TANZANIA DIARY

Mountain to climb: Despite the natural beauty of the country, health care in Tanzania remains spartan

Out of Africa

In a trip that was both inspiring and tinged with sadness and helplessness, **Mr John McGrath** recalls his eye opening sabbatical to Northern Tanzania

DAY 1
Sat for two hours in the pouring rain outside KLM freight department at Heathrow. Finally loaded the medical equipment into the cargo bay before looking away in pain as the pallet was raised skyward by a forklift truck. It was a precious cargo, put together by Mr Ruaraidh 'Ru' MacDonagh and I over the previous months and made possible by the generous donations of Olympus UK and the expertise of Ray Biggs, our hospital medical electronics genius. Not confident about the chances of a safe reunion.

DAY 2
Up at 4am to check in for flight to Kilimanjaro Airport. Any concerns about getting cystoscopes through as hand luggage unfounded, as not even searched. Difficult to imagine what they thought a collection of six-inch metal barrels were on the X-ray scanner. Bought two bottles of Bombay Sapphire gin to bolster the anti-malarial prophylaxis and boarded the flight.

Amazed by the sheer size of the Sahara Desert – nothing to see except sand for over three hours. As landing time approached, my wife, Emily, and I became increasingly apprehensive about the three months ahead.

The lights of Moshi town came into view as we descended, followed by the darkness of the barren Maasai Steppe. Straight through immigration – so far, so good. However, no sign of the hospital driver and 48km of road ahead of us. A few negotiations with Mr Moses, 'chairman' of the taxi firm, US$50 less in the wallet and we were under way with our driver and his superfluous co-pilot.

A thunderstorm broke and sheets of rain poured down as we joined the main route to Moshi. Particularly troublesome as we had all the windows open due to the stench of petrol inside the car. The lightning was making me uneasy.

Reached Kilimanjaro Christian Medical Centre (KCMC) about 10pm, passing the premises of 'Godmark Graveyard Furniture' outside the gates. Drove around several times before finding the accommodation officer's house. Embarrassingly, I couldn't get out of the car, as all the handles were missing and she was clearly put off by the smell of petrol coming from the back seat.

Finally collapsed into bed under shelter of mosquito net – very hot and humid with the deafening night sound of crickets.

DAY 3
Form-filling extravaganza – resident's permit, hospital registration, accommodation papers, and so forth. Told we needed four passport photos each, so set off on our first challenge into Moshi town. Joined 27 other people and a box of live chickens in a dalla-dalla (minibus) and upset the driver by pulling the side-door off.

International relations restored by handing over a dollar for the trip – too early to know it should cost ten cents. Found a place offering passport photos, complete with an impressive selection of hairbrushes for the client.

Back at the hospital, met with Dr Jasper Mbwambo, head of urology, and arranged to meet for the ward round tomorrow.

Joined Emily at the Regional Dermatology Training Centre, where we met Prof Henning Grossman (head of department) and Dr Claire Fuller, a dynamic consultant from King's Hospital on a year's sabbatical. Bought two dozen bananas on the way home for equivalent of 20p – apparently overcharged.

DAY 4
Rainy season has taken hold. Walked to work in overtrousers and raincoat, feeling like a Himalayan explorer compared to the locals, who use banana leaves as umbrellas. Became taller as the mud congealed on the soles of my shoes.

Reached the urology ward where all patients were dressed in identical brown, cotton pyjamas with 'KCMC Urology' printed on the front. Flasks and food containers brought in by family members lined the bedside tables, as meals cannot be provided by the hospital. Dr Mugalo led us in prayers and we headed off to see 40 or so patients.

Amazing array of conditions from simple prostate enlargement to complex urethral strictures, schistosomiasis, vesico-vaginal fistulas and children with posterior urethral valves and Wilm's tumours. Wounds were 'expressed' in turn and laid open on account of a relatively high infection rate.

Upset to see a four-year-old boy with an abdomen full of masses, so far indistinguishable from his own organs on ultrasound scan. No CT available, so a repeat scan was requested if his parents could afford it.

To be put in the position of deciding if you can afford your child's medical care didn't bear thinking about. Child looked as though he may have HIV and hence lymphoma.

DAYS 5 TO 8
Easter weekend. Considered the stark contrast of health care in Africa with that at home – many in Africa will not receive basic treatment because of inability to pay as little as 25p.

Emily tried to teach me some Swahili and sent me out to trial my new phrases in Moshi market. Basic misunderstandings led to a very large bag of runner beans and more bananas. Got a feel for hectic street stalls, friendly locals, fumes from antiquated cars and sticky humidity.

DAY 9
Soaked again. Like the NHS, a few less patients on the ward after the bank holiday weekend and a huge backload of work.

An old man, voiding after a transurethral resection of the prostate (TURP), had been kept in as his family had not raised the money for his bill. To add insult to injury, his bill was increasing as he waited for family to rally round.

Repeat ultrasound scan on the four-year-old boy was again inconclusive so empirical chemotherapy was started from a batch of donated drugs from Holland. Giving a child chemotherapy in the UK on the 'presumption' of lymphoma is unthinkable.

Revised a vesicostomy on a five-month old baby boy with posterior urethral valves, then completed a TURP with one of the trainees. Had to work by eye with no camera system and kept steaming up because of the temperature in theatre. Struck by the percentage of medical needs that are unmet and our 'disposable' culture with equipment back home.

DAY 10
Went to the clinical meeting, a weekly event attended by all medical and paramedical staff. Introduced ourselves to the audience but overshadowed by 30 Swedish medical students, half of whom were called Anna, who individually described their backgrounds and their elation at being in Africa.

Challenging lecture by Prof Alan Foster about a global project (Vision 2020) designed to restore sight to 85 per cent of blind people in developing countries.

Uncomfortable to hear the project would cost £90m per year for ten years, whereas the funds designated for rehabilitation of Iraq are estimated to total £900bn. Asked to consider if funding such a project is a 'favour' to the developing world or meeting our obligations to a basic human right to sight.

DAY 11
Very anxious doing prostate surgery with only one unit of the patient's own blood available (autologous donation is the only reliable means of transfusion). List ended prematurely as ran out of irrigation fluid. Ran a journal club at the request of the trainees – impressed by their motivation to learn.

Crowded into a dalla-dalla bus again and gutted to see the old man who couldn't pay his bill struggling on board with his catheter bag concealed in a plastic bag.

DAY 12
No rain and the first amazing views of Mount Kilimanjaro. Incongruous to see a snow-covered peak rising to nearly 6,000m just south of the Equator. Spent the day at Kilimanjaro Airport negotiating the release of the medical kit from an obstructive and corrupt import agent. Also angry at having to enter into dodgy negotiations. However, unable to risk losing the equipment and feeling outnumbered. Cynicism begins to bite.

DAY 13
Met up with a German surgeon working at the district hospital where I am due to visit and agreed to travel together on the following Monday with the equipment. He has 30 years' experience in Africa and I feel relieved to have his company. He tells me the condition of the hospital is likely to shock me. Now apprehensive about working there and leaving Emily in Moshi.

DAY 15
Received a warm welcome from Dr Adam Groeneveld, an accomplished Dutch-trained urologist and head of the Association of Surgeons of East Africa Institute of Urology. Challenged by his vocational desire to train East African surgeons.

DAY 17
Did a couple of retropubic prostatectomies, an operation now infrequently practised in the UK compared to TURP. Finding ward care frustrating at times as individual accountability by staff is not a prominent feature day-to-day.

DAY 19
Attempted cystectomy with

Adam on a young man with extensive squamous cell cancer of the bladder secondary to schistosomiasis. Unable to mobilise the tumour from his rectum so decided not to divert his obstructed ureters. No provision for radiotherapy, hospice care or counselling.

DAY 22

Set off for the east coast to work in the district hospital. Loaded the four-wheel drive and headed out across the Maasai Steppe, soon reaching the foothills of the Pare Mountains. Two hours later, after endless crops of sisal, began the journey south along the Usmabara Mountains. As night fell, the villages were lit by the glow of kerosene lamps and charcoal fires before the nightglow of coastal villages heralded the provision of electricity once more.

DAY 23

Woke early to see a stunning bay with small fishing boats combing the inshore waters. Eggs, mango and coffee for breakfast then walked the short distance to the hospital. Declined a lift on the back of a passing bicycle, but thanked the owner.

Taken aback by the state of the hospital with dilapidated buildings, windowless wards and overcrowding. Seemed to be a predominance of trauma – all types of rudimentary traction, several open fractures and few basic measures such as simple elevation.

Assessed several patients for prostate surgery, but personal feeling of great reluctance to provide anything other than emergency care in such circumstances. Decided to inspect theatres the following day.

DAY 24

Theatres worse than expected, with no oxygen or diathermy, a single suction machine, a handful of instruments and only ether as anaesthesia.

'The only evidence of it being an intensive care unit was the fact that it had a doorbell. There was no oxygen, no monitoring and only one trained nurse'

Operated on a young woman who had sustained bilaterally ligated ureters during an emergency hysterectomy for a ruptured uterus of pregnancy. Lost suction halfway through to an emergency caesarean section.

The local surgeons had less urological experience than we expected and without doubt it was the hardest day of my surgical training.

Left two large drains and followed the patient to the 'intensive care unit'. The only evidence of it being an ITU was the fact that it had a doorbell. There was no oxygen, no monitoring and only one trained nurse. Contacted my boss Mr Ru MacDonagh – who is also vice-chairman for Urolink (see box lower right) – desperate for his advice.

DAY 25

Young man died during the morning before we could get him to theatre, following a traumatic amputation of his leg by a crocodile. Seriously re-considering the wisdom of plans to teach elective urology, as basic needs of the hospital are unmet and emergency care barely established.

DAY 26

Spent the day repairing flexor tendons with German colleague on a father and son who had been wounded by a machete. Email communication with Ru again and glad to have his advice, demonstrating – as ever – his ability to read into an alien situation with alarming accuracy. Exhausted and struggling with the right thing to do – is doing your best enough in this environment? It doesn't feel like enough.

DAY 30

Despite months of preparation, it was to my relief that the endoscopy equipment I had brought had developed a temporary electric fault in transit.

It was inappropriate for our situation and could be used more effectively elsewhere. Disappointment would soon follow, but for today it was simply relief.

I corresponded with Ru once more and suggested we had miscalculated and that the hospital needed very basic equipment, rather than the high-tech equipment it had requested.

Particularly concerned the equipment would do more harm than good, as the vital infrastructure required to support an endoscopic service was not in place.

Spent the night considering how to approach the next few days and felt weighed down by the enormity of removing any equipment from such a deprived setting.

DAYS 31 TO 34

A very difficult few days explaining our rationale for revising objectives. Suggested we needed to help improve basic facilities prior to teaching specialised procedures. Not much operating done as ran out of anaesthetic agents temporarily and lost another day's operating due to a power failure. Drove back to Moshi feeling deflated.

DAYS 37 TO 41

Resumed work at KCMC. Assisted in uretero-sigmoidostomy urinary diversion in a nine-year-old boy with bladder exstrophy. He had a previous failed repair as a baby but it had taken eight years for his parents to save enough money for the second attempt. In the interim, the child had been wet. Seemed unfair that the family were put under financial strain by a failed first attempt.

DAYS 42 TO 43

Safari in Arusha National Park, where there were lots of giraffes, zebra, buffalo, hippopotami and vervet monkeys with strikingly blue testicles. Message from Dr Groeneveld that AMREF, the flying doctor's service, could offer me a week observing vesico-vaginal fistula (VVF) repairs in Dar-es-Salaam. Managed to arrange a flight the next day from the local airport.

DAYS 44 TO 48

Flew to Dar and took in breathtaking views of the Zanzibar Archipelago and coral reefs. Take-off was like a minibus doing 160mph down a Devon lane and becoming airborne. Met Thomas Raasen, a close friend of Adam's, who has become the leading VVF-repair specialist in East Africa. Spent a privileged week seeing four repairs a day and learning how to perform a procedure done so infrequently in the UK that adequate exposure as a trainee is almost impossible.

DAYS 49 TO 50

Spent two dreadful days inspecting the toilet bowl at home and feeling I may die. It was the gastrointestinal equivalent of 'boy-flu' and just as serious.

DAYS 51 TO 52

Passed the illness on to Emily – can't have been as severe as she didn't make any of the dreadful groaning sounds or incessantly talk about how she might die. Must have been a less virulent strain and unlikely to be related to the gender difference in coping with illness.

DAY 53

Stalled the four-wheel drive in Moshi in the middle of the main market – mortified. A local teenager got under the bonnet, diagnosed a worn lead to the battery then proceeded to strip a new piece of wire with his teeth, having first bitten it to length. Suitably compensated, he waved us off with both parties happy.

DAY 54

Difficult nephrectomy on an eight-year-old boy with a Wilm's tumour and HIV. Incompletely resected so given intra-operative chemotherapy and scheduled for further doses, if available.

DAY 55

Travelled to Selian Lutheran Mission Hospital in the foothills of Mount Meru. An off-road drive for the last few miles guided by the local anaesthetist, who had hitched a lift in the village.

Expected to simply introduce myself and arrange a future visit, but a list of cases had been prepared. Instead, did a couple of retropubic prostatectomies with their 'resident' then joined Paul Kisanga, the local general surgeon, to do a TURP with the oldest endoscopic equipment I had ever seen.

Drove back down the hill with my cargo of one anaesthetist, two ward sisters, a lab technician and a mystery passenger nobody could identify.

DAYS 63 TO 65

Climbed Mount Meru (4,500m) with Emily. Three days up and one very long, painful day down. Worthwhile for breathtaking views to the east, seeing the sun rise over Mount Kilimanjaro with the cloud base thousands of feet below.

DAYS 66 TO 70

Reviewed a five-year old girl with an extensive tumour extending from her thorax into the chest wall and abdominal cavity. Almost too breathless to eat the soup her relatives had brought. Histology was inconclusive and chemotherapy started empirically by the team.

Almost couldn't bear to visit the paediatric ward the following few days as she got weaker and developed lower limb paralysis. There is a great sense of helplessness, yet it is difficult not to become immune to the situation.

Dreadful end to the week when a young girl admitted from a distant region with vaginal bleeding and overt sexual abuse. No apparent facility to take the child out of the situation and no police involvement because mother, father and daughter all denied abuse – very rudimentary counselling of a frightened child. Nurses informed me some local witch doctors advise fathers to sleep with their youngest daughter to guarantee wealth and happiness.

FINAL WEEK

Nostalgia phase and great sadness at the prospect of leaving Africa. By Tuesday we have already operated on Wilm's tumours, hypospadias, vesico-vaginal fistula and urethral strictures, yet it has the feel of a routine week. A trip outside of my comfort zone has made me reconsider my own circumstances.

I have more questions than answers and experienced uncomfortable as well as inspiring moments. Many good friends will be left behind but we have already priced return flights to Kilimanjaro . . . just out of curiosity. HD

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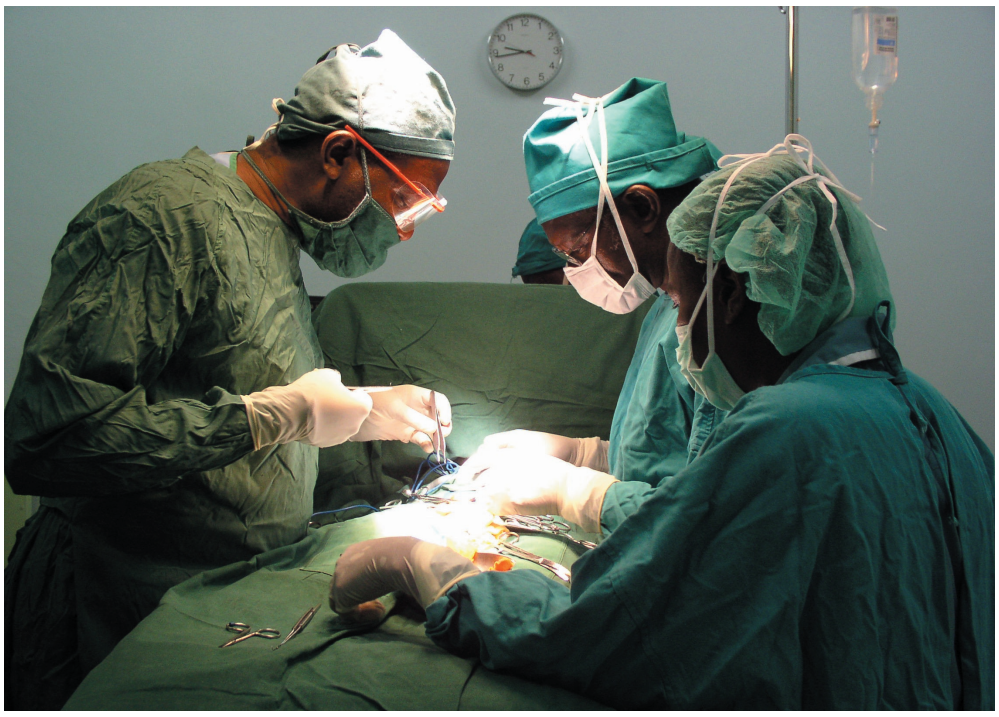

Back to basics: Local hospitals sometimes lacked facilities for even the most rudimentary procedures

UROLINK

Mr McGrath's trip was supported by Urolink, a sub-committee of the British Association of Urological Surgeons, and assisted by the Senior Urology Registrar Group/Urolink Travel Award.

The remit of Urolink includes promoting the provision of appropriate urological expertise and education particularly in the developing world. The organisation provides books, equipments and advice to overseas members.

It aims to encourage training and teaching links between the UK and overseas departments. For example, Mr McGrath is assessing the feasibility of establishing formal twinning links with a number of centres in Tanzania.

web www.baus.org.uk
www.surg-online.net

ref Setting up a twinning link: British Journal Of Urology International 2002; 89(Suppl 1): 13-7