Reflections

Tariro

Finding hope in Zimbabwe

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Tariro is the Shona word for *hope.* Shona is the ancient tribal language of many of the people of Zimbabwe. It is with the promise of *tariro* that the Shona people are able to struggle against the scourge of HIV and AIDS, poverty, rampant inflation, and government corruption. In May and June 2006 I had the privilege of volunteering as an attending physician at the Howard Hospital, a Salvation Army Mission Hospital in the Mazowe district of Zimbabwe.

I came to Howard by way of Veahavta (**www.veahavta.org**), a Jewish humanitarian organization based in Toronto, Ont, that partners with organizations throughout the world to carry out its mandate of *tikkun olam,* Hebrew for *repairing the world.* Veahavta (Hebrew for *you shall love*) has long been associated with and supported programs at Howard Hospital; most notably in recent years, they brought conjoined twins Tinotende and Tenashe, born at Howard Hospital, to the Hospital for Sick Children for ultimately successful separation and repair of cleft lips and palates.

The attending physician at Howard, Dr Paul Thistle, a University of Toronto graduate, headed to Zimbabwe about 12 years ago. This unsung Canadian hero has dedicated his life to caring for this community of about 300 000 people (with a nearly 22% HIV prevalence), assisted by only 2 local GPs. The challenges they face are immense.

As a community-based palliative care physician with the Temmy Latner Centre for Palliative Care in Toronto, and with a background as a family physician with a primary care HIV and AIDS practice, I was particularly intrigued to learn about the approach to pain and symptom management at the end of life in a low-resource setting. I also wanted to learn how these remarkable people cope with such loss and hardship in a society where life expectancy is 37 years of age for men and 34 years of age for women.

Daily routine

My daily routine included morning ward rounds on the men's ward, where most of the patients were suffering from end-stage AIDS or fulminant pulmonary tuberculosis (TB). I also saw malaria, pneumonia, schistosomiasis, and gastroenteritis, and more common conditions, such as burns, fractures, myocardial infarctions, strokes, and uncontrolled diabetes. Interestingly, I rarely saw malignancy (aside from Kaposi sarcomas), even in the older population. After ward rounds (and the never-to-be-missed tea break at 10:00 AM) I headed to what might best be called the *outpatient department*, where the remainder of the day was spent seeing countless "ambulatory" patients, many of whom traveled for hours by foot, overcrowded broken-down vehicles, and oxcarts to see us. We encountered infectious diseases of every sort, the whole spectrum of primary care, and all the complications of HIV and AIDS and TB.

After regular working hours I would sometimes remain on call and attend to emergencies at the hospital and to the inpatients' problems, mostly to give Dr Thistle a well-deserved break. We saw the usual stream of injuries and illnesses one would see in any community in Canada, but also more unusual presentations of illness, such as cerebral malaria. Depression and stress-related symptoms were common but were often not recognized or addressed in any meaningful way. Mostly I learned that people are people. The will to live and survive, despite all obstacles, overrode everything—no different from Canadians.

Treatment options

Dr Thistle provided comprehensive surgical treatment for the usual range of problems (cesarean sections, abdominal surgery, and cranial bur holes), with anesthesia provided by a volunteer nurse-anesthetist from the Netherlands. Midwives delivered most of the babies, with the assistance of a second-year Canadian family medicine resident. Antiretroviral (ARV) treatment was also available for HIV-positive mothers in labour, and a University of Toronto study was being conducted to evaluate postpartum treatment of mothers and infants to reduce mother-to-child transmission of HIV while maintaining breastfeeding.

The most frustrating part of the whole experience was the lack of common medications we take for granted. The whole country ran out of anti-TB medications for most of the time I was there. Aside from oral morphine, and a limited supply of acetaminophen and ibuprofen, no other analgesics were available. In addition, there was reluctance to use morphine, even in the most dire circumstances. On the other hand, considerable progress has been made in the provision of ARV therapy, and the Howard Hospital is leading the country in this area. Currently 500 people (out of a potential 50 000 eligible

patients with HIV) receive ARVs and many more receive *Pneumocystis carinii* pneumonia prophylaxis.

Teaching

One of my most rewarding experiences was teaching medical students from the University of Zimbabwe. Eager and keen, they could not get enough of the comprehensive family medicine approach we all take for granted here. For example, I was able to show them how to diagnose and treat asthma successfully when I realized, after visiting a few patients in their homes, that the constant fires in the centre of their round houses caused many patients to have chronic cough. Reducing this environmental exposure, and using inhaled corticosteroids and salbutamol that I had brought along, led to substantial relief for many patients for the first time in their lives. Psychosocial issues were common, but were often neglected in this atmosphere of abject poverty and infectious disease. Attention to these often resulted in comfort and anxiety reduction for patients and taught the students that healing can still occur without drugs and physical treatment.

Home-based palliative care

I had the opportunity to participate in Howard's home-based palliative care program. This 10-year-old program, led by a Salvation Army chaplain, takes a psychosocial-spiritual approach. Medical palliative care as we know it is virtually nonexistent. At Howard, all medical care, palliative or otherwise, was spiritually grounded. This spiritual foundation provided support to health care providers, families, and patients alike.

About 3 times a week, if there was enough petrol, I traveled out through the Mazowe district in a beat up old van with the chaplain, a nurse, and a few medical students. We visited each patient on the list and offered support, comfort, and prayer for their well-being. We brought what medical supplies we could, according to the circumstances and availability of items (stethoscope, oral morphine tablets and antibiotics, sterile dressings, etc). The patients I saw varied from ambulatory but symptomatic to bedridden and dying. Most patients I saw were treated with oral morphine, as there were no parenteral analgesics of any kind. Oral nystatin was available for thrush, and loperamide was used for any form of diarrhea. Even when no specific treatment was available, patients and their families were incredibly grateful for the attention, effort, and support.

Yet simple manageable interventions were often very difficult. I encountered one 70-year-old man with AIDS, benign prostatic hypertrophy, and urinary retention, lying in a dark windowless room on a dirt floor. He was complaining of suprapubic discomfort. Flow from his urinary catheter, which had been in for longer than 18 months, was cloudy and poor. Transportation to the hospital was impossible, owing to his weakened state, the cost, and unavailability. So the nurse and I, by the beam of a small pen light, inserted a new catheter under conditions best described as "limited." But our patient's comfort improved dramatically.

I saw countless children. One 10-year-old boy was clearly dying of AIDs-related illness. If he didn't get ARV therapy quickly, he was surely going to die. I insisted we get him to the hospital and arranged transportation through a local tradesman. The boy did extremely well, but I broke the rules in many ways. And herein lies the ethical dilemma: this home-based care program was not supposed to provide transportation to hospital for patients needing care—there was no sustainable ambulance service. What about the next deserving child who needed treatment? This child did not go through the usual screening, diagnostic workup, and antibiotic prophylaxis required for HIV patients. Why should he jump the queue? I was only around for a short while; I was setting a precedent that could not be maintained. I struggle with this issue still. Is band-aid medical care ethically justifiable? Should efforts really only be made that will provide sustainable, systemic change and fairer care to all those who require such care over time?

Sustainability

To to provide more sustainable medical and nursing attention with the home-based care program, we received funding of $20 000 (US) from the Stephen Lewis Foundation. This could easily support a registered nurse to visit these patients with the chaplain on a regular basis. Given the registered nurse's salary of $80 (US) per month, this funding can go a long way.

I also taught at the nursing school at Howard. Using the World Health Organization's program, I taught many practical aspects of symptom management (from nausea to pruritus to rehydration) in a low-resource setting, using available local products and plants. This has also proven useful for my patients in Canada.

I sometimes asked my Shona friends whether it was more helpful for a family doctor like me to come and provide medical services for a short period of time or whether the money that was spent on my stay could have been better spent on medical equipment, medications, or even basics such as food and housing. Without exception, they all replied that having a physician come, even for short periods of time, was extremely helpful to the community, as it put a human face on their problems and gave them hope that ongoing assistance would follow.

Since I've been home, I've had the opportunity to share my experiences with several community groups. The response from Canadians has been phenomenal. The home-care nurses in my community are collecting unused supplies and medications from palliative patients and have organized large shipments to Zimbabwe. We are establishing links between the University of Toronto

and the University of Zimbabwe to aid in the exchange of students, residents, and faculty, and are working on exchanges between the College of Physicians and Surgeons of Ontario and the Medical and Dental Council of Zimbabwe. Veahavta continues to send volunteers and money and to provide support. These ongoing personal connections provide immense hope to a community desperate for any assistance at all.

I learned that, despite hardship, with dedicated, self-sacrificing health care professionals, clergy, and community, people will cope and survive against all odds when they have hope. *Tariro* is the promise that crosses all cultural boundaries and unites the necessary human resources to overcome the most challenging circumstances.

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Competing interests

None declared