were tested, with 366 (5%) turning out as positive cases.

Adult patients are on TDF

In 2011, after permission of MoHCW, MSF introduced as the standard treatment TDF/3TC/EFV (simpler to the patient with only 1 pill per day). In 2012 we introduced Viral Load (as opposed to CD4) to monitor patient progress. This will reduce the number of visits to the clinics by patients and also provide a better treatment monitoring tools.

A total of 9,651 adult patients (77% from the active cohort) are switched from D4T to TDF by end 2012. Testing viral load (VL) and creatinine clearance prior to switching patients from D4T to TDF is being implemented. To ease the workload, MSF increased the human resources at clinic sites through provision of incentives for 12 additional nurses contracted by MoHCW.

Children phased out from D4T first line

Close to 80% of the children have been phased out from D4T regimen. The reason for not reaching 100% yet are that some children are not eligible for TDF because of weight (have not reached 35 kg yet), some children have contraindications for AZT and some other children still have to complete their counseling, before the switch can be realized.

Human Resources support

A total of 21 clinics have primary counselors (PCs) in place. MSF supported the training of 18 PCs in clinics offering opportunistic infections (OI)/ART services and paid their allowances. The PC training was completed in August 2012, and 1 week training about HIV counseling and testing was held in September 2012. This valued support contributed immensely towards the achievement of our goals.

Drug Supply

There were problems noted with Natpharm supply to the clinics and they have been solved by MSF buffer stock. The Natpharm supply only represented 0.4% in 1st quarter (MSF 99.6%) but increased to 62.1% in 2nd quarter (MSF 37.9%). In the 3rd quarter, supply from NatPharm further improved to 85%. In the 4th quarter, Natpharm supply decreased to 21.3% (MSF supplied 78.7%). We noted a problem in the calculation of the NatPharm orders by clinic nurses in the 4th quarter. Additional training on the job was given.

Joint support and supervision visits

Each clinic was visited jointly with the district health team at least 3 times for the whole year and most clinics performed well with average supervision scores of 70%. MSF facilitated the visits.

In June 2012 the national immunization days and launch of new childhood vaccines interrupted the visits.

Integrating OI/ART/TB/OPD services at Murambinda Mission Hospital

Opportunistic Infections/ART and Out Patient Department (OI/OPD) is now 100% integrated at Murambinda Mission Hospital (MMH). TB services are still not integrated. TB patients are still consulted separately in the TB clinic. Main cause for this is some resistance by the TB department who are still not in support of this activity.

Viral Load (V.L)

A total of 13.334 VL samples were collected in Murambinda in 2012 and processed in a private laboratory in South Africa. Results on the first 11,233 samples showed that 14% of VL 1 is > 1000 (of those 7% are > 5000). Results of the first 161 VL2 results show that on average 60% of patients can be re-suppressed; whilst 40% will need switch to 2nd line.

In practice, during the first year of introducing VL, we did not switch a lot of patients to 2nd line. We had only 229 patients in total on 2nd line by end 2012; which is only a fraction of those we estimate need it based on extrapolation.

Extrapolating the results (14 % detectable VL1, 40 % re-suppression); although still from limited data; we anticipate that our 2nd line cohort will increase most likely to 5%. Our experience shows that this 5% will not be reached straight after introduction of routine VL (due to the many bottlenecks observed) but most likely will be reached in 3-4 years time.

Enhanced Adherence Counseling

As a reaction to high viral load results, the enhanced adherence counseling (EAC) of these respective patients started in July 2012. At the end of 2012 we conducted an analysis on VL monitoring and the effect of EAC session on 236 patients from 14 clinics who had both VL done (before and after EAC). The following were our observations:

- 66% of the patients with an initial VL between 1000 – 5000 achieved a drop of their VL to <1000 (n = 123)
- 25% of the patients with an initial VL between 5000 – 10000 had a VL drop to <1000 after EAC (n = 36)
- Only 15% of the patients with an initial VL >10000 had a VL drop to <1000 (n = 77)
- 62% of all patients (n = 236) could be switched to appropriate 1st line since they were deemed not failing with a VL <5000 after EAC.
- 38% had to be switched to 2nd line, when

A health worker prepares to treat a drug resistant tuberculosis patient in Buhera

A health worker prepares medication for a drug resistant tuberculosis patient

despite of EAC the 2nd VL was still >5000 and treatment failure was assumed.

From our analysis: a higher percentage of children and adolescents had a high initial VL compared to adults. The lower the initial VL, the higher the chances of it dropping to undetectable levels after EAC. EAC was efficient as evidenced by 62% of initially high VLs, which could be suppressed after the counseling sessions. Even though we do not know what the effect of the VL result by itself is on patient's adherence.

The counseling itself was done in 3 EAC sessions, which take time since specific issues need to be addressed. Generally patients appreciated the sessions as they noted the importance of having a low VL and staying on first line ART. Challenges have been the delays between date of the 1st VL result and 1st EAC session, the inconsistent support and/or unavailability of guardians for EAC sessions of children and adolescents and the timing of the review visits for patients from out of district or school attending children/adolescents.

Difficulties were experienced monitoring the change in behaviors concerning alcohol abuse and unsafe sex.

Kaposi Sarcoma

In Buhera MSF offer treatment for Kaposi Sarcoma at Murambinda Mission Hospital. In 2012 MSF treated 90 Kaposi Sarcoma patients.

TB/ MDR TB

GeneXpert technology continues to function well in Buhera as all clinics have access to it, since the sputum samples are transported by the MSF cars.

Since December 2010 to December 2012, there have been 23 DR TB patients enrolled in the program. 1 patient completed treatment in Aug 2012, 3 patients died, and 18 are still on treatment (8 are on intensive phase, 10 on continuation phase), 1 patient was initially put on treatment but later on refused to continue with the treatment. 11 of the patients are coming from the North of Buhera and 7 from the South. 5 of the northern patients are managed by the local clinics (Nerutanga (2 patients), Garamwera, Munyanyi, Bere) with MSF support.

The other 6 from the North are managed by the MSF DR team based in MMH. The Birchenough Bridge Hospital (BBH) staff takes care of 1 patient from the South, while the other 6 patients from the South are managed by MSF.

Generally 12 patients are living far from the clinic and are visited on a daily basis in their homes by the MSF DR TB nurse with a flying counselor at least once per month and per rising need. 1 MSF doctor is consulting those patients at least once per month.

We have two DR TB teams to manage the distances in

an appropriate time. The furthest distance one team has to cover in one day is 265km. Challenges emerge during the rainy season when flooded and muddy paths and sometimes rivers crossing roads interfere with the access to the patients' homes.

Maximum delay of treatment initiation has now been reduced to 2 weeks.

GeneXpert assures early DRTB diagnosis and the communication between clinic, lab and DR-TB team assures that cases are identified as soon as they are diagnosed. Patients are assessed by the team within 2 weeks from diagnosis and put on treatment either through home-based or clinic-based care, depending on their condition and other circumstances, like distance from the clinic.

Emergency preparedness

No outbreaks were reported during this period. MSF commits to help whenever need arises. During 2012, MSF supported MoHCW in mobile outreach EPI activities which really helped in increasing the coverage.

Conclusion

The support to MoHCW by MSF, through incentives to 12 nurses end mentoring of clinic staff on the job, made it possible to decentralise and build capacity at the clinics to manage OI/ART patients themselves. This improved health care delivery in the clinics.

Through introduction of innovative strategies and technology, MSF changed it's model of care. Mobile teams brought services closer to the community and patients homes, increasing access to healthcare. Novel diagnostic tools for HIV monitoring and (drug resistant-)TB diagnosis were installed, making nurse based patient management easier and results reach patients faster.

New treatment regimens with fewer side effects and the introduction of fixed-dose combinations (FDC) has considerably reduced the pill burden and improved quality of life of patients on ART.

Some 2012 statistics from Buhera:

- Mentoring MoHCW staff in 26 clinics as to gradually hand over daily care of HIV patients to MoHCW;.now that > 100% ART coverage has been reached.
- By Dec 2012: 20.588 patients ever initiated on ARV , with 15.031 remaining in care. A total of 1563 new patients were initiated in 2012.
-About 75% of patients are treated at rural clinics.
-Introduced routine VL monitoring in Buhera district (> 13.000 VL test conducted in 2012)
-GeneXpert TB diagnosis continues to be first line test for any TB suspect (average of 320 test performed/ month).
-Started 15 patients on MDR TB treatment in 2012.
Since Dec 2010 - Dec 2012, 23 DR -TB patients have been enrolled in the program. 1 DR-TB patient completed treatment in Aug 2012.
-A total of 13.334 VL samples were collected in Murambinda.
-In 2012, MSF continued to provide TDF for our adult patients in the cohort. 9651 adult patients from the active cohort are on TDF as of December 2012.

A doctor examine a TB patient at Murambinda Mission Hospital

Laboratory 2012 Report

Laboratory Activities

In general, the laboratory workload for Birchnough Bridge Hospital (BBH) and Murambinda Mission Hospital (MMH) labs have declined for the year 2012 compared to the previous year, 2011. In particular, the total tests done were 76 310 tests in 2012 down from 88 767 tests in 2011, indicating an averaged 14% decrease in the number of tests done in both laboratories. Specifically, MMH showed the greater decline of 18% year on year, compared to BBH of 4.7% .

The shift in the Viral load monitoring from CD4 immunological monitoring of treatment had the major impact on the reduction of tests done. The use of the GeneXpert as first-line test for diagnosing TB also had an impact on the workload as only DR-TB detected sputum samples are smeared for microscopy and also samples of follow-up for TB treatment.

Preparation of VL-DBS samples from venous blood was decentralised to clinics and is improving in quality. There is still need for close follow up. The laboratory, through the District laboratory scientist carries regular supervision to the clinics to monitor activities such as collection of samples, Quality Control and proper use of point of care devices.

Human Resources

The human resources situation has remained largely unaltered for both labs. BBH has a staff complement of 5; 2 lab techs and 3 microscopist. Of these, 1 MSF microscopist and 1 MoHCW lab tech with MSF incentive. MMH has now 6 staff members down from 7; 3 lab techs and 3 microscopists. Of these, 1 lab tech and 2 microscopists are MSF, 1 microscopist Global fund and the rest MoHCW.

Currently in MMH the HR is not sufficient to operate in a stable manner as the lab manager/district lab tech is at times out on duty and there is no replacement to cover vacations. Furthermore, for the Global Fund staff supported their salaries are erratic,

MSF supported the Ministry of Health and Child Welfare during the National Immunization days

hence it is difficult at times to plan involving them.

Quality Control

MMH and BBH labs are enrolled in the EQA schemes with ZINQAP of Zimbabwe and NHLS of South Africa. The labs achieved 89% concordance with the expected results, an improvement from 87% of 2011. The improvement could be said to emanate from better quality management systems for MMH lab in particular due to implementation of the SLMTA program.

It fell short of the 95% target due to a number of possible reasons; over-reliance on students on industrial attachment without adequate supervision at times due to human resources shortages, the frequent breakdown in analyzers especially for chemistry and also infrequent request for the test by the clinicians which may result in the lab being less proficient e.g. lactate and serum glucose.

Orders and Inventory

In 2012 MSF remained the major supplier for laboratory items. Only very limited supplies came from MoHCW. We hope to integrate with MoHCW supply in 2013, once the new laboratory supply chain system is in place.

Logistics and Maintenance

The last quarter of 2012 proved challenging due to the frequent breakdowns in analyzers especially the chemistry machines for both labs. It also reinforced the need to have a backup analyzer for emergency situations. The acquisition of the Sadza laboratory new chemistry analyzer might solve this problem as the humalyzer 3000 that had been lent to them by MSF will now be used as backup.

Two of the GeneXpert machine modules from MMH due for calibration were replaced and a total of 6 more remained need to be replaced. All analyzers and air-condition were maintained according to schedules and the contracts.

On another note, the main challenge to the full integration of the lab is the transportation of samples especially the creatinine samples from the clinic which need to be at the lab the same day.

Achievements

All lab services were done without major hiccups.
The lab managed to achieve 2 stars in the SLMTA-WHO scheme, being one of the first District laboratories to attain that status in Zimbabwe.

Challenges

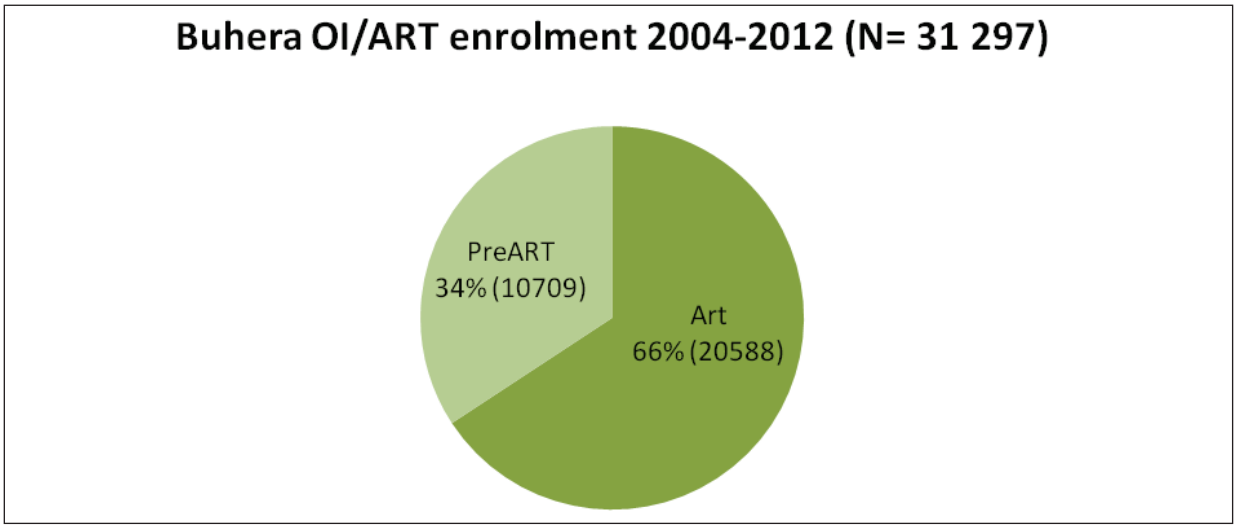
Human Resources is the main challenge for MMH lab. Also, equipment breakdown can be overwhelming, caused significant service interruptions.

With the rollout of fixed-dose combination ARV's patients will be able to take one pill daily

Folder Review Report 2012

The total number of patients enrolled in HIV care since 2004 is 31 297 and of these 20 588(66%) have bee enrolled on ART. See fig 1 below.

Fig 1



The outcomes of all the patients enrolled on ART are shown in table 1 below. The ones highlighted in red are considered active. A total of 15 031 patients on ART are still being followed in Buhera district which translates to overall retention in care for all ART patients since 2004 to 73%. However if transfer out are not included on the denominator the overall retention in care is (15031/(20588-1772))*100 which translates to 80%. The total initiations for the year 2012 were 947 female and 616 with an average of 130 initiations per month for both adults and children.

Table 1 Outcomes for Art patients

Health Facility Name : Buhera District Art												
	Active		Lost to follow up		Transfer out		Defaulters		Deaths		2012 initiations	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-18 mnths	25	39	7	4	3	2	0	2	4	2	18	21
19-4yrs	157	134	21	16	13	15	3	3	6	4	28	19
5-14yrs	511	512	60	61	41	55	6	6	16	15	37	44
15-24YRS	297	510	67	141	39	68	5	12	25	23	37	90
>25yrs	4252	8320	875	1520	486	1070	102	135	397	501	496	773
Total	5242	9515	1030	1742	582	1210	116	158	448	545	616	947

Outcomes for preART patients are presented in table 2 below. These patients have never been enrolled on ART. The lost to follow up are very high but most of them are cumulative from all years and got lost to follow up during the 2007-2009 crisis.

Table 2 Outcomes for pre Art patients

Health Facility Name : Buhera District Pre - Art										
	Active		Lost to follow up		Transfer out		Defaulters		Deaths	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-18 mnths	8	7	7	12	0	2	0	2	3	0
19-4yrs	17	18	17	20	1	2	0	1	0	1
5-14yrs	149	176	262	242	30	21	6	1	27	17
15-24YRS	45	296	119	268	17	32	4	7	18	12
>25yrs	564	1654	2111	3418	141	307	23	57	247	320
Total	783	2151	2516	3960	189	364	33	68	295	350

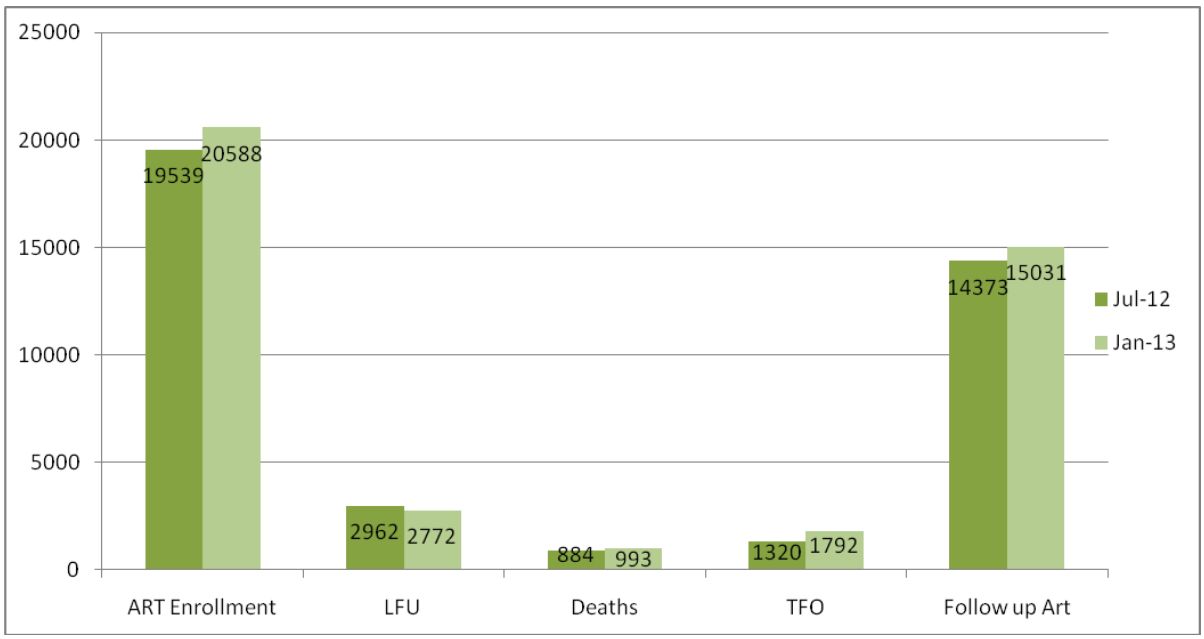
During verification exercise we also take note of the different ART regiments of the patients.

Table 3 Art Regimens for patients.

Children	AZT	879
	D4T	318
	Other	154
	2nd line	46
Adults	TDF	9651
	D4T	2872
	AZT	914
	Other	35
	2nd line	162

Comparison was also done between the July 2012 and January 2013 folder review. Total initiations as expected are ever rising as well as deaths and transfer out (see fig 2 below). The total lost to follow up went down because nurses managed to update files and trace some patients. Also the folder review team had more experience and was paying attention to detail.

Fig 2: ART Outcomes Comparison (July 2012 and Jan 2013)



Recommendations

This exercise is very good in terms of finding active cohort, however for determining retention in care over a time period, there is need to change the format but it means more time and more human resources.

Maybe for cases where a clinic has very poor overall retention in care it could be important to do further folder review including retention in care over specific time period for particular cohorts.

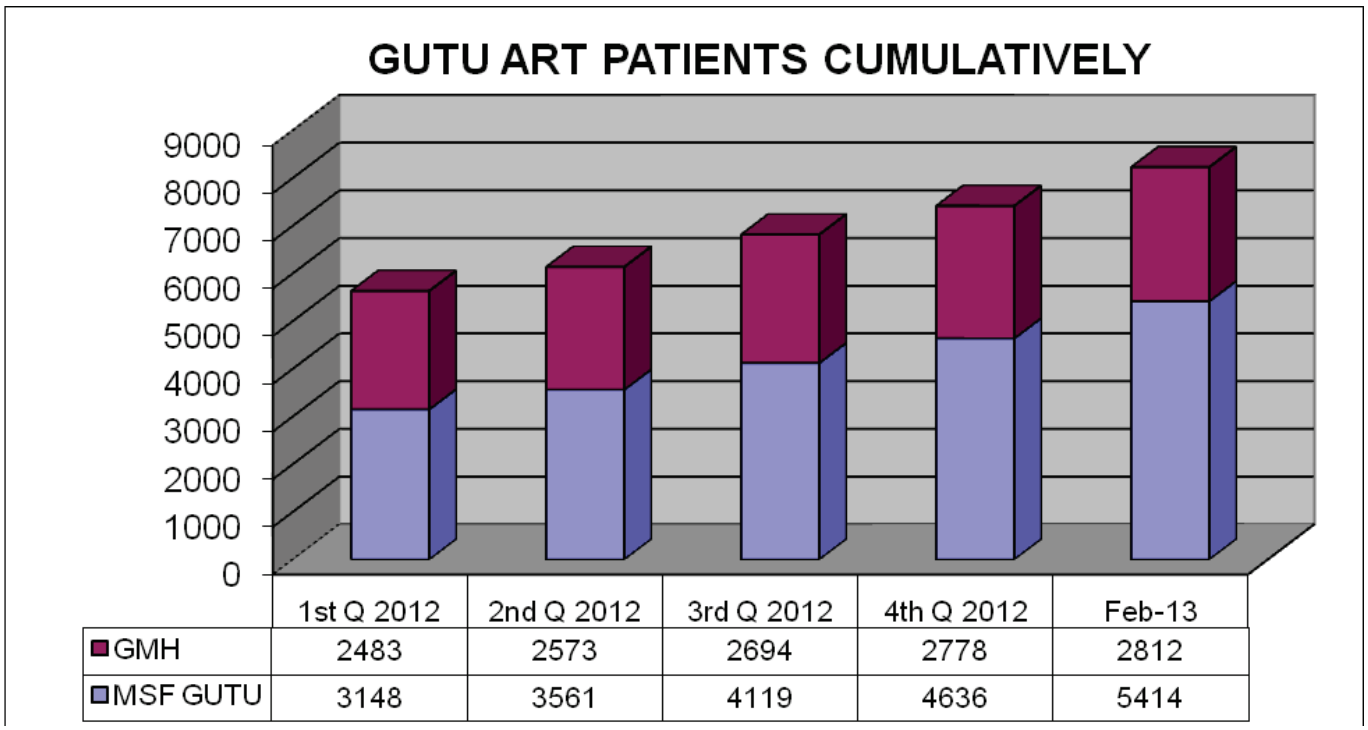
Conclusion

Most clinics are now updating files; except for a few which are still having problems. There is need to strengthen these clinics in terms of updating patient information.

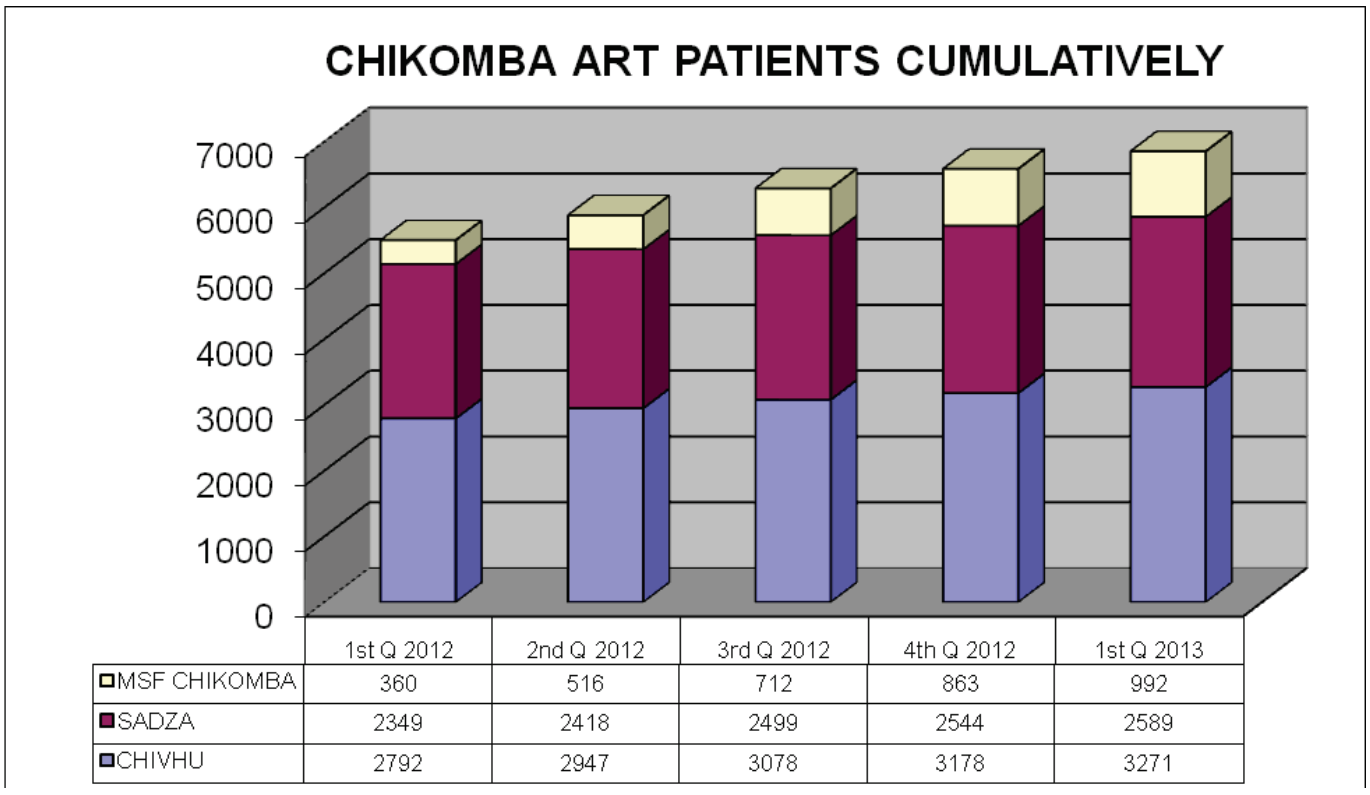
GUTU - CHIKOMBA

In Gutu District, HIV patients ever initiated and transfer in were totaling 7.415 by December 2012. We estimate this corresponds with an overall coverage of 69% and 54% for children. The child cohort is 10.7% of the total cohort. Patients on treatment before MSF arrival in February 2011 were 1.931

In Chikomba District, patients ever initiated and transfer in was totaling 6.585. We estimate to have reached universal coverage for adults and 59% coverage for children. The child cohort is 9% of the total cohort. Patients on treatment before MSF arrival in September 2011 was 3.796.



	1st Q 2012	2nd Q 2012	3rd Q 2012	4th Q 2012	Feb-13
GMH	2483	2573	2694	2778	2812
MSF GUTU	3148	3561	4119	4636	5414



	1st Q 2012	2nd Q 2012	3rd Q 2012	4th Q 2012	1st Q 2013
MSF CHIKOMBA	360	516	712	863	992
SADZA	2349	2418	2499	2544	2589
CHIVHU	2792	2947	3078	3178	3271

In Gutu District, which has a total of 32 clinics, 17clinics are able to initiate ART on their own, while an additional 6 clinics can follow up themselves totalling to 23 clinics (72%). In addition, 4 clinics are providing ARV drugs to patients but via mobile teams coming to serve the patients.

In Chikomba District, which also has 32 clinics, 13 clinics are able to initiate ART. The low number of clinics initiating in Chikomba is mainly due to the very slow pace of accreditation. However, clinics not accredited are providing HIV services through the mobile team from Chivh & Sadza Hospital. Though the percentage of clinics initiating is relatively small, the district coverage for access to ART at decentralised sites is achieved far above target through mobile teams and the joint OI/ART services by different teams.

Gutu:
Loss to follow – up :1.8% in adults and 0.3% in children
Death rate: 3.2% in adults and 1.7% in children
Overall retention in care is 90.6% (6718/7414*100).

Chikomba:
Loss to follow – up: is 2/214*100=0.9%.
Death rate Chikomba is 9/214*100=4.2%.
Overall retention in care & treatment is 5705/6585*100=86,6%.

Mobile teams

In Gutu, a MoHCW mobile mentoring team was not in place by end 2012. Gutu Mission Hospital has a team, but visits to clinics has been irregular. At clinic level the nurses have been very involved and motivated. Many of them are able to continue HIV care of first line patients without MSF presence.

A decision on joint supervision in Gutu finally came to fruition in November. 15 health facilities were jointly supervised in various areas of health deliveries.

In Chikomba the district health team was already engaged a lot before MSF's arrival. The presence of 2 MoHCW mobile teams will make hand over easier in the future. As well our efforts to engage those teams in mentoring clinic staff and handing over patients to clinics will have a big impact on retention and continuation of care in the future. Before MSF arrival those MoHCW mobile teams were completely working in isolation from clinic staff.

In Chikomba supervision visits are done by the District Health Team. Quarterly supervision is ongoing in Chikomba. It will be more structured in 2013, targeting the stand alone sites and using the same supervision tool used in Murambinda. In Gutu, this has just started.

Accreditation needs to be pushed in 2013.

PMTCT

Gutu:

- MER: 481 (MSF)+ 381 (GMH) = 862 - MoHCW and MSF
- PW on ART: 84 (MSF) + 37 (GMG) = 121 - MoHCW and MSF
- Total: 983

Chikomba :

- MER : 321 (MSF) + 130 (MOH) = 451 - MoHCW and MSF
- ART : 239 (MSF) + 30 (MOH) = 269 - MoHCW and MSF
- Total : 720

TB

A GeneXpert machine was introduced in May 2012 at Gutu Mission Hospital. This increased the positivity rate of sputum samples. As well laboratory proven TB cases increased from 100 in 2010 to 306 in 2012 (200% increase).

In addition, we noted that the number of samples sent to the laboratory has really increased since arrival of MSF with the introduction of the sample transport system by EHT (May 2011). There was an increase of number of samples taken with 99% comparing to 2010.

The MSF team managed to put the 2 MDR TB patients detected with GeneXpert on treatment.

Sputum Results

2010: 100 Smear (+) / 1482 samples received (6.7%)

2011: 109 Smear (+) / 2176 samples received (5.0%)

2012: 306 Smear (+) / 2945 samples received (10.4%)

Primary Counselors

Ideally each health centre providing ART should have a Primary Counselor (PC). Unfortunately MSF did not manage to find the funds to cover all the training needs. For 2012 MSF managed to assist in training 6 additional PC's (3 for Gutu and 3 for Chikomba).

M&E

In both districts quality data is available. MSF uses line listing (with SPSS completed by the MSF data encoder in Gutu). There is good collaboration with

MoHCW as we share ART and PMTCT monthly reports.

E-registers have been successfully introduced in the 4 selected sites. Especially for the 2 sites in Chikomba there is a very good MoHCW commitment for completing the data on regular bases.

Drug supplies

There were stock ruptures in supply from Natpharm to clinics but MSF managed to fill the main gaps.

Labaratory

All CD4, creatinine, sputum, HB & pregnancy tests are available free of charge. In Gutu motorized EHT's & MSF mobile team are responsible for sample transport which is functioning well. The same has been reported in Chikomba.

All the district laboratories are enrolled on ZINQAP.

Yearly viral load monitoring was introduced in Gutu in April 2012. In Chikomba viral load was available for switching patients from the D4T to TDF.

There were serious problems with the Biochemistry machine in GMH towards end of 2012.

Logistics

In Gutu, waste zones in all health centers have been completed while in Chikomba only 2 out of 8 were completed. Seven out of the planned 7 gazebos were constructed in Gutu and 5 out of 6 waiting areas were completed. The 6th at GRH, can only be done based on government's public works department design and we have been awaiting the design since August 2012.

In Chikomba, a total of 5 waiting areas were completed. Additionally, in Chikomba, 8 damaged radios at health centers were repaired and are functioning well.

All Gutu and Chikomba sites were provided with furniture.

A total of 5 sites in Gutu were provided with minimum water requirements while in Chikomba 3 sites were catered for. For the 4th site , Sadza, MSF has engaged the district authorities to find a lasting solution to the water problem: the existing dam will provide water to the hospital and its environs independent of the existing public water system (borehole). For the 5th site, in Chivhu, all the materials needed were provided by MSF to the Public Works Department who are going to do the construction.

Conclusion

Considering the current trend of HIV/AIDS, the "light approach" might just be the best way MSF can support MoHCW in addressing HIV/AIDS in Zimbabwe.

It is possible, not only for achieving high ART coverage of HIV care, but sustaining it using light approach. However, it is largely dependent on availability of needed human resources, drug supply and supply of laboratory reagents and commodities by the MoHCW.

By far the most important in this approach is the ability of the mentored Ministry of Health and Child Welfare (MoHCW) staff to perform any HIV/TB related task independent from MSF. Access to HIV/AIDS & TB services reached 19 facilities in Gutu and 8 in Chikomba by end of 2012. In Gutu, 8 of the 19 health facilities being supported by MSF have been weaned off – conducting full package of HIV/AIDS & TB activities with very minimum support from MSF. In Chikomba 90% of all the initiation are done by MoHCW Nurses.

In May 2012 MSF introduced the GeneXpert machine in Gutu Mission Hopital. In 2013 MSF intends to introduce GeneXpert in Chikomba district boosting MoHCW's effort to decentralize this technique up to district level. Also to boost the finding that at present price of a cartridge (10 USD) GeneXpert is cost effective compared to an algorithm referring all smear negatives to doctor and X-ray which costs USD20.

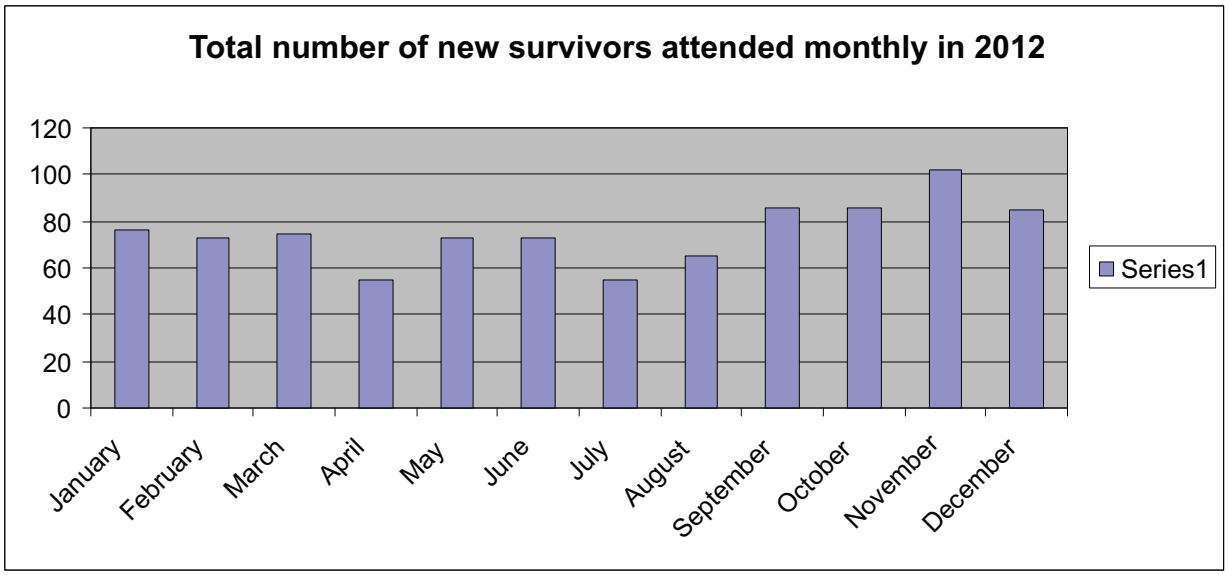
To date with the aid of the GeneXpert, 2 DR-TB cases have been detected in Gutu. Using individualized approach to DR-TB care - community driven, patient centered, MoHCW clinic staff taking full responsibility of medical care, family members regularly provide food that is supplemented by the MOHCW. MSF's sole role is providing the technical knowledge, initial MDR-TB drugs to the health staff to manage DR-TB case. This has proven successful in managing the first case and will continue for future cases.

MBARE

From January to December 2012 the SGBV clinic at Edith Opperman attended to a total of 1831 survivors; among them 904 new survivors which corresponds with an average of 75 new survivors per month or 18 new survivors per week. This is an increase compared to 2011 when we noted an average of 31 new cases per month.

Especially since August 2012 onwards we are noticing an increased trend of survivors attending the clinic; possibly due to better awareness. This positive trend continued in the first quarter of 2013 which saw an average of 106 new survivors per month.

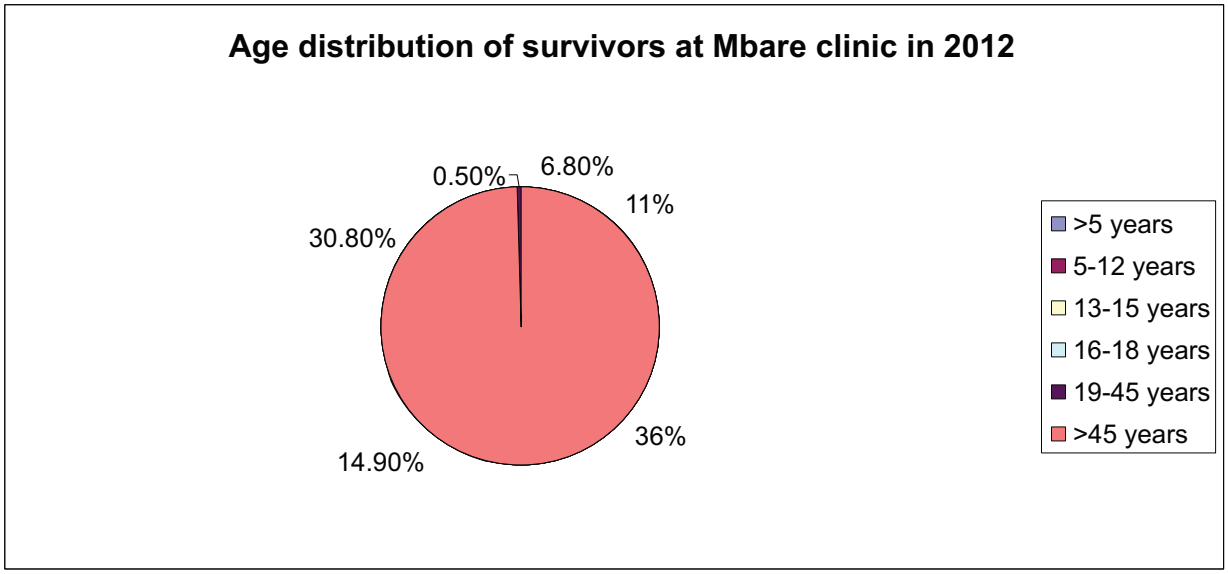
Figure 1:



Sex rate: 94% of the new survivors are female (851) compared to 5.8% males (53)..

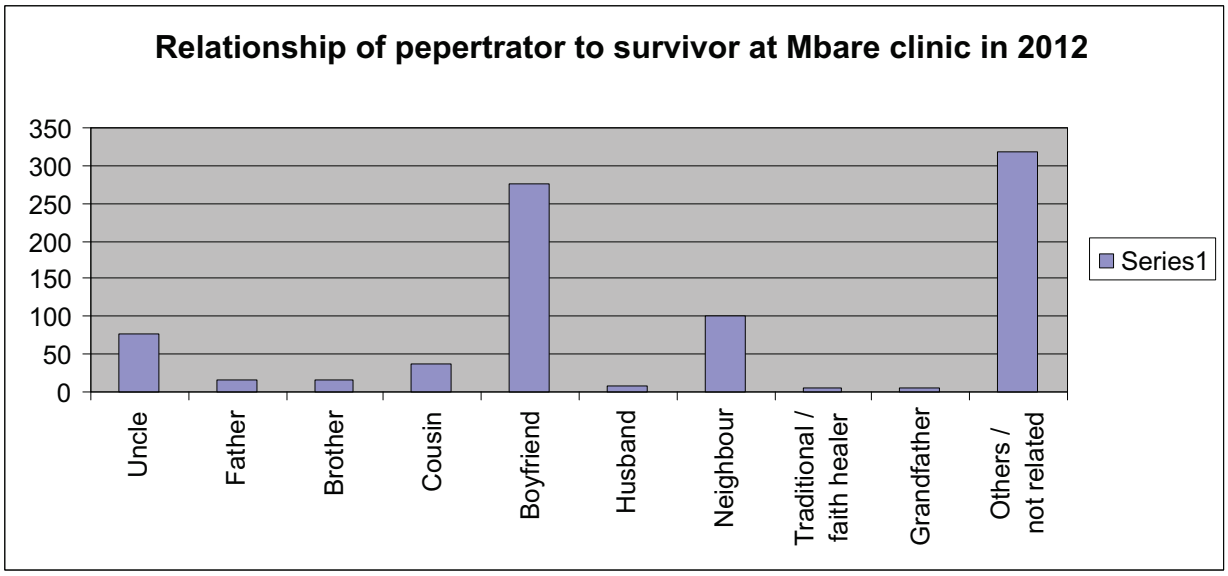
Age ratio: The majority of the survivors were in the age group from 13 to 15 years (326 new survivors, 36%), then the age group of 19 to 45 years (279 survivors, 30.8%), followed by the age group of 16 to 18 years 14.9% (135). The reason behind is not clearly known; although we suspect that stigma for adults combined with the fact that people are aware of legal implications of not reporting child rape; are reasons why we see more child survivors in the clinic.

Figure 2:



Relationship to perpetrator: Of the 865 cases with detailed information 319 (37%) were not related and 546 (63%) were related. Among the related the majority we noted: 277 boyfriends (32%), 102 neighbours (11.7%) and 78 were uncles (9%).

Figure 3:



Place of abuse: 33% of sexual abuse cases happened at the survivors´ homes, 30% at the perpetrators´ homes, 14% occurred in bushy areas (i.e maize fields).

Type of violence: 5% of survivors were raped by more than 1 perpetrator. Beating, bites, burns occurred in 4% of cases. Mutilation was reported in 1 case. Detention was reported in 3,4% of cases, 4% of cases referred to the use of threatening weapons.

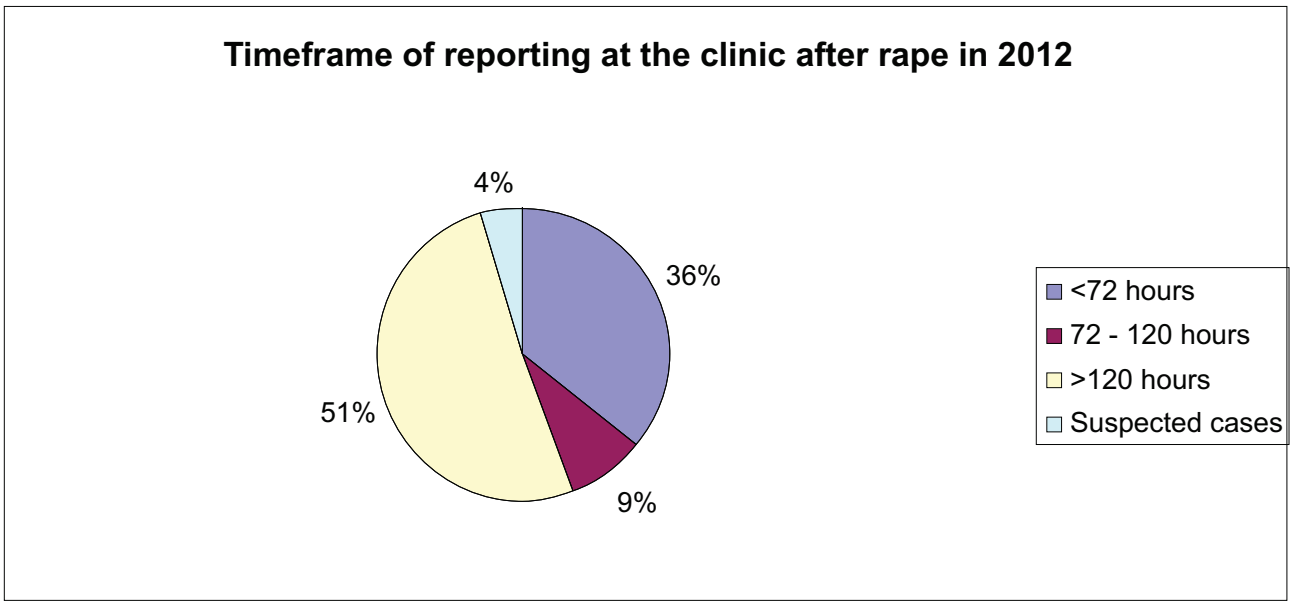
In the year 2012 we noted a total of 927 follow up visits; 145 FU visits at W1 (16% of new cases), 352 at W2 (39%), 202 at W6 (22%) and 158 at W12 (17%) at W12. Seventy (70) patients came for FU visits unscheduled.

We note that our expectations for number of follow up visits might be higher than the needs expressed by patients. We will continue to review the follow up schedule carefully. In addition the nurse counsellors will continue to provide the maximum quality care on the first visit knowing that survivors tend not to come back for their reviews because of different issues and circumstances. It is also difficult for us to trace patients not coming for FU visits because of following reasons: for several survivors their phone numbers were no longer in use when we contacted them, some relocated, some could not come back for review, some were staying with perpetrators by the time of follow up and others had different reasons.

Survivors that received medical care according to protocol

In 2012 we noted that 36% of the survivors presented within 72 hours; very similar than what we noted in 2011 (35%) and what is noted by other care providers such as ARC. Late presenters´ main reasons for delay were negotiations with the family and fear. We would like to see this figure of people presenting within 72 hours increase further, as this is key for maximal preventive impact.

Figure 4:



In 2012, all presenting survivors received medical care and counselling sessions according to the protocol. Medically this involved the initiating of 247 rape survivors on PEP; the others were either known HIV (+) or presented late. Survivors who were found HIV+ at the clinic were referred for further treatment to BRIDH (Beatrice Road Infectious Disease Hospital). On 3 month follow up there was 100% success as there was no sero conversion. Further prophylaxis and treatment was given to all those survivors who were eligible: emergency contraception was given to 244 female survivors, 666 survivors received STI prophylaxis and 155 STI treatment. Tetanus vaccinations were necessary for 126 survivors and Hepatitis B vaccinations for 236 survivors. 30 survivors had to be referred for further treatment at other health facilities.

Psychosocial and Legal Support

Psychosocially, every survivor received counselling by a nurse and further counselling and support by the social worker, when need arose.

The Social Worker prepares the survivors for their court hearings through pre and post trial counselling and escorting them to the court as per need. Thus a total of **42** clients were assisted. These included the survivors who were in shelter and those who requested for support in monitoring the progress of their case trials. In addition a list of 194 survivors was compiled and submitted to the VFU Coordinator so that he would assist to check on their court outcomes. To date the outcomes are still pending. Also 14 survivors were referred for legal support, 8 to **Justice for Children trust**, 3 to the **Victim Friendly** coordinator and 3 to the Police.

As per Zimbabwe guideline ALL survivors get affidavits. Nurses and Social Worker have attended to all cases we have been called for. The legal duties of the nurse-counsellors are the filling of the medical affidavits and to witness in court, if they are summoned. In 2012, we were summoned to testify to 21 court cases.

Drug and Equipment supplies

The medical and technical equipment is in place and a sufficient stock of drugs and diagnostic materials is guaranteed (inclusive PEP, STI management and family planning tools, and cold chain medication/vaccination). We are working towards integrating our supplies within the City of Harare supply chain as we have started working on decentralisation.

Survivors residing outside Harare

A number of patients living outside Mbare have been assisted with transportation fee by MSF. Only survivors that can not afford transport and come with public transport from outside Mbare were re-reimbursed their cost of transportation.

Referrals from the clinic to other care providers - 2012

Survivors with further health issues (HIV positive, pregnant or injured) were referred to the respective health facilities. For those cases we provided transport allowances or we escorted them when necessary. If a survivor could not afford the drugs prescribed by the hospital or specialist, we absorbed the costs.

Table 1:

OI clinic	**27**	**Department Social Services**	**19**
Further medical management	**3**	**Justice for children**	**8**
Police	**3**	**Childline**	**3**
VFU Coordinator	**3**	**Msasa**	**10**
Padare	**1**	**Scan**	**11**
Antenatal clinic	**65**	**TOP**	**11**
Parirenyatwa for maternity services	**2**		

- ***The Department of Social Services:***

- 13 young survivors were referred for assistance with shelter
- 2 pregnant survivors were referred for assistance in giving away their children for the adoption process.
- 1 survivor was referred to formalize the custodianship of her daughter who had been informally fostered by a certain couple.
- 1 Survivors was referred for assistance with school fee.
- 1 survivor was referred to social services department for assistance with a birth certificate.
- 1 survivor was referred to the probation officer to write a report to the courts applying for a court order as well as consenting, authorizing termination of pregnancy and assistance through the reintegration process.

- ***Childline:***

- 1 minor survivor was referred for further counseling after changing her stories in court and protecting the perpetrator.
- 1 survivor was referred to Childline to report her case of abuse by her stepmother.
- 1 survivor was referred for follow up of her case which had been reported to the police.

- ***Justice for Children Trust:***

- 8 survivors were referred for free legal assessment and assistance. This role in line with the principles of human rights and social justice that is fundamental in assisting the clients.

- ***Parirenyatwa Hospital:***

-2 Survivors were referred for free maternity delivery.

- ***Padare*** (a male organization working against SGBV issues):

-1 Male Survivor was referred for further counseling.

- ***Musasa Project:***

  -2 survivors were referred for assessment and assistance with financial or material support.

  -3 adult survivors were referred to Musasa for shelter

  -5 survivors were referred to Musasa for livelihoods training.

- ***Police VFU:***

  3 survivor's parents were referred to the senior police officer to report their cases, which were not progressing at police level.

Multi-disciplinary and Multi-sectoral approach

1) Stakeholder meetings

We have bi-monthly meetings with ARC, FST, MSF Holland & MOH&CW

2) Network established

The main partners of our network are: Childline Zimbabwe, Streets ahead, Hupenyu hutsva children's Home Department of Social Services (shelter for children), City of Harare Health, Ministry of Health, Ministry of Woman affairs, Victim friendly Court and Victim Friendly Unit of the Police, Family Support Trust, Adult Rape Clinic, Musasa (shelter for adults) and Justice for Children Trust. We are also linked up with schools, churches and with local and community based organizations, such as ZNPP+, and to ensure the recognition and general acceptance of this project, an agreeably well-working relationship with the local authorities and political leadership has been established and maintained so far.

3) Steering committee meetings held on 3 monthly bases (ARC):

In 2012 only 2 steering committee meetings were held at ARC, one in March and in June 2012.

Towards the end of 2012 quarterly partnership forum meetings were held; including all partners involved in medical care linked to SGBV. The regular partners for this meeting are ARC, FST, MOH, MSF-OCA, Childline and MSF-B.

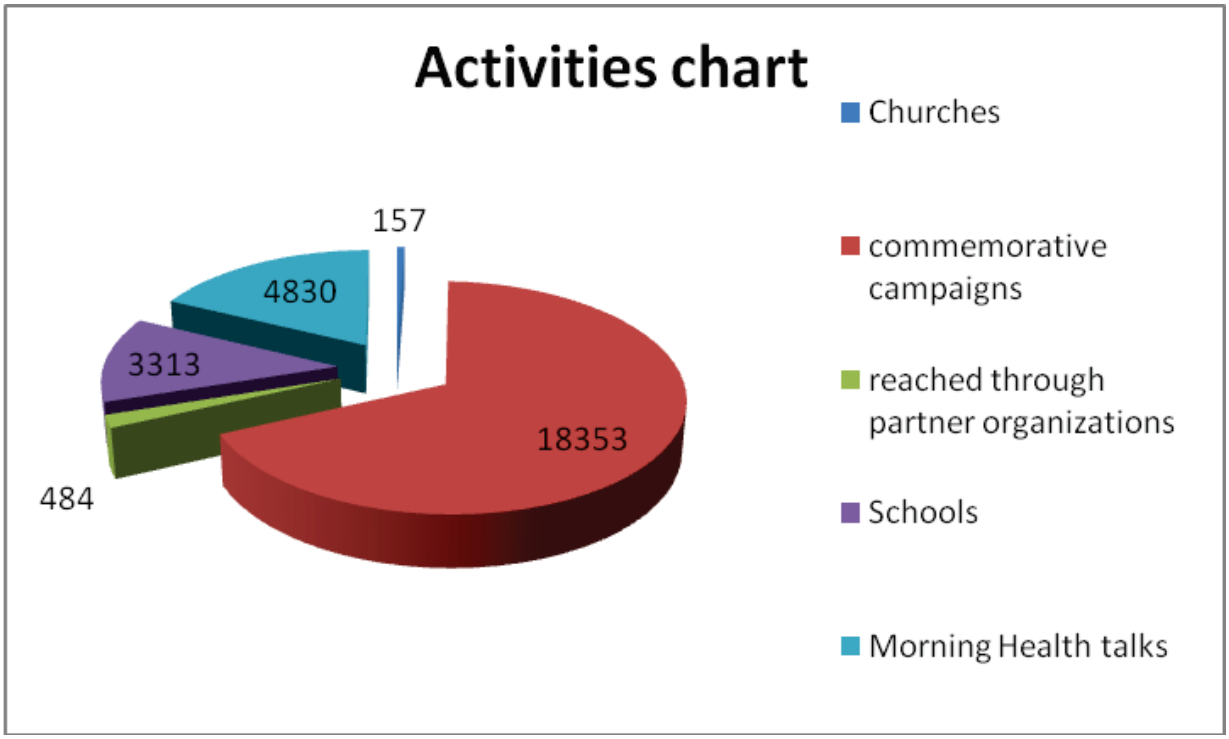
Community HP activities

Community awareness

Health promotion activities continued to work on improving access to health services to SGBV survivors.

The development of a comprehensive, long-term approach to health communication that responds appropriately to audience needs was emphasized and put into effect by morning health talks, sensitization and awareness raising activities in churches, schools, commemorative campaigns and other NGOs that are performed continuously.

Figure 5:



A total of 27 137 people were reached during the period under report. At clinic level we continue to observe that majority of people came after being referred by the police (96%). This is on one hand a positive sign of the close collaboration with the VFUs of the ZRP. On the other hand it reflects that we most likely attend to only the tip of the iceberg as we assume many people do not want to report to police seen high percentage of family cases.

Further options of awareness raising and outreach measures have been discussed, to make sure that survivors know, that they can come to receive care and support independently from a police report.

Table 2:

Source of Referrals to the clinic in 2012	Number
Victim Friendly Unit	872
Self	11
Health Promotion	10
Other Partners	9
Health Structure	2
Total	**904**

A total of 9 patients (1%) referred by police was delayed; as the police told them to come to the clinic during week days. At the beginning of the year police were not aware that the clinic at Mbare is open during the weekends and public holidays so this caused the delay. We no longer observe such cases.

Toll free line

A 6 month agreement was signed in September with Childline to increase accessibility of services and encourage the reporting of cases on SGBV. Prior to the establishment of the service 25 Childline volunteer helpline counselors were trained on SGBV. So far we have not yet observed its added value due to lack of public awareness of this new service. Sensitization campaigns using Billboard and stickers on public transport were launched first quarter of 2013..

We are afraid that challenges linked to fear and stigma still have NOT been overcome . We conclude this since we only see a few survivors coming straight to the clinic (4%) compared to those coming through referral by police (96%) and as child survivors far out way adult survivors which we do not believe is the true picture (DHS Zimbabwe 2006 reports 23.7% of women in Harare ever to have experienced sexual violence) .

Whilst it is not a problem that people report first to the police; we are still convinced that this is a bottleneck for many. Still, there exists stigma and people are not aware that medical care is offered at clinic independent of a police report.

Traditionally and legally, cases of SGBV had to be first reported to the Police as the first port of call, but due to

Health promotion through drama in Mbare

As part of comprehensive medical support MSF also provides psychological support to survivors of sexual abuse

the continued changes in the Protocol in the Management of Sexual Abuse and violence in Zimbabwe, medical care is now given absolute priority. With continued awareness of the new protocol to the public, it is expected communities will be aware of the benefits of prompt medical care available after sexual violence without Police notification.

Trainings

The assessment of hospitals and clinics in the nearby province of Harare (Mashonaland West and East) was completed, and we finally managed to conduct two (2) SGBV trainings in April and November 2012. We trained:

-Staff from all 12 polyclinics in greater Harare (37 clinicians and 2 Social workers).

-Staff from 3 hospitals/ Rural Health Centers in Mashonaland West and East (9 clinicians).

In addition we send 12 nurses from the city of Harare for 1 week Rapid HIV testing in December 2012.

After the trainings in April and November we wrote City of Harare to invite the nurses for 1 week attachment to complete the training and gain confidence on filling the Affidavit. Only in March 2013 City of Harare gave a positive response and nurses are now being attached to the SGBV clinic as part of the decentralisation plan.

Donations and rehabilitation work done to out of Harare facilities

-At Mhondoro Rural Hospital (Mashonaland West), we renovated 1 room to serve for SGBV care and donated 1 Examination Lamp, 1 Examination Bed, 1 Foot stool, 1 Drug Trolley, 1 Office desk and 2 office Chairs .

At St Joseph Chishawasha Clinic (Mashonaland East), we conducted minor rehabilitation of the room identified for SGBV services and donated 1 Examination Lamp, 1 Examination Bed, 1 Foot stool, 1 Drug Trolley, 1 Office desk and 2 office Chairs.

-At Makumbe Mission Hospital (Mashonaland East), there was no need for renovations as this hospital had the required space to accommodate SGBV services. We only donated 1 Examination Lamp, 1 Examination Bed, 1 Foot stool, 1 Drug Trolley, 1 Office desk and 2 office Chairs

MSF support to other actors

ARC was assisted financially from September – December 2012 and FST were assisted in funding to cover part of the doctors hours.

Response to emergencies

Besides the support given to SGBV activities, MSF also assisted City of Harare-Health Department to respond to the typhoid in Harare from October 2011 to May 2012. We assisted again when a new increase in patients was recorded at the end of 2012..

In June 2012, on request of City of Harare, we assisted with staff for the NIDS (national immunisation days). Health Promotion activities were also carried out during this campaign in Mbare (Southlea Park, Hopley),

Kuwadzana (Kuwadzana extension, Granary) and Dzivarasekwa, (Tynwald South and North).

Conclusion

In the year 2012 we completed the first full calendar running the SGBV clinic in Mbare. We are looking back now at fifteen (15) months of quality health and social care provision for SGBV survivors, successful teamwork, network and collaboration. We managed to maintain and improve the availability, accessibility, awareness and acceptance of our SGBV service at Mbare polyclinic and cared for 904 new survivors during the 12 months of 2012. Survivors reporting to clinic in more than 72 hours after the incident is quite high (64%) and we are greatly concerned about this.

We are now on the way to focus on the decentralisation to health facilities in Harare and 3 in Mashonaland Province. We have planned to start with focussing attachment training for nurses in four polyclinics then move to other clinics as we see how they are coping. We are looking forward to see a decrease in number of survivors seen at Mbare polyclinic with starting decentralization; as survivors will be attended at their nearest clinics.

However we are very concerned by the fact that completing Affidavit is very time consuming; and as such polyclinics might prefer to continue referring their clients to vertical SGBV clinics citing lack of time. Especially as 2012 was also the year that saw OI/ ART care and Follow up being finally decentralized from hospitals to polyclinics in Harare city. Although this is a very necessary and positive step; this as well has increased workload at polyclinic level.

Way forward

Further issues that have to be addressed in the following months are:

1) working on how to expedite decentralisation of the complete package of SGBV care (including social support and completion of Affidavit) with City of Harare Department and other surrounding hospitals,

2) work closely with other partners in creating awareness on seeking health care as early as possible within 72 hrs (3 days)

3) work closely with other partners on reducing fear and stigma for adult SGBV survivors so that more adults report timely for SGBV care..

A health care worker checking on drugs

PRISONS

With the aim of reducing morbidity and mortality of water born diseases, MSF is involved in water and sanitation interventions in various prisons across Zimbabwe.

In 2012, several prisons in Masvingo and Manicaland Regions received support from the MSF watsan team.

Bikita and Zaka Satelite Prisons had some toilets being constructed by MSF as well as installation of water tanks, showers and construction of some septic tanks. Water tanks were installed at Mutimurefu Maximum Prison as well as construction of a complete waste zone with beehive incinerator.

In Manicaland, Nyazura and Mutare Farm Prisons as well as Mutare Remand Prison received water and sanitation support which included a connection of submersible pump to mainline of prison and replacing a cylinder and foot valve on the installed Pressure hand pump and repairs to showers and toilets.

In 2013, more support will also be channeled to Chivi , Shurugwi ,Connemara and Whawha Prisons. The aim of this intervention is to provide safe drinking water to help reduce waterborne diseases and improve the overall environmental and personal hygiene of the inmates.

MSF is involved in water and sanitation interventions in various prisons across Zimbabwe

EMERGENCY RESPONSE

MSF has been working in collaboration with the Harare City Health Department in the provision of safe drinking water through setting up mini water treatment sites in affected areas

As part of its emergency response Médecins Sans Frontières (MSF) interventions, MSF responds to emergency medical needs when called upon. Working in support of the Ministry of Health and Child Welfare (MoHCW), MSF in Zimbabwe has responded to typhoid, cholera, measles and malaria outbreaks across the country.

Since November 2012, MSF has been supporting people in Harare and surrounding suburbs in a typhoid outbreak. This is the second engagement in this outbreak that started in October 2011 and has affected around 7,000 people so far.

MSF supported the emergency response during the first spike of the outbreak from October 2011 until April 2012, when the number of patients significantly decreased.

Since late November, when patient numbers went up again, four MSF nurses were involved with treating patients at three polyclinics and one hospital, and two laboratory technicians were supporting Beatrice Road Infectious Disease Hospital in Harare on diagnostics.

In addition, the team is working in collaboration with the Harare City Health Department in the provision of safe drinking water through setting up mini water treatment sites in affected areas and institutions such as clinics, schools, churches and mosques, as well as rehabilitating already existing boreholes.

Other activities include supporting community sensitization, involvement at coordination meetings and information gathering to monitor the situation across the city and its surrounding suburbs to map the outbreak. Harare and surrounding areas are yet again faced with an outbreak of typhoid and diarrhoea.

FORTHCOMING IN 2013...

Support National Micro-biology Reference Laboratory at Harare Hospital for running viral loads on DBS on NucliSENS platform

Van for community night clinic and HIV testing & counseling campaigns

Support a new district focusing on peadriatric ART - Nyanga

Support PMTCT B(+) - Gutu

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