

## Scott Clarke – Travel and Study Report – Summer 2009

During July and August 2009, I travelled to Moshi, a town at the foot of Mt Kilimanjaro in Northern Tanzania. As part of a team of volunteers from the organisation First Aid Africa, my main aim was to teach first aid and basic medical skills to school children and members of the community. In addition, as I was one of the most experienced volunteers in the area of First Aid and because I am a medical student with an interest in Pre-Hospital Care, I was aiming to research Emergency Medicine in Tanzania and help set up a rural ambulance service to serve the area around Moshi.

For my report, I have decided to give three stories from my time in Moshi that I think best show the problems we faced, the solutions we managed to find, and how I will use what Tanzania taught me last summer to achieve much more this year.

### **Pole Sana**

On my first night in Tanzania I was laid in bed in our hotel in Moshi when a knock on the door woke me up and Sam, the Project Coordinator, opened the door and shouted that “grab your bags, we have a problem”.

On the way back to the house he was staying in he had found a local man in the street that had been attacked with a machete. He had taken him to the local government hospital and found it was closed and so had headed for the local private hospital. En route, the man's condition deteriorated and he decided to pick Dan, Team Leader and Medic in Remote Areas and myself up as the two most experience members of the team to treat the casualty on the way.

Outside in our 4x4 we assessed the casualty who was clearly in shock as result of a large laceration to the face, the head, the chest and an almost complete amputation of his left hand. Dan working from the seat next to the casualty and myself from the front passenger seat stabilised him as much as we could on the journey to the hospital and on the way we picked up Harry, another team leader who best new the local area and Kiswahili, the local language.

During that journey, it was the first time I really wished that I had learnt more Kiswahili before travelling to Moshi. All I could remember to say at the point was “pole sana”. The literal translation is “sorry a lot” but it used to mean “I feel sorry for you”. Throughout the journey we had a continual conversation of “pole sana” to which he replied “asante sana” – thank you very much.

Kilimanjaro Christian Medical Centre (KCMC) is regarded as one of the best hospitals in East Africa. When we arrived, Sam and Harry ran into find a trolley and we pushed him into the ‘Emergency Room’ where two local women were stood waiting.

We waited for them to start treating him and they did nothing.

We asked if they had equipment we could use and they said nothing.

Sam ran back out to our vehicle, got our kits and we continued to treat him as best we could. A few minutes later another woman walked into the room and said, “How do you know him?” to which we replied that we didn't. She then asked, “Why have you brought him here? Why did you not take him to the police?” Sam replied, “Because he's bleeding...” She didn't reply.

That woman was the emergency room doctor.

Dan asked if they had oxygen and the doctor replied “why does he need oxygen?” – “Because he's bleeding a lot” – “We normally check oxygen saturations first”. She looked at one of the other women who then left. A few minutes later she came back with a bowl full of hot water – the man's arm was covered in blood and before they could use the pulse oximeter they needed to clean one of his fingers. She took out some cotton wool and slowly cleaned his arm – starting at his shoulder.

At this point I realised that we couldn't treat this man forever and eventually we would have to leave him in the care of the medics at the hospital and so I convinced the others to leave.

On the way out of the room I saw a SEWS chart on the wall. I had done my first year SSC project on using SEWS to identify and treat critically ill patients. Next to it was a protocol on how to fluid resuscitate.

The medics at KCMC had education, skills and good equipment, all of the things I thought I wouldn't find in East Africa. What they didn't have was the mind-set to treat someone they didn't know who couldn't pay.

Before we arrived we had the brilliant idea of setting up a rural ambulance service. What was that going to achieve if the people who were transported to the hospital were then just ignored by the people trained to help them?

This summer we are working with the Tanzanian Red Cross to find people who are willing to treat and to try and change the attitudes of those who aren't. We are also looking to build a small hospital in another area of Tanzania in conjunction with a doctor who has a team of people who, like us, want to try and help anyone, regardless of the circumstances.

## **TIA Mzungu**

I spent the majority of my time in Moshi working with an organisation which supports vulnerable children, including street children, called Mkombozi.

For the first two weeks, I worked alongside Devotha (Mama Nurse), a locally trained nurse who works with Mkombozi. During this time I learnt a lot about healthcare in Tanzania: nothing is sterile, every wound gets antibiotic cream, every cold gets amoxicillin and every headache gets treated (or at least tested) for Malaria.

First Aid Africa's teaching syllabus is based on the UK four day first aid course for voluntary aid organisation volunteers with a few obvious exceptions such as calling for an ambulance. We had brought out a large stock of first aid kits with us including items like ambulance dressings, triangular bandages and crepes which we were distributing around the schools and other organisations where we were teaching.

Mama Nurse and Mkombozi staff treated hundreds of injuries a year including those of street boys who then went out and got their dressings covered in mud and dust amongst other things. The UK course would teach her and all of the other staff to change dressings regularly in those situations and to use sterile dressings all the time. Our stock of bandages would not last long and then what?

At some point during those first couple of weeks someone used the phrase "TIA Mzungu" – this is Africa, white man. They were right; I realised that we were trying to apply a UK solution to an African problem and convinced Dan that we needed to think of an alternative.

We went around all the local pharmacies and found that ambulance dressings were not available and that crepes and triangular bandages were but were very expensive.

Dan had two brilliant ideas: Firstly, he made 'ambulance dressings' using local material cut into strips or local bandages and stuck a sanitary towel onto it to form a clean, absorptive pad to go onto the wound. At first, other members of the team laughed, but as he pointed out they are designed for soaking up blood and even in Tanzania, are available incredibly cheaply, in bulk.

Secondly, we realised that triangular bandages were simply material cut into triangles. We bought local material and paid local 'tailors' to cut the material into triangles and sew hems. This method

produces 10 bandages for the cost of buying one from the shop. The material could be boiled and re used on numerous occasions.

We rewrote our syllabus to incorporate improvised first aid and how to make and use locally available equipment rather than equipment imported from the UK and ran a pilot training session with the staff at Mkombozi.

Mama Nurse is now regularly using the 'new' bandages and we are planning to teach these methods to all the schools, in all the different countries in which First Aid Africa are working this year.



## **Sijui**

Throughout my time in Moshi, I received phone calls from other volunteers asking me to jump in a taxi and come and help with their 'emergency'. Arriving at one such emergency, I was told that a man who had recently been released from the local government hospital, Mawenzi, following surgery for a 'groin lump' had been hit by a Coaster, the Tanzanian equivalent of a coach.

On examination, the man appeared shocked with a decreased level of consciousness and he had a rigid abdomen which appeared to be filled with fluid. With an apparent history of trauma and the signs we found, the man appeared to be bleeding internally and we managed to carry him into a taxi and rush up to Mawenzi Hospital.

On arrival at Mawenzi we encountered a similar experience to the one described above at KCMC, no-one was willing to help us until the paperwork for the man was filled out by the doctor in the Emergency Room because of hospital rules. Eventually the doctor recognised that the patient was severely ill and arranged for transport to KCMC.

Whilst we were in the Emergency Room, a piercing scream came from outside. We looked out and an old woman was laid in the middle of the road, unconscious with blood coming from her head. A dalla-dalla, another type of Tanzanian bus, was driving away.

In our broken Swahili we asked what had happened and were met with "the bus hit her" and "Sijui" ("don't know"). We began checking for response and immobilising her head whilst trying to calm down her daughter who was with her. Eventually, she managed to tell us that her mother was not hit by the bus, she had just collapsed.

Looking down at the elderly woman, her dress was soaked through. She had profuse diarrhoea and was severely dehydrated. We carried her inside and to our surprise, this time we were met by

nurses in the courtyard. They said that she would be getting the transport to KCMC instead and so we went to check on our other patient.

He was sat up on the bed looking completely different from when we had left him. We eventually found someone who could explain: He had not been hit by a bus either. He had been kicked in the groin earlier in the day and due to his previous surgery and this trauma he had developed urinary retention, become weak and fallen into the bus. Following catheterisation his condition had improved dramatically.

Two patients, both we were told had been hit by a bus. Neither had and had completely different injuries to what they appeared. Throughout medical school, lecture after lecture emphasises that taking a thorough and accurate history is the most important part of treating a patient. That afternoon proved it for me.

We walked out of the Emergency Room into the courtyard. The elderly laid was left on her own, sprawled on the floor near where we had left her with blood still coming from her head and a pool of diarrhoea around her. Somehow, she dragged herself up and started to run across one of the walkways – head first into a metal pole.

No one moved to help her.

One of the nurses said “mwendawazimu” – “crazy person.”

TIA Mzungu.