MSF ZIMBABWE NEWSLETTER

MEDECINS SANS FRONTIERES

Médecins Sans Frontières

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

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

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

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

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

Stories complied by Gloria Ganyani - MSF Communication Officer
Design: Reshmi Majumdar
Photographs: MSF Zimbabwe
Kindly send your feedback and comments to:
msf-harare-com@msf.org
Telephone: +263 772156175

CONTENT

Issue I / 2019

Mrs Caltas Hlerima, a member of of the Kuwirirana Community Health Club in Glenview Harare

MSF's response to cholera outbreak

MSF provided case management support, infection control, and technical and logistical support for cholera treatment centres set up in Glenview and at the Beatrice Road Infectious Diseases Hospital.

Cover page photo
is captured from one of the projects implemented by MSF in Zimbabwe

COUNTRY DIRECTOR'S NOTE

Going strong in Zimbabwe

Welcome to the first edition of the Medecins Sans Frontieres in Zimbabwe 2019 newsletter. This is a newsletter that highlights various activities and developments that took place within MSF in Zimbabwe, in the second half of 2018.

In this edition of the newsletter, you will read articles about our Cholera interventions in Zimbabwe. MSF supported the Ministry of Health and Child Care (MoHCC) to respond to the cholera outbreak that hit Harare at the beginning of September and left more than 50 people dead while close to 10 000 suspected cholera cases were treated.

We also showcase how Community Health Clubs assisted communities to prevent the spread of cholera in high density suburbs like Glen View.

You will also read about our HIV program in Mwenezi where MSF introduced new models of HIV treatment and care to patients in hard to reach areas. Through the outreach program, MSF teams travel long distances to provide treatment to patients who stay in areas where there are no clinics. MSF also introduced a model of HIV treatment called the Out of Facility Community ART Distribution model (OFCAD). Patients who have benefitted from these services, also share their testimonies.

In Chipinge, MSF launched a Chronic Care clinic at St Peters Mission hospital to provide comprehensive treatment to patients with many conditions thereby integrating services. People living with chronic diseases will now receive comprehensive treatment in one place at the same time, by the same staff, thus saving time and money.

We also share testimonies from staff who have used Geographic Information Systems (GIS) in their work. They explain how GIS has helped them in their day to day work. Staff members who have also gone for detachment programs in other MSF missions, also shared their experiences and lessons learnt.

In Mbare, MSF officially opened the Adolescent clinic at the Edith Opperman Clinic. At this clinic, MSF provides free adolescent friendly sexual and reproductive health services, general health check-ups, contraception, STI screening and HIV testing among other things. MSF also provided the listed services during the Harare Agricultural Show.

After seven years of providing treatment and psychosocial support to more than 8200 survivors of sexual violence, MSF handed over the SGBV project at the end of November, 2018 to the City of Harare health department.

When programmes have been supported through the growth and development phase, MSF hands over project activities to the MoHCC, where people continue to receive uninterrupted treatment. This handover is a process during which capacity is built to sustain the quality of care provided with MSF support. MSF will continue its projects in Beitbridge, Chipinge, Gutu, Harare, Mutare and Mwenezi treating patients living with HIV, TB, non-communicable diseases, migrants on the move and providing emergency response. ■

BJORN NISSEN

3

PROVIDING NEW COMMUNITY LED MODELS OF HIV CARE IN MWENEZI

17-year-old Charles,* from Mwenezi, a rural district in Masvingo province, south-east Zimbabwe, was born with HIV. His mother died when he was still very young. By the time he was 14, Charles had to walk long distances from Mwenezi to Mberengwa, a neighbouring district to collect his HIV medication at Musume clinic.

In Mwenezi, people living with HIV used to travel long distances, as far as 60 kilometres, to collect antiretroviral (ARV) medication from the nearest clinics. In extreme cases, patients had to walk for two days to collect their medication.

"We used to wake up early in the morning and leave home around six o'clock to go and collect medication. We would arrive around 1pm if we walked fast," explained Charles. Walking these long distances will soon be a thing of the past following the introduction of new community-led models of HIV care.

While mentoring nurses from the Ministry of Health and Child Care (MoHCC) in Mwenezi, MSF staff noted that many patients were defaulting on treatment and not taking their medication consistently. Most were defaulting because of the long distances to their nearest clinic and because they could not cross some rivers during the rainy season. MSF also noted that many young people in Mwenezi migrate to neighbouring South Africa in search of employment, causing them to default on treatment while away and coming back very sick.

This prompted MSF to introduce an outreach programme in partnership with the MoHCC where MSF teams visited over 1,200 outreach patients in hard to reach areas and provided antiretroviral treatment (ART) and general outpatient department treatment.

Charles is happy that MSF has introduced an outreach programme as it means he can collect his medication at an outreach point rather than the main clinic which is too far away.

Although the distance from their home to the outreach point is still far, it is much more manageable; a three-hour walk rather than a seven-hour one.

"I benefitted a lot from the services because I was sick but I have recovered now. I had chest problems and stomach pains, but I am feeling much better. I feel that I am healthier now," said Charles.

Outreach programmes

MSF outreach teams travel distances of almost 200 km to reach patients who need medication. In the early days of our outreach programme, we saw many late presenters; people who had taken a very long time to get treatment after contracting HIV and HIV had progressed a lot,"
Edson Chidovi, *MSF doctor.*

"We saw patients who had been tested before, but had not begun their ART. They had been referred to the nearest clinic, which was 60 km away, and they had been forced not to collect their medication because of the distance.

Some patients had gone to collect their ARVs a few times, but because they had to cross major rivers that become impassable during the rainy season from October to March, they could not collect their medication for half the year. These are the people we are helping with our outreach programmes. Close to 40 percent of our clients presented with advanced HIV."

Even with the outreach points, some patients were still travelling 40 to 60 km to collect their medication. After this realisation,

MSF introduced new community-led ways for patients to get HIV treatment and care closer to their homes.

Some of the alternative models of care introduced by MSF in Mwenezi include community ART refill groups (CARGs), family refills, and out-of-facility community ART distribution (OFCAD). These models helped to improve patient access and adherence to treatment.

In the OFCAD model, village health workers are trained to distribute ARVs to registered people living with HIV in their communities. The village health workers collect ARVs from the nearest clinic and then keep them in their houses. People living with HIV are referred from clinics or outreach points to the village health workers facilitating OFCAD and can collect their ARVs from the village health workers approximately once every three months. **This is the first time that OFCAD is being piloted in Zimbabwe. It is also the first time it has been tried in a rural setting in the Southern African region. The concept has been used in Swaziland and the Democratic Republic of Congo, but in both cases it was implemented in urban settings.**

Criteria for joining OFCAD

"For patients to be included in OFCAD, there is a criteria that has to be followed," explains MSF nurse mentor, Tinashe Mbirimi. "Patients wishing to join OFCAD should have been on ART for at least six months, and their viral load should be below 1,000 or undetectable. They should be taking the fixed-dose regimen, which is Tenolum E. There needs to be a village health worker near the area where they are staying."

Advantages of OFCAD

The advantage of using OFCAD is that people living with HIV can collect medication closer to home, saving them money and time, and greatly reducing the chance of defaulting from treatment. "Community members will benefit from collecting their medication from the village. Before, they were facing many challenges," said Rinet Zhou, a village health worker responsible for dispensing ARVs.

"There are many rivers around and sometimes people are not able to cross them. In some rivers there are crocodiles. If the river is full, people can die while the pills are here. Introducing OFCAD is a good initiative because we noticed that people were stressed just thinking that the day to go and refill their medication was approaching. Some live alone or are old, and collecting medication presented them with challenges," said Rinet.

Other models of HIV care

CARGs are an established model of care that allow stable HIV patients on ART to form community groups. Group members take turns attending the health facility to pick up ARVs for the whole group. The system means that members spend less time at the clinic collecting their medication. Similarly, family refill is where one person can collect ARVs for other members of their family. The family refill is beneficial to people who migrate to neighbouring countries in search of employment but often come back home. MSF started the Mwenezi HIV/TB project in March 2016. The project mainly focused on providing treatment and care for HIV and drug-resistant tuberculosis (DR-TB) patients.

The introduction of differentiated models of care, like OFCAD, presents potentially sustainable solutions for hard to reach areas like Mwenezi. The model can be replicated around Zimbabwe where there are similar needs. MSF is in the final phase of demonstrating that the OFCAD model is feasible and will soon call for its national implementation.

* Not real name

■

*

4 TESTIMONY

Tinashe Mbirimi is a nurse mentor with MSF. He joined MSF in October 2008 under the Murambinda project in Buhera before transferring to Gutu in 2011 and Mwenezi in 2016.

"The greatest impact we made in Mwenezi was reaching the people and providing the services that they require."

Tinashe Mbirimi, *MSF nurse mentor*

"When we first came to Mwenezi in 2016, we were mentoring Ministry of Health and Child Care (MoHCC) nurses to provide antiretroviral treatment and care to patients with HIV and TB. While visiting clinics, we noted that many patients were not attending follow-up appointments and were not regularly taking their medication. When we tried to establish what was happening to these patients, we found that they were patients that were coming from hard to reach areas with no clinics nearby.

In September 2016, we started an outreach programme in Mwenezi, which proved very popular. There was a high volume of patients accessing the services and we were not able to manage all of them with the limited number of staff that were available.

Many of these patients had advanced HIV, some were defaulting and some were already failing on treatment. Treatment failure occurs when a patient is not responding well to treatment. Some of the patients were very ill with a lot of opportunistic infections; these are infections that often occur in people with weakened immune systems.

We would see 120 to 130 people a day. Due to the long distances we had to travel, sometimes we would only have four hours to work.

We decided to introduce community ART refill groups (CARGs) to decongest the outreach sites. CARGs are a new model of care that allow stable HIV patients, who are on ART, to form groups in the community. Group members rotate attending the health facility to pick up antiretroviral medications (ARVs) for the whole group.

However, even with the CARGs, we continued to see many patients at the clinics and people who were coming from other nearby districts like Mberengwa and they started to transfer to come to the outreach sites. Patients were continuing to arrive even when it was time for us to leave, some were coming from more than 40km away and it was also expensive and time consuming for them to travel.

We asked ourselves if there was anything else we could do to assist these patients.

We decided to introduce a model of care called Out of Facility Community ART Distribution (OFCAD), which would address the sustainability of the programme.

Through the OFCAD model, village health workers are trained by the Ministry of Health and our partner BHASO to distribute ARVs to registered people living with HIV in their communities.

BHASO is a community-based organisation that mobilises people in the community.

Selected village health workers collect ARVs from their nearest clinic and keep them at their houses. People living with HIV are referred from clinics or outreach points to the village health workers facilitating OFCAD. In turn they are registered to collect their ARVs from the village health workers approximately once every three months. We are keeping the medication in the community, with the patients, to cut down distances and reduce travel costs.

For patients to be included in OFCAD, there is a criteria that has to be followed. Patients must be willing to join OFCAD, they need to have been on ART for at least six months, and their viral load should be below 1,000, or undetectable. They should be taking the fixed dose regimen, Tenolum E. There has to be a community village worker near where they live.

Village health workers attend meetings every month where they order more medication for the patients in their community.
The drugs can be kept at a room temperature, in a well-aired room. MSF provides lockable trunks.
MSF conducted two training sessions, one for nursing staff and one for village health workers. We follow this with on-the-job training whenever we visit them. There is continuous mentoring. When they go for their monthly clinics, they also get training.

We hope OFCAD will address sustainability issues so that communities continue to benefit from the services even after NGOs have left the area.

A day I will always remember was when we got stuck on one side of a river. We wanted to go for the medical outreach programme so we left early in the morning, around 6.30 am, but by midday we were stuck on the wrong side of a swollen river that we couldn't cross.

We waited for almost two hours and were wondering what we were going to do about the 100 patients we were meant to see that day. We had to wait until about four o'clock before it was finally safer for us to cross. When we eventually managed to get to the outreach point our patients were still waiting for us. They had patience and confidence that we were coming to provide treatment. It was so touching. When we arrived, they were so happy. Some patients even cried. They could not hold back their tears. We had told them that we are MSF; whatever happens, we will come.

As a humanitarian worker, I was so happy and satisfied that, although we were late, we managed to finally arrive and provide healthcare services. Seeing patients recovering from illness makes my life worthwhile.
When we are coming to the field, our work is patient centred. We ensure patients get well and improve their lives.

The biggest challenge in Mwenezi is that there is no safe drinking water. Villagers get their water from wells they drill on the river banks. People and animals sometimes get water from the same water source. There are also very few clinics in the area.

The general environment in Mwenezi is not very favourable, but what kept us going was the desire to see people benefiting from our services. I want to see these patients improving and getting the services they require. That is my motivation. I believe people here should get the same services as people in Harare.
The greatest impact we made is Mwenezi was reaching the people and providing the services that they require. We really improved their quality of life. They are now able to access treatment. Other NGOs are now also coming in and we are glad to have pioneered the process and shown them how it can be done." ■

5 TESTIMONIES from Mwenezi

Siyafa Dube, 47, from Dombodemba village in Mwenezi, south-east Zimbabwe, is married with six children. He is one of more than 1,200 patients who have benefitted from the MSF outreach programme that began in Mwenezi in 2016 to provide antiretroviral treatment (ART) and general outpatient department care to patients in hard to reach areas.

"I was wasting away but now I can feel that I am much better. I don't waste money anymore."

Sifaya Dube, MSF beneficiary

"My whole body used to feel weak. I was coughing and I could not walk because my legs were so weak. I also had stomach pains. I was referred to the outreach point so I could get the medication I needed. When I first came to the outreach point in 2017, I was tested for HIV. They told me that my condition had deteriorated and I was late starting my treatment. I was put on medication immediately and given extra doses so that I could take some medication from home.

In June 2018, I was diagnosed of tuberculosis (TB) and put on treatment. That's when I started feeling better. Before that, I could not get tested because I did not have money for transport.
Today, I have come to collect my treatment for TB. There is a distance between my home and this outreach point. I left in the morning and I walked slowly until I got here. This is the nearest treatment centre to where I live.
I used to collect my medication from a local clinic called Chirindi clinic. I would leave home and walk for three hours to get to my brother's place where I would sleep and look for transport to the clinic the following day. I would come back in the evening.
Transport to and from Chirindi cost $10. My brother would give me money when I didn't have any. But now, I can use shorter routes to get here. I bring food from home and my wife gave me maheu (a traditional Zimbabwean drink) to drink on the way. My wife is also HIV-positive and I sometimes collect medication for her as well.

I feel that I have benefitted from the services because before I could not work even in the fields, but now I can. Last year, I could not do any farming because I was too ill. My wife and my child worked in the fields. Before I fell sick, I used to work in a mine but I am not formally employed now."

"I am very happy with the developments because I no longer walk long distances"

Tawedzerwa Ndlembewu, 45, lives in Muvhoko village in Mwenezi, in south-east Zimbabwe. He is married with five children, four girls and one boy.

"I went to Musume clinic for a check-up because I was not feeling well. I was always thirsty, was urinating constantly and felt weak. After being tested, I was diagnosed with diabetes. I used to go to Musume often, but it's very far away from here. I had to go to Musume because there were no clinics in this area, but transport was a problem. I would spend about five hours on the road and pay about $3 to get to Musume. I did not always have enough money, but even when I did, it was still a challenge because there were so few cars. If I missed one, I had to wait for another day.
When I heard about this outreach programme, I came to see if I could get my diabetes medication here. They were not planning to stock these, but they ended up looking for the supplies and bringing them for me. I wish MSF could put a permanent structure in the form of a clinic around the area so that many people could benefit from the services. There are many people around and this is an indication that many people are really in need of clinics. People come here from different areas.
If I walk long distances and it's hot, I feel dizzy. I do not like to walk in the sun. I have to walk for an hour to get home. ■

6

ZIMBABWE RESPONDING TO CHOLERA OUTBREAK

"When I found out I had cholera, I was shocked and scared. I thought I was going to die. My thoughts went to my daughter," says 25-year-old Atlas Murima from Mashonaland West province in northern Zimbabwe. She had visited her sister in Harare, over 160km away, where an outbreak of cholera had been sweeping through the city since early September. Although Atlas had heard of the outbreak, she never imagined she too could be infected.

After developing the tell-tale symptoms – continuous vomiting, watery diarrhoea, a severe headache and sunken eyes – she was diagnosed with cholera at a treatment centre set up by the local health department and MSF.

"It's very rare to get cholera in the rural areas," says Atlas. "We just hear about outbreaks in Harare and it ends there."

Cholera develops after ingesting contaminated food or liquid. It causes severe dehydration and even death if left untreated, but prevention is simple with good hygiene and sanitation practices and safe drinking water. In Zimbabwe, outbreaks of the disease are common during the rainy season in November until the end of May.

"I am going to teach my child to wash her hands before handling food, before eating and after using the toilet. She must use cups that are clean," explains Atlas.

Atlas is one of many patients who were affected by cholera in Harare, after the outbreak was officially declared an emergency on 12 September. It is the second largest outbreak of the disease the country has seen, after a devastating epidemic in 2008 left more than 4,000 people dead. The disease claimed more than 60 people and was the fourth outbreak to occur in 2018.

After the first case was reported in Glenview suburb, the disease quickly spread to other residential areas in Harare, with more cases seen across the country. Harare's water system is old and falling apart, causing water loss and contamination from growing dumping sites and sewage.

Densely populated suburbs like Glenview are particularly prone to waterborne diseases, as inadequate supplies of safe water force people to use unsafe alternatives like hand-dug wells and boreholes.

Photo: Atlas Murima (25) from Mashonaland West province in the north of Zimbabwe receives treatment for cholera at the Glenview Cholera Treatment Centre set up by MSF in collaboration with the City of Harare health department in Glenview, Harare. Atlas had travelled to Glenview to visit her sister at the time of the outbreak.

MSF response

When the outbreak was declared, MSF was invited by national authorities to provide logistical and technical support as they mobilised human resources and materials.

"This integrated approach allowed MSF to intervene in a way that was resource efficient," says Bjorn Nissen, MSF's country director in Zimbabwe. "We took on the role of mentor, providing nurses, skilled water and sanitation experts and logisticians at various critical points to build the technical capacity of city and national health authorities."

As the situation evolved, MSF provided case management support, infection control, and technical and logistical support for cholera treatment centres set up in Glenview and at the Beatrice Road Infectious Diseases Hospital. Further technical support was provided at stabilisation centres in Budiriro, Buhera, Chitungwiza and at Harare Central Hospital.

The treatment for cholera is simple but has to be delivered swiftly. In the treatment centres, patients were rehydrated with oral rehydration solution and intravenous fluids, while suspected cholera cases in communities were encouraged to make their own salt and sugar solutions before reaching clinics.

"MSF places critical importance on saving lives. The patient is at the centre of everything we do. So we identified gaps and adapted to what was needed," says MSF's emergency coordinator, Farayi Marume. "We trained nurses on how to manage patients so that they work according to international standards, provided resources to run the centres and trained general workers and nurse's aides on infection control."

MSF also supported the planning and management of vaccination campaigns mounted by the health ministry, with support from the World Health Organization (WHO) and other partners, in order to prevent the spread of cholera. The first two phases, launched on 3 and 15 October respectively, vaccinated around 760,000 people in four Harare suburbs as well as Epworth and Chitungwiza. The third phase of the campaign which starts on 25 October, is targeting 714 760 people in nine suburbs in Harare.

MSF has been responding to recurrent outbreaks of cholera and typhoid in Zimbabwe, particularly in Harare, since 2008. In 2018 alone, MSF has supported the response to eight outbreaks of cholera and typhoid across the country.

Photo : A water point managed by members of the Kuwirirana community health club in Glenview, Harare. Kuwirirana community health club is one of the 60 community health clubs in high density areas of Harare created by MSF since 2015 to promote sustainable water, sanitation

Preventing outbreaks with longer term solutions

Since 2015, MSF has been developing solutions to bring safe, clean water to vulnerable communities in high density suburbs in Harare. Teams have been drilling new boreholes and upgrading existing ones to help prevent waterborne diseases in the city. A crucial element of these efforts has been empowering communities to manage and maintain water points through trained community health clubs. Committee members oversee the provision of clean water to members who contribute a small monthly fee to pay for chlorine and maintenance of the points. Over 70 rehabilitated boreholes are now managed by more than 60 community health clubs in 13 high density residential suburbs in Harare.

Mrs Caltas Hlerima, a community based facilitator and member of of the Kuwirirana Community Health Club in Glenview Harare

> **“We did not encounter any problems when the Cholera outbreak started and none of the people who fetch water from this water point was affected by cholera”**
>
> **Mrs Caltas Hlerima,** *Community Based Facilitator*

The importance of community health clubs

When the outbreak began in September, the importance of the community health clubs – particularly those in the most cholera affected suburbs including Glenview, Budiriro, Mbare and Glen Norah – became very apparent. Members trained in water and hygiene safety immediately started conducting door to door health education campaigns and sharing knowledge with their communities to prevent the further spread of cholera.

“When the outbreak was declared, we already had information. We had learnt about the causes of cholera and ways of preventing it. We had clean water which we were treating. So we immediately started to teach others in the community about the disease,” said Rachel Marodza, a member of the Kuwirirana community health club in Glenview.

These health promotion activities, and the provision of clean water may likely have prevented some members of these communities from being affected by cholera. An initial survey conducted by MSF of 16 community health clubs covering more than 8,000 people in the four most affected suburbs found only 4 suspected cholera cases. As the outbreak progressed, a significant number of new community members signed up to receive clean water. Follow up continues of the remaining 45 community health clubs.

“In our area, we haven’t seen anyone with cholera, while others nearby – who don’t fetch water from our water point – were infected,” said Caltas Hlerima, a community-based facilitator for Kuwirirana Community health club.

As the cholera outbreak subsides, the importance of sustainable water solutions to ensure a continuous supply of clean drinking water is vital. MSF will continue to provide emergency support during outbreaks, while building longer term solutions – owned by communities themselves – for the future. ■

7

WASH

MSF STRENGTHENS EFFORT TO COMBAT WATER BORNE DISEASES IN HARARE

MSF has been working to address the frequent outbreaks of water borne diseases like cholera and typhoid in the Matapi area of Mbare, one of the most densely populated suburbs of Harare by implementing a safe water distribution network connected to three high yielding boreholes, drilled and constructed using industry-standard drilling and cementation techniques.

Constructed in collaboration with the City of Harare (COH) and UNICEF, the water distribution network will soon provide safe drinking water to communities in the Matapi flats area.

“When we first started rehabilitating boreholes, MSF’s WASH team noticed there were problems with the way older boreholes had been situated, drilled and constructed. The boreholes were mainly relying on shallow aquifers which are prone to contamination.

Many sanitary seals were either not placed properly or there were no sanitary seals at all. These poor practices meant that older boreholes were still being easily contaminated, making them a public health risk,” **Danish Malik,** *MSF WASH Project Coordinator.*

Through this experience, MSF WASH team identified the strong need to introduce improved borehole siting, drilling and construction techniques to the borehole drilling industry in Zimbabwe.

Through its WASH program, MSF has rehabilitated 70 existing boreholes providing safe and sufficient water to communities and institutions like churches, clinics and schools across Harare since 2015. These boreholes were rehabilitated using a unique borehole diagnostic tool kit, mounted in a self-contained vehicle.

The Mbare intervention is not only aimed at providing safe, clean water to communities living in vulnerable situations but is also training different stakeholders from various WASH-related organizations on how to site, drill and construct boreholes in accordance with the geology of the ground as well as correctly placing sanitary seals to protect the newly drilled boreholes.

At the end of 2017, MSF introduced a new generation of boreholes by siting and drilling six new boreholes in two suburbs of Harare, through a joint collaboration with partner organizations including the District Development Fund (DDF), WaterNet and UNICEF. Since then, no incidents of water contamination from these newly drilled boreholes have been reported. In the second phase of the project, MSF tested the same techniques in Matapi, Mbare, where three boreholes were sited using 2D Electrical Resistivity Tomography (ERT) surveying methods and drilled with the new drilling and cementation techniques. The water quality analysis results showing “zero” bacteriological and chemical contamination.

The Mbare intervention is not only aimed at providing safe, clean water to communities living in vulnerable situations but is also training different stakeholders from various WASH-related organizations on how to site, drill and construct boreholes in accordance with the geology of the ground as well as correctly placing sanitary seals to protect the newly drilled boreholes.

The depth of the sanitary seal depends on the local geology and the depth of the contaminated shallow water aquifers present at each site. So far, MSF has cemented newly drilled boreholes at Mbare up to 30 meters thus ensuring a long-term safe water supply to the community with an anticipated reduction in diarrheal diseases.

The sanitary seal itself is the mixture of water and cement, mixed together in the proportions to acquire the density of 1.8 kg/m3 and is injected in between the steel casing and the geologic formations inside the target borehole to make a proper seal.

Both the Zimbabwe National Water Authority (ZINWA) and DDF have now sought information from MSF on purchasing borehole siting equipment, with reports that some new boreholes have been constructed through the DDF platform using the new drilling and construction methods.

The WASH project will continue as a regional project supporting MSF projects in Southern Africa, but also developing much needed WASH techniques for the organisation.

The project plans to disseminate a good practice WASH toolkit, which will include:

1. How to set up a WASH Community Health Club in an urban setting

2. Diagnostic: How to troubleshoot a borehole and make targeted and rational interventions, building on findings from the Niger WASH project

3. Cementation: How to protect the water source from contamination

4. Geophysical: How to drill in best location for maximum water yield

New and innovative portfolios will be piloted in 2019 with the ambition to keep the time from idea to pilot to roll-out as short as possible. ■

Thanks to advanced borehole siting techniques, the drilled boreholes hit the right lithological contacts (surfaces that separate rock bodies of different lithologies, or rock types) deep in the ground, increasing the borehole yields. The the newly drilled boreholes reach up to 15,000liters/hour and in some cases up to 40,000 liters/hour.

8 WASH

"HOW GIS SUPPORT IS IMPACTING MY WORK"

Kudakwashe Sigobodhla – HP and IEC Officer – WASH Project

" GIS has helped me in carrying out my work through the use of coordinates. Since position is the underlying factor connecting all things in GIS, I have been able to quickly locate the correct communities for each borehole area I work in and mobilize them regarding their proximity to the water point. This in turn saves me a lot of time in carrying out my work by eliminating errors due to wrong locations/positions. When the community health clubs I work with have been placed on a map, I can easily keep track of the progress on their sessions and monitor progress on the community trainings which helps me strategize my support to them. Navigation apps such as Osmand have helped me not to get lost when I'm working in areas that I'm unfamiliar with. GIS has really helped my work get easier!" ■

Geographic Information System (GIS) is a system which links locational (spatial) information and enables a person to visualize patterns, relationships and trends. This process helps one achieve a unique type of data analysis that cannot be observed in a table or list format. This type of information system uses gepgraphy as its organizing principle. GIS involves the use of maps, starting from basic use of maps in the field to the use of GPS, remote sensing (satellite imagery), and all kinds of geo-referenced information (location, of boreholes, patients, buildings etc)

Photo left : HPV vaccination for Gutu

The roll-out of the HPV vaccination campaign gave GIS another opportunity to showcase the endless possibilities of improving efficiency in delivery of health services to the community. The campaign was to be done for the whole district of Gutu (7053km2) for approximately 14600 children distributed in 240 sites throughout the district in a timeframe of 9 days at most. To ensure a proper plan was made for logistics, an update of the road network was done through the activation of the Missing Maps community who helped capture the base geo-data used for the mapping. Thereafter the planning of the daily fleet movement was done using spatial analysis tool, whereby the most efficient routes for each team was selected as well as the optimum sequence of flow for the vaccination points. To bring the results closer to reality, algorithms were applied during the analysis inorder to make approximate vaccination time calculations at each station as well as the time spent travelling. The end result was a compilation of daily maps used by the team in the field and a worksheet containing vaccination station data such as number of beneficiaries, distance between the next station including travel time as well as the expected time spent during vaccination at a station. ■

My first experience with GIS was in 2017 as we worked on an HIV project for people in a hard to reach (Remote) settings in Mwenezi Project. The district is one of the largest in the country with vast amounts of land which is mainly involved in farming. Due to the population redistribution due to the land reform program, 83% of the population has no ready access to health facilities. With the help of GIS, we were able to map the spatial distribution of the health facilities as related to the human settlement. This wonderful illustration became the focus of a poster presentation which was subsequently presented in at a gathering in Maputo, Mozambique. Furthermore, because of this striking analysis achieved by this mapping we then set out to develop a differentiated service delivery concept that would see the area of un-serviced people greatly reduced using the outreach model and and the recently launched Out of Facility model. The most amazing thing that GIS did was to take a dire situation, visualize it and make it a scientific, measurable reality. Indeed I now understand why they say a picture is worth a thousand words!!

(Written by Last Mufooya, MIS GIS Specialist)

Dr Edson Chidovi

Mbare suburb has been the most recent hub of recurring typhoid outbreaks in Harare off lately. The MSF (WASH project) in collaboration with City of Harare and other partners are working to improve the access to clean water as well as better sanitation infrastructure in the Matapi flats area a section of Mbare, which was the epicenter of the last outbreak. Geographic Information Systems has been playing a pivotal role in the process of achieving this goal. Firstly the mapping of existing boreholes in the area was made then a selection of suitable sites for drilling new borehole sites was done coupled with geophysical surveys of the area to determine hydrogeological character of the area and select the exact locations to drill, 3 of the 4 drilled sites produced extremely good yields of water when tested. Currently plan is underway to design a water supply network system to provide the community with water obtained from these drilled boreholes which will first be pumped into a mega-reservoir, treated before being supplied to the community through gravitation. So the topography of the terrain was mapped after measuring the spot heights of ground points in a grid pattern then interpolating the heights to produce a contour map of the terrain. Since the water is to be supplied to taps using gravitational means, height difference was measured using high precision GPS equipment only for the major points of concern i.e. borehole (source of water), reservoir (storage) and proposed supply point locations (outlet taps). The final design of the system is shown in the map below. The system is will potentially supply the 30000 residents of Matapi and will definitely ease the water shortages in the area thanks to the support of MSF and City of Harare.

MSF GIS Specialist, Last Mufoya and driver John Katumbadza share a light moment during a topographical survey for water network installations in the Matapi area, in Mbare

9 CHIPINGE

MSF SUPPORTS MOHCC TO LAUNCH CHRONIC CARE CLINIC IN CHIPINGE

Patients awaiting consultation at the newly constructed chronic care clinic in Chipinge

*Paurosi Chimusoro (65) from Chipinge is not only living with HIV, but he also suffers from diabetes and hypertension.

He started taking antiretrovirals in 2008 before he was diagnosed of hypertension in 2016 and diabetes in 2017.

Every day he takes 11 tablets to treat his various conditions. Taking this amount of pills makes him continually sleepy and he often feels like he's overdosing himself.
Paurosi wishes he could take his drugs together, in a fixed combination so that he would only need to take two or even one tablet a day, just as he does with his HIV medication. The treatment for HIV has long been simplified by combining three antiretrovirals in one daily pill, easing patients' lives in many ways.
"I wish I could take at least two tablets or even one tablet, just like we do for HIV," says Paurosi. "Every time I take 11 tablets, I feel like I am overdosing."

Paurosi is one of many people in Zimbabwe who live with more than one health condition. Like him, many struggle to take different types of medication for various conditions, not to mention the time and travel costs that result from visiting the nearest clinic to collect medication on different days.

In 2016, MSF piloted a project with the Ministry of Health and Child Care (MoHCC) to provide treatment, care and support to patients with non-communicable diseases (NCDs) with a specific focus on hypertension and diabetes in nine clinics and two district hospitals in Chipinge using a mentoring approach.

A team of MSF doctors and nurses visited the supported health facilities every two weeks to provide mentoring services to MoHCC staff on the management of NCDs and other medical conditions like HIV and TB.

During their routine visits, the MSF medical team in collaboration with MoHCC, noted that there were a number of patients who were affected by many conditions and in need of comprehensive treatment for all conditions. People living with HIV are more susceptible to infections and are more likely to be affected by diseases such as tuberculosis, hypertention and diabetes.

"Patients who are HIV negative were being seen at the out-patients department (OPD) by the same medical team. The massive influx of patients on a limited number of days led to overcrowding of the OPD, to the extent that the emergency department was overwhelmed by patients in need of chronic care," said Mr Mbofana.

To overcome the hurdle, MoHCC with support from MSF decided to construct the Chronic Care Clinic (CCC) at St Peter's Hospital in Checheche to provide comprehensive treatment to patients with many conditions thereby integrating services, saving costs and time. The Chronic Care Clinic consists of two consultation rooms, a pharmacy, dispensary, the Opportunistic Infections Clinic and its waiting area.

The Chronic Care Clinic was launched recently at St Peters Hospital in Checheche to integrate HIV and NCD services, thus decongesting the outpatient department.

"Patients living with both HIV and NCDs will now receive comprehensive treatment in one place at the same time, by the same staff, thus saving time and money," said Mr Mbofana.

The model of care used was adapted to suit the rural context. Nurse led diagnosis and management approach was used at the primary and secondary health levels. The clinic will provide services through nurses but will refer complicated cases to doctors.

Setting up nurse-led NCD services at the Chronic Care Clinic at St Peter's Mission Hospital means task-shifting of diagnosis and management of hypertension and/or diabetes to nurses and task sharing with doctors for complicated cases.

" While providing treatment to HIV and tuberculosis (TB) patients at the Opportunistic Infections (OI) clinic, MoHCC and MSF continued to see many patients with hypertention and diabetes"

Dr Nisbert Mukumbi

Delegates attending the launch of the Chronic Care Clinic in Chipinge

"Task shifting and introducing nurse led NCD services is possible and necessary in resource constrained settings. We hope MoHCC and other service providers will adopt the model,"

Nisbert Mukumbi, *MSF Doctor*

This pilot has demonstrated that with adequate investment, including ensuring the availability of affordable medication, it is possible for diseases like hypertention and diabetes to be managed in primary health facilities – and this will save lives, added Dr Mukumbi.

According to the World Health Organisation, diabetes and hypertension are among the leading causes of deaths globally. In Zimbabwe, NCDs are estimated to account for 31 percent of total deaths (WHO).
Although the disease burden from NCDs is rapidly increasing, little is known on how to provide access to NCD care in rural settings and in environments where resources such as medicines or diagnostic services are not always available. While other diseases such as HIV/AIDS, Tuberculosis and other communicable diseases have received much attention, little has been done about NCDs, which have become silent killers.

There is a need to continue to adapt different models of service that can target different vulnerable groups, just like what was done with success in the field of HIV where so-called Community Art Refill Groups (CARGS) have proved to be sustainable. There is need for patient education/ patient empowerment/ patient self-management and what we in the end call expert patients, said doctor Mukumbi. ■

**Name changed to maintain confidentiality*

10 CHIPINGE

"I wish I could take only one pill instead of taking many tablets"

Lillian Tandaanguni (63) from Mugadza village in Chipinge tested HIV positive in April 2006 and she was initiated on antiretroviral treatment (ART) in December of the same year.

She was diagnosed of diabetes and hypertension in 2017. She is taking a total of nine tablets but she complains that the taste of the tablets is not very nice.

She is supposed to take six tablets in the morning and three tablets in the evening but she is now taking three tablets only.
"The tablets make me feel nauseous, very hungry and I sweat a lot after taking the tablets. Because of these side effects, I have decided to stop taking all nine tablets, but I am now taking only three tablets," says Lillian.

She is getting her medication for free from at Mutema clinic in Chipinge, with support from MSF.

"I keep my tablets in my purse so that I don't forget to take them and also, so that children do not take them. I have labelled the different containers where I keep the tablets.

"I don't normally forget to take my tablets but on two occasions, I took the wrong tablets because I had mixed them up.

"I was also told about the benefits of eating healthy food. Ever since, I stopped eating junk food, I can now feel the difference.

"I used to spend a lot of time sleeping and I was unable to work for two years but I am now able to work in the field.

"I wish the number of tablets could be reduced to one just like we do for ART, because it is painful for me to take many tablets," says Lillian.

11 CHIPINGE

UNWANTED GUESTS OR 'THE WRITING ON THE WALL'

Zozomera Zozomera, Chipinge project Logistician and Barbara Jung, Field Coordinator

The first person to discover them was Zozo, the Logistician. He actually went to inspect the newly installed Air Conditioner in a clinical attachment to an MSF-supported hospital.

The new Chronic Care Clinic was supposed to look attractive, clean, and should be ready to accept patients in a pleasant environment. Entering one of the consultation rooms, Zozo saw brown lines above the light switch. He suspected a child could have drawn a picture showing a branch of a tree without leaves using brown chalk. 'Must have been quite a tall kid, though,' he concluded.

He approached the mysterious writing on the wall, scratched a bit with a key and found a vibrant community of termites moving like cyclists on a mud road. As he knew them coming up from the ground not in the middle of a wall, he was slightly confused and decided to investigate the matter with criminological feel. He then walked around the building to see if there are more and definitely, there were more, a lot more!

With a public event on the agenda and limited time left, Zozo right away took action and bought a chemical product with the intention to kill – totally against MSF principles. The chemical apparently consisted of old engine oil and proved not to be strong enough. For a few days the unwanted

visitors stopped chewing up the wall but only to come back with renewed energy. Zozo looked at the photos Barbara (PC) showed him, which clearly provided evidence of continued activism. Now he knew, he needed to fire back with heavier ammunition. He injected carboliniam (chemical used to treat gum poles used for electricity overhead wires locally) into the small holes the termites had dug and this was the last he saw of them on the new building.

This was not end though. While Zozo was fighting his war, the laboratory staff saw him and informed that there was the same problem in the laboratory. Thinking of the wooden cabinets in the laboratory facility, he immediately became aware that trouble was brewing because wood is highly popular on the dietary plans of termites. What they've eaten up is filled with mud in a clever way, so that they leave only the outer layer of the wood and people thing it is still there, while the inside is hollow. Entering the laboratory, Zozo hit one of the cabinet doors and it simply fell off. He then knew what had happened. This was hard because even the cabolinium did not work until mixed with used oil and so-called 'termite poison'. They sprayed, applied, and injected everywhere in the laboratory leaving an infernal smell and a chemically infested lab. So far the beasts disappeared but Zozo and the laboratory staff are alert and still wondering when the termites will reappear again. ■

Lesson learned: When locating a construction site, it is crucial to first treat the ground as part of the construction process so that things won't have to be redone over and over again. Even though termites also have the right to live (do they?), it is important to show them the limits and apply chemicals that do not kill but relocate them.

12

COORDINATION

Virginia Garanewako, the Supply Chain Officer for MSF Zimbabwe recently returned from Lebanon where she was on detachment for three months from 15 April to 15 July, 2018 as Supply Team Leader.

"During my detachment, I experienced working in a refugee environment which is different from our context"

"I was detached as a Supply Team Leader in the Lebanon Mission for a period of three months (15 April to 15 July 2018). I worked in the Supply department supporting the Bar Elisa Project where there was a construction of a new hospital for refugees. Lebanon is a mission which has four projects namely, Shatila (a refugee camp), Akkar Refugee Camp, Saida and Bar Elias. MSF is intervening in a context where an estimated 1.5 million Syrians have sought refuge in Lebanon since the beginning of the war in Syria in 2011. MSF is working in two Palestinian Refugee camps (established in 1949) where most of the services for Palestinian Refugees are covered by the UN Relief and Works Agency (UNWRA). Syrian Refugees are being provided assistance through the UN Refugee Agency (UNHCR). MSF manages a primary health care center (PHC) with pediatric, chronic diseases and mental health consultations, vaccinations, health promotion and referrals for emergency/complicated cases; and a women's health center (WHC) with sexual and reproductive health consultations, normal deliveries, referral of complicated pregnancies and neonatal emergencies. During my detachment, I experienced working in a refugee environment which is different from our HIV context. Within my profession, I leant more on management of contracts for both log medical supplies. I also got to understand the Lebanon Drug Procurement Policy where the Ministry of Health (MOH) has a database of all regulated drugs with prices on their website and 97 percent of the drugs are locally purchased. The government has validated their own distributors to do the importations and MSF has to choose from those validated Agents or distributors and the prices are guided by MOH. The purchase was quote unique in the sense that we were to procure for a newly built hospital. We had to procure almost 300 medical devices receiving quotations from 17 suppliers and do the analysis process for all the quotes and negotiate for fixed price discounts. I also learnt the process of Supplier validation and development of Key Performance Indicators (KPIs). The purchasing process includes the purchase of Biomed devices, Hospital Detergents, Basic Surgery Sets, Amputation Surgery Sets, Abdominal Surgery Sets, and Plastic Surgery Sets etc. Further to that I was also involved in the formulation of supply key performance indicators, monitoring and evaluation of the KPIs against our supplier as well as standardization of requirements within the mission. I was also involved in the ethics of handling tenders, giving feedback to suppliers as well as awarding the contracts. My contribution was on having a flexible standard list that has more brands validated on medical supplies, more drug strengths on medical drugs as a way of smoothening the supply process. I also made recommendations on validation on suppliers of recurring materials and printing services and shared the database within the mission because all the projects are located close to the coordination office and they share the same market. Back to my mission, I brought the same knowledge of having a well-defined SDL database for all projects; the use of tracking sheets for order follow ups and backorder monitoring. Lebanon mission has drug database with prices controlled by MOH. 97 percent is local purchase and only three percent is on exceptional validation for importation. My expectations were to support in procuring all the requirements for the kick start of Bar Elias Hospital but we had to postpone the procuring process due to the delays by the contractor in finishing the hospital construction. So it was my wish to leave Bar Elisa Hospital functioning."

Tawanda Mutungama's detachment experience in Mozambique

Tawanda Mutungama (third from rght) with Finance team members in Mozambique

Tawanda Mutungama, the Accountancy Manager for MSF Zimbabwe recently returned from a three months mission in Mozambique from June to August 2018 as Finance and Accountancy Manager. Tawanda was in Mozambique from Tawanda's expectations for the detachment were; to have a good manager supervising him, to have a friendly team that is committed to work so that he could achieve the set goals for the mission. He also expected to live in a comfortable home and be able to communicate well considering that Mozambique is a Portuguese speaking country.

Tawanda's expectations were fully met and he enjoyed the mission as the team was friendly, hardworking and kind. The Financial Coordinator, Gustavo, was a pleasure to work with. Sharing the house allowed friendships to be made and all in all the goals for the mission were met, as indicated by the positive evaluation.

The detachment experience was very positive and a learning experience. Tawanda learnt to lead an international team as well as to inspire team members that did not share the same nationality as himself. He also learnt to share a house with people who came from cultures different from his own and to live in a country that is not his own for a longer period than what he was used to.

Zimbabwe mission is bigger than the Mozambique Mission. The quality of work in both missions is good. Tawanda's team in Zimbabwe can learn how to become more valuable to MSF from the team in Mozambique. Language was a barrier, but Google Translate was a bridge to the challenge.

Tawanda was not aware of his ability to inspire and coach a team from a different country. He did not know he had this skill within him. He will apply this attribute in his work in Zimbabwe to influence his team to bring quality service to the Zimbabwean beneficiaries.

As icing on the achievements of the detachment, a baby boy was born to his family in his absence and in honor of him, was named after him in his absence. He would like to influence many to desire and pursue detachment, it is a blessing indeed.

Tawanda learnt to lead an international team as well as to inspire team members that did not share the same background as him.

13

SRH

MSF OFFERS YOUTH FREE SEXUAL AND REPRODUCTIVE HEALTH SERVICES DURING THE HARARE AGRICULTURAL SHOW

During the Harare Agricultural Show (Monday 27 August to Saturday, 1 September, 2018) MSF provided free sexual and reproductive health (SRH) services with specific focus on people aged between 10 to 24 years.

MSF partnered with the National AIDS Council (NAC), Young Peoples' Network on Sexual and Reproductive Health, HIV and AIDS (YPNSRHHA) to provide a range of SRH services that included HIV testing and counselling, screening for sexually transmitted infections (STIs), contraception, general health check-ups and health information.

"As MSF, we decided to provide services at the show as a way of profiling SRH services and why they are important particularly for young people,"
Mr Brian Hove, *Assistant Project Coordinator, MSF Mbare Project.*

"In Mbare, where MSF has been providing free SRH services to adolescents in collaboration with the City of Harare health department since 2015, we have seen that many young people don't access sexual and reproductive health services due to a host of barriers that prevent them," said Mr Hove.

The barriers that prevent young people from accessing SRH services include user fees, health service providers' attitudes, stigma and discrimination, lack of knowledge and cultural beliefs. For example, adults believe that issues of sexual and reproductive health are for adults only while ignoring the fact that many adolescents are already sexually active and at risk of unplanned pregnancies, and contracting sexually transmitted infections including HIV.

"We would like to encourage young people to access sexual and reproductive health services which include health education, HIV testing and counseling, STI screening and treatment, and medical services for survivors of sexual violence to prevent sexually transmitted infections and pregnancy," said Mr Hove.

"We also want to encourage parents and guardians to allow their children to access sexual and reproductive health services and information free of charge. It is better for the young people to access SRH services and prevent themselves from sexually transmitted infections than for them to be infected. If parents and guardians allow young people to access sexual and reproductive health services, it would also help to fight HIV and empower them to make informed choices," explained Mr Hove. ■

Mr Brian Hove

14

SGBV

MSF OFFICIALLY HANDS OVER THE SGBV PROJECT TO THE CITY OF HARARE

After seven years of providing quality treatment, care and support to survivors of sexual violence, MSF officially handed over the Sexual and Gender Based Violence (SGBV) project to the City of Harare health department at the end of November 2018.

MSF started the Sexual and gender based violence (SGBV) project in Mbare in 2011 in collaboration with the City of Harare health department after conducting a baseline survey which showed that there were many incidences of sexual violence in Mbare but the majority of people were not seeking help and the services provided were not adequate.
Since inception of the SGBV project in 2011, MSF had been providing free, confidential medical treatment and psycho-social support to survivors of sexual violence.

Between 2011 and 2017, more than 8200 survivors of sexual violence received comprehensive care at the clinic. Of these survivors, seven out of ten were children and adolescents below the age of 15 years while in eight out of ten of the cases, the perpetrators of sexual violence were people that were known either by the child or the family.

MSF was working with the City of Harare Health Department in Mbare and eight other polyclinics (in Glenview, Budiriro, Kuwadzana, Mabvuku, Hatcliff, Rujeko – Dzivarasekwa and Rutsanana - Glen Norah) where SGBV services were decentralized to provide free, confidential medical treatment and psycho-social support to survivors of sexual violence, and referrals for legal aid. The roll out of SGBV services will now continue under the leadership of the City of Harare and other partners.

MSF created a center of excellence where more than 100 nurses were trained on SGBV management and close to a 100 nurses were attached to the Edith Opperman clinic for mentorship.

MSF is confident that the City of Harare with financial support from UNFPA will continue to develop the center of excellence and continue to provide quality SGBV care to all survivors of sexual violence.
MSF support to the City of Harare did not end with the handover of the SGBV project. MSF will continue to provide free sexual and reproductive health services to adolescents at the same clinic.

MSF also officially opened a new adolescent clinic, which is not just disability friendly but also adolescent friendly to make it an attractive and safe place to seek assistance.The free services offered at the clinic include HIV testing, STI screening, contraception, mental health consultations and general health checkups among other things. ■

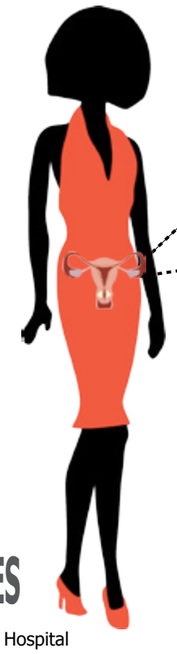
MSF NEWSLETTER ISSUE I/2019

15 CERVICAL CANCER - ONE OF THE TOP KILLER DISEASES FOR WOMEN

MSF started supporting the roll out of MoHCC initiated cervical cancer screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) & Cryotherapy in 2015. It provided the necessary equipment to set up services in 2 districts and 2 rural hospitals, trained and mentored staff from these hospitals in collaboration with a private- not-for-profit hospital in Harare (Newlands).

CERVICAL CANCER:
SCREENING FACILITIES IN GUTU

Gutu is the third largest district in Masvingo Province, with a population of 203.533
The estimated population of women above the age of 15 is 51034, of which an estimated of 8735 are HIV positive. The overall HIV prevalence in the province is at 14.9%.



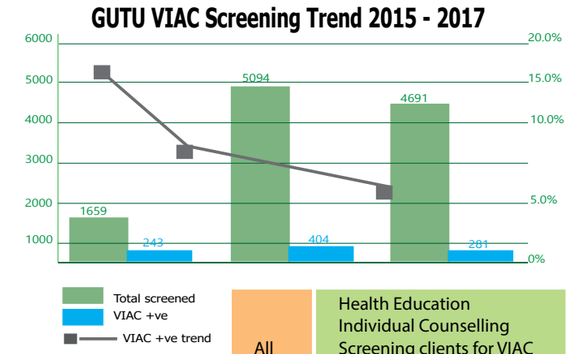
MSF SERVICES OFFERED

Primary prevention, health education/promotion and vaccination

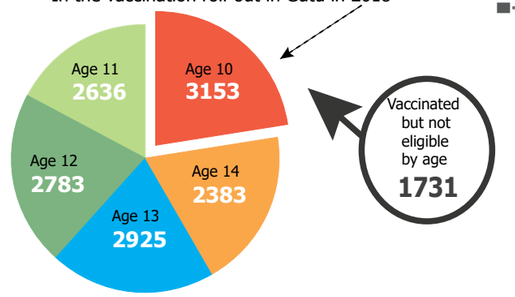
Health education
HPV vaccination

Early detection of pre-cancer lesions: screening

Cytology
Visual Diagnostic Techniques



In the vaccination roll-out in Gutu in 2018



All Facilities	Health Education Individual Counselling Screening clients for VIAC VIAC; Cyrotherapy Breast Examination HIV Testing Testing of STI Referrals
Gutu Rural Hospital	All the above LEEP procedures
Gutu Mission Hospital	All the above Cervical punches biopsies Cervical cancer diagnosis

SET UP FOR CERVICAL CANCER SERVICES

2014
Centralized VIAC set up in the Gutu Mission Hospital
2 nurses were trained

2015
Task force committee formed
VIAC mentorship programme was implemented
Ongoing trainings and referrals to Harare for further management

2016
VIAC services were scaled upto 2 additional health points
Biposy services for suspicious cancer started
Surgical support for patients with early cancer was implemented
5 additional nurses and 1 clinical officer were trained in VIAC

2017
1 MD trained in VIAC and LEEP
4 additional nurses trained in VIAC
Montly mentorship visits and ad-hoc clinical support

2018
HPV vaccination for girls aged 9 - 14 years
Research: HIV +ve women from 15 - 26 years. HPV vaginal swabbing as pre-screening tool for VIAC - vaginal swabbing and detection using Gene xpert

METHODOLOGY

Women are recruited through Health Education in the waiting bays & referred for VIAC and cervicography

For less than 75% Cryotherapy is done.
For more than 75% lesion, the patient is referred for LEEP) to remove lesions from the cervix.

KEY MESSAGES

The decentralization of VIAC and cryotherapy services to increase access to cervical cancer screening

Facilities should be equipped staff trained & mentored, community sensitized on the availability of services

Ongoing mentorship and quality assurance of services and professional development

In 2015, **1659** women were screened and 244 (14.6%) were found VIAC +ve

In 2016, **4787** women were screened and 386 (14.6%) were found VIC +ve and 4349 VIAC-ve

In 2017, **4691** women were screened and 284 (14.6%) were found VIAC +ve and 4352 VIAC-ve

In 2018, **16000** girls from 9 - 14 years were vaccinated in collaboration with MoHCC

WAY FORWARD

1. While implementation all guiding indicators should be laid down
2. Reinforce **condom use** & access to condom
3. HPV vaccination for children (2 doses in a 6-months), girls of 10 years & teenagers prior to first sexual contact
4. Start screening women in HIV/AIDS programmes
5. **"Screen and treat"** on a single visit screen & treatment approach for women aged 30-49 years (WHO recommendation)

MEDECINS SANS FRONTIERES

MSF Principles and Values

CORE MSF HUMANITARIAN PRINCIPLES

- Humanity
- Impartiality
- Independence
- Neutrality

GUIDING STANDARDS

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

OPERATIONAL VALUES

- Proximity
- Transparency
- Accountability
- Voluntarism
- Associative nature

MSF contact details:

9, Bantry Road
Alexandra Park,
Harare,
Zimbabwe.
Tel: +263 242 745823
Email: msfocb-harare@brussels.msf.org
Website: www.msf.org

@MSF_Zimbabwe