



SA MEDICAL SCHOOLS TO RESCUE ZIMBABWE'S ASPIRANT DOCTORS



A scene at Beit Bridge in mid-November last year when more than 1 500 cases of cholera were reported over 1 week.

Picture: Joanna Stavropoulou/MSF

With Zimbabwe's central teaching hospitals in dysfunctional collapse, South Africa's medical schools plan to rescue 50 of the 180 stranded final-year students at the University of Zimbabwe by slotting them into their own clinical training programmes.

Professor Midiom Chidzonga, Dean of the University of Zimbabwe's College of Health Sciences in Harare was initially hoping the programme could be expanded to rescue the clinical components of several other health professions on his campus. However, this will probably be beyond the quality assurance capacity of the local university infrastructure. Accommodating just the 50 medical students was proving a major undertaking by late February, when the South African Association of Deans of Medical Schools agreed on this number, pending successful funding and accommodation arrangements.

Chidzonga said any rescue attempt was 'absolutely vital' to prevent further health care collapse in his already

decimated country. The alternative was 'no doctors in Zimbabwe for a very long while – it would be very difficult to make up that deficit, time wise'.

Chairperson of the SA Association of Medical Deans, Professor Wynand van der Merwe, was in late February urgently liaising with the South African Development Community (SADC), the national department of health and requesting data from the vice chancellors of all local universities to address funding, accommodation and logistics issues. He told *Izindaba* that unless the 50 could be slotted into existing rotation programmes at various faculties by the end of March, 'we're not sure how much benefit it would add to them'.

'The longer they delay, the more problematic it becomes. Then they have to fit into rotation programmes at our faculties where a significant component is already over. The sooner they come the better,' he said.

Chidzonga has optimistically promised his local counterparts that

he will do all he can to help ensure his tertiary hospitals are back up and running by the end of this year.

A sorry tale...

Parienyatwa Hospital and Harare Central Hospital, the country's two teaching hospitals (both in Harare), shuttered to a halt in November last year, 3 months after running water dried up, leaving toilets overflowing and wards filthy. Doctors, nurses and other vital staff stopped going to work because their (Zimdollar) salaries were less than the cost of transport. Drugs are unavailable and hospital facilities that still function are falling increasingly into disrepair.

Chidzonga, whose own salary now equals the price of about four loaves of bread, said the limitation on the amount of Zimdollars one could draw from the bank meant 'you cannot afford to go into town to the bank to draw money'. Most transactions were in US dollars or South African rands, 'yet we are paid in Zimdollars'.

He and his senior staff held several meetings with Zimbabwe's health minister, Dr David Parienyatwa (the eponymous hospital name comes from his clinician grandfather), to see if they could address any of the issues, but in spite of promise after promise, 'nothing materialised'.

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By early December last year the Zimbabwean government had managed to provide buses for the health care workers to get to hospital, but there were still no drugs or vital equipment. 'Effectively there's nothing much going on,' Chidzonga said. 'We needed to find somewhere where we can get clinical exposure while efforts are made to address the situation at home so that by the time our set-up is revitalised they are able to come back, write exams and move on.'

Train them or bust

If the rescue mission fails there will be no doctors in Zimbabwe's district hospitals, which have come to rely almost exclusively on junior doctors. Only Zimbabwe's mission hospitals are still delivering a service, but these are neither suitable nor oriented for clinical training. 'The exposure there is very useful, but they're not geared up for training,' Chidzonga added.

Examples of these (mainly Baptist) mission hospitals which have become the backbone of Zimbabwe's health care delivery system, included Karanda (near Mount Darwin), Morgenstown, Howard Mission Hospital near Harare and Driefontein. Almost all were relatively well funded (overseas money) with access to drugs and 'could be roped in' for teaching at a desperate stretch.

Getting the latest crop of medical students, let alone the other disciplines, absorbed into the South African university system will involve some creativity around finding lodgings and inter-campus haggling on how to share the increased workload appropriately without compromising outcomes.

Van der Merwe explained that most campuses were already at their maximum levels of Medical and Dental Professions Board (MDPB) 'capping' of student numbers – meaning there were just sufficient academic staff and expertise for theoretical teaching and enough patient exposure via a



An emergency, makeshift cholera treatment centre in Kadoma, Zimbabwe.

Picture courtesy of MSF

sufficiency of clinical teaching staff on each provinces' service platform.

He said there was not much difference in curriculum – and the Zimbabweans were happy to have the additional exposure to anaesthetics and urology and ENT mixed into the surgical rotations. 'It'll be up to their faculty to assess via their own exams whether the exposure was sufficient.'

Upon graduating, Zimbabweans also have a 2-year compulsory housemanship and a 1-year 'district posting' (equivalent to South Africa's community service).

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The Zimbabwean students have lost 5 months of clinical training (they were due to have completed it in October this year), but have picked up just enough exposure to be able to slot into the South African rotations.

Chidzonga said funding at about R70 000 per medical student was being sought through the SADC, who will 'hopefully inspire the World Health Organization to follow'. He said one option to enable the Zimbabweans to fit into the current South African clinical programme would be to cut down on the time they needed for exposure to a discipline. He cited the possibility of cutting down on the 3-month period currently required to learn the five basic surgical procedures. 'But we'd rather they start all over and do the full 12 months with obstets and gynae, paediatrics, medicine and surgery,' he added.

Infrastructure collapse bedevils cholera outbreak

Of Zimbabwe's cholera and general health care crisis, Chidzonga said there had been a 'massive response' from organisations like MSF, UNICEF and the WHO, setting up camps across the countryside. 'It is impacting, but the whole problem is that the infrastructure is not being worked upon. So people go back to where they got the cholera from and get reinfected. Donors can't





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According to the WHO, the death toll from the 5-month epidemic by mid February stood at 3 759, with 80 000 reported infections. Experts say these figures, which have already surpassed the UN's worst-case scenario, were by then already a fortnight out of date.

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Zimbabwe's health needs required an annual output of at least 220 doctors, but his university was doing the best it could with what it had, with some ward rounds (when they were still conducted) seeing more than 20 students at a time.

The extra clinical training workload will be shared among six South African campuses because Medunsa and Walter Sisulu University do not have sufficient capacity to ensure quality outcomes.

Chris Bateman