The Struggle for Access to Essential Medicines in East and Southern Africa

Voices of consumers on affordability and availability

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Compiled by Matilda Moyo
Design & Cartoons by Noah Pomo
noahpomo@yahoo.com

Introduction

Access to essential medicines remains a major challenge in most African countries.

For the majority of Africans, essential medicines remain largely unavailable and inaccessible. Factors affecting availability and affordability range from corruption to lack of proper planning, resulting in stock-outs of medicines for diseases such as malaria and tuberculosis, as well as common and manageable conditions such as diabetes and HIV.

African Heads of State and Government have long acknowledged the urgent need to improve access to essential medicines across the continent. The essential medicines concept was first introduced by the World Health Organisation's Expert Committee on the Use of Essential Medicines in 1977. Since then, various African Union statements document how inadequate access to essential medicines has resulted in a severe health crisis, which has led to millions of lives being lost from diseases that are otherwise treatable and/or preventable.

This selection of short stories from different parts of East and Southern Africa shows the great difficulties that ordinary people face in accessing essential medicines. It brings out the glaring inequalities that exist between the rich and poor when it comes to accessing basic services. Many people have been forced to forego treatment, accept compromised service or turn to quack cures, while others live in fear of premature death simply because their limited income affects their health choices.

Meanwhile, governments seem to make minimal effort in ensuring that people access these medicines. Despite acknowledging the need for affordable and accessible treatments, supported by commitments such as the *Abuja Declaration on HIV/AIDS, TB and other Infectious Diseases*[1], there is little action on the ground to demonstrate such concern for the health care of ordinary citizens. In most cases, state-run health facilities, that should cater for the poor majority, are inefficiently run, ill-equipped and lack the capacity to meet the basic health needs of the general population. Bureaucratic systems within such institutions actually constitute part of the problem, particularly when it comes to stock-outs. This forces patients to seek medicines at private pharmacies, which charge exorbitant prices.

The cost of health has thus become unbearable to many. Basic health care is now a luxury and a preserve for the rich few. Millions of people in the region live on less than US$2 per day. Examples of barter trade and people using their monthly rent to purchase small doses of medication are indeed disconcerting.

This calls for urgent action by governments to ensure that ordinary people can access health care through systems that work. Adherence to commitments such as the Abuja Declaration, provision of free medicines and the institution of better procurement systems, all form part of the solution. Equally, civil society has to step up advocacy efforts in order to influence the decisions made by governments.

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[1] On 26 and 27 April 2001, African Heads of States and governments of the Organisation of African Unity (OAU) declared that they would allocate no less than 15% of their annual national budgets to health services in order to meet "the exceptional challenge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases." The OAU officially became the African Union on 9 July 2002 at the Durban Summit.

Dedication

This collection of short stories is dedicated to the millions of Africans who died because they could not access essential medicines. May their souls rest in peace and from this, may we all draw lessons that will help us to prevent more unnecessary deaths.

Acknowledgements

This publication would not have been possible without the support of the Open Society Institute (OSI). Special thanks also to all the activists from East and Southern Africa who have shared their experiences. We hope sharing these experiences will open the eyes and minds of policy makers so they can effect change that brings positive results and improves our lives. This is possible through greater access to essential medicines and will help us all to avoid preventable, premature deaths that result from treatable conditions.

List of acronyms and abbreviations

AGHA	Action Group for Health Human Rights and HIV/AIDS
AIDS	Acquired Immune Deficiency Syndrome
ARASA	AIDS and Rights Alliance for Southern Africa
ARV	Antiretroviral
ART	Antiretroviral Therapy
COSATU	Confederation of South African Trade Unions
HAI-Africa	Health Action International Africa
HEPS	Coalition for Health Promotion and Social Development
HIV	Human Immunodeficiency Virus
MHEN	Malawi Health Equity Network
OSI	Open Society Institute
SISAL	Sambatra Izay Salama
TAC	Treatment Action Campaign
TB	Tuberculosis

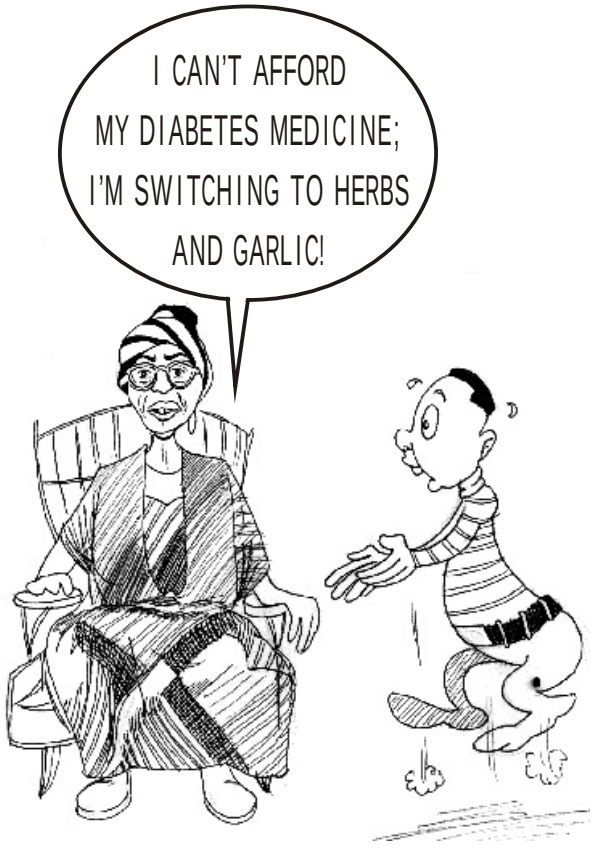
Stories from Kenya

Turning to nature to avoid the high cost of drugs

Onyango Wambia is a small-scale farmer from Lela village in Kisumu district, in the western part of Kenya. Although Onyango is diabetic, he rarely uses medicine because he cannot afford to buy the prescribed regimen. How does he then manage his condition? “This is what I use for diabetes,” he says peeling off a clove of garlic and throwing it into his mouth. “I eat an average of eight of these a day. I have done this since 1998, when I was diagnosed with diabetes. Someone tipped me about the garlic, and I have found it to be useful.” The cloves of garlic and a sizeable piece of ginger that he also adds to his self-treatment cost him about KSh10 per day. He is convinced that this routine controls his blood sugar.

“This is what I use for diabetes,” he says peeling off a clove of garlic and throwing it into his mouth. “I have done this since 1998...I have found it to be useful.”

*** HAI Africa first published this story (February 2009) in a book titled “The costly access to essential medicines in Kenya: Voices of consumers on affordability and availability”.*



50% of patients cannot afford common drugs

Jillian Oranga, is a pharmacist at a church-owned hospital in Maseno location in Western Kenya. According to Jillian, out of the average 60 patients who come through the hospital's pharmacy daily, about 30 will not afford the medicines that have been prescribed. “About half the number of patients who come here for medicines are not able to afford them. Most of them are unemployed and aged, and some are orphans,” she says.

She points out that most commonly antibiotics tend to be too expensive for many patients. “Antibiotics and drugs for rare conditions are especially more expensive. For example, the medicine required to manage a skeletal muscle condition costs Sh15,000 for a single dose, and a patient would need to take it for almost the rest of their lives. A high school teacher who had this condition could not afford that amount. We had to put the patient on a less expensive alternative, which cost less than KSh1,000 a dose. But this only kept the patient going and did not really manage the condition.”

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**1US$ = KS80.3160*

I am thankful that we don't fall sick often

When we spoke to Margaret Fondo, a primary school teacher in Takaungu sub-location in Coast Province, she was deeply concerned about the availability of medicines in the area.

As a teacher, the 44 year-old mother had a medical allowance which paid for most of the treatment that Margaret and her family of four needed. However, despite having the assurance of a medical allowance, unavailability of medicines within the village and the inconvenience of having to travel far to get medicines was a major worry.

“I am thankful that we don't fall sick often. I say 'thankful' because I know that when someone falls sick they have to spend a lot of money on medical expenses. As a teacher I have a monthly medical allowance, so I hardly spend money from my pocket on treatment. But even so, there is still a problem in getting medicines. In September 2007, for example, I had a skin rash that needed attention. The local dispensary was out of stock of the medicine I needed, so I had to travel to the next town to buy it. Medicines are not regularly available at the local dispensary. There may be medicines at the dispensary today and none tomorrow. That is unfortunate because many people rely on the dispensary which, as a government health facility, is supposed to offer medicines free of charge. The dispensary is also the only health facility in Takaungu. Some medicines, such as malaria drugs and painkillers, are usually available. However, medicines for chronic illnesses, such as HIV and AIDS, are hardly ever available.

As a teacher I have a monthly medical allowance, so I hardly spend money from my pocket on treatment. But even so, there is still a problem in getting medicines.

Worse still, there is no chemist shop in Takaungu where people can buy prescribed medicines. If the local dispensary was well stocked, Takaungu residents would not have to travel all the way to Kilifi town to buy medicines. To get to Kilifi using public transport involves one taking a boda boda (scooter) ride from the village to the main road, that costs KSh50. After that, one has to spend an additional KSh50 on a matatu (minibus) to Kilifi town, which means spending KSh200 for the round trip. Many people have resorted to consulting traditional medicine-men when they are sick.”

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Stories from Lesotho

Dental Care a Luxury in Lesotho

Submitted by Maketekete Alfred Thotolo, ARASA

A severe shortage of Lignocaine (local anaesthesia) cartridges early in 2009 left hundreds of Basotho dental patients in pain, desperate, and victims of unskilled private dental personnel.

Lesotho experienced a stock-out of Lignocaine cartridges in four district hospitals in February 2009. As a result, patients with dental problems could not be assisted at government hospitals in Mokhotlong, Buthabuthe, Leribe and Mohale's Hoek. By February, this essential drug had not been available in Mokhotlong and Buthabuthe for more than one month, and in Leribe and Mohale's Hoek for more than three weeks.

Patients were forced to either return home and wait until the drug became available, or pay for expensive but poor quality services at some private dentists where the sterilisation of equipment was also questionable.

A dental surgery near Motebang (Leribe) Hospital was charging patients M50.00 for the extraction of one tooth. Most of the patients ended up with broken pieces of teeth. They were referred to the dentist at the government hospital, where they had to pay again for the extraction of the broken pieces.

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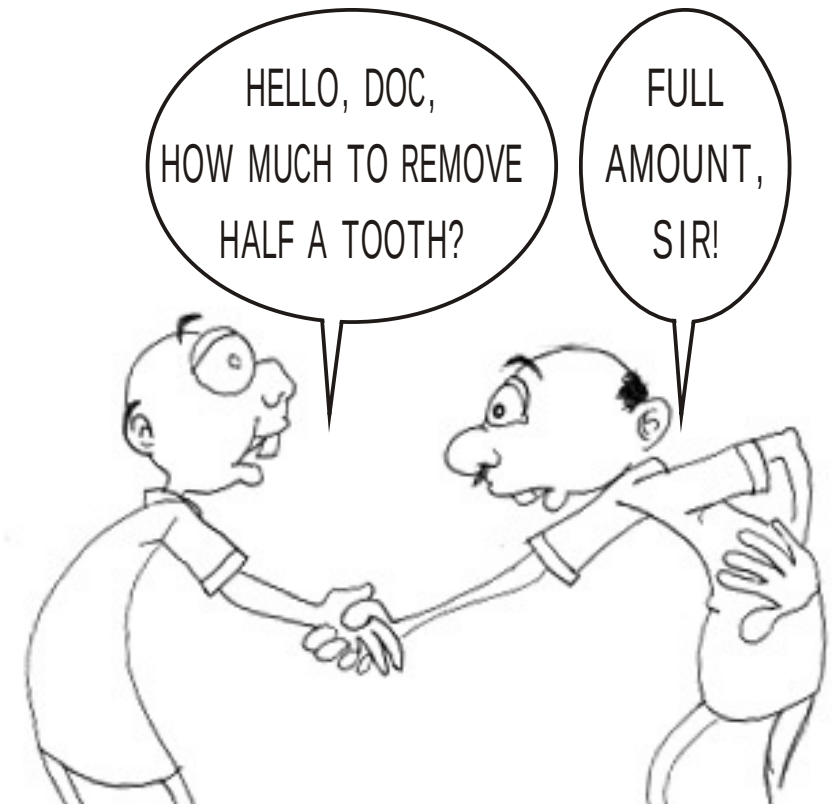
**Maketekete Alfred Thotolo is the ARASA Treatment Literacy and Advocacy Coordinator in Lesotho, based under ADRA Lesotho*

**1US$ =M10*



Stories from Madagascar

Patients in Madagascar forced to take expired drugs

Submitted by Dr. Rasoloarimanana Andry Ny Aina, SISAL

Olga, 54, is living with HIV and currently on antiretroviral treatment (ART). She is worried about frequent stock-outs of drugs, the distribution of expired medicines and the unavailability of diagnostic tests such as the CD4 count.

“My greatest concern is that I have been taking drugs that have expired. Despite the doctor's assurance that one can still take these drugs for six months after the expiry date, I still worry about the consequences but accept the medication because I have no other choice.

I am very disappointed with the State because they promised us a constant supply of ARVs and quality care for PLWHA, yet this has not happened. We were taught that the ARVs must be taken regularly, but because supplies are erratic sometimes this does not happen and as a result we are constantly worried about our health. We waste a lot of time traveling to and from health facilities in search of drugs and services and this is negatively affecting our daily lives. This takes us away from work and upsets our daily routines while we live in fear of opportunistic infections.”

“I am very disappointed with the State because they promised us a constant supply of ARVs and quality care for PLWHA, yet this has not happened.”

Patient foregoes treatment for fear of stock-outs

Submitted by Dr. Rasoloarimanana Andry Ny Aina, SISAL

Although Andry, 22, is not yet on antiretroviral treatment (ART), hearing the current problems faced by people on the programme discourages him from enrolling for treatment, as he does not want to be in their situation.

“I know very well that sooner or later, I must take ARVs. The result of my last CD4 count test showed that I will have to take the drugs soon. The problem is that there is limited access to diagnostic tests such as the CD4 count to measure my immunity level. Each time I do not feel well I fear that I may catch an opportunistic infection and wonder what the doctor would do without the necessary diagnostics. I fear for the future of the PLWHA in Madagascar if this problem persists. This could be the problem that kills us.”

“Each time I do not feel well I fear that I may catch an opportunistic infection and wonder what the doctor would do without the necessary diagnostics.”

Stories from Malawi

High prices fuel illicit trade of essential drugs

Submitted by Martha Kwataine, MHEN

Some essential drugs have found their way to the informal market in Malawi. For example, antiretroviral (ARV) drugs and artemether-lumefantrine (LA) for malaria are being sold by vendors at Lizulu trading center in Ntcheu district. Although vendors display a wide range of drug stocks on their stalls, ARVs, LA and other prescription drugs are kept away in dark corners under the benches or in hideouts away from the stalls. Vendors sell Bactrim at MK2 per tablet, with ARVS costing between MK250 and Mk300. LA sells at MK100 per tablet. The painkiller that goes with the anti-malaria tablet costs MK2.

Lizulu is a trading centre that borders Malawi and Mozambique in the district of Ntcheu. The drugs are packed in plastic packets with labels written in Portuguese and marked Mozambique.

According to the Lizulu Training AIDS Support Organization (Litaso), a group of people engaged in business at the market, the illegal drug trade has been going on for a long time. The support group was formed in July 2008 to tackle this informal drug marketing, among other problems.

Communities surrounding Lizulu are forced to buy drugs from vendors... This is a health hazard as the consumers may not access the right dosage for either malaria or HIV, leading to drug resistance.

Communities surrounding Lizulu are forced to buy drugs from vendors due to frequent drug stock-outs at government health facilities. This is a health hazard as the consumers may not access the right dosage for either malaria or HIV, leading to drug resistance.

**This story was jointly investigated by MHEN and a journalist. MHEN has partnered with some journalists to engage in investigative reporting on access to medicines, as one way of popularising the campaign on access to essential medicines.*

Stories from South Africa

ART stock-outs in the Free State place patients on death row

Submitted by Anso Thom and Lungi Langa

In November 2008, budgeting shortfalls in the Free State province of South Africa resulted in the provincial Department of Health enacting a devastating moratorium on access to antiretroviral therapy (ART) for patients in need. Stocks of the drugs dried up at clinics, and there is strong evidence to suggest that many patients who were already on ART had their treatment regimens interrupted, in addition to new patients being denied access.

The ART moratorium in the Free State has resulted in untold suffering and deaths in the province, whilst about 15,000 people are on waiting lists. Many have been turned away without being added to waiting lists. Tantaswa Kotamo is one such person.

Tantaswa is 32 years old and lives in Pelindaba, in Bloemfontein's Mangaung township. She tested HIV positive in October 2008 at National Hospital in Bloemfontein, with a CD4 count of 484. Her health swiftly deteriorated. “I had been coughing more often than usual and suffering from diarrhoea. I was not eating well and I had also lost a lot of weight,” she said.

Dissatisfied with the monitoring efforts of her local government clinic, Tantaswa consulted a private doctor. The doctor confirmed that she needed to start on ART immediately, and offered to sell her the pills at R300 per month. Having had to leave her R1000 per month job in a restaurant kitchen due to her poor health, it was an impossible task to meet these financial demands every month. After a donor-funded NGO informed her that they no longer had any capacity to help, Tantaswa was forced to return to the National Hospital. Again, she was turned away with the advice that she should buy the medication privately. This culture of passing the buck has left Tantaswa still awaiting treatment and living in fear of what could happen to her without ARVs.

“I am afraid that if my condition deteriorates I won't be able to return to work and I won't be able to support my child. But most of all I'm scared of dying while waiting for treatment,” she said.

Despite promises by the provincial Department of Health in the Free State that the ART moratorium would be lifted in February 2009, in March, doctors and activists continued to report that they still did not have access to the drugs within the province. The Southern African HIV Clinicians Society (SAHCS) conservatively estimates that about 30 people continue to die each day, due to their inability to access ART in the Free State. Tantaswa is fearful that she may one day be included in this figure.

“Death is painful and serious. I have seen other people die of this sickness and it scares me,” she admitted.

“I have seen other people die of this sickness and it scares me”

The Treatment Action Campaign (TAC) continues to collaborate with the AIDS Law Project (ALP), the Confederation of South African Trade Unions (COSATU) and other civil society and activist stakeholders to ensure that ART is made available to all those in need in the Free State and South Africa at large. TAC has held meetings, marches and pickets in the province to demonstrate its strong opposition to the violation of patients' rights. TAC also picketed outside Parliament on the day of the finance minister's budget speech to protest against the poor financial planning and budgeting mismanagement, which has resulted in ART stock-outs in the Free State.

1US$ = R10

Stories from Uganda

Drugs stock-outs place TB and Malaria patients in danger

Submitted by Denis Kibira, HEPS and Sandra Kiapi, AGHA

Uganda is having problems getting the right type of medicines to the right people at the right time. There are essential medicines out of stock, documented expiry of large quantities prior to utilisation, unqualified personnel at the prescription/dispensing window, and self medication or medication of others (eg children). What has been the consequence? Pain, increased or chronic ill health, under-dosing or over-dosing, treatment failure, emergence of drug resistance, negative socio-economic consequences and in some cases, death.

When essential medications are out of stock, especially in remote villages where the communities do not have an alternative solution, patients blame health workers who in most cases have no control over the medicine supply chain. The Uganda National Millennium Health Care package obliges the government to make essential drugs available to the population -- including drugs for TB, malaria and infectious diseases.

At a workshop on Health Sector Transparency and Accountability organized by the Action Group for Health, Human Rights and HIV/AIDS (AGHA) in Uganda between 21 and 22 January 2009 targeting leaders and civil society organisations working in health-related activities in Soroti district, it was revealed that Coartem, fancida and chloroquine are out of stock at the district. As a result, malaria is being treated with quinine in many of the facilities. In addition, there are no paediatric formulations for children. “Quinine for children is not available, so we have to break the medicines so as to have the right dosage,” an official from the Soroti district health office said, adding that the institution received Tuberculosis (TB) medications that were three months from their expiry date.

“We are being faced with stock-outs of a number of drugs, such as Coartem and TB medicines for adults and children. This has pushed my work behind and the government keeps making announcements over the radio about sending in drugs, which never arrive. This has made my work at the hospitals very hard because people flock in big numbers and on reaching there the drugs have not yet arrived,” he said.

He further noted that stock-outs had led to resistance among patients, particularly those with TB.

“They start the course of the treatment and somewhere in the course of treatment the drugs are out of stock, causing resistance in the body,” the official said.

Some of the participants at the workshop attributed the stock-outs to hoarding by communities. It was reported that when a new supply of essential drugs arrives at health centres, many community members flock to the unit to get drugs, which they store for future use in case of stock-outs. Health workers are dispensing drugs to communities without accurate prescriptions.

> “One of the major causes of the stock-outs is poor management. The people in charge of procurement make the drug orders late.”

“Stock-outs have created an overwhelming turn-up of patients at the hospitals when malaria drugs and pain killers like Panadol arrive at the hospitals. When the drugs arrive, patients pour in at once to get their share of the drugs for storage, due to the fear that the drugs are going to run out soon. The stock-outs have made hospital work lag behind because then they cannot run the hospital without drugs.”

However much of the blame for the drug stock-outs was placed on the bureaucracy and monopoly of the National Medical Stores (NMS). The NMS was set up in 1993 with the mandate to ensure the efficient procurement, storage, sale and marketing of quality medical drugs and other supplies. Districts can procure drugs either through conditional grants or through the District Medicines Credit Line System. Through this system, districts can procure essential drugs from the NMS on credit, and funds will be paid directly to the NMS from the Ministry of Health.

However the NMS may take 60 days instead of 30 to process and deliver an order to the district. The General Manager for NMS has explained to civil society organisations at a workshop organised by the Medicines Transparency Alliance on April 27th 2009 that the delay and bureaucracy is caused by the fact that the procurement of medicines is regulated by the Public Property and Disposal of Assets Act. This law sets down prolonged procedural requirements for procurement, which have to be followed to the letter -- hence the delays.

“One of the major causes of the stock-outs is poor management. The people in charge of procurement make the drug orders late,” one health worker complained.

The bureaucracy and monopoly at the NMS is the major factor affecting the supply of drugs and participants at the workshop called upon the government to decentralise the drug supply and procurement mechanism.

Neighbours lend a hand with expired drugs

Submitted by Denis Kibira, HEPS Uganda

A woman admitted to the Pallisa district hospital in July 2008 was prescribed Fluconazole, among other drugs. However, the drug was out of stock at the hospital pharmacy and it cost UG SHs 3000 per capsule at the local drug shops. Not having money, the patient's attendant tried to seek for help from the community. She was lucky to receive a few capsules from a neighbor and proceeded to give these to her patient. However, the capsules she got were long expired.

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*US$1 = Uganda Shilling 2,041.00

Stories from Zambia

Corrupt health practitioners divert essential medicines to private businesses

As told to Casco Mubanga

“I am a 36-year-old man who is married with two children. I tested HIV positive five years ago. In November 2008, my CD4 count dropped below 200 and I was started on ART. I developed severe side effects, which included swelling of my legs. This caused severe pain along my left leg, such that I could not sleep at night. I was really in great pain. In the morning my wife escorted me to the highest hospital, the University Teaching Hospital (UTH). The doctor at the hospital told me that there was nothing they could do as they did not have much equipment and special drugs. He prescribed a strong pain killer and recommended that I visit a specific private clinic. When I visited the private clinic, I was surprised to learn that it was his clinic. He re-examined me with some simple test and told me that I had to take the very pain killer he had prescribed earlier. The bill was ZMK1 million, although I did not believe that such a drug would cost that much.

He emphasised that he could not proceed to treat me without the payment. The amount he was demanding was equivalent to my monthly rental for accommodation, but being in a desperate state I had no choice but to pay. I took this case for investigation and it was discovered that most patients who go to the UTH and other government health centres are only given prescriptions referred to private drug stores and clinics. Most of the drugs, including essential medicines, are smuggled into private clinics and pharmacies. I also discovered that the painkiller I was given at the private clinic was on the country's essential medicine drug list and therefore should be available and affordable in local clinics or pharmacies.

“ Consumers must know which ones are essential medicines that should be found in clinics or affordable at pharmacies.”

I feel for reasons of transparency, our government should involve consumers from the time of procurement to the time of distribution of essential medicines. Most health personnel are taking advantage of patients' ignorance of these drugs. Consumers must know which ones are essential medicines in primary health care that according to the national drug policy, should be found in clinics or affordable at pharmacies.”

Patients lament hidden costs of ARV treatment in Zambia

As told to Casco Mubanga

“I am a woman aged 42, married with four children. I started taking my antiretroviral drugs (ARV) in 2005 when my CD4 count was 78. I take Triamune 30. Although antiretroviral treatment (ART) has improved my life, I still face huge difficulties in maintaining the drug regime. I have to travel 50 kilometers from my village to the nearest clinic in Chipata District every month. My journey starts in the morning either on foot, or if am lucky I find a van which costs me 40,000 Kwacha going and coming back. Upon arrival at the clinic I usually spend 5 to 6 hours in the queue. During this time, I have to find some food to eat which costs me 10,000 Kwacha. When the time comes for me to see the doctors (who only take less than 10 minutes to do routine check ups without giving me a chance to ask questions), too often they are moody.

I get my medication from the pharmacy on the same day and travel back home. Since I started taking my ARVs, I have done liver function and other diagnostic tests, which cost a lot of money. I feel the government is obliged to offer these drugs at health facilities nearest to the consumers. These traveling costs are hindering my ability to access the medication and maintain the regime. The government should ensure that drugs and services provided are of good quality as doctors spend little time explaining these drugs to us.”

US$1 = K5 000

Stories from Zimbabwe

The battle for treatment in a collapsed health system: A personal account

Submitted by Martha Tholanah

While acknowledging the limitations of the public health system, and also consciously deciding that because I am employed and can afford the treatment I could pay for my own HIV and other healthcare services, on hindsight this seems to have been suicidal, and the height of foolishness on my part.

I started taking antiretroviral drugs (ARVs) in 2003, a year before the government commenced the public ART programme. At first I thought I would enrol for the government programme, but then I got discouraged by the long waiting lists and the fact that since I was already on ART I would not be a priority for enrolment on the programme.

On the 19th of April 2008, after a long time of complaining about pain in my back and lower limbs, the doctor recommended that I switch part of my combination from stavudine to zidovudine. I complied. In May, as I reached near the end of the first 30 days on the new combination, I went back to the clinic. I reported no relief from the pains and aches, and got more painkillers, and a repeat prescription to continue on the zidovudine-lamivudine-nevirapine combination. The clinic pharmacy only had nevirapine and the other drugs were out of stock, so I had to look for lamivudine and zidovudine at private pharmacies in town.

I spent the greater part of May scanning pharmacies for lamivudine and zidovudine, or the combination Combivir, which were out of stock. I finally found the drugs at a cost of Z$16,3 billion.

"I spent the greater part of May scanning pharmacies for lamivudine and zidovudine, or the combination Combivir, which were out of stock. I finally found the drugs at a cost of Z$16,3 billion."

I got no relief from the back pain and in June the physician recommended a scan of my whole spine. The scanning machine at the Avenues Hospital, which the doctor referred me to, was not working. I tried Parirenyatwa Hospital Radiology Department, and they said they were not interested in doing a scan that was so extensive, and would have done it if it was a smaller area. When I phoned around for radiologists, I was quoted fees ranging from Z$170 billion to Z$350 billion. I eventually had the scan at a private radiologist and it revealed that I had a lower spine prolapsed disc. The doctor referred me for physiotherapy and prescribed painkillers. It took me 10 days of moving from pharmacy to pharmacy to find the painkillers.

So far, there has been some relief with the physiotherapy. However, the health system has failed Zimbabwean citizens in many ways. Medical insurance schemes are not working well, as contributions are eroded by hyperinflation. When one needs medical attention now, one actually gets more health problems due to the distress caused by maneuvring through the systems, be they public or private. People who have no money and have to rely on the public health system are in real danger of dying while waiting for the treatment.

**Zimbabwe has since suspended the use of its currency as a medium of exchange in efforts to curb hyperinflation. However, between May and June 2008, US$1 was equivalent to Z$1billion.*

No anesthetic, we're on strike: An HIV positive mother's ordeal

Submitted by Matilda Moyo

When Rosa Nyathi, who is living with HIV, discovered that she was pregnant, she decided to take all necessary precautions to protect her baby from the virus. This included giving birth by caesarian section.

Since she was already on antiretroviral (ARV) treatment, she did not receive prevention of mother to child transmission (PMTCT) medication.

However, her plans to protect the baby were scuttled when she went into labor in December 2008. Health personnel in Zimbabwe were on a strike that began in August 2008 and ended in January 2009. As a result most hospitals were closed, including the maternity ward at Parirenyatwa hospital where she was booked to deliver.

She was referred to Mbuya Nehanda hospital, where she was told that there was no resident anesthetist to aid the caesarian operation. Although her husband managed to find a private anesthetist to administer the anesthesia, there was no help on hand to aid with the operation as there was only one doctor and a few student nurses.

There was no resident anesthetist to aid the caesarian operation. Although her husband managed to find a private anesthetist to administer the anesthesia, there was no help on hand to aid with the operation as there was only one doctor.

Nurses at the hospital told her that only women who were facing complications could deliver by caesarian section.

“Since giving birth by caesarian section was out of choice, they refused to conduct the operation on me so I was forced to give birth the normal way,” she said.

At the time of the interview, her baby had not yet been tested for HIV, although she was hopeful that he had not contracted the virus during birth. Rosa continued to take precautions to protect her son, including strict formula feeding, despite the high cost of importing the milk at US$10 for a 400g tin that would only last four days.

Controllable cholera wreaks havoc in Zimbabwe

Submitted by Noah Pomo

When Takudzwa Ndove visited his relatives in Chitungwiza last November, he was shocked to find his uncle's household in a deathly state. Chitungwiza, a sprawling satellite town near Zimbabwe's capital city Harare, is where the cholera epidemic that has swept through the country started. Between August 2008 and March 2009, more than 90 000 cases and over 4 000 cholera deaths were recorded countrywide. Takudzwa's family members were among these statistics.

Takudzwa was not surprised by the outbreak, given the unsanitary conditions in which his relatives were living. Streams of raw sewage and effluent could be seen flowing in the middle of the urban suburb, a situation worsened by heavy rains.

"When I arrived at my uncle's house, I immediately noticed that the usual army of cousins that would have greeted me was either subdued or absent. My aunt was lying in a room where we could not see her and my grandmother had just resurrected from a near-death experience, all from cholera," Takudzwa said.

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His cousin, James, had just been deserted by his wife. She went back to her parents because he could not provide for her and she was afraid he would not be able to pay for treatment if she contracted the illness. Each family on that street had lost at least one member because they could not afford treatment, either in the form of antibiotics or oral rehydration salts. Patients were encouraged to drink lots of water and make their own oral rehydration solution, yet the Zimbabwe National Water Authority (ZINWA) was failing to supply water to the city and surrounding areas. Failure to manage water resources and the reticulation system triggered the epidemic. His uncle complained that the Ministry of Health and Child Welfare was conducting an awareness campaign through which they advised people to wash their hands and clean their food, yet there was no access to clean water.

"You see the sewage is flowing in the streets. In the meantime, our drainage system is blocked. If anybody opens the tap the waste level rises because we don't have a toilet seat but a much cheaper hole, and it is full to the brim," he said.

Takudzwa lamented that "people are dying like six-day-old flies through an illness that can be controlled because they cannot afford treatment." He observed that sadly, some relatives who came to bury their dead contracted the disease and carried it back to their homes, perpetuating the epidemic.

Campaign partners

Kenya:

CIN Kenya
Consumer Information Network

KETAM
Kenya Access Treatment Movement

KEPHCA
Kenya Hospices and Palliative Care Association

EPN
Ecumenical Pharmaceutical Network

Malawi:

MHEN
Malawi Health Equity Network

Madagascar:

SISAL
Sambatra Izay Salama

Uganda:

AGHA
Action Group for Health Human Rights and HIV/AIDS

HEPS
Coalition for Health Promotion and Social Development

NAFOPHANU
National Forum of PLHA Networks in Uganda

Zambia:

NZP+
Network of Zambian People Living with HIV/AIDS

TALC
Treatment Advocacy and Literacy Campaign

Zimbabwe:

CWGH
Community Working Group for Health

Regional /International partners:

OXFAM

HAI Africa - *Health Action International Africa*

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For more information contact::
Email: info@stopstockouts.org
Website: www.stopstockouts.org