THE
message
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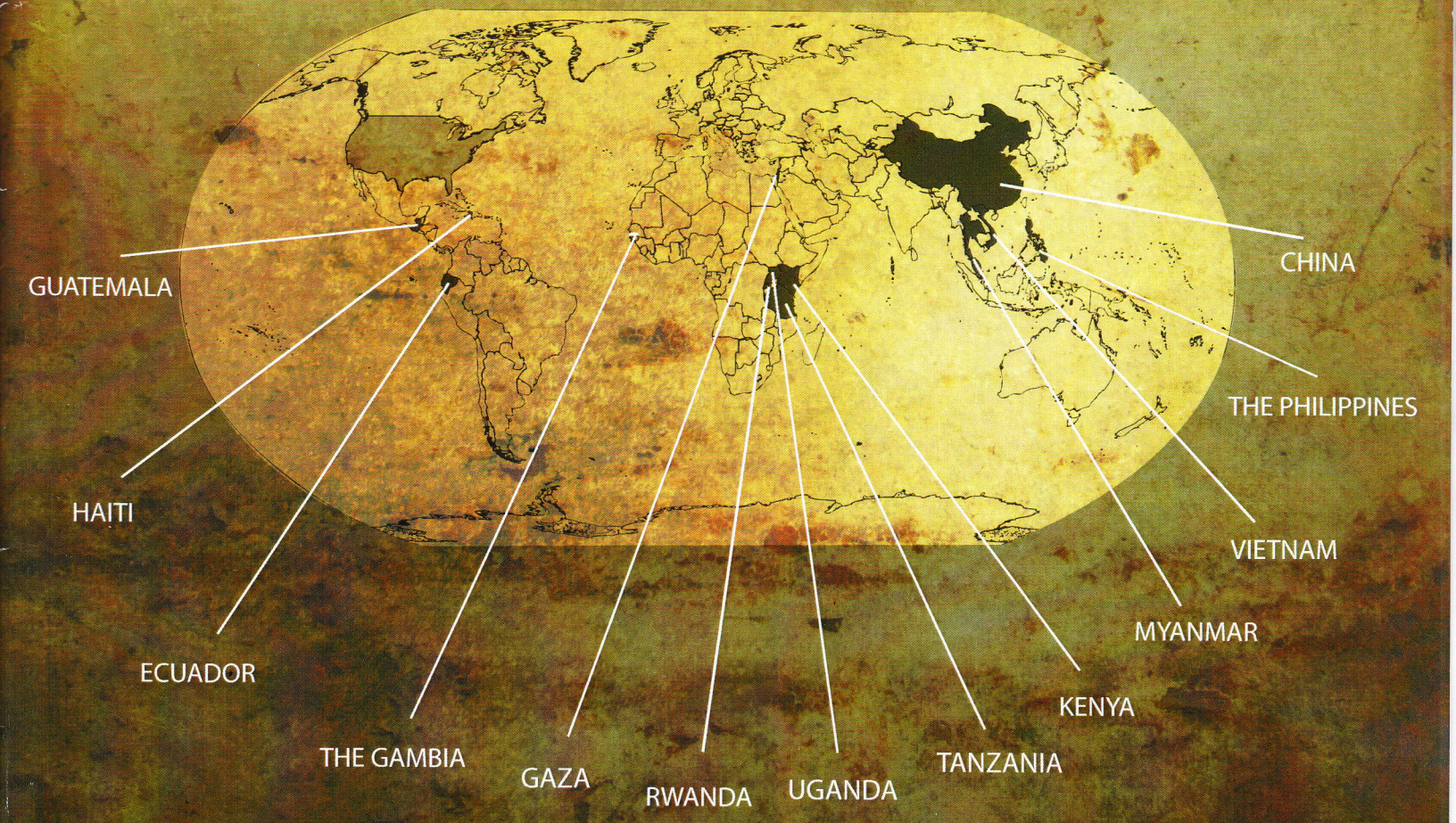
SPOKANE COUNTY MEDICAL SOCIETY – MAY 2012

Lending a Hand in Foreign Lands

By Terri Oskin, MD
SCMS President

VOLUNTEERING ABROAD



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In late March I had the privilege of traveling to Washington, D.C. in order to discuss my efforts with other young leaders from around the world at the Clinton Global Initiative University. On the back of such, two additional medical mission organizations in Haiti have agreed to work with me this summer in the implementation of their first patient record systems!

While this is just a first step, if temporary, mobile clinics in Haiti can transform from treating a patient on the basis of a single snapshot to treating a patient on the basis of a greater picture, we are one step closer to ideal. What's the next step? Working to incorporate the local clinic in the travelling clinic's work. This provides for the continued care of the patient after the foreign volunteers have returned home, and creates an immediate leap forward in the long-term recovery of the entire country, medically, structurally and economically, as it recovers from the combined disasters of recent years.

If you have any information or other help to offer that could assist in my modest, but quickly growing efforts to implement patient record systems in the travelling clinic, please be in touch! isher@u.washington.edu

From Spokane to Kopanga, Kenya

By Debbie Stimpson, PA-C and Kari Holman, PA-C

"Coming together is a beginning. Keeping together is progress. Working together is a success."--Henry Ford.

With this in mind, Physician Assistants Kari Holman and Debbie Stimpson joined a Spokane based non-profit organization, Partnering for Progress (P4P). Debbie specializes in HIV and Kari in pediatrics. They traveled to Kenya, where they provided medical care for both adults and children. The two PAs spent a week at the clinic, along with two other medical providers. The team examined and treated over 400 patients in one week! In addition to providing medical care, there were 10 other volunteers on the team who provided health education, eye care, water sanitation and engineering consultation and administrative support for the clinic.

The mission of P4P is to help provide access to healthcare, basic health education and clean water to people in developing nations. For the past four years the focus has been on the remote village of Kopanga located in western Kenya. P4P aims to be a catalyst for change, rather than a crutch. The goal is to enable communities to break the long-standing cycle of poverty and poor health, with the ultimate goal of creating a sustainable future for the people of Kopanga.

The clinic was funded by P4P and built in 2008. It is the only significant structure, seen in a countryside dotted with plots of corn, tobacco and other local crops. The clinic is made of mud bricks with a stucco finish and a red tin roof, whereas most other structures in the region are mud huts with a thatched roof. Water is drawn from a nearby well that P4P funded and electricity recently reached the clinic. It's about a 45-minute drive on a windy, bumpy, dirt road from the closest town and an eight-hour drive from the major city of Nairobi. The clinic has several rooms, connected by an open-air walkway, including four exam rooms, a lab, a pharmacy, a larger observation room for overnight hospital stays and a storage room for medical supplies. A two-stall outhouse nearby serves as the latrine. The clinic has a profit margin so it can become self-sustaining. The visit fee while the P4P team is at the clinic is 50 shillings ($.50) and this includes all medications. If a patient needed to be admitted to the observation room, the charge was 250 shillings ($2.50) per day.

Patients arrived at the clinic as early as 6:30 in the morning and some would wait to be seen until late afternoon without water or lunch. By mid-morning, the "waiting tent" (see photo) would be at full capacity.

Kari's Perspective - Pediatrics in Kopanga

It was not uncommon for as many as nine mothers, with babies swaddled to their backs, to be patiently waiting in my exam room for their turn to be seen. Often, the older children were tending to their infant siblings. No tantrums. No fussing. No screwing around. They would just wait quietly. The Kenyans taught me a true lesson in patience. Extreme patience!

Malnutrition seemed less prevalent than I anticipated. From my observation, many older children and adults were undernourished, not malnourished. The highest risk group for malnutrition was children from 6 months to 2 years old. In fact, in this age group there were several cases of severe malnutrition.

The most common causes for malnutrition were that the mother couldn't keep up with the child's nutrient demands (for example, twin gestation, exclusively breast feeding when a child should be on solids and breast milk or poor caloric density of breast milk) or the child's metabolism and nutrient requirement was increased secondary to disease (most commonly malaria, typhoid, or intestinal parasites).

The climate there helps prevent famine; since Kopanga is near the equator they grow crops all year around. Common crops include maize (corn), cabbage, bananas and tomatoes. They can get fish from Lake Victoria. Beef, chicken, and eggs were a treat. The cash crop was tobacco—thankfully, I never saw anyone smoking it!

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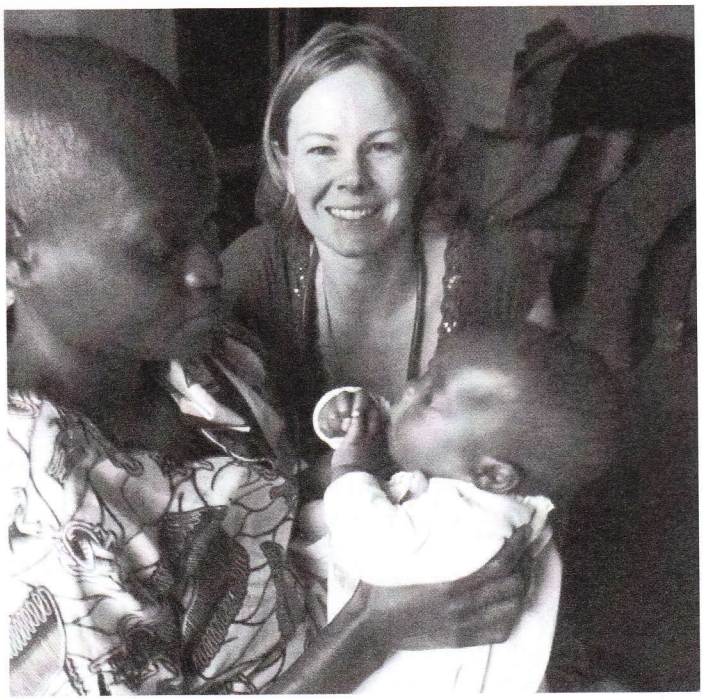
As you look out across the fields there are women and children tending to the crops. Since many women are doing intense physical labor in the fields, in addition to packing water on top of their head for miles to provide for their family, they often burn more calories than they can consume and this leads to poor breast milk supply.

Thus far, our approach to combating malnutrition is to provide formula supplementation after each breast-feeding for infants less than 11 months. Children six months and older can also receive high calorie oral supplement packets. We also instructed mothers with prevention tips, such as starting solid food intake at six months of age, continuing to take prenatal vitamins and increasing mom's calorie intake while breast-feeding.



Kari Duclos Holman, PA-C talking with mother and child

I was able to show Alice Wasilwa, the Kenyan nurse who founded the clinic, how to improve nutrition assessments by weighing and measuring each child and plotting their growth curve.

Although that sounds simple, keep in mind that the clinic lacks so many basic tools and equipment we take for granted in the USA. In fact, we supplied them with a measuring tape this visit.

Alice is also doing a good job with childhood immunizations that are supplied by the government. They are virtually the same as here, with the addition of yellow fever.

Debbie's Perspective - HIV/AIDS in Kenya

When we arrived at the clinic the first day of our November 2011 trip, Alice immediately ushered me in to see a very sick patient. As the "HIV Specialist", she hoped I would have some answers. This man was end-stage AIDS with a severe headache, fever and dehydration. He had received some IV fluids but needed IV medications along with head imaging and a definitive diagnosis! All I could do was treat empirically with available local medications. It was too little too late; he passed away during the night.

HIV infection rates are reported to be 7% of the population in Kenya. In the Migori region, the rate is estimated at 14%. In the village of Kopanga the infection rate is above 20% - during one three-month period 54 adults and 50 children were diagnosed with HIV. The rationale for the higher rate in this rural community includes a number of factors - immigration from neighboring Tanzania, vicinity to Lake Victoria and its fishing trade, as well as poverty are among those identified.

Nine months ago the clinic was designated as an "antiretroviral therapy" clinic (ART) by the Kenyan government. This was happy news as Alice and her staff can provide HIV medications and HIV care to the patients they diagnose.

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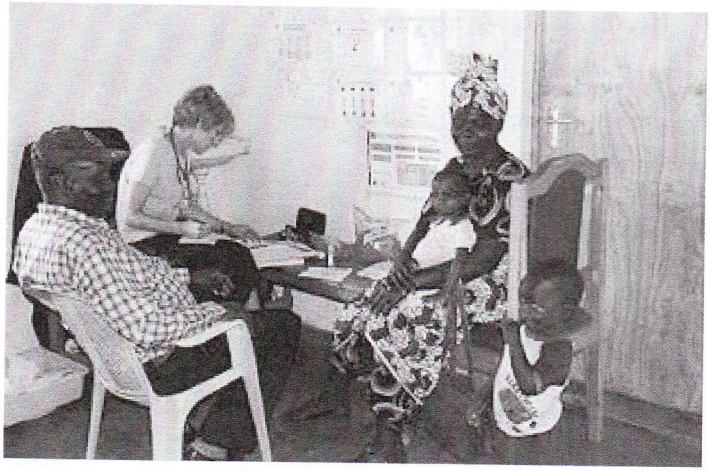
Prior to this designation, Alice had to send all newly diagnosed HIV patients to clinic 5 km away to receive HIV medications and care. Alice's clinic had so many new HIV diagnoses that the other clinic could not handle all the new patients. After someone is diagnosed with HIV/AIDS, there is extensive counseling provided on follow-up visits to help the patient adjust to the diagnosis, tell sexual partners about the HIV diagnosis and learn about the strict adherence needed for the lifetime of HIV medications.



Debbi Stimpson, PA-C with patients

As resources have improved in Kenya, the more toxic HIV medications have been phased out and less toxic medications have become the standard of care. Medications are provided free of charge by the government. There is not a second line treatment for those patients who fail first line and medication failure with resistance is emerging. Resistance testing and additional HIV regimens will need to be added. I have worked with Alice and her staff to enhance HIV/AIDS care in many areas including antiretroviral toxicities, how to decrease HIV transmission to infants post delivery and identification of physical exam findings that suggest HIV and opportunistic infections.

I have seen a noticeable change in the attitude, awareness and education regarding HIV/AIDS since my first trip to Africa in 2006. The new generation of young people are addressing the challenge and becoming leaders in the fight against HIV/AIDS. At the high schools when the team visits to provide education, they clamor for in-depth information and ask hard questions. They seem intent on winning this battle.

In Conclusion- by Kari and Debbie

Overall there were very few chronic illnesses, but there is a huge need for preventive medicine and simple acute treatment regimens! Malaria, typhoid and HIV are common diseases. We must admit that it was refreshing to never see childhood obesity, metabolic syndrome, COPD, or drug addiction!

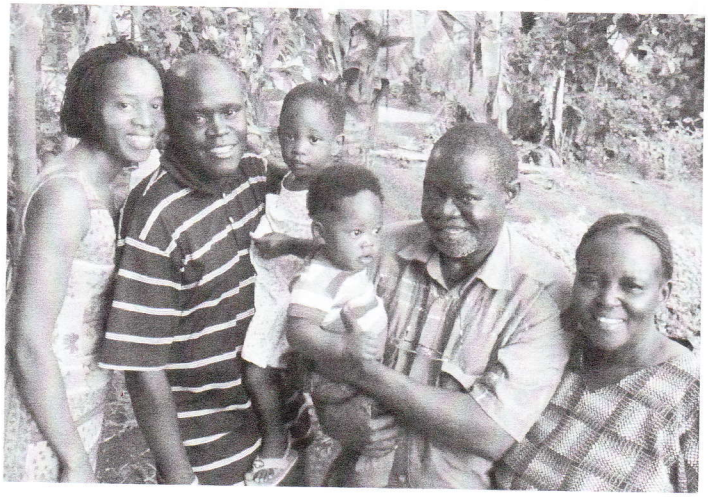
As we expected, there were many stories of extreme poverty, but nothing prepared us for how warm the embraces and greetings were from everyone we encountered in Kopanga. We've never seen so many smiles or shaken so many hands -- and we're not talking about a cursory, two-shake, howdy greeting – this is a warm grip that doesn't let go until the greeting is completed with a hand-to-the-wrist signifying respect. By the time you meet someone a second time, the handshake was usually converted to a full hug! No matter the age, a greeting is an event in itself! An event that we may be missing out on here in our American culture, with our fast paced life.

For an overview on P4P and to learn how you can be involved and offer your support, visit: www.PartneringForProgress.org. If you would like to hear more about our personal experience in Kenya, you can contact Debbie Stimpson at stimpsd@intmedspokane.org or Kari Holman at kariduclos@yahoo.com.

Spokane Physicians Sponsor Children in East Africa

By Sam Palpant, MD

Seven year-old Philip Kivunike and his parents waded across the Malaba River between Uganda and Kenya during the night, with Idi Amin's soldiers in pursuit. Philip's dad found a teaching job at the lowest salary as a refugee. Philip and his siblings attended school in Kenya. They returned to Uganda after the overthrow of two brutal dictators. Philip proved to be an able student. When he was accepted to Kampala's Makerere University, a Spokane physician agreed to pay his tuition. Now a prominent architect in Kampala with his own business and about 10 employees, Philip is project manager on a government contract to build a giant hangar for C140 transport planes and jumbo jets.



Philip Kivunike and family

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