

# MSF ZIMBABWE NEWSLETTER



**Clean water provision, physical distancing  
-#C19 - #Community-led initiatives;  
Matapi Flats, Mbare, Harare**



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# MÉDECINS SANS FRONTIÈRES CHARTER

**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 who might help in achieving its aims. All of its members agree to honour the following principles:

**Médecins Sans Frontières** provides assistance to populations in distress, victims of natural or man-made disasters and 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.

## ABOUT MSF IN ZIMBABWE

MSF is an international medical humanitarian organisation that has been working in Zimbabwe since 2000. It runs projects in partnership with the Ministry of Health and Child Care (MoHCC) that include treatment and care of people living with HIV, cervical cancer, non communicable diseases, Migration, Adolescent Sexual and Reproductive Health, water and sanitation services and emergency preparedness. MSF projects are currently located in Beitbridge, Harare, Gutu, Mutare and Chipinge.

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# CONTENTS

COUNTRY'S DIRECTOR NOTE	4
HOW MSF TEAMS HAVE RESPONDED TO COVID-19	6
COMMUNITY ENGAGEMENT FOR COVID-19: VILLAGE HEALTH WORKERS' VIEWS ON THE GUTU PROJECT	8
STRENGTHENING MANAGEMENT OF NON COMMUNICABLE CONDITIONS IN MANICALAND	10
WE WELCOMED MIGRANTS AT BEITBRIDGE AND PROVIDED HEALTH SERVICES UPON ARRIVAL	12
WE PREPARED REFERRAL CENTRES IN THE CAPITAL CITY	13
COVID-19 TEAM OBSERVATIONS	14
CONTINUED ACCESS TO MEDICATION AND CARE REMAINS PRIORITY FOR PEOPLE WITH CHRONIC CONDITIONS	14
FIGHTING CHOLERA, TYPHOID IN HARARE	19
"NO BORDERS" TO HEALTH CARE ACCESS. A CALL TO SUPPORT	24
MONITORING AND EVALUATION OF THE NCD/ HIV PROJECT IN CHIPINGE (EVOLUTION OF DATA COLLECTION TOOLS)	27
RESEARCH PAPER ON NURSE-LED NCD MANAGEMENT PUBLISHED IN THE SCIENTIFIC JOURNAL, BMC	31
TESTIMONIALS: GIS BRAMU	33
SRH PROJECT: MENSTRUAL CUPS COULD END PERIOD POVERTY	36
WHY ARE WE GOING SOLAR? WHY YOU SHOULD TOO!	39
WORKING TO ENSURE HEALTH FOR MIGRANTS AT BEITBRIDGE BORDER POST	41
FINANCE TEAM SUCCESSFULLY COMPLETES UNIFIED TRAINING ONLINE	42
MEET OUR STAFF	43
STAFF NEWS	44
FAREWELL, BJORN	45



## COUNTRY DIRECTOR'S NOTE

This year's first edition of MSF Zimbabwe Newsletter comes against the backdrop of an unprecedented global pandemic in recent history. As we carry out our mandate to provide medical assistance in situations such as these, our teams have been at the forefront working with various partners to reach patients, communities, health facilities and workers, providing resources and services needed in such times.

The Government of Zimbabwe, like other governments around the world, has the responsibility to tackle and reduce the impact of COVID-19 pandemic on its citizens. This is not an easy task, more so in a country

where the health system is already overburdened. What we have witnessed in the first six months of the year, and in the first three months since the first case of COVID-19 in the country, are very low numbers of confirmed cases. Questions have been raised on the correctness of these figures, given the low numbers of tests carried out, and the initial use of rapid test kits, which have since been disregarded as less effective for COVID-19 testing. We continue to work with the Government of Zimbabwe and partners, advocating for more resources to be channelled towards fighting the pandemic.

During such overwhelming situations, other non-pandemic conditions tend to suffer as resources and energies are redirected towards addressing the emergency. However, we have continued to work with the Ministry of Health and Child Care (MOHCC) and the Ministry of Labour and Social Welfare to provide support within MSF's projects in the areas of HIV and TB, Non Communicable Diseases (NCDs), Migration, Environmental Health/WASH and cervical cancer.

Our mandate is to ensure that populations in distress, the most marginalised and those that have difficulty accessing health services, have access to COVID-19 care, and continue to receive regular care for non-COVID-19 conditions.

Our outreach and health promotion teams will continue to provide vital information to communities in need through the training of health and non-health workers, community members, staff and other partners MSF implements its activities with.

MSF can still access vital medications and medical equipment, including the much-needed PPE for use in the facilities and communities that we support. The country is in dire need of more medicines and equipment.

Collectively the efficient, transparent and immediate supply of these will save many lives.

Without its volunteers, MSF would not exist. My gratitude goes to our nurses, doctors and support team stationed at our various offices across the country for being at the forefront of providing care and services to the most vulnerable people.

As I bid farewell to the MSF team in Zimbabwe, I wish all our partners and the people of Zimbabwe prosperity and a good fight against COVID-19.



*I wish my colleague and current Medical Coordinator, Reinaldo Ortuno all the best as he begins his new role as MSF Country Director for Zimbabwe effective July 2020.*

**Happy reading!**

# HOW MSF TEAMS HAVE RESPONDED TO COVID-19

Managing COVID-19 in Zimbabwe requires a collective effort as the novel disease has brought unprecedented morbidity and mortality levels globally. MSF begun its response and support to the Ministry of Health directly, and across its projects in the country. Our staff on the ground, MSF Coordinators stationed in Gutu, Mutare, Beitbridge and Harare relate how their projects have responded to COVID-19 since the first case was reported in Zimbabwe.

**In Gutu, MSF boosted community engagement and resilience for COVID-19 in the rural community.**

**By Rinako UENISHI**

Our response to COVID-19 in Gutu District started immediately after the first case was reported in Zimbabwe. Discussing with the district health executive (DHE), we decided to begin raising awareness on the disease in the health facilities and setting up screening tents and hand washing points at the gates of the two main hospitals in Gutu Town. Thereafter, MSF organised training for the frontline health care workers and the DHE members in the following weeks. MSF has since contributed to setting up and improving screening and referral unit (SRU) and infection prevention control (IPC) in the health facilities.

The disease control for COVID-19 requires IPC measures at different

levels, not only at institutional level, but also emphasizing on the need for physical distancing, cough etiquette, and hand washing at community level. We noticed that compliance to these measures was sub-optimal in the community. As promotion of behaviour changes requires a good understanding of the target population, it then made us question many things like; "How do community members perceive the situation?", "What is their understanding of the disease?" and "How can we enhance community engagement for COVID-19 response?"

Paul Matsinise, the health promotion officer of Gutu Project went to the community to conduct some group discussions and interviews to better understand the perceptions, knowledge and practices on the disease in the community.



*This would be helpful for us to adapt health promotion messages and design some community activities to boost their engagement and resilience to tackle the situation.*

PAUL MATSINISE

“It was a very good exercise as we identified a big knowledge gap and different perceptions on the disease in the community. Community members highlighted their fear for COVID-19, which exaggerated the stigma around the disease. However, due to a knowledge gap on the transmission, they did not know how to protect themselves properly. On the other hand, in very rural communities, many people felt the pandemic was insignificant, therefore, irrelevant to them as they strongly believed it would not reach their community which is far away from everywhere else,” noted Paul.

We developed a community intervention pilot based on the needs and knowledge we gained through community interviews. The idea was for community dialogues addressing COVID-19, surveillance and referrals to be done by village health workers (VHW) using a door-to-door approach. Additionally, this was to enhance continuum of care – VHWs check children’s nutrition and vaccination status and refer them to the health facilities. This was particularly important because we saw increased defaulters in the nutrition programme and EPI under lockdown due to restricted movements from the community to health facilities.

The pilots were conducted in three health facilities’ catchment areas namely Gutu town, Matizha and Chimombe. VHWs attended two days training and started door-to-door activities. During the one-month pilot, 1 137 households were visited and

sensitized by VHWs and 195 individuals were referred to health care workers for malnutrition, vaccinations or COVID-19 suspects.

In the debriefing session after the pilot, VHWs shared their experiences and opinions, reporting that activities had been well-received by the community, and even supported by community leaders. Distribution of the visual materials (pamphlets) enabled better understanding as the information was shared with family members who were not present during VHW’s visits. VHWs also mentioned that hand hygiene practices improved as they started to see hand-washing points at the entrance of many homesteads. However, they also shared their concerns that it wouldn’t be easy to enforce the measures at gatherings such as funerals and church services, and that some people hid their travel history due to stigma.

After debriefing sessions with VHWs, Paul says, “It is vital to make such activities integrated into regular community activities in order to make the activities sustainable and feasible, even without increasing resources as VHWs already have mandates to take care of community members’ health.”

MSF Gutu Project has conducted many innovative community activities for its HIV and cervical cancer programmes since 2011. Such experiences were helpful in designing and implementing this pilot to respond to COVID-19. MSF will continue its community-centered approach until its programme handover in September 2020.

# COMMUNITY ENGAGEMENT FOR COVID-19: VILLAGE HEALTH WORKERS' VIEWS ON THE GUTU PROJECT



*Our messages in the communities were to do with issues like: what is Covid-19, what are the signs and symptoms of Covid-19, how it is spread and what can we do to prevent the spread of the pandemic*

“As Village Health Workers in Gutu, we are very grateful for the training on COVID 19 that we received from MSF and the support that we got in going out into the community to sensitize our communities on the pandemic. We received a two-day training workshop on COVID 19 and piloted this programme for one month in our communities. Our messages in the communities were to do with issues like: what is COVID 19, what are the signs and symptoms of COVID 19, how it is spread and what can we do to prevent the spread of the pandemic. We also

focused on community surveillance for those people with a travel history, particularly people returning to their homes either from towns in the country or from countries outside Zimbabwe. We were able to identify these people and referred them to our local Environmental Health Technicians (EHTs) from our health facilities so that measures were taken to have them receive the necessary assistance.

Of interest was the fact that our community leaders, whom we also first approached and sensitized as our first port of entry, supported us. They encouraged communities to allow us to work with them, receive us and take seriously what we were teaching them. More importantly, they also took a bigger role in referring those people with a travel history to our health facilities through us. They made our day!!! Changes were noted after our visits as more hand washing facilities could be seen at most of the homesteads and at boreholes where communities fetch water. Hand hygiene improved a great deal after this pilot programme. Of interest was the introduction and heavy use of the newly improvised leg-operated 5-litre container that discourages the opening and closing of the tap using



hands. Use of the face masks and their correct use also improved.

Our work in the communities also helped to reduce the amount of gatherings albeit with minor resistance in some small pockets of the community (churches, community meetings and beer gatherings) that were very common in these communities before the launch of this intervention. Short lived as it was a pilot, it assisted in a big way in raising COVID 19 awareness in communities. The IEC material that we gave out in the process helped a lot. We gave out COVID 19 flyers and informative

leaflets on mental health. We also took the opportunity to do surveillance on malnutrition and vaccination gaps.

We as Community Village Health workers are very grateful to MSF for affording us this opportunity to receive this training on COVID 19 and rolling it out in the community. Even after the end of the pilot programme, we will continue sensitizing our communities on COVID 19. Our hope is for it to be extended to other sites that were not included in the pilot so that the whole district is covered and is able to access this vital information on COVID 19.



*HWs R. Mamina L and R. Madyiwa in the fight against COVID 19.*

# STRENGTHENING MANAGEMENT OF NON COMMUNICABLE CONDITIONS IN MANICALAND

**By Elton MBOFANA**

Diabetes Mellitus and Hypertension are chronic non communicable conditions that need lifelong appropriate and affordable medical treatment, and also lifestyle changes. In 2020 MSF is supporting the MOH to provide good quality diabetes and hypertension services, including patient education at Mutare Provincial Hospital, and at six sites in Chipinge district.

*COVID-19 patients with comorbidities such as hypertension and diabetes mellitus are at higher risk of severe progression and death from the disease.*

And when COVID-19 threatened to enter our world, we quickly figured out that we were right there where it was going to make a “landfall”: indeed, COVID-19 patients with comorbidities such as hypertension and diabetes mellitus are at higher risk of severe progression and death from the disease.

This meant that we had to rapidly come up with strategies to confront the pandemic while ensuring continuity of care for patients with

chronic conditions. We helped the MSF-supported health facilities to build a ring-fence of knowledge and organization against COVID-19, and to keep essential services going including those for diabetes and hypertension. Patients accessing the health facilities were now screened for fever, cough, and shortness of breath (SOB) so as to identify presumptive cases of COVID-19, and separate them for further management from the general patient flow.

Networking: To mitigate the mental pressure on health care workers, we supported Dr. Machinga, Psychotherapist, and Mental Health Specialist in Manicaland to compile Guidelines on Mental Health Care strategies for health care workers. Under her leadership and with support of Africa Ahead, we conducted corresponding trainings at Mutare Provincial Hospital for 79 staff. We initiated the screening for COVID-19 patients entering the health facilities and provided COVID-19 training at Manicaland Provincial Hospital.

We are shielding the patients with chronic conditions from the pandemic by increasing the duration of their drug refills and empowering them with knowledge to safe keep and administer the medication.



*MSF Chipinge team educating NCD patients*

And eventually we embraced the “new normal” to improve quality of care and restart where we had stopped: intensifying insulin initiations for patients in need, and empowering patients to manage their chronic conditions together with the clinicians.

“ Since 2016, MSF has successfully implemented the diabetes and hypertension pilot project in Manicaland Province in collaboration with Ministry of Health and Child Care ”

# WE WELCOMED MIGRANTS AT BEITBRIDGE AND PROVIDED HEALTH SERVICES UPON ARRIVAL



*MSF Public Health Promotion at the Beitbridge Quarantine and Reception Centre*

In 2016, MSF opened a clinic at the Reception Centre in Beitbridge, in collaboration with the MoHCC and Department of Social Services, to provide primary health care to Zimbabwean deportees arriving from South Africa. The following year, MSF supported the Dulivadzimu council clinic with one additional nurse, gap filling for the pharmacy, and laboratory support. In 2018, we expanded our scope to provide a comprehensive Outpatient Department (OPD) package to the migrants received at the Reception Centre. With the advent of COVID-19, MSF heightened its support to migrants and assisted the MoHCC and department of Social Services through Public Health promotion offered to returning residents and those in transit, offering services at the clinic and vital information material.



*MSF Health workers providing regular medical care to returning residents and those in transit at the MSF Clinic*

MSF's Migration and Health Project aims to provide evidence and knowledge in the field of migration health that will increase and normalise access to care for migrants and will help to transform how migration is perceived within the region and beyond.

# WE PREPARED REFERRAL CENTRES IN THE CAPITAL CITY

By **Hebert MUTUBUKI**

## **Mbare Screening and Referral Unit**

With a rotating staff compliment of two Registered Nurses, four hygienists and a standby ambulance driver, a day is characterized by health education activities to patients on physical distancing, personal hygiene, respiratory etiquette and self-surveillance. 'We make sure every patient correctly washes their hands and is putting on a mask on their way in and out of the polyclinic', said Shingai Mawarire, an MSF nurse.

'Patients are screened using the WHO guidelines and criteria', added another MSF nurse Romeo Bwizi based in Mbare. Infection control measures are adhered to and all staff pre-trained on IPC and COVID-19.



*We clean all floors, chairs  
and the SRU unit with soap  
and water then 0,5% chlorine  
solution*



**Priscilla Mapfumo**  
**MSF hygienist**

The team is highly motivated and the guiding philosophy is teamwork, commitment and professionalism.

**Wilkins Infectious Disease Hospital Support.** In the framework of COVID-19 intervention, and during the period under review, MSF supported Wilkins hospital screening and patient care from 10-28 April 2020. With the Harare City Council staff withdrawing their labour demanding incentives/allowances, MSF took an institutional decision to suspend this activity until further instructions. Two RGN's and three hygienists, who were supporting day activities at Wilkins hospital mainly on patient screening, collection of samples and IPC were seconded to Mbare SRU and Sample collection teams.

## **Community Rapid Response Team**

MSF started supporting this activity on 22 April 2020. The team is working together with the Harare City ambulance division and medical staff by responding to daily alerts and collecting swabs from isolation/quarantine centres and from individuals. Staff establishment on rotation includes two nurses, two hygienists, one driver and one City Health hygienist. MSF provides a car for use to beef up the eight teams in motion.

# COVID-19 TEAM OBSERVATIONS

- > Physical distancing is not respected by people
- > Masks are not properly worn with most people 'doing it for the police'
- > Most Zimbabweans do not believe the disease is real, referring to it as a 'European problem' and that the cases reported are not of our own but from outside Zimbabwe's borders
- > Control measures, including lockdowns, are not followed, with a large population going on with their daily business, especially the informal traders, who represent a significant part of the economy
- > Unlike in the past when there was a greater fear of COVID 19 with fewer infections, now people have less fear of the virus, yet, with more infections





# “CONTINUED ACCESS TO MEDICATION AND CARE REMAINS PRIORITY FOR PEOPLE WITH CHRONIC CONDITIONS”

By Caroline GWATURE



Global pandemics like COVID-19 have put a strain on individuals, communities, national and global healthcare systems. They divert attention and resources, much to the detriment of ongoing health conditions still in need of care. Naturally, focus shifts to the prevailing crisis, at times leaving a fatal gap on the delivery of essential health services for non-pandemic related chronic conditions.

**Continuum of care** is a concept involving an integrated system of care that guides and tracks a patient over time through a comprehensive array of health services spanning all levels of intensity of care. During a pandemic, continuum of care not only safeguards provision of medical assistance to those infected, but also allows for holistic interventions, including continued care for non-pandemic related conditions. It is based on the understanding that even as priorities shift due to the pandemic,

management of non-pandemic conditions must continue to avoid creating other disasters when the prevailing pandemic eventually ends. Non-pandemic care is especially important for the most vulnerable populations: the elderly, patients with chronic illnesses like HIV and tuberculosis (TB), and non-

communicable diseases (NCDs) such as cancer, diabetes and hypertension.

Since starting work in Zimbabwe in 2000, MSF has implemented a number of projects in partnership with the MoHCC that includes the treatment and care for people living with HIV, TB, drug-resistant TB (DR-TB) non-communicable diseases and mental disorders. It also provides Adolescent



Sexual and Reproductive Health (ASRH) services, Sexual and Gender-based Violence (SGBV) interventions, cervical cancer screening, water and sanitation service and emergency preparedness. MSF projects are currently located in Harare, Gutu, Beitbridge, and the greater part of Manicaland Province.

It is critical that our projects continue to manage these conditions in times of COVID-19, more so for vulnerable populations, as they are at higher risk of severe forms of the disease if they don't gain access to care and continued medication supply. The task is complicated as the already strained health resources are under more pressure and non-COVID-19 conditions suffer due to inattention resulting from issues of global supply, domestic shifts of priorities and resources, as well as new measures aimed at managing the pandemic but that have unintended effects on prevailing conditions.

Over the years and in times of medical distress, MSF has designed clinic and/or community-based strategies such as a decentralisation of services to health centres and health posts to ensure continued and longer drug supplies and refills and reduce the burden on health workers and patients.

Community ART Groups (CAGs) are one such strategy for ART distribution, whereby groups of patients rotate for clinic visits and drug refill at the clinic while dispensing drugs to their peers in the community and ensuring peer support.

Borne out of CAGs, the Out of Facility Community ART Distribution (OFCAD) is a new differentiated antiretroviral

(ART) service-delivery model initiated by MSF that provides training to health workers to distribute ART to registered users in the community and ensures that people living with HIV in hard-to-reach areas, mainly rural areas, have uninterrupted access to their supply of ARV's. Before implementation of OFCAD, many patients walked for hours, or days in extreme cases, to reach health centres or outreach sites.



*With the introduction of OFCAD, people on ART can now collect their medication from the nearest OFCAD site. The same approach has been successfully replicated for diabetes drugs in Manicaland.*

Just recently, MSF learnt that chronic patients travelling to collect their medication were being turned away in Mutare by security personnel at traffic control points. This followed travel restrictions being experienced nationwide as part of the lockdown measures currently in place. The same reports were also made in other parts of the country. This means that patients are not able to continue with their treatment during this period, and defaulting on medication is a major challenge in healthcare as it comes with many complications.

Patients who default treatment become easily susceptible to other illnesses and are at risk of developing complications such as damage to eyes, kidneys and

nerves (peripheral neuropathy) heart complications and complications that result in amputation, stroke and organ failure, all that could result in death. Drug resistance is another result of treatment default, and leads to treatment failure and fatality.



MSF team in Chipinge district in Manicaland giving health education for diabetes patients who had come for their regular group sessions. Issues discussed included COVID-19 in relation to chronic conditions, adherence to medication, continued health lifestyles and their vulnerability to COVID-19.

“In the wake of COVID-19 we are doing as much as we can to continue services for projects,” explains Dr. Brian Nyagadza, a doctor working for MSF.

“We have made a lot of progress to deliver a structured approach to the health system that has resulted in clearer, safer, better organised and regular access to chronic medication.

As we come to terms with the new realities to deal with COVID-19, we must take all the necessary steps to ensure that the impact of this pandemic does not create disruptions to these approaches that result in tragedies now and in the future.”

MSF programmes continue to intervene by raising awareness on COVID-19 and the importance of continuing to take medication, contraceptives and other health-care needs. Through discussions, training and health promotion activities, MSF addresses concerns by patients such as infection issues, how they can adhere to their medication, lifestyle management and how to better protect themselves from, and during COVID-19. They are equipped with measures to take when visiting health facilities at the time of COVID-19 surge to avoid infection.

But continuum of care requires that we increase focus on surveillance and monitoring of the existing programmes and their performance to ensure that funding is strengthened and sustained. Psychological safety must be provided to all health care workers to enable them to perform their duties, and part of that is access to personal protective equipment (PPE) and a safe and well-managed working environment.

Shaping of this environment requires extensive coordination and training, timely and decisive channelling of resources to ensure that they are available where they are needed most and at the right time. Only then can we ensure efficient management of COVID-19 and other health conditions simultaneously.

# FIGHTING CHOLERA, TYPHOID IN HARARE

In Zimbabwe's capital Harare, recurring outbreaks of cholera and typhoid fever are a pressing health concern. In many of the city's suburbs, public water supply is unreliable, and leaking sewage pipes, pit latrines, and poor waste management contaminate the groundwater. Using innovative borehole technology and empowering communities to manage their own water points, Médecins Sans Frontières (MSF) has developed a highly effective environmental health toolkit.

A small, dimly lit entrance leads into the dozen rundown apartment blocks of Mbare flats in southern Harare. Satellite dishes and laundry lines clutter the weathered building facades, and small groups of children play between rain puddles in the courtyard. In front of the adjacent building, a congested waste container spills into a large field of household waste and plastic.

The barrack-like buildings date back to pre-independence, built for single



*Women fetching water at a water point in the informal settlement of Stoneridge in southern Harare. MSF drilled a solar-powered borehole and trained the local community health club, who are now maintaining the site. Photo: Samuel Sieber/MSF*

male migrant labourers working in the nearby city centre. Today, over 20 000 people live in these flats, and up to four families share a single room. Unreliable fresh water supply, clogged and leaking sewage pipes, and virtually no public garbage collection make Harare's high-density suburbs prone to recurring outbreaks of waterborne infectious diseases like cholera and typhoid.



*Waste management remains notoriously challenging in Harare's high-density suburbs like Mbare. Household waste is known to contaminate shallow groundwater and causes diarrheal disease outbreaks. Photo: Samuel Sieber/MSF*

"We know the sewage and waste puts our health at risk", said Jane Masanga, a mother of three who lives in one of the buildings right next to the vast waste pile. "But we currently depend on one single borehole with a hand-pump right next to the main road, and have no means to dispose or recycle our household waste", she added.

On this cloudy December morning, the roaring of a large mobile drilling echoes through the buildings. Next to the old hand pump by the main entrance,

Médecins Sans Frontières is drilling a new borehole with the help of a local drilling company, with pipes leading to a water point with taps.



*Using innovative rehabilitation and drilling technologies, MSF has drilled over 70 new boreholes in Zimbabwe. Photo: Samuel Sieber/MSF*

"We are drilling 80 metres deep into the ground, and are installing a sanitary seal that we have perfected over the last years to avoid any contamination from waste, sewage or shallow groundwater", explained Danish Malik, MSF coordinator for the regional environmental health hub in Harare.

The new drilling technique is part of a comprehensive set of environmental health tools developed by MSF. Where possible, a specially fitted vehicle is used to rehabilitate existing boreholes instead of drilling new ones, which is often more cost efficient. For new boreholes like the one in Mbare, electromagnetic siting technology helps choose the best drill site. Since 2016, 50 water points were rehabilitated and 12 new boreholes drilled using the toolkit.



*Over 20 000 people depend on this hand pump for drinking water at Mbare flats. Now, MSF is drilling a borehole with a pump and water taps, and is training a local community health club to maintain the water point and engage in community surveillance. Photo: Samuel Sieber/MSF*

The true driving force of the toolkit are, however, the communities of Harare's suburbs. After drilling or repairing a borehole, MSF's outreach team trains a small group of local facilitators to establish and run a community health club. These health clubs then manage and maintain the water point site independently, ensure water quality, and pass on vital health and hygiene messages to their communities.

"For one US dollar a month, we provide over 250 families in our neighbourhood with clean water every day, buy the needed chlorine, maintain the pump, and invest into making our water point accessible and safe for everyone", said Nyarai Dzingai, a community health

club member in Kuwadzana, another suburb in the western outskirts of Harare.



*A community health club meeting in Kuwadzana. Here, MSF drilled and rehabilitated several boreholes in response to a typhoid outbreak around shallow boreholes and hand-dug wells in 2017. Photo: Samuel Sieber/MSF*

Here, MSF repaired and drilled several boreholes in 2017, in response to a typhoid fever outbreak with clusters of cases around old boreholes and hand-dug wells. The clubs also help pass on important health messages for minor ailments. “Sometimes we are nurses, too, and explain to mothers how to prepare salt or sugar solutions for a child or husband with diarrhoea”, added Nyarai.

The strong participatory approach is the main ingredient in the community health clubs’ recipe for lasting success. “We train and encourage clubs to be autonomous right from the start, so they can continue their work with or without MSF”, said MSF health promoter Kudakwashe Sigobodhla. Over 70 health clubs are currently active in Harare, and many managed to invest into additional fencing or decorating their water points.



*Cementation of the sanitary seal at the drill site in Mbare, Harare. Photo: Samuel Sieber*

MSF

This year, Nyarai and fellow health club members in Kuwadzana will receive additional training on community-led surveillance. “We are strengthening the health clubs’ capacity to notify cases of severe diarrheal diseases”, said Reinaldo Ortuño Gutierrez, MSF’s

medical coordinator in Zimbabwe. “At the same time, we are supporting a study testing the effectiveness of a new typhoid vaccine, an additional tool to fight outbreaks of the waterborne infectious disease.

The combination of technical, medical, and community empowering elements in a modular kit allows upscaling environmental health interventions beyond Zimbabwe too. Over the course of 2019, MSF’s regional environmental health team and local partner organisations have set up 19 water points with health clubs in Malawi, and an additional six in Mozambique. Other MSF projects in West Africa and South America are next on the pilot list.



*Water point in Matapi, Mbare. Improving waste management and wastewater recycling are next on MSF’s environmental health hub agenda. Photo: Samuel Sieber/MSF*

At the drill site in Mbare, night is falling as the team starts cementing the 20-meter long plastic pipe that seals the upper part of the borehole. Once this borehole is up and running, two new toolkit elements will shortly be available to tackle the waste piles and leaking sewage contaminating the shallow groundwater.

Together with local companies buying recyclable materials from communities at several collection points across Mbare, MSF is about to launch a new scheme for managing solid waste. In Stoneridge, an informal settlement in the outskirts of Harare, a pilot with local company Jojatis has just fitted ten households with a decentralised system to clean and recycle household wastewater using earthworms.



*We are evaluating these waste management innovations with local research partners like the University of Zimbabwe. Once proven successful, we will include them in our environmental health toolkit and keep scaling them regionally,*



**Danish Malik.**

# “NO BORDERS” TO HEALTH CARE ACCESS. A CALL TO SUPPORT SELF-FORMED NON

**By Walter MUGONI – Nurse Mentor**

Seven middle aged women and one elderly woman have shown that the hurdles of crossing the mighty flooded Save River during the rainy season can be overcome by the need to access the Non Communicable Diseases (NCDs) treatment for their survival.

The women have continued to adhere to their appointment dates at Chibuwe Clinic in Chipinge for consultation and supply of medication, braving the wide crocodile infested Save River. They are unable to get medicines in a clinic that is in their district hence their travel to Chibuwe Clinic. Crossing the river is a challenge especially during the rainy season when the river is deep and current is too strong to cross on foot. The expenses of hiring the canoe has made them hopeless as they sometimes fail to raise enough money to pay for the transport to ferry them to the river bank. Patients fork out an average of thirty dollars for a round trip, which is subject to increase due to hyperinflation environment. Nevertheless, the frequency of crossing the river using the makeshift canoe is always putting them at risk. There is however no other alternative but to cruise the risky tides during the rainy season.

When the water levels go down, they resort to crossing the river on foot but it

is not easy an task either. Some areas will still be deep that the water reaches their torso. The women however bravely cross the river holding each other for support until they reach the banks. They do that when crossing from Bikita district where they reside to Chipinge district where Chibuwe clinic is located.

Geographically they are in Bikita District but opt to go to Chibuwe clinic in Chipinge due to availability of medication and proximity. The geographical borders are indeed not a hindrance in their quest to get access to treatment.

Their ordeal is not only overcoming the dreaded Save River, it is also travelling 10 km on foot from home to get to the Save river bank. Others who come further away are forced to hire a car. The route they use on foot crosses the path of wild animals coming to drink water from Save Conservative Game Reserve. The villagers around the game reserve have vandalized the security fence thus risking the lives of people to wildlife attack. The eight women expose themselves to such risks with every trip they make to Chibuwe to collect medication. A close relative of one of the ladies was killed by an elephant years ago.

The MSF team in Chipinge visited Chibuwe clinic to capture the stories of the women and the challenges they



encounter in accessing treatment for Diabetes Mellitus and Hypertension services. The MSF team and women waded across the river and continued the journey on foot. The team saw elephant footprints and the canoe which they use. The river was deep in some areas and we had to roll our trousers so we could not drench them in water. We were psychologically not at ease walking on the path as we saw the elephant dung which was evidence that it was the route of the elephants going to the river to drink water. We were cautiously listening to any weary sound in the bushes adjacent to the pathway. The short experience that the MSF medical team was exposed to made them appreciate what it meant when these women would ask for the same review date and at least 3 months' supply of medication as it made it feel safer to travel as a group and to reduce frequency of coming to the clinic. This prompted the medical team to support the self-formed groups by creating Facility based NCD clubs. Facility based NCD clubs are groups of people who have Diabetes Mellitus and Hypertension who come to the clinic on the same review date to get supplies, followed up on tests and to get peer support.

Formalization of such groups has been due to the demand from the patients to get a tolerable way of accessing medication and medical services. This helps to foster adherence and ensures sustainability. The team has come up with inclusion criteria for such clubs. The clubs are suitable for Diabetes patients who have controlled sugar levels and those still to meet the target blood sugar levels. The group might include others who have hypertension. The inclusion of hypertension requires the group members to have blood pressure checks done routinely. Reducing frequency of coming to the clinic to get blood pressure checks can be necessitated by training some members of the group to help them in self-management in terms of monitoring glucose and BP at home. This whole idea of self-management and peer support management still needs to be developed. The "stable patient" i.e. the patient with controlled sugar levels only visits the clinics for consultation and blood tests after 6 months. The patient will come for drug pick up 3 months after the consultation and blood test visit.

Health facilities should sensitise the NCD patients particularly those with DM about various DSDs through NCD



*Walter Mugoni, one of MSF nurse mentors crossing the river with the women in Diabetes and Hypertension DSD as they shared their experience.*

expert patients and the patients make informed decisions on what DSD is best for them. Collaboration of health facility staff and NCD patients is vital in ensuring the initiative is adopted and is sustainable. MSF will continue to provide technical support to the health facilities staff and assist in development of Information Education Communication (IEC) material for patient education.

# MONITORING AND EVALUATION OF THE NCD/HIV PROJECT IN CHIPINGE (EVOLUTION OF DATA COLLECTION TOOLS)

By **Sudden Abubakr MASAKA**, Medical Data Processing Officer

The MSF NCD/HIV project started in Chipinge in 2016. The main objective was to demonstrate reduction of morbidity and mortality due to HIV/AIDS, drug-resistant tuberculosis (DRTB) and NCDs through a nurse-led programme in 11 MSF supported MOHCC health facilities. Alternative integrated refill models for collecting medication were set up later. The refill models set up for HIV were Facility Clubs, Community ART

Groups, Fast track and Family ART Refill Groups. This was per the 2016 logical framework.

Initially five health facilities namely Chipinge district hospital, Chibuwe, Rimbi St Peters and Mt Selinda were selected by MSF Mutare co-ordination and Chipinge MOHCC to launch the programme. After the Medical team's introductions to the authorities, permission was granted to visit health facilities. Baseline data was collected by the Monitoring and Evaluation team. Data collected comprised of total ART cohorts, number of TB patients, Malaria cases and number of NCD cases for diabetes, hypertension, asthma, and epilepsy. All the data was collected from already existing MOHCC tools.

Six more health facilities were later selected to make up a total of 11. The selection criteria for the health facilities involved the use of a structured tool ranking each identified health facility. Some of the parameters looked at included population size, ART cohort, distance from Chipinge district hospital, number of NCD cases and number of nurses.

Total Scores	Sites	Population served	Population served score	ART COHORT	ART COHORT score	Time from CDH	Time from CDH score	Recommended by	Recommended by score	No. of Nurses	No. of Nurses score	NCDs total	NCDs total score	Presence of other NGOs
12	Junction Gate	5802	2	254	2	40 mins	3	DNO, TB Co, O.I. in charge, DEHO	2	2	3	81	2	FACT
11	Kopera	5823	2	220	2	1h 30 mins	0	O.I. in charge, TB Co, DEHO	2	2	3	80	2	FACT, Jekesa pfungwa
11	Mabee	8507	4	216	2		0	DMO	1	3	4	0	0	
9	Chinyamukwakwa	9325	4	204	2		0		0	2	3	0	0	
12	Tanganda	5672	2	198	1	40 mins	3	DNO, TB Co, O.I. in charge, DEHO	2	3	4	138	2	FACT
11	Mutema	5955	2	212	2	50 mins	3	DNO, DMO	1	2	3	48	0	FACT, AFRICAID
19	Chikore	9858	4	563	5	1h	0	DNO, DMO	1	4	5	403	5	FACT, FHI 360, OPHID
11	Zamuchiya	8609	4	346	3	1h 30 mins	0	DNO, DMO	1	2	3	37	0	FACT, AFRICAID, DOMCAP
9	Madhuku	9054	4	245	2	1h 30 mins	0		0	2	3	21	0	FACT, FHI 360, OPHID, DOMCAP
10	Kondo	9235	4	355	3	60 mins	0		0	2	3	46	0	FACT, FHI 360, OPHID
14	Paidamoyo	7520	3	389	3	40 mins	3		0	3	4	58	1	
10	Mutandahwe	6396	3	275	2	120 mins	0	DMO, O.I. focal, Pharmacy technician	2	2	3	11	1	3
KEY														
	Proposed new sites													

Matrix of the tool used for NCD/HIV site selection in Manicaland

After scoring,  
the six sites  
selected were  
Junction Gate,  
Kopera, Mabee,  
Tanganda,  
Zamchiya and  
Mutandahwe.

During the project, HIV and TB data was collected mainly using MoHCC tools namely monthly return form and registers.

MSF also introduced some innovative data collection tools which were non-existent in the district. Some of the tools included the High Viral Load Form and Enhanced Adherence Counselling register used when following up patients failing on Anti-Retroviral Therapy. The High Viral Load form was used to monitor Viral Load progress for patients with High Viral Load and outcomes indicated, such as switch to second line or controlled viral load. The

High Viral Load form was later adopted by MoHCC and remains in use up to date to monitor patients. However, the Enhanced Adherence Counselling register did not fare well due certain challenges such as not being filled in well by the MOHCC nurses and counsellors hence it was ultimately dropped.

Furthermore, a Viral Load Cascade was conducted in the third quarter of 2017 at two health facilities, one hospital and one clinic namely Chipinge district hospital and Rimbi clinic respectively. The summary for the VL cascade results is as below:

Mutare - Health Facility	# of eligible clients for VL	# of clients with VL test done	VL coverage rate (%)	# of clients with detectable VL results	VL detectability rate (%)
Chipinge District Hospital	1288	552	43%	62	11%
Rimbi	557	197	35%	43	22%

*VL coverage rate and VL detectability rate of Mutare project*

On the NCD component, MoHCC did not have standardized NCD data collection tools.

The health facilities had improvised chronic diseases registers where they just indicated the number of NCD patients they had, but had no information on the follow up and treatment the patients were getting. MSF through its Epidemiologist drafted an NCD paper-based booklet Version 1 to capture NCD patient information on their conditions, follow up, monitoring and treatment. An HIV/ART booklet already existed in the MoHCC system. MSF adopted the structure and parameters from the HIV/ART booklet and substituted with the NCD parameters we wanted to collect and analyze. The NCD booklet underwent a number of modifications, taking into consideration the number of changes implemented as the pilot project progressed. Most notably, the algorithms for managing diabetes and hypertension went through different phases of evidence-based scientific revision hence the need to modify the NCD booklet several times. The NCD booklet evolved from version 1 in 2016 to the latest one – version 8 in March 2018. The process was dynamic and extremely interesting for the teams on the ground to evolve in order to produce the best tool for NCD patient care.

To complement the NCD booklet, MSF also developed an electronic database to capture the information recorded in the booklet. The NCD electronic database was developed using the Epi-Data software and it was encoded by the MSF data encoder. The electronic database variables

also went through different changes in line with the changes made to the NCD booklet. MSF Epidemiologists and Medical team were instrumental in the shaping of the NCD database and the indicators to be analyzed.

As the NCD booklet was being used in the health facilities, it was observed that it was not filled-in completely. Firstly, the booklet had many parameters for data to be collected. Most of these parameters were not filled-in especially by MoHCC nurses who cited work pressure as the main reason for not completing the files. During quarterly report writing, a lot of information was missing making it hard to do analysis. Secondly, the MoHCC nurses had a tendency of writing only in the patient books that the patients take home whilst neglecting to update the NCD booklet at the facility hence creating false lost to follow up.

After taking into consideration the challenges encountered in utilisation of the NCD booklet, an idea of developing a chronic care card was suggested at the beginning of 2018. A proposal was put forward by Chipinge MSF medical team to Mutare co-ordination. A number of unnecessary parameters from the NCD booklet were removed. There were further modifications to capture quantities of medication consumed by patients. The main advantage of the chronic care card is that it affords a rapid clinical assessment because all monitored parameters are tabulated on it.

The chronic care card was then printed and health facility nurses at MSF-supported sites were oriented on the new changes. The card was then rolled

out in October 2018 at the health facilities. The nurses welcomed the card since it reduced their workload when consulting patients and is currently still in use. The Epi-data database was also modified to the specifications of the new chronic care card.

**CHRONIC CONDITION MONITORING RECORD CARD**

Name: \_\_\_\_\_ Sex: fem/male Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 OI No: \_\_\_\_\_ NCD No: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic: \_\_\_\_\_ District: \_\_\_\_\_ Province: \_\_\_\_\_

Diagnosis 1: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 2: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 3: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 4: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date	Wt	BP	RBS	FBS	HBA1C	Cr Cl	V/L	Other	Other

**MEDICATION**

Date	Review date

MSF 20/12/18

**CHRONIC CONDITION MONITORING RECORD CARD**

Name: \_\_\_\_\_ Sex: fem/male Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 OI No: \_\_\_\_\_ NCD No: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic: \_\_\_\_\_ District: \_\_\_\_\_ Province: \_\_\_\_\_

Diagnosis 1: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 2: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 3: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Diagnosis 4: \_\_\_\_\_ Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date	Wt	BP	RBS	FBS	HBA1C	Cr Cl	V/L	Other	Other

**MEDICATION**

Date	Review date

MSF 20/12/18

*The new easy-to-use chronic care card developed by MSF in collaboration with Ministry of Health and Child Care to assist NCD data collection in Zimbabwe*

MSF's objective is to pilot its data tools, NCD chronic care card and Epi database with an end goal to facilitate better data collection and record keeping for patients. With the consolidated data collection tools and strategies engaged in the pilot project, our hope is for MoHCC to eventually adopt the MSF-led tools and utilize them at national level, similar to the HIV patient booklet. This will eventually lead to improved quality of care to our beneficiaries and NCD patients in Zimbabwe and regionally in Southern Africa.

# RESEARCH PAPER ON NURSE-LED NCD MANAGEMENT PUBLISHED IN THE SCIENTIFIC JOURNAL, BMC

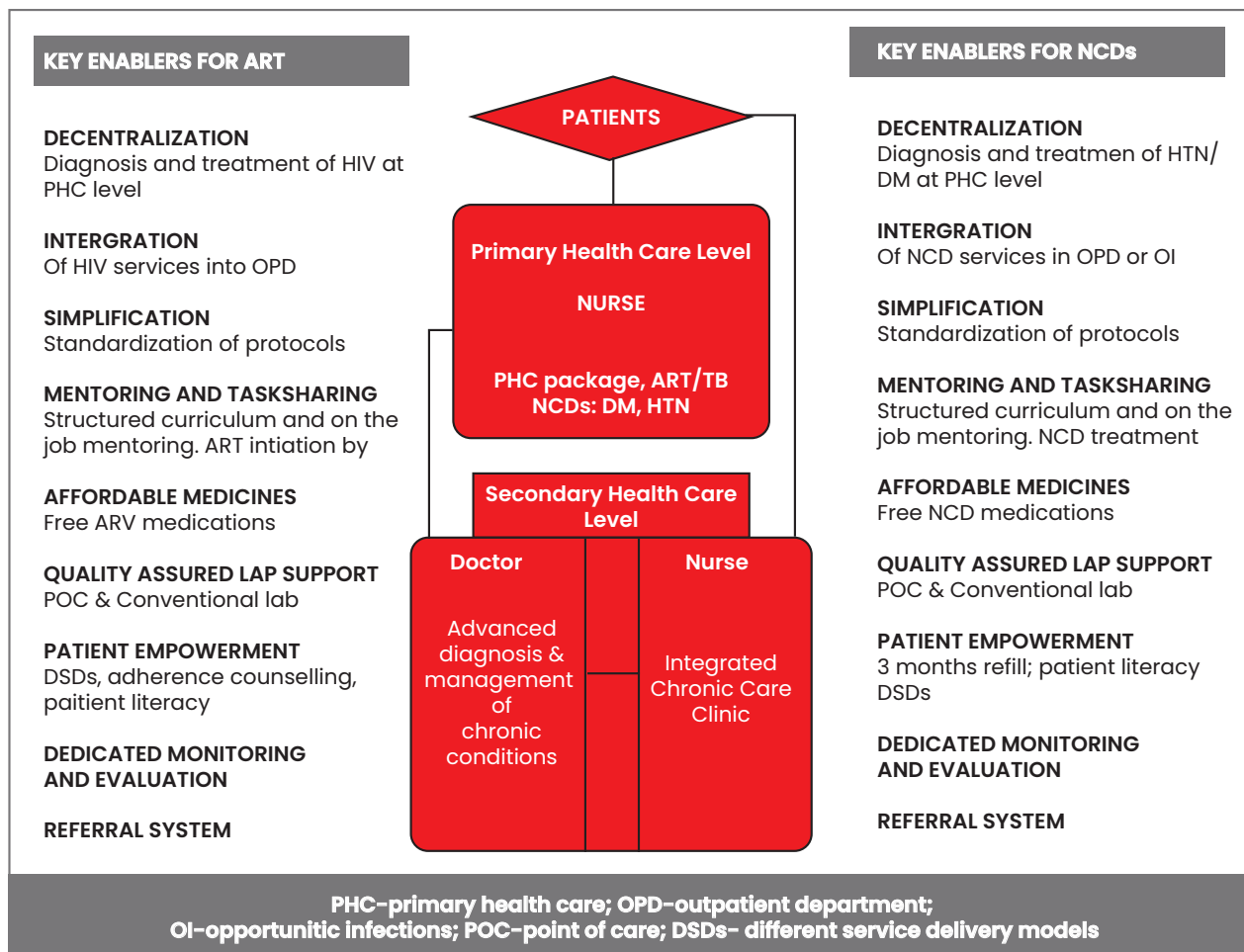


*MSF is supporting the diagnosis, treatment and care for diabetes and hypertension patients at health facilities in Manicaland Province.*

Since July 2016, we have been working hard to empower nurses at nine primary health care facilities and two hospitals in Chipinge District, Manicaland Province, to diagnose and treat diabetes and hypertension in patients accessing health facilities. This is innovative in the sense that currently, according to the Zimbabwean national policy, diagnosis of DM and HTN is under the responsibility of doctors at hospital level.

On the first of June 2020, we had a paper published in a scientific journal (BMC Health Services Research) describing our experience and the lessons learned on how to set up a nurse-led model of care for the management of hypertension and diabetes mellitus.

We describe how, inspired by the lessons learned from the ART program, we developed context-adapted guidelines, mentored nurses, provided free medicines and laboratory support for patients with diabetes or hypertension. We explain how we enabled patients to acquire knowledge and skills to understand and take responsibility for their own health.



*How a nurse-led model of care is typically structured*

We emphasize on the dedicated monitoring and evaluation system that we developed and on the evolution of the program as it was implemented and the lessons learned. We do hope that this may add value to other Non-Communicable Diseases programs in Sub Saharan Africa.

Interested to learn more? You can find the open access article for free under

the following link: <https://doi.org/10.1186/s12913-020-05351-x>

And you can even access our context-adapted guidelines for the management of diabetes and hypertension!

We promise you a colourful read of a standard public health approach!



# TESTIMONIALS -GIS BRAMU

**“How GIS support impacted the BRAMU survey of February 2020”**



GIS support has greatly improved the quality of my work during a survey conducted in the Beitbridge project. Whereas I was more used to working in urban settings, where we could easily define rule of thumbs to randomly select households in quantitative studies, the distribution of settlements in the rural areas of Beitbridge posed an important challenge. Residences in Shashe, Dite and Chikwarakwara villages were highly scattered and, often, difficult to access. We had no time to do a census of the areas in order to define a sample frame, but luckily, GIS support enabled us to maintain high methodological standards within a short timeframe.

Our MSF GIS referent generated random sample geo-points in the

three mentioned villages which corresponded to household buildings. The sample points were loaded onto the smartphone tablets that were used by the team of data collectors to ensure that they would easily locate prospective interviewees. Each day, an interviewer was assigned a set of points from which he was to carry out the interviews.

Using OSMAND – an app based on the Open Street Map Platform, the data collectors were able to precisely target and navigate to each sample point. In terms of survey methodology, this tool enabled us to target households that would otherwise not have been reached since the areas are sparsely settled. Also from a logistical perspective, the drivers and field supervisors knew where the members of the team were located at any given time as they were able to share their coordinates among each other when so required, which also assured everyone’s safety even in very remote locations. Personally, now that I am aware of this resource I am sure I will use OSMAND and implement GIS techniques in my future surveys.

**NUNI JORGENSEN – POPULATION DATA AND RESEARCH ADVISOR – BRAZILIAN MEDICAL UNIT**

[nuni.jorgensen@rio.msf.org](mailto:nuni.jorgensen@rio.msf.org)



GIS significantly complemented our effectiveness and efficiency as the BRAMU Survey team. It capacitated us to flexibly allocate, identify and substitute households to reach the desired quotas. We experienced network challenges in all the rural communities and this was worsened by inadequate radios. However, with the use of GIS we were able to identify safe points for all data collectors and navigate to where they are in case of emergency.

In addition, we managed to supervise data collection, attend to referrals, provide technical support and establish pick-up points even in the areas where the teams were not well-versed because they were able to navigate and orient themselves using the maps designed by our GIS Specialist. With network challenges I did not know where exactly the team members were sometimes, but because of the Maps and OSMAND app I knew where to search and look. Now I definitely understand and appreciate the meaning of the popular phrase: "The Answer Is GIS!! What's Your Question??"

**LOUREEN TSHUMA - BRAMU SURVEY DATA COLLECTION TEAM LEADER** loureent@gmail.com



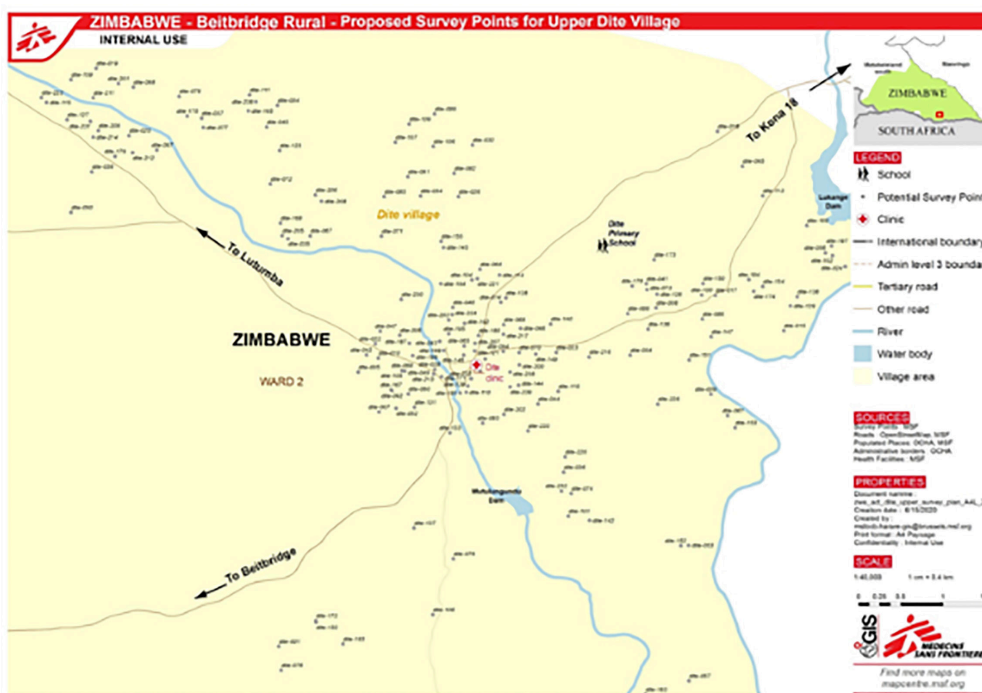
Previously, I have been involved in many surveys with different organisations and during these surveys I had employed the use of tools and techniques for aiding me during those surveys. However, after my recent encounter with GIS tools and methods employed during the BRAMU MSF survey that was carried out in February 2020, I realised the importance of GIS work in the field as it helps one to accurately pinpoint the exact location of the households and settlement.

Unlike previous encounters when one would just be allocated an area without any location awareness, and you'll be expected to traverse around the zone hoping to come across a household where you can conduct interviews. In many instances you'll walk for long distances without finding households and thus are not able to carry out any interviews. With the use of GIS, it also brought a sense of security towards the enumerators as we were able to navigate our way back to the defined safe points (on printed Maps) using our tablets and the OSMAND app. This reduced the risk of getting lost because of unfamiliarity with the area that we were carrying out the survey.

**NKOSIYABO SIBINDI - BRAMU SURVEY DATA COLLECTOR**  
nkosiesibindi@gmail.com



MSF GIS Specialist, Last Mufoya, inducting data collectors on how to read and interpret maps in the field during the pilot for the BRAMU SURVEY in Beitbridge (Feb 2020)



Map of Dite village which was used in the field by the data collectors whilst carrying out interviews

# SRH PROJECT: MENSTRUAL CUPS COULD END PERIOD POVERTY



The subject of menstrual hygiene is taboo to the majority of families in Zimbabwe. Many poor girls, especially those in their adolescent age find their monthly cycle a nightmare as they have to endure the discomfort of using unorthodox means such as rags, old pants, tissues, grass, leaves and many others, as sanitary wear. Most families find it hard to set aside a monthly budget of about \$2 for this requirement on a regular basis because of the economic challenges. The cost of sanitary pads in Zimbabwe

is about \$1 per packet and for each month, one requires 1 to 2 packets, translating to about \$2 monthly.

In light of these challenges MSF Mbare Adolescent Sexual and Reproductive Health (ASRH) project provides menstrual cups to adolescent girls to address the specific needs of availability of safe options that offer privacy and decency and information on MHM. The project has managed to distribute more than 1 400 cups to adolescent girls. The major challenge

around the use of the cups is the acceptance of the cup by parents and guardians with the need for increased awareness raising on the menstrual cup as an alternative MHM option. The menstrual cup is a type of reusable feminine hygiene product. It's a small, flexible funnel-shaped cup made of medical grade silicone that is inserted into the vagina to catch and collect period fluid. Cups can hold more blood than other methods, menstrual cups are eco-friendly and a cost effective alternative as one cup can last up to 10 years and depending on the flow, one can wear a cup for up to 12 hours.

The project innovative intervention has been the inclusion of men and boys as essential partners to challenge the cultural norms around menstruation that breed stigma, and it challenges gender inequality and compromise women's ability to manage menstruation hygienically and with dignity. This has been achieved through the training of male teachers and peer educators who are trained to provide MHM services in schools and the community. As a result of the initiative, men and boys have begun to talk about menstruation more freely and are better able to support the MHM needs of women and girls within the household, community, and school.

**Thelma is a 19-year old adolescent and has been using the M-cup for 2 years and she testifies that:**

It has been more than two years since I started using the menstrual cup. It is a very clean method and ever since I



started using the menstrual cup I have never spoiled my clothes whilst using the cup. Whilst menstruating and using the cup I am able to do my normal daily activities and sporting activities such as swimming and even going to work. You don't feel the cup whilst using it. The use of the cup is very cost effective having over the past two years I have managed to save USD72. Menstrual cups are environmentally friendly because I don't have to dispose my pads away.

*Menstrual cups provide girls with a safe, confidential and clean option as menstrual cups do not produce bad odour. Having also travelled long distances using the menstrual cup, I did not experience issues of discomfort.*





**Vanessa is a 20-year old renowned dancehall artist using the M-cup.**

It's been a year of using the menstrual cup as a menstrual method, the method is cost effective with the current economic situation the m cup is a cost effective method. The cup is easy to sterilize as I use hot water in an empty bottle pre menstruation and post menstrual.

My confidence has improved when I participate in daily activities because I can manage my periods. I am also happy that I can also share information to help my sisters and friends at home. I thank MSF for being there for me, I have all the information I need.

*I wish every girl could be empowered with the same knowledge and information that I have. I would want to urge all other adolescent girls to try it, menstrual cup is very comfortable and you cannot feel it, I have never seen blood on my clothes since the day I*



*started using the cup.*

# WHY ARE WE GOING SOLAR? WHY YOU SHOULD TOO!

## **Munyaradzi KADZIMU, Deputy Coordinator, Logistics**

My interest in solar or renewable energy within MSF initially came to me when we were still running the 'EH Project', then known as WASH as Prevention, under the Logistics Department. The interest was driven by the general buzzword, 'going green' and the almost cliché, 'renewable energy'!

Towards the end of 2019, as Logistics Department, we were assessing our power back-up needs as an organisation and looking at the needs for some suggested health facilities. An opportunity arose from our HQ for additional resources towards the mission and I suppose some few extra dollars realised from some old vehicle disposals, this was a shot in the arm for us towards a solution for some of the power problems. Solar power would alleviate the massive load shedding / power cuts, which were sometimes averaging as much as 18 hours per day. Besides that, it is a clean and renewable form of energy, it would also help with reducing electricity bills.

The basic economic problem of scarcity is something that we as people, as Logistics and indeed the

MSF movement have to deal with. Balancing the limited resources vs the unlimited wants. We can only try to be efficient in our decision making which is why in all the installations that we do, we have to target areas where it makes the most sense efficiency wise and impact wise. It is easier said than done yes but through effective consultations with management, our medical counterparts, the team on the ground, recipient organisations and even our beneficiaries where possible, we are able to define the needs to be addressed.

At St Peters Hospital, Checheche Growth Point, the installation that we did was targeting the laboratory specifically. I am happy to go to the hospital six months after the installation and learn that the system installed is still intact and well maintained. The feedback that they are running at 100% capacity against figures as low as 30% during the peak of load shedding and also the fact that they at the moment are even processing TB Sputum from Chiredzi district is good news. Talking with some hospital or clinic staff members and them expressing how the 'seemingly simple' installation that MSF did improved their working conditions

always make sure you leave the site happier and somewhat content, with a feeling of usefulness and great sense of achievement. Yes, it happens that during a follow up visit sometimes, you just notice how another small extra investment would have been perfect, but this doesn't take away the joy at all.

Yes, solar is costly in setting up, especially compared with just being connected to the grid or buying a generator sometimes, but it has very low maintenance cost, mainly just cleaning the panels. Solar system can present a challenge of space, e.g. where do you place 28 panels if the roof is not suitable? Another challenge of solar is that it is, to an extent, weather dependant but this can be addressed in the design stage.

Compared with few years back, I am happy that solar power is embraced today because, the more it is used means components are manufactured at economies of scale hence prices coming down over the years. More players in the industry also means more competition hence companies keep researching and innovating, as evidenced even by warranty periods being offered nowadays by manufacturers. Average good panels now come with 20 – 25 years' warranty and inverters are moving from 3 – 4 years to even 5 – 10 years' warranty.

When all is said and done, I am happy that we are 'going green'. (someday we'll be green)

#### **Installation sites and their sizes summarised below:**

<b>Name of Site</b>	<b>Location/ Project</b>	<b>Summary of Installation (just major components)</b>
Adolescent Corner (new building)	Matapi Clinic, Mbare	2 X 330W panels, 2 x 225Ah batteries 1.5Kva – 24V inverter
Reception Centre (Office & Pharmacy)	Beitbridge	16 X 330W Panels, 8 x 225Ah Batteries 10Kva – 24V inverter
Zamuchiya Clinic	Chipinge	6 X 375W panels, 2 X 200Ah batteries, 2Kva inverter,



# WORKING TO ENSURE HEALTH FOR MIGRANTS AT BEITBRIDGE BORDER POST

**Beitbridge border post is the busiest port in southern Africa due to the huge number of people fleeing harsh economic conditions in their countries of origin and opting to “try their luck in South Africa” or intending to pursue some form of economic activity. Sometimes this works out, sometimes it does not, and together with other socio-political conditions they face, returning migrants share their experiences with us.**

**Date of interview** 10/05/20

**Facility:** Rainbow quarantine centre

**Gender – Female**

**Age – 47 years**

**Migrant status – self returning from South Africa**

**Citizenship status – Zimbabwean**

**Duration of stay in South Africa – 10 years**

**Migratory reasons – had gone to search for employment**

The woman has been working in Cape Town South Africa in Care homes for a period of 10 years. She, however, lost her job in December 2019 at the onset of

the COVID-19 pandemic in the country. The woman found it hard to accept the loss and suffered anxiety disorders. She went for medical consultation in South Africa and was put on medication for the condition.

The woman volunteered to go back home since she no longer had any source of income. She came in the company of her 22-year old son who was actually acting as her treatment buddy. The two came as part of a group of other Zimbabweans who had volunteered to go back home. The family members of the woman had agreed that the problem she was suffering from was a traditional one and wanted her to go to Zvishavane for traditional healing. However, due to mandatory quarantining she opted to go and be quarantined in Harare where there are closer relatives than in Masvingo.

The woman was visibly anxious and the son was concerned about how she was going to stay in the quarantine centre with her condition. The question which remained unanswered was whether there are any special arrangements for people with other medical conditions in the quarantine centres.

# FINANCE TEAM SUCCESSFULLY COMPLETES UNIFIELD TRAINING ONLINE

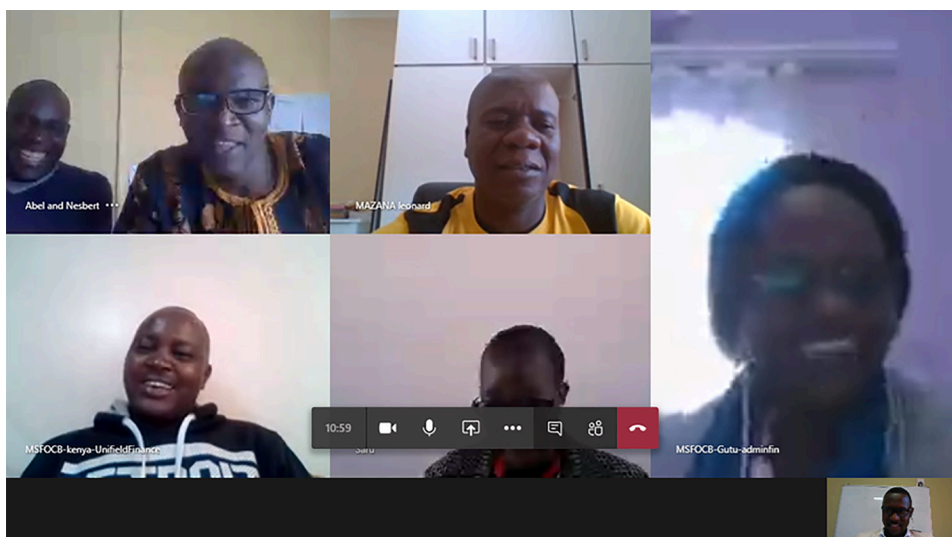
**By Kudzai RUZVIDZO - Accountancy Manager**

In this COVID-19 era, which has become the new normal a lot of 2020 plans have been affected, however the Zimbabwe finance team is glad to have successfully gone through an online Unifield finance training. With the travel restrictions and lockdowns put in place in almost every country in the world, trainings have been greatly affected as international facilitators or/ and the trainee's travel have become very difficult. The gathering restrictions have also negatively affected the plans in terms of planned meetings and trainings.

With the support of our Field Accounting Controller - Makhabbat Isabekova, the Regional Unifield Finance Officer - Fredrick Akongo and the Zimbabwe Mission Finco Larisa Nazmeeva we are happy to announce that we have gone through a successful online training. The training which was done over a

number of days from the 1st of June 2020 was facilitated through various online platforms which included Microsoft teams. Representatives from Project finance teams from all the five projects in MSF Zimbabwe mission came together in this Unifield training which covered a number of issues which mainly includes the new functions which were yet to be implemented in the mission.

This training was an eye opener, whose contributions will go a long way in improving the quality of our accounting procedures and reports, as we will be running a follow up programme to deal with the implementation of various functions in our Unifield accounting system. The experience also highlighted the importance of adopting the emerging technology for the benefit of the organisation as it proved to be cost effective and convenient in allowing the day to day operations of the projects to run concurrently with the training



# MEET OUR STAFF



## Oripa Chimtashu Malasha

When did you join MSF?

**2017**

What is your job title?

**Emergency Nurse**

What does your work involve?

I do emergency care nursing in disease outbreaks such as cholera and typhoid. I also do staff health, that is nursing care to staff who need it at work.

Why do you think this is important/ this matters in MSF?

These are the core activities of our organisation. We provide emergency care in times of distress.

In your job, what do you consider as being successful

Being successful is managing to curb an outbreak before it spreads or kills more people. Working together with MoHCC, we have succeeded in doing that in the past years.

Where would you/would you like to see improve

So far MSF keeps improving standards on a day to day basis. I am sure if we keep up with technology in our field of work, we will become more efficient.

Any challenges you face as you execute your work?

The only challenge we face in the field when assisting in outbreaks is cooperation with other health workers as they are constantly disgruntled with their salaries and working conditions. This leaves us exhausted. For emergency nursing care to be effective, it needs motivated staff.

What is the one thing that makes you get up to come to work for MSF? Do you have a picture of it? Please share if you do

I get pleasure in being able to provide for my family. Working in an environment where my services are rewarded is a motivator.

Where do you see yourself in MSF in the future?

I wish to continue in Emergency Care and study further on project management and identification of people in distress.

# STAFF NEWS

## We bid farewell to the following during the first half of the year..

- Gloria Ganyani, Field Communications Officer who left MSF for different career challenges in January 2020
- Farai Marume, the Deputy Project Coordinator, responsible for Emergency Response and TCV Study project left at the end of May 2020 joining UNICEF
- Elizabeth Kawaza, HR Development Manager who joined the Johannesburg office as HR Manager in January 2020
- Amen Mutamba, Deputy Supply Coordinator who left end of June 2020
- Mortein Molgaard, Beitbridge Project Logistics Supply Manager due to end of his mission
- Salifon Sadoou, Regional WASH Manager due end of his mission
- Aurore Goddard, WASH Manager due to early end of her mission
- Edwin Chanakira, Medical Doctor for ASRH Project, who resigned to pursue his studies

## And Welcomed...

- Caroline Gwature, Field Communications and Advocacy Manager who joined in March 2020
- Tellme Madidi, who joined as HR Development Manager who joined in January 2020
- Prosper Gatsi, an Epidemiologist who joined in February 2020
- Vuso Feratti, a Driver for Coordination who joined in January 2020
- Stephen Steven, a Driver for the ARSH and WASH Project, effective February 2020
- Ezekiel Kachidza, a Driver for the TCV Study, effective March 2020

## Staff development

- A number of staff training and development programs were implemented over the past six months, especially during the first three months before the effects of COVID 19. When face to face training programs were difficult to facilitate, staff learnt through online platforms

- A Sanou training workshop for twenty two staff members was facilitated by Monica Genya and Robert Chikowero from the Johannesburg team
- An innovative online learning platform, Tembo, was launched on the 4th of May 2020 which is greatly helping staff to do self-managed online learning
- Three undergraduate interns from the University of Zimbabwe were hired in January and February for an annual attachment program

## FAREWELL, BJORN



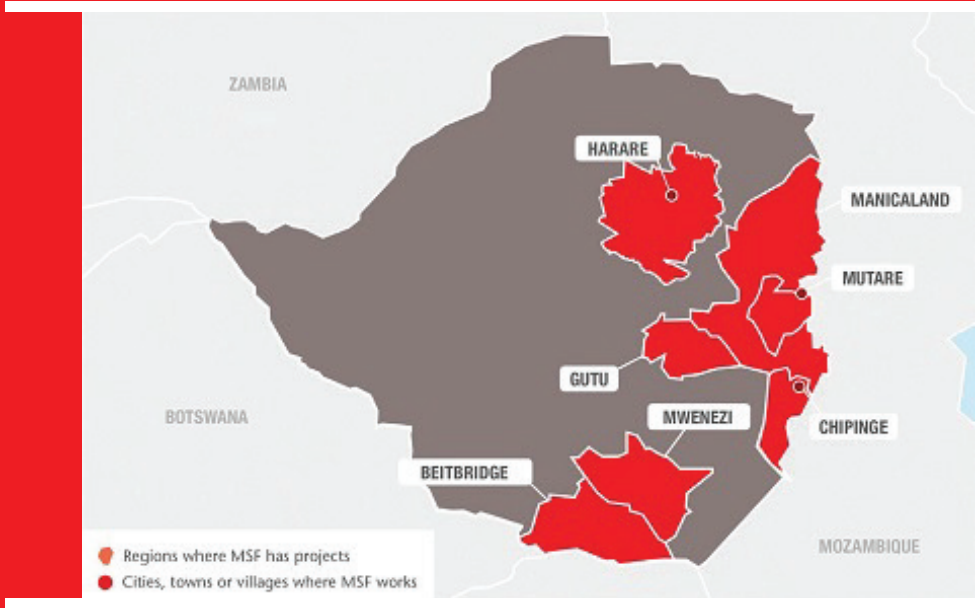
*MSF Zimbabwe staff members say farewell to Head of Mission, Bjorn Nissen (far right) after four years at the Zimbabwe mission*

We say farewell to Head of Mission/ Country Director, Bjorn Nissen, who has been with the Zimbabwe Mission since 2016. He will be remembered for positioning MSF Zimbabwe on the global arena, both within and outside of MSF. We wish him well on his new path in life.



*In many ways, I wish I could have been part of this continued journey, but life is often what is happening while you plan something else.*

*- Bjorn.*



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