A year in Zimbabwe
– facing the reality of AIDS

Saba Lambert

Saba Lambert was born in Ethiopia and lived in Zimbabwe for four years before going to Medical School in Dundee, Scotland. In 1999 she returned to work in Zimbabwe. She spent a year at Harare Hospital before deciding to move to New Zealand in December 2001. She is currently a GP registrar in the GP training scheme and has recently moved from Wairoa to Dannevirke.

After graduating in Scotland in 1998, I went to Zimbabwe for a year to take up an SHO post in Obstetrics and Gynaecology. I had spent some time as a medical student in Harare Hospital, and wanted to go back there knowing that it was a busy job where I was sure to learn a great deal.

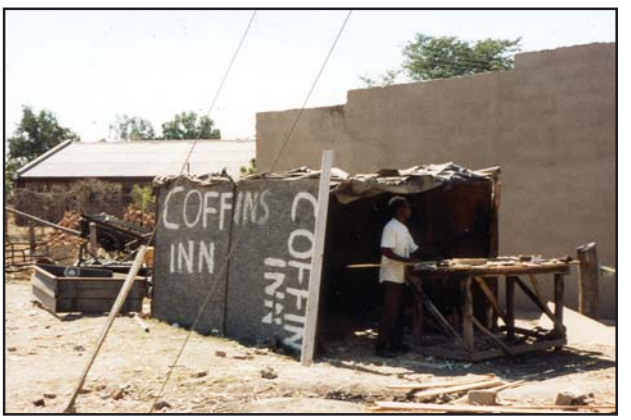
Harare Hospital is the main tertiary referral center in Zimbabwe. Built in the 1950–60s, mainly to serve the black population of the then Rhodesia, it is a large hospital with almost every specialty represented. Traditionally it is the hospital for the poor, although even here they now had to pay to be seen by a doctor.

A study in our unit showed almost 45% of the young women coming to the labour ward were HIV positive

At the beginning of my job in November 1999, the political and economic situation was still fairly stable, with the hospital seemingly having ample supplies of medicines. My local colleagues were already complaining of the fast decline in standards, but since I had nothing to compare with, I was more concerned with dealing with the sudden large amount of responsibility I was given. Senior support was at times poor and I found myself acquiring a mobile phone to be able to contact my seniors when I needed them. The pager system was virtually non-existent and land-lines were usually out of order, so even in operating theatres, the sound of mobile phones was common.

As a referral center, the hospital dealt with 'complicated' cases. With

Dr Saba Lambert on the grounds of Harare Hospital – the photo shows squatters who are waiting for treatment living on hospital grounds .



One of the many make-shift 'funeral parlours' or coffin shops in Zimbabwe – the best money-making venture at present.

more than a 100 admissions a day into the labour ward, I learnt fast and was expected to do a variety of procedures within a short time of arrival. Without the support and supervision I had been accustomed to, I found this particularly stressful. The 'see one, do one, teach one' attitude extended to even complicated Caesareans!

Although this was an O & G job, there was an amazing variety of infectious diseases that co-presented. Malaria in pregnancy was a frequent presentation, leprosy in pregnancy appeared occasionally, however, AIDS was an important part of my working day. A study in our unit showed almost 45% of the young women coming to the labour ward were HIV positive. Having seen the whole array of opportunistic infections within weeks of my arrival, I had acquired great 'spot-diagnosing' skills, but my treatment plans were often useless because of the lack of drugs. Some drugs were available in the private sector but few could afford them. The hospital could not even provide treatment for medical staff who had had a needle-stick injury from confirmed cases of HIV. No prophylaxis for vertical transmission of HIV was available. Counselling had no real part and advice on breast-feeding was rarely given as there was no 'safe' and cheap alternative for this poor section of society.

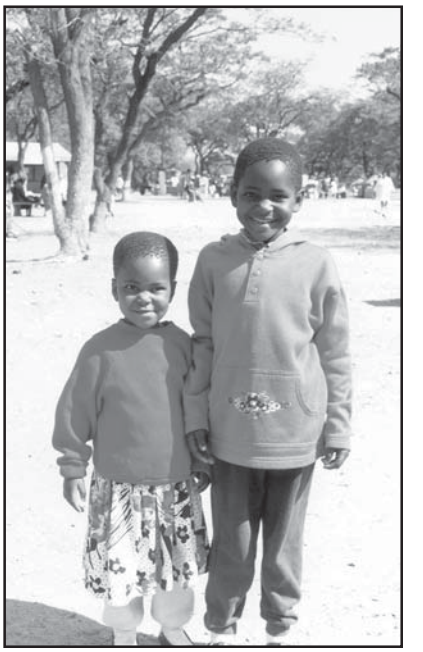
The 'see one, do one, teach one' attitude extended to even complicated Caesareans

HIV in this part of the world is mainly due to heterosexual transmission. In a culture where a young woman has to prove her fertility before her man marries her, the importance of 'safe sex' is lost. In a society where men have city jobs whilst their wives tend to the land back in the rural area, extra-marital affairs and polygamy are the norm. In a tradition where you inherit your dead brother's wife, without worrying about what he may have died of or what she may be carrying, the number of funerals and households made up of tired grandparents and a dozen orphans is hardly surprising. When myths tout 'sex with a virgin' as a cure for male HIV infection, desperation makes the myth a reality, and rape cases involving young girls and children increase. Despite distribution of free condoms, usage is probably low as they are often seen as the cause of the problem ('free condoms must be too cheap to be safe and the ones made overseas carry disease or holes are put in them so that Africans will die'). And when no one wants to admit he has HIV/AIDS – the black man calling it TB or a curse from some ill-wishing relative, and the white man hiding behind the label of cancer – it is easy to lose hope of a real fight against this modern day plague.

With the transmission of HIV goes the whole array of STDs; one can have a field day at 'spot-diagnosing' as patients presented late with their symptoms and signs. Before visiting the 'Western doctor', a visit to a variety of witch-doctors and traditional or faith healers is preferred as they are cheaper: by this time genital warts have grown to the size of broccoli!

The hospital could not even provide treatment for medical staff who had had a needle-stick injury from confirmed cases of HIV

Tuberculosis is common and the usual precautions to prevent transmission that I had learned in the UK, seemed superfluous. Isolation rules were virtually ignored. Women in labour shared the same space whether they were healthy or ill. Only the cases that had been referred from the Infectious Disease Hospital and were under treatment for TB were kept in single rooms, but only after they had delivered! Although DOT (Directly Observed Treatment) was the only remaining free therapy in Zimbabwe, somehow the battle seemed lost. Contact tracing and follow-up are a real Public Health nightmare in a third world country.



The next generation: the eldest (7) was a patient of our gynae outpatient clinic – pictured on the 'tea area' of Harare Hospital.

As the political and economic situation worsens, poverty increases at an amazing speed. Hygiene and nutrition plummet as families struggle to make ends meet. The sharing of already cramped rooms becomes common, clean water, a luxury. When an epidemic of gastroenteritis hits, 'lack of foreign currency' is the excuse used by the Government to explain why there are no chemicals to purify the tap water. An excuse which also explains why the power cuts are so frequent, why there is no fuel for ambulances, why the hospitals are

running out of medicines and sundries, why condoms are no longer free, why the workers are striking after not getting paid for two months... During the cleaners' strike, the Maternity section was so disgusting that patients self-discharged saying they had not come there to 'catch diseases'. After seven days of corridors filled with contaminated sheets, over-flowing bins and toilets, cleaning help finally arrived in the form of two trucks filled with prisoners chained to each other by ankle chains!

Working in a government hospital made one more aware of the suffering of the poorer people and the disintegration of health services. Regular power cuts led to equally regular clear-outs of the ICU, as there was no back-up power supply ('no diesel to run the emergency generators!'). The over-crowded neonatal unit also had regular clear-outs related to power-cuts. Our small mortuary, originally built to host 60 corpses, often held up to 600. The refrigeration was inadequate and as relatives unable to afford yet another funeral abandoned their dead, the Government was forced into organising mass burials on a monthly basis.

Our small mortuary, originally built to host 60 corpses, often held up to 600

Hopelessness and exhaustion set in fast amongst health workers, and in my last four months in Harare, many of the good doctors and nurses had resigned without giving notice, others died of Aids. For those of us left behind the workload more than doubled and we eagerly awaited the arrival of two hundred Cuban doctors which Castro had promised, only to find that few of them spoke English!

After nine months I was exhausted and I too resigned. There is a limit to the amount of suffering one can stand without the hope of imminent change. Of course, it was an amazing learning experience but I also forgot a lot, especially when it came to treatment options or interpretation of the rarely seen ECG. One of my greatest realisations was the importance of the link between Public Health and Infectious Diseases and their dependence on political and economic stability. With the 'silent' sanctions against Zimbabwe, the fight against this modern day plague seems insurmountable. Still, some donations of condoms and Nevirapine are coming in, education programmes are still going on and courageous individuals devote their lives to ease the plight. But the real war against AIDS in Zimbabwe has not even begun.

Poetry

Robynanne Milford is a GP who has enjoyed the best of general practice in Ponsonby, Queenstown and now in Christchurch. She was a member of Womanspirit, published in *Roses and Razorblades* and *In this Bitter Season*. The challenge, she says, is to sculpt a body of words that breathe their own life.

Sea Glass

YES, there was a breaking
crystal clear
they were sharp, cutting edge
multihued and faceted
with sparkle that
weathered tides ebb and flow
pummell and dash
withstanding
wave upon wave of
sick man upon sick man.

Whereas sea upon sands
renews soothes
these crazy currents erode
reforming reforms at will without
wellness their heart
glazing those wisening gazes
smooth and reliced.
Some make pleasing shapes
sculpted
most lie, just chips, cast

RIP GP 2002

Robynanne Milford