Medical Challenges in Sudan

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Working with Médecins du Monde, Dr. Kushner spent 12 weeks working for a mission in Malakal, Sudan. This article, written as a journal, is his account of the first six weeks. Through his work, Dr. Kushner has helped many and witnessed the impressive ability of doctors in Malakal to work in stressful and sub-par conditions. He also came face to face with the cholera crisis and worked to get support and supplies for a second Cholera Treatment Center site.

It is the end of my first day in Malakal, Sudan, but all that matters now is the orange streaks accentuating the indigo hues of the clouds, darkness slowly descending after the sunsets, and the almost palpable silence. Across the river, a flat plain extends for miles. Lada grasses and shrubs are no houses or signs of activity; it looks like a no-man’s-land. On one side, the river bends, a tangle of activity a slowly commingling. Long, metal, cowlike boats discharge their passengers and bound-up, bongo drums and kikiki bundles of bawu, bafa, and sanfafa—the building materials throughout the region. The pilots are stacked and stretch in random patterns along the shore. Traders and passengers amble, closely packed, by some climb into smaller boats and head further up or down the river to neighboring villages. Malakal, the city where I will stay for the next two to three months, is considered the gateway to southern Sudan. It is the capital of the Upper Nile state and home to more than 150,000 people. With a peace agreement reached in August between the North and South’s civil war that lasted for more than two decades ended, Daily, more and more refugees return to the south seeking jobs and a way to rebuild their lives. They also return to unstable numbers of inmates. But at the time of day the Nile is quiet. Masses of green and brown resilience and other debris—small floating islands. “You don’t need to be a wizard to train rats. You need only to repeat a lot of patience. And in case one of my animals has a problem that I don’t know how to deal with, there are always experienced instructors around to help me out,” he says.

For additional references for this article, please visit http://www.jmu.edu/journal/10.1/weetjens/weetjens.htm/#addlrefs. See Endnotes, page 112.

Bart Weetjens

Working with the Mine Action Information Center, his focus is the development of the direct detection concept and the coordination of the Subsistence Project. Bart Weetjens is a product development engineer and a practicing Zen monk.

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On the way to the guest house, other staff members and I pass the back of the hospital and the office of Médecins du Monde (the choice of you like me, who are rather francophile-challenged: Doctors of the World). MDM is a humanitarian assistance organization, founded in 1905 by former Médecins Sans Frontières (Doctors Without Borders) staff. I am currently working for MDM.

Working in Malakal

The mission in Malakal is to improve the surgical services at the Upper Nile State Teaching Hospital, a 14-bed, government-run facility originally built by the British in the early 1900s. It is the only government hospital providing surgical services to the inhabitants of three states: Upper Nile, Jonglei and Unity. Funding for the current project is provided by the French Embassy in Khartoum. The scope of the project includes building new operating rooms, providing new surgical equipment and supplies, and developing a training program to improve the knowledge of the local surgeons, anesthesiologists, gynecologists and nurses.

My responsibilities focus primarily on working with Dr. Mamou, the local Sudanese general surgeon, and his surgical assistants, I must admit, on my first day, I was rather impressed. I have a fair amount of Third-World experience, and I’m sure most of you would be horrified by what I saw. In fact, in some ways, Kamu Central Hospital in Malakal looks a bit like the Mayo Clinic in compassion, but contrast the context: Malakal was sans-dah in the middle of a 24-hour war zone. Sure, things are better now, but if anything, the financial situation for obtaining supplies has deteriorated. So the issue is what are they doing with the limited resources they have? And what is the outcome.

Well, that is where I am really impressed. In January 2006, they recorded 327 cases, 56 were appendicitis, but they also did eight Bypasses, six gallbladders and five prostatectomies. In addition, postoperative wound infections are almost unheard of. Basically, they are doing an amazing job with very minimal resources. My role is to help them improve on what they already have. As far as the care of the surgical services, I really give Dr. Mamou a lot of credit. Trained in Khartoum, he has his madar, late-40s, and has been in Malakal for three years.

After finishing rounds on my first day, we went to Canterbury to check on a new admission. We were free to do so because all elective operations were cancelled due to lack of sterile drapes. The reason, from what I understand, is that very few sterile drapes were made during the evening from 7 p.m. until midnight, but since there had been no case since the night before, the drapes and gowns could not be sterilized. Ah, life in Africa.

It turned out to be good that the ward were busy. One newly admitted patient was a young man, maybe 18 or 20 years old, lying on a matress drummed up nearby. A number of his head and upper half of his body were wrapped in bandages. It was a Type-III landmine victim.

Despite the fact that Malakal is near some of the fighting, relatively few people know to stay away from the fighting. On rounds, we saw a few of people returning to Malakal and treating injuries as usual and exploring. It’s a sad fact that this is a common occurance after land mines.

What most struck me was the number of people returning to Malakal and treating injuries as usual and exploring. It’s a sad fact that this is a common occurrence after land mine injuries in many areas around the world. The Third World, this case may have been the most important. The surgeons here have experience in war surgery, and although I certainly have had many years of experience in war surgery, I am not focusing on landmine casualties. I do general surgery. A few cases had to be cancelled due to lack of enough sterile drapes and gowns. We strided into surgery, sufficient drapes, or forceps with teeth. However, I am told that a batch of new instruments is being sent from Paris in a week or so—the supplies will eventually be welcomed. In addition, work on the new operating rooms is proceeding nicely and they will hopefully be completed soon. This lack of supplies or new operating room has, of course, not really limited our operating; we managed to do numerous appendectomies and hernias, a few cholecystectomies, thyroidectomies, a burn contracture release and skin grafts, a

In speaking with the head of the United Nations Mine Action Service here in Malakal, I find he feels that once the rains begin and the ground settles, there will be a significant increase in the number of landmine injuries. In the past two months, there have been seven victims brought to the Malakal Hospital. I have operated on two; the soldier I saved was above shrapnel (whose limbs I was able to save), and a six-year-old who required an above knee amputation. A third child is also on the ward recovering from injuries he suffered after playing with a piece of unexploded ordnance. I was told the other victims were very severely injured and died soon after admission.

To understand the landmine situation more clearly, I have also spoken with the UNMAS folks about making sure the victim data is incorporated into the Information Management System for Mine Action databases. For those of you who don’t know, UNSMA is a global standardized database that collects information on landmines and unexploded ordnances. It, too, has a victim component. In addition, I am hoping to get a better hospital surveillance program on victim data established and have also written a proposal to get a workshop of surgical consumables in place for aid and when we begin to receive large numbers of landmine victims. Data shows landmine victims utilize vast amounts of hospital resources, and we need to be prepared for such a disaster.

As far as helping, there has been the usual funkumore of operating in suboptimal conditions. While here, I am not focusing on landmine casualties. I do general surgery. A few cases had to be cancelled due to lack of enough sterile drapes and gowns. We strided into surgery, sufficient drapes, or forceps with teeth. However, I am told that a batch of new instruments is being sent from Paris in a week or so—the supplies will eventually be welcomed. In addition, work on the new operating rooms is proceeding nicely and they will hopefully be completed soon. This lack of supplies or new operating room has, of course, not really limited our operating; we managed to do numerous appendectomies and hernias, a few cholecystectomies, thyroidectomies, a burn contracture release and skin grafts, a
The presence of landmines all over the world is an issue the United Nations and other world organizations are trying to address. But the difficult question lies in how to find landmines that are undetectable using metal detectors, making it personal.

Another Landmine Incident

Saturday night, while walking to our favorite grilled goat restaurant, I was informed about another landmine/UXO accident. I immediately went to the hospital and discovered four nine-year-old boys who had literally been playing in a minefield (about 100 yards from their houses) and who had only suffered injuries. One was yelling in pain, had a large chunk of his shirt catching on fire. The last boy had a few scratches. The other two had more severe injuries. One was yelling in pain, had a large chunk of his shirt catching on fire. The last boy had a few scratches.

The Bad News

So, it all sounds fine and dandy, and not too difficult. There are local nurses to assist with the majority of the work and the doctor merely supervises. Well, the problem is we are in Sudan. Which for those of you who hate, is in Africa, where things never really go as planned. An additional guideline for me is that I don’t speak Arabic or the local languages of Shilluk, Dinka or Nuer. This lack of communication adds to the frustration of working in over 100 degrees Fahrenheit in the middle of a hot, dusty stadium to contain fluid, intermittent vomiting and diarrhoea. Sure there are beds with large holes in the center and buckets placed under them, but often they do not collect all the fluid. Patients, especially little children, vomit on the beds or the floor, and occasionally on the staff.

Getting Through CTC

Many medical challenges in Sudan are beyond our control. Today, however, 21 more cases were reported with one death. Hopefully things will remain under control.

UNMAS has agreed to fund our proposal for the survey of UXO. They have agreed to 12,000不够 enough surgical supplies to treat 100 landmine victims. Due to the change in funding sources for the local Ministry of Health from Khartoum to Juba, no one is certain that the current hospital supplies will be replaced. I was excited to hear the project was approved as a quick-impact project, and it was quickly approved within two weeks of writing the proposal. The supplies should be delivered within 10 days.

We have found that people are building homes closer and closer to the minefield. Last week three were even more landmine victims. Two young girls were slightly injured when a goat detonated a landmine close to where they were squatting. Their wounds were dressed at the hospital and they did not require an admission.

The Cases started arriving a week and a half ago, and so far over 500 patients have been treated at the MSF Cholera Treatment Centre. After we were notified about the arrival of numerous cholera patients, we stepped up our Thursday morning visit to see if MSF needed any help. They stated that they were desperate for more medical personnel. So, being part of Medical Personnel, myself I felt my services were needed (the approval of MSG). For four days, or actually three days and one night, I worked in the MSF CTC. Let me tell you, it was certainly eye-opening.

The CTC is set up in the local soccer stadium, a large expanse of dusty and dry, cracked ground. The entire area is enclosed by a corrugated metal fence, which is helpful in keeping people away from the infected patients; however, there are four entrances to the stadium and people and goats continue to enter despite the armed police stationed at the entrance. In the stadium there is a grandstand on which patients are playing cards and in the south part of it is a mass of tents and plastic sheeting. The CTC is divided into four zones—one each for observation, recovery, for hospitalization, and for the staff and supplies. Sprayers are set at the entrance and a central point in order to spray everyone’s hands and feet with a dilute chlorhexidine solution in order to limit contamination.

In theory, the medical care for a cholera patient is fairly easy and basic. Patients are admitted with severe diarrhoea, suffering and evidence of dehydration. The way to treat them is with fluid, lots of fluid, and then more fluid. And then when you think they have had enough and are beginning to drink, you make sure they are getting more fluid. Now when I say fluid what I mean is Ringer’s solution, an electrolyte mixture given intravenously. Most guidelines say about 6 to 11 quarts per patient.

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Getting Through CTC

The language barrier prevents me from efficiently communicating with many of the nurses, the patients and the caretakers of the children. Sure, I am learning some phrases, and although they were helpful in...
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As my stress increased, I realized that not only were the nurses not continuing IVs, but that nurses, and apathy of the caretakers was almost too much to bear. I must admit, it was by far one of the most horrible days of my life. But at all events, we did it. Finally ended.

Overwhelming Cholera Crisis

I had my return to the CTC and the following evening for the night shifts. By this time we were all aware that the cholera crisis was beginning to overwhelm the MSF site. Rouman (one field co-ordinator) had been in contact with the MDM headquarters in Paris and a decision was made to send an emergency wagon to Malakal and set up a second MDM CTC. Monday was spent going around town trying to get support and material for the second site. As the surgery project is so small, our available resources and personnel are severely limited. In fact, we only have one vehicle. And yes, it is white with the MDM logo on the side as all non-governmental organization vehicles should be.

News Brief

“Colombia without Mines” Concert Held

Juanes, a South American singer-turned-activist, recently held a Colombia sin Minas (Colombia without Mines) concert. The event raised money to support Colombian children harmed by anti-personnel landmines. A native of the country, Juanes, performed May 24, 2006, at the Gibson Amphitheatre in Los Angeles, Calif.

Also appearing were Alejandro Sanz, Ana Gabriel, Carlos Vives and others. The concert denounced the use of landmines, raised awareness of the landmine danger to children and provided assistance to children in need of prostheses.

Juanes is a long-standing supporter of mine action, and the concert was organized by his Mi Sangre (My Blood) Foundation. Other groups also pledged support for Colombia sin Minas. The Wheelchair Foundation agreed to donate wheelchairs totaling double the value of money raised through ticket sales. Sponsors for the concert included Univision Television, the Colombia Coffee Federation, American Airlines and Red Bull energy drink.