# Out of Angola

Denis Lockman, MD

**RÉSUMÉ :** Le Dr Denis Lockman présente un journal de son expérience comme bénévole pour Médecins Sans Frontières dans la région du nord de l'Angola déchirée par la guerre. Il décrit ses tentatives d'offrir un semblant de soins médicaux organisés au milieu du chaos. Son travail lui donnera l'occasion de rencontrer plusieurs personnages inoubliables, dont certains s'adaptent, d'autres non, chacun à sa façon. Face à la guerre et à la désintégration sociale où la corruption et la cupidité sont rampantes, l'aide des pays occidentaux bien intentionnés profite-t-elle aux pauvres et aux démunis, ou nourrit-elle tout simplement l'appétit prédateur insatiable des éléments criminels?

Deep in western Africa, the wavering sound of a short-wave radio brings me moments of hope from home. Radio-Canada International reports that Ontario Premier Mike Harris' visit to Ottawa will be rocked by protest over the announced closure of Montfort Hospital, Ontario's only French-language teaching hospital. Montfort, my home base, is one of the province's best performing hospitals, with one of the Ottawa region's finest teams of emergency physicians.

It was in the midst of this storm that I left Canada, embarking on my second mission with Médecins Sans Frontières (MSF), to lead a group of 5 expatriates in northern Angola's Uige province. Miraculously, I had avoided a machine-gun and grenade attack against the expat house in Ruhengeri, Rwanda, where I was originally scheduled to go. As this horrific attack occurred, I was stuck in Ottawa, struggling to guarantee physician coverage of my shifts. The lack of locum availability had saved me.

This episode, along with the murders of 3 members of Médecins du Monde in Rwanda and 6 Red Cross workers in Chechnya, had convinced me to avoid areas like the Great Lakes region of Africa, which have established records of violence against foreign humanitarian aid workers. Instead I was assigned to Maquela do Zombo, Angola, a village of approximately 17,000 people located 41 km from the border of Zaire (a.k.a. the Democratic Republic of Congo).

## Like a bad opera

**March 19th, 1997.** It has already been a week in Angola. After a quick briefing in Luanda, followed by a choppy ride with the boys of Aviation Sans Frontières, the rolling hills of Angola finally reveal Maquela the lost. Happily, the pilot lands perfectly on the strip, as the area around it is mined. I have arrived at my new home.

The 25-year civil war that followed the end of Portuguese colonialism ended in 1994. It was replaced by a shaky truce, under which each faction maintained its territories, but the United Government of National Reconciliation (largely MPLA-dominated) progressively took over administrative and military control of the country. Maquela do Zombo, or Zombo's bullet in the local Kikongo dialect, is under Jonas Savimbi's UNITA control. This rebel faction controls half of the country, generally the rural portions, while government forces (American-backed MPLA, led by Eduardo dos Santos) control most cities. In spite of the truce, Angola is one of the world's most mined countries, and flare-ups of guerilla activity are commonplace.

As field leader, I am to coordinate the efforts of a team comprised of a midwife, a nutrition-pediatrics nurse, a lab tech, a logistician, all in their late 20s and French, and a 62-year-old Filipino GP-surgeon. We are to provide "substitutive" care at the district hospital, a 70-bed structure built by the

Médecine d'urgence, Hôpital Montfort, Ottawa, Ont.

Portuguese and maintained in the Angolan way (i.e., left to rot, to the point that many rooms are closed due to unbearable levels of bat dung). It has a small OR, a quaint maternity annex, general medicine and pediatric wards, and yes, a *banco das urgências*.

Angolans supposedly staff the hospital, but local doctors or nurses are nowhere to be found. Angola's 60% illiteracy rate and perpetual civil war have left the young health care providers with disastrous patient care abilities but amazing Kalashnikov skills, as many are demobilized soldiers. They received a 2-month training course (courtesy of MSF) a year ago, and are divided into consultants (who can read, write, and calculate medication dosages) and nurses (who are generally relatives of the consultants). I am to take care of pediatrics, medicine, the ED, and the tuberculosis ward, provide training for the locals and act as the MSF liaison with the local authorities.

I soon meet Senhor Fausto, the UNITA-appointed director of the hospital, who has a nasty reputation among the more seasoned members of the team. I resolve to be fair and objective, not a biased colonialist like those French guys. Fausto, about 30 years old, sporting a silk "Pretty Woman" shirt, turns on the charm for the initial visit, alternating verbose politeness with appetite-suppressing snorts of unknown etiology. Unwavering, I ask him to enlighten me with his perception of the hospital's most pressing needs.

His face contorts, as if I have asked him to name Canada's provinces and their capitals. "Electricity for my house," he blurts happily, "and yes, for the hospital too."

Patient care? Vaccinations anyone?

Paris we have a problem.

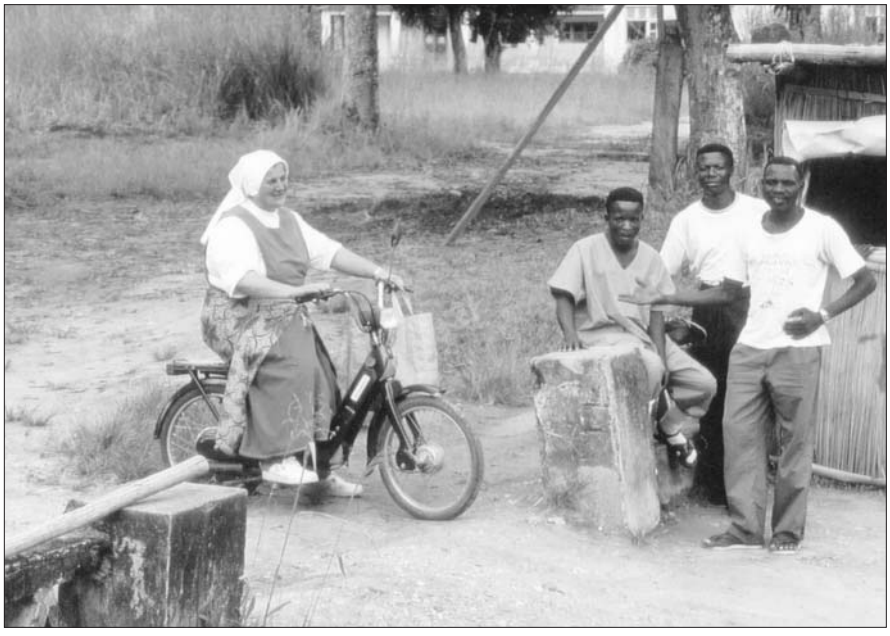
## Saints and sinners

**April 8th, 1997.** The daily grind of rounds is now a familiar routine. I am at ease with the weird and wonderful diseases I see: falciparum malaria, onchocerciasis, meningitis, tetanus, Loa-Loa and, of course, all the gut parasites you can dream of. You can often peg a diagnosis from 100 metres away, such as when an entire ward has been emptied of its makeshift cots: obviously an inundating case of cholera. Though the pace is slower than your average emergency shift, the hours are longer and you are a prisoner of the hospital and the area: no mail, no phones, and not too much exploring, parce que les mines.

As I found on my first mission in Rwanda, the variety of characters you meet in humanitarian missions is fascinating. I learn quickly that our team has a Mother Teresa type. Summoned to the hospital in the middle of the night, I find Corinne, the midwife, desperately performing CPR on a one-month old with sepsis, already on maximal antibiotics. Dominique, the logistician, is the Indiana Jones variety, bearded à la Capitaine Haddock. He has lived in the South American rain forests, crossed western Africa by jeep, and worked in Liberian refugee camps, among other things, since leaving France with the military at age 18. He is now 27.

Another humanitarian association in Maquela do Zombo boasts of Gërd, a thirty-something carpenter who runs the "road rehabilitation" program. At sunset, he appears on our doorstep and with his rendition of "Humanitarian organizations, unite!" and polishes off our reserve of Primus, the Zairean beer that is one of our few sweet comforts. Gërd loves his alcohol and lives with a local woman (in an equal relationship, of course), whom he anoints with Gaultier perfume after each visit home. He has been here forever.

Undoubtedly, the most unique character is Irma Louisa, an Italian nun of the order of the Sisters of Mercy. At five-foot-nine, 180 pounds, complete with furry forearms and a mustache, she is a relentless miracle, speeding around town on her moped, racing here and there to comfort and heal undeserving souls. She has been here for 10 years, battled local religious



**The one and only Irma Louise**

deregulation (there are 27 different Christian denominations in Maquela), and seen humanitarian organizations come and go. No thieves, liars, machine-gun toting thugs, wars or deception can slow down this formidable woman. The locals consider her one of theirs; they respect and occasionally fear her. In response to ridiculous bantering from Fausto, the local power-broker and hospital director, she has been known to feed him a crisp forearm to the head, causing him to retreat without so much as a word. Before MSF's arrival, Irma Louisa ran the hospital with Madre Pia, another elderly nun who, in contrast, has the burnt-out appearance of having sold her soul to the spiritual opposition. Foolishly, MSF ousted them to the TB treatment house, then, with the first signs of guerilla activity, fled town, leaving Irma Lou-Lou shaking her head: "Those young ones."

Finally, our town has the reassuring presence of UNAVEM (United Nations Angola Verification Mission). They consist of 6 soldiers, from Bangladesh, Brazil, Holland and Malaysia, who drive around seeking signs of guerilla activity — or play volleyball. One day, one of them, Roberto, consults me about a sudden onset of painless hematuria. The history reveals he has been swimming in the local river; the physical exam is normal. I ask him for a urine sample, confident I'll spot Schistosoma hematobium eggs. I resolve to discuss the results with him later that day, as I have to reassess the workings of one of our dispensaries 30 km away. However, on returning, I see a small four-seater airplane making low passes over Maquela. The fearless Roberto has fallen in battle and requested medical evacuation to the capital, for fear of losing his "weapon" I suppose. Any larger threat would have unleashed the might of the United Nations Airborne.

**Maquela do Zombo's pride: the only hospital for hundreds of kilometers around**

## Requiem for Domingo Kiala

**April 15th, 1997.** It is night. André Kezo, the nurse from the medicine ward, advises me of Domingo's death. Domingo had unexplained ascites, weight loss and diffuse adenopathy. I had empirically tried antituberculous medications despite negative sputum and ascites fluid stains for AFB, but my treatment had failed. Domingo became oliguric and his lungs filled inexorably with fluid.

As André and I cover the 200 metres separating our house from the hospital, our flashlights cast an uncertain glow that will hopefully ward off the snakes that have killed two in the past year. We make our way to the morgue, next to the tuberculosis house and the latrines, through high grasses divided by a narrow path, through the smell of human misery. A bamboo cross, held together by a few strands of rope, casts a sinister shadow.

The morgue is a single-room, baked-earth hut. Inside, on bare ground under the flickering light of an oil lamp, Domingo's body lies on a stretcher, covered by dirty sheets. I unveil his face. It is swollen and there is foam at the corner of his mouth. Poor kid: he was fifteen.

There are cries in the distance. We shine our flashlights on the path, and Domingo's sister appears, sobbing uncontrollably. She stops at the doorstep but does not enter, looking at the shrouded body without exposing it. André tells me Angolan culture is such. A few men carry the boy's body to his father's hut, and the father appears shortly thereafter, wailing as he walks, with tears that speak of men broken. He is bent over from the pain.

I can do nothing but put an arm on his shoulder.

## Pink Floyd

**April 22nd, 1997.** On the education front, I have observed long enough. Now in my second month, I embark on the ministry of improvement. My potential students are young men who don't know their basic multiplication tables and who routinely cause deaths by prescribing quinine for any fever. My lessons — carefully tailored, translated into Portuguese, specific to the

educational level of the consultants, aimed at crucial, simple life-saving changes, and typed immaculately — will be interesting, stimulating and pertinent to them. My topic is "Approach to the febrile patient." I announce the dates at the hospital and purchase Zairean soft drinks and peanuts for the students. I am ready to go.

But then: The Wall; the consultants refuse to come. They announce with righteous indignation that the subject matter is "beneath them."

I am furious. I have repeatedly attempted to introduce the subject of meningitis, but to no avail. I desperately remind myself of all the politically correct bullshit — that as a white Westerner, giving courses is a form of neo-colonialism. I remind myself that they have suffered through all those years of war and God knows what else. I think of Kindoki, the evil spirits that masquerade as cats during the daytime and fly about Angola at night. I remind myself that these young men have fought guerilla warfare, yet all I have to do is wave a cat in their direction to terrorize them. It is garbage! People are dying needlessly, yet these morons are unwilling to learn skills that might prevent these deaths.

Unbeknownst to me at the time, this is only the beginning of my woes. For the next two months, I will involve the hospital director (to no avail), cut the consultants' symbolic salaries, and invoke the furry forearms of God to repatriate the students into the classroom. All with disheartening results.

## Winds of war

**May 19th, 1997.** I am awakened at four in the morning, partly because of the deadly REM-eliminating effects of Primus beer, partly because of a rumble outside my window. Lights. Motors. Trucks. I count 12 of them. Angolans normally drive without their headlights on at night, as a matter of economy. Bizarre.

At lunch, Dominique returns from the town market to inform us that there are 15 beige 4-by-4s without identification on them, driven by young men wearing military boots. That afternoon, as I wrestle again with Fausto, a convoy of 5-ton trucks filled with red balaclava-wearing men carrying white bags whisks by our house. They're back.

In Zaire, Mobutu has fallen to Kabila's American-trained alliance. These men are UNITA rebels whose attempt to support the dictator has failed. Savimbi has quite a few bases on the Zairean side of the border. These are the source of weapons smuggled into Angola and the first stop for diamonds taken out of the rich Lunda Norte province.

Then, speeding along the road leading to Zaire, a steel grey Toyota 4-by-4 accompanies the trucks, carrying an olive-skinned, middle-eastern man. No, not another humanitarian worker; it's my first mercenary. A few hours later, the same vehicle stops in front of our house. Out comes Mr. Laurindo, our local surgical technician, who asks me to examine Mr. Fernando Manuel, an "out-of-town visitor." I oblige him, learning that this 45-year-old man, whose name is the Portuguese equivalent of John Doe, has been diagnosed with fatty liver during a visit to France a few years ago. He has nothing of the Third world: he has GE reflux.

And then, as swiftly as they arrive, they disappear into the wilderness. Gone to beef up UNITA guerilla bases elsewhere in Angola, just in case.

## Kafka

**May 28th, 1997.** I have just returned from yet another voyage to the twilight zone: a meeting with the local authorities featuring Senhor Jorge Felipe, the secretary of the UNITA party for the northern Uige province, a big fish in a small pond. He represents the highest level of power locally, and is our "partner" in this interesting health venture.

The problems of theft, chronic absenteeism, and absolute lack of motivation have persisted. Our consultant in the nutrition ward is stealing pappa, the high protein mixture, from the malnourished children. Our consultants in the emergency department continue, despite explicit instructions, to prescribe at least 2 or 3 medications to patients where only one is necessary. This gives them the chance to sell the extra pills on the local market. Last night our food bank was raided. The thieves carved a hole in its wall large enough to allow passage of a full-grown man and, miraculously, our security guards heard nothing. They were fired, but on the second night a bunch of machete-armed thugs appeared in the early hours of the morning and scared off the replacements.

We bring up these topics, notably the problems that arise when the "pharmacies" in town unashamedly sell MSF medications and equipment. We explain the very real threat of inefficient medications due to antibiotic resistance, not to mention the ill-effects on citizens from incompetent use.

But the clincher has to do with an incident that occurred four days earlier. Faced with growing instability in the area, we decided to discreetly evacuate one of our jeeps on the cargo plane, as part of a broader preparation for emergency evacuation. Amazingly, the local administration heard of this and, on the day of evacuation, actually ordered us to leave the vehicle in Maquela, invoking papers hitherto unknown. In response to the prospect of "losing" a jeep that, in this theft-rotten society, they truly considered

theirs, they prevented the free and rightful movement of humanitarian material to a needier site.

Senhor Felipe is a fat man, eloquently trilingual at will, but as I politely express my anger at his complete absence of leadership and actual obstruction of MSF's work, he suddenly develops convenient French expressive aphasia, and must resort to an interpreter whom even I understand to be unable to translate Portuguese into French. When I insist that MSF will not remain idly by in the absence of responsible partners, and that we will actually leave this mission or downsize it dramatically, he answers (in French!) with a chilling smile: "MSF cannot leave Maquela do Zombo." End of interview.

So it is simple: the biggest problem in Maquela do Zombo is, unfortunately, the Angolans.

Leadership, to paraphrase, flows downhill. Our beloved hospital director, Fausto, steals 35 litres of treated water every day for his bathing needs, leaving the hospital reserve high and dry despite my furious admonishments. On another day, he goes on a prescription-writing tear totalling 900 tabs of various unphysiologically-prescribed antibiotics and anti-malarials for 10 patients all named Jorge or Paulo. Simply put: fraud, theft and deceit are ways of life.

Our medication stocks disappear at a dizzying rate, with 500 penicillin pills one week joining 1000 quinine tablets from the previous week in medication hinterland. Then, on the town market they slowly reappear for resale, bearing the MSF logo as a voucher of quality. New equipment disappears almost daily, be it stethoscopes, sphygmomanometers, oxytocin drips, intravenous kits, even hospital beds.

Just how much good are we doing here? Southeast Asians already know the horrors of quinine-resistant falciparum malaria. Now we are racing forward to join them, collecting resistance to most of the common antibiotics along the way.

One expects catastrophes — and gets them. Malaria is treated with intravenous tea injections courtesy of one of our local lab techs, for a fee, of course. A speculum and a small kit for umbilical cord processing disappear from the maternity. The following week, I am called to assess a 17-year-old with nasty fever and abdominal pain, who had miscarried a few days before. And yes, despite the amp–genta–metronidazole cocktail, we take her to the OR twice to drain the gallons of pus in her abdomen from the septic abortion that her sister, one our trusted midwifes, performed on her — for $30 US!

And finally, the prevailing mentality: Give me! It is virtually impossible for the local people to recognize that your presence here, far from family, friends, non-enterotoxic foods, and a decent salary among other normal comforts, means anything. You are white; you are rich: Give me! Your pills. Your flashlight. Your tee-shirt. Your walkman.

In fact, Médecins Sans Frontières is no more. It is Pills Sans Frontières, motor of the local economy.

**Reality in Angola**

## Adeus Maquela: a new paradigm of humanitarian assistance

**June 6th, 1997.** Willy, our consultant in pediatrics, is a very intelligent man. Today, he is suddenly motivated — a crisp change from his usual laziness, stealing and recurrent absenteeism. His brother was found unconscious and febrile this morning after being treated by a village charlatan with the standard cure-all injection of vitamin B for a fever. Suddenly, all the lessons from the *mundele* (white man) return: what if this wasn't malaria? And would I do a lumbar puncture on him if it was appropriate?

I initiate the appropriate therapy here (quinine, amp and chloramphenicol intravenously), and perform a gross neurological examination before an LP that yields frank pus. Off with the anti-malarial, and on with the prayers to ward off the Kindoki.

And indeed, Willy's brother did recover completely, without the slightest neurological sequela. You see, I had fought tooth and nail with the consultants to force them to come to the courses for exactly that reason. I had taught the more gifted ones to perform lumbar punctures on febrile patients who had seizures, for instance, after initiating "triple therapy" to cover meningitis and cerebral malaria. And although many a lumbar puncture had been positive for meningitis, the message of the use of learning was but the proverbial candle in darkness. Suddenly though, it became real, and by divine intervention had struck the most intelligent and influential of the consultants.

Willy's story was symbolic of the relationship between Maquela and MSF: parasitic, uninterested and irresponsible rather than enhancing learning, autonomy and honesty. Three months of my backbreaking attempts and one and a half years of MSF had yielded one sensitized Willy. During my first mission in the Hutu refugee camps of eastern Zaire following the Rwandese genocide of 1994, I had seen butchers and murderers who felt it was normal to machete women and children. However, the energy they invested in treating their own in the tent hospital I ran made it look like the Mayo clinic compared to Maquela.

## Worth the cost?

Was MSF's involvement with Maquela worth the cost?

I have come to believe that this question is one of the most important ones facing humanitarian organizations today. By virtue of its politically and emotionally charged nature, we, the First World, would probably rather avoid the problem and give ourselves a warm, fuzzy feeling by burying it under millions of dollars. But by supporting such irresponsible and locally uncommitted endeavours as Maquela do Zombo, we are perpetuating the problem of dependency, inhibiting progress, and enriching a select few in a totally parasitic society. And Maquela is not alone: Eyebrows must be raised when the gargantuan amounts of money pumped into Haiti are compared, by any measure, to the results obtained, no matter how tolerant the evaluator may be.

In societies such as these, I fear that we cause more harm than good, in both medical and social terms. In these environments, as more material goods transit through local hands, less reaches the needy and more is siphoned off to enrich unscrupulous middlemen. Without responsible partners who can actually control these intermediaries, the notion of humanitarian assistance is nothing but wishful thinking on the part of the First World.

I do not pretend to hold all the answers for solving such formidable problems. However, I do believe that the correct course of action has to focus on simple general public health measures. For example, courses given directly to the population (on fundamentals such as hand washing, boiling water, general hygiene), and the construction of adequate latrines to decrease the risks of fecal–oral transmission of common pathogens. Medications should be de-emphasized until a responsible interface can be identified and maintained. Furthermore, medication should never, ever, be given independently of a clearly defined commitment to learning on the part of the receiving population.

Finally, humanitarian organizations themselves ply their trade in what has become a dog-eat-dog competition to assist the ultimate victims of this earth, with little in terms of critical review of their actual efficiency. I have seen vast amounts of money wasted by all humanitarian organizations, most notably the UN. Because of the comfort brought about by the ideals they represent, it takes courage to confront the taboo that shields them from criticism.

Over the last few years, a trend toward increased financing of non-governmental humanitarian organizations, at the expense of nationally run aid programs has emerged. This represents, in my eyes, a further distancing of the First World from the Third, and reduces even further its interest and capacity to ask for some measure of accountability from these organizations.

As a physician, a blessed citizen of a rich country, and a human being, I believe it is time to take a hard look at humanitarian work, beyond the splashy headlines. Only through a frank evaluation of the helpers and the helped will we truly improve our attempts to assist our less fortunate brothers and sisters of this world. And that, indeed, is what it is really all about.

**Acknowledgements:** The author wishes to acknowledge the assistance of Robert Bourrier in the preparation of his manuscript.

**Correspondence to:** denis@cactuscom.com