ANNUAL NEWSLETTER

AN UPDATE OF RESEARCH ACTIVITIES, 2022

NHRDC ANNUAL UPDATE DECEMBER 2022

SOCIAL AND BEHAVIOURAL SCIENCES RESEARCH

INTRODUCTION TO EARLY PHASE RESEARCH

FUNDING HEALTH RESEARCH IN ZIMBABWE

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FOREWORD

Chairman of Board, Medical Research Council of Zimbabwe (MRCZ)

The Health Ethics Review, a newsletter of the Medical Research Council of Zimbabwe (MRCZ) is published annually and timely to coincide with the occasion of the MRCZ's Annual Research Forum and this year is no exception. Welcome to the Newsletter.

As the National Ethics Health Ethics Committee in Zimbabwe, (a specialized council of the Research Council of Zimbabwe RCZ), the MRCZ is mandated to, (inter alia), provide regulatory oversight for health research. To carry out its mandate adequately, the MRCZ operates though a number of technical subcommittees, including the **National Health Research and Development Subcommittee (NHRDC**) which is obligated to conduct scientific and ethical review of submitted research proposals. The subcommittee oversees research compliance to agreed ethical standards and conducts training for researchers and for research ethics committees in the country.

The other mandate-related technical subcommittee is the **Traditional and Complementary Medicines Research Committee (TCMRC),** which provides oversight on all research involving traditional and complementary medicines. It is mandatory that all research involving traditional and complementary medicines which involve human beings should be reviewed and approved by the TCMRC before commencement of research.

The MRCZ annual research forum and annual publication of this newsletter is a logical extension and progression of its mandate. These two activities in particular, provide a mouthpiece and face of the MRCZ. It is no wonder therefore that it is always a gratifying pleasure to publish this newsletter and to enact the research forum.

The MRCZ is aware and most humbled that some of the brightest minds in HEALTH RESEARCH attend annual research forum and read the Health Ethics Review Newsletter. It is our honor.
The articles published in the newsletter are an appropriate vehicle of the values of the MRCZ which are, Ethics, Relevance, Credibility, Knowledge, Transparency, Commitment, Integrity and Fairness.

I invite you all to enjoy reading the HEALTH ETHICS REVIEW.

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Dr Nyaradzo M Mgodi (MBChB, MMed) is a Board Member the Medical Research Council of Zimbabwe, and she leads the Traditional and Complementary Medicines Research Committee (TCMRC) She has over 15 years' experience conducting clinical trials assessing novel biomedical interventions for HIV prevention in women of reproductive age in Sub-Saharan Africa.

From the editorial desk

It is our pleasure to present the 2022 edition of the MRCZ Annual Newsletter, We thank the authors, stakeholders, and readers for supporting this newsletter which endeavours to keep all abreast with new and changing regulations in human research. As MRCZ, we aim to assist researchers in adhering to international and local guidelines in the ever-evolving fraternity of research ethics. This issue covers some of the work the MRCZ and health researchers are conducting.

This year, the editorial team had the pleasure of engaging a multi-disciplinary panel to contribute to this edition. The entire world has been impacted by COVID-19 but have the Covid-19 effects been all negative.? Not quite, Dr Javangwe navigates the implications C-19 for Public Health from a socio-behavioural point of view. The year 2022 was busy for the MRCZ;with COVID-19 somewhat relenting, the largest and busiest committee of the MRCZ, the NHRDC was able to conduct some of its activities in-person though the vast majority remained virtual. We congratulate the NHRDC for having successfully reviewed all new applications, renewals, and amendments in a timely manner. In this edition Dr Stranix-Chibanda gives a comprehensive report of the NHRDC's activities in 2022. She being the vice chair of the NHRDC, I am taking advantage of this opportunity to hint to her that in 2023 all monthly meetings should be held at the beautiful new MRCZ premises on Cambridge Road. In this edition, Ms Natasha Tsandukwa welcomes you all to our lovely new premises.

There is an urgent need to scale up health research in Zimbabwe, empower African researchers, create collaborative networks and generate evidence-based that will inform health policy and improve the quality of life for all. I invite you to read on and find out how research and development can promote innovation, entrepreneurship, equitable development, and prosperity for Zimbabwe. Scale up of research and development requires that Zimbabwean health researchers be capacitated to conduct all phases of research. As you will read in this issue, several opportunities, and capabilities exist that allow the conduct of early phase clinical trials in resource-limited settings. The health research agenda should include local thought and ideas, from inception through completion, to the implementation of policies arising from the research. We must recognize and strengthen the research and development capacity of Zimbabwean investigators to facilitate full and sustainable ownership of health research into the future.

According to Owusu-Ansah FE 2013, knowledge or science, and its methods of investigation, cannot be divorced from a people's history and cultural context An emancipatory and participatory type of research values and includes culture, indigenous knowledge and peoples. Zimbabwe has deep-rooted ingenious, indigenous knowledge and expertise which must be harnessed to strengthen ethical traditional medicine research in Zimbabwe. We also embrace the critical role played by communities in research. This edition includes a word from a research participant. In my opinion, health research must innovative, ethical, culturally appropriate, human-centred, with a solid human-rights based approach. According to Albert Schweitzer "Ethics is nothing else than reverence for life," In other words, ethics is all about upholding Ubuntu

Thank you once again for supporting our newsletter. As the year draws to an end, I wish all of you happy holidays and quality time with family and friends. Be safe on the roads and take care. Let us meet in 2023 with renewed vigor to promote and conduct ethical health research that will address the health needs of Zimbabweans

Dr Lynda Stranix-Chibanda is a Zimbabwean Paediatrician and advocate for children's health with over 20 years of clinical trial experience and direct HIV service delivery to women and children at primary care level. Lynda has served on the MRCZ review committee since 2006. She lectures at the University of Zimbabwe, mentors postgraduate students, and directs multi-country clinical trials related to the prevention and treatment of HIV in women, adolescents, and children.

National Health Research and Development Committee (NHRDC) Annual Update, December 2022

The NHRDC activities align with the MRCZ mission to regulate, promote, facilitate and coordinate the conduct of health research that is ethical, scientifically sound, relevant, and influences health policy and practice in Zimbabwe. The year 2022 saw MRCZ operations move to a new physical premise, and research activity picking up after the COVID-19-related lockdowns of the previous year. The committee met monthly, as scheduled, recording a quorum present at each session. The scope of NHRDC activities includes the approval of human research and GCP site inspections.

Review Timelines

A total of 108 new applications were submitted for review. Of the 42 protocols submitted through the normal review process, 18 (43%) were reviewed and approved within the target 60-day period. Broadly speaking, the average turnaround of the 26 protocols submitted by Ph.D. candidates (62% of normal reviews) was longer than non-PhD protocols and in the region of 75 days vs 52 days. Of the 66 protocols submitted through the expedited process, 20 (30%) met the 30-day target period.

Assessing Delays

The committee revisited the review process to identify opportunities for reducing turnaround times without compromising the quality of reviews. Factors contributing to the delay for both normal and expedited reviews included:

1. Researcher not responding to reviewer comments within the requested period (2-weeks);
2. A second round of comments issued after the reviewer assessed the response as inadequate to address the comments raised; and
3. Very occasional reviewer failing to submit comments within the required 2-week period.

Reviewers frequently commented that inadequate detail was provided for them to assess each required aspect of the submission. To clarify, reviewers are tasked to evaluate a protocol to confirm any ethical considerations are acknowledged and sufficiently attended to, the intended scientific approach is valid and fully described in the submitted materials, and the topic holds national relevance.

Improving the Review Process

To counter the common sources of delay, the NHRDC developed a 3-pronged remedial strategy for the year ahead—

1. Expand the external reviewer base to increase the availability of highly experienced researchers trained to assess new applications. Four new reviewers were added to the pool in 2022, with plans to train an additional 4 in the year ahead.
2. Communicate expectations to researchers clearly by reviewing the application form instructions which specify required sections for a research protocol and offering to deliver webinars about the application process to research groups and postgraduate programmes.
3. Offer pre-submission interactions to Ph.D. candidates and their Supervisors. This approach was piloted with 3 Ph.D. candidates after initial review and found to be useful in avoiding back-and-forth responses to address the multiple comments.

NHRDC continues to interact with Institutional Ethics Committees and other regulatory authorities, aiming to harmonize and streamline the research review process across all bodies.

GCP Inspections

The NHRDC inspectorate conducted 6 site inspections to monitor research conduct for compliance with GCP standards. Three GCP inspections were done with inspectors from the Medicines Control Authority of Zimbabwe. There were no major findings identified requiring suspension of research activity, although multiple opportunities for improvement were observed. In general, citations are mostly related to deficient filing practices for essential documents, including correspondence with regulatory authorities, and inadequate evidence of internal quality control activities for research data.

Encouraging Site Inspection Readiness

To promote the continued improvement of GCP practice across the research community, researchers are encouraged to maintain proficiency in GCP by completing refresher training every 3 years for their site teams.

The NHRDC remains committed to the MRCZ vision of a sustainable health research sector in Zimbabwe that has the capacity to drive the future health, social and economic development of Zimbabwe. This vision recognizes that an effective health research sector must be founded on research that is relevant, ethical, and scientifically sound, and informs health policy and practice.

Dr. Gwatirera Javangwe Ph.D. is a Senior Lecturer in the Department of Applied Psychology at The University of Zimbabwe. He is a Registered Psychologist and a Forensic Mental Health Advocate with over 15 years of experience in applied research in the areas of evidence-based assessment, treatment, rehabilitation, and reintegration of offenders. He is the Chairperson of the Zimbabwe Prisons and Correctional Service-Harare Metropolitan Province, Advisory Board. He is a member of over 15 international professional associations and a member of the Medical Research Council of Zimbabwe, National Health Research Development Committee (NHRDC).

Social and Behavioural Sciences Research in Zimbabwe in the Era of COVID- 19 Pandemic: Implications for Public Health

Whilst the COVID- 19 pandemic has had several negative impacts, it had countable positive effects. New companies emerged, new ways of doing business emanated. The new normal sprang to life. The Covid-19 pandemic provided us with an opportunity to learn much, but much is still to be learned. In particular, society and national leaders must act on what we already know and take appropriate decisions to mitigate the harmful effects and inequalities infuriated at the district, provincial, and national level. the pandemic is a behavioral and social phenomenon that has to be controlled by public health measures, of which adequate treatment and vaccination only are parts in a multifaceted system of social, economic and political interventions needed to effectively deal with the pandemic.

From March 2020 up to date we have clearly come to realise that the pandemic for numerous reasons and never in the history of mankind has affected socially and economically disadvantaged groups, to that extent. It is nearly 2 years, now since the first case was recorded. It is also clear that the pandemic has significantly worsened and continues to widen the health inequalities. The evidence abound to date indicates that it is imperative that all national responses to COVID-19 should include specific responses for marginalised groups and ethnic minorities. Research has shown us that vaccines need to be distributed in urban, rural, farming, mining and peri-urban communities including people in prisons, corrections, detention facilities and even institutionalised care. This resonates very well with WHO and European Union's declaration that: 'no one is safe until everyone is safe'.

We have benefited from the efforts of global and national researchers who undertook to synthesize knowledge and make knowledge available to policymakers. Their input is greatly appreciated and should be used. The pandemic has been punctuated by misinformation and disinformation and by a rising distrust in political institutions. The Covid-19 vaccine hesitancy, misinformation and disinformation have been huge and yet not much has been done locally to accurately inform the public.

The local people have been very sceptical of vaccines produced elsewhere. Perhaps, this is an opportunity for the local drug and vaccine industry. Good news of the existence of new vaccines came. But the Covid-19 vaccine campaigns seem to have hit a snag, culminating in low uptake. This has seen the age of vaccine uptake being lowered to 12 years and yet not many have taken up the vaccines. On a positive note, the government has made significant strides with the two-phase approach that was bolstered by the third booster. This is because we thought the pandemic could be beaten with the development of several effective vaccines, but new important problems arose, including the efficiency of vaccines. Globally, equitable access to vaccines and vaccination passports disproportionately allowed those vaccinated to travel. In the context of this new imperative, research has ushered the need to relax the restrictions. Albeit, in Zimbabwe, an ongoing debate remains on whether there should be restrictions for those not vaccinated, not only in travel and in indoor activities. This debate echoes a standard public health ethical problem, formulated around 20 years ago as a preamble to a code of public health ethics. There is the paradox around the need to ensure control aimed at protecting the health of populations and, at the same time, the need to navigate potential abuses of such power in the context of public health ethics.

At the start of the pandemic the health workforce, found themselves in a quandary. They had to look after very sick people, at the same time plunging into a crocodile infested river, knowing very well the likely effects not only on personal health but their lives. The result was that many health care workers experienced burnout. Some studies focused on the health care workforce, indicating that they are underpaid, underappreciated and stretched to the maximum. The government intervened with the provision of a dollarized COVID- 19 risk allowance across the board. Arguably, health care has tended to focus on COVID-19 patients and yet neglecting normal health care. We have seen a surge in mental health problems and drug and substance abuse among the youth and young people. The focus on COVID- 19 has shifted our attention away from other chronic illnesses and we are sitting on a public health time bomb. Early diagnosis and delayed treatment have a net negative impact and can potentially erode all the gains in HIV and TB research and intervention. We also need to prioritise cancer diagnosis and treatment. We must remind ourselves that health research, and health care will continue to be lopsided long after the COVID-19 pandemic has disappeared. The time to act is now in order to avoid the knee jack.

There was a huge economic impact of COVID-19 on not only health care but all spheres of life. The impact should not be underestimated. The fact that parts of Zimbabwean industry are now going all time high, makes us forget the many closures that have occurred and that over a year of education and training has been lost to large groups. The government and public health professionals had no choice but to propose restrictive measures and interventions that did not go down well with the general populace. The measures were perceived as an unwarranted intrusion on the right to freedom and on the economy. A sizable number of organisations had to downsize, while some career switches were witnessed. Research has shown that companies continue to reel in agony as they frantically attempt to remain open and afloat with a view to retain some degree of economic stability. Some people were forced to undergo training that they had not anticipated. For example, many have had to take a three-month Red Cross course and continue migrating to the Diaspora. The Covid-19 induced brain drain has affected many. This means that when the economy opens up again, it may be difficult to find staff in specific settings.

Covid-19 pandemic impact on mental health has been huge. Everyone was afraid of dying. Nationally, Econet used to provide daily updates on the situation but it took an irked citizen to court. The informational overload created anxiety, fear, uncertainty and fear of dying. Some population groups have been hit harder than others. For instance, stress and burn-out can be seen in the health workforce and in social services that have had to cope with reduced staff but higher demands. Lockdowns and closures isolated persons and groups, families have been split and there were reports of increased gender based violence and intimate partner violence. The lockdowns also meant limited access to research participants and disruptions in various research activities. Reporting deadlines, late study commencements and having to request for roll over became the norm. Funders also resorted to repurposing of existing grants to focus on COVID- 19, while some funders shifted their attention from the previous thematic issues to COVID -19 too.

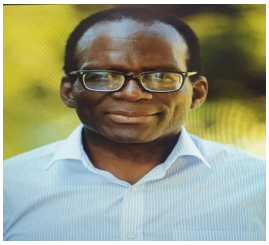
In terms of education and schooling, the haves had to resort to online and virtual learning. The have nots who ordinarily did not afford a meal could not even afford a smart phone and even if the smart phone were available the data were beyond the reach of many, thereby widening the disparity of education provisioning not only between those in urban centres and rural areas but even between the marginalised groups and the affluent. The mobile tech companies could also not help. They had not figured out how to create the technological infrastructure needed in the context of the COVID-19 pandemic. The design, deployment and absorption of disruptive technologies became the order of the day. However, new problems also emerged. For example, internet use increased probably tenfold, This culminated in increases internet use disorder, WhatsApp use disorder, Facebook use disorder and other technology induced disorders that have also become rampant. We need to find ways of wiggling ourselves out of this mess. Thus, even if the highly educated, well to do groups have been able to cope with the pandemic and even benefiting from home work, others have suffered unemployment or lack of support and company because some people were locked away from their families. The reconnection and reunion looked like a nightmare.

On a positive note, the pandemic has seen a heightened sensitivity to environmental health. National clean up campaigns have been the norm. This has incrementally reduced environmental pollution, especially waste collection in almost all urban centres. Even rural areas have joined the movement. The pandemic also showed the need to reduce air pollution as it has an effect on the spreading of the virus. The lesson we learnt from this pandemic is that in the future we need environmental policies that will help to reduce air pollution and as well as developing new urban planning strategies. Thus, smart cities, smart energy, smart production systems, smart health, e-government, e-commerce, smart water supply systems among others become health priorities. Electronic protocol submissions and electronic reviews have become a norm, going forward. The need to look at artificial intelligent systems and nanotechnology is now. We need to glean into the social and behavioural implications of harnessing these systems beyond the pandemic.

Perhaps, it is good to ask ourselves, what have we learned so far? How can we leverage on the lessons learnt? The better start is to acknowledge the health inequalities that existed before the pandemic and to glean into those that have been induced by the pandemic. As such, we need to invest in health care and never to underestimate the mental health ramifications. We need to invest

in the health care system and health care workers, not just when another epidemic comes around the corner, but for now and forever. The evidence emanating from our experience of the pandemic seems to suggest that public health should play a vital role in our future planning. Importantly, we have come to realise that: environmental policies can contribute to the health and wellbeing of all, urban planning needs to include health factors. Against all odds, public health should be in the driving seat. Public health is the cornerstone of a functioning and healthy society. And public health is there for everyone, not just national and African but also at globally.

This article did not provide an exhaustive account of all challenges and lessons learned in relation to the COVID pandemic. An attempt was made to look at some issues on which the Zimbabwe should continue focusing on.



Prof. Collen Masimirembwa is the founding President and Chief Executive Officer of the African Institute of Biomedical Science and Technology (AiBST) in Zimbabwe. He is also a Distinguished Professor at the University of the Witwatersrand working at the Sydney Brenner Institute for Molecular Bioscience (SBIMB). Collen obtained his DPhil in Biochemistry at the University of Zimbabwe and a Ph.D. in Medical Biochemistry and Biophysics from the Karolinska Institute, Sweden.

Conducting Early Phase Clinical Trials in Resource-Limited Settings: Challenges, Opportunities and Recommendations

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[3]Clinical Research Officer

Early phase clinical trials (EPCT) include phase I and phase II trials that aim to find the correct dose and safety profile of a new medicine. Most phase I trials are done in health volunteers whereas phase II efficacy studies are done in patients. Africa contributes less than 3% of clinical trials globally, indicative of an underdeveloped R&D pharmaceutical industry. A survey of global clinical trial registries showed that of about 4500 clinical trials done in Africa between 2010-2020, only 200 and 100 where Phase I and phase II respectively (Eden et al., 2021). Zimbabwe is among the top 10 African countries in the registries. Most studies in Africa are phase III trials on interventions for infectious diseases like HIV, TB, and malaria. This has major health implications for our populations as we are treated with medicines whose safety and efficacy has not been tested in our population. Our research and that of others is increasing showing that the genomic diversity of populations has implications for risk for disease and for drug safety & efficacy (Rajman et al., 2017).

EPCT require specialized infrastructure to test new interventions for the first time in man, either healthy volunteers or specific disease patients. Such studies usually involve few patients, less than 100. EPCT studies aim to collect intensive data on safety and efficacy, hence the need to have in-country access to imaging, genomic and bioanalytical services for the capture and evaluation of pharmacokinetic (PK) and pharmacodynamic (PD) measurements. This makes the setup and maintenance of EPCT units very expensive requiring a robust jobs pipeline to be sustainable.

A recent partnership involving a pharmaceutical company and research institutes in Africa resulted in the establishment of 8 clinical centers with capacity for clinical pharmacology research that meets international regulatory requirements. Zimbabwe was one of the beneficiaries of that scheme (Gutierrez et al., 2017). In Zimbabwe a Phase I Trial Unit has been established by the African Institute of Biomedical Science and Technology (AiBST). The 30-bed clinical trial unit is linked to an advanced bioanalytical and genomics laboratory, bioinformatics and pharmacometrics data analytics platforms. This has enabled the unit to attract investigator initiated clinical studies from major international companies needing specific genetic status only found in people of African ancestry. AiBST used its database of genotyped study volunteers to identify such participants. (Soko et al., 2016, Mutiti et al., 2021, Li et al., 2021

A major challenge for the existing EPCT centers is the lack of a constant stream of studies to perform and currently, all first-in-human studies involve products from outside Africa. Most international companies have not yet seen value in conducting these early studies in Africa due long-standing wrong perceptions about conducting advanced research like EPCT studies on the continent. African EPCT centers must be innovative in making a case for their suitability to conduct these studies for major pharmaceutical companies. Without this push for sustainability the equipment and infrastructure established will eventually fall apart, furthermore the skilled manpower will be lost to Global North.

Another challenge is the complexity and delays in the regulatory framework for clinical research and registration of medicines in Africa. This needs to be addressed and initiatives such as the African Medicines Regulatory Harmonization (AMRH) are welcome.

Despite these challenges, opportunities exist to make it attractive to do such studies in Africa. First is the changing disease trends in Africa. NCDs like cancer and cardiovascular diseases, are increasing in Africa, thus presenting an opportunity for patient populations required for some of these studies. With the fastest growing and youngest population in the world, access to Phase I study volunteers in Africa is easier. There is less competition for study participants in general, most potential participants have not been exposed to other prior treatments, and the most intriguing opportunity is the genomic diversity of African populations which is higher than that of any other population on earth. Doing clinical studies in such a population provides more scientific insights and the results obtained are more generalizable to other populations.

EPCT facilities are also suitable for conducting bioequivalence (BE) studies required for generic drug manufacture and registration. There is a call for Africa to build a manufacturing capacity of essential drugs to meet the health needs of its people. The Pharmaceutical Manufacturing Strategy for Zimbabwe 2020-2025 identified the need for key partners like AiBST to provide BE/BA in its implementation.

To address the limited supply chain of EPCT studies in Africa, the identification of these EPCT sites across Africa as centres of excellence could be a first step. This could be done under the guidance of the various AU initiatives such as Pharmaceutical Manufacturing Plan for Africa (PMPA), African Continental Free Trade Area (AfCFTA) and African Medicines Agency (AMA) which could accredit such centres. Such a regulatory support would help sustain EPCT centre with a set minimum number of studies annually per site creating sustainability. Other forms of activities include creation of disease registries linked to biobanking, databases of health genotyped volunteers, continuous consultation with various pharmaceutical companies with R&D product pipelines to scout for likely candidate drugs requiring clinical research in the future and supporting generic drug manufacturing companies with BE/BA studies.

Tendayi Kureya is the Executive Secretary of the Medical Research Council of Zimbabwe. He is a Biostatistician (MSc), and Environmental Engineer (MPhil) and is currently pursuing a Doctor of Philosophy in Business and Management.

A Case for Funding Health Research in Zimbabwe

There is an opportunity to scale up health research in Zimbabwe. The policy framework has never been more enabling. Zimbabwe's ambitious vision to become an upper-middle-income country by the year 2030 requires a strong research and development component that is guided by a well-thought research strategy. The current National Development Strategic 1 (NDS 1: 2021-2025), the blueprint for the required transformation, places research and innovation at the top of priorities. Research and development can promote innovation, entrepreneurship, equitable development, and prosperity for all. Zimbabwe's constitution recognizes health as a fundamental human right and improved health as central to human happiness, well-being, and economic progress.

Research and development are urgently required to address new and old problems. Novel and resurgent epidemics, including COVID-19, measles, and even polio, have shown us that while international support and collaboration are necessary, home-grown solutions for local problems are urgently needed. Research and innovation are important to restore and maintain the national Health System and utilize the country's competitive edge. A developed research sector will entail a skilled, knowledgeable, and

professional health workforce, firm foundations for primary health and hospital care, and improved quality of public health outcomes.

All the ingredients of a vibrant health research and development sector are in place. Zimbabwe boasts of a well-developed higher and tertial education sector, a rebounding and reviving industry, and a critical mass of health researchers and scientists in government and the private sector. These three ingredients are important for setting up a triple front to health research. Informed by a nationally agreed health research agenda, researchers in universities and other institutions of higher learning can adequately link with industry and turn their successful research into products and services. It is possible to produce the bulk of medicines, equipment, and other supplies locally, and become a net exporter of these.

Training for medical professionals in the country is of excellent quality and sets the correct grounding for new research scientists. Physicians, biologists, pharmacologists, engineers and all the other relevant disciplines are presented with an opportunity to choose a career path that combines the practice of medicine with a career in medical or scientific research. Zimbabwe's young physicians are a crucial bridge between research and patient care and can be provided with grants to advance their research ideas.

There is commitment at the highest level to fund research from government resources. The Minister of Health and Childcare, currently the Vice President, is also responsible for research in the country. He ensures that health research receives adequate attention and presidium level. Guided by the Constitution and Research Act, there is a commitment to set aside at least 1% of the national budget for research. This is a good practice that is observed in many developed countries. Notwithstanding, medical research in the country is still currently mostly funded by external entities and this is the paradigm that should change. The primary source of funding for health research should be government, and funding should be predictable and guided by an agreed research agenda. Government funding for health research can recapture lost ground in the health sector and position the country's standing as a world leader in medical research and advancements.

Natasha Tsandukwa is a member of the MRCZ Secretariat. She is a junior compliance officer and part of the MRCZ Inspectorate. She has a Nursing Science background and has been with the Council since 2018.

The Medical Research Council of Zimbabwe's New Premises.

The Medical Research Council of Zimbabwe is an arm of the Ministry of Health and Child Care, responsible for promoting, regulating, coordinating, funding, and conducting health research. Established in 1974, it was housed at the National Institute of Health Research which was generous enough to provide it with prefabricated housing. As the research community expanded, staff at the council increased in numbers, the station was slowly but surely becoming too small for its intended purpose.

The MRCZ staff were housed in a pool office, all departments were accessible from the reception desk. We had the accountant in one corner, which we always joked about calling, '**the accounts department**' and the rest of the technical officers shuffling around the available desks in the pool. Our head of compliance was found in an inner office, which also doubled as a store room for stationery and supplies, and then last but not least our boardroom, which also doubled as our filing room and per rising need, a kitchen.

After over 40 years of existence, the Council finally purchased its property and sealed the deal in February 2022. I suppose it was a combination of factors that finally led to the acquiring of a property, this includes a supportive mother Ministry, a determined board, financial stability, the undisputed need for expansion, and a hardworking secretariat that carried out the groundwork. The new premise is located at number **20 Cambridge Road, Avondale, Harare.** Besides being an evident upgrade in terms of space, the premise is located in a neighborhood that is not too far from the Central Business District, which remains accessible for most of our researchers.

Not to blow our own trumpet, the new offices are nothing less than stunning. Upon entrance through the main gate, the first stop is the cladded reception area which is detailed by fine granite and tiling. The same space has a waiting area set up for our walk-in clients which has been beautifully furnished with leather couches and matching coffee tables for our researchers' comfort.

The technical officers are located a couple of steps upwards from the reception area, in separate cubicles! We literally can still see each other over the glass doors but it does the most in ensuring a bit of privacy in the work area and a little less stepping on each other's toes.

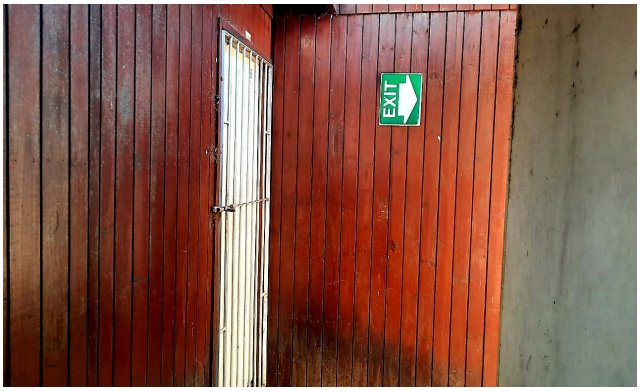
Management and administration are found along the corridor, in separate offices of course. We finally now truly have the long wished 'Accounts Department.' Just past their offices is our new training room, which was set up for GCP and Ethics training that the Council offers from time to time. The room is big enough to house at least 25 participants at a go, which is ideal for the training classes.

Out back is our Executive Secretary's office and our massive Boardroom. Because the Council now has over 3000 files open for terminated and ongoing studies, there was a need to build a fire, water, and pest-proof filing room to store all the hardcopy data. This was promptly built and set up, filing is currently still ongoing but we aim to have completed sequential filing by January 2023. Other perks that came with the house include a swimming pool, a neat parking area, a beautiful yard, a huge kitchen, and a stop-over office for our board chairman.

We like to think of the new house as a home for all health researchers, both students, and professionals. Your continued support has kept the Council afloat, and for that we are grateful. Many thanks also go to the Ministry of Health Child Care, particularly the National Institute of Health Research for housing the Council from its inception until the time it was ready to branch off on its own. I liken it to having a 40-year-old child, who still stays under your roof with no prospect of leaving, but never chucking them out. It took a great deal of patience and hospitality, and for that we sincerely thank you. Lastly, we would like to recognize the current board members, Professor C.F.B Nhachi, Dr. E. Shana, and Dr. N.M.Mgodi, Mr. A. Rutanhira, and Dr. M. Hove, and leadership within the secretariat for seeing this through. It had long been in the pipeline, but they finally made it happen.

The year 2022, has been good to us, and we are enthusiastic about our endeavors for the next one to come. Although our address has changed, we would like to clarify that our telephone number and other contact details remain the same and our doors remain open for business. **Our Information and IT department are currently working on updating our forms, please check our website regularly for the current versions of all documents and guidelines.**

New Address: Medical Research Council of Zimbabwe
20 Cambridge Road
Avondale
Harare
Email: mrcz@mrcz.org.zw / Telephone: 08644073772
Website: www.mrcz.org.zw




20
Cambridge Rd

Research in Traditional Medicine ™ by Dr Wisdom C. Gwatidzo

Research in Traditional Medicine (TM) is more of a verification of what has been known and used for ages. In most cases, we are dealing with sure and secure assurance regarding efficacy and safety in simplicity- much more than with artificial and allied substances that are non-constitutional and foreign to Nature's Creation and the human body

Recommended Mode of Studies

These are soundly retrospective and on record tracking of already proven cases of healing of extreme lifestyle challenges (e.g Cancers, Diabetes, Renal Dysfunction, Epilepsy, ADHD etc). Then planned anterospective study proposals within a specific period, will reinforce the retrospect findings regarding particular therapists and/or their therapies.

Highlights of best results in healing of challenges well-known will be the lead to the selection of further study areas by students of post-graduates.

Research Reinforcement for lasting impact

- Spearheading of a herald journal together with the emerging universities will reinforce preservation, in cooperation, recruiting at large and more systematic application.
- TM Research Day for presentations and awards will highlight and safeguard as well as secure with linkages and possible integration opportunities
- Establishments of a University Teaching Hospital for TM – in conjunction with a relevant University Traditional Medical College.
  Research level/depth
  This will depend on level of the researcher or researching team-capacity building may be promoted as needful. Otherwise Research in TM is more interesting if kept in its simplistic form to conform with nature's healing. This is no roadblock to those with a complex mind and perspective- so long safety is the rule.

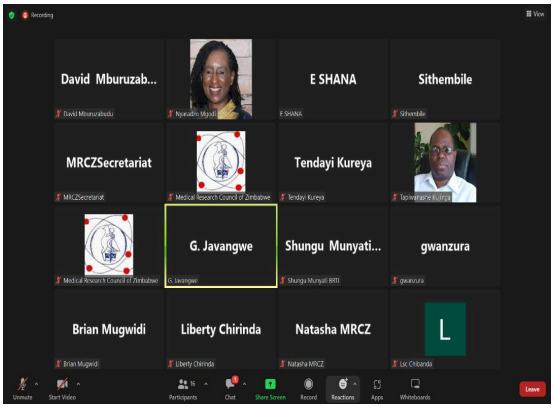
Perspective of a trial participant

When l first heard about the clinical research trials it was the $15 reimbursement that lured me. I enrolled October 2018 and it wasn't as easy as l expected. I had challenges disclosing to family members and friends about the study as many quickly frowned upon hearing the word research. l was even labelled "guinea pig"

Then came the long visits to the site which were commonly associated with swollen arms from the blood draws and two or three days later swollen buttocks from the injection and you trying to act as if everything is fine to avoid discrimination. There were many adjustments to lifestyle as adherence was a major issue. Fours yours later, l have come to realize the importance of Prep and how l am a living testimony of it's efficiency. Though the disadvantages may overweigh the advantages, the one and only goal was achieved.

On the 19th of June l left Zimbabwe headed to Uganda. I was chosen to participate in the community perspective meeting which was being held in Kampala Uganda where people from all over the world were advocating for the availability of all methods of HIV Pre-exposure Prophylaxis, especially the injectable form. The main objective was to come up with a plan to make CAB-LA available not only to us trial participants but to the general population. l as a participant in the trials was even shocked by cost of CAB-LA as it had not been availed to me during the four year per two months visits at the clinical research centre. I gained lots of experience and knowledge during the meeting and was proud that Zimbabwean women like me had contributed to this injectable HIV prevention method and that Zimbabwe was the first ever country in Africa to register CAB-LA for HIV prevention. I am proudly Zimbo!

MRCZ IN PICTURES

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You can contribute to future issues of this newsletter by contacting our secretariat at: mrcz@mrcz.org.zw

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