Into the Cradle of Life
Providing Health Care in Rural Kenya

by: Benjamin Gersh, Class of 2006

Five Brody students visited Kenya last summer to provide health care as part of a fourth year elective. The group included Ben Gersh, Courtney Edgar, David McMillan, Liz Buzkirk and Angela Hartsell. Called Dr. Tom in Kenya, Dr. Thomas Kerkering, division chief of internal medicine infectious disease at Brody, served as their mentor and preceptor. It was in his capacity as senior health advisor to the Christian Children’s Fund (CCF) that Dr. Kerkering organized the journey to Kenya where the team helped to set up clinics with Kenyan CCF offices. Betsy Richards, an infectious disease nurse practitioner from Wilson, North Carolina, also accompanied the team.

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Harambee is a Swahili word and the national motto of Kenya. It means pulling together or unity and it is the philosophy the people of Kenya try to follow and uphold. It was harambee that would guide our small group as we set out to try to make a difference in the lives of Kenyans.

Roughly twice the size of Nevada, Kenya is located in East Africa. Though it is one of the world’s major exporters of tea and has some of the most popular game reserves in Africa, roughly fifty percent of its population lives below the poverty level.

Preparation for our international elective began in January, when we began to meet weekly with Dr. Tom Kerkering to discuss disease states, treatment options, and logistics. No matter how much we prepared, we knew we would face many challenges. No matter what was to unfold, we were told one thing, “We are here for the Kenyans.” This was OUR motto; our philosophy for traveling halfway around the world.

As our plane taxied to a stop at Jomo Kenyatta International Airport in Nairobi, Kenya’s capital city, we knew it was for real. Once in Nairobi we visited the headquarters
The Underdeveloped World is not very Far from Home

That’s actually the title of a lecture I give about serving the underserved in remote and disadvantaged parts of the world. The unique thing about the presentation is that it juxtaposes data and photos related to my experiences in southwestern India with similar experiences in eastern NC. These two sets of communities and their people are more similar than they are different in many ways.

I present this information to encourage present and future health professionals to give serious thought to spending time on local health projects instead of in foreign mission health. Doing so has raised eyebrows, and questions have been raised about whether my outlook is too xenophobic. Nothing could be further from the truth. Especially for students, the opportunity to spend time observing and participating in health care abroad may well set the stage for their doing similar work here. But, if the problems are similar, why do I support going abroad? I do so not for the similarities, but for the differences.

Even in the most remote corner of NC, there are advantages that people in underdeveloped nations can only dream of. In India, during rounds, surrounded by the residents at a university medical center, we saw, among others, a young child with hemolytic uremic syndrome. He was sent there for dialysis and it had been done, once! He was then to be sent home with no plans for further dialysis because there was no funding from his family or from the hospital, and no health professionals in his community available to care for him. He was going home likely to die. Contrast that to eastern NC where by telephone, Internet, or even telemedicine links, consultation for this child could be made available. Medicaid, as inadequate as it might be, would pay for his care or if his disease was end-stage, Medicare would provide coverage. Air or ground transportation could be arranged, and if his kidneys never functioned again, a transplant would be a viable option. The comparison makes one appreciate what we have here and makes the isolation of rural practice seem so much less so.

On the other side of the world, we frequently saw that basic diagnosis usually only requires hands, eyes, ears and brain rather than CT, MRI, and an outrageous quantity of laboratory work. Spending time abroad makes it very clear that the diagnosis of appendicitis, for example, is most appropriately made through the diagnostic skills of the patient’s physician, and surgeon, and that waiting until the results of a CT scan might be known only increases the risk that the child will perforate before surgery.

Working with translators, understanding the real meaning of cultural differences, recognizing that what is easy for us to prescribe is not always easy for families to obtain, seems so much clearer in an international setting. So while “there is no place like home” I encourage students to broaden their horizons and walk for a time in some foreign shoes so that they’ll ultimately appreciate the good fit of eastern NC.
The toughest job I’ve ever loved, true to its motto, was serving in Peace Corps Honduras. Upon my return to NC and acceptance into medical school at Brody School of Medicine, I realized how much I missed development work.

A strategically placed bulletin-board promoting the Schweitzer Fellowship catches the attention of medical students en route to vending machines. However, the quote from Dr. Schweitzer grabbed my soul, “I do not know what your destiny will be, but one thing I know: the only ones among you who will be really happy are those who have sought and found how to serve.” To me service is more than volunteerism. It is putting the needs of others first in your thoughts, and to think of their needs from their perspectives. As I learned about the Fellowship, I realized Dr. Schweitzer understood grassroots development, sustainability, and the need to challenge oneself outside of one’s comfort zone to truly serve others. To find balance in my life I need to serve, not volunteer.

My project, LUPSA: Luchando por la Salud, was designed to ameliorate health care discrepancies within the Hispanic community through: Education, Medical Assistance Plan Enrollment, and Disease Screenings with Direct Care. LUPSA included a health educator’s manual with basic medical Spanish grammar, copies of materials used, and what I learned about creencias or cultural beliefs regarding health and medicine.

Since Greenville lacks a Hispanic Center, I spoke at a local church to over 700 Spanish speakers about asthma, diabetes, hypertension, substance abuse, first aid, and cancer awareness. I helped individuals without health insurance to complete medical assistance paperwork to finance medical visits, hospitalizations, and medications. Being non-Hispanic, it took weeks and several good words from Church leaders to gain the confianza of people to entrust me with personal information required for medical assistance enrollment.

Other Fellows, Church staff, and I organized hypertension screenings, cancer screenings, and a bilingual health fair. I designed Spanish materials including posters, pamphlets, and a children’s short-story I authored and illustrated about a little fish finding his place in his pond. In addition, I translated materials for other Fellows’ (former and current) projects that contributed to the fair. Child safety-seats, vaccines, disease screenings and activities were provided by the 70 volunteers to over 400 community members. My Schweitzer Fellow friends worked tirelessly during the eight hour fair, their enthusiasm and attempts at Spanish when awaiting interpreters filled me with admiration for their dedication to serve. I felt a warm sense of fellowship at 1:00AM the morning of the fair sitting with other Fellows in my kitchen, bagging hundreds of pamphlets and goodies donated for distribution. One Fellow called earlier to see if I needed help, and four others arrived without hesitation. It was uplifting to share company with people who understood why I drove 400 miles to find Spanish pamphlets that needed further revision to account for dialect and reading level variances. For me the Schweitzer Fellowship is sharing with dedicated people an unspoken need to serve the community just as much as finding a community to serve.

Upon completion of LUPSA I will continue organizing hypertension, diabetes, and cancer screenings, cancer screenings, and a bilingual health fair. I designed Spanish materials including posters, pamphlets, and a children’s short-story I authored and illustrated about a little fish finding his place in his pond. In addition, I translated materials for other Fellows’ (former and current) projects that contributed to the fair. Child safety-seats, vaccines, disease screenings and activities were provided by the 70 volunteers to over 400 community members. My Schweitzer Fellow friends worked tirelessly during the eight hour fair, their enthusiasm and attempts at Spanish when awaiting interpreters filled me with admiration for their dedication to serve. I felt a warm sense of fellowship at 1:00AM the morning of the fair sitting with other Fellows in my kitchen, bagging hundreds of pamphlets and goodies donated for distribution. One Fellow called earlier to see if I needed help, and four others arrived without hesitation. It was uplifting to share company with people who understood why I drove 400 miles to find Spanish pamphlets that needed further revision to account for dialect and reading level variances. For me the Schweitzer Fellowship is sharing with dedicated people an unspoken need to serve the community just as much as finding a community to serve.

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As a first year medical student, I was under constant pressure to learn as much as I could and to excel academically. However, I knew that to be happy with myself, I had to fulfill a desire to serve others and to keep sight of my ultimate goal, to become a well-rounded physician who believes in and practices service leadership. After reading about Albert Schweitzer, I was certain that the ideals of the Schweitzer Foundation ran parallel with my personal ideals and would help me on a journey to helping others. As a Fellow, I identified a need in my community and set out on the journey to help address that need.

In Collaboration with the Indian Education Program of Robeson County, I held my project, Improving our Future by Moving through our Past, in conjunction with their Summer 2005 program for Native American elementary and middle school students. My program was designed to promote healthy eating habits and physical activity. At every session, I emphasized the idea of W.A.L.K.

To be Wise in decisions they make when choosing snacks and foods, to be Active (exercise is key), to Learn about their role as caretakers of their bodies, and to Know the information so they can educate others.

Lupsa

ways of their ancestors and therefore, are not culturally knowledgeable resulting in low self-esteem which often results in a loss of pride of who they are. They are unaware of their great-grandparents’ daily lifestyle, the type of work they did, the types of foods they ate, the medicines they used, and the social activities they engaged in. My program focused on restoring that pride and teaching them a healthier way of living.

Originally, my project was designed to work with 50 Lumbee students, but by the end of the summer, approximately 300 youth had participated in my program. I sometimes wondered if my service made a difference? One day after finishing a session with a group of third graders, their teacher asked them what they wanted as a reward if they completed an activity she had assigned. She gave them choices such as potato chips and candy bars. A little boy raised his hand and said, “I would prefer to have fruit.” At that moment I realized I had, in fact, planted a seed!

Previously, I hoped my project would improve my Spanish, cultural competencies, and grant writing proficiencies. These alone are valuable skills for me as a future physician. My project provided linguistic challenges beyond improving my grammar, such as explaining mammogram procedures and interpretations during cancer screening events. When I learned Spanish in Honduras, such advanced technology was not available in my rural community. The Schweitzer Fellowship encouraged pursuit of sustainable work, which I found most gratifying. Providing education, helping other educators, and connecting individuals with resources to assist with financing medical care fulfilled my need for service.
Paving the Way for Seniors to Medicare Part D

When I first learned about the North Carolina Schweitzer Fellows Program, I thought back to a time I spent as a front office clerk in a family practice clinic, and how this experience clearly brought into focus the healthcare needs of my community.

I remembered being bombarded with questions and concerns about the addition of prescription coverage to Medicare: What exactly is the plan, What are the options, How will this affect present coverage? The patients who had questions at my office were confused despite their having access to information about the plan on television and the internet. Not only was the plan complicated, but it was apparent that those patients who lack access to Medicare’s website, or do not have televisions to see the advertisements would be left in the dark about the upcoming changes and how they would receive prescription coverage? I designed my project to target those patients whose only information about the Medicare plan would have to come through their doctor’s office. My goal for this project was to teach, counsel, and dispel some of the chaos that was inevitably looming ahead with the Medicare plan.

As my project progressed, I discovered that I was not teaching so much as I was learning from my patients about their struggles to afford medications. Many of my patients who were forced to spend their limited income on essentials such as food, leaving them with insufficient income to cover the costs of their prescription drugs. Inevitably, a majority end up with poorly controlled medical conditions. Their stories forced me to consider the effect this has on a patient’s quality of life, a factor I had not previously analyzed thoroughly. As health care professionals, we strive to improve a patient’s quality of life, but the very tools we use for this improvement can cause additional hardship through financial burden. A hypertensive patient who begins taking a pill for his blood pressure gains nothing in terms of quality of life if he must go hungry to afford the medication.

Though there are resources such as the Medicare plan to assist people, many still do not know how to access them and some don’t even know that they exist. I believe it is the role of the primary care physician to be familiar with the agencies and resources available, and to point patients in the right direction. Physicians may be the only source of information that many patients have, and are in a prime position to help them on their way.

When I arrived at medical school, I was prepared to be a lifetime learner, always keeping up with the latest in medical technology, pharmacotherapy, etc. After completing this project, I now understand the true meaning of the phrase. This lifetime of learning comes not only from books, journals, or conferences, but also from the patients we see every day, who teach us how to really reach people and affect their lives through medicine.

Into the Cradle of Life

of CCF-Kenya. We were warmly greeted. As is custom in Kenya, we were introduced to everyone there. We were told the introductions would take only a few minutes. Yet, an hour later we were still meeting staff members. An important lesson about traveling outside the United States, especially to a developing country, is to be patient with and respectful of your hosts. We were both. The employees of CCF were very excited to host us. Two of them, joined our team and accompanied us to our clinics. Simon Kaboki, who worked for a travel agency, would serve as our driver and guide. We all quickly became friends.
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On July fourth, our taxi driver took us on a ride we would never forget. “Oh, they’re for pedestrians.” replied the driver to Dr. Tom’s question regarding the purpose of red lights. There were many near misses but we arrived safely at the wholesale chemist to assist Betsy, Courtney, and Liz to obtain the medications we needed. We had brought many medications with us from Greenville, but still needed to purchase large amounts of anti-malarials, Bactrim and paracetamol (acetaminophen).

It was during this time that we learned a valuable lesson. Kenyans don’t like to say no. If the chemist wasn’t able to accommodate us or fill our order, she wouldn’t say no. Kenyans don’t want to lose face, so the way around this was to keep asking and rephrasing the question until you got a response that satisfied you. We learned this very well, and were able to obtain most of the medications we needed.

After five days of gathering supplies and finalizing our plans, we left Nairobi and headed west toward Lake Victoria and Rusinga Island—the site of our first clinic. This trip was to be our first glimpse into the countryside of Kenya. We planned to leave by 8AM but were behind schedule. Another lesson we learned was that time itself is relative in Kenya. One cannot be in too much of a rush, it would only cause ulcers. I’d have gladly left my wristwatch behind if I didn’t need it for the alarm, and for taking heart and respiratory rates at clinic.

Our drive from Nairobi to Lake Victoria would be about eight hours. It was an exciting trip! We had to descend through the Great Rift Valley, and continue driving through the Kenyan savannah. On the sides of the road, we saw herds of zebra and antelope, as well as Maasai tribesmen herding cows and goats. Some of these herders were as young as five!

One of our first observations along this stretch of highway was the large number of pedestrians. People walking! Hundreds of people were walking to and from market; to and from school. No other way to transport themselves, except by foot. We were traveling through areas of Kenya that tourists rarely see.

We were just as interesting to the pedestrians, as they were to us. We waved at each other.

After eight hours of off-roading we arrived at our destination before dusk. We stayed at the International Center for Insect Pathology and Epidemiology on the shores of Lake Victoria. On our arrival, it was time to reflect on the day’s travel and the sites we saw, but also to prepare for our first day of clinic. What would it be like? Would we be well received? Would we be able to help them? Would we miss something important? I was most worried that someone would die because of me.

Rusinga Island is one of the islands in Lake Victoria, and was the site of our first set of clinics. The island is only accessible by a causeway that was recently constructed. It is home to the Luo, the second largest tribe in Kenya. Diseases affecting the Luo include malaria, gastrointestinal parasites, and HIV/AIDS.

The Luo practice a tradition of wife inheritance. If a husband dies, a family member will inherit his wife. If she refuses, she will lose everything she has. In this region it is fair to assume that if a husband died of an AIDS-related illness, he probably infected his wife too. She will then pass to another family member whom she will infect. This is an example of how culture can negatively affect the health of a people.

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we were welcomed by singing school-aged children. “We are happy to see you, Teacher, Teacher!” they would sing while clapping their hands in unison. “So happy to see you, Teacher, Teacher!” Their singing brought instant smiles to our faces. We were welcomed to Rusinga Island!

My first patient was small for his age and weight. He appeared weak, as if he were wasting away. Dr. Tom and I looked at his age for weight and age for height indices. They were much lower than what would be expected for his age. He was not well. My first mistake—I sent him to Voluntary Counseling and Testing (VCT) for HIV testing when he needed to go to the hospital. Luckily, we were able to track him down, and get him to the district hospital. This child also had zinc-deficiency dermatitis, rarely seen in the US.

VCT is a government-funded HIV testing center. We referred patients there if they had a history of possible exposure to HIV, if they were suffering from conditions that result from HIV-related immunosuppression (like tuberculosis), or if they appeared very sick. I began sending every child who was an orphan to VCT because the parents probably died as a result of HIV/AIDS.

Tragically, we saw many orphans. These children were then adopted by other relatives or members of the community. Betsy referred one melancholic orphaned girl to me, due to my interest in psychiatry. It was very sad to see the lack of hope in this girl’s eyes. She represented the ever-growing problem of HIV in Africa: the loss of families, the loss of the workforce, and the loss of hope. HIV is devastating Africa. On our first day in Rusinga, we referred 15 patients to VCT, and nine were positive. What was even more frustrating is that we could do nothing to help them with HIV! Something I think about to this day.

The Luo people are especially susceptible to HIV/AIDS due to the custom of wife-inheritance and the problem brought by the Jaboya, who trade goods and services for sex. These fisherman, who fish the waters of Lake Victoria, dock at sex beaches where they trade their fish to women for sex. The women then sell the fish to support their families. Much, if not all, of the sex is unprotected, only spreading HIV more. There are efforts to stop the Jaboya, but it is hard for the women to give up what may be their only source of livelihood. It is truly a difficult situation.

Our first day of experiencing Third World medicine was exhausting. We examined almost everyone who visited the clinic, still some had to be turned away. We saw many

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cases of malaria and gastrointestinal parasites, but the laboratory shut down at about 3 PM because the sun was no longer shining into the lab. It is difficult to use the microscopes without a light source. We then treated patients empirically for malaria if they had clinical signs or symptoms, of fever, anemia, and headache.

That day, I examined Collins, a 12-year-old boy with a painfully swollen knee. We aspirated 30-40 cc’s of yellow fluid resembling synovial fluid consistent with gout. A twelve year old with suspected gout! John, his brother had rickets and HIV. The boys weren’t blood-related. Collins’ family left Rusinga for an unknown reason, and both of John’s parents died from HIV/AIDS. Though they were orphans, they supported and loved each other like brothers; a testament to their strength.

Day two saw much of the same as day one: malaria, HIV/AIDS, diarrhea and malnutrition. My teammate, Courtney made an interesting diagnosis. One of her patients had very noticeable hydrocephalus, and one of his pupils was pale. This was significant. It could indicate a retinoblastoma, a tumor of the eye usually affecting young children. She and Dr. Tom immediately set about getting some radiological images of this child’s head from CCF.

Although much more common, I saw a patient who probably had chronic obstructive pulmonary disease. He admitted to being a long-term smoker. We couldn’t do much to treat him, so I referred him to the hospital for a chest x-ray, and drew a no-smoking sign on a prescription pad. He knew what I meant!

Day three found us engaged in a turf war with a nurse who ran his own clinic on Rusinga Island. He didn’t want us there because we were taking money away from him. After much negotiation, he allowed us to use a portion of his clinic to set up our own CCF clinic. As said before, there is no such thing as NO! in Kenya. Everything is subject to negotiation! My first patient of the day was the mother of my HIV-positive interpreter. I felt honored that she wanted me to help her mother. We also saw a patient with Madura foot, a chronic infection from fungi or bacteria. This diagnoses, rarely seen in the United States often requires amputation.

The next day we saw a young woman with polio. She was probably in her early teens, if that old, but her mother brought her to our clinic for help. Her legs had long since atrophied and all we could do is show her that we cared. Dr. Tom took a picture and gave her a bottle of Coca-Cola to thank her for allowing us to photograph her. This was yet another example of our contact with disease states rarely seen in the United States.

I later saw a 21-year-old man suffering from five-years of poorly controlled rheumatoid arthritis. He had the characteristic hand joint swelling, as well as inflamed knees, and he was in such incredible pain. He was taking medication at one time, but his friends told him that the medication would negatively affect his sexual performance. We assured him that was pure nonsense. I wanted to give him 700 Kenyan Shillings so he could get to the district hospital for appropriate medication. We were worried that he might use this money for food or other supplies, so I gave it to one of the CCF workers who then helped him get proper care. My hope was once the pain was controlled, he would be able to take care of himself better.

By the end of our five days of clinic on Rusinga Island we had seen almost 1,000...
patients, which is 5% of the population! It was very difficult work. We experienced long days, frustrations with interpreters from Luo to English, long lines and hot weather. But we remained steadfast to our main philosophy of this trip… *Put the Kenyans first!* And we did. I was very proud of our team.

Day six was scheduled for patient education and HIV awareness. In the morning, we boarded a motor-powered boat and headed out to Godthi Island on Lake Victoria. One of our interpreters lived on the island and would row 45 minutes each way to help us. We were now visiting his island to offer health education to the school there. Each member of our team planned to speak on a topic such as hygiene, malaria, HIV, breast feeding, diarrhea, and skin care.

Most of the crowd, which included the island leadership as well as about 100 school kids, wanted to talk about HIV/AIDS. Dr. Tom mentioned that the virus originated on the African continent, and one of the elders, who appeared very frustrated, demanded to know which country was to blame! He was adamant that Kenya was not at fault!

That afternoon we made home visits to several patients living with HIV. Our first stop introduced us to a group of women with AIDS who had formed their own cooperative to raise money for HIV medications. They knew they could not rely on anyone else; so they took matters into their own hands. Together they farm a small plot of fertile land close to the shores of Lake Victoria. They also keep a few bee hives to sell the honey. They were doing quite well for themselves, and were very strong and determined!

The next patient we visited was in a much weaker state. He was only diagnosed in May, but appeared to have been suffering the disease for quite a while, and at this point he probably had AIDS. His clinic was more than ten miles away, and he had to walk there once a month. Because of his disease, he was only able to walk a short distance at a time before having to rest. He would start his journey before day break and arrive back home very late in the evening. But he was adherent to his medical regimen, taking his medicine correctly and regularly.

On Rusinga Island we saw many examples of resilience, strength, and innovation; but sadly we also saw the devastating effects of HIV/AIDS, malaria, and malnutrition. This war on poverty in Africa is very difficult. We made some small victories during our stay on Rusinga Island, but this war can only be won with better education, better access to health care and medicines, and by instilling a sense of hope, allowing Kenyans to look ahead to the next day and to the future.

From Rusinga Island, we drove north to Maralal, home to the Samburu people, which required us to cross the equator. Maralal was in the northern hemisphere, but would be much drier, dustier, and at a higher elevation than Rusinga Island.

Our immediate observation on our first morning in Maralal was the temperature. It was cold! It was probably in the 40’s or 50’s which one would not expect at the equator.
Before we embarked to our clinic site on this first day, we had to go through the formalities of a proper introduction. We met our CCF team. Then we met the district commissioner to officially get his permission to provide health care to his constituents. After this, we were introduced to Dr. Too, the administrator of the district hospital, who was very interested in applying to a residency program at the Brody School of Medicine. A relatively new physician, he told us he has already performed more than fifty appendectomies. One cannot graduate medical school in Kenya without becoming somewhat proficient in general surgical techniques.

The district hospital had a separate Manyatta, a village for patients with tuberculosis (TB). The Samburu are a nomadic people, thus making it difficult to treat a person with TB. Those diagnosed with TB are required to live in the village for two months. They can do anything they normally would do in a village, except leave its confines. This is Kenya’s alternative version of directly observed treatment, which is vital to ensure the health of its nomadic peoples.

Reaching our first clinic site required us to ascend 2,000 feet (by van, of course). This was done via poor roads, and then no

roads. But we made it to a clearing, with a Samburu village in the near distance. We were greeted by a few Samburu men, one with a machine gun and another with an older British 303 rifle. The Samburu men wore their red cloth wrap, while the women were adorned with many, many layers of beaded necklaces. The colorful beads, however, made it difficult to listen to heart and lung sounds.

We expected to see many of the same diseases as in Lake Victoria, with a few notable exceptions. Maralal is in a much dryer environment than Lake Victoria. Many of the people in this area suffer from a chronic non-productive cough (i.e., bronchitis) as a result. There are also many flies in the area which contributes to the higher incidence of trachoma. Because of the drier climate, we did not expect to see many cases of malaria, but we would look for this as well.

This first day was one of our most difficult days. We started at about 1:30 PM, and finished at 6:30 PM because the sun was setting. We still managed to see 230 patients, probably the entire population of the village.

My most memorable patient encounter of that day involved a younger woman with a two-year history of stomach pain. I asked her more about her symptoms, as well as going through

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a complete review of systems. I asked my interpreter to ask this woman about her last menstrual period, but he would not do it. He said it was not proper. I asked a CCF worker to ask her. He also was not comfortable with my request. I then asked a woman standing in line to ask her. The interpreter asked questions regarding menstrual history to this random woman in line, in front of my patient, and this woman would then ask my patient the same questions she had just heard! It turned out that this young woman was suffering from dysmenorrhea. I gave her a prescription for Motrin and referred her to a gynecologist who would be visiting the district hospital in the coming week.

The next day we drove into the mountains for an hour-and-a-half. For a moment, I was sure the van would tumble off the cliff. It was nerve-wracking, but I knew Simon would not let anything happen to us (or his van)! Our clinic was at a primary school at a high elevation. My last patients for the day were memorable, a family of four, a mother and her three children. All three of the children had scabies and impetigo. It was easy to identify the scabies, because of the sores between the fingers, but there was one factor that made this patient encounter a very difficult one... FLIES! Scores and scores of flies! The flies covered the mother and her children, and also began crawling on me. It was very difficult to concentrate on lung and heart sounds with flies crawling all over my face and arms.

In this region of Kenya, the flies are not considered a nuisance. Instead, it is a symbol of status. The Samburu tribe, like the Maasai of the southern region of Kenya, are nomadic herders, where the number of cattle and goats signify the wealth of that person. As a natural process, the cattle and goats attract flies. So logically, the more flies a person has then the more cattle and goats he or she must possess. Unfortunately, the flies bring disease, especially trachoma, which is a major cause of blindness in the developing world.

On day three, we drove an even longer distance in another direction. This time the terrain was flat and we could see for miles. The sun reflected off the grass making it appear golden. It was beautiful. We again set up our clinic at a school. There were only a few patients at first, but word quickly spread. We worked through lunch in an effort to see as many as we could.

I had a patient I believed to suffer from generalized anxiety disorder. We had nothing to help her except a multivitamin and the strong suggestion that it would help her when she started feeling nervous. I was counting on the placebo effect to work for her. She had many children, and probably not much help with them. It was apparent that she cared for them very much, and seeking treatment for herself was an afterthought. I hope we were able to help her find some relief, even if only through a multivitamin and strong words of encouragement.

After lunch, Simon drove us to an escarpment overlooking the Great Rift Valley. It was green with breath-taking distant mountains and rolling hills. Believed to be the Cradle of Life, we were awed by this magnificent geological expanse. It was as if we were looking back through time. The Samburu people also gave the impression of an earlier time. Many of them practice the same style of herding and living as did their ancestors generations ago.

The fourth day found us driving on muddy roads. We again used a school for our clinic site, but this time it was a regular school day. When we arrived, children of all ages greeted us. I think they were very curious to see what we were up to. Dave and I were on triage which required us to take vital signs as well as move sicker patients quickly ahead through the line.

We were having a particularly difficult day. The room was dark and the line was getting longer and longer. This already stressful situation was made worse with the difficulty in getting patients to place the thermometer under their tongues! We had an incredibly frustrating time this particular day in taking temperatures. It became apparent to us that...
Our experience in Kenya gave us an opportunity to improve our physical examination skills and our ability to diagnose disease without the luxury of imaging studies or a multitude of laboratory tests, while opening our eyes to a whole new world.

The concept of forming a single line was not a standard practice to the Samburu. I think the stressors of the trip and the pressure of trying to see more than 250 patients each day started to build within all of us. I still regret feeling frustrated that maybe I let these patients down. We wish we could have done more. Unfortunately, our resources were limited, as was our energy and the light source. As was the case on Rusinga Island, when the sun went down, we were no longer able to work in the classrooms or use the light microscope to diagnose parasites.

We began to realize our time in Kenya was drawing to an end. It was upsetting that we didn’t have any more clinics; that we weren’t able to provide more health care or to dispense much needed medications. Did we make a difference? We saw almost 2,000 patients, but there was so much more to be done. Just as we were becoming comfortable with our roles, it was time to leave.

Thus, our clinical experience was over. People ask us why we would want to go overseas when there is so much to do here in North Carolina. This is difficult question to answer. Many of the CCF workers, were surprised and shocked to hear that there are impoverished areas of the United States that compare to areas of Kenya and other developing countries. I also think about the fact that some counties in eastern North Carolina have very few doctors, if any. Then I reflect on the devastation caused by Hurricane Katrina, where health care workers were working without many of the medical technologies we take for granted. Our experience in Kenya gave us an opportunity to improve our physical examination skills, and our ability to diagnose disease without the luxury of imaging studies or a multitude of laboratory tests, while opening our eyes to a whole new world. This trip has truly changed our lives forever. I long for the day when I return to Africa.