Two weeks in Tanzania: how the other half lives

Dr Bernard Lee, a GP from East Hills, NSW, writes about his volunteer stint in Tanzania.

IT HAD been a long time since my mission to Banda Aceh after the tsunami in 2004. I was yearning to go on another volunteer mission but the length of time one had to take off from work was rather prohibitive. So I jumped at the chance when the DocTours brochure came across my desk: a two-week medical program plus seven-day safari in Tanzania. Perfect!

DocTours accommodates doctors with a local host family, which is the best way to learn about the culture.

Two weeks before my departure for Tanzania, I received a personal website page with information regarding the placement, country information, contact and accommodation details.

On arrival in Dar es Salaam, I was met at the airport by an employee of the local ground operator. Because of the traffic jams, it took more than two hours to drive to the hosts' house.

I was expecting to see a dilapidated hut, but not so. The house was a two-storey mansion with beautifully maintained gardens. There was a granny flat, where I stayed, with one bedroom, lounge and a kitchen.

After a quick shower – it had to be quick because it was cold – I had dinner in the dining room in the main house with the hosts, Roby and Martha, and their children Mariella and Reuben.

For the next two weeks I was to be working in Mwananyamala Hospital, a fair distance from our house. The other volunteers and I were shown how to catch a *bajaj* (auto-rickshaw) and *dala dala* (bus).

The dala dala must have been made for short people as there was no way a passenger over 5ft 10in could stand straight without hitting his or her head on the roof. We decided to use the bajaj for our daily transport.

I was the only doctor volunteering at the hospital at the time. There were nurses, paramedics, medical students, pre-medical and pre-dental students, a psychologist and a childcare worker. There were volunteers from Australia, the US, UK, Ireland, Holland, Germany and Luxembourg.

After we filled out the necessary forms, we were taken to a small cafe next door for lunch. That was my first introduction to *chips mayai* (chips omelette). This was to become my staple food for lunch for the next two weeks. I was too scared to eat salad, which gave some of the volunteers gastroenteritis, and I could not stomach *ugali*, a dish made from maize flour.

I was rostered onto the neonatal ward for one week and medical and emergency medicine for the second week.

Though we were working in a public hospital, the patients had to pay to see a doctor, for any drugs prescribed, and any investigations ordered. Patient compliance was therefore very poor because of financial difficulties.

All photos courtesy of Dr Bernard Lee

CLOCKWISE FROM TOP LEFT: **Dr Lee up close with the wildlife in Zambia during his stint in Africa; View of Dar es Salaam from the ferry bound for Zanzibar; A volunteer nurse cleans a baby suffering from burns at the hospital; A low birthweight baby is weighed.**

On the first day, when I had to collect blood from a child for testing and I was looking for a tourniquet, the nurse gave me a latex glove. I did not realise that it was to be used as a tourniquet. Then another nurse pointed out that it was the only form of tourniquet I would find in the whole hospital. I felt so stupid! Even these latex non-sterile gloves were hard to come by.

Often doctors relied on the backs of the hands to determine whether the patient had fever. The majority of doctors did not carry a stethoscope. On one occasion a doctor used a stethoscope that had the diaphragm missing. I wondered what he could possibly hear.

As is the case in many developing countries, several patients shared a bed. Can you imagine what this does to cross-infection? It was amazing to see several women huddled together on one bed, breastfeeding their newborn babies. The oxygen machine, likewise, could be shared by several patients at a time, just by joining the tubes.

I found out that the FBC machine had not been functioning for months. Only the haemoglobin level could be done.

The suture equipment was old and impossible to use. I was given a needle holder, suture needle and a scalpel blade to suture a vaginal tear following the delivery of a baby. There were no forceps. The needle holder would not even grab the needle. Local anaesthetic was not supplied and I tried my best to suture by holding the needle with my fingers, and with the woman clenching her teeth. This was a risky procedure, to say the least, in a country where HIV/AIDS was rife.

There was a ward full of patients with HIV. Luckily there was a department for treating HIV donated by the Americans, which supplied antiretrovirals and counselling services, while an Islamic charity supplied food for patients who had been abandoned due to their condition. Nowhere on the patient's file would one find that the patient was HIV positive. Apparently this was for confidentiality purposes. The file would only have the word "seropositive" written in one corner in small writing.

There were many children in the paediatric ward with burns sustained from hot cooking oil or stoves. Every day the nurses and parents cleaned the burns in the bathroom, and one can imagine the screaming children when they were being washed without any analgesic cover.

No procedures were performed in the emergency department. Patients were assessed by the doctors and given a script if they could be treated with medications. But if they required sutures or other minor surgery, they were sent to the minor theatre room.

If they required an injection, they were sent to another section, and to yet another for their blood pressure to be taken. Then they had to come back to the emergency room where they may or may not get to see the same doctor. The patient normally carried the notes from one department to another and at times the doctors would refuse to see them if they forgot to bring the notes. They just walked away without arguing.

Some doctors were on strike during my placement in Dar es Salaam. They were demanding better pay and conditions and also better equipment and medical supplies so that they could provide better quality of care for patients.

In order to make a tangible improvement in the health of the population, there needs to be better education, good nutrition and financial support.

However, the staff were all very kind and helpful. Despite the limited resources, everyone at the hospital seemed to manage with minimum fuss or complaint.

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