REPORT OF THE CITY HEALTH DEPARTMENT

2012

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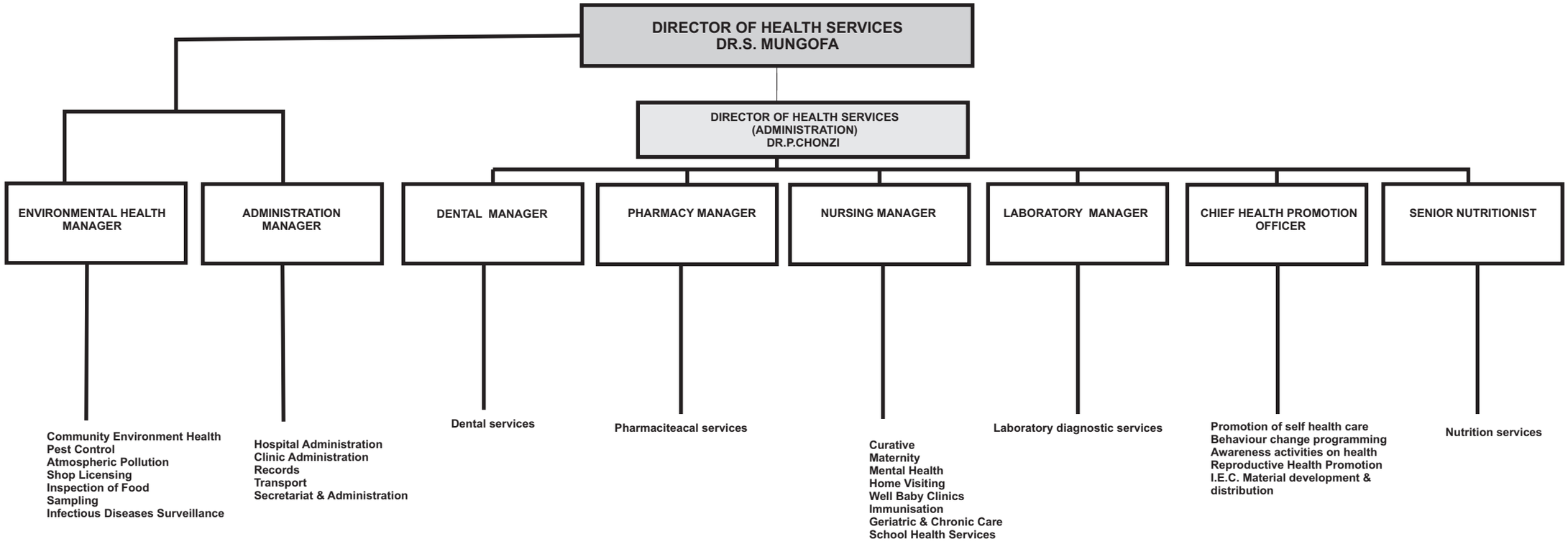
ORGANISATION CHART AS AT 31ST DECEMBER 2012
HARARE CITY HEALTH DEPARTMENT, ZIMBABWE



CHAPTER I

VITAL STATISTICS

GENERAL INFORMATION

Height above sea level - 1 500 m

Area of Greater Harare - 890 km^2

RAINFALL	2011	2012
Actual: (January - December)	1003.1ml	659.4 ml
Seasonal: (July 2009 - June 2010)	735ml	984.9 ml

TEMPERATURE	2011	2012
Maximum Temperature	36.3^{o}C (26th Oct)	33.5^{o}C (19th Oct)
Minimum Temperature	2^{O}C (26th June)	2.6^{o}C (20th July)

POPULATION

Total Population	-	**1 601 324**
Male (50.2)	-	**803 865**
Female (49.8)	-	**797 459**
Assumed population growth rate	-	**2%**

DEPENDENCY RATIO

Dependency Ratio = 52

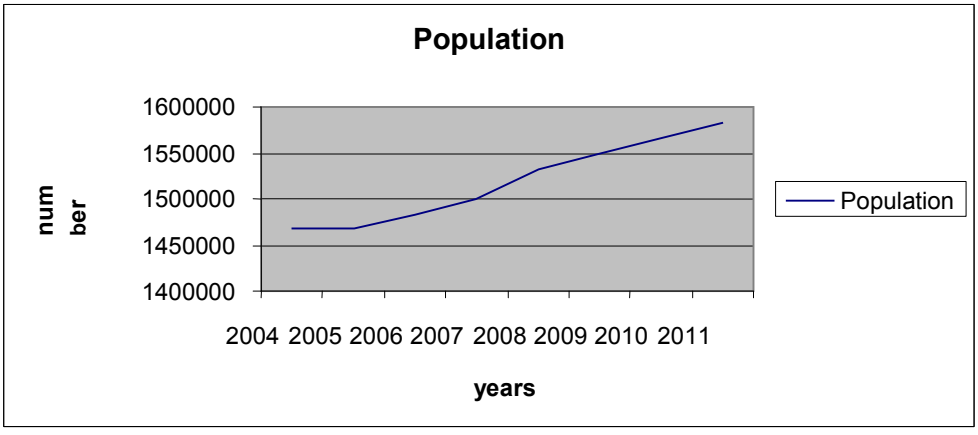


Table 1: LIVE AND STILL BIRTHS FOR 2011 AND 2012

Place	Live Births		Born Before Arrival (BBA)		Total Live Births		Still Births		Total Births		Still Birth Rate per 1000 Total Births	
	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011
Harare Municipal Clinics	27 372	29 057	1 754	1715	29 126	30 772	144	145	29 270	30 917	4.9	4.7
Harare Central Hospital	16 244	12 944	146	160	16 390	13 104	649	659	17 039	13 763	38.1	50.3
Mbuya Nehanda Hospital	8 653	8 689	191	246	8 844	8 935	472	499	9 316	9 434	50.7	55.8
Avenues Clinic	2 026	1 713	8	7	2 034	1 720	23	11	2 057	1 731	11.2	6.4
Belvedere Maternity	2 419	1 656	17	13	2 436	1 672	48	21	2 484	1 690	19.3	11.4
Queen of Peace	500	501	1	2	501	503	2	6	503	509	4	11.9
Glen View Maternity Private	327	282	0	0	327	282	0	0	327	282	0	0
Mbuya Maria	0	236	0	0	0	236	0	3	0	269	0	3.7
Baines Avenue Clinic	2 722	2 224	18	7	2 740	2 231	28	14	2 768	2 245	10.21	6
Harare East Memorial	299	217	3	3	302	220	6	2	308	222	19.5	9
West End Hospital	304	814	6	5	310	819	2	7	312	826	6.4	8.5
Starlight	213	131	0	9	213	140	0	0	213	140	0	0
Pacific (Mabvuku)	87	0	1	0	88	0	1	0	89	0	11.2	0
Mabvuku family health	209	179	0	9	209	188	0	0	209	188	0	0
#other	161	40	0	5	161	45	5	0	166	45	30.1	0
Total	61 536	58 686	2 145	2 181	63 681	60 867	1 380	1 367	65 061	62 234	21.2	22

NB #Others: - Oasis and Cranborne Medical Centre **Source: Records from above institutions**

- **Total population - 1 601 324**
- **Total births - 65 061**
- **Live births based on maternity units - 63 681**
- **Crude birth rate - 40 per 1 000 population**
- **Still birth rate - 21 per 1 000 live births**
- **Mortality under one week and still births - 2 396 (age<1 week=1016)**
- **Perinatal Mortality Rate - 36.8 per 1 000 total births**
- **Registered infant mortality (under one year) - 1 982**
- **Infant mortality rate - 31.1 per 1 000 live births**
- **Total deaths - 10 242**
- **Crude death rate - 6.4 per 1 000 population**
- **Rate of natural increase (birth -death) - 3.3 per total population**

CHAPTER II

MORTALITY PATTERNS IN HARARE

INTRODUCTION

This report represents Harare urban mortality statistics for 2012 and presents detailed data on deaths according to a number of medical characteristics. These data provide information on mortality patterns among residents of Harare by such variables as age, sex, race, and suburb of residence, place of death and cause of death. Information on these mortality patterns is important for understanding changes in the health and wellbeing of the Harare residents.

Mortality data in this report can be used to monitor and evaluate the health status of the residence of Harare in terms of current mortality levels and long term mortality trends, as well as to identify segments of the Harare urban population at greatest risk of death from specific diseases and injuries. Differences in death rates among demographic groups may reflect group differences in factors such as socioeconomic status, access to medical care and the prevalence of risks specific to a particular group.

Data in this report are based on information from all death certificates filed at the Registration of Births and Deaths, Harare District Office. It is believed that all deaths occurring in Harare and for Harare residents are registered. Cause–of-death statistics presented in this report are classified in accordance with the International Classification of Diseases (ICD). Mortality data on specific demographic and medical characteristics cover all suburbs of Harare. Measures of mortality in this report include the number of deaths; crude, age-specific, infant, neonatal, post-neonatal and maternal. Changes in death rates across demographic groups in 2012 are not tested for statistical significance.

In 2012 a total of 10 242 deaths were registered at the Harare District of Births and Deaths Registration as compared to 8 583 in 2011 and the population of Harare urban was 1 601 324 in 2012. The crude death rate was 6.4 per 1 000 population. The five leading causes of death in 2012 accounted for 4 117 of all deaths in Harare. In rank order the leading causes of death were: Pneumonia (33.9%), HIV Related (32.2%), Tuberculosis (14.5%), Cardiac failure (10.3%) and Renal Failure (9.2%). The data presented in this report is compiled from death certificates collected from the Registration of Births and Deaths from Harare District and represents only residents of Harare.

In 2012 the number of deaths from suicides was 96 (0.9%) compared to 58 in 2011. Of the total suicides the highest deaths occurred in the 25-44 years age-group and the most common methods of suicide were ingestion of organophosphates, hanging and gunshot.

The suburbs which recorded the highest deaths in rank order of total deaths were: - Southern Suburbs: 2 004 (19.6%), Northern Suburbs: 914 (8.9%), Mbare: 793 (7.7%), Highfield: 779 (7.6%) and Glen View: 720 (7.06%)

There was an increase in deaths attributed to RTA to 297 in 2012 compared to 259 in 2011 of the total deaths. This is also a cause for concern considering these could easily be avoided if proper intervention strategies are put in place. Table 2.1 gives a detailed analysis of death by age-group, race and sex. Table 2.2 shows the deaths registered in Harare by different age-group categories. Tables 2.3 to 2.12 shows deaths by specific individual age groups

Table 2.1: Deaths Registered in Harare by Age-Group, Race and Sex

AGEGROUP	RACE													GRAND TOTAL	
	AFRICAN				EUROPEAN			ASIAN			COLOURED				
	M	F	Unknown	Total	M	F	Total	M	F	Total	M	F	Total	2012	2011
Under 1yr	1 027	953	1	1 981	0	1	1	0	0	0	1	0	1	1 982	1 412
1-4	233	230	0	463	0	1	1	0	0	0	1	0	1	465	402
5-15	124	113	0	237	0	0	0	0	0	0	0	0	0	237	252
16-24	218	278	0	496	2	0	2	0	0	0	0	0	0	498	430
25-44	1 502	1 360	0	2862	0	0	0	0	0	0	3	1	4	2 866	2 543
45-64	961	925	0	1 886	15	8	23	0	2	2	4	3	7	1 918	1 693
65-84	823	827	0	1 650	51	35	86	1	1	2	2	7	9	1 747	1 478
85++	201	216	0	417	14	33	47	1	1	2	4	1	5	471	325
Unknown	33	21	4	58	0	0	0	0	0	0	0	0	0	58	48
Total	5 122	4 923	5	10 050	82	78	158	2	4	6	15	12	27	10 242	8 583

Table 2.2: Mortality Pattern by Age-group 2012 and 2011

Age Group	2012		2011	
	Number	% of Total	Number	% of Total
Under 1 week	1 016	9.9	475	5.5
1weekto 1 month	177	1.7	317	3.7
1 - 11 months	789	7.7	620	7.2
1 - 4 years	465	4.5	402	4.7
5 - 14 years	237	2.3	252	2.9
15 - 24 years	498	4.9	430	5.0
25 - 44 years	2 866	28.0	2 543	29.6
45 - 64 years	1 918	18.7	1 693	19.7
65+ years	2 218	21.7	1 803	21
Unknown	58	0.6	48	0.6
Total	10 242	100	8 583	100

The highest proportion of deaths (28.0%) occurred in the 25-44 years age-group as has been the trend in the preceding years.

Tables 2.3 to 2.12 give a detailed analysis of deaths which occurred in each age-group compared with the 2011 death occurrences.

Table 2.3: Mortality Pattern Under 1 Week 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Asphyxia/Aspiration	131	12.9	50	10,5
Congenital Anomaly	104	10.2	4	0.8
Gastroenteritis	7	0.7	7	1.5
Septicaemia	93	9.2	49	10.3
Respiratory distress	196	19.3	46	9.7
Pneumonia	131	12.9	57	12.0
*Other causes	84	8.2	73	15.4
Prematurity	270	26.6	189	39.8
Total	1 016	100	475	100

Prematurity remains the leading cause of deaths in this age-group.

Table 2.4: Mortality Pattern 1 Week to 1 Month 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Pneumonia	45	25.4	124	39.1
Septicaemia	29	16.4	47	14.5
Pre-maturity	26	14.7	43	13.6
Gastroenteritis	10	5.6	8	2.5
Meningitis	4	2.3	5	1.6
Congenital Anomaly	17	4.0	5	1.6
Asphyxia/Aspiration	9	5.1	6	1.9
HIV	5	2.8	9	2.8
Malnutrition	1	0.5	2	0.6
Other Causes	31	17.4	68	21.5
Total	177	100	317	100

Pneumonia was the leading cause of death in this age-group, accounting for 25.4% followed by Septicaemia which accounted for 16.4% of all the deaths. A significant decrease of Prematurity deaths was recorded in this age-group.

Table 2.5: Mortality Pattern: 1 - 11 Months Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Pneumonia	369	46.8	325	52.4
HIV Related	36	4.6	41	6.6
Meningitis	12	1.5	17	2.7
Gastroenteritis	55	7.0	45	7.2
Septicaemia	36	4.6	10	1.6
Tuberculosis	5	0.6	6	1.0
Malnutrition	15	1.9	11	1.8
Congenital Anomaly	27	3.4	5	0.8
Prematurity	30	3.8	5	0.8
Asphyxia/Aspiration	23	2.8	11	1.8
#Other Causes	181	23.0	144	23.2
Total	789	100	620	100

 # Other causes were 21 deaths Dehydration
Gastroenteritis and HIV related remained the leading causes of death in this age-group.

Table 2.6: Mortality Pattern: 1 - 4 Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Pneumonia	111	23.9	105	26.1
Gastroenteritis	49	10.5	34	8.5
Malnutrition	30	6.5	28	7
HIV related	33	7.1	37	9.2
Tuberculosis	6	1.3	7	1.7
Meningitis	10	2.2	12	3
Misadventure	29	6.2	15	3.7
Road Traffic Accident	17	3.6	11	2.7
Dehydration	43	9.2	5	1.2
Asphyxia/Aspiration	34	7.3	2	0.5
Other Causes	103	22.2	146	36.3
Total	465	100	402	100

Pneumonia, gastroenteritis and dehydration remain the leading causes of death in this age-group.

Table 2.7: Mortality Pattern: 5 - 14 Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Pneumonia	35	14.8	35	13.9
HIV Related	32	13.5	54	21.4
Tuberculosis	10	4.2	18	7.1
Gastroenteritis	12	5.1	9	3.6
Meningitis	6	2.5	11	4.4
Road Traffic Accident	17	7.2	13	5.2
Other Cardiovascular	11	4.6	11	4.4
Typhoid	0	0	1	0.4
Malignancies	17	7.2	10	4.0
Malaria	5	2.1	5	2.0
Misadventure	8	3.4	8	3.2
Rheumatic heart disease	3	1.3	4	1.6
Other Causes	81	34.1	73	29.0
Total	237	100	252	100

Pneumonia (14.8%), HIV related conditions (13.5%) RTA (7.2%), Gastroenteritis (5.1%), Tuberculosis (4.2%) and other cardiovascular (4.6%) remain the leading causes of death in this age-group.

Table 2.8: Mortality Pattern: 15 - 24 Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Tuberculosis	36	7.2	27	6.3
Pneumonia	35	7.0	32	7.4
HIV Related	99	19.9	99	23.0
Meningitis	25	5.0	28	6.5
Gastroenteritis	11	2.2	7	1.6
Malignancies	24	4.8	17	4.0
Diabetes	1	0.2	4	0.9
RHD	2	0.4	2	0.5
Misadventure	17	3.4	13	3.0
Road Traffic Accident	42	8.4	53	12.3
Cardiovascular**	47	9.4	10	2.3
Malaria	2	0.4	5	1.2
Trauma	0	0	7	1.6
Suicide	29	5.8	17	4.0
Pregnancy Related	20	4.0	26	6.0
Other Causes#	108	21.7	83	19.3
Total	498	100	430	100

****2 Congestive Cardiac Failure**
HIV related conditions, RTA, Pneumonia, and Tuberculosis remain the leading causes of death in this age-group

Table 2.9: Mortality Pattern: 25 - 44 Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Tuberculosis	330	11.5	222	8.7
Pneumonia	254	8.9	194	7.6
HIV Related/	691	24.1	959	37.7
Meningitis	184	6.4	133	5.2
Gastroenteritis	86	3.0	42	1.7
Malignancies	163	5.7	126	5.0
Road Traffic Accident	158	5.5	121	4.8
Cardio-vascular diseases	150	5.2	80	3.1
Malaria	16	0.6	17	0.7
Renal Failure	108	3.8	48	1.9
Trauma	2	0.1	1	0.04
Suicide	54	1.9	34	1.3
Pregnancy related	68	2.4	42	1.7
Hypertension	26	0.9	25	1.0
Other Causes#	576	20.1	499	19.6
Total	2 866	100	2 543	100

HIV related conditions was the leading cause of death in this age-group (37.7%)

Table 2.10: Mortality Pattern: 45 - 64 Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Tuberculosis	131	6.8	105	6.2
Pneumonia	153	8.0	138	8.2
HIV Related	365	19.0	407	24.0
Meningitis	60	3.1	33	2.0
Gastroenteritis	24	1.3	26	1.9
Malignancies	293	15.3	92	5.4
Road Traffic Accident	33	1.7	31	1.8
Cardiovascular*	164	8.5	168	9.9
Malaria	2	0.1	11	0.7
Renal failure	88	4.5	66	3.9
Hypertension	75	3.9	102	6.0
Cerebrovascular Accident	105	5.4	102	6.0
Diabetes	44	2.3	50	3.0
Other Causes#	381	19.9	362	21.4
Total	1 918	100	1 693	100

* 157 Congestive Cardiac Failure, 39 Myocardial Infarction
\# Other causes: 6 Epilepsy, 2 Typhoid

Table 2.11: Mortality Pattern: 65+ Year Age-group 2012 and 2011

Cause of Death	2012		2011	
	Number	% of Total	Number	% of Total
Pneumonia	252	11.3	214	11.9
Malignancies	338	15.2	247	13.7
Other Cardiovascular *	346	15.6	227	12.6
Hypertension	142	6.4	150	8.3
Cerebrovascular accident	243	11.0	201	11.1
Tuberculosis	50	2.2	58	3.2
Gastroenteritis	45	2.0	36	2.0
Diabetes	86	3.9	65	3.6
Renal failure	147	6.6	116	6.4
Myocardial infarction	39	1.8	32	1.8
Meningitis	22	1.0	7	0.4
HIV related	51	2.3	79	4.4
Road traffic accident	18	0.4	14	0.8
Senility	12	0.5	9	0.5
Other Causes	427	19.2	348	19.2
Total	2 218	100	1 803	100

***226 deaths Congestive Cardiac Failure**

Malignancies

A total of 835 deaths due to malignancies occurred in all age-groups representing 8.1% of all recorded deaths.

Table 2.12: Number and Percentages of Malignancies for all Ages, 2012 and 2011

Malignancy	2012		2011	
	Number	% of Total	Number	% of Total
Kaposi Sarcoma	36	4.3	20	3.3
Cervix	97	11.5	75	12.4
Liver	65	7.8	40	6.6
Prostate	89	10.7	58	9.6
Breast	49	5.9	56	9.3
Oesophagus	70	8.4	30	5.0
Bronchus/lung	55	6.6	42	7.0
Stomach	54	6.5	33	5.5
Lymphoma	36	4.3	29	4.8
Bladder	19	2.3	10	1.7
Other Cancers	265	31.7	210	34.8
Total	835	100	603	100

There was a marginal increase in deaths as a result of malignancies. Cancer of cervix (11.5%) was the most common malignancy.

Place of Death

The proportion of deaths that occurred in the home, dropped significantly than the previous years. Sixty- seven (67%) of deaths occurred at the Central hospitals and other hospitals with 27.4% occurring at home. The two central hospitals, Parirenyatwa and Harare Hospital registered 5 977 deaths, private hospitals 586, municipal hospitals 133 and other hospitals 670 whereas deaths that occurred in the home were 2 803. The majority of the patients who die at home were diagnosed HIV, TB and Pneumonia.

Conclusion

This report highlighted that Pneumonia, HIV related conditions, Tuberculosis, cardiac failure and renal failure remain the leading causes of deaths in the City of Harare. This is noticeable in the productive age-groups of 15 years to 44 years. Chronic conditions like Hypertension and Diabetes need to be closely monitored since there has been significant increase in deaths as a result of them.

The proportion of deaths in the productive age-group (25-44) remains unacceptably high. Pneumonia, Tuberculosis and HIV related conditions which could be prevented remain the leading causes of deaths in this age group. The high mortality in this age group impacts negatively on the economy since deaths occur prematurely. Efforts to prevent these deaths in this most productive age group should be strengthened if the economy has to be sustained.

CHAPTER III

ENVIRONMENTAL HEALTH

INTRODUCTION

Environmental Health Officers were operating from their respective district offices to facilitate operations especially licensing of businesses. Routine monitoring of licensed premises was minimal due to limited transport.

The key result areas of the unit are monitoring of food and water quality, enforcement of relevant pieces of legislation e.g. Public Health Act: Chapter 15:09 revised 1996, Municipal by-laws, licensing of all business and commercial activities and control of communicable diseases.

The planned resuscitation of monitoring of ambient air quality failed to take off due to lack of resources especially transport. It is unfortunate that with the increase in public awareness on air pollution the City does not know the burden of air pollution within its area of jurisdiction. The City should make resources available so that air pollution monitoring is resumed so as to mitigate against any adverse effects on human health.

There was a marked increase in imported food items which did not comply with the national statutes. The high demand for these products as compared to locally produced is mainly because they are cheaper. The majority of these being of Chinese origin and did not comply with the labelling requirements. The hot months of September to December witnessed an unprecedented increase in the number of bottled water on the market. Of major concern was the fact that the majorities were from unlicensed premises and were not approved by the Ministry of Health and Child Welfare.

As highlighted in previous reports, the rural to urban migration resulted in overcrowding in most residential areas with some of them sleeping rough. Some of the homeless were responsible for fouling of street pavements and service lanes in the Central Business District. The increased population had a negative impact on Council's infrastructure such as sewer systems and water supply.

The Municipal water supply situation was worse than the previous year as some areas which used to get water went for about a week or more with no supplies. In some residential areas water was made available only at night.

Boreholes which were drilled by various partners provided an alternative source of domestic water supply. Where there were no boreholes the residents resorted to unprotected water sources especially shallow wells. This situation contributed to outbreaks of water related diseases like typhoid and watery diarrhoea.

Environmental Conditions

The northern suburbs have experienced mushrooming of offices, restaurants and roadside car sales whilst in the western suburbs people were selling anything from food to furniture along the streets. As highlighted in previous reports, there was an increase in vendors who have formed a corridor stretching from Rufaro stadium through Mbare grounds to the fly-over

along Cameroon Street. These people have no water and sanitary facilities thus exposing themselves and other residents to the risk of faecal-oral epidemic diseases.

Refuse collection was erratic in most areas throughout the year. This compelled residents to dump refuse on street corners and any vacant open space. Council resorted to clear these illegal dumps on a regular basis.

The number of public health nuisances and complaints dealt with are reflected in Table 3.1.

Informal Trading

There was a proliferation of illegal vending activities throughout the City. These activities were ever on the increase due to low levels of formal employment. Illegal vending activities were rife at shopping centres, school gates, along main roads and open spaces. Shopping centres in low density residential areas were not spared from this scourge.

In the Central Business district there was an unprecedented increase in the number of vendors who operated on shop frontages and pavements resulting in obstruction of pedestrian movement and littering of the Central Business District environment. The service lanes became places where vendors and street kids relieved themselves. The sites designated for small to medium enterprises such as Mbare SiyaSo, Machipisa Open Market and Glen View 8 were overcrowded that other traders were operating outside these sites.

In the previous report it was highlighted that there was a high risk of fire at Glen View 8 and this year a fire broke out damaging some properties belonging to these traders. There were no human casualties. Illegal crèches and colleges continued to mushroom in both high and low density residential areas. In these places there was overcrowding and also inadequate sanitary facilities.

Housing and squatter settlements

Due to lack of adequate funding for housing developments, desperate home seekers formed housing cooperatives which were registered with Council. The members were allocated unserviced stands with no provision of water and sewer. The City is surrounded by such developments and the number is increasing by the day. Water is obtained from unprotected shallow wells and pit latrines are built at each individual stand for the disposal of human excreta. The average size of these stands is about one hundred (100) square meters.

As highlighted in the previous reports the provision of decent housing accommodation still remains a big challenge to the City. The situation at Hopley has not changed. Residents continue to suffer from lack of potable water supply and approved sanitary facilities. The living conditions were no different from other settlements like Dzivaresekwa Extension, Hatcliffe, Budiriro 4, Southey Park and Snake Park.

Some of the materials used for the construction of houses included plastics, wood and any scrap material people could lay their hands on. Such living conditions are a great health risk and will result in disease outbreaks like diarrhoea, respiratory infections and other communicable diseases.

Table 3.1: Inspections Following Complaints and Nuisances in Year 2012 by District

Inspections	Central	Northern	Vg7Eastern	Southern	Western	Total 2012	Total 2011
Drainage (Blockages/defects septic tanks)	35	384	73	24	376	892	2 529
Air Pollution (smells/smoke/soot)	97	263	207	7	659	1 233	242
Flies/Manure/Waste matter	8	57	35	14	171	285	166
Mosquitoes & other collection of water	0	58	50	31	113	252	47
Rodents	4	289	70	1	122	486	136
Overcrowding	1	2	2	7	34	46	123
Sanitary Conveniences	38	43	20	5	91	197	153
Unprotected and condemned Food	8	7	4	4	18	41	226
Farm Animals	0	3	6	3	4	16	12
Absence of water supplies	22	1	0	0	182	205	171
Poultry	0	64	26	3	47	140	92
Illegal Cooking	133	110	78	68	627	1 016	734
Refuse	173	197	178	110	944	1 602	1 001
Squatters	0	0	5	5	28	38	59
Derelict Buildings	6	0	0	0	4	10	5
Others	54	23	0	13	886	976	225
Total	579	1 501	754	295	4 306	7 435	3 645

Food hygiene, Food premises and licensed premises

Routine monitoring of licensed premises was maintained at minimal level throughout the year due to lack of adequate transport for use by Environmental Health Officers. However there was a marked improvement on the preceding year's performance. There was a collaborative effort with Zimbabwe Tourism Authority to create awareness among food handlers. This resulted in workshops being held to train food handlers from big hotels and restaurants. The programme covered 95% of food outlets in the Central Business District.

Water quality monitoring activities were done at district level. Samples of Municipal water were collected for chemical and microbiological analysis at the Government Analyst Laboratory and the results were satisfactory. However, about 33% of borehole water samples failed the coliform test.

Table 3.2 gives a breakdown of foods that were condemned as unfit for human consumption.

Table 3.2: Breakdown of Foodstuffs Condemned by District

TYPE OF FOOD	WEIGHT IN KILOGRAMMES (KGS)/LITRES (L)				
	Central	Northern	Eastern	Southern	Western
Miscellaneous Meats	59kgs	0	22kgs	0	165kgs
Assorted Foodstuff	1000kgs	0	120kgs	2937.9kgs	565kgs
Fish	0	0	0	498.9kgs	0
Dairy Produce	0	0	0	0	0
Poultry	0	0	0	0	0
Pork and pork products	0	0	0	0	0
Frozen Vegetables	0	0	0	0	0
Sausages	0	0	0	0	0
Beef	0	0	28kgs	103kgs	415kgs
Totals	1059kgs	0	170kgs	3539.8kgs	1145kgs

The number of inspections conducted in licensed premises and the number of legal matters which were dealt with during the year under review are reflected in Table 3.3 and Table 3.4 respectively.

Table 3.3: Licensed Premises Inspections by District

Premises	Central	Northern	Eastern	Southern	Western	Total 2012	Total 2011
Bakeries	402	148	50	104	51	755	327
Butcheries	496	405	219	278	522	1 920	1 671
Caterers	4	0	5	7	7	23	46
Food Purveyor	1 027	523	319	294	725	2 888	2 346
Food Vending Machines	1	0	0	2	0	3	3
Food Factories	5	2	4	126	126	263	372
Fishmongers	158	207	60	43	41	509	220
Equine Animals	0	0	1	0	12	13	6
Fruit & Vegetable Dealers	120	39	4	21	0	184	128
Hairdresser Class A	350	110	91	74	78	703	603
Hairdresser Class B	39	9	0	17	10	75	92
Hotels	77	0	7	0	0	84	53
Laundry Depots	55	51	178	11	20	31 5	312
Launderettes	0	10	1	1	4	16	14
Lodging/Boarding Houses	185	44	31	14	3	277	154
Restaurants & Tearooms	494	194	184	82	100	1 054	702
Take away/Food shops	993	333	222	221	173	1 942	1 137
Total	4 406	2 075	1 376	1 295	1 872	11 024	8 215

Other inspections are reflected in table 3.5.

Table 3.4: Legal Issues Attended to by District

Legal Matters	Central	Northern	Eastern	Southern	Western	Total 2012	Total 2011
Condemnation Certificates	4	0	1	4	3	12	13
Matters Referred to ZRP	240	121	48	17	0	426	278
Intimation Notices Served	168	74	67	47	3	359	227
Intimation Notices Complied with	37	4	9	7	0	57	74
Final Notices Served	5	1	4	5	2	17	15
Final Notices Complied with	14	1	0	1	1	17	4
Reports to other departments	20	3	23	35	26	107	23
Deposit fines issued	0	0	0	0	0	0	0
Health reports issued	69	70	46	80	86	351	207
Closure orders issued	21	0	46	7	3	77	371
Total	578	274	244	203	124	1 423	1 212

Table 3.5: Health Registration Premises Inspected by Districts

PREMISES INSPECTED	Central	Northern	Eastern	Southern	Western	2012	2011
Banks	39	23	27	13	7	109	110
Liquor outlets	146	2	67	303	528	1 046	513
Tailoring	404	53	24	12	9	502	149
Beauty Parlour	38	30	34	2	1	105	48
Phone Shop	67	1	1	2	0	71	157
Garages	69	44	39	84	16	252	397
Engineering	13	1	0	40	22	76	102
Crèches/Nursery School	24	155	139	107	58	483	291
Dwellings	7	498	449	0	1052	2 006	213
Commodity broking	144	15	12	31	4	206	73
Factories non-food	29	7	1	230	133	400	452
Electrical repairs	67	3	9	26	3	108	46
Flea markets	0	24	10	10	3	47	128
Grinding Mills	0	3	40	21	32	96	84
Hawkers Premises	1	10	4	52	34	101	149
Home Industries	0	22	0	0	125	147	31
Dump Sites	0	2	0	0	0	2	115
Markets	18	157	119	10	373	677	204
Medical Institutions	156	75	67	92	74	464	295
Night Clubs	21	28	12	31	44	136	308
Parking Sites	47	34	61	0	305	447	24
Public Convenience	105	223	78	5	241	652	70
Plans	194	122	68	13	240	637	137
Refuse Sites	0	139	3	0	826	968	151
Sanitary Lanes	248	108	47	0	357	760	36
Printing Shops	98	9	16	36	7	166	31
Public Building	73	62	91	0	311	537	20
TV and Radio Repair Shops	74	6	12	2	7	101	33
Vending Sites	137	472	271	44	1 275	2 199	2 187
Sports grounds/Clubs	20	13	2	0	1	36	54
Others	814	551	231	190	932	2 718	2 202
Totals	3 053	2 892	1 934	1 356	7 020	16 255	8 161

Infectious Disease

The City experienced a Typhoid outbreak beginning October 2011 in Dzivaresekwa high density residential area for the period under review. The outbreak later spread to other suburbs such as Warren Park, Kuwadzana, Mufakose, Mabelreign and the peri-urban area of Granary and by the end of the year there were sporadic cases throughout the City. For the period under review, the cumulative total of cases treated as in-patients or out-patients was 3 083 and of these 133 were confirmed as Salmonella typhi by the laboratory. There were 5 deaths reported. As highlighted in previous reports, the lack of provision of adequate potable water and sanitation is a disease outbreak time bomb. In order to prevent disease outbreaks Council must provide adequate potable water to its residents 24/7.

Details of infectious diseases investigated during the year under review are reflected in Table 3.6.

Table 3.6: Infectious Diseases

DISEASE	CENTRAL		NORTHERN		EASTERN		SOUTHERN		WESTERN		TOTAL	
	Loc	Imp	Loc	Imp	Loc	Imp	Loc	Imp	Loc	Imp	2012	2011
Typhoid	3	0	806	25	47	5	187	5	2040	0	1 282	7 322
Cholera	0	0	0	1	0	0	0	0	0	0	1	0
Hepatitis B	0	0	0	0	0	0	0	0	0	0	0	0
Infective hepatitis	0	0	0	0	0	0	5	0	21	0	26	0
Malaria	0	1	0	4	0	1	0	29	0	25	60	0
Meningococcal Meningitis	0	0	0	0	0	0	1	0	0	2	3	1
Pulmonary TB	6	0	336	5	342	7	329	3	526	25	1 579	1 235
Salmonella	0	0	0	0	7	0	0	0	7	0	14	4
Shigella	0	0	0	0	13	0	4	0	32	0	49	3
TB Others	2	0	154	7	143	0	183	6	364	20	877	774
Diarrhoea	0	0	0	0	0	0	0	0	388	0	388	0
Others	0	0	6	0	0	0	0	0	6	0	0	0
Unable to Trace	1		10		0		31		48			
Total	13		1 354		571		785		3 500		4 279	2 801

Health reports of various institutions

One hundred and twelve (112) health reports for institutions such as creches, medical and educational institutions were processed during the year under review.

Health reports liquor licensing

Ninety nine (99) liquor health reports were processed during the year.

Hawkers' Licenses issued

The table below shows the licenses issued:-

HAWKERS'DISCS ISSUED (TYPE)	NUMBER
Non foodstuffs	5
Foodstuffs	543
Total	548

Harare Agricultural Show trading permits

A total of 512 trading permits were processed.

Trading permits

A total of 56 trading permits were issued during the HIFA period

Table 3.7: Harare (Licensed Premises) By-Laws, 1975: Approved

NEW LICENSES APPROVED	TOTAL
Fish monger	23
Bakers	4
Boarding houses	0
Butchers	110
Caterers	0
Food factory	1
Food purveyors	168
Hairdresser's 'A'	0
Laundry depots	0
Restaurants	0
Takeaways	67
Tea rooms	0
TOTAL	372

There was an increase in the licensing of premises which had food purveyor's licences during the year and also most licensed premises amended their licences to include foodstuffs.

Shop Licenses Act, 1996, Chapter 14:17

A summary of the number of shop and municipal licences processed in 2012 is shown in the Table 3.8 below:-

Table 3.8: Shop and Municipal License Approved by Council in 2012

DATE OF MEETING	NO. OF PREMISES	RETAIL	WHOLESALE	NOTIFICATION OF CHANGE OF PERSON IN CONTROL	TOTAL
05.01.12	96	95	0	1	96
06.02.12	180	176	3	4	183
06.03.12	155	152	2	2	156
10.04.12	167	163	1	4	168
07.05.12	65	64	1	1	66
11.06.12	71	66	0	5	71
09.07.12	49	49	0	0	49
06.08.12	55	55	2	0	57
10.09.12	54	54	7	0	61
08.10.12	68	67	1	1	69
05.11.12	76	73	0	3	76
06.12.12	79	77	0	2	79
Total	1 115	1 091	17	23	1 131

HEALTH REPORTS FOR NEW LIQUOR LICENCES APPLICATIONS

Bottle store	47
Bar	22
Night club	13
Restaurant	8
Hotel	2
Club	4
Wholesale	3
Total	99

Building Plans

A total of 312 building plans were submitted for scrutiny to the Department in terms of the Model Building By-laws, 1977 as amended.

PEST CONTROL

The Pest Control unit has the following responsibilities:-

- **Control of nuisance pests and potential vectors of diseases**
- **Surveillance of vector borne diseases**

(a) General pest control

The unit received a total of 148 complaints of bees, mosquitoes, flies, termites, cockroaches and other insects.

(b) Control of commuter malaria

In line with the National Malaria Control programme, the unit carried out the annual spraying of long distance buses using a residual insecticide. The exercise was carried out at Mbare main bus terminus, Mutare bus terminus and at the cross border bus terminus at Roadport.

BUSES SPRAYED AND REVENUE COLLECTED

	Conventional buses	Commuter omnibuses	Revenue
Mbare Musika	290	88	$3 340.00
Road port	58	0	$580.00
TOTAL	348	88	$3 920.00

Challenges

1. Most buses arrive and leave Road port between 1800hrs and 0400hrs
2. Cashier must bank day's collection by 1500hrs
3. Team starts work at 0400 hrs and finishes at 1430hrs
4. Some buses were not sprayed

Recommendations

1. Cashier be made available up to 2200 hrs
2. Cashier to be provided with overnight safe to deposit cash collected

Table 3.9: Complaints received/attended to by Pest Control Unit according to months in 2012

Rodents	31
Termites	24
Bees	42
Cockroaches	25
Mosquitoes	16
Fleas	2
Ants	5
Black Spider	1
Weeds	1
Snake	1
Total	148

CHAPTER IV

HEALTH EXTENSION SERVICES

- **Family Health Services**
- **Curative Health Services**
- **Municipal Maternity Units**

FAMILY HEALTH SERVICES

- **Attendance at under five clinic**
- **Immunization coverages**
- **EPI Diseases Surveillance**
- **Family Planning Services**
- **School Health Services**

Harare City Health Department is mandated to provide integrated services through promotive, preventive, curative and rehabilitative care to individuals, families and communities. Below are highlights of services provided to the under fives whose objective is to reduce morbidity and mortality in line with the 4th Millennium Development Goal.

ATTENDANCE AT UNDER FIVE CLINICS

Table 4.1: Attendance for Weighing, Advice and Immunization for Under Fives by District 2012 and 2011

DISTRICT	2012	2011	% INCREASE
Northern	80 908	77 091	5.0
Eastern	96 900	78 423	23.6
South Eastern & Central	68 073	62 718	8.5
Southern	104 588	86 571	20.8
South Western	141 474	137 152	3.2
West South West	207 842	195 244	6.5
Western	175 441	173 038	1.4
North Western	160 744	161 759	0.6
Grand Total	1 035 970	971 996	6.6

Attendance for weighing advice and immunizations increased by 6.6%. All districts realized an increase in attendance.

Master Card Summary

Table 4.2: Comparison of Children weighed in each age group and percentage below the 3rd Centile for 2012 and 2011

AGE GROUP	2012			2011		
	NO. WEIGHED	NO.BELOW 3RD CENTILE	% BELOW 3RD CENTILE	NO. WEIGHED	NO.BELOW 3RD CENTILE	% BELOW 3RD CENTILE
0-5 months	257 740	4 253	2	264 220	4 848	2
6-11 months	233 075	5 134	2	229 745	8 733	4
12-23 months	270 616	10 064	4	245 569	8 733	4
24- 59months	235 069	6792	3	210 389	6 030	3
TOTAL	1 006 500	26 243	3	949 923	24 073	3

There was an increase of 6.0% in children weighed in 2012. An average of 3.0% of total children weighed were below the 3rd centile line. Age group 12-23 months has a problem of malnutrition as 4.0% of the children were below the 3rd centile line. This age group is affected by bad weaning practices, as most children are taken off the breast before 18 months. Hence nutrition education in all communities needs to be strengthened.

IMMUNISATIONS

New Vaccination Schedule

The WHO recommended a new vaccination schedule which starts at birth up to 18 months. A new vaccine PCV 13 was also introduced in July 2012. Below is the new vaccination/immunisation schedule.

Table 4.3: The New Vaccination Schedule

AGE OF ADMINISTRATION	NAME OF VACCINE
At birth	BCG
6 weeks	OPV 1, Pentavalent 1, PCV 1
10 weeks	OPV 2, Pentavalent 2, PCV 2
14 weeks	OPV 3, Pentavalent 3, PCV 3
9 months	Measles
18 months	DPT Booster, OPV Booster

COVERAGES

Table 4.4: Immunizations given by District for under fives 2012

DISTRICT	PENTAVALENT 1	PENTAVALENT 3	POLIO 1	POLIO 3	PCV 13 1	PCV 13 3	POLIO 18/12 BOOSTER	DPT 18/12 BOOSTER	DT 5 yrs	POLIO 5 years	MEASLES	BCG INITIAL	VITAMIN A
Northern	4 737	4 152	4 854	4 160	1 552	1 242	3 247	3 115	1 790	1 790	3 921	2 129	13 405
Eastern	6 064	5 742	6 200	5 769	2 235	1 383	5 706	4 965	2 491	2 491	5 126	3 563	13 836
South E & Central	4 165	3 680	4 127	3 519	1 515	1 240	2 854	2 650	1 40	1 40	3 056	1 130	19 606
Southern	6 697	5 803	6 879	5 908	2 359	1 584	4 516	4 132	1 940	1 940	5 033	5 695	29 017
South Western	10 503	9 300	10 521	9 273	3 748	2 572	8 492	7 567	4 021	4 021	9 291	5 694	60 900
West South West	12 388	11 169	12 218	10 739	4 303	3 213	10 232	9 600	5 374	5 374	10 235	6 854	50 760
Western	10 226	9 783	10 432	10 104	3 827	2 972	7 878	7 664	3 636	3 636	9 188	6 950	18 954
North Western	8 141	7 226	8 014	7 023	2 895	1 751	5 992	5 183	3 639	3 639	7 160	2 954	225 809
Total	62 921	56 855	63 245	56 495	22 427	15 957	48 917	44 876	22 491	22 491	53 010	34 969	225 809
Other Institutions	2 405	2 009	2 460	2 008	-	-	1 348	1 327	1 120	1 120	1 539	27 828	2 635
Grand Total	65 326	58 864	65 705	58 503	44 861	31 914	50 265	46 203	23 611	23 611	54 549	62 797	228 444

NB Other institutions include Central Hospitals, Uniformed Forces' clinics and surgeries.
PCV13 doses are for the period July to December 2012.

Table 4.5: Trend in Immunization Coverage rates for the under ones 2008 – 2012

ANTIGEN	COVERAGE RATES (%)				
	2012	2011	2010	2009	2008
BCG	123.7	127	118	87	72
Polio 1	134.6	122	116	89	90
Polio 3	126.1	114	102	83	79
Pentavalent 1	133.8	125	114	98	88
Pentavalent 3	120.6	116	102	83	78
Measles	111.8	112	103	83	83
Vitamin A	85.8	86	55.6	100	44.8

Vitamin A coverage (under 5) was 85.8%. Coverage for all other antigens exceeded the 95.0% target. This is because Harare caters for the peri-urban areas and those visitors from rural areas to visit fathers working in town. Calculations were based on population estimates from 2002 census. There are still unimmunised children, the hard to reach, laggards and objectors in all suburbs.

Babies born protected from neonatal tetanus- protected at birth (PAB) - 2012

The table below shows babies born in the city clinics including BBAs, whose mothers had valid tetanus protection.

Table 4.6: Babies Born Protected from Neonatal Tetanus Protection at Birth (PAB) - 2012

District	Maternity Unit (12)	Babies Born	Mothers Delivered With Valid TT Doses	No. Of Babies Born Protected Against NNT	% Of Babies Born Protected
Northern	Hatcliffe	1 671	1 574	1 576	94.3
Southern	Edith Opperman	5 627	5 594	5 614	99.7
Eastern	Mabvuku	3 709	3 440	3 374	91.0
Western	Kambuzuma	828	817	819	98.9
	Warren Park	1 741	1 731	1 740	99.9
	Kuwadzana	2 921	2 916	2 919	99.9
South Western	Highfield	1 464	1 460	1 464	100.0
	Rutsanana	3 017	3 006	3 017	100.0
West South West	Glen View	1 960	1 951	1 958	99.9
	Budiriro	2 689	2 678	2 688	100.0
	Mufakose	1 134	1 120	1 135	100.1
N Western	Rujeko	2 474	2 467	2 471	99.9
TOTAL		29 237	28 754	28 775	98.4

NB. Babies born in Central Hospitals and private Clinics were not included in the table as they do not monitor babies born protected from NNT. The coverage for PAB was 98.4% in 2012 and 97.1% in 2011.

Tetanus Toxoid Vaccination (TT) January to December 2012

TT vaccine is given to Women of Child Bearing Age (WCBA) and Antenatal mothers to protect them from tetanus and thereby prevent neonatal tetanus in the newborn infants. At least five doses give protection throughout the child bearing period.

Table 4.7: Tetanus Doses given to women of Child Bearing Age and Antenatal Mothers and TT2+ Coverage January – December 2012

DISTRICT	1ST DOSE	2ND – 5TH DOSE TT 2+
South Eastern & Central	61	808
Eastern	0	1 794
Northern	45	630
North Western	91	2 925
Western	25	2 243
South Western	217	1 789
West South West	167	2 736
Southern	208	1 532
Total	814	14 457

Target Population (Expected Pregnancies) - 73 216
Total doses given - 14 457
Coverage - 19.7%

The low coverage is due to the fact that the majority of young mothers received their five doses of TT during childhood. There is a need to continue screening all pregnant women who book with us.

National immunisation days (NIDS)

National Immunisation days were held from 18th to 22nd of June 2012.

The following coverages were achieved:-

Measles 119.0%
Polio 98.0%
Vitamin A 94.0%

Dropout rates

Table 4.8: Dropout rates between Pentavalent 1 and 3 by District - 2012

District	Pentavalent 1	Pentavalent 3	2012 % Drop out rate
Northern	4 737	4 152	12.3
Eastern	6 064	5 742	5.3
South Eastern/Central	4 165	3 680	11.6
Southern	6 697	5 803	13.3
South Western	10 503	9 300	11.5
Western	10 226	9 783	4.3
North Western	8 141	7 226	11.2
West South West	12 388	11 169	9.8
Other Organizations	2 405	2 009	16.5
Total	65 326	58 864	9.9

It has been recommended that dropout rates be calculated by using Pentavalent 1 and 3. A dropout rate of 10.0% and below is acceptable. High mobility contributes to the high dropout rates.

The dropout rate for Private Organizations though extremely high is not surprising because the Private Institutions' core business is delivering patients and routine vaccination is continued in the City clinics.

Table: 4.9 Overall Dropout Rates

DISTRICT	PENTAVALENT 1	MEASLES	OVERALL DROPOUT RATE
Northern	4 737	3 921	17.2
Eastern	6 064	5 126	15.5
South East and Central	4 165	3 056	26.6
Southern	6 697	5 033	24.8
South Western	10 503	9 291	11.5
Western	10 226	9 188	10.2
North Western	8 141	7 160	12.1
West South West	12 388	10 235	17.7
Other institutions	2 405	1 539	-
Total	65 326	54 549	16.5

Health education is continuously done to mothers on the importance of completing the Primary course.

Vaccine wastage monitoring

Table 4.10: Vaccines Wastage Rates January – December 2012

DISTRICT	BCG %	OPV %	PENTAVALENT %	DT %	MEASLES %	TT %
Northern	74.1	4.7	0.2	2.8	51.2	2.7
Southern	60.8	0	0	0.8	40.9	0
Eastern	94.0	6.4	0	13.3	71.4	7.0
West	80.0	0.1	0.1	0	30.9	0.1
South Western	70.3	11.6	2.5	4.4	43.3	9.5
South East/Central	85.7	9.5	1.5	8.3	60.7	2.5
West South West	68.0	10.0	0	2.0	24.6	5.0
North Western	75.4	0	0	0	48.0	0
City Wastages	76.0	5.3	0.5	4.0	46.6	2.8

Some degree of vaccine wastage is expected in any vaccination service at any stage. Reconstituted vaccines have a high wastage rate e.g. BCG and measles. These are discarded as per manufacturer's recommendation after opening or after outreach services. The multi dose vial policy is practiced for all toxoids i.e. DPT, DT, TT, Pentavalent and PCV to minimize wastage. These can be used for up to 30 days for as long as the vaccine vial monitor is at stage one, has not expired, label is intact and has not been contaminated.

EPI DISEASE SURVEILLANCE

The diseases under surveillance are Measles, Polio, Neonatal Tetanus and monitoring of Adverse Events Following Immunisation (AEFIS).

OBJECTIVE

- **The objective of the surveillance is to monitor the effectiveness of the EPI Programmes.**

MEASLES SURVEILLANCE

There was no outbreak in 2012. A total of 21 suspected cases of measles were notified.
Total negative cases = 21
Total measles IGM positive cases = 0 Lab confirmed
Total cases confirmed Rubella = 0

Acute Flaccid Paralysis Surveillance

Table 4.11: AFP surveillance Performance Indicators 2008 - 2012

INDICATORS	2012	2011	2010	2009	2008
Expected no of AFP cases	24	16	10	10	14
Detected cases	22	8	18	18	4
% of AFP cases with adequate stools	91.7	85	88.8	77.7	50

Table 4:12: Harare City AFP Surveillance Performance Indicators by District Jan to Dec 2012

District	Target cases	Cases Detected	% of AFP cases with adequate stools	Results
Eastern	-	2	100	Negative
South Western	-	2	50	Negative
Western	-	5	50	2 suspected Polio post NID
Northern	-	1	100	Negative
Southern	-	3	80	Negative
South Eastern & Central	-	2	100	Negative
North Western	-	5	50	Negative
West South West	-	1	80	Negative
Parirenyatwa	-	3	100	Negative
Harare Hospital	-	6	100	Negative
PMD	-	6	50	1 case Polio virus isolated
Avenues	-	0	-	-
Total	24	36	78	

Cases identified surpassed the Harare target of 24. There is need to improve on stool collection so as to achieve 100% stool adequacy.

Neonatal Tetanus

One case of neonatal tetanus was identified in the first quarter. Both parents belonged to the Marange Sect. They resided in Warren Park but went to Mabelreign Clinic for treatment then referral to Parirenyatwa. No follow up was done since parents did want to be followed up at home.

Adverse events following immunisation (AEFIs)

Table 4:13: Adverse events following Immunization (AEFI) - 2012

ANTIGEN	NUMBER	TYPE OF REACTION	ACTION TAKEN
BCG	0	N/A	N/A
PCV 13	0	N/A	N/A
Pentavalent	19	Abscess formation	Treated and recovered
Polio	9	Vomiting weakness	Referred, recovered,
Measles	7	Fever, weakness	treated, recovered
DPT	4	Pain, swollen site	Treated, recovered
DT	0	N/A	N/A
Total	39		

A total of 39 AEFIs were reported in 2012, an increase from 9 that were reported in 2011. All reactions were monitored, reported and followed up.

SCHOOL HEALTH PROGRAMME

School health services are offered in high density schools and a few in low density suburbs. A total of 60 875 school children were screened in 2012.

The main objective is to detect early nutritional problems, physical defects, mental problems and infections.

Below is a table showing the number of children screened:-

Table 4:14: Number of Pupils Screened per District and Grade – 2012

Schools in the following areas	Grade 1		Grade 3		Grade 7		Total		Total
	M	F	M	F	M	F	M	F	
Hatcliffe	0	0	213	227	0	0	213	227	440
Glen View Satellite	524	465	477	493	463	439	1 464	1 397	2 861
Southerton	5202	570	171	176	280	344	1 090	1 090	2 043
Highfield	1 010	902	392	399	520	520	1 821	1 821	3 751
Rutsanana	854	952	431	425	888	850	2 173	2 227	4 400
Western Triangle	994	934	468	433	894	804	2 356	2 171	4 527
Glen Norah	1 116	1 206	381	379	592	720	2 089	2 305	4 394
Glen View FHS	632	636	609	614	502	582	1 743	1 832	3 575
Mufakose FHS	762	734	716	711	717	775	2 195	2 220	4 415
Budiriro	1 206	1 214	1 104	1 206	1 000	1 142	3 310	3 562	6 872
Tafara	0	0	345	345	0	0	345	345	690
Warren Park	661	607	422	397	512	586	1 595	1 590	3 185
Kuwadzana	1 178	1 147	0	0	0	0	1 178	1 147	2 325
Kambuzuma	377	325	362	371	343	417	1 082	1 113	2 195
Mabelreign	671	676	0	0	0	0	671	676	1 347
Dzivarasekwa	794	750	488	520	568	688	1 850	1 958	3 808
Marlborough	269	292	0	0	0	0	269	292	561
Avondale	301	327	0	0	0	0	301	327	628
Sunningdale	146	108	172	160	163	176	481	444	925
Eastlea	97	107	37	39	0	0	134	146	280
Mt Pleasant	39	40	128	124	0	0	167	164	331
Mbare FHS	620	575	657	631	560	545	1 837	175	3 588
Mabvuku Sat	509	542	0	0	0	0	509	542	1 051
Waterfalls	145	115	117	167	126	116	388	398	786
Belvedere	666	668	0	0	0	0	666	668	1 334
Highlands	218	349	0	0	0	0	218	349	567
Grand total	14 291	14 241	7 690	7 817	8 136	8 704	30 117	30 762	60 879

Health education was also given. Due to resource limitations screening was limited to grades zero and one in the first school term, grade 7 during the second term and grade 3 during the third term.

Table 4:15: Health conditions in children identified during screening 2011 - 2012

CONDITIONS	2012		2011	
	Number screened	% of Total Conditions Screened	Number screened	% of Total Conditions Screened
Ringworm	5 525	37.3	4 919	46.7
Dental Caries	3 965	26.8	3 542	33.6
Coughs and Colds	1 624	11.0	1 634	15.5
Visual difficulties	368	2.5	260	2.5
Other dental problems	55	0.4	74	0.7
Other skin conditions	588	4.0	61	0.6
Scabies	19	0.1	28	0.3
Other conditions	2 668	18.0	-	-
Total	14 812	100.0	10 518	100

Ringworm recorded 37.3% of total conditions screened in children (14 812) followed by dental caries, 26.8%. Appropriate treatment and referrals were done.

FAMILY PLANNING SERVICES (FP)

Table 4:16: Attendances for Family Planning by District for 2012 and 2011

DISTRICT	2012	2011	% INCREASE
Northern	2 289	2 746	16.6
Eastern	15 434	10 988	40.5
South Eastern/Central	2 057	1 896	8.5
Southern	3 348	3 901	14.2
South Western	4 459	3 608	23.6
West South West	4 297	5 214	17.6
Western	5 312	4 906	8.3
North Western	4 784	3 897	22.8
Total	41 980	37 156	13.0

Table 4:17: Trends in New Acceptors and Attendances 2009-2012

	2012	2011	2010	2009
New Acceptors	10 577	9 486	7 550	3 703
Total Attendances	41 980	27 670	25 425	28 329

New acceptors increased by 11.5% and total attendance for Family Planning by 51.7%. Clients continue to utilise City Clinics for Family Planning Services.

Table 4:18: Trends in New Acceptors by method 2009 – 2012

METHOD	2012	2011	2010	2009
Progestogen (POP)	7 713	6 810	5 358	2 396
Combined Oral Pill (COP)	819	544	644	286
Depo Provera	2 045	2 132	1 548	1 021

P.O.P was the most preferred method of Family Planning followed by Depo Provera recording an uptake of 72.9% and 19.3% respectively.

Table 4:19: Five year comparison of Family Planning Attendance and Issues 2008 - 2012

YEAR	ATTENDANCES	PILL PACKETS	DEPO PROVERA
2012	41 980	163 395	14 223
2011	27 670	131 269	13 859
2010	25 425	51 744	12 424
2009	28 239	48 962	18 449
2008	27 314	15 799	29 113

Pill issues continue to rise since the reduction of the cost. There is an insignificant rise in Depo issues as a notable rise was last recorded in 2008 and 2009.

CURATIVE SERVICES

- **Primary care clinics**
- **Chronic services**

PRIMARY CARE CLINICS

There was a 6.3% increase in total number of initial attendances comparing 2012 and 2011.

Table 4:20: Clinic Attendance for 2012 compared to 2011

2012				2011			
Clinic Attendances	Males	Females	Grand Total	Males	Females	Grand Total	% Increase/ Decrease
Initial	402 624	469 361	871 985	376 437	444 208	820 645	6.3
Repeats	219 122	237 978	457 100	216 431	226 399	442 830	3.2
Total	621 746	707 339	1 329 085	592 868	670 607	1 263 475	5.2

Table 4:20: Initial Attendance by age group 2012 compared to 2011

2012				2011			
Clinic Attendances	Males	Females	Grand Total	Males	Females	Grand Total	% Increase/ Decrease
0 – 4	180 035	150 881	330 916	168 851	138 627	307 478	7.6
5 +	222 589	318 480	541 069	207 586	305 581	513 167	5.4
Total	402 624	469 361	871 985	376 437	444 208	820 645	6.3

Initial visits in both age groups have shown a slight increase.

Table 4:21: Total Clinic Attendances and referrals for 2012 compared to 2011

ATTENDANCES	2012	2011	% Increase
Clinic Attendances	1 329 085	1 263 475	5.2
Referrals	57 912	52 302	10.7
% Referrals to Attendances	4.4	2.9	1.5

- **Referrals to hospital in 2012 increased when compared to those in 2011. This could be because patients are seeking treatment late due to economic challenges.**

Table 4:22: Clinic Attendance for 2012 by clinic and district

DISTRICT/CLINIC	INITIAL ATTENDANCES			TOTAL ATTENDANCES		
	Male	Female	Total	Male	Female	Total
Central						
Parirenyatwa	5 333	6 566	11 899	9 336	11 713	21 049
Northern						
Borrowdale	5 374	4 775	10 149	9 392	11 362	20 754
Mt. Pleasant	4 420	4 807	9 227	7 615	9 338	16 953
Hatcliffe	11 565	12 625	24 188	17 798	19 666	37 464
Total	21 357	22 207	43 564	34 805	40 366	75 171
Eastern						
Mabvuku Polyclinic	27 215	35 122	62 337	50 427	66 781	117 208
Highlands PCC	7 442	9 023	16 465	11 929	12 321	24 250
Mabvuku Satellite	6 405	6 729	13 134	8 449	8 963	17 412
Total	41 062	50 874	91 936	70 805	88 065	158 870
South Eastern						
Hatfield	9 601	10 747	20 348	12 380	13 392	25 772
Arcadia	4 664	6 309	10 973	8 932	8 800	17 732
Total	14 265	17 056	31 321	21 312	22 192	43 504
Southern						
Mbare Polyclinic	17 489	22 860	40 349	27 172	31 756	58 928
Matapi	10 915	13 539	24 454	20 155	20 933	41 088
Mbare Hostels	10 127	11 760	21 887	12 314	13 547	25 861
Sunningdale	9 775	8 888	18 663	14 225	13 586	27 811
Waterfalls	8 185	10 791	18 976	13 648	17 564	31 212
Hopley	7 644	7 779	15 423	11 848	11 753	23 601
Total	64 135	75 617	139 752	99 362	109 139	208 501
South Western						
Southerton	3 642	3 631	7 273	5 550	5 297	10 847
Highfield	17 189	21 205	38 394	23 270	27 099	50 369
Rutsanana	13 297	14 855	28 152	24 457	27 356	51 813
Western Triangle	7 618	8 041	15 659	17 470	19 159	36 629
Glen Norah Satellite	13 185	17 834	31 019	18 972	23 739	42 711
Total	54 931	65 566	120 497	89 719	102 650	192 369
West South West						
Glen View	24 161	22 456	46 617	36 690	32 209	68 899
Budiriro	10 028	12 545	22 573	15 405	17 479	32 884
Glen View Satellite	18 281	21 826	40 107	34 417	40 003	74 420
Mufakose	25 217	28 563	53 780	35 687	39 260	74 947
Total	77 687	85 390	163 077	122 199	128 951	251 150
Western						
Warren park	15 375	20 119	35 494	23 377	30 063	53 440
Kuwadzana	27 389	32 931	60 320	38 619	45 695	84 314
Kambuzuma	22 140	20 969	43 109	29 560	27 583	57 143
Total	64 904	74 019	138 923	91 556	103 341	194 897
North Western						
Avondale	5 754	8 381	14 135	7 276	9 949	17 225
Marlborough	10 051	13 855	23 906	12 292	16 424	28 716
Mabelreign	11 726	9 987	21 713	18 989	17 869	36 858
Rujeko	25 629	33 141	58 770	36 608	48 537	85 145
Belvedere	5 790	6 702	12 492	7 487	8 143	15 630
Total	58 950	72 066	131 016	82 652	100 922	183 574
Total Clinics only	402 624	469 361	871 985	621 746	707 339	1 329 085

Morbidity Pattern

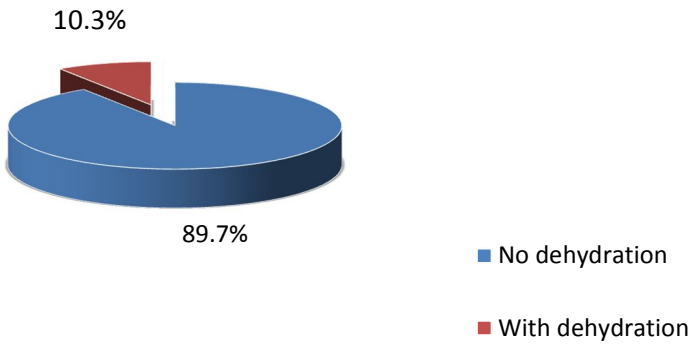
Table 4:23: Comparison of the 5 Commonest Conditions at Primary Care Clinic, 2011 and 2012

CONDITIONS	2011	2012	% Increase/ Decrease
Acute Respiratory infection (ARI)	459 059	455 473	- 0.8
Skin Conditions	91 988	99 551	8.2
Ear Nose and Throat Infection (ENT)	103 920	103 095	-0.8
Sexually Transmitted Infection (STI)	34 555	37 081	7.3
Diarrhoea	40 133	49 564	23.5

The above table shows the five commonest conditions seen in the Primary Care Clinics. There was a 23.5% increase in diarrhoea comparing 49 564 in year 2012 to 40 133 in year 2011.

There was a 0.8% decrease in ARI cases of 455 473 in year 2012 compared to 459 059 in year 2011.

Fig 1: Diarrhoea



Diarrhoea – 89.7% cases had no dehydration while 10.3% had dehydration.

Table 4:24: Morbidity Pattern by Age Group per 100 initial attendances 2012

CONDITION	0 – 4 YEARS			5 - 14 YEARS			ALL AGES
	Male	Female	Total	Male	Female	Total	NO.
Watery Diarrhoea							
No dehydration	12 787	11 316	24 103	8 424	9 829	18 253	42 356
Mild dehydration	1 596	1 457	3 053	845	978	1 823	4 876
Nutritional Conditions							
Kwashiokor	253	272	525	13	11	24	549
Marasmus	62	67	129	4	0	4	133
Pellagra	0	3	3	24	28	52	35
Malaria							
Clinical	784	735	1 519	4 388	4 769	9 152	10 671
Tested	780	732	1 512	4 344	4 704	9 048	10 560
Positive Slides	162	139	301	1 087	1 027	2 114	2 415
Abortion					1 681	1 681	1 681
Bilharzia	226	159	385	1 029	484	1 513	1 898
Acute Mental Disorders	2	0	2	54	62	116	118
Acute Respiratory Tract Infection							
Mild (Cough & colds)	52 758	50 797	103 555	33 063	35 209	68 272	171 827
Moderate	80 609	80 036	160 645	51 401	58 785	110 186	270 831
Severe	5 168	4 487	9 655	1 553	1 607	3 160	12 815
Diseases of the Eye							
Cataracts	26	20	46	271	299	570	616
All other eye diseases	9 625	8 3355	17 980	6 514	7 065	13 579	31 559
Skin diseases							
Chicken pox	706	719	1 425	1 299	1 280	2 579	4 004
Herpes Zoster	46	45	91	1 172	1 423	2 595	2 686
Scabies	1 314	1 131	2 445	711	684	1 395	3 840
Other forms of skin dis.	25 906	23 377	49 283	19 313	20 425	39 738	89 021
Dental	185	150	335	1 383	1 680	3 063	3 398
Injuries							
Burns and Scalds	3 145	2 874	6 019	1 501	1 510	3 011	9 030
Other Injuries	6 645	5 348	11 993	11 924	9 036	20 960	32 953
Poisoning Tonic Effects	246	217	463	292	360	652	1 115
All other diseases	80 368	79 454	159 822	114 775	136 708	251 483	411 305

A total of 10 671 cases of clinical malaria were seen. The positivity rate was 22.6%.

Chronic Diseases

TB/HIV/AIDS ATTENDANCES

Total attendances for both TB and HIV/AIDS related conditions increased by 39.7% comparing 611 471 in year 2012 to 437 813 for 2011.

Table 4:25: Top six conditions seen in 2012 compared to 2011

CONDITION	2012 ATTENDANCES	2011 ATTENDANCES	% INCREASE
Hypertension	95 121	67 425	41.1
Diabetes	12 383	9 365	32.2
Gout anthritis		8 337	
Asthma	9 376	7 852	19.4
Epilepsy	7 761	5 380	44.3
CCF	4 806	3 936	22.1

- **There was a significant increase in the top six conditions seen in 2012 compared to 2011.**

Table 4:26: Chronic Conditions by District year 2012

CONDITION	NORTHERN		EASTERN		SOUTH EASTERN AND CENTRAL		SOUTHERN		SOUTH WESTERN		WEST SOUTH WEST		WESTERN		NORTH WESTERN		CITY TOTAL	
	NP	Follow up	NP	Follow up	NP	Follow up	NP	Follow up	NP	Follow up	NP	Follo w up	NP	Follow up	NP	Follow up	NP	Follow up
Diabetes	28	565	12	1 280	21	1 029	83	1 663	131	2 356	88	3 284	55	1 567	43	1 784	461	13 528
Asthma	46	511	11	1 434	40	418	87	1 271	86	1 544	150	2 382	45	886	73	1 329	538	9 766
Epilepsy	74	449	12	983	53	546	136	852	148	924	137	1 612	139	766	96	942	795	7 074
Mental Illness	21	3 213	10	906	14	241	21	417	27	716	32	1 067	29	669	14	340	168	4 721
Dis./Hand	0	5 870	0	0	0	0	0	0	0	0	0	0	0	0	0	119	9	122
Hypertension	281	3	115	9 690	19 7	5 364	244	12 063	363	15 451	508	23 500	482	12 374	373	14 420	256 3	98 732
RHD	0	231	4	2	0	13	3	8	0	25	0	0	0	0	0	3	7	54
CCF	13	0	03	582	7	177	25	687	64	1 033	42	1 466	33	769	17	494	204	5 439
CRF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ca Breast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

MUNICIPAL MATERNITY UNITS

- Attendances
- Transfers
- Deliveries
- Liaison Meetings
- Still births
- Post Natal Examinations
- Maternal Deaths
- Prevention of Parent to Child Transmission of HIV

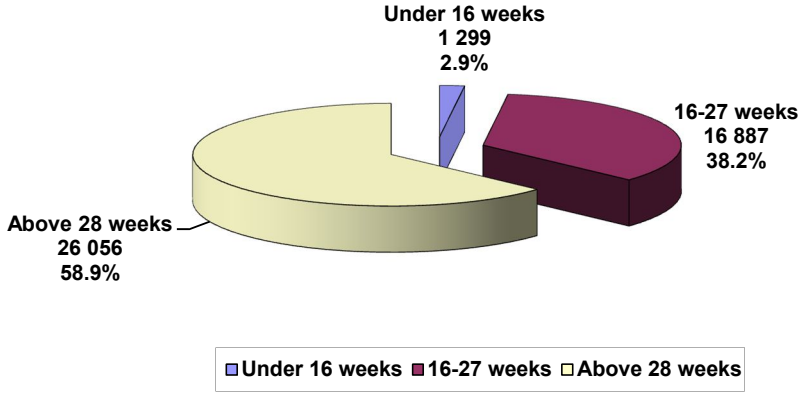
Attendances for antenatal clinic

The percentage of early bookers slightly increased. The slight increase could be due to reduction in maternity fees and introduction of part payment.

Table 4:27: Booking by district for 2012 compared to 2011

District	2012			2011		
	<16 Weeks Early	>16 Weeks Late	% Early Bookers	<16 Weeks Early	>16 Weeks Late	% Early Bookers
Central	20	439	4.5	26	439	5.6
Northern	100	2 902	3.4	96	2 899	3.2
Eastern	183	4 992	3.6	122	5 186	2.3
South Eastern	81	2 216	3.5	65	1 873	3.4
Southern	129	5 280	2.4	85	5 903	1.4
South Western	176	6 419	2.7	135	6 809	1.9
West South West	144	8 147	1.7	96	8 055	1.2
Western	212	6 779	2.7	141	7 748	1.8
North Western	254	4 969	4.9	138	4 993	2.7
Total	1 299	42 943	2.9	904	43 905	2.0

Fig II: Booking Status by Gestation



In 2012, 2.9% were early bookers compared to 2% in year 2011 whilst 58.9% booked late after 28 weeks. Health workers should educate on importance of early booking and the dangers of booking late. North Western District 19.6% had the highest percentage of early bookers of 19.6%.

ANTENATAL BOOKING, ATTENDANCE AND TRANSFERS

Table 4:28: Bookings, ANC attendances and transfers for 2012 and 2011

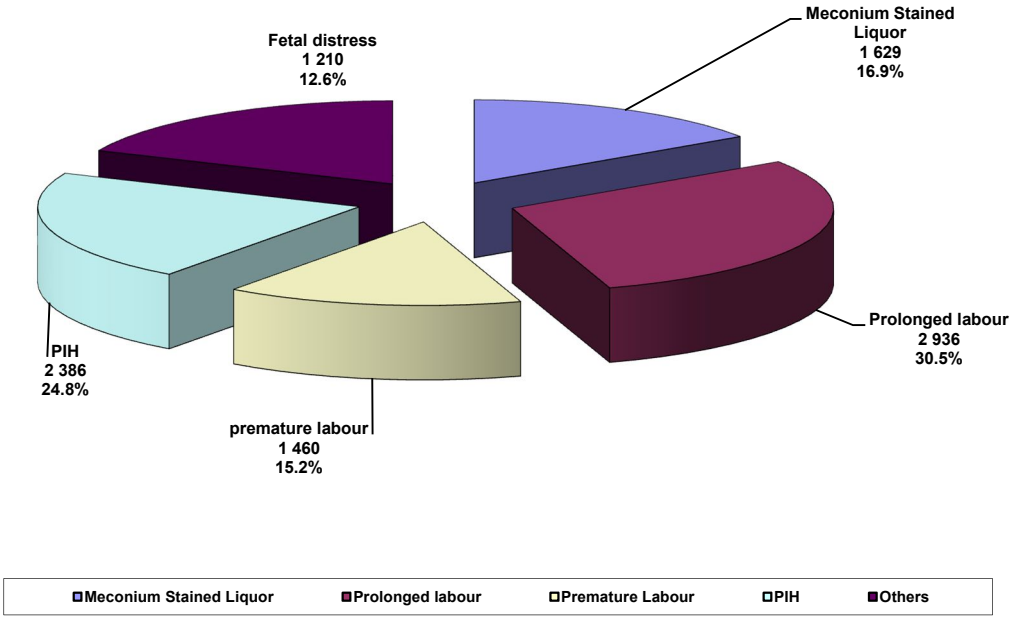
DISTRICT/CLINIC	2012				2011			
	Bookings	Attendances	Transfers	% TF Bookings	Bookings	Attendances	Transfers	% TF Bookings
Central								
Parirenyatwa	459	1 045	158	34.4	465	1 001	220	47.3
Northern								
Highlands	245	644	79	32.2	220	602	53	24.1
Borrowdale	288	721	48	16.7	297	552	76	25.6
Mt Pleasant	383	1 050	85	22.2	424	1 043	100	23.6
Hatcliffe	2 086	5 418	234	11.2	2 054	4 836	143	7
Total	3 002	7 833	446	14.9	2 995	7 033	372	12.4
Eastern								
Mabvuku	3 443	9399	594	17.3	3 911	9 792	326	8.3
Tafara	865	1 819	24	2.8	628	1 758	33	5.3
Greendale	418	1 055	78	18.7	368	853	113	30.7
Eastlea	449	1 014	71	15.8	401	799	93	23.2
Total	5 175	13 287	767	14.8	5 308	13 202	565	10.6
South Eastern								
Hatfield	971	2 453	183	18.8	928	1 958	180	19.4
Braeside	1 326	2 290	175	13.2	1 010	2 599	176	16.9
Total	2 297	4 743	358	15.6	1 938	4 557	351	18.1
Southern								
Edith Opperman	3 884	8 501	401	10.3	4 320	7 569	370	8.6
Sunningdale	651	1 151	97	14.9	772	1 342	77	10
Waterfalls	874	1 509	105	12.0	896	1 143	106	11.8
Total	5 409	11 161	603	11.1	5 988	10 054	553	9.2
South Western								
Highfield	2 366	4 349	311	13.1	2 570	8 077	329	12.8
Rutsanana	4 229	7 265	313	7.4	4 374	7 364	304	7
Total	6 595	11614	624	9.5	6 944	15 441	633	9.1
West South West								
Glen view	2 859	6 244	478	16.7	2 971	5 358	468	15.8
Budiriro	3 579	7049	266	7.4	3 402	6 923	274	8.1
Mufakose	1 853	4 224	261	14.1	1 778	3 819	269	15.1
Total	8 291	17 517	1 005	12.1	8 151	16 100	1 011	12.4
Western								
Warren Park	2 279	7 479	281	12.3	2 252	6 410	384	17.1
Kuwadzana	4 152	6 207	505	12.2	4 228	6 532	542	12.8
Kambuzuma	1 360	3 859	260	19.1	1 409	4 166	238	16.9
Total	7 791	17 545	1 046	13.4	7 889	17 108	1 164	14.8
North Western								
Avondale	414	2 884	103	24.9	332	5 685	96	28.9
Marlborough	637	1 560	155	24.3	597	1 236	162	27.1
Mabelreign	595	1 658	129	21.7	608	1 681	161	26.5
Rujeko	3 034	7 624	495	16.3	↑ 3 073	7 309	513	16.7
Belvedere	543	1 616	150	27.6	521	1 411	181	34.7
Total	5 223	15 342	1 032	13.6	5 131	17 322	1 113	21.7
Grand Total	44 242	100 087	6 039	13.6	44 809	101 818	5 982	13.3

An area of concern is a 1.2% reduction in total bookings comparing 44 242 in year 2012 to 44 809 the previous year. Rutsanana Clinic had the highest number of booked mothers 4 229 (9.6%) of the total bookings. 13.6% of booked mothers were transferred to hospitals for high level care indicating a 5.7% increase in transfers in 2012 compared to 13.3% in the year 2011.

TRANSFERS IN LABOUR

Total number of mothers transferred during labour to higher level of care: – 13 718

Fig III: Top 5 conditions



Prolonged labour constitutes 30.5% of the total top transfers in labour in the year 2012. Transfer rate is 33.4%.

Table 4:29: Deliveries for 2012 and 2011 by district and clinics

DISTRICT	2012			2011			% Increase/ Decrease
	Booked	Unbooked	Total	Booked	Unbooked	Total	
Northern							
Hatcliffe	1 361	210	1 571	1 406	198	1 604	- 2.1
Eastern							
Mabvuku	2 907	364	3 271	2 907	545	3 452	- 5.2
Total	2 907	364	3 271	2 907	545	3 452	- 5.2
Southern							
Edith Opperman	4 403	841	5 244	4 324	1 049	5 373	- 2.4
Total	4 403	841	5 244	4 324	1 049	5 373	- 2.4
South Western							
Highfield	1 235	171	1406	1 285	238	1 523	- 7.7
Rutsanana	2 238	542	2 780	2 397	588	2 985	- 6.9
Total	3 473	713	4 186	3 682	826	4 508	- 7.1
West South West							
Glen view	1 486	370	1 856	1 434	534	1 968	- 5.7
Budiriro	2 129	455	2 584	2 215	739	2 954	- 12.5
Mufakose	924	164	1 088	920	220	1 140	- 4.6
Total	4 539	989	5 528	4 569	1 493	6 062	- 8.8
Western							
Warren Park	1 555	134	1 689	1 527	196	1 723	- 2
Kuwadzana	2 246	481	2 727	2 328	667	2 995	- 8.9
Kambuzuma	695	103	798	744	122	866	7.6
Total	4 496	718	5 214	4 599	985	5 584	- 6.6
North Western							
Rujeko	1 959	415	2 374	2 019	478	2 497	- 4.9
Total	1959	415	2 374	2 019	478	2 497	- 4.9
Grand Total	23 138	4 250	27 388	23 506	5 574	29 080	- 5.8

Edith Opperman clinic had the highest percentage of deliveries (19.1% of city deliveries)
There is a 5.8% reduction of total deliveries in the City Health Clinics. This could be due to migration or that mothers now have more options privately.

Maternal deaths

There were 4 maternal deaths in the City of Harare:-

- **1 institution death –cause pneumonia at 20 weeks gestation.**
- **Two community deaths – one was due to post partum haemorrhage and the other was due to pulmonary oedema after delivery at home.**
- **One died of post partum haemorrhage in transit to Harare Hospital following twin delivery at home.**

Table 4:30: Still births by booking status

STILL BIRTHS	2012				2011			
	Booked	Unbooked	Total	SB Rate Per 1000	Booked	Unbooked	Total	SB Rate Per 1000
Fresh	50	17	67	2.5	32	15	47	1.5
Macerated	47	32	79	2.9	50	36	86	2.8
Fresh (BBA)	6	8	14	0.5	8	13	21	0.7
Macerated (BBA)	8	4	12	0.4	4	5	9	0.3
Total	111	61	172	6.3	94	69	163	6.3

Neonatal deaths/Still births

There were a total of 172 still births (fresh and macerated) for the year 2012 compared to 163 the previous year 2011. Still birth rate remains at 6.3 per 1000.

There was a total of 22 neonatal deaths in 2012 which was 0.08% of the deliveries for the year. There is need for strengthening the Helping Babies Breathe Programme.

Table 4:31: Post Natal Attendances 2012 vs 2011

POSTNATAL CHECK UP	2012			2011			Percent Increase/ Decrease
	City Booked Patients	Booked with other Institutions	Total	City Booked Patients	Booked with other Institutions	Total	
Total	16 740	4 711	21 451	16 626	4 348	20 974	2.3

There was a 2.3% increase in Post natal attendances.

An area of concern is 22% of the mothers who delivered in the City clinics but did not return for six weeks post natal care. There is need to emphasize on the importance of post natal check up.

Visual inspection with acetic acid and cervicograph (VIAC) based cervical cancer screening management.

Table 4:32 VIAC Clinic 2012

	Mbare Polyclinic	SVC	Total
Number of clients screened	3 614	1 613	5 227
HIV positive	750	696	1 446
HIV negative	2 830	816	3 646
HIV unknown	34	101	135
VIAC positive (+ve)	205	121	326
VIAC negative	3 349	1 479	4 828
Suspicious cervix	60	13	73
Cervical polypi	19	10	29
Nabothothian cysts	76	11	87
Strawberry cervix	26	3	29
Leep treatment	0	1	1
Cryotherapy	0	16	16
Uterine prolapse	3	4	7

6.2% of the total clients screened for cervical cancer for the year 2012 were VIAC positive. A training course undertaken by 4 participants in Bulawayo in September 2011 led to the availability of VIAC services in the City of Harare. The City of Harare has trained nurses for VIAC services.

PREVENTION OF PARENT TO CHILD TRANSMISSION OF HIV (PMTCT)

Table 4:33: Sites offering PMTCT in the Harare City

TYPE	NUMBER
Number of comprehensive sites	27
Number of minimum sites	0
Number of sites offering ART (adults)	26
CD4 count machines	2
Number of sites EID (DBS collection)	27
Number of sites offering paediatric ART	2

HIV positivity rate for 2012 in women attending antenatal clinic increased to 10.1% as compared to 10% in 2011. Uptake of PMTCT remains at 95%. Health education on PMTCT continued in all antenatal clinics.

Table 4:34: PMTCT activities in Harare City 2012 and 2011

INDICATOR	2012	2011	% Increase/ decrease
ANC first visits	44 242	44 427	- 0.4
Pregnant women counselled	44 242	45 026	-1.7
Pregnant women tested	42 910	44 821	-4.3
Pregnant women HIV positive (pos rate) 10%	4 334	4 807	-9.8
Pregnant women dispensed sdNVP	49	2 921	-98.3
Pregnant women initiated on AZT	4 363	4 359	0.1
HIV infected women assessed clinically	5 424	4 071	33.2
HIV infected women assessed CD4 count	4 721	4 325	9.1
Infants receiving sdNVP & AZT	5 835	1 624	259
Number of institutional deliveries	27 388	29 080	-5.8
Number of home deliveries	1 804	1 657	8.9
Pregnant women receiving combivir	2 773	1 309	111.8
Infants dispensed sdNVP only	3 503	209	57.6
Infants dispensed sdNVP and AZT	5 835	1 672	248
Mother started on CTX	2 400	2 267	5.9
Infants started on CTX	3 801	2 859	32.9
Mothers exclusively breastfeeding for 3 months	6 607	2 633	150
Infants <2 months tested (PCR) and received results	2 758	1 435	92
Infants <2 months tested (PCR) positive	150	59	154
Infants >2-9 months tested (PCR) & received results	1 615	1 132	43.6
Infants >2-9 months tested (PCR) positive	150	81	85.2
Infants >9 months tested (Rapids) & received results	1 880	1 427	31.7
Infants >9 months tested (Rapids) positive	251	117	114.5
Male partners tested	3088	2 753	12.2

In 2012, 96.9% of the antenatal visits were tested as compared to 100.8% HIV tested in 2011. There was an increase of 12.2 male partners tested in 2012 as compared to 2011.

LIAISON MEETINGS

The Nursing Directorate and midwives attended the Maternal and Neonatal Mortality Liaison Meetings at Harare Hospital. The good public relations of the two departmental midwives/coordinators based at Harare and Parirenyatwa Hospitals maintained effective communication between the City Clinics and the referral hospitals. The feedback by the coordinators provided a link between the clinics and the hospital thereby improving patient/client care. The departmental maternal and neonatal audit meetings were held every quarter in 2012.

Other Activities

The Nursing Section continued to collaborate with other health personnel in providing the following programmes throughout the year:-

Health Promotion

The Nursing staff gave health information to individuals and groups in the clinics and other institutions visited by Community Sisters. Specific groups such as antenatal and postnatal mothers, HIV positive individuals, mothers attending for immunisation and nutrition sessions, school and crèche children were given appropriate advice.

Research and Staff Development

Nursing personnel participated in research projects conducted in the department by different researchers including students from Nursing and Medical Schools.

Orientation and Secondment of Nursing and Medical Students

The Senior Nursing Officers continued to lecture at the Basic, Post Basic and Midwifery Schools of Nursing.

The students from Basic schools of Nursing, Post Basic School of Nursing, department of Nursing Science and Medical School were seconded to the Department for their research projects under the supervision and guidance by the Senior Nursing Officers.

Staff Development, Workshops Courses

- **2 District Nursing Officers were promoted to Deputy Nurse Managers, 4 Sisters in Charge were promoted to District Nursing Officers and 30 Registered General Nurses to Sisters in Charge.**
- **One Registered General Nurse successfully completed the Diploma in Community Nursing whilst two are going to supplement in March 2013.**
- **PMTCT review workshops – 40 Senior Nursing Officers attended (midwives.**
- **EPI workshop – 47 participants were trained.**
- **IMAI IMPAC – 60 nursing staff attended (2 workshops).**
- **Paediatric O.I. – 34 staff members attended**
- **Infection Control Workshop for clerks, Clinic Orderlies and Clinic Attendants – 80 participants were trained**
- **Management of Survivors of Sexual Abuse – 40 participants were trained.**
- **STI and HIV workshops – 10 participants attended**
- **Helping Babies Breathe – 40 midwives were trained**

SUCCESSES

Maternity Services

- **The departmental Maternal and Neonatal Audit Meetings were held quarterly.**
- **Introduction of Magnesium Sulphate benefited Pregnancy Induced Hypertension mothers.**
- **Backup system for electricity using Invertors was installed in 4 polyclinics and in some clinics to service in the event of ZESA power load shedding.**
- **PMTCT uptake was maintained at 95%.**
- **HIV positivity rate for antenatal mothers remained at 11%.**
- **Cervical cancer screening services available in the City and have proved to be beneficial to women of child bearing age were screened using Visual Inspection with Acetic Acid (VIAC) treated and referred to Hospital.**

Primary Care Clinics

- **TB treatment initiation in all clinics and ART drugs available since August 2012.**
- **Initiation of intermittent presumptive treatment of INH to HIV positive patients.**
- **Installation of TB sheds in the clinics.**
- **Primary Care Counsellors were seconded to clinics by the Ministry of Health and Child Welfare.**
- **Burglar bars in the clinics have improved security of drugs.**
- **New furniture for those clinics in need was supplied.**
- **Decentralization of OI/ART and TB services in the polyclinics and availability of drugs improved services to the patient.**
- **Cholera and typhoid cases identified and managed promptly.**
- **Construction of patient's toilets at Rujeko Clinic and Budiriro completed.**
- **Microscopists for Polyclinic Laboratories were deployed and started tuberculosis diagnosis on site.**
- **Exit interview for the districts were informative.**

Family Health Services

- **Attained high coverages in all EPI antigens**
- **Held one week African Child Immunisation in June 2012.**
- **Successful launch of PCV 13 and the new child health card on 26 July 2012.**
- **Secure remains the highest preferred method of family planning.**
- **School health services in all high density schools and institutional visits/inspections done in spite of no locomotion allowances for Community Sisters who use their own cars.**
- **EPI outreach services were conducted in the surrounding peri-urban areas**
- **Community based Management of Acute Malnutrition (CMAM) and SPLASH programmes going on well.**

Challenges

- **Unreliable ambulance services especially for maternity units.**
- **Frequent power outages for long periods of more man hours 8 hours affecting vaccine potency.**
- **Crowded working environment due to too many programmes in clinics compromising privacy of patients/clients.**
- **Monitoring and Evaluation paper based resulting in heavy workload for nurses.**
- **Communication problems due to constant breakdown of landline phones in clinics with no cell phones.**
- **Shortage of space for storing drugs in smaller clinics that are now issuing ARVs.**
- **Erratic supplies of Niverapine, Streptomycin and MDR drugs.**
- **Lack of transport for community visits and supervision by Senior Nursing Officers as no locomotion was paid for their own vehicles.**
- **Shortage of midwives resulting in permanent midwives frequently working night duty and causing burnout.**
- **Doctor coverage was only at Polyclinics but was erratic.**
- **Erratic water supply in clinics and constant breakdown of boreholes.**
- **Competing programmes such as PMTCT, OI/ART/TB, EPI, and Reproductive Health such as VIAC resulting in shortage of permanent staff and causing burnout.**
- **Male involvement in PMTCT programme was low.**

Way forward

- **To maintain all EPI antigen coverages above 90%.**
- **To intensify AFP, measles, neonatal tetanus surveillance.**
- **To increase PMTCT and neonatal HIV testing to 100%.**
- **To carry out a research on Customer Care and to conduct exit interviews.**
- **Need a digital X-ray machine.**
- **A shelter for food handlers at MEC.**
- **Regular transport for EPI outreach to be provided.**
- **Continue on job training in EPI, PMTCT, helping babies breathe.**
- **Needs ambulance per district to strengthen the referral system.**
- **There is need for male involvement in PMTCT programmes**
- **One clinic to have at least 2 tanks of water to alleviate water shortage.**
- **Needs computerisation of all units to alleviate staff from the increased workload.**
- **Continue strengthening the activities through monitoring and evaluation using check list, policies and Standard Operating Procedures.**
- **PMTCT counselling and testing to be maintained at 100%.**
- **Sisters in Charge to be trained in Rapid Testing of HIV.**

CHAPTER V

NUTRITION

- **Nutrition Unit**
- **Assessment of Nutritional Status**
- **Community Based Management of Acute Malnutrition (CMAM)**
- **Sustainable Programme for Livelihoods and Solutions for Hunger (SPLASH)**
- **Kwashiorkor and Pellagra**
- **Vitamin A supplementation**
- **Dietetic Services**
- **Low birth weight**
- **Nutrition Surveillance Through Growth Monitoring**
- **Baby Friendly Hospital/Health Centre Initiative**
- **Community Infant and young Child Feeding Counselling Course**
- **World Breastfeeding Week**

INTRODUCTION

The theme for the Nutrition Unit has over the years remained that of maintaining "Nutrition security". Nutrition security for all conveys nutrition well-being for everyone and gives a sense of sustainability by ensuring adequate intake and utilization of nutritious and safe food to meet dietary requirements.

The overall goal of the nutrition unit remains that of improving the nutritional status of people of the City of Harare. The unit's aims were to: -

- **prevent malnutrition and nutritionally associated illnesses**
- **prevent micronutrient deficiencies**
- **provide the needy and vulnerable groups with appropriate supplementary feeding.**
- **coordinate therapeutic feeding programmes for malnourished children**
- **promote, protect and support breastfeeding**
- **provide our clients with relevant nutrition education information to be able to make informed choices.**

The data on nutritional status continued to yield very useful information, which the department uses for planning and programming purposes.

- **Chronic malnutrition or stunting decreased during the year for both boys and girls, while wasting and underweight increased.**
- **Over one million children attended growth monitoring sessions in 2012.**
- **The number of pellagra cases increased significantly during the year.**
- **The prevalence of LBW decreased from 7.1% in 2011 to 6.7% during the year under review.**
- **The number of children who were recruited to the CMAM Programme decreased to 412in 2012 as compared to 645 in 2011.**
- **By the end of the year over two thousand people had benefited from the SPLASH programme.**

- **2012 Breastfeeding week theme was "Understanding the Past, Planning the Future: Celebrating 10 Years of Global Strategy for Infant and Young Child Feeding". The national event was commemorated in Mubaira, Mhondoro in Mashonaland West province.**
- **The National Micronutrient Survey was conducted in November 2012. Data was collected in selected enumeration areas in Harare for children under five years, children 5-12 years and women of childbearing age.**
- **The child health card was revised in 2012 and a new card is in circulation; blue for boys and pink for girls.**

The nutrition unit conducted several workshops and trained health workers in relevant nutrition topics and continued to update other health personnel on current issues relating to nutrition.

ASSESSMENT OF NUTRITIONAL STATUS

Yearly the nutritional well being of individuals continues to be a key objective in human development and remained at the helm of our development strategies, plans and priorities. Nutritional status was assessed for grade one pupils in schools in high density suburbs in Harare.

SAMPLE

The nutritional status of those pupils present on the day of surveillance was assessed. Grade 1 data was collected during the first term of 2012. Weights and heights of 14 868 pupils from 80 high-density schools in the City of Harare (Table 1) were measured during 2012.

Of these, 51.3% were males and 48.7% females with ages ranging from 5 years to 8 years. Pupils whose dates of birth were missing were only assessed on the weight-for-height index but excluded from both the height-for-age and weight-for-age indicators.

The number of pupils with dates of birth missing increased during the year with 273 male and 206 female grade 1 pupils having missing dates of birth in 2012.

Pupils whose heights exceeded 145 cm for the boys and 137 cm for the girls were excluded from the weight-for-height index. Most grades 1 were within the expected range.

Table 5.1: Distribution of Primary Schools where Assessment of Nutritional Status was carried out by Area, and Pupils Assessed in 2012

Area	No. of Schools	No. Of Pupils
Budiriro	5	1 219
Dzivarasekwa	7	1 546
Glen Norah	8	1 625
Glen View	10	2 289
Hatcliffe	*	*
Highfield	11	1 916
Kambuzuma	5	745
Kuwadzana	*	*
Mabvuku	4	803
Mbare	8	1 195
Mufakose	10	1 550
Southerton & Lochinvar	2	373
Sunningdale	2	328
Tafara	*	*
Warren Park	8	1 278

*Indicates missing data

Indicators of nutritional status based on the age, sex, weight and height of the children were used to analyse data. Three indicators were derived: stunting (low height for age), wasting (low weight for height) and underweight (low weight for age).

Stunting: (HFA<-2SD) or (Low Height-for-age)

Stunting among school going children reflects the levels of chronic under nutrition in a community. Table 5.2 gives the overall prevalence of stunting using <-2SD (HFA) as a cut-off-point for all children assessed.

Table 5.2: Prevalence of Stunting and Wasting using <- 2SD as cut- off-points for all pupils assessed

	Males	Females	Total
	%	%	%
Height-for-Age	8.7	5.1	6.9
Weight-for-Height	4.5	3.8	4.2
Weight-for-Age	7.7	4.0	5.9

Of the 14 868 grade 1 pupils assessed on the HFA indicator during 2012, 6.9% were stunted with the boys (8.7%) worse off than the girls (5.1%), Table 5.2.

Table 5.3 gives the prevalence of stunting for the whole city for the grade one pupils by area. There was a decrease of stunting in Harare amongst pupils at entry point (grade 1) for the year 2012 compared to 2011.

Table 5.3: Prevalence of Stunting (Height-For-Age <- 2SD) by Sex, Area, Grade 1 2012

AREA	GRADE 1	
	Male	Female
Height-for-age		
Budiriro	9.3	3.0
Dzivaresekwa	10.0	5.9
Glen Norah	7.7	7.7
Glen View	7.9	3.1
Hatcliffe	*	*
Highfield	7.5	5.0
Kambuzuma	8.5	2.9
Kuwadzana	*	*
Mabvuku	10.2	7.1
Mbare	11.7	7.3
Mufakose	9.6	5.1
Southerton & Lochnivar	0.5	0.4
Sunningdale	13.0	17.7
Tafara	*	*
Warren Park	6.6	3.7

*** Indicates missing data**

WASTING: (WFH <- 2SD) or (Low Weight-For-Height)

Wasting amongst primary school children reflects the level of acute under nutrition in a community. A total of 14 805 grade 1 pupils were assessed on the weight-for-height index. The prevalence of acute malnutrition was 4.2% with the boys (4.5%) worse off than the girls (3.8%). Overall there were no areas with more than 1 in 10 children wasted.

Table 5.4: Prevalence of Wasting (Weight-For-Height <- 2SD) by Sex, Area Grade 1: 2012

Area	Grade 1	
	Male	Female
Weight-For-Height	%	%
Budiriro	1.0	1.5
Dzivarasekwa	3.0	3.3
Glen Norah	8.8	2.0
Glen View	4.1	4.3
Hatcliffe	*	*
Highfield	5.8	7.1
Kambuzuma	2.0	2.6
Kuwadzana	*	*
Mabvuku	8.0	5.4
Mbare	1.1	1.0
Mufakose	3.3	2.8
Southerton & Lochinvar	0.8	0.6
Sunningdale	8.9	0.6
Tafara	*	*
Warren Park	5.0	6.8

Fig I: Stunting for Grade 1 Pupils in Harare
% Height for Age <-2SD by Sex

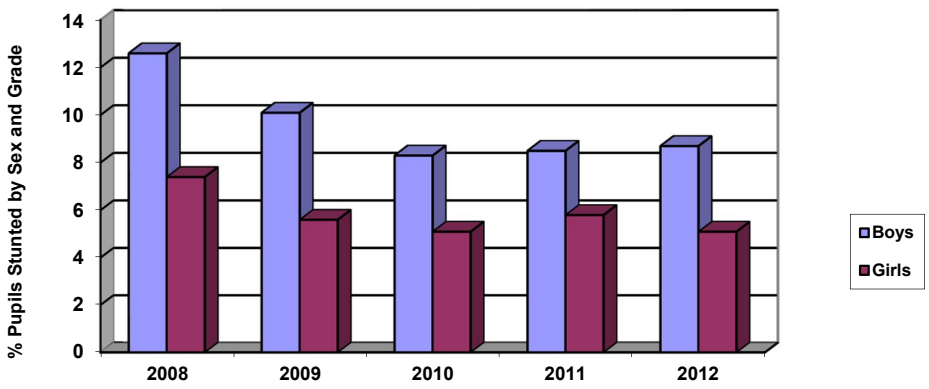
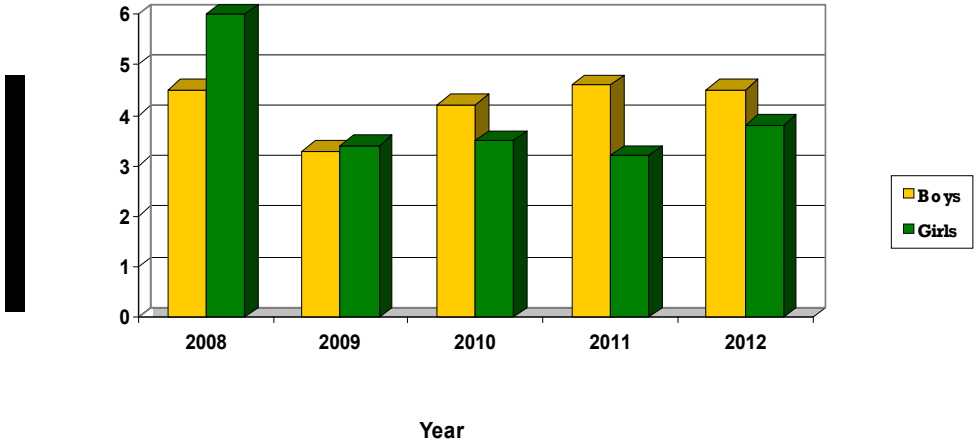


Fig V: Wasting for Grade 1 Pupils in Harare
% Weight for Height <-2SD



Figures I and II illustrate the trends in the prevalence of stunting and wasting respectively in Harare for both boys and girls between 2008 and 2012. Stunting increased slightly for boys and decreased for girls in 2012while wasting increased for girls and remained unchanged for boys.

Discussion

- **Chronic malnutrition decreased during the year.**
- **Acute malnutrition or wasting and underweight increased in 2012.**
- **Similar to previous years the boys were as a whole worse off than girls on all indicators.**
- **Distinct area differences remained quite apparent, with the levels of malnutrition in Mbare being significantly high.**

NUTRITION REHABILITATION

Severe Cases of Malnutrition

Severe cases of kwashiorkor continued to be managed at Harare and Parirenyatwa Hospitals before being discharged back to our clinics for follow up care.

COMMUNITY BASED MANAGEMENT OF ACUTE MALNUTRITION

The Community-based Management of Acute Malnutrition (CMAM) programme is operational in ten clinics in the city of Harare. The programme was introduced to try and address the growing numbers of malnourished children before they deteriorated to full blown kwashiorkor.

The aims of the CMAM programme are:

- **To decentralise treatment of malnourished children,**
- **To provide a revised screening and admission criteria (based on new classification of acute malnutrition) using the mid –upper- arm- circumference (MUAC).**
- **To make sure that hospitalisation was only for children with medical complications requiring stabilisation.**

Commodities used in the CMAM:

The ready to use food (RUTF) in the form of plumpy nut is used in this programme. RUTF invented in the 1990s is a peanut butter based food specifically designed to treat severe malnutrition without complications. It is an oil –based food containing little water (making it microbiologically safe), which can be kept for several months in simple packaging and can be eaten raw. It contains most important micronutrients and comes in 92grams sachets.

Areas of operation:

The programme is operational at a clinic in each of the 8 districts as highlighted below:-

- **Southern District** **Mbare Poly and Hopley Clinics**
- **Northern District** **Hatcliffe Poly Clinic**
- **North Western District** **Dzivarasekwa Poly Clinic**
- **Eastern District** **Mabvuku Satellite Clinic**
- **South Eastern District** **Hatfield Clinic**
- **West South West** **Mufakose FHS Clinic**
- **South Western** **Rutsanana and Highfield Poly Clinics**
- **Western District** **Kambuzuma Poly Clinic**

Table 5.6: No of children recruited to the CMAM by Month 2012

Clinic	Total admitted	No discharged	No. in programme By Month end
January	39	108	189
February	33	39	183
March	42	45	180
April	27	35	172
May	37	36	173
June	16	33	156
July	44	35	165
August	36	46	155
September	28	32	151
October	44	40	155
November	54	21	188
December	12	5	195
Total	412	475	

By the end of December 2012, 412 severely malnourished children with good appetite but no medical complications had been recruited on the programme. This is a 36% decrease compared to 2011. Of the discharged cases the cure rate was 42.9%, death rate 0.4% and defaulter rate of 55.6%. The high defaulter rate could be attributed to the highly mobile nature of Harare's population. Most of the recruited children do not complete treatment, hence the high defaulter rate.

The SPLASH Programme

Sustainable Programme for Livelihoods and Solutions for Hunger (SPLASH) is a WFP initiative to provide food support to the needy in the urban safety net programme.

Beneficiary targeting and registration

- **The programme drew its beneficiaries from the Health based safety net programme i.e. Nutrition support for HIV and TB treatment, ART, and mothers and children (MCH).**
- **Targeting of patients was done jointly by the health institution and the implementing partner ADRA Zimbabwe.**
- **The number of clinics implementing the programme increased to six in 2012. These are Dzivarasekwa, Highfield, Rutsanana, Hatcliffe Poly clinics, Tafara FHS clinic and Beatrice Road Hospital. Patients recruited from Wilkins Hospital were referred to Parirenyatwa OI clinic.**

Selection Criteria

- **ART, PRE-ART and TB patients**

  Patients with a Body Mass Index (BMI) below 18.5 or
  A Patient showing signs of excessive weight loss (weight loss of more than 10% body weight between 2 consecutive monthly weighing)

- **MCH**

  Pregnant women with a Mid Upper Arm Circumference (MUAC) below 23cm, Children with Mid Upper Arm circumference less than 12.5cm qualifies the patient to be referred for supplementary food support.

  Benefits:

  Patients meeting criteria were provided with Corn Soya Blend Porridge (CSB). Subsequently, their households were screened based on food security indicators, and those deemed to be food insecure were enrolled into the programme for a household food basket.

Household food basket

- **Patients received 10kg CSB for nutrition rehabilitation and their households if food insecure also received a food voucher which enabled them to collect 5kg mealie meal, 1kg beans, 750mls vegetable oil per person per month from designated retailers. Up to 5 members of the household could be supported with a food basket.**

Discharge Criteria

- **Patients were discharged from the programme after 6months or having a BMI above 18.5 for 2 consecutive months**
- **Pregnant women were supported from 3months of pregnancy up to delivery, thereafter if the mother decides to breastfeed support is continued for 6 months.**

Table 5.6: Number of SPLASH beneficiaries by programme category 2012

PROGRAMME CATEGORY	NUMBER OF BENEFICIARIES		
	Males	Females	Total
Pre-ART	30	48	78
ART	147	241	388
TB	148	126	274
MCH-Mothers	0	701	701
MCH-Children 0-59months	316	529	845
TOTAL	641	1 645	2 286

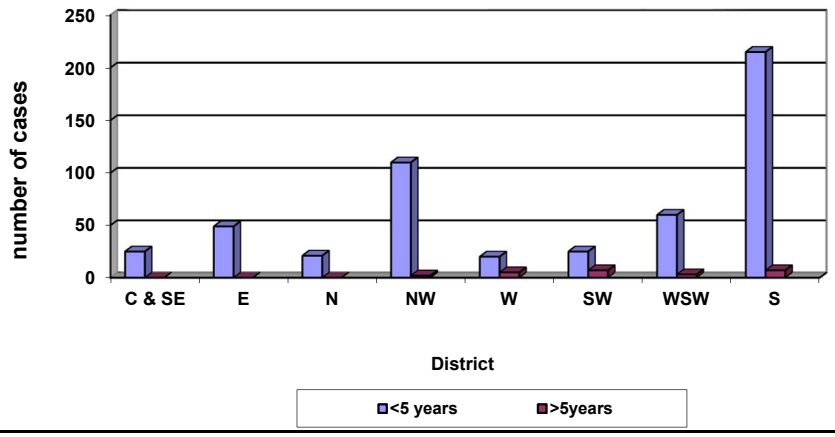
By the end of December 2012 over two thousand people had benefited from the programme. The programme is also set to include livelihood activities as a way of providing a comprehensive rehabilitation package that removes dependency and manages and/or minimizes chances of relapse into malnutrition.

Kwashiorkor Cases

There was a 9% increase in the number of Kwashiorkor cases in 2012. In total 549 cases of kwashiorkor were seen at our clinics throughout the year, the majority (95.6%) of whom were under fives, and 4.4% above the age of five. The distribution of these cases by district is shown in Figure III.

The majority (40%) of these cases were from the Southern District. Similar to previous years, severe cases of kwashiorkor were sent to Harare and Parirenyatwa Central Hospitals for stabilization before they were discharged back to our clinics for CMAM programme.

Fig III: No. of Kwashiokor Cases by Age and District 2012

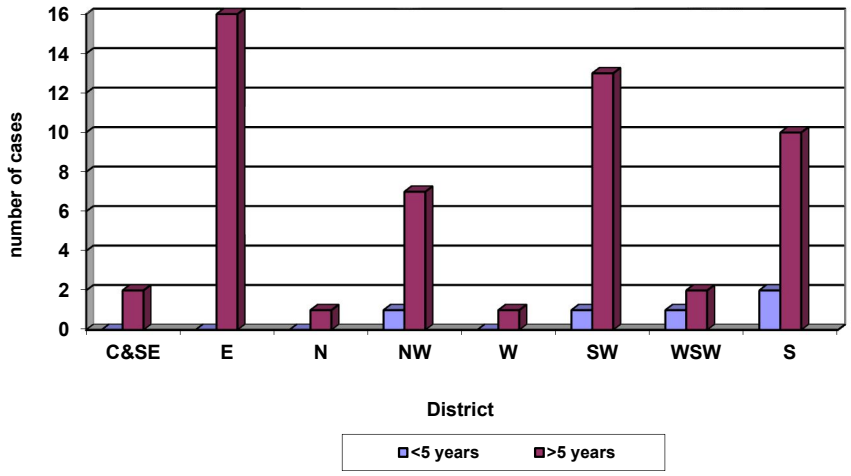


Pellagra Cases

There was a notable increase in the number of Pellagra cases seen, from 19 in 2011 to 56 in 2012. Most (94.6%) of these cases were over the age of 5, with only 3 cases below the age of five.

Figure VII illustrates districts where these cases were reported from. 28.6% of these cases were from the Eastern District, followed by the South Western district with 23.2% and Southern district with 21.4%.

Fig IV : No. of Pellagra Cases by Age and District



VITAMIN A SUPPLEMENTATION

Vitamin A or retinal is an essential micronutrient for humans that the body cannot produce. It is a fat-soluble vitamin that is stored in the liver and helps with growth and development, protects the body against infections and reinforces the body's immunity. Vitamin A is necessary for the maintenance and reconstitution of certain tissues such as:

- **The conjunctiva, the cornea and certain retinal tissues of the eye**
- **The mucous membrane of the gastro-intestinal tract**
- **The lining of the bronchioles in the lungs**

Strategies for the control of Vitamin A Deficiency include:

- **Promotion of the production of Vitamin A rich foods**
- **Promotion of breastfeeding**
- **Nutrition education on the consumption of vitamin A rich foods**
- **Food fortification with Vitamin A and**
- **Supplementation with vitamin A capsules**

Following the micronutrient survey, Vitamin A supplementation was embarked upon as a national strategy in 2003.

Supplementation

Nationally, all children (0 to 59 months) and lactating women (soon after delivery) were targeted for supplementation during 2012. The children were supplemented at 6 months intervals.

Dosage:

Infants	**6 to 11 months**	**100 000 IU orally every 6 months**
Children	**12 to 59 months**	**200 000 IU orally every 6 months**
Mothers	**post partum – lactating**	**200 000 IU orally once soon after delivery**

The City Health Department continued to offer Vitamin A supplementation throughout the year. Routine supplementation was strengthened in all clinics.

Table 5.7 gives percentage coverage of vitamin A given to children 6-59 months during2012.

Table 5.7: Percentage coverage of vitamin A given to children 6-59 months during 2012

	Under 1 year	1 year and older
January- June	82.2%	89.4%
July- December	42.8%	11.3%

Vitamin A coverage was above the national target of 80% for the first dose administered between January and June for the two age groups. This is because Vitamin A supplementation was combined with polio and measles national immunisation days in June.

However coverage through routine and outreach health services was low: 42.8% for children under one year and 11.3% for children one year and older.

Table 5.8: Number of newly- Delivered- Mothers given Vitamin A (200 000 units) by Maternity Units and Month

AREA	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Budiriro	250	218	195	0	231	243	230	188	214	202	202	207	2 380
Edith Opperman	401	434	506	535	451	293	461	492	515	426	466	433	5 413
Glen View	149	163	175	156	179	162	133	162	178	139	162	175	1 933
Hatcliffe	136	154	155	148	147	156	137	124	132	130	127	129	1 675
Highfield	130	130	124	118	125	131	110	100	138	127	144	109	1 486
Kambuzuma	50	70	87	75	65	56	77	94	67	67	59	68	835
Kuwadzana	212	265	239	277	244	272	211	250	240	222	223	243	2 898
Mabvuku	237	273	330	317	325	285	295	287	281	304	260	282	3 476
Mufakose	94	72	94	94	69	98	77	100	115	83	96	91	1 083
Rujeko	202	200	196	238	227	210	190	192	221	181	246	235	2 538
Rutsanana	207	254	254	254	230	243	280	248	254	267	240	223	2 954
Warren Park	144	172	143	143	108	174	141	143	140	144	147	137	1 736
Total	2 212	2 405	2 498	2 355	2 401	2 323	2 342	2 380	2 495	2 292	2 372	2 332	28 407

There was a 5.7% decrease in the number of mothers given vitamin A supplementation. Twenty-eight thousand four hundred and seven (28 407) mothers were each given Vitamin A supplementation before discharge, and those who delivered at home or elsewhere but presented themselves at our clinics within the first 4 weeks of delivery were also offered and given vitamin A.

DIETETIC SERVICES

Beatrice Road and Wilkins Hospitals

Closer liaison was maintained between the nutrition unit and the Hospital food Services Supervisors of Wilkins and Beatrice Road Hospital kitchens. Several meetings were held with senior kitchen staff and several improvements were noticed in the catering for patients. Meal times and the provision of snacks, which used to cause some problems, were adjusted so as to reduce the long gap that existed for patients without meals. The two hospitals continued to plate individual meals for the patients, and were also implementing the National Hospital Food Services Guidelines.

LOW BIRTH WEIGHT (BIRTH WEIGHT BELOW 2.5 KG)

The overall prevalence of Low Birth Weight (LBW) in 2012 amongst babies delivered or attended to soon after delivery, at the City of Harare's 12 Maternity Clinics decreased from 7.1% in 2011 to 6.7% in 2012. Table 5.9 shows prevalence of low birth weight for maternity clinics in 2012.

Table 5.9: Prevalence of low birth weight (birth weight below 2.5 kg) by maternity clinic and month in 2012

Area	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Budiriro	4.1	2.8	5.4	7.0	6.0	4.5	5.5	3.8	6.8	1.5	4.0	6.1	4.8
Edith Opperman	4.2	6.0	7.4	7.8	8.0	6.0	2.5	4.9	7.1	5.1	5.8	7.4	6.0
Glen View	.4	2.4	3.6	4.7	2.9	12.4	3.9	1.3	2.3	3.8	2.5	4.7	4.2
Hatcliffe	3.2	3.5	6.7	6.9	5.8	7.4	6.7	10.9	8.3	7.3	4.0	8.4	6.6
Highfield	8.5	9.5	4.0	7.0	3.4	4.0	0	1.1	0	9.9	8.7	0.9	4.0
Kambuzuma	12.2	8.8	9.4	6.9	0.0	7.8	4.0	5.4	10.8	10.9	5.3	8.1	7.5
Kuwadzana	14.9	8.5	6.8	10.5	9.8	3.9	15.0	13.2	7.6	10.6	8.9	10.0	10.0
Mabvuku	11.3	8.4	8.3	8.3	11.2	6.3	5.9	2.3	5.1	8.2	7.1	8.6	7.6
Mufakose	16.3	10.0	7.1	13.5	8.8	13.8	10.4	12.4	8.8	12.5	3.3	15.4	11.0
Rujeko	2.5	9.0	2.7	6.1	6.7	5.4	8.7	4.0	9.5	6.0	4.2	9.4	5.6
Rutsanana	4.6	11.8	7.1	4.9	10.0	3.8	6.3	8.9	12.1	8.2	9.6	11.8	8.3
Warren Park	6.2	0	2.1	11.7	5.4	5.7	7.1	3.0	7.0	1.4	10.3	3.6	5.3
Total	6.9	6.6	6.2	7.8	6.8	6.1	6.1	6.1	7.1	6.5	6.3	7.9	6.7

Table 5.9 shows the prevalence of low birth weight by maternity centre for the year 2012. More than 1 in 10 babies delivered at Mufakose maternity for eight months of the year were LBW. More than 1 in 10 babies delivered at Kuwadzana for 6 months of the year were LBW, while Rutsanana had more than 1 in 10 babies who were LBW for more than four months of the year. Budiriro, Edith Opperman, Glen View and Highfield recorded low prevalences of LBW throughout the year with rates not exceeding 10% during any of the months.

Of all the babies delivered or attended to soon after delivery at our maternity units, 6.5% of them (1 799) were Born Before Arrival (BBA), with 16.1% (290) of them being LBW. Of the 769 babies delivered at our maternity units prematurely (born before 37 weeks gestation) 74.9% of them were LBW, and 989(3.6%) were small for gestational age, or small for dates, indicating growth retardation during pregnancy, which could be associated with poor nutritional status during pregnancy.

NUTRITION SURVEILLANCE THROUGH GROWTH MONITORING:

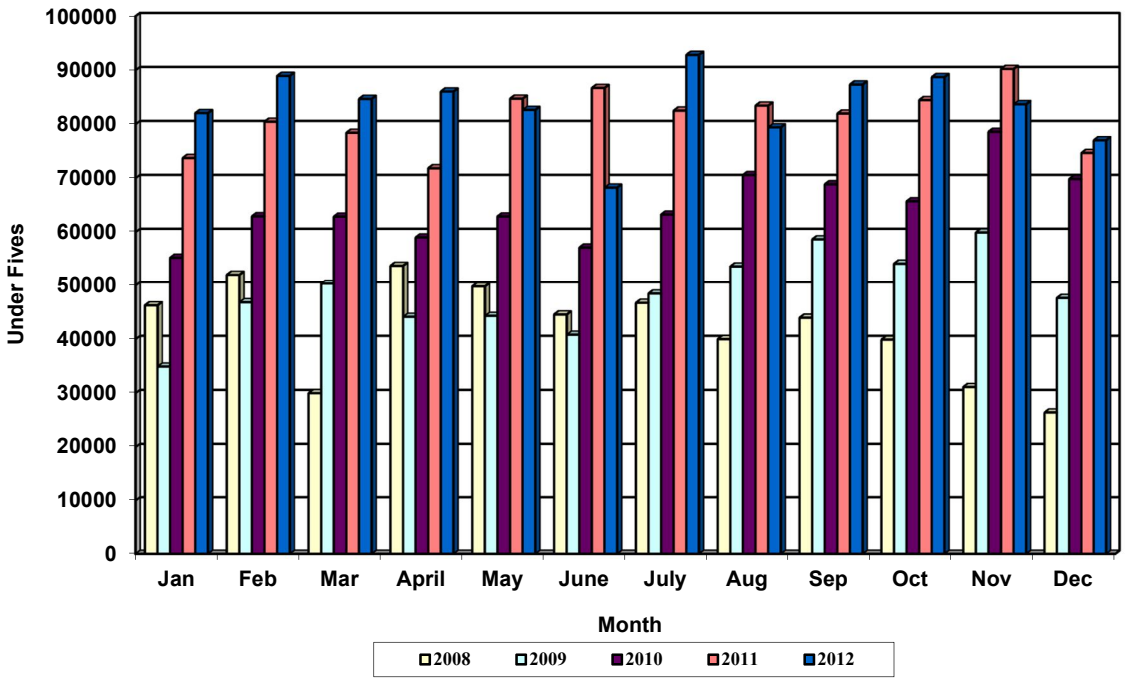
Table 5.10 shows nutrition surveillance figures for the year 2012. Over one million children attended growth monitoring sessions throughout the city. There was a 2.9% increase in attendance for growth monitoring in 2012 compared to 2011. Overall 10.1% were found to be nutritionally at risk, with 6.4% losing weight and 3.7% static weight.

Table 5.10: Nutrition Surveillance by Age Group 2012

		0-5 Months	6-11 Months	12-23 Months	24-59 Months	Total
New attendances	No.	43 998	3 850	7 588	16 016	71 452
Re-attendances	No.	223 170	228 523	262 900	215 642	930 235
Total (new + repeats)		267 168	232 373	270 488	231 658	1 001 687
Gaining Weight	No.	219 269	207 830	222 534	186 727	836 360
	%	98.3	90.9	84.6	86.6	89.9
Static	No.	2 068	8 795	14 330	9 673	34 866
	%	0.9	3.8	5.5	4.5	3.7
Losing Weight	No.	1 901	11 723	26 342	19 560	59 526
	%	0.9	5.1	10.0	9.1	6.4
Above the line	No.	264 554	229 213	264 833	227 790	986 390
	%	99.0	98.6	97.9	98.3	98.5
Below the line	No.	4 358	4 702	9 742	6 528	25 330
	%	1.6	2.0	3.6	2.8	2.5
Born below 2.5 kg	No.	2 915	1 657	1 918	1 273	7 763
	%	1.1	0.7	0.7	0.5	0.8
Attending Nutrition Sessions	No.	1 707	6 877	12 933	9 026	30 543
	%	0.8	3.0	4.9	4.2	3.3

Figure VI graphically shows monthly attendances for growth monitoring for the past five years. As with previous years, the number of children attending growth monitoring continues to increase.

Fig VI : Growth Monitoring by Month Total Attendance



REVISED CHILD HEALTH CARD

The child health card was revised in 2012 and a new card is in circulation. New child growth charts were introduced following World Health Organization recommendations for countries to adopt child growth standards developed using data from a longitudinal study of breast-fed babies from six countries representing six different continents; Brazil, Ghana, India, Norway, Oman and the United States of America (an internationally representative sample). There are now different growth curves for boys and girls with the boys having a blue card and girls a pink card. This is because girls and boys grow at different paces, and hence should have their growth assessed using growth charts specific to them.

The height for age chart was introduced in addition to weight for age chart previously used in the old card. Measuring height monthly will allow early detection of stunting in children. Stunted children are shorter compared to their age counterparts due to prolonged under nutrition or repeated illness.

The standards establish breast-fed infants as the model for normal growth and development. As a result, health policies and public support for breast-feeding will be strengthened.

Advantages of the new standards

- **More sensitive to detect children at high risk of death, particularly in the younger age group**
- **More children in need of treatment will be diagnosed**
- **Should lower the mortality from severe malnutrition**
- **Identifies the different risk by gender with single sex tables**
- **Contribute further to reaching MDGs 1 and 4**

All children who visit the clinic for growth monitoring are now required to have their heights and weights measured and growth assessed using the weight for age and height for age indicators.

COMMUNITY INFANT FEEDING AND YOUNG CHILD FEEDING COUNSELLING COURSE

The community infant and young child feeding course is a training course designed to equip community health workers and primary health care staff to support mothers, fathers and other caregivers to optimally feed their infants and young children. The training package is intended to equip community-based health workers with technical knowledge on the recommended breastfeeding and complementary feeding practices for children from 0 up to 24 months. In addition, the course enhances their counselling, problem solving and negotiation skills which they can employ when counselling caregivers.

The objectives of the course are

- **To train community health workers on breastfeeding counselling.**
- **To train community health workers on HIV and infant feeding counselling.**

  - **A total of 232 health promoters were trained in the course in July 2012. Training community workers is an intervention aimed at improving survival, growth and development of children by improving infant and young child feeding (IYCF) practices at community level.**

WORLD BREASTFEEDING WEEK (1 – 7 AUGUST 2012)

2012 Breastfeeding week theme was "Understanding the Past, Planning the Future: Celebrating 10 Years of Global Strategy for Infant and Young Child Feeding". The theme drew attention to lessons learnt and the achievements over the past 20 years on infant and young child feeding (IYCF), and is a call to action to bridge existing gaps in policies and programs supporting breastfeeding and IYCF.

Annually the World Alliance for Breastfeeding Action (WABA) organizes the World Breastfeeding Week (WBW) as part of its global mobilization strategy to increase public awareness on the importance of breastfeeding. From August 1–7 each year, communities around the world campaign for the revival and maintenance of a culture of natural breastfeeding worldwide

Mashonaland West had the honour of hosting the national event which was launched in Mubaira in Mhondoro district. The Deputy Minister of Health and Child Welfare Dr. Douglas Mombeshora graced the occasion by giving the keynote address.

NEEDY AND ORPHANED CHILDREN

Similar to previous years, many orphaned babies and triplets presented at our clinics and were screened, but the department was only able to assist a few due to shortage of resources. The majority of these cases continue to come from very disadvantaged and destitute families. Although assistance was sought for such children, the numbers were becoming too high and most of them were referred to social services for assistance, which was never forthcoming. The number of orphaned children continues to increase throughout the City, most of which is due to the HIV/AIDS pandemic.

CONCLUSION

Yearly the nutritional status data continues to yield invaluable information, which was used for nutrition planning and intervention purposes.

- **Chronic malnutrition or stunting decreased during the year for both boys and girls, while wasting and underweight increased.**
- **Over one million children attended growth monitoring sessions in 2012.**
- **The number of pellagra cases increased significantly during the year.**
- **The prevalence of LBW decreased from 7.1% in 2011 to 6.7% during the year under review.**
- **The number of children who were recruited to the CMAM Programme decreased to 412in 2012 as compared to 645 in 2011.**
- **By the end of the year over two thousand people had benefited from the SPLASH programme.**
- **2012 Breastfeeding week theme was "Understanding the Past, Planning the Future: Celebrating 10 Years of Global Strategy for Infant and Young Child Feeding". The national event was commemorated in Mubaira, Mhondoro in Mashonaland West province.**
- **The National Micronutrient Survey was conducted in November 2012. Data was collected in selected enumeration areas in Harare for children under five years, children 5-12 years and women of childbearing age.**
- **The child health card was revised in 2012 and a new card is in circulation; blue for boys and pink for girls.**

Nutrition education remained at the centre of all nutrition unit's activities during the year. Special emphasis was placed on making communities cope with all nutritional problems by using the available resources. Special emphasis was paid to counselling especially mothers with breastfeeding problems, on infant feeding choices and to mothers of babies who failed to thrive. Nutritional support was provided for malnourished ART and TB patients and mothers and children. The nutrition unit would like to thank all the other units for working well with us throughout the year. Our gratitude also goes to our students from the Institute of Food and Nutrition, at the UZ who assisted the unit with data analysis, and the Director of Health Services, for the constant support and encouragement in executing nutrition programs in the city.

CHAPTER VI

HEALTH EDUCATION

INTRODUCTION

The overall goal of the health education section for the year 2012 was "to facilitate increased social and community participation in health". This was contextualized through disease prevention, promotion of well being, reduction of risk factors associated with specific diseases, fostering positive lifestyles, creating conditions conducive to health and promoting increased use of available health services. The Primary health care approach remains the pillar of activities i.e. addressing priority health issues, equity and emphasizing health education and disease prevention so as to contribute towards the overall reduction in morbidity and mortality.

The section assumed that the outcomes of health promotion will be realized through:

- **Increased social and community participation in health.**
- **Promotion of wellbeing.**
- **Reduction of risk factors associated with specific diseases.**
- **Increasing client demand of available health care services.**
- **Supportive health public policies.**
- **Health education for individual behavioural lifestyles and**
- **Promotion of community action as part of creating an enabling environment for health development.**

The section lost 4 health promoters in the course of the year 2012. The staff situation in the section remains critical as Health promotion Officer Posts are yet to be filled. The current staff establishment is as follows:-

TABLE 6.1: HEALTH PROMOTION STAFF ESTABLISHMENT AS OF 31.12.2012

POSITION	IN-POST	ESTABLISHMENT	VARIANCE
Chief Health Promotion Officer	1	0	0
Senior Health Promotion Officer	1	0	0
District Health Promotion Officers	0	8	8
Graphic Artists	1	2	1

Operational key areas emphasized during the year were:-

- **Increasing people's awareness on health issues (health literacy).**
- **Working with community structures to prevent outbreaks.**
- **Development and implementation of reproductive health and health well being program.**
- **Provision of comprehensive information to parents, guardians and child focused service providers on child health.**
- **I.E.C. material development in line with target needs and health focused exhibitions.**
- **Coordination of health promotion activities within Harare.**
- **Managing and supervising the health promoter program.**

- **Monitoring and evaluating health educational and promotional activities and strategies.**
- **Coordinating partner activities in health promotional activities.**
- **Exhibitions and publicity.**

Topic Guide for 2012

A community health education topic guide was developed and distributed throughout greater Harare. This guide is used by Health Promoters and community sisters to deliver health education in the community and at the clinics

Table 6.2: SCHEDULE OF HEALTH EDUCATION TOPICS FOR THE YEAR 2012

MONTH	TOPICS
January	▪ Control of diarrhoeal diseases ▪ School lunch box promotion ▪ Bilharzia ▪ Mushroom poisoning ▪ Importance of early booking (maternity) ▪ PMTCT (MER) ▪ Post Natal Care ▪ 31 January- World Leprosy Day
February	▪ Control of diarrhoeal diseases ▪ Sexually Transmitted Infections ▪ OI/ ART and drug adherence ▪ Malaria
March	▪ HIV and AIDS ▪ 13 March- World Kidney Day ▪ Trade fair ▪ Tuberculosis ▪ 24 March- World TB Day ▪ Skin Conditions ▪ VCT
April	▪ 7 April- World Health Day ▪ Child Abuse ▪ Depression ▪ Stress ▪ EPI Promotions ▪ Hypertension, Diabetes mellitus, Asthma, ▪ 25 April - World Malaria Day ▪ Global Road Safety Week
May	▪ Dog bites ▪ Family Planning ▪ Child Health Days (EPI) ▪ Reproductive Health ▪ ARI/ CDD ▪ Burns ▪ 31 May - World no Tobacco Day

June	▪ **Home Accidents** ▪ **Road Accidents** ▪ **Day of the African Child** ▪ **Child rights and Child Abuse** ▪ **Life skills promotion** ▪ **Career Guidance** ▪ **26 June - Alcohol and Drug Abuse Day**
July	▪ **11 July- World Population Day** ▪ **Nutrition (promotion of locally available foods)** ▪ **Nutrition in pregnancy** ▪ **PMTCT and ANC**
August	▪ **1-7 August- Breastfeeding Week** ▪ **Infant feeding options in PMTCT** ▪ **Dental Health** ▪ **12 August- International Youth Day** ▪ **Home Based Care** ▪ **Nutrition in HIV and AIDS** ▪ **Harare Agricultural Show Week** ▪ **31 August - Traditional Medicine Day**
September	▪ **Refuse disposal** ▪ **Sanitation Week** ▪ **Personal and Environmental Hygiene** ▪ **Menopause** ▪ **Andropause** ▪ **Last week of September - Oral Health week**
October	▪ **Anti-cancer month (Breast cancer, cancer of the cervix)** ▪ **World mental health week** ▪ **Hand washing Day** ▪ **Communication in the home** ▪ **Counselling skills**
November	▪ **Child Health Days** ▪ **14 November - World Diabetes Day** ▪ **Immunizations - 8 killer diseases** ▪ **Adverse Events Following Immunization** ▪ **Gender Based Violence** ▪ **25 November - International Day for the elimination of violence against women**
December	▪ **1 December- World AIDS Day** ▪ **3 December- Day of the disabled** ▪ **STIs, HIV and AIDS** ▪ **Opportunistic Infections** ▪ **Support Groups**

Table 6.3: IEC Material production and distribution in 2012

THEMATIC AREA	PRODUCTION TYPE	QUANTITY
EPI	Calendars	5 000
	Kids T-shirts	100
	Adult T-shirts	100
	Hats	100
	A5 Flyer	100 000
	A2 Posters	52 500
	PVC Banners	100
	Pull up banners	35
	T- shirts	1 650
	Calendars	35 000
	Car stickers	60 000
	Bags	400
Annual HP Conference	PVC Banner	1
	Bags	230

PROMOTION OF CHILD HEALTH AND CHILD RIGHTS

OBJECTIVES

- **Provision of comprehensive information to parents or guardians and health workers on child health.**
- **Community awareness on identifying abused children**
- **Involving partners in EPI activities through advocacy, social mobilization and programme communication.**

ACTIVITIES IMPLEMENTED

The section was involved in the African vaccination week which was done prior to the programme though social mobilization was done. The community sisters and health promoters managed to do a thorough social mobilization programme making sure that each and everyone is informed about the new vaccines, the pnuemococcal and rotavirus vaccines. Area Health Team meetings were also conducted as part of advocacy, whereby community influential leaders were sensitized about the programme. Focus Group Discussions were held mostly with the apostolic groups. The Health Promoters were involved in door to door campaigns. The African vaccination week was commemorated in the week 23 – 28 APRIL 2012 under the theme "AN UNIMMUNIZED CHILD IS ONE TOO MANY: GIVE POLIO THE LAST PUSH"

OBJECTIVE

To conscientise the community about the new vaccines and the need for them to bring out their children for vaccination.

Table 6.4: Number of people reached during the social mobilization programme

DISTRICT	HOUSEHOLDS REACHED	PEOPLE EDUCATED IN HOMES	PEOPLE EDUCATED IN CHURCHES	PEOPLE EDUCATED IN OTHER GATHERINGS
EASTERN	5 914	12 522	4 430	5 574
SOUTHERN	5 793	12 014	13 283	8 508
SE/C	47	3 863	2 536	15
NW	2 150	14 611	5 693	12 498
SW	6 999	22 206	41 282	26 436
WSW	6 346	14 219	6 681	9 495
WESTERN	8 961	24 333	69 735	22 820
NORTHERN	4 834	6 198	1 944	2 461
TOTAL	41 044	109 966	145 584	87 807

A total of 343 357 people were reached through the social mobilization programme

THE NATIONAL IMMUNIZATION DAYS: 22 - 28 June

Health workers and Health Promoters were trained before the programme was implemented. The HPs were involved in a thorough social mobilization campaign, 2 weeks before the vaccinations started.

A total number of people were mobilized for 593 430 NIDs

COVERAGES
Measles: 119%
Polio: 98%
Vitamin A: 94%

The coverages were so high which is a reflection of a successful social mobilization programme.

The section participated in the launch of the NIDSs on the 22nd of June at Meikles Hotel and that of the Revised Child Health Card and Pnuemococcal vaccine on the 29th of June at Rainbow Towers. The section was mostly involved in providing entertainment by the Health Promoters, preschool kids and one of the apostolic church groups.

PREVENTION OF COMMUNICABLE DISEASES

The section implemented a variety of strategies in the fight against Typhoid and other diarrheal diseases. These include: Road shows, IEC material Distribution, Interpersonal communication (IPC) through door to door health education, Drama and Theatre, School Health Promotion, Workplace programmes, Patient Education, Econet SMSs, involvement of Combi Drivers and their assistants.

TYPHOID CAMPAIGN STATISTICS 2012

- **Households reached: 68 188**
- **Number of people educated in homes: 200 964**
- **Number educated in churches: 22 747**
- **Number educated at the clinics: 8 534**
- **Number educated in other gatherings: 7 281**
- **School Health Promotion: 1 428 Teachers and 73 266 school children reached**
- **Number of stakeholders sensitized: 759**
- **Workplace programmes: 500 sensitized**
- **TOTAL EDUCATED: 315 479**

Table 6.5: Road shows done in Community Health Education (coverages)

AREAS VISITED	ATTENDANCE
Lusaka	900
Machipisa	1,500
Gazaland	800
Glen Norah B	500
Glen View 7 Extension	400
Glen View 3	800
New Canaan	100
Engineering	200
Cherima	650
Glen Norah C	700
Glen View 1 - 7	3,000
Glen View 4	1,000
Dzivarasekwa	650
Kuwadzana	1 280
Mabvuku	350
Tafara	150
Mufakose	500
Warren Park	600
Budiriro	930
TOTAL NUMBERS REACHED (APRO.)	15,550

PUBLICITY AND EXHIBITION

HARARE AGRICULTURAL SHOW

The section represented the department at the Agricultural show where the theme for 2012 was: Innovation, Inspirational and Informative.

Materials distributed

- **Calendars: 1 000 (Typhoid)**
- **Fliers: 5 000 (Typhoid)**
- **Posters: 2 000 (Typhoid)**
- **T-shirts: 20**
- **Banners: 4**
- **Car Stickers: 2 000**

Zimbabwe International Trade Fair

THEME: "Investing locally, reaping globally"

MATERIALS DISTRIBUTED

- **500 Calendars**
- **1 000 flyers**
- **8 T-shirts**
- **8 Bags**

Table 6.5: STAFF DEVELOPMENT AND CAPACITY BUILDING SESSIONS.

Workshop	No of Sessions	No of Participants
Mass Drug Treatment for Neglected Tropical diseases 19-25 August (Schistosomiasis and Roundworms): Bulawayo	5	63
PMTCT IMAI: Kadoma	5	35
EPI: Chibhanguza	5	45
DHE Workshop: Mutare	3	45
EPI Review Meeting: Masvingo	5	45
IEC Material development on childhood illnesses: Mutare	3	11
Malaria Case Management: Pumpkin Hotel	4	31
Gender mainstreaming in HIV and AIDS	2	40

HEALTH PROMOTERS' PROGRAMME

Health Promoters programme is the backbone of all health promotion activities in the communities. Harare currently has two hundred and thirty (230) Health Promoters.

Table 6.6: A SUMMARY OF HP ACTIVITIES

CONDITION	DISTRICT								TOTAL
	S	SW	WSW	W	SE/ C	E	N	NW	
Number of unbooked pregnancies	317	352	329	134	52	233	136	200	1 753
Number of teenage pregnancies counselled	410	411	249	138	57	652	153	114	2 184
Number of child abuse problems other than rape	129	33	43	44	0	105	193	50	597
Rape cases	2	6	14	2	0	5	6	5	40
Number of baby dumping cases encountered	8	7	17	4	0	7	3	6	52
Patients referred for initial treatment at clinics and hospitals	543	1 086	401	205	128	402	355	193	3 432
Patients helped at home	954	688	386	215	114	643	460	249	3 709
Patients accompanied to clinics	638	433	188	167	54	84	505	190	2 260
Practical sessions disposal of rubbish	405	283	477	209	56	206	543	17	2 200
First aid cases dealt with TB and other	278	87	164	202	196	45	560	186	1 718
Number of follow up cases (TB, OI/ART)	921	1 917	736	449	267	985	760	328	6 363
Successful motivation for immunisation	1 778	135	1 345	4 628	29	784	8 499	269	17 467
Disabled patients rescued from confinement	169	4	25	5	0	0	213	42	456
Diarrhoeal cases dealt with	1 292	1 915	898	604	19	732	580	169	6 436
ARI cases dealt with	1 550	1 898	517	790	242	965	218	501	6 681
STI cases encountered	8	47	21	4	1	30	1	172	284
Burns	56	114	57	32	33	83	91	82	548
Abortions	19	44	26	4	3	19	8	12	135
Dog bites	6	21	23	9	12	43	69	9	236
Suicide cases	5	11	18	9	0	4	2	2	79
RTA	49	34	27	61	53	34	2	102	296
Number of home based care patients helped	793	131	79	115	152	210	172	136	1 771
Epilepsy cases	128	10	21	10	15	82	133	0	573
Skin conditions	138	146	335	95	148	364	54	187	2 465

Table 6.7: PMTCT/OI/ART ANNUAL STATISTICS

ACTIVITY	PMTCT	OI/ART
No of clients given health education	4 790	2 359
Number referred to clinics	1 790	1 359
Number counselled	2 766	1 484
Number of support groups in the area	78	21
Number referred to support groups	362	459

TOP FIVE HEALTH PROMOTION ACTIVITIES

HIV, AIDS and TUBERCULOSIS

Health promoters are involved in following clients on the ART programme. They also motivate all age groups on HIV testing and counseling giving out IEC materials where necessary. Pregnant mothers are encouraged to book early and join the PMTCT programme. Patients on TB treatment are followed up to monitor drug compliance and nutrition. They are given counseling and health education on relevant topics and IEC materials as well. The Health Promoters were involved in mobilizing men to go for male circumcision, working with PSI.

ACUTE RESPIRATORY INFECTIONS

A number of ARI cases (6 681) were dealt with. Health Promoters were trained on the basic facts about the pandemic influenza. They were involved in educating communities on prevention of ARI. People mostly under fives (U5s) with signs and symptoms were being referred or accompanied to the health facilities.

DIARRHOEAL CASES

Health Promoters were busy educating communities on prevention of diarrheal diseases since the beginning of the year. They were involved in health education, distribution of IEC materials, aqua tablets, rehydration solution and some clean up campaigns. They referred cases to health institutions though a number of communal deaths were reported. Health Promoters were trained to facilitate Community Health Clubs (C.H.C) and this was a success in Dzivarasekwa and Kuwadzana as pilot areas. 64 community members joined the Dzivarasekwa CHC and 84 and 98 for the two groups in Kuwadzana.

HOME BASED CARE (HBC)

Total number of patients on HBC: 1771

Prévalent conditions	**1. Diarrhoeal diseases** **2. HIV, AIDS and TB** **3. Diabetes Mellitus** **4. ARI** **5. Hypertension**
Problems being encountered	**1. Inadequate food for the patients** **2. Water shortages** **3. Cannot afford hospital fees** **4. Unavailability of HBC kits**
H.P activities	**1. Health education** **2. IEC material distribution** **3. Counseling**

PMTCT AND OI/ART ANNUAL REPORT

ACTIVITIES	PMTCT	OI/ART
1. Number of clients given Health Education	4424	550
2. Number referred to clinics	1520	445
3. Number counseled	2828	510
4. Number referred to support groups	62	135
5. Number referred to support groups	3171	660

The health promotion section continues to capacitate, support and supervise the grassroot. A number of training workshops were done for the health promoters namely:

- **EPI social mobilization**
- **New card and New Vaccine**
- **Typhoid Social Mobilization**
- **Male Circumcision**
- **Infant feeding**
- **Reproductive Health**
- **Cancer issues**

RECOMMENDATIONS

- **There is need to recruit more Health Promotion Officers and a graphic artist.**
- **Training equipment should be procured for the Section.**
- **Procurement of a vehicle for the section for efficient service delivery and supervision of district programmes.**
- **Health promoters need to be supplied with uniforms and stationery regularly.**
- **If possible all areas should have Health Promoters since they play a very crucial role in the health delivery system.**
- **Home Based Care kits should be availed to the health promoters so that their work is not disturbed.**
- **Funds should be made available for the Health Promoters annual conferences for HPs so that they are trained on various topics every year.**
- **The responsible sections for burst sewer pipes, water and refuse collection should take action before the rains come so that if an outbreak occurs, it can be contained.**

CHAPTER VII

RESEARCH AND DEVELOPMENT

INTRODUCTION

The overall objective of the unit is to contribute to the generation of evidence based information for use by policy makers and managers at all levels of the health system for strengthening the health system and services. Emphasis is placed on promoting the generation, dissemination and use of knowledge for enhancing health system performance.

ANALYSIS OF PUERPERAL SEPSIS CASES OF HARARE CITY CLINICS REFERRED TO HARARE AND PARIRENYATWA

BACKGROUD HARARE CITY HEALTH

Harare City has a population of 1 601 324 in which (49%) women and (51%) male. The women of child bearing age constitute 27% population (Source 2002 census projection). The Harare city has 12 maternity clinics and private institutes which provide the maternity services to Harare population. These health Centre conduct ante–natal, intra-partum and postpartum care of normal delivery, Harare and Parirenyatwa hospitals are the main referral hospital centre handling high risk pregnancies. Annually city clinics has an average delivery 29 270 and refer about 13 566 of its patient during antenatal, ante partum and postnatal period to hospital according to the set criteria of referral. The City conducts antenatal, intra partum and post partum care of normal delivery.

Of late it has been observed that puerperal sepsis morbidity were on the increase both from the patients who had delivered the two hospitals through caesarean section normal vaginal deliveries. According to W.H.O. sepsis is number six as major causes of maternal deaths. As most of the deliveries happen at health centres we can attribute that the majority of puerperal infection are nosocomiual. Studies have revealed that some of the cause of puerperal sepsis can be prevented by improving infection control management during the ante, post natal period at all. The best way to prevent maternal morbidity and mortality is to improve general health and obstetrical care of the patients at all health facility levels.

Trends of puerperal sepsis from 2000 to 2012

Years	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Cases	42	30	13	5	2	12	3	8	*8	3	23	13	20
Maternal death	#77 (12)	77 (53)	101 (57)	74 (18)	94 (39)	76 (33)	66 (38)	93 (38)	-(33)	62 (26)	133 (42)	(30)	138 (35)

NB*(January- June 2008).The remaining months the hospitals were closed.

It seems in 2008 they were resurfacing with post partum infections

NB :( ) figures in the brackets are maternal death refer from clinics for further treatment
 # Great Harare maternal death

This is an analysis of puerperal sepsis cases which happened to mothers who were seen at the city clinics and were referred to government hospitals for further management. This analysis will help us to identify the factors that lead to women to develop puerperal sepsis.

METHODLOGY

Two maternal death reports of women who report at city clinic which are submitted to the Director Health service were review and analyses:-

- **First report from the local clinic on what transpired until the patient is transferred.**
- **Second report is from the nurse co-coordinator stationed at the hospital where the patient is referred to until her discharge or death.**

RESULTS

DEMOGRAPHIC DATA

They were 20 pregnant women who report at city clinics of which who were further were referred to Harare and Parirenyatwa hospital for further management.

TABLE 7.1: Women affected by age group, booking and HIV status

Age group years	Freq	Booking status		HIV status		
		Booked	Unbooked	-ve	+ve	Ns
<21	11	9	2	9	1	0
21-25	1	0	1	0	1	0
26-30	6	5	1	5	1	0
31-35	1	1	0	1	0	0
36++	1	1	0	2	0	0
Total	20	16	4	17	3	0

All women were married and their age range from 16-44 years with mode = (<21 age group). Majority (9) were gravida 3 and parity 2. The gravida of the patients range from 1 to 7 (mode =3) and parity ranging from 0 to 6 (mode = 2). Sixteen were booked with city clinics and 4 were unbooked cases and one was a BBA.

MANAGEMENT OF DELIVERY

The duration of labour ranged from 4 hours to 6 hours with (mode of 4-6 hours).

Perineum

Perineum	Frequency
Intact	17
Laceration	1
Gapping episiotomy	1
Skin shick	1

One had episiotomy; first degree tear and vulva suture which where septic during presentation: Vaginal examination of pregnant women was done to the mothers. The majority had more than 3 vaginal examinations (something which was discouraged because it was seen as port of infection especial for puerperal sepsis).

TYPE OF DELIVERY AND CAUSEOF SEPSIS

Type of delivery	Secondary causes	Frequency
Normal delivery	Sepsis	9
Normal delivery	Retained products of conception	5
Caesarean section	Septic suture	3
Caesarean section after delivery	Sepsis suture -Retained products of conception	3

14 women had vaginal delivery but third stage of labour was not properly managed because of retained products of conception. Six (6) had caesarean section which later developed septic suture.

CLINICAL DIAGNOSIS

Most women were transferred to the high level of management due to the following diagnosis.

Diagnosis	Frequency
Puerperal sepsis	9
PPH due to RPOC	5
Early labour	5
HIV	1

HOSPITAL DIAGNOSIS

Impression	Frequency
Puerperal due to RPOC	5
Puerperal sepsis	9
PPH /sepsis (caesarean)	3
Malaria	1
Septic suture line	3
Separation of symphsis pubis	3

NB: The diagnoses are more that the client because some had more one cause

Management

When transferred to hospital USS was done to some women as part of management. Those with the remained product of conception were evacuated and given antibiotics. Blood transfusion was done to post partum hemorrhage cases

AVOIDABLE FACTORS

Table 7.2: AVOIDABLE FACTORS

Avoidable factor	Frequency
Patients orientated • **no attending ante natal care** • **delay in seeking help**	**4** **2**
Administration factor • **Delay in management at high level of health centre** • **Lack of skill personnel**	**3** **1**

DISCUSSION:

The most affect women were less than 21 years and gravida 3 and parity 2. Women who had caesarean section and those with NVD had retained product of conception after delivery were affected. Four did not seek medical attention, did not attend ANC at all because there were unbooked. Two who had previous lower segment of caesarean section (lscs) delayed coming to the clinic when they know they should be transferred. Three were delayed in being attended to at high level when were referred early for early intervention but where delayed until they had still birth. Some were discharged without antibiotic after lower segment of caesarean section (lscs).

CONCLUSION

There was a delay in management of referred patient from the clinics. There is lack of skills on the third management of labour. Especial the retained product found in most patients. There is little knowledge on how to manage the caesarian suture and perineum tears at home after discharge by women.

RECOMMENDATION

- **Need for patients to seek health care fast so as to be assisted quick.**
- **High level of health facility to serve the referred patients fast**
- **Health education for mother on proper hygiene after delivery especially caesarean cases**
- **Refresher course for nurses especially on management of third stage of labour.**

MEDICO SOCIAL WORK SECTION

Introduction

A total of 1 153 cases were attended during the period under review. Out of these cases, 265 were Home Based Care cases, 558 received Free Medical Treatment Orders, 27 were Multi-Drug Resistant Tuberculosis (MDR-TB) cases, and 64 were mortuary cases including Still Births and deaths among adults, 13 cases required referral to other agencies. Thirty seven students were on internship.

Home Based Care

Two hundred and sixty five (265) patients were considered for Home Based Care. They received psycho-social support counselling.

Free Medical Treatment Orders

Five hundred fifty eight (558) patients received Free Medical Treatment Orders to enable them access Anti-retroviral Treatment (ART). Means - testing was employed to determine their eligibility for free treatment.

Multi Drug resistant -TB

Twenty seven (27) patients on MDR-TB treatment were assessed for psycho-social and economic function. In the process of counselling most of them received adherence counselling. It was observed that most patients on MDR-TB treatment require material support including Financial and food-aid as most of them have poor socio-economic backgrounds.

Referral for assistance to other Government department and Non-governmental Organisation

Thirteen (13) cases were referred to other agencies in the community for assistance. Most of these cases were referred to National Registrar's office for documentation.

Mortuary Cases

Sixty four (64) cases were referred to the Department of Social Services for State assisted (Pauper) burial. Out of these cases 30 were unclaimed still births and 1 unclaimed body of an adult. Mortuary cases refer to as unclaimed bodies in the hospital mortuary awaiting state assisted (Pauper burial). Applications for the burial have since been made with the DSS.

SUMMARY OF SOCIAL WELFARE CASES ATTENDED QUARTERLY IN 2012

SERVICES	Total Cases	1st quarter cases	2nd quarter cases	3rd quarter cases	4rd quarter cases
Home base care	265	56	79	96	34
Free medical treatment order	558	287	104	74	93
Multi drug resistant TB	27	7	10	5	5
Referrals to other organizations	50	14	4	23	9
Mortuary	253	60	61	61	71
Total	1 153	424	258	259	212

STUDENTS ON INTERNSHIP

Thirty seven (37) students were placed at the Medico social work office for their practical learning. These students were from the local state universities pursuing their social work studies.

CHALLENGES

- **Home visit were not conducted on time due to lack of transport**
- **Still born babies were disposed of after in ordinate delays as clients often provided false contact information and addresses making it difficult to trace parents of still born babies.**
- **Petty cash needed to assist stranded patients often resulted in patients over staying after being discharged**
- **Staffing issues remain a challenge as only two social workers man the two hospitals. It medically risky for one social worker to continuously work in an infectious environment without relief.**

RECOMMENDATIONS

- **Transport to be allocated at least fortnightly to enable home visit and other essential tasks to be carried out.**
- **System of handling and disposing of still births needs to be revisited with a view to have it overhauled.**
- **Need to recruit more social worker to ease the staff shortage at the two hospitals.**

CHAPTER VIII

SEXUALLY TRANSMITTED INFECTIONS (STIs)

- **Genitourinary Centre (GUC)**
- **City Primary Care Clinics**
- **Voluntary Counselling and Testing (VCT)**
- **Training**

GENITO URINARY CENTRE

INTRODUCTION

The Genito-Urinary Centre is situated within the Wilkins Infectious Diseases Hospital premises. It serves as a referral centre for complicated cases of STI's and for screening of cervical cancer through a VIAC clinic which was opened in May 2012. The referrals are from the private sector, general hospitals and municipality clinics. Walk in cases are also catered for.

The centre is divided into the administration wing, laboratory, lecture hall, discussion rooms, and male and female clinical areas. The New Start Centre which is operated in partnership with the Population Services International (PSI) is also part of the unit.

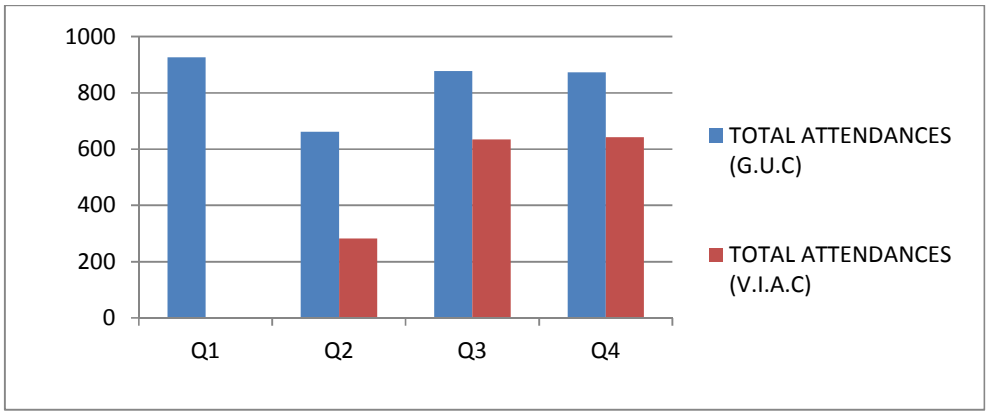
The Centre is also a training institution for qualified nurses in the syndromic management of STI's. During the times when there is no training, the Centre serves as a venue for meetings and workshops that are organised within the City Health Department

TABLE 8.1: STAFF ESTABLISHMENT

TITLE	ESTABLISHMENT	IN POST	VACANCY
DMO (Venereology)	1	1	0
Sister in-charge	1	1	0
RGN	9	5	4
Clerical officer	1	1	0
Clinic orderly	2	1	1
Clinic attendant	5	5	0
Total	19	14	5

GUC CLINIC ATTENDANCES

INDICATOR	Q1	Q2	Q3	Q4	TOTAL 2012	TOTAL 2011	% CHANGE
TOTAL ATTENDANCES (G.U.C)	927	662	878	873	3 342	3 675	
TOTAL ATTENDANCES (V.I.A.C)	--	283	634	643	1 560	----	
GRAND TOTAL	929	945	1 512	1 516	4 902	---	33,4



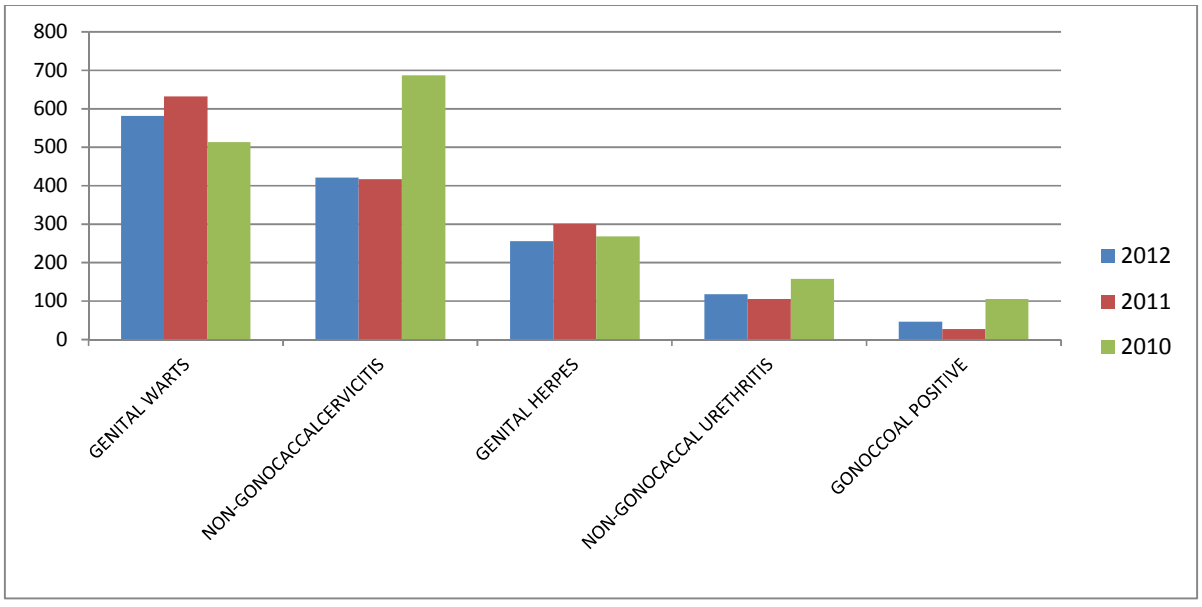
The year 2012 recorded a total attendance of 4902 and this includes initial visits, repeats and VIAC attendances. There was a 33.4% increase in attendances compared to the previous year when 3675 clients were recorded.

However, for clients specifically seeking GU services there has been a steady decline in clientele since 2010 as illustrated below.

Year	2010	2011	2012
GU attendances	4 387	3 675	3 342

Table 8.2: TOP FIVE CONDITIONS SEEN AT GUC FROM 2010 – 2012

CONDITION	2012	2011	2010
GENITAL WARTS	581	632	513
NON-GONOCOCAL CERVICITIS	421	417	687
GENITAL HERPES	255	301	268
NON-GONOCOCCAL URETHRITIS	118	105	158
GONOCOCAL POSITIVE	46	27	105



Genital warts were the most common condition seen at the centre in the year 2012 and this is due to the recurrent nature of the condition, leading to many repeat visits by clients.

VIAC Clinic

The clinic was opened on 21st May 2012 with UNFPA as a partner and it offers cervical cancer screening. At its inception, a greater number of clients were referred from Opportunistic Infections Clinic, but as for now clients are coming from all over Harare and outside Harare.

Attendances

The total number of attendances was 1560.

HIV Status of clients screened

HIV Positive	**684**
HIV Negative	**780**
Unknown	**96**

V.I.A.C Results

Positive	**121**
Negative	**1427**
Suspicious of cancer	**12**

The VIAC positivity rate 8.6%, and of the VIAC positive, 6.2% were HIV positive. Of the VIAC positive 6.2 % were HIV positive.

Services offered to VIAC clients

Service	Number of clients
STI treatment and others	**97**
Cryotherapy	**22**
LEEP	**1**
Punch Biopsy	**2**

STAFF DEVELOPMENT

- **4 nurses attended a 3 day workshop on STI updates**
- **2 nurses attended a 1 day workshop on STI updates**
- **1 nurse attended a 5 day workshop on drug stock management**
- **4 nurses and 1 doctor were trained in VIAC**
- **2 nurses attended a 5 day workshop on IMMAI**
- **1nurse attended a workshop on IMPAC**
- **2 clinic attendants and 1 clinic orderly attended a 1 day workshop for infection control**
- **3 clinic attendants attended a 1 day workshop in basic computer skill**
- **1 nurse attended a 6 day infection control workshop**

PROVIDER INITIATED TESTING AND COUNSELLING (PITC)

Table 8.3 shows the total number of clients who have been tested in the PITC program at the GU centre and Wilkins TB clinic since 2010. The GU centre contributed 16% of the clients while the TB clinic contribution was 84%. There has been a gradual decline in numbers of clients who have been getting tested.

Compared to the year 2011, there was a 35% reduction in the number of clients tested. This could be due to the fact that testing and counselling services are also being offered in all the council clinics hence a number of clients will already be aware of their HIV status.

Table 8.3: PITC attendances by month from January 2010 to December 2012

Month	2012	2011	2010
January	322	309	381
February	312	306	343
March	283	389	393
April	266	301	348
May	182	303	371
June	192	351	342
July	216	248	385
August	170	378	344
September	212	341	416
October	128	299	325
November	135	337	279
December	101	290	243
TOTAL	2 519	3 852	4 170

BREAKDOWN OF PITC ATTENDANCES

Table 8.4: TB OUTPATIENT DEPARTMENT PITC 2012

MONTH	TOTAL	POSITIVE	NEGATIVE
January	249	87	162
February	264	96	168
March	256	69	187
April	253	97	156
May	166	45	121
June	145	50	95
July	163	44	119
August	135	42	93
September	203	55	148
October	109	26	83
November	107	31	76
December	76	18	58
Total	2 126	660	1 466

The positivity rate for clients tested in the TB outpatients was 31%.

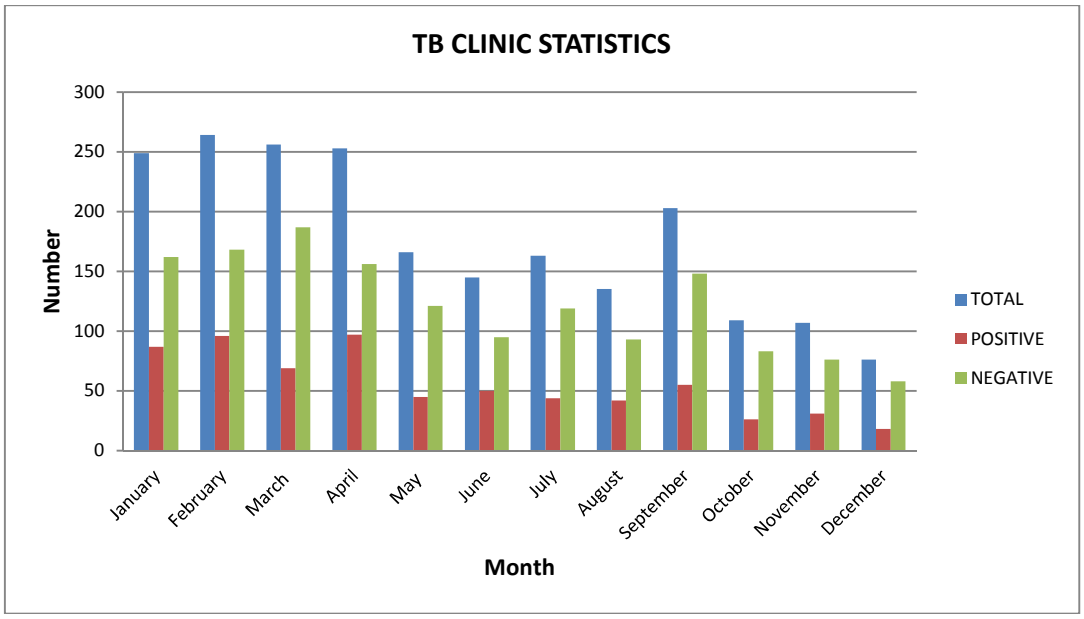
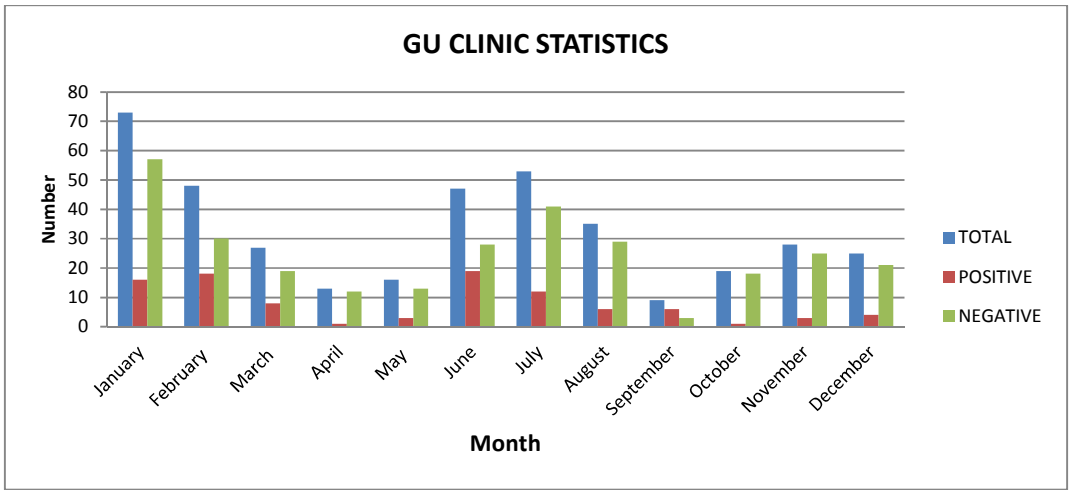


Table 8.5: GUC CLINICS PITC

MONTH	TOTAL	POSITIVE	NEGATIVE
January	73	16	57
February	48	18	30
March	27	8	19
April	13	1	12
May	16	3	13
June	47	19	28
July	53	12	41
August	35	6	29
September	9	6	3
October	19	1	18
November	28	3	25
December	25	4	21
Total	393	97	296



The overall positivity rate for those that opted to be tested among STI clients seen in the year 2012 was 25%.

Achievements

VIAC clinic opened and offers cryotherapy, LEEP and punch biopsy.

Constraints

- **Frequent power outages have affected operations at the centre negatively in that the female GU and VIAC clients cannot be examined without adequate lighting and have to come back when there is power. The power cuts also result in having no sterile packs resulting in delay in seeing clients. There is need for power back up at the centre.**
- **Water cuts also affected operations at the centre.**
- **The ablution facilities at the centre have problems with continuous water low pressure and frequent burst pipes. This problem is long standing and needs to be addressed as a matter of urgency.**
- **The autoclave machine broke down and it took time to have it repaired. Packs had to be sent to BRIDH for autoclaving and transport was a constant challenge.**
- **Staff shortage: two nurses went on maternity leave, and one was promoted. Due to the shortage of nurses, quality of care is compromised. With the opening of the VIAC clinic, one clinic orderly cannot meet the demands of the centre. On the establishment of the clinic attendants, all the posts are filled, however two clinic attendants have been acting in other positions for the past two years. This has affected the standards of cleanliness at the centre.**

Plans for 2013

- **To deliver syndromic STI training courses to City Health nurses in 2013.**
- **To run workshops within the department on update of STI's management.**
- **To have more nurses trained in V.I.A.C and cryotherapy.**

STIs in HARARE CITY HEALTH CLINICS for 2012

During the year 2012 the total number of STIs recorded in the Harare City health department clinics was 37 081. This represents an 18% increase compared to the previous year when 31 524 cases were recorded. The commonest condition in females was the vaginal discharge syndrome in the 25 to 49 year age group and urethral discharge in males of the same age group.

VOLUNTARY COUNSELLING AND TESTING

Table 8.6: TOTAL ATTENDANCES AT GENITO URINARY CENTRE SITE FOR TESTING AND COUNSELLING SINCE 2010

Month	2012	2011	2010
January	651	707	741
February	579	571	665
March	602	671	728
April	512	571	607
May	658	583	691
June	557	636	705
July	605	613	704
August	604	603	643
September	593	603	691
October	710	630	613
November	629	630	653
December	540	484	572
Total	7 240	7 302	8 013

There has been a gradual decrease in the number of clients presenting to the site for testing services since the year 2010. There was a 10% decrease in attendances compared to the year 2010 and a 1% decrease compared to the year 2011. This could be due to the fact that a considerable number of people in the general population now know their status since testing services are now readily available through the Provider Initiated Testing and Counselling program.

Table 8.7: BREAKDOWN OF CLIENTS BY PRESENTATION

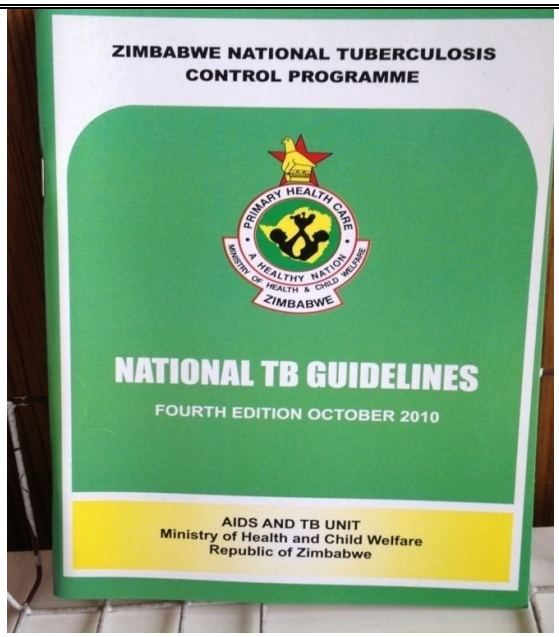
MONTH	SINGLES	COUPLES	TOTAL
January	429	222	651
February	349	230	579
March	414	188	602
April	324	188	512
May	422	236	658
June	377	180	557
July	395	210	605
August	422	182	604
September	369	224	593
October	482	228	710
November	435	194	629
December	320	220	540
Total	4 738	2 502	7 240

The couple contribution to the total number of clients presenting for VCT services was 35%. The target for couples at the site is 29%.

CHAPTER IX

SPECIALIST SERVICES

- **Tuberculosis**
- **Pharmaceutical Services**
- **Medical Laboratory**
- **Dental Services**



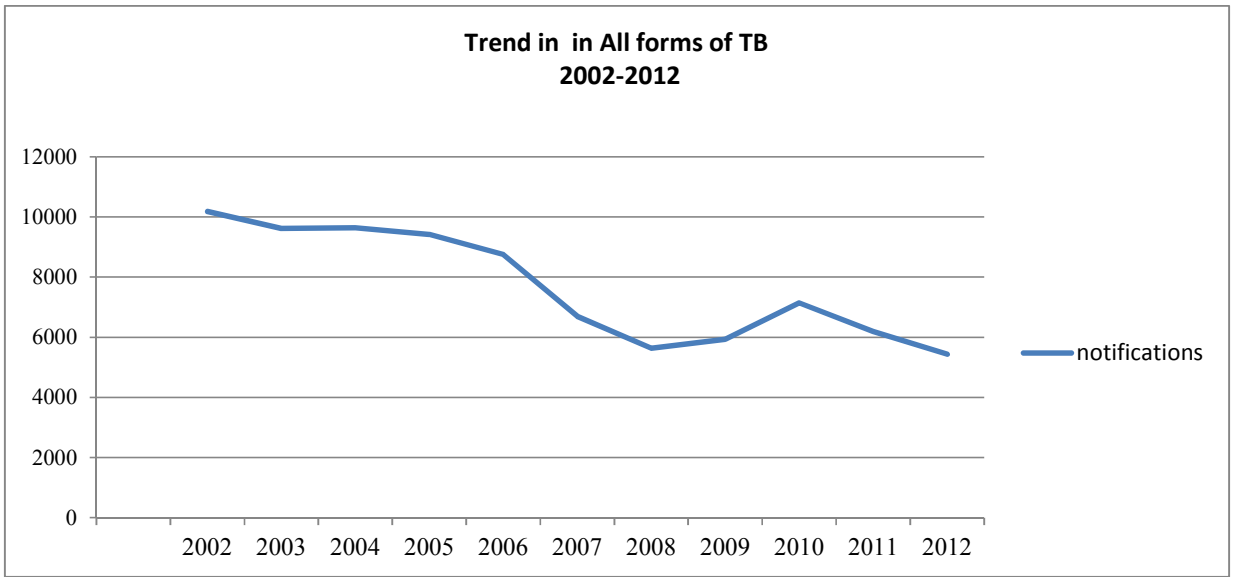
INTRODUCTION

The City of Harare's Tuberculosis programme is premised on the policies of the Ministry of health and Child Welfare (MOHCW). Specifically the programme is dove-tailed to the National Tuberculosis Programme (NTP) which in turn is guided by the principles of the STOP TB Strategy.

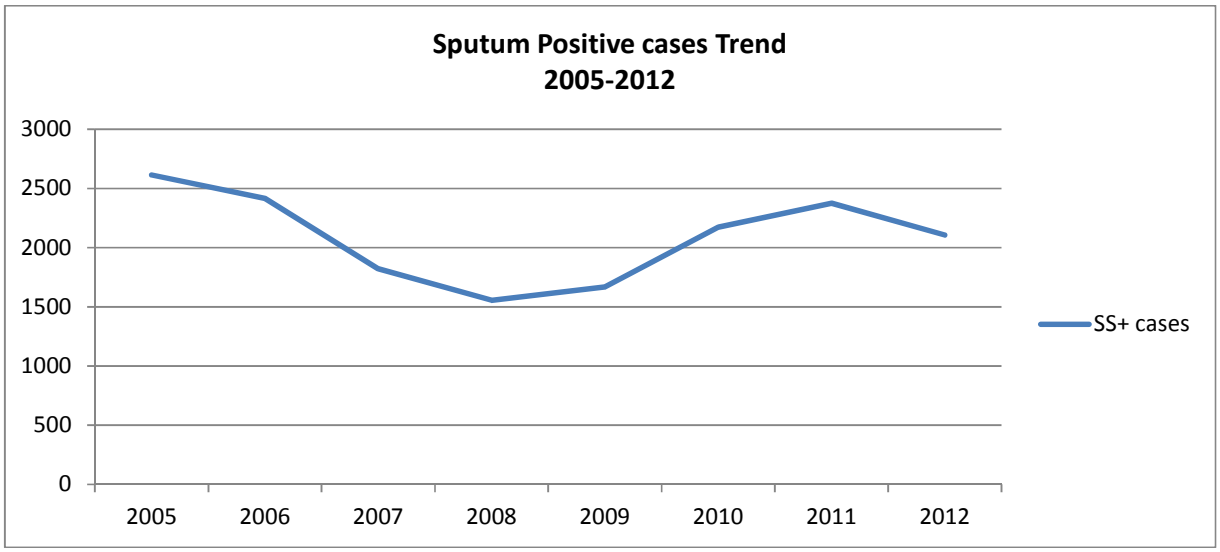
The components of this strategy are as follows:-

- **Pursue high –quality DOTS**
- **Address TB/HIV, MDR-TB and other challenges**
- **Contribute to health systems strengthening**
- **Engage all care providers**
- **Empower people with TB and communities**
- **Enabling and promoting research**

The City has experienced a decline in its notifications over the years. This could be explained by a decline in the tuberculosis disease burden within the community. This decline in the notifications correlates well with the decline in HIV prevalence in the community. Another explanation could be that the strategy in place can no longer detect TB. Whatever the reason for the decline TB remains a major health challenge in the City and as such the programme will have to craft strategies to eliminate TB. The table below illustrates the decline in TB notifications.



Among all forms of tuberculosis, Pulmonary Tuberculosis (PTB) is of the greatest public health concern since the patients have a high bacillary load. Patients with this type of TB can spread the disease to others and have increased mortality and morbidity if untreated. The trend of sputum smear positive TB in the City of Harare is illustrated below. There has been a slight decline in the number of sputum positive cases from 2011 even though the average number has been two thousand per year. In light of declining notifications the proportion of sputum positives is increasing.



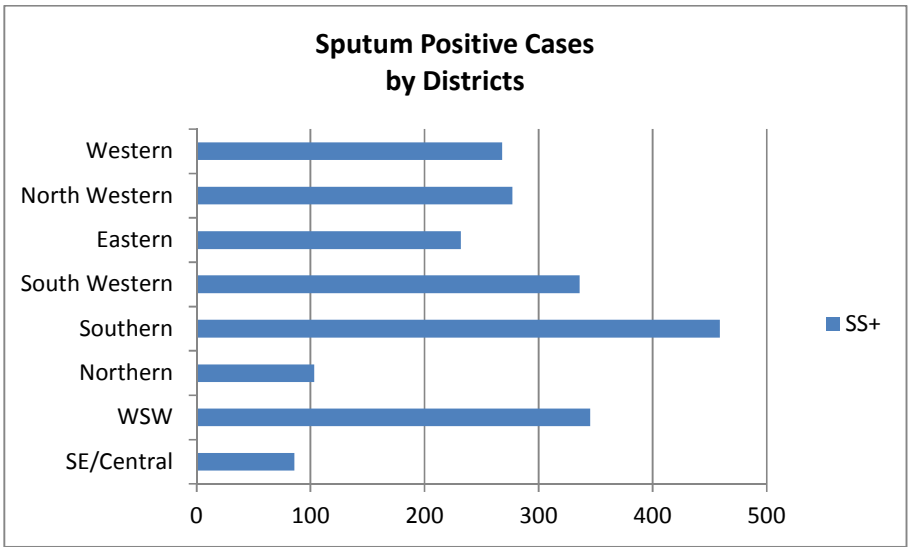
Below is the cases notified throughout the year 2012. Among the new sputum positive cases there is a predominance of males over females. Sputum negative cases are more than the sputum positives cases. This is to be expected in Zimbabwe because of the high HIV prevalence and the high co-infection between TB and HIV. There was lower activity in the second and third quarters compared to the 1st and 4th quarters.

NOTIFICATIONS																	
	PTB+								PTB-ve		PTB N/D		EPTB		Others previously treated		Total cases
	New		Relapse		Re-treatment after RX failure		Re-treatment after Default		New cases		New cases		New cases				
	M	F	M	M	M	F	M	F	M	F	M	F	M	F	M	F	
QTR1	278	199	35	25	9	6	3	0	290	247	46	39	73	75	49	31	1 405
QTR2	251	184	30	26	10	4	7	1	261	198	36	23	42	50	62	38	1 223
QTR3	273	202	26	21	9	6	3	2	321	257	41	32	70	48	54	27	1 392
QTR4	285	189	41	25	2	0	6	1	354	270	38	30	60	33	60	27	1 421
Total	1087	774	132	97	30	16	19	4	1226	972	161	124	245	206	225	123	5 441

The majority of TB patients are being tested for HIV before TB diagnosis

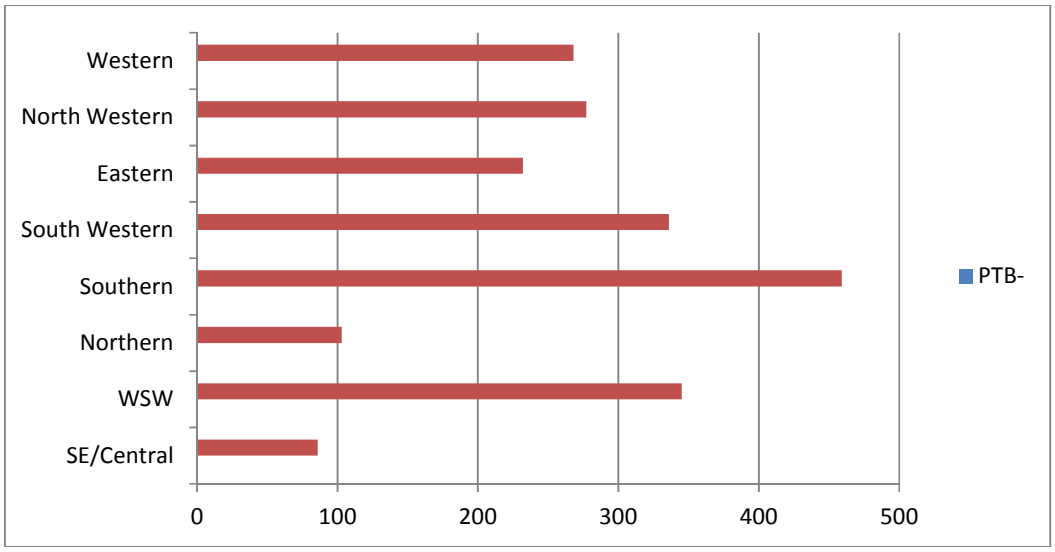
All TB cases	No. of TB patients tested for HIV before TB diagnosis	No. of patients found HIV +ve before TB diagnosis	No. of TB patients tested for HIV during TB treatment	No. of TB patients found HIV +ve during treatment
QTR1	941	718	410	269
QTR2	877	612	395	252
QTR3	767	584	486	337
QTR4	662	607	429	251
Total	3 247	2 521(78%)	1 720	1 109(64%)

Distribution of Sputum Positive TB cases by Districts

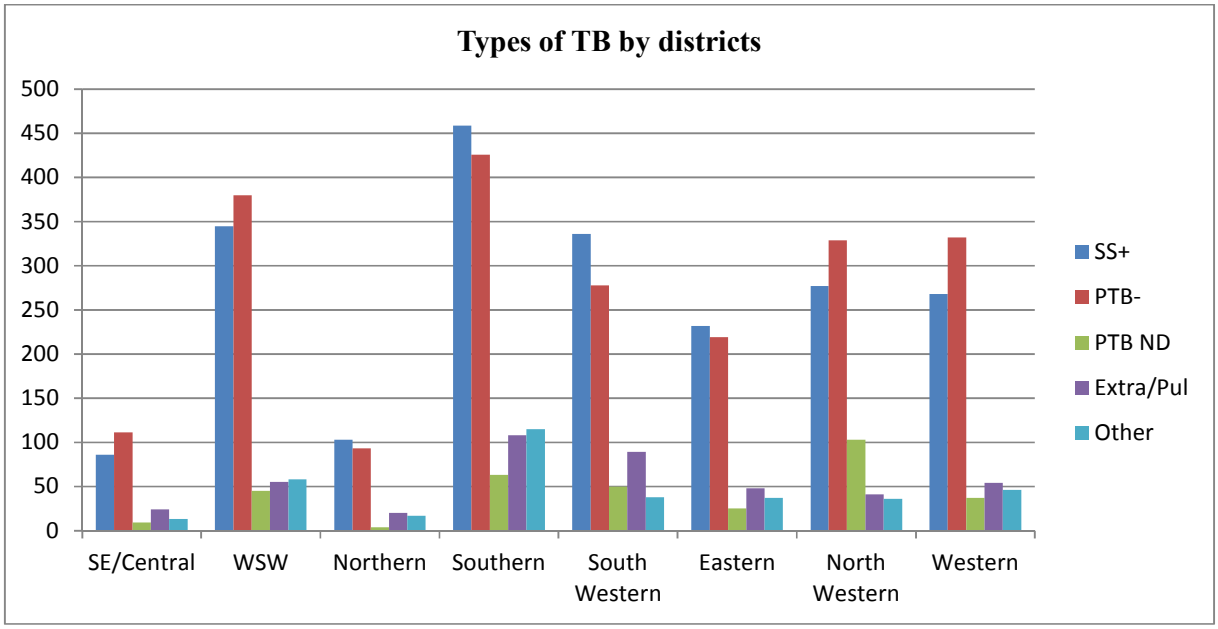


The high density areas have the highest numbers of smear positive TB. Southern, Western and West South West districts are the most affected and South Eastern and Central and northern districts have the least numbers

Distribution of Sputum negative PTB by district

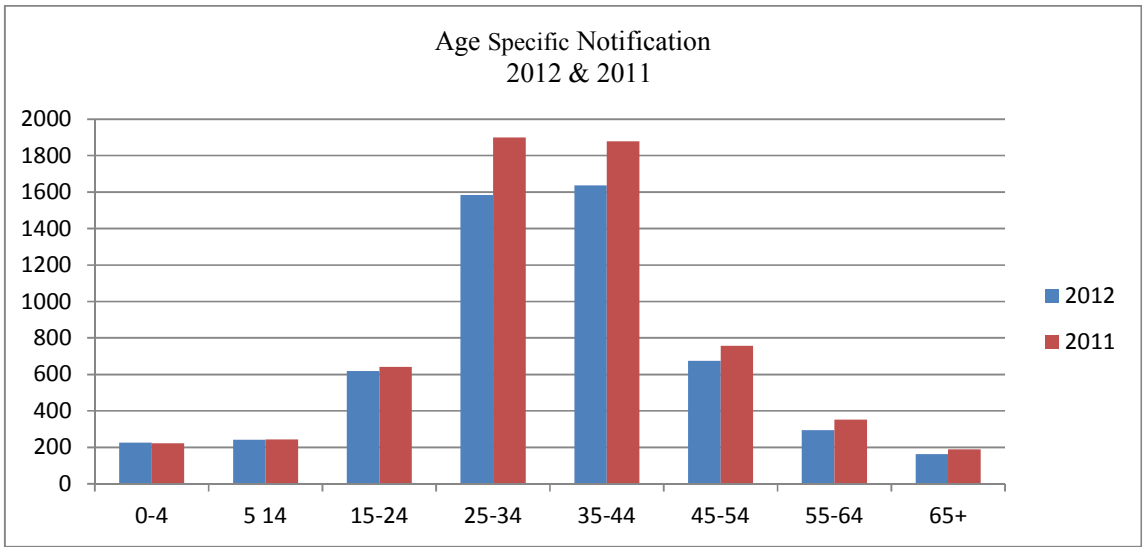


The distribution of smear negative pulmonary TB matches that of smear positive cases. TB remains a challenge in the high density areas



Pulmonary TB sputum not done, extra pulmonary TB and other forms of TB were reported less in all districts compared to sputum negative and smear positive cases.

Age Specific Notification Rates



TB affects mostly the productive age group of 25 to 44 years (the same that is affected by HIV). There were fewer cases in 2012 compared to 2011 in most age groups.

Relapses/Failures/Re-treatments cases

Outcome analysis 2011

Type of Out come	Total registered	Cured	Rx completed	Died	RX failure	Defaulted	Transfer / out	Total
New Sputum microscopy positive	2 027	1 731	26	100	14	18	133	2 038
Previously treated sputum smear microscopy positive	241	184	13	21	6	2	15	241
All other cases (sputum negative, smear not done, EP other previously treated)	3 814	####	312	6	63	33	248	3 655

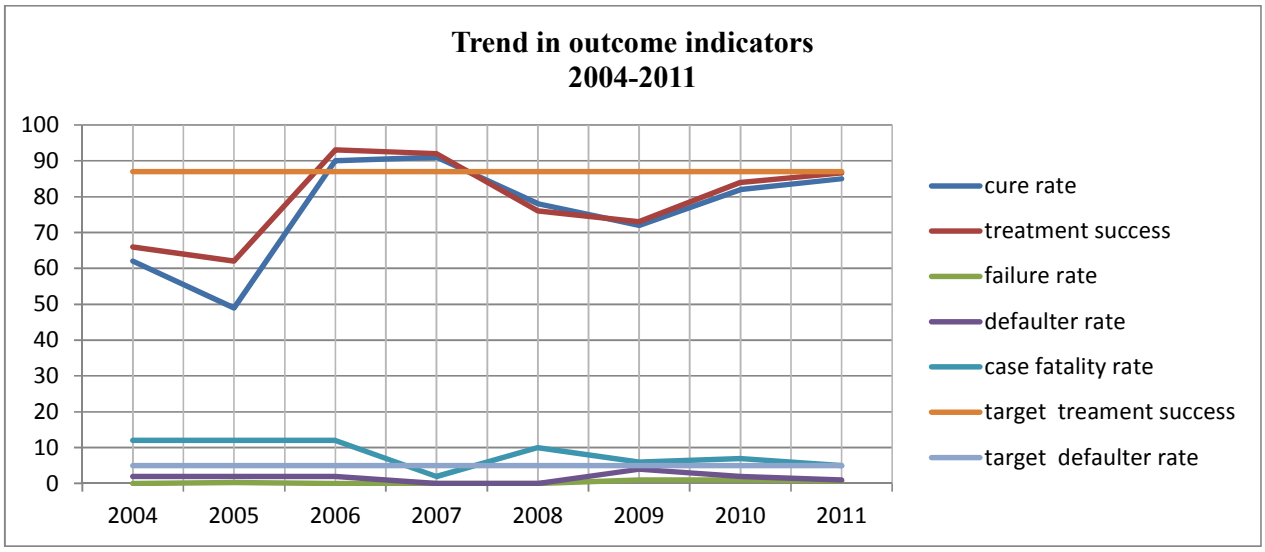
It is important to note that the outcome analysis done here is of the 2011 cohort. The table below shows the outcome indicators in the different quarters.

OUTCOME INDICATORS IN THE DIFFERENT QUARTERS

2011	Q1	Q2	Q3	Q4	AVERAGE
Cure rate	85%	88.7	84.5	84.5	85
Success rate	88.0%	88.3	85.4	85.7	86.6
Death rate	5%	5	5.3	5	5.0
Failure rate	1%	1		.36	0.7
Defaulter rate	1%	1	1.6	0.5	1.0
% on ART	50.8	53.6	53.8	46.5	51.1

Both the cure rate and treatment success rates are below the national target of 87% and as such strategies have to be found to improve this outcome. The death rate of 5% is just within the acceptable national level. The number of HIV positive TB patients on anti retroviral therapy (ART) is too low. It is expected that all HIV positive TB patients are to be on ART as they are eligible. Again there is need to address this weakness.

Trend in Cure rate and treatment Success



Collaborative TB/HIV Activities

TB screening among HIV+ patients

	1st Qtr	2nd QTR	3rd QTR	4th QTR	Total
TB suspects	3 735	3 877	4 794	4 061	16 467
Suspects submitting sputum	3 332	3 517	4 266	3 694	14 809
Sputum Smear Positive suspect	136	212	193	226	767
Positivity rate	4%	6%	4.5%	6.1%	5.2%

Systematic recording and reporting of the screening of HIV patients for TB was started during Wave 1 of the TB Reach project in 2010. On average about 5% of the suspects were put on treatment after being smear positive. This exercise of screening HIV patients for TB could also reduce incidence of IRIS (immune Reconstitution syndrome).

Comparison of 2012 and 2011

	2012	2011	Variance
TB suspects	16 467	13 011	26.6%
Number of suspects submitting Sputum	14 809	12 167	21.7%
Number of suspects Smear Positive	767	709	8.2%
Positivity Rate	5.2%	5.8%	0.6%

SUMMARY OF OTHER ACTIVITIES

Training

Most of the trainings and workshops on TB were held under MOHCW. These trainings were on monitoring and evaluation, childhood TB case management among others. One medical officer was in ARUSHA for the training on programmatic management of TB.

Research

Data on HIV negative TB patients was collected and is to analysed to determine the pattern of those with TB but are HIV negative. There is room for more research in the New Year.

Challenges and way forward

ART coverage remains a challenge. The programme has introduced opening of files for HIV TB patients at MEC. Patient s are being asked to come back to the unit after one week for the initiation of counselling and eventually ART. Follow up of patients from PMDs for outcome is very difficult. In the New Year all patients who visit the units and stay in the PMDs will be seen and sent for notification in their respective provinces. Support and supervision will need to be scaled up and support from the transport section will have to be at its best. There was a shortage of streptomycin especially in the later half of the year.

The City was once again successful in convincing TB Reach under the Stop TB partnership to fund case finding activities in the City. The aim of the project is to be able to detect TB using the GeneXpert machine in HIV positive patients and among diabetics.

The end for the TB programme should be very clear to all involved in the programme (No TB in the City of Harare by 2050) challenges will have to be taken head on and opportunities taken.

PHARMACEUTICAL SERVICES

INTRODUCTION

The City Medical Stores (Pharmacy) is situated within the Beatrice Road Infectious Disease Hospital premises. Its mandate is to provide adequate Pharmaceutical services to the 56 units in the City Health Department. It also provides vaccines to all health institutions in the City of Harare that offer the Extended Programme on Immunisation.

Vision

The vision of the Pharmacy Services is to be a provider of world class quality pharmacy services to the residents of Harare.

Mission

The mission of the Pharmacy Services is to provide within the available resources good quality medicines and medical supplies that are safe, effective, accessible, affordable and rationally used to the population of Harare.

Objective

To ensure 100% availability of vital medicines, at least 80% availability of essential medicines, and reduce stock loses to less than 5% of holding stock.

Funding

The City of Harare, Ministry of Health and Child Welfare (MOHCW) and the International Committee of the Red Cross (ICRC) continued to fund the City Health Department's Pharmaceutical requirements.
The Ministry of Health through the National Pharmaceutical Company (NatPharm) continued to supply donor funded Anti-Malaria Commodities, Anti- TB medicines, Primary Health Care Packages (PHCP), Hospital Supplementary Kits, Zimbabwe National Family Planning Council (ZNFPC) Commodities and Anti-Retroviral medicines as tabulated in table 1 below.

ICRC supported the 12 polyclinics with 66 medicines and 37 medical sundries based on a memorandum of understanding signed on the 21st of March 2011. Although the memorandum stated that they would gradually reduce their support yearly, they did not reduce their support in 2012. The City's inability to fully capacitate the Health Department to procure the requirements of the City and the insufficient support from the Ministry of Health and Child Welfare obliged the ICRC to maintain their support in 2012. The support however for 2013 will be cut by 50%.

The City supplemented some of the fast moving PHCP and hospital kit commodities that were not adequately provided for by the Ministry of Health and Child Welfare. The City also funded the procurement of the balance of vital and essential medicines and medical sundries which were not supplied by MOH and ICRC. The City Medical Stores has a product line of 359 (Medicines and Medical sundries).

Table 9.1: Commodities supplied by Ministry of Health and Child Welfare

Ministry of Health commodities	MEDICINES	MEDICAL SUNDRIES
Anti-Malaria commodities	7	1
Anti-TB commodities	11	1
Anti-Retroviral commodities	14	8
PHCP	26	12
Hospital Supplementary Kit	22	5
ZNFPC commodities	10	16

NatPharm and its Strategic Business Unit continued to experience shortages of medicines which were not funded/supplied by donors. Natpharm is experiencing these stock outs because its debtors are failing to settle their bills on time.

As a result the City Medical Stores was forced to procure such stocks from private sector suppliers at much higher prices.

QUALITY OF PHARMACEUTICAL SERVICES

The Pharmacy provided compromised Pharmaceutical Services due to the reasons cited below:-

- **A critical shortage of staff. The pharmacy section continued to face a critical shortage of key Pharmacy Staff as a result of a moratorium on staff recruitment. Out of a staff establishment of seventeen (17) only nine (9) are in post. Five of these posts should be occupied by a Pharmacist and four Pharmacy Technicians. The dedicated skeleton staff however, worked tirelessly throughout the year in such a challenging and difficult working environment.**
- **The unavailability of reliable and adequate transport service also adversely affected the quality of Pharmaceutical services. The procurement and distribution of vaccines, medicines and sundries were seriously compromised. Delays in delivering pharmaceuticals to the clinics and hospitals were rampant and some stocks outs were a direct result of the poor transport service.**
- **Inadequate Pharmacy delivery cages. Medicines and Non bulky sundries are despatched to the Hospital and clinics in pharmacy delivery cages. Each facility is meant to have at least two such cages. However, there is a critical shortage of these cages. The few that were available had to be shared among the 56 facilities, hence delays when the cages were not returned to the Pharmacy on time.**
- **The City Medical Stores was unable to maintain the optimum stock levels (6 months worth of stock) of certain bulky stock items due to inadequate storage space.**
- **Non computerisation of the stock management.**

EXPENDITURE ON MEDICINES AND MEDICAL SUNDRIES

The total expenditure on medicines and medical sundries from the private sector for the year 2012 amounted to $1 318 966.42. The budget for medicines and medical supplies for 2012 was $ 1 666 400 financed by the City's Revenue budget. The 2012 expenditure was lower than the budgeted amount due to the cash flow problems that the City experienced throughout the year. Purchases were limited to only a few vital medicines and medical supplies. In the month of April and December all purchases were suspended except for medical oxygen. The expenditure increased by 15.64% when compared to the same period in 2011. See table 2 below:-

TABLE 9.2: COMPARISON OF PRIVATE SECTOR PURCHASES FOR 2012 AND 2011

MONTH	2012	2011
	Private sector Purchases vital and essential items $	Private sector Purchases vital and essential items $
January	4 505.68	42 269.00
February	192 817.25	239 477.62
March	126 847.50	259 803.37
April	1 430.00	38 592.00
May	97 459.86	216 407.00
June	93 770.94	Nil
July	169 354.28	53 623.66
August	177 934.73	66 314.00
September	106 730.00	9 915.00
October	254 654.18	48 291.90
November	93 462.00	85 226.00
December	nil	80 615.30
TOTAL	1 318 966.42	1 140 534.85

ICRC distributed medicines and medical sundries on quarterly intervals based on the jointly agreed standard list to each of the twelve polyclinics. The amount of assistance was based on consumption figures and stock monitoring to avoid stock outs. Supplies were temporarily suspended in the third quarter, due to a technical challenge which was quickly resolved and supplies resumed in the fourth quarter. Find tabulated below the quarterly assistance to polyclinics.

TABLE 9.3: COMPARISON OF ICRC ASSISTANCE TO POLYCLINICS FOR 2012 AND 2011

MONTH	VALUE OF MEDCINES & MEDICAL SUPPLIES IN USD 2012	VALUE OF MEDICINE & MEDICAL SUPPLIES IN USD 2011
JAN-MARCH	92 622.00	134 448.00
APRIL-JUNE	58 542.00	64 249.00
JULY -SEPT	Nil	66 766.00
OCT-DEC	*23 8516.00*	108 561.41
Total	389 680.00	374 024.41

STOCK STATUS

A. TB MEDICINES

Tabulated below is a stock out summary per quarter for all the health institutions in the Harare City Health Department. The stock outs are highlighted as per product.

Table 9.4.STOCK OUT SUMMARY FOR TB MEDICINES FOR QUARTER 1-3

STOCK ITEMS	NO OF INSTITUTIONS	QUARTER 1		QUARTER 2		QUARTER 3	
		STOCKED OUT INSTITUTIONS	% STOCK OUT	STOCKED OUT INSTITUTIONS	% STOCK OUT	STOCKED OUT INSTITUTIONS	% STOCK OUT
RHZE 150/75/400/275MG	32	1	3.125	0	0	0	0
RH 150/75	32	0	0	0	0	0	0
RH 60/30	32	7	21.875	5	15.625	1	3.125
RHE 150/75/275	32	3	9.375	3	9.375	1	3.125
RHZ 60/30/150MG	32	6	18.75	2	6.25	6	18.75
Streptomycin injection	32	0	0	0	0	1	3.125
Sputum cups	32	2	6.25	1	3.125	1	3.125
Ethambutol 100mg	32	3	9.375	2	6.25	1	0
Ethambutol 400mg	32	1	3.125	1	3.125	1	3.125
Isoniazid 100mg	32	1	3.125	1	3.125	5	15.625
Pyrazinamide 500mg	32	4	12.5	4	12.5	3	9.375
Rifampicin 150mg	32	0	0	1	3.125	1	3.125

DISCUSSION

- **The ZIP/PHCP deliveries for the fourth quarter were suspended due to insufficient stocks at Natpharm. Therefore no data is available for the quarter as this data is collected during the delivery run.**
- **There were adequate supplies of sputum cups and all TB medicines throughout the year except for streptomycin injection and RHZE tablets.**
- **The stock outs of RHZE and streptomycin injection were reported in the fourth quarter due to stock outs at Natpharm. There was a nationwide shortage of streptomycin and efforts were made to redistribute the limited stocks throughout the City so as to ensure equity. In an effort to ensure that none of its patients defaulted treatment the Pharmacy sourced the most sort after streptomycin injection from over stocked institutions in Masvingo, Rusape, Guruve, Gutu, Bulawayo and Zimbabwe Prison services.**
- **There were erratic and inadequate supplies of multidrug resistant medicines in the third and fourth quarter. Wilkins Hospital was forced to ration supplies and patients at times were given 2-4 weeks supplies instead of the two months' supply.**

B. MALARIA MEDICINES AND COMMODITIES

Tabulated below is a stock out summary per quarter for all the health institutions in the Harare City Health Department. The stock outs are highlighted as per product.

TABLE 9.5: STOCKOUT SUMMARY FOR MALARIA COMMODITIES FOR QUARTER 1-3

STOCK ITEMS	NO OF INSTITUTIONS	QUARTER 1		QUARTER 2		QUARTER 3	
		STOCKED OUT INSTITUTIONS	% STOCK OUT	STOCKED OUT INSTITUTIONS	% STOCK OUT	STOCKED OUT INSTITUTIONS	% STOCK OUT
AL 1X6	32	0	0	0	0	2	6.25
AL 2X6	32	0	0	2	6.25	1	3.125
AL 3X6	32	12	37.5	6	18.75	4	12.5
AL 4X6	32	1	3.125	0	0	0	0
RDT	32	4	12.5	0	0	1	3.125
SP	32	3	9.375	1	3.125	1	3.125
QUININE 300MG	32	0	0	2	6.25	0	0
QUININE 600MG inj	32	2	6.25	4	12.5	0	0

KEY: AL = ARTEMETHER/LUMEFANTRINE, SP = SULPHADOXINE+PYRIMETHAMINE TABLETS

DISCUSSION

- **Artemether 20mg-Lumefantrine 120mg tablets were available throughout the year in all the clinics. However some clinics experienced stock outs of the different pack sizes (1x6's, 2x6's, 3x6's and 4x6's). Patients however were not affected by these stock outs. The clinics were able to repack the different pack sizes.**
- **The first quarter had the highest stock outs of malaria rapid diagnostic test kits, with four clinics making such reports. Only one clinic reported stock outs in the third quarter.**
- **There were no stock outs of Quinine 300mg tablets in the first and third quarter. Two and four clinics were stocked out of quinine 600mg/2ml injection in the first and second quarter respectively. In the fourth quarter stocks were recalled for redistribution to Manicaland Province.**

C. HEALTH CARE PACKAGE COMMODITIES

Table 9.6: STOCKOUT SUMMARY FOR PHCP COMMODITIES – QUARTER 1 & 2

STOCK ITEMS	NO OF INSTITUTIONS	QUARTER 1		QUARTER 2	
		STOCKED OUT INSTITUTIONS	% STOCK OUT	STOCKED OUT INSTITUTIONS	% STOCK OUT
Amoxicillin 250mg Caps	32	0	0.0	1	3.1
Benzylpencilin Powder For Inj. 3g (5mu) Vial	32	1	3.1	0	0.0
Amoxicillin Powder/Oral Susp 125mg/5ml	32	5	15.6	6	18.8
Ciprofloxacin 500mg Tabs	32	2	6.3	3	9.4
Co-Trimoxazole 480mg Tabs	32	1	3.1	1	3.1
Doxycyclin 100mg Caps	32	0	0.0	0	0.0
Erythromycin 250mg Caps	32	1	3.1	2	6.3
Metronidazole 200mg Tabs	32	0	0.0	0	0.0
Ors New Form 1l Sachet	32	4	12.5	7	21.9
Zinc 20mg Tabs	32	2	6.3	2	6.3
Co-Trimoxazole 120mg Disp Tabs	32	1	3.1	4	12.5
Hydrochlorothiazide 25mg Tabs	32	2	6.3	1	3.1
Paracetamol 500mg	32	0	0.0	0	0.0
Paracetamol Elixir 120mg/5ml 60ml	32	7	21.9	4	12.5
Salbutamol 4mg Tabs	32	4	12.5	2	6.3
Adrenaline 1mg/Ml Inj. 1ml Amp	32	1	3.1	2	6.3
Glucose Hypertonic 50% Inj. 50ml Vial	32	1	3.1	1	3.1
Lignocaine Inj. 2% Vial	32	1	3.1	2	6.3
Diazepam Inj 5mg/Ml 2ml Amp	32	1	3.1	0	0.0
Povidone Iodine Soln 10%	32	0	0.0	0	0.0
Tetracycline 1% eye ointment 5g tube	32	8	25.0	10	31.3
Albendazole tab 400mg chewable	32	0	0.0	1	3.1
Ferrous + folic 60+0.4mg tab	32	0	0.0	1	3.1
Magn.sulph.inj 500mg/ml	32	6	18.8	8	25.0
Miconazole Nitrate Cream2%	32	8	25.0	11	34.4
Bandage Gauze 8cm*4cm roll	32	10	31.3	0	0.0
Cotton Wool 500g roll non-sterile	32	0	0.0	7	21.9
Compress Gauze 10*10cm non ster	32	7	21.9	6	18.8
Tape Adhesive Zinc 0x 2.5cm*5m	32	4	12.5	3	9.4
Syringe 2ml	32	0	0.0	1	3.1
Syringe 5ml	32	0	0.0	0	0.0
Needle disp 19G	32	0	0.0	1	3.1
Needle disp 21G	32	0	0.0	0	0.0
Needle disp 23G	32	0	0.0	2	6.3
Sut absorbable need 3/8 26mm	32	2	6.3	1	3.1
Sut non absorbable need 3/8 30mm	32	1	3.1	1	3.1
Gloves exam latex medium disposable	32	0	0.0	0	0.0
Cotrimoxazole syrup	32	1	3.1	1	3.1

DISCUSSION

- **A standard kit contains 38 stock items listed above. Quarterly deliveries were made except for the fourth quarter due to stock outs at Natpharm. A kit is meant to carter for four hundred patients per institution per month. However Natpharm supplied less than the recommended number of kits per clinic due to logistical challenges.**

- **The City continued to supplement some of the fast moving PHCP and hospital kit commodities that were not adequately provided for by the Ministry of Health and Child welfare.**
- **The stock status data for these items is collected during the quarterly zip/phcp delivery run. No data was collected for the third quarter due to funding challenges from the Ministry of Health and Child welfare. Therefore quarter three and four stock out data is not reflected above.**
- **The stock outs were highest in the fast moving category of stock items namely: Amoxycillin 250mg capsules, Amoxycillin 125mg/5ml suspension, cotrimoxazole 480mg tablets, cotrimoxazole 240mg/5ml suspension, paracetamol 500mg tablets, paracetamol 120mg/5ml, hydrochlorothiazide 25mg tablets, miconazole nitrate 2% cream, tetracycline 1% eye ointment, zinc 20mg tablets, oral rehydration salts (new formula) sachets, disposable needles 21g, disposable syringes 5ml, zinc oxide 2.5cm adhesive tape, non sterile gauze swabs 10x10cm.**
- **Throughout the year all clinics reported excess stocks of slow moving stock items namely: Adrenaline injection, Ampicillin injection, Atropine injection, Benzyl pen injection, Dextrose 50% injection, diazepam injection, Hydrocortisone injection, Lignocaine 2% injection, Water for injection, Albendazole tabs, Doxycyclin 100mg caps, Frusemide 40mg tablets, Ferrous sulphate + folic acid tablets, Suture absorbable DEC2 needle 3/8 26mm, and Suture non absorbable DEC3 needle 3/8 30mm.**

ANTIRETROVIRAL MEDICINES AND TEST KIT

- **Due to erratic and inadequate supplies of ARV medicines all the initiating and follow up sites in the City were unable to maintain their stocks between the minimum and maximum stock levels of 3 and 5 months worth of stock respectively.**
- **Natpharm delivers ARV medicines and test kits directly to the clinic every two months. Throughout the year however, the stocks were not equitably allocated and distributed to the clinic. The pharmacy section was therefore faced with the challenge of correcting this anomaly. Without a vehicle allocated to the pharmacy, this task was difficult to accomplish. Avoidable stock outs could have been averted if transport had been made available.**
- **There were erratic and inadequate supplies of Nevirapine 200mg tablets, Efavirenz 600mg tablets, lopinavir/ritonavir, atazanavir/ritonavir 300/100mg throughout the year due to stock ruptures at Natpharm. In an effort to avoid stock outs, the City was forced to use some stocks of Nevirapine and Efavirenz 600mg tablets from the IHC2 Mabvuku project.**
- **In the fourth quarter there were limited stocks of SD bio line test kits.**
- **All sites experienced storage challenges due to redundant stocks of Tenolam & the bulkiness of FDC Tenofovir co-pack. Tenolam was redundant because of stock outs of Nevirapine 200mg tablets.**

ACHIEVEMENTS

- **Recruitment of two Pharmacy Technicians**
- **Disposal of expired medicines and sundries that had accrued over several years.**
- **Improved stock management at the City Medical Stores.**
- **Medicine management training of 25 nurses and 2 dispensary assistants.**
- **100% availability of vaccines throughout the year and a sound cold chain maintenance and stock control.**
- **Increased productivity despite a critical shortage of staff.**
- **Developed standard operating procedures for all process pertaining to Pharmaceutical services at the City Medical Stores and clinics.**

CONSTRAINTS/ CHALLENGES

- **Critical shortage of staff and skills gap.**
- **The absence of a substantive Pharmacist to assist the Chief Pharmacist with her work is hampering the efficiency of the department. The recruitment exercise must be given urgent attention.**
- **Unavailability of a computerised stock management system.**
- **Absence of a routine stock status reporting system. The City was therefore unable to accurately quantify the stock levels of medicines and medical sundries at clinic level. This is largely due to the absence of a computerised stock management system and lack of manpower to capture this information manually.**
- **Unavailability of reliable and adequate transport service.**
- **Inadequate storage facilities.**
- **Delays in ZIP / PHCP deliveries & inadequate supplies.**
- **Delayed deliveries of Anti-Retroviral medicines from Natpharm throughout the year due to transport challenges.**

- **Beatrice road Hospital OI adult is holding excess stocks of short dated Tenolam (March & June 2013). This is stock that cannot be utilised due to stock outs of Nevirapine 200mg tablets. Efforts are being made to redistribute this stock through Natpharm to other public health Institutions**

- **Increased volumes of short dated and slow moving medicines and medical sundries. These are a direct result of the Zimbabwe Informed Push System of PHCP and Hospital Supplementary kit. This is compounding an already existing storage problem. At the current rate of usage these stocks are bound to expire on our shelves before they are used. NatPharm is currently unable to take these stocks off our shelves despite requests to that effect.**

- **Expiration of some ZIP/PHCP short dated and slows moving stock items on our shelves before usage. Three clinics also reported expiration of Nevirapine syrup, Abacavir tablets and lopinavir/ritonavir. This is due to poor stock management, a direct result of storage constraints. Consequently First expiry first out principle (FEFO) could not be practiced.**

- **We had planned to promote and monitor rational use of medicines in all City Health Institutions in the third and fourth quarter. However, the findings of the second quarter support and supervision, revealed the need to train and strengthen stock management. Therefore no rational use monitoring was done.**

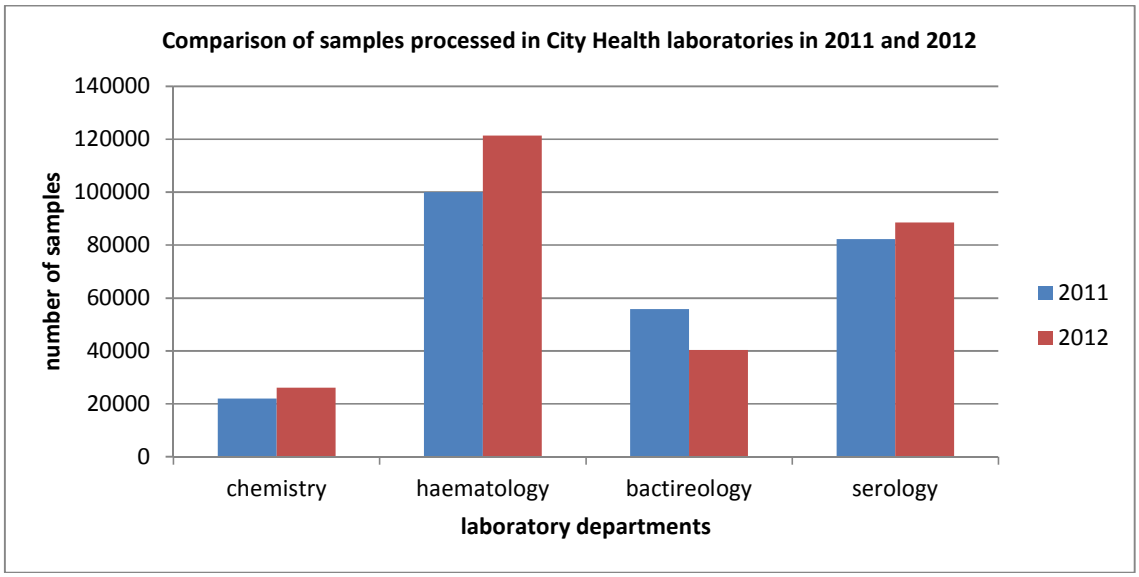
PLANNED ACTIVITIES FOR 2013

- **Aim to achieve 100% availability for vital medicines and sundries and 80% availability for essential medicines and medical sundries.**
- **Staff recruitment and development.**
- **Change and performance management.**
- **Computerisation of stock management.**
- **Conduct clinic and hospital support & supervision.**
- **Formation of a Hospital Medicine and Therapeutic Committee, which will monitor rational use of medicines.**
- **Educate clinic staff on the importance of quarterly stock returns.**
- **Strengthen Logistics Management Information System (LMIS) data collection and reporting.**
- **Address storage problem.**
- **Procurement of Pharmacy delivery cages**

MEDICAL LABORATORY

Introduction

2012 has been a busy year for the twelve polyclinic and two hospital laboratories where a total of 276 300 samples were analyzed in comparison to 171 339 of 2011. Majority of the samples were recorded in Haematology. A decline in bacteriology samples is mainly due to low sputum submission which can be attributed to the closure of the 45 collecting sites that had been introduced in 2011 under TB reach.



Constrains

- **Shortage of staff at both WIDH and BRIDH laboratories resulted in failure to meet the targeted turnaround time of 24hours which is one of the indicators for accreditation. In order to meet the targets, the laboratory through the management review increased the TAT to a maximum of 72 hours.**
- **Supervisory visits to WIDH and polyclinic laboratories was a major constraint due unreliable transport and in areas not covered by motor cycles, sample and result transportation remains a major challenge**
- **Failure to introduce bacteriology culture at WIDH due to lack of manpower.**

Goals for 2013

- **Accreditation: To go for certification**
- **Accreditation for WIDH and polyclinic laboratories**
- **Bacteriology-culture at Wilkins hospital**
- **To fill vacant posts in the laboratory**
- **Introduction of more tests at the poly clinics**
- **Offer PCR and Viral load testing**
- **Generate revenue**

CONCLUSION

The laboratory staff has worked extremely hard during the two epidemics as well as towards accreditation. With the operation of clinics and WIDH laboratories, sputum TAT has improved. Transport remains a major challenge.

STATISTICAL REPORT ON TESTS PERFORMED IN LABORATORIES

1. CLINICAL CHEMISRTY

CLINICAL CHEMISTRY TESTS	2011	2012
Alkaline phosphatase	1 309	516
Aspartate aminotransferase	1 301	601
Alanine amino transferase	2 627	4 710
Direct bilirubin	1 211	267
Total bilirubin	1 253	595
Albumin	1 316	593
Uric acid	3	-
Blood glucose	1 437	1 072
Creatinine	2 191	4 710
Urea	3 702	6 778
Sodium	2 105	2 194
Potassium	2 032	2 143
chloride	-	867
Total protein	19	602
γ-GT		31
Lactate	112	125
Triglycerides	29	67
Total cholesterol	29	67
HDL	13	59
LDL	13	59
Total	22 070	26 056

2. SEROLOGY

Serology tests	2011	2012	Positives for 2012
Rhesus antigen	39 362	41 941	41 850
Du antigen	605	91	91
Antibody screen	0	0	
Antibody identification	0	0	
Malaria	113	298	4
RPR	39 950	42 230	162
HIV	1 915	3 672	1 468
HbsAg	224	162	22
TPHA		162	162
Pregnancy tests	28	28	13
Total	82 197	88 584	

3. BACTERIOLOGY

A: Stool cultures	2011	2012
Salmonella typhi	26	109
Shigella	185	249
E. coli	76	6
Vibrio cholerae Inaba	0	0
Vibrio cholera Ogawa	0	0
Total stool samples	2 429	4 363
B: Sputum for AFBs		
AFB positives	2 696	3 743
Total sputum samples	42 846	28 141
C: Urine cultures		
Urine salmonella typhi		3
Presence of pathogens	3 231	2 066
Total urines samples	5 077	5 014
D: STIs microscopy		
Gonococci	33	
Yeasts cells	258	597
Bacteria vaginosis	142	97
Total samples	798	1 398
E: Others		
Blood cultures	374	794
S-typhi in Blood cultures	-	75
CSF/Swabs/Aspirates	354	475
Total bacteriology samples	51 882	40 260

4. HAEMATOLOGY

Haematology tests	2011	2012
Full blood count	42 440	49 561
Differential count	42 440	49 561
Reticulocyte counts	0	0
Sickle cell count	O	0
ESR	2	5
Coagulation studies	0	0
CD4	15 190	22 284
Peripheral smear	0	5
Total	100 072	121 416

4. TOTAL SAMPLES ANALYSED

Test total by discipline	2011	2012
Chemistry	22 070	26 056
Haematology	100 072	121 416
Bacteriology	51 882	40 260
Serology	82 197	88 568
GRAND TOTAL	171339	276 300

SUCCESSES OF YEAR 2012

- **Accreditation: The laboratory managed to get four stars and was one of the best laboratories that went through the assessment.**
- **TB microscopy centre opened at WIDH**
- **All the 12 polyclinic laboratories were TB microscopy and HIV testing**
- **Turn Around Time for TB results reduced to a range of between one(1) to five(5) hours**
- **Received 30 microscopists under global fund**
- **Received the following equipment;**
  - **Two Chemistry analyzers**
  - **One Autoclave**
  - **Gene X-pert**

- **Timeous confirmation of typhoid outbreak in Kuwadzana and Glenview**
- **Provided sensitivity pattern *of Salmonella typhi* through the two outbreaks**
- **Improved sample and result transportation**
- **Occupied new wing of the recently extended laboratory**
- **Interacted with other health sections through meetings, workshops etc.**
- **In line with our strategic plan, we are ahead of most planned activities for 2015.**
- **Support from the directorate**

DENTAL SECTION

Introduction

A total of 7 868 clients visited our Dental clinics during 2012. This represents an increase of 11% compared to the year 2011. The number of patients increased considerably because we were now accepting HMMAS from March 2012.

Gershon Dental Clinic saw a bigger number as usual. A total number of 6 485 visited Gershon Dental Clinic which is 82% the total number of patients seen in all dental clinics. There was an increase of 19% compared to 2011 at Gershon Dental Clinic despite the decrease in the number of operators.

Attendance at Kuwadzana Dental Clinic showed no significant change since the total number of patients of 1 029 patients were seen in 2011 compared by 1 026 patients seen in 2012. There was decrease in attendance at Mufakose Dental Clinic by 17%.

Keeping Mabvuku and Hatcliffe Dental Clinics operational was a challenge because of transport problems during the 1st and 2nd quarters. In the last half of the year, another factor that is staff shortage came into play such that we closed Hatcliffe and Mabvuku Dental Clinics temporarily.

Oral Health programs were not done throughout the year 2012 due to shortage of staff except only two visits done during end of year accompanied by Aqua-fresh agents.

Three (3) Dental Therapists and the Dental Services Manager left the dental section during the course of 2012. This exodus left the section in a significant shortage of staff especially the operators.

Two (2) dental chairs, autoclave and two scaler machines were repaired. One compressor was serviced. 12 Dental Interns from the University of Zimbabwe were on rotational basis every three months throughout the year 2012.

BREAKDOWN OF SERVICES PROVIDED AT THE VARIOUS DENTAL UNITS

GERSHON DENTAL

Total Number of Patients - 6 485
Paid - 4 277 (66%)
Free - 810 (12%)
Medical Aid - 1 397 (22%)

TREATMENT		0-6 YEARS	7-17 YEARS	18+ YEARS	TOTAL
Examination Paid :	Paid	45	122	896	1 063
	Free	46	55	431	532
Reviews		0	32	52	84
Extractions :	Paid	80	233	5 305	5 618
	Free	44	57	465	566
Scaling		0	5	364	369
Filling Amalgam		0	6	310	316
Filling Aesthetic		0	4	94	98
Temporary Fillings		0	1	49	50
Disimpactions:	Paid	0	0	122	122
(+ surgical.extraction.)	Free	0	0	15	15
Root Canals (sessions)		0	0	48	48
Apicectomy		0	0	22	22
Septic socket (Dry socket)		0	2	40	42
Splinting		0	4	7	11
Orthodontics (sessions)		0	5	0	5
Oral Surgery (minor)		0	4	13	17
X-ray :	Paid	0	9	300	309
	Free	0	0	0	0
Dentures (sessions)		0	0	136	136
Crown & Bridge		0	0	0	0
Antibiotics :	Paid	0	40	364	404
	Free	37	104	908	1 049
Referrals		1	2	32	37
Not treated/Appointments		0	1	17	18
Suturing		0	0	36	36
TOTAL		253	686	4 721	10 967

Acrylic Dentures: - Full - 9
- Partial - 77
- Repair - 31

KUWADZANA DENTAL

Total Number of Patients - 1 026
Paid - 587 (57%)
Free - 225 (22%)
Medical Aid - 214 (21%)

TREATMENT		0-6 YEARS	7-17 YEARS	18+ YEARS	TOTAL
Examination Paid :	Paid	7	57	647	711
	Free	32	8	141	181
Reviews		0	1	19	20
Extractions :	Paid	10	57	536	603
	Free	23	9	123	155
Scaling		0	0	41	41
Filling Amalgam		0	1	29	30
Filling Aesthetic		0	0	19	19
Temporary Fillings		0	1	9	10
Septic socket (Dry socket)		0	0	16	16
Antibiotics :	Paid	2	1	52	55
	Free	0	0	0	0
Referrals		0	0	17	17
Not treated/Appointments		0	0	0	0
Suturing		0	0	0	0
TOTAL		72	134	1 649	1 858

MUFAKOSE DENTAL

Total Number of Patients - 357
Paid - 138 (38.7%)
Free - 140 (39.2%)
Medical Aid - 79 (22.1%)

TREATMENT		0-6 YEARS	7-17 YEARS	18+ YEARS	TOTAL
Examination Paid :	Paid	11	24	162	197
	Free	20	3	110	133
Reviews		0	0	5	5
Extractions :	Paid	16	29	136	181
	Free	19	3	99	121
Scaling		0	0	24	24
Filling Amalgam		0	0	15	15
Filling Aesthetic		0	0	9	9
Temporary Fillings		0	0	7	7
Septic socket (Dry socket)		0	0	11	11
Antibiotics :	Paid	1	0	31	31
	Free	0	0	0	0
Referrals		0	1	9	10
Not treated/Appointments		0	0	0	0
Suturing		0	0	0	0
TOTAL		67	59	618	744

CHAPTER X

INFECTIOUS DISEASES HOSPITALS

- **Beatrice Road Infectious Diseases Hospital**
- **Wilkins Infectious Diseases Hospital**
- **HIV Programme**
- **MDR TB Programme**

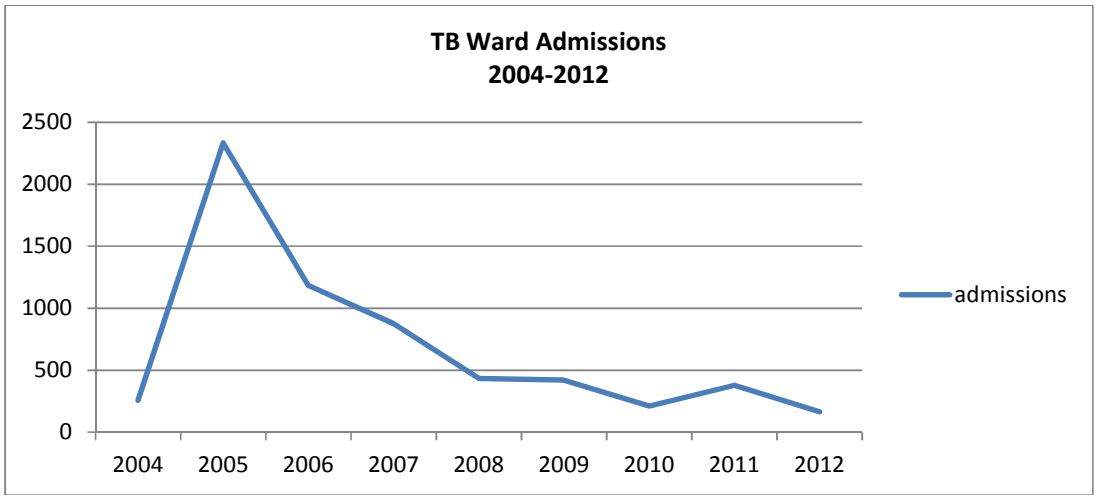
BEATRICE INFECTIOUS DISEASE HOSPITAL (BRIDH)

Isolation facilities for infectious conditions in the City of Harare are offered at BRIDH and Wilkins Infectious diseases hospital (WIDH). BRIDH was established 1 921 offering isolation for infectious conditions. The 160 bedded unit has since developed to offer other services to the residents of Harare. Of note there has been establishment of the opportunistic infections clinic in December 2006 and a bigger laboratory in 2012.

In 2012 the City was able to detect and determine the typhoid outbreak in Kuwadzana-Dzivarasekwa and Glen-View. Most of the work was around containment of the typhoid outbreaks but other units continued to offer the different services which are outlined below.

TB WARDS

Trend in Tuberculosis Ward Admission

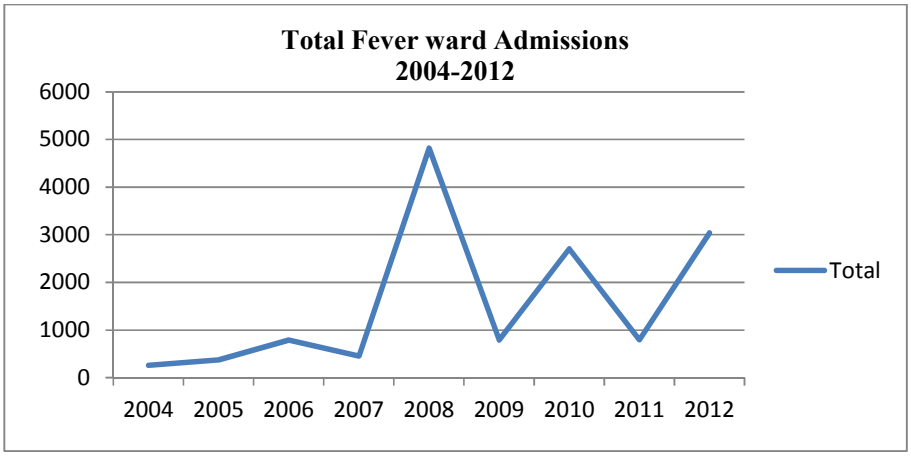


There has been a downward trend in TB ward admissions. This is possibly attributable to the fact that TB patients are referred to WIDH during outbreaks and possibly the reduction in TB cases requiring admission due to hospital policies among other reasons.

TB admissions: Comparison between 2011 and 2012

	2012			2011		
	Admissions	Deaths	CFR%	Admissions	Deaths	CFR%
PTB SS+	38	7	18.4%	97	32	33%
PTB SS-	78	17	21.7%	175	50	29%
PTB Not done	14	2	14.2%	9	4	44%
Other forms of TB	35	6	17.1%	98	30	31%
Total	165	32	19.3%	379	116	31%

FEVER WARDS



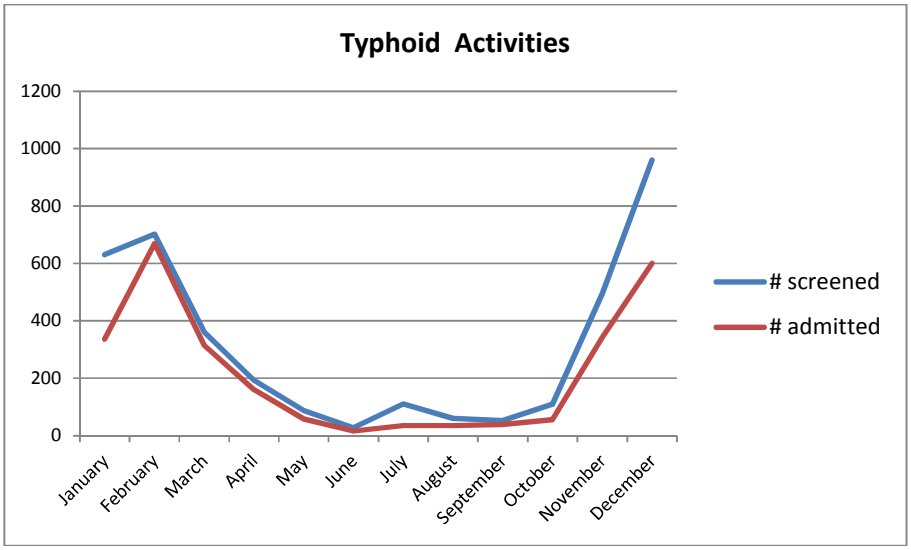
Fever ward admissions have followed the outbreak trend in the City (2008 Cholera, 2010 Kuwadzana-Dzivarasekwa typhoid and 2012 Glen view typhoid)

FEVER ADMISSIONS BY DISEASE

Disease	2012			2011		
	Admissions	Deaths	CFR %	Admissions	Deaths	CFR %
Typhoid	2 681	8	0.3	519	0	0
Dysentery	163	6	3.7	110	2	1.8
Measles	8	0	0	23	1	14.3
Gastroenteritis/Diarrhoea	157	11	7	85	3	3.5
Hepatitis A	30	-	-	-	-	-
Hepatitis B	5	-	-	-	-	-
Jaundice	8	1	12.5	22	2	9.1
Herpes zoster	2	0	0	14	0	0
Chicken pox	15	0	0	16	0	0
Suspected Rabies	0	0	0	3	1	33
Scabies	0	0	0	1	0	0
M. Meningitis	2	0	0	0	0	0
Total	3 042	26	0.9	795	9	1.1

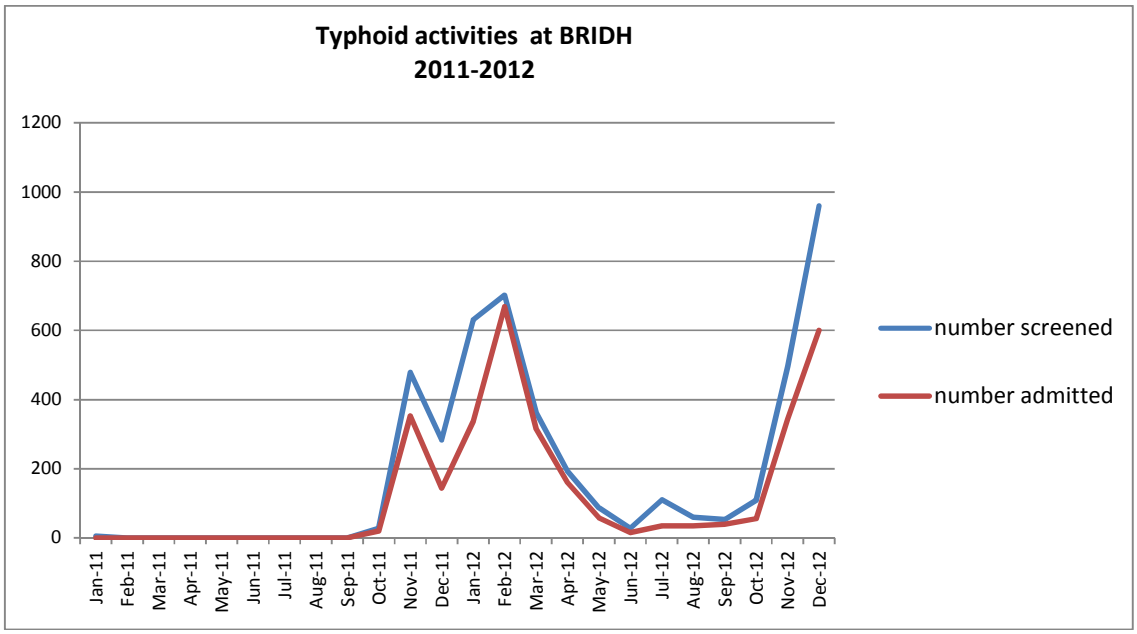
There was an increase in the case fatality rate among patients presenting with jaundice, dysentery and typhoid cases in 2012 in comparison with 2011

TYPHOID ACTIVITIES 2012

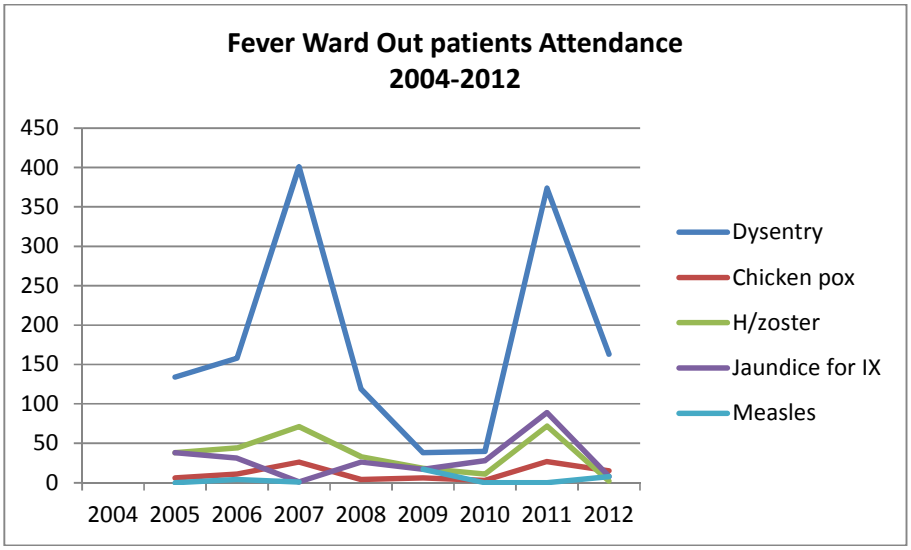


There was an increased number of typhoid cases during the rainy season and the city is recommended to address problems arising during this period. The hospital has however put in place a mechanism to prepare for outbreaks.

TYPHOID ACTIVITIES TREND 2011-2012



There was an increase in similar periods September to May in 2011 and 2012



MEDICAL EXAMINATION CENTRE
Case Notifications

	PTB +ve				PTB-Ve	PTB N/D	EPTB	Other	Total
	New	Relapse	Re treatment after RX failure	Re treatment after Default	New cases	New cases	New cases		
2012	878	119	13	23	1 321	233	635	242	3 464
2011	1 394	181	17	4	1 329	281	752	294	4 252

There is a decrease in number of notifications at MEC from 4 252 in 2011 to 3 464 in 2012. However the number of patients being retreated after default has increased.

TB/HIV ACTIVITIES

Year	Total patients notified	Total offered testing	Total accepted testing on notification	Found positive before TB diagnosis	Found HIV positive during TB Diagnosis	Total found HIV positive	Total HIV negative	Total put on CPT	Total HIV not done
2012	3 464	3 464	3 316	1 483	918	2 401	915	2 358	148
2011	4 252	4 252	3 813	1 531	1 215	2 746	1 204	2 710	302

HIV COUNSELLING/TESTING

Total HIV testing	Total accepting HIV testing	Total tested for HIV	TB patients testing Positive	TB patients testing negative	None TB testing HIV positive	None TB patients testing negative	HIV + TB patients put on cotrimoxazole	HIV+ TB patients put on ART files opened
2 212	2 189	2 188	370	388	510	920	589	467

The unit has introduced opening of files for HIV positive patients at the unit in order to increase those starting ART. There is also a drive to monitor the numbers that are coming back after 2 weeks of starting TB treatment. This exercise is expected to improve ART initiation.

Activity at MEC	
Physical Screening	
City of Harare	0
External Job Seekers	2 711
Immigrants	0
Typhoid Vaccinations	197
Nurses Review	8 609
DR's Clinic	
Attendances	4 143
Admissions	73
X-rays	
BRIDH: Hospitals & OIC	2 104
MEC & Clinic	3 753
WIDH: Hospital & OIC	1 124
Total X-RAYS	6 981

FOOD HANDLERS ACTIVITIES

Total food handlers	Food handlers with disease		Food handlers without disease	Food handlers treated
	Shigella	Salmonella	703	48
751	11	36		

The unit handled a small number of food handlers in 2011. the goal in 2013 is to increase the numbers and hopefully the income.

OUTCOME ANALYSIS OF CASES

Type of	Total number of patients registered	Cured	Treatment completed	Died	Treatment failure	Defaulted	Transfer out	Total number evaluated	Total lost to follow up
New SS+ cases	1 394	910	4	40	17	20	157	1 148	246
Previously treated SS+ cases	202	108	1	6	7	3	22	147	55
All other cases	2 656	0	1 668	122	1	20	333	2 145	511

There is a challenge in getting outcome for patients that are notified at MEC and then move to PMDs. The unit will seek to address this problem.

OPPORTUNISTIC INFECTIONS CLINIC

This unit was opened to address the increasing number of HIV infected residents of Harare. It was opened to also complement the OI clinic at Wilkins hospital. Treatment at the unit is in principle for free with a small admin fee of a dollar. The idea behind the free treatment is to accommodate those residents that cannot afford the private sector services.

The unit is nurse run and doctor led with a compliment of primary care counsellors, peer educators and clerks

OPPORTUNISTIC INFECTIONS Progress Report

	Paeds 2012	Paeds 2011	% Change	Adults 2012	Adults 2011	% Change
New OI /ART registrations	44	40	10	1 362	1 551	-12
Total on Cotrimoxazole	270	529	49	5 640	8 562	-34
Total on Fluconazole for candidiasis	0	4	100	48	1 720	-97
Total on fluconazole for cryptococcal meningitis	0	0	0	177	353	-50
Total on 1st Line ART	339	543	-38	9 185	10 044	-9
Total on 2nd line ART	2	2	-38	204	101	102
Total initiations	59	63	0	1 223	1 047	17
Initiations Cumulative	772	506	Cum	21 322	16 169	Cum
Total registration to date	1 063	782	+36	32 461	28 516	14
Clinic Attendance	893	1 549	-42	12 752	13 108	-3

PMTCT ACTIVITIES

	2012	2011	%
HIV + pregnant mothers initiated on ART	44	21	110
Post Natal mothers initiated on mothers	9	1	900
Infants on ART	47	19	147
NVP exposed infants initiated on ART	16	4	300

There has been a general increase in the initiation of ART

DECENTRALISATION

	Paeds 2012	Paeds 2011	% Change	Adults 2012	Adults 2011	% Change
Within Harare	25	0	100	1244	1120	11
Outside Harare	6	6	6	176	129	36

Decentralisation has helped decongest the unit and credit should be given to the OIC team for their efforts.

HIV/TB COLLABORATIVE ACTIVITIES

	Paeds 2012	Paeds 2011	% Change	Adults 2012	Adults 2011	% Change
TB Patients who are HIV+ started on ART	12	5	38	277	116	138

There has been an increase in the number of TB patients being started on ART

MORTUARY

Time	Private Undertakers		Hospital Bodies		Still Births		Total	
	2012	2011	2012	2011	2012	2011	2012	2011
1st QTR	68	83	15	46	19	19	102	148
2nd QTR	121	72	16	49	32	17	144	153
3rd QTR	95	101	28	42	26	18	141	169
4th QTR	111	55	23	25	18	22	157	98
Total	395	311	72	162	95	76	544	568

In 2012 trolleys, racks and mortuary compartment doors were repaired. The chapel and trolleys were painted whilst the geysers were replaced.

The section remains without a storeroom computer and is in need of new furniture

The hospital gardens procured brush cutters and lawn mowers. There was replacement of wild grass by proper 'Durban' lawn which should make maintenances easier. The areas which have low water pressure remain a major challenge.

LAUNDRY

The laundry section services the whole City. It is not spared during the outbreaks as the City battles to contain outbreaks. There is staff shortages and break down of the old machinery. The section did process its workload but has a challenge as regards some machinery that is now obsolete. The machinery the section is using by year of purchase is shown in the table below:-

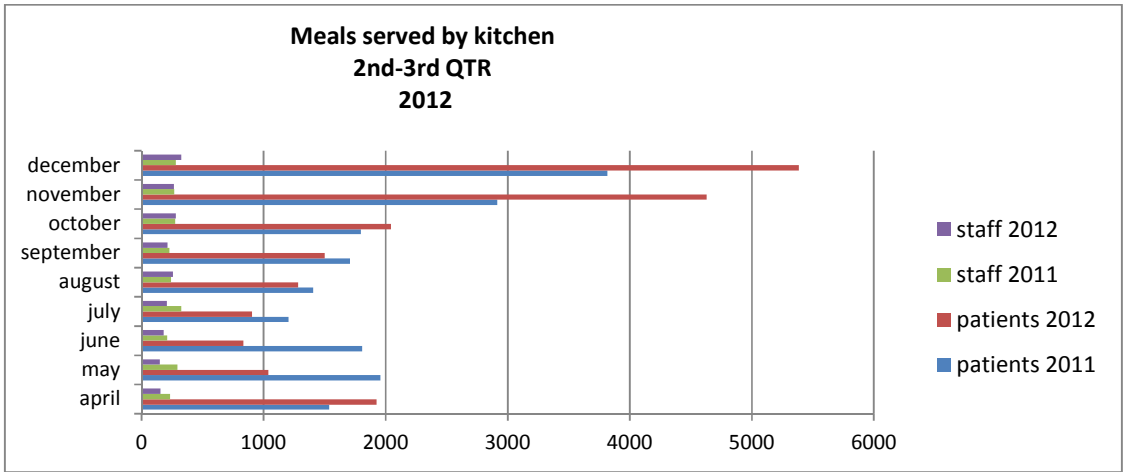
MACHINERY

TYPE	NUMBER OF MACHINES	LOAD / KG MASS	YEAR OF PURCHASE
Front Loading washing Machine	2	100kg each	1987
Speed Queen Washing machine	2	100kg each	2008
Big Spin drier	1	200kg	1994
Small Spin drier	1	100kg	1975
Drying Tumblers	4	25kg each	1984/1987
Pressor	1		1987
Blue Roller Iron(Miele Professional)	1		1987
Large Roller iron(Mariner)	1		1966
Small Roller Iron (Norva)	1		1987
Large Roller iron(Nyborg ex Wilkins Hospital)	1		1963
Roller iron Grandimpiati	1		2008
Compressor	1		1987
Side loading Washing Machine	1	100kg	1968

The machinery has outlived its lifespan. The machines constantly breaking down. It is recommended that the department procures modern machines. The hospital has a planned maintenance and service plan in place and hopes department of works will be supportive

KITCHEN

The kitchen was painted in 2012, ceramic tiles were fitted, food trolley was bought and yet to be finished. The food supplies were adequate with no major shortages. There was an increase in the number of meals served in 2012 due to the outbreak as illustrated below:-



The kitchen requires an industial stoves to replace the old stoves.

THE FUTURE

The hospital still needs to keep its eye on the vision of excellence by 2025. The concept of performance mangement buttressed by the RBM concepts should definitely see the hospital navigating to its intended destination.

WILKINS INFECTIOUS DISEASES HOSPITAL

INTRODUCTION

Wilkins is a 35 bedded hospital situated in Milton Park. This hospital offers:

- **Admission and in patient care for patients with infectious diseases**
- **Outpatient management of infectious diseases**
- **Genito-Urinary Centre which offers management of Sexually Transmitted Infections**
- **Opportunistic Infections Clinic which offers HIV care, treatment and support**
- **New Start Centre for HIV counselling and testing services**

The year 2012 was characterised by strengthening of management structures within the hospital. To this effect the hospital executive worked together with the hospital management to implement hospital operations and administration. The infection prevention and control (IPC) structures, headed by the IPC nurse, were established. The quality management system (QMS) internal audit team was also constituted. The hospital management team participated in the process of development a BIQ system for the hospitals in the City, in conjunction with the IT department.

The following is a report of the activities that took place in the different sections within the hospital.

MANAGEMENT AND COORDINATION

Management Meetings Held, January – December 2012

Indicator	Target	Achieved
Hospital Executive meetings	12	8
Hospital Management meetings	12	15
Works Council meetings	4	2

The table illustrates that more hospital management meetings than had been scheduled were held. This was because some of these meetings were feedback meetings called for by the QMS focal person, IPC nurse and the IT team during the development of the BIQ system. Failure to constitute a quorum resulted in some of the works council meetings not proceeding.

OTHER TARGETS VERSUS ACHIEVED, WILKINS HOSPITAL, 2012

Component	Target	Achieved
Increase ART coverage among TB patients	> 90% by Dec	91.7% in Q4
Offer VIAC clinic	31 March	21 May
Offer sputum microscopy services onsite	April 2012	July
Reduce turnaround time for routine ward specimens to less than 3 hours	February 2012	Achieved during first half of year
Conduct mortality audits at least once a month	Monthly	One in second quarter
Train hospital staff in computers	2nd quarter	2nd quarter
Exit interviews on customer satisfaction	Jun, Dec	July, January 2013
Train hospital staff in performance appraisal	2nd quarter	Not yet
Performance appraisal bi-annually	Biannual	Not yet done

The majority of the targets set for the year were achieved although for some it was not within the set timeframes. Activities related to performance management were done because staff office could not train the hospital team as initially they were revising the performance appraisal form and later on they were now introducing a new system, results based management.

2. HIGHLIGHTS OF NURSING SERVICES

Several staff development activities took place during the course of 2012 and these are summarised as follows.

- **One RGN was attached to Parirenyatwa Hospital for 3 months and was mentored on infection control**
- **One male RGN was trained on medical male circumcision at Spilhaus.**
- **Two RGNs were promoted to be sisters in charge and were deployed to other districts**
- **A fourth sister in charge was added to the hospital staff establishment**
- **The GUC started offering VIAC services**
- **The hospital nurses participated in the exit interviews on customer satisfaction**
- **The OIC nurses conducted a survey to determine reasons for discrepancies between registered patients and those initiated on ART**

3. IN PATIENT SERVICES

TB Admissions and deaths, Wilkins Hospital, 2012

Disease	Q1		Q2		Q3		Q4		2012	
	Adm	Death	Adm	Death	Adm	Death	Adm	Death	Adm	Deaths
PTB +ve	43	6	31	15	9	3	17	2	100	26
PTB -ve	8	3	11	8	10	2	44	11	73	26
PTB ND	3	3	7	1	7	1	16	2	33	7
EPTB	12	4	12	6	11	1	18	5	53	16
MDR TB	4	2	5	3	13	3	4	0	26	8
TOTAL	70	19	66	33	50	10	99	20	285	83

A general decline in TB admissions was observed from the first to the third quarter followed by an upsurge in the fourth quarter. The high numbers recorded in the first and fourth quarters were because of the referral of all TB patients requiring admission to Wilkins since BRIDH was not admitting the same patients. This was because of the typhoid outbreak that was going on in the City at that time. The fourth quarter recorded the highest proportion of patients with sputum not done TB. This was partly because a significant proportion of the admitted patients died or was transferred to a higher level within 24 hours of admission and this was before sputum specimens had been collected for analysis. There is need to strengthen sputum collection in all admitted patients.

COMPARISON OF 2012 AND 2011 TB ADMISSIONS AND DEATHS, WILKINS HOSPITAL, 2012

Disease	2012			2011		
	Admissions	Deaths	CFR	Admissions	Deaths	CFR
PTB +ve	100	26	26.0	71	7	9.8
PTB -ve	73	26	36.0	40	7	17.5
PTB ND	33	7	21.2	27	10	37.0
EPTB	53	16	30.0	61	11	18.0
MDR TB	26	8	31.0	10	1	10.0
TOTAL	285	83	28.7	209	36	17.2

Relative to 2011 there was an increase in admissions of all forms of TB in 2012. This was also coupled by an almost doubling of TB deaths from 17.2% to 28.7%. The highest share of TB deaths was among the patients with sputum negative TB. These were mostly patients with HIV co-infection and other opportunistic infections like PCP and cryptococcal meningitis. The mortality among PTB ND patients declined from 37.0% to 21.2%, a positive observation for this population group.

ADMISSIONS AND DEATHS IN FEVER CASES, WILKINS HOSPITAL, 2012

Disease	Q1		Q2		Q3		Q4		2012	
	Adm	Death	Adm	Death	Adm	Death	Adm	Death	Adm	Deaths
Hep A	1	0	6	0	4	1	0	0	11	1
Jaundice	3	0	0	0	1	0	1	0	5	0
Dysentery	0	0	0	0	2	0	2	0	4	0
Chicken pox	1	0	0	0	0	0	1	0	2	0
Herpes Zoster	0	0	0	0	0	0	0	0	0	0
Rabies	0	0	0	0	0	0	0	0	0	0
Measles	0	0	0	0	0	0	0	0	0	0
Other non-fever	0	0	8	2	7	1	3	0	18	1
TOTAL	5	0	14	2	14	2	7	0	40	1

Fever admissions doubled from 21 in 2011 to 40 in 2012. Of the patients admitted in 2012, one deceased giving a case fatality of 2.5%. Eighteen of the patients presented with other non-fever conditions like PCP, acute G/E and lactic acidosis. One member of staff was admitted in the wards with acute asthma.

4. OUTPATIENT SERVICES

TABLE 7: TOTAL OUTPATIENTS DEPARTMENT ATTENDANCES, WILKINS HOSPITAL, 2012

Disease	Q1	Q2	Q3	Q4	2012	2011
New TB	668	497	523	493	2 181	2 706
TB Discharge	362	312	327	318	1 351	1 016
Unregistered TB	412	679	630	401	2 122	0
Measles	0	0	2	1	3	12
Chicken pox	1	3	0	1	5	10
Herpes zoster	8	3	5	7	23	35
Rabies vaccine	35	11	10	4	25	48
Diarrhoea / dysentery	36	8	34	42	120	69
Hepatitis			Combined			
Hep A	14	3	– 17	3	20	5
Hep B	8	2		9	19	2
Jaundice	31	8		12	68	60
TB Reviews	996	908	719	710	3 333	3 779
MDR	159	120	185	137	601	74
Enquiries	965	891	941	671	3 468	3 537
TOTAL	3 695	3 445	3 393	2 841	13 339	11 353

An increase of 17.5% was noted in the total attendances in 2012 compared to 2011. The noted increase was because of the DRTB clinic cases that have been on the increase. The noted increase was also due to capturing of unregistered TB cases and enquiries. There was a decline in new TB patients attended to in 2012.

QUARTERLY TB NOTIFICATIONS, WILKINS HOSPITAL, 2012

Disease		Q1	Q2	Q3	Q4	2012	2011
PTB +ve	New	176	174	118	106	574	674
	Relapse	19	15	5	19	58	34
	ReRx after failure	39	0	0	0	39	9
	ReRx after default	0	4	0	2	6	1
PTB –ve		190	203	295	277	965	1 104
PTB ND		27	29	30	32	113	89
EPTP		111	73	30	26	240	332
Other previously treated			39	24	36	96	74
TOTAL		562	529	502	498	2 091	2 317

The table illustrates a gradual decline in notifications from the first quarter to the fourth quarter of 2012 and a decline in total notifications in the year 2012 compared to 2011. This could be explained by the roll out of TB treatment to the clinics which saw sputum positive TB patients being initiated on treatment at clinic level. A gradual but small increase in patients with sputum not done was observed throughout 2012 as a result of an increase in children who were treated for TB in this year. However the proportion of those with sputum not done remained below 5% in line with the national recommendations.

TB TREATMENT OUTCOMES, WILKINS HOSPITAL, 2011

TB CASE	Q1	Q2	Q3	Q4	2011	2010
Total registered	581	619	690	605	2 495	2 367
Sputum +ve and Relapse	153	144	210	124	631	660
Cured	88	102	140	126	456	422
Treatment completed	368	308	273	278	1 227	1 212
Died	16	17	37	23	93	108
Treatment failure	1	3	0	1	5	10
Transferred out	32	119	100	95	346	280
Untraced	74	67	93	44	278	310
Total evaluated	505	549	550	523	2 127	2 032

The cure rate increased from 64.0% in 2010 to 72.3% in 2011. This increase could be partly explained by the availability of microscopy services on site which made sputum results more accessible. A marginal decrease of TB deaths from 16.4% to 14.7% could be due to early initiation of ART in those who were TB/HIV co-infected. There was a discrepancy between the registered TB cases and those evaluated. This was as a result of unavailability of transport to make follow ups on without phones.

TB/HIV COLLABORATIVE ACTIVITIES, WILKINS HOSPITAL, 2012

Component	Q1	Q2	Q3	Q4	2012	2011
All TB cases	550	529	523	493	2 095	2 496
HIV counselled	510 *(92.7%)*	529 *(100%)*	523 *(100%)*	493 *(100.0%)*	2 055 *(98.1%)*	606 *(24.3%)*
HIV tested	406 *(76.9%)*	473 *(89.4%)*	198 *(37.8%)*	473 *(95.9%)*	1 550 *(75.4%)*	606 *(100.0%)*
HIV +ve	272 *(67.0%)*	333 *(62.9%)*	99 *(50.0%)*	436 *(92.2%)*	1 140 *(73.5%)*	529 *(87.3%)*
Cotrimoxazole	259 *(95.2%)*	263 *(78.9%)*	99 *(50.0%)*	211 *(48.4%)*	832 *(73.0%)*	413 *(78.1%)*
ART	223 *(82.0%)*	189 *(57.0%)*	61 *(61.5%)*	400 *(91.7%)*	873 *(76.6%)*	228 *(43.1%)*

From the first to the fourth quarter a steady increase in the proportion of those offered HIV counselling who then got tested was noted except for the dip in the third quarter. This dip was because the majority of the patients registered during this quarter had already been tested and some were also on ART. An increase in ART coverage was noted from the first quarter to the fourth quarter and also from 2011 to 2012. This was because primary counsellors were seconded to the TB clinic and the ward to counsel and test all TB patients for HIV, to register and prepare for ART those who tested HIV positive and to identify those TB patients who would not have been initiated on ART at 2 weeks of TB treatment. ARV drugs were availed at the OPD so that those patients who would have been prepared for ART would be commenced on ART at the OPD, thereby reducing the time they spent in queues.

MDR TB ACTIVITIES, WILKINS HOSPITAL, 2012

Component	Q1	Q2	Q3	Q4	2012	2011
Confirmed DRTB registered to date	52	63	74	79	79	42
DRTB cases confirmed and enrolled on Rx	11	8	10	8	37	34
DRTB suspects	24	92	44	4	164	43
Total attendances	144	120	185	137	488	74
New pts confirmed and out on Rx	11	6	12	8	37	42
Deaths	0	0	3	0	3	5
Discharges	1	1	3	7	12	0

Out of the 79 patients registered to date, 12 have been cured, a total of 9 patients have died and one had his treatment stopped due to poor adherence whilst another patient had his treatment stopped after DRTB had been ruled out. Of 56 patients on treatment, 24 are from Harare, 9 from Chitungwiza and 23 are from provinces.

VIAC CLINIC ATTENDANCES

The VIAC clinic was opened on 21st May 2012. At its inception, the majority of clients were referred from O.I.C but over time clients were now coming from all over and outside Harare. The total number of clients attended to in 2012 was 1560 and 1 552 of these were screened for cervical cancer. The following graphs show the distribution of clients by different variables.

Fig 1a: HIV status

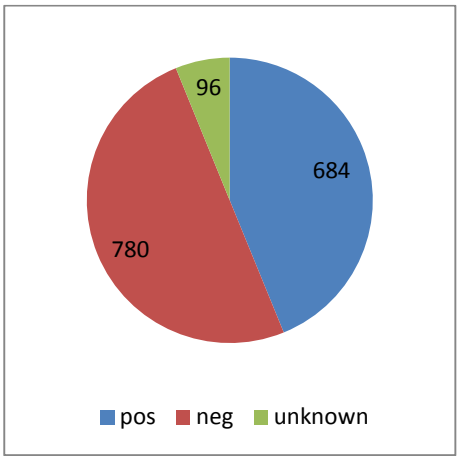
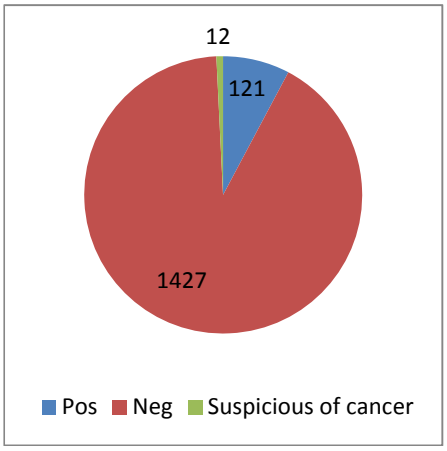


Fig 1b: VIAC results



Almost 50% of the VIAC clinic attendances were HIV positive because these patients came in as referrals from the OI clinic. The majority of the screened women had negative VIAC results. The positivity rate was 8.6%. Those whose results were suspicious of cancer either had punch biopsies done or were referred to the gynaecologists for further management. Among the women who had positive VIAC findings, 6.2% were HIV positive, 2% HIV negative and 0.3% had an unknown HIV result. The most commonly affected age group was 30 – 39 year olds.

7. OPPORTUNISTIC INFECTIONS CLINIC

TABLE 13: SUMMARY OF OIC STATISTICS, WILKINS HOSPITAL, 2012

Component	Q1	Q2	Q3	Q4	2012	2011
New registrations	1 525	1 611	1 244	1 178	5 558	6 178
New registrations to date	30 963	32 547	33 791	34 969	34 969	29 411
New initiations	1 170	1114	622	728	3 634	4 941
New initiations to date	28 283	29 397	30 019	30 747	30 747	27 113
Number started on CMZ this period	1 523	1 601	1 212	1169	5 505	6 170
Adolescents started on ART this period	19	31	20	20	90	86
Adolescents on ART to date	1 712	1 743	1 763	1 783	1 783	1 693
Chn < 5 put on ART this period	26	14	15	13	68	94
Chn <5 on ART to date	120	134	149	162	162	94
Transfer in this period	1250	101	484	538	1 373	2 889
Transfer in to date	3 139	3 240	3 724	4 262	4 262	2 889
Transfer out	201	247	266	155	869	850
Decentralised this period	1 385	818	526	427	3 199	5 342
Decentralised to date	21 544	22 362	22 888	23 315	23 315	20 159
Deaths this period	9	4	7	10	30	25
Switched to 2nd line this period	6	4	6	10	26	26
Switched to 2nd line to date	282	286	292	302	302	276

There was a decrease in patients who were registered and those who were commenced on ART in 2012 compared to 2011. This could be because of the roll out of ART initiation services to 7 primary health care clinics which saw a significant number of patients now being commenced on ART at their local clinics. More than two thirds of the patients ever initiated on ART have been transferred to the peripheral clinics for follow up.

8. HOSPITAL MORTUARY

BODIES HANDED BY MORTUARY, WILKINS HOSPITAL, 2012

Component	Q1	Q2	Q3	Q4	2012	2011	% change
Total bodies received	153	151	138	141	583	645	-9.6
Bodies from hospital	19	37	13	20	89	53	67.9
Bodies from private parlours	134	114	125	121	494	592	-16.6
Male bodies	73	73	80	72	303	356	-14.9
Female bodies	80	63	58	69	280	289	-3.1

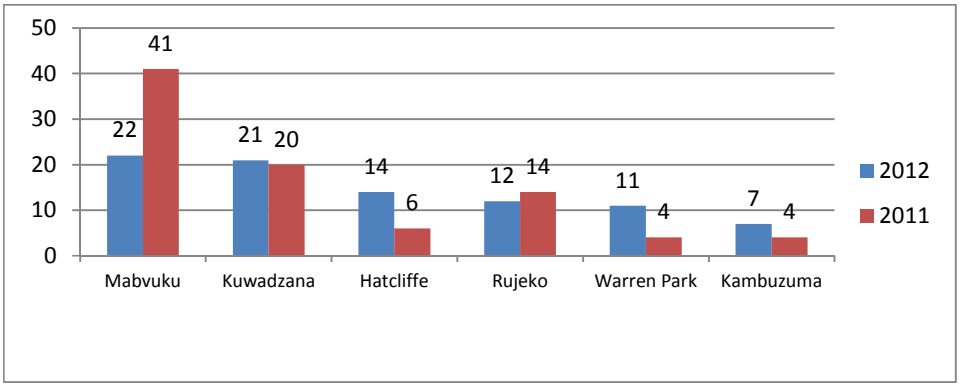
The number of bodies admitted into the hospital mortuary remained fairly stable throughout the four quarters of 2012. A decline of 9.6% was noted from 645 in 2011 to 583 in 2012. Private parlours remained the biggest source of the mortuary admissions throughout 2012 and 2011.

STILLBIRTHS HANDLED BY HOSPITAL MORTUARY, WILKINS HOSPITAL, 2012

Component	Q1	Q2	Q3	Q4	2012	2011
Macerated SBs	6	14	5	13	38	46
Fresh SBs	16	3	8	8	35	25
Neonatal deaths	2	4	5	3	14	18
TOTAL	24	21	18	24	87	89

A marginal decrease in stillbirths (SBs) admitted into mortuary was observed in 2012. Macerated SBs were the commonest type received both in 2012 and 2011. The graph below shows the clinics from which the SBs came from both in 2012 and 2011.

Fig 2: Distribution of stillbirths by source clinic, Wilkins Hospital, 2012



Mabvuku polyclinic remained the leading source of SBs in both years and the second common source of SBs in the two years as well as throughout the four quarters of 2012 was Kuwadzana polyclinic. Out of the 87 SBs admitted into mortuary, 15 had not yet been collected for either incineration or burial by the end of December in 2012

All fridges were working well throughout the year. Security lights in and outside the mortuary were functional. Unavailability of a mortuary trolley continued to affect mortuary operations as the section had to share one trolley with the ward. Maintaining good control of fridge temperatures was difficult because of frequent power outages.

9. KITCHEN SERVICES

Table 18: Meals served by kitchen, Wilkins Hospital, 2012

Meals served to:	Q1	Q2	Q3	Q4	2012	2011	% change
Patients	844	789	597	821	3 051	1 818	67.8
Kitchen staff and other staff	953	973	965	994	3 885	3 672	5.8
Doctors and matrons	154	152	166	27	499	626	-25.5
PHE Meetings	0	0	0	0	0	15	--
Functions	84	0	162	110	356	381	-6.6
TOTAL	2 035	1914	1 890	1 952	7 791	6 512	19.6

There was an increase in the meals served to patients in 2012 as a result of the increased admissions. On average patients stayed longer in the ward in 2012 compared to 2011. A

marginal increase in the meals served to kitchen staff was also recorded and the teas served to doctors and matrons decline in number as a result of the interruption in doctors meetings in the last quarter of the year. This was brought about by the PHE meetings which were held at Rowan Martin daily for about two months.

Generally supplies were good in 2012 although the kitchen had either low levels or nothing of some food items. In the first quarter there were no eggs and the quality of meat received was poor. The second quarter was characterised by a stock out of beans, margarine and eggs but petty cash was readily available to buy these food items. In the third quarter the kitchen had a shortage of tomatoes and milk and poor water supplies. There were frequent power cuts in the third quarter. The fourth quarter saw a critical shortage of mealie-meal resulting in the kitchen using petty cash to buy this commodity. However eggs were received during this period and power cuts continued. Throughout 2012 no repairs to broken down electrical appliances were made.

10. LABORATORY SERVICES

Tests run by the hospital laboratory , Wilkins Hospital, 2012

Component	Q1	Q2	Q3	Q4	2012	2011
CD4 absolute count	1 895	2 020	1 270	1228	5 185	7 324
C4 %	63	16	43	13	135	102
FBC	354	216	122	116	808	1 298
LFTs	167	293	140	154	784	474
U & Es	433	650	584	217	1 884	854
Glucose	44	106	65	30	245	140
GC smears	396	237	393	372	1 398	1 965
RPR	162	76	96	115	449	582
Urine microscopy	8	5	4	1	18	31
HBsAg	9	10	9	29	57	23
Pregnancy test	16	2	9	1	28	85
Serum lactate	30	14	33	7	125	112
Lipid profile	15	-	19	5	67	29
Uric acid	0	0	0	0	0	3
Chlamydia	0	0	0	0	0	13
Sputum microscopy	N/A	N/A	440	365	805	N/A
TOTALS	3 617	3 798	3 268	2 668	12 123	13 074

On the overall there was a 7.3% decline in the lab tests performed by the hospital lab. A sharp increase in total chemistry tests was recorded in 2012 whilst significant decreases were observed in CD4 absolute counts, GC smears and FBC samples processed in 2012.

11. QUALITY MANAGEMENT SYSTEMS REPORT

After realising that the formal QMS implementation route was very expensive as it entailed engaging a consultant, Wilkins Hospital Executive team decided to first focus on the major aspects of ISO 9001: 2008 Standard which emphasise customer satisfaction and safety. As a result the following activities were initiated:

- **Exit interviews on customer satisfaction in the OPD, OIC, GUC and adult ward**
- **Sprucing up of hospital grounds**
- **Strengthening infection prevention and control**

- **Implementation of suggestion boxes and complements/ complaints books**

As a means of widening the hospital's knowledge on QMS, the QMS focal person was sent for a course on ISO 9001: 2008 Internal Auditing organised by Standards Association of Zimbabwe in September 2012. Using the knowledge gained the Hospital Management team resolved the following.

- **Crafting the hospital quality statement and quality objectives which would then be displayed in all units within the hospital *(partially done)***
- **Setting up a hospital QMS Audit Team which would audit QMS activities in the different units *(done)***
- **Development of SOPs by all the hospital units *(done)***
- **Orientation of staff members on customer focus and customer satisfaction (an important clause in the ISO 9001: 2008 Standard *(not done)***
- **Procurement of the ISO 9001: 2008 Standard, its duplication and distribution to all the hospital units (*not done)***
- **Implementation of mandatory clauses of the ISO 9001: 2008 Standard *(not done)***

The following table summarises findings from the Exit Interview on customer satisfaction in OIC, OPD and GUC.

RESPONSES OF PARTICIPANTS ON CUSTOMER SATISFACTION, WILKINS HOSPITAL, 2012

Component	OPD		OIC		GUC	
	YES	NO	YES	NO	YES	NO
Greeted by staff member	92	8	79	14	34	14
Able to freely express concerns to HCW	99	1	89	4	42	6
Satisfied with how concerns were addressed	99	1	86	7	44	4
Would recommend hospital to other patients	99	1	92	1	44	4
Are there areas that need improvement	18	80	43	44	17	31

The majority of clients interviewed were satisfied with the quality of the service received from the hospital. The average dissatisfaction level was 8.8% with the GUC recording the highest (12.8%) followed by the OIC (8.6%) then the OPD (5.0%). Some of the reasons for dissatisfaction included poor customer care, inadequate time accorded to the patients by staff and shortage of drugs. Corrective action to address the causes of dissatisfaction was taken.

12. MUNICIPAL POLICE ACTIVITIES

The municipal police continued to provide the hospital with adequate security. Activities conducted to achieve this included scheduled and random hospital patrols, scheduled and random vehicle searches, responding to unit and individual requests for police cover as well as working together with the hospital executive to come up with a vehicle security disk system. Request for food provision for night shift officer was accommodated. Security lights were repaired and trees along the pathways were pruned. A table was provided to enable the officers to conduct searches properly. Some of the requests not addressed include the following:

- **No power back up for most hospital sections – negatively affect the rounds at night**
- **Perimeter fence at Zimcada and St Giles side was not repaired**
- **Broken down window panes were not replaced**
- **OIC doors which do not lock were not repaired**
- **A stop sign was not put at the main gate**
- **Informative signs were not developed**

- **Telephone handset in guardroom was not repaired**

13. ACHIEVEMENTS

- **Opening up of VIAC clinic**
- **Construction of adolescent recreation corner through Africaid**
- **Exit interviews on customer care satisfaction**
- **Registration of the hospital lab with ZINQAP**
- **Connection of adult ward to a power back up system – generator**
- **Renovation of the public toilets to suit public use**
- **Installation of soap dispensers and servicing of fire extinguishers**
- **Refurbished of OIC with assistance from RTG**

14. CHALLENGES

- **Unavailability of wheelchairs, stretchers and mortuary trolleys**
- **Outstanding repairs `and renovations in all the units**
- **Erratic supplies of HIV commodities and medicines**
- **Space limitations – drug storage in OIC, counselling**
- **Shortage of staff – nurses, grounds men, mortuary attendants, lab, CAs**
- **Manual data management system**
- **Erratic transport allocation to the hospital**
- **Inadequate co-operation from other departments especially Works**

HIV PROGRAMME

Introduction

Over the years Harare City has recorded growth in the different areas of HIV care, treatment and support. This growth has been in the form of increasing numbers of patients and clients accessing care, increase in the number of sites offering the various HIV care related services, increase in the number of health care workers who are competent and confident to manage patients with HIV infection and increased involvement of the community in running HIV care programmes among others. The following is a summary of the activities that took place in the HIV programme in 2012.

1. PERFORMANCE OF THE PROGRAMME RELATIVE TO SET TARGETS

Performance of the HIV Programme against set targets, Harare City, 2012

Service area	Q1		Q2		Q3		Q4	
	Tgt	Achvd	Tgt	Achvd	Tgt	Achvd		Achvd
PMTCT coverage	-	96.2%	92%	106.1%	93.0%	100.1%	95%	100.1%
ART coverage	-	30.8%	33%	32.2%	36.5%	35.8%	40%	36.3%
Decentralisation coverage	-	61.2	61%	63.2%	65%	58.3%	70%	63.3%
Quarterly review meetings	1	1	1	0	1	0	1	0
Support visits	-	2	10	12	10	13	10	11
Clinic assessments	-	7	3	3	6	5	0	0
Adult OI Management	0	0	40	26	40	0	40	0
Paeds OI Management	0	0	40	96	40	0	40	0
Integrated Curriculum	0	0	0	0	0	0	35	30

Throughout the year 2012 the achieved PMTCT coverage was above the set level, a sign of adherence to the national guidelines by all the midwives in the City. The programme continued to perform below the set targets in the ART coverage, decentralization coverage and most of the trainings. More support and supervision visits than what had been planned for were conducted in the second, third and fourth quarters because this was when some clinics started offering ART initiation services. So these visits were mainly mentorship visits on the clinics that had just started ART initiation.

A decline in the decentralization coverage was noted in the third quarter because an increase in patients who were referred from the private sector and research projects was observed. Given the SOP which states that patients transferred in from the non public sector providers are monitored for about three months before down referral to the clinics, these patients contributed to the number that was on ART from the hospitals thereby reducing the decentralization coverage. There is need to revisit the ART coverage targets factoring in the latest population of Harare and the current (2012) prevalence of HIV in the same province. The programme had problems accessing information on the numbers of patients on ART in the different sectors and service providers outside Harare City and as such these were not included in calculating the above reported ART coverage.

2. HIV PROGRAMME PROGRESS REPORT

a. OI/ART PROGRESS REPORT

Table 2: Opportunistic Infections Clinics Performance, Harare City, 2012

Component	Q1	Q2	Q3	Q4	Total 2012	Total 2011
New registrations	8 274	6 999	6 134	7 777	29 184	23 864
Total registrations to date	64 493	67 200	69 031	71 743	71 743	61 466
New initiations on ART	3 773	1 802	2 700	2 135	8 971	11 726
Total initiations to date	48 186	49 023	51 657	53 792	53 792	45 955
Transfers in this period	-	-	-	-	1 992	2 889
Transfers in to date	-	-	-	-	4 262	2 889
Total children on ART to date	2 214	1 938**	2 066	3 096	3 096	2 169
Total on 1st line				56 139	56 139	45 044
Number switched to 2nd line	22	39	33	38	132	62
Total on 2nd line	400	439	472	510	510	378
Total on ART to date	47 569	49 802	55 349	56 156	56 156	43 796
Number started on CMZ this period	5 978	5 371	5 687	5 274	22 310	22 658
Number switched due to TB	190	238	430	330	1 188	983
Switched due to TB to date	4 642	4 087	4 806	5 136	5 136	4 340
Number known to have died	19	44	40	55	158	82
Total known to have died to date	629	673	713	768	768	256
Lost to follow up this period	226	485	268	276	1 255	672
Lost to follow up to date	1 288	1 431	1 507	1 640	1 640	1 153
Number transferred out this period	456	257	448	379	1 530	1 363
Number decentralised	3 255	2 372	1 795	2 236	9 658	9 795
Total decentralized to date	29 125	31 497	33 292	35 528	35 528	25 870

The table above demonstrates that there was an increase in patients newly registered, total children on ART, number switched to second line, switches due to TB and transfers out. However there was also a general decline in parameters like new initiations, transfers in and number decentralized. Despite the fact that more initiating sites came on board, the numbers initiated were less than in 2011 when initiation were only limited to the two hospitals, BRIDH and Wilkins. Reasons for this decline are still not clear. The programme continued to have problems of data quality emanating from poor recording and reporting practices by some sites resulting in some indicators not giving a true reflection of what is on the ground. There is an urgent need to computerize HIV programme data.

b. HIV TESTING AND COUNSELLING

Table 3: HIV Testing and Counselling Services, Harare City, 2012

Component	Q1	Q2	Q3	Q4	Total 2012	Total 2011
Total new clients	22 753	24 316	30 371	28 473	105 913	81 874
Total offered HIV counseling	23 921 *(105.1%)*	21 856 *(89.9%)*	25 993 *(85.6%)*	27 872 *(97.9%)*	99 642 *(94.1%)*	83 725 *(102.3%)*
Total tested for HIV	23 662 *(98.9%)*	20 807 *(95.2%)*	23 810 *(93.7%)*	25 131 *(90.2%)*	93 410 *(93.7%)*	76 550 *(91.4%)*
Total who tested HIV +ve	5 349 *(22.6%)*	4 173 *(20.1%)*	4 493 *(18.9%)*	5 220 *(20.8%)*	19 635 *(21.0%)*	17 088 *(22.3%)*
Total referred for OI/ART	4 979 *(93.1%)*	3 881 *(93.0%)*	4 539 *(101.0%)*	4 473 *(85.7%)*	17 872 *(91.0%)*	15 402 *(90.1%)*
Total referred for psychosocial support	5 008 *(93.6%)*	3 536 *(84.7%)*	4 163 *(92.7%)*	4 028 *(77.2%)*	16 735 *(85.2%)*	14 702 *(86.0%)*

The majority of the new clients opted in for the HIV test after counseling and positivity rate remained fairly stable around 20%. Compared to the estimated HIV prevalence in Harare province which is 13%, the positivity rate was high and this may be an indication that there is still need to strengthen provider initiated testing and counseling. In line with the national recommendation that all patients who test HIV positive should be registered for chronic HIV care, most of the patients were referred for OI/ART services.

HIV positivity among pregnant women remained stable throughout the four quarters of 2012 as well as between 2012 and 2011. The proportion of women who were assessed for ART eligibility using CD4 count was more than 100% as it not only included those women who tested HIV positive during the reporting period but women who fell pregnant with a known HIV positive result or those who fell pregnant whilst already on ART. There was a steady increase in the proportion of women who were eligible for ART using the CD4 count from January to December in 2012, an indication that more women were falling pregnant with more advanced HIV disease than before. There is therefore need to strengthen HIV testing and counselling in women of reproductive age. From the first to the third quarter there was a steady increase in the ART coverage among PMTCT women. This trend was followed by a decline in the fourth quarter from 48.9% to 41.6%. The overall for 2012 was 39.2%, a decline from 50.1% in 2011.

A review of statistics from the initiating sites indicated that all the eligible women who had been referred to these sites were initiated on ART. This then means that a significant proportion of HIV positive pregnant women who had been referred to the initiating sites did not report to these sites and were therefore not initiated on ART. More ART initiating sites need to be added on in 2013 so that all patients are initiated on ART at the sites where the diagnosis of HIV infection is made. The number of HIV exposed infants below the age of 9 months who tested HIV positive remained unknown although indications from few sites that were visited for support and supervision gave a positivity rate among infants below 9 months of about 5%. ART coverage among HEIs remained low in 2012 and there is need for strengthening of this component in 2013.

c. PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV SERVICES

Prevention of Mother to Child Transmission of HIV Services, Harare City, 2012

Component	Q1	Q2	Q3	Q4	Total 2012	Total 2011
ANC first visits	11 511	11 052	10 907	10 772	44 242	44 427
ANC women tested for HIV	11 286 *(98.0%)*	10 553 *(95.5%)*	10 582 *(97.0%)*	10 489 *(97.4%)*	42 910 *(97.0%)*	44 821 *(100.9%)*
ANC women HIV positive	1 187 *(10.5%)*	1 137 *(10.8%)*	1 015 *(9.6%)*	995 *(9.5%)*	4 334 *(10.1%)*	4 807 *(10.7%)*
Women first booking with HIV known +ve result	274	331	353	339	1 297	409
Pregnant whilst on ART	217	245	268	248	978	275
HIV +ve preg mothers started on cotrimoxazole	603 *(50.8%)*	582 *(51.2%)*	639 *(63.0%)*	576 *(57.9%)*	2 400 *(55.4%)*	2 267 *(47.0%)*
HIV +ve preg mothers assessed for ART eligibility using CD4	1 145 *(96.5%)*	1 179 *(103.7%)*	1162 *(114.5%)*	1 235 *(124.1%)*	4 721 *(108.9%)*	4 325 *(90.0%)*
HIV +ve preg mothers eligible for ART	308 *(26.9%)*	336 *(28.5%)*	329 *(28.3%)*	409 *(33.1%)*	1 382 *(29.3%)*	549 *(12.7%)*
HIV +ve preg mothers started on ART	92 *(29.9%)*	119 *(35.4%)*	160 *(48.6%)*	170 *(41.6%)*	541 *(39.1%)*	275 *(50.1%)*
HIV +ve preg mothers put on single dose Nevirapine (sdNVP)	1	0	17	31	49	119
HIV +ve preg mothers put on MER	1 141 *(96.1%)*	1 206 *(106.1%)*	1 014 *(99.9%)*	1 002 *(100.1%)*	4 363 *(100.7%)*	2 026 *(42.4%)*
HE infants initiated on sdNVP	925	871	899	808	3 503	1 999
HE infants put on zidovudine	6	0	0	0	6	48
HE infants on extended Nevirapine @ 6/52	1 444	1 330	2 023	1 038	5 835	2 278
HE infants started on cotrimoxazole	1 231	896	833	841	3 801	2 859
HE infants < 2/12 who have PCR	656	665	720	717	2 758	821
HE infants < 2/12 with PCR +ve	-	-	-	-	-	-
HE infants 2-9 months who have PCR	486	460	343	355	1 644	706
HE infants 2-9 months with PCR +ve	-	-	-	-	-	-
HE infants > 9 months who have rapid HIV test	406	453	437	584	1 880	625
HE infants > 9 months with rapid HIV test +ve	70 *(17.2%)*	51 *(11.3%)*	53 *(12.1%)*	77 *(17.0%)*	251 *(13.4%)*	237 *(37.9%)*
HE infants started on ART	25	6	62	57	150	2

d. TB / HIV COLLABORATION

Management of HIV among TB patients, 2011, Harare City

Component	Q1	Q2	Q3	Q4	Total 2011	Total 2010
Total TB patients	1 495	1 472	1539	1 575	6 081	7 069
TB patients offered HIV testing	1 479 *(98.9%)*	1 467 *(99.7%)*	1539 *(100.0%)*	1 575 *(100.0%)*	6 060 *(99.7%)*	7 025 *(99.3%)*
TB patients tested for HIV	1 442 *(97.5%)*	1 442 *(98.3%)*	1534 *(99.7%)*	1 537 *(97.6%)*	5 955 *(98.3%)*	6 608 *(94.1%)*
TB patients HIV +ve	949 *(65.8%)*	994 *(68.9%)*	1082 *(70.5%)*	1 041 *(67.7%)*	4 066 *(68.3%)*	5 032 *(76.2%)*
HIV +ve TB pts started on cotrimoxazole	860 *(59.6%)*	921 *(92.7%)*	1024 *(94.6%)*	989 *(95.0%)*	3 794 *(93.3%)*	4 583 *(91.1%)*
HIV +ve TB pts started on ART	483 *(33.5%)*	433 *(43.6%)*	585 *(54.1%)*	485 *(46.6%)*	1 986 *(48.8%)*	2 076 *(41.3%)*

HIV testing and counselling coverage remained high among TB patients during 2012. Positivity was in the range of 60 – 70%, a figure that has also been reported at national level. Cotrimoxazole preventive therapy coverage remained above 90% from the second quarter onwards. Although ART coverage increased from the first to the fourth quarter and between 2011 and 2012, it still remained lower than the national target of 100%. The figures reported were for the year 2011. There is need to start reporting on real time data on TB/HIV collaborative activities following the revision of the recording and reporting tools.

MANAGEMENT OF TB AMONG HIV PATIENTS, HARARE CITY, 2012

Component	Q1	Q2	Q3	Q4	Total 2012	Total 2011
HIV positive pts with features of TB	3 735	3 877	4 794	4 061	16 467	13 011
HIV positive patients submitting sputum	3 332 *(89.2%)*	3 517 *(90.7%)*	4 266 *(89.0%)*	3 694 *(91.0%)*	14 809 *(89.9%)*	12 147 *(93.4%)*
HIV positive pts with sputum positive TB	136 *(4.1%)*	212 *(6.0%)*	193 *(4.5%)*	226 *(6.1%)*	767 *(5.2%)*	756 *(6.2%)*

The proportion f HIV positive patients with features of TB steadily increased over the four quarters of 2012 but decreased from 2011 to 201. The rate of sputum positivity among the HIV positive clients who submitted sputum remained fairly stable in 2012.

Achievements

- **Adolescent recreational centres construction started**
- **Accreditation of Glen View Satellite clinic as a follow up site**
- **Reduced HIV positivity among exposed infants highlighting the efficacy of the PMTCT programme**
- **Accreditation of Mbare, Hatcliffe and Rutsanana, Hatfield, Budiriro, Hatfield, Caledonia as ART initiating sites**
- **Received 12 nurses from MSF to complement ART initiation services at 6 of the above clinics**
- **Improvement in PMTCT coverage**
- **Operations research at some of the OI sites**

Challenges

- **Manual data management system – health care workers loaded with paperwork resulting in a compromise on clinical work**
- **Weak defaulter tracing system – system's inability to correctly define the number of deaths and lost to follow up patients**
- **Delayed and erratic drug deliveries from Natpharm – stock ruptures at site level resulting in increased visits to the clinics by patients and sometimes unplanned drug substitutions**
- **Inadequate working space – counselling, consultation, drug storage, record storage**
- **Long turnaround time for CD4 count (due to power outages) and DBS results**
- **Stock outs of stationery – HIV chronic care registers, clerk sheets and patient files for initiating sites**
- **Lack of funds for quarterly review meetings – none conducted in second, third and fourth quarters**
- **Lack of a viral load machine resulting in delayed diagnosis of treatment failure in some patients**

DRTB

Introduction

Seventy-nine (79) confirmed DRTB patients had ever been registered at Wilkins Hospital since the beginning of the programme in January 2011. 12 patients had either completed treatment or cured. Nine patients died. One patient had treatment stopped after eight weeks after he was later found not to have DRTB on repeat tests and clinical evaluation. 56 patients were still alive and on DRTB treatment at Wilkins Hospital. 24 patients were from Harare. Nine were from Chitungwiza. 23 were from provinces and districts outside Harare.

DRTB Suspects and Confirmed patients

	To date	Q4 2012	Q4 2011
Total Suspects	**175**	**12**	**15**
Confirmed	**79**	**8**	**7**

One hundred and seventy-five (175) suspects were in the Suspect Register and 79 were confirmed DRTB cases, since the beginning of the programme in January 2011. There was under reporting of suspects during year 2011 and prior to August 2012. This was because M and E tools were printed and distributed in August 2012.Training on M and E tools were done in November 2012. As such there was poor recording and reporting of DRTB activities.

DRTB Clinic Attendances – Year 2012 and 2011

Period	2012	2011	Q4 2012	Q4 2011
Attendances	488	170	137	74

There was an increase of 318 attendances from 170 attendances in 2011 to 488 attendances in 2012 representing a 232% year on year increase.

DEMOGRAPHIC CHARACTERISTICS OF THE DRTB PATIENTS

Gender distribution of DRTB patients

	MALE	FEMALE
2012	19	25
2011	17	18
TOTAL	36	43
%AGE	45.6%	54.4%

More female 54.45 (43) were diagnosed and enrolled on DRTB treatment from 2011 to 2012 compared to male patients. More (44) patients were enrolled in 2012 compared to 35 patients in 2011. This was a 25.75 increase in enrolment of DRTB patients.

Age distribution of DRTB patients

Age (Years)	0-4	5-21	22-50	50+
2012	1	8	33	2
2011	-	1	31	3
Total	1	9	64	5
%AGE	1.2%	11.4%	81%	6.3%

The majority of the DRTB patients were aged between 22 to 50 years contributing 81% of all enrolled patients. The least enrolled age were the under fives where only one child aged 15 months was enrolled. This child was a contact and a baby of an MDRTB patient. The age 22 to 50 years is the most infected with HIV infection and reflects HIV/TB co-infection and co-morbidity pattern.

ENROLMENT OF DRTB PATIENTS BY QUARTER, 2011 TO 2012

	Q1 2011	Q2 2011	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Total
DRTB Cases confirmed and enrolled on treatment	9	11	7	7	11	8	10	8	69
Confirmed DRTB cases enrolled on treatment	10	11	7	7	11	8	10	8	69
Confirmed XDRTB cases enrolled on treatment	0	0	0	0	0	0	0	0	0
TOTAL	9	11	7	7	11	8	10	8	69

There were about nine average number of DRTB of patients enrolled per quarter. 71 patients were confirmed and enrolled on Category 4 anti TB treatment in 2011 and 2012. No cases of XDRTB were neither confirmed nor enrolled on treatment since the programme started. Four patients were already on treatment prior to 2011 either from South Africa or from the private sector in conjunction with Ministry of Health. One patient was diagnosed on empirical grounds and died before specimens were collected for drug sensitivity testing. Another patient was later proved to be not DRTB after repeated culture and DST and clinical evaluation.

History of previous treatment among DRTB patients

	2012						2011					
	Q4	Q3	Q2	Q1	Total	%age	Q4	Q3	Q2	Q1	Total	%age
Previously treated with FLDS	7	5	5	9	26	84	7	6	5	7	25	96%
New	0	1	1	2	4	13	0	0	0	1	1	4
Previously treated with SLDs	1	0	0	0	1	3	0	0	0	0	-	-
TOTAL	8	6	6	11	31	100	7	6	5	8	26	100

Almost all DRTB patients were previously treated with first line TB drugs for year 2012 with 26 (84%) patients out of the 31 patients in 2012 and 25 (96%) patients out of 26 in 2011, with full DST results. There were more new patients, 4 (13%), in 2012 compared with only one (4%) in 2011. One patient was previously treated with DRTB drugs in 2012 and was enrolled in Q4 2012.

MDRTB LABORATORY/DETECTION DATA

	2012						2011					
	Q4	Q3	Q2	Q1	Total	%age	Q4	Q3	Q2	Q1	Total	%age
MDRTB	3	6	4	11	24	72%	7	5	7	8	27	93%
PDRTB	-	-	-	-	0		-		-	-	0	
Rifampicin non-resistant	2	1	-	-	3	10%	-	-	-	-	0	-
Gene Xpert only result	3	-	2	-	5	17%	-	-	-	-	0	-
Other	0	1*		0	1	1%	-	I*	1**	-	2	7%

Key:

***Empirical diagnosis (Primary TB in a baby)**

****Died before DST specimen**

Most of the patients had MDRTB for both 2012 and 2011 with 72% and 93% MDRTB proportions respectively. There were three cases of rifampicin mono-resistance in 2012 compared to none in 2011. Three patients were still awaiting full DST having been enrolled in Q4 2012 and had been enrolled with Gene Xpert results. There was increasing use of Gene Xpert testing in 2012 compared to 2011.

DRTB Patient Risk Groups (excluding MSF Sites)

Risk Group	2012						2011					
	Q4	Q3	Q2	Q1	Total	%age	Q4	Q3	Q2	Q1	Total	%age
Failed CAT 2	7	6	5	4	23	62.2%	7	5	7	5	24	77.4%
Failed CAT 1	-	3	-	4	7	18.9%	-	1	1	1	3	9.7%
DRTB Contact	-	1	-	2	3	8.1%	-	-	-	1	1	3.2%
Sputum Positive end of IP	1	1	-	-	1	2.7%	-	-	-	-	0	-
Return after default	-	-	-	-	0	-	-	-	-	1	1	3.2%
Exposure to high DRTB burden institute ones	-	-	-	-	0	-	-	-	-	-	0	-
Relapse	-	-	-	-	0	-	-	1	1	-	2	6.4%
Exposure to high DRTB burden region	-	1	1	1	3	8.1%	-	-	-	-	0	-
Failure of treatment from private sector	-	-	-	-	0	-	-	-	-	-	0	-
Other	-	-	-	-	0	-	-	-	-	-	0	-
TOTAL					37	100%					31	100%

Failed Category 2 treatment regimen was the biggest risk group for developing DRTB for 2012 as well as 2011. There was strengthening of contribution in 2012 compared to 2011, from other risk groups such as failed category 1 treatment (18.9%), DRTB contacts (8.1%), exposure to high burden DRTB regions (8.1%), and sputum positive at end of intensive phase of treatment (2.7%). This might have been a reflection of increased surveillance of DRTB including more focused history taking on TB patients.

PATIENT REGISTRATION GROUPS WILKINS HOSPITAL AND NORTHERN REGION

Registration Group	2012						2011					
	Q 4	Q 3	Q 2	Q 1	TOTAL	%	Q 4	Q 3	Q 2	Q 1	TOTAL	%
New	1	1	1	2	5	13.5 %	-	-	-	1	1	3.2%
Relapse	-		-	1	1	2.7%	-	1	1	-	2	6.4%
Treatment after default	-		-	-	-	-	-	-	-	-	-	-
Rx after failed Cat 1	-	3	-	4	7	18.9 %	-	1	1	1	3	9.4%
Rx after failed Cat 2	6	6	5	4	21	56.8 %	7	5	7	6	25	80.6 %
Transfer-in	-		-	-	-	-	-	-	-	-	-	-
Other(specify) *	1	2	-	-	3	8.1%	-	-	-	-	-	-
TOTAL	8	12	6	11	37	100%	7	7	9	8	31	100%

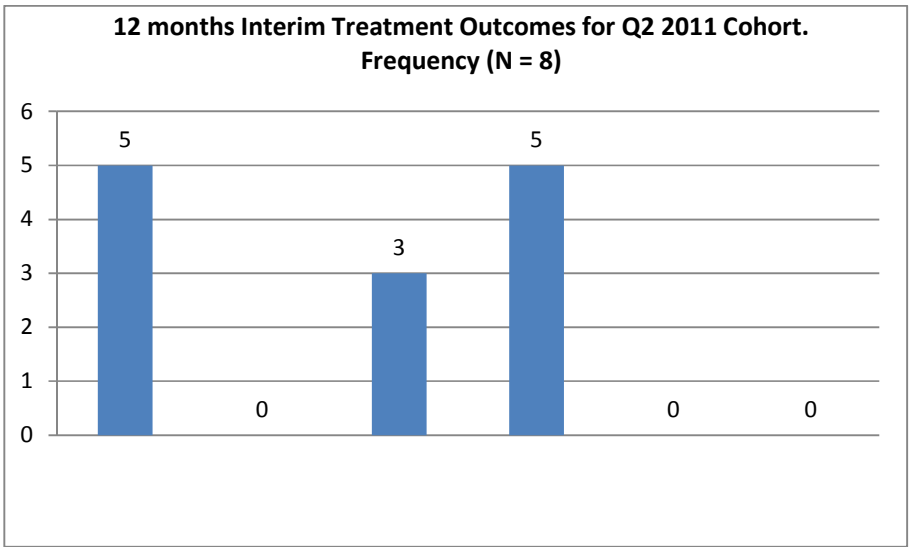
Key: *Sputum positive at end of intensive phase of TB treatment
Treatment after failure to Category 2 TB treatment was the biggest registration group for 2012 (56.8%) as well as for 2011 (80.6%). Efforts to increase early DST among relapses and failed Category 1 TB treatment might have increased contribution of the other registration categories and earlier DRTB diagnosis.

TABLE: SIX MONTH INTERIM OUTCOMES

Cohort	Q1 2012		Q1 2011	
	Numbers	Percentage	Numbers	Percentage
Total enrolled on treatment	11	100%	7	100%
Alive on treatment	6	56%	7	100%
Defaulted	3	27%	0	0%
Died	3	27%	0	0%
Culture Negative	8	73%	6	86%
Culture positive	0	0%	0	0%
Sputum results unknown	0	27%	1	14%

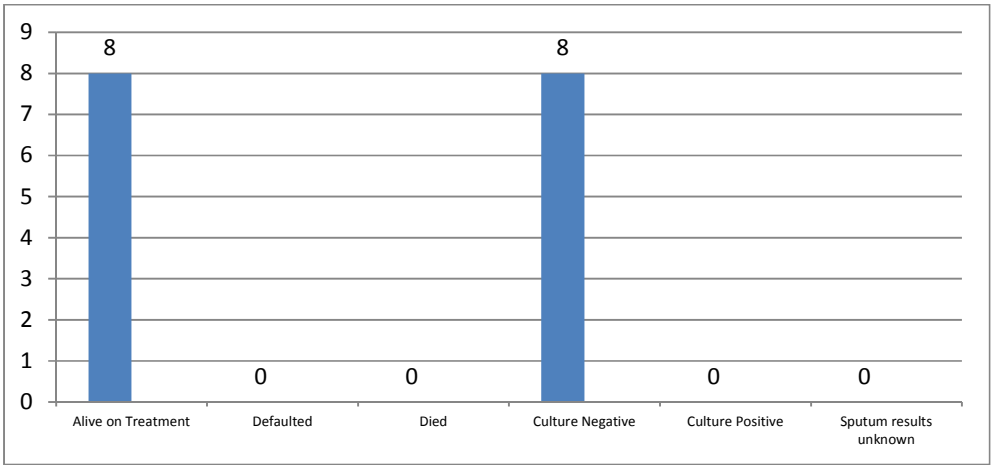
56% (6) DRTB patients were alive on treatment at six months in 2012 compared to 100% (7) patients the same quarter in 2011. There was increased mortality 27 %(3) in 2012 compared to 0 %(zero) the same quarter of 2011. 27% (3) of the patients defaulted in 2012 compared to none in 2011. There was increased DOT decentralization in 2012. Training of staff in DOT clinics was limited due lack of funding. No patients remained sputum positive between the two cohorts with 100% sputum negativity among all the available results.

12 MONTHS INTERIM TREATMENT OUTCOMES FOR Q2 2011 COHORT



Five out of the nine patients enrolled on treatment in second quarter of 2011 were alive on treatment. One patient was discontinued treatment after the diagnosis of DRTB was reversed following clinical evaluation and repeat culture and DST testing. All the patients alive on treatment were sputum culture negative at twelve months. No patient defaulted treatment. Three out of eight patients died.

15 MONTHS INTERIM TREATMENT OUTCOMES FOR Q1 2011 COHORT



All eight patients enrolled in the first quarter of 2011 (Q1 2011) were alive and on treatment at 15 months. All eight out of the eight patients were culture negative. No patient in this cohort died nor defaulted treatment. None was culture positive nor had sputum results unknown. In fact seven out of these eight patients had cured and had treatment stopped. One patient had yet to be documented in the Unit register. According to the PMDT guidelines these final outcomes would be reported at 36 months that is in December 2013.

CHALLENGES

	Challenge	Proposed Solution	Responsible Office/r
1	Drugs expiring and drug shortages	• Order drugs with longer shelf life. • Improve drug forecasting methods using local consumption data.	1. Harare City Chief Pharmacist. 2. Department of Pharmacy Services, MOHCW
2	No cell phone, printer, toners, and internet for DRTB clinic	• Provide broad band internet connection to the computer in the DRTB clinic. • Buy a printer and maintain resupplies of tonners for the printer for the DRTB clinic	1. TB Program Manager, MOHCW 2. DHS City of Harare
3	No financial vote for DRTB emergencies	• Provide an emergency account/vote for DRTB patients	TB Program Manager MOHCW
4	Long turn-around time for laboratory results	• Dedicate a cadre to timely dispatch and communicate laboratory results to Wilkins Hospital and other treatment centres	1. NMRL Manager 2. TB Program Manager MOHCW
5	Poor DRTB programme decentralization to districts and provinces	• Activate running of DRTB clinics and creation of DRTB isolation rooms in provincial and district Hospitals. • -Advocate with Mission Hospitals (e.g. All Souls and Murambinda Mission Hospital) to buy into the DRTB Programme and manage DRTB patients at mission hospitals.	1. TB Program Manager 2. PMDs 3. DMOs 4. Administrators of Mission Hospitals
6	Inadequate MOHCW commitment, support, and participation in the DRTB programme	MOHCW to increase focus and support on operational challenges of the DRTB programme especially strengthening decentralization and logistics and medicines management.	1. TB Program Manager, MOHCW 2. PMDs 3. DMOs 4. DPS, MOHCW

CHAPTER XI

ADMINISTRATION AND FINANCE

FINANCE AND ADMINISTRATION

Support from Government has continued to dwindle as they have been unable to honour the 1976 Public Health Agreement where Government is obligated to fund 50% of recurrent expenditure on clinics and infectious diseases hospitals.

BUDGET PERFORMANCE TO DECEMBER 2012

The department continues to fund its recurrent expenditure from its user fees, save for salaries and allowances which are funded from the rates account. The Government's promise to meet the salaries and allowances for all the health personnel within the department has remained on hold due to the Government's other pressing commitments. The donor community has continued to play a pivotal role in budgetary support, though on a much reduced scale citing the political and economic stability prevailing in the country. The purchasing of hospital equipment and programmed repairs of buildings continued during the year giving most of the buildings the much needed ambiance.

SOURCES OF HEALTH FINANCING

The department collected a total of US$3 109 560 against a budget of US$3 693 800. This was caused by the increase in un-booked cases for maternity patients and the general increase in patients who cannot afford to pay clinic fees, who are Social Welfare cases. The main source of funding of health services in the City, as in previous years, remained the Rates account followed by user fees and government grant.

The contribution by Central government, at 0.00%, is worrying particularly since the department is, by and large, guided by government policy on its user fees. More than 95% of the patients accessing health care at the two hospitals do not pay fees and at all our clinics we do not deny access to care because of inability to pay. Expenditure on health services is a major funding burden on Harare ratepayers and funding of health services in the City therefore remains a major challenge.

The department, with the support of the International Committee of the Red Cross (ICRC) commissioned a study in 2011 on the evaluation of Health Financing Policies and strategies in the City. The study confirms the department's over dependence on donor funding and rightly suggests that this strategy is unsustainable.

Among other recommendations, the study recommends:-

- **Retention of user fees by the department with improved accountability to the City Treasurer in terms of the use of such retained fees.**
- **That the sustainable out-patient fees are $5 and $3 for adults and children respectively.**
- **Explore the possibility of a local health fund/insurance scheme.**

INCOME ANALYSIS

The major sources of income for the department have remained user fees and licensing. The residents of the City are already overburdened through other levies and the prevailing fee structure is envisaged to remain static for the forseeable future. In light of this, income from the current sources can only improve through improved service at the clinics and hospitals. Efforts to engage Central Government to honour the 1976 Health Agreement will be redoubled.

Improved inspection for the Licensing Section has contributed largely to the increase in income from this section. In 2011, US$2 548 236.00 was collected from licensing against the current US$ 3 978 700.00. It is therefore important to equip the Licensing Section with more resources after showing such positive signs.

EXPENDITURE ANALYSIS

The department is labour intensive and always operates at a deficit which is funded from rates. The operating deficit in the year under review was US$ 18 279 683.00 with salaries and allowances being the biggest item of expenditure at 79% of total expenditure. This is a slight increase from the previous year where salaries were 77% of total expenditure. Most critical vacant positions where filled from within during the year. There were no budget overruns on most expenditure items as a result of tight budgetary monitoring and control.

Table 11.2 is the Income and Expenditure Statement for the year 2012.

Table 11.2: Summarized Income and Expenditure Account for the year ended 31 December 2012

Details	2012		2011	
	Income	Expenditure	Income	Expenditure
Administration, Clinics, FHS	2 939 436	11.00	3 032 920	14.23
Dental clinic	69 142	0.26	59 759	0.28
Tuberculosis and Medical Centre	12 666	0.05	12 387	0.06
Environmental Services	3 978 700	14.89	3 332 597	15.64
Hospitals	88 316	0.33	101 237	0.48
Government Grant		0.00	200 000	0.94
Donations	1 355 200	5.07	2 276 000	10.68
Net deficit transferred to summarized Rate Account	18 279 683	68.40	12 300 900	57.69
Grand Total	26 723 143	100	21 315 800	100

RESULTS BASED FINANCING

The department through the Ministry of Health and Child Welfare approached the World Bank on the concept of Results Based Financing as implemented in selected rural districts in the country. We hope this concept, which aims to capacitate the supply side of the health delivery system as well as stimulate the demand for health services, will introduce a new and innovative health financing strategy.

Table 11.1: Revenue inflows for the year ended 31 December 2012

Vote	Clinic	Annual potential	Total inflow
3706	Genito Urinary Centre	23 900	30 182
3726	Dental Clinic	64 600	69 142
3727	Medical Examination Centre	16 000	12 666
3730	Mabvuku Polyclinic	237 800	193 320
3731	Tafara Clinic	25 900	29 366
3732	Mabvuku FHS	22 800	25 643
3733	Greendale FHS	16 100	13 481
3734	Eastlea FHS	19 600	15 403
3735	Highlands FHS	7 000	7 021
3736	Highlands Polyclinic	53 400	47 157
3737	Borrowdale Polyclinic	48 900	37 234
3738	Hatcliffe Polyclinic	148 800	92 865
3740	Hatfield PCC	73 300	64 460
3741	Sunningdale Satellite	62 800	46 937
3742	Waterfalls PCC	68 400	59 642
3743	Arcadia PCC	32 700	26 283
3744	Braeside FHS	38 800	52 429
3750	Dzivaresekwa Polyclinic	217 700	172 148
3751	Kuwadzana Polyclinic	302 700	235 013
3752	Mabelreign Satellite	73 700	57 275
3753	Marlborough Satellite	77 700	66 643
3754	Avondale PCC	46 900	42 060
3755	Mt Pleasant Polyclinic	50 100	42 483
3760	Mufakose Polyclinic	141 700	103 658
3762	Mufakose FHS	2 700	2 829
3763	Kambuzuma Polyclinic	117 300	93 968
3764	Southerton Polyclinic	14 400	12 884
3765	Warren Park Polyclinic	168 300	135 127
3766	Budiriro Polyclinic	246 300	191 351
3770	Rutsanana Polyclinic	223 000	165 556
3773	Highfield Polyclinic	156 600	121 173
3774	Western Triangle PCC	36 800	35 198
3775	Glen Norah Satellite	41 300	35 139
3776	Glen View Polyclinic	182 300	143 686
3777	Glen View Satellite	47 600	38 961
3780	Mbare Polyclinic	262 300	190 737
3781	Matapi Polyclinic	38 100	33 438
3782	Mbare Hostels Polyclinic	26 900	29 720
3783	Parirenyatwa PCC	57 400	48 430
3785	Belvedere FHS	62 000	51 287
3786	Hopley Satellite	44 404	49 249
	Medical Aid		462 866
TOTAL		3 554 600	3 021 244
3771	Beatrice Road Hospital	71 300	43 059
3772	Wilkins Hospital	67 900	45 257
TOTAL		139 200	88 316
GRAND TOTAL		3 693 800	3 109 560

REPAIRS AND MAINTENANCE

With the refurbishment of Mbare Polyclinic, Rujeko Polyclinic and Mufakose Polyclinic, Kuwadzana Polyclinic and Gershon Dental Clinic completed in 2011, emphasis in 2012 was shifted to the City' bigger hospital, Beatrice Road Infectious Diseases Hospital. Substantial refurbishment was done for the wards, Kitchen Laboratory and the Medical Examination Centre.

CAPITAL PROJECTS

Work started in earnest in 2012 to complete the two clinics in Kuwadzana Extension and Budiriro 5. The Bulk of the building material required to complete the two clinics was purchased and we expect Kuwadzana Extension clinic to open in the first quarter of 2013 and Budiriro 5 clinic should be operational by mid 2013.

The department also plans to upgrade Highlands clinic to a Satellite clinic and we expect this to be completed before the end of 2013.

Council agreed in principle to work with ZimHealth to expand the health infrastructure at Mabvuku Polyclinic and this project will be vigorously pursued in the ensuing year.

The $150 000, double storey laboratory at Beatrice Road Infectious Diseases Hospital built with the support from Global Fund will be commissioned in early 2013. The six laboratories at the polyclinics that were refurbished to enhance TB diagnosis near the point of service delivery are now fully functional, thanks to funding of US$ 36 000 from Global Fund Round 5.

Council has failed to complete the wards at Wilkins Infectious Diseases Hospital and the department will continue to seek strategic partners to complete the project.

The Department's Strategic Plan "Crafting a World Class Health Service 2010 -2015" identifies the setting up of District Hospitals in Harare as a major strategic priority for the development of the public health system in the City. The Ministry of Health and Child Welfare has supported the setting up of district hospitals in Harare.

HOSPITAL AND CLINIC SUPPORT SERVICES

Water supply

The water supply situation in the clinics and hospitals improved in 2012 due to the improved supplies by the city and also due to the availability of back up water at most of the clinics. All the polyclinics have back up water supply, however there is need for borehole pumps that are connected to the water reservoirs at all the Polyclinics.

Water back at the two hospitals is still a major issue of concern and efforts will continue in 2013 to secure a water backup system for the two hospitals

Electricity Supply

Thanks to the support from the International Committee of the Red Cross, all the City's twelve polyclinics now have electricity invertors and generators. The system worked very well in 2012 and this has led to giant leap forward in the quality of patient care at these clinics

A 300kva generator that was donated to Beatrice Road Infectious Diseases Hospital through the Mayor's initiative was commissioned in 2012 and has improved service delivery in the wards and the health support services at the hospital.

Disposal of clinical waste

Thanks to the partnership with ICRC, the department secured eight incinerators which were installed and commissioned at the polyclinics in 2012. This was resulted in considerable savings since the amount of medical waste that was sent to private incinerators was significantly reduced.

The department still requires incinerators for the two hospitals and the remaining 4 polyclinics.

Laundry and linen services

The department managed to replace a lot of linen items in 2012 and most of the clinics have now reasonable stocks of linen.

However the department continues to face challenges in the timely laundering of linen due to both aged laundry equipment and to the logistics of moving dirty and clean linen throughout the city.

Hospital Mortuaries

The two mortuaries at Beatrice Road and Wilkins Infectious Diseases Hospitals have carrying capacity of 42 bodies. The department continued to sell excess capacity to private players. Harare Municipal Funeral Society, who are the major users of Wilkins hospital mortuary, continue to assist in the refurbishment of the mortuary. Beatrice Road Infectious Diseases Hospital mortuary needs major refurbishment.

Catering Services

The lack of catering facilities and food service at the polyclinics continued to be a challenge in 2012. Efforts will continue to find a permanent solution to this service deficiency. The catering equipment at the hospital is aged and need to be replaced. There are no staff canteen facilities at the two hospitals and this is an area management will continue to look for resources including seeking strategic partners.

TRANSPORT AND LOGISTICS

The department's vehicle fleet has constituted mainly by donated vehicles. This has improved the implementation of the various programmes.

Elsewhere in this report we have highlighted the problems faced in referring maternity patients to the next level of care. The partnership with Netstar needs to be further refined. The department needs a fleet of ambulances to support the referral system of patients.

Below is a table showing the vehicles in the department:-

TABLE 11.4: SHOWS THE MOTOR BIKES STATUS AS AT 31 DECEMBER 2012

REG. NO	VEHICLE MAKE	YEAR	STATUS	USER & SECTION
AAU9008	Yamaha YB100	1994	Non runner	Environmental Health
AAU9009	Yamaha YB100	1994	Non runner	Environmental Health
AAU9010	Yamaha YB100	1994	Non runner	Environmental Health
AAU9011	Yamaha YB100	1994	Non runner	Laboratory
AAU9012	Yamaha YB100	1994	Non runner	Laboratory
AAY8051	Yamaha YB100	1994	Non runner	Carpenters
AAY8052	Yamaha YB100	1994	Non runner	Environmental Health
AAU9214	Hero Panther	2007	Runner	Environmental Health
AAU9221	Hero Panther	2007	Runner	Environmental Health
AAU9202	Hero Panther	2007	Runner	Environmental Health
AAU9211	Hero Panther	2007	Runner	Environmental Health
AAU9161	Hero Panther	2007	Runner	Transport
AAU9224	Hero Panther	2007	Runner	Transport
	Yamaha	1994	Non runner	Transport
	Yamaha	1994	Non runner	Transport
ABF0264	Honda	2009	Runner	TB
ABF0266	Honda	2009	Runner	TB
GHCW0957	Honda	2009	Runner	TB
GHCW	Honda	2009	Runner	TB
GHCW	Honda	2009	Runner	TB
ACD9979	Yamaha ybr125	2011	Runner	TB
ACD9980	Yamaha ybr125	2011	Runner	TB
ACD9982	Yamaha ybr125	2011	Runner	TB
ACD9983	Yamaha ybr125	2011	Runner	TB

TABLE 11.5: SHOWS THE VEHICLE STATUS AS AT 31 DECEMBER 2012

REG. NO	VEHICLE MAKE	YEAR	STATUS	USER & SECTION
AAE7621	Mitsubishi L200	2001	Runner	Transport
AAE7602	Mitsubishi L200	2001	Runner	Transport
AAE8402	Mazda T35	2006	Runner	Transport
AAE8479	Mazda BT 50	2006	Runner	Transport
GHCW1304	Mazda BT50	2011	Runner	Transport
AAE5579	Mazda BT-50	2007	Runner	Admin
AAE8336	Nissan Largo	1990	Runner	Admin
AAE5641	Toyota Rav 4	1995	Runner	Admin
AAE5980	Toyota Hiace	1992	Runner	Admin
AAE7608	Mitsubishi Lancer	1994	Runner	Admin
AAE5001	Nissan Sentra	1997	Runner	Admin
AAE7579	Toyota Landcruiser	1990	Non runner	Admin
AAE7604	Nissan Sentra	1997	Non runner	Admin
AAE7578	Mitsubishi L200	1994	Runner	Transport
AAE7618	Mitsubishi Lancer	1994	Runner	Admin
ACA3005	Toyota Spacio	1997	Runner	Licensing
ACA3007	Toyota Spacio	1997	Runner	Licensing
ACA3012	Toyota Spacio	1997	Runner	Licensing
ACA3014	Toyota Spacio	1997	Runner	Licensing
ACA3015	Toyota Spacio	1997	Runner	Licensing
AAE5587	Mazda BT-50	2007	Runner	Environmental Health
AAE8421	Isuzu KB250	2000	Non runner	Environmental Health
AAE7601	Mitsubishi L200	1994	Runner	Environmental Health
AAE7616	Mitsubishi L200	1994	Non runner	Environmental Health
491-QE	Rhino Cam	2007	Runner	Environmental Health
SF490QE	Rhino Cam	2007	Runner	Medical Officer
GHCW1097	Toyota Hilux	2010	Runner	HIV Programme
AAE7624	Mitsubishi L200	1994	Runner	Environmental Health
AAT8815	Toyota Prado	2006	Runner	Director of Health
ABA6353	Nissan Hardbody	2006	Runner	Director of Health
AAE8490	Mazda BT-50	2007	Runner	Nursing
AAE8498	Nissan Hardbody	2007	Runner	IHC2
ABI1640	Nissan Hardbody	2008	Runner	PMTCT
ABA4744	Nissan Hardbody	2008	Runner	Nutrition
GHCW925	Toyota Hilux	2009	Runner	TB
AAE7619	Isuzu KB280	1997	Non runner	TB
GHCW929	Toyota Hilux	2009	Runner	Cholera
AAE7612	Toyota Landcruiser	1989	Non runner	Health Education
AAE7623	Toyota Landcruiser	1989	Non runner	Health Education
204TCE12	Toyota Hilux	2000	Runner	EPI
ACB3831	Ford Ranger	2011	Runner	TB
ABY9786	Ford Ranger	2011	Runner	TB
ABY9789	Ford Ranger	2011	Runner	TB
ABY9794	Ford Ranger	2011	Runner	TB
ABY9795	Ford Ranger	2011	Runner	TB
ABY9798	Ford Ranger	2011	Runner	TB
AAE8887	Nissan NP300	2011	Runner	TB
ACK3010	Toyota Mark 11	1996	Runner	TB
ACK3011	Toyota Mark 11	1997	Runner	TB

CHAPTER 12

HUMAN CAPITAL SERVICES MANAGEMENT

12.0 Introduction

The Human Capital Division of the City Health Department is responsible for all Human Resources Planning of the Department, Human Capital Forecasting, Human Capital Accounting and Auditing, Recruitment and Selection, Processing and validation of Salary Inputs, Establishment Control, Staff Welfare, Staff Records Management, Training and Development, Employee Relations and implementation of Council Resolutions among other duties. The 2012 was a hectic year for the Division as it had to work extra hard in recruitment of locum nurses necessitated by Typhoid outbreak, Recruitment of Sister in Charge, Deputy Nursing Managers, Health Education Officers and leave updates and management. The Human Capital Section managed to conclude a backlog of pending disciplinary cases of absenteeism, manage employee welfare through the Social Welfare Section, conducting training workshops on customer care and induction training courses for the newly promoted employees.

12.1 Establishment Control

The Department's establishment remained at 1600 which was agreed and adopted by Council in November 2011. As reported in 2011, the transfer of other functions like finance function, electrical and mechanical workshops and deletion of the positions of operators grass cutters at Council Clinics and hospitals compromised services delivery in this regard. The Department had an average rate of 80% of filled position and the 20% vacant was mainly in the Nursing and Environmental Health Divisions.

The 2012 Major Highlights

The Department managed to retain most of the professional staff in the category of Dental Health, Medical Services, Environmental Health Services, Nursing Managers, Administrators and General Nurses during the period under review. Human Capital Services employee data base indicated that even though the majority of Nurses were retiring from Council Services other Division had an average age of between 40 to 45 years, an indication that the human capital base for the Department is still good.

Most employees who absconded employment during the years of economic hardships appeared before the Council Disciplinary Committees and their cases were finalized. The table below summarized the City Health Department establishment and employees who were on acting capacity as at 31st of December 201

SUMMARY OF THE ESTABLISHMENT

Table 12.1: Establishment Table

DIVISION	EST	STR	VAC	EXCESS	ACTING
EXECUTIVE	02	02	00	00	00
ADMINISTRATION	130	107	23	06	02
MEDICAL SERVICES	29	18	11	00	02
NURSING	882	765	117	00	04
DENTAL HEALTH	24	13	12	00	01
PHARMACY	18	10	08	00	04
NUTRITION	3	01	02	00	01
HEALTH EDUCATION	12	03	09	00	02
EPIDEMIOLOGY & DISEASE CONTROL	13	7	6	00	02
ENVIRONMENTAL MANAGEMENT	108	87	28	07	03
BRIDH HOSPITAL					
NURSING SECTION	132	95	37	00	00
ADMINISTRATION/ LAUNDRY	82	67	18	01	04
MEC	32	30	02	00	00
LABORATORY	34	15	19	00	00
WILKINS HOSPITAL					
NURSING	63	53	10	00	01
ADMINISTRATION	36	23	13	00	04
TOTAL	1600	1299	312	14	32

- **A total of 312 positions were vacant as at 31st of December 2012 and the majority of the vacant positions were from Nursing Division, Hospitals, Environmental Health and Health Education;**
- **The Human Capital Manning levels were 81% as at 31 December 2012, an increase of 3% as compared to 2011;**
- **A total of 14 employees were excess staff as at December 2012. The employees have not redeployed as reported in 2011 that redeployment was to be done in 2012 and**
- **A total of 32 employees were in acting capacity and the number is expected to be reduced in the year 2013 as the Department has Ministerial and Council authority to fill all critical vacant positions.**

Manning level strength = Strength / total establishment *100
=1299/1600*100
=81%

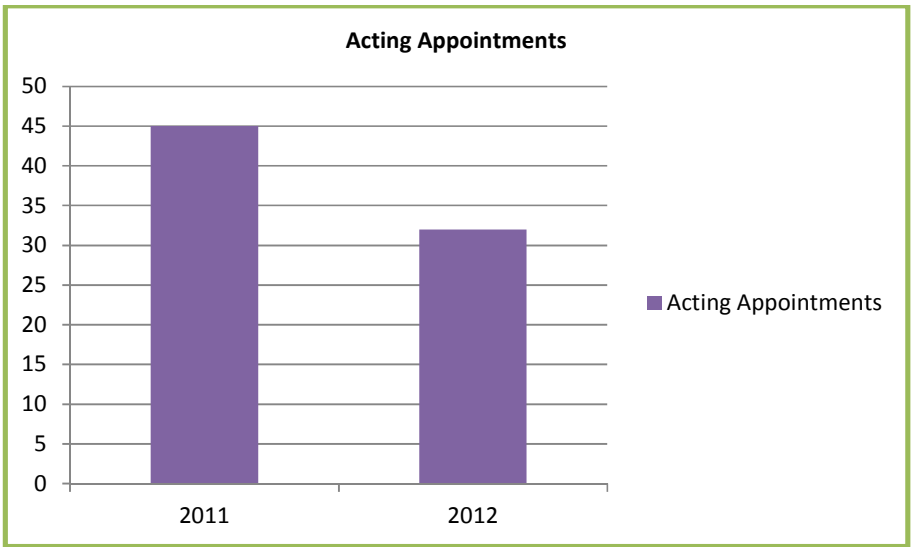
The manning levels for the City Health Department as at December was 81% and this is a result of proper manpower planning. There is however need to increase human capital staff manning City Health Staff Office in order to complement the level of competences at the Department.

Human Capital Staff Ratio = Human Capital Staff / Total establishment
=4/1600*100
=0.0025% (not good enough)

12.2 Acting Appointments

A total of 32 employees of various Divisions of City Health Department were appointed to act in higher vacant positions during the year under review. The number of employees decreased in 2012 as compared to the 45 employees who were in acting capacity in 2011. The reduction is as a result of some positions which were filled especially in the Nursing Division where the Department promoted thirty (30) Registered General Nurses to fill in the vacant positions of Sister-In-Charge.

Fig 12.1: Summary of acting appointments

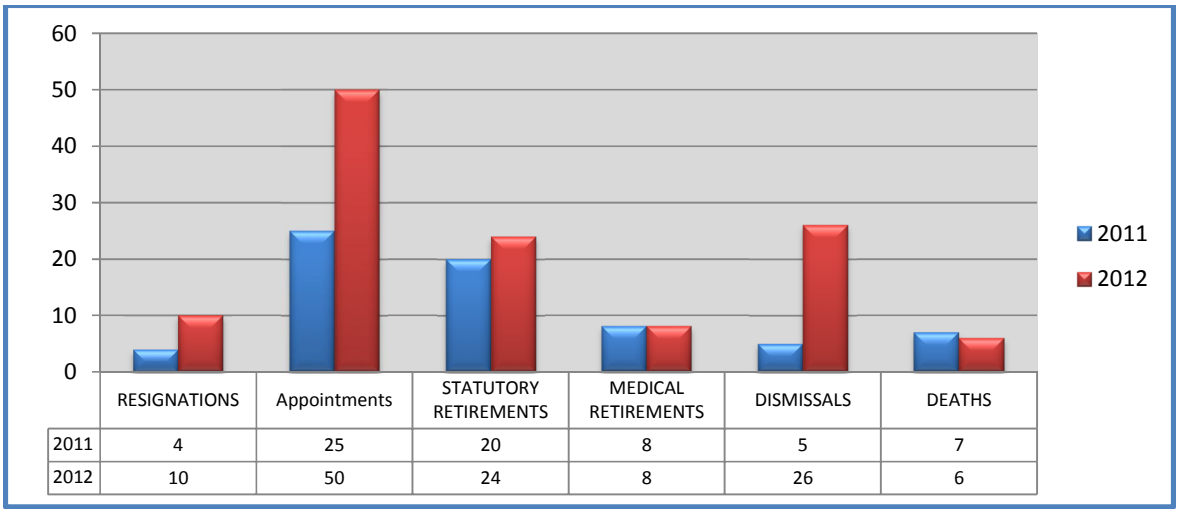


The Department is hoping to reduce the number of employees acting on vacant positions to zero by July 2013 as most of the vacancies are going to be filled from within first (promotions) and from outside where there are no competences within the Department and across Council Departments. The data from staff records indicated that the Division with most acting appointments during the course of the year was the Administration (Clinics- employees acting in the vacant positions of Senior Clerical Officers) and Hospitals.

12.3 Human Capital Staff Movements

The following table is a record of staff movement for the period under review and a comparison of 2011 was done in order to analyze the trends in the human capital movement of the Department. The human capital movement in all the measured factors was very high as compared to 2011.

Fig 12.2: Human Capital Staff Movement



	RESIGNATIONS	Appointments	STATUTORY RETIREMENTS	MEDICAL RETIREMENTS	DISMISSALS	DEATHS
2011	4	25	20	8	5	7
2012	10	50	24	8	26	6

12.3.1 Appointments

A total of 54 of employees were appointed during the course of the year as compared to 25 in 2011. The increase in appointments for was high because of the promotion of Thirty (30) Registered General Nurses to fill in vacant positions of Sister-in-Charge, the promotion of two (2) District Nursing Officer to fill in the vacant position of Deputy Nursing Manager, the promotion of four (4) Senior Environmental Health Officer to fill in the vacant positions of District Environmental Health Officer and the promotion of two (2) employees of the Health Education Division amongst others.

The table below is a summary of appointments by designation

Table 12.2 Summary of employment

DESIGNATION	GRADE	TOTAL
Deputy Nursing Manager	5	2
Deputy Environmental Health Manager	5	1
District Nursing Officer	7	4
Chief Health Promotion Officer	6	1
Hospital Matron (MEC)	7	1
Senior Health Promotion Officer	7	1
District Environmental Health Officer	7	4
Sister in Charge	8	30
Pharmacy Technicians	9	2
Health Information Clerk	11	1
Locum Nurses	9	108
Reinstatements		7
Totals		158

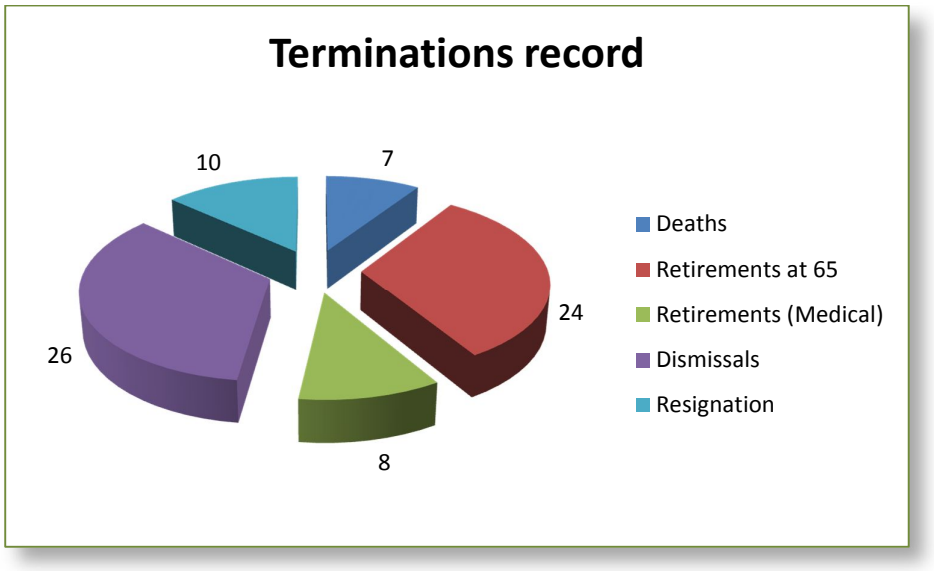
In order to increase the manning levels at City Health Clinics and Hospitals, the Department appointed one hundred and eight (108) Locum Nurses on four months six months contract. The nurses were deployed at all Council Clinics with the Majority deployed at Beatrice Road Infectious Disease Hospital and Glenview in order to deal with the Typhoid outbreak. A total of seven (7) employees were reinstated into Council Services during the period under review.

12.3.2 Terminations

In 2012, there was an increase in the number of terminations processed as a total of Seventy (74) employees terminated their Services with City Health Department compared to fourty (45) in 2011. The turnover ratio for the year 2012 was 5.7%

Turnover ratio **= Termination/ total manpower strength*100**
=74/1299*100
=5.7%

Fig 12.3 Summary of terminations



The turnover ratio as at December 2012 was high and this can be attributed to increase in dismissals and retirements as compared to 2011. The following is a summary of terminations by designation

Table 12.3 terminations by resignations

DESIGNATION	GRADE	TOTAL
Dental Services Manager	4	1
Dental Therapist	8	2
Nursing Sister	9	5
Kitchen Attendant	14	1
General Labourer	16/15	1
Total		10

Registered General Nurses constituted the highest number of resignations during the year under review. Secondary data obtained from employee records and information obtained from exit interviews reviewed that most of the nurses who resigned were offered employment outside the country.

Table 12.4 terminations by Dismissals

DESIGNATION	GRADE	TOTAL
Senior Radiographer	8	1
Dental Therapists	8	1
Nursing Sister	9	7
Environmental Health Officer	9	1
Senior Clerical Officer	11	1
Senior Hospital Stewart	11	1
Clinic Orderlies	13	1
Mortuary Attendants	13	1
Domestic Attendants	16/15	12
Total		26

The majority of the dismissals recorded in 2012 were of Domestic attendants and Registered General Nurses who absconded employment in 2008, and their cases were still pending for all the years.

Table 12.5 Terminations by deaths

DESIGNATION	GRADE	TOTAL
District Environmental Health Officer	7	1
Sister-in-Charge	8	1
Clinic Orderlies	13	2
General Attendant	16/15	1
Total		7

The City Health Department sadly lost f seven (7) employees during the year. The Welfare Officer reported that the deaths were as a result of prolonged illness which was not work related.

TERMINATIONS BY RETIREMENTS

Table 12.6 summary of retirements

DESIGNATION	GRADE	TOTAL
Administrative Officer	8	1
Sister in Charge	8	2
Nursing Sister	9	12
Laundry Supervisor	10	1
Senior Clerical Officer	11	1
Clinic Orderlies	13	6
Laundry Operator	13	1
Total		24

The number of employees retiring from Council Services is increasing each year with Nursing Division being the most affected. The department has however introduced talent management during the year under review where talent is identified, natured and groomed to replace those living the organization.

Human Capital Depletion =Total number left organization/total manpower*100
=74/1600*100
=4.6%

The human capital depletion has a negative impact on human capital management. The City Health Department experienced a human capital depletion of 4.6% through turnover as intellectuals' walks out the door through voluntary separation, involuntary separation and total separation as outlined above. The Department is committed to reduce the human capital depletion to less than one (1) in 2013 through improved working conditions, improved employee relations and health and safety at work place.

12.4 Leave management

Table 12.7 leave statistics

TYPE	2011	2012	Comment
Days lost through maternity leave	905	1862	Increase
Days lost through sickness	5681	4542	Decrease
Days lost through Disablement leave	-	198	
Medical board (number of employees booked)		22	

The number of employees applied and granted maternity leave increased in 2012 as compared to 2011. The increase was highly expected given that the department recruited and employed 201 Nurses in 2010 and the majorities were female nurses (more than 95%)

There was an improvement in the management of employee wellness as evidenced by reduced number of days lost through sickness and this is a positive development. Employees were booked for medical board after they were reported sick and a total of twenty two (22) employees' attendant medical board where their health status was examined and correct informed decisions taken thereafter.

12.5 STAFF ESTABLISHMENT AS AT 31 DECEMBER 2012

DESIGNATION	ESTABL	IN POST	VACANCY
EXECUTIVE			
Director of Health Services DR S MUNGOFA	1	1	0
Director of Health Services (A) DR P C CHONZI	1	1	0
HOSPITAL SUPRINTENDENT			
Beatrice Road Hospital DR C DURI	1	1	1
Wilkins Hospital DR H BARA	1	1	1
MEDICAL SERVICES			
Genitor Urinary Specialist	1	0	1
Epidemiology and Disease Control	1	0	1
District Medical Officer	8	5	3
Clinical Medical Officer	10	6	4
MEDICAL SERVICES STAFF ***DMO'S : DR BAR W, DR MASIYIWA D M, DR MUPAMBO AC, DR NYATSAMBO C, DR MADEMBO C***			
CMO'S: DR ZANZA M' DR MUSHANGWE B S, DR MASUNDA KP, DR MTAHWA G T, DR VENGERE C AND DR VERE M			

DENTAL HEALTH			
Dental Services Manager DR Ngwenyama E	**1**	**1**	**0**
Dental Services Officers	**2**	**0**	**2**
Principal Dental Therapist	**1**	**0**	**1**
Dental Therapist	**8**	**5**	**3**
Dental Attendant	**7**	**5**	**2**
ADMINISTRATION AND HUMAN RESOURCES			
Chief Health Services Administrator Mr R Chigerwe	**1**	**1**	**0**
Chief Human Capital Officer Mr V Kaponda	**1**	**1**	**0**
Fund Accountant Mr. M Chinho	**1**	**1**	**0**
Senior Administrative Officer (Hospital) Ms Nyaguse D	**1**	**1**	**0**
Secretary to Director of Health Services Mrs G Mahiya	**2**	**1**	**1**
Administrative Officer (Clinics and General admin)	**2**	**0**	**2**
Administrative Assistant (Clinics, Stores and Hospital)	**6**	**6**	**0**
Transport Supervisor, Registry Supervisor	**2**	**2**	**0**
Clerical Officers (Clinics, admin, Hospital, Licencing)	**88**	**70**	**18**
Typing/Divisional Secretary	**9**	**5**	**88**
Other administration personnel	**30**	**15**	**4**
Drivers	**14**	**9**	**15**
Laundry personnel	**23**	**23**	**5**
Mortuary personnel	**25**	**13**	**0**
Kitchen personnel	**14**	**13**	**12**
General Labourers	**46**	**46**	**1**
SPECIALIST SECTIONS/ DIVISIONS			
NURSING DIVISION			
Nursing Manager Mrs P Munyaradzi	**1**	**1**	**0**
Deputy Nursing Manager (Mrs P Chitando & P	**2**	**2**	**0**
Manungo	**1**	**1**	**0**
Hospital Matron (BRIDH) Mrs Mabhaudhi	**1**	**1**	**0**
Hospital Matron (Wilkins) Mrs Nyoni D	**1**	**1**	**0**
Matron Medical Examination Centre Mrs Matimbe	**1**	**1**	**1**
Clinical Matron (BRIDH)Mrs Chikondo S	**1**	**0**	**1**
Sexual Reproductive Health Officer			
NURSING STAFF (Clinics and Hospitals)	**8**	**4**	**4**
District Nursing Officer	**73**	**73**	**0**
Sister in Charge (Clinics)	**11**	**11**	**0**
Sister in Charge (Hospitals)	**505**	**418**	**87**
Registered General Nurse (Clinics)	**132**	**85**	**47**
Registered General Nurse Hospitals	**35**	**35**	**35**
Primary Care Counsellors	**167**	**145**	**22**
Clinic Orderly	**170**	**160**	**10**
Domestic Attendant			
PHARMACY PERSONNEL			
Chief Pharmacist Mrs F Chingwena	**1**	**1**	**0**
Pharmacist	**1**	**0**	**1**
Pharmacy Technicians	**5**	**3**	**2**
Chief Clerical Officer, Stores Assistant and Stores Hand	**9**	**5**	**4**
LABORATORY SECTION			
Laboratory Manager Mrs Govore	**1**	**1**	**0**
Laboratory Scientist	**11**	**9**	**2**
Laboratory Technicians	**5**	**2**	**3**
Microscopist and Laboratory Hand	**14**	**1**	**13**

ENVIRONMENTAL HEALTH SERVICES			
Environmental Health Manager Mr J Kandwe	**1**	**1**	**0**
Deputy Environmental Health Manager (Mrs Sikwila E F and Mrs Tapera R)	**2**	**2**	**0**
Chief Pest Control Officer	**1**	**0**	**1**
Divisional Environmental Health Officers	**5**	**1**	**4**
Environmental Health Officers	**42**	**29**	**13**
Environmental Health Technicians	**37**	**26**	**11**
Operations Supervisor	**1**	**0**	**1**
Pest Control Attendant	**13**	**20**	**0**
Medical Examination Centre			
Senior Radiographer	**1**	**1**	**0**
Radiographer	**1**	**1**	**0**
X Ray operator	**2**	**1**	**1**
Positioner x ray and Darkroom Attendant	**4**	**4**	**0**
NUTRITION			
Nutrition Specialist	**1**	**0**	**1**
Nutritionist	**2**	**1**	**1**
HEALTH EDUCATION			
Chief Health Promotion Officer	**1**	**1**	**0**
Senior Health Promotion Officer	**1**	**1**	**0**
Health Promotion Officer	**8**	**0**	**8**
Graphic Artist	**2**	**1**	**1**
EPIDEMIOLOGY AND DISEASE CONTROL			
Senior Medico Social Worker	**2**	**2**	**0**
Medico Social Worker	**4**	**2**	**2**
Establishment grand total	***1600***	***1299***	***312***

CAPABILITY AND DEVELOPMENT

The City Health Department continued to support its staff by increasing number of in-house training, conferences. The City managed to finance these conferences. There was positive development on productivity as employees were equipped with basic skills and employees were being kept abreast with current developments in their particular fields. All employees from various departments attended the Launch of Vision 2025.

The table below reflected an increase in Training and Development activities that took place within the Department. A total of 26 employees managed to obtain various certificates, degrees and Post Graduate degree programmes during the year.

Table 12.6 POST GRADUATE STUDIES AND IN-SERVICE TRAINING

TYPE OF TRAINING	2011	2012
RBM Train the Trainer	0	3
Diploma in Midwifery	3	6
Certificate in OSHEMAC	0	2
Diploma in Community Nursing	3	3
Masters Degree in Public Health	1	4
Diploma in Personnel Management	3	1
Degree in HIV/AIDS Management	3	1
Diploma in Management	1	1
Diploma in Counselling	1	0
Diploma in HIV/AIDS Counselling	0	1
Bachelor in Technology Degree in Environmental Health	4	1
Diploma in Systematic Counselling	0	1
Bsc. Honors Degree in Sociology	2	2
MBA	2	0
TOTAL	21	26