WHAT MAKES A MISSION

Zimbabwe 2000 to 2017

MEDECINS SANS FRONTIERES

ACKNOWLEDGEMENTS

Médecins Sans Frontières (MSF) would like to express its heartfelt thanks and gratitude to all members of staff and patients who took time to share their experiences for this book.

MSF would also like to thank all the partners and stakeholders that contributed to the success of MSF's activities over the years. These partners include the Ministry of Health and Child Care (MoHCC), Zimbabwe Prisons and Correctional Services (ZPCS), City of Harare health department, the Ministry of Justice, Legal and Parliamentary Affairs, the University of Zimbabwe, the Department of Psychiatry, international, governmental and non-governmental organisations, UN agencies, various civil society organisations, members of the public, thousands of patients in various MSF projects, national and international staff, among others. MSF is proud of the excellent collaboration and good working relationships that it has enjoyed with all these partners.

MSF would also like to acknowledge the contribution of its donors that made it possible to provide treatment and care to thousands of patients in Zimbabwe. MSF values the independence it is afforded by millions of individual private donors.

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00 PREFACE

‘What makes a mission: Zimbabwe 2000 to 2017’ is a compilation of stories from selected staff and patients who worked with Médecins Sans Frontières (MSF) between 2000 and 2017 in Zimbabwe.

In this book, patients and staff members highlight their experiences of working with MSF. Patients relate how they were assisted by MSF while staff members share their memorable moments of working for MSF in Zimbabwe.

MSF handed over the Harare psychiatry project including the community psychiatry intervention, the prison psychiatric and HIV and tuberculosis (TB) project and the Epworth HIV/TB projects in December 2017.

Chikurubi Maximum Security Prison

MSF handed over its prison psychiatry and HIV/TB project activities to the Zimbabwe Prisons and Correctional Services (ZPCS) on Monday 4 December 2017 after five years of providing quality treatment, care and support to inmates with mental illness at the Chikurubi Maximum Security Prison psychiatric unit and in eight other prisons in the country. MSF also invested in training for ZPCS staff specifically on the World Health Organization's mental health Gap Action Programme (mhGAP) and in advanced management of HIV, TB and multidrug-resistant tuberculosis (MDR-TB), rapid diagnostic testing and infection control among other things.

Epworth

After 11 years of providing quality treatment, care and support for HIV, TB and MDR-TB to the Epworth community, MSF handed over its project activities to the Ministry of Health and Child Care (MoHCC) and partners on Wednesday 6 December 2017.

MSF invested in training for MoHCC staff and in infrastructure development, including building the Overspill clinic, the Epworth opportunistic infection and TB clinic, the pharmacy, laboratory and the partial rehabilitation of the Mission clinic. MSF also introduced the concept of task-shifting (empowering nurses in the absence of medical doctors and training primary care counsellors in the absence of professional counsellors and/or psychologists), as well as decentralising care for HIV and TB, care for survivors of sexual and gender-based violence and the integration of services. MSF invested in community-based models of HIV care and set up visual inspection with acetic acid and cervicography (VIAC) clinics for cervical cancer screening and treatment using cryotherapy and Loop Electrosurgical Excision Procedure (LEEP) at the Overspill and Epworth polyclinics in 2014, among other things. MSF also invested in training 47 community health workers who have contributed immensely to the success of the programme.

Harare psychiatry project

MSF handed over the Harare psychiatry project after a two-year collaboration with the Zimbabwe Ministry of Health and Child Care (MoHCC) and the University of Zimbabwe. MSF has been supporting the MoHCC to provide treatment, care and support for patients with mental illness at the Harare Central Hospital psychiatric unit since October 2015. MSF invested in training for MoHCC staff; in infrastructure development including building the Outpatient Department (OPD), rehabilitating the Inpatient Department (IPD) with 100 beds and the acute admission ward; and improving the overall water and hospital hygiene. MSF also introduced the concept of community psychiatry thereby ensuring the availability of treatment, care and support at the primary health care level (in 13 polyclinics within Harare) for those patients discharged from the Harare psychiatric unit at any given time as well as for the patients from the community concerned.

While MSF's psychiatry projects including prison psychiatry, HIV/TB and Epworth HIV/TB have been handed over to the MoHCC, the ZPCS and other partners, the organisation will continue its projects in Beitbridge, Chipinge, Gutu, Harare, Mutare and Mwenezi, treating patients who are living with HIV, non-communicable diseases like asthma, hypertension and diabetes as well as providing cervical cancer screening and emergency response. In the past, MSF has supported HIV projects in Gweru and Gokwe in the Midlands Province, Tsholotsho in Matabeleland Province, and Buhera and Nyanga in Manicaland province.

MSF national and international staff members from the Coordination office, Epworth, Prison and Harare psychiatric project

> I will miss the humble and hard-working people with whom I worked, the smiles I received from the staff and the patients each time I visited the health facilities. I will miss the community healthcare workers in Epworth a lot. We would not have accomplished much if it were not for their unrelenting efforts.

01 INTRODUCTION – HEAD OF MISSION ABI KEBRA BELAYE

Abi Kebra Belaye joined Médecins Sans Frontières (MSF) in 2001 and has worked with the organisation in Angola, China, Mozambique and Zimbabwe. She joined the Zimbabwe mission as a project coordinator in 2008 before becoming head of mission in June 2013.

I started working in humanitarian aid in 1985 during the famine in Ethiopia. During that time, I was working for another humanitarian organisation in a nutrition programme in northern Ethiopia. MSF had a treatment centre for sick children next to our site. I was impressed by the MSF nurses and doctors who came to visit the children in my block. It was my dream to become a doctor or a nurse one day just like them.

I left my job to study in a nursing school in Addis Ababa, graduating with a distinction in 1988. I was sent back to northern Ethiopia, where I started my nursing career as a clinic manager at the tender age of 20.

In 1991, after three years as a nurse, I left my country. From 1991 to 1999 I had the privilege to travel and work abroad in Italy, Sri Lanka, Eritrea and across other Asian countries. In 2000, I did my Masters in Community Health at the University

A five-year old girl from Epworth who was born HIV negative from an HIV positive mother, as a result of the prevention of mother to child transmission (PMTCT) program. About 90 percent of women on the PMTCT program give birth to an HIV negative child.

Zimbabwe has reduced HIV prevalence from

30%

in the early 2000s to less than

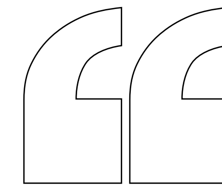
15%

to date

of Liverpool and the following year, I joined MSF. Through the years, I worked as a project manager for MSF in China, Angola, Mozambique and Zimbabwe, but I also worked with other international aid agencies in South Africa and Malawi.

The biggest achievement we take pride in during our mission in Zimbabwe is the change we brought to the country in terms of treating HIV, tuberculosis (TB), multidrug-resistant TB (MDR-TB) and policy change in mental health. I witnessed thousands of people dying of AIDS in Africa. When I came to Zimbabwe as project coordinator in Manicaland province in 2008, we were supporting 26 rural health centres. The HIV prevalence in this community was quite high, with one in four people HIV-positive. However, only doctors were allowed to initiate patients on treatment and there were not many doctors in the province.

Our vision then was to train and empower nurses to start patients on antiretroviral (ARV) treatment, follow HIV patients and provide quality care. Government policy had to change before this happened and MSF led the way towards delegating these tasks to less specialised health staff - by decentralising services, integrating HIV and TB care into existing services and making basic healthcare available to tens of thousands of people. Today, nurses across Zimbabwe are proudly initiating HIV-positive patients on ARV treatment. Prevention of mother-to-child transmission (PMTCT) in Zimbabwe is a success story because of the nurses' involvement.



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Once the policy changed, MSF built two clinics in Epworth and Overspill and trained healthcare workers and community health workers. Currently, the two clinics provide ARV treatment to more than 20,000 HIV-positive patients. Thousands of TB patients have been treated and cured. Among these, thousands have had access to cervical cancer screening and treatment. We also set up a clinic to provide treatment, care and support for survivors of sexual violence.

Zimbabwe has reduced HIV prevalence from 30 per cent in the early 2000s to less than 15 per cent to date. All the activities are being handed over to the Ministry of Health and Child Care (MoHCC).

The second, most beautiful, anecdote is about the first patient to be cured of MDR-TB.[1] Mary was very sick and extremely emaciated when she started on MDR-TB treatment. The MSF team visited her and provided daily treatment. Despite having experienced side effects from the drugs and having little family support, she responded well and was the first MDR-TB patient to be cured in our programme. I remember my own home visit to her, to encourage her to take her medication when tired because of the side effects. She now works as a volunteer at the Epworth Polyclinic and encourages other MDR-TB patients to keep to their treatment. She is my star and the joy within me will never fade! We now have many champions supporting other people affected by MDR-TB.

One of the most challenging experiences was how to craft an inspiring vision and then make it a reality. Our psychiatry project took months of lobbying to get everyone to understand the rationale and urgent need for intervention. We wanted psychiatric patients to be treated with dignity and to receive quality treatment. Our intervention has resulted in policy change. We built a state-of-the-art psychiatry hospital and are lobbying to decentralise psychiatry care. Despite our work on bringing mental health into the open, it is still not getting enough attention and resources in Zimbabwe.

In Chikurubi Maximum Security Prison and Harare Central Hospital we have spent a significant amount of time training and developing staff. We believe the existing MoHCC and Zimbabwe Prison and Correctional Services staff can now provide good quality care despite continuing challenges including a lack of resources (human and financial). We have highlighted the gaps to donors and authorities.

We are handing over the projects because we feel that we have accomplished our mission and now need to focus on other urgent needs.

I will miss the humble and hard-working people with whom I worked, the smiles I received from the staff and the patients each time I visited the health facilities. I will miss the community healthcare workers in Epworth a lot. We would not have accomplished much if it were not for their unrelenting efforts.

I would like to take this opportunity to say a big thank you to all the staff for the remarkable support, commitment and dedication they have shown. I would like to thank them for the fantastic job they have done. Clearly the situation is challenging, the job market is tight in Zimbabwe. They have seen the community needs, have been part of the MSF family and have seen what can be done to help the needy. Therefore they need to have the courage and think outside the box to continue this legacy.

[1] See Mary Marizani's story on page 52

02 PHILOMENA JARAVAZA

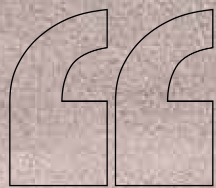
“I really enjoyed giving the cultural briefings to staff because I realised that there are lots of different cultural perspectives.”

Philomena Jaravaza, a nurse, is assistant to MSF’s head of mission. She started working with MSF in 2003 during a cholera outbreak as an assistant medical coordinator. Prior to MSF, Philomena worked with the Ministry of Health for 26 years.

My job entails supporting the head of mission to achieve the mission objectives. I am also the key ‘institutional memory’ entailing lots of documentation and writing. Since 2009, I have worked with six heads of mission and that was a good experience for me, in terms of professional and cultural diversity.

I really enjoyed giving the cultural briefings to staff because I realised that there are lots of different cultural perspectives in terms of individuals. Of course the profession can remain the same but when you go to our partners like Harare City health, Zimbabwe Prisons and Correctional Services, the Ministry of Health and Child Care, you realise that they have a different professional culture from MSF. For example a big smile and a ‘yes’ during the meetings doesn’t mean it’s an automatic approval.

MSF is a free organisation, there is no real dress code, unlike our partners. All our partners are socialised in the white collar job, suit, tie, smart dressing – but at MSF we are ready



I always talk about [principles and values] in meetings, because we want to make sure that staff uphold the principles and values of MSF because this is key to our organisation.

Tanya is eleven years old and is unable to walk. She was diagnosed with HIV when she was just a few months old. She spends a lot of time in and around the house.

for emergencies even in our tekkies, (casual shoes) slippers and caps. But you cannot attend a professional meeting in that attire.

I always talk about [principles and values] in meetings, because we want to make sure that staff uphold the principles and values of MSF because this is key to our organisation. It's like the core of MSF, in place since inception in 1971. They are in our charter and other documents. So we keep reminding people of those principles and values – impartiality, neutrality, independence, humanitarianism, all are important. If we keep reminding people when they are gathered together, the message is reinforced.

The most memorable thing that happened to me in MSF was that personal touch between the patient and the caregiver and MSF as a mission, especially with those conditions that are looked down upon culturally or even professionally in Zimbabwe.

In terms of HIV/AIDS, the formation of football teams among the HIV-positive cohort was a highly memorable event. The teams like the ARV Swallows, the HIV Stigma teams, were really created to form a different type of support group. MSF flew them to South Africa. Some hadn't owned passports before, they had them for the first time. This helped to build their self-esteem – and it was a demonstration of humanitarianism.
This helped with stigma eradication because the belief was that you cannot play football with a [HIV-] positive person, in case they bleed on you or the like. There were patients who were really picked from wheelbarrows and boosted through treatment to the point of being physically fit to play football. This really brought the teams together, not only them but their families and significant others in their lives. This would really attract attention even of future donors.

What I will miss the most is my work. I used to enjoy it to the last minute such that by 4.30pm when everyone is preparing to go home, I have this fresh energy from nowhere. I think it was the level of commitment, the level of job satisfaction that is within me to date, to the point that I enjoy my work, maybe risking workaholism!

03 SABAS OLOMI

“One of the biggest strengths are the systems which we have at MSF.”

Sabas Olomi is MSF’s finance accountancy manager at the Capital Office in Harare. He has worked for MSF since 2012.

Basically, my job is about dealing with the day-to-day finance and accounting issues in the mission. I support the finance staff in the projects, as well as the finance staff in the coordination office, by reviewing their work. I give feedback on what they will be doing on accounting issues, and also if they have any accounting problems that they encounter in the day-to-day work.

I work with them in solving those problems, so that they can focus on their regular jobs. I also assist the financial coordinator in producing budgets and budget control reports, so that we can assist the mission budget-holders in keeping track. This is so that they know where their money is being spent.

The role of MSF is to try to give maximum benefit to the patient, so that everybody knows what was spent in which way and also that our donors know where their money is going.

We try as far as possible to produce timely reports so that all our stakeholders know exactly any issues regarding the spending of the mission’s resources. Though MSF is known for being a medical organisation, one of the biggest strengths are the systems which we have at MSF. For us to be able to deploy those medical resources efficiently, we have a very strong logistic system, an administration system and a strong finance system.

Within MSF, we are valued very highly because people know that, for example, without a proper budget you can’t plan effectively. Without proper financial reports, you can’t meet certain regulatory requirements.

If you can’t plan for the resources it’s difficult for you to use them wisely. My satisfaction comes from my day-to-day solving of problems, especially for the people with whom I work. My role involves trying to troubleshoot issues. People come to me, like the project finance staff, if they have any problems or any issues. Solving those problems on a daily basis is to me, my biggest satisfaction. You know that tomorrow you are going to wake up, and probably they are going to come up with something new, another challenge, another problem. If that is solved I always go home and sleep peacefully.

04 ZOZOMERA ZOZOMERA

“MSF actually is really addictive.”

Zozomera Zozomera from Zimbabwe is a project logistician and has worked with MSF since 2008.

I was born and bred here in Harare. My father is from Malawi and my mother is from Zimbabwe. I joined MSF in 2008 as an assistant logistician.

As logisticians we are here to supply the staff – the doctors and the nurses – with what they need to do their job.

MSF actually is really addictive – once you work for more than three years you get addicted. There is a spirit that comes to you and this spirit, I don’t know where it comes from, you keep wanting more and more. That’s why it’s called the MSF family instead of the MSF organisation. So, it’s like working as a family, and you wouldn’t ever want to leave your family.

What was so rewarding is the experience that I had working with international staff from different parts of the world during the cholera outbreak in Kadoma. It was a huge outbreak. About 16 logisticians from all over the world came, and they were all in Kadoma. I was the only local project logistician by then.

So I learnt a lot of things from all these different logisticians. The experience, skills and knowledge that I got from these logisticians, are still the knowledge and skills that I use today. I was happy to work with these logisticians from all over the world.

The role of logistics is to support medical activities. We will be looking at the end user – our patients – to see whether they have received our stuff and whether what is delivered is what they needed.

So, we track from when the request comes to the destination – to where our service is going. This is basically the role of logistics.

The doctors, the nurses, the psychologist, the occupational therapist – these are the people who are working directly with the beneficiaries and these people need tools to work with. The role of logistics is valued in MSF because what we do is to ensure that they receive those tools. Our department is there to provide that service to them, so that they can also bring the service to the beneficiaries in a better, more standardised way.

I was motivated [to work for MSF] by the spirit that the team had, and also the care that they gave to the patients who were coming in suffering from cholera. This motivated me and I kept on wanting more, until the head of mission asked me if I could sign a short-term contract with MSF. I was so happy to do that and that’s how I joined MSF.

05 EMMERSON GONO

“We managed to change the attitude of staff at Chikurubi. We ended up leaving like a family.”

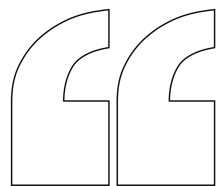
Emmerson Gono, 30, is the deputy project coordinator for the Harare Psychiatric Project. He joined MSF in May 2012 as the founding team leader for the prison-based project.

I was the founding team leader of the Harare Psychiatric Project and we started as a very small team of one nurse, one psychologist and one occupational therapist.

At the beginning, the fact that I was going to work at a maximum security prison with patients who had committed serious crimes, ranging from murder and rape to armed robbery, was a bit scary to me. But it really turned out that it was just a fear in my mind. When we went there, the patients were very loving and receptive.

I remember the first day I set foot in the psychiatric unit, there were so many patients, almost close to 300. There were very few staff from the Zimbabwe Prisons and Correctional Services (ZPCS). The only way they could manage these patients with five nurses was to sedate them with medication, so that they wouldn't be active, so that they were controllable. That first day, when they saw me, with Abi [Zimbabwe head of mission] who was our project coordinator at the time, they tried to come and greet us, but because they were sedated they

MSF provided treatment, care and support to inmates with mental illness at the Chikurubi Maximum Security Prison psychiatric unit from May 2012 to December 2017.



We brought in a lot of activities as diversional therapy such as football, cooking, rabbit-keeping and gardening, which also helped to engage patients in the prison and improve their treatment. I think that way the quality of care really increased.

fell on the ground, they couldn't walk. But still on the ground they tried to smile, drooling saliva. It was so sad. I can't really say that they were dressed. Some had pieces of cloth on their bodies because there were severe shortages of clothes. The sanitation situation, imagine 300 people living in an enclosed area, there is no water to clean the toilets – imagine how the situation is going to be like.

Surprisingly we got lots of support from the officer in charge to the lowest ranking officers when we got there. I think I fitted in earlier than I expected and the relationship that we established from the beginning up to now really is amazing; I never expected that. I think in the five years that we worked in the prison the nature of that relationship really helped to achieve most of our objectives because our partners had accepted us. We started in May, that is when our winter in Zimbabwe starts – the patients slept on the floor, with no bed, no blanket, nothing whatsoever.

After seeing that situation, we quickly made requests to provide clothing for those people so that we could bring dignity to the patients. We provided uniforms, we provided the blankets, we provided the detergents to at least make the environment habitable and prevent the spread of communicable diseases. Also we donated some water storage tanks. We lobbied with other organisations and finally we were lucky, the International Committee of the Red Cross (ICRC) drilled about five boreholes. We donated two 10,000-litre tanks to store water in case there is a power cut so that there is a reservoir of water.

In terms of quality of care, we supported the training of the nurses to increase their knowledge and skills. We also brought in additional human resources, because we came as a team with various skills and backgrounds, which expanded in 2013. We now had four mental health nurses, two clinical psychologists, two occupational therapists and psychiatrists. That gave additional human resources and improved the quality of care. Previously ZPCS didn't have clinical psychologists, a psychiatrist or occupational therapists – only nurses and social workers who were managing all those patients. I think because there was improved knowledge and skills and additional human resources, the quality of care for the patients increased and we also brought in some medication. We brought in a lot of activities as diversional therapy such as football, cooking, rabbit-keeping and gardening, which also helped to engage patients in the prison and improve their treatment. I think that way the quality of care really increased.

I will miss everything about the prison project - it has been part of me. When I came to MSF, I was 24 years old - I was still a very young man. I grew up with the patients. I grew up with the prison officers. We had time together. We had this bond. I will miss the place. I am only glad that we have managed to change a lot of things to do with the perception and everything regarding the staff. I am hoping that even if we leave, the patients that we are leaving will be in the good hands of the ZPCS officers because of the training, the capacity-building that we have done and also everything that we have done together. At MSF, we always meet to part.

06 TRYMORE CHIZHAKA

"When this team from MSF arrived, a lot of things started changing."

Trymore Chizhaka is 42 and from Hwedza. He was discharged from Chikurubi Maximum Security Prison psychiatric unit where he was serving a jail sentence for killing his father.

While at work I started smoking marijuana and drinking alcohol excessively. My father took me to several traditional healers but I did not get better. One day while I was in the midst of an alcohol binge, my father told me that he was not happy with the situation. I got very angry and I took a log and beat my father. He was badly injured and was taken to hospital. He subsequently died. After, the police came to arrest me and charged me with murder. I was sent to Marondera prison and I was incarcerated for two years before appearing at the High Court in May 2010. In his judgement, the judge stated that I had committed the crime while I was mentally ill so he said he was going to be lenient, otherwise I would have been sentenced to death, or to life imprisonment. They opted to send me to Chikurubi Psychiatric Unit, where I would stay either for life or until the health personnel agreed to set me free. When I arrived at Chikurubi there were five psychiatric nurses. Life in prison at that time was very difficult because there was no water, no blankets or clothing for the prisoners. The toilets were always dirty and life was very difficult. I used to wonder if life would ever improve.

Then we heard one day that there were some visitors coming to our unit. I had almost spent one year in the prison by then. That is when I met the MSF staff and they told us they were psychologists who came from university. There were also occupational therapists and registered mental health nurses who had come to assist us. So we were very hopeful and happy that things might change.

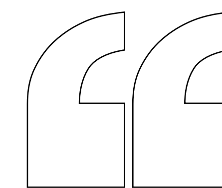
When this team from MSF arrived, a lot of things started changing. They gave us tissue paper because we never used to have that. They disinfected the toilets. They wanted our prison unit to be clean and they cleaned all the cells. They gave us new clothing because they wanted to disinfect the place from lice. There was an infestation of lice at Chikurubi. They disinfected the prison cells and the prisoners were given lotions for protection from lice. We were also given seven blankets each. We were all surprised. More health personnel arrived at the unit coming from various places like Germany and Italy. Things got so much better and there were no longer any lice in our cells. Then they told us that they wanted to improve our diet and they started giving us meat. Our diet improved and we realised that MSF was a good organisation. Later they decided to install water taps and tanks for storage. People were able to have baths and wash their clothes at any time. This also gave me an opportunity to always be clean.

One day, the sister in charge, Makore, called me aside and told me she wanted me to do office work to replace an officer called Danmore who had left. I started working in the office doing various errands.

One day I was called by a social worker, known as Michie, to recommend my release by the board. This was based on good behaviour as seen by the health personnel. They asked me if I had a relative who could vouch for my release. At first my mother came and signed for my release. I had nephews who used to come and visit me regularly. My mother agreed for me to be released but it appears the board was not willing for me to be released into the hands of my mother. There was a fear that I would hurt my mother since she was a woman. They said that they wanted a man to come and vouch for me. The following year there was an attempt to have me released. My younger brother came and signed for my release but the board turned down the proposal on the grounds that my brother was not married. On the third attempt, both my relatives and several health personnel signed for my release on the grounds of good behaviour.

I was released on 14 November 2014 and I finally went home. MSF has been of great help to the prisoners. They would also assist those who wanted to upgrade their educational qualifications. They provided textbooks, exercise books, pens and pencils. So there was no excuse not to take up the offer. I took advantage of this opportunity and I was assisted by another psychiatric patient, who used to be an English teacher. He used to be an accredited examination marker. I told him that I did not have the English subject and he started tutoring me while in prison. I wrote the subject in June and passed. In the future, I want to become a registered mental health nurse so that I can assist patients at Chikurubi.

Inmates with mental illness parade in the service yard at the Chikurubi Maximum Security Prison psychiatric unit.



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07 JACOPO TUBINI

"I find it easy to talk about what I've learnt, because I've learnt a lot."

Jacopo Tubini, from Italy, began his first posting with MSF in June 2016 in Zimbabwe. He is an MSF psychiatrist at Harare Central Hospital Mental Health Unit (HPP) and at Chikurubi Maximum Security Prison psychiatric unit.

I'm a psychiatrist and I'm interested in ethno-psychiatry. Ethno-psychiatry considers that culture is a key factor in the identity of each person; it's one of the factors that influences how a person develops a sickness like mental illness for example. This approach considers it important to study different types of therapeutic tools and ways of treating people. I work in two parts of the project – in the Central Hospital Psychiatric Unit three days a week, or half a week, and half a week in the Chikurubi Maximum Security Prison.

In Chikurubi, I work with the nurses and we see patients together. Slowly we have moved from the nurses just translating for me, to the nurses taking the lead during the consultation with patients. More and more they have become independent and they will be able to take over when we leave. So now it's more about mentoring. Initially we were sitting with the nurses, I was taking notes about the patients and I was asking the nurse to translate (what the patient was saying) from Shona into English and so it was more of a passive role. We have moved from that slowly and they have taken over. Now what happens is that we sit together and sometimes I take the notes, sometimes they take the notes, they talk with the patients and they explore how they are, they talk about their findings and they tell me their decisions about patients and then we discuss [what to do]. Most of the time it goes well and it is what I would have decided to do as well.

I find this work very rewarding and I am happy to have the honour to work on this project. The best relationships I have here are with MSF staff, we are really on the same page and we really have the same ideas about things.

I find it easy to talk about what I've learnt, because I've learnt a lot. I really found it very important for my work as a psychiatrist, from a professional point of view, especially to see how the patients differ from those in Italy in terms of my background.

What I have learnt from here is that if you want changes, you really have to be patient. I think that especially when you first join MSF, you come here and say "okay, I see, I know better, I want to change this and this and this." While that's not the case, if you want to make changes that are meaningful, that remain, they just take time. I have seen that as a group, we have made a big impact as a team, we have made a big impact here at the Harare Hospital, as well as in prison.

Here in HPP we have seen a reduction in over-treatment or over-medication, so we don't often see now a patient lying down or limping because they have been over-medicated. Also the way the doctors' rounds are conducted, I think that in general you can say now that the patients are seen more as people who have their own stories and their own fragilities but have to be considered as a person. They are seen less as objects, meaning that they are not someone whom people treat like objects in the sense that it's not worth discussing things with them, or explaining to them what is going on or about their medication. They are just like us and are in a moment of fragility.

There is a rewarding part when you are treating a patient and then they improve but this is rewarding everywhere, also in Italy. Here it has been more rewarding to see, for example, nurses changing their attitude to patients and trying to manage them, if they are agitated for example, treating them by calming them down and talking to them instead of jumping on them and giving them injections straight away. I hope it will last even when we are not here, just because it works better.

What I will miss here, more than the patients is the way people relate to each other, especially among the MSF staff. I've seen how good they are at handling arguments and how good they are in managing their emotions. I come from a country where it's normal if you are angry to shout at people, to swear at them, also at work. Here I have seen that there is a deep respect for the other person and there is always a way to say "okay, I am angry with you and there's no point in denying it but let's talk about it or let's find other ways to not be so aggressive, other non-violent ways, to address our anger.

08 OMER ABDALLAH

“If there is willingness, then you can unlock the impossible.”

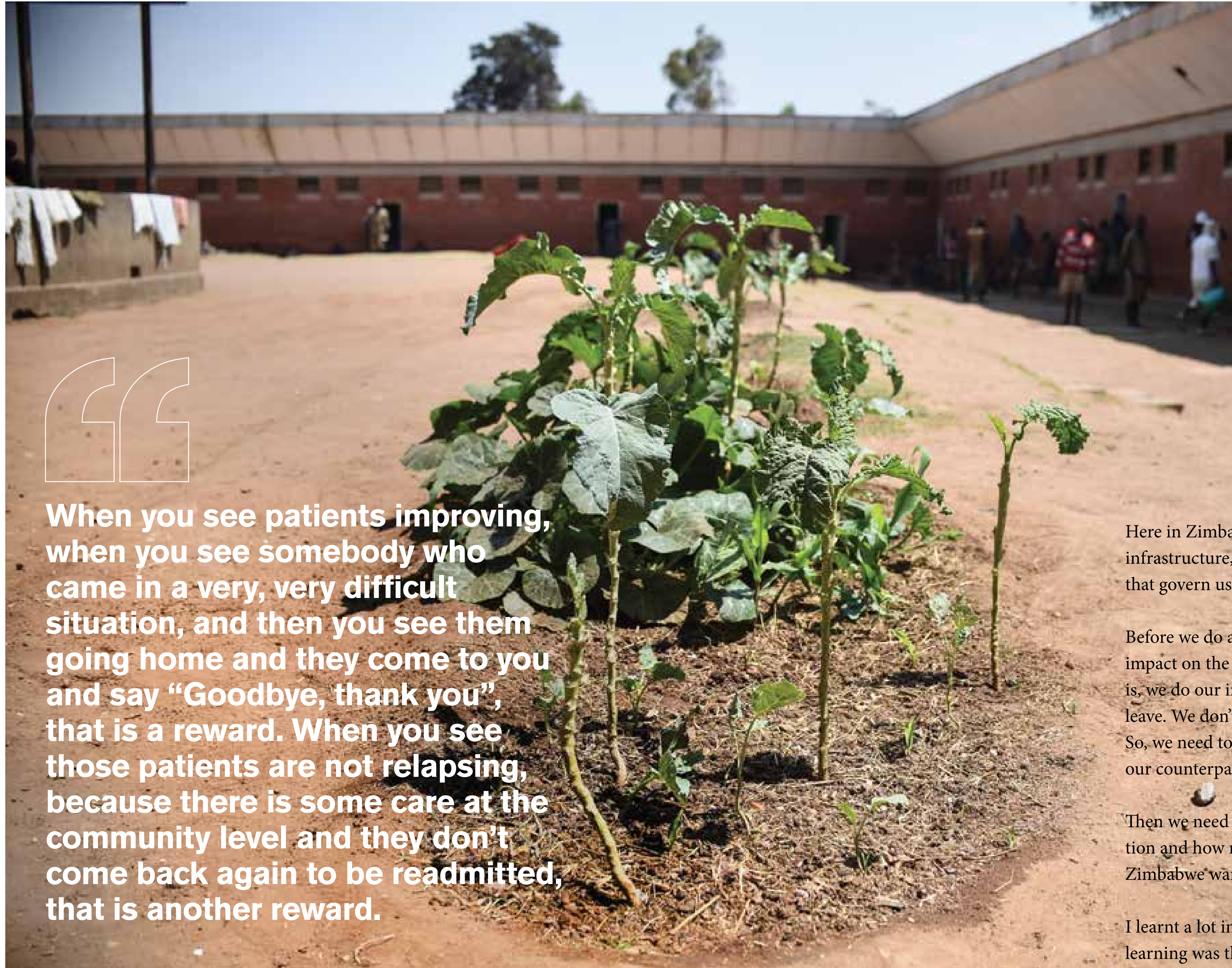
Omer Abdallah is the project coordinator for the Harare Psychiatric Project. He joined MSF in 2009 as a pharmacist in his home country, Sudan. Since that time he has worked for MSF in Pakistan, Turkey, Syria, Libya, Malawi, Jordan and Zimbabwe.

As a project coordinator I am responsible for implementation, monitoring and evaluation of our intervention here and this involves a variety of tasks. It starts with staff supervision, operation supervision and external negotiation and communication, with our different partners, be it with the Ministry of Health and Child Care, the Zimbabwe Prisons and Correctional Services or other partners at community level, maybe local non-governmental organisations.

I am familiar with mental health projects in general. In Libya, we had a Tripoli mental health project. In other projects it was mostly providing counselling and support in Libya, for example, to those victims of war.

When you look at the Harare psychiatric project it is not just one project. I see it as four main projects within one project.

We have the construction which was a project by itself; then



Chikurubi Maximum Security Prison psychiatric unit service yard.

When you see patients improving, when you see somebody who came in a very, very difficult situation, and then you see them going home and they come to you and say "Goodbye, thank you", that is a reward. When you see those patients are not relapsing, because there is some care at the community level and they don't come back again to be readmitted, that is another reward.

we had the discharge activity; we had the prison which has two interventions – psychiatric and HIV; and we have here Harare Central Hospital. We need to work on the policy for mental health in the country, as well as the health system itself – which is quite challenging and demanding.

We are working at central level, polyclinic level – centralised and decentralised approaches at the same time. So, it is quite challenging. However, I can say that I have been privileged to work with my staff here. I have very confident staff who know what they are talking about and what they want to achieve. At the same time collaboration with the Ministry of Health is excellent and I really appreciate it. In Zimbabwe, we are working in a country with a well-established health system, and at the same time, the strategies and ambitions of the country are very clear.

Here in Zimbabwe we already have structures, we have the infrastructure, we have the personnel, we have the regulations that govern us; we have a system.

Before we do anything we need to think in advance about the impact on the general system. So, the overall situation in MSF is, we do our intervention no matter for how long, then we leave. We don't want to hurt the system rather than support it. So, we need to make sure that we are on the same page with our counterparts in the Ministry of Health, or in the prison.

Then we need to ensure also the sustainability of the intervention and how realistic it is, and if it is really what people of Zimbabwe want.

I learnt a lot in Zimbabwe. One of the interesting points of learning was the discharge activities and how to make these sustainable even after we leave. I learnt that if we collaborate together then we can make it happen. When I look back, when I arrived a year ago, in Harare Central Hospital the staff were really well trained but there was a lack of standard operating procedures. So, together with our counterparts in the Ministry of Health, we developed standard operating procedures and then we conducted several training sessions and put in place monitoring tools and processes. Now we see there is a huge difference in patients' care.

Now we managed to bring on board not only MSF and the Ministry of Health but also other stakeholders. We established mental health working groups, which are really working to cascade this decentralisation to the whole of Zimbabwe.

So I see there is awareness about mental health. We did statement papers to call for the whole international community of donors to support mentally ill patients. Now through the working group, we have this plan in advance for patients and we managed to connect those patients to respective polyclinics, even if these are not in Harare itself. One of our objectives was to de-stigmatise mental illness. We wanted people to see it just like another disease like flu and malaria, but it affects the mental wellbeing of people. We did this through networking, we did a lot of presentations with local actors. We have even approached the media. We have done several press releases, we have hosted and supported mental health day commemorations, which had quite good media coverage. I think it is a big campaign and we have started to see the fruits of this.

Of course, one of the main challenges is the lack of an adequate number of mental health professionals in Zimbabwe; be it nurses or psychiatrists, or even the other medical staff involved like psychologists. This remains one of the major challenges. Although we see improvement in psychotropics supplies, it is not satisfactory, we are still lacking supplies here and there. So, in prison, Chikurubi particularly, one of our main challenges is to decongest the psychiatric wing.

When you see patients improving, when you see somebody who came in a very, very difficult situation, and then you see them going home and they come to you and say "Goodbye, thank you", that is a reward. When you see those patients are not relapsing, because there is some care at the community level and they don't come back again to be readmitted, that is another reward.

Let me say that if there is something I can take from my tenure here in Zimbabwe, it will be that if there is willingness, then you can unlock the impossible.

09 VIOLET TSIKIWA

"It was nice to see the butterfly was not stopped by the walls of the prison."

Violet Tsikiwa started working at MSF's Epworth Clinic in 2009 providing occupational therapy services and now provides therapy for patients at Chikurubi Maximum Security Prison.

My role as an occupational therapist involves assessing patients who are within the psychiatric unit.

I need to assess, how does this person function? How are they able to participate in activities in spite of being mentally ill? So my daily routines with a patient in the psychiatric unit would involve comprehensivae history-taking, giving them activities that would help me to do a mental assessment, or what people would also like to call a cognitive assessment.

The activities are used for assessment as well as for treating the patient. So activities of daily living are the activities that you and I do everyday – the most basic, like when you wake up, you comb your hair, you brush your teeth, you bath, you eat, you talk to people. The little things that make us human to start with.

Regarding how the person communicates, interacts with the people around them – you'll find some patients don't understand some of the social rules that we take for granted. They come up very close to you, so you can understand already how they get into trouble once they leave the prison. Outside prison, no one understands that they are not well. So if they go out and they go up very close to someone and offend them, they may get into a fight and then they go back into prison. So you need to teach them about that.

I will never forget the dancing sessions I did with patients. Maybe because I love to dance myself, but also because for myself I found therapy among the patients. I am trying to give them therapy but I also found it very nice and enjoyable and very therapeutic for me. By the time you are done there, you find an ease with the patients. They enjoy it, so anything with a lot of dancing became quite memorable. Anything that took us from those mental health days, when we were dancing with patients, to the ones we organised among ourselves. If we were dancing together, that was always such good energy.

For us when we do the music sessions it doesn't have to be in tune. For us, music is an expression. So we want them to express themselves and if they can do that, even if it doesn't seem like it's in rhythm, that's perfect.

I had a moment when I was in prison when we were playing volleyball and then there was a butterfly that flew across the field, I always talk about it. I had a moment when all the inmates stopped for a while and started running like little children, chasing the butterfly. It's a little thing but in the moment you begin to realise that they miss the things we take for granted. But it was also nice to just watch them. And it was nice to see the butterfly was not stopped by the walls of the prison. It was a poetic moment for me when I watched it and I will never forget it.

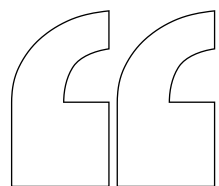
Initially, working in Chikurubi was both scary and exciting. It was a challenge to intervene where no one else seemed to be intervening. I wanted to be part of the group that worked where so many people didn't want to be. There were numerous security checks so at times I felt like I was not as free as the person I wanted to assist. I felt like a prisoner because I was also locked in. Seeing patients was scary at first and I imagined the worst. But as time went by, I realised that the patients were just unfortunate. When I sat down and talked to them, I understood that, despite being incarcerated, they were fathers, brothers, someone's friend or uncle. They had families out there who came to see them, who were hopeful that they would recover and leave prison. I realised that these people in prison uniform would one day wear a shirt and a tie and walk in town like anyone else. They were human beings who needed help. They had a difficult life and I could make myself useful. When I saw beyond their crimes and into their illness and the kind of help they needed and realised what changes I could effect to make this person's life better, I found a lot of motivation.

10 PATRONELLAH CHUMA

"What motivated me was how I was seeing the patients, because they were very ill. They did wrong but they were ill, so I had to help them."

Patronellah Chuma is a senior counsellor for MSF at the Chikurubi HIV project. She has worked for MSF since 2006, in Gweru, Gokwe and Epworth. She joined the prison HIV project in May 2016.

The aim [of the project] was to help the prison staff on the management of HIV and tuberculosis (TB). The idea was to monitor whether inmates were coming for voluntary counselling and testing (VCT) or not. When we arrived, we discovered that there was no counselling in the prison.
My duties were to mentor the prison staff, and to train the peer educators in helping in these cells, with everything for HIV testing.
[This included] pre- and post-test counselling sessions; basic counselling session; ARV treatment one counselling session; TB counselling session and adherence counselling sessions.
We were received well, and the staff were willing to learn.
What we discovered is that, the nurses didn't even know the patients in the halls, they didn't know the number of inmates who were on ARV treatment. But the peers did. Peers take care of those who are ill, washing their clothes and bathing them. I saw that maybe it is a very good idea to train the peer educator first, then train the staff so that they will control and monitor.
The prison staff come every morning with the trollies [with medication]. They are given the medication in directly observed treatment (DOT). They are not allowed to keep the medication in the halls. So I had to train them to facilitate, mobilise, identify the TB patients, those who are very ill, and to monitor adherence. They are helping us to take the sputum from the patients for TB screening.
I trained them to do post-test counselling sessions, but they are not the ones giving results – I was.
Now I am training counsellors to give results, and for basic counselling sessions, basic one and ARV treatment one counselling sessions. They will be doing the basic two, and the ARV treatment two counselling sessions. Then they will do adherence counselling sessions and will monitor whether the patient collects his tablet at the trolley.
The peer educators monitor whether they are taking their medication on time, at the same time. They trace for defaulters. They record all those people who are supposed to come for follow-ups, review dates about viral loads, CD4 counts, ARV treatment initiation and others. [CD4 cell counts give an indication of the health of one's immune system].
They have the registers for that. They have formed support groups in the cells, in order to overcome stigma. Now everyone is free to talk about his status and to ask about the problems he will face.



They have formed support groups in the cells, in order to overcome stigma. Now everyone is free to talk about his status and to ask about the problems he will face.

MSF Counsellor, trains inmates to conduct peer to peer counselling sessions in Chikurubi Maximum Security Prison. MSF piloted a program to train inmates to take roles and responsibilities for their own health and that of their peers through the peer to peer counselling and support. MSF appeals to ZPCS and other partners to cascade the program to other prisons throughout the country.

Someone can refuse to take their medication at the trolley, through fear of being stigmatised by others. Through peer educators giving counselling sessions, awareness and information in the halls, things are changing. They can ask their peers questions if they are not feeling well about the ARV treatment. If their peers cannot answer the question, they come back to us, the counsellors, so that we'll help them. There's a great change there.

Even disclosure was very difficult before. Now they can disclose it to their treatment buddies. This is someone who can help you, or remind you if you fail to take the medication. So I can say that now they are free, they can talk about their status freely.

For those who were not tested, they are willingly coming for VCT, because of the information given by peer educators. Adherence has improved.

In prison there were no review dates. Now the peer educators have the registers. They know who is due for viral load, who is due for initiation, who is due for a basic counselling session – things are in order. They are willing to know their results, especially the viral load results, the TB results or the CD4 count results.

You can see that they want to know their results, to know whether they are improving. They now understand that, yes, we can control this disease. At first they were saying, "we are all going to die anyway."

Early detections of illnesses and TB are reducing opportunistic infections and deaths from these. So there's a great improvement in their health. They are looking better than when we started ARV treatment.

At first it was a challenge because I was afraid, because the people I was going to meet were criminals, but I am not supposed to judge, because I am a counsellor so I take them as they are.

But now, I can move freely, I can communicate with them and you can see that they need help. They come willingly. They want help from us, things have changed. I think working in that type of environment helps a lot because you will know that you are very strong.

What motivated me was how I was seeing the patients, because they were very ill. They did wrong but they were ill, so I had to help them. I wanted to help; that motivated me to say "this one is a human being." Despite some of the things he did, he now understands that he did something wrong, so I must help that person. They were very ill.

Among the memorable moments I had was the time when a client comes to you, an old man crying that he was now missing home saying, "I don't know why I did this, but I am missing home."

Also, just mentoring, peer-to-peer and [to see] these peers now managing, knowing that I've mentored these people and that they can now manage to do these things. I am very proud of myself.

11 ALICE OTIATO

“What keeps me going is the humanitarian aspect. I do this job because I love it. I work for MSF because I like what MSF does. I like the ethics of MSF, I like what MSF stands for.”

Alice Otiato is MSF’s project coordinator at Epworth Clinic, on Harare’s outskirts. She joined MSF in 2012, and has previously worked under MSF missions in South Sudan, Ethiopia and Angola. Alice’s sister was diagnosed with HIV 20 years ago so she understands, on a personal level, what being HIV-positive means.

I started working in Epworth in May 2015. Prior to that, I worked for three years from 2012 in the Midlands region of Zimbabwe at Gokwe district. It was a three year programme, with capacity-building for the Ministry of Health.

I’ve done many previous assignments with MSF, in South Sudan twice, Angola and twice in Ethiopia.

The other missions were emergency missions and the context is different, but the needs are there. They’re different needs. The Ministry of Health is overburdened and the staff need training. Now HIV patients have access to medications they need and nurses are trained to prescribe that medication (antiretroviral (ARV) treatment). MSF has campaigned for access to ARV treatments and donors are helping to pay for those drugs. Now we have the National Pharmacy distributing them to health facilities around the country.

My typical day at Epworth is a busy day. I never know what’s going to come up. We have a cohort of more than 11,000 patients so on average we see 350 to 400 patients a day. On a low day, we see 300 patients. All of them are different: we have children coming in who are HIV-positive, we have mothers, fathers, adolescents, so it is a mixed bag.

What keeps me going is the humanitarian aspect. I do this job because I love it. I work for MSF because I like what MSF does. I like the ethics of MSF, I like what MSF stands for. MSF is able to help the vulnerable, is able to lobby for the voiceless, is able to make a difference. That difference for that patient, when they tell me “thank you” is what drives me, making that simple difference. A child who comes here, dehydrated, very ill, HIV-positive, is started on treatment and then I see the child running around the clinic the next day, that is what keeps me going. A challenge in this country is that patients have to pay for their medication and they have to pay for their medical care. It’s also not easy to get enrolled in medical aid. In Epworth, which is outside Harare, on the periphery, the people who live here are actually displaced because it’s the cheapest place they can afford to live. They live in very small rooms, so if one member has tuberculosis (TB), it’s a possibility that it will spread to the rest of the family. For MSF in Zimbabwe we do a lot of training for the staff here, so that

It's important that the patient comes to understand their illness. Once the patient understands they are able to better manage the illness. It is not for the clinic to manage the patient, it is for the patient to manage their illness. My hope is that in 10 years, the drugs will be available and better drugs will be on the market, with less toxicity, for TB and HIV.

A 10 year-old girl takes her ARVs with assistance from her care giver in Epworth.

they can give quality care. MSF has also invested in investigations, including a laboratory (at Epworth).

We had a patient called Violet with multidrug-resistant TB (MDR-TB). When I started working in this project in May 2015 she was bedridden. She is a mother of two. The oldest child was 14 years old and the youngest was six months. The oldest son couldn't cope with the cleaning and caring for the mother. We had a private physiotherapist who came in and worked with her and after two months she was able to walk, do her cooking and do her own washing. The project bought her a walking frame, which assisted with her walking, and also her crutches, and that has transformed her life. Because then her son doesn't have to stay home to look after her, she is able to do that for herself. She's still part of the MDR-TB programme and when we have a meeting, I send a car to pick her up.

It's important that the patient comes to understand their illness. Once the patient understands they are able to better manage the illness. It is not for the clinic to manage the patient, it is for the patient to manage their illness. My hope is that in 10 years, the drugs will be available and better drugs will be on the market, with less toxicity, for TB and HIV.

For TB, some of the patients become deaf, because of the side effects. A hearing aid costs US$2,000. None of the patients can afford that. For HIV, some patients become anaemic because of the ARV drugs. For some patients, the distribution of fat changes and they get fat deposits on the upper part of their body. For women, if they're taking family planning pills, sometimes the treatment can stop that from working.

There is life beyond, if you talk to the HIV patients. My own sister (who is HIV-positive) has been taking HIV medication and she is coping very well. She's living positively and she works with the City Council of Nairobi. She goes around to other cities in Kenya and tells people that she is living positively and taking the medication. She has seen the children grow, she now has grandchildren and she's going to retire in a few years' time. She has lived a full life. So there is hope, people should not give up.

12 CAROLINE CHIEZA

“The patients we were seeing were so ill. We would see patients in wheelbarrows.”

Initially when I worked in the pharmacy, I was responsible for ordering drugs and stock management. I then moved to the position of deputy project coordinator from 2010.

The patients we were seeing were so ill. We would see patients in wheelbarrows. The (HIV) positivity rate was very high. There was a great need, probably an urgent need, for antiretroviral (ARV) treatment.

The community that we were serving is quite mobile. A lot of people were coming in from other parts of Harare, probably to stay for a very short time, and then probably to leave to look for work in other areas like Harare or other industrial areas.

There were a lot of opportunistic infections which then needed to be treated, and at the same time people also needed to be put on ARV treatments. We were one of the few centres that had just started to offer ARV treatment and there was an overwhelming response in terms of healthcare needs and a lot of people were quite happy in terms of us providing the services here in Epworth.

Because the clinic initially started in 2006, but our HIV intervention officially began in 2007, there was really a huge response in terms of patients coming to the clinic. We have evolved over the many years that have passed by. We are now in the eleventh year. I'm also glad that we still have our very first patients that we initiated on ARV treatment.

However, there is a huge difference in terms of the type of patients whom we are seeing right now. Having been in the same community for more than 10 years, we are assured that whoever is staying in Epworth has had a chance to be tested once or twice, probably more.

In terms of quality care, the positivity rate has dropped which is an indicator that at least a lot of people are being treated.

I'm very glad that of the patients whom we are seeing now, very few come in wheelbarrows.

We initially started with HIV and tuberculosis (TB) intervention, then we added a sexual and gender-based violence intervention around 2012. We up-scaled in TB and started a drug-resistant tuberculosis (DR-TB) programme in conjunction with the TB programme already in existence. After, we also engaged in cervical cancer screening.

DR-TB started as a unique programme because it was offered in very few centres, Harare being one of them and us in Seke.

We were actually working in close collaboration with City of Harare health department to offer treatment to the patients. We were lobbying with the ministry for some time from Harare City, to make sure that there is a protocol for DR-TB management which the ministry has taken up and is rolling out successfully.

We have come up with support groups for paediatrics and adolescents. We have strengthened adherence counselling sessions and covered issues like disclosure sessions where we encourage caregivers to disclose to the children at the appropriate time and age or after certain sessions of counselling.

We have heavily invested in paediatric and adolescents' care and I think this is one of the success stories. Children and adolescents know that if they come to the clinic on Tuesday or Thursday, they go straight to their room and then they get their medication and also get their appointments done from the same room.

Apart from that, we have built what we call a Youth Friendly Corner that is specifically for the youths. There you find entertainment. We have got a television set and games that they play.

As MSF is handing over the Epworth project, I would like to encourage the patients to continue taking their medications, adhering well to the treatment and making efforts to ensure that at least the viral load is suppressed. I would like to ensure that we continue with the programme. To the Epworth Local Board and Ministry of Health and Child Care staff, I would like to wish them well, urge them to continue with the quality care that we have been providing together to the patients – and to keep up the good work for the benefit of the community.

13 SHERPHARD SOZA

"I always want to achieve whenever I assist people."

Sherphard Soza is MSF's community liaison officer for the Epworth Project and has been with MSF since 2008. His role mainly involves following up on patients in the community to ensure that they are able to continue their treatment.

I became a community liaison officer in 2011. My job entails patient tracing, liaison and community education.

If someone is diagnosed with tuberculosis (TB) and he doesn't turn up [to the clinic], we follow up so that the individual can come to the clinic so that they can be notified [that they've tested positive].

My main purpose is to build a rapport with the patient. This involves knowing the social cycles of the patient, so that I can build up support for that patient. There are some instances where we go to trace a patient to notify them about a condition – or a test has been done and the patient is detected to be positive, for example, meningitis positive. That patient is needed urgently, they can't wait for the next review date. So we do follow-ups of those patients.

The other form of tracing that we do is for those who have missed their appointments. When someone misses an appointment, we will be told and then we do the follow-up so that at least we encourage them to come and attend the clinic.

We also follow patients for treatment outcomes. We liaise with other stakeholders, so that at particular moments, they will support patients whom we are assisting. This is not only because we have found individuals who have the greatest need but at some particular moment we might realise that we are looking for a group of patients so that they get broader support. Most of the activities we do as organisations are highly dependent upon community support.

When I go into the community I always try to avoid saying to anyone, other than the patient, that I am there to meet with patients. I always make sure that at least I take the social approach whereby even when I arrive, I will act probably as if I have been there several times and we already know each other. I have always tried to make sure that at least when I interact with patients, especially in the community, in special cases where I am following up, I develop that trust with the patient. Even when they fail to get support anywhere else at least they have the assurance that when they come back to me, I will be able to support them.

While in the community where we are working, there are a lot of social issues which might arise because of a medical condition. There are several instances where we identify some patients who are interrupting treatment. You go there, you want to support them but you might notice that the patient doesn't have anything to eat, no longer has shelter and will be telling you that he doesn't know what to do next. He is telling you – to be honest I really want to take my drugs but I don't have food, I don't have anywhere to stay, I am now staying on the streets. The only thing you can do is lobby so that probably they can at least get support from other partners.

As an individual I am mostly interested in just assisting. Probably that's my inner drive. I always want to achieve whenever I assist people. Sometimes you realise that people tell you, "no Sherphard sometimes you go to the extremes in trying to assist." If I commit myself that I am going to do these things, I don't want to reach a point whereby I will say I will abandon the journey without having achieved something. But it is also because I grew up in Epworth and it is a community where I belong. Having seen the benefit, I really want people to benefit so that a lot of lives can be saved.

14 GIVEMORE MADHANZI

“We really made a difference because we would see patients coming in wheelbarrows … but after two to three weeks, you see those patients are walking.”

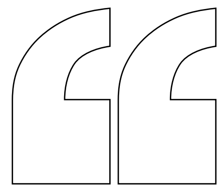
Givemore Madhanzi is a medical doctor who joined MSF in October 2008 and has worked in the Gweru, Gokwe and Epworth projects.

We were seeing patients who were very poor - they could not afford standard treatment at any of our hospitals. Most of them are very, very sick. At all three projects you see very, very ill patients coming. They are desperate, they haven't been seen anywhere else, but they just know about the experience of MSF clinicians in tackling HIV and tuberculosis (TB). Most of them test HIV-positive and are enrolled in the programme.

They hear how MSF is well resourced with doctors, unlike other polyclinics. There doctors may visit once a week or month, or do rotations because one doctor may be covering six or seven polyclinics. Here there are resident doctors who are there from morning to end of day. So they know they will be getting the services that they require.

Most come when their illnesses are advanced and most of these late presenters are men. It's a common finding that men seek help late, unlike women. I think it's an issue of ignorance; and some know, but they just do not want to know they have HIV. Their wives are already on antiretroviral (ARV) treat-

Patients in the waiting area at the Epworth polyclinic where MSF was providing treatment, care and support to a large cohort of HIV/TB/MDR-TB patients in collaboration with MoHCC.



When I joined the [Gweru] project, we really made a difference because you would see patients coming in wheelbarrows, some in scotch carts [trailers], but after two to three weeks, those patients were walking.

ment, maybe they tested HIV-positive during ante-natal care, delivery or the post-natal period. They have been on ARV treatment for many years, while the man has refused to be tested, only to come when very sick.

When I joined the [Gweru] project, we really made a difference because you would see patients coming in wheelbarrows, some in scotch carts [trailers], but after two to three weeks, those patients were walking.

Then, after a year or two they are working. In terms of patient care, there are a lot of significant improvements in patients' lives. Patients who were bed-ridden would end up working. They will now be taking care of their families and then doing the prevention of mother-to-child transmission (PMTCT) programme. There were lots of sick children who were dying in the first month, or first year after delivery, but with our PMTCT programme we saved a lot of children from contracting HIV from their mothers.

Most of our patients are marginalised in the community – they couldn't afford many medical services, like chest x-rays or ultrasound scans. These things we'd do for them, and they would get their TB diagnosed. Of course, TB is the major thing that kills most of our patients. Actually in all projects, co-infection of TB and HIV was the major killer. So, the moment you diagnose the TB, you treat it, the patient is stable and will do well.

With MSF, one thing that I really appreciated and still appreciate are the workshops that you have before you start work. To be in the field, to be competent, you need training. This training really equipped us to take care of our patients. We passed on a lot of on-the-job training to our counterparts, especially nursing staff, as well facilitating a lot of training for them, even before we started the handover in Gweru for instance.

You end up with this humanitarian mind, because of taking care of these hard-to-reach areas. There are places like Vumba where a patient had never been in contact with a medical doctor. They were really surprised that MSF could send medical doctors to a place like Vumba, where in the rainy season they could go six or seven months without access to medical services, social services and even shops.

With our trucks, MSF would go there even in the rainy season. At one time we had to give them ARV treatments for six months, so that no one would be left without them during the rainy season if the place became unreachable. They really appreciated our presence in their communities. This really motivated me.

VIAC – [cervical cancer screening using visual inspection with acetic acid] – was a very excellent programme. I think cervical cancer screening (CCS) has to be rolled out at every opportunistic infection clinic. Actually, every woman should be screened for cervical cancer.

[In Epworth] we were doing CCS for all HIV-positive women. This is really an eye-opener, because if you look at our positivity rate it actually nears the national prevalence of cervical cancer in women. We are around 33 per cent which means that one in every three women probably has a lesion, which if not treated will lead to cervical cancer.

Those who are [HIV-] positive must be screened every year; those who are HIV-negative will be screened every two years. In any programme, especially in HIV programmes, we have a high prevalence of HPV (human papillomavirus) infection. So these patients really need to be screened. Our patients have been on ARV treatment for many years, so we are prolonging that patient's life. Now if you have HPV, your chances of it progressing to a pre-cancerous lesion and then to cancer is high – because of the depressed immune system. This predisposes these patients to high-grade lesions which will, in a shorter period of time, progress to cancer. So, this CCS programme has saved a lot of women whom we have seen with lesions and have treated either through cryotherapy or through Loop Electrosurgical Excision Procedure (LEEP).

Initially when we started our programme we were afraid of getting very high numbers that we couldn't cope with. We restricted entry to those who started ARV treatment in a particular month. For example, all patients who started their ARV treatment in June got the CCS in June.

We trained a lot of staff – five extra staff and one doctor to do VIAC at Epworth. We then opened the doors to everyone, and this screening was really on a voluntary basis. We knew through experience that if women have HPV infection, they could progress to cancer very quickly.

In the morning patients have group talks, and learn that every woman should be screened for cervical cancer. Those who get that message will come to be screened. We really need to expand this programme.

MSF has been doing a splendid job in terms of quality of work and care for the patients. This is what we want to continue when MSF leaves. We want this level of competence to continue and have made a lot of headway. We hope that in the future when MSF leaves, [MOHCC staff's] standards in carrying out their duties will match, or even be above, those of MSF.

15 MARY MARIZANI

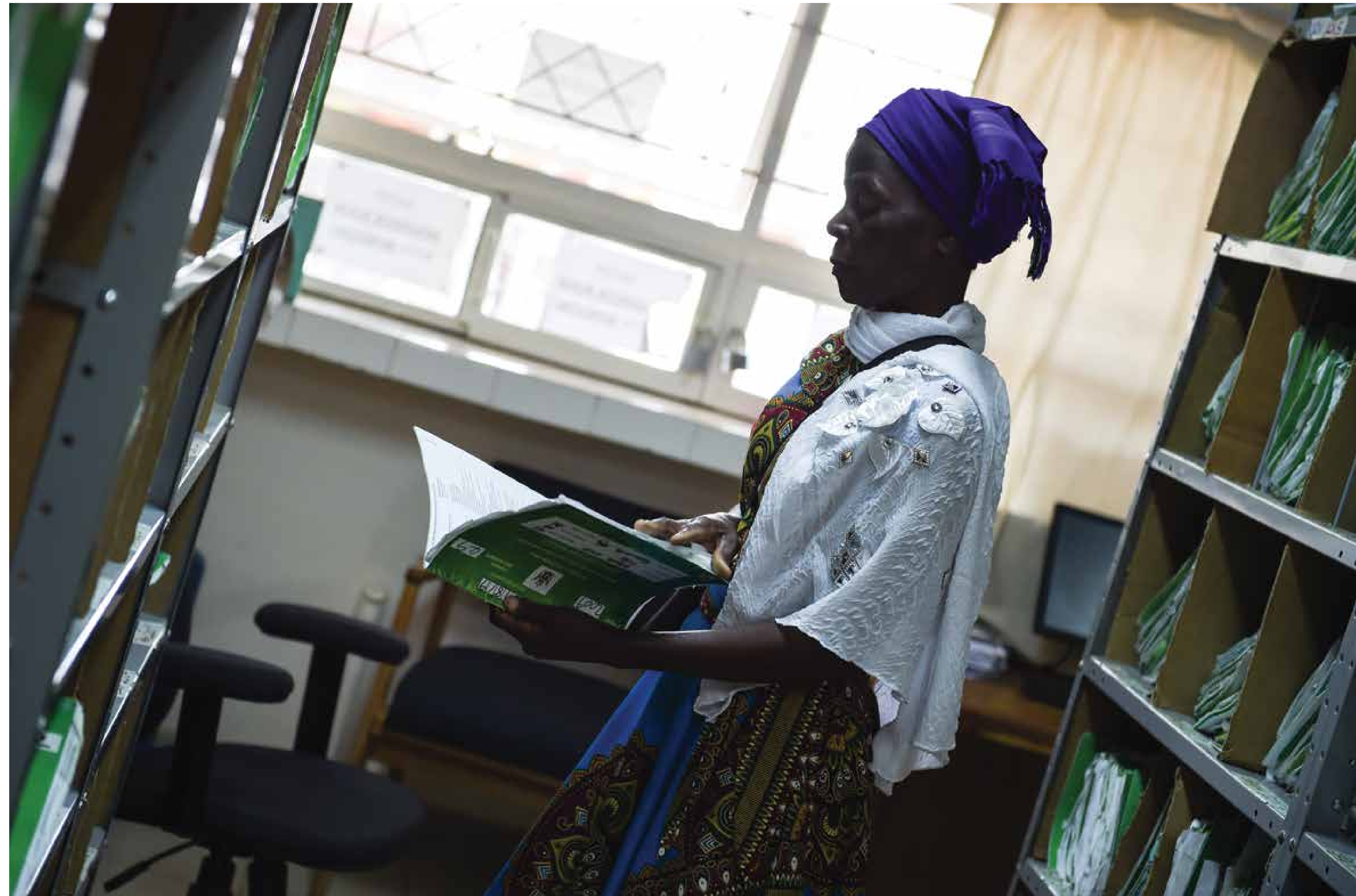
“I was determined to take that medication, and face the challenges.”

Mary Marizani, 54, was the first person to be treated for drug-resistant tuberculosis in Zimbabwe. She was treated at the Epworth polyclinic where MSF has worked in partnership with the Ministry of Health and Child Care (MoHCC) to provide quality treatment, care and support for HIV-positive and tuberculosis (TB) patients.

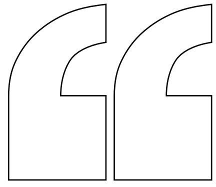
MSF wanted to investigate why my TB was not being treated. After some time they came to my home with uncle Sherphard [from MSF] and told me that I had multidrug-resistant tuberculosis (MDR-TB) and that it could not be treated with the drugs that I was taking. The drugs to cure this type of TB cannot be found in Zimbabwe. They advised me to go to China or South Africa for treatment. I said I couldn't afford to go.

They asked me to wait while they considered what to do. I continued with the same drugs as before. When they came back they said they would seek permission from ministry [of Health] to import those drugs. The government could not afford to buy those drugs because they are expensive.

Later they said that they had talked to the ministry which had agreed for the drugs to come into Zimbabwe. However, the drugs get here via sea, which takes time. I asked myself



Mary Marizani was the first person to be treated of drug resistant tuberculosis (DR-TB) in Zimbabwe. She is now a volunteer at the Epworth poly clinic.



I felt motivated and determined to take it, to recover and take care of my family. I feel so happy, more than happy [that I was the first to be treated for DR-TB in Zimbabwe]. I am happy because what you did for me was extraordinary and I don't want to be separated from you. I cannot say there is anything that makes me sad, what is in me is the joy of being able to do what I want in good health, without experiencing any pains.

could it be possible that they order the drugs for me alone in the whole of Zimbabwe, maybe it's just talk. They told me to continue taking my medication, but for a time I thought that these people were deceiving me.

Since I did not have [the right] medication to treat my condition, I was as good as dead. I had a talk with my children, and told them that when I finish my old drugs I would not go to the clinic for more, I would just stay at home – whatever happens, happens. My children could not say anything. When the day came, I said I've had enough.

Three days passed. On the fourth, Uncle Sherphard visited to ask why I had not collected my medication. I told him that I was tired of taking it, what was the point when it does not treat the condition. He advised me to continue until the drugs for my treatment came as promised. I refused. I took out my hospital cards to show him that I had a heap of them, and to show that I had been consistent with my medication but nothing had changed.

Uncle Sherphard tried to encourage me. He brought my drugs to me. He told my children to make sure I took them. I continued on with the same treatment for about five to six months, before the proper drugs finally arrived in December 2010.

The MSF team said that now that the drugs were there, it was up to me to take them or not. They asked if I had what it takes to take them, and I said if you give me the instructions I will follow. They gave me papers which showed me the [side] effects, and what to expect. They explained that if I take these drugs, they would treat me but cause pain at the same time – some pains all over the body. They can cause dizziness or you can have a mental illness or you may not know what you're doing; you can vomit or have running stomach; you can go blind or become deaf; or you get irritable – all these can happen after you start to take these drugs. They said that if I experience any of the side effects, I should quickly inform them so that they could quickly attend to it.

On 28 December, they came to my house and took out all the medication. They said now it's your duty to take the drugs. We are not giving you a lot because they are dangerous; they will treat, they can heal you, but it is dangerous so now it needs your commitment. I was given the paper to sign, and they asked if I had committed myself. I assured them that I was fully committed.

There was a drug which was taken with Mazowe or milk or yogurt. I would also be injected every day for six months except for Sundays, when I rest. They arranged their medicine, and asked me if I was ready, and I said I was.

For two days I was taking all the medication at once. Those days, I felt like a drunk person. When I slept, I would black out. I was woken up to eat and for a bath but it was with reluctance because all I wanted was to sleep. They changed my dosage, because it was too much for me. After that, they gave me medication twice a day, half in the morning and the other half in the evening. It was a bit better but the drunken feeling stayed for three weeks before beginning to fade. Then I started experiencing the other side effects; today a headache - you get treated, then tomorrow vomiting - you are treated and it alternated like that.

I was determined to take that medication, and face the challenges. I wanted to see what would happen and if I would be cured. They said, once you start do not stop, take your medication regardless of what is happening until it ends. I took that advice and kept it in mind all the time. I told myself that I want to see how far this will go. After six months of taking the medication I fainted. I could not hear and wasn't aware of what was happening. I found myself on drips. It never happened again.

Another time I shook right from inside my body for a day. All the side effects that I experienced were only for a moment; once I got treatment for it, I would be fine then it would be something else. I persevered until I finished my medication.

Other times I would ask for something I was holding or forget where I was going. Sometimes if I went outside the gate, and walked a short distance past home, I would forget where home was, so I would end up sitting there where I was.

I had a mental illness, I went crazy. I would flee from the house because I believed it was on fire. I would actually see the flames yet there was nothing. I grabbed all my children's important documents like birth certificates and ran.

I twice became deaf. Sometimes it would seem like things had been put in my eyes. If I got treatment it would not take long before I was fine. My body changed complexion, and the other parts would look like an albino. After I finished my medication parts of my skin became normal; some of the spots are on my back. When I was about to finish, I experienced a lot of vomiting. I could take two or three types of medication and vomit but I did not give up.

I don't have a husband or anyone to look after me. People from the community would come, but none of my relatives took care of me, not even my mother. My sisters and brothers could not pay a visit. They were close by, but would not set foot in my home and they avoided me.

I was supposed to finish in December 2012 to make it two full years of treatment, but I finished on 18 September 2012. Since completing my treatment and recovering, I can now do things on my own and can walk. I can work, using my hands. Before I got sick, I used to crochet and make bed spreads, table cloths, dresses, jackets, hats. I would give the items to those going to South Africa. They would order from me, then go and resell. My husband passed away in 2004, and from then I looked after my children using that money. I could afford to send them to school, and then once I was sick, I couldn't afford to do what I used to do. I could not do anything, it all ended abruptly.

Now I feel that I am strong, and I do not feel any pain. I am still crocheting and knitting, but I cannot do it like I used to before I got sick.

MSF asked me to assist them and I am now working as a volunteer. I was trained in all areas and started at the family clinic, collecting patients' files. I moved to outpatients consultations, taking files again and giving directions. Next I was in the TB department for about 10 months, collecting files, taking results and fetching drugs from the pharmacy. After that was the filing department, where my responsibility is to put patients' files and results in order.

I am also a peer educator. We have support groups for DR-TB, where people educate each other about taking the medication. We support each other so that people keep taking their treatment.

What gave me strength is that the MSF team sacrificed for me to get the medication. I asked myself what would prevent me from taking my medication, when the medication has been provided? All that was left was for me to take the medication.

I felt motivated and determined to take it, to recover and take care of my family. I feel so happy, more than happy [that I was the first to be treated for DR-TB in Zimbabwe]. I am happy because what you did for me was extraordinary and I don't want to be separated from you. I cannot say there is anything that makes me sad, what is in me is the joy of being able to do what I want in good health, without experiencing any pains. Even though things can be hard, I get to a place where I say if it's going to be hard today, why was it not hard before.

Yes you are now leaving but as MSF, just continue doing your mission. Help others in the same way you helped me. Do not get discouraged because your works are great. I have seen it myself. Whenever I see someone who is heavily laden, I know you are there to help carry the burden.

To patients, I want to say that they should persevere in taking their medication. There is another patient whom we lost, this really touched me. She failed to take the medication – she just put it in her mouth, under her tongue.

My wish is that you look for people to help monitor patients as they take their medication at home. I think some are not taking their medication properly. They get to a point of being frail and unable to take the medication. That is all that troubles me – I was cured but why are others failing, and others dying?

PROGRESS IN NUMBERS

The total number of patients seen by MSF at Epworth Poly clinic, HPP and Chikurubi Maximum Security Prison, from 2006 to October 2017

At Epworth Poly clinic:

Number of patients tested for HIV	**128,144**
Number of patients who tested HIV-positive	**28,691**
Number of patients initiated on antiretroviral (ARV) treatment	**24,406**
Number of patients treated for tuberculosis (TB)	**9,197**
Number of patients treated for drug-resistant TB (DR-TB)	**66**
Number of HIV-positive pregnant women treated on the prevention of mother-to-child transmission (PMTCT) programme	**2,414**
Number of children born	**2,344**
Number of survivors of sexual and gender-based violence (SGBV) provided with medical and psychosocial care	**532**
Number of viral load tests done	**26,879**
Number of people with high viral load > 1,000 copies	**3,398**
Number of follow-up viral load done	**2,011**
Number of high viral load for follow-up > 1,000 copies	**1,046**
Number of patients switched to second-line treatment	**969**
Number of women screened for cervical cancer at Overspill clinic	**4,747**
Number of women who tested VIAC-positive at Overspill clinic	**845**
Number of women screened for cervical cancer at Epworth Polyclinic	**4,918**
Number of women who tested VIAC-positive at Epworth Polyclinic	**1,139**
Number of women screened for cervical cancer	**9,665**
Number of women who tested VIAC-positive	**1,984**
Number of patients treated for cholera	**17,763**

From 2012 to October 2017 at the Chikurubi Maximum Security Prison:

Mental health

Number of mental health patients admitted	**1,651**
Number of mental patients readmitted into Chikurubi	**341**

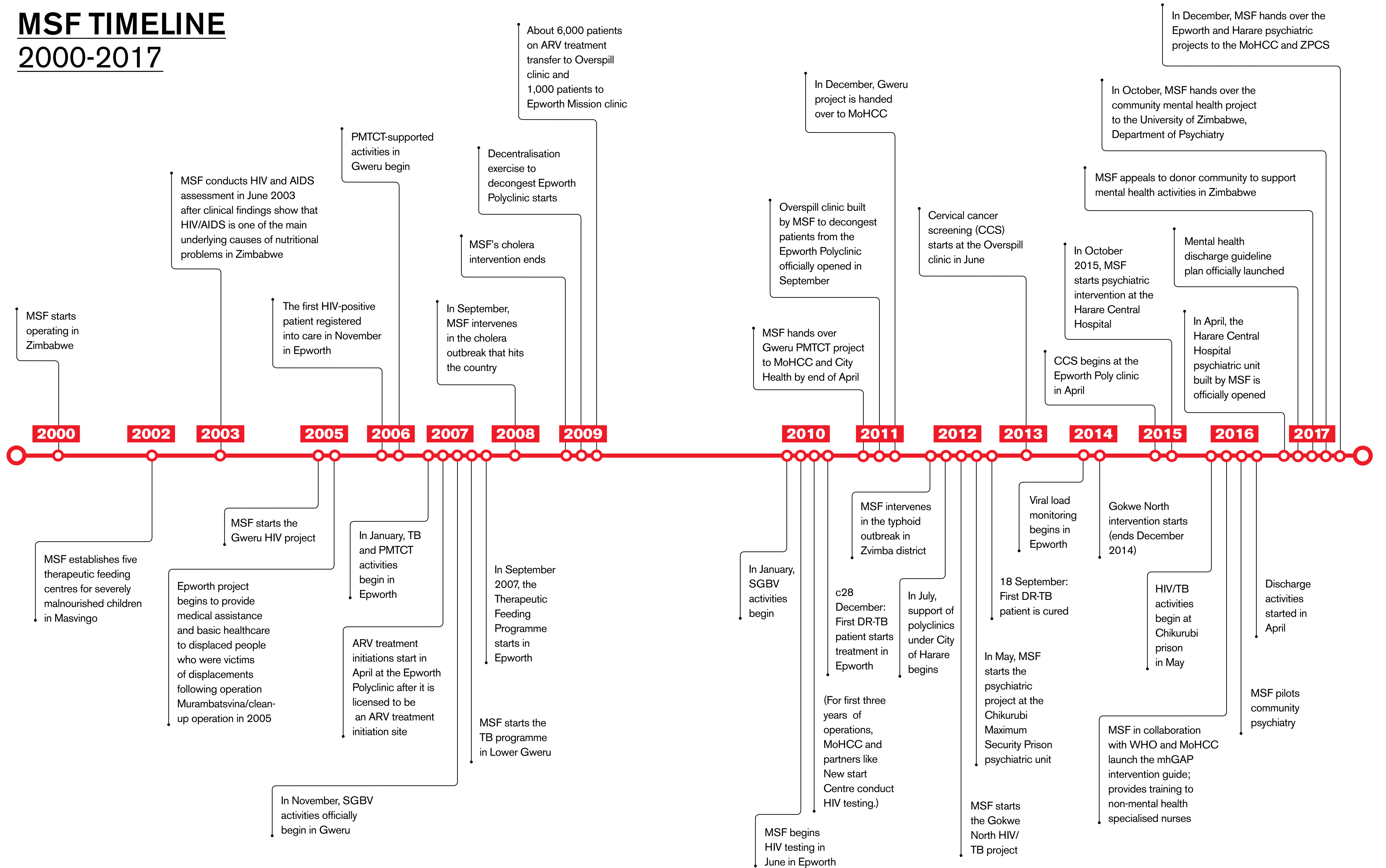
HIV and TB

Number of patients tested for HIV	**3,697**
Number of patients tested HIV-positive	**269**
Number of patients initiated on ARV treatment	**282**
Number of viral load tests done	**1,136**
Number of patients with high viral load > 1,000 copies	**131**
Number of inmates treated for tuberculosis (TB)	**101**
Number of inmates treated for drug-resistant TB (DR-TB)	**13**

From 2015 to October 2017 at Harare Psychiatric Unit (HPU):

Number of mental health patients admitted	**1,270**
Number of patients readmitted but not followed by discharge team	**492 (39%)**
Number of patients followed up by the discharge team	**454**
Number of patients readmitted after MSF discharge team intervention	**14 (3.8%)**
Total number of consultations by the discharge team	**3,787**

MSF TIMELINE 2000-2017



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