MSF IN ZIMBABWE

ACTIVITY REPORT 2012

MEDECINS SANS FRONTIERES

Médecins Sans Frontières Charter

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

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

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

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

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

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

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

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Cover Picture: *A boy accompanied by a gurdian recieves his medication in Tsholotsho*

Picture by:
Pedro Ballesteros/Susana Onoro

FOREWORD

Fasil Tezera,
Paul Foreman,
Victor Garcia Leonor
(Heads of Missions - MSF in Zimbabwe)

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

Speaking on behalf of the whole of Médecins Sans Frontières (MSF) in Zimbabwe, it is with great honour, that we present our 2012 inter-sectional activity report. MSF has been working in partnership and close collaboration with the Ministry of Health and Child Welfare (MoHCW) 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 MoHCW continues to drive our programmes in Zimbabwe. As always, driven by direct medical action, we are present in a number 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. MSF has an international presence that allows us to influence important funding decisions. In 2012 our New York office met with the President's Emergency Program for AIDS Relief (PEPFAR); Zimbabwe was one of the countries high on the funding agenda.

And MSF also has a place as an observer on the board of the Global Fund for AIDS, TB and Malaria (GFATM), with the advocacy opportunity that it gives.

The evolution in HIV care is dynamic and constant. When first active in the country, MSF was working alongside the MoHCW to provide access to ART for the first HIV / AIDS patients in Zimbabwe. Then, as the cost of drugs was driven down by increased demand, the issue was for the MoHCW to roll out access across all of Zimbabwe.

Universal access required a different approach to diagnosis and treatment initiation, and MSF responded by supporting the drive towards task-shifting whereby nurses could put patients onto ART.

Now, 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 a preventative measure.

In the pages of this report you will be able to read about the activities of MSF in Zimbabwe in 2012. In addition to the provision of care for people living with HIV, other thematic areas for MSF include the provision of TB treatment. Up to 80% 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 2012 continued to invest in MDR TB diagnosis and treatment.

We also prioritise the medical treatment of survivors 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 MoHCW to respond to typhoid and malaria outbreaks.

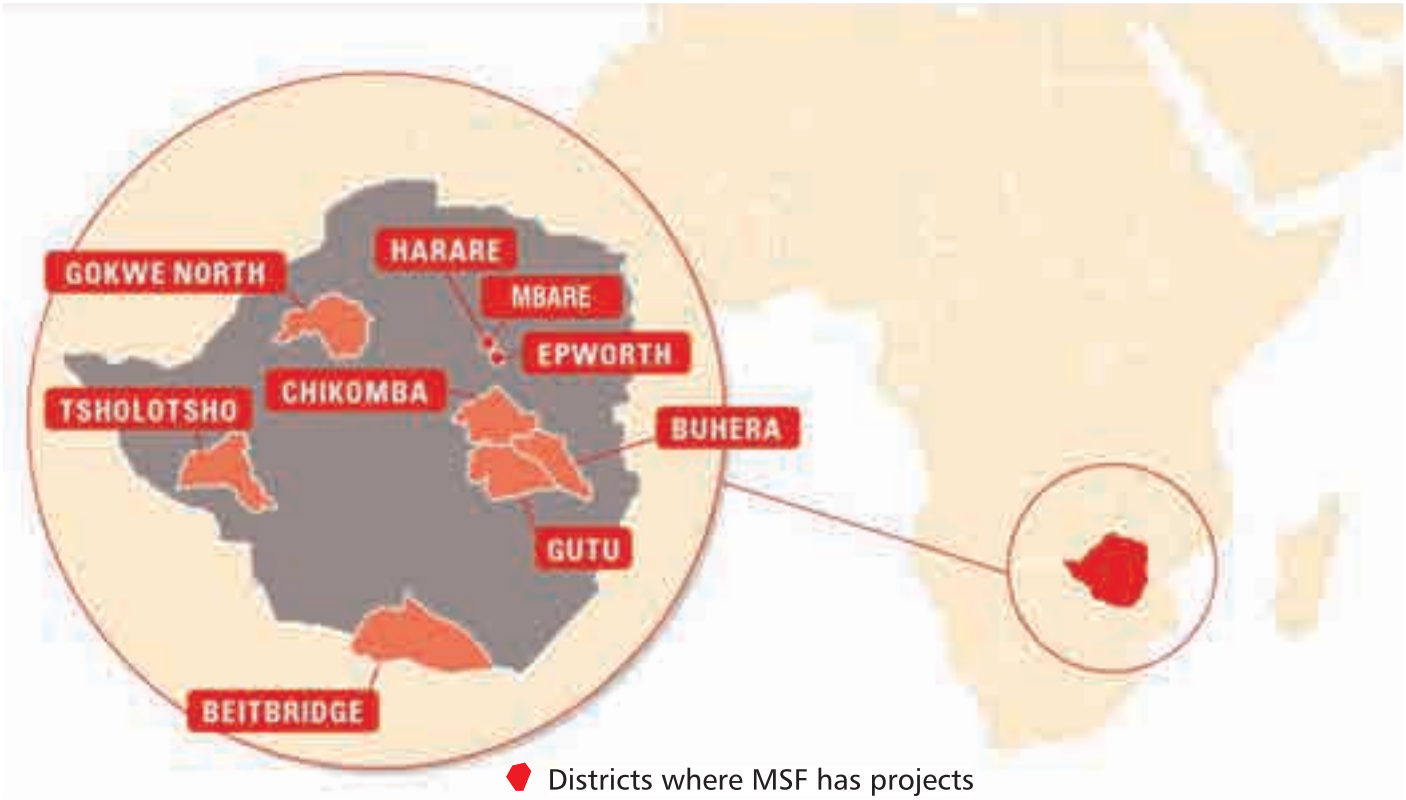
Our partnership with the MoHCW is a common factor across all projects and in all activities; we value the professional relationship that continues to flourish at central, provincial and district levels.

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 MoHCW 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 certainly not would have all 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 MoHCW; 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; long may it continue!

MSF PROJECT LOCATIONS



Districts where MSF has projects

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 Welfare (MOHCW).

In all their projects, MSF provides a comprehensive package of quality HIV/TB care through an integration approach in 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, planned for 2013, viral load testing for HIV patients), 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 E-prep and surveillance component 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, 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 MoHCW within existing health structures.

OCA (Harare, Mashonaland East and Midlands Provinces)
Epworth Polyclinic, and decentralization sites Overspill and Mission clinics in Epworth
City of Harare (CoH) Caledonia Farm plus HR support to six CoH polyclinics
Gokwe North [district-wide, 16 rural clinics plus two mission hospitals]

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

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

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 Welfare (MoHCW), that include treatment and care of people with HIV, tuberculosis (TB) and drug-resistant TB (DR-TB), Sexual and Gender based Violence (SGBV) interventions and emergency preparedness. Projects are currently located in Beitbridge, Buhera, Chikomba, Epworth, Gokwe North, Gutu, Mbare, and Tsholotsho.

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A doctor conducting a consultation with a mother enrolled in the Prevention of Mother to Child Transmission (PMTCT) programme

Mothers visiting a Prevention of Mother to Child Transmission clinic in Tsholotsho

Fighting HIV/AIDS

Our major focus in Zimbabwe is on the fight against the HIV/Aids epidemic and related opportunistic infections which continue to overwhelm the healthcare system. 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 46,000 HIV+ people.

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 support and technical assistance to health authorities in the implementation of a national DR-TB strategy.

Clinical management of survivors of sexual abuse

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

Handing over of projects to ministry of health and child welfare

When programmes have been supported through the growth and development phase, we hand project activities over to the MoHCW, where people continue to receive uninterrupted treatment.

For example, in 2011 MSF successfully handed over support activities in Gweru and Bulawayo to the MoHCW.

HIV SCALE UP IN ZIMBABWE

Children and teenagers are being neglected when it comes to treatment and too many children are still unnecessarily born with the virus

HIV and HIV/TB co-infection remain an emergency in Zimbabwe with 13.5%, or 1.2 million of the country's adults and 200,000 children are living with HIV.

Despite having made big advances and an increase effort in offering HIV/TB services and putting people on treatment, the humanitarian needs related to the HIV/TB pandemic are still enormous and the health system is still struggling to cope.

On the one hand, we have to keep putting new patients on treatment who do not have access to life-saving treatment yet, and on the other hand, we have to keep up a good level of care for the thousands of people who are already in care.

Additionally, transmission rates from HIV positive mothers to their babies are still too high and children and young adults are still often excluded from the HIV response. Special attention and adapted services are needed to make sure, more children and adolescents start timely ARV treatment and are supported to stay on treatment for the rest of their lives.

Treatment for people suffering from multidrug resistant tuberculosis (MDR-TB) needs to be further decentralized to community levels, Médecins Sans Frontières (MSF) helps to introduce treatment models that are more adapted to patient realities, i.e. that allow them to be treated in or close to their homes rather than at central, national level.

Speed Up Scale-Up

For over a decade, people living with HIV, treatment advocates, clinicians, and health ministries have been grappling with how to ensure increased access to quality antiretroviral therapy in resource-limited settings.

Although there have been enormous strides over the past decade, constrained budgets and sub-optimal policies that are only slowly changing are impeding the effort to reach all people in need. In addition, too many people are still dying because they do not know they are living with HIV. And many people are being diagnosed with HIV late or fall out of care before starting treatment.

Time is a critical factor: getting treatment to people before their disease progresses is important both for their own health and for preventing further infections.

HIV treatment policy is quickly responding to this new evidence. In April 2012, the World Health Organization (WHO) issued two critical new pieces of guidance on HIV treatment.

Firstly, its April 2012 programmatic update *"Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants,"* points to the benefits and momentum behind offering lifelong antiretroviral therapy to all pregnant women living with HIV for preventing mother-to-child transmission and for their own health.

This protocol, known as option B+, is easier to manage in many settings than the current practice for preventing mother-to-child transmission of starting and stopping antiretroviral therapy with each pregnancy.

It is also better for mothers and babies, especially in places where women have multiple pregnancies but may not be accessing services for preventing mother-to-child transmission of HIV early enough.

Second, WHO's Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples recommends treatment for everyone living with HIV who has an HIV-negative partner (serodiscordant couples), regardless of their CD4 count, to help prevent the sexual transmission of HIV.

These two interventions targeting specific populations, when considered in addition to efforts based on growing evidence of clinical benefit to reach others earlier in their disease progression, collectively constitute a care package referred to as accelerated antiretroviral therapy.

Strategies: Reaching More People With Treatment

1) Making testing and treatment accessible

A major challenge in increasing access to care is that most people with HIV do not know their HIV status. A growing number of countries now allow lay health workers to administer HIV testing. Ensuring that treatment is available free of charge is also essential. And although user fees and other charges passed down to service users are a documented barrier to access, there is a risk that

A maternity ward at a district hospital

treatment free of user charges might be reversed if funding levels are not increased.

Decentralization: Getting treatment into every clinic

2) Scaling-up facility-based treatment

Getting care out of centralized hospitals and into community clinics and local health posts has been the cornerstone of expanding access to antiretroviral therapy; making treatment available in more health facilities allows more people to be reached.

Shifting health care tasks

One of the key obstacles to decentralized treatment has been reluctance on the part of some policy-makers to shift health care tasks from doctors to nurses and nurses to lay health workers. Nevertheless, this has changed in some countries.

There is also need to have policies that allow the task shifting of treatment initiation; policies that allow lay workers to dispense antiretroviral drugs will ease the strain on the health system.

Integrating antiretroviral therapy with other health services

Optimizing antiretroviral therapy delivery also requires providing treatment within settings where people can have their broader health care needs addressed at the same time, in one location, and from the same health worker. This means addressing health needs beyond HIV.

3) Managing treatment at the community level

With the continuing shift away from specialised clinic HIV care, antiretroviral therapy programmes are increasingly looking towards newer models for chronic disease management, whereby the community manages people living with HIV with a stable condition and interventions to support treatment adherence.

This further decentralization and task-shifting involves strategies such as peer antiretroviral therapy groups, which can boost adherence and relieve the burden on people living with HIV and health systems.
Other policies can help reduce the number of required clinic visits, simplify clinical appointments and/or reduce burdens by providing people with several months of medicines in one refill visit.

Recent research results along with novel treatment models provide a genuine possibility to both reduce the number of people acquiring HIV infection and ensure long-term survival for people already living with HIV.

National governments, donors, and other key actors must seize this opportunity to turn around the epidemic.

Nevertheless, the right policies must be in place. Policies should be promoted that support the production of affordable medicines and the development of medical tools that enable massive scale-up and sustainable long-term treatment provision.

Further, international donors must re-engage and recommit to HIV globally. If they continue to withdraw support, the progress achieved over the last decade of investing in global HIV treatment risks being unravelled.

By documenting both the progress and the threats, MSF will continue pushing for renewed commitment to HIV treatment, backed up by predictable financing of global health, and for access to the affordable medicines needed to keep people alive in the long run.

MSF is still grappling with the HIV/AIDS epidemic, and is committed to ensuring more people can get better treatment, sooner.

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.

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A community health worker in Epworth disseminating on the importance of getting an HIV test

TB / GeneXpert / MDR TB

Xpert® MTB/RIF is a new molecular diagnostic tool, developed to increase detection and shorten time to diagnosis of sputum-smear-negative tuberculosis in addition to detecting Rifampicin resistance.

Zimbabwe still trails behind other countries in Southern Africa in its response to TB. Diagnostics need improving, and treatment needs to be further decentralized to community levels: models have to be adapted to patient realities. As with all countries where multi-drug resistant tuberculosis (MDR TB) is prevalent, there is urgent need for updated treatment protocols for MDR TB.

TB and MDR-TB are a major health concern with the TB Mortality at 47 deaths per 100.000 people in 2011. TB Incidence: 603 new infections per 100.000 people in 2011. MDR-TB: 8.3% of TB infected people under retreatment have MDRTB. Only 118 MDRTB cases were laboratory confirmed in 2011, of which 64 started treatment.

In the Médecins Sans Frontières (MSF) project in Epworth, we are treating 1,500+ TB patients per year and currently treating 15 MDR TB patients while in Buhera MSF supports home-based treatment of 15 MDR-TB patients.

About 80% of TB patients are HIV co-infected, making positive

outcomes harder to achieve. In Gutu, 2 MDR-TB patients are receiving treatment from homes. For the Gokwe North project, 324 TB patients were treated in 2012 against a baseline of 19 patients on treatment before MSF arrived in the district. The first MDR TB patient in Gokwe North started treatment in February 2013.

In Tsholotsho and Beitbridge, 360 and over 1,000 patients TB patients were treated in 2012. Currently, 11 MDR TB patients are under treatment in these projects.

All the projects in Epworth, Gokwe North and City of Harare include the use of GeneXpert diagnostic machines.The upcoming introduction of GeneXpert in Tsholotsho and Beitbridge is expected to increase this figure substantially due to enhanced case detection.

The model of care, by which to manage patients in a rural setting, presented its own challenges as the national protocol recommended hospitalization as the mode of treatment in the initial phase.

Most patients declined treatment due to the long hospitalization duration, and more so when it meant loss of income/livelihood. To redress this and increase treatment access, MSF initiated the mobile DRTB treatment programme, involving a combination of daily home visits and health facility-based treatment.

The approach so far has benefitted patients, but not without its own challenges which include long daily distances travelled, the current model is too expensive to be sustained by the public health system. If more patients are diagnosed in the future (which they will), the strain on these resources will be massive and patients do not have the possibility for admission in the local health facilities, in case of complications, and they have to be referred to Harare.

Even with these challenges, the advantages of treatment close to home are quite evident: low defaulter rates, good clinical/treatment progression, community education and information dissemination to families, health workers involvement in treatment, less stigmatization and de-mystification, reduced pressure to health facilities, health worker capacitation.

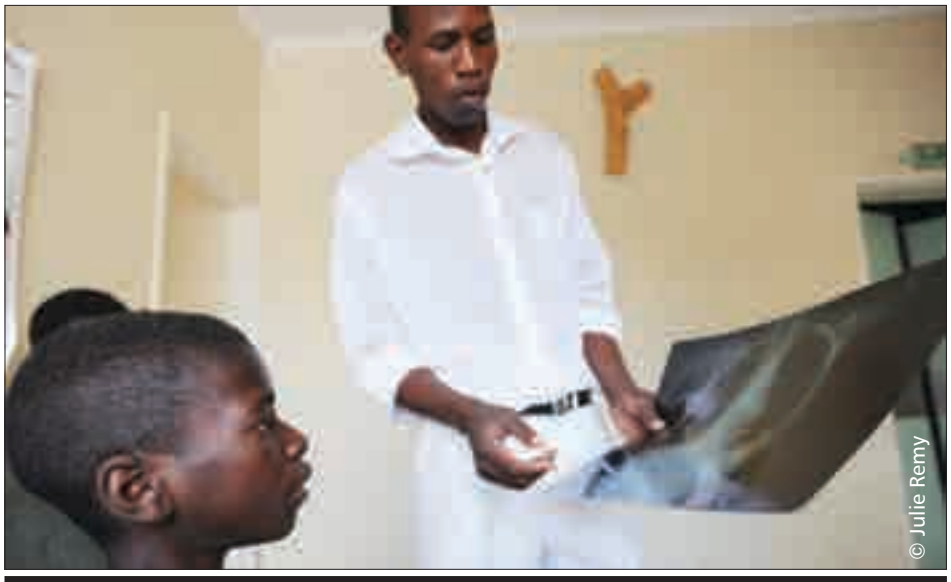
In the future, MSF envisions the structure where the facility based model of care is reduced to managing complicated cases, while a community based model would manage the relatively "straight forward" cases. This strategy has been tried in other countries (Peru, Lesotho), where it has been shown to relieve the pressure in public health facilities in managing DRTB patients.

New TB molecular testing

A new rapid molecular test, Xpert MTB/RIF, represents an important advance. Not only does it speed up diagnosis (giving results in two hours versus up to two months with other methods) and therefore significantly shortens the time from TB test to initiating TB treatment, improving chances of survival for people living with HIV who have TB, it also screens for drug-resistant TB and improves TB detection among people who have falsely tested negative through sputum smear (prominent among people living with HIV who have TB).

A comparison by MSF in Zimbabwe showed that, of 1,672 sputum samples, 184 were positive for TB using sputum smear microscopy, but of the remaining negative 1,488 samples, Xpert MTB/ RIF detected TB in a further 116, which had been missed by microscopy. After implementing Xpert MTB/RIF, the median time from diagnosis of smear negative TB among people living with HIV who have TB to the initiation of treatment was reduced from 18.5 days to seven days.

Although Xpert offers new potential in TB diagnosis, it has a number of drawbacks including its relatively high price (120 countries will be soon eligible for a new price of US$ 9.98 per cartridge) and its reliance on a stable electricity supply and controlled temperature.



A teenager receiving chest X-ray results at Murambinda Mission Hospital

HIV, CHILDREN AND ADOLESCENTS

Protecting the next generation through PMTCT

An MSF nurse providing post natal care to a newly born baby and mother who followed the Prevention of Mother to Child Transmission (PMTCT) program.

"My seventh child is three years old and has tested HIV negative. This is my eighth pregnancy and I want to take care of this baby breastfeeding exclusively for six months and making routine visits to the MSF clinic," says 35-year old Thokozani Mathe from Mvagazini Village in Tsholotsho.

27-year old Thokozani was put on anti retroviral therapy in 2009 after she tested positive for HIV.

"I gave birth to my seventh child in 2010 and exclusively breastfed her for six months. Then I visited the clinic where my child tested HIV negative and I was happy, I really felt relieved. I continued breastfeeding her for nine more months. Later on I weaned her because I was developing some sores on my breast and I was afraid that she could be infected with HIV. So I will do the same this time," added Thokozani.

"I learned that I was positive when I fell seriously ill in 2009. My husband is very supportive and right now he is the one who is

taking care of the children as I am at the hospital awaiting delivery," said Thokozani, adding that she usually tells other women the importance of knowing one's HIV status early.

"It is important for people to know the virus doesn't have to interrupt your normal life, and that people need to visit their nearest clinic and that care is available for free. I owe the life of my two-year old daughter to this PMTCT programme and I am certain that I will deliver an HIV free bouncing baby again."

Thokozani is one of the thousands of pregnant mothers who are receiving free medical support from Médecins Sans Frontiers (MSF) Prevention of Mother-to-Child Transmission (PMTCT) programmes across Zimbabwe.

Through the PMTCT programme, expecting mothers are encouraged to get tested for HIV during antenatal clinic visits. They are then initiated on treatment if positive and counseled on how they can prevent transmitting the virus to their unborn baby.

The vast majority of children become infected with HIV through transmission from their mothers during pregnancy, childbirth or breastfeeding. These infections are entirely preventable.

But while it is crucial to prevent child infections to begin with, the treatment needs of children living with HIV also cannot be ignored. Such new infections are entirely preventable, by putting the mother on HIV treatment, as well as the baby on prophylaxis at birth and during breastfeeding.

Expanding prevention of mother-to-child transmission services could ensure that many other women, like Thokozani, are able to protect their families from HIV. The World Health Organization recently issued new guidelines to prevent mother-to-child transmission of HIV. The recommendations include getting more women on treatment sooner and staying on it for life.

Previously, the recommendations were that women who were pregnant and HIV positive were to be given antiretroviral medicines during pregnancy, but if they did not need those medicines for their own health then once they had delivered the baby they would stop the medicines. And they would only restart the medicines if they had another pregnancy or if they fell very ill.

Although nationwide treatment coverage is officially estimated to be 80%, there are still areas were the coverage is extremely low. We need to reach those people that still lack access to live-saving treatment!

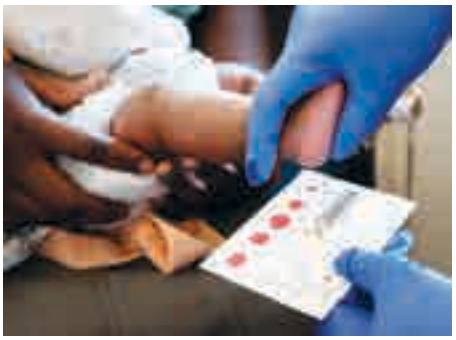
Children and teenagers are being neglected when it comes to treatment and too many children are still unnecessarily born with the virus. Transmission rates can and have to be reduced. An expected 46.000 pregnant women were HIV+ and in need of PMTCT in 2010.

Only 56% of HIV-positive pregnant women received ARVs for PMTCT in 2009; only 35% of HIV-exposed infants received prophylactic ARVs for PMTCT in 2009. Each year, around 13,000 children get newly infected with HIV. In total, 200,000 children and adolescents (<15 years of age) are estimated to be HIV+ in Zimbabwe (2011).

Main barriers to access are a lack of human resources, especially doctors, as well as user fees in clinics, distance, transport and restrictive opening hours of health services. Task shifting to lower health cadres as well as decentralization of health services to health center level are important strategies to respond to these challenges.

In Tsholotsho, for instance, MSF is offering services for youths and PMTCT. Support groups of mothers who have gone through PMTCT program themselves and are now supporting other mothers living through the experience for the first time. Seeing all the voluntary work carried out by these mothers, the passion with which they speak about the programme and the miracle of giving birth to HIV-negative children, is impressive.

In Beitbridge, there is an emphasis on activities at the Resource Centre, a small container where the team promotes and disseminates information about HIV and testing. There are also special treatment literacy workshops and support groups for adolescents . The project in Epworth is also offering PMTCT services.



PMTCT is an important component of MSF's projects so as to prevent newborn infections

EMERGENCY RESPONSE

A nurse is counselling a suspected patient during the 2012 typhoid outbreak. Kuwadzana, Zimbabwe.

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

Since November 2012, MSF has been supporting people in Harare and surrounding suburbs in a typhoid outbreak.

This is the second engagement in this outbreak that started in October 2011 and has affected around 7,000 people so far.

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

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

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

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

Typhoid is a bacterial, water-borne disease transmitted by the ingestion of food or water contaminated with faeces of an infected person.

This happens in conditions of poor sanitation, and poor supply of clean water. In areas where sanitary facilities are well developed and maintained, there has been virtual elimination of typhoid, but Harare's water supplies are polluted by sewerage from burst pipes and decaying infrastructure.

Water supplies in some areas are still irregular as taps remained dry most of the time leaving people with no option but to rely on wells.

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.

Malaria Outbreak

In April 2012, MSF responded to a small outbreak of Malaria in Epworth. Normally, the scale of this outbreak would not concern health authorities.

However, Harare is generally considered a low-risk area for malaria due to its elevation above sea level, so any outbreak in Harare's suburbs presents a considerable risk to a population not used to identifying the symptoms and seeking appropriate treatment.

MSF worked alongside the local authorities and health structures to provide free diagnosis and treatment, and also engaged in health awareness and vector control activities.

Out of a total of 1,087 patients tested for malaria, 278 were found to be positive and treated; five severe cases were referred to hospital.

There were no deaths. Incidence of plasmodium falciparum malaria declined rapidly and the outbreak was declared over after approximately one month, due no doubt to the rapid coordinated response of all concerned.

SGBV

Clinical Management of Survivors of Sexual Abuse

All of Médecins Sans Frontieres (MSF) HIV programmes offer care for survivors of sexual abuse.

Through community outreach and health promotion, our teams are working to increase the number of people who seek assistance after they have been abused.

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

The teams provide free medical and psychological care, counselling, as well as referral options for psycho-social and legal support.

Through this intervention, MSF work in close collaboration with various partners.

MSF AND ZPS

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

More recently in late 2011, again at the invitation of the Ministry of Justice, MSF carried out return visits and needs assessments in a number of previously supported prisons.

The general nutrition and healthcare needs of the inmates were vastly improved when compared to the low point of 2009, and no MSF assistance was indicated in these areas.

However, there was a clear need for additional medical capacity in the area of mental health care.

Most prisons in Zimbabwe have a clinic attached, and medical staff attend to the basic healthcare needs of inmates; more severe acute or complex chronic cases are referred to local hospitals.

In contrast, the referral pathway for inmates in need of mental health care is to one of the two ZPS psychiatric secure units, Mlondolozi in Bulawayo or Chikurubi in Harare.

The 2011 assessment indicated need for MSF support in the latter, and so in 2012 MSF started a programme of psychiatric care for the patients in the secure psychiatric wing of Chikurubi Maximum Security Prison.

The programme employs a psychologist, an occupational therapist, and mental health nurses, who visit the psychiatric wing on a regular basis and attend to the mental health care of the patients both individually and in groups.

MSF staff interact with patients on a daily basis in one-to-one and group therapy sessions.

The team is professionally led by an internationally hired psychiatrist, who consults with, diagnoses and prescribes medication to patients on an individual basis.

All aspects of the medical programme are shared with mental health nursing staff of the ZPS, and training is a large part of the programme. MSF also assists ZPS in maintaining an adequate stock of psychotropic drugs to treat mental health conditions.

From May 2012 up until the end of the year, although early days in terms expecting positive outcomes from psychiatric care, our team and officers of ZPS observed a significant improvement in some patients, and the general atmosphere in the psychiatric unit is improved by regular access to therapeutic sessions.

It is clear that mentally ill patients are benefiting from regular psychiatric care and from psychological and occupational therapy; the hope from ZPS is that continued MSF support to the programme through medical intervention and training will make a positive contribution to the aim of rehabilitating these patients.

In 2012, from the launch of therapy in May until the end of the year, MSF conducted 372 individual psychiatric consultations, 192 individual counselling sessions and 105 individual occupational therapy sessions.

There were 343 group counselling and 194 group OT sessions. At the end of the year, there were some 230 male and 30 female psychiatric patients detained in Chikurubi prison.

In 2013 MSF will continue with its mental health support programme, aiming to link direct provision of therapy with an extensive programme of training of ZPS mental health nurses.

Attention will also focus on mental health nurses in district prisons, with the aim of increasing capacity to diagnose and treat mental health issues without the need to refer to Chikurubi.

In addition, MSF is working with ZPS health department in the promotion and training for nurse-led initiation of ART and improved TB diagnostics.

One of the major challenges remains the congestion in the secure psychiatric unit, which is overcrowded; MSF will work in close collaboration with ZPS to find durable solutions to this problem.

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

Water and Sanitation

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

Bikita and Zaka Satelite Prisons had some toilets being constructed by MSF as well as installation of water tanks, showers and construction of some septic tanks.

More water tanks were installed at Mutimurefu Maximum Prison as well as construction of a complete waste zone with beehive incinerator.

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

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

BEITBRIDGE

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Community leaders and MSF staff in Beitbridge during a community outreach session on male involvement in Prevention of Mother to Child Transmission

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

By the end of 2010, the project was reoriented to concentrate on comprehensive HIV/TB Prevention, Treatment & Care, as well as treatment and care to survivors of SGBV, in support of the Ministry of Health and Child Welfare (MoHCW) in the district with emphasis on the hard to reach groups as well as rural mobile populations.

The project is involved in supporting activities that include information education & communication (IEC), voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT), OI/ART, TB, DR-TB, nutrition support to HIV and HIV/TB co-infected patients, post exposure prophylaxis (PEP), sexual and gender based violence comprehensive support, radiology and laboratory services.

In addition, training and mentoring of healthcare workers as well as monitoring and evaluation are also essential components of the program.

In 2012, these activities were concentrated in Beitbridge urban area (Beitbridge District Hospital), and 6 selected Rural Health Facilities in the District (Majini, Chikwarakwara, Chaswingo, Swereki, Tongwe and Sashe). MSF is also supporting Dulibadzimu Clinics PMTCT program in Beitbridge urban.

IEC and counselling activities are conducted in all of the supported sites and their catchment areas. MSF is involved in information sharing, health education and different campaigns aimed at promoting various health activities. We are also involved in activities such as support groups, peer education and VCT.

There is a resource centre and an information kiosk located in town which provides information as well as support and VCT to the beneficiaries.

Mentoring

Formal and on the job mentoring is continuing on a day to day basis, as well as emphasis on data collection through different tools so as to measure the effectiveness of our interventions.

During the year 2012, many patients were initiated on ART as well as switch from D4T to TDF based regimen, which is also still on going, to enable all the patients to be on the TDF based regimen by mid 2013 in the MSF supported sites. The cohort of patients on ART in the MSF supported sites by the end of November 2012 was 5,999.

We are working closely with health authorities to ensure that TB screening is done to all HIV patients and that management of TB/HIV is according to prescribed guidelines. During 2012, we managed to increase the amount of TB/HIV+ patients on ART to 82.2%, which is significant increase from year 2011 (53%).

In 2013 MSF will continue supporting the MoHCW in the decentralization of the ART programme to Rural Health Centres in the District, as well as the integration of opportunistic infections and out patient department services in the hospital. MSF is focusing on improving the current health services in Beitbridge District as well as directing the focus even more towards targeted vulnerable groups.

MSF will continue concentrating on the cross border collaboration and devise ways to enhance adherence to treatment to the population of Beitbridge that is highly mobile, and therefore needs specific strategies to ensure quality and adherence to treatment.

Some facts and figures from 2012:	
Number of HIV tests done in Beitbridge clinics	3,493
Of those, number of positive results	444
Number of patients initiated on ART	1,500
Number of patients on Art at end of 2012	4,637
Number of new TB patients newly diagnosed	1,039
Number of first consultations for SGBV	30
Number of staff as of end of 2012:	
International	2
National	72

BUHERA

In June 2002, Médecins Sans Frontières (MSF) conducted a situation assessment in response to the alarming food security situation in Manicaland Province and in November of the same year, as a result of this assessment, an in-patient Therapeutic Feeding Centre (TFC) was opened at Murambinda Mission Hospital in Buhera district.

The TFC was integrated into the pediatric ward of the hospital in March 2004 and an Opportunistic Infections (OI) clinic was opened. In the first 2 years, the number of patients initiated at the OI clinic remained low; but there was a gradual increase in the third year.

The nutrition programme was then developed into a community based care programme with opening of an out- patient therapeutic feeding centre (OTP) and stabilization centre (SC) in 2006.

As patients started defaulting due to unaffordable transport costs, the OI clinic at Murambinda Mission Hospital was decentralized to 6 follow up sites. In 2007, decentralization sites were expanded to 23 initiation sites through a network of 2 mobile clinics and this was expanded to 4 teams of 7 staff each in 2009.

By the end of 2009, a network of 27 OTP's and 2 SCs was operational and in 2010 the nutrition programme was handed over to the Ministry of Health and Child Welfare (MoHCW).

In 2010/11, the integration of HIV care within the existing MoHCW facilities and decentralization of care from Murambinda Mission Hospital was launched as there was a realization that a centralized approach denied the most vulnerable populations access to life saving treatment.

An MSF doctor mentoring a Ministry of Health and Child Welfare nurse in Buhera

In 2011, the decision was taken to implement a lighter approach, with reduced MSF presence and more MoHCW involvement.

The same year, MSF introduced new technology by use of GeneXpert, to diagnose drug resistant TB, and TB that could not be detected by standard tests, and also began the treatment of MDR TB.

MSF also launched the out of district programme in neighboring Gutu and Chikomba Districts, increasing the number of patients in care and also reducing the workload in the Buhera clinics. This also allowed patients from these locations, who were being treated in Buhera, to access care in clinics closer to their homes.

In 2012, MSF proposed the introduction of fixed dose combination TDF/ 3TC/ EFV as the standard treatment, and the use of Viral load as opposed to CD4 to monitor patient progress. This aims at reducing the number of visits to the clinics by patients and also provide better treatment monitoring tools.

Through MSF support, the access to ART drugs became so good in the district that we are now faced with high numbers of patients coming from surrounding districts where access remains minimal.

Today, over 20.000 patients have been started on ART and 15.000 of them are in active follow-up. Through the introduction of innovative strategies and technology, MSF changed its model of care. Mobile teams brought services closer to the community and patients' homes,

A nurse taking a blood sample

increasing access to healthcare. Novel diagnostic tools for HIV monitoring and drug resistant TB diagnosis were installed; making nurse based patient management easier. New treatment regimens with fewer side effects and the introduction of fixed-dose combinations (FDC) has considerably reduced the pill burden and improved quality of life of patients on ART. MSF also supports the Prevention-of-mother-to-Child-Transmission (PMTCT) programme and assistance to victims of Sexual Gender Based Violence (SGBV).

Some facts and figures from 2012:	
Number of HIV tests done in	18,611- done by MoHCW/New Start
Of those, number of positive results	2, 411
Number of new HIV+ patients taken under care	2,619
Total number of HIV+ patients ever enrolled in care by end of 2012	31,297
Number of patients initiated on ART	1,563
Number of patients on Art at end of 2012	15,031
Number of new TB patients newly diagnosed and put on treatment	897
Number of MDR TB patients taken into care	15
Number of staff as of end of 2012	
International	4
National	108

CHIKOMBA - GUTU

Despite significant declines in HIV incidence in the past few years, the current HIV prevalence rate at 13.5% continues to make Zimbabwe one of the worst affected countries in the world. It is also ranked 17th of the 22 high-burden TB countries in the world.

Through Médecins Sans Frontières (MSF) support, access to anti-retroviral treatment (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 burden for patients who were travelling to Buhera district for ART, and to improve the quality of life and retention in care for far distant patients, MSF decided to support ART care in two adjacent districts (Gutu and Chikomba) using a "LIGHT APPROACH".

In 2010, the MSF team in Buhera District provided support to Gutu district through assessments and attachment of 16 Gutu nurses in the Buhera project for 2 weeks in an attempt to attract many Gutu patients on treatment in Buhera back to Gutu. This method of attracting patients for OI/ART services in the district did not materialize because of the lack of dedicated resources.

A health worker prepares medication for a drug-resistant tuberculosis patient

Early 2011, MSF launched a project to support HIV/TB care and treatment in Gutu and Chikomba districts using a "Light Approach" concept for a period of 3 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 Welfare (MoHCW) nurses with absolute integration right from the start.

Although the project was to be evaluated only after 3 years; it is believed that it has already proven its value, hence the team is starting to document this experience. In June 2012 the Buhera team started transferring patients back to Gutu.

The lighter approach in Zimbabwe does not only save significant costs, but it has also proven to be a very good strategy balancing access to HIV/AIDS & TB treatment and sustainability.

Access to HIV/AIDS & TB services reached 19 facilities in Gutu and 8 in Chikomba by end of 2012. By far the most important lesson from this approach is the ability of the mentored MoHCW staff to perform any HIV/TB related task independently.

At present in Gutu, 8 of the 15 health facilities being supported by MSF are now able to conduct a full package of HIV/AIDS & TB activities with very minimum support from MSF. In Chikomba 90% of all the initiation are done by MoHCW nurses.

Local leadership in Masvingo province touring an MSF stand during a World AIDS Day Exhibition in Gutu

In May 2012 MSF introduced the GeneXpert machine in 1 hospital in Gutu District. Although cost effectiveness was already analyzed in Murambinda district; the added value in Gutu district would be to compare the increase in case detection in a district without easy access to X-ray.

In 2013 MSF intends to introduce the GeneXpert machine in Chikomba district, boosting MoHCW's efforts to decentralize this technique up to district level.

To date with the aid of the GeneXpert, 2 DR-TB cases have been detected in Gutu. One is currently on treatment while the other will soon start. MSF is applying the individualized approach to DR-TB care which is community driven, patient centered, with MoHCW clinic staff taking full responsibility of medical care, while family members regularly provide food that is supplemented by the MoHCW. MSF's sole role is providing the technical support, initial MDR-TB drugs to the health staff to manage DR-TB cases. This has proven successful in managing the first case.

Some facts and figures from 2012:	**Gutu**	**Chikomba**
Number of HIV tests done in 2012	20,767	2,859
Of those, number of positive results	1,749	376
Number of new HIV+ patients taken under care	2,398	1,032
Number of patients initiated on ART	1,448	625
Number of patients on Art at end of 2012	5,605	1,287
Number of new TB patients newly diagnosed and put on treatment	306	189
Number of MDR TB patients taken into care	1	0
Number of staff as of end of 2012		
International	3	0
National	20	13

EPWORTH

Community health care workers and MSF staff at Domboramwari clinic

In November 2006, Médecins Sans Frontières (MSF) started treating HIV+ patients in Epworth, and the first anti retroviral therapy (ART) initiation was in April 2007. The main site of activity is Domboramwari Polyclinic, where MSF works in support of the Ministry of Health and Child Welfare (MoHCW); this is also where the MSF Epworth project office is located.

By 2010 the demand for care had exceeded capacity and so, in response to the increasing HIV patient cohort in Epworth, MSF built a satellite clinic in Overspill.

This brand new state of the art structure was handed over to the MoHCW in September 2011. Overspill clinic is staffed by 35 MoHCW personnel, supported by MSF, who fund the Local Board to pay for their salaries. HIV care is also delivered at the Mission Clinic, which is run independently by the Methodist Mission on behalf of the MoHCW and supported by MSF.

Outside of Epworth, MSF also 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 and HIV test, treatment and care including psychosocial care in an integrated approach.

MSF is also working in six City of Harare Polyclinics to increase access to ARVs to HIV+ patients through Nurse led ART initiation. In this partnership MSF offers a support mechanism by offering small numbers of trained personnel to support and mentor the Polyclinics as they put into practice the City of Harare Health Department's strategy of decentralising HIV care. The reach of the Epworth project also extends to offering support in assisting with the diagnosis of TB/MDRTB.

In 2012, the broad range of services supported by MSF across different Epworth Project locations included a full package

of HIV, TB/MDR-TB and SGBV care. The style of SGBV care was developed in conjunction with partners over the course of 2012, resulting in the opening of a one-stop SGBV clinic offering a 24/7 service, which was launched in August 2012.

Another specific focus in the project has been on TB diagnosis and care; the use of the GeneXpert diagnostic system in the MSF laboratory in Epworth has contributed to far quicker test confirmation and greater sensitivity. In 2012 we had a total of 2,798 sputum samples tested for TB.

Of these samples, traditional microscopy examination had identified 416 (15%) sputum positives, but Gene Xpert picked 613 (22%) positives results; showing a significant improvement in TB diagnosis. Additionally, GeneXpert identified Rifampicin resistance in samples, leading to 9 new patients in 2012 being added to the MDR TB programme.

Some facts and figures from 2012:	
❖ Number of HIV tests done in Epworth and Caledonia Farm clinics	21,462
❖ Of those, number of positive results	6,124
❖ Number of new HIV+ patients taken under care	5,620
❖ Total number of HIV+ patients under care at end of 2012	17,341
❖ Number of patients initiated on ART	3,815
❖ Number of patients on Art at end of 2012	13,086
❖ Number of new TB patients newly diagnosed and put on treatment	1,171
❖ Number of TB patients transferred in from other health facilities	125
❖ Of these, number of MDR TB patients taken into care	9
❖ Number of first consultations for rape	90
Number of staff as of end of 2012	
❖ International	6
❖ National	132
❖ ELB / MoHCW establishment	48

A health worker dispensing multi-drug resistant tuberculosis treatment

GOKWE NORTH

Médecins Sans Frontières (MSF) started to work on HIV in the Midlands Province in 2005, when we set up activities in Gweru city. Services spread rapidly in support of local health facilities to offer care in both urban and rural areas of Gweru district, and the first HIV+ patient was initiated on ART in 2006.

By 2010 the cohort of Ministry of Health and Child Welfare (MoHCW) HIV+ patients supported by MSF exceeded 8,000. The process of handing patient care activities wholly back to the MoHCW started in 2010, and during 2011 the care of approximately 7,150 HIV+ patients was fully re-integrated into the primary healthcare system of the MoHCW in Gweru district.

The final group of second line patients were fully reintegrated into the system by the end of March 2012. In addition, the SGBV care programme was handed back to the District at the beginning of the year, and has continued to run successfully throughout the year, providing an integrated medical and psychosocial care package, fully under the ownership of the District Health Team, to more than 200 survivors of sexual violence in 2012.

Drawing on valuable lessons learned in Gweru, and also using experience from the other projects in Zimbabwe, MSF launched the Gokwe North District project in January 2012 with the objective of creating a new way of working between MSF and the MoHCW.

Collaboration and partnership, always present in the relationship, has given rise to a 'light' approach, whereby a small team of highly experienced MSF clinicians works alongside MoHCW colleagues with a reduced level of direct implementation, but with a strong element of mentorship and technical support.

Gokwe North has 18 health facilities in the District; the range of services delivered by the MoHCW in these clinics that is supported by MSF includes HIV testing, counselling and care; TB diagnosis and

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Community members dancing during a HIV and AIDS outreach exercise in Gokwe North

treatment; and comprehensive medical response to SGBV.

The choice of Gokwe North District was based on various geographical and social constraints that had seemingly left the district behind in the drive to make HIV & TB services more accessible.

Early successes included that Chireya mission hospital was accredited as an ART initiation site (alongside Mutora Mission Hospital in Nembudziya), and the clinics at Zhomba and Gumunyu were accredited as follow-up sites.

A total of 60 nurses from the district were trained in ART initiation and the clinical management of opportunistic infection (OI).

Clinical care and health systems management were greatly enhanced when a District Medical Officer was allocated to the district in May 2012, the first MoHCW doctor present in Gokwe North for over 2 years.

By the end of 2012 the district laboratory and the Chireya laboratory was functioning; GeneXpert equipment was installed by MSF in the district laboratory to aid with TB diagnostics. Aside from the district-wide roll-out of integrated HIV care services, the increase in numbers of TB patients diagnosed and put on treatment has been one of the major successes of MSF's partnership with the MoHCW.

Some facts and figures from 2012:	
Number of HIV tests done in Gokwe North clinics	13,910
Of those, number of positive results	1,614
Number of patients initiated on ART	1,168
Total number of HIV+patients under care at end of 2012,	5,658
Number of patients on Art at end of 2012	3,391
Number of new TB patients newly diagnosed and put on treatment	324
Number of first consultations for rape	47
Number of staff as of end of 2012	
International	3
National	24
Gokwe North District / MoHCW establishment	1

MSF in Gokwe during an outreach

MBARE

CLINICAL MANAGEMENT OF SURVIVORS OF SEXUAL ABUSE

Since September 2011 Médecins Sans Frontières (MSF) has been running a clinic for victims of Sexual & Gender Based violence (SGBV) at the Edith Opperman Polyclinic in Mbare, Harare. Mbare, a highly populated residential area was identified for support after an assessment carried out in 2009 showed that it is one of the highest populated district in Harare. In addition, it houses the biggest bus terminal and laggest fruit/ vegetable market.

The clinic has 3 rooms designated for registration, consultation and counselling. It is run by 4 nurse/ counsellors assisted by 2 nurse aids. This team provides the needed medical care, counselling as well as completing medical affidavits for legal follow ups.

The clinic in Mbare is purely run by nurses and provides care to both children and adults. In case of complications, patients are referred to doctors for further management. The medical team works in collaboration with the Victim Friendly Unit (VFU) of the Zimbabwe Republic Police.

In addition, there is a health promoter who is responsible for awareness raising on the existence of free confidential SGBV services and sensitization on the need to seek care within 72 hours for maximum medical benefits such as prevention of STIs, HIV transmission and pregnancy.

There is also a social worker who facilitates the linkage of patients in need with the Ministry of Social Welfare and other local NGO's such Musasa Project for provision of temporary safe shelter & social support.

In 2012, MSF conducted a total of 1 858 consultations in the clinic, among which 904 were for new survivors. This corresponds to an average of 75 new survivors per month. Fifty four (54%) of the survivors are children below 15 years; with majority of cases in the age group 13-15 years (36%). Most of the patients come through referral by the police (96%) and only 36% of patients seek care within 72 hours.

SGBV Toll free line

In a bid to increase access to information and multi-sectoral support to adults and child survivors of Sexual and Gender Based Violence in Zimbabwe, MSF partnered with Childline Zimbabwe, a local non-governmental organization that operates a 24 hour toll free helpline for children through a community volunteer base. Childline Zimbabwe seeks to provide children, families and those involved with children, a preventative, educational, therapeutic and rehabilitation service, in addition to research and advocacy.

The partnership started late 2012. MSF has aided in the development of existing Helpline services, training of the Helpline counsellors to manage SGBV Hotline calls and the maintenance of Helpline services for the SGBV line. The services are accessible through mobile networks on the 116 toll free number.

In 2013 MSF will, in collaboration with other partners, continue to support expansion of SGBV services within the other clinics in Harare city. This will be achieved through training and mentoring of staff.

This training program will run in close collaboration with Harare City Health department, Adult Rape Clinic, Family Support Trust and Ministry of Health and Child Welfare.

MSF will be working together with other partners to craft a message of awareness raising for a billboard to be erected in the city.

Health promotion in schools on sexual and gender based violence

TSHOLOTSHO

A mother enrolled in the Prevention Mother to Child Transmission Programme in Tsholotsho

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 and started a nutrition program establishing a Therapeutic Feeding Centre for the under five's at the district hospital.

In 2004, the nutritional program was handed over to the Ministry of Health and Child Welfare (MoHCW) and simultaneously, a memorandum of understanding was signed with MoHCW to engage in the provision of HIV/AIDS services culminating in setting up an OI/ART clinic at the district hospital where patients could access comprehensive OI/ART care.

Over the years, MSF supported MoHCW to introduce and roll out comprehensive OI/ART program with components in HIV prevention, treatment, care and support.

The project has evolved to cover different aspects of HIV management ranging from the initial MSF access-focused framework of "simplification, decentralization and integration" into a more comprehensive framework of integration of TB, DR-TB, new improved ART regimens and Prevention of Mother to Child Transmission (PMTCT) protocols as per the WHO 2010 OI/ART and PMTCT recommendations.

The project also supports Early Infant Diagnosis (EID), Sexual Gender Base Violence (SGBV), Nutrition, Laboratory & pharmacy services and Information, Education & Communication (IEC).

During 2012, MSF activities were concentrated in Tsholotsho urban area (Tsholotsho district hospital, Tsholotsho urban clinic and the VCT and Resource Centre) and 12 rural health centres (Pumula Mission hospital, Sipepa rural hospital, Nkunzi, Makaza, Mtshayeli, Sikente, Bubude, Jimila, Dlamini, Mlagisa, Sodaka and Mdlangombe clinics). In addition, the project also started supporting Nyamandlovu Hospital in Umguza district.

The IEC department was engaged in the formation of PLWHAs support groups, PMTCT support groups, Community ART groups, social mobilisation for TB, DR-TB, OI/ART, SGBV, PMTCT and nutrition. Special support was also given to the peer education programs (Community Adult Peer

Education) among the San community in Sikente and Pumula; In-school Peer Educator program at primary and secondary schools throughout the district, Youth-Out of School Peer Education program and through Youth corners located at MSF supported health facilities in the district.

The department was involved in condom distribution, HIV/AIDS workplace based programs in the formal and in-formal sectors in Tsholotsho.

Some other activities also included community empowerment programs which culminated in the formation of Treatment Literacy and Advocacy community based Trainers of Trainers, TB/HIV collaborating committees and community based TB DOT supporters.

Theatre was introduced as a communication tool and this proved effective among the youth. In 2012, TB activities were strengthened by investing in new diagnostic techniques (Fluorescent microscopy, the GeneXpert machine and TST).

DRTB halfway homes were introduced at Tsholotsho District Hospital, Sipepa and Pumula and this in addition to incentivising MDR-TB DOT supporters improved community management of DRTB in the district. The project also invested in a new modern state of ART bio-safety cabinet and Chemistry Analyser at the district hospital laboratory.

In the same year, the OI/ART program continued drug substitutions from D4T to less toxic TDF based regimens. Nurse led ART initiation was introduced in paediatrics, TB/HIV and PMTCT and this has resulted in increases in the numbers of TB patients, children and pregnant women accessing ART.

Trainings formal and on the job mentoring continued as part of health human resource capacity building.

The logistics department was involved in carrying out rehabilitations at all MSF supported health facilities to create conditions to meet MoHCW/MSF standards.

Major highlights were the construction of counselling rooms at all MSF supported health facilities, sinking of a borehole at Bubude which had no running water for the past 10 years, donation of an all terrain vehicle to MoHCW and procurement of bicycles for the 52 lay peer counsellors to enable them to engage more effectively in defaulter tracing.

The department also carried out renovations at Tsholotsho District Hospital Family Support Clinic to create conducive conditions for comprehensive care of survivors of SGBV, theatre and PMTCT departments.

In 2013, MSF will continue supporting MoHCW to decentralize OI/ART services to the remaining 5 health facilities in Tsholotsho district program and as many health facilities as possible in Umguza district. In addition, IPT, PMTCT option B+, Mentor Mother and Mentor Father programs, cervical cancer screening, sperm wash and male circumcision will be introduced and rolled out in Tsholotsho and Umguza districts.

The Youth and Adolescent program will be strengthened and decentralised to all health facilities in two districts. The project intends to engage other partners and stakeholders to ensure sustainability of the various activities initiated by MSF over the years. MSF will also engage in operational research and share our experiences with MoH and other relevant partners.

Some facts and figures from 2012:	
Number of HIV tests done in Tsholotsho	11,786
Of those, number of positive results	1,946
Number of patients initiated on ART	2,168
Number of patients on Art at end of 2012	9,103
Number of new TB patients newly diagnosed	416
Number of first consultations for SGBV	100
Number of staff as of end of 2012:	
International	3
National	73

FACTS AND FIGURES

Intersectional facts and figures from 2012:	
❖ Number of HIV tests done in all MSF projects in Zimbabwe	92,888
❖ Of those, number of positive results	14,664
❖ Number of new HIV+ patients taken under care	11,669
❖ Total number of HIV+ patients under care at end of 2012	54,296
❖ Number of patients initiated on ART	12,287
❖ Number of patients on Art at end of 2012	52,140
❖ Number of new TB patients newly diagnosed and put on treatment	4,342
❖ Of these, number of MDR TB patients taken into care	25
❖ Number of first consultations for rape	1,171
v	
vNumber of staff as of end of 2012	
❖ International	40
❖ National	626

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With the rollout of fixed-dose combination (FDC) antiretrovirals (ARVs) patients on the triple-therapy regimen will be able to take just one pill daily to control the virus.

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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.

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