Medical Humanitarian Mission in Kenya: Making a Difference One Life at a Time

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In May 2013 a team of 11 registered nurses, 1 physician, 1 physician assistant, 1 radiology technician, and 2 college students sponsored by Project Helping Hands (PHH; www.projecthelpinghands.org) traveled to Oyugis, Kenya, a small town in western Kenya near the Tanzanian border (Fig. 1). The community has limited health care services for a population of 55,000, and a building was erected 2 years ago to provide health care services to residents who live in the farming areas outside the city. It was here we would be holding our clinics. After a day's rest in Nairobi, we packed our supplies into vans and traveled 200 miles to Oyugis. As we bumped along dusty and rutted highways, the drive became the first of our many adventures on the trip. Our capable drivers were just as relieved as we were to arrive at our destination about 8 hours later.

The clinic site was a 3-mile walk from our accommodations, and as we arrived for our first day of clinic, we saw several hundred people sitting on the grass waiting for us (Fig. 2). Many had arrived before daybreak so they would be among the first to be treated. The team quickly set up tables and chairs for treatment stations, distributed supplies, and created a pharmacy. Staff members were assigned to the triage/intake area, treatment stations (Fig. 3), and pharmacy (Fig. 4) on a rotating basis during our time in Oyugis so each team member could experience the different components of care. Supporting us as translators were adult members of a community group in Oyugis and several university students from Nairobi. During our time in Oyugis, our physician and physician assistant also made house calls to treat persons too sick to be transported to the clinic. The intake team collected chief complaints, vital signs, and weights for children and assigned an acuity rating. They created a smooth flow of patients for the treatment station staff. Another successful strategy was having one team member available to begin treatment for a higher acuity patient if all the treatment stations were busy. In many cases the "float" team member administered antipyretic drugs and initiated oral rehydration therapy for children with suspected malaria.

Malaria is caused by the Plasmodium parasite, which is transmitted via the bites of infected mosquitoes. In the human body, the parasites multiply in the liver and hemolyze red blood cells, resulting in profound anemia and organ failure. Symptoms of malaria include fever, headache, and vomiting, and they usually appear between 10 to 15 days after the mosquito bite. If not treated, malaria can quickly become life-threatening by disrupting the blood supply to vital organs. Key interventions to control malaria include prompt and effective treatment with artemisinin-based combination therapies, use of insecticidal nets by people at risk, and spraying insecticide inside homes to control the vector mosquitoes.[1]

Malaria is rampant in the Oyugis region, and the team became very proficient in identifying malaria symptoms at intake. Children with high fever and signs of anemia (ie, pale conjunctiva and poor capillary refill) and dehydration were treated without delay by our "float" team member. After antipyretic drugs were administered and a rapid malaria test was completed, oral rehydration therapy was initiated. The children would then sit quietly on their mother's lap in the shade until it was time to recheck their status. It was very rewarding to see them respond to rehydration and leave the clinic feeling much better than when they arrived. We gave the families of the children with malaria antimalaria medication for all family members and mosquito nets for their homes to prevent further transmission and infection.

In addition to malaria, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is prevalent, and many children brought to the clinic for a check-up were in the care of an "aunt" or "grandmother"—older village women who were raising these orphaned children after the death of their parents. When a school-aged child was asked where his mother was, he replied softly, "In the morgue." She had died from AIDS the day before, according to the women caring for the child.

One of the greatest joys of our daily walks to clinic was being accompanied by the school children we passed along the way. They called us "Mzungu," which is Swahili for "white person." Each one would greet us with "How are you today?" and we would reply, "Fine, fine." As we walked the path to the clinic, we would find a small hand reaching up

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FIGURE 1
Oyugis, Kenya.

FIGURE 2
Patients waiting for clinic to begin.

to ours, and then another hand on the other side. A few feet more and we were surrounded by these smiling, cheerful children (Fig. 5). We took their pictures and showed them their faces, which caused them to squeal with laughter. The walk to the clinic was also a bonding time for the team. We worked nonstop while we were at the clinic, with a short break for lunch, leaving little time during our work hours to talk. During the 30 to 40 minutes it took us to get from our accommodations to the clinic, we got to know each other. At dinner each evening, each team member described a "high and low" experience during that day. During these conversations, tears often flowed as each person grappled with the enormity of the community's health needs, the desperate social disruption due to HIV/AIDS, especially for children, and the disparity between our lives and the lives of those among whom we were living. Despite the differences