Working with Médecins-Sans-Frontières in China: a personal account

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A genitourinary medicine trainee's experience of delivering HIV care in China

When I received the job offer to work in a Médecins-Sans-Frontières (MSF) HIV clinic in the southern Chinese city of Nanning, I was quite overwhelmed. Finally, I thought, I was going to make real the vague idealistic notions I had had of working with the needy in a remote location. Was I going to enjoy it or would I fold under unfamiliar work conditions and lack of mod cons? Where was Nanning? (What I found when I googled Nanning were basic statistics, misleading weather descriptions and a web link to finding a Chinese wife!)

MSF is known for providing emergency medical aid, but in recent years has pioneered HIV treatment in resource-poor settings, but China? The news is filled with reports of her double-digit economic growth and ambitious public works. However, healthcare decentralisation and the lack of economic growth in the rural population have led to gaps in medical provision. Following the outbreak of severe acute respiratory syndrome (SARS) and the scandal of peasants contracting HIV through contaminated needles during blood donations, there was a more open and urgent confrontation of the HIV epidemic.

Of the 650 000 people estimated to be infected with HIV in China, 20 000 are in Guangxi province. Nanning is the provincial capital with a population of 2.5 million. The main route of transmission here is through contaminated needles by intravenous drug users, as it is on a major drug-trafficking route into China from Vietnam.

Opened in December 2003, our clinic provides a confidential service to patients residing in Nanning, with free consultations, tests and medication delivered by a largely Chinese staff. For 8 months, my job was to supervise and train our Chinese doctors, run a pharmacy and see the inpatients in the hospital twice a week. The clinic is run in collaboration with the Chinese Centre of Disease Control (CDC) of Guangxi Province.

It has been a fruitful partnership with the CDC, but the limits to which MSF can act independently are constantly tested. As a medical organisation, MSF is not well recognised in China. In a city that is jaded with quacks and miracle cures, there is obviously scepticism. Suspicions from patients and other healthcare workers are not uncommon: "Were we conducting experiments? What were these free medicines? (Many antivirals were imported.) Why was it not possible to disclose our patients' identities?" On the other hand, we are foreign and western, which the Chinese associate with quality and expertise and have shown success in other similar projects. MSF has been in the province for barely 2 years, and is already advocating changes at national and international levels. We probably blundered through many meetings with officials, unaware of friction, with nuances and hints lost in translation. Learning to be more culturally sensitive, we have started attending speeches and banquets to build the necessary relationships. As MSF is not yet a registered medical organisation in China, we have to tread carefully.

When I left in May 2006, there were 530 registered patients, including 30 children, and 315 had started receiving antiretrovirals. Many present with late disease (57% are WHO stage 3–4). Tuberculosis and *Penicillium marneffei* infection (a geographically limited invasive fungal infection) are rife. Since 2004, certain drugs (lamivudine, stavudine, zidovudine and nevirapine) and screening tests have been available free on the Chinese health service, but implementation of these policies is slower in some provinces than in others. MSF HIV treatment protocols are informed by WHO guidelines. Combivir and nevirapine were our first-line regimens until January 2006, when we switched to a fixed dose combination of stavudine/lamivudine and nevirapine. Efavirenz remains an alternative agent. Didanosine, abacavir and ritonavir-boosted indinavir are reserved

for treatment failures. Measurement of CD4 counts are routine, but HIV viral load tests are not easily available. Outside the MSF/CDC clinic, laboratory tests for confirming diagnoses and monitoring HIV treatment and the costs of opportunistic infection treatments are still borne by patients themselves.

The shortage of trained HIV physicians, nurses and pharmacists is a major barrier in implementing China's HIV care programme. There remains a considerable amount of stigma associated with HIV in the medical community. So I learned to appreciate my Chinese coworkers. Many are eager to learn and teaching sessions were well-attended. Questions can sometimes be bizarre—for example, "Can one acquire HIV from eating a watermelon injected with HIV-positive blood?" and sometimes complex—for example, "Is HIV a social or medical problem?" As I had no Chinese medical registration, I had to be "supervised" by a Chinese doctor, especially in the hospital. This works as long as there is mutual agreement on patient management, which is not always the case. My Chinese counterparts frequently invoke "In China, we do things differently", a phrase often meaning the end of the argument. In the last decade, having lost central funding, hospitals had to raise revenues themselves. Hospital admissions have become prohibitively expensive with the increasing use of sophisticated diagnostics and medicines. Patients' beliefs in long hospital stays and intravenous drugs of questionable benefit are left unchallenged. It is a lonely business to be the one arguing for discharge or switching to simpler treatments in order to keep costs from spiralling as MSF pays for hospital stays too.

HIV has affected many farmers and migrant workers from the countryside, and a third of our patients are former or current drug users. Many cannot afford to be ill and hospital admission spells financial disaster. If the illness turns out to be AIDS, the stigma of HIV infection has wide repercussions. The Chinese medical system requires identification before one can access care, and thus there is no comfort even in confidentiality. Naturally, this deters patients from testing, especially drug-users. For HIV patients, access to available specialist paediatric, ophthalmic and psychiatric services is limited. The medical community aside, patients face discrimination from family, friends and employers and have learned the value of banding together. The Government, realising that stigma is a significant barrier to HIV prevention, has recently drawn up new legislation to reduce discrimination and encourage patients to access care.

Our patients often find it difficult to speak of drug use and sex with us. (This is also true among Chinese doctors.) This might be a cultural barrier, but what made me nervous at times were the occasional knives found when patients are examined, and the odd verbal threats. Some of our patients are used

to a tougher life I guess, and there is no blanket approach to 500 Chinese individuals. Overall, many are plain grateful and bring gifts from their farms during the festive season. On World AIDS Day last year, some of our patients braved the public, wearing red ribbons to promote HIV awareness and show

solidarity. Times like these made it all worthwhile!

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