



MSF IN ZIMBABWE
ACTIVITY
REPORT 2013



www.msf.org

Médecins Sans Frontières Charter

Doctors Without Borders/Médecins Sans Frontières (MSF) is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honor the following principles:

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

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

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

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

Médecins Sans Frontières (MSF) is a international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation.

MSF is a non-profit organisation. It was founded in Paris, France in 1971. Today MSF is a worldwide movement of 23 associations. Thousands of health professionals, logistical and administrative staff manage projects in more than 60 countries worldwide. MSF international is based in Geneva, Switzerland.

MSF in Zimbabwe

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This report provides descriptive overviews of MSF's operational activities in Zimbabwe between January and December 2013.

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

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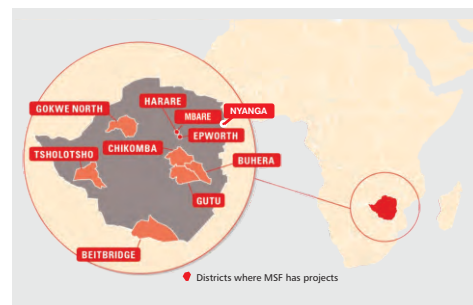
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Cover Picture: MSF treats thousands of children in Zimbabwe
Picture by: *Juan-Carlos Tomasi*



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FOREWORD

By Head of Missions - MSF in Zimbabwe

On behalf of Médecins Sans Frontières / Doctors Without Borders (MSF) in Zimbabwe, it is with great honour, that we present our 2013 intersectional activity report.

MSF has been working in partnership and close collaboration with the Ministry of Health and Child Care (MoHCC) since the year 2000. We have, over the years, contributed to the partnership through implementation of medical programmes, by innovation within those programmes and, when required, by supporting emergency response to medical crises.

Our geographical diversity is driven by our organisational structure, but our underlying methodology derives from the

shared principles and values that bind us together as one organisation, dedicated to medical humanitarian action. In MSF, we assert that our principles and values define us as a unique international organisation, equipped to respond to the challenges we aim to meet in a singularly distinctive way that is defined by MSF. However, our style is also guided by the context and the nature of our working relationships.

The reason for entry into Zimbabwe was the HIV / AIDS pandemic; the whole of Southern

Africa was gripped with high HIV prevalence, which put an enormous strain on national health systems due not just to the morbidity and mortality, but also the immense socio-economic disruption. Even when the rest of the aid world refused to accept that treatment was an economically viable option, MSF was implementing mass treatment with anti-retroviral drugs. It was with a background of direct medical action that MSF launched its medical programme in Zimbabwe.

Today, the unique advantage that we aim to bring to the partnership with the MoHCC continues to drive our programmes in Zimbabwe. As always, driven by direct medical action, we are present in a number



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Pill count at Overspill Clinic Pharmacy in Epworth



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A laboratory technician with PIMA machines at a Health Facility

of select locations nationally. The international developments in understanding of HIV as a public health challenge and as a medical crisis may have improved access to life-preserving anti-retroviral therapy (ART), but numerous challenges still remain.

The greatest of these, in many respects, is the access to funding. Based on the medical evidence we are witnessing in the field, we are saying AIDS isn't over yet, some HIV/AIDS endemic countries may be left behind, crippling the momentum built over the last 12 years.

The HIV/AIDS emergency is far

from over. And it cannot be ended with domestic funds alone – the numbers are still too high.

While in Zimbabwe the Government's commitment to address the issue of sustainable financing for HIV is demonstrated by the establishment of the National HIV and AIDS levy, there is need to further develop sustainable financing which will strategically focus on:

1. Increasing domestic and international funding
2. Strengthening effectiveness and efficiency in the use of financial resources in service delivery and prioritization of the national response strategies.

There are proven strategies for community-based care that puts more people on treatment earlier and helps them adhere to treatment in the long-term. Getting patients on treatment early keeps them healthy, it avoids overloading health facilities and it reduces the spread of the virus. And better drugs are available, such as Tenofovir which is less toxic and easier to take.

Through our partnership with MoHCC, we are proving that people can start HIV care earlier and that they can get their treatment through community networks, taking the burden off from overwhelmed health facilities

and improving people's adherence. We need to act on that knowledge, and Zimbabwe needs to continue on that progressive path it has taken.

The evolution in HIV care is dynamic and constant. As Zimbabwe approaches universal coverage, new technical issues will come to the fore: how to address the shortfall in paediatric diagnosis and treatment; how to address the increasing challenge posed by TB and drug-resistant TB co-infection; how to respond to the emerging research on treatment as prevention.

Early Infant Diagnosis (EID) is vital for the diagnosis of infants so they can begin treatment as soon as possible.

With more than nine million people now receiving ART in developing countries, the ability to monitor and optimise treatment effectiveness is vital to the success of HIV treatment programmes. Viral load and CD4 testing are critical tools in this effort.

MSF continues to advocate for increased scale-up of 'viral load' monitoring in order to help improve people's HIV treatment outcomes. The benefits of implementing viral load testing are really obvious—it's the gold standard for treatment monitoring, but it's largely unavailable in developing countries because cost is a major factor.

On the other note, MSF had to abruptly hand over activities to the Ministry of Health and Child Care in Beitbridge district on the 31st of December 2013 when the memorandum of understanding at local level was not extended. Therefore, the Ministry of Health and Child Care took over the

responsibility of all medical support, including ARV's supplies, for more than 5,500 patients in the rural areas of the district. Before their departure and to avoid treatment interruption, MSF provided three months' supply of ARVs that were made available centrally at Beitbridge District Hospital as a buffer stock.

The focus of MSF intervention is the patients and there is no other agenda behind our medical activities. MSF has and will not engage in any other activities which are outside our core mandate as enshrined in our Charter as well as in tandem with various laws which regulate our operations in Zimbabwe. Our work is based on neutrality and impartiality principles and medical ethics and it is in our aim to provide quality medical care for people in need. We always adhere to these principles in the interest of the population we are serving.

In the pages of this report you will be able to read about the activities of MSF in Zimbabwe in 2013. In addition to the provision of care for people living with HIV, other thematic areas for MSF include the provision of TB treatment. Generally, 80 percent of our TB patients are HIV co-infected, and the suppression of the immune system caused by HIV creates additional risks that multi-drug resistant (MDR) TB will become increasingly prevalent; for this reason MSF has in 2013 continued to invest in MDR TB diagnosis and treatment.

We also prioritise the medical treatment of sexual and gender-based violence (SGBV) in our HIV programmes due to the need for post-exposure HIV prophylaxis in high-prevalence HIV settings. And MSF has also responded to

emergency medical needs when called upon, working in support of the MoHCC to respond to typhoid and malaria outbreaks.

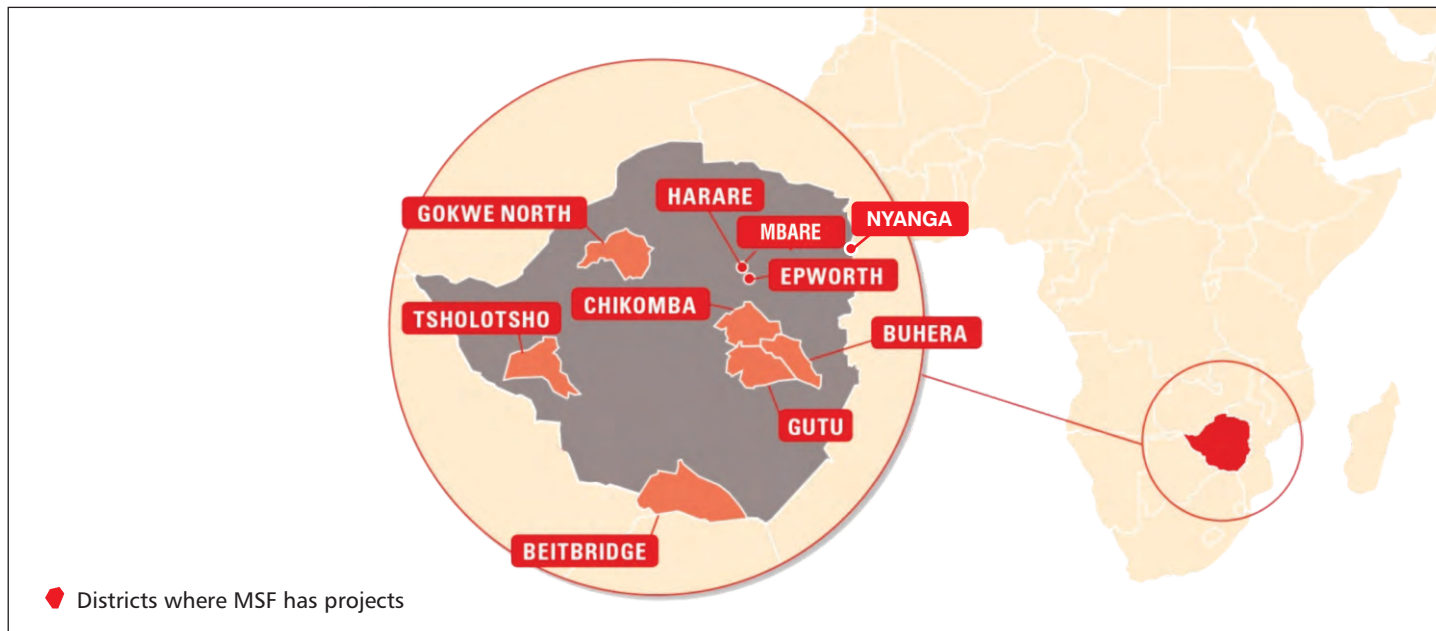
Our partnership with the MoHCC is a common factor across all projects and in all activities; we value the professional relationship that continues to flourish at central, provincial and district levels.

To close, it is appropriate to state our appreciation for all those who have contributed to the success of MSF's activities over the past year. The staff recruited and employed here in Zimbabwe, those recruited internationally, and all the MoHCC staff who have worked together either in the health facilities or in support roles; without the continued professional input of all those working with us, the tens of thousands of patients supported by MSF would certainly not have achieved the same positive outcomes.

Also, we would like to acknowledge the contribution of our donors. MSF values the independence afforded to us by millions of individual private donors. International in our sources of funding as well as in our humanitarian action, we are driven only by the needs of our patients and never by the demands of individual donors; we are grateful for that independence.

Finally, we would like to thank the MoHCC; the professional and supportive working environment nurtured by health professionals in Zimbabwe continues to contribute to the improvement in healthcare provision and medical services for those most vulnerable in Zimbabwean society.

MSF PROJECT LOCATIONS



Médecins Sans Frontières (MSF) has been working in Zimbabwe since the year 2000, and runs projects in partnership with the Ministry of Health and Child Care (MOHCC).

In all projects, MSF provides a comprehensive package of quality HIV/TB care through an integration approach in the Ministry of Health structures. This package includes testing, diagnosis, treatment and counselling for HIV, TB, and MDR-TB (decentralized, community approach) and the treatment for other opportunistic infections.

Services include antenatal care (ANC) and prevention of mother to child transmission (PMTCT) services, laboratory support (in some locations with Gene Xpert for rapid detection of MDR-TB and routine viral load testing for people living with HIV), health promotion activities, nutrition and SGBV components.

Cross cutting issues are support in waste management at health facilities and capacity building activities. In Harare, there is also a vertical project providing care to survivors of sexual and gender-based violence (SGBV). MSF also has emergency preparedness and surveillance components to be able to respond to

emergencies, such as epidemic outbreaks of cholera, typhoid, measles etc.

Projects are currently located in Beitbridge, Buhera, Chikomba, Epworth, Gokwe North, Gutu, Mbare, Nyanga and Tsholotsho. MSF acts as implementer, partner, facilitator and catalyst, mobilising resources to increase coverage and deliver life-saving treatment to patients in our project locations. We work in full collaboration and partnership with MoHCC within existing health structures. Three MSF sections are present in Zimbabwe:

OCA (Harare, Mashonaland East and Midlands Provinces)

Epworth, Overspill and Mission clinic - decentralized HIV/ART/TB/MDRTB treatment, care and support and Prison Mental health intervention in collaboration with MoHCC, Ministry of Justice and Zimbabwe Prisons and Correctional Services.

City of Harare - increase access to

ARV through Nurse-led ART initiation in collaboration with CoH staff and authority in seven clinics including Caledonia Farm, Mabvuku, Hatfield, Mbare, Rutsanana, Budiriro, and Hatcliff.

Midlands -Gokwe North district, decentralization of HIV/TB/SGBV treatment, care and support to 18 rural health facilities including two hospital

OCB (Harare, Manicaland, Masvingo and Mashonaland East Provinces)

Mbare [project for survivors of SGBV]
Buhera District [Murambinda hospital and 23 rural clinics]

Gutu and Chikomba Districts [ART initiation and follow up through mentoring approach to MoHCC]

Nyanga District (HIV/TB care and treatment with more emphasis on pediatric ART care)

OCBA (Matabeleland North and South Provinces)

Tsholotsho [Tsholotsho District Hospital and 14 rural clinics]

Beitbridge [Beitbridge Hospital and 6 rural clinics]

OVERVIEW OF ACTIVITIES IN ZIMBABWE



Everyday, the MSF supported HIV clinic at Epworth has long queues of patients waiting for medication

Médecins Sans Frontières (MSF) has been working in Zimbabwe since the year 2000, and runs projects in partnership with the Ministry of Health and Child Care (MoHCC), that include treatment and care of people with HIV, tuberculosis (TB) and drug-resistant TB (DR-TB), Sexual and Gender based Violence (SGBV) interventions and emergency preparedness. Projects are currently located in Beitbridge, Buhera, Chikomba, Epworth, Gokwe North, Gutu, Mbare, Nyanga and Tsholotsho.



Patients waiting for their ARVs at Murwira Clinic, a decentralised clinic in Buhera

Fighting HIV/AIDS

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

MSF programmes, which are implemented within the Zimbabwean health structures, are ensuring medical care to more than 56,000 people living with HIV. More than 39,000 of these HIV+ people are receiving life-saving antiretroviral therapy (ART) and 44,000 people have been put on ART since the beginning of the programme.

Training medical staff

MSF is also implementing task-shifting and clinical mentoring in our programmes, training nurses

in routine HIV care, including the administration of ARV drugs, so that more staff are able to treat more patients in more locations.

Improving Tuberculosis care

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

Clinical management of survivors of sexual abuse

All of MSF's HIV programmes offer care for survivors of sexual abuse. Through community outreach and health promotion, our teams are working to increase the number of people who seek assistance after they have been abused. They offer

medical treatment and psychological services, establish support groups for survivors of sexual and gender-based abuse, and campaign for education about the issue.

Handing over of projects to Ministry of Health and Child Care

When programmes have been supported through the growth and development phase, we hand project activities over 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. For example, in 2011 MSF successfully handed over support activities in Gweru and Bulawayo to the MoHCC.

However, as explained in the foreword, MSF had to abruptly end operations in Beitbridge District on 31 December 2013 when the local memorandum of understanding was not extended.

VIRAL LOAD

Four essential interventions to improve HIV treatment, save lives, and reduce transmission

Today, nearly ten million people are receiving antiretroviral therapy (ART) in developing countries, but with an estimated additional 18 million people¹ eligible for treatment, the job is far from done. With the release of new ART guidelines in 2013, the World Health Organization (WHO) has laid out a clear benchmark for the quality of care that national treatment programmes, treatment providers and donors should strive to achieve.

The challenge faced today by Médecins Sans Frontières / Doctors Without Borders (MSF) and other treatment providers is therefore two-fold: to scale up treatment at

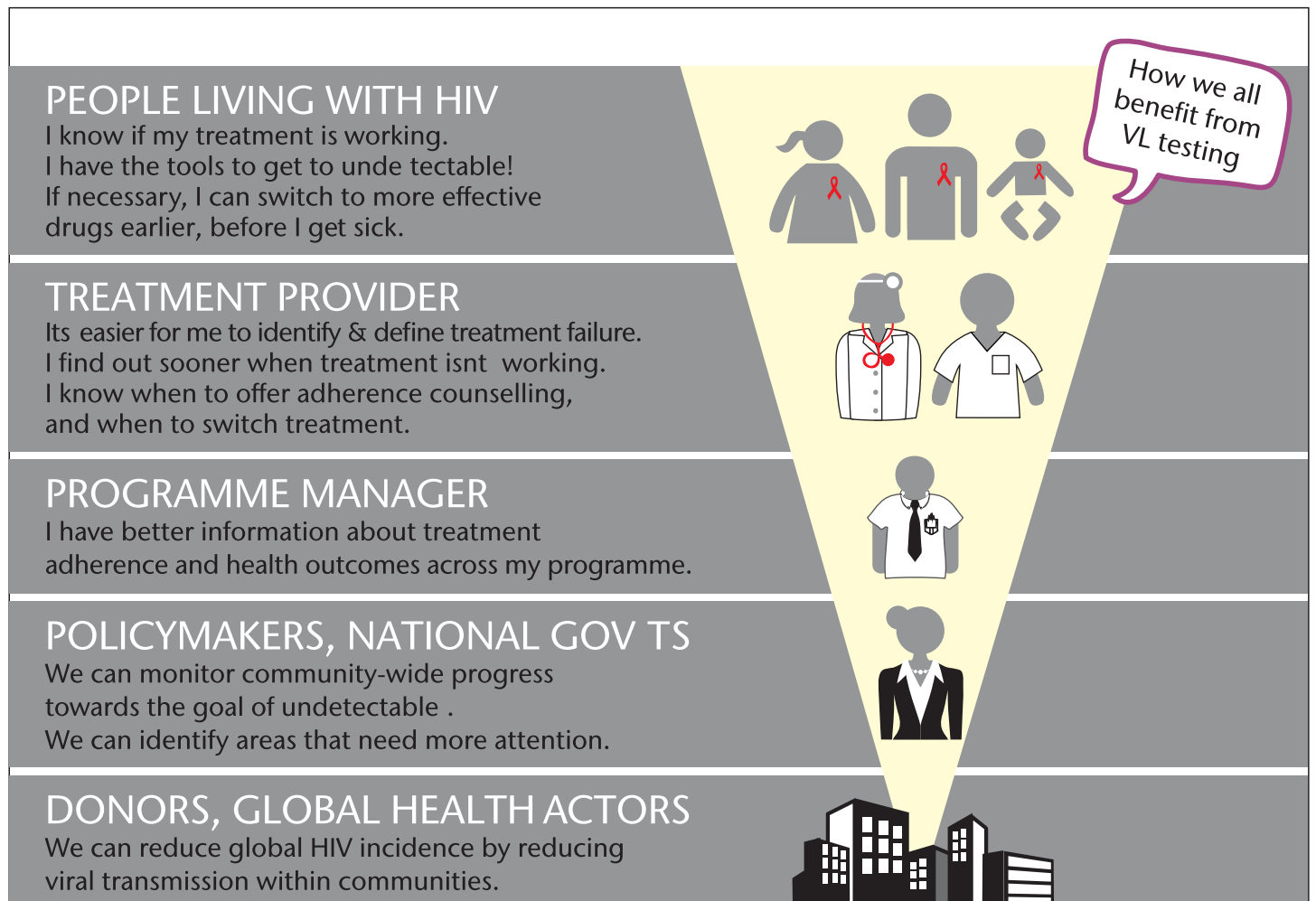
an ever-faster pace, and to ensure that those on treatment are achieving and maintaining 'undetectable' levels of HIV in their blood – an indication that the virus is optimally suppressed and no longer can attack the body's immune system.

To support this goal, the following four interventions should be prioritised: earlier treatment, viral load monitoring, enhanced adherence support and increased rollout of community-based models of care. This issue brief will use MSF's experience to illustrate how such interventions can help reach more people with treatment, helping them remain in

care and attaining and maintaining undetectable viral load.

The 2013 WHO ART guidelines include the following recommendations:

- Starting people on ART earlier in their disease progression (at a CD4 cell count of 500 cells/μl);
- Implementing more effective protocols to prevent mother-to-child transmission of HIV (PMTCT) that better benefit both baby and mother (lifelong ART for all HIV-positive pregnant mothers);
- Providing immediate treatment for all HIV-positive children under five years old
- Scaling up viral load testing, the gold standard in HIV treatment monitoring; and
- Offering treatment to all HIV-



positive people who have HIV-negative partners ('sero-discordant' couples), regardless of the status of their immune system.

To scale-up optimal ART, governments must fulfil their UN-brokered commitment from 2011 to contribute US\$22 – 24 billion annually by 2015. The cost of implementing the new WHO guidelines represents a marginal increase of 10 percent over this figure.

1. Early Treatment Saves Lives and Helps Prevent the Virus from Spreading

WHO recommends people be offered treatment when their CD4 cell count drops to 500 cells/l, a change from its previous recommendation to wait until the immune system is further weakened, at a CD4 count of 350 cells/l.

Increasing evidence shows that earlier treatment keeps individuals healthier, while preventing

irreversible damage to the immune system. Earlier treatment is not only beneficial to people's own health, but by helping people achieve undetectable levels of HIV in their blood at an earlier point, the chance that the virus will be transmitted to others can also be reduced.

A number of countries are preparing to implement earlier initiation of ART, and these efforts should be supported, particularly in light of the fact that this will involve people being on treatment who may not yet feel ill, and therefore paying close attention to their adherence will be critical. MSF is also beginning to offer treatment to people at CD4 500 in some countries.

2. Viral Load Monitoring is the Best Way to Make Sure Treatment is Working

Viral load testing is the gold standard for treatment monitoring and has long been

routine in resource-rich settings. Measuring how many copies of virus are in the blood indicates how well the virus is being suppressed by ART.

When people are doing well on their treatment, viral load monitoring ideally reveals an 'undetectable' level of virus in the blood (the virus is below the lower limit of test detection) – this is the state where people have the maximum impact of being on ART. Regular viral load monitoring (WHO recommends routine viral load monitoring six months after starting ART and then annually thereafter) can help people stay on track with their treatment, and knowing their status is 'undetectable' is an important motivating factor.

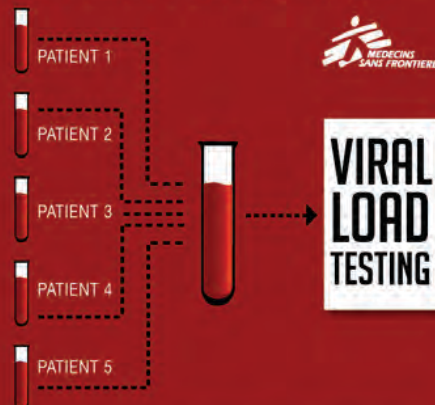
Viral load monitoring is crucial for detecting problems in two ways: First, it helps identify people who may be having trouble adhering to their treatment and need additional support to get back on

STRATEGIES USED TO SIMPLIFY & REDUCE COST OF VIRAL LOAD TESTING IN RESOURCE POOR SETTINGS



DRIED BLOOD SPOT SAMPLES

(using simple finger-prick to obtain blood)

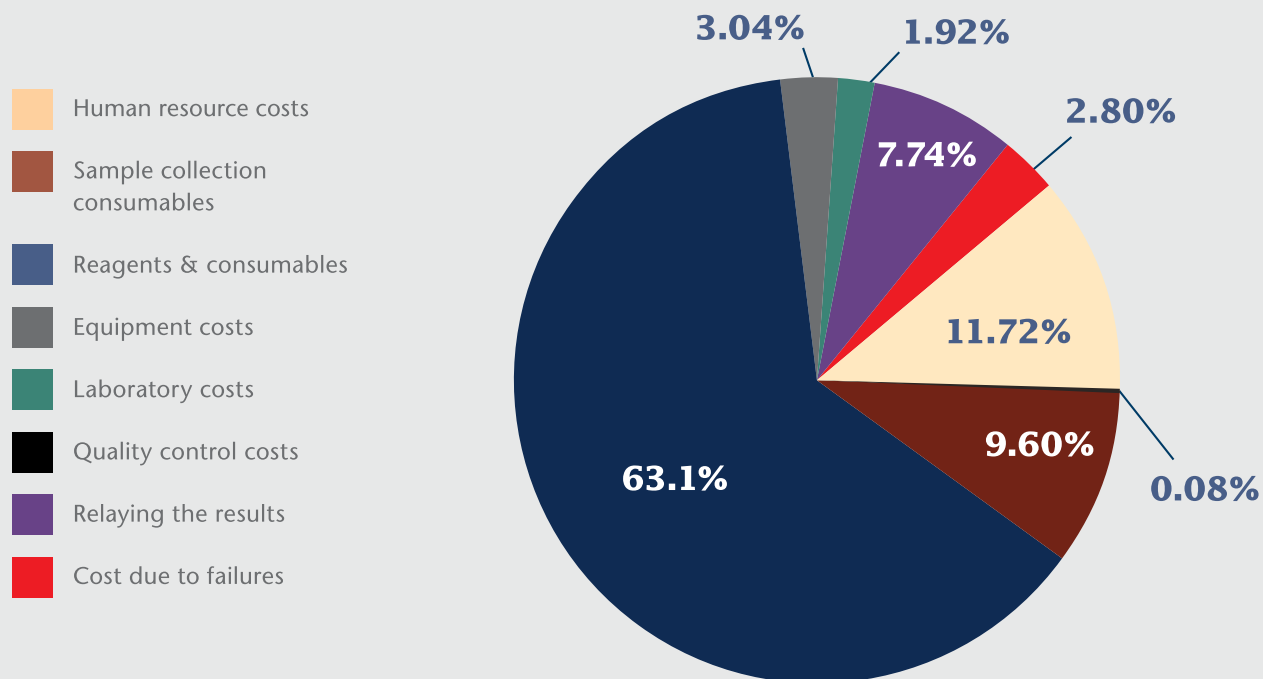


POOLED BLOOD SAMPLES

(doing one test instead of five*)

*re-test individually if virus is detectable

FIGURE 1: BREAKDOWN OF AVERAGE COST PER VIRAL LOAD TEST



track. Second, it helps identify people who are indeed failing their treatment and need to be switched to another set of medicines.

Viral load monitoring can identify these problems much sooner than CD4 testing, as it tracks the replication of the virus in the blood as opposed to the immune response of the body, where CD4 count drop only happens a while after the virus has begun to replicate. Waiting for the immune response to reveal problems, or for a person to show clinical signs of treatment failure, misses the ideal moment to make course corrections through adherence counselling or to make a necessary switch in treatment. In the worst-case scenario this could be too late altogether to save a person.

When viral load monitoring reveals that a person's HIV is at significantly detectable levels (above 1000 copies/ml), this sends an important signal to treatment providers to follow up with targeted adherence support. Viral

load monitoring should be repeated three months after adherence interventions, in order to determine whether the intervention has helped get the person back on track, and ideally to undetectable levels, or whether it is in fact time to switch to alternative treatment because resistance to the medicines has developed.

Treatment failure is under-diagnosed in low- and middle-income countries, with WHO estimating only 3% of people on ART receive second line treatment. The estimated number of patients with virological failure worldwide in 2012 is however estimated to be one million people.

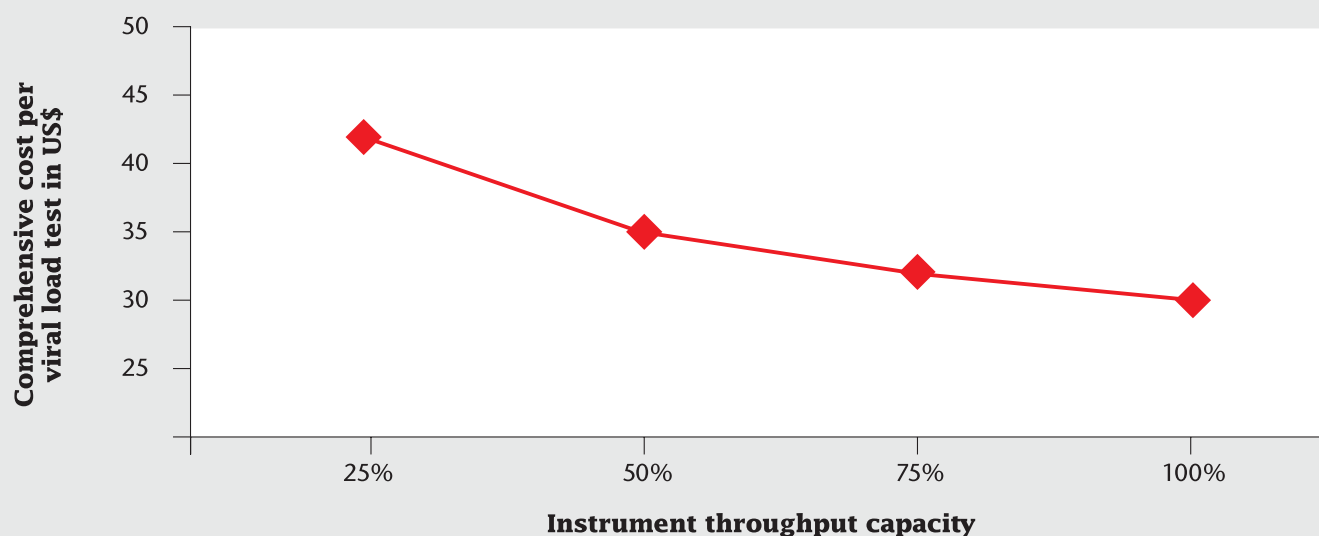
Because viral load can more accurately detect whether a switch in treatment is necessary or not, it also helps prevent unnecessary switching to more expensive alternative treatment regimens. This is crucial, considering that in most resource-limited settings, only first- and second-line medicines are available, with

limited or no treatment options if people fail second-line treatment. Salvage therapy for those failing second-line treatment, when available, costs nearly 15 times as much as first-line therapy in the poorest countries, with prices much higher in 'middle-income' developing countries. Due to cost and complexity, viral load monitoring to date has only been implemented in few places in resource-limited settings.

A survey of 23 countries by MSF in 2012 revealed that while viral load was included in national treatment protocols in nearly all the countries, it was only actually available in four countries. But with a growing number of viral load technologies being developed – including 'point-of-care' tests that can be used outside of laboratory settings – the price and complexity barriers can and must be overcome.

Additionally, innovative sample technologies and techniques, like dried blood spots and pooling of viral load samples to make sample

FIGURE 2: EFFECT OF THROUGHPUT ON VIRAL LOAD COSTS PER TEST



transport easier and reduce the number of tests that need to be performed, respectively, make testing less costly and more feasible in rural areas.

According to publicly available information, the lowest price of reagents is \$11 and based on MSF's experience, additional associated costs (such as human resources, equipment, etc.) can be as low as \$7 per test. Reagents and consumables represent the bulk of the costs of viral load testing, with prices varying across countries. Higher volumes and pooled procurement across countries by the Global Fund and PEPFAR, would help reduce prices through greater economies of scale.

MSF is currently undertaking a project in seven countries, with support from UNITAID, to roll out various different viral load technologies (both laboratory-based and point-of-care) to determine the best way to implement viral load testing in different contexts in resource-limited settings.

3. Providing Enhanced Support to Help People

Adhere to Their Treatment

To be most effective, viral load monitoring roll out in developing countries should be inextricably coupled with the capacity to provide enhanced adherence counselling for those people who are identified with detectable viral load. In MSF programmes, counselling often involves a monthly adherence counselling session over three months after an adherence problem is detected.

A second viral load test is then administered after three months to determine whether the intervention has had the desired effect of getting the person back on track with their treatment, and back to an undetectable level of HIV. By identifying people who need the most attention in terms of adherence support, viral load monitoring can also help health staff focus their efforts on people who need the most support.

In a large MSF-supported programme in Chiradzulu, Malawi, where ART has been available since 2001, community health workers could focus on the less than 10 percent of people with detectable viral load, among the

roughly 30,000 people on ART in the district.

While MSF and others have found that adherence counselling is a vital tool to improving people's adherence and also preventing unnecessary switching to other, more expensive, treatment regimens, an alarming trend MSF has been witnessing is that support from national governments and donors for lay or peer counsellors, who are the cornerstone of adherence counselling, is waning. Without these counsellors, it is not possible to adequately and effectively address adherence problems.

4. Increasing People's Autonomy: Moving to Community-Based Treatment Models and Self-Managed Care

Over the last decade, MSF and other treatment providers have recognised the importance of ensuring treatment is available as close to where people live as possible. Decentralising care to rural clinics and health posts has been critical to fostering treatment scale-up, and has been enabled by shifting medical tasks, so that lower levels of health staff

can perform tasks previously reserved for doctors.

Over the last few years, MSF has been working to get care even closer to where people live, and to further ease the burden on their personal and professional lives, while at the same time easing the burden on the health system. Extending facility linked health services at the community level has shown to reach more people and improve retention in care. As such, a number of different strategies have been implemented in various contexts to reduce the number of visits to clinics that patients who are stable on treatment must make.

In some contexts, this entails people on ART forming 'adherence clubs' where a group of up to 30 people come together to a clinic or a venue in the community, receive a quick clinical assessment, meet with an adherence counsellor as a group, receive their ARV refill and are in and out of the facility in under two hours. This has helped decongest overburdened health facilities. In other contexts, 'community ART groups' (CAGs) are formed with six friends or neighbours teaming up and taking turns getting the medicine refills for the rest of the group.

This means that each CAG member goes to the clinic just once or twice a year, at which point they get their medical check-up and

monitoring blood tests, pick up the refills for all other group members, and distribute them to the rest of the group in a convenient location.

This way, each CAG member gets their monthly refill from the CAG member 'on call' that month. This strategy has shown tremendous success in boosting people's likelihood to remain in care, reducing the time and effort spent to get a monthly ART refill, creating peer support that helps improve adherence, empowering people to deal with stigma, generating interest among others in the community to get tested, and resulting in a feeling of relief and comfort.

In other contexts, fast-track refill systems have been put in place at clinics, separating the need for a clinical assessment versus a simple drug refill, and in other settings medicine refills are provided in the community by community-based organisations, community health workers, and other people on treatment.

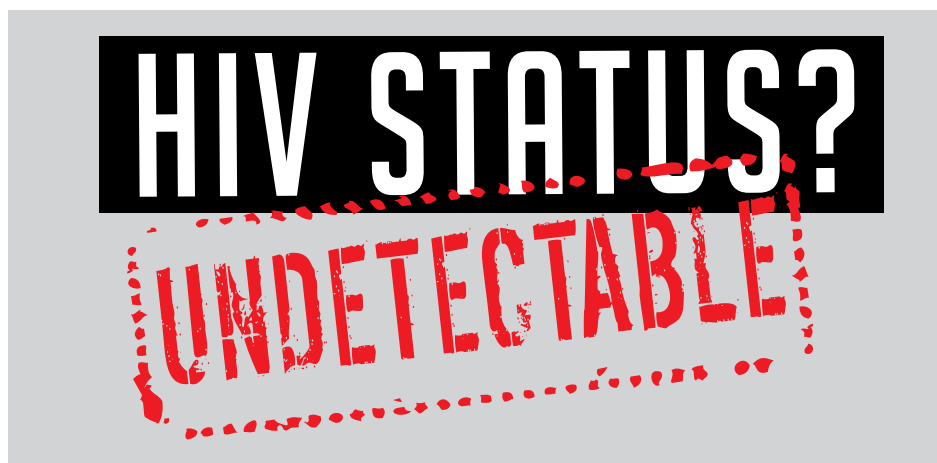
Access to viral load monitoring helps clinicians more easily refer stable and adherent people on ART for community based follow up and dispensing, with only a smaller proportion of patients needing to be referred to health centres in order to be seen by medical staff.

All of these strategies reduce the burden on people's lives by helping them fit ART into their lives rather than forcing them to arrange their life around their treatment.

It also reduces the burden on over-worked staff at health centres, enabling them to have more time to treat people in need of clinical care (for example, better treatment of opportunistic infections and dealing with patients who are failing their treatment). These models are an important step in taking HIV care more in the direction of other chronic disease management models.

While the last 13 years of ART in developing countries have brought many important advances, there needs to be a concerted global effort to expand treatment to more people while ensuring the best treatment and monitoring is available. Implementing the new WHO treatment guidelines must be a priority for all national governments as well as donors, with a specific emphasis on ensuring viral load monitoring coupled with enhanced adherence support is made broadly available.

Finally, moving to models of care that emphasise increased autonomy for people living with HIV should be prioritised.



MSF's Access Campaign works to help our medical teams give quality care to our patients through promoting the development of new vaccines, medicines and tests, and challenging existing barriers to treatment such as costs- for patients in poorer counties. To learn more, visit www.msfaccess.org or follow @MSF_access on Twitter.

EMERGENCY RESPONSE

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

Since October 2012 MSF was supporting the Harare City Council in managing an outbreak of typhoid.

Assistance was rendered in the form of nurses, laboratory scientists, ambulance and logistical support in the two most affected suburbs of Glen View and Dzivarasekwa.

This was the third typhoid outbreak after the first one in 2010 which affected Mabvuka/Tafara and the second of 2011-12 which hit Kuwadzana and Dzivarasekwa. Over 5,000 people were affected by

the typhoid outbreak and 264 confirmed positive during this spell with a relatively low case fatality rate of less than 0.5 percent.

MSF transported over 1,800 cases for admission to Beatrice Road Infectious Hospital where all referrals were made. Support was provided with other partners in containing this outbreak together with the local authority.

Since lack of provision of safe drinking water was one of causes of the outbreak, MSF then took the initiative and distributed water

treatment sachets especially to the affected as a measure to encourage treatment of water.

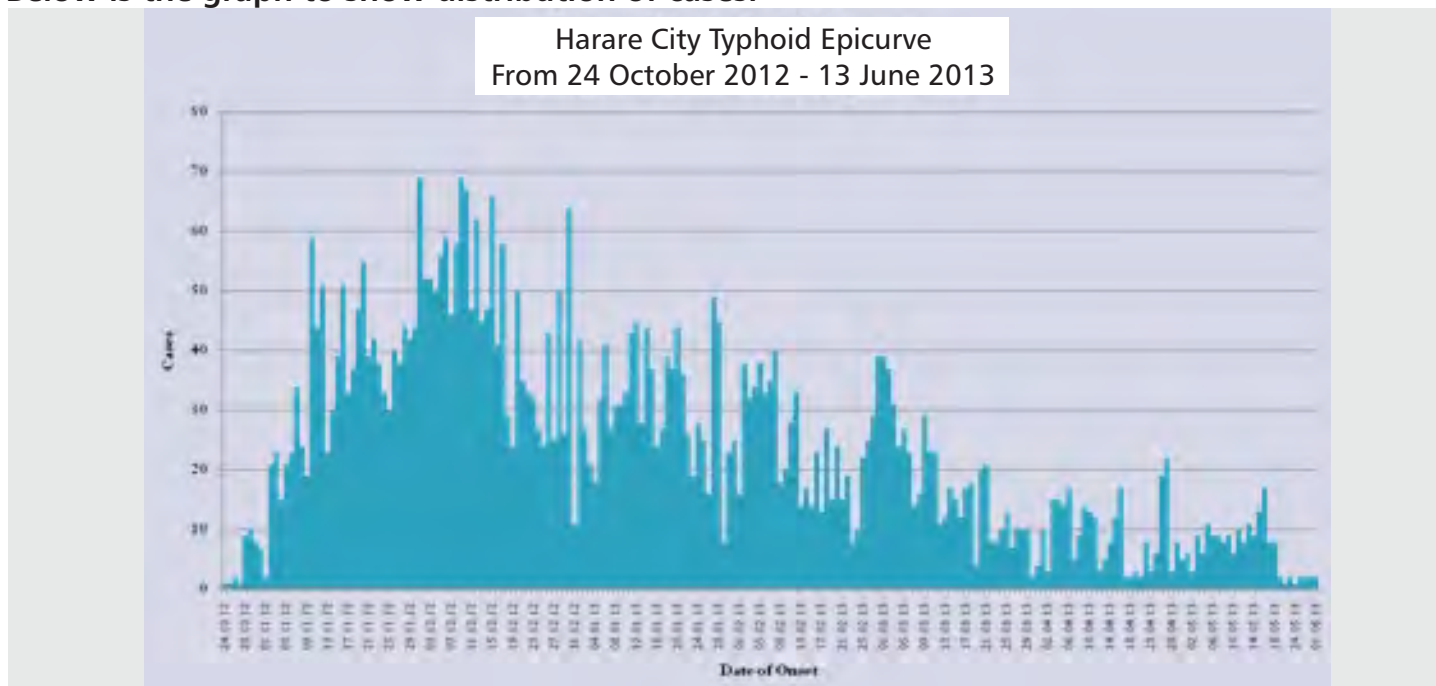
MSF also then set up mini water treatment points in secure sites like churches, schools and clinics so that people could access clean drinking water at all times.

In health promotion we assisted in production of posters pamphlets and T-shirts which were distributed to the community health care workers.

Areas which have been mostly affected by typhoid outbreaks are suburbs like Mbare, Kuwadzana and Dzivarasekwa where water and sanitation conditions are favourable to water-borne diseases like cholera and typhoid.

In January 2013, MSF also supported the local Civil Protection Unit during some flash floods in Tsholotsho.

Below is the graph to show distribution of cases.



MSF AND ZPS

Médecins Sans Frontières (MSF) assistance to the Zimbabwe Prisons and Correctional Service (ZPCS) dates back to 2009, when the Ministry of Justice invited MSF to render nutritional, water & sanitation and medical assistance.

The Médecins Sans Frontières (MSF) prison project began in the middle of 2012 as part of the Epworth project. The main focus of the project is to provide appropriate diagnosis and treatment for mentally ill inmates in Chikurubi Maximum Security Prison psychiatric unit.

MSF provides mental health support in eight additional prisons in the East and Central Prison District. In 2013 MSF provided Basic Mental Health training to 91 health care workers from the targeted (10) prisons (44 from Chikurubi and 47 from the eight selected prisons).

MSF in collaboration with the Zimbabwe Prison and Correctional Services (ZPCS) ensured that all of the mentally ill inmates in the Chikurubi maximum security psychiatric unit had access to quality psychiatric diagnosis, treatment and care. All new admissions were consulted by the psychiatrist and nurses. 400 psychological group sessions were carried out by psychologists.

The occupational therapists carried out 699 occupational therapy sessions. The project plans to continue throughout 2014 providing mental health support through intensified collaboration with the Ministry of Justice, Ministry of Health and Child Care, ZPCS and other stakeholders.

MSF plans to enhance access to antiretroviral therapy (ART) and tuberculosis (TB) diagnosis and care through providing opportunistic infections and antiretroviral therapy (OI/ART) management training to all Ministry of Justice nurses in the selected prisons.

Water and Sanitation in Prisons

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

In addition to training and providing health services, MSF installed a reservoir water tank at Chikurubi maximum prison psychiatric unit. Washing basins were installed for laundry to improve the sanitation of patients. Additionally, MSF in collaboration with ZPCS, fumigated patients' clothes, blanket and rooms and donated new clothes and blankets for the patients.

Also in 2013, MSF water and sanitation teams provided support to Chivi, Shurugwi, Connemara and Hwahwa Prisons. The aim of this intervention is to provide safe drinking water to help reduce waterborne diseases and improve the overall environment and personal hygiene of the inmates.

Hwahwa Young Offenders Prison

This prison is designed for inmates below 18 year old. Besides the inmates, the prison clinic also caters for an estimated catchment area of 6,000 to 8,000 people that includes prison staff and their families as well as the population from the surroundings. MSF supported the prison with installation of a 10m³ water tank, supply and installation of complete cisterns and C-packs for the toilets in the showers and stand alone toilets. The showers were also rehabilitated while a complete waste zone was constructed.

MSF also donated some drain rods to unblock sewer line, die set and protective clothing (gumboots + gloves), cement for the construction of 2 blocks of toilets with 2 squat holes each for the clinic and supplied together with connections of a 5m³ water tank and tank stand for the clinic.

Shurugwi Female Prison

This is a female prison also managed by female prison officers. At Shurugwi Female Prison, MSF built a water tank stand and repaired a broken 5m³ tank. Support was also given with metal cisterns and complete C-packs while showers were repaired through provision of shower roses and stopcocks.

Connemara Open Prison

MSF supported Connemara Open Prison with the installation of a 5m³ tank for the inmates as well as repairing of the toilets and showers. The MSF team also supplied drain rods, welding rods and gumboots & gloves.

Chivi Satellite Prison

The prison had five cells specifically designed for the inmates but they were not being used because they did not have toilets inside. They were using police cells which some times were holding more than their design capacity. MSF installed a 5m³ water tank and tank stand. The prison was also supported with water buckets for bathing, setting up / installation of 5 toilets in the cells.

The prisons project is a collaborative effort whereby MSF provides some materials while the prison authorities provide the labour and other locally available materials like bricks and sand.

MDR-TB IN TSHOLOTSHO

Early detection and prompt treatment of confirmed cases is key to tuberculosis (TB) prevention, treatment and control. Multi-Drug Resistant TB (MDR-TB) is a dangerous form of TB that is very difficult to treat and has poorer outcomes compared to drug sensitive TB.

MDR-TB diagnosis in Zimbabwe traditionally is based on laboratory culture of the TB bacillus and subsequent drug sensitivity testing (DST), both processes are time consuming. The minimum turnaround time for TB culture and DST results is around six weeks, but in reality can be much longer taking into consideration logistical and programmatic bottle necks relating to sending sputum for culture and DST from remote rural health facilities in Tsholotsho to the National TB Reference laboratory at Mpilo Central Hospital in Bulawayo.

Médecins Sans Frontières (MSF) in Tsholotsho acquired a GeneXpert machine. This machine is capable of detecting resistance to rifampicin within two hours. Because Rifampicin is the key first line TB drug, for practical purposes, Rifampicin resistance is managed as MDR-TB. In principle, therefore, GeneXpert saves on the lag time between sending specimens and receiving results thereby ensuring early detection of MDR-TB. In addition this machine can also detect TB in cases of poor bacillary load (pauci-bacillary TB).

Since the implementation of GeneXpert at Tsholotsho District Hospital on 8 April 2013, 441 samples were processed of which 101 were positive for TB (detection rate 22.9 percent), of these 11 (10.9 percent) showed resistance to Rifampicin. Of the confirmed cases, 7 (63.6 percent) patients were commenced on second line TB drugs and are doing well. All patients

diagnosed by GeneXpert commenced second line TB treatment within two weeks of confirmation of diagnosis. In contrast before GeneXpert, it would take 4 to 6 months to get TB culture and DST results.

Some of the patients diagnosed MDR-TB by GeneXpert and currently undergoing treatment and housed at the TB Halfway House in Efusini, just a stone throw away from Tsholotsho District Hospital were really grateful of this timely intervention. Below are some of the brief testimonies:

NB: Testimonies have been translated from Ndebele (local language).

'I was helpless, hopeless and I nearly died'

'I stay 15km away from the nearest clinic. I did not want to receive my injections in hospital for the entire eight months. Thanks to MSF for coming up with a home where we can stay and get our injections.'

It is clear from the above testimonies that all are hopeful that they will be cured of TB at some point. Their diagnosis was facilitated by GeneXpert and indeed this machine is source of hope to them and their families.



A laboratory technician working using the GeneXpert

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BEITBRIDGE

The Médecins Sans Frontières (MSF) Beitbridge project started in 2008 as an emergency response to a cholera outbreak. In February 2009, a primary health care project was started in the town in order to provide comprehensive support for the medical needs of mobile populations and other highly vulnerable groups such as orphans and vulnerable children as well as high risk groups such as commercial sex workers with a main focus on HIV/AIDS and sexually transmitted infections (STIs). In addition, the project also had an important component of emergency response including continued epidemiological surveillance.

In 2010, the project was reoriented to concentrate on comprehensive HIV/TB prevention, treatment & care in support of the district wide coverage by the Ministry of Health and Child Care (MoHCC).

From the beginning of 2011, MSF was implementing medical activities related to opportunistic infections (OI) and antiretroviral therapy (ART) in Beitbridge District Hospital (BDH), Dulibadzimu Clinic and in seven health facilities in the

rural areas covering Majini, Chaswingo, Chitulipasy, Tongue, Swereki, Dite and Sashe. From mid-2013, MSF also supported the six remaining health facilities in the rural area with transport, and clinical support and supervision.

TB
In Beitbridge, MSF was also the main partner of MoHCC in the tuberculosis (TB) and drug resistant tuberculosis (DRTB) program. A GeneXpert machine for DRTB diagnosis was donated to

BDH in May 2013 and country's pilot Intermittent Preventive Therapy program was implemented from April 2013. Transport's allowances for TB and DRTB patients were included in the project.

OI
Regular drug supply was provided to the MoHCC, covering the stock ruptures and needs of all the facilities in the district. For instance, during 2012 and most of 2013, MSF was the only supplier of cotrimoxazole in the District.

Logistics
From 2011 to 2013, MSF managed to construct Waste Management Areas (WMA) in BDH, Swereki, Chaswingo, Majini, Chikwarakwara, Sashe, Tongwe and Dite. The team also rehabilitated maternity ward and laboratory, constructed out patient department extension and Sputum Booth in Beitbridge District Hospital and completed water and sanitation maintenance in all mentioned sites.

Waste Management Area at Swereki Rural Health Centre



BEFORE



AFTER

Out-Patients Department Extension at Beitbridge District Hospital



BEFORE



AFTER

In 2013, MSF also supported the assessment process (two rounds of visits were done, one in April and the second one in October) for accreditation of 12 Health facilities of the district.

ARV treatment

By end of November 2013, 7,568 patients (2,068 in the urban area and 5,500 in the rural one) had been commenced on ART in the

project. Meanwhile, 999 patients (urban and rural) were initiated on ART between January and November 2013. During this period, the number of clients diagnosed with TB was 809 and they were all commenced on Anti-TB treatment.

Additionally, 528 HIV infected pregnant women and 462 HIV exposed infants were commenced

on ARVs to prevent mother to child transmission of HIV during the same period. The total number of HIV test done in the urban area during same period was 2,006 on which 206 were positive (76 male and 130 female).

Information, education and communication (IEC) activities

During this period, MSF provided



Health promotion through song and dance

counselling care to 41 victims of SGBV in both sides, urban and rural areas. The overall counselling sessions in urban and rural area was 16,108. Among them 587 were commercial sex workers; 1,427 orphans and vulnerable children and 1,951 migrants.

IEC and counselling activities were conducted in all of the supported sites and their catchment areas. MSF was involved in information sharing, health education and

different campaigns to promote the activities. The team was also involved in activities such as support groups, peer education and HIV testing and counselling.

MSF was also running a resource centre located in town, where MSF provided information, as well as support and voluntary counselling and testing to the beneficiaries. MSF also had an information kiosk that was used for information dissemination only, and was run by

volunteers, who were essential part of the program in all of the catchment areas.

Training

Trainings –formal and on the job mentoring– were done on a day to day basis, as well as emphasis on data collection through different tools so as to ensure good continuity of care for beneficiaries.

Beitbridge Figures from January to December 2013

HIV tests done	2,052
HIV positive tests	213
Total registrations(HIV+)	1,535
new ART initiations	1,023
Total patients on ART(Active cohort)	5,152
New TB patients	840
MDRTB patients taken into care	5
1st consultations for rape	42

MSF had to abruptly hand over activities to the Ministry of Health and Child Care in Beitbridge district on the 31st of December 2013 when the memorandum of understanding at local level was not extended. Therefore, the Ministry of Health and Child Care took over the responsibility of all medical support, including ARV's supplies, for more than 5,500 patients in the rural areas of the district.

Before their departure and to avoid treatment interruption, MSF provided three months' supply of ARVs that were made available centrally at Beitbridge District Hospital as a buffer stock.

BUHERA



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Médecins Sans Frontières (MSF) started to support HIV services in Buhera district in 2004. Initially treatment of opportunistic infection and antiretroviral treatment (OI-ART) were administered only at central level in Murambinda Mission Hospital (MMH).

Over the years, initiation of ART was decentralized to most clinics in the district. This was made possible by training and intensive mentoring of nurses by MSF mobile mentoring teams. Task-shifting of ART initiation to nurses led to an increased access to ART services with a total of 29 sites out of 31 providing ART in 2013 in the district.

Mentoring and capacity building

In 2013 MSF supported 25 health facilities providing ART through a

mentoring approach of Ministry of Health and Child Care (MoHCC) staff with the help of mobile mentoring teams.

The objective is to capacitate clinic staff to deliver good quality HIV/TB treatment and care. A training on pediatric HIV/TB issues was given to the medical supervisors of MOHCC. This training included participants from Buhera, Gutu and Chikomba Districts. Staff mentored were doctors, nurses, nurse aides on dispensing and drug ordering, primary

counselors, laboratory technicians and microscopists.

Finding actively people with HIV and linking them to care

In 2013, MSF invested in intensified HIV testing and counseling in collaboration with MoHCC and PSI (New Start) with special emphasis on reaching adolescents, men and partners of HIV positive women. Main strategies were mobile night clinics, soccer tournaments and HIV testing and counselling campaigns with immediate

1. National Survey of HIV and Syphilis Prevalence among women attending ANC clinics in Zimbabwe, 2012, AIDS & TB Program 2013, MOHCC, ZIMBABWE ANC sero-surveillance 2013 final copy

assessment of the immune status with help of a mobile testing device called PIMA.

A total of 1,751 HIV tests were done in outreach activities of which 116 tested positive. The positivity rate (6.6 percent) was very low, less than the provincial HIV prevalence among adults which is 13.9 percent.

64 percent of clients tested during outreach activities were males

New ARV treatment regimens and innovative tools for monitoring people on ART

The ART regimen of choice in use in Buhera is TDF/3TC/EFV, introduced by MSF in 2011. This regimen, recommended by WHO, has to be taken only once a day and has fewer side effects than previously used regimens.

All patients are offered routine yearly viral load – the new WHO GOLD standard for monitoring the effectiveness of ART treatment - instead of using the 6 monthly CD4 cell count previously recommended. People identified with treatment failure to 1st line ART regimens were switched to a 2nd line treatment, while poor adherence was corrected through enhanced adherence counseling.

A total of 1,255 people were initiated on ART during 2013, and at the end of the year 15,084 remained on ART. Viral Load testing (VL) was performed on a total of 13,776 blood samples. 2287 samples (including patients who were tested for the second time after enhanced adherence counseling) showed a VL above 1000 copies/ml, a threshold which suggests resistance to the current ART. At least 210 patients were switched to second line ART as a consequence of high VL results.

PMTCT, Early Infant Diagnosis (EID) and paediatric HIV

In 2013 MSF has continued to provide support to the Prevention-of-Mother-to-Child-Transmission (PMTCT) through the provision of ART drugs, the transport of samples for Early Infant Diagnosis, and through routine viral load monitoring with appropriate management of pregnant women and mothers on ART. With regards to HIV in children, MSF continued working on the disclosure of the HIV status with the aim to have the young HIV positive patients fully disclosed about their status at least at the age of 12.

Diagnosis and treatment of drug resistant TB diagnosis

A new technology to intensify diagnosis of TB and diagnose drug-resistant TB (GeneXpert) was introduced by MSF in two hospitals in the district (MMH and Birchnough Bridge Hospital) in 2011.

This platform has become the first line test for any TB suspect in the district instead of the traditional sputum smear microscopy. Patients diagnosed with confirmed DR-TB were attended through a model offering care and treatment in nearby clinics or at home with the help of mobile teams; this includes ART for people suffering both from TB and HIV, and screening of household members for active TB/DR-TB.

By end of 2013, cumulatively 36 patients had been diagnosed with DR-TB since 2011, and put on treatment. While eight have been declared cured, 15 remain on treatment at the end of the year, 6 had died on treatment, one defaulted and five were transferred out of the district.

Transport of sputum and blood samples

Transport of sputum and blood samples from the clinics to the district laboratories was handed

over to Riders for Health, who employed one motorbike driver to serve the clinics weekly. MSF continued to transport samples to Harare making use of its regular movements. The turn-around-time for VL results is less than 30 days, and for sputum results it is less than seven days for clinics.

A patient-centered drug dispensing system

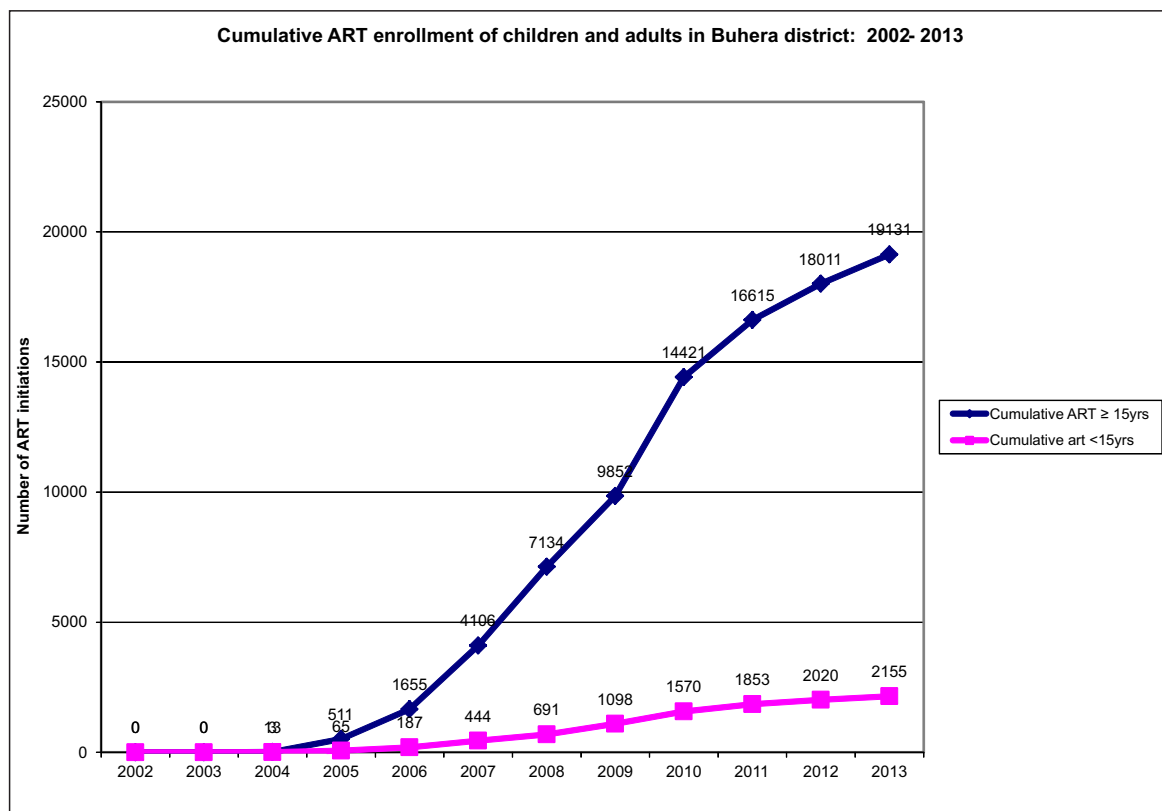
MSF supported the roll out of the 3-monthly "ARV pick up" system to MMH, BBH and Buhera Rural Hospital. This system allows patients to collect ARV drugs on a quarterly basis.

Introducing e-PMS (electronic Patient Monitoring System) in 6 static sites

MSF supported MoHCC to scale up the use of an electronic database for recording patients on ART from the two hospitals to six heavy workload clinics, using MSF data encoders. Computers with battery were installed in four sites and a sustainable solution for the actual encoding is being discussed with the district health team.

Technical support from a health economist to Murambinda Mission Hospital

MSF sponsored a three months visit of a health economist to assist the hospital management committee in identifying ways to improve the strategic and financial management of the hospital, to control costs and improve efficiency of existing resources, and to identify new funding mechanisms while MSF is phasing out.



Facts and figures from 2013 for Buhera District:

Total Number of HIV tests done by MoH/MSF	28,894
Number and % of males tested	10,250 (35.5%)
Number and % of positive HIV test results	2,510 (8.7%)
Number and % of female with positive test	1,612
Number of new HIV+ patients enrolled in care	704
Total number of HIV+ patients in pre-ART care at the end of 2013	5,020
Number and % < 15 years in pre-ART care out of total in pre-ART care, end of 2013	434 (8.7%)
Number of patients initiated on ART	1,255
Number and % < 15 years initiated on ART out of total initiated	135 (10.8%)
Number of patients on ART at end of 2013	15,084
ART coverage for adults (with CD4 350)	71%
ART coverage for children (with CD4 350) (proxy indicator: based upon age at initiation)	83%
Number of new TB patients diagnosed and put on treatment (NTB program)	638
Cumulative Number of DR-TB patients diagnosed & put on treatment (by end of 2013)	36
Number already cured:	8
Remain on treatment:	15
Died on treatment:	6
Defaulted:	1
Transferred:	6
Number of MSF staff end of 2013 for Buhera	International: 4
	National: 72

CHIKOMBA - GUTU

Despite a significant decline in HIV incidence in the past few years as witnessed by the falling HIV prevalence rate, Zimbabwe is still among the most affected countries by HIV/AIDS in the world coupled by high tuberculosis (TB) burden.

Through Médecins Sans Frontières (MSF) support, access to anti-retroviral therapy (ART) drugs in Buhera district became exemplary in the country, reaching close to universal coverage by 2010. However the quality of care offered by MSF as well as the short time to initiation attracted a large number of patients from surrounding areas such as Gutu and Chikomba districts. In a bid to alleviate this high burden for

patients who were travelling to Buhera district for ART, and to improve the quality of life and retention in care for patients leaving far away, MSF decided to support ART care in two adjacent districts (Gutu and Chikomba) using a "LIGHT APPROACH".

Early 2011, MSF launched a project to support HIV/TB care and treatment in Gutu and Chikomba districts using a "Light Approach"

concept for an initial period of three years. The objective of the light approach is to increase access to HIV care through decentralization of ART care, treatment and follow-up at clinic level through training and mentoring of Ministry of Health and Child Care (MoHCC) nurses.

This "Light Approach" does not only cut significant costs but it has also proven to be a very good strategy balancing access to full package of HIV/AIDS & TB treatment, and sustainability. The mentored MoHCC staff will be able to perform any HIV/TB task with minimum support from MSF.



Through the light approach, MSF seeks to increase access to HIV care through decentralization of ART care, treatment and follow-up at clinic level through training and mentoring of Ministry of Health and Child Care (MoHCC) nurses.

In three years time MSF managed to increase access for patients by decentralizing HIV/TB care to more than 90 percent of the operational health facilities in the district staffed by MoH : 28 facilities in Gutu district which translates to 93 percent of all health facilities and 31 facilities in Chikomba district (97 percent of all health facilities). This was achieved with a mobile team visiting clinics on a fortnightly basis and mentoring the MoHCC staff on site, followed up by close supervision after completion of the mentoring period. This increased coverage for ART from 10-15 percent in 2010 to 90.5 percent at the end of 2013 for Gutu district and from 36.8 percent in 2011 to 93 percent at the end of 2013 for Chikomba district.

At present, two MoHCC mobile mentoring teams in both districts are doing mentoring of their own sites. Sites supported by MSF mobile team will be gradually handed over to these mobile

teams. From the start it was anticipated that our “light/mentoring approach” project to scale up ART coverage by decentralizing care would have a duration of three years. This was achieved in both districts by the end of 2013.

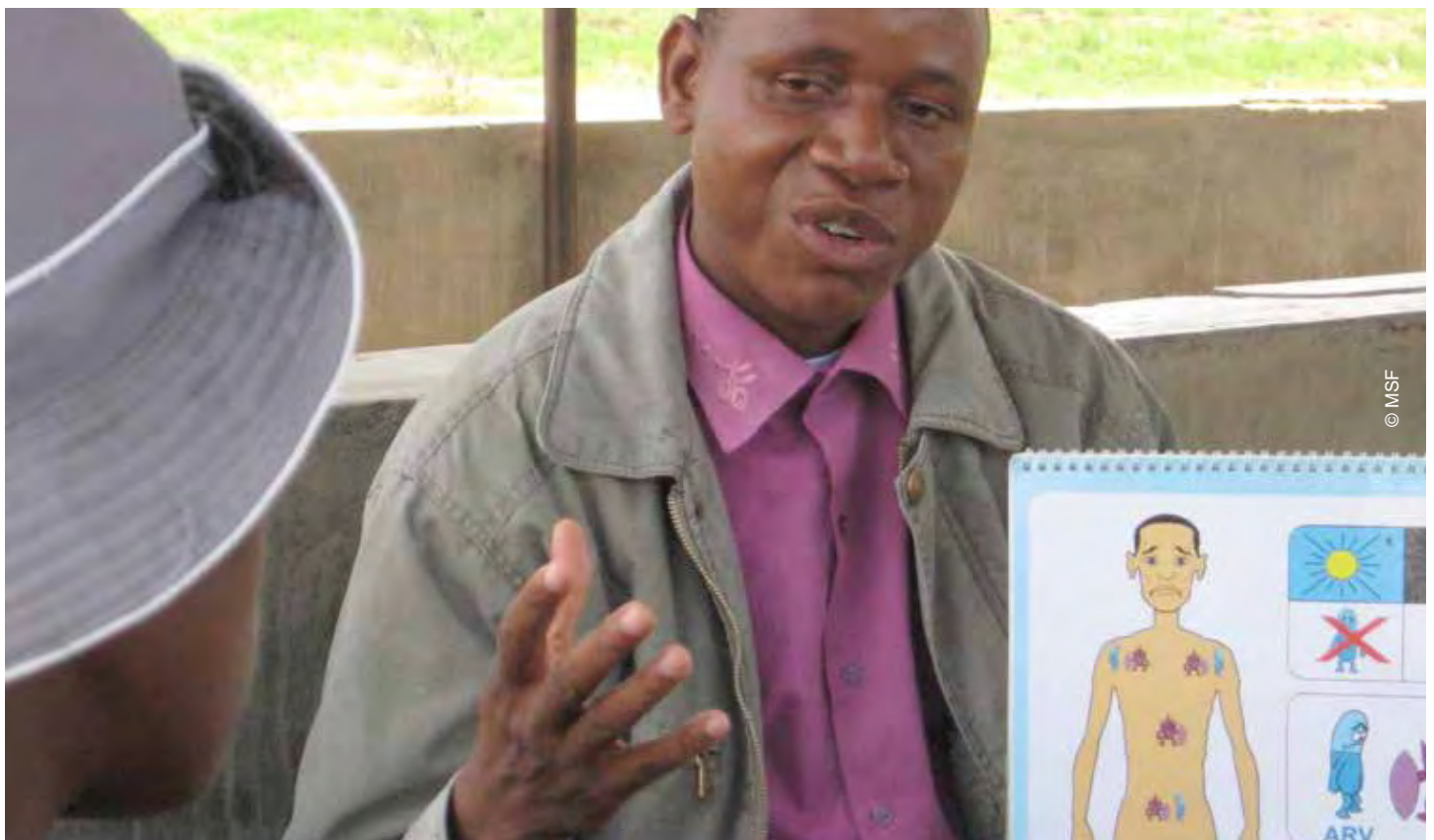
Since its inception, the Chikomba district project had greater involvement of the District Health team (DHT), functioning mobile teams, a better ART coverage and good TB outcome indicators. MSF phased out a big part of its support to Chikomba district in December 2013 but will continue to support Viral load and Monitoring & Evaluation

In Gutu the teams faced some difficulties to reach the average national ART coverage and TB treatment outcomes. Though the light approach will be maintained through a mobile on-the job mentoring and supervision approach, the focus will be on increasing the activities in order to

have a positive impact on the epidemic by initiating earlier and achieving community undetectable viral load. This new phase is planned for an additional three years (2014 – 2016). Testing is the first step in the HIV care cascade hence finding people infected with HIV earlier, linking them to HIV care prevents morbidity and mortality and reduces further transmission.

In 2013, special attention was given to adapt the existing model of care, that is “testing and counseling at the level of the health facilities” to needs, as well as considering its acceptability for different groups which include men, working population, adolescents and young adults, sex workers, hard-to-reach areas and resettlement sites.

Alternative models of testing were introduced such as weekly night clinics, adolescents and youths HIV testing and counseling campaigns in combination with



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Patient literacy on the need for Viral Load testing is essential to support the demand for viral load and is likely to aid adherence.

sport events and in the neighborhood of schools, HIV testing and counseling campaigns (HTCs) in remote area and in the communities in order to overcome the existing barriers to access care when tested in the clinic settings.

Also, in mid 2013, the concept of Community ART Refill through Support Group (CARSG) was introduced as an innovative community care model in Zimbabwe to benefit hard-to-reach communities.

HIV support groups of people living with HIV/AIDS formed by adult patients, stable on ART, meet in the community to check pill counts, verify the health status of members and choose a representative to travel to the clinic to collect ARVs for the group.

By the end of 2013, 21 support groups with 116 members

collected their refill ARVs through CARGS. To retain people in care, a "same day treatment approach" for people detected through alternative testing models was implemented as they are very likely not to report to clinics for treatment initiation after receiving a positive test.

Starting from July 2013, pregnant and lactating women as part of the PMTCT B+ : prevention mother to child transmission, Sero Discordant Couples, Commercial Sex workers and children less than 5 years old could start treatment regardless of baseline CD4.

In November 2013, the GeneXpert was also introduced in Chikomba district to improve the access to diagnosis of TB and MDR-TB. Not only is the GeneXpert more cost-effective compared with the initial medical consultation and X-ray for all smear negative clients, but also

TB cases will be detected earlier. To improve the turnaround time from the time TB is suspected until when treatment starts, MSF continues to support the Environmental Health Technicians on motorbikes in the transport of the samples / results from the health facilities to Harare and vice versa.

At date, eight DR-TB patients were initiated in Gutu district. One nurse of each respective clinic was sent for attachment to Murambinda to increase their knowledge in the management of DR-TB.

In 2014, focus will be on scaling up care for the new eligible groups according to 2013 WHO ART guidelines for initiations in the health facilities in close collaboration with the MoHCC mobile mentoring teams using the light mentoring approach.

Facts and figures from 2013 for Chikomba and Gutu Districts:

	MSF in GUTU	MSF in CHIKOMBA
Number of HIV tests done (HTC only)	1,680	1,177
Of those, number of positive results	66 (3.9%)	75 (6.4%)
Number of HIV tests done (at health facility) for the district 2013	14,479	
Of those, number of positive results	1,572 (10.9%)	
Number of HIV tests done (night clinic only)	1,194	
Of those, number of positive results	124 (10.3%)	
Number of new HIV+ patients taken under care (District Pre-ART patients)	2,588	
Total number of HIV+ patients under care at end of 2013 (ART only)	7,113	2,084
Number of patients initiated on ART 2013 (MSF Sites)	1,827	452
Number of patients on ART at end 2013 - MSF Active Cohort	7,113	2,084
Number of new TB patients newly diagnosed and put on treatment	335	139
Of these, number of MDR TB patients taken into care	6	
Number of staff as of end of 2013		
International	3	(for both projects)
National	16	10

EPWORTH



Patients being assisted in retrieving their personal files in Epworth

Médecins Sans Frontières (MSF) started providing treatment, care and support for people living with HIV in Epworth Polyclinic (Domboramwari) in November 2006. Between 2007 and 2009, around 10,500 patients were registered in the HIV program, 5,000 were started on antiretroviral therapy (ART) and 1,000 on tuberculosis (TB) treatment.

To alleviate the resulting congestion at Domboramwari, a new clinic was constructed at Overspill which is 4.4 km from Domboramwari, opened on 9 September 2011.

This clinic took over 3,000 stable patients on ART from Domboramwari and is now managing both HIV and TB patients independent of MSF. A small number of patients were also diverted to an existing Methodist Church-run clinic (Mission).

MSF's objective has been to create a sustainable HIV and TB program

in Epworth that eventually could be managed entirely by the Ministry of Health and Child Care (MoHCC).

As a strategy, this has been achieved through integrating MSF activities with MoHCC activities and promoting task sharing as well as task shifting.

During 2012 and 2013, MSF provided training and on-the job mentoring on ART initiation for both its own staff and for MOHCC staff at Dombo, Overspill and Mission clinics.

At the same time it advocated at district and provincial level to allow nurses to initiate ART without the presence of a medical doctor. MoHCC has since certified both Domboramwari and Overspill as nurse-led initiation sites.

HIV rapid testing and counseling training was provided to MSF and MoHCC nurses, as well as 15 Primary Care Counsellors (PCCs), to alleviate the work load of the nurse-counsellors. Currently, all nurses and PCCs can test and counsel HIV patients. Over 40 nurses have been trained in the

appropriate management of sexual and gender based violence (SGBV) in order for the clinics to be prepared at all times to provide care to SGBV survivors. Training has also been provided for TB and MDR-TB management and malnutrition.

Besides providing training and gradually integrating MSF with MoHCC activities, MSF has introduced the use of GeneXpert in the Domboramwari laboratory contributing to a quicker and more accurate diagnosis of TB and MDR-TB.

A cervical cancer screening program has also been launched at Overspill for all the women in the clinic's HIV program and a new laboratory and pharmacy building is now being constructed for Domboramwari clinic.

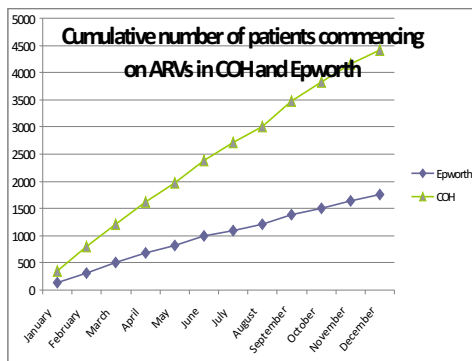
Currently MSF activities in Epworth are focused on Domboramwari clinic but minimal support is continuously provided to Mission and Overspill clinics in the form of regular medical doctor visits.

During 2013 in Domboramwari clinic, 8,712 patients were tested for HIV; 1,762 were initiated on ART while 388 patients were

started on TB treatment and 8 on MDR-TB treatment. The priority in 2014 is to improve management of children and adolescents with HIV, patients that are failing on ART and patients with MDR-TB.

City of Harare

Outside of Epworth, MSF supports the City of Harare satellite clinic in Caledonia Farm, close to Mabvuku. This clinic, which serves the newly settled population of the area, was constructed by MSF in 2011 and opened in early 2012. The clinic provides basic health care, HIV testing, treatment and care including psychosocial support using an integrated approach.

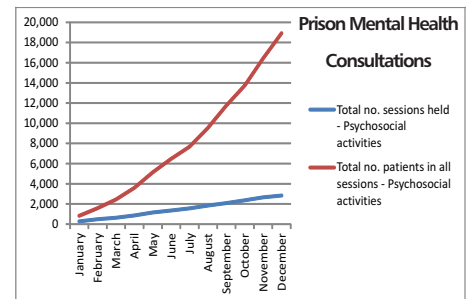


Additionally, MSF nurses have been deployed in six City of Harare Polyclinics in order to support the City of Harare Health Department's HIV care decentralization strategy.

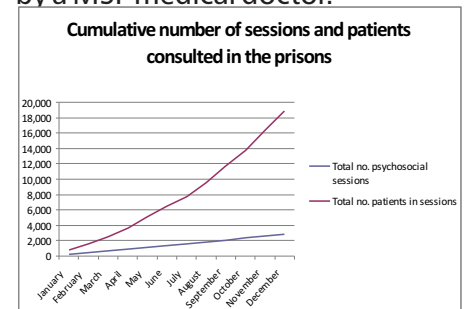
Through providing training and on the job mentoring a considerable scale up of nurse led ART initiation has been achieved. In 2014 support will continue to be provided to these clinics, but as in Epworth, focus will be directed towards children and adolescents with HIV, ART failure and MDR-TB.

Prison Mental Health

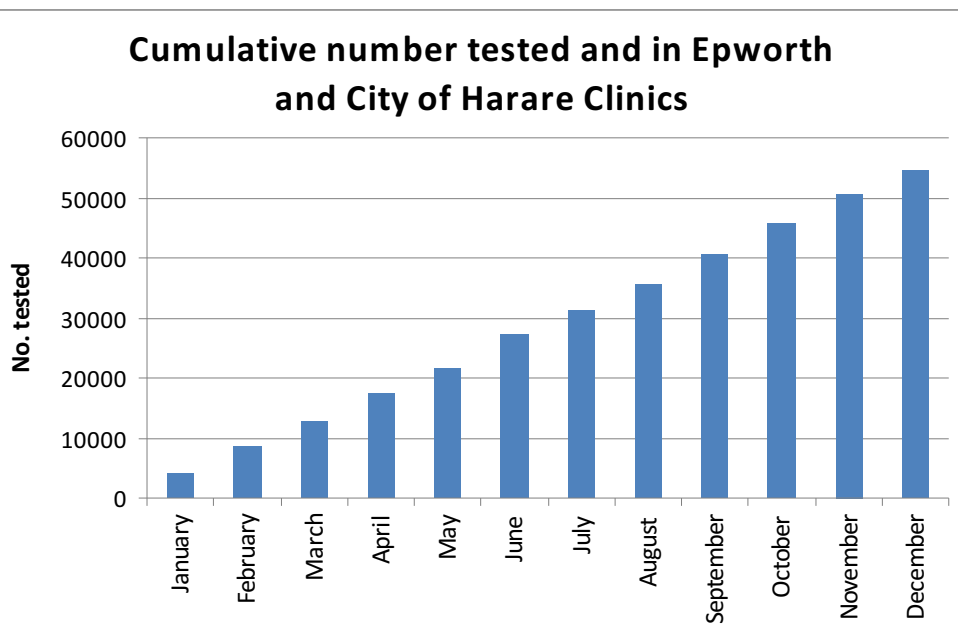
Since 2012 one MSF psychiatrist together with a team of psychologists, mental health nurses and occupational therapists delivers psychiatric care to mentally ill inmates in Chikurubi Maximum Prison's Psychiatric Ward.



This component of the Epworth project is also providing training in mental illness management to 8 selected prisons outside Harare as well as supporting HIV and TB care in Chikurubi Prison Hospital through training and regular visits by a MSF medical doctor.



Cumulative number tested and in Epworth and City of Harare Clinics





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A medical doctor during a consultation in Epworth

Facts and figures from 2013 for Epworth and City of Harare Projects:

	Epworth	City of Harare
Number of HIV tests done in clinics	8,712	45,942
Of those, number of positive results	2,407	7,797
Number of patients initiated on ART 2013	1,762	4,413
Number of patients on ART at end of 2013	8,236	5,762
Number of new TB patients newly diagnosed and put on treatment	494	
Number of MDR TB patients taken into care	8	
Number of first consultations for rape	167	
Number of staff as of end of 2013:	International	(for both projects)
	National	
	94	

GOKWE NORTH

Médecins Sans Frontières (MSF) has been working in Gokwe North district, Midlands province since 2012 with the objective to exit at the end of 2014 after three years of intervention. During the two years MSF was able to support 18 health facilities; including the District Hospital and a mission hospital in Chireya.

The joint MSF and Ministry of Health and Child Care (MoHCC) partnership in the fight against HIV, tuberculosis (TB) and Sexual and Gender Based Violence (SGBV) programmes has led to successful decentralization of the services to the rural health facilities.

MSF implemented the project activities through a " *Light approach strategy model*" that focused on training of the health providers from the 18 health facilities and on-job mentoring; community awareness on HIV and essential structural improvement. Two teams of well skilled health

workers under the leadership of a medical doctor went from clinic to clinic mentoring the rural clinic nurses in management of HIV/ART management. During the mentoring sessions an integrated approach was adapted in order to reduce stigma and integrate HIV/ART services in the primary health care activities at the clinics. The teams mentored the clinic nurses in primary health care management in addition to the HIV management.

This resulted in improved patient care at these facilities. Fewer resources were used with greater

achievements. All clinics had their drug stores security re-enforced through fixing of an additional screen iron gate and fixing of metallic shelves, painting, waste management improvement, office furniture donations and small rehabilitations. The ownership of the project activities remained in the hands of the MoHCC facility care givers.

MSF took a lead in HIV/TB/SGBV services decentralization from the district hospital to the rural facilities to bring services closer to the communities and reduce the long travelling distances. Patients had to journey for long distances, sometimes up to 160 kilometres, to access services at the district hospital.

In addition, health education and HIV/TB/SGBV awareness through



Precious Zvikonyo mentoring a Ministry of Health and Child Care nurse on sputum collection

village health workers reduced stigma in the community and helped the communities understand the HIV plight and importance of knowing individual HIV status as well as the availability of ART at the clinics.

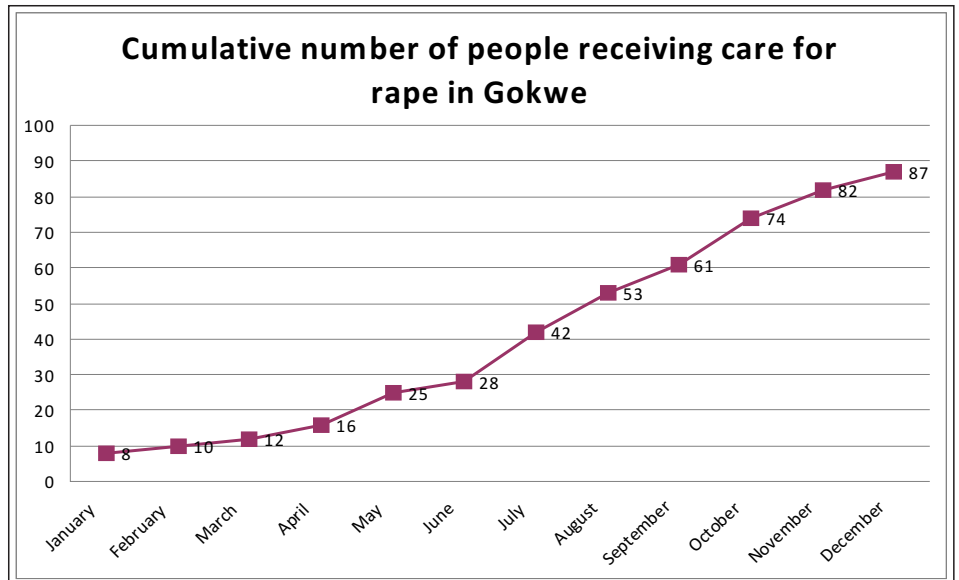
The number of patients initially managed at the district hospital before decentralization was 3,500. After decentralization the district hospital remained with a cohort of 1,164. By the end of 2013, all the health facilities were able to provide management of opportunistic infections and antiretroviral treatment services effectively.

The MSF and MoHCC partnership has led to improvement in the management of patients enrolled in the HIV, TB and sexually gender based violence programmes. Trainings were conducted at the

district and national levels to improve management skills of the health providers.

Health campaigns were conducted in schools and in the community in collaboration with other stakeholders who included the Police Victim Friendly Unit, Ministry of Gender and Women

Affairs as well as the Ministry of Education in the SGBV programme. Community participation and local leadership involvement has contributed immensely to the reduced stigma in reporting rape or domestic violence. There has been an improvement in the diagnosis and treatment of TB and MDR-TB



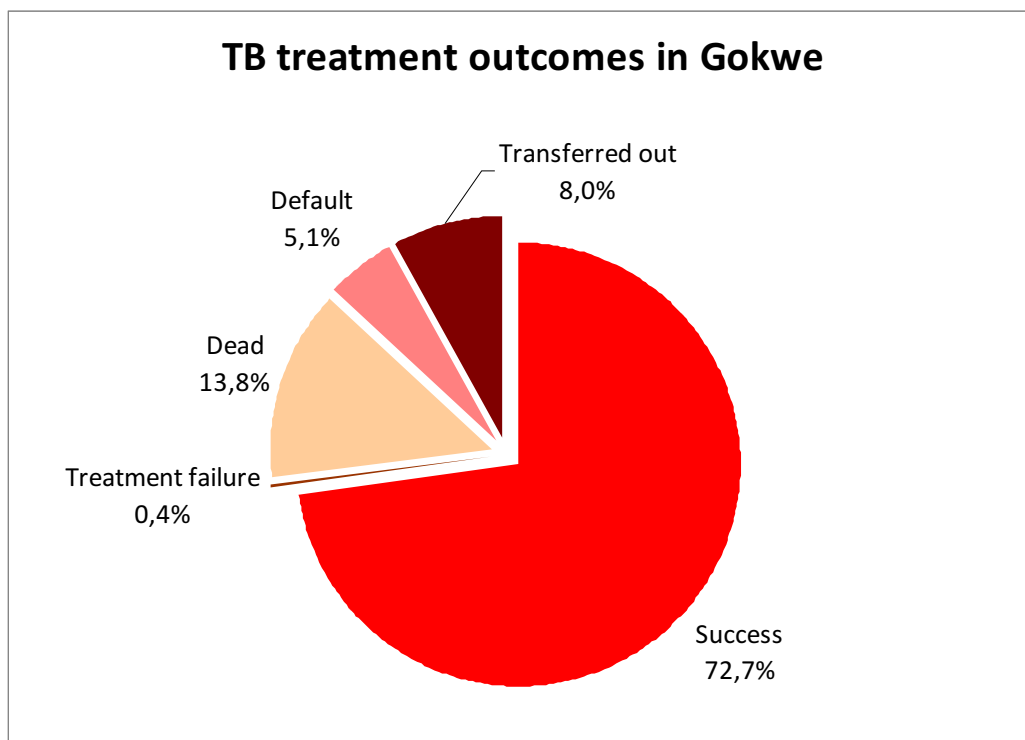
MSF team delivering some medical supplies to a rural health facility in Gokwe

through the acquisition and use of the GeneXpert machine and training of MoHCC staff who are actively involved in case detection. Initially MSF was responsible for the salaries of two Laboratory scientists in the district but this has since been taken over by the MoHCC. Gokwe North district has made positive progress in the

management of HIV/TB/and SGBV. The light approach has resulted in less resource with great achievements. The health care givers have gained the necessary skills to manage the mentioned programs.

Since the ownership of the project activities remained in the hands of

the MoHCC facility care givers, MSF exit will not leave a gap. The district health executive and the nurses at most rural health facilities are confident that a decentralised and integrated HIV/TB/MDRTB/SGBV treatment, care and support will continue in Gokwe North district.



Facts and figures from 2013 for Gokwe North District:		
Number of HIV tests done in Gokwe North clinics		23,655
Of those, number of positive results		1,643
Number of patients initiated on ART 2013		1,141
Number of patients on Art		1,141
Number of patients on ART at end of 2013		5,533
Number of new TB patients newly diagnosed and put on treatment		444
Number of MDR TB patients taken into care		6
Number of first consultations for rape		87
Number of staff as of end of 2013:	International	2
	National	24
Gokwe North District / MoHCW establishment		1

MBARE

CLINICAL MANAGEMENT OF SURVIVORS OF SEXUAL ABUSE



Awareness campaigns on sexual violence in Mbare

Médecins Sans Frontières (MSF) opened the Sexual and Gender based Violence (SGBV) project at Mbare Polyclinic in September 2011. While the clinic operates within the polyclinic, this is a specialized service, providing comprehensive care to survivors of sexual violence. The clinic is fully staffed and run by the four MSF nurse counsellors and two nurse aids.

Rape devastates the lives and health of survivors. Comprehensive care is aimed at reducing the impact of the rape on the survivors lives. It can be loosely divided into four components:

Medical care – medications are given to prevent some of the

medical consequences of rape like HIV transmission, sexually transmitted diseases and pregnancy. For example post exposure prophylaxis (PEP) - after someone has been raped he/she can be given anti HIV medications for one month to help PREVENT HIV infection. Prior to

administering of PEP, survivors are tested for HIV. PEP is most effective when it is given as soon as possible after the rape, and it can only be up to 72 hrs after the rape. In 2013 several women and children came to the clinic too late to be given PEP. They were infected with HIV as a result of the rape. Medical care after rape is an emergency.

Psychosocial care – this is perhaps the most complex area of support to survivors in the project. It involves both an understanding of the psychological consequences of



Health promotion through song and dance

rape such as sadness, anger, sleeplessness and depression as well as an understanding of the family dynamics of the survivor and her or his social environment, for example, not enough money for school fees, parents away, poverty.

The nurse counsellors provide the immediate counselling for all survivors seen in the clinic and the social worker receives cases referred from the nurses for social issues which include legal advice, department of Social Services input, support with their pregnancy or protection for those that need to be placed in a safe houses.

Forensics – while it is not compulsory for survivors to lodge a complaint to the police before they seek medical care, more than 90 percent of survivors still come to the clinic via the Victim Friendly

Officers of the police. These officers volunteer for the role, are mostly women and have been sensitized to the issues around SGBV. There are VFU officers based in each police station. Each survivor seen in the clinic is examined, evidence collected if possible and a medical affidavit is written. The medical affidavit is a legal document which can then be used as evidence in court. MSF nurses can be called to the court to give expert testimony about the affidavit. This happens 2 – 3 times a month. For some survivors, seeking justice through the court is an important part of their road to recovery.

Follow-up – follow-up is scheduled over three months for each survivor seen in the clinic, for both counselling and medical care which include a new HIV and pregnancy test and management of the side effects of the PEP. The

social worker is very active in the follow up of complex cases over long periods – moving between the clinic and the community - escorting survivors to court, arranging legal advice, lobbying for school fees, helping to resolve conflicts within families and reunifying survivors with care givers.

All care provided in the clinic is free.

MSF is currently constructing a new clinic in Mbare Polyclinic. Construction started in October 2013 and should be finished before the end of 2014. The new space will mean that the team has an extra room (four in total) as well as hand basins in each room and a toilet and shower for the survivors. In 2013, a total of 1,220 survivors were provided care by MSF in the Mbare clinic. Since the clinic opened a total of 2,249 survivors have been seen. On average, 35

percent come within 72 hrs and are assessed as to whether or not they need PEP. Getting survivors to come earlier so that they can receive the complete treatment package remains a challenge in the project.

Who are the survivors: most of the survivors seen in the clinic are young females, aged between 13 – 15 years. Most live in Mbare or the high density suburbs close to Mbare – this does not mean that rape is more common in those areas, rather that medical services are available close by. Most are raped by someone they know, a family member or their employer. Often the younger girls tell that the man is their boyfriend.

Health Promotion (HP): HP is more about raising awareness in the community, often targeting specific groups, via key messages expressed through different mediums. Health promotion can be global through use of mass media like TV, radio and large bill boards or more focused, for example targeting schools in Mbare. HP activities in the MSF SGBV activities focus on:

- Development of IEC material with key messages which include “Medical Care After Rape is an Emergency”. This message has been produced on stickers for public transport, a flip chart, posters, t-shirts and calendars. All material

produced carries the details of the key service providers – not just MSF.

- Community trainings – targeting village health workers, VFU officers and community leaders.
- Training of teachers in the schools in Mbare – because the majority of survivors seen in the clinic are school age, and because they are often not able to disclose the abuse to a family member, the team works with teachers in Mbare to sensitize them to the SGBV theme and the importance of medical care and support.
- Participation in events: including World AIDS Day, the Agricultural Show and 16 Days of Activism against SGBV.
- Mass media – participation in both in print and electronic media.

There are multiple actors working on SGBV in Zimbabwe. MSF has formal partnerships with Adult Rape Clinic (ARC), Family Support Trust (FST) and Childline. We also collaborate with many organisations which include Musasa, Department of Social Services, Zimbabwe Women's Lawyers Association (ZWLA) and Pregnancy Crisis. These relationships are vital to ensure that survivors receive good care. For example, survivors requiring more medical care are referred to a medical doctor at FST. The Help

Line is a free phone line run in collaboration with Childline. People can dial 116 for free to get advice on what to do in case of sexual violence.

MSF participates in the training of the helpline volunteers. While the number of survivors seen in the clinic as direct referrals remains low at less than 3 percent it is not known how many survivors go to the police as a result of calling 116. MSF remains committed to supporting the 116 line. In 2014, MSF will continue to providing comprehensive care to survivors from the Mbare clinic throughout 2014.

MSF also aims to improve access to services by decentralising services to eight poly clinics within Harare. The training of City Health nursing staff in sexual violence care, including placement in the Mbare clinic, is a key part of the strategy. Decentralisation will be planned in collaboration with the authorities, the VFU and the local community. In the same vein, MSF in collaboration with the Zimbabwe Red Cross plans a targeted health promotion intervention in the hostels in Mbare, and encouraging people who are raped to access medical care promptly.

The planning for 2014 is ambitious and in order to keep on top of activities the team will be expanded to include additional nurse counsellor, health promoter and driver.

Sexual Abuse Can Happen To Anyone
Get Free Confidential Medical Service Within 72hrs For Maximum Benefit
CALL 116 FOR FREE...
 and get help from the following Clinics, District, Provincial, Mission & Central Hospitals or The Police Victim Friendly Unit

NYANGA

The presence of Médecins Sans Frontières (MSF) in seven of the country's ten provinces of Zimbabwe gave us an opportunity to closely follow the country's opportunistic infections and antiretroviral therapy (OI/ART) activities. Despite the country reporting to have achieved an overall ART coverage around 86 percent there were negatively low reports on pediatric ART coverage of 42 percent for the whole country and worse in certain districts.

MSF carried out assessments in four districts within two of the provinces where MSF is already present, thus Manicaland (Nyanga, Chipinge) and Masvingo (Chivi, Chiredzi). We assessed the achievements in terms of ART coverage, tuberculosis (TB) notification, presence of mobile Ministry of Health and Child Care (MoHCC) ART refill teams, performance in HIV care and treatment of hospitals and four clinics per district among many other health related issues. The assessments concentrated on main findings and aimed at evaluating in which district MSF

could make a major difference for patients using a "light resource and mentoring" approach that could be launched with minimal delay.

Generally the four assessed districts were all in need of assistance having realized an adult ART coverage below the national achievement (around 45 percent in two districts, 68 percent in Nyanga and 76 percent in Chivi, using patients ever initiated on ART as parameter). Pediatric ART coverage was particularly bad in all the districts (< 22 percent in three districts) and only five percent in Nyanga. In addition there was only

minimal decentralization of ART care to primary health care clinics in the four districts.

On that basis, in September 2013, MSF in agreement with the provincial Health authorities of Manicaland province, launched a project to support HIV/TB care and treatment with more emphasis on pediatric ART care in Nyanga district using the "Light Approach" concept for a period of one and half years.

The objective of the light approach is to increase access to HIV care through decentralization of good



MSF is supporting Nyanga District focusing on pediatric ART

quality ART and TB care, treatment and follow-up at clinic level, while making use of existing services and resources.

- **Capacity building**

Existing nurses and primary counselors (PCs) employed by the Ministry of Health and Child Care (MoHCC) are being trained and mentored by MSF on the job with regards to ART and TB diagnosis, care and treatment in nine clinics and in the district hospital. As part of the capacity building, MSF is training and supporting a MoHCC mentoring team. This team is going to provide mentoring for sites not reached by the MSF team.

- **Integration and reorganization of services**

The new ART/TB services are being integrated right from the start into existing services to facilitate the

provision of a comprehensive package of primary health care in a cost-effective way. MSF supports the district health team and clinic staff to organize services, patient records and patient flow so as to enable the clinics to cope with the increased ART/TB treatment and follow up demand. This includes models of care to keep healthy patients out of the clinics, such as Community ART refill groups and three month drug supply.

- **Support to laboratories:**

MSF assists in establishing an effective sample transport system between clinics and laboratories at district and national level. In addition MSF will provide access to Viral Load (VL) testing for patients suspected of treatment failure, to assure appropriate switch to second line ART in case of

need. MSF will provide a more sensitive tool called GeneXpert for the diagnosis of TB and Drug Resistant TB (DR TB) to enhance early diagnosis and treatment of TB.

- **Support to pharmacies**

The light approach includes strengthening of the pharmacy management at clinic and district level, and the provision of a fixed dose combination of tenofovir + lamuvidine + efavirenz (known as TDF + 3TC + EFV). This is an adherence friendly one pill a day formulation and is currently the best available option recommended by WHO and MoHCC. MSF is supporting the transition to this new 1st line regimen for newly initiated patients.

OCTOBER 2013 TO DECEMBER 2013 ART INITIATIONS

	Children	Adults
October	8	34
November	9	22
December	3	3
Total	20	56

4 patients diagnosed of TB and started on treatment, 3 adults and 1 child
 2 MDR TB patients diagnosed and started on treatment
 1 consultation of rape survivor

Staff compliment

8 National Staff

TSHOLOTSHO



A mother in Tsholotsho is happy after her baby tests HIV negative

Tsholotsho is one of the oldest regular projects for Médecins Sans Frontières (MSF) in Zimbabwe. In 2001, MSF started monitoring the nutritional situation in Tsholotsho district culminating in the establishment of a Therapeutic Feeding Centre (TFC) for children less than five years at Tsholotsho District Hospital (TDH).

In 2004, the TFC was handed over to the Ministry of Health and Child Care (MoHCC) and simultaneously, a memorandum of understanding (MoU) was signed with MoHCC to engage in the provision of HIV/AIDS services. Resultantly, an opportunistic infections (OI) and antiretroviral treatment (ART) clinic was set up at the district hospital.

Over the years, MSF supported MoHCC to introduce and roll out a comprehensive OI/ART program targeting all aspects of HIV prevention, treatment, care and support. The project has evolved

to cover different strategies ranging from the initial access-focused framework of “simplification, decentralization and task shifting/sharing” into a more comprehensive framework of integration of OI/ART services to general clinical services which include tuberculosis (TB), prevention of mother to child transmission (PMTCT) and out patient department (OPD) as well as the use of less toxic antiretroviral therapy regimens.

In Tsholotsho, MSF also supported survivors of sexual and gender-based violence (SGBV), nutrition,

laboratory & pharmacy services. All the 19 health facilities in Tsholotsho district were opened as ART follow up sites in 2013, with MSF extending its support to these sites. In addition, MSF also supported Nyamandlovu Hospital in Umguza district.

Information, education and communication (IEC) activities

During 2013, the IEC department worked closely with Treatment Literacy and Advocacy community based Trainers of Trainers to form more people living with HIV/AIDS (PLWHA) support groups, PMTCT

support groups and Community ART groups.

Social mobilisation for TB, HIV/AIDS, SGBV, PMTCT and nutrition continued. The Community Adult Peer Education (CAPE) program among the San community in Sikente and Pumula was expanded by recruiting and training 20 more cadres. To date, a total of 40 members of the San Community have been trained as CAPE since the inception of the program. Youth in and out of school peer educator programs continued at all primary and secondary schools, Youth Corners at all health facilities and convenient community meeting places such as dip tanks throughout the district.

The out of school youth programme was introduced in 2013 mainly to cater for unemployed youths. Condom promotion and distribution continued as well as HIV/AIDS workplace based programs

targeting both the formal and informal sectors in Tsholotsho. Theatre for communication was expanded by training 20 more youths from Jimila clinic catchment area.

TB

The GeneXpert MTB/RIF, a cartridge-based, automated diagnostic test that can identify Mycobacterium tuberculosis (MTB) and resistance to rifampicin (RIF), and Fluorescent microscopy, strengthened TB diagnostics in 2013. Through the GeneXpert, 465 new cases were diagnosed rifampicin resistant. They were promptly commenced on second line anti-TB treatment. DRTB patients need long-term treatment. Therefore, MSF created "DRTB halfway homes" in Efusini and Pumula, which are now fully operational. A total of five patients were admitted in these homes in 2013.

New ARV regime

In 2013, MSF continued to support

viral load testing before the drug substitutions from d4T to TDF based regimens. A total of 1,674 viral load tests were done through this arrangement.

Training

Clinical mentorship, on-job training and formal trainings were supported in paediatric OI/ART, TB/HIV, ART logistics and PMTCT as part of capacity building.

Logistics

In 2013, the MSF logistics department was involved in carrying out rehabilitations at all MSF supported health facilities. To this end, counselling rooms were constructed in Nyamandlovu, Mlagisa, Nshaba and Bemba. An additional Waiting Mothers Shelter was constructed at TDH.

Waste Management areas were constructed in Nyamandlovu, Mlagisa, Kapane, Samahuru, Bemba, Mpanedziba and Nshaba. Additional shelves and security was improved at drug storerooms



© Pedro Ballestoros/Susana Onoro

An expecting woman at a waiting mothers shelter

and dispensaries at Samahuru, Kapane, Nshaba, Mpanedziba, Sodaka, Nyamandlovu and Bemba. Sputum booths were constructed in Nyamandlovu, Kapane, Mpanedziba, Bemba, Samahuru and Nshaba. Double pit latrines were constructed in Nshaba and Pumula. Water tanks with a holding capacity of 5,000 litres were donated to Bemba, Madlangombe and Samahuru.

MSF departure from Tsholotsho in 2014

After more than nine years of

working on VIH in Tsholotsho, in close collaboration with MoHCC, more people have currently access to ART as well as there is more local capacity to continue implementing health programmes. Therefore, the organisation will hand over its activities to the MoHCC next year. From October 2013, stakeholder consultations and a Handover Steering Committee (HSC) have been formed to gradually exit from Tsholotsho district at the expiration of the current MoU at the end of 2014. The HSC has been

meeting monthly to discuss and implement strategies that will ensure smooth exit of MSF from the district without any prejudice to beneficiaries.

After MSF departure, the MoHCC should be able to continue improving OI/ART services in the district as evidenced by the adoption of the World Health Organisation 2013 OI/ART guidelines by the government of Zimbabwe.

Facts and figures from 2013 for Tsholotsho District:

HIV/TB co-infected patients were started on ART in 2013.	238
Patients under active follow-up.	10,798
SGBV survivors of were attended. 21 of them could be treated <72h.	119
OI/ART medical consultations.	82,200
Pregnant women tested for HIV	1,245
Pregnant women with positive test results were started on treatment	87
Babies born to HIV+ mothers were started nevirapine prophylaxis after birth.	423
Babies were tested for HIV at 6 to 8 weeks.	116
Number of HIV tests done in Tsholotsho	10,443
Of those, number of positive results	785
Number of patients initiated on ART	1,628
Total number of HIV+ patients under care at end of 2013	10,798
Number of new TB patients newly diagnosed	437
Number of first consultations for SGBV	119
Number of staff as of end of 2013:	
International	3
National	76

TRAINING DEPARTMENT



Participants of Data Management Training workshop proudly displaying their certificates soon after completing the five day training.

The Training Department has proved to be a vital department for Médecins Sans Frontières (MSF) as it has enabled the organization to go full throttle in fulfilling one of its key mandates, that of capacitating health personnel from the Ministry of Health and Child Care (MoHCC), Zimbabwe Prisons and Correctional Service (ZPCS), as well as from City of Harare.

The department conducted several trainings during the course of 2013 with trainings being hosted every month from January to December. The bulk of the trainings were conducted at the MSF Training Room which is situated at its Capital Office at 95 Lytton Road with only a few being conducted at outsourced venues.

The department has got a well-equipped training room with an inbuilt LCD projector as well as an air conditioner. There is also a kitchen that is manned by two staff members responsible for providing catering services for training participants.

The facilitators were experts drawn from various Government Departments such as Ministry of Health and Child Care (MoHCC), Zimbabwe Republic Police Victim Friendly Unit, Zimbabwe Judiciary Service Commission Victim Friendly Court, Forensic Department, Zimbabwe Prisons Service, and City of Harare.

Some of them were hired from other local civic organizations such as Musasa Project, who specialize in combating sexual and gender based violence, and Adult Rape Clinic and Family Support Trust who play a leading role in assisting survivors of rape and sexual assault. Others were Independent Consultants who were also hired for their expertise. National and International MSF staff members also featured as facilitators for some of the courses.

Participants were given the chance to evaluate the entire training process on a daily basis through completing some evaluation forms which assessed issues such as training objectives, training content, training material, training methods, preparedness of

the facilitators, as well as relevance of course.

This feedback would then be used as a basis to address particular issues that would have been identified as deserving attention.

As per policy, participants were issued with certificates of attendance upon the completion of training courses whose duration would have been at least 2 days. Those who attended the trainings were mostly nurses, and these were drawn from Epworth and Gokwe, with Epworth providing the bulk of the participants. There were however, some training courses that were designed specifically for all MSF staff members such as Stress management, Homere Software Training, and Unifield Training.

During the entire year, a total of five workshops were conducted on Sexual and Gender Based Violence (SGBV), whose main thrust is to equip health personnel with skills on how to manage and assist survivors of sexual assault and rape. From these SGBV workshops, a total of 101 health personnel were trained, and of these only eight were MSF staff with the entire difference having been drawn from MoHCC and City of Harare. The Field Management Course was the first course to be conducted in 2013 and it had a total of 15 participants, all of them being MSF staff members.

Another training that also dominated the year was the Mental health training for Prison staff which had a total of five workshops in its favour. This was specifically designed for prison nurses who work with psychiatric patients, even though a minimal number of other prison health personnel such as Dispensary

Assistants and Social workers were also invited to attend. A total of 92 participants were trained on Mental health during the course of the year, and these were all from the Zimbabwe Prisons Service.

HIV Integrated Training for nurses also featured prominently on the training calendar as it had three workshops being conducted for three different groups with the total number of participants coming up to 70 nurses.

Of these participants, seven were MSF employees while the remaining 63 were from MoHCC. Of all trainings conducted, this particular one had the longest duration of 12 consecutive days including weekends, and it is a vital component for every nurse's training curriculum as it is a pre-requisite for every nurse who aspires to administer the initiation of ART on HIV positive patients.

The Department also hosted the ICHA training which had a total of 15 participants, all of them being MSF staff members. A ten-day long training on Cervical Cancer Screening was also conducted which had a total attendance of four nurses and one medical doctor, and among these only the doctor was from MSF, with the other four nurses being from MoHCC.

Other 5-day long workshops that were hosted by the Training department were the Multi-drug Resistant TB Training (27 participants), the Data Management Training (16 participants). From the combined total of 43 participants, 15 were MSF participants while the remaining 28 were from MoHCC and City of Harare.

Trainings that were conducted by

International facilitators included the following: 1) Counselling for Primary Care Counsellors, which were 3 day workshops that attracted a total of 91 participants, and among these 28 were MSF staff members, while the remaining 63 were from MOHCC and City of Harare. 2) Homere Software training had a total of 8 participants and they were all MSF staff members. 3) UNIFIELD training was conducted for 3 sections, namely ICT, Finance as well as Supply and Logistics. These had a combined total of 23 participants who were all MSF staff members.

The following one day training workshops were also conducted by the Training Department: Energy plan Refresher training- 34 participants with only 1 being from MSF, 33 from MOHCC and City of Harare; M & E workshop which had a total of 58 participants among whom were 9

MSF employees and 16 MOHCC and City of Harare staff; Stress Management which was attended by a total of 115 MSF staff members; Psychiatric Training with 21 participants, 18 of them coming from MSF, while only 3 were from City of Harare; Paediatric Training with 65 participants, 21 of them being MSF staff while 44 were from MOHCC and City of Harare; Finance Training attracted 8 participants who were all from MSF; Budget cooking and Hygiene had a total of 12 participants, all of them being MSF staff members as well as CV Writing and Interview Skills training whose total number of participants was 61, with 30 of them being non-MSF participants, while the other 31 were those who were leaving MSF. There were also trainings on Research which were conducted on behalf of the Research section of the Medical Department, these were attended by 44 participants,

and among these only 2 were MSF employees, the remaining 42 being from MOHCC and City of Harare.

Finally the Training department also hosted other important events such as the Scientific Day Live Screening which had 17 participants, OCA Live Screening which was attended by 12 participants, as well as important meetings such as the Annual planning meeting which had 14 participants, and the 8M Review Meeting which was attended by a total of 37 members from the Epworth Project.

PAIN IS ONLY TEMPORARY WITH MDR-TB

My name is Elisha Tshuma and I live in Gokwe, a remote area in Zimbabwe, with my wife and four children. I am 37 years old and I was first diagnosed with TB in September 2007 but I did not accept the diagnosis and I went back home without getting any help or medicine. It was only in 2008 when I was getting worse by the day when I decided to go back to the clinic.

I was put on TB treatment for 6 months but I did not go back for my doctors review or for the scheduled sputum tests as I could not afford the transport to the clinic. I did not think this would cause any harm seeing that I was starting to feel better. I was certain that I was cured since I could do the things that I had stopped

doing before like playing soccer or ploughing in the field.

In 2009 I started coughing much more than I had ever done before. I went back to the hospital and they confirmed that I had TB again. I was put back on TB treatment, but because I lived far from the clinic I could not get the recommended injections all the time or on time. Later one I was told that all of this had added to the reasons why I had developed MDRTB. In 2011, I was diagnosed with TB for the third time. I was admitted into hospital for 60 days to ensure that I received my medication and injections every day. However my health did not improve. I continued to cough; I had joint aches and pain all over my body.

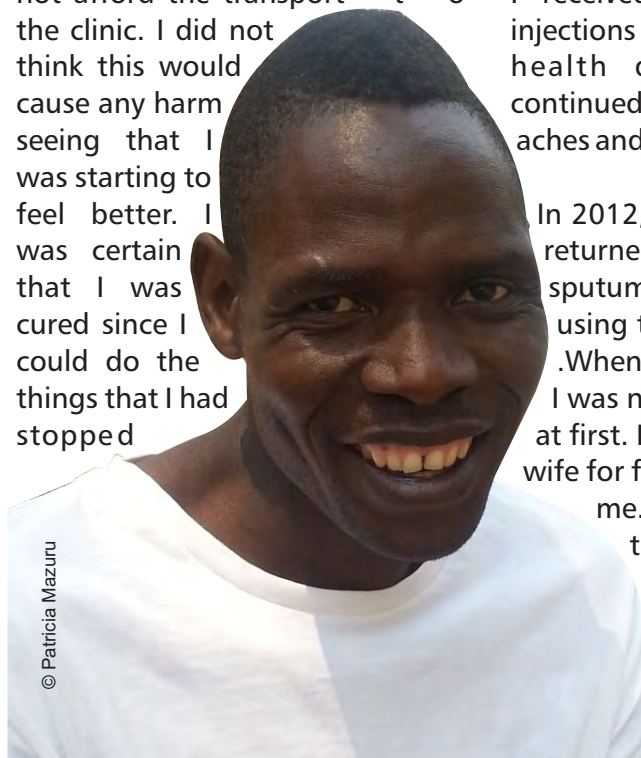
In 2012, with the help of MSF, I returned to the hospital and my sputum was tested for MDRTB using the Gene Xpert Machine. When I was told I had MDRTB, I was not sure how to handle it at first. I was afraid of telling my wife for fear that she would leave me. Before they told me that MSF would be paying for my entire treatment I had been discouraged. I had lost all hope. I was not sure I could be on treatment for such a long time, in

view of the other TB treatment failures. I officially started my MDRTB treatment on Valentine's Day of this year.

The start of treatment was not easy. It was hard. It was really very hard. I experienced what seemed like endless side effects such as a bloated stomach, psychosis and hot flushes. I am certain that the heavens had it written down that February 2013 was the month that Elisha Tshuma was supposed to die. My neighbors jeered at me and they told the entire community that I was HIV positive and that they should start digging my grave. My family wanted to leave me; my friends were disgusted by me. I was all alone.

I wanted to give up but I decided to focus on the value of my life and what it meant to me. I thought about my children growing up without a father and this gave me the strength to fight to get better. This is what I would like to tell other people who may be in a similar situation. Our lives do not belong to us alone, we share them with other people such as our children and we should never give up on them.

Pain is only temporary. This medication has returned to me all of the years that MDRTB had planned to steal from me.



© Patricia Mazuru

Elisha Tshuma

FACTS AND FIGURES

Intersectional facts and figures from 2013:

❖ Number of HIV tests done in all MSF projects in Zimbabwe	138,226
❖ Of those, number of positive results	10,443
❖ Number of patients initiated on ART	17,706
❖ Number of patients on Art at end of 2013	65,980
❖ Number of new TB patients newly diagnosed and put on treatment	3,603
❖ Of these, number of MDR TB patients taken into care	63
❖ Number of first consultations for rape	1,636

❖ Number of staff as of end of 2013

❖ International	25
❖ National	394

ABBREVIATIONS

Acquired Immuno-deficiency Syndrome	AIDS
Antenatal Care	ANC
Anti-retroviral drugs	ARVs
Anti-retroviral therapy	ART
City of Harare	CoH
Community ART Groups	CAGs
Community ART Refill through Support Group	CARSG
Drug sensitivity testing	DST
Early Infant Diagnosis	EID
Efavirenz	EFV
Emergency Preparedness	E-Prep
Global Fund to Fight against AIDS, TB and Malaria	GFATM
Health Transition Fund	HTF
HIV Testing Campaign	HTC
Human Immuno-deficiency Virus	HIV
Information, Education and Communication	IEC
United Nations Joint Programme on HIV/AIDS	UNAIDS
Lamivudine	3TC
Médecins Sans Frontieres	MSF
Monitoring and Evaluation	M&E
Ministry of Health and Child Care	MoHCC
Multi Drug Resistant Tuberculosis	MDRTB
National AIDS Council	NAC
Opportunistic Infections	OI
Operational Centre Amsterdam	OCA
Operational Centre Brussels	OCB
Operational Centre Barcelona/Athens	OCBA
Post Exposure Prophylaxis	PEP
Prevention of Mother to Child Transmission	PMTCT
Primary Care Counsellors	PCCs
Sexual and Gender-Based Violence	SGBV
Sexually Transmitted Infections	STIs
Tenofovir	TDF
Tuberculosis	TB
Viral Load	VL
Voluntary Counselling and Testing	VCT
World Health Organisation	WHO
Zimbabwe Prisons and Correctional Services	ZPCS

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Paintings at the Childrens' corner in Epworth

