JAARVERSLAG 2017-2020

Stichting Ushamwari OLVG-Zimbabwe

Inhoud

Over de Stichting Ushamwari OLVG-Zimbabwe

De Stichting Ushamwari OLVG-Zimbabwe is in 2012 opgericht. Ushamwari is Shona voor “vriendschap”. De Stichting ondersteunt de Dominican Sisters in Harare, Zimbabwe. Vanuit Harare sturen de Dominican Sisters een drietal ziekenhuizen aan die verspreid liggen over Zimbabwe: het St Theresa’s ziekenhuis in Mvuma, het St Joseph’s in Mutare en Regina Coeli in het afgelegen noordoosten van Zimbabwe. De Dominican Sisters zijn ook intensief betrokken bij het Emerald Hill Children’s Home in Harare, en zij verzorgen een middelbare schoolopleiding in Harare.

Sinds de oprichting zijn door bestuursleden van de Stichting en door andere medewerkers van het OLVG verscheidene werkbezoeken aan onze partnerziekenhuizen gebracht. Anderzijds bezochten meerdere medewerkers van de Dominican Hospitals in Zimbabwe het OLVG.

Doelstelling

Doelstelling van de stichting is de drie ziekenhuizen te ondersteunen waarbij het accent ligt op de behandeling van Hiv en TBC, de preventie van baarmoederhalskanker en diabetes. De afgelopen jaren zijn er twee nieuwe aandachtsgebieden bijgekomen: quality of life van HIV-geïnfecteerden (PLHIV) en palliatieve zorg. We richten ons daarbij op kennisoverdracht, onder meer door werkbezoeken over en weer en door het faciliteren van congresbezoek en deelname van cursussen, we richten ons op het verbeteren van de diagnostische faciliteiten, en het beschikbaar stellen en onderhouden van instrumentarium.

Bestuur

Het bestuur van de stichting heeft de afgelopen periode enige personele veranderingen ondergaan, en bestaat thans uit:

Willem Blok, internist-infectioloog, voorzitter

Guido van den Berk, internist-infectioloog, penningmeester

Harold Verhoeve, gynaecoloog, secretaris

Steven van de Vijver, huisarts

Kaj Wage, kinderarts

Jikke Elzinga, verpleegkundige

Maurice van den Bosch, voorzitter RvB OLVG

Voortgang bestaande projecten

VIAC

In het jaarverslag 2015-2016 werden de achtergronden en de eerste aanzet voor het project Visual Inspection with acetic acid and cervicography (VIAC) beschreven. Inmiddels heeft dit project in de drie Dominican Hospitals een vaste plek gekregen. Sr Christine Murombedzi is lokaal de drijvende kracht achter dit project, en zij overlegt regelmatig met Dr. Harold Verhoeve over de voortgang. Dankzij een doorlopende sponsoring door de Stichting Tilly en Albert Waaijer Fonds zijn we in staat geweest dit project succesvol voort te zetten. De jaarverslagen 2018 en 2019 van het VIAC project zijn als bijlage 1 en 2 aan dit jaarverslag toegevoegd.

Diabetes

Het eerder, mede met ondersteuning van de Evert van Ballegooije Stichting, opgestarte project “Enhancing the diagnosis and management of diabetes” is gecontinueerd. In de verschillende ziekenhuizen zijn opnieuw scholingen gegeven aan verpleegkundigen, en zijn potentiele patiënten bevraagd naar hun kennis en perceptie van diabetes en leefstijl.

Ook in de afgelopen jaren werden glucose sticks ter beschikking gesteld in de zogenaamde primary health centers (satelliet gezondheidscentra die worden aangestuurd vanuit de ziekenhuizen) om tot een daadwerkelijk vroegere opsporing van diabetes te komen, en daarmee ook complicaties te voorkomen.

Diagnostiek TB

De moderne en uptodate echografie apparatuur, ter beschikking gesteld door de firma Philips, en met bemiddeling van Jan Peringa, radioloog, overgevlogen naar Zimbabwe wordt nog steeds in de dagelijkse klinische praktijk intensief gebruikt door de artsen in het St Theresa’s ziekenhuis. De artsen hebben zich verder bekwaamd in het gebruik van de echografie van de thorax in het kader van de TB diagnostiek.

Quality of life

In het vorige jaarverslag werd de inhoud van dit project kort beschreven. In mei 2018 heeft Marie-José Kleene, verpleegkundig specialist infectieziekten, een bezoek gebracht aan de drie Dominican Hospitals om de mogelijkheden voor dit project te onderzoeken. Onze collega’s aldaar waren enthousiast over de opzet van het project, en er werd contact gelegd met een psychiater in Harare die ook graag betrokken zou worden bij de uitvoering. Hoewel wij overtuigd zijn van het nut van deze nieuwe en baanbrekende benadering is het nog niet gelukt hiervoor financiële middelen te verwerven. In bijlage 3 wordt de inhoud van het project uitvoerig beschreven.

Online consultancy

Ook de afgelopen jaren is er via e-mail, whatsapp, Skype etc veelvuldig contact met onze collega’s in Zimbabwe. Regelmatig sturen wij relevante artikelen uit de wetenschappelijke tijdschriften door, en deze worden levendig bediscussieerd. Een waardevolle manier van wederzijdse kennisoverdracht die wij koesteren.

Nieuwe projecten sinds 2017

Buddy project

Om het werk van de Stichting Ushamwari meer bekendheid te geven in het ziekenhuis en de betrokkenheid van OLVG-ers en onze Zimbabwaanse collega's onderling te vergroten, is het buddy project in het leven geroepen. Dr Steven van de Vijver en Sr Christine Murombedzi hebben het project bekendheid gegeven en hebben meerdere verpleegkundigen aan elkaar gekoppeld. Op deze wijze zijn de banden onderling versterkt.

Palliatieve zorg

Sr Agnes Chipo Tererai, een van de Dominican Sisters en zelf ook arts, heeft zich als eerste arts in Zimbabwe bekwaamd in palliatieve zorg. Om haar in de gelegenheid te stellen haar expertise verder uit te bouwen, heeft de stichting Ushamwari haar gesponsord voor het bijwonen van een palliative care course in Kigali, Ruwanda in 2019. Het lag in de bedoeling dat Dr Tererai en Sr Christine in maart 2020 naar Nederland zouden komen om een Advanced course 'Suffering, Death and Palliative Care' bij te wonen in Nijmegen. De stichting Ushamwari heeft de reis- en verblijfkosten hiervoor ter beschikking gesteld, en na bemiddeling was het mogelijk dat onze Zimbabwaanse collega's kosteloos aan de cursus konden deelnemen. Helaas is deze cursus niet doorgegaan vanwege de Covid-19 maatregelen. We hopen dat de cursus tezijnertijd alsnog doorgang kan vinden. Een verslag van Sr Agnes betreffende haar werkzaamheden als arts palliatieve zorg is als bijlage 4 toegevoegd aan dit jaarverslag.

Ad hoc hulp

Cycloon Idai

De cycloon Idai was een tropische cycloon die in maart 2019 veel schade aanrichtte in Mozambique, Malawi en Zimbabwe. Idai veroorzaakte sterke winden en ernstige overstromingen in Mozambique, Malawi, Zimbabwe en Madagaskar die 733 mensen hebben gedood - 417 in Mozambique, 259 in Zimbabwe, 56 in Malawi en één in Madagaskar - en meer dan 1,7 miljoen anderen hebben getroffen. Met name onze collega's van het St Joseph's hospital in Mutare hebben de gevolgen ondervonden van de cycloon. Artsen en verpleegkundigen hebben de getroffen gebieden bezocht en hebben ter plaatse hulp verleend. De stichting Ushamwari heeft gelden gedoneerd om in de extra uitgaven tegemoet te komen

Vuilverbrandingsoven St Theresa's

De vuilverbrandingsoven in het grootste van de drie ziekenhuizen, St Theresa's, raakte in 2020 ernstig beschadigd en is niet meer te repareren. Op verzoek van onze collega's heeft de stichting Ushamwari middelen ter beschikking gesteld om de vuilverbrandingsoven te vervangen.

Financiele ondersteuning

De Stichting Ushamwari heeft de afgelopen jaren financiele ondersteuning ontvangen uit verschillende bronnen:

Opbrengsten jaarlijkse TB symposium Amsterdam

Opbrengsten Kerstgeschenk (personeelsleden OLVG kunnen ervoor kiezen als kerstgeschenk een donatie aan de Stichting Ushamwari te doen

Individuele giften bij promoties, afscheid etc

Donaties van deelnemers aan de 2000-HIV studie

Financieel Jaarverslag

		Jaar									
Code	Rubriceren	2013	2014	2015	2016	2017	2018	2019	2020	2021	Eindtotaal
Beginsaldo	Beginsaldo	29.259,76									29.259,76
Donatie	Particulier	1.320,00	380,00	305,00	865,00	1.985,00	2.510,00	3.474,60	1.445,00	225,00	12.509,60
	OLVG		5.543,69		3.860,00		3.290,00	4.107,95			16.801,64
Sponsoring	TBC symposium		7.167,35			5.587,00	7.742,29	4.200,00			24.696,64
	MRC Holland		5.000,00								5.000,00
	Evert van Ballegooie			4.500,00							4.500,00
	Tilly en Albert Waaijer Fonds				44.480,00					8.900,00	53.380,00
Schenking	Ziekenhuis							5.000,00			5.000,00
Overig	Overig		-995,10	-72,50		-1.089,00		-726,00			-2.882,60
	Reis en verblijfskosten	-7.162,71	-2.490,88		-1.135,61	-3.172,60	-953,87				-14.915,67
	Vergaderkosten	-1.460,00									-1.460,00
	Bankkosten	-23,01	-160,45	-164,60	-262,10	-142,80	-142,00	-126,00	-156,90	-90,90	-1.268,76
	Transportkosten				-1.856,13						-1.856,13
	TBC symposium kosten	-300,00	-355,00	-335,00	-350,00	-200,00	-205,00				-1.745,00
Projectgelden	Cervixca		-734,00		-2.300,00	-7.232,19	-47.163,11				-57.429,30
	Diabetes Care		-9.000,00		-3.550,30						-12.550,30
	INRIPHE				-1.424,05						-1.424,05
	FASH				-1.939,47	-1.100,00					-3.039,47
	Pediatric nutrition				-930,41						-930,41
	HIV Quality of Life						-1.331,98				-1.331,98
Schenking	Ziekenhuis		-5.400,00					-16.000,00			-21.400,00
	Weeshuis		-1.000,00								-1.000,00
	Interest workshop			-425,00							-425,00
	Scholingskosten							-2.000,00	-2.430,26		-4.430,26
		21.634,04	-2.044,39	3.807,90	35.456,93	-5.364,59	-36.253,67	-2.069,45	-1.142,16	9.034,10	23.058,71

	Jaar	2013	2014	2015	2016	2017	2018	2019	2020	2021	
	Saldo einde jaar	21.634	19.590	23.398	58.854	53.490	17.236	15.167	14.025	23.059	

Bijlage 1

The VIAC program is viable in our three hospital since February 2018 when two nurses from each of our three hospitals trained at Newlands training center. Before the training of the nurses from St Joseph's and Regina Coeli, only St Theresa's hospital was conducting VIAC screening. The other two hospitals were conducting only VIA. We appreciate the support we receive from the Ushamwari project to make our VIAC program a success. Fortunately some of the institutions had nurses trained by the government which calls for an easy functioning and flow of the program as the government also support the program. The doctors at Regina Coeli and St Joseph's Mutare were also trained by the government whereby there is no trained doctor at St Theresa as the one who had trained left the place in January 2018. This makes it difficult in as far wanting the doctor's opinion in some the complicated VIAC positive or cancer suspicious cases.

The six nurses from our three hospitals who trained at Newlands, had 3 successful mentorship visits. Some needed items and areas of improvement were noticed during mentorship visits and were attended to. We saw some improvement with each mentorship visit as it has been highlighted on the mentorship reports l sent you.

In September we had 4 more nurses trained at Newlands. The training was a success and they completed the first mentorship. Now awaiting the other two mentorship visits. The last two mentorships to be conducted at St Joseph's.

Since the beginning of the program we managed to screen the patients as indicated in the table below. All in all our three hospitals screened 1 468 clients so far from January to November 2018. St Josephs and Regina Coeli started VIAC in March so much so that the statistics for January and February are for VIA only. While St Theresa's statistics are all VIAC screening because the program was commenced in 2016. Of the169 clients who were VIAC positive, 116 were treated with cryotherapy and 49 were referred out. Four clients were not treated because they were screened at an out-reach were they were told to go the clinic for cryotherapy because there was no nitrous oxide at the outreach center. However some of those women never came for cryotherapy treatment. For more information about the monthly statistics see the attachment I have sent together with this report.

ACHIEVEMENTS:

- Number of trained nurses: St Theresa's – 6 nurses and no doctor , St Joseph's 4 nurses and 1 doctor, Regina Coeli – 4 nurses and 1 doctor
- Managed to get most of the needed equipment
- Some facilities are managing to conduct outreach programs which is a good opportunity to meet a number of women who cannot afford to come to the hospitals.
- Getting support from the Ushamwari project and the ministry of health which makes our clinics valid and viable
- Some VIAC positive women eligible for LEEP are attended to at the government hospital free of charge.

- Quite a number of women who were diagnosed of VIAC positive or suspicious are gratefully as they express it when they either bring back their results or when we make a follow up of their results per phone.

CHALLENGES:

- At times failing to reach the target
- Some clients have problems of finance to go to the referred hospitals for further management.
- One of the trained nurses at Regina Coeli has been asked by the government to transfer to a local clinic in January 2018 of which one of the three is a member of administration
- Need for a small portable cylinder of nitrous oxide when conducting out-reach programs.
- Need a VIAC trained doctor for St Theresa's.
- Need for a lensfilter (UV-filter) for the Regina Coeli's camera.

RECOMMENDATIONS/ 2019 PLANS:

- There is need to conduct a quality control of the images as we think it would be best to move around our three hospitals doing an image quality control (this can be done 3 three time per year taking a period of our 3 school terms. During these visits, we will select a hospital and some representatives from the other hospital will come to the chosen hospitals and will discuss the images for the purpose of quality improvement)
- To conduct more out-reach programs so as to reach out to those who cannot afford to come to the institutions.
- Need to have a monthly budget allocated for each hospital for administrative purposed and purchasing some VIAC sundries especially during the times when the hospitals will not be in a state to buy them, enhance continuity of the program. Administrative purposes such as Wifi, stationary and telephone purposes.

FINANCIAL REPORT

We received a total of $58 000.00 from Holland Ushamwari project. The money was used for training of the nurses which included travelling expenses, training fee, other training expenses such as transport, accommodation and food costs. We used the Newlands charges in all the training expenses. Also, the money was used to buy some needed equipment and other VIAC sundries such as latex gloves, ascetic acid, sanitary pads and wipers as this was the requirement from the training facility and the government. The expenditures incurred were just as sent on the previous mail. The

balance from the 2018 income is $17 415.00. We are proposing the following expenditure from the balance; to use it for the remaining 2 mentorship follow up from Newlands which will be conducted at St Josephs, as well as to purchase some equipment like the 3 trollies, 3 nitrous oxide cylinders, 2 heaters and 1 fan. We did not manage to purchase the trollies and the second cylinders of nitrous oxide because they were forever out of stock and were said to be purchased from South Africa. We hope with this unstable economic situation, our hopes will be fulfilled.

Name of Hospital	**New Clients**	**Repeat Clients**	**HIV Neg**	**HIV Pos**	**Unknown HIV Status**	**VIAC Neg**	**VIAC Pos**	**Treated with Cryotherapy**	**Referred-out (Lesions above 75%)**	**Suspected Cancer of the Cervix**	**Total number of clients attended**
St Theresa's	629	129	224	484	50	624	108	73	**30**	23	758
St Joseph's	348	115	359	104	0	414	36	27	11	13	463
Regina Coeli	354	7	310	68	1	320	34	22	13	7	361
Total	**1331**	**251**	**893**	**656**	**51**	**1358**	**178**	**122**	**54**	**43**	**1582**

Bijlage 2

In 2019 the VIAC program went on very well. Some hospitals managed to conduct some out-reach clinics so as to reach out to those who could not afford the bus fare to the hospital.

ACHIEVEMENTS:

- All VIAC positive clients who were treated by cyrotherapy responded well to the treatment.
- Knowledge and skill were boosted as we attended the quality control workshop held at St Joseph's Mutare.
- The VIAC clinics were opened almost every day and no clients were sent back home without being attended to.
- Of the VIAC positive clients 93.8% were either treated with cryotherapy or referred for further management.

CHALLENGES:

- It is very painful to see patients' conditions deteriorating and more so dyeing as they cannot afford to go for further managed due to lack of funds. We used to get some coupons from the government but seeming this was done only for about the first 2 or 3 months of 2019.
- We don't have any LEEP machine at any of our hospital and this results in having to refer all the patients for LEEP to other government institutions. Because of costs clients are often unable to reach these institutions and at times those who managed to go, are turned down without being attended to because of either long waiting list or the unavailability of the doctors.

WAY-FORWARD:

- If funds avails we need to have at least one doctor from St Theresa's trained in VIAC, moreso, for a LEEP-machine and training in the use of it.
- If funds avails, we need to support the clients who are referred for further management so that they don't feel that they are just told they are suspicious and there-after dumped to see to themselves dyeing. To make matter worse, the majority are very poor and live in pathetic situations.
- To have a back-up solar system in case of electricity cut-off and for other stations to repair the existing solar system.
- To have 100% treatment of the VIAC positive clients.

SUMMARY FOR VIAC STATISTICS 2019

Name of Hospital	New Clients	Repeat Clients	HIV Neg	HIV Pos	Unknown HIV Status	VIAC Neg	VIAC Pos	Treated with Cryotherapy	Referred-out (Lesions above 75%)	Suspected Cancer of the Cervix	Total number of clients attended
St Theresa's	337	130	356	87	24	422	32	10	**16**	13	467
St Joseph's	548	171	371	348	0	649	64	19	43	6	719
Regina Coeli	217	30	197	50	0	226	17	7	11	4	247
Total	**1 102**	**331**	**924**	**485**	**24**	**1 297**	**113**	**36**	**70**	**23**	**1 433**

Bijlage 3

Improving Quality of HIV Care in Three Mission Hospitals in Zimbabwe

Project proposal

Ushamwari Foundation

Amsterdam

(www.ushamwari.nl)

June 2017

Background

Zimbabwe has a projected population of 13 million people and is among the countries in Sub-Saharan Africa worst affected by the HIV and AIDS epidemic. The HIV prevalence among adults 15 years and above was 15% according to the Zimbabwe Demographic Health Survey in 2010/11. The adult HIV prevalence has shown a declining trend since 2001 and is now plateauing. The decline in prevalence is attributed to the impact of prevention programs aimed at behavior change (high condom use and reduction in multiple sexual partners), prevention of Mother to Child Transmission, and treatment care and support services.

The anti-retroviral therapy (ART) program was launched in 2004. ART access was scaled up from 5 learning sites in April 2004 to 1545 sites with 879.271 (62% coverage) HIV infected patients (adults and children) on ART by December 2015.

The Ushamwari OLVG-Zimbabwe Foundation – a non-profit organization – focusses on improving care for individuals with HIV in Zimbabwe. Since 2012, the Ushamwari Foundation collaborates closely with three rural mission hospitals that are overseen by the Dominican Sisters in Harare. The hospitals are St. Theresa's Hospital in Charandura, Mvuma, St. Joseph's Hospital in Mutare, and Regina Coeli Hospital in Nyanga District. Together, the three hospitals care for over 6000 people living with HIV (PLHIV). ART is provided through international funding according to national guidelines. The three hospitals are characterized by high commitment of the caregivers as well as a high level of quality and continuity of care. Amongst other projects, the Ushamwari Foundation has provided the hospitals with state-of-the-art LED microscopes for improved TB diagnosis, and a modern ultrasound device for early TB diagnosis. A diabetes awareness and detection program was implemented, and the Foundation helped launch a cervical cancer screening program in the three hospitals. Doctors and nurses from our partner hospitals visited Amsterdam through a program of mutual knowledge exchange.

The Ushamwari Foundation coordinates its activities with the Organization for Public Health Interventions and Development (OPHID), a local trust which develops and implements innovative approaches and strategies to provide enhanced access for communities to comprehensive HIV prevention and care.

The present project aims at four goals:

1. Improving infrastructure of the three hospitals.
2. Improving laboratory diagnostic processes.
3. Estimating and improving quality of life of PLHIV through structured questionnaires and adequate psychosocial support.
4. Improving cardiovascular risk management amongst PLHIV

Improving infrastructure of the hospitals

The three hospitals face frequent shortages in supplies and frequent power cuts, obstructing the diagnostic and therapeutic processes. Installing more solar power would greatly improve the quality of care, and it would cut the costs of electricity.

Improving laboratory diagnostic processes

The supply and distribution of ART is generally well taken care of in three hospitals. However, regular follow-up of HIV viral load and of kidney and liver function is missing due to the lack of local laboratory equipment and high cost of transportation of blood samples to central laboratories. Dried blood spots may be send to a central laboratory in Harare where costs are kept low. Dr Tariro Makadzange, a Zimbabwean infectious diseases specialist, who divides her time between Boston and Zimbabwe, and who has established a laboratory in Harare, can provide HIV VL testing at a very competitive price. Local installation of biochemistry analysers may greatly improve proper follow-up of PLHIV on ART, and may benefit other services as well, such as maternity services, diabetes care and cardiovascular risk management.

Estimating and improving quality of life of PLHIV through structured questionnaires and adequate psychosocial support

Little is known on the quality of life of PLHIV in sub-Saharan countries such as Zimbabwe, especially data on patients living in rural areas are lacking. Comparing quality of life measurements with local healthy controls and with PLHIV in ab affluent country such as the Netherlands, may give important insights in the directions health care providers may have to explore in order to improve the quality of life of PLHIV in these circumstances. Applying value-based health care (VBHC) principles to investigate these needs may give valuable insights in the quality of care both in Zimbabwe and in the Netherlands.

Improving cardiovascular risk management amongst PLHIV

Extensive scientific literature shows that PLHIV are at increased risk for cardiovascular endpoints, despite successful treatment of HIV. Increased attention for the classic risk factors such as hypertension, diabetes, hypercholesterolemia, diet and life style is warranted. The estimation of these risk factors in a rural population of PLHIV in a country such as Zimbabwe may provide us with valuable insights in the optimal care to be delivered both in Zimbabwe as well as in the Netherlands.

Projected Costs

Project	Projected cost (Euro)
Installing and improving solar power	
St Theresa's	20000
St Joseph's	30000
Regina Coeli	20000
Autoclave St Joseph's	15000
Biochemistry analysers	
St Theresa's	30000
Regina Coeli	20000
Reagents three hospitals	40000
Blood collection materials	20000
HIV viral load dried blood spots	
6000 x 10 Euro x 5 years	300000
Quality of life program/VBHC	
Education of staff	5000
Development local tools (Questionnaires, labtops; tablets)	5000
Program manager during three years	60000
Cardiovascular risk management	
Electronic blood pressure monitors in hospitals and primary health care centers (20)	1000
Counselling nurses and local opinion leaders	2000

Bijlage 4

My end of year reflections: 31 December 2020

Dear Family/friends

Greetings to you all. As we come to the end of 2020, I thought of sharing some reflections acknowledging the past, the present and the future as God has rightly allowed me and all of us to experience and be.

Firstly; I would like to thank each one of you for your friendship and companionship to me, for the past 7 years. Returning from East Africa (Tanzania) at the end of 2013, Emerald Hill became my home and base as I worked at Parirenyatwa hospital, Oncocare and private practice. At Emerald Hill we have a children's home and a school for the deaf, 6 of the years of my stay I was the local superior of the place. My term of office has now come to an end and I will now belong to the community of Dominican convent 4th street in town (my first home as a very young sister 1994-1996). I am happy to be relieved of the responsibilities I had at the hill, but I will miss Emerald Hill very much as it is for me a place which expresses in action the social justice responsibilities we have as human beings towards each other as manifested by the care of 100 vulnerable children in the children's home and another group of hearing-impaired children who attend the school for the deaf. Having these 2 great institutions at one facility and having the opportunity to spend 9 years (Apr1990-Dec1991 and Nov2013-2020) of my life there is for me a blessing and a constant reminder of the words of Jesus "what-so-ever you do to the list of my brothers/sisters, that you do unto me…." As a palliative care doctor, I deal with serious often very draining issues which reveal many other dimensions of our vulnerability as human beings. Combining the demands and challenges of my work and the life back home at Emerald Hill always reinforced the UBUNTU (I am because we are..) spirit in me and desire to share with all God's people.

I have also been a council member of the Dominican sisters in Zimbabwe leadership for the past 4 years and this ended at the end of 2020, a responsibility which allowed me to be in close contact with our health institutions and activities throughout Zimbabwe. I am very humbled and inspired by all who continue to give themselves wholeheartedly to the care of the sick in our facilities and all the support staff without whom the health facilities would not operate. Our sisters and the lay staff members' commitment and hard-work in the face of today's many challenges is greatly appreciated. St Theresa continues to be cradle of training of the future nurses, while St Joseph hospital in Mutare is getting busier every day due to the big catchment area and being the only other big hospital in the town after the provincial hospital. I am grateful to all who supported and responded to my applications which enabled reaching out to other social needs around the hospitals e.g. putting up of houses and blair toilets around Regina Coeli and St Theresa areas and responses to cyclone Idai. I will continue to support our Dominican health facilities and indeed the Zimbabwean health system as much as I can probably now more by linking of interested partners and in my palliative care mentorship role.

I am noticing a striking shift in the health system in Zimbabwe between rural and town (perhaps a study into this is necessary). Probably due to the socio-economic dynamics of the country there is a movement towards urban in terms of not only job-seeking but even illnesses and poverty. While at the beginning of the 20th century it was a common thing to have full hospitals with even floor beds in rural mission hospitals (I recall my years at St Theresa 2002-2007) due to HIV/AIDS then and many people were dying, the current trend seem to be a reversal of those years with fewer in-patients as HIV/AIDS has now become a chronic illness. Rural mission hospitals while they are still relevant, their patient clientele is now mostly out patients based, some maternity and sometimes seasonal (e.g. malaria season). On the other hand; the town set up is now a hive of many cases (St Joseph statistics can testify); many

conditions such as the cruel COVID 19 pandemic (numbers high in towns), complications of many chronic illnesses etc. With our struggling health-care delivery system, and the many challenges now being posed; there is need to think outside the box and usual way of doing things at the same time be relevant to our times. I will be now fully involved in palliative care provision clinically in Harare using our small Domhealth private practice (attached to our House of Adoration – house with elderly and frail sisters) as a base to operate from while continuing to actively see patients at homes and/or hospitals, at the same time continue to mentor/teach other health care workers and allied professions at different levels. Palliative care is a basic human right, however covid19 has come with many challenges in offering quality life to patients with serious health related suffering and their families, hence I am hopeful that through mentoring many others in palliative care; alternative humane approaches will be surfacing especially in the provision of palliative care to Covid 19 (and any other such isolating condition) patients. I look forward to partnerships with like-minded individuals/organizations in conducting research in this area which can contribute to evidence-based practice.

United in Christ

Agnes Chipo