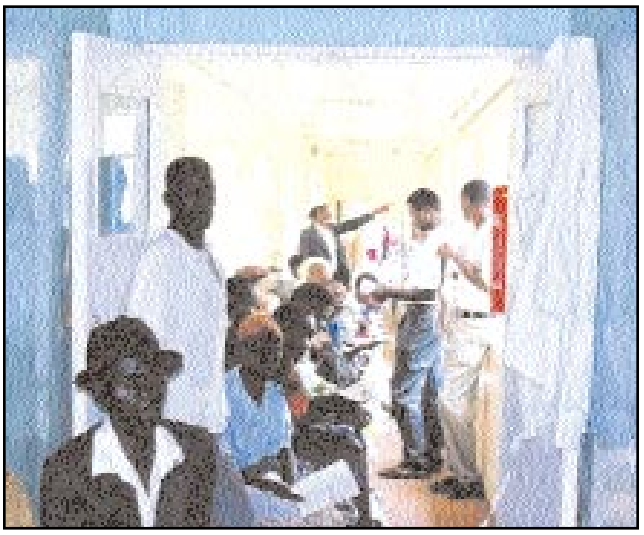
Out of Africa — Experiences of a Canadian Doctor in Zimbabwe

Andrew E. Simor

In our most recent federal election, in November 2000, there was some discussion of the future of health care in Canada, including the possibility of a "two-tiered system" and its effect on universal access, a hallmark of the Canadian system. In 2001, our front cover will feature pictures to illustrate the stories of Canadians who have volunteered or worked in health care in other countries.



In November 2000, Andrew Simor, the Head of Microbiology at Sunnybrook and Women's College Health Sciences Centre, travelled to Zimbabwe as a medical volunteer. He took this issue's cover picture during his stay. It shows at least 14 people who were undergoing active investigation for tuberculosis (TB) on one day in the TB clinic at Howard Hospital.

Countries in Africa are among the poorest in the world. As a result, they often do not have resources for basic health care. The most common medical problems are related to a variety of infectious diseases, and African countries have the highest incidence rates in the world of life-threatening infections such as tuberculosis, meningitis, malaria, and acquired immunodeficiency syndrome (AIDS).

In November 2000 I went to Zimbabwe as a medical volunteer with a Canadian–Jewish humanitarian organization called Veahavta. I worked at a rural Salvation Army hospital, the Howard Hospital, in a small farming community called Gweshe, about 90 km north of Harare, the capital city. The area is primarily agricultural, with numerous small subsistence farms. The hospital has 150 inpatient beds, a very busy outpatient facility, and a regional obstetrical service with more than 3000 deliveries per year. There is one full-time physician, an obstetrician born and trained in Canada.

I spent nearly 3 weeks at the Howard Hospital, where I was responsible for medical care for both inpatients and outpatients, assisted at surgical procedures, supervised a clinical research study, and provided educational sessions for nurses and nursing students. As might have been expected, the major medical problems encountered were a variety of infectious diseases, including AIDS, tuberculosis, pneumonia, gastroenteritis, and schistosomiasis. We also treated patients with rheumatic fever, malaria, hepatitis, meningitis, sexually transmitted diseases, pelvic inflammatory disease, mucocutaneous candidiasis, burns, and traumatic wound infections. The only laboratory tests available were hemoglobin level, white blood cell count, blood glucose level, pregnancy testing, Gram staining, acid-fast staining, malaria prep, direct smears for ova and parasites, and VDRL (Venereal Disease Research Laboratory). Microbial cultures were not available. It was possible to perform plain radiography and abdominal ultrasonography, but no other imaging studies. As a result, most of our diagnoses and treatment were empiric. A restricted group of anti-infective agents were available — penicillin, cloxacillin, ampicillin, erythromycin, tetracycline, clindamycin, cotrimoxazole, nalidixic acid, metronidazole, kanamycin, chloroquine,

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quinine, and antituberculous drugs — but nocephalosporins, fluoroquinolones, or antiviral agents. The only antifungal drugs were gentian violet and griseofulvin.

Zimbabwe has among the highest rates of infection with the human immunodeficiency virus (HIV) in the world, and 1 of every 4 women who presented in labour at the Howard Hospital had the virus. Treatment for this infection is generally nonexistent in Zimbabwe because of the high cost. Veahavta started a study at the Howard Hospital to investigate the use of short-course (and affordable) antiretroviral treatment for HIV-infected women in labour, with the aim of preventing transmission of the infection to newborns. HIV testing supplies and medications have been donated. One of my responsibilities was to audit the conduct of the study, which has been under way for a little less than a year.

I found my brief experience at the Howard Hospital in Zimbabwe enjoyable and immensely rewarding. I am certain that I learned much more than I was able to contribute in such a short time. I was most affected by the observation that, despite our concerns in Canada about shrinking health-care resources, there is no comparison between what we have access to here and what is available there. Zimbabwe is a beautiful country with many natural resources and enormous potential. Unfortunately, it now faces huge political, economic, and social challenges, largely because of a corrupt and inefficient government. I have returned home with a much greater appreciation for the freedom and benefits we enjoy in Canada.

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