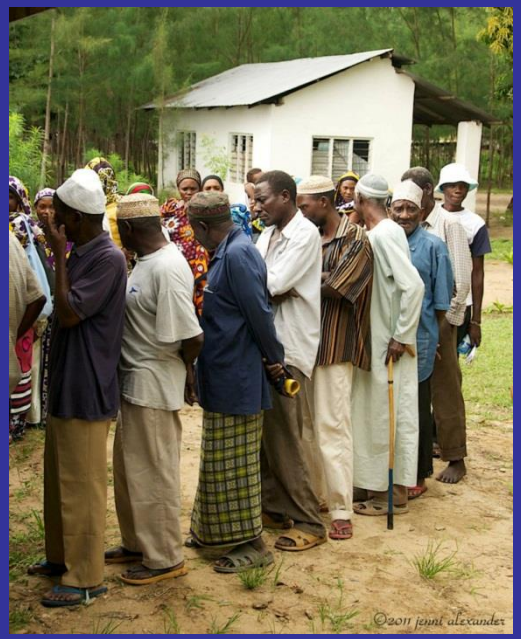
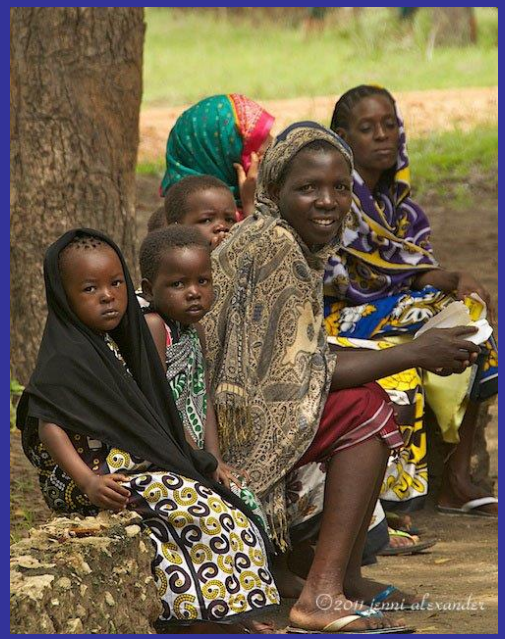
Annual Rural Healthcare Outreach Programme in Kenya 2009- 2013.





Joint RCN/Travel Health Training Ltd
Travel Health Conference

Saturday 13th September 2014

Karen Rudd RGN BA
Diploma in Travel Medicine [UCL]
Certificate in Travel Health [ISTM]

Who am I and why do I volunteer in Africa?

Group 269
QESN
Birmingham

Then Life Happens

So what changed?

- I had an epiphany when helping my son research and find a suitable volunteering organisation and spend some of his gap year in Africa before starting Uni.
- One company stood out for me as being ethical, responsible, and established, with a proven record of starting and maintaining projects that are beneficial and sustainable.
- They have a unique system of purpose built camps, co-located, integrated and in partnership with rural communities NGOs and wildlife reserves.
- They would clearly provide a wide ranging experience for my son, but also benefit the local communities and economies and provide employment for many locally.
- In addition they had adequate security, health and safety policies, and well worked out extraction plans if needed.

Aaron plants the seed!

- Aaron spent 3 months working on various construction, and conservation projects and sent me pictures of how little healthcare the rural villagers could access.

- Muhaka Dispensary had no clean water, no electricity, and very few pieces of medical equipment, but nurses based there were expected to deliver babies, immunise and run TB clinics and treat malaria!

- I then contacted Camps and asked why they did not do any short term medical outreach work as many health care professionals could spare 2 weeks and they obviously had the required contacts, infrastructure and logistical expertise?

CI gave me a challenge Immediately!

They said:

- ‘find 20 nurses or health support workers who are willing to fund themselves or fund raise to join a 2 week medical outreach programme and we will liaise with the Kenyan Ministry of Health, and NGOs and organise a Programme!’

That same evening: I posted on-

- ‘Any body interested in a 2 week gap year nursing in rural Kenya?
- I had 50 replies from Nurses throughout the UK within 30mins!

And So the outreach Programme was Born in 2010, The first expedition of 22 health care workers was in November 2011.

Expectations of UK Nurses

- **We had no idea what we would be required to do, allowed to do, or what would take priority.**

- **We knew that in rural Kenya, around 70% of people are living below the poverty line and access to proper sanitation, clean drinking water, healthcare and an education are often limited or non-existent.**

- **According to a UN sponsored population study of Kwale state, between 2005 and 2010:**

- **INFANT MORTALITY RATE (IMR) 70/1000**
- **UNDER 5 MORTALITY RATE 118/1000**
- **MATERNAL MORTALITY 650/100,000**
- **HIV PREVALENCE RATE 25%**
- **LIFE EXPECTANCY 51.2**
- **DOCTOR/PATIENT RATIO 1:82,690**

http://www.kecosce.org/downloads/KWALE_DISTRICT_STRATEGIC_PLAN.pdf

What did our Kenyan Colleagues expect from us?

- Local camps staff, Medical staff, Nursing staff and politicians had no idea how the programme would be received or whether the community would attend?

- Some of the Nurses and technicians were brought in from Mombasa and had never been to the rural areas them selves and were as nervous as we were.

- Others based within the locality thought the local population would not trust us as they did not trust modern medicine and relied heavily on traditional tribal medicine men rather than Kenyan HCPs and especially women.

What they got was:

- A group of British Nurses, many of whom had never left the UK before or travelled outside the developed world who said:

‘Do whatever you want with us…. No job is below us …. Just give us something useful to do!’

Those of us that had travelled widely did not expect to be able to make a difference in 2 weeks but we thought we might be able to treat this as a ‘recce’ and improve things identifying rolling programmes.

Mombasa to Diani then Makongeni

Scary ferry ride longest 15mins of my life!!

None of us could have envisaged how many hours we would spend in an open ex- army truck for 2 weeks in rural Kenya when it collected us from the airport!

Mixed accommodation greeted us upon arrival in Makongeni which is 50 miles on almost non existent roads from Diani on the coast south of Mombassa. We had travelled for 30hrs!

TENTS versus BANDA ?

Accommodation continued

- The Banda beds!

Amenities

Cold showers with stored rain water and two toilets in Camp but long drops when working in villages

Communal area with a roof but no walls where the next days work was planned and meals were served. There was a supply of treated drinking water or soft drinks/bottled water/tusker beer purchased from fridge.

High Security Camp
surrounded by electrified fences to keep wild animals out

We were informed on arrival that our clinics would be

- Offering treatment for all villagers simultaneously for:

- Jigger infestation
- fungal skin infections
- And helminths (worms)

- Nurses and health care assistants with a treatment room background quickly volunteered for this.

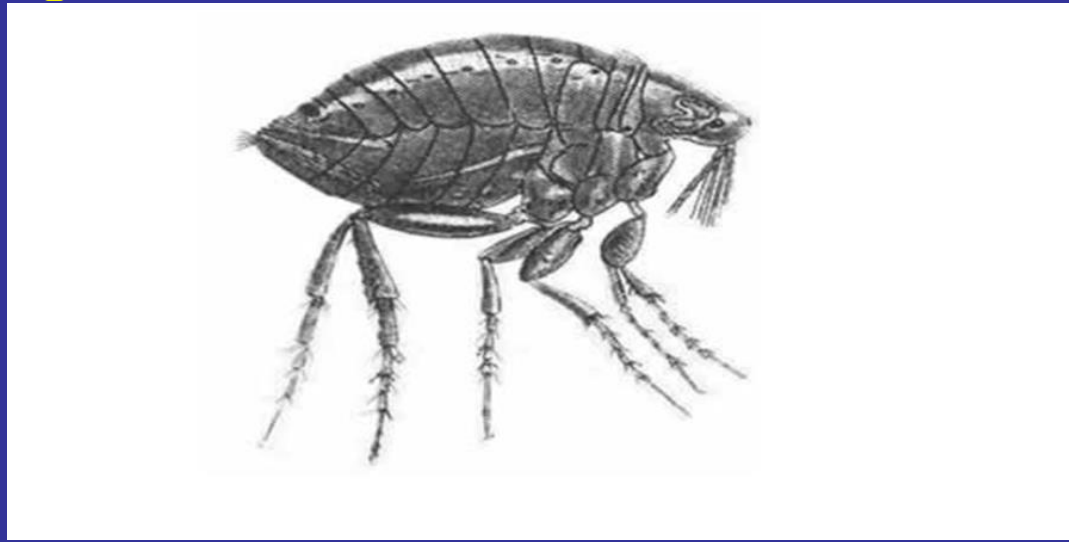
- Those of us who could prescribe medications and diagnose the common minor illnesses and common tropical diseases or give family planning and sexual health advice were nominated to consult.

- A third group would run the mobile dispensary and dispense medication.

- Each group was supported by Kenyan HCPs and interpreters.

What are Jiggers? [Chiggers]

- A sand flea



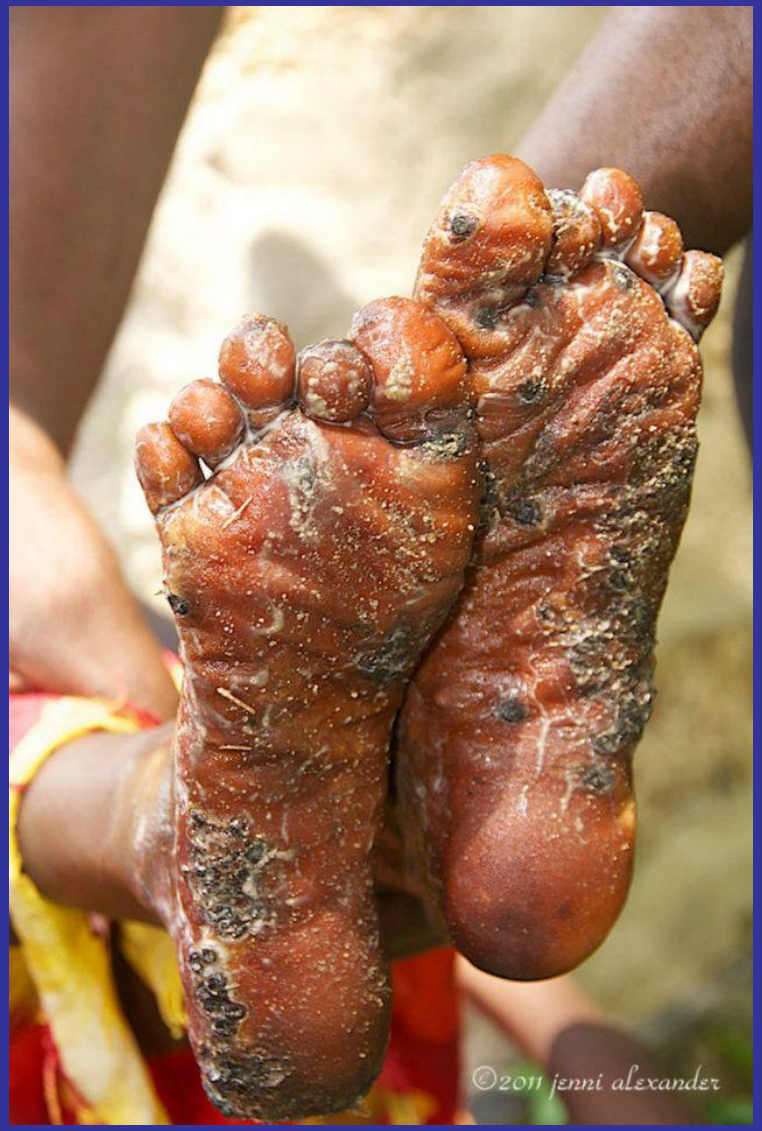
- They are very small with an angular body and head. The female will burrow under the skin of toenails and fingernails

- Huge consequences if left Untreated .They cause pus-filled sores, itchiness, disabling pain, inflammation, and ulceration and many missed days at school.
- (heavily stigmatised)

Ultimately gangrene, sepsis, auto amputation, and death can result.

The good news is the cost of treatment is less than a £1 per foot!

We were taught how to treat Jiggers on the 1st evening



1000s of villagers turned out and it was back breaking work for the ‘Jigger girls’

Ellie my daughter was one of them!

She fetched gallons of water from wells,

Washed filthy feet infected with jiggers and often with secondary bacterial infections.

Then soaked them in potassium permanganate to kill the fleas

Then finally applying copious amounts of emollient to suffocate any surviving fleas

Each child was then given a new pair of flip flops so that they were not immediately re-infected.

Never enough bowls to go round!

The community could not believe we would wash their feet!

This woman has severe malnutrition and also has malaria as does her infant and both were rushed to hospital that day

but she insisted on having her jiggers treated first!

Education

The Jigger Girls would then teach older children and adults how to repeat these treatments and equip them to treat their homes with small containers of potassium permanganate. Most importantly to stop using shared needles and pins!

They also treated all of the classroom floors.

Last year some volunteers also fumigated homes and schools and this has been repeated at intervals

Trialling new methods since 2013

Use of potassium permanganate / antiseptic solutions are too expensive to be sustainable for self management.

Several trials currently taking place including, kerosene soaks, kerosene and vegetable oil soaks and footbaths installed in every school.

- Provisional reports are suggesting these are viable alternatives and being followed up every three months by the now established rolling programmes carried out by the various NGOs that we are now partnered with working together rather than independently of one another.

De-worming and antifungals are given to every child

- Nearly every child in every village visited needed these. Current plans since 2013 are to make meds available to community workers in each village to

Consultations

My most memorable consult from 2013

Adult consultations included multiple problems

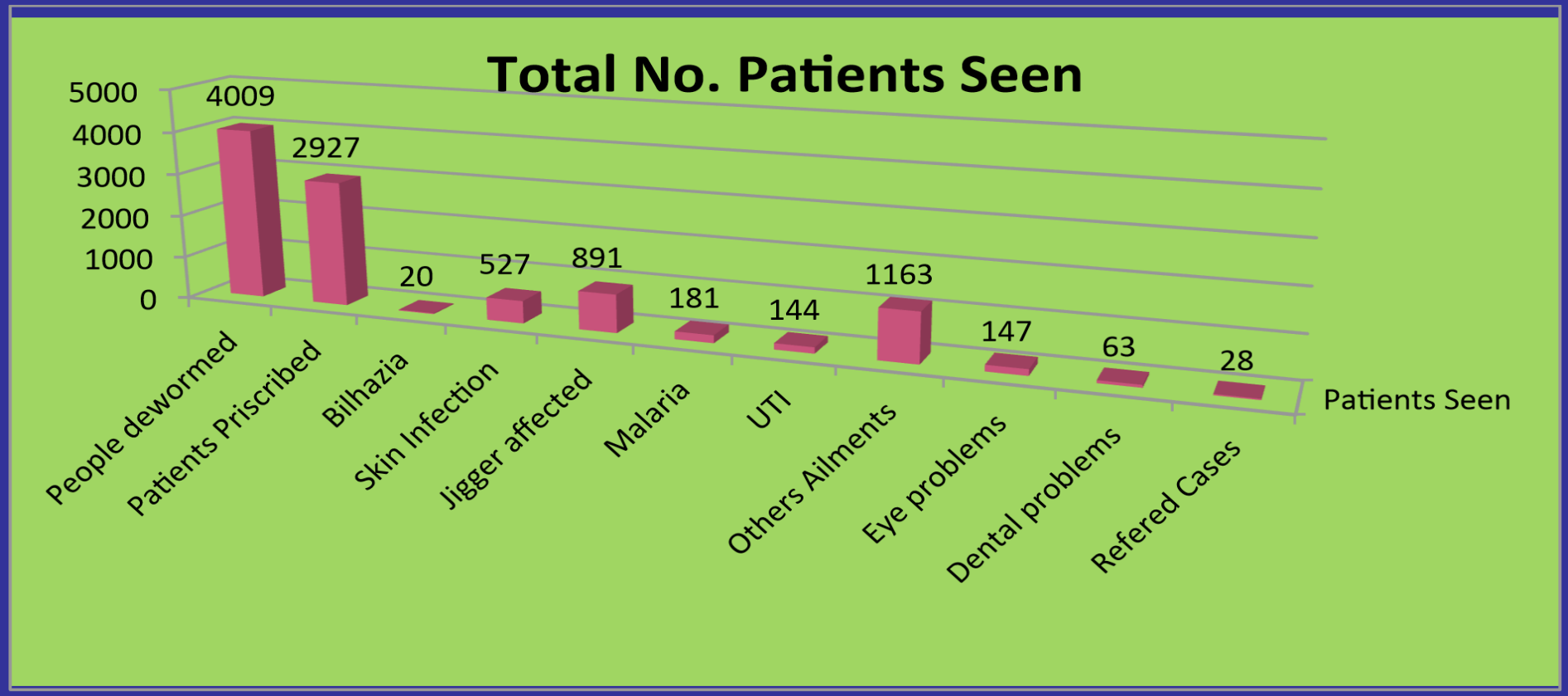


Figure 8

Most common diseases found were fungal skin infections, jiggers, Malaria, (UTI), malnutrition, (URTI& LRTI) Bilhazia, eye/ear infections, joint pains, jiggers, pelvic infections:

Referrals were made for ?typhoid, leprosy and filariasis, one woman was admitted as a obstetric emergency and several men referred with inguinal hernias. TB and HIV very stigmatised and underreported still.

Stigma

- Even those who knew they could get free treatment would not seek it as TB and HIV has a stigma attached within the village.

- Women particularly were cast out by their husbands with their children and many would not have survived without CI intervention.

- They set up a community of such women and enabled them to care for themselves and their children whilst getting treatment by setting up a fishing industry in the mangrove area of the village!

HIV/TB support

- This is an area that has improved over the last three outreaches and we now have A public health Consultant who will see all suspect TB/HIV patients within the outreach

- The field laboratory staff now collect samples including sputum

- We have been able to treat all cases of schistosomiasis over the last two years if testing positive in the field lab. Incidence has fallen greatly since our first outreach and this must be largely due to the education we give and numerous toilet blocks provided by Camps International and built by young Gappers.

This is me eagerly awaiting the chance to see a schistosome !

Malaria screening

- To make sure that anti-malarial drugs are used more efficiently we now have access to rented microscopes and malaria films are taken from everyone with a fever, and only those with parasites are treated.

- RDTs are also useful and we only use the two brands advised by Prof Peter Chiodini. Fundraising always required for this as there are never enough though some are govt supplied.

We have obviously got much better with experience and 70% or all those we suspected had sufficient parasite loads to require treatment, and advice and education were heeded in that 15 people returned within 48 hrs and were diagnosed on their second test.

Additional services in 2013

- In addition to continuing previous work we had the additional help of Kwale Eye centre, who examined everyone with ophthalmic problems and dispensed the many pairs of donated glasses we take out with us, and diagnosed and treated or arranged treatment of other ophthalmic conditions such as cataracts.
- We had the Red cross teaching first aid
- And we had a very popular dentist!

Not all sadness and illness

- These villagers had nothing, but would share anything.

- Nothing was thrown away and all welcomed us with a friendly ‘Jambo’ once word of our 1st clinic got out.

- We were greeted with cheers and smiles everywhere our Army truck went. Even in the supermarket where we bought every pair of flip flops in the place!

Entertainments officer

Many villagers queued and waited for hours some having walked long distances

We worked 6am to 11pm 5 days/week with occasional R&R

Learning to dance with the Masai one evening

One day and night on safari in Tsavo

Not luxurious safari!

TSAVO ….Not a good place to break down

But another photo opportunity before the soldiers walked us to a safe area while a mechanic sorted out the truck.

This small 1st team of pioneers and our Kenyan Colleagues treated 7.5 thousand patients in 8 clinics.2011

The UK team alone in 2013 was almost double

Combined with the Kenya HCPs NGOs and volunteers they treated and educated thousands more!

REVERSE CULTURE SHOCK

- This is something I warn most of the volunteers now.
- I did not expect to experience this after two weeks!
- Yet we all did! And it gets worse each time!
- Partly because we leave on a dark winter's day then return to the razzmatazz of xmas and materialism after two intense weeks of hard work, joyful new friendships and experiences, and a different outlook.
- You cant sleep without the bushbaby noise for a

Strategies

- We now make a point of debriefing one another within a week of our return. Nobody understands what you are feeling but the people you were with.
- As we are all over the UK Skype and Facebook is very handy for this and we have regular reunions
- Every picture evokes a memory but I encourage all to keep a journal and read it 2-3 mths later.
- The pictures remind us of what we have seen…. The journal reminds us of how we felt!
- One of the worst feelings is that nothing is finished and more needs to be done!

Nobody ever wants to say Goodbye!

We all say
See You Next Year!

So we carry on working from here !

- Within weeks of our 1st return we raised enough money to ensure that our Heroine Mama Tabitha had clean water for the 1st time in 30 years at her nurse led clinic in Muhaka where she has been on 24hr call for most of her professional life!

- Since then she now has some electricity and an

On-going Fundraising

- We are trying to fund a local girl to train as a nurse and serve the local community.
- We are trying to fund a local team of health support workers to keep a rolling jigger eradication and worming programme going long term
- We are trying to support a reusable sanitary towel programme to stop girls from missing school every month.
- We are trying to fund various youth groups, and women's groups to encourage education especially around HIV.

In just 8 weeks time we will be pioneering in Maungu , between Tsavo and Mombassa

- If anyone is interested in joining this year or next years programmes please Email me on

- kruddis@Hotmail.com

- If anyone is interested in donating to help nurses to get out there or

- Donating reading glasses/ umbrellas/ solar powered lanterns/ wind up torches, or money to further the programme or Kenyan nurse training
- Please also email me.

Asante Sana!

ANY QUESTIONS?

kruddis@hotmail.com