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Tanzania March and April of 2010

I have decided to break down this essay into a few different areas. Some will be more "informative" than others while some are excerpts from my journal that I kept over the 2 months.

Contents:

Our Voyage to Tanzania

Minneapolis to Amsterdam - 8 hours of flawless preparation, communication, and execution. A beautiful thing; not at the time however...this is old hat.

Amsterdam airport - still pretty western around here; familiar clothes, familiar food, lots of white people; clean water, nice toilet complete with the little picture of the fly you can pee on in the urinal. Oh the little things in life.

Amsterdam to Nairobi - descent communication with slightly delayed execution; just enough to make us too late for our connecting flight out of Nairobi. Now what? Stuck in an odorous airport surrounded by unfamiliar people with unfamiliar faces wearing unfamiliar clothes speaking an unfamiliar language. We just became the minority. It's okay, we have homemade chocolate chip cookies.

10 pm roles around and the airport still hasn't figured out what to do with us. There are no more flights out tonight; we'll have to stay in Nairobi. "We're not paying for that". Thank you KLM for putting us up in the Intercontinental along with dinner, breakfast, and 2 drinks. Hotel lobby surrounded by guards with large guns - the automatic kind.

Us – "Any good places you recommend to get a cold beer?"
Lobby guy – "I don't recommend going out at night."
Us - "ok"

Taxi back from hotel to airport; first time on the other side of the road; well, intentionally that is.

Passports, IDs, immunization cards, visas, security checks, health checks, luggage checks, work permits, Kenyan schillings, US dollars, Tanzanian schillings, boarding passes, and cookies. Check.

Nairobi to Kilimanjaro airport – finally; worked out for the best we discovered as our flight was now during the day time and we flew by mount Kilimanjaro (the tallest peak on the continent).

Kilimanjaro airport – no communication with anyone; nobody knows where we are since we missed our connection; We don't know where to go. We don't know where our "house" is. Here's an idea. Let's just get in a taxi and tell them to take us to Arusha…that's the city where the hospital we are supposed to work at is right?

Airport to Selian Hospital – Rode in complete silence for the 1 hr and 20 minutes it took us to arrive at Selian. Nothing needed to be said. Not that we would be able to explain anything we saw anyway.

Our house on Ilburo

1 car ride, 3 flights, 1 hotel, 1 shuttle, 2 taxis, 1 land rover and we have finally arrived with nothing more than a glorified nap in the past 36 hours. How in the world did we actually make it to this jungle in the middle of Eastern Africa?

The property is surrounded by 10 foot walls with spikes. We pulled in through a gate and unloaded our luggage onto the porch. The house is beautiful compared to everything else on Ilboru road, but just a touch different than home.

There is a shower and two working toilets. Mebo is the maid who comes by 3 times a week to clean and wash your clothes. We pay her 15,000 schillings per week ($12.00 or so). There are about 10 water bottles we kept full (after boiling of course) for our drinking water. There are cabinets to store food and plenty of dishes to cook with. Internet connection is spotty and $60.00 per month. Skype is crucial to stay in contact with loved ones at home; just have to get around an 8 hour time difference.

Living in Tanzania

There are a few rules to live by:
1. Things in Africa hurt
2. Water must be boiled – think about this. How often do you use water? Want a quick drink? Wash up some dishes? Rinse out a glass? Brush your teeth?
3. The word "road" is a term used loosely here
4. Bugs and plants with thorns get big – see number 1
5. Anything worth guarding has 2 guards
6. Our day guard is our gardener and our night guard sleeps – must bring him tea
7. Never pay asking price
8. Take a big-ole helping scoop of patience before you arrive. You'll need it. There is no sense of urgency in Africa what-so-ever.

Tanzanian culture holds greetings in high regard. Often times the first several minutes of

a conversation will be spent simply greeting one another. These greetings need to be learned in a hurry.

Habari – nzuri
Mambo – poa
Jambo – si jumbo (for tourist mzungu)
Vpi – safi
Shicamu – marahaba

Shopping –
Most things don't have prices and white people who don't learn the language pay more.
Moja, mbili, tatu, nne, tano, sita, saba, nane, kisa, kumi (1 through 10)
Mia – 100
Elfu – 1000
Ni bei gani – "how much"

When we asked other students and friends who were here before us what Tanzania was like, we heard the same word a lot. Poor…

Poor is one of those words that can role off your tongue so quickly that you don't really think twice about it. It is so easy to jump to what you understand as poor in your own world. In reality, the definition of this word is entirely based on your surroundings. Poor in Tanzania is not flipping burgers from 9 to 5 and having your phone shut off because you havn't been able to make payments. No, Tanzania-poor is walking 25 miles to the nearest hospital carrying your dying child in your arms because you do not own a phone to call for help and much less, no one around your owns one either. You do not have the money to send your children to school, so instead they learn how to herd the goats and feed the chickens starting at the ripe old age of 5. They wear the same clothes day after day no matter how worn and tattered they become. You have taught them to ask for money whenever they see a white person, and each day of your life is spent worrying about two things: avoiding disease and getting enough food.

Not to put everyone in a downer mood I'll spruce things up a bit with some of the beauty of Tanzania.

The Kids

Don't tell any of the kids here that they are missing out because they would have no idea what you are talking about. The ear-to-ear smiles that each one of these young Tanzanians display is enough to make anyone want to scoop one up and attempt to sneak them through customs. They can find enjoyment in just about anything. I once saw a small boy pushing an old bike tire with a stick as he ran down the road; he was attempting (and quite successfully) to keep the wheel from falling on its side. This was his fun.

You don't need a soccer ball to play soccer either. Pretty much anything that is round can

be kicked around, passed, dribbled, or shot. The athletic skill these kids develop at such young ages is enough to make any American little league parent envious.

You'd never know that most of these kids have never heard of baseball before… The first day we played we had a couple of kids stop, set down their buckets, and watch us (no doubt trying to figure out what in the hell these two mzungu were doing). We let them toss the ball a couple of times and they absolutely ate it up. We had to find a way to teach them the game, so the next day we walked a total of 12 miles between going to the hospital and going to town looking for: tennis balls, something that could be used for a bat, and something for a grip. Our trip was a huge success as we found one canister of Dunlop tennis balls, a pick axe handle (with no pick ax), and a roll of medical tape from a duka la dawa (pharmacy).

The next day, we walked up to the "soccer field" prepared to bring the sport of baseball to Tanzania. When we arrived at the field, we were surprised to find it empty. Where was everyone? No matter, we just set our stuff down, pulled out our own gloves and baseball and started to play catch. As if a levy had just been broke, as soon as we started tossing the baseball, the kids flooded out onto the field. Within an hour we were teaching the fundamentals of hitting and fielding. Just like American kids, they all love to hit and no one wants to be out in the field. Unlike American kids, they have absolutely no concept of what the point of all this is. They have never seen a baseball card, watched a game, or even listened to one called on the radio. They don't know the rules, the objective, or even why we have to go get the ball after someone hits it (aside from the fact we only play with 2 at a time).

As mentioned before, the natural athletic ability of these kids is astounding. All we did is show them how to hold the bat and where to stand. They did the rest…and quite well ☺ Each time we played we have a bigger group then the time before and the smiles on their faces were enough to keep us coming back each day.

The Medicine

Selian hospital is a small campus, owned by the Tanzanian government (as of this past year), which houses a number of small buildings sectioned off into separate wards for medicine patients (male and female), pediatric patients, surgical patients, and Ob-gyn patients. There is also an area for the NICU (neonatal intensive care unit), an operating theater, a radiology building (complete with 1 x-ray machine), a small canteen (serves a limited number of Tanzanian options), and a few administrative offices. Most of the staff have permanently moved to the new hospital in town and the rotation is quite different because of it.

There are 4 interns who are medical students from Tanzania that are basically in charge of the hospital. One of them is on call every 4th night and they cover every service by themselves. We have a few staff physicians who are more part-time that round on patients and do some teaching.

I have spent most of my time on the medicine ward as this is where Dr. Eggert works. He is one of the few full time staff docs Selian has anymore since the new hospital opened up. He is a wealth of information and truly makes the hospital a better learning environment. The patients on medicine are quite sick and a large proportion of them are HIV (+). If they are not admitted for some complication related to HIV/AIDS, then they are usually in for pneumonia or malaria. It has taken a great deal of time to "get used" to seeing the things I see when rounding. Something as simple as a clean bed with a comfortable mattress is a luxury that is not present at Selian. Many of these patients are constantly hounded by flies, lying in filthy rags saturated with diarrhea or at least the odor of it.

It is not infrequent to have 1 or 2 fewer patients each day; many times they were likely not able to be treated either because of a lack of resources or because they did not come in to the hospital until they were already on their last breath of life. So our days continue like this…round on patients, prescribe antibiotics when we can, order some blood work, maybe a chest x-ray, give some fluids, treat malaria empirically and basically pray.

Each day we arrived at the hospital, we were prepared to witness more suffering, death, and despair. It didn't ever get easier to do, but we did begin to "get used to it". A few patients left lasting impressions on me…

1. 30 something year old seropositive (meaning HIV +) woman lying almost motionless on her mattress pad. She presented with altered mental status and fever. Long thin tube running into her nose, down her throat, and into her stomach – this is how she eats now. Her neck refuses to flex forward. A family member dutifully sits by her during all hours that she's allowed. Our team arrives at the patient's bedside on rounds. We learn that she has refused her anti-retrovirals supplied by the USAID program; this means she is no longer covered by the program and nothing during her hospital stay will be paid for by USAID. The family has no money. They pray. Our exam reveals her to be obtunded. She starts to seize. The sounds of wet lungs are soon heard as she attempts to cling to a breath. She has aspirated contents from her stomach into her lungs. She doesn't have long now. She continues to seize. Patient is deemed too far gone and what limited resources are available are not spent. The team moves on. While listening to the progress of the next patient, we hear the commotion stop. We turn and pull a curtain around the last patient and pronounce her. She was now at peace.

2. Another 30 something year old sero(+) woman lying in bed looking almost completely wasted away. Her sheet is draped over her and looks like a tattered rag lying on a pile of jagged bones. She turns her head to look at me as I start to examine something I see on her neck. She is in pain. A lot of it. Both sides of her neck are littered with swollen and firm lymph nodes. She is so thin and cachectic looking that these lymph nodes stand out like giant beacons declaring advanced disease. Her CD4 count is 10. Likely lymphoma secondary to EB virus infection that has taken over in her weakened immune state. She is going to die, but not without teaching me first. I struggle with the emotion of learning from dying patients.

On the lighter side of things…

One Saturday, we were offered the opportunity to tag along with the ambulance driver to an Arusha rugby game. Having an interest in sports medicine, I was not about to pass this up. So, we hopped a ride with the ambulance from ALMC and arrived at the rugby complex one Saturday afternoon. It was when we arrived that we realized we would not be "tagging along" with anyone. We were the medical service – end of story. After coming to this realization, crapping ourselves, and then cleaning up we decided we better have a look in our medical kit to see what we have to work with.

Most likely rugby injuries will include the following:
1. Sprains (ligaments of ankles or knees or whatever else gets twisted around)
2. Cuts – or gashes if you prefer
3. Concussions

So what did our kit have in it? Seven foley cathetars (in case we really need to get that urine out), a box of 5-FU (for the sudden attack of colon cancer), and no suturing kit to be found anywhere. Perfect. Deciding to stay at the field, we tried to explain to the nurse and driver what we would need from the hospital and sent the ambulance back to retrieve it. Good thing we did. Not 5 minutes after the ambulance pulled out we were hailed by a coach to look at one of the kids from the 16 and under game; two and ½ inch gash above his right eyebrow. Ouch. We gave him some gauze and had him keep some pressure on it until the ambulance returned. When it did, we cleaned the area, drew up some lidocaine, injected it, and threw in 5 stitches that he now could show off to his friends.

Later towards the evening during the adult match it suddenly came to a stop. I saw a group of players huddled around one downed teammate and I had no idea what happened. My heart was in my throat as I ran out onto the field unsure of what I was about to see. Patient's name was Graham – he told me that; good. He did not hit his head or neck. Good. He cannot stand up because his R knee just "popped out". Bad. It all happened too fast. He's unsure what exactly took place. His skin was intact, as were his distal pulses and neurological sensation. Good. Nothing else hurts, just the knee. Good. I place my hands on his uninjured left knee and move it around some. A few quick maneuvers tell me what his right sided knee ligaments should feel like. His legs are huge and sweaty. My hands have a slight tremble in them as the players continue to huddle around. The ambulance driver ran out with the stretcher. There was no end feel in the Lachman's on Graham's R knee as there had been on his left. There wasn't even a hint of one. ACL gone. We loaded him onto the stretcher and carried his 250 pound frame to the ambulance. Time to head to ALMC for an x-ray, knee immobilizer, and crutches. No worries about money here. He can quite easily afford everything.

Parting Words and Tips:

Must bring:
Stethoscope, white coat, khakis, polo t-shirts, comfortable walking shoes, Oxford tropical medicine hand book, drug resource of some kind, hand sanitizer (lots), lap top, enough US dollars to pay for rent, work permit, visa, shower sandles.

Sunscreen, aloe, bug spray (plain old OFF is just fine; don't spend a fortune on high-end stuff). I think I saw a total of like 20 mosquitoes in the 2 months in Tanzania.

Rent is $200 per month, visa is $100, and work permit is $120.

Food:
Western food is expensive so bring anything you can't live without. Miscellaneous expenses ended up being around $100.00 per week. ATMs work fine to get schillings out with minimal expense.

Dr. Eggert brings students into town once a week usually for grocery shopping.

Safaris and mountain climbing are expensive. Larger groups save you some money but still spendy. If you can afford it, do it. We could not.

I know I have left a lot out, please email me with any other questions you may have.
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