MSF IN ZIMBABWE NEWSLETTER

Intersectional Newsletter for Médecins Sans Frontières in Zimbabwe. Issue 1:2014

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.

Kindly send your feedback, comments and articles to: msf-harare-com@msf.org

The project text in this report provides descriptive overviews of MSF's operational activities in Zimbabwe.

Project summaries are representational and, owing to space considerations, may not be comprehensive. Some patients' names have been changed for reasons of confidentiality – *Stambuli Kim (Editor)*

Message from the Head of Missions in Zimbabwe

Dear Colleagues,

As we bid farewell to 2013 and welcome the new year, we would like to share with you the first issue of our internal intersectional newsletter.

We have witnessed through our collective experiences in the field that our collaboration with the Ministry of Health and Child Care (MoHCC) since the year 2000 has really gone a long way in alleviating the plight of the most vulnerable populations.

Through this partnership, over the years we have managed to support the implementation of innovative medical programmes and when required supported emergency response to medical crises. Despite that our project locations are geographically diverse, we have managed to impact positively to thousands of patients through dedicated and guided medical humanitarian action. Exciting developments in the fight against HIV/AIDS as well as TB have are happening. The adoption and launch of the new WHO guidelines by the government of Zimbabwe reflects how progressively we are all moving on in our quest to have an HIV free generation.

The launch of the elimination of mother-to-child transmission of HIV will definitely impact positively as we believe that no child should be born with HIV where there are proven prevention measures.

In the following pages you will read interesting articles from the field such as:-

- If measures to tackle multidrug-r e s i s t a n t tuberculosis (MDR-TB) are not significantly stepped up, MDR-TB rates will continue to increase worldwide and a historic opportunity to improve abysmal cure rates will have been squandered. The causes and reasons surrounding all this in one article.
- Matron Chitiyo, the Team leader for SGBV intervention at Gokwe North District Hospital takes us through how the Ministry of Health and Child Care (MoHCC) supported by Medecins Sans Frontieres (MSF) is implementing and strengthening the clinical management of survivors of sexual violence effectively and how this is being don e.
- Shackman Mapuranga, an emermegency coordinator tells of his experiences during the cholera, measles and tyhpoid outbreaks.
- Precious Zvikonyo, a TB nurse in Gokwe reveals the misconceptions she had about Gokwe and how she witness the roll out of TB/DR TB care in the communities.

None of our success stories would have been achieved without our hardworking staff and members in all three MSF sections and our partners especially the Ministry of Health and Child Care and their commitment and support in our endeavors. We take this opportunity to thank you all. Siyabonga. Tatenda.

Our next issue carries an interesting article on our team in Tsholotsho and their quest to educate, train and empower the minority San community of Sikente and Pumula in an innovative and unique program. The program covers different aspects of HIV/AIDS; water sanitation and hygiene among other relevant topics of their choice.

But for now, till then, sit back, relax and enjoy this issue!

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Marching towards an HIV free generation

... a testimony from MSF PMTCT programme beneficiary

Sikhethille has fulfilled her dream of having a child. She never thought she would do it because in addition to suffering severe cases of tuberculosis, she was diagnosed with HIV.

"I got really sick and I was taken to the hospital where I was diagnosed with tuberculosis. They gave me the treatment but I was still very sick. I went back to the hospital where they tested me for HIV and the result was positive ".

Sikhethille's hope of having a baby was scarce until she became part of the programme to Prevent Mother-to-Child Transmission (PMTCT) of HIV that MSF runs in Tsholotsho. "I went to the hospital. They gave me all the support and care I needed. A nurse gave me the medicine I had to take before, during and after giving birth, and she told me what I had to do on the day of delivery. I did everything as the nurse told me, and when I went into labour, I took the two pills that I had been given at the hospital. I remember very well that day, it was very painful, it started at 3:00 am and at 8:00 in the morning my daughter was born.

"Thanks to the prevention programme, my daughter was born HIV-free. I was so surprised that I called her Surprise. Soon she will be a year old and she has already begun to take her first steps", explains Sikhethklle Ncube, one of the women who followed the MSF PMTCT programme in Tsholotsho.

Six weeks after giving birth, her daughter was tested for HIV and the result was negative. "I was so surprised that I called her Surprise" says Sikhethille. In December 2012, Surprise will be a year old. She has already begun to take her first steps, but still totters, slowly approaching towards her mother. "I am so happy to see her; especially after all the time I suffered while I was sick. At that time I never imagined I could have a baby, but thanks to the prevention programme I managed to have my daughter free of HIV."

Sikhethille is happy, simply because her daughter Surprise is able to have a long life, free of HIV and full of hope.

"I want her to study and to learn how to take care of herself. I will try to educate her so she can take care of herself and be happy," she explains. But Sikhethille's happiness is not just for the fate of her daughter Surprise, but for all HIV-positive mothers who can realize the dream of having children free of HIV through the prevention programmes.

On the road to better managing survivors of sexual violence

Part of the MSF/MoHCC SGBV Team in Gokwe North

By Matron Chitiyo
Team leader SGBV Gokwe North District Hospital

The Ministry of Health and Child Care (MoHCC) supported by Medecins Sans Frontieres (MSF) is implementing and strengthening the clinical management of survivors of sexual violence effectively by training of staff, resource mobilization and preparation of manuals.

The Gokwe North SGBV clinic started operating in 2009 after 4 nurses were trained by the government supported by National Health Care Trust.

MSF reduced the workload at the hospital by training health workers in all the rural health facilities in the district. Therefore management of all sexual violence cases is being managed holistically at each health center.

Sensitization on SGBV was done to community leaders, stakeholders, schools both primary and secondary to bring awareness on the types of violence, the effects of violence, what to do after being raped and outline of the comprehensive management given in the clinic. Thanks to MSF who brought the light to our community, "medical attention first then reporting to the police".

MSF made communication easier with clients through signposts to privately direct victims to the unit, a phone for appointments and follow-up as well as kits to transport specimens for forensic assessment. Thanks for making the clinic known.

Last but not least the comprehensive management includes;

- STI prophylaxis
- PEP
- Emergency contraception
- HIV testing and counseling
- Tetanus Vaccination
- Hepatits B vaccination
- Psychosocial counseling

People living with MDR-TB and their healthcare providers call for urgent action

By Stambuli Kim

IF measures to tackle multidrug-resistant tuberculosis (MDR-TB) are not significantly stepped up, including addressing barriers that prevent both research into better drug combinations and treatment scale up, MDR-TB rates will continue to increase worldwide and a historic opportunity to improve abysmal cure rates will have been squandered.

Two new drugs effective against MDR-TB must be used to make treatment much shorter, more effective and less toxic. This demand is among others made by people living with the disease and MSF medical staff from around the world in a public manifesto launched during the World TB Day commemorations.

"Tuberculosis was brought under control in the second half of the 20th century, but the antibiotic treatments developed then haven't been updated in more than 50 years, and now we're increasingly faced with new, drug-resistant strains of TB." said Paul Foreman, then MSF Head of Mission in Zimbabwe. "The lack of investment and the general indifference to this global health risk is shocking. Getting better treatment is beyond urgent, but we are not seeing anything like the level of prioritisation required to make this a reality."

MSF projects are seeing unprecedented numbers of people with MDR-TB around the world, with drug resistance found not only among patients who have previously failed TB treatment but also in patients newly diagnosed with TB – a clear sign that MDR-TB is being transmitted in its own right in the communities in which we work.

After close to five decades of insufficient research and development into TB, two new drugs - bedaquiline and delamanid - have recently been or are about to be approved. Research is urgently needed to determine the best way to use these new drugs so that treatment can be made shorter and more effective, and rolled out to treat the growing number of people with MDR-TB. People on MDR-TB treatment and their caregivers from around the world outline these and other demands in the Test me, treat me manifesto, and urge others to join their call for urgent action.

In Zimbabwe, there is massive stigma around TB, and many people wrongly believe that the disease is incurable.

"Most of my family deserted me for two years while I was on MDR-TB treatment. My own relatives didn't come to visit me when I was on death's doorstep. The only family I had left was MSF and my two children."

It was a horribly difficult time: "I had to pass through hell to get to heaven," says Chipo Mhlanga (not real name), one of the first patients from MSF projects in Zimbabwe to beat multidrug-resistant tuberculosis (MDR-TB) after two years of treatment.

She was able to see the treatment through to its end with the support of MSF staff, who also shared their knowledge with government doctors throughout Zimbabwe, most of whom had no previous experience of treating the disease.

"It's extremely difficult to watch your patients try to cope with the side effects caused by this arduous two-year treatment. We urgently need treatment for DR-TB that can cure people in less time and with fewer side effects," says Dr Marve Duka, MSF TB Doctor in Buhera.

The number of people receiving MDR-TB treatment globally remains shockingly low, at less than one in five. Greater political and financial support from the international community is needed to address this gap.

"Right when TB should be the global priority, the trend we're seeing is that it is being deprioritised. This is unacceptable," says Dr. Manica Balasegaram, executive director of MSF's Access Campaign.

The Global Fund provides about 90% of international support for TB, but it has recently reduced the share going to the disease. Ahead of a key replenishment meeting later this year, donors must ensure the Fund is adequately financed so that countries have the support they need to strengthen the MDR-TB response. With better treatment on the way, affected countries should scale up efforts to diagnose and treat MDR-TB today, so that robust programmes are in place once the new drugs are introduced.

Movement Wide Association
– real without borders movement

By Patricia Mazuru

THE innovative character of the Movement Wide Association (MWA) urged me to join this sprouting society. In my opinion it was an opportunity to be part of the factual "without borders movement" even though I did not quite understand how the virtual platform was going to make this happen.

Having been a part of the MSF family for almost five years now, I appreciate that Médecins Sans Frontières is inherently a field-based movement .Evidence of this can be seen in the field associative debates (FAD) , and the various other forums where the MSF voices can be heard urging the movement forward.

When plans of the first Movement-Wide Associative Debate (MAD) were announced, it was difficult for me to conceptualise how these 'global discussions' were going to take place. Seeing as the MAD was going to be held wholly online, I feared that the MWA would lose the MSF field basis and that it would not be able to accommodate technologically developing countries such as Zimbabwe.

Earlier this year we managed to locate ten MWA members working in the various MSF projects in Zimbabwe. Six of us gathered in the capital city, with one member having travelled nearly 700kms overnight to be part of the team. We were going to take part in the first ever Movement-Wide Associative Debate ...online.

As a group we share a common vision of developing the MWA so that it gains a sturdy voice in the larger movement and not become irrelevant over time. I was certain we could connect to the live meeting however I was not convinced that our technology would grant us the platform to interact effectively. We certainly did not expect to feel like part of the larger group, particularly because our conversations relied heavily on cables, microphones, switches and screens.

The interactive, dynamic dialogues taking place in the main discussion and the parallel conversations were a clear indication that I had underestimated the MWA's personality. It did not feel like just any other association, it felt like an anthology of associations --"an association of associations" as it has been rightly named. The members conveyed themselves as true proprietors of the international alliance and it was a practical lesson for me to learn that in addition to being a field based movement, MSF thrives on dialogues and discussions.

The personal commitment illustrated by each person who participated in the MAD demonstrates that the responsibility of the international association lies with all of us.

The MAD was a resounding success. Similar conventions must be encouraged and facilitated in the near future. The most difficult stage has passed; the modern qualities of the MWA have torn down borders placed by time zones, technology and settings, allowing each MWA member an opportunity to contribute to the direction of the movement. I was above all impressed by the relevance of the topics reflecting MSF's work and goals despite being a budding group. The personal commitment illustrated by each person who participated in the MAD demonstrates that the responsibility of the international association lies with all of us. This is undoubtedly the platform where MSF'ers can make MSF the organization they want it to be.

Become a member of the Movement Wide Association

The movement-wide association is the association of the individual members of MSF International. As such, it offers an open space for direct and open communication at an international level, breaking down national borders and ensuring that individual members far from a local associative group can also contribute to the movement.

By associating with MSF at an international level, members will be able to:

- Discuss topics that concern the whole of MSF and propose solutions to drive the movement forward;
- Interact and (re)connect with other members across associations, including those they have met on mission;
- Share their thoughts and experiences with other MSFers, starting and sharing ideas;
- Contribute to policies that affect all Operational Centres by debating MSF's work and strategies at the global level;
- Undertake associative action, by organising their own informal events, gatherings and discussions with other members close by or not.

Join the Movement-Wide Association
www.association.msf.org/register

My life as an Emergency Coordinator

By Shackman Mapuranga

It all started on the 25th of November 2008 when I was assigned by the then MSF- Luxemburg to work as an emergency nurse in Masvingo's Mushandike communal lands.

A cholera outbreak was at its peak.

The first few days were both hectic and a bit frightening considering that cholera had been more theoretical than practical in my ten year practice as a nurse.

Because I was in my final year at the University doing Health Education and health promotion, I did clinical work for a few weeks and then opted to lead the health promotion activities.

It became very exciting each and every day as I slowly began to realize my true potential as a community person dealing with advocacy work.

There were a lot of misconceptions in relation to Cholera and these issues had to be addressed and as challenging as it was, my satisfaction grew each day knowing how my contributions were really positively impacting on the community.

MSF's swiftness and reaction to events made me envy and told myself how much I would love to commit myself to this brand.

Little did I know that barely a year later I would be called back on another mission this time the hot and dry regions of Buhera on a measles outbreak mission.

The sorrow full state of the patients, this time children, was quite pathetic with their parents tied to religious beliefs resisting medical interventions.

It was a long 8 months of moving mountains in this type of setting but like any road it comes to an end no matter how much it may meander, twist and turn but success was the ultimate achievable target.

In all this it was sharpening my negotiating skills which proved very worthy in the elite places of Harare during the Typhoid outbreak between Nov 2011 to April 2013.

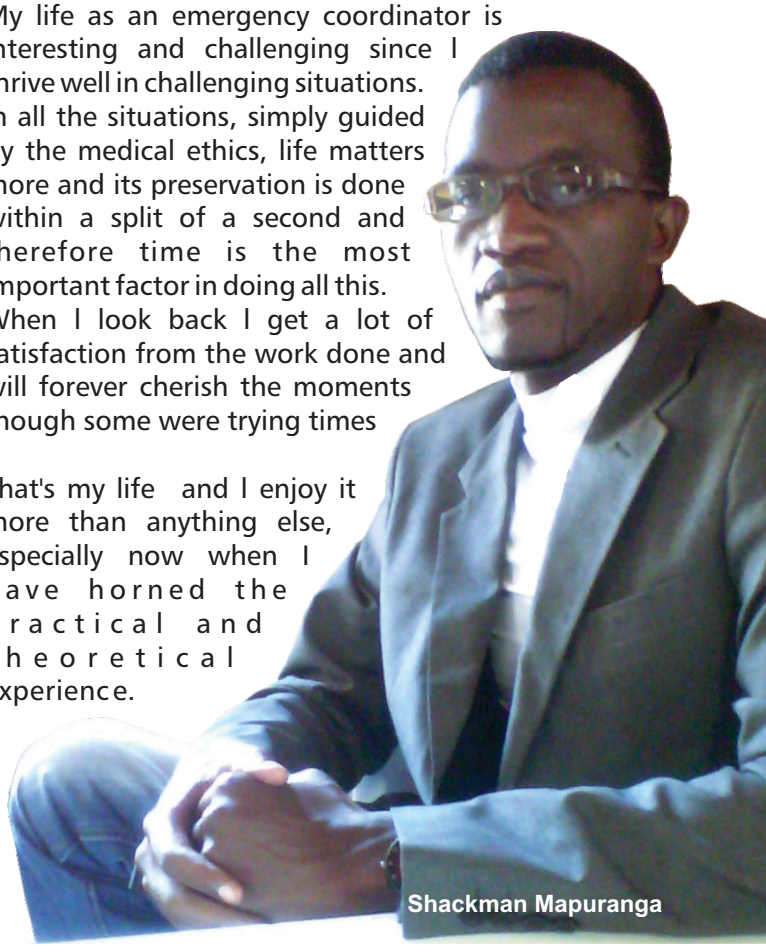
Despite all the hurdles, the immense support from the organization through all this was the motivating factor knowing that there are supportive hands behind me having invested all their trust in my decisions at the same time safeguarding the reputation of the organization from its core values of neutrality impartiality and integrity.

My life as an emergency coordinator is interesting and challenging since I thrive well in challenging situations.

In all the situations, simply guided by the medical ethics, life matters more and its preservation is done within a split of a second and therefore time is the most important factor in doing all this.

When I look back I get a lot of satisfaction from the work done and will forever cherish the moments though some were trying times .

That's my life and I enjoy it more than anything else, especially now when I have horned the practical and theoretical experience.



Shackman Mapuranga

Expanded programme on immunization in Buhera District continues

By Farai Marume

JOINTLY organized by MSF's Surveillance department and the Ministry of Health and Child Care (MoHCC) Buhera District Health Executive, the Expanded Programme for Immunisation (EPI) is run for two weeks every month.

It consists of 30 outreach points and are beyond the five kilometres radius from the nearest clinic.

To ensure the swift running of the program and quality service delivery, the Surveillance department assists MoHCW in reinforcing the cold chain and smooth supply of vaccines and gas through existing channels.

The program has since proved vital in improving the herd immunity of the communities in vaccine related diseases such as measles.

Though vaccine objectors are still present in the communities and cases of vaccine related diseases like measles are being detected, the channels of spreading are being blocked by high coverage of the non-objectors such that the cases will not exceed the epidemic thresholds.

The Surveillance Department, in close collaboration with MoHCW, will continue to implement necessary measures and make amendments to continue improving the coverage and reducing the dropout rates in order to reach every child in the district.

Farai Marume is a MSF Surveillance Nurse in the Buhera project

Father-to-Father programme: Improving male participation in the PMTCT programme

By Yamurai Fusire and Kasujja Francis Xavier

Thandi Moyo*is a three months pregnant house wife from Mathe who recently enrolled into the Prevention of Mother to Child Transmission of HIV (PMTCT) programme at the Medecins Sans Frontieres (MSF) supported health facility of Nkunzi in Tsholotsho District.

According to her story, the first time she had heard about the PMTCT programme was during a Mentor Mothers' meeting at a local church. On this day, an HIV-positive mother who had succeeded in giving birth to an HIV-negative baby was invited to talk to the congregation. Such mothers, known as mentor mothers, are pivotal in sharing their PMTCT success stories with other women in the community.

Thandi found this story nothing short of a miracle. Prior to this incident, she did not know that it was possible for an infected woman to give birth to an HIV-negative baby.

However, thanks to the story from the mentor mother, she now knew that she could join the PMTCT programme at Nkunzi health facility to receive the needed medical support for her to give birth to a healthy baby. When she told her husband about the good news, he was equally elated and supportive. He gave her US$5 for the fare which made it easy for her to travel to and from the health facility. However, Thandi was luckier than most women in Tsholotsho.

Her husband had attended one of the Father-to-Father meetings in the village during which the male members of the community had discussed the merits of the PMTCT programme. Although both the Mentor mother and the Father-to-Father programmes are supported by MSF, they work a little differently. Unlike the case of Mentor mothers, the Father-to-Father programme relies on men who choose to become champions of the PMTCT programme in their communities.

Today, the programme boasts of five Father-to-Fathers in Nkunzi. These men come from all walks of life. From a pastor of a local Pentecostal church, three headmen to several ordinary men. In Pumula, the husbands to the Mentor mothers have formed themselves into 'mentor father' groups which they use to reach out to their peers.

In patriarchal communities like Tsholotsho, men find it easier to discuss topics such as condom use and exclusive breast feeding with fellow men. Generally, there is a link of male involvement in PMTCT programmes with greater uptake of HIV testing, ARV treatment, condom use and support of infant feeding choices.

Male involvement ensures that men have the information they need to make healthy behaviours while supporting their wives, children and families. Involving men would also ensure that they provide firewood, food, water and other provisions to their wives during their stay in the Waiting Mothers' Shelter.

For women like Thandi, the interest of men in PMTCT programmes is a welcome intervention which will help women to get the support they need in going through the programme successfully. This will be not only in the form of permission to visit the health facility timely and getting the bus fare they need to get there but also much needed psychosocial support.

As MSF, we remain committed to empowering the community to participate in the making of positive health care choices. Our hope is that the mentor mother, father-to-father and perhaps 'mentor father' programmes will catch on and spread throughout the Tsholotsho district and the rest of the country.

***(not her real name)**

MSF commemorates World AIDS Day

By Stambuli Kim

Medecins Sans Frontiers, MSF, intersectionally joined hands with the National AIDS Council, Ministry of Health & Child Care and others including business, diplomatic community, religious sector and AIDS service organizations in commemorating World AIDS Day through public marches and exhibitions which were held at Garwe Stadium in Chivhu, Mashonaland East Province on Sunday 01 December 2013.

MSF also participated in the national candlelight memorial which was organised by the Zimbabwe National Network for People Living with HIV. A press briefing and premièring of the short video, See What We See, was also done on the 30th November .

Small and Medium Enterprises and Co-operative Development Minister Sithembiso Nyoni who was representing the guest of honour, First Lady Amai Grace Mugabe, at the event said no child should be born with HIV or be infected at birth because preventive treatment is readily available and accessible in the country. In a speech read on her behalf by at the World Aids Day commemorations in Chivhu, Amai Mugabe said all leaders and parents should promote uptake of mother to child transmission services.

In a speech read on his behalf by his deputy Dr Paul Chimedza, Health and Child Care Minister Dr David Parirenyatwa also added that people could only access treatment when they knew their status.

MSF's participation in the World AIDS Day commemorations was aimed at increasing MSF visibility, profile the work we are doing and also amplify voices of the vulnerable populations we are serving across Zimbabwe and the world over. This event also afforded MSF the opportunity to profile the humanitarian work it is doing.

The See What We See campaign further sought to challenge misconceptions and assertions that progress is all pervasive and the war against AIDS is almost won as complacency is illustrated by lack of firm commitments by donors to the Global Fund that helps finance national AIDS, TB and malaria programme. This was in the form of a short 15 minute video, shown to the journalists and some significant stakeholders, depicting the dire needs on the ground which MSF teams are witnessing worldwide.

As part of pre-launch activities, there were HIV Testing and Counselling campaigns as well as general WAD community sensitization in the period preceding the commemorations. A component on SGBV awareness was also added as the commemorations fell in the 16 days of activism campaign on SGBV.

On the day, a total of 360 people were tested for HIV while more than 4 000 people passed through the MSF exhibition stand. The exhibition highlighted general MSF programming, ART, TB and SGBV.

Several government officials, including the Deputy Minister of Health and Child Care Dr Paul Chimedza, Permanent Secretary Dr Gwinji, Health Advisor in the Office of the President Dr Timothy Stamps and many other government officials, diplomatic community and civil society leaders attended the event.

Bringing treatment closer to home and empowering patients

By Munyaradzi Makari

ANY mention of winning the fight against HIV generally conjures up ideal images of people living with HIV, PLHIV, easily accessing HIV treatment and care, as well as related services. However, despite having the fight against HIV/AIDS being celebrated as the most successful public health victory in the history of human kind, increasing access to HIV services to most people remains a big challenge.

With some success in scaling up HIV treatment and care, the most uncomfortable question is raised: Are we there yet, now that the HIV emergency is undeniably at its tipping point as everyone everywhere across the globe is already celebrating victory?

It is important to note that conventional HIV care is ever getting overwhelmed. With the limited meaningful involvement of PLHIV themselves, what is the future? This question has become both urgent and important against the background of growing numbers of new patients being put on life-saving treatment and on the other hand, to keep up acceptable level of care for people who are already in care thereby making the search for a way out even more urgent.

Taken against the background of the prevailing situation, MSF was not outdone by the extra ordinary circumstances surrounding HIV response as it started to explore ways of making HIV treatment and care accessible.

Recently MSF successfully piloted Community ART Refill Groups (CARGs) in Zimbabwe in two sites (Matizha clinic, ward 1 and Soti Source clinic ward 3) in Gutu. CARGs are peer HIV drugs refill groups made up of up to 15 people who no longer need clinical follow-up regularly, with a stable condition, without any active sickness, having been 3 month on Tenolam E based regiment and a Viral Load result less than 1 year old below 1000, and only coming to the clinic just for drug refill.

These people send one representative to collect drugs for the rest of the group and distribute in the community. Groups members can support each other with adherence and strengthen patient tracing capacities through the established social networks. This in turn relieves the burden on people living with HIV and health systems through reduced number of clinic visits, simplified clinical appointments, providing PLHIV with several months of medicines in one refill visit.

These models of care should not ordinarily go unnoticed for the fact that specialized clinic HIV care are increasingly looking towards simpler models for chronic disease management. This further decentralization and task-shifting involves strategies such as peer antiretroviral therapy.

To date, a total of 21 groups are in place benefiting a total of 116 patients and the groups have all successfully had their initial refills. As a result, and going forward since the few months of starting the CARGs in the two pilot sites in Zimbabwe, the model has served well as a way of promoting HIV testing and counseling (entry point into the HIV care cascade) with a total of 340 people having been referred for testing.

Precious takes us through her Gokwe journey

By Precious E. Zvikonyo

My humanitarian journey started in Gweru in 2007 when I joined Medicines Sans Frontiers (MSF) untill 2011 when the project was successfully handed over to the Ministry of Health and Child Care (MoHCC). When the Gweru project was handed over, I was one of the staff which was requested to go and work in the new MSF project in Gokwe North District.

Gokwe, I had heard then, is a remote, dry, and malaria infested area. I was to find out again that there was only one public transport bus to Nembudziya and the road network was terrible, very few trucks were used to ferry people from other towns and cities to Nembudziya which is a principle growing point and centre of Gokwe North district.

I can still recall my first trip to Nembudziya; it was a very hot and wet day with my thoughts lost in fixation of how the life was going to be. I remember sweating badly even during the nights. I tried to imagine how I was going to survive for the next 3 years in such a harsh environment. The marauding mosquitoes can even bite in broad daylight, let alone the dusk and night time.

And after working in a hospital setting in a city like Gweru, I had no idea how we could support and coordinate the project activities in such a big rural district with poor road networks and communication. The district is so vast, with 16 rural health posts and 2 hospitals where we were intend to support.

I was told that the approach we will adopt will be a bit different from the Gweru approach; we will collaborate and work in partnership with MoHCC, doing mentoring right from the onset. Our prime target was OI/HIV, TB and SGBV program. There was no TB diagnoses centre in the district; there were only 19 patients on treatment.

Soon we had numerous meetings with MoHCC and MSF started supporting TB programmes in the District. We moved in teams, travelling for hours to different rural clinics every day. Sometimes we would doze off in the heat of morning sun or sometimes we will just talk all along the way as we struggle to keep ourselves stable from jerking up and down.

We then started mentoring the clinic nurses on what is TB, its symptoms, the co infection cases, importance of collecting sputum and TB treatment. In short, nurses were mentored on comprehensive management of TB including screening for HIV and follow up of sputum samples.

Numbers of TB clients started to increase. By the end of 2013, we had 450 cases which were registered for TB treatment in the district. This is in comparison to a mere 19 patients we had registered for TB in early 2012.

Two well functioning laboratories were opened in the 2 district with our active support; MSF also installed the GeneXpert in the district hospital laboratory for diagnosing TB cases, besides it can also screen cases of MDR TB. It was simple remarkable that such a vital and sophisticated machine could be used in such a remote district.

By November 2012, the 1st MDR TB case was identified in Gokwe North district. A young man, Elisha Tshuma, aged 33, who had given up hope after failure to improve from several years of treatment for TB and had actually returned home to die.

I personally went through several counselling sessions with him, trying to give him hope. He would often ask me to assist his young wife to look after the 4 children after he die as his condition was worsening by each passing day.

After finally getting approval from authorities, we then started the patient on MDR TB treatment on February 14 this year. He remarkably improved with medication and slowly started gaining weight. All along we encouraged him to take his medication every day.

Gokwe North now has one of the best TB program in the province, all the suspected TB patients are now screened for MDR TB, all 18 health facilities has a well functioning system of sending samples to the district laboratory. The district has a functioning MDR TB committee which means that the decisions for starting MDR TB treatment can now be timely taken at the district level.

We adopted and promoted the community based approach where we treat and decentralise the MDR TB patients to their nearest health clinics after initial treatment in the hospitals. We believe with counselling and knowledge on infection control, MDR TB patients can be treated at homes; the place where they belong, instead of long isolated stay in the hospital. We now have six patients on DR TB treatment.

Our 1st MDR TB treatment is now 11 months on treatment. He was discharged back to his home, now receiving treatment on strict DOTS from DOTS provider. He is now very happy and healthy man.

Looking back with him how he had lost hope for life, we just laugh it away.

Precious E. Zvikonyo is a State Registered Nurse, Registered Mental Nurse, Midwife and Opportunistic Infections/TB nurse based in the MSF Gokwe North Project. She has been working with MSF since 2007.

MSF South Africa

MSF has carried out projects in South Africa since 1999. In 2007, MSF consolidated its presence in the country by opening a delegate office in Johannesburg, which is part of a network of 20 MSF offices worldwide.
MSF South Africa recruits medical staff and other professionals to work in MSF projects around the world while also raising funds to support our international work.
We share information with the public, the media, government agencies, and other non-governmental organisations to raise awareness about the plight of those people we assist. MSF South Africa also supports MSF programmes in the region by providing medical expertise, including specific medical training for MSF field staff.

Meet the MSF SA Board

Garret Barnwell
President and Voting member

Garret Barnwell is a former MSF field worker. He first started working for MSF in the Johannesburg office in 2010. Since then, Garret has worked as an assistant field coordinator in Somaliland in 2011 and helped coordinate MSF's response for Syria Mission in 2012. He has also been actively engaged in the Southern African association, carrying out association activities in Malawi, Zimbabwe and South Africa. Previously holding non-medical positions within MSF, he has recently registered as a clinical psychologist in training, studying and working in Port Elizabeth, South Africa. Garret holds an MA in Conflict Transformation and Management and a Professional Diploma in Humanitarian Assistance.

Fasil Tezera
Vice President
Voting member

Fasil Tezera has a background in Pharmacy. He has an extensive experience in MSF from 1991 to present. Over the years he has participated and assisted in many of the FADs, MSF B general assemblies and many other important debates including La Mancha, and the Chantilly process. He values associative life in the project.

Nora Meniri
Treasurer and voting member

Meinie Nicolai
Voting member

Meinie Nicolai is Chairperson of the MSF Belgium and the Operational Centre Brussels boards. A nurse by profession, Meinie has worked in the field with MSF for more than 10 years and previously served as Director of Operations for MSF Operational Centre Brussels.

Anthony Mdeni
Voting member

Anthony Mdeni has a background in Nursing and Midwifery and has studied Community Development recently. He is currently Technical Officer in the Medical Department of MSF in Thyolo, Malawi. He has been a dedicated MSF staff since 2005.

Edson Chidovi
Voting member

Dr Edson Chidovi joined MSF in 2007, when he was working as a doctor at a mission hospital in rural Buhera district, Zimbabwe. After joining MSF he spearheaded the roll-out of the decentralized HIV/O.I/ART care program, which had been started earlier at a smaller scale. Under his supervision, the project grew to cover 22 rural heath centres and 2 rural hospitals, reaching out to thousands of disadvantaged and remote patients affected and infected with HIV. The concept of decentralized care was shown to be effective and innovative. At the same time, Dr. Chidovi managed nurse-based ART initiation and mentorship, and an integration into the MOH program. He went on to become the assistant medical coordinator, where he oversaw operations in the MSF HIV, Nutritional as well as the Sexual and gender based violence projects in Zimbabwe. Edson became a board member for MSF South Africa in April 2013. He is currently working towards an executive diploma in business leadership.

Steve Miller
Voting member

Stephen is a development professional with over seven years' experience at the senior management level. Born and bred in the former Transkei, Stephen received his primary and secondary education at Mthatha High School. He then went on to obtain his BA degree from Rhodes and his Masters in Public and Development Management from the University of the Witwatersrand. Stephen has

supervised relief and development programmes in Namibia and Liberia, and has also served as the Head of Resource Mobilization at MSF South Africa. Currently, as the Country Representative for Trias in South Africa, he works to improve the capacity of Business Membership Organizations representing small and medium enterprises. Stephen resides with his wife in Johannesburg.

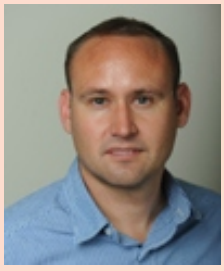
Nathan Ford
Voting member

Nathan Ford is an HIV/AIDS specialist with extensive MSF field experience between 1998 and 2010 with a main focus on HIV/Aids and malaria. Nathan has worked in many different countries, of which he worked mostly in Malawi, Mozambique and Thailand. Later he was twice head of MSF's South African Medical Unit (SAMU) and worked as advocacy officer on 'Access to Medicine' in the South African mission. Meanwhile he also wrote a PHD and is currently working on HIV/Aids programmes for WHO.

Nicolas de Torrente
Voting member

Nicolas de Torrente has worked for MSF since 1993, he started his career in the wake of the Rwandese genocide in 1994. As head of mission he became responsible, at the field level, for the design and implementation of humanitarian aid programs and advocacy in Rwanda (1994-95), Somalia (1995-96), Liberia (1996), Macedonia (1996), DR Congo (1996) and Afghanistan (1997). In 2001 he finished his PHD on Post-conflict reconstruction in Uganda for the London School of Economics and returned back to MSF as executive director of MSF USA until 2009. Since 2009 Nicolas runs for the Deepening Democracy Program, a multi-donor fund to improve democratization in Uganda.

Observers at MSF SA Board of Directors



Andrew Mews
MSF Country Representative in South Africa: Ex-officio, non-voting

Andrew Mews joined MSF in 2005 and has over 7 years of direct experience in the field, working in Zimbabwe, Chad, Central African Republic and The Democratic Republic of the Congo, where he was Head of Mission for 18 months before joining the South Africa & Lesotho mission in 2012. He holds an MSc in Disaster Management and Sustainable Development and previous to MSF was a management consultant in London, specialising in providing management advice to Small to Medium Enterprises.

Daniel Berman
General Director MSF SA: Ex-officio, non-voting

Dr Isabelle Muyangayu
Non-voting member

Frackson Ngoza
Non-voting member

Arthur Nhantumbo
Non-voting member

Tuku speaks out on men's HIV ignorance

Music superstar Oliver Mtukudzi says more Zimbabwean men are dying of HIV/AIDS because they don't want to come out in the open and join HIV/AIDS support groups where they can get help on positive living.

Speaking during the launch of "Positive Generation: Voices for an AIDS-free Future," launched by MSF, Mtukudzi said several Zimbabwean men were reluctant to reveal their status and learn how to respond to the virus.

"Its mainly women in these support groups. where they learn how to live positively with the disease". Mtukudzi said.

Through MSF which runs an HIV/AIDS project in Tsholotsho, Mtukudzi collaborated with Jimila support group choir and the late Chiwoniso Maraire in composing songs for the international CD Positive Generation.

Mtukudzi also praised MSF for coming up with the project.

"MSF has done a great job by sponsoring this project and I am very happy to be part of this noble endeavor as we fight HIV related stigma through music", he said.

Letter of appreciation to MSF OCB (MURAMBINDA)

VOTE OF THANKS

On behalf of all Zimbabweans as well as on organization MSF-B for making this decade

To begin with you created so many employme

Your humanitarian action is reflected in yo in Africa, Japan over to China you have mar Borders.

HIV and AIDS had wiped a notable percentage of deaths through free ARVs and your selfle end of the time.

You impacted positively in our beloved Zimb irrespective of creed , color or political or Care. This shows you have got the intrinsic by the medical ethics. You uplifted poor peo

Conclusively, I would like to thank you for e Zimbabweans envied and failed to get. Thoug blessings from the Most High, God for a job

Yours Bonafide

Kennedy Mangondo Mupindu

Kennedy Mupindu was born on 24 January 1966 and joined MSF in the Buhera project on 01 June 2009 as a Guard. Mapindu is married and blessed with 3 children.

"TEST ME, TREAT ME" MANIFESTO

People with drug-resistant TB and their medical providers worldwide call for urgent change

We, the people infected with drug-resistant TB (DR-TB), live in every part of the world.

Most of us were exposed and became infected with DR-TB because of the poor conditions in which we live. Undiagnosed, this disease spreads among us. Untreated, this disease kills. But in the countries in which we live, fast and accurate diagnosis is rarely available, and only about one in five of us actually get effective DR-TB treatment.

Those of us 'lucky' enough to receive treatment have to go through an excruciating two-year journey where we must swallow up to 20 pills a day and receive a painful injection every day for the first 8 months, making it hard to sit or even lie down. For many of us, the treatment makes us feel sicker than the disease itself, as it causes nausea, body aches, and rashes. The drugs make many of us go deaf permanently, and some of us develop psychosis.

For most of us, life as we knew it changes dramatically. We cannot go to work, or take care of our loved ones, or go to school. Often, we are stigmatised and face social exclusion.

Surviving this treatment itself is a huge challenge—one that many people cannot manage. But we have no choice if we want to live. So we must be brave, strong-willed and have hope that we will be cured. We need immense support from our medical staff, our family and our friends to help us complete our treatment.

And even then, only half of us are successfully treated with the current drug regimens. For every person with drug-resistant TB who signs this manifesto, there is another person who is no longer able to. The demands we make in this manifesto are therefore made in honour of their memory.

We, the medical staff who provide medical care for people with DR-TB, find it unacceptable that the only treatment options that we can offer people cause so much suffering, especially when the chance of cure is so low. We have no choice but to juggle combinations of largely ineffective and toxic drugs, while doing our best to manage the debilitating side effects and provide as much support and counselling as possible with limited resources.

As the epidemic continues to spread, DR-TB becomes increasingly hard to tackle. The treatment is too long, too toxic, and too costly – the drugs alone cost at least $4,000 just to treat one person. We want to save many more lives, but we desperately need shorter, safer and more effective treatment to do so.

We, the undersigned people with DR-TB and those involved in their care, here raise the alarm about the devastating toll this disease is taking on us, our families and communities across the globe, and therefore make the following three demands:

1) We call for universal access to DR-TB diagnosis and treatment now: so everyone who needs it can access fast and accurate diagnosis and good treatment close to their homes.

2) We call for better treatment regimens: the TB research community, including research institutes and drug companies, must urgently deliver effective, more tolerable, shorter and affordable DR-TB drug regimens, making the best possible use of new drugs coming to the market.

3) We call for more financial support: to increase DR-TB treatment and a commitment to support research into developing better treatment.

We as patients and healthcare providers commit ourselves to:

- Encouraging each other to test for TB, take our treatment, and remain in care
- Protecting those people close to us from TB transmission
- Holding our governments accountable and pushing them to respond to the crisis
- Sharing our stories to improve TB awareness and reduce stigma in our communities