Volunteering and Learning in Mombassa

Kathryn Leggate, a first year Podiatry student at Queen Margaret University, Edinburgh, was awarded the Cosyfeet Podiatry Award 2009.The £1000 grant helped to fund her voluntary work in the slums of Mombassa, Kenya. Her report is published here.

Arriving in Mombassa after an eight hour flight, my feelings of anxiety, excitement and curiosity had begun to settle. I was ready for my adventure. The project I had volunteered for was targeted at individuals with some medical training. As a first year Podiatry student, it provided me with an opportunity to volunteer my skills in a developing country and increase my own knowledge along the way.

I was greeted at the airport by the volunteer coordinator, John. He escorted me to my accommodation and introduced me to my Kenyan host family. I was to share Mahaad and Zahra Hassans' home for a month.

Mahaad worked at Bomu Hospital as chief pharmacist. On the Monday morning, after a restful weekend, I received my induction to Bomu Hospital and met lots of people from various departments. It was a daunting prospect to have so many new names and faces to remember. Everyone gave me a warm welcome and made me feel part of the team instantly. Thankfully, the majority of staff members could speak English as my Swahili was far from perfect.

Bomu Hopsital aims to provide quality care in family planning, general medical care, antenatal care, and since 2004 provides HIV care to the poor living in urban Mombassa. It is the largest non-profit healthcare facility serving the shanty towns of Mombassa.

I was lucky enough to spend time in each area of the hospital assisting the doctors and nurses. Although my main interest is of course Podiatry, there is no Podiatric department within the hospital. Podiatry in general is not a well developed area of medicine in Africa. As a result, I had spread the word that if anything came through the door of a Podiatric nature, I would be delighted to be informed. This opened many windows of opportunity for me as the helpful, friendly work place ethic at Bomu Hospital revealed itself. The phone never stopped ringing and I was extremely pleased to become a regular assistant in the Diabetic clinic.

Patients came to their appointments with various problems, wounds being the most interesting to me. Patients often presented with diabetic foot ulcers and fungating wounds, their tissues broken down, forming a route of entry for bacteria.

One particular case encapsulated for me much of the endemic difficulties facing diabetic patients in Kenya. The patient, named Justice, was a 48 year –old male. He came to the

Diabetic Clinic at Bomu after being diagnosed as a non-insulin dependent diabetic by a private doctor in Mombassa. He worked in the docks as a baggage handler and often found himself feeling very tired, thirsty and suffering from increasing hunger. Justice had been prescribed Metformin but was not given the correct information about how to take his medication. His diabetes was therefore poorly controlled and was having a damaging effect on his body: the result of him having very high blood sugar for long periods of time.

Justice was under the impression that if he took all the medication prescribed to him and finished the course then he would be cured. When he came to clinic we had to educate him about diabetes and explain to him that the medications are not a cure and that he would need to take them for life. He was an intelligent man and once properly informed he understood the risks of his condition and the importance of controlling his blood sugar.

Justice felt let down by his previous doctor and had lost trust in medics. Only after a lengthy discussion was he willing and prepared to follow his prescribed regime. Justice's experience of the medical profession is not uncommon in Kenya. Doctors sometimes tailor treatment so that the patient will keep returning with problems requiring further consultation and treatments, all at additional cost to the patient.

I explained to Justice the importance of keeping blood sugars at an appropriate level and educated him on dietary choices and the importance of good foot health. I also encouraged him to check his feet regularly for changes in sensation, colour and circulation and proceeded to examine him. His diabetes had been poorly controlled for a relatively short time and no visible damage had been done to his feet. Justice had good colour, sensation, movement, pulses and proprioception. His feet did have severe fissures, however, which I explained were potential routes of infection into already vulnerable feet. I encouraged him to keep them clean, use emollients regularly, and to increase his fluid intake to help rehydrated his skin.

Whilst working in Mombassa I struggled on a daily basis with the fact that people would save against the odds to get medical help only to find they could not afford the ongoing cost of treatment. The sheer numbers affected were daunting.

In the Diabetic clinic I became quite skilled at dressing foot ulcers with the limited supplies that were available. We had only Betadine-soaked gauze and bandages to work with. Broad strain antibiotics were available to use when necessary. They were prescribed if patients presented with signs of infection, for example if the skin was hot to touch, red, swollen, itchy or if yellow exudate was present. If the patient presented with a temperature and potential systemic infection, they would be brought in for intravenous antibiotic therapy and observation to prevent it from worsening and becoming life threatening.

Once a wound was identified it was important to discuss its appropriate care with the patient. This became complex at times. Patients with very little money were unlikely to spend it on medications for foot care in favour of feeding themselves or their family. Even more so if their foot problem was currently manageable. As a result, great emphasis was placed on teaching the patient how to deal with wounds at home, so reducing the need for hospital visits.

We taught the importance of boiling water to sterilise it, waiting for it to cool and then using it to cleanse the wound. Even these very basic measures were, however, very difficult for many patients to carry out at home. Much of the population lives in unsanitary slum conditions, frequently sharing a home with livestock. In the rainy season it is common for rubbish to be swept through people's dwellings. The force of water running down the hills can even destroy people's homes altogether. The aftermath of the rains is a warm, moist environment which is a breeding ground for bacteria.

Around 20% of patients are immuno-suppressed. So what starts as a small graze, nick or cut can easily break down, becoming gangrenous within weeks. The saving grace for Bomu patients suffering from HIV is that all their healthcare cost are covered by the assistance of programme partners, donors and USAID sponsored organisations like Family Health International (FHI), Pathfinders International and the International Centre of Reproductive Health (ICRH).

A large number of patients attended the Diabetic clinic for wound care treatment. Working within the clinic gave me an insight into what to expect when I am a qualified Podiatrist. I gained a great deal of hands-on experience at cleaning, irrigating, debriding and dressing wounds. I learned to asses each patient as an individual, taking into consideration their social and home back ground, and whether they were likely or able to comply with instructions. Individual care plans were created for each patient so the best possible results were obtained for them. The whole experience was extremely rewarding for me.

At the clinic I would see patients with many interesting conditions. Some I had prior knowledge of, but many others were new to me. I got accustomed to the sight of onychomycosis within the toe nails and fingernails. This was evident by the thickening of the nail plate and yellow discolouration. People often came wondering what this was and why it had occurred rather than complaining of pain or discomfort.

Some patients presented with fevers from septic wounds. They frequently had pain and discomfort from lacerations caused by standing on sharp objects, jagged rocks or shells in the sea. Such injuries are more common in countries where the population cannot readily afford shoes. Patients were treated and sent home, with antibiotics if necessary, and with instructions on how to take their analgesia.

Other patients presented with problems caused by ill fitting shoes. Many wore shoes donated from the Western World and could not afford the luxury of properly fitting footwear. This encouraged onychauxis - thickening of the nail due to ill fitting shoes and toes becoming cramped and crowded as a result. Toe deformities such as claw toes or hammer toes, and blisters caused by friction, were also apparent among the patients I treated.

Even on our days off the work experience never stopped. John and Sammy, the volunteer co-ordinators, often gave up their Saturdays to help those who could not make it to hospitals or medical centres due to illness, poverty or the distance they were expected to travel. Through Sammy's church community, parishioners and local people would volunteer their skills to help others. I was fortunate to be a part of this on many occasions and travelled with them. We often drove for more than four hours on dirt track roads (if we were lucky enough to have roads at all) to reach our destination.

We would set up See and Treat clinics in slum areas, treating patients with basic supplies donated by local business people, or bought with funds raised by the Church. Doctors and nurses listened to those requiring medical attention, made diagnoses accordingly and provided on-the-spot treatment. For those patients requiring further investigations, appointments would be made at local hospitals.

HIV testing camps were frequently run alongside the See and Treat clinics. These tested people for HIV within slums and in schools and orphanages as part of the outreach programme.

Whilst working away at one of the See and Treat clinics I encountered a seven year old boy from the slums named Malambe Mwena. Malambe had been identified with walking problems from the age of 1 year when he was not achieving his usual milestones of growth and development. When all the other children his age were starting to walk, Malambe shuffled along on his bottom. Unable to weightbear, he mobilised and got around in a sort of 'bum shuffling' and dragging motion.

Malambe's parents saved and took him to a local doctor and his legs were bound up in plaster splints for two weeks. His family could not cope with the demand on their limited finances to assist him further, however. Medical treatment fell by the way side and Malambe did not recieve the care he needed to improve his condition. He was left with severe mobility problems.

Malambe could move around a tiny enclosure of 10m² with the assistance of a makeshift scooter that a local carpenter had made for him to use like a zimmer frame. This enabled Malambe to support his own weight and steady his balance. Due to the slum being at the bottom of a hill, and the surrounding terrain being unsafe for him,

Malambe was restricted to this tiny area in which to live. Here he ate, slept, washed and looked after himself when his mother was working.

On examination and gait analysis, Malambe presented with his head cocked to the left when mobilising, his shoulders uneven, the left lower than the right. His arm swing was impossible to assess as he was holding onto his frame for stability. His hips were uneven and he appeared to be hip hiking. Malambe's bilateral knees were internally/medially rotated. His right foot had a considerable amount of foot drop at times and did not always clear the ground during the swing phase of the gait cycle. His stronger, left leg, although weak and deformed, was the one he used to weightbear. The sole of his left foot appeared supinated, adducted, plantar flexed and inverted.

Malambe's mother, Mambe Mwena, aged 20, had to leave her son alone from 8am to midday each day in search of work in order to buy food. His father, who was HIV positive and an alcoholic, was away from home from 8am to 8pm daily looking for work, and spent much of his earnings on alcohol. He frequently arrived home drunk and argumentative, with disputes that needed to be settled by the village chief as mediator. Mambe expressed a desire to leave her husband and become self sufficient.

With the small amount of money that Mambe made from washing clothes, her diet and Malambe's consisted mainly of maize, peas, beans and wheat. Malambe's mother described him as a very intelligent, bright boy. She wished that he was able to walk, go to school, play with other children, and not be isolated.

Of all my experiences in Kenya, Malambe's case touched me the most. Staff at Bomu are aware of his condition and will do all they can to equip him for his life ahead. Until I am qualified and can offer further help myself to Malambe and others like him, I intend to donate to Bomu regularly. Bomu relies on supporters like myself to reach out to those in desperate need.

I really enjoyed and appreciated my time in Kenya and feel I learnt a great deal on a professional and personal level that I will carry with me for a lifetime. At times, though, due to not yet being a fully qualified Podiatrist, I did feel I was not as helpful as I might otherwise have been. I do intend to go back once qualified, to offer further help to people who cannot afford treatment, and to assist them to achieve a better quality of life.

If you have questions for Kathryn, or would like more information about donating to Bomu Hospital, email: kml94@aol.com

Kathryn with children at the See and Treat Clinic

Malambe

Patients wait to be seen

Kenyan Homes

Shoe Shopping Kenyan Style